

Billing 101 Training for Providers

Billing process start to finish

In this training...

- Covid-19 Policy Changes – policies are still in effect.
- New Provider Questions.
- Reminders.
- What order should things be done?
- Where to I go to get information, submit & reconcile claims?
- What access do I need before I can begin?
- What are my resources?
- Most common billing errors. Individual Adjustment forms.
- Questions?

Covid-19 Policy Changes

Covid-19 Policy Changes

Covid-19 Communications

Provider Notices:

Most changes were effective March 1, 2020

Medicaid Coverage and Reimbursement Policy for Telemedicine/Telehealth

Frequently Asked Questions on Telemedicine / Telehealth

Suspension of Face to Face Requirements for Some Medicaid Programs

Suspension of Prior Authorizations or Continued Stay Reviews and Clinical requirements for Some Medicaid Programs

Covid-19 Communications

Non-Covered Services Agreement Policy Change

Developmental Disabilities 0208 Comprehensive Waiver Providers

Temporary Revision to Case Management General Provisions

Provider Relief Fund General Allocation rev. 08/11/2020

Behavioral Health Grants

Provider Relief Fund General Allocation rev. 08/28/2020

We still have no end date for these policies.

Questions from Providers

Q: What are the guidelines for billing/payment of administration of medications? Ex: 96372

A: Physician administered drugs – Also known as Buy & Bill.

Montana Medicaid does not reimburse for convenience, off label or experimental use of drugs, per Administrative Rules of Montana (ARM) 37.85.207. In general, drugs billed with unlisted codes require prior authorization from the State. Also, the NDC must be rebateable.

For Outpatient Hospital services please refer to the OPPS fee schedule for allowable services. In reviewing the fee schedule CPT 96372 is an allowable code.

[For RHC services, please use the link below.](#)

<https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2018/provnoticeVCF10032018.pdf?ver=2019-04-09-082617-450>

Questions from Providers

Q: What is the difference between vaccines for children and vaccines for adults?
Administration fees?

A:

The main difference between vaccines for children and adults is that you cannot bill for the actual vaccine for children. However, they must still appear on your claim to justify your admin fee charges. List the vaccine as a \$0.01 charge. Vaccines do not require NDC information.

Important Reminders about our Automated Systems

The MATH portal and the IVR do not give services limits.

Always contact the Call Center to confirm service limits.

The verbiage on the IVR can be confusing when it comes to covered services.

Examples:

It may say the member is eligible for eye exam & glasses. That only means that the member's coverage allows for this service.

It may say that the member is eligible for vision or dental services when the member only has QMB. This is because Medicare may cover some services in medical setting.

Inconsistent waiver information on MATH portal.

What order should things be done?11

New Web-Based Provider Services Portal

What to expect...

Self-service portal for a single point of access to enroll, update & maintain provider files, verify eligibility, submit claims and obtain remits.

- Web based system – works on any computer.
- Self-service for new enrollments and changes. Allows you to track applications and upload supplemental documents.
- Provider file updates – licenses, change of address, change of ownership. Allows you to upload these documents and follow up on changes.
- Link Rendering providers to your facility.

What to expect...cont'd

- Verify member eligibility with clear easy to understand screens.
- Easily add and delete additional users.
- New billing system with the ability to create templates for ongoing treatment. Most beneficial for those using WINasap.
- Obtain payment remits.
- And much more!

What order should things be done?¹²

What order should things be done?

What order should things be done?

1. Verify member eligibility & service limits (if applicable).
2. Obtain & review member's prior authorization (if applicable).
3. Select the proper diagnosis code.
4. Select place of service.
5. Select the proper CPT code (service provided).
6. Verify Fee Schedule
7. Enter and submit claim
8. Verify claim status
9. Obtain eSor to reconcile claims/payments

Eligibility Verification with Portal

Eligibility Verification with Portal

Verify Member's Eligibility

It is important to verify your member's eligibility each month.

MATH Provider Web Portal
<https://mtaccesstohealth.portal.conduent.com/>

Call Center

[1800-624-3958](tel:1800-624-3958) Opt. 7, Opt. 3.

MATH Portal Access

2/26/2020

CONDUENT 
Montana Provider Relations
P O Box 4936
Helena, MT 59604
tel 800-624-3958 Opt3

Provider name
Address
City ST Zip

Dear Montana Submitter:

Welcome to Conduent EDI Solutions. Please find below the information necessary to submit electronic transactions, based on your enrollment selections. Carefully review all the items in this package. If you find any discrepancies, please call Montana Provider Relations at 1-800-624-3958.

Trading Partner Login Information

| | |
|---------------------------------------|-----------------------------------------|
| Trading Partner Category | Provider name |
| Trading Partner Name | 7777777 |
| Trading Partner / Submitter ID | TMP: 123456 |
| User Name | Q9JJJOVF5 |
| Password/User ID | |
| Submission Telephone Number(s) | 1-800-334-2832 or 1-800-334-4650 |

We recommended that all providers register for the Montana Access to Health Web Portal. To register, use the credentials in this letter. Visit the Provider Website (<https://medicaidprovider.mt.gov>) and select the MATH Web Portal link from the menu on the left. Or, go directly to the web portal (<https://mtaccesstohealth.portal.conduent.com/mt/general/home.do>) and choose Web Registration from the menu.

1. Enter the Submitter Number in both the NPI and Submitter fields.
2. Enter your Tax Identification Number and the password *from this letter*.
3. From the prompt, create your User ID that you will use to log in. Once the account is registered, an email will be generated with a temporary password.
4. Log in with the user ID you created and copy/paste the password *from the email*.
5. From the prompt, change your password. (Use the temporary password from the email as the old password.).
6. Once logged in to the MATH web portal, click Manage users and select Update or Remove Users to change access.

Note: All Vendors, Billing Agents, and Clearinghouses must enroll and test with Conduent EDI Solutions prior to submitting production transactions. If you are a provider, please check with your contracted Vendor, Billing Agent, or Clearinghouse

MATH Portal Access

Web Portal Registration

Step One - Verification Set Up Process

* denotes required field(s)

Montana Access to Health Web Portal requires registration for use of its secure functions. Step one is a verification process and step two is the creation/selection of the first Office Administrator (OA) for your organization. This OA will be responsible for managing users within your organization.

If you anticipate managing more than one Provider Number, enter the Submitter ID in both the Provider Number and Submitter ID fields. Otherwise, enter your Provider Number in the Provider Number field. Then fill in the other required fields and click 'Continue.' This information will be used for verification purposes only.

* NPI or Provider Number:

* EIN/SSN:

* Submitter ID**:

* Submitter Password:

Continue

Clear Fields

** Submitter ID is the Trading Partner ID

Log In



Montana Access to Health Web Portal

Log In

Web Registration

Provider Enrollment

Provider Information
Website

Electronic Billing

Provider Locator

Welcome to Montana Access to Health Web Portal!

Montana Access to Health Web Portal provides the tools and resources to help healthcare providers conduct business electronically. If you have already registered to use the Montana Access to Health Web Portal, Log In below. If you have already completed a Montana Enrollment Form, but have not yet registered to use the Montana Access to Health Web Portal, click the [Web Registration](#) button on the left side of this page to begin. If you are a new provider or have not already completed a Montana Enrollment Form, visit [Provider Enrollment](#) for step-by-step instructions.

Log In

Enter your User ID and Password and click 'Log In.' If you do not have a User ID and Password, contact your Office Administrator.

User ID:

Password:

Log In

[Forgot Your Password?](#)

Eligibility Verification



Montana Access to Health Web Portal

[Exit](#)

MONTANA MEDICAID TEST1

Montana Access to Health Web Portal Home Page

Navigate to any of the functions in the Web portal by clicking the following links or by using the top navigation bar. For information about each function, click the corresponding column header. Click on 'My Profile,' located in the 'My Access' section, to display your current Montana Access to Health Web Portal profile. You will be able to perform only those tasks allowed by the user privileges assigned to you.

