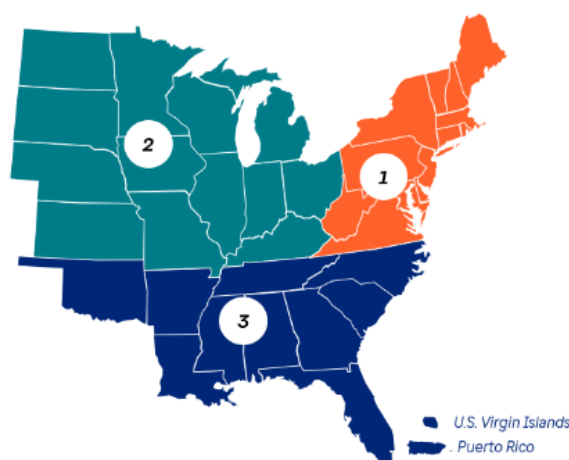


myVACCN.com XPressClaim® Professional Provider Guide

Overview

myVACCN.com serves providers in the VA CCN network for regions 1, 2 and 3.

Region 1	Region 2	Region 3
<ul style="list-style-type: none"> Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York North Carolina Pennsylvania Rhode Island Vermont Virginia West Virginia 	<ul style="list-style-type: none"> Illinois Indiana Iowa Kansas Kentucky Michigan Minnesota Missouri Nebraska North Dakota Ohio South Dakota Wisconsin 	<ul style="list-style-type: none"> Alabama Arkansas Florida Georgia Louisiana Mississippi Oklahoma Puerto Rico South Carolina Tennessee U.S. Virgin Islands



This guide explains how to use the XPressClaim (XPC) web application to submit professional VA CCN claims (CMS 1500).

Important: XPC uses PGBA's Provider Information Management System (PIMS) as the source of provider data. The Tax ID Number (TIN) and assigned National Provider Identifier (NPI) must be on PIMS before the provider can use XPC. How do you get into PIMS? Join the VA CCN network!

To sign up for XPC:

1. If you are not already a member of myVACCN secure, use the "Register Now" link to create an account. The registration process includes an option to sign up for XPC.
2. If you already have a myVACCN secure account, sign in with your username and password
3. Click on the "XPressClaim" option in the top navigation menu
4. Select "Submit an XPressClaim"
5. Choose "Sign me up now!"
6. Review, sign and accept the XPC agreement
7. Confirm your acceptance for immediate access to submit claims

Already signed up. Submit a claim:




1. Sign into myVACCN.com using your unique username and password created during registration
2. Click on the "XPressClaim" claim option in the top navigation menu
3. Select "Submit an XPressClaim"

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XPressClaim Start


Select the **Enter an XPressClaim now** link.

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[Veteran Information](#) [Claim Information](#) [myAccount Information](#) [XPressClaim](#) [Chat](#)

[Home](#) > [Submit an XPressClaim](#)

[Start](#) > [Location](#) > [Provider](#) > [Veteran](#) > [Service](#) > [OHI](#) > [Results](#)




Start your VA CCN XPressClaimSM

Here's a quick overview of the XPressClaim process:

1. Select the location where the care was provided.
2. Select the doctor who provided the care.
3. Select the patient who received the care.
4. Enter the list of services and charges for this claim.
5. Submit and make any online corrections.
6. Receive your results right away.

[Enter an XPressClaim now.](#)

Please note:

To see [XPressClaim Help](#), you'll need Adobe Reader. Download it now for free. 

So that we can update our files and keep your information current, XPressClaim may be temporarily down each night between 3 a.m. and 4 a.m. (EST) and Sundays from 5 p.m. to midnight (EST).

Location Selection

Select the location where services were provided by selecting a National Provider Identifier (NPI) link.

Search by NPI, location name, state, status or specialty to narrow the list. Click on any underlined column name in the location grid to sort by column.

Locations that were active on PIMS within the past year (365 days) and have an assigned NPI are displayed. An NPI is not required for atypical locations.

Select the location where services were provided

To change or narrow the list, please enter the NPI, location name, state, status and/or specialty in any combination.

NPI: Location name: State: Status:

Specialty:

<u>NPI</u>	<u>Location name</u>	<u>Address</u>	<u>City</u>	<u>State</u>	<u>ZIP</u>	<u>Specialty</u>	<u>Status</u>	<u>Status date</u>
1234567890	CONCORD OTO HEAD & N	123 MAIN ST	CONCORD	NH	03301-2952	MIXED SPECIALTY CLIN	ACTIVE	01/01/2019
9876543210	CONCORD OTO HEAD & N	456 ANY ST	PETERBOROUGH	NH	03458-1122	MIXED SPECIALTY CLIN	ACTIVE	05/01/2019

A maximum of 300 locations are returned in a single search. Providers with many locations may be required to narrow the search to find a specific location. An alert will display:

Select the location where services were provided

⚠ Please note the following:

More than 300 locations were found. Please change or narrow your selection.

To change or narrow the list, please enter the NPI, location name, state, status and/or specialty in any combination.

Claim Type

The specialty of the location selected determines whether the user is presented with a **professional claim path or an institutional claim path**. (Example: A Mixed Specialty Clinic would always be presented with the professional claim path.)

There are a few specialties that are presented with the option to choose between professional or institutional:

- Corporate Service Provider (CSP) Comprehensive Outpatient Rehab Facility
- CSP Home Health Agency
- Hospital Based Laboratory
- Federally Qualified Health Care Agency
- Rural Health Clinic
- Ambulatory Surgical Center
- Urgent Care
- State Vaccine Program
- Ambulance Service
- Laboratory

Optum
UnitedHealthcare
VA Community Care Network

Home Print Provider Feedback Logout

myVACCN
by PGBA

Veteran Information Claim Information myAccount Information XPressClaim Chat

Home > Submit an XPressClaim

Start > Location > Provider > Veteran > Service > OHI > Results

Enter the patient who received care at: LABORATORY CORP

Veteran Information

To submit a claim for a veteran, please enter the following:

First Name MI Last Name Veteran's date of birth

Veteran's

☐ MVI ICN

☒ SSN

Claim type

☒ Professional

☐ Institutional

Submit



Cancel this XPressClaim Back

This option only displays for the above listed provider specialties.

