



Claims Training Webinar

IHSC Provider Portal

September 28, 2026



Table of Contents

Introduction

What to Know

Successful Claims Adjudication

Submitting a Professional Claim

Submitting an Institutional Claim

Submitting a Dental Claim

Electronic Data Interchange (EDI)

Claim Status

Important Claims Processing Information

Provider Resources

Introduction

Acentra Health has partnered with ICE Health Service Corps (IHSC) and is proud to begin managing claims processing, payment administration, and customer support in 2026. As the third-party administrator on behalf of ICE and U.S. Customs and Border Protection, we are launching a new, user-friendly portal designed specifically to improve health care processes and simplify organizational tasks.

On **Oct 12, 2026**, claims submission will go-live and providers will be able to:

- Submit claims via Direct Data Entry (DDE)
- Submit claims via Electronic Data Interchange (EDI)

In this presentation, we will cover the process of submitting a claim through the provider portal.

What to Know



On Oct 12, 2026, Acentra Health is authorized to process claims on behalf of ICE and CBP for claims with service dates of federal fiscal year (FFY) 2025 and after.



All billing providers must create a new IHSC Provider Portal account.



Claims can be submitted through the IHSC Provider Portal or Electronic Data Interchange (EDI). Claims will need a valid authorization number to adjudicate successfully.



The IHSC Provider Portal is accessible through the Acentra Health IHSC website:

<https://ihsc-dhs.acentra.com/>

Successful Claims Adjudication

Successful claims processing and adjudication requires the following:



AN ACTIVE IHSC PROVIDER
PORTAL ACCOUNT.



BILLING PROVIDERS MUST
COMPLETE A NEW
ENROLLMENT APPLICATION
OR REVALIDATION



ELECTRONIC SUBMISSION
OF CLAIMS (DENTAL,
PROFESSIONAL, AND
INSTITUTIONAL) WITH A
VALID AUTHORIZATION
NUMBER.

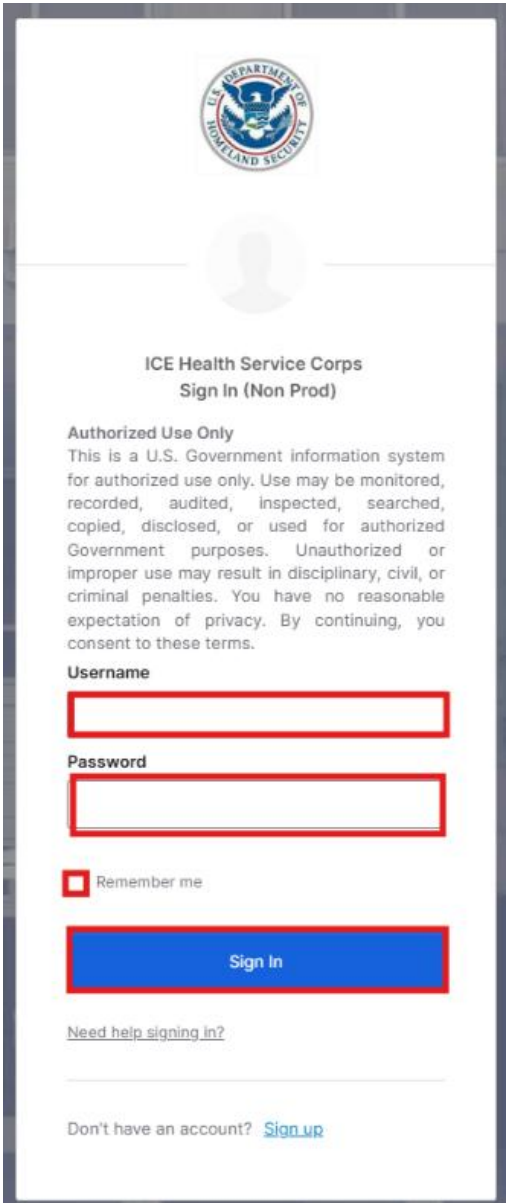
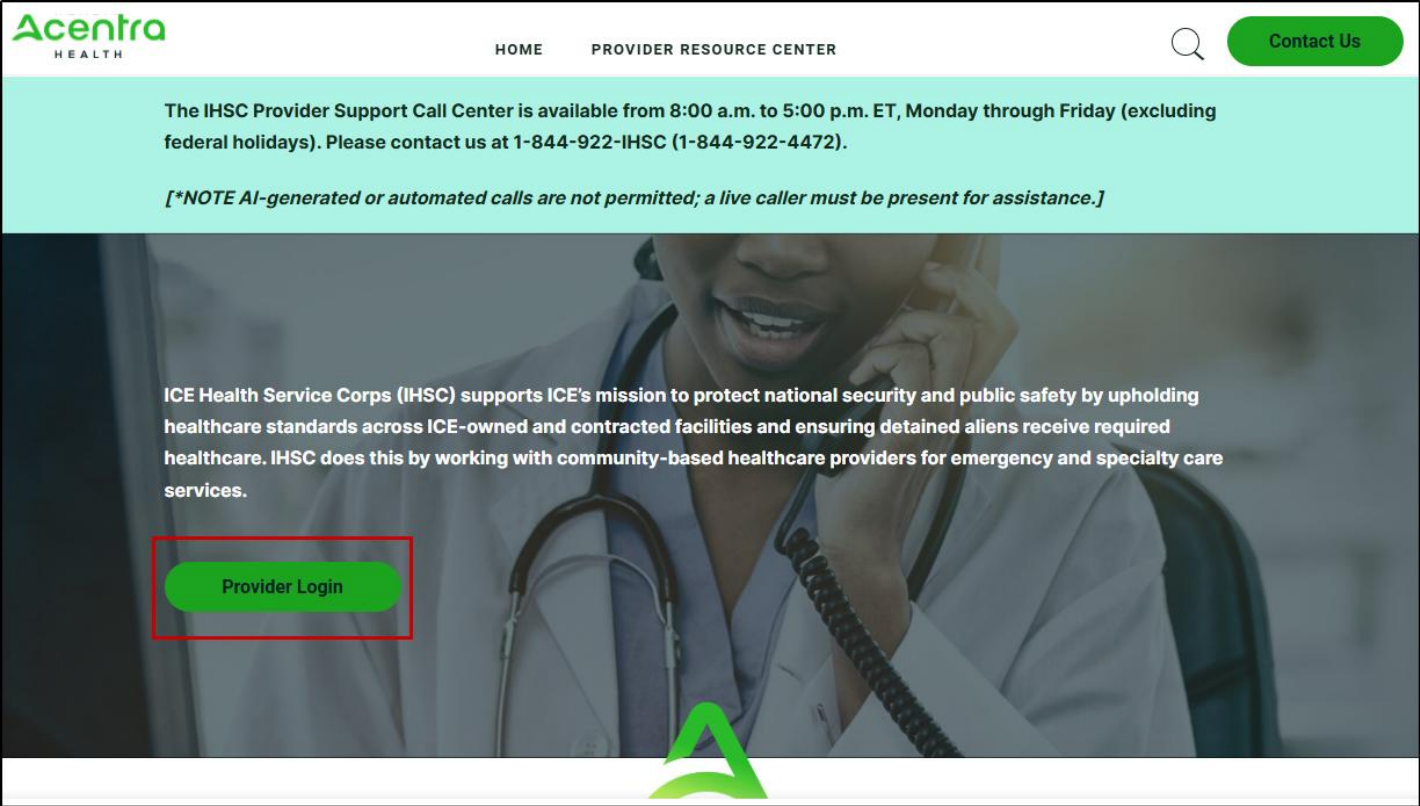
Note: Acentra Health and IHSC do not accept physical mail or process paper claims.



IHSC Provider Portal Log In Process

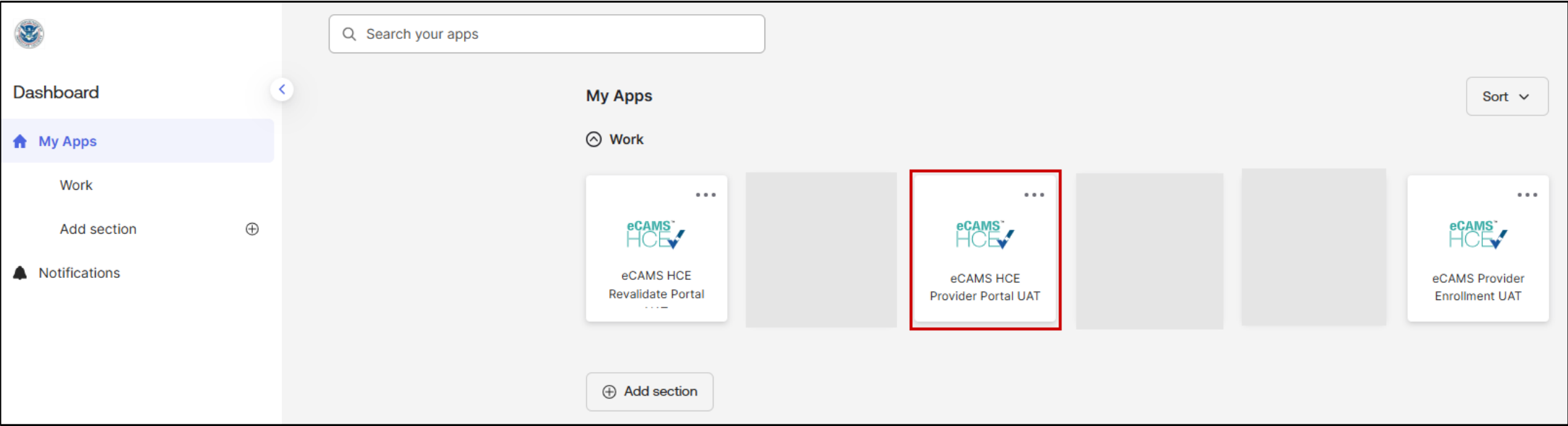
Provider Login

Go to the IHSC Provider Portal website at: <https://login-ihsc-nprod.acentra.com> and enter your username and password to log into the system. Select Sign In to enter the secure IHSC Provider Portal.



Provider Portal Dashboard

After logging in, the system **Dashboard** will display. Select **eCAMS HCE Provider Portal** to continue.



Welcome to the eCAMS Health Care Engine for IHSC

eCAMSTM
HCE 

Select a Domain to use during this session:

* 

Provider Profile

Select a **Profile** to use to submit claims. You will need to select **EXT Provider Claims Submitter**.
Select **Go** to continue.

Welcome to the eCAMS Health Care Engine for IHSC

eCAMSTM

HCE

Profile:

EXT Provider Claims Payment Stat

▼

*

Go

EXT Provider Claims Payment Status Checker

EXT Provider Claims Submitter

EXT Provider File Maintenance

EXT Provider System Administrator

On-line Claims Entry

To start a new claim, in the **IHSC Provider Portal**, select **On-line Claims Entry** under the Online Services and Claims tabs.

Online Services

Claims

Claim Inquiry

View Payment

Claim Adjustment

On-line Claims Entry

Resubmit Denied Claims

Manage Templates

Create Claims from Saved Templates

Provider

Maintain Provider Information

Add Additional Provider

Admin

Maintain Users

My Interactions

Correspondences

My Reminders

Filter By : -- Please Select -- - Read Status -- Please Select -- Go Save Filter My Filters

	Alert Type	Alert Message	Alert Date	Due Date	Read	Attachment
No Records Found!						

Your Recent Online Activities

You have logged in with Account with IP Address

Previous Site Visit: 09/10/2026 12:06:01 PM

Last login failed attempt:

Claim Options

The **Claim Submission** window displays three claim submission options:

- Professional
- Institutional
- Dental

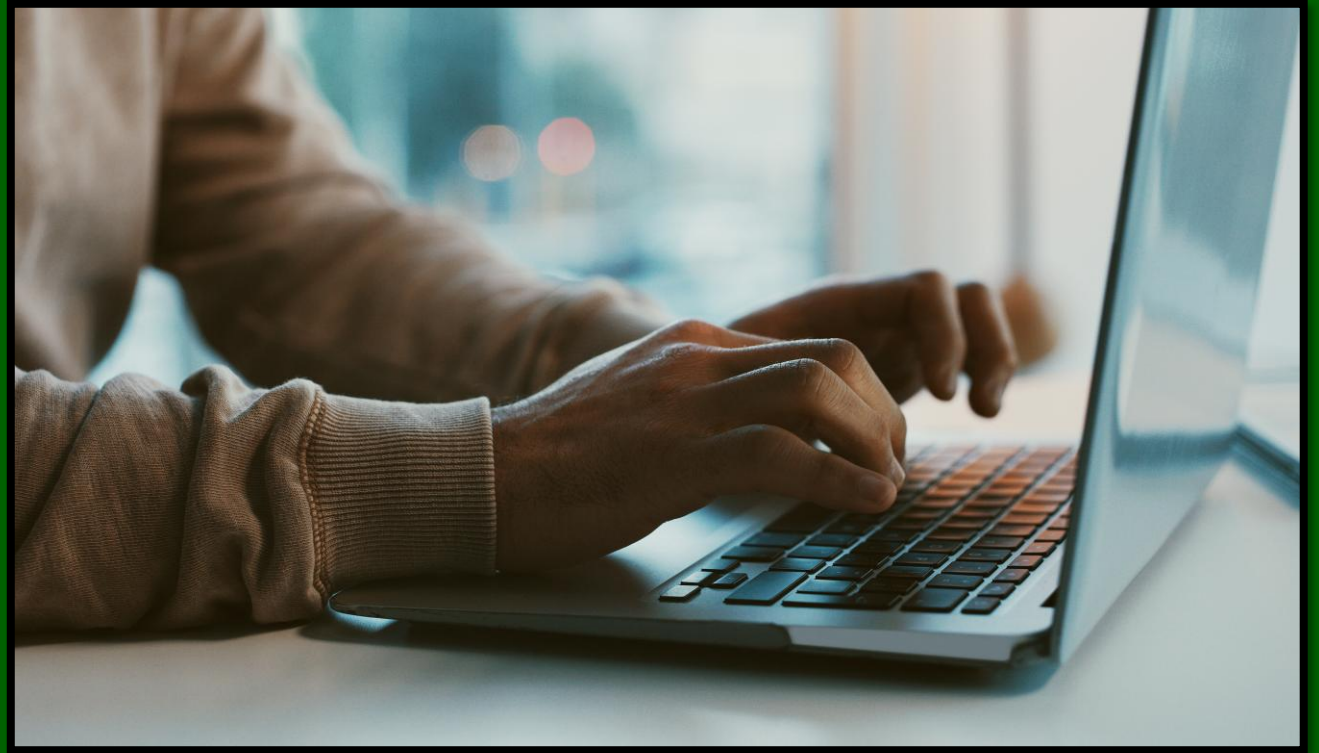
 > [Provider Portal](#) > [Claim Submission](#)

 Close

Choose an Option.

