SMARTDATASTREAM
Clearinghouse Services

SMART DATA STREAM COMPANION GUIDE

PORTAL.SMARTDATASTREAM.US

SDS Provider Support

stream.support@sdata.us

855-297-4436

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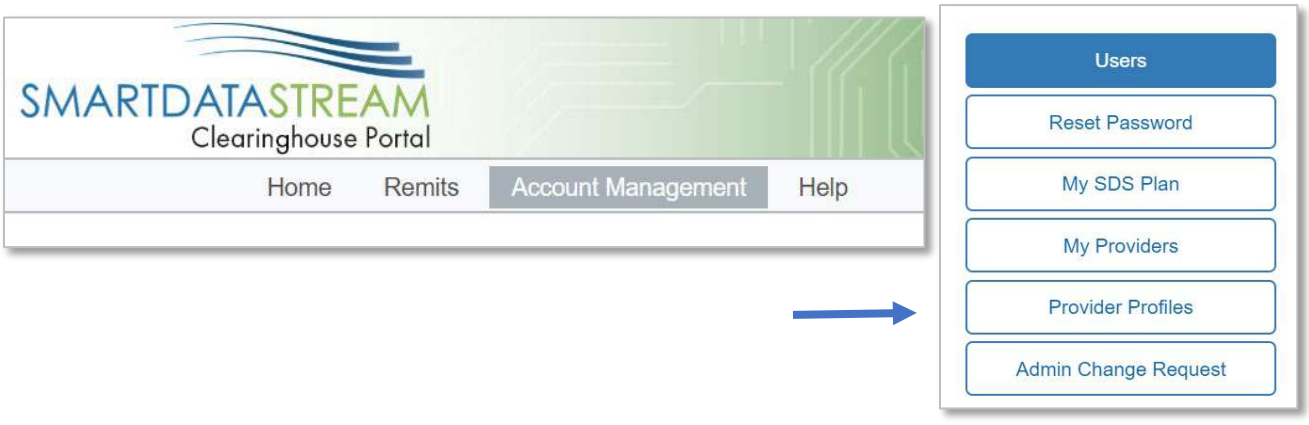
ERA ENROLLMENT

- There are several different methods for starting an ERA account with Smart Data Solutions depending on which payer you're enrolling for. If you have an account that doesn't include ERA enrollment already, or if you have a specific ERA account and would like access to additional payer's ERAs, please contact us as stream.support@sdata.us or 855-297-4436 opt. 2 for more information.

STARTING ERA ENROLLMENT

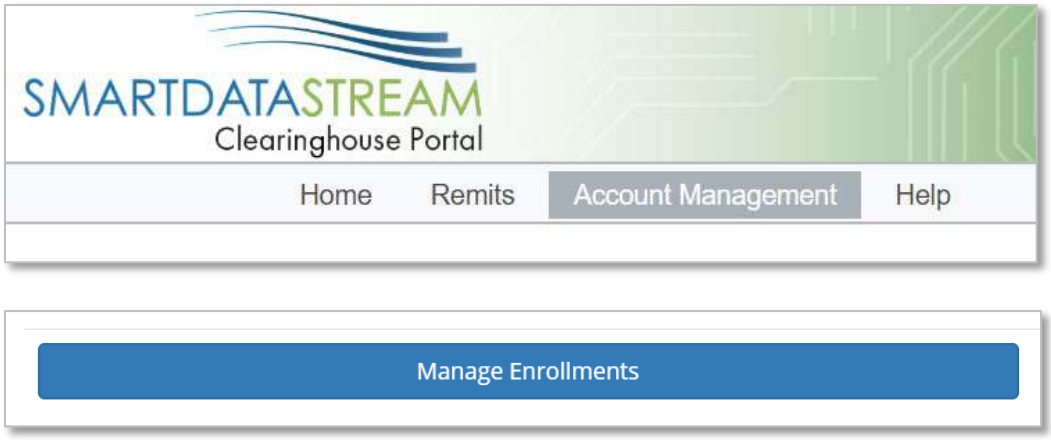
- After you've logged in and changed your password, you should be immediately prompted to start your ERA enrollment.

- If the above screen does not automatically appear you can select Account Management at the top bar. Then select Provider Profiles

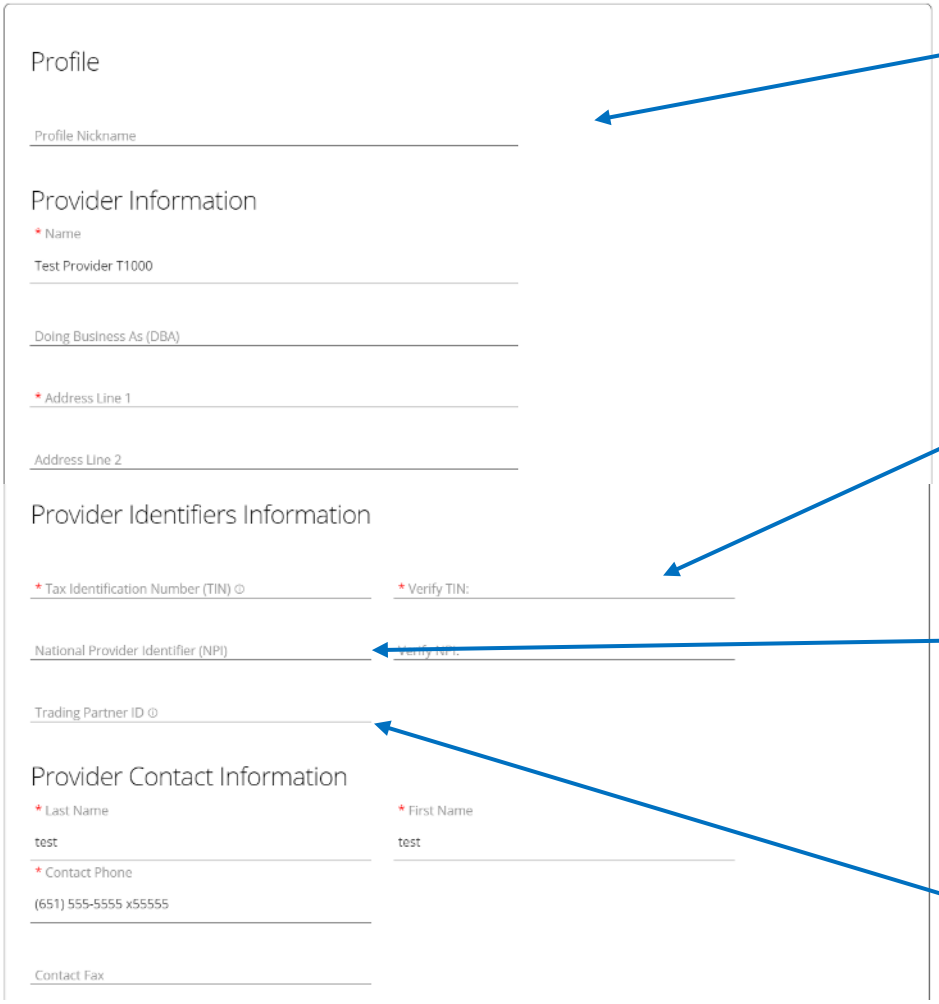


OR

- Select Remits at the top bar then Manage Enrollments



ENROLLMENT FORM



Profile Name will not affect your ERAs and is only for labeling enrollments on your account