Rendering Provider


Next, select the rendering provider (doctor, therapist, etc.). The list can be narrowed by name, status or specialty. Click on any underlined column name in the grid to sort by column.

This page only displays when applicable to the location selected on the prior page.



VA Community Care Network

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by PGBA

[Veteran Information](#) [Claim Information](#) [myAccount Information](#) [XPressClaim](#) [Chat](#)

[Home](#) > [Submit an XPressClaim](#)

Start > Location > **Provider** > Veteran > Service > OHI > Results



Select the doctor who provided the care at: CONCORD OTO HEAD & NECK SURG, PETERBOROUGH

To change or narrow the list, please enter the provider's name and/or specialty in any combination.

Provider's name:

Status:
Active

Specialty:
-- All Specialties --

Provider's name	Social Security Number	Specialty	NPI	Status	Status date
<u>JAMES DOE AUD</u>	*****0007	AUDIOLOGIST	9999999990	ACTIVE	05/01/2019

Veteran Information

Enter the veteran's first name, middle initial (if applicable), last name, date of birth and MVI ICN or SSN. Then, click **Submit**.

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UnitedHealthcare
VA Community Care Network

[Home](#) [Print](#) [Provider Feedback](#) [Logout](#)

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Veteran Information **Claim Information** **myAccount Information** **XPressClaim** **Chat**

[Home](#) > [Submit an XPressClaim](#)

[Start](#) > [Location](#) > [Provider](#) > **Veteran** > [Service](#) > [OHI](#) > [Results](#)

Enter the patient who received care at: LABORATORY CORP

Veteran Information

To submit a claim for a veteran, please enter the following:

First Name	MI	Last Name	Veteran's date of birth		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Veteran's

☐ MVI ICN

☒ SSN

Submit

Cancel this XPressClaim **Back**

Enter your office's patient account number as the "Veteran's account number." This corresponds to block 26 on the CMS1500 claim form and will help identify the patient later in your system. Finish entering the veteran's information or verify that the information displayed is correct.

Update the veteran's information or confirm the following is correct.

Required *

Veteran's MVI ICN: 6245069782V524196

Veteran's Social Security Number: XXXXX1651

Veteran's name: Jane Doe

Date of birth: January 1, 1985

Gender: ☐ Male ☐ Female ☐ Unknown

Veteran's account number:

Address line 1:

Address line 2:

City:

State:

ZIP code: -

Relationship to veteran:

Pregnancy indicator:

Date of death: / / (mm/dd/yyyy)

Patient's weight: - (lbs)

General Claim Information and Claim Note Information

Enter the general claim information and claim note information. Then, select **Continue with XPressClaim**.

Some fields are pre-populated with the most common values.

General claim information	
Benefits assigned to provider:*	Yes
Release of information:*	<div><input type="radio"/> Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes <input checked="" type="radio"/> Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim</div>
Patient's signature source:	
Provider signature on file:*	Yes
Place of service:*	~ Select ~
Claim type:*	1- Original Claim
Medical record number:	
Prior claim number:	
Claim note information	
Claim notes can be added here that apply to the entire claim. You may also enter notes that apply to specific claim lines in the Supplemental line information section.	
Claim note type:	
Claim note:	
<div>Continue with XPressClaim</div> <div>Cancel this XPressClaim</div>	

Place of Service

Place of service is a required field. Current values in the drop-down menu:

~ Select ~

01- PHARMACY
02- TELEHEALTH PROVIDED OTHER THAN IN PATIENT'S HOME
03- SCHOOL
04- HOMELESS SHELTER
05- INDIAN HEALTH SERVICE FREE-STANDING FACILITY
06- INDIAN HEALTH SERVICE PROVIDER-BASED FACILITY
07- TRIBAL 638 FREE-STANDING FACILITY
08- TRIBAL 638 PROVIDER-BASED FACILITY
09- PRISON-CORRECTIONAL FACILITY
10- TELEHEALTH PROVIDED IN PATIENT'S HOME
11- OFFICE
12- HOME
13- ASSISTED LIVING FACILITY
14- GROUP HOME
15- MOBILE UNIT
16- TEMPORARY LODGING
17- WALK-IN RETAIL HEALTH CLINIC
19- OFF CAMPUS-OUTPATIENT HOSPITAL
20- URGENT CARE FACILITY
21- INPATIENT HOSPITAL
22- ON CAMPUS-OUTPATIENT HOSPITAL
23- EMERGENCY ROOM - HOSPITAL
24- AMBULATORY SURGICAL CENTER
25- BIRTHING CENTER
26- MILITARY TREATMENT FACILITY
31- SKILLED NURSING FACILITY
32- NURSING FACILITY
33- CUSTODIAL CARE FACILITY
34- HOSPICE
41- AMBULANCE - LAND
42- AMBULANCE - AIR OR WATER
49- INDEPENDENT CLINIC
50- FEDERALLY QUALIFIED HEALTH CENTER
51- INPATIENT PSYCHIATRIC FACILITY
52- PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53- COMMUNITY MENTAL HEALTH CENTER
54- INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
55- RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56- PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
57- NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
60- MASS IMMUNIZATION CENTER
61- COMPREHENSIVE INPATIENT REHABILITATION FACILITY
62- COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
65- END-STAGE RENAL DISEASE TREATMENT FACILITY
71- STATE OR LOCAL PUBLIC HEALTH CLINIC
72- RURAL HEALTH CLINIC
81- INDEPENDENT LABORATORY
99- OTHER UNLISTED FACILITY

Corrected Claims (Replacements and Voids)

To submit a replacement of a prior claim or a void of a prior claim:

1. Select Claim type = **7- Replacement of Prior Claim** or **8 – Void of Prior Claim** as appropriate
2. Enter the Prior claim number

Please note: The veteran information, provider information and billed charges for an **8 -Void of Prior Claim** should match the original claim entered as the Prior claim number.

