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Contact Us:

Medicare Mac J5 Part A – Iowa, Kansas, Nebraska, Missouri and J5 National - 866-518-3285 (option 1)
Medicare Mac J8 Part A – Michigan and Indiana - 866-234-7331 (Option 1)

WPS Health Insurance, ARISE, VAPC3, and Tricare – 800-782-2680 (Option 1)

or visit our website at:
http://www.wpshealth.com/resources/provider-resources/edi/
WPS EDI Disclaimer

This User’s Guide is designed to assist PC ACE users with entering claim data and preparing electronic claim files for transmission to WPS Health Solutions only. Not all the software functionality is addressed in this document. For additional assistance with the software, access the ‘Help’ function referenced above. It is the sole responsibility of the software user to ensure that all claim submission and/or policy requirements are met.

PC ACE is a standalone software. WPS Health Solutions does not support Networking or Server set up.

WPS does not support PC ACE software that has been downloaded onto a MAC based computer. This is also not supported by the vendor.

Go to https://www.wpsic.com/edi/pcacepro32.shtml on a quarterly basis (January, April, July and October), to update your program and avoid the software expiring.

**NOTE:** The Installation of PC ACE will create a folder in your C: Drive titled ‘WINPCACE”. It is important that this folder is not manipulated (Add, Remove or Move folders within this folder) in any way as it will cause the PC ACE software to not proper correctly.

Installation

Website Full Install

Go to: https://www.wpsic.com/edi/pcacepro32.shtml

Complete the following steps to install PC ACE:

• **Step 1:** Scroll down to the PC ACE Installations, Click the link titled “Download the PC ACE Full Install”
  (The screen shown below will appear.)
Step 2: Click “Run”

Step 3: You will be asked to enter a password to continue. You will want to contact one of the numbers below that applies to the line of Business you bill for, to receive the password.

Medicare Helpdesk:
1-866-518-3285 (Option 1) - J5 and J5 National
1-866-234-7331 (Option 1) - J8

Or by email
Part A  edimedicarea@wpsic.com
Part B  edimedicareb@wpsic.com

TRICARE/VAPC3/ARISE/WPS Health Insurance /Family Care/BLTS Help desk at:
1-800-782-2680 (Option #1).

Or by e-mail
edi@wpsic.com
**Note:** The password will appear as asterisks (*******) on your screen when you type it.

- **Step 4:** A window labeled ‘Drive Selection’ will appear. PC ACE must be installed on your systems hard drive (C). **DO NOT SELECT A DIFFERENT DRIVE.**

  ![Drive Selection Window](image)

  Do not change what appears in the destination drive field

  Click on **Next >**

- **Step 5:** A window labeled ‘Start Installation’ will appear.

  ![Start Installation Window](image)
Click on Next >.

**Step 6:** A ‘Read Me File’ window will now appear. Read this information.

Click on Next >.

**Step 7:** A window labeled ‘Installation Complete’ will appear.

Click on Finish >.

A PC ACE icon will appear on your desktop.
Website Upgrade

Quarterly updates to the software are created. You will need to regularly access the following link to determine if the current quarterly upgrade applies to your software. Please make sure you are always on the most current version of the software to utilize the most up-to-date industry information and business edits for the Line of Business you submit claims for.

If you have internet access on the computer with your PC ACE, please follow the directions below to upgrade via the internet. If you do not have internet access, please contact the EDI Help Desk to request that a disc with the upgrade be sent to you in the mail.

**Upgrade to the most recent version of PC Ace**

- **Note:** You must have the WPS version of PC ACE already installed to complete this upgrade.

**Step 1:**

- On the Main PC ACE toolbar select ‘Help’ and ‘Upgrade your PC Ace’. This will open your default internet browser to URL: http://www.wpsic.com/edi/pcacepro32.shtml. This is the website where you will find the link to upgrade to the most current version and find other helpful information regarding PC ACE.

*** Be sure your PC ACE is shut down after selecting ‘Upgrade your PC Ace or you will not be able to successfully upgrade. The Upgrade will not work while PC ACE is running.***

- Once on the website close, you’re PC ACE completely (the upgrade cannot be done while PC ACE is open). Be sure to view the ‘Upgrade Instructions’, as these instructions contain helpful information you should know, including how to obtain the
upgrade password. Then select: ‘Download the PC Ace Upgrade to Version…’ and proceed through the update.

**PC ACE Installations**

**PC ACE Full Installation V4.5**

(If you do not have any version of PC ACE on your PC)

- Complete Install Instructions
- Download the PC ACE Full Install for Version 4.5

**PC ACE Upgrade to V4.5**

(If you currently have a version of PC ACE on your PC)

- Upgrade Instructions
- Download the PC ACE Upgrade to Version 4.5
  **Note:** You must first quit PC ACE to install the upgrade.

**PC ACE Version 4.5 Change Summary**

- Professional Change Summary
- Institutional Change Summary

**Step 2:**

The ‘File Download’ box will appear

![File Download - Security Warning](image)

a) Select ‘Run’ if you wish to perform the upgrade now, while on-line.

b) Select ‘Save’ if you wish to save the file, pcaceup.exe, to your hard (C:) drive and run the upgrade later. **DO NOT SAVE PCACEUP.EXE TO YOUR WINPCACE FOLDER.** When you are ready to perform the upgrade, locate the file pcaceup.exe in your hard drive and double click on the file to execute the upgrade program.

**Step 3:**

A pop-up box will appear that acknowledges the PC ACE Claims Processing System Wise Installation Wizard has been initialized.
Step 4:

You will be asked to enter a password to continue. You will want to contact one of the numbers below that applies to the line of Business you bill for, to receive the password.

You can email the Medicare Helpdesk for Medicare at:
   edimedicarea@wpsic.com
   edimedicareb@wpsic.com

or call
   J5 and J5 National – 866-518-3285 (Option 1)
   J8 – 866-234-7331 (Option 1)

You can contact TRICARE/VAPC3/WPS Health Insurance/ARISE/Family Care/BLTS Help desk at:
   1-800-782-2680 (Option #1) or by e-mail at edi@wpsic.com.

Note: The password will appear as asterisks (*******) on your screen when you type it.

Step 5:

You will see a ‘Backup Reminder’, if you wish to back up your PC ACE prior to doing the upgrade click ‘No’ and do so. If not, click ‘Yes’ to proceed with the update.
Step 6:
Review the ‘Welcome’ information and follow the suggested actions. When you are ready to continue, click the ‘Next’ button.

Step 7:
Click the ‘Next’ button to continue with the upgrade.

Step 8:
Click the ‘Next’ button to continue with the upgrade.
Step 9:
Upon successful completion of the upgrade you will see the ‘Update Complete’ pop-up box. Click ‘Finish.’

Step 10:
The last notice is a ‘Backup Reminder’, be sure to run another backup after you have completed this upgrade. Click ‘Ok’ to exit.
Disk Full Install

Please complete the following steps to install your PC ACE software:

Step 1:

- Double-click the ‘setup.exe’ icon in your CD-ROM drive:

![setup.exe icon]

Step 2:

- You will be asked to enter a password to continue. You will want to contact one of the numbers below that applies to what line of Business you bill for, to receive the password.

**Medicare** Helpdesk:
1-866-518-3285 (Option 1) – J5 and J5 National
1-866-234-7331 (Option 1) – J8

Or by email
Part A edimedicarea@wpsic.com
Part B edimedicareb@wpsic.com

**TRICARE/VAPC3/ARISE/WPS Health Insurance /Family Care/BLTS Help desk at:**
1-800-782-2680 (Option #1).

Or by e-mail
edi@wpsic.com
Note: The password will appear as asterisks (*****) on your screen when you type it.

Step 3:

- Once the password is entered you will see the following warning. If you wish to proceed click 'Next'. If not, select 'Cancel' and the installation will close.

Step 4:

- A window labeled 'Drive Selection' will appear. PC ACE must be installed on your systems hard drive (normally the (C: drive). DO NOT SELECT A DIFFERENT DRIVE. Click ‘Next’ to proceed.
Step 5:

- You are now ready to begin the installation. Click ‘**Next**’ to begin the installation:

Step 6:

- You will see this screen as the installation begins:

Step 7:

- You will now see a ‘**Read Me**’ file. Read this information and click ‘**Next**’ to proceed:
Step 8:

- Click ‘Finish’ and the installation is complete:

- You will now have the **PC ACE** icon on your desktop:

---

**Disk Upgrade**

**Please complete the following steps to upgrade your PC ACE software to the most current version:**

**Step 1:**

- Double-click the ‘pcaceup.exe’ icon in your CD-ROM drive:
Step 2:

- You will be asked to enter a password to continue. You will want to contact one of the numbers below that applies to what line of Business you bill for, to receive the password.

  **Medicare** Helpdesk:
  1-866-518-3285 (Option 1) – J5 and J5 National
  1-866-234-7331 (Option 1) – J8

  Or by email
  Part A   edimedicarea@wpsic.com
  Part B   edimedicareb@wpsic.com

  **TRICARE/VAPC3/ARISE/WPS Health Insurance /Family Care/BLTS** Help desk at:
  1-800-782-2680 (Option #1).

  Or by e-mail
  edi@wpsic.com

![Password dialog box](image)

**Note:** The password will appear as asterisks (******) when you type it.
Step 3:

- You will see a ‘Backup Reminder’. If you wish to back up your PC ACE prior to doing the upgrade, click ‘No’. If not, click ‘Yes’ to proceed with the update.

![Backup Reminder](image1)

Step 4:

- You will now see the following warning. If you wish to proceed click ‘Next’. If not, select ‘Cancel’ and the update will close.

![Warning](image2)

Step 5:

- You are now ready to start the update. Click ‘Next’.

![Start Update](image3)
Step 6:

- You will see this screen as the upgrade begins installing:

![Installing Screen](image)

Step 7:

- You will now see a 'Read Me' file. Read this information and click 'Next' to proceed:

![Read Me File](image)
Step 8:

- Click ‘Finish’ and the update is complete:

![Update Complete Window]

Step 9:

- You will see a ‘Backup Reminder’. Read the reminder and click ‘OK’.

![Backup Reminder Window]

- You have now been updated to the most recent version of PC ACE!
**Access/Exit PC ACE**

Once PC ACE installation is complete, an icon for the software will be present on your desktop. Double click the 'PC Ace' icon to begin using the software.

The ‘Main Form’ of PC ACE should now appear on your screen.

- Click the ‘X’ in the upper right corner of the ‘Main Form’ to exit the software.

  You will receive a text message asking if you wish to back up the software.

- If you wish to back-up your software, enter a path indicating where you want the software backed up in the field labeled ‘Destination Drive or Folder’ then click ‘Start Backup’.

- Click ‘Cancel’ if you do not wish to back up PC ACE now.
Overview of PC ACE ‘Main Form’

Institutional Claims Processing

Professional Claims Processing

Reference File Maintenance

Data Communications Functions (not used at this time)

Claim Activity Scheduling (not currently available)

ANSI 835 Functions (can be used to process Electronic Remittance Notice (ERN) files.)

System Utilities

Sign On

Each time you begin a PC ACE session by selecting from the Main Form, you will be prompted to enter a User ID and Password.

The initial User ID is SYSADMIN. The initial password is SYSADMIN. This User ID and password can be used at any time to initiate a PC ACE session. You can also set up your own PC ACE User IDs and passwords by accessing the security option from the Main Form toolbar.
Security/Create Users ID’s

WPS Health Solutions suggests that a unique User ID be created for each individual PC ACE user in your office.

**Note:** The User IDs and passwords you create for PC ACE have nothing to do with your User ID and Passwords for the WPS Bulletin Board System (BBS) or Gateway Express Website. User IDs for these systems assigned by WPS Health Solutions EDI staff and are not affected by PC ACE access. Do not confuse the two.

Complete the following steps to create a new PC ACE User ID:

● **Step 1:** Click on ‘Security’ from the ‘Main Form’ toolbar and select ‘Add/Update’ user.

![PC-ACE Pro32 Claims Processing System](image)

● **Step 2:** Click ‘New’ at the bottom of the ‘Security List’ screen that appears:

![Security List](image)

The ‘User Security Update’ screen will appear.
•**Step 3:** Enter the User ID and Password you wish to assign in the appropriate fields. Then enter the user’s name.

![User Security Update screen](image)

**Step 4:** Use the scroll bar at the right of the **User Security Update** screen to view access options. Click on the access option(s) you wish to grant to this user.

If you wish to give the user full access to all options you are licensed for, click ‘Check All’.

