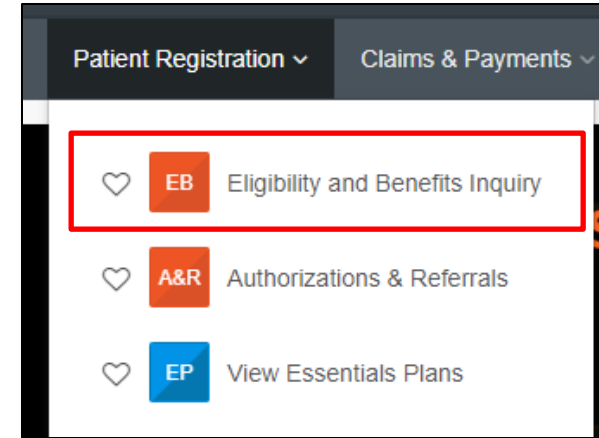


Availity® Provider Portal Inpatient Authorization Submission

Prior to submitting a prior authorization request, you should first check the member's Eligibility and Benefits, including authorization requirements. It is the provider's responsibility to confirm that the member's benefit plan provides the appropriate benefits for the anticipated date of service.

To do so in Avality, go to **Patient Registration** in the menu bar and click on **Eligibility & Benefits Inquiry**.

Complete the form, including Provider, Member and Service Information.

A screenshot of the 'Eligibility & Benefits' form in Avality. The form has a header with the 'EB' icon and a 'Feedback' button. A yellow warning banner at the top reads: 'To search for out of area members, use the Single Patient Search tab. Enter the facility or group NPI instead of the individual provider NPI.' Below the banner, there are two required fields: '* Organization' (dropdown menu showing 'Highmark PA Provider Test') and '* Payer' (dropdown menu showing 'HIGHMARK BLUE SHIELD'). A section titled 'Provider Information' contains a dropdown menu for 'Provider' and a search prompt: 'Select a provider or enter one of the following: Provider NPI or Provider Tax ID. Search for a provider by name, NPI, tax ID, taxonomy code, or address.' A 'Clear Section' button is located to the right of the 'Provider Information' section.

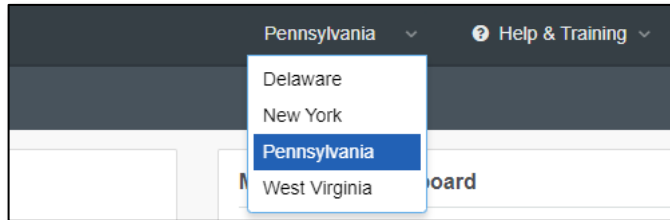
*Verifying Eligibility and Benefits prior to submitting a prior authorization request and/or submitting a claim can:

- 1) Help you avoid submitting unnecessary prior authorization requests
- 2) Confirm patient copays and/or coinsurance
- 3) Minimize claims rejections

Submitting the Prior Authorization Request

In Availity Essentials, there are two paths for prior authorization submission.

After logging into Availity, first choose the appropriate state for your practice/facility.



Next, choose your authorization path:

Path 1 Predictal via Payer Spaces	Path 2 Authorizations & Referrals
--	--

Authorization Status / Authorization Inquiry:
Only Available via Path 1:
Predictal via Payer Spaces

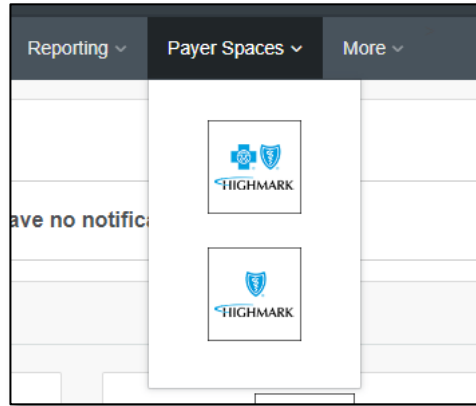
Exception 1:
Retail Pharmacy Authorization Submissions
Can ONLY Use Path 1

Exception 2:
Out of Area (OOA) Member Authorization Submissions
Can ONLY Use Path 2

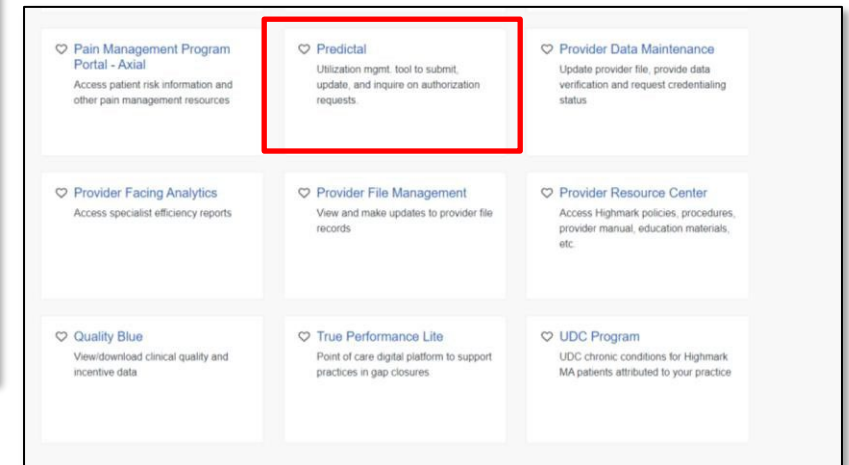
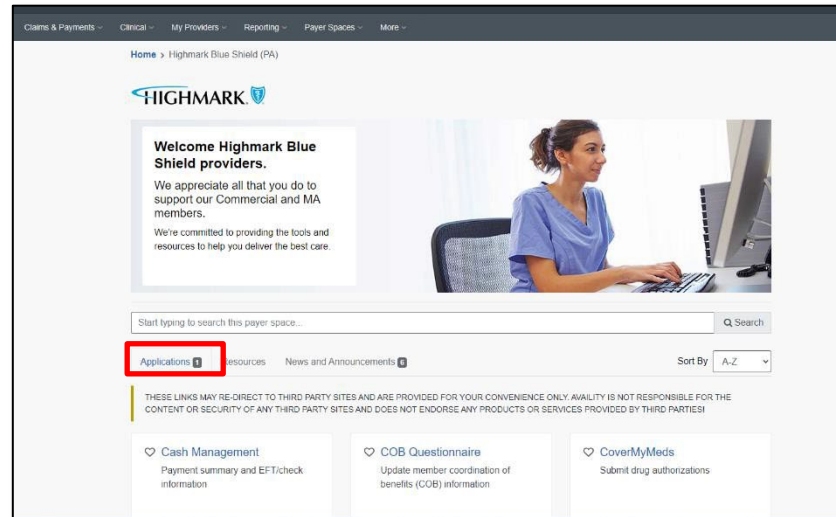
Path 1

To access Highmark's Payer Spaces in Avality Essentials, click on **Payer Spaces** from the top menu and choose the appropriate Health Plan.

***To check Authorization Status and/or submit an Authorization Inquiry, you must use this path to access Predictal via Payer Spaces.**



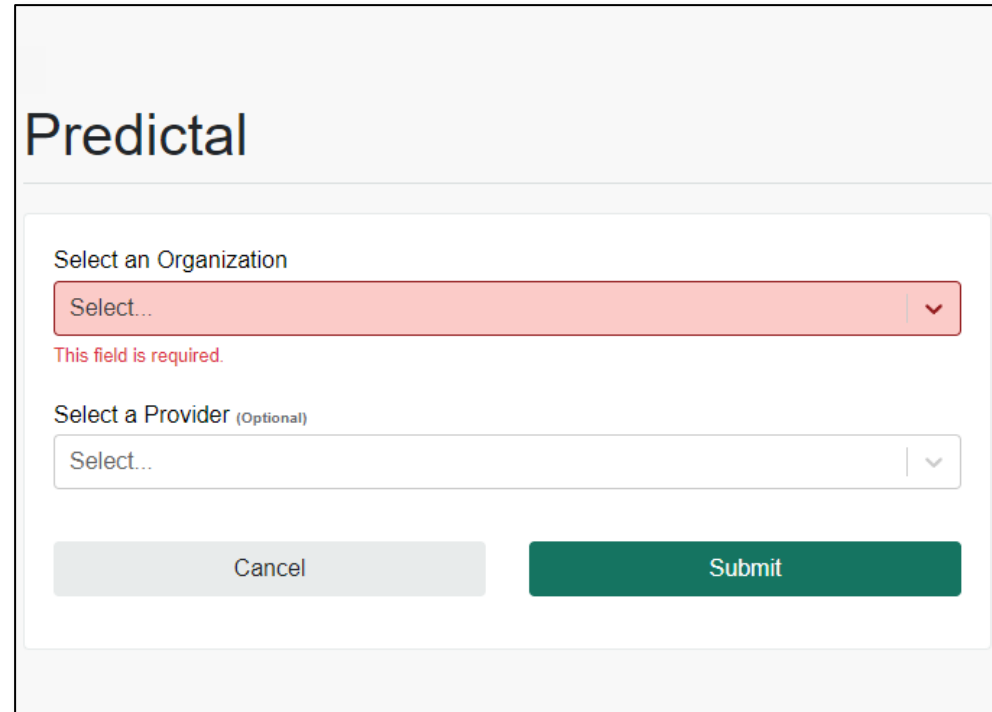
Within **Payer Spaces**, look under **Applications** and select **Predictal**.



Path 1

Once you've selected Predictal, you will need to choose your **Organization**.

- Select a **Provider** (optional)
- Click **Submit** to get to a new tab.

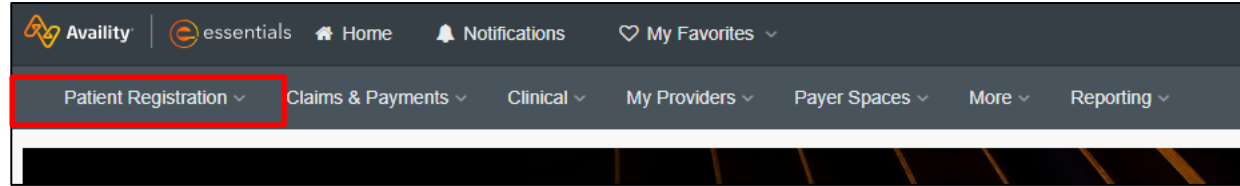


The screenshot shows a web form titled "Predictal". It contains two dropdown menus. The first is labeled "Select an Organization" and has a red border with a "Select..." placeholder and a downward arrow. Below it is a red error message: "This field is required." The second dropdown is labeled "Select a Provider (Optional)" and has a "Select..." placeholder and a downward arrow. At the bottom of the form are two buttons: "Cancel" (light gray) and "Submit" (dark green).

