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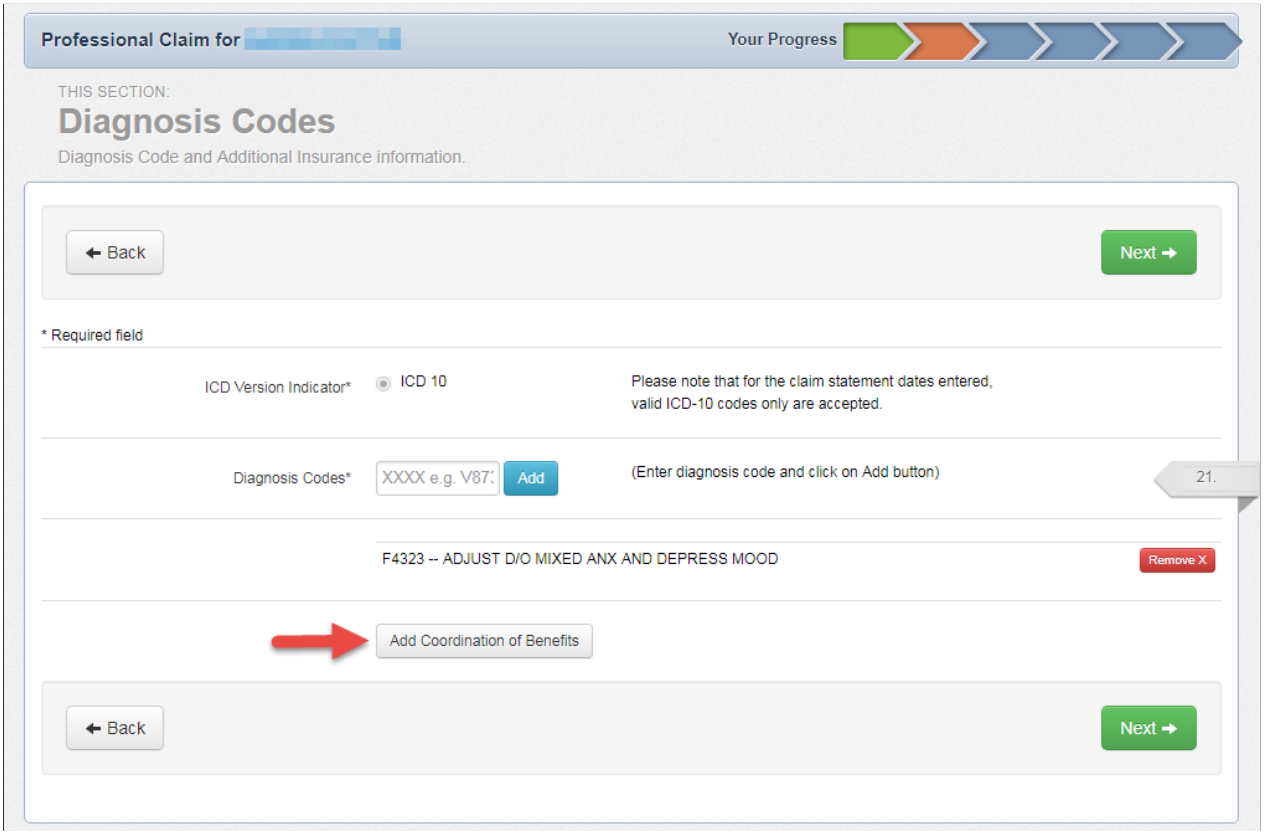
Medicaid | Marketplace | Medicare

Coordination of Benefits Entry Walkthrough

This guide serves as a walkthrough for entering Coordination of Benefits (COB) information on professional claims submitted via the Secure Provider Portal.