Submit Professional	Submit Professional Use this option for services rendered by providers enrolled as Individual, Group or Ambulatory Surgical Centers.
Submit Institutional	Submit Institutional Use this option for services rendered by providers enrolled as a facility.
Submit Dental	Submit Dental

Professional Claims



Professional Claim – Basic Claim Info

In the **Professional Claim** window, the **Basic Claim Info** section contains the information required to complete the claim. This section includes **Provider**, **Subscriber**, **Claim**, and **Service**.

The **Provider Information** section is pre-populated with enrollment information.

The **Provider ID**, **Tax ID**, **Type** and **Address** fields are system-generated and cannot be modified.

CloseReset

Professional Claim

Note: asterisks (*) denote required fields.

Basic Claim Info

ProviderSubscriberClaimService

Program:-- Please Select --*

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID:2084000Type:HCE Provider IDTaxonomy Code:261QF0400X

Tax ID:848000000

Provider Name:SEWARD COMMUNITY HEALTH CEN

To enter address details, click +Address. A new window will open where address details can be entered.

Address Line 1:417 FIRST AVE*Address Line 2:

Address Line 3:

City/Town:SEWARD*State/Province:Iowa*County:Other*Country:United States*Zip Code:99664-2895+ Address

Note: All fields marked with an asterisk (*) are required fields.

CloseReset

Professional Claim

Note: asterisks (*) denote required fields.

Basic Claim Info

ProviderSubscriberClaimService

Program:-- Please Select --*

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

IHSC - ICE Health Service Corp

Provider Information – Billing Questions

As part of the Provider Information section there are five questions that require review. The system has pre-populated responses for these fields with default values. Review each question carefully and update the information as needed.

Is the Billing Location also the Pay-To Location?

☒Yes ☐No

Is the Billing Location also the Service Facility Location?

☒Yes ☐No

Is the Billing Provider also the Rendering Provider?

☐Yes ☒No

RENDERING PROVIDER INFORMATION

Note: This rendering provider will apply to all lines. If any line requires a different provider, please specify the rendering provider information at that line.

NPI:

*

Type:

-- Please Select --

▼

*

Taxonomy Code:

Is the Billing Provider also the Supervising Provider?

☒Yes ☐No

Is this service the result of a referral?

☐Yes ☒No

Billing Location – Pay-To Location

For the question, “**Is the Billing Location also the Pay-To Location?**”, a different pay-to location can be entered if it differs from the billing location on file.

Is the Billing Location also the Pay-To Location?

☐ Yes ☒ No

PAY-TO LOCATION

To enter address details, click +Address. A new window will open where address details can be entered.

Address Line 1: *

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: -

+ Address

Select **Address** to enter a new address. the **Address Details** pop-up window opens, allowing address information to be entered.

Enter the street number and street name in **Address Line 1**. Then enter the **ZIP Code** and select **Validate Address**.

Note: The system uses USPS address validation to verify the address entered.

Address details

Enter the street number and name in the Address Line 1 field.
Enter the zip code in the Zip Code field.
Select Validate Address.

Address Line 1: *

(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: -

+ Validate Address

OK Cancel

Billing Location – Service Facility Location

For the question, “**Is the Billing Location also the Service Facility Location?**”, a different service facility location can be entered if it differs from the billing location on file.

Is the Billing Location also the Service Facility Location?

No

SERVICING FACILITY LOCATION

Servicing Facility NPI:

*

Type:

*

Provider Name:

To enter address details, click +Address. A new window will open where address details can be entered.

Address Line 1:

*

Address Line 2:

Address Line 3:

City/Town:

*

State/Province:

*

County:

*

Country:

*

Zip Code:

-

+ Address

Select **Address** to enter a new address. the **Address Details** pop-up window opens, allowing address information to be entered.

Enter the street number and street name in **Address Line 1**. Then enter the **ZIP Code** and select **Validate Address**.

Address details

Enter the street number and name in the Address Line 1 field.

Enter the zip code in the Zip Code field.

Select Validate Address.

Address Line 1:

*

Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town:

*

State/Province:

*

County:

*

Country:

*

Zip Code:

-

+ Validate Address

OK

Cancel

Rendering Provider and Supervising Provider

The rendering provider response defaults to “**No**” and the rendering provider’s NPI information is required. Selecting “**Yes**” does not require the rendering provider’s NPI information because the system will determine the billing provider and rendering provider are the same.

Is the Billing Provider also the Rendering Provider?

☐ Yes ☒ No

RENDERING PROVIDER INFORMATION

Note: This rendering provider will apply to all lines. If any line requires a different provider, please specify the rendering provider information at that line.

NPI:

Type:

-- Please Select --

Taxonomy Code:

The supervising provider response defaults to “**Yes**” and no NPI information is required. Selecting “**No**” does require NPI information for the supervising provider.

Is the Billing Provider also the Supervising Provider?

☐ Yes ☒ No

SUPERVISING PROVIDER INFORMATION

NPI:

Type:

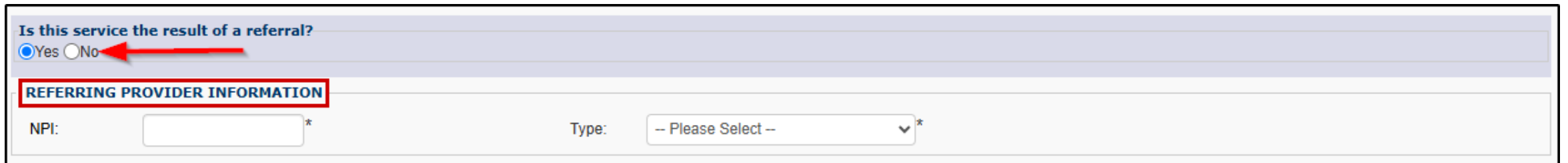
-- Please Select --

Referring Provider

For the question, “**Is this service the result of a referral?**”, indicate whether another provider referred the patient for the services being billed.

The default selection is “**No**”.

If another provider referred the patient for these services, select “**Yes**” and enter the referring provider's **NPI**. For **Type**, select **NPI**.



Is this service the result of a referral?

☒ Yes ☐ No

REFERRING PROVIDER INFORMATION

NPI: *

Type: *

Subscriber/Patient Information

In the **Subscriber/Patient Information** section, enter the patient's information. The term Subscriber and Patient are used interchangeably. Enter the **Patient ID** (Client ID) and the system will populate the **Last Name**, **First Name**, **Date of Birth** and **Gender**.

SUBSCRIBER/PATIENT INFORMATION

SUBSCRIBER/PATIENT

Patient ID:

*

Last Name:

*

Middle Name:

Date of Birth:

MM

DD

CCYY

*

*

*

MM

DD

CCYY

Date of Death:

Patient Paid Amount:

Type:

Client ID

*

First Name:

*

Suffix:

Gender:

-- Please Select --

*

Payer Responsibility:

P-Primary

To enter address details, click +Address. A new window will open where address details can be entered.

Address Line 1:

*

Address Line 2:

Address Line 3:

City/Town:

*

State/Province:

*

County:

*

Country:

*

Zip Code:

-

+ Address

Does Subscriber have any Other Insurance?

☐ Yes

☒ No

Note: The term Subscriber and Patient are used interchangeably

Claim Information

The **Claim Information** requires the **Patient Account Number**, **Place of Service** and **Diagnosis Codes** to be entered. All other fields are optional.

CLAIM INFORMATION

RELEVANT DATES

PRIOR AUTHORIZATION/REFERRAL

Prior Authorization Number:

Referral Number:

CLAIM NOTE

Is this claim accident related?
☐ Yes ☒ No

CLAIM DATA

Patient Account No.:

Place of Service:

Diagnosis Codes (Do not use decimals or spaces)

Diagnosis Codes: 1: 2: 3: 4: 5: 6:
7: 8: 9: 10: 11: 12:

ANESTHESIA RELATED PROCEDURE

CONDITION INFORMATION

DELAY REASON

AMBULANCE INFORMATION

CLAIM DATA

Patient Account No.:

Place of Service:

Diagnosis Codes (Do not use decimals or spaces)

Diagnosis Codes:

ANESTHESIA RELATED PROCEDURE

CONDITION INFORMATION

DELAY REASON

AMBULANCE INFORMATION

BASIC LINE ITEM

BASIC SERVICE LINE ITEM

Service Date From:

Place of Service (If different from header):

Procedure Code:

Submitted Charges:

01-PHARMACY

02-TELEHEALTH

03-SCHOOL

04-HOMELESS SHELTER

05-INDIAN HLTH SVC FREE-STANDING FACILITY

06-INDIAN HLTH SVC PROVIDER-BASED FACILITY

07-TRIBAL 638 FREE-STANDING FACILITY

08-TRIBAL 638 PROVIDER-BASED FACILITY

09-PRISON/CORRECTIONAL FACILITY

10-Telehealth

11-OFFICE

12-Home

13-ASSISTED LIVING FACILITY

14-Group Home

15-MOBILE UNIT

16-TEMPORARY LODGING

17-WALK-IN RETAIL HEALTH CLINIC

18-PLACE OF EMPLOYMENT/WORKSITE

19-OFF CAMPUS-OUTPATIENT HOSPITAL

Accident Related

If the services rendered to the patient were accident related. Select “**Yes**” and enter the accident-related causes. The default answer is “**No**”, which does not require additional information to be entered.

Is this claim accident related?

☒Yes ☐No

RELATED CAUSES INFORMATION

Related Causes:

1 -- Please Select --

* 2 -- Please Select --

Auto Accident State:

-- Please Select --

Auto Accident Country:

Accident Date:

MM

DD

CCYY

*

*

*

RELATED CAUSES INFORMATION

Related Causes:

1 -- Please Select --

* -- Please Select --

AA-Auto Accident

EM-Employment

OA-Other Accident

CLAIM DATA

Patient Account No.:

Relevant Dates and Claim Notes

The **Relevant Dates** field can be expanded to enter specific dates when certain care and services were provided to the patient.

RELEVANT DATES

Onset of Current Illness/symptom Date:

MM

DD

CCYY

Discharge Date:

MM

DD

CCYY

Relinquished Care Date:

MM

DD

CCYY

Admission Date:

MM

DD

CCYY

Assumed Care Date:

MM

DD

CCYY

Hearing or Vision Prescription Date:

MM

DD

CCYY

The **Claim Note** field can be expanded to enter notes about the claim or patient’s care.

CLAIM NOTE

Claim Note:

Characters Remaining:

500

Anesthesia, Condition and Delay Reason

The **Anesthesia Related Procedure** field expands to allow the user to enter anesthesia procedure code.

ANESTHESIA RELATED PROCEDURE

Principle HCPCS Code: *

Other HCPCS Code:

The **Condition Information** field can be expanded to enter condition codes.

CONDITION INFORMATION

1 Condition Code: *

Add Another

Delay Reason is used to indicate why the claim was not submitted within the standard filing timeframe.

DELAY REASON

Delay Reason Code:

-- Please Select --

*

AMBULANCE INFORMATION

BASIC LINE ITEM

BASIC SERVICE LINE ITEM

Service Date From:

Place of Service (If different from header):

Procedure Code:

Submitted Charges:

-- Please Select --

1-Proof of Eligibility Unknown or Unavailable

10-Administration Delay in the Prior Approval Process

11-Other

15-Natural Disaster

2-Litigation

3-Authorization Delays

4-Delay in Certifying Provider

5-Delay in Supplying Billing Forms

6-Delay in Delivery of Custom Made Appliances

7-Third Party Processing Delay

8-Delay in Eligibility Determination

9-Claim Denied Unrelated to Billing Limitation Rules

Ambulance Information

If the patient required ambulance transportation services, the **Ambulance Information** field can be expanded to enter the **Ambulance Address Information**, **Ambulance Transport Information** and **Ambulance Certification**.

AMBULANCE INFORMATION

Ambulance Address Information

Ambulance Transport Information

Ambulance Certification

The Pick-up address and the Drop-off address can be entered in the **Ambulance Address Information** field.

Ambulance Address Information

Pick Up Location Details

Address Line 1:

*

Address Line 2:

City:

*

State:

-- Please Select --

*

Zip Code:

*

Country:

-- Please Select --

*

Drop-off Location Details

Org/Last Name:

Address Line 1:

*

Address Line 2:

City:

*

State:

-- Please Select --

*

Zip Code:

*

Country:

-- Please Select --

*

Ambulance Transport Information

If entering **Ambulance Information**, the transportation reason and distance can be entered in the **Ambulance Transport Information** field.

Select an appropriate reason code from the drop-down list in the **Transportation Reason Code** field.

