



ND MMIS INSTITUTIONAL WEB PORTAL TRAINING

LAURA HOLZWORTH, MEDICAL SERVICES DIVISION



Health & Human Services

ND MMIS Web Portal Institutional Claim Form Submission Instructions



Go to

<https://mmis.nd.gov/portals/wps/portal/EnterpriseHome>



Home

Program ▶

Member ▶

Provider ▶

Documentation ▶

Directories ▶



Welcome Print | - □

Welcome to the North Dakota MMIS Web Portal.

ND MMIS has established a scheduled maintenance window for calendar year 2019 from 9:00PM to 4:00AM Central Time on the 2nd Thursday of the month with the following exceptions: Jan 17, Apr 17, May 16, Nov 7, and Dec 19. During the maintenance window, the

Provider Registration - □

To obtain a user id and password, Providers and Trading Partners must have an approved enrollment with North Dakota and have received their Provider or Trading Partner ID.

[Register](#)

Quick Links - □

- [FAQ](#)
- [Find a Healthcare Provider](#)
- [Benefits Overview](#)
- [Provider Enrollment](#)
- [Report Fraud & Abuse](#)

Sign In - □

Log into the system based upon your role:

- [Providers](#)
- [Internal Users](#)

➤ Sign In - Provider



Quick Links

- Enrollment
- ProviderManuals
- FAQ
- Billing Manuals
- Messages & Announcements

News

Governor's Task Force on Access to Affordable Health Insurance.

ND MMIS has established a scheduled maintenance window for calendar year 2019 from 9:00PM to 4:00AM Central Time on the 2nd Thursday of the month with the following exceptions: Jan 17, Apr 17, May 16, Nov 7, and Dec 19. During the maintenance window, the system may not be accessible.

Provider

The Health Enterprise Portal is a state-of-the-art electronic health care administration system that gives patients, doctors, pharmacists and other users easy, secure and efficient access to health care information.

ProviderLogin

To access secure areas of the portal, please log in by entering your User ID and Password.

* User ID:

* Password:

[Forgot User Name or Password ?](#)

- **Provider Login**
 - **USER ID** and **Password**



[Home](#) |
 [Member](#) |
 [Provider](#) |
 Claims |
 [EDI](#) |
 [Authorizations](#) |
 [My Account](#) |
 [FES](#)

- Create Claims**
 - Create Professional Claim
 - Create Institutional Claim**
 - Create Dental Claim
 - Create Claim from Template
 - Create Claim from Processed Claim
 - Travel/Lodging Claim
 - HCBS/DD Claim
- Manage Claims
- Create Templates
- Manage Templates
- Claim Status Inquiry
- Payment Inquiry
- 1099 Inquiry
- Pharmacy Claims

Quick Links [Print](#) | [-](#)

- [Add Service Location](#)
- [Trading Partner Enrollment](#)
- [Provider Manuals](#)
- [Provider Inquiry/Update Request](#)
- [Provider Training Registration](#)
- [Provider FAQ](#)
- [Provider Resources](#)
- [Messages & Announcements](#)
- [EFT Enrollment](#)
- [ERA Enrollment](#)

Provider Message [Print](#) | [Help](#) | [-](#) | [Delete](#)

Status [^](#) [v](#)

Subject [^](#) [v](#)

New Document for Online Viewing:

1-1 of 1

If you are unable to view PDFs, please [download Adobe Reader](#).

➤ **Submit a Claim**

- Claims
- Create Claims
- Create Institutional Claim

Basic Claim Info

Other Claim Info

[Provider](#) [Member](#) [Basic Claim](#) [Service Line Items](#)

? Is this a void/replacement?

 Yes No

Submitter Information

Submitter ID

XXXXXXXXXX

➤ New Institutional Claim

- Is this a void/replacement?
 - ✓ Defaults to "No."
 - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim.

Basic Claim Info

Other Claim Info

[Provider](#) [Member](#) [Basic Claim](#) [Service Line Items](#)

? Is this a void/replacement?

 Yes No

Claim Resubmission Information

*Resubmission Type Code

Replacement
Void

*TCN to Void/Replace

Note: For Void/Replacement of a Claim, prior claim data (if available) will populate once the user has either a) tabbed out of the TCN field, or b) selected another field on this page.

➤ New Institutional Claim

- Is this a void/replacement?
 - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim.
 - ✓ Resubmission Type Code – Replacement or Void
 - ✓ TCN to Void/Replace

Basic Claim Info

Other Claim Info

[Provider](#) [Member](#) [Basic Claim](#) [Service Line Items](#)

? Is this a void/replacement?

 Yes No

Submitter Information

Submitter ID

XXXXXXXXXX

Provider Information

Go to [Other Claim Info](#) to enter information for other providers.

Billing Provider

Note: Healthcare Providers are required to submit National Provider ID.

