

Eye Health Manager Portal

User Guide for Providers
and Office Staff



Table of Contents

- Table of Contents 2
- Get Started 3
- Review Member Benefits 6
- Confirm Member Selection 7
- Submit a Claim 8
- Check Status of Claim10
- Reprint Explanation of Payment (EOP) 11
- Request Prior Authorization..... 13
- View Authorization18
- Search for Authorization 20
- Review Office Manuals 21
- Review Policies and Procedures22
- Activate/Deactivate Providers23
- Update Login Information25
- Revision Table 26

Get Started

To sign in, enter your username and password, complete any verification prompt if presented, and select **Login**.

CENTENE VISION SERVICES | **envolve** Benefits Options

Welcome Vision Providers!

www.envolvevision.com

If you are a contracted provider, [click here](#) to request Eye Health Manager portal access. Once you have created an account, you can use the provider portal to:

- ✓ Check member eligibility and benefits
- ✓ Review past claim submissions
- ✓ Manage and track claims
- ✓ Reprint EOPs
- ✓ View plan specifics
- ✓ Manage directory information Coming Soon

[Request access](#) [View manual & policies](#) [Manage info](#)

[Update Email](#) [Report Fraud / FWA](#)

Three convenient ways to update your directory information:
[Online Provider Update Form](#) | [Call us at 800-531-2818](#) | [Email our Advanced Case Unit](#)

Provider Login

Username
Enter your username
Case Sensitive, Max 35 characters

Password
Enter your password
Case Sensitive, Max 25 characters

☐ Verify you are human CLOUDFLARE

[Forgot Password?](#)

[Login](#)

The secure on-line Eye Health Manager is available to all participating Providers. By logging in to this site, you indicate your acceptance of the [On-line Health Information Sheet, Disclosures, and Access Agreement](#).

[Terms and Conditions](#) | [Privacy Notice](#) | [Contact Us](#)

Figure 1: Login window.

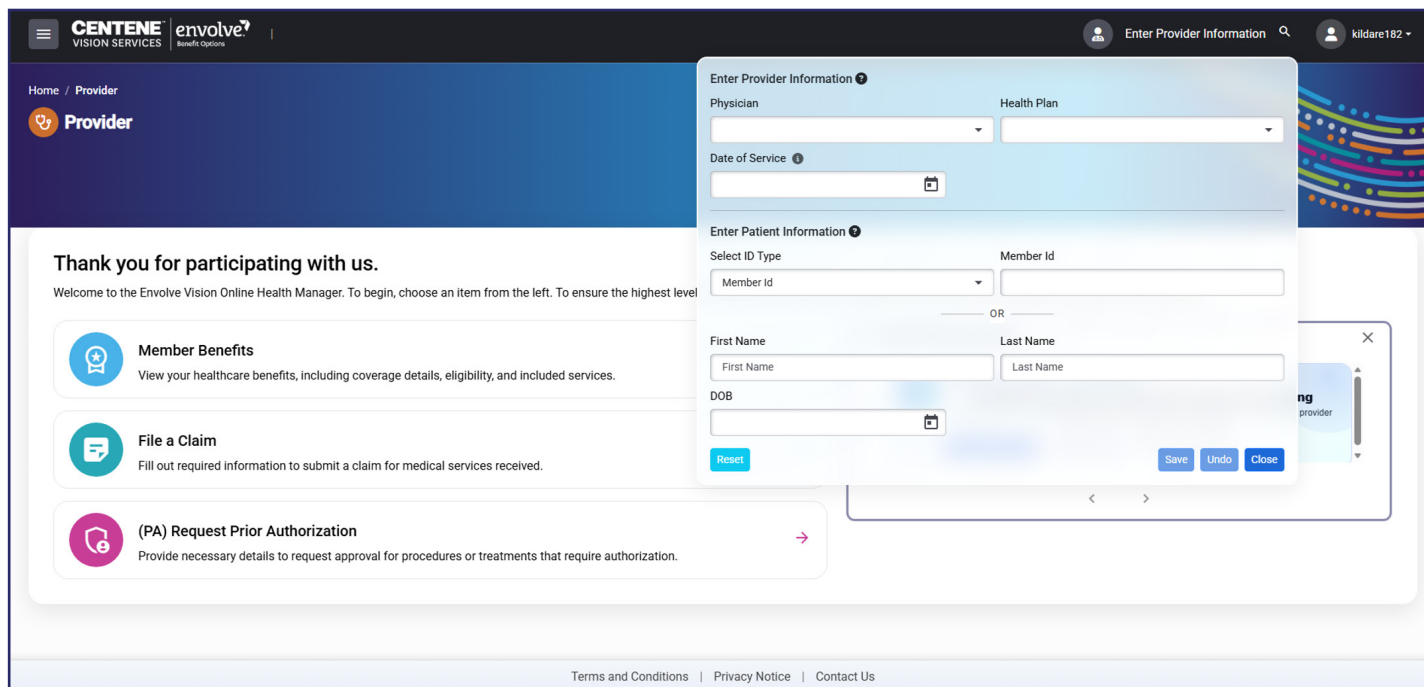


Figure 2: Portal window that shows after you login.

- The portal supports several day-to-day workflows. Two of the most frequently used are:
 1. Review member benefits
 2. Submit a claim
- To access the full menu, select the menu icon in the upper-left corner and expand the available sections.
- Check portal messages regularly for updates, notices, and system information relevant to your contracted health plans.

1. Secure messages you will see after logging in:

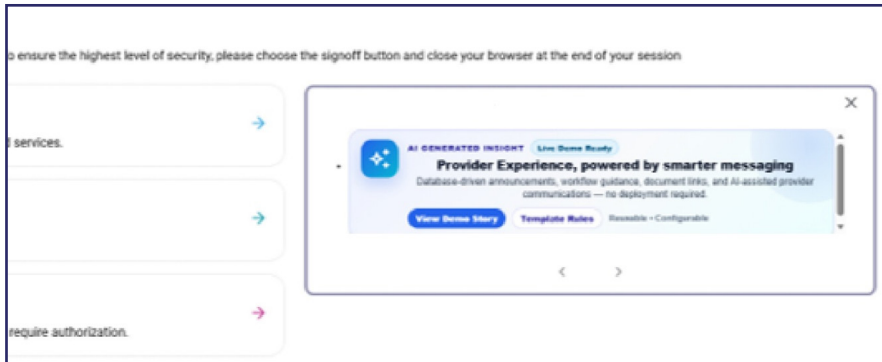


Figure 3: Relevant provider messages will show up in this area.