Ambulance Transport Information

Transportation Reason Code:

-- Please Select --

*

Transport Distance:

* Miles

Patient Weight:

lbs.

Round Trip Purpose Description:

Characters Remaining:

80

Stretcher Purpose Description:

Characters Remaining:

80

Transportation Reason Code:

-- Please Select --

*

Transport Distance:

-- Please Select --

Patient Weight:

Round Trip Purpose Description:

Characters Remaining:

A-Patient trnsprt to near fcly

B-Patient trnsprt for bnft physn

C-Patient trnsprt to family mbr

D-Patient trnsprt to Specilist

E-Patient Trnsfr to Rehab fcly

Ambulance Certification

To enter a Condition Indicator, expand the **Ambulance Certification** field. Use the drop-down list to select the most appropriate indicator. Up to five (5) indicators can be entered.

 Ambulance Certification

Condition Indicator: 1:

-- Please Select --

 * 2:

-- Please Select --

 3:

-- Please Select --

 4:

-- Please Select --

5:

-- Please Select --

Condition Indicator: 1:

-- Please Select --

5:

-- Please Select --

BASIC LINE ITEM

01-Ptnt was admitted to hospital

04-Patient was moved by stretcher

05-Ptnt unconscious or in shock

06-Ptnt transported emergency strn

07-Ptnt had to be phy. restrained

08-Ptnt had visible hemorrhaging

09-Amb. srvc medically necessary

12-Patient is confined to a bed or chair

Service Date From:

27 | Privileged and Confidential

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Basic Line-Item Information

In the **Basic Line-Item Information** section enter the service line details.

Required fields are:

- Service Dates
- Procedure Code
- Submitted Charges
- Units/Quantity
- Diagnosis Pointer

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date From:

MM DD CCYY

Service Date To:

MM DD CCYY

Place of Service (If different from header):

-- Please Select --

Procedure Code:

Modifiers:

Submitted Charges:

1: 2: 3: 4:

Units/Quantity:

1: -- Please Select -- 2: -- Please Select -- 3: -- Please Select -- 4: -- Please Select --

UOM:

UNT-Unit

Approved Units:

Claim Note:

500

Rendering NPI (If different from header):

Type: -- Please Select --

Taxonomy Code:

Ordering NPI:

Type: -- Please Select --

Referring NPI (If different from header):

Type: -- Please Select --

Is the Header Service Facility Location also the Service Line Facility Location?

☒ Yes ☐ No

LINE DRUG INFORMATION

Does Subscriber have any Other Insurance?

☐ Yes ☒ No

Add Service Line Item

Update Service Line Item

Service Line Facility Location

For the question, “**Is the Header Service Facility Location also the Service Line Facility Location?**”, the default answer is “**Yes**”. If “**No**” is selected, then the Servicing Provider’s NPI, Name and Address must be entered.

Is the Header Service Facility Location also the Service Line Facility Location?

☐ Yes ☒ No

Servicing Facility Location

Servicing Facility Provider NPI:

Type:

Provider Name:

To enter address details, click +Address. A new window will open where address details can be entered.

Address Line 1:

Address Line 2:

Address Line 3:

City/Town:

State/Province:

County:

Country:

Zip Code:

+ Address

Drug Information

If drug information needs to be entered, the **Line Drug Information** field can be expanded to enter drug information.

LINE DRUG INFORMATION

National Drug Code:

*

Quantity:

*

Unit:

-- Please Select --

*

Qualifier:

-- Please Select --

Prescription/Link No:

Prescription Date:

MM

DD

CCYY

Adding a Service Line

Once the service line details have been entered, select **Add Service Line** to add the service line to the claim. A pop-up window will display a confirmation message when a service line has successfully been added.

LINE DRUG INFORMATION

Does Subscriber have any Other Insurance?
☐ Yes ☒ No

Add Service Line Item

Update Service Line Item

Previously Entered Line Item Information

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

Total Units/Quantity: 0.000

Total Submitted Charges \$ 0.00

Line No	Service Dates From	To	Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	Approved Units	PA Number
---------	--------------------	----	------------	-----------	--	--	--	-----------------	--	--	--	-------------------	-------	----------------	-----------

Top

Submit Claim

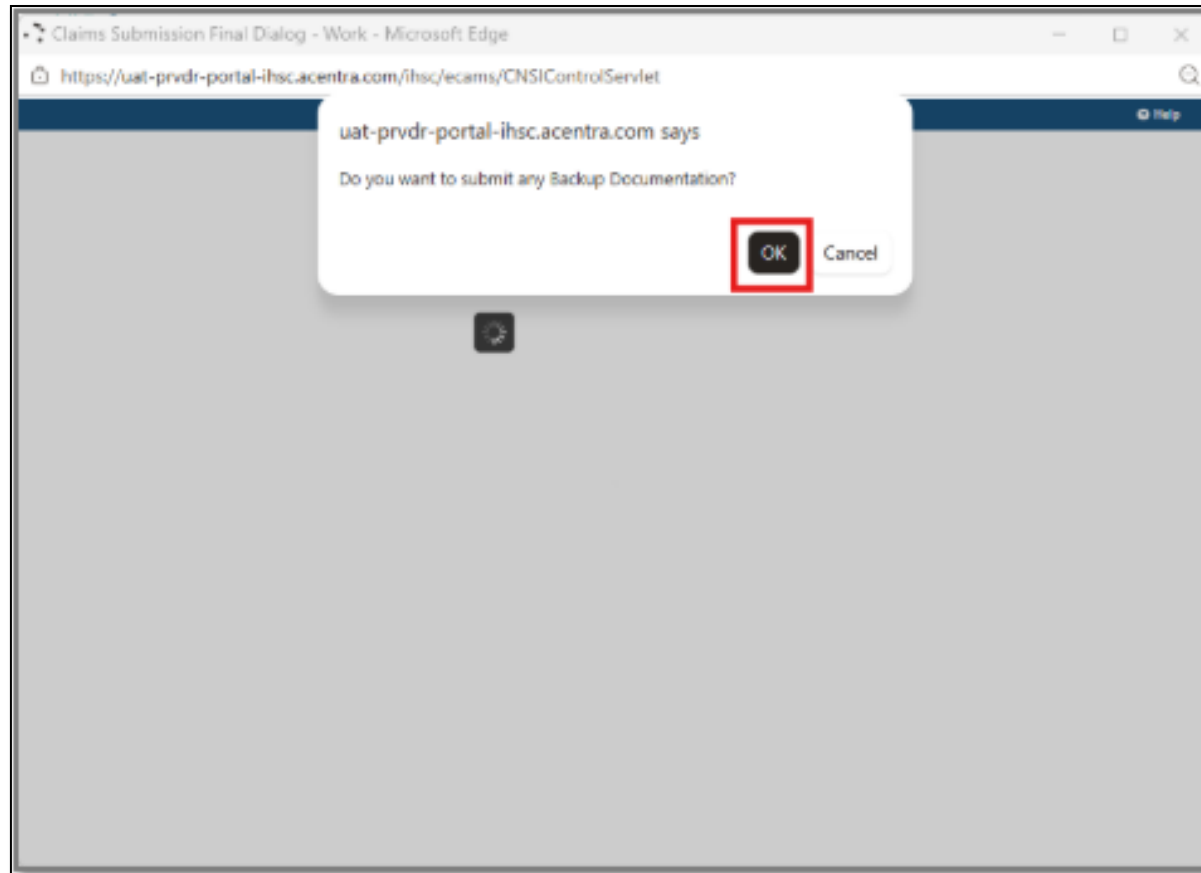
Alert Message

Service line is added successfully.

OK

Claims Submission Final Dialog

A Claims Submission Final Dialog pop-up window appears to confirm the claim submission. Select **OK** to continue with the claim submission.





Institutional Claims

Institutional Claim – Provider Information

In the **Institutional Claim** window, the **Basic Claim Info** section contains the information required to complete the claim. This section includes **Provider**, **Subscriber**, **Claim** and **Service**. The **Provider Information** section is pre-populated with enrollment information. The **Provider ID**, **Tax ID**, **Type** and **Address** fields are system-generated and cannot be modified.

Close

Reset

Institutional Claim

Note: asterisks (*) denote required fields.

Basic Claim Info

Provider | Subscriber | Claim | Service

Program:

-- Please Select --

*

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID:

208448

Type:

HCE Provider ID

Taxonomy Code:

261QF0400X

Tax ID:

04862010

Provider Name:

SEWARD COMMUNITY HEALTH CEN

To enter address details, click +Address. A new window will open where address details can be entered.

Address Line 1:

101 FIRST AVE

*

Address Line 2:

Address Line 3:

City/Town:

SEWARD

*

State/Province:

Nebraska

*

County:

Other

*

Country:

United States

*

Zip Code:

68104

- 2895

+ Address

Note: All fields marked with an asterisk (*) are required fields.

Institutional Claim

Note: asterisks (*) denote required fields.

Basic Claim Info

Provider | Subscriber | Claim | Service

Program:

-- Please Select --

*

PROVIDER INFO

-- Please Select --

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BILLING PROVIDER INFORMATION

Billing Location - Pay-To Location

For the question, “**Is the Billing Location also the Pay-To Location?**”, a different pay-to location can be entered if it differs from the billing location on file.

Select **Address** to enter a new address. the **Address Details** pop-up window opens, allowing address information to be entered.

Enter the street number and street name in **Address Line 1**. Then enter the **ZIP Code** and select **Validate Address**.

Is the Billing Location also the Pay-To Location?

☐ Yes ☒ No

PAY-TO LOCATION

To enter address details, click +Address. A new window will open where address details can be entered.

Address Line 1:

Address Line 2:

Address Line 3:

City/Town:

State/Province:

County:

Country:

Zip Code:

+ Address

Note: The system uses USPS address validation to verify the address entered.

Address details

Enter the street number and name in the Address Line 1 field.
Enter the zip code in the Zip Code field.
Select Validate Address.

Address Line 1:

Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town:

State/Province:

County:

Country:

Zip Code:

+ Validate Address

OK

Cancel

Attending Provider

The **Attending Provider** Information is optional. If an attending provider information needs to be included, add the NPI, Type and Taxonomy code for the attending provider in the **Attending Provider Information** field.

Is the Billing Location also the Pay-To Location?
☒ Yes ☐ No

ATTENDING PROVIDER INFORMATION

NPI:

Type:

-- Please Select --

Taxonomy Code:

Subscriber/Patient Information

In the **Subscriber/Patient Information** section, enter the patient's information. The term Subscriber and Patient are used interchangeably. Enter the **Patient ID** (Client ID) and the system will populate the **Last Name**, **First Name**, **Date of Birth** and **Gender**.

SUBSCRIBER/PATIENT INFORMATION

SUBSCRIBER/PATIENT

Patient ID:

*

Type:

Client ID

*

Last Name:

*

First Name:

*

Middle Name:

Suffix:

Date of Birth:

MM

DD

CCYY

*

Gender:

-- Please Select --

*

Payer Responsibility:

P-Primary

Patient Estimated Amount:

To enter address details, click +Address. A new window will open where address details can be entered.

Address Line 1:

*

Address Line 2:

Address Line 3:

City/Town:

*

State/Province:

*

County:

*

Country:

*

Zip Code:

-

+ Address

Does Subscriber have any Other Insurance?

Yes

No

Note: The term Subscriber and Patient are used interchangeably.

Other Insurance Information

At the bottom of the **Subscriber/Patient Information** section, the question, “**Does Subscriber have any Other Insurance?**”, displays.

If the provider does have other insurance, then select “**Yes**” and enter the other insurance information.

Does Subscriber have any Other Insurance?

☒ Yes ☐ No

OTHER INSURANCE INFORMATION

1. Other Payer Information

Other Payer ID:

*

Other Payer Type:

-- Please Select --

*

Other Payer Last Name or Organization Name:

*

Amount Paid \$:

Amount Patient Liable \$:

Paid Date:

MM

DD

CCYY

Claim Adjustment Group Code:

-- Please Select --

*

Claim Adjustment Reason Code:

-- Please Select --

*

Amount \$:

*

Quantity:

Add Another:

Add Another Payer

Claim Information

The **Claim Information** section contains the information required to complete and submit the claim. The fields that must be completed are:

- Patient Account Number
- Type of Facility
- Claim Frequency
- Bill Classification
- Statement Dates
- Admission Source
- Patient Status
- Principal Diagnosis

CLAIM INFORMATION

CLAIM DATA

Patient Account No.:

*

Medical Record Number:

Type Of Facility:

-- Please Select --

*

Claim Frequency:

-- Please Select --

*

Bill Classification:

-- Please Select --

*

Statement Dates:

From:

MM

*

DD

*

CCYY

*

To:

MM

*

DD

*

CCYY

*

Admission Date/Hour:

MM

DD

CCYY

HH

MM

Admission Type:

-- Please Select --

Admission Source:

-- Please Select --

*

Discharge Hour:

HH

MM

Patient Status:

-- Please Select --

*

Auto Accident State:

-- Please Select --

DIAGNOSIS INFORMATION (Do not use decimals or spaces)

Principal Diagnosis Code:

*

Present On Admission:

-- Please Se

Admitting Diagnosis Code:

PPS/DRG:

Reason For Visit:

1:

2:

3:

1 E-Code:

Present On Admission:

-- Please Se

[Add Another](#)

Additional Claim Information

At the bottom of the **Claim Information** section, there are multiple expandable fields where additional claim information can be added.

OTHER DIAGNOSIS INFORMATION

CONDITION INFORMATION

OCCURRENCE INFORMATION

OCCURRENCE SPAN INFORMATION

VALUE INFORMATION

DELAY REASON

PRIOR AUTHORIZATION/REFERRAL NUMBER

Prior Authorization Number:

Referral Number:

PROCEDURE INFORMATION

OPERATING PHYSICIAN INFORMATION

OTHER OPERATING PHYSICIAN INFORMATION

RENDERING PHYSICIAN INFORMATION

REFERRING PHYSICIAN INFORMATION

CLAIM NOTE

Top

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Diagnosis, Condition and Occurrence Information

The **Other Diagnosis Information** field can be expanded to add additional diagnoses.