Medicaid Provider ID

XXXXXXXXXX

National Provider ID

XXXXXXXXXX

Taxonomy Code

*Tax ID

Location Number

- **Enter** - Billing Provider Taxonomy Code
- **Enter** - Billing Provider Tax ID or SSN Number

Additional Billing Provider Information

Currency Code

*Org/Last Name

*Address 1

*City

State

Zip and Extension

Country

Subdivision Code

Address 2

➤ **Additional Billing Provider Information**

- **REQUIRED**

- **Enter** – Org/Last Name, Address, City, State and Zip Code

? Is the Billing Provider Address also the Pay-To Address?

Yes No

Pay-To Address

*Address 1

*City

State

Zip and Extension

Country

Subdivision Code

Address 2

➤ Is the Billing Provider also the Pay-To Address?

- **Required** - Defaults to "Yes"
- Pay-To Address is **different**, select "**No**"
 - ✓ Complete the Pay-To Address section with the Address, City, State and Zip Code

Attending Provider

Medicaid Provider ID National Provider ID Taxonomy Code Location Code

Additional Attending Provider Information

*Org/Last Name First Name MI Suffix

Secondary IDs

➤ **Attending Provider**

- **Required**
- Medicaid Provider ID, National Provider ID and Taxonomy

➤ **Additional Attending Provider Information**

- **Required**
- Org/Last Name, First Name, MI and Suffix

Member Information

*Member ID	*Last Name	First Name	MI	Suffix	*Date of Birth	*Gender	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Property Casualty Number							
<input type="text"/>							

➤ Member Information

- **REQUIRED**
- **Enter** - Member's 9-digit ID number
- **Enter** - Member's Last Name
- **Enter** - Member's First Name
- **Enter** - Member's Date of Birth
 - ✓ Use format: MM/DD/YYYY
- **Enter** - Member's Gender
 - ✓ F = Female
 - ✓ M = Male

[Member Address](#)

*Address 1 *City State Zip and Extension Country Subdivision Code

Address 2

➤ Member Address

- **REQUIRED**
- **Enter** - Member's Address, City, State and Zip Code

Other Insurance Information

? *Does the member have other insurance?

Yes No

- **Does the member have other insurance?**
 - **Yes or No**
- **If “No” - member does not have other insurance – proceed to slide 28**
- **If “Yes” - member has other insurance– proceed to slide 15**

Other Insurance Information

? *Does the member have other insurance?

Yes No

Note: Please go to the [Other Claim Info Tab](#) in the Coordination of Benefits Section.

➤ **Other Insurance Information**

- **REQUIRED**
- Does the member have other insurance?
- Select "Yes"
- Click and complete the **Other Claim Info Tab** with the Other Insurance information

Coordination of Benefits

Go to [Basic Claim Info](#) to enter basic claim information.

Other Insurance

Other Insurance

Add Other Insurance

Sequence Number ▾	Subscriber ID ⇅	Payer/Carrier ID ⇅	Payer/Insurance Org Name ⇅	Payer Paid Amount ⇅
No Data				

Submit Claim

Save Claim

Reset

Cancel

➤ Coordination of Benefits

- **REQUIRED**
- Other Insurance
- Add Other Insurance

Other Subscriber

*Entity Qualifier

*Subscriber ID

*Last Name

First Name

MI

Suffix

SSN

➤ New Other Insurance

- **REQUIRED**
- **Other Subscriber**
- Entity Qualifier – Non-Person
- Subscriber ID – Member's Primary Insurance ID number
- Last Name – Member's Last Name

Other Subscriber Information

*Relation to Individual

Claim Filing Code

Group or Policy Number

Cadaver Donor
 Child
 Employee
 Life Partner
 Organ Donor
 Other Relationship
 Self
 Spouse
 Unknown

Claim Filing Code

Automobile Medical
 Blue Cross/Blue Shield
 Champus
 Commercial Insurance Co.
 Dental Maint Org (DMO)
 Disability
 Exclusive Provider Organization (EPO)
 Federal Employee Program
 Health Maint Org (HMO) Medicare Risk
 Health Maintenance Organization
 Indemnity Insurance
 Liability
 Liability Medical
 Medicaid
 Medicare Part A
 Medicare Pt B
 Mutually Defined/Unknown
 Other Federal Program
 Other Non-Federal Programs
 Point of Service (POS)
 Preferred Provider Organization (PPO)
 Title V
 Veteran Administration Plan
 Workers' Compensation Health Clm

➤ Other Subscriber Information

- **REQUIRED**
- Relation to Individual
- Claim Filing Code
- Group or Policy number

Other Subscriber Information

*Relation to Individual

Claim Filing Code

Group or Policy Number

*Payer Responsibility Seq # Code

Group or Plan Name

Payer Responsibility Eight
Payer Responsibility Eleven
Payer Responsibility Five
Payer Responsibility Four
Payer Responsibility Nine
Payer Responsibility Seven
Payer Responsibility Six
Payer Responsibility Ten
Primary
Secondary
Tertiary
Unknown

➤ Other Subscriber Information Cont.

