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About PayerLink

PayerLink provides connectivity to CMS systems including, FISS/DDE for Part A providers, PPTN for Part B providers, VIPS for DME providers, HETS for Medicare eligibility, and EDI for transfer of electronic claim files (837) and remittance files (835).

FISS/DDE or Direct Data Entry, PPTN and VIPS are terms associated with the access of CMS claim data by healthcare providers. Claim data submitted to Medicare contractors is posted nightly to update the Common Working File (CWF). This centralized CMS file system includes a collection of all Medicare claims for the entire country.

Once in the CMS system if you have questions on how to use DDE, PPTN or VIPS, refer to your Medicare Contractor.

Medicare Contractors maintain user manuals for the FISS/DDE, PPTN and VIPS systems and are available for download from their websites:

Palmetto

- **J1 Part A, J1 Part B, J11 HH & H, J11 Part A, J11 Part B**
<http://www.palmettogba.com/palmetto/palmetto.nsf/SiteHome?ReadForm>

NGS

- **J6 Part A, J6 Part B J6 HH & H, J13 Part A, J13 Part B, JB DME**
<http://www.ngsmedicare.com/wps/portal/ngsmedicare>

CGS

- **J15 Part A, J15 Part B, J15 HH & H, JC DME**
<http://www.cgsmedicare.com/Medicare.html>

Novitas

- **JH Part A, JH Part B, J4WPS Legacy Part A, J12 Part A, J12 Part B**
<https://www.novitas-solutions.com/>

WPS

- **J5 Part A, J5 Part B, J8 Part A, J8 Part B, Legacy Part B for IL, MN & WI**
<http://www.wpsmedicare.com/index.shtml>

NHIC

- **J14 Part A, J14 Part B, J14 HH & H, JA DME**

<http://www.medicarenhic.com/>

Noridian

- **JE Part A, JE Part B, JF Part A, JF Part B, JD DME**

<https://www.noridianmedicare.com/>

Cahaba

- **J10 Part A, J10 Part B**

<https://www.cahabagba.com/>

FCSO, Inc.

- **J9 Part A, J9 Part B**

<http://medicare.fcso.com/>

HETS or HIPAA Eligibility Transaction System is a real time eligibility inquiry system developed by Centers for Medicare & Medicaid Services (CMS). HETS is updated each night by the Common Working File (CWF) so it contains billing data collected through the previous day. This system uses the HIPAA 270/271 transaction to respond to eligibility verification and benefit inquiries.

HETS includes data for specific services such as home health and hospice as well as general Medicare eligibility information. This data can be used to make detailed reports displaying a patient's prior billing history including providers they have seen and secondary/Part D coverage.

Internet Settings

Payerlink may be accessed through any browser. Below are the instructions for Internet Explorer settings. The settings must be configured before accessing **Payerlink**.

To configure settings for **PayerLink**:

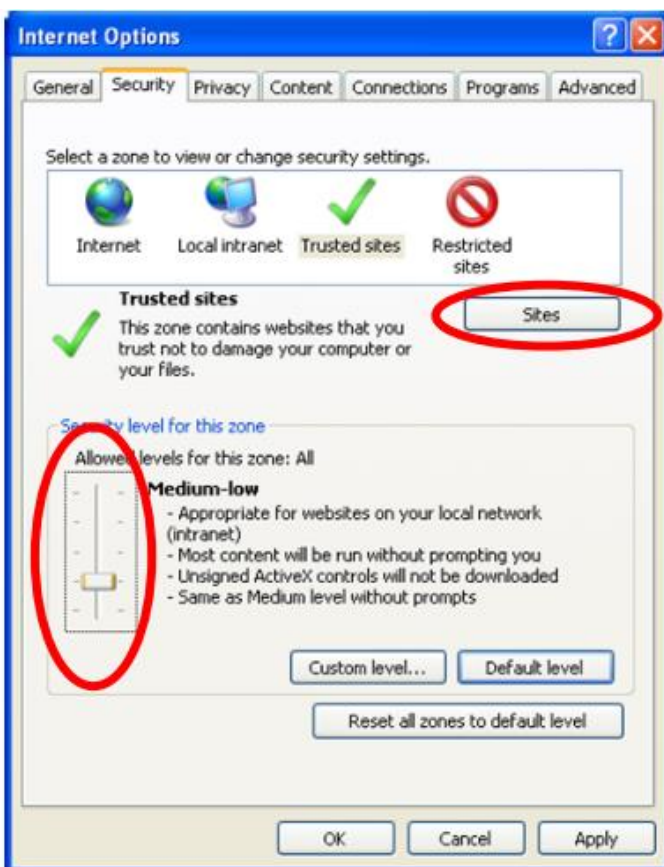
*From the internet browser go to **Tools/Internet options**



*Click the **Security Tab**.

*Click **Trusted Sites** (a green check mark should appear)

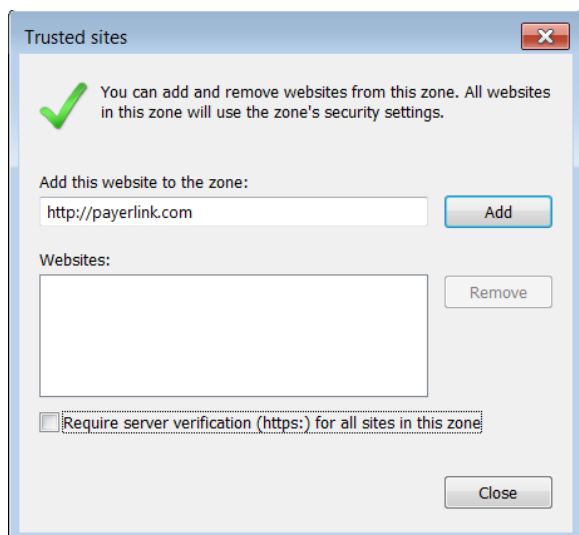
*Click the **Default Level** button. The following window will appear.



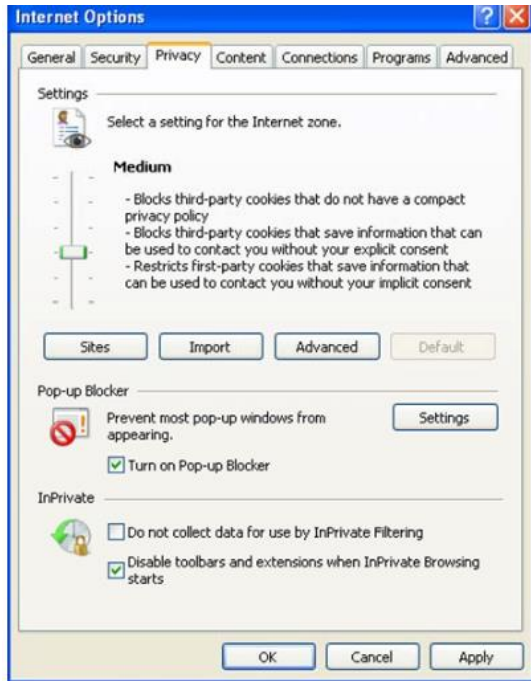
*Slide the slider bar on the left to Medium-low.