That will take you into the Predictal Authorization Automation Hub to complete your prior authorization request.

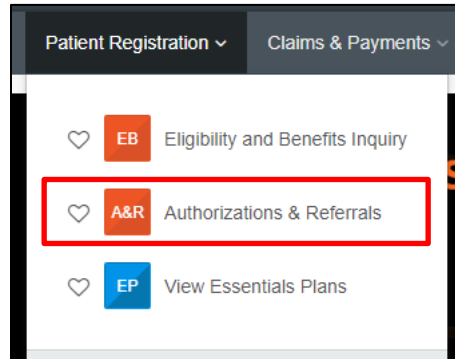
Path 2

To access Authorization & Referrals, first click on Patient Registration in the top menu.

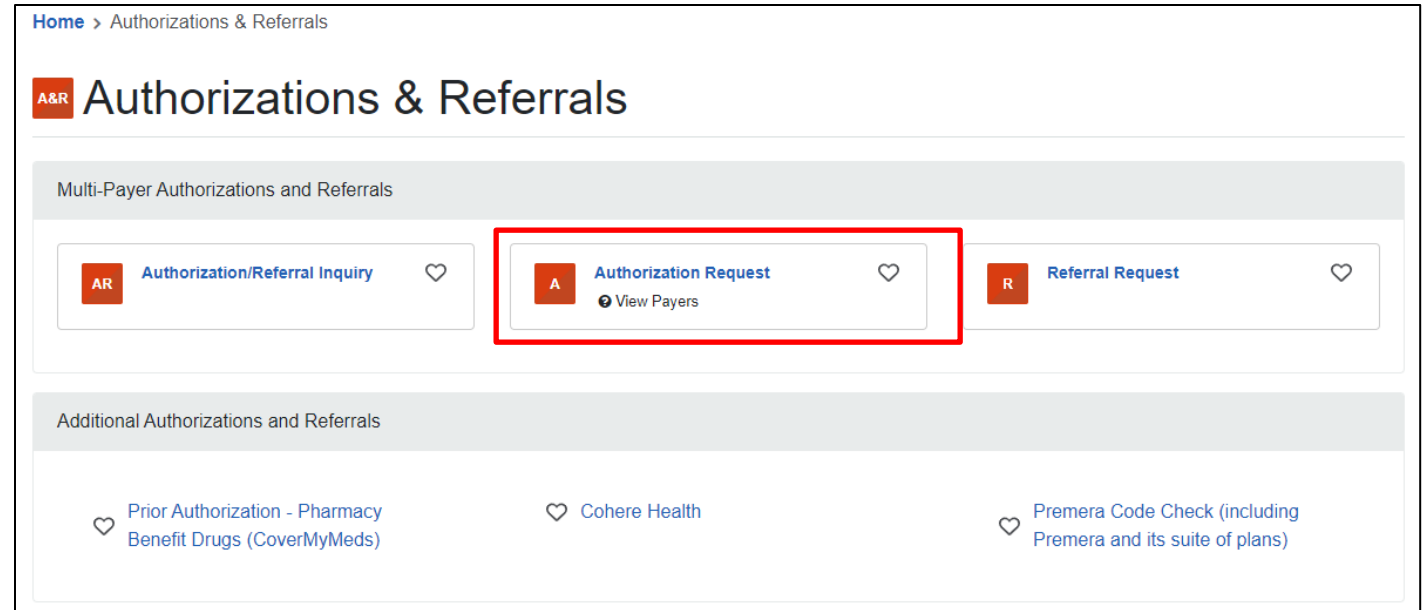


***For prior authorization requests for Out of Area members, you must use this path for submission.**

Then choose Authorizations & Referrals.



And select Authorization Request.



Path 2

Once you've selected Authorization Request, you will fill out the form with the appropriate information.

Additional fields will appear as you begin to complete the online form.

Home > Authorizations & Referrals > Authorizations Need help? Watch a demo about Authorizations and Referrals.

Authorizations Give Feedback New Request

SELECT A PAYER

Organization •
Highmark

Template(s) optional • Manage Templates
No template selected

Select a template from the list or continue with Payer and Request Type fields.

Payer •
Select a Payer

Request Type •
Select Authorization Type

Next

v7.403.3

Predictal Auth Automation Hub

The Predictal home page has links to the Prior Authorization List, Cover My Meds submission, and a view into authorizations that have not been completed.

predictal™ Auth Automation Hub Exit AAH

Highmark Welcomes

Helpful Links


- List of Procedures and DME Requiring Authorization
- List of FEP Standard and Basic Procedures Requiring Prior Approval
- List of FEP Blue Focus Procedures and DME Requiring Prior Approval
- Request a prescription drug authorization request through CoverMyMeds

Information you will need to submit an authorization:

- Member Demographics
- Procedure/Service Details
- Diagnosis Details
- Provider Details
- Clinical Criteria

[New Auth Submission](#)

My Unsubmitted Auths

Member Name	DOB	Start of Care Date	Authorization Type	Service Type	Last updated by	Actions
 No Items						

The left side navigation panel includes links to the functions available within Predictal.

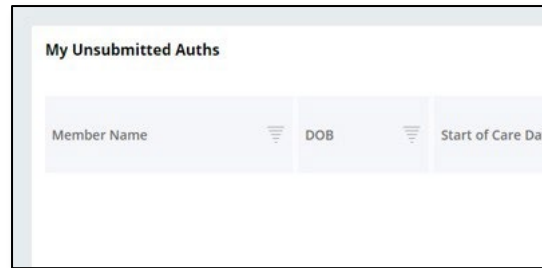
Select **New Auth Submission** to initiate a new request.

Select **Auth Inquiry** to do any of the following:

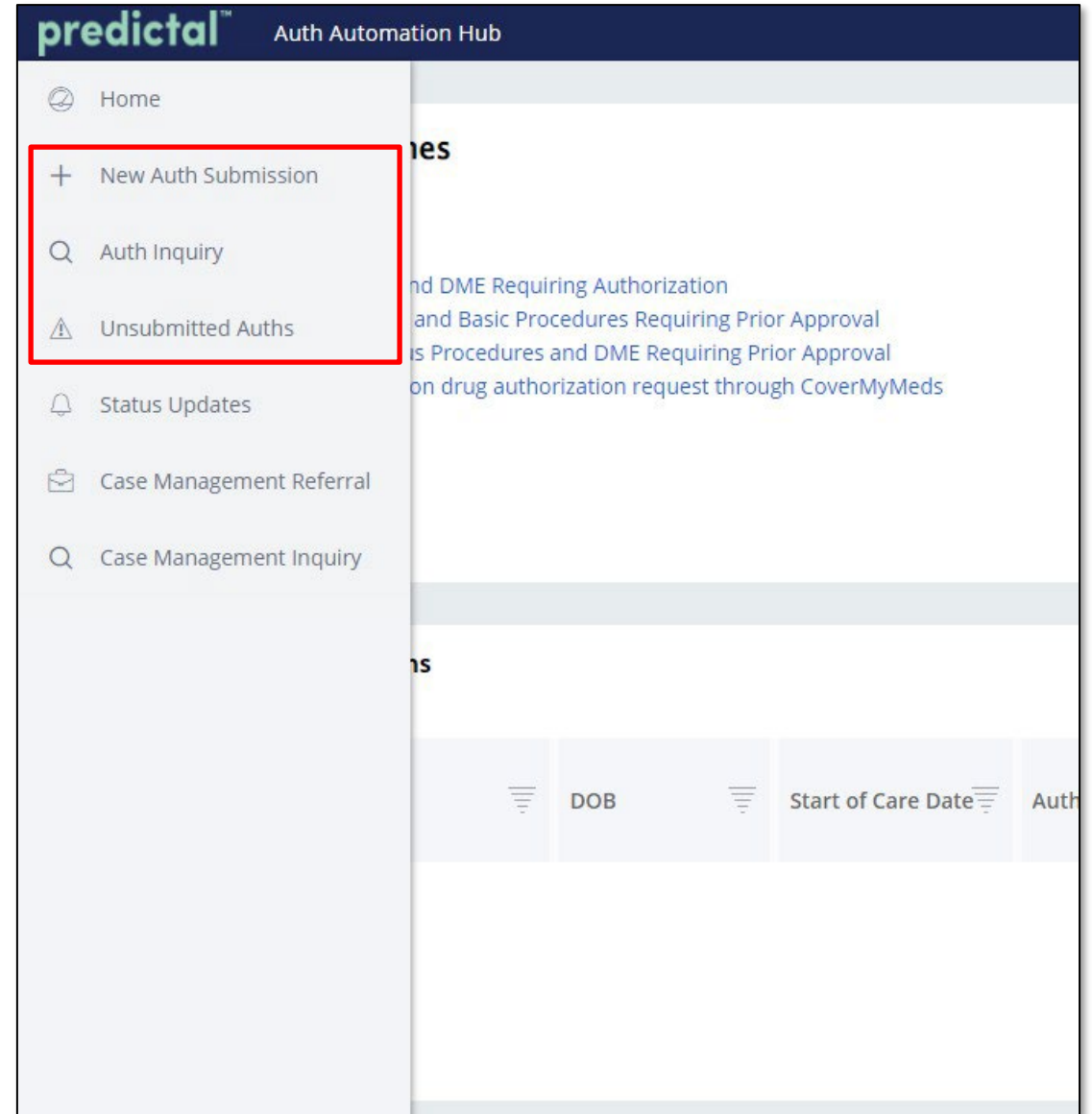
1. Check Authorization Status
2. Change/Update Start of Care Date
3. Review Approval and Denial Letters
4. Discharge Planning
5. Concurrent Review
6. Respond to a Request For Additional Information

Select **Unsubmitted Auths** to view an authorization request that was started but not yet submitted.

You can also view your **Unsubmitted Auths** on the Predictal homepage.