- **REQUIRED**
- Payer Responsibility Seq # Code
- Group or Plan Name

Other Insurance Coverage

*Release of Information Code

Informed Consent to Release Information
Yes, Provider has signed statement

➤ Other Insurance Coverage

- **REQUIRED**
- Release of Information Code
- Select appropriate value

Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes

Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

Other Payer - Including Medicare A and B

*Payer/Carrier ID Qualifier


*Payer/Carrier ID

*Payer/Insurance Organization Name

➤ **Other Payer – Including Medicare A and B**

- Payer/Carrier ID Qualifier – Select Payer Identification
- Payer/Carrier ID – Insurance Payer/Carrier ID number
 - **Medicare and Medicare Advantage plans need to use Payer/Carrier ID of 0000003302**
- Payer/Insurance Organization Name – Insurance Name

Additional Other Payer Information

*Address 1 <input type="text"/>	*City <input type="text"/>	State <input type="text" value="▼"/>	Zip and <input type="text"/>	Extension <input type="text"/>	Country <input type="text"/>	Subdivision Code <input type="text"/>
Address 2 <input type="text"/>						
Adjudication Date <input type="text" value=""/> 	Authorization Number <input type="text"/>	Referral Number <input type="text"/>	Claim Control Number <input type="text"/>			

Payer Claim Adjustment:

➤ **Additional Other Payer Information**

- Adjudication Date

COB Monetary Amounts

Payer Paid Amount

\$ (TPL Amount)

Remaining Patient Liability

\$

Non-Covered Charge Amount

\$

➤ **COB Monetary Amounts**

- Payer Paid Amount
- Remaining Patient Liability
- Non-Covered Charge Amount

Other Subscriber

*Entity Qualifier

*Subscriber ID

*Last Name

First Name

MI

Suffix

SSN

➤ **New Other Insurance**

- **REQUIRED**

- Scroll to the top of **New Other Insurance** section

➤ **SAVE**

Other Insurance

Other Insurance
System successfully saved the Information.

Add Other Insurance

Sequence Number	Subscriber ID	Payer/Carrier ID	Payer/Insurance Org Name	Payer Paid Amount
1	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	

1 - 1 of 1

Submit Claim Save Claim Reset Cancel

➤ System successfully saved the Information

- Verify the Insurance was added
- Sequence Number
- Subscriber ID
- Payer/Carrier ID
- Payer/Insurance Org Name
- Repeat slides 16 – 24 if member has more than 1 payer

Other Insurance

System successfully saved the Information.

Add Other Insurance

Sequence Number	Subscriber ID	Payer/Carrier ID	Payer/Insurance Org Name	Payer Paid Amount
1	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	

1 - 1 of 1

Submit Claim

Save Claim

Reset

Cancel

➤ Save Claim

Basic Claim Info

Other Claim Info

➤ **Navigate to the Basic Claim Info Tab**

Faxing in an Attachments

Yes No

Does this claim have Attachments?

Claim Attachments

Add Attachment

Type Attachment	Delivery Method	Attachment Control #
No Data		

➤ Does this claim have Attachments?

- Yes or No
 - ✓ Yes
 - ✓ Add Attachment

New Attachment

*Type Attachment

*Delivery Method

Attachment Control #

- Admission Summary
- Allergies/Sensitive Document
- Ambulance Certification
- Autopsy Report
- Baseline
- Benchmark Testing Results
- Blanket test Results
- Certification
- Certified Test Report
- Chemical Analysis
- Chiropratic Justificaiton
- Consent Form
- Continued Treatment
- Death Notificaiton
- Dental Models
- Diagnostic Report
- Discharge Mont Report
- Discharge Summary**
- DME Prescription
- Drug Administered
- Drug Profile Document
- Explanation Of Benefits
- Funtional Goals
- Health Certificate
- Health Clinic Record
- Immunization Record
- Initial Assessment

➤ Type Attachment

- Select the appropriate type of attachment
 - ✓ Example: Discharge Summary

New Attachment **Save** | Reset | Cancel

*Type Attachment *Delivery Method Attachment Control #

- Available on Request
- By Mail
- E-mail
- Electronic Only
- Facsimilie**
- File Transfer

➤ **Delivery Method**

- Select the Facsimilie
- Faxed documentation needs to have a SFN177 cover form
- SFN 177 link: <https://www.nd.gov/eforms/Doc/sfn00177.pdf>

➤ **SAVE**

➤ **Claim Submitted Confirmation Page may be substituted for the SFN 177**

MMIS ATTACHMENT COVER SHEET – SFN 177



MMIS ATTACHMENT COVER SHEET
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 177 (6-2015)

Clear Fields

Complete this form and include it as the cover sheet for all attachments or additional documentation being submitted to the North Dakota Department of Human Services Medicaid.