Site Contents

| Inquiries | Submissions | Retrievals | Manage Users | My Access |
|----------------------------------------------|------------------------------|-------------------------------------|-------------------------------------------------------|-------------------------------------|
| Eligibility | Upload Files | View/Download Files | Add New User to Organization | My Profile |
| Claim Status | | View e!SOR Reports | Add Existing User to Organization | Change Organization |
| Provider Payment Summary | | My Inbox | Update or Remove Users/Reset Password | Change Password |
| Claims-based Medical History | | | Manage Submitter IDs | Manage Proxies |
| Electronic Health Record | | | | |
| Provider Locator | | | | |

ATTENTION PROVIDERS: The Electronic Health Record link has been added to allow you to view your patients' claims medical history. If you need this access and do not have it, please contact your office administrator. E-prescribing is now available. Please contact your office administrator to add prescribing rights to your user account.

You've logged into the organization displayed under the navigation bar on the right. This organization will be used to determine the Provider Number and Submitter IDs you can use for your transactions (i.e., Inquiries, Submissions and Retrievals). To change this organization, click 'Change Organization' and follow the instructions.

Member Information



Montana Access to Health Web Portal

[Exit](#)

[Home](#) > [Inquiries](#) > Eligibility Inquiry

MONTANA MEDICAID TEST1

Eligibility Inquiry

To submit an Eligibility Inquiry on a specific member, select a Provider Number, enter a Date of Service, complete one of the following criteria sets and click 'Submit.' If your inquiry returns more than one member, you will be asked to check your information and/or enter a different set of information.

* denotes required field(s)

* NPI or Provider Number:

* Date of Service: mm dd ccyy

* Member Information:

Member ID:

or

Last Name:

First Name: M.I.:

Date of Birth: mm dd ccyy

Service Type Code: Health Benefit Plan Coverage

Submit

Clear Fields

Verify Member



Healthy People. Healthy Communities.

Department of Public Health & Human Services

Montana Access to Health Web Portal

[Exit](#)

[Home](#) > [Inquiries](#) > [Eligibility Inquiry](#) > Eligibility Inquiry Confirmation

MONTANA MEDICAID TEST1

Eligibility Inquiry Confirmation

If this is the member you wish to inquire on, click 'View Member Eligibility.'

Member Original
ID:

Name:

Date of Birth:

Gender Code:

[Back to Eligibility Inquiry](#)

[View Member Eligibility](#)

Eligibility Response



Montana Access to Health Web Portal

[Exit](#)

[Home](#) > [Inquiries](#) > [Eligibility Inquiry](#) > Eligibility Inquiry Confirm > Eligibility Inquiry Response

MONTANA MEDICAID TEST1

Eligibility Inquiry Response



Member Demographic Information

Member Original ID:

Member Current ID:

Member ID:

Name:

Address:

City:

County Code:

State:

Zip Code:

Date of Birth:

Gender Code:

NPI or Provider ID: 1003008251

Date of Service: 07/09/2019

Valid Request Indicator: Y: Yes

Reject Reason Code: 50: Provider Ineligible for Inquiries

Follow-up Action Code: N: Resubmission Not Allowed

Date of Death:

Trace Number: 201919012543480IT

Eligibility Response

Eligibility Spans

| Service Type Code | Insurance Type Code | Payer Name | Plan Coverage Description | Eligibility Effective Date | Eligibility End Date |
|----------------------------------|---------------------|------------|---------------------------|----------------------------|----------------------|
| 30: Health Benefit Plan Coverage | MC: Medicaid | Medicaid | Standard Medicaid Plan | 05/01/2019 | 07/31/2019 |



Managed Care Information

| Plan Coverage Description | Plan/PCP Name | Plan/PCP Phone Number | Begin Date | End Date |
|---------------------------|---------------------------------|-----------------------|------------|------------|
| Passport Provider | NORTHWEST COMMUNITY HEALTH CENT | 4062836900 | 09/01/2018 | 07/31/2019 |



Dental Treatment Information

| Dental Treatment Type | Treatment Limit | Used Amount | Remaining Reimbursement Balance | Effective Begin Date | Effective End Date |
|------------------------------|-----------------|-------------|---------------------------------|----------------------|--------------------|
| ADULT DENTAL TREATMENT LIMIT | \$ 1,125.00 | \$ 0.00 | \$ 1,125.00 | 07/01/2019 | 06/30/2020 |



Please be advised that there may be other claims pending adjudication by the system which may be paid before your claim is submitted thereby reducing the available remaining balance from the amount reported above. Limits should be verified on each visit for the current date of service. The Treatment Limit amount shown is the amount Medicaid will reimburse for dental services.

Eligibility Response

Eligibility Spans

About HMK/CHIP

HELP Plan

Standard Medicaid

| Service Type Code | Insurance Type Code | Payer Name | Plan Coverage Description | Eligibility Effective Date | Eligibility End Date |
|----------------------------------|------------------------------------|------------------|--------------------------------|----------------------------|----------------------|
| 30: Health Benefit Plan Coverage | MC: Medicaid | Medicaid | Standard Medicaid Plan | 01/01/2019 | 07/31/2019 |
| 30: Health Benefit Plan Coverage | QM: Qualified Medicare Beneficiary | Medicaid/HMKPlus | Qualified Medicare Beneficiary | 11/01/2009 | 07/31/2019 |
| 54: Long Term Care | LC: Long Term Care | Medicaid | Nursing Home | 01/01/2011 | 07/31/2019 |

Medicare Information

| Insurance Type Code | Member Policy ID | Eligibility Effective Date | Eligibility End Date |
|---------------------|------------------|----------------------------|----------------------|
| MA: Medicare Part A | | 08/01/2002 | 12/31/2099 |
| MB: Medicare Part B | | 11/01/2009 | 12/31/2099 |

Questions?

Prior Authorizations

Prior Authorizations

Prior Authorization letters are mailed by Conduent any time a prior authorization has been entered into our system.

Letters may contain multiple members. Each member will have their own prior authorization number.

If you do not receive your prior authorizations in time for billing; contact the Call Center.

Prior Authorization Letter

APPROVER ID:702

DATE 07/22/19

NPI:

PROVIDER:

PO BOX

WA 98383

RECIPIENT ID

NAME

PRIOR AUTH NUMBER

920370

AUTHORIZE FROM

DATES TO

060519

060519

STATUS: APPROVED

REASON: 999

LINE

ITEM

UNITS

DOLLARS

FR-DTE

TO-DTE

PROC RANGE / MOD

DIAG

RANGE

02

1

0.00

060519

060519

A0428 A0428 HE

TOOTH NUM / SURFACE: THERA CLASS: STATUS: APPROVED REASON:

STATUS: APPROVED

REASON: 999

LINE

ITEM

UNITS

DOLLARS

FR-DTE

TO-DTE

PROC RANGE / MOD

DIAG

RANGE

01

15

0.00

060319

060319

A0425 A0425 RH

TOOTH NUM / SURFACE: THERA CLASS: STATUS: APPROVED REASON:

02

1

0.00

060319

060319

A0429 A0429 RH

TOOTH NUM / SURFACE: THERA CLASS: STATUS: APPROVED REASON:

STATUS: APPROVED

REASON: 999

LINE

ITEM

UNITS

DOLLARS

FR-DTE

TO-DTE

PROC RANGE / MOD

DIAG

RANGE

01

1

0.00

060719

060719

A0427 A0427 NH

TOOTH NUM / SURFACE: THERA CLASS: STATUS: APPROVED REASON:

Questions?

Diagnosis Codes (ICD-101)

Diagnosis Codes (ICD-10)

Diagnosis Codes

ICD-10 is short for *International Classification of Diseases, 10th Revision*.

