Acentra HEALTH

Claims Training Webinar

IHSC Provider Portal

October 8, 2026

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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.

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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.

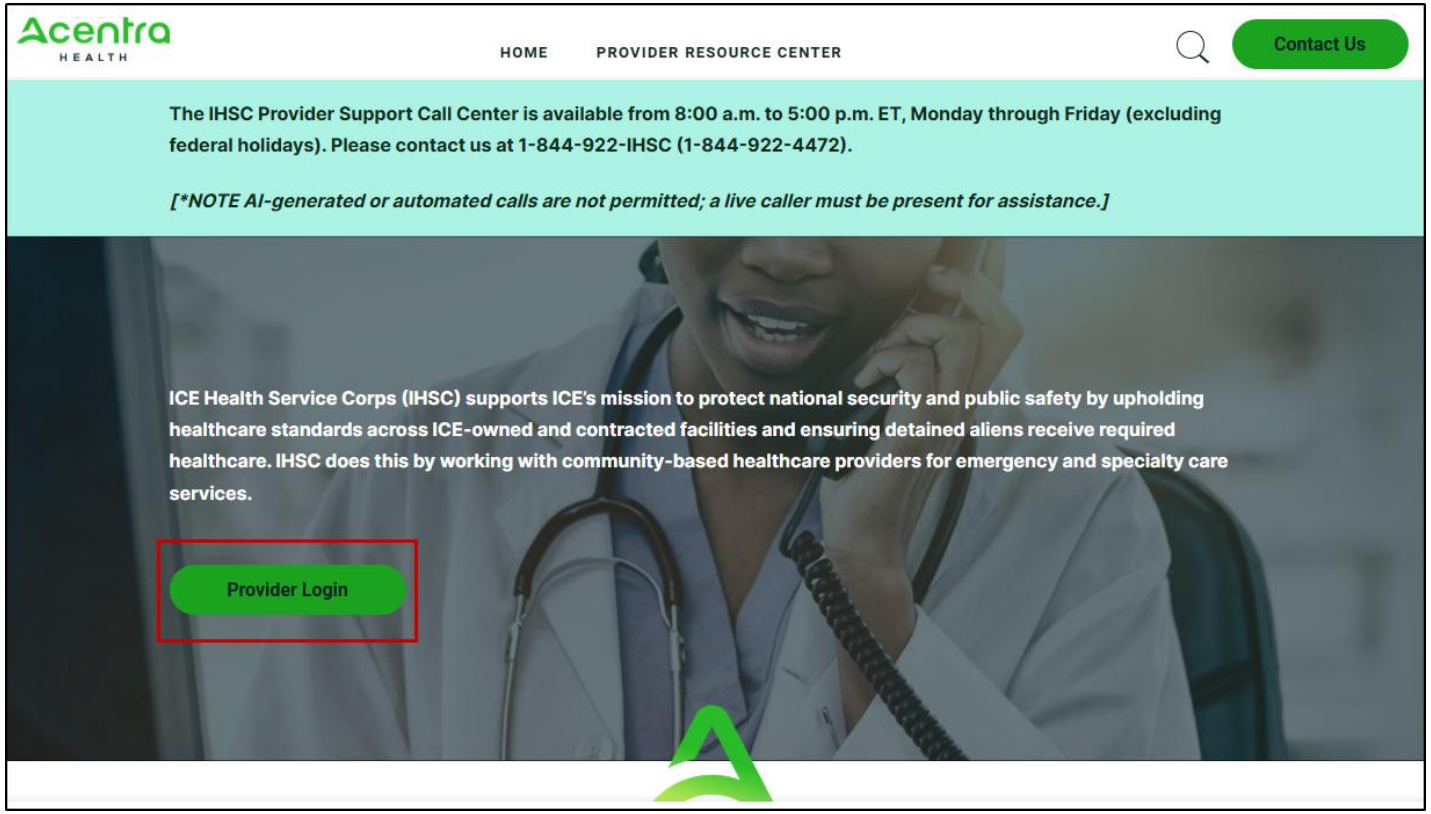
Note: Acentra Health and IHSC do not accept physical mail or process paper claims.

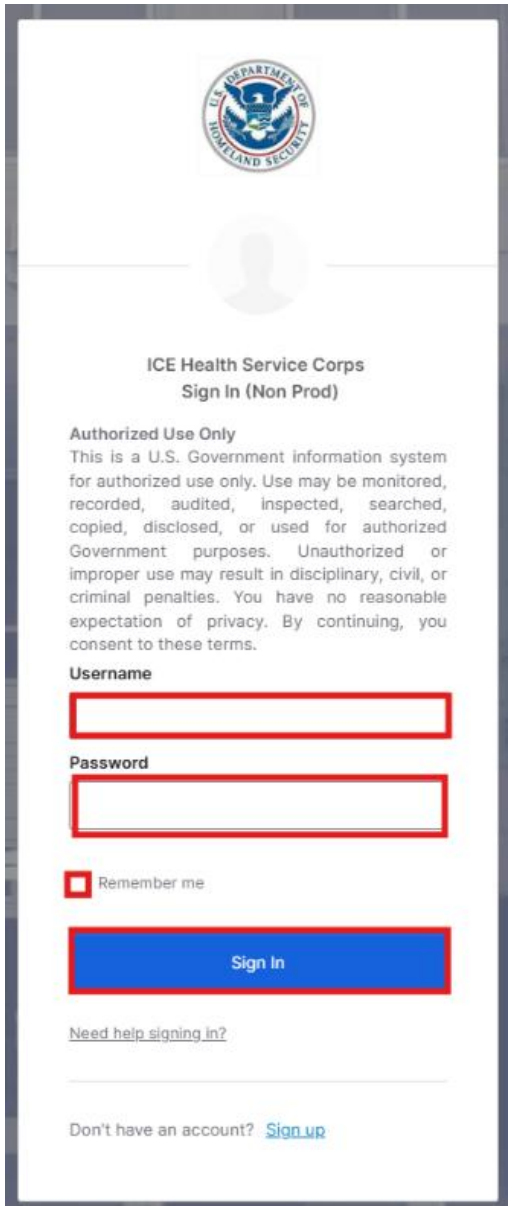


IHSC Provider Portal Log In Process

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.





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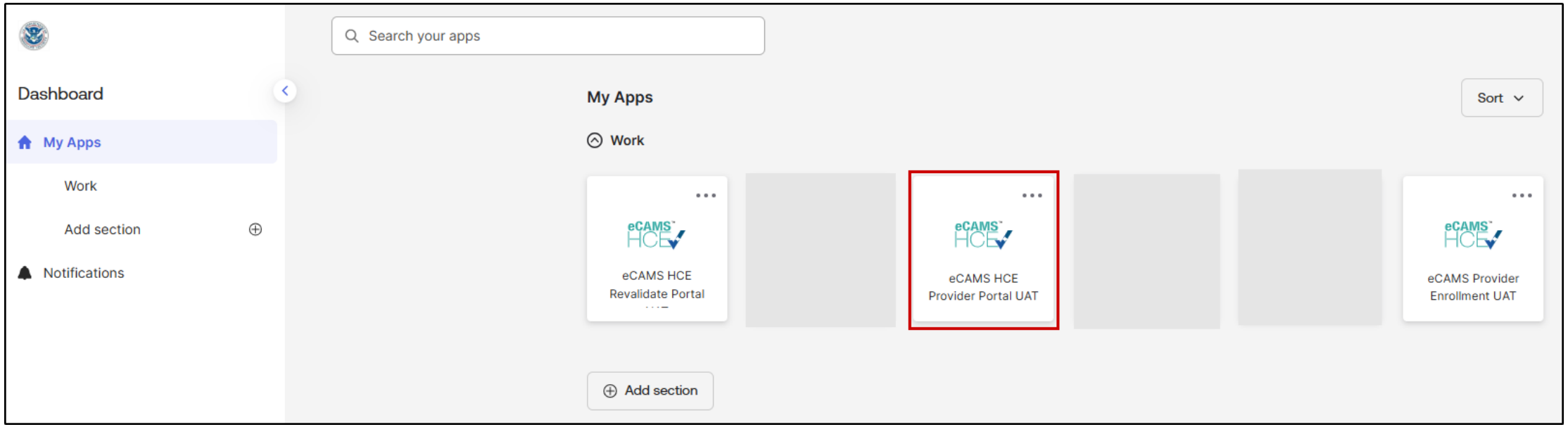
Provider Portal Dashboard

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



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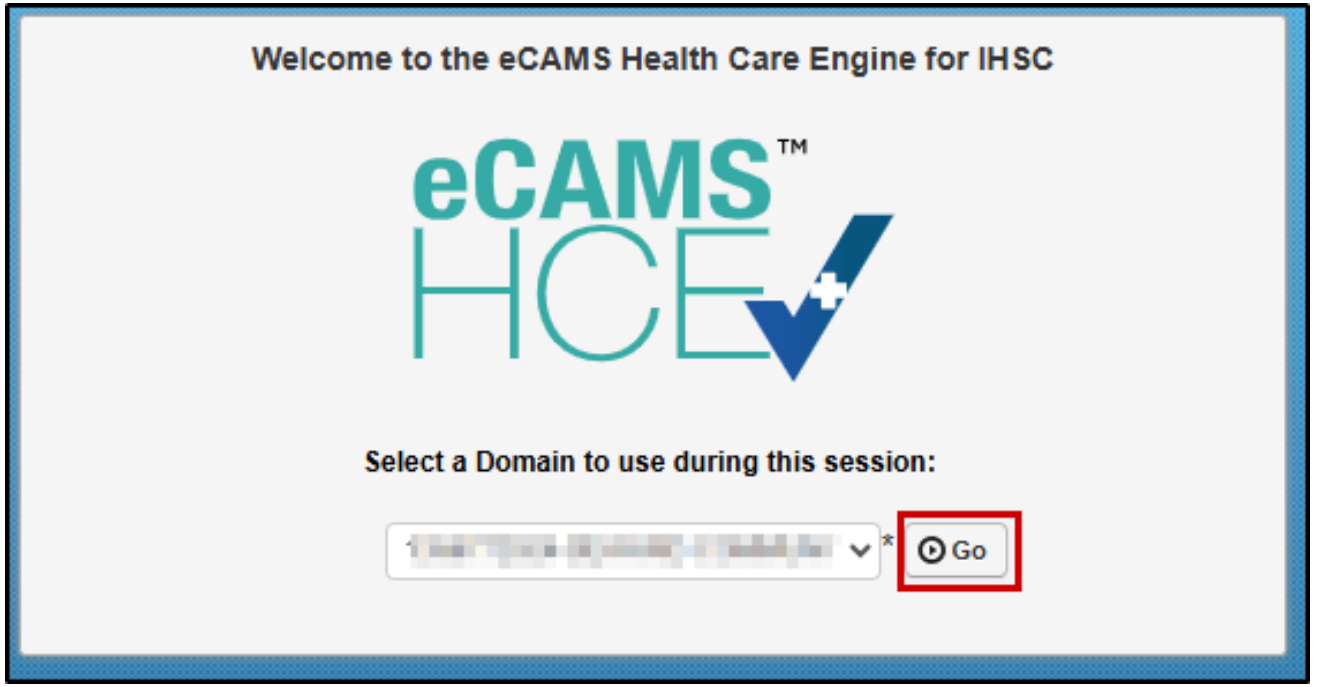
Provider Domain

Select a **Domain** to use during this session. This includes the provider's ID and name. Select **Go** to continue.



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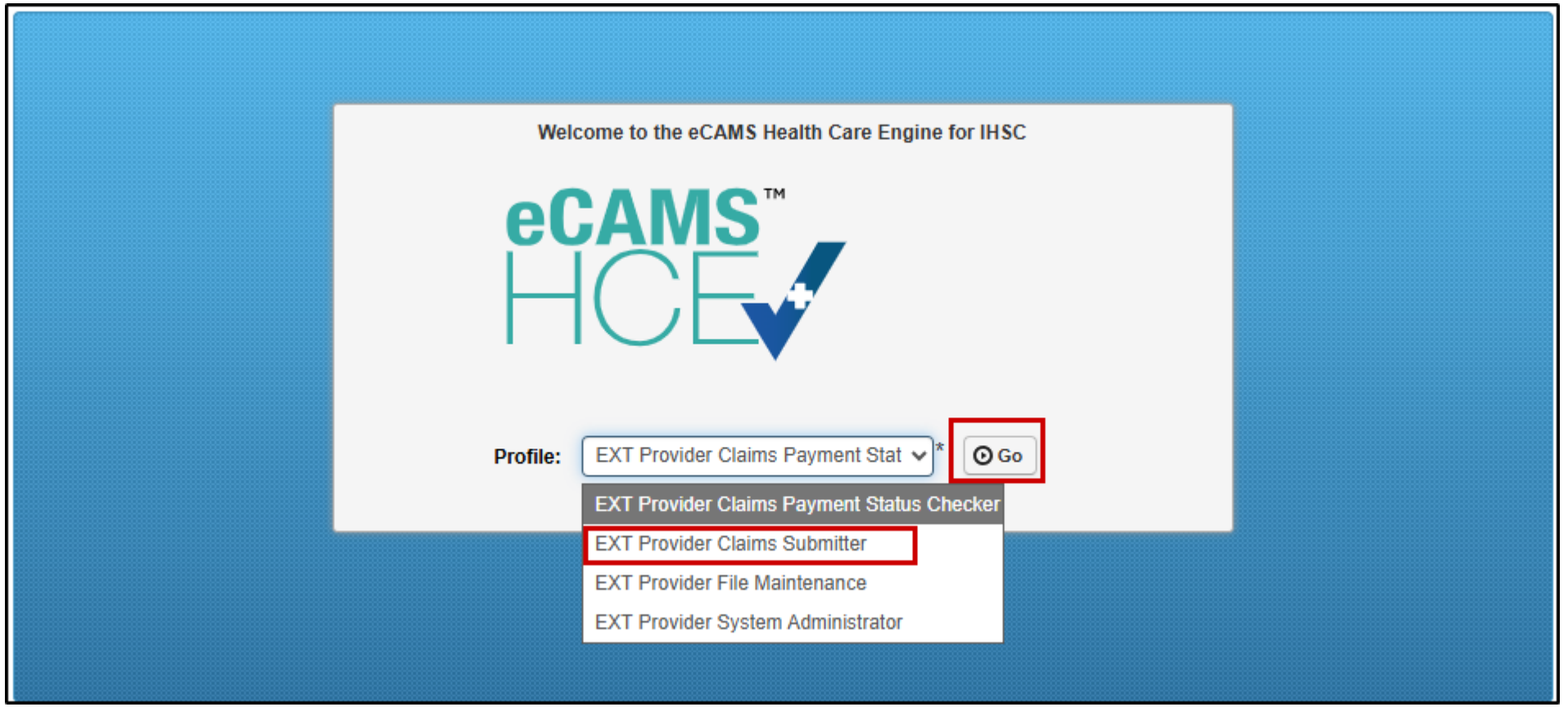
Provider Profile

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

Select **Go** to continue.



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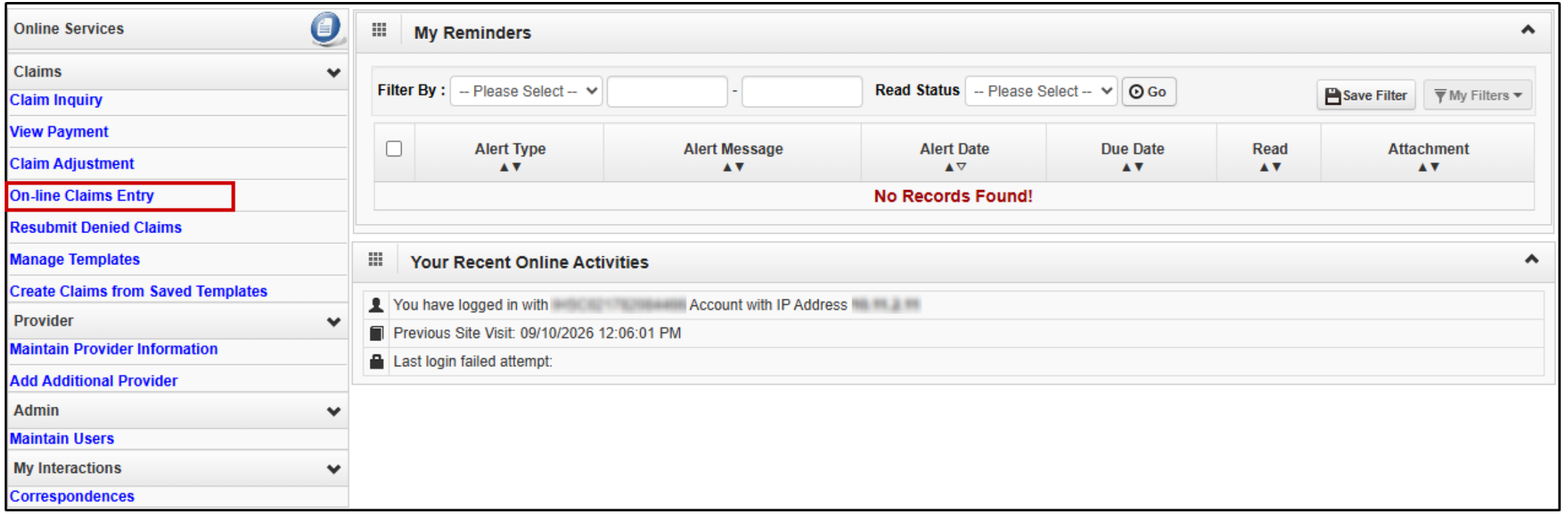
On-line Claims Entry

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



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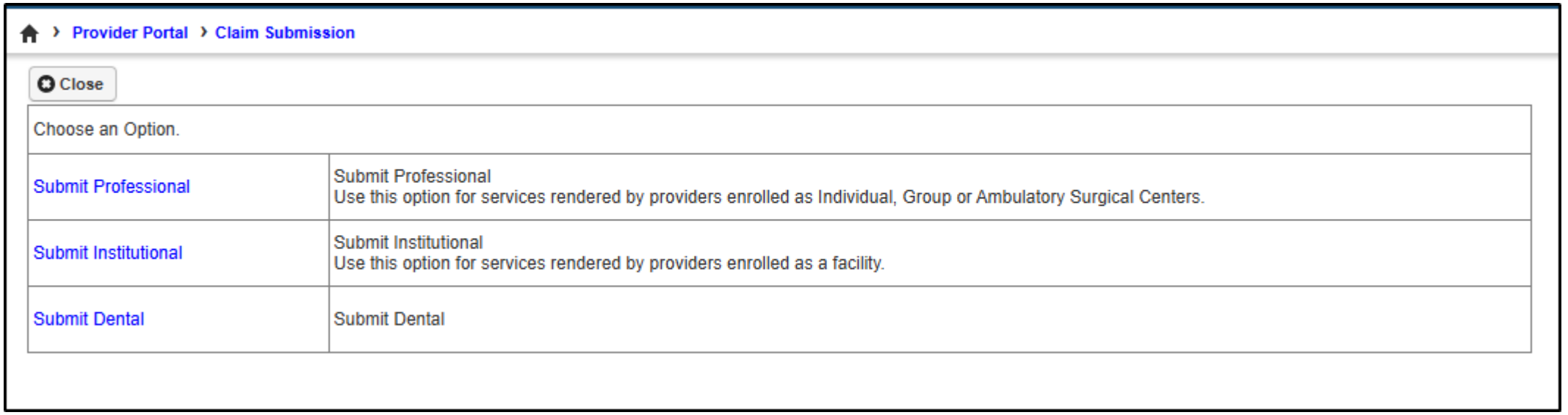
Claim Options

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

- Professional
- Institutional
- Dental



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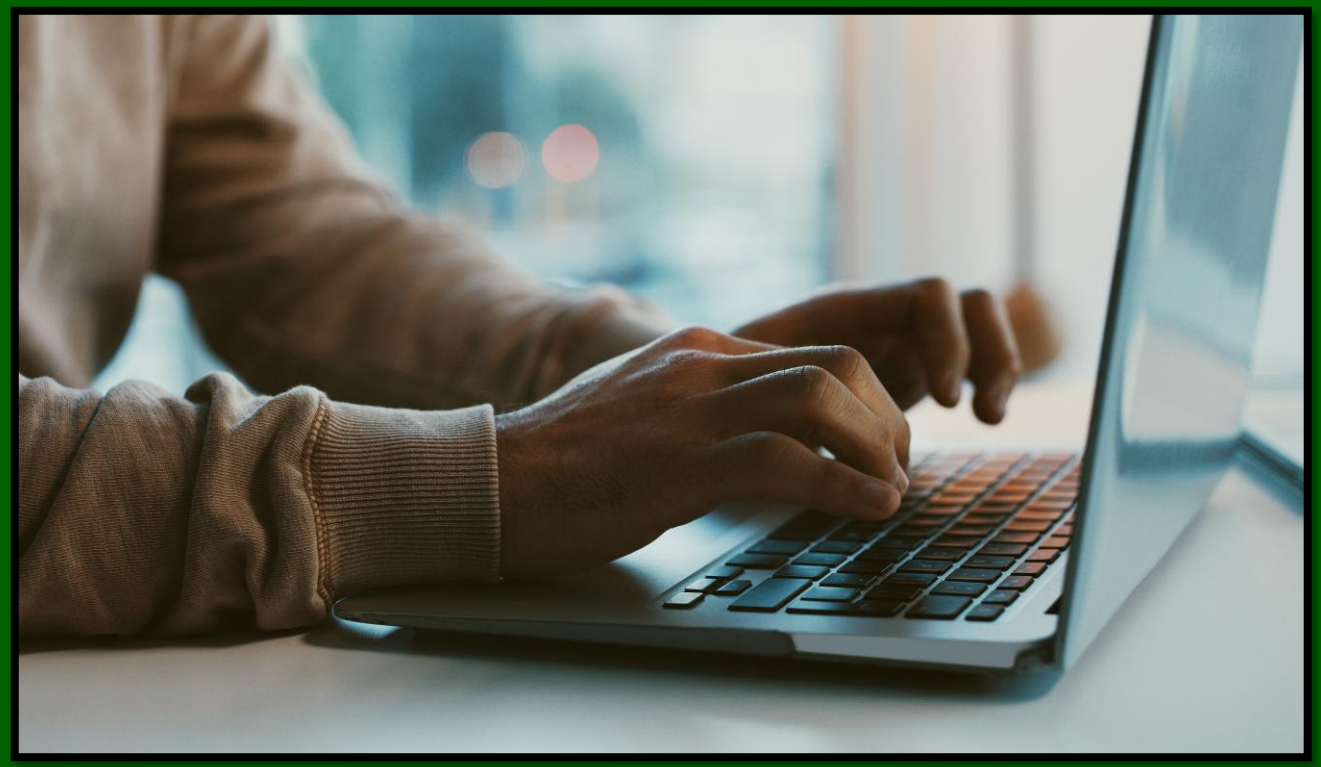
Professional Claims

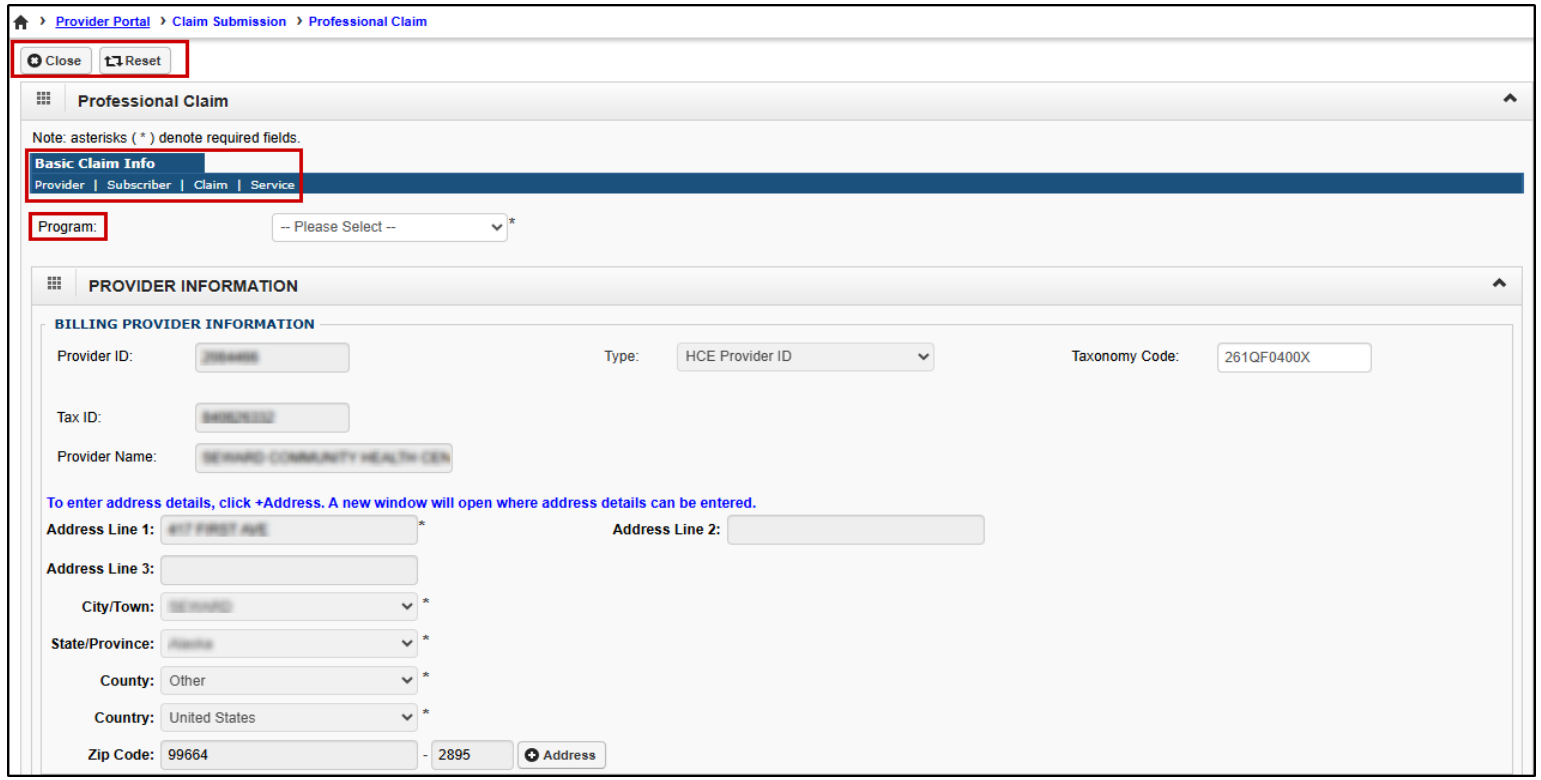


Professional Claim – Basic Claim Info

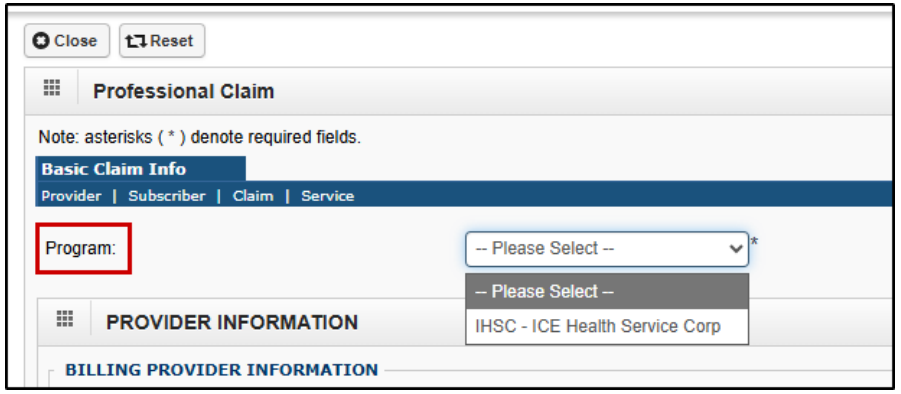
In the **Professional Claim** window, the **Basic Claim Info** section contains the information required to complete the claim. This section includes **Provider**, **Subscriber**, **Claim**, and **Service**.

