

Dental Claims in MPATH

Presented by Tasha Harris, Provider Relations Field Rep

In this training

- MPATH Claims Setup
- MPATH Claims Solution
- MPATH Additional Portal Features
- Adjustments
- Where do I go for help

MPATH Claims Setup

Manage Billing Providers

Add Billing NPIs to this section
ONLY if,

- You will be submitting claims through MPATH
- You need access to the weekly Remittances for this NPI

This is the Optum assigned Provider ID number. *Not the PID from MT Medicaid. You will need to contact the PR Call Center for this information.*

Note : Fields marked with an asterisk * are required.

Provider Name or Organization Name? * Provider Name Organization Name

NPI or API? * NPI API

TIN/FEIN: *

Enter Provider ID Number: *

Manage Affiliations







This function is required to populate Rendering providers to the drop-down list, in the MPATH claims entry system.

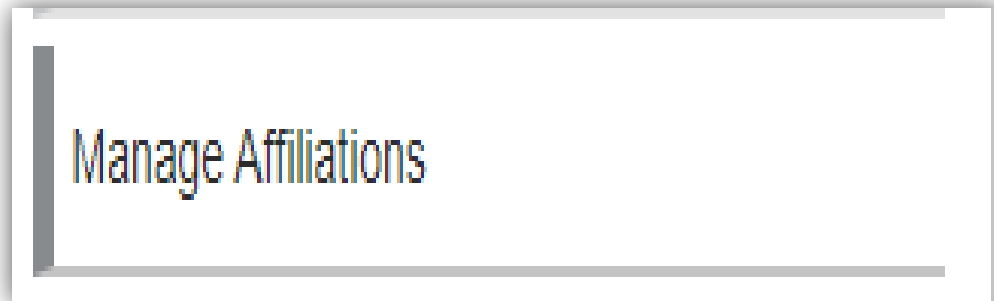
Add an Affiliation

Click the **Provider Enrollment** tab under myMenu.

Select the **Radio button** on the Enrollment line of the organization NPI.

Click the **Manage Affiliations** button now visible under the Enrollment Menu.

Actions	Type	Status
     	Enrollment	Enrolled



Add an Affiliation Cont.

Search for Providers tab.

Enter **Provider's NPI or name.**

Click Search.

Click the **Radio button** on the provider line now visible.

Assigned Locations line is now visible.

Search for Providers Pending Approval Requested Affiliations Existing Affiliations User Guide

Search for Provider ? Help

To build an affiliation, search for the provider you want to affiliate by entering the first name, last name, or NPI. If no information displays the provider isn't an active enrolled provider and the application will display a 'no affiliation found' message. Based upon your search criteria multiple providers may display, if this is the case, select the provider you want to participate by selecting the radio button next to the provider's name. For authentication and security, please enter the last four (4) digits of the provider's Social Security Number and enter the effective date of the affiliation. When completed select the add and continue button at the bottom of the screen and the request will move to the pending approval tab.

First Name i Last Name i NPI/Atypical ID i i

	First Name	Last Name	NPI/Atypical ID	Effective Date ↓	Last 4 digits of SSN/ITIN *	Actions	File Name
<input checked="" type="radio"/>	HEATHER	THOMAS-CLARK	1083670285	MM/DD/YYYY	<input type="text"/>	i	

Assigned Locations i

	Address Line
<input type="checkbox"/> i	1111 BAKER AVE

Items per page 10 1 - 1 of 1 < >

Add an Affiliation Cont.

Enter **Effective Date** & last 4 digits of the provider's **SS#**.

Click the **box** under Assigned Locations for all where the provider will be practicing. Then click the **Pencil** icon.

In the Pop-up box, enter **Effective Date** again. Click **Save**.

Click **Add and Continue**.

The image shows a screenshot of a web application interface. The top part displays a table with columns: First Name, Last Name, NPI/Atypical ID, Effective Date, Last 4 digits of SSN/ITIN, Actions, and File Name. The data row shows: ROBERT, NITSCHELM, 1598719064, 05/12/2022, and a redacted SSN. Below this is a section for 'Assigned Locations' with a table containing one entry: 1111 BAKER AVE. A pop-up box titled '1111 BAKER AVE' is open, showing a table with columns: Select, Program Name, Effective Date*, and Termination Date. The data row shows: [checked], Montana Medicaid (HMK Plus), 05/12, and MM/DD/YYYY. The pop-up box has 'Save' and 'Cancel' buttons at the bottom right.