There are many websites out there to obtain this information.
Here is my favorite:

<https://icd10coded.com/>

Diagnosis Codes

ICD-10 Code Lookup

Oct 01, 2018 - Sep 30, 2019

2019 ICD-10 data & code lookup

Alphabetic Index

ICD-10-CM

ICD-10-PCS

Search

Place of Service1

Place of Service

Place of Service

Place of Service List:

<https://dphhs.mt.gov/Portals/85/dsd/documents/DDP/MMIS%20Transition/PlaceofServicelist.pdf>

This link will give you a list of acceptable place of service codes.

Place of Service

Place of Service list needed for claim submission.

01 Pharmacy

03 School

04 Homeless Shelter

05 IHS Freestanding Facility

06 IHS Provider-Based Facility

07 Tribal 638 Freestanding Facility

08 Tribal 638 Provider-Based Facility

11 Office

12 Home

Questions?

CPT Code (service provided) Fee Schedule

CPT Code (service provided) Fee Schedule

CPT Code

Billable CPT Codes can be located on your provider page, under Fee Schedule.

Provider manuals should be reviewed for service specifics.

Check recent Provider Notices for any changes that may affect your claim.

<https://medicaidprovider.mt.gov>

Rev Codes

In addition to CPT codes; Hospitals, Federally Qualified Health Centers, Rural Health Clinics, Indian Health Services, Hospice and Critical Access Hospitals also use Rev Codes.


Rev Codes can be found in the UB-04 manual.

Locating your Provider Page

MONTANA.GOV
OFFICIAL STATE WEBSITE

SERVICESAGENCIESLOGIN

SEARCH MONTANA.GOV

**Sheila Hogan, Director**
[About Us](#) [Meetings & Events](#) [Health Data & Statistics](#) [Contact Us](#) [A - Z Index](#)

[Montana Healthcare Programs Provider Information » home](#)

Montana Healthcare Programs
Thank you for serving Montana's Healthcare Program Members.

- ▶ [Provider File Updates, Revalidation, and New Provider Information](#)
- ▶ [MATH Web Portal](#)
- ▶ [Resources by Provider Type](#)
- ▶ [Provider Enrollment](#)

Welcome to the Montana Healthcare Programs Provider Information Website.
Important Announcements
Call Center Telephone Options Have Changed

As of Monday, January 28, 2019 the options in the Call Center phone systems will change for both providers and members. Please listen carefully to the options when calling the call centers in order to be directed to the correct extension.

WebEx Training Available

Did you know there are monthly WebEx Trainings with the Program Officers? These trainings are a great opportunity for providers to learn about their program, policy changes, and ask questions.

Navigating the Provider Website - Finding the information you need without making a phone call.

Emilie Boyles, Publications Specialist, Montana Provider Relations July 18 at 2:00 PM MST

Resources by Provider Type

Providers are listed in alphabetical order

Select Your Provider Type

Provider types are listed in alphabetical order. Available resources include fee schedules, provider notices, provider manuals, and more.

[A–C](#)

[D–F](#)

[G–K](#)

[L–O](#)

[P–Q](#)

[R–Z](#)

Providers A – C

| | |
|------------|---------------------------------------------------|
| 03/26/2019 | <u>Ambulance</u> |
| 03/26/2019 | <u>Ambulatory Surgical Center</u> |
| 03/26/2019 | <u>Audiologist</u> |

Resources Available on Your Page

All provider pages are set up the same.

Ambulance

[Prior Authorization](#)

[Forms](#)

[Claim Jumper Newsletters](#)

- ▶ [**Provider Manuals**](#)
- ▶ [Medicaid Rules and Regulations](#)
- ▶ [Fee Schedules – Ambulance](#)
- ▶ [Provider Notices](#)
- ▶ [Other Resources](#)
- ▶ [To locate older documents, access the Archive Page.](#)

Example: Ambulance

All provider type sections are set up in the same format

Ambulance

▼ [Provider Manuals](#)

[General Information for Providers](#) 06/2018

Medicaid manual with general information for all provider types.

[Ambulance Services](#) 08/2017

This manual has information specific to your provider type.

Fee Schedule: Ambulance

All provider type pages have this section

▼ *Fee Schedules – Ambulance*

[July 2018 Ambulance Coversheet Version 2](#)
[July 2018 Ambulance Fee Schedule Version 2 PDF](#)
[July 2018 Ambulance Fee Schedule Version 2 Excel](#)

[July 2018 Ambulance Coversheet](#)
[July 2018 Ambulance Fee Schedule PDF](#)
[July 2018 Ambulance Fee Schedule Excel](#)

[January 2018 Ambulance Cover Sheet](#)
[January 2018 Ambulance Fee Schedule PDF](#)
[January 2018 Ambulance Fee Schedule Excel](#)

Coversheet: [January 2017 Ambulance](#) rev. 10/26/2017
PDF: [January 2017 Ambulance](#) rev. 10/26/2017
Excel: [January 2017 Ambulance](#) rev. 10/26/2017

Fee Schedule Example

Montana Healthcare Programs Fee Schedule Ambulance Services July 1, 2019

| Proc | Mod | Description | Effective | Method | Fees | PA | Pass |
|-------|-----|------------------------------|-----------|-----------|-------------|----|------|
| A0021 | - | OUTSIDE STATE AMBULANCE SERV | 7/1/2019 | FEE SCHED | \$15,696.55 | Y | - |
| A0380 | - | BASIC LIFE SUPPORT MILEAGE | 7/1/2019 | FEE SCHED | \$3.86 | Y | - |
| A0382 | - | BASIC SUPPORT ROUTINE SUPPLS | 7/1/2018 | MSRP | \$0.00 | - | - |
| A0384 | - | BLS DEFIBRILLATION SUPPLIES | 7/1/2018 | MSRP | \$0.00 | - | - |
| A0390 | - | ADVANCED LIFE SUPPORT MILEAG | 7/1/2019 | FEE SCHED | \$3.86 | Y | - |
| A0392 | - | ALS DEFIBRILLATION SUPPLIES | 7/1/2018 | MSRP | \$0.00 | - | - |
| A0394 | - | ALS IV DRUG THERAPY SUPPLIES | 7/1/2018 | MSRP | \$0.00 | - | - |
| A0396 | - | ALS ESOPHAGEAL INTUB SUPPLS | 7/1/2019 | FEE SCHED | \$12.70 | - | - |
| A0398 | - | ALS ROUTINE DISPOSBLE SUPPLS | 7/1/2018 | MSRP | \$0.00 | - | - |
| A0422 | - | AMBULANCE 02 LIFE SUSTAINING | 7/1/2019 | FEE SCHED | \$13.08 | Y | - |
| A0425 | - | GROUND MILEAGE | 7/1/2019 | FEE SCHED | \$3.86 | Y | - |
| A0426 | - | ALS 1 | 7/1/2019 | FEE SCHED | \$164.22 | Y | - |
| A0427 | - | ALS1-EMERGENCY | 7/1/2019 | FEE SCHED | \$260.05 | Y | - |
| A0428 | - | BLS | 7/1/2019 | FEE SCHED | \$136.85 | Y | - |

Example: Ambulance

All provider type pages have this section.

Provider Notices

2019

03/20/2019 [Prior Authorization Qualitrac Portal](#)

2018

11/20/2018 [Appropriate Billing Reminder](#)

11/08/2018 [Rate Updates Mass Adjustment](#)

10/19/2018 [Medicaid Fee Schedules](#)

07/02/2018 [Updated CLIA Claims Editing](#)

06/04/2018 [Coding Resources Change](#)

04/04/2018 [Updated Passport Eligible Populations & Reimbursement](#)

02/26/2018 [New Rendering Only Provider Enrollment Application](#)

2017

12/20/2017 [Ambulance Reimbursement Rate Changes](#)

12/11/2017 [Montana Plan First Procedure and Service Codes - Contraceptive \(IUD\) Update](#)

12/01/2017 [Montana Medicaid Expansion Prior Authorization Changes](#)

11/20/2017 [Qualified Medicare Beneficiary \(QMB\) Claim Adjustments](#)

11/02/2017 [New Medicare Card](#)

10/02/2017 [Montana Medicaid Expansion Changes](#)

09/14/2017 [Montana Plan First Anesthesia Update](#)

08/21/2017 [Clinical Pharmacist Practitioner](#)

08/08/2017 [HMK-CHIP Ambulance Claims Administration Change](#)

08/01/2017 [Telemedicine - Correction](#)

05/26/2017 [Federal Final Rule, "Nondiscrimination in Health Program and Activities" and Implication for Coverage of Services Related to Gender Transition](#)

04/06/2017 [New EPSDT Request Form](#)

Questions?