General claim information

Benefits assigned to provider:*

Yes

Release of information:*

☐ Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes

☒ Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

Patient's signature source:

Provider signature on file:*

Yes

Place of service:*

~ Select ~

1 Claim type:*

1- Original Claim

Medical record number

1- Original Claim

Prior claim number

7- Replacement of Prior Claim

Prior claim number

8- Void of Prior Claim

Claim note information

Claim notes can be added here that apply to the entire claim. You may also enter notes that apply to specific claim lines in the Supplemental line information section.

Claim note type:

Claim note:

Continue with XPressClaim

Cancel this XPressClaim

General claim information

Benefits assigned to provider:*

Yes

Release of information:*

☐ Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes

☒ Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

Patient's signature source:

Provider signature on file:*

Yes

Place of service:*

~ Select ~

Claim type:*

1- Original Claim

Medical record number:

2 Prior claim number

Claim note information

Claim notes can be added here that apply to the entire claim. You may also enter notes that apply to specific claim lines in the Supplemental line information section.

Claim note type:

Claim note:

Continue with XPressClaim

Cancel this XPressClaim

Claim Header Level Notes

To enter claim header level notes (additional information that applies to the whole claim):

1. Select the Claim note type from the drop-down menu
2. Enter the notes in the Claim note field.

There is also an option to enter notes at the line level which is shown later in this document.

General claim information

Benefits assigned to provider:*
Release of information:*
Patient's signature source:
Provider signature on file:*
Place of service:*
Claim type:*
Medical record number:
Prior claim number:

Yes

☐ Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes

☒ Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

Yes

~ Select ~

1- Original Claim

Claim note information
Claim notes can be added here that apply to the entire claim. You may also enter notes that apply to specific claim lines in the Supplemental line information section.

1

Claim note type:
Claim note:

ADD - Additional Information

CER - Certification Narrative

DCP - Goals, Rehabilitation Potential, or Discharge Plans

DGN - Diagnosis Description

TPO - Third Party Organization Notes

Continue with XPressClaim

Cancel this XP

Claim note information
Claim notes can be added here that apply to the entire claim. You may also enter notes that apply to specific claim lines in the Supplemental line information section.

Claim note type:

2

Claim note:

Continue with XPressClaim

Cancel this XPressClaim

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XPressClaim Professional 20250328.

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Diagnosis Codes and Claim Line Details

Enter the ICD10 diagnosis code(s) and details for each claim line. When finished, select **Continue with XPressClaim**.

Important: Do not enter zeroes in the OHI Paid field if the patient does not have Other Health Insurance. Leave the field blank.

Start > Location > Provider > Veteran > Service > OHI > Results



Enter the professional claim line details

Provider: CONCORD OTO HEAD & NECK SURG
Veteran's name: Jane B Doe
Date of birth: June 16, 1925
Account number: DOE123

Required *

Diagnosis code(s)

1.*	<input type="text"/>	2.	<input type="text"/>	3.	<input type="text"/>	4.	<input type="text"/>	5.	<input type="text"/>	6.	<input type="text"/>
7.	<input type="text"/>	8.	<input type="text"/>	9.	<input type="text"/>	10.	<input type="text"/>	11.	<input type="text"/>	12.	<input type="text"/>

From* and to dates of service: (mm/dd/yyyy)	Place of service:	Procedure * & modifiers:	NDC:	Diagnosis: * 1, 2, 3, etc.	Charge: *	Units: *
4 / 26 / 2019	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/> 0.00	<input type="text"/> 0
Clear the line above						
4 / 26 / 2019	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/> 0.00	<input type="text"/> 0
Clear the line above						
4 / 26 / 2019	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/> 0.00	<input type="text"/> 0
Clear the line above						
4 / 26 / 2019	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/> 0.00	<input type="text"/> 0
Clear the line above						
Add another claim line						

Accepts assignment:
Assigned

OHI Paid:
\$

Patient paid you:
\$

Your total submitted charges:
\$ 0.00


Continue with XPressClaim

Back

Save and finish later

Help

Cancel this XPressClaim



Claim Edits

Once the user selects **Continue with XPressClaim**, the system will check for errors. Edits that the user needs to correct before continuing will display at the top of the webpage.

Example:

Start » Location » Provider » Veteran » **Service** » OHI » Results

Enter the professional claim line details

Please note the following:

Line 1: Diagnosis 1 missing.

National Drug Codes (NDC)

If a National Drug Code (NDC) is applicable to the claim, select the NDC checkbox and additional fields will open as shown below.

Start > Location > Provider > Veteran > Service > OHI > Results

Enter the professional claim line details

Provider: CONCORD OTO HEAD & NECK SURG
Veteran's name: Jane B Doe
Required *

Date of birth: June 16, 1925

Account number: DOE123

Diagnosis code(s)

1.*			2.			3.			4.			5.			6.		
7.			8.			9.			10.			11.			12.		

