MyAmeriBen Provider Portal FAQ

1. How do I set up a username and password or change my password for the provider portal?
   If you do not currently have a username and password go to *www.MyAmeriBen.com*.

   Select and follow the instructions of the Provider Signup hyperlink.

2. What are the supported browsers to utilize the provider portal?
   Internet Explorer 10 and 11 and Google Chrome.

3. I am experiencing errors not addressed elsewhere in this documentation. What should I do?
   Verify the internet browser you are using will accept cookies. Please contact your administrator or technology help desk with any questions regarding security settings.

4. I have never used the provider portal. Where can I find instructions?
   A list of printable instructions can be found at *www.MyAmeriBen.com*.

5. Do I have to include clinical documentation at the time of my request?
   You will have the option to attach or fax in clinical documentation during the submission of your authorization request. However, submission of clinical documentation is required to support medical necessity; incomplete authorization requests may result in a delay of processing.

6. What are the phone and fax numbers to use if I need help or need to fax documentation?
   For detailed eligibility and benefit information call our Customer Service Representatives at 1-800-786-7930.

7. What do the following product abbreviations represent when choosing appropriate guidelines for clinical documentation?

   AC: Ambulatory Care
   HC: Home Care
   ISC: Inpatient & Surgical Care
   RFC: Recovery Facility Care

8. I am trying to access the authorization summary for a request I submitted, and keep getting a message "Authorization not found." What does this mean?
   If a case is currently being worked by AmeriBen staff, you may not be able to access the Authorization Summary and will get a message "Authorization not found." Please check back at another time or contact AmeriBen Medical Management to check the status.

9. My patient needs a procedure tomorrow. Can I still use the provider portal?
   If the service is to occur in the next 24 hours, please contact AmeriBen Medical Management.

10. I searched and found my patient, but their information is in red. What does this mean?
    If a member name appears in red on member search, they may have an eligibility termination date. Use the magnifying glass on the right side of the screen to find additional eligibility information specifics. For detailed eligibility and benefit information call our Customer Service Representatives at 1-800-786-7930.

11. I have entered a retrospective review on a service already completed. Why can't I see the request I submitted?
    When medical review is completed on retrospective reviews, these cases will drop from your list of submitted authorization requests and your determination will come via your EOB (Explanation of Benefits) once you submit your claim.

12. How do I check to see if a request has already been submitted for my patient?
    When entering a request, you will need to make sure the request is not a duplicate. This can be done after selecting the appropriate member and view current requests.

13. The patient does not have a diagnosis. Can I still enter the request?
    You are required to enter a diagnosis code for all requests. Chief complaint is an optional field.

14. I am having difficulty entering ICD-9 and ICD-10 diagnosis codes. How can I get the codes to populate?
    ICD-9 codes you are required to enter the decimal in the code (ie. 250.00). ICD-10 codes you must enter without the decimal (ie. E1122).

15. What is the purpose of the “Additional Information” box?

This information will go directly to AmeriBen Medical Management for review, so please include all pertinent information for this request including:

1. Point of contact individual and contact phone number.
2. Date span for requested outpatient services or number of days requested for inpatient stay.
3. If the request is for Durable Medical Equipment, please list approximate cost so determination can be made if Precertification is required. You will be able to attach or fax clinical documentation in a later step.

16. I completed steps one and two in the authorization request submission, but need to make a change. What do I do?

Once you complete *Step 1: Select a member and classification* and *Step 2: Complete detail fields* in the authorization request submission, you are able to go back and make changes. However, once you have submitted the authorization request and are taken to Step 3: Document Medical Necessity, you can no longer make changes.

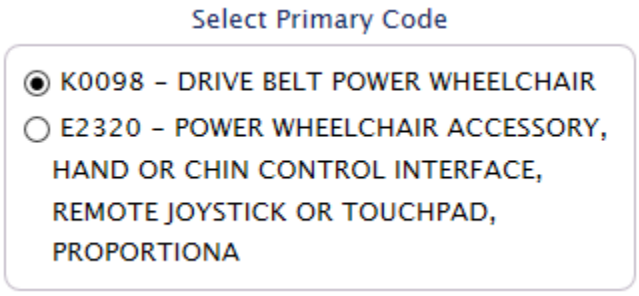
If you need to cancel your request or make changes, please contact AmeriBen Medical Management to void and cancel your request.

17. How do I cancel a request?

If you need to cancel your request or make changes, please contact AmeriBen Medical Management to void and cancel your request.

18. I have multiple CPT codes to enter. Does it matter which order they are entered?

If using multiple CPT codes, you must select a primary code in the authorization request submission:



19. After I have submitted my clinical documentation and information, am I able to add additional information after receiving the authorization reference number?
You are not able to change your documentation after submission.

However, if additional information becomes available for medical review, this can be faxed to AmeriBen Medical Management with your pending authorization number for reference. You also have the ability to attach additional documents for review in the authorization summary of the submitted case as long as the case is not currently being reviewed by medical staff.