*Click the **Sites** button.

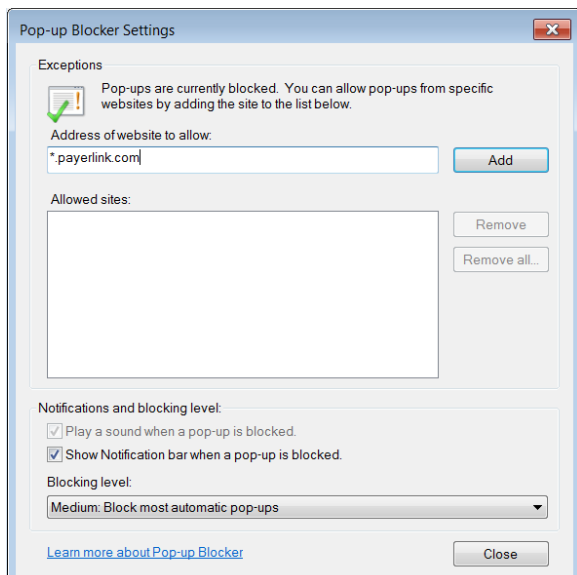
*Type <http://payerlink.com> in the 'Add this website to the zone' box



- * Be sure that the **Require server verification** check is **unchecked**.
- *Click **Add** to add the site to the Trusted sites list.
- *Click **Close**.
- *Click the **Privacy** tab in the **Internet Options** window.
- *In the **Pop-up Blocker** section click on the **Settings** button if it is enabled.



- *In the **Pop-up Blocker settings** window type *.payerlink.com in the **Address of website to allow**:

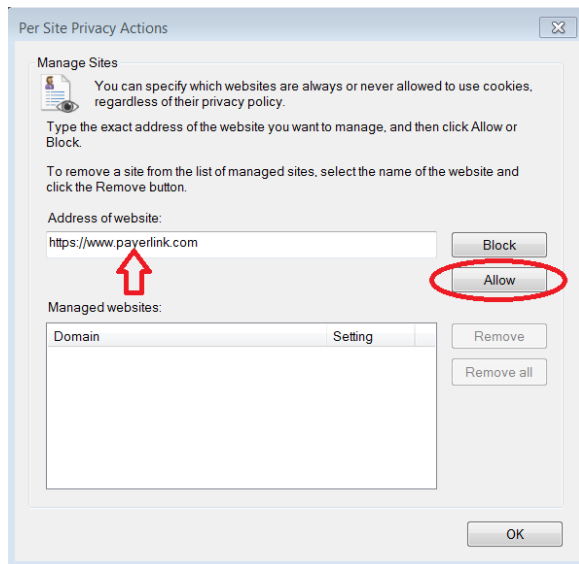


*Click **Add**, click **Close**

* Also in the **Privacy** tab under **Settings**, click Sites to Allow cookies in **PayerLink**

*Type <https://www.payerlink.com> in the Address of website field

*Click **Allow**



*Click **OK**

*In the internet Options window click **apply**

*Click **OK** to save all settings

*You may proceed to login

Logging In

To Login to **PayerLink** navigate to the web page:

<https://www.payerlink.com/>

The image shows the PayerLink login interface. At the top is the PayerLink logo. Below it is a white login box with a green button labeled 'Login to your account' and a blue button labeled 'No account? Click here!'. Under these buttons are two input fields: 'Email' and 'Password'. At the bottom of the box is a 'Login' button and a link that says 'or recover your password'.

*Type the **Email** and **Password**

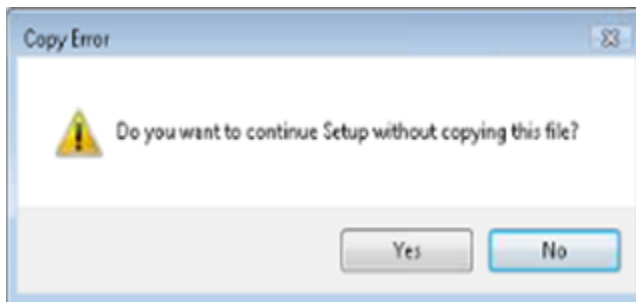
*Click **Login**.

*The **PayerLink** main menu screen will appear



DDE

To install the DDE software on your computer you must be an administrator for the computer or have an administrator login and install the software for you. If you do not have administrative rights to install software, you will receive the following message.



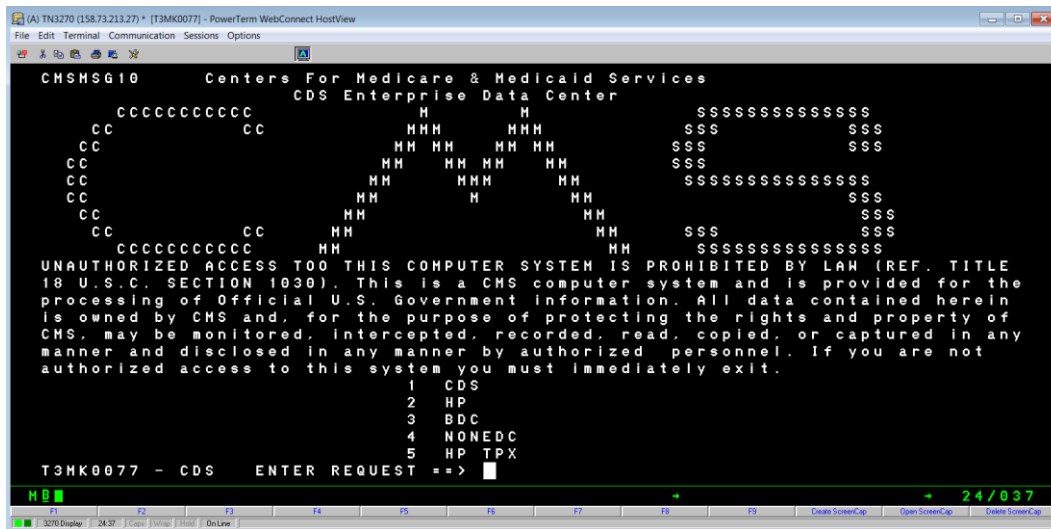
To Access and install DDE, on the main **PayerLink** screen click **DDE**.



*A pop-up security warning about installing software will appear. Click **Install** to continue access to DDE. This message will only appear one time.



*Wait as components are downloaded and installed (This could take several minutes depending on the internet connection speed.)



*Select **1** For PGBA or **2** for all other Medicare Administrative Contractors.

The DDE system will only allow one user to be logged in at a time. If you attempt to login when another user is already logged in you will receive an error message.

Note: If windows Firewall is enabled, the Ericom terminal program for access will need to be enabled if notified by windows. Click the **Windows Security Alert** button in the taskbar at the bottom of the screen and click **unblock** the window. This will remove any window Firewall notifications from popping up in the future.