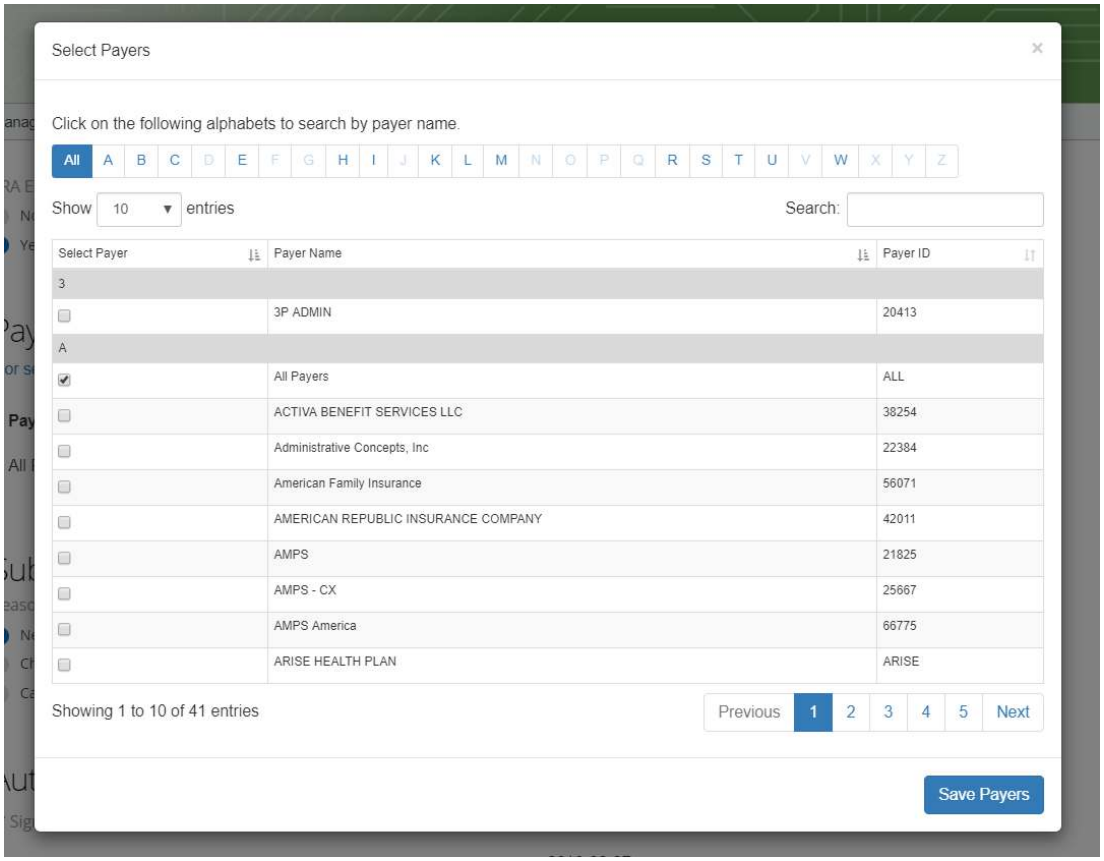
Don't forget to verify your tax ID

NPI is not required for your ERA enrollment. If left blank, you will receive ERAs for all NPIs associated with the Tax ID you enroll

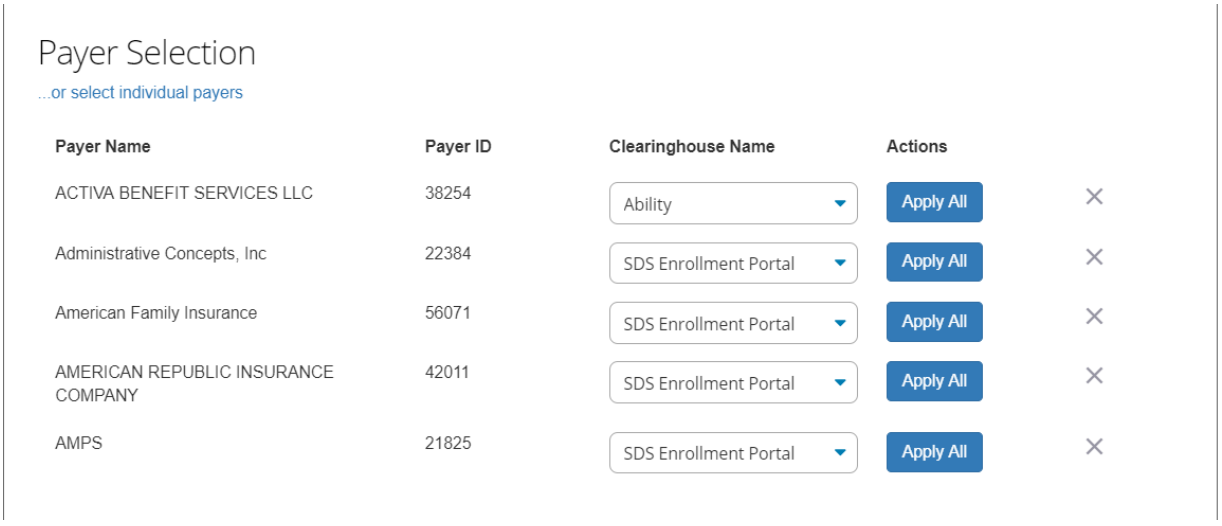
Trading Partner ID is not required if you do not have one

Fax may be left blank if unavailable

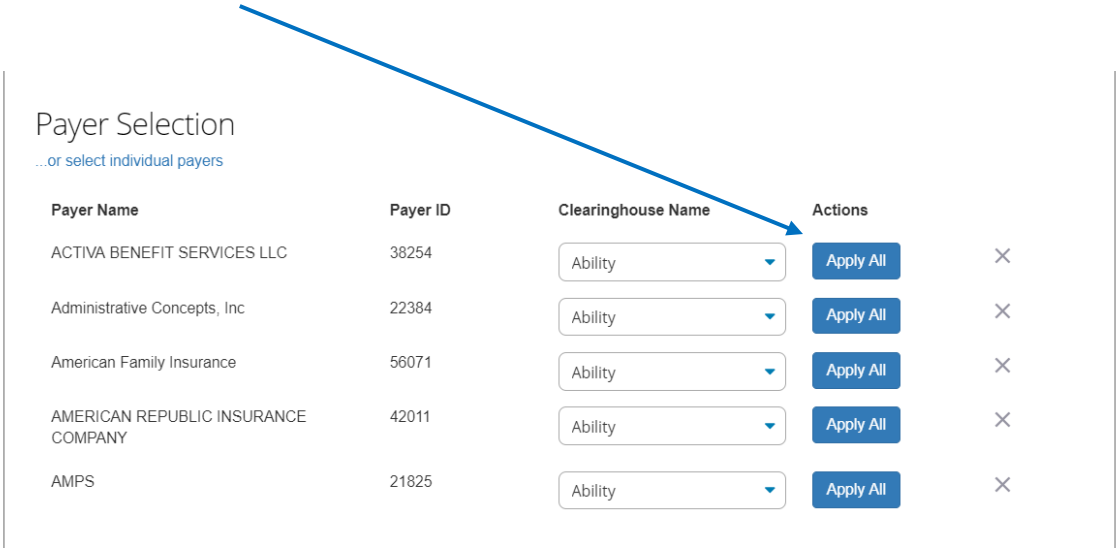
- Under Payer Selection select "or select individual payers" You will then see the screen below:



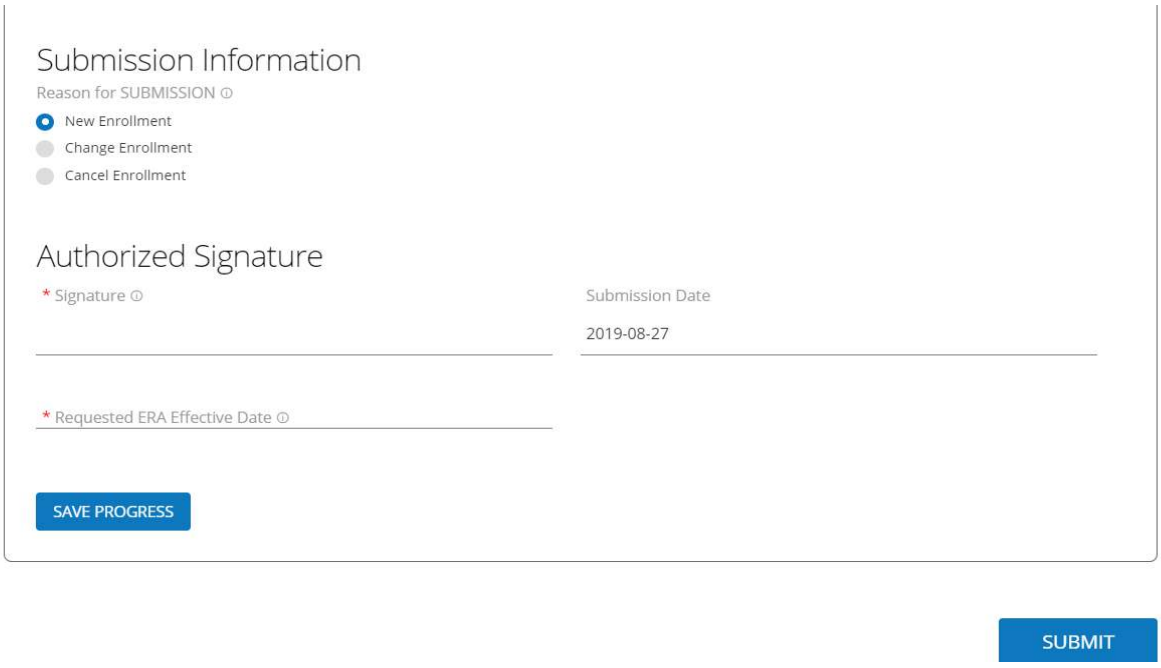
- Select Clearinghouse



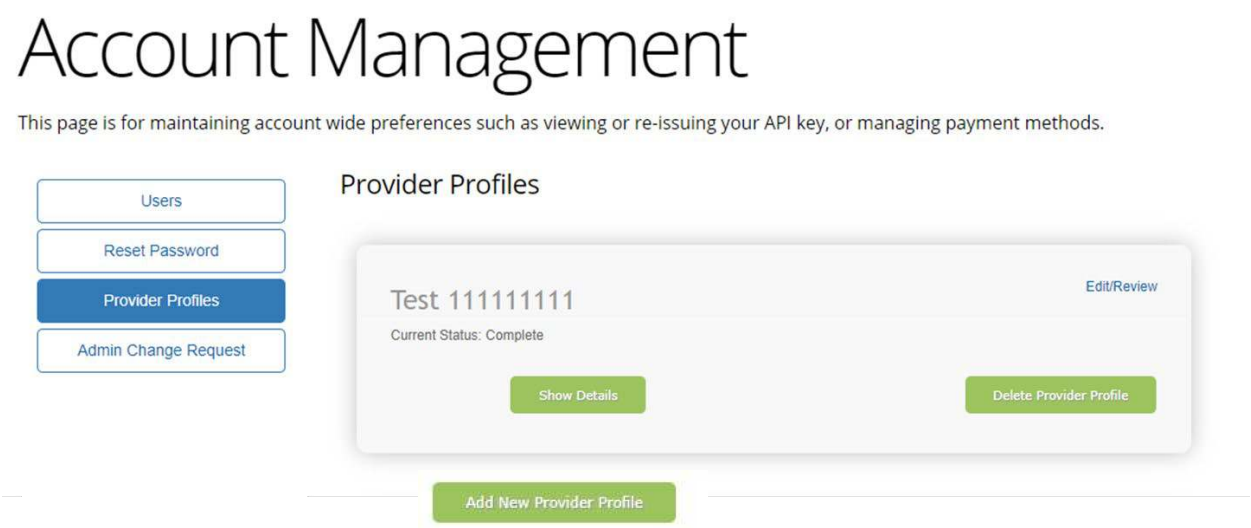
- Select "Apply All" to the right of the Clearinghouse Name and you will see the following result

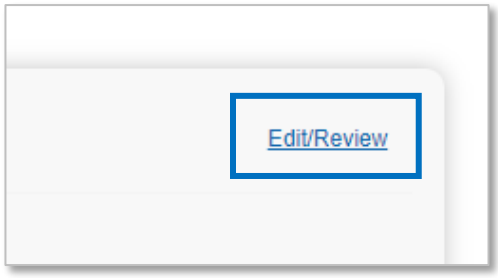


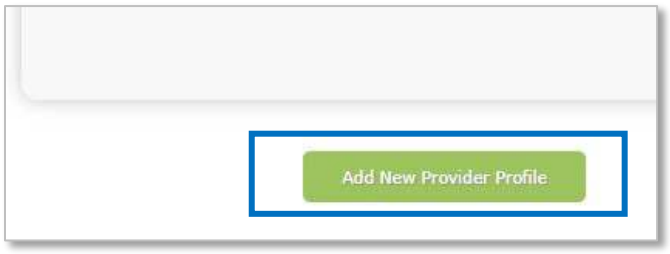
- The form will automatically have New Enrollment selected. If you click Save Progress and then come back to it, it will say Change Enrollment.
    - This does not affect your enrollment and only indicates that this is no longer the first time you are accessing this form.
- Type in your name for the signature.
- For the effective date, the soonest date available will be three days after the submission date. Any payments you receive after that submission date will have a corresponding ERA sent to your account.



- After you click Submit it will redirect you to a page that looks like this. If you see this page, you have successfully submitted your ERA enrollment.





