



ND MMIS PROFESSIONAL WEB PORTAL TRAINING

LAURA HOLZWORTH, MEDICAL SERVICES DIVISION



Health & Human Services

ND MMIS Web Portal Professional 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



- Home**
- Program ▾
- Member ▾
- Provider ▾
- Documentation ▾
- Directories ▾

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**



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 [Provider](#) ▾ |
 Claims ▾ |
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Quick Links [Print](#) | [-](#)

- [Add Service Location](#)
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[Create Claims](#) ▾ |
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 [Claim Status Inquiry](#) |
 [Payment Inquiry](#) |
 [1099 Inquiry](#) |
 [Pharmacy 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](#)

Provider Message				Print Help - □	
Status				Subject	
	<input type="checkbox"/>	YSTEM, SYSTEM	03/04	New Document for Online Viewing:	
	<input type="checkbox"/>	YSTEM, SYSTEM	02/12	New Document for Online Viewing:	

1-3 of 3

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



➤ Submit a Claim

- Claims
- Create Claims
- Create Professional Claim

***Required Field**

Basic Claim Info

Other Claim Info

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

? Is this a void/replacement?

 Yes No

Submitter Information

Submitter ID

➤ New Professional Claim

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

***Required Field**

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 Paid 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 Professional 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

***Required Field**

Basic Claim Info

Other Claim Info

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

? Is this a void/replacement?

 Yes No

Submitter Information

Submitter ID

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

National Provider ID


Taxonomy Code

Tax ID

SSN

Location Number

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

 **Additional Billing Provider Information**

*Entity Qualifier <input type="text" value=""/>	Currency Code <input type="text" value=""/>					
*Org/Last Name <input type="text" value=""/>	First Name <input type="text" value=""/>	MI <input type="text" value=""/>	Suffix <input type="text" value=""/>			
*Address 1 <input type="text" value=""/>	*City <input type="text" value=""/>	State <input type="text" value=""/>	Zip and <input type="text" value=""/>	Extension <input type="text" value=""/>	Country <input type="text" value=""/>	Subdivision Code <input type="text" value=""/>
Address 2 <input type="text" value=""/>						

➤ **Additional Billing Provider Information**

- **REQUIRED**
- **Select** - Entity Qualifier – non-person or person
- **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 Billing Provider Name, Address, City, State and Zip Code

? Is the Billing Provider also the Rendering Provider?

Yes No

Rendering (Performing) Provider

Medicaid Provider ID


National Provider ID

Taxonomy Code

Location Number


➤ Is the Billing Provider also the Rendering Provider?

- **Required** - Default to "Yes"
- Rendering (Performing) Provider is **different** select "**No**"
 - ✓ **Enter** – Rendering (Performing) Provider Medicaid Provider ID
 - ✓ **Enter** – Rendering (Performing) Provider NPI Number
 - ✓ **Enter** – Rendering (Performing) Provider Taxonomy Code

 Is this service the result of a referral?
 Yes No

Referring Provider

Medicaid Provider ID National Provider ID

 [Additional Referring Provider Information](#)

*Org/Last Name First Name MI Suffix

➤ **Is this service the result of a referral?**

- **Defaults to "No"**
- If **"Yes"** - Referring Provider Medicaid Provider ID and NPI (National Provider ID)

➤ **Additional Referring Provider Information**

- Org/Last Name and First Name
- MI and Suffix – if applicable

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 29**
- **If “Yes” - member has other insurance– proceed to slide 16**

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

Cadaver Donor

Child

Employee

Life Partner

Organ Donor

Other Relationship

Self

Spouse

Unknown

Claim Filing Code

Group or Policy #

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 #

Insurance Type Code

*Payer Responsibility Seq # Code

Group or Plan Name

MC 2nd - Disabled Bene 65 w LGHP
MC 2nd - No-Fault Auto is Primary
MC 2nd End-Stg Rnl Dis w Emp Grp Hlt
MC 2nd Wrkg Agd Ben or Sps w Emp Grp Hlt
MCare 2nd - Other Liability Ins Primary
MCare 2nd Public Health Serv or Fed Agcy
MCare 2ndary Workers Comp
Medicare Secondary Black Lung
Medicare Secondary Veteran's Admin

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

- **REQUIRED**
- Insurance Type Code
- 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 # <input type="text"/>	Referral # <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 Amount
\$

Total Non-Covered Amount
\$

➤ COB Monetary Amounts

- Payer Paid Amount
- Remaining Patient Liability
- Total 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 17 – 25 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 X	

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**

Claim Information

Go to [Other Claim Info](#) to include the following claim level information:
Specialized Line Information, Line Providers , Other Payer Service Line information, Test Result and Form Identification Information.