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.



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



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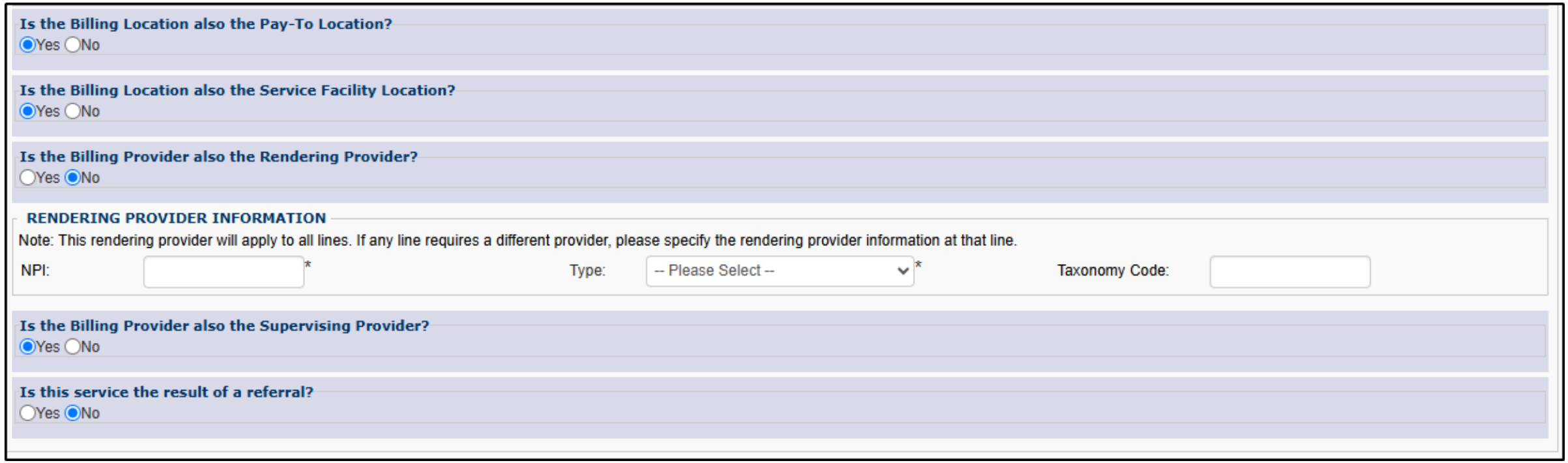
Provider Information – Billing Questions

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.



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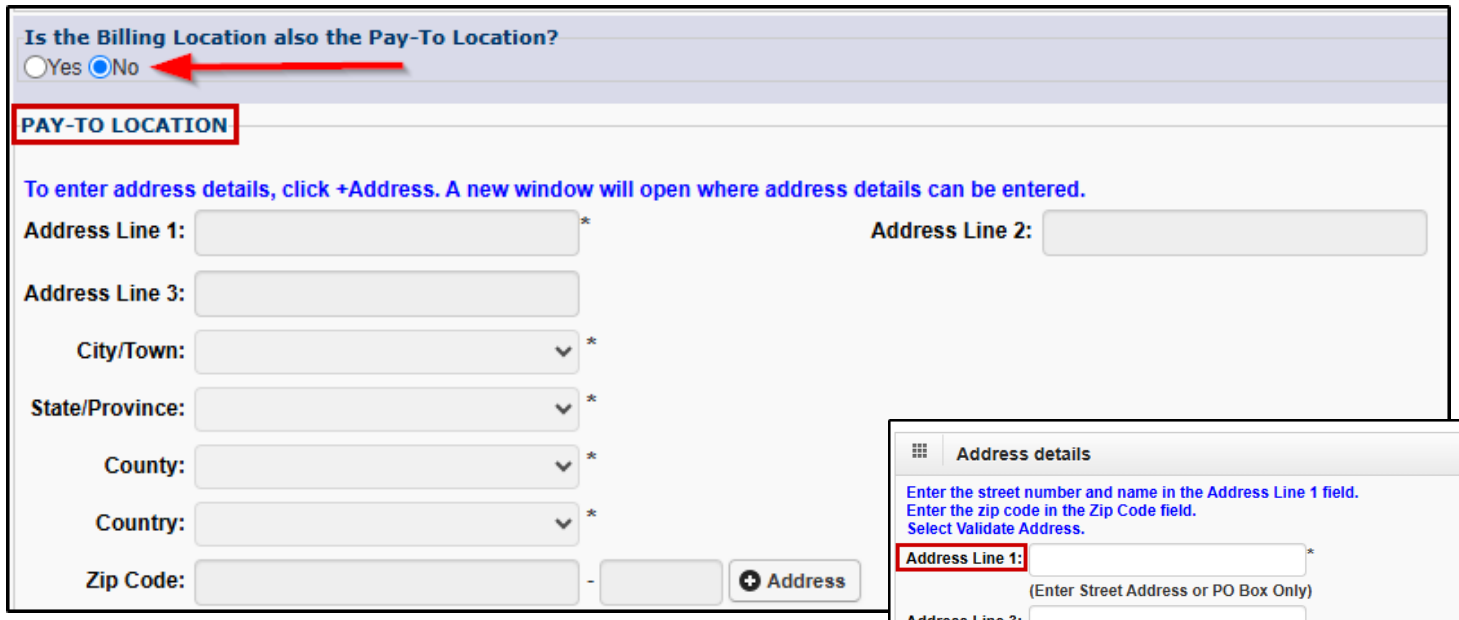
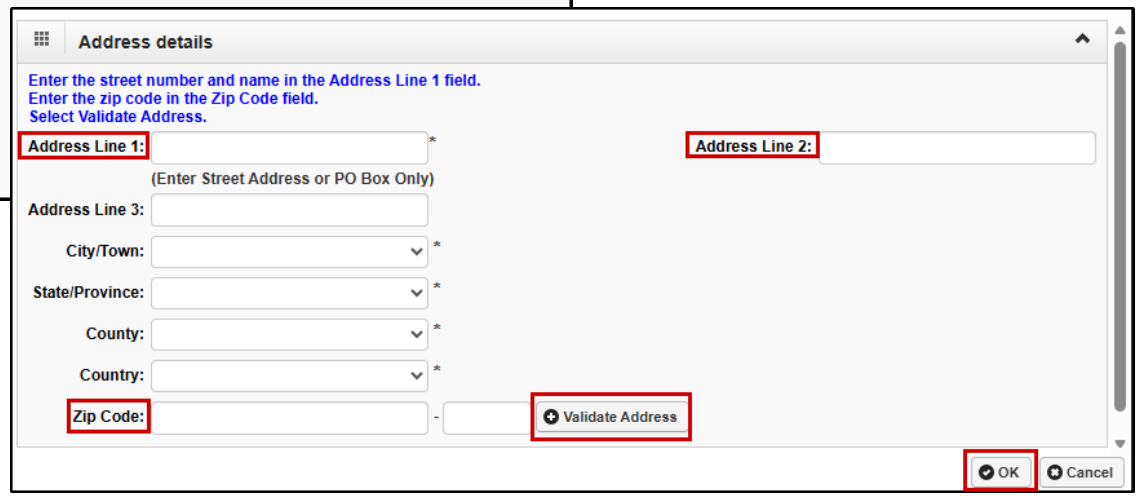
Billing Location – Pay-To Location

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**.



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

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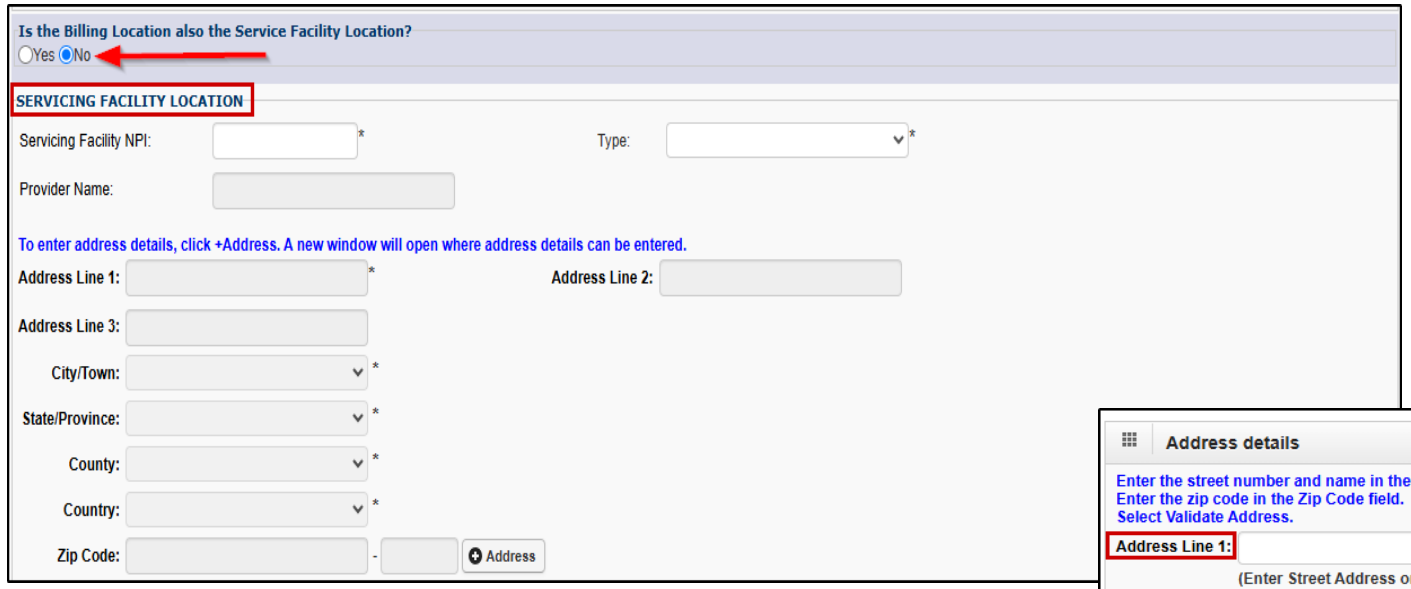
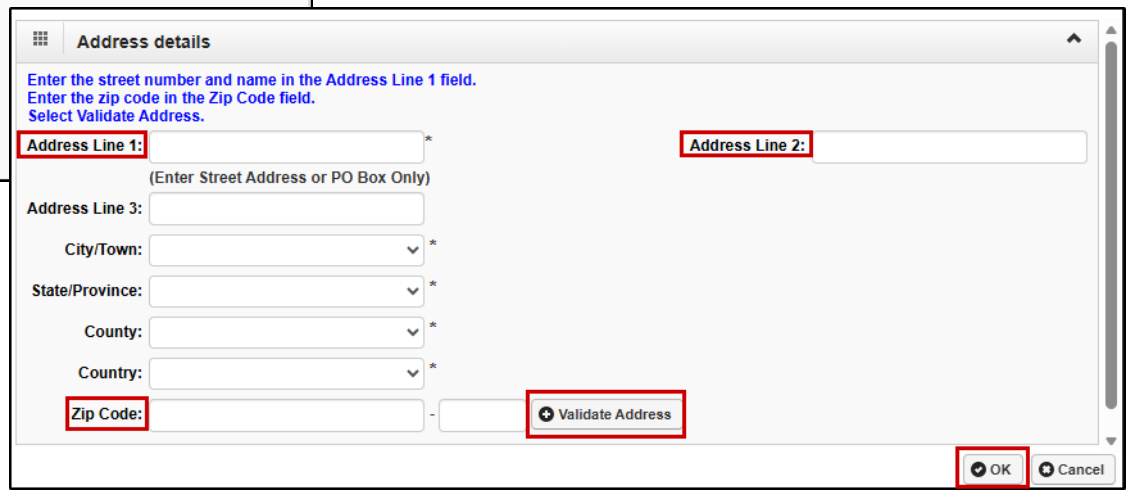
Billing Location – Service Facility Location

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.



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**.



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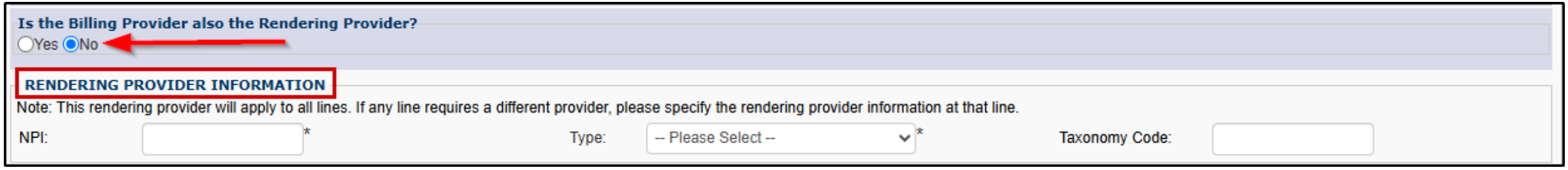
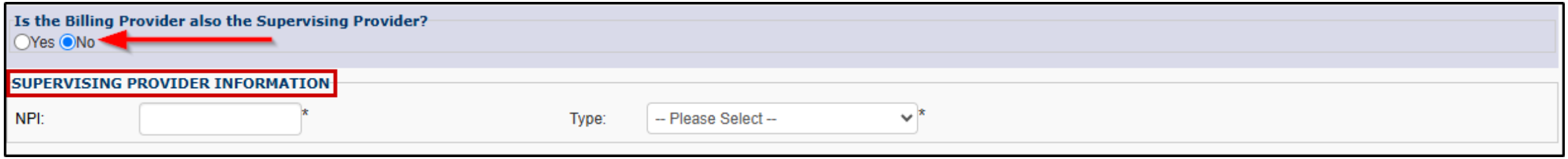
Rendering Provider and Supervising Provider

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.



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



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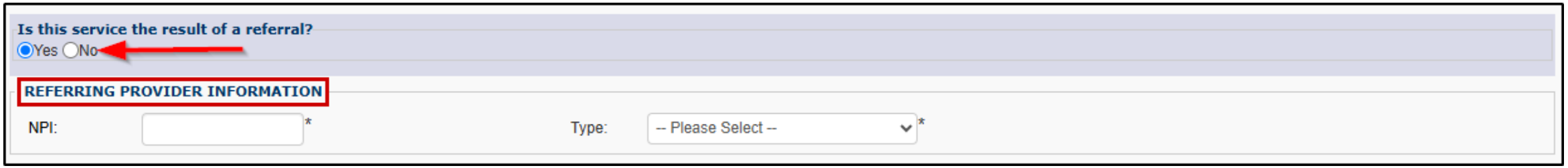
Referring Provider

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**.



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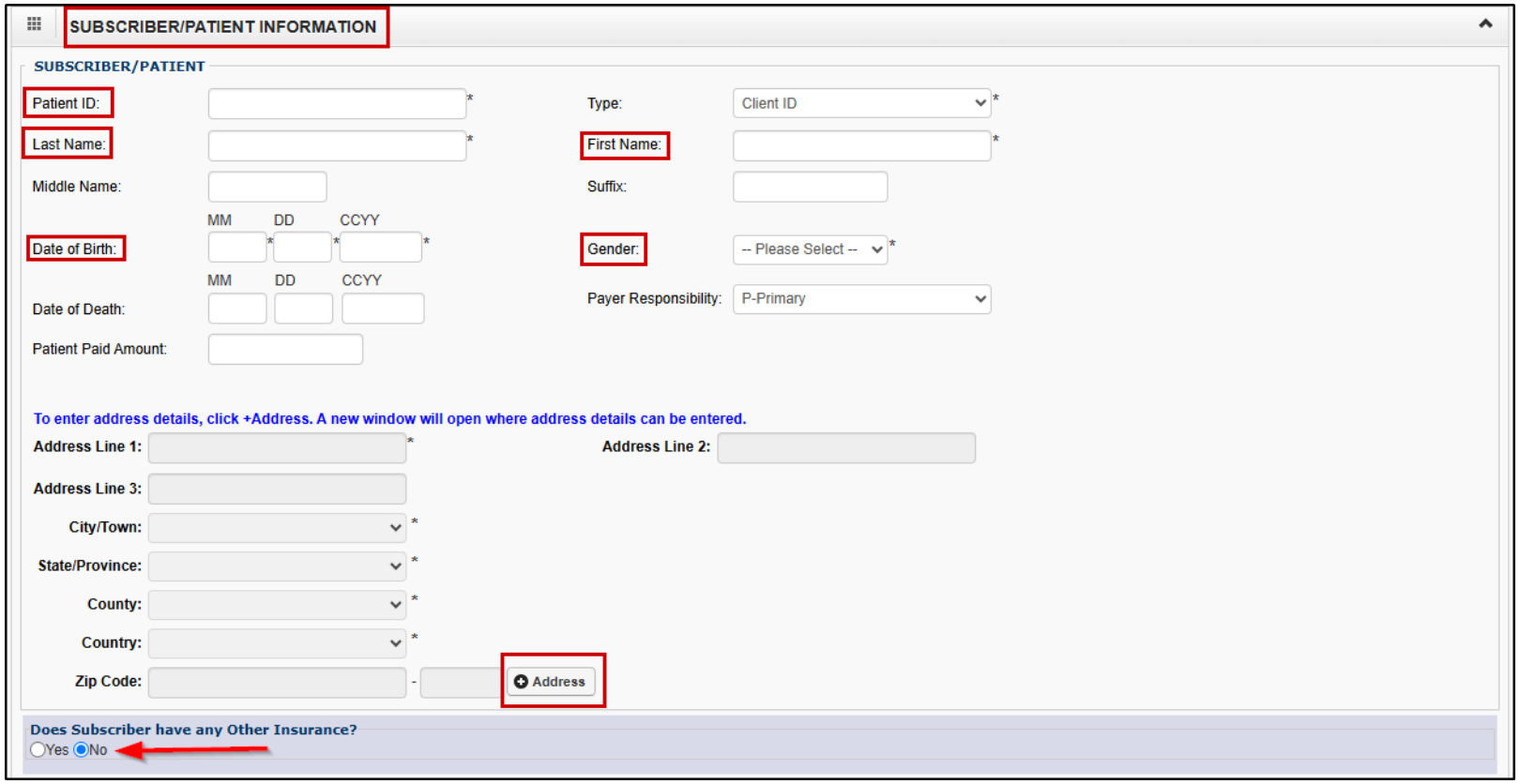
Subscriber/Patient Information

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**.



Note: The term Subscriber and Patient are used interchangeably

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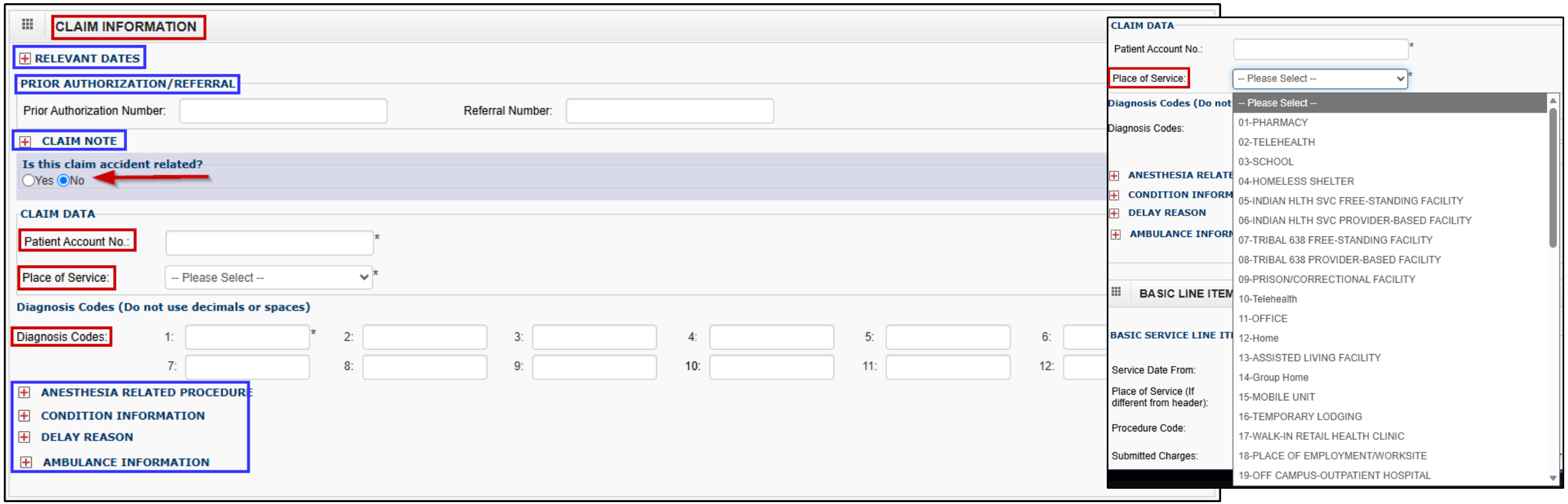
Claim Information

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



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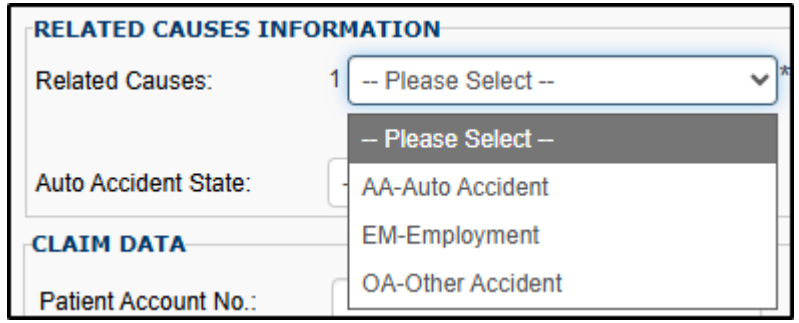
Accident Related

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.





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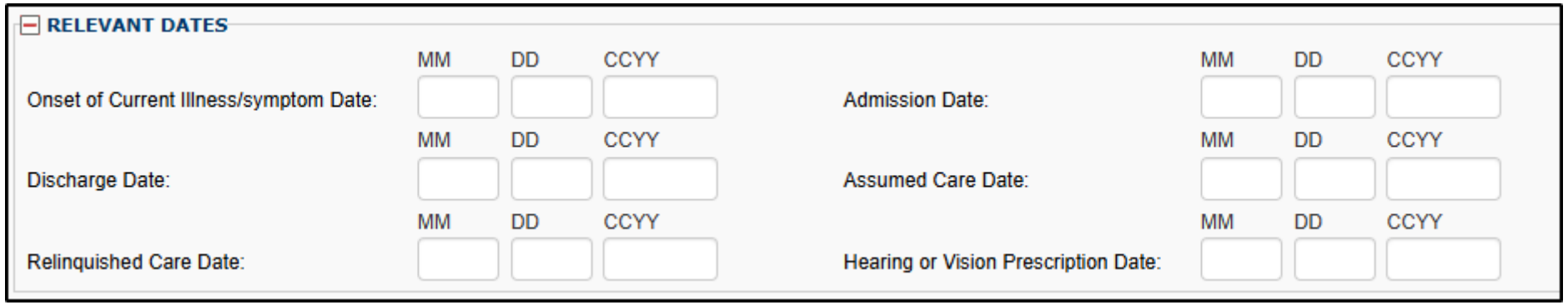
Relevant Dates and Claim Notes

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



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



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Anesthesia, Condition and Delay Reason

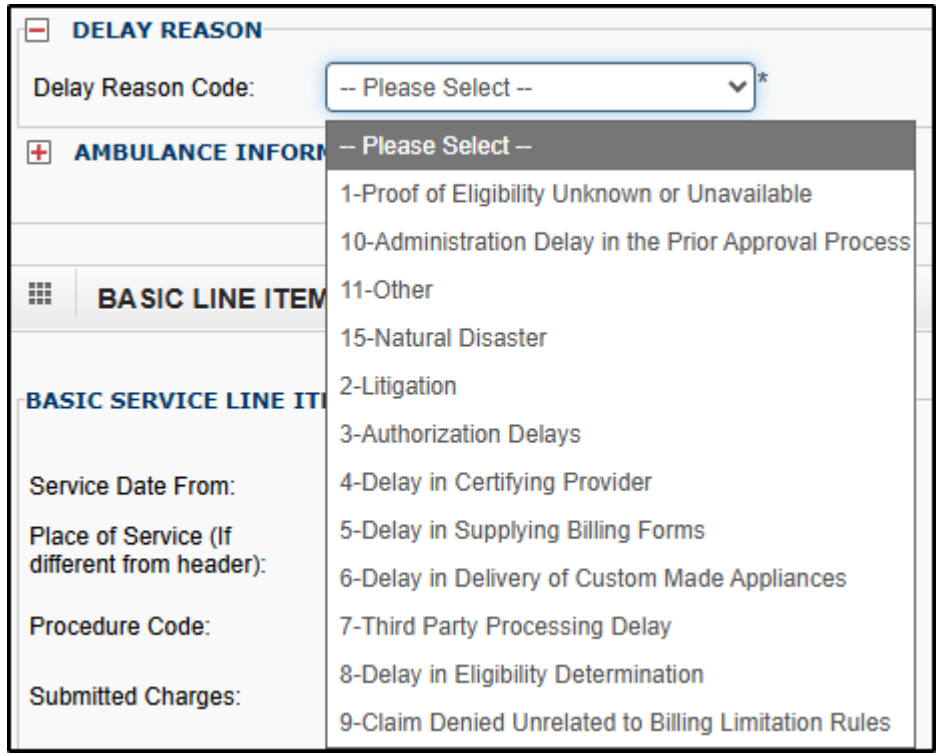
The **Anesthesia Related Procedure** field expands to allow the user to enter anesthesia procedure code.