My Unsubmitted Auths		
Member Name	DOB	Start of Care Date



predictal™ Auth Automation Hub

- Home
- New Auth Submission**
- Auth Inquiry
- Unsubmitted Auths**
- Status Updates
- Case Management Referral
- Case Management Inquiry

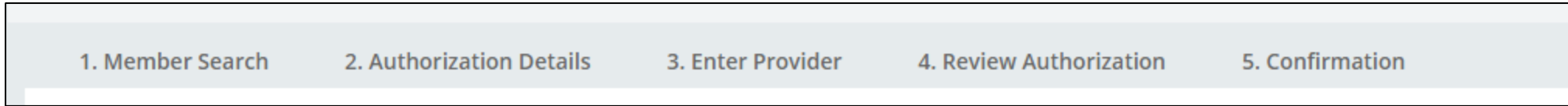
Auth Automation Hub

and DME Requiring Authorization
and Basic Procedures Requiring Prior Approval
is Procedures and DME Requiring Prior Approval
on drug authorization request through CoverMyMeds

	DOB	Start of Care Date	Auth

New Authorization Submission

The top menu bar in the Predictal Auth Automation Hub will walk you through the steps of the electronic authorization submission process.

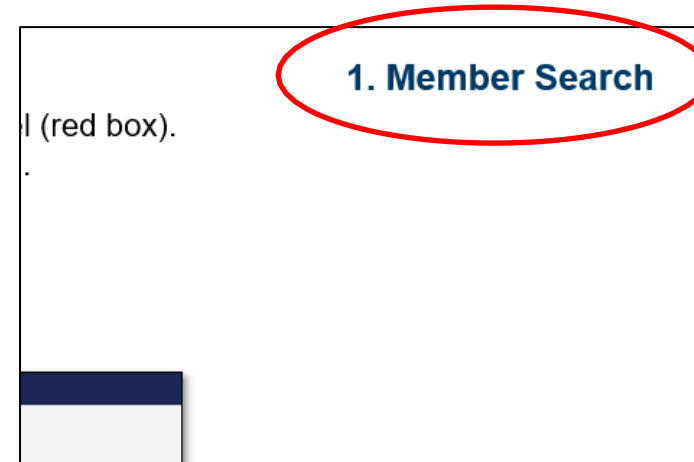


After each step listed in the top menu bar, you will be asked to hit **Submit**. Your authorization will not be submitted to Highmark until the final **Submit** on the Confirmation screen (Step 5 above.)

Throughout the authorization process, you will have the opportunity to **Save** your work without submitting. Hitting **Save** at the bottom of the screen will move the authorization request into your **Unsubmitted Auths** queue.

There is also a **Back** button that will allow users to go back and make any corrections to information that is incorrect.

In the upper right-hand corner of the following slides, we've noted where you are in the submission process.



For a new Authorization Request:

1. Select **New Auth Request** from the left side navigation panel (red box).
2. Select the **Ordering/Attending Provider** from the dropdown.

Search the Member ID.

Fill in the Start of Care Date.

Select Search.

predictal™ Auth Automation Hub

Authorization Request

Member Name Member ID Date of Birth Client Name Plan Type Case Type Authorization Type Service Type

1. Member Search 2. Authorization Details 3. Enter Provider 4. Review Authorization 5. Confirmation

Ordering/Attending Provider
Select provider *

To select a member, click on the search results table to expand the desired member. Then, highlight the correct Group Number/LOB row to select and continue

Search
Search For
 Member

Search for member * Start of Care Date *
Member ID 11/30/2023

Member UMI * **Search**

Search Result: 4 matches found...

Member ID	First Name	Last Name	Date of Birth	Gender
			07/20/1985	FEMALE

1. Member Search

When results return, to select the appropriate member, you will need to complete the following steps to select the specific member.

- Click on the **widget** to highlight the **member** and open the **additional information** about the member.
- Click on the **member** you wish to submit an authorization to highlight the row.

Doing this will select the member on the policy that the authorization will be submitted for.

You can then select **Submit** to move to the next step.

The screenshot displays a web interface for member search. At the top, there is a radio button labeled "Member". Below it are search filters: "Search for member *" with a dropdown menu set to "Member ID", "Start of Care Date *" with a date input field containing "11/30/2023", and "Member UMI *" with an empty input field. A blue "Search" button is positioned to the right of the UMI field. Below the search filters, it says "Search Result: 4 matches found...". There are two tables. The first table has columns: Member ID, First Name, Last Name, Date of Birth, and Gender. The second table has columns: UMI, Client Name, Group Name, Group Number, LOB, COB, Start Date, End date, and Relationship. Two red arrows point to the first cell of the first row in each table, indicating the selection process.

Member ID	First Name	Last Name	Date of Birth	Gender
[Red Arrow]	[Red Arrow]	[Red Arrow]	07/20/1985	FEMALE

UMI	Client Name	Group Name	Group Number	LOB	COB	Start Date	End date	Relationship
[Red Arrow]	[Red Arrow]	[Red Arrow]	[Red Arrow]	PPO		01/01/2021		EMPLOYEE

2. Authorization Details

After you have completed the member information, can you move on to the following steps:

3. Select the Authorization Type
4. Select the Place of Service
5. Select the Service Type

Fill in the appropriate case information and indicate if this is an Emergent or NICU admission.

The screenshot displays the Predictal Auth Automation Hub interface. At the top, it says "predictal™ Auth Automation Hub". Below this is a header for "Authorization Request" with a table of member information:

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
				Commercial	Prior Authorization	Medical-Inpatient	---

Below the table is a progress bar with five steps: 1. Member Search, 2. Authorization Details (current), 3. Enter Provider, 4. Review Authorization, and 5. Confirmation.

The main form area is divided into two columns:

- Case Information:**
 - Authorization Type *
 - Medical-Inpatient
 - Medical-Outpatient
 - Behavioral-Inpatient
 - Behavioral-Outpatient
 - Pharmacy
 - Case Type
 - Prior Authorization
 - Is this an ER or NICU admission ? *
 - Yes
 - No

- Request Information:**
- Start of Care Date *
 - 10/31/2023

This close-up shows the "Detail Information" section of the form. It contains two dropdown menus:

- Place of Service ***: A dropdown menu with "Select..." and a downward arrow.
- Service Type ***: A dropdown menu with "Select..." and a downward arrow.

As you scroll down on the page you will complete the **Diagnosis Information** and **Procedure Information**.

The type of authorization you are seeking will determine whether the **Procedure Information** is a required field.

Note: Procedure codes are NOT required for an inpatient urgent authorization request; however, they are required for inpatient planned admissions.

Auth Automation Hub BA

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
					Prior Authorization	Medical-Inpatient	Non-Urgent	Medical Care

Diagnosis Information (marked with a red star)

Code Set Type *	Code *	Description *
ICD 10 ▾	Enter Code/Description	—

Add Remove

Procedure Information (marked with a red star)

Add

Indicate Location of Clinical Information

Add

Caller Information

Contact name *	Phone Number *	Ext.
	(###) ###-####	ext.

Please enter any additional information *

If clinical documentation is not added as an attachment, please include the relevant clinical documentation here.
If clinical documentation is added as an attachment, please indicate so here.

2. Authorization Details

In the **Diagnosis Information** section- entering a partial diagnosis code or description will populate a list of codes for you to select from. You must include the **decimal point** when entering your **diagnosis**.

The screenshot displays the 'Auth Automation Hub' interface. At the top, there is a header with the text 'Auth Automation Hub' and a user icon labeled 'BA'. Below the header is the 'Authorization Request' section, which includes a table with columns for Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), Authorization Type (Medical-Inpatient), Urgency (Non-Urgent), and Service Type (Medical Care). The main content area is titled 'Diagnosis Information' and features a table with columns for Code Set Type, Code, and Description. A dropdown menu is open for the 'Code' field, showing a list of ICD 10 codes starting with '183.'. The first code, '183.001', is highlighted. Below the dropdown, there are sections for 'Procedure Information', 'Indicate Location of C', and 'Caller Information', each with an 'Add' button. The 'Caller Information' section includes a 'Contact name' field and a 'Please enter any additional' field with a sub-label 'If clinical documentation'. A gear icon is visible in the bottom right corner of the interface.

2. Authorization Details

If you have entered an incorrect code, you can click the **Remove** link to delete that diagnosis from the request. Select the **Add** link to add additional diagnosis codes.

Auth Automation Hub BA

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
					Prior Authorization	Medical-Inpatient	Non-Urgent	Medical Care

Medical Inpatient | Medical Care

Diagnosis Information

Code Set Type*	Code*	Description*	
ICD 10	83.019	VARICOSE VEINS OF RIGHT LOWER EXTREMITY WITH ULCER OF UNSPECIFIED SITE	Remove

[Add](#)

Procedure Information

CPT/HCPCS Disclaimer: Current Procedural Terminology (CPT®) is copyright 2020 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. Current Dental Terminology © American Dental Association. All rights reserved. Service provider acknowledges that the information being provided is based on data currently available. Processing of all claims is subject to medical policy, a determination of the member's benefit program and eligibility at the time of service.

[Add](#)

Indicate Location of Clinical Information

[Add](#)

2. Authorization Details

When entering the **Procedure Information** – you **must** select the appropriate **Code Set Type**. If this is not selected, your procedure code will not be found.

The screenshot shows the 'Auth Automation Hub' interface for an 'Authorization Request'. At the top, there is a header with the logo and 'Auth Automation Hub' text, and a user profile icon labeled 'BA'. Below the header, the 'Authorization Request' title is followed by a table of member information:

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
					Prior Authorization	Medical-Inpatient	Non-Urgent	Medical Care

Below the table, there is a 'SITE' dropdown menu and an 'Add' button. The main section is titled 'Procedure Information' and contains a disclaimer: 'CPT/HCPCS Disclaimer: Current Procedural Terminology (CPT®) is copyright 2020 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. Current Dental Terminology © American Dental Association. All rights reserved. Service provider acknowledges that the information being provided is based on data currently available. Processing of all claims is subject to medical policy, a determination of the member's benefit program and eligibility at the time of service.'

The form includes the following fields:

- Code Set Type ***: A dropdown menu with 'CPT' selected.
- Code ***: A text input field with a placeholder 'Enter Code/Description'.
- Description**: A text input field.
- Through ***: A date picker field.
- Number of days ***: A text input field.
- Requested units ***: A text input field.
- Unit Type ***: A dropdown menu with 'Remove' button.

At the bottom of the form, there are sections for 'Indicate Location of Clinical Information' and 'Collector Information', each with an 'Add' button. A settings gear icon is located in the bottom right corner.

Note: A **CPT** Code is a 5-digit numeric code.

A **HCPCS** is a 5-digit code that begins with an alphanumeric value.

Once you have selected the **Code Set Type**, enter a partial procedure code or description to see a list of codes you can select.

Next, complete the remaining required fields.

Like the **Diagnosis** section, you can select **Remove** if you have entered something incorrectly. Click **Add**, if you need to authorize more than one procedure code.

Note: There is no limit to the number of procedure codes that can be added.

