ND Health Enterprise MMIS Medical Travel/Lodging Claim Form Instructions (SFN 1731)

These instructions address the North Dakota Health Enterprise MMIS paper claim requirements.

You must be an enrolled ND Medicaid provider to submit a claim. If you are not an enrolled provider, you can apply at: https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment.

Enrollment instructions, updates, billing manuals, and companion guides are available online at http://www.nd.gov/dhs/info/mmis.html.

Questions

If you have any questions, please email ND Medicaid at MMISinfo@nd.gov or call the ND Health Enterprise MMIS Call Center at 1-877-328-7098.

Claims Mailing Address

ND Department of Human Services
Medical Services Division
Department 325
600 East Boulevard Ave
Bismarck, ND 58505-0250

Field Requirement Definitions

Required

Fields marked **Required** in the claim form instructions are required on all paper claim submissions. The claim will be denied if a **Required** field is incomplete.

Situational

Fields marked *Situational* are required when they apply to the claim.

Field	Requirement	Field Name and Description
1	**Required**	Health Enterprise Provider ID: Enter your 7-digit provider number. NOTE: Do not use your old provider
2	**Required**	Provider Name (Last, First, MI)
3	**Required**	Member ID Number: Enter the member's 9-digit member ID. Must include preceding zeroes.
4	**Required**	Member Name (Last, First, MI)
5	*Situational*	Prior Authorization Number: Enter the 12-digit authorization number if you are submitting a claim for a service that was prior authorized. Otherwise, leave this field blank.
6	**Required**	• Billing Period: Enter the billing period in MM DD YYYY format. For example; 01 01 2016 • Through (Billing Date): Enter the through date in MM DD YYYY format. For example; 01 02 2016 Bill each month separately on a different claim form.
7	**Required**	Procedure Code: All 5 digits are required.
8	**Required**	From Day: Enter the begin date of service.
9	**Required**	Through Day: Enter the end date of service. If a service was provided on one day only, enter the same date in both the From Day and Through Day fields.
10	**Required**	Units: Enter the number of units being billed. Enter units as a whole number; do not use decimals.
11	**Required**	Billed Amount: Enter your usual and customary charge for the procedure code on each claim line.
12	**Required**	Comments: Shall include where the recipient was picked up, where the recipient was transported to (the facility name and location), and where the recipient was returned to.
13	*Situational*	Original Claim Number: Complete this field to replace or void a previously paid claim (including a zero paid claim). Otherwise, leave this field blank. Resubmitting a denied claim is not considered a replacement. • Check the appropriate box for replacement or void. • If replacing a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim. • If replacing a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim. Example: Legacy ICN: 1015015320010 Replaced Legacy ICN: 10**20**15015320010
14	**Required**	Signature and Date: Required to be completed by the medical travel/lodging provider.

MEDICAL TRAVEL/LODGING BILLING FORM

North Dakota Department of Human Services
SFN 1731

1

Provider ID

5

Prior Authorization Number

6

Billing Period:

M M / D D / Y Y Y Y

through

M M / D D / Y Y Y Y

Provider Name (Last, First, MI) 2

Member ID Number 3

Member Name (Last, First, MI) 4

7 Procedure Code	8 From Day	9 Through Day	10 Units	11 Billed Amount	12 Comments
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Use only when correcting claims

Original Claim Number: 13

☐ **Void**

☐ **Replacement**

47442

Providers: Please Retain a copy for your records.

Certification and Agreement of Providers: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and accept, as payment in full, the amounts paid, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable federal or state laws. That the services herein charged were actually rendered and were rendered under the conditions specified; and that no part of such bill, claim, account or demand has been paid. That the services provided and billed for qualify for federal participation under 42 USC 1396 (A) ET. SEQ. and that rules and regulations promulgated and adopted thereunder. I further certify that goods and services hereby designated are furnished without discrimination as to age, sex, race, color, national origin, political affiliation or handicap. I agree to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the state plan and to furnish the state agency with such information, regarding any payments claimed by such person or institution forproviding services under the state plan, as the state agency may from time to time request.

14 Provider Signature: _____ Date: _____