**Step 5:** Click ‘Ok’ when you have finished with this user. You will be returned to the **Security List** and the user you added will appear on the list.

You can make changes at any time by selecting the user you wish to change and clicking on ‘View/Update’ and modifying the record.

**PC ACE Key Mouse Functions**

**Basic Key Functions:**

- **<Tab>** Press the **<Tab>** key will move your cursor forward from one field to the next in all screens.

- **<Shift><Tab>** Hold down the **<Shift>** key and pressing **<Tab>** to move your cursor back one field within any screen.

- **<F2>** Press the **<F2>** key to display a menu of valid values when your cursor is in a field with an associated ‘lookup’.
<Alt><F2> Hold down the <Alt> key and press <F2> to display all the fields on any screen with associated ‘lookup’ menus of valid values.

<F4> Press <F4> to copy data from the same field on the previous line when entering line item data.

<Backspace> Press <Backspace> to move backward one space within a field while deleting data.

Basic Mouse Functions

‘Left Click’ Use a single left click to make menu selections, select screen tabs, activate buttons, etc.

**Note:** Any time you are instructed to ‘click’ on (or select) an item, assume it is a single left click unless otherwise specified.

‘Right Click’ Use a single right click to display a menu of valid values when your cursor is in a field with an associated ‘lookup’. (Same as <F2>)

**Note:** Once you have finished using any of the PC ACE screens, click ‘X’ in the upper right corner of the screen to exit and return to the previous menu or Main Form.
Getting Started

Before entering claim data, you will need to complete some system setup. Specifically, you will need to create a **Submitter Reference File**, **Provider Reference File** and **Payer Reference File** on the ‘Reference File Maintenance’ database.

The ‘Reference File Maintenance’ database is also used to enter Patient records, Attending/Operating/Rendering/Referring/Other Provider records and Facility records as well as others. These records can be created ‘on-the-fly’ while entering claim information and do not have to be present prior to claim entry.

System Setup/Reference File Maintenance

Submitter File Setup

**Must** be completed before claim entry.

The first file that needs to be setup is the ‘Submitter’. This file attaches Submitter information to each file you create and transmit to WPS Health Solutions. A separate ‘Submitter’ record needs to be added for **EACH** line of business you will be billing for (i.e. TRICARE, VAPC3, ARISE, WPS Health Insurance or Medicare).

If you submit claims using only one WPS Submitter ID (regardless of how many Lines of Business, you submit to) then you will simply update the <ALL> <ALL> default record. Follow step 5 but instead of clicking ‘New’, select ‘View/Update’ (note, you will not be able to update the LOB and Payer ID field because this information will apply to ALL claims created).

Separate ‘Submitter’ records need to be added for Institutional and Professional claims if you plan on submitting both types. Each ‘Submitter’ record needs to be created one time only.

Complete the following steps to create an Institutional claims ‘Submitter’ record:

- **Step 1:** Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

![Reference File Maintenance](Image)
• **Step 2:** Select the ‘Codes/Misc’ Tab from the ‘Reference File Maintenance’ screen that appears.

![Reference File Maintenance](image)

• **Step 3:** Select the ‘Submitter’ button from the list of Reference Files on the ‘Codes/Misc’ tab.

![Submitter](image)

• **Step 4:** Click the ‘Claim Type – Institutional’ radio button near the top of the ‘Submitter Setup’ screen.

![Submitter Setup](image)

• **Step 5:** Click ‘New’ at the bottom of the ‘Submitter Setup’ list that appears.
•**Step 6:** Complete the following ‘**Required**’ fields on the ‘**General**’ Tab of the ‘**Institutional – Submitter Information**’ screen:

![Institutional Submitter Information](image)

1. **LOB Field (Line of Business) – Required**
   (Right click in field to obtain list of values.)
   - TRI = TRICARE
   - COM = WPS Health Insurance
   - MCA = Medicare Part A
   - VA = VAPC3

2. **Payer ID Field – Required**
   (Right click in field to obtain list of values.)
   - 08101 = Medicare A for Indiana
   - 05901 = Medicare A for J5 National
   - 08201 = Medicare A for Michigan
   - 05101 = Medicare A for Iowa
   - 05201 = Medicare A for Kansas
   - 05301 = Medicare A Missouri
   - 05401 = Medicare A for Nebraska
   - ‘WPS’ = WPS Health Insurance
   - ‘00235’ = WPS Secondary Medigap
   - ‘ARISE’ = ARISE
   - ‘EPIC’ = EPIC
   - ‘FOREN’ = TRICARE Overseas (Foreign)
   - ‘TDFIC’ = TDFIC Direct (5010 Only)
   - ‘TREST’ = TRICARE EAST
   - ‘VAPCCC3’ = Patient-Centered Community Care (VAPC3 Region 3)
   - ‘VAPCCC5A’ = Patient-Centered Community Care (VAPC3 Region 5A)
   - ‘VAPCCC5B’ = Patient-Centered Community Care (VAPC3 Region 5B)
   - ‘VAPCCC6’ = Patient-Centered Community Care (VAPC3 Region 6)
3. **ID Field – Required**
Enter your WPS Submitter ID (User ID for the WPS Bulletin Board System (BBS) and Gateway Express Website). Press <Tab> to go on to the next field.

4. **EIN Field (Employer Identification Number) – Not Applicable**
Press <Tab> to skip this field.

5. **Name Field – Required**
Enter the submitter’s company name. Press <Tab>.

6. **Address/City/State/Zip Fields – Required**
Complete these fields with the submitter address information. Press <Tab> to move from field to field.

7. **Phone Field – Required**
Enter the submitter’s telephone number, including the area code. Press <Tab>.

8. **Fax Field – Optional**
Enter the submitter’s Fax number, including the area code or press <Tab> to leave this field blank.

9. **Country Field – Not Applicable**
Press <Tab> to skip this field.

10. **Contact Field – Required**
Enter the submitter’s contact name (your name). Press <Tab>.
Step 7: Complete the following '*Required* fields on the 'Prepare' Tab:

![Institutional Submitter Information](image)

1. **Include Error Claims Field** – *Required*
   The default is 'N' for 'No'. Leave this field as is. Press <Tab> to access the next field.

2. **Submission Status Field** – *Required*
   - 'P' = Production File
   - 'T' = Test File
   Choose 'P' when building your Submitter Setup

3. **EMC Output Format Field** – *Required*
   - 'A' = ANSI – 837 output format

4. **ANSI Version (837) Field** – *Required*
   The default is '005010A2'. Leave this field as is. Press <Tab> to access the next field.

5. **ANSI Version (270) Field** – *Required*
   The default is '005010A1'. Leave this field as is. Press <Tab> to access the next field.
6. **ANSI Version (276) Field – Required**

The default is '005010'. Leave this field as is. Press <Tab> to access the next field.

7. **EMC File Field – Required (IMPORTANT!)**

Enter your Submitter ID (User ID) followed by .DAT

**Example:** If your User ID is 94999, type 94999.DAT (Note: This is an EXAMPLE. Your Submitter/User ID is specific to you!)

**This field determines the name of the file that is created and transmitted to WPS Health Solutions**

8. **Vendor – Leave Blank**

9. **Intermediary Fields – Default is 00451. If different please contact the Edi help Desk**

**Vendor/Intermediary and Next Serial No./Next File Seq. Fields are automatically tracked by the software and should not be change/accessed by the user.**

10. **Next Serial No./Next File Seq. Fields – System Automatically Assigns**

**Step 8:** Complete the following ‘Required’ fields on the ‘ANSI Info’ Tab.

1. **Submitter Intchg ID Qual Field – Required**

Enter ‘ZZ’ for all Lines of Business

2. **Receiver Intchg ID Qual Field – Required**
Enter ‘28’ or ‘ZZ’ for all Lines of Business

3. **Authorization Info Field – Not Used**

Leave this field blank.

4. **Security Info Field – Not Used**

Leave this field blank.

5. **AcknowledgementRequested Field – Not Used**

Leave this field blank.

6. **AdditionalSubmitter EDI Contact Information Fields – Optional**

These fields can be used to enter your email address, fax number, etc. They can be left blank.

**Note:** Information is not required on the ‘ANSI Info (2)’, ‘ANSI Info (3)’ or the ‘ANSI Info (4)’ tabs.

**Step 9:** Once you have completed all the required fields on the ‘General’, ‘Prepare’ and ‘ANSI Info’ tabs, click ‘Save’.

You will be returned to the initial ‘Submitter Setup’ screen and the Submitter Record that you added will appear on the list.

Complete the same steps to create another ‘Submitter’ record if you will be submitting claims for a different Line of Business (LOB) with a separate WPS Health Solutions Submitter ID. Note, it is not necessary to have more than one WPS Health Solutions Submitter ID even if you submit claims for multiple Lines of Business, but some may prefer it.

Complete the same steps to create a ‘Submitter’ record for Professional claims if you intend to submit that claim type as well. (Refer to the PC Ace Users Guide for the Professional claim type to obtain additional information.)

You can modify/correct or update the information in any of your ‘Submitter’ records by selecting the record from the ‘Submitter Setup’ screen and click ‘View/Update’. Be sure to click ‘Save’ after making any modifications.
Provider File Setup

Must be completed before entering claim data.

Complete the following steps to create an Institutional provider record:

**Note:** Separate Professional provider records must be created if you plan on using PC ACE for creation of Professional claims.

- **Step 1:** Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

- **Step 2:** Select the ‘Provider (Inst)’ Tab from the ‘Reference File Maintenance’ screen that appears.

- **Step 3:** Click ‘New’ at the bottom of the ‘Provider (Inst)’ screen that appears.
• Step 4: Select ‘Create a completely new provider (all fields blank)’ from the ‘New Provider Options’ window that appears. Click ‘OK’.

** Note: If no Providers have previously been set up, when you click new you will be taken to the screen in Step 5 to enter the Provider Information. If any Providers have already been set up, then you will have the option to ‘Inherit name/address information from the selected provider’ or ‘Create a completely new provider (all fields blank)’, as seen below. The inherit option allows you to copy information from another Provider and then make updates according to the new providers specifications. Either selection will take you to the ‘Provider Information – General Info’ Tab. This is where you will enter new information or update inherited information.

• Step 5: Complete the following ‘Required’ fields on the ‘Institutional Provider Information – General Info’ Tab:
1. **Name Field – Required**
   
Enter the provider name (institution name) in this field.

2. **Address/City/St/Zip – Required**
   
Enter the provider’s address, city, state and zip code in the appropriate fields. This is the institution’s physical address. It is not necessarily the billing address.

   - This **MUST BE A PHYSICAL ADDRESS**.
   - Do not use PO Boxes.
   - The Zip Code must be 9 digits

3. **Phone Field – Required**
   
Enter the provider’s telephone number (including the area code).

4. **Fax Field – Optional**
   
Enter the provider’s fax number (including the area code) if applicable.

5. **Contact Field – Required**
   
Enter the provider contact name.

6. **Provider ID/No. Field – Required**
   
Enter the Provider’s ID that is appropriate for the line of business this record will be used for.

   ♦ For Medicare Part A, this field should contain the assigned National Provider Identifier (NPI) provider or the PTAN.
   ♦ For WPS Health Insurance, TRICARE and VAPC3, this is the provider’s Tax ID.
   
   **Note:** Provider ID/NO Type on the ‘Extended Info’ Tab should be ‘EI’ for VAPC3.
7. **LOB Field (Line of Business) – Required**

Press `<F2>` or ‘right click’ while your cursor is in the field to obtain a list of valid Line of Business values.

- TRI = TRICARE
- COM = WPS Health Insurance
- MCA = Medicare Part A
- VA = VAPC3

8. **Payer ID Field – Required**

Press `<F2>` or ‘right click’ while your cursor is in the field to obtain a list of valid Payer ID values.

- 08101 = Medicare A for Indiana
- 05901 = Medicare A for J5 National
- 08201 = Medicare A for Michigan
- 05101 = Medicare A for Iowa
- 05201 = Medicare A for Kansas
- 05301 = Medicare A Missouri
- 05401 = Medicare A for Nebraska
- ‘WPS’ = WPS Health Insurance
- ‘00235’ = WPS Secondary Medigap
- ‘ARISE’ = ARISE
- ‘EPIC’ = Epic
- ‘FOREN’ = TRICARE Overseas (Foreign)
- ‘TDFIC’ = TDFIC Direct (5010 Only)
- ‘TREST’ = TRICARE EAST
- ‘VAPCCC3’ = Patient-Centered Community Care (VAPC3 Region 3)
- ‘VAPCCC5A’ = Patient-Centered Community Care (VAPC3 Region 5A)
- ‘VAPCCC5B’ = Patient-Centered Community Care (VAPC3 Region 5B)
- ‘VAPCCC6’ = Patient-Centered Community Care (VAPC3 Region 6)

9. **Tag Field – Optional**

This field can be used to ‘Tag’ this provider record for your identification. The data from this field is not required, nor is it submitted to WPS Health Solutions. You can press `<Tab>` to bypass this field.

