Purpose of the Manual
This document is intended to be an operational guide for External Users of the “Novitasphere” Provider Portal, which is an internet—based program that offers Providers, Billing Offices and Novitas Solutions staff access to Claim and Appeals-related functionality. This document includes instructions for Users (Providers & Billing Offices) carrying out each available transaction type, as well as directions for individuals wishing to report problems or ask questions about the portal.

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# General Information

## Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approver Role</td>
<td>Controlling user for an organization; Provider or Billing Office. This user will establish all End User roles for the organization's employees and/or employees of associated organizations.</td>
</tr>
<tr>
<td>End User Role</td>
<td>Supervised user for an organization; Provider or Billing Office. This user will be assigned a role by their organization’s Approver.</td>
</tr>
<tr>
<td>IACS</td>
<td>The Individuals Authorized Access to the CMS Computer Services (system).</td>
</tr>
<tr>
<td>Internal User</td>
<td>Novitas Solutions employee registered for Novitasphere access.</td>
</tr>
<tr>
<td>Metadata</td>
<td>Data relevant to a specific Provider, NPI, PTAN, Contract (State).</td>
</tr>
<tr>
<td>Novitas Internal Associates</td>
<td>Novitas Solutions employee registered for Novitasphere access.</td>
</tr>
<tr>
<td>Novitasphere</td>
<td>Software application which offers access to Claims and Appeals-related functionality for MAC Providers and their contracted Billing Offices, as well as Novitas Solutions staff.</td>
</tr>
<tr>
<td>User</td>
<td>Provider or Billing Office employee registered for Novitasphere access.</td>
</tr>
<tr>
<td>837 Claim File</td>
<td>Inbound Electronic Claim File.</td>
</tr>
<tr>
<td>999 Acknowledgement</td>
<td>Indicates whether the file successfully passed the initial file structure edits.</td>
</tr>
<tr>
<td>277CA Claims Acknowledgement</td>
<td>The 277CA indicates whether claims have been accepted, or rejected for processing consideration.</td>
</tr>
<tr>
<td>835 Electronic Remittance Advice (ERA)</td>
<td>The ERA is the Health Insurance Portability and Accountability Act (HIPAA)-compliant remittance file containing finalized payment or rejection information from the Medicare processing system.</td>
</tr>
</tbody>
</table>
1.2  *Acronym Listing*

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDE</td>
<td>Direct Data Entry</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>ERA</td>
<td>Electronic Remittance Advice</td>
</tr>
<tr>
<td>HIC/HICN</td>
<td>Health Insurance Claim Number</td>
</tr>
<tr>
<td>IACS</td>
<td>The Individuals Authorized Access to the CMS Computer Services (system)</td>
</tr>
<tr>
<td>ICN</td>
<td>Internal Control Number</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>PTAN</td>
<td>Provider Transaction Access Number</td>
</tr>
<tr>
<td>PDF</td>
<td>Portable Document Format in Adobe Acrobat Reader software</td>
</tr>
</tbody>
</table>

2  *Getting Started*

2.1  *Initial Novitasphere Access*

Once a User has registered in IACS, and been approved under a specific role, access to Novitasphere will be available via the following URL:

https://www.novitasphere.com

*Note:* After 15 minutes of inactivity, Novitasphere will automatically log the user off, and the user will need to sign back on to Novitasphere to continue.

*Note:* To Access the Novitasphere website, you must be running **Internet Explorer Version 8** (or newer) Google Chrome, Apple Safari, or Mozilla Firefox on the computer that is being used for access.

*Instruction:* Access the Novitasphere URL and enter the User Name and Password provided via IACS.

*Note:* If this is your first time signing into Novitasphere you will receive the following error message: “Your request cannot be processed at this time due to a system outage, we apologize for the inconvenience and encourage you to try again later.” Please contact your Security Official and have them assign specific roles to your user profile.
**Instruction:** Accept the disclaimer displayed on the screen in order to proceed to the Novitasphere home page, see Figure 1 Novitasphere Disclaimer.

From this point on, access to each screen will depend on the role the individual was assigned in IACS.

**Provider Office Approver Role:**

Provider Office Approvers will have default access to the following functions:

- Eligibility (Includes information on Benefits and Eligibility)
- Claim Information: Summary, Status and Remittance Request (includes mailbox access to Remittance data)
- Claim Submission/ERA
- Claim Correction: Reopening (includes mailbox access to Appeal Confirmation data)
- Mailbox

Instructions for completing these transactions can be found in Sections 5.1 – 5.7.

In addition, Provider Office Approvers are responsible for assigning roles to End Users and their billing services/clearing houses; this can be facilitated using the following steps:

**Instruction:** Select the User Management option on the Novitasphere toolbar, as shown in Figure 2 – User Management; Provider Officer Approver.
This screen will be used to select roles for your organization’s End Users, as well as for the Approvers for Billing Offices with which your Provider Office works.

**Instruction:** Select the following using the boxes displayed in Figure 2 – User Management; Provider Officer Approver.

- (a) A combination of Provider Office End Users and/or Billing Office Approver/s.
- (b) A set of appropriate NPI-PTAN-Contract combinations from the drop down.
- (c) A set of functional capabilities (Roles).

**Instruction:** Select “Save” to store the information selected.

**Note 1:** Once the Provider Office Approver assigns roles to their End User and/or Billing Agencies and clicks “Save”, the checkmarks for roles assigned will no longer be visible. To review the roles assigned, select the “Saved Data Report.”

**Note 2:** The “Saved Data Report” will not include the dates when changes were made for user roles.

**Note 3:** The Provider Office Approver and the Provider Office Backup Approver names will not be displayed in the User Management screen. These roles are automatically granted access to all aspects of Novitasphere.

**Note 4:** The Provider Office Approver will see any linked Billing Office Approver and Billing Office Backup Approver names in the User Management screen. They will not see the billing agency’s End Users.

