



TELUS Health eClaims Portal

# Frequently Asked Questions

May 5, 2011

For more information about the TELUS Health eClaims Service,  
please call TELUS Health Solutions at 1-866-240-7492 option 1.

Question	Answer
<h2 style="text-align: left; margin: 0;">General Information</h2>	
<p><b>What is the TELUS Health eClaims Portal?</b></p>	<p>The TELUS Health eClaims Portal is a web based system where healthcare providers can submit patient's claims online. The portal is accessible via the internet and it offers extended healthcare providers the convenience of capturing and submitting electronic claims to their patient's insurance company at their point-of-sale.</p>
<p><b>How does the TELUS Health eClaims Portal Extended Healthcare service work?</b></p>	<p>As an extended healthcare provider, you can sign up to use the TELUS Health eClaims Portal Extended Healthcare service. TELUS will then provide all of the account and security information needed to access the Provider Portal. The new service will allow you to submit claims or estimates (predetermination of benefits) on behalf of your patients at the point of service. The submission will normally adjudicate automatically, with validation on coverage, the types of expenses claimed and provider eligibility. You will then receive immediate notice of the result of the transaction to share with the patient.</p>
<p><b>Why is Great-West Life offering this?</b></p>	<p>The TELUS Health eClaims Portal is a service offered to providers and their patients that provides the following benefits:</p> <ul style="list-style-type: none"> <li>■ Faster response and payment from the Insurance Company</li> <li>■ Convenience to patients who will no longer need to submit paper claims</li> <li>■ Environmentally friendly by reducing the quantity of paper claims</li> </ul>
<p><b>Is Great-West Life partnered with TELUS Health Solutions to provide the eClaims service?</b></p>	<p>Yes. Great-West Life has partnered with TELUS Health Solutions to offer the first national eClaims exchange service for extended healthcare providers in Canada.</p>
<p><b>Why is TELUS contacting me and not Great-West Life?</b></p>	<p>Great-West Life has partnered with TELUS Health Solutions. TELUS is responsible for the registration service of providers as well as offering a secure online Portal to providers that they can use to submit extended healthcare claims to Great-West Life.</p>
<p><b>Who is TELUS Health Solutions?</b></p>	<p>TELUS Health Solutions, backed by Emergis, represents a unique set of technology, expertise and resources to help transform how information is used in the healthcare industry. TELUS Health Solutions has years of expertise in successfully implementing healthcare applications and information communication technology processes through industry leading solutions and consulting services to customers in Canada and around the world. It is backed by more than 1,500 TELUS Health Solutions team members including healthcare professionals. For more information, please visit <a href="http://www.telushealth.com">www.telushealth.com</a>.</p>
<p><b>Where can I find additional information about this?</b></p>	<p>More information is available on the TELUS website, under eClaims Exchange Service, section Extended Health at:  <a href="http://telushealth.com/en/solutions/claims_and_benefits_management/eclaims_exchange.aspx">http://telushealth.com/en/solutions/claims_and_benefits_management/eclaims_exchange.aspx</a>.</p> <p>If you would like more information or printed material, please contact TELUS Health Solutions at 1-866-240-7492 option 1.</p>