Claim Submission1

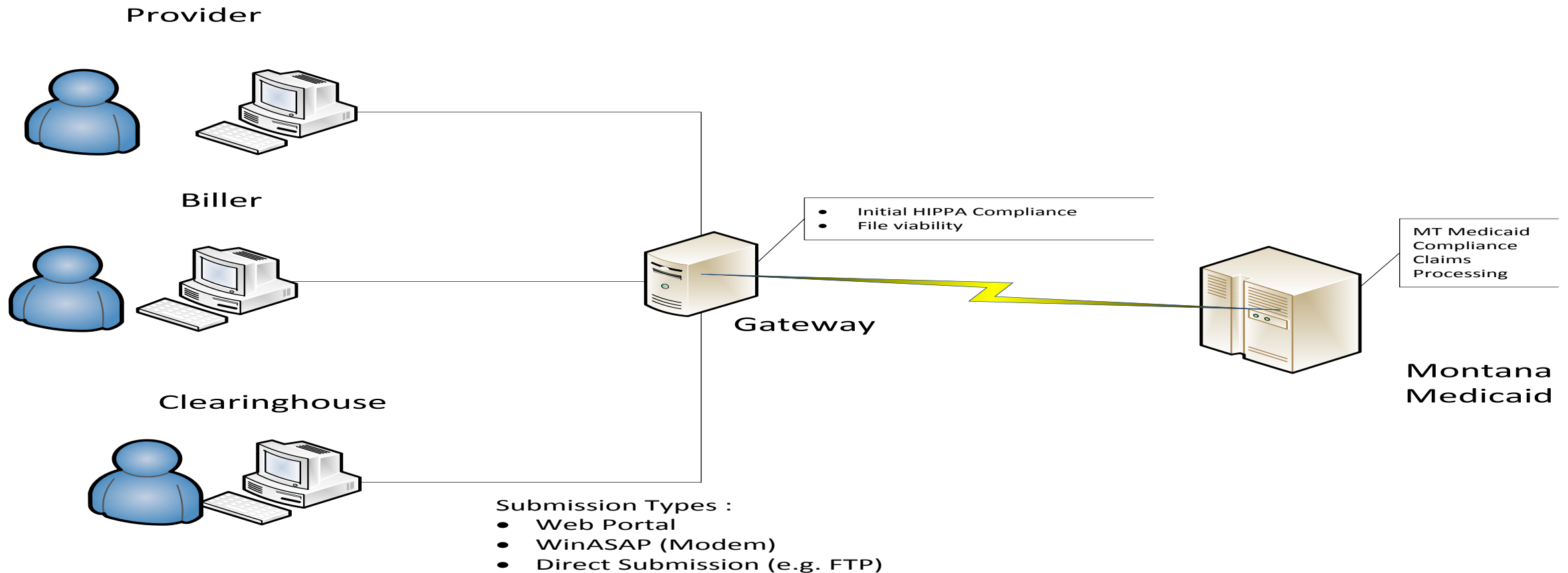
Claim Submission

Electronic Transactions

- EDI = Electronic Data Interchange
- ASC = Accredited Standards Committee is a subcommittee of American National Standards Institute (ANSI)
- X12N = Insurance format for the transfer of sensitive information
- X12N became a requirement for insurance transactions with the passage of HIPAA in 1996.

Electronic Claims

Different ways the Claim Files get to us.



Paper Claims

Paper Claims submitted for payment must be on:

- CMS 1500 - For Professional Billing
- UB-04 - For Institutional Billing
- ADA 2012 - For Dental Billing
- MA-3 - Nursing Home

All paper claims must be mailed to:

Claims Processing
P. O. Box 8000
Helena, MT 59604

Please use original forms not copies.

- CMS requirement
- Forms can be purchased from most office supply stores.
- Forms can speed up processing time allowing automated processes to read them.

Specific Field Requirements

Instructions can be found at:

MT specific instructions for the CMS-1500 and the CMS-1450/UB-04

- [Montana specific information can be found under the forms section of the medicaidprovider.mt.gov](https://www.medicaidprovider.mt.gov)
- Sample forms are detailed information for the individual box/field.

NUCC and NUBC

- [The full instructions for the CMS-1500 can be found at: www.nucc.org](http://www.nucc.org)
- [Information for the UB-04 can be found at: www.nubc.org](http://www.nubc.org)

CMS 1500

- Members ID-box 1a
- Members Name- box 4
- DX-box 21
- DOS-box 24
- POS-box 24b
- Procedure code-box 24d
- DX pointer-box 24e
- Line Charge-box 24f
- Days/Units-box 24g
- Taxonomy & Qualifier
- NPI or Atypical PID –box 24j-(and qualifier)24i
- Total Charges-box 28
- Provider Signature and Date-31
- Billing Provider Name, Address, & Zip code +4-box 33
- NPI or Atypical PID (and qualifier)-box 33 a&b

[illegible]

Required Fields

UB 04

Required Information:

- Providers Physical Address-field 1
- Bill Type-field 4
- Covered Dates-field 8
- Patient Name-field 8a
- Admit Date/hour-field 12
- Discharge Status-field 17
- Rev Codes-field 42
- HCPCS Codes field 44
- Service Dates-field 45
- Service units-field 46
- Charges-field 47
- Creation Date
- Payer Name-field 50
- Plan ID-field 51
- Prior Payments-field 54
- Billing Provider NPI-field 56
- Member Name-field 58
- Member ID-field 60
- DX Codes-field 66
- Attending Provider NPI-field 76
- Billing Provider Taxonomy (B3 Qualifier)-field 81



The image shows a screenshot of a UB 04 form, which is a standard format for submitting medical claims to Medicare. The form is divided into several sections, with various fields highlighted in yellow and green to indicate required information. The highlighted fields include:

- Provider Name, Physical Address, City, ST, Zip (Field 1)
- Bill Type (Field 4)
- Covered Dates (Field 8)
- Patient Name (Field 8a)
- Admit Date/hour (Field 12)
- Discharge Status (Field 17)
- Rev Codes (Field 42)
- HCPCS Codes (Field 44)
- Service Dates (Field 45)
- Service units (Field 46)
- Charges (Field 47)
- Creation Date
- Payer Name (Field 50)
- Plan ID (Field 51)
- Prior Payments (Field 54)
- Billing Provider NPI (Field 56)
- Member Name (Field 58)
- Member ID (Field 60)
- DX Codes (Field 66)
- Attending Provider NPI (Field 76)
- Billing Provider Taxonomy (B3 Qualifier) (Field 81)

The form also includes a section for "Total Charges and Amounts Due" and a section for "Billing Information". The highlighted fields are distributed across the form, with some fields in the top section and others in the bottom section.

