

**Provider
Web Portal
Authorization
Process**

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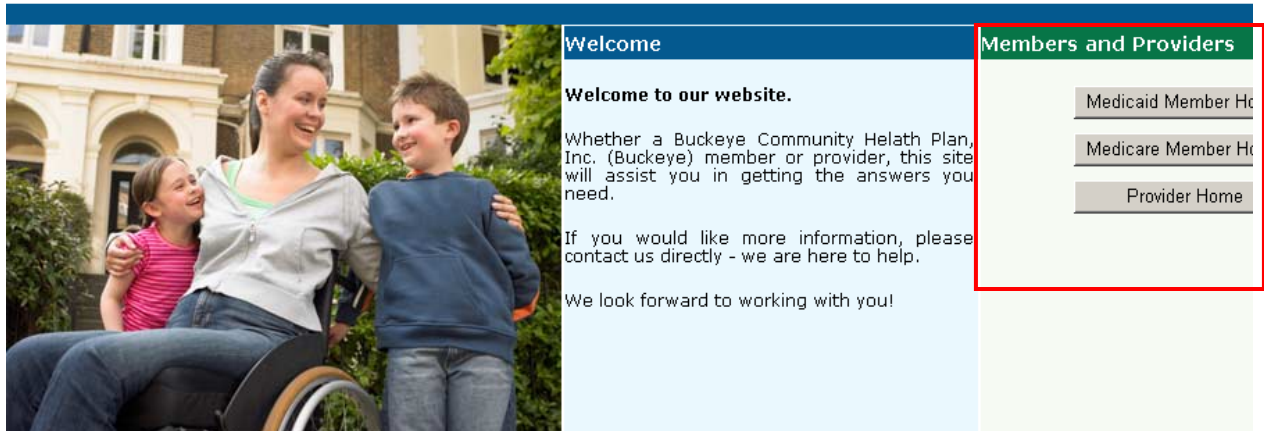
Buckeye Web Service (Authorization) Request



The following materials are a step by step demonstration showing how to submit an online authorization request through the Buckeye Community Health Plan (Buckeye) website. **Authorizations are for initial requests only. Extensions of authorizations must be completed by phone or fax to the health plan.**

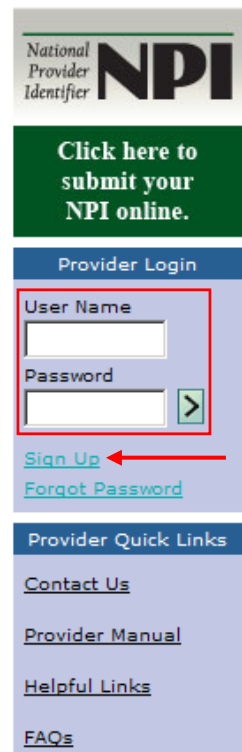
Log onto the Buckeye website via the following link;

[Buckeye Community Health Plan Home](#)



Click on Providers to access the login page.

Before you can log in you will need to create a user account. Click the "Sign Up" link to set up a login and password if you do not have one already. Follow the instructions given. Once you have received your login information, enter your ID in the Provider Login User Name field and the password in the Password field. Login and passwords are case sensitive. If you enter your login or password incorrectly 5 times, you will receive an error message that your account has been locked out. Contact your Provider Relations representative to have your login information reset. Once you have correctly entered the information, press the button on the screen or the enter key on your keyboard. This will take you to the secure web portal where requests for authorizations can be made.



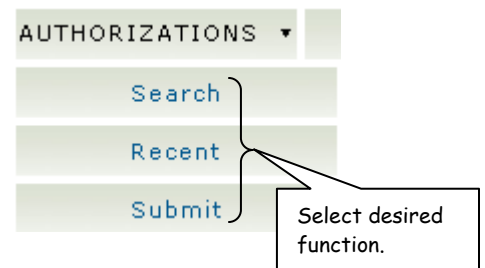
User Search

Tax ID:

Status:

Three functions may be performed from the Authorizations tab.
Click on one of the three desired functions.

- **Search:** Search for an existing authorization previously submitted via the web, to see if the request has been approved, denied, or remains under review by the health plan.
- **Recent:** Look at a summary of requests submitted in the previous 90 days.
- **Submit:** Submit a request for anticipated outpatient services or hospital admissions that will occur on a future date. Urgent/emergent requests must be requested by phone or fax.
 - Authorization requests can only be submitted via the web portal on patients who are currently eligible and for services that have not yet been rendered. Both inpatient and outpatient requests can be submitted by phone or fax. The turn around time for web submitted requests typically takes about two (2) business days, but can take up to five (5) business days.