Step 1
On the Diagnosis Codes page, click **Add Coordination of Benefits.**



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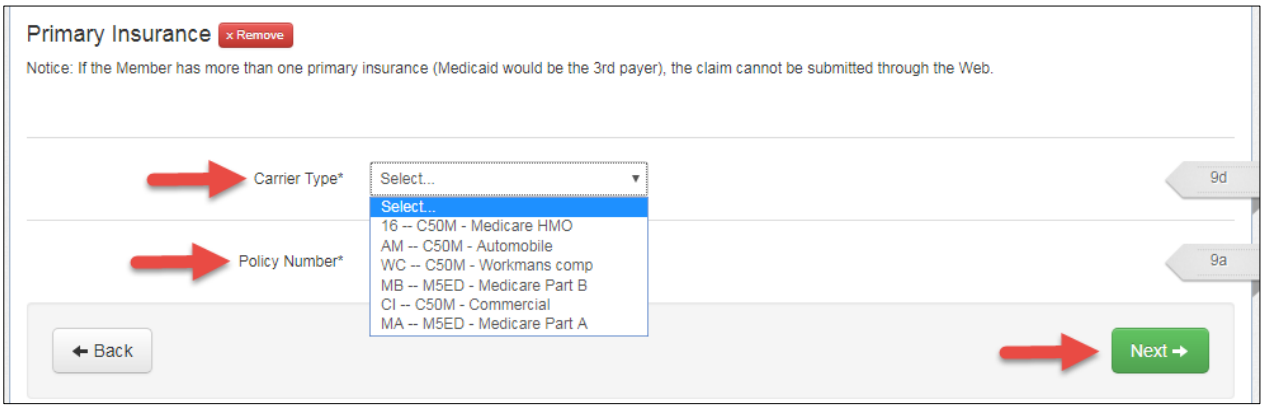
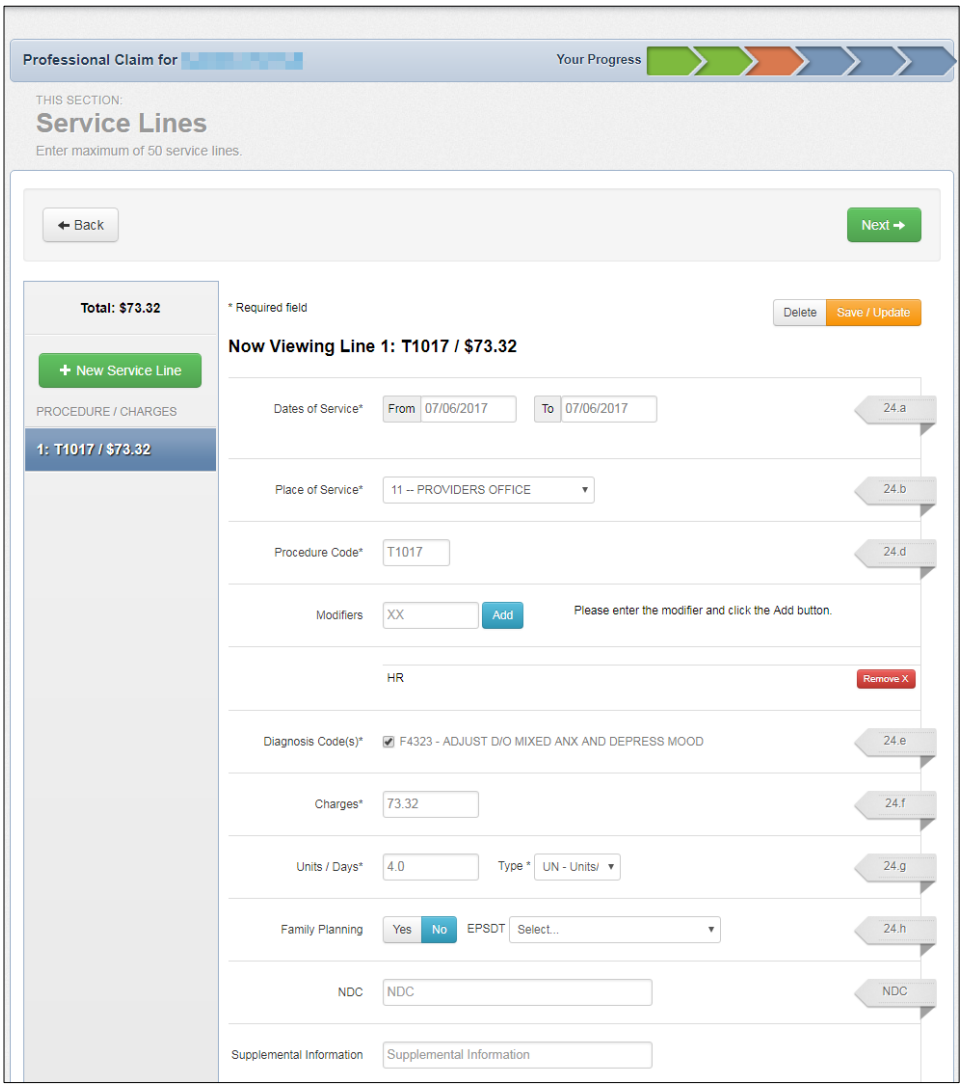
Step 2