Provider NPI or Medicaid Number
Member Medicaid Number
Corresponding Record Number

Type of Attachment (select only one)	
<input type="checkbox"/> Claim	
Transaction Control Number (TCN)	Fax To: 701-328-0374
<input type="checkbox"/> Service Authorization (SA)	
Service Authorization (SA) Number	Fax To: 701-328-1544
<input type="checkbox"/> Referral	
Referral Number	Fax To: 701-328-1544
<input type="checkbox"/> Other	
Description	Fax To: 701-328-1544



Required

- Provider NPI or Medicaid Number
- Member Medicaid Number
- Type of Attachment – **Select only one**
 - ✓ Claim - Transaction Control Number (TCN)
 - ✓ Service Authorization (SA) – SA Number
 - ✓ Referral – Referral Number
 - ✓ Other - Description

Mail to:

North Dakota Department of Human Services
MMIS Attachments
600 East Blvd Ave.
Bismarck, ND 58505

Telephone Number: 1-877-328-7098

Electronic Only in an Attachment

Does this claim have Attachments?
 Yes No

Claim Attachments

[Add Attachment](#)

Type Attachment ▾	Delivery Method ⇅	Attachment Control # ⇅
No Data		

➤ Does this claim have Attachments?

- Yes or No
 - ✓ Yes
 - ✓ Add Attachment

New Attachment

*Type Attachment

*Delivery Method

Attachment Control #

- Admission Summary
- Allergies/Sensitive Document
- Ambulance Certification
- Autopsy Report
- Baseline
- Benchmark Testing Results
- Blanket test Results
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- Certified Test Report
- Chemical Analysis
- Chiropratic Justificaiton
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- Death Notificaiton
- Dental Models
- Diagnostic Report
- Discharge Mont Report
- Discharge Summary**
- DME Prescription
- Drug Administered
- Drug Profile Document
- Explanation Of Benefits
- Funtional Goals
- Health Certificate
- Health Clinic Record
- Immunization Record
- Initial Assessment

➤ Type Attachment

- Select the appropriate type of attachment
 - ✓ Example: Discharge Summary

*Type Attachment

*Delivery Method

Available on Request
By Mail
E-mail
Electronic Only
Facsimile
File Transfer

Attachment Control #

- **Delivery Method**
 - Select the Electronic Only

- **Save**

? Does this claim have Attachments?

Yes No

Claim Attachments

System successfully saved the Information.

Add Attachment

Type Attachment ▾

Delivery Method ⇅

Attachment Control # ⇅

[Discharge Summary](#)

Electronic Only

2589

1 - 1 of 1

- **Save – System successfully saved the Information**
- **Scroll down to Other Insurance Information**

Other Insurance Information

? *Does the member have other insurance?

Yes No

Other Insurance Information

? *Does the member have other insurance?

Yes No

Claim e-Attachments

Add e-Attachment

Date Added ▾

Added By ▾

File Name ▾

Description ▾

No Data

➤ Claim e-Attachment

- Add e-Attachment

Claim e-Attachments

Add e-Attachment

Date Added ▾ Added By ▾ File Name ▾ Description ▾

Add e-Attachment

Save Reset|Delete|Cancel

* File Name

Browse...

* Description

- **File Name**
 - **Cannot** be more than 55 characters
 - **Cannot** have special characters: example !@#\$
- **Select Browse**
 - Insert/select file that is saved to your computer
- **Description**
 - Content of attachment: example Periodontal Chart
- **SAVE**

Add e-Attachment Save | Reset | Delete | Cancel

* File Name
TEST.pdf Browse...

* Description
Discharge Summary

➤ File Name

- **Cannot** be more than 55 characters
- **Cannot** have special characters: example !@#\$

➤ Select Browse

- Insert/select file that is saved to your computer

➤ Description

- Content of attachment: example Periodontal Chart

➤ SAVE

System successfully saved the Information.

Date Added ▾	Added By ▾	File Name ▾	Description ▾
04/12/2022		TEST.pdf	Discharge Summary

➤ **Save – System successfully saved the Information**

➤ **Note:** If resubmitting/adjusting a claim, all documents need to be attached again.

? Does this claim have Attachments?

Yes No

Claim Attachments

System successfully saved the Information.

Add Attachment

Type Attachment ▾

Delivery Method ▾

Attachment Control # ▾

[Discharge Summary](#)

Electronic Only

2589

Claim e-Attachments

Add e-Attachment

System successfully saved the Information.

Date Added ▾

Added By ▾

File Name ▾

Description ▾

[04/12/2022](#)

TEST.pdf

Discharge Summary

- **Save – System successfully saved the Information**
- **Claim Attachment and Claim e-Attachment must be completed**
- **Note:** If resubmitting/adjusting a claim, all documents need to be attached again.

Claim Information


Go to [Other Claim Info](#) to include the following claim level information:
Specialized Services, Misc. Claim, Service Facility, Coordination of Benefits and Adjustments.