**Note 5:** If the Provider Office Approver grants the billing agency access to the “Request Remittance” option, the billing agency will have the ability to view remittance information in Novitasphere.
agency will not receive the Electronic Remittance Advise files (835) unless specified on the EDI Portal Enrollment form.

Note 6: We do not recommend using the “ALL Future Billing Agencies” option in the User Management screen.

Billing Office Approver Role:

Billing Office Approvers are responsible for assigning roles to their organization’s End Users. This can be facilitated using the following steps:

Note: Billing Office Approvers can only assign functional capabilities to an End User which their Provider Office Approver has granted them access.

Instruction: Select the User Management option on the Novitasphere toolbar, as shown in Figure 3 – User Management; Billing Office Approver.

![Figure 3 – User Management; Billing Office Approver](image)

This screen will be used by the Billing Office Approver to select roles for their organization’s End Users.

Instruction: Select the following using the boxes displayed in Figure 3 – User Management; Billing Office Approver.

a) A combination of Billing Office End Users
b) A set of functional capabilities (Roles)
**Instruction:** Select “Save” to store the information selected.

*Note 1:* Once the Billing Office Approver assigns roles to their End Users and clicks “Save”, the checkmarks for roles assigned will no longer be visible. To review the roles assigned, select the “Saved Data Report.”

*Note 2:* The “Saved Data Report” will not include the dates when changes were made for user roles.

*Note 3:* The Billing Office End Users’ names will not display in the User Management screen until after they have attempted to log in to Novitasphere with their IACS User ID. They will receive an error message advising they have “No roles assigned.” The Billing Office Approver will then be able to assign the End User’s roles in the User Management screen.

*Note 4:* The Billing Office Approver will not have an option to select roles for “All Future End Users”. Billing office End User roles must be assigned individually.

**End User Role:**

*Note:* Before an End User can complete any transaction at Novitasphere, a Provider Office/Billing Office Approver belonging to their organization must assign functional capabilities within the Portal.

End Users will be assigned one or more of the following functional capabilities by their associated Provider Office/Billing Office Approver:

- Eligibility (Includes information on Benefits and Eligibility)
- Claim Information: Summary, Status and Remittance Request (includes mailbox access to Remittance data)
- Claim Submission/ERA
- Claim Correction: Reopening (includes mailbox access to Appeal Confirmation data)
- Mailbox

**Instruction:** The End User should select the appropriate option on the Novitasphere toolbar to complete the transaction/s.

*Note:* If you are a Novitasphere End User and you think an error has been made in your role assignment, OR you would like access to functionality which is not currently available to you, please contact your organization’s Approver.
3 Printing in Novitasphere

**Instruction:** Select the “PDF” icon on the screen you would like to print. This opens a PDF of all information. You will need Adobe Acrobat Reader software. Once the PDF document is open, you may print to your local printer.

If the “PDF” icon is not available on your screen you will need to perform a browser print by clicking “File, Print” on your browser toolbar.
4 User linked to multiple providers

4.1 Quick Links – Switch Provider

**Instruction:** Select the “Switch Provider” option at the bottom of the Novitasphere toolbar, as shown in Figure 5 – Switch Provider.

![Figure 5 – Switch Provider](image)

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**Instruction:** Select the **provider name in the box that appears**, as shown in **Figure 6 – Select Provider**.
5 Using Novitasphere – Carrying out Transactions

5.1 Benefit & Eligibility Inquiry

**Instruction:** Select the “Eligibility” option on the Novitasphere toolbar, as shown in Figure 7 Benefit & Eligibility Input.

![Figure 7 – Benefit & Eligibility Input](image)

**Instruction:** Enter the following information to complete an eligibility inquiry (*Notates required information):

- First Name* (of beneficiary)
- Last Name* (of beneficiary)
- Health Insurance Claim number (HIC)*
- Date of Birth
- Suffix
- Date(s) of Service

**Instruction:** Select the **Submit** button displayed in Figure 7 – Benefit & Eligibility Input.

*Note: The user must enter a valid Date of Service Range within 27 months of the current date.*
The screen shown in Figure 8 – Benefit & Eligibility Output will be displayed.

The information entered by the user will be displayed in the Inquiry Tab, as displayed in Figure 8 – Benefit & Eligibility Output.

When there is data available under a specific category, the tab will be displayed in blue, see Beneficiary tab above.

When there is no data available under a specific category, the tab will be displayed in grey, see MAP tab above.

If you want to complete subsequent inquiries, the following steps are required:

**Instruction**: Select the Clear button, as displayed in Figure 8 – Benefit & Eligibility Output.

**Instruction**: Enter new inquiry information, and select the Submit button, as displayed in Figure 8 – Benefit & Eligibility Output.

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**Figure 8 – Benefit & Eligibility Output**

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If the eligibility inquiry transaction fails, an error message will be displayed, as shown in Figure 9 – Benefit & Eligibility Error Message.

Figure 9 – Benefit & Eligibility Error Message

5.2 Benefit & Eligibility Tab Definitions

5.2.1 Inquiry Tab

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Information Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber First Name</td>
<td>First Name the exact way the User keyed the information.</td>
</tr>
<tr>
<td>Subscriber Last Name</td>
<td>Last Name the exact way the User keyed the information.</td>
</tr>
<tr>
<td>Subscriber Date of Birth (MMDDYYYY)</td>
<td>Date of Birth the exact way the User keyed the information.</td>
</tr>
<tr>
<td>Subscriber Primary ID (HICN)</td>
<td>HICN the exact way the User keyed the information.</td>
</tr>
<tr>
<td>Date of Service/Date of Service Range</td>
<td>The Date of Service/Date of Service Range the User used to initiate the search. See the table below of acceptable query date ranges.</td>
</tr>
</tbody>
</table>

Note: The User will receive an error message stating “The _______ provided for this Beneficiary does not match what we have on file. Please verify this information with the Beneficiary” if the information is miskeyed.
Table of Acceptable Query Date Ranges