20. I have completed all of the steps and have my authorization reference number. Now what?
Once you have been issued a pending authorization reference number, you can check the status by selecting the clipboard from the tool bar on the left of your screen, under ***Pre Certification Requests***, select ***My Authorizations***. This is also where you can access any communication sent by AmeriBen Medical Management.

21. Once I have submitted my request, how will I know if additional information is required?
Once you have been issued a pending authorization reference number, you can check the status by selecting the clipboard from the tool bar on the left of your screen, under ***Pre Certification Requests***, select ***My Authorizations***. This is also where you will access any communication sent by AmeriBen Medical Management.

22. What do the Status options mean?

Status	**Definitions**
(IRO) Ext Review Evaluation	Independent Review Organization/External Review being evaluated for initial processing by Appeals Team.
(IRO)Ext Review In Process	Documents being prepared for Independent Review Organization/External Review
(IRO)Ext Review MD	Documents sent to Independent Review Organization/External Review
(IRO)Ext Review Rec'd	Request received to initiate Independent Review Organization/External Review
(IRO)Ext Review Upheld	Independent Review Organization/External Reviewer Upheld Decision

Appeal 1 - In Process	Medical Review in process for 1st level Appeal
Appeal 1 - Request Received	Request/Clinical received for first level appeal
Appeal 1 Review in Process	Medical Review in process for 1st level Appeal
Appeal 2 - Request Received	Request/Clinical received for second level appeal
Appeal 2 - In Process	Medical Review in process for 2nd level Appeal
Appeal Evaluation	Appeal being evaluated for processing by Appeals Team
Appeal Evaluation 1	Appeal 1 being evaluated for processing by Appeals Team
Appeal Evaluation 2	Appeal 2 being evaluated for processing by Appeals Team
Appeal Process Complete/Closed	Appeal process complete
Appeal Upheld	Initial determination was appealed and Upheld on appeal
Approved	Request has been certified as medically necessary
Auth Not Required	Request did not require precertification
BH Services Approved	Outpatient Behavioral Health services request has been certified as medically necessary
Claims Process Completed	Claims review is complete
Clinical Received	Clinical documents received
Completed and Closed	All work is completed and case is closed
Concurrent Review	Review in process for additional inpatient days
Cost Savings	Managed Savings
Date of Service Change	Date of service extended or changed upon request
Denied	Requested services not found medically necessary
DENIED - Exclusion	Requested Services determined to be a plan exclusion
Denied-EXP/INV	Requested services determined to be experimental and/or investigational
GAP_Review Approved	Out of network facility/provider approval
GAP_Review Denied	Out of network facility/provider denial
GAP_Review in Process	Review for out of network facility/provider
In Process	Request ready for review by medical staff
Incomplete	Request is lacking required information to initiate precertification
Intake Review	Internal use only
IP Days Approved	Inpatient days approved during a concurrent stay.
Lack of Information	Request is lacking required information to complete precertification
LOI Letter	Lack of information letter is pending
LOI – Completed and Closed	Lack of information letter has been sent to requesting provider or facility
Make Status Decision	Internal use only (Internal user needs to set a status)
MCMC In Process	Review in process with medical reviewer
Modified	Modified

New Auth Request	New precertification request received
OP Services Approved	Outpatient services request has been certified as medically necessary
Partial Denial	Split decision of requested services with some services approved and some denied on the same certification request
Pended	Waiting for review
PFC_ Request 1	Pending for Clinical-First Request to obtain necessary clinical documentation for medical review
PFC_Request 2	Pending for Clinical- Second Request to obtain necessary clinical documentation for medical review
PFC_Request 3/Read LOI	Pending for Clinical- 3rd and Final request / Lack of Information disclaimer read
PHC	Initial referral for Post Hospital Call follow up
PHC _ Request 1	Post Hospital Call follow up-1st Call
PHC _ Request 2	Post hospital Call follow up-2nd Call
Refer to CM	Member has been referred for Case Management Services
Refer to DM	Member has been referred for Disease Management Services
Re-Open	Case has been reopened per request
Review in Process	In medical review
Routed From MCMC	Medical reviewer sending back the determination
Routed To MCMC	Requested services sent for Medical review for initial precertification review or for an appeal determination
Routed From MD Reviewer	Medical advisor sending back the determination or request for additional information
Routed To MD Reviewer	Requested services sent for Medical Advisor review for initial precertification review or for an appeal determination
Routed From Medical Advisor	Medical advisor sending back the determination or request for additional information
Routed To Medical Advisor	Requested services sent for Medical Advisor review for initial precertification review or for an appeal determination
TRF from Pre Service	Case is being created for post service appeal
TRF to Post Service	Case is being reviewed for post service appeal
Void/Cancel	Request voided or cancelled due to no prior auth needed, plan exclusion or error.