The screenshot displays the 'Auth Automation Hub' interface. At the top, there is a header with the logo and the text 'Auth Automation Hub' and a user icon labeled 'BA'. Below the header, the main content area is titled 'Authorization' and shows a list of procedure codes with their descriptions. The list includes:

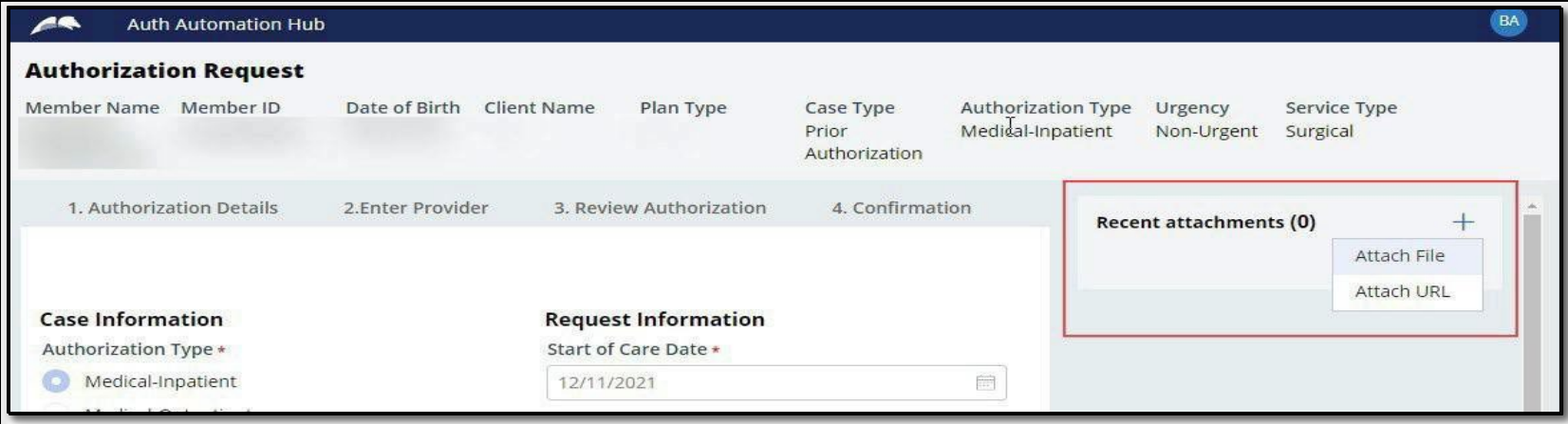
- 33647**: REPAIR OF ATRIAL SEPTAL DEFECT AND VENTRICULAR SEPTAL DEFECT, WITH DIRECT OR PATCH CLOSURE
- 36470**: INJECTION OF SCLEROSANT; SINGLE INCOMPETENT VEIN (OTHER THAN TELANGIECTASIA)
- 36471**: INJECTION OF SCLEROSANT; MULTIPLE INCOMPETENT VEINS (OTHER THAN TELANGIECTASIA), SAME LEG
- 36473**: ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, MECHANO-CHEMICAL; FIRST VEIN TREATED
- 36474**: ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, MECHANO-CHEMICAL; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CO
- 36475**: ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS RADIOFREQUENCY; FIRST VEIN TREATED
- 36476**: ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS RADIOFREQUENCY

Below the list, there are several input fields and controls:

- Code Set Type ***: A dropdown menu currently set to 'CPT'.
- From ***: A date field containing '12/09/2021'.
- Through ***: A date field with a calendar icon.
- Number of days ***: A text input field.
- Requested units ***: A text input field.
- Unit Type ***: A dropdown menu with 'Select...' and a 'Remove' button.

At the bottom of the form, there is an 'Add' button.

The **Recent Attachments** section will allow you to send attachments with an authorization by clicking on the **+** icon.



Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
					Prior Authorization	Medical-Inpatient	Non-Urgent	Surgical

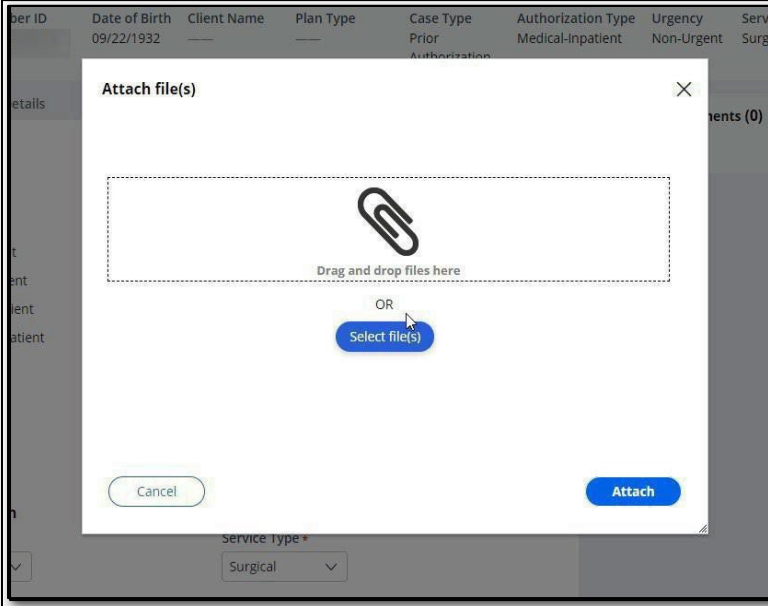
1. Authorization Details 2. Enter Provider 3. Review Authorization 4. Confirmation

Recent attachments (0) +
Attach File
Attach URL

Case Information
Authorization Type *
Medical-Inpatient

Request Information
Start of Care Date *
12/11/2021

You can also attach a file or a URL in the **Recent Attachments** section.



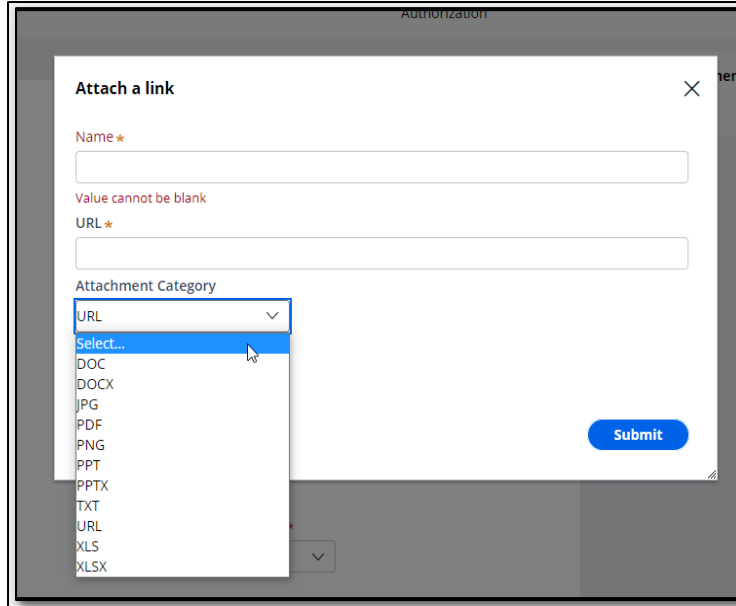
Attach file(s)

Drag and drop files here

OR

Select file(s)

Cancel Attach



Attach a link

Name *

Value cannot be blank

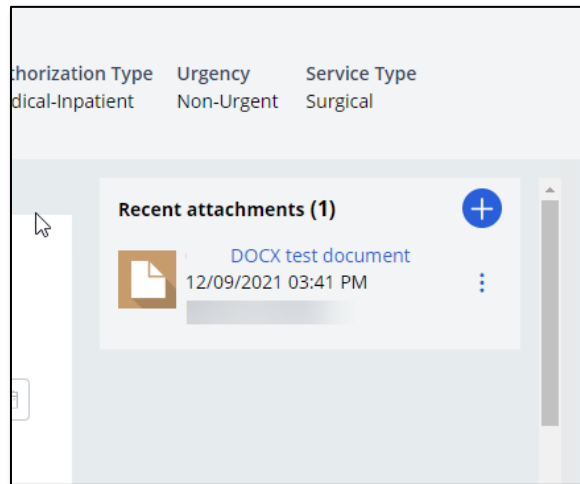
URL *

Attachment Category

- URL
- Select...
- DOC
- DOCX
- JPG
- PDF
- PNG
- PPT
- PPTX
- TXT
- URL
- XLS
- XLSX

Submit

Note: If your authorization is for urgent inpatient admission, you will have the opportunity to utilize MCG criteria later in the workflow. Utilizing MCG criteria and attaching any supporting documentation will greatly reduce response time as well as provide additional clinical to support the inpatient request.



When a document has been attached in the **Recent Attachment** section, you should complete the **Indicate Locations of Clinical Information** section to provide additional information about the attachment such as:

- The type of attachment
- Select the attachment being referenced.
- Enter any comments that will assist those reviewing the attachment in finding necessary information.
 - For example – Clinical notes found on page 3 of attachment

A screenshot of the 'Auth Automation Hub' interface. The main heading is 'Authorization Request'. Below it are fields for 'Member Name', 'Member ID', 'Date of Birth', 'Client Name', 'Plan Type', 'Case Type', 'Prior Authorization', and 'Service Type' (set to 'Medical Care'). A section titled 'Indicate Location of Clinical Information' contains a table with columns for 'Clinical Document Type', 'Found in', and 'Comment:'. A dropdown menu is open for the 'Clinical Document Type' column, listing various document types such as '77-Support Data for Verification', 'AS-Admission Summary', 'B2-Prescription', 'B3-Physician Order', 'B4-Referral Form', 'CT-Certification', 'DA-Dental Models', 'DS-Discharge Summary', 'EB-EOBs (Explanation of Benefits)', 'MT-Models', 'NN-Nursing Notes', 'OB-Operative Note', 'OZ-Support Data For Claim', 'PN-Physical Therapy Notes', 'PO-Prosthetics or Orthotic Certification', 'PZ-Physical Therapy Certification', 'RB-Radiology Films', and 'RR-Radiology Reports'. There are also input fields for 'Number' and 'Ext.' and a 'Remove' button.

Complete the **Caller Information** section by:

- Noting any additional clinical information (there is a 255-character limit)
- If information isn't added in an attachment, include the necessary clinical information here.
- If the clinical information is added as an attachment, please note that here (this is a mandatory field).

NOTE: The phone number field format is (XXX) XXX-XXXX. However, if you enter only the numeric portion it will automatically format.

When all fields are complete, click **Submit**.