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



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



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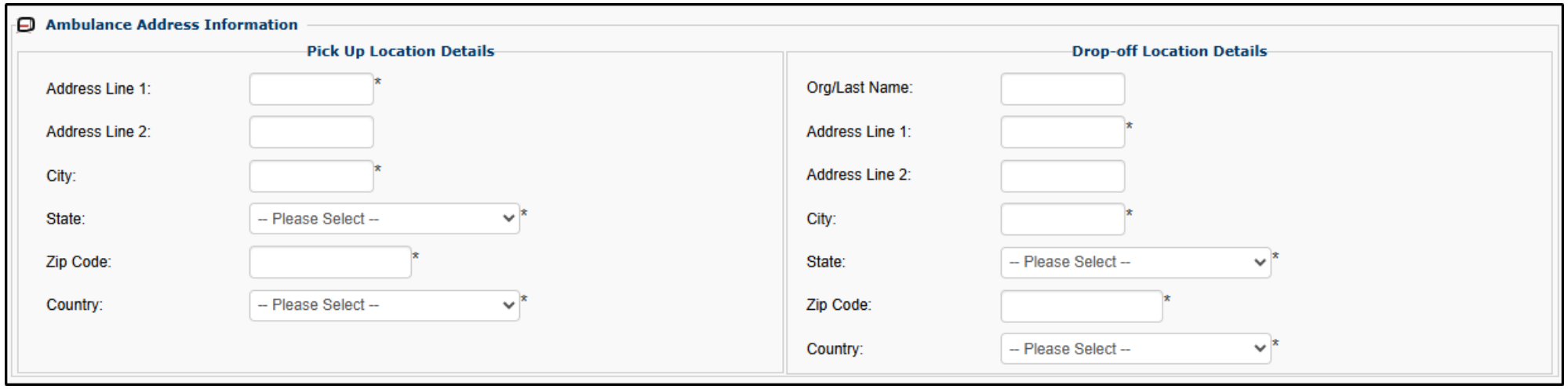
Ambulance Information

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**.



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



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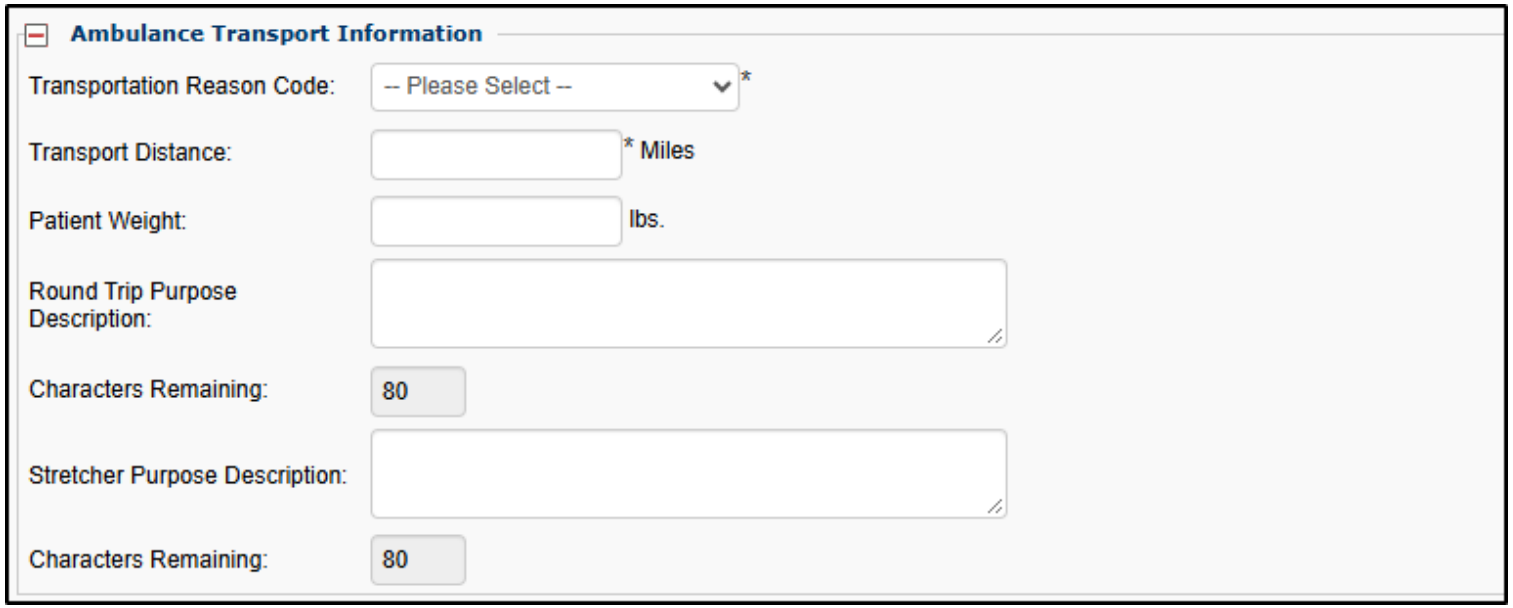
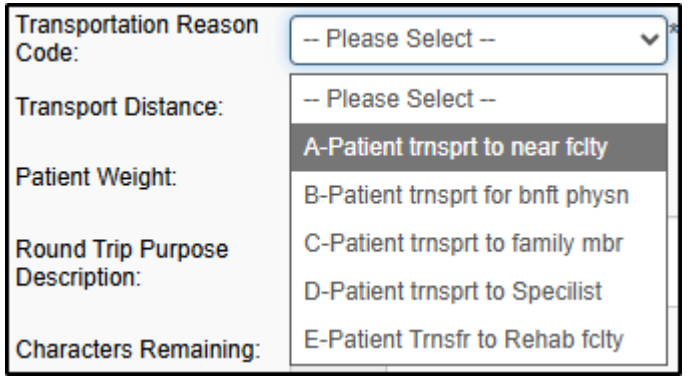
Ambulance Transport Information

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.





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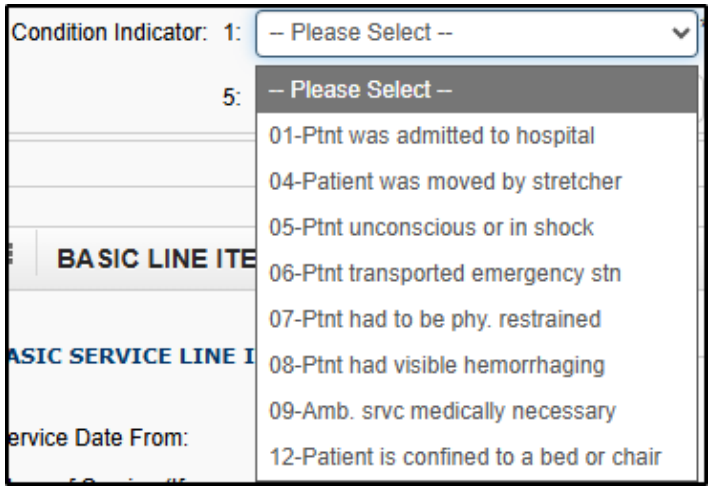
Ambulance Certification

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.





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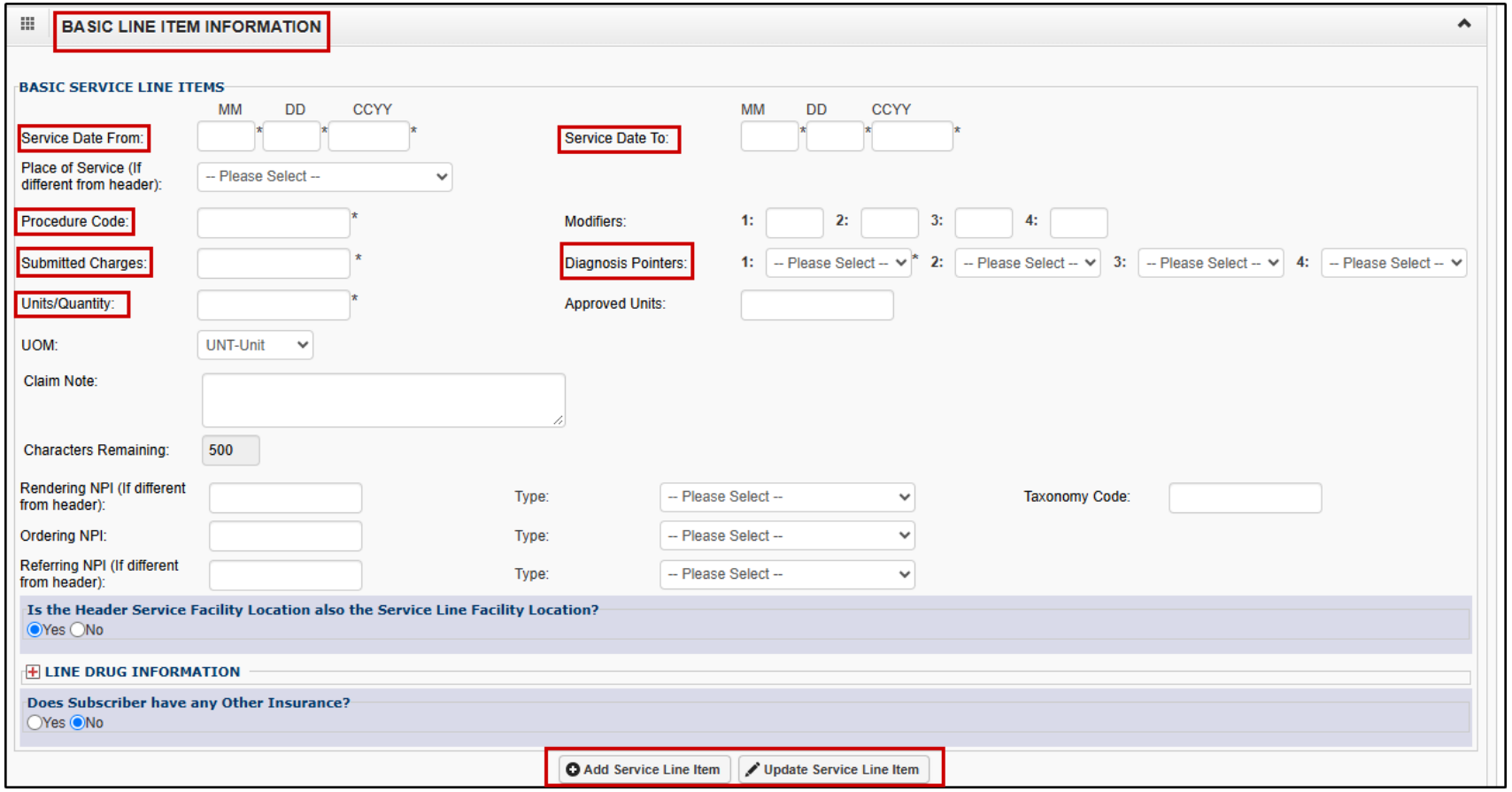
Basic Line-Item Information

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



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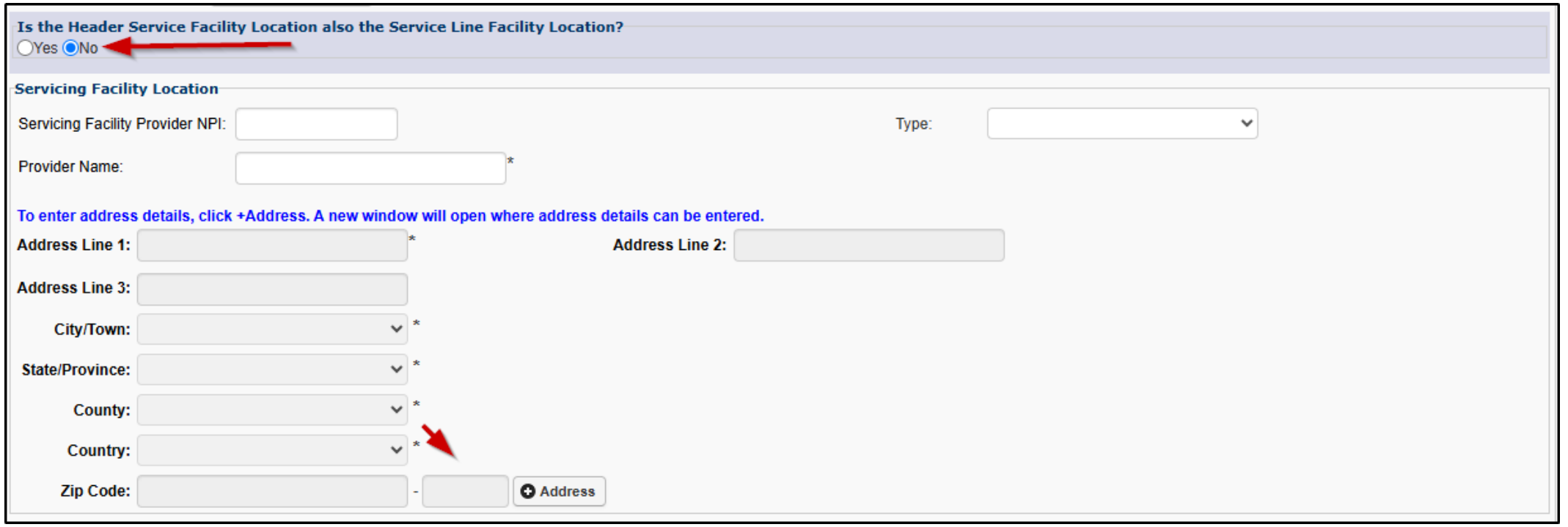
Service Line Facility Location

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.



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Drug Information

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



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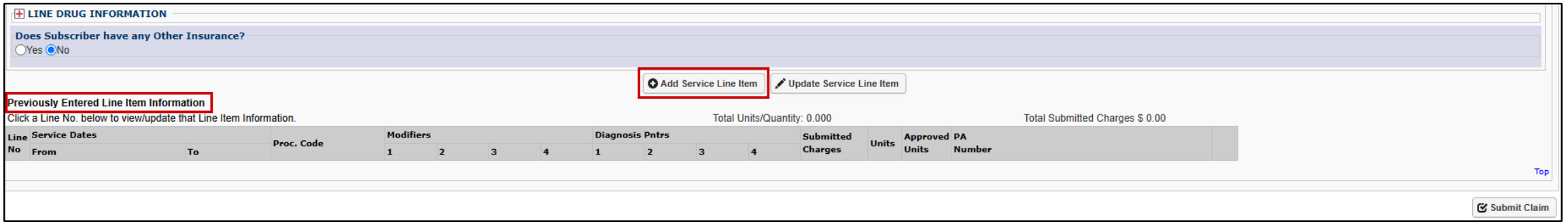
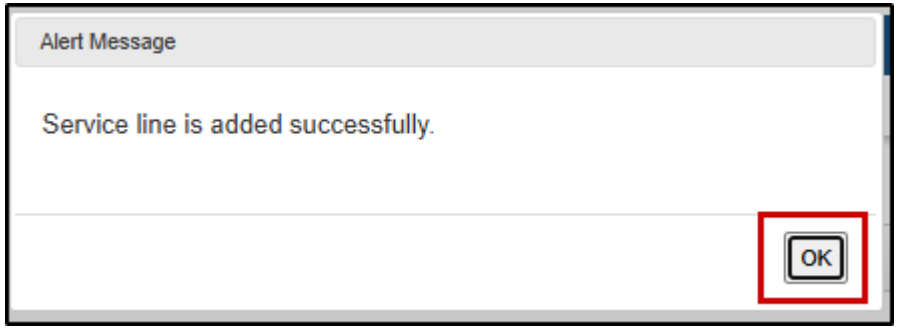
Adding a Service Line

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.





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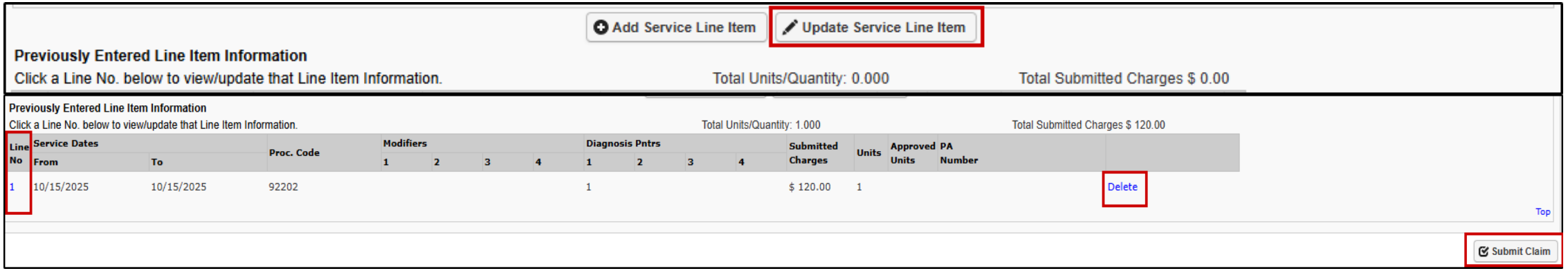
Claim Submission

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.



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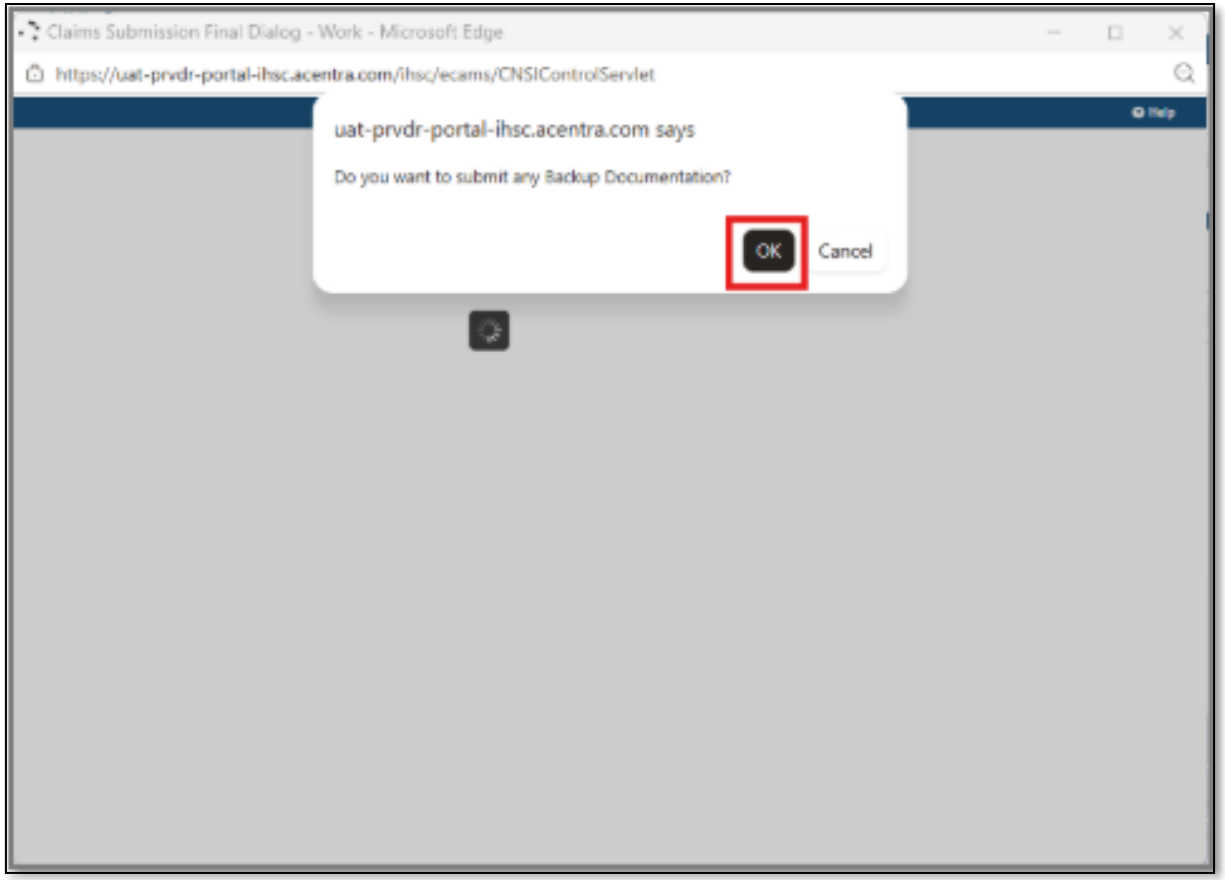
Claims Submission Final Dialog

A Claims Submission Final Dialog pop-up window appears to confirm the claim submission.

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



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Institutional Claims

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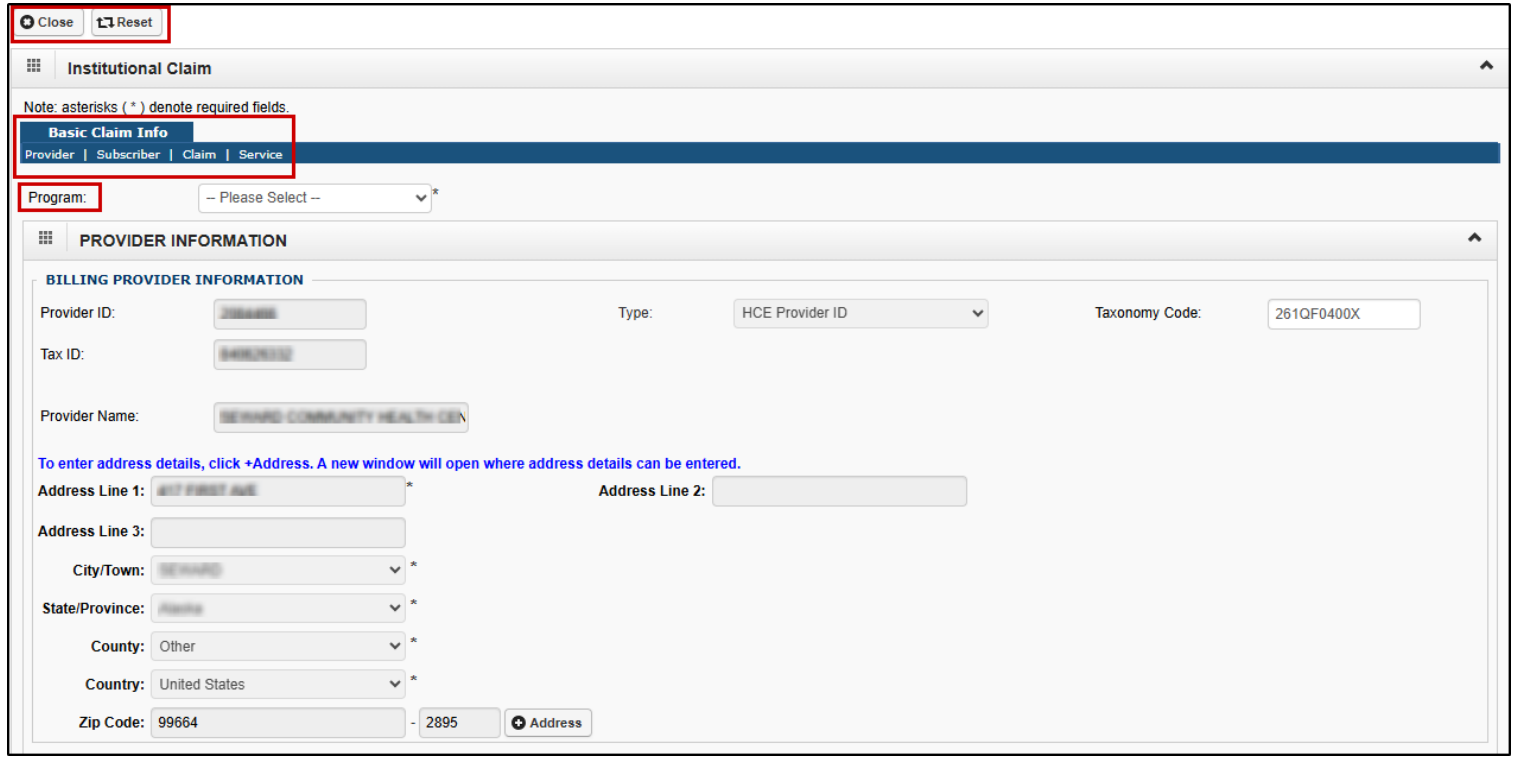
Institutional Claim – Provider Information

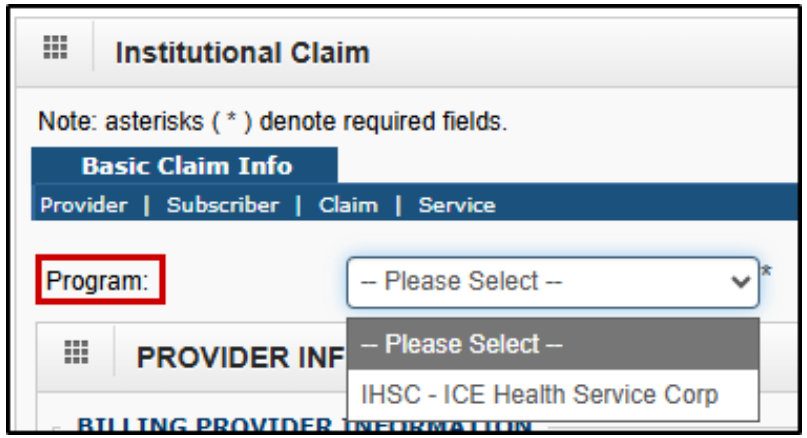
In the **Institutional Claim** window, the **Basic Claim Info** section contains the information required to complete the claim. This section includes **Provider**, **Subscriber**, **Claim** and **Service**.

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.