ADA Dental

Required Information:

- Member Name
- Member ID
- Provider Name
- Provider Taxonomy (No qualifier needed)
- Provider Signature
- Bill Date
- Line Date of Service
- Procedure Code
- Total Charge for Each Line

Billed by:

Dentists, Dental Hygienists, Denturists, and HMK Dentists

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Prior Authorization
☐ EPSDT / Title XIX

2. Predetermination/Prior Authorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/YYYY) 14. Gender ☐ M ☐ F 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number 17. Employee Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other **18a. Reserved For Future Use**

19. Patient's Relationship to Person named in #3
☐ Self ☐ Spouse ☐ Dependent ☐ Other

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/YYYY) 22. Gender ☐ M ☐ F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

| 24. Procedure Date (MM/DD/YYYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 29a. CDT Code | 29b. CDT Code | 30. Description | 31. Fee |
|---------------------------------|-------------------------|------------------|----------------------------------|-------------------|--------------------|---------------|---------------|-----------------|---------|
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33. Missing Teeth Information (Place an "X" on each missing tooth)
 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

34. Diagnosis Codes (See CDT Codebook)
 34a. Primary Diagnosis Code (A) 34b. Secondary Diagnosis Code (B) 34c. Tertiary Diagnosis Code (C) 34d. Quaternary Diagnosis Code (D) 34e. Quinary Diagnosis Code (E)

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractually agreed upon arrangement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

☒ Patient/Guardian Signature _____ Date _____

37. I hereby authorize direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

☒ Submitter Signature _____ Date _____

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number () - 53. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

40. Is treatment for orthodontics?
☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/YYYY)

42. Months of Treatment Remaining ☐ No ☐ Yes (Complete 44)

43. Replacement of Prosthesis Remaining ☐ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/YYYY)

45. Treatment Resulting from
☐ Occupational Trauma/Surgery ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/YYYY) 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

54. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

☒ Signed (Treating Dentist) _____ Date _____

54. NPI 55. License Number
 56. Address, City, State, Zip Code 56a. Provider Specialty Code

57. Phone Number () - 58. Additional Provider ID

©2012 American Dental Association
 HSD (Same as ADA Dental Claim Form - J430, J431, J432, J433, J434)

To request call 800.947.4746 or go online at ada.org

MA-3 Claim Type Billers

Nursing Homes

*Each section is one claim

*One form can have 6 claims

ICF-Intermediate Care Facility

SNF-Skilled Nursing Facility

SNF/ICF Mental Aged

*Montana Mental Health Nursing Care Center

- Turn around documents (TADs) are MA-3 reports pre-completed with billing information for residents who were in the facility the previous month.
- These are generated and sent to facilities during the 3rd week of the month.
- Providers must make all the necessary changes to the TADs before returning them for processing.
- If there are changes, the provider must make out the No. of days, total charges, personal resources and/or net charges and enter the corrected information.
- Any new or additional information such as a new DX/recent complications may also be entered
- The authorized agent must sign, date and send in the reports after all changes are made and after the last billing date.

MA-3

Required Information:

1. NPI and taxonomy
2. Patient last and First Name
3. Member ID
4. DX Code
5. Date of Birth
6. Date of Admission
7. Statement Period
8. Number of Days
9. Level of Care
10. Total Charges
11. Personal Resource
12. Net Charges
13. Provider Signature and Date

STATE OF MONTANA - PUBLIC HEALTH & HUMAN SERVICES

FOR USE BY NURSING HOMES PLEASE TYPE OR PRINT FORM NO. MA-3

| | | | | |
|------------------------------------|-------|---------------------------|-------------------------------------------------------------|---------------|
| NURSING HOME - NAME AND ADDRESS | | PROV. INFORMATION. | MAIL TO: MONTANA MEDICAID DEPT. MA-3 P.O. BOX 8000 | |
| | | 1 | | |
| PATIENT: LAST NAME | FIRST | | 3 | AUTH. |
| 2 | | | | |
| DIAGNOSIS | | STATEMENT PERIOD | | |
| | | FROM TO | | |
| | | MO. 7 YEAR | | |
| NEW DIAGNOSIS/RECENT COMPLICATIONS | | TOTAL CHARGES | (LESS) PERSONAL RESOURCES | NET CHARGES |
| | | 10 | 11 | 12 |
| PATIENT: LAST NAME | FIRST | INDIVIDUAL NUMBER | | AUTH. |
| 2 | | | | |
| DIAGNOSIS | | STATEMENT PERIOD | | |
| | | FROM TO | | |
| | | MO. DAY YEAR MO. DAY YEAR | | |
| NEW DIAGNOSIS/RECENT COMPLICATIONS | | DIAG. CODE | NO. OF DAYS | LEVEL OF CARE |
| | | | | |
| | | TOTAL CHARGES | (LESS) PERSONAL RESOURCES | NET CHARGES |
| | | | | |

58



Paperwork Attachments and Electronic Claims

EOB for Primary Insurance

It is important that you send in all required information from the primary insurance's EOB.

- The page that shows the member and all their charges. Must show date of service, CPT codes, amount billed and amount paid by the primary insurance.
- The page that shows the “Key” to the codes listed on the EOB. This is normally the last page of the EOB.
- If there is more than one patient on the page, please cross out the information for other patients.

PATIENT:
PERF PRV:
CLAIM NO:

PATIENT NO:

| FROM / TO | PROC | AMOUNT | ALLOWABLE | SERVICES | DEDUCTIONS/OTHER | AMOUNT |
|-------------------|--------------|--------|-----------|-------------|------------------|--------|
| DATES | PSN PAY CODE | BILLED | AMOUNT | NOT COVERED | INELIGIBLE | PAID |
| 01/09-01/09/18 03 | PPD 90837 | 100.00 | 0.00 | 100.00 (1) | 0.00 | 0.00 |
| 01/29-01/29/18 03 | PPD 90837 | 100.00 | 0.00 | 100.00 (1) | 0.00 | 0.00 |
| 02/14-02/14/18 03 | PPD 90837 | 100.00 | 0.00 | 100.00 (1) | 0.00 | 0.00 |
| 03/09-03/09/18 03 | PPD 90837 | 100.00 | 0.00 | 100.00 (1) | 0.00 | 0.00 |
| 03/30-03/30/18 03 | PPD 90837 | 100.00 | 0.00 | 100.00 (1) | 0.00 | 0.00 |
| 04/17-04/17/18 03 | PPD 90837 | 100.00 | 100.00 | 0.00 | 0.00 | 100.00 |
| | | 600.00 | 100.00 | 500.00 | 0.00 | 100.00 |

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: \$100.00

| | |
|-----------------------------|---------------|
| TOTAL SERVICES NOT COVERED: | <u>500.00</u> |
| PATIENT'S SHARE: | \$0.00 |

| | | | | |
|-------------------------|----------|--|------------------------------|--------|
| NUMBER OF CLAIMS: | 1 | | AMOUNT PAID TO SUBSCRIBER: | \$0.00 |
| AMOUNT BILLED: | \$500.00 | | AMOUNT PAID TO PROVIDER: | \$0.00 |
| MAXIMUM ALLOWANCE: | \$0.00 | | RECOUPMENT AMOUNT: | \$0.00 |
| SERVICES NOT COVERED: | \$500.00 | | NET AMOUNT PAID TO PROVIDER: | \$0.00 |
| AMOUNT PREVIOUSLY PAID: | \$0.00 | | SUPPRESSED PAYMENT AMOUNT: | \$0.00 |

* PLACE OF SERVICE (PS)

03. PHYSICIAN'S OFFICE.

MESSAGES:

(1). DUPLICATE BILLING, PREVIOUS CLAIM SUBMITTED.

