

Availity® Provider Portal Inpatient Authorization Submissions

Before beginning use of the Availity application, users should make sure the browser is **Chrome**.

Web Browser Best Practices

Every **tab** you open consumes working memory (aka RAM), which can eventually lead to significant performance issues, so keeping the number of open tabs to a minimum is always in your best interest when using any web-based application.



When you use a browser, like Google Chrome™ or Microsoft Edge™, it saves some information from websites in its "cache" and "cookies". Clearing them fixes certain problems, like loading or formatting issues on sites.

YOU SHOULD KNOW...

Availity supports Google Chrome, Firefox® and Microsoft Edge v79, or higher



Be sure to allow for all pop-ups. Clearing your cache and cookies can also ensure the best user experience.

PFA/ Value Insights Center should only be accessed using Google Chrome browser.

Steps to clearing the cache

Google Chrome

1. Open your browser and click the  at the top right of the screen
2. Choose **Delete browsing data**
3. Click the **Advance** tab
4. Change time range to "**All time**"
5. Select the check boxes noted below, as desired:
 - Browsing history
 - Download history
 - Cookies and other site data
 - Cached images and files

Note: If the check box next to cookies and other site data is selected, you will be signed out of most websites.

6. Select **Clear Data**
7. Once the cache is cleared, close all open Chrome browsers, and them restart Chrome.

Microsoft Edge

1. Open your browser and click the  at the top right of the screen
2. Choose **Settings**
3. Choose **Privacy, search and services**
4. Scroll down to select **Clear browsing data now**
5. Click on **Choose what to clear**
6. Ensure **Cookies** and **Temporary Internet files** are marked

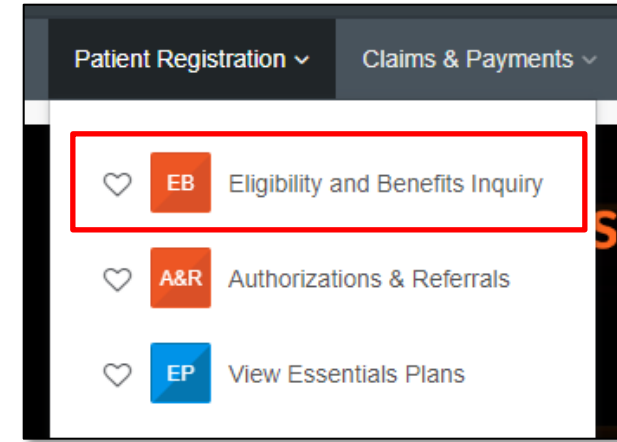
Note: If the check box next to cookies and other site data is selected, you will be signed out of most websites.

7. Select **Delete**

Note: If users are experiencing unexpected errors with functionality, reboot or consider checking to see if the cache has been cleared.

Prior to submitting a prior authorization request, users should first check the member's Eligibility and Benefits, including authorization requirements. It is the provider's responsibility to confirm that the member's benefit plan provides the appropriate benefits for the anticipated date of service.

To do so in Availity, go to **Patient Registration** on the main menu bar and click on **Eligibility and Benefits Inquiry**. Complete the form, including Provider, Member and Service Information.

A screenshot of the Availity 'Eligibility & Benefits' form. The form has a header with an 'EB' icon, the text 'Eligibility & Benefits', and a 'Feedback' button. Below the header is a yellow warning banner with a triangle icon and the text: 'To search for out of area members, use the Single Patient Search tab. Enter the facility or group NPI instead of the individual provider NPI.' Below the banner, there is a note: 'Fields marked with an asterisk * are required.' There are two required fields: '* Organization' with a dropdown menu showing 'Highmark PA Provider Test', and '* Payer' with a dropdown menu showing 'HIGHMARK BLUE SHIELD'. Below these fields is a 'Provider Information' section with a 'Clear Section' button. The section contains the text: 'Select a provider or enter one of the following: Provider NPI or Provider Tax ID'. There is a 'Provider' dropdown menu and a search box with the text: 'Search for a provider by name, NPI, tax ID, taxonomy code, or address'.

*Verifying Eligibility and Benefits prior to submitting a prior authorization request and/or submitting a claim can:

- 1) Help users avoid submitting unnecessary prior authorization requests
- 2) Confirm patient copays and/or coinsurance
- 3) Minimize claims rejections

For additional assistance on Eligibility & Benefits Inquiry in Availity, go to **Help & Training** in Availity Essentials.

Submitting Prior Authorization Requests

Also, refer to:

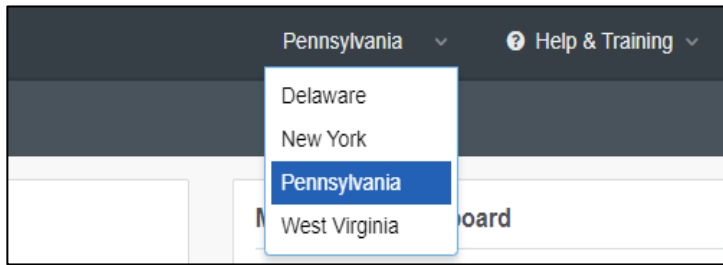
<https://providers.highmark.com/claims-and-authorization/authorization-guidance/obtaining-authorizations>

On the Provider Resource Center (PRC).

In Avality Essentials, there are two paths for prior authorization submission:

Next, choose the authorization path:

After logging into Avality, first choose the appropriate state for your practice or facility.
(Required for Path 1, but not for Path 2.)



Path 1
Predictal via
Payer Spaces

Path 2
Authorizations and
Referrals

Authorization Status / Authorization Inquiry:
Only Available via Path 1:
Predictal via Payer Spaces

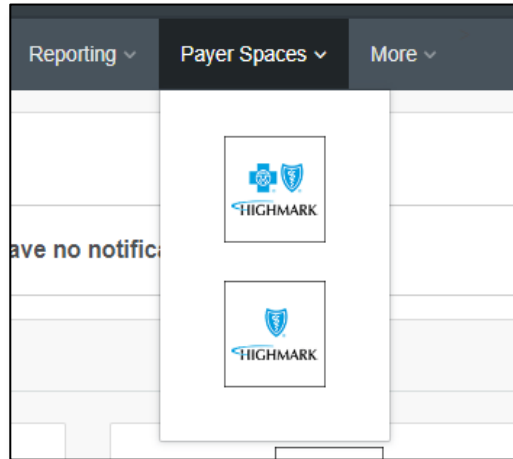
Exception 1:
Retail Pharmacy Authorization Submissions
Can ONLY Use Path 1

Exception 2:
Out of Area (OOA) Provider Authorization Submissions
Can ONLY Use Path 2

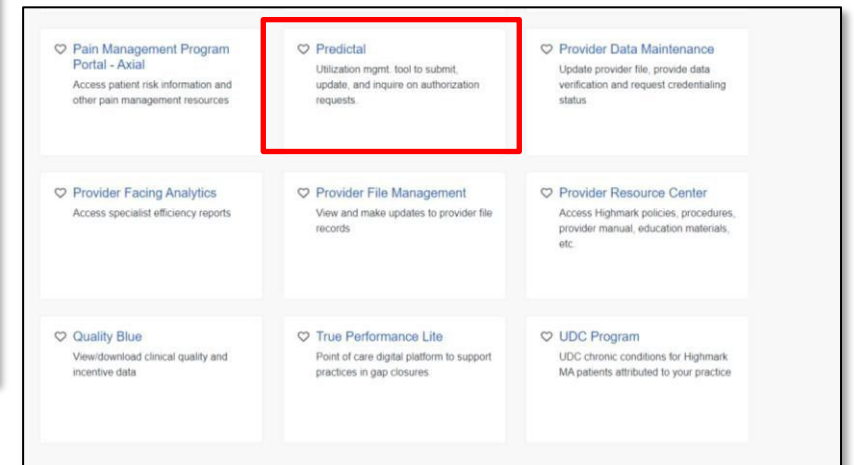
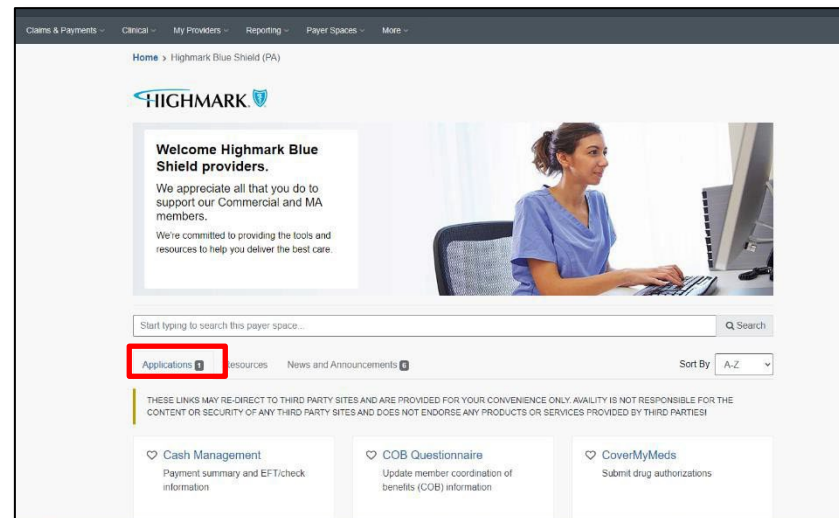
Path 1

To access Highmark's Payer Spaces in Avality Essentials, click on **Payer Spaces** from the top menu and choose the appropriate Health Plan.

Note: To check an Authorization Status and/or to submit an Authorization Inquiry, Path 1 must be used to access Predictal via Payer Spaces.



Within **Payer Spaces**, look under **Applications**, scroll down, and select the **Predictal** tile.



Path 1

Once users have selected Predictal, they must choose the **Organization**.

- Select a **Provider** (*optional*)
- Click **Submit** to get to a new tab

That will take users into the Predictal Authorization Automation Hub (AAH) to complete the prior authorization request.

When the Predictal AAH opens in the next screen (or during the next step) users will then be prompted to select the **Submitting Provider** (the individual practitioner or provider requesting the authorization).

The screenshot shows the Predictal web interface. At the top, the word "Predictal" is displayed in a large, bold font. Below it, there are two main sections: "Select an Organization" and "Select a Provider (Optional)". The "Select an Organization" section has a dropdown menu with "Provider Org One" selected. A red box highlights this dropdown, and a red arrow points from the "NOTE" section to it. Below the dropdown, the text "This field is required." is displayed in red. The "Select a Provider (Optional)" section has a dropdown menu with "Provider Office One" selected. A red arrow points from the "NOTE" section to this dropdown. At the bottom of the form, there are two buttons: "Cancel" (light gray) and "Submit" (dark green).

Also refer to this Provider registration resource on the new Provider Resource Center (PRC): <https://providers.highmark.com/latest-updates/availability/registration>

NOTE:

If your Organization within Availity's Manage My Organization (MMO) only has one Tax ID, it is recommended to only **Select an Organization** to return more search results in the next step within Predictal's Authorization Automation Hub.

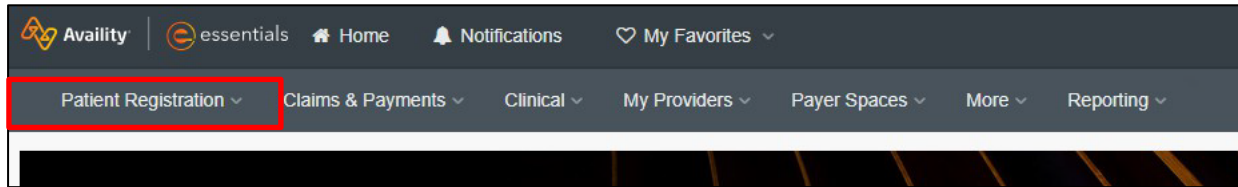
If you have multiple Tax IDs within the Organization within MMO, choose the Group (Type 2) NPI for the specific tax ID — NOT the individual Practitioner's (Type 1) NPI — in the **Select a Provider** drop-down menu.

- If you do not see your Group (Type 2) NPI in this list, or you choose a practitioner (Type 1) NPI, you will not see your requesting provider properly in the Predictal AAH next step when beginning the authorization or could result in a system error.
- Your Administrator would need to add the Morenaza121314!!group as a provider under the Organization in **Manage My Organization** within Availity as referenced with the Highmark specific Manage My Organization Guide*.

