

# SMART DATA STREAM COMPANION GUIDE

[PORTAL.SMARTDATASTREAM.US](https://portal.smartdatastream.us)

SDS Provider Support

[stream.support@sdata.us](mailto:stream.support@sdata.us)

855-297-4436

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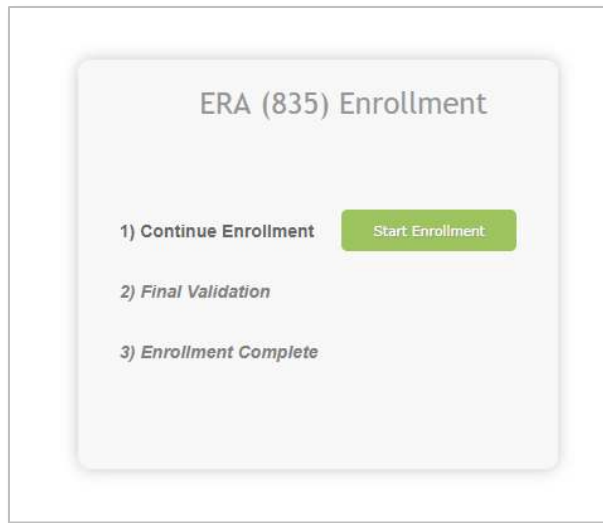
    Dental ..... 16

# ERA ENROLLMENT

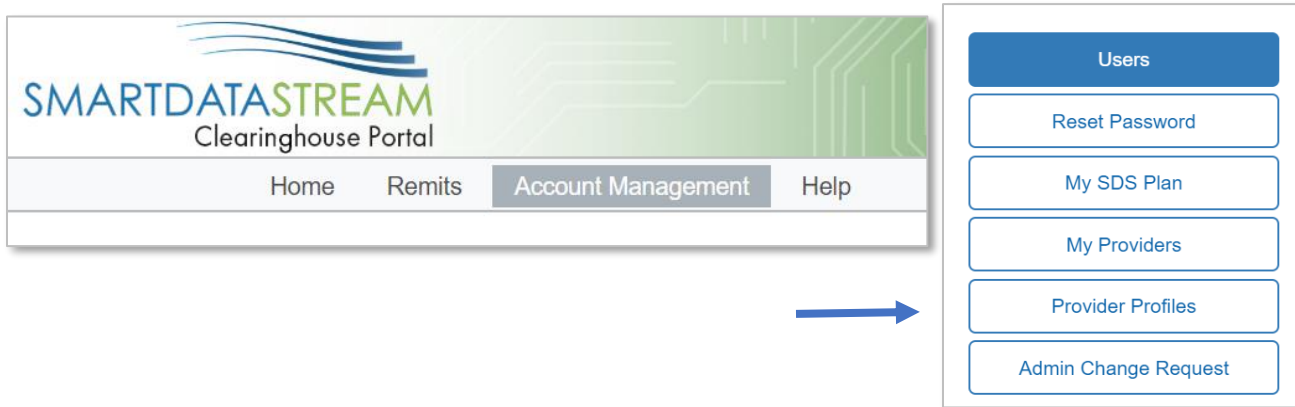
- There are several different methods for starting an ERA account with Smart Data Solutions depending on which payer you're enrolling for. If you have an account that doesn't include ERA enrollment already, or if you have a specific ERA account and would like access to additional payer's ERAs, please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

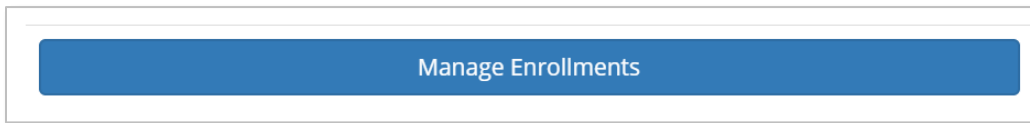
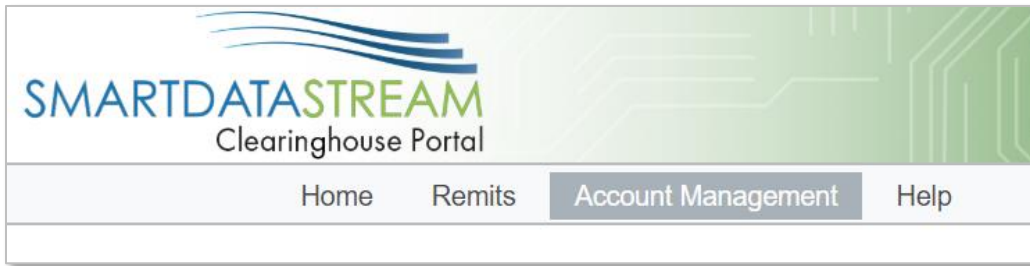


