



ND MMIS PROFESSIONAL WEB PORTAL TRAINING

LAURA HOLZWORTH, MEDICAL SERVICES DIVISION

NORTH
Dakota
Be Legendary.

| 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 ▾](#)

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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 ▸

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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 ?](#)

Login

Reset

➤ Provider Login

- **USER ID** and **Password**



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

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

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

Provider Message

Status | [+](#) | [-](#)

	☐	YSTEM, SYSTEM	03/04	New Document for Online Viewing:	
	☐	YSTEM, SYSTEM	02/12	New Document for Online Viewing:	

1-3 of 3

Claims | **Create Claims** | **Create Professional Claim**

[Manage Claims](#)
[Create Templates](#)
[Manage Templates](#)
[Claim Status Inquiry](#)
[Payment Inquiry](#)
[1099 Inquiry](#)
[Pharmacy Claims](#)

[Create Institutional Claim](#)
[Create Dental Claim](#)
[Create Claim from Template](#)
[Create Claim from Processed Claim](#)
[Travel/Lodging Claim](#)
[HCBS/DD Claim](#)

Subject | [+](#) | [-](#)

[Print](#) | [Help](#) | [-](#) | [+](#)

[Delete](#)

News | [-](#) | [+](#)

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 InformationGo 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 	Currency Code 					
*Org/Last Name 	First Name 	MI 	Suffix 			
*Address 1 	*City 	State 	Zip and 	Extension 	Country 	Subdivision Code
Address 2 						

➤ 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

Property Casualty Number

➤ 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

The screenshot shows a web form titled "Member Address" with a red border. The form contains several input fields: a text box for "Address 1" (marked with a red asterisk), a text box for "City" (marked with a red asterisk), a dropdown menu for "State", two text boxes for "Zip" and "Extension" (grouped under "Zip and"), a text box for "Country", and a text box for "Subdivision Code". Below these fields is a section for "Address 2" with a text box. The entire form is set against a light yellow background.

○ **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 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 Seq # Code 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	Group or Plan Name

➤ 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 	*City 	State ▼	Zip and 	Extension 	Country 	Subdivision Code
Address 2 						
Adjudication Date 	Authorization # 	Referral # 	Claim Control Number 			
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	XXXXXXXX	XXXXXXXX	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 ▴ ▾
<u>1</u>	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX X	

1 - 1 of 1

Submit Claim

Save Claim

Reset

Cancel

➤ **Save Claim**

New Institutional Claim Print | Help - ☐

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

The screenshot shows a web form titled "Claim Note". It contains two main input fields: a dropdown menu labeled "*Type Code" and a text area labeled "*Note". The dropdown menu is highlighted with a red border, and a red arrow points from it to a list of options. The list of options includes: "Additional Information", "Certification Narrative", "Diagnosis Description", "Goals, Rehab Potential, or Dsch Plans", and "Third Party Organization Notes". Below the text area, there is a character count field showing "80 Characters Remaining".

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

Save | Reset | Cancel

*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
Facsimile
File Transfer

➤ **Delivery Method**

- Select the Facsimile
- 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

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

Save | Reset | Cancel

*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

SaveResetCancel

*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

* File Name
TEST.pdf Browse...

* Description
Discharge Summary

Save Reset Delete Cancel

- **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](#)

*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	



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

New Line Item

Save

Save & Add Other Svc Info/TPL

Reset

Cancel

*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**

New Professional Claim Other Service Information Print | Help

***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](#)

Service Line Information

[+ Relevant Dates](#)

[- Drug Identification](#)

***National Drug Code** ***Unit Code** ***National Drug Unit Count** Prescription Qualifier Prescription # Prescription Date

➤ Service Line Information

➤ Drug Identification – Repeat on each line if applicable

- National Drug Code
- Unit Code
- National Drug Unit Count

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

- **Service Line Provider Information**
- **Ordering Provider Information – Repeat on each line**
- 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

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			
1	03/20/2020	03/20/2020	99204					First Diagnosis				\$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 [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
 - ✓ Procedure Code
 - ✓ Revenue Code
 - ✓ Remaining Patient Liability



[Service Adjustment](#)

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

*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

*Reason Code

1

Reason Code 2

2

Reason Code 3

Reason Code 4

*Amount

\$

Amount 2

\$

Amount 3

\$

Amount 4

\$

Quantity

Quantity 2

Quantity 3

Quantity 4

Save

Reset

Cancel

➤ 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 ▴ ▾
<u>1</u>	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

Edit Line Item

SaveSave & Add Other Svc Info/TPL | Reset | Delete | Cancel

*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

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*Total Recipient Liability: \$0.00

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1 - 4 of 4**Remark Codes**

Line #	Remark Code	Description
No Data		

➤ **Print and Save for your records**