Path 2

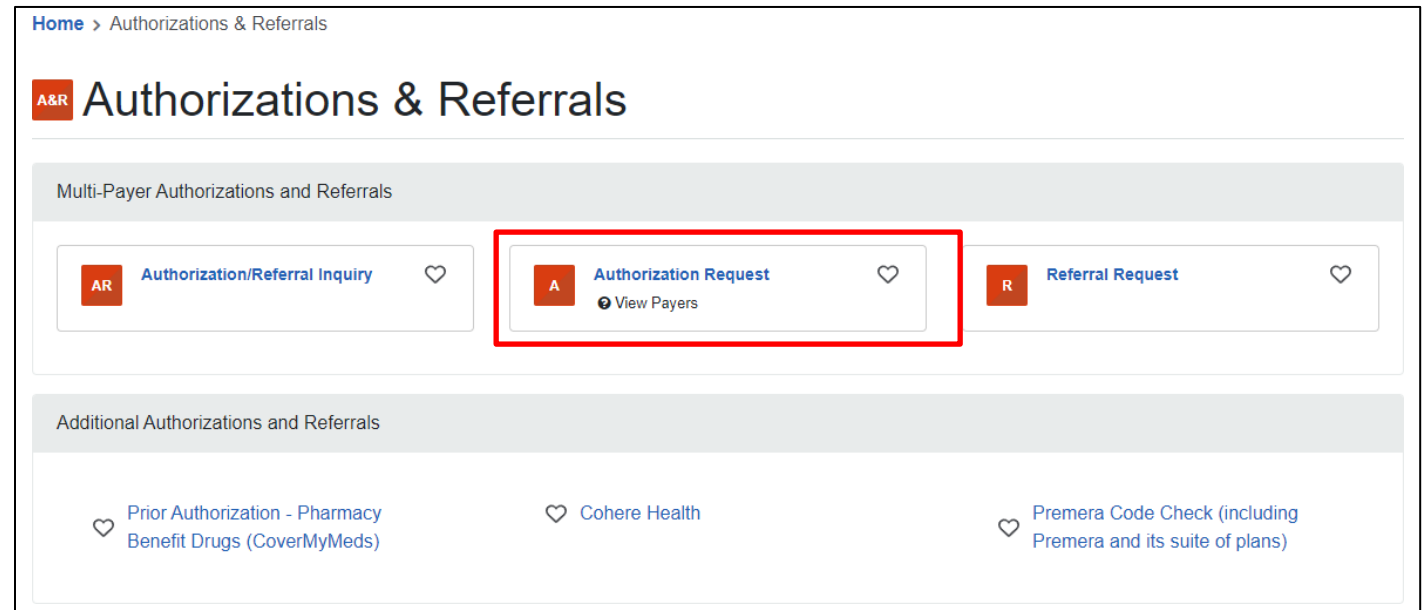
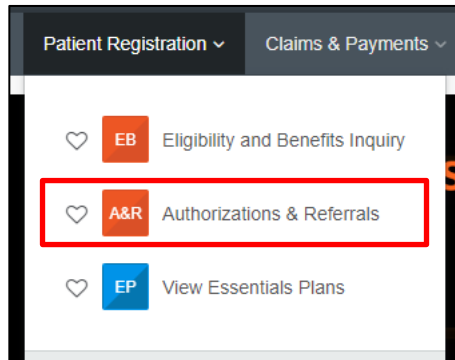
To access **Authorization & Referrals**, first click on **Patient Registration** from the main menu at the top of the screen.

Note: For prior authorization requests for Out-of-Area members, Path 2 must be used for submissions..



Then select the **Authorizations & Referrals** option.

Next, select the **Authorization Request** option.



Path 2

Once the **Authorization Request** is selected, complete the form with the appropriate information. Additional fields will appear as the user completes the online form.

Home > Authorizations & Referrals > Authorizations

Need help? Watch a demo about Authorizations and Referrals.

A Authorizations Give Feedback New Request

SELECT A PAYER

Organization •
Highmark

Template(s) optional [Manage Templates](#)
No template selected

Select a template from the list or continue with Payer and Request Type fields.

Payer •
Select a Payer

Request Type •
Select Authorization Type

Next

v7.403.3

For Out-of-Area (OOA) providers to submit a request for a Highmark member, they need to use the path of **Patient Registration**, then under **Payer** — if Highmark is not listed — they must select **Other Blues** to proceed

Home > Authorizations & Referrals > Authorizations

Need help? Watch a demo about Authorizations and Referrals.

A Authorizations Give Feedback Go to Dashboard New Request

SELECT A PAYER

Organization •
Buffalo General Hospital

Template(s) optional [Manage Templates](#)
No template selected

Select a template from the list or continue with Payer and Request Type fields.

Payer •
Select a Payer

Request Type •
Select Authorization Type

Path 2

First, **Select an Organization** (the tax ID that contains the Group (Type 2 NPI) for the requesting provider. Select the **Payer** and **Request Type** then click **Next**.

Then, under the Requesting Provider, **Select a Provider** dropdown, choose the Billing Group (Type 2) NPI for the specific tax ID but NOT the individual Practitioner (Type 1 NPI).

If the user does not see the Group (Type 2) NPI in this list, or the user erroneously chose a practitioner (Type 1) NPI, the user will not see the requesting provider properly in the Predictal AAH next step when beginning the authorization (or could result in a system error).

Your Administrator would need to add the group as a provider under the Organization in **Manage My Organization** within Availity as referenced with the Highmark specific Manage My Organization Guide*.

When the Predictal/AAH opens in the next screen (or during the next step) users will be prompted to select the **Submitting Provider** (the individual practitioner or provider requesting the authorization).

Note: This applies to any **Select an Organization** or **Select a Provider** list within Availity for HIGHMARK.

The screenshot shows the Availity Authorizations interface. At the top, there is a navigation bar with 'Availity essentials Home Notifications My Favorites' and a user profile for 'Heather's Account'. Below the navigation bar, there are tabs for 'Patient Registration', 'Claims & Payments', 'Clinical', 'My Providers', 'Payer Spaces', 'More', and 'Reporting'. A search bar is on the right. The main content area is titled 'Authorizations' and includes buttons for 'Give Feedback', 'Go to Dashboard', and 'New Request'. A yellow alert banner at the top says 'Alert: Enter the facility or group NPI instead of the individual provider NPI'. Below this is the 'SELECT PAYER' section, which has a dropdown menu for 'Organization' with 'Provider Org One' selected. Below the dropdown is a 'Template(s)' section with a 'Manage Templates' link. The 'Payer' dropdown is set to 'HIGHMARK BLUE SHIELD'. Below this is the 'REQUESTING PROVIDER' section, which has a dropdown menu for 'Select a Provider' with 'Provider Office One' selected. A red box highlights the 'Organization' dropdown in the 'SELECT PAYER' section, and a red arrow points from this box to the 'Payer' dropdown in the 'REQUESTING PROVIDER' section. The word 'THEN' is written in large black letters between the two sections.

*Also, refer to: https://apps.availity.com/availity/help-providers/source/portal_providers/account_administration/my_account/topics/t_view_edit_team_member_role.html

The Predictal Auth Automation Hub (AAH)

The Predictal home page has links to the Prior Authorization List, CoverMyMeds submissions, and a view into authorizations that the user has started but not completed.

predictal™ Auth Automation Hub Exit AAH

Highmark Welcomes

Helpful Links


- List of Procedures and DME Requiring Authorization
- List of FEP Standard and Basic Procedures Requiring Prior Approval
- List of FEP Blue Focus Procedures and DME Requiring Prior Approval
- Request a prescription drug authorization request through CoverMyMeds

Information you will need to submit an authorization:

- Member Demographics
- Procedure/Service Details
- Diagnosis Details
- Provider Details
- Clinical Criteria

[New Auth Submission](#)

My Unsubmitted Auths

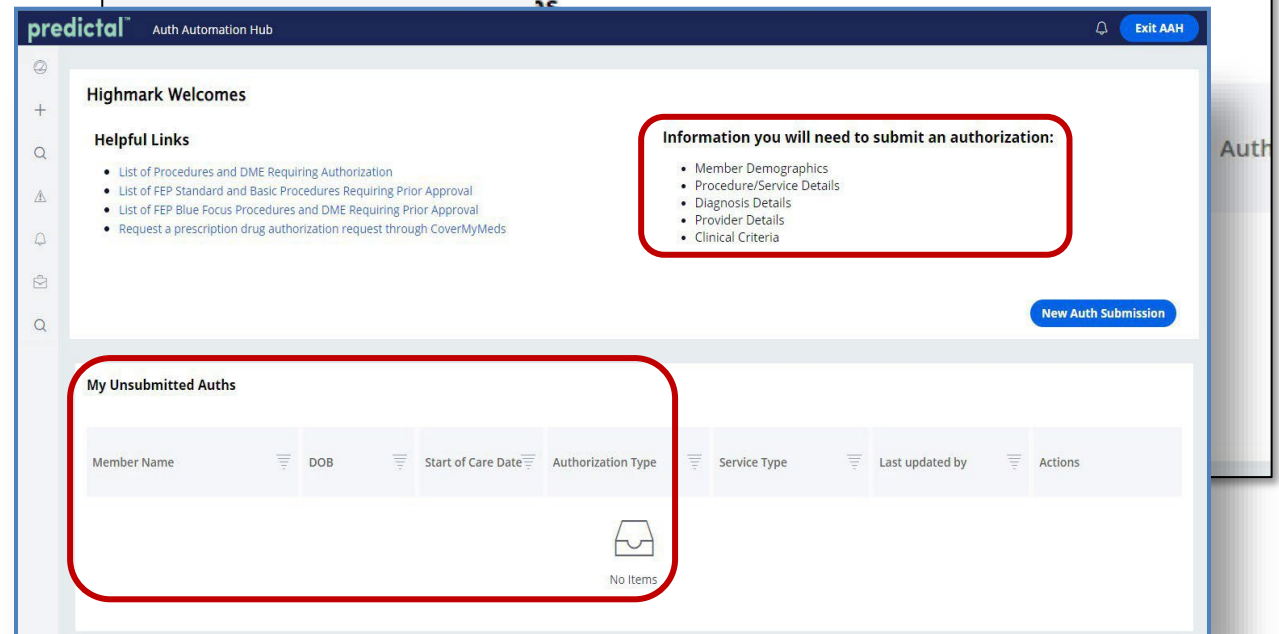
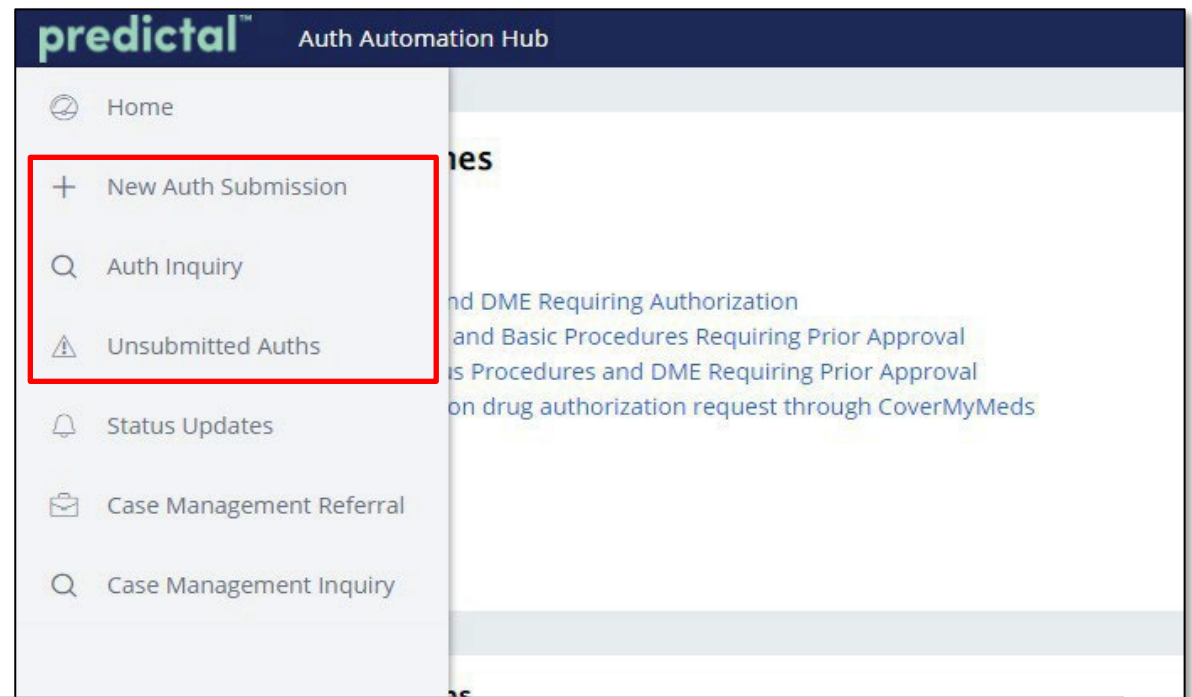
Member Name	DOB	Start of Care Date	Authorization Type	Service Type	Last updated by	Actions
 No Items						

The left navigation panel includes links to the functions available within Predictal. Select **New Auth Submission** to initiate a new request. Select **Auth Inquiry** to do any of the following:

1. Check Authorization Status
2. Review Approval and Denial Letters
3. Discharges
4. Concurrent
5. Respond to a Request For Additional Information
6. Extensions

Select **My Unsubmitted Auths** to view an authorization request that was started but not yet submitted.