Claim Data

*Statement From Date



*Statement To Date



*Total Claim Charge Amount

\$

*Patient Account#

*Type of Bill

First 2 Type of Bill digits.

*Claim Frequency Code

Last Type of Bill digits; automatically populated on resubmission.

➤ Claim Data Information

➤ Claim Data

- **REQUIRED** – regardless if there is a red asterisk by the field
- Statement From Date and Statement To Date
 - ✓ Use format: MM/DD/YYYY
- Total Claim Charge Amount
 - ✓ Enter the total amount billed

*Patient Account#

*Type of Bill
 First 2 Type of Bill digits.

*Claim Frequency Code
 Last Type of Bill digits; automatically populated on resubmission.

83
75
74
76
85
84
73
72
11
32
34
33
81
82
12
79
14
13
86
71
21
18

1
2
4
3
7
8

➤ Claim Data Information

- Patient Account # - Enter the internal patient account number will print on remittance advice
- Type of Bill – First 2 digits of the Type of Bill
- Claim Frequency Code – last digit of the Type of Bill

The image shows a screenshot of a form with two rows of fields. The first row contains three dropdown menus: '*Patient Status', 'Admission Type', and 'Admission Source'. The second row contains two time/date input fields: 'Admission Date / Hour:Minute' and 'Discharge Hour:Minute'. The 'Admission Date / Hour:Minute' field includes a calendar icon and 'hh ; mm' input boxes. The 'Discharge Hour:Minute' field includes 'hh ; mm' input boxes. A red border highlights the first row, and a red border highlights the second row.

➤ Claim Data Information

- **REQUIRED** – regardless if there is a red asterisk by the field
- Patient Status
- Admission Type
- Admission Source
- Admission Date/Hour:Minute
 - ✓ Use date format: MM/DD/YYYY. Use military format: HH:MM
- SITUATIONAL – Discharge Hour:Minute
 - ✓ If patient is other than "Still a Patient" you must enter the hour:minute the member was discharged. Use military format: HH:MM

*Medicare Assignment Code

*Benefits Assignment Certification



*Release of Information Code



➤ Claim Data Information

- **REQUIRED**
- Medicare Assignment Code
- Benefits Assignment Certification
- Release of Information Code

Service Authorization #

Referral #

➤ **Service Authorization**

- **REQUIRED – if applicable**
- Service Authorization Number
- Referral Number

Condition Information

Add Condition Code

Condition Code ▾

No Data

New Condition Code **Save** Reset | Cancel

*Condition Code

➤ Condition Information

➤ Add Condition Code

- **REQUIRED** – if applicable
- Condition Code
- **Save**


Occurrence Code Information

Add Occurrence

Occurrence Code	Occurrence Date
No Data	

New Occurrence **Save** Reset | Cancel

*Occurrence Code

*Occurrence Date 

➤ Occurrence Code Information

➤ Add Occurrence

- **Required – if applicable**
- Occurrence Code
- Occurrence Date
- **Save**


Occurrence Span Information


Add Occurrence Span

Occurrence Span Code	Begin Date	End Date
No Data		

New Occurrence Span Code **Save** | Reset | Cancel

*Occurrence Span Code

*Begin Date 

*End Date 

➤ Occurrence Span Information

➤ Add Occurrence Span

- **Required – if applicable**
- Occurrence Span Code
- Begin Date
- End Date
- **Save**

The screenshot shows a web form titled "Value Information". At the top right is an "Add Value" button. Below it is a table with a blue header containing "Value Code" and "Value Amount". The table body contains the text "No Data". Below the table is a "New Value" section with a "Save" button and "Reset | Cancel" links. Two input fields are present: "*Value Code" and "*Value Amount" with a dollar sign prefix. Red boxes highlight the "Value Information" title, the "Add Value" button, the "Save" button, and both input fields.

➤ Value Information

➤ Add Value

- **REQUIRED – if applicable**
- Value Code - 80 = Covered Days
- Value Amount - Value Amount should be entered as a dollar amount
 - ✓ Example: 30 days = 30.00
- **Save**

Diagnosis Information

Version #

ICD-09 ICD-10

*Principal Diagnosis Code

Principal Diagnosis POA Code

Admitting Diagnosis Code

➤ Diagnosis Information

- **REQUIRED**
- **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
- **Principal Diagnosis Code**
 - ✓ Enter the diagnosis code for the member's primary diagnosis
- **Principal Diagnosis POA Code – if applicable**
- **Admitting Diagnosis Code – if applicable**

➤ Other Diagnosis

➤ Add Other Diagnosis

- **REQUIRED – if applicable**
- **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
- **Other Diagnosis Code - Additional Diagnosis Codes**
 - ✓ Enter the diagnosis code for the member's additional diagnosis's
- **POA Code - if not applicable – select Clinically undetermined**
- **Save**

