



Community Integration Manager

Provider User Guide

This guide explains how to use Community Integration Manager (CIM) to verify member eligibility, submit and track care types, search claims, upload documentation, look up vouchers and check coverage against the Oregon Health Plan Prioritized List of Health Services.

It is written for provider office staff. Access to CIM is granted by Ayin Health Solutions and is available to both in-network and out-of-network providers.

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About This Guide

CIM is the provider portal for Umpqua Health Alliance, hosted by Ayin Health Solutions. It is the system of record for eligibility verification, care type submission, claims research and documentation upload.

How this guide is organized

Each module covers one area of CIM and can be read on its own. Modules follow the order most offices work in: confirm eligibility, submit the care type, track it, then research the claim and payment.

- Module 1 — Member eligibility
- Module 2 — Care types and preauthorization
- Module 3 — Referral Manager
- Module 4 — Referral Reports
- Module 5 — Claims and Document Manager
- Module 6 — Vouchers and the DMAP line

Before you begin

You need an active CIM account. Requests for a new account are submitted through the Ayin Help Center, not through Umpqua Health Alliance. Appendix B has the full sign-up procedure and support contacts.

A note on screenshots

Screenshots show test member records. Any name, identification number or address shown is fictitious.

The CIM interface changes periodically. If a screen does not match what you see, contact Ayin Health Solutions using the details in Appendix B.

Module 1: Member Eligibility

Verify eligibility before delivering a service or submitting a care type. Eligibility can be checked from Member Search on the CIM dashboard or from the left navigation menu.

The dashboard is your starting point. The left navigation menu and the main tiles — Member Search, Referral Manager, Referral Reports and Claim Search — open the tools covered in this guide.

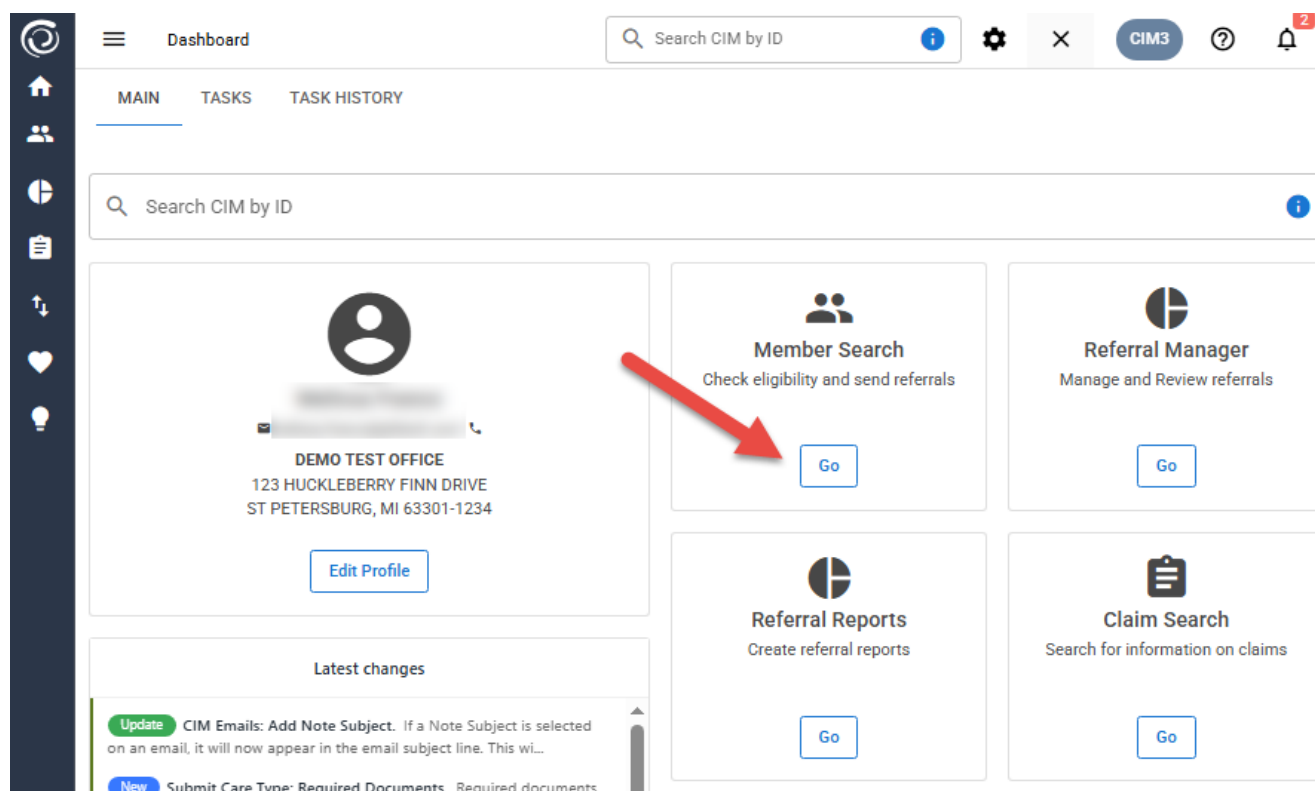


Figure 1. The CIM dashboard.

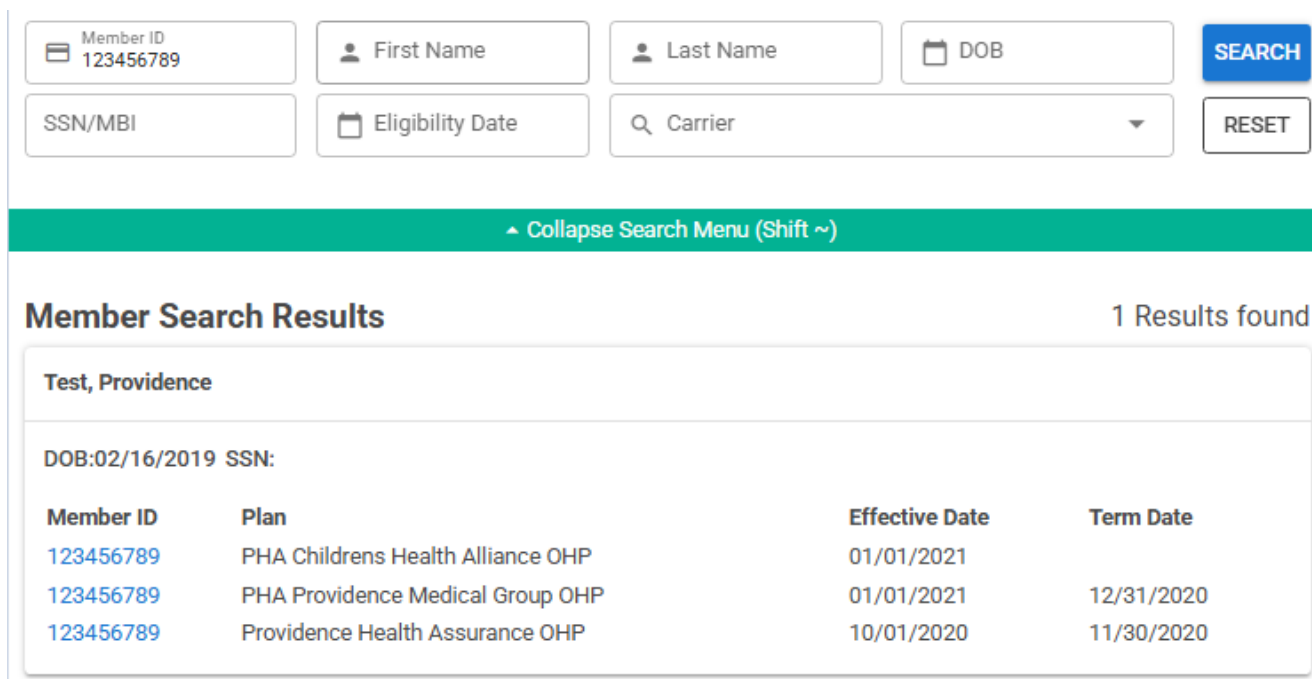
Search for a member

The Member Search page requires either the member's identification number on its own, or at least two of the following:

- First and last name
- Date of birth
- Social Security number, if applicable

You can narrow results further by eligibility date.

1. Open Member Search from the dashboard or the left navigation menu.
2. Enter your search criteria, then select Search.
3. If the member has more than one eligibility record, every record appears in the results list.



Member ID	Plan	Effective Date	Term Date
123456789	PHA Childrens Health Alliance OHP	01/01/2021	
123456789	PHA Providence Medical Group OHP	01/01/2021	12/31/2020
123456789	Providence Health Assurance OHP	10/01/2020	11/30/2020

Figure 2. Member Search results showing multiple eligibility records.

CIM returns a “No member found” message. Confirm the identification number and date of birth, then search again. If the member should be eligible, contact Umpqua Health Alliance.

Select the member ID link that matches the effective date of your inquiry. The Member Summary screen opens with benefit plan, eligibility and demographic detail.

▲ Collapse Search Menu (Shift ~)

1 Results found

Test, Providence			
DOB:02/16/2019 SSN:			
Member ID	Plan	Effective Date	Term Date
123456789	PHA Childrens Health Alliance OHP	01/01/2021	
123456789	PHA Providence Medical Group OHP	01/01/2021	12/31/2020
123456789	Providence Health Assurance OHP	10/01/2020	11/30/2020

The Member Summary screen also provides several interactive tabs that display different information depending on your access level.