<table>
<thead>
<tr>
<th>If This Month Is</th>
<th>Historical Requests Are Valid Through:</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>October, 3 years ago</td>
</tr>
<tr>
<td>February</td>
<td>November, 3 years ago</td>
</tr>
<tr>
<td>March</td>
<td>December, 3 years ago</td>
</tr>
<tr>
<td>April</td>
<td>January, 2 years ago</td>
</tr>
<tr>
<td>May</td>
<td>February, 2 years ago</td>
</tr>
<tr>
<td>June</td>
<td>March, 2 years ago</td>
</tr>
<tr>
<td>July</td>
<td>April, 2 years ago</td>
</tr>
<tr>
<td>August</td>
<td>May, 2 years ago</td>
</tr>
<tr>
<td>September</td>
<td>June, 2 years ago</td>
</tr>
<tr>
<td>October</td>
<td>July, 2 years ago</td>
</tr>
<tr>
<td>November</td>
<td>August, 2 years ago</td>
</tr>
<tr>
<td>December</td>
<td>September, 2 years ago</td>
</tr>
</tbody>
</table>

5.2.2 Beneficiary Tab

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Information Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber First Name</td>
<td>First Name of the Beneficiary.</td>
</tr>
<tr>
<td>Subscriber Last Name</td>
<td>Last Name of the Beneficiary.</td>
</tr>
<tr>
<td>Subscriber Middle Name</td>
<td>Middle Name of the Beneficiary.</td>
</tr>
<tr>
<td>Subscriber Date of Birth (MMDDYYYY)</td>
<td>Date of Birth of the Beneficiary.</td>
</tr>
<tr>
<td>Subscriber Primary ID (HICN)</td>
<td>HICN of the Beneficiary.</td>
</tr>
<tr>
<td>Subscriber Date of Death</td>
<td>Date of Death of the Beneficiary.</td>
</tr>
<tr>
<td>Date of Service/Date of Service Range</td>
<td>The Date of Service/Date of Service Range the User used to initiate the search.</td>
</tr>
</tbody>
</table>

5.2.3 Eligibility Tab

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Information Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A Eligibility - Effective Date</td>
<td>A date that indicates the start of eligibility for Medicare Part A</td>
</tr>
<tr>
<td>Part A Eligibility - Termination Date</td>
<td>A date that indicates termination of eligibility for Medicare Part A. No date in this field means Medicare Part A eligibility has not terminated.</td>
</tr>
<tr>
<td>Part B Eligibility - Effective Date</td>
<td>A date that indicates the start of eligibility for Medicare Part B.</td>
</tr>
<tr>
<td>Part B Eligibility - Termination Date</td>
<td>A date that indicates termination of eligibility for Medicare Part B. No date in this field means Medicare Part B eligibility has not terminated.</td>
</tr>
<tr>
<td>XXXX Year Part B Rem/Total Deductible</td>
<td>Remaining Deductible amount associated with the calendar year indicated/Total deductible associated with the calendar year indicated.</td>
</tr>
</tbody>
</table>
### 5.2.4 MAP Tab

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Information Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Name</td>
<td>A descriptive name of the beneficiary’s insurance coverage organization</td>
</tr>
<tr>
<td>Contractor #</td>
<td>The contract number followed by the plan number (if on file)</td>
</tr>
<tr>
<td>Plan Type</td>
<td>Plan Type Code:&lt;br&gt;Health Maintenance Organization Medicare Non Risk – HM&lt;br&gt;Health Maintenance Organization Medicare Risk – HN&lt;br&gt;Indemnity – IN&lt;br&gt;Preferred Provider Organization – PR&lt;br&gt;Point of Service – PS&lt;br&gt;Pharmacy – Part D</td>
</tr>
<tr>
<td>MCO Bill Opt Code</td>
<td>The bill option code of the Plan Type. This field only applies to plan types HM, HN, IN, PR, and PS. This field will not be displayed for Part D plan type.</td>
</tr>
<tr>
<td>Eff Date</td>
<td>The date that indicates the start of enrollment to the coverage plan</td>
</tr>
<tr>
<td>Term Date</td>
<td>The date that indicates the termination of enrollment to the coverage. No date in this field means the plan enrollment has not been terminated.</td>
</tr>
<tr>
<td>Address</td>
<td>The Coverage Plan’s Address</td>
</tr>
<tr>
<td>Tel Number</td>
<td>The Coverage Plan’s Contract Telephone Number (if on file)</td>
</tr>
</tbody>
</table>

### 5.2.5 MSP Tab

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Information Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason Code</td>
<td>12 = Medicare Secondary Working Aged Beneficiary or spouse with Employer Group Health Plan&lt;br&gt;13 = Medicare Secondary End Stage Renal Disease Beneficiary in the 12 month coordination period with an Employer Group Health Plan&lt;br&gt;14 = Medicare Secondary No-Fault insurance including auto is primary&lt;br&gt;15 = Medicare Secondary Workers’ Compensation&lt;br&gt;16 = Medicare Secondary Public Health Service (PHS) or other Federal Agency&lt;br&gt;41 = Medicare Secondary Black Lung&lt;br&gt;42 = Medicare Secondary Veteran’s Administration&lt;br&gt;43 = Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan&lt;br&gt;47 = Medicare Secondary other liability insurance is primary&lt;br&gt;WC = Workers’ Compensation Medicare Set-aside Arrangement</td>
</tr>
<tr>
<td>Eff Date</td>
<td>The date that indicates the start of the primary insurer’s coverage</td>
</tr>
<tr>
<td>Term Date</td>
<td>The date that indicates the termination of the primary insurer’s coverage. No date in this field means primary insurance coverage has not terminated</td>
</tr>
<tr>
<td>Insurer Name</td>
<td>The name of the insurance company</td>
</tr>
<tr>
<td>Address</td>
<td>The address of the insurance company</td>
</tr>
</tbody>
</table>
### 5.2.6 Hospice/Home Health Tab