EOB Example - Correct

SUBSCRIBER ID:
CLAIM DATE:
REND PROV ID:

SUBSCRIBER NAME:
DATE RECEIVED:
REND PROV:

CLAIM NUMBER:
PRODUCT:

| PATIENT CONTROL NUMBER | PATIENT ID | AUTH/REF NUMBER | DRG | DRG WEIGHT | CLAIM CHARGE AMOUNT | CLM ADJ AMT | GRP CD | CLM ADJ RSN CD | CLAIM PAYMENT AMOUNT | PATIENT RESPONSIBILITY |
|------------------------|------------|-----------------|-----|------------|---------------------|-------------|--------|----------------|----------------------|------------------------|
| 06077581925 | | | | | \$100.00 | | | | \$0.00 | \$100.00 |

SERVICE LINE DETAIL(S)

| LINE CTRL# | DATES OF SERVICE | SUB PROD/ SVC/ MOD | ADI PROD/ SVC | MOD | REV | UNITS | ADI QTY | CHARGE | AMOUNT ALLOWED | ADI AMOUNT | GRP CD | CLM ADJ RSN CD | PAYMENT AMOUNT | REMARK/ NOTES |
|---------------|---------------------|--------------------|---------------|-----|-----|-------|----------|----------|----------------|------------|--------|----------------|----------------|---------------|
| 0602677581925 | 11/11/19 - 11/11/19 | | 95837 | | | 1 | | \$100.00 | \$100.00 | \$100.00 | PR | 1 | \$0.00 | W1 |
| CLAIM# | | | | | | | SUBTOTAL | \$100.00 | \$100.00 | \$100.00 | | | \$0.00 | |

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

| | | | | | | | | | | | | | |
|---------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--------|
| TOTAL PAYABLE TO PROVIDER | | | | | | | | | | | | | \$0.00 |
|---------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--------|

NOTES

PR1

PATIENT RESPONSIBILITY - DEDUCTIBLE AMOUNT

W1

BENEFITS FOR THIS SERVICE HAVE BEEN APPLIED TO YOUR DEDUCTIBLE. THE AMOUNT YOU OWE SHOWN ON THIS STATEMENT IS THE AMOUNT YOU MAY OWE YOUR PROVIDER.


Electronic with Paper Attachments

Control Number

- NPI/API
- Members ID#
- Date of Service

Completed forms should be Mailed or Faxed to:

P.O. Box 8000
Helena, MT 59604
Fax: 406-442-4402



Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number _____

Date of Service _____

Billing NPI/API _____

Member ID Number _____

Type of Attachment _____

Electronic with Paper Attachments

- Must indicate that Paperwork is being sent in the electronic claim file.
- Loop 2300, PWK segment
- Must be received by Claims Dept. within 30 days of electronic submittal.
- After 30 days, the claim will be denied and will need to be resubmitted with paper attachments.
- Must include Paperwork Attachment Cover Sheet.
- Can be found on the website:
<https://medicaidprovder.mt.gov/forms#240933498-forms-p--z>
- Must include the Attachment Control Number.

| | | | | |
|------------|---|---------------------|---|--------------------|
| 9999999999 | - | 888888888 | - | 11182015 |
| NPI | | Member ID Number | | Date of Service |

Questions?

Claim Status1

Claim Status

Claim Status



Montana Access to Health Web Portal

[Exit](#)

MONTANA MEDICAID TEST1

Montana Access to Health Web Portal Home Page

Navigate to any of the functions in the Web portal by clicking the following links or by using the top navigation bar. For information about each function, click the corresponding column header. Click on 'My Profile,' located in the 'My Access' section, to display your current Montana Access to Health Web Portal profile. You will be able to perform only those tasks allowed by the user privileges assigned to you.

Site Contents

| Inquiries | Submissions | Retrievals | Manage Users | My Access |
|----------------------------------------------|------------------------------|-------------------------------------|-------------------------------------------------------|-------------------------------------|
| Eligibility | Upload Files | View/Download Files | Add New User to Organization | My Profile |
| Claim Status | | View e!SOR Reports | Add Existing User to Organization | Change Organization |
| Provider Payment Summary | | My Inbox | Update or Remove Users/Reset Password | Change Password |
| Claims-based Medical History | | | Manage Submitter IDs | Manage Proxies |
| Electronic Health Record | | | | |
| Provider Locator | | | | |

ATTENTION PROVIDERS: The Electronic Health Record link has been added to allow you to view your patients' claims medical history. If you need this access and do not have it, please contact your office administrator. E-prescribing is now available. Please contact your office administrator to add prescribing rights to your user account.

You've logged into the organization displayed under the navigation bar on the right. This organization will be used to determine the Provider Number and Submitter IDs you can use for your transactions (i.e., Inquiries, Submissions and Retrievals). To change this organization, click 'Change Organization' and follow the instructions.

Claim Status Inquiry



Montana Access to Health Web Portal

[Exit](#)

[Home](#) > [Inquiries](#) > Claim Status Inquiry

MONTANA MEDICAID TEST1

Claim Status Inquiry

Select a Provider Number and enter available information in the remaining fields before clicking 'Submit'. Searches will be performed only against claims processed in the last three years.

* denotes required field(s)

* NPI or Provider
Number:

* Member Information:

Client ID:

Claim First Date of Service:

| | | |
|----------------------|----------------------|----------------------|
| mm | dd | ccyy |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

Claim Last Date of Service:

| | | |
|----------------------|----------------------|----------------------|
| mm | dd | ccyy |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

or

ICN/TCN:

Submit

Clear Fields

MONTANA
DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

[Home](#) [Inquiries](#) [Claim Status Inquiry](#) [Claim Detail](#)

MONTANA MEDICAID TEST1

| | | | |
|------------------------------------|-----------------------------------------------|-----------------------------------------|--------------------|
| Status Information Effective Date: | 07/31/2019 | ICN/TCN: | |
| Status Category Code: | D0: Entity not found - change search criteria | | |
| Status: | 132: Entity's Medicaid provider id. | | |
| Service Period: | From To | | |
| Bill Type Identifier: | | Patient Account Number or Trace Number: | dbraga_ [REDACTED] |
| Charged Amount: | \$ 0.00 | Adjudication or Payment Date: | |
| Payment Amount: | \$ 0.00 | Check Issue or EFT Effective Date: | |

NPI or Provider Number: [REDACTED]
Name or Servicing Organization: NOT AVAILABLE

| | | | |
|----------------|-----------------|------------|---------------|
| Name: | unknown unknown | Client ID: | '99-99999999' |
| Date of Birth: | | Gender: | |

| | |
|-----------------|------------------|
| Name: | Montana Medicaid |
| Identification: | 77039 |

| | |
|----------------------------------|---------|
| Name or Submitting Organization: | UNKNOWN |
| Portal User ID: | 7779999 |

[Back to Claim Status Inquiry](#)

eSors1

Obtaining Statement of Remittance (eSors)

Obtaining your eSOR



Montana Access to Health Web Portal

[Exit](#)

MONTANA MEDICAID TEST1

Montana Access to Health Web Portal Home Page

Navigate to any of the functions in the Web portal by clicking the following links or by using the top navigation bar. For information about each function, click the corresponding column header. Click on 'My Profile,' located in the 'My Access' section, to display your current Montana Access to Health Web Portal profile. You will be able to perform only those tasks allowed by the user privileges assigned to you.

Site Contents

| Inquiries | Submissions | Retrievals | Manage Users | My Access |
|----------------------------------------------|------------------------------|-------------------------------------|-------------------------------------------------------|-------------------------------------|
| Eligibility | Upload Files | View/Download Files | Add New User to Organization | My Profile |
| Claim Status | | View e!SOR Reports | Add Existing User to Organization | Change Organization |
| Provider Payment Summary | | My Inbox | Update or Remove Users/Reset Password | Change Password |
| Claims-based Medical History | | | Manage Submitter IDs | Manage Proxies |
| Electronic Health Record | | | | |
| Provider Locator | | | | |

ATTENTION PROVIDERS: The Electronic Health Record link has been added to allow you to view your patients' claims medical history. If you need this access and do not have it, please contact your office administrator. E-prescribing is now available. Please contact your office administrator to add prescribing rights to your user account.

You've logged into the organization displayed under the navigation bar on the right. This organization will be used to determine the Provider Number and Submitter IDs you can use for your transactions (i.e., Inquiries, Submissions and Retrievals). To change this organization, click 'Change Organization' and follow the instructions.

Obtaining your eSOR

Montana Access to Health Web Portal

[Home](#) > [Retrievals](#) > View/Download Electronic Statement of Remittance

MONTANA MEDICAID TEST1

[Exit](#)

View/Download Electronic Statement of Remittance

Select a provider number and click "Submit" to retrieve a list of Electronic Statement of Remittance Report files.