10. **NPI – Required**

The National Provider Identifier ID (NPI) assigned to this provider (for ANSI 837 use only).

**Note:** If you are an atypical provider who is not required to obtain an NPI, please enter EXEMPT in the NPI field.

11. **Tax ID/Type Field – Required**
Enter the 9-digit number assigned to the provider by the Federal Government. **Do not include hyphens or spaces.**

Press `<F2>` or ‘right click’ while your cursor is in the field to obtain a list of Tax Type values. Enter:

- E – Employer Identification Number

12. **Tax Sub ID Field – Not Applicable**

Press `<Tab>` to bypass this field.

13. **Taxonomy Field – Optional**

Press `<F2>` or ‘right click’ while your cursor is in this field to obtain a list of valid Provider Taxonomy codes.

14. **Country Field – Optional**

Press `<Tab>` to bypass this field.

15. **Site Field – Not Applicable**

Press `<Tab>` to bypass this field.

16. **Include in Lookups Field – Required**

The default value for this field is ‘Y’ for ‘Yes’. Leave this as is.

**Step 6:** Once you have completed all the fields on the ‘General Info’ tab, select the ‘Extended Info’ tab.

![Institutional Provider Information](image)

**Note:** None of the fields on the ‘Institutional Provider Information – Extended Info’ tab is required. Complete any that applies to this provider record.
• Step 7: Once you have completed all the required ‘Institutional Provider Information’ fields, click ‘Save’.

If any required fields are not completed or if any fields contain invalid code values, the specific errors will be highlighted. You will need to make corrections before saving the record.

Once the record has been saved, you will be returned to the ‘Provider’ Tab of the ‘Reference File Maintenance’ screen. The provider records you added will appear on the list. If you wish to view or modify the record, click ‘View/Update’, make any necessary changes and ‘Save’ the record again.

Payer File Setup

Must be completed before entering claim data if the Payer ID is not already on the list. If the Payer ID is on the list already, no action is necessary.

Anytime you need to report insurance coverage other than Medicare Part A, TRICARE, VA PC3, ARISE or WPS Health Insurance, a ‘Payer’ record must exist for the plan before entering patient data and claim information. You will need to create a ‘Payer’ record for each insurance company/benefit that your patients have as PRIMARY or SECONDARY plans. Complete the following steps to create a ‘Payer’ reference file record for a primary or secondary insurance plan/benefit:

• Step 1: Select ‘Reference File Maintenance’ from the PC ACE Main Form.

• Step 2: Select the ‘Payer’ Tab from the ‘Reference File Maintenance’ screen that appears.

A list of ‘Payer’ records that have already been added to the file will be displayed.

• Step 3: Click ‘New’ at the bottom of the ‘Payer’ list.
•Step 4: Complete the following ‘Required’ fields on the ‘Payer Information’ screen:

1. Payer ID Field – Required

Enter the ‘Payer ID’ assigned to this Payer.

If you do not know the ‘Payer ID’, use ‘99999’.

2. LOB Field (Line of Business) – Required

Press <F2> or ‘right click’ while your cursor is in the field to obtain a list of valid values.

- ‘BC’ = Blue Cross (Inst)
- ‘BS’ = Blue Shield (Prof)
- ‘COM’ = Commercial Insurance Plan
- ‘GAP’ = Medigap Policy
- ‘HMO’ = Managed Care
- ‘MCA’ = Medicare Part A
• ‘MCB’ = Medicare Part B
• ‘MCD’ = Medicaid
• ‘TRI’ = TRICARE
• ‘VA’ = VAPC3

3. **Receiver ID Field** – *Not Applicable for Primary and Secondary Payers*

   Press <Tab> to bypass this field.

4. **ISA08 Override** – *Not Applicable*

   Press <Tab> to bypass this field.

5. **Full Description Field** – *Required*

   Enter the ‘Payer’ (Insurance Plan/Benefit) name.

6. **Address/City/State/Zip Fields** – *Optional*

   Enter the payer’s address in the appropriate fields if known. WPS Health Solutions recommends that you complete these fields.

7. **Contact Name/Phone/Ext/Fax fields** – *Optional*

   Enter the name and telephone/fax number(s) of your contact at this payer’s office if known.

8. **Source Field** – *Required*

   Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid ‘Source’ values. Select the most appropriate value for this payer.

9. **Media Field** – *Optional*

   Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid ‘Media’ values. Select the most appropriate value for this payer.

10. **Usage Field** – *Leave Blank*

    Leave this field blank. The software will auto-populate this field.
Step 5: Once you have completed all the required `Payer Information` fields, click `Save`.

If any required fields are not completed or if any fields contain invalid code values, the specific errors will be highlighted. You will need to make corrections before saving the record.

Once the record has been saved, you will be returned to the `Payer` Tab of the `Reference File Maintenance` screen. The payer records you added will appear on the list. If you wish to view or modify the record, click `View/Update`, make any modifications and save the record again.

Physician File Setup

Records can be added to this file `on-the-fly` while entering claim data.

Create a `Physician` record for all `Attending`, `Operating`, `Referring`, `Rendering` or `Other`, providers. The provider records from this file can be inserted into any claim you enter.

Complete the following steps to create a `Physician` record:

**Step 1:** Select `Reference File Maintenance` from the PC ACE `Main Form`.

**Step 2:** Select the `Codes/Misc` Tab from the `Reference File Maintenance` screen that appears.

**Step 3:** Select the `PHYSICIAN` button from the list of Reference Files on the `Codes/Misc.` Tab.
• Step 4: Click ‘New’ at the bottom of the ‘Physician’ list that appears.

![Image of Physician Setup window]

• Step 5: Complete the following ‘Required’ fields on the ‘Physician Information’ screen:

![Image of Physician Information window]

1. **Physician ID/Type Field** – *Optional*

   Enter the physician’s(provider’s) ID.

   Enter the ‘Type’ of physician.

   Press <Tab> to access the next field.

2. **Physician’s Last Name/First Name/MI** – *Required*

   • Enter the physicians/providers Last Name.
   Press <Tab>.

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Enter the physicians/providers First Name (or at least first initial). Press <Tab>.

The physicians/providers Middle Initial (‘MI’) is optional. Press <Tab>.

3. **Address/City/State/Zip/Phone – Optional**

Enter the physician’s/provider’s address, city, state, zip and phone number in the appropriate fields if known.

4. **Federal Tax ID/Type – Optional**

Enter the physician’s/provider’s Federal Tax ID in the appropriate field if known. **Do not include hyphens or spaces.** The ‘Type’ E must be entered in the smaller of the two fields if you indicate the Federal Tax ID.

5. **NPI (National Provider Identifier) – Required**

Enter the physician’s/provider’s National Provider Identifier in the appropriate field.

**Note:** If you are an atypical provider who is not required to obtain an NPI please enter **EXEMPT** in the NPI field.

**Step 6:** Click ‘Save’ to store the record.

You will be returned to the initial ‘Physician Setup’ screen and the Provider record that you saved will appear on the list.

Complete the same steps to create another ‘Physician’ record.

You can modify/correct or update the information in any of your ‘Physician’ records by selecting the record from the ‘Physician Setup’ screen and clicking ‘View/Update’. Be sure to click ‘Save’ after making any modifications.

Facility File Setup

- **Not required for Institutional claims.** –
Records can be added to this file ‘on-the-fly’ while entering claim data.

Create a ‘Facility’ record for all facilities (other than the patient’s home or provider’s office) where services you bill are provided.

Complete the following steps to create a ‘Facility’ record:

• **Step 1:** Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

• **Step 2:** Select the ‘Codes/Misc.’ Tab from the ‘Reference File Maintenance’ screen that appears.

• **Step 3:** Select the ‘Facility’ button from the list of Reference Files on the ‘Codes/Misc.’ Tab.

• **Step 4:** Click ‘New’ at the bottom of the ‘Facility’ list that appears.
Step 5: Complete the following Required fields on the ‘Facility Information’ screen that appears:

1. **Facility ID/Type Field** – Optional
   
Enter the facility ID if known. Press <Tab>.  
In the ‘Type’ field, enter the ‘Type’ or ‘right click’ while in the ‘Type’ field for a list of options.

2. **Facility Name** – Required
   
Enter the name of the facility. Press <Tab>.

3. **Address/City/St/Zip** – Required for HIPAA.
   
Enter the facility address, city, state and zip code.

4. **Facility Type** – Required
   
Press <F2> or ‘right click’ for a list of facility type options.

5. **Tax ID/Type** – Required
   
Enter the provider tax id, and ‘Type’ = E

6. **NPI** – Required
   
Enter the National Provider ID (NPI) assigned to this provider.
Note: If you are an atypical provider who is not required to obtain an NPI please enter EXEMPT in the NPI field.

**Step 6:** Click ‘Save’ to store the record.

You will be returned to the initial ‘Facility Setup’ screen and the Facility record that you saved will appear on the list.

Complete the same steps to create another ‘Facility’ record.

You can modify/correct or update the information in any of your ‘Facility’ records by selecting the record from the ‘Facility Setup’ screen and clicking ‘View/Update’. Be sure to click ‘Save’ after making any modifications.

**Patient File Setup**

Records can be added to this file ‘on-the-fly’ while entering claim data. You need to create a Patient File record for each patient either before entering claims for that patient or while entering the first claim for the patient.

The Patient Information function of PC ACE consists of 5 separate tabs. Please complete the following ‘**Required**’ tabs:

- **General Information Tab** *(Required)*
  
  This tab contains general information such as the patient’s name, address and demographic information.

- **Extended Information Tab** *(Optional)*
  
  This tab contains ‘Legal Representative’ and patient-specific provider information. None of this information is required.

- **Primary Insured Tab** *(Required)*
  
  This tab contains information regarding the patient’s PRIMARY INSURANCE information. This tab can contain Medicare Part B information if Medicare is the primary payer. It can also contain WPS Health Solutions information or information pertaining to any other primary payer.

- **Secondary Insured Information** *(Situational)*
  
  This tab must be completed only if the patient has a secondary insurance benefit (i.e. TRICARE/VAPC3 supplemental policy, etc.).

- **Tertiary Insured Information** *(Optional)*

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This tab is used to report information pertaining to a patient’s third insurance benefit if applicable.

Complete the following steps to create a new patient record:

• **Step 1:** Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

  ![Reference File Maintenance](image)

  **Note:** If you are entering the patient record while keying the first claim for the patient, you will access the Patient File by right clicking on the ‘Patient Control No.’ field on the first claim entry screen.

• **Step 2:** Select the ‘Patient’ Tab from the ‘Reference File Maintenance’ screen that appears.

  ![Reference File Maintenance](image)

• **Step 3:** Click ‘New’ at the bottom of the ‘Patient’ Tab screen that appears.

  ![Reference File Maintenance](image)

  The ‘Patient – General Information’ Tab will be displayed.
Step 4: Complete the following **Required** fields on the ‘**Patient – General Information**’ tab:

1. **Last Name Field – Required**
   Enter the patient’s last name.

2. **First Name Field – Required**
   Enter the patient’s first name.

3. **MI (Middle Initial) Field – Optional**
   Enter the patient’s Middle Initial or press **<Tab>** to bypass the field.

4. **Gen. (Generation) Field – Optional**
   Enter any applicable ‘generation’ information (i.e. I, II, III, Jr, Sr, etc.) or press **<Tab>** to bypass the field.

5. **Patient Control No. (PCN) Field – Required**
   Enter a ‘**Patient Control Number**’ that you have assigned to this patient. This field can be any patient account number you wish to use. The data can be alpha, numeric or a combination of the 2 data types.
6. **Address/City/State/Zip Fields – Required**

Enter the patient’s address, city, state and zip code in the appropriate fields.

7. **Phone Field – Optional**

Enter the patient’s home telephone number (including the area code) or press `<Tab>` to bypass the field.

8. **Active Field – Required**

Enter ‘Y’ to indicate that this is an active patient. ‘N’ will indicate that the patient record is inactive.

9. **Sex Field – Required**

Enter ‘F’ for female; ‘M’ for Male.

