ProviderOne for the WA Cares Fund

GETTING STARTED AND BILLING ESSENTIALS GUIDE

INTRODUCTION

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority (HCA) or Department of Social and Health Services (DSHS) rule arises, the rule supersedes.

This guide provides a step-by-step resource to help registered WA Cares Fund providers ("providers") and billing staff understand the topics named in the table of contents below.

The billing guide is written in English, however, online tools such as Google Translate, Microsoft Edge Translate Feature, and Adobe Acrobat's AI Assistant allow you to translate documents into a different language. Providers whose primary language is not English may find these tools helpful when viewing the guide.

Note: Be advised that online translation tools may not provide accurate translations. DSHS and HCA do not endorse these tools and cannot guarantee their accuracy. The official, authoritative text is the original English version. DSHS and HCA are not liable for any loss or damage arising from the use of online translation services. If you have questions regarding the contents of this document, please reach out to a WA Cares team member.

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GETTING STARTED

General

- "OK" signifies a Yes response and "Cancel" a No Response
- Asterisk (*) denotes a required field
- "%" acts as a wildcard, returning information that corresponds with the current search
    - For example, if searching for authorizations for multiple locations you could enter your seven-digit Provider ID and add % to the end in order to return all authorizations for every location under your ProviderOne domain
- Make sure your pop-up blockers are turned off on the browser (i.e., Chrome, Edge) you use to access ProviderOne
    - If pop-up blockers are not turned off, it will cause errors when submitting claims
    - If you choose to turn pop-up blockers back on when you are not using ProviderOne, remember to turn them back off when you are using ProviderOne
    - Each specific browser has their own instructions on how to turn off pop-up blockers
- Regularly clearing your browser history (cache) will help the overall performance of ProviderOne
- Clearing browser history does not delete saved favorites, bookmarks, or passwords
- Columns can be sorted from A-Z or Z-A by using the controls below the name of each column:



Passwords and security questions

The first time you log into ProviderOne you will be required to change your temporary password and create a security question. Please note passwords and security questions are case sensitive.

When creating a password for ProviderOne it must:

- Be at least eight characters long
- Contain at least one letter
- Contain at least one number

- Contain at least one special character (!@ # $ % ^ & * ( ) _ + - < >)
- Not be the same as your last five passwords

After three unsuccessful attempts to login, your domain will be locked. You can unlock and reset your password by emailing provideronesecurity@hca.wa.gov.

When you update your password, you will be asked if you want to update your secret question. You can change it at this time or select "No."

Note: As a security measure, ProviderOne passwords must be changed every 90 days.

ACRONYMS AND DEFINITIONS

AAA means Area Agency on Aging.

Beneficiary means a qualified individual who is age 18 or older, has been determined to meet the minimum level of assistance with activities of daily living necessary to receive benefits through the trust program, as established in this chapter, and has not exhausted the lifetime limit of benefit units.

CARS means Collections and Accounts Receivable System. CARS is the system the DSHS Office of Financial Recovery uses to manage provider debt (overpayments).

COFF means CARS Offset (lien).

DDE means direct data entry.

Domain is also referred to as **ProviderOne ID**.

DOS means date of service.

DSHS means the Department of Social and Health Services.

EFT means electronic funds transfer. This is when funds are deposited directly into a banking account for claims payments.

HCA means Health Care Authority. HCA is WA State's Medicaid agency. HCA is in charge of managing the ProviderOne system.

HCLA means Home and Community Living Administration. HCLA is a newly formed administration within DSHS effective May 1, 2025.

HIPAA means Health Insurance Portability & Accountability Act

MOS means month of service.

NOC means non-offset to CARS.

NPI means National Provider Identifier. Most social service vendors are not required to have an NPI.

OFIN means the Oracle Financial System, which is a part of ProviderOne.

OFR means the Office of Financial Recovery.

P1OFF means ProviderOne Offset (claim adjustment).

PHI means protected health information.

ProviderOne or P1 means the Medicaid management information system (MMIS) utilized by WA State.

ProviderOne ID means a seven-digit ID assigned to each provider's ProviderOne account. Also known as the **Provider Domain ID** or **Domain**.

RA means remittance advice. RAs provides details about paid, denied, adjusted and in-process claims submitted in ProviderOne.

TCN means transaction control number. A unique tracking number assigned to each claim (also known as the claim number).

Warrant means a paper check issued for claim payments.

CONTACT INFORMATION

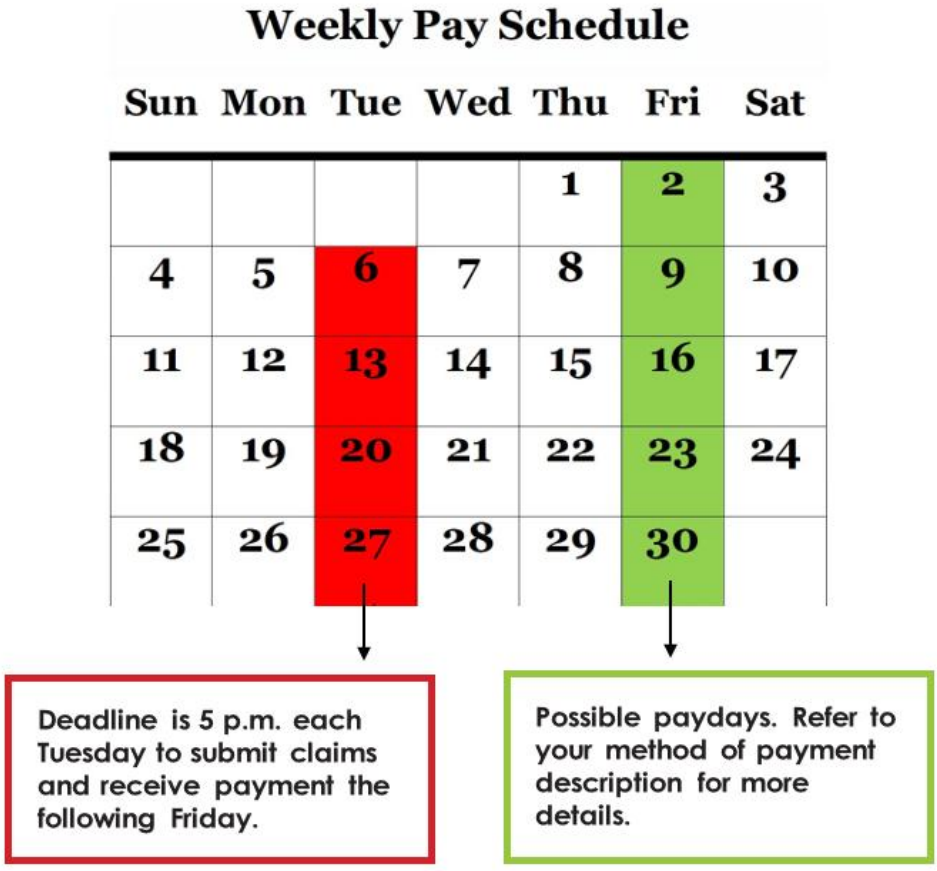
Description of issue…	Contact…
I created a pre-authorization, but the beneficiary has not approved or denied it in their WA Cares account.	The beneficiary! The beneficiary's circumstances may have changed, or they may need a gentle reminder to take action on the pre-authorization.
I am having trouble creating a pre-authorization, including issues with dates, units, or rates. The pre-authorization I created is "in error" status. Direct data entry (DDE) basic billing and claims assistance. Creating claim templates or using template batch billing. Resolving payment issues (lost checks). Navigating ProviderOne. Setting up additional users, profiles, or system administrators.	Health Care Authority--Medical Assistance Customer Service Center (MACSC) Phone: 1-800-562-3022, choose Option 4, WA Cares Fund Provider. Hours: 8 a.m. - noon and 1 p.m. - 4:30 p.m., Monday through Friday. Online: Contact Us – WA Cares providers
I need support with setting up my ProviderOne account. I am a ProviderOne-enrolled medical provider, and I need to update my business license, taxonomy, NPI, or DOH-issued license. I want to set up electronic payments (EFT). I need to update location addresses, email addresses, or communication preferences.	Health Care Authority--Provider Enrollment Phone: 1-800-562-3022 ext. 16137 Phones are open: Tuesdays and Thursdays from 7:30 a.m. to 4:30 p.m. (Closed from noon to 1 p.m.) Online: HCA Support For account creation, visit P1 Contact Us and select the topic "ProviderOne Access Request Form." Complete and submit this form. If you are not a medical provider with an NPI number, enter "N/A" in the NPI field.
I am a medical provider, and I need a core provider agreement	Enroll as a provider | Washington State Health Care Authority

Description of issue…	Contact…
with the Health Care Authority to begin using ProviderOne.	
I need help accessing ProviderOne after initial setup. System Administrator assistance (e.g., setting up new access, changing system administrator, setting up additional users, password reset, locked out).	Health Care Authority—ProviderOne Security Email: ProviderOneSecurity@hca.wa.gov Online: HCA Secure form
I am a nonmedical provider, and I need help with .dat file claim submissions and adjustments.	Health Care Authority--HIPAA Help Desk Email: hipaa-help@hca.wa.gov Subject line: "WA Cares Fund .dat Batch Upload" In the body of the email include your: Name ProviderOne ID/domain Name of the batch file you are referencing "SOC.xxxxxxx.20150131xxxxxx.SAMPLE_BATCH.dat" Description of your issue or what you need help with Your telephone number if you request a return call
Overpayment questions	DSHS Office of Financial Recovery Phone: 60-664-5700, option 3; 1-800-562-6114; or 1-800-833-6388 (TTY WA).

CLAIM SUBMISSION DEADLINES AND PAY DATES

You may enter claims at any time before the timely filing deadline. Providers must submit a clean, error-free claim no more than 60 calendar days after the end date of the pre-authorization. Claims submitted by **5 p.m. pacific time on Tuesdays** will usually pay as follows:

- If you have EFT, your payment transfer should be initiated on Friday of the same week.
- If you are paid by warrant (check), it should be put in the mail on Friday.
- Holidays and ProviderOne maintenance may impact the claim submission deadline and pay date.



To see a list of your paid claims, view your Remittance Advice (RA). New RAs are available in ProviderOne each Friday. See the View and Download RA for more information on viewing your RAs.

Note: Claims successfully entered after the weekly deadline of 5 p.m. on Tuesday will pay on Friday of the next week. If the claims deadline is changed due to a holiday, an alert will be viewable in ProviderOne in your alert list and communicated via email.

Holidays may delay receipt of paper warrants dependent on mailing schedules. Check with your local post office for more information about holiday mailing schedules.

WHAT IS PROVIDERONE?

ProviderOne is the system used by WA Cares providers to create pre-authorizations and claims. ProviderOne is also the payment system for most Medicaid-funded Medical and Social Services in Washington State. The Health Care Authority (HCA) oversees the ProviderOne system.

As a registered WA Cares Fund provider, you will receive payment for authorized services by claims in ProviderOne.

One of the first things to do as a new provider is to ensure that you have access to your ProviderOne account (also known as your domain). The next few pages explain how to access and log into your ProviderOne account.

Note: It is important that your popup blockers are turned off while using ProviderOne. See How to Turn off Popup Blockers.

Accessing ProviderOne as a nonmedical provider

Once your DSHS contract is in signed status, information to create your ProviderOne Domain is sent to ProviderOne.

Note: Once your account is active, the Health Care Authority will mail a welcome letter with information on accessing your account by completing the ProviderOne Access Request Form. If you already have an established ProviderOne account, WA Cares will be added to your ProviderOne account after contract signing and you will not receive a welcome letter or need to set up a new account.

Alternatively, you can also complete the online ProviderOne Contact Us form to set up access. If you are new to ProviderOne, use this form to establish a ProviderOne System Administrator. Your System Administrator will manage user access for your business.

If you are a new employee, work with your System Administrator to establish ProviderOne access for:

- Reviewing, creating, and tracking pre-authorizations; and
- Submitting claims.

Note: To remove the current System Administrator, submit the ProviderOne User Access Request form and a letter on official letterhead.

Accessing ProviderOne as a medical provider

You must first work with the Health Care Authority to establish a ProviderOne domain and obtain a core provider agreement, and then you will work with DSHS to become a contracted provider with WA Cares Fund.

If you are new to ProviderOne, use the ProviderOne Contact Us form to begin establishing a ProviderOne domain and to establish a ProviderOne System Administrator. Your System Administrator will manage user access for your business.

If you are a new employee, work with your System Administrator to establish ProviderOne access for:

- Reviewing, creating, and tracking pre-authorizations; and
- Submitting claims.

  Note: To remove the current System Administrator, submit the ProviderOne User Access Request form and a letter on official letterhead.

ProviderOne Login

System administrators

After you submit the ProviderOne User Access Form to HCA, you will receive your ProviderOne login information via secure email.

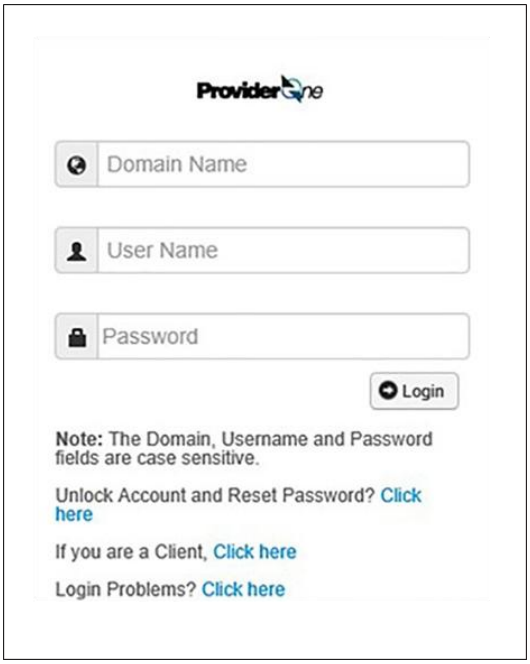
Additional users

Your system administrator will add you as a ProviderOne user and give you your login information.

All users

Once you have your login information, open the ProviderOne login page.

Enter your login information into the corresponding fields. Username and password are case sensitive.



Your domain name is your seven-digit Provider ID in your welcome letter from HCA.

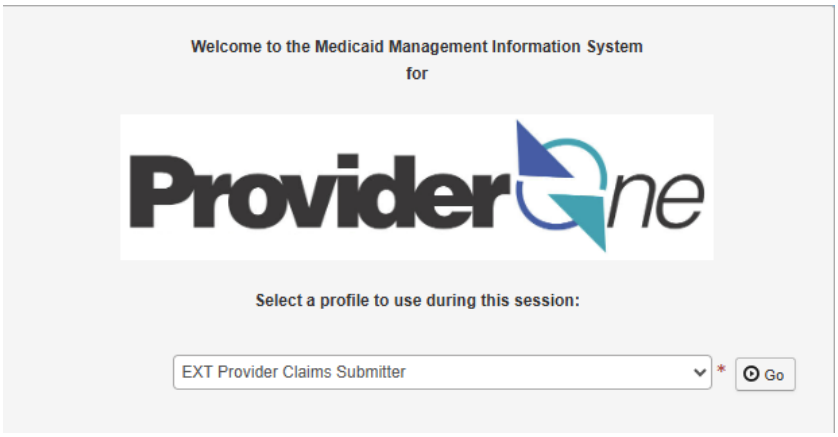
The password provided to you from ProviderOne Security is temporary, and you will be prompted to establish a new password upon initial login.

See details about passwords in General Tips. More information about passwords can also be found on the ProviderOne Security webpage.

Profiles

Profiles allow a user to access specific parts of ProviderOne. Profiles are assigned by ProviderOne Security or your System Administrator.

WA Cares providers will choose one of the following profiles based on functionality needed for their business.



EXT Provider System Administrator

Used to manage access to ProviderOne within your business. This profile is not used for billing or authorization activities.

EXT Provider Claims Submitter

Used to complete WA Cares beneficiary benefit inquiry, view and create new WA Cares pre-authorization, WA Cares claim submission, view claim, adjust claim and resubmit claims.

EXT Provider Eligibility Checker

Used to compete WA Cares beneficiary benefit inquiry, create new and view submitted WA Cares pre-authorization.

EXT Provider Eligibility Checker-Claims Submitter

Used to complete WA Cares beneficiary benefit inquiry, view and create new WA Cares pre-authorization, WA Cares claim submission, view claim, adjust claim and resubmit claims.

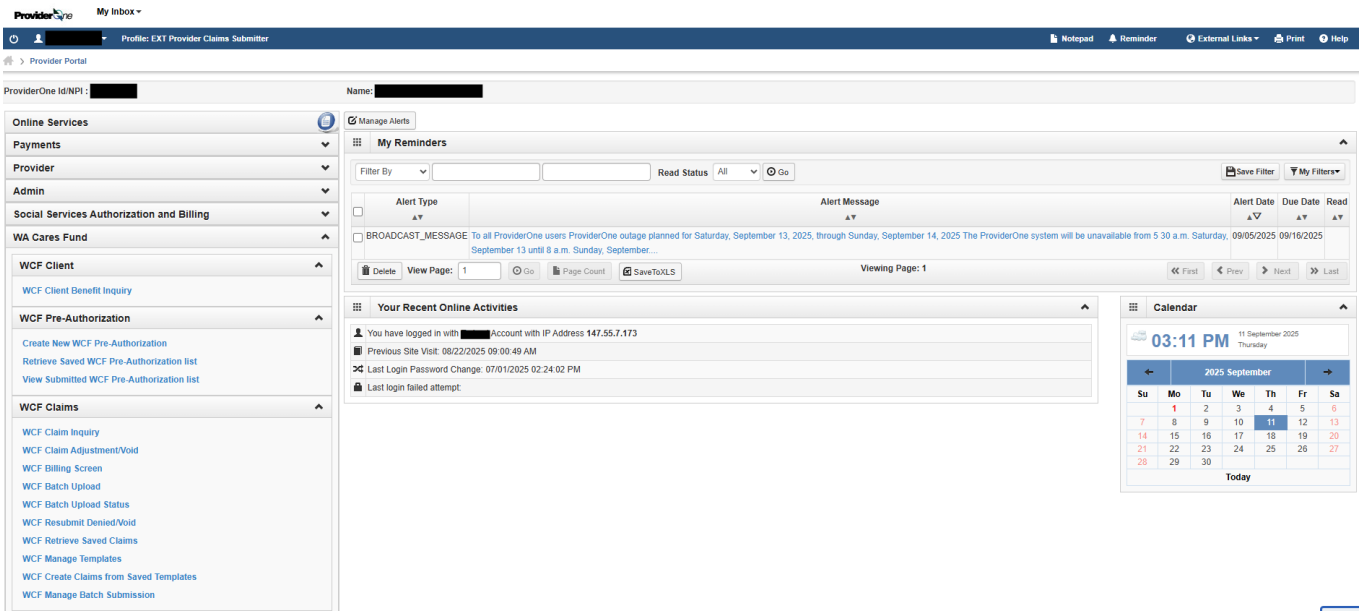
EXT Provider Super User

Allows the user full access to ProviderOne functions with exception of maintaining ProviderOne users.

Note: Other profiles may be available in ProviderOne. If one of these profiles is applicable to your duties, contact your system administrator.

Provider portal

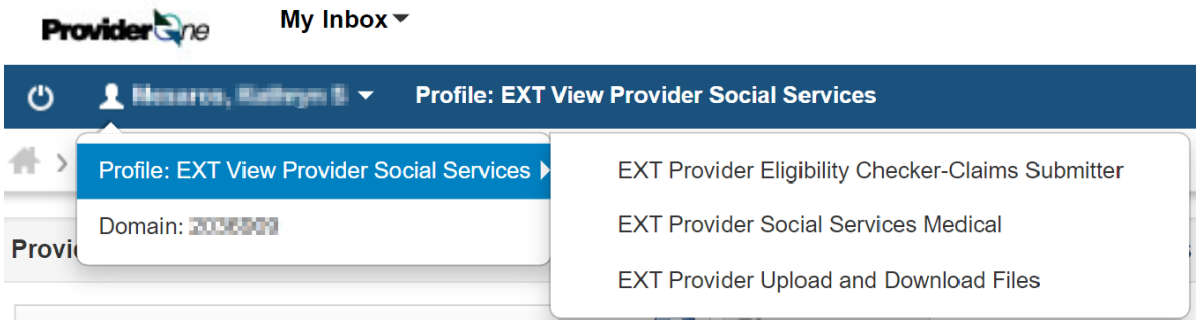
The Provider Portal is the first screen you see after logging into ProviderOne.



In the portal you can:

- View ProviderOne alerts
- View, create, and manage WA Cares pre-authorizations
- View beneficiary eligibility and available balance
- View payment history
- Manage provider data
- Change passwords (system admins only)
- Maintain users (system admins only)
- Look up claim information
- Adjust claims
- Submit and resubmit claims
- Retrieve saved claims
- Manage claim templates

On the portal page you will see information on the current user, the profile that user is signed in with, and any additional profiles the user has available.

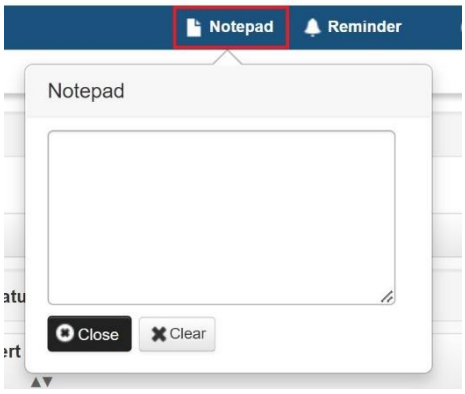


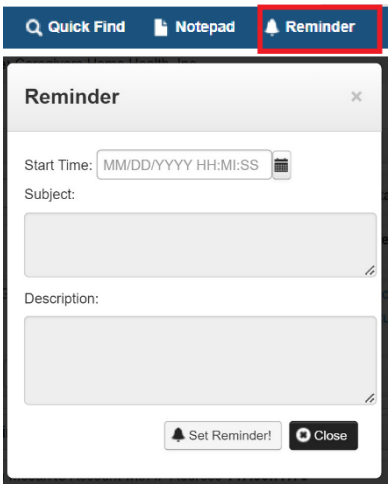
Note: You can toggle between profiles using the dropdown option next to your name or the dropdown option in **My Inbox**.

Portal features

Notepad and reminders

The notepad feature is useful when navigating between screens such as authorizations and claims. The notepad stores information until the current session is over. The session ends when you log out, or if you are timed out due to inactivity. You can also set reminders, print pages, and get help.



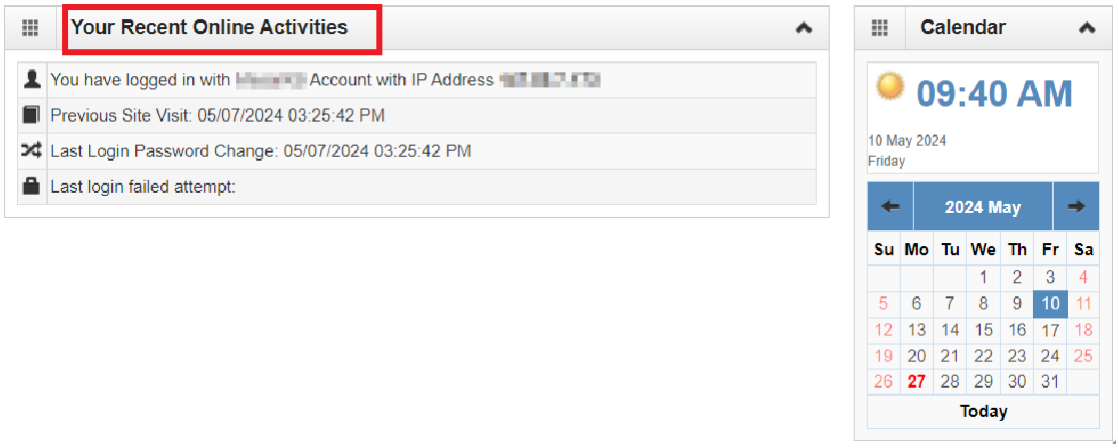


Note: Search criteria for alerts and reminders can be set using filters to help providers navigate between older and newer messages.

Recent online activities

Your recent online activities show:

- Which account you are logged in as, and from which IP address;
- Previous site visits;
- Failed login attempts; and
- Password changes.



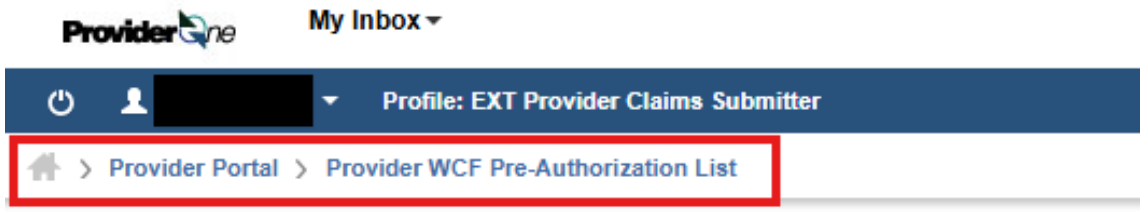
ProviderOne also has a calendar for your use. The calendar is helpful for remembering dates and tracking when payments should be expected. The calendar will also alert you to upcoming holidays. For example, Memorial Day is bolded in red above.

Path

The path at the top part of the portal shows a history of the pages you have visited.

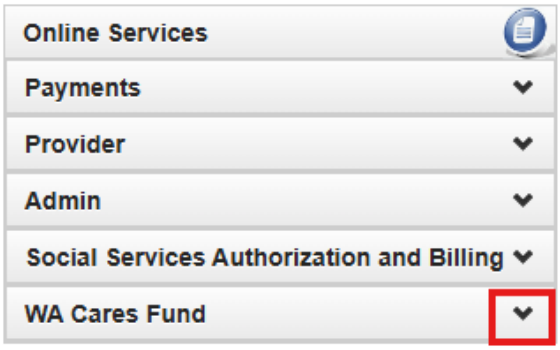
By clicking the name of a page, you return to that page.

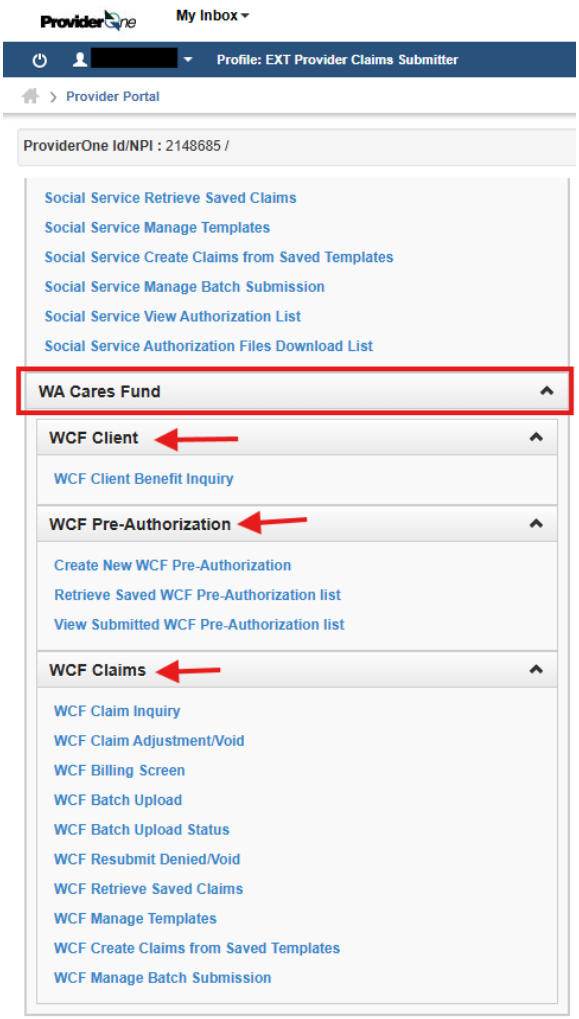
> Note: The path and ProviderOne control buttons are best for navigation because using the browser controls can cause errors later in your session.



Hiding sections

ProviderOne gives you the option to close or hide sections of the Online Services Menu. This function is similar to opening and closing subfolders in a file explorer.



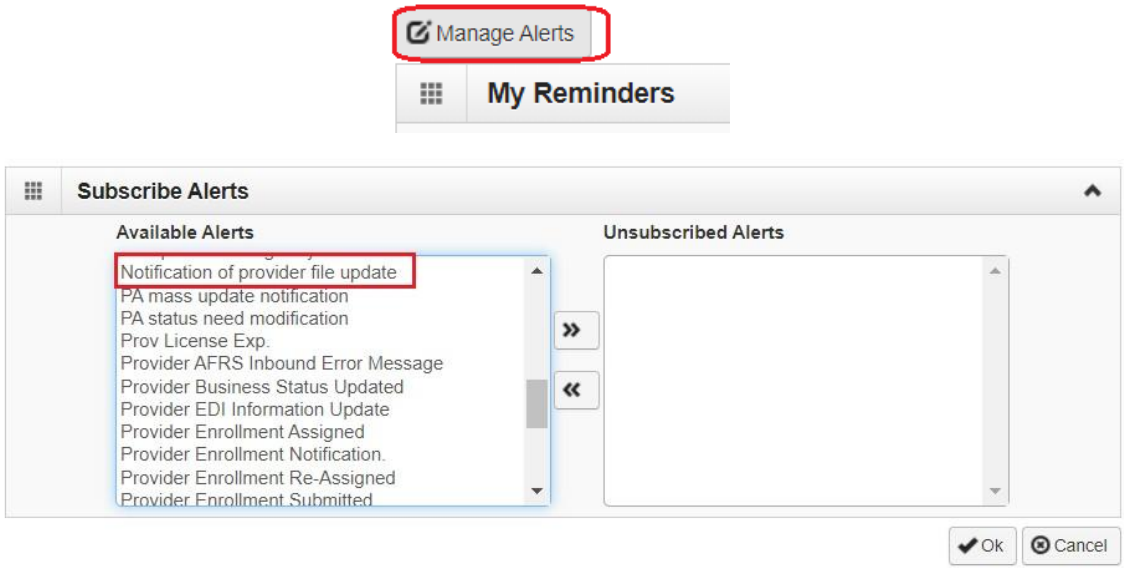


Note: You will complete billing activities in the online services section **WA Cares Fund**.

Managing alerts

You can subscribe or unsubscribe from alerts from the "My Reminders" list. To do so:

- Click **manage alerts**.
- When the subscribe alerts pop-up appears, select desired alerts.
- Click the left and right arrows to customize your alert subscriptions. Your selection will move between subscription options.
- When you are done with your changes, click **OK**.



MANAGING PROVIDER INFORMATION

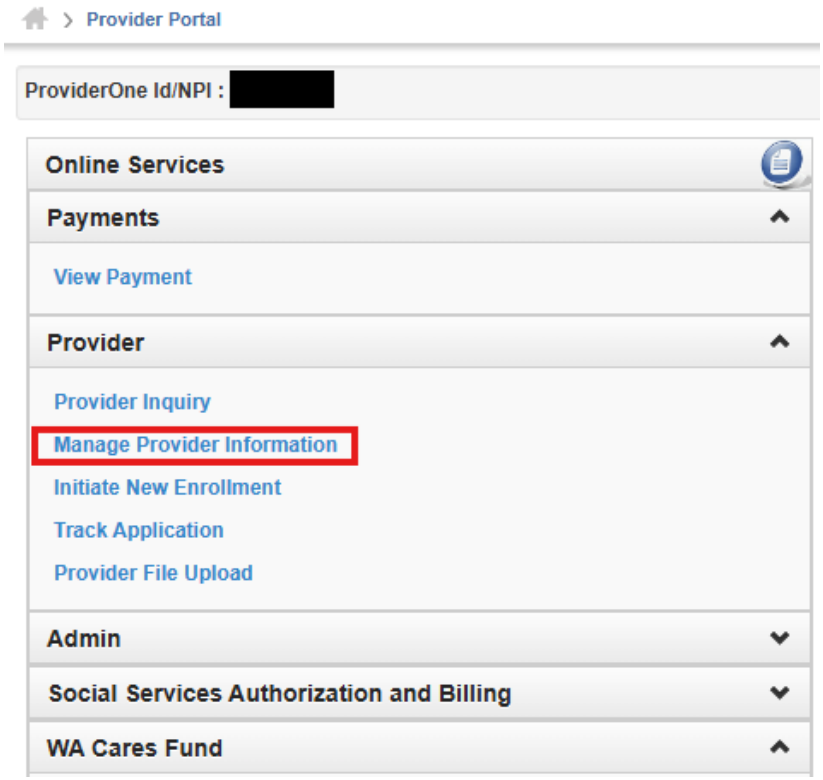
As a WA Cares Fund provider:

- If you are a nonmedical provider, your information is preloaded into ProviderOne based on your DSHS contract information. To update your information in ProviderOne, contact your DSHS contract manager. It is not recommended that you update your information in ProviderOne manually because it will cause a discrepancy between your billing and contract information.
- If you are a medical provider, your information was obtained as part of provider enrollment when you signed your core provider agreement with Health Care Authority. You may modify your information in ProviderOne as described below.

It is recommended you annually check this information for accuracy.

To view and modify your provider info, from the Provider Portal, click on **Manage Provider Information**.

> Note: The EXT Provider System Administrator profile does not have the ability to make changes to provider info. Please use EXT Provider Super User to make and save changes.



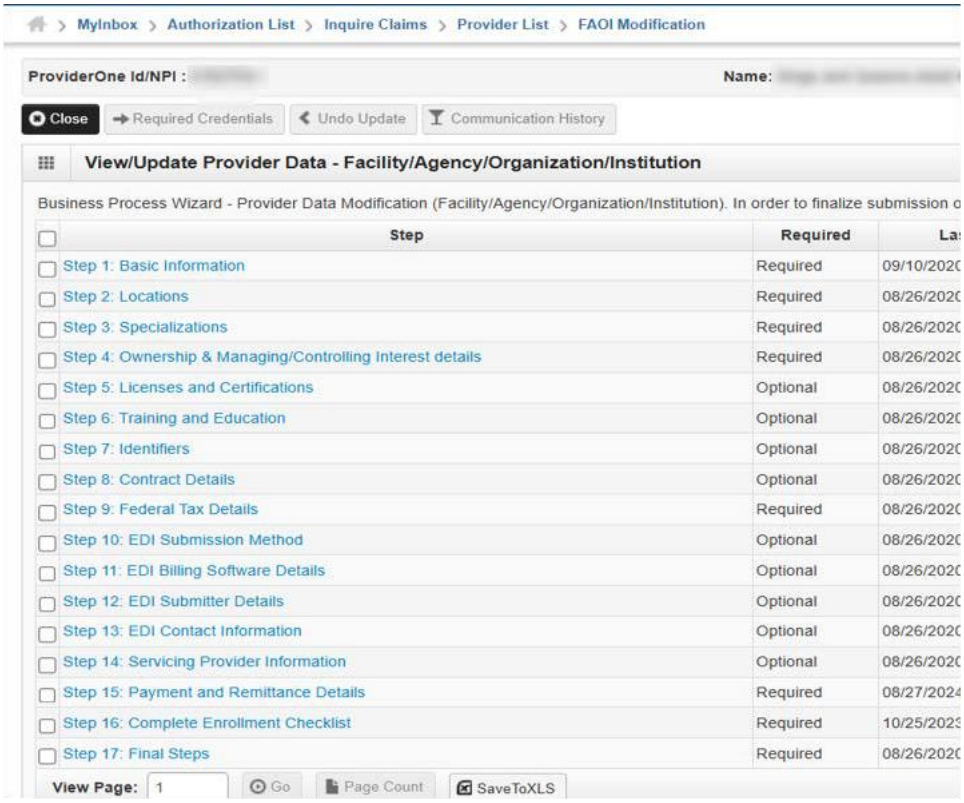
After you click **Manage Provider Information**, the **View/ Update Provider Data** page appears. This page is also called the "Business Process Wizard."

1. Check the data in all steps marked "required." Update information in these steps as needed.
2. If you make changes to your location, you must inform your DSHS Contract Specialist of these changes.
3. Although you cannot make changes to the Specializations step or the Contract Details step, you should review the information for accuracy. If updates are needed, contact your DSHS Contract Specialist.

   Note: If a previous required step has a status of incomplete, you must complete that step before moving on to the next. For assistance, contact HCA Provider Enrollment.
4. After you make changes, you must click the last step titled "Final Steps" to submit the changes to HCA for review. After you submit the modification, you will not be able to make additional changes to your account until HCA approves the changes.

   Note: Based on your provider type, the step numbers you see on your screen may be different than the step numbers seen below.

Basic information



When you click on step 1, the **Provider Details** pop-up will appear. From here you can see:

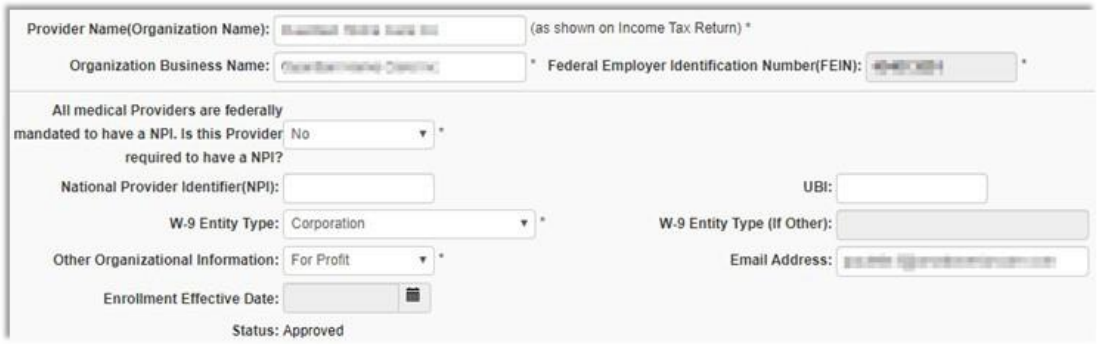
- Provider or organization name

- Organization business name
- W-9 entity type
- Federal employer identification number
- Organizational information
- UBI



Step	Required	Last Modification Date	Last Review Date	Status
Step 1: Basic Information	Required	08/28/2014	08/28/2014	Complete
Step 2: Locations	Required	05/10/2024	08/28/2014	Complete

Note: The primary email address shown below is where communication from ProviderOne will be sent.



Make any changes needed on this page (except EIN or NPI), and then click **OK** in the lower right corner to save them. If you did not make changes, or don't want to save changes made, click **Cancel** instead. Either option will return you to the Business Process Wizard.

Locations

Step 2 shows your location codes and the addresses associated with each location. If you have multiple locations associated with your business, you will have multiple location codes.

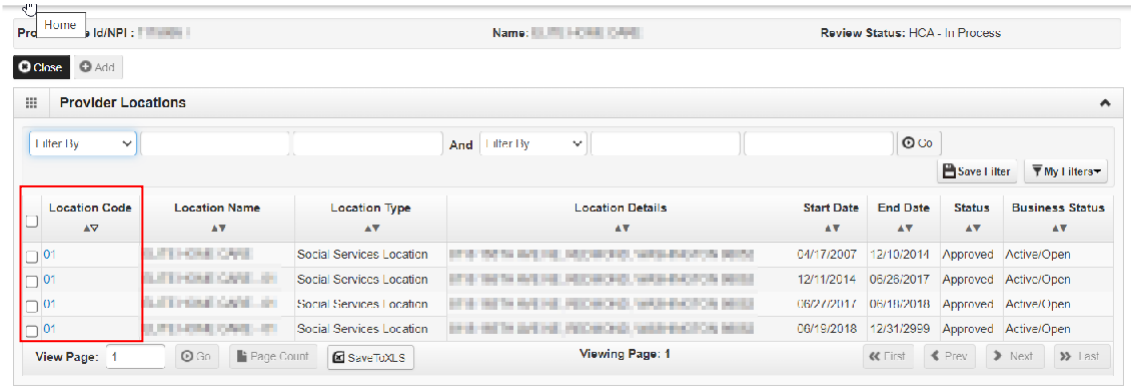
> Note: During the WA Cares Fund pilot (beginning January 6, 2026) until statewide program launch, only one location codes is available in ProviderOne.

If you are a nonmedical provider, contact your Contracts Specialist to update your location information.

If you are a medical provider, you may view and modify your own location information in ProviderOne. To view and modify information:

- Click on **Step 2: Locations**.
- The **Provider Locations** page will appear showing all the locations within your domain.

- Click on **each blue location code** to view the addresses associated with each location.
- View and correct data as needed.

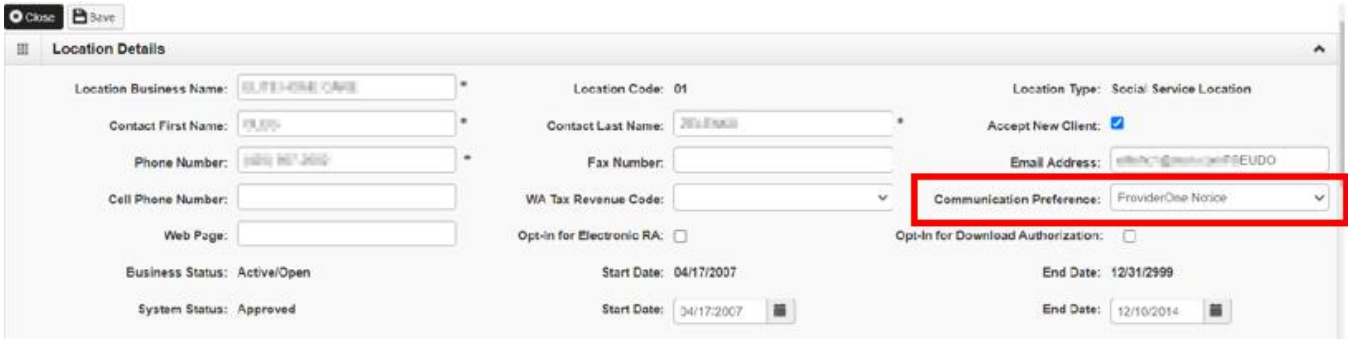


Note: The location code is a two-digit number that is added to the end of your seven-digit Provider ID. This nine-digit ID is used for your authorizations.

Email and notifications

Each location can have a unique contact or share the same contact as the domain. Verify the email address for each location.

Each location can have a different notification method. Email is the default communication preference, but you can choose to receive notifications only through the ProviderOne Portal or through standard mail instead.



Address types

There are three address types for each location.

1. **Location** is the physical address of the location that you are managing. This address cannot be a P.O. Box.

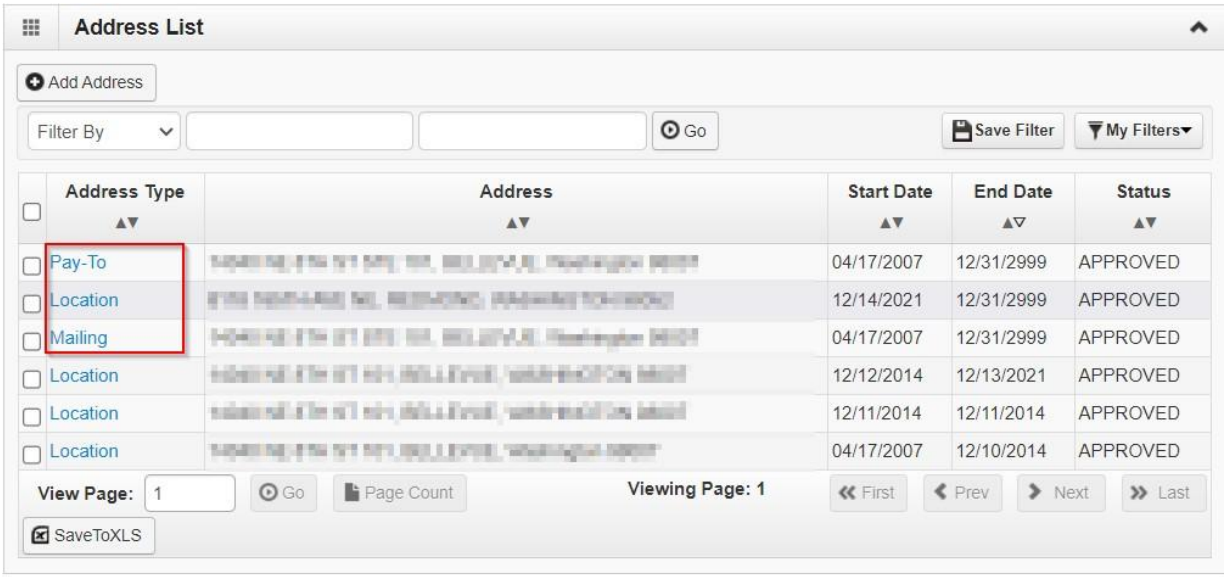
   You must alert your DSHS Contract Specialist if you:

   - Make changes to your physical address in ProviderOne.

- Provide a service that requires a license that is connected to a specific physical location (e.g., adult family home, assisted living facility, or nursing home) and your facility is moving to a new physical address.

Note: If moving locations, a DSHS-licensed facility will need to sign a new contract and obtain a new ProviderOne Location ID. This is not required for other businesses.

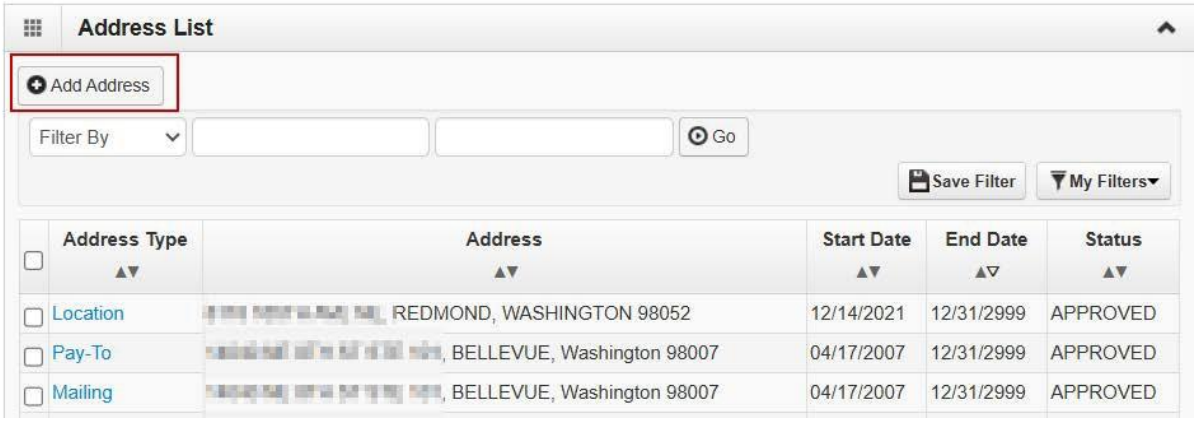
2. **Mailing** is the address where ProviderOne sends mail for this location. This may include notifications about authorization changes, contract updates, etc. Payments are not mailed to this location
3. **Pay-to** is the address where ProviderOne mails your check (warrant) payments.
   - If you set up EFT, this address is used as a backup in case the direct deposit fails.
   - Your tax documents are also mailed to this address.



Note: Previous addresses also appear on this screen, and current addresses have an end date of 12/31/2999.

To manage address information, click the hyperlinked text in the **Address Type** column. The link opens the **Manage Provider Locations** page.

This page shows the dates the address is active, and all the address information associated with the address type. To make changes to the address, type directly in the address and begin editing.



This will open the **Address Details** pop-up where information can be entered. Make any changes or corrections that are needed and then click **Validate Address**. This validates the address information provided against data from the United States Postal Service.

- If successful, you will see a message in blue that says **address validation successful**.
- If unsuccessful, you will see a message in red that says **address not found with street address and zip code combination**.

  Note: If the address validation is unsuccessful, you can still use the address entered. The Validate Address button is a tool to see if your entry matches postal records, and the system does not prohibit non-matches.

After validating, click **OK** to accept the changes and close the pop-up.

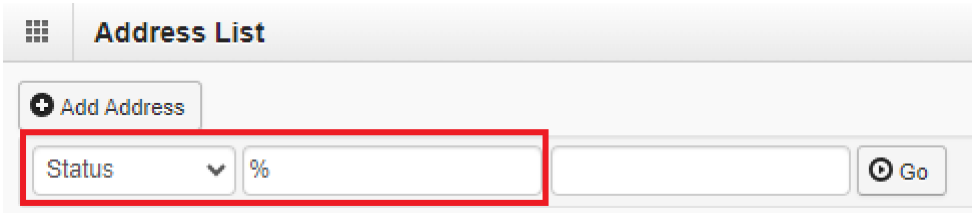


To save your changes and go back to the previous screen, on the **Manage Provider Location Address** page, click **Save** and then **Close**.

If you scroll back down to the **Address List**, by default you won't see the new address listed while it is in In Review status. To ensure your changes saved, you can do the following:

- Select **Status** from the Filter By dropdown.
- Enter **%** into the search field.
- Click **Go**.

The new address will be shown as In Review.



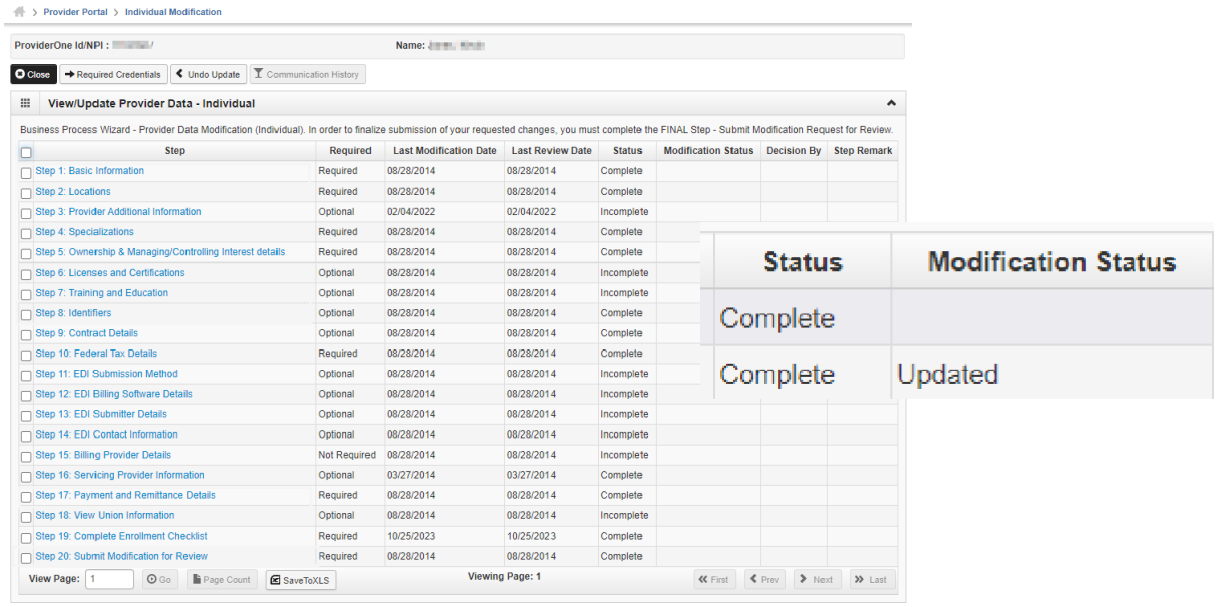
You can change as many of the addresses as you need to in this way. Once you have made all the necessary changes to these addresses, click **Save** and then **Close** at the top of the screen, which returns you to the Provider Locations page and the list of all your locations.

Make any changes to the other locations that you might need to, then the **Provider Locations** screen to return to the **Business Process Wizard**.

Modification status

If you have made any changes and used **OK** to save them then the **Modification Status** field will say **Updated**.

If you did not modify any data and used **Cancel** to close the pop-up, **Modification Status** field will be blank.



Note: An updated **Modification Status** does not mean that the changes have been submitted to ProviderOne for review. This will be covered in Final Steps.

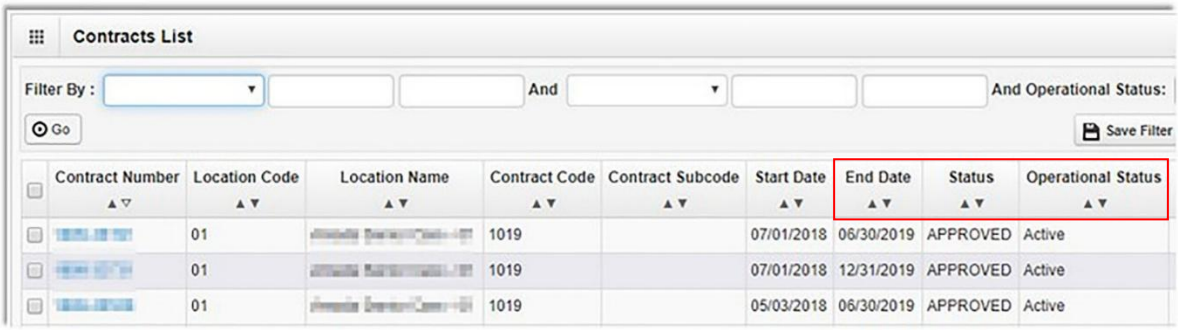
CONTRACT DETAILS

Your ProviderOne account/domain includes all DSHS contracts linked to your tax ID number.

To view your contracts, click on **Contract Details** to be taken to your **Contracts List** page.



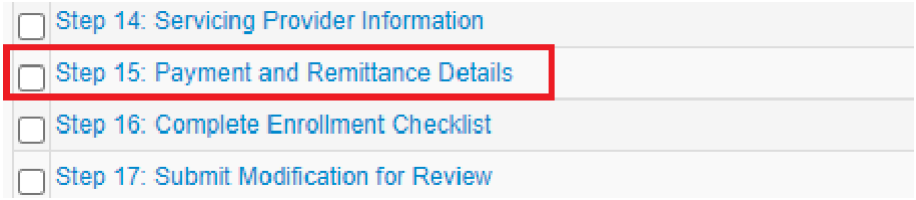
You cannot make any changes to your contracts in ProviderOne, but you can review to make sure the information is correct. If any changes are required, contact your DSHS Contract Specialist.



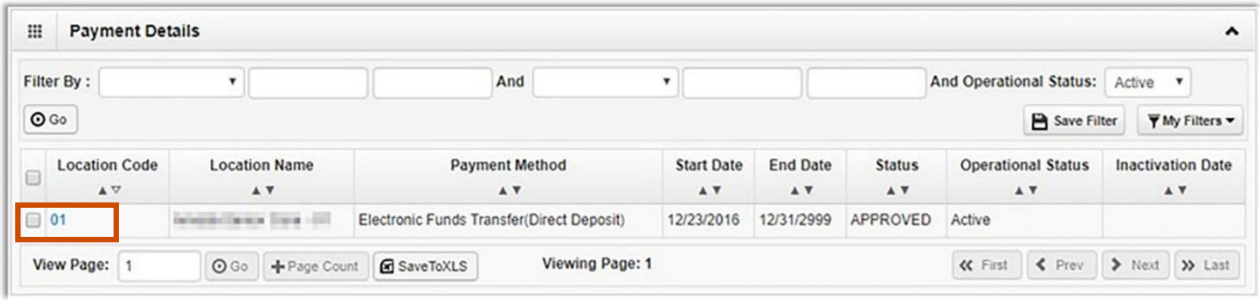
Note: You can view the end date and status of your contracts here. If your contract is expired, or is expiring in the next two months, contact your DSHS Contract Manager. You may see errors in your authorizations until the contract is updated.