- If the above screen does not automatically appear you can select Account Management at the top bar. Then select Provider Profiles



OR

- Select Remits at the top bar then Manage Enrollments



## ENROLLMENT FORM

**Profile**

Profile Nickname

**Provider Information**

\* Name  
Test Provider T1000

Doing Business As (DBA)

\* Address Line 1

Address Line 2

**Provider Identifiers Information**

\* Tax Identification Number (TIN)  \* Verify TIN:

National Provider Identifier (NPI)  Verify NPI

Trading Partner ID

**Provider Contact Information**

\* Last Name  \* First Name

test  test

\* Contact Phone

(651) 555-5555 x55555

Contact Fax

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

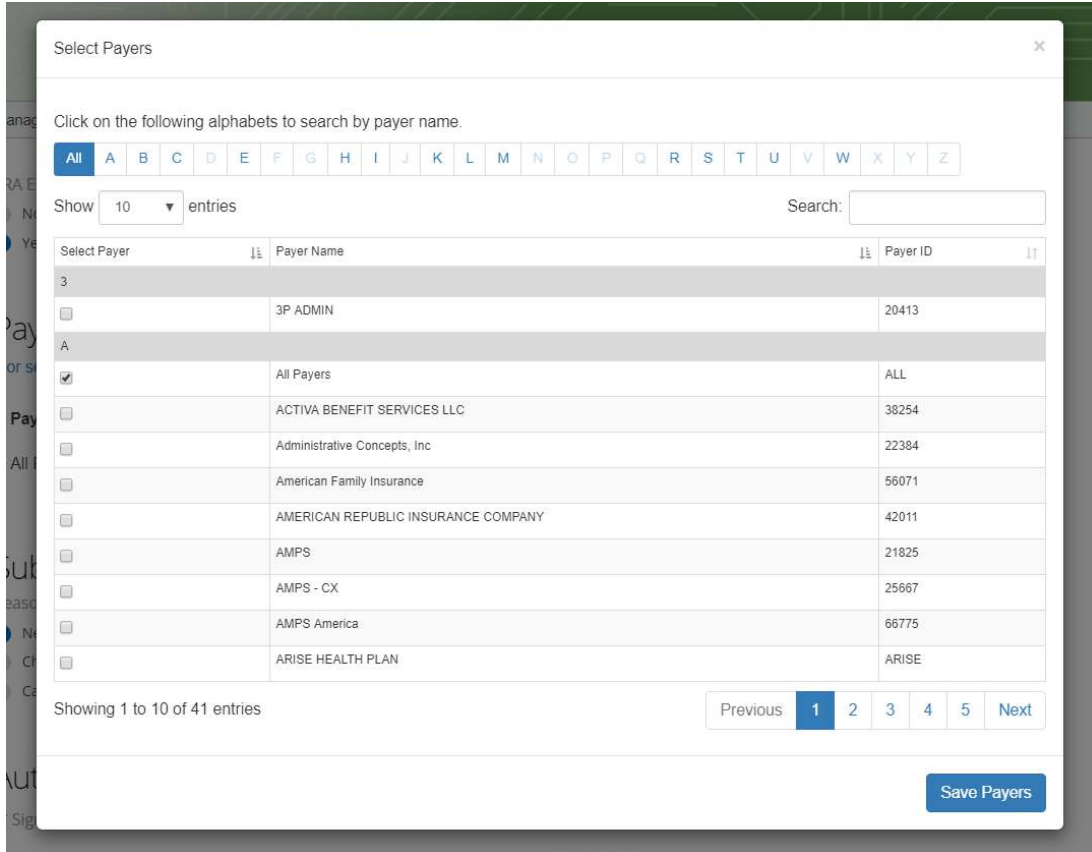
Don't forget to verify your tax ID

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

### Payer Selection

[...or select individual payers](#)