External Cause of Injury Diagnosis Code

Cause **Add Cause**

E-Code ▾	POA Code ▾
No Data	

New Cause **Save** | Reset | Cancel

Version # ICD-09 ICD-10

*E-Code

*POA Code

- Clinically undetermined
- Documentation insufficient to determine
- Dx not present at time of inpt admit
- Dx present at time of inpt admit

➤ External Cause of Injury Diagnosis Code

➤ Add Cause

- **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
- Enter E-Code
- POA Code
- **Save**

Procedure Information

Version #

ICD-09 ICD-10

Principal Procedure Code

Procedure Date



➤ Procedure Information

- **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
- Principal Procedure Code
- Procedure Date

Other Procedure Code

Other Procedure Date

No Data

New Other Procedure

Save Reset | Cancel

Version #

ICD-09 ICD-10

*Other Procedure Code

*Other Procedure Date

➤ Other Procedure Information

➤ Add Other Procedure

- **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
- Other Procedure Code
- Other Procedure Date
- **Save**

Billing Note

Billing Note Text

80 Characters Remaining

➤ **Billing Note**

- Add any pertinent information
 - ✓ Example Note: Proving the One-Year Timely Filing Limit Policy Remittance Advice (RA) Date and TCN Number

? Does this claim have Attachments?

Yes No

Claim Attachments

Add Attachment

Type Attachment ▾

Delivery Method ⇅

Attachment Control # ⇅

No Data

➤ Does this claim have Attachments?

- Yes

➤ Add Attachment

- Add Attachment

New Attachment

*Type Attachment

*Delivery Method

Attachment Control #

- Admission Summary
- Allergies/Sensitive Document
- Ambulance Certification
- Autopsy Report
- Baseline
- Benchmark Testing Results
- Blanket test Results
- Certification
- Certified Test Report
- Chemical Analysis
- Chiropratic Justificaiton
- Consent Form
- Continued Treatment
- Death Notificaiton
- Dental Models
- Diagnostic Report
- Discharge Mont Report
- Discharge Summary
- DME Prescription
- Drug Administered
- Drug Profile Document
- Explanation Of Benefits
- Funtional Goals
- Health Certificate
- Health Clinic Record
- Immunization Record
- Initial Assessment

➤ New Attachment

- Type Attachment
- Select the appropriate type of attachment
 - ✓ Example: Explanation of Benefits – members other insurance EOB

New Attachment **Save** | Reset | Cancel

*Type Attachment *Delivery Method Attachment Control #

- Available on Request
- By Mail
- E-mail
- Electronic Only
- Facsimilie**
- File Transfer

➤ **New Attachment**

- Delivery Method
- Select the Facsimilie – fax into the appropriate number
- Faxed documentation needs to have a SFN177 cover form
- SFN 177 link: <https://www.nd.gov/eforms/Doc/sfn00177.pdf>

➤ **SAVE**

➤ **Claim Submitted Confirmation Page may be substituted for the SFN 177**

MMIS ATTACHMENT COVER SHEET – SFN 177



MMIS ATTACHMENT COVER SHEET
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 177 (6-2015)

Clear Fields

Complete this form and include it as the cover sheet for all attachments or additional documentation being submitted to the North Dakota Department of Human Services Medicaid.

Provider NPI or Medicaid Number

Member Medicaid Number

Corresponding Record Number

Type of Attachment (select only one)

Claim

Transaction Control Number (TCN)

Fax To:

701-328-0374

Service Authorization (SA)

Service Authorization (SA) Number

Fax To:

701-328-1544

Referral

Referral Number

Fax To:

701-328-1544

Other

Description

Fax To:

701-328-1544

Required

- Provider NPI or Medicaid Number
- Member Medicaid Number

• Type of Attachment – Select only one

- ✓ Claim - Transaction Control Number (TCN)
- ✓ Service Authorization (SA) – SA Number
- ✓ Referral – Referral Number
- ✓ Other – Description
- ✓ Fax to the appropriate phone number

Mail to:

North Dakota Department of Human Services
MMIS Attachments
600 East Blvd Ave.
Bismarck, ND 58505

Telephone Number: 1-877-328-7098

Service Date Begin <input type="text"/>	Service Date End <input type="text"/>	*Revenue Code <input type="text"/>	Procedure Code <input type="text"/>	Modifiers 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>
*Unit Qualifier <input type="text"/>	*Service Units <input type="text"/>	*Line Item Charge Amount \$ <input type="text"/>	Non-Covered Line Charges \$ <input type="text"/>	Procedure Description <input type="text"/>

[+ Additional Service Line Information](#)

? Is there additional line-specific information/TPL to be entered?
 Yes No

➤ New Line Item

- Service Date Begin – Use Format: MM/DD/YYYY
- Service Date End – Use format: MM/DD/YYYY
- Revenue Code
- Procedure Code – if applicable
- Unit Qualifier
- Service Units
- Line Item Charge Amount
- Non-Covered Line Charges – if applicable