Users can also view *all* **Unsubmitted Auths** on the Predictal home page.



New Authorization Submissions

The top menu bar in the Predictal Auth Automation Hub (AAH) will walk users through the steps of the electronic authorization submission process through **Confirmation**.



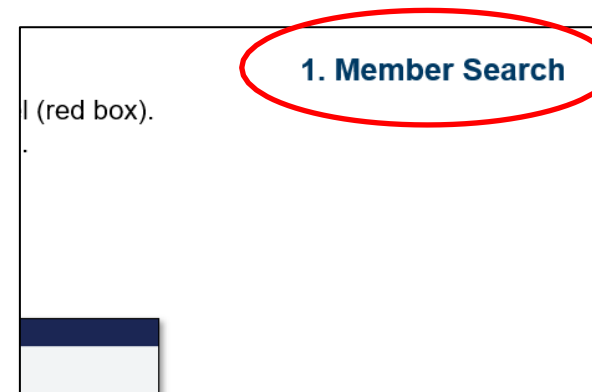
After each step listed in the top menu bar, users will be prompted to hit **Submit**. The authorization will not be submitted to Highmark until the *final Submit* on the **Confirmation** screen is selected (*Step 6 above.*)

Throughout the authorization process, users will have the opportunity to **Save** their work without submitting. Hitting **Save** at the bottom of the screen will move the authorization request into the user's **Unsubmitted Auths** queue in Availity.

*There is also a **Back** button that will allow users to go back and make any corrections to information that is incorrect.*

Note: In the upper right corner of the following slides, we've noted where the user is within the submission process:

1. Member Search
 2. Authorization Details
 3. Enter Provider
 4. Review Guidelines
 5. Review Authorization
 6. Confirmation
- (Includes Helion Arc Submissions)



For a new Authorization Request:

1. Select **New Auth Request** from the left side navigation panel (red box).
2. Select the **Ordering/Attending Provider** from the dropdown.

Search for the Member ID in the **Search for member** field.

Fill in the **Start of Care Date** which should be the date the request is being submitted. Select the blue **Search** button (the member information screen appears).

predictal™ Auth Automation Hub

Authorization Request

Member Name Member ID Date of Birth Client Name Plan Type Case Type Authorization Type Service Type

1. Member Search 2. Authorization Details 3. Enter Provider 4. Review Authorization 5. Confirmation

Ordering/Attending Provider
Select provider *

To select a member, click on the search results table to expand the desired member. Then, highlight the correct Group Number/LOB row to select and continue

Search
Search For
 Member

Search for member * Start of Care Date *
Member ID 11/30/2023

Member UMI * **Search**

Search Result: 4 matches found...

Member ID	First Name	Last Name	Date of Birth	Gender
			07/20/1985	FEMALE

When results return, to select the appropriate member, users must complete the following steps to select the specific member:

- Click on the **widget** to highlight the **member** and open the **additional information** about the member.
- Click on the **member** users wish to submit an authorization to highlight the row.

Doing so will ensure that the authorization is being submitted accurately for the member on the policy.

Finally, users select the blue **Submit** button to move to the next step.

The screenshot displays a web interface for member search. At the top, there is a radio button labeled "Member". Below it are two search filters: "Search for member *" with a dropdown menu set to "Member ID", and "Start of Care Date *" with a date input field containing "11/30/2023". A "Member UMI *" field is also present, followed by a blue "Search" button. Below the search filters, it says "Search Result: 4 matches found...". There are two tables. The first table has columns: Member ID, First Name, Last Name, Date of Birth, and Gender. The second table has columns: UMI, Client Name, Group Name, Group Number, LOB, COB, Start Date, End date, and Relationship. Red arrows point to a dropdown arrow in the first table and a row in the second table.

Member ID	First Name	Last Name	Date of Birth	Gender
			07/20/1985	FEMALE

UMI	Client Name	Group Name	Group Number	LOB	COB	Start Date	End date	Relationship
				PPO		01/01/2021		EMPLOYEE

After users have completed the member information, can users move on to the following steps:

1. Select the **Authorization Type**
2. Select the **Place of Service**
3. Select the **Service Type**

Fill in the appropriate case information and indicate if this is an emergent (**ER**) or **NICU admission**.

The screenshot displays the 'predictal™ Auth Automation Hub' interface. At the top, it shows 'Authorization Request' with a progress bar indicating five steps: 1. Member Search, 2. Authorization Details (current), 3. Enter Provider, 4. Review Authorization, and 5. Confirmation. Below the progress bar, there are two main sections: 'Case Information' and 'Request Information'. The 'Case Information' section includes 'Authorization Type *' with radio buttons for Medical-Inpatient (selected), Medical-Outpatient, Behavioral-Inpatient, Behavioral-Outpatient, and Pharmacy; 'Case Type' set to 'Prior Authorization'; and 'Is this an ER or NICU admission? *' with radio buttons for Yes (selected) and No. The 'Request Information' section includes 'Start of Care Date *' with a date input field showing '10/31/2023'. At the top of the form, there are labels for Member Name, Member ID, Date of Birth, Client Name, Plan Type (Commercial), Case Type (Prior Authorization), Authorization Type (Medical-Inpatient), and Service Type (---).

This close-up shows the 'Detail Information' section of the form. It features two dropdown menus: 'Place of Service *' with a 'Select...' option and a downward arrow, and 'Service Type *' with a 'Select...' option and a downward arrow.

Scroll down on the page and complete the **Diagnosis Information** and **Procedure Information** fields.

The type of authorization that the user seeks will determine whether the **Procedure Information** is a required field.

Note: Procedure codes are NOT required for an inpatient urgent authorization request; however, they *are* required for inpatient planned admissions.

Auth Automation Hub BA

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
					Prior Authorization	Medical-Inpatient	Non-Urgent	Medical Care

Diagnosis Information *

Code Set Type *	Code *	Description *	
ICD 10 ▾	Enter Code/Description	—	Remove

Add

Procedure Information *

Add

Indicate Location of Clinical Information

Add

Caller Information

Contact name *	Phone Number *	Ext.
	(###) ###-####	ext

Please enter any additional information *

If clinical documentation is not added as an attachment, please include the relevant clinical documentation here.
If clinical documentation is added as an attachment, please indicate so here.

In the **Diagnosis Information** section, users should enter the entire diagnosis code. Make your selection once the screen populates.
(Note: It must include the decimal point when entering a diagnosis).

The screenshot shows the 'Auth Automation Hub' interface. At the top, there's a header with a logo and the text 'Auth Automation Hub'. Below that, the main title is 'Authorization Request'. Underneath, there are several fields for member and case information: Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (with a dropdown showing 'Prior Authorization'), Authorization Type (with a dropdown showing 'Medical-Inpatient'), Urgency (with a dropdown showing 'Non-Urgent'), and Service Type (with a dropdown showing 'Medical Care').

The 'Diagnosis Information' section is the focus. It has a table with columns 'Code Set Type*', 'Code*', and 'Description*'. A dropdown menu is open for the 'Code*' field, showing a list of ICD 10 codes. The code '183.001' is selected, and its description 'VARICOSE VEINS OF UNSPECIFIED LOWER EXTREMITY WITH ULCER OF THIGH' is visible. Other codes in the list include 183.002, 183.003, 183.004, 183.005, 183.008, and 183.009.

Below the 'Diagnosis Information' section, there are other sections: 'Procedure Information' with an 'Add' button, 'Indicate Location of C' with an 'Add' button, and 'Caller Information' with a 'Contact name *' field. At the bottom, there's a note: 'Please enter any additional information in the comments field. If clinical documentation is required, please include it in the comments field.'

If an incorrect code was entered, users can click the **Remove** link to delete that diagnosis from the request. Select the **Add** link to add additional diagnosis codes.

Auth Automation Hub BA

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
					Prior Authorization	Medical-Inpatient	Non-Urgent	Medical Care

Impatient Hospital Inpatient Medical Care

Diagnosis Information

Code Set Type*	Code*	Description*	
ICD 10	83.019	VARICOSE VEINS OF RIGHT LOWER EXTREMITY WITH ULCER OF UNSPECIFIED SITE	Remove

[Add](#)

Procedure Information

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[Add](#)

Indicate Location of Clinical Information

[Add](#)

When entering the **Procedure Information**, the user **must** select the appropriate **Code Set Type** from the dropdown menu. If this is not selected, that procedure code will not be found.

The screenshot displays the 'Auth Automation Hub' interface. At the top, there's a header with the logo and 'Auth Automation Hub' text, and a user profile icon labeled 'BA'. Below the header is the 'Authorization Request' section, which includes a table with columns: Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type, Authorization Type, Urgency, and Service Type. The table contains one row with some blurred information. Below the table is a section for 'Procedure Information'. It starts with a disclaimer about CPT/HCPCS codes. Then, there's a form with a dropdown menu for 'Code Set Type' (currently showing 'Select...'), a text input for 'Code' (with placeholder 'Enter Code/Description'), and a 'Description' field. Below these are fields for 'Through' (with a calendar icon), 'Number of days' (with a calendar icon), and 'Requested units'. There's also a 'Unit Type' dropdown (showing 'Select...') and a 'Remove' button. At the bottom of the form, there are 'Add' buttons and a section for 'Indicate Location of Clinical Information' with another 'Add' button. A 'Caller Information' section is partially visible at the very bottom.

Note: A **CPT Code** is a 5-digit numeric code.

A **HCPCS Code** is a 5-digit code that begins with an alphanumeric value.

Once the **Code Set Type** has been selected:

- Enter the entire procedure code and select that code. (Use the actual code to avoid searching for the description.)
- Next, complete the remaining required fields.
- Users can select **Remove** if something has been entered incorrectly. If the user needs to authorize more than one procedure code, click the **Add** link.

Note: There is no limit to the number of procedure codes that can be added.

The screenshot displays the 'Auth Automation Hub' interface. On the left, there are fields for 'Member Name', 'Service Type' (Medical Care), and 'Code Set Type' (CPT). The main area shows a list of procedure codes with their descriptions. The codes listed are 33647, 36470, 36471, 36473, 36474, 36475, and 36476. Below the list, there are input fields for 'From' (12/09/2021), 'Through', 'Number of days', 'Requested units', and 'Unit Type' (Select...). A 'Remove' button is located next to the 'Unit Type' field. An 'Add' button is at the bottom left of the list area.

(This screenshot is only a CPT code example.)

The **Recent Attachments (0)** section will allow users to send attachments with an authorization by clicking on the **+** (plus sign) icon.

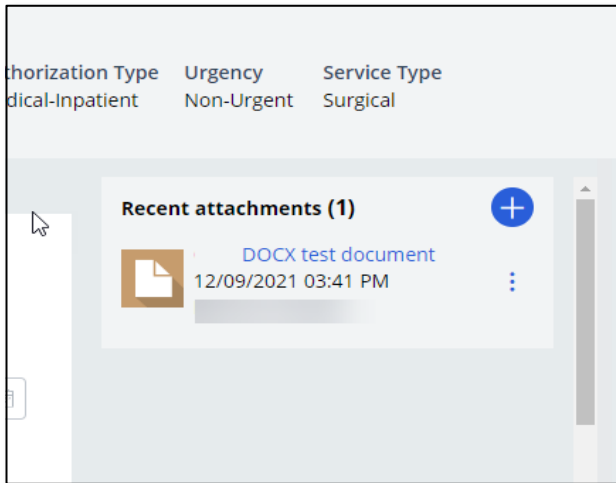
The screenshot shows the 'Auth Automation Hub' interface. At the top, there's a header with the logo and 'Auth Automation Hub' text. Below that, the main title is 'Authorization Request'. A table lists various fields: Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), Authorization Type (Medical-Inpatient), Urgency (Non-Urgent), and Service Type (Surgical). Below the table, there are four steps: 1. Authorization Details, 2. Enter Provider, 3. Review Authorization, and 4. Confirmation. A 'Recent attachments (0)' section is highlighted with a red box, containing a plus sign icon and buttons for 'Attach File' and 'Attach URL'. Below this, there are two sections: 'Case Information' with 'Authorization Type *' set to 'Medical-Inpatient' and 'Request Information' with 'Start of Care Date *' set to '12/11/2021'.

Users can attach a file or a URL in the **Recent Attachments** section.