File Transfer

File Transfer in **PayerLink** replaces the additional cost of using another vendor to upload billing claims to your Medicare Administrative Contractor (MAC).

Files are transferred to and picked up from MAC's in **PayerLink** on an hourly schedule. Keep in mind if you create claim files (837) and upload them to **PayerLink**, they will be visible in the outbound folder until the scheduled hourly transfer. Likewise, inbound files (999, 277CA and 835) will not appear until the scheduled system refresh.

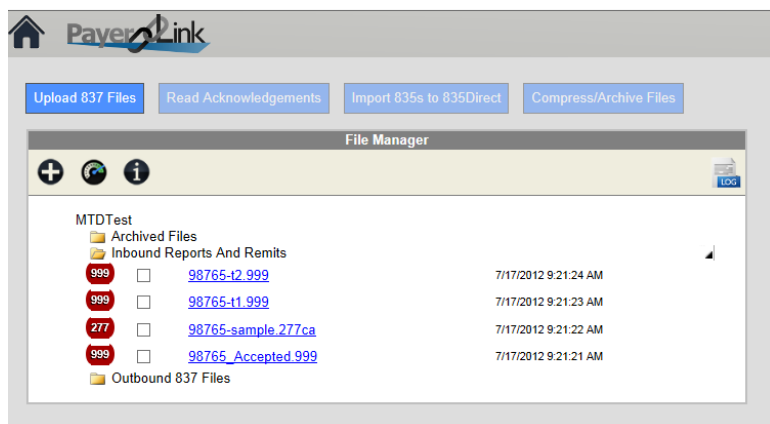
999 response files should be received at the response file receipt time following the upload time as these files are typically processed quickly. **277CA** response files may take hours to a couple days to receive.

Submitter Numbers

After entering your Submitter ID and password when requesting File Transfer, there will be a delay before File Transfer is activated. During this delay you will not be able to access File Transfer when clicking on the icon.

If your organization has multiple submitter ID numbers, after File Transfer is activated, you will need to enter the additional submitter ID numbers and corresponding passwords.

1. On the main screen click **File Transfer**.



2. The File Manager screen will appear.

3. Click **Add Submitter**



4. Select the Medicare Administrative Contractor (MAC) **Receiver** the agency uses from the drop-down menu.

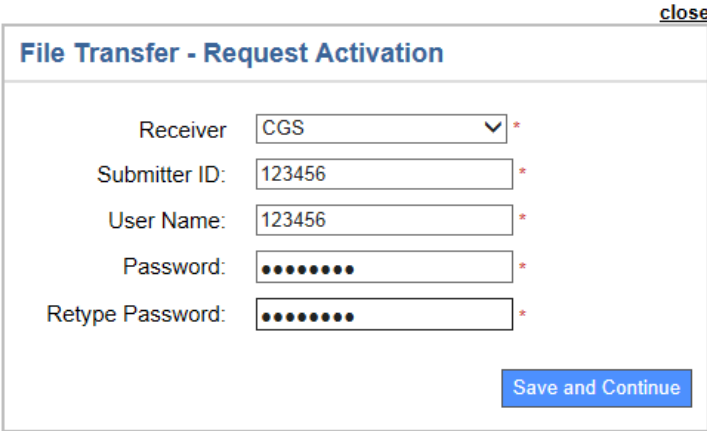
5. Enter the additional MAC **Submitter ID** number.

6. The User Name will automatically be populated the Submitter ID when it is entered.

*****Some MAC's use a different User Name vs. the Submitter ID. If so, type over the User Name**

7. Enter your MAC submitter **Password** (the password obtained from the former file transfer vendor).

8. Retype Password.



close

File Transfer - Request Activation

Receiver: CGS *

Submitter ID: 123456 *

User Name: 123456 *

Password: *

Retype Password: *

Save and Continue

*Click **Save and Continue**.

***You will automatically return to the main menu screen.**

Repeat steps 1-9 for each additional submitter ID number.

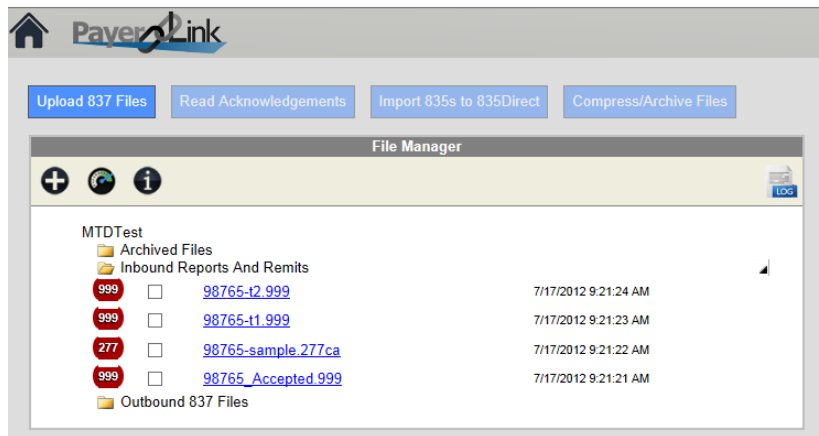
Uploading Files

File Transfer is available for electronic claims that have been processed in the 837 format or billing. Once claims have been processed you will be able to upload files to the MAC.

*On the Main Screen click **File Transfer**.



*The File transfer Upload screen will appear



*Click Upload **837 files**

.

* A window will appear. Select the Submitter ID if you have more than one. Select the Claim Type. Click Browse to find the location where your **837 files** are stored.

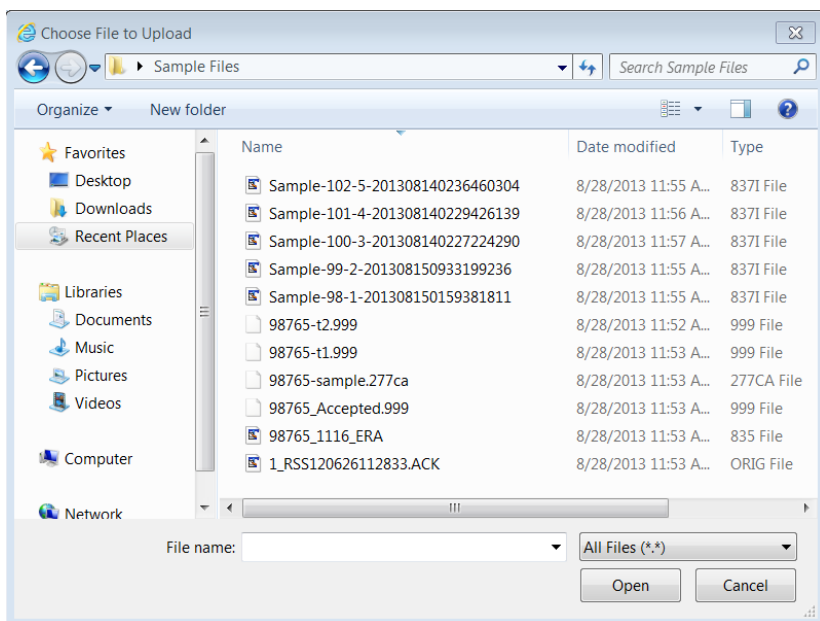
Submitter ID: **MTDTest** ▼

Claim Type:
☒ Institutional ☐ Professional

Browse...