Authorizations-Submit

1. Select Submit from the drop down choices under Authorizations.

ACCOUNT HOME	ELIGIBILITY	AUTHORIZATIONS	CLAIMS	CONTACT US	RESOURCES
--------------	-------------	----------------	--------	------------	-----------

Authorizations > Submit

1

2

3

4

5

Select Member

Describe Service

Select Provider

Confirm Submission

Received Request

* = Required Information

I have received written permission from member to request the following services on their behalf.

Please enter Medicaid ID or Member ID and the Date of Service (DOS).

Medicaid ID: or Member ID:

Requested Date of Service (DOS):* (MM/DD/YYYY)

Click here once member ID is populated

Please note: Member eligibility and authorization of services are conditions of reimbursement, not a guarantee of payment.

2. In order to select a patient, you must check the permission box stating you have been authorized to act on his/her behalf. Once this box is checked the fields for entering the Member ID will be activated.
3. Enter the Medicaid ID number or the Buckeye ID number for the patient you are requesting services for. You will only be allowed to request services for patients who have current coverage with Buckeye. Patients who need retroactive services, or who are not eligible on the day of the request, may not be submitted via the web portal. You will need to contact Buckeye via the toll free authorization line and speak with a Medical Management representative.
4. Enter the date you are requesting the service to begin. For admissions this would be the proposed admission date. For outpatient services, the day the services are to begin. This date must be a future date. For services beginning on the current or past date, you must call the toll free Medical Management phone number.
5. Click the right arrow once data is entered. This will take you to the screen where you will describe the requested service.

①
Select Member
②
Describe Service
③
Select Provider
④
Confirm Authorization
⑤
Received Authorization

***=Required Information**

Member Information:

Name:	Doe, John D	Date of Birth:	10/05/1968	Eff. Date:	01/15/2007
PCP:	HANNON, LAURA A	Medicaid ID:	:	7099	Term Date: 12/31/2050

Validate information

Service Information:

Inpatient
 Outpatient

Service Type:*
 - Select -

Select setting and service type

Diagnosis Information:

Principal Dx. Code:*		Validate	Diagnosis Lookup
Dx. Code (ICD-9):		Validate	Diagnosis Lookup
Dx. Code (ICD-9):		Validate	Diagnosis Lookup
Dx. Code (ICD-9):		Validate	Diagnosis Lookup

Select primary Dx code. You may also select up to 3 additional dx. codes.

←
→

6. Validate the correct patient name, DOB and effective coverage for reference.
7. Two types of authorization requests can be submitted.
 - a. **Inpatient:** Patient has been admitted to an inpatient setting and will be staying overnight to receive care. Admission reasons include:
 - Border Baby
 - C-Section Delivery
 - Hospice
 - Medical
 - NICU/SCN
 - OB Non-Delivered
 - Rehab
 - Skilled Nursing
 - Sub-Acute
 - Surgical
 - Transplant
 - Vaginal Delivery

b. **Outpatient:** Patient needs services provided in an outpatient delivery setting. This includes the following request types:

- Diagnostic Test/Imaging
- Dialysis
- DME
- Home Health
- Injectables
- Observation
- Orthotic & Prosthetics
- Pain Management
- Professional Services (fees for physician in conjunction with surgery on the prior auth list)
- Specialists (Office Visits)
- Surgery
- Therapy/Rehab (Physical, Occupational and Speech)
- Transportation

8. Next complete the diagnosis information. Enter the primary ICD-9 code. If you are uncertain of the code, a lookup library is provided to the right of the field. You can use a partial ICD-9 code or key words to find the correct code. You must click 'validate' prior to moving on to the next page. If an incomplete or invalid code was entered, you will need to look up a valid code using the lookup table. If you have entered a valid ICD-9 code, your diagnosis box will populate with the numeric and text description of the code.
9. Click the forward arrow key to move to the next screen.

Submitting a Request

This next section will describe how to submit a request for Inpatient Services, followed by instructions for submitting a request for outpatient services.