PAYMENT DETAILS

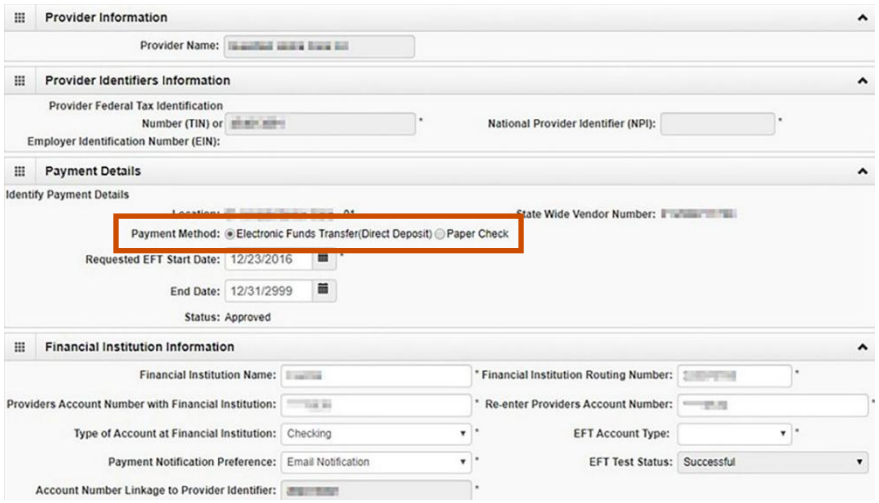
In the **Payment and Remittance Details** step you can review and update your payment information (i.e., sign up for direct deposit). From the Business Process Wizard, click on Payment and Remittance Details to open the Payment Details screen.



Here you will see an entry for each of your locations. Each of these location codes has their own payment details that need to be reviewed, but they can all be the same if you want all payments sent to the same place. Click on the blue hyperlinked **Location Code** to open information for that location.



If you choose a location, the **Provider Information** pop-up appears.



ProviderOne is defaulted to send out paper checks (warrants). If you want to receive electronic payments:

- Change the **Payment Method** radio button to **Electronic Funds Transfer** (Direct Deposit) instead of Paper Check.
- Under **Financial Institution Information**, add your banking information for the direct deposits.

Receiving payments directly to your bank account is fast, safe, and reduces lost and late payments.

If you prefer warrants, they will be sent to the pay-to address for each location from the locations section. Ensure your pay-to addresses are correct!

Updating EFT information

To add or change EFT information:

- Under **Submission Information**, verify that the **Reason for Submission** is **Change Enrollment**.
- Enter the name that represents an **Authorized Signature.**
  - Click **OK** to save changes.
  - If you didn't make changes or don't want to keep the changes you made, click **Cancel** instead.



Repeat this process for each of your locations, then return to the main Business Process Wizard page by clicking the **Close** button.

Note: Providers can sign up for EFT so payments go directly to their bank account. After you update your payment preferences, be sure to click **Final Steps**. After you submit the modification, The changes will be automatically approved.

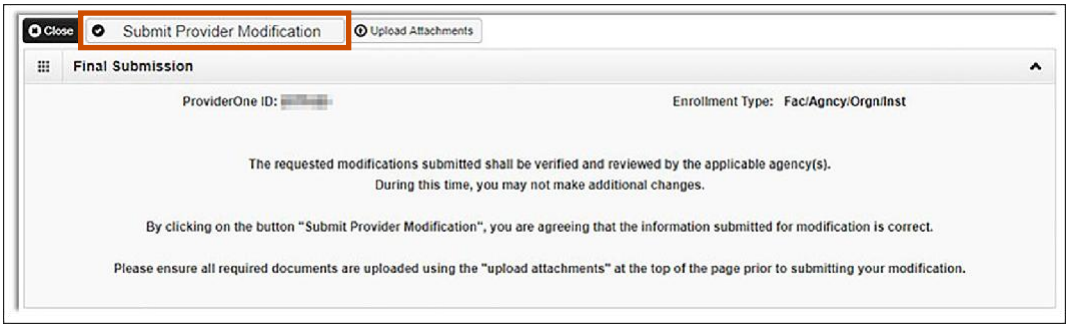
Final steps

If you are ready to submit your changes, make sure that all of your changes are accurate; they will be automatically approved. You won't be able to make further changes until the review is complete.



To submit your changes:

1. Click on the last step titled **Final Steps** to bring up the **Final Submission** page.
2. Click on **Submit Provider Modification**.
3. The button will turn gray, then click **Close**.

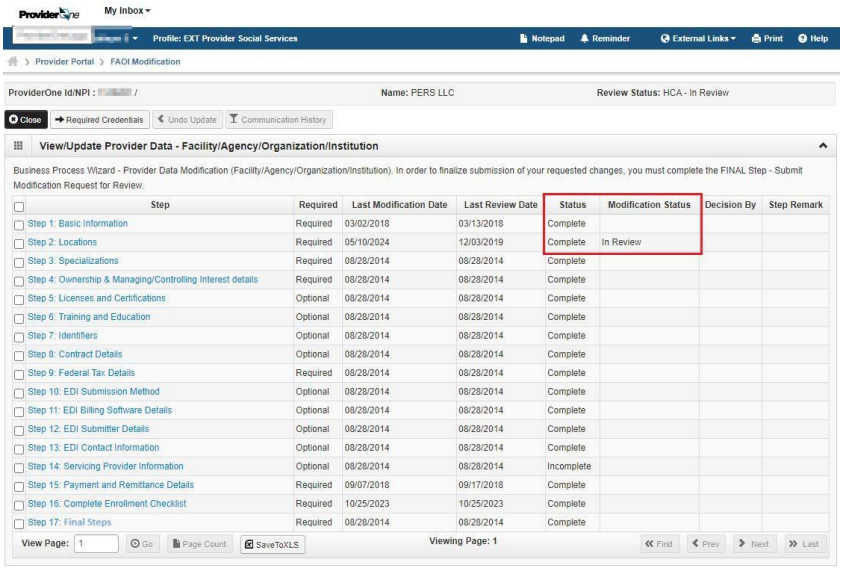


Note: You must click on "Final Steps" for your changes to be processed. Please remember to click this step any time you make changes to your account!

If you need assistance or if the system won't let you submit your changes, contact Provider Enrollment at 1-800-562-3022 ext. 16137.

4. After you submit your modifications, you will be returned to the **Business Process Wizard screen**.
5. Here you will see any modifications you made with a Modification Status of 'In Review'.
6. The Review Status at the top of the screen will also show as 'HCA—In Review'. If the status shows as 'HCA—In Process', this means the modification was not submitted.

Depending on the type of change and the current volume of requests submitted to HCA, it can take anywhere from several business days up to several weeks for the changes to be reviewed and approved.



ADDING NEW USERS AND ASSIGNING PROFILES

Profile overview

A profile allows a user to access specific parts of ProviderOne. Profiles are assigned by ProviderOne or your System Administrator.

Most WA Cares Fund providers will see two or three of the following profiles.

EXT Provider System Administrator
Used to manage access to ProviderOne within your business. This profile is not used for billing or authorization activities.

EXT Provider Claims Submitter
Used to complete beneficiary benefit inquiry, view and create new WA Cares pre-authorization, WA Cares claim submission, view claim, adjust claim and resubmit claims.

EXT Provider Social Service Medical
Used to complete beneficiary benefit inquiry, view and create new WA Cares pre-authorization, WA Cares claim submission, view claim, adjust claim and resubmit claims.

EXT Provider Eligibility Checker
Used to complete beneficiary benefit inquiry, create new and view submitted WA Cares pre-authorization.

EXT Provider Eligibility Checker-Claims Submitter
Used to complete beneficiary benefit inquiry, view and create new WA Cares pre-authorization, WA Cares claim submission, view claim, adjust claim and resubmit claims.

EXT Provider Super User
Allows the user full access to ProviderOne functions with exception of maintaining ProviderOne users.

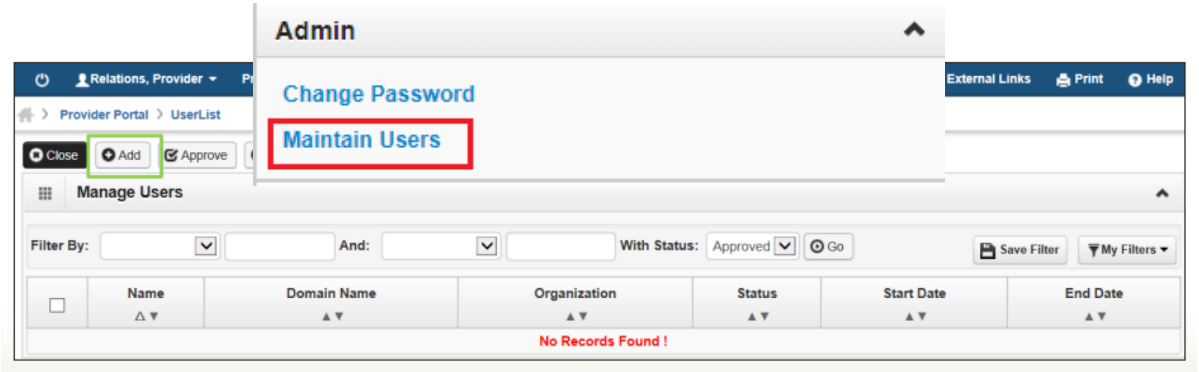
> Note: Other profiles may be available in ProviderOne. Check with your administrator to see if these profiles will be applicable to your duties.

Adding a user

To add a user in ProviderOne:

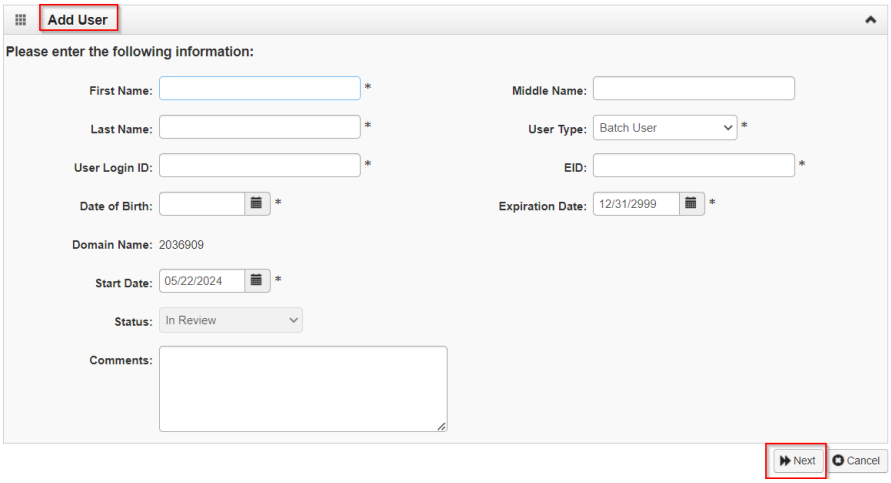
1. Log in with the EXT Provider System Administrator Profile.
2. In the **Provider Portal**, click on **Maintain Users** in the Admin section.
3. On the **Manage Users** screen, click **Add.**
4. The **Add User** screen will appear. Fill in all required boxes (indicated by an asterisk *).

   User Type auto-populates to 'Batch User'.



User Login ID auto-populates after the user's first and last name are entered.

For the **EID**, you can enter any #. EID stands for Employee Identification. You must enter a different # for each user.

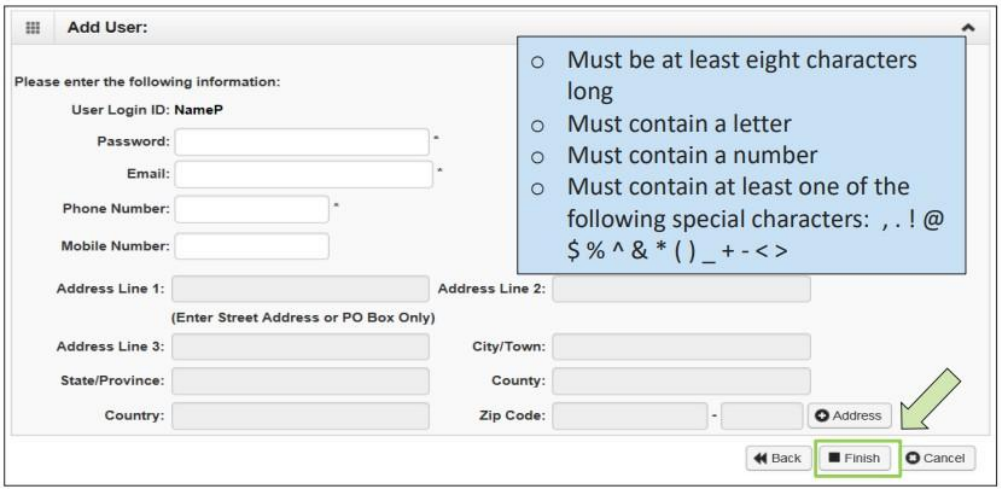


The **Start Date** auto-populates to the date the user is added.

The **Expiration Date** auto-populates to 12/31/2999. If you want user access to end on a specific date, you can change the expiration date.

5. When all required fields are complete, click **Next**.

6. Complete the remaining required fields.



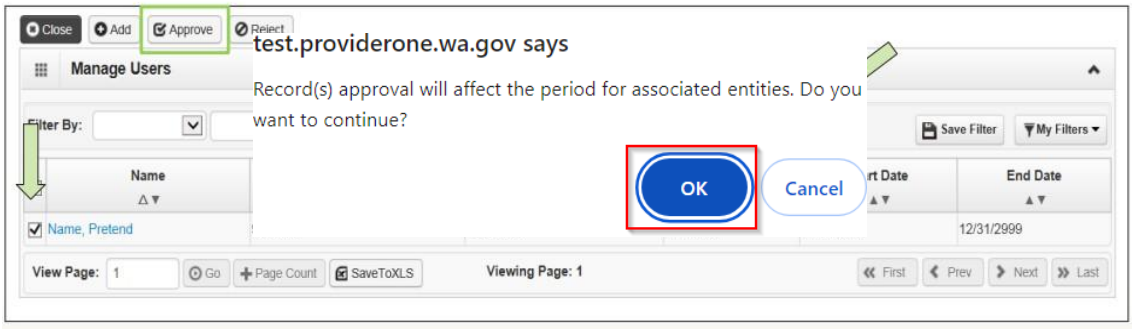
Password established will be temporary. The user will be prompted to change their password upon initial login.

For security reasons, please use an unshared **email** address.

Phone number.

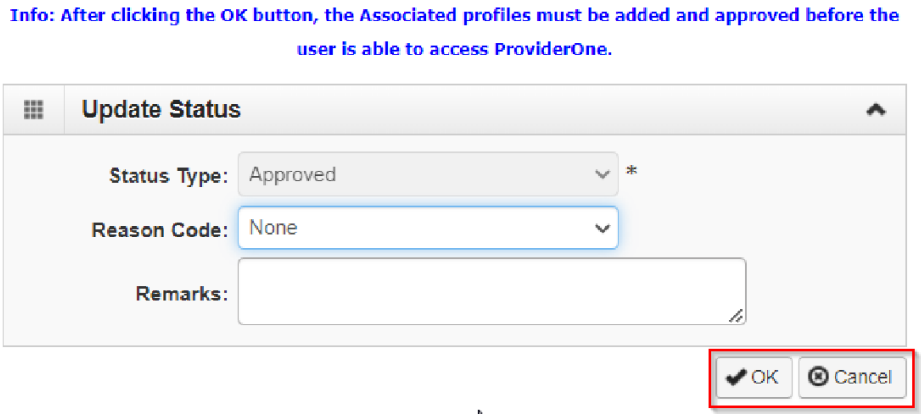
7. Click **Finish** when done. You will be returned to the Manage User page. To display the new user:
   - In the **With Status** drop-down, select **In Review** and click **Go.**
   - The user's name is displayed with an **In Review** status.
   - Next, select the user you want to approve. Find them on the list and check the box next to their name.

8. Once checked, click the **Approve** button. A dialogue box will appear.



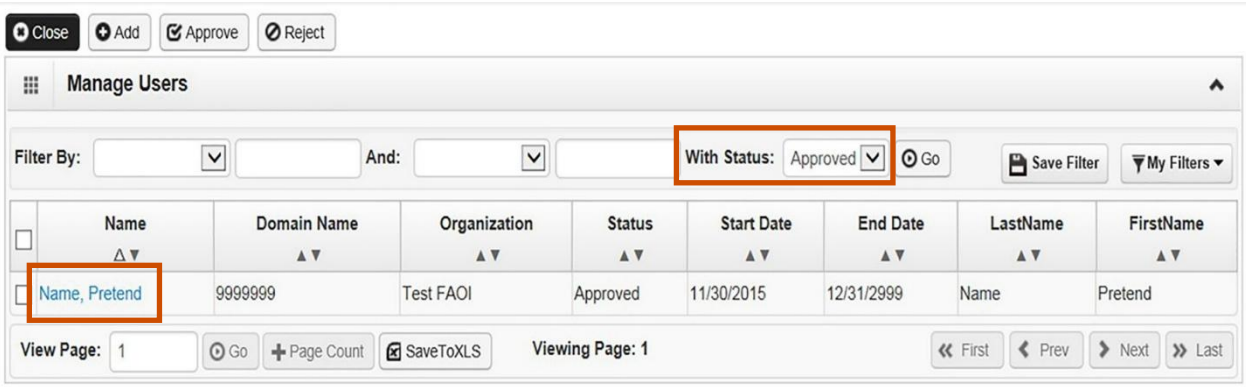
9. Read the message and click **OK**.

10. Next, another pop-up will appear with important information at the top. Click **Ok** to continue or **Cancel** to return to previous screen.



Assigning profiles

The user is now in **Approved** status. Next, select the blue hyperlinked username to choose the profiles the user will have assigned to them in ProviderOne.

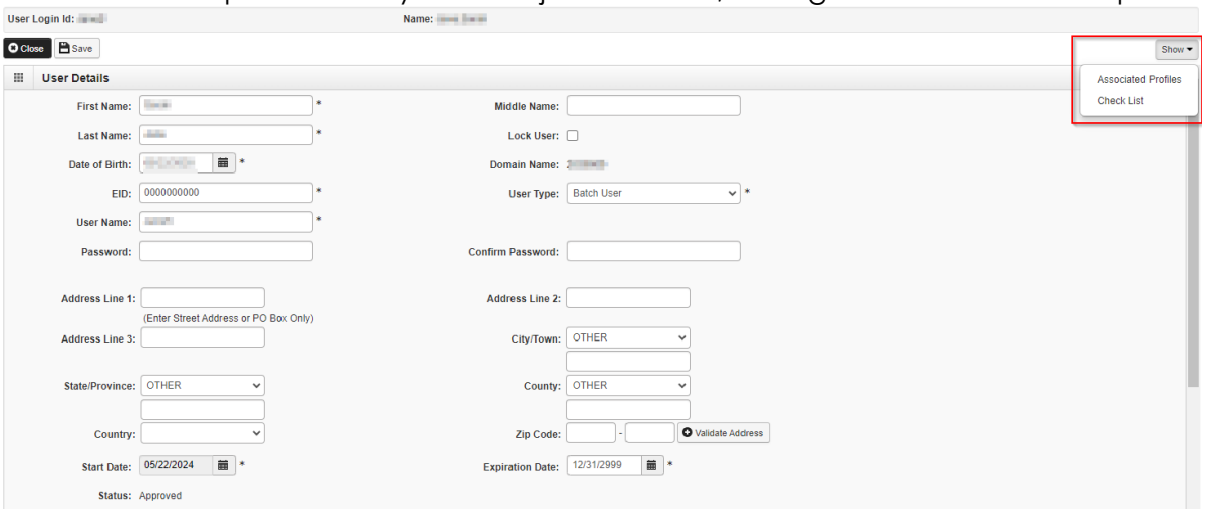


Once you have selected the user's name, you will be directed to the **User Details** page. From the **Show** menu (located top right corner of page) select **Associated Profiles**. This will bring up the **Mange User Profiles** page.

On the **Manage User Profiles** page, select **Add**. You will be directed to the **Add New Profiles to User** page. Here you will select all the desired profiles for the chosen user. To assign profiles, use the left and right arrow buttons to move desired profiles from the left column (available) to the right column (associated). Click **OK**.

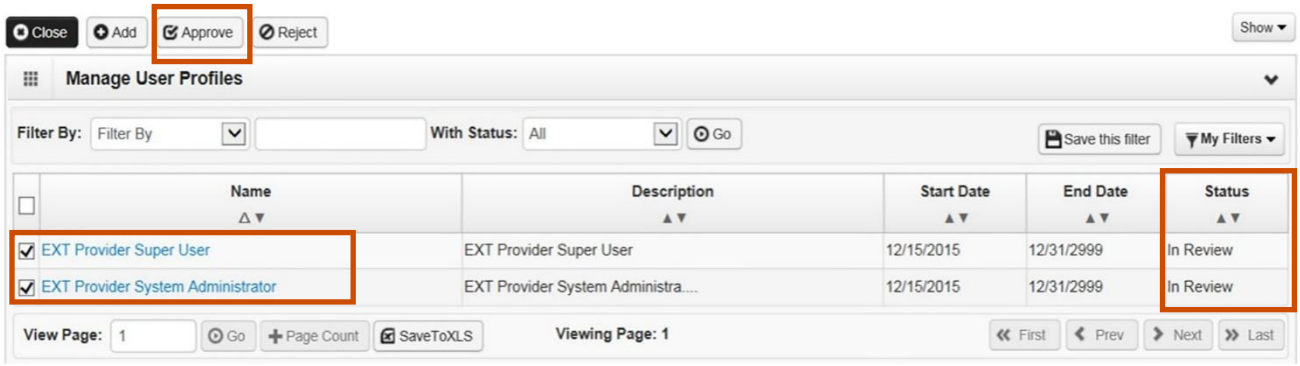
> Note: Users will have a default end date of 12/31/2999. To restrict a user, the System Administrator can remove profiles or select a different end date. Removal of profiles is the reverse of assignment.

Back on the **Manage User Profiles** page, you will see the new profiles with an **In Review** status. If you do not see the profiles that you have just selected, change the **With Status** dropdown to



All and select **Go**.

Check the box next to the profile name and then click **Approve**.



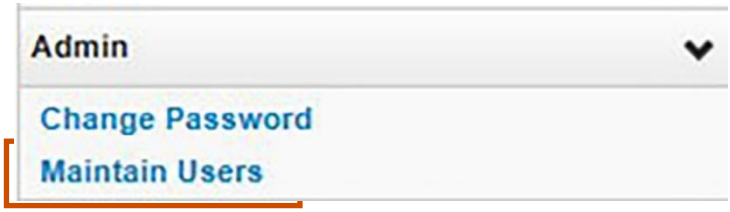
An **Update Status** pop-up will appear and show **Status Type: Approved**. Click **OK**.



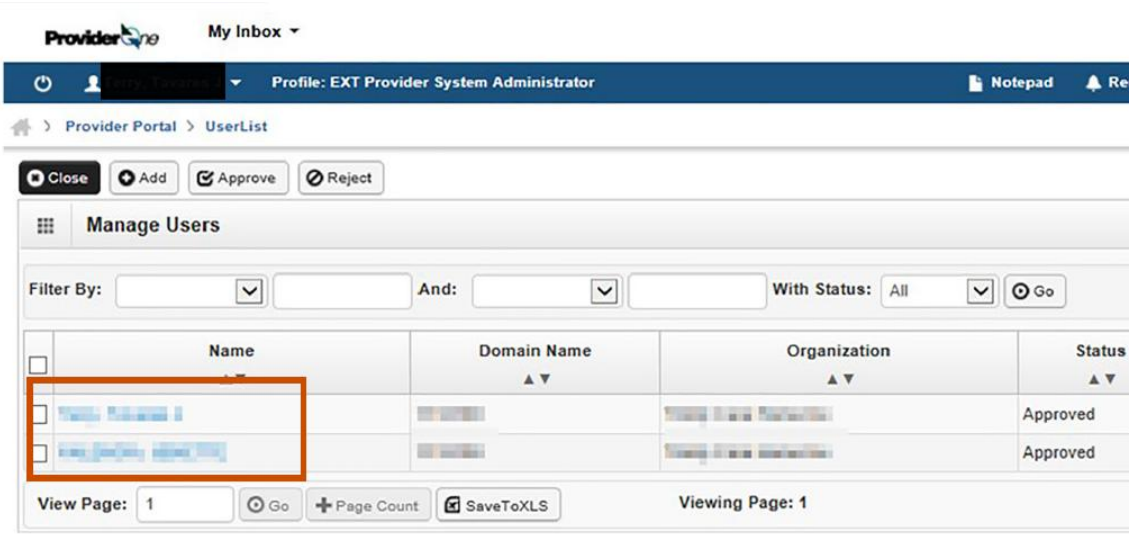
Returning to the **Manage User Profiles** page, the status of the profile(s) is now Approved. Select **Close** to return to the **User Details** page.

LOCKING, UNLOCKING, AND ENDING USERS

Managing users can be done by logging in with the EXT Provider System Administrator profile and selecting **Maintain Users** from the Provider Portal.



Next, select the blue hyperlinked username you need to manage.



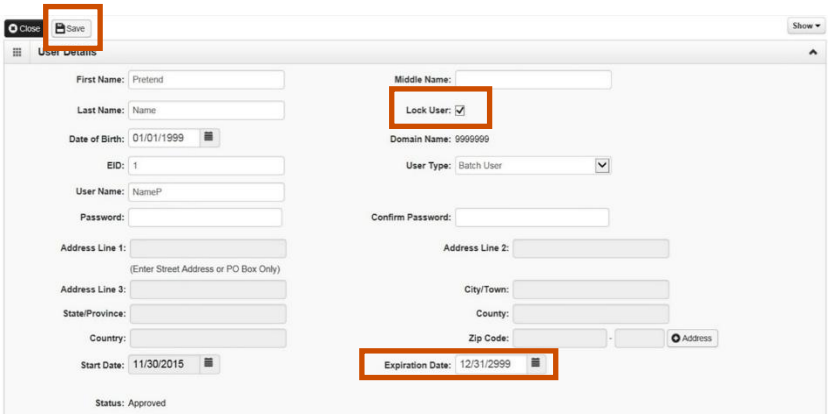
ProviderOne System Administrators can lock, unlock, and end date user profiles.

> Note: If you are a ProviderOne user and you are locked out of your account, contact your System Administrator.

Locking a user: Click the box next to **Lock User**.

Unlocking a user: Remove the check mark from box next to **Lock User**.

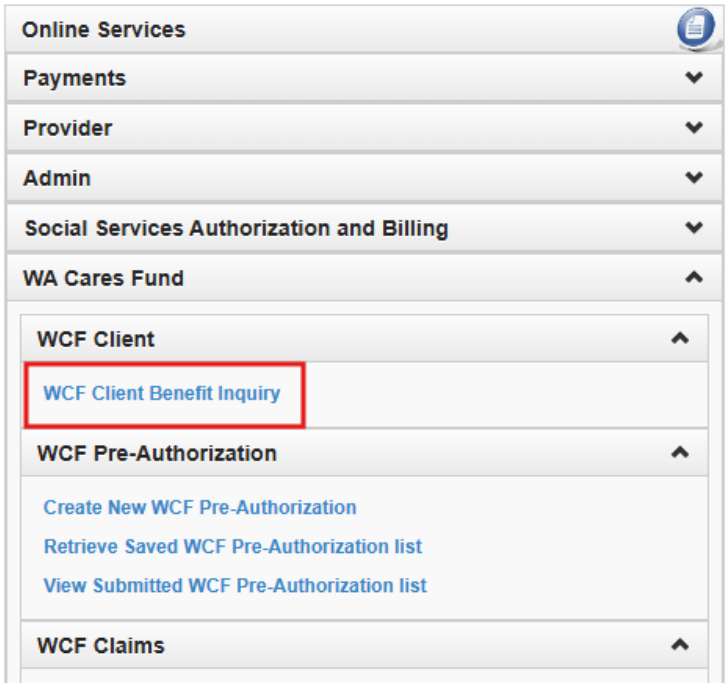
End-dating a user: Change the **Expiration Date** to a date in the near future.



CONFIRMING BENEFICIARY'S ELIGIBILITY AND AVAILABLE FUNDS

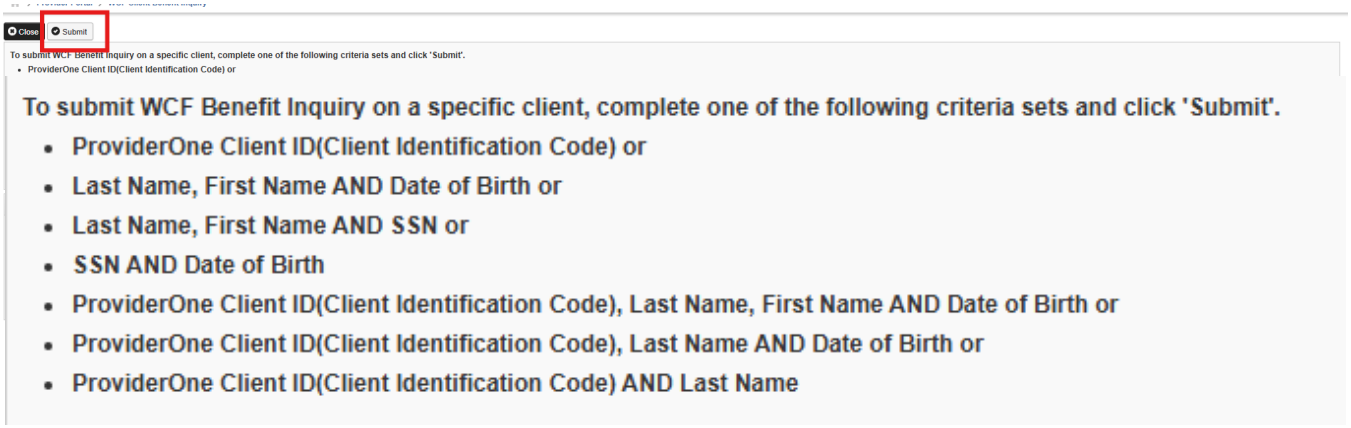
To verify a beneficiary's WA Cares eligibility:

1. Log into ProviderOne using one of the following WA Cares profiles.
   EXT Provider Claims Submitter
   EXT Provider Eligibility Checker
   EXT Provider Eligibility Checker-Claims Submitter
   EXT Provider Eligibility Verification
   EXT Provider Super User
2. In the provider portal, navigate to the WA Cares Fund section located at the very bottom of the online services list on the left.
3. Select **WCF Client Benefit Inquiry**.

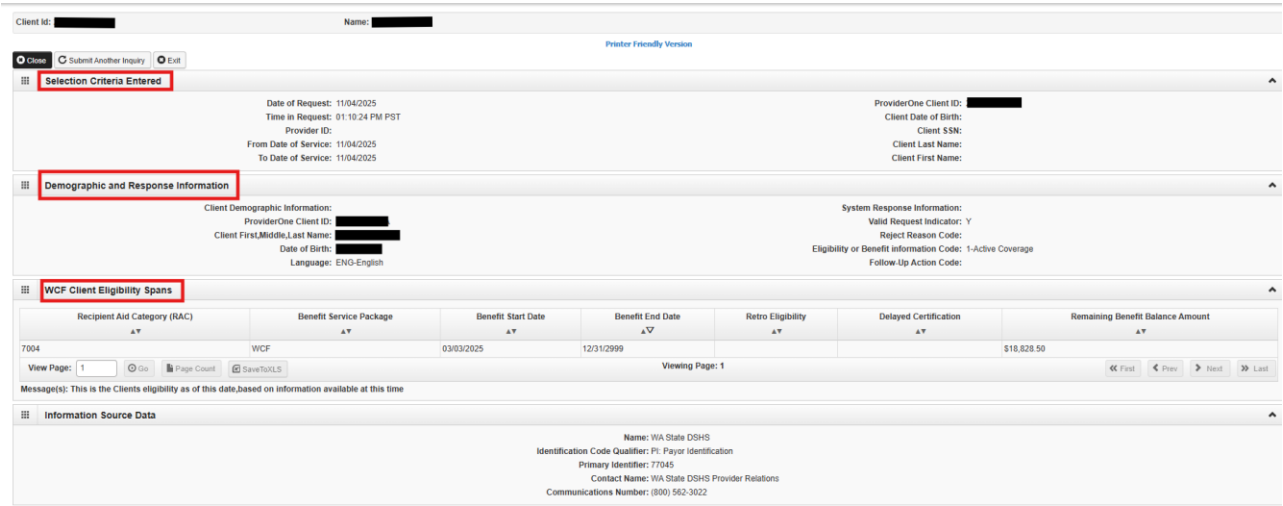


4. You will be taken to the WCF Client Benefit Inquiry menu. From here you can enter the following:
   - Beneficiary's ProviderOne ID number
   - Inquiry start date
   - Inquiry end date
5. Click the **Submit** button.

6. If you do not have the beneficiary's ProviderOne ID number, search using one of the following criteria below.

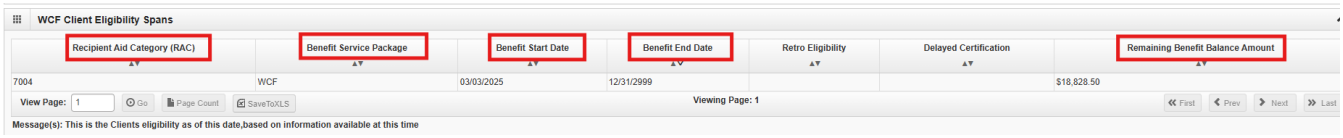


7. Once the information is entered and ProviderOne finds a match, you will see the **WCF Client Benefit Inquiry Response** screen.
   - **Selection Criteria Entered** shows the date and time the inquiry was submitted. You will also see the criteria entered to search for the beneficiary.
   - **Demographic and Response Information** shows basic demographic information for the beneficiary you are searching.

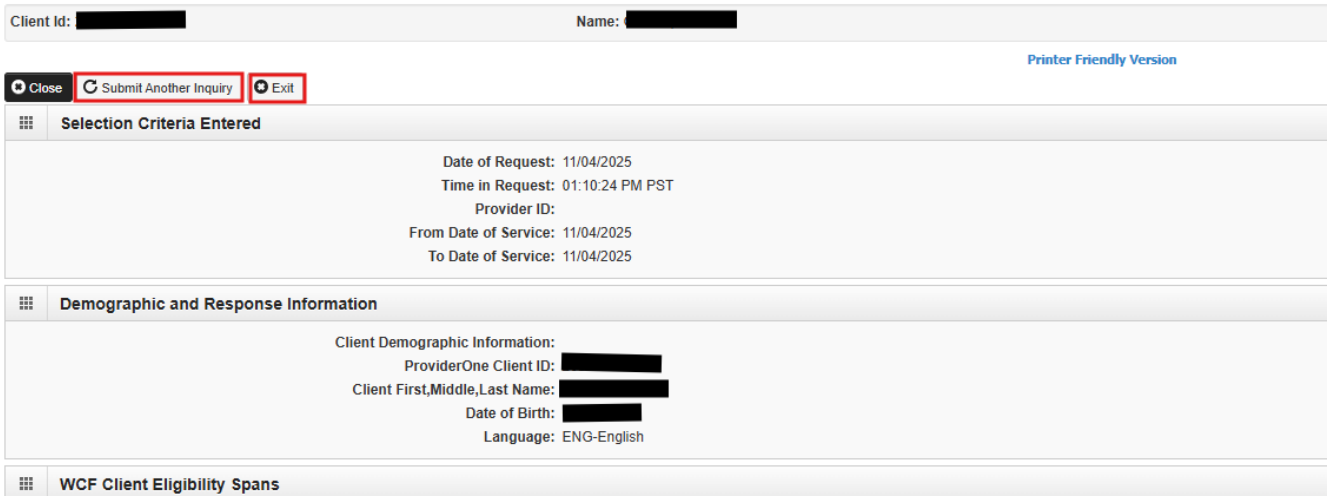


   - **WCF Client Eligibility Spans** shows you the beneficiary's eligibility information, including:
     - **Recipient Aid Category** (RAC) code, this code is used in ProviderOne to indicate the total benefit the beneficiary is eligible to receive as determined by Employment Security Division.
     - **Benefit Service Package**. This indicates that the beneficiary is eligible for their WA Cares benefit.

- **Benefit Start Date**. Date that beneficiary became eligible to access their WA Cares benefit.
- **Benefit End Date**. There will be a default end date of 12/31/2999. Once the beneficiary exhausts their benefits, the date will reflect when the available balance is 0.
- **Remaining Benefit Balance Amount**. Funds available to the beneficiary for WA Cares services.



8. To do another search, click on **Submit Another Inquiry**.
   If you do not need to do another search, click **Exit** to go back to your home page.



COORDINATION OF BENEFITS

The Health Care Authority is responsible for coordination of benefits to ensure no Medicaid funds are used when a Medicaid (Apple Health) service is also available in WA Cares and the beneficiary is enrolled in both programs. Medicaid funded services include services provided by Home and Community Services (HCS) and the Developmental Disability Administration (DDA). ProviderOne will automatically apply coordination of benefits once eligibility for both programs is established. As a result, any open Medicaid authorizations for an overlapping service will enter error status. Registered WA Cares Fund providers will need to submit a pre-authorization for beneficiary approval for the service to then be paid for by WA Cares. You will continue to bill WA Cares for shared services until the beneficiary has exhausted their benefits or they have a remaining balance of less than $250. If payment for services provided was denied due to coordination of benefits, WA Cares providers can submit an exception to request payment. Additional information can be found on A Medicaid provider's guide to coordination of benefits with the WA Cares Fund.

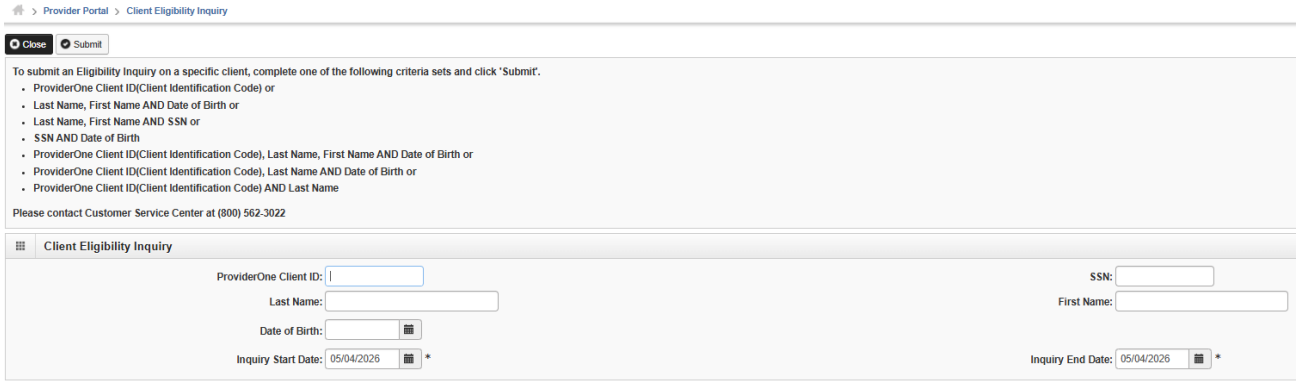
Using ProviderOne to check Medicaid enrollment

To verify a beneficiary's Medicaid enrollment:

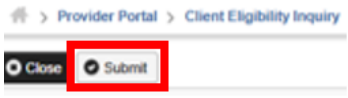
1. Log into ProviderOne using one of the following WA Cares profiles.
   - EXT Provider Claims Submitter
   - EXT Provider Eligibility Checker
   - EXT Provider Eligibility Checker-Claims Submitter
   - EXT Provider Eligibility Verification
   - EXT Provider Super User
2. In the provider portal, navigate to the Online Services Menu on left side of screen and select Benefits Inquiry.



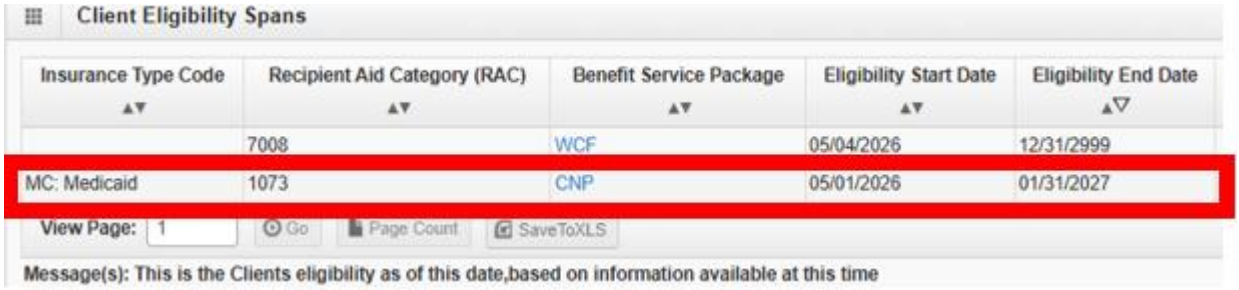
3. You will be taken to the Search window where you will be able to search for the beneficiary by their ProviderOne ID number or one of the other search criteria options listed below.



4. Click on the "Submit" button at the top left of the screen.



5. If a match is found, the client's information will be displayed on the Client Benefit Level screen. Medicaid eligibility will be displayed under the Client Eligibility Spans section of this page. Use the Eligibility Start Date and Eligibility End Date to confirm current eligibility.



PRE-AUTHORIZATIONS OVERVIEW

The WA Cares Fund Pre-authorization List provides pre-authorization information for each beneficiary. The pre-authorization list shows the:

- Pre-authorization number;
- Authorized service code(s);
- Pre-authorized units;
- Pre-authorized dates of service; and
- Pre-authorized rates.

Providers use information found in the pre-authorization list to enter claims in ProviderOne. **It is important for providers to review and understand their pre-authorization list so they can more easily identify when there may be an issue that could affect client services or the provider's payments.**

> Note: For a beneficiary who is also enrolled in Medicaid, WA Cares pays before Medicaid for services available in both programs because Medicaid must always be the payor of last resort.

Payment and unit types

Before creating a pre-authorization, it is important to review the payment type and unit type of the service code you will be using to ensure it is entered correctly. See the service code data sheet for your contract located on the Provider Toolkit to see the payment type of the corresponding service code.

Payment types

Payment types define the frequency of units and how they can be entered in a pre-authorization. Payment type codes include:

RB (monthly recurring) means the units/dollars repeat for each month in the date span. If multiple months are pre-authorized, the amount will apply to each month in the pre-authorization.

> Example: A pre-authorization of 100 units with the RB payment type over a three-month period would mean the beneficiary is approved for 100 units for *each* of the three months authorized – for a total of 300 units.

MB (span multiple) means the authorized units are the total amount that can be claimed for the entire pre-authorized timeframe.

> Example: A pre-authorization of 100 units that spans a three-month period would mean the beneficiary is approved for 100 units total within the three months authorized. The provider could then claim payment against the authorization multiple times as long as the total claimed within the three-month period does not exceed 100 units.

SB (span single) means the authorized units are the total units that can be claimed within the entire dates of service and can only be claimed from one time (on a single date of service).

> Example: A pre-authorization of 100 units that spans a three-month period would mean the beneficiary is approved for 100 units total within the three months authorized. The provider would only be able to claim all 100 units on a single date (same start and end date) within the three-month timeframe.

Unit types

Unit types are the metric for the specific measured amount, quantity or timeframe of a good or service. Unit type codes include:

DL means one unit is equal to one day.

OF means one unit is equal to one quarter hour (15 minutes).

EA means one unit is used for each item.

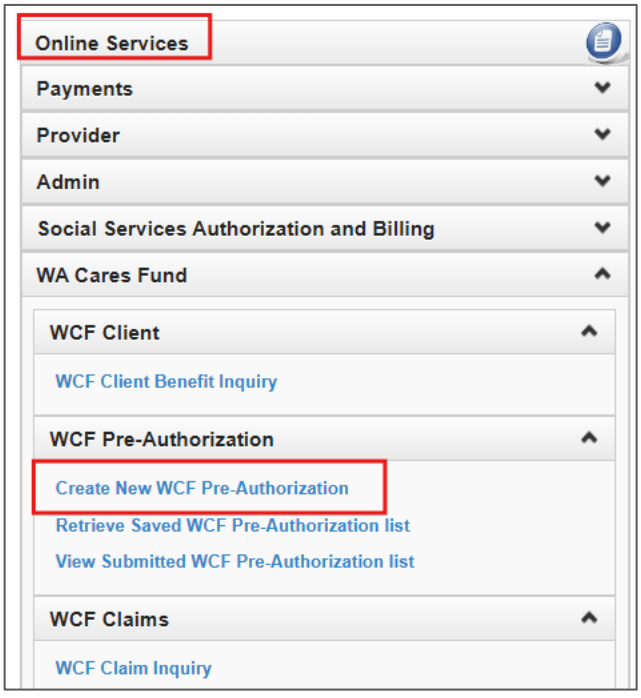
US means one unit is equal to the quantity of goods or services provided.

MN means one unit is equal to one month.

MI means one unit is equal to one mile.

Steps to creating a pre-authorization

An in-depth pre-authorization guide with examples, troubleshooting and more as well as basic pre-authorization steps are available on the provider toolkit for quick reference. To create a new WA Cares Fund pre-authorization follow the directions below.

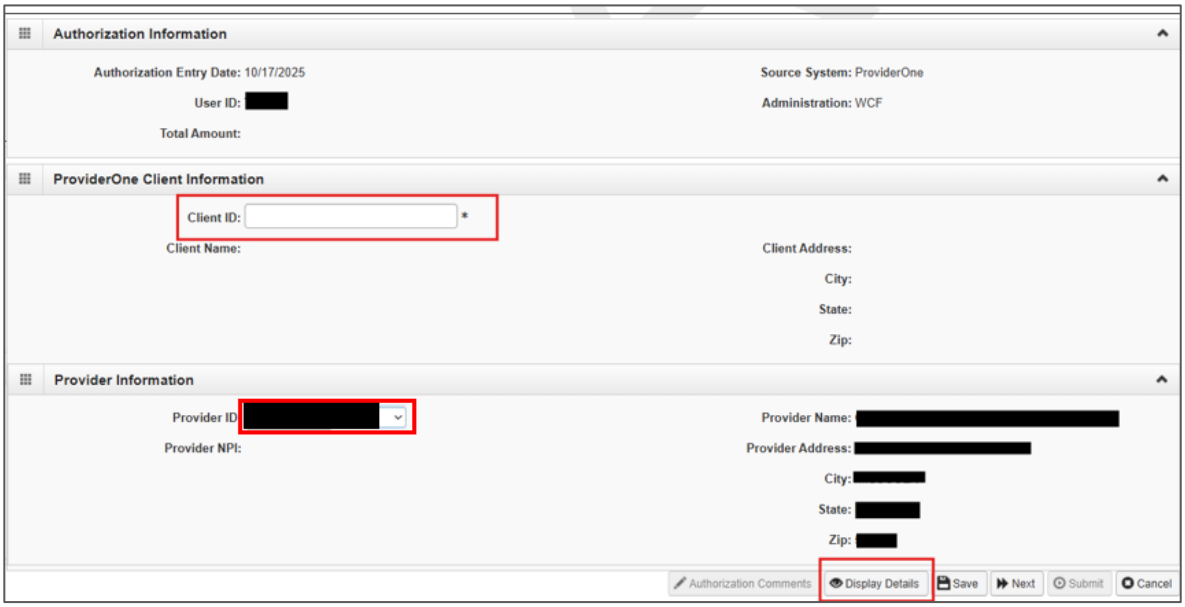


1. Log into ProviderOne using the appropriate WA Cares profile that allows you to create a pre-authorization request (i.e., any profile other than the administrator profile).

2. In the provider portal, navigate to the WA Cares Fund section located at the very bottom of the online services list on the left.

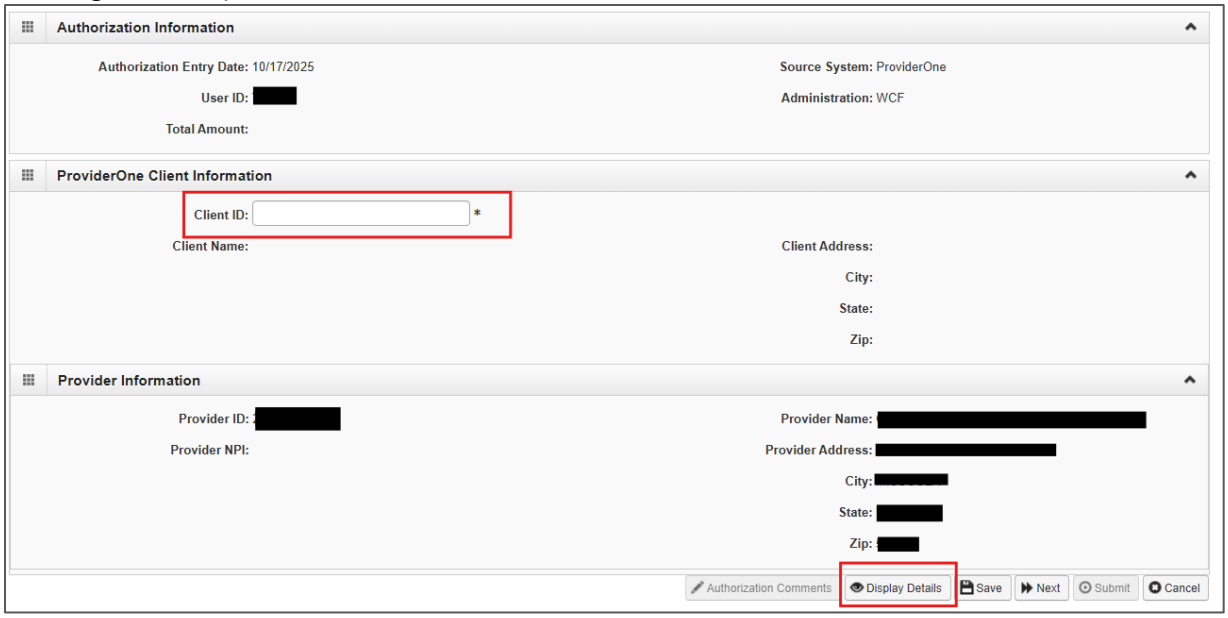
3. Select **Create New WCF Pre-Authorization.**

4. After clicking **Create New WCF Pre-Authorization,** you will be taken to the WCF Pre-Authorization Header. The system will auto populate the fields Authorization Entry Date, Source System, User ID and Administration. If your organization has multiple contracts for different business locations, select the Provider ID from the dropdown menu that corresponds to the location you'd like to assign to this pre-authorization.



5. Enter a valid ProviderOne Client ID in the Client ID field and click **Display Details**.

   NOTE: If your organization has multiple contracts for different business locations, select the Provider ID from the dropdown menu that corresponds to the location you'd like to assign to this pre-authorization.

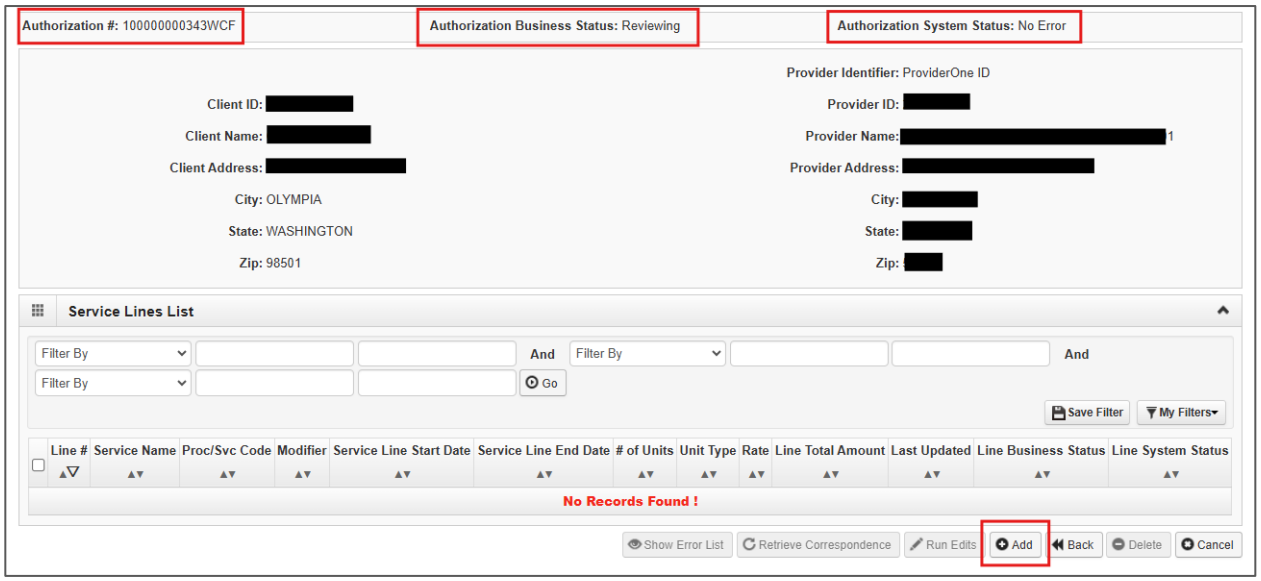


6. The system will auto-populate Client Name, Client Address, City, State and Zip details when a valid Client ID has been entered. If the client information is correct, click on the **Next** button.

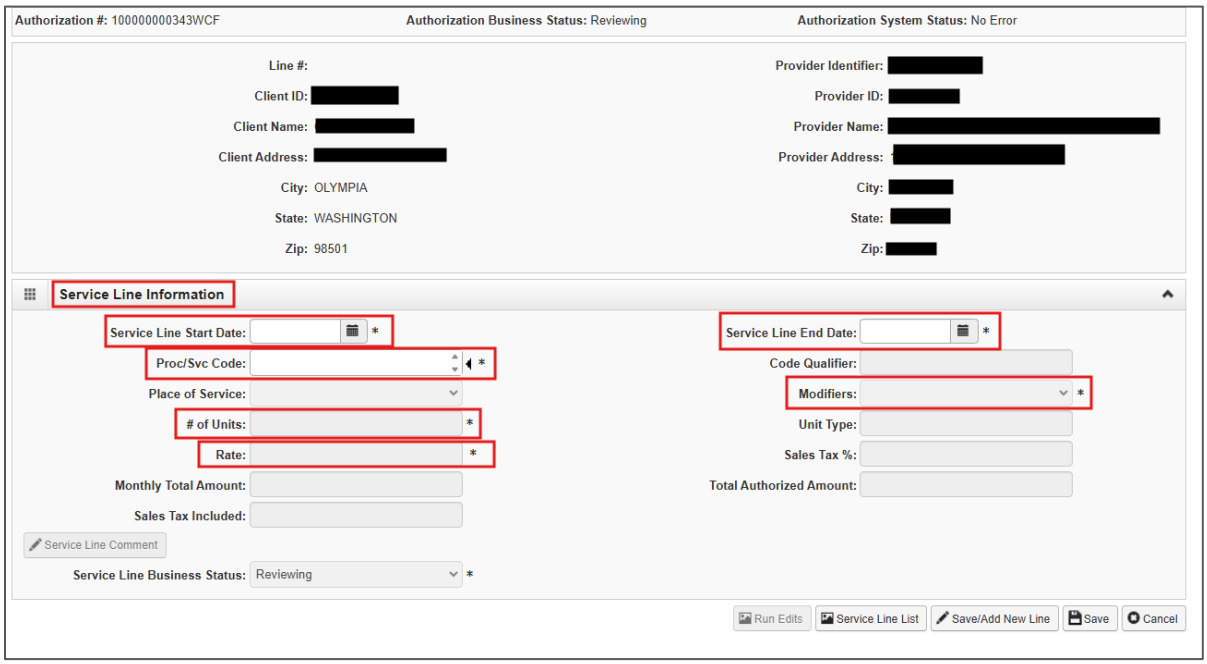


7. You will be taken to the Services Line List which displays your Authorization Number, Authorization Business Status, Authorization System Status, the client's information and your provider information.