10. **DOB (Date of Birth) Field – Required**

Enter the patient’s date of birth (MM/DD/CCYY). You must use the 4-digit year (i.e. 1944).

11. **Marital/Employment Status Fields – Optional**

Press `<F2>` or ‘right click’ in any of these fields to obtain a list of valid values for each. You can press `<Tab>` to bypass these fields.

12. **Student Status Field – Optional**

Press `<F2>` or ‘right click’ in the field to obtain a list of valid values.

13. **CBSA – Situational**

Core Based Statistical Area, a 5-digit code specifying the core statistical area in which the patient lives. Used
during patient lookup on specific Institutional Medicare claims to populate the Value Code 61 amount.

14. **Discharge Status Field – Optional**

This applies to Institutional claim billing only. Press <Tab> to bypass the field.

15. **Death Ind. Field – Optional**

‘Y’ indicates that the patient is deceased. ‘N’ or blank indicates that the patient is not deceased. You can press <Tab> to bypass this field.

16. **DOD (Date of Death) Field – Situational**

Enter the date of death (if applicable) or press <Tab> to bypass the field.

17. **Signature on File (2 Fields)**

- **First Field (SOF1) – Required**

  This field is for Institutional claim filing only. ‘Y’ indicates that the facility has the patient’s signature on file.

- **Second Field (SOF2) – Required**

  Press <F2> or ‘right click’ while in this field to obtain a list of valid ‘Signature on File’ values.

18. **Release of Info. Field – Required**

‘Y’ – The provider has a signed statement permitting data release.

‘I’ – Informed consent to release data regulated by statute.

19. **ROI (Release of Information) Date – Optional**
Enter the date the patient authorized the release of information. (MM/DD/CCYY).

•Step 5: Once you have completed the required fields on the ‘Patient – General Information’ tab, you can select the optional ‘Patient – Extended Information’ tab and complete any of the fields that may apply.

•Step 6: Select the ‘Primary Insured (Inst)’ tab and complete the following ‘Required’ fields.

Note: If the patient has the same insurance coverage for institutional and professional claims, click on the ‘Common Inst & Prof’ radio button near the top, right corner of this tab. The information you enter will then be applied to both claim types that are entered for this patient.

1. **Payer ID Field – Required**

Press <F2> or ‘right click’ while your cursor is in this field to access the ‘Payer Selection’ screen from the ‘Reference File – Payer Tab’. Left click on the record from this selection screen that corresponds with this patient's primary insurance and click ‘Select’.
You will be returned to the ‘Patient – Primary Insured’ screen and the required ‘Payer ID’, ‘Payer Name’ and ‘LOB’ fields will be completed.

**Note:** All payers MUST have a record on in the ‘Payer’ reference file BEFORE entering patient information. You MAY need to add payer records.

2. **Group Name – Optional**

   This field does not apply to TRICARE/VAPC3. Enter the Group Name for WPS Health Insurance or any other benefit or press <Tab> to bypass the field.

3. **Group Number – Optional**

   This field does not apply to TRICARE/VAPC3. Enter the Group Number for WPS Insurance or any other benefit or press <Tab> to bypass the field.

4. **Claim Office – Optional**

   This field does not apply to TRICARE/VAPC3 or WPS Health Insurance. Enter the Claim Office ID for any other benefit or press <Tab> to bypass the field.

5. **Rel (Relationship) Field – Required**

   This field appears on the ‘Insured Information’ tab at the bottom of the ‘Primary Insured’ tab screen.

   **Note:** If the patient is the insured (TRICARE/VAPC3/ARISE Sponsor or WPS Customer) and you enter ‘01’ in the ‘Rel’ field,
most of the other required ‘Insured Information’ tab will be filled with the patient’s information. You will only need to complete the ‘Insured ID’ and ‘Assign of Benefits’ fields.

6. **Last Name Field – Required**

   Enter the insured’s (TRICARE/VAPC3/ARISE Sponsor or WPS Customer) last name.

7. **First Name Field – Required**

   Enter the insured’s (TRICARE/VAPC3 Sponsor or WPS Customer) first name.

8. **MI (Middle Initial) Field – Optional**

   Enter the insured’s middle initial or press <Tab> to bypass the field.

9. **Gen (Generation) Field – Optional**

   Enter the insured’s generation (i.e. II, III, Jr, Sr, etc.) or press <Tab> to bypass the field.

10. **Insured ID Field – Required**

    Enter the Insured ID. For TRICARE/VAPC3, this is the TRICARE/VAPC3 Sponsor’s Social Security Number. Check the TRICARE/VAPC3 Insurance card for the appropriate TRICARE/VAPC Sponsor number. For WPS Health Insurance, this is the Customer Number from the patient’s insurance card.

11. **Address/City/State/Zip Fields- Optional**

    Enter the insured’s address, city, state and zip code in the appropriate fields or press <Tab> to bypass each field.
12. **Country** - *Optional*
   
   Insured individual’s Country code (if other than U.S., for ANSI 837 use only).

13. **Telephone Field** – *Optional*
    
Enter the insured’s telephone number (including the area code) or press <Tab> to bypass the field.

14. **Sex Field** – *Required*
    
Enter ‘F’ if the insured is female; ‘M’ if the insured is male.

15. **DOB (Date of Birth) Field** – *Required*
    
Enter the insured’s date of birth (MM/DD/CCYY).

   **Note:** This information is required by HIPAA.

16. **Employ Status Field** – *Optional*
    
   This field indicates the insured’s employment status.
   Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid employment status code values or press <Tab> to bypass the field.

17. **Assign of Benefits Field** – *Required*
    
Enter ‘Y’ if the provider is authorized to receive benefit payments on behalf of the insured individual. Enter ‘N’ if this is not the case.

18. **Release of Info Field** – *Required*
    
   ‘Y’ – The provider has a signed statement permitting data release.

   ‘I’ – Informed consent to release data regulated by statute.
19. **ROI Date Field – Optional**

Enter the date the patient/insured authorized the release of information. (MM/DD/CCYY).

20. **Retire Date – Optional**

Enter the insured’s retirement date (if applicable) or press <Tab> to skip this field.

**Step 7:** If the patient has a secondary insurance benefit, select the ‘Secondary Insured’ Tab and complete the same fields you completed on the ‘Primary Insured’ Tab. You can indicate ‘Common Institutional and Professional’ secondary payers.

Remember, the ‘Payer’ information must reside on the ‘Payer’ Tab of the ‘Reference File Maintenance’ function before completing the patient’s insured information.

**Step 8:** If the patient has a tertiary (third) insurance benefit select the ‘Tertiary Insured’ Tab and complete the same fields you completed on the ‘Primary Insured’ Tab.

Remember, the ‘Payer’ information must reside on the ‘Payer’ Tab of the ‘Reference File Maintenance’ function before completing the patient’s insured information.

**Step 9:** Once you have entered the patient’s general information, primary insured information and any applicable secondary and tertiary insured information, click ‘Save’ at the bottom of the ‘Patient Information’ screen.

If you have not completed any required patient information, a list of errors will appear. The fields involved will be highlighted. Correct these fields and click ‘Save’ again.

After the patient record has been saved, you will be returned to the ‘Patient’ tab of the ‘Reference File Maintenance’ screen. The patient you just added will appear on the ‘Patient’ list.

Create a Claim File for Submission to WPS

**Step 1:** Enter Claim Information
Step 2: List Claims and Create a Detail Report

Step 3: Prepare Claims (Create Claim File for Transmission)

Step 4: Transmit your Claim File using the WPS Bulletin Board System (BBS) or Gateway Express Website

Enter Claim Information

The claim entry function of PC ACE consists of multiple ‘tabs’ of data. Some of the data required on these ‘tabs’ will be filled when you select records from other files (i.e. Patient/Insured Information, Provider Information, etc.).

The layout of the claim entry screens basically follows the layout of the Institutional claim form. Most fields are labeled with the corresponding Form Locator from the claim form.

Complete the following steps to enter claim information:
• Step 1: Institutional Claims Processing.

Select ‘Institutional Claims Processing’ from the ‘Main Form’

The ‘Institutional Claims Menu’ will appear:

• Step 2: Enter Claims.

Select ‘Enter Claims’ from the ‘Institutional Claims Menu’

The ‘Institutional Claim Form’ window will be displayed. The first tab, ‘Patient Info and Codes’ will be presented initially.

• Step 3: Patient Info & Codes.

Complete the following ‘Required’ fields on the ‘Patient Info & Codes’ tab. This tab contains the information that appears at the top portion of the Institutional claim form.
1. **LOB (Line of Business) Field – Required**

Press `<F2>` or ‘right click’ while your cursor is in this field to obtain a list of valid ‘LOB’ codes.

**Note:** If the software is licensed to you for one LOB only, that code value will automatically appear.

2. **Patient Control No. Field – Required**
   *(Form Locator 3)*

Press `<F2>` or ‘right click’ while your cursor is in this field to access a list of patients’ you have already entered in PC ACE. You can select the patient record from this list. **Hint:** Use the ‘List Filter’ section at the bottom of the ‘Patient Selection’ window that appears to sort the list by PCN (Patient Control Number) or Patient Name.

If the patient records you wish to use does not appear on the list, click ‘New’ and add the patient record.

Click ‘Select’ once you have highlighted the patient record you wish to use. You will be returned to the Institutional Claim Form and the patient information fields (patient name, address, birth date, etc.) will be filled in for you.

3. **Type of Bill Field – Required**
   *(Form Locator 4)*

Either enter the ‘Type of Bill’ or ‘right click’ for a complete list of values for the first 2 positions in the ‘Type of Bill’. The third character is the ‘Frequency Code’, enter the appropriate character based on the claim you are submitting.
4. **Patient Last Name/First Name/MI – Required**  
(Form Locator 12)

These fields will all be automatically filled after you select the appropriate patient record in the ‘**Patient Control No.**’ field.

5. **Federal Tax ID Field – Optional**  
(Form Locator 5)

Enter the facility's Tax ID (without hyphens or spaces).

**Note:** You will be selecting a valid Provider Record on the ‘**Payer Information**’ tab. The Tax ID information will be brought to the claim at that point even if this field is left blank.

6. **Statement Covers Period Fields – Required**  
(Form Locator 6)

Enter the first and last service dates being billed on this claim in the fields provided (MM/DD/CCYY).

7. **Patient Address1/Address2/City/State/Zip Fields – Required**  
(Form Locator 13)

These fields will be automatically filled after you select the appropriate patient record in the ‘**Patient Control Number**’ Field.

8. **Patient Phone Field – Optional**

This field will be automatically filled if you entered the patient’s phone number in the patient database.

9. **FL38 Buttons – Not Used**

Do not use this button to enter any information.

10. **Birth date Field – Required**  
(Form Locator 14)

The patient’s birth date will be filled in when you select the patient record in the ‘**Patient Control Number**’ field.

11. **Sex Field – Required**  
(Form Locator 15)
‘M’ or ‘F’ will be filled in this field when you select the patient record in the ‘Patient Control Number’ field.

12. MS Field (Marital Status) – Optional
(Form Locator 16)

Either ‘right click’ or press <F2> for a list of valid code values for this field or press <Tab> to bypass the field.

13. Admission Date Field – Situational
(Form Locator 17)

Required for Inpatient Claims. Enter the admission date for this claim.

14. HR Field (Admission Hour) – Situational

Enter the admission hour (2-digits) in this field for Inpatient bill types.

15. Type Field (Admission/Visit Type) – Situational
(Form Locator 19)

This field is required for all Institutional claims. ‘Right click’ or press <F2> while in this field for a list of valid admission type codes.

16. SRC Field (Point of Origin for Admission/Visit Source) – Situational
(Form Locator 20)

This field is required for all Institutional claims. ‘Right click’ or press <F2> while in this field for a list of valid admission type codes.

17. D-HR Field (Discharge Hour) – Situational
(Form Locator 21)

This field is required for inpatient claims. ‘Right click’ or press <F2> while in this field for a list of valid admission type codes.

18. Stat Field (Patient Discharge Status) – Situational
(Form Locator 22)

This field is required for all Institutional claims. ‘Right click’ or press <F2> while in this field for a list of valid admission type codes.
19. **Medical Record Field** – *Optional*  
(Form Locator 23)  
Enter the Medical Record Number in this field if applicable.

20. **Condition Codes Fields** – *Optional*  
(Form Locators 24-30)  
Enter any applicable Condition Codes in these fields.

21. **Occurrence Code/Date Fields** – *Optional*  
(Form Locators 32-35)  
Enter any applicable Occurrence Codes and Dates in the fields provided.