Auth Automation Hub

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency
					Prior Authorization	Medical-Inpatient	Non-Urgent

Service Type
Medical Care

Add

Caller Information

Contact name *	Phone Number *	Ext.
<input type="text"/>	<input type="text"/>	ext <input type="text"/>

Please enter any additional information *

★ If clinical documentation is not added as an attachment, please include the relevant clinical documentation here.
If clinical documentation is added as an attachment, please indicate so here.

Value cannot be blank

Exit

3. Enter Provider

The **Provider Details** page will automatically populate with the **Ordering/Attending Practitioner** that was selected previously.

Select **Search** to choose the ordering/attending provider's location.

When results return, to select the appropriate ordering/attending practitioner, you will need to complete the following steps.

- Click on the **widget** to highlight the **Ordering/Attending Practitioner** and open to view additional information.
- Click on the **address line** to highlight the address

Doing this will select the ordering/attending practitioner that will be submitted with the auth request.

You can then move on to the next field.

The screenshot shows the 'Authorization Request' form. At the top, there are fields for Member Name, Member ID, Date of Birth, Client Name, Plan Type (Commercial), Case Type (Prior Authorization), Authorization Type (Medical-Inpatient), and Service Type (Surgical). Below this is the 'Ordering/Attending Provider' section, which includes a 'Select provider *' dropdown menu and a 'Search' button. A red box highlights the 'Search' button. Below the search results, it says '1 match found'. A table lists the provider details with columns: Facility / Vendor NPI, Facility / Vendor Name, Facility / Vendor Address, Facility / Vendor City, State, and Zip code. A red arrow points to the first row of the table. Below the table is an 'Addresses' section with fields for Tax ID and BSID. Another table lists address details with columns: Address type, Facility / Vendor Address, Facility / Vendor City, State, Zip code, and Contact Details. A red arrow points to the first row of this table.

Here you will find the **Copy As Servicing Facility/Vendor** and **Copy As Performing Provider** buttons which will allow you to copy the **Ordering/Attending Practitioner** information into the **Servicing Facility/Vendor** and **Performing Provider** information.

The screenshot shows the 'Auth Automation Hub' interface. At the top, it displays 'Authorization Request' with fields for Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), Authorization Type (Medical-Inpatient), and Urgency (Non-Urgent). Below this, the 'Service Type' is 'Medical Care'. A progress bar shows four steps: 1. Authorization Details, 2. Enter Provider (current), 3. Review Authorization, and 4. Confirmation. The 'Provider Details' section is titled 'Ordering/Attending Practitioner' and shows '1 match found'. A table lists the provider information:

Facility / Vendor NPI	Facility / Vendor Name	Facility / Vendor Address	Facility / Vendor City	State	Zip code
XXXXXXXXXX	GENERAL HOSPITAL	Street Address	City	PA	15212

Below the table, two buttons are highlighted with a red box: 'Copy as Servicing Facility/Vendor' and 'Copy as Performing Provider'. At the bottom, there is a section for 'Servicing Facility/Vendor'.

If you do not use the copy links, you can:

Search for the **Servicing Facility/Vendor** by the following mandatory fields:

- Provider ID (using NPI or Blue Shield ID)
- Name (Facility/Vendor)

Auth Automation Hub

Authorization Request

Member Name Member ID Date of Birth Client Name Plan Type Case Type Authorization Type
Prior Authorization Medical-Inpatient

Urgency Service Type
Non-Urgent Medical Care

Copy as Servicing Facility/Vendor Copy as Performing Provider

Servicing Facility/Vendor

Search for

Facility / Vendor

Search by

Provider ID Name

Search for

NPI or BSID

NPI or BSID *

Search

Search for the **Performing Provider** by:

Practitioner using:

- Provider ID (using NPI or BlueShield ID)
- Name

(or) Practice Group using:

- Provider ID (using NPI, Blue Shield ID or Tax ID)
- Name

3. Enter Provider

Auth Automation Hub

Authorization Request

Member Name Member ID Date of Birth Client Name Plan Type Case Type Authorization Type
Prior Authorization Medical-Inpatient

Urgency Service Type
Non-Urgent Medical Care

Performing Provider

Search for

Practitioner Practice Group

Search by

Provider ID Name

NPI or BSID

Search

Authorization Request Submitted By *

Select... ▼

Back Save Submit

When results return, to select the appropriate facility/vendor, you will need to complete the following steps to select the specific facility/vendor.

- Click on the **widget** to highlight the **facility/vendor** and open the **additional information** about the facility/vendor.
- Click on the **address line** to highlight the address

Doing this will select the facility/vendor that will be submitted with the auth request.

You can then move on to the next field.

predical Auth Automation Hub

Authorization Request

Member Name Member ID Date of Birth Client Name Plan Type Case Type: Prior Authorization Authorization Type: Medical-inpatient Urgency: Non-Urgent Service Type: Surgical

Servicing Facility/Vendor

Search for: Facility / Vendor

Search by: Provider ID Name

Search for: NPI or BSID

NPI or BSID *

1 match found

Facility / Vendor NPI	Facility / Vendor Name	Facility / Vendor Address	Facility / Vendor City	State	Zip code
XXXXXXXXXX	GENERAL HOSPITAL	Street Address	City	PA	12345

Addresses

Tax ID: ***** BSID: DRG: Yes No

Address type	Facility / Vendor Address	Facility / Vendor City	State	Zip code	Contact Details
Main	Street Address	City	PA	12345	Phone Fax Fax

Performing Provider

Search for: Practitioner Practice Group

Search by: Provider ID Name

NPI or BSID

Authorization Request Submitted By *

Back

3. Enter Provider

Select the provider who is requesting the authorization in the **Authorization Request Submitted By** drop down.

Click **Submit** when all information has been completed.

Auth Automation Hub

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency
					Prior Authorization	Medical-Inpatient	Non-Urgent

Service Type
Medical Care

Search for
 NPI or BSID Tax ID

NPI or BSID

Authorization Request Submitted By *

- Select...
- Select...
- Ordering/Attending Practitioner
- Servicing Facility/Vendor
- Performing Provider

Back

Inpatient Urgent authorization submissions will require additional clinical criteria. To add the criteria, select **Invoke Criteria**, then **Launch MCG**.

The screenshot shows the 'Review Guidelines' section of the Predictal Auth Automation Hub. A table lists 'Invoke Criteria' with a red box around the button. Below the table are 'Save' and 'Submit' buttons.

The screenshot shows the 'Invoke Clinical Criteria' screen. The 'Launch MCG' button is highlighted with a red box. Below it is a table with columns for 'Authorization request', 'Provider', and 'Member', containing summary and detail information.

Complete the MCG Criteria by saving before submitting.

The screenshot shows a modal dialog box titled 'Invoke CareWebQ® Guidelines'. It contains a progress bar, a 'Submit Request' button, and a 'Document Clinical' button. The dialog also displays authorization details like 'Authorization: EPS-INQL-1804-20230224T181624' and 'Diagnosis Codes: I48.0 (ICD-10 Diagnosis)'.

After submitting the **Provider Details**, users will be taken to the **Review Authorization Details** page to review all information submitted to this point.

Scrolling to the bottom will allow users to **Submit**. This is the **final submission** which will send your authorization request for review.

Auth Automation Hub BA

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency
					Prior Authorization	Medical-Inpatient	Non-Urgent

Service Type
Medical Care

1. Authorization Details 2. Enter Provider 3. Review Authorization 4. Confirmation

Recent attachments (0) +

Review Authorization Details

Case Information

Authorization Type	Urgency
Medical-Inpatient	Non-Urgent

Request Information

Start of Care Date
12/09/2021

Member Information

First Name	Member ID
Last Name	Date of Birth

Auth Automation Hub BA

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency
					Prior Authorization	Medical-Inpatient	Non-Urgent

Service Type
Medical Care

HOSPITAL

Servicing Facility/Vendor SUBMITTED BY THIS PROVIDER

Provider ID	XXXXXXXXXX	Provider Name	GENERAL HOSPITAL
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Performing Provider

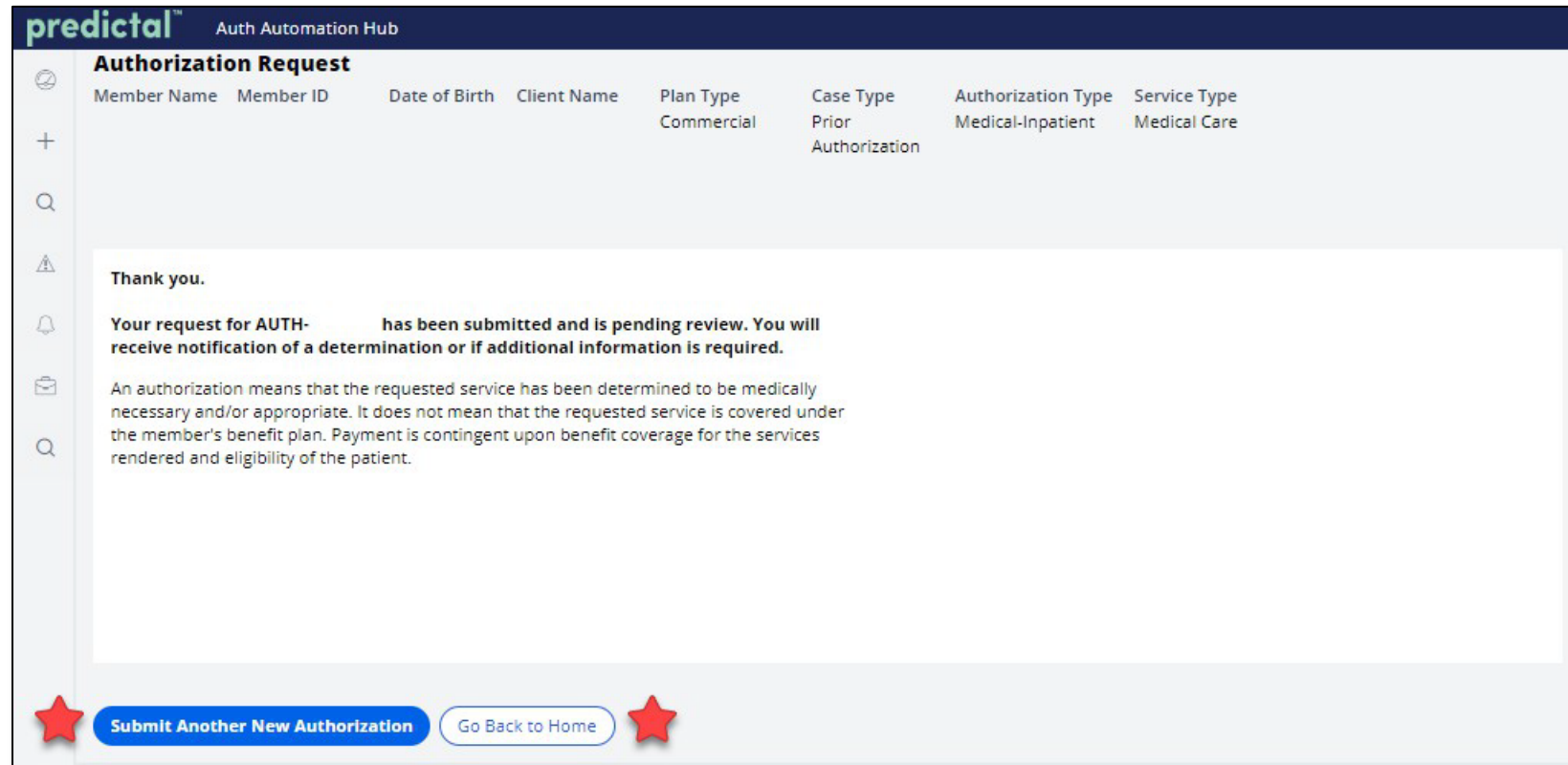
Provider ID	XXXXXXXXXX	Provider Name	GENERAL HOSPITAL
-------------	------------	---------------	------------------

Back Save Submit

5. Confirmation

When the authorization is submitted, a confirmation will be displayed on the page with the **Authorization Number**.