From* and to dates of service: (mm/dd/yy)	Place of service:	Procedure * & modifiers:	NDC:	Diagnosis:* 1, 2, 3, etc.	Charge:*	Units:*
4/26/2019 ~ Select ~					\$ 100.00	1.0

NDC code:*	Quantity:*	Measurement code:*	Rx number:	Rx number qualifier:	Rx date:
		~ Select ~		~ Select ~	/ /

Clear the line above

4/26/2019 ~ Select ~

Clear the line above

4/26/2019 ~ Select ~

Clear the line above

4/26/2019 ~ Select ~

[Add another claim line](#)

Accepts assignment:
Assigned

OHI Paid:
\$

Patient paid you:
\$

Your total submitted charges:
\$ 100.00

Continue with XPressClaim

Back

Save and finish later


Help

Cancel this XPressClaim

Anesthesia Services

For anesthesia services, enter the minutes in the Units field.

[Start](#) > [Location](#) > [Provider](#) > [Veteran](#) > **Service** > [OHI](#) > [Results](#)



Enter the professional claim line details

Provider: **CONCORD OTO HEAD & NECK SURG**
Veteran's name: **Jane B Doe**
Date of birth: **June 16, 1925**
Account number: **DOE123**

Required *

Diagnosis code(s)

1.* 2. 3. 4. 5. 6.
7. 8. 9. 10. 11. 12.

From* and to dates of service: (mm/dd/yyyy)	Place of service:	Procedure * & modifiers:	NDC:	Diagnosis: * 1, 2, 3, etc.	Charge: *	Units: *
4 / 26 / 2019	<input type="text"/> / <input type="text"/> / <input type="text"/>	~ Select ~	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> 0. <input type="text"/> 00	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Clear the line above						
4 / 26 / 2019	<input type="text"/> / <input type="text"/> / <input type="text"/>	~ Select ~	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> 0. <input type="text"/> 00	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Clear the line above						
4 / 26 / 2019	<input type="text"/> / <input type="text"/> / <input type="text"/>	~ Select ~	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> 0. <input type="text"/> 00	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Clear the line above						
4 / 26 / 2019	<input type="text"/> / <input type="text"/> / <input type="text"/>	~ Select ~	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> 0. <input type="text"/> 00	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Clear the line above						
Add another claim line						


Accepts assignment:
Assigned

OHI Paid:
\$

Patient paid you:
\$

Your total submitted charges:
\$ 0.00

[Continue with XPressClaim](#) [Back](#) [Save and finish later](#) [Help](#) [Cancel this XPressClaim](#)



Sleep Studies

If a sleep study procedure code is entered, a referring physician is required. A modal window will automatically display. Enter the physician information and select **Continue**.

The screenshot displays the XPressClaim Professional software interface. At the top, a breadcrumb trail reads: Start > Location > Provider > Veteran > Service > OHI > Results. The main header area includes the text "Enter the professional claim line details" and the XPressClaim logo. Below this, the provider information is shown: "Provider: FRISBIE MEMORIAL HOSPITAL", "Veteran's name: John A Doe", "Date of birth: July 06, 1992", and "Account number: HEA1234".

A modal window titled "Enter the referring provider information" is centered on the screen. It contains the following text and fields:

- Required ***
- Diagnosis code(s): 1.* g47 33 2. 7. 8.
- From* and to dates of service: (mm/dd/yyyy) 5/ 22/ 2019
- Clear the line above
- 5/ 22/ 2019
- Clear the line above
- 5/ 22/ 2019
- Clear the line above
- 5/ 22/ 2019
- Add another claim line
- Accepts assignment: Assigned
- Continue with XPressClaim

The modal window text includes:

- Enter the referring provider information
- Claims involving sleep studies are required to identify the referring provider.
- Required***
- Please note:** Either a Primary or Secondary ID must be entered but not both.
- First name: [text box]
- M.I.: [text box]
- Last name: * [text box]
- Suffix: [text box]
- Primary ID: [text box] (NPI)
- Secondary ID: [text box] (Provider Commercial Number)
- Continue
- Back

The background interface also shows a "Charges" section with a table of charges and a "Continue with XPressClaim" button.

Consultations

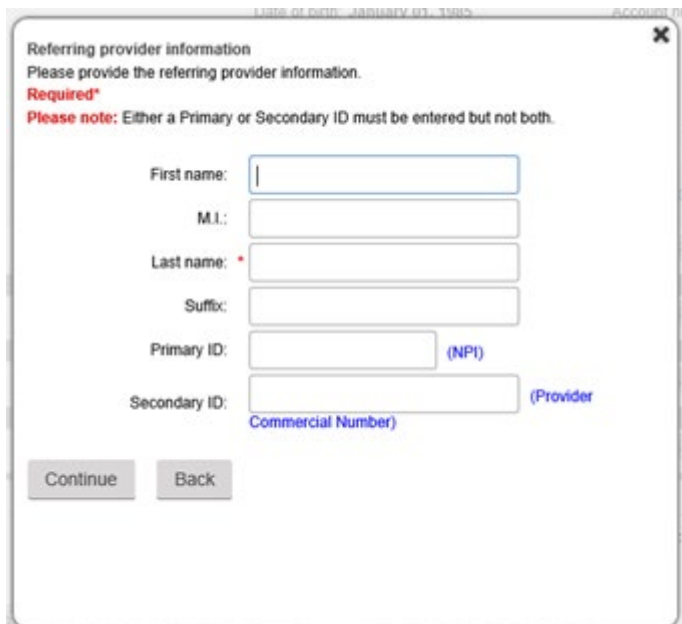
If a consultation procedure code is entered, a modal window will automatically display to ask if there is a referring physician. If yes, a prompt for referring physician information will display.



Referring provider information
Is there a referring physician on this claim?

Yes No

Enter the referring physician information and select **Continue**.



Referring provider information
Please provide the referring provider information.
Required*
Please note: Either a Primary or Secondary ID must be entered but not both.

First name:

M.I.:

Last name:

Suffix:

Primary ID: (NPI)

Secondary ID: (Provider Commercial Number)

Continue Back

Save Claim and Finish Later

Select the **Save and finish later** button if you need to finish entering the claim later.