First Name	Last Name	NPI/Atypical ID	Effective Date ↓	Last 4 digits of SSN/ITIN	Actions	File Name
ROBERT	NITSCHELM	1598719064	05/12/2022	[REDACTED]	[Add] [Info]	

Assigned Locations ⓘ

	Address Line	
[checked] ⓘ	1111 BAKER AVE	[Pencil]

Items per page: 10 | 1 - 1 of 1

1111 BAKER AVE

Select	Program Name	Effective Date*	Termination Date
[checked] ⓘ	Montana Medicaid (HMK Plus)	05/12 [Calendar]	MM/DD/YYYY [Calendar]

[Save] [Cancel]

Manage Existing Affiliations

Pending Approval tab will show any providers you have submitted to be affiliated.

Requested Affiliations are providers who are requesting affiliation.

Approved affiliations can be searched under the **Existing Affiliations** tab.

The screenshot displays the 'Manage Affiliations' interface. At the top, there are four tabs: 'Search for Providers', 'Pending Approval', 'Requested Affiliations', and 'Existing Affiliations'. The 'Existing Affiliations' tab is currently selected. Below the tabs, there is a 'Search for Provider' section with three input fields for 'First Name', 'Last Name', and 'NPI/Approval ID', followed by a 'Search' button. A 'User Guide' link is visible in the top right corner. Below the search section, there is a table listing existing affiliations. The table has columns for 'First Name', 'Last Name', 'NPI/Approval ID', 'Effective Date', 'Terminate Date', 'Actions', and 'File Name'. Two rows of data are visible in the table.

	First Name	Last Name	NPI/Approval ID	Effective Date	Terminate Date	Actions	File Name
0	Reels	Chade		08/1/2021	08/31/2021		
0	Jerelle	Adams		12/01/2021	12/31/2021		

Ending Affiliations

Click the **Existing Providers** tab.

Click the **Search** button.

This will bring up a list of the providers affiliated to this NPI.

Click the **Radio button** for the provider you wish to terminate.

Search for Providers | Pending Approval | Requested Affiliations | **Existing Affiliations** | User Guide

Search for Provider Help

The existing affiliation tab lists all affiliations linked to the organizational provider. To manage the affiliation, enter in additional information. For example, adding a new physical address to an existing rendering affiliation. Within this tab, the organizational user has the ability to terminate the affiliation by entering in a termination date.

First Name i Last Name i NPI/Atypical ID i i

	First Name	Last Name	NPI/Atypical ID	Effective Date ↑	Terminate Date	Actions	File Name
<input type="radio"/>	KATHRYN	NEFF	1710945829		MM/DD/YYYY	i	
<input type="radio"/>	DANIEL	MUNZING	1700844966		MM/DD/YYYY	i	
<input type="radio"/>	HIKMAT	MAALIKI	1295897650		MM/DD/YYYY	i	
<input type="radio"/>	JOHN	KALBFLEISCH	1609824283		MM/DD/YYYY	i	
<input type="radio"/>	ANITA	BEACH	1922064401		MM/DD/YYYY	i	
<input type="radio"/>	SUZANNE	DANIELL	1811966526		MM/DD/YYYY	i	
<input type="radio"/>	JON	MILLER	1841267192		MM/DD/YYYY	i	

ANITA BEACH 1922064401 i

Ending Affiliations Cont.

The **Assign Locations** box is now visible.

Click the **radio button** under **Deactivate**.

Enter the **termination date**.

Click the **Save and Continue** button.

The provider will remain on your Affiliations list. However, it will not appear in the claims drop down.



Address Line	Active	Deactivate	Effective Date	Terminate Date	
1111 BAKER AVE	<input type="radio"/>	<input checked="" type="radio"/>	01/01/2006	05/11/2022	

Questions?