NPI or Provider Number:

▼

Submit

eSOR by Date

View/Download State of Remittance



A portion of this payment is made from American Recovery Investment Act funds. Go to <http://recovery.mt.gov> to follow how we are reinvesting and rebuilding Montana with funding from the Recovery and Reinvestment Act.

Report files will be stored for 90 days, after which time they will be deleted from the Web Portal.

| Payment Date | File Name | File Size | Download Speed |
|--------------|--------------------------------------------|---------------|---------------------------|
| 05/27/2019 | 05272019_1003902909_01.pdf | 68,369 bytes | Calculate |
| 05/20/2019 | 05202019_1003902909_01.pdf | 29,707 bytes | Calculate |
| 05/13/2019 | 05132019_1003902909_01.pdf | 39,367 bytes | Calculate |
| 05/06/2019 | 05062019_1003902909_01.pdf | 58,707 bytes | Calculate |
| 04/29/2019 | 04292019_1003902909_01.pdf | 39,373 bytes | Calculate |
| 04/22/2019 | 04222019_1003902909_01.pdf | 29,707 bytes | Calculate |
| 04/15/2019 | 04152019_1003902909_01.pdf | 39,371 bytes | Calculate |
| 04/08/2019 | 04082019_1003902909_01.pdf | 39,371 bytes | Calculate |
| 04/01/2019 | 04012019_1003902909_01.pdf | 39,375 bytes | Calculate |
| 03/25/2019 | 03252019_1003902909_01.pdf | 49,039 bytes | Calculate |
| 03/18/2019 | 03182019_1003902909_01.pdf | 58,701 bytes | Calculate |
| 03/11/2019 | 03112019_1003902909_01.pdf | 68,363 bytes | Calculate |
| 03/04/2019 | 03042019_1003902909_01.pdf | 87,695 bytes | Calculate |
| 02/25/2019 | 02252019_1003902909_01.pdf | 68,367 bytes | Calculate |
| 02/18/2019 | 02182019_1003902909_01.pdf | 126,352 bytes | Calculate |

Remit Example

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

HELENA

MT 59602

VENDOR # 0000 REMIT ADVICE # 431 EFT/CHK # 241 DATE 01/07/2019 PAGE 2
NPI #: 14 TAXONOMY:

| RECIP ID | NAME | SERVICE FROM | DATES TO | UNIT OF SVC | PROCEDURE REVENUE NDC | TOTAL CHARGES | ALLOWED | CO-PAY | REASON & REMARK CODES |
|-----------------------------------|-----------------|--------------|----------------------|-------------|-----------------------|---------------|---------|--------|-----------------------|
| PAID CLAIMS - MISCELLANEOUS CLAIM | | | | | | | | | |
| | | TAN | 12042018 12042018 | 1.000 | 90837 | 165.00 | 89.92 | | |
| | ICN 21836100255 | | PATIENT NUMBER=73710 | | | | | | |
| ***CLAIM TOTAL***** | | | | | | 165.00 | 89.92 | | |
| | | | 12052018 12052018 | 1.000 | 90837 | 165.00 | 89.92 | | |
| | ICN 21836100255 | | PATIENT NUMBER=73720 | | | | | | |
| ***CLAIM TOTAL***** | | | | | | 165.00 | 89.92 | | |

Example of Denial Reason Codes

*****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE *****

- N286** **Missing/incomplete/invalid referring provider primary identifier.**
- 133** **The disposition of this service line is pending further review. (Use only with Group Code OA). Note: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).**
- 15** **The authorization number is missing, invalid, or does not apply to the billed services or provider.**

Questions?

Errors1

Common Billing Errors

Common Billing Errors

- Missing/Incorrect Passport number or in incorrect field. (17a for 1500/7 for UB)
- Missing PWK indicator on electronic claims.
- Incomplete primary EOB. Missing pages that contain code remarks.
- Member not eligible on date of service. Remember coverage could change monthly.
- Exact duplicates. Can be avoided by checking eSORs weekly or using IARs for claim corrections.
- Missing/incorrect Prior Authorization number or in incorrect field. (23 for 1500/63 for UB)

Individual Adjustment Requests¹

Submitting Individual Adjustment Requests

Submitting Adjustments

When should I request an adjustment?

- Claim was overpaid or underpaid.
- Claim was paid but the information on the claim was incorrect (e.g., member ID, provider number, date of service, procedure code, diagnoses, units).
- Individual line is denied on a multiple-line UB-04 claim. The denied service must be submitted as an adjustment rather than a rebill.

If there are a lot of corrections to make, you may want the “claim voided and reprocessed”. This has to be requested on the adjustment form and needs to include the corrected claim.

Adjustment Requirements

- Must be requested on the Individual Adjustment Request Form.
- Only be submitted on paid claims; denied claims cannot be adjusted.
- Always require a remit from the paid claim.
- Claims Processing must receive individual claim adjustments within 12 months from the date of Payment. After this time, gross adjustments are required via DPHHS.

Adjustment Request Form

One adjustment form per Internal Control Number

Section A – Must be completely filled out

Section B – Only the info that needs changing

MONTANA DPHHS
Healthy People • Healthy Communities
Protect • Promote • Prevent

Montana Healthcare Programs
Medicaid • Mental Health Services Plan • Healthy Montana Kids

Individual Adjustment Request

Instructions:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your remittance statement. Complete only the items in Section B that represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advice and Adjustments chapter in the General Information for Providers manual or call Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1837 (Helena).

A. Complete all fields using the remittance advice for information.

| | |
|-------------------------------------------------|----------------------------------|
| 1. Provider Name, Address, and Telephone Number | 3. Internal Control Number (ICN) |
| Name _____ | _____ |
| Street or P.O. Box _____ | 4. NPI/API _____ |
| City _____ State _____ ZIP _____ | 5. Member ID Number _____ |
| Telephone Number _____ | 6. Date of Payment _____ |
| 2. Member Name _____ | 7. Amount of Payment \$ _____ |

B. Complete only the items which need to be corrected.

| Item | Date of Service or Line Number | Information on Statement | Corrected Information |
|-----------------------------------------|--------------------------------|--------------------------|-----------------------|
| 1. Units of Service | | | |
| 2. Procedure Code/NDC/Revenue Code | | | |
| 3. Dates of Service (DOS) | | | |
| 4. Billed Amount | | | |
| 5. Personal Resource (Nursing Facility) | | | |
| 6. Insurance Credit Amount | | | |
| 7. Net (Billed - TPL or Medicare Paid) | | | |
| 8. Other/Remarks (Be specific.) | | | |

Signature _____ Date _____

When the form is completed and signed, attach a copy of the remittance advice and a copy of the corrected claim, and mail to Claims, P.O. Box 8000, Helena, MT 59604, or fax to 406.442.4402.

Adjustment Request Form - Section A

Completing an Individual Adjustment Request Form – Section A

| Field | Description |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Provider Name and Address | Provider's name and address (and mailing address if different). |
| 2. Name | The member's name |
| 3. Internal Control Number (ICN) | There can be only one ICN per Adjustment Request Form. When adjusting a claim that has been previously adjusted, use the ICN of the most-recent claim. |
| 4. Provider number | The provider's NPI/API. |
| 5. Member Medicaid Number | Member's Medicaid ID number. |
| 6. Date of Payment | Date claim was paid. |
| 7. Amount of Payment | The amount of payment from the remittance advice. |

Adjustment Request Form - Section B

Completing an Individual Adjustment Request Form – Section B

| Field | Description |
|-----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Units of Service | If a payment error was caused by an incorrect number of units, complete this line. |
| 2. Procedure Code/NDC Revenue Code | If the procedure code, NDC, or revenue code are incorrect, complete this line. |
| 3. Dates of Service (DOS) | If the date of service is incorrect, complete this line. |
| 4. Billed Amount | If the billed amount is incorrect, complete this line. |
| 5. Personal Resource (Nursing Facility) | If the member's personal resource amount is incorrect, complete this line. |
| 6. Insurance Credit Amount | If the member's insurance credit amount is incorrect, complete this line. |
| 7. Net (Billed - TPL or Medicare Paid) | If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid. |
| 8. Other/Remarks | If none of the above items apply or if unsure what caused the payment error, complete this line. |

Adjustment Form Examples

Example #1 – Incorrect units billed

Actual Claim

```
1541234 Mouse, Mickey          08012019 08312019  1.000 S0215  53.04 0.39
ICN 21925200255001234 PATIENT NUMBER=1541234
TEAM NUMBER 01

***CLAIM TOTAL***** 53.04 0.39
```

This is what the initial paid claim looks like on the eSOR.