22. **Occurrence Span Code/Date Fields** – *Optional*  
(Form Locator 36)  
Enter any applicable Occurrence Span Codes and Dates in the fields provided.

23. **Value Code/Amount Fields** – *Optional*  
(Form Locators 39-41)  
Enter any applicable Value Codes and Amounts in the fields provided.

**Step 4: Billing Line Items.**

Select the ‘Billing Line Items’ tab of the ‘**Institutional Claim Form**’

![Image of Institutional Claim Form](image.png)
Fill in the applicable Revenue Codes, Procedure (HCPCS) Codes, Modifiers, Rates, Service Dates, Units, and Total Charges and Non-Covered Charges (Form Locators 42-48).

Once you have entered the line items for this claim, click ‘Recalculate’. The totals at the bottom of the screen will be calculated for you.

**Note:** The ‘Extended Details (Line 1)’ sub-tab is available to enter miscellaneous extended details (example: National Drug Code [NDC]).

• **Step 5:** Payer Information.

Select the ‘Payer Information’ tab of the ‘Institutional Claim Form’.

Many of the fields on this tab are automatically filled from the Patient Record when it is selected in the ‘Patient Control Number’ field on the ‘Patient Info & Codes’ tab.

Complete the following ‘Required’ fields:
1. **Payer ID/Payer Name Fields – Required**

These fields will be auto filled when the patient record is selected on the ‘Patient Info & Codes’ tab.

**Note:** The first line should contain information pertaining to the PRIMARY payer, which may or may not be TRICARE/VAPC3 or WPS Health Insurance.

2. **Provider Number Field – Required**

‘Right click’ or press <F2> while in this field and select the appropriate Provider record.

**Note:** If you have only one Institutional Provider record entered in your Provider database, this field will be auto filled.

3. **ROI and AOB Fields – Required**

These fields should be auto filled when the Provider record is selected.

4. **Prior Payments Field – Situational**

Enter the amount paid by a primary insurance benefit toward the charges being billed on this claim if applicable. Be sure to enter the charge on the line containing the appropriate insurance benefit payer information.

5. **Amount Due Field – Not Applicable**

Do not use this field.

6. **Totals Fields – Situational**

Enter the total amount paid by other insurance benefits toward the charges being billed on this claim.

7. **P Rel Field (Patient Relationship to Insured) – Required**
This field will be automatically filled in when the Patient record is selected.

8. **Insured's Name (Last, First, MI) Fields – Required**

These fields will be automatically filled in when the Patient record is selected, provided that the Insured Information was correctly entered when the Patient record was created.

9. **Insured's ID Fields – Required**

These fields will be automatically filled in when the Patient record is selected, provided that the Insured Information was correctly entered when the Patient record was created. Be sure that the correct Insured ID corresponds to the appropriate Payer (Form Locator 50).

10. **Authorization Code Field – Situational**

Enter the prior authorization number for the services being billed on this claim.  
**Note:** This is **REQUIRED** for Family Care claims.

11. **Type Field (Authorization Type) – Situational**

This field **MUST** be completed if a prior authorization number is entered in the previous field.

‘G1’ = Prior Authorization Number. ‘**Right click**’ for a list of other code values.

12. **ESC Field (Employment Status Code) – Optional**

This field is not required. You can right click on the field to obtain a list of valid Employment Status Code values.

13. **Employer Name/Address/City/State/Zip Fields – Optional**

These fields are not required.
• Step 6: Diagnosis/Procedure.

Select the ‘Diagnosis/Procedure’ tab and complete the following required fields.


Enter the principle diagnosis code that applies to this claim. **Do not include the decimal point.**

For a list of valid diagnosis codes, press <F2> or ‘right click’ while your cursor is in the field. A list of valid diagnosis codes will appear. Use the ‘List Filter Options’ at the bottom of the screen to sort the codes and narrow your search. Highlight the appropriate code and click ‘Select’.

If you are reporting Present on Admission (POA) information, enter your diagnosis code, one space, and then the POA qualifier which applies all in the same field

- ‘Y’ = Yes
- ‘N’ = No
- ‘U’ = Unknown
- ‘W’ = Clinically Undetermined
‘1’ = Represents a space or blank and means the dx code is exempt from reporting POA (default if POA is selected but no value entered.

The field will populate like the example below:

2. Other Diagnosis Fields – Optional

Enter any additional diagnosis codes that may apply to this claim. **Do not include the decimal point.**


Enter the admitting diagnosis code. In many cases, this is the same as the principle diagnosis code.

4. Patient Reason for Visit Codes – Situational

Enter codes which apply

5. External Cause of Injury Codes – Situational

Enter codes which apply

6. PPS/DRG Field – Not Used

Leave this field blank. If a DRG is applicable, the WPS Health Insurance or TRICARE/VAPC3 processing system will determine the appropriate DRG based on the diagnosis codes, procedures, etc. that are submitted on the claim.

‘Right click’ or press <F2> while in this field for a list of alternative values for this field.

7. Principal Procedure Code/Date – Situational

Enter the principle procedure code and date, if applicable.
8. **Other Procedure Codes/Dates** – *Situational*
   
Enter the other procedure codes and date, if applicable.

9. **NPI (National Provider Identifier) Exempt** – *Situational*
   
Enter ‘Y’ if you are exempt from NPI reporting requirements. If you are not NPI exempt, leave blank.

10. **POA (Present on Admission) Type** – *Situational*
    
    If you are required to send POA information on your claim, choose one of the following indicators:
    
    Z – Standard POA Indicator Processing Method (default)
    
    X – Special POA Indicator Processing Method

11. **COB?** – *Situational*
    
    An indicator (Y or N) that activates the Coordination of Benefits (COB) screens used for submitting Medicare Secondary Payer (MSP) claims, or other COB info, under the ‘Billing Line Items’ or ‘Extended Payer’ main tabs.

12. **H.H CR6** – *Situational*
    
    An indicator (Y or N) that reflects whether ANSI-837 Home Health Certification Data is to be included with the claim (in the ANSI-837 CR6 segment). A value of ‘Y’ will trigger the creation of a separate Home Health sub-tab containing the data elements to the entry option.

13. **Attending ID Type/Last Name/First Name, etc. Fields** – *Required*
    
    ‘Right click’ or press <F2> while in the ‘Attending ID’ field to access your ‘Physician’ database and select the record that corresponds with the attending physician. The fields will be populated with data from your ‘Physician’ database.

14. **Operating Physician ID/Type Fields** – *Optional*
‘Right click’ or press <F2> while in any of the ‘ID’ fields to access your ‘Physician’ database and select the record that corresponds with the attending physician. The fields will be populated with data from your ‘Physician’ database. Enter the Physician ID Type. Enter the ‘Operating Physician’ last name, first name, middle initial, Federal Tax ID and Type.

15. **Remarks Field – Optional**

Enter any applicable remarks in this field.

- **Step 7:** Extended Patient/ General and Extended Payer/Insured.

The only additional claim entry tabs are ‘Extended Patient/ General’ and ‘Extended Payer/Insured’. The ‘Extended Patient/General’ tab is used to enter any Facility Information, Claims Supplemental Information (PWK), or Claim Notes (NTE)/File Information (K3), for example. These are not required fields and can be used when applicable.

The ‘Extended Patient/General’ tab is used to enter payment information when Medicare, TRICARE/VAPC or WPS Health Insurance is the secondary payer.

The ‘Extended Payer/Insured’ tab is used to enter Payer and Insured miscellaneous information.

**Note:** You will be able to access and enter any applicable information on the ‘COB Info (Primary)’ and ‘COB Info (Secondary)’ sub-tabs (IF you entered COB? = ‘Y’ see Step 6, #11 above).

- **Step 8:** Save.

After you have completed all the required and applicable situational fields for the claim, click ‘Save’.

The claim data you entered will now be subjected to PC Ace edits to ensure that required information is present and valid. If there are no errors, you will be returned to a blank ‘Institutional Claim Form’ where you will be able to enter another claim.

If there are errors, you will receive a list of errors and will be returned to the first field that contains invalid data. Correct the errors and click ‘Save’ again.
If you have entered all the claims you wish to transmit now, click ‘Cancel’. You will be asked if you wish to abandon these changes. Click ‘Yes’ to return to the ‘Institutional Claims Menu’.

You are now ready to create a report of the claim information you will be placing in your file for transmission to WPS Health Solutions.

---

**Create and Print Report of Claims to be Transmitted**

After you have entered the claims you wish to include in your claim file, create a report of those claims for your records.

Complete the following steps to create a report of the claims that will be in your next claim file:

- **Step 1:** Select ‘Institutional Claims Processing’ from the ‘Main Form’.

  The ‘Institutional Claims Menu’ will appear.
**Step 2:** Click the 'List Claims' button.

A screen containing a list of the 'New' (ready for transmission) claims will appear.

**Note:** The 'Location' code 'CL' (to be transmitted) indicates you are viewing a list of claims that have not been prepared and a file created for transmission. To view claims that were in previously built claim files click on the drop-down arrow to the right of the 'Location' field and select a different location.
**Note:** The ‘Status’ code ‘CLN’ indicates that a claim has passed the PC ACE software edits and is ready to be prepared for transmission. ‘Status’ code ‘ERR’ indicates that the claim was saved with at least one error.

**Step 3:** Click on ‘Report’ (toolbar at top of screen) and select ‘Print Claim Detail Report (All listed claims)’.

**Note:** If you ‘Check’ (✔) any claims, you will be able to create a report of ‘All checked claims’ instead of ‘All listed claims’.

A report of the listed (or checked) claims will be created:

**PC-ACE Pro32 CLAIM DETAIL REPORT**

Report Date: 12/31/2003

<table>
<thead>
<tr>
<th>PROV #/</th>
<th>PCN/</th>
<th>HIC</th>
<th>SERVICE DATES</th>
<th>NAMES/</th>
<th>FIRST/</th>
<th>TOB/</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>391223333A</td>
<td>PATFIR</td>
<td>1111111111</td>
<td>12/31/03 12/31/03</td>
<td>PATIENT</td>
<td>FIRST</td>
<td>131</td>
<td>CLN</td>
</tr>
<tr>
<td>391223333A</td>
<td>PATSEC</td>
<td>2222222222</td>
<td>12/01/03 12/03/03</td>
<td>PATIENT</td>
<td>SECOND</td>
<td>111</td>
<td>CLN</td>
</tr>
</tbody>
</table>

REPORT TOTALS: CLAIMS: 2 CHARGES: $1,800.00 AMT PAID: $0.00
UNITS: 4 AMT DUE: $1,800.00
• Step 4: Click on [printer icon] to direct the report to your printer.

• Step 5: Click on ‘Close’ to return to the ‘Institutional Claims List’.

Prepare Claims for Transmission (Create a Claim File to Transmit to WPS)

The next step is to create a file of ‘Clean’ (CLN) Medicare, TRICARE, VAPC3, ARISE or WPS claims for transmission to WPS.

**Notice: Date editing on all inbound transactions will be done based on WPS Health Solutions local time, e.g. CST (Central Standard Time)

Complete the following steps to create a claim file:

• Step 1: Select ‘Institutional Claims Processing’ from the ‘Main Form’.

The ‘Institutional Claims Menu’ will appear.
• **Step 2:** Click ‘Prepare Claims’.

The ‘Institutional Claim Prepare for Transmission’ screen will appear.

• **Step 3:** Select the line of business (LOB) assigned to the claims you wish to submit.

  - TRI = TRICARE
  - COM = WPS Health Insurance
  - MCA = Medicare Part A
  - VA = VAPC3

• **Step 4:** Select the appropriate ‘Payer’

  - 08101 = Medicare A for Indiana
• 05901 = Medicare A for J5 National
• 08201 = Medicare A for Michigan
• 05101 = Medicare A for Iowa
• 05201 = Medicare A for Kansas
• 05301 = Medicare A Missouri
• 05401 = Medicare A for Nebraska
• ‘WPS’ = WPS Health Insurance
• ‘00235’ = WPS Secondary Medigap
• ‘ARISE’ = ARISE
• ‘FOREN’ = TRICARE Overseas (Foreign)
• ‘TDFIC’ = TDEFIC Direct (5010 Only)
• ‘TREST’ = TRICARE EAST
• ‘VAPCCC3’ = Patient-Centered Community Care (VAPC Region 3)
• ‘VAPCC5A’ = Patient-Centered Community Care (VAPC Region 5A)
• ‘VAPCC5B’ = Patient-Centered Community Care (VAPC Region 5B)
• ‘VAPCC6’ = Patient-Centered Community Care (VAPCC Region 6)

• **Step 5:** Click ‘Prepare Claims’. You will be asked to confirm the preparation of your claim file. Click ‘OK’.