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



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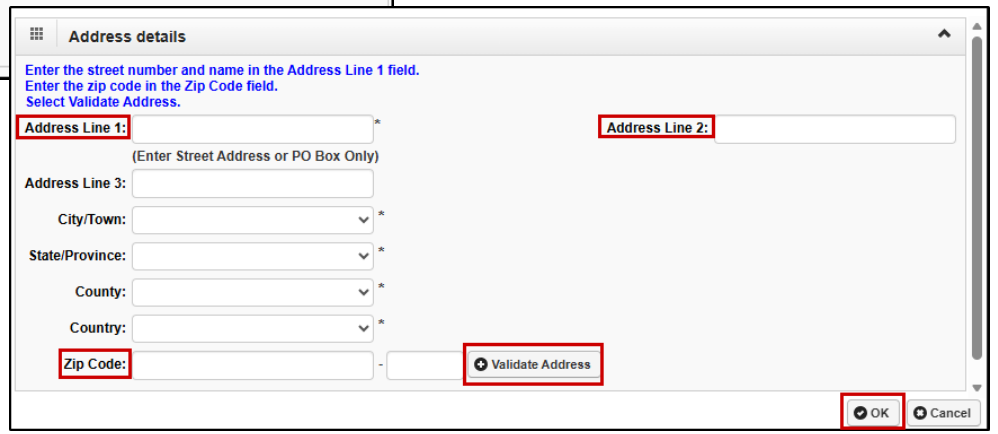
Billing Location - Pay-To Location

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**.



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

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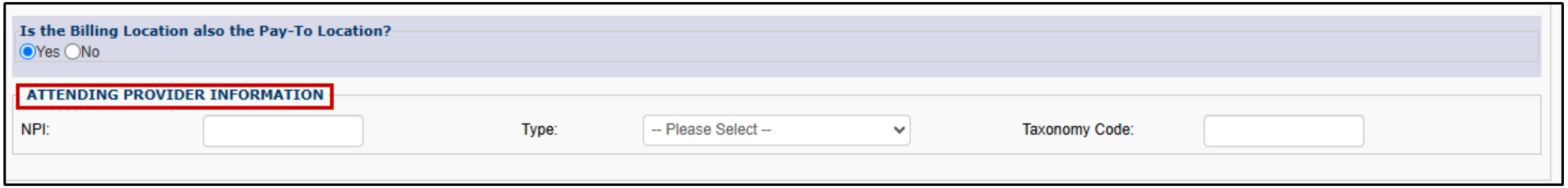
Attending Provider

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.



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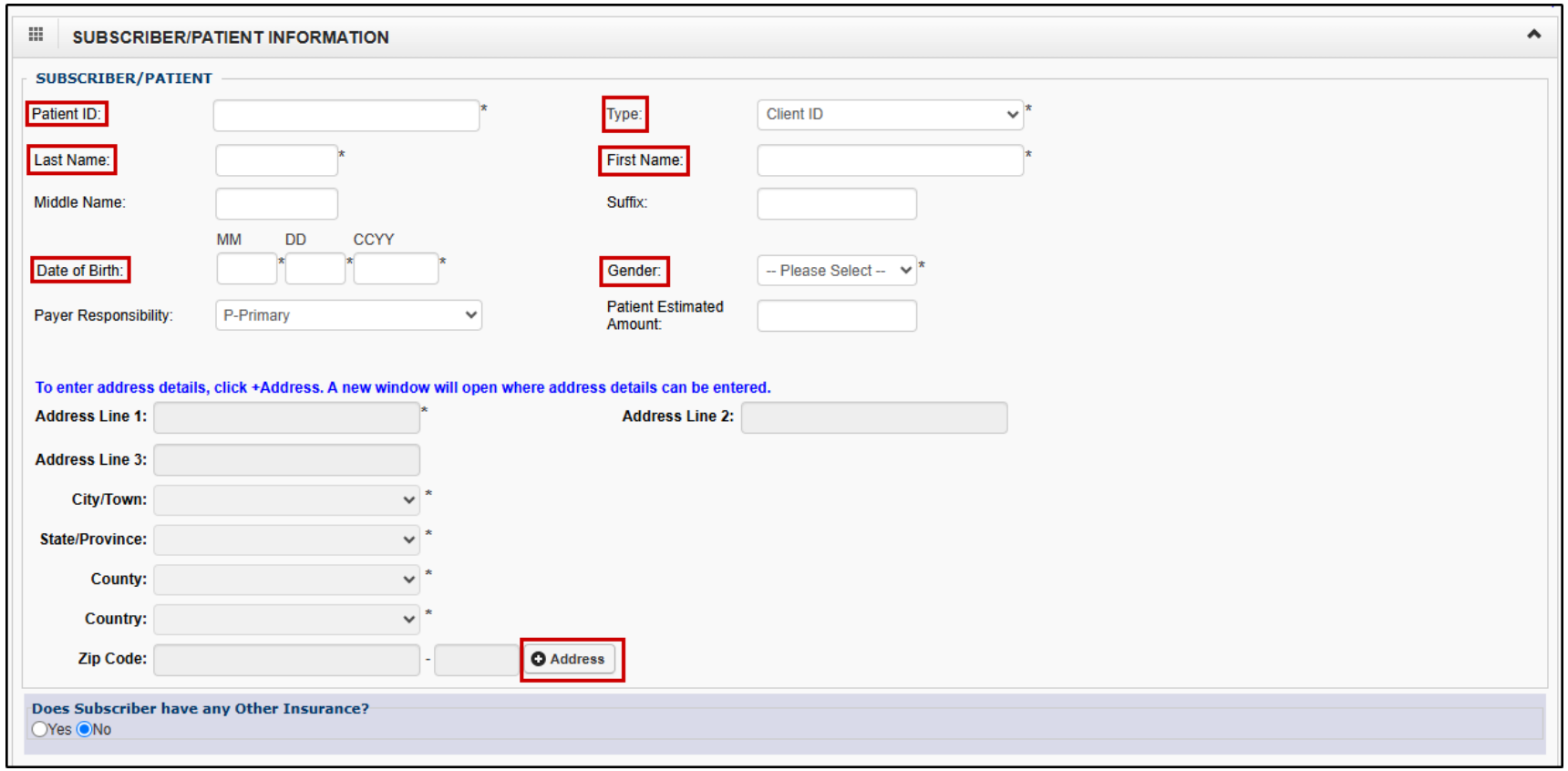
Subscriber/Patient Information

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**.



Note: The term Subscriber and Patient are used interchangeably.

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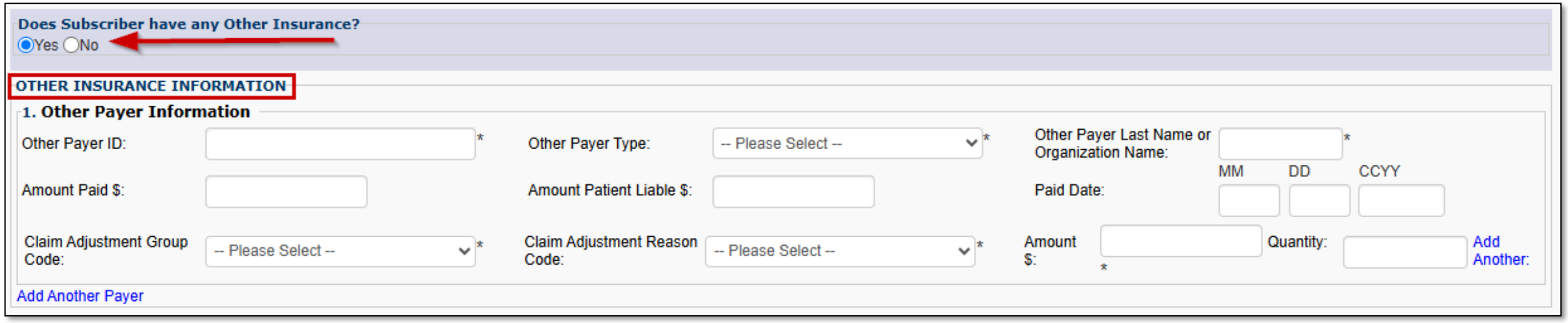
Other Insurance Information

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.



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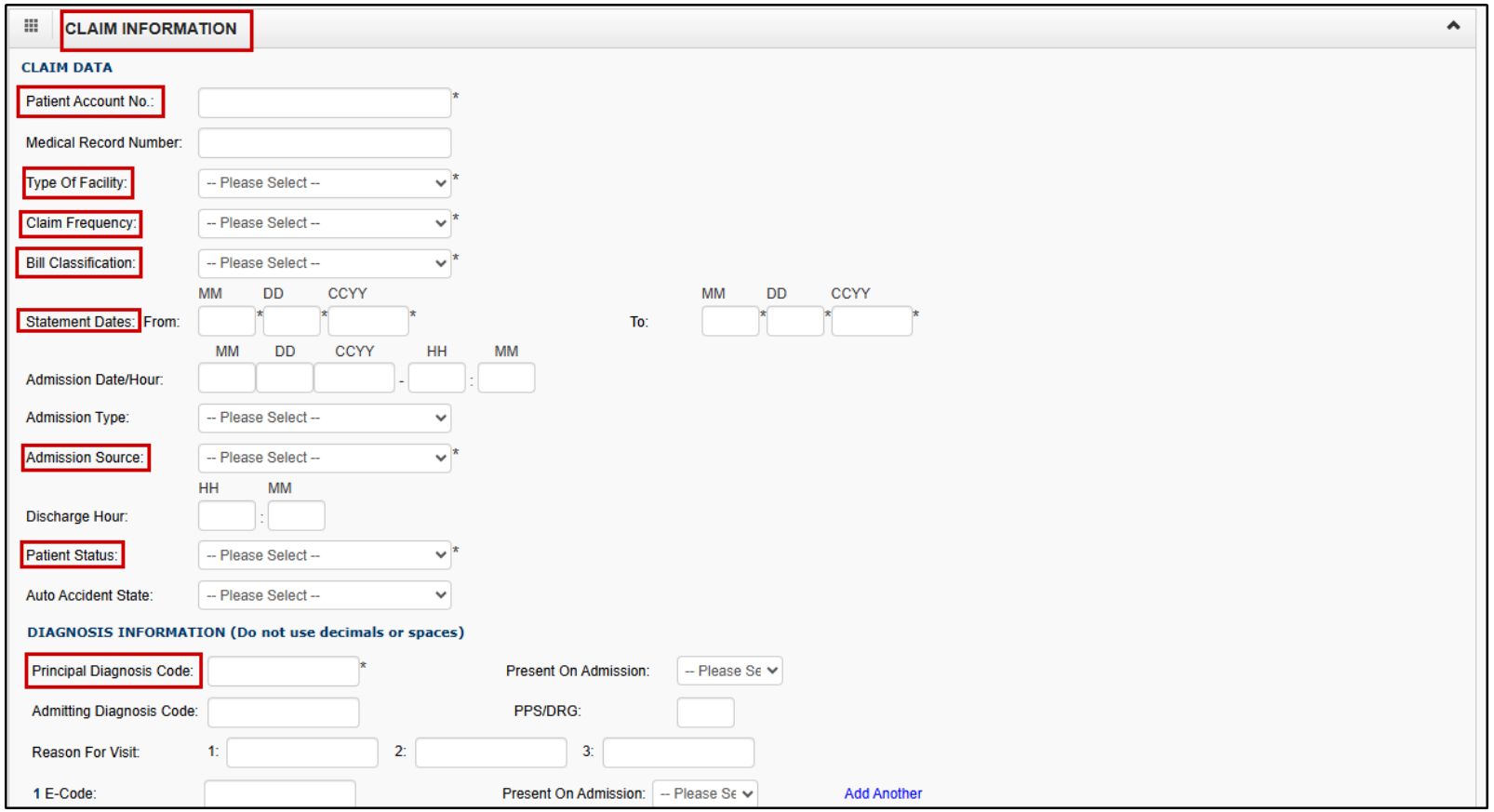
Claim Information

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



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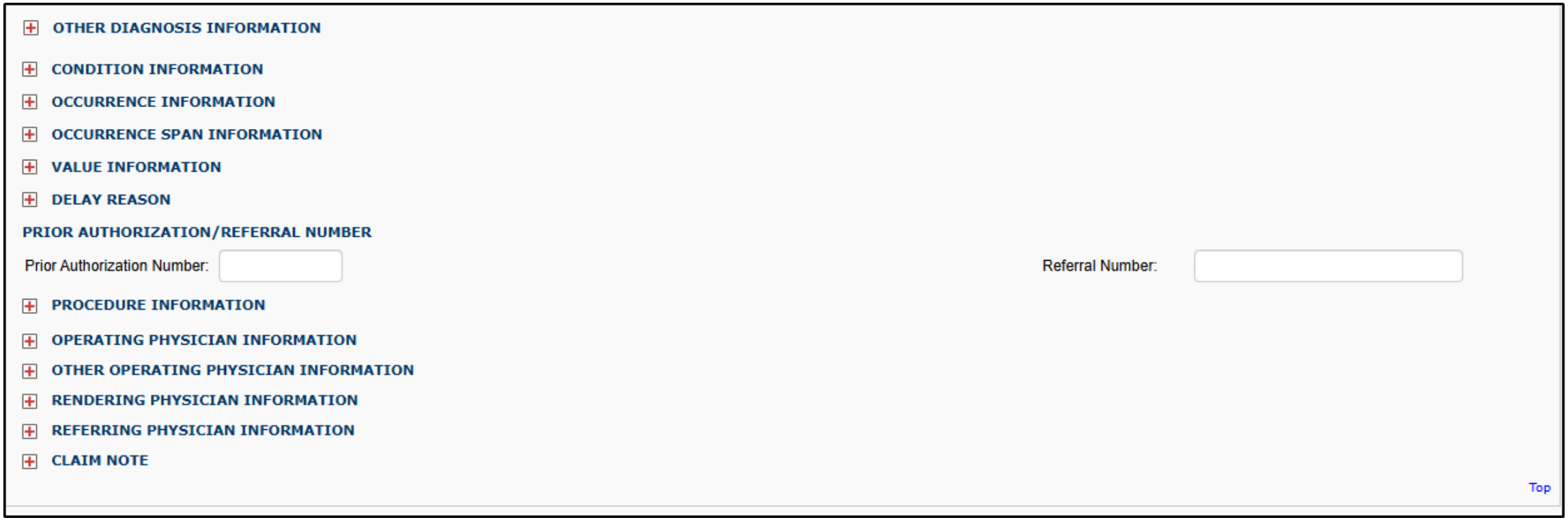
Additional Claim Information

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



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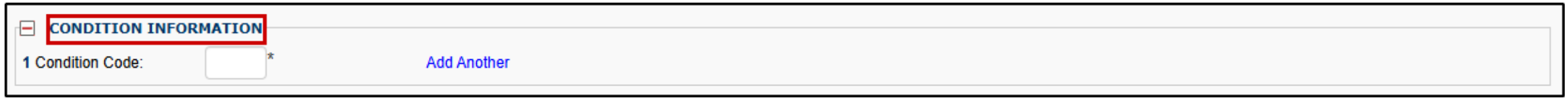
Diagnosis, Condition and Occurrence Information

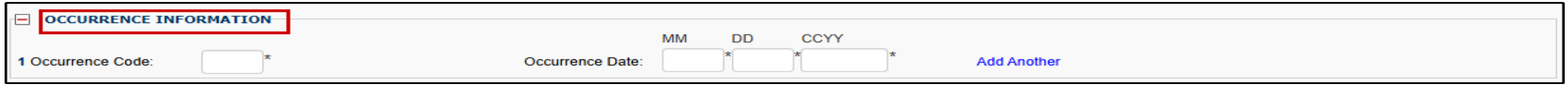
The **Other Diagnosis Information** field can be expanded to add additional diagnoses.



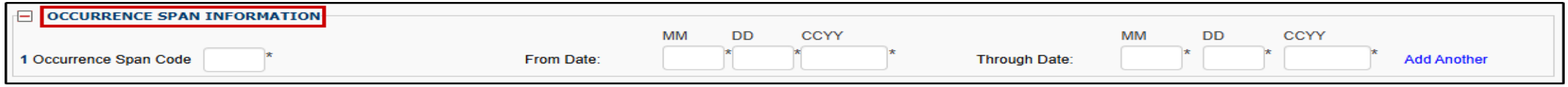
Additional condition codes can be entered by expanding the **Condition Information** field.



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



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.



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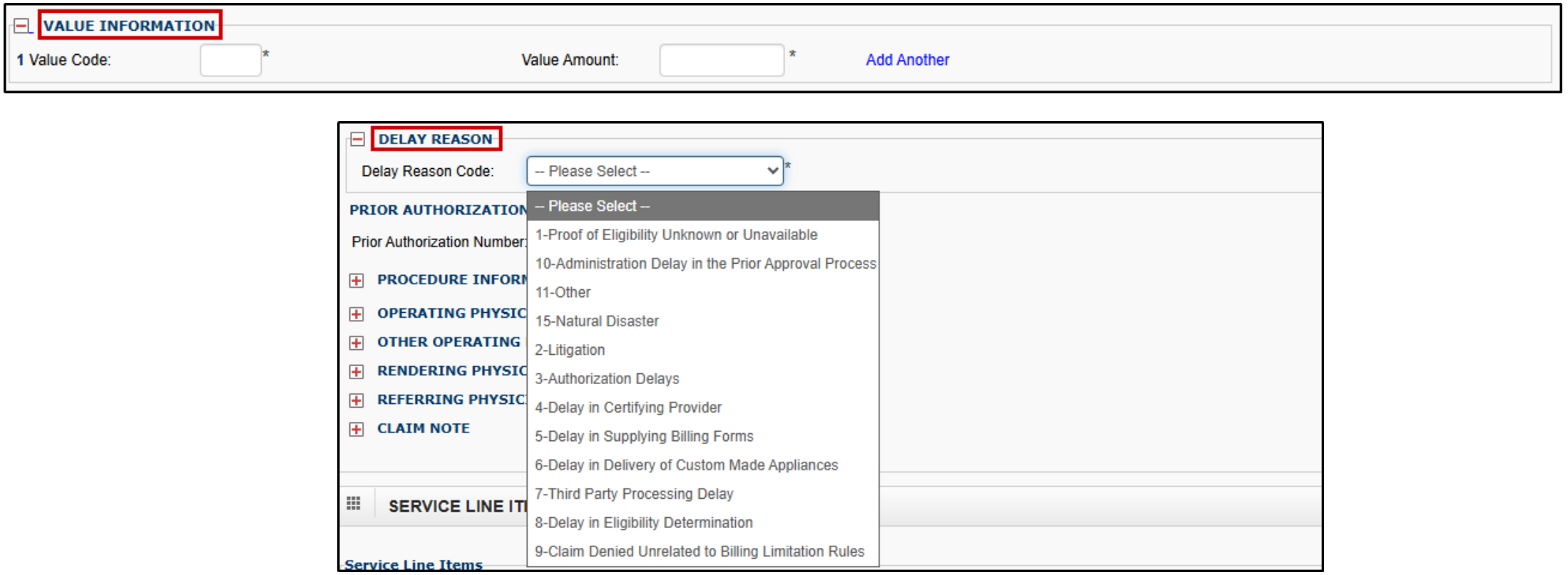
Value Information

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.



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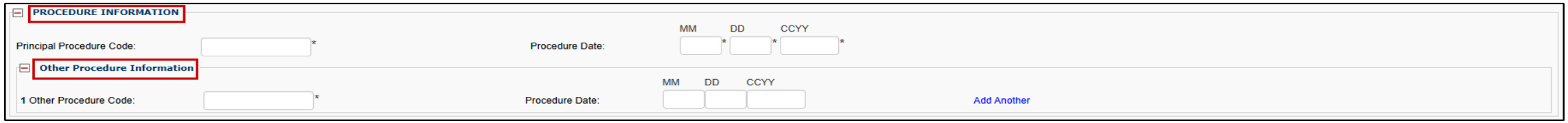
Prior Authorization, Procedure, Operating Physician Information

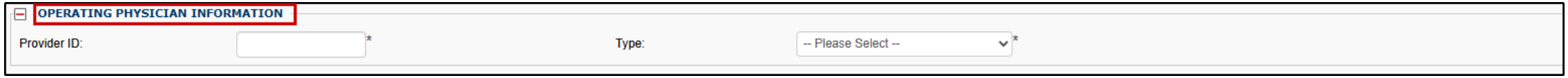
For services that require a prior authorization or referral, enter the information in the **Prior Authorization/Referral Number** fields.



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



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



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



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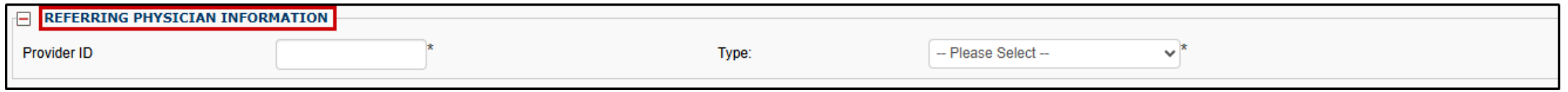
Rendering Physician, Referring Physician, Claim Note

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



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



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



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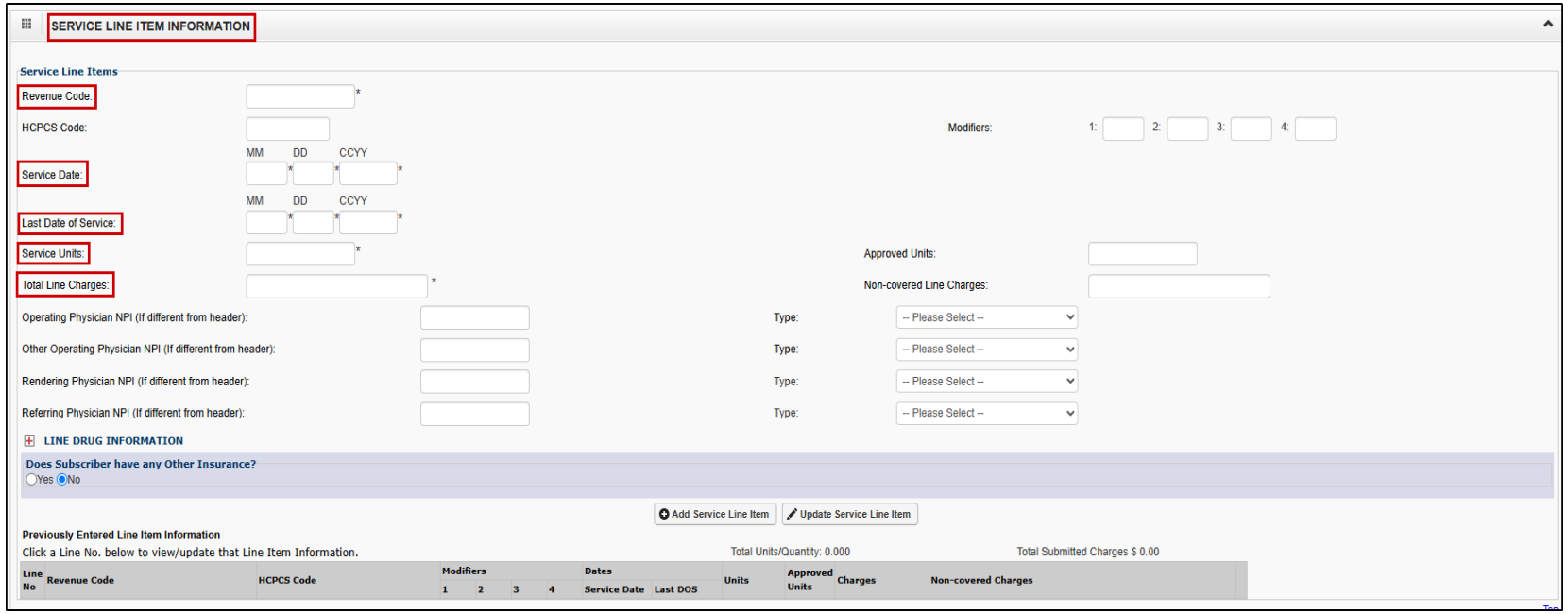
Service Line Item Information

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

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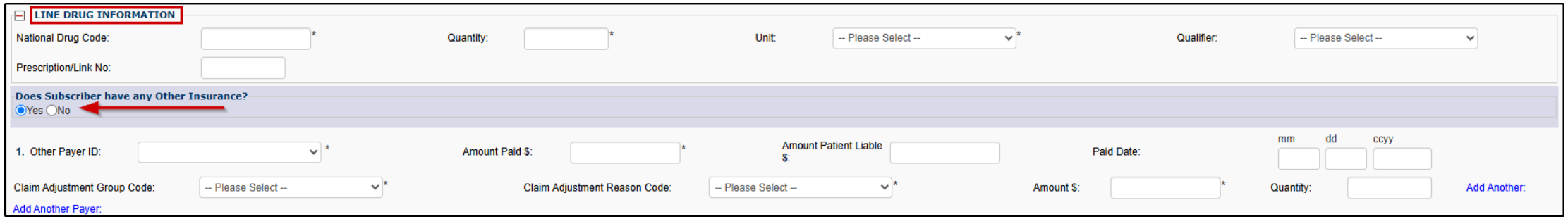
Drug Information and Other Insurance

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.



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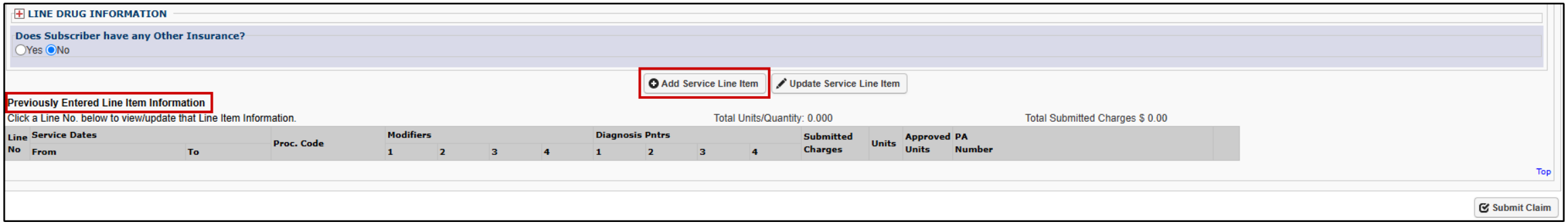
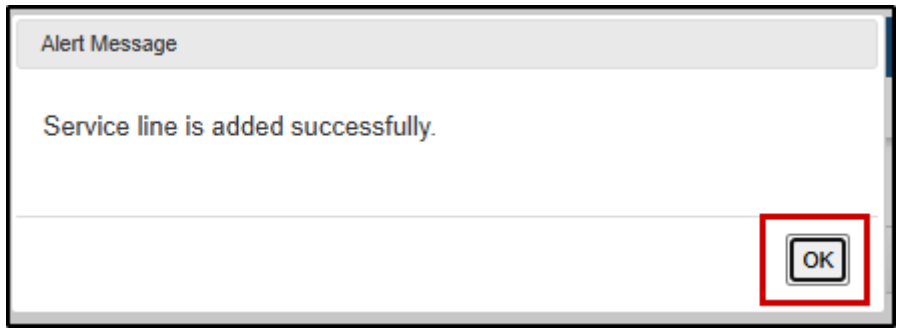
Adding a Service Line

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.