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Question	Answer
<b>What languages are supported by eClaims?</b>	The Portal is available in both English and French. Note that the language of the messages generated by the Insurance Company can be different than the user's language as they depend on the language on file for the covered member.
<b>How do I change the language of the Portal?</b>	At this time, to request a change to the user's Portal language from English to French or French to English, you must contact TELUS Health Solutions at 1-866-240-7492 option 3.
<b>What browsers are supported by eClaims?</b>	To ensure expected operation of the Portal, please use Internet Explorer 6 or 7.  Note that Internet Explorer 8 is not supported by the current version of the Extended Healthcare (eClaims) application.
<b>I have some feedback I'd like to share regarding the eClaims service... Who can I contact?</b>	Your feedback is greatly appreciated. You can email us at <a href="mailto:provider.registry@telus.com">provider.registry@telus.com</a> with any questions or comments.
<h2>Registration</h2>	
<b>Which Providers are eligible for eClaims?</b>	The service is being initially deployed to support benefit claims from select providers: physiotherapists, chiropractors and vision care providers. Over time, this will be broadened to include a wider range of providers delivering services covered by group benefit plans.
<b>I heard about this but TELUS hasn't contacted me. Why not? How can I register?</b>	If you are a chiropractor, a physiotherapist, a vision care professional or an organization affiliated with these healthcare professionals, you may be contacted now or in the future and provided with registration information. If you are interested in this service, you can sign up by going to the following link: <a href="http://telushealth.com/en/eclaims/register.aspx">http://telushealth.com/en/eclaims/register.aspx</a> .  At this time, the service is only available to select providers but you may be contacted in the future as the solution is broadened to include a wider range of providers delivering services covered by group benefit plans.
<b>How can I sign up for the TELUS Health eClaims service?</b>	If you would like to register and you are a chiropractor, a physiotherapist, a vision care professional or an organization affiliated with these healthcare professionals, you can sign up by going to the following link: <a href="http://telushealth.com/en/eclaims/register.aspx">http://telushealth.com/en/eclaims/register.aspx</a> .
<b>After I have registered for eClaims, how long will it take for me to receive my user name and password?</b>	The registration process can take up to three weeks of your initial registration application. Once your registration has been processed, you will be sent your user name and password to use the TELUS Health eClaims Portal.
<b>Can I register or terminate the services at any given time?</b>	If you are eligible for eClaims, you can register with TELUS at any time and terminate your utilization of the service at any time, without penalty. You can also reactivate your registration after terminating your registration. Simply notify TELUS Health Solutions of your desired status.

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Question	Answer
<p><b>Is there a charge for using the TELUS Health eClaims Portal?</b></p>	<p>The TELUS Health eClaims Portal is available at no cost to eligible providers. You simply need access to a micro-computer, equipped with a web browser (example Internet Explorer) and a connection to the internet.</p>
<h2 style="text-align: center;">Registration for active WSIB providers</h2>	
<p><b>If I am already using the TELUS Service for WSIB claims, do I still need to register?</b></p>	<p>You do not need to register. If you are an eligible provider, you will be given access automatically to the new TELUS Health eClaims service. However, in some cases, if further formalities are required, TELUS will communicate with you.</p>
<p><b>I am already using the TELUS Service for WSIB claims. Why do I get a user access alert when I click on the Extended Healthcare link?</b></p>	<p>The user access alert message generates if you are already using the TELUS Service for WSIB but have not been given access to Extended Healthcare service. This alert generates only for providers who are eligible for this new service.</p> <p>To gain access to Extended Healthcare service, all you have to do is fill out the following form and fax it to TELUS Health Solutions – Provider Registration at 1-866-840-1466:  <a href="http://telushealth.com/en/eclaims/Ammendment_and_Cover_page.pdf">http://telushealth.com/en/eclaims/Ammendment_and_Cover_page.pdf</a></p>
<h2 style="text-align: center;">Login Issues</h2>	
<p><b>I'm having problems logging into the system.</b></p>	<p>If you forget your login username or password or have problems logging into the system, please contact the TELUS Health Solutions Service Desk at 1-866-240-7492 option 3.</p>
<p><b>Why isn't my new password accepted? Why isn't my password working?</b></p>	<p>Your password must respect the following conditions:</p> <ul style="list-style-type: none"> <li>■ Contain at least one alphabetic and one non-alphabetic character</li> <li>■ Must be 8-10 characters in length</li> <li>■ Must not contain any spaces</li> <li>■ Must not be the same as your user name</li> <li>■ Must not be a previously used password</li> </ul> <p>When you are typing your password, ensure CAPSLOCK is not activated on your keyboard.</p>
<h2 style="text-align: center;">Claim Submission Questions</h2>	
<p><b>What do I enter in the Policy and Member ID fields? Where do I get the Policy and Member ID for my patient?</b></p>	<p>The "Plan No" and "Member ID" on a GWL card are entered respectively in the Policy and Member ID fields of the coverage section in the Portal. Great-West Life accepts Policy and Member ID values that have character length of 10 or less. Go to Appendix B of the eClaims User Manual - August 2010.pdf for a sample GWL card.</p> <p>If using an Assure card, enter digits 3 to 8 in the Policy field and the next 10 digits/characters in the Member ID field. Do not enter the first or last 2 digits of the card. Leading zeros do not need to be entered.</p> <p><b>NOTE:</b> Entering Policy (or Member ID) that is longer than 10 digits (or 10 characters) may lead to a Connection Error or a "No patient record found..." problem encountered message from GWL.</p>