Your claim file will now be built, and the results will be displayed for you.

• **Step 6:** Click ‘View Results’ to create a detail report of the claims that were actually placed in your claim file that you can print for your records.

• **Step 7:** Click ‘Close’ to return to the ‘Institutional Claims Menu’
**File name and Path**

The file you just created will be in the C:\WINPCACE directory (folder). The file should be named your User ID followed by .DAT if you set up your ‘Submitter Setup’ information correctly (i.e. If your User ID is ‘99999’, your file name should be ‘99999.dat’.)

If you did not set up your ‘Submitter’ information correctly, the file name will be BCTRANS.DAT.

**Note:** You must now transmit (upload) this claim file to our Bulletin Board System (WGBBS) or Gateway Express Website. If you prepare another file of claims prior to transmitting (uploading) to WPS Health Solutions, the file will be over-written by the new file.

**Upload Claim File to WPS**

**Notice:** Date editing on all inbound transactions will be done based on WPS Health Solutions local time, e.g. CST (Central Standard Time)

Until you upload (send) your file to WPS Health Solutions using the Bulletin Board System (BBS) or Gateway Express Website your claim file is still on your computer. PC ACE only creates the claim file; it does not transmit it to WPS Health Solutions.

When you registered with WPS Health Solutions to become a trading partner, you would have selected your transmission method and should have received a User Guide, Username and Password for that protocol. If you have any questions regarding this, please contact the appropriate EDI Helpdesk

**Contact Us:**

Medicare Part B – MAC J5 (866) 518-3285 Option 1), MAC J8 (866) 234-7331 (Option 1)

WPS Health Insurance, ARISE, VAPC3 and TRICARE – 800-782-2680 (Option 1)

or visit our website at:

[https://www.wpshealth.com/resources/provider-resources/edi/index.shtml](https://www.wpshealth.com/resources/provider-resources/edi/index.shtml)

**WPS BBS/Gateway Express – Edits and Reports**

Once your claims are transmitted to the WPS Health Solutions, the data is subjected to a short series of edits that check information at the file level as well as the claim level.
Individual claims are loaded into the appropriate Medicare, TRICARE, VAPC3, ARISE or WPS Health Insurance claims processing system only after the data received passes these edits.

I. INITIAL EDIT STEP. (5010A2: Produces a ‘TA1 Interchange Acknowledgement and/or a 999 Implementation Acknowledgement for Health Care Insurance’)

When WPS Health Solutions receives your claim file, it is run through the INITIAL EDIT step. This edit step checks the file you transmitted to ensure that the data is in the correct format. This is usually done immediately after the file is received. At times, however, there may be a delay if the WPS Health Solutions processor is unusually busy or not available.

The results of the initial edit step are sent to you in the form of a download report for you to retrieve from the WPS BBS or Gateway Express Website. If the report indicates that your file passed the initial edits, it will be sent on to the next edit step. If the report indicates that your file failed the initial edits, your entire file of claims is rejected.

NOTE: If your file fails the initial edit step and you do not understand the reason(s) in the email message, contact the appropriate WPS Health Solutions EDI Department.

II. SECOND EDIT STEP (5010A1: produces a ‘999 Implementation Acknowledgement for Health Care Insurance’ and a ‘277CA Health Care Claim Acknowledgement’).

If your file passes the initial edits, information on individual claims is checked for compatibility with the claims processing system. The results of this edit step are obtained through the WPS BBS or Gateway Express Website.

Reports from this edit step are sent to you in the form of a downloadable file. These reports will be available for you to download minutes after you transmit your claim file.

Note: It is IMPERATIVE that you download the attached file after EACH transmission!!! Claims that appear on these reports with error messages MUST BE CORRECTED AND RESUBMITTED.

Claims deleted during this phase are not referenced in any other way, so this is your only notice of deleted claims.

TA1 – Interchange Acknowledgement.
Starting with version 5010A2 the ‘TA1 Interchange Acknowledgment’ allows WPS Health Solutions to notify you that a valid envelope was received or that problems were encountered within the interchange control structure. The TA1 verifies the envelope of the file only.

To translate your TA1 into a ‘human-readable’ format:

1. Download the TA1 using your selected transmission method of either the WPS BBS (Bulletin Board System) or the Gateway Express Website.

2. Place the TA1 file in folder: C:\WINPCACE\MAILBOX

3. Open PC ACE

4. Click the ‘Institutional Claims Processing’ icon from the ‘PC ACE main form’:

![PC ACE main form](image)

5. Click ‘Maintain’ on the toolbar of the ‘Institutional Claims Menu’.

6. Click ‘Acknowledgement File Log’ on the drop-down menu.

![Institutional Claims Menu](image)

7. You will now see the ‘Institutional Acknowledgement Log’. Select the record you wish to view by clicking on it to highlight it. Then click ‘View Report’.
8. You will now see your ‘PC Ace ANSI – TAI Interchange Acknowledgment Report’. You will also have the capability to print this report by clicking the ‘Print’ icon on the toolbar:

![Institutional Acknowledgment File Log]

**999-Acknowledgement for Health Care Insurance.**

Starting with version 5010A2 WPS will send 999 Acknowledgement reports which will report syntactical and implementation errors against a functional group based on implementation guidelines. The 999 will also confirm receipt of a functional group which fully complies with implementation guidelines.

To translate your 999 (5010A2) into a ‘human-readable’ format:

1. Download the 999 using your selected transmission method of either the WPS BBS (Bulletin Board System) or the Gateway Express Website.

2. Follow the same steps as listed above for translating the ‘TA1 Interchange Acknowledgement’ starting on page 77.

**277CA – Health Care Claim Acknowledgement.**

Starting with version 5010A2, WPS Health Solutions will no longer be sending proprietary ‘Batch Detail Listing’ reports showing your accepted and/or rejected claims. In its place, WPS will be sending the **277CA (Claim Acknowledgement)** transaction.

To translate your 277CA into a ‘human-readable’ format:

1. Download the 277CA using your selected transmission method of either the WPS BBS (Bulletin Board System) or the Gateway Express Website.

2. Place the 277CA file in folder: C:\WINPCACE\MAILBOX
3. Open PC ACE

4. Click the ‘Institutional Claims Processing’ icon from the ‘PC ACE main form’:

![PC ACE main form](image)

5. Click ‘Maintain’ on the toolbar of the ‘Institutional Claims Menu’.

6. Click ‘Claim Status Response & Acknowledgement Log’ on the drop-down menu.

![Institutional Claims Menu](image)

7. You will now see the ‘Institutional Claim Status Response & Acknowledgement Log’. Select the record you wish to view by clicking on it to highlight it. Then click ‘View Ack Report’.

8. You will now see your ‘PC Ace ANSI -277 Claim Acknowledgment Report’. You will also have the capability to print this report by clicking the ‘Print’ icon on the toolbar.

### MSP/COB (Secondary Payer/Coordination of Benefits)

1. When you create the ‘Patient Information’ record for a patient who has an insurance benefit that is primary to the insurance you are currently billing, be sure to enter the other insurance information in the ‘Primary Insured Tab’ fields. The payment information for the insurance you are currently billing would be entered in the ‘Secondary Insured Tab’ fields. Remember to choose the option (Separate Inst and Prof) on the Patient Information screen as below:
2. When entering a new claim for a patient that has insurance that is primary to Medicare (or the insurance you are submitting to), you will need to enter a ‘Y’ in the ‘COB?’ field on the ‘Diagnosis/Procedure’ tab.

3. You will now have the screen necessary for entering the Primary Insurance COB information on the ‘Extended Payer’ tab.
4. Enter the Primary Payer's **Claim Adjudication Date**. Also enter the Primary insurance payment information in the ‘Claim Level Adjustments’ and ‘COB/MIA/MOA Amounts’ areas. You may place your mouse pointer in the ‘Group’, ‘Reason’ and ‘Code’ fields and ‘Right Click’ to provide a list of values to choose from. For example, ‘Right Clicking’ in the ‘Group’ field would produce the following:

![Image of Claim Adjustments / COB Amounts / MIA - MOA Information (ANSI-837 Only) form]

### 276 (Claim Status Request)

**Preparation**

Claims status request file ‘**preparation**’ in PC ACE refers to the action required to generate an **ANSI-276 claims status request file** appropriate for transmission. This transmittable file will contain all relevant status request details for one, or more, previously transmitted claims. Once WPS Health Solutions receives your **ANSI-276 file**, we will generate a corresponding **ANSI-277 claim status response file** containing status information for the requested claim(s). The actual **ANSI-277 response file** can be processed by PC ACE and the user will be able to view the status request file.

**Note:** Only the claims that have been added to the status request queue will be included in the ANSI-276 claim status request file. Refer to the ‘**Claim List Form Features**’ summary.
Complete the following to prepare a claim status request file in PC ACE:

Add one or more transmitted claims in the status request queue using the ‘Request Selected Claim Status’ or ‘Request All Checked Claims Status’ action in the ‘Institutional Claims List’ form.

- Click the ‘Institutional (INST)’ icon:

- This will bring you to the ‘Institutional Claims Menu’ screen. Select the ‘List Claims’ option

- Be sure to change your claim location to ‘TR-Transmitted Only’ and select your ‘LOB’ for the claim(s) you are requesting.
Go through the list of transmitted claims and place a check in the box to the right of the claims you wish to request status on. Then ‘Click’ on actions and then a drop-down box will appear. Please select either ‘Request Selected Claim Status’ (for one claim) or ‘Request All Checked Claims Status’ (for more than one claim).

- Click the ‘Close’ button to return to the ‘Institutional Claims Menu’.

- Within the ‘Institutional Claims Menu’ select ‘Maintain’ and choose the ‘Prepare Claim Status Request File’.
• Select your Line of Business (LOB) and ‘Payer’, and then click the ‘Prepare Status Request’ button. You will then get a ‘Confirm’ box asking if you are ready to ‘Prepare the Institutional Claim Status Request File’, click ‘OK’.

• Click the ‘View Results’ button to see the ‘PC ACE Claim Status Request Report’

• Select the ‘Print’ and/or ‘Close’ button to exit this page when your review is complete.
The prepared **ANSI-276 claim status request file** is in your ‘(C😊) drive’ within the ‘WINPCACE’ folder. The file name is ‘bcreq276.dat’ for Institutional claims.

**Transmission**

You may now proceed to transmit the **ANSI-276 claim status request file** to WPS Health Solutions via the BBS or Gateway Express Website. Follow the steps outlined in the WPS Bulletin Board System (BBS) or Gateway Express Website Instructions to transmit/upload your request file to WPS Health Solutions.

**277 – Claim Status response**

**Viewing and Maintaining Claim Status Response Files**

After WPS receives your **ANSI-276 format claim status request files** generated by PC Ace WPS will retrieve the requested claim status information and respond to you by sending an **ANSI-277 Claim Status response file** back to you. PC ACE allows you to archive the **ANSI-277 claim status response files** for subsequent review and/or printing. This section will summarize how to stage your **ANSI-277 files** so that they are automatically archived and posted by PC ACE. Other summarized topics include: **functions for viewing, printing, maintaining**, and **using** the archived claim status response files and how to post files.

**Staging Claim Status Response Files for Automatic Archiving**

At program startup, PC ACE automatically scans separate Institutional and Professional ‘staging’ directories looking for new **ANSI-277 claim status response files** to be archived.
If any **ANSI-277** files are present in the staging directories, they are edited for the appropriate format and automatically archived. In addition, the individual responses are automatically posted to the appropriate claims. This automatic archive/post process is also performed when the ‘Claim Status Response Log’ form is opened or when the user manually refreshes the ‘Claim Status Response Log’ list.

With this edition of PC ACE, the user is required to manually copy the ANSI-277 files received from WPS Health Solutions into the appropriate staging directory. The Institutional staging directory is: **Institutional = Winpcace\ansi277\statub92**

For single-user installations, these directories will reside on the local drive to which PC ACE was originally installed. Typically, your ‘(C: drive.’ For multi-user, or networked installations, these staging directories will reside on the shared network drive letter to which PC ACE was installed.

**Note:** It is critical that you ensure copying only Institutional Claim Status Response files to the Institutional staging directory. In addition, you will need to make sure that the most recently staged claim status response file has been archived before copying a newer response file into the staging directory.