[← Search Results](#) / Test, Providence





[ADD NEW TYPE OF CARE](#)

MEMBER NOTES CARE TYPE HISTORY CURRENT CARE TYPES CLAIMS COPAY INFO DISCLOSURE EXTRA INFO FLAGS

Providence Test
 Member Id: 123456789
 / 12345678900
 Address:
 1234 Anyplace St
 Anyplace, OR 97304
 Primary Contact:
 (503) 584-6414
 Contact:
 Sally —only talk to Sally about this member
 Alt Phone:
 (971) 584-6414
 Care Management:
 None Found

Plan Information

PHA Childrens Health Alliance OHP Eligible
 Benefit Plan: Member ID: Effective:
 Childrens Health Alliance OHP CCOA 123456789 / 12345678900 01/01/2021
 Termination: Coverage Code: Email:
 None phacs.team@ayin.com

CONTACT INFORMATION

Member's Care Team [View PCP History](#)

Primary Care Physician
 Name: Specialty:
 PMG The Plaza - Family Medicine, Ambulatory Health Care Facilities : Clinic/Center

Figure 4. Member Summary with the tab row.

Member Summary tabs

The tabs available on the Member Summary screen depend on your access level.

Tab	What it shows
Notes	Public and private notes on the member's account, with the option to attach documentation and create a task.
Care type history	Historical care types to or from your office, for the eligibility record selected. The date range is fixed to that record and cannot be edited.
Current care types	Care types that have not expired as of your search date. The date range is fixed to the eligibility record selected.

Tab	What it shows
Claims	Claims your office has billed for the member, with the status of each claim in the adjudication process.
Copay info	Member cost-sharing information, where applicable.
Disclosure	Disclosure records associated with the member.

Table 1. Member Summary tabs.

The screenshot shows the 'MEMBER' tab selected in the top navigation bar. The main content area displays member information for 'test test' (Member ID: test123). The interface includes several interactive elements and callouts:

- MEMBER** (Selected tab)
- NOTES**
- CARE TYPE HISTORY**
- CURRENT CARE TYPES**
- CLAIMS**
- COPAY INFO**
- EXTRA INFO**
- FLAGS**
- Plan Information** (Yamhill CCO PHYS, Termed)
 - Callout: "Click to send an inquiry to the health plan's customer service team." (points to Primary Contact)
 - Callout: "Click here to view current or historical Coordination of Benefit records." (points to COB Records Exists link)
 - Callout: "Click here to view health plan contact information." (points to CONTACT INFORMATION section)
- Member's Care Team** (View PCP History)
 - Callout: "Click here to request a PCP change on the member account." (points to REQUEST TO ADD PCP FOR THIS MEMBER button)
 - Callout: "Click here to view historical PCP assignment." (points to View PCP History link)
- CONTACT INFORMATION** (Section header)
- Demographic Information** (Section header)
 - Callout: "Displays the member's demographic information." (points to SSN field)

Figure 5. Member Summary interactive tabs.

Care Type History tab

Shows historical care types to or from your office for the eligibility record selected. The date range is fixed to that record.

MEMBERNOTESCARE TYPE HISTORYCURRENT CARE TYPESCLAIMSCOPAY INFOEXTRA INFOFLAGS

1 Results Found

Date Range:12/15/2022-12/15/2025

Care Types- All Care Types -

SEARCH

Medical - Prior Auth - Medical

LAST NAME, FIRST NAME

TEST MEMBER

1/1/2000 - ID Test123 (Providence Health Assurance OHP)

Authorization Details

Status:Received

Authorization #:None

Reference #:2011255

Episode #:20112551122025

Diagnosis Code:A54.83

Diagnosis Code:Default (Use specific codes)

Groups:

Referring Provider:PMG Scholls Family Medicine

Delivering Provider:Hearty, Benjamin, PA

Facility:None

Services

Service Identifier:2011255-1

Start:11/12/2025

End:12/12/2025

Max Dollars:None

Cost to Date:\$ 0.00

Procedure Codes:33011

Visits/Units:0

Visits to Date:0

Procedure Code:Default (Use specific codes)

Groups:

Figure 6. The Care Type History tab.

Current Care Types tab

Shows care types that have not expired as of your search date, for the eligibility record selected.

MEMBER NOTES CARE TYPE HISTORY **CURRENT CARE TYPES** CLAIMS COPAY INFO EXTRA INFO FLAGS

1 Results Found

Date Range: 12/15/2022 - 12/15/2025 Care Types - All Care Types - **SEARCH** 

Medical - Prior Auth - Medical 

 **LAST NAME, FIRST NAME**
TEST MEMBER
1/1/2000 - ID Test123 (Providence Health Assurance OHP)

Authorization Details

Status:	Received	Urgency:	Standard	Referring Provider:	PMG Scholls Family Medicine
Authorization #:	None	Diagnosis Codes:	A54.83	Delivering Provider:	Hearty, Benjamin, PA
Reference #:	2011255	Diagnosis Code	Default (Use specific codes)	Facility:	None
Episode #:	201125511122025 	Groups:			

Services

Service Identifier:	2011255-1	Max Dollars:	None	Visits/Units:	0
Start:	10/20/2025	Cost to Date:	\$ 0.00	Visits to Date:	0
End:	12/15/2025	Procedure Codes:	33011	Procedure Code	Default (Use specific codes)
				Groups:	

Figure 7. The Current Care Types tab.

Claims tab

Shows claims your office has billed for the member, with the status of each in the adjudication process.

MEMBERNOTESCARE TYPE HISTORYCURRENT CARE TYPESCLAIMSCOPAY INFODISCLOSUREEXTRA INFOFLAGS

Claim ID:

Claim Type:

Professional

Invoice Number:

Submitter:

GATEWAY EDI for OCHIN

Received Date:

10/10/2025

+

Delivering Provider:

Referring Provider:

[None]

Vendor:

0 Documents

0 Related Claims

DX 1:Z00.01 DX 2:N63.20

Referral	Codes	Units	Dates	POS	Status	EOB	Charges	Write Off	Allowed	Net Amt	Info	
	[None]	Proc: 99395	1	10/08/25	11	APPROVED	[None]	\$300.00	\$181.29	\$118.71	\$118.71	TRN Type: ACH (Electronic) TRN#: Rpt Date: 10/17/2025 Batch:
Totals:							\$300.00	\$181.29	\$118.71	\$118.71		

Figure 8. The Claims tab.

Add a note to a member's account

- Notes create a record of contact on the member's account and can carry attached documentation.
1. Open the Notes tab on the Member Summary screen.
 2. Select a subject. More than one subject may be selected.
 3. Set visibility. Private notes are visible to the health plan, to you as the author and to others within your organization.
 4. Set a status. Choosing Open lets you add further notes, creating a trail where follow-up is needed.
 5. Select Save.

Member Notes 

Enter at least 2 characters to search

  New Note
Open Inline

 New Note ×

Template

☐ Create task from note 

Visibility
 Private - Visible only to the health plan and the author's office

Status
 Closed

Priority
 Low

Formatting               

Type note here...

CAUTION: We strongly encourage users NOT to include highly sensitive information, such as Substance Use Disorder (SUD) treatment-related, using this specific note function. Emails and notes in CIM are designed to document information of an administrative rather than clinical nature.

Figure 9. Adding a note to a member's account.

Create a task from a note

Before saving, select the task checkbox in the upper left corner to turn the note into a task. Tasks work like a to-do list: assign one to yourself or to another person for follow-up. Tasks are viewable from the Tasks tab on the dashboard.

Module 2: Care Types and Preauthorization

A care type is a request submitted to the health plan for review. This module covers preauthorization care types — when they are required, who submits them and how to complete the six-step submission workflow.

When preauthorization is required

Submit a preauthorization care type for any service that:

- is specified in the preauthorization grid
- falls below the DMAP line as nonfunded
- does not rank on the DMAP line, meaning the codes do not pair
- appears on the excluded services and procedures list

Who submits a preauthorization

Submitter	When
Primary care provider	Any service meeting the criteria above, and any referral to an out-of-network specialist.
Specialist	Any service meeting the criteria above.

Table 2. Preauthorization submitters.

Start a care type

1. Open Member Search and locate the member.

- 2. Select the appropriate eligibility record, if more than one is listed.
- 3. Select Add New Type of Care in the upper right corner of the search results screen. The care type workflow opens.