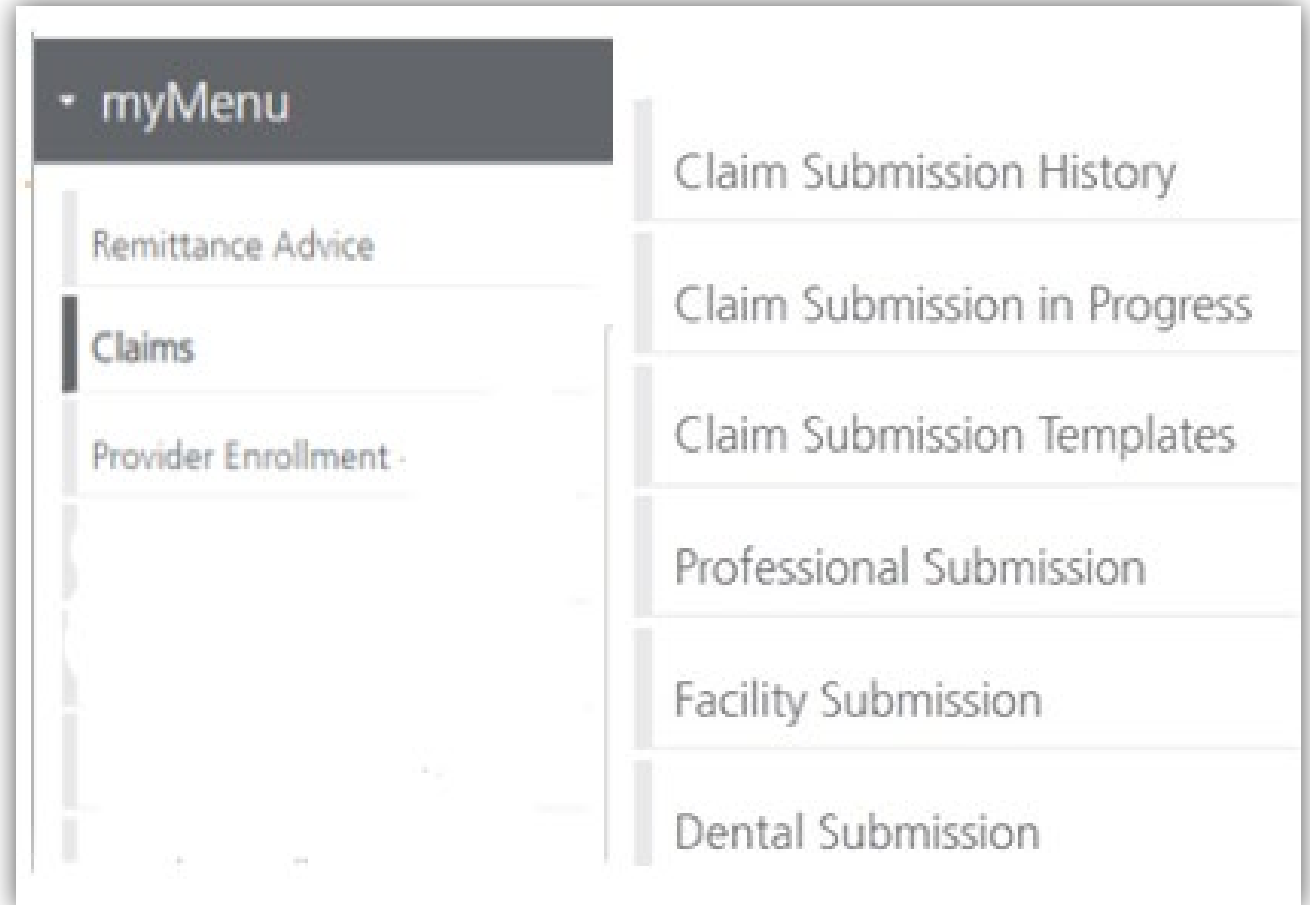
MPATH Claim Submission

Claim Submission Menu

Under myMenu, without clicking, place your cursor on the **Claims** tab.