2. General messages for all users seen on login page:

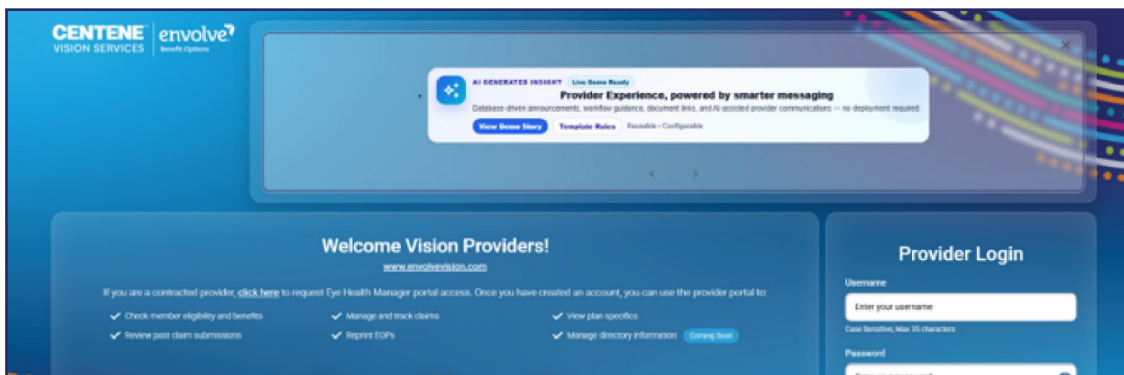


Figure 4: General provider messages will show up in this area on the login page.

Review Member Benefits

1. Start by selecting the active provider, contracted health plan, and the identifier you want to use for the member search (See Figure 5):
 - a. Choose active provider
 - b. Choose contracted health plan
 - c. Select what you want to search member by:
 - i. Member ID
 - ii. Claim ID/Number
 - iii. Authorization ID/Number
 - iv. SSN
 - v. N/A (when performing provider only functions like reprint EOP)

Hint: You can key in part of the provider or health plan name to narrow the list when working with larger groups.

The screenshot shows a web application interface titled 'Set Provider & Member'. It contains two main sections: 'Enter Provider Information' and 'Enter Patient Information'. In the 'Enter Provider Information' section, there are dropdown menus for 'Physician' (labeled with a pink arrow 'a') and 'Health Plan' (labeled with a pink arrow 'b'). Below these is a 'Date of Service' field with a calendar icon. The 'Enter Patient Information' section has a 'Select ID Type' dropdown (labeled with a pink arrow 'c') and a 'Member Id' text field. Below these are fields for 'First Name', 'Last Name', and 'DOB' with a calendar icon. At the bottom right are 'Save', 'Undo', and 'Close' buttons. A 'Clear Form' button is at the bottom left. The top right of the interface shows a user profile for 'kildare182'.

Figure 5: Arrows show which identifiers you need to change when searching for members.

Confirm Member Selection

After entering the member ID, select **Save**. Confirm that the correct account, health plan, provider, and member record appear before continuing. (See Figure 6)

- 1. Account in use
- 2. Health Plan selected
- 3. Provider (NPI) chosen

The member's record will be displayed in the selection banner.

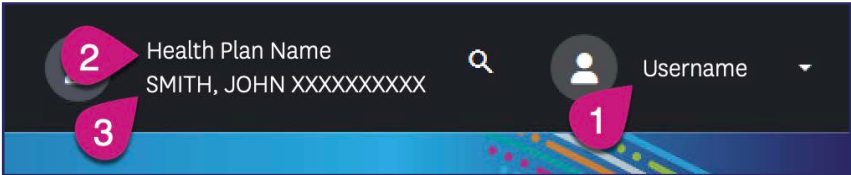


Figure 6: Highlighted areas showing the areas that need to be confirmed for each member.

Select Member Benefits or use the menu path Patients → View Member Benefits.
Select the member record you want to review.

Name - ID #	DOB	Effective	Terminates	Benefit	Active Member	Physician Can Provide Services?	Member has Primary Insurance through other Insurance
LASTNAME, FIRSTNAME - XXXXXXXXXX	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	XXXXXXX	Yes	Yes	No

Figure 7: Sample member record.

This page displays current eligibility information available at the time of the request. If you cannot locate a member, contact Customer Relations at 800-840-7032 or refer to the contact information in the applicable plan specifications.

Submit a Claim

1. From the home page, select **File a Claim**, or use the menu path **Claims** → **Claim Entry**.
2. Confirm the correct member, then select the member record to begin claim entry. This opens the claim entry screen.
3. Select **+Add** only when you need more than the default diagnosis fields.
4. Under **Claim Details**, update **Provider COB** from **No** to **Yes** when applicable.
5. Enter the dates of service and add additional service lines only if needed.
6. To copy values from the first service line to the next line, complete Row 1 and then select **Copy Row #1** on Row 2.
7. The **Account Information** section is optional. Select **Continue** to proceed.
 - a. *Patient Rx information is optional and may be skipped if not applicable.*
8. Select the address where the services were rendered, then choose **Continue**.
9. Before submission, expand each section to confirm the information entered. When all details are correct, select **Submit**.
10. After submission, a confirmation message appears and the system assigns a claim number.
11. After a claim is submitted, you can upload supporting documentation such as a primary EOB/EOP, medical records, or a statement of medical necessity. If no attachments are required, you may print the claim for your records (See Figure 8 on the next page).