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Information Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHED Start Date</td>
<td>The date the 60-day Home Health episode period started</td>
</tr>
<tr>
<td>HHEH End Date</td>
<td>The date that the Home Health episode terminated</td>
</tr>
<tr>
<td>Provider Number</td>
<td>The NPI Number of the Home Health Facility</td>
</tr>
</tbody>
</table>

### 5.2.7 Preventative Services Tab

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Information Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking Cessation - Total Sessions</td>
<td>Number of Smoking Sessions remaining for the beneficiary.</td>
</tr>
<tr>
<td>Smoking Cessation - Next Session Date</td>
<td>The next available begin date for Smoking Session program if there are no sessions remaining in their current period.</td>
</tr>
<tr>
<td>Preventive</td>
<td>If beneficiary waived deductible and coinsurance a message will be displayed.</td>
</tr>
<tr>
<td>Preventive - Service Code</td>
<td>Procedure Code</td>
</tr>
<tr>
<td>Preventive - Eligible Date</td>
<td>The date the beneficiary is eligible for the associated procedure code.</td>
</tr>
<tr>
<td>Preventive - Calendar Year</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Preventive - Deductible Applied</td>
<td>Deductible Applied for the Calendar Year.</td>
</tr>
<tr>
<td>Preventive - Deductible Remaining to be met</td>
<td>Deductible Remaining for the Calendar Year.</td>
</tr>
<tr>
<td>Preventive - Coinsurance</td>
<td>Coinsurance Remaining for the Calendar Year.</td>
</tr>
</tbody>
</table>
5.3  Claims Information

5.3.1  Claims Summary

Instruction: Select the “Summary” option under “Claims Info” on the Novitasphere toolbar, as shown in Figure 10 – Claims Summary Input.

![Figure 10 – Claims Summary Input](image-url)
**Instruction:** Select the PTAN from the drop down and select **Submit** to perform a Claim Summary Inquiry. Claim Summary output will be displayed in **Figure 11 - Claims Summary Output**.
5.3.2 Claims Status

Note: For adjusted claims, the status information displayed on Novitasphere may vary from the information available via the Interactive Voice Response unit (IVR). This is due to the fact that the IVR is updated throughout the business day; and interfaces real-time with the claims processing system, whereas Novitasphere is updated using an overnight batch cycle.

Instruction: Select the Status option under Claims Info on the Novitasphere toolbar, as shown in Figure 12 – Claims Status Input.

Instruction: Select or enter the following data elements to complete a Claim Status Inquiry (*Notates required information):

- NPI*
- PTAN*
- State*
- Health Insurance Claim Number (HICN)*
- Internal Control Number (ICN)
- First Name - Initial* (of Beneficiary)
- Last Name – First 7 letters* (of Beneficiary)
- Procedure Code
- Status
- Date(s) of Service*

Instruction: Select the Search button displayed in Figure 12 – Claims Status Input.
The screen shown in Figure 13 – Claims Status Output will be displayed.
**Instruction:** To view data for an individual claim (or ICN), select the relevant row from the results tables for the ICN you want to view.

Individual Claim Data / Detailed Claim Data will be displayed as shown in **Figure 14 – Claims Status Output Header Level.** A detailed listing of all messages is located on the reference tab.

![Claims Status Output Header Level](image-url)

**Figure 14 – Claims Status Output Header Level**
You will now be able to view line level data for an individual claim:

**Instruction:** Select the line you wish to “View” from the table displayed in **Figure 14 - Claims Status Output Header Level**.

Line level Claim Data will be displayed as shown in **Figure 15 – Claims Status Output Line Level**.

In addition to viewing detailed claim data Users may have access to Reopening functionality, access depends upon role assignments, see **Section 5.6** for Claim Correction – Reopening.
5.4  **Remittance Request Advice**

**Instruction:** Select the **Request Remittance Advice** option under **Claims Info** on the Novitasphere toolbar, as shown in **Figure 16 – Request Remittance Advice Input**.

![Novitasphere toolbar and Request Remittance Advice form](image)

**Instruction:** Select the following data elements to complete a Remittance query (*Notates required information):

- NPI*
- Date of Remittance* (“From”)
- Date of Remittance* (“To”)

**Instruction:** Select the **Submit** button displayed in **Figure 16 – Request Remittance Advice Input**.

Following the Remittance query, the following results may be returned:

- Where the **date range** selected is **within the last 45 days**, and there is a match with the NPI selected, 1 or more Remittances will be available for **View**.
- Where the **date range** selected **extends beyond the last 45 days**, and there is a match with the NPI selected, 1 or more Remittances will be available for **Request**.
View/Request results will be displayed as shown in **Figure 17 – Request Remittance Advice Output**.

![Figure 17 – Request Remittance Advice Output](image)

Where a query returns a large number of matching Remittances, you will be able to page through results in the table.

**To View a Remittance:**

**Instruction:** Select the *View* button displayed in **Figure 17 – Request Remittance Advice Output**, for the appropriate Remittance record; Remittance information will be displayed in PDF format.

**To Request a Remittance:**

**Instruction:** Select the *Request* button displayed in **Figure 17– Request Remittance Advice Output**, for the appropriate Remittance record.
**Instruction:** Select the **Yes** button on the **Request Confirmation** pop-up, as shown in **Figure 18** – **Remittance Request Confirmation Message.**

![Remittance Request Confirmation Message](image)

**Figure 18**– Remittance Request Confirmation Message

**Note:** Requested Remittances will be made available the next day via the Mailbox feature; for more information on viewing Requested Remittances see **Section 5.7.1; Mailbox – Requested Remittance Advices.**
5.5  **Claims Submission**

**Instruction:** Select the **Claims Submission / ERA** option on the Novitasphere toolbar as shown in Figure 19 – Claims Submission/ERA.

![Novitasphere toolbar](image)

A new window will open that will allow the User to upload the 837 inbound file, directly enter claims into the Medicare system or download the 999, 277CA and ERA file reports.