OTHER DIAGNOSIS INFORMATION

1 Other Diagnosis Code: *

Present On Admission: -- Please Se ▾

Add Another

Additional condition codes can be entered by expanding the **Condition Information** field.

CONDITION INFORMATION

1 Condition Code: *

Add Another

To enter occurrence codes, expand the **Occurrence Information** field.

OCCURRENCE INFORMATION

1 Occurrence Code: *

Occurrence Date: MM DD CCYY ***

Add Another

For length of stay that requires a date span for the occurrence code, expand the **Occurrence Span Information** field to enter span codes and dates.

OCCURRENCE SPAN INFORMATION

1 Occurrence Span Code *

From Date: MM DD CCYY ***

Through Date: MM DD CCYY ***

Add Another

Value Information

To enter value codes, expand the **Value Information** field. If the claim is being submitted late and impacting timely filing, use the drop-down menu to view a list of reasons for the **Delay Reason** field. Select the most appropriate reason the claim submission missed timely filing.

VALUE INFORMATION

1 Value Code:

Value Amount:

Add Another

DELAY REASON

Delay Reason Code:

-- Please Select --

PRIOR AUTHORIZATION

Prior Authorization Number:

-- Please Select --

PROCEDURE INFORMATION

OPERATING PHYSICIAN

OTHER OPERATING PHYSICIAN

RENDERING PHYSICIAN

REFERRING PHYSICIAN

CLAIM NOTE

SERVICE LINE ITEMS

Service Line Items

1-Proof of Eligibility Unknown or Unavailable

10-Administration Delay in the Prior Approval Process

11-Other

15-Natural Disaster

2-Litigation

3-Authorization Delays

4-Delay in Certifying Provider

5-Delay in Supplying Billing Forms

6-Delay in Delivery of Custom Made Appliances

7-Third Party Processing Delay

8-Delay in Eligibility Determination

9-Claim Denied Unrelated to Billing Limitation Rules

Prior Authorization, Procedure, Operating Physician Information

For services that require a prior authorization or referral, enter the information in the **Prior Authorization/Referral Number** fields.

PRIOR AUTHORIZATION/REFERRAL NUMBER

Prior Authorization Number:

Referral Number:

In the **Procedure Information** field, the principal procedure code information can be entered.

PROCEDURE INFORMATION

Principal Procedure Code:

Procedure Date:

MM

DD

CCYY

Other Procedure Information

1 Other Procedure Code:

Procedure Date:

MM

DD

CCYY

Add Another

To enter the operating physician NPI information, expand the **Operating Physician Information** field.

OPERATING PHYSICIAN INFORMATION

Provider ID:

Type:

-- Please Select --

Expand the **Other Operating Physician Information** field to enter additional operating physician information.

OTHER OPERATING PHYSICIAN INFORMATION

Provider ID:

Type:

-- Please Select --

Rendering Physician, Referring Physician, Claim Note

Expand the **Rendering Physician Information** field to enter the rendering provider’s NPI information.

[-]

RENDERING PHYSICIAN INFORMATION

Provider ID:

Type:

-- Please Select --

Expand the **Referring Physician Information** field to enter the referring provider’s NPI information.

[-]

REFERRING PHYSICIAN INFORMATION

Provider ID

Type:

-- Please Select --

To add a note to the claim, expand the **Claim Note** field.

[-]

CLAIM NOTE

Claim Note:

Characters Remaining: 500

Service Line Item Information

The **Service Line Item Information** section contains the service line details required to complete and submit the claim.

Required fields are:

- Revenue Code
- Service Date
- Last Date of Service
- Service Units
- Total Line Charges

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code:

HCPCS Code:

Service Date:

MM

DD

CCYY

Last Date of Service:

MM

DD

CCYY

Service Units:

Total Line Charges:

Operating Physician NPI (If different from header):

Other Operating Physician NPI (If different from header):

Rendering Physician NPI (If different from header):

Referring Physician NPI (If different from header):

Modifiers:

1: 2: 3: 4:

Approved Units:

Non-covered Line Charges:

Type:

-- Please Select --

Type:

-- Please Select --

Type:

-- Please Select --

Type:

-- Please Select --

LINE DRUG INFORMATION

Does Subscriber have any Other Insurance?

Yes

No

Add Service Line Item

Update Service Line Item

Previously Entered Line Item Information

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

Total Units/Quantity: 0.000

Total Submitted Charges \$ 0.00

Line No	Revenue Code	HCPCS Code	Modifiers	Dates	Units	Approved Units	Charges	Non-covered Charges
			1234	Service DateLast DOS				

Drug Information and Other Insurance

At the bottom of the **Service Line-Item Information** section the **Line Drug Information** field can be expanded, and drug information can be entered.

Additionally, the question, “Does the Subscriber have any Other Insurance?”, displays.

The default answer is “**No**”, and no further information is needed. If “**Yes**” is selected, enter the other insurance information.

LINE DRUG INFORMATION

National Drug Code:

*

Quantity:

*

Unit:

-- Please Select --

*

Qualifier:

-- Please Select --

Prescription/Link No:

Does Subscriber have any Other Insurance?

☒ Yes ☐ No

1. Other Payer ID:

*

Amount Paid \$:

*

Amount Patient Liable \$:

Paid Date:

mm

dd

ccyy

Claim Adjustment Group Code:

-- Please Select --

*

Claim Adjustment Reason Code:

-- Please Select --

*

Amount \$:

*

Quantity:

[Add Another.](#)

[Add Another Payer.](#)

Adding a Service Line

Once the service line details have been entered, select Add Service Line to add the service line to the claim. The service line will appear under the **Previously Entered Line Item Information** section. A pop-up window will display a confirmation message when a service line has successfully been added.

LINE DRUG INFORMATION

Does Subscriber have any Other Insurance?
☐ Yes ☒ No

Add Service Line Item

Update Service Line Item

Previously Entered Line Item Information

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

Total Units/Quantity: 0.000

Total Submitted Charges \$ 0.00

Line Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	Approved PA Units	PA Number
No	From		1	2	3	4	1	2	3	4				

Top

Submit Claim

Alert Message

Service line is added successfully.

OK

Claim Submission

To update a service line, select the hyperlink under the **Line No column** to open the line item and make any needed changes or updates. Once changes are made select the **Update Service Line Item** to finalize the update.

To delete the line item, select the **Delete** option for the line item.

Once all claim information and service line items have been entered, select **Submit Claim** to submit the claim for processing.

Previously Entered Line Item Information

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

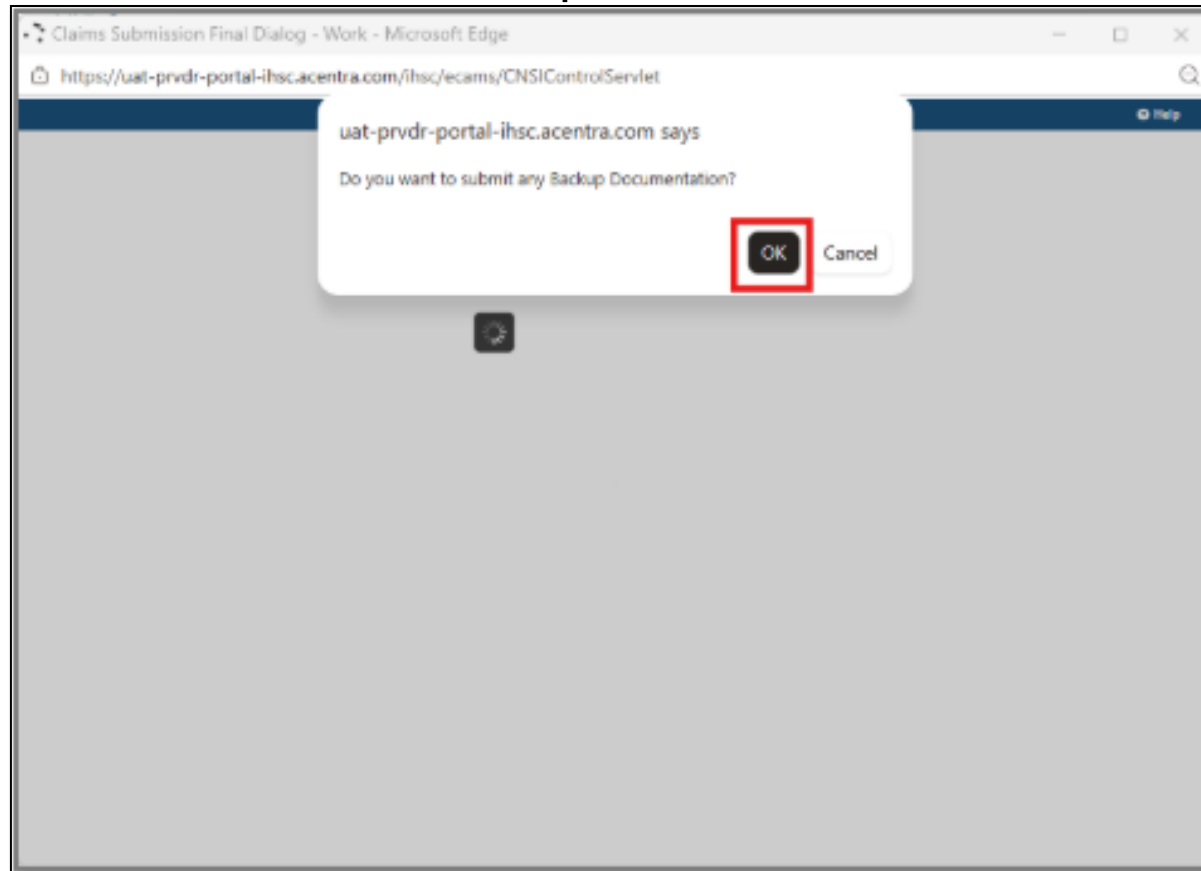
Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Approved Units	Charges	Non-covered Charges	
			1	2	3	4	Service Date	Last DOS					
1	0360						07/05/2026	07/05/2026	2		\$ 4,200.00		Delete

[Top](#)

Claims Submission Final Dialog

A Claims Submission Final Dialog pop-up window appears and displays the question, “**Do you want to submit any backup documentation?**”.

Select **OK** to continue with the claim submission process.





Dental Claims

Dental Claim – Provider Information

In the **Dental Claim** window, the **Basic Claim Info** section contains the information required to complete the claim. This section includes **Provider**, **Subscriber**, **Claim**, and **Service**.

The **Provider Information** section is pre-populated with enrollment information.

The **Provider ID**, **Tax ID**, **Type** and **Address** fields are system-generated and cannot be modified.

The screenshot shows the 'Dental Claim' window with the 'Basic Claim Info' tab selected. The 'Program' dropdown is highlighted with a red box. Below it, the 'PROVIDER INFORMATION' section is visible, containing fields for 'Provider ID', 'Tax ID', 'Type', 'Taxonomy Code', 'Provider Name', and 'Address'. The 'Address' field is also highlighted with a red box. The 'Billing Provider Information' section is partially visible at the bottom.

Note: All fields marked with an asterisk (*) are required fields.

This screenshot shows the 'Dental Claim' window with the 'Basic Claim Info' tab selected. The 'Program' dropdown menu is open, showing a list of options including 'IHSC - ICE Health Service Corp'. The 'Close' and 'Reset' buttons are highlighted with red boxes. The 'Basic Claim Info' tab is also highlighted with a red box.

Provider Information – Billing Questions

As part of the Provider Information section there are four questions that require review. The system has pre-populated responses for these fields with default values. Review each question carefully and update the information as needed.

Is the Billing Location also the Pay-To Location?

☒Yes ☐No

Is the Billing Provider also the Rendering Provider?

☐Yes ☒No

RENDERING PROVIDER INFORMATION

Note: This rendering provider will apply to all lines. If any line requires a different provider, please specify the rendering provider information at that line.

NPI:

*

Type:

-- Please Select --

▼

*

Taxonomy Code:

Is the Billing Provider also the Supervising Provider?

☒Yes ☐No

Is this service the result of a referral?

☐Yes ☒No

Billing Location - Pay-To Location

For the question, “**Is the Billing Location also the Pay-To Location?**”, a different pay-to location can be entered if it differs from the billing location on file.

Select **Address** to enter a new address. the **Address Details** pop-up window opens, allowing address information to be entered.

Enter the street number and street name in **Address Line 1**. Then enter the **ZIP Code** and select **Validate Address**.

Is the Billing Location also the Pay-To Location?

☐ Yes ☒ No

PAY-TO LOCATION

To enter address details, click +Address. A new window will open where address details can be entered.

Address Line 1:

*

Address Line 2:

Address Line 3:

City/Town:

▼

*

State/Province:

▼

*

County:

▼

*

Country:

▼

*

Zip Code:

-

+ Address

Note: The system uses USPS address validation to verify the address entered.

Address details

Enter the street number and name in the Address Line 1 field.

Enter the zip code in the Zip Code field.

Select Validate Address.

Address Line 1:

*

Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town:

▼

*

State/Province:

▼

*

County:

▼

*

Country:

▼

*

Zip Code:

-

+ Validate Address

OK

Cancel

Rendering Provider and Supervising Provider

The rendering provider response defaults to “**No**” and the rendering provider’s NPI information is required. Selecting “**Yes**” does not require the rendering provider’s NPI information because the system will determine the billing provider and rendering provider are the same.

Is the Billing Provider also the Rendering Provider?