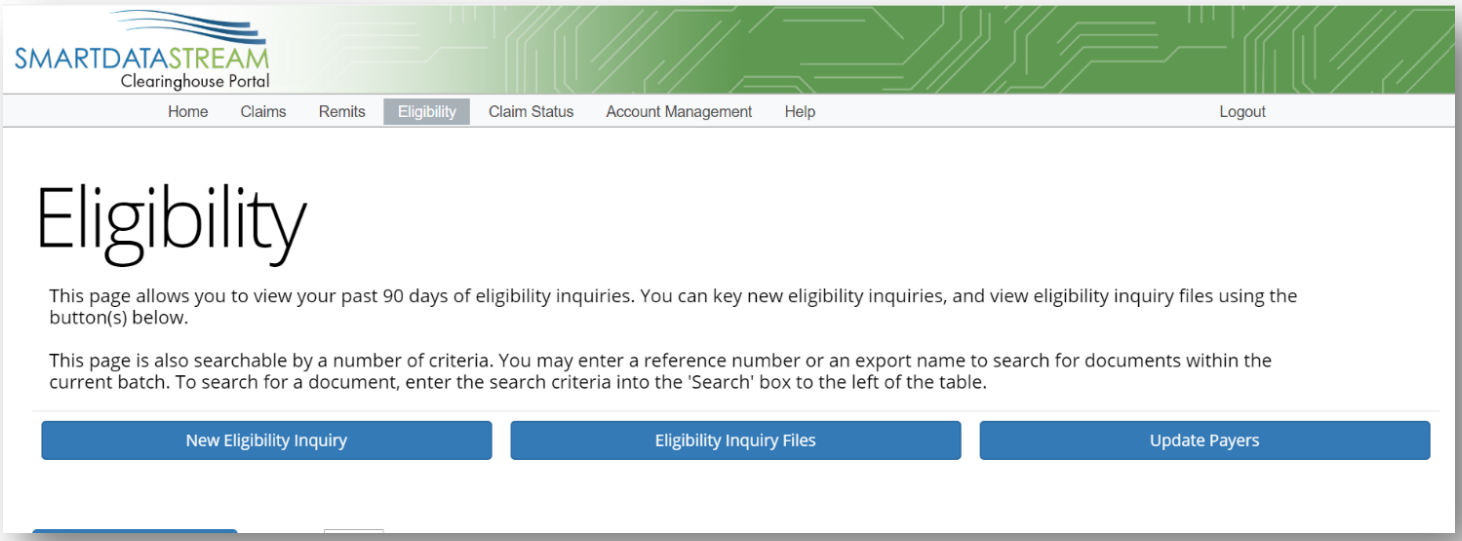


- To change contact information, add or remove payers, change retrieval method, or cancel your enrollment you can click on Edit/Review

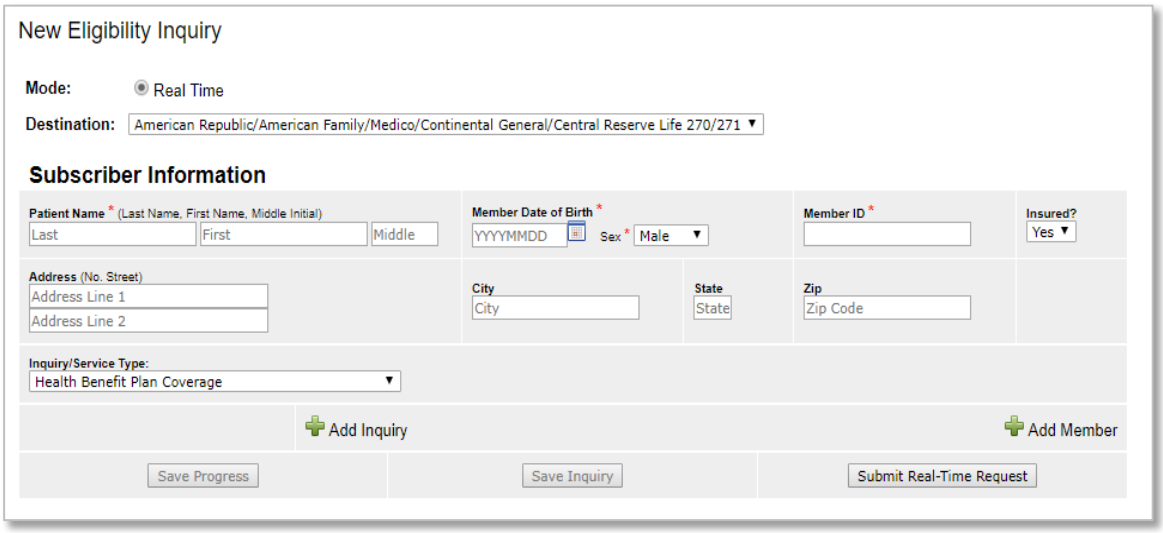
- To enroll additional tax ID's or NPI's click Add New Provider Profile

ELIGIBILITY INQUIRY

- Select the Eligibility Tab on the top bar of the page

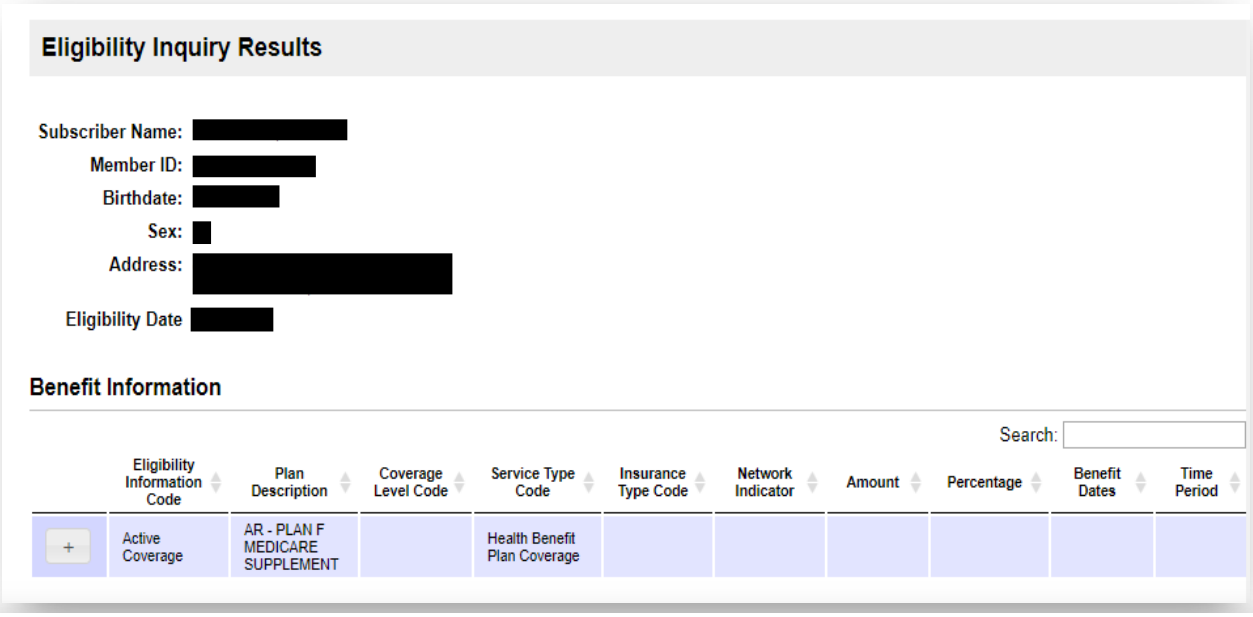


- Select New Eligibility Inquiry



- Fill out the starred boxes on the form and click Submit Request

- Results will vary, but will standardly appear in this format:



Eligibility Inquiry Results

Subscriber Name: [redacted]
Member ID: [redacted]
Birthdate: [redacted]
Sex: [redacted]
Address: [redacted]
Eligibility Date [redacted]

Benefit Information

Search:

	Eligibility Information Code	Plan Description	Coverage Level Code	Service Type Code	Insurance Type Code	Network Indicator	Amount	Percentage	Benefit Dates	Time Period
+	Active Coverage	AR - PLAN F MEDICARE SUPPLEMENT		Health Benefit Plan Coverage						

Eligibility Inquiry Results

Subscriber Name: [redacted]
Member ID: [redacted]
Birthdate: [redacted]
Sex: [redacted]
Address: [redacted]
Eligibility Date [redacted]

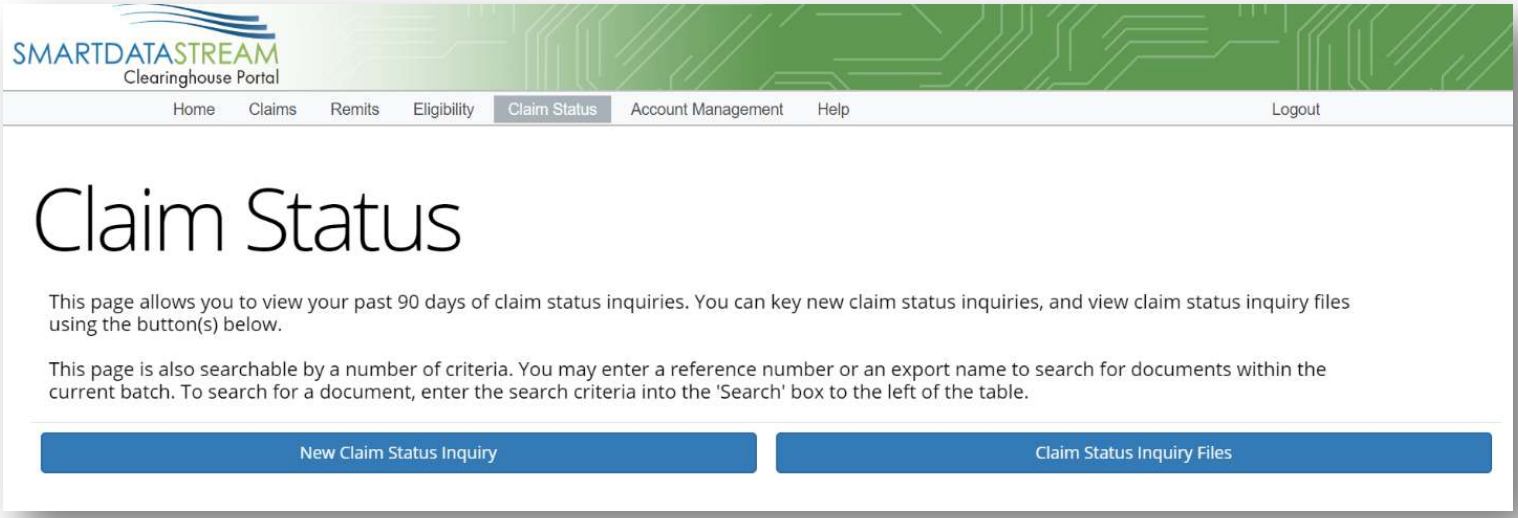
Benefit Information

Search:

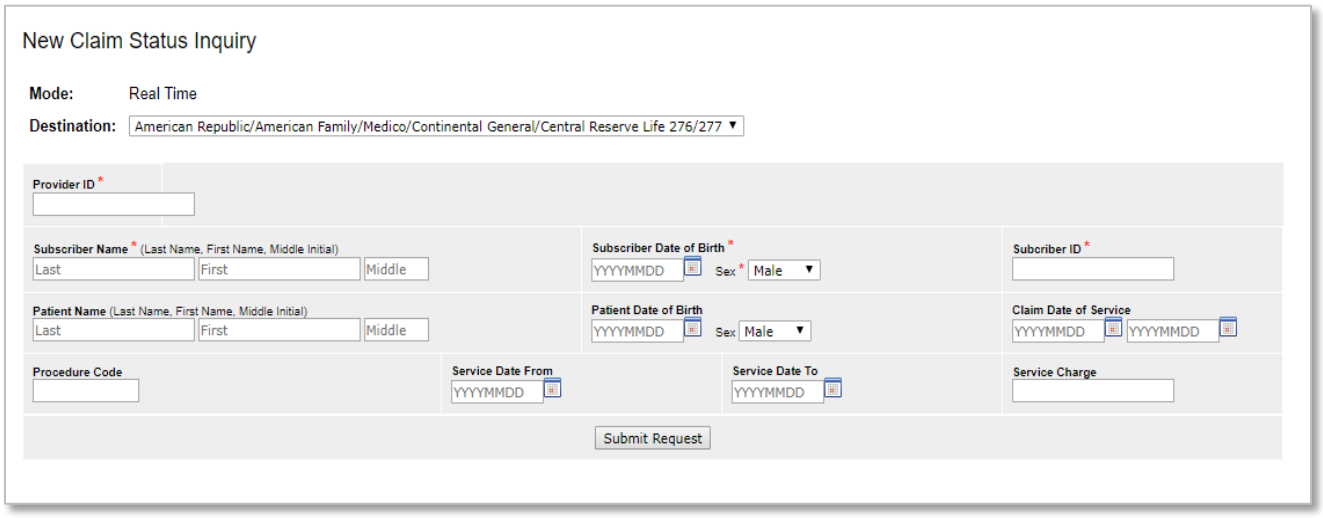
	Eligibility Information Code	Plan Description	Coverage Level Code	Service Type Code	Insurance Type Code	Network Indicator	Amount	Percentage	Benefit Dates	Time Period
+	Active Coverage	MEDICARE SUPP PLAN F		Health Benefit Plan Coverage						
+	Active Coverage	MEDICARE SUPP PLAN F		Medical Care Chiropractic Dental Care Hospital Emergency Services Professional (Physician) Visit - Office Vision (Optometry) Mental Health Urgent Care		Not Applicable			Benefit Begin Date : 20160101	
+	Active Coverage	MEDICARE SUPP PLAN F		Chiropractic Pharmacy Medical Care Dental Care Hospital Vision (Optometry) Mental Health Emergency Services Urgent Care Professional (Physician) Visit - Office						
+	Non-Covered	MEDICARE SUPP PLAN F		Pharmacy		Not Applicable			Benefit Begin Date : 20160101	
+	Co-Insurance	MEDICARE SUPP PLAN F		Health Benefit Plan Coverage		Not Applicable		0.00%	Benefit Begin Date : 20160101	Calendar Year
+	Co-Payment	MEDICARE SUPP PLAN F		Health Benefit Plan Coverage		Not Applicable	$0.00		Benefit Begin Date : 20160101	Calendar Year
+	Deductible	MEDICARE SUPP PLAN F		Health Benefit Plan Coverage		Not Applicable	$0.00		Benefit Begin Date : 20160101	Calendar Year