×

Save claim to work later


We will save the claim you are working on in a "cookie" on your computer. When you return to XPressClaim we will prompt you to rework this claim. You can only save one claim at any time and will not be able to submit another XPressClaim until you complete or cancel this claim.

Note: If you share this computer with others and someone else signs in to submit an XPressClaim while you are away, your saved claim may be discarded.

Yes, save this claim on my computer

No, return to the claim list

When returning to XPC, an option to finish the saved claim will be presented.



You have a saved claim. Would you like to return to this claim now or delete it and start a new XPressClaim?

Yes, I would like to finish my saved claim.


Delete my saved claim and let me start a new one.

Other Health Insurance (OHI)

If the patient has OHI, enter the amount paid in the OHI Paid field on the line details page. Once the **Continue with XPressClaim** button is selected, additional OHI fields will display as shown below.

1. Prior adjudication date is required. This is the date that the OHI processed the claim.
2. Claim adjustment group code: "Patient responsibility" is pre-populated as this is the most common reason for adjustments.
3. Reason code, Amount and Quantity should be entered if there is an outstanding balance owed by the patient. Reason codes can be found at: <http://www.x12.org/codes/claim-adjustment-reason-codes/>

Start > Location > Provider > Veteran > Service > OHI > Results



Enter other health insurance information

Please note: Completion of this page is required when VA CCN is not the primary payer.

Provider:

Veteran's name:

Date of birth:

Account number:

Required *

Please enter other health insurance information as received from the other payer, including claim adjustments. This information tells VA CCN how the claim was processed by the other payer and what needs to be considered for coverage under VA CCN.

Coordination of benefits

Please indicate how you would like to enter adjustments for the payer. The choice should be driven by how the other payer provided the adjustment information to you on their electronic (835) or paper remit.

Level of adjustments: *

Claim Adjustments Only

Other payer paid: *

\$

25

00

Remaining patient liability: *

\$

1

Prior adjudication date: *

Claim Adjustments

The most common claim adjustments are Deductible, Co-Insurance or Non-Covered. If you would like to view a list of HIPAA Claim Adjustment Reason Codes, please go to www.wpc-edi.com.

2

Claim adjustment group code:

1. Patient responsibility

3

Reason code:	Amount:	Quantity:
1.1:	\$	
1.2:	\$	
1.3:	\$	
1.4:	\$	
1.5:	\$	
1.6:	\$	

[Add another adjustment group](#)

Enter the Other payer information including the name of the Other Health Insurance in the Payer's name field and click the **Continue with XPressClaim** button.

[Add another adjustment group](#)

Outpatient adjudication information: **[+]**

Other payer information

Payer's sequence: *

Individual relationship: *

Patient's signature release: *

Benefits assignment: *

Claim filing indicator: *

Other subscriber's claim#: *

Subscriber's ID: *

Secondary ID (SSN):

Subscriber's name: OR

Address line 1:

Address line 2:

City:

State:

ZIP code: -

Group name: Group#:

Prior Authorization#:

Referral#:

Last name/Organization name

Payer's name: * Primary ID (NAIC): *

Secondary type: Secondary ID:

[Continue with XPressClaim](#) [More Health Insurance](#) [Back](#) [Save and finish later](#) [Cancel this XPressClaim](#)

Submit the Claim

If there is no supplemental information to add, click the **Yes, submit this claim** button.

Start > Location > Provider > Veteran > Service > OHI > Results

XPRESSCLAIM

Enter the professional claim line details

Provider: CONCORD OTO HEAD & NECK SURG
Veteran's name: Jane B Doe
Date of birth: June 16, 1925
Account number: DOE123

Required *
Diagnosis code(s)

1.* m54 56 2. 3. 4. 5. 6.
7. 8. 9. 10. 11. 12.

From* and to dates of service: (mm/dd/yy) Place of service

4/ 26/ 2019 ~ Select ~

[Clear the line above](#)

4/ 26/ 2019 ~ Select ~

[Clear the line above](#)

4/ 26/ 2019 ~ Select ~

[Clear the line above](#)

4/ 26/ 2019 ~ Select ~

[Clear the line above](#)

[Add another claim line](#)

1. 2. Charge:* Units:*

\$ 100.00 1.0


\$ 0.00 0.0

\$ 0.00 0.0

\$ 0.00 0.0

Accepts assignment: Assigned
OHI Paid: \$
Patient paid you: \$
Your total submitted charges: \$ 100.00

[Continue with XPressClaim](#) [Back](#) [Save and finish later](#) [Help](#) [Cancel this XPressClaim](#)



Supplemental Information

To enter supplemental information (such as a referral number), select **No, I have supplemental claim and/or line data to enter.**

Start > Location > Provider > Veteran > Service > OHI > Results

XPRESSCLAIM

Enter the professional claim line details

Provider: CONCORD OTO HEAD & NECK SURG
Veteran's name: Jane B Doe
Date of birth: June 16, 1925
Account number: DOE123

Required *
Diagnosis code(s)

1.* m54 56 2. 3. 4. 5. 6.
7. 8. 9. 10. 11. 12.

From* and to dates of service: (mm/dd/yyyy) Place of service

4/ 26/ 2019 ~ Select ~

[Clear the line above](#)

4/ 26/ 2019 ~ Select ~

[Clear the line above](#)

4/ 26/ 2019 ~ Select ~

[Clear the line above](#)

4/ 26/ 2019 ~ Select ~

[Clear the line above](#)

[Add another claim line](#)

1, 2. Charge: * Units: *

\$ 100. 00 1. 0

\$ 0. 00 . 0


\$ 0. 00 . 0

\$ 0. 00 . 0

\$ 0. 00 . 0

Accepts assignment: Assigned
OHI Paid: \$
Patient paid you: \$
Your total submitted charges: \$ 100.00


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Claim Level Supplemental Information

Select a checkbox from the “Supplemental claim information” page to add claim level data. The page will re-display with the fields related to the checkbox selected. Once all applicable information has been entered, click **Continue with XPressClaim**.