Upload File

*The 'Choose File to Upload' window will appear.



*Select the file that needs to be uploaded.

*Click **Open**.

*On the first Upload File window click **Upload File**.

*Files will be placed in the outbound folder until the file transfer/update occurs .

Downloading Response Files

Response files are automatically stored in **PayerLink**. 999 and 277CA files will not need to be downloaded unless you want to store a copy of the files on your hard drive. 835 files will not be able to be translated and viewed in **PayerLink**. They must be Downloaded and then Uploaded into another 835 translation software to become human readable. If you have 835Direct, you may import the file to 837Direct within **PayerLink**. Follow the steps below to download files:

1. Go to the Inbound Reports and Remits folder to see a list of all the response files.
2. Click the blue hyperlink for the file to be downloaded.
3. A file Download window will appear. Click **Open** or **Save/Save As**.

Viewing Response files

You have the ability to view the response files within **PayerLink**.

1. Go to the Inbound Reports and Remits folder to see the list of all response files.
2. Checkmark the box next to each file that needs to be viewed.

*****Only 277 and 999 files will be available for viewing. 835 files must first be downloaded. (see steps above for downloading 835 files.)**

3. Click **Read Acknowledgements** to view the response files.

The 277CA files will appear as seen below. Rejected claims will appear in red shading, accepted response files will appear in a green shading.

1234-4 - PUBLIC, JOHN Policy: 11111111F Date of service: 20090828 Payer Claim Control #: MB-ICN (WQ) Accepted (A2) Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system. (20) Accepted for processing.
1234-5 - PUBLIC, JOHN Policy: 11111111F Date of service: 20090828 Payer Claim Control #: MB-ICN (U) Rejected (A7) Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected. (504) Entity's Last Name. Note: This code requires use of an Entity Code. (DN) Referring Provider (512) Length invalid for receiver's application system. Note: At least one other status code is required to identify the data element in error.
1234-6 - PUBLIC, JOHN Policy: 11111111F Date of service: 20090828 Payer Claim Control #: MB-ICN (U) Rejected (A7) Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected. (504) Entity's Last Name. Note: This code requires use of an Entity Code. (PR) Payer (511) Invalid character. Note: At least one other status code is required to identify the data element in error.

The 999 Claim Status accepted files will appear as shown below.

98765_Accepted.999

999	Status: Accepted
Segment Only Errors:0 Element Errors:0	

The 999 Claim Status rejected files will appear as shown below.

98765-t1.999

999	Status: Rejected
Segment Only Errors:2 Element Errors:2	<p><u>Implementation dependent segment missing</u></p> <p>Loop 2000 : HL @ line: 3 Invalid code value on Element #4 ("1")</p> <p>Loop 2110 : EQ @ line: 11</p> <p><u>Segment has data element errors</u></p> <p>Loop 2000 : HL @ line: 5 Required data element missing on Element #2</p> <p><u>Implementation dependent 'not used' segment present</u></p> <p>Loop 2000 : TRN @ line: 8</p>

NOTE: If you Double Click the inbound file itself from the File Manager screen without clicking the **Read Acknowledgement** button, the reponse file will open, however the format will not be readable. In order to read the response file you must click the **Read Acknowledgements** button.

Accessing Archived Files

Response files are never deleted from **PayerLink**. They will remain as visible current files in the Inbound Reports and Remits folder for 10 days following the receipt of the response file. After 10 days the response files will automatically be archived and will be available for viewing in the Archived Files folder.

Additionally, response files may manually be archived by the user at any time during the 10 day period. To manually archive response files:

*Check the box to the left of the file to archive

*Click **Compress/Archive Files**.

*A window will appear. If you do not want to compress the file, Leave the filename blank. Click **OK**.

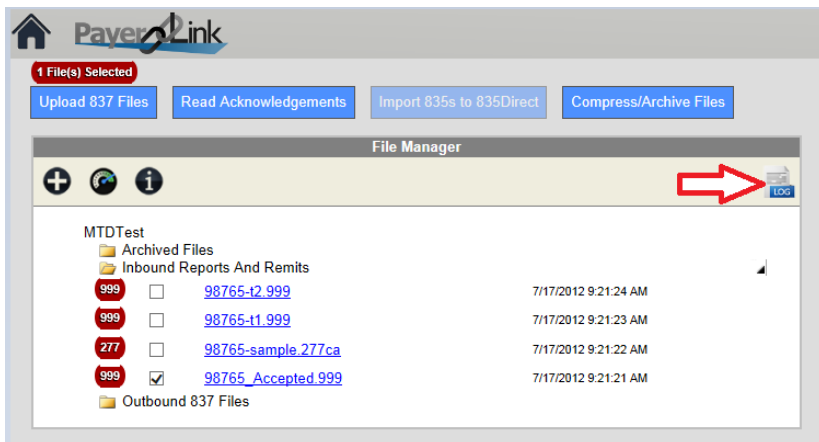


If you want to compress the file enter the filename and click **OK**.

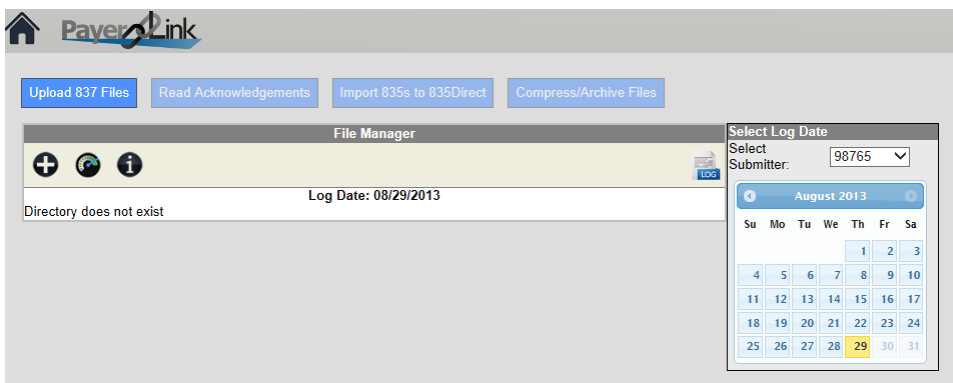
Transaction Log

To view files in the transactions log:

*Click  to the right of 'File Manager'.



*A Calendar will appear. Select the log date to view.



*A list of transactions will appear if files were sent and received this date.

Eligibility

PayerLink generates a 270 eligibility transaction request based off the patient information entered in the Eligibility inquiry screen. **PayerLink** then accesses CMS' HIPPA Eligibility Transaction System (HETS) which is available 24 hours a day, 7 days a week. CMS sends back a 271 Eligibility response file that **PayerLink** translates into an Eligibility report.