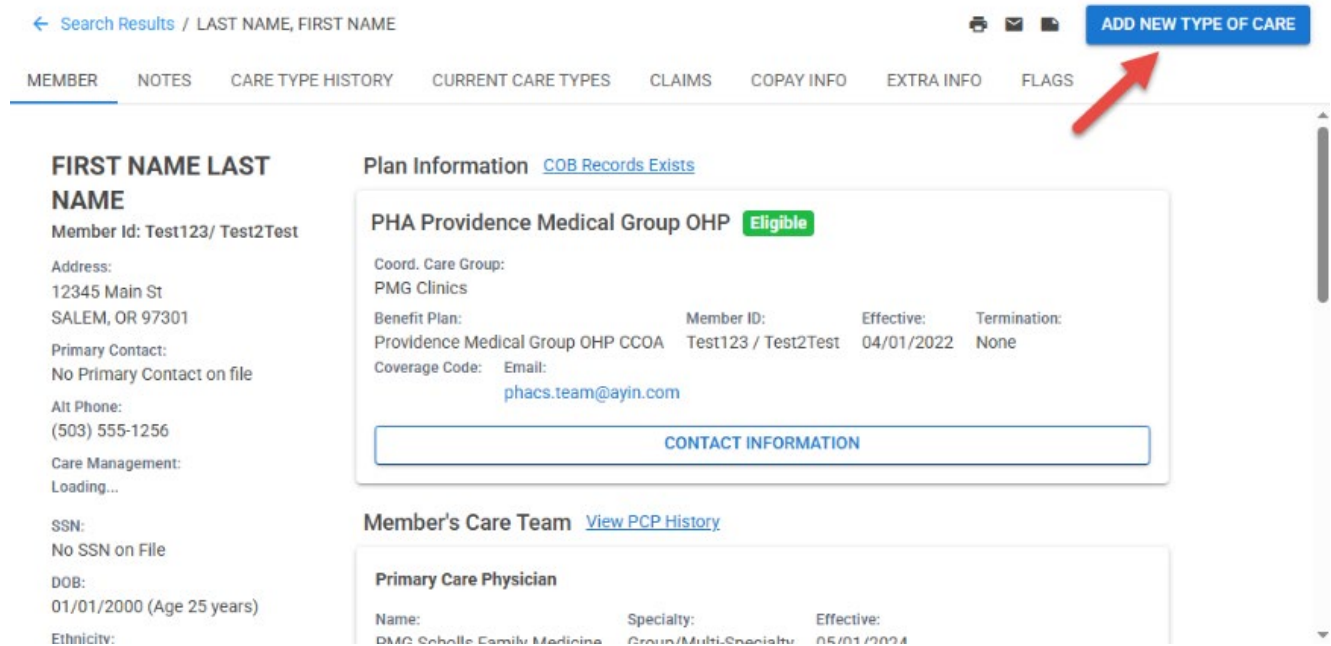
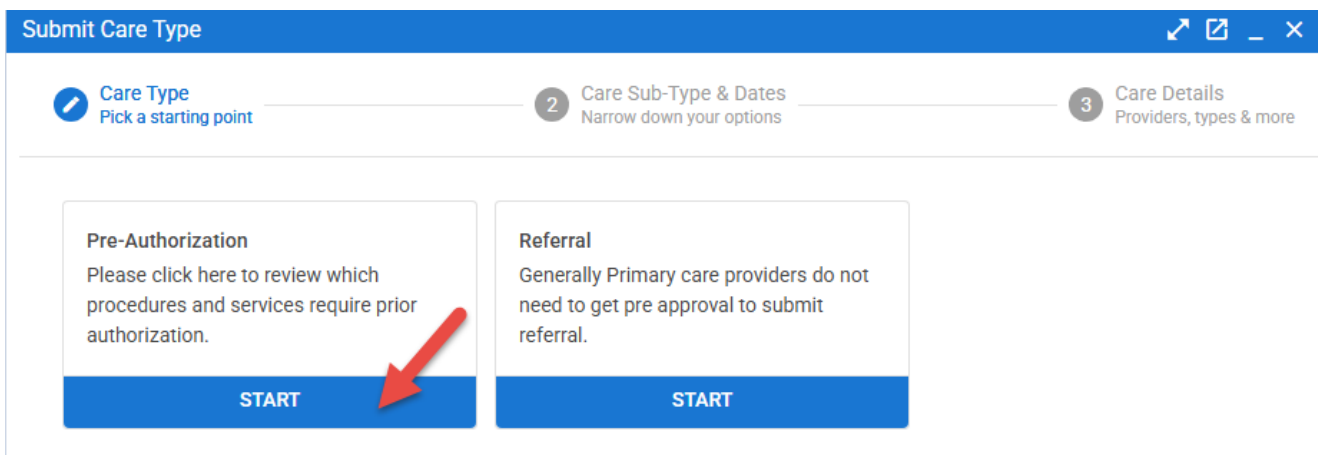


Figure 10. The Add New Type of Care button on the search results screen.

Step 1: Select the care type

Select the Preauthorization tile to launch the preauthorization workflow.



Submit Care Type

1 Care Type
Pick a starting point

2 Care Sub-Type & Dates
Narrow down your options

3 Care Details
Providers, types & more

Pre-Authorization
Please click here to review which procedures and services require prior authorization.

START

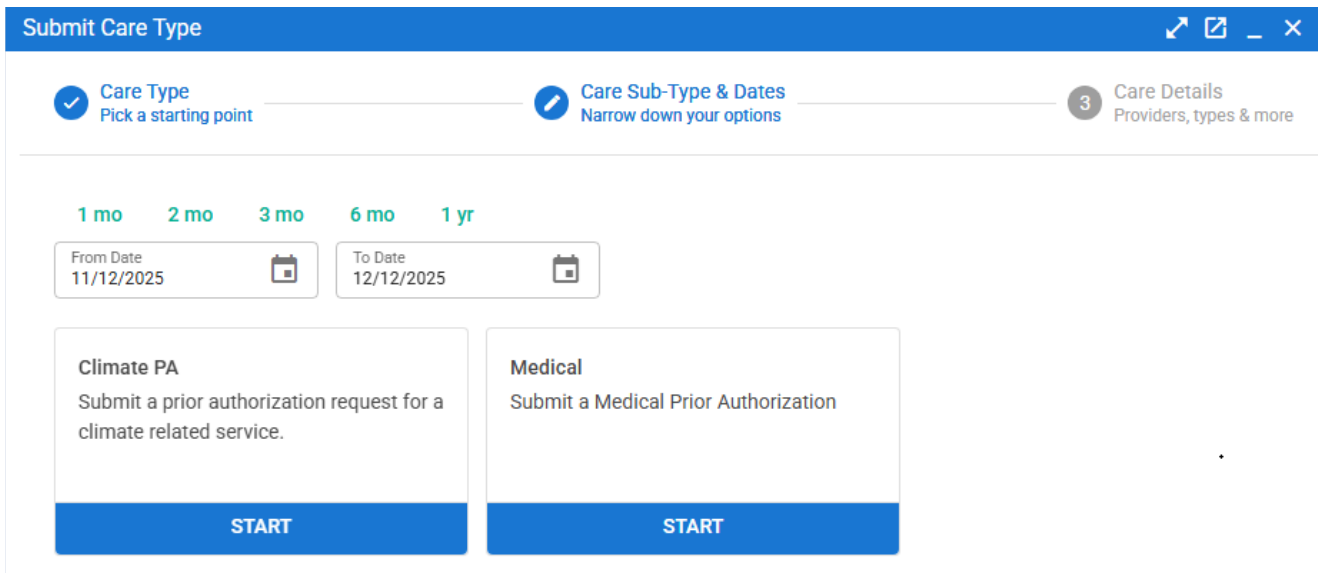
Referral
Generally Primary care providers do not need to get pre approval to submit referral.

START

Figure 11. Care type selection.

Step 2: Care subtype and dates

Health plans can configure separate care subtypes, such as medical, behavioral health and pharmacy. Select the appropriate subtype, then set the dates for the request. Enter the date in MM/DD/YYYY format or choose from the prepopulated options, which range from one month to a year.



Submit Care Type

1 Care Type
Pick a starting point

2 Care Sub-Type & Dates
Narrow down your options

3 Care Details
Providers, types & more

1 mo 2 mo 3 mo 6 mo 1 yr

From Date 11/12/2025

To Date 12/12/2025

Climate PA
Submit a prior authorization request for a climate related service.

START

Medical
Submit a Medical Prior Authorization

START

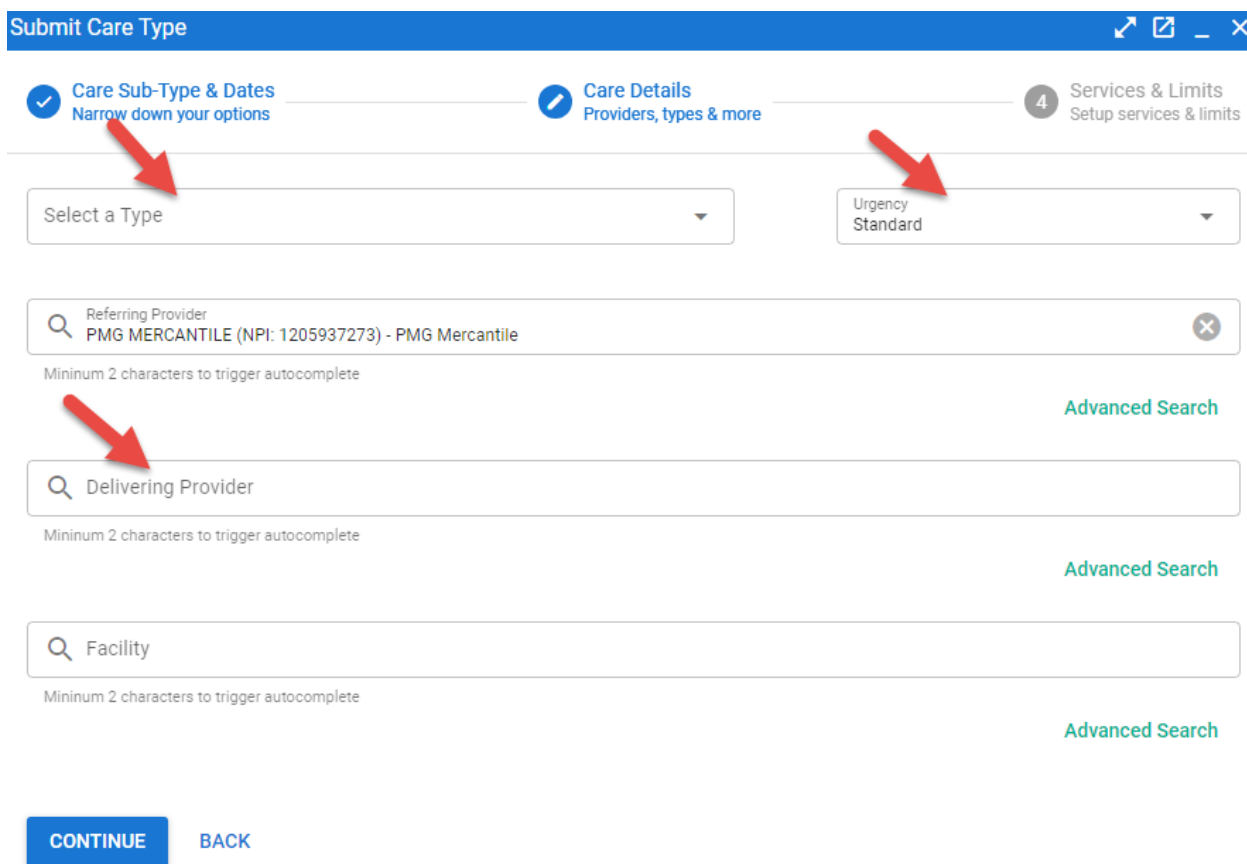
Figure 12. Care subtype and date selection.