The screenshot shows the 'Attach file(s)' dialog box. It has a title bar with 'Attach file(s)' and a close button. Inside, there's a dashed box with a paperclip icon and the text 'Drag and drop files here'. Below that, there's an 'OR' label and a 'Select file(s)' button. At the bottom, there are 'Cancel' and 'Attach' buttons.

The screenshot shows the 'Attach a link' dialog box. It has a title bar with 'Attach a link' and a close button. Inside, there are two input fields: 'Name *' and 'URL *'. Below the 'URL *' field, there's an 'Attachment Category' dropdown menu with a list of options: URL, Select..., DOC, DOCX, JPG, PDF, PNG, PPT, PPTX, TXT, URL, XLS, XLSX. A 'Submit' button is located at the bottom right.

Note: If the authorization is for anything non-delegated, the user will have the opportunity to utilize MCG criteria later in the workflow. Utilizing MCG criteria and attaching any supporting documentation will greatly reduce response time as well as provide additional clinical to support the inpatient request.



Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Priority
					Authorization	

Service Type
Medical Care

Indicate Location of Clinical Information

Clinical Document Type	Found in	Comment:	
Select...	Select...		Remove

- Select...
- 77-Support Data for Verification
- AS-Admission Summary
- B2-Prescription
- B3-Physician Order
- B4-Referral Form
- CT-Certification
- DA-Dental Models
- DS-Discharge Summary
- EB-EOBs (Explanation of Benefits)
- MT-Models
- NN-Nursing Notes
- OB-Operative Note
- OZ-Support Data For Claim
- PN-Physical Therapy Notes
- PO-Prosthetics or Orthotic Certification
- PZ-Physical Therapy Certification
- RB-Radiology Films
- RR-Radiology Reports

When a document has been attached in the **Recent Attachments** section, complete the **Indicate Locations of Clinical Information** section to provide additional information about the attachment such as:

- The type of attachment (**Clinical Document Type**).
- Select the attachment being referenced.
- Enter any comments that will assist those reviewing the attachment in finding necessary information.
 - For example: “Clinical notes can be found on page three of this attachment”

Complete the **Caller Information** section by:

- Noting any additional clinical information (there is a 255-character limit)
- If information isn't added in an attachment, include the necessary clinical information here
- If the clinical information is added as an attachment, please note that here (note that this is a mandatory field)
- The **Save** button allows users to bookmark work and can return to it (recycles the same page)

Note: The phone number field format is (XXX) XXX-XXXX. However, entering the numeric portion only will still automatically format.

When all fields are complete, select the blue **Submit** button.

Auth Automation Hub

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency
					Prior Authorization	Medical-Inpatient	Non-Urgent

Service Type
Medical Care

Add

Caller Information

Contact name * Phone Number * Ext.

Please enter any additional information *

If clinical documentation is not added as an attachment, please include the relevant clinical documentation here.
If clinical documentation is added as an attachment, please indicate so here.

Value cannot be blank

Exit

3. Enter Provider

The **Provider Details** page will automatically populate with the **Ordering/Attending Practitioner** who was selected previously.

Select the blue **Search** button to choose the ordering/attending provider's location.

When results return, to select the appropriate ordering/attending practitioner, users will need to complete the following steps.

- Click on the **widget** to highlight the **Ordering/Attending Practitioner** and open it to view additional information.
- Click on the **address line** to highlight the address

Doing this will select the ordering/attending practitioner that will be submitted with the auth request.

Users can then move on to the next fields: **Servicing Facility** and **Performing Provider**..

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Service Type
				Commercial	Prior Authorization	Medical-Inpatient	Surgical

Ordering/Attending Provider

Select provider *

1 match found

Facility / Vendor NPI	Facility / Vendor Name	Facility / Vendor Address	Facility / Vendor City	State	Zip code

Addresses

Tax ID	BSID

Address type	Facility / Vendor Address	Facility / Vendor City	State	Zip code	Contact Details

Note: There is a blue **Edit** button to the right of this screen where the provider can change contact information.

Here users will find the **Copy As Servicing Facility/Vendor** and **Copy As Performing Provider** buttons which allows users to copy the **Ordering/Attending Practitioner** information into the **Servicing Facility/Vendor** and **Performing Provider** information.

The screenshot displays the 'Auth Automation Hub' interface. At the top, the title 'Auth Automation Hub' is visible. Below it, the 'Authorization Request' section shows fields for Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), Authorization Type (Medical-Inpatient), and Urgency (Non-Urgent). The Service Type is listed as Medical Care. A progress bar indicates the current step is '2. Enter Provider'. The 'Provider Details' section for the 'Ordering/Attending Practitioner' shows '1 match found'. A table lists the provider information:

Facility / Vendor NPI	Facility / Vendor Name	Facility / Vendor Address	Facility / Vendor City	State	Zip code
XXXXXXXXXX	GENERAL HOSPITAL	Street Address	City	PA	15212

Below the table, two buttons are highlighted with a red box: 'Copy as Servicing Facility/Vendor' and 'Copy as Performing Provider'. The 'Servicing Facility/Vendor' section is partially visible at the bottom.

If users do not use the copy links, they can also search for the **Servicing Facility/Vendor** by the following mandatory fields:

- Name (**Facility/Vendor**)
- **Provider ID**
- **NPI or BSID** (Blue Shield ID)

The screenshot shows the 'Auth Automation Hub' interface. At the top, there's a header with the logo and 'Auth Automation Hub' text. Below that, the 'Authorization Request' form is displayed. It includes fields for Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), and Authorization Type (Medical-Inpatient). There are also fields for Urgency (Non-Urgent) and Service Type (Medical Care). Below these fields, there are two buttons: 'Copy as Servicing Facility/Vendor' and 'Copy as Performing Provider'. The 'Servicing Facility/Vendor' section is expanded, showing search options: 'Search for' (Facility / Vendor, Provider ID, NPI or BSID) and 'Search by' (Facility / Vendor, Provider ID, Name). There is a 'Search' button and a 'NPI or BSID *' field with a 'Search' button.

Search for the **Performing Provider** by **Practitioner** using the:

- **Practitioner** or **Practice Group** name
- **Provider ID** (using the **NPI, BSID** - Blue Shield ID or Tax ID)

The screenshot shows the 'Auth Automation Hub' interface. At the top, there's a header with the logo and 'Auth Automation Hub' text. Below that, the 'Authorization Request' form is displayed. It includes fields for Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), and Authorization Type (Medical-Inpatient). There are also fields for Urgency (Non-Urgent) and Service Type (Medical Care). Below these fields, there are two buttons: 'Copy as Servicing Facility/Vendor' and 'Copy as Performing Provider'. The 'Performing Provider' section is expanded, showing search options: 'Search for' (Practitioner, Practice Group) and 'Search by' (Provider ID, Name). There is a 'Search' button and a 'NPI or BSID' field with a 'Search' button. There is also a dropdown menu for 'Authorization Request Submitted By *' with a 'Select...' option. At the bottom, there are 'Back', 'Save', and 'Submit' buttons.

When results return, to select the appropriate facility/vendor, users will need to complete the following steps to select the specific facility/vendor:

- Click on the **widget** to highlight the **facility/vendor** and open the **additional information** about the facility/vendor.
- Click on the **address line** to highlight the address

Doing this will select the facility/vendor that will be submitted with the authorization request.

Users can then move on to the next field.

The screenshot shows the Predictal Auth Automation Hub interface. At the top, there is a header with the Predictal logo and 'Auth Automation Hub'. Below this is a section titled 'Authorization Request' with a table of fields: Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), Authorization Type (Medical-Inpatient), Urgency (Non-Urgent), and Service Type (Surgical). The main content area is divided into three sections: 'Servicing Facility/Vendor', 'Addresses', and 'Performing Provider'. The 'Servicing Facility/Vendor' section has search options for Facility/Vendor, Provider ID, and NPI or BSID. A search box contains 'XXXXXXXXXX' and a 'Search' button. Below the search box, a table shows one match found with columns for Facility/Vendor NPI, Facility/Vendor Name, Facility/Vendor Address, Facility/Vendor City, State, and Zip code. A red arrow points to the first row of this table, which contains 'XXXXXXXXXX', 'GENERAL HOSPITAL', 'Street Address', 'City', 'PA', and '12345'. The 'Addresses' section has search options for Tax ID, BSID, and DRG (Yes/No). Below this, another table shows address details with columns for Address type, Facility/Vendor Address, Facility/Vendor City, State, Zip code, and Contact Details. A red arrow points to the first row of this table, which contains 'Main', 'Street Address', 'City', 'PA', '12345', and 'Phone', 'Fax', 'Fax'. The 'Performing Provider' section has search options for Practitioner and Practice Group, and Provider ID and Name. A search box is empty and a 'Search' button is present. At the bottom, there is a dropdown menu for 'Authorization Request Submitted By' with 'Select...' as the current selection. At the very bottom, there are 'Back', 'Save', and 'Submit' buttons.

Select the provider who is requesting the authorization in the **Authorization Request Submitted By** dropdown. Click **Submit** when all information has been completed.

The screenshot shows the 'Auth Automation Hub' interface for an 'Authorization Request'. The form is titled 'Authorization Request' and contains several sections:

- Member Information:** Member Name, Member ID, Date of Birth, Client Name, Plan Type.
- Case Information:** Case Type (Prior Authorization), Authorization Type (Medical-Inpatient), Urgency (Non-Urgent).
- Service Type:** Medical Care.
- Search Section:** Search for (NPI or BSID, Tax ID), NPI or BSID input field, and a Search button.
- Authorization Request Submitted By *** dropdown menu, which is currently open and shows the following options:
 - Select...
 - Select...
 - Ordering/Attending Practitioner
 - Servicing Facility/Vendor
 - Performing Provider
- Navigation:** Back button and Submit button.

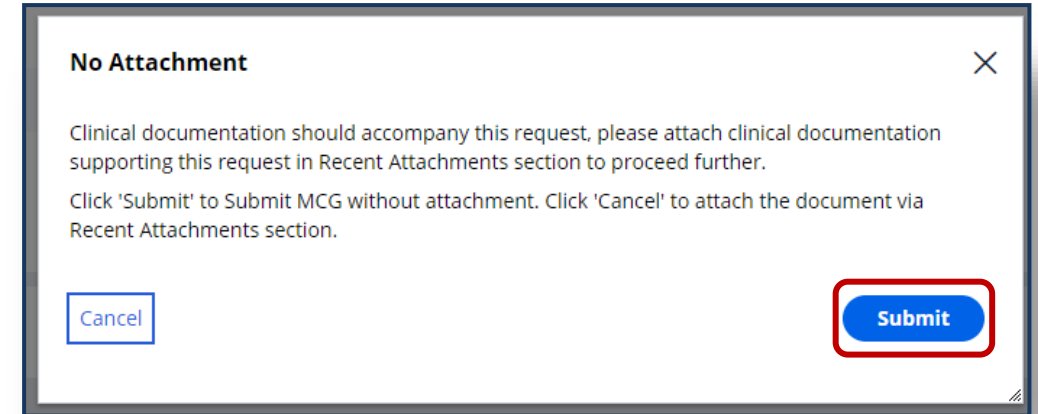
Invoking MCG Criteria

Effective Oct. 14, 2024, Highmark launched a new enhancement to the Predictal Auth Automation Hub that will streamline the authorization review process, saving time and effort for providers and their teams. When submitting a prior authorization request, providers and licensed clinical personnel will now be able to invoke MGC's clinical criteria, triggering a faster review of their request.

IMPORTANT NOTE: *Non-clinical staff will not be able to use this enhancement, and all users will be able to bypass the MCG process. As MCG questions arise during the authorization request, Highmark's clinical staff can only communicate with the Provider or another licensed clinical staff member.*

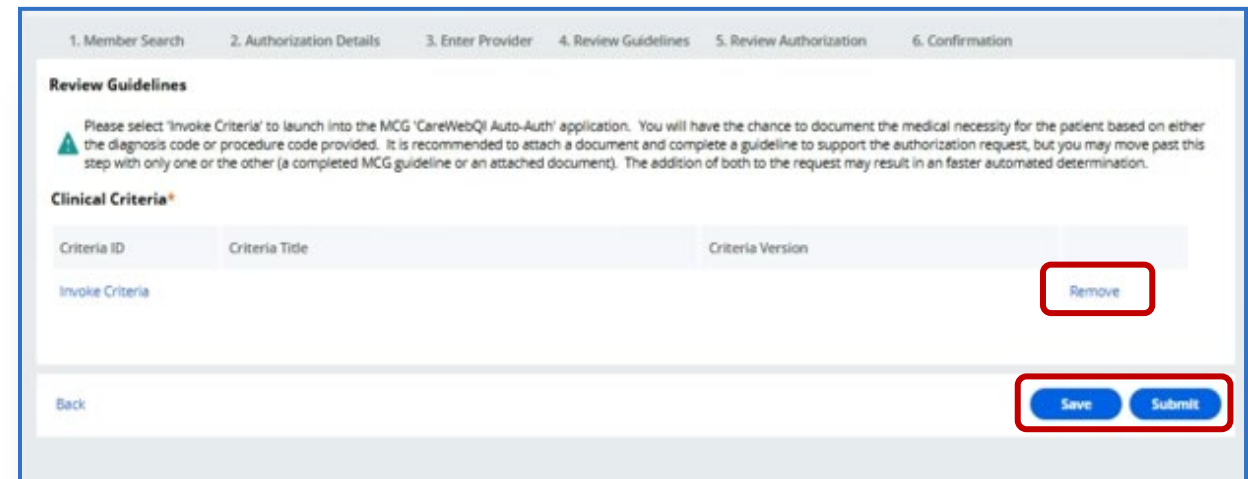
Bypass for Attaching Clinical Documentation

If the user attempts to invoke criteria *before* attaching clinical documentation, the system will alert the user with the pop-up warning message (as seen here to the right).