*Note: If the new window does not open automatically, you may need to turn off your internet browser’s pop-up blocker or add the website address to list of the allowed sites.*
5.5.1 File Submission

Instruction: Click on the words “File Submission” under the green file cabinet, as shown in Figure 20 – File Status/ File Submission Launch.

Or click on “File” and “File Submission” from the middle menu bar drop down options.

![File Status and File Submission](image)

Figure 20 – File Status/ File Submission Launch

Instruction: Click “Browse”, as shown in Figure 21 – File Submission Browse. A file selection window will open.

![File Upload](image)

Figure 21 – File Submission Browse

Navigate to the claim file you want to submit.

Select the file and click “Open”.

The selected file will display in “file” textbox.

Click “Upload” to submit the file.
5.5.2 File Status

Status will be provided in the form of Electronic Reports (999, 277CA, and ERA) for batch claim files or DDE acknowledgement and Claim Acknowledgement for DDE claims. More information on the Electronic reports is provided in Chapter 9 of the Electronic Billing Guide.

Instruction: Click on the words “File Status” under the green file cabinet, as shown in Figure 22 – File Status/File Submission Launch.

Or click on “File” and “File Status” from the middle menu bar drop down options.
5.5.3 To View all Electronic Reports

Instruction: Enter the start and end dates then select “Search New Files” to view new files available or select “Search Old Files” to view files that have already been viewed or downloaded, as shown in Figure 23 – File Status Search.

![Figure 23 – File Status Search](image)

The Compact View check box changes the display of the file select panel, by removing the Time and Size columns. This feature reduces the number of columns that a speech to text reader would read for each row in the file selection panel.

To refine the search further, the user can put in part or all of the file name in the File Name field.

Note: For claims submitted using “Professional claims DDE,” you must view the DDE acknowledgement to find out if the claim was received for further processing. The file name will be in the following format: Dde_claim.SubmitterID.CLAIMID*************.xml.err

If the report contains the following text, it was received successfully:

```
<response>
  <result>Your claim has been received successfully</result>
</response>
```

If the report contains an error message, the claim failed immediately upon submission. The Claim Acknowledgement report will tell you if the claim was accepted for processing or was rejected. If rejected, the report will give the reason for rejection. Refer to the “To Correct and Resubmit Claims” instructions in Section 5.6.
5.5.4 To Download or View a File

Instruction: Click on the file and select “Download File”. Select “Open” to view. To download, click “Save” then navigate to the proper location on your computer to save, as shown in Figure 24 – File Status File Download.

![Figure 24 – File Status File Download](image)

To Save a File from the View Screen:

Instruction: Click “File” and “Save As” then navigate to proper location on your computer.
5.6 **Professional Claims DDE**

**Instruction:** Select the **Claims Submission / ERA** option Figure 25 on the Novitasphere toolbar.

![Novitasphere toolbar](image)

*Figure 25 – Claims Submission / ERA*

A new window will open that will allow the User to upload the 837 inbound file, directly enter claims into the Medicare system or download the 999, 277CA and ERA file reports.

*Note:* *If the new window does not open automatically, you may need to turn off your internet browser’s pop-up blocker or add the website address to list of the allowed sites.*
5.6.1 Claim Submission

**Instruction:** Click on the words “Professional Claims DDE” under the keyboard letters, as shown in Figure 26 – Professional Claims DDE Launch. Or click on “Direct Data Entry” and “Professional Claims DDE” from the middle menu bar drop down options.

![Figure 26 – Professional Claims DDE Launch](image1)

**Instruction:** Click “Start New Claim”, as shown in Figure 27 – DDE Start New Claim.

![Figure 27 – DDE Start New Claim](image2)
To Enter Patient Information:

**Instruction:** Select a patient from the list shown and click “Continue” or click “New Patient”, as show in Figure 28, and complete all applicable fields. Click “Save” when finished.

- The Account ID field should be the patient account number.
- Zip codes should be valid and entered as 9-digits to meet billing requirements (xxxxx-xxxx). Key dates in YYYY/MM/DD format or access the calendar option.

**Figure 28 – DDE Patient**

To Enter Patient’s Insurance Information:

**Instruction:** Click “New Insurance”, as shown in Figure 29 – DDE Insurance, and enter the Patient’s Primary insurance information (multiple insurance records can be entered). Click “Save” when finished.

- The claim filing indicator should be “Medicare Part B”.
- The Insurance ID Number should be the patient’s Health Insurance Claim (HIC) number.
- The “Patient Source” box should be checked if the signature was executed on the patient’s behalf under state or federal law.
- Zip codes should be valid and be entered as 9-digits to meet billing requirements(xxxxx-xxxx).
- Medicare Secondary Payer (MSP) claims cannot be submitted through DDE at this time.

To Enter Payer Information:

**Instruction:** Click the “Send To” radio button from the list shown and click “Continue” or click “New Payer” and complete all applicable fields. Click “Save” when finished. The “Other” box is provided to report secondary insurance in addition to the Medicare primary insurance.
The recommended information for Novitas is as follows:

- Enter “MEDICARE PART B – and the state code” in the “Name” field
- Enter the five-digit contract ID in the “Identification” field.

<table>
<thead>
<tr>
<th>State</th>
<th>Contract ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCMA</td>
<td>12202</td>
</tr>
<tr>
<td>DE</td>
<td>12102</td>
</tr>
<tr>
<td>MD</td>
<td>12302</td>
</tr>
<tr>
<td>NJ</td>
<td>12402</td>
</tr>
<tr>
<td>PA</td>
<td>12502</td>
</tr>
<tr>
<td>AR</td>
<td>07102</td>
</tr>
<tr>
<td>LA</td>
<td>07202</td>
</tr>
<tr>
<td>MS</td>
<td>07302</td>
</tr>
<tr>
<td>CO</td>
<td>04102</td>
</tr>
<tr>
<td>NM</td>
<td>04202</td>
</tr>
<tr>
<td>OK</td>
<td>04302</td>
</tr>
<tr>
<td>TX</td>
<td>04402</td>
</tr>
</tbody>
</table>

- Enter “PO Box 3011” in the “Street” field
- Enter “Mechanicsburg” in the “City” field
- Enter “Pennsylvania” in the “State” field
- Enter “17055-1801” in the “Postal Code” field

- Zip codes should be valid and entered as 9-digits to meet billing requirements.