Click **Carrier Type** drop-down to select the applicable carrier type and then enter the policy number. Once completed, click **Next**.



Fill out Service Line information as per normal procedure. Then scroll down to complete the Primary Insurance fields.

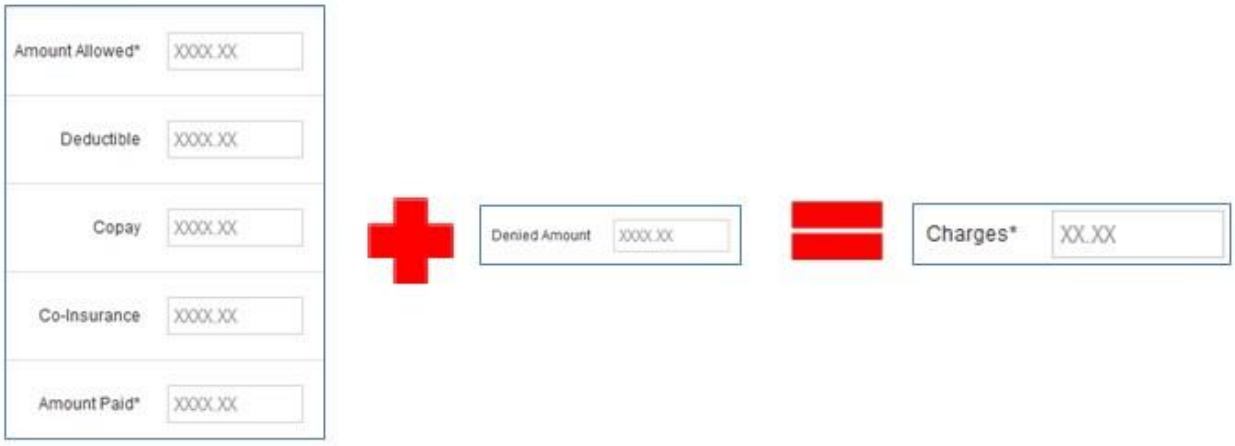


Step 4

Enter the line items on the primary insurance in accordance with the rules of the section.

COB entry rules: The amount charged for services (entered by provider on line 24f) must equal the total of the line items from the **Primary Insurance** fields and the **Service Line Denial Reason** section. So the following must be true before moving forward:

Total of the **Primary Insurance** fields + **Denied Amount** = **Total Charges**