? *Is this claim accident related?

Yes No

Service Authorization #

Referral #

➤ Claim Information

- Is this claim accident related?
 - ✓ Yes or No
- Service Authorization # - if applicable
- Referral # - if applicable

Claim Note

*Type Code

*Note

80 Characters Remaining

*Type Code

- Additional Information
- Certification Narrative
- Diagnosis Description
- Goals, Rehab Potential, or Dsch Plans
- Third Party Organization Notes

➤ Claim Note

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

Faxing 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
- 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 e-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
- 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

*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

Claim e-Attachments

Add e-Attachment

Date Added ▾

Added By ▾

File Name ▾

Description ▾

No Data

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

? 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

Claim e-Attachments

Add e-Attachment

Date Added ▾	Added By ▾	File Name ▾	Description ▾
No Data			

➤ Does this claim have Attachments?

- Yes or No
 - ✓ Yes
 - ✓ 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

? 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

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 Data

*Patient Account #

*Place of Service

*Assignment Code

*Benefits Assignment Certification

*Release of Information Code

➤ Claim Data

- Patient Account #
- Place of Service
- Assignment Code
- Benefits Assignment Certification
- Release of Information Code

Diagnosis Codes

Version #

ICD-09 ICD-10

*1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

➤ Diagnosis Codes

- **REQUIRED**

- Version # - Defaults to ICD-10 - if Date of Service is older than 10/01/2015 select ICD-09

- Principal Diagnosis Code

- ✓ Enter the Diagnosis Code for the Member's primary, secondary condition ect.

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

<p>*Service Date Begin</p> <input type="text"/>	<p>Service Date End</p> <input type="text"/>	<p>Place of Service</p> <input type="text"/>
<p>*Procedure Code</p> <input type="text"/>	<p>Procedure Description</p> <input type="text"/>	<p>Modifiers</p> <p>1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/></p>
<p>*Line Item Charge Amount</p> <p>\$ <input type="text"/></p>	<p>Diagnosis Pointers</p> <p>*1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/></p>	
<p>*Unit Code</p> <input type="text"/>	<p>*Units</p> <input type="text"/>	

➤ New Line Item

- Service Date Begin and Service Date End - Use format: MM/DD/YYYY
- Place of Service
- Procedure Code
- Modifiers – if applicable
- Line Item Charge Amount
- Diagnosis Pointers – Primary, Secondary ect.
- Unit Code and Units

Service Authorization

Service Authorization #

Referral #

➤ Service Authorization – if applicable

- Service Authorization #
- Referral # - if applicable

Additional Service Line Information

EPSDT Indicator:

Family Planning Indicator:

Emergency Indicator:

Co-pay Status:

➤ Additional Service Line Information – if applicable

- EPSDT Indicator
- Family Planning Indicator
- Emergency Indicator
- Co-pay Status

*Service Date Begin



Service Date End



Place of Service

*Procedure Code

Procedure Description

Modifiers

1. 2. 3. 4.

*Line Item Charge Amount

\$

Diagnosis Pointers

*1. 2. 3. 4.

*Unit Code

*Units

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, Specialized Line Information, and Other Payer Service Line Information

Submit Claim

Save Claim

Reset

Cancel

➤ **Is there Additional line-specific information/TPL to be entered?**

- **Yes** – Enter **Ordering Provider** – repeat on each line entered
- **Save & Add Other Svc Info/TPL**

*Required Field

System successfully saved the Information.

[Service Line Info](#) [Service Line Provider](#) [Specialized Line Info](#) [Other Payer Service Line Provider](#)

Ln#:1

Submit Claim

Save & Return to Basic Service Line Item

Save Claim

Reset

Cancel

➤ **New Professional Claim Other Service Information**

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

Service Line Provider Information

Ordering Provider Information

Medicaid Provider ID

National Provider ID

Additional Ordering Provider Information

* Org/Last Name

First Name

MI

Suffix

*Address 1

*City

State

Zip and

xtension

Country

Subdivision Code

Address 2

➤ Ordering Provider Information – Repeat on each line

- Scroll down to Service Line Provider Information
- Medicaid Provider ID
- National Provider ID
- Org/Last Name, First Name
- MI and Suffix – if applicable
- Address, City, State and Zip Code

- **Does the member have Other Insurance**
 - **No** – Member **does not** have Other Insurance
 - **Save & Return to Basic Service Line Item**

Submit Claim

Save & Return to Basic Service Line Item

Save Claim

Reset

Cancel

Edit Line Item
Save
Save & Add Other Svc Info/TPL | [Reset](#) | [Delete](#) | [Cancel](#)