☐ Yes ☒ No

RENDERING PROVIDER INFORMATION

Note: This rendering provider will apply to all lines. If any line requires a different provider, please specify the rendering provider information at that line.

NPI:

Type:

-- Please Select --

Taxonomy Code:

The supervising provider response defaults to “**Yes**” and no NPI information is required. Selecting “**No**” does require NPI information for the supervising provider.

Is the Billing Provider also the Supervising Provider?

☐ Yes ☒ No

SUPERVISING PROVIDER INFORMATION

NPI:

Type:

-- Please Select --

Referring Provider

For the question, “**Is this service the result of a referral?**”, indicate whether another provider referred the patient for the services being billed.

The default selection is “**No**”.

If another provider referred the patient for these services, select “**Yes**” and enter the referring provider's **NPI**. For **Type**, select **NPI**.

Is this service the result of a referral?

☒Yes ☐No

REFERRING PROVIDER INFORMATION

NPI:

*

Type:

-- Please Select --

▼

*

Taxonomy Code:

Subscriber/Patient Information

In the **Subscriber/Patient Information** section, enter the patient's information. The term Subscriber and Patient are used interchangeably. Enter the **Patient ID** (Client ID) and the system will populate the **Last Name**, **First Name**, **Date of Birth** and **Gender**.

SUBSCRIBER/PATIENT INFORMATION

SUBSCRIBER/PATIENT

Patient ID:

*

Last Name:

*

Middle Name:

Date of Birth:

MM

*

DD

*

CCYY

*

Payer Responsibility:

P-Primary

Type:

Client ID

First Name:

*

Suffix:

Gender:

-- Please Select --

*

Patient Paid Amount:

To enter address details, click +Address. A new window will open where address details can be entered.

Address Line 1:

*

Address Line 2:

Address Line 3:

City/Town:

*

State/Province:

*

County:

*

Country:

*

Zip Code:

+ Address

Does Subscriber have any Other Insurance?

Yes

No

Note: The term Subscriber and Patient are used interchangeably

Other Insurance Information

For the question, “**Does Subscriber have any Other Insurance?**”, the response defaults to “**No**”. If the patient has another insurance that will cover the services, select “**Yes**” to enter other insurance information.

Does Subscriber have any Other Insurance?

☒ Yes ☐ No

OTHER INSURANCE INFORMATION

1. Other Payer Information

Other Payer ID:

*

Other Payer Type:

-- Please Select --

*

Other Payer Last Name or Organization Name:

*

Amount Paid \$:

Amount Patient Liable \$:

Paid Date:

MM

DD

CCYY

Claim Adjustment Group Code:

-- Please Select --

*

Claim Adjustment Reason Code:

-- Please Select --

*

Amount \$:

*

Quantity:

Add Another:

Add Another Payer

Claim Information

In the Claim Information section, the following fields are required:

- Patient Account Number
- Place of Service
- Service Start Date
- Service End Date

If the services require a prior authorization, enter the prior authorization in the **Prior Authorization Number** field.

CLAIM INFORMATION

CLAIM DATA

Patient Account No:

Place of Service:

-- Please Select --

Service Start Date:

MM

DD

CCYY

Service End Date:

MM

DD

CCYY

PRIOR AUTHORIZATION/REFERRAL NUMBER

Prior Authorization Number:

Referral Number:

+

DELAY REASON

+

CLAIM NOTE

Is this claim accident related?

Yes

No

Is this claim related to orthodontic services?

Yes

No

Does this claim require a diagnosis code?

Yes

No

If a patient was given a referral, enter the referral number in the **Referral Number** field.

Delay Reason and Claim Note

DELAY REASON

Delay Reason Code: -- Please Select --

CLAIM NOTE

Claim Note:

Characters Remaining: 500

Is this claim accident related?
☐ Yes ☒ No

Is this claim related to a pre-existing condition?
☐ Yes ☒ No

Does this claim require prior approval?
☐ Yes ☒ No

- 1-Proof of Eligibility Unknown or Unavailable
- 10-Administration Delay in the Prior Approval Process
- 11-Other
- 15-Natural Disaster
- 2-Litigation
- 3-Authorization Delays
- 4-Delay in Certifying Provider
- 5-Delay in Supplying Billing Forms
- 6-Delay in Delivery of Custom Made Appliances
- 7-Third Party Processing Delay
- 8-Delay in Eligibility Determination
- 9-Claim Denied Unrelated to Billing Limitation Rules

There are a few expandable fields in the claim information section. Select the plus (+) to open the following fields:

- **Delay Reason** – if the claim submission was delayed, and impacts timely filing, select the delay reason code using the drop-down arrow to view the list.
- **Claim Note** – the claim note field allows the provider to enter a note regarding the claim.

CLAIM NOTE

Claim Note:

Characters Remaining: 500

Accident Information and Orthodontic Services

If the claim is accident related, select “**Yes**” to enter the accident information.

Is this claim accident related?
☒ Yes ☐ No

RELATED CAUSES INFORMATION

Related Causes: 1.

-- Please Select --

 2.

-- Please Select --

Auto Accident State:

AA-Auto Accident
EM-Employment
OA-Other Accident

Accident Country:

Accident Date:

MM

DD

CCYY

If the claim is related to orthodontic services, select “**Yes**” to enter orthodontic treatment information.

Is this claim related to orthodontic services?
☒ Yes ☐ No

ORTHODONTIC TREATMENT

Orthodontics Treatment Months:

Orthodontics Treatment Months Remaining:

Appliance Placement Date:

MM

DD

CCYY

TOOTH STATUS

1 Tooth Number: Tooth Status Code:

-- Please Select --

[Add Another.](#)

Diagnosis Code

The last question in the **Claim Information** section is:

Does this claim require a diagnosis code?

The response defaults to “No” and no additional information is needed. Selecting “Yes” will require at least one diagnosis code to be entered.

Does this claim require a diagnosis code?

☒ Yes ☐ No

Diagnosis Codes (Do not use decimals or spaces)

Diagnosis Codes: 1: * 2: 3: 4:

Basic Line Item Information

In the Basic Line Item Information section, the service information is entered. The required fields are:

- Service Date
- Fee
- Procedure Code
- Quantity

All other fields, such as Oral Cavity Designation and Appliance Placement Date, can be completed if needed.

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date:

MM

DD

CCYY

*

*

*

Appliance Placement Date:

MM

DD

CCYY

Place of Service (If different from header):

-- Please Select --

Oral Cavity Designation:

1: -- Please Select --

2: -- Please Select --

3: -- Please Select --

4: -- Please Select --

5: -- Please Select --

Fees:

*

+

 Tooth Information

Procedure Code:

*

Quantity:

*

Approved Units:

Diagnosis Pointers:

1: -- Please Select --

2: -- Please Select --

3: -- Please Select --

4: -- Please Select --

Rendering NPI (If different from header):

Type:

-- Please Select --

Taxonomy Code:

Supervising NPI (If different from header):

Type:

-- Please Select --

+

 Additional Service Line Information

Does Subscriber have any Other Insurance?

☐ Yes

☒ No

Tooth and Additional Service Line Information

Fields that can be expanded in the **Basic Line-Item Information** are:

- Tooth Information – the provider can enter tooth number and tooth surface information.
- Additional Service Line – the provider can enter information about prosthesis, crown or inlay.

Tooth Information

1. Tooth Number/Letter:

Add Another:

Tooth Surface:

1: -- Please Select --

2: -- Please Select --

3: -- Please Select --

4: -- Please Select --

5: -- Please Select --

Additional Service Line Information

Prosthesis, Crown or Inlay Code:

-- Please Select --

Replacement Date:

MM

DD

CCYY

Prior Placement Date:

MM

DD

CCYY

Other Insurance Information

At the end of the **Basic Line Item Information** section, there is the question, “**Does the subscriber have any other insurance?**”

The response defaults to a “**No**” and no further entry is needed. If the provider does have other insurance, then select “**Yes**” and enter the other insurance information.

Does Subscriber have any Other Insurance?

☒ Yes ☐ No

1. Other Payer ID: -- Please Select -- *

Amount Paid \$:

Amount Patient Liable \$:

Paid Date: mm dd ccyy

Claim Adjustment Group Code: -- Please Select -- *

Claim Adjustment Reason Code: -- Please Select -- *

Amount \$:

Quantity:

Add Another:

Add Another Payer:

Adding a Service Line

Once the service line details have been entered, select **Add Service Line Item** to add the service line to the claim. The service line will appear under the **Previously Entered Line Item Information** section. A pop-up window will display a confirmation message when a service line has successfully been added.

LINE DRUG INFORMATION

Does Subscriber have any Other Insurance?
☐ Yes ☒ No

Add Service Line Item

Update Service Line Item

Previously Entered Line Item Information

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

Total Units/Quantity: 0.000

Total Submitted Charges \$ 0.00

Line Service Dates		Proc. Code	Modifiers				Diagnosis Pntns				Submitted Charges	Units	Approved PA	
No	From		1	2	3	4	1	2	3	4			Units	Number

Top

Submit Claim

Alert Message

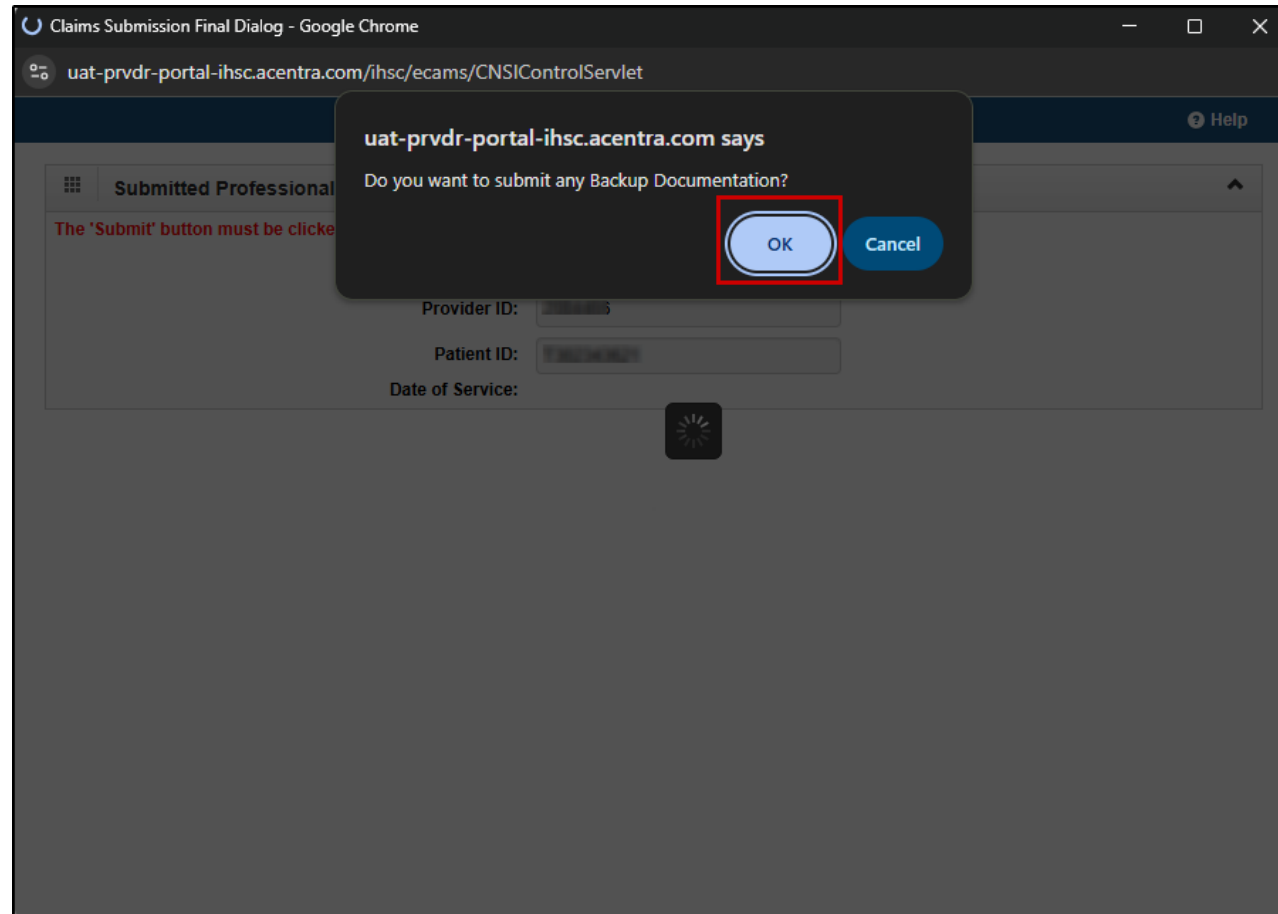
Service line is added successfully.

OK

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Claim Submission Final Dialog

A **Claims Submission Final Dialog** pop-up window appear asking, “Do you want to submit any back up documentation?” Select **OK** to continue with the claim submission process.

