MEDITRAC/ITRANSACT – REMITTANCE ADVICE (RA) COMPANION GUIDE

The purpose of this guide is to outline the format and layout of the MediTrac/iTransact Remittance Advice (RA) to assist in reviewing claims status within a check write period.

WHAT IS AN RA?

The Remittance Advice (RA) is the documentation of adjudicated claims status. The RA should be used to post claim status to the Provider Agency's system. When a claim is submitted to Trillium Health Resources a RA will be posted in the iTransact Portal to explain any payment, adjustment or denial to the claim. The RA provides reason codes to identify any additional action on the claim. Example – a denied claim may need to be resubmitted as a new claim with the correction as stated by the denial code.

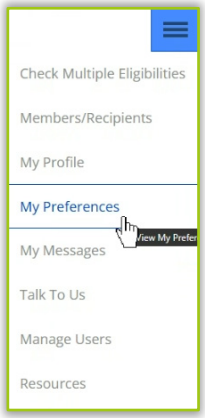
WHAT TYPES OF RA'S ARE AVAILABLE?

- A Remittance Advice (RA) is available in PDF format so it can be printed for easy reading.
- RAs are generated for Provider Agencies who enter claims in the iTransact Portal and who submit 837 electronic files.
  - The RAs are generated in an easy-to-read downloadable PDF format.
- An electronic RA or 835 is sent back to the Provider Agency via Trillium's Trading Partner Agreement.
  - The 835 formatted RA is for Providers to post payments back to member accounts electronically.
  - 835 files are generated for Provider Agencies submitting electronic 837 files.

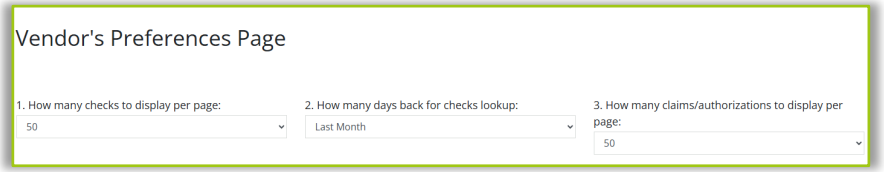
HOW TO LOCATE THE RA'S IN ITRANSACT

Login to iTransact

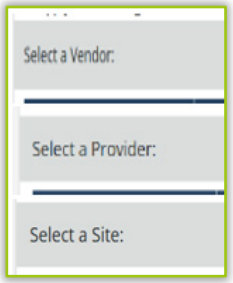
- Login to iTransact
- Navigate to the three bars in the right corner of the website and select My Preferences



- Under Vendor Preferences Page select correct corresponding search options

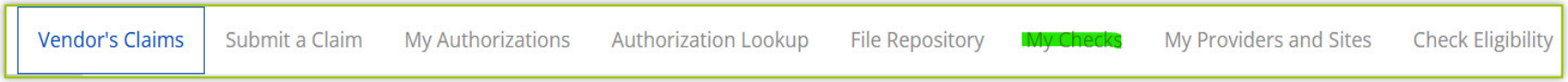


- Select correct Vendor, Provider, and Site

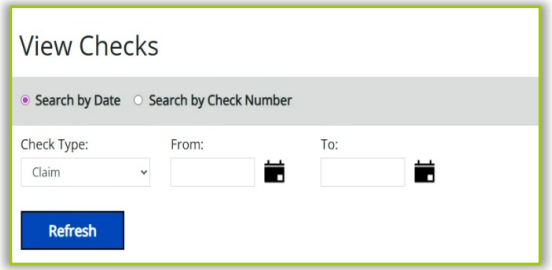


- Click save at the bottom of the page

- Navigate to the tab at the top that reflects My Checks



- View checks by date or by check number



- To pull up information click on Refresh
- Available RA's will populate- select the correct RA and the RA can then be opened and viewed.

WHAT SHOULD BE DONE WITH AN RA?

When the RA is received it should be used to:

- Post Payments to Member accounts
- Balance the RA to the deposit in the bank
- Identify the reason for any denials
  - When the denial can be corrected submit a new claim with the corrected information

RA LAYOUT

The RA is grouped by Provider NPI Number and then alphabetically by member Last Name, First Name under the NPI number.