Manage Attachment(s) for Claim Number: XXXXXXXXXXXX

Attachment(s) for Claim Number: XXXXXXXXXXXX
Please upload supporting documents for this claim. Please note, only image files are supported. Click on "Add files...", and click on the "Start upload" button to begin uploading the selected file(s). (gif | jpg | png | tiff | pdf)
Please note, files are limited to 5mb in size.

+ Add files... Start upload Cancel upload Delete ☐ Select All

Finished

Figure 8: Click the "Add Files" button (circled) to upload supporting documentation to the claim.

To Attach a Claim:

1. After the files are added, select **Start upload**.
2. If the wrong file is uploaded, select the delete icon to remove it. After all files are validated, select **Finished** to attach them to the submitted claim.

Check Status of Claim

(available only for claims submitted through the web portal)

1. Select the provider who rendered the service on that claim
2. Select the health plan the claim was submitted under
3. Type in the member ID whose claim you are searching for (Note: you can leave the DOS empty)
4. Click on [Save]
5. Click on the top menu → Click on Claims → Click on Claim Status Check
 - a. If no date of service is entered and more than one line of coverage is returned, select the active line of coverage.
 - b. Select the active member record to view claim details.

Reprint Explanation of Payment (EOP)

EOPs are related to providers, so member ID is not needed for this task.

The screenshot shows a web form with two main sections: 'Enter Provider Information' and 'Enter Patient Information'. The 'Enter Provider Information' section includes a 'Physician' dropdown menu with the value 'DR. SAMPLE, XXXXXXXXXX', a 'Health Plan' dropdown menu with the value 'Health Plan Name - Medicare, HPMP', and a 'Date of Service' date picker. The 'Enter Patient Information' section includes a 'Select ID Type' dropdown menu with the value 'N/A', a 'Member Id' text input field, and an 'OR' separator. Below the 'OR' separator are 'First Name' and 'Last Name' text input fields, and a 'DOB' date picker. At the bottom of the form are 'Clear Form', 'Save', 'Undo', and 'Close' buttons.

Enter Provider Information ?	
Physician	Health Plan
DR. SAMPLE, XXXXXXXXXX	Health Plan Name - Medicare, HPMP
Date of Service ⓘ	
[Date Picker]	

Enter Patient Information ?	
Select ID Type	Member Id
N/A	[Text Input]
OR	
First Name	Last Name
First Name	Last Name
DOB	
[Date Picker]	
[Clear Form] [Save] [Undo] [Close]	

Figure 9: Menu to access Explanation of Payment (EOP)

1. Select provider and health plan, and for ID Type, select N/A and click on Save.
2. Click on the top menu and choose **Reprint EOPs**.
3. Enter the check date, select the provider, select location if there is more than one and the correct Reference number will be populated. Click on Continue to retrieve EOP from Zelis and view PDF. (See Figure 10)

Figure 10: Enter check date, provider, and location here.

The PDF is located and displayed for the selected provider and check date.

Figure 11: PDF of EOP pulled from Zelis.

Request Prior Authorization

To request prior authorization:

1. Select the servicing provider and contracted health plan, then enter the member ID or leave the date of service blank if needed.
2. From the home page, select (PA) Request Prior Authorization, or use the menu path Authorizations → Request Authorizations.

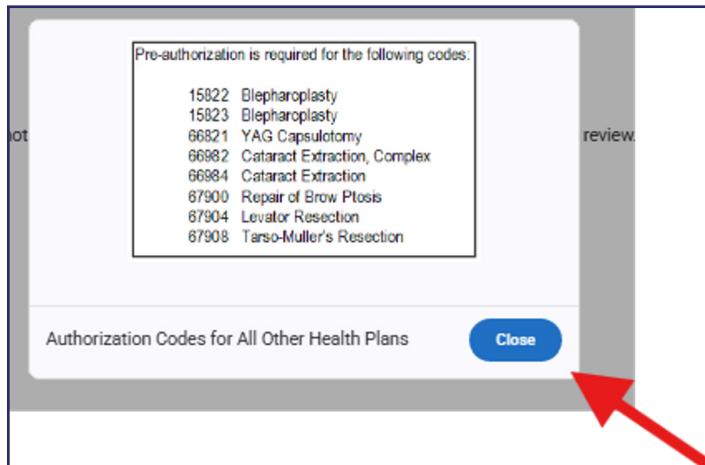


Figure 13: Example of "All Other Health Plans" being selected for Prior Authorizations.