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Question	Answer
<b>Can you claim for multiple patients at a time?</b>	Each patient's claim must be submitted separately. If you have multiple patients for the same family, once the Insurance Company's response has been printed and saved, you can create a claim for a different member of the same family and the system will pre-populate some fields for you.
<b>How many days do we have to submit a claim electronically?</b>	Claims should be submitted while the patient is in your office at the time the service is provided. The Insurance Company will return a response immediately for you to view and print for your patient. When an EOB is returned, you and your patient will know right away what the Insurance Company will cover and you can request the balance owing, if any, from your patient before he or she leaves the office. You have up to 7 days from the date the services were rendered to submit the service electronically but the sooner the claim is submitted, the faster payment will be issued by the Insurance Company.
<b>Are claims processed the same day as I submit them?</b>	In general, claims are processed the day they are submitted by the automated system. However, at times claims cannot be automated in which case you will receive an Acknowledgment advising you that the claim has been accepted for further processing. A paper response will be generated once processing has completed.
<b>What is a "Predetermination Request" and how can I submit one?</b>	<p>A Predetermination is simply a request to know how much the Insurance Company would pay if the services were provided on that day for services that have not yet taken place.</p> <p>You can submit a predetermination by selecting a Predetermination request type instead of a payment request. However, if the service has already been provided, there is no need to submit a Predetermination first.</p> <p>Please note that GWL will not return details of what would be paid unless the request can be automatically adjudicated.</p>
<b>What type of expenses can be submitted electronically?</b>	Vision expenses, Chiropractor treatments and Physiotherapy treatments can be submitted using the TELUS Health eClaims Portal.
<b>Can optometrist services be submitted when affiliated with an optical supplier?</b>	<p>If you represent an optical supplier where eye exams or prescriptions of ocular appliances are offered, the optometrist(s) must be included at the time of registration of the optical supplier.</p> <p>When submitting optometrist services, the optometrist who performed the services must be selected at the start of the request. If payment is requested to be made to the optical supplier, the "Clinic/organization" payment option can be selected.</p>
<b>Why can't claims for Medical Supplies be submitted?</b>	As additional information not currently captured by the Portal is required for adjudication of medical supplies, they cannot be submitted electronically at this time.
<b>How can I tell whether the claim was submitted?</b>	<p>After you have submitted your request and the Insurance Company has completed processing the request, the Insurance Company's response will be shown. Should an error occur before the response is received, you will be advised of the error and what next steps are available to you.</p> <p>Should you require further assistance, please contact TELUS Health Solutions at 1-866-240-7492 option 4.</p>