To access Eligibility:

*On the main **Payerlink** screen click **Eligibility**.

*The Eligibility inquiry screen will appear.

*Type the **HICN/Member ID** (required field).

*Type the **Last Name**, **First Name**, and the **Date of Birth** (two of these three fields are required).

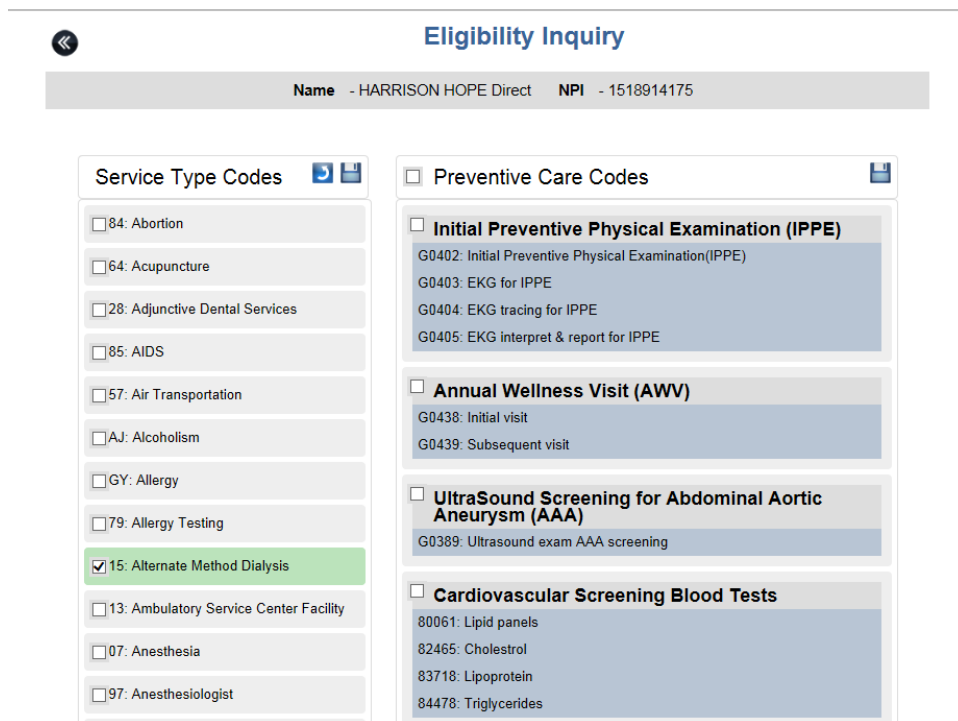
*The **Date Type**, **From**, **Thru**, **Code 1**, **Code 2** and **Code 3** fields are automatically set so that the maximum values/data are retrieved in the Eligibility response.

*Click **Eligibility**


*The eligibility response will appear in a new browser tab.

The **PayerLink** Eligibility module gives the user control over which Preventive Care codes and Service Type codes are used when requesting benefit information for selected services.


These code sets can be accessed from the **Eligibility Inquiry** page by clicking on the pencil icon  at the top right of the screen. The following screen will appear.



*****All Eligibility Inquires will be set with default Preventative Care codes and Service Type codes available in the 270 and 271 files unless otherwise changed by the user. Only codes being used in the inquiry will appear in the file.**

*Click  at the top right of the Eligibility Inquiry screen to modify the eligibility request (270).

*To add codes, simply check the box next to the heading of the section of applicable codes to be added. To remove codes from inquiry, simply uncheck the box next to the heading of the section of applicable codes to be removed.

*After adjustments are completed, click the save icon  to continue.

*A screen will appear allowing the user to review the changes made on the previous screen and 'Save' as shown below.

Eligibility Inquiry

Name - HARRISON HOPE Direct NPI - 1518914175

Save Preventive Codes

Current Preventive Codes:	New Codes: None	Removed Codes: None
<ul style="list-style-type: none"> • G0402, G0403, G0404, G0405 • G0438, G0439 • G0389 • 80061, 82465, 83718, 84478 • 82947, 82950, 82951 • G0123, G0143, G0144, G0145, G0147, G0148, P3000, Q0091 • G0101 • 77057, G0202 • G0104, G0105, G0106, G0120, G0121, G0328, 82270 • G0102, G0103 • G0117, G0118 • 90669, 90670, 90732 • G0446 • G0445 • G0447 		

Eligibility Inquiry

Name - HARRISON HOPE Direct NPI - 1518914175

Save STC Codes

Current STC Codes:	Newly Added STC Codes:	Removed Codes: None
<ul style="list-style-type: none"> • 15: Alternate Method Dialysis • 10: Blood Charges • BG: Cardiac Rehabilitation • DM: Durable Medical Equipment • 12: Durable Medical Equipment Purchase • 18: Durable Medical Equipment Rental • 42: Home Health Care • 45: Hospice • 47: Hospital • 48: Hospital - Inpatient • 49: Hospital - Room and Board • AD: Occupational Therapy • AE: Physical Medicine • BF: Pulmonary Rehabilitation • 14: Renal Supplies in the Home • AG: Skilled Nursing Care • AF: Speech Therapy • 11: Used Durable Medical Equipment 	<ul style="list-style-type: none"> • 84: Abortion • 64: Acupuncture • 28: Adjunctive Dental Services • 85: AIDS • 57: Air Transportation • AJ: Alcoholism • GY: Allergy • 79: Allergy Testing • 13: Ambulatory Service Center Facility • 07: Anesthesia • 97: Anesthesiologist 	

*****Codes selected and saved now be the default codes for the selected customer for all future Eligibility requests.**

*After reviewing the updated information, and saving, you will be returned to the Eligibility home page.

Viewing Previous Eligibility Reports

All previously requested Eligibility responses may be viewed again.

To view previous Eligibility responses:



*On the Eligibility Inquiry screen click [Previous Responses](#)

*A list of previous responses will appear.

The screenshot shows the 'Eligibility Manager' interface. At the top, there is a back arrow icon. Below it, there is a search bar with the text 'Search by Member ID' and a 'Search' button. To the right of the search bar is a dropdown menu labeled 'Select by Status:' with 'CMS Report Success' selected. Below these elements is a table with the following columns: Name, Date of Birth, Member ID, Timestamp, and two action icons (a magnifying glass and a refresh icon). The table contains three rows of data, all with the same values: Name 'Sm A', Date of Birth '[REDACTED]', Member ID '[REDACTED]', and Timestamp '8/20/2013 4:35:34 PM', '8/20/2013 4:35:26 PM', and '8/20/2013 4:35:14 PM' respectively.

Name	Date of Birth	Member ID	Timestamp		
Sm A	[REDACTED]	[REDACTED]	8/20/2013 4:35:34 PM		
Sm A	[REDACTED]	[REDACTED]	8/20/2013 4:35:26 PM		
Sm A	[REDACTED]	[REDACTED]	8/20/2013 4:35:14 PM		

*Click on the row of the response file that you wish to view.