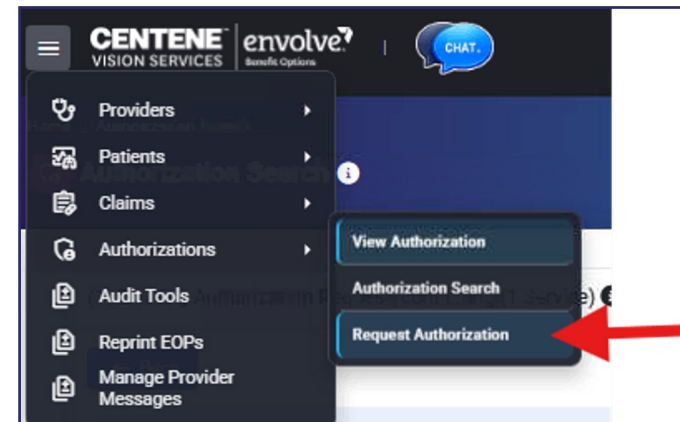
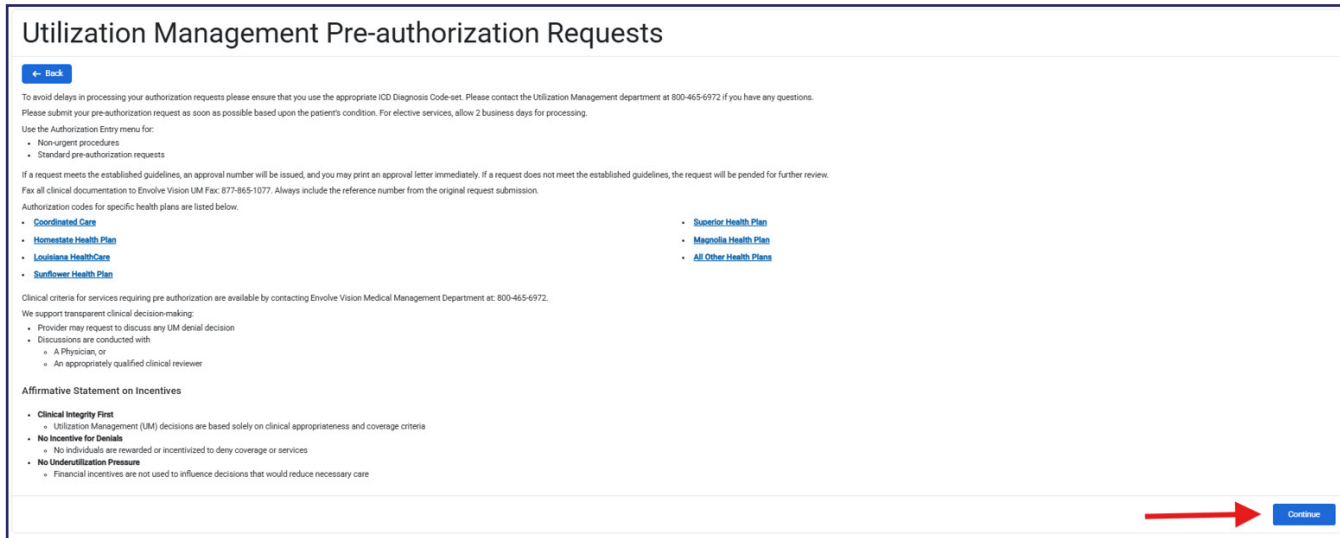


Figure 12: Arrows showing which buttons to choose when requesting Prior Authorizations.

3. This page summarizes prior authorization details and health plan options. Select the appropriate health plan to review which codes require preauthorization. In Figure 13, All Other Health Plans is selected.
4. After selecting All Other Health Plans, the authorization codes are displayed. Select Close in the lower-right corner to return to the request authorization information page.

Review the page instructions, then scroll to the bottom and select Continue to begin the request (See Figure 14).



Utilization Management Pre-authorization Requests

[← Back](#)

To avoid delays in processing your authorization requests please ensure that you use the appropriate ICD Diagnosis Code-set. Please contact the Utilization Management department at 800-465-6972 if you have any questions. Please submit your pre-authorization request as soon as possible based upon the patient's condition. For elective services, allow 2 business days for processing.

Use the Authorization Entry menu for:

- Non-urgent procedures
- Standard pre-authorization requests

If a request meets the established guidelines, an approval number will be issued, and you may print an approval letter immediately. If a request does not meet the established guidelines, the request will be pending for further review. Fax all clinical documentation to Enville Vision UM Fax: 877-965-1077. Always include the reference number from the original request submission.

Authorization codes for specific health plans are listed below:

- [Coordinated Care](#)
- [Hemstate Health Plan](#)
- [Louisiana HealthCare](#)
- [Sunflower Health Plan](#)
- [Superior Health Plan](#)
- [Magnolia Health Plan](#)
- [All Other Health Plans](#)

Clinical criteria for services requiring pre authorization are available by contacting Enville Vision Medical Management Department at: 800-465-6972.

We support transparent clinical decision-making:

- Provider may request to discuss any UM denial decision
- Discussions are conducted with
 - A Physician, or
 - An appropriately qualified clinical reviewer

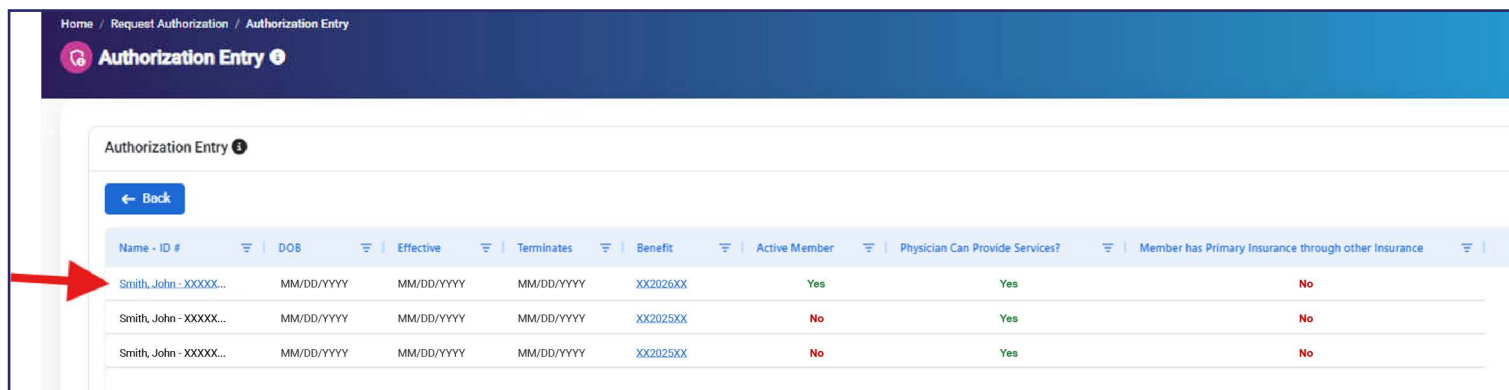
Affirmative Statement on Incentives

- **Clinical Integrity First**
 - Utilization Management (UM) decisions are based solely on clinical appropriateness and coverage criteria
- **No Incentives for Denials**
 - No individuals are rewarded or incentivized to deny coverage or services
- **No Underutilization Pressure**
 - Financial incentives are not used to influence decisions that would reduce necessary care

[Continue](#)

Figure 14: Arrow pointing to the “Continue” button to complete the Prior Authorization request.

The member history screen appears next. If no date of service is selected and more than one line of coverage is returned, select the active line of coverage (see Figure 15).



