

Illinois Department of Healthcare and Family Services

Internet Electronic Claims (IEC) System

Institutional Invoice Claim Submission Direct Data Entry (DDE)

Last Update: May, 2017
Version 1.15

Table of Contents

IEC System – Institutional Claim Submission DDE Training Materials	3
General Navigation	7
Institutional Claim Invoice Header Information	10
Patient/Subscriber Tab	11
Provider Tab.....	13
Claim Tab.....	14
Principal Diagnosis and Procedure Information	17
Other Diagnosis and Procedure Information	19
Value, Condition, Occurrence Codes Tab	21
Physician Info Tab.....	24
Claim TPL Tab	26
Service Line Tab	29
Entering a Claim – errors returned	32
Entering a Claim – successful submission	33
Patient/Subscriber Tab	33
Provider Tab	34
Claim Tab	35
Principal Diagnosis and Procedures Tab.....	36
Other Diagnosis and Procedure Information Tab.....	37
Value, Condition, Occurrence Codes Tab.....	39
Physician Info Tab	41
Claim TPL Tab.....	42
Service Line Tab.....	48
Confirmation Page	55
Entering another Claim.....	59

IEC System – Institutional Claim Submission DDE Training Materials

Type the following URL into your browser address line: www.myhfs.illinois.gov

The screenshot shows the myHFS website interface. At the top, there is a navigation bar with the HFS logo and the text "ILLINOIS DEPARTMENT OF Healthcare and Family Services". To the right of the logo, there are links for "HFS Home", "Illinois.gov", and "Bruce Rauner, Governor". A search bar is also present with the text "Search this site..." and a "GO" button. Below the navigation bar, there are four main menu items: "MY HEALTHCARE", "MEDICAL PROVIDERS" (highlighted in red), "INFO CENTER", and "ABOUT US".

Under the "MEDICAL PROVIDERS" menu, there is a breadcrumb trail: "HFS > Medical Providers > Electronic Data Interchange (EDI) >". Below this, the "MEDI Home" section is displayed. It features an "Update March 14, 2017" and several paragraphs of text providing information about a Microsoft Windows update that will block all Java versions below 8u121. A red arrow points from the text "Do not change your Java if you can login." to the "MEDI Home" option in a dropdown menu on the right side of the page.

The dropdown menu is titled "Medi" and contains the following options: "EDI Home", "MEDI", "MEDI Home" (highlighted with a blue bar and a red arrow), "MEDI Login", "MEDI Frequently Asked Questions", "MEDI Help", "MEDI Help (pdf)", "Getting Started with MEDI", "Register for Medi", and "Contact Us".

Below the dropdown menu, there is a "Need Assistance?" section with a warning icon and the text "Report a Webpage Problem".

The "MEDI News" section follows, with a welcome message and a list of links: "Medical Assistance Information for Medicaid Providers", "All Kids and FamilyCare Programs", "Child Support Case Information", and "Cost Calculation For Medicaid School-Based Health Services".

The "New Users" section provides resources for establishing and troubleshooting MED access, including links for "Getting Started", "Registration Toolbox (pdf)", and "Help Documentation".

Registered Users



Login [here](#) or click the login button above.

Note: Some features of this site will be unavailable between 3 and 3:30 a.m. on a daily basis, and between 10 p.m. to midnight on Saturdays, due to regular system maintenance. Please keep this in mind when using this site during this time frame, and thank you for your cooperation.

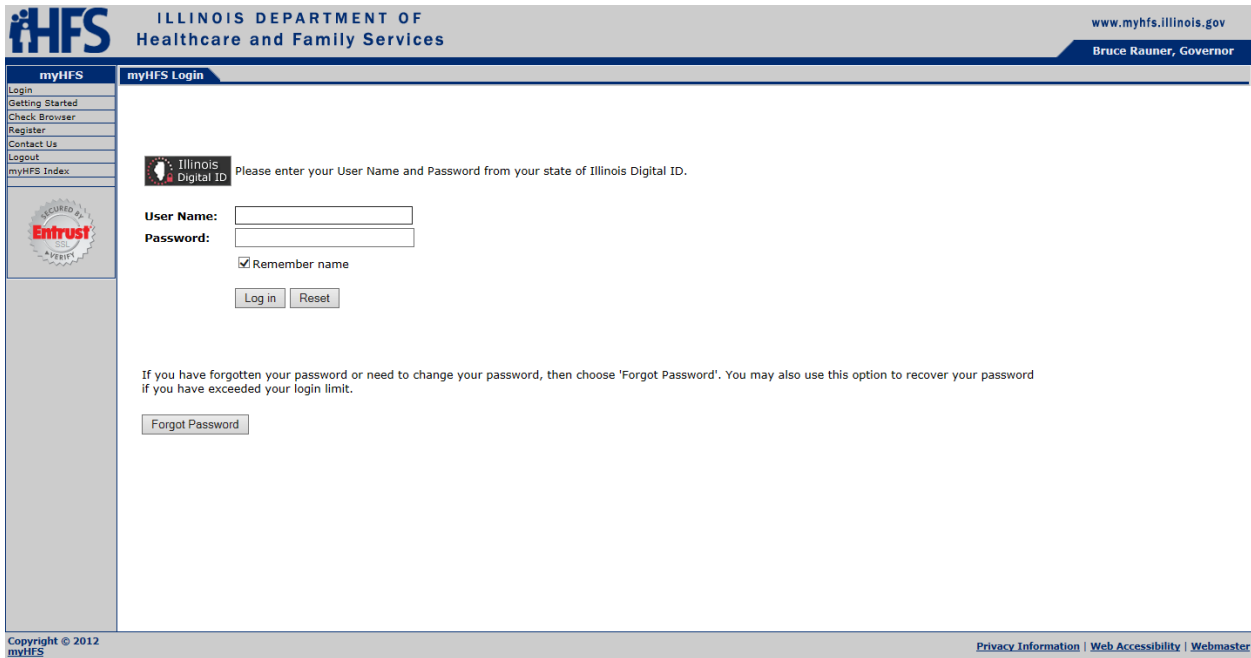
Provider Updates

Providers can register to receive E-mail notification, when new provider information has been posted to the Web site, by completing the form for [Provider Releases and Bulletins E-mail Notification Request](#).

Providers can register to receive an E-mail notification when a new preferred drug list has been posted to the Web site, by completing the form for the [Preferred Drug List E-Mail Notification Request](#).

Click on the **Login** hyperlink

Enter your User Name and Password that you created for your State of Illinois Digital ID.

The screenshot shows the myHFS Login page. At the top, there is a header for the Illinois Department of Healthcare and Family Services, with the website URL www.myhfs.illinois.gov and the name of the Governor, Bruce Rauner. On the left side, there is a navigation menu with links for Login, Getting Started, Check Browser, Register, Contact Us, Logout, and myHFS Index. Below the menu is an "Entrust" logo. The main content area is titled "myHFS Login" and contains a message: "Please enter your User Name and Password from your state of Illinois Digital ID." There are two input fields for "User Name:" and "Password:". Below these fields is a checkbox labeled "Remember name" which is checked. There are "Log in" and "Reset" buttons. Below the login fields, there is a link for "Forgot Password" with the text: "If you have forgotten your password or need to change your password, then choose 'Forgot Password'. You may also use this option to recover your password if you have exceeded your login limit." At the bottom of the page, there is a copyright notice for 2012 and links for Privacy Information, Web Accessibility, and Webmaster.

ILLINOIS DEPARTMENT OF Healthcare and Family Services www.myhfs.illinois.gov
Bruce Rauner, Governor

MEDI Links | **MEDI Home** **Help**

MEDI Home
Manage My Account
Registration Menu
Manage NPI Account
Help Index
Contact Us
Logout

If you have billing problems, please call a billing consultant at 1-877-782-3565.
For all other questions, please call DoIT Service Desk at 1-312-814-0011 (2648).
Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Welcome, MEDI TEST 4!

Select Application

[Internet Electronic Claims System \(IEC\)](#)
The IEC System provides the ability to perform basic processing functions such as:

- * Eligibility Inquiry
- * Claim Status Inquiry
- * Upload/Download HIPAA-compliant transactions

[English All Kids Application Agent \(AKAA\) / Spanish All Kids Application Agent \(AKAA\)](#)

[Illinois Health Connect \(ILHC\)](#)

[Electronic Health Records/Provider Incentive Payment \(EHR/PIP\)](#)

[Drug Prior Approval/Refill Too Soon Entry System](#)

[Primary Care Attestations](#)

[Long Term Care \(LTC\)](#)

[Sexual Assault Survivor Registration Site \(ERSASS\)](#)

[Standardized Illinois Early Intervention Referral Form, Form 650](#)

A referral to the Department of Human Services (DHS) Early Intervention (EI) program, Child and Family Connections (CFC) offices can be made using the Standardized Illinois Early Intervention Referral Form, Form 650. The form can be printed or saved to your computer for use. The form includes a link to an on-line tool to look up the CFC office(s) serving your area.

The **MEDI Home** Page is displayed.

(These instructions assume you have completed your MEDI registration. If not, follow the link to the Registration Menu.)

Click on the **Internet Electronic Claims System (IEC)** hyperlink.

After clicking on the link, the **IEC Home** page appears. This page has general information, such as functionality overviews, additional information, and help documentation. Clicking on these hyperlinks opens a new window that displays the topic information. Note the left hand menu bar. This menu has buttons that allow authorized users access to the different functions within IEC. To submit a claim, click on the **Claim Submission** button.

HFS ILLINOIS DEPARTMENT OF Healthcare and Family Services www.myhfs.illinois.gov
Bruce Rauner, Governor

IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565.
For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

IEC Home Page

IEC News

TO ENSURE PROPER MEDI AUTHORIZATION, PLEASE READ THE FOLLOWING CAREFULLY.
Do not submit an NPI that has not been registered with HFS. These claims will not be processed.
You may now use your NPI number, for the Billing Provider, on your batch claim files and Professional/Institutional DDE claim submission screens.

835 Electronic Remittance Advice Now Available
The 835 Electronic Remittance Advice Function is now available in the IEC system. The use of this function requires that a **PAYEE** registration be completed using the [Medi Home Page](#).
Please read the Remittance Advice Overview below for instructions on how to use this function.

Overviews

- [IEC Overview](#)
An overview of the IEC system.
- [Upload Overview](#)
An overview of the Upload process.
- [Download Overview](#)
An overview of the Download process.
- [Claim Status Inquiry Overview](#)
An overview of the Claim Status Inquiry process.
- [Claim Status Response Overview](#)
An overview of the Claim Status Response process.
- [Remittance Advice Overview](#)
An overview of the ERA viewing and download processes.

Additional Information

- [IDPA Supported HIPAA Transactions and Versions](#)
A list of the current HIPAA transactions and versions that IDPA is supporting.
- [Submission Guidelines](#)
Guidelines providing help on the submission of files through the IEC System.
Use this link to access Department Billing Instructions.

Help Manuals

- [FAQs](#)
A list of frequently asked questions about the IEC System.
- [IEC Help Manual](#)
A printable manual for the IEC System in Portable Document Format (PDF).

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The **Claim Form Submission Selection** page is displayed. A user's authorization to submit a given form is dependent on the Provider Type that they are associated with in the MEDI Authorization database. Click on the **Institutional Claim** link.

The screenshot shows the IEC Links page for the Illinois Department of Healthcare and Family Services. The page is titled "Claim Form Submission Selection" and features a sidebar with various links. The main content area is divided into "Available Claim Forms", "Professional Forms", and "Institutional Forms". A red arrow points to the "Institutional Claim" link under the "Institutional Forms" section.

IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565. For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Available Claim Forms

Professional Forms

- [Provider Invoice](#)
- [Transportation Invoice](#)
- [Medical Equipment/Supplies Invoice](#)
- [Laboratory/Portable X-Ray Invoice](#)
- [Health Insurance](#)
- [Medicare Crossover](#)
- [Community Mental Health Centers](#)

Institutional Forms

- [Institutional Claim](#)

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General Navigation

The Institutional Claim Submission DDE pages are displayed. The pages are arranged in a tabular format to simplify data entry. There are nine tabs: Patient/Subscriber; Provider; Claim; Principal Diagnosis and Procedure Information; Other Diagnosis and Procedure Information; Value/Condition/Occurrence Codes; Physician Info; Claim TPL; and Service Line. The **Patient/Subscriber** tab is the default tab displayed when you first access the form.

Note that there is a **Submit** button, a **Reset** button, and a **Help** button in the upper right corner. The **Submit** button allows the user to Submit the claim for processing. The **Reset** button clears all of the fields on the form. The **Help** button opens another window with content sensitive help. The **Submit** and **Reset** buttons are also available at the bottom right corner of the screen as well.

To access a specific tab, simply click on the tab name. You can also move between tabs by using the **Next** and **Previous** buttons located at the bottom of each tab if applicable. See circled buttons below on the **Provider** tab. Information can be entered on any of the tabs in any order. For example, you can enter information on the **Provider** tab before entering information on the **Patient / Subscriber** tab. The same rule applies to all fields. You can enter information into any field in any order.

The screenshot shows the 'Institutional Claim Submission' form. At the top left is the HFS logo and the text 'ILLINOIS DEPARTMENT OF Healthcare and Family Services'. At the top right is the website 'www.myhfs.illinois.gov' and 'Bruce Rauner, Governor'. A sidebar on the left lists 'IEC Links' such as 'IEC Home', 'Eligibility Inquiry', 'Claim Submission', etc. The main content area has a header 'Institutional Claim Submission' and a note '* Denotes required field'. Below this is a summary table:

Total Claim Charge Amount:	Total Net Amount Billed:	Total TPL Payments:
0.00	0.00	0.00

Below the table are input fields for 'Submitter Tax ID:*', 'Submitter Contact Name:*', and 'Submitter Contact E-mail Address: *'. A navigation bar contains tabs: 'Patient / Subscriber', 'Provider' (selected), 'Claim', 'Prin Diag and Procs', 'Other Diags and Procs', 'Value, Cond, Occur Codes', 'Phys Info', 'Claim TPL', and 'Service Line'. Under the 'Provider' tab, there is a section for 'Provider Information' with fields for '(Billing) Provider ID: *', 'NPI: *', and 'Provider Taxonomy Code: *'. At the bottom of the form, there are 'Previous', 'Next', 'Submit', and 'Reset' buttons. The 'Submit', 'Reset', and 'Help' buttons at the top right, and the 'Previous', 'Next', 'Submit', and 'Reset' buttons at the bottom, are circled in red. The footer contains 'Copyright © 2017 myHFS' and links for 'Privacy Information', 'Web Accessibility', and 'Webmaster'.

Data entry notes:

1. A user can navigate through the fields on a page by using the **Tab** key on your keyboard. Using the **Tab** key will move from one field to the next field moving from the left to the right.
2. After tabbing to a **button**, pressing the **Enter** key on your keyboard will engage the button, and has the same effect as clicking on the button with your mouse.
3. When working with **dropdown lists**, using the **Up and Down Arrows** on your keyboard will navigate through the options in the **dropdown list**.
4. When working with **radio buttons** such as those used for **Gender** (Male, Female, Unknown), the **Up and Down Arrows** on your keyboard can be used to move through the choices and the **Space Bar** on your keyboard can be used to select an option.
5. When working with **dates**, the **Year** portion of any date must be entered as YYYY (4-digits). **Month** can be entered as M or MM (5 or 05 for example). **Day** can be entered as D or DD (7 or 07 for example). All dates entered must be valid calendar dates, must be numeric, and must be on or before the current date.
6. **Dollar amounts** can be entered with or without decimal places. Amounts that are whole numbers (dollars only with no cents) can be entered with or without the decimal places. For example, \$50 can be entered as 50 or 50.00. The dollar sign is not needed and is not valid.
7. **Zip code** fields must be numeric and can contain either the five or nine-digit zip code. For nine-digit zip codes enter all nine digits without the dash (-) in between the first five digits and the last four digits.
8. In order to print the claim form, users will click on **Print a Copy of Claim Submission** button, which will print all of the tabs from the claim submission and will include the claim submission confirmation number.
9. Each of the fields on a tab will either be *Required* or *Situational*. A required field, which will be denoted with an asterisk (*) following the field name, is mandatory under all circumstances. A situational field is essentially not required, but may be required under certain circumstances.
10. All required fields on each tab are denoted with an asterisk. If you ever have a question about a specific field and what is required, select the **Help** button in the upper right corner of the page. This will provide details on all fields on the page.
11. In a dropdown list, typing a letter will automatically jump to the first entry in the list that begins with that letter.

Institutional Claim Invoice Header Information

At the top of the claim form is the claim header. The header is where the user selects and enters information about the submitter of the claim. It also displays the **Total Claim Charge Amount**, the **Total Net Amount Billed**, and the **Total TPL Payments** that have been entered in the form. These fields will be viewable regardless of the tab that is currently in focus. See these fields shown below.

The screenshot shows the 'Institutional Claim Submission' form header. At the top left is the IEC logo and 'ILLINOIS DEPARTMENT OF Healthcare and Family Services'. The URL 'www.myhfs.illinois.gov' and 'Bruce Rauner, Governor' are at the top right. A sidebar on the left lists 'IEC Links' such as 'IEC Home', 'Eligibility Inquiry', 'Claim Submission', etc. The main form area has a title bar 'Institutional Claim Submission' and buttons for 'Submit', 'Reset', and 'Help'. Below the title bar, a red circle highlights three summary fields: 'Total Claim Charge Amount: 0.00', 'Total Net Amount Billed: 0.00', and 'Total TPL Payments: 0.00'. Below these are input fields for 'Submitter Tax Id:*' (a dropdown menu), 'Submitter Contact Name:*', and 'Submitter Contact E-mail Address: *'. At the bottom of the form are several tabs: 'Patient / Subscriber', 'Provider', 'Claim', 'Prin Diag and Procs', 'Other Diags and Procs', 'Value, Cond, Occur Codes', 'Phys Info', 'Claim TPL', and 'Service Line'. The 'Patient / Subscriber' tab is currently selected, showing 'Patient/Subscriber Information'.

Select a **Submitter Tax ID** from the dropdown list. This is a required field. This indicates the individual or organization that is submitting the claim.

A close-up of the 'Submitter Tax Id:*' dropdown menu. The label 'Submitter Tax Id:*' is in bold. The dropdown menu is currently empty and has a blue background with a downward arrow on the right side.

Submitter Contact Name is a required field. This is the contact person for the submitter.

Submitter Contact Email address is a required field. This is the e-mail address for the person who is the contact for the submitter.

Total Claim Charge Amount is a display only field. This is the sum of the Line Item Charge Amounts on each service line on the claim.

Total Net Amount Billed is a display only field. It is a calculated field. The calculation is as follows: Total Net Amount Billed = Total Claim Charged Amount - (sum of all TPL amounts).

Total TPL Payments is a display only field. It is a calculated field. The calculation is as follows: Total TPL Payments = sum of all TPL amounts.

Patient/Subscriber Tab

The **Patient/Subscriber** tab allows entry of fields related to the Patient and Subscriber for the claim.

The screenshot shows the 'Patient/Subscriber' tab of the 'Institutional Claim Submission' form. The page header includes the myHFS logo, 'ILLINOIS DEPARTMENT OF Healthcare and Family Services', the website 'www.myhfs.illinois.gov', and 'Bruce Rauner, Governor'. A sidebar on the left lists 'IEC Links' such as 'IEC Home', 'Eligibility Inquiry', 'Claim Submission', etc. The main form area has a 'Submit', 'Reset', and 'Help' button set in the top right. Below this is a summary table:

Total Claim Charge Amount:	Total Net Amount Billed:	Total TPL Payments:
0.00	0.00	0.00

Below the table are fields for 'Submitter Tax Id:*' (a dropdown menu showing 'MEDI TEST HOSPITAL PROVIDER - 030030030001'), 'Submitter Contact Name:*' (text input), and 'Submitter Contact E-mail Address:*' (text input). A navigation bar contains tabs for 'Patient / Subscriber' (selected), 'Provider', 'Claim', 'Prin Diag and Procs', 'Other Diags and Procs', 'Value, Cond, Occur Codes', 'Phys Info', 'Claim TPL', and 'Service Line'. The 'Patient/Subscriber Information' section includes:

- 'Recipient ID Number (RIN):*' (text input)
- 'First Name:*', 'Middle Name:', and 'Last Name:*' (text inputs)
- 'Date of Birth: *' with 'Month: *', 'Day: *', and 'Year: *' (text inputs)
- 'Gender: *' with radio buttons for 'Male', 'Female', and 'Unknown'
- 'Recipient Address:' with 'Address Line 1:*' and 'Address Line 2:' (text inputs)
- 'City:*', 'State:*', and 'Zip Code:*' (text inputs)

Buttons for 'Next', 'Submit', and 'Reset' are located at the bottom right. The footer contains 'Copyright © 2017 myHFS' and links for 'Privacy Information', 'Web Accessibility', and 'Webmaster'.

All required fields on each tab are denoted with an asterisk. If you ever have a question about a specific field and what is required, select the **Help** button in the upper right corner of the page. This will provide details on all fields on the page.

The **Recipient ID Number (RIN)** is required and must be a valid RIN and is 9 digits long. This is the Medicaid ID number for the individual receiving medical service. Enter the nine-digit number assigned to the individual on the MediPlan Card or the Temporary MediPlan Card. Use no punctuation or spaces. Do not use the Case Identification Number.

The Patient/Subscriber **First Name** and **Last Name** are required. The **Middle Name** is optional.

The **Date of Birth** is required. The Date of Birth must be numeric and must be on or before the **Service From Date. Year** must be entered as YYYY (4 digits), for example you must enter the year as 2005. The **Day** and **Month** fields can be entered as either one digit or two. For example, the month of July can be entered as 7 or as 07. A subscriber can have a birth date up to 125 years earlier than the current date.

Gender is required. You must select one of the radio buttons for Male, Female, or Unknown. A user would enter unknown if they cannot tell by the name if it is male or female.

The **Recipient Address** is required. There are two address lines, and **Address Line 1** is required. This is the street address. **Address Line 2** is optional, and this is for additional information such as Apartment number, or Suite number.

The **City** field is required and should be the recipient's city.

The **State** field is required, and should be the two character State code. For example Illinois should be entered as IL.

The **Zip Code** field is required. It must be numeric and can contain either the five or nine-digit zip code. For nine-digit zip codes, enter all nine digits without the dash (-) in between the first five digits and the last four digits.

Tab to the **Next** Button and press the **Enter** key on your keyboard, or click on the **Next** button with your mouse. This takes you to the **Provider** tab. See the next page for a screen print of the **Provider** tab.

Provider Tab

The **Provider** tab allows entry of provider specific information, such as Provider Name, and Payee Information.

The screenshot shows the 'Institutional Claim Submission' form in the 'Provider' tab. The form includes a sidebar with 'IEC Links' such as 'IEC Home', 'Eligibility Inquiry', and 'Claim Submission'. The main content area features a summary table with columns for 'Total Claim Charge Amount', 'Total Net Amount Billed', and 'Total TPL Payments', all showing 0.00. Below this is the 'Provider Information' section, which includes a dropdown for '(Billing) Provider ID', a dropdown for 'NPI', and a text input for 'Provider Taxonomy Code'. Navigation buttons for 'Previous', 'Next', 'Submit', and 'Reset' are present. The footer contains copyright information and links for 'Privacy Information', 'Web Accessibility', and 'Webmaster'.