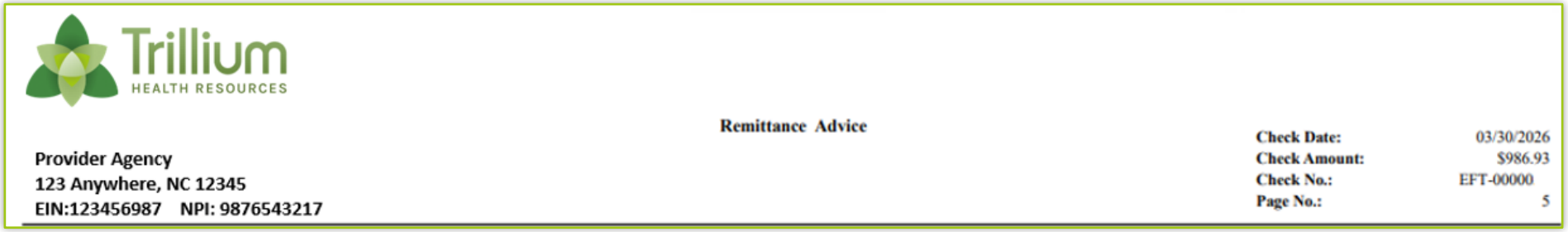
RA Outlined:

Header Section 1:	Claim Field Section:	Claim Detail Section:	RA Total Section:	Summary Section:
Provider Name and Address Provider EIN and NPI Numbers Check Date Check Amount Check Number Page No.	Member # Line of Business Patient Name Provider Name Claim # Lin/Ver# Received Date Service Date From & To Proc Mod. Rev Code Qty Amount Billed Amount Allowed Not Covered Copay/Coins. Deduct Amount Withhold Amount Net Paid ST (Status) Reason Interest	Claim Data	Interest Totals Claim Totals Member Totals Provider Totals Vendor Totals	Total Number of Claims Total Number of Claim Lines Positive Claim Payments Overpayment Claim Adjustments Refund Recoupments Total Payment Explanation Code Legend Appeal Info.

RA BREAKDOWN

Header Information:

The RA header displays core information such as check number, check amount, check date, provider name, address, NPI and EIN IDs.



Trillium HEALTH RESOURCES

Remittance Advice

Provider Agency
123 Anywhere, NC 12345
EIN:123456987 NPI: 9876543217

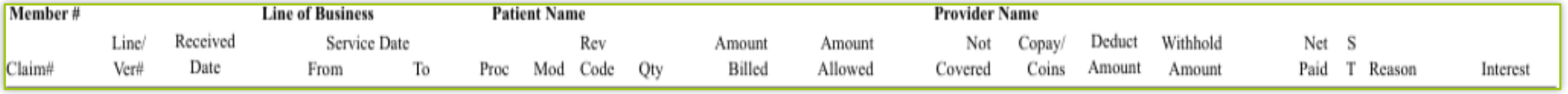
Check Date: 03/30/2026
Check Amount: $986.93
Check No.: EFT-00000
Page No.: 5

NPI Number:

The RA is broken down by each NPI Number submitted on the claim and the payments made on that NPI number.

Claim Field Labels:

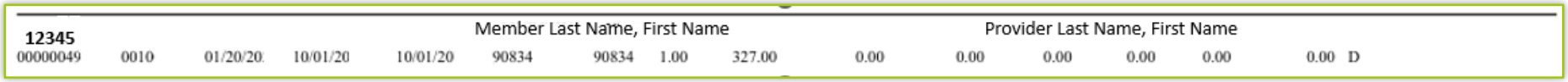
At the top of every page, there is a Header Description Table that identifies what each data element on the claim represents (shown below):



Member #			**Line of Business**		**Patient Name**						**Provider Name**						
Claim#	Line/ Ver#	Received Date	Service Date From	To	Proc	Mod	Rev Code	Qty	Amount Billed	Amount Allowed	Not Covered	Copay/ Coins	Deduct Amount	Withhold Amount	Net Paid	S T	Reason	Interest

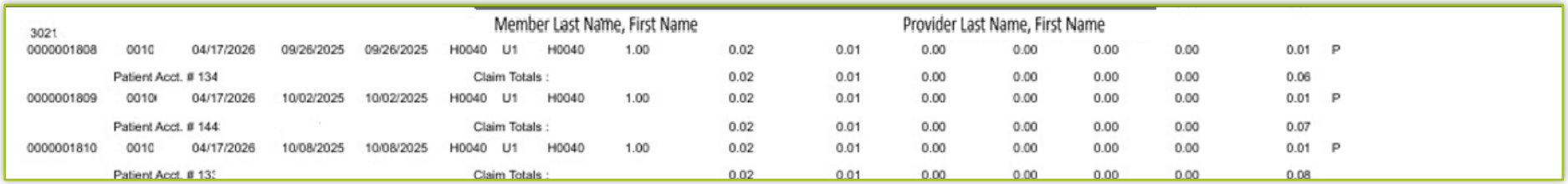
Claim Detail Rows:

The adjudication of each claim is explained per claim line. Use the claim field labels to identify each data element. Each claim line will have 2 detail rows:



Paid Claims (Professional)

Below is an example of a paid claim. Notice how both claims came in on the same claim header, but are broken down per claim line. Since adjudication is at the claim line level, then this claim is viewed as 3 separate claims on the RA. *(In the illustration below Type 1 reflects the payment of a claim).*



Paid Claims (Institutional)

Below is an example of a paid institutional claim. This claim does show a breakdown of each date of service billed in the date range on the claim. There is one detail line only with the claim adjudication. *(In the illustration below Type 1 reflects the payment of a claim).*

Trillium HEALTH RESOURCES

Remittance Advice

Provider Agency
123 Anywhere, NC 12345
EIN:123456987 NPI: 9876543217

Check Date: 03/30/2026
Check Amount: $986.93
Check No.: EFT-00000
Page No.: 5

Member #			Line of Business		Patient Name						Provider Name							
Claim#	Line/ Ver#	Received Date	Service Date From	To	Proc	Mod	Rev Code	Qty	Amount Billed	Amount Allowed	Not Covered	Copay/ Coins	Deduct Amount	Withhold Amount	Net Paid	S T	Reason	Interest
3015					Member Last Name, First Name						Provider Last Name, First Name							
0000000022	001002	03/28/2026	03/14/2026	03/14/2026	80053		0301	1.00	400.00	15.41	0.00	0.00	0.00	0.00	15.41	P		
0000000022	002002	03/28/2026	03/14/2026	03/14/2026	80178		0301	1.00	134.00	12.06	0.00	0.00	0.00	0.00	12.06	P		
0000000022	003002	03/28/2026	03/14/2026	03/14/2026	80307		0301	1.00	229.00	106.32	0.00	4.00	0.00	0.00	102.32	P		
0000000022	004002	03/28/2026	03/14/2026	03/14/2026	99285	25	0450	1.00	3,556.00	804.01	0.00	0.00	0.00	0.00	804.01	P		
0000000022	005002	03/28/2026	03/14/2026	03/14/2026	93005		0730	1.00	235.00	53.13	0.00	0.00	0.00	0.00	53.13	P		
Patient Acct.				Claim Totals :					4,554.00	990.93	0.00	4.00	0.00	0.00	986.93			
				Member Totals :					4,554.00	990.93	0.00	4.00	0.00	0.00	986.93			
				Provider Totals :					4,554.00	990.93	0.00	4.00	0.00	0.00	986.93			
				Vendor Totals :					4,554.00	990.93	0.00	4.00	0.00	0.00	986.93			

Denied Claims

Denied claims are shown in the same format as paid claim lines on the claim. A denial will show as D at the far left of the row. On the claim line that denied, the denial code is under the reason codes column.