   To add a service line, click on the **Add** button.



8. You will be taken to the **Service Line Information** screen. All fields marked with an asterisk (*) are required fields. For information regarding the required fields, see the applicable Service Code Data Sheet (SCDS) in the WA Cares Provider Toolkit.

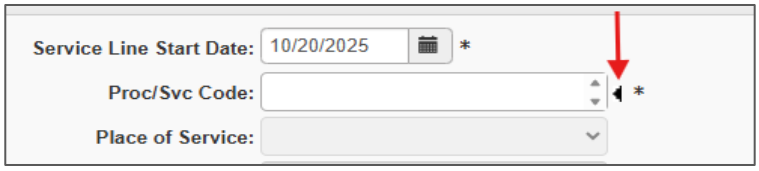


Service Line Start Date and Service Line End Date

Date span that services may be rendered, using MM/DD/YYYY as the format. The SCDS for the service provides date span limit information.

Proc/Svc Code

Choose the applicable procedure or service code from the drop box. To do this, click on the arrow, choose from the available list, click **OK**. Note: the drop-down list is based

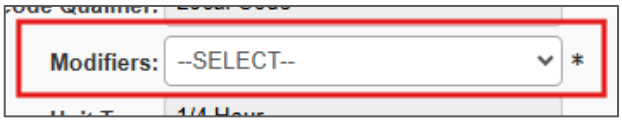




on your taxonomy. You must ensure you hold the correct contract/subcode to provide the tasks associated with the service code you select. See the SCDS for more information.

Modifier

Procedure codes may require a modifier. If one is not required, the field will auto-populate an N/A. If a modifier is required, the field may auto populate the appropriate modifier. If there are multiple modifiers available, choose the appropriate modifier from the drop-down list (see SCDS for more information if multiple modifiers are in the drop down).



Number of Units

Enter the number (#) of units for services being rendered during the date span entered in the Service Line Start Date to Service Line End Date. Note: Units entered in this field vary depending on type of service rendered and payment type. See the SCDS for information on payment and unit types for each service code. Examples of how to calculate units can be found on the pre-authorization guide.



Rate

Enter the rate per unit for services being rendered based on your agreement with the beneficiary. ProviderOne will display the rate (if fixed) or rate range available per unit for the procedure code that was entered.



Sales Tax

Some service codes require sales tax to be collected, typically for goods you will provide. You must manually enter the appropriate sales tax rate to the service line based on the beneficiary's zip code, the location where the service will be delivered, etc.



Click **Save** in the bottom right corner for ProviderOne to calculate your total.



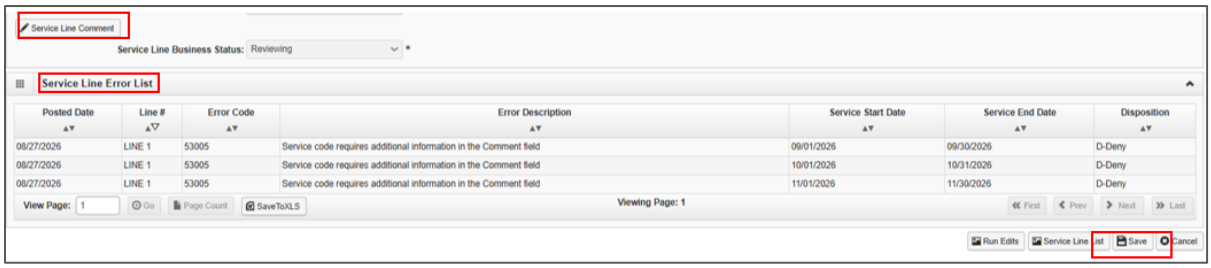
Total Authorized Amount

The system will multiply the number of units entered and the rate, to calculate the Total Authorized Amount, adding sales tax when applicable.



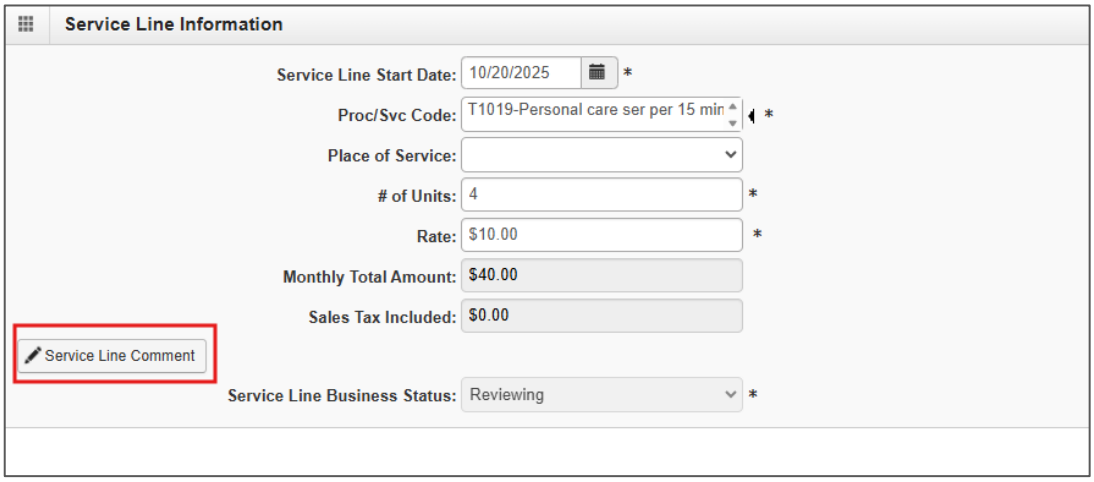
Service Line Comment

After saving, an error may post if the service code utilized requires a service line comment. You must save first to be able to select the service line comment button.

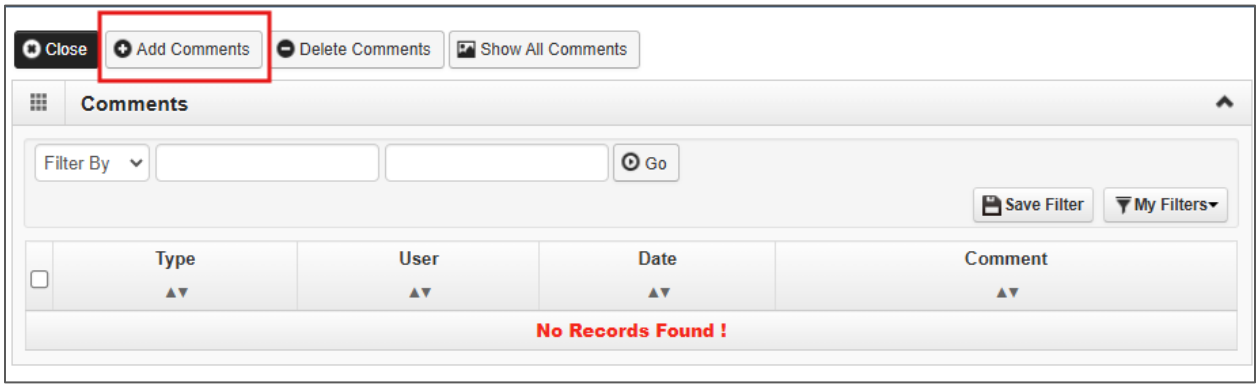


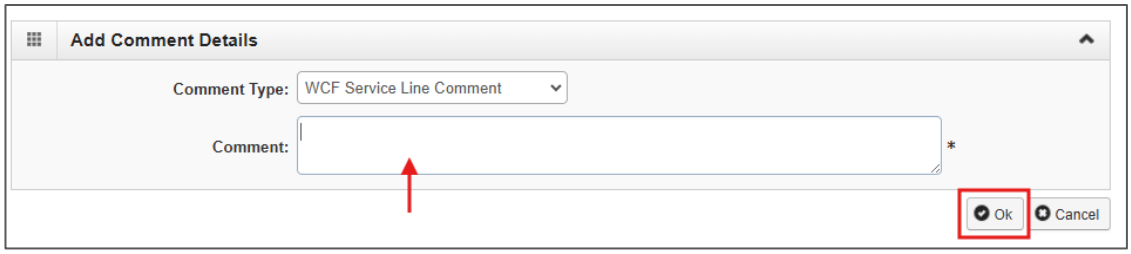
Service line comments are required for some service codes but encouraged for all service codes. Use the comments to itemize goods or services, or to provide additional details for the beneficiary's consideration when approving the pre-authorization.

Click on the **Service Line Comment** button to open the Comments window.



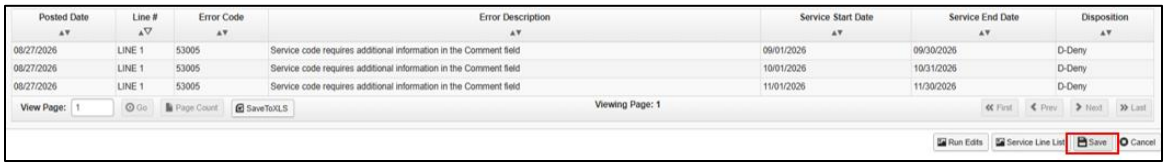
From the Comments window, click on the **Add Comments** button.
You will be able to enter your comments in the Add Comment Details window. Once you have done that, click on the **Ok** button. The Comments window will reflect the notes you just entered.



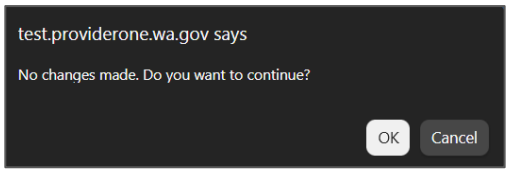


Click on **Close** in the upper left corner to go back to the Service Line Information window.

If additional service lines are needed, proceed to step 9. If no additional service lines are needed, select **Save** in the bottom right corner.



You will receive a message asking if you wish to continue, choose **OK**.



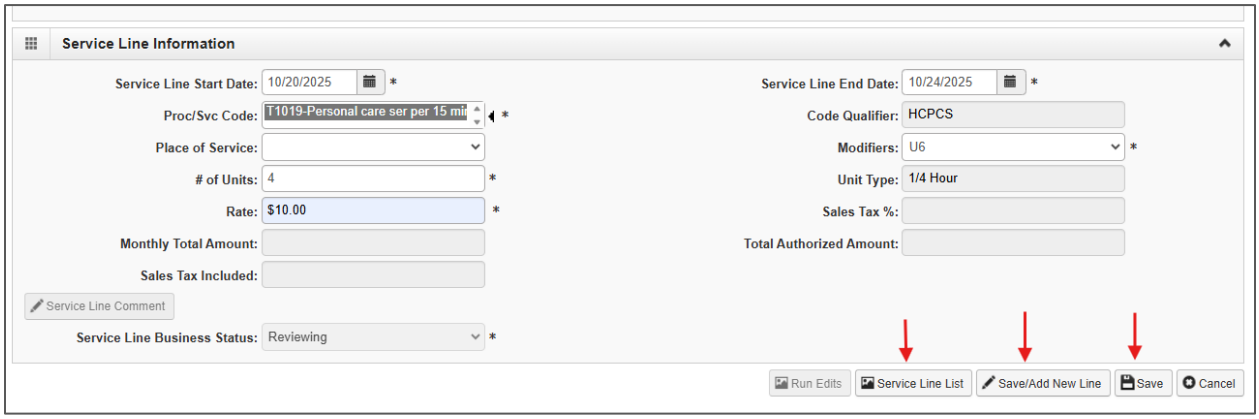
The error list will disappear, and the authorization system status will show No Error.

9. **Additional Service Lines.** If you are submitting multiple lines on one pre-authorization, you can click on the Save/Add New Line button.

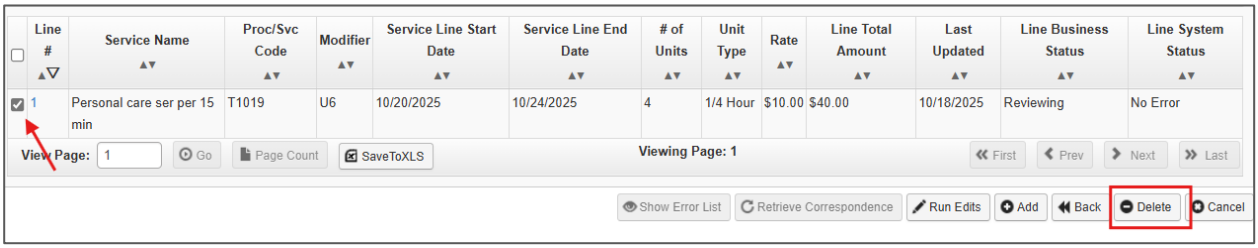
   NOTE: Additional service lines can be used to enter multiple procedure or service codes on one pre-authorization. For example, an adaptive equipment and technology provider who supplies an assistive technology good and installs it for the beneficiary can submit one pre-authorization with one service line for the assistive technology good using code SA075 and an additional line for installation of the product using service code SA 636/U2.

10. **Save.** Once all service lines are entered, click on the Save button.

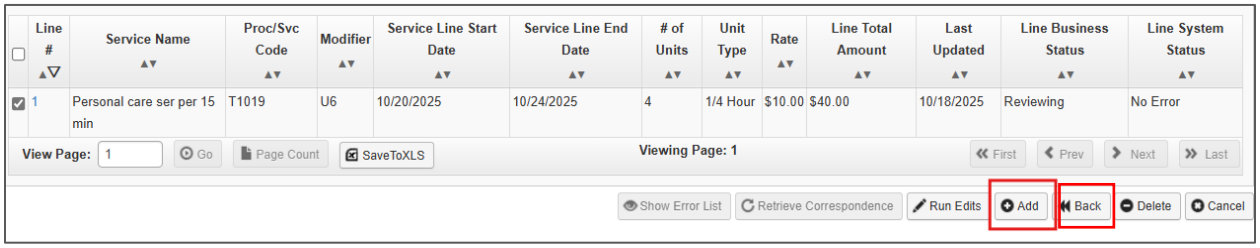
Once saved, click on the **Service Line List** button to go back to the Service Line List screen. The **Service Line List** screen should reflect the service lines you entered and saved.



If you need to delete a line, check the box next to the line you want to delete and click on the **Delete** button.



If you need to add an additional line, you can add it by clicking on the **Add** button. If no changes are needed and all the lines have a Line System Status of No Error, click on the **Back** button to go back to the WCF Pre-Authorization Header page.



11. **Submission for Beneficiary Review**

The WCF Pre-Authorization Header page will now reflect the total amount of the entire pre-authorization. Click on the Submit button to complete your pre-authorization request. The beneficiary must take action to approve the pre-authorization and begin services.

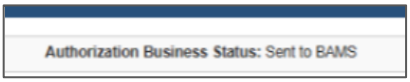
For pre-authorizations entered in advance, the beneficiary has:

- Up to 30 days to approve or deny the pre-authorization; or
- Until midnight two calendar days before the Start Date

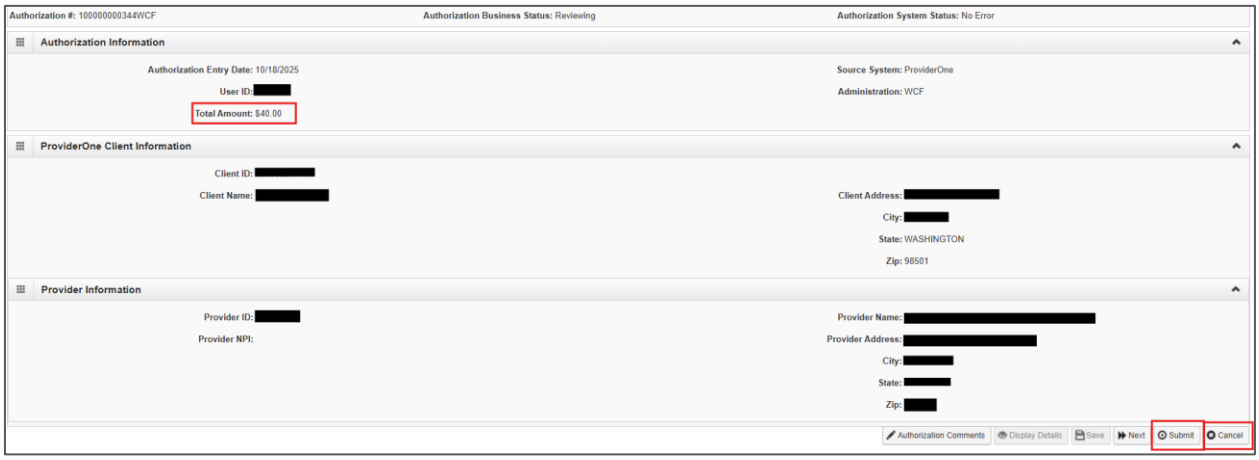
For pre-authorizations entered for next day start only, the beneficiary must

- Approve or deny the pre-authorization the same day it was entered by the provider, before midnight the morning of the service start date.

Your Authorization Business Status will update to "Sent to BAMS", which is the beneficiary's WA Cares account, where they manage their benefits and pre-authorizations.



Once submitted, you can click on the Cancel button to go back to the Online Services menu.



Pre-authorization lists

There are two preauthorization list pages.

1. Saved pre-authorizations – in process by the provider but not yet submitted.
2. Submitted pre-authorizations – the provider has submitted for beneficiary response.

To view WA Cares Fund pre-authorizations, log into ProviderOne using the appropriate profile that allows you to view the lists.

Profiles that can view and create pre-authorizations include:

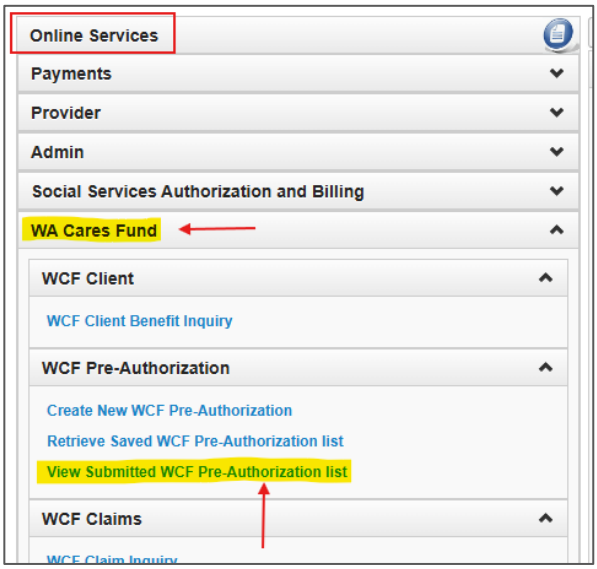
EXT Provider Claims Submitter;

EXT Provider Eligibility Checker;

EXT Provider Eligibility Checker-Claims Submitter; and

EXT Provider Super User.

In the provider portal, navigate to the WA Cares Fund section located at the very bottom of the online services list on the left.



Next, select **View Submitted WCF Pre-Authorization list**. From here you will be able to see pre-authorization information for each of your beneficiaries.

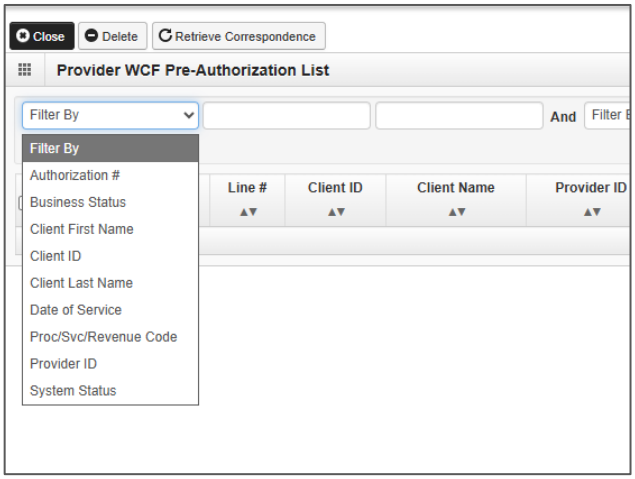
After clicking View Submitted WCF Pre-Authorization list, the **Provider WCF Pre-Authorization List** appears.

The default view shows only the active authorizations for the current month. To view your authorizations for other months or for specific criteria (e.g., beneficiary or service code), use the **Filter By** options to customize your results.

When using filters to search for pre-authorizations, you can enter a variety of search criteria, including:

- Beneficiary name or client ID
- Authorization #
- Service code
- Authorization dates

  Note: You can download the authorization list to Excel by clicking the **Save To XLS** button at the bottom of the results table.



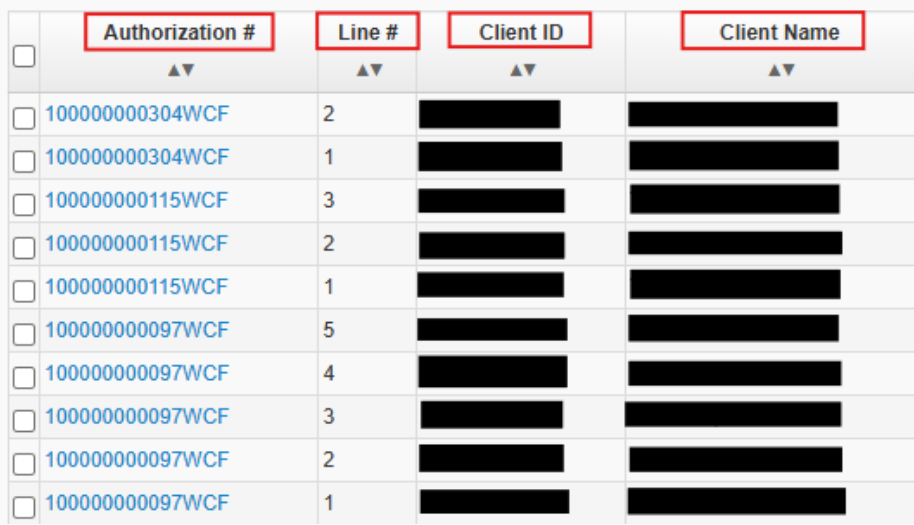
Components of the authorization list

Authorization number

An authorization number is a 12-character alpha-numeric value that uniquely identifies services for a specific client and provider pair with WA Cares Fund. Pre-authorizations can be made for up to three months for most services.

Client ID/client name

The Client ID is an 11-character alphanumeric identifier used in ProviderOne. This ID will always end in WA.



Authorization #	Line #	Client ID	Client Name
100000000304WCF	2	[redacted]	[redacted]
100000000304WCF	1	[redacted]	[redacted]
100000000115WCF	3	[redacted]	[redacted]
100000000115WCF	2	[redacted]	[redacted]
100000000115WCF	1	[redacted]	[redacted]
100000000097WCF	5	[redacted]	[redacted]
100000000097WCF	4	[redacted]	[redacted]
100000000097WCF	3	[redacted]	[redacted]
100000000097WCF	2	[redacted]	[redacted]
100000000097WCF	1	[redacted]	[redacted]

Note: When submitting your claims in ProviderOne, it will be important to verify that the claim details (authorization number, client ID, dates, service code and modifier) match the authorized details.

Note: If all service lines on an authorization are canceled, the authorization number is considered canceled and services that are later re-authorized will have a new authorization number.

Line/suffix number

The line number denotes the line of service on the authorization. The service line number will have a point after called a suffix. Verify accuracy of line details (service code, dates, units, etc.).

Provider ID

The Provider ID shown on the Authorization List is your Domain + Location ID. If you have more than one location, you will have multiple Provider IDs.

Example for a provider who has two locations:

Domain: 1234567 + Location ID: 01= 123456701

Domain: 1234567 + Location ID: 02 = 123456702

Service code and modifier

Each service authorized will have a service code and brief description of the service. Any authorized modifiers will also be listed here. If a code is authorized with a modifier, you must be sure to enter both the service code and the modifier on the claim in order for the claim to pay.

Start and end Date

The start and end date of when authorized services can be provided.

Note: Refer to the Service Code Data Sheets published in the WA Cares Fund Provider Toolkit.

Provider ID	Service Code	Service Code Description	Modifier	Start Date	End Date
[redacted]	H2014	Skills train and dev, 15 min	U5	07/01/2023	06/30/2024
[redacted]	H2014	Skills train and dev, 15 min	U5	07/01/2023	07/31/2024
[redacted]	H2014	Skills train and dev, 15 min	U5	10/01/2023	06/30/2024

Rate

The rate at which the vendor will be paid.

Units

The number of units authorized per service line.

Unit Type

How a service code will be billed. Unit types are:

- 1/4 Hour
- Hour
- Each
- Mile
- Daily
- Monthly

Rate	Units	Unit Type	Last Up
$10.00	10	1/4 Hour	10/15/2025
$10.00	10	1/4 Hour	10/15/2025
$10.00	10	1/4 Hour	10/15/2025
$10.00	10	1/4 Hour	10/15/2025
$11.25	15	1/4 Hour	10/14/2025
$10.00	10	1/4 Hour	10/10/2025
$10.00	10	1/4 Hour	10/10/2025
$10.00	10	1/4 Hour	10/10/2025
$10.00	10	1/4 Hour	10/10/2025
$10.00	10	1/4 Hour	10/10/2025

Last updated date

This column shows the date the authorization was most recently updated.

Business status

It is important that pre-authorizations are in Approved status before providing services and submitting claims. You should check pre-authorizations each time before billing to ensure there are no errors that will impact your claims.

> If a pre-authorization is in **Canceled** status, either the beneficiary or the provider canceled the pre-authorization.

Last Updated	Business Status
10/15/2025	Approved
10/15/2025	Approved
10/15/2025	Approved
10/15/2025	Approved
10/14/2025	Denied Timeliness
10/10/2025	Approved
10/10/2025	Approved
10/10/2025	Approved
10/10/2025	Approved
10/10/2025	Approved

Help with billing errors

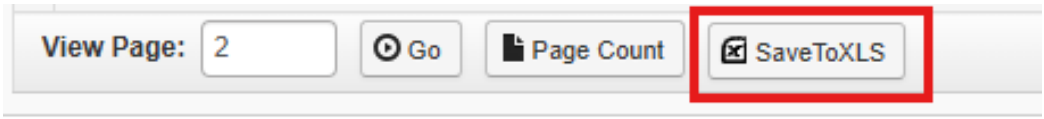
Billing questions should be directed to HCA's medical assistance customer service center (MACSC).

Navigating the pre-authorization lists

The default view of the pre-authorization list returns 10 authorizations per page in ProviderOne. If you need to view more pre-authorizations, you may do so by using the page controls at the bottom of the screen.

Note: Recall that there are two types of pre-authorization lists. **Saved** and **Submitted**.

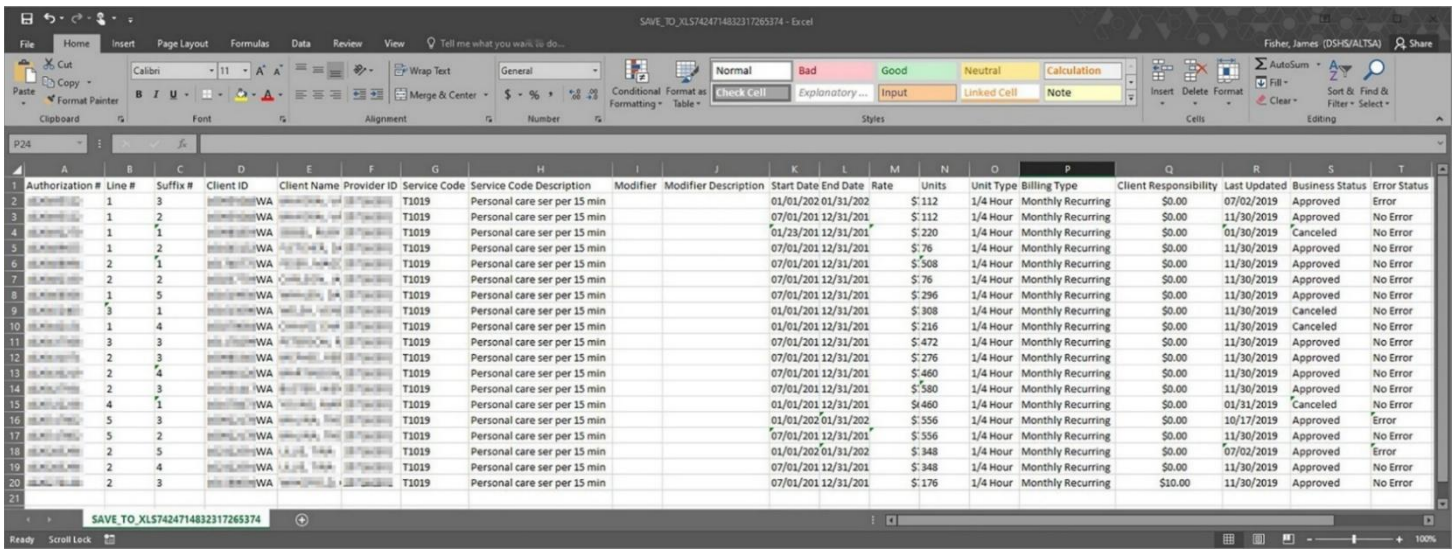
You can also download the pre-authorization list to an Excel file, which allows you to view your entire pre-authorization list. Click the **SaveToXLS** button to download as an Excel file.



Exporting your pre-authorization information to Excel can help with billing. You can copy data from the file and paste into the ProviderOne claim form. This helps improve accuracy and reduces the potential for typing errors.

If you use this method, be sure to export a new Excel file before billing for the service as authorizations may change. The Excel file contains all the information available on the Provider Authorization List page.

Below is an example exported to Excel using the "Save to XLS" button.



Authorization #	Line #	Suffix #	Client ID	Client Name	Provider ID	Service Code	Service Code Description	Modifier	Modifier Description	Start Date	End Date	Rate	Units	Unit Type	Billing Type	Client Responsibility	Last Updated	Business Status	Error Status
[redacted]	1	3	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			01/01/202	01/31/202	$	112	1/4 Hour	Monthly Recurring	$0.00	07/02/2019	Approved	Error
[redacted]	1	2	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	112	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	1	1	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			01/23/201	12/31/201	$	220	1/4 Hour	Monthly Recurring	$0.00	01/30/2019	Canceled	No Error
[redacted]	1	2	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	76	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	2	1	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	508	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	2	2	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	76	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	1	5	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	296	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	3	1	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			01/01/201	12/31/201	$	308	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Canceled	No Error
[redacted]	1	4	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			01/01/201	12/31/201	$	216	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Canceled	No Error
[redacted]	3	3	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	472	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	2	3	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	276	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	2	4	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	460	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	2	3	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	580	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	4	1	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			01/01/201	12/31/201	$	460	1/4 Hour	Monthly Recurring	$0.00	01/31/2019	Canceled	No Error
[redacted]	5	3	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			01/01/202	01/31/202	$	556	1/4 Hour	Monthly Recurring	$0.00	10/17/2019	Approved	Error
[redacted]	5	2	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	556	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	2	5	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			01/01/202	01/31/202	$	348	1/4 Hour	Monthly Recurring	$0.00	07/02/2019	Approved	Error
[redacted]	2	4	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	348	1/4 Hour	Monthly Recurring	$0.00	11/30/2019	Approved	No Error
[redacted]	2	3	[redacted]WA	[redacted]	[redacted]	T1019	Personal care ser per 15 min			07/01/201	12/31/201	$	176	1/4 Hour	Monthly Recurring	$10.00	11/30/2019	Approved	No Error

Modifying/correcting a pre-authorization

Only an active pre-authorization's end date may be modified once it has been approved, and this must be done by WA Cares staff at the request of the beneficiary. If the end-date of the pre-authorization is in the past, the pre-authorization cannot be modified. Pre-authorizations that have not yet been approved by the beneficiary can be denied by the beneficiary or cancelled by the provider and a new, updated pre-authorization can be submitted for approval.

If a pre-authorization was entered incorrectly, such as wrong dates or rate, but still approved by the beneficiary, do not work off that pre-authorization. You will need to inform the beneficiary who will then need to contact WA Cares to request that the incorrect pre-authorization is cancelled or end-dated. In the meantime, you can create a new, correct pre-authorization for the beneficiary's review and approval for future dates of service. If services are completed on an incorrect service authorization that has been approved, you will only be able to claim what has been approved.

Requesting additional units

The number of units cannot be modified on approved pre-authorizations. If the beneficiary decides they would like to authorize additional units, you will need to submit an additional pre-authorization. Pre-authorizations cannot be backdated, so additional units can only be approved for future dates. Pre-authorizations entered ahead of time must be approved by the beneficiary at least two days before the service start date. If a last-minute pre-authorization is entered for next day start, the beneficiary must approve this by midnight before starting services. Any additional pre-authorizations created will add to the total approved units for the timeframe authorized (including the units approved on the original pre-authorization).

Example: If a beneficiary has an approved pre-authorization for 30 units per month from 9/1/26 -11/30/26 but the beneficiary determines they need an additional 10 units for November, the provider will create another pre-authorization for the additional 10 units for 11/1/26-11/30/26. Once they have approved this, the beneficiary will have a total of 40 units available in November.

When claiming, typically all units provided on the same date of service must be claimed together or the system will view it as a duplicate claim and deny. However, in this case if the units span multiple pre-authorizations for the same date, you can claim for this date on two claims but must identify the pre-authorization number you are pulling from in each claim so the system does not treat it as a duplicate.

Example: The initial pre-authorization accounted for 30 units for November 2026. A second pre-authorization was approved to add an additional 10 units for this date range. When the provider claims for November 2026, they enter the following dates of service and units as provided to the beneficiary:

- 11/04/2026 – 15 units (authorization #1)

- 11/11/2026 – 7 units (authorization #1)
- 11/18/2026 – 9 units (two submissions – 8 units under authorization #1, 1 unit under authorization #2)
- 11/25/2026 – 9 units (authorization #2)

The units entered on 11/18/2026 exceed the original 30 units and pulls one additional unit from the second pre-authorization that was approved. In this case, the provider would submit a claim under the first pre-authorization for 8 units and a second under the second pre-authorization number for the remaining 1 unit.

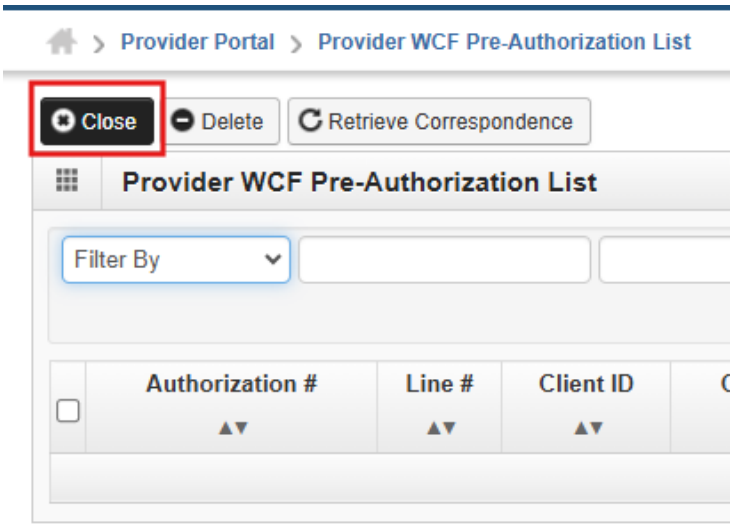
Unused units

If a beneficiary does not use the entire amount pre-authorized, the remaining balance will be returned to the beneficiary's WA Cares account 60 days after the end-date of the pre-authorization. This aligns with the timely filing deadline as providers must submit a clean, error-free claim no more than 60 days after the end date of the pre-authorization.

Refreshing the WCF pre-authorization list

When changes are made to a pre-authorization, you will not see them right away if you are already on the Provider WCF Pre-Authorization List page. If you are resolving authorization issues and are unable to see the changes in the current view, do the following:

- Click the **Close** button in the upper left corner.
- This will bring you back to the main Provider Portal page.
- Next, select **View Submitted WCF Pre-Authorization list**.
- In the **Filter By** drop-down menu, select the manner in which you wish to search the pre-authorizations list (e.g., authorization number).
- Enter the information and click **Go** at the end of the row.





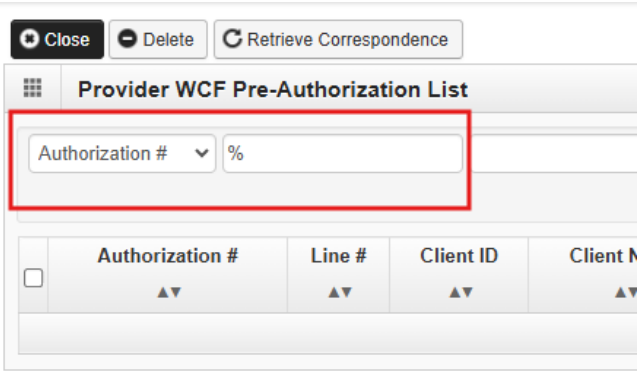
- The authorization list will now be refreshed to the most current information available.

Viewing updates to a pre-authorization

Occasionally there will be updates to a pre-authorization. You will be alerted to these changes the way you indicated in Step 2: Locations.

If you need to review the history of a particular authorization to see what has changed:

- Navigate to the **View Submitted WCF Pre-Authorization list**.
- Once the page appears, use the **Filter By** drop-down menu to search for the authorization number and processing status.
- In the Authorization # field, enter the authorization number you are searching for. In the Processing Status field enter % and then click **Go** at the end of the row. (The % acts as a wildcard, showing all possible results for that filter.)



The filtered list appears, showing the Business Status as **Approved**, **Canceled**, or **In Review**.

> Note: In Review is not an applicable status when viewing the list of approved pre-authorizations.

The list shows the **Processing Status** as **Active** or **Inactive**.

Authorization length

See the relevant Service Code Data Sheet in the Provider Toolkit for information on length of authorization.

BASIC CLAIMS (A.K.A. DDE)

Submitting a basic claim is also known as direct data entry (DDE) billing. For DDE, you must enter all billing information (Provider ID, Client ID, Authorization Number, Dates of Service, Service Code, and Units) each time you submit a claim.

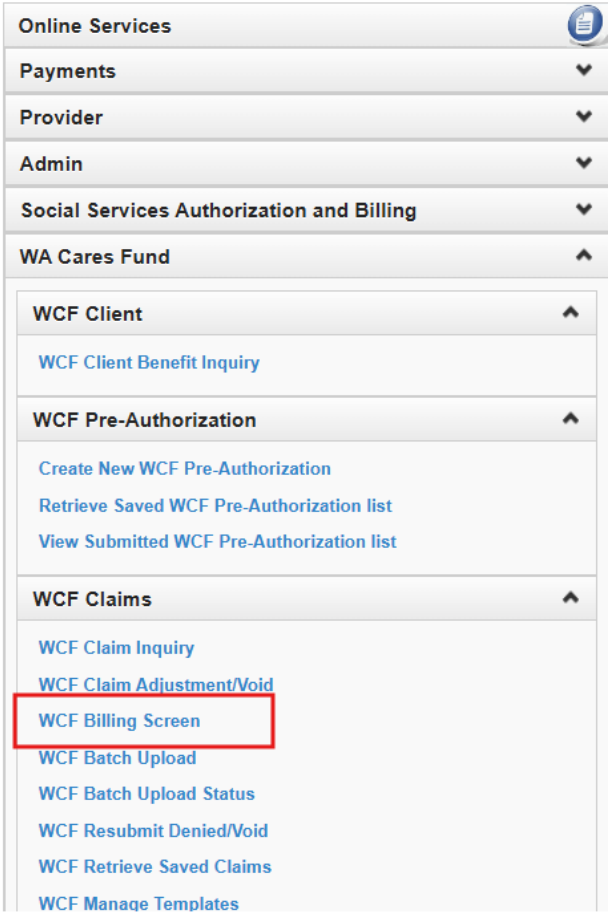
Required claim information (e.g., authorization #, procedure code, modifier) can be found by navigating to the View WCF Pre-authorization list.

Submitting a basic claim

To submit a basic claim, log into ProviderOne using one of the following profiles.

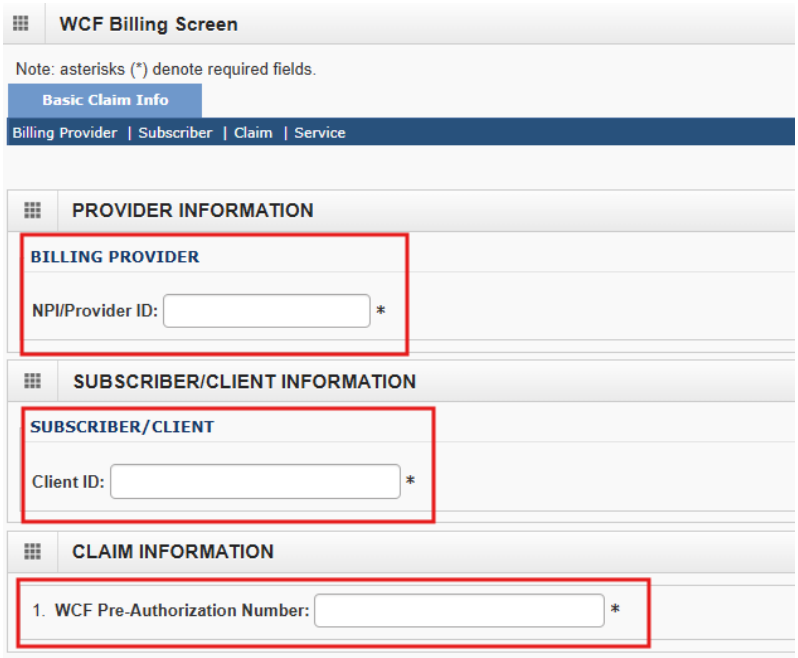
- EXT Provider Claims Submitter
- EXT Provider Eligibility Checker-Claims Submitter
- EXT Provider Super User

In the provider portal, navigate to the WA Cares Fund section located at the very bottom of the online services list on the left. Click on **WCF Billing Screen**.



The WCF Billing Screen will appear. Enter the following information:

- **Provider ID** (your 7-digit domain/ProviderOne ID plus your 2-digit location code for WCF Location type)
- **Client ID** (11-digit alphanumeric value that ends in WA)
- **WCF Pre-Authorization Number** (12-digit number that ends in WCF)



Note: You must turn off your pop-up blocker before you begin billing.

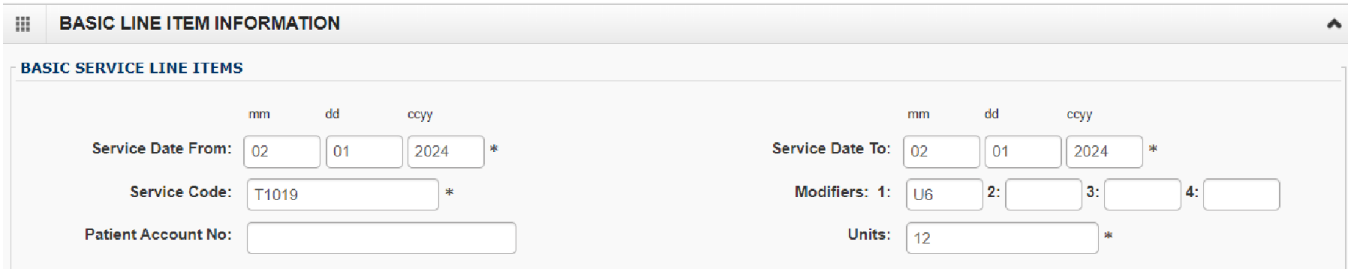
Note: Asterisks (*) denote required fields.

The billing information is taken directly from the pre-authorization. Exporting the pre-authorization info to an Excel file ("Save to XLS") allows you to copy and paste information for accuracy. Check your pre-authorization before each billing as pre-authorizations may change.

Under **Basic Line-Item Information**, fill out the following information:

- **Service Date From**
- **Service Date To**
- **Service Code**
- **Modifier** (if applicable)

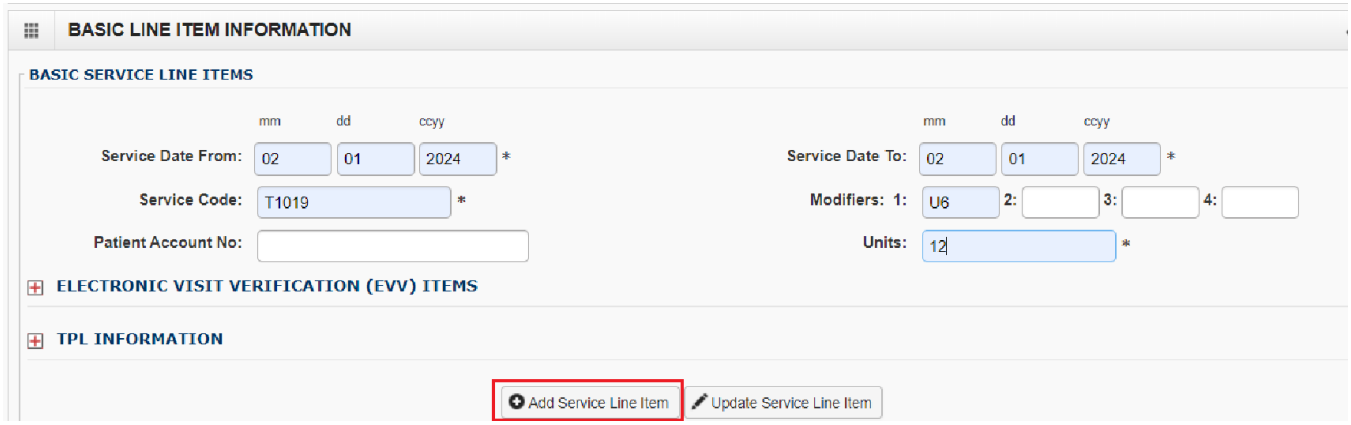
- **Units**



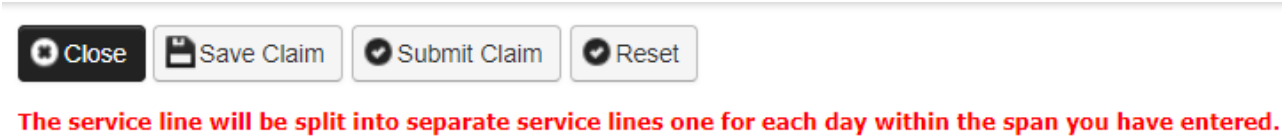
Notes:

- Each service line spans a single day.
- All units of a specific code for the same day should be on the same line.
- A date range can be used only if:
  - The unit types are daily or monthly
  - Days are consecutive (worked in a row)
  - All days are within the same calendar month or include entire months
- The unit type can be found on the client's authorization

Once all billing information is entered on the **Basic Service Line Items** section and EVV Items section (optional for WA Cares), select **Add Service Line Item**.



If you entered a date range and are billing for a DAILY unit type, a note will appear telling you that the date range will be broken down into individual daily service lines when the claim is processed:



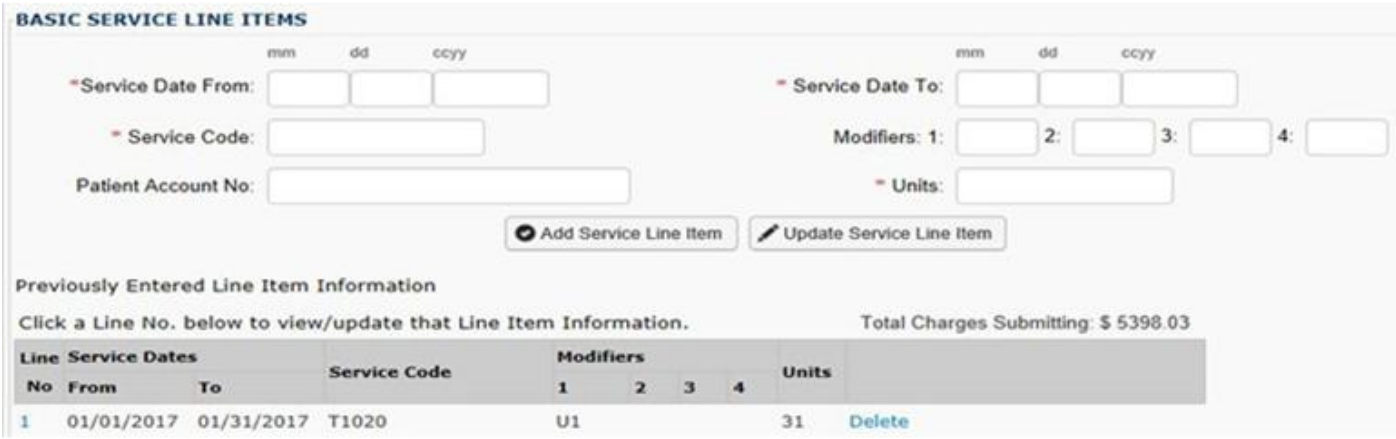
Note: ProviderOne will display instructional information before this message if any data entered is incorrect, i.e., **Provider ID, Client ID, Preauthorization Number**, or if **Service Date To** is earlier than **Service Date From**. Correct data per message and continue.

Once you click **Add Service Line Item** the **Basic Service Line Items** section clears. This allows entry of any subsequent service lines before submitting your claim.

Note: Different service codes are allowed on the same pre-authorization and claim, but all service lines must be for the same beneficiary.

A claim service line appears under **Previously Entered Line-Item Information**. The claim service line will show service dates, service code and modifier, as well as units entered. The total charges submitted will also be available to view.

Check the line information for accuracy



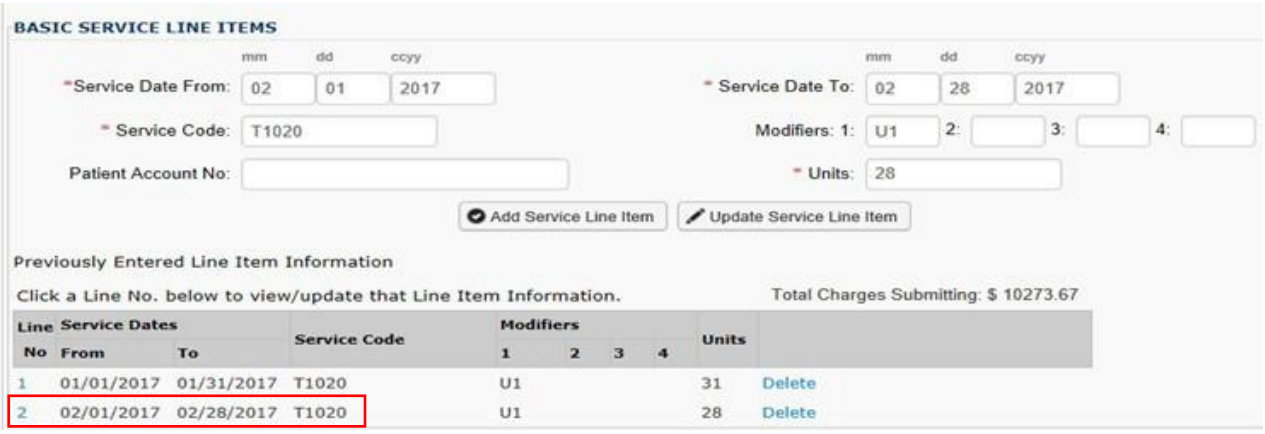
Adding service lines

If you are billing for multiple service codes or timeframes for one beneficiary, you can bill this on the same claim by adding service lines. There are two methods for adding service lines to a claim. You can add up to 31 service lines per claim.

Method 1

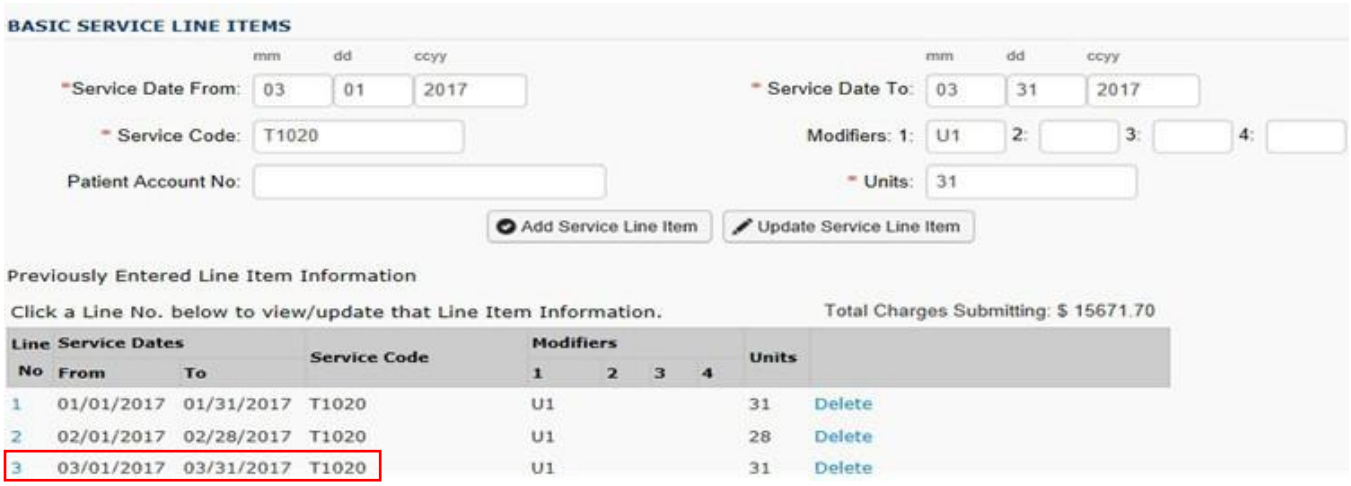
- Enter basic service line information in the cleared fields:
  - **Service Date From/To**
  - **Service Code**
  - **Modifier**
  - **Units**
- Next, click on **Add Service Line Item**

- The new service line appears (shown below as line #2).



Method 2

- Click on an existing service line number (click on the blue hyperlinked **Line No**). The entered service line information populates.
- Enter new data.
- Click **Add Service Line Item**.
- The new service line appears (shown below as line #3).

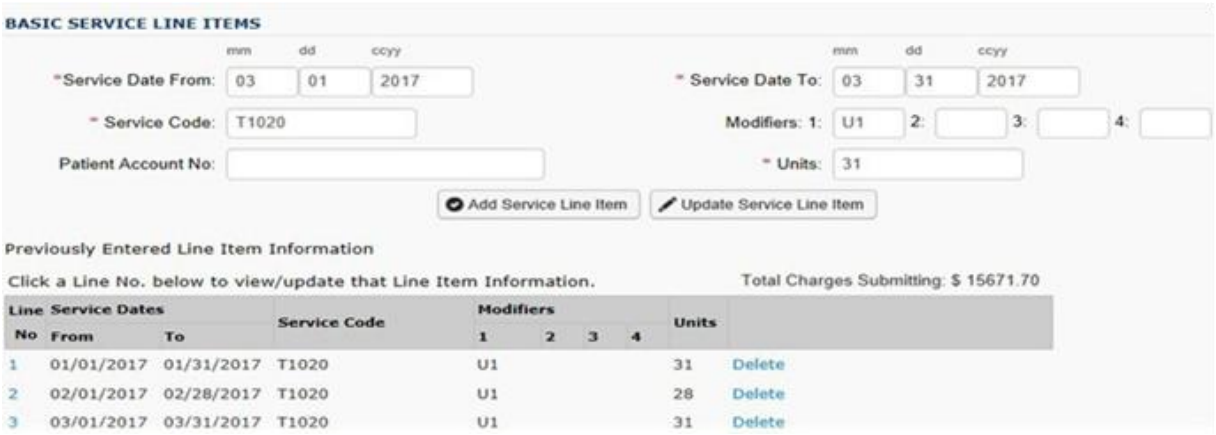


Editing a service line

You may see the information previously entered has an error. To correct the data so that the service line is correct:

- Select the line number you wish to edit.
- The service line data appears.
- Make the needed correction to the service line data.