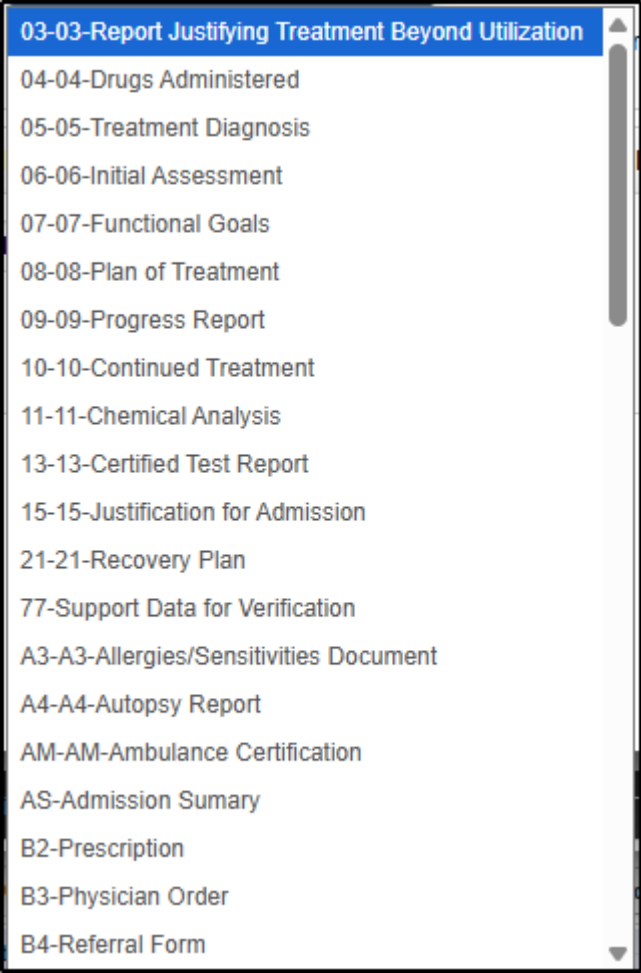
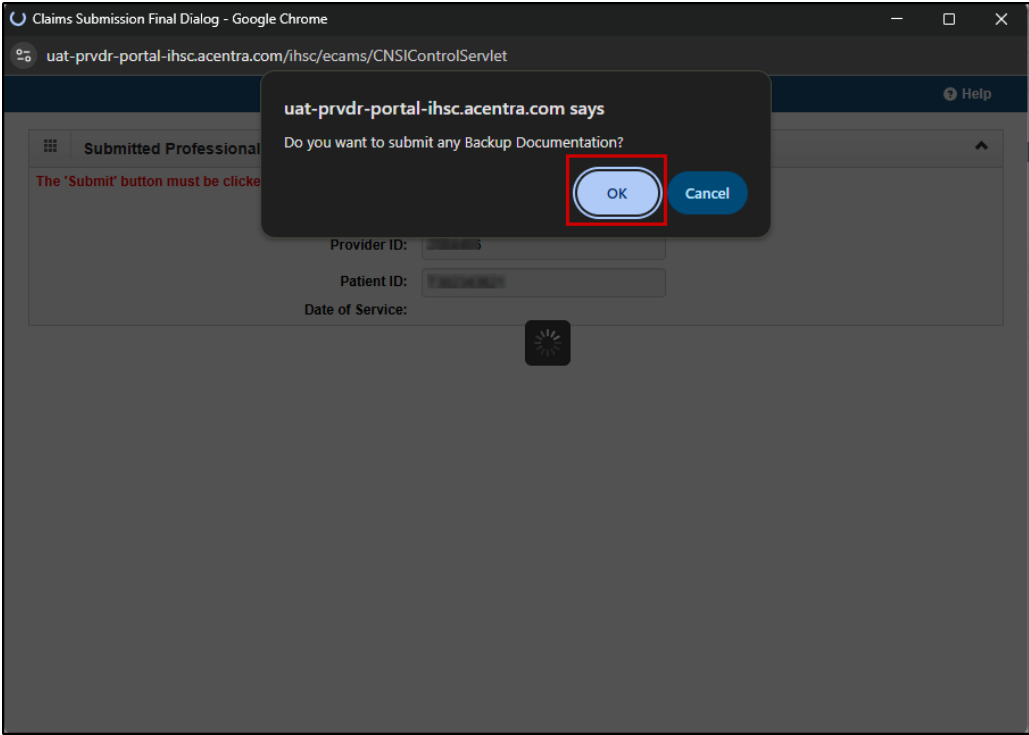


Attachments and Claim Submission



Attachment Types

Once a Professional, Institutional or Dental claim is submitted a pop-up window will display asking if the user wants to upload attachments to their claim. Select **Ok** for a list of **Attachment Types** to display.



Upload Attachment

Add the attachment by selecting the appropriate file.

Supported file formats include **PDF**, **TIFF**, and **TIF** only.

Select **OK** to submit claim.

Please select one of the option from the Required Fields * and select Line No, if the attachment is for specific Service Line Item.

Attachment Type:03-03-Report Justifying Treatment E *

Transmission Code:EL-Electronically Only *

Line No:-- Please Select --

(Do not select Line No to attach a document at header level)

Please attach the file(s). The file format must be PDF,TIF,TIFF

Upload File

No file uploaded *

OK

Cancel

Please select one of the option from the Required Fields * and select Line No, if the attachment is for specific Service Line Item.

Attachment Type:03-03-Report Justifying Treatment E *

Transmission Code:EL-Electronically Only *

Line No:1

(Do not select Line No to attach a document at header level)

Please attach the file(s). The file format must be PDF,TIF,TIFF

Upload File

Admitting Plan.pdf *

OK

Cancel

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A confirmation page is displayed once the claim has been submitted successfully.

The **Submitted Claim Details** page contains essential information about the submitted claim.

It is recommended to print or save this page for future reference, as the information may be needed to review or track the claim submission.

Submitted Professional Claim Details	
The 'Submit' button must be clicked to send the Claim for processing.	
TCN:	20250713000000000000
Provider ID:	20250713
Patient ID:	T20250713
Date of Service:	07/13/2025-07/13/2025
Total Claim Charges:	\$ 350.00

Please click "Add Attachment" button, to attach the documents.

+ Add Attachment

Attachment List								
☐	Line No ▲▼	File Name ▲▼	Attachment Type ▲▼	Transmission Code ▲▼	Attachment Control # ▲▼	File Size ▲▼	Delete ▲▼	Uploaded On ▲▼
☐	1	Admitting Plan.pdf	03	EL	1396	56kb	X	09/21/2026

View Page: Go + Page Count Viewing Page: 1 << First < Prev Next > Last >>

☒ SaveToXLSX

Copy of Claim

Select **Print** to print a copy of the claim details for your records.

Submitted Professional Claim Details

The 'Submit' button must be clicked to send the Claim for processing.

TCN:

20

Provider ID:

2084408

Patient ID:

1362343623

Date of Service:

07/13/2025-07/13/2025

Total Claim Charges:

\$ 350.00

Please click "Add Attachment" button, to attach the documents.

Add Attachment

Attachment List

☐	Line No ▲▼	File Name ▲▼	Attachment Type ▲▼	Transmission Code ▲▼	Attachment Control # ▲▼	File Size ▲▼	Delete ▲▼	Uploaded On ▲▼
☐	1	Admitting Plan.pdf	03	EL	1396	56kb	X	09/21/2026

View Page: 1

Go

+ Page Count

Viewing Page: 1

<< First

< Prev

> Next

>> Last

SaveToXLSX

Print

Submit

73 | Privileged and Confidential

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Submit Claim

Select **Submit** to complete the claim submission process.

Submitted Professional Claim Details

The 'Submit' button must be clicked to send the Claim for processing.

TCN:

20

Provider ID:

Patient ID:

Date of Service:

07/13/2025-07/13/2025

Total Claim Charges:

\$ 350.00

Please click "Add Attachment" button, to attach the documents.

Add Attachment

Attachment List

☐	Line No ▲▼	File Name ▲▼	Attachment Type ▲▼	Transmission Code ▲▼	Attachment Control # ▲▼	File Size ▲▼	Delete ▲▼	Uploaded On ▲▼
☐	1	Admitting Plan.pdf	03	EL	1396	56kb	X	09/21/2026

View Page: 1

Go

+ Page Count

Viewing Page: 1

<< First

< Prev

Next >

>> Last

SaveToXLSX

Print

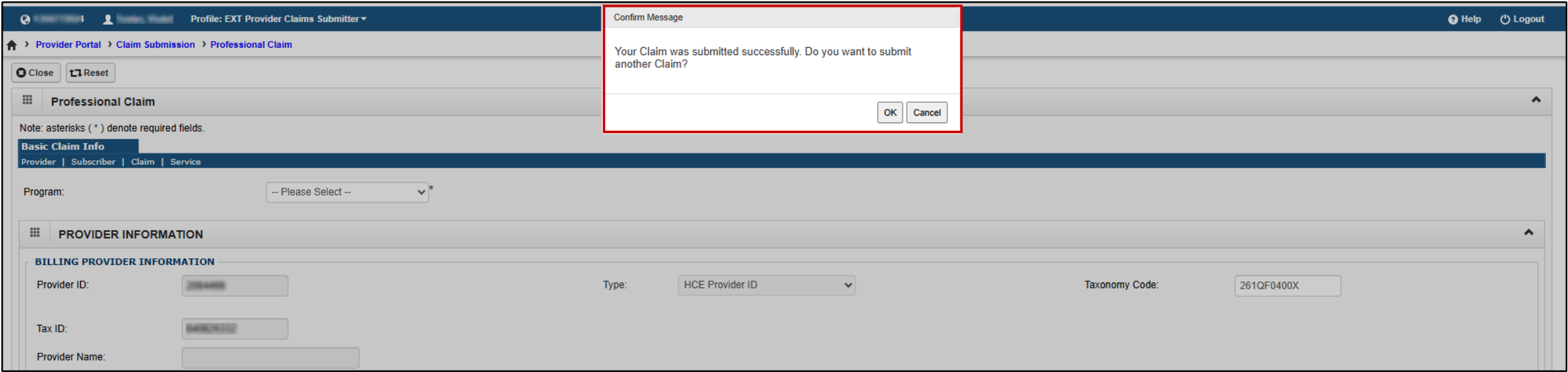
Submit

74 | Privileged and Confidential

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Claim Submission Confirmation Message

A **Confirmation Message** is displayed indicating that the claim was submitted successfully. The message asks, **"Your claim was submitted successfully. Do you want to submit another claim?"**