Inpatient Requests

1. The actual admission date field is for the date the patient was admitted. Since requests are submitted prior to the patient actually being admitted, please leave this field blank.
2. Enter the principal procedure code and any additional procedure codes, clicking the 'Validate' button after each entry. Procedure codes are required for any surgical or invasive procedure. Utilize only standardized, current CPT codes. If you are uncertain of the code, you may use the lookup tables. If you enter an incorrect code an error message will be generated. If there are more than 4 CPT codes, enter the additional codes in the *Additional Clinical Information* field.
3. Complete the Inpatient Clinical Information section, including symptoms, medications, and all other pertinent information to support the admission.
4. Click the right arrow to move to the next screen.

Actual Admission Date: (MM/DD/YYYY)

Procedure Information:

Principal Proc. Code: *	<input type="text"/>	Validate	Procedure Lookup
Proc. Code(CPT):	<input type="text"/>	Validate	Procedure Lookup
Proc. Code(CPT):	<input type="text"/>	Validate	Procedure Lookup
Proc. Code(CPT):	<input type="text"/>	Validate	Procedure Lookup

Inpatient Clinical Information:

Symptoms: *

Enter clinical information to substantiate need for admission

Medication: *

Enter all medications that the patient is currently taking.

Additional Clinical Information:

Enter additional pertinent clinical information



5. Click the right pointing arrow to select the provider.
6. Select the admitting provider from the drop down list or click the Provider/Facility lookup link to select the admitting provider.
7. Click the Adm. Provider Lookup button to select the admitting physician.

NOTE: Names of providers may appear more than once on the list. Multiple listings are part of the health plan's internal processes to reimburse providers to correct geographical sites. The system is functioning correctly with multiple listing of the same name.

8. Click the Provider/Facility Lookup button to select the admitting facility.



Member Information:

Name: **SIMONS, PATTY G** Date of Birth: 04/13/1974 Eff. Date: 10/01/2002
 PCP: THEILER, RANDY T Medicaid ID: 3957450670 Term Date: 12/31/2050

Diagnosis Information:

Principal Dx. Code: **123.**
 Principal Dx. Desc: other cestode
 infection

Service Information:

Service Type: **Medical**
 Req. Date of Service: 7/25/2007 Actual Admission Date:
 Principal Proc. Code:
 Principal Proc. Desc:

*=Required Information

Contact Information:

Name: **Regtest RegtestMon**
 Phone#: (123) 456-7890
 Fax#:

Adm. Provider :* [Provider/Facility Lookup](#)

Servicing Provider Information:

Please select the appropriate facility.

Facility :* [Provider/Facility Lookup](#)



Please note: Member eligibility and authorization of services are conditions of reimbursement, not a guarantee of payment.

Click the lookup button to select the admitting provider and the facility where the admission will be.

9. A list of facilities matching the search criteria will open. In this example we browsed for hospitals whose name starts with "Green". It is best to select a facility with 'Y' under Participating, as this indicates the facility is in the Buckeye network. Select the facility based on the address. As indicated above, a facility may be listed multiple times with the same information. Once the provider is selected, click *Accept* at the bottom of the page.

Provider Lookup Results

Provider/Facility entries may appear more than once to account for internal claims processing rules. Please select one Provider/Facility entry based on name and address.

Provider/Facility Not Listed 

Name	Address	Phone #	Participating
<input type="radio"/> GREEN VALLEY CARE CENTER	3118 GREEN VALLEY RD NEW ALBANY, IN 47150	(812) 945-2341	N
<input type="radio"/> GREENE CNTY GEN HOSP 100269150		(812) 847-5208	N
<input type="radio"/> GREENE CNTY GEN HOSP 100269150	RR 1 BOX 1000 LINTON, IN 47441	(812) 847-5208	N
<input checked="" type="radio"/> GREENE CNTY GEN HOSP 100269150	RR 1 BOX 1000 LINTON, IN 47441	(812) 847-5208	Y
<input type="radio"/> GREENE MEMORIAL HOSPITAL	LOCATOR 802 CINCINNATI, OH 45271		N
<input type="radio"/> GREENE MEMORIAL HOSPITAL	LOCATOR 802 CINCINNATI, OH 45271		N
<input type="radio"/> GREENVIEW REGIONAL HOSPITAL			N
<input type="radio"/> GREENVIEW REGIONAL HOSPITAL	PO BOX 90024 BOWLING GREEN, KY 42102		N
<input type="radio"/> GREENVIEW REGIONAL HOSPITAL	PO BOX 90024 BOWLING GREEN, KY 42102		N

1 - 9 of 9 Results << First | < Prev | Next > | Last >>

ACCEPT

CANCEL

10. If the provider is not listed, click the Provider/Facility Not Listed button. Click the right arrow to move to the next page.