Provider ID is a required field. You must make your selection from the dropdown list. The dropdown list is populated based on the choice you make for the Submitter Tax ID field.


NPI is the National Provider Identifier and is required. After selecting the provider from the Provider field, the NPI dropdown list will be populated with the corresponding NPI numbers associated with that provider.

The **Provider Taxonomy Code** is a required field. This is the code designating the provider type, classification, and specialization. Please refer to the appendices in the Chapter 300 Companion Guides located at <http://www.illinois.gov/hfs/medicalproviders/handbooks/pages/5010.aspx>

Click on the **Next** button to go to the next tab, the **Claim** tab.

Claim Tab

The **Claim** tab is where the user can enter information about the claim, statement dates, and attachment information.



ILLINOIS DEPARTMENT OF
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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565. For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Institutional Claim Submission

Submit **Reset** **Help**

*** Denotes required field**

Total Claim Charge Amount:	0.00	Total Net Amount Billed:	0.00	Total TPL Payments:	0.00
-----------------------------------	------	---------------------------------	------	----------------------------	------

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Patient / Subscriber
Provider
Claim
Prin Diag and Procs
Other Diags and Procs
Value, Cond, Occur Codes
Phys Info
Claim TPL
Service Line

Claim Information

Covered Days and Non-Covered Days must be entered as value codes on the Value, Cond, Occur Codes tab.

** All dates must be entered in Month, Day, Year format
** Statement Through Date is required for Bill Types 21, 22, 65, 66, 79, 86 & 89

Patient Account Number:* **Type of Bill Frequency Code:***

*** Delay Reason Code is currently unavailable

Delay Reason Code:

Type of Bill Facility Code:*

Priority (Type) of Admission or Visit:* **Patient Discharge Status:***

Point of Origin for Admission or Visit:*

Prior Authorization Number:

Original DCN:

Medical Record Number:

Admission/Start of Care Date:

Statement Dates

From Date:* **Through Date:**

EPSDT Screening

Was this patient referred for services as a result of an EPSDT screening? * YES NO

Attachment Information

** Attachment Information is currently unavailable

Type of Attachment: **Attachment Control Number:**

Previous **Next**

Submit **Reset**

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[Privacy Information](#) | [Web Accessibility](#) | [Webmaster](#)

Patient Account Number is a required field. This should be a number used in the Submitter's accounting system for identification. **This value will be reported back to the provider on the Department's Remittance Advice, up to 20 characters.**

Type of Bill Frequency Code is a required field. You must select from a dropdown list. This is a code specifying the frequency of the claim.

The **Delay Reason Code** is currently unavailable. In the future, users may select from a dropdown list. This is a code indicating the reason why a request was delayed.

Type of Bill Facility Code is a required field. You must select a value from a dropdown list. This is the code identifying the type of facility where services were performed.

Priority (Type) of Admission or Visit is a required field. You can select a value from a dropdown list. This is the code indicating the priority of this admission.

The **Patient Discharge Status** is a required field. This is the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in FL6, Statement Covers Period.

The **Point of Origin for Admission or Visit** is a required field. You can select a value from a dropdown list. This is a code indicating the point of patient origin for this admission or visit.

Prior Authorization Number is not required. This is the claim level Referral or Prior Authorization Number. A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization.

The **Original DCN** is not required. This is the original document control number for replacement and void of prior claims. This is reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.

The **Medical Record Number** field is not required. This is used to record the Medical Record Number if available. This is a unique number assigned to patient by the provider to assist in retrieval of medical records.

Admission/Start of Care Date is situationally required. There are three fields for **Month**, **Day** and **Year**. When working with dates, the **Year** portion of any date must be entered as YYYY (4-digits). **Month** can be entered as M or MM (5 or 05 for example). **Day** can be entered as D or DD (7 or 07 for example). All dates entered must be valid calendar dates, must be numeric, and must be on or before the current date.

Statement From and Through Dates are required. There are three fields for **Month**, **Day** and **Year**. When working with dates, the **Year** portion of any date must be entered as YYYY (4-digits). **Month** can be entered as M or MM (5 or 05 for example). **Day** can be entered as D or DD (7 or 07 for example). All dates entered must be valid calendar dates, must be numeric, and must be on or before the current date.

EPDST Screening is a situationally required entry depending on claim submittal. You must click on the radio button choosing either Yes or No.

Type of Attachment is currently not available. In the future users will be able to select from a dropdown list.


Attachment Control Number is currently not available. In the future users will be able to type a control number into this field.

Click on the **Next** button to go to the **Principal Diagnosis and Procedures Information** tab.

See the next page for a screen shot of the **Principal Diagnosis and Procedures Information** tab.

Principal Diagnosis and Procedure Information

This **Principal Diagnosis and Procedure Information** tab is used to record diagnosis and procedure codes, dates, and qualifiers for the claim.



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Bruce Rauner, Governor

IEC Links

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Institutional Claim Submission

*** Denotes required field** **Submit** **Reset** **Help**

Total Claim Charge Amount:	Total Net Amount Billed:	Total TPL Payments:
0.00	0.00	0.00

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Patient / Subscriber
Provider
Claim
Prin Diag and Procs
Other Diags and Procs
Value, Cond, Occur Codes
Phys Info
Claim TPL
Service Line

Principal Diagnosis and Procedure Information

** All dates must be entered in Month, Day, Year format

Principal Diagnosis:*	POA Indicator:	Admitting Diagnosis:
<input type="text"/>	<input type="text" value=""/>	<input type="text"/>
External Cause of Injury (ECI Code):	POA Indicator:	
<input type="text"/>	<input type="text" value=""/>	
External Cause of Injury (ECI Code):	POA Indicator:	
<input type="text"/>	<input type="text" value=""/>	
External Cause of Injury (ECI Code):	POA Indicator:	
<input type="text"/>	<input type="text" value=""/>	

Principal Procedure Code:	Principal Procedure Date:	
<input type="text"/>	<input type="text" value=""/>	

1) Patient Reason for Visit: 2) Patient Reason for Visit: 3) Patient Reason for Visit:

Previous
Next

Submit **Reset**

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ICD-9/ICD-10 Coding:

ICD-9 Diagnosis Codes are used with Service Through dates prior to 10/01/2015.

ICD-10 Diagnosis Codes are used with Service From dates on/after 10/01/2015.

ICD-9 procedure Codes are used with Service Through dates prior to 10/01/2015.

ICD-10 procedure Codes are used for Service From Dates on/after 10/01/2015.

The **Principal Diagnosis** is a required field. The user should enter the code indicating the main diagnosis from a specific industry code list. The **POA Indicator** associated with the Principal Diagnosis is situationally required based on the type of claim submitted. The user will select from a drop down menu one of the following values for a claim where POA is being sent:

Y = meaning “Yes, present at the time of inpatient admission”

N = meaning “No, not present at the time of inpatient admission”

U = meaning “Unknown, documentation is insufficient to determine if condition is present at the time of inpatient admission”

W = meaning “Clinically undetermined, provider is unable to clinically determine whether condition was present at time of inpatient admission or not”

1 = meaning “Unreported/Not Used – Exempt from POA reporting. This code is equivalent of a blank on the UB04, but blanks are not desirable when submitting data via the 4010A1 format (837I).”

Admitting Diagnosis is situationally required. The user can enter the code indicating the diagnosis upon admission from a specific industry code list.


External Cause of Injury (ECI Code) is not required. The user can enter the code indicating the ECI: diagnosis from a specific industry code list. “E” codes are obsolete with ICD-10 coding. Please refer to ICD-10 coding manuals for replacement coding requirements.

Principal Procedure Code is a situationally required field depending on claim submittal.

Principal Procedure Date is a situationally required field depending on claim submittal. If a **Principal Procedure Code** is entered then a **Principal Procedure Date** is required. There are three fields for **Month**, **Day** and **Year**. When working with dates, the **Year** portion of any date must be entered as YYYY (4-digits). **Month** can be entered as M or MM (5 or 05 for example). **Day** can be entered as D or DD (7 or 07 for example). All dates entered must be valid calendar dates, must be numeric, and must be on or before the current date.

Patient Reason for Visit is unavailable at this time.

Other Diagnosis and Procedure Information



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- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission

Submit Reset Help

*** Denotes required field**

Total Claim Charge Amount:	Total Net Amount Billed:	Total TPL Payments:
0.00	0.00	0.00

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Patient / Subscriber
Provider
Claim
Prin Diag and Procs
Other Diags and Procs
Value, Cond, Occur Codes
Phys Info
Claim TPL
Service Line

Other Diagnosis and Procedure Information

*** All dates must be entered in Month, Day, Year format

Other Diagnosis and POA Indicators:

1) <input type="text"/> <input type="text"/>	2) <input type="text"/> <input type="text"/>
3) <input type="text"/> <input type="text"/>	4) <input type="text"/> <input type="text"/>
5) <input type="text"/> <input type="text"/>	6) <input type="text"/> <input type="text"/>
7) <input type="text"/> <input type="text"/>	8) <input type="text"/> <input type="text"/>
9) <input type="text"/> <input type="text"/>	10) <input type="text"/> <input type="text"/>
11) <input type="text"/> <input type="text"/>	12) <input type="text"/> <input type="text"/>
13) <input type="text"/> <input type="text"/>	14) <input type="text"/> <input type="text"/>
15) <input type="text"/> <input type="text"/>	16) <input type="text"/> <input type="text"/>
17) <input type="text"/> <input type="text"/>	18) <input type="text"/> <input type="text"/>
19) <input type="text"/> <input type="text"/>	20) <input type="text"/> <input type="text"/>
21) <input type="text"/> <input type="text"/>	22) <input type="text"/> <input type="text"/>
23) <input type="text"/> <input type="text"/>	24) <input type="text"/> <input type="text"/>

Other Procedure Code: Other Procedure Date:

1) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
2) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
3) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
4) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
5) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
6) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
7) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
8) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
9) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
10) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
11) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
12) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
13) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
14) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
15) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
16) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
17) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
18) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
19) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

20)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
21)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
22)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
23)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
24)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Previous](#)
[Next](#)

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[Reset](#)

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The **Other Diagnosis and POA Indicators** code fields are situationally required. The user can enter the other codes if necessary from a specific industry code list. The POA Indicator associated with the Other Diagnosis codes is situationally required based on the claim submitted. The user will select a value from a drop down box (values described above.)

Other Procedure Code is situationally required. This is the code identifying the other procedure, product or service. The user can enter up to 24 Other Procedure Codes.

Other Procedure Date is required, if Other Procedure Codes are reported. There are three fields, one for **Month**, one for **Day**, and one for **Year**. This is the date of the other procedure, product or service. When working with dates, the **Year** portion of any date must be entered as YYYY (4-digits). **Month** can be entered as M or MM (5 or 05 for example). **Day** can be entered as D or DD (7 or 07 for example). All dates entered must be valid calendar dates, must be numeric, and must be on or before the current date.

Value, Condition, Occurrence Codes Tab

The **Value, Condition, Occurrence Codes** tab is used to record occurrence span codes with from and to dates, occurrence codes with dates, values codes and their associated amounts, and condition codes for the claim. The user may enter up to seven occurrence span codes, up to eleven occurrence codes, up to fifteen value codes, and up to fourteen condition codes.