*If the Previous Responses list is long, you can click the **Select by Status** drop-down menu to filter the list to show only the status types that you wish to view. (See below for additional information on Status Types.)

This screenshot is identical to the one above, but with a red arrow pointing down to the 'Select by Status:' dropdown menu, which currently shows 'CMS Report Success'.

*To go back to the Eligibility Inquiry screen click

Status Types

Eligibility includes four response status types. These status types explain the type of response received, and allow you to filter previous responses by status.

The Four status types include:

- ***CMS Report Success**-Your Eligibility request was processed and successfully converted to a report.
- ***Eligibility Entry Error**- One of the pieces of data you entered about the patient does not match what CMS has in the common working file.
- ***Eligibility Transaction Error**- No Eligibility 271 response was received due to an error from CMS.
- ***Failed CMS Report**-Your Eligibility request was received, but there was an error converting it to a readable report.
- ***Failed CMS Response**-Your Eligibility request was received from CMS, but there was an error retrieving the 271 response and no report was generated.

Printing Eligibility

After you click Get Eligibility and the response appears on the screen you will have the ability to print the response.

*After the response appears two icons will appear on the top right screen.

*Click 

*A print window will appear. Click Print.

Saving Eligibility


After you click **Get Eligibility** and the response appears on the screen, you will have the ability to print the response.

To print the Eligibility response:

*After the response appears two icons will appear on the top right of the screen.

*Click .

*Different browser versions will pop up various windows. You may need to click Save and/or Open for the response to appear in a new tab.

*Click  on the browser toolbar to print the report.

Viewing Eligibility Responses

Eligibility responses that Do not contain errors will contain several categories of information if they are entered, including the following:

Agency/User

The Agency/User section appears as follows:

Agency/User			
Agency:	ABC Home HEALTHCARE	Provider:	111111
PayerLink	Jane Doe	Date/Time Requested:	5/31/2012 1:55 PM

Subscriber

The Subscriber section appears as follows:

Subscriber			
Name:	Johns, Elizabeth	Date of Birth:	7/29/1921
Gender:	F	HICN/Member Id:	496093871A

Eligibility

The Eligibility section appears as follows:

Eligibility	
Part A Effective Date:	7/1/1986
Part B Effective Date:	7/1/1986
Inactive Period Effective Date:	
Beneficiary Address Line 1:	1234 West Ozark Avenue
Beneficiary Address Line 2:	
Beneficiary City:	Ozark
Beneficiary State:	MO
Part A Termination Date:	
Part B Termination Date:	
Inactive Period Effective Date:	
ESRD Benefit Desc. Svc Type Code:	
ESRD Transplant DC Date:	
ESRD Effective Date:	

Report Item	Description
Part A Effective Date	A date that indicates the start of eligibility for Medicare Part A benefits.
Part A Termination Date	A date that indicates the termination of eligibility for Medicare Part A Benefits. No date in this field means Medicare Part A eligibility has not terminated.
Part B Effective Date	A date that indicates the start of eligibility for Medicare Part B benefits.
Part B Termination Date	A date that indicates the termination of eligibility for Medicare Part B benefits. No date in this field means Medicare Part B eligibility has not terminated.
Inactive Period Effective Date	A date that indicates the start of an inactive period due to unlawful, deported, or incarcerated reasons.
Inactive Period Termination Date	A date that indicates the end of an inactive period due to unlawful, deported, or incarcerated reasons.
Beneficiary Address Line 1, Line 2	The address line of the subscriber (beneficiary), if available.
Beneficiary City	The city of the subscriber (beneficiary), if available.
Beneficiary State	The state of the subscriber (beneficiary), if available.
Beneficiary Zip	The zip code of the subscriber (beneficiary), if available.
ESRD Effective Date	The date that indicates the start of eligibility for ESRD services.
ESRD Benefit Desc. Svc Type Code	The Type of Dialysis (14 or 15) services that are being rendered.
ESRD Transplant DC Date	The Date the Transplant services were discharged.

Deductible

The Deductible section appears as follows:

Deductible			
Part B Deductible Year:	1/1/2012 – 12/31/2012	Part B Remaining Deductible Amount:	\$0
Blood Calendar year:	1/1/2012 – 12/31/2012	Blood Number of Units Remaining:	3
OT Cap Calendar year:	1/1/2012 – 12/31/2012	OT Cap Remaining Amount:	\$1880
PT & ST Cap Calendar year:	1/1/2012 – 12/31/2012	PT & ST Cap Remaining Amount:	\$1880
Pulmonary Rehab. Sessions Remaining (T):	72	Pulmonary Rehab. Sessions Remaining (P):	72
Cardiac Rehab. Sessions Remaining (T):	0	Cardiac Rehab. Sessions Remaining (P):	0
Int. Cardiac Rehab. Sessions Remaining (T):	0	Int. Cardiac Rehab. Sessions Remaining (P):	0

Report Item	Description
-------------	-------------

Part B Deductible Year	The calendar year associated with the remaining deductible amount.
Part B Remaining Deductible Amount	Medicare Part B remaining deductible amount associated with the calendar year indicated.
Blood Calendar Year	The calendar year associated with the remaining deductible amount.
Blood Number of Units Remaining	The Blood Deductible units remaining associated with the calendar year indicated.
OT Cap Calendar Year	The calendar year associated with the remaining capitation amount.
OT Cap Remaining Amount	Occupational Therapy remaining amount associated with the calendar year indicated.
PT & ST Cap Calendar Year	The calendar year associated with the remaining capitation amount.
PT & ST Cap Remaining Amount	Physical and Speech Therapy remaining amount associated with the calendar year indicated.
Pulmonary Rehab. Sessions Remaining (T)	The number of Pulmonary Rehabilitation sessions remaining for the Technical Component.
Pulmonary Rehab. Sessions Remaining (P)	The number of Pulmonary Rehabilitation sessions remaining for the Professional Component.
Cardiac Rehab. Sessions Remaining (T)	The number of Cardiac Rehabilitation sessions remaining for the Technical Component.
Cardiac Rehab. Session Remaining (P)	The number of Cardiac Rehabilitation sessions remaining for the Professional Component.
Int. Cardiac Rehab. Sessions Remaining (T)	The number of Intensive Cardiac Rehabilitation sessions remaining for the Technical Component.
Int. Cardiac Rehab. Sessions Remaining (P)	The number of Intensive Cardiac Rehabilitation sessions remaining for the Professional Component.