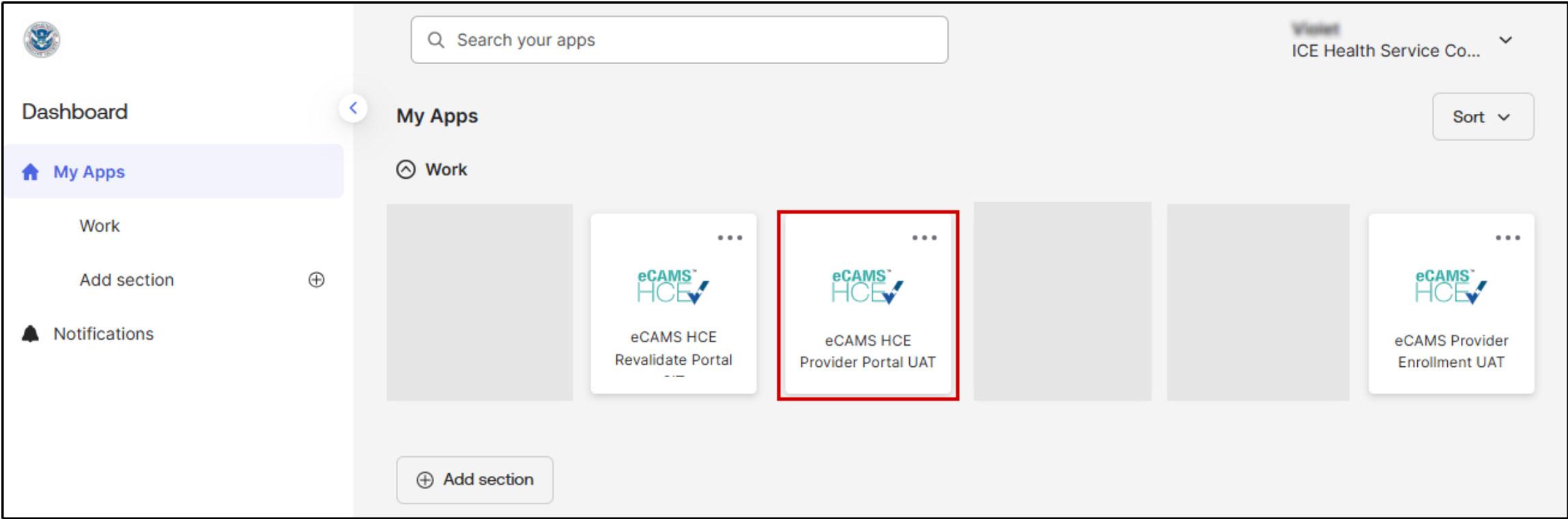




Claim Status

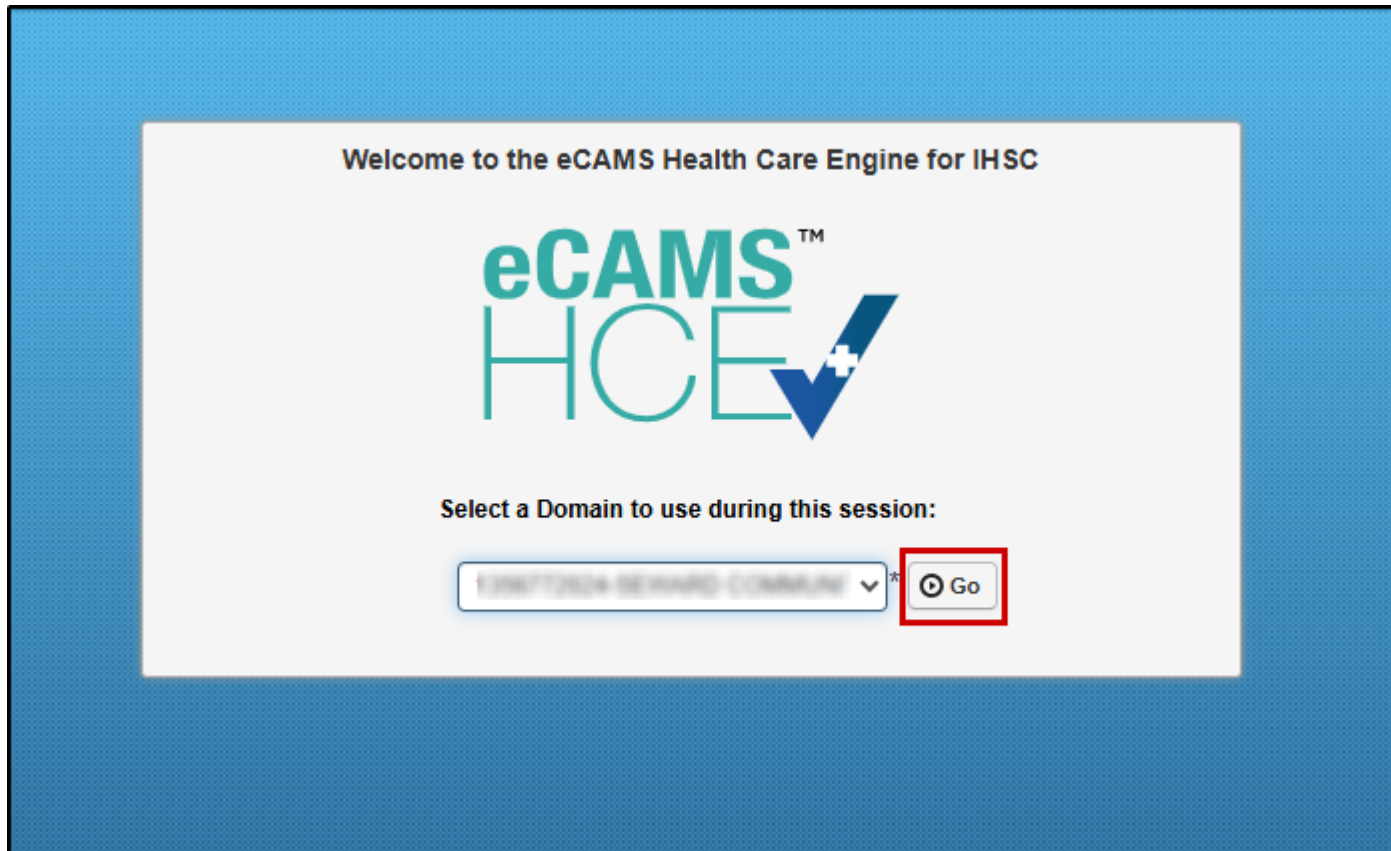
Provider Portal Tile

To check the status of a claim, log into your **IHSC Provider Portal** and select the **eCAMS HCE Provider Portal** tile.



Provider Portal Domain

Select the **Domain** or provider account used to submit the claim for processing. Then select **Go**.



Welcome to the eCAMS Health Care Engine for IHSC

eCAMSTM
HCE

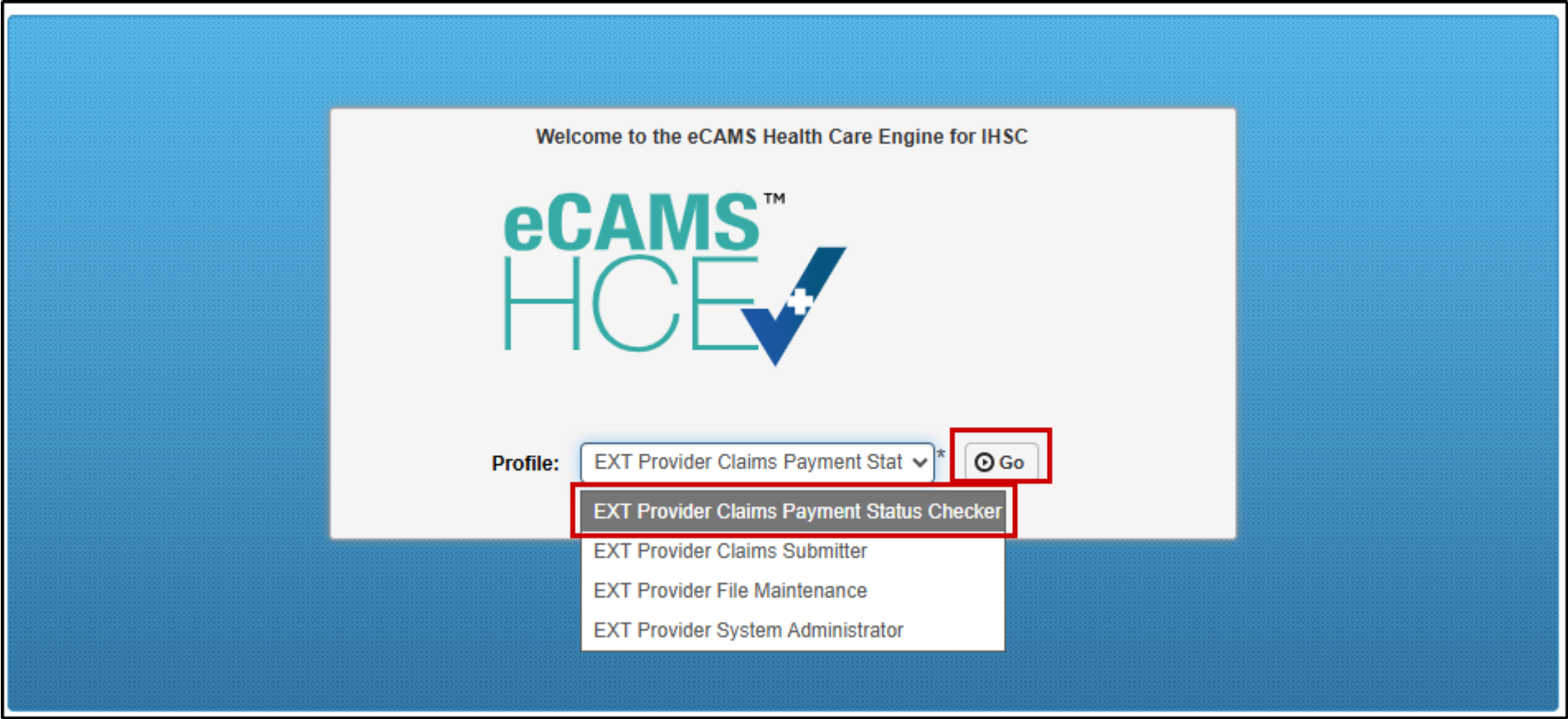
Select a Domain to use during this session:

LIMBETTER-DEWANE COMPANY ▼*

Go

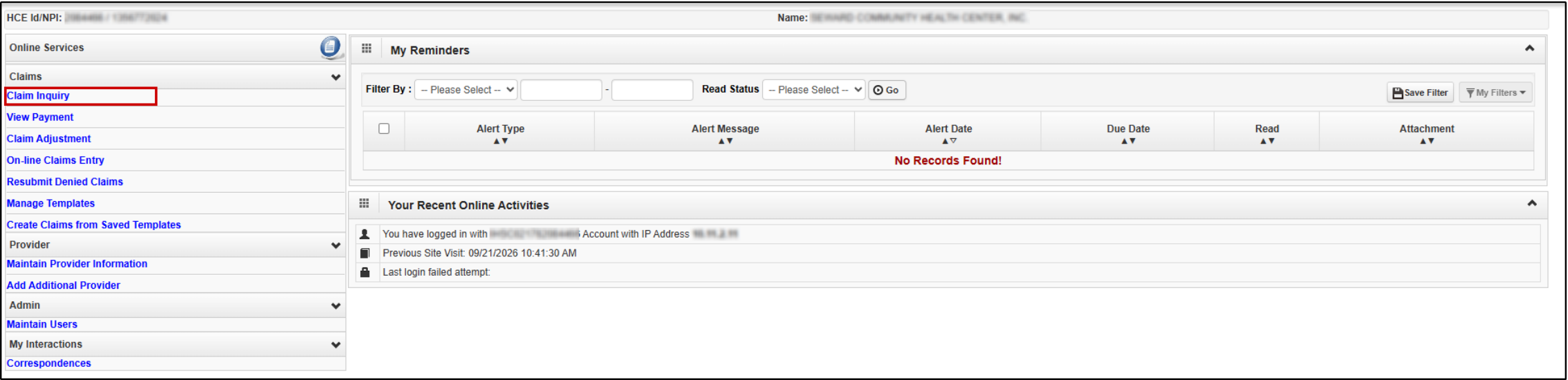
Provider Portal Profile

Select the **EXT Provider Claims Payment Status Checker** for the **Profile**. Then select **Go**.



IHSC Provider Portal Home Page

After selecting the Profile, the user will be on their provider portal homepage. Select **Claim Inquiry** from the menu on the left of the screen.



Claim Inquiry Providers List

Displayed is the **Claim Inquiry Providers List** page. This page displays a list of submitted claims along with some additional details. The **Claim Status** column shows whether the claim is paid, denied or In Process. Select the **Claim ID** to view additional details about the associated claim.

Close

The search results are limited to recent 100 Claims by default. You can use filters to display all the Claims matching the criteria.

Claim Inquiry Providers List

Filter By : -- Please Select --

And

-- Please Select --

And

-- Please Select --

In

Header List

Programs

All

Claim Status

All

Go

Clear Filter

Save Filter

My Filters

	Claim ID	From Date	To Date	Claim Status	Billed Amount	Paid Amount	Client Name	Client ID
☐	30	09/01/2020	09/01/2020	Paid	\$1,010.00	\$64.00	Becky Mackey	BP1234567891234567
☐	30	10/01/2021	10/01/2021	Denied	\$1,000.00	\$0.00	Becky Mackey	BP1234567891234567
☐	30	09/01/2020	09/01/2020	Denied	\$100.00	\$0.00	TOM DIX	BP1234567891234567
☐	30	03/31/2022	03/31/2022	Paid	\$60.00	\$50.00	TOM DIX	BP1234567891234567
☐	30	04/01/2022	04/01/2022	Paid	\$150.00	\$53.46	Becky Mackey	BP1234567891234567
☐	30	07/01/2022	07/01/2022	Paid	\$60.00	\$50.00	Becky Mackey	BP1234567891234567
☐	30	04/30/2020	04/30/2020	Paid	\$150.00	\$52.92	Becky Mackey	BP1234567891234567
☐	30	06/30/2022	06/30/2022	Paid	\$60.00	\$50.00	TOM DIX	BP1234567891234567
☐	30	12/09/2021	12/09/2021	Paid	\$500.00	\$178.48	DANIELA WELLS	BP1234567891234567
☐	30	01/11/2022	01/11/2022	In Process	\$15,000.00	\$0.00	RAE HARRIS	BP1234567891234567

View Page: 2

Go

Page Count

SaveToXLSX

Viewing Page: 1

First

Prev

Next

Last

Claim Details

Claim Inquiry Providers List

Filter By : -- Please Select --

And -- Please Select --

And -- Please Select --

In Header List

Programs All

Claim Status All

Go

Clear Filter

Save Filter

My Filters

☐	Claim ID	From Date	To Date	Claim Status	Billed Amount	Paid Amount	Client Name	Client ID
☐	30121000000000000000	09/01/2020	09/01/2020	Paid	\$1,010.00	\$64.00	Sealy, Michael	BP12345678901234567
☐	30121000000000000000	10/01/2021	10/01/2021	Denied	\$1,000.00	\$0.00	Sealy, Michael	BP12345678901234567
☐	30121000000000000000	09/01/2020	09/01/2020	Denied	\$100.00	\$0.00	TOM DIX	BP12345678901234567
☐	30121000000000000000	03/31/2022	03/31/2022	Paid	\$60.00	\$50.00	TOM DIX	BP12345678901234567
☐	30121000000000000000	04/01/2022	04/01/2022	Paid	\$150.00	\$53.46	Sealy, Michael	BP12345678901234567
☐	30121000000000000000	07/01/2022	07/01/2022	Paid	\$60.00	\$50.00	Sealy, Michael	BP12345678901234567
☐	30121000000000000000	04/30/2020	04/30/2020	Paid	\$150.00	\$52.92	Sealy, Michael	BP12345678901234567
☐	30121000000000000000	06/30/2022	06/30/2022	Paid	\$60.00	\$50.00	TOM DIX	BP12345678901234567
☐	30121000000000000000	12/09/2021	12/09/2021	Paid	\$500.00	\$178.48	SHAW, WILL	BP12345678901234567
☐	30121000000000000000	01/11/2022	01/11/2022	In Process	\$15,000.00	\$0.00	WILSON, JAMES	BP12345678901234567

View Page: 2

Go

+ Page Count

SaveToXLSX

Viewing Page: 1

<< First

Filter By : -- Please Select --

All

Claim Status

-- Please Select --

Billed Amount

Billed Units

Billing Provider NPI/Tax ID

Check/EFT Trace Number

Claim ID

Client ID

Client Name

Error code

From/To Date

Modifiers

Paid Amount

Parent Claim ID

Patient Account Number

Procedure Code

Received Date

Revenue Code

SSN

View Page

To view the **Claims Details**, select the claim ID hyperlink under the **Claim ID** column. To search for a claim, use the **Filter By** option to do a search using one of the filter options.

Claim Status

The **Claim Status** page will open and display the Edit # for the denial and a description of the denial. To exit the **Claim Status** page, select **Cancel** to navigate back to the **Claim Details** page.

Claim Status

Line # ▲▼	Edit # ▲▼	Provider Specific Language ▲▼	Erroneous Data ▲▼
1	93026	96 -Non-covered charge(s). N640 - Exceeds number/frequency approved/allowed within time period.	

View Page: 1

Go

+ Page Count

Viewing Page: 1

SaveToXLSX

<< First

< Prev

Next >

>> Last

Cancel

Electronic Data Interchange (EDI)



Electronic Data Interchange (EDI)

Healthcare EDI is the secure, automated transfer of structured healthcare, administrative and financial data, such as insurance claims, eligibility inquiries, payment remittances, and prior authorizations, between providers, payers, and clearinghouses.