From here, you can select to submit another **Authorization Request**, or return to the Predictal home screen.



The screenshot displays the Predictal Auth Automation Hub interface. At the top, the header reads "predictal™ Auth Automation Hub". Below this, the title "Authorization Request" is followed by a table with the following columns: Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type, Authorization Type, and Service Type. The table contains one row with the following data: Commercial, Prior Authorization, Medical-Inpatient, and Medical Care. A sidebar on the left contains navigation icons: a home icon, a plus sign, a search icon, a warning icon, a bell icon, an envelope icon, and another search icon. The main content area features a confirmation message: "Thank you. Your request for AUTH- [redacted] has been submitted and is pending review. You will receive notification of a determination or if additional information is required." Below this message is a paragraph explaining that an authorization means the requested service is medically necessary and/or appropriate, and that payment is contingent upon benefit coverage. At the bottom of the interface, there are two buttons: "Submit Another New Authorization" (highlighted with a red star) and "Go Back to Home" (highlighted with a red star).

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
				Commercial	Prior Authorization	Medical-Inpatient	Medical Care

Thank you.

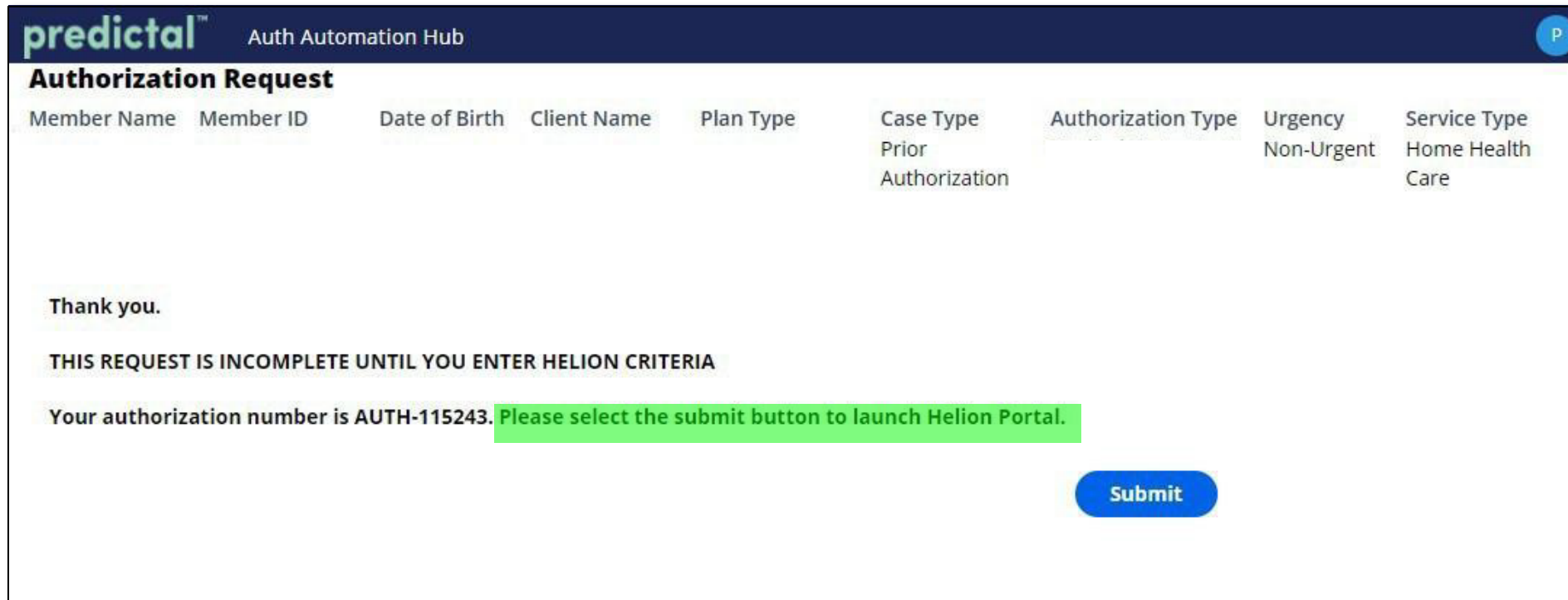
Your request for AUTH- [redacted] has been submitted and is pending review. You will receive notification of a determination or if additional information is required.

An authorization means that the requested service has been determined to be medically necessary and/or appropriate. It does not mean that the requested service is covered under the member's benefit plan. Payment is contingent upon benefit coverage for the services rendered and eligibility of the patient.

[Submit Another New Authorization](#) [Go Back to Home](#)

Please note: When submitting Inpatient Transfer – Skilled Nursing Facility, Acute Rehab or Long-Term Acute Care requests, be sure to click **Submit** to launch to the Helion Portal.

Additional information Helion Arc begins on the next page of this guide.



The screenshot shows the Predictal Auth Automation Hub interface. At the top, the Predictal logo and "Auth Automation Hub" are visible. Below this is a section titled "Authorization Request" with a table of fields: Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), Authorization Type, Urgency (Non-Urgent), and Service Type (Home Health Care). The main content area displays a confirmation message: "Thank you." followed by "THIS REQUEST IS INCOMPLETE UNTIL YOU ENTER HELION CRITERIA". Below this, it states "Your authorization number is AUTH-115243." and includes a green callout box with the text "Please select the submit button to launch Helion Portal." A blue "Submit" button is located at the bottom right of the form.

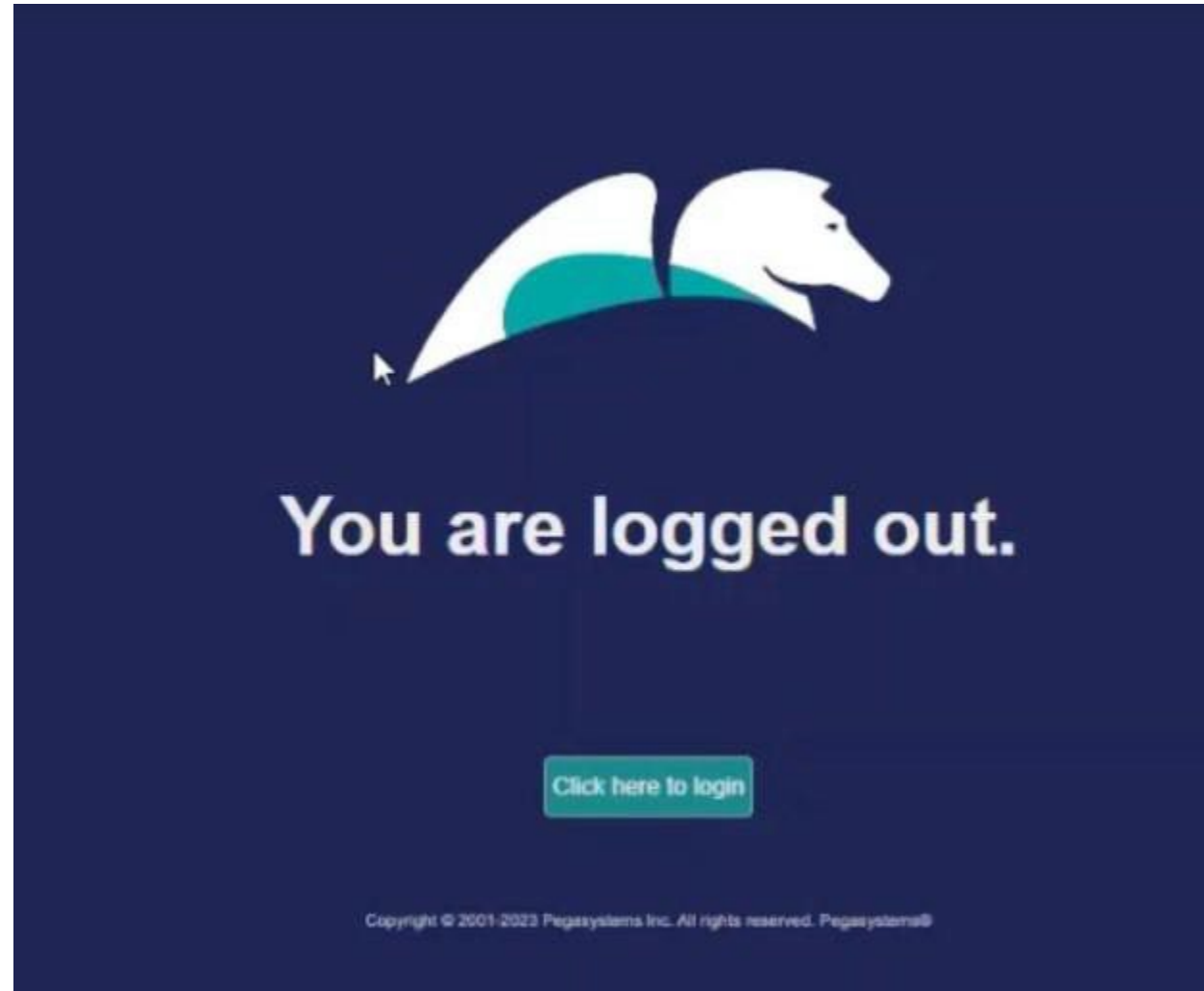
Helion Arc Authorization Submission

If you are submitting a request for an Inpatient Transfer – Skilled Nursing Facility, Acute Rehab or Long-Term Acute Care - You will get a notification that the request is incomplete until Helion criteria is entered.