Home / Request Authorization / Authorization Entry

Authorization Entry

[← Back](#)

Name - ID #	DOB	Effective	Terminates	Benefit	Active Member	Physician Can Provide Services?	Member has Primary Insurance through other Insurance
Smith, John - XXXXX...	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	XX2026XX	Yes	Yes	No
Smith, John - XXXXX...	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	XX2025XX	No	Yes	No
Smith, John - XXXXX...	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	XX2025XX	No	Yes	No

Figure 15: The red arrow is pointing to the active line of coverage.

In the **Contact Info** section, the current date populates automatically. Enter the office contact, phone number, and fax number, then select *Next* (see Figure 16).

The screenshot shows the 'Authorization Entry' screen with the 'Contact Info' tab selected. At the top left is a blue 'Back' button. Below the tabs, the heading 'Enter Contact Information' is followed by a question mark icon. The form contains four input fields: 'Date' (pre-filled with '06/04/2026 11:46:02 AM'), 'Office Contact', 'Phone', and 'Fax'. All input fields are currently empty except for the pre-filled date.

Figure 16: Contact information screen for prior authorization.

In the **Provider Info** section, the provider ID populates automatically. Select the correct provider name from the list, then choose *Next* (see Figure 17).

The screenshot shows the 'Authorization Entry' screen with the 'Provider Info' tab selected. At the top left is a blue 'Back' button. Below the tabs, the heading 'Enter Provider Information' is followed by a question mark icon. The form contains two input fields: 'Provider ID' and 'Provider Name'. The 'Provider ID' field is pre-filled with a value. The 'Provider Name' field is a dropdown menu showing a list of providers, with 'SMITH, JOHN, XXXXXXXXXX' selected and highlighted in blue. A search bar is visible above the dropdown list.

Figure 17: Provider Info screen for prior authorization.

In the **Patient Info** section, several fields populate automatically. Complete the remaining required fields, including other insurer information if applicable, date of admit, and date of service, then select *Next* (see Figure 18).

The screenshot shows the 'Authorization Entry' screen with the 'Patient Info' tab selected. The 'Enter Patient Information (02/01/2026 Thru 12/31/2026)' section contains the following fields:

- Name, Dob**: A text input field with the placeholder 'ID/YYYY'.
- ID#, Hmo, Group**: A text input field.
- Other Insurer (if any)**: A text input field.
- Date Of Admit**: A date picker field.
- Date Of Service***: A date picker field with a red asterisk indicating it is required.

Figure 18: Patient info screen for prior authorization.

In the **Service Info** section, complete all required fields marked with a red asterisk, then select *Next* (see Figure 19).

Note: Procedures that require preauthorization vary by product. Refer to the applicable plan specifications. Many requests are approved immediately when criteria are met; others may be pending for review.

The screenshot shows the 'Authorization Entry' screen with the 'Service Info' tab selected. The 'Enter Service Information' section contains the following fields:

- Place of service ***: A dropdown menu with 'XX Doctor's Office' selected.
- Facility**: A dropdown menu with 'XXXX' selected.
- Service Location ***: A dropdown menu with '123 STREET ADDRESS CITY STATE XXXXX' selected.
- ICD 1***, **ICD 2**, and **ICD 3**: Text input fields.

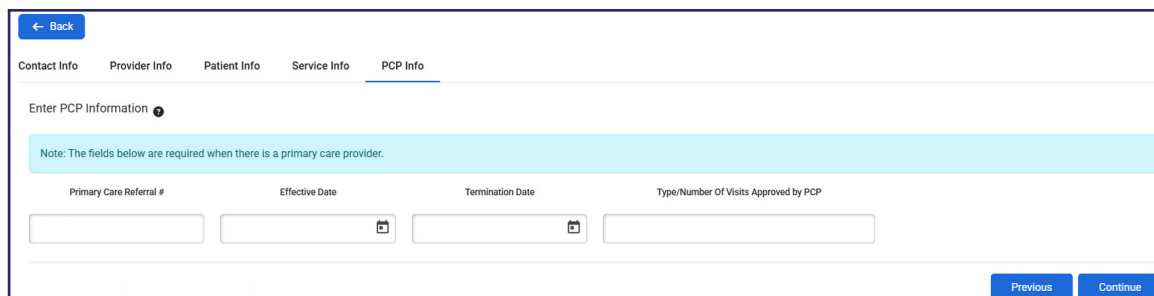
Below these fields is a table with 6 rows and 5 columns:

Line	QPT *	Modifier *	REF *	QTY
1.				
2.				
3.				
4.				
5.				
6.				

At the bottom right of the form are 'Previous' and 'Next' buttons.

Figure 19: Service info screen for prior authorization.

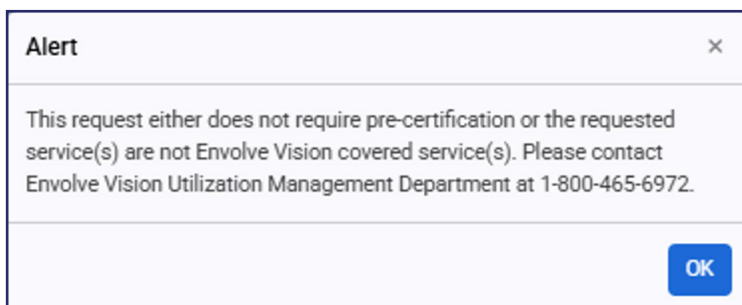
In the **PCP Info** section, complete the required fields when a primary care provider applies. When finished, select *Continue* to submit the authorization request (see Figure 20).



The screenshot shows a web application interface with a top navigation bar containing a 'Back' button and tabs for 'Contact Info', 'Provider Info', 'Patient Info', 'Service Info', and 'PCP Info'. The 'PCP Info' tab is selected. Below the tabs is a section titled 'Enter PCP Information' with a help icon. A light blue note box states: 'Note: The fields below are required when there is a primary care provider.' Below the note are four input fields: 'Primary Care Referral #' (text), 'Effective Date' (calendar icon), 'Termination Date' (calendar icon), and 'Type/Number Of Visits Approved by PCP' (text). At the bottom right are 'Previous' and 'Continue' buttons.

