



ND MMIS QSP HCBS/DD PROFESSIONAL
WEB PORTAL TRAINING
LAURA HOLZWORTH, MEDICAL SERVICES DIVISION

NORTH
Dakota
Be Legendary.

| Health & Human Services

ND MMIS Web Portal QSP HCBS/DD Professional Claim Form Submission Instructions



Go to

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



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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

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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**



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

[Add Service Location](#)
[Trading Partner Enrollment](#)
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[Provider Inquiry/Update Request](#)
[Provider Training Registration](#)
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Provider Message

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

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

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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](#)

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

New Professional Claim Print | Help - □

***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 	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

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. Below the title, there are several input fields. A red box highlights the first row of fields: "*Address 1", "*City", "State", "Zip and", "Extension", "Country", and "Subdivision Code". Each field has a corresponding text input box. The "State" field is a dropdown menu. Below this row, there is a field for "Address 2" with a text input box.

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

Address 2

○ Member Address

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

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 separate list of options. Below the text area, there is a character count showing "80 Characters Remaining".

***Type Code**

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

***Note**

80 Characters Remaining

➤ 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

Admission Summary

Allergies/Sensitive Document

Ambulance Certification

Autopsy Report

Baseline

Benchmark Testing Results

Blanket test Results

Certification

Certified Test Report

Chemical Analysis

Chiropractic 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

*Delivery Method

Attachment Control #

➤ **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

Chiropractic 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 Visit Documentation
- **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

? 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**

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**