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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission

*** Denotes required field** **Submit** **Reset** **Help**

Total Claim Charge Amount: 0.00 **Total Net Amount Billed:** 0.00 **Total TPL Payments:** 0.00

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Patient / Subscriber
Provider
Claim
Prin Diag and Procs
Other Diags and Procs
Value, Cond, Occur Codes
Phys Info
Claim TPL
Service Line

Value, Condition, and Occurrence Code Information

Accident State:

** All dates must be entered in Month, Day, Year format

Occurrence Span Code:	From Date:	To Date:
1) <input type="text"/>	<input type="text"/>	<input type="text"/>
2) <input type="text"/>	<input type="text"/>	<input type="text"/>
3) <input type="text"/>	<input type="text"/>	<input type="text"/>
4) <input type="text"/>	<input type="text"/>	<input type="text"/>
5) <input type="text"/>	<input type="text"/>	<input type="text"/>
6) <input type="text"/>	<input type="text"/>	<input type="text"/>
7) <input type="text"/>	<input type="text"/>	<input type="text"/>

Occurrence Code:	Occurrence Date:
1) <input type="text"/>	<input type="text"/>
2) <input type="text"/>	<input type="text"/>
3) <input type="text"/>	<input type="text"/>
4) <input type="text"/>	<input type="text"/>
5) <input type="text"/>	<input type="text"/>
6) <input type="text"/>	<input type="text"/>
7) <input type="text"/>	<input type="text"/>
8) <input type="text"/>	<input type="text"/>
9) <input type="text"/>	<input type="text"/>
10) <input type="text"/>	<input type="text"/>
11) <input type="text"/>	<input type="text"/>

Covered Days and Non-Covered Days must be entered with Values 80 and 81 and their associated Amounts.

Value Code:	Associated Amount:
1) <input type="text"/>	<input type="text"/>
2) <input type="text"/>	<input type="text"/>
3) <input type="text"/>	<input type="text"/>
4) <input type="text"/>	<input type="text"/>
5) <input type="text"/>	<input type="text"/>
6) <input type="text"/>	<input type="text"/>
7) <input type="text"/>	<input type="text"/>
8) <input type="text"/>	<input type="text"/>
9) <input type="text"/>	<input type="text"/>
10) <input type="text"/>	<input type="text"/>
11) <input type="text"/>	<input type="text"/>
12) <input type="text"/>	<input type="text"/>
13) <input type="text"/>	<input type="text"/>
14) <input type="text"/>	<input type="text"/>
15) <input type="text"/>	<input type="text"/>

Condition Codes:

1) <input type="text"/>	2) <input type="text"/>
3) <input type="text"/>	4) <input type="text"/>
5) <input type="text"/>	6) <input type="text"/>
7) <input type="text"/>	8) <input type="text"/>
9) <input type="text"/>	10) <input type="text"/>
11) <input type="text"/>	12) <input type="text"/>
13) <input type="text"/>	14) <input type="text"/>

[Previous](#)

[Next](#)

[Submit](#)

[Reset](#)

Accident State is not required.

Occurrence Span Code is a situationally required field. This is required if **From Date** and **To Date** have been entered. This is a code that identifies an event that relates to payment of the claim. This event occurs over a span of days.

From Date is required if you enter an Occurrence Span Code. This is the from date associated with the occurrence span code. There are three fields, one for **Month**, one for **Day**, and one for **Year**. This is the date of the other procedure, product or service. When working with dates, the **Year** portion of any date must be entered as YYYY (4-digits). **Month** can be entered as M or MM (5 or 05 for example). **Day** can be entered as D or DD (7 or 07 for example). All dates entered must be valid calendar dates, must be numeric, and must be on or before the current date.

To Date is required if you enter an Occurrence Span Code. This is the **To** date associated with the occurrence span code. There are three fields, one for **Month**, one for **Day**, and one for **Year**. This is the date of the other procedure, product or service. When working with dates, the **Year** portion of any date must be entered as YYYY (4-digits). **Month** can be entered as M or MM (5 or 05 for example). **Day** can be entered as D or DD (7 or 07 for example). All dates entered must be valid calendar dates, must be numeric, and must be on or before the current date.

Occurrence Code is a situationally required field. This is required if an **Occurrence Date** has been provided. This is a code defining a significant event relating to this bill that may affect payer processing.

Occurrence Date is required if you enter an Occurrence Code. This is the date associated with the occurrence code. There are three fields, one for **Month**, one for **Day**, and one for **Year**. This is the date of the other procedure, product or service. When working with dates, the **Year** portion of any date must be entered as YYYY (4-digits). **Month** can be entered as M or MM (5 or 05 for example). **Day** can be entered as D or DD (7 or 07 for example). All dates entered must be valid calendar dates, must be numeric, and must be on or before the current date.

Value Code is a situationally required field depending on claim submittal. This is required if an **Associated Amount** has been provided. This is a code that identifies data of a monetary nature necessary for processing the claim as required by the payer organization. Effective with dates of service on/after 07/01/2007, Value Codes A1, A2, A7, B1, B2, B7, C1, C2, C7 cannot be used in electronic claims. Please refer to the Claim TPL tab for further instructions. Certain claim submittals require value codes such as, but not limited to, Covered Days, Non-Covered Days, Facility Code for Day Training Services, Hospice MSA Code, and others.

Associated Amount is required if you enter a Value Code. This is the Amount associated with indicated code value. Dollar amounts can be entered with or without decimal places. Amounts that are whole numbers (dollars only with no cents) can be entered with or without the decimal places. For example, \$50 can be entered as 50 or 50.00. The dollar sign is not needed and is not valid.

Condition Code is a situationally required field. These codes are used to identify condition(s) relating to this bill or relating to the patient.

Physician Info Tab

The **Physician Info** Tab is where you can record information about the attending physician, operating physician, and other physician.

The screenshot shows the 'Physician Info' tab in the myHFS system. The page header includes the HFS logo, 'ILLINOIS DEPARTMENT OF Healthcare and Family Services', the website 'www.myhfs.illinois.gov', and 'Bruce Rauner, Governor'. A left sidebar lists 'IEC Links' such as 'IEC Home', 'Eligibility Inquiry', 'Claim Submission', etc. The main content area is titled 'Institutional Claim Submission' and includes a summary table with 'Total Claim Charge Amount: 0.00', 'Total Net Amount Billed: 0.00', and 'Total TPL Payments: 0.00'. Below this are fields for 'Submitter Tax Id:*' (a dropdown menu), 'Submitter Contact Name:*' (a text field), and 'Submitter Contact E-mail Address: *' (a text field). A navigation bar contains tabs for 'Patient / Subscriber', 'Provider', 'Claim', 'Prin Diag and Procs', 'Other Diags and Procs', 'Value, Cond, Occur Codes', 'Phys Info' (selected), 'Claim TPL', and 'Service Line'. The 'Physician Information' section contains several sub-sections, each with 'First Name:', 'Middle Name:', and 'Last Name:' text boxes, followed by an 'NPI:' text box:

- Attending Physician Information:** Fields for First Name, Middle Name, Last Name, and NPI.
- Operating Physician Information:** Fields for First Name, Middle Name, Last Name, and NPI.
- Rendering Physician Information:** Fields for First Name, Middle Name, Last Name, and NPI.
- Referring Physician Information:** Fields for First Name, Middle Name, Last Name, and NPI.
- Other Operating Physician Information:** Fields for First Name, Middle Name, Last Name, and NPI.

 At the bottom of the form are 'Previous' and 'Next' buttons, and 'Submit' and 'Reset' buttons. The footer contains 'Copyright © 2017 myHFS' and links for 'Privacy Information', 'Web Accessibility', and 'Webmaster'.

Physician number/name fields are situationally required depending on claim type submitted with the exception of the Attending Physician name/number.

Attending Physician First Name is required. All claims must report an Attending Physician. The required fields are **First Name** and **Last Name**. **MI** is an optional field.

Attending Physician Middle Name is optional field but is not required.

Attending Physician Last Name is required.

Attending Physician NPI is required. A **Physician NPI** is a 10-digit number.

Operating Physician First Name is not required unless something is entered into one of the other fields for operating physician.

Operating Physician Middle Name is not required. The operating physician middle name can be entered if provided.

Operating Physician Last Name is not required unless something is entered into one of the other fields for operating physician.

Operating Provider NPI is not required unless something is entered into one of the other fields for operating physician.

Rendering/Referring/Other Physician First Name is not required unless something is entered into one of the other fields for other physician.


Rendering/Referring/Other Physician Middle Name is not required. The other physician middle name can be entered if provided.

Rendering/Referring/Other Physician Last Name is not required unless something is entered into one of the other fields for other physician.

Rendering/Referring/Other Physician Provider NPI is not required unless something is entered into one of the other fields for other physician.

Claim TPL Tab

The **Claim TPL** tab allows entry of Claim level TPL fields. Note the **Save Claim TPL Line** button. The **Save Claim TPL Line** button allows a user to save a Claim TPL line and then enter a subsequent line. There is also a **Remove All Claim TPL Lines** button which removes every Claim TPL line that is entered on a claim.



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Healthcare and Family Services**

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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission

* Denotes required field **Submit** **Reset** **Help**

Total Claim Charge Amount:	Total Net Amount Billed:	Total TPL Payments:
0.00	0.00	0.00

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Patient / Subscriber
Provider
Claim
Prin Diag and Procs
Other Diags and Procs
Value, Cond, Occur Codes
Phys Info
Claim TPL
Service Line

Claim TPL Information

Other Insured Information

First Name: * **Middle Name:** **Last Name: ***

ID: * **Claim Filing Code:**

Other Payer Information

Other Payer Name:* **Other Payer Identifier:***

TPL Code:* **TPL Status Code:***

Payer Paid Amount/ TPL Amount:* **Deductible:** **Coinsurance:** **CoPayment:**

Adjudication or Payment Date:*

Month: **Day:** **Year:**

Save Claim TPL Line
Remove All Claim TPL Lines

ID	Claim Filing Cd	TPL Cd	TPL Stat Code	Paid TPL Amt	Adj Pmt Date	Payer ID	
Previous Next							

Submit **Reset**

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This tab is situationally required depending on claim submittal. If TPL is reported, the user should follow the instructions for each field on the screen.

The other insured **First Name** is required if Claim TPL information is entered. This is the first name of the other insured party. The other insured **Middle Name** is optional. The other insured **Last Name** is required if Claim TPL information is entered. This is the last name of the other insured party.

The other insured **ID** is required if Claim TPL information is entered.

The **Claim Filing Code** is not required. The user can select from a dropdown list. This is the code identifying the type of claim or expected adjudication process.

Other Payer Name is required if Claim TPL information is entered. This is for the name of the other payer if provided.

Other Payer Identifier is required if Claim TPL information is entered. This is for the other payer identifier if provided.

The **TPL Code** is required if Claim TPL information is entered. The TPL Code contained on the patient's MediPlan Card (MEC) is to be entered in this field.

The **TPL Status Code** is required if Claim TPL information is entered. This is a two-digit code indicating the disposition of the third party billing must be entered. The user can select from a dropdown list.

The **Payer Paid Amount/TPL Amount** is required if Claim TPL information is entered. Enter the amount of payment received from the third party resource. Dollar amounts can be entered with or without decimal places. Amounts that are whole numbers (dollars only with no cents) can be entered with or without the decimal places. For example, \$50 can be entered as 50 or 50.00. The dollar sign is not needed and is not valid.

Deductible code is a situationally required field. This is a monetary amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer.

Coinsurance code is a situationally required field. This is a monetary amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.

Copayment code is a situationally required field. This is a monetary amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.

The **Adjudication or Payment Date** is required if Claim TPL information is entered. The **Year** must be entered as YYYY (4 digits), for example you must enter the year as 2005. The **Day** and **Month** fields can be entered as either one digit or two. For example, the month of July can be entered as 7 or as 07. This indicates the date of the claim level TPL Payment.