CLAIM STATUS

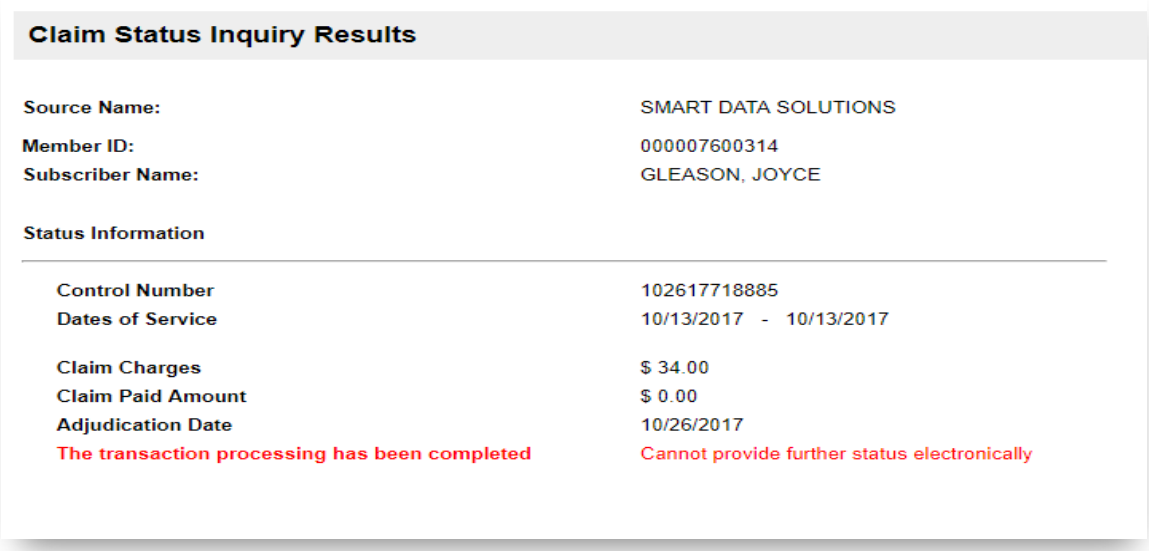
- Select the Claim Status tab on the top bar of the page



- Fill out the starred boxes on the form and click Submit Request



- Results will vary, but will standardly appear in this format:



Claim Status Inquiry Results

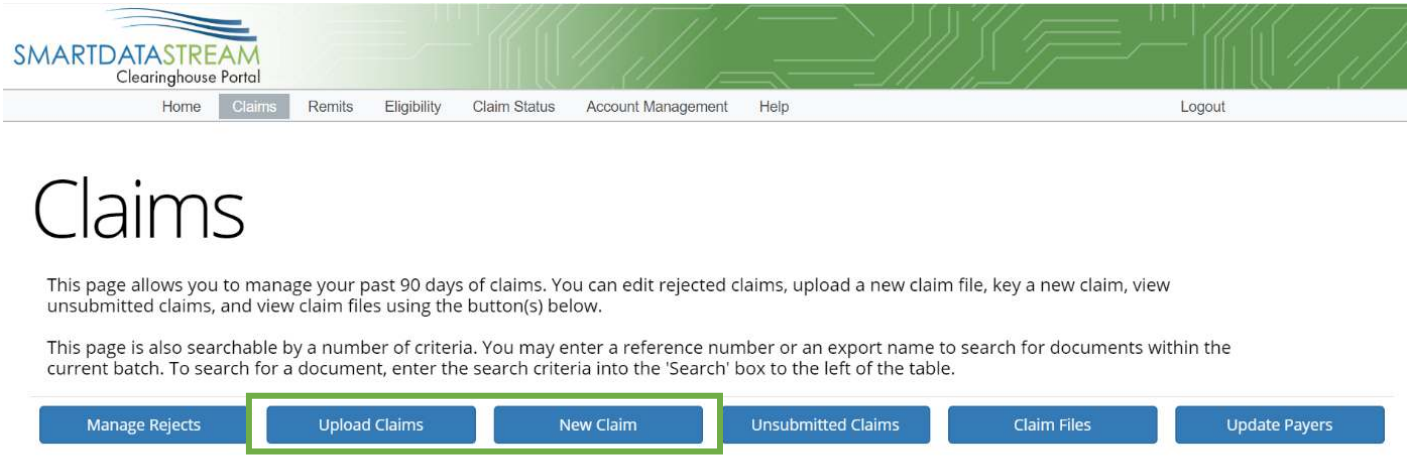
Source Name:	SMART DATA SOLUTIONS
Member ID:	000007600314
Subscriber Name:	GLEASON, JOYCE

Status Information

Control Number	102617718885
Dates of Service	10/13/2017 - 10/13/2017
Claim Charges	$ 34.00
Claim Paid Amount	$ 0.00
Adjudication Date	10/26/2017
The transaction processing has been completed	Cannot provide further status electronically

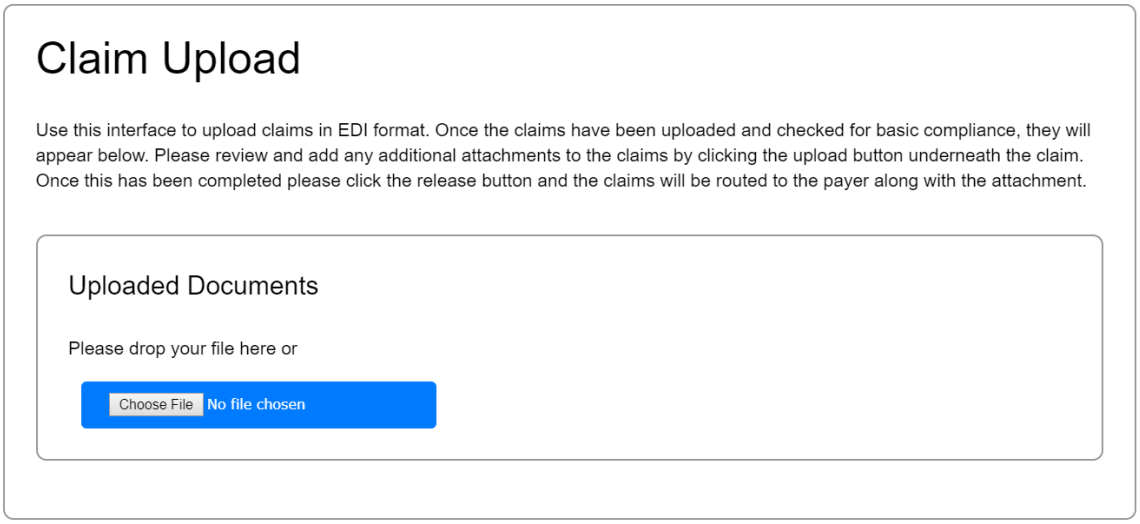
SUBMITTING A CLAIM

- There are two options to submit a claim through the Smart Data Stream Clearinghouse Portal. You can either upload a claim file or you can do Direct Data Entry and key in a new claim.