**Viewing, Printing & Maintaining Claim Status Response Files and Post Reports**

The archived 277-ANSI Claim Status Response Files and **Post Reports** can be viewed and/or printed from the ‘Claims Status Response Log’ form. To view the currently archived **ANSI-277 files**, select the ‘Maintain’ option from the ‘Institutional Claims Menu.’

From the drop-down list of options select the ‘Claim Status Response Log’ menu item.

It will bring up the ‘Institutional Claim Status Response Log’ screen displaying information related to your **ANSI-277 files**.
The following options are available at this point:

1) To view and/or print and archived **ANSI-277 response file report**, select the desired record and click the ‘**View Response Report**’ button (or double click the desired record). The report may be printed from the preview form if desired.

2) To view and/or print the post report for an archived **ANSI-277 response file**, select the desired record and click the ‘**View Post Report**’ button.

3) To delete an archived **ANSI-277 file** and its associated post report, select the desired record, click the ‘**Delete**’ button, and confirm the deletion.

**NOTE:** Archived ANSI-277 Claim Status Response Files will be automatically purged after six months. Individual claim status responses that have been posted to claims will remain on file even after the original archived response file has been manually deleted or automatically purged.

4) To refresh the list of archived **ANSI-277 files**, click the ‘**Refresh**’ button. The staging directory will be re-scanned for the presence of new **ANSI-277 files**. If new files are present in the staging directory, they will be checked for the proper format, and automatically archived and posted.

5) The displayed list will then be rebuilt to reflect the current archive contents. You can ‘**right click**’ the mouse on your desired archive record to access all the available actions. This popup menu provides several additional actions which will allow the user to print post reports containing only the successfully posted responses or only responses that could not be posted.
Using the Claim Status Response Reports

The **ANSI-277 report** will provide the user with general identification information along with the claim-level status response codes and payment returned by WPS for each claim. Since the individual responses are posted directly to the applicable claims, this report is typically used as a secondary reference source. There may be situations where WPS will need to post ambiguous status responses to the original claim. In these situations, you will be referred to the original claim status response file (and this report) for additional information.

Using the Claim Status Response Post Reports

The **ANSI-277 claim status response report** provides the claim-by-claim results of the automatic response posting operation. A response posting will fail for either of the following reasons:

1. The claim for which status was requested no longer exists. The claim has been purged, archived, or reactivated from the ‘**TR-Transmitted Only**’ or ‘**PD – Paid Only**’ locations.

2. Multiple claim status responses have been returned by the intermediary for the same unique claim trace number. This typically indicates that WPS Health Solutions could not uniquely identify the claim of interest based on the identifying information included in the **ANSI-276 claim status request file**. Multiple responses may be returned at WPS’ discretion. PC ACE will not post any of the ambiguous responses back directly to the claim but will instead post an ‘**attention**’ notification that will direct you back to the original archived claim status response file/report. The user must review this report to determine which one of the multiple responses (if any) is applicable. The **ANSI-277 Claim Status Response Post Report** will display an explanatory error message for each response that could not be posted.

277 Claim Status Request/Response History

Complete the following to generate a **277, transaction history report**:

1. From the PC ACE ‘**Main Form**’ select the ‘**Inst**’ icon.
2. This will bring you to the ‘**Institutional Claims Menu**’ screen. Select the ‘**List Claims**’ option.

![Institutional Claims Menu Screen]

3. Within the ‘**Institutional Claim List**’ you need to change your location to ‘**TR-Transmitted**’ and you need to select your Line of Business (LOB).

![Institutional Claim List Screen]

4. Select and highlight the claim for which you will be creating the ‘**Claim Status Request/Response History**’ report.

5. ‘**Right click**’ on your mouse. From the drop-down list select the ‘**Show Selected Claim Status History**’ option.

   This will bring up the ‘**Claim Status Request/Response History**’ screen:
6. Click the ‘Print History’ button. This will bring up the ‘Report Preview’ screen displaying a copy of your report that you can review and print.

7. Click ‘Close’ to exit this screen. Click ‘Close’ to exit the ‘Claim Status Request/Response History’ screen.

You will be returned to the ‘Institutional Claim List’ screen. Click the ‘Close’ button in the lower right-hand corner to exit this screen.

At this point the ‘Institutional Claims Menu’ screen will appear. Select ‘Maintain’ from the top of the page and select the ‘Prepare Claim Status Request File’ option.
8. Select your Line of Business (LOB) and 'Payer'. Then click on the 'Prepare Status Request' button.

9. You will be prompted with a ‘Confirm’ box, click ‘OK’ to continue.
10. The ‘Information’ box will advise that your claim status request has successfully completed. Click ‘OK.’ Then select the ‘View Results’ button for your report.

You can select the printer icon to print this report for your records. Click the ‘Close’ button to return to the prior screen. Click ‘Close’ again to return to the ‘Institutional Claims Menu’ and continue within PC ACE.

270/271 – Eligibility Benefit Request List Form Features

The PC ACE Eligibility Benefit Request List form provides a versatile interface from which the user can create, list, modify and otherwise maintain patient eligibility benefit requests. Click the “Institutional Claims Processing” button on the PC ACE Main Toolbar to open the corresponding Claims Menu form. Then click
the “Maintain Eligibility Benefit Requests” item on the Claims Menu Form’s “Maintain” menu to open the Eligibility Benefit Request List form. You may reposition and resize this form if desired. After your list has been created, it can be easily sorted and filtered to display only the requests of interest.

- Creating New Requests – Click the “New” button (or choose the “Create New Request”, “Create New Request (Service Type)” or “Create New Request (Complete)” action) to create a new eligibility benefit request.

After selecting the New Request Type, you will get the screen below. The required fields for this screen are:
- Payer
- Provider
- Member ID
- Relationship
- Subscriber Last Name
- Subscriber First Name
After entering this information select save. If you have any errors, please correct and save again. If no errors, you will see the following screen, where your request was added to the list.
• **Viewing/Modifying Requests** – Click the “View/Update” button (or choose the “View/Update Selected Request” action) to view and/or modify the selected eligibility benefit request. See the “Eligibility Benefit Request Form” topic for details on using the PC ACE eligibility benefit request entry form.

**Tip:** The View/Update action is the default eligibility benefit request action. In addition to the techniques described above, this action can also be invoked by double-clicking on the desired request record or by selecting the desired record and pressing the “ENTER” key.

**Tip:** Holding down the “SHIFT” key while invoking the View/Update action on an eligible eligibility benefit request will force an automatic save attempt on the request. This is a shortcut technique equivalent to invoking the View/Update action and subsequently clicking the “Save” button on the request entry form. It minimizes the keystrokes required to work requests from the Eligibility Benefit Request List form. Eligible requests are those in the “to be submitted” (EL) location with a status of either “unprocessed” (UNP), “has errors” (ERR), or “has fatal errors” (ERF).

• **Deleting Requests** – Click the “Delete” button (or choose the “Delete Selected Request” action) to delete the selected eligibility benefit request.

***Note: Deleted eligibility benefit requests are permanently removed from PC ACE … they cannot be recovered.***

### Sorting Eligibility Benefit Requests

The eligibility benefit request list may be sorted by Patient Name, Patient Control Number (PCN), Entry Date and Submit Date. Simply select the desired sort order from the available “Sort By” radio buttons.

### Filtering Eligibility Benefit Requests

The eligibility benefit request list may be filtered to display a select subset of requests by manipulating the “Eligibility Request List Filter Options” drop-down lists.

**Basic filter options include:**

- **Location** – filters the eligibility benefit request list to include only requests in the “to be submitted” (EL) or “transmitted” (TR) locations.

- **Status** – filters the eligibility benefit request list to include only requests assigned a specific status. The possible status codes are: “clean/ready” (CLN), “has fatal errors” (ERF), “has errors” (ERR), “held” (HLD) and “unprocessed” (UNP).

- **LOB** – filters the eligibility benefit request list to include only requests for a specific line of business. In addition to these basic filter options, the Eligibility Benefit Request List form also provides several **Advanced Filter Options**. These advanced options permit filtering on the request’s patient, payer, entry date range, submission date range, and numerous other criteria. When multiple filter criteria are specified, only those requests that meet **all** filter criteria will be displayed.
Eligibility Benefit Request Actions
The Eligibility Benefit Request List form may also be used to perform specific actions on any individual request or a group of selected requests. To perform an action on an individual request, simply select the request from the list and click the desired action button (along the lower edge of the form). The complete list of request actions can be accessed from the Eligibility Benefit Request List form’s main “Actions” menu or from the convenient pop-up menu (accessed by right clicking the mouse over the selected request). Available eligibility benefit request actions include:
• **Copy Requests** – Click the “Copy” button (or choose the “Copy Selected Request” action) to copy the selected eligibility benefit request. The eligibility benefit request entry form will be displayed containing the details of the newly copied request.

• **Hold Requests** – Choose the “Hold Selected Request” action to change the status of the selected eligibility benefit request to “held” (HLD). Held requests are not eligible for preparation.

• **Release Requests** – Choose the “Release Selected Request” action to release a previously held eligibility benefit request. In addition to releasing the request, this action also sets the status of the selected request to “unprocessed” (UNP).

• **Reactivate Requests** – Choose the “Reactivate Selected Request” action to reactivate the selected eligibility benefit request. This action will move the previously submitted request from the “submitted” (TR) location into the “to be submitted” (EL) location. The reactivated request will be assigned the “unprocessed” (UNP) status.

• **View Responses** – Choose the “View Response for Selected Request” action to view the ANSI-271 eligibility benefit response information for the selected eligibility benefit request. Refer to the “Viewing the eligibility benefit response for a specific request” topic for additional information.
Note: This action is available only when the Eligibility Benefit Request List is filtered to view requests in the “submitted” (TR) location. The “Reply?” column will selected eligibility benefit request.

- **Refresh the Request List** – Choose the “Refresh Request List” action (or press the “F5” function key) to refresh the current Eligibility Benefit Request List form contents. This action can be useful in a multi-user installation to be sure that the request list properly reflects additions and/or modifications made by other users.

  Note: You will notice that only applicable actions are enabled for use in the main “Actions” menu or pop-up menu. For example, it makes no sense to “reactivate” an eligibility benefit request that has yet to be submitted, so this action will be disabled for requests in the “to be submitted” (EL) location.

### 270/271 Actions on Multiple Eligibility Benefit Requests

Some actions can be performed on multiple eligibility benefit requests at once. Multiple request selection is accomplished by “checking” the request of interest and subsequently performing one of the “… All Checked Requests” actions. To check a request, click the left mouse button over the checkbox in the first column of the desired list row. Alternatively, all requests in the current list can be checked using the “Check All Requests” item from the list’s pop-up menu.

Use the flexible Eligibility Benefit Request List form filter techniques to display only the subset of requests to be deleted, held, reactivated, etc. Then simply check all eligibility benefit requests and perform the desired action on all checked requests at once.

#### Eligibility Benefit Request List Filter Menu

Several eligibility benefit request list filtering and related functions are accessible from the Eligibility Benefit Request List form’s main “Filter” menu:

- **Clear Filters** – Clears any existing filter criteria and refreshes the eligibility benefit request list to display all requests in the selected location

- **Advanced Filter Options** – Opens the Advanced Eligibility Request List Filter Criteria form to permit filtering on the request’s patient, payer, entry date range, submission date range and numerous other criteria. When multiple filter criteria are specified, only those requests that meet all filter criteria will be displayed.

- **Check (Uncheck) All Requests** – Permits the user to “check” (or “uncheck”) all eligibility benefit requests currently displayed in the request list – presumably in anticipation of some action to be performed on this block of requests. See the “Actions on Multiple Eligibility Benefit Requests” section above for more information.

#### Eligibility Benefit Request Preferences

Certain aspects of the Eligibility Benefit Request Form operation are customizable. The default behavior is typically determined by your software distributor, so you should check with your vendor before making changes to these settings. The Eligibility Benefit Request Preferences are accessible from the Eligibility Benefit Request List form’s main “File” menu “Preferences” item. The following options are available for configuration:

- **General Eligibility Benefit Preferences** – Select the “General” tab to view and/or modify
• **Default Information Source Type to Payer (Code = ‘PR’)** – This option controls the default value assigned to the Information Source Type field for new requests. When checked, the Information Source Type is defaulted to the “Payer” code (PR). Most distributors expect a payer to be identified in the Information Source fields. Setting this field to “PR” enables Information Source lookups from the Payer reference file. When unchecked, the Information Source Type field is left empty and must be entered by the user (or selected from the right-click popup menu).