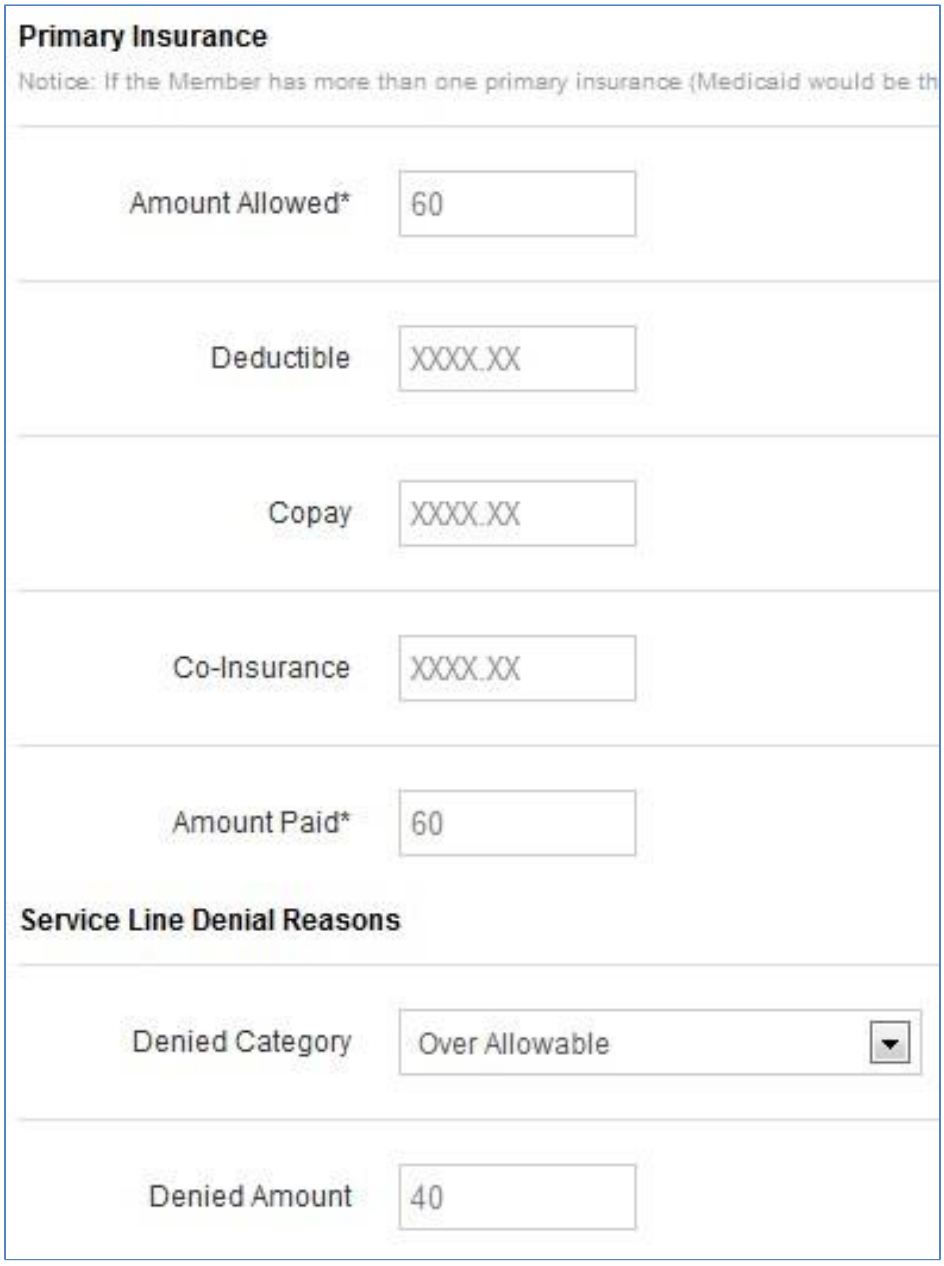


Another way to display the equation is:
Charges - Total of **Primary Insurance Fields** = **Denied Amount**

There are a number of scenarios that may be encountered when entering this information. Please review the following examples for more information.

Example 1
Total Charges on line 24f = $100
Amount Allowed by primary = $60
Amount Paid by primary = $60