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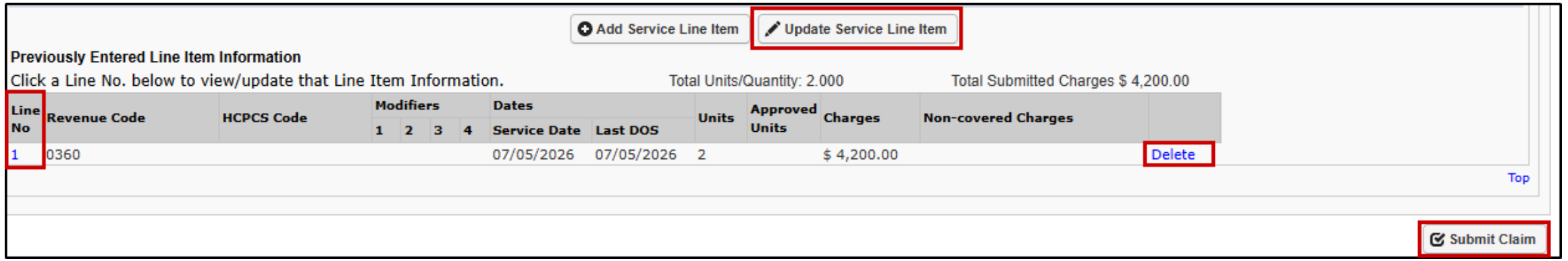
Claim Submission

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.



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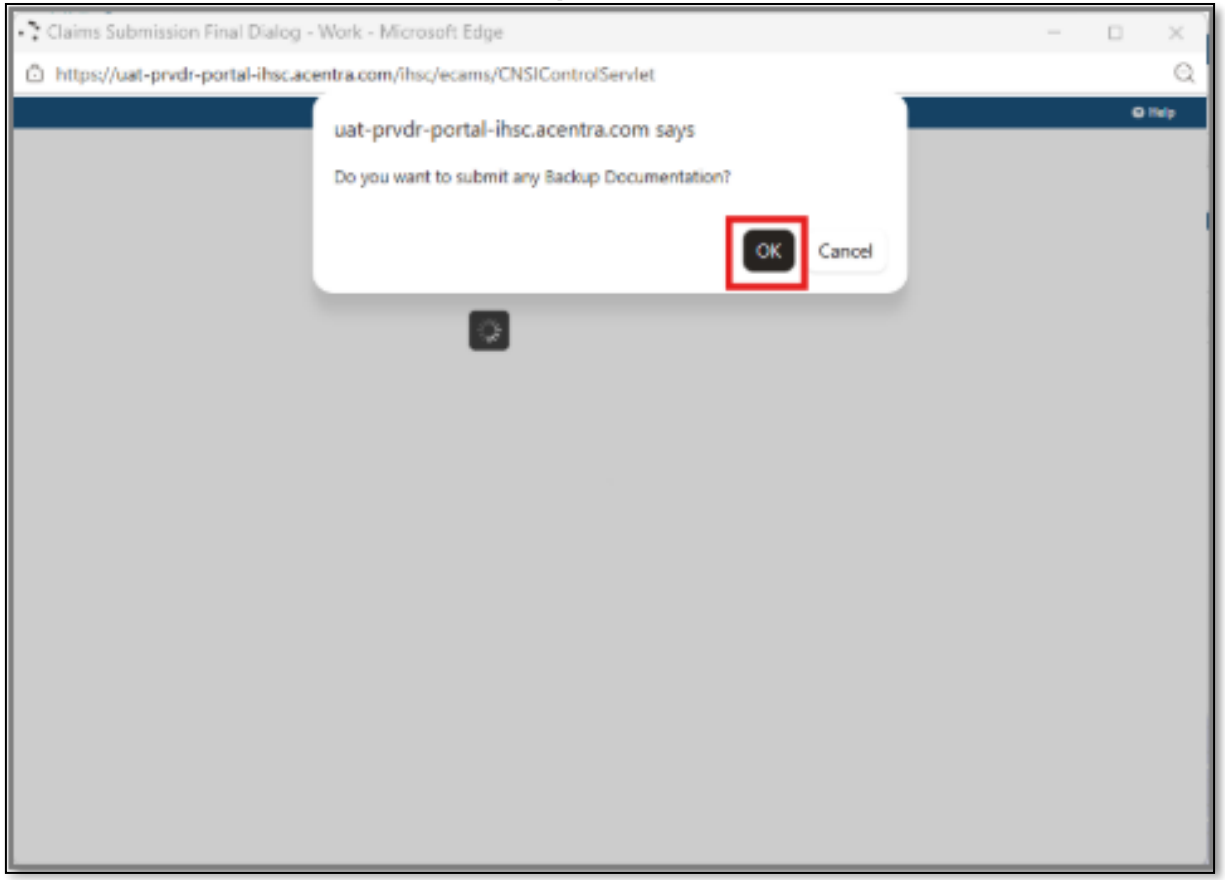
Claims Submission Final Dialog

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.



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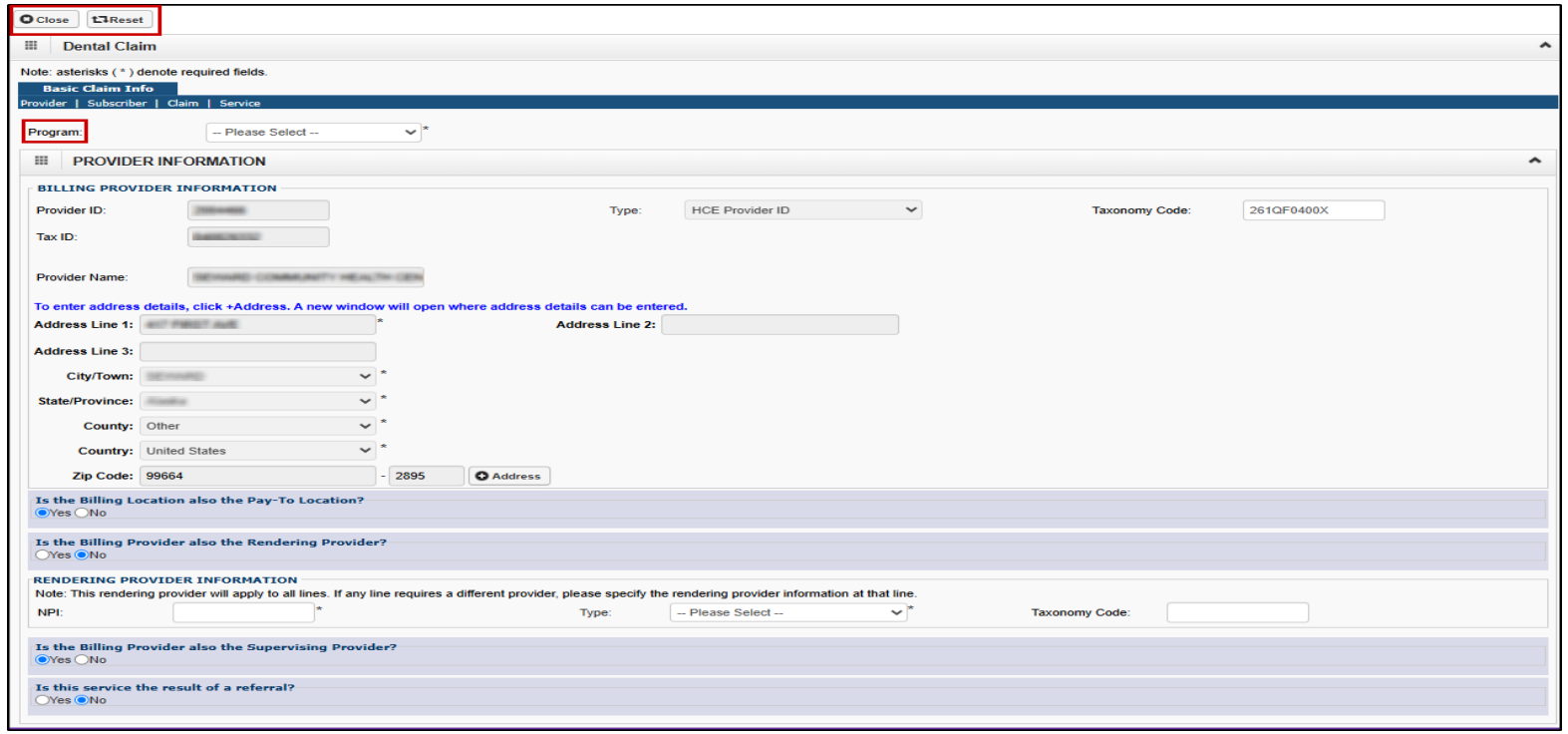
Dental Claims

Dental Claim – Provider Information

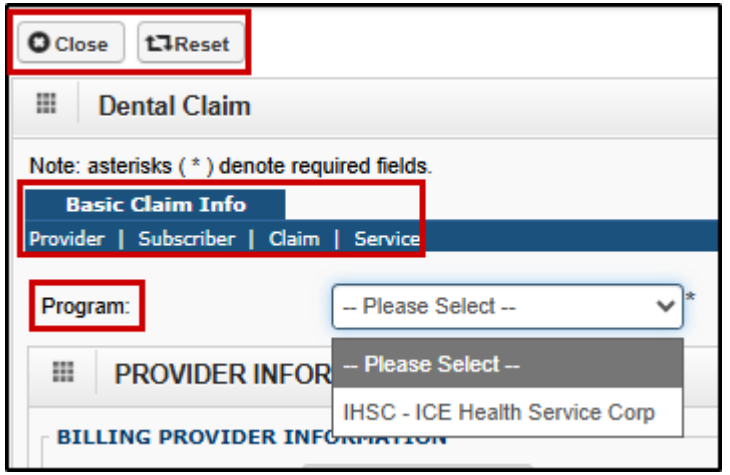
In the **Dental Claim** window, the **Basic Claim Info** section contains the information required to complete the claim. This section includes **Provider**, **Subscriber**, **Claim**, and **Service**.

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.



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



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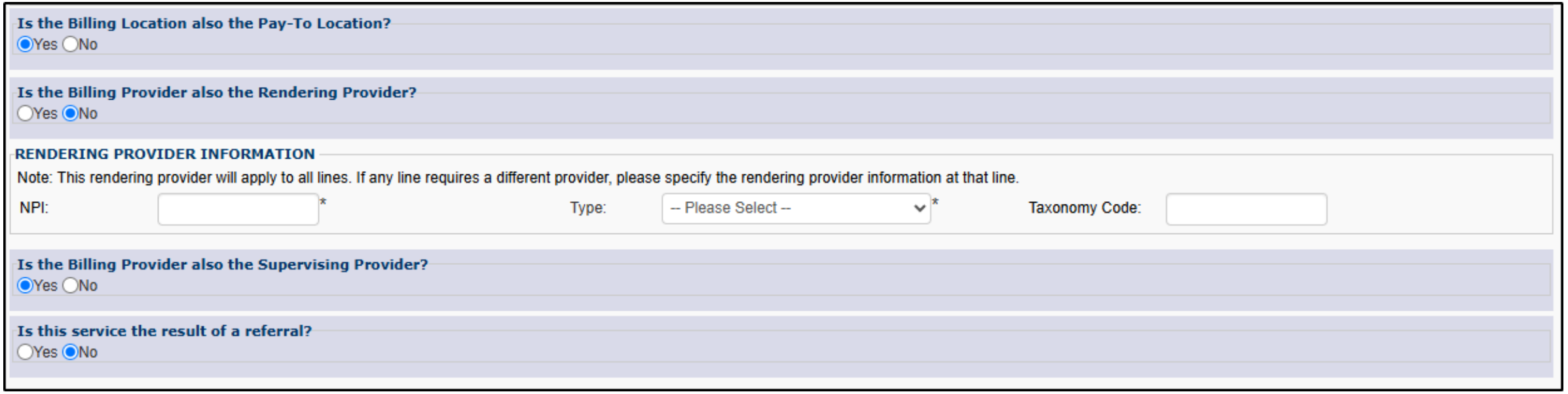
Provider Information – Billing Questions

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.



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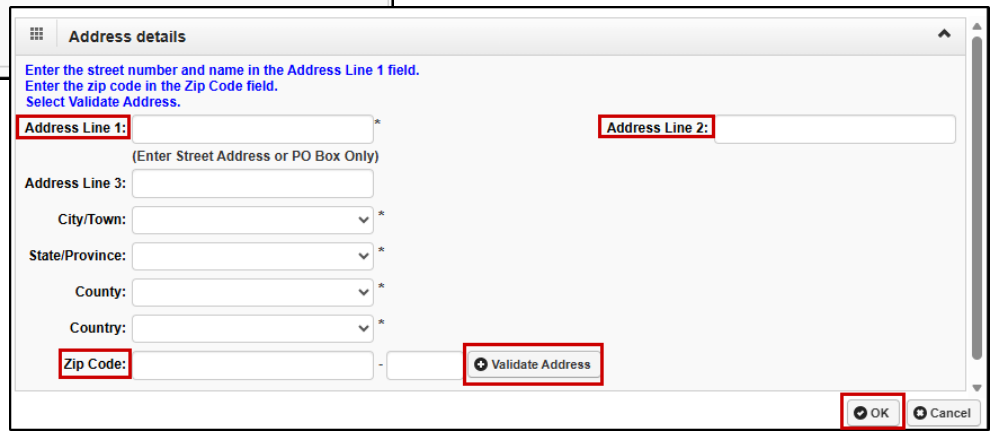
Billing Location - Pay-To Location

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**.



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

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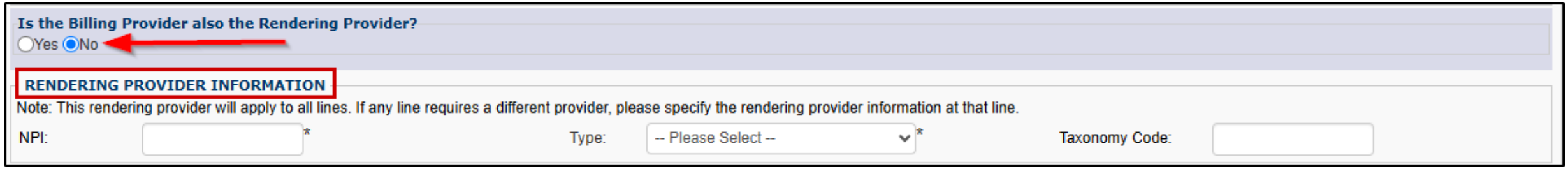
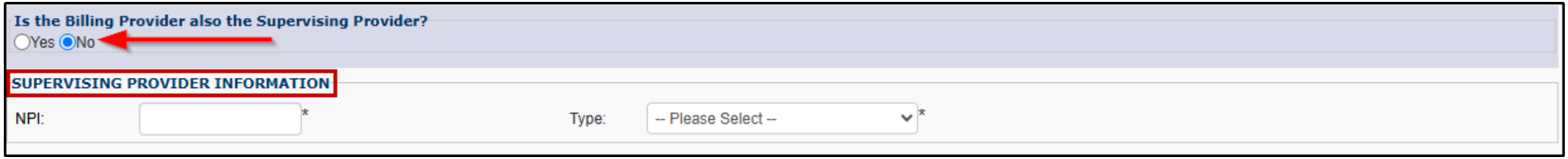
Rendering Provider and Supervising Provider

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.



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



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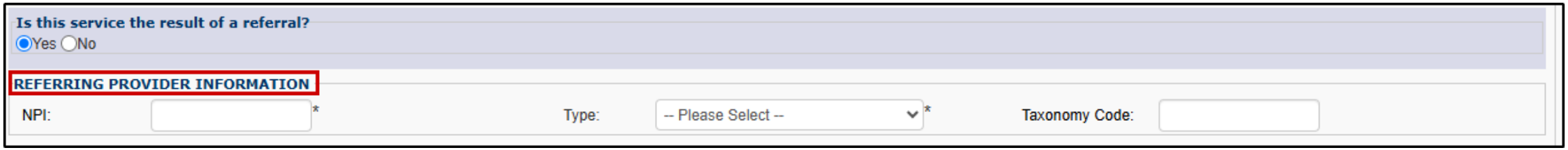
Referring Provider

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**.



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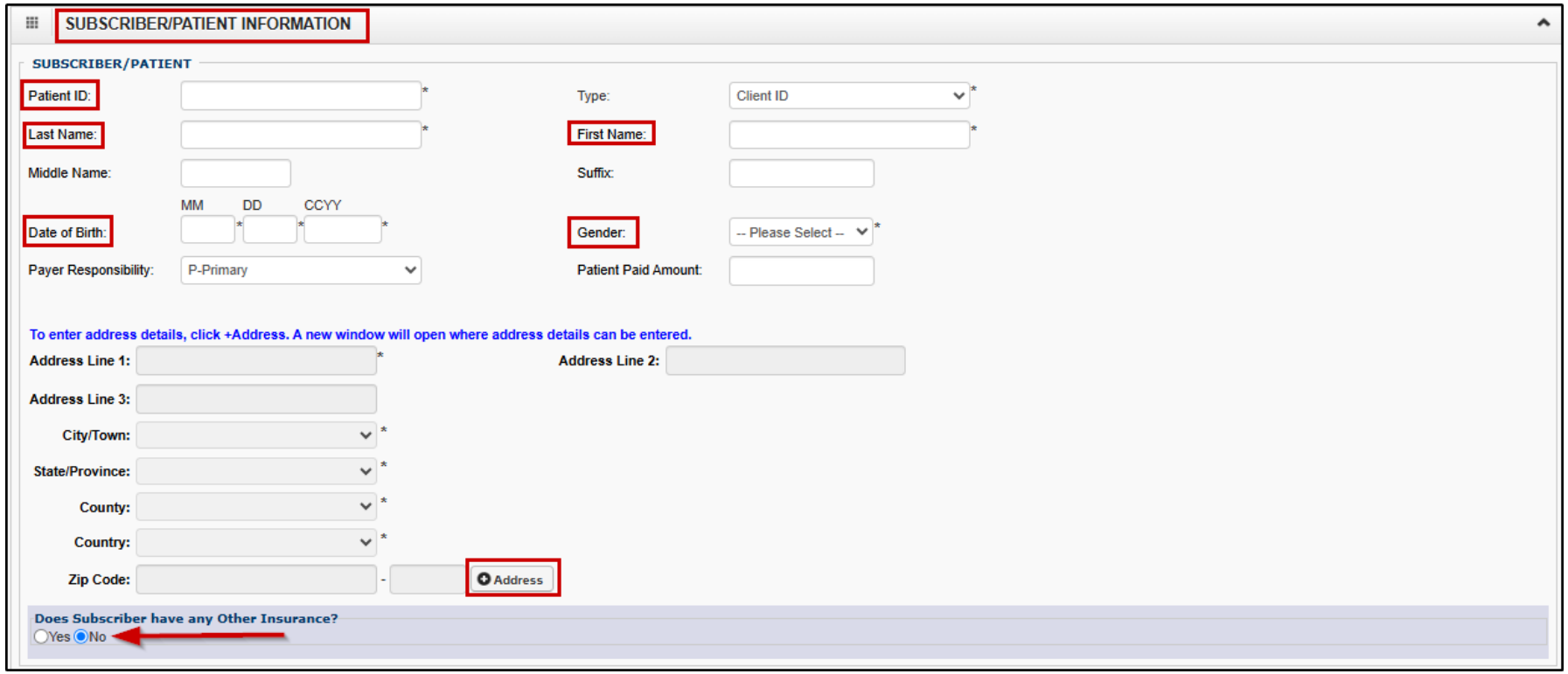
Subscriber/Patient Information

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**.



Note: The term Subscriber and Patient are used interchangeably

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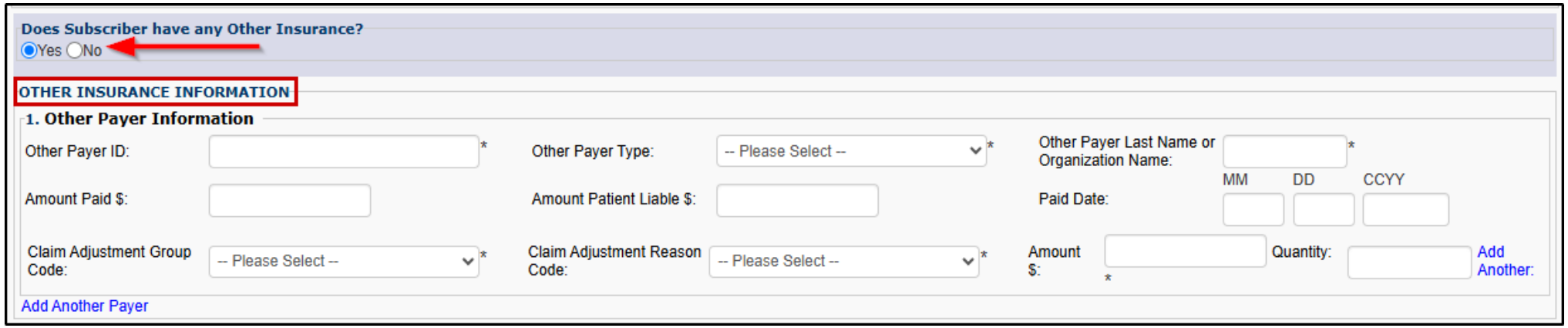
Other Insurance Information

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.



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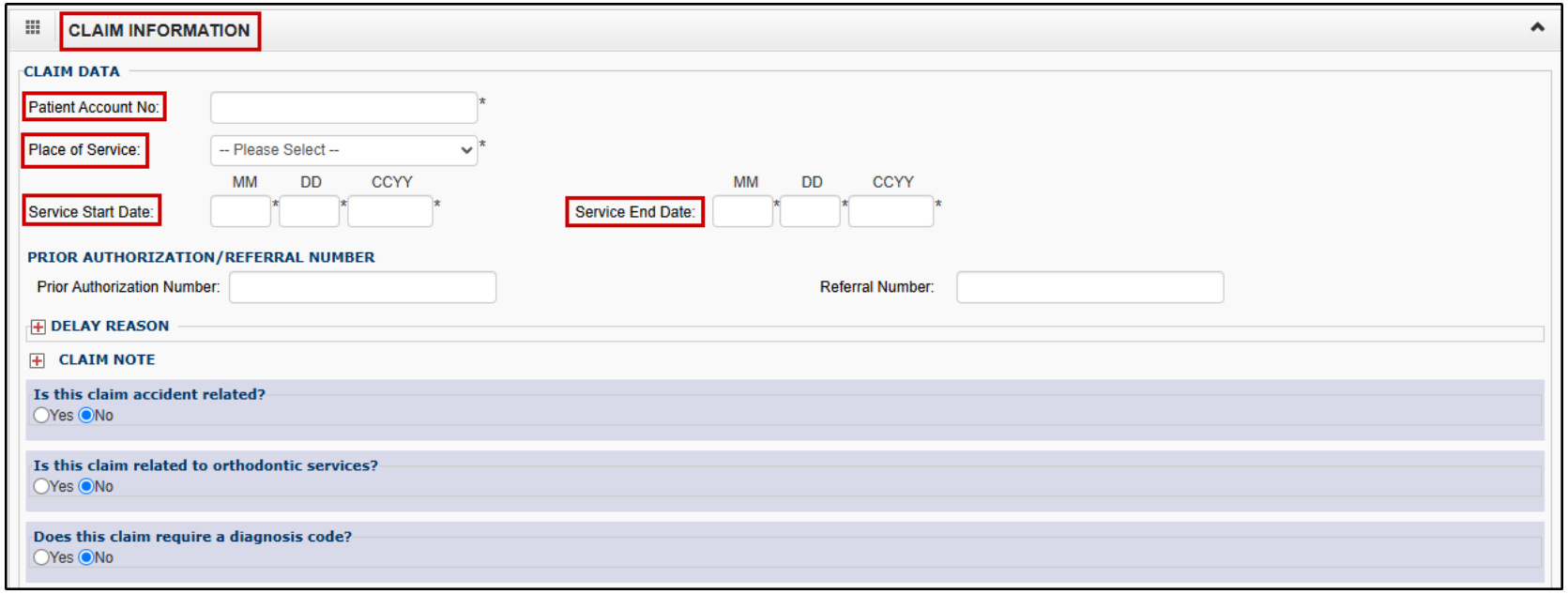
Claim Information

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.