Most commonly entered supplemental data at the header level includes **prior referral number** and **referring provider information**.

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Supplemental claim information
Provider: **CONCORD OTO HEAD & NECK SURG**
Veteran's name: **Jane Doe** Date of birth: **January 01, 1985** Account number: **DOE123**

Please check the box for the information you wish to add to this claim. Uncheck the box to delete the information.

Required*




<input type="checkbox"/> Accident information	<input type="checkbox"/> Hearing and vision prescription date	<input type="checkbox"/> Patient condition information - vision
<input type="checkbox"/> Ambulance information	<input type="checkbox"/> Hospitalization date(s)	<input type="checkbox"/> Prior authorization or referral number
<input type="checkbox"/> Anesthesia related surgical procedure code	<input type="checkbox"/> Initial treatment date	<input type="checkbox"/> Referring provider information
<input type="checkbox"/> Assumed or relinquished care date	<input type="checkbox"/> Investigational device exemption number	<input type="checkbox"/> Rendering provider information
<input type="checkbox"/> CLIA information	<input type="checkbox"/> Last menstrual period date	<input type="checkbox"/> Service authorization exception code
<input type="checkbox"/> Delay reason code	<input type="checkbox"/> Last x-ray date	<input type="checkbox"/> Service facility information
<input type="checkbox"/> Demonstration project identifier	<input type="checkbox"/> Mammography certification number	<input type="checkbox"/> Spinal manipulation service information
<input type="checkbox"/> Disability related dates	<input type="checkbox"/> Onset of current illness/symptom date	<input type="checkbox"/> Supervising provider information
<input type="checkbox"/> EPSDT information	<input type="checkbox"/> Patient condition codes	<input type="checkbox"/> Supplemental paperwork information

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Prior Referral Number

Enter your VA referral number (ex. VA0000000000, UC0000000000) in the Referral number field.

Referral numbers can also be entered at the line level, but only one referral number is allowed per claim.




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Supplemental claim information

Provider: CONCORD OTO HEAD & NECK SURG
Veteran's name: Jane Doe
Date of birth: January 01, 1985
Account number: DOE123

Please check the box for the information you wish to add to this claim. Uncheck the box to delete the information.

Required*

<input type="checkbox"/> Accident information	<input type="checkbox"/> Hearing and vision prescription date	<input type="checkbox"/> Patient condition information - vision
<input type="checkbox"/> Ambulance information	<input type="checkbox"/> Hospitalization date(s)	<input checked="" type="checkbox"/> Prior authorization or referral number
<input type="checkbox"/> Anesthesia related surgical procedure code	<input type="checkbox"/> Initial treatment date	<input type="checkbox"/> Referring provider information
<input type="checkbox"/> Assumed or relinquished care date	<input type="checkbox"/> Investigational device exemption number	<input type="checkbox"/> Rendering provider information
<input type="checkbox"/> CLIA information	<input type="checkbox"/> Last menstrual period date	<input type="checkbox"/> Service authorization exception code
<input type="checkbox"/> Delay reason code	<input type="checkbox"/> Last x-ray date	<input type="checkbox"/> Service facility information
<input type="checkbox"/> Demonstration project identifier	<input type="checkbox"/> Mammography certification number	<input type="checkbox"/> Spinal manipulation service information
<input type="checkbox"/> Disability related dates	<input type="checkbox"/> Onset of current illness/symptom date	<input type="checkbox"/> Supervising provider information
<input type="checkbox"/> EPSDT information	<input type="checkbox"/> Patient condition codes	<input type="checkbox"/> Supplemental paperwork information

Prior authorization or referral number


Prior authorization number:

Referral number:

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Referring Provider Information

Start > Location > Provider > Veteran > Service > OHI > Results



Supplemental claim information

Provider: CONCORD OTO HEAD & NECK SURG
Veteran's name: Jane Doe
Date of birth: January 01, 1985
Account number: DOE123

Please check the box for the information you wish to add to this claim. Uncheck the box to delete the information.

Required*

<input type="checkbox"/> Accident information	<input type="checkbox"/> Hearing and vision prescription date	<input type="checkbox"/> Patient condition information - vision
<input type="checkbox"/> Ambulance information	<input type="checkbox"/> Hospitalization date(s)	<input type="checkbox"/> Prior authorization or referral number
<input type="checkbox"/> Anesthesia related surgical procedure code	<input type="checkbox"/> Initial treatment date	<input checked="" type="checkbox"/> Referring provider information
<input type="checkbox"/> Assumed or relinquished care date	<input type="checkbox"/> Investigational device exemption number	<input type="checkbox"/> Rendering provider information
<input type="checkbox"/> CLIA information	<input type="checkbox"/> Last menstrual period date	<input type="checkbox"/> Service authorization exception code
<input type="checkbox"/> Delay reason code	<input type="checkbox"/> Last x-ray date	<input type="checkbox"/> Service facility information
<input type="checkbox"/> Demonstration project identifier	<input type="checkbox"/> Mammography certification number	<input type="checkbox"/> Spinal manipulation service information
<input type="checkbox"/> Disability related dates	<input type="checkbox"/> Onset of current illness/symptom date	<input type="checkbox"/> Supervising provider information
<input type="checkbox"/> EPSDT information	<input type="checkbox"/> Patient condition codes	<input type="checkbox"/> Supplemental paperwork information

Referring provider information

Please note: Either a Primary or Secondary ID must be entered but not both.