Step 3: Care details, type and providers

Select the type of preauthorization, the urgency, and the delivering or referring provider where applicable to the service.

Note

The facility field is typically reserved for surgical procedures and imaging services taking place in a hospital, ambulatory surgical center or imaging facility.



Submit Care Type

1 **Care Sub-Type & Dates**
Narrow down your options

2 **Care Details**
Providers, types & more

4 **Services & Limits**
Setup services & limits

Select a Type

Urgency
Standard

Referring Provider
PMG MERCANTILE (NPI: 1205937273) - PMG Mercantile

Minimum 2 characters to trigger autocomplete

Advanced Search

Delivering Provider

Minimum 2 characters to trigger autocomplete

Advanced Search

Facility

Minimum 2 characters to trigger autocomplete

Advanced Search

CONTINUE BACK

Figure 13. Care details entry.

Step 4: Diagnosis, services and limits

Enter the diagnosis codes, procedure codes and limits for the request.

Field	How to complete it
Diagnosis codes	Required. Type the first two characters of the code, or search by description.
Procedure codes	Required. Type the first two characters of the code, or search by description.
Procedure code group	Choose a specific group, or use the default group that populates once codes are entered.
Dates	Entered by you or populated automatically at the start of the submission.

Table 3. Diagnosis and service fields.

Select Add after each procedure code to save it. You can enter more than one code; each appears at the bottom of the screen under Services. Select Continue once all codes are entered.

Diagnosis Codes (Allows multiple entries)

A54.83 - GONOCOCCAL HEART INFECTION ✕ Type to search diagnosis codes

Minimum 2 characters to trigger autocomplete

Diagnosis Code Groups

☒ Default (Use specific codes)

Services & Limits

Add Service

Procedure Code

Procedure Code Group

Procedure CodeGroup is required

From Date

11/12/2025

To Date

12/12/2025

Max Dollars

Max Units

0

CLEAR

ADD

Services

☐ Code Group	Procedure Code	Service Dates	Limits
☐ Default (Use specific codes)	33011 - Repeat drainage of heart sac	11/12/2025 - 12/12/2025	[None]

Records per page: 5 1-1 of 1

BACK

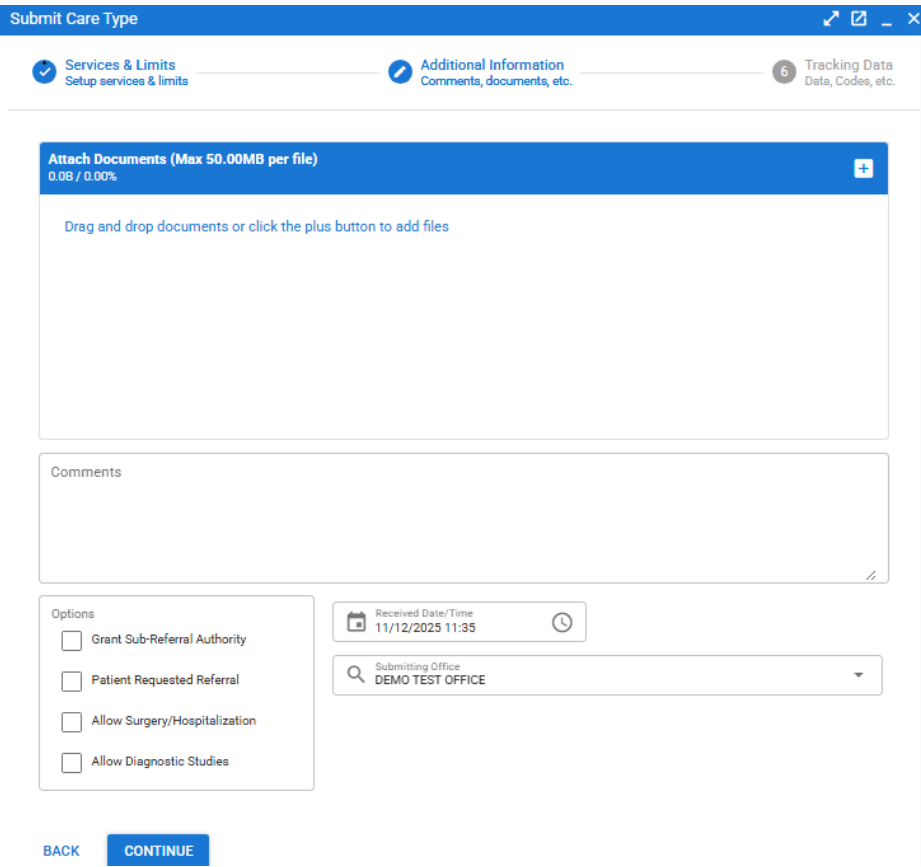
CONTINUE

Figure 14. Procedure codes listed under Services.

Step 5: Supporting documents

Use the attach documents tool to upload documentation supporting the request. Select the plus sign to add a file.

If you skip this step, you can still upload at the end of the submission by selecting Review Referral/Auth from the confirmation screen.

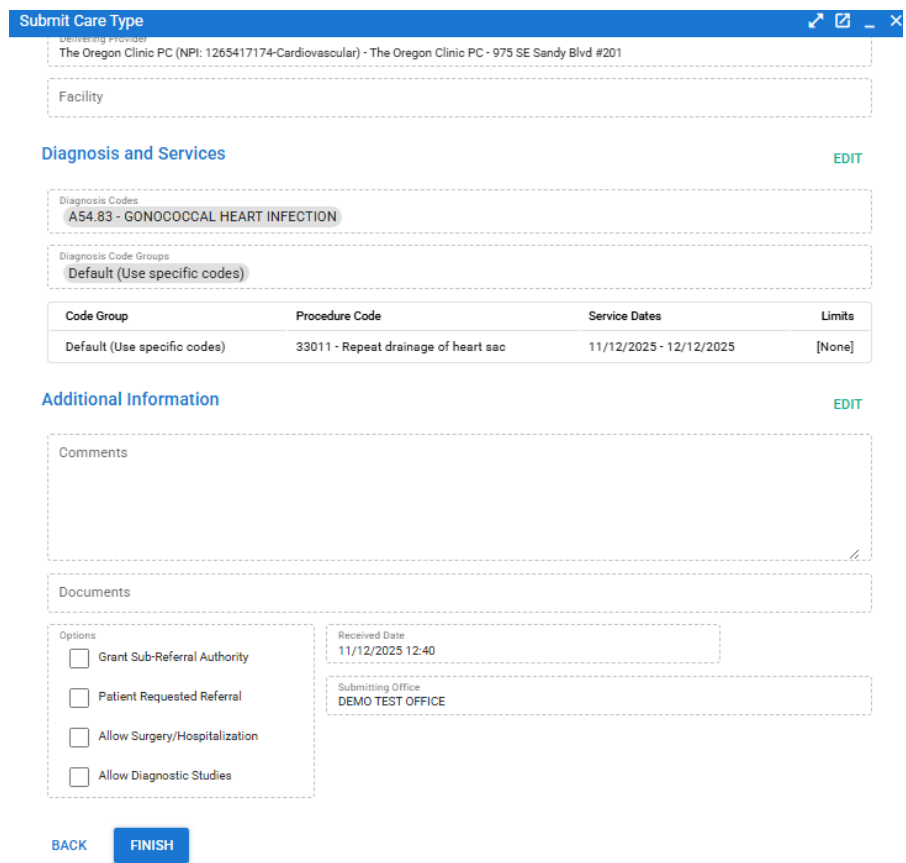


The screenshot shows a web application window titled "Submit Care Type". At the top, there are three tabs: "Services & Limits" (Setup services & limits), "Additional Information" (Comments, documents, etc.), and "Tracking Data" (Data, Codes, etc.). The "Additional Information" tab is active. Below the tabs, there is a section titled "Attach Documents (Max 50.00MB per file)" with a progress indicator "0.08 / 0.00%". Below this, there is a large text area with the instruction "Drag and drop documents or click the plus button to add files". Below the text area, there is a "Comments" section. At the bottom, there are "Options" with checkboxes for "Grant Sub-Referral Authority", "Patient Requested Referral", "Allow Surgery/Hospitalization", and "Allow Diagnostic Studies". To the right of the options, there is a "Received Date/Time" field showing "11/12/2025 11:35" and a "Submitting Office" dropdown menu showing "DEMO TEST OFFICE". At the bottom left, there are "BACK" and "CONTINUE" buttons.

Figure 15. Attaching supporting documents.

Step 6: Review and submit

Review and edit the request before submitting. Select Finish at the bottom of the page to send it to the health plan for processing.



Code Group	Procedure Code	Service Dates	Limits
Default (Use specific codes)	33011 - Repeat drainage of heart sac	11/12/2025 - 12/12/2025	[None]

Figure 16. Review and submit.

Confirmation of submission

A confirmation screen appears once the request is submitted. From this screen you can print the confirmation as a receipt, view the submission, or ask to be notified when the status changes.