**Instruction:** Select the appropriate “Send To” radio button, as shown in **Figure 29 – DDE Insurance**, and then click “Continue”.

![Figure 29 – DDE Insurance](image)
To Enter Provider Information:

**Instruction:** Select an existing provider from the list shown and click “**Continue**” or click “**New Provider**”, as shown in **Figure 30 – DDE Provider**, and complete all applicable fields. Click “**Save**” when finished.

- If the billing provider is a provider group, the “Provider” entered should be the rendering physician.
- PO Box is not allowed for billing address.
- Zip codes should be valid and be entered as 9-digits to meet billing requirements (xxxxx-xxxx).

The following steps are only needed when entering a new provider.

**Instruction:** Enter the Provider Identity information (provider and billing NPI are required) and click “**Save**” when finished.

- If the billing NPI is a provider group, the provider NPI should be the rendering provider NPI.

**Note:** The next screen is the “**Editing Claim**” screen that contains multiple tabs toward the top. The first five tabs contain the information that was just entered on the previous screens.
To Enter Claim Details:

**Instruction:** Click the “Incident” tab, as shown in Figure 31 – DDE Claims Tabs, and in the “Claim Frequency” field choose “Admit through Discharge Claim” from the drop-down menu and complete all applicable incident information

- At least one diagnosis is required.

**Instruction:** Click the “Services” tab, as shown in Figure 31 – DDE Claims Tabs, and click “Add Service”. Enter all applicable service information and click “Add/Update Service to Claim” when finished. Repeat “Add service steps” or if there are no additional services click “Save”. There has to be at least one service added to each claim. A maximum of 50 lines of service can be entered per claim.

- The service date is copied from the incident screen but can be changed, if needed.
- The “Charges” filed is the total charge amount for this service. The amount is inclusive of the provider’s base charge and any applicable tax and/or postage claimed. Zero “0” is an acceptable value for this field.
- EPSDT is early and periodic screen for diagnosis and treatment of children involvement.

**Instruction:** Repeat “Add service steps” or if there are no additional services click “Save”.

After saving the claim, it will be available on your dashboard as a “Claim in Progress” for future editing, review, and submission. To save claims for later submission or modifying, do not submit the claim.

**Note:** The “Save” button is not visible when you are in a required field. To activate the “Save” button, you must click out of the required data field.

To Enter Ambulance Claim Details:

**Instruction:** Click on the “Ambulance” tab, as shown in Figure 31 – DDE Claims Tabs, and complete all applicable information. Click “Save” when finished.

- Ambulance information is not required. If there is not any ambulance information for the claim, skip to the next instruction.
- If any fields in the ambulance tab are filled out, then all required fields must be completed.
To Edit Patient Information:

**Instruction:** Click “Edit” on the Patient Records screen or “Edit Patient” on the Confirm Selected Patient screen. After changes are made, click “Save”, as shown in Figure 32 – DDE Edit Patient.

![Figure 32 – DDE Edit Patient](image)

To Copy the Last Claim Entered:

**Instruction:** Click on “Start New Claim” and select the patient, insurance and provider. Click on “Copy Last Claim”. Select the date of service. Data from the last claim entered for the patient, insurance and provider selected will be copied to the current claim entry screens.

- The “Copy Last Claim” button is only visible when the same patient and provider is selected that was previously used to create the claim.
- All information from the incident, ambulance and service tabs will be copied over to the new claim but can be changed, if needed.

To Correct Claim Entry Errors:

Errors can occur if required fields have not been completed or were completed incorrectly. Notification of an error appears as a pink box with a message. Scroll through any pages with errors to see all pink box messages. To correct errors found during the claim review, click “Correct these Errors” and it will take you to the screen needing corrections.

**Instruction:** To correct an error, read the error message details and complete the required field with the correct information. After changes are made, click “Save”.
To Submit the Claim:

Instruction: Click “Review Claim”.

- If any errors are found on the claim, the field with an error will be highlighted in Red and a message will be displayed in the right side bar. To correct any errors, click the “Correct These Errors” button in the right side bar and make the necessary changes by clicking the appropriate tabs on the editing claim screen. Click “Save” and then “Review Claim” after completing changes.

Instruction: Click “Continue Editing” if any changes are needed, after changes are made, click “Save” and “Review Claim” again. If no changes are needed, click “Submit”.

After clicking “Submit”, the following messages should be received: “File upload successful” and “Claim submitted successfully”. The claim should now be visible on the dashboard in the “Submitted Claim” section. Always view the submitted claims to check status.

To View Submitted Claims:

The bottom of the dashboard screen contains a listing of the most recently submitted claims.

The number provided in the “num entries” column is the number of messages in the lifecycle of the claim.

Instruction: Click “View All Submitted”, as shown in Figure 33 – DDE Dashboard. This will list all claims submitted and provide the status of each claim. The status descriptions are below:

- FAILED – claim contained errors and needs resubmitted
- SUCCESS – claim was clean and processed
- SENT – claim has been sent but not yet received/reviewed to determine failed or success status.
To Correct Claim Submission Errors and Resubmit Claims:

**Instruction:** Click “View All Submitted”, as shown in Figure 33 – DDE Dashboard. This will list all claims submitted and provide the status of each claim. Status descriptions are shown above.

**Instruction:** Click “View Thread”, as shown in Figure 33 – DDE Dashboard, for any claim that is in the FAILED status and then click “Correct Claim”. Make the necessary corrections and then submit as described in the “To Submit a Claim” instructions above.

![Figure 33 – DDE Dashboard](image)

**Claims in Progress**

**Instruction:** Click on the words “Professional Claims DDE” under the keyboard letters, as shown in Figure 26 in the section above. Or click on “Direct Data Entry” and “Professional Claims DDE” from the middle menu bar drop down options.