UPLOAD CLAIMS

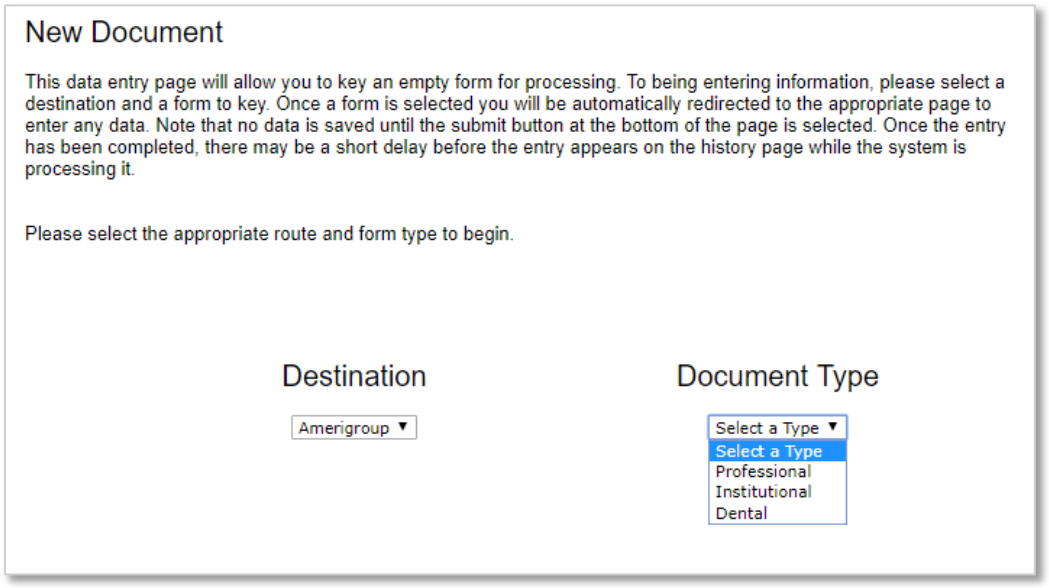
- If you selected "**Upload Claims**", this screen will appear:



- This feature allows you to upload claims in batches to portal. As long as it's a valid 837 file and has a payer ID in the REF02 segment, SDS will successfully route your claims on to the payer.

NEW CLAIM

- If you selected "**New Claim**", this screen will appear. From here you can either choose a Professional/CMS1500 claim form, an Institutional/UB04 claim form, or a Dental claim form.



- Once the claim type has been selected, it will bring up a template for the claim information to be typed into. The various document types are shown below:

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PROFESSIONAL

More

1. Type OTHER		1a. INSURED'S I.D. NUMBER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Last First Middle	3. PATIENT'S BIRTH DATE YYYY/MM/DD Sex	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Last First Middle
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO INSURED Self	7. INSURED'S ADDRESS (No. Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE		ZIP CODE / TELEPHONE
9. OTHER INSURED's NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED's POLICY OR GROUP NUMBER [More...]	10. IS PATIENT'S CONDITION RELATED TO: Employment? No / Auto Accident? No / Other Accident? No	a. INSURED'S BIRTH DATE YYYY/MM/DD Sex
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? No
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Signed		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Signed
14. DATE OF CURRENT ILLNESS, INJURY, PREGNANCY (LMP) YYYY/MM/DD QUAL	15. OTHER DATE QUAL YYYY/MM/DD	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION YYYY/MM/DD TO YYYY/MM/DD
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Last First	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES YYYY/MM/DD TO YYYY/MM/DD
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? No / $ CHARGES 0.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. ICD-10 A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 1 / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE	B. POS	C. EMG	D. PROC	MODIFIER	E. DIAG	F. CHARGE	G. D/U	H. EPSDT	I. QUAL	J. PROVIDER ID

Add Line

25. FEDERAL TAX I.D. NUMBER	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? No	28. TOTAL CHARGE $ 0.00 / 29. AMOUNT PAID $ 0.00	30. RSVD for NUCC Use
31. SIGNATURE OF PHYSCIAN OR SUPPLIER Last First Middle Credential	32. SERVICE FACILITY LOCATION INFORMATION Name Address City / Zip / Phone a. NPI / b.		33. BILLING PROVIDER INFORMATION Name Address City / Zip / Phone a. NPI / b.	

Save Progress | Save Billing Information | Submit Document

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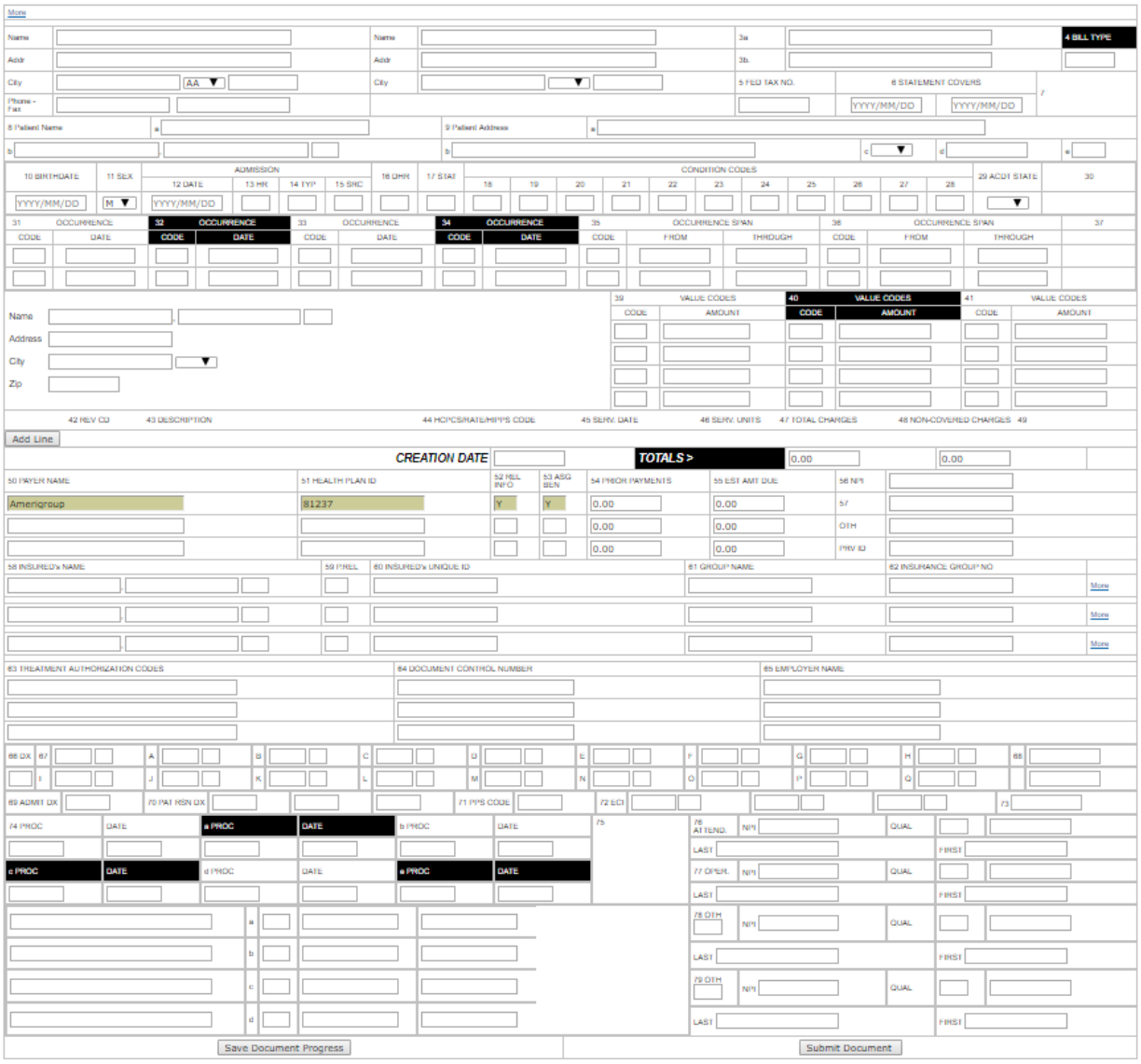
INSTITUTIONAL