- Select **Update Service Line Item.**



Deleting a service line

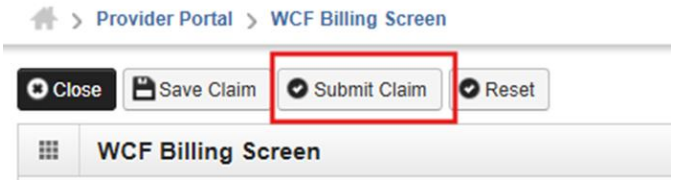
You may see a line previously entered that was created in error and needs to be deleted in order to correct the data.

- Determine which line needs to be deleted in the **Previously Entered Line-Item Information** section.
- Click **Delete** at the end of the line you wish to remove. The line will disappear from the claim.



Submitting finalized claim

Once all service line information is entered and checked for accuracy, click **Submit Claim** at the top of the screen.



After selecting **Submit Claim**, the Submitted WCF Claim Details screen appears.

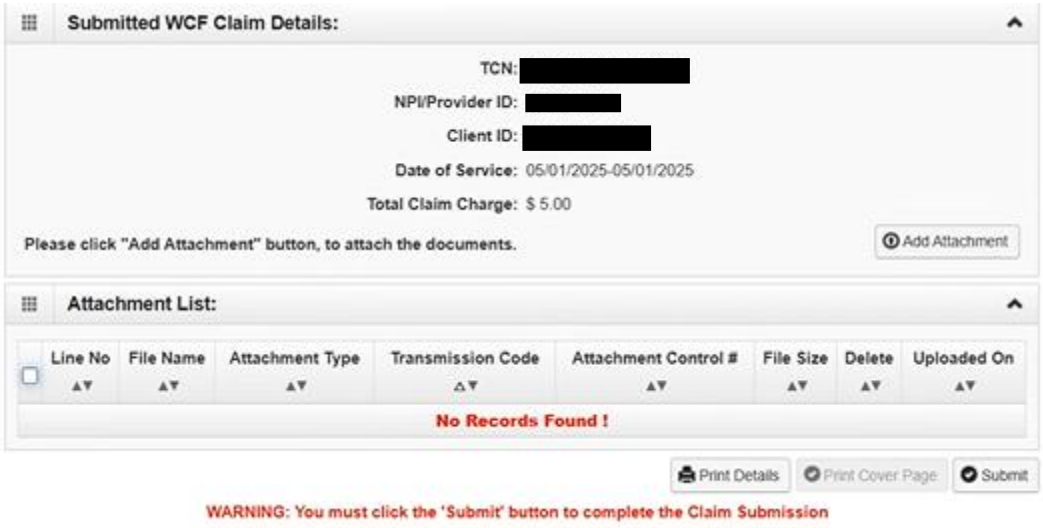
Next you will see the **Transaction Control Number (TCN), Provider ID, Client ID, Date of Service** and **Total Claim Charge.**



Note: If you do not receive a pop-up message displaying the TCN, Provider ID, etc., it is probably because your pop-up blockers are turned on. You will have to turn off your pop-up blockers and then try submitting the claim again.

When you see the **Submitted WCF Service Claim Details** screen, you may want to record the information. You can print a hard copy, print to a file on your computer, or record this information in another manner.

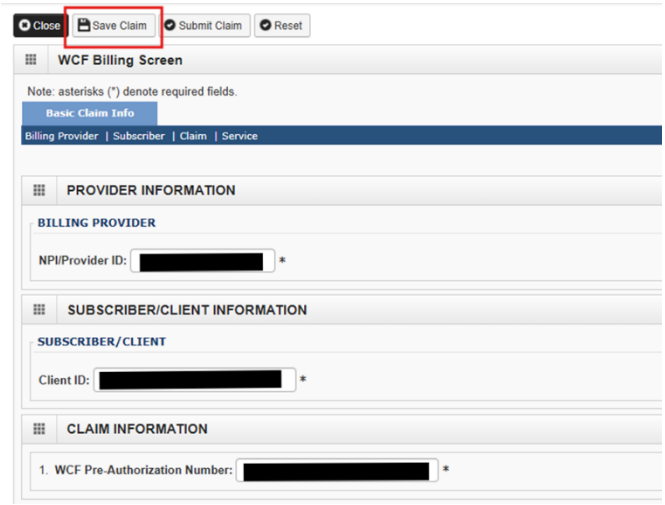
To complete claim submission, click on the **Submit** button (located on the bottom right corner of the page).



SAVE BASIC BILL

If you need to stop your work and return later to complete it, you can save the claim by:

- While in the **WCF Billing Screen** make sure you have filled out at least these three fields:
  - **Provider ID**
  - **Client ID**
  - **WCF Pre-Authorization Number**
- Click **Save Claim** (located near the top left of the screen).
- Confirm that you would like to save the claim by pressing **OK** on the pop-up message.

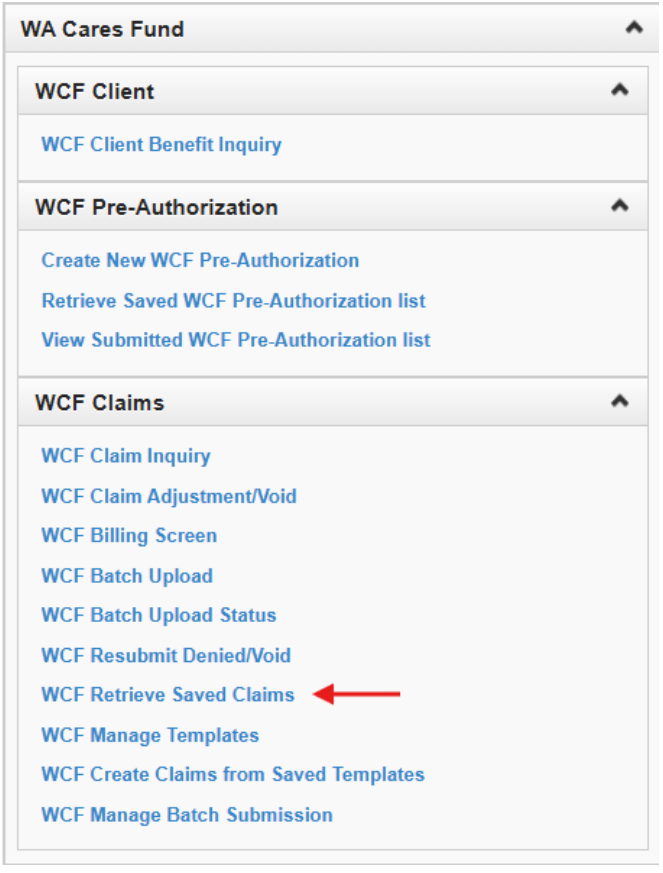


Retrieving a saved claim

In order to retrieve a claim, you saved:

- Log in to ProviderOne using one of the following profiles:
  - EXT Provider Claims Submitter
  - EXT Provider Eligibility Checker-Claims Submitter
  - EXT Provider Super User
- In the provider portal, navigate to the WA Cares Fund section located at the very bottom of the online services list on the left. Click **WCF Retrieve Saved Claims.**
- Click next to the claim you want to retrieve.

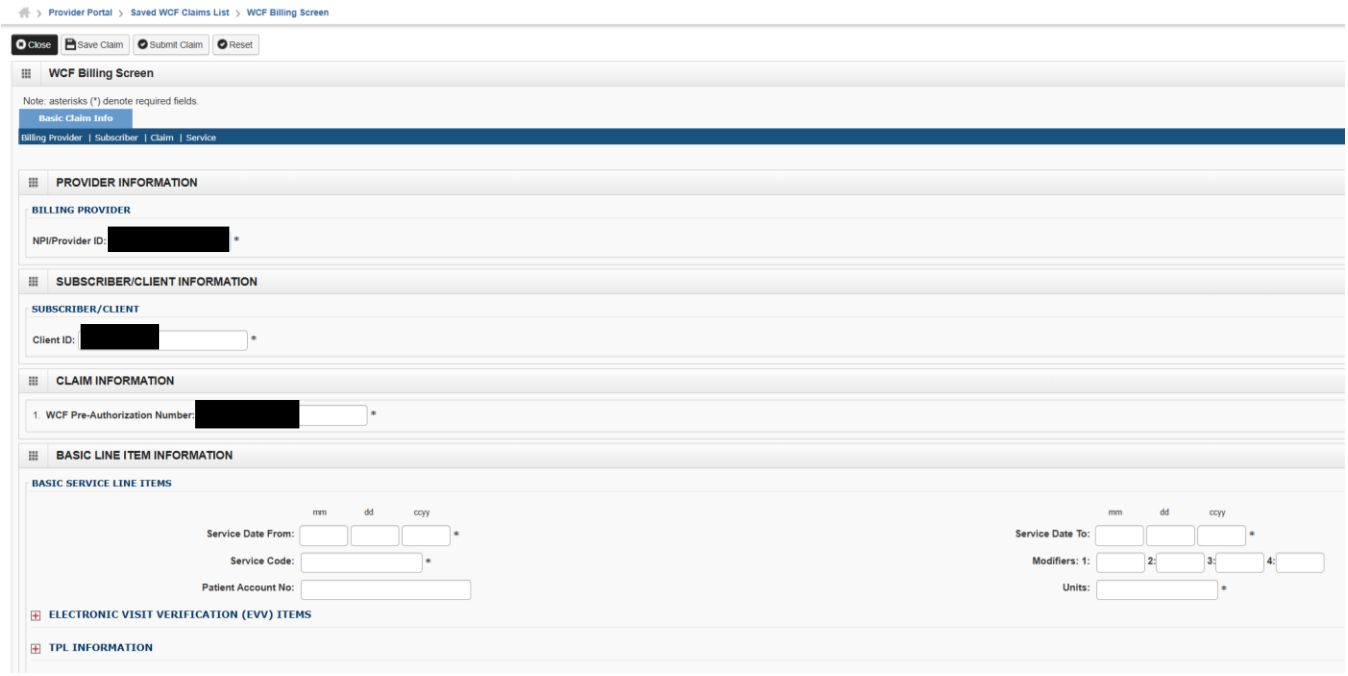
Note: You can see that a TCN has been created for the claim, however, this TCN has not been submitted for



ProviderOne to process and will not be submitted until you complete the claim submission.

Once the claim you wish to finish has been selected, the **Basic Billing** screen appears.

The previously saved information will populate. From here, the process continues the same as submitting any other claim. (Refer to pages 63-72 for instructions.)



LOOKING UP A CLAIM

After submitting a claim, you can confirm the claim was successfully submitted by using the WCF Claim Inquiry feature.

1. From the Provider Portal, click WCF Claim Inquiry.
2. Search by the TCN or the Client ID and Claim Dates or the Authorization # and Claim Dates.
3. If the claim was submitted successfully, you will be able to see the claim. The claim status will show as 'In Process' until the claim pays or denies at which point the status will change to 'Finalized'.

CREATING WCF CLAIM TEMPLATES

This section explains how to create claim templates. Claim templates allow you to save data (e.g., Provider ID, Client ID, and pre-authorization number) which helps eliminate errors by reducing the amount of data entry for each claim.

Creating a template

Creating claim templates are a good option if you have repetitive billing (i.e., the claim is the same or nearly the same each time you bill).

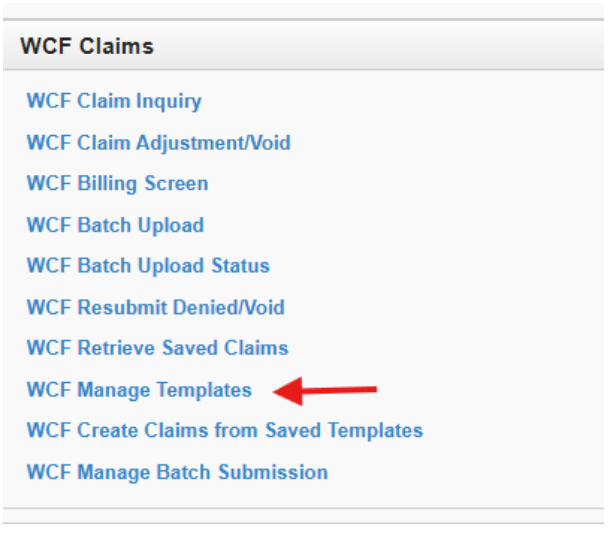
Using templates with previously saved information will help cut down on errors by reducing the amount of data entry for each claim, and it is a great way to save time and make billing easier.

To create a WA Cares Fund Claim Template:

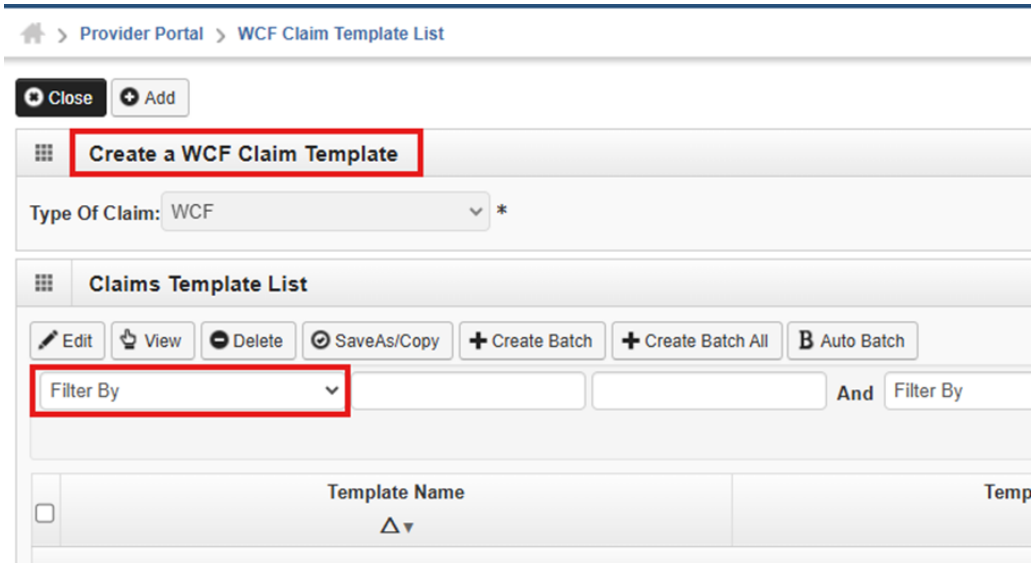
1. Log into ProviderOne using the appropriate profile. Navigate to the **WA Cares Fund** section located at the very bottom of the online services list on the left.
2. Then select **WCF Manage Templates**.

   Note: Creating or 'managing' a template is not the same as submitting a claim.

   The Manage Templates screen is for creating, editing, or removing templates. No claims can be submitted from the Manage Templates screen. For directions on how to submit claims using a template, see Submitting a Template Batch.



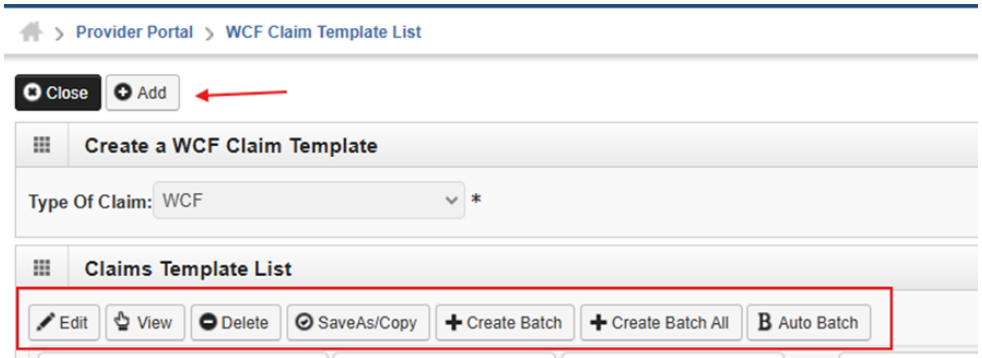
The Create a WCF Claim Template page will appear. Here you will see any previously saved templates. When there are a large number of templates, you can use the **Filter By** function to find a template.



Note: The default **Type of Claim** is WCF and should not be changed.

The **Create a WCF Claim Template** page can be used to do several things:

- **Add** a new template
- **Edit** a saved template
- **View** a saved template
- **Delete** a saved template
- Change template name (**Save as/Copy**)
- **Create** a template batch



3. To create a new template, click **Add**. The **WA Cares Fund Provider Billing Screen** will appear.

4. Fill out all of the following:

   Template Name. This is determined by you and is only used to identify the template.

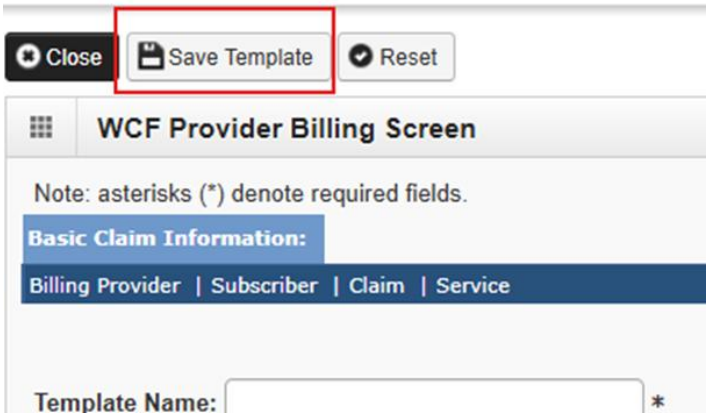
   Provider ID as listed on the authorization.

   Client ID as listed on the authorization.

   Authorization Number as listed on the authorization.

   Basic Line-Item Information as listed on the authorization, except for the 'Service Date From' and 'Service Date To' data.

5. Once the required data elements have been entered, save the template by clicking on **Save Template** in the upper left corner of the screen.



6. After choosing **Save Template**, you will be asked, "**Do you want to save the Template?"**

   Select **OK** to save the template.

   Select **Cancel** if you are not ready to save the template or need to make changes.

You will be returned to the **Create a WCF Claim Template** page, where you will see the template, you have created. You can see the template name, template type, the user who made the last update and the last updated date.

7. To view or delete the template, check the box next to the template name and choose the appropriate action (e.g., edit, view, delete).

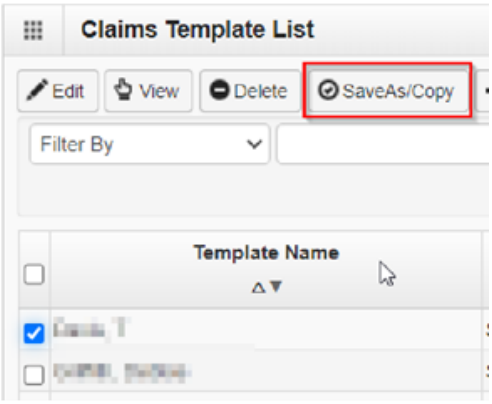
Copying a template

To save time, you can use a template you created to make similar templates for other clients.

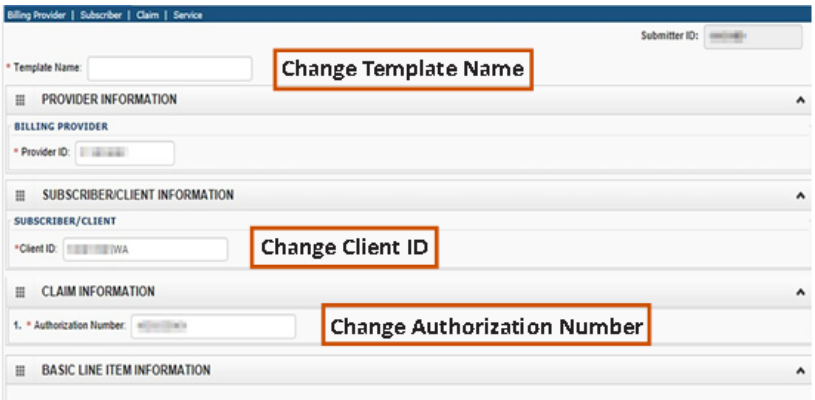
To do this, you can make a copy of an existing template, change the client information, rename the template, and save.

To copy a template:

1. Check the box next to the desired template name. Select **Save As/Copy**.



2. The original saved template will appear. Customize the template by changing any of the details below as needed:
   - **Template Name**
   - **Provider ID**
   - **Client ID**
   - **Preauthorization Number**



3. To save the template, click **Save Template**.
4. After choosing **Save Template**, you will be asked, "**Do you want to save the Template?"**

   Select **OK** to confirm the save of the template.

Select **Cancel** if you are not ready to save the template or need to make changes.

You will now be returned to the **WCF Claim Template** page. The newly saved template will be shown along with the original template.

Repeat the process as many times as needed.

Submitting claims from saved templates

As previously mentioned, claims cannot be submitted from the WCF Manage Templates screen.

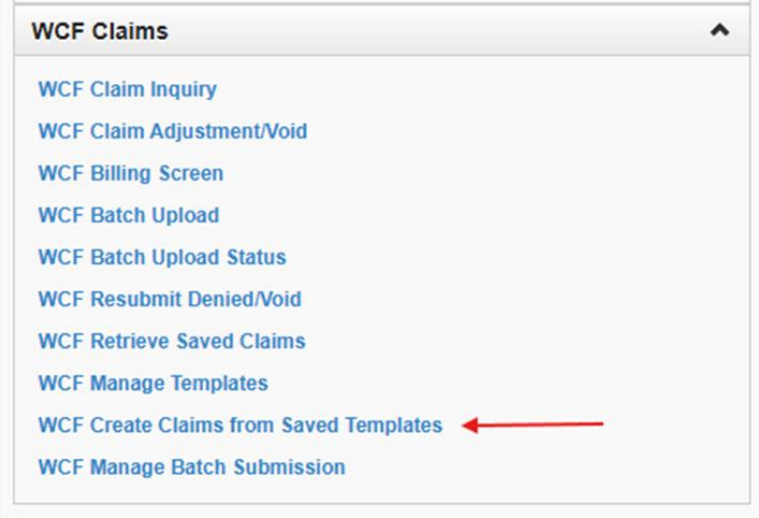
To submit claims using the templates you have saved:

1. Log into ProviderOne using the appropriate profile.
2. Select **WCF Create Claims from Saved Templates**.
3. When the **Create WCF Claim from Saved Templates List** appears, you will see all of your claim templates. Select a template by clicking on the blue hyperlinked template name.
4. After selecting a template, you will see the saved information from the chosen template. This will include:

   Provider ID

   Client ID

   WCF Pre-Authorization Number
5. Next, fill out the rest of the claim information and then submit the claim.



WCF BATCH CLAIMS

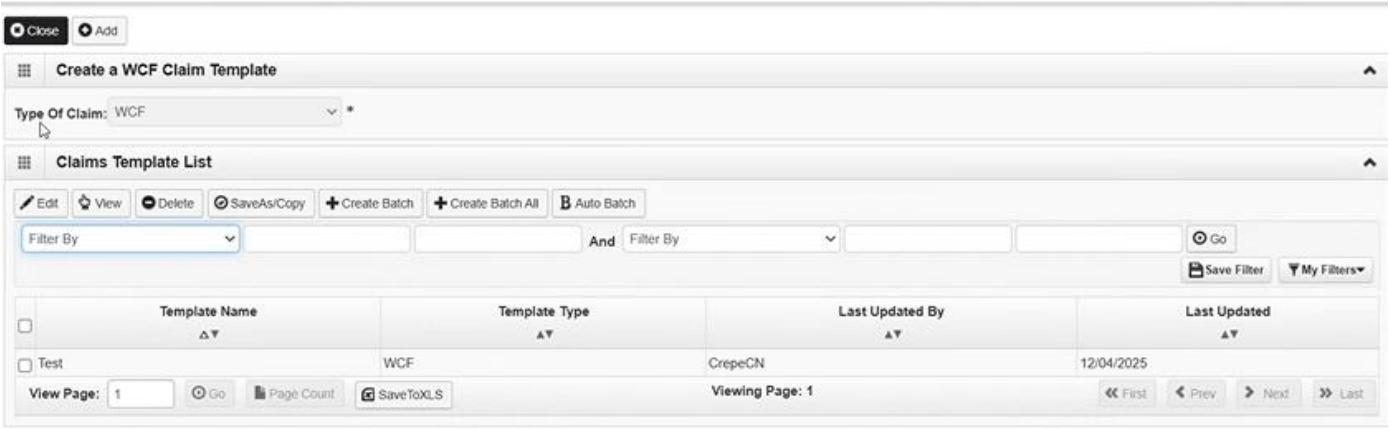
A batch (template) is a group of claims which share the same date of service. A batch allows the provider to create a group of templates, change the date of service on all the templates at one time, and submit the batch all at once.

Creating a template batch

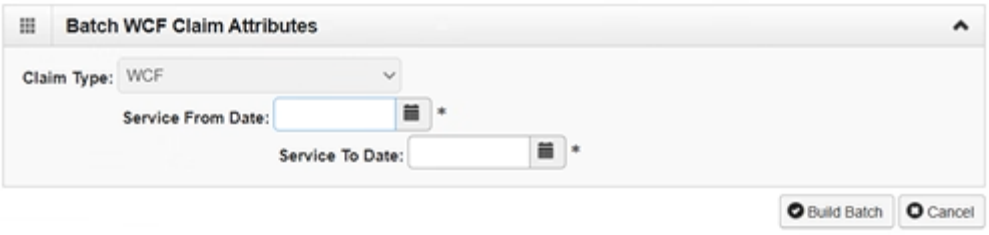
To create a template batch:

1. From the Provider Portal, navigate to the WA Cares Fund section located at the very bottom of the online services list on the left. click **WCF Manage Templates.**

2. When the **Create a WCF Claim Template** page appears, you will see all the claim templates you have created. The Template Type should be WCF.



3. Before creating a Batch Template, review the individual templates. Individual templates must include Basic Service Line Items.
4. To submit templates in a batch, select the box next to each template you want to include in the batch and then click **Create Batch.** (To include <u>all</u> templates in the batch, click **Create Batch All**.)
5. When a pop-up appears and asks, "**Do you want to save the Template?**" click **OK**.
6. When **Batch Claim Attributes** appears:
   - The **Claim Type** defaults to WCF (do not change this).
   - Enter **Service From Date**.
   - Enter **Service To Date**.

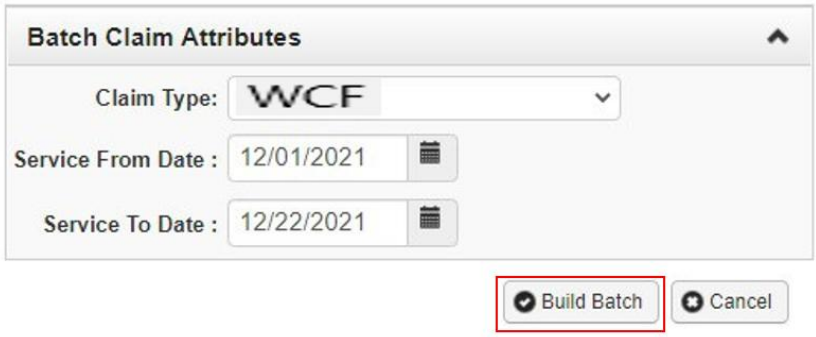


Notes:

- The Date of Service will be changed on all the service lines on each template. All claims within the template must be for services provided on the date entered.
- The Date of Service can only be a single day.
- A date range can be used only if:
  - All unit types are daily or monthly

- Days are consecutive (worked in a row)
- All days are within the same calendar month or include entire months
- # of units on templates equals the days or months within the range
- All the templates have the same date range

7. Click on **Build Batch**.



8. Assigned **Batch Number** appears along with the number of total claims included in the batch.
9. Click **Cancel**.

Your claim has now been built, but it is not yet submitted.

10. Repeat the process to create additional batches or click **Close** to return to the **Provider Portal**.

Notes:

11. After a batch is created, ProviderOne checks the batch to ensure the templates have complete claim information:
    - **Passed Validation** means all the templates have complete, valid information and the batch can be submitted.
    - **Failed Validation** means one or more items within the batch is not valid and the batch cannot be submitted.

    For more information, see revalidate a template batch.

11. When you are ready to submit a batch, see Submitting a Template Batch..

Revalidating a template batch

After a template batch is created, ProviderOne checks the batch to ensure the billing data is valid. This section is on how to check the validation of a batch and revalidate a template batch that fails validation.

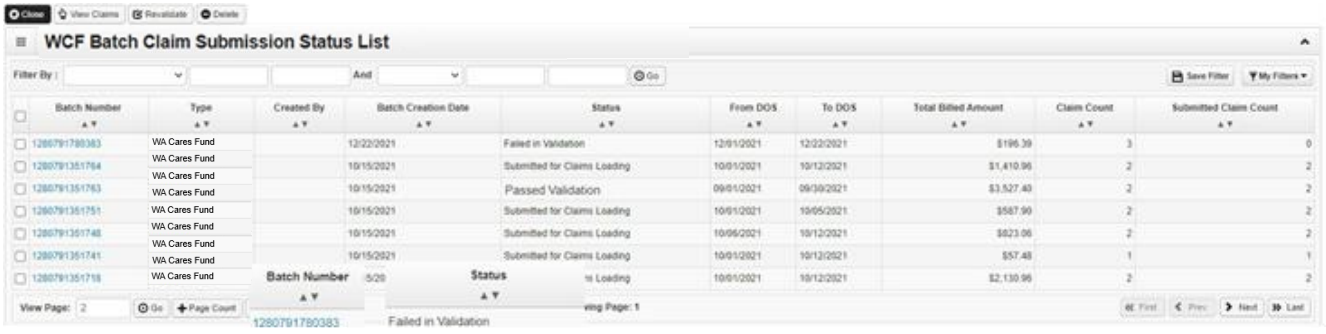
1. From the Provider Portal, navigate to the WA Cares Fund section located at the very bottom of the online services list on the left. Click **WCF Manage Batch Submission**.



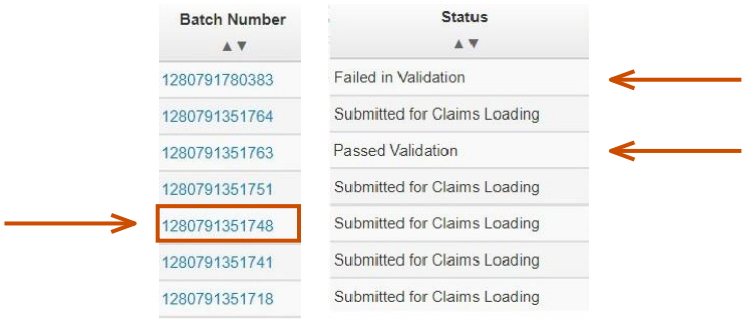
2. The Batch Claim Submission Status List appears.

   Pass Validation means all the templates have valid information and the batch can be submitted.

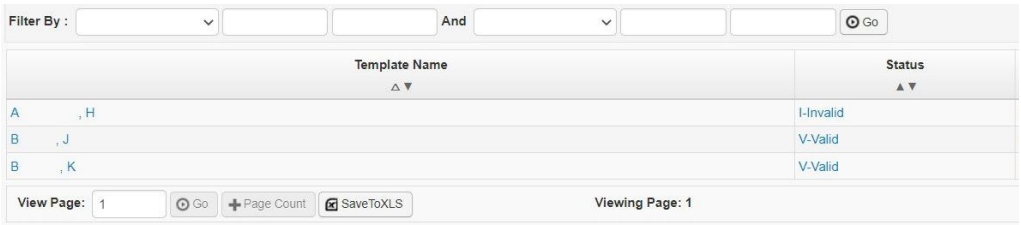
   Failed Validation means one or more items within the batch is not valid and the batch cannot be submitted.



3. To view why a batch failed validation, click the batch number.



4. The **View Template List from Batch** appears.

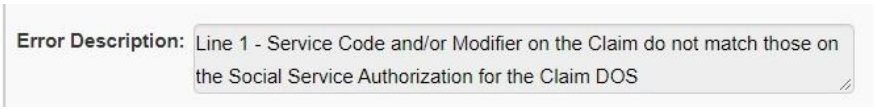


5. Click on the blue hyperlinked **I-Invalid** under the Status column.

6. **Template Validation Errors** will appear.

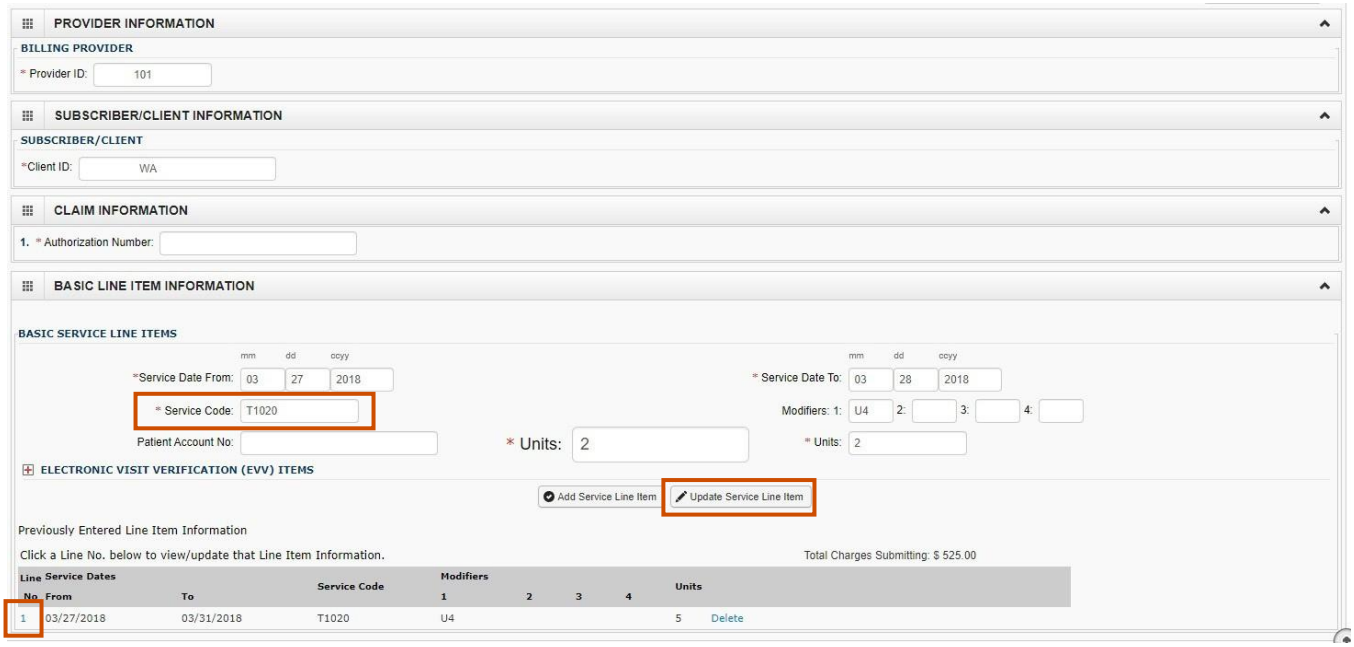


7. Read and take note of the **Error Description**.

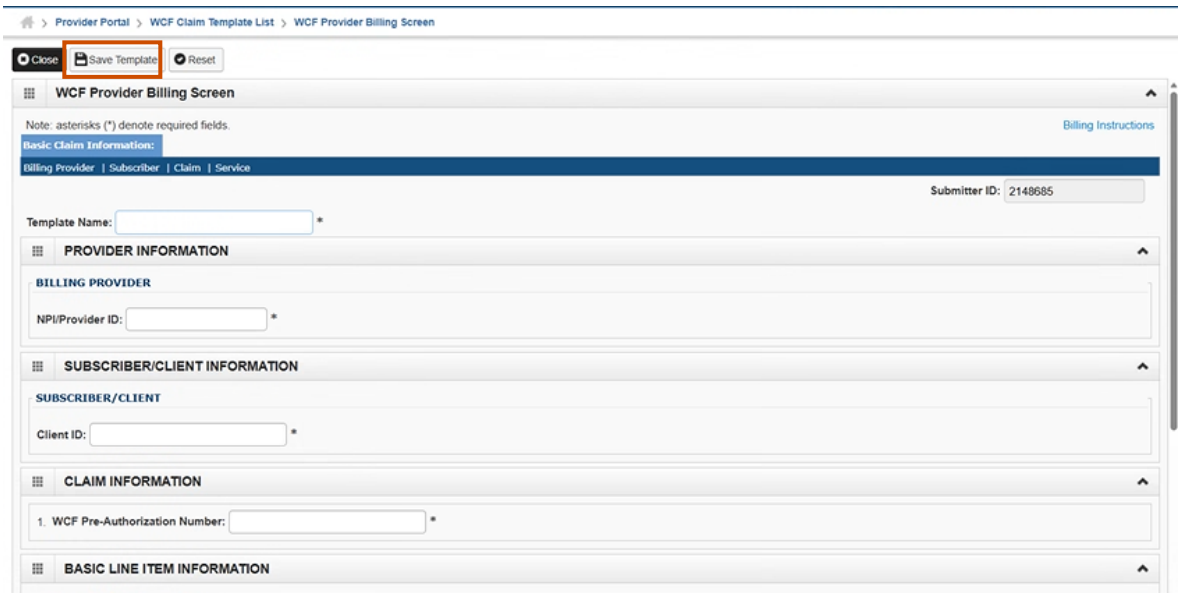


8. Click **Cancel**.
9. Click the template you need to fix. The template will appear.

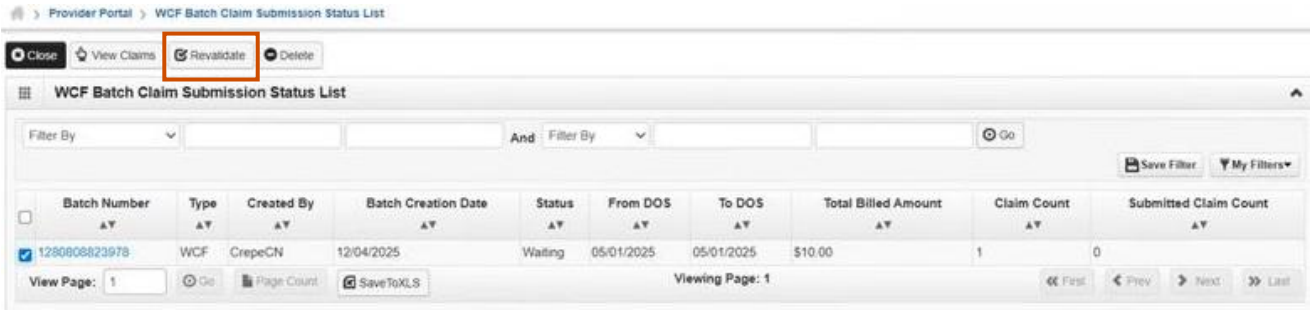
10. To fix the errors:
    - Click on the line number you need to fix.
    - **Basic Line Information** populates.
    - Enter missing data/correct error.
    - Click on **Update Service Line Item**.



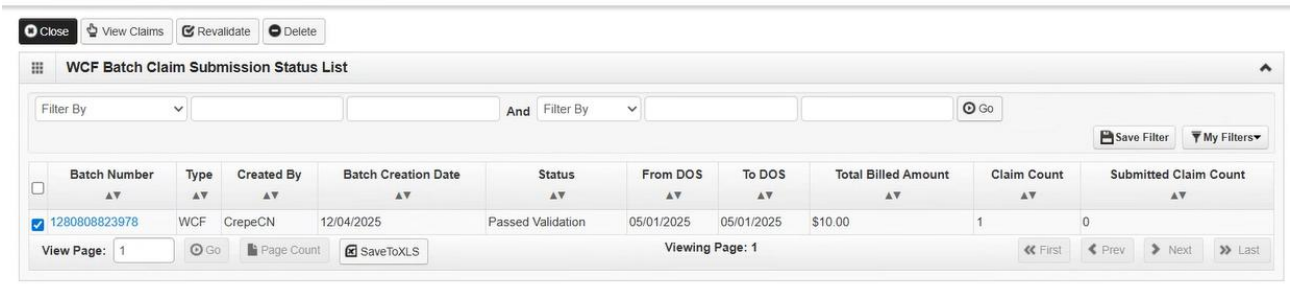
11. Corrected service line will appear. Click **Save Template**.



12. Pop-up appears asking **Do you want to save the Template?** Click **OK**.
13. Click **Close**.
14. Click **Revalidate**. The **Batch Claim Submission Status List** will appear.



15. The status will show as **Waiting**. Refresh the page.
16. If the status changes to **Passed Validation**, the batch can now be submitted.

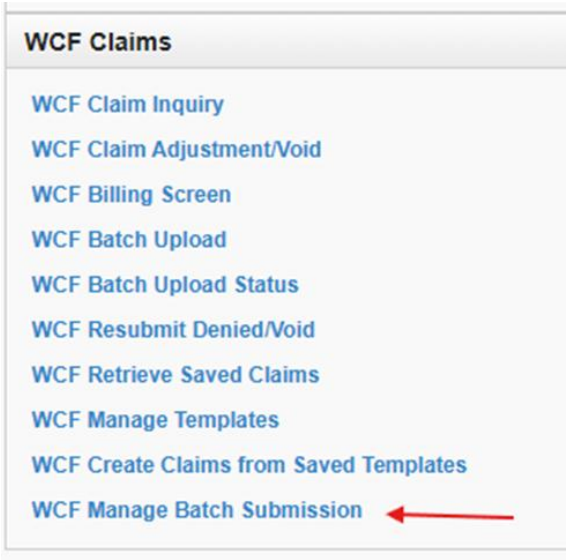


17. After you have created and revalidated your Template Batch, you are now ready to submit the Template Batch for processing.

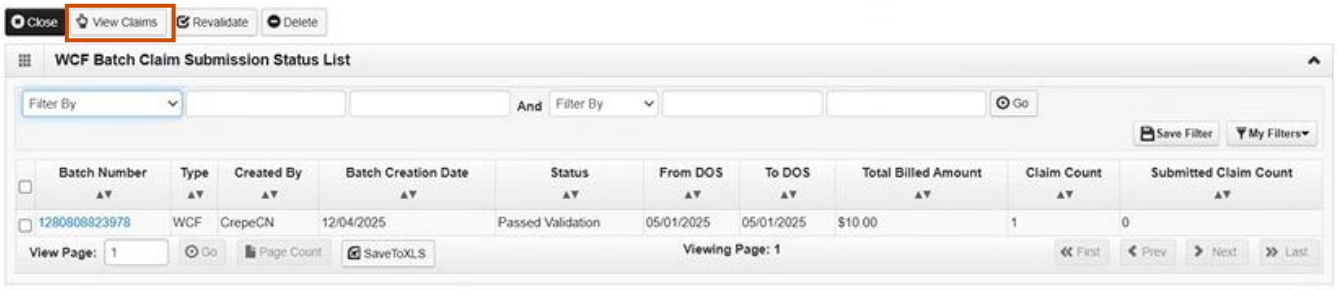
Submitting a template batch

To submit a Template Batch:

1. From the Provider Portal, navigate to the WA Cares Fund section located at the very bottom of the online services list on the left. Click on **WCF Manage Batch Submission**.



2. Click the box next to the desired batch. (A batch must have Passed Validation before it can be submitted.)
3. Click **View Claims**.



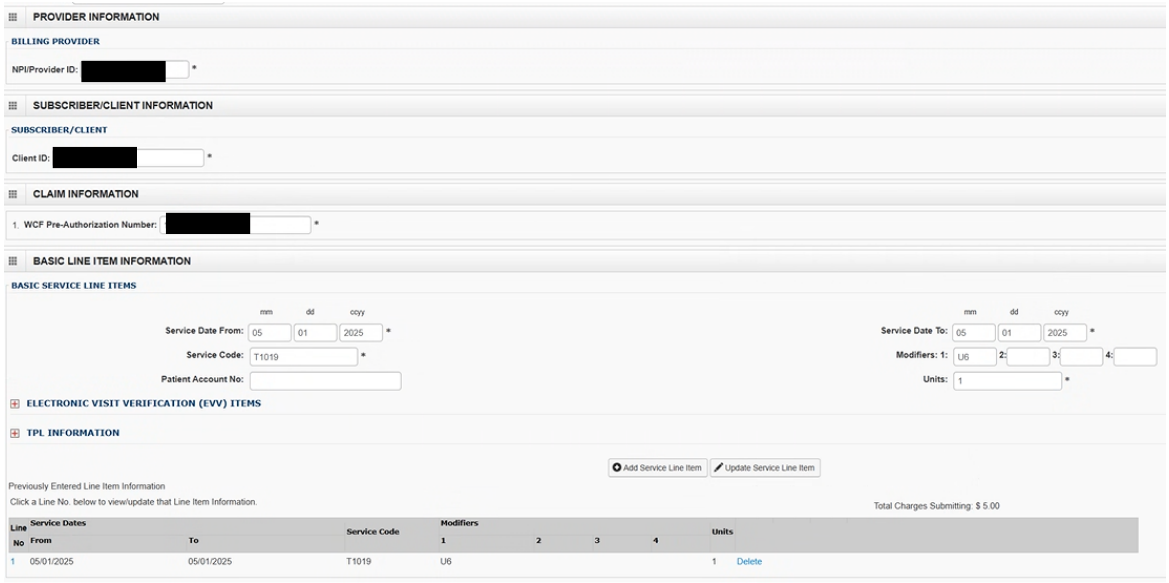
4. **Claims Created from Batch List** appears.
5. Each template is assigned a **System-Generated Claim ID**.



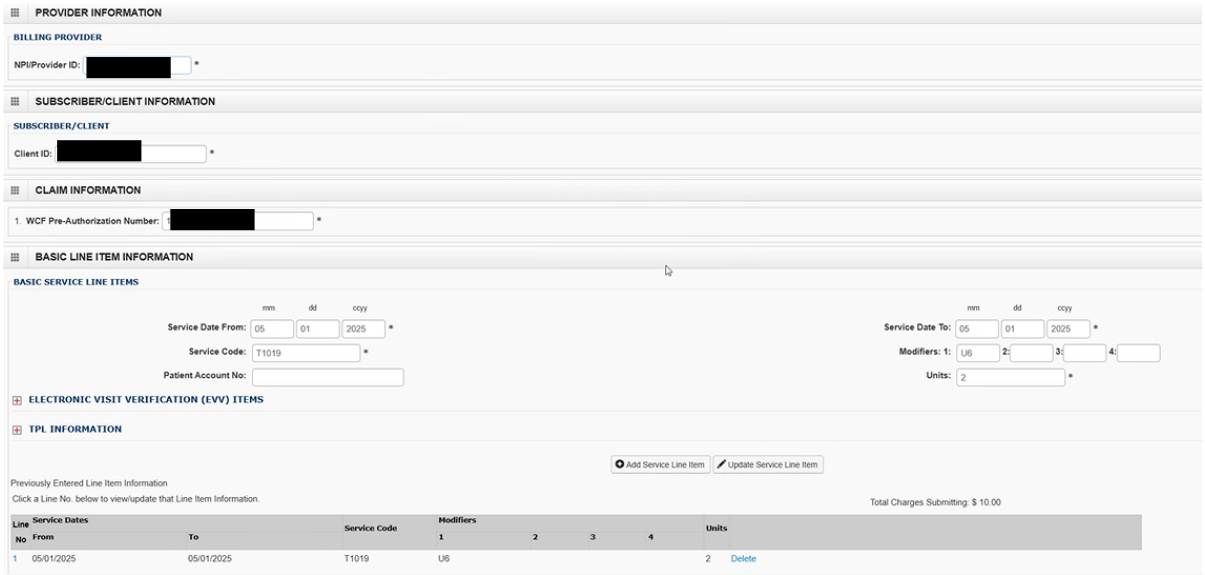
Note: The System-Generated Claim ID is the batch number and saved claim number.

6. You can modify a template before you submit the Batch.
    - Click the **System-Generated Claim ID**.
    - The template will appear.
    - Modify the template as needed.
    - **Save** template.

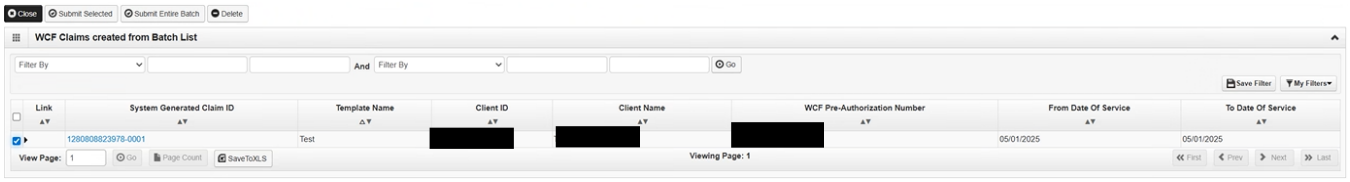
7. To modify the claim:
    - Click on the Line Number
    - Basic Line Information populates
    - Enter modification
    - Click **Update Service Line Item**



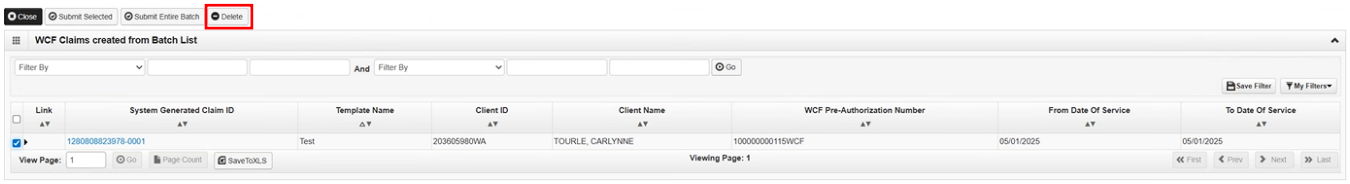
8. The modified service line item will appear. Click **Save Claim**.



9. **WCF Claims Created from Batch List** appears.



10. You can delete a claim prior to submission of the batch. Select the box next to the desired batch. Click **Delete.**



11. You can submit all or some of the listed claims.

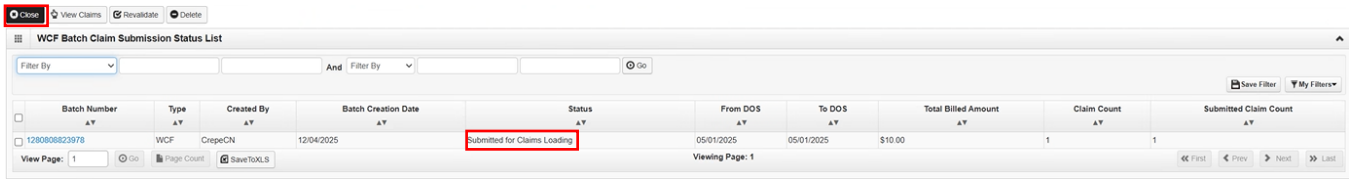
    - To submit only some of the claims, click on the box next to each claim you want to submit and then click **Submit Selected**.

    - To submit all of the listed claims, you do not need to click on each claim and instead can just click **Submit Entire Batch.**

12. After submitting the batch, the System-Generated Claim ID is replaced with the Transaction Control Number (TCN). Click **Close**.



13. **Batch Claim Submission Status List** will appear and show the upload **Status and Submitted Claim Count.** Click **Close**.



.DAT BATCH UPLOAD SETUP

WA Cares Fund caret delimiter (.dat) batch upload billing is an optional billing method that allows WA Cares Fund (non- medical) providers[1] to extract billing data elements from their current timekeeping or billing software and upload the claim(s) data into the ProviderOne system. Although .dat batch upload requires additional preparation, your organization could save time and effort with this option.

The .dat batch upload billing method is suitable for large providers and providers who are required to bill by date of service such as:

- Home care agencies
- Consumer-directed employer(s)
- Adult day care/adult day health centers
- Large residential facilities
- Home-delivered meals programs
- Personal emergency response systems

Please share the technical information found in this section with your timekeeping, billing, and EVV staff or vendor.

Note: For assistance with .dat batch claims, contact HCA's HIPAA Help Desk.

Business rules

- A provider can only upload one .dat file to ProviderOne at a time.
- Data is not required for optional fields for file upload.
- The provider must enter data for required fields for file upload.
  - Additional data may be required for claims payment (i.e., modifier).
- Only '.dat' extension file types are accepted by the system. If provider attempts to upload a file whose extension is not '.dat', the system will display an error message.
- The file will be transmitted over secure HTTP using encryption.

[1] WA Cares Fund Medical Providers do not use the .dat batch upload. Medical providers use the HIPAA batch upload process. If you are a WA Cares Medical Provider interested in HIPAA batch upload, contact HCA's HIPAA Help Desk at hipaa-help@hca.wa.gov.

- When a batch is successfully uploaded, the system will generate the file name while displaying the confirmation message. Example system-generated file name after successful ProviderOne upload:

  "SOC.xxxxxxx.20130131xxxxxx.SAMPLE_BATCH.dat" (*contains 'x' for numbers to mask provider and client information)

- When an uploaded .dat batch file contains no validation errors, the batch file status will be accepted and claims will be loaded into the system for processing.
- When a batch file has encountered errors during file validation, the status of the file will be rejected and claims will not be loaded into the system for processing.

Special design constraints or considerations

- All claim lines of the batch file must not exceed one day of service, with the exception of monthly unit types such as personal emergency response systems.
- The system will only accept one claim line per each day of service, service code, and authorization number combination. The system will deny duplicate claim lines.
- The batch file layout and format must comply with the specifications outlined in the **WA Cares Fund .dat Batch Upload Format Specification** Table.

  Note: Daily rates cannot span bill using batch upload method. Span billing is only used in direct data entry and templates methods with daily or monthly unit types.
- Unit types must be consistent with what is listed on the client's authorization. Most billing hours are reported in 15-minute increments (15 min = 1 unit).
- Each field in each .dat claim line must be separated/ delimited by the ^ (caret symbol). This applies to all fields, regardless if they are required or not for the file to load. Do not add spaces between carets. Each claim line must have 32 carets (^) and include a tilde (~) at the end of the line.
- These .dat claim line fields require data for successful file upload[2]:
  - Provider ID
  - Client ID
  - Authorization number
  - Service date from
  - Service date to
  - Service code

[2] Additional data may be required for claims to pay (i.e., modifier if a modifier is authorized with the service code).

- Units
- Claim frequency type

- In addition to the above claim elements, these .dat claim line fields are optional for In-home Personal Care and In-Home Respite Care using EVV:
  - Service Start Time
  - Service End Time
  - Service Start Time Geo-Data
  - Service End Time Geo-Data

Example .dat claim line with all fields filled in:

Provider ID^Client ID^Authorization Number^Service Date From^Service Date To^Service code^Mod 1^Mod 2^Mod 3^Mod 4^Units^Patient Account Number^SSSOP (ID)^Start Time^End Time^Service Start Time Geo-Data -

Latitude^Service Start Time Geo-Data-Longitude^Service End Time Geo-Data - Latitude^Service End Time Geo-Data-Longitude^Cl- Pr Prox ST^Cl-Pr Prox ET^Cl Ver End Time^Clm Freq Type^Parent TCN^Policy Number^Payer/Organization Name^Amount^Adjustment Reason Code^Policy Number^Payer/Organization Name^Amount^Adjustment Reason Code^Manual Claims Indicator~

In order for your .dat file to be accepted by ProviderOne, you must enter data for any 'Required' field. 'Optional' fields are not required for batch upload but may be required for claim payment (see page 78-79 for more information).