Providers will have the option to bypass this page by clicking **Remove** in the lower right section of the screen. Select the blue **Save** button after each action, and select the blue **Submit** button to submit the authorization.

Please Note: Choosing to bypass the criteria may result in a longer processing time for your authorization request. We encourage all providers and licensed clinical personnel on your team to utilize the criteria system whenever possible to expedite your authorizations.



The Former Process

The former authorization submission process was a 5-step process:

1. Member Search
2. Authorization Details
3. Enter Provider
4. Review Authorization
5. Confirmation

What Has Changed?

With the addition of the MCG enhancement, a new step (**Review Guidelines**) has been added, making authorization submission now a 6-step process:

1. Member Search
2. Authorization Details
3. Enter Provider
4. **Review Guidelines**
5. Review Authorization
6. Confirmation

The screenshot shows a web interface for the 'Review Guidelines' step. At the top, a progress bar indicates the current step (4. Review Guidelines) is highlighted in red, with other steps (1. Member Search, 2. Authorization Details, 3. Enter Provider, 5. Review Authorization, 6. Confirmation) shown in grey. Below the progress bar, the heading 'Review Guidelines' is followed by a warning icon and a paragraph of instructions: 'Please select 'Invoke Criteria' to launch into the MCG 'CareWebQI Auto-Auth' application. You will have the chance to document the medical necessity for the patient based on either the diagnosis code or procedure code provided. It is recommended to attach a document and complete a guideline to support the authorization request, but you may move past this step with only one or the other (a completed MCG guideline or an attached document). The addition of both to the request may result in a faster automated determination.' Below this is a section titled 'Clinical Criteria*' containing a table with columns for 'Criteria ID', 'Criteria Title', and 'Criteria Version'. One row is visible with 'Invoke Criteria' in the ID column and a 'Remove' button in the right column. At the bottom of the form, there is a 'Back' link and two blue buttons labeled 'Save' and 'Submit'.

Once **Step 3** is complete, authorizations for services managed by Helion, eviCore, or another third-party administrator will redirect the user to those sites to continue their submission process outside of Predictal. *(See later in this job aid.)* For authorization requests routing through Predictal, these submissions will arrive at **Step 4: Review Guidelines**:

1. Member Search 2. Authorization Details 3. Enter Provider 4. Review Guidelines 5. Review Authorization 6. Confirmation

Review Guidelines

Please select 'Invoke Criteria' to launch into the MCG 'CareWebQI Auto-Auth' application. You will have the chance to document the medical necessity for the patient based on either the diagnosis code or procedure code provided. It is recommended to attach a document and complete a guideline to support the authorization request, but you may move past this step with only one or the other (a completed MCG guideline or an attached document). The addition of both to the request may result in a faster automated determination.

Clinical Criteria*

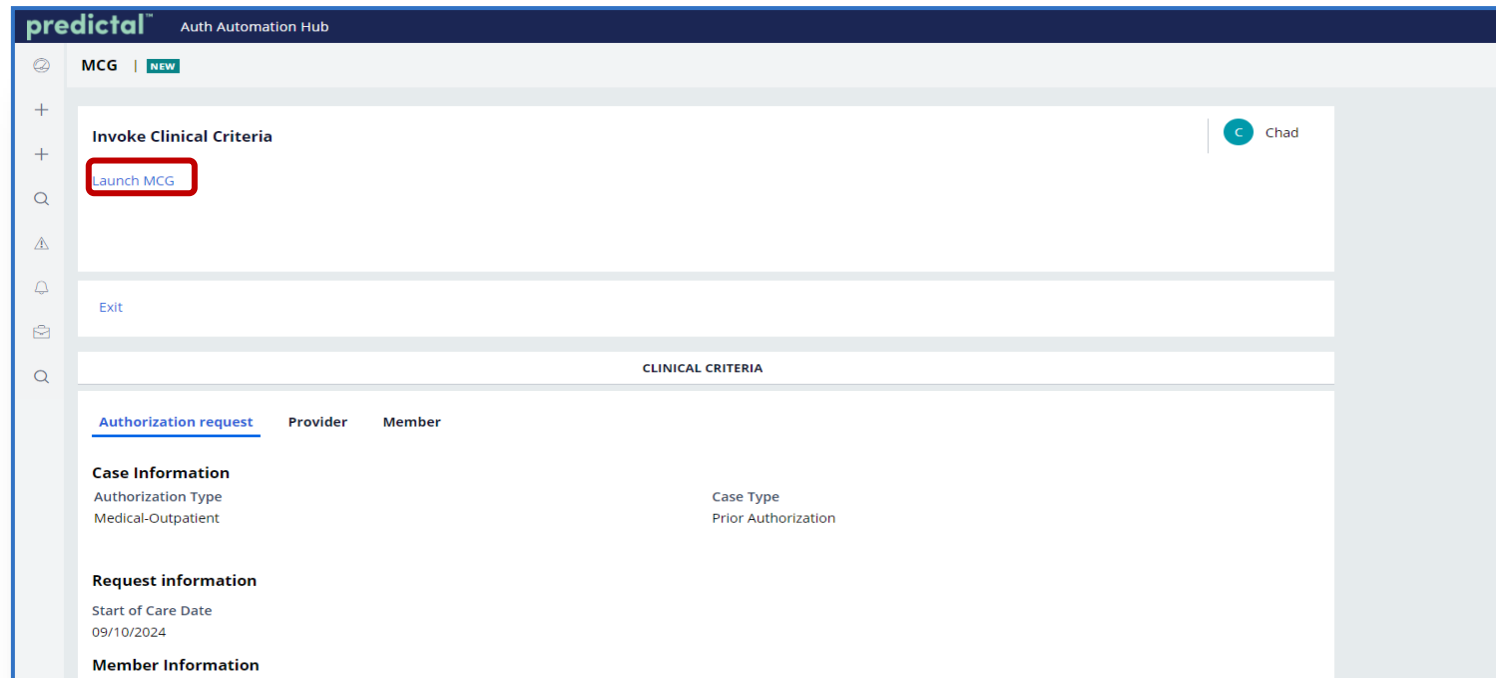
Criteria ID	Criteria Title	Criteria Version	
Invoke Criteria			Remove

Back Save Submit

Under **Step 4**, Providers and other users will have the opportunity to **Invoke Criteria** in the form of an MCG guideline or custom policy that will support the need for the patient's requested care. Invoking criteria (***when clinical documentation has been attached***) will streamline the review process and may result in a faster approval for appropriate treatment. Select the blue **Invoke Criteria** link and the **Invoke Clinical Criteria** pop-up window will appear (*see next slide*).

Attaching relevant clinical document and invoking criteria submission also decreases the administrative burden for both providers and the health plan. If providers and licensed clinical personnel do choose to attach a document and launch the MCG application after selecting the **Invoke Criteria** link, users will see the **Invoke Clinical Criterial** pop-up window (as shown below):

- Select the blue **Launch MCG** link to activate the **MCG Invoke CareWeb Guidelines** form (seen on the next slide)
- (**Note:** See the authorization information previous input below under the **Clinical Criteria** section)



The screenshot shows the 'predictal Auth Automation Hub' interface. At the top, there's a header with 'predictal' and 'Auth Automation Hub'. Below that, a navigation bar shows 'MCG | NEW'. The main content area is titled 'Invoke Clinical Criteria' and includes a user profile for 'Chad'. A red box highlights the 'Launch MCG' button. Below this, there's an 'Exit' button. The 'CLINICAL CRITERIA' section is active, showing a table with columns for 'Authorization request', 'Provider', and 'Member'. The table contains the following information:

Authorization request	Provider	Member
Case Information Authorization Type Medical-Outpatient		Case Type Prior Authorization
Request information Start of Care Date 09/10/2024		
Member Information		

Providers will see the CPT/HCPCS code or diagnosis code from their request next to the orange **Document Clinical** button (guidelines appear). Click on the button that shows the most applicable guidelines or custom policies related to the CPT/HCPCS or diagnosis code.

Select the guideline and product type that matches the request and click the blue **add link** at the end of the guideline. After selecting **add**, users will be shown the information that they can select to support their need for an authorization (*see the clinical detail on the next slide*).

Guideline Title	Product Code	Action
HMK Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	AC HMK Z-8-069	add
HMK Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	AC HMK Z-64-018	add
Surgical Treatment of Obstructive Sleep Apnea	AC S-280-002 HMK	add
Surgical Treatment of Obstructive Sleep Apnea	AC HMK S-280-001	add
No Guideline Applies		add

Before attaching any MCG guidelines, users can view the detailed guidelines and select each of the relevant **Clinical Indications** that substantiate the need for the auth request's care or procedure as warranted.

Check off any of the appropriate reasons listed, and then select the blue **Submit** button to complete the Invoke MCG Criteria process.

Invoke CareWebQI® Guidelines

Click Submit after the transaction is complete

Clinical Indications

[Link to Policy: Z-64](#)

The healthcare resource is/was needed for appropriate care of the patient because of ...

- Diagnosis of OSA in pediatric individuals is made when ... criteria are met
- Diagnostic Testing via a facility/laboratory attended PSG may be medically necessary if ...
- PSG/RLS may be considered medically necessary for the diagnosis of periodic limb movement disorder when ... are criteria met
- Multiple Sleep Latency Testing (MSLT) may be considered medically necessary in pediatric individuals, after OSA has been ruled out by PSG, for ... medical conditions
- Actigraphy in conjunction with PSG may be considered medically necessary to evaluate sleep disorders when ... is present
- Positive Airway Pressure (PAP), CPAP in pediatric individuals may be considered medically necessary in ... situations

NOTE: PSG may be considered medically necessary when evaluating individuals with parasomnias when there is a history of sleep related injurious or potentially injurious disruptive behaviors.

NOTE: PSG in pediatric individuals not meeting the criteria as indicated in

[Cancel](#) [Submit](#)

4. Review Guidelines

The MCG data requested will appear in the main **Authorization Request** window under the **Review Guidelines MCG** section of the screen. Complete the attachment of the MCG Criteria by selecting the blue **Save** button after adding each criteria. Finally, select the blue **Submit** button to complete **Step 4**.

The screenshot displays the Predictal Auth Automation Hub interface. At the top, the header includes the Predictal logo and 'Auth Automation Hub' on the left, and a user profile icon and 'Exit AAH' button on the right. The main title is 'Authorization Request' with an 'Actions' dropdown menu. Below the title is a progress bar with five steps: 1. Authorization Details, 2. Enter Provider, 3. Review Guidelines, 4. Review Authorization, and 5. Confirmation. The 'Review Guidelines' step is highlighted with a red box. Under this step, the 'Review Guidelines MCG*' section is visible. It contains a table with columns for ID, Name*, Status, and an empty column. A row is present with 'Invoke Criteria' in the Name* column and 'New' in the Status column. Below the table is an 'Add' button. At the bottom of the interface, there are 'Back', 'Save', and 'Submit' buttons, with the 'Save' and 'Submit' buttons highlighted by a red box. On the right side, there is a 'Recent attachments (0)' section with a plus sign and a checkbox labeled 'Show subcase attachments'.

After submitting the **Review Guidelines**, users will be taken to the **Review Authorization Details** page to review all information submitted to this point.

Auth Automation Hub BA

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency
					Prior Authorization	Medical-Inpatient	Non-Urgent

Service Type
Medical Care

1. Authorization Details 2. Enter Provider 3. Review Authorization 4. Confirmation

Recent attachments (0) +

Review Authorization Details

Case Information

Authorization Type	Urgency
Medical-Inpatient	Non-Urgent

Request Information

Start of Care Date
12/09/2021

Member Information

First Name	Member ID
Last Name	Date of Birth

Scrolling to the bottom will allow users to **Submit**. This is the **final submission** which will send the user the authorization request for final review.