All claims that were previously saved, but not submitted, will show in the “Claims in Progress” list on your dashboard, as shown in Figure 33 – DDE Dashboard in the section above.

**To Submit Previously Entered Claims:**

**Instruction:** Click “Review” for the claim from the list shown and then click “Submit”.

- If any errors are found on the claim, the field with an error will be highlighted in Red and a message will be displayed in the right side bar. To correct any errors, click the “Correct These Errors” button in the right side bar and make the necessary changes by clicking the appropriate tabs on the editing claim screen. Click “Save” and then “Review Claim” after completing changes.
To Modify Previously Entered Claims

**Instruction:** Click “Edit” for the claim from the list shown and make any necessary changes. Click “Save” when finished. To submit the claim, click “Review Claim” and then click “Submit”.

5.6.2 Logging out of the Claim Submission/ERA Option

**Instruction:** When the User is finished uploading the 837 inbound file, directly entering claims into the Medicare system or downloading the 999, 277CA and ERA file reports, the User should click “Logout” at the top right corner of the screen, as shown in Figure 34 – Claim Submission/ERA Logout. The User will need to close the second window that opened. This will return the User to the Novitasphere browser. If Novitasphere has not timed out and auto logged the User out of Novitasphere, they will also need to select “Logout” at the top right corner of the screen.

![Figure 34 – Claim Submission/ERA Logout](image)
5.7  **Claim Correction/Reopening**

5.7.1  **Claim Correction via Claim Status Link**

**Instruction:** User completes a Claim Status Inquiry (for instructions see Section 5.2.2) and views data for an individual claim:

![Claim Status](image)

**Figure 35 – Claim Status (Reopening)**

**Instruction:** Select **Reopen** using the button displayed in **Figure 35 – Claim Status (Reopening)**.

A Reopening button will be present only on claims that are eligible to be reopened via the Novitasphere. If the **Reopen** button is not present, the claim is not eligible to be reopened via Novitasphere, please follow the normal reopening process located on the [Novitas Appeals Center website](#).
**Instruction:** Select **Edit**, using the button displayed in **Figure 36 – Reopening Claim Level** (below), to reopen a specific line of the claim.

![Figure 36 – Reopening (Claim Level)](image-url)
**Instruction:** Make desired modifications to line level claim data using the text boxes provided; see Figure 37 – Reopening (Line Level).

**Figure 37 - Reopening (Line Level)**

**Instruction:** Upon completion of desired modifications select **Save**, using the button displayed in Figure 37 – Reopening (Line Level).

**Note:** The Comment box should ONLY be used to provide new/additional information to support the modifications. Do NOT use the Comment box to recap the changes made. This will result in additional time to process your reopening. There is limited space and you cannot append an attachment.
If any invalid data was entered into any of the modifiable fields when Save is selected an error will be highlighted for correction as shown in Figure 38 – Reopen Data Validation Error Message.

**Figure 38 – Reopening Data Validation Error Message**

**Instruction:** Resolve any errors make further modifications to line level data as needed, select Save to save changes once all modifications have been completed.

**Instruction:** Select Submit Reopen Request using the button displayed in Figure 36 – Reopening (Claim Level) above.

**Note:** Within 24 hours of submission, an Appeal Confirmation will be published to the User’s Mailbox. See Section 5.7.3 for details. Within 48 hours of submission, you will be able to see the status of the reopening request by performing a claim status inquiry on the portal.
5.7.2  Reopening via Claim Correction Link

**Instruction:** Select the “Claim Correction” option on the Novitasphere toolbar.

**Figure 39 – Claim Correction Data Input (Reopening) will be displayed:**

![Claim Correction Data Input (Reopening)](image)

**Instruction:** Select / enter the following data elements to identify a Claim for Reopening (*Notates required information):

- NPI*
- PTAN*
- Contract*
- HICN*
- ICN
- First Name Initial*
- Last Name*
- Procedure Code
- Status
- Date(s) of Service*

**Instruction:** Select the **Search** button as displayed in **Figure 39 – Claim Correction Data Input (Reopening)**.
If a claim matching the data entered which is eligible for a Reopening Figure 40 – Claim Correction Results (Reopening) will be displayed:

![Claim Correction Results (Reopening)](image)

To view an individual claim:

**Instruction:** Select the relevant claim from the results table displayed in Figure 40 – Claim Correction Results (Reopening).
The following screen will be displayed:

![Claim Correction Screen]

**Figure 41 - Claim Correction Results Claim Level (Reopening)**

**Instruction:** Select **Reopen**, using the button displayed in **Figure 41 – Claim Correction Results Claim Level (Reopening)**, to modify the claim data.
Figure 42 – Claim Correction Modification Screen (Reopening) will be displayed:

Instruction: Complete desired modifications to line level claim data using the Edit button displayed in Figure 42 – Claim Correction Modification Screen (Reopening).
When Edit is selected, **Figure 43 – Claim Correction Modification Second Screen (Reopening)** will be displayed:

![Figure 43 - Claim Correction Modification Second Screen (Reopening)](image)

**Instruction:** Complete desired modifications, select **Save**, using the button displayed in **Figure 43 – Claim Correction Modification Second Screen (Reopening)**.

**Note:** The Comment box should ONLY be used to provide new/additional information to support the modifications. Do NOT use the Comment box to recap the changes made. This will result in additional time to process your reopening. There is limited space and you cannot append an attachment.
If any invalid data was entered into any of the modifiable fields when **Save** is selected an error will be returned in red for correction as shown in **Figure 44 – Claim Correction Data Validation Screen (Reopening)**.

![Figure 44 - Claim Correction Data Validation Screen (Reopening)](image)

**Instruction:** Make any further modifications to line level data as necessary, including adding any relevant **Comments**, and select **Save** in each case.

User will be returned to the screen displayed in **Figure 42 – Claim Correction Modification Screen (Reopening)**.