*Service Date Begin <input type="text" value="03/20/2020"/>	Service Date End <input type="text" value="03/20/2020"/>	Place of Service <input type="text" value="Office"/>
*Procedure Code <input type="text" value="99204"/>	Procedure Description <input type="text"/>	Modifiers 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>
*Line Item Charge Amount \$ <input type="text" value="200.00"/>	Diagnosis Pointers *1. <input type="text" value="First Diagnosis"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>	
*Unit Code <input type="text" value="Units"/>	*Units <input type="text" value="1.00000"/>	

+ [Service Authorization](#)

+ [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, Specialized Line Information, and Other Payer Service Line Information

➤ Edit Line Item

- Save

Basic Line Item Information

System successfully saved the Information.

Total Claim Charge Amount: \$200.00

Add Service Line Item

Ln #	Service Dates		Procedure Code	Modifiers				Diag Pointers				Line Item Charge Amount	Unit Code	Unit
	Begin	End		1	2	3	4	1	2	3	4			
1	03/20/2020	03/20/2020	99204					1				\$200.00	Units	1.00000

1 - 1 of 1

Submit Claim Save Claim Reset Cancel

- **Basic Line Item Information**
 - **System successfully saved the Information**
 - **Save Claim**
 - **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: \$200.00

*To Be Paid Amount: \$0.00

*Co-Payment: \$0.00

*Total Recipient Liability: \$0.00

Submission Date/Time: Tue Mar 24 11:28:05 CDT 2020

*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	204	This service/equipment/drug is not covered under the patient?s current benefit plan
1	A1	Claim/Service denied. 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.)
1	26	Expenses incurred prior to coverage.
1	27	Expenses incurred after coverage terminated.

1 - 4 of 4

Remark Codes

Line #	Remark Code	Description
No Data		

➤ **Print and Save for your records**

- **Does the member have Other Insurance– Repeat on each line**
- **Yes** – Member has **Other Insurance** – proceed to **Slide 55** for instructions
 - Scroll down to **Other Payer Service Line Information**

Other Payer Service Line Information

Other Payer Service Information

Add Other Payer Service Information

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

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

📅

*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
 - ✓ 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 \$	Quantity
Reason Code 2 2	Amount 2 \$	Quantity 2
Reason Code 3	Amount 3 \$	Quantity 3
Reason Code 4	Amount 4 \$	Quantity 4

- New Line Level Adjustments**
- *Claim Adjustment Group Code
 - 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** – up to 4 Reason Codes per detail line - **Save**
 - ✓ **Contractual Obligations** – up to 4 Reason Codes per detail line - **Save**

Service Line Adjudication

Sequence Number

1

Other Payer Primary ID

*Service Line Paid Amount

\$

*Adjudicated or Pay Date

*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

\$

Service Adjustment

Line Level Adjustments

Add Line Level Adjustments

Claim Adjustment Group Code	Reason Code	Amount	Quantity
Patient Responsibility	1	\$50.00	

1 - 1 of 1

➤ New Other Payer Service Information

- Additional Adjustments - Add Line Level Adjustments – if applicable
- Verify Line Level Adjustments
- **Save**

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	0000000330	99204	1.00000	\$100.00	03/23/2020

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 55 – 59
- ✓ Primary is Sequence Number #1
- ✓ Secondary is Sequence Number #2

➤ If the member has 1 insurance

➤ Save & Return to Basic Service Line Item

*Service Date Begin

03/20/2020

Service Date End

03/20/2020

Place of Service

Office

*Procedure Code

99204

Procedure Description

Modifiers

1. 2. 3. 4.

*Line Item Charge Amount

\$ 200.00

Diagnosis Pointers

*1. First Diagnosis 2. 3. 4.

*Unit Code

Units

*Units

1.00000

+ Service Authorization

+ 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, Specialized Line Information, and Other Payer Service Line Information

➤ Edit Line Item

- Save

Basic Line Item Information

System successfully saved the Information.

Total Claim Charge Amount: \$200.00

Add Service Line Item

Ln #	Service Dates		Procedure Code	Modifiers				Diag Pointers				Line Item Charge Amount	Unit Code	Unit
	Begin	End		1	2	3	4	1	2	3	4			
<u>1</u>	03/20/2020	03/20/2020	99204					First Diagnosis				\$200.00	Units	1.00000

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: \$200.00

*To Be Paid Amount: \$0.00

*Co-Payment: \$0.00

*Total Recipient Liability: \$0.00

Submission Date/Time: Tue Mar 24 11:28:05 CDT 2020

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1 - 4 of 4

Remark Codes

Line #	Remark Code	Description
No Data		

➤ **Print and Save for your records**