Figure 20: PCP info screen for prior authorization.

If there is an issue with the CPT or service code entered, the system may display the following message (see Figure 21).



The screenshot shows an 'Alert' dialog box with a close button (X) in the top right corner. The message text reads: 'This request either does not require pre-certification or the requested service(s) are not Envolve Vision covered service(s). Please contact Envolve Vision Utilization Management Department at 1-800-465-6972.' An 'OK' button is located at the bottom right of the dialog.

Figure 21: Alert message that populates when there is an issue with the CPT or service code with prior authorizations.

View Authorization

(available only for prior authorizations submitted through the web portal)

1. Select the servicing provider and contracted health plan, enter the member ID if available, and save your selection.
2. Use the menu path **Authorizations** → **View Authorizations** (see Figure 22).

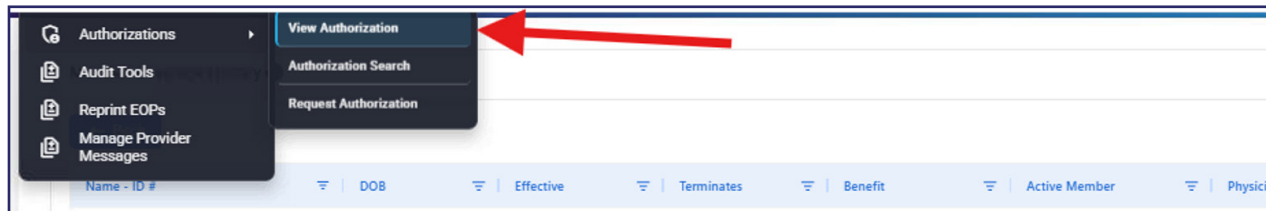


Figure 22: The menu path that allows you to view authorizations submitted through the web portal.

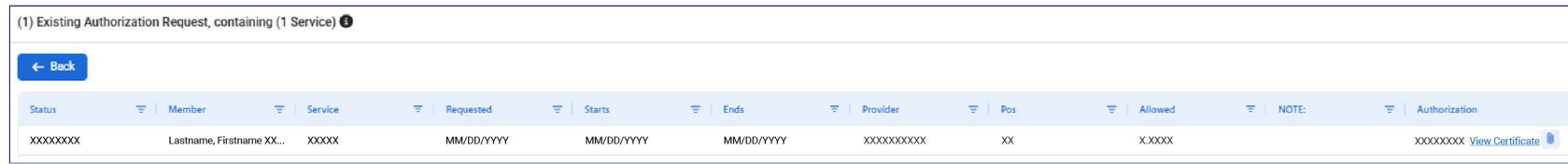
3. The member history screen appears. If no date of service is selected and more than one line of coverage is returned, select the active line of coverage (see Figure 23).

A screenshot of the 'View Authorizations' page. At the top, there is a header with 'Home / View Authorizations' and a 'View Authorizations' button. Below this is a 'Member Coverage History' section with a 'Back' button. The main part of the screen is a table with columns for member information and coverage details. The table contains five rows of data for a member named John Smith, showing different effective dates and coverage statuses. The 'Active Member' column uses green text for 'Yes' and red text for 'No'.

Name - ID #	DOB	Effective	Terminates	Benefit	Active Member	Physician Can Provide Services?	Member has Primary Insurance through other Insurance
Smith, John - XXXXXXXXXX	MM/DD/YYYY	MM/DD/2026	MM/DD/YYYY	XX2026XX	Yes	Yes	No
Smith, John - XXXXXXXXXX	MM/DD/YYYY	MM/DD/2025	MM/DD/YYYY	XX2025XX	No	Yes	No
Smith, John - XXXXXXXXXX	MM/DD/YYYY	MM/DD/2024	MM/DD/YYYY	XX2024XX	No	Yes	No
Smith, John - XXXXXXXXXX	MM/DD/YYYY	MM/DD/2023	MM/DD/YYYY	XX2023XX	No	Yes	No
Smith, John - XXXXXXXXXX	MM/DD/YYYY	MM/DD/2022	MM/DD/YYYY	XX2022XX	No	Yes	No

Figure 23: Member history screen, where you can select the member's active line of coverage.

This page lists existing authorizations. The authorization number appears on the far right (see Figure 24).



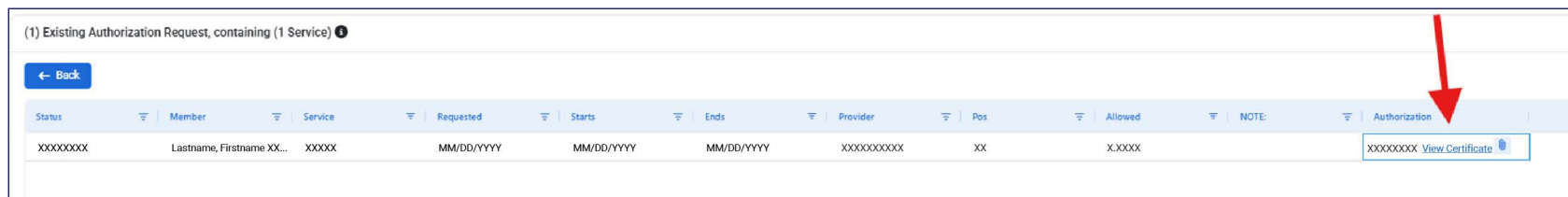
(1) Existing Authorization Request, containing (1 Service) ⓘ

← Back

Status	Member	Service	Requested	Starts	Ends	Provider	Pos	Allowed	NOTE:	Authorization
XXXXXXXX	Lastname, Firstname XX...	XXXXX	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	XXXXXXXXXXXX	XX	X.XXXX		XXXXXXXX View Certificate ⓘ

Figure 24: Existing Authorizations for selected members.