Auth Automation Hub BA

Authorization Request

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency
					Prior Authorization	Medical-Inpatient	Non-Urgent

Service Type
Medical Care

HOSPITAL

Servicing Facility/Vendor **SUBMITTED BY THIS PROVIDER**

Provider ID	XXXXXXXXXX	Provider Name	GENERAL HOSPITAL
-------------	------------	---------------	------------------

Performing Provider

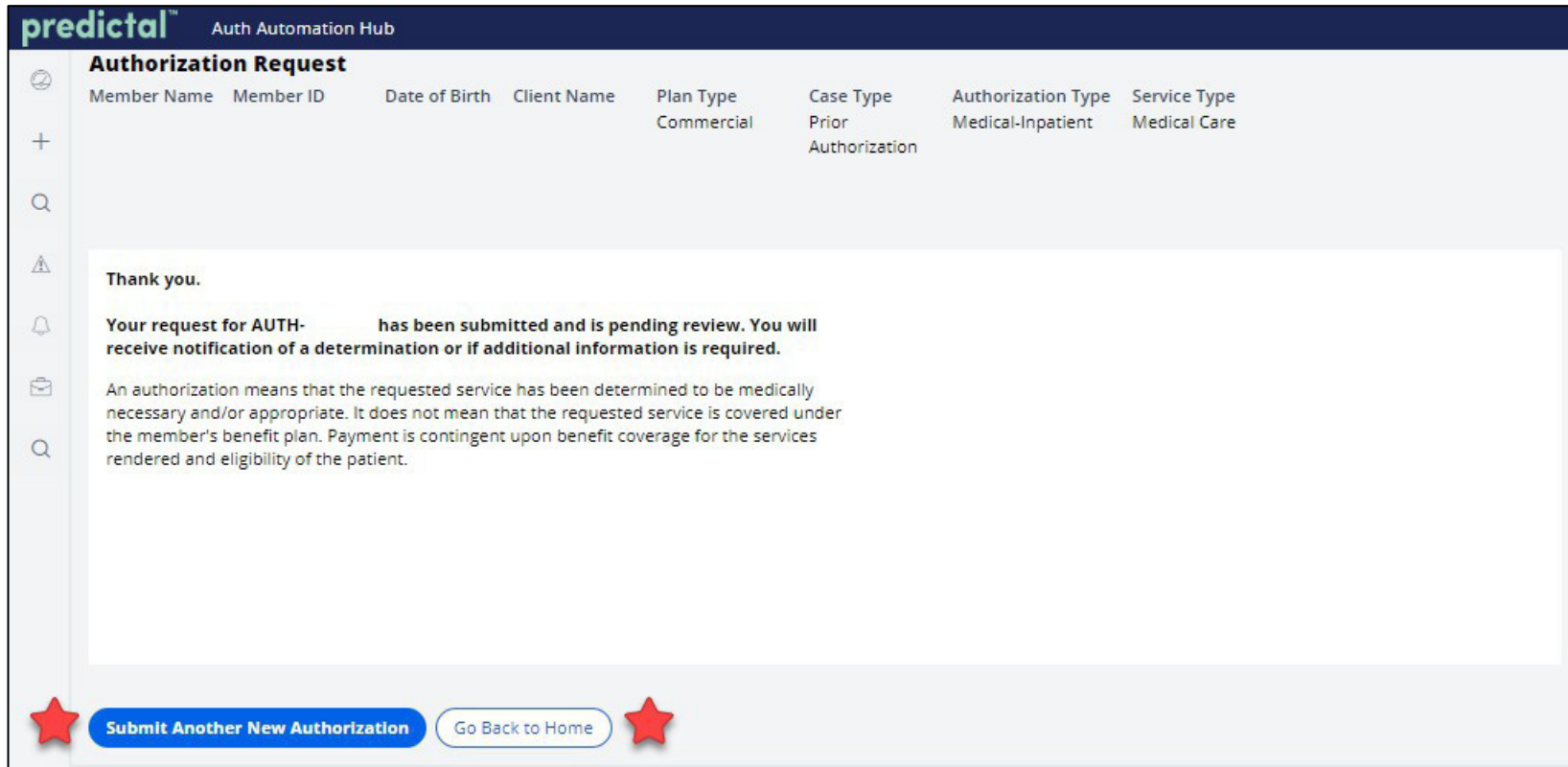
Provider ID	XXXXXXXXXX	Provider Name	GENERAL HOSPITAL
-------------	------------	---------------	------------------

Back Save Submit

When the authorization is submitted, a reference number will be displayed (AUTH-_____).

Note: Users do not receive an official Authorization Number until the review is complete.

From here, users can select to submit another **Authorization Request** or return to the Predictal home screen.



The screenshot displays the Predictal Auth Automation Hub interface. At the top, the header reads "predictal™ Auth Automation Hub". Below this, the title "Authorization Request" is shown. A table lists various fields: Member Name, Member ID, Date of Birth, Client Name, Plan Type (Commercial), Case Type (Prior Authorization), Authorization Type (Medical-Inpatient), and Service Type (Medical Care). A central message box contains the following text:

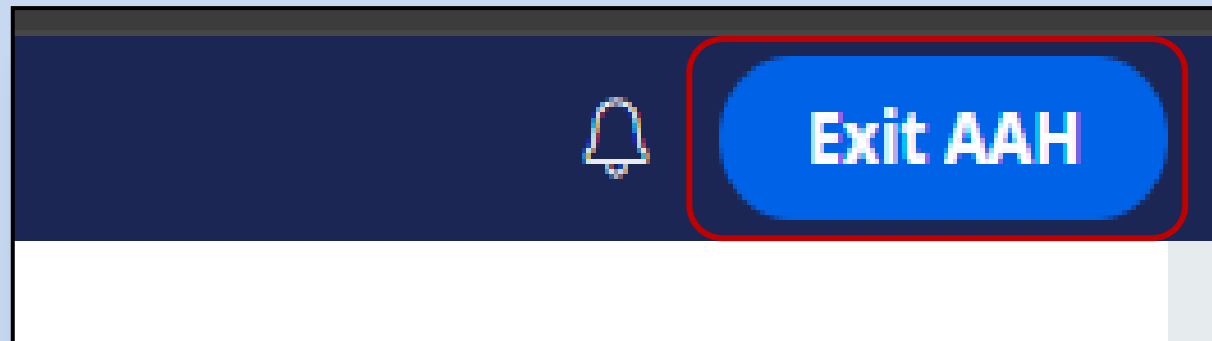
Thank you.

Your request for AUTH-_____ has been submitted and is pending review. You will receive notification of a determination or if additional information is required.

An authorization means that the requested service has been determined to be medically necessary and/or appropriate. It does not mean that the requested service is covered under the member's benefit plan. Payment is contingent upon benefit coverage for the services rendered and eligibility of the patient.

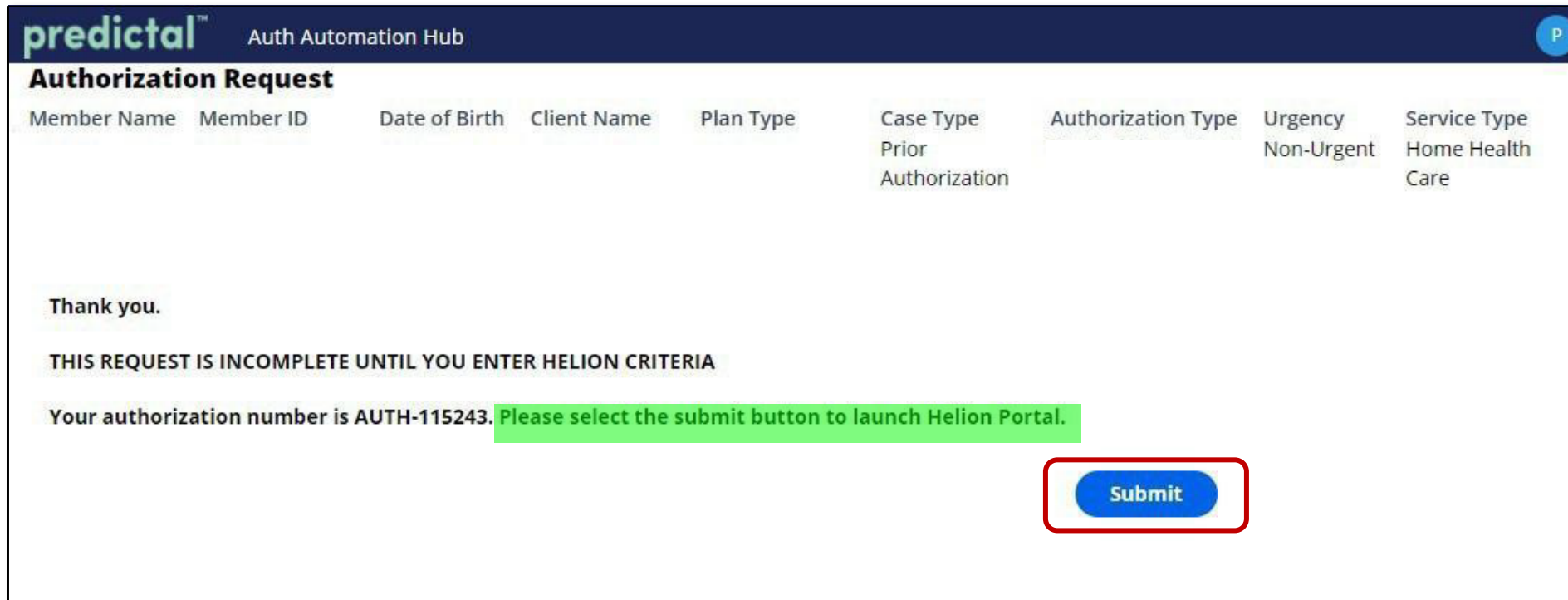
At the bottom of the interface, there are two buttons: "Submit Another New Authorization" (highlighted with a red star) and "Go Back to Home" (highlighted with a red star).

Note: When users are done in Predictal, officially exit the application by selecting the blue **EXIT AAH** button at the top right corner of the screen.



Please note: When submitting Inpatient Transfer – Skilled Nursing Facility, Acute Rehab, or Long-Term Acute Care requests – be sure to click the blue **Submit** button to launch the **Helion Portal**.

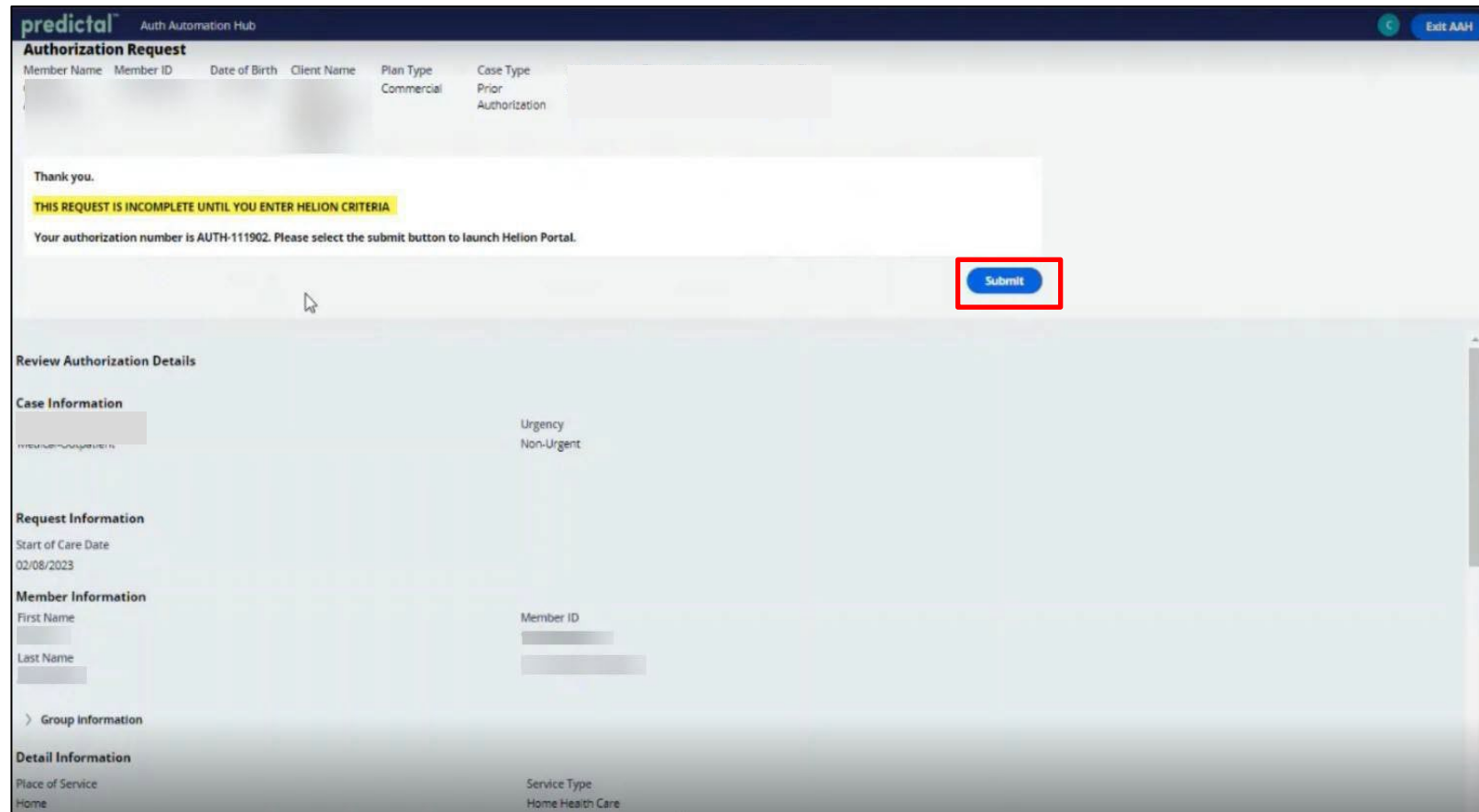
Additional information on Helion Arc begins on the next page of this guide.