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Question	Answer
<p><b>How long is a saved transaction available in Today's Transactions?</b></p>	<p>A saved transaction is only available for completion on the day it was saved. Saved transactions in "Today's Transactions" are deleted at the end of each day.</p>
<p><b>Why can't I change the servicing provider when I choose New Claim – Same family?</b></p>	<p>You can only use the New Claim – Same Family option if the provider performed the services for both members of the same family.</p> <p>If different providers performed the services, you must create an entirely new claim and select the correct provider on the second claim.</p>
<p><b>Why can't I access the Service code search tool?</b></p>	<p>To enable the Service Code search tool, you must enter a date of service for payment requests.</p>
<p><b>Why is a provider missing in the list of servicing providers?</b></p>	<p>If you expect a provider to be available as a servicing provider (provider who performed the service) but the provider is not listed, it can be for one of the following reasons:</p> <ul style="list-style-type: none"> <li>■ The wrong user ID was used to login to the Provider Portal</li> <li>■ You have not been identified as a user able to submit for this provider</li> <li>■ The provider is not registered for Extended Healthcare</li> <li>■ The delay for the provider to become active has not yet passed</li> <li>■ The provider is expired</li> </ul> <p>The provider or provider's organization needs to contact the TELUS Health Solutions Service Desk at 1-866-240-7492 option 1 to register or to have you added as a delegate.</p>
<p><b>Why can't I select both eyes for a service?</b></p>	<p>You cannot select both Left and Right eye for the same claim line. If the service code applies to both eyes, either do not use the eye checkboxes or split the service into two lines, one for each eye.</p>
<p><b>What is the "Provincial Insurance Exhausted" field for?</b></p>	<p>In certain provinces, it is not permitted to submit healthcare expenses covered by the provincial plan to a private healthcare Insurance Company until the provincial coverage has been fully exhausted. Only check this box if this applies in the province and for the services rendered and all provincial coverage has been used up.</p>
<h2 style="color: purple;">Payment</h2>	
<p><b>How are we paid for claims we submit via the portal? Can we set up direct deposit for payments?</b></p>	<p>GWL issues a cheque to the provider or provider's organization when the response's "Payable to" is Servicing Provider or Clinic/organization. At this time, provider direct deposit is not offered by GWL.</p> <p>A single cheque per day will be issued for all claims under the same family. GWL can issue multiple cheques to a provider if the claims done during the day were not for patients of the same family.</p>
<p><b>Is payment to provider (benefit assignment) possible?</b></p>	<p>Yes benefit assignment is possible. The payment options available include payment to the provider or the provider's organization.</p> <p><b>Note:</b> In some cases, the patient's coverage does not permit the provider or provider's organization to be paid.</p>

Question	Answer
<b>Can you do bulk payments?</b>	Payment is made directly by the Insurance Company. TELUS does not currently bulk or bundle multiple payments to a provider on behalf of Insurance Companies participating in the TELUS Health eClaims service.
<b>When will I know how much the Insurance Company will pay when I get an Acknowledgement response?</b>	While a firm timeline for a response to an Acknowledgement cannot be established, the handling of electronically submitted claims are given a high priority by Insurance Companies.
<b>What do I charge my patient when I receive an Acknowledgement response?</b>	<p>If the acknowledgement's "Payable to" indicates that the payment will go to the "Insured member", request full payment from your patient since any payment made by the Insurance Company will go to the insured member.</p> <p>If the "Payable to" on the response is not indicated, you can either:</p> <ul style="list-style-type: none"> <li>■ Wait to receive the Insurance Company's final response then request the unpaid portion, if any, from your patient or the insured member</li> <li>■ If you are concerned about not getting a possible unpaid portion from your patient after he or she has left the office, cancel (void) the acknowledgement and resubmit the same claim with payable to "Insured member". You can thus request full payment from your patient on the spot and he or she will be reimbursed by the Insurance Company without having to submit a paper claim. In the future, select Insured member for "Payable to" for that patient's claims.</li> </ul>
<b>Why can't I select who the payment will go to?</b>	The Payable To field is only available for Payment Requests. If the type of request chosen was a Predetermination (visible at the top right of the page), you need to cancel the predetermination and begin a new claim, but this time choosing a Payment request type instead.
<b>How do I change who the payment should go to?</b>	To change who should receive the Insurance Company's payment, you must first void the request then resubmit a new request with the new value for Payable to. You can only change who the payment should go to the same day the request was first submitted.
<b>Can optometrist services be paid to the optical supplier when the optometrist is affiliated with an optical supplier?</b>	<p>Yes, the "Clinic/organization" payable to option can be selected when an optometrist is affiliated with an optical supplier.</p> <p>The account used to log into the Portal must be associated with the optical supplier where the optometrist works. The optometrist must be selected at the start of the request in order to submit optometrist services.</p>
<h2>Coordination of Benefits</h2>	
<b>Are all private Insurance Companies available under eClaims?</b>	At this time, only Great-West Life accepts electronic extended healthcare requests submitted through the TELUS Health eClaims Portal when Primary coverage is with GWL. We hope to expand the availability of eClaims to more insurance companies in the near future.