Save Claim TPL Line

Remove All Claim TPL Lines

ID	Claim Filing Cd	TPL Cd	TPL Stat Code	Paid TPL Amt	Adj Pmt Date	Payer ID		
787878	CI	421	01	400.00	07/22/2007	468471	Edit	Remove

Previous

Next

At the bottom of the **Claim TPL** tab, there is a table as shown above. After clicking on the **Save Claim TPL Line** button, an entry is put into the table. All the data that was entered for that Claim TPL line has been stored and is summarized by this line. The form on the page is then cleared to allow entry of an additional TPL if needed.

Remember: If you are submitting a claim with claim TPL line(s) you must save each one to this table.

The **Edit** button allows the user to make changes to the Claim TPL line after it has been saved. After pressing this button, all of the line information previously entered is repopulated into the data entry boxes at the top of the page for editing. Once you have made your changes, you can again click on the **Save Claim TPL Line** button to save your changes. The **Remove** button allows a user to remove a specific line.

The features and functionality of this table on the **Claim TPL** tab are also used on the **Service Line** tab. See the next pages discussing the **Service Line** tab for more details.

Service Line Tab

The **Service Line** tab allows entry of service line fields. Note the **Save Service Line** button. As with the **Claim TPL** tab, the **Save Service Line** button allows a user to save a service line and then enter a subsequent service line, which will populate the table at the bottom of the tab.

Note: You MUST save your service line information before entering information for a second service line.

There is also a **Remove All Service Lines** button which removes every Service Line that is entered on a claim.

The **Edit** button allows the user to make changes to the service line after it has been saved. After pressing this button, the line information will appear in the data entry boxes at the top of the page. The **Remove** button allows a user to remove a specific service line.

See the next page for a screen shot of the **Service Line** tab.

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IEC Links
 IEC Home
 Eligibility Inquiry
 Claim Submission
 Claim Status Inquiry
 Remittance Advice
 Upload X12 File(s)
 Download X12 File(s)
 Help Index
 Companion Guides
 Contact Us
 MEDI Home
 Logout

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Institutional Claim Submission

* Denotes required field

Total Claim Charge: 0.00 Total Net Amount Billed: 0.00 Total TPL Payments: 0.00

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Service Line Information

Revenue Code:*

Revenue Code Description

NDC Code: Unit of Measure: Quantity: Prescription Number:

Procedure Code:

Modifiers:
 1) 2) 3) 4)

Unit Code:*

Unit Count:*

Line Item Charge Amount:*

Denied or Non-Covered Charge Amount:

Service From Date:
 Month: Day: Year:

Revenue Code	Procedure Code	Line Item Charge Amt	Service Date
Total Claim Charge Amount: 0.00			

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The **Revenue Code** is required. These codes indicate the revenue code for the specific service line being submitted.

The **Revenue Code Description** field is situationally required. The user will enter the **NDC code** of any physician-administered injectable drug that is subject to NDC reporting requirements.

The **NDC Unit of Measure** is a situationally required field. The user will choose a value from a drop down list. This will be for any detail drug being billed on the claim.

The **NDC Unit Quantity** is a situationally required field. The user will enter the unit quantity of the NDC code. This will be for any detail drug being billed on the claim.

The **NDC Prescription Number** is a situationally required field. The user will enter the NDC prescription number, if applicable. This will be for any detail drug being billed on the claim, if applicable to report the prescription #.

The **Procedure Code (HCPCS/Rate field)** is situationally required. These codes indicate the procedure code for the specific service line being submitted. If you enter a Procedure Code, you cannot enter a Service Line Rate.

The **Modifier** field(s) is situationally required. This is for the procedure modifiers and the user can enter up to four modifiers. Each **Modifier** can be two characters.

Unit Code is required. This is a dropdown list describing the units in which a value is being expressed. There are only 3 values, minutes, units, and international units.

Unit Count is a required field. This is the quantity, units or minutes as described by the unit code.

The **Line Item Charge Amount** is a required field. This is the amount charged for the service line. Dollar amounts can be entered with or without decimal places. Amounts that are whole numbers (dollars only with no cents) can be entered with or without the decimal places. For example, \$50 can be entered as 50 or 50.00. The dollar sign is not needed and is not valid.

Denied or Non-Covered Charge Amount is a situationally required field. This is the amount charged for the service line. Dollar amounts can be entered with or without decimal places. Amounts that are whole numbers (dollars only with no cents) can be entered with or without the decimal places. For example, \$50 can be entered as 50 or 50.00. The dollar sign is not needed and is not valid.

The **Service From Date** is required. The **Year** must be entered as YYYY (4 digits), for example you must enter the year as 2005. The **Day** and **Month** fields can be entered as either one digit or two. For example, the month of July can be entered as 7 or as 07.

Entering a Claim – errors returned

For a valid claim submission, each of the required fields denoted with an asterisk (*) on each tab must be populated (with the exception of the TPL tab. The fields with an asterisk are only required if there is TPL information to report). In this example, we did not enter any data into the claim at all and clicked on the **Submit** button.

After pressing the **Submit** button, red error messages are returned to the screen. Note that there is an error message for each field that is in error. The error message itself is a link, and clicking on the link will take the user to the tab where the error has occurred. If you have many error messages, the list of errors will be presented with a scroll bar to the right. Some errors will not be visible unless you scroll down to view them.

The screenshot shows the myHFS Institutional Claim Submission form. At the top, the Illinois Department of Healthcare and Family Services logo and name are displayed, along with the website URL www.myhfs.illinois.gov and the name of the Governor, Bruce Rauner. The form is titled "Institutional Claim Submission" and includes a list of IEC Links on the left side. The main content area shows the following information:

- IEC Links:** IEC Home, Eligibility Inquiry, Claim Submission, Claim Status Inquiry, Remittance Advice, Upload X12 File(s), Download X12 File(s), Help Index, Companion Guides, Contact Us, MEDI Home, Logout.
- Errors:** Three red error messages are listed: "The Submitter Contact Name is required.", "The Submitter Contact Email Address is required.", and "The Recipient ID (RIN) is required." A red arrow points to the error messages.
- Buttons:** Submit, Reset, Help.
- Summary:** Total Claim Charge Amount: 0.00, Total Net Amount Billed: 0.00, Total TPL Payments: 0.00.
- Submitter Tax Id:*** MEDI TEST HOSPITAL PROVIDER - 030030030001
- Submitter Contact Name:*** (empty field)
- Submitter Contact E-mail Address:*** (empty field)
- Navigation Tabs:** Patient / Subscriber, Provider, Claim, Prin Diag and Procs, Other Diags and Procs, Value, Cond, Occur Codes, Phys Info, Claim TPL, Service Line.
- Patient/Subscriber Information:** Recipient ID Number (RIN):* (empty field), First Name:*, Middle Name:, Last Name:*, Gender: * (Male, Female, Unknown), Date of Birth: * (Month, Day, Year), Recipient Address: Address Line 1:*, Address Line 2:, City:*, State:*, Zip Code:*
- Buttons:** Next, Submit, Reset.
- Footer:** Copyright © 2017 myHFS, Privacy Information | Web Accessibility | Webmaster.

Entering a Claim – successful submission

As was previously mentioned, for a valid claim submission, each of the required fields denoted with an asterisk (*) on each tab must be filled out (with the exception of the TPL tab. The fields with an asterisk are only required if there is TPL information to report). In the following screen prints, each of the required fields on the form has been populated.


Patient/Subscriber Tab

The screenshot shows the 'Patient/Subscriber' tab of the 'Institutional Claim Submission' form. The form is titled 'ILLINOIS DEPARTMENT OF Healthcare and Family Services' and includes the website 'www.myhfs.illinois.gov' and 'Bruce Rauner, Governor'. The form is divided into several sections:

- IEC Links:** A sidebar menu with options like 'IEC Home', 'Eligibility Inquiry', 'Claim Submission', etc.
- Summary:** A table showing 'Total Claim Charge Amount: 0.00', 'Total Net Amount Billed: 0.00', and 'Total TPL Payments: 0.00'.
- Submitter Information:** Fields for 'Submitter Tax Id:*' (ACME LTC TEST - 123456789003), 'Submitter Contact Name:*' (Jan), and 'Submitter Contact E-mail Address:*' (Jan@test.com).
- Navigation:** A row of buttons for 'Patient / Subscriber', 'Provider', 'Claim', 'Prin Diag and Procs', 'Other Diags and Procs', 'Value, Cond, Occur Codes', 'Phys Info', 'Claim TPL', and 'Service Line'.
- Patient/Subscriber Information:** Fields for 'Recipient ID Number (RIN):*' (123456789), 'First Name:*' (Melissa), 'Middle Name:', 'Last Name:*' (Testperson), 'Date of Birth: *' (Month: 08, Day: 04, Year: 1999), and 'Gender: *' (Female selected).
- Recipient Address:** Fields for 'Address Line 1:*' (44 Country Way), 'Address Line 2:', 'City:*' (Springfield), 'State:*' (IL), and 'Zip Code:*' (62777).
- Buttons:** 'Next', 'Submit', and 'Reset' buttons are located at the bottom right.

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Provider Tab



**ILLINOIS DEPARTMENT OF
Healthcare and Family Services**

www.myhfs.illinois.gov

Bruce Rauner, Governor

IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565. For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Institutional Claim Submission

[Submit](#) [Reset](#) [Help](#)

*** Denotes required field**

Total Claim Charge Amount:	Total Net Amount Billed:	Total TPL Payments:
0.00	0.00	0.00

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Patient / Subscriber
Provider
Claim
Prin Diag and Procs
Other Diags and Procs
Value, Cond, Occur Codes
Phys Info
Claim TPL
Service Line

Provider Information

(Billing) Provider ID: *

NPI: *

Provider Taxonomy Code: *


[Previous](#)
[Next](#)

[Submit](#) [Reset](#)

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<https://qmedi.hfs.illinois.gov/iec/ClaimEntrySelection.do>

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Claim Tab



**ILLINOIS DEPARTMENT OF
Healthcare and Family Services**

www.myhfs.illinois.gov
Bruce Rauner, Governor

IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission

*** Denotes required field**

Total Claim Charge Amount:	0.00	Total Net Amount Billed:	0.00	Total TPL Payments:	0.00
-----------------------------------	------	---------------------------------	------	----------------------------	------

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Claim Information

Covered Days and Non-Covered Days must be entered as value codes on the Value, Cond, Occur Codes tab.