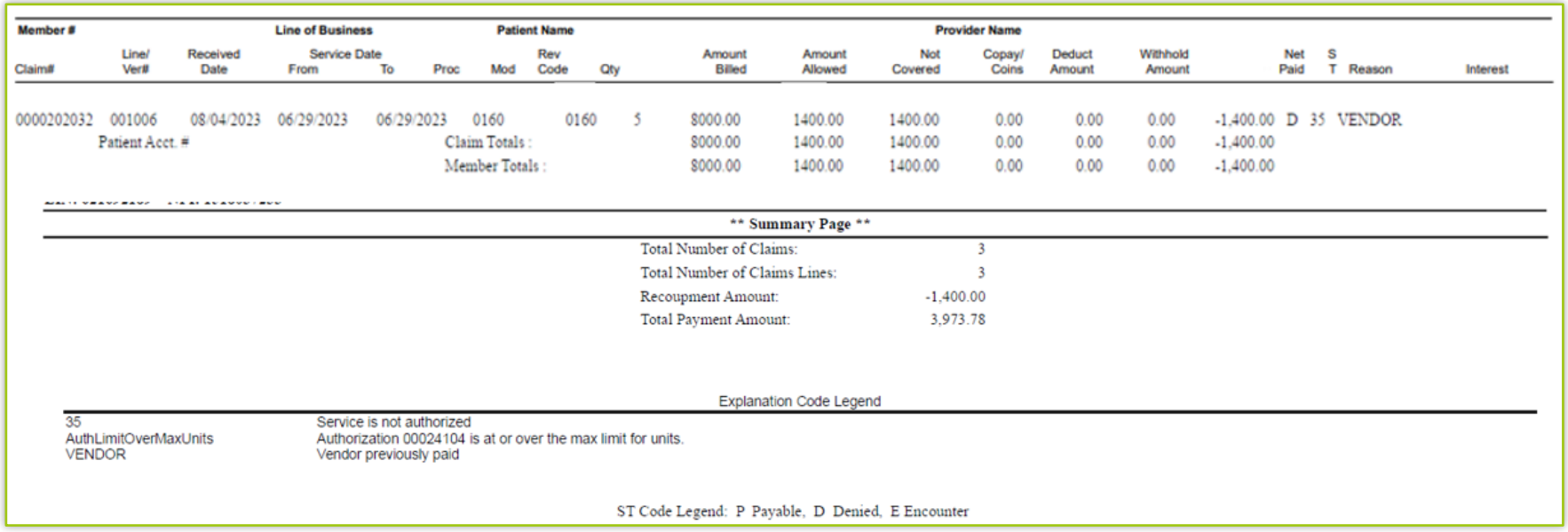
This code is defined at the end of the RA to assist in working denials. In this example the denial reason is TXA which is for " The Billing Taxonomy is not active (suspended/termed) for the date of service".

Member #			Line of Business		Patient Name						Provider Name							
Claim#	Line/ Ver#	Received Date	Service Date From	To	Proc	Mod	Rev Code	Qty	Amount Billed	Amount Allowed	Not Covered	Copay/ Coins	Deduct Amount	Withhold Amount	Net Paid	S T	Reason	Interest
302					Member Last Name, First Name						Provider Last Name, First Name							
0000003605	001002	05/05/2026	04/01/2026	04/01/2026	99217		99217	1.00	395.00	59.48	59.48	0.00	0.00	0.00	0.00	D	TXA	
Patient Acct. # 14				Claim Totals :					395.00	59.48	59.48	0.00	0.00	0.00	0.00			
				Member Totals :					395.00	59.48	59.48	0.00	0.00	0.00	0.00			
				Provider Totals :					395.00	59.48	59.48	0.00	0.00	0.00	0.00			

Recoupments (Memos)

Recoupments create memos when claims are replaced and/or voided.

- The claim(s) may have been paid on a previous RA. The replacement and/or voided claim(s) will create the credit memo which will recoup the originally paid claim(s).
- When a claim(s) is replaced and recoups the original payment and the new claim(s) is denied the recoupment will show up on the RA while a denial is generated on the new claim(s).
- The new denial will have to be corrected and resubmitted as a new claim before the repayment of the claim(s) will occur. If this happens the Provider will temporarily have a recouped original claim(s) while awaiting a successful adjudication of the new claim(s).
- When a claim(s) (unpaid or paid) is replaced during the check write period for an RA, both the original, reverted claim(s) and the new claim(s) will be populated in the RA.



Member # | **Line of Business** | **Patient Name** | **Provider Name**

Claim#	Line/ Ver#	Received Date	Service Date From	Service Date To	Proc	Mod	Rev Code	Qty	Amount Billed	Amount Allowed	Not Covered	Copay/ Coins	Deduct Amount	Withhold Amount	Net Paid	S T	Reason	Interest
0000202032	001006	08/04/2023	06/29/2023	06/29/2023	0160		0160	5	$000.00	1400.00	1400.00	0.00	0.00	0.00	-1,400.00	D	35 VENDOR	
Patient Acct. #				Claim Totals :					$000.00	1400.00	1400.00	0.00	0.00	0.00	-1,400.00			
				Member Totals :					$000.00	1400.00	1400.00	0.00	0.00	0.00	-1,400.00			

**** Summary Page ****

Total Number of Claims:	3
Total Number of Claims Lines:	3
Recoupment Amount:	-1,400.00
Total Payment Amount:	3,973.78