• **Default Information Source Primary Identification Type to NAIC (Code = ‘NI’)** – This option controls the default value assigned to the Information Source Primary Identification Type field for new requests. It is available only when the Information Source Type is being defaulted to the “Payer” code (PR). When checked, the Information Source Primary Identification Type will be defaulted to the “NAIC” code (NI) during Information Source lookups from the Payer reference file. When unchecked, the Information Source Primary Identification Type will be defaulted to the “Payer Identification” code (PI) during Information Source lookups from the Payer reference file.

• **Default Information Receiver Type to Provider (Qualifier = ‘1P’)** – This option controls the default value assigned to the Information Receiver Type field for new requests. When checked, the Information Receiver Type is defaulted to the “Provider” code (1P). Most distributors expect a provider to be identified in the Information Receiver fields. Setting this field to “1P” enables Information Receiver lookups from the Provider reference file. When unchecked, the Information Receiver Type field is left empty and must be entered by the user (or selected from the right-click popup menu).

• **Load Information Receiver Primary ID with Federal Tax ID on Provider lookups** – This option controls the source for the value assigned to the Information Receiver Primary ID / Type fields during lookups from the Provider reference file. When checked, the Information Receiver Primary ID / Type fields are populated with the Federal Tax ID / Type fields from the selected Provider record. When unchecked, the Information Receiver Primary ID / Type fields are populated with the standard Provider ID/No. / Type fields from the selected Provider record.

• **Default Tax ID Type to generic code ‘FI’ instead of ‘24’ (EIN) or ‘34’ (SSN)** – This option controls the source for the value assigned to the Information Receiver Primary ID Type field during lookups from the Provider reference file. This option is only available when the Federal Tax ID has been selected to populate the Information Receiver Primary ID field. When checked, the Information Receiver Primary ID Type field is forced to the generic Tax ID type code (FI). When unchecked, the Information Receiver Primary ID Type field is populated with the ANSI/X12 qualifier corresponding to the Federal Tax ID Type value from the selected Provider record. Valid qualifier values are “24” (EIN) and “34”
• Give preference to non-person Organization name on Information Receiver lookups
- This option controls the preferred source for the value assigned to the Information Receiver Name fields during lookups from the Provider reference file. When checked, the Information Receiver Name fields are populated with the nonperson “Organization” field from the selected Provider record, if available. If no organization is specified on the selected Provider record, then the proper (i.e., person) name fields are used instead. When unchecked, the Information Receiver Name fields are populated with the proper (i.e., person) name fields from the selected Provider record, if available. If no proper name is specified on the selected Provider record, then the value in the “Organization” field is used instead.

Simplified Service Type Request Form Preferences – Select the “Service Type” tab to view and/or modify Service Type Eligibility Benefit Request Form preferences:

• Use the simplified Service Type request form by default for new eligibility benefit requests – This option controls which of the two, available eligibility/benefit request forms to display when the user clicks the “New” button on the Eligibility Benefit Request List Form. When checked, the simplified Service Type Eligibility Benefit Request Form will be displayed when the user clicks the “New” button on the Eligibility Benefit Request List Form. When unchecked, the complete Eligibility Benefit Request Form will be displayed when the user clicks the “New” button on the Eligibility Benefit Request List Form. Tip: New eligibility/benefit requests may be added using either request form by selecting the desired “Create New Request …” item from the Eligibility Benefit Request List form’s main “Actions” menu.

• Payer Selection List – This list box holds the payers that will be available for selection on the simplified Service Type Eligibility Benefit Request Form. If visible, click the “Add” button to choose a payer from the Payer reference file and add this payer to the selection list. Select an existing payer in the list and click the “Remove” button to remove this payer from the selection list. Use the “Up Arrow” and “Down Arrow” picture buttons to rearrange the order of payers in the selection list. The first Payer in the selection list will be the default payer when creating new Service Type eligibility benefit requests.

Note: PC ACE distributors have the option to pre-configure and restrict this default eligibility/benefit payer selection list. The “Add”, “Remove”, “Up Arrow”, and “Down Arrow” buttons will not be visible when this restriction has been imposed by the distributor.

• Allow selection from Payer reference file – This option controls whether users will be allowed to select payers other than those in the Payer Selection List when creating new Service Type eligibility/benefit requests. When checked, selection of alternate payers from the Payer reference file will be allowed. The payer dropdown list on the Service Type Eligibility Benefit Request Form will include a special “<< Select from Payer Reference File >>” item to initiate the Payer file selection process. When unchecked, only payers included in the Payer Selection List will be available for selection when creating new Service Type eligibility/benefit requests.
• **Provider Selection List** – This list box holds the providers that will be available for selection on the simplified Service Type Eligibility Benefit Request Form. Users should add commonly used providers to this list to streamline the process of creating new Service Type eligibility/benefit requests. Click the “Add” button to choose a provider from the Professional Provider reference file and add this provider to the selection list. Select an existing provider in the list and click the “Remove” button to PC ACE User’s Manual56 remove this provider from the selection list. Use the “Up Arrow” and “Down Arrow” picture buttons to rearrange the order of providers in the selection list. The first provider in the selection list for a given LOB and Payer ID combination will become the default provider when creating new Service Type eligibility benefit requests for that payer.

**Note:** In addition to the providers listed in the Provider Selection List, users will also be allowed to select from the complete Professional Provider reference files when creating new Service Type eligibility/benefit requests. The provider dropdown list on the Service Type Eligibility Benefit Request Form will include a special “<< Select from Provider Reference File >>” item to initiate this Provider file selection process.

**Preparing your Eligibility Benefit Request**

Once you have one or more clean requests, select the “Maintain” and “Prepare Eligibility Benefit Request File” menu options to access the Eligibility/Benefit Request form. This form functions just like its claim counterpart. The ANSI-270 file produced by the prepare operation is named BSREQ270.DAT (Professional), and are written to the “Winpcace” folder.

**Downloading your 999 and 271 response reports**

To translate your 999 into a ‘human-readable’ format:

1. Download the 999 using your selected transmission method of either the WPS BBS (Bulletin Board System) or the Gateway Express Website.

2. Place your 999 files in folder: C:\WINPCACE\Mailbox

3. Open PC ACE

4. Click the **Institutional Claims Processing** icon from the **PC ACE main form**
5. Click ‘**Maintain**’ on the toolbar of the ‘**Institutional Claims Menu**’.

6. Click ‘**Acknowledgement File Log**’ on the drop-down menu.

7. You will now see the ‘**Professional Acknowledgement Log**’. Select the record you wish to view by clicking on it to highlight it. Then click ‘**View Report**’.

8. You will now see your 999 ‘**Report**’. You will also have the capability to print this report by clicking on ‘**File**’ and then ‘**Print**’ icon on the toolbar:
**Downloading your 271 Eligibility Benefit Response**

The returned 271 response files should be saved to the “C:\WINPCACE\Ansi271\Elig1500” (Professional) staging folders. Once the ANSI-271 files are in the appropriate staging folder, select the “Eligibility Benefit Response Log” item from the “Maintain” menu on the appropriate Claims Menu (5-button) form.

![Institutional Claims Menu](image)

The staging folder will be scanned, and all ANSI-271 files present in this folder will be archived and made available in the list. Double-click a response record to view/print the corresponding report in its entirety.

![Institutional Eligibility Benefit Response Log](image)

**Archiving Process**

The ANSI-270 files are not archived to keep the module as simple as possible. Neither are the prepare reports archived. You can view the report for the most recent request prepare operation from “View” menu on the Claims Menu form.

**Performing System Backup and Restores**
You will be prompted to perform a backup each time you exit the PC Ace program. Creating a backup and storing it in a place other than where your PC Ace is installed to is an important step to ensure that your most up to date information is stored in a safe place. In the event of computer failure or other issues you will have a copy of PC ACE which can be restored and bring all your data back to where it was before the incident. Therefore, creating a backup frequently is important and why you are prompted to update your backup every time you exit the software.

To Backup:

- If backing up when closing PC ACE skip to next step. If backing up from the ‘Main Form’ Click ‘System Utilities’ button from the ‘Main Form’. Then click the ‘Backup’ tab.
- Select the ‘Destination Drive’ that you wish the backup to be saved to. Do not select ‘Include infrequently changed database files’.
- Click ‘Start Backup’. Then click ‘OK’. You will be notified upon successful backup completion.

To Restore your Backup:

- Click ‘System Utilities’ button from the ‘Main Form’. Then click the ‘Restore’ tab.
- Select the ‘Source Drive’ containing the backup to be restored. This would be the ‘Destination Drive’ you saved your backup to (Please note if you saved the backup to on removable storage i.e. flash/jump drive, CD, etc., you may have to move the backup to your hard drive/desktop before you can ‘Restore’). Then click ‘Start Restore’.
- Click ‘OK’
- Click ‘OK’ again.

You will be notified when the restore operation completes. PC Ace will terminate automatically following a restore operation. The restored database files and configuration settings will be available the next time the program is executed.

Note: The restore operation will overwrite your current database files with older data from the specified backup.

**PC ACE and Electronic Remittance Advice – 835**

Your PC Ace software can be used to read and print your electronic remittances. You must sign up for this service with your carrier.

Once an electronic remittance is available to you, you will download the file to the following location:
• Open your PC ACE software and select ‘**ANSI 835 Functions**’ from the ‘**Main Form**’.

![PC ACE software screenshot](image1)

• Select ‘**Institutional**’

![Institutional selection options](image2)

• Select ‘**Select ANSI File**’

![Select ANSI File](image3)

• Select the file to be printed or viewed:

![File selection dialog](image4)

• Select ‘**Translate/Import ETRA**’
• Select ‘Print/View Reports’

• Select Type of Report you wish to view from List Below

• The All Claims Report, All Claims Report with Line Detail, Bill Type Summary and Provider Summary Report will allow you to Print certain page Ranges from the report. Enter the First Page you wish to see in the Start Page and the Last Page you wish to see in the End Page.

• Click ‘OK’

Now the Report of the Pages you requested will appear on the screen. You may print now.

• The Single Claims report offers the options to search by Provider (NPI), PCN (Patient’s Control Number), HIC (Health Insurance Claim number) or ICN (Internal Control Number). If the search results produce too many records, combinations of the fields used in Conjunction, can reduce amount of results found.
Electronic Media Claim (EMC) Import

PC ACE allows you to import an ANSI X12 file created on different claim entry software. This function is normally performed to utilize the Payer specific business edits for the Line of Business you are creating claims for. If you choose to use PC ACE to import EMC claims, you must first set up your PC ACE. Be sure you have already set up the:

- **Submitter File Setup** (pg. 26)
- **Provider File Setup** (pg. 33)

**Preferences for EMC Claim Import** (Contact the EDI Help Desk for assistance)

- TRICARE/VAPC3/ARISE/WPS: 1-800-782-2680 (Option 1)
- MAC J5 and J5 National Part A: 1-866-518-3285 (Option 1)
- MAC J8: 1-866-234-7331 (Option 1)

Once you set up your PC ACE and created a claim file on your other software you are ready to import.

Find the claim file created by your other software and rename it with a .DAT extension (i.e. TestFile.DAT)

Go to the drive where your PC ACE is installed (normally your C: drive)

1. Enter the ‘WINPCACE’ folder
2. Place your claim file in the ‘IMPUB92’ folder.
3. Back on the **PC ACE Main Form** click:

4. Then click:

5. On the **Institutional Claim Import** screen click ‘**Import**’:

6. You will be asked if you are ready to import, click ‘**OK**’

7. If there were no errors click ‘**OK**’ (If you receive an error and are unable to determine the cause, call the EDI Help Desk at the telephone number listed above).
8. You will now see the results of your Import. Click ‘Close’.

9. Your claims are now ready to be **Prepare Claims for Transmission (pg. 72)**.

**Additional Assistance using the ‘Help Topics’ Link**

- On the Main PC ACE toolbar select ‘Help’ and then ‘Help Topics’ on the dropdown menu.

- Enter a general keyword in the ‘Search’ field pertaining to the trouble you are experiencing to access further troubleshooting information.
Introducing ABILITY | PC-ACE™

Welcome to the ABILITY | PC-ACE™ Claims Processing System - the system of choice for electronic healthcare claims submission and management. PC-ACE is a complete, self-contained electronic claims processing system. It can be used in a stand-alone configuration or in conjunction with your existing claims management system. Designed exclusively for Microsoft Windows, PC-ACE is the latest generation of the PC-ACE family of electronic claims processing systems that have been successfully serving the healthcare community for decades.

Key Features

PC-ACE is a comprehensive claims management system. Some of the more prominent features include:

- Combined Medicare Part A, Institutional All-Payer and Professional claims system
## Change Summary

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