Payer Name	Payer ID	Clearinghouse Name	Actions
ACTIVA BENEFIT SERVICES LLC	38254	Ability	Apply All <input type="checkbox"/>
Administrative Concepts, Inc	22384	SDS Enrollment Portal	Apply All <input type="checkbox"/>
American Family Insurance	56071	SDS Enrollment Portal	Apply All <input type="checkbox"/>
AMERICAN REPUBLIC INSURANCE COMPANY	42011	SDS Enrollment Portal	Apply All <input type="checkbox"/>
AMPS	21825	SDS Enrollment Portal	Apply All <input type="checkbox"/>

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

Payer Selection  
[...or select individual payers](#)

Payer Name	Payer ID	Clearinghouse Name	Actions
ACTIVA BENEFIT SERVICES LLC	38254	Ability	Apply All ×
Administrative Concepts, Inc	22384	Ability	Apply All ×
American Family Insurance	56071	Ability	Apply All ×
AMERICAN REPUBLIC INSURANCE COMPANY	42011	Ability	Apply All ×
AMPS	21825	Ability	Apply All ×

- 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.

Submission Information

Reason for SUBMISSION Ⓞ

New Enrollment  
 Change Enrollment  
 Cancel Enrollment

Authorized Signature

\* Signature Ⓞ \_\_\_\_\_ Submission Date  
 2019-08-27

\* Requested ERA Effective Date Ⓞ \_\_\_\_\_

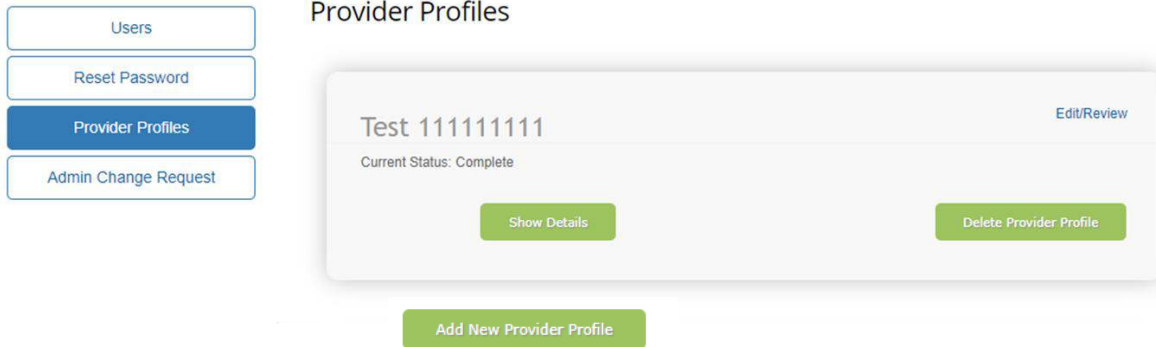
**SAVE PROGRESS**

**SUBMIT**

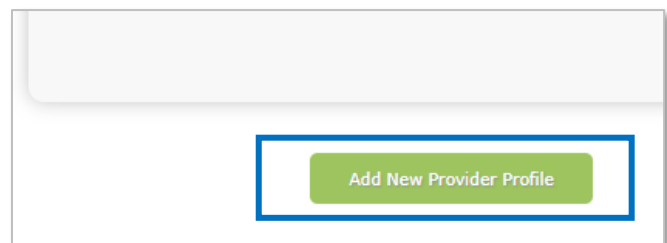
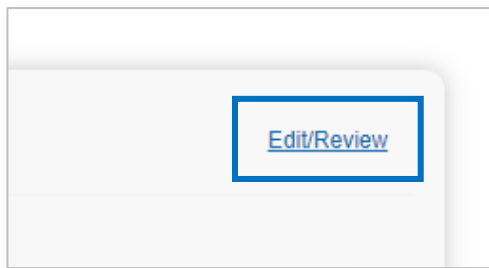
- After you click Submit it will redirect you to a page that looks like this. If you see this page, you have successfully submitted your ERA enrollment.

# Account Management

This page is for maintaining account wide preferences such as viewing or re-issuing your API key, or managing payment methods.