11. Enter the correct provider name, address, and phone number.

Non-Par Provider/Facility Information:

Svc. Provider Name :*

Svc. Provider Address :*

Svc. Provider Phone :* Enter format as XXXXXXXXXXXX (10 digits).

Svc. Provider Speciality:*

Enter the actual name of the provider, as well as the physical address, phone number, and specialty.

12. Click the right arrow to move to the next page.

13. Review the information for accuracy. If any changes are needed, click the back arrow. If everything is correct, click the Submit button.

NOTE: *Authorization* is a condition of reimbursement, not a guarantee of payment.

14. Examples of submitted requests will be after the section for submitting Outpatient Requests.

1 Select Member 2 Describe Service 3 Select Provider 4 **Confirm Submission** 5 Received Request

Please review the following to ensure accuracy before submitting. If you need to make changes, please click the back button. This authorization submission is for initial requests only.

Print button

Member Information:
 Name: REUILLE, JOHANA J Date of Birth: 10/28/1970 Eff. Date: 01/01/2007
 PCP: HOWARD, MICHAEL D Medicaid ID: 100246224899 Term Date: 12/31/2050

Diagnosis Information:
 Principal Dx. Code: 659.7D
 Principal Dx. Desc: cesarean deliv
 non-urgd

Service Information:
 Service Type: C-Section Delivery
 Req. Date of Service: 5/10/2007 Actual Admission Date: 5/1/2007
 Principal Proc. Code: 59510
 Principal Proc. Desc: cesarean delivery

Service Detail Information:

Provider Information:
 Adm. Provider: SAYED ASIF A Address: 3030 LAKE AVE STE 10 FORT WAYNE, IN 46805 Phone #: (219) 422-2448
 Specialty: PEDIATRICS Participating: N

Facility: GREENE CNTY GEN HOSP 100269150 Address: RR 1 BOX 1000 LINTON, IN 47441 Phone #: (812) 847-5208
 Specialty: HOSPITAL Participating: Y

← SUBMIT

Outpatient

1. Select the type of service requested.
2. Enter the end date, or last day, of services, (the start date will already be populated).
3. Enter the units (i.e. the pieces of equipment, number of visits, etc.). Each referral reason will explain how units are determined.
4. Enter medical necessity information to assist in the decision making. You will also need to add specific information for the request type as indicated below:
 - a. **Diagnostic Test/Imaging** - includes MRIs, CT Scans, PET scans, sleep studies, etc.
 - ♦ Enter the procedure code.
 - ♦ Enter the number and name of the test(s) to be performed.
 - b. **Dialysis**
 - ♦ Describe requested services
 - c. **Durable Medical Equipment (DME)**. All DME over \$500.00 must be prior authorized, as well as any equipment from a non participating provider.
 - ♦ Enter Type of Equipment.

- ♦ Enter HCPCS code. You may enter up to 3 items. If more than 3 items are being requested, enter the additional codes in the *Medical Necessity Information* field.
 - ♦ Indicate whether item is being purchased or not.
 - ♦ If item is being rented, enter the number of months to rent.
 - ♦ Enter the purchase or maximum rental price of the item.
- d. **Home Health**, including Hospice care, physical, occupational, and/or speech therapy rendered in the home setting.
 - ♦ Select the type(s) of service being requested.
 - ♦ For each type selected, enter the number of visits and the duration (i.e. 3 days, 1 week, 1 month, etc.)
 - ♦ If the request is for infusion therapy, enter the name of the drug, the dose, and the duration.
- e. **Injectable Drugs** with a price of \$100.00 or more per dose.
 - ♦ Enter name of the medication, along with the dose, frequency, and duration.
- f. **Observation**
 - ♦ Describe the requested service.
- g. **Orthotics/Prosthetics**
 - ♦ Select type (Orthotic or Prosthetic).
 - ♦ Enter type of orthotic or prosthetic, and the HCPCS code.
 - ♦ Indicate whether the item is bilateral or not.
- h. **Pain Management**
 - ♦ Enter requested services.
- i. **Professional Services** (required for surgical procedures on the prior auth list. Please enter the request for the admission before submitting the outpatient services request. If the member is not going to be admitted, you do not need this referral).
 - ♦ Enter the name of the surgical procedure to be performed
 - ♦ Enter the reference number from the admission request in the Additional Information field.
- j. **Specialists** - all requests for services to a non participating provider, as well as a few other participating specialty types, require a prior authorization. Please see the prior authorization list for participating specialties that require a prior auth.
- k. **Surgery**
 - ♦ Enter the CPT code for the procedure(s).
 - ♦ Enter Medical Necessity Information.
 - ♦ Enter all medications that the patient is currently taking.
- l. **Therapy/Rehab**
 - ♦ Select the type(s) of therapy.
 - ♦ For each type, enter the number of visits and the duration.
- m. **Transportation**
 - ♦ Indicate whether transportation is one way or round trip.