Selecting the notification checkbox sends email updates about status changes for that specific authorization. Notifications go to the email address on file for the profile you are logged into.

Selecting Review Submission opens a new tab in Referral Manager with the full details of the authorization.

Received

Reference ID: 2011255

Authorization #: None

Final Status: Received

From Date: 11/12/2025

To Date: 12/12/2025

☐ **Notify me of Auth status changes**

[REVIEW SUBMISSION](#)

[PRINT THIS RECEIPT](#)

[CLOSE](#)

Figure 17. Confirmation of submission.

1 Referral found

LAST NAME, FIRST NAME

Episode# 201125511122025
Reference# 2011255 (MSL)
Carrier: Providence Health Assurance OHP
Auth/Referral Type: Prior Auth - Medical
Urgency: Standard
From: PMG Scholls Family Medicine
To: Hearty, Benjamin, PA
Start/End Date: 11/12/2025 - 12/12/2025
Submitted Date: 11/12/2025 12:58:54 PM
Received Date: 11/12/2025 12:56 PM
Last Modified Date: 11/12/2025 12:58:54 PM
Status: Received
Service Statuses: Received
Auth Num: None

Member Details TEST MEMBER

Member: LAST NAME, FIRST NAME (History)

Gender: Female

DOB: 01/01/2000 (25 years)

Benefit Plan: PHA OHP CCOA

Member ID: Test123 / Test2Test

Elig. Dates: 04/01/2022 - Present

Coverage:

Condition:

PCP: PMG Scholls Family Medicine

Office: PMG Scholls Family Medicine

Contact: None Specified

Status: hna_flag

Flags:

Other Coverages (COB):
[COB Record Exists](#)

Preauthorization Details

Episode: 201125511122025

Type of Care: Medical

Auth/Referral Type: Prior Auth - Medical (MSL)

Multi-Service Line (MSL): Yes 1

Urgency: Standard

Referring Provider: PMG SCHOLLS FAMILY MEDICINE (NPI: 1093815243) - PMG Scholls Family Medicine

Delivering Provider: [Hearty, Benjamin, PA \(NPI: 1366890386-1912282369\) - Providence Hospitals Unified Login](#)

Facility: None

Dates: Start: 11/12/2025 End: 12/12/2025

Diagnosis Code(s): A54.83 GONOCOCCAL HEART INFECTION

Diagnosis Code Group(s): Default (Use specific codes) ([view codes](#))

Services

Filter Table

Showing 1 to 1 of 1 entries

Service Id	Code Groups	Service Dates	Procedure Codes	Status	Limits
2011255-1	Default (Use specific codes)	11/12/2025 - 12/12/2025	33011: Repeat drainage of heart sac	[None] Use Authorization Status 1	Cost to Date \$0.00 Max Visits/Units [None]

Figure 18. The authorization detail in Referral Manager.

Module 3: Referral Manager

Referral Manager is where you check the status of a care type after submission. Status can also be reached from Member Search.

Open Referral Manager and search

1. Select Referral Manager from the dashboard or from the menu on the left side of the screen.
2. Adjust the submitted-from and submitted-to dates, which default to the current date.
3. Enter the member's identification number, or first and last name.
4. Select Search.

The quickest way to locate a specific care type is to search on one of the following:

- Care type authorization number, once finalized
- Episode number
- Reference number
- Submitted-from and submitted-to dates, combined with the member's ID, first name or last name

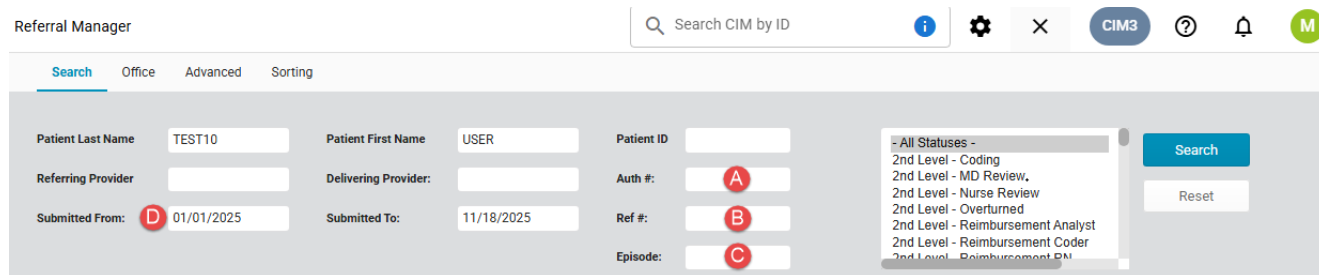
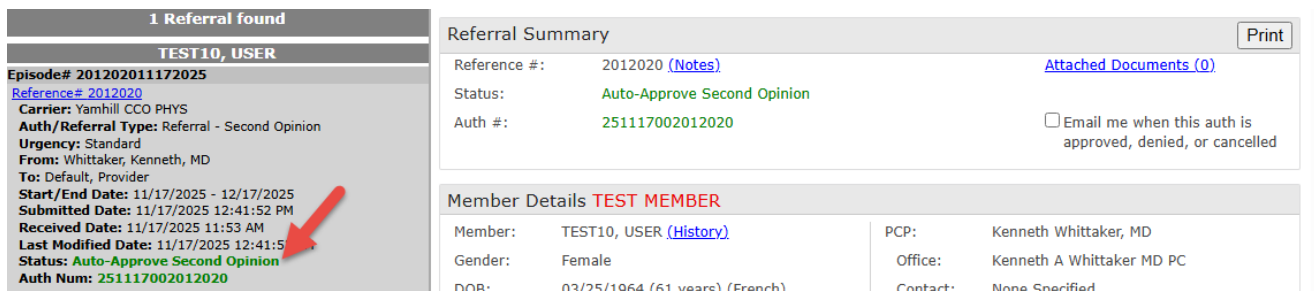


Figure 19. Referral Manager search.

Read the results

Results appear in the left window pane, with the status shown inside each result. The details of the first care type display automatically on the right. To view another care type from the same result set, select its reference number.



1 Referral found

TEST10, USER

Episode# 201202011172025
[Reference# 2012020](#)
 Carrier: Yamhill CCO PHYS
 Auth/Referral Type: Referral - Second Opinion
 Urgency: Standard
 From: Whittaker, Kenneth, MD
 To: Default, Provider
 Start/End Date: 11/17/2025 - 12/17/2025
 Submitted Date: 11/17/2025 12:41:52 PM
 Received Date: 11/17/2025 11:53 AM
 Last Modified Date: 11/17/2025 12:41:52 PM
 Status: **Auto-Approve Second Opinion**
 Auth Num: 251117002012020

Referral Summary Print

Reference #: 2012020 ([Notes](#)) [Attached Documents \(0\)](#)
 Status: **Auto-Approve Second Opinion**
 Auth #: 251117002012020
☐ Email me when this auth is approved, denied, or cancelled

Member Details TEST MEMBER

Member:	TEST10, USER (History)	PCP:	Kenneth Whittaker, MD
Gender:	Female	Office:	Kenneth A Whittaker MD PC
DOB:	03/25/1964 (61 years) (French)	Contact:	None Specified

Figure 20. Referral Manager search results and care type detail.

Care type detail fields

Field	What it shows
Reference number	Six-digit number assigned to the care type at submission.
Status	Current status of the care type.
Authorization number	Approval number, assigned once the care type has processed.
Documents	Used to upload supporting documentation and clinical records to the care type.
Notification checkbox	Subscribes you to email updates on status changes for this care type.
Member and benefit plan	Member detail and the benefit plan in effect.
Other insurance	Primary care provider and other insurance information.

Field	What it shows
Referring provider	The referring or ordering provider.
Delivering provider	The delivering or rendering provider.
Effective and end date	The date range the care type covers.
Diagnosis code group	The diagnosis codes on the request.
Visits or units allowed	The quantity authorized.
Procedure codes	Requested procedure and HCPCS codes, listed below the diagnosis code group. Referrals do not list procedure codes.

Table 4. Care type detail fields.

Referral Summary

Reference #:

A

2012020

[\(Notes\)](#)

Status:

B

Auto-Approve Second Opinion

Auth #:

251117002012020

C

D

[Attached Documents \(0\)](#)

E

☐ Email me when this auth is approved, denied, or cancelled

Print

Member Details

TEST MEMBER

Member:

TEST10, USER

[\(History\)](#)

F

Gender:

Female

DOB:

03/25/1964 (61 years) (French)

Benefit Plan:

Yamhill CCOB PHYS

Member ID:

YCOTEST0006

Elig. Dates:

07/01/2023 - Present

Coverage:

Condition:

PCP:

Kenneth Whittaker, MD

Office:

Kenneth A Whittaker MD PC

G

Contact:

None Specified

Status Flags:

Gender Specific Pronoun Identified

Other Coverages (COB):

No Current COB

Referral Details

Episode:

201202011172025

Type of Care:

Referral

Auth/Referral Type:

Referral - Second Opinion

Multi-Service Line (MSL):

No

Urgency:

Standard

Referring Provider:

H

Whittaker, Kenneth, MD (NPI: 1073606687) - Kenneth A Whittaker MD PC

▼

Delivering Provider:

I

Default, Provider (OMAP: 999999-DF)

▼

Facility:

None

Dates:

J

Start: 11/17/2025

End: 12/17/2025

Diagnosis Code Group(s):

K

Second Opinion Referral

[\(view codes\)](#)

Limits

M

L

Max Dollars: None

Max Visits/Units: 1

Cost to Date: \$0.00

Figure 21. Care type detail.