Question	Answer
<p><b>What if the patient's Insurance Company is not listed in the Primary Coverage section?</b></p>	<p>Only Insurance Companies currently participating in the TELUS Health eClaims service are listed in the list of Insurance Company in the primary coverage section. If your patient's Insurance Company is not listed in the Primary Coverage section, your patient must submit the claim to his Insurance Company the same way as before.</p>
<p><b>What if the patient's secondary Insurance Company is not listed in the Secondary Coverage section?</b></p>	<p>If the Insurance Company is not listed in the Secondary Coverage section and the patient has secondary coverage, you can select the value "Other Health Care Insurance Company".</p>
<p><b>Is it mandatory to enter secondary coverage information through eClaims?</b></p>	<p>It is not mandatory to enter secondary coverage if the patient does not have any additional coverage. However, if the patient does have secondary coverage, this information needs to be provided to the primary Insurance Company to assist in the coordination of benefits.</p>
<p><b>Can I coordinate benefits if my patient has both primary and secondary coverage with GWL?</b></p>	<p>If your patient has both primary and secondary coverage with GWL, you must fill both the Primary and Secondary Coverage sections of your patient's claim. GWL will respond electronically to the primary coverage only and will automatically coordinate and handle the secondary claim manually. Though you will not receive an electronic response to the secondary claim, there is no need for your patient to submit a paper claim to GWL for the secondary claim.</p>
<p><b>When submitting a claim when both husband and wife have GWL coverage, how do you determine who is primary and who is secondary?</b></p>	<p>The following provides guidelines to determine how to properly identify primary and secondary coverage:</p> <ul style="list-style-type: none"> <li>■ If the patient is the husband, he submits to his policy first and indicates his wife's policy as secondary</li> <li>■ If the patient is the wife, she submits to her policy first and indicates her husband's policy as secondary</li> <li>■ If the patient is a child and is covered under both policies, the claim is submitted under the policy of the parent whose birthday occurs earlier in the year. For example, if the husband's birthday is February 1 and the wife's birthday is September 1, indicate the husband's policy first and the wife's policy as secondary.</li> </ul>
<p><b>Can I submit a claim to an Insurance Company that is not participating in the eClaims service or can I coordinate benefits between GWL and another Insurance Company?</b></p>	<p>At this time, only claims to GWL as Primary Insurance Company are eligible for electronic submission through the TELUS Health eClaims Portal.</p> <p>To coordinate benefits with another Insurance Company, the patient must submit a paper claim to the Secondary Insurance Company, along with a copy of the Explanation of Benefits response showing what GWL has paid.</p>