New Line Item Save Save & Add Other Svc Info/TPL Reset Cancel

? Is there additional line-specific information/TPL to be entered?
 Yes No

Submit Claim Save Claim Reset Cancel

- **Is there Additional line-specific information/TPL to be entered?**
 - **No** – member does not have other insurance
 - **Save – New Line Item**
- **SAVE CLAIM**
- **SUBMIT CLAIM**

New Line Item Save Save & Add Other Svc Info/TPL Reset Cancel

? Is there additional line-specific information/TPL to be entered?
 Yes No

- **Is there Additional line-specific information/TPL to be entered?**
 - **Yes** – Member has Other Insurance – proceed to **Slide 63** for instructions
 - **Save & Add Other Svc Info/TPL**

TCN: [REDACTED]

Your claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

Claim Information

TCN: [REDACTED]
 Date of Service: 03/20/2020 - 03/20/2020
 Provider #: [REDACTED]
 Member ID: [REDACTED]

Claim Status: C - To Be Dnd

Total Charge: \$500.00

*To Be Paid Amount: \$0.00

*Co-Payment: \$0.00

*Total Recipient Liability: \$0.00

Submission Date/Time: 08/14/2020 2:49:11 PM CDT

*This may not be the actual amount. Please refer to your remittance advice for detailed payment information.

Adjustment Reason Codes

Line #	Adjustment Reason Code	Description
0	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
0	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

1 - 2 of 2

Remark Codes

Line #	Remark Code	Description
0	N253	Missing/incomplete/invalid attending provider primary identifier.

➤ **Print and Save for your records**

New Line Item Save **Save & Add Other SvcInfo/TPL** Reset | Cancel

Service Date Begin <input type="text"/>	Service Date End <input type="text"/>	*Revenue Code <input type="text"/>	Procedure Code <input type="text"/>	Modifiers 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>
*Unit Qualifier <input type="text"/>	*Service Units <input type="text"/>	*Line Item Charge Amount \$ <input type="text"/>	Non-Covered Line Charges \$ <input type="text"/>	Procedure Description <input type="text"/>

[+ Additional Service Line Information](#)

? Is there additional line-specific information/TPL to be entered?
 Yes No

NOTE: Click the Save & Add Other Svc Info/TPL link to enter line-level TPL amounts, and to include the following line-level information: Service Line Information, Service Line Provider Information, and Other Payer Service Line Information.

- **Is there Additional line-specific information/TPL to be entered?**
- **Yes** – Member has Other Insurance
 - **Save & Add Other Svc Info/TPL**

System successfully saved the Information.

Ln #:1

Submit Claim

Save & Return to Basic Service Line Item

Save Claim

Reset

Cancel

➤ New Institutional Claim

- System successfully saved the Information
 - ✓ **Line # 1**

Other Payer Service Line Information

Other Payer Service Information

Other Payer Service Information

Add Other Payer Service Information

Sequence Number ▾

Other Payer Primary ID ⬆

Procedure Code ⬆

Paid Service Unit Count ⬆

Service Line Paid Amount ⬆

Adjudicated or Pay Date ⬆

No Data

➤ Other Payer Service Line Information

- Add Other Payer Service Information

Service Line Adjudication

Sequence Number 1 ▾	Other Payer Primary ID ▾	*Service Line Paid Amount \$	*Adjudicated or Pay Date [Calendar Icon]	*Paid Service Unit Count
*Procedure Qualifier ▾	*Procedure Code ▾	Procedure Code Description ▾	Bundled Line Number ▾	Procedure Code Modifiers 1. ▾ 2. ▾ 3. ▾ 4. ▾
*Revenue Code ▾	Remaining Patient Liability \$			

➤ **New Other Payer Service Information**➤ **Service Line Adjudication**

- ✓ **REQUIRED**
- ✓ Other Payer Primary ID
- ✓ Service Line Paid Amount
- ✓ Adjudicated or Pay Date
- ✓ Paid Service unit Count
- ✓ Procedure Qualifier - ABC
- ✓ Procedure Code
- ✓ Revenue Code
- ✓ Remaining Patient Liability

Line Level Adjustments

[Add Line Level Adjustments](#)

Claim Adjustment Group Code ▾

Reason Code ⬆️⬆️

Amount ⬆️⬆️

Quantity ⬆️⬆️

No Data

- **Service Adjustment**
- **Add Line Level Adjustments**

New Line Level Adjustments Save Reset Cancel

*Claim Adjustment Group Code
 Patient Responsibility

*Reason Code
 1

*Amount
 \$ 75.00 x

Quantity

Contractual Obligations
 Correction and Reversals
 Other Adjustments
 Patient Responsibility
 Payor Initiated Reductions