Once the new IHSC system is live:

- On October 12th, 2026, providers will be able to submit new EDI claims to IHSC.
- On a Oct. 5, 2026, a new payor ID, DIHSC, will be available and must be included on EDI submissions to Acentra Health IHSC.
- Prior EDI claims that may have been submitted to VA-FSC between Sept. 5, 2026, and Oct. 4, 2026, with payor ID, VAICE, will be internally transitioned to the new required payor ID, DIHSC, and will not require provider resubmission.
- FY 2023-2024 filing years have closed for dates of service Oct. 1, 2022 – Sept 30, 2024. Claims submissions for FY 2023 – 2024 will be rejected at the clearinghouse level.
- Providers can submit EDI claims using 837 electronic claim transactions.

EDI Clearinghouses

Acentra Health has partnered with PnT (Post-n-Track Data) as its EDI clearinghouse and trading partner. PnT maintains connectivity with multiple national and regional clearinghouses and billing vendors. These vendors include the following:

- Ability Network
- AdvancedMD
- Apero Health Inc.
- Apex Edi, Inc
- AthenaHealth
- CareCloud, Inc.
- Change Healthcare Solutions
- Claim.MD
- ClaimLogic, LLC
- Computers Solutions and Consultant, Inc.
- Eligible Inc
- InstaMed
- Lincare
- nThrive, Inc.
- Office Ally Inc.
- Optum
- Practice Insight, LLC
- Quadax Inc.
- Rycan Technologies
- SmartData
- Stedi
- The SSI Group
- Trizetto
- VVC Holdings Corporation
- Zotec Partners LLC

Note: If your clearinghouse is not listed, contact the IHSC Provider Support Call Center at 1-844-922-4472.



Important Claims Processing Information

Timely Filing

The chart below shows when a timely filing edit will post on claim based on the date of service on the claim and when it is received for processing.

Date of Service (DOS) Period	Timely Filing Edit Posts When
Before 10/01/2024	Claim received over a one (1) year after DOS
10/01/2024 – 09/30/2025	Claim received on or after 03/01/2027
10/01/2025 – 09/30/2026	Claim received on or after 10/01/2027
10/01/2026 and later	Claim received over one (1) year after DOS

Claim Denials

It is important to submit a clean (error free) claim in order for a claim to successfully adjudicate in a paid status. Errors or incorrect information on a claim may result in a claim denial. Some common claim denials are:

- 1 Invalid Patient ID
- 2 Missing Prior Authorization
- 3 Missing Diagnosis Code
- 4 Duplicate Claim Submission
- 5 Invalid Dates of Service

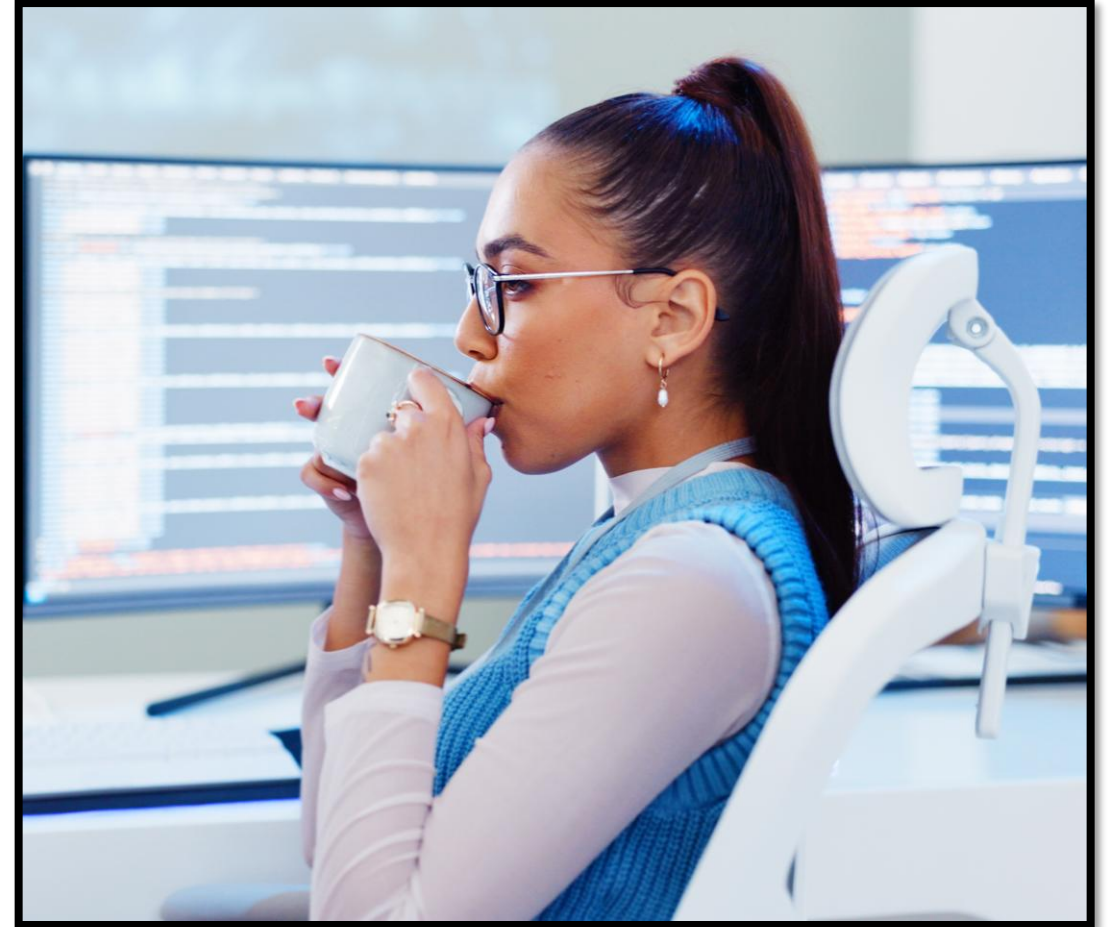


Provider Resources

Contact Information

If you have any questions or need assistance with revalidation, new enrollments or general inquiries, please contact the IHSC Provider Support Call Center at 1-844-922- IHSC (1-844-922-4472).

Note: The IHSC Provider Support Call Center is available from 8:00am to 5:00pm EST, Monday through Friday (excluding federal holidays).



Appeals

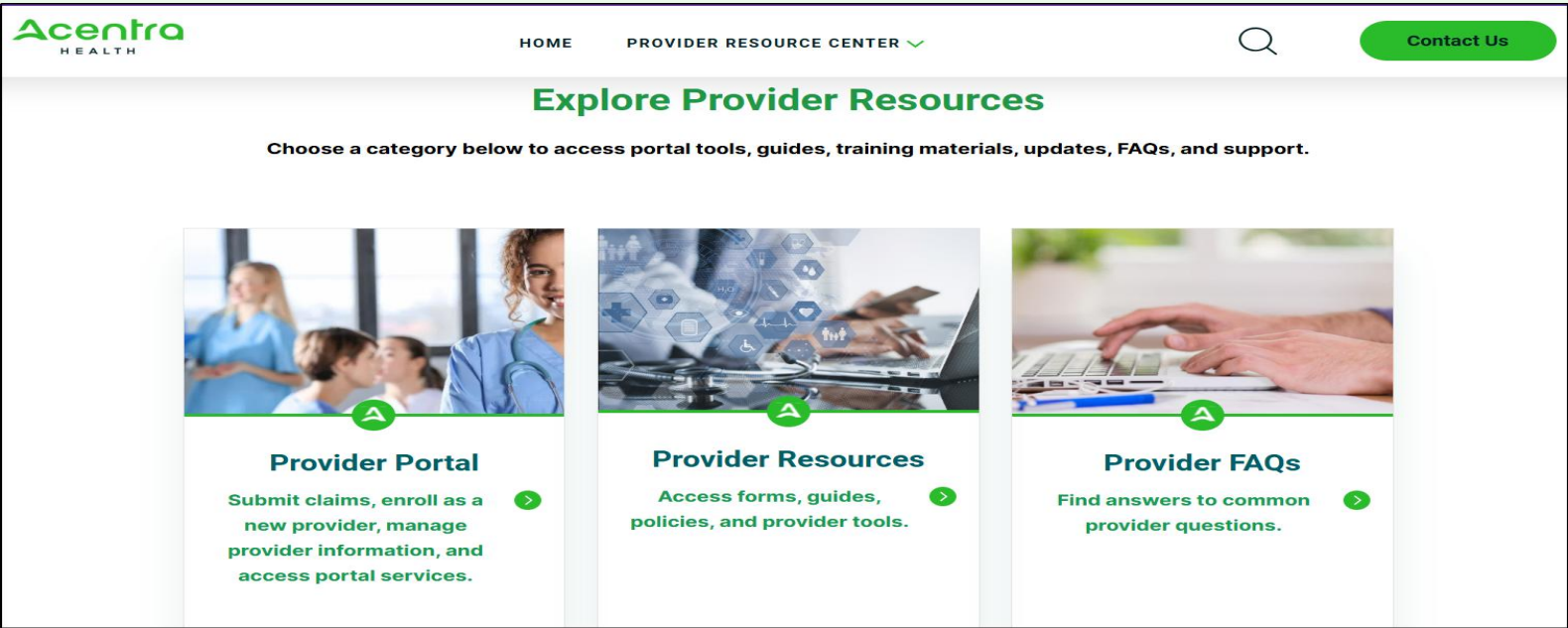
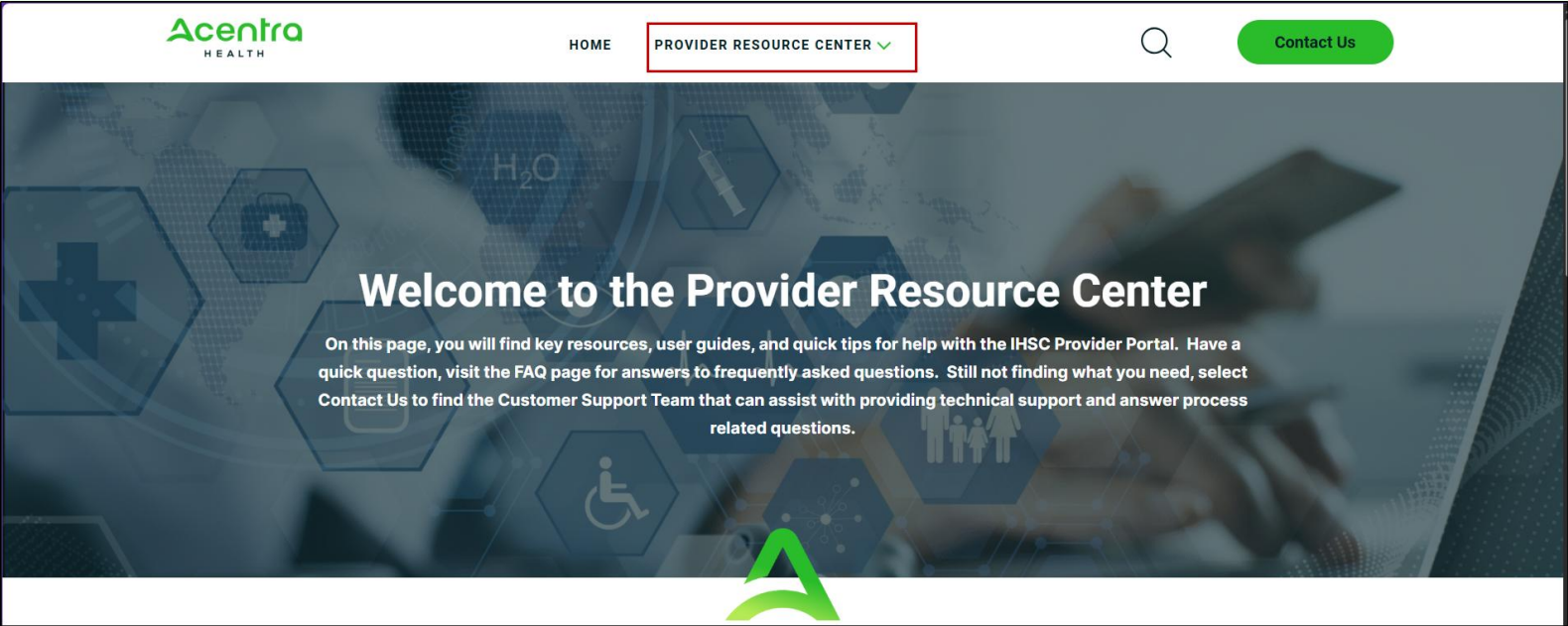
The IHSC Provider Support Call Center can assist you with many questions, including providing guidance on how to submit an appeal.

IHSC providers who have successfully registered through the IHSC Provider Portal, can appeal a denial of their enrollment application, credentialing decision, termination of enrollment, or rejection of an enrollment modification request.

- Providers will visit the Acentra Health IHSC website at <https://ihsc-dhs.acentra.com/> and select the **Provider Resource Center** tab at the top of the web page.
- Navigate to the Provider Resources tab and download the Provider Appeals form
- Once the form is completed, the provider will log in to their secure IHSC Provider Portal Account and select the IHSC Provider Appeals link to upload and submit their completed Appeals form.
- Appeals will have a turnaround time of thirty (30) business days for processing.
- Providers will be informed of their appeal outcome through their IHSC Provider Portal account.

Additional resources can also be found on the **Acentra Health Provider Resource Center**.

Visit the Acentra Health IHSC website at <https://ihsc-dhs.acentra.com/> and click on the **Provider Resources Center** tab at the top of the page. The user will be redirected to the Provider Resources page where they can find resources such as guides, FAQs, training videos, latest updates and much more!





Accelerating
Better Outcomes