Module 4: Referral Reports

Referral Reports locates and displays referral and authorization care types specific to your office. Only care types to or from your office appear. Reach it from the dashboard or the sidebar menu.

Build a report

Every field on the Search tab affects the results. The Search tab is the default and covers basic criteria; the remaining tabs refine and tailor the results. Export report data using the To File button.

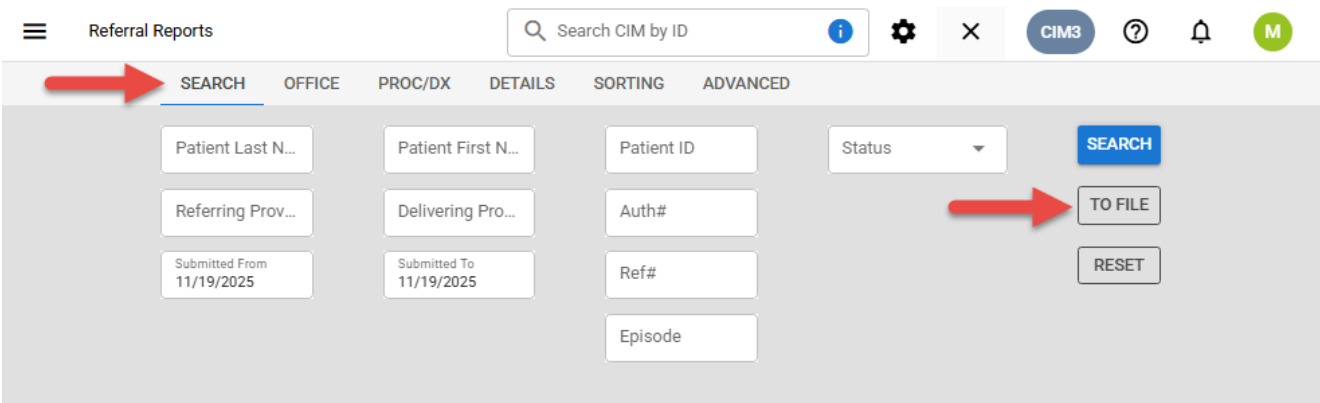


Figure 22. The Referral Reports search tab.

Refine the results

Tab	What you can filter or set
Office	Referring office, delivering office or the submitter's office.
Details	Carrier, urgency, effective dates or dollar amount.

Tab	What you can filter or set
Sorting	Sort order across several criteria, ascending or descending.
Advanced	Care type and health plan, meaning the coordinated care organization.

Table 5. Referral Reports tabs.

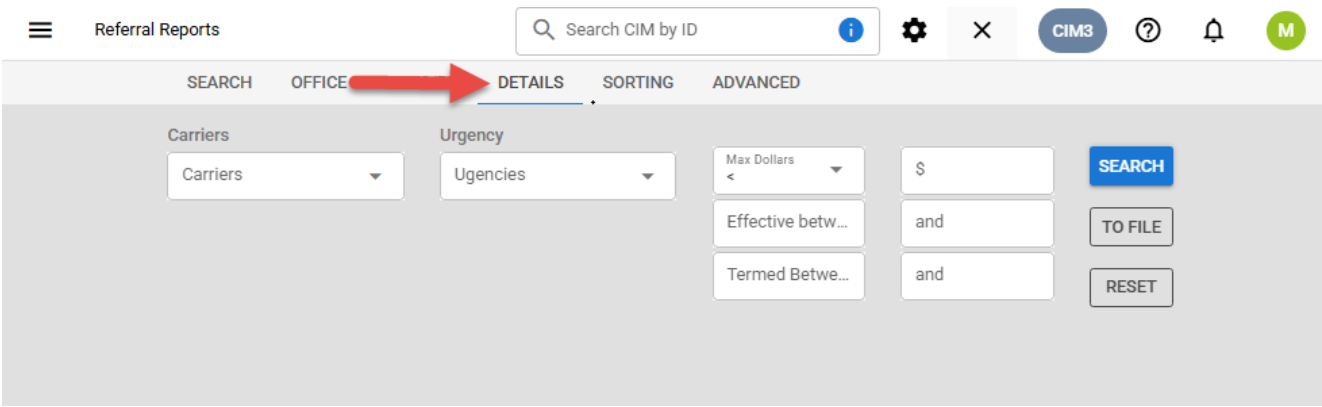


Figure 23. The Details tab.

Module 5: Claims and Document Manager

Claim Search returns claims your office has billed. Document Manager is the tool used to attach documentation to those claims.

Search for a claim

Open Claim Search from the dashboard or the left navigation menu. The tab section defaults to Search. The Service From and Service To date fields default to the current date, and the status defaults to All Statuses. Adjust the criteria to be as broad or as narrow as you need.

Search result limit

Search results are limited to the 50 most recent claims on file. If more claims exist for the date range, export the report to an Excel file using the To File button to view them all.

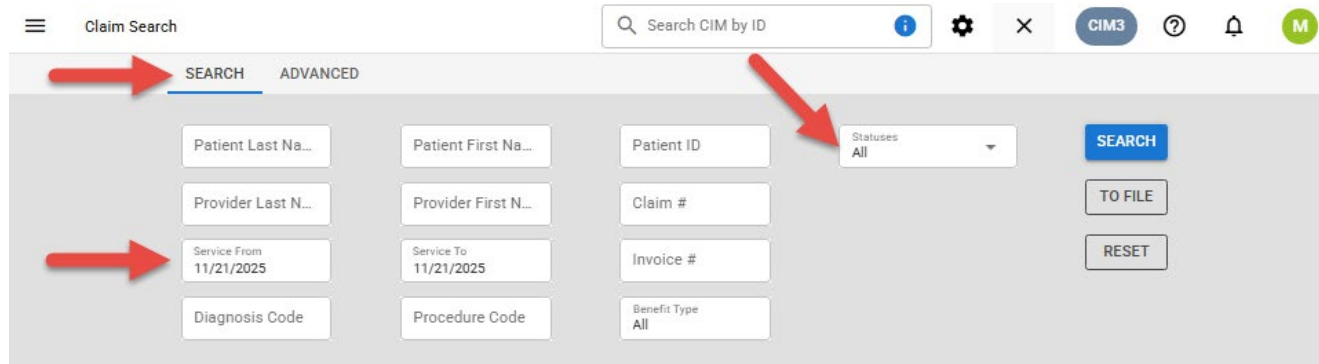


Figure 24. The Claim Search page.

The Advanced tab allows a more detailed search, accepting a check number, referral number or tax identification number where applicable.

Claim Search    CIM3   M

ADVANCED

Carriers
All

Check Number

Referral Number

Coordinated Care Gro...
All

SEARCH

Batch

Claim Type
All

Sort Service Date
Descending

TO FILE

Received Date
//

Vendor Name or...

RESET

Check Date
//

Figure 25. The Advanced search tab.

Located claims display in the search results.

Total Charges: \$158,877.09 Total Amt. Allowed: \$31,230.08 Total Payments: \$30,804.90 50 of 50 Claims 

Claim ID: [redacted]

Claim Type: Professional

Invoice Number: [redacted]

Submitter: RelayHealth PCS

Received Date: 01/15/2024

Delivering Provider: [redacted]

Referring Provider: [None]

Vendor: [redacted]

0 Documents
0 Related Claims

DX 1: M54.6

Referral	Codes	Units	Dates	POS	Status	EOB	Charges	Write Off	Allowed	Net Amt	Info
	Proc: 99223 Mods: AI	1	01/05/24	21	APPROVED REVIEW	[None]	\$462.00	\$334.66	\$127.34	\$127.34	TRN#: [redacted] Rpt Date: 01/24/2024 Batch: [redacted]
	[None] Proc: 99233	1	01/09/24	21	APPROVED REVIEW	[None]	\$317.00	\$229.64	\$87.36	\$87.36	TRN#: [redacted] Rpt Date: 01/24/2024 Batch: [redacted]
	[None] Proc: 99233	1	01/10/24	21	APPROVED REVIEW	[None]	\$317.00	\$229.64	\$87.36	\$87.36	TRN#: [redacted] Rpt Date: 01/24/2024 Batch: PHA20240124PD
	[None] Proc: 99233	1	01/11/24	21	APPROVED REVIEW	[None]	\$317.00	\$229.64	\$87.36	\$87.36	TRN#: [redacted] Rpt Date: 01/24/2024 Batch: [redacted]
Totals:							\$1,413.00	\$1,023.58	\$389.42	\$389.42	

Figure 26. Claim search results.

Claim status definitions

Status	What it means
In process	The claim has been received and is processing. The status will not change until processing is complete. Allow up to 30 days. Do not call or email about these claims unless the claim was billed in error.
Approved	The claim was auto-adjudicated and auto-approved. It releases once a report date and transaction number are assigned.
Approved review	An analyst reviewed and approved the claim. It releases once a report date and transaction number are assigned.
Denied	The claim was auto-adjudicated and auto-denied. It releases once a report date and transaction number are assigned.
Denied review	An analyst reviewed and denied the claim. It releases once a report date and transaction number are assigned.

Table 6. Claim status definitions.

Opening a claim shows its full detail, including the referral or preauthorization used to process it, line-item status, and where to find notes and the email function.