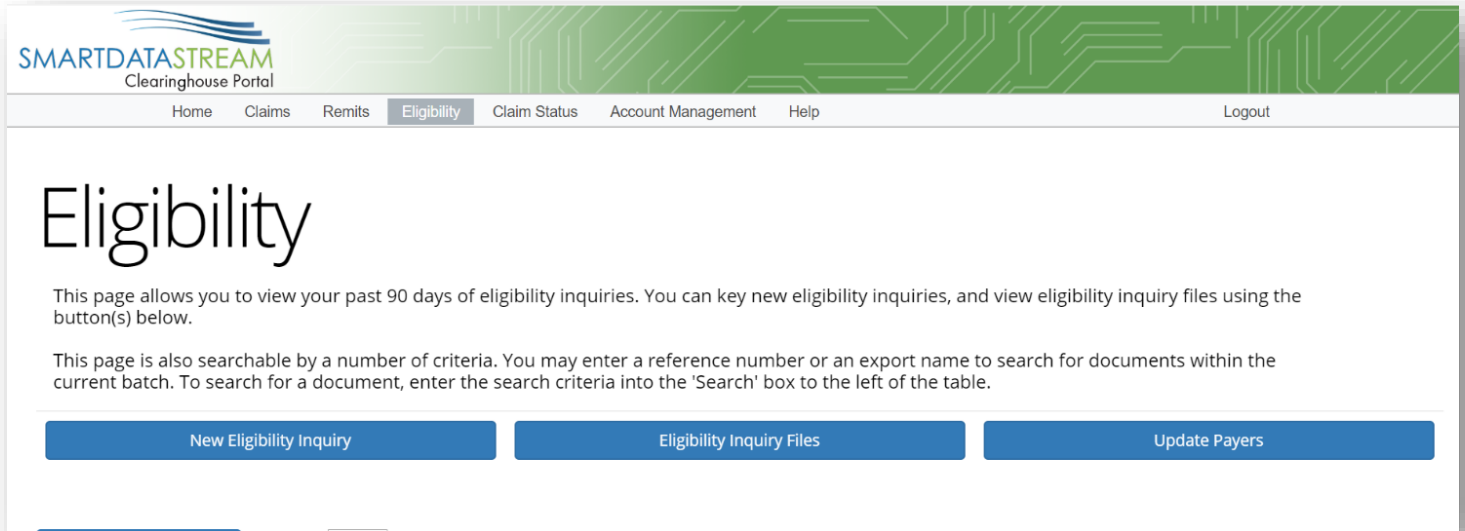
The screenshot shows the 'Provider Profiles' section of the account management interface. On the left is a vertical menu with four buttons: 'Users', 'Reset Password', 'Provider Profiles' (highlighted in blue), and 'Admin Change Request'. The main content area is titled 'Provider Profiles' and displays a profile for 'Test 111111111'. The profile card includes the text 'Current Status: Complete' and an 'Edit/Review' link in the top right corner. Below the profile name are two green buttons: 'Show Details' and 'Delete Provider Profile'. At the bottom center of the main area is a green button labeled 'Add New Provider Profile'.



- 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

### New Eligibility Inquiry

**Mode:**  Real Time

**Destination:** American Republic/American Family/Medico/Continental General/Central Reserve Life 270/271 ▼

**Subscriber Information**

<b>Patient Name *</b> (Last Name, First Name, Middle Initial)			<b>Member Date of Birth *</b>		<b>Member ID *</b>	<b>Insured?</b>
Last	First	Middle	YYYYMMDD	Sex * Male ▼		Yes ▼
<b>Address (No. Street)</b>			<b>City</b>	<b>State</b>	<b>Zip</b>	
Address Line 1			City	State	Zip Code	
Address Line 2						
<b>Inquiry/Service Type:</b> Health Benefit Plan Coverage ▼						
<input type="button" value="+ Add Inquiry"/>				<input type="button" value="+ Add Member"/>		
<input type="button" value="Save Progress"/>		<input type="button" value="Save Inquiry"/>		<input type="button" value="Submit Real-Time Request"/>		

- 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]