WA Cares Fund .dat Batch Upload Format Specification Table

Column Name	Required Field (Y / N)	Data Type	Maximum size	String Format	Development Notes
Provider ID	Y	string-9	9 digits	Numeric	9-digit Provider ID (7-digit ID + 2-digit location code)
Client ID	Y	string – up to 20	20 characters	Alphanumeric	Client ID (9-digits + WA)
WCF Pre-Authorization Number	Y	string – 15	15 characters	Alphanumeric	WCF Pre-Authorization Number (12 digits + WCF)
Service Date From	Y	string – 8	8 digits	Date (mmddccyy)	Service Date From
Service Date To	Y	string – 8	8 digits	Date (mmddccyy)	Service Date To
Service Code	Y	string – 5	5 characters	Alphanumeric	Service Code
Modifier 1	N	string – 2	2 characters	Alphanumeric	Modifier 1
Modifier 2	N	string – 2	2 characters	Alphanumeric	Modifier 2
Modifier 3	N	string – 2	2 characters	Alphanumeric	Modifier 3
Modifier 4	N	string – 2	2 characters	Alphanumeric	Modifier 4
Units	Y	string – up to16	16 digits	Numeric	Units
Patient Account Number	N	string – up to13	13 characters	Alphanumeric	This is not the same as Client ID. Patient Account Number is an optional number that can be entered to identify clients (e.g., an internal account number).

Column Name	Required Field (Y / N)	Data Type	Maximum size	String Format	Development Notes
Servicing Only ProviderOne ID	N	string-9	9 digits	Numeric	**Home Care Agencies/CDE only.** Each caregiver will receive an SSSOP ID after they are rostered to your ProviderOne Domain.
Service Start Time	N	string-6	6 digits	Numeric (hhmmss)	Must be in 24-hour format
Service End Time	N	string-6	6 digits	Numeric	Must be in 24-hour format
Service Start Time Geo-Data - Latitude	N	string-9	6 or 7 digits with Sign and a decimal	Numeric	Service Start Time GPS coordinates. This will contain Sign. EX: "-12.99999" The system accepts either 4 or 5 digits after decimal
Service Start Time Geo-Data-Longitude	N	string-10	7 or 8 digits with Sign and a decimal	Numeric	Service Start Time GPS coordinates. This will contain Sign. EX: "-123.99999" The system accepts either 4 or 5 digits after decimal
Service End Time Geo-Data - Latitude	N	string-9	6 or 7 digits with Sign and a decimal	Numeric	Service End Time GPS coordinates. This will contain Sign. EX: "-12.99999" The system accepts either 4 or 5 digits after decimal
Service End Time Geo-Data-Longitude	N	string-10	7 or 8 digits with Sign and a decimal	Numeric	Service End Time GPS coordinates. This will contain Sign. EX: "-123.99999"

Column Name	Required Field (Y / N)	Data Type	Maximum size	String Format	Development Notes
					The system accepts either 4 or 5 digits after decimal
Client-Provider Proximity for Start Time	N	string – 1	1 character	Alphanumeric	Client-Provider Proximity for Start Time
Client-Provider Proximity for End Time	N	string – 1	1 character	Alphanumeric	Client-Provider Proximity for End Time
Client Verification for End Time	N	string – 1	1 character	Alphanumeric	Client Verification for End Time
Claim Frequency Type	Y	string – 1	1 digit	Numeric	Values can be: 1 = Original Claim 7 = Adjustment 8 = Void
Parent TCN	N	string – 18	18 digits	Numeric	18-digit original TCN (claim #) that is being adjusted or voided. Required if 7 or 9 is entered in the 'Claim Frequency Type' field.
Policy Number	N	string – 15	15 characters	Alphanumeric	Third Party policy #. This is 13 Characters in ProviderOne.
Payer / Organization Name	N	string – 50	50 characters	Alphanumeric	Must be in ALL CAPITAL LETTERS.
Amount	N	string – 17	13 digits with Sign and two decimals	Floating Number	TPL Amount by the Payer/Org
Adjustment Reason Code	N	string – 3	3 digits	Alphanumeric	Adjustment Reason Code.

Column Name	Required Field (Y / N)	Data Type	Maximum size	String Format	Development Notes
Manual Claims Indicator	N	string – 6	6 characters	Alphanumeric	Valid values include: SPST01 SPET01 SPEV01 EVSF01

WA CARES FUND .dat BATCH UPLOAD FILE CREATION

Sample WA Cares Fund Batch Upload Excel File Before .dat Conversion

Below is an example of what your Excel file should look like before converting to a .dat file:

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
Provider ID	Client ID	Authorization Number	Service Date From	Service Date To	Service code	Mod 1	Mod 2	Mod 3	Mod 4	Units	Patient Account Number	SSSOP (ID)	Start Time	End Time	Service Start Time Geo-Data - Latitude	Service Start Time Geo-Data-Longitude
[redacted]	[redacted]	999888555	10012024	10012024	S5161					1						
		999888555	10012024	10012024	S5161	U1				1						
		777555444	10012024	10012024	S5161					1						
		666333222	10012024	10012024	S5161					1						

R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG
Service End Time Geo-Data - Latitude	Service End Time Geo-Data-Longitude	Cl-Pr Prox ST	Cl-Pr Prox ET	Cl Ver End Time	Clm Freq Type	Parent TCN	Policy Number (1)	Payer / Organization Name (1)	Amount (1)	Adjustment Reason Code (1)	Policy Number (2)	Payer / Organization Name (2)	Amount (2)	Adjustment Reason Code (2)	Manual Claims Indicator
					1										~
					1										~
					7	55222222222682000									~
					1										~

Note: Download a printable version of the Sample WA Cares Fund Batch Upload Excel File Before .dat Conversion.

.dat Format Examples

When creating or extracting the .dat file from your system, take extra care not to add extra spaces, characters, extra carriage returns, or column headers. You must remove any extra spaces, characters, returns, and column headers before uploading the .dat file to ProviderOne. Compare your .dat file side by side to the examples below. (Samples contain 'x' for numbers to mask provider and client information). As shown below, each line contains a total of 32 carets and a tilde at the end.

Sample original claim with optional patient account number and without EVV data

xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx^01012014^01012014^T1019^U6^^^^8^xxxx^^^^^^^^^^^^1^^^^^^^^^^^~ xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx
^01042014^01042014^T1019^U6^^^^10^xxxx^^^^^^^^^^^^1^^^^^^^^^^^~
xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx
^01102014^01102014^T1019^U6^^^^15^xxxx^^^^^^^^^^^^1^^^^^^^^^^^~

Sample original claim without optional patient account number and without EVV data

xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx^01012014^01012014^T1019^U6^^^^8^^^^^^^^^^^^^1^^^^^^^^^^~ xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx
^01042014^01042014^T1019^U6^^^^10^^^^^^^^^^^^^1^^^^^^^^^^~
xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx
^01102014^01102014^T1019^U6^^^^15^^^^^^^^^^^^^1^^^^^^^^^^~

Sample adjusted claim with optional patient account number and without EVV data

xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx^01012014^01012014^T1019^U6^^^^8^xxxx^^^^^^^^^7^55170100011710700O^^^^^^^^^^~ xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx
^01042014^01042014^T1019^U6^^^^10^xxxx^^^^^^^^^7^55170100011710700O^^^^^^^^^^~ xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx

^01102014^01102014^T1019^U6^^^^15^xxxx^^^^^^^^^^7^551701000117107000^^^^^^^^^^^~

Sample adjusted claim without optional patient account number and without EVV data

xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx^01012014^01012014^T1019^U6^^^^8^^^^^^^^^^^^^^^7^551701000117107000^^^^^^^^^^~
xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx^01042014^01042014^T1019^U6^^^^10^^^^^^^^^^^^^^^^7^551701000117107000^^^^^^^^^^~
xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx^01102014^01102014^T1019^U6^^^^15^^^^^^^^^^^^^^^^7^551701000117107000^^^^^^^^^^~

Sample adjusted claim with optional patient account number and with EVV data

xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx^01012020^01012020^T1019^U6^^^^8^xxxx^999999999^083412^114413^-12.99999^-123.99999^-12.9999^-123.99999^^7^551701000 11710 7000^^^^^^^^^^~

xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx^01042020^01042020^T1019^U6^^^^10^xxxx^999999999^083412^114413^-12.99999^-123.99999^-12.9999^-123.99999^^7^551701000 117107000^^^^^^^^^^~

xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx^01102020^01102020^T1019^U6^^^^15^xxxx^99999999^083412^114413^-12.99999^-123.99999^-12.9999^-123.99999^^7^5517010001 17 107000^^^^^^^^^^~

.dat file naming convention

Before converting your files to the .dat format, it is beneficial to create a naming convention to suit your business needs. Use a unique name for each file. For example:

- Name the batch to identify the submitter.
- Name the batch to identify the location.
- Name the batch to identify the type of service provided.

Naming convention rules

- You must include .dat at the end of the file name.
- File names cannot contain spaces.
- File names are alphanumeric and can only allow the following special characters: . - _
- File names cannot contain any of the following characters:

  \ / : * ? < >

- File names cannot exceed 50 characters including the four characters: '.dat'

  Example file name: 123456701_20250515_PersonalCareServices_.dat

  Billing provider ID — Date submitted — Type of service billed

When a batch is successfully uploaded, the system will generate the file name while displaying the confirmation message. The standard file name for the generated message is:



"<SOC>.<Provider ID (7 digit)>.<Date & Time Stamp>.**<Provider naming convention including '.dat' extension>".**

Example:

"SOC.XXXXXXX.20130131XXXXXX.SAMPLE_BATCH.dat"

(Example contains 'x' for numbers to mask provider identification)

Converting your Excel (.xls) file to a .dat file

If your billing or timekeeping vendor only allows .xls extraction and not .dat file extraction, this section will show you two methods for converting an Excel document into the .dat format.

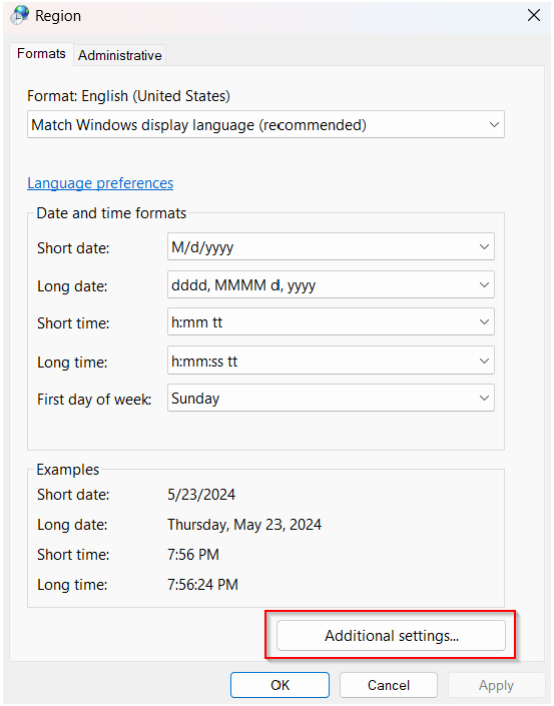
If you do not want to use either of these methods, you can find or purchase utility programs online for Excel that will easily convert files into the .dat format. For the best results, try using a Google search and type "Excel utilities" or ".xls convert to .dat."

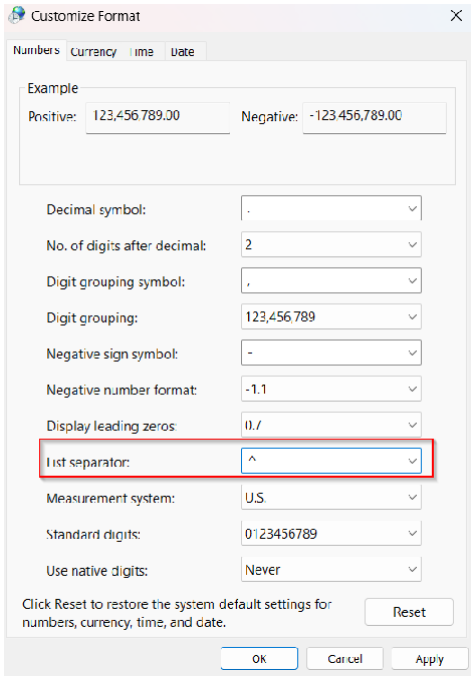
Method One: Create a .dat file from Excel to CSV

This method is recommended for large .dat files with over 1000 records.

Step1: Change your computer's Regional settings

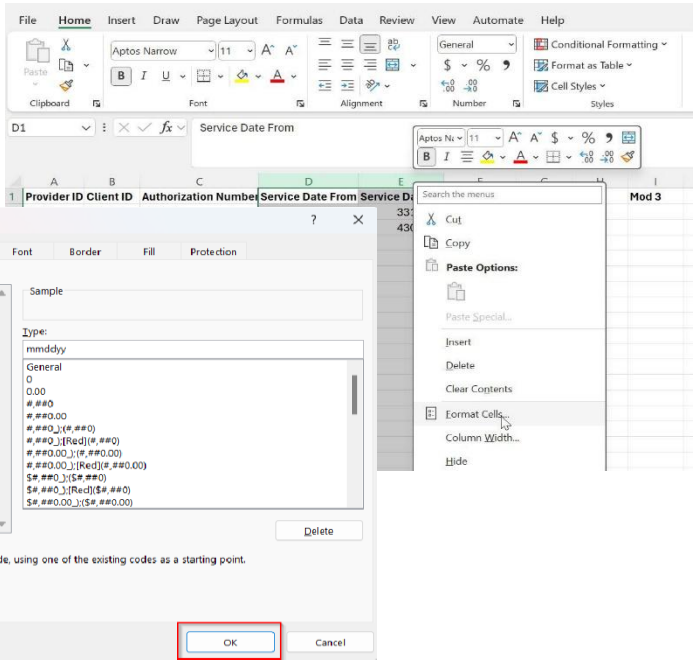
- In Microsoft Windows, click inside the search icon and type 'Control Panel.'
- Click the 'Region' icon.
- Click 'Additional Settings.'
- Find the 'list separator' drop down and type ^
- Click 'apply' and 'OK' twice.





Step 2: Format date columns in Excel

- Format your 'Service Date From' and 'Service Date To' cells to mmddyyyy by highlighting these columns then,
- Right click and select 'Format Cells'
- Select 'Custom' and place your cursor in the 'Type' field and type mmddyyyy.
- Click 'OK'



Step 3: Format additional fields

- If you do NOT add data in the Manual Claims Indicator column, in that cell add a tilde ~
- If you do add data in the Manual Claims Indicator column, you will need to add a tilde ~ in the cell after the Manual Claims Indicator column

AE	AF	AG
Amount (2)	Adjustment Reason Code (2)	Manual Claims Indicator
		~
		~
		~
		~

Step 4: Delete the header row of your worksheet

Step 5: Delete additional worksheets

Step 6: Save your file

- Click 'File' and then 'Save As'
- Locate the folder where you want to save your file
- In the 'File Name', name your file. Remember to add .dat to the end of the file name.

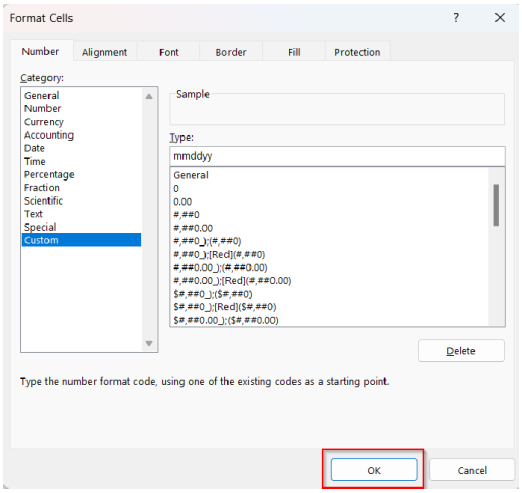
AE	AF	AG	AH
Amount (2)	Adjustment Reason Code (2)	Manual Claims Indicator	
		SPST01	~
		SPST01	~
		SPST01	~
		SPST01	~

- In the 'Save As Type' drop down, select 'CSV (Comma Delimited) (*.csv)'
- Click 'Save'
- The .dat in your file name may disappear. If it does, you will need to type it again.
- You have successfully created a .dat file!

Method two: Create a .dat file from Excel to Word

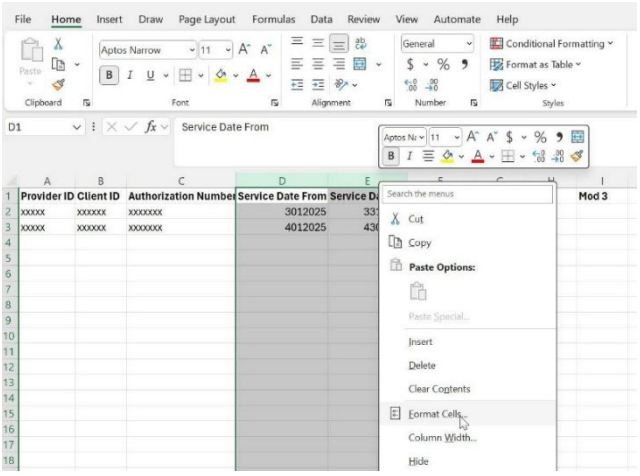
Step 1: Correctly format the date columns in Excel

- Format your 'Service Date From' and Service Date To' date cells to mmddyyyy by highlighting these columns and then,
- Right click and select 'Format Cells'
- Select 'Custom' and place cursor in the 'Type' field and type mmddyyyy
- Click 'OK'



Step 2: Format additional Excel fields

- If you do NOT add data in the Manual Claims Indicator column:
  - In that cell add a tilde ~
- If you do add data in the Manual Claims Indicator column:
  - You will need to add a tilde ~ manually during Step 6.



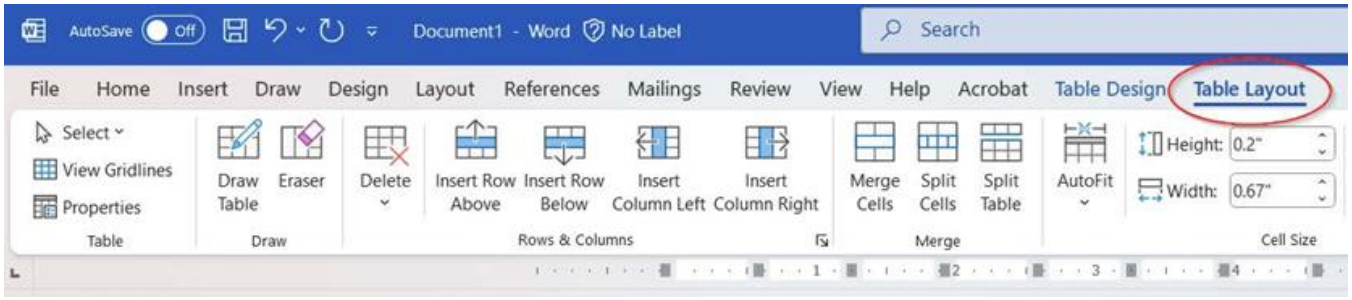
Step 3: Delete the header row in your Excel spreadsheet

Step 4: Delete additional worksheets

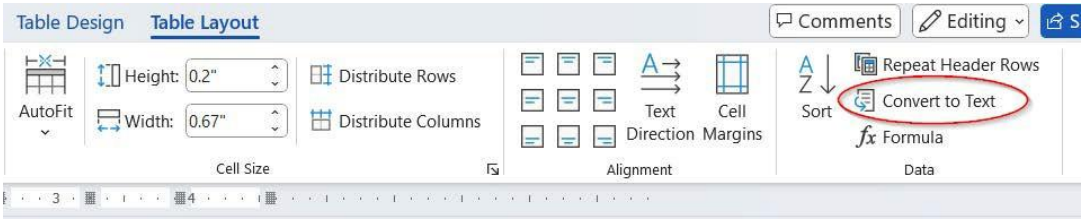
Step 5: Copy the entire worksheet by clicking Ctrl A and then Ctrl C.

Step 6: Paste into Word:

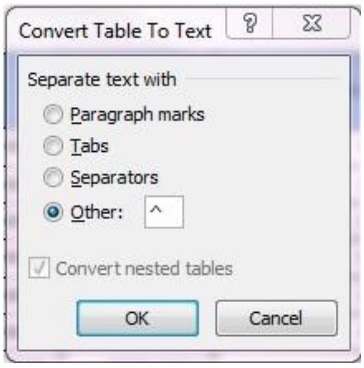
- Open a new blank Word document
- Paste the copied file into Word by clicking Ctrl V. Do not worry if the contents here do not fit onto the document margins.
- Select the table by clicking the box at the left hand top corner.
- Click on the 'Table Layout' Tab.



- On the Table Layout tab, select the box 'Convert to Text'

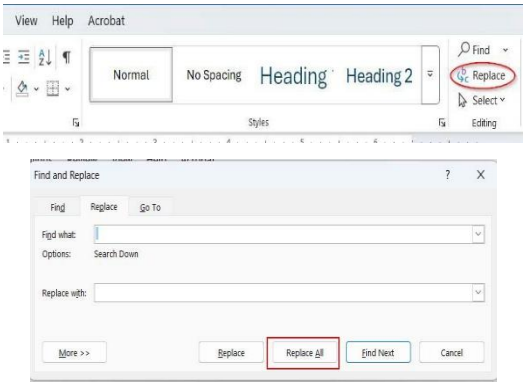


- You will be prompted to select 'Separate text with'
- Select 'Other' and insert the caret symbol ^ and click 'OK'



If you added data in the Manual Claims Indicator column, add a tilde ~ at the end of that line of data

If there are any spaces between the ^, those must be removed before copying the data.



- You can remove spaces by selecting the Replace button under the home tab.
- Put a space in the "Find what" line and make sure there is no data or spaces in the "Replace with" line. Then click on "Replace All"
- Highlight the entire document (Ctrl A) and copy (Ctrl C)

Step 7: Paste into Notepad

Open Notepad (located in All Programs/Accessories file)

Click Ctrl V to paste data into Notepad

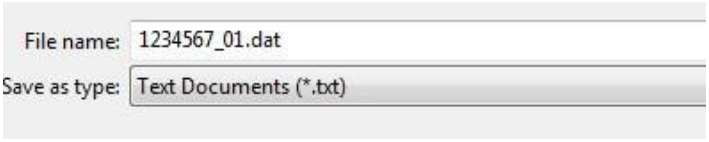
Step 8: Save your file

Within Notepad, click on 'File' and select 'Save As'

Locate the folder you would like to save your file

In the 'File Name', name your file and add .dat at the end of the file name

In the 'Save As' section, click the drop down and select 'Text Documents' (*.txt) and click 'Save'



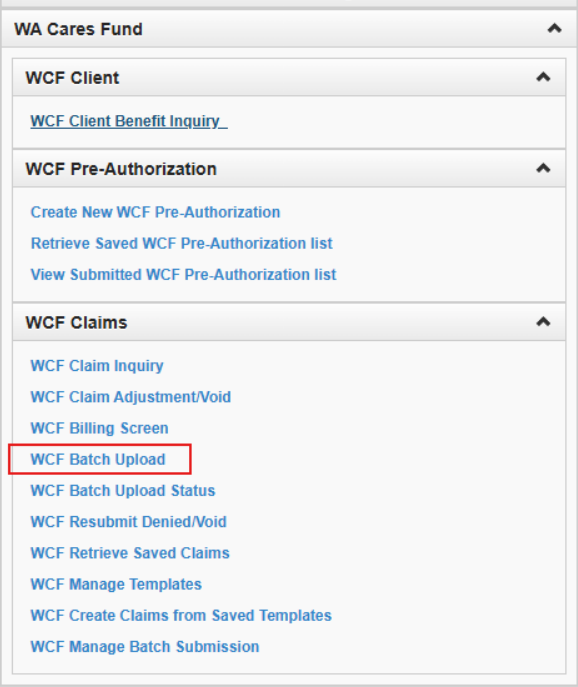
Note: If the icon for notepad does not appear before the file name is saved to your computer, right click, select 'Open with' and choose 'default program.' Select 'Notepad' and make sure the box is checked for 'Always use the selected program to open this kind of file' and click OK. If this last step is not completed, an unexplained rejection will occur in the ProviderOne system.

Note: If the computer changes the saved file extension and adds .txt to the .dat extension file name, go back to your saved document. Do not open the document. Highlight the document, right click and remove .txt from the name, and type .dat. If that does not solve the issue, consider using a different method of conversion. Try using an Excel utility to convert your files to the .dat extension

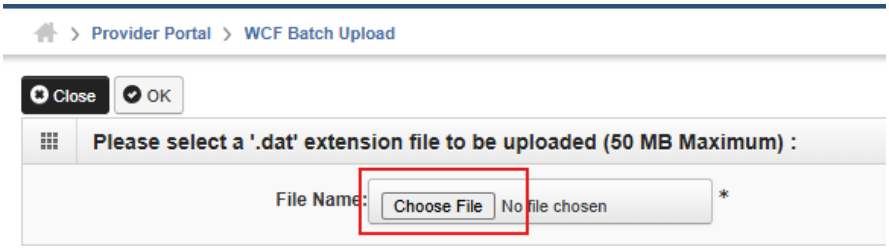
Uploading a .dat batch file

After the .dat file is created and saved to your computer system, you are ready to upload the file into ProviderOne for claims submission.

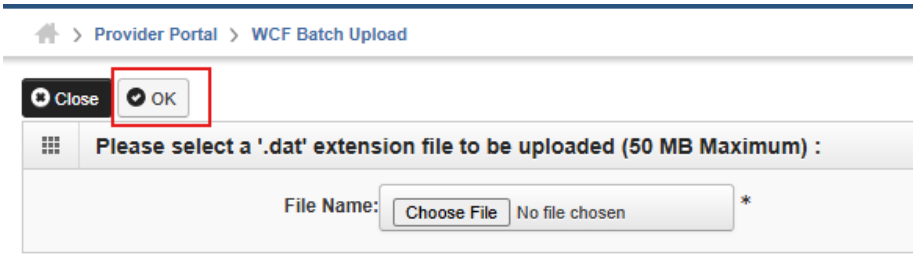
Step 1: On the Provider Portal, navigate to the WA Cares Fund section located at the very bottom of the online services list on the left. Click **WA Cares Fund Batch Upload.**



Step 2: Click Choose File

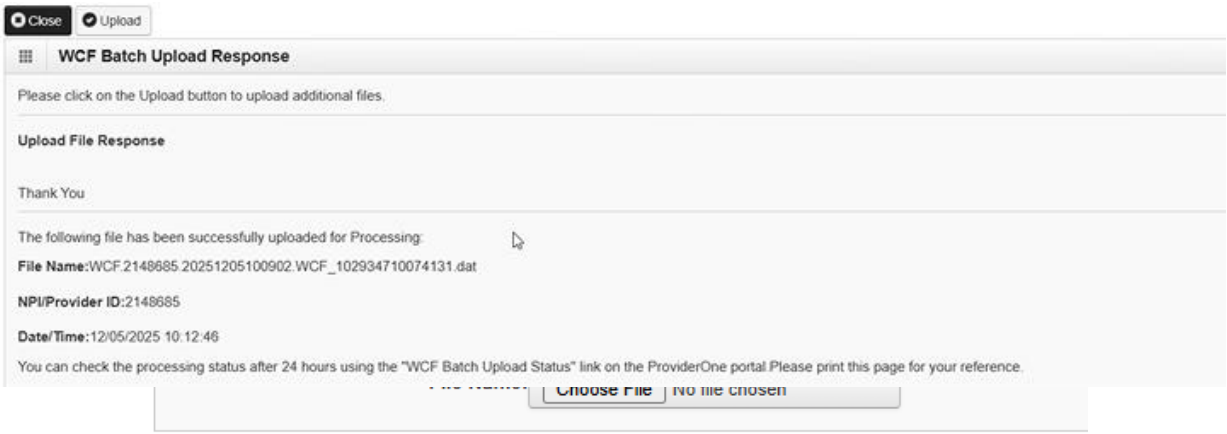


Step 3: Select the saved .dat file located on your computer and select **OK** to upload.



Step 4: Once the initial system check verifies the .dat file extension and file size meet the system requirements, a confirmation message will pop up. Click **Close**.

Step 5: To upload additional files, select **Upload** and repeat Steps 2-4 of this section.



Acceptance message

The next step will validate format and content. An acceptance message on the WA Cares Fund Batch Upload Status List page means the file passed format and content requirements. This means all your claim lines have been submitted for claims processing.



Rejection messages

The WA Cares Fund batch upload file will be rejected if the file does not meet the WA Cares Fund batch upload requirements.

Sometimes the system will give one rejection reason for each submission. You may correct or remove the rejected lines and resubmit and find a new rejection message will appear.

If one line on the batch rejects, no claim lines are submitted for adjudication and payment. You must fix any issues before resubmitting. To see why the file rejected, click **Rejected** under the **Status** column.



Note: It is highly recommended providers remove the rejected lines and resubmit the .dat file to receive an accepted message for lines that do not contain errors to receive timely payment. Rejected lines require further research. Reasons may include:

- Authorization error
- Authorization in canceled status

WA Cares Fund batch upload error instance list

After clicking **Rejected**, you will see the WA Cares Fund Batch Upload Error Instance List.

The list shows the line number in the batch (record reference number), the error code, the error message and an example of the .dat batch line in the 'Additional Message' column.

Record reference ▲ ▼	Error Code ▲ ▼	Error Message ▲ ▼	Additional Message ▲ ▼
Record Reference- 69	92141	Service Code and/or Modifier on the Claim do not match those on the WA Cares Fund Authorization for the Claims DOS	xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx-^01022014^01022014^T1019^^^^^12^
Record Reference- 70	92141	Service Code and/or Modifier on the Claim do not match those on the WA Cares Fund Authorization for the Claims DOS	xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx-^01102014^01102014^T1019^^^^^12^
Record Reference- 71	92141	Service Code and/or Modifier on the Claim do not match those on the WA Cares Fund Authorization for the Claims DOS	xxxxxxxxx^xxxxxxxxxWA^xxxxxxxxxx-^01102014^01102014^T1019^^^^^12^

Error code reference table

Below is the Error Code Reference Table, containing system error types you may receive when a batch upload file is rejected.

Error Code	Error Message	Possible Causes
90001	File content is empty	There is no data in the caret delimiter (.dat) file.
90002	File not present in physical location	The file being attached is not present.
90003	Record does not end with ~ symbol	The line is missing the ~ symbol at the end of the record.
90004	Field does not end with ^ symbol	There is no ^ symbol after the units and before the ~ symbol.
90005	Field count in the record is not equal to the actual field count needed for that record	There are too few numbers in one of the date fields (example; Provider Id, Client ID, Authorization #, etc.
91011	Provider ID not present in file	This message can occur for different reasons: • The provider ID is missing from the line and/or file. • Your provider record is in the process of being updated and may not be payable for the next 24 hours.
91012	Provider ID must be numeric	The provider number contains letter(s).
91013	Provider ID length exceeds max allowed characters	The provider number is too long.
91021	Client ID not present in file	The client ID is missing.
91022	Client ID must be alphanumeric	The client ID number contains symbols or other characters.
91023	Client ID length exceeds max allowed characters	The client ID is too long.
91031	Authorization Number not present in file	The authorization number is missing.
91032	Authorization Number must be numeric	The authorization number contains symbols or other characters.
91033	Authorization Number length exceeds max allowed characters	The authorization number is too long.
91041	Service From Date not present in file	The service from date is missing.
91042	Service From Date is not a valid date	The service from date is not a date.
91043	Service From Date is a future date	The service from date is a future date
91051	Service To Date not present in file	The service to date is missing.
91052	Service To Date is not a valid date	The service to date is not a date.
91053	Service To Date is prior to Service From Date	The service to date is before the service from date.
91054	Service To Date is a future date	The service to date is a future date
91055	'Service Date From' and 'Service Date To' must be within the same calendar month, please update the dates of service and submit a separate claim for each calendar month	The service from and service to date must occur in the same month.
91061	Service Code is not present in file	Service code is missing.
91062	Service Code must be alphanumeric	The service code contains symbols or other characters.
91063	Service code length exceeds max allowed characters	The service code is too long.
91071	Modifier Code 1 must be alphanumeric	The modifier contains symbols or other characters.
91072	Modifier Code 1 length exceeds max allowed characters	The modifier is too long.
91081	Modifier Code 2 must be alphanumeric	The modifier contains symbols or other characters.
91082	Modifier Code 2 length exceeds max allowed characters	The modifier is too long.
91091	Modifier Code 3 must be alphanumeric	The modifier contains symbols or other characters.
91092	Modifier Code 3 length exceeds max allowed characters	The modifier is too long.
91101	Modifier Code 4 must be alphanumeric	The modifier contains symbols or other characters.
91102	Modifier Code 4 length exceeds max allowed characters	The modifier is too long.

Error Code	Error Message	Possible Causes
91111	Units not present in file	The number of units are not in the file.
91112	Units must be numeric	The units contain symbols or other characters.
91113	Units length exceeds max value	The units are too long
91131	Patient Account Number must be alphanumeric	The patient account number contains symbols or other characters.
91132	Patient Account Number length exceeds max allowed characters	The patient account number is too long.
92011	Provider ID does not exist in the system	The provider ID is not correct.
92012	Submitter Provider ID does not match with the Provider ID in the batch file	The provider ID is not assigned to your domain.
92021	Client ID does not exist in system	The client ID number is not correct.
92031	Authorization Number does not exist in system	The authorization number is not correct.
92032	Provider ID mismatch in Authorization	The provider ID and authorization number are not authorized together.
92033	Client ID in batch does not match ProviderOne authorization	The client ID does not match the authorization number.
92061	Service Code does not exist in system	The service code is not correct.
92062	Medical Proc/Svc Code cannot be billed on a WA Cares Fund Claim	Medical service codes cannot be billed in the WA Cares Fund billing page.
92063	A separate claim line is required for each date of service for the service/ service code entered	The unit type daily, hourly, each, and quarter hour must be billed by date of service using the batch upload method. Those unit types cannot be billed using span.
92064	The Proc/Svc Code Entered is designated for automated payment generated only. This code cannot be submitted or resubmitted for payment.	This service cannot be billed. Payment is sent after the authorizing worker end dates the authorization.
92071	Modifier Code 1 invalid	The modifier is not correct.
92081	Modifier Code 2 invalid	The modifier is not correct.
92091	Modifier Code 3 invalid	The modifier is not correct.
92101	Modifier Code 4 invalid	The modifier is not correct.
92140	Only one unit must be entered for a single day	You are billing more than one unit on a daily unit type.
92141	Service Code and/or Modifier on the Claim do not match those on the WA Cares Fund Authorization for the Claims DOS (date of service)	This message can occur for different reasons: 1. The authorization is in Error for the DOS 2. The authorization has been canceled for the DOS 3. The DOS on the claim is outside the authorization DOS. 4. If none of the above notify ProviderOne Health Care Authority at hipaa-help@hca.wa.gov. Type in the subject line: WA Cares Fund Batch Upload <insert domain #> In the body of the email include the name of the batch file you are referencing: sample: SOC.xxxxxxx.20150131xxxxxx.SAMPLE_BATCH.dat. and other pertinent information. Include your telephone number if you request a return call.

Analyzing error codes

To analyze rejection error codes follow the steps below.

Step 1: Save the WA Cares Fund Batch Upload Error Instance List (found in ProviderOne) to an Excel file. (Click the "Save to XLS" button.)

Step 2: View the 'Error Message' and 'Additional Message' column that displays the line that was submitted.

Step 3: Compare your .dat file to the .dat Format Examples. Make corrections to the .dat file as needed.

If no formatting errors are found, go to your authorization list in ProviderOne and conduct a 'Filter by' search for the month you are submitting your claims.

> Note: You may need to add an additional filter for processing status % in order to see authorization history.

Is the authorization in error for the date of service (DOS) you are billing?

If yes, confirm the beneficiary's eligibility for the date of service.

Has the authorization been canceled for the DOS you are billing?

If yes, and it was canceled by the beneficiary, contact the beneficiary.

Are the dates on the claim outside of the authorized DOS?

If yes, confirm the dates on the claim are correct. If they are not correct, correct the DOS. If they are correct, contact the beneficiary.

If you have checked all formatting errors and verified the authorization information and cannot find the source of the error, contact: Health Care Authority at hipaa-help@hca.wa.gov.

- Type in the subject line: WA Cares Fund Batch Upload<insert domain #>
- In the body of the email include the name of the batch file you are referencing: sample: SOC.xxxxxxx.20150131xxxxxx.SAMPLE_BATCH.dat. and any other pertinent information.
- Include your telephone number if you request a return call.

Common error code table

Many errors are common and some can be challenging to analyze. Below are several examples identified by other WA Cares Fund .dat batch upload providers. To increase your chances of a successful submission, pay special attention to NOT making the errors listed below.

Problem Description	Error Code and Description	Solution
Service dates reported are not for the month authorized.	92141 Service Code and/or Modifier on the Claim do not match those on the WA Cares Fund Authorization for the Claim DOS (date of service).	Ensure the service dates fall within the month the service was authorized.

Problem Description	Error Code and Description	Solution
The authorization is in error or canceled for the dates of service submitted.	92141 Service Code and/or Modifier on the Claim do not match those on the WA Cares Fund Authorization for the Claim DOS (date of service).	Contact the beneficiary to resolve error or explain why preauthorizations have been canceled.
Service dates are for span billing and not for the date the service was provided. Daily rates, quarter hours, and each unit types cannot use span billing. Span billing is considered a date range. *Only monthly service codes such as personal emergency response systems can use span billing for WA Cares Fund batch upload.*	92063 A separate claim line is required for each date of service for the service/ service code entered.	Correct the dates and bill for services by indicating the day the services were provided. Below is an example. CORRECT: From 12012013 To 12012013 From 12022013 To 12022013 ERROR: From 12012013 To 12312013
Service dates are not formatted correctly.	91042 Service From Date is not a valid date. 91052 Service To Date is not a valid date.	Correct the date format. Below is an example. CORRECT: From 12012013 To 12012013 ERROR: From 12/01/2013 To 12/01/2013
The file does not contain caret placeholders for the four service code modifiers even though there is no modifier assigned to the service code in the preauthorization list page.	90005 Field count in the record is not equal to the actual field count needed for that record.	Add the placeholder caret symbol for the service code modifiers. Do not add spaces between the carets. Below is an example of the service code and the caret placeholders in between the number of units.

Problem Description	Error Code and Description	Solution
The caret delimiter (.dat) file contains a caret after the last EVV field when data is entered.	90005 Field count in the record is not equal to the actual field count needed for that record.	Remove the caret.
There are too many or too few caret delimiters in your data string.	90005 Field count in the record is not equal to the actual field count needed for that record.	Count the total number of carets before the ~ and verify there are 32.*
File contains extra characters, spaces or delimiters that do not follow the required format. Do not use periods, commas, # symbols, etc.	90004 Field does not end with ^ symbol.	The client ID is missing.
Units must be in whole numbers.	90005 Field count in the record is not equal to the actual field count needed for that record.	Only use whole numbers to represent the number of units and remove the .0000 that is displayed in the crosswalk file. Below is an example: CORRECT: ^13^ ERROR: ^13.0000^

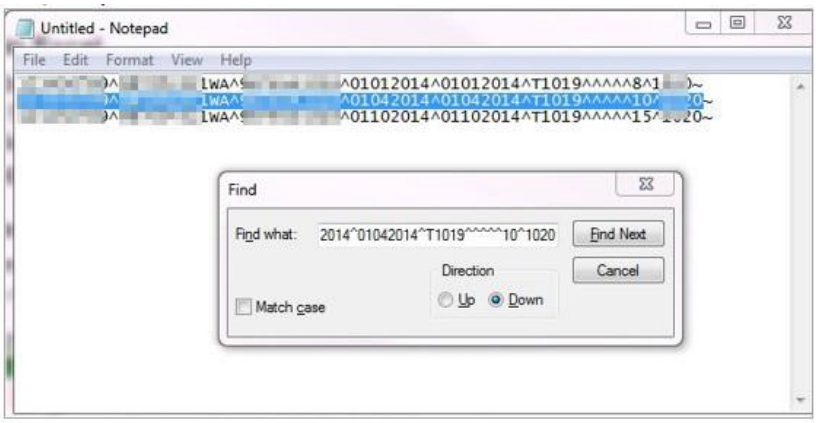
Finding the record reference in error

After your batch is rejected, it will be necessary to find the record reference in the .dat file to either remove the record or correct the record.

There are two methods for finding the record.

Method One

1. Open the .dat file that contains the errors.
2. Download the 'Rejected' messages from ProviderOne.
3. Copy the 'Additional Message' in the rejection list.
4. Place your curser at the top of the first record in the .dat file and click Ctrl F.
5. Paste that record reference line in the 'Find what' box.
6. Click 'Find Next' and the line will be highlighted in the .dat file.
7. Remove the line or make corrections.
8. Save and rename the .dat file.
9. Upload the corrected .dat file into ProviderOne.

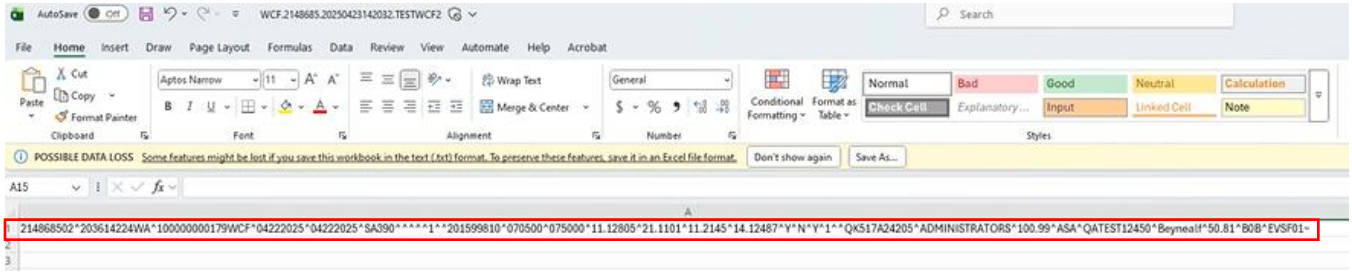


Method Two

1. Convert the .dat file to Excel (see page 94 for directions).
2. View the .dat file line number.
3. The .dat file line number in Excel will correspond to the record reference error found in ProviderOne.
4. Remove the line or make corrections.
5. Save and rename the file to a .dat file.
6. Upload the corrected .dat file to ProviderOne.

The images below show how to find the errors on a .dat file. The record reference, (1, below) corresponds to the line number in Excel. The error message indicates a Provider ID mismatch. For more information on .date errors, see Error Code Reference Table.





Converting .dat file to Excel

1. Right click on the selected saved caret delimiter (.dat) file



2. Right click, or on the tabs above, select Open With: Excel

If Excel is not listed…

- Right click, or on the tabs above, click Open With: Choose Default Program.
- Select the browse button.
- In the search program files type Excel.
- After Excel appears, double click the Excel program.
- Excel appears.
- Select Excel.
- Unclick the box: 'Always Use the Selected Program to Open This Kind of File,' if you do not want to change the default for NotePad. Click OK.

ADJUST, VOID AND RESUBMIT WA CARES FUND CLAIMS

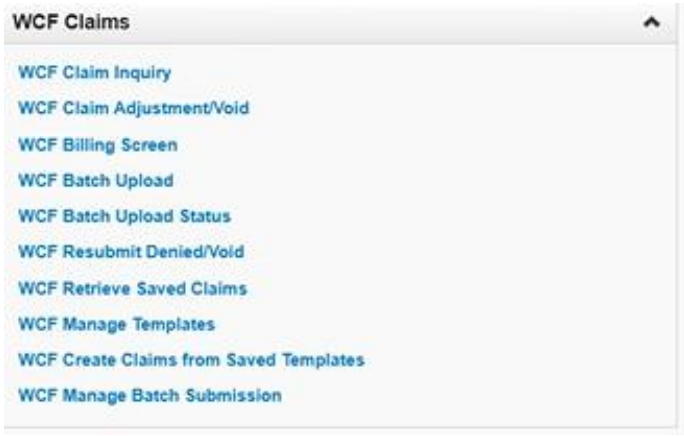
This section explains how to adjust and void claims. A previously paid claim may need to be adjusted (to change the dates, units, or other details) or voided (changing the claim so it is no longer in paid status). This section also shows how to resubmit a claim that has been denied or voided.

> Note: Reasons you may want to adjust or void a claim include (but not limited to): realizing the original claim had incorrect data or finding out the client was not eligible for services on the dates claimed.

Adjusting paid claims

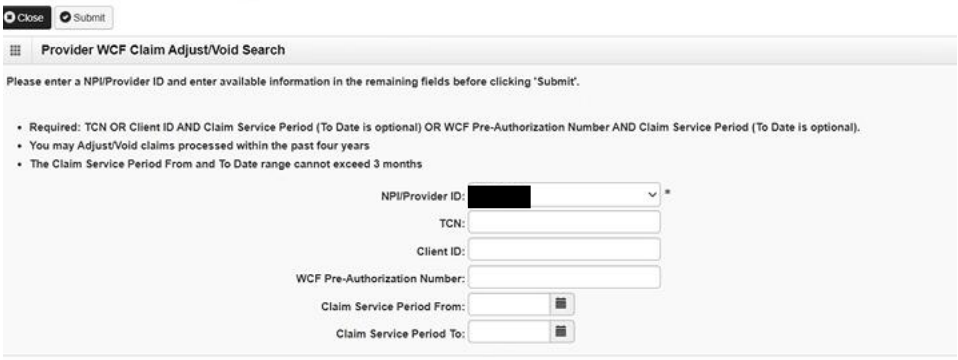
To adjust a paid claim:

1. Log into ProviderOne using the appropriate profile. Navigate to the WA Cares Fund section located at the very bottom of the online services list on the left.
2. Click **WA Cares Fund Claim Adjustment/Void**.



3. The **Provider WA Cares Fund Claim Adjust/Void Search** page appears. The Provider ID associated with the domain currently in use will automatically be listed in the Provider ID dropdown.

4. To find for the claim you need to adjust, you can search by:
   a. **TCN** (claim #); or
   b. **Claim Service Period From Date** plus **Client ID** or **Pre-Authorization Number**.



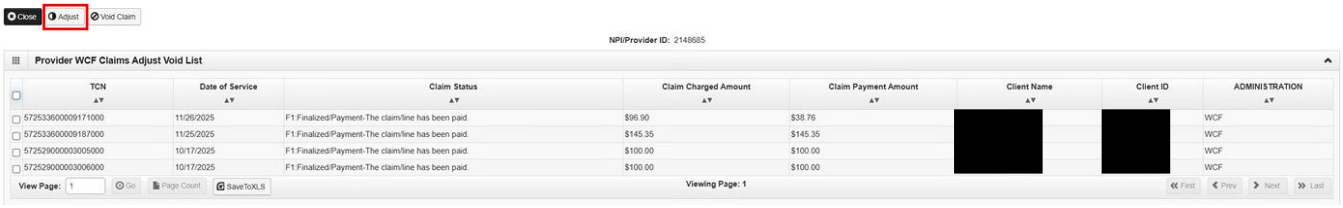
Note: When searching by Client ID Or Authorization Number, 'Claim Service Period From' is required but 'Claim Service Period To' is optional.

Note: Search requests must be for claims submitted within the past 60 days.

5. The Provider WA Cares Fund Claims Adjust Void List appears.

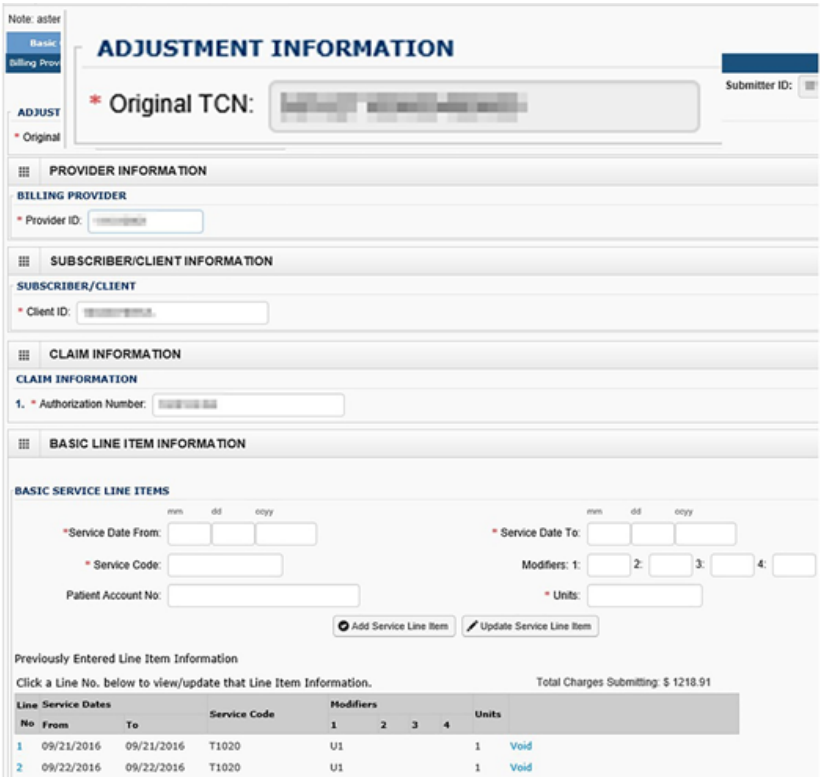
   Check the box next to the TCN.

6. Click **Adjust**.



Note: The populated list will show the TCN, Date of Service, Claim Status, Claim Charged Amount, Claim Payment Amount, Client ID and the Administration providing services for the client.

7. The **Adjust WCF Claim** page appears.
8. This screen is similar to the Billing Screen, however, the page includes an **Original TCN**.



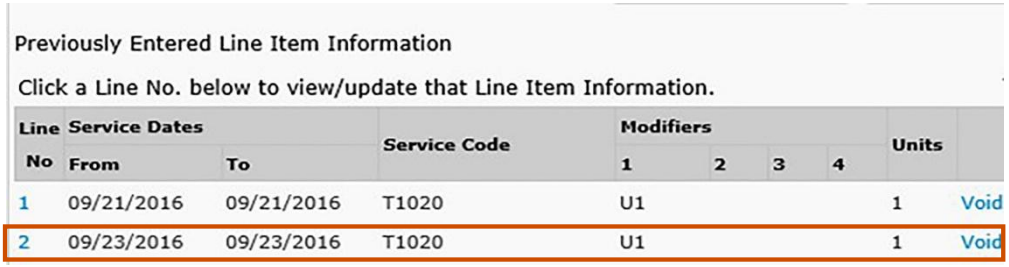
9. If you just need to reprocess the claim and do not need to change any information on the claim (example there has been a rate change), simply click the Submit button to reprocess the claim.

   Note: If you need to change data on the claim, consider reading these other sections as applicable: Modifying Service Line data; Adding Service Lines; and Voiding Service Lines.

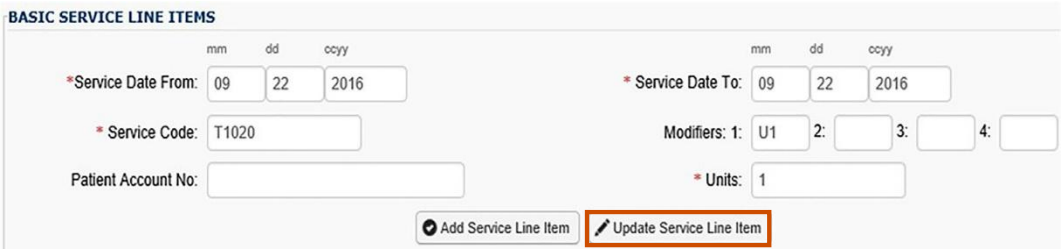
Modifying service line data

To modify service line data on a paid claim:

1. Click on a **Service Line Number**.



2. The corresponding service line information appears in the **Basic Service Line Items** fields.
3. Make needed changes to the data fields.
4. Click **Update Service Line**.



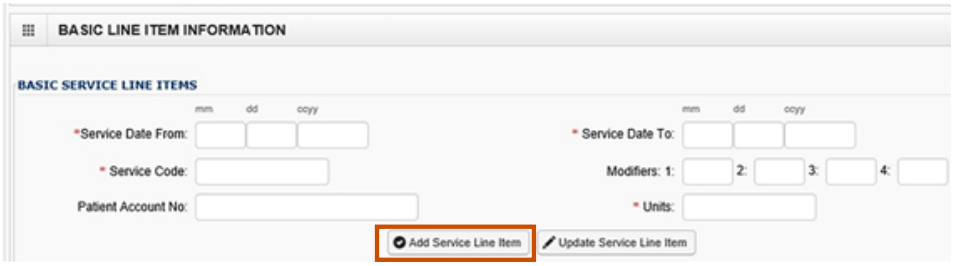
5. Go to Adjust Claims to finish the adjustment process.

   Note: When adjusting paid claims, changes cannot be made to the Provider ID, Client ID, or Authorization number. If you need to make those types of changes, void the original claim and submit a new claim.

Adding dates of service

To add a date of service to a paid claim:

1. Enter **Basic Service Line** information.
2. Click **Add Service Line** and enter applicable data.

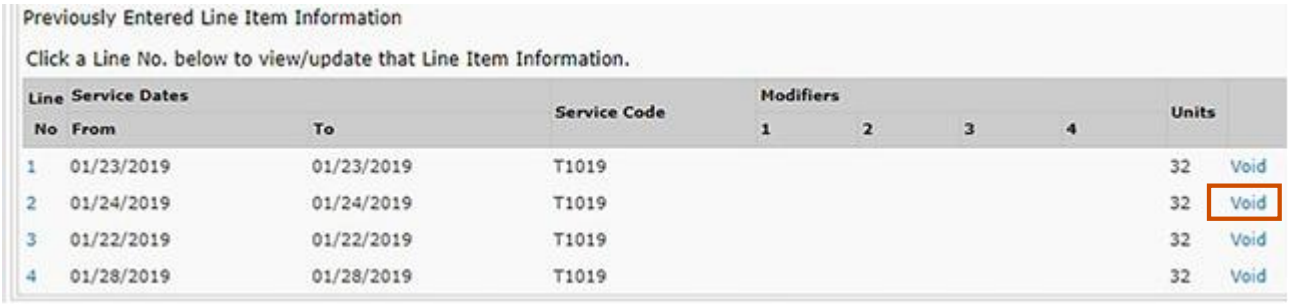


3. Go to Adjust Claims to finish the adjustment process.

Voiding service lines

To void service line data within a paid claim:

1. Determine which line(s) needs to be voided.
2. Click **Void** at the end of the line you wish to remove.



Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Line No	Service Dates From	To	Service Code	Modifiers 1	2	3	4	Units	
1	01/23/2019	01/23/2019	T1019					32	Void
2	01/24/2019	01/24/2019	T1019					32	Void
3	01/22/2019	01/22/2019	T1019					32	Void
4	01/28/2019	01/28/2019	T1019					32	Void

3. The line will disappear from the claim, and any subsequent lines will change numbers to match the new order. (Notice that the line for 1/24/2019 (above) has been removed (below), and lines 3 and 4 have moved up in the order).