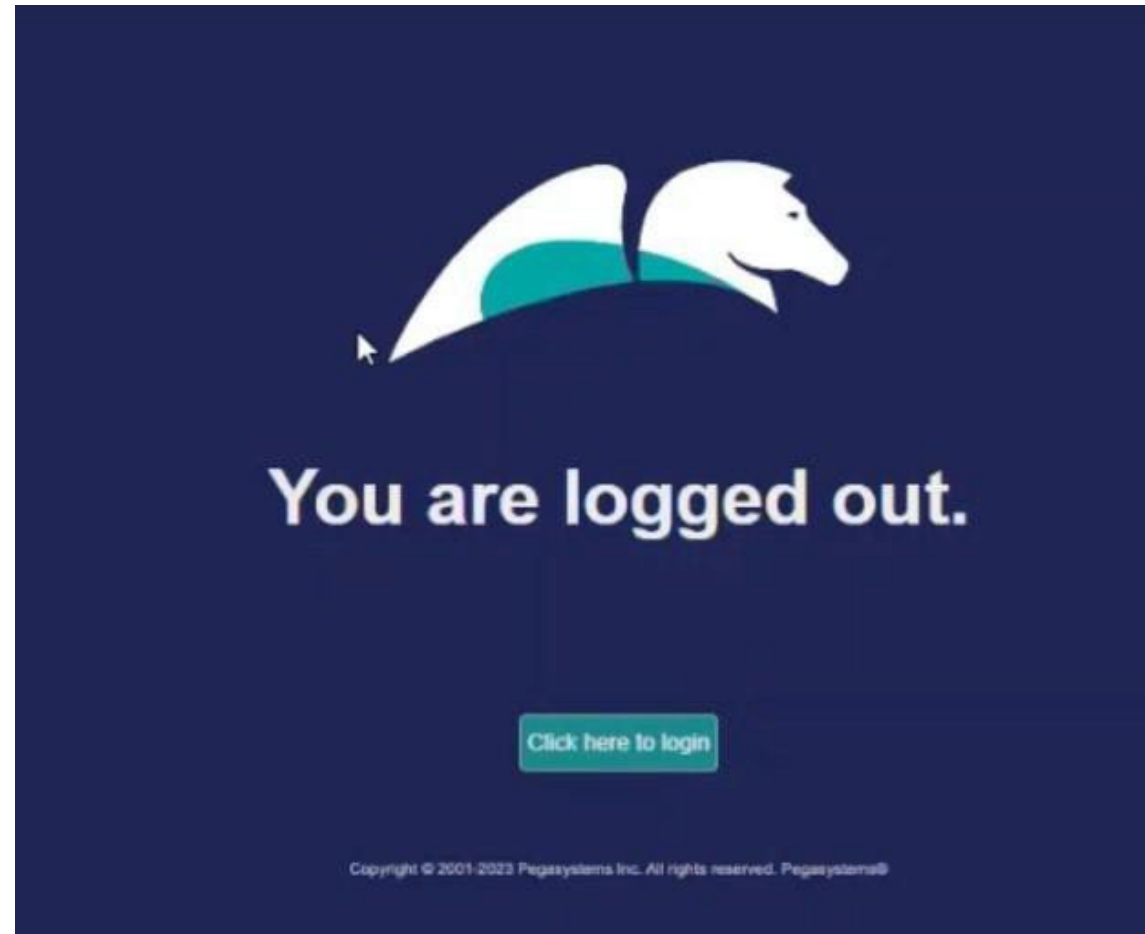
The screenshot shows the Predictal Auth Automation Hub interface. At the top, the Predictal logo and "Auth Automation Hub" are visible. Below this is a section titled "Authorization Request" with a table of fields: Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type (Prior Authorization), Authorization Type, Urgency (Non-Urgent), and Service Type (Home Health Care). The main content area contains the text "Thank you." followed by a warning: "THIS REQUEST IS INCOMPLETE UNTIL YOU ENTER HELION CRITERIA". Below this, it states "Your authorization number is AUTH-115243." and includes a green callout box with the text "Please select the submit button to launch Helion Portal." A blue "Submit" button is highlighted with a red rectangular border.

Helion Arc Authorization Submissions

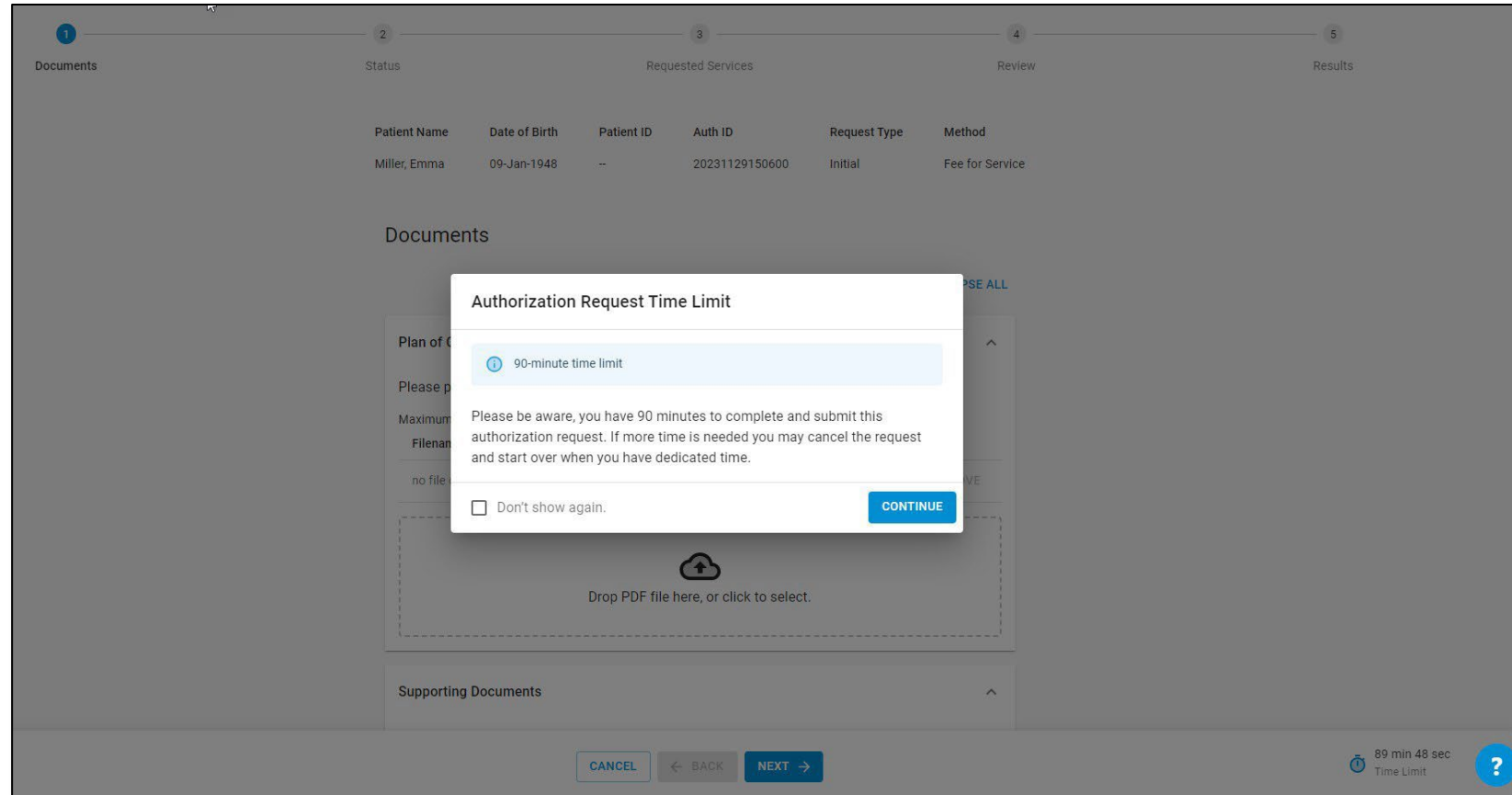
If users are submitting a request for an Inpatient Transfer – Skilled Nursing Facility, Acute Rehab, or Long-Term Acute Care — they will get a notification that the request is incomplete until the Helion criteria is entered. Hit **Submit**.



Users will be automatically logged out of the Predictal Auth Automation Hub and taken directly to Helion Arc.



Once in Helion Arc, users will receive a message regarding the **Authorization Request Time Limit**, which indicates **users have 90 minutes to complete and submit the authorization**.



Users can upload the **Plan of Care** here. It can be uploaded as a PDF file.

The screenshot displays a multi-step submission process. The first step, 'Documents', is highlighted with a blue circle and the number '1'. A progress bar at the top shows five steps: 1. Documents (active), 2. Status, 3. Requested Services, 4. Review, and 5. Results. Below the progress bar, the 'Plan of Care' section is visible. It includes a red 'Required' indicator, a text prompt 'Please provide an updated plan of care.', and a 'Maximum file size: 10MB' restriction. A table below shows a single entry with the filename 'no file chosen' and an 'Actions' column containing a 'REMOVE' button. At the bottom of the section is a dashed box with a cloud and arrow icon, containing the text 'Drop PDF file here, or click to select.'

This is the review screen. Users can edit any information using the **Edit** button located in each section (scroll down). If all information looks correct, hit the blue **Submit** button.

The screenshot displays a multi-step review process. At the top, a progress bar shows five steps: Documents, Status, Requested Services, Review (current step), and Results. Below the progress bar, patient information is displayed in a grid: Patient Name, Date of Birth, Patient ID, Auth ID, Request Type, Method, Start Of Care, and Fee for Service. A 'Review' section contains a blue informational banner: 'Note: After submitting to see Results you will NOT be able to make edits to this request.' Below this, the 'Documents' section shows '3 of 3 Required Items Complete' and an 'EDIT' button. The document list includes 'Assessment' (checked), 'OASIS XML File' (with a 'Filename' field containing 'Valid OASIS-E SOC.xml'), and 'Supplementary Assessment Items' (checked). At the bottom, there are 'CANCEL', 'BACK', and 'SUBMIT' buttons, a '22 min 33 sec Time Limit' indicator, and a help icon.

The request will be “Approved” or “Pended”.

If the authorization does **not** meet medical necessity through Helion Arc, it will be **Pended** to a clinician at the Health Plan for review. Users will be notified of the final determination via the provider portal. Click **Submit to Insurer**.

The screenshot displays a web interface for Helion Arc submissions. At the top, a progress bar shows five steps: Documents (checked), Disclaimer (checked), Status (checked), Requested Services (checked), Review (checked), and Results (5). Below the progress bar is a disclaimer text box. A blue information box contains the note: "Note: You must click the 'Submit to Insurer' button below to finalize this authorization request." The "Requested Services" section shows "Skilled Nursing Approved: 2 visits" with a green checkmark icon. Below this, there is a field for "Requested visits" with the value "2" entered. At the bottom center, a blue button labeled "SUBMIT TO INSURER" is highlighted with a red box. In the bottom right corner, there is a timer showing "18 min 26 sec Time Limit" and a help icon (question mark).

Users will be directed to the Helion Arc dashboard, where they can view all active authorization requests. Clicking the arrow will open the patient and request information.