First name:

M.I.:

Last name:

Suffix:

Primary ID: (NPI)

Secondary ID: (Provider Commercial Number)

Continue with XPressClaim

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Save and finish later



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Cancel this XPressClaim

Line Level Supplemental Information


Once **Continue with XPressClaim** is selected, the user is presented with the option to enter line level supplemental data.

Select a line by clicking the [Edit](#) or [Add](#) link.



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Supplemental claim information

Provider: **OTO HEAD & NECK SURG**
Veteran's name: **Jane Doe**
Date of birth: **June 08, 1972**
Account number: **DOE123**



Please select a line to which the supplemental information will be added.

Line selection


Line	Procedure code	From date of service	Charges	Supplemental information
1	99213	1/3/2024	\$100.00	Edit
2	36415	1/3/2024	\$20.00	Add

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The “Supplemental line information” page will display for the line selected. Select the desired checkboxes, enter the corresponding information and click **Continue with XPressClaim**. Most common supplemental data at the line level includes [claim line notes](#) and [rendering provider information](#).


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Supplemental line information

Provider: **CONCORD OTO HEAD & NECK SURG**
Veteran's name: **Jane Doe**
Date of birth: **January 01, 1985**
Account number: **DOE123**

Claim Line: 1 Provider ID: **123456789** Procedure Code: **99213** Date of service: **5/20/2019** Charges: **\$100.00**

Please check the box for the information you wish to add to this claim. Uncheck the box to delete the information.

Required*

<input type="checkbox"/> Ambulance information	<input type="checkbox"/> Family planning indicator	<input type="checkbox"/> Purchased service information
<input type="checkbox"/> Ambulance patient count	<input type="checkbox"/> EPSDT indicator	<input type="checkbox"/> Procedure code description
<input type="checkbox"/> Begin therapy date	<input type="checkbox"/> Initial treatment date	<input type="checkbox"/> Referring provider information
<input type="checkbox"/> Certification revision date	<input type="checkbox"/> Last certification date	<input type="checkbox"/> Rendering provider information
<input type="checkbox"/> Claim line note	<input type="checkbox"/> Last x-ray date	<input type="checkbox"/> Sales tax amount
<input type="checkbox"/> CLIA information	<input type="checkbox"/> Line item control number	<input type="checkbox"/> Service facility information
<input type="checkbox"/> Copay waiver indicator	<input type="checkbox"/> Mammography certification number	<input type="checkbox"/> Shipped date
<input type="checkbox"/> DME Certificate of Medical Necessity	<input type="checkbox"/> Obstetric anesthesia additional units	<input type="checkbox"/> Supervising provider information
<input type="checkbox"/> DMERC condition indicator	<input type="checkbox"/> Ordering provider information	<input type="checkbox"/> Supplemental paperwork information
<input type="checkbox"/> Durable medical equipment certification	<input type="checkbox"/> Postage amount	<input type="checkbox"/> Test date
<input type="checkbox"/> Durable medical equipment service	<input type="checkbox"/> Prior authorization & referral number	<input type="checkbox"/> Test results
<input type="checkbox"/> Emergency indicator		

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Claim Line Notes

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Supplemental line information
Provider: **CONCORD OTO HEAD & NECK SURG**
Veteran's name: **Jane Doe** Date of birth: **January 01, 1985** Account number: **DOE123**
Claim Line: **1** Provider ID: **123456789** Procedure Code: **99213** Date of service: **5/20/2019** Charges: **\$100.00**

Please check the box for the information you wish to add to this claim. Uncheck the box to delete the information.

Required*

<input type="checkbox"/> Ambulance information	<input type="checkbox"/> Family planning indicator	<input type="checkbox"/> Purchased service information
<input type="checkbox"/> Ambulance patient count	<input type="checkbox"/> EPSDT indicator	<input type="checkbox"/> Procedure code description
<input type="checkbox"/> Begin therapy date	<input type="checkbox"/> Initial treatment date	<input type="checkbox"/> Referring provider information
<input type="checkbox"/> Certification revision date	<input type="checkbox"/> Last certification date	<input type="checkbox"/> Rendering provider information
<input checked="" type="checkbox"/> Claim line note	<input type="checkbox"/> Last x-ray date	<input type="checkbox"/> Sales tax amount
<input type="checkbox"/> CLIA information	<input type="checkbox"/> Line item control number	<input type="checkbox"/> Service facility information
<input type="checkbox"/> Copay waiver indicator	<input type="checkbox"/> Mammography certification number	<input type="checkbox"/> Shipped date
<input type="checkbox"/> DME Certificate of Medical Necessity	<input type="checkbox"/> Obstetric anesthesia additional units	<input type="checkbox"/> Supervising provider information
<input type="checkbox"/> DMERC condition indicator	<input type="checkbox"/> Ordering provider information	<input type="checkbox"/> Supplemental paperwork information
<input type="checkbox"/> Durable medical equipment certification	<input type="checkbox"/> Postage amount	<input type="checkbox"/> Test date
<input type="checkbox"/> Durable medical equipment service	<input type="checkbox"/> Prior authorization & referral number	<input type="checkbox"/> Test results
<input type="checkbox"/> Emergency indicator		

Claim line note
Claim line note type:*

~ Select ~

Claim line note:*

Continue with XPressClaim

Back

Save and finish later

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Cancel this XPressClaim

Claim line note type drop-down choices:

Claim line note
Claim line note type:*

~ Select ~
ADD - Additional Information
DCP - Goals, Rehabilitation Potential, or Discharge Plans

Claim line note:*

Continue with XPressClaim

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Cancel this XPressClaim

Rendering Provider Information

If different rendering providers performed each service, select the Rendering provider information checkbox for each line and key the provider details.