Line No	Service Dates From	To	Service Code	Modifiers 1	2	3	4	Units	
1	01/23/2019	01/23/2019	T1019					32	Void
2	01/22/2019	01/22/2019	T1019					32	Void
3	01/28/2019	01/28/2019	T1019					32	Void

4. Go to Adjust Claims to finish the adjustment process.

Submitting an adjusted claim

Once all service line information is entered and checked for accuracy, click **Submit Claim** at the top of the screen.



The Adjust WA Cares Fund Claim Details will appear. The adjusted claim will have a new TCN. This allows for tracking of the changes made to the original claim.

Claim details will include the new TCN, Original TCN, Provider ID, Client ID, Date of Service and Total Claim Charge.

To complete claim submission, click on the **Submit** button (located on the bottom right corner of the page).



Once the claim is processed by ProviderOne, the adjustment is complete. The claim details will be available in the Adjustments category of your Remittance Advice (RA).

Notes:

- Make sure to click **Submit** on this screen.
- **No Records Found!** refers to attachments such as backup documentation. Social Service providers will not add attachments.

Voiding paid claims

To void an entire paid claim:

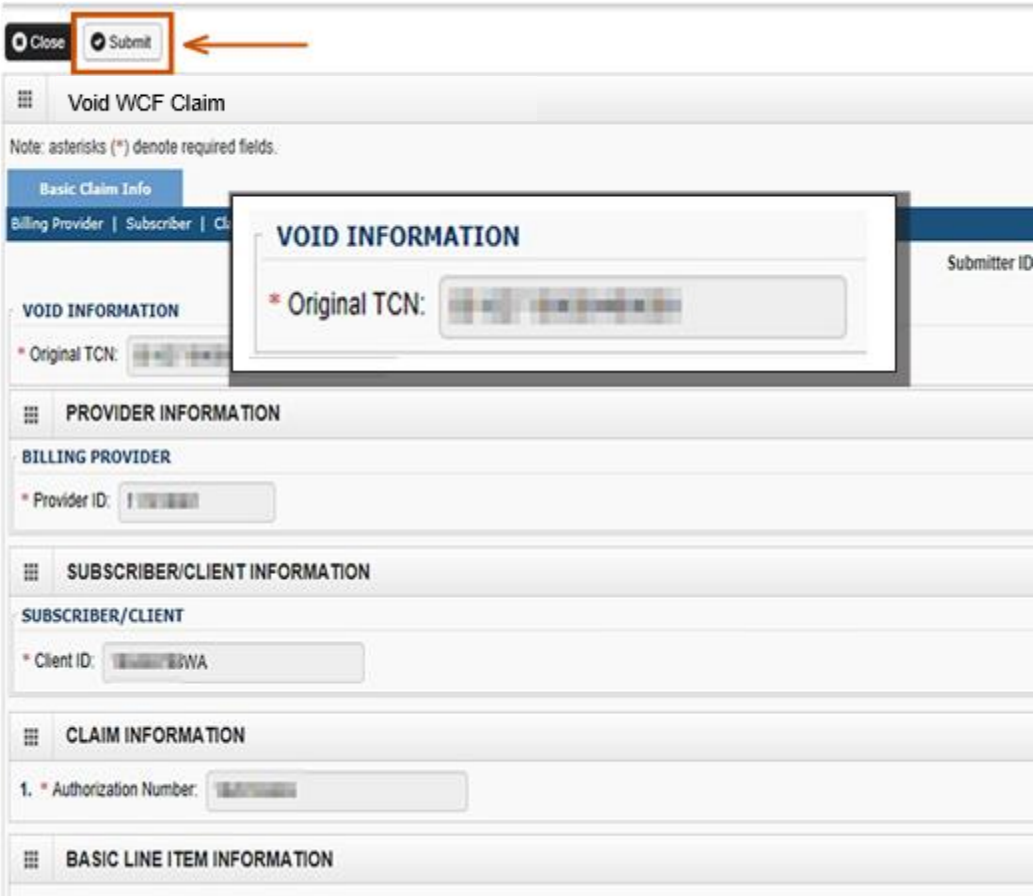
1. Locate and select the claim you wish to update. (For help searching and selecting specific claims, see Adjusting Paid Claims.)
2. Check the box next to the claim you want to void.
3. Click **Void Claim**.



4. The **Void WCF Claim** page appears with all the fields grayed out.

   Note the specific TCN.

   To void this claim, click **Submit**.



5. The voided claim will have a new **TCN**. This allows for tracking of the changes made to the original claim.
6. Claim details will include the new **TCN**, **Original TCN**, **Provider ID**, **Client ID**, **Date of Service** and **Total Claim Charge**.

7. Click **Submit** to submit the voided claim.



Notes:

- Make sure to click **Submit** on this screen.
- **No Records Found!** refers to attachments such as backup documentation. Social Service Providers will not add attachments. You can ignore this message.

Resubmitting denied or voided claims

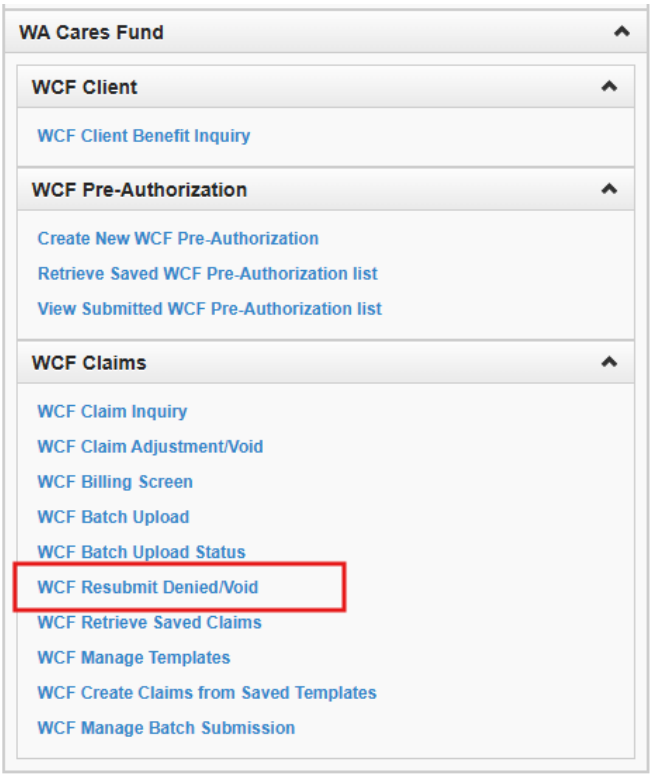
The main reasons a denied claim may need to be resubmitted include:

- The authorization was in error when the claim was originally submitted, causing the claim to deny. The error has been resolved and the denied claim now needs to be reprocessed.
- Basic claim data had incorrect date, service code, or units causing the claim to deny.

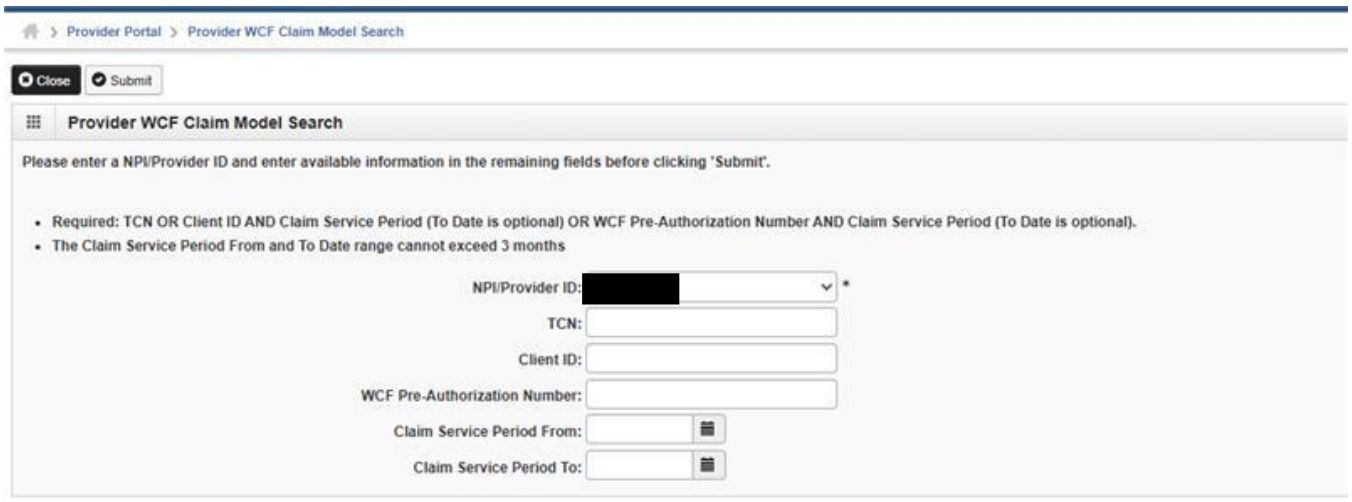
A voided claim may need to be resubmitted if a provider discovers they voided the paid claim in error.

To resubmit a denied or voided claim:

1. Login to ProviderOne using the appropriate profile.
2. Click **WA Cares Fund Resubmit Denied/Void**.
3. The **Provider WA Cares Fund Claim Model Search** page appears. The Provider ID associated to the domain currently in use will automatically be listed in the Provider ID dropdown.

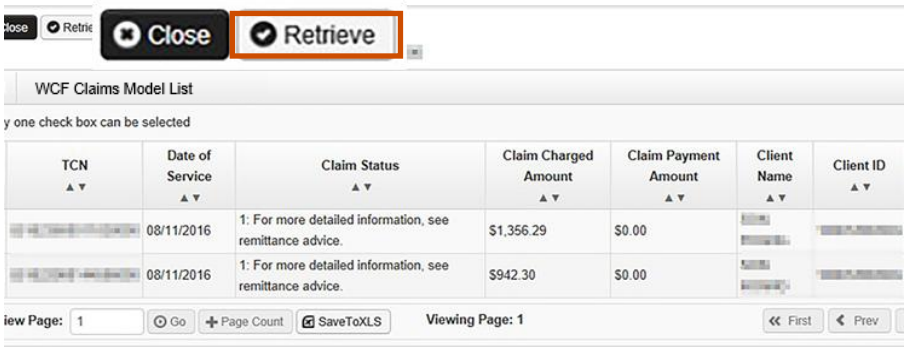


4. To find the claim you need to resubmit, you can search by:
    - **TCN**; or
    - **Client ID and Claim Service Period** (From and To Date).
5. Once you enter the necessary search criteria, click **Submit**.



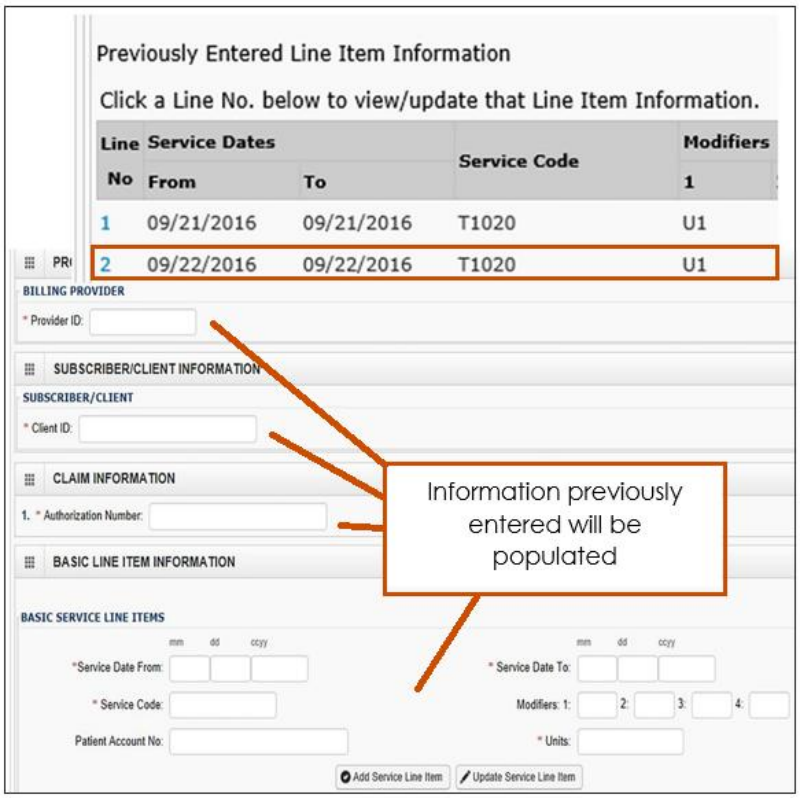
Note: Search requests must be for claims submitted within the past 60 days. I

6. The **WA Cares Fund Claims Model List** appears.
7. To resubmit a denied or voided claim:
    - Check the box next to the TCN.
    - Click **Retrieve**.



8. The basic billing screen appears.
9. If you do not need to make any changes and just need to resubmit the claim for reprocessing, click **Submit Claim**.

10. If you need to make changes to the claim before resubmitting, make these changes now. The change options when resubmitting a claim are the same as when adjusting a claim. Common items you may need to add or update on a denied claim:
    - Taxonomy
    - Preauthorization number
    - Service code
    - Modifier
    - Date of service
11. After updating the information, click **Submit Claim**.

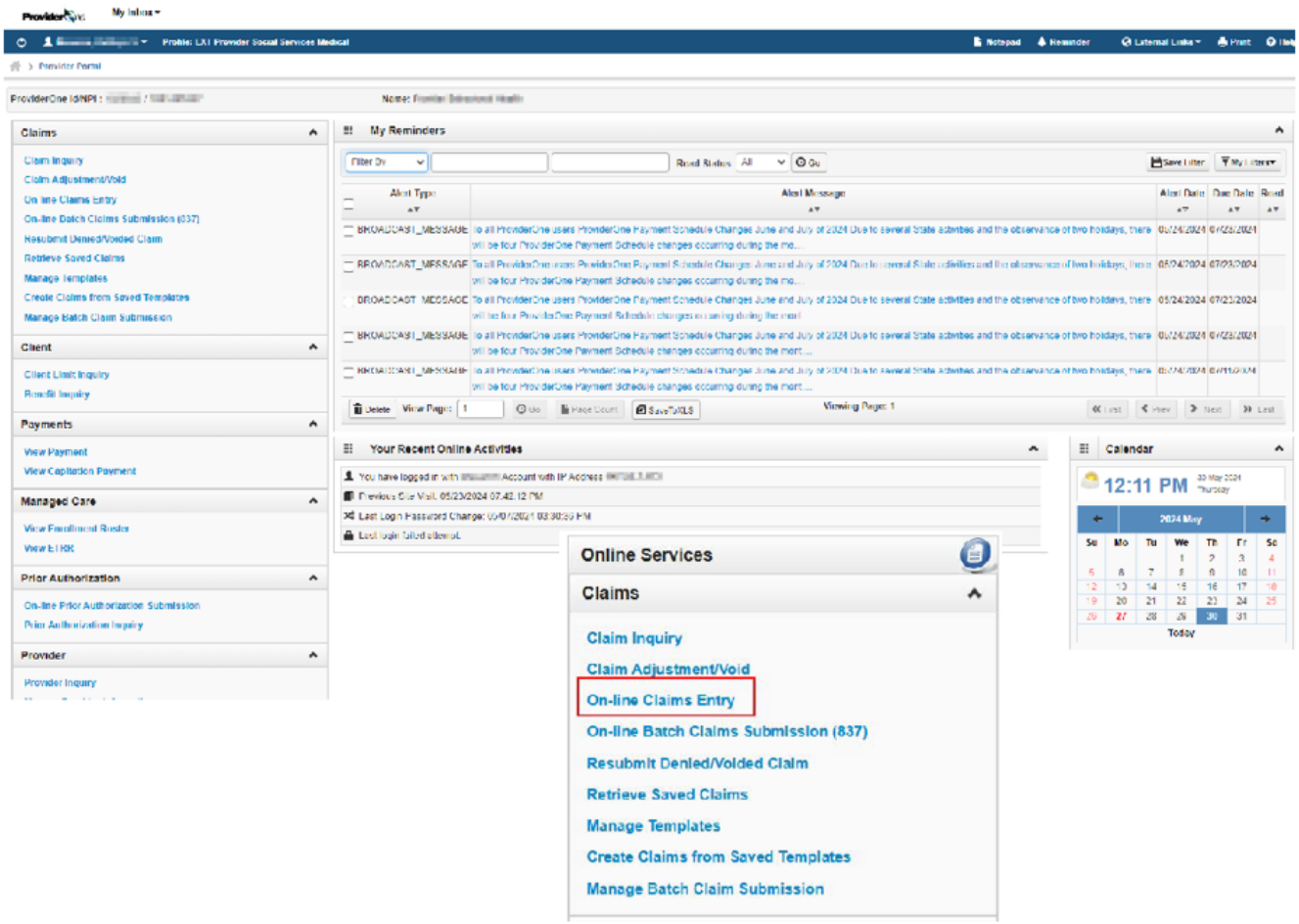


12. The resubmitted claim will have a new **TCN**. This allows for tracking of the changes made to the original claim.
13. Claim details will include the new **TCN**, **Original TCN**, **Provider ID**, **Client ID**, **Date of Service** and **Total Claim Charge**.
14. Click **Submit** to resubmit the claim.

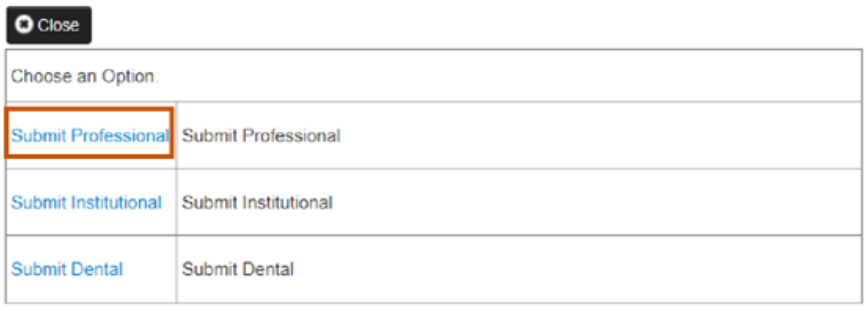
Submitting professional claims

To submit a professional claim:

1. Log in to ProviderOne using the appropriate profile.
2. Click **On-line Claims Entry**.



3. The **Choose an Option** page appears.
4. Click on the blue hyperlinked **Submit Professional**.



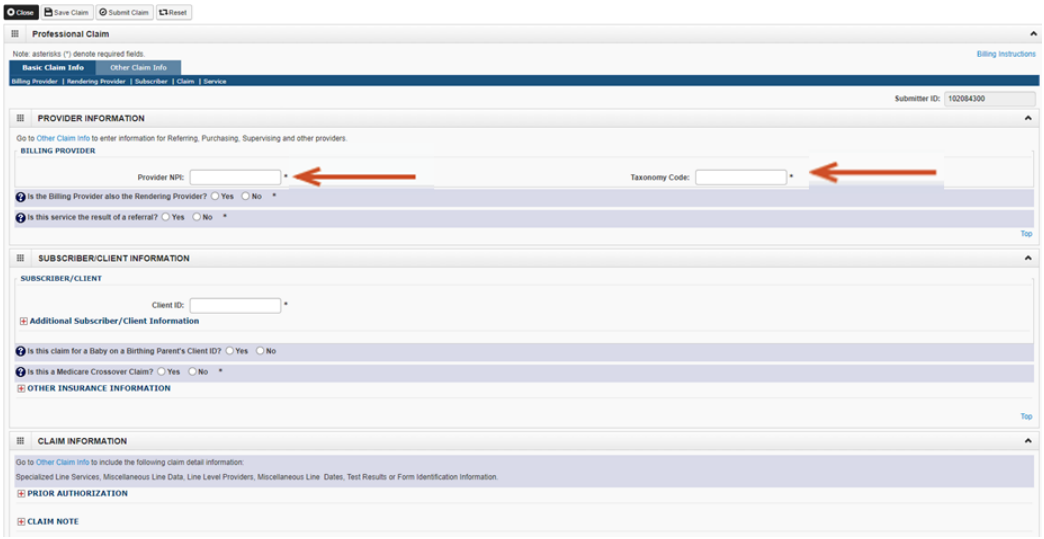
5. The **Professional Claim** screen appears. Enter the following information:

   Provider NPI: Enter your National Provider Identifier (NPI). Your NPI is a 10-digit # issued by the federal government. To apply for or look up your NPI, visit the NPPES website.

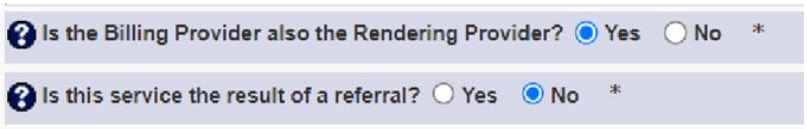
   Taxonomy Code: Enter the taxonomy associated with the service you are contracted to provide.

   Your taxonomy codes can be found under the Specializations step on the ProviderOne Business Process Wizard.

6. Select **Yes** for the question, **'Is the Billing Provider also the Rendering Provider?'**



7. Select **No** for the question, **'Is this service the result of a referral?'**



Client information

1. Under Subscriber/Client Information:

   Enter the **Client ID**. This is the client's ProviderOne ID (9-digit # ending in 'WA').

   Click the box next to **Additional Subscriber/Client Information**.

2. Enter the following information for the client:

   Last Name

   Date of Birth

Gender



Note: Client last name, DOB, and gender are the only required fields. Patient is pregnant and Patient Weight fields do not apply.

3. Under **Subscriber/Client Information**, answer **No** to the questions:

   Is this claim for a Baby on a Birthing Parent's Client ID?

   Is this a Medicare Crossover Claim?



Prior authorization (WCF pre-authorization)

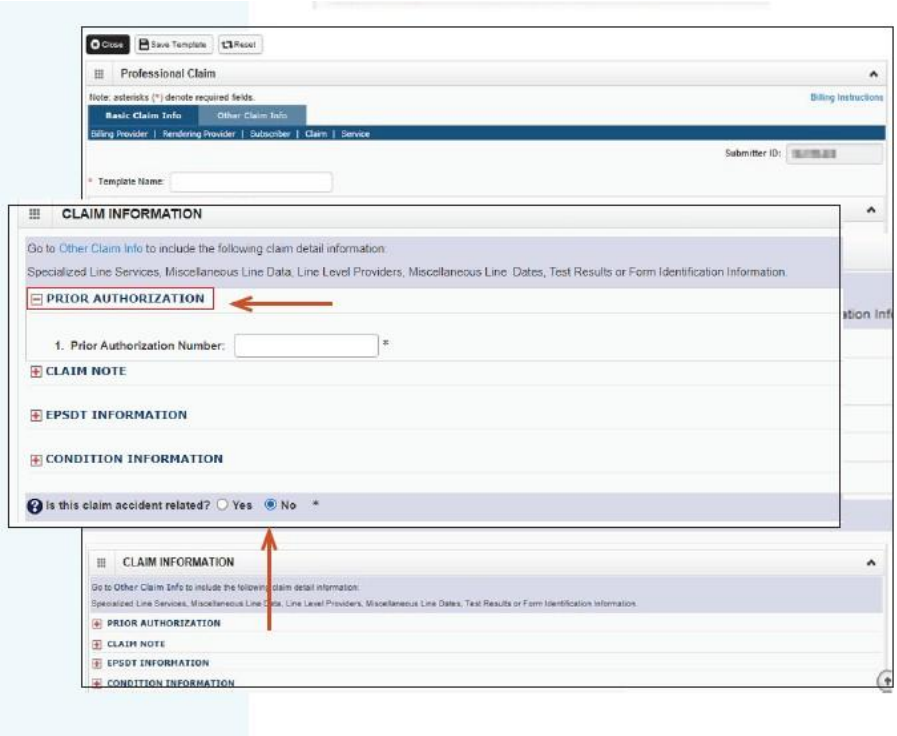
1. Select the box next to prior authorization.
2. Enter the following information.

   Prior Authorization Number[3]: Enter the approved WCF pre-authorization number for the client.

   Claim Note: Some claims may require a claim note for additional information.

[3] When billing as a WA Cares provider in ProviderOne, read **Prior Authorization** as a synonym for **WCF Pre-Authorization**.

Is the claim accident related?: **No**.



Note: **EPSDT Information** and **Condition Information** are not applicable to these claims.

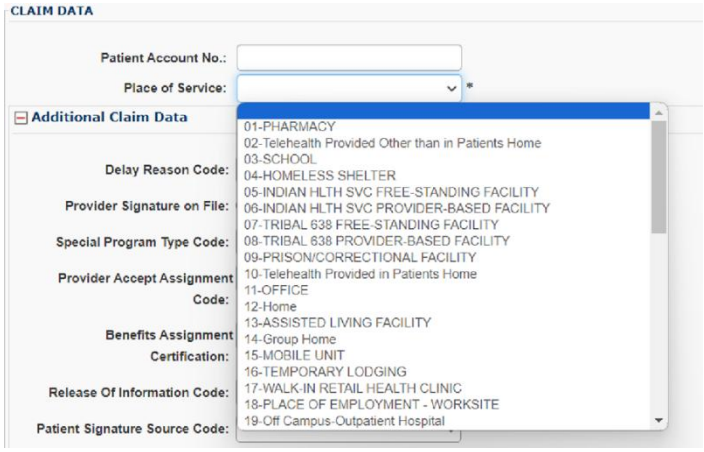
Place of service

Under **Claim Data**:

Using the dropdown menu, choose the appropriate **Place of Service**.

Most services performed will be in either an office or the client's home.

If the service is performed outside of those locations, choose the appropriate place of service from the list.



Note: Adult Family Homes, Assisted Living Facilities and Enhanced Service Facilities are residential settings and are considered to be the client's home.

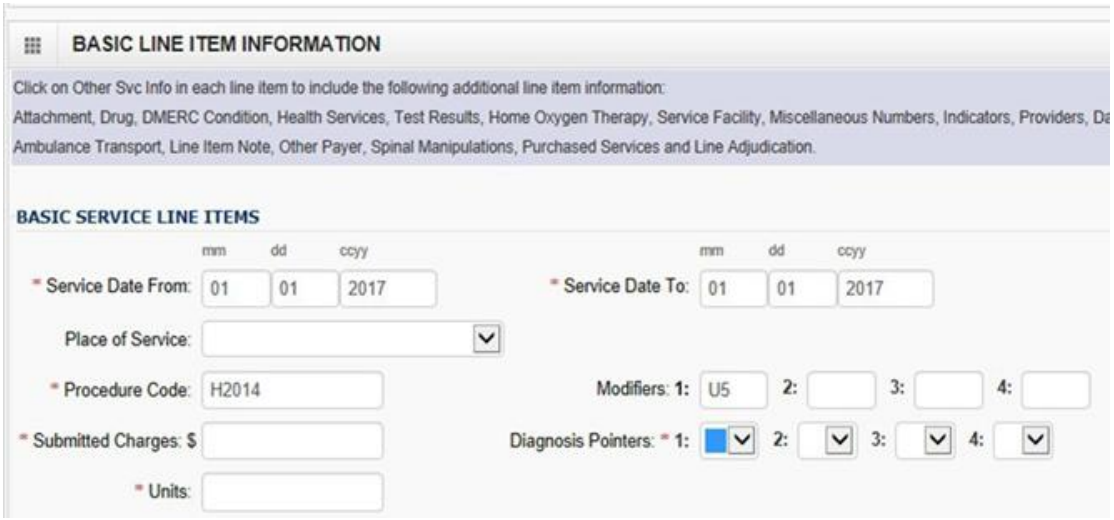
Diagnosis codes

WA Cares does not require diagnosis codes.

Service lines

1. Under **Basic Line Item** Information, enter the following information:
   - **Service Date From** and **Service Date To**
   - **Modifier** (if applicable)
   - **Procedure Code**

     The procedure code (also known as the service code) and the modifier can be found on the client's authorization



Notes:

Each service line spans a single day.

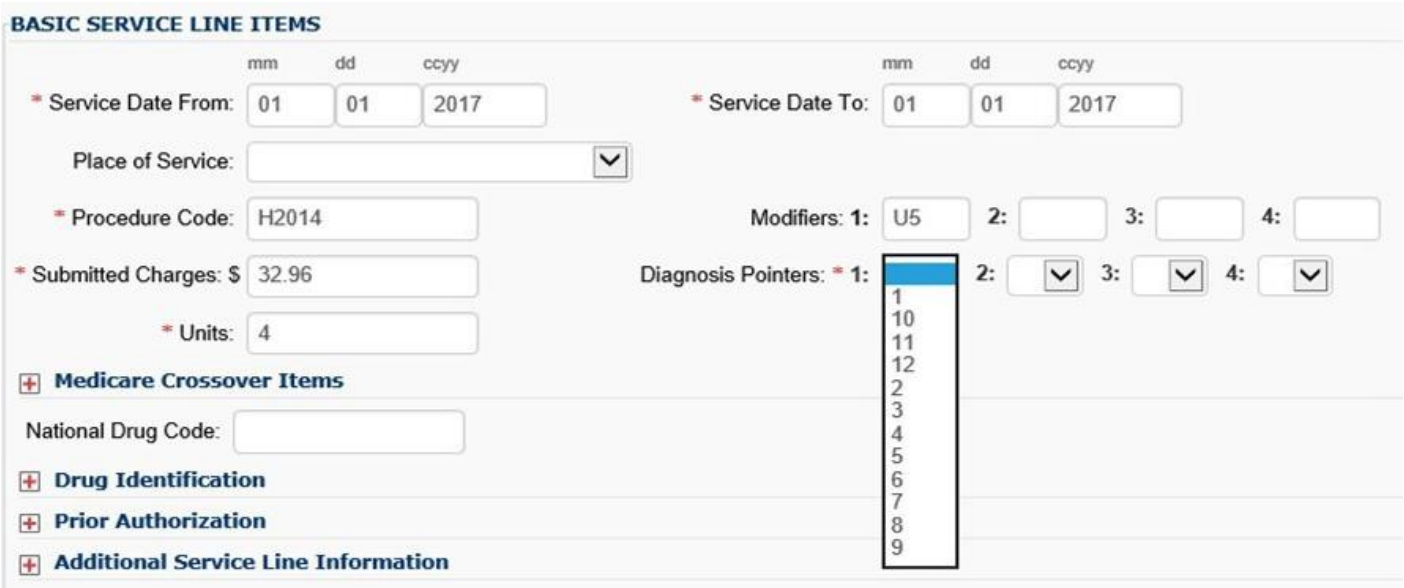
All units of a specific code for the same day should be on the same line.

A date range can be used only if:

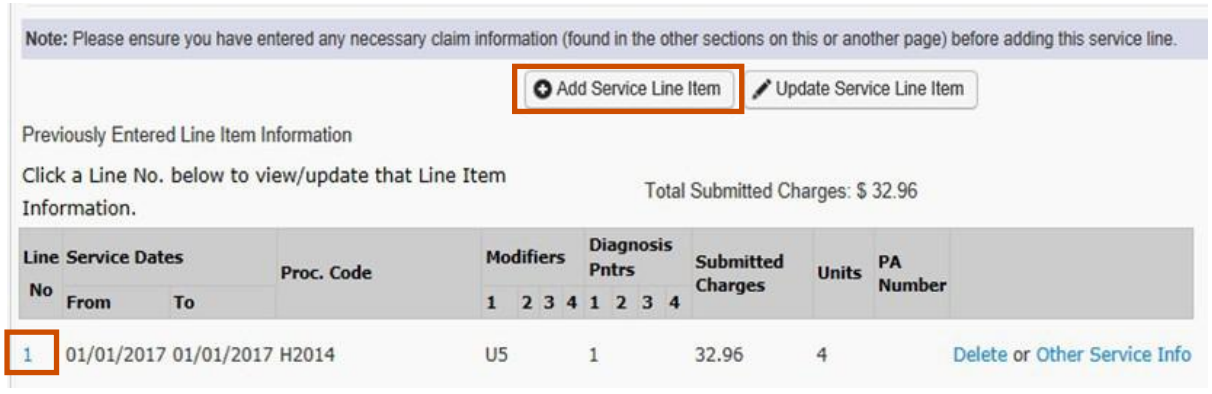
- The unit types are daily or monthly.
- Days are consecutive (worked in a row)
- All days are within the same calendar month or include entire months

The unit type can be found on the client's authorization.

2. Enter **Submitted Charges** (The provider is responsible for the calculation of submitted charges. Units x Rate = Submitted Charge).
3. Enter the number of **Units**.
4. Select the corresponding **Diagnosis Pointer** number from the diagnosis pointers drop-down. (Data entered into the first diagnosis code box = #1 diagnosis pointer).



5. Once the service line information has been entered, click **Add Service Line Item**.
6. The **Basic Service Line Items** section clears. This allows entry of any subsequent service lines before submitting your claim (i.e., billing for multiple days in a month).
7. A claim service line appears under **Previously Entered Line Item Information**. The claim service line will show service dates, service code and modifier, as well as units entered. The total charges submitted will also be available to view.
8. Check the line information for accuracy.



Notes:

Different service codes can be billed on the same claim as long as they have the same authorization number.

If a provider is authorized a medical service code and a non-medical social service code (e.g., bed-hold code) on the same authorization, the nonmedical code must be billed separately. See Basic Claims for directions on how to submit a non-medical claim.

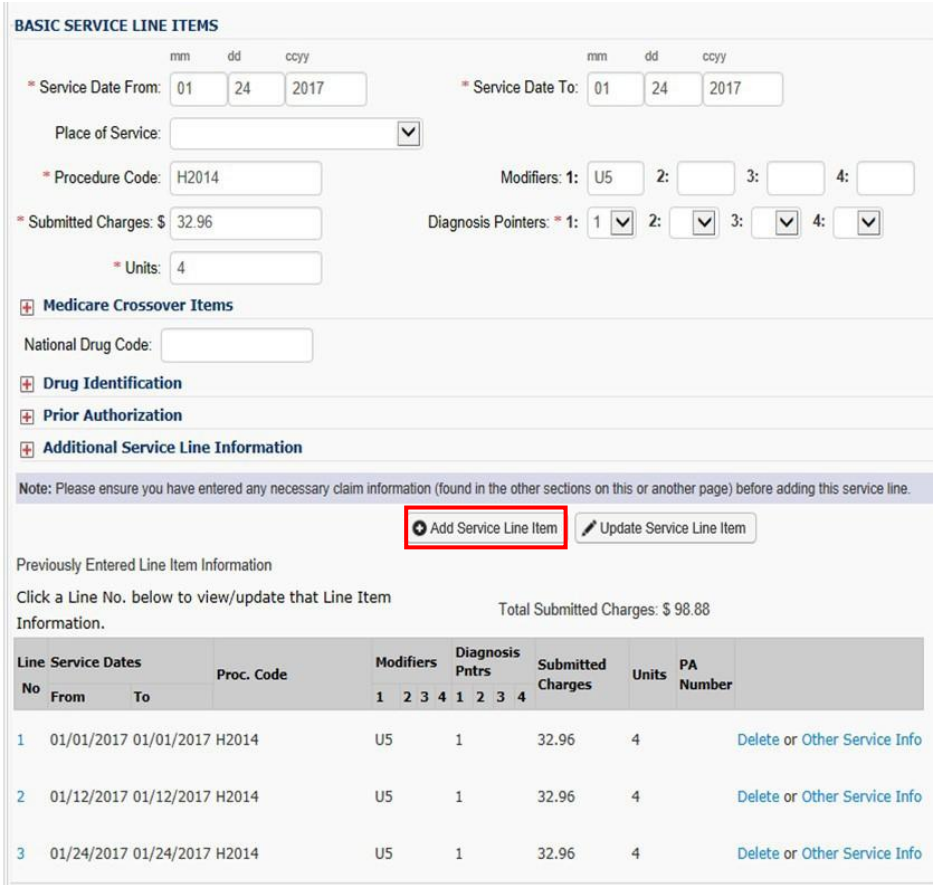
9. To enter additional service lines there are two options.

Option 1

Click on the service line number. The entered service line information populates.

Replace the information with new data.

Click **Add Service Line Item**. (The new service line appears. Shown as line #3 below).



Option 2

Enter basic service line information in the cleared fields.

- Service Date From/To
- Service Code and Modifier
- Submitted Charges, Units and Diagnosis Pointer
- Click Add Service Line Item. (The new service line appears. Shown as line #2 below).

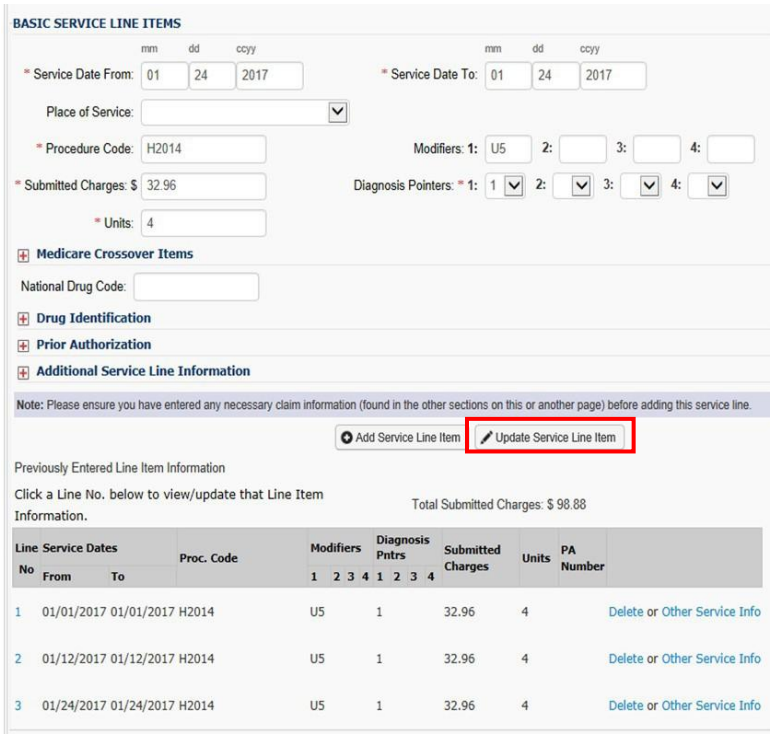


Editing a service line

If you see the information previously entered has an error, you can correct the data by doing the following:

- Select the line number you wish to edit
- The service line data appears
- Make the needed correction to the service line data
- Select **Update Service Line Item**

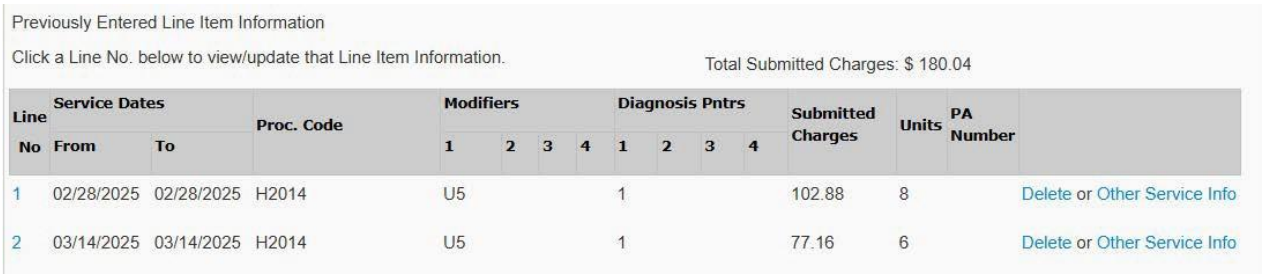
Note: The new data you entered will be shown on the chosen line. (Shown here as line #3.)



Deleting a service line

If you need to remove a previously added service line:

- Determine which line needs to be deleted in the **Previously Entered Line Item Information** section.



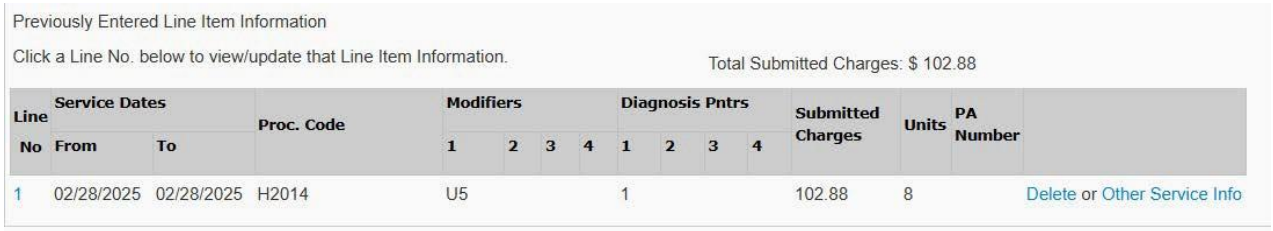
Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: $ 180.04

Line No	Service Dates From	Service Dates To	Proc. Code	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Diagnosis Pntrs 1	Diagnosis Pntrs 2	Diagnosis Pntrs 3	Diagnosis Pntrs 4	Submitted Charges	Units	PA Number	
1	02/28/2025	02/28/2025	H2014	U5				1				102.88	8		Delete or Other Service Info
2	03/14/2025	03/14/2025	H2014	U5				1				77.16	6		Delete or Other Service Info

- Click **Delete** at the end of the line you wish to remove.



Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: $ 102.88

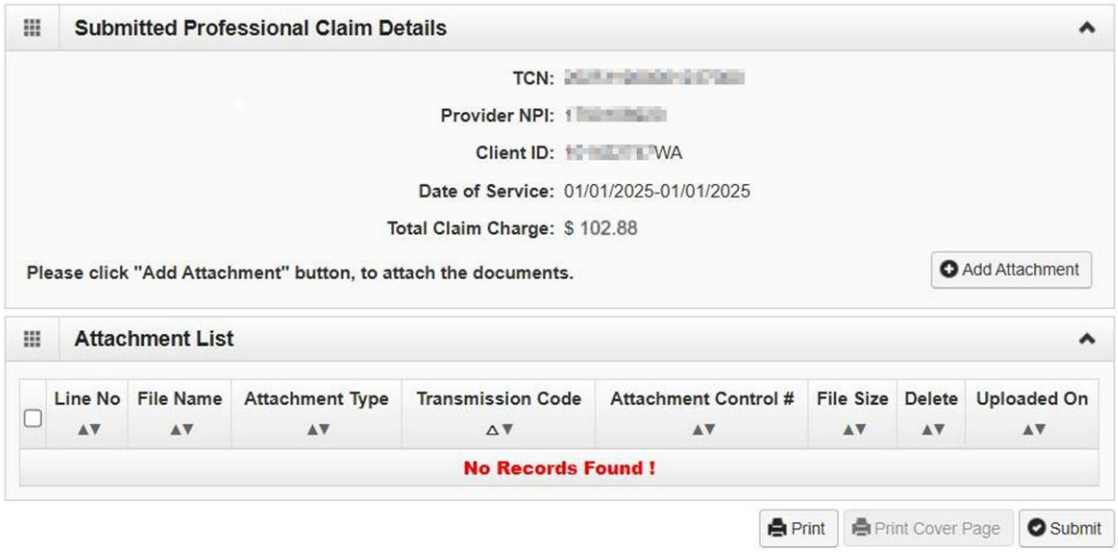
Line No	Service Dates From	Service Dates To	Proc. Code	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Diagnosis Pntrs 1	Diagnosis Pntrs 2	Diagnosis Pntrs 3	Diagnosis Pntrs 4	Submitted Charges	Units	PA Number	
1	02/28/2025	02/28/2025	H2014	U5				1				102.88	8		Delete or Other Service Info

- The line disappears from the claim.
- Once all service line information is entered and checked for accuracy, click **Submit Claim**.
- After clicking on Submit Claim, a message will appear asking, **Do you want to submit any Backup Documentation?**

  If required, select OK and upload the needed documentation before continuing to submit the claim.

  If no backup documentation is needed, select **Cancel** and continue submitting the claim.
- Once you click **Submit Claim**, the **Submitted Professional Claim Details** screen appears.

- Claim details will include the **TCN** (claim #), **Provider NPI**, **Client ID**, **Date of Service** and **Total Claim Charge**.



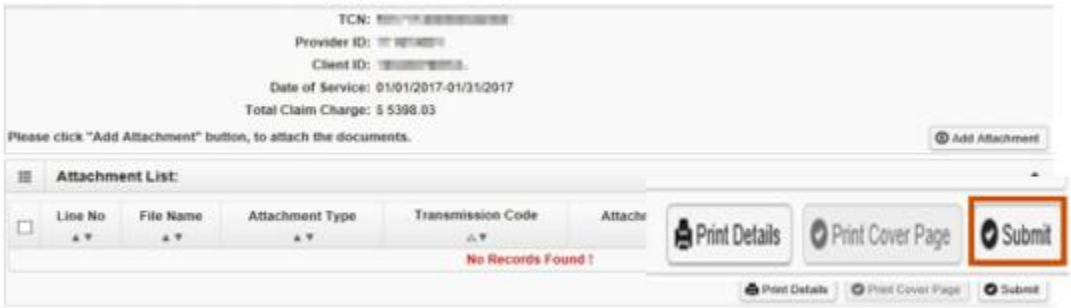
WARNING: You must click the 'Submit' button to complete the Claim Submission

Note: **No Records Found!** refers to attachments such as backup documentation. If you did not attach necessary documents earlier you may do so here by clicking **Add Attachment**. If you do not have any documents to attach, you can ignore this message and click on **Submit**.

- When you see the **WA Cares Fund Claim Details** screen you may want to record the information. You can print a hard copy, print to a file on your computer, or record this information in another manner.

Your claim has not yet been submitted!

- To submit the claim, you must click on the **Submit** button (located in the bottom right corner of the page).



CREATE PROFESSIONAL CLAIM TEMPLATES

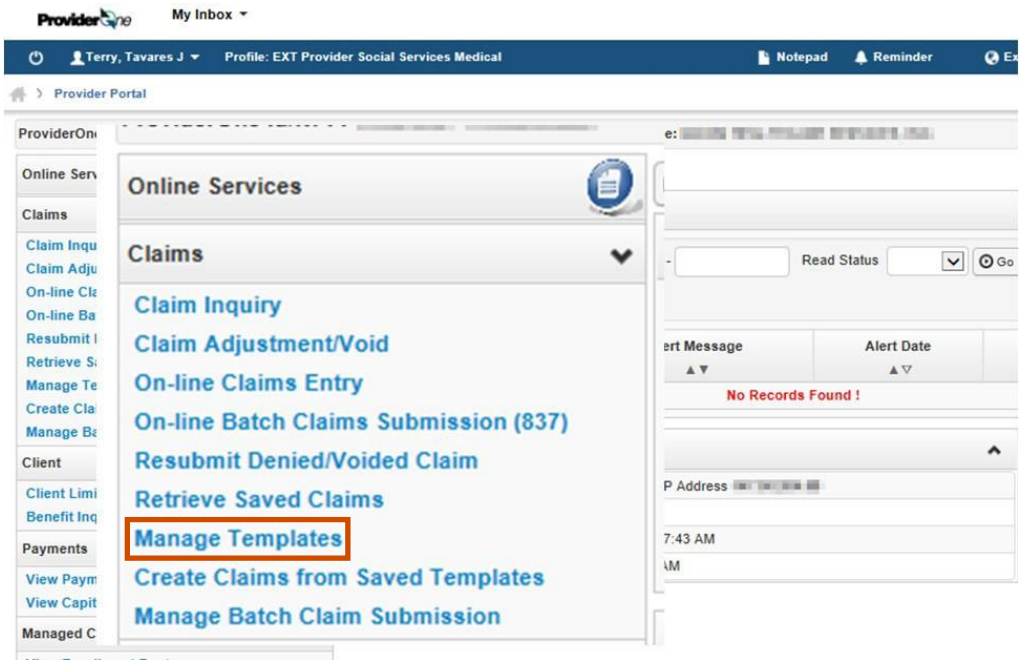
This section explains how to create WA Cares Fund Medical claim templates. Claim templates allow you to save data such as Provider ID, Client ID, and authorization number which helps save time as well as eliminate errors by reducing the amount of data entry for each claim.

Creating claim templates is a good option if you have repetitive billing (e.g., the claim is the same or nearly the same each time you bill).

Using templates with previously saved information will help cut down on errors by reducing the amount of data entry for each claim, and it is a great way to save time and make billing easier.

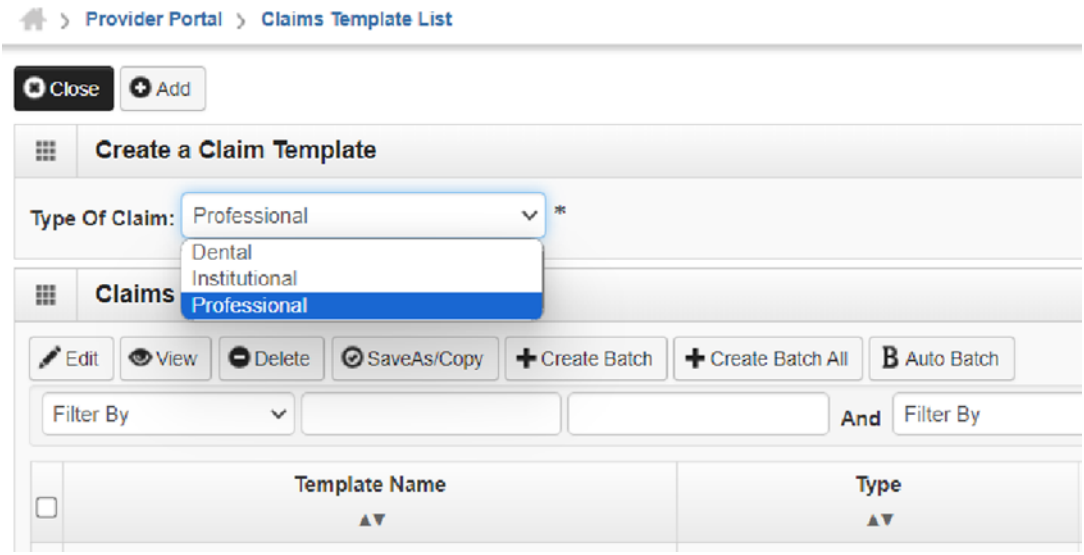
To create a WA Cares Fund Medical Claim Template:

1. First log in to ProviderOne using the appropriate profile. Select **Manage Templates**.



Note: Creating a template is not the same as submitting a claim. The Manage Templates section is for creating, editing, or removing templates. No claims can be submitted from the Manage Templates area. See pages 37-39 for directions on how to submit a claim from a template.

2. The **Create a Claim Template List** screen appears, where you will see any previously saved templates.
3. When there are a large number of templates, you can use the **Filter By** function to find a template.
4. The **Create a Claim Template** screen can be used to:



Add a new template

Edit a saved template

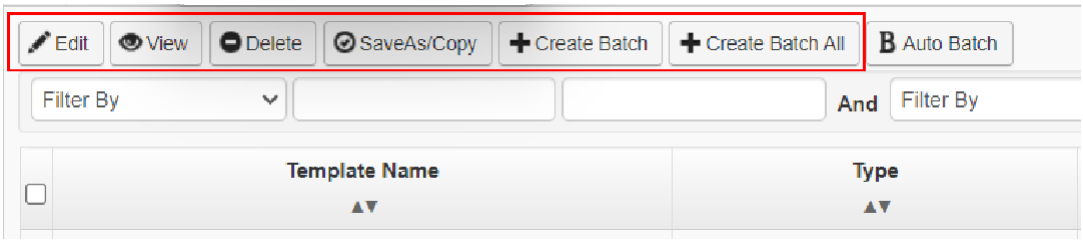
View a saved template

Delete a saved template

Change template name (**SaveAs**) or

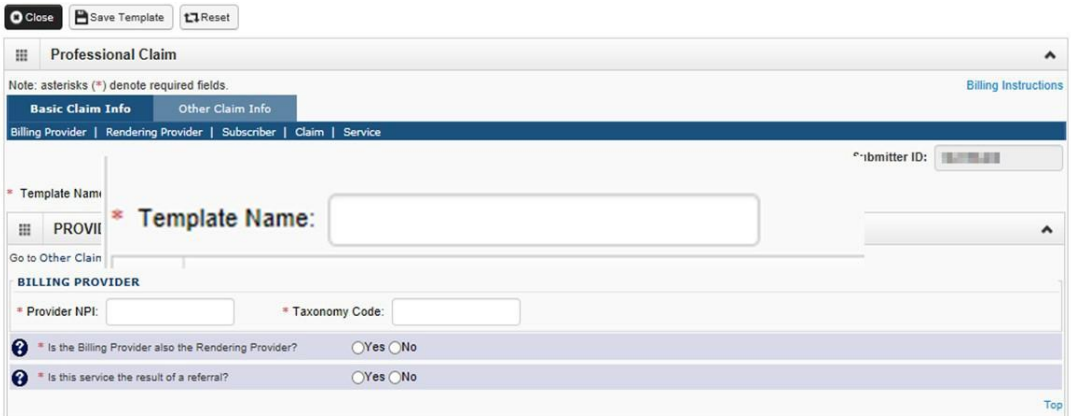
Copy a template

Create a template batch



5. To create a new template, make sure to choose **Professional** as the claim type and then click on **Add**.
6. The **Professional Claim** screen appears. Fill out the claim details per the directions found starting on page 9.

7. Enter a **Template Name**. This is determined by you and is only used to identify the template.



Note: ProviderOne will check the following before allowing the template to be saved:

- Provider NPI
- Taxonomy Code
- Client ID
- Authorization Number

8. At this point you have entered the minimum required information needed to save a template.
9. To save the template, click **Save Template** in the upper left corner of the screen.
10. You will be asked, **Do you want to save the Template?**

    Select **OK** to confirm the save of the template.

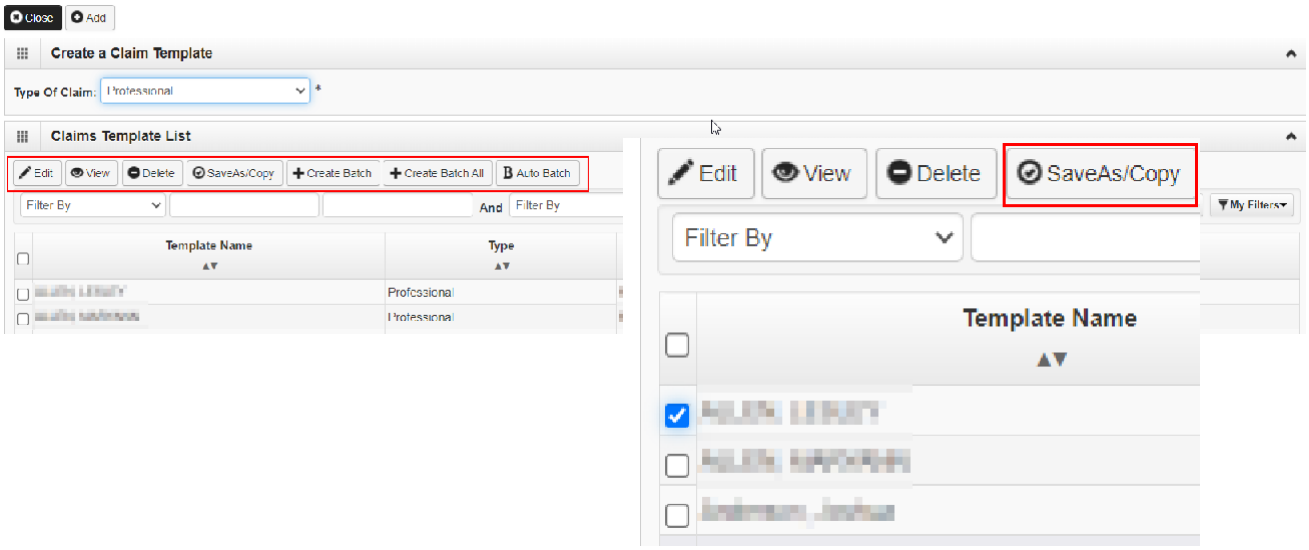
    Select **Cancel** if you are not ready to save the template or need to make changes.
11. You will be returned to the **Create a Claim Template** page, where you will see the template you just created. You can see the template name, template type, the user who made the last update, and the last updated date.
12. To edit, view, or delete the template, check the box next to the template name and select Edit, View, or Delete. If you are editing the template, once you have made the needed changes make sure you save the updated template.