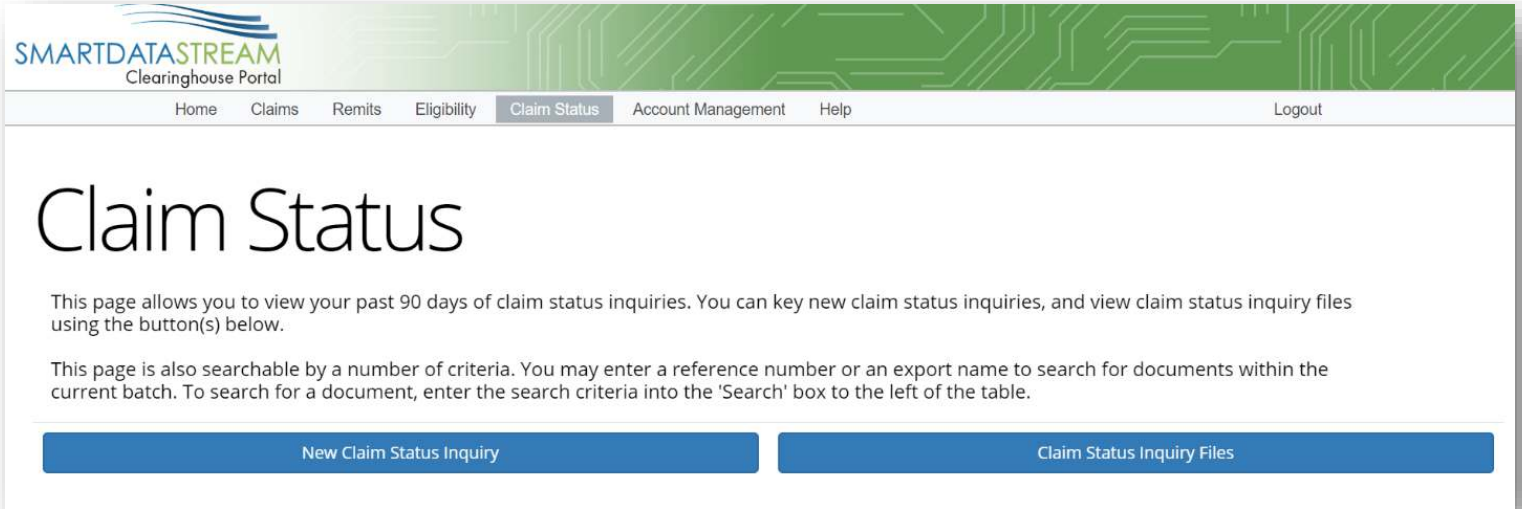
#### Benefit Information

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

**New Claim Status Inquiry**

**Mode:** Real Time

**Destination:** American Republic/American Family/Medico/Continental General/Central Reserve Life 276/277 ▼

<b>Provider ID *</b>			
<b>Subscriber Name *</b> (Last Name, First Name, Middle Initial)		<b>Subscriber Date of Birth *</b>	<b>Subscriber ID *</b>
Last	First	Middle	YYYYMMDD [calendar icon] Sex: Male ▼
<b>Patient Name</b> (Last Name, First Name, Middle Initial)		<b>Patient Date of Birth</b>	<b>Claim Date of Service</b>
Last	First	Middle	YYYYMMDD [calendar icon] Sex: Male ▼
<b>Procedure Code</b>	<b>Service Date From</b>	<b>Service Date To</b>	<b>Service Charge</b>
	YYYYMMDD [calendar icon]	YYYYMMDD [calendar icon]	
<input type="button" value="Submit Request"/>			

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

<b>Claim Status Inquiry Results</b>	
<b>Source Name:</b>	SMART DATA SOLUTIONS
<b>Member ID:</b>	000007600314
<b>Subscriber Name:</b>	GLEASON, JOYCE
<b>Status Information</b>	
<b>Control Number</b>	102617718885
<b>Dates of Service</b>	10/13/2017 - 10/13/2017
<b>Claim Charges</b>	\$ 34.00
<b>Claim Paid Amount</b>	\$ 0.00
<b>Adjudication Date</b>	10/26/2017
<b>The transaction processing has been completed</b>	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.