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

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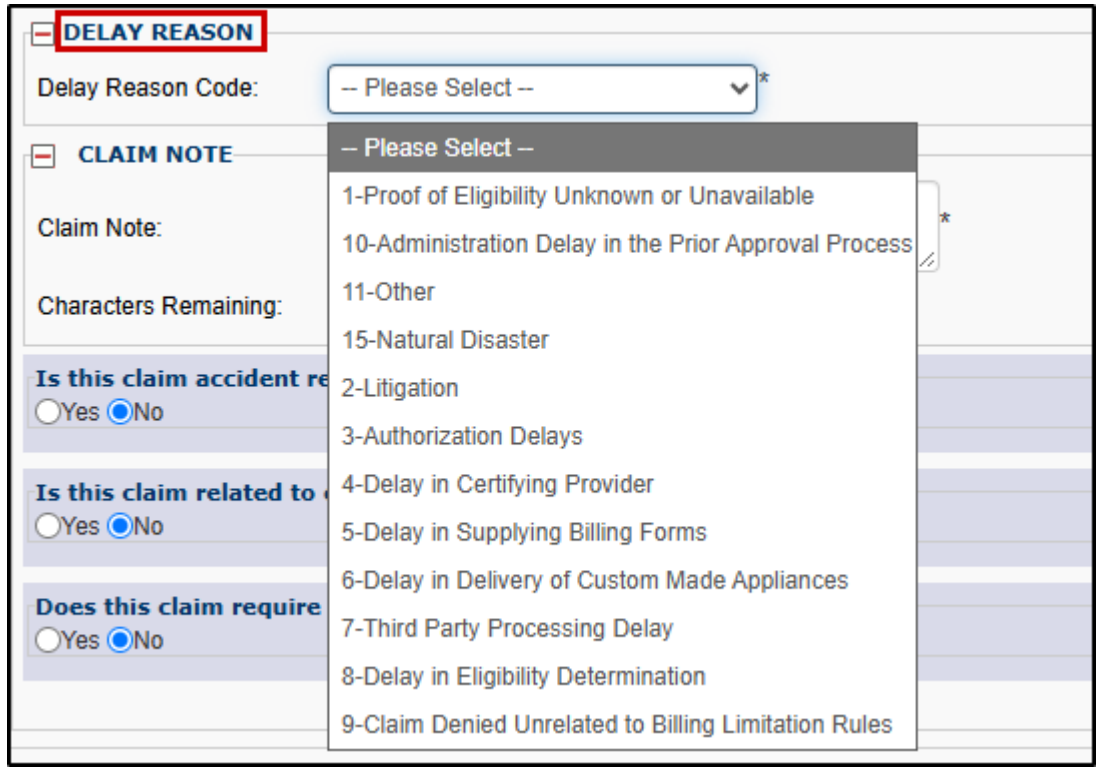
Delay Reason and Claim Note



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.



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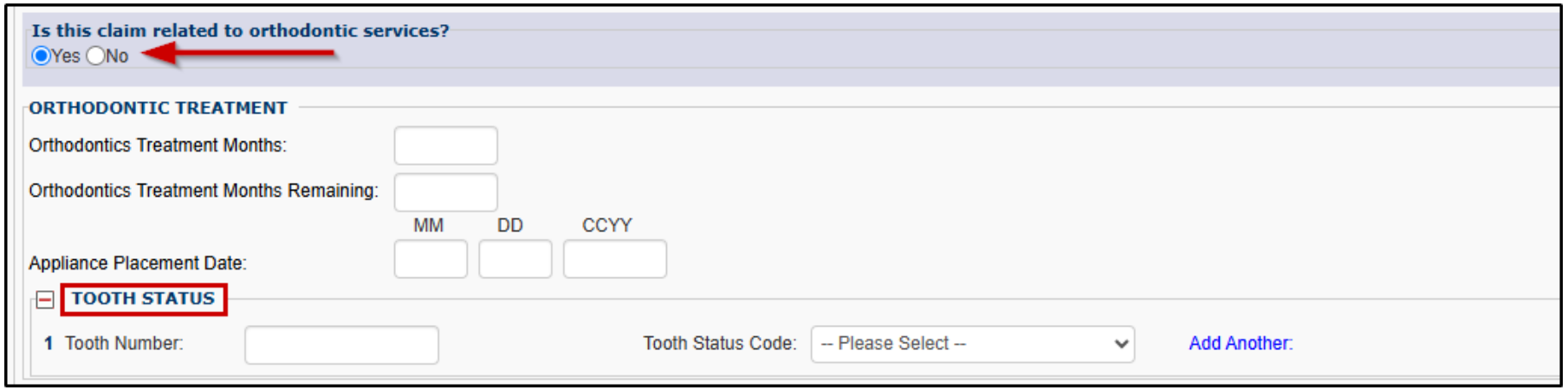
Accident Information and Orthodontic Services

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



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



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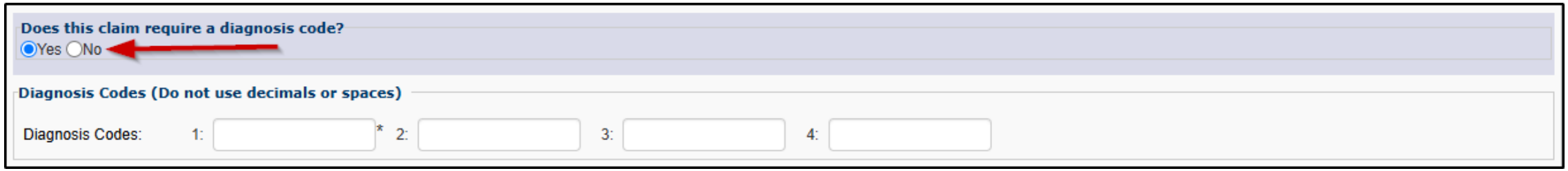
Diagnosis Code

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.



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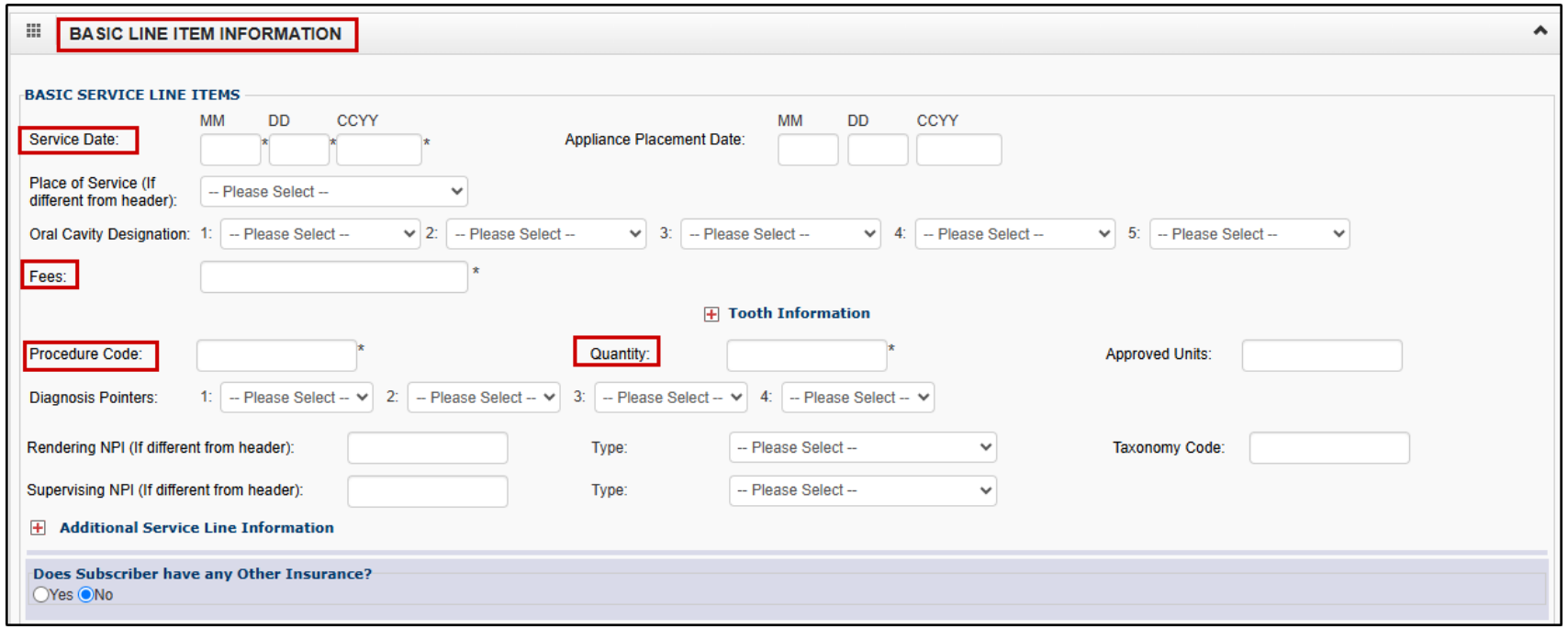
Basic Line Item Information

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.



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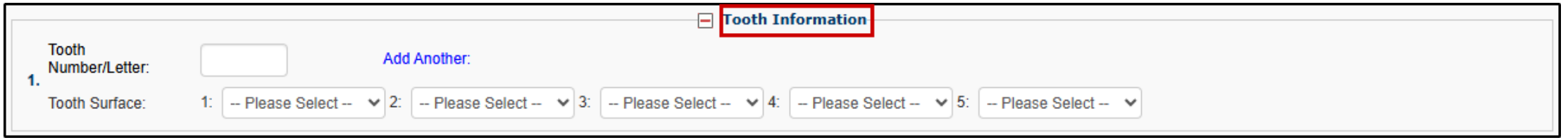
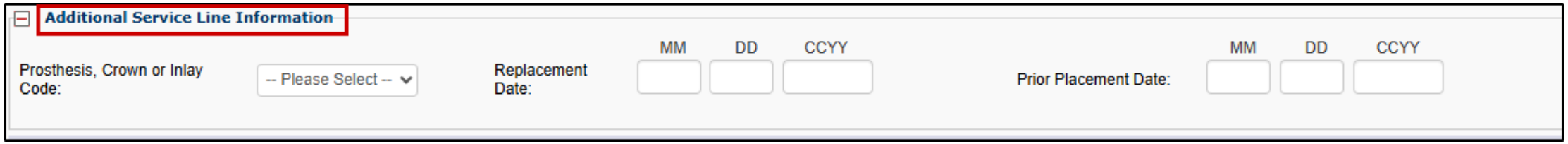
Tooth and Additional Service Line Information

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.





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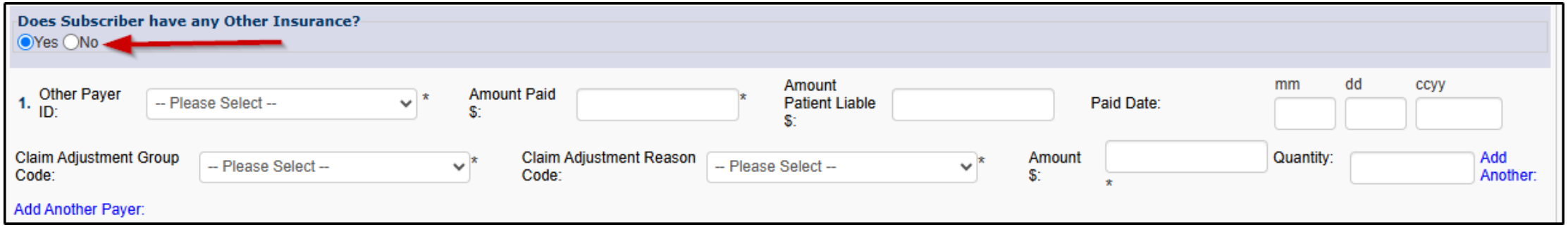
Other Insurance Information

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.



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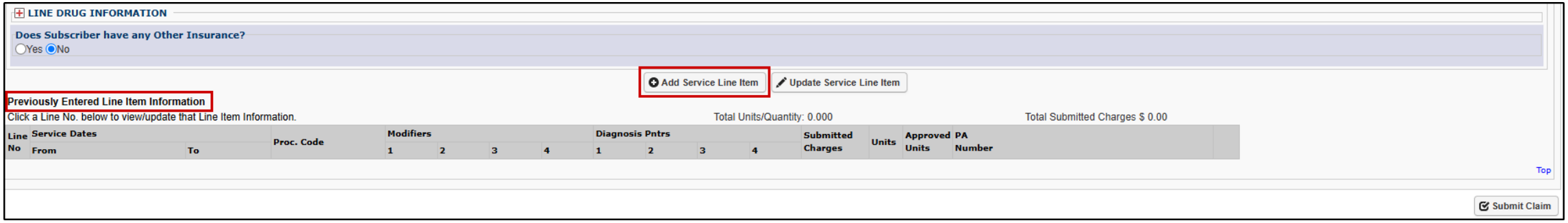
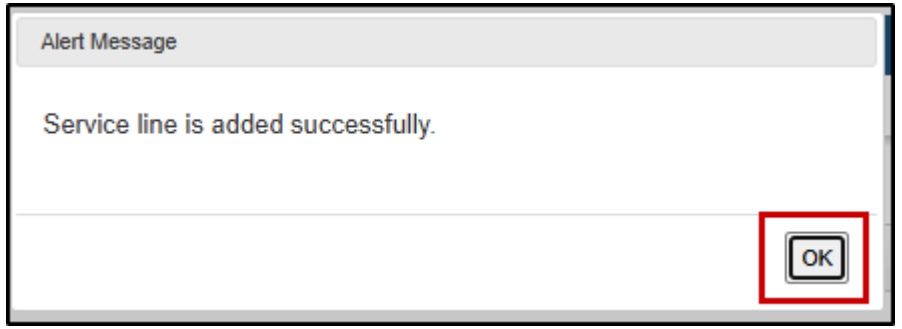
Adding a Service Line

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.





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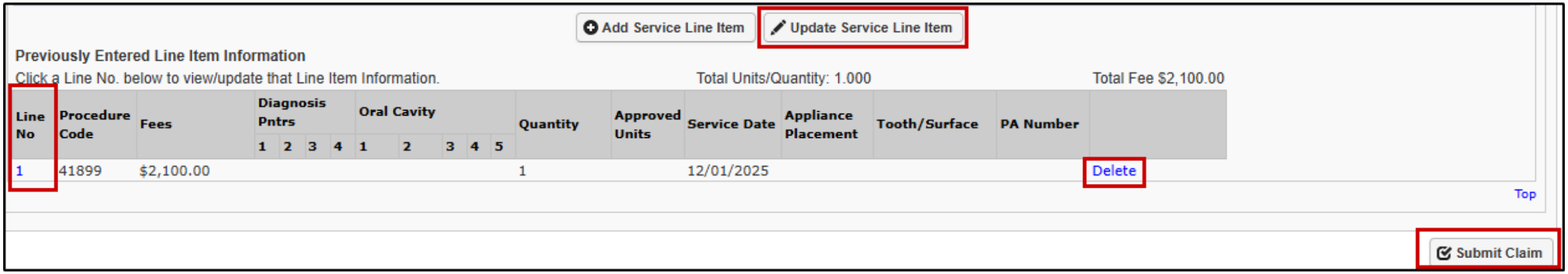
Claim Submission

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.



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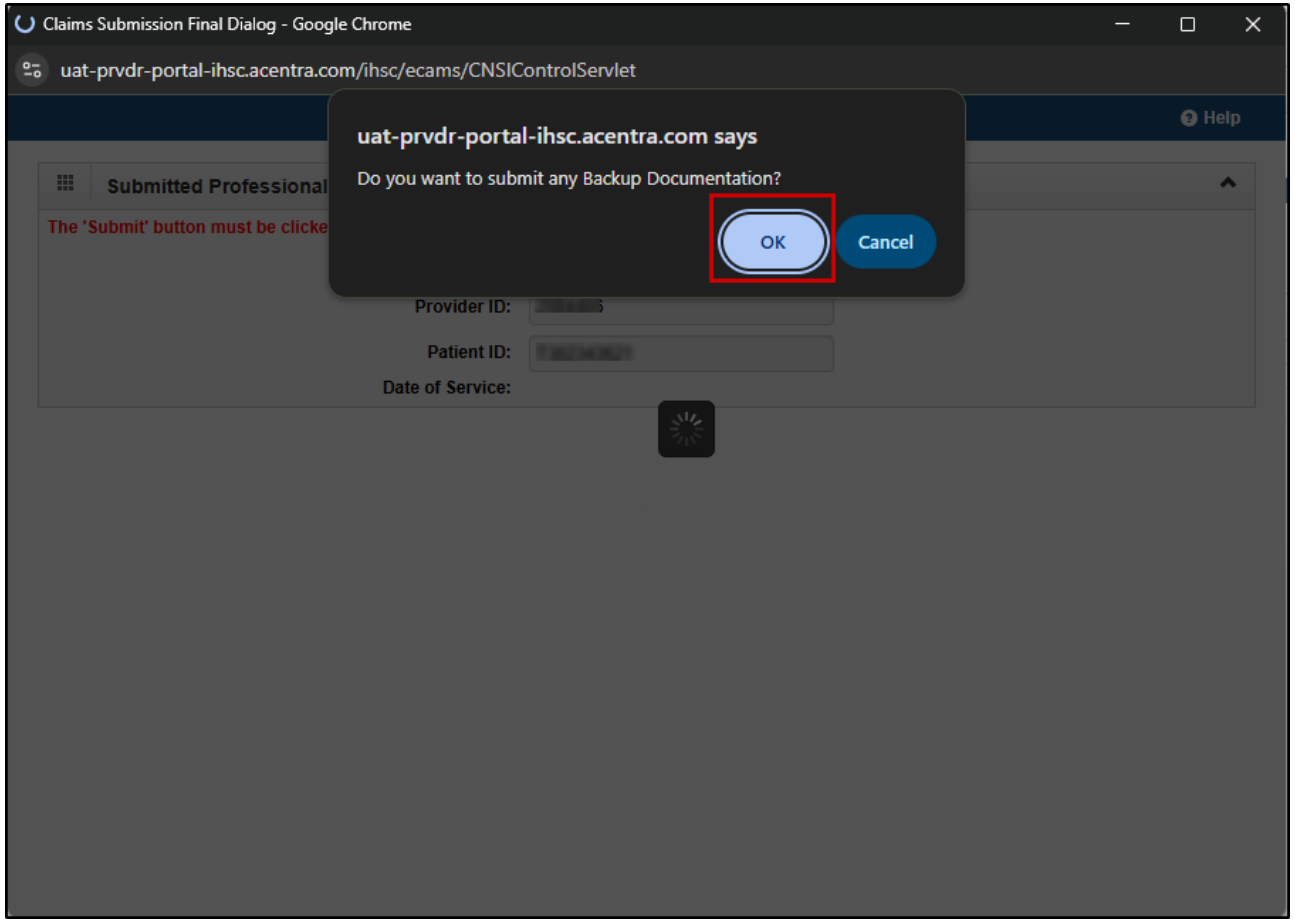
Claim Submission Final Dialog

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.



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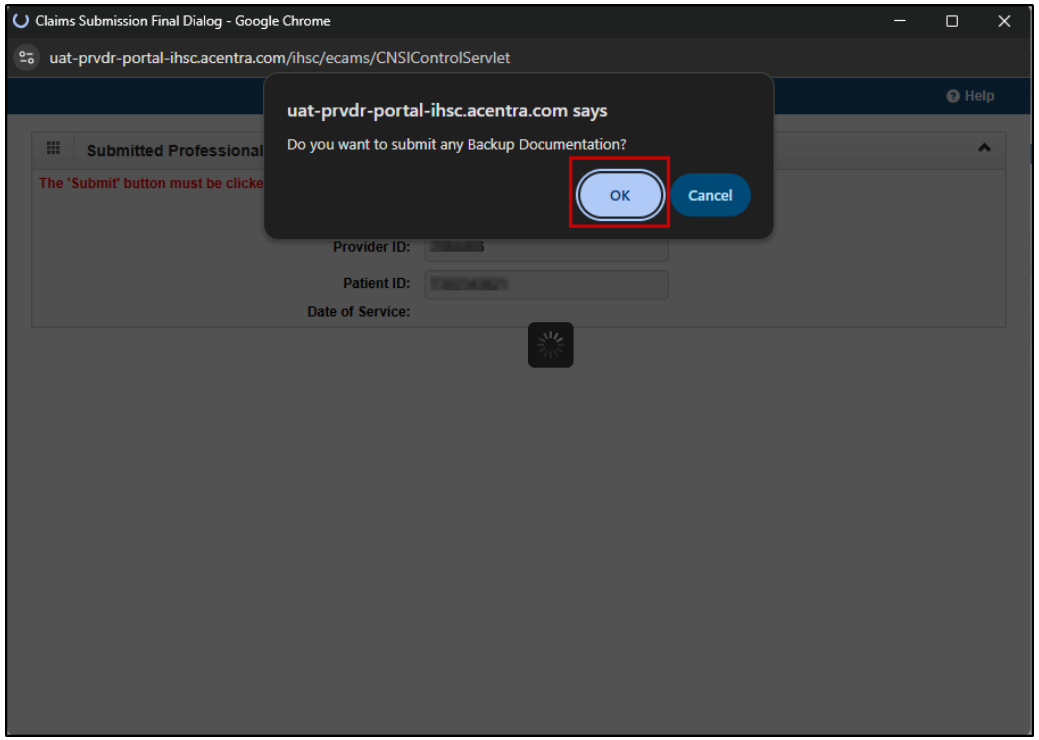
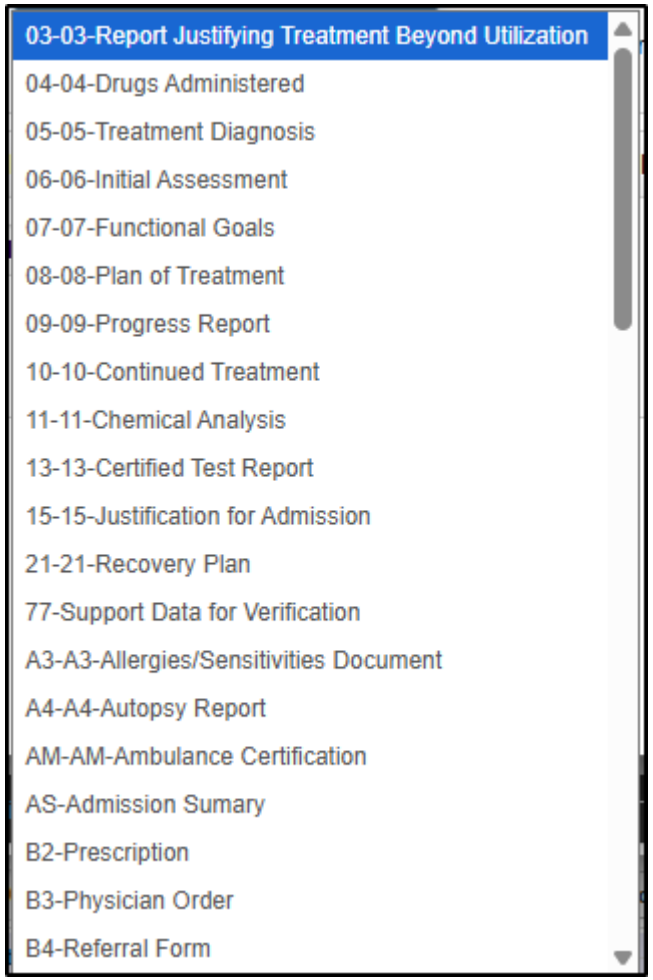
Attachments and Claim Submission



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.





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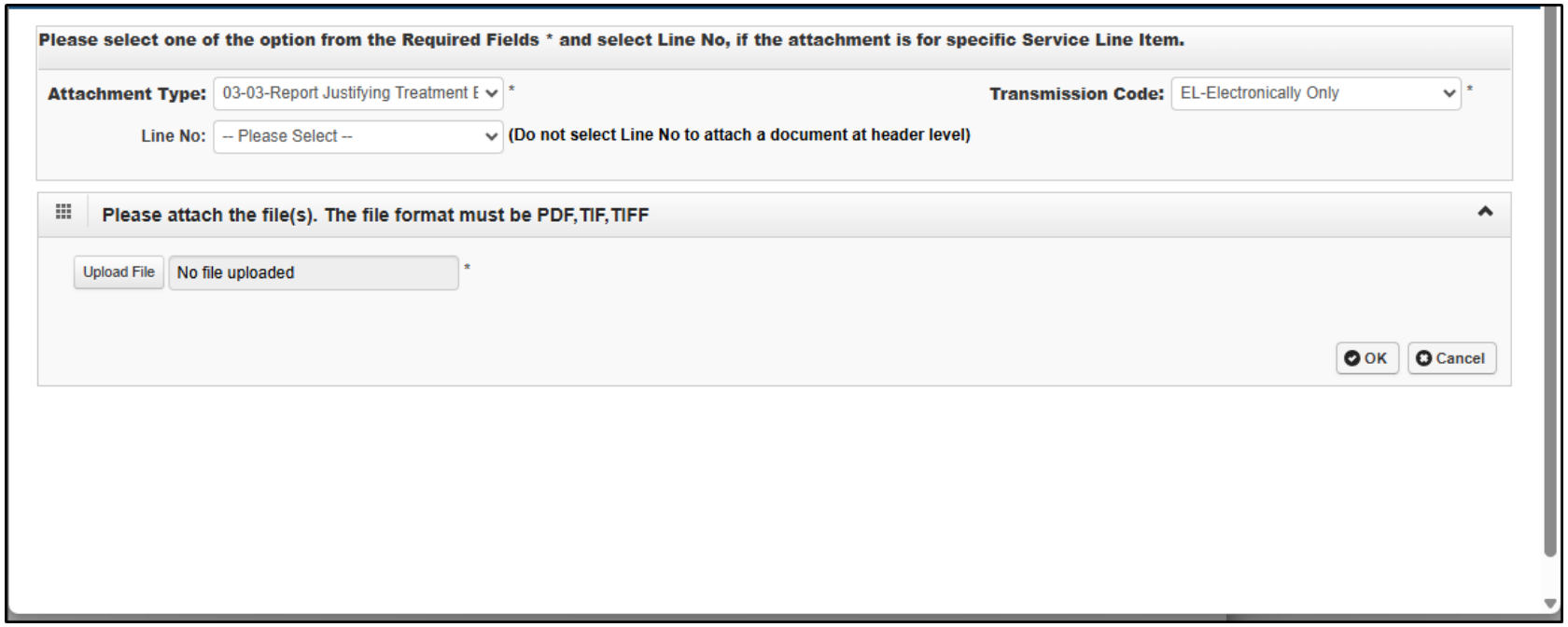
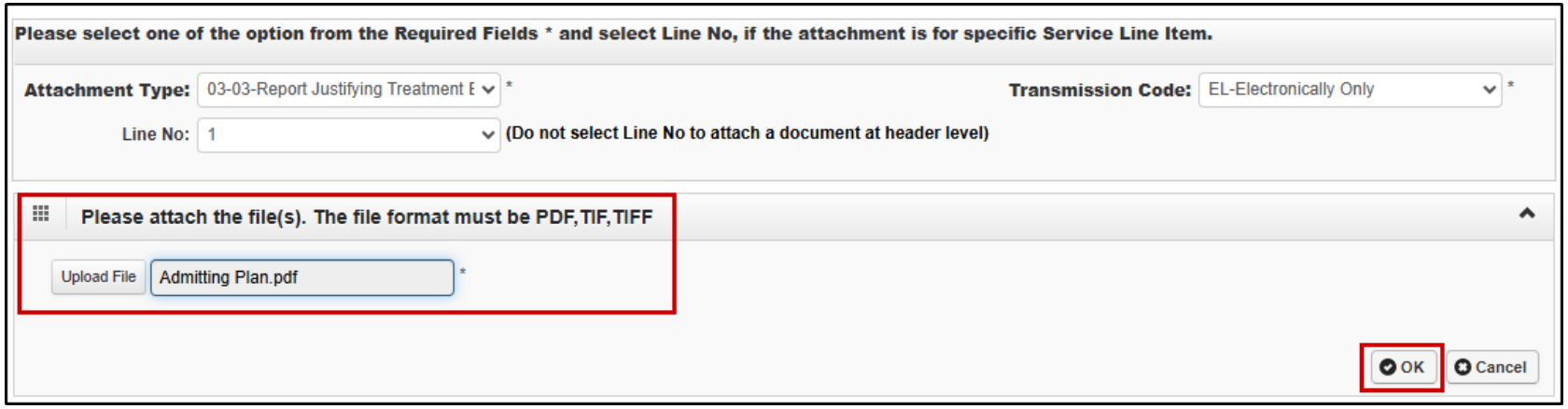
Upload Attachment

Add the attachment by selecting the appropriate file.