- ♦ Indicate vehicle type: Basic Life Support, Advanced Life Support, or Air Transport.
5. Click the Provider/Facility Lookup link and enter the last name of the provider requesting the referral.
 6. Then click the Provider/Facility Lookup link and enter the last name of the provider that will be rendering the service requested.

NOTE: Names of providers may appear more than once on the list. Multiple listings are part of the health plan's internal processes to reimburse providers to correct geographical sites. The system is functioning correctly with multiple listings of same name.

7. If the provider is not listed, click the Provider/Facility Not Listed button. Click the right arrow to move to the next screen.
8. Enter the correct provider name, address, and phone number.

Non-Par Provider/Facility Information:

Svc. Provider Name :*	<input type="text" value="Non-Par Provider/Facility"/>	Enter the name of the provider, as well as the physical address, phone number, and specialty.
Svc. Provider Address :*	<input type="text"/>	
Svc. Provider Phone :*	<input type="text"/> Enter format as XXXXXXXXXXXX (10 digits).	
Svc. Provider Speciality:*	<input type="text" value="- Select -"/>	

9. Click the right pointing arrow to select the provider.

1
Select
Member

2
Describe
Service

3
Select
Provider

4
Confirm
Submission

5
Received
Request

Please review the following to ensure accuracy before submitting. If you need to make changes, please click the back button. This authorization submission is for initial requests only.



Member Information:
Name: **REUILLE, JOHANA J** Date of Birth: 10/28/1970 Eff. Date: 01/01/2007
PCP: **HOWARD, MICHAEL D** Medicaid ID: 100246224899 Term Date: 12/31/2050

Diagnosis Information:
Principal Dx. Code: **669.70**
Principal Dx. Desc: cesarean deliv
nos-unsp

Service Information:
Service Type: **C-Section Delivery**
Req. Date of Service: 5/10/2007 Actual Admission Date: 5/1/2007
Principal Proc. Code: **59510**
Principal Proc. Desc: cesarean delivery

Service Detail Information:

Provider Information:
Adm. Provider : **SAYED ASIF A** Address: 3030 LAKE AVE STE 10 FORT WAYNE, IN 46805 Phone #: (219) 422-2448
Specialty: PEDIATRICS Participating: N
Facility : **GREENE CNTY GEN HOSP 100269150** Address: RR 1 BOX 1000 LINTON, IN 47441 Phone #: (812) 847-5208
Specialty: HOSPITAL Participating: Y



10. Review the information for accuracy. If any changes are needed click the back arrow. If everything is correct, click the Submit button.

NOTE: *Authorization* is a condition of reimbursement, not a guarantee of payment.

Confirmation of Submission

After submitting your request, a reference number will be generated. This number is not the actual authorization number, but confirmation of a successful transaction via the web. The request is now 'under review' by the health plan medical management department. Check back in 1-2 business days for a response to your request. It may take up to 5 business days for a decision to be rendered.



Reference number is to show successful web transaction. This is not the authorization number

Reference #: 60000100007254301

SUBMIT NEW AUTHORIZATION



Under Review Information:

Review Reason: Medical management is reviewing the information submitted. Reference # does not confirm authorization approval.



Please check back within the next **1 - 2 business days** for authorization status. Once authorization is approved, the authorization # needed to file your claim will be available.