** All dates must be entered in Month, Day, Year format
** Statement Through Date is required for Bill Types 21, 22, 65, 66, 79, 86 & 89

Patient Account Number:* **Type of Bill Frequency Code:***

** Delay Reason Code is currently unavailable

Delay Reason Code:

Type of Bill Facility Code:*

Priority (Type) of Admission or Visit:* **Patient Discharge Status:***

Point of Origin for Admission or Visit:*

Prior Authorization Number:

Original DCN:

Medical Record Number:

Admission/Start of Care Date:

Statement Dates

From Date:* **Through Date:**

EPSDT Screening

Was this patient referred for services as a result of an EPSDT screening? * YES NO

Attachment Information

** Attachment Information is currently unavailable

Type of Attachment: **Attachment Control Number:**

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Principal Diagnosis and Procedures Tab



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Bruce Rauner, Governor

IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission

Submit Reset Help

*** Denotes required field**

Total Claim Charge Amount:	0.00	Total Net Amount Billed:	0.00	Total TPL Payments:	0.00
-----------------------------------	------	---------------------------------	------	----------------------------	------

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Patient / Subscriber

Provider

Claim

Prin Diag and Procs

Other Diags and Procs

Value, Cond, Occur Codes

Phys Info

Claim TPL

Service Line

Principal Diagnosis and Procedure Information

** All dates must be entered in Month, Day, Year format

Principal Diagnosis:*	POA Indicator:	Admitting Diagnosis:
<input type="text" value="V4040"/>	<input type="text" value="Y - Yes, Present"/>	<input type="text"/>
External Cause of Injury (ECI Code):	POA Indicator:	
<input type="text"/>	<input type="text"/>	
External Cause of Injury (ECI Code):	POA Indicator:	
<input type="text"/>	<input type="text"/>	
External Cause of Injury (ECI Code):	POA Indicator:	
<input type="text"/>	<input type="text"/>	

Principal Procedure Code:	Principal Procedure Date:
<input type="text"/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>

1) Patient Reason for Visit: **2) Patient Reason for Visit:** **3) Patient Reason for Visit:**

Previous


Next

Submit Reset

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Other Diagnosis and Procedure Information Tab



**ILLINOIS DEPARTMENT OF
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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission

*** Denotes required field** **Submit** **Reset** **Help**

Total Claim Charge Amount:	0.00	Total Net Amount Billed:	0.00	Total TPL Payments:	0.00
-----------------------------------	------	---------------------------------	------	----------------------------	------

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Patient / Subscriber
Provider
Claim
Prin Diag and Procs
Other Diags and Procs
Value, Cond, Occur Codes
Phys Info
Claim TPL
Service Line

Other Diagnosis and Procedure Information

** All dates must be entered in Month, Day, Year format

Other Diagnosis and POA Indicators:

1) <input type="text" value="V5050"/> <input type="text" value="U - Unknown"/>	2) <input type="text"/> <input type="text"/>
3) <input type="text"/> <input type="text"/>	4) <input type="text"/> <input type="text"/>
5) <input type="text"/> <input type="text"/>	6) <input type="text"/> <input type="text"/>
7) <input type="text"/> <input type="text"/>	8) <input type="text"/> <input type="text"/>
9) <input type="text"/> <input type="text"/>	10) <input type="text"/> <input type="text"/>
11) <input type="text"/> <input type="text"/>	12) <input type="text"/> <input type="text"/>
13) <input type="text"/> <input type="text"/>	14) <input type="text"/> <input type="text"/>
15) <input type="text"/> <input type="text"/>	16) <input type="text"/> <input type="text"/>
17) <input type="text"/> <input type="text"/>	18) <input type="text"/> <input type="text"/>
19) <input type="text"/> <input type="text"/>	20) <input type="text"/> <input type="text"/>
21) <input type="text"/> <input type="text"/>	22) <input type="text"/> <input type="text"/>
23) <input type="text"/> <input type="text"/>	24) <input type="text"/> <input type="text"/>

Other Procedure Code: Other Procedure Date:

1)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
11)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
12)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
13)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
14)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
15)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
16)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
17)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
18)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
19)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
20)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
21)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
22)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
23)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
24)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>


[Previous](#)

[Next](#)

[Submit](#)

[Reset](#)

Value, Condition, Occurrence Codes Tab



**ILLINOIS DEPARTMENT OF
Healthcare and Family Services**

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Bruce Rauner, Governor

IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission

*** Denotes required field**

Total Claim Charge Amount:	Total Net Amount Billed:	Total TPL Payments:
0.00	0.00	0.00

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Patient / Subscriber
Provider
Claim
Prin Diag and Procs
Other Diags and Procs
Value, Cond, Occur Codes
Phys Info
Claim TPL
Service Line

Value, Condition, and Occurrence Code Information

Accident State:

** All dates must be entered in Month, Day, Year format

Occurrence Span Code:	From Date:	To Date:
1) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
2) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
3) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
4) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
5) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
6) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
7) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Occurrence Code:	Occurrence Date:
1) <input type="text" value="22"/>	<input type="text" value="07"/> <input type="text" value="01"/> <input type="text" value="2006"/>
2) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
3) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
4) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
5) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
6) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
7) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
8) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
9) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
10) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
11) <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Covered Days and Non-Covered Days must be entered with Values 80 and 81 and their associated Amounts.

Value Code:

Associated Amount:

1)	<input type="text"/>	<input type="text"/>
2)	<input type="text"/>	<input type="text"/>
3)	<input type="text"/>	<input type="text"/>
4)	<input type="text"/>	<input type="text"/>
5)	<input type="text"/>	<input type="text"/>
6)	<input type="text"/>	<input type="text"/>
7)	<input type="text"/>	<input type="text"/>
8)	<input type="text"/>	<input type="text"/>
9)	<input type="text"/>	<input type="text"/>
10)	<input type="text"/>	<input type="text"/>
11)	<input type="text"/>	<input type="text"/>
12)	<input type="text"/>	<input type="text"/>
13)	<input type="text"/>	<input type="text"/>
14)	<input type="text"/>	<input type="text"/>
15)	<input type="text"/>	<input type="text"/>

Condition Codes:

1)	<input type="text"/>	2)	<input type="text"/>
3)	<input type="text"/>	4)	<input type="text"/>
5)	<input type="text"/>	6)	<input type="text"/>
7)	<input type="text"/>	8)	<input type="text"/>
9)	<input type="text"/>	10)	<input type="text"/>
11)	<input type="text"/>	12)	<input type="text"/>
13)	<input type="text"/>	14)	<input type="text"/>


[Previous](#)

[Next](#)

[Submit](#)

[Reset](#)

Physician Info Tab



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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission

* Denotes required field

Submit
Reset
Help

Total Claim Charge Amount:	0.00	Total Net Amount Billed:	0.00	Total TPL Payments:	0.00
-----------------------------------	------	---------------------------------	------	----------------------------	------

Submitter Tax Id:*

ACME LTC TEST - 123456789003
▼

Submitter Contact Name:*

Jan

Submitter Contact E-mail Address: *

Jan@test.com

Patient / Subscriber

Provider

Claim

Prin Diag and Procs

Other Diags and Procs

Value, Cond, Occur Codes

Phys Info

Claim TPL

Service Line

Physician Information

Attending Physician Information

First Name:	Middle Name:	Last Name:
<input type="text" value="Michael"/>	<input type="text"/>	<input type="text" value="Testdoctor"/>

Attending Physician NPI:

1801877337

Operating Physician Information

First Name:	Middle Name:	Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Operating Physician NPI:

Rendering Physician Information

First Name:	Middle Name:	Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Rendering Physician NPI:

Referring Physician Information

First Name:	Middle Name:	Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Referring Physician NPI:

Other Operating Physician Information

First Name:	Middle Name:	Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Other Operating Physician NPI:

Previous
Next

Submit
Reset

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Claim TPL Tab

In this case we decided to enter Claim TPL information.

The screenshot shows the myHFS Institutional Claim Submission form. The 'Claim TPL' tab is selected. The form contains the following sections and fields:

- IEC Links:** A sidebar menu with options like IEC Home, Eligibility Inquiry, Claim Submission, etc.
- Header:** ILLINOIS DEPARTMENT OF Healthcare and Family Services, www.myhfs.illinois.gov, Bruce Rauner, Governor.
- Buttons:** Submit, Reset, Help.
- Summary:**
 - Total Claim Charge Amount: 0.00
 - Total Net Amount Billed: 0.00
 - Total TPL Payments: 0.00
- Form Fields:**
 - Submitter Tax Id: * (Dropdown: ACME LTC TEST - 123456789003)
 - Submitter Contact Name: * (Text: Jan)
 - Submitter Contact E-mail Address: * (Text: Jan@test.com)
- Navigation:** Patient / Subscriber, Provider, Claim, Prin Diag and Procs, Other Diags and Procs, Value, Cond, Occur Codes, Phys Info, Claim TPL (selected), Service Line.
- Claim TPL Information Section:**
 - Other Insured Information:**
 - First Name: * (Text: Mary)
 - Middle Name: (Text:)
 - Last Name: * (Text: Otherinsured)
 - ID: * (Text: 787878)
 - Claim Filing Code: (Dropdown: CI - Commercial Insurance)
 - Other Payer Information:**
 - Other Payer Name: * (Text: Commercial Payer Test)
 - Other Payer Identifier: * (Text: 468471)
 - TPL Code: * (Text: 421)
 - TPL Status Code: * (Dropdown: 01 - TPL Adju)
 - Financials:**
 - Payer Paid Amount / TPL Amount: * (Text: 400.00)
 - Deductible: (Text: 10.00)
 - Coinsurance: (Text: 10.00)
 - CoPayment: (Text:)
 - Adjudication or Payment Date: ***
 - Month: (Text: 07)
 - Day: (Text: 22)
 - Year: (Text: 2007)
- Buttons:** Save Claim TPL Line, Remove All Claim TPL Lines.
- Table:**

ID	Claim Filing Cd	TPL Cd	TPL Stat Code	Paid TPL Amt	Adj Pmt Date	Payer ID	
- Buttons:** Previous, Next, Submit, Reset.
- Footer:** Copyright © 2017 myHFS, Privacy Information | Web Accessibility | Webmaster.

Once you are finished filling in the information for that Claim TPL line, click on the **Save Claim TPL Line** button. As shown below, that claim TPL line now appears in the table at the bottom of the **Claim TPL** tab. Also notice that the data that you entered in the fields on the **Claim TPL** tab has been cleared.

The **Save Claim TPL Line** button allows a user to save a claim TPL line and then enter a subsequent claim TPL line, which will populate the table at the bottom of the tab. If needed, you can enter another Claim TPL line, and then click on the **Save Claim TPL Line** button again and the second Claim TPL will show in the table.

Note: You MUST save your claim TPL information before entering information for a second claim TPL.

There is also a **Remove All Claim TPL Lines** button which removes every claim TPL line that is entered on a claim.

The **Edit** button allows the user to make changes to the Claim TPL after it has been saved. After pressing this button, the line information will appear in the data entry boxes at the top of the page. The **Remove** button allows a user to remove a specific claim TPL line. There is also a **Remove All Claim TPL Lines** button that removes every Claim TPL line that is entered on the claim.

[Save Claim TPL Line](#) [Remove All Claim TPL Lines](#)

ID	Claim Filing Cd	TPL Cd	TPL Stat Code	Paid TPL Amt	Adj Pmt Date	Payer ID		
787878	CI	421	01	400.00	07/22/2007	468471	Edit	Remove

[Previous](#) [Next](#)

Click on the **Edit** button. Notice in the screen shot on the next page that all the information that you entered for that Claim TPL is now populated on the screen for editing.



IEC Links

- IEC Home
 - Eligibility Inquiry
 - Claim Submission
 - Claim Status Inquiry
 - Remittance Advice
 - Upload X12 File(s)
 - Download X12 File(s)
 - Help Index
 - Companion Guides
 - Contact Us
 - MEDI Home
 - Logout
- If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565. For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Institutional Claim Submission

* Denotes required field

Submit **Reset** **Help**

Total Claim Charge **Total Net Amount Billed:** **Total TPL Payments:**
Amount:
 0.00 -400.00 400.00

Submitter Tax Id:*
ACME LTC TEST - 123456789003

Submitter Contact Name:*
Jan

Submitter Contact E-mail Address: *
Jan@test.com

Claim TPL Information

Other Insured Information

First Name: * **Middle Name:** **Last Name: ***
 Mary Otherinsured

ID: * **Claim Filing Code:**
 787878 CI - Commercial Insurance

Other Payer Information

Other Payer Name:* **Other Payer Identifier:***
 Commercial Payer Test 468471

TPL Code:* **TPL Status Code:***
 421 01 - TPL Adju

Payer Paid Amount/ TPL Amount:* **Deductible:** **Coinsurance:** **CoPayment:**
 400.00 10.00 10.00

Adjudication or Payment Date:*

Month: 07 **Day:** 22 **Year:** 2007

Save Claim TPL Line **Remove All Claim TPL Lines**

ID	Claim Filing Cd	TPL Cd	TPL Stat Code	Paid TPL Amt	Adj Pmt Date	Payer ID		
787878	CI	421	01	400.00	07/22/2007	468471	Edit	Remove

Previous

Next

Submit **Reset**

Notice that the data from that Claim TPL has populated the fields for editing

Once you have made your changes to this Claim TPL line, click on the **Save Claim TPL Line** button again to save. Also notice that the data that you entered in the fields on the Claim TPL tab has been cleared.