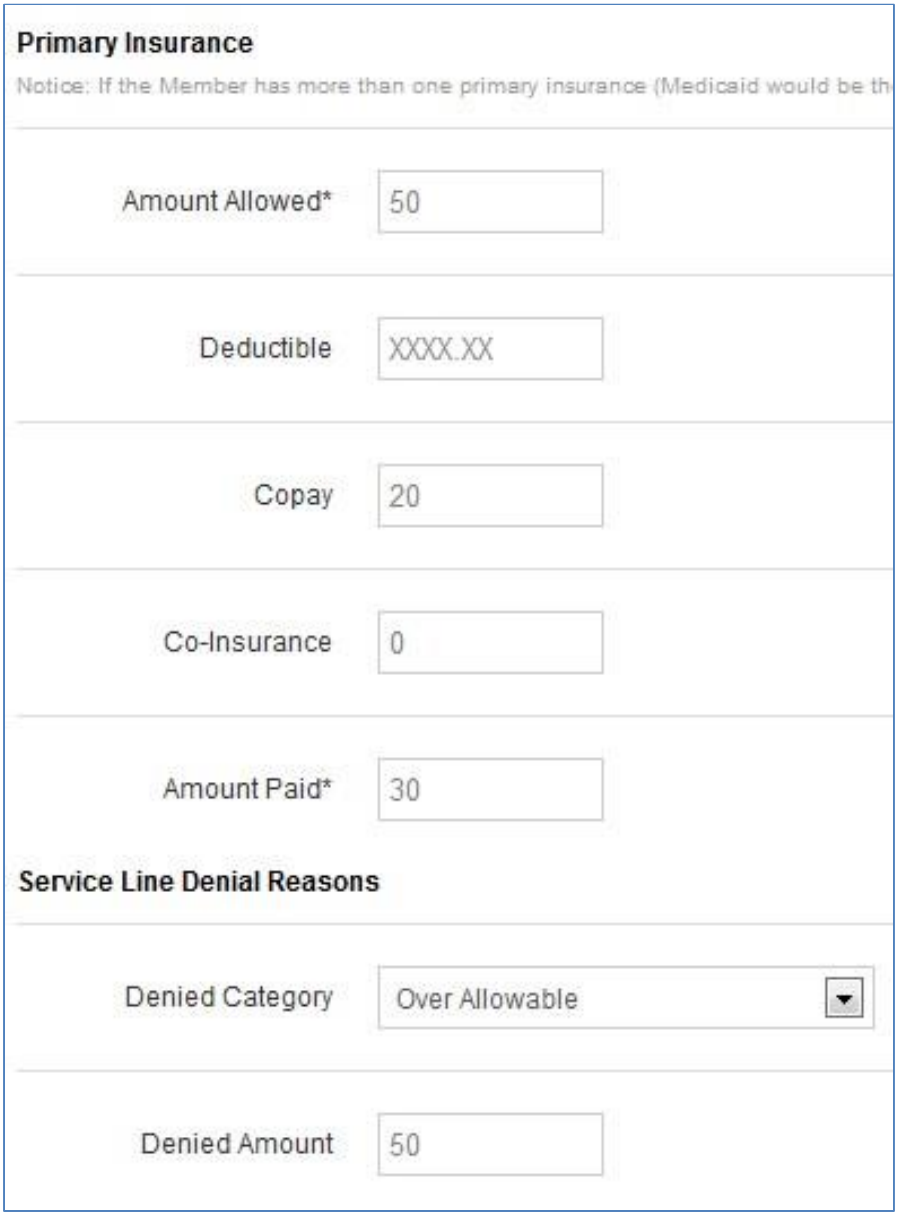
In this example, the provider is charging $100 and the primary paid $60. This leaves a remainder of $40, which should be entered in the Denied Amount field and a Denied Category must be selected.



Example 2
Total charges on line 24f = $100
Amount Allowed by primary = $50
Member responsibility is a copay = $20
Amount Paid by primary = $30