4. To open the authorization for the selected member, select **View Certificate** (see Figure 25).



(1) Existing Authorization Request, containing (1 Service) ⓘ

← Back

Status	Member	Service	Requested	Starts	Ends	Provider	Pos	Allowed	NOTE:	Authorization
XXXXXXXX	Lastname, Firstname XX...	XXXXX	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	XXXXXXXXXXXX	XX	X.XXXX		XXXXXXXX View Certificate ⓘ

Figure 25: The red arrow shows where you can view the authorization certificate.

5. An authorization letter is displayed. You can print this letter for your records.

Search for Authorization

(available only for prior authorizations submitted through the web portal)

1. Select the servicing provider and contracted health plan, enter the member ID if needed, and save your selection.
2. Use the menu path **Authorizations** → **Authorization Search** (see Figure 26).

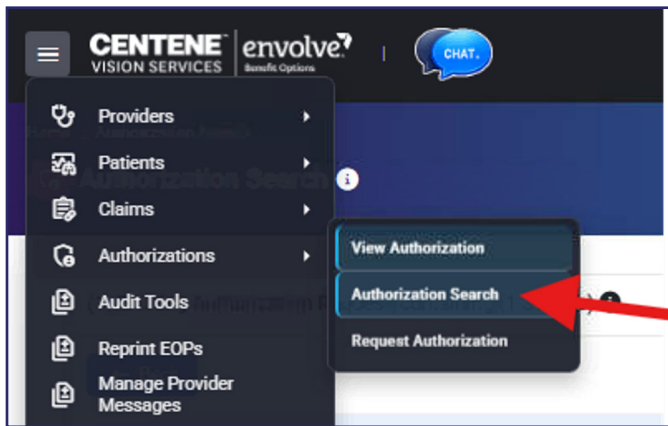


Figure 26: Menu path for Authorization Search.

All web-submitted authorizations for the selected provider will appear on this screen (See Figure 27).

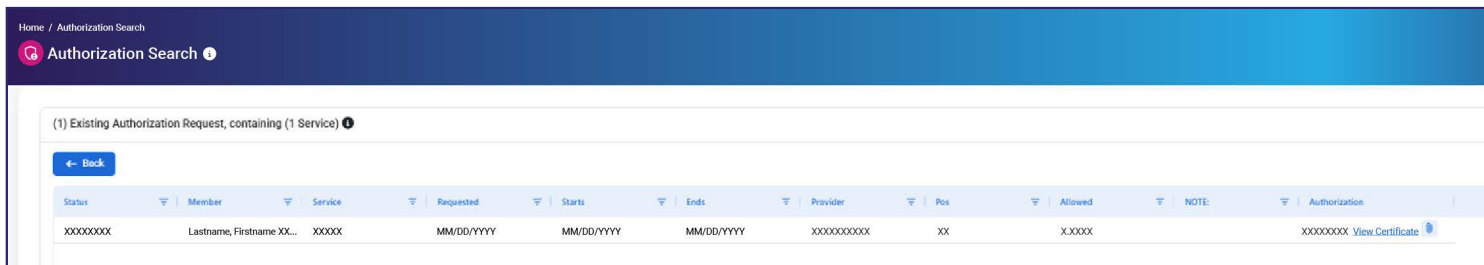
A screenshot of the 'Authorization Search' screen. The header shows 'Home / Authorization Search' and a search icon. Below the header, there is a message: '(1) Existing Authorization Request, containing (1 Service)'. A 'Back' button is visible. The main content is a table with the following columns: Status, Member, Service, Requested, Starts, Ends, Provider, Pos, Allowed, NOTE, and Authorization. The table contains one row of data with placeholder text: 'XXXXXXX', 'Lastname, Firstname XX...', 'XXXX', 'MM/DD/YYYY', 'MM/DD/YYYY', 'MM/DD/YYYY', 'XXXXXXXXXX', 'XX', 'X.XXXX', and 'XXXXXXXXX View Certificate'.

Figure 27: Image showing all web-submitted authorizations for the selected provider.

Review Office Manuals

1. Open the menu in the upper-left corner.
2. Select “Providers” and then “Provider Resources.”
3. From the drop-down menu choose “Office Manuals.”
4. From here, you can expand the “Plan Specifics” tab to locate the contracted plan manuals available to your office.

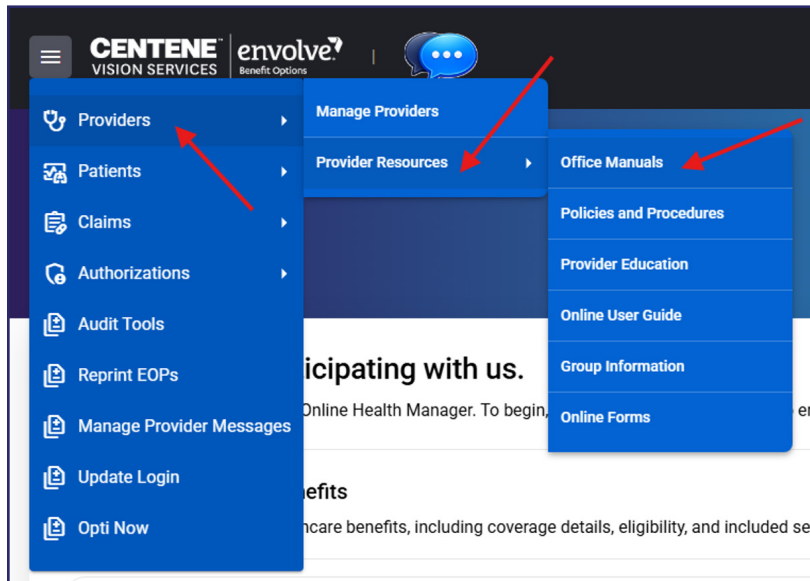


Figure 28: Path to view contracted plan manual available to your office.

Review Policies and Procedures

Open the menu and go to **Providers** → **Provider Resources** → **Policies and Procedures** to review available policy documents.

