

Provider Validation Requirements for Taxonomy Submission UB-04: CHC Connect Portal

Providers treating Empower members must be enrolled with Arkansas Medicaid and must have an active Arkansas Medicaid ID, registered taxonomy, NPI and full physical billing address on file with both Arkansas Medicaid and Empower in order to receive reimbursement.

Empower will be validating data via front-end claim edits. If the data submitted on the claim does not match the data registered with Arkansas Medicaid, claims will reject and providers will need to resubmit with corrected data.

Atypical Validation

Medicaid ID
Physical Billing Address (zip 5+4)

Provider types- 06,15,23,27,32
6,39,50,51,52,53,54,55,56,57,67,
70,71,72,73,74,75,82,83,84,85,86
87, 95*

*PT 95 with NW, NT, NU, NV specialties
require NPI

Standard Validation

NPI
Taxonomy
Physical Billing Address (zip 5+4)

Taxonomy Submission UB-04 CHC Connect Portal

Taxonomy details are stored under the “Claim Details” tab for both Billing and Attending Providers

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Claim | UB-04 FORM | **CLAIM DETAILS** | SERVICE LINE DETAILS

Taxonomy detail is stored on the Claim Details Tab

Destination Payer ID: _____ Destination Payer Name: _____ Payer Responsibility: P-Primary [v] [CLEAR] [FIND PAYER]

1. Provider Name: [x] [+]
Address Line One: _____ **Address Line Two:** _____
City: _____ **State:** _____ **Zip:** _____
Telephone (include Area Code): _____

2. Pay-To-Provider Name: [x] [+]
Address Line One: _____ **Address Line Two:** _____
City: _____ **State:** _____ **Zip:** _____

3a. Pat. Cntl # _____ **3b. Med. Rec #** _____ **4. Type Of Bill** _____

5. Fed. Tax No. _____ **6. Statement Covers Period** From (MM/DD/YYYY) _____ Through (MM/DD/YYYY) _____ **7.** _____

8. Patient's Name a. _____ **9. Patient Address** Address Line One: _____ Address Line Two: _____

Enter Billing Provider data on the UB-04 Form screen

Enter the Taxonomy in the “Taxonomy” field for both Billing Provider and Attending Provider Information Tabs

▶ **Additional Patient Information**

▼ **Billing Provider**

Billing Provider Information **ID's**

Organization Name				NP1	
<input type="text"/>				<input type="text"/>	
Address 1		Address 2		Taxonomy	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
City	State	Zip Code	Country Code		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Accepts Assignment	<input type="checkbox"/>			Tax ID	
<input type="text"/>				<input type="text"/>	
<input type="button" value="CLEAR"/> <input type="button" value="FIND PROVIDER"/>				ID Type	Other ID
				<input type="text"/>	<input type="text"/>

▶ **Contact Information**

Attending Provider Information **ID's**

Last Name	First Name	Middle Name	Suffix	NP1	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
				Taxonomy	
				<input type="text"/>	
ID Type		Other ID			
<input type="text"/>		<input type="text"/>			
ID Type		Other ID			
<input type="text"/>		<input type="text"/>			
ID Type		Other ID			
<input type="text"/>		<input type="text"/>			
ID Type		Other ID			
<input type="text"/>		<input type="text"/>			