## Claims

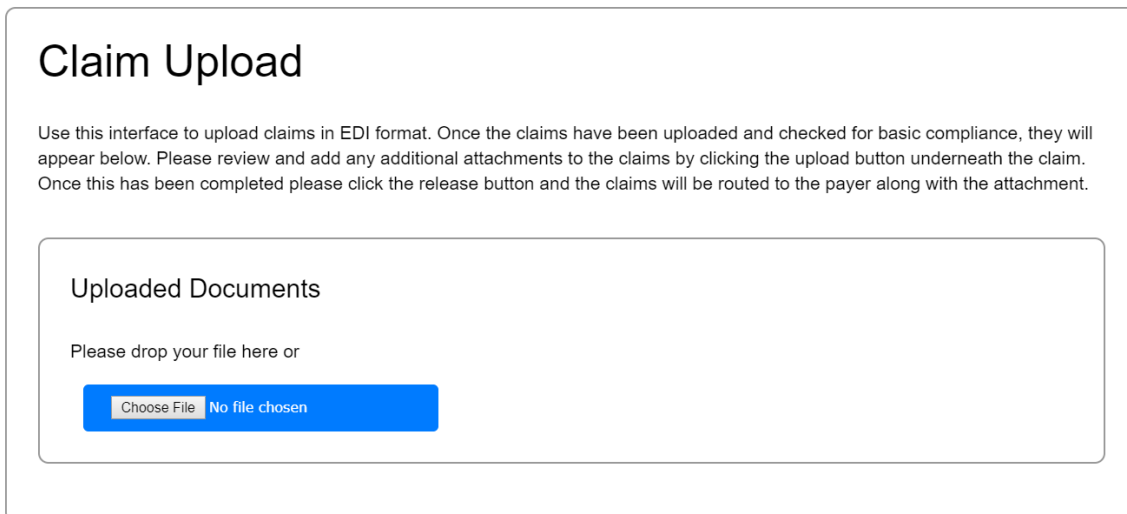
This page allows you to manage your past 90 days of claims. You can edit rejected claims, upload a new claim file, key a new claim, view unsubmitted claims, and view claim files using the button(s) below.

This page is also searchable by a number of criteria. You may enter a reference number or an export name to search for documents within the current batch. To search for a document, enter the search criteria into the 'Search' box to the left of the table.



### 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.

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## 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.

### New Document

This data entry page will allow you to key an empty form for processing. To begin entering information, please select a destination and a form to key. Once a form is selected you will be automatically redirected to the appropriate page to enter any data. Note that no data is saved until the submit button at the bottom of the page is selected. Once the entry has been completed, there may be a short delay before the entry appears on the history page while the system is processing it.

Please select the appropriate route and form type to begin.

Destination	Document Type
<input type="text" value="Amerigroup"/>	<input type="text" value="Select a Type"/> <input type="text" value="Select a Type"/> <input type="text" value="Professional"/> <input type="text" value="Institutional"/> <input type="text" value="Dental"/>

- 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:

## PROFESSIONAL

<a href="#">More</a>		
1. Type (OTHER <input type="text"/> )		1a. INSURED'S I.D. NUMBER <input type="text"/>
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Last <input type="text"/> First <input type="text"/> Middle <input type="text"/>		3. PATIENT'S BIRTH DATE YYYY/MM/DD Sex <input type="text"/>
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Last <input type="text"/> First <input type="text"/> Middle <input type="text"/>		5. PATIENT'S ADDRESS (No. Street) <input type="text"/>
6. PATIENT RELATIONSHIP TO INSURED Self <input type="text"/>		7. INSURED'S ADDRESS (No. Street) <input type="text"/>
CITY <input type="text"/>	STATE <input type="text"/>	8. RESERVED FOR NUCC USE
ZIP CODE <input type="text"/>	TELEPHONE <input type="text"/>	CITY <input type="text"/>
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <input type="text"/>		STATE <input type="text"/>
10. IS PATIENT'S CONDITION RELATED TO: Employment? <input type="text"/> No <input type="text"/> Auto Accident? <input type="text"/> No <input type="text"/> Other Accident? <input type="text"/> No <input type="text"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER <input type="text"/>
a. OTHER INSURED'S POLICY OR GROUP NUMBER <input type="text"/> <a href="#">[More...]</a>	b. RESERVED FOR NUCC USE	a. INSURED'S BIRTH DATE YYYY/MM/DD Sex <input type="text"/>
c. RESERVED FOR NUCC USE	d. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>	b. OTHER CLAIM ID (Designated by NUCC) <input type="text"/>
d. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>	10d. CLAIM CODES (Designated by NUCC) <input type="text"/>	c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Signed <input type="text"/>	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Signed <input type="text"/>	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="text"/> No <input type="text"/>
14. DATE OF CURRENT ILLNESS, INJURY, PREGNANCY (LMP) YYYY/MM/DD QUAL <input type="text"/>	15. OTHER DATE QUAL <input type="text"/> 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 <input type="text"/> Last <input type="text"/> First <input type="text"/>	17a. <input type="text"/> 17b. NPI <input type="text"/>	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES YYYY/MM/DD TO YYYY/MM/DD
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? <input type="text"/> No <input type="text"/>	\$ CHARGES 0.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A. <input type="text"/> B. <input type="text"/> C. <input type="text"/> D. <input type="text"/> E. <input type="text"/> F. <input type="text"/> G. <input type="text"/> H. <input type="text"/> I. <input type="text"/> J. <input type="text"/> K. <input type="text"/> L. <input type="text"/>	ICD Ind (ICD-10) <input type="text"/>	22. RESUBMISSION CODE <input type="text"/>
24. A DATES OF SERVICE B. POS C. EMG D. PROC MODIFIER E. DIAG F. CHARGE G. DU H. EPSDT I. QUAL J. PROVIDER ID		23. PRIOR AUTHORIZATION NUMBER <input type="text"/>
<a href="#">Add Line</a>		
25. FEDERAL TAX I.D. NUMBER <input type="text"/>	26. PATIENT'S ACCOUNT NO. <input type="text"/>	27. ACCEPT ASSIGNMENT? <input type="text"/> No <input type="text"/>
28. TOTAL CHARGE \$ 0.00	29. AMOUNT PAID \$ 0.00	30. RSVD for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER Last <input type="text"/> First <input type="text"/> Middle <input type="text"/> Credential <input type="text"/>	32. SERVICE FACILITY LOCATION INFORMATION Name <input type="text"/> Address <input type="text"/> City <input type="text"/> STATE <input type="text"/> Zip <input type="text"/> Phone <input type="text"/>	33. BILLING PROVIDER INFORMATION Name <input type="text"/> Address <input type="text"/> City <input type="text"/> STATE <input type="text"/> Zip <input type="text"/> Phone <input type="text"/>
a. NPI <input type="text"/>	b. <input type="text"/>	a. NPI <input type="text"/>
<a href="#">Save Progress</a>		<input type="checkbox"/> <a href="#">Save Billing Information</a>
<a href="#">Submit Document</a>		