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

Select **OK** to submit claim.





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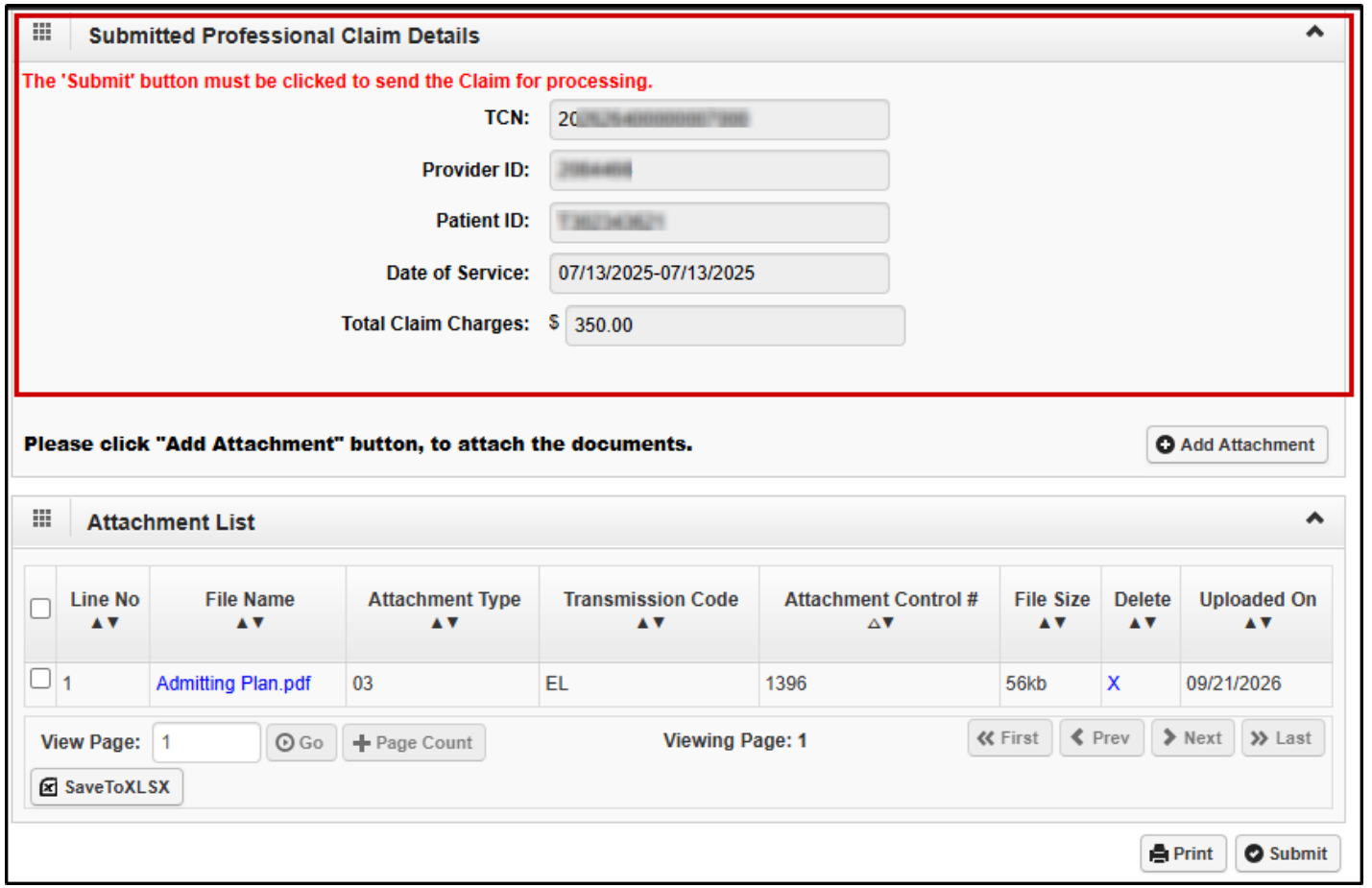
Confirmation Page

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.



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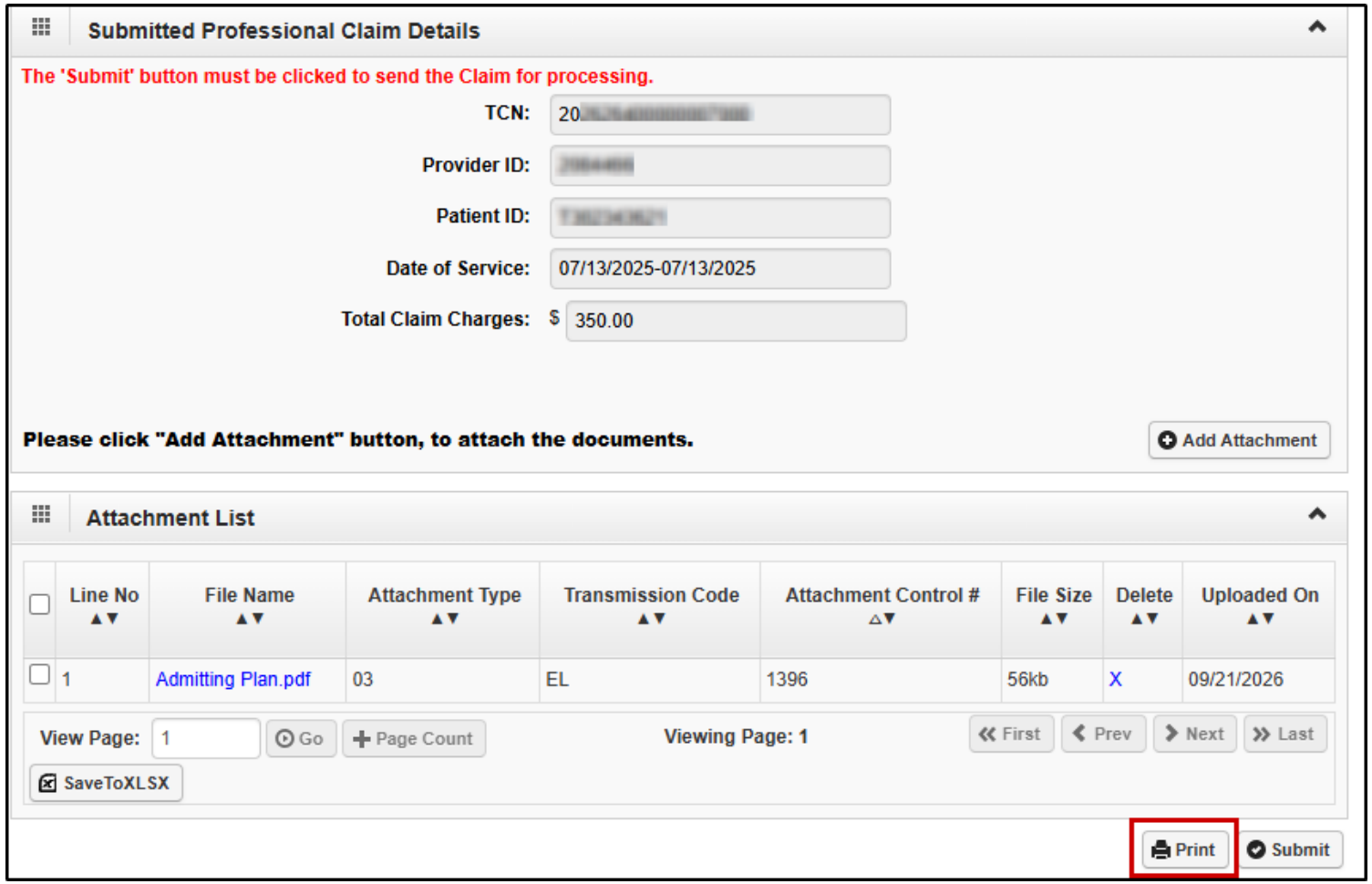
Copy of Claim

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



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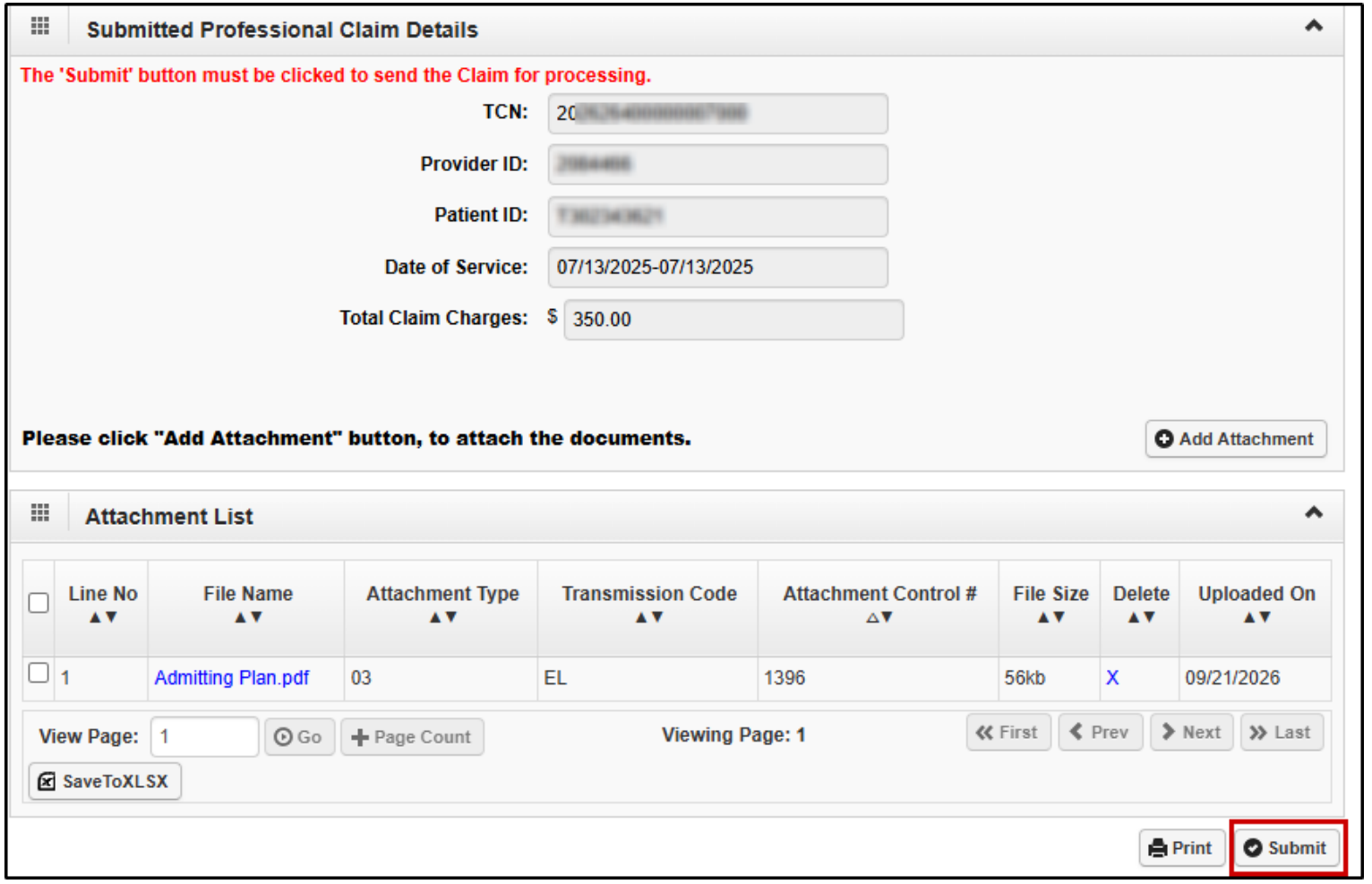
Submit Claim

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



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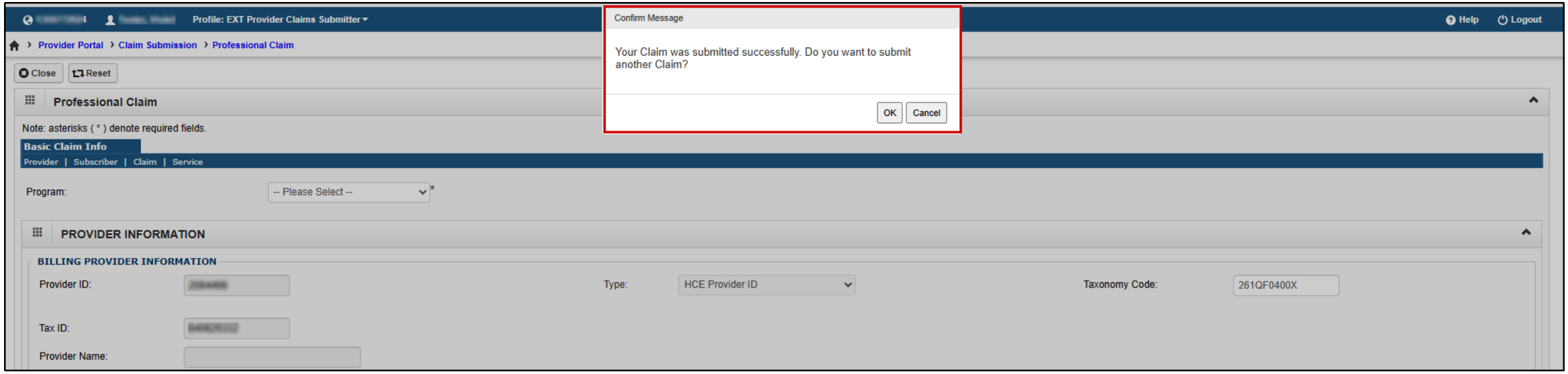
Claim Submission Confirmation Message

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?"**



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Claim Status

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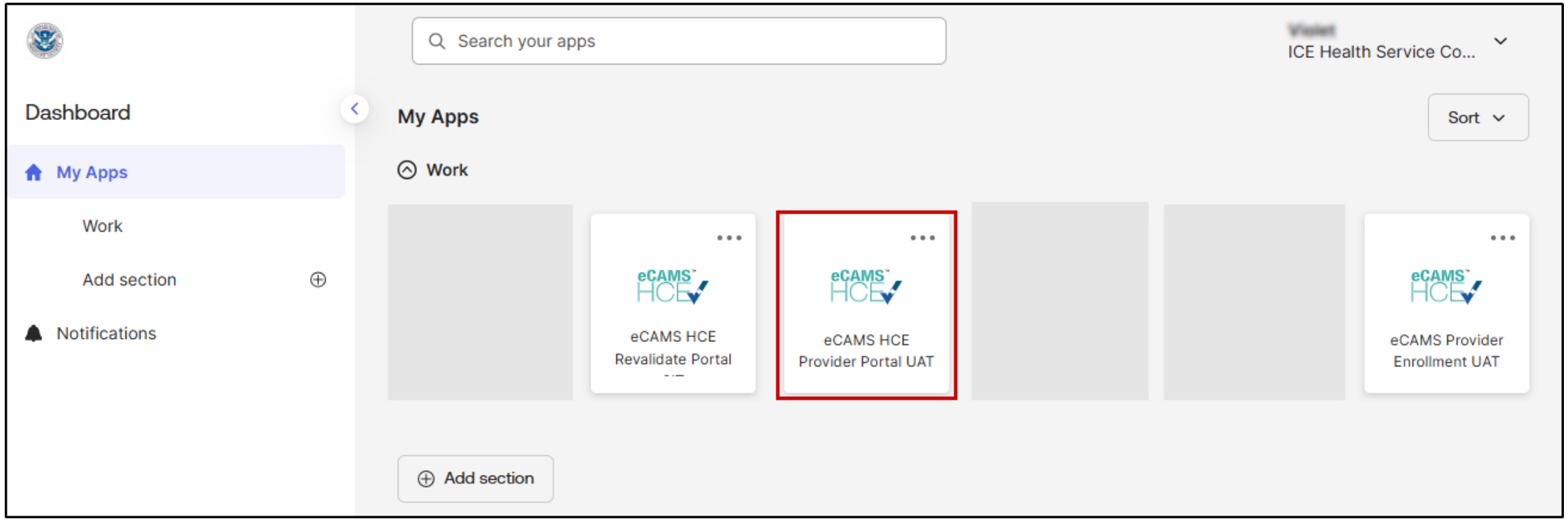
Provider Portal Tile

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



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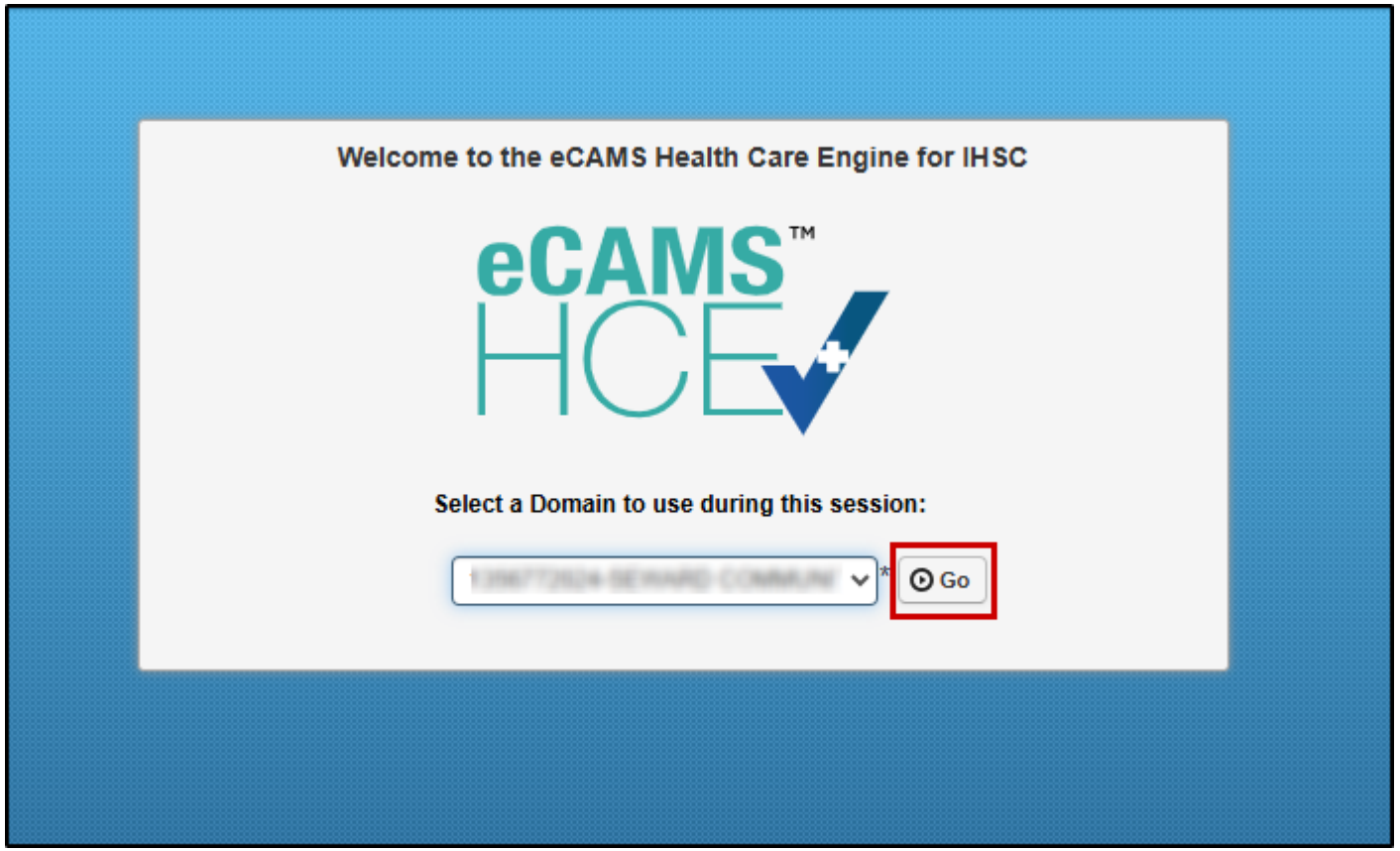
Provider Portal Domain

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



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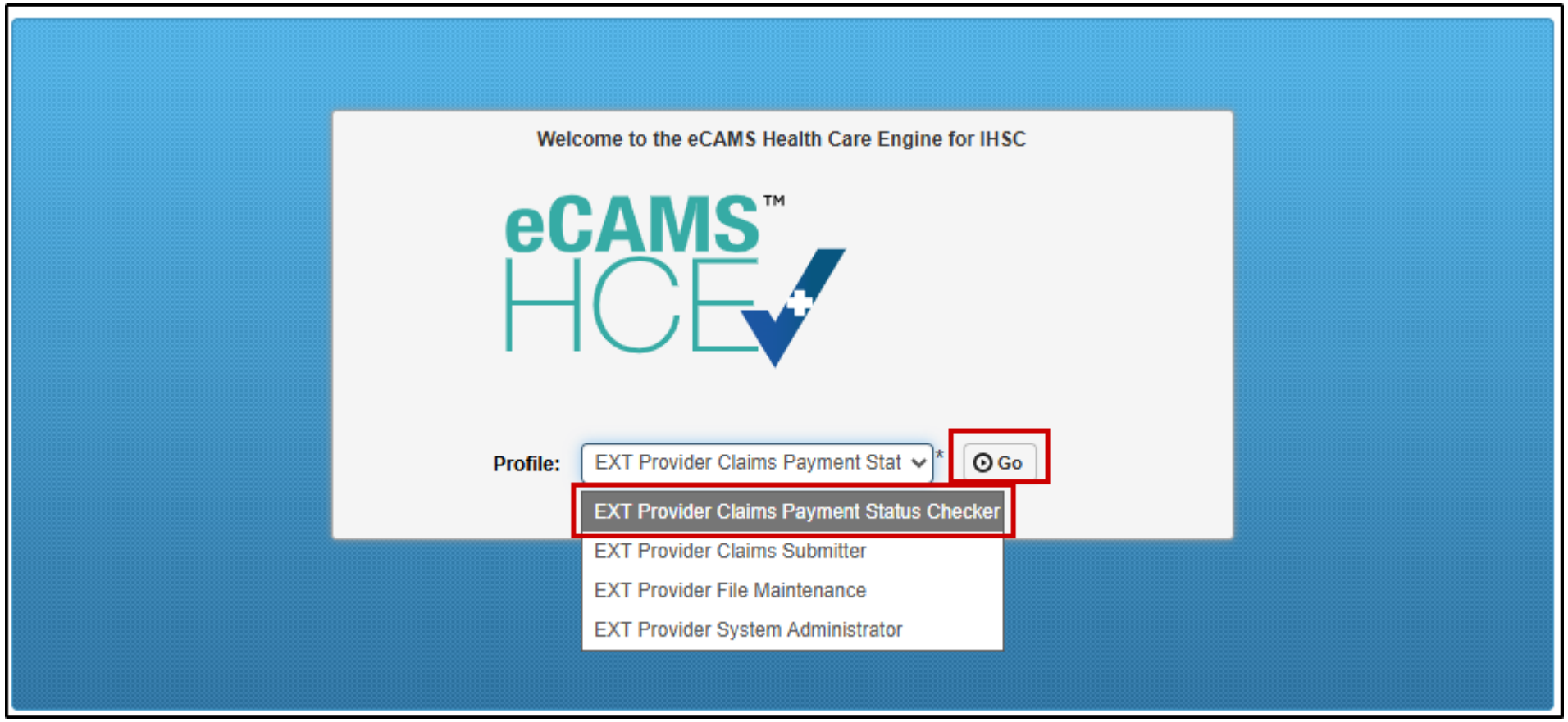
Provider Portal Profile

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



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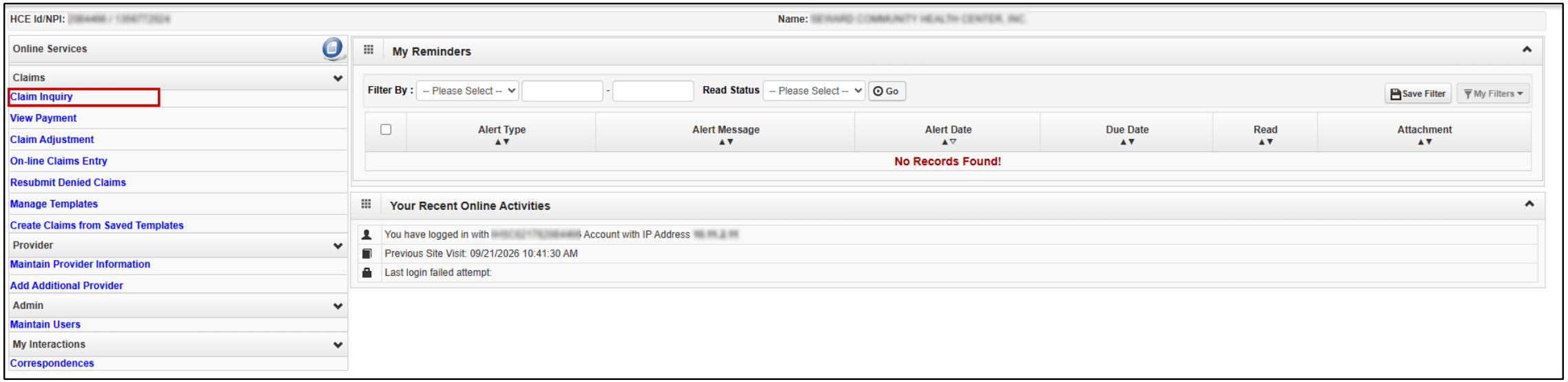
IHSC Provider Portal Home Page

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.