**Instruction:** Select **Submit Reopen Request** using the button displayed in **Figure 42 – Claim Correction Modification Screen (Reopening)**.

**Note:** Within 24 hours of submission, a **Claim Correction Confirmation** will be published to the User’s Mailbox. See **Section 5.7.3** for details.
5.8 Mailbox

NOTE: Internal Novitas Users have access to view an External User’s Mailbox in order to assist the User with questions.

5.8.1 Requested Remittance Advices

Instruction: Select the Mailbox option on the Novitasphere toolbar, and then select the Requested Remittance Advices tab.

Instruction: Select an individual Remittance Advice by selecting View beside the appropriate Remittance Advice in the table displayed in Figure 45 – Requested Remittance Advices.
Figure 46 - Mailbox Requested Remittance shown below will display the Remittance Advice data in a PDF format. You will need Adobe Acrobat Reader to view.

Note 1: You can page through the different Remittance Advice records using the arrow buttons provided at the top of the page.

Note 2: You can print or save the Remittance Advice record using the browser settings at the top of the page.

Note 3: You can also delete Remittance Advice records once they have been viewed by selecting the appropriate radio button next to the relevant Remittance Advice and then selecting the delete button.
If you are linked to multiple provider offices using the same User sign on you can view the Remittance Advice records for each provider by choosing the Switch Provider link at the bottom left of your screen. A box will pop up allowing you to choose the appropriate provider as shown in Figure 47 – Remittance Advice Switch Provider below.

![Figure 47- Remittance Advice Switch Provider](image-url)
5.8.2 Medicare Communications

All Users will have access to relevant Medicare Communications about the portal and related functionality via their Novitasphere Mailbox. For example, this Medicare Communications feature will be used to post information about system problems (i.e., HETS or Mpower not available) or new/modified functionality.

Note: We encourage Users to access the Medicare Communications tab upon logging into Novitasphere for any new portal related information. However, it is important to note that this does not replace the www.novitas-solutions.com website for general Medicare updates.

Instruction: Select the Mailbox option on the Novitasphere toolbar, and then select Medicare Communications.

Figure 48 – Mailbox Medicare Communications: View any Medicare Communications which have been published to your Mailbox, using the View button.

![Mailbox Medicare Communications](image-url)
5.8.3 Claim Correction Confirmations (Reopening) Notices

Following a Claim Reopening (see Section 5.6.2 for instructions), the following steps are required to view a Claim Correction Confirmation Notice:

Instruction: Select the Mailbox option on the Novitasphere toolbar, and then select Claim Correction Confirmation.

Figure 49 – Mailbox Claim Correction Confirmation will display:

![Mailbox Claim Correction Confirmation](image)

Instruction: to gain access to specific Claim Correction Confirmation records, you will choose the following information using the drop down menu (*Notates required information):

- NPI*
- PTAN*
- State*

Note: If you hit enter after keying the NPI, the associated PTAN and state will populate. If multiple PTANs are tied to an NPI, then you will be prompted to select the appropriate associated PTAN. See Figure 49 – Mailbox Claim Correction Confirmation (Multiple PTANs).
**Instruction:** Select an individual **Confirmation Reference** to view, by selecting the appropriate row in the table, and selecting View button next to the record. The information displays on the right hand side of the screen, see **Figure 50 – Mailbox Claim Correction Confirmation (Display)** and you will need to scroll to view the entire confirmation.

![Figure 50 - Mailbox Claim Correction Confirmation (Display)](image)

**Note 1:** You can page through the different Claim Correction Confirmation records using the **arrow buttons** below the table.

**Note 2:** You also have the option to print the Claim Correction Confirmation using your internet browser. You will need to print on the landscape setting.

Select File; page set up then choose Landscape. Click OK at the bottom. Select File; print.

**Note 3:** You can also **delete** Claim Correction Confirmation records once they have been viewed by selecting the appropriate radio button next to the record and then selecting the **delete** button. This does not delete the Claim Correction itself, just the Confirmation record.

**Note 4:** If you delete a record, there is no ability to recreate the record. It is suggested that you do not delete Claim Correction Confirmation records for 48 hours after initial posting, which is the timeframe by which the adjustment should be reflected in the Claims Inquiry function.
If you are linked to multiple provider offices using the same User sign on, you can view the Claim Correction Confirmation records for each provider by choosing the Switch Provider link at the bottom left of your screen.

A box will pop up allowing you to choose the appropriate provider as shown in Figure 51– Claim Correction Confirmation Switch Provider below.

![Figure 51 - Claim Correction Confirmation Switch Provider](image-url)
5.9  **Portal Help**

5.9.1  **Reference/User Manual**

All Users will have the ability to access Reference information for Novitasphere use at any point during a Novitasphere session.

**Instruction:** Select the **Reference** option on the horizontal Novitasphere toolbar, see **Figure 52 - Reference**.

![Figure 52 - Reference](image-url)
5.9.2 Comments

All Users will have the ability to submit Comments at any point during a Novitasphere session.

Instruction: Selects the Comments option on the horizontal Novitasphere toolbar, see Figure 53 – Comments.

![Fig 53 Comments](image)

**Figure 53 - Comments**

Instruction: Key comments, and select Submit, using the button shown above. The comments box will accept a maximum of 250 characters.

Note: Comments should be limited to information related to the Novitasphere portal user experience. These comments will be reviewed but no response will be returned.
5.9.3 **Forsee Survey**

All Users will have the opportunity to participate in the Forsee Survey. The Forsee Survey will be generated for each User every 30 days.

When the Forsee Survey is generated the User should choose “No, thanks” or “Yes, I’ll give feedback, see Figure 54– Forsee Survey:
5.9.4 Contact Us

All Users will have the ability to access contact information for Novitas Solutions at any point during a Novitasphere session, with questions or information related to their Novitasphere portal user experience.

To access contact information select the Contact Us option on the horizontal Novitasphere toolbar, see Figure 55 – Contact Us.