Auth. Information:

Status: **Under Review**

Member Information:

Name:	REUILLE, JOHANA J	Date of Birth:	10/28/1970	Eff. Date:	01/01/2007
PCP:	HOWARD, MICHAEL D	Medicaid ID:	100246224899	Term Date:	12/31/2050

Diagnosis Information:

Principal Dx. Code: **669.70**
 Principal Dx. Desc: cesarean deliv nos-unsp

Service Information:

Service Type: **C-Section Delivery**

Req. Date of Service: 5/3/2007 Actual Admission Date: 5/1/2007

Principal Proc. Code: **59430**
 Principal Proc. Desc: care after delivery

Service Detail Information:

Provider Information:

Adm. Provider :	SAYED ASIFA	Address:	3030 LAKE AVE STE 10 FORT WAYNE, IN 46805	Phone #:	(219) 422-2448
Specialty:	PEDIATRICS	Participating:	N		
Facility :	GREENE CNTY GEN HOSP 100269150	Address:	RR 1 BOX 1000 LINTON, IN 47441	Phone #:	(812) 847-5208
Specialty:	HOSPITAL	Participating:	Y		

Please note: Member eligibility and authorization of services are conditions of reimbursement, not a guarantee of payment.

Auth. Information:

Status: **Under Review**

To submit another request on the same or different patient, click the *Submit New Authorization* button. This will return you to the first screen where the process begins (go back to page 3 for directions).

Checking the Status of Authorizations


There are two ways to search for authorization requests submitted via the web portal: Recent or Search. Only requests submitted via the web portal can be searched. Picking the *Recent* selection allows you to view a summary of authorizations requested via the web during the last 90 days.

The *Search* feature allows you search using specific parameters such as date range, patient, servicing provider, service type, or reference number.

- To use the Search function, click Authorizations, then Search.
 - Enter the search parameters (date range, Member ID, Servicing Provider, Service Type or Reference Number).
 - Click the Search button.

Search Authorizations

The search feature allows you to find authorizations that date back farther than 90 days, using one of the search methods below.

 Only authorizations submitted online will be searchable.

* =Required Information

Search By

Date Range
 Member
 Servicing Provider
 Service Type
 Reference #

Search By Date Range

From: * (MM/DD/YYYY)

To: * (MM/DD/YYYY)

SEARCH

The following example shows the results after selecting search by date range. The screen shows there are eighteen approvals, seven under review and fifteen not authorized. You may click on the any tab to view the outcomes. To view information for a specific request, click the Reference Number.

Search Authorizations Results



Approved(18) Under Review(7) Not Authorized(15)							
Reference #	Member	Svc.Provider / Facility	Auth #	Req.Svc.Date	Units	Service Type	Auth.Date
60000400009374301	CELI, [REDACTED]	ABA [REDACTED] / [REDACTED]	XR1 [REDACTED]	08/31/2007	3	Surgery	06/14/2007
60000300021067301	AYED [REDACTED]	CORNING	XR1 [REDACTED]	08/08/2007	2	Surgery	06/14/2007

- To use the Recent function, click Authorizations, then select Recent.

Example of Denied Authorization

Reference #: 6000300020980401



Request Information:



After review of the submitted clinical information, your request is not authorized at this time.

If you have additional pertinent clinical information that would more clearly define the medical necessity for the service requested, please contact the health plan Medical Management Department at 800-429-4585 (option 5). A Notice of Action letter will be sent in the mail explaining grievance and/or appeal rights and procedures.

Auth. Information:

Status: **Not Authorized** Start Date: 06/23/2007 Units Req.: 2
Submission Date: 06/14/2007 End Date: 06/23/2007

Member Information:

Name: **SALAZAR, ELMER** Date of Birth: 07/12/1991 Eff. Date: 05/01/2006
PCP: BOKHARI, NAIMAT Medicaid ID: 093010673320 Term Date: 12/31/2050

Diagnosis Information:

Principal Dx.Code: **002.1**
Principal Dx.Desc: paratyphoid fever
a

Service Information:

Service Type: **Surgery**

Principal Proc.Code: **00.12**
Principal Proc.Desc: adm inhal nitric
oxide

Service Detail Information:

Provider Information:

Ref. Provider: **GRECO JR,
JOHN S** Address: 776 SHREWBURY AVENUE Phone #: (732) 741-7997
TINTON FALLS, NJ 07701
Specialty: OPHTHALMOLOGY Participating: Y

Svc. Provider: **VIRTUA MEMORIAL,** Address: 175 MADISON AVENUE Phone #: (609) 261-7011
MOUNT HOLLY, NJ 08060
Specialty: HOSPITAL Participating: Y