➤ New Line Level Adjustments

- Claim Adjustment Group Code – **Patient Responsibility** or **Contractual Obligation**
 - ✓ Only 1 Claim Adjustment Group Code may be selected at a time
- Reason Code and Amount - **(Do Not enter PR or CO in front of Reason Code)**
 - ✓ **Patient Responsibility** – add reason code and amount
 - ✓ **Save**
 - ✓ **Contractual Obligations** – add reason code and amount
 - ✓ **Save**
- **Add new Line Level Adjustments for each Reason Codes per detail line**

Service Line Adjudication

Sequence Number: 1
 Other Payer Primary ID: 0000002370
 *Service Line Paid Amount: \$ 200.00
 *Adjudicated or Pay Date: 04022020
 *Paid Service Unit Count: 1.00000
 *Procedure Qualifier: ABC Code
 *Procedure Code: 99212
 Procedure Code Description:
 Bundled Line Number:
 Procedure Code Modifiers: 1. 2. 3. 4.
 *Revenue Code: 0512
 Remaining Patient Liability: \$ 100.00

Service Adjustment

Line Level Adjustments

System successfully saved the Information.

Add Line Level Adjustments

Claim Adjustment Group Code	Reason Code	Amount	Quantity
Patient Responsibility	1	\$75.00	
Patient Responsibility	2	\$25.00	

1 - 2 of 2

➤ New Other Payer Service Information

- Additional Adjustments - Add Line Level Adjustments – if applicable
- Verify Line Level Adjustments saved
- **Save – New Other Payer Service Information**

Other Payer Service Information

Other Payer Service Information
System successfully saved the Information.

[Add Other Payer Service Information](#)

Sequence Number ▾	Other Payer Primary ID ▾	Procedure Code ▾	Paid Service Unit Count ▾	Service Line Paid Amount ▾	Adjudicated or Pay Date ▾
1		99212	1.00000	\$200.00	04/02/2020

1 - 1 of 1

[Submit Claim](#)
[Save & Return to Basic Service Line Item](#)
[Save Claim](#)
[Reset](#)
[Cancel](#)

➤ If the member has 2 Insurance Policies

- **Add Other Payer Service Information**

- ✓ Complete a 2nd Sequence Number – Repeat slides 49 – 53
- ✓ Primary is Sequence Number #1
- ✓ Secondary is Sequence Number #2

➤ If the member has 1 insurance

➤ Save & Return to Basic Service Line Item

Basic Line Item Information

Total Claim Charge Amount: \$500.00

Add Service Line Item

Line #	Rev Code	Proc Code	Modifiers				Service Dates		Unit Qualifier	Units	Line Item Charge Amount \$	Non-covered Charges \$
			1	2	3	4	Begin	End				
1	0521	99212					03/20/2020	03/20/2020	Units	1.00000	\$500.00	

1 - 1 of 1

Edit Line Item Save Save & Add Other SvcInfo/TPL | Reset | Delete | Cancel

Service Date Begin 03/20/2020	Service Date End 03/20/2020	*Revenue Code 0521	Procedure Code 99212	Modifiers 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>
*Unit Qualifier Units	*Service Units 1.00000	*Line Item Charge Amount \$ 500.00	Non-Covered Line Charges \$ <input type="text"/>	Procedure Description <input type="text"/>

+ Additional Service Line Information

? Is there additional line-specific information/TPL to be entered?

Yes No

NOTE: Click the Save & Add Other Svc Info/TPL link to enter line-level TPL amounts, and to include the following line-level information: Service Line Information, Service Line Provider Information, and Other Payer Service Line Information.

Submit Claim Save Claim Reset Cancel

➤ Save Line

Basic Line Item Information

System successfully saved the Information.

Total Claim Charge Amount: \$500.00

Add Service Line Item

Line #	Rev Code	Proc Code	Modifiers				Service Dates		Unit Qualifier	Units	Line Item Charge Amount \$	Non-covered Charges \$
			1	2	3	4	Begin	End				
1	0521	99212					03/20/2020	03/20/2020	Units	1.00000	\$500.00	\$0.00

1 - 1 of 1

Submit Claim

Save Claim

Reset

Cancel

- **System successfully saved the Information**
- **Save Claim – Needs to be done before submitting the claim**
 - In order to re-submit the claim from a processed claim if need be
- **Submit Claim**

TCN: [REDACTED]

Your claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

Claim Information

TCN: [REDACTED]
 Date of Service: 03/20/2020 - 03/20/2020
 Provider #: [REDACTED]
 Member ID: [REDACTED]

Claim Status: C - To Be Dnd

Total Charge: \$500.00

*To Be Paid Amount: \$0.00

*Co-Payment: \$0.00

*Total Recipient Liability: \$0.00

Submission Date/Time: 08/14/2020 2:49:11 PM CDT

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1 - 2 of 2

Remark Codes

Line #	Remark Code	Description
0	N253	Missing/incomplete/invalid attending provider primary identifier.

➤ **Print and Save for your records**