# INSTITUTIONAL

Name		Name		3a		4 BILL TYPE																															
Addr		Addr		3b																																	
City		City		5 FED TAX NO.		6 STATEMENT COVERS																															
Phone - Fax						7																															
8 Patient Name				9 Patient Address																																	
10 BIRTHDATE		11 SEX		ADMISSION				CONDITION CODES				29 ACCT STATE		30																							
12 DATE		13 PRK		14 TYP		15 SRC		16 DHR		17 STAT		18		19		20		21		22		23		24		25		26		27		28					
31 OCCURRENCE		32 OCCURRENCE		33 OCCURRENCE		34 OCCURRENCE		35 OCCURRENCE SPAN		36 OCCURRENCE SPAN		37		38		39		40		41		42		43		44		45		46		47		48		49	
CODE		DATE		CODE		DATE		CODE		DATE		CODE		DATE		CODE		DATE		CODE		DATE		CODE		DATE		CODE		DATE		CODE		DATE			
Name		Address		City		Zip		39 VALUE CODES		40 VALUE CODES		41 VALUE CODES		42		43		44		45		46		47		48		49		50		51		52			
42 REV CD		43 DESCRIPTION		44 HC/STATE/PPS CODE		45 SERV DATE		46 SERV UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		50		51		52		53		54		55		56		57		58		59			
Add Line		CREATION DATE		TOTALS >		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00					
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASS BEN		54 PRIOR PAYMENTS		55 EST AMT DUE		56 NPI		57		58		59		60		61		62		63		64		65		66					
Amerigroup		B1237		Y		Y		0.00		0.00		OTH		PRV ID																							
58 INSURED'S NAME		59 PHEL		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO		63		64		65		66		67		68		69		70		71		72		73		74					
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		66		67		68		69		70		71		72		73		74		75		76		77		78							
66 DX		67		68		69		70		71		72		73		74		75		76		77		78		79		80		81		82					
69 ADMIT DX		70 PAT RSN DX		71 PPS CODE		72 ECI		73		74		75		76		77		78		79		80		81		82		83		84		85					
74 PROC		DATE		75 PROC		DATE		76 PROC		DATE		77		78		79		80		81		82		83		84		85		86		87					
78 AT TEND		NPI		QUAL		80		81		82		83		84		85		86		87		88		89		90		91		92		93					
LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST							
77 DIR/RE		NPI		QUAL		80		81		82		83		84		85		86		87		88		89		90		91		92		93					
LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST							
78 OTH		NPI		QUAL		80		81		82		83		84		85		86		87		88		89		90		91		92		93					
LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST							
79 OTH		NPI		QUAL		80		81		82		83		84		85		86		87		88		89		90		91		92		93					
LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST		LAST		FIRST							