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Supplemental line information
Provider: **CONCORD OTO HEAD & NECK SURG**
Veteran's name: **Jane Doe**
Date of birth: **January 01, 1985**
Account number: **DOE123**

Claim Line: 1 Provider ID: **123456789** Procedure Code: **99213** Date of service: **5/20/2019** Charges: **\$100.00**

Please check the box for the information you wish to add to this claim. Uncheck the box to delete the information.

Required*

<input type="checkbox"/> Ambulance information	<input type="checkbox"/> Family planning indicator	<input type="checkbox"/> Purchased service information
<input type="checkbox"/> Ambulance patient count	<input type="checkbox"/> EPSDT indicator	<input type="checkbox"/> Procedure code description
<input type="checkbox"/> Begin therapy date	<input type="checkbox"/> Initial treatment date	<input type="checkbox"/> Referring provider information
<input type="checkbox"/> Certification revision date	<input type="checkbox"/> Last certification date	<input checked="" type="checkbox"/> Rendering provider information
<input type="checkbox"/> Claim line note	<input type="checkbox"/> Last x-ray date	<input type="checkbox"/> Sales tax amount
<input type="checkbox"/> CLIA information	<input type="checkbox"/> Line item control number	<input type="checkbox"/> Service facility information
<input type="checkbox"/> Copay waiver indicator	<input type="checkbox"/> Mammography certification number	<input type="checkbox"/> Shipped date
<input type="checkbox"/> DME Certificate of Medical Necessity	<input type="checkbox"/> Obstetric anesthesia additional units	<input type="checkbox"/> Supervising provider information
<input type="checkbox"/> DMERC condition indicator	<input type="checkbox"/> Ordering provider information	<input type="checkbox"/> Supplemental paperwork information
<input type="checkbox"/> Durable medical equipment certification	<input type="checkbox"/> Postage amount	<input type="checkbox"/> Test date
<input type="checkbox"/> Durable medical equipment service	<input type="checkbox"/> Prior authorization & referral number	<input type="checkbox"/> Test results
<input type="checkbox"/> Emergency indicator		

Rendering provider information

Please note: Either a Primary or Secondary ID must be entered but not both.

Provider type:*

First name:

M.I.:

Last name/Organizational name:*

Suffix:

Primary ID: (NPI)

Secondary ID: (Provider Commercial Number)

Continue with XPressClaim

Back

Save and finish later

Help

Cancel this XPressClaim

When finished, select the **Yes, submit this claim** button.

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Veteran Information **Claim Information** **myAccount Information** **XPressClaim** [Chat](#)

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Supplemental claim information
Provider: CONCORD OTO HEAD & NECK SURG
Veteran's name: Jane Doe
Date of birth: January 01, 1985
Account number: DOE123

Please select a line to which the supplemental information will be added.

Line selection

Line	Procedure code		Charges	Supplemental information
1	99213		\$100.00	Edit
2	36415	5/20/2019	\$20.00	Add

Are you ready to submit this claim?
Yes, submit this claim. **No, take me back to the claim.**

[Continue with XPressClaim](#) [Back](#) [Save and finish later](#) [Help](#) [Cancel this XPressClaim](#)

XPressClaim Submission Confirmation – In-Process Claim

If the claim has edits that need to be resolved internally by PGBA, the XPC submission confirmation page will be returned with the claim number and a message to check status later.

XPressClaim submission confirmation
Veteran's Social Security Number: XXXXX8111
Veteran's name: JANE DOE

Claim number: F179X0001

There are additional edits we must resolve, but we will process this claim on a priority basis. Please check the status of your claim at a later time.

Submit an XPressClaim for another VACCN patient:

[At the same location](#)

[At another location](#)

XPressClaim Submission Confirmation – Finalized Claim

If the claim processes immediately, the Finalized XPC page will be returned with a link to the patient summary receipt.

Your finalized XPressClaim
[Print a summary receipt to give your patient](#) Only available now--this page is not saved and won't be available again.)

Veteran's Social Security Number: XXXXX8111
Veteran's name: TEST TEST


Claim number: F183X0001

Submit an XPressClaim for another VACCN patient:

[At the same location](#)

[At another location](#)

Patient Summary Receipt

Patient Summary Receipt				
Date Completed: February 9, 2024				
Veteran's SSN:		XXXXX8111		
Veteran's Name:		JANE DOE 123 TESTING LANE CITY, NC 28333		
Services Provided by:		JOHN SMITH MD		
Location:		CONCORD HEAD & NECK PO BOX 123 SOUTHAMPTON, PA		
Claim Number:		K002X0000		
Claim Status:		Complete		
Dates of Service:		01/01/2024 through 01/01/2024		
Total Billed:		\$	145.00	
VA Allowed Amount:		\$	3.00	
Non-Covered Amount:		\$	142.00	
Other Health Insurance Allowed Amount:		\$	0.00	
Other Health Insurance Paid Amount:		\$	0.00	
Penalty Amount:		\$	0.00	
Amount Paid to CONCORD HEAD & NECK:		\$	3.00	
Total Amount Paid:		\$	3.00	
<u>Patient Liability Summary</u>				
Patient's Deductible:		\$	0.00	
Patient's Cost-Share:		\$	0.00	
Patient's Copay:		\$	0.00	
Date of Service	Services Provided	Amount Billed	VA Allowed	Remarks
01/01/2024	99213	\$ 125.00	\$ 0.00	This service does not meet VA CCN criteria. AUTHORIZATION/REFERRAL NOT ON FILE FOR THE SERVICES RENDERED.
01/01/2024	36415	<u>20.00</u>	<u>3.00</u>	
		\$ 145.00	\$ 3.00	
Claim Number:		K002X0000		
This is not an official Explanation of Benefits (EOB).				
Please note: In rare cases, some payment values may change between this receipt and the official EOB.				
		Print this receipt	Close	