MEDI - Claim Status Inquiry for Professional Claims

MEDI allows registered providers access to verify participant eligibility, check claim status, and submit claims directly to the Department. This document provides information on how to check claim status through the MEDI portal.

MEDI provides status on paper claims and electronic claims submitted to the Department. Status can be verified three days after submission of an electronic claim or receipt of a paper claim. Claim status is only available for 90 days from bill date. After 90 days, claim status must be requested by submitting a 276 *batch* request file. The Department will respond with a 277 response file. Batch requests and responses are available through MEDI.

To retrieve Claims Status, a user must be either a Registered Administrator or Registered Employee on the Provider's MEDI account.

- Login to MEDI:
  1. Select *Internet Electronic Claims System* (IEC)
  2. Select *Claims Status Inquiry*
  3. Complete only the Required Fields (*asterisk)
  4. Select correct provider from the *Submitter* drop-down box
  5. Enter required information: RIN (9 digit Recipient Identification Number), Last Name, Date of Birth, and Gender
  6. Click *Next*
  7. *Claim Status Tracking Number* is a Unique Number for the User to enter in field. (It can be any number). It must be one or more digits. The same number may be used on each claim status inquiry.)
  8. *Application or Location System Identifier* (dropdown) select *Professional-.*
  9. Enter *Service Date* or *Date Range* (this field does not have an asterisk, but is required)
  10. Click *Submit*.

*DO NOT enter information in the *Service Line* section (third screen). Information entered incorrectly in these fields will generate an inaccurate response.

Claim Status Category Codes:

A = Acknowledgement

- A1 *Acknowledgement/Receipt*. The claim has been *received* by the Department. *This does not mean the claim has been accepted for adjudication.*
- A2 *Acknowledgement/Acceptance* The claim was *accepted* for processing into the system.
- A3 *Acknowledgement/Returned* as unprocessable. The claim was *not accepted* by the system and has not been entered into the adjudication system.
- A4 *Acknowledgement/Not Found*. The claim cannot be found in the adjudication system.

P = Pending

- P0 *Pending.* Adjudication/Details – This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued or only part of the claim has been paid.
- P1 *Pending/in Process*. The claim is being processed in the system.
- P2 *Pending/In Review*. The claim is suspended pending review. The claim may take additional time to either process for payment or be assigned error codes.

F = Finalized

- F1 *Finalized/ Payment*. The claim has been paid.
- F2 *Finalized/Denial*. The claim has been denied. HIPAA reason and remark codes will be returned. The Department continues to mail the paper remittance advice with HFS specific error codes that provide more detail.