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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission

* Denotes required field

Submit **Reset** **Help**

Total Claim Charge **Total Net Amount Billed:** **Total TPL Payments:**
Amount:
 0.00 -400.00 400.00

Submitter Tax Id:*
 ACME LTC TEST - 123456789003

Submitter Contact Name:*
 Jan

Submitter Contact E-mail Address: *
 Jan@test.com

Patient / Subscriber **Provider** **Claim** **Prin Diag and Procs** **Other Diags and Procs** **Value, Cond, Occur Codes** **Phys Info** **Claim TPL** **Service Line**

Claim TPL Information

Other Insured Information

First Name: * **Middle Name:** **Last Name: ***

ID: * **Claim Filing Code:**

Other Payer Information

Other Payer Name:* **Other Payer Identifier:***

TPL Code:* **TPL Status Code:***

Payer Paid Amount/ TPL Amount:* **Deductible:** **Coinsurance:** **CoPayment:**

Adjudication or Payment Date:*

Month: **Day:** **Year:**

Save Claim TPL Line **Remove All Claim TPL Lines**

ID	Claim Filing Cd	TPL Cd	TPL Stat Code	Paid TPL Amt	Adj Pmt Date	Payer ID		
787878	CI	421	01	400.00	07/22/2007	468471	Edit	Remove

Previous **Next**

Submit **Reset**

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If you decide to remove one of the Claim TPL lines, click on the **Remove** button beside the one you want to remove. When you click on the **Remove** button, the line is removed immediately. There is no warning message asking if you are sure you want to remove that line.

Save Claim TPL Line **Remove All Claim TPL Lines**

ID	Claim Filing Cd	TPL Cd	TPL Stat Code	Paid TPL Amt	Adj Pmt Date	Payer ID		
787878	CI	421	01	400.00	07/22/2007	468471	Edit	Remove
46846468	BL	222	01	50.00	07/31/2007	35438434333	Edit	Remove

Previous **Next**

Notice that the line is now removed from the table and from the claim as shown below.


							Save Claim TPL Line	Remove All Claim TPL Lines
ID	Claim Filing Cd	TPL Cd	TPL Stat Code	Paid TPL Amt	Adj Pmt Date	Payer ID		
787878	CI	421	01	400.00	07/22/2007	468471	Edit	Remove
							Previous	Next

Click on the **Remove All Claim TPL Lines** button to remove all Claim TPL lines from the claim as well as from the table as shown below. You will receive a message saying Are you sure you would like to remove all Claim TPL Lines? Click on the **OK** button and notice that all the Claim TPL lines are removed from the table.

							Save Claim TPL Line	Remove All Claim TPL Lines
ID	Claim Filing Cd	TPL Cd	TPL Stat Code	Paid TPL Amt	Adj Pmt Date	Payer ID		
							Previous	Next

The **Service Line** tab has the same functionality.

Service Line Tab



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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

If you have billing problems, go to www.myhfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565. For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Institutional Claim Submission

[Submit](#) [Reset](#) [Help](#)

*** Denotes required field**

Total Claim Charge Amount:	0.00	Total Net Amount Billed:	-400.00	Total TPL Payments:	400.00
-----------------------------------	------	---------------------------------	---------	----------------------------	--------

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

[Patient / Subscriber](#)
[Provider](#)
[Claim](#)
[Prin Diag and Procs](#)
[Other Diags and Procs](#)
[Value, Cond, Occur Codes](#)
[Phys Info](#)
[Claim TPL](#)
Service Line

Service Line Information

Revenue Code:*	NDC Code:	Unit of Measure:	Quantity:	Prescription Number:
<input type="text" value="4553"/>	<input type="text" value="68768768764"/>	<input type="text" value="UN - Unit"/>	<input type="text" value="30.000"/>	<input type="text" value="35486-55569"/>

Procedure Code:

Modifiers:
 1) 2) 3) 4)

Unit Code:* **Unit Count:***

Line Item Charge Amount:*

Denied or Non-Covered Charge Amount:

Service From Date:
Month: **Day:** **Year:**

Save Service Line
Remove All Service Lines

Revenue Code	Procedure Code	Line Item Charge Amt	Service Date
Total Claim Charge Amount: 0.00			

[Previous](#)

Submit
Reset

Once you are finished filling in the information for that service line, click on the **Save Service Line** button. As shown below, that service line now appears in the table at the bottom of the **Service Line** tab. Also notice that the data that you entered in the fields on the **Service Line** tab has been cleared.

- IEC Links**
- IEC Home
 - Eligibility Inquiry
 - Claim Submission
 - Claim Status Inquiry
 - Remittance Advice
 - Upload X12 File(s)
 - Download X12 File(s)
 - Help Index
 - Companion Guides
 - Contact Us
 - MEDI Home
 - Logout
- If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-762-5565. For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Institutional Claim Submission

* Denotes required field [Submit](#) [Reset](#) [Help](#)

Total Claim Charge Amount: 560.00 **Total Net Amount Billed:** 560.00 **Total TPL Payments:** 0.00

Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

- [Patient / Subscriber](#)
- [Provider](#)
- [Claim](#)
- [Prin Diag and Procs](#)
- [Other Diags and Procs](#)
- [Value, Cond, Occur Codes](#)
- [Phys Info](#)
- [Claim TPL](#)
- [Service Line](#)

Service Line Information

Revenue Code:*	Revenue Code Description		
<input type="text"/>	NDC Code:	Unit of Measure:	Quantity:
	<input type="text"/>	<input type="text"/>	<input type="text"/>
		<input type="text"/>	Prescription Number:
			<input type="text"/>

Procedure Code:

Modifiers:
 1) 2) 3) 4)

Unit Code:* **Unit Count:***

Line Item Charge Amount:*

Denied or Non-Covered Charge Amount:

Service From Date:
Month: **Day:** **Year:**

[Save Service Line](#) [Remove All Service Lines](#)

Revenue Code	Procedure Code	Line Item Charge Amt	Service Date		
4553		560.00	07/01/2007	Edit	Remove

Total Claim Charge Amount: 560.00
[Previous](#)

[Submit](#) [Reset](#)

As with the **Claim TPL** tab, the **Save Service Line** button allows a user to save a service line and then enter a subsequent service line, which will populate the table at the bottom of the tab.

Note: You **MUST** save your service line information before entering information for a second service line.

There is also a **Remove All Service Lines** button which removes every service line that is entered on a claim.

The **Edit** button allows the user to make changes to the service line after it has been saved. After pressing this button, the line information will appear in the data entry boxes at the top of the page. The **Remove** button allows a user to remove a specific service line.

Now enter another service line.



- IEC Links**
- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout
- If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565.
- For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Institutional Claim Submission **Submit** **Reset** **Help**

* Denotes required field

Total Claim Charge Amount: 560.00 **Total Net Amount Billed:** 160.00 **Total TPL Payments:** 400.00

Submitter Tax Id:*
ACME LTC TEST - 123456789003

Submitter Contact Name:*
Jan

Submitter Contact E-mail Address: *
Jan@test.com

- Patient / Subscriber**
- Provider
- Claim
- Prin Diag and Procs
- Other Diags and Procs
- Value, Cond, Occur Codes
- Phys Info
- Claim TPL
- Service Line**

Service Line Information

Revenue Code:*	Revenue Code Description			Prescription Number:
4522	NDC Code:	Unit of Measure:	Quantity:	

Procedure Code:

Modifiers:
1) 2) 3) 4)

Unit Code:* UN - Unit **Unit Count:*** 2

Line Item Charge Amount:* 233.45

Denied or Non-Covered Charge Amount:

Service From Date:
Month: 07 Day: 01 Year: 2007

Save Service Line **Remove All Service Lines**

Revenue Code	Procedure Code	Line Item Charge Amt	Service Date		
4553		560.00	07/01/2007	Edit	Remove

Total Claim Charge Amount: 560.00

Previous **Submit** **Reset**

Click on the **Save Service Line** button, and that service line now appears in the table at the bottom of the **Service Line** tab along with the one in the previous example. There are two lines in the table. Again notice that the data that you entered in the fields on the **Service Line** tab has been cleared.



- IEC Links
 - IEC Home
 - Eligibility Inquiry
 - Claim Submission
 - Claim Status Inquiry
 - Remittance Advice
 - Upload X12 File(s)
 - Download X12 File(s)
 - Help Index
 - Companion Guides
 - Contact Us
 - MEDI Home
 - Logout
- If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565. For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Institutional Claim Submission

* Denotes required field **Submit** **Reset** **Help**

Total Claim Charge **Total Net Amount Billed:** **Total TPL Payments:**
Amount:
 793.45 393.45 400.00

Submitter Tax Id:*
ACME LTC TEST - 123456789003

Submitter Contact Name:*
Jan

Submitter Contact E-mail Address: *
Jan@test.com

- Patient / Subscriber**
- Provider**
- Claim**
- Prin Diag and Procs**
- Other Diags and Procs**
- Value, Cond, Occur Codes**
- Phys Info**
- Claim TPL**
- Service Line**

Service Line Information

Revenue Code:* **Revenue Code Description**
NDC Code: **Unit of Measure:** **Quantity:** **Prescription Number:**

Procedure Code:

Modifiers:
1) 2) 3) 4)

Unit Code:* **Unit Count:***

Line Item Charge Amount:*

Denied or Non-Covered Charge Amount:

Service From Date:
Month: **Day:** **Year:**

Save Service Line **Remove All Service Lines**

Revenue Code	Procedure Code	Line Item Charge Amt	Service Date		
4553		560.00	07/01/2007	Edit	Remove
4522		233.45	07/01/2007	Edit	Remove

Total Claim Charge Amount: 793.45

Previous

Submit **Reset**

The **Edit** button allows the user to make changes to the service line after it has been saved. After pressing this button, the line information will appear in the data entry boxes at the top of the page. The **Remove** button allows a user to remove a specific service line. There is also a **Remove All Service Lines** button that removes every service line that is entered on a claim.


Revenue Code	Procedure Code	Service Line Rate	Line Item Charge Amt	Service Date		
4553			560.00	07/01/2007	Edit	Remove
4522			233.45	07/01/2007	Edit	Remove

Total Claim Charge Amount: 793.45

Previous

Edit button

Click on the **Edit** button. Notice in the screen shot below that all the information that you entered for that service line is now populated on the screen for editing.



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Healthcare and Family Services

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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission **Submit** **Reset** **Help**

*** Denotes required field**

Total Claim Charge Amount: 793.45 **Total Net Amount Billed:** 393.45 **Total TPL Payments:** 400.00

Submitter Tax Id:*
ACME LTC TEST - 123456789003

Submitter Contact Name:*
Jan

Submitter Contact E-mail Address: *
Jan@test.com

Patient / Subscriber

Provider

Claim

Prin Diag and Procs

Other Diags and Procs

Value, Cond, Occur Codes

Phys Info

Claim TPL

Service Line

Service Line Information

Revenue Code:*	Revenue Code Description	NDC Code:	Unit of Measure:	Quantity:	Prescription Number:
4522					

Procedure Code:

Modifiers:
1) 2) 3) 4)

Unit Code:* UN - Unit **Unit Count:*** 2

Line Item Charge Amount:* 233.45

Denied or Non-Covered Charge Amount:

Service From Date:
Month: 07 **Day:** 01 **Year:** 2007

Save Service Line Remove All Service Lines

Revenue Code	Procedure Code	Line Item Charge Amt	Service Date		
4553		560.00	07/01/2007	Edit	Remove
4522		233.45	07/01/2007	Edit	Remove

Total Claim Charge Amount: 793.45


Previous

Submit Reset

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Notice that the data from that service line has populated the fields for editing

Once you have made your changes, click on the **Save Service Line** button again to save. Now notice that the data that you entered in the fields on the **Service Line** tab has been cleared.