Hit **Submit**.

The screenshot shows the Predictal Auth Automation Hub interface. At the top, there is a header with the Predictal logo and 'Auth Automation Hub'. Below this is a section titled 'Authorization Request' with a table of request details. The table has columns for Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type, Authorization Type, Urgency, and Service Type. The Plan Type is 'Commercial', Case Type is 'Prior Authorization', and Authorization Type is 'Authorization'. Below the table, there is a 'Thank you.' message and a yellow highlighted warning: 'THIS REQUEST IS INCOMPLETE UNTIL YOU ENTER HELION CRITERIA'. Below the warning, it says 'Your authorization number is AUTH-111902. Please select the submit button to launch Helion Portal.' A blue 'Submit' button is highlighted with a red rectangle. Below this is a 'Review Authorization Details' section with several sub-sections: 'Case Information' (Authorization Type, Urgency: Non-Urgent), 'Request Information' (Start of Care Date: 02/08/2023), 'Member Information' (First Name, Last Name, Member ID), 'Group Information' (expandable), and 'Detail Information' (Place of Service: Home, Service Type: Home Health Care).

You will be automatically logged out of the Predictal Auth Automation Hub and taken directly to Helion Arc.



Once in Helion Arc, you will receive a message regarding the **Authorization Request Time Limit**, which indicates you have 90 minutes to complete and submit the authorization.

Click **Continue**.

(Content may differ between requested services)

The screenshot displays the Helion Arc interface with a modal dialog box titled "Authorization Request Time Limit". The dialog contains the following text:

90-minute time limit

Please be aware, you have 90 minutes to complete and submit this authorization request. If more time is needed you may cancel the request and start over when you have dedicated time.

Don't show again. **CONTINUE**

The background interface shows a progress bar with five steps: 1 Documents, 2 Status, 3 Requested Services, 4 Review, and 5 Results. Below the progress bar is a table with the following data:

Patient Name	Date of Birth	Patient ID	Auth ID	Request Type	Method
Miller, Emma	09-Jan-1948	--	20231129150600	Initial	Fee for Service

Below the table is a "Documents" section with a "Drop PDF file here, or click to select." area. At the bottom of the interface, there are navigation buttons: CANCEL, ← BACK, and NEXT →. A timer in the bottom right corner shows "89 min 48 sec Time Limit" and a help icon (?).

You can upload your **Plan of Care**. This can be uploaded as a PDF file.

The screenshot displays a multi-step submission process. At the top, a progress bar shows five steps: 1. Documents (active), 2. Status, 3. Requested Services, 4. Review, and 5. Results. Below the progress bar, the 'Plan of Care' section is highlighted. It includes a red 'Required' indicator and a message: 'Please provide an updated plan of care. Maximum file size: 10MB'. A table below shows a file upload area with the text 'no file chosen' and a 'REMOVE' button. At the bottom of the upload area, there is a dashed box containing a cloud icon with an upward arrow and the text 'Drop PDF file here, or click to select.'

This is a review screen. You can edit any information using the **Edit** button located in each section. If all information looks correct, hit **Submit**.

Documents Status Requested Services **Review** Results

Patient Name Date of Birth Patient ID Auth ID Request Type Method
Start Of Care Fee for Service

Review

Note: After submitting to see Results you will NOT be able to make edits to this request.

Documents 3 of 3 Required Items Complete **EDIT**

Assessment	✓ ^
OASIS XML File	
Filename	
Valid OASIS-E SOC.xml	

Supplementary Assessment Items ✓ ^

CANCEL ← BACK **SUBMIT**

22 min 33 sec Time Limit ?

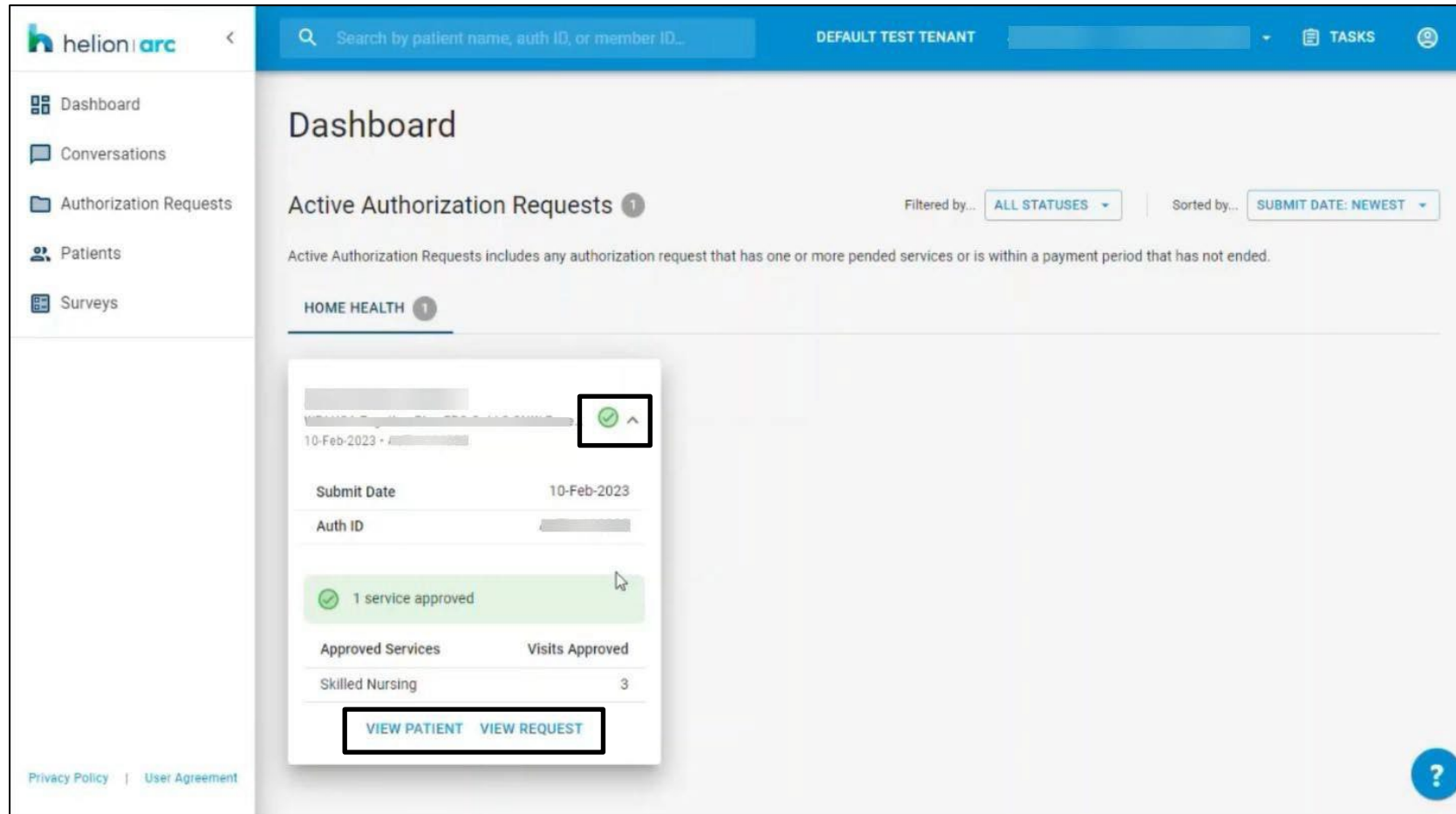
The request will be “Approved” or “Pended.”

If the authorization does **not** meet medical necessity through Helion Arc, it will be pended to a clinician at the Health Plan for review. You will be notified of the final determination via the provider portal.

Click “Submit to Insurer.”

The screenshot displays a web interface for submitting an authorization request. At the top, there is a progress bar with four steps: Documents (checked), Disclaimer (checked), Requested Services (checked), and Results (5). Below the progress bar is a disclaimer text box. A blue information box contains the note: "Note: You must click the 'Submit to Insurer' button below to finalize this authorization request." The main section is titled "Requested Services" and includes the instruction: "Please allow time for the review process and determination." Under this section, there is a card for "Skilled Nursing" with a green checkmark, indicating it is approved for 2 visits. Below the card, there is a field for "Requested visits" with the value "2" entered. At the bottom center, there is a prominent blue button labeled "SUBMIT TO INSURER". In the bottom right corner, there is a timer showing "18 min 26 sec Time Limit" and a help icon (question mark).

You will be directed to the Helion Arc dashboard, where you can view all active authorization requests. Clicking the arrow will open the patient and request information.



Clicking on either **View Patient** or **View Request** will open the **Authorization Request Details**.

You can see the Auth number at the top, as well the Requested Services, Status, and any Documentation that has been uploaded.

The screenshot displays the Helion Arc web application interface. The top navigation bar includes the Helion Arc logo, a search bar, and the text "DEFAULT TEST TENANT". The left sidebar contains navigation options: Dashboard, Conversations, Authorization Requests, Patients, and Surveys. The main content area shows the breadcrumb "Dashboard > Authorization Requests > Auth ID: AUTH-1" and the title "Auth ID: AUTH-1". Below this, a summary table provides details:

Care Setting	Request Type	Product	Servicing Provider	Reimbursement Method
Home Health	Start Of Care			Fee for Service

The "Authorization Request Details" section includes a sub-header "View requested service(s), reason(s) for care, and additional details for this authorization request." Below this are three tabs: "REQUESTED SERVICES" (highlighted with a '1' badge), "STATUS", and "DOCUMENTS". The "REQUESTED SERVICES" tab is active, showing a "Skilled Nursing" service with a "START CONVERSATION" button. A green notification states: "This requested service has been approved. See additional information below." A table below provides service details:

Visits Approved	Visits Requested	Last Covered Date	Proposed Date of Service
3	3	05-Apr-2023	08-Feb-2023

Additional sections include "Reasons For Care" (with "Onaoina Assessment Needs" listed) and "Patient Details" (with fields for Patient Name, Date of Birth, and Patient ID). The "Submission Details" section shows a submission date of 10-Feb-2023 at 14:39. The bottom right corner features an "Authorization Request Activity" section with a help icon.

The panels on the right-hand side of the screen show you Patient Details, Submission Details, and an audit history under 'Authorization Request Activity.'