The screenshot displays the Helion Arc dashboard interface. At the top, there is a search bar with the placeholder text "Search by patient name, auth ID, or member ID..." and a "DEFAULT TEST TENANT" dropdown menu. The left sidebar contains navigation options: Dashboard, Conversations, Authorization Requests, Patients, and Surveys. The main content area is titled "Dashboard" and features a section for "Active Authorization Requests" with a notification badge (1). Below this, there are filters for "ALL STATUSES" and "SUBMIT DATE: NEWEST". A descriptive text states: "Active Authorization Requests includes any authorization request that has one or more pending services or is within a payment period that has not ended." A sub-section titled "HOME HEALTH" (1) is visible. A detailed view of a request is shown, including a status indicator (a green checkmark in a box), a submit date of "10-Feb-2023", and an "Auth ID". A green bar indicates "1 service approved". Below this, a table lists "Approved Services" and "Visits Approved":

Approved Services	Visits Approved
Skilled Nursing	3

At the bottom of this view, there are two buttons: "VIEW PATIENT" and "VIEW REQUEST". The footer includes links for "Privacy Policy" and "User Agreement", and a help icon (question mark) is located in the bottom right corner.

Clicking on either **View Patient** or **View Request** will open the **Authorization Request Details**. Users can see the Auth number at the top, as well the **Requested Services**, **Status**, and any **Documents** that have been uploaded.

helion arc

Search by patient name, auth ID, or member ID...

DEFAULT TEST TENANT

TASKS

Dashboard > Authorization Requests > Auth ID: AUTH-1

Auth ID: AUTH-1

Care Setting	Request Type	Product	Servicing Provider	Reimbursement Method
Home Health	Start Of Care			Fee for Service

Authorization Request Details
View requested service(s), reason(s) for care, and additional details for this authorization request.

REQUESTED SERVICES 1 STATUS DOCUMENTS

Skilled Nursing [START CONVERSATION](#)

✔ This requested service has been approved. See additional information below.

Visits Approved	Visits Requested	Last Covered Date	Proposed Date of Service
3	3	05-Apr-2023	08-Feb-2023

Reasons For Care

Onaoina Assessment Needs

Patient Details

Patient Name

Date of Birth

Patient ID

Submission Details

Submission Date: 10-Feb-2023

Submission Time: 14:39

Submitter

Authorization Request Activity

Privacy Policy | User Agreement

The panels to the right of the screen show the **Patient Details**, **Submission Details**, and an audit history under **Authorization Request Activity** (scroll down).

The screenshot displays the Helion Arc interface for an authorization request. The top navigation bar includes a search field, the text 'DEFAULT TEST TENANT', and a 'TASKS' button. A left sidebar contains navigation options: Dashboard, Conversations, Authorization Requests, Patients, and Surveys.

The main content area is titled 'View requested service(s), reason(s) for care, and additional details for this authorization request.' It features three tabs: 'REQUESTED SERVICES' (with a notification badge '1'), 'STATUS', and 'DOCUMENTS' (which is active). Under the 'DOCUMENTS' tab, there is a table with the following data:

Type	Name	Date Added
OASIS Assessment	Valid OASIS-E SOC.xml	10-Feb-2023
Plan of Care:	testfax.pdf	10-Feb-2023

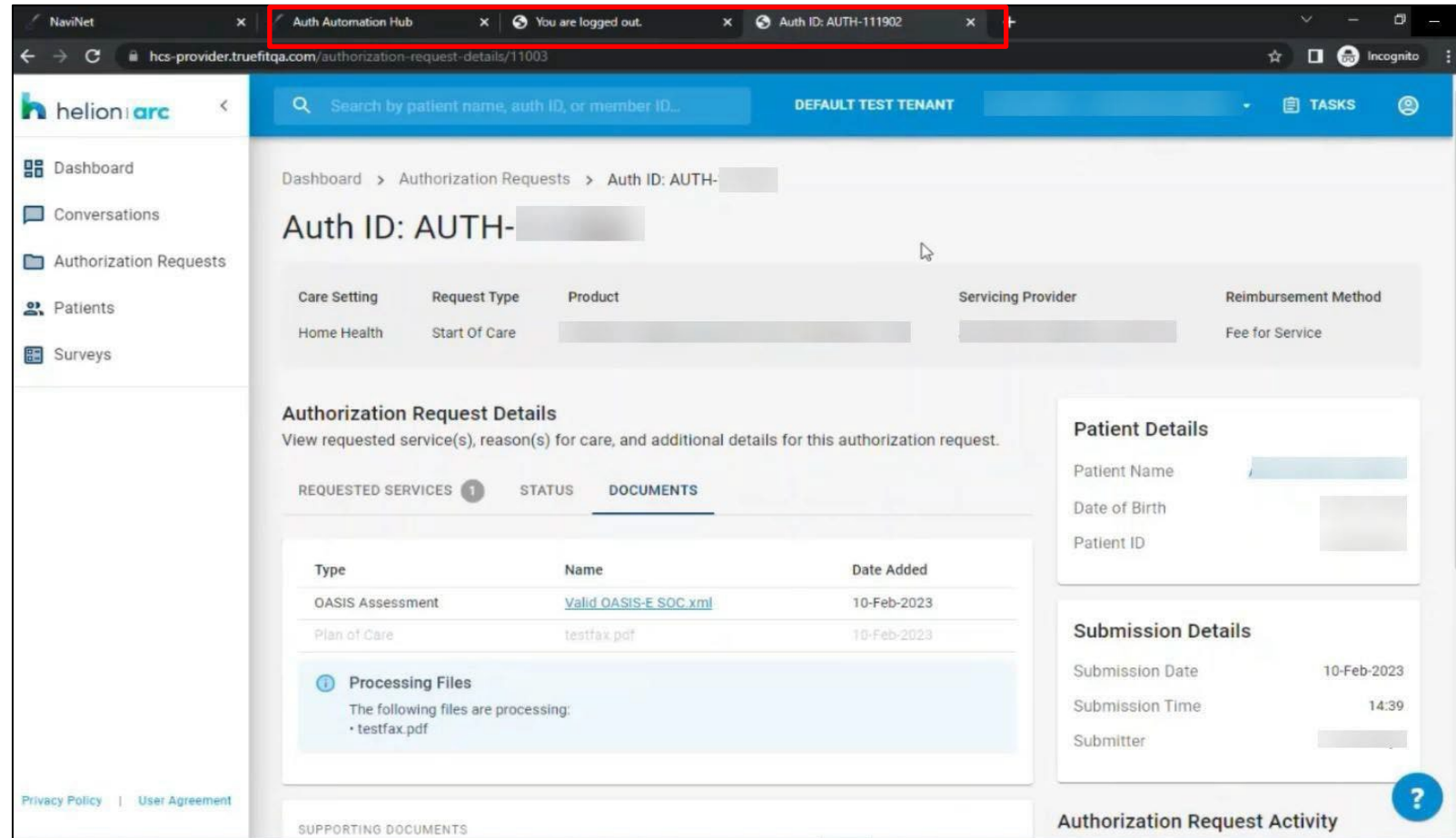
Below the table is a 'Processing Files' section with an information icon and the text: 'The following files are processing: • testfax.pdf'. At the bottom of the main area is a 'SUPPORTING DOCUMENTS' section with a table header (Name, Date Added) and the message 'No documents uploaded'. Below this is a dashed box containing a cloud upload icon and the text: 'Drop PDF, DOC, or DOCX file here, or click to select.' Links for 'Privacy Policy' and 'User Agreement' are in the bottom left.

On the right side, there are three panels:

- Patient Details:** Shows fields for Patient Name, Date of Birth, and Patient ID.
- Submission Details:** Shows Submission Date (10-Feb-2023), Submission Time (14:39), and Submitter.
- Authorization Request Activity:** Contains the instruction 'Stay up to date on status changes specific to this authorization request.' and two activity items:
 - Approved by Insurer (Approved Skilled Nursing)
 - Request Submitted by Provider

At the bottom right of the activity panel are two circular buttons: an upward arrow and a question mark.

This completes the submission process for a request through Helion Arc. Users can now close out of any browser tabs as needed using the **X** on each tab.

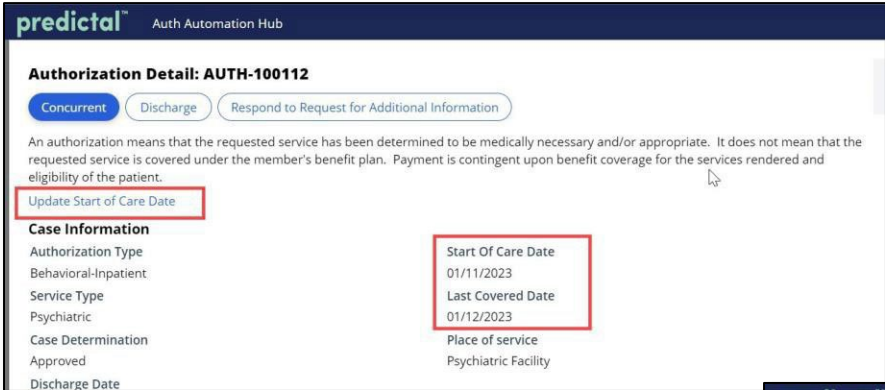


Availity Provider Portal Predictal Authorization Inquiry

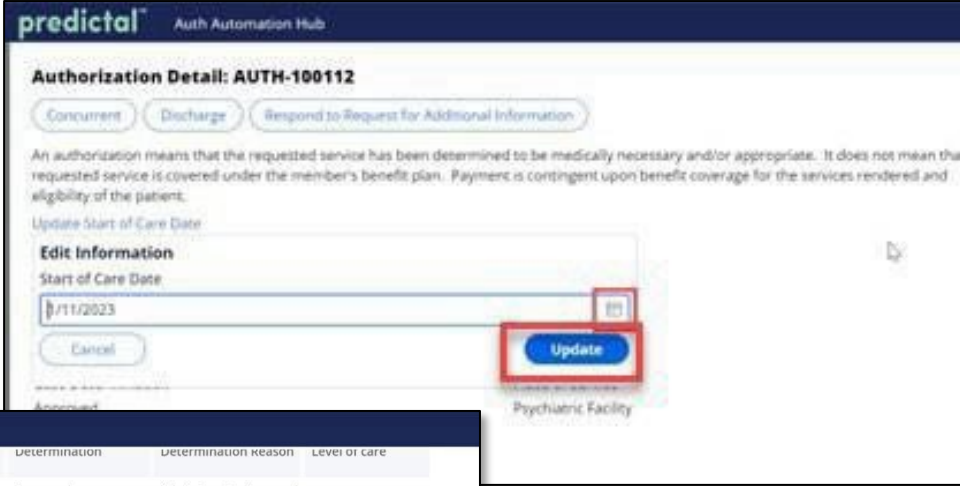
To update the **Start of Care Date** after the authorization is submitted:

1. Go to **Auth Inquiry**
2. Click the **Update Start of Care Date** hyperlink.
3. Click the calendar in the **Edit Information** field, select the appropriate **Start of Care Date**, and click **Update**.
IMPORTANT: This date must be within 7 days prior to the original Start of Care Date that was selected or within 30 days in the future of the original Start of Care Date.
4. Select the **Save Changes** button.

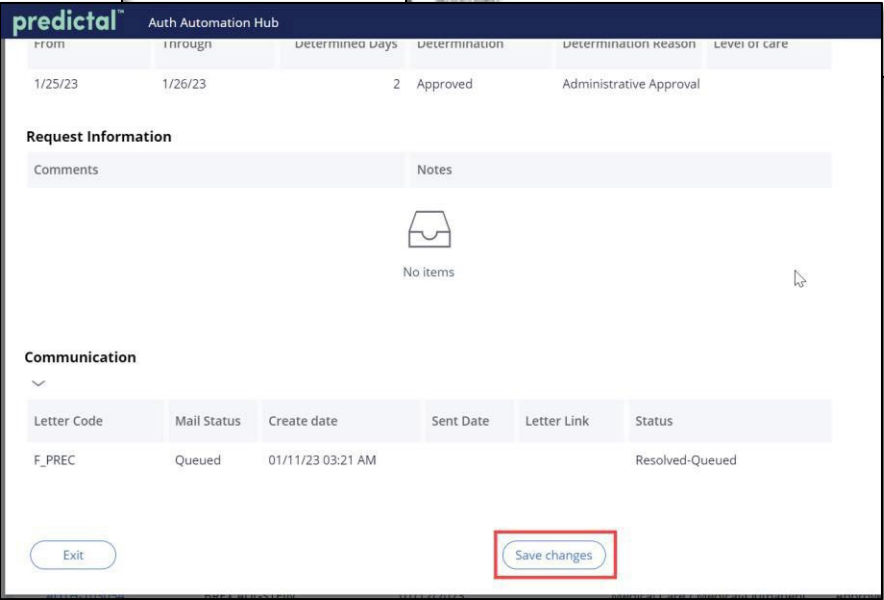
Step 1



Step 2



Step 3



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