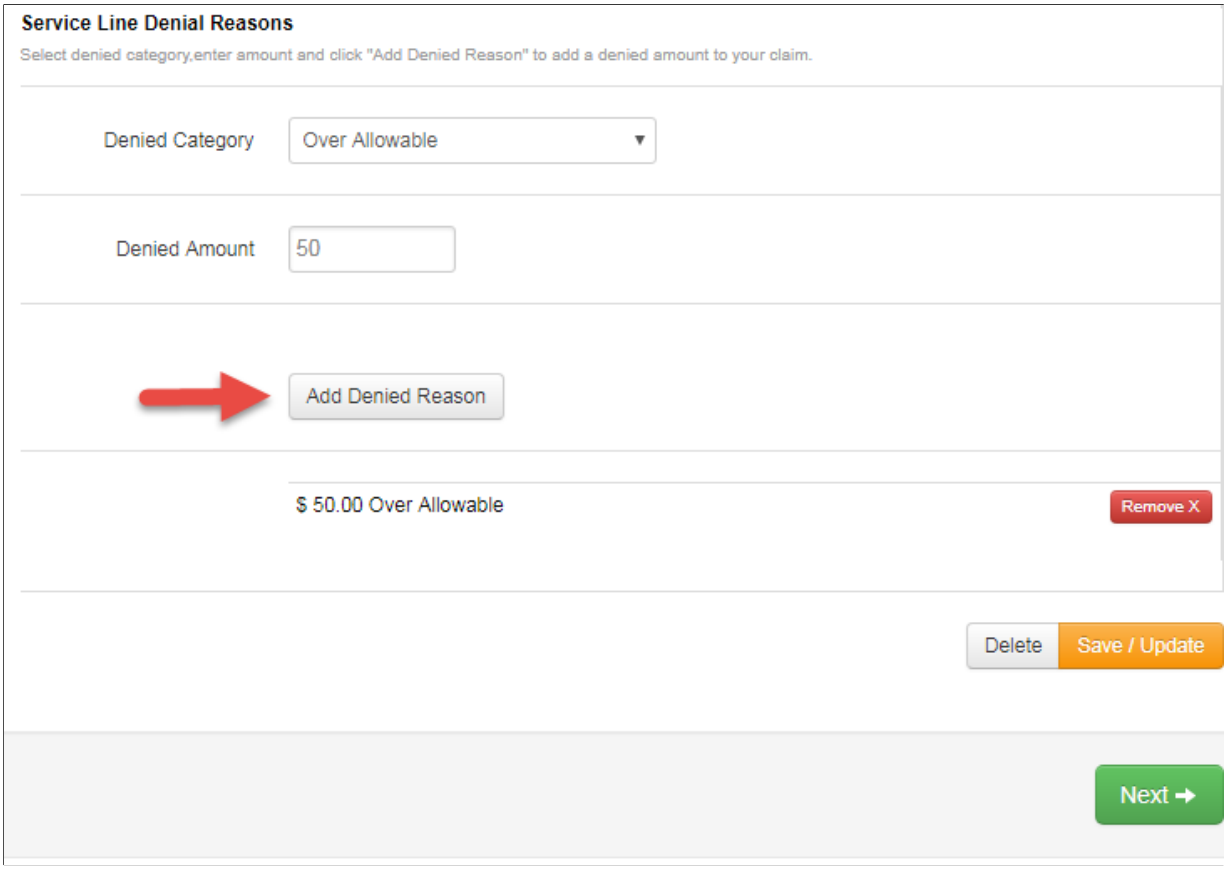
In this example, the total charges are $100. The primary Amount Allowed is $50 and the member had a co-pay responsibility of $20. Therefore, the primary paid the remaining $30. (i.e. Amount Allowed ($50) – Copay ($20) = Amount Paid ($30).

The amount received from the primary ($30) and member ($20) totals $50. This leaves a remainder of $50, which should be entered in the Denied Amount field and a Denied Category must be selected.



Step 6

Click **Add Denied Reason**, to add the EOB information entered to the Service Line. Once clicked, the denied amount and category will appear below the button.



Step 7

Click the **Save/Update**.

If everything was entered correctly, then there will be no error messages and you can continue on.

Please Note: Steps 4 – 7 must be completed for each Service Line on the web claim.

Step 8

After entering the Provider Details on step 3 of claim submission, proceed forward to step 4 - Attachments. It is **not a requirement** to include a copy of the explanation of Benefits received from the primary payer. We offer this as an optional feature.

Note: If the EOB is from Medicare and includes the EOB information for several other claims, this does not present a problem. You can attach the entire image.