## Voids / Reversals / Cancel

<p><b>What if I realize I made a mistake after I got a response? Can I make a correction to the request?</b></p>	<p>To correct the claim, you must first void or cancel the first claim then resubmit a new claim with the error corrected. It is not possible to simply update a previously submitted request even if the Insurance Company has not generated an Explanation of Benefits.</p> <p>You can void and resubmit only the same day the claim was originally submitted.</p> <p>If you become aware of the error one or more days after the request was submitted, you must contact the Insurance Company directly to inform them of the error.</p>
<p><b>Am I allowed to void or cancel a request after I have submitted it through eClaims?</b></p>	<p>The only time you should void a claim is if there was an error made in the submitted information. You can void or cancel a Payment Request only on the day it was originally submitted. If you need to void a payment request after the date it was originally submitted, you must contact the Insurance Company directly.</p> <p>There is no need to void or cancel a Predetermination as the services have not been provided. For this reason, the void option is not available for predeterminations.</p>
<p><b>How do I void or cancel a request?</b></p>	<p>If the request was submitted that day, you can void or cancel the request in the “Today’s Transactions” section. Simply find the original request then click on the Void command button.</p> <p>The TELUS Health Solutions eClaims Extended Healthcare User Manual provides further instructions on how to cancel or void a transaction.</p>
<p><b>Do I have to void a claim if it has been rejected?</b></p>	<p>There are many reasons why a claim can be rejected. However, the only time you should void a claim is if there was an error made in the submitted information about the patient, the patient’s coverage or the claim details.</p>
<p><b>How can I tell whether I have reversed or voided the claim?</b></p>	<p>When a claim was successfully voided or cancelled, the original response will display the word “Voided” to the right of the response original title.</p> <p>In Today’s Transactions, the response status of the request will change to Voided.</p> <p>If the claim could not be successfully voided or cancelled, the original response will display with “Void request declined” to the right of the title. When this situation occurs, a message indicating the problem will be provided in the notes section.</p>
<p><b>When do I choose “Altered decision” as void reason?</b></p>	<p>If you are voiding a request because of the response obtained and not because an error was made on the original request, choose “Altered decision” as the reason for voiding the request. For example, when you wish to change the payable to value because an Acknowledgement was generated, you would select “Altered decision” as void reason.</p>

<h2 style="text-align: left; margin: 0;">Claim Response Questions</h2>	
<p><b>How long does it take to receive a response when an Acknowledgement generates and not an EOB?</b></p>	<p>While a firm timeline for a response to an Acknowledgement cannot be established, the handling of electronically submitted claims are given a high priority by Insurance Companies.</p>
<p><b>Why was the EOB in English and French?</b></p>	<p>The messages generated on the responses are based on the language the member has on file with his Insurance Company.</p> <p>If the user and member language are different, it will cause the displayed response messages generated by the Insurance Company to be different than the user's language.</p> <p>The printed responses are always based on the member language as the printed response is created for the member's benefit.</p>
<p><b>If I receive a “problem encountered” error message while submitting a claim, will it automatically be saved under “Today’s Transactions”?</b></p>	<p>Yes. For all submitted claims where a "Problem Encountered" message is returned, they are automatically saved in “Today’s Transactions” whether successful or unsuccessful. However, for claims where an "Application Error" is returned, these may not always be saved depending on what caused the error.</p>
<p><b>Will I get an electronic response once the Insurance Company has completed its processing of the Acknowledgement?</b></p>	<p>No. When Acknowledgement response is generated, you will not receive an electronic notification once the Insurance Company has completed its adjudication process for the payment request. A paper response will be sent once the claim has been processed.</p>
<p><b>Why did I get a “Problem Encountered” for the claim I submitted instead of an EOB or an Acknowledgment? What do I do?</b></p>	<p>It is quite possible that incorrect coverage information or patient information was entered. A message stating what the problem was will provide you with guidance on how to fix the problem. Try resubmitting the claim once you have verified the information with your patient and an error was found. Do not resubmit unless a change is made to the originally submitted information and advise the patient to validate his coverage information with the Insurance Company.</p> <p>If you are still experiencing problems, please contact TELUS Health Solutions at 1-866-240-7492 option 4.</p>
<p><b>Why am I receiving an application error or connection error?</b></p>	<p>For help with any connection or application error you have received, contact TELUS Health Solutions at 1-866-240-7492 option 3.</p>
<p><b>Why was the request I submitted last night not accepted?</b></p>	<p>If the request was submitted outside of the system’s hours of operation, it will not be processed. When this occurs, you will receive notification to submit the request manually. You can try to resubmit again the following day or have the patient submit a paper claim to his Insurance Company.</p>