Copying a professional template

As a way to save time, you can use the template you just created to make similar templates for other clients.

To Copy a Template:

1. Check the box next to the desired template name, then
2. Select **SaveAs/Copy**.



Note: Copying a template can save you time, however, be mindful to ensure you update information as needed (client ID, auth #, etc.). Incorrect authorization numbers, provider IDs or client IDs will cause the claim submitted with the template to be denied.

3. After choosing SaveAs/Copy, the original saved template appears.

4. To Update the Template:
   - Change the **Template Name**
   - Change the **Client ID**
   - Open **Additional Subscriber/ Client Information** and change the client's:
     - **Last Name**
     - **Date of Birth**
     - **Gender**





5. Click the **+** next to **Prior Authorization** and change the:

   Authorization Number

   Diagnosis Code





6. To save the template, click **Save Template**.

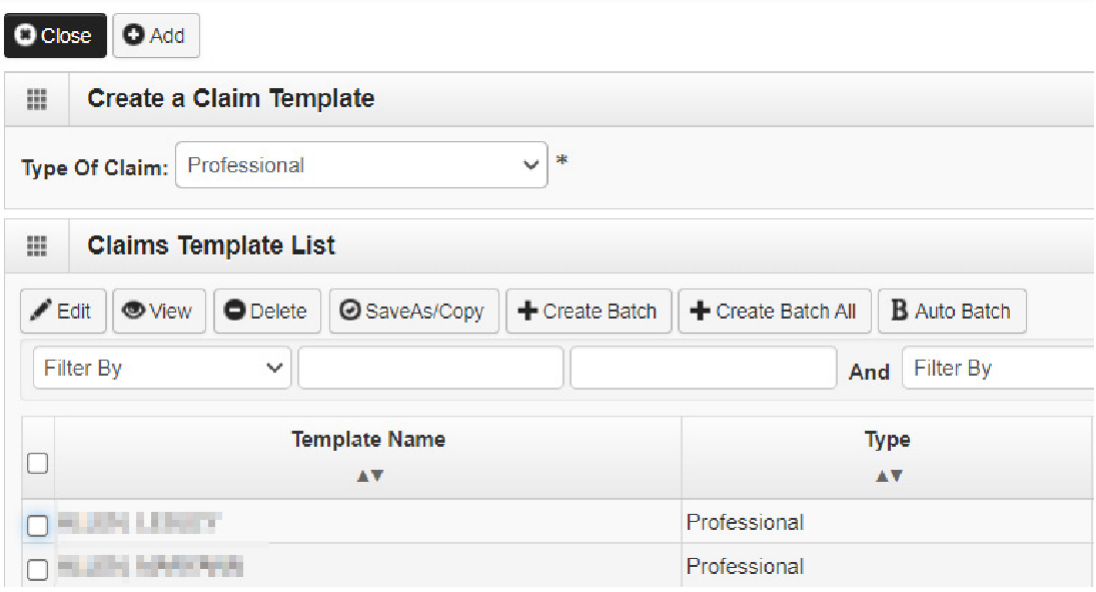
   Note: The Provider NPI will remain the same when copying a template. However, you may need to change the ProviderOne ID if you are billing for a different location.

7. After clicking **Save Template** you will be asked, **Do you want to save the Template?**

   Select **OK** to save the template.

   Select **Cancel** if you are not ready to save the template or need to make changes.

8. You will now be returned to the **Create a Claim Template** page.
9. The new, saved, template will be shown along with the original template.



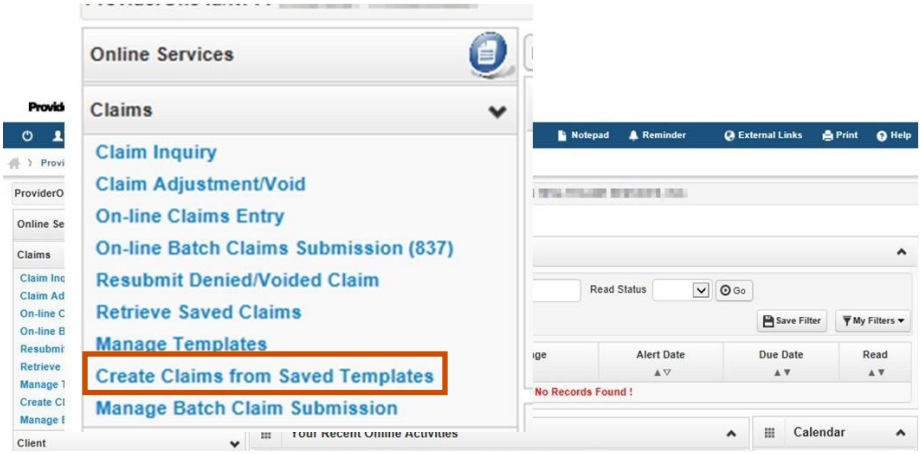
10. Repeat the process as many times as needed.

Submitting claims from saved templates

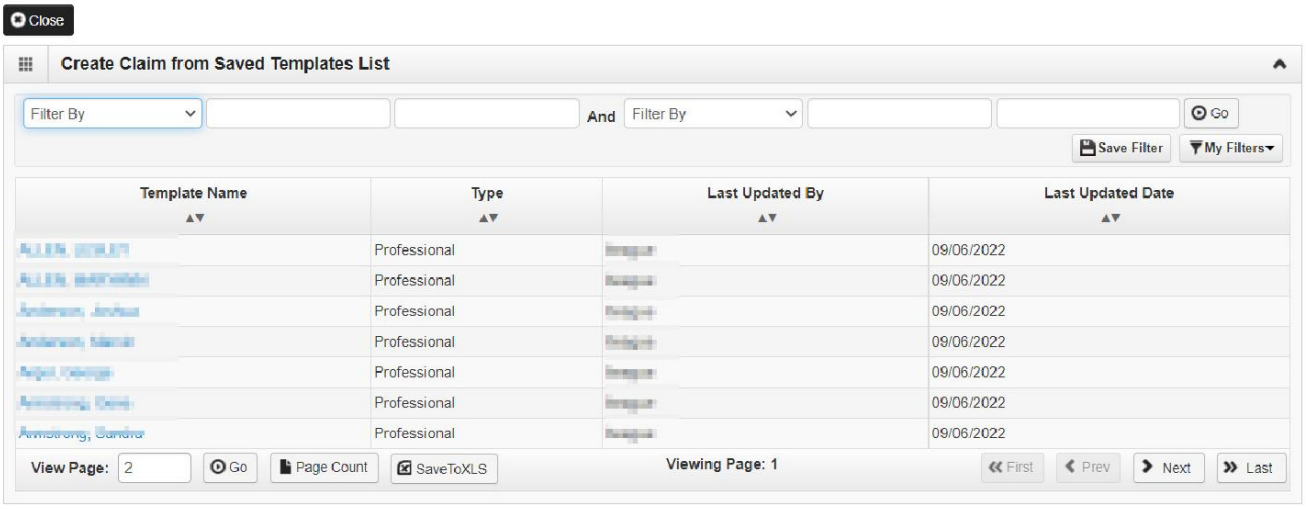
As previously mentioned, claims cannot be submitted from the **Manage Templates** section.

To submit claims using the templates you have saved:

1. First log in to ProviderOne using the appropriate profile.
2. Select **Create Claims from Saved Templates**.



3. The **Create Claim from Saved Templates List** appears.
4. Here you will see all of your saved templates. To select a template, click on the blue hyperlinked name.



5. After selecting a template, you will see the saved information from the chosen template. This will include the:

   Provider NPI

   Taxonomy Code

   Client ID, Last Name, Date of Birth and **Gender**

   Authorization Number

   Place of Service

   Diagnosis Code

6. Fill out the rest of the claim information and then submit the claim.

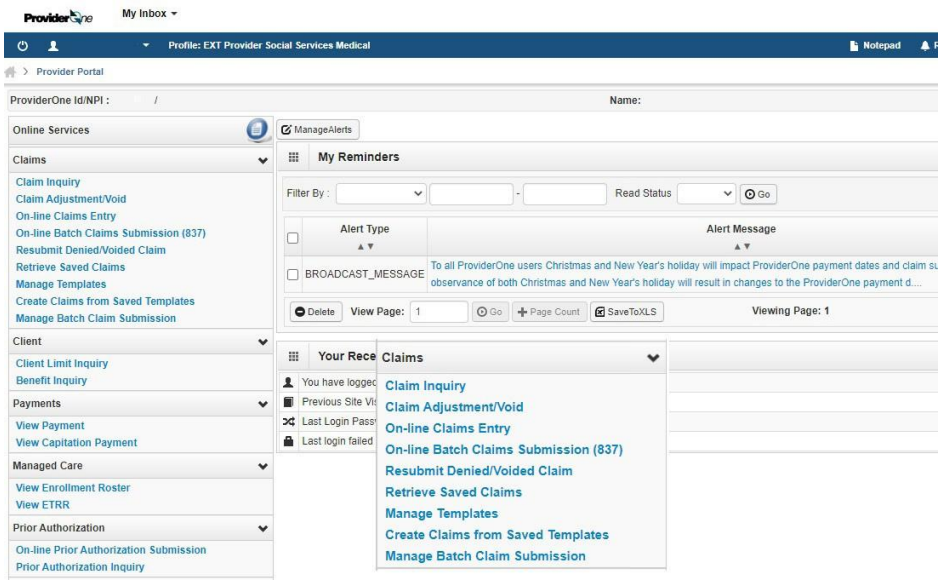
Creating and submitting professional batch claims

A batch (template) is a group of claims which share the same date of service. The Batch allows the provider to create a group (batch) of templates, change the date of service on all the templates at one time, and submit the batch all at once.

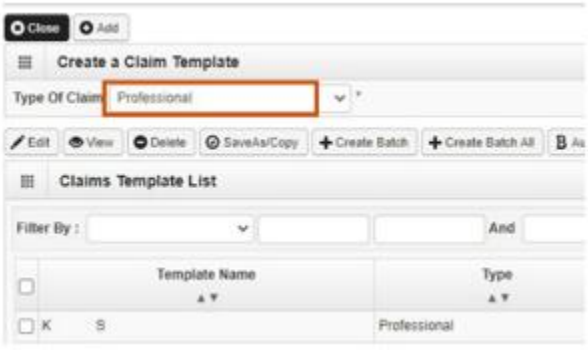
This process should not be confused with the HIPAA Batch Upload process. Medical providers (including WA Cares Fund Medical Providers) can submit claims via a process called HIPAA Batch Upload. More information about this process can be found on HCA's HIPAA Electronic Data Interchange (EDI) webpage. Questions about this billing option should be directed to HCA's HIPAA Help Desk at hipaa-help@hca.wa.gov.

To create a template batch:

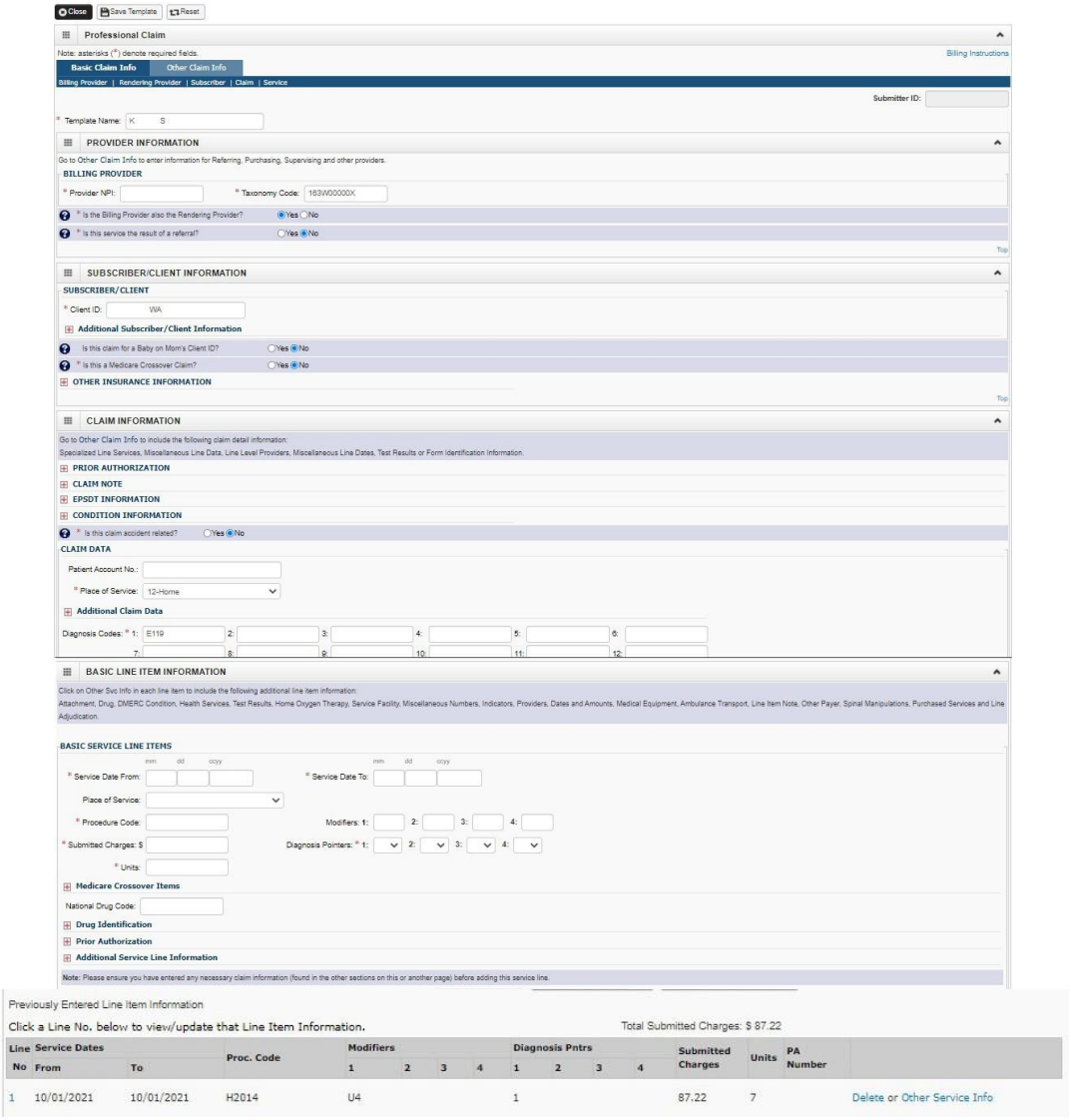
1. From the Provider Portal, click **Manage Templates.**



2. The **Create a Claim Template** page appears, where you will see all the claim templates you have created.
3. The **Template Type should** be **Professional**. If this is not showing, use the drop-down menu to select Professional.



Click on each template to verify the template is complete, including basic service line items. Change the template as needed.



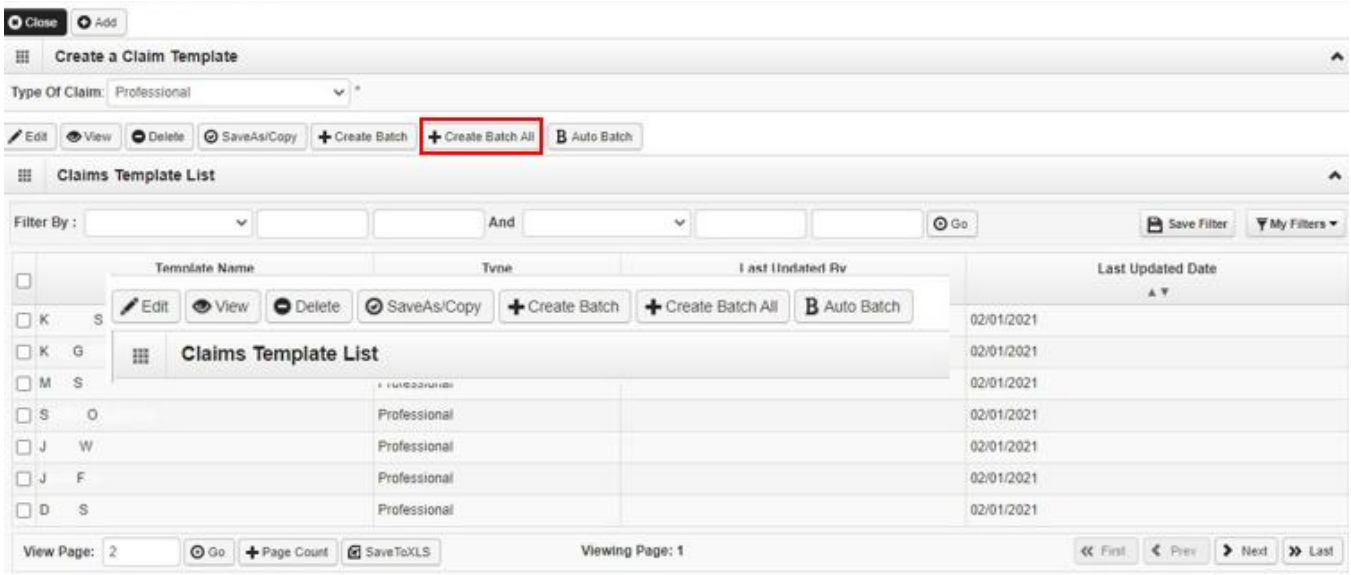
Note: Submitted charge and number of units must be for this billing period.

4. Click **Save Template**. Click **Close.**

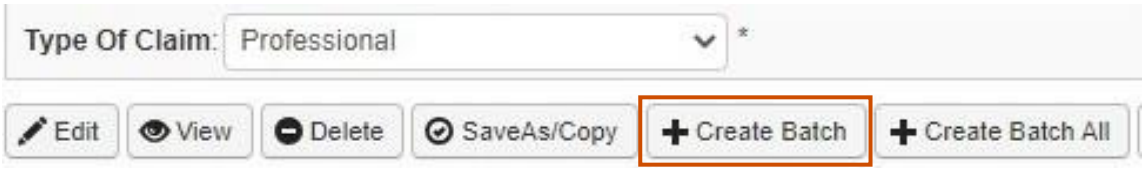
   Note: Repeat the process of checking that a template is complete for each of the templates that will be included in the batch.

5. The **Claims Template List** appears.
6. To include all the templates on the list in a batch, click **Create Batch All**.

   Note: If you have a large number of templates, you can use the 'Filter By' function to



   customize the template list so that you can use 'Create Batch All'.
7. Instead of including all templates in the batch, you can instead select specific templates to include in the batch.
8. Click on the box next to the desired templates to include in the batch.
9. Click **Create Batch**.



10. A pop-up appears asking, **Are you sure you want to create Batch?**
11. Click **OK**.
12. The **Batch Claims Attribute screen** appears. Select **Professional** under **Claim Type**.
13. Enter **From Date of Service**.
14. **Enter To Date of Service.**
15. Enter **To Date of Service**.



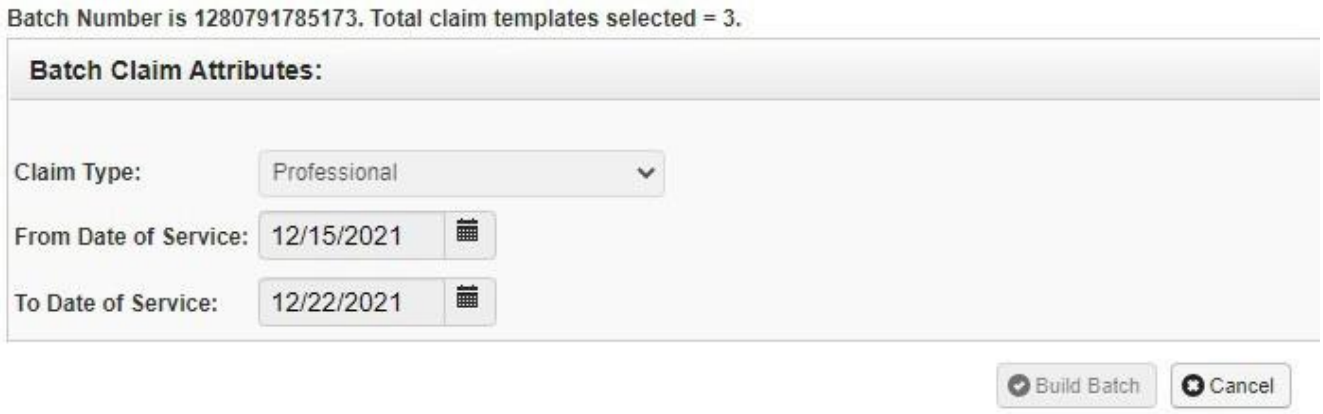
Notes:

- The Date of Service will be changed on all the service lines on each template. All claims within the template must be for services provided on the date entered.
- The Date of Service can only be a single day.
- A date range can be used only if:
  - All unit types are daily or monthly (Few medical codes are daily or monthly)
  - Days are consecutive (worked in a row)
  - All days are within the same calendar month or include entire months
  - # of units on templates equals the days or months within the range
  - All the templates have the same date range

16. Click **Build Batch**.



17. **Batch Number** appears along with the number of total claims included in the batch.
18. Click **Cancel**



Your claim has been built, but it has not yet been submitted.

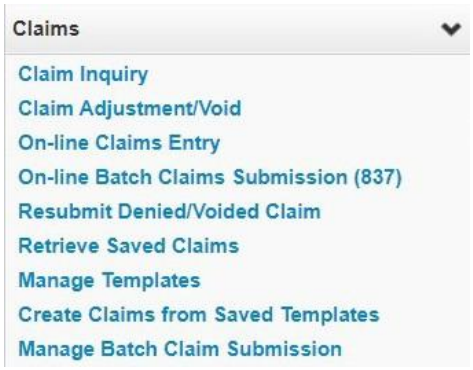
19. Repeat the process to create additional batches. Or click Close to return to the Provider Portal.

    Notes: After a batch is created, ProviderOne checks the batch to ensure the templates have complete claim information:

    - **Passed Validation** means all the templates have complete, valid information and the batch can be submitted.
    - **Failed Validation** means one or more items within the batch is not valid and the batch cannot be submitted.
    - See pages 50-54 for directions on how to revalidate a template batch.

Revalidating a template batch

After a template batch is created, ProviderOne checks the batch to ensure the billing data is valid. This section shows how to check the validation of a template batch and how to revalidate a template batch that has failed validation.

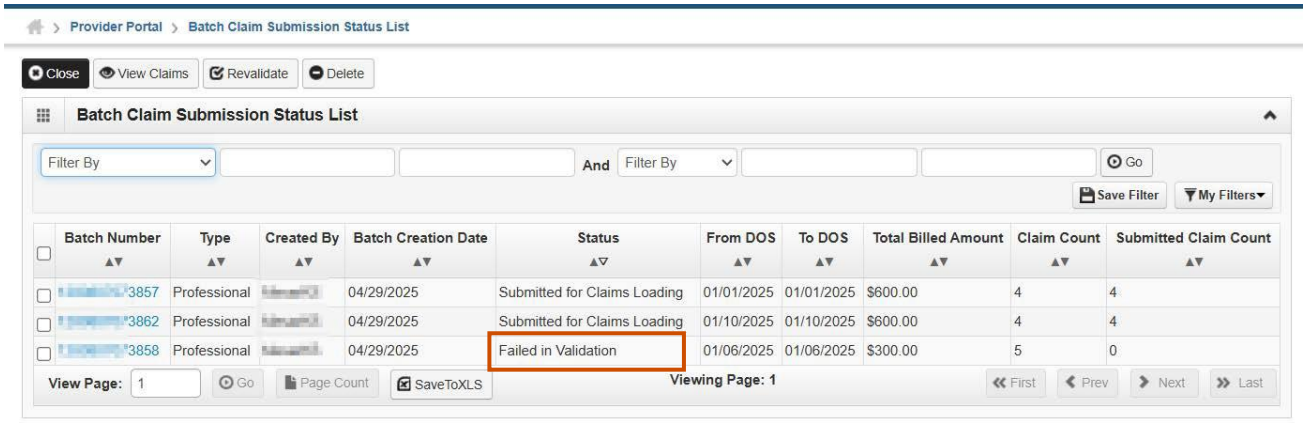


1. From the Provider Portal, click **Manage Batch Claim Submission**.
2. The **Batch Claim Submission Status List** appears.

   Pass Validation means all the templates have complete, valid information and the batch can be submitted.

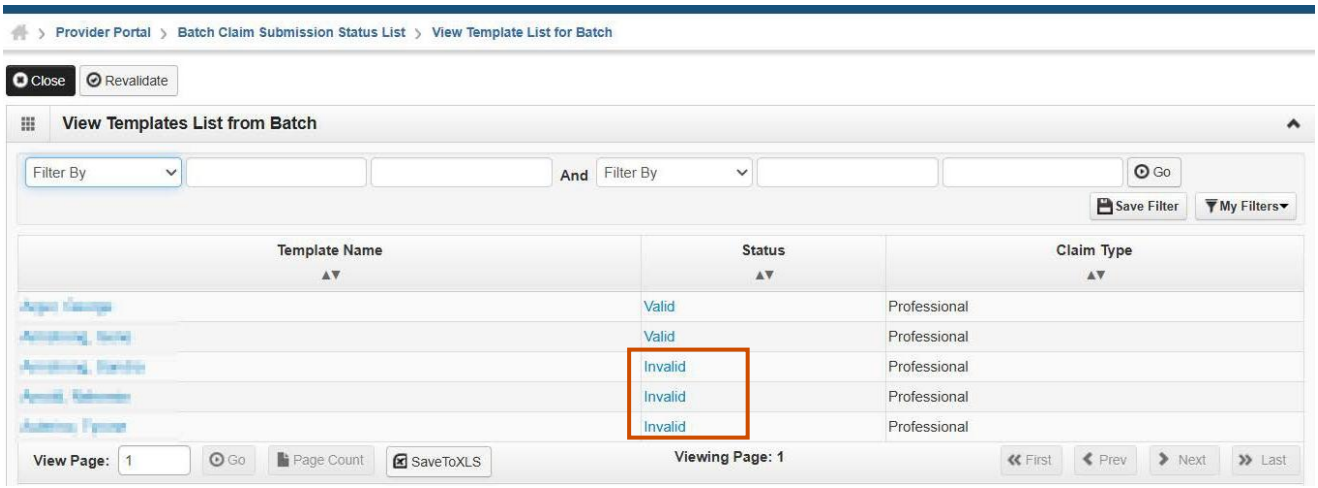
   Failed in Validation means one or more items within the batch is not valid and the batch cannot be submitted.

3. To view why a batch failed validation, click on the blue hyperlinked batch number.



4. The **View Template List from Batch** screen appears.

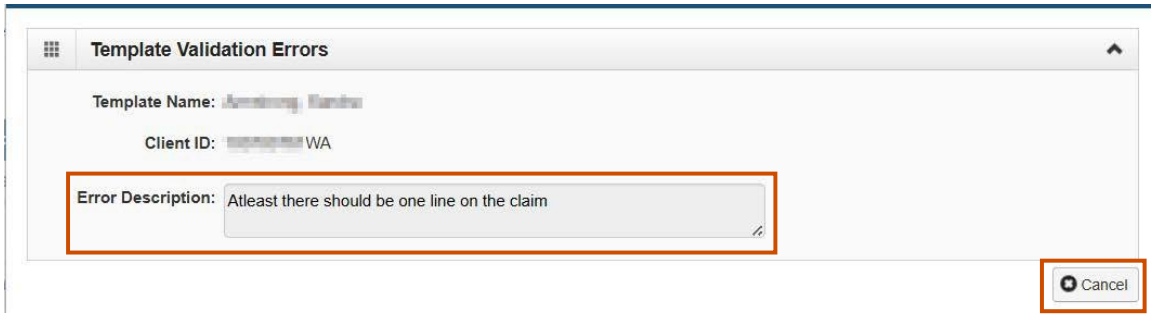
5. Click on blue hyperlinked **Invalid** status.



6. **Template Validation Errors** pop -up appears.

7. View and make note of the **Error Description** (e.g., ''service code is invalid/empty").

8. Click **Cancel**.



9. Next, click on the **Template Name**.
10. The template displays.
11. To correct an error:

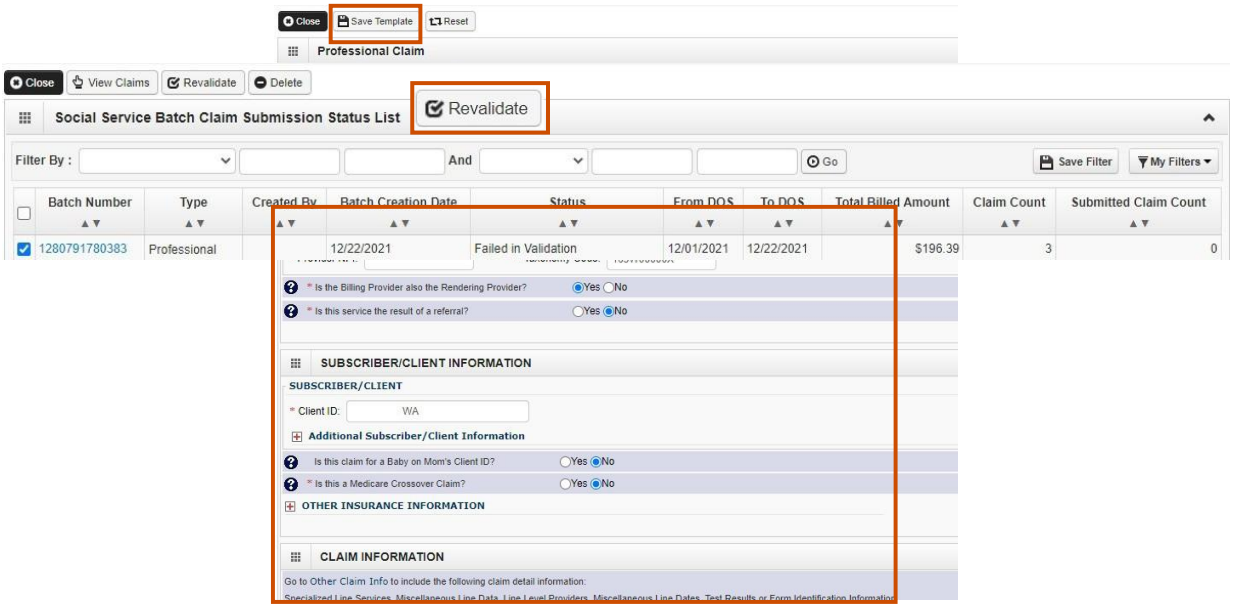
    Click on the line number you need to fix.

    Basic Line Information populates.

    Enter missing data/correct error.

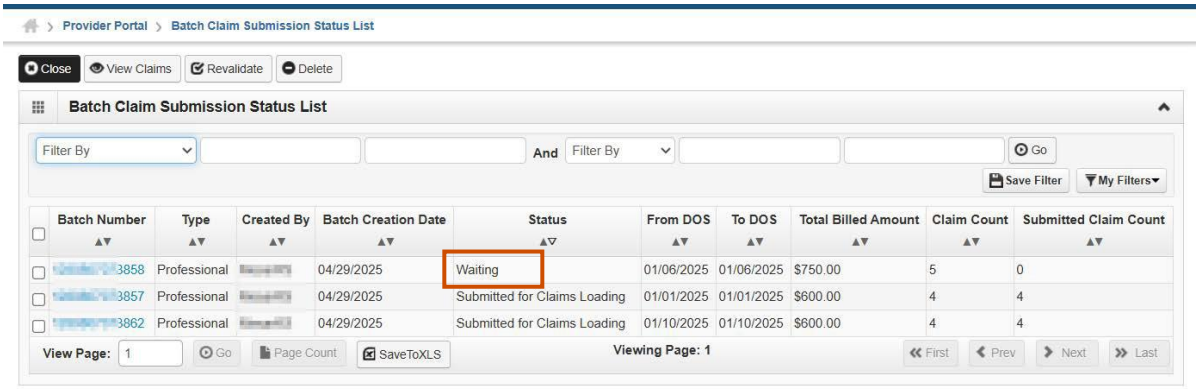
    Click **Update Service Line Item**.

12. Click **Save Template**.



13. After fixing any errors, click **Revalidate**.
14. The **Batch Claim Submission Status List** appears.
15. The status will show as **Waiting**.

16. Refresh the page.

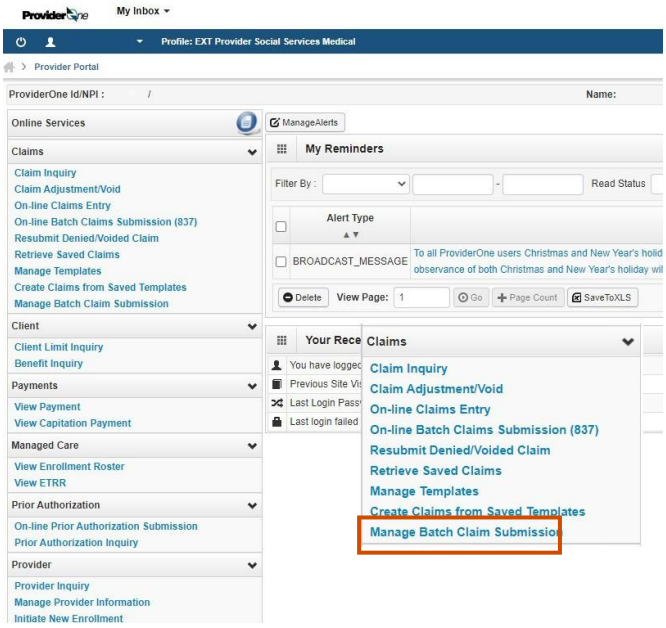


17. If the status changes to **Passed Validation**, the batch can now be submitted.

Submitting a template batch

After you have created and revalidated your Template Batch, you are now ready to submit the Template Batch for processing. To submit a template batch:

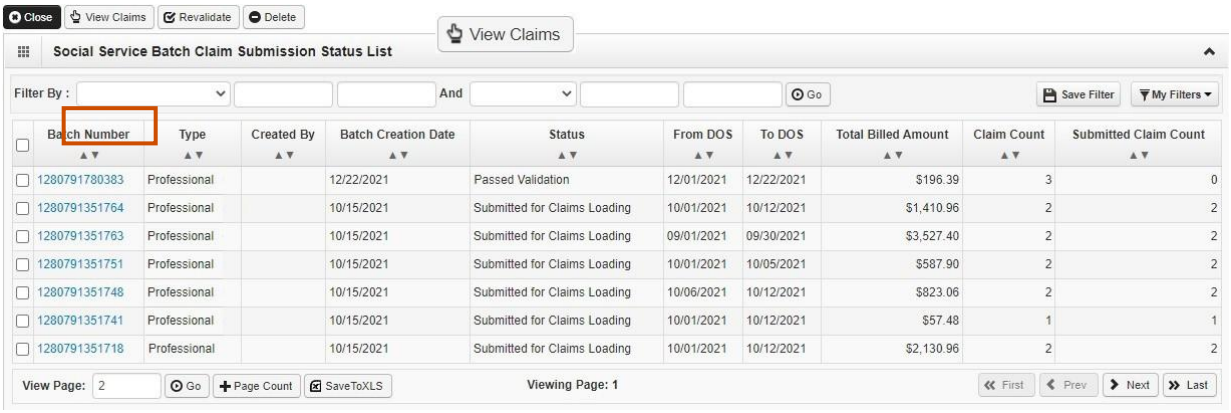
1. From the **Provider Portal**, click **Manage Batch Claim Submission**.



2. From the **Batch Claim Submission Status List**, click on the box next to the desired batch. (Note: A batch must pass validation before it is submitted.)

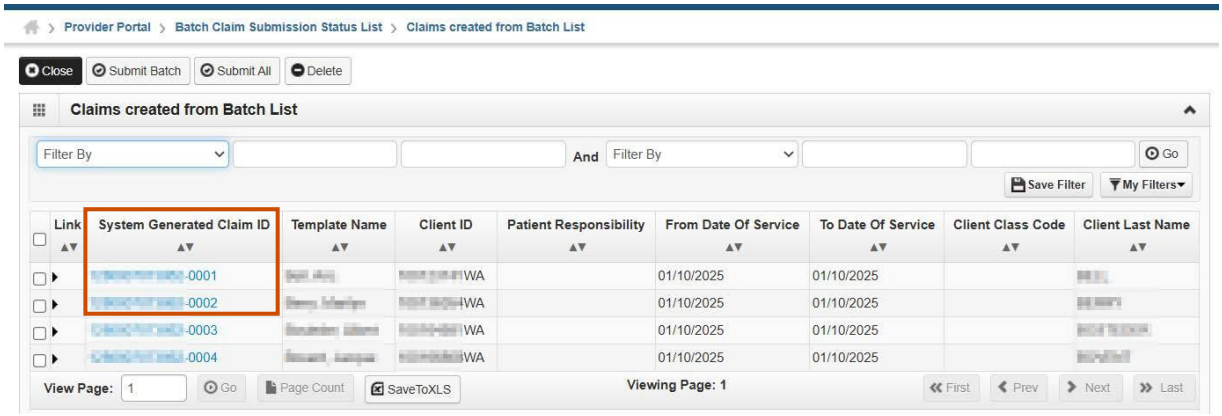
Batch Number	Type	Created By	Batch Creation Date	Status	From DOS	To DOS	Total Billed Amount	Claim Count	Submitted Claim Count
1280775980983	Professional	BenavSC	04/06/2018	Passed Validation	03/27/2018	03/31/2018	$525.00	1	0

3. Click **View Claims**.



4. **Claims Created from Batch List** appears.

   Each template batch is assigned a System-Generated Claim ID.

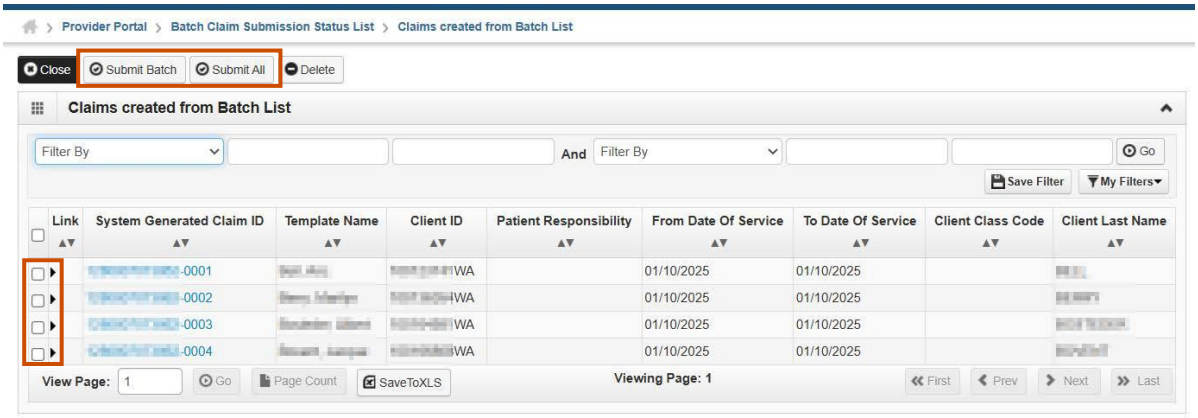


   Note: The System-Generated Claim ID is the batch number. This is not the same as the TCN (claim number). The TCN will be generated after you submit the batch.

5. You can submit all or some of the listed claims.

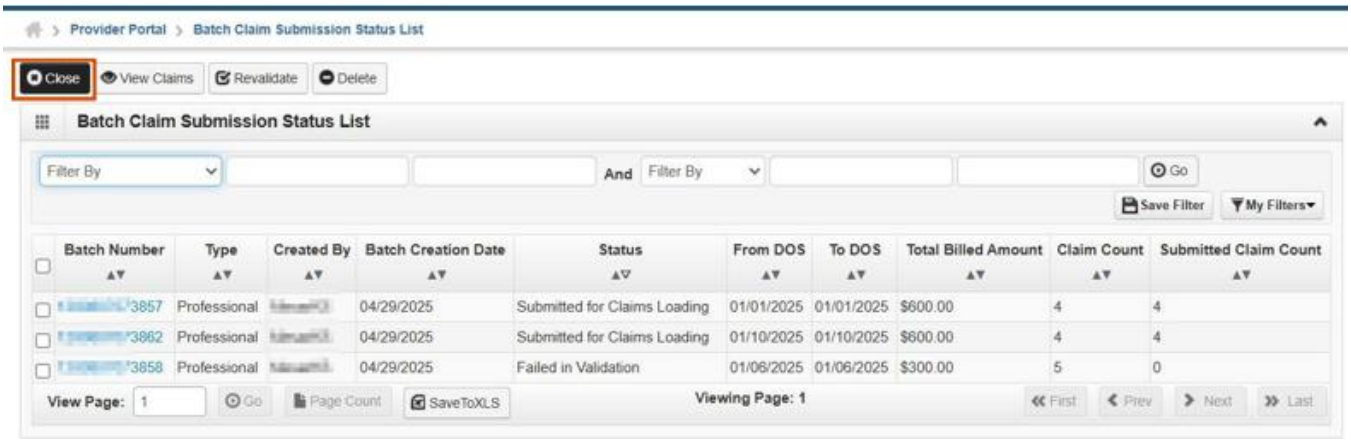
   To submit some of the claims, click the box next to the desired claims and click **Submit Selected**.

To submit all of the listed claims, click on **Submit Entire Batch**.



Note: A batch can only be submitted one time.

6. After submitting the batch, the System-Generated Claim ID is replaced with the Transaction Control Number (TCN). Click **Close**.
7. Batch Claim Submission Status List appears and shows Status and Submitted Claim Count. Click **Close**.



ADJUST, VOID, AND RESUBMIT PROFESSIONAL CLAIMS

There are times when a previously paid claim needs to be adjusted, meaning a change to the dates, units or other details; or voided meaning to change the claim so it is no longer in paid status. This section will also discuss how to resubmit a claim that has been denied or voided.

Adjusting paid claims

There are times when you (or DSHS) may need to adjust a claim. An example of when a claim may need to be adjusted is if the original claim had incorrect data (incorrect code or date claimed). Note: Only claims in PAID status can be adjusted.

To adjust a paid claim:

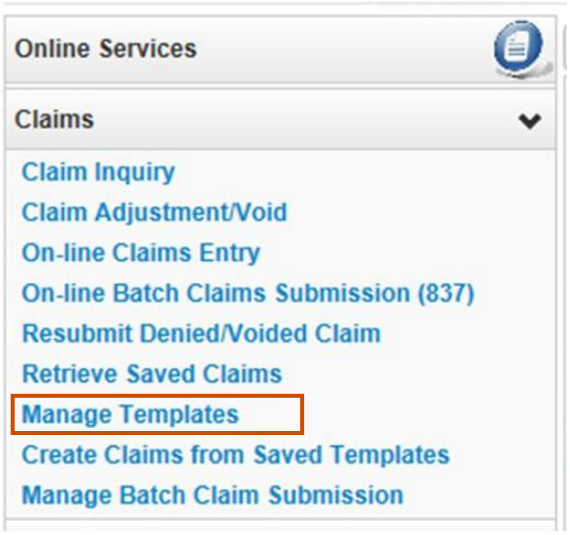
1. Log in to ProviderOne using one of the following WA Cares profiles.

   EXT Provider Claims Submitter

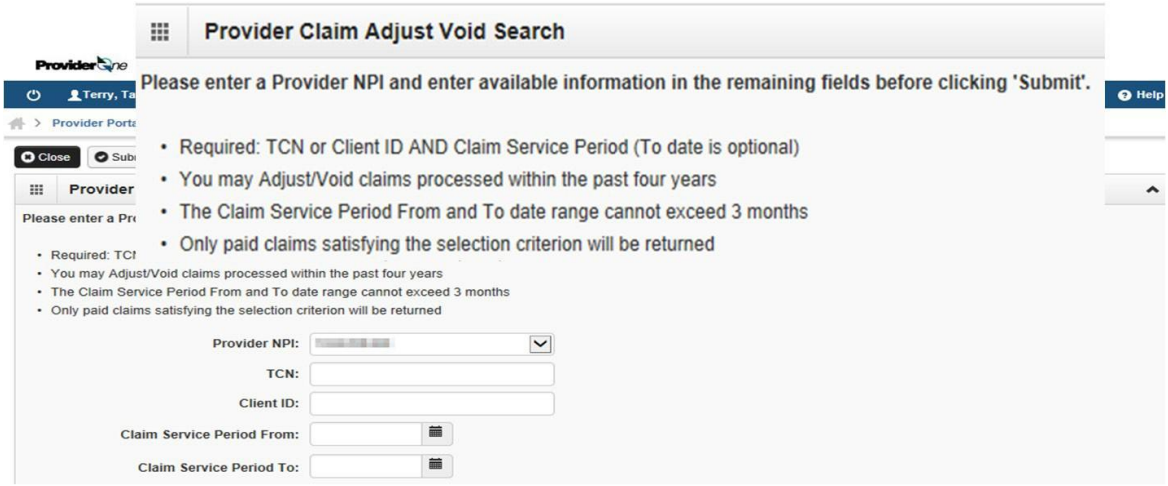
   EXT Provider Eligibility Checker-Claims Submitter

   EXT Provider Super User

2. Click **Claim Adjustment/Void**.
3. The Provider Claim Adjust Void Search screen appears. There are search requirements to be aware of when searching for claims.

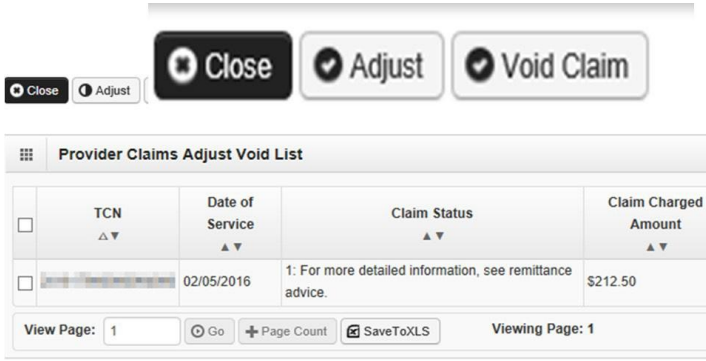


4. The Provider NPI associated with the domain currently in use will automatically be listed in the Provider NPI drop-down. You can search by TCN, or Client ID and Claim Service Period.



Note: Search requests must be for claims submitted within the last 60 days. If you enter Claim Service Period From date, the range cannot exceed three months.

5. The **Provider Claims Adjust Void** List appears.
6. Check the box next to the TCN you want to adjust.
7. Click **Adjust**.



Note: The populated list will show the TCN, Date of Service, Claim Status, Claim Charged Amount, Claim Payment Amount, Client ID and the Administration providing services for the client.

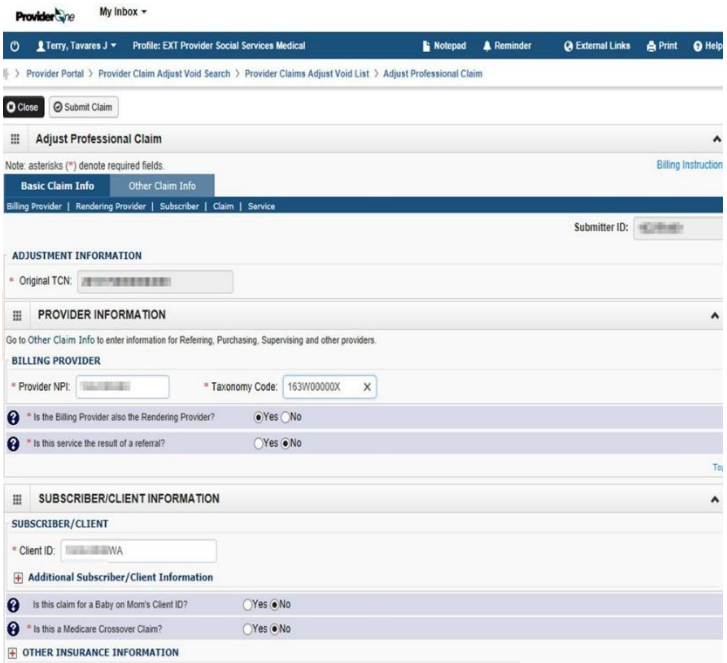
8. The **Adjust Professional Claim** page appears.
9. This screen is similar to the Billing Scree; however, the page includes an **Original TCN**.
10. If you just need to reprocess the claim and do not need to change any information on the claim (example there has been a rate change or a change to the client responsibility amount), click **Submit** to reprocess the claim.

Note: If you need to make changes to the claim before resubmitting, see:

Modifying Service Line data

Adding Service Lines

Voiding Service Lines



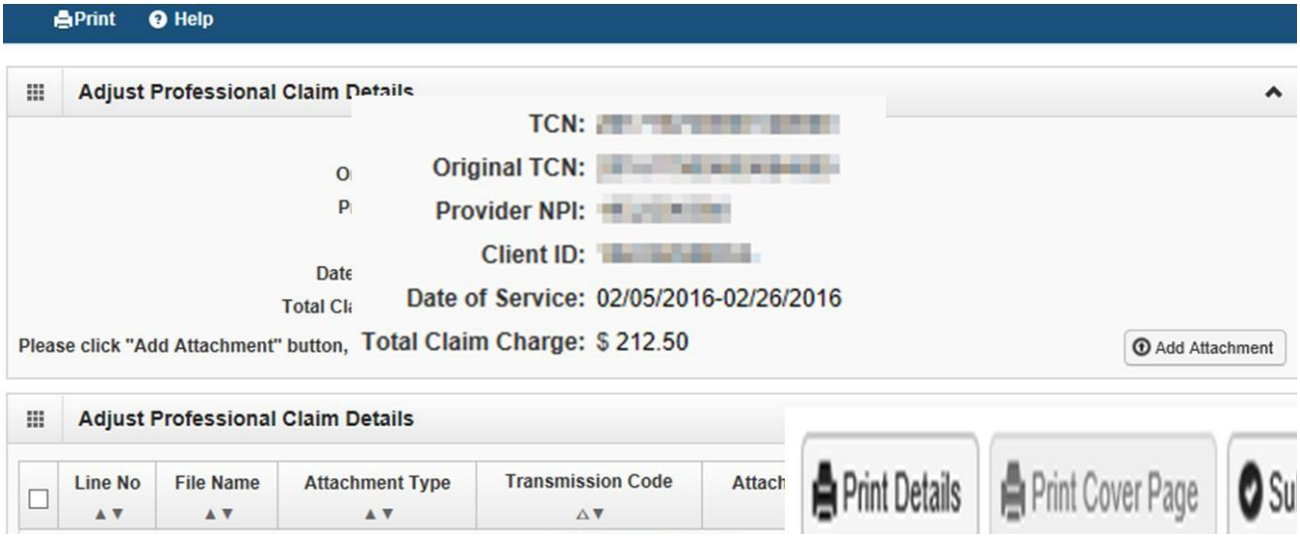
11. If all service line information is entered and checked for accuracy, click **Submit Claim** at the top of the screen.
12. A message will appear asking, **Do you want to submit any Backup Documentation?**

Certain shared services* require backup documentation, such as a denial from another payer; however, WA Cares does not require back up documentation. If you would like to include it for your own

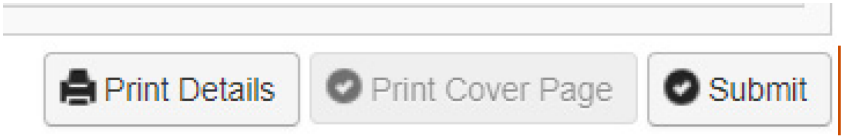
records, select **OK** and upload the documentation before continuing to submit the claim.

If no backup documentation is needed, select **Cancel** and continue submitting the claim.

13. Once you have clicked **Submit**, the **Adjust Professional Claim Details** page appears. Please note, the adjusted claim will have a new TCN number. This allows for tracking of the changes made to the original claim.
14. Claim details will include the new **TCN**, **Original TCN**, **Provider NPI**, **Client ID**, **Date of Servic**e and **Total Claim Charge**.
15. To complete claim submission click **Submit**.



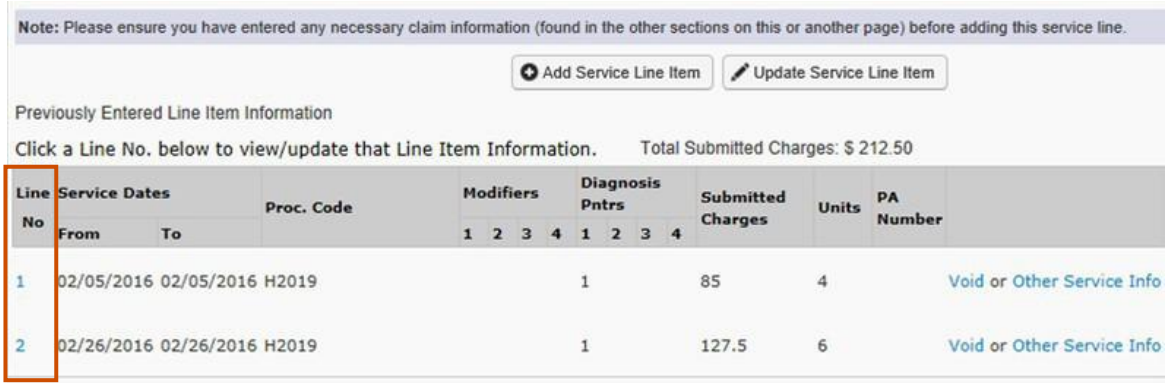
Notes: Make sure to click **Submit** on this screen. **No Records Found!** refers to attachments such as backup documentation. If you did not attach necessary documents earlier you may do so here by clicking Add Attachment. If you do not have any attachments, you can ignore this message.



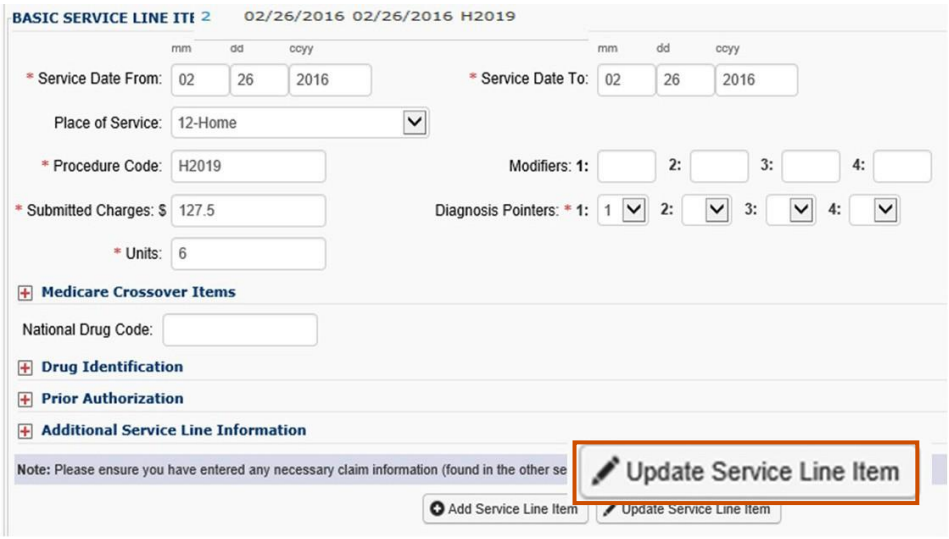
16. Once the claim is processed by ProviderOne, the adjustment is complete.
17. The claim details will be available in the Adjustments category of your next Remittance Advice (RA). For information on how to view your RA, see the View and Download RA.