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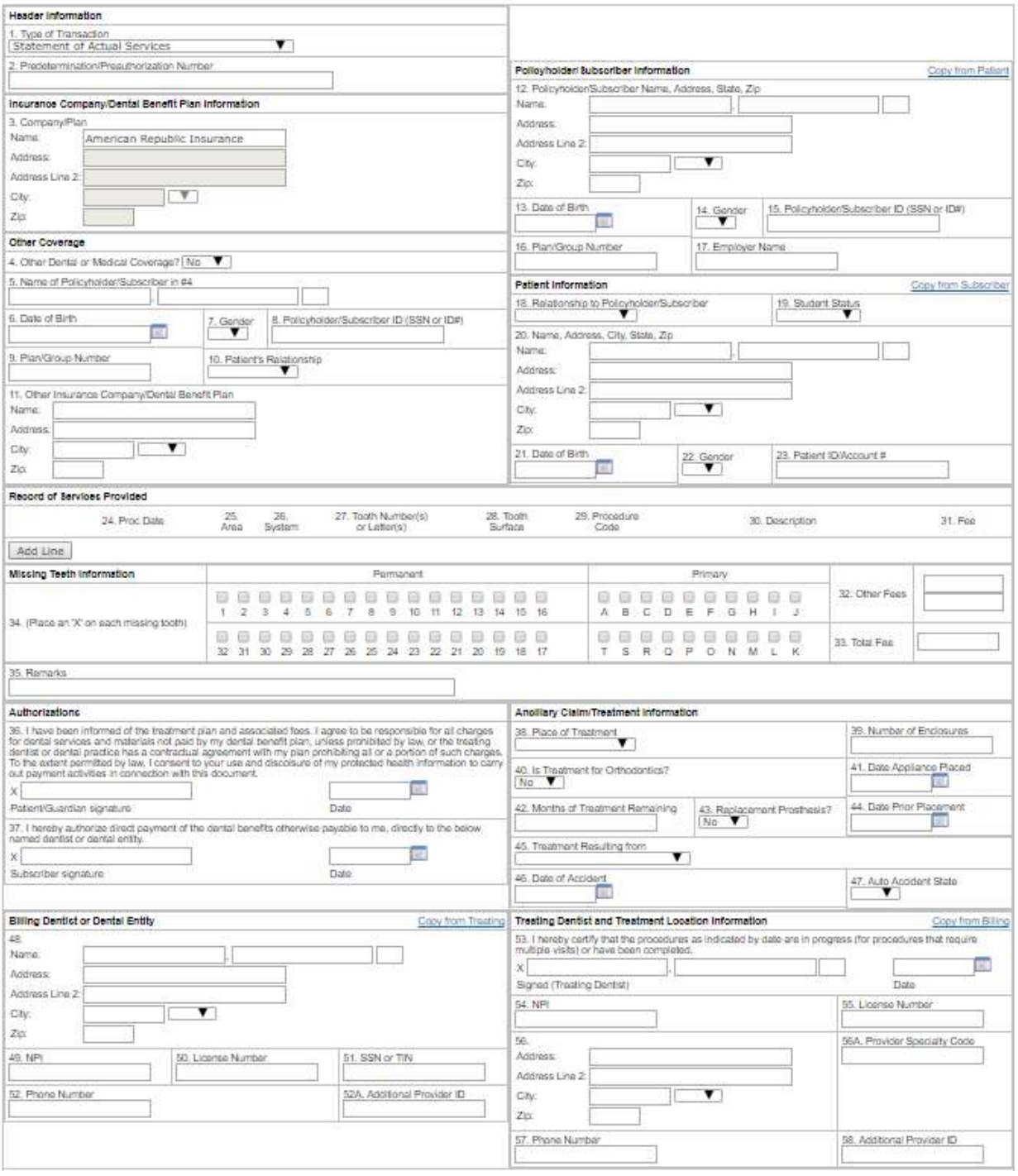
DENTAL



Header Information

1. Type of Transaction: Statement of Actual Services

2. Predetermination/Preauthorization Number

Insurance Company/Dental Benefit Plan Information

3. Company/Plan
Name: American Republic Insurance
Address:
Address Line 2:
City:
Zip:

Other Coverage

4. Other Dental or Medical Coverage? No

5. Name of Policyholder/Subscriber in #4

6. Date of Birth | 7. Gender | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship

11. Other Insurance Company/Dental Benefit Plan
Name:
Address:
City:
Zip:

Policyholder/ Subscriber Information Copy from Patient

12. Policyholder/Subscriber Name, Address, City, State, Zip
Name:
Address:
Address Line 2:
City:
Zip:

13. Date of Birth | 14. Gender | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

Patient Information Copy from Subscriber

18. Relationship to Policyholder/Subscriber | 19. Student Status

20. Name, Address, City, State, Zip
Name:
Address:
Address Line 2:
City:
Zip:

21. Date of Birth | 22. Gender | 23. Patient ID/Account #

Record of Services Provided

24. Proc Date	25. Area	26. System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee

Add Line

Missing Teeth Information

34. (Place an 'X' on each missing tooth)

Permanent															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Primary									
A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

32. Other Fees

33. Total Fee

35. Remarks

Authorizations

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this document.
X | Date
Patient/Guardian signature

37. I hereby authorize direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X | Date
Subscriber signature

Ancillary Claim/Treatment Information

38. Place of Treatment | 39. Number of Enclosures

40. Is Treatment for Orthodontics? No | 41. Date Appliance Placed

42. Months of Treatment Remaining | 43. Replacement Prosthesis? No | 44. Date Prior Placement

45. Treatment Resulting from

46. Date of Accident | 47. Auto Accident State

Billing Dentist or Dental Entity Copy from Treating

48.
Name:
Address:
Address Line 2:
City:
Zip:

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number | 52A. Additional Provider ID

Treating Dentist and Treatment Location Information Copy from Billing

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X | Date
Signed (Treating Dentist)

54. NPI | 55. License Number

56.
Address:
Address Line 2:
City:
Zip:

56A. Provider Specialty Code

57. Phone Number | 58. Additional Provider ID