Preventative

The Preventative section contains all prevetative care and appears as follows:

Preventative	
Smoking Cessation Sessions Remaining: 8	Smoking Cessation Next Session Date:
<u>Prev. HCPCS Code</u> G0439-Annual Wellness Visit (AWV) G0438-Annual Wellness Visit (AWV)	<u>Prev. Next Professional Date</u> <u>Prev. Next Technical Date</u> 1/1/2011 1/1/2011 1/1/2011 1/1/2011
Report Item	Description
Smoking Cessation Sessions Remaining	Number of Smoking/Tobacco Cessation Counseling Sessions remaining for a subscriber.
Smoking Cessation Next Session Date	The next available begin date for Smoking/Tobacco Cessation Counseling Session program if there are no sessions in their current period.
Prev. HCPCS Code	A Healthcare Common Procedure Coding System (HCPCS) code.
Prev. Next Professional Date	The date a subscriber is next eligible for professional services associated with the indicated HCPCS code.
Prev. Next Technical Date	The date a subscriber is next eligible for technical services associated with the indicated HCPCS code.

Plan Coverage

The Plan Coverage section appears as follows:

Plan Coverage			
Enrollment Date :	1/1/2012	Term Date:	
Type:	Preferred Provider Organization (PPO)	Option:	MCO Bill Option Code C
Name	Humana Insurance Company	ID:	H0939 879
Address Line 1	1100 Insurance Blvd.	Telephone:	2120C, N402, (Hower 148)
Address Line 2:		Zip:	697586384
City:	St. Louis	Website	www.humana-medicare.com
State:	MO		

Report Item	Description
Enrollment Date	The date that indicates the start of enrollment to the coverage plan.
Type	A full plan description followed by Plan Type Code: HM — Health Maintenance Organization Medicare Non Risk HN — Health Maintenance Organization Medicare Risk IN — Indemnity PR — Preferred Provider Organization PS — Point of Service Part D — Pharmacy
Name	A descriptive name of the beneficiary's insurance coverage organization.
Address Line 1, 2	The Coverage Plan's Address lines.
City	The Coverage Plan's City Address.

State	The Coverage Plan's State Address.
Term Date	The date that indicates the termination of enrollment to the coverage. No date in this field means the plan enrollment has not terminated.
Option	The bill option code of the Plan Type. This field only applies to plan types HM, HN, IN, PPO, and PS. This field will not be displayed for Part D plan type.
ID	The contract number followed by the plan number (if on file).
Telephone	The Coverage Plan's Contract Telephone Number (if on file) displayed as XXX-XXX-XXXX.
Zip	The Coverage Plan's Zip Code.
Website	Contract Plan's website address that will provide information on the subscriber's insurance.

Medicare Secondary Payer

The Medicare Secondary Payer section will contain Secondary Payer information if there is any entered and appears as follows:

Medicare Secondary Payer	
Effective Date:	Address Line 1:
Termination Date :	Address Line 2:
Insurer Name:	City:
Policy Number:	State:
Type of Primary Insur:	Zip:

Report Item	Description
Effective Date	The date that indicates the start of the primary insurer's coverage.
Termination Date	The date that indicates the termination of the primary insurer's coverage. No date in this field means primary insurance coverage has not terminated.
Insurer Name	The name of the insurance company.
Policy Number	The primary insuring organization's policy number for the Medicare beneficiary.
Type of Primary Insur	The type code and description of the Primary Insurance Plan: 12 — Medicare Secondary Working Aged Beneficiary or spouse
	with Employer group health plan 13 — Medicare Secondary End Stage Renal Disease Beneficiary in the 12 month coordination period with and Employer group health plan 14 — Medicare Secondary No-Fault insurance including auto is primary 15 — Medicare Secondary Workers Compensation 16 — Medicare Secondary Public Health Service or other Federal Agency 41 — Medicare Secondary Black Lung 42 — Medicare Secondary Veteran's Administration 43 — Medicare Secondary Disabled Beneficiary under age 65 with Large Group Health Plan 47 — Medicare Secondary other liability insurance is primary WC — Workers Compensation Medicare Set aside arrangement.
Address Lines 1, 2	The address Line of the insurance company.
City	The city of the insurance company.
State	The state of the insurance company.
Zip	The Zip Code of the insurance company.

Home Health Certification

The Home Health Certification section appears as follows:

Home Health Certification	
Certification:	G0180
Re-Certification:	G0179
Certification Date:	1/4/2011
Re-Certification Date:	2/28/2012

Report Item	Description
Certification	The HCPCS code used when the subscriber became certified for home health care services.
Certification Date	The date the subscriber was certified to receive home health care services.
Re-Certification	The HCPCS code used when the Beneficiary became recertified for home health care services.
Re-Certification Date	The date the beneficiary was recertified to receive home health

	care services.
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Home Health

The Home Health section appears as follows:

Home Health

<u>Start Date</u>	<u>End Date</u>	<u>DOEBA Date</u>	<u>DOLBA Date</u>	<u>Provider #</u>	<u>Provider Name</u>	<u>Contractor #</u>	<u>Contractor Name</u>
2/28/2012	4/27/2012			135968456	other	44697	PGBA
12/30/2011	2/27/2012	12/31/2011	2/27/2012	135968456	other	44697	PGBA

Report Item	Description
Start Date	The date the 60-day Home Health episode period started.
End Date	The date that the Home Health episode terminated.
DOEBA Date	The date of earliest billing activity for spell of illness.
DOLBA Date	The date of latest billing activity for spell of illness.
Provider #	Provider name and number, will show only the NPI if the Provider name is not available.
Contractor #	A display of the Contractor number.
Contractor Name	A display of the Contractor name.



If DOEBA and DOLBA dates are not available in the 271 Eligibility file retrieved, they will not be listed on the report. It is possible to have PPS period information with no DOEBA and DOLBA information.

Hospice

The Hospice section appears as follows:

Hospice				
<u>Benefit Period</u>	<u>Start Date</u>	<u>Term Date</u>	<u>Provider #</u>	<u>Revocation Code</u>
2	5/5/2010	8/2/2010	968365789	1 Revoked by notice of revocation
1	2/3/2010	5/4/2010	968365789	1 Revoked by notice of revocation

Report Item	Description
Benefit Period	The number of the Benefit Period.

Start Date	The start date of a subscriber's elected period of Hospice coverage.
Term Date	The termination date of a beneficiary's elected Hospice coverage. No date in this filed means the beneficiary's elected period of Hospice coverage has not terminated.
Provider #	Provider name and number, will show only the NPI if the Provider name is not available.
Revocation Code	Code indicating whether hospice coverage was terminated or not. "0" indicates continuing hospice coverage. "1", "2", or "3" indicates the hospice coverage was terminated (revoked).