Claim Detail Summary:

- Charges:** \$158,877.50
- Received Date:** 01/15/2024
- Total Payments:** \$30,804.90
- 50 of 50 Claims**

Claim Information:

- Claim ID:** [Redacted]
- Claim Type:** Professional
- Invoice Number:** [Redacted]
- Submitter:** RelayHealth PCS
- Received Date:** 01/15/2024

Provider Information:

- Delivering Provider:** [Redacted]
- Referring Provider:** [None]
- Vendor:** [Redacted]

Documents: 0 Documents, 0 Related Claims

DX 1: M54.6

Referral	Codes	Units	Dates	POS	Status	EOB	Charge	Net Amt	Info
[Icon]	Proc: 99223 Mods: AI	1	01/05/24	21	APPROVED REVIEW	[None]	\$462.00	\$127.34	TRN#: [Redacted] Rpt Date: 01/24/2024 Batch: [Redacted]
[Icon]	[None]	1	01/09/24	21	APPROVED REVIEW	[None]	\$317.00	\$87.36	TRN#: [Redacted] Rpt Date: 01/24/2024 Batch: [Redacted]
[Icon]	[None]	1	01/10/24	21	APPROVED REVIEW	[None]	\$317.00	\$87.36	TRN#: [Redacted] Rpt Date: 01/24/2024 Batch: PHA20240124PD
[Icon]	[None]	1	01/11/24			[None]	\$317.00	\$87.36	TRN#: [Redacted] Rpt Date: 01/24/2024 Batch: [Redacted]
Totals:							\$1,413.00	\$1,023.58	\$389.42

Figure 27. Claim detail.

Attach documentation to a claim

Document Manager is reached two ways: through Member Search, then Claims; or directly through Claim Search.

1. Open Member Search and locate the member's eligibility record.
2. Select the appropriate eligibility record. The Member Summary screen opens.
3. Select Claims. Claims on the member's record load.
4. Select the documents link on the claim you want to attach to.
5. Select Upload New Document.
6. Drag and drop the file, or select the plus sign to choose a saved file.

7. Select Save.

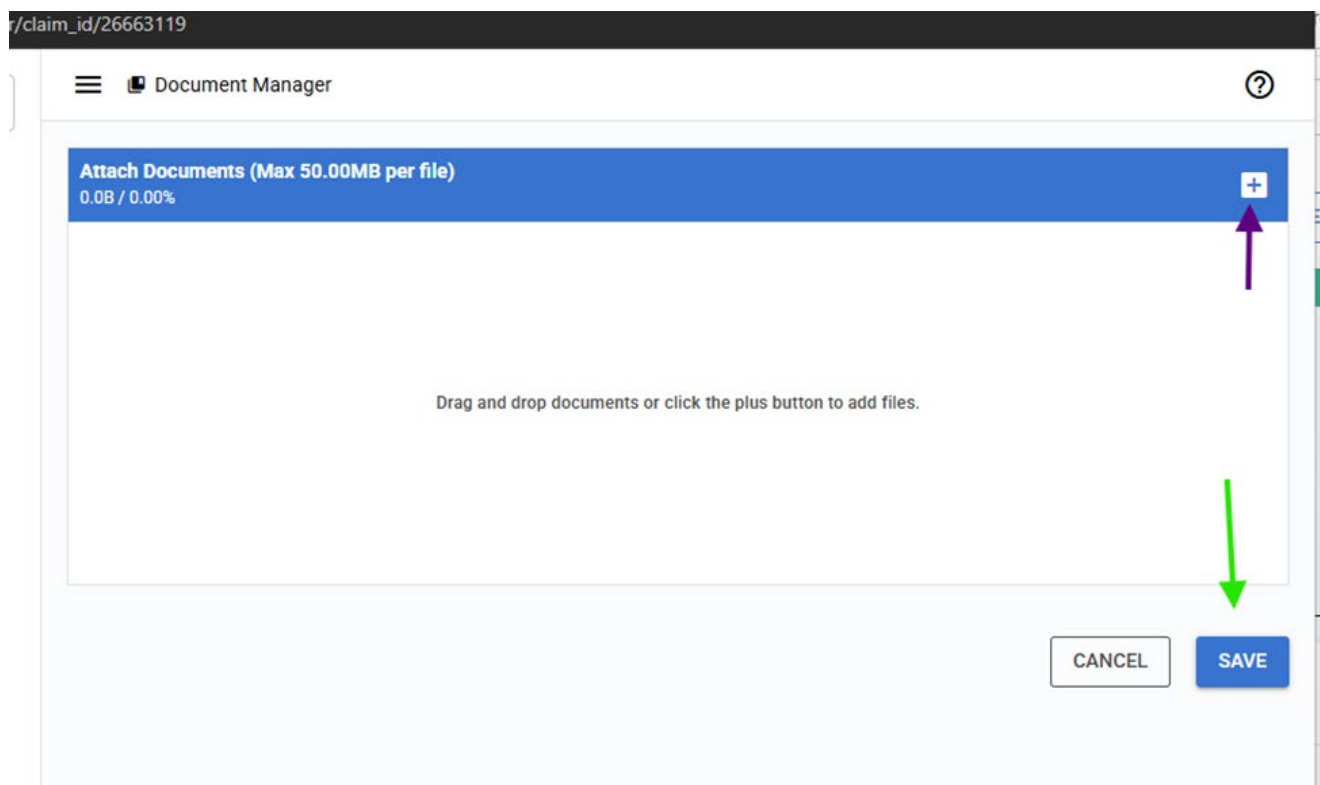


Figure 28. Uploading a document to a claim.

Important: email the claims team

Uploading a document does not notify anyone. After attaching documentation to a claim for review, you must use the email function within the claim to notify the claims team. A document uploaded without that email will not be reviewed.

TESTER, TESTY

DOB: 01/20/1972

Member ID: IF301F1X

Carrier: Umpqua Health Alliance

Benefit Plan: Umpqua Health Alliance CCOA Med/MH/Dental

Claim ID: 01282019VY0001

Claim Type: Professional

Invoice Number: [None]

Submitter: [None]

Received Date: 01/28/2019

Delivering Provider: Test PCP Provider (Unknown Office)

Referring Provider: [None]

Vendor:

DX 1: Z48.01

3 Documents

0 Related Claims

Referral	Codes	Units	Dates	POS	Status	EOB	Charges	Write Off	Allowed	Copay	COB	Net Amt	Info
[None]	Proc: 99441	1	01/01/23	22	In Process	[None]	\$1.00	\$0.00	\$1.00	\$0.00	\$60.00	\$0.00	Batch: UHA Benefit Testing 1

Figure 29. The email function within a claim.

Module 6: Vouchers and the DMAP line

Voucher Viewer shows payment detail for processed claims. The DMAP line search tool shows whether a diagnosis and procedure code pair is funded under the Oregon Health Plan.

Look up a voucher

1. From the CIM dashboard, open the left navigation menu, select Claims and Payments, then select Voucher Viewer.
2. Adjust the check-from and check-to dates. They default to a 30-day look-back window from today.
3. Search one of two ways: (a) a date or date range together with the tax ID number, or (b) the voucher, EFT or check number.
4. Select the plus sign on a result to view voucher payment detail.
5. Choose View or Download.

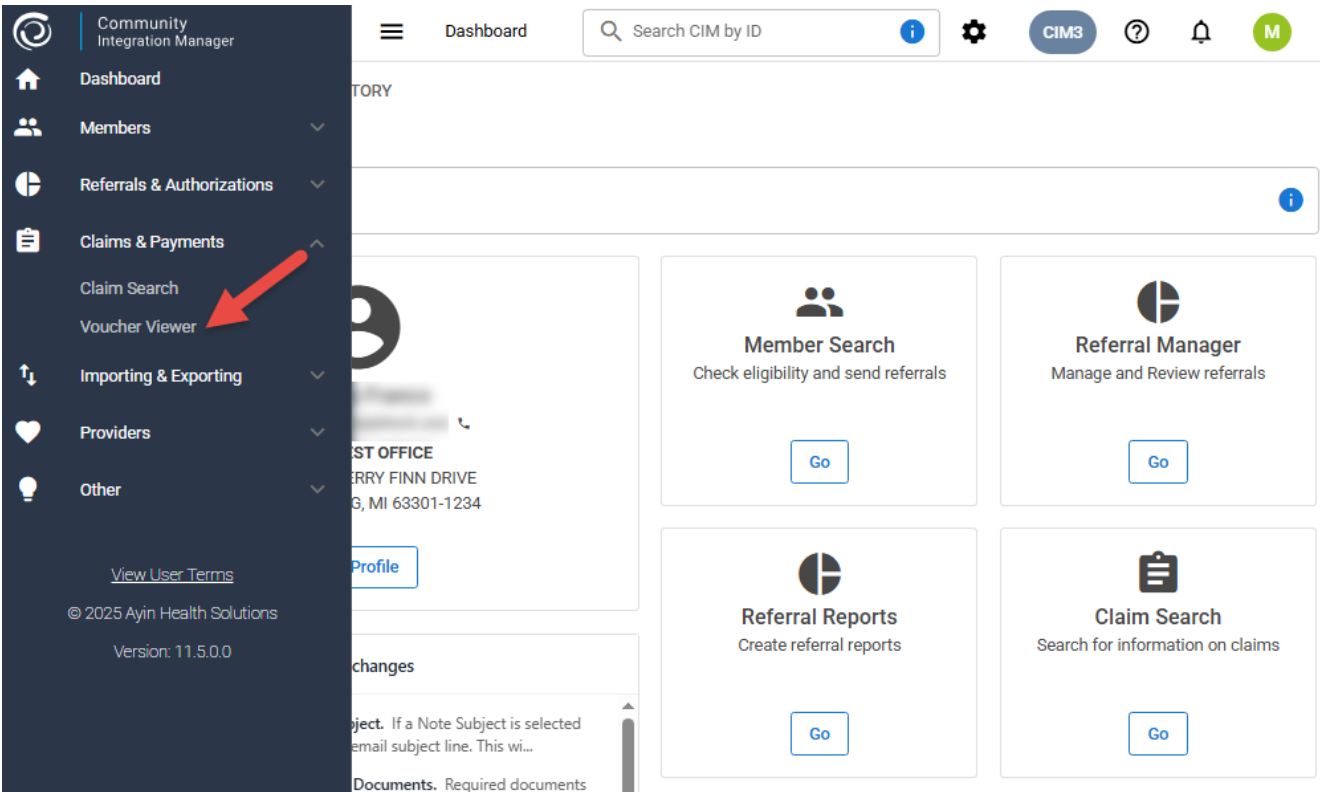


Figure 30. Voucher Viewer in the navigation menu.