Explanation Code Legend

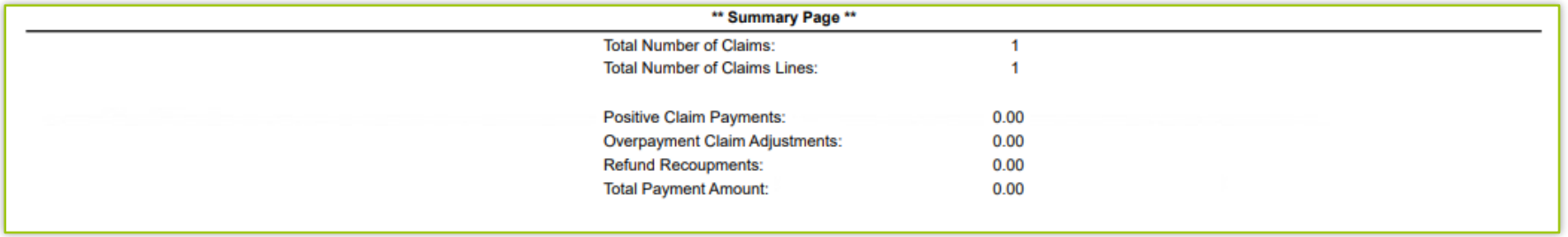
35	Service is not authorized
AuthLimitOverMaxUnits	Authorization 00024104 is at or over the max limit for units.
VENDOR	Vendor previously paid

ST Code Legend: P Payable, D Denied, E Encounter

Summary Page

The Summary Page of the RA will appear at the bottom of the RA.

- Total Number of Claims
- Total Number of Claim Lines
- Positive Claim Payments
- Overpayment Claim Adustments
- Refund Recoupments
- Total Payment Amount



** Summary Page **

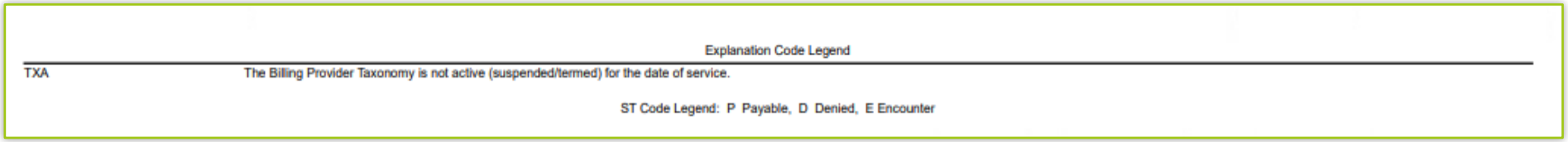
Total Number of Claims:	1
Total Number of Claims Lines:	1
Positive Claim Payments:	0.00
Overpayment Claim Adjustments:	0.00
Refund Recoupments:	0.00
Total Payment Amount:	0.00

*

***Process dates selected designate the denied and fully adjusted claims included in this RA. Paid approved claims included in this RA are all claims paid by check number EFT000000*

Explanation Code Legend

At the end of the RA, immediately under the grand totals for the RA, is a reason code that assists in identifying why a claim denied. The listed denial reasons are not all of the Trillium denial reasons, but a list of denial reasons included on the RA being reviewed. Please refer to the example below:



Explanation Code Legend

TXA	The Billing Provider Taxonomy is not active (suspended/termed) for the date of service.

ST Code Legend: P Payable, D Denied, E Encounter

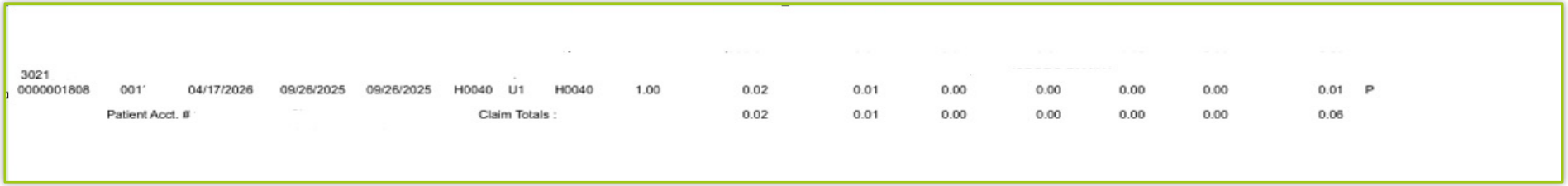
Field Descriptions /Definition Guide:

Patient Name	Patient Last, First Name
Member #	ID number assigned to member by the MCO system
Received Date	The Date the claim was received by the MCO.
Patient Acct #	Patient ID number submitted by the Provider Agency
Line/Ver#	Claim detail number assigned to specific service line within the claim.
Status	Explanation Code this key explains the claim line amount (i.e.: (P) Payable, (D) Denied, (E) Encounter
Proc	Procedure Code submitted on the claim
Mod	Modifiers submitted on the claim
Rev Code	Revenue code submitted on the claim. (Used for claims submitted on 837 Institutional or UB04 claim)
Claim #	Claim number assigned to the claim upon adjudication of the claim.
Service Date	The individual date of service submitted on the claim. Each date of service within a claim will have its own detail line.
Reason	The detailed explanation of the reason the claim denied.
Qty	The amount of units submitted on the claim
Allowed Amount	Rate associated with provider contract for service rendered
Amount Billed	The total amount of the claim submission
Not Covered	Total Denied amount for the claim
Withhold Amount	The total of any withheld amount from the claim
Net Paid	Total amount paid for the claim
Copay/Coins	The amount that the patient has paid towards meeting their deductible.
Deduct Amount	Total amount that the patient must meet before payment is rendered.
Interest	Total amount of interest owed on claim.

FREQUENTLY ASKED QUESTIONS:

1. Where can I find the claim number for my replacement claim on the RA?

The Meditrac claim number under the member #. Please refer to the second line to find the claim number. This number often begins with multiple zeros "0".



3021																
0000001808	001	04/17/2026	09/26/2025	09/26/2025	H0040	U1	H0040	1.00	0.02	0.01	0.00	0.00	0.00	0.00	0.01	P
Patient Acct. #					Claim Totals :				0.02	0.01	0.00	0.00	0.00	0.00	0.06	

2. The Remittance Advice shows a negative amount. Where does this come from?

Negative payments are the recoupment of an originally paid claim. This can happen when a claim is replaced and/or voided by the Provider Agency.

When Trillium Health Resources has updates to rates and services, etc. claims may be re-adjudicated to correct the claim to the updated status. If the difference is a negative amount, the difference will be recouped. .

Void claim(s) *will recoup the original payment of the claim. Unlike a replacement claim there will not be repayment of a voided claim.*

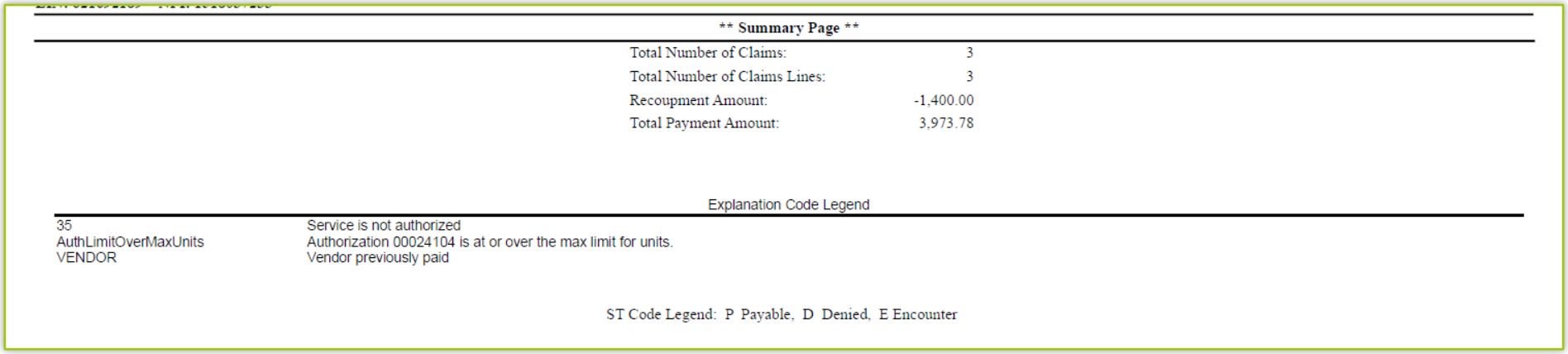
Audit Denial(s) *if any kind of Trillium Health Resources audit has been done and the results of the audit are to recoup the payment of the audited claim; these recoupments will also appear as a Recoupment There will not be any repayments when this occurs.*

3. The check amount does not match the Positive Claim Payments on the Summary Page of the RA. Why is this?

Recoupments can reduce the check amount. The Check Amount is listed at the top of the RA and includes EFT data. The Total Payment Amount is located on the summary page.

When claims are recouped and repaid for the same amount on the same RA these two amounts should match. (Example noted below:)

When claims are recouped and repaid for a different amount (i.e. a denial or a voided claim) the paid amount will be decreased by the amount of recoupments. This will cause the check amount and the paid amount to not match.



** Summary Page **

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