Adjustment Form Examples

A. Complete all fields using the remittance advice for information.

1. Provider Name, Address, and Telephone Number

DDP Provider

Name

123 Any Street

Street or P.O. Box

City

MT

12345

City

State

ZIP

4065551212

Telephone Number

2. Member Name

Mickey Mouse

3. Internal Control Number (ICN)

21925200255001234

4. NPI/API

1010101010

5. Member ID Number

1541234

6. Date of Payment

09/09/2019

7. Amount of Payment

\$ 0.39

B. Complete only the items which need to be corrected.

| Item | Date of Service or Line Number | Information on Statement | Corrected Information |
|---------------------|--------------------------------|--------------------------|-----------------------|
| 1. Units of Service | 01 | 1 | 136 |

Adjustment Form Example #1

Adjustments – Two parts.

1541234 Mouse, Mickey 08012019 08312019 1.000 S0215 53.04- 0.39-
ICN 21928800255101700 PATIENT NUMBER=1541234
TEAM NUMBER 01

CLAIM TOTAL** 53.04- 0.39-

1541234 Mouse, Mickey 08012019 08312019 136.000 S0215 53.04 53.04
ICN 21928800255201700 PATIENT NUMBER=1541234
TEAM NUMBER 01

CLAIM TOTAL** 53.04 53.04

This is what the paid adjusted claim looks like on the eSOR.

Adjustment Form Example #2

Example #2 – Incorrect Units and Billed Amount

```
1123175 Duck, Donald      08012019 08312019      1.000 T2021      596.47 195.19
ICN 21925300255013567 PATIENT NUMBER=1123175
TEAM NUMBER 01
                                08012019 08312019      1.000 T2002      248.45 248.45
                                ***CLAIM TOTAL***** 844.92 443.64
```

This is what the initial paid claim looks like on the eSOR.

Adjustment Form Example #2

A. Complete all fields using the remittance advice for information.

1. Provider Name, Address, and Telephone Number

DDP Provider

Name

123 Any Street

Street or P.O. Box

City

MT

12345

City

State

ZIP

4065551212

Telephone Number

2. Member Name

Donald Duck

3. Internal Control Number (ICN)

21925300255013567

4. NPI/API

1010101010

5. Member ID Number

1123175

6. Date of Payment

09/09/2019

7. Amount of Payment

\$ 443.64

B. Complete only the items which need to be corrected.

| Item | Date of Service or Line Number | Information on Statement | Corrected Information |
|------------------------------------|--------------------------------|--------------------------|-----------------------|
| 1. Units of Service | 01 | 1 | 18 |
| 2. Procedure Code/NDC/Revenue Code | | | |
| 3. Dates of Service (DOS) | | | |
| 4. Billed Amount | 01 | 596.47 | 955.95 |

Adjustment Form Example #2

Adjustments – Two parts.

1123175 Duck, Donald 08012019 08312019 1.000 T2021 596.47- 195.19-
ICN 21928800255102500 PATIENT NUMBER=1123175
TEAM NUMBER 01

08012019 08312019 1.000 T2002 248.45- 248.45-

CLAIM TOTAL** 844.92- 443.64-

1123175 Duck, Donald 08012019 08312019 18.000 T2021 955.95 995.95
ICN 21928800255202500 PATIENT NUMBER=1123175
TEAM NUMBER 01

08012019 08312019 1.000 T2002 248.45 248.45

CLAIM TOTAL** 1244.40 1244.40

This is what the paid adjusted claim looks like on the eSOR.

Adjustment Form Example #3

Example #3 – Multiple lines to correct

| | | | | | | |
|----------------------------------------------|---------------------|----------|--------|-------|--------|--------|
| 4054321 Doo, Scooby | 08012019 | 08072019 | 60.000 | S5135 | 331.35 | 331.35 |
| ICN 21923800255069330 PATIENT NUMBER=4054321 | | | | | | |
| TEAM NUMBER 01 | | | | | | |
| | 08102019 | 08102019 | 12.000 | S5135 | 66.27 | 66.27 |
| | 08132019 | 08172019 | 60.000 | S5135 | 331.35 | 331.35 |
| | ***CLAIM TOTAL***** | | | | 728.97 | 728.97 |

This is what the initial paid claim looks like on the eSOR.

Adjustment Form Example #3

| A. Complete all fields using the remittance advice for information. | | | |
|---------------------------------------------------------------------------------------------------------------------------------------|-------|----------------------------------|--|
| 1. Provider Name, Address, and Telephone Number | | 3. Internal Control Number (ICN) | |
| DDP Provider | | 21923800255069330 | |
| Name | | | |
| 123 Any Street | | 4. NPI/API | |
| Street or P.O. Box | | 1010101010 | |
| City | MT | | |
| City | State | ZIP | |
| 4065551212 | | 5. Member ID Number | |
| Telephone Number | | 4054321 | |
| 2. Member Name | | 6. Date of Payment | |
| Scooby Doo | | 09/02/2019 | |
| | | 7. Amount of Payment | |
| | | \$ 728.97 | |
| 8. Other/Remarks (Be specific.) | | | |
| Line 1 - decrease from 60 units to 15 units. Line 2 - decrease from 12 units to 3 units. Line 3 - decrease from 60 units to 15 units. | | | |
| 8. Other/Remarks (Be specific.) | | | |
| Line 1 - Decrease from 15 units to 3 units & Decrease billed amount from \$82.84 to \$66.27 | | | |
| Line 2 - Decrease from 14 units to 4 units & Increase billed amount form \$77.32 to \$88.36 | | | |
| | | | |

Adjustment Form Example #3

Adjustments – Two parts.

| | | | | | | |
|-----------------------|------------------------|----------|--------|-------|---------|---------|
| 4054321 Doo, Scooby | 08012019 | 08072019 | 60.000 | S5135 | 331.35- | 331.35- |
| ICN 21928800255103600 | PATIENT NUMBER=4054321 | | | | | |
| TEAM NUMBER 01 | | | | | | |
| | 08102019 | 08102019 | 12.000 | S5135 | 66.27- | 66.27- |
| | 08132019 | 08172019 | 60.000 | S5135 | 331.35- | 331.35- |
| | ***CLAIM TOTAL***** | | | | 728.97- | 728.97- |

| | | | | | | |
|-----------------------|------------------------|----------|--------|-------|--------|--------|
| 4054321 Doo, Scooby | 08012019 | 08072019 | 15.000 | S5135 | 331.35 | 331.35 |
| ICN 21928800255203600 | PATIENT NUMBER=4054321 | | | | | |
| TEAM NUMBER 01 | | | | | | |
| | 08102019 | 08102019 | 3.000 | S5135 | 66.27 | 66.27 |
| | 08132019 | 08172019 | 15.000 | S5135 | 331.35 | 331.35 |
| | ***CLAIM TOTAL***** | | | | 728.97 | 728.97 |

This is what the paid adjusted claim looks like on the eSOR.

Questions?



If You Have Questions...

Provider Relations Contact Information

Provider Relations Call Center:

- (800) 624-3958 or (406) 442-1837
- Monday through Friday
- 8 a.m. - 5 p.m. Mountain Time

IVR - Automated system available 24/7:

- (800) 714-0060

Field Representative:

- Deb Braga (406) 457-9553

Conclusion