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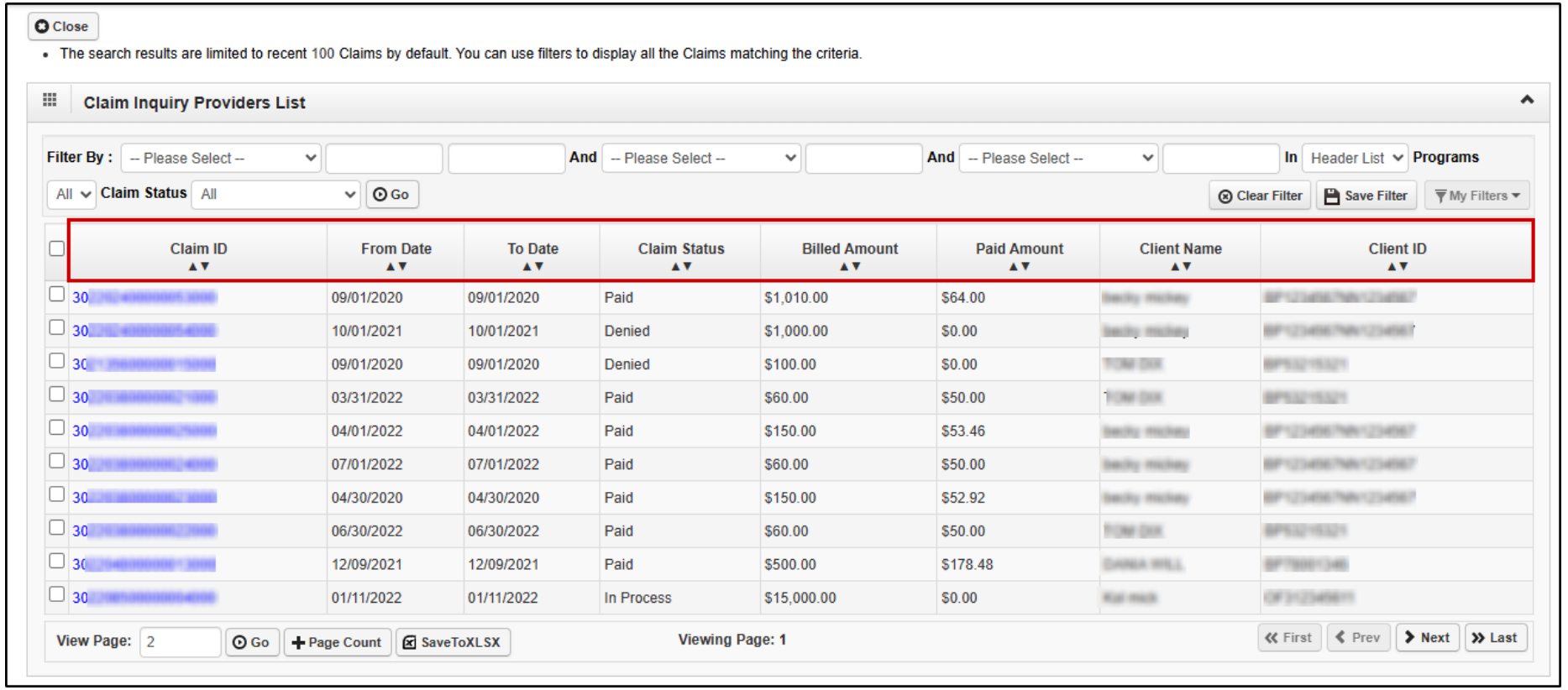
Claim Inquiry Providers List

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.



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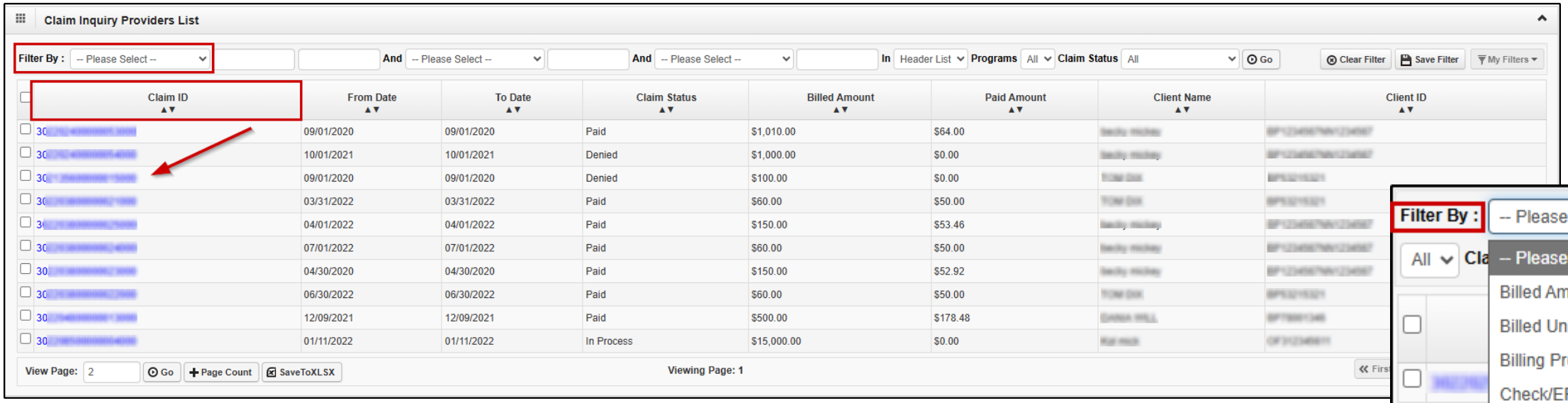
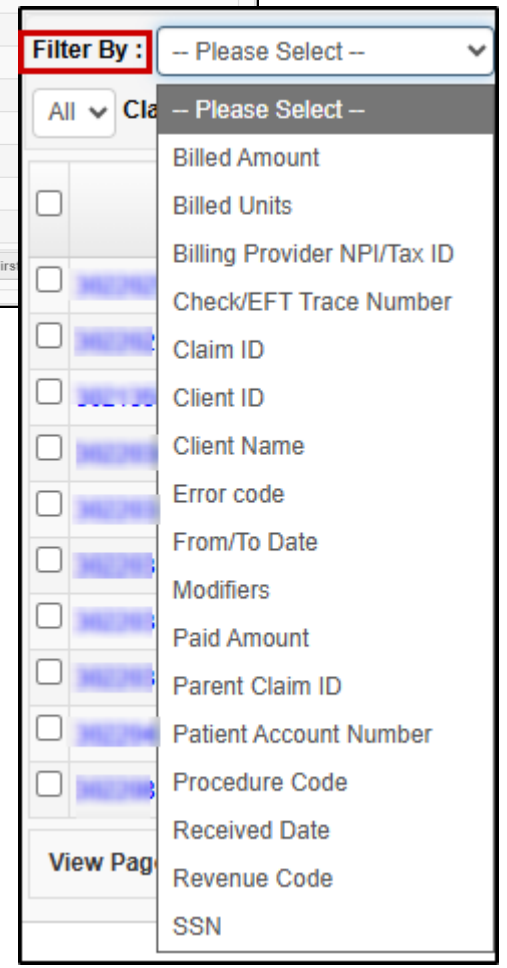
Claim Details

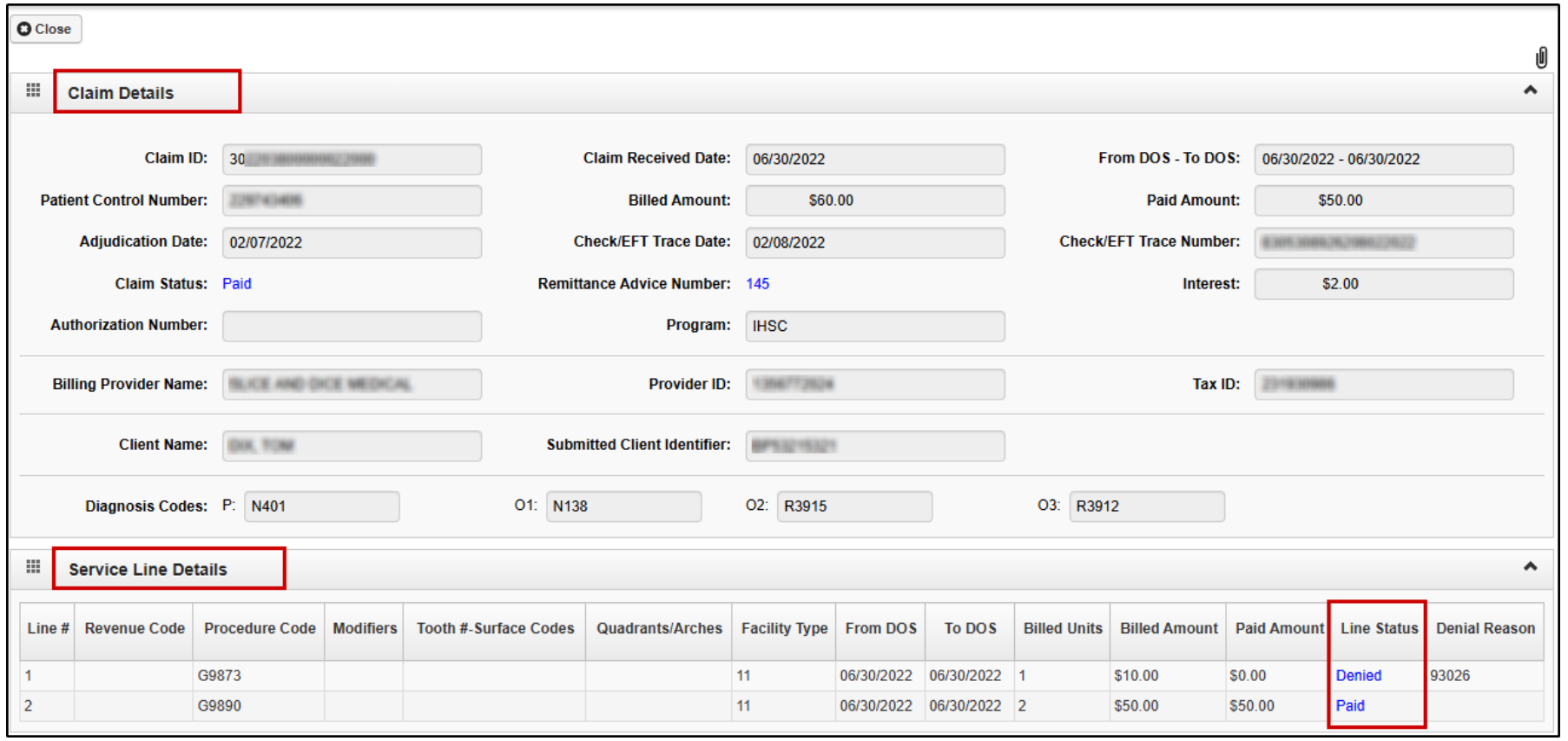




To view the **Claims Details**, select the claim ID hyperlink under the **Claim ID** column. To search for a claim, use the **Filter By** option to do a search using one of the filter options.

Claim Details Page

The **Claim Details** page will open and display the claim information. At the bottom of the page, the **Service Line Details** are visible. To view the details for a service line that has been denied, select the hyperlink for the line item under the **Line Status** column.



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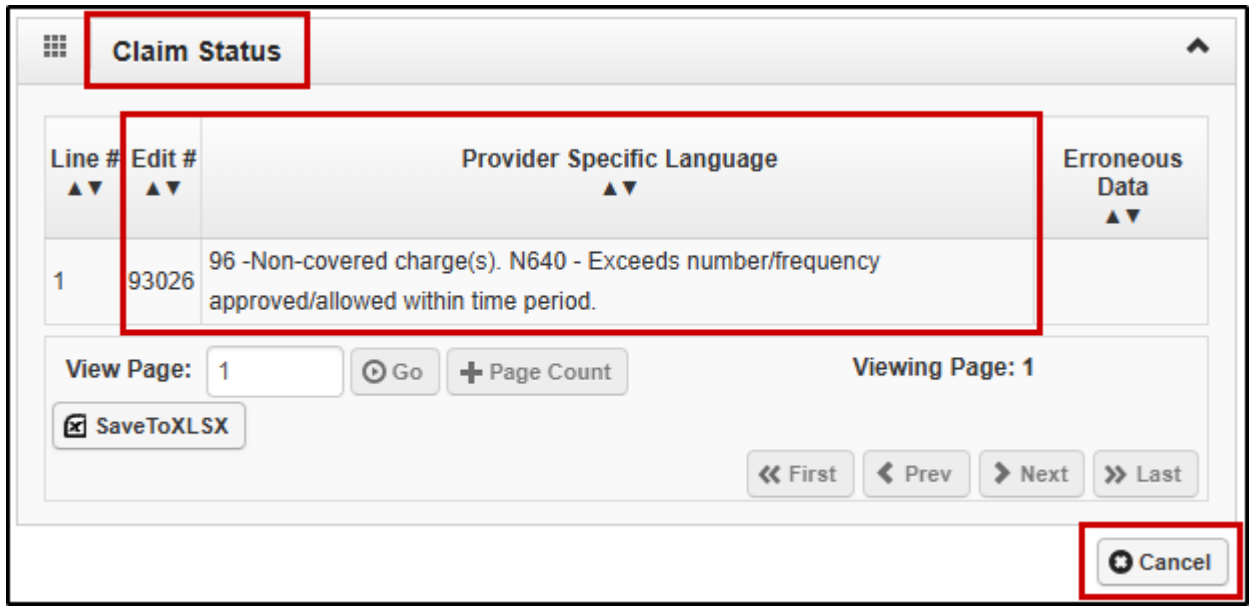
Claim Status

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.



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Electronic Data Interchange (EDI)



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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.

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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

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Important Claims Processing Information

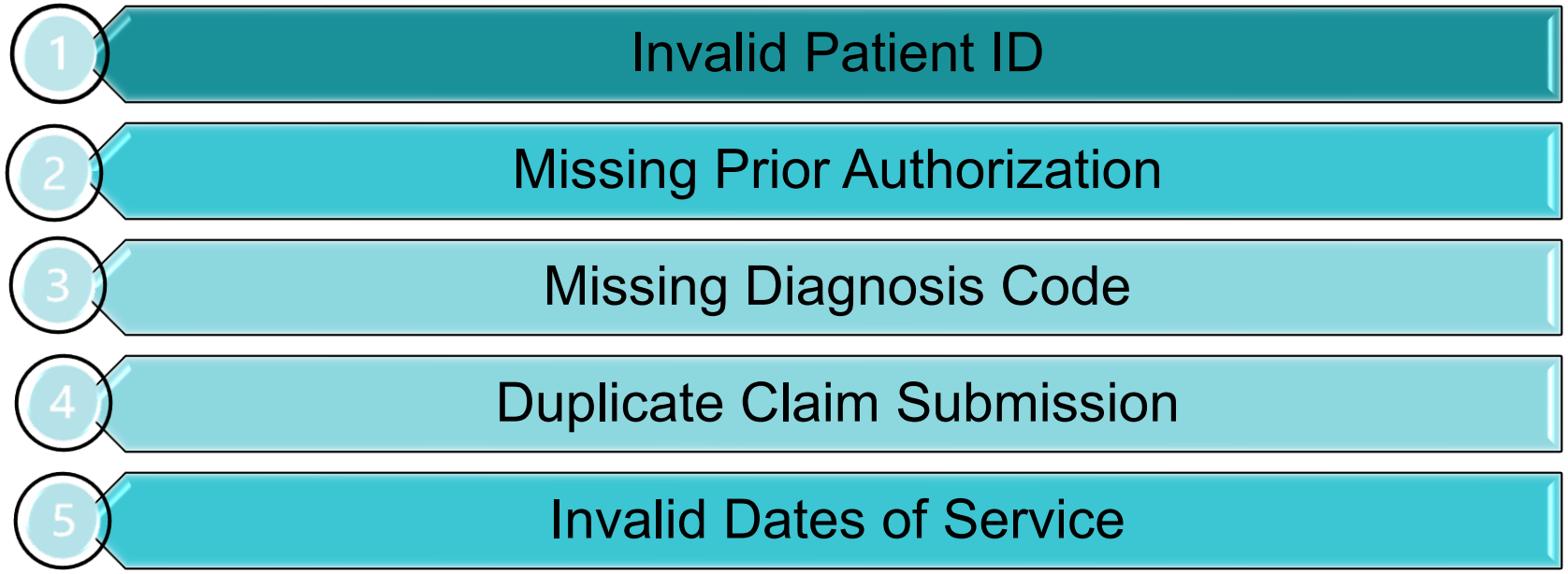
Timely Filing

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:





Provider Resources

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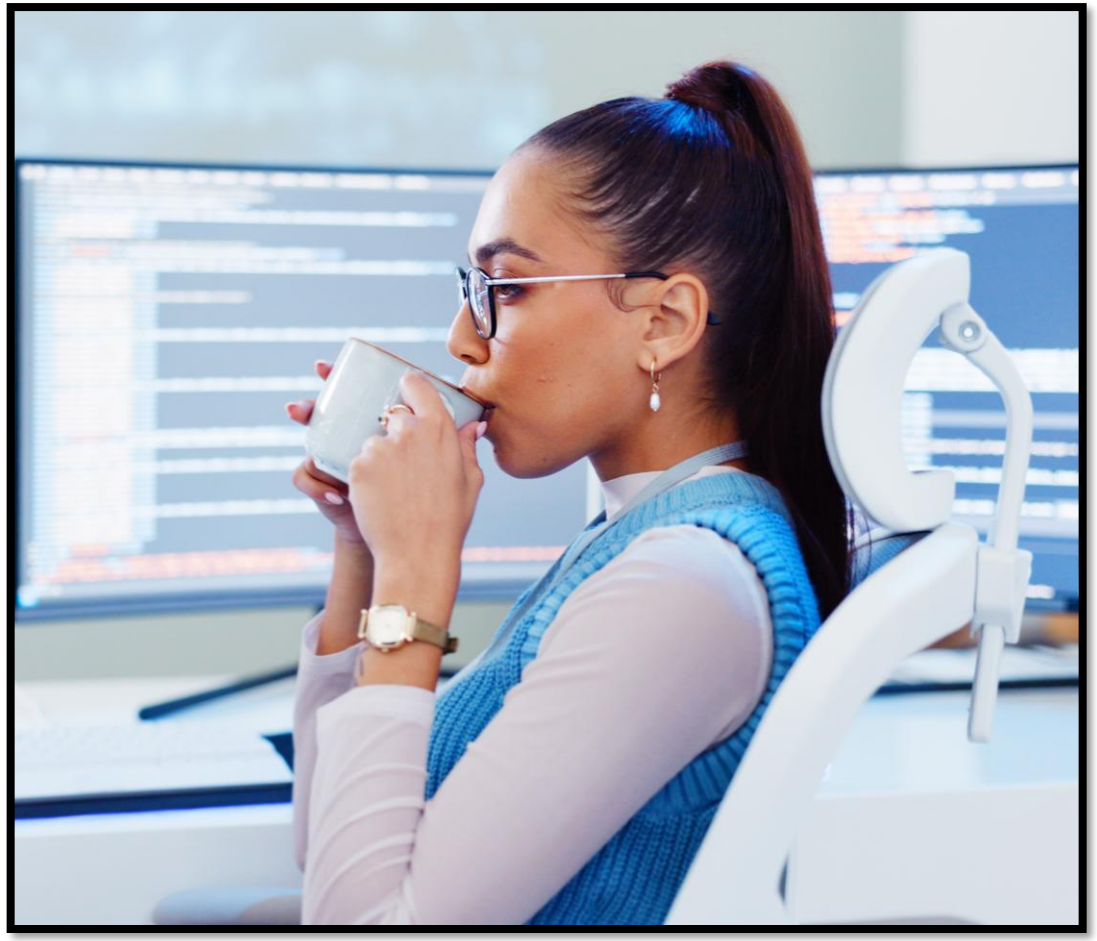
Contact Information

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).



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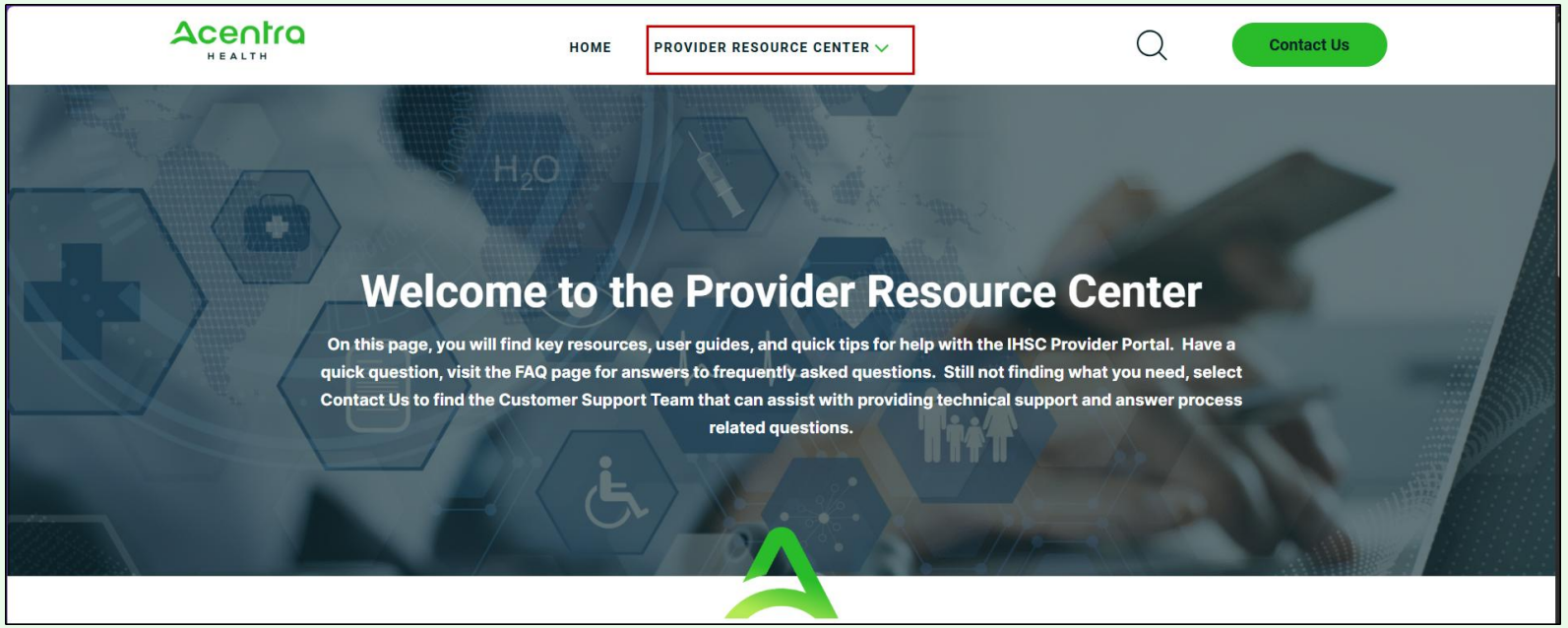
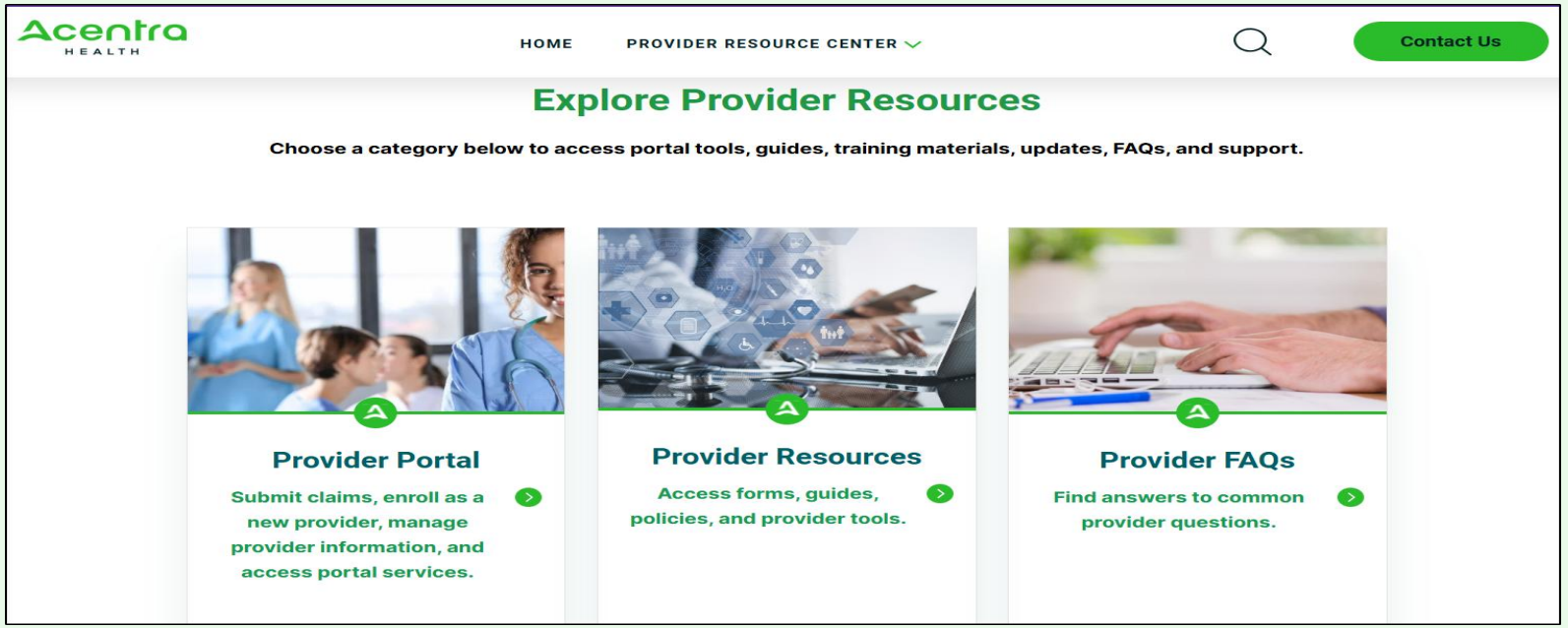
Additional resources can also be found on the **Acentra Health Provider Resource Center**.

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!





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Better Outcomes