No Data Available


If No Data is available for a section, the section will appear as follows:

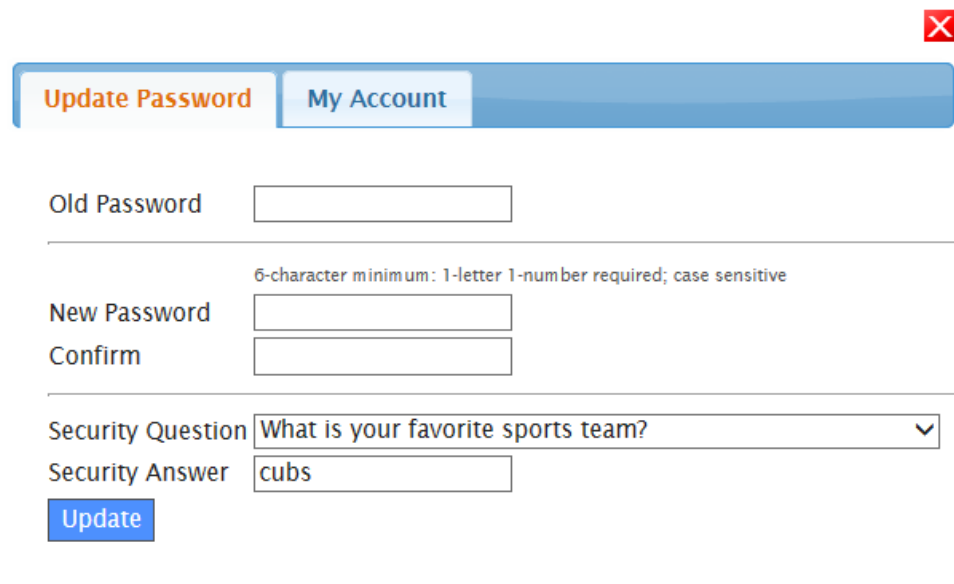
Medicare Secondary Payer
<i>No Medicare Secondary Payer data available</i>

Account Options

After logging in with the default password for the first time the password and security question will need to be changed.

To change the account settings:

*On the main **PayerLink** screen click the account Options/Settings icon  at the top right of the screen and click My Account.



Update Password My Account

Old Password

6-character minimum: 1-letter 1-number required; case sensitive

New Password

Confirm

Security Question

Security Answer

Update

*Type the **Old Password**

*Type the **New Password**

*Confirm **New Password**

*Select a new **Security Question**

*Type a new **Security Answer**

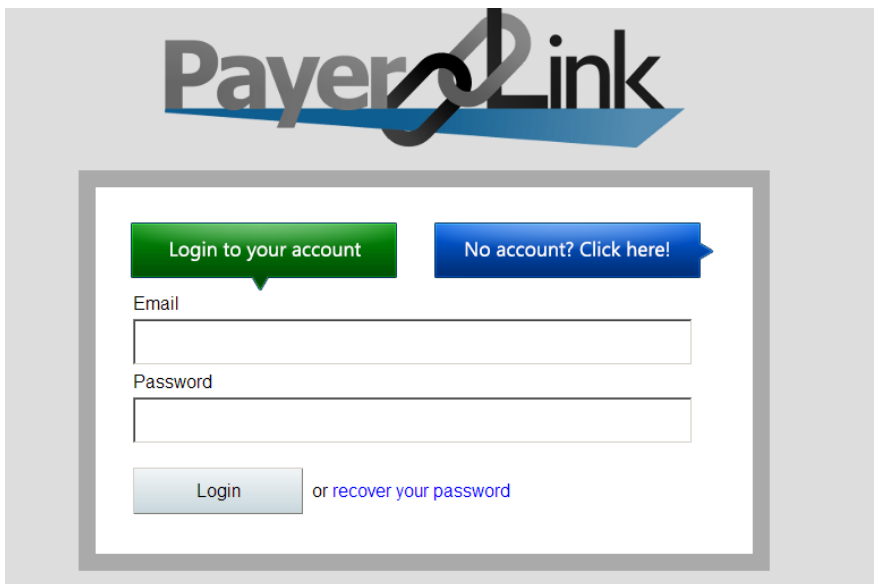
*Click **Update**

Reset Password

If you forget your password you can request to have the password reset.

To request a password reset:

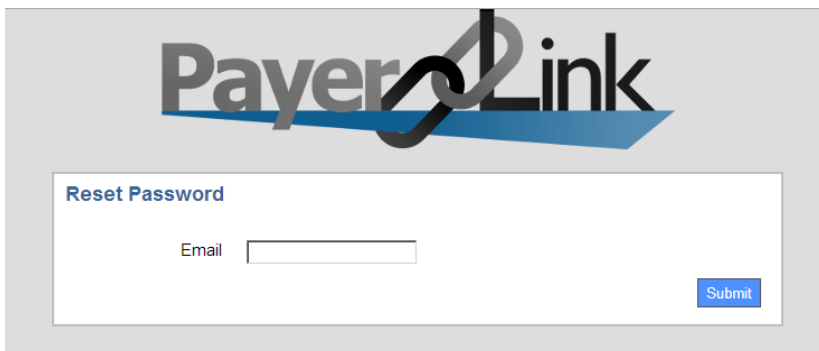
*From the Login page at <https://www.payerlink.com/>; Click **Recover your password**



The image shows the PayerLink login interface. At the top is the PayerLink logo. Below it is a white box containing two buttons: a green 'Login to your account' button and a blue 'No account? Click here!' button. Under these buttons are two input fields: 'Email' and 'Password'. At the bottom of the box is a 'Login' button and a link that says 'or recover your password'.

*Type you **Email** Address

*Click **Submit**



The image shows the PayerLink 'Reset Password' page. It features the PayerLink logo at the top. Below the logo is a white box with the title 'Reset Password'. Inside this box is an 'Email' label followed by an input field. At the bottom right of the box is a blue 'Submit' button.

*A screen will appear requesting you to **Answer Security Question**



Answer Security Question

Security Question

Security Answer

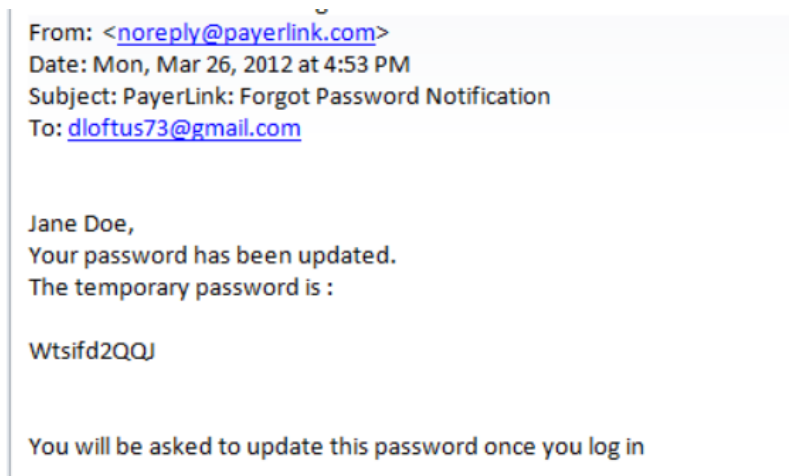
Reset

*Select the **Security Question** from the drop-down menu.

*Enter your **Security Answer**.

*Click **Reset**.

You will receive an email similar to the message below notifying you that your password has been reset.




You will need to change the password after you login

Logging Out

To log out from the CMS System:

*Click **File/Exit**

To Log out of **PayerLink**

*Click the logout icon  at the top of the right of the screen.

After you logout the following window will appear notifying you that you have successful logged out.