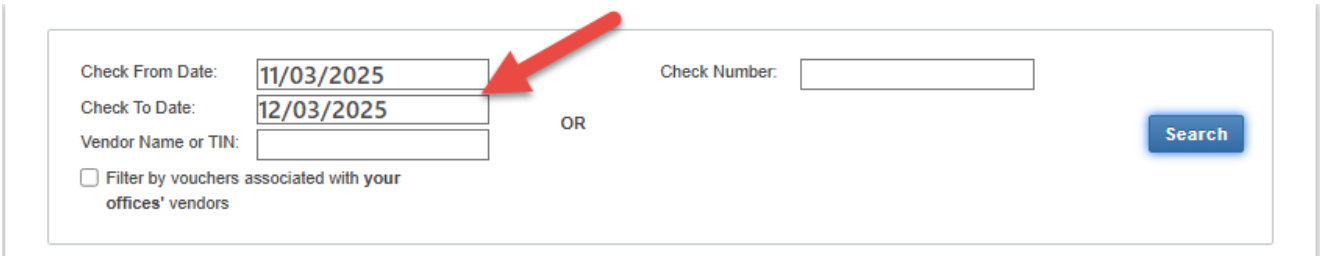


Figure 31. Voucher Viewer search and results.

The Prioritized List and the DMAP line

The Oregon Health Authority's Division of Medical Assistance Programs administers the Oregon Health Plan. Coverage is determined against the Prioritized List of Health Services, which is

maintained by the Health Evidence Review Commission. The list ranks treatment pairs, each combining a diagnosis code with a procedure code. It is reviewed periodically, and a funding line is drawn between the last covered pair and the first noncovered pair.

The Other page in the left navigation menu links to the DMAP line search tool, plan-specific forms and related information.

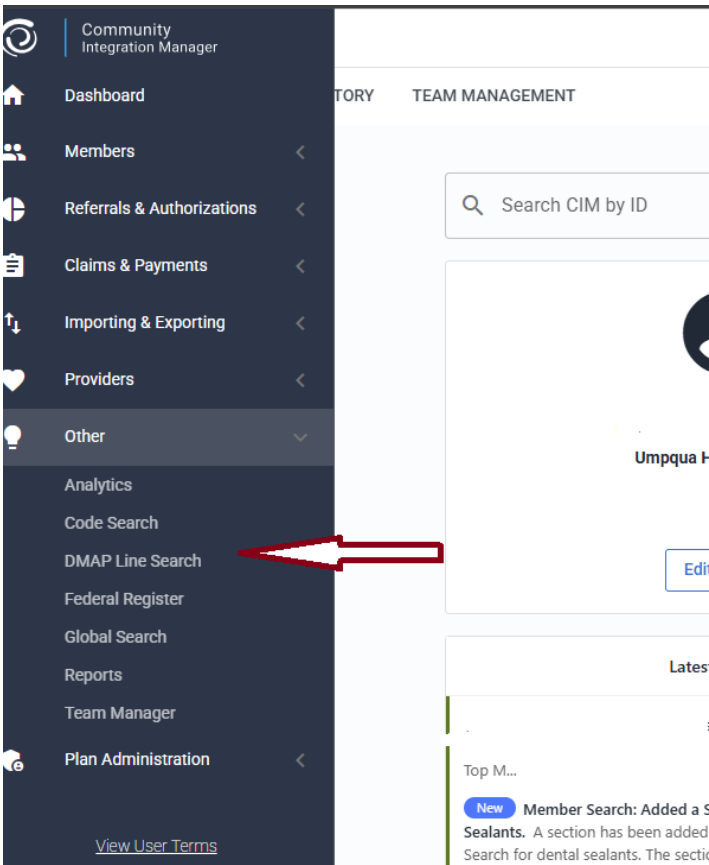


Figure 32. The Other page in the navigation menu.

Use the DMAP line search tool

- 1. Choose the Prioritized List that applies to your date of service.
- 2. Enter a diagnosis code to check the funding level.

3. Enter a procedure code to check the funding level.
4. Read the funding level. This is where the code or code pair ranks on the line, which determines coverage.

Note

If neither the procedure code nor the diagnosis code ranks, the codes do not pair and will not rank. See the non-ranked results guidance below.

1
 Prioritized List
 DMAP Line (10/1/2025 - Present)

2
 Diagnosis Code(s)

3
 Procedure Code(s)

Filter

Reset

This search is provided for reference only and does not incorporate correct coding or billing guidelines (e.g., complete vs. incomplete codes, primary vs. secondary diagnosis, etc.).

Funding level: 469
 4
 Page Size: 100
 << 1 of 7 >>

Line #	Description	Treatment	
+ 1	PREGNANCY (See Guideline Notes 2.4, 22, 39, 85, 92, 99, 108, 147, 150, 153, 175, 176 and 197)	MATERNITY CARE	Funded
+ 2	BIRTH OF INFANT (See Guideline Note 153)	NEWBORN CARE	Funded
+ 3	PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS (See Guideline Notes 1, 17, 106, 122, 140, 179, 181 and 197)	MEDICAL THERAPY	Funded
+ 4	SUBSTANCE USE DISORDER (See Guideline Notes 92 and 175)	MEDICAL/PSYCHOTHERAPY	Funded
+ 5	TOBACCO DEPENDENCE (See Guideline Notes 4 and 92)	MEDICAL THERAPY/BEHAVIORAL COUNSELING	Funded
+ 6	REPRODUCTIVE SERVICES (See Guideline Notes 70, 162 and 176)	CONTRACEPTION MANAGEMENT; STERILIZATION	Funded
+ 7	MAJOR DEPRESSION, RECURRENT; MAJOR DEPRESSION, SINGLE EPISODE, SEVERE (See Guideline Notes 69 and 102)	MEDICAL/PSYCHOTHERAPY	Funded
+ 8	TYPE 1 DIABETES MELLITUS (See Guideline Notes 62, 108, 227 and 228)	MEDICAL THERAPY	Funded

Figure 33. DMAP line search results.

Reading the results

Result	What it means
Above the line	Code pairs that rank at or above the current funding line are valid for payable services. Payment still depends on member eligibility, medical necessity and preauthorization approval where required.
Below the line	Codes that rank below the current funding line are not covered.
Non-ranking	Codes that return no result. These include HCPCS codes such as durable medical equipment and J codes, diagnostic procedures, and informational or undefined diagnosis codes. They are not covered without a more specific diagnosis code.

Table 7. DMAP line search results.

Non-ranked results

Code pairs returning no result are called non-ranked. The following will not rank:

- HCPCS codes, including durable medical equipment and J codes
- Diagnostic services and laboratory services
- Diagnostic procedure codes and diagnosis codes

Procedure and diagnosis codes in these groups do not appear on the Prioritized List. They are covered by the Oregon Health Plan fee-for-service program when billed with a procedure code from the diagnostic procedure codes group and a diagnosis from the Diagnostic Workup file. Because the funding line changes, verify current coverage on the Umpqua Health Alliance website or by calling 541-229-4842.

If a diagnosis does not appear on the Diagnostic Workup file but ranks as funded, it is covered. If it is not on the Diagnostic Workup file and ranks below the line, preauthorization is required.

Searching the Diagnostic Workup file

Do not use the decimal point when searching. For Z79.891, enter Z79891.

Other categories

Category	What it means
Diagnostic and laboratory services	Diagnostic procedure codes will not rank. Current codes on the Oregon Health Authority diagnostic procedure code list are covered when billed with a current diagnosis code from the Diagnostic Workup file.
Excluded procedures	These may or may not rank. See the Oregon Health Plan excluded procedures list.
Nonspecific ICD-10 codes	Informational and undefined diagnosis codes are not a covered benefit under the Oregon Health Plan.
Comorbidity	A circumstance where a noncovered benefit is considered for coverage because the patient has two or more simultaneous conditions. Coordinate through the plan's medical management team.

Table 8. Additional coverage categories.

Appendix A: Getting Access and Support

CIM accounts are requested through the Ayin Health Center, not through Umpqua Health Alliance.

Request a CIM account

1. Go to help.ayin.com.
2. Select Sign In in the top right corner.
3. Select Sign Up in the bottom left corner of the new window.
4. Enter your full name and email address, then select Sign Up.
5. Check your email, including your spam folder, and verify your address. Unverified requests are not received.
6. Sign in to the Help Center and select Submit a Request from the top menu.
7. Select I am with a provider office, then select Submit a Request.
8. In the topic field, choose the CIM support option for a new account or an access issue.
9. In the issue field, choose New CIM account needed.
10. Complete the remaining required fields, then select Submit.

Turnaround

Once your request is approved, access is granted within one to seven business days.

Support contacts

Who to contact	For what	How
Ayin Health Solutions	CIM access, account problems, portal errors	503-584-2169, option 2 · support@ayin.com · www.ayin.com
Umpqua Health Alliance	Eligibility, coverage, claims, and care type questions	541-229-4842 · Toll free 866-672-1551
Prior Authorizations	Preauthorization requirements and grids	priorauthorizations@umpquahealth.com