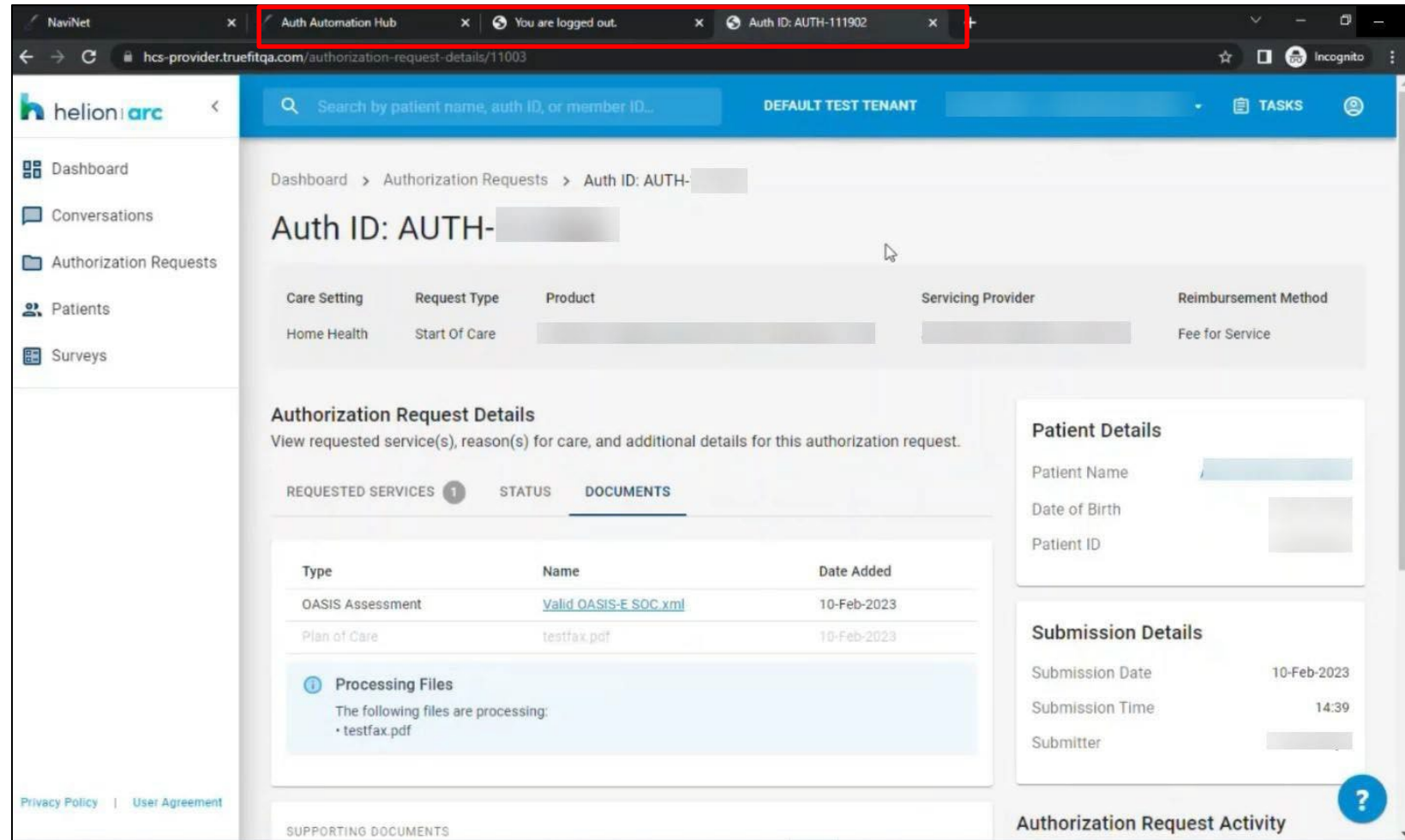
The screenshot displays the Helion Arc interface for an authorization request. The top navigation bar includes the Helion Arc logo, a search bar, the tenant name 'DEFAULT TEST TENANT', and a 'TASKS' button. A left sidebar contains navigation options: Dashboard, Conversations, Authorization Requests, Patients, and Surveys. The main content area is titled 'View requested service(s), reason(s) for care, and additional details for this authorization request.' It features three tabs: 'REQUESTED SERVICES' (with a notification badge), 'STATUS', and 'DOCUMENTS'. The 'REQUESTED SERVICES' tab is active, showing a table with the following data:

Type	Name	Date Added
OASIS Assessment	Valid OASIS-E SOC.xml	10-Feb-2023
Plan of Care	testfax.pdf	10-Feb-2023

Below the table is a 'Processing Files' section with a blue header and an information icon. It states: 'The following files are processing: • testfax.pdf'. Underneath is a 'SUPPORTING DOCUMENTS' section with a table header for 'Name' and 'Date Added'. The table is currently empty, displaying 'No documents uploaded'. Below the table is a dashed box containing a cloud upload icon and the text: 'Drop PDF, DOC, or DOCX file here, or click to select.' At the bottom left of the main area are links for 'Privacy Policy' and 'User Agreement'. On the right side, there are three panels: 'Patient Details' with fields for Patient Name, Date of Birth, and Patient ID; 'Submission Details' with fields for Submission Date (10-Feb-2023), Submission Time (14:39), and Submitter; and 'Authorization Request Activity' with a description 'Stay up to date on status changes specific to this authorization request.' and a vertical timeline of two events: 'Approved by Insurer' (Approved Skilled Nursing) and 'Request Submitted by Provider'. At the bottom right of the activity panel are two circular buttons: an upward arrow and a question mark.

This completes the submission process for a request through Helion Arc.

You can now close out of any browser tabs as needed using the 'X' on each tab.

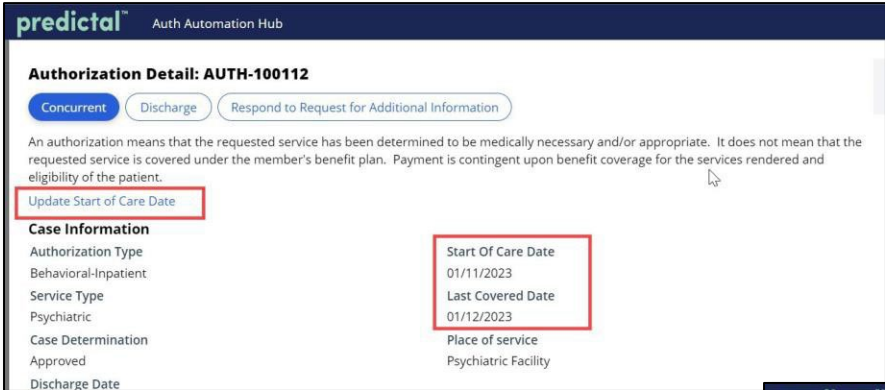


Availity Provider Portal - Predictal Authorization Inquiry

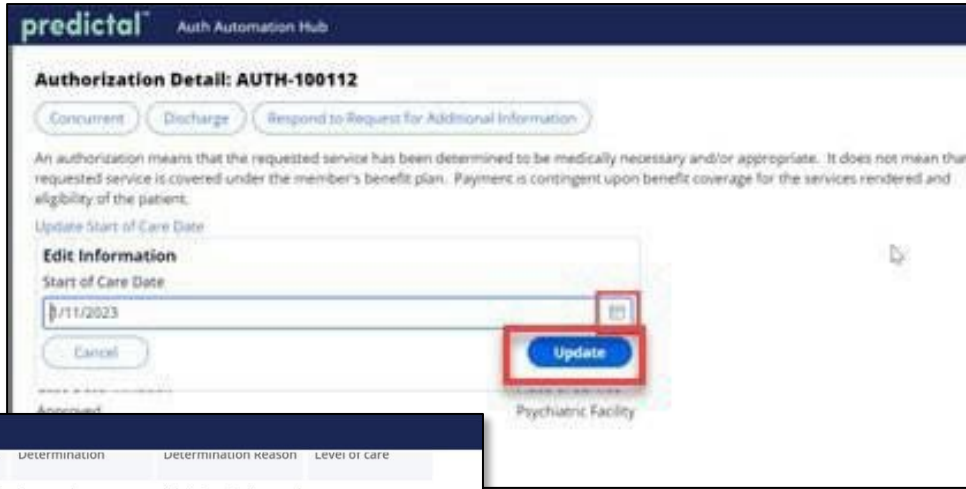
To update the Start of Care Date after the authorization is submitted:

1. Go to **Auth Inquiry**
2. Click the **Update Start of Care Date** hyperlink.
3. Click the calendar in the **Edit Information** field, select the appropriate Start of Care Date, and click **UPDATE**.
IMPORTANT: This date must be within 7 days prior to the original Start of Care Date that was selected or within 30 days in the future of the original Start of Care Date.
4. **Save your changes.**

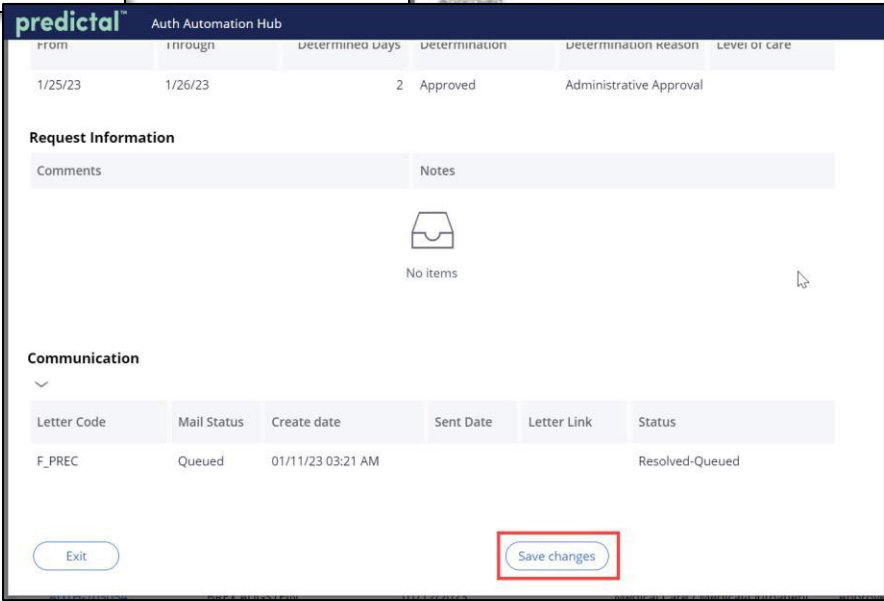
Step 1



Step 2



Step 3



The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association:

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