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<p><b>What are Great West Life's hours of operation?</b></p>	<p>Great-West Life's system can respond with payment details during these hours:</p> <p style="text-align: center;">Monday to Friday from 6:30 am to 8:30 pm ET Saturday from 6:30 am to 8:00 pm ET</p> <p>Outside these periods, only an Acknowledgement response will be generated.</p>
<p><b>Why did I receive a reject message on the Insurance Company's response?</b></p> <p><b>My patient doesn't understand the Insurance Company's response.</b></p>	<p>At times, a claim may not be able to complete automated processing and requires an adjuster at the Insurance Company to review the claim. In this case, you will receive an Acknowledgment advising that the claim has been accepted for further processing or to submit the claim manually.</p> <p>If you have further questions about the Insurance Company's response, you or your patient must contact the Insurance Company directly.</p> <p>For questions regarding a Great-West Life response, please contact them at 1-800-957-9777.</p>
<h2 style="text-align: center;">Viewing History</h2>	
<p><b>Can I view claims that were previously submitted?</b></p>	<p>Yes. You are able to view transactions previously submitted in the current month and for an additional month in the past. Simply go to the "Past Transactions" section where you can search transactions from those available in the past two months.</p>
<p><b>Why can't I see the transactions done last month in Past Transactions?</b></p>	<p>By default, the period (From and To dates) is set to a 10 day period. Simply change the From date to the beginning of the previous month.</p>
<p><b>I got a connection error yesterday but can't find it. How do I resubmit the claim?</b></p>	<p>Transactions that have led to a connection error are only available for resubmission the day they were originally submitted. A new request will need to be created if you want to resubmit the request the next day or later.</p>
<p><b>I want to print or save an electronic copy of the response but can't find it. Where is it?</b></p>	<p>The full original request and response are only available on the day the request was submitted. Starting the day after a claim is submitted, only a summarized view of the request and response is available in the "Past Transactions" section.</p>
<p><b>I want to view or print a request I submitted earlier but there are no options available in Today's Transactions?</b></p>	<p>The application will only display the options available after a transaction is actually selected. The options available for a transaction is based on the type of transaction selected.</p> <p>The print function is unavailable for certain types of responses; in those cases, you can use your browser's print functionality.</p>
<h2 style="text-align: center;">Terminology</h2>	
<p><b>What is an EOB or Explanation of Benefits?</b></p>	<p>An Explanation of Benefits is a response generated by the Insurance Company when it has fully adjudicated or processed the payment request. This statement provides the actual results of the adjudication, including what amounts, if any, will be paid by the Insurance Company.</p>

<p><b>What is a Claim Acknowledgement?</b></p>	<p>A Claim Acknowledgement is a response generated by the Insurance Company when it has successfully received the payment request but is unable to complete its adjudication process. This statement simply serves to confirm receipt of the payment request.</p> <p>Actual adjudication results will be provided at a later time through a paper means based on who was identified to receive the payment. In some cases, this may be different than what was on the request. A note will normally be present in the bottom note section when this situation occurs.</p>
<p><b>What is Coordination of Benefits?</b></p>	<p>Coordination of benefits applies when a patient has coverage under more than one plan that may or may not be from the same Insurance Company. Coordination rules exist to determine which Insurance Company pays first and which pays subsequently.</p>
<p><b>What is adjudication?</b></p>	<p>This refers to the process where the Insurance Company's claim processing system assesses the claim details and issues the results of the assessment in the form of a response to the request.</p>
<p><b>What is Benefit Assignment?</b></p>	<p>Assignment of benefits corresponds to the patient or patient's parent/guardian requesting that the amount paid by the Insurance Company be paid directly to the provider or the provider's organization.</p>
<p><b>What is a Deductible?</b></p>	<p>When applicable, the deductible represents the amount required to be paid by the patient for a given service before any amount can be paid by the Insurance Company.</p>
<p><b>What is Eligible Amount?</b></p>	<p>The eligible amount is the amount that the Insurance Company deemed eligible for the service before calculating the amount that it will pay for the service. If it is less than the submitted amount, there would be a message stating the reason the eligible amount is less than what was submitted.</p>