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Healthcare and Family Services**

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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

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Institutional Claim Submission

Submit **Reset** **Help**

*** Denotes required field**

Total Claim Charge Amount:	793.45	Total Net Amount Billed:	393.45	Total TPL Payments:	400.00
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Submitter Tax Id:*

Submitter Contact Name:*

Submitter Contact E-mail Address: *

Patient / Subscriber
Provider
Claim
Prin Diag and Procs
Other Diags and Procs
Value, Cond, Occur Codes
Phys Info
Claim TPL
Service Line

Service Line Information

Revenue Code:*	Revenue Code Description	NDC Code:	Unit of Measure:	Quantity:	Prescription Number:
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Procedure Code:

Modifiers:
 1) 2) 3) 4)

Unit Code:* **Unit Count:***

Line Item Charge Amount:*

Denied or Non-Covered Charge Amount:

Service From Date:
Month: **Day:** **Year:**

Save Service Line **Remove All Service Lines**

Revenue Code	Procedure Code	Line Item Charge Amt	Service Date		
4553		560.00	07/01/2007	Edit	Remove
4522		233.45	07/01/2007	Edit	Remove

Total Claim Charge Amount: 793.45

Submit **Reset**

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If you decide to remove one of the service lines, click on the **Remove** button beside the one you want to remove. When you click on the **Remove** button, the line is removed immediately. There is no warning message asking if you are sure you want to remove that line.

Revenue Code	Procedure Code	Service Line Rate	Line Item Charge Amt	Service Date		
4553			560.00	07/01/2007	<input type="button" value="Edit"/>	<input type="button" value="Remove"/>
4522			233.45	07/01/2007	<input type="button" value="Edit"/>	<input type="button" value="Remove"/>

Total Claim Charge Amount: 793.45

Notice that the line is now removed from the table and from the claim as shown below.

Revenue Code	Procedure Code	Service Line Rate	Line Item Charge Amt	Service Date		
4553			560.00	07/01/2007	<input type="button" value="Edit"/>	<input type="button" value="Remove"/>

Total Claim Charge Amount: 560.00

Click on the **Remove All Service Lines** button to remove all service lines from the claim as well as from the table as shown below. You will receive a message saying Are you sure you would like to remove all Service Lines? Click on the **OK** button and notice that all the service lines are removed from the table.

Revenue Code	Procedure Code	Service Line Rate	Line Item Charge Amt	Service Date		
--------------	----------------	-------------------	----------------------	--------------	--	--

Total Claim Charge Amount: 0.00

The **Claim TPL** tab has this same functionality.

Confirmation Page

After pressing the **Submit** button, the claim is successfully submitted and the Confirmation page is displayed. The Confirmation page displays all of the fields that were entered on the claim submission. The **Print Copy of Claim Submission** button will allow the user to print the entire claim submission, including the Date of Submission, Time of Submission, and Confirmation Number (which can be used for tracking purposes).

See next pages for screen print of entire confirmation page.

Once you click on the **Submit** button, it will be disabled to prevent duplicate submissions.

Use this button to print the claim.

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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

Claim Submission - Institutional

The Claim has been submitted.

Date: 05/09/2017 **Time:** 09:25 **Confirmation Number:** 000041906

To enter another claim, select an option from the drop down below:

Submitter Tax Id: 123456789003
Submitter Name: ACME LTC TEST
Submitter Contact Name: Jan
Submitter Contact E-mail Address: Jan@test.com

Total Net Amount Billed: 160.00 **Total TPL Payments:** 400.00


Patient/Subscriber Information

Recipient ID Number (RIN): 123456789
Recipient Name: Melissa Testperson
Date of Birth: 08/04/1999 **Gender:** Female
Recipient Address:
Address Line 1: 44 Country Way
Address Line 2:
City: Springfield
State: IL **Zip Code:** 62777

Print Copy of Claim Submission

It is a very good practice to print a copy of your claim submission. Make note of the confirmation number. If there is a question about your claim it will help us resolve any questions that may arise.

Views of the entire confirmation page



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IEC Links

- IEC Home
- Eligibility Inquiry
- Claim Submission
- Claim Status Inquiry
- Remittance Advice
- Upload X12 File(s)
- Download X12 File(s)
- Help Index
- Companion Guides
- Contact Us
- MEDI Home
- Logout

If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565. For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Claim Submission - Institutional

Print Copy of Claim Submission

The Claim has been submitted.

Date:	Time:	Confirmation Number:
05/09/2017	09:25	000041906

To enter another claim, select an option from the drop down below:

Submitter Tax Id:
123456789003

Submitter Name:
ACME LTC TEST

Submitter Contact Name:
Jan

Submitter Contact E-mail Address:
Jan@test.com

Total Net Amount Billed:	Total TPL Payments:
160.00	400.00

Patient/Subscriber Information

Recipient ID Number (RIN):
123456789

Recipient Name:
Melissa Testperson

Date of Birth:	Gender:
08/04/1999	Female

Recipient Address:

Address Line 1: 44 Country Way

Address Line 2:

City:
Springfield

State:	Zip Code:
IL	62777

(Billing) Provider Information

Provider:	NPI:	Provider Taxonomy Code:
123456789003	1234567893	1234567891

Claim Information

Patient Account Number:	Type of Bill Frequency Code:
3255haha	1 - Admit through Discharge Claim

Delay Reason Code:

Total Claim Charge Amount:
\$560.00

Type of Bill Facility Code:
14 Hosp - Other

Priority (Type) of Admission or Visit:
9 - Information Not Available

Point of Origin for Admission or Visit:
9 - Info Not Avail

Patient Discharge Status:
01

Prior Authorization Number:	Original DCN:

Medical Record Number:

Admission/Start of Care Date:	Admission Hour:

Discharge Hour:	Statement From Date:
	07/01/2007

Statement Through Date:	07/01/2007
--------------------------------	------------

EPSDT Screening

Was this patient referred for services as a result of an EPSDT screening? No

Attachment Information

Type of Attachment: Attachment Control Number:

Principal Diagnosis and Procedure Codes

Principal Diagnosis: POA Indicator: Admitting Diagnosis:
V4040 Y

E Diagnosis: POA Indicator:

E Diagnosis: POA Indicator:

E Diagnosis: POA Indicator:

Prin. Proc. Code: Prin. Proc. Date:

1) Patient Reason for Visit: 2) Patient Reason for Visit: 3) Patient Reason for Visit:

Other Diagnosis and Procedure Codes

Other Diagnosis and POA Indicators:

1) V5050 U

Other Proc. Code: Other Proc. Date:

Value, Condition, and Occurrence Code Information

Accident State:

Occurrence Span Code: From Date: To Date:

Occurrence Code: Occurrence Date:
22 07/01/2006

Value Code: Associated Amount:

Condition Codes:

Physician Information

Attending Physician Information

Attending Provider Name:

Michael Testdoctor

Attending Provider NPI:

1801877337

Operating Physician Information

Operating Provider Name:

Operating Provider NPI:

Rendering Physician Information

Rendering Provider Name:

Rendering Provider NPI:

Referring Physician Information

Referring Provider Name:

Referring Provider NPI:

Other Operating Physician Information

Other Operating Provider Name:

Other Operating Provider NPI:

Claim TPL Information

Claim TPL Line 1

Other Insured Information

Other Insured Name:

Mary Otherinsured

ID: 787878 Claim Filing Code: CI - Commercial Insurance

Other Payer Information

Other Payer Name: Commercial Payer Test Other Payer Identifier: 468471

TPL Code: 421 TPL Status Code: 01 - TPL Adju Payer Paid Amount/ TPL Amount: \$400.00

Deductible: \$10.00 Coinsurance: \$10.00 CoPayment: \$0.00

Adjudication or Payment Date: 07/22/2007

Service Line Information

Service Line 1

Revenue Code: 4553

Procedure Code:

Revenue Code Description

NDC Code: 68768768764 Unit of Measure: UN - Unit Quantity: 30.000 Prescription Number: 35486-55569

Modifiers: 1) 2) 3) 4)

Unit Code: UN - Unit Unit Count: 30

Line Item Charge Amount: \$560.00

Denied or Non-Covered Charge Amount:

Service From Date: 07/01/2007

Entering another Claim

At the top of the Confirmation page, there is a dropdown list available to allow the user to more easily create a New Claim. There are four options for how the new claim will appear: with no fields pre-populated, with the same Submitter fields pre-populated, with the same Submitter and Provider fields pre-populated, or with the same Submitter, Provider and Recipient fields pre-populated.

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IEC Links
IEC Home
Eligibility Inquiry
Claim Submission
Claim Status Inquiry
Remittance Advice
Upload X12 File(s)
Download X12 File(s)
Help Index
Companion Guides
Contact Us
MEDI Home
Logout
If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565. For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.

Claim Submission - Institutional

Print Copy of Claim Submission

The Claim has been submitted.

Date: 05/09/2017 **Time:** 09:25 **Confirmation Number:** 000041906

To enter another claim, select an option from the drop down below:

- New Claim
- New Claim for same Submitter
- New Claim for same Submitter/Provider
- New Claim for same Submitter/Provider/Recipient

Submitter Name: ACME LTC TEST

Submitter Contact Name: Jan

Submitter Contact E-mail Address: Jan@test.com

Total Net Amount Billed: 160.00 **Total TPL Payments:** 400.00

Patient/Subscriber Information

Recipient ID Number (RIN): 123456789

Recipient Name: Melissa Testperson

Date of Birth: 08/04/1999 **Gender:** Female

Recipient Address:
Address Line 1: 44 Country Way
Address Line 2:
City: Springfield
State: **Zip Code:**

In this example, choose the option "New Claim for same Submitter/Provider/Recipient". Note in the screen print on the next page that the tabs are pre-populated with the Submitter, Provider and Recipient fields that were entered on the initial claim submission. At this point you can continue entering data in order to submit another claim.



- IEC Links
 - IEC Home
 - Eligibility Inquiry
 - Claim Submission
 - Claim Status Inquiry
 - Remittance Advice
 - Upload X12 File(s)
 - Download X12 File(s)
 - Help Index
 - Companion Guides
 - Contact Us
 - MEDI Home
 - Logout
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Institutional Claim Submission

* Denotes required field

Submit Reset Help

Total Claim Charge Amount: 0.00 Total Net Amount Billed: 0.00 Total TPL Payments: 0.00

Submitter Tax Id:*
ACME LTC TEST - 123456789003

Submitter Contact Name:*
Jan

Submitter Contact E-mail Address:*
Jan@test.com

- Patient / Subscriber
- Provider
- Claim
- Prin Diag and Procs
- Other Diags and Procs
- Value, Cond, Occur Codes
- Phys Info
- Claim TPL
- Service Line

Patient/Subscriber Information

Recipient ID Number (RIN):*
123456789

First Name:* Melissa Middle Name: Last Name:* Testperson

Date of Birth: * Month: * Day: * Year: *
08 04 1999 Gender: *
 Male
 Female
 Unknown

Recipient Address:
Address Line 1:* 44 Country Way
Address Line 2:
City:* Springfield State:* IL Zip Code:* 62777

Next

Submit Reset