Modifying service line data

1. Click on a **Service Line Number.**



2. The corresponding service line information appears. Make needed changes to the data fields.
3. Click **Update Service Line Item.**

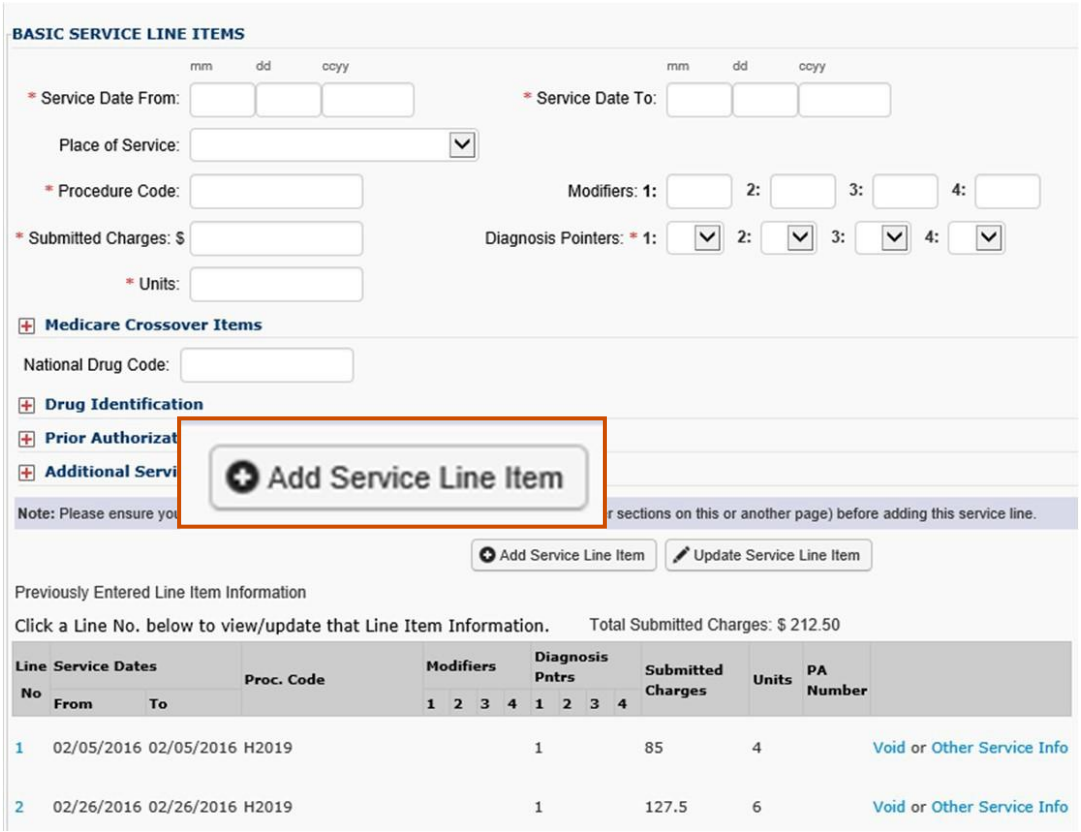


4. The service line updates with the new information.
5. Go to page 70 to finish the adjustment process.

Adding dates of service

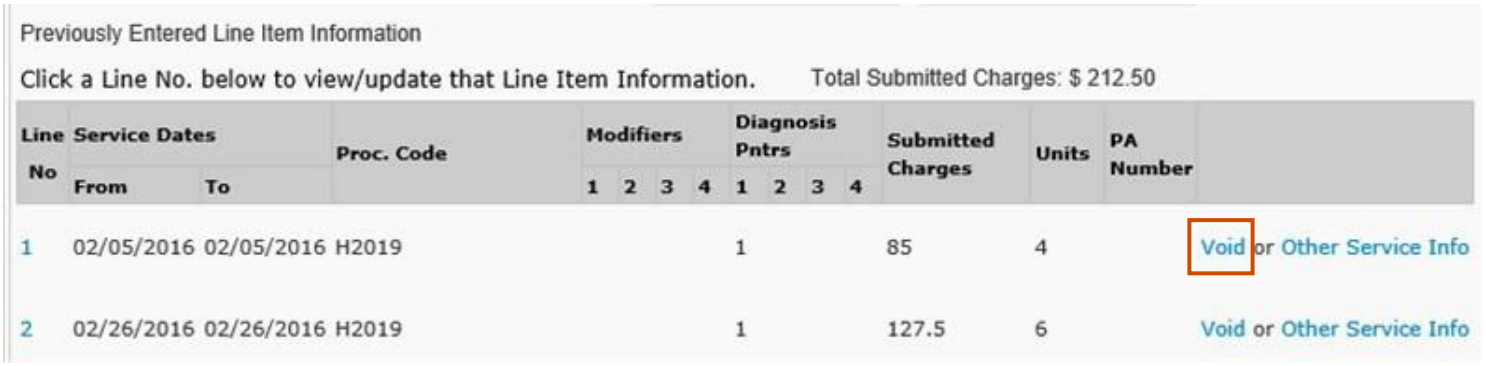
To add a date of service to a previously paid claim:

1. Enter **Basic Service Line** information.
2. Click **Add Service Line** item.
3. The new service line appears.
4. Add the new dates of service, then go to page 70 to finish the adjustment process.



Voiding service line data within a paid claim

1. Determine which line needs to be voided in the **Previously Entered Line Item Information** section.
2. Click **Void** at the end of the line you wish to remove.



Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 212.50

Line No	Service Dates From	Service Dates To	Proc. Code	Modifiers 1	2	3	4	Diagnosis Pntrs 1	2	3	4	Submitted Charges	Units	PA Number	
1	02/05/2016	02/05/2016	H2019					1				85	4		Void or Other Service Info
2	02/26/2016	02/26/2016	H2019					1				127.5	6		Void or Other Service Info

3. The line disappears from the claim, and any subsequent lines will change numbers to match the new order.
4. Go to page 70 to finish the adjustment/void process.

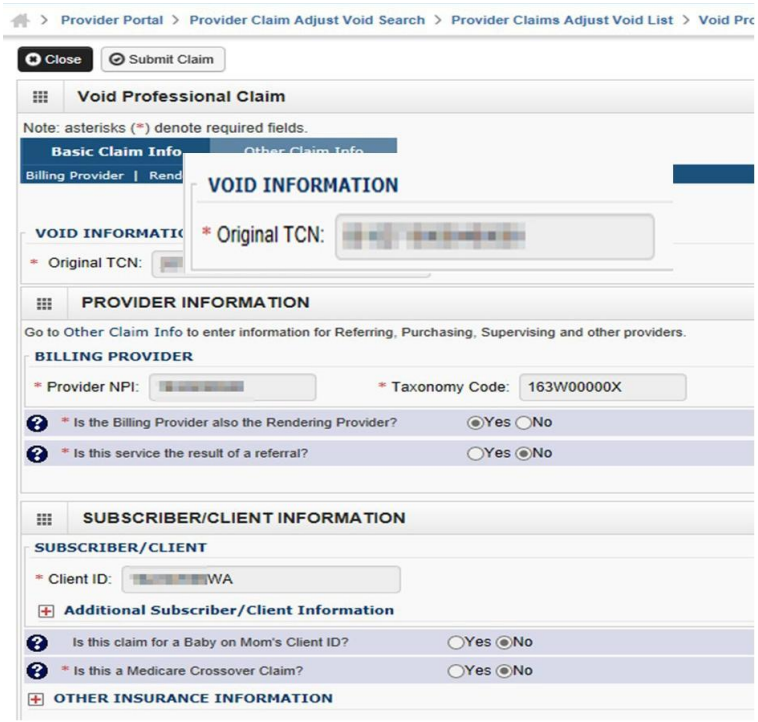
Voiding a paid claim

To void an entire paid claim:

1. Locate and select the claim you wish to void (see pages 62- 63).
2. Check the box next to the TCN.
3. Click **Void Claim**.

   Note: You should only void an entire claim if you should not have been paid for any of the claim line details associated with the TCN. Voiding a claim will result in overpayment. This means you must pay DSHS back the original paid amount. ProviderOne does not automatically take the money back. See Overpayments.

4. The **Void Professional Claim** page appears with all the fields grayed out.
5. Please note the specific **TCN**.



6. To void this claim, click **Submit Claim**.
7. The **Void Professional Claim Detail** appears. The voided claim will have a new **TCN** number. This allows for tracking of the changes made to the original claim.
8. Claim details will include the new **TCN**, **Original TCN**, **Provider ID**, **Client ID**, **Date of Service** and **Total Claim Charge**.
9. Click Submit to submit the voided claim.
10. Check your next RA to confirm the claim processed the way you expected it to.

Resubmitting denied or voided claims

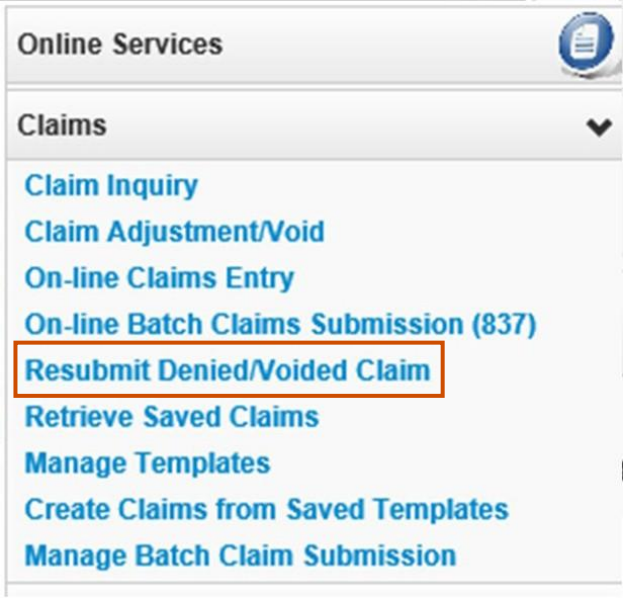
The main reasons a denied claim may need to be resubmitted include:

- The authorization was in error when the claim was originally submitted, causing the claim to be denied. The error has been resolved, and the denied claim now needs to be reprocessed.
- Claim info had an incorrect date, service code, or units causing the claim to be denied.

A voided claim may need to be resubmitted if a provider discovered they voided the paid claim in error.

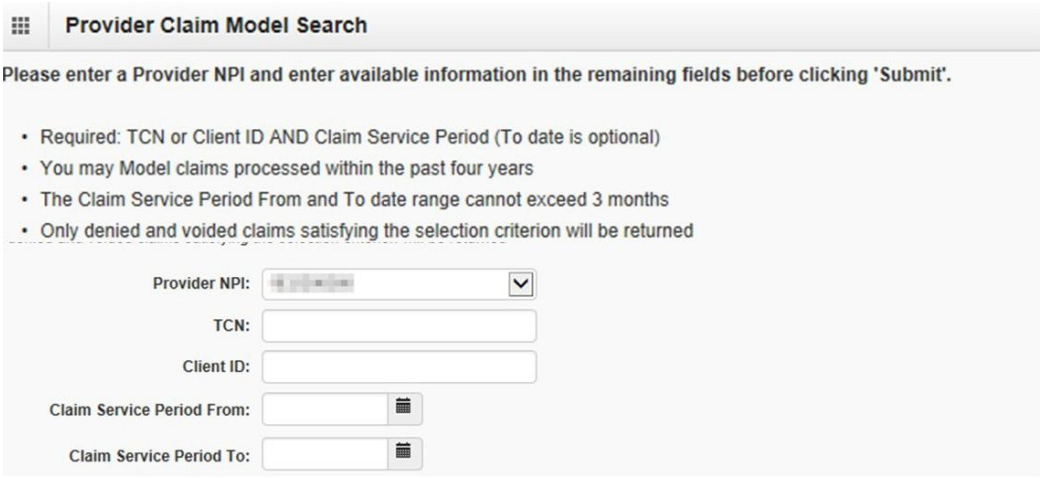
To resubmit a denied or voided claim:

1. Log in to ProviderOne using the **EXT Provider WA Cares Funds Medical** profile.
2. Click on **Resubmit Denied/Voided Claim.**



3. The **Provider Claim Model Search** page appears.
4. The **Provider NPI** associated with the domain currently in use will automatically be listed in the Provider ID drop-down.

5. To find the claim you need to resubmit, you can search by TCN, or Client ID and Claim Service Period.



6. Once you enter the necessary search criteria, click **Submit**.

   Note: Search requests must be for claims submitted within the last 60 days. If you search using the Claim Service Period From/To dates, the date range cannot exceed three months.

7. The **Provider Claims Model List** appears. Only claims that have been denied or voided will be shown here.

8. Check the box next to the **TCN**. Click **Retrieve**.



9. If you do not need to make any changes and just need to resubmit the claim for reprocessing, click **Submit Claim**.
10. If you need to make changes to the claim before resubmitting, make these changes now.
11. The change options when resubmitting a claim are the same as when adjusting a claim. (Common items you may need to add or update on a denied claim: taxonomy; authorization number; diagnosis code; modifier; date of service.)
12. After updating information, click **Submit Claim**.
13. A message will appear asking, **Do you want to submit any Backup Documentation?**

    Certain shared services* require backup documentation, such as a denial from another payer; however, WA Cares does not require back up documentation. If you would like to include it for your own records, select **OK** and upload the documentation before continuing to submit the claim.

    If no backup documentation is needed, select **Cancel** and continue submitting the claim.
14. The **Submit Professional Claim Details** page appears. The resubmitted claim will have a new **TCN**. This allows for tracking of the changes made to the original claim.
15. To complete claim submission, click **Submit**.
16. Check your next RA to confirm whether the claim processed the way you expected it to.

VIEWING CLAIM STATUS AND PAYMENTS

This section addresses the following:

- Overpayments.
- Claim Status Inquiry and Viewing Remittance Advice.

Overpayments

This section explains the difference between offset and non-offset adjustments, how to identify an overpayment on the remittance advice (RA), and how to work with the Office of Financial Recovery (OFR) to repay any overpayments that resulted from a non-offset adjustment.

Overpayments can be generated when a paid claim is voided or adjusted.

> Note: When an overpayment occurs, you will see it in the Adjustments Summary on page two of your remittance advice (RA). You will also receive an overpayment letter, which will identify the payment details for your original paid claim.

Overpayments resulting from voided claims

- When a claim is voided, it will always generate an overpayment because DSHS has paid out money for a claim that is no longer in paid status. The overpayment will default to non-offset in ProviderOne and will be sent to the Office of Financial Recovery.
- You should only void a claim if you shouldn't have received payment, but this applies specifically to situations where the entire claim was submitted in error and needs to be completely canceled. If a claim has multiple lines and some of the lines are correct and some are incorrect (i.e., incorrect date billed), you would adjust the claim rather than void it.

Overpayments resulting from adjusted claims

- When a claim is adjusted, an overpayment may be generated if the new paid amount is less than the original paid claim amount.
- When a claim is adjusted and an overpayment is generated, ProviderOne will default to non-offset and the overpayment will be sent to the Office of Financial Recovery.

Non-offset

This is the default adjustment option for WA Cares Fund Providers. When a debt (overpayment) is created as a result of a voided or adjusted claim, the overpayment is sent to the Office of Financial Recovery (OFR).

OFR mails you a Vendor Overpayment Notice which provides the overpayment amount, payment instructions, as well as information on how to request an administrative hearing if you disagree with the overpayment.

The notice will list the TCN (claim #) that was adjusted/ voided and there will be a reason code on the notice that gives some information as to why the claim was adjusted or voided.

You should also review your remittance advice (RA) associated with the adjustment to see the specific days or service lines being recouped. The RA will be generated and available in ProviderOne on the Friday before the week the overpayment notice is generated.

Offset

When a claim is adjusted as 'offset' and an overpayment occurs, the overpayment is not referred to OFR. You might not receive a Vendor Overpayment Notice if the entire amount is recouped. If you do receive a Vendor Overpayment Notice, you will not have administrative hearing rights to dispute the overpayment.

With this option, the overpayment amount will be deducted from future paid claims in ProviderOne within a 6-month window. After 6 months, if the debt is not satisfied, any remaining balance will be sent to OFR for recovery as a non- offset adjustment.

You can track offset claim payments on Page 2 of your RA in the Adjustments Summary. You can also call OFR to confirm your current overpayment balance.

To adjust a claim as 'offset', you must contact HCA at 1-800-562-3022 or online prior to adjusting the claim. You must include the claim # (TCN) that needs to be adjusted. After contacting HCA, they will adjust the claim as offset for you.

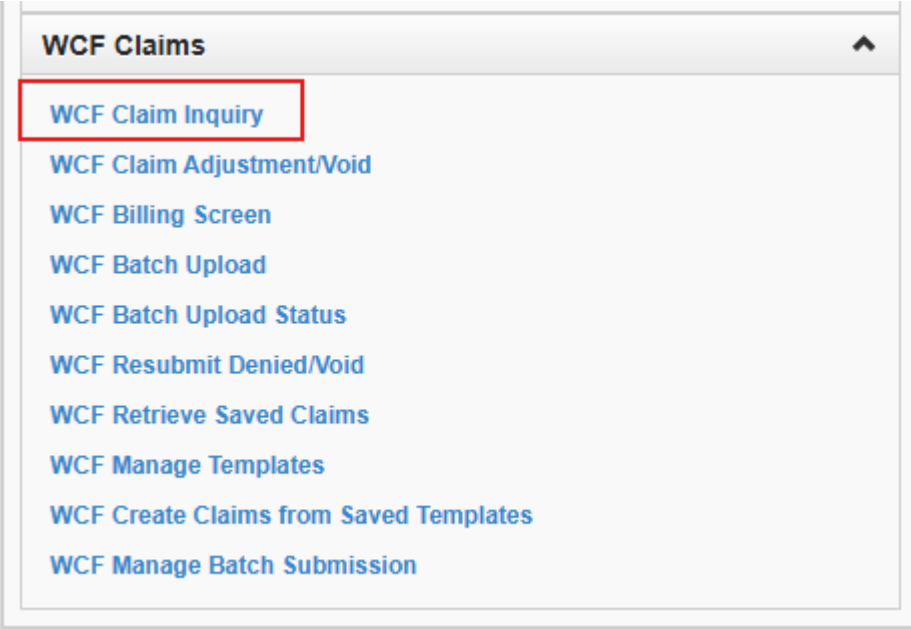
If a claim has already been adjusted as 'non-offset' but you want to pay the overpayment via future claim payments, you can contact OFR to request this.

Inquiry and viewing remittance advice

This section explains how to view claim status in ProviderOne as well as how to view the remittance advice (RA).

Providers may need to view the status of a claim in ProviderOne if they can't locate the claim on the RAs.

RAs provide a detailed breakdown of paid, denied, adjusted, and in process claims. RAs are available in ProviderOne each Friday. To ensure claim submissions processed correctly, it is important for providers/billers to review their RAs as soon as they become available in ProviderOne.



Claim inquiry

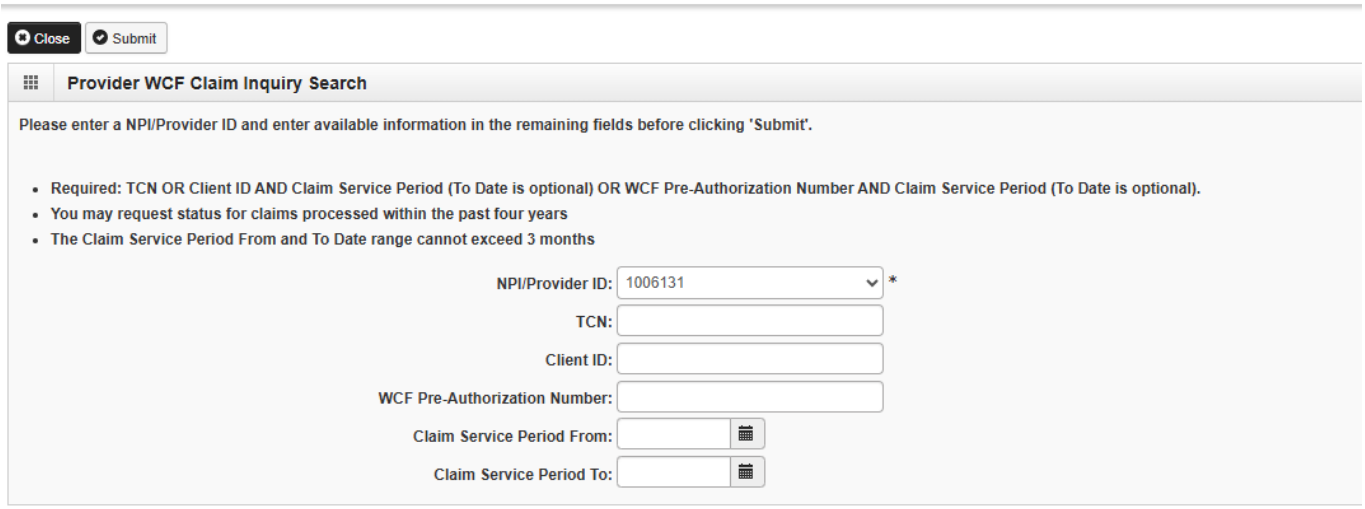
For WA Cares Fund (non-medical) claims:

- Log in using the appropriate profile
- From the Provider Portal, click **WCF Claim Inquiry** (under the WCF Claims section).

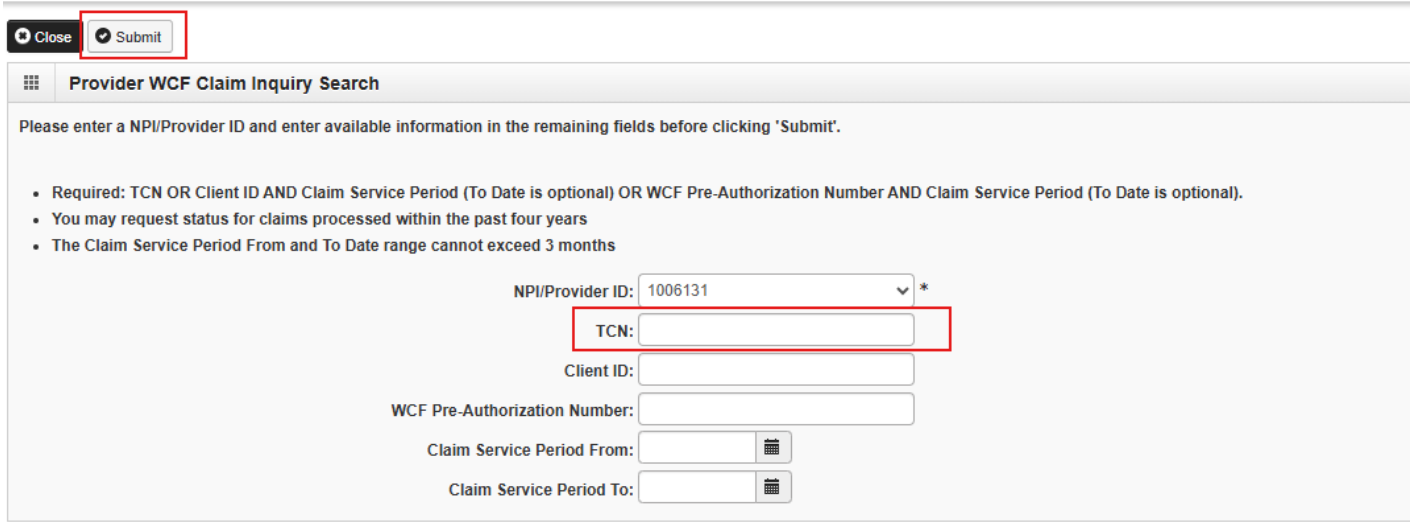
For WA Cares Fund (medical/professional) claims:

- Log in using the appropriate profile
- From the Provider Portal, click **Claim Inquiry** (under the Claims section)

1. The **Claim Inquiry Search** page appears.
2. Your Provider ID (Domain) should auto-populate in the Provider ID field.
3. Enter your search criteria to search for a claim. You can search for a claim multiple ways:
   - TCN (claim number)
   - Client ProviderOne ID and Claim Service Period
   - Authorization number and Claim Service period

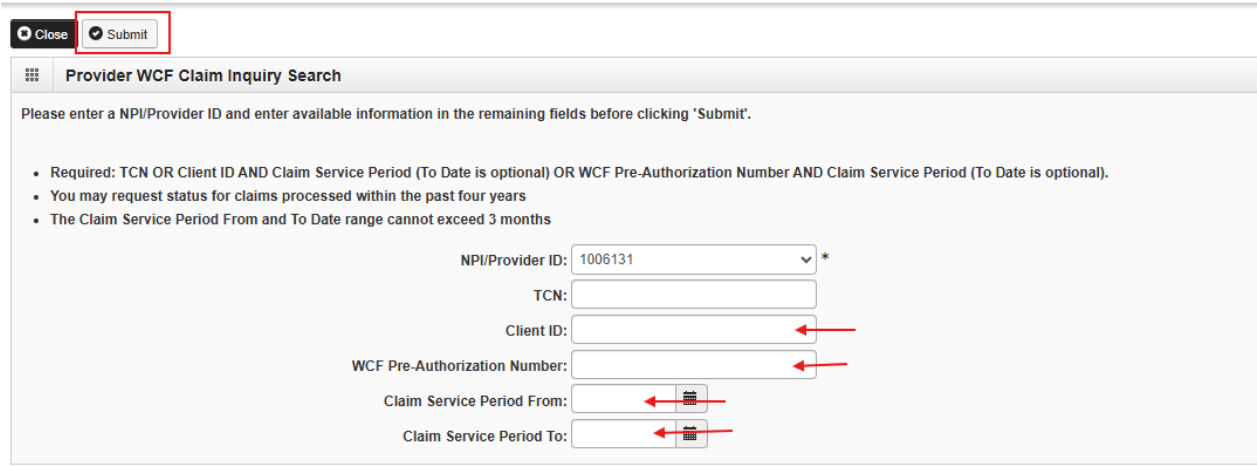


4. To search by Transaction Control Number (TCN)/Claim number:
   - Enter Transaction Control Number (TCN) in the **TCN field**
   - Click **Submit**



5. To search by Client ID or Authorization number:
   - Enter either the:
     - **Client ID number** or
     - **WCF Pre-Authorization number**
   - Enter the:
     - **Claim Service Period From** date (Required)
     - **Claim Service Period To** date (optional)

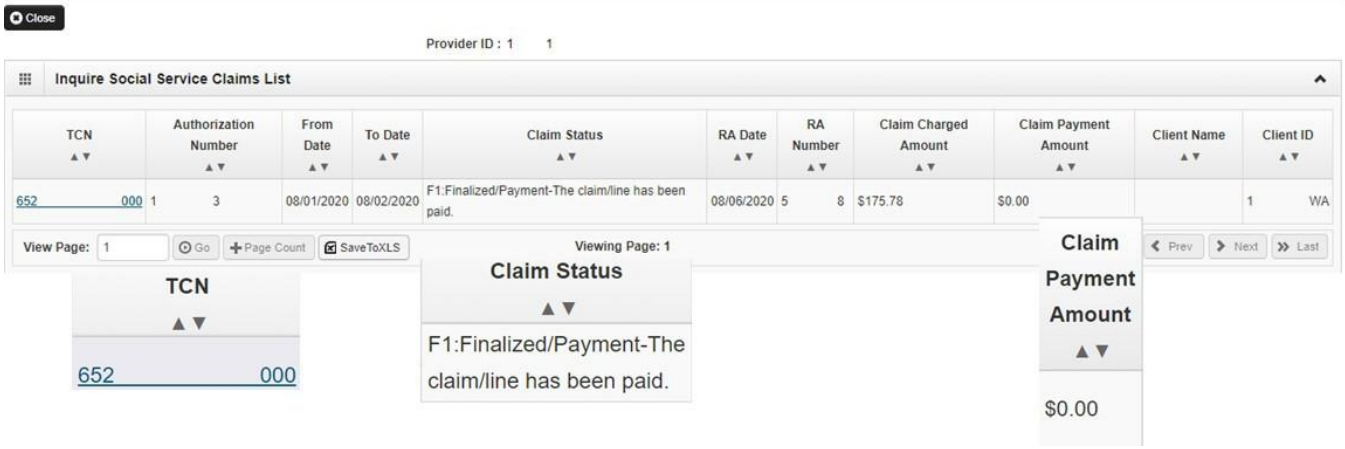
       Note: The date range cannot exceed three months.
   - Click **Submit.**



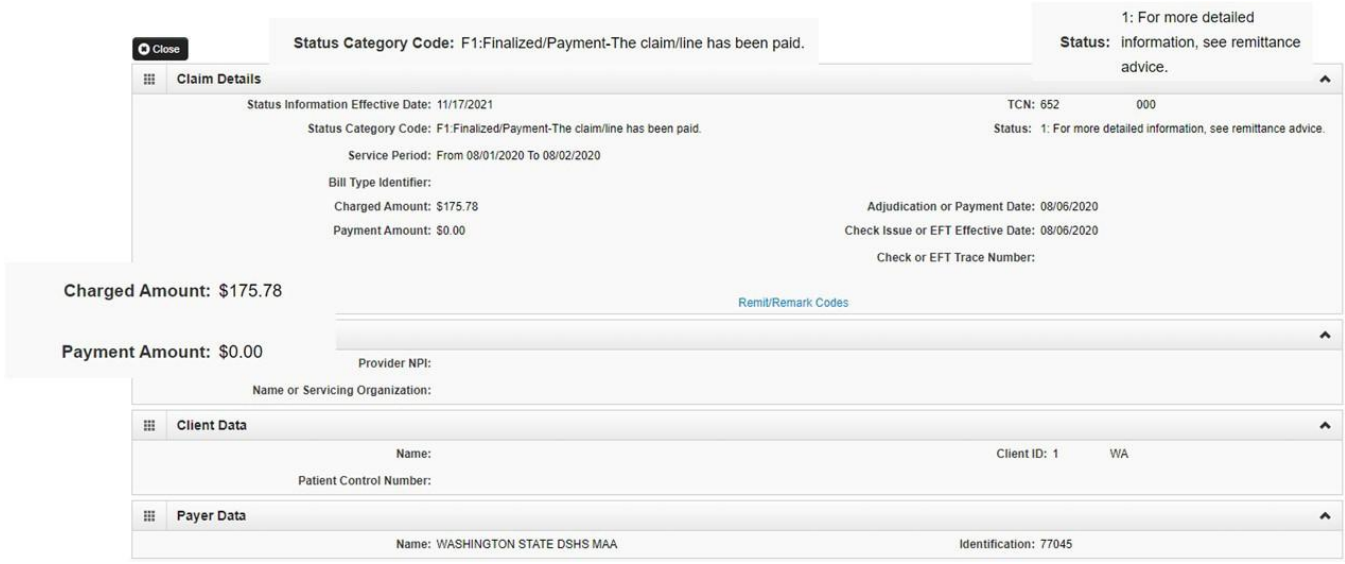
Note: ProviderOne will only return results when the Header TCN From/To Date are within your searched dates. If the Header TCN date range is outside of your search dates, the claim won't show in search results.

Example: The claim From Date is 4/27/25 and To Date is 5/2/25. If you enter 5/1/25 as the 'Claim Service Period From' date in your search criteria, the claim will not show up in the search results. You must enter 4/27/25 as the 'Claim Service Period From' date.

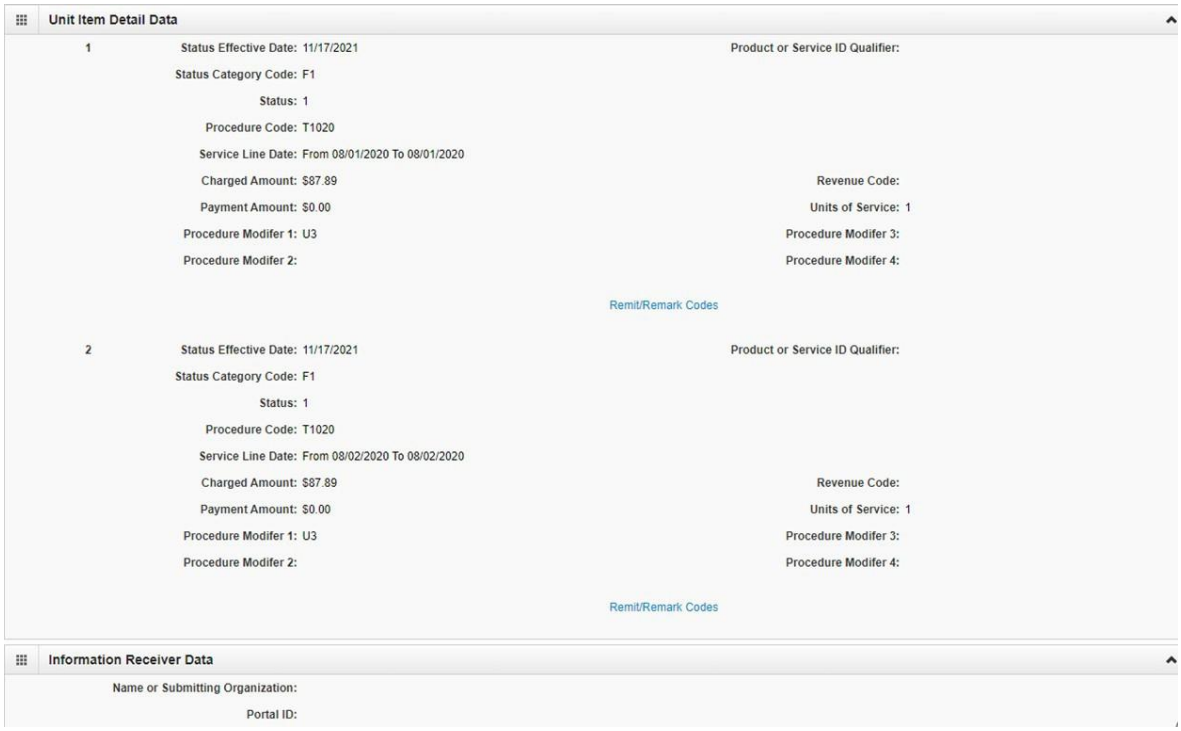
6. Inquire Claims List appears showing search results. Here you can view: TCNs; Claim Status; Claim Payment Amount.



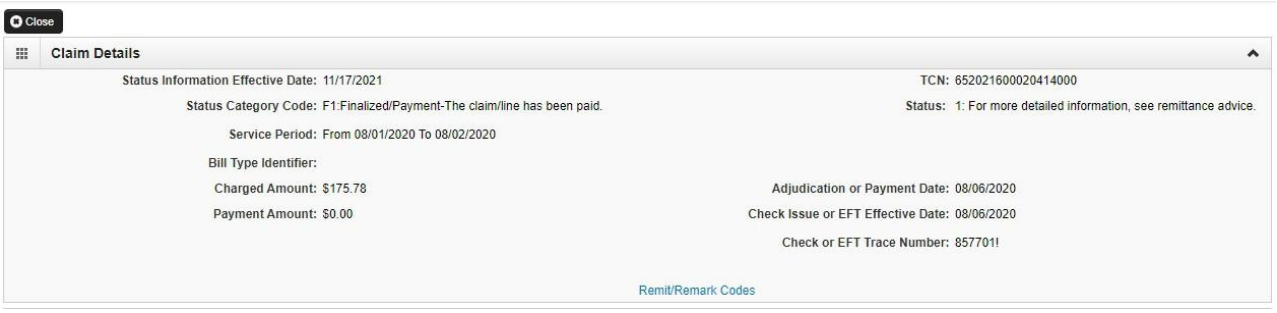
7. Click on the blue hyperlinked TCN to view more information.
8. After clicking the TCN, **Claim Details** appears. Here you can view: Status Category Code; Status; and Charge and Payment amounts. Scroll down to see additional information.



9. As you scroll down, you can see Unit Item Detail Data and Information Receiver Data.



10. To exit this screen, scroll up and hit the Close button in the upper left corner.



View and download RA

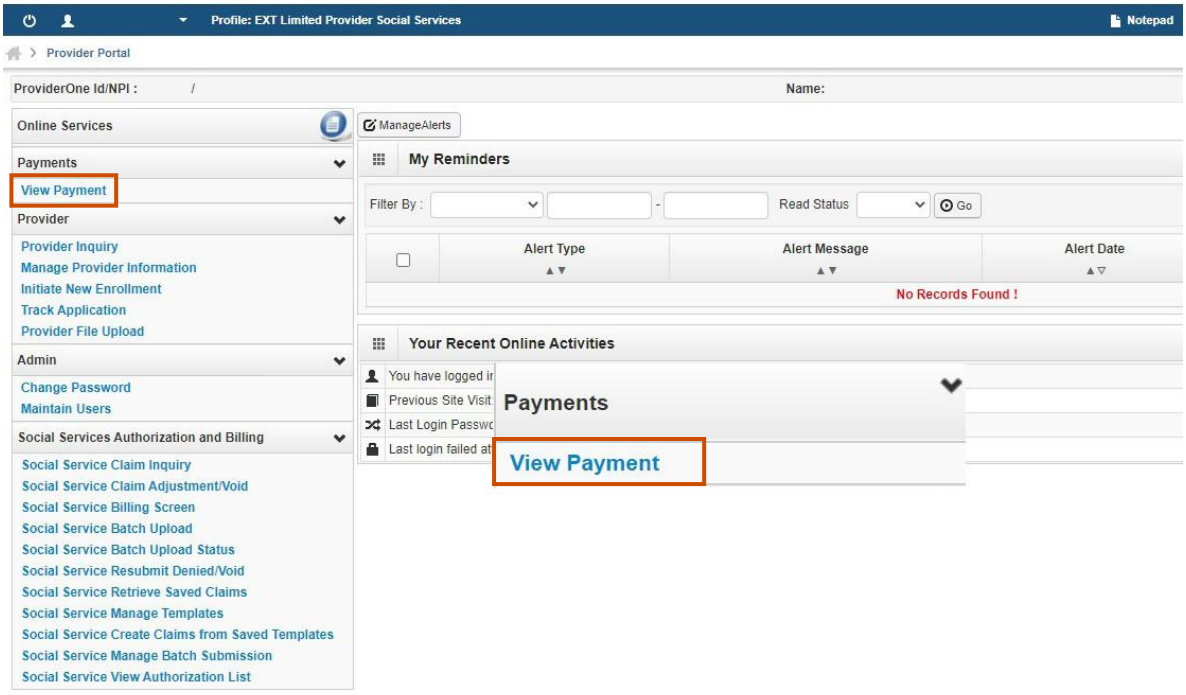
This section provides a brief overview of how to view and download the remittance advice (RA). RAs are available in ProviderOne each Friday and include claim details for claims entered during the previous week before the Tuesday, 5p.m. deadline.

The RA provides a list of paid, denied, adjusted, and in-process claims.

For an in-depth review of each page of the RA and what to look for in each section, view the How to Review Your Remittance Advice document.

To view your RAs:

1. Log into ProviderOne using the appropriate profile.
2. From the Provider Portal, Click **View Payment** (under the Payments section).



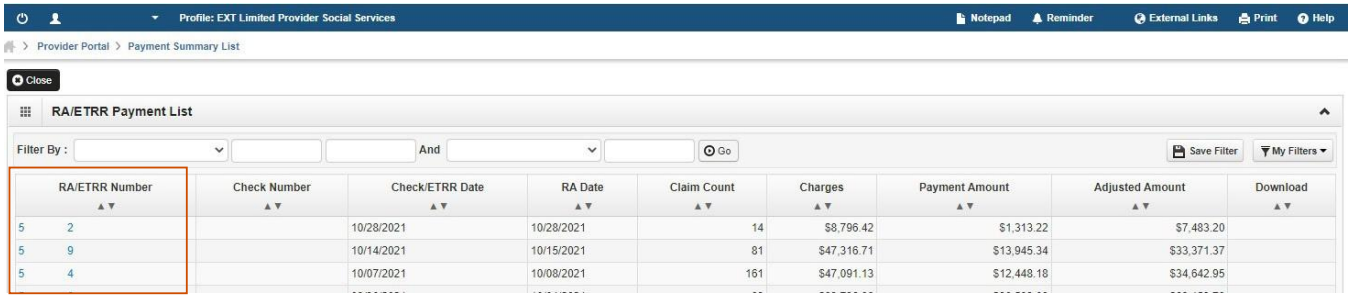
Note: RAs are retrievable in ProviderOne for up to four years. Providers are required to retain records for up to six years and are responsible for retaining copies for this purpose.

3. After clicking on **View Payment**, the **RA/ETRR Payment List** appears

   You will see a list of your recent RAs. To view more RAs, click the arrows at the bottom of the screen to scroll.

   The RA/ETRR Payment List shows basic information for each RA, but the list should not be used to reconcile your payments.

4. To reconcile and review all payments, adjustments, and denials, click on the RA you want to review. To view an RA, click the blue hyperlinked RA/ETRR Number.



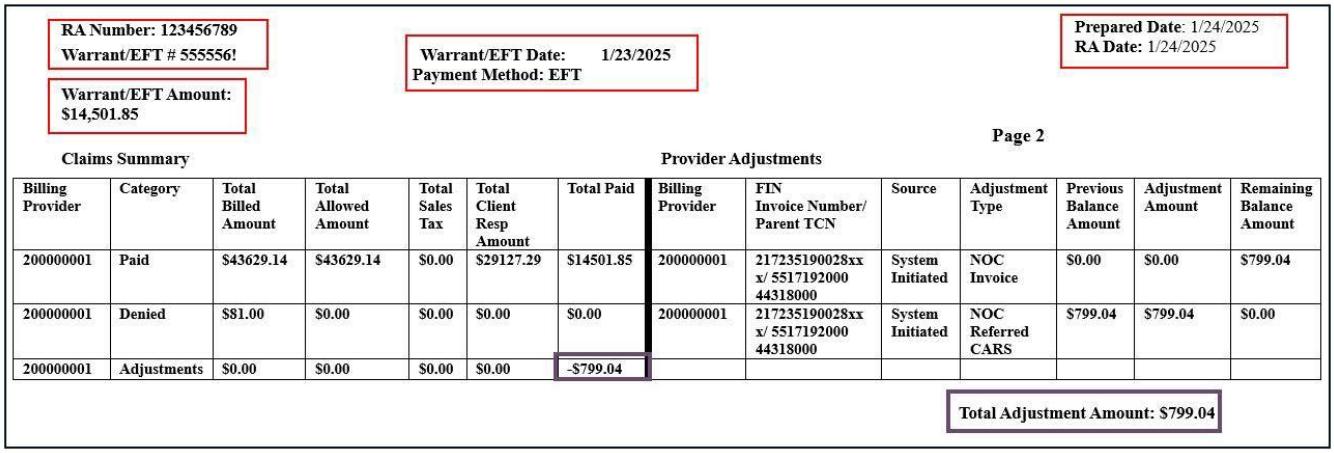
5. After clicking on a blue hyperlinked RA number, the RA opens in PDF format. The cover page of the RA includes the provider name and mailing address, and the RA creation date.

   Note: If your mailing address has changed, it is important to update that information in ProviderOne.

6. Page one of the RA contains:
   - RA Number
   - Billing Provider ID (this is your 7-digit ProviderOne ID + two digit location code for the location the RA is associated with)
   - Prepared Date: Date the RA was prepared
   - RA Date: Date payment was released

- Key Messages: These are alerts from HCA or DSHS about changes to ProviderOne functions or claims deadlines.

7. Page 2 of the RA includes the:
   - RA Number
   - Warrant/EFT number
   - Warrant/EFT date (date of payment)
   - Warrant/EFT amount
   - Payment Method



RA Number: 123456789
Warrant/EFT # 555556!

Warrant/EFT Amount: $14,501.85

Warrant/EFT Date: 1/23/2025
Payment Method: EFT

Prepared Date: 1/24/2025
RA Date: 1/24/2025

Page 2

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total Sales Tax	Total Client Resp Amount	Total Paid
200000001	Paid	$43629.14	$43629.14	$0.00	$29127.29	$14501.85
200000001	Denied	$81.00	$0.00	$0.00	$0.00	$0.00
200000001	Adjustments	$0.00	$0.00	$0.00	$0.00	-$799.04

Provider Adjustments

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Invoice	$0.00	$0.00	$799.04
200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Referred CARS	$799.04	$799.04	$0.00

Total Adjustment Amount: $799.04

8. On page two you will aslo find a Payment Summary that includes:
   - **Claims Summary**: Provides a summary of all claims submitted in the most recent weekly claim cycle.
     - **Category**: There are four possible claim categories (Paid, Denied, Adjustments, or In Process). The rest of the RA shows a breakdown of each claim by client.
     - **Total Billed Amount**: Total dollar amount submitted during the previous week.

- **Total Allowed Amount**: The amount DSHS is allowed to pay.
- **Total Paid**: This is the total amount paid by DSHS (allowed amount minus client responsibility).

- **Provider Adjustments**: Provides a summary of claim adjustments initiated during the previous week.
  - Claims can be adjusted by the provider or DSHS.
  - In this section you will be able to see if an overpayment was assessed for any claim adjustments. If you see 'NOC Invoice' and 'NOC Referred to CARS', this means an overpayment was referred to OFR.

9. On the Adjustment Summary on page two of the RA, you will see an adjustment type listed next to each adjusted claim. The adjustment type is a result of your action on a claim or an action initiated by DSHS. The most common adjustment types seen on WA Cares Fund Provider RAs are listed below:

   NOC Referred to CARS: This occurs when a voided claim or an adjusted claim resulted in a non-offset overpayment and the overpayment has been referred to OFR's Collection and Accounts Receivable System (CARS) for recovery. An overpayment means you were paid too much and you now owe this money back to DSHS.
   NOC Invoice: This posts together with a "NOC Referred to CARS" line. This means that the overpayment was referred to OFR and an invoice was created. OFR mails the invoice to you informing you how much you owe.
   P1OFF Invoice: This occurs when you owe DSHS due to adjustments exceeding payments. In these cases, DSHS creates an account receivable which is satisfied by either:
   - Taking payment from a future paid claim, or
   - Through a receivable sent to OFR to initiate the recovery; this only happens if the P1OFF is not satisfied after six months.

   P1OFF Recoupment: This identifies the payments used to satisfy the P1OFF receivable. This typically posts immediately following a P1OFF Invoice line.
   COFF Invoice: OFR creates a CARS Offset Invoice in OFIN for each request sent to ProviderOne from CARS. Direct all questions about COFF offsets to OFR at 1-800-562-6114.
   COFF Recoupment: OFR accepts a receivable to collect, and OFR sends back a request to take other payments for paid claims from you to satisfy the receivable. There should be other paid claims on

the RA, and some of those payments go to OFR to help satisfy the debt.

COFF Referred to CARS: ProviderOne tried to recover a dollar amount you owed DSHS but did not have a sufficient total of claim payments post in the last six months to satisfy the debt. The balance owed is sent to OFR for collection.

10. The rest of the RA contains specific information for claims submitted during the previous week before the 5 p.m., Tuesday deadline. This section is broken down by claim type (Paid, Denied, Adjustments, In Process). Within each claim category, the claims are further broken down by client. The next page will provide detailed information about what you will find in each claim category.

RA Number: 123456789 Warrant/EFT #: 555556! Warrant/EFT Date: 1/23/2025 Prepared Date: 1/24/2025 RA Date: 1/24/2025

Page 3

Category: Paid Billing Provider: 20000001

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	1/16/2025 - 1/16/2025	T1020 U1	1.0000	$70.85	$70.85	$0.00		$70.85		
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	1/17/2025 - 1/17/2025	T1020 U1	1.0000	$70.85	$70.85	$0.00		$70.85		
Document Total: 1/16/2025-1/17/2025						2.0000	$141.70	$141.70			$141.70		

Service code entered on claim

Amount paid from beneficiary's fund

RA Number: 123456789 Warrant/EFT #: 555556! Warrant/EFT Date: 2/13/2025 Prepared Date: 2/14/2025 RA Date: 2/14/2025

Page 3

Category: Paid Billing Provider: 20000001

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	2/1/2025-2/1/2025	T1019	1.0000	$125.00	$125.00	$0.00		$0.00		142 45 94 = $125.00
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	2/2/2025-2/2/2025	T1019	1.0000	$125.00	$125.00	$0.00		$125.00		
Document Total: 2/1/2025-2/2/2025						2.0000	$250.00	$250.00			$125.00		

Adjustment codes (see next page)

The RA is divided into client sections.

Each service line of the claim is listed. If you used a date range, the range has been divided into daily lines.

11. The last page of your RA includes explanations of the Adjustment Reason Codes/NCPDP Rejection Codes and Remark Codes that may be listed throughout the Payment Information section.

Adjustment Reason Codes / NCPDP Rejection Codes
18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) 198 : Precertification/notification/authorization/pre-treatment exceeded.

Remark Codes
N640 : Exceeds number/frequency approved/allowed within time period.

Common adjustment and denial codes

Below is a list of common adjustment reasons and remarks codes you might find on your RA.

RA adjustment reason/remark code/description	Possible causes	Provider action
198 Precertification/authorization exceeded	WA Cares Fund Authorization Approved Units have already been claimed	Refer back to the details of the pre-authorization
16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication	Claimed dates of service are not within the authorization period The authorization line is in error	Contact the beneficiary if you have questions about the preauthorization dates
18 Exact duplicate claim/service	Claimed the same units on two different lines for the same day, or Claim is an exact duplicate of one already submitted	Adjust the claim and report the number of units on a single claim line No action is needed if duplication was unintended
A1 Claim/Service denied	The authorization is in cancelled status	Contact the beneficiary to determine to discuss the preauthorization cancellation
B7 This provider was not certified/eligible to be paid	Your contract may be expired	Contact your contract manager if you have questions

for this procedure/service on this date of service		
B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.	Date of Service and Service Code were paid on a previous claim. For Providers with EVV claims: ProviderOne cannot yet distinguish between shifts on the same date of service that are provided by the same caregiver. The claims line(s) denied because same date of service, client, and billing ID were claimed.	Review past RAs to see if you have already received payment for this client, date of service and code. Look in ProviderOne to see when/if you received payment. For any questions, contact HCA at 1-800-562-3022. For Providers with EVV Claims: Since shifts should be combined on one line submission when one caregiver works multiple shifts for a single date of service, providers may need to adjust the paid claim for the date of service to combine shifts worked.
N54 Claim information is inconsistent with pre-certified/authorized services	Authorization line is in error	Refer to the preauthorization
N63 Rebill services on separate claim lines	A separate claim line is required for each date of service for the service/procedure code entered	If you are billing quarter hour units or for each unit types, do not use a date span (example: 1/1/2015 to 1/31/2015) to bill. Adjust the claim to reflect separate claim lines for the date of service for each service provided and resubmit claim
N362 The number of Days or Units of Service	Too many units claimed. Example: Provider	Change the number of units to the correct

RA examples

Below is an example of what the RA looks like for an original paid claim. Notice how the claim details are listed in the Paid category of the RA.

RA Number: [redacted] Warrant/EFT #: [redacted] Warrant/EFT Date: 01/31/2019 Prepared Date: 02/01/2019 RA Date: 02/01/2019
Category: Paid Billing Provider: [redacted] Page 3

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
[redacted]	[redacted]	1	S59	01/23/2019-01/23/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
	[redacted]	2	S59	01/24/2019-01/24/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
	[redacted]	3	S59	01/22/2019-01/22/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
	[redacted]	4	S59	01/28/2019-01/28/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
Document Total:				01/22/2019-01/28/2019		128.0000	$924.16	$924.16	$0.00	$0.00	$0.00	$924.16		

Below is an example of what page 2 of the RA looks like when a claim has been adjusted and there is an overpayment.

Prepared Date: 01/02/2020
RA Date: 01/02/2020

RA Number: [redacted]
Warrant/EFT # [redacted] Warrant/EFT Date: 01/02/2020
Warrant/EFT Amount: $0.00 Payment Method: EFT

Page 2

Claims Summary

Provider Adjustments

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Sales Tax	Total Client Resp Amount	Total Paid
[redacted]	Adjustments	-$231.04	-$231.04	$0.00	$0.00	$0.00	-$231.04

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
[redacted]	[redacted]	System Initiated	NOC Invoice	$0.00	$0.00	$231.04
	[redacted]	System Initiated	NOC Referred to CARS	$231.04	$231.04	$0.00

Total Adjustment Amount $231.04

Below is an example of what claims look like that resulted from an adjustment of a paid claim. Note that the details are in the adjustments category of your RA.

RA Number: [redacted] Warrant/EFT #: [redacted] Warrant/EFT Date: 01/02/2020 Prepared Date: 01/02/2020 RA Date: 01/02/2020
Category: Adjustments Billing Provider: [redacted] Page 5

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
[redacted]	[redacted]	1	S59	01/23/2019-01/23/2019	T1019	32.0000	-$231.04	-$231.04	$0.00	$0.00	$0.00	-$231.04		129 = $0.00
	[redacted]	2	S59	01/24/2019-01/24/2019	T1019	32.0000	-$231.04	-$231.04	$0.00	$0.00	$0.00	-$231.04		129 = $0.00
	[redacted]	3	S59	01/22/2019-01/22/2019	T1019	32.0000	-$231.04	-$231.04	$0.00	$0.00	$0.00	-$231.04		129 = $0.00
	[redacted]	4	S59	01/28/2019-01/28/2019	T1019	32.0000	-$231.04	-$231.04	$0.00	$0.00	$0.00	-$231.04		129 = $0.00
Document Total:				01/22/2019-01/28/2019		128.0000	-$924.16	-$924.16	$0.00	$0.00	$0.00	-$924.16		
[redacted]	[redacted]	1	S59	01/23/2019-01/23/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
	[redacted]	2	S59	01/22/2019-01/22/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
	[redacted]	3	S59	01/28/2019-01/28/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
Document Total:				01/22/2019-01/28/2019		96.0000	$693.12	$693.12	$0.00	$0.00	$0.00	$693.12		

RESOURCES

Visit the ProviderOne for WA Cares Fund webpage for more resources:

- Updates and newsletters
- Self-guided training: WA Cares Billing Guide, Standards, and ProviderOne
- Additional contact information

For questions, feedback, or suggested changes to this document, please email WCFProviderPolicy@dshs.wa.gov.

WHAT HAS CHANGED?

The table below summarizes how this publication differs from the previous version.

Subject	Change	Reason for change
Pre-authorizations	Added information regarding modifying a pre-authorization, adding additional units and what happens to unused units.	Additional information as a result of provider inquiry
Pre-authorizations	Added information regarding next-day pre-authorization timeline.	Confirmed next day starts are possible but must be approved before the start date. All other pre-authorizations entered ahead of time must be approved at least two days in advance.
Claim submission deadlines and pay dates	Added 60-day timely filing deadline.	Add additional clarity.
Translation	Added information regarding resources available to translate this document.	Accessibility.
DAT file format specification table	Removed "one occurrence" and "two occurrence" language.	Alignment with HCA billing guide.