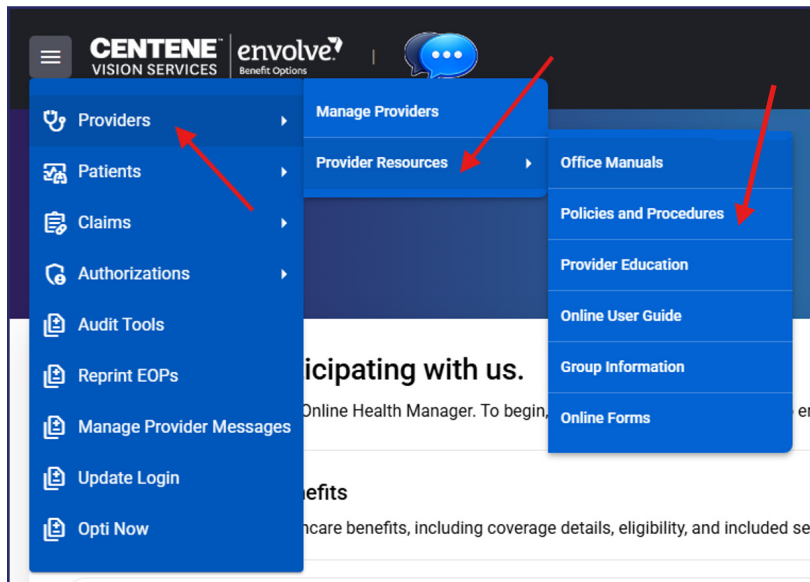


Figure 29: Path to view Policies and Procedures.

Activate/Deactivate Providers

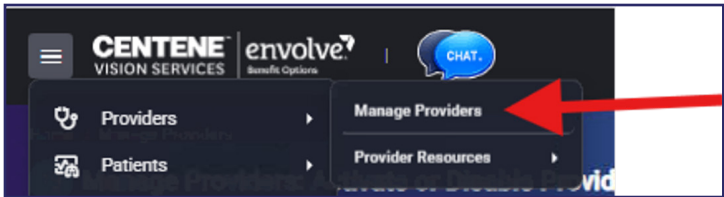


Figure 30: Arrow showing how to go to the “Manage Providers” list to activate/deactivate providers.

To activate or deactivate a provider, open the menu in the upper-left corner, select “Providers” and “Manage Providers” (see Figure 30). Select **Activate/Disable** in the *Action* column. You can also use **Activate All** or **Disable All** to update multiple providers at once. A confirmation message appears when the action is complete.

Examples

- If a provider is currently Disabled and should be made active, select the option shown for activation (See Figure 31).

A screenshot of a table with columns: Row#, Provider Name, Npi #, Verified, Active, and Action. The first row shows a provider named SMITH, JOHN with a disabled status (indicated by a red 'X' in the Active column). A red arrow points to the 'Activate' button in the Action column.

Row#	Provider Name	Npi #	Verified	Active	Action
1	SMITH, JOHN	XXXXXXXXXX	✓	✗	<button>Activate</button>

Figure 31: An example of a deactivated provider and where to click in the Action column to activate the provider.



Figure 32: Pop-up that the provider has been activated.

- If a provider is currently Activated and should be made inactive, select the option shown for deactivation (see Figure 33).

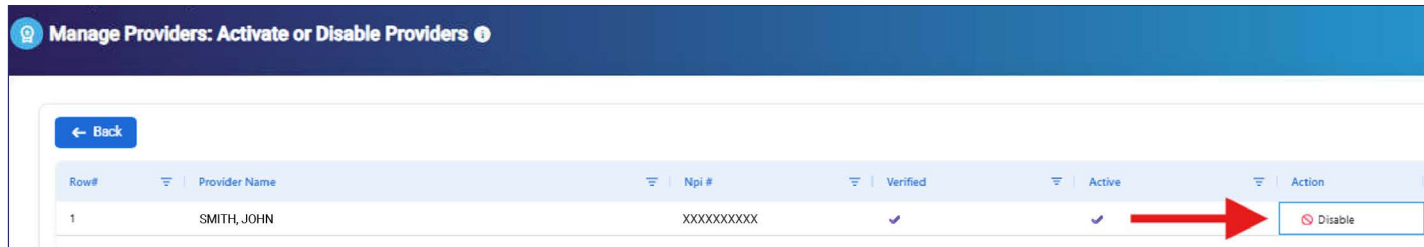


Figure 33: An example of an active provider and where to click in the Action column to deactivate the provider.



Figure 34: Pop-up that the provider has been disabled.

- To update all listed providers at once, use the bulk action options shown below (See Figure 35).

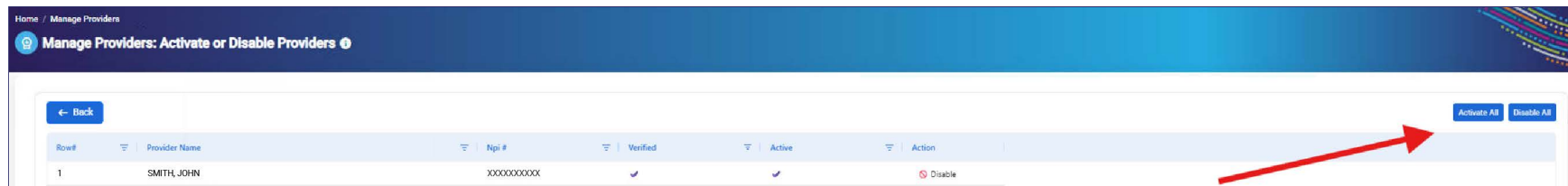


Figure 35: The arrow shows how you can bulk activate or deactivate providers.

Update Login Information

Users can update their password within the portal. Email addresses and usernames cannot be changed in the portal and require Customer Service support. To contact, please visit centenevision.com/mystate to find the appropriate phone number for your plan/market.

Revision Table

Change Description	Revision Date	Effective Date
Initial Draft	6/9/2026	
Design Completed	6/17/2026	