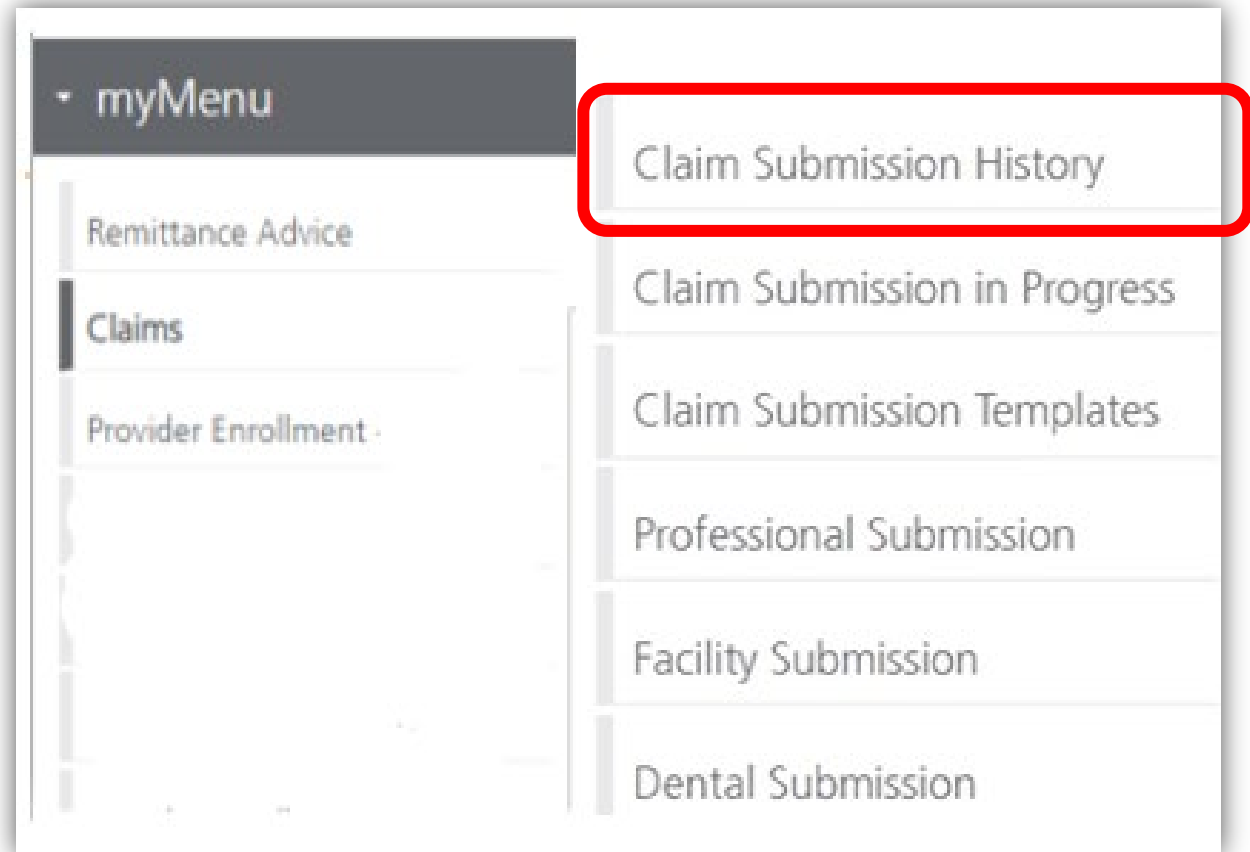
A side menu with submission options will appear.

The following slides will describe each function.



Claims Submission History

This option will show you the most recent claims submitted in the MPATH portal to Montana Medicaid for processing.




Claims Submission in Progress

This function is for claims started but not submitted.

Example:

You begin to complete the information for claim. You are interrupted and need to exit the system. When you click Save and Exit at the bottom of the current claim screen; your claim moves to this section.

When you return, click Claims Submission in Progress. Click the **Pencil** icon to pick up where you left off on that claim.

Action	Member Name	Date of Service	NPV/API	Date Last Modified
	JOEL DUPREE	12/06/2021	1073820965	12/15/2021

Claim Submission Templates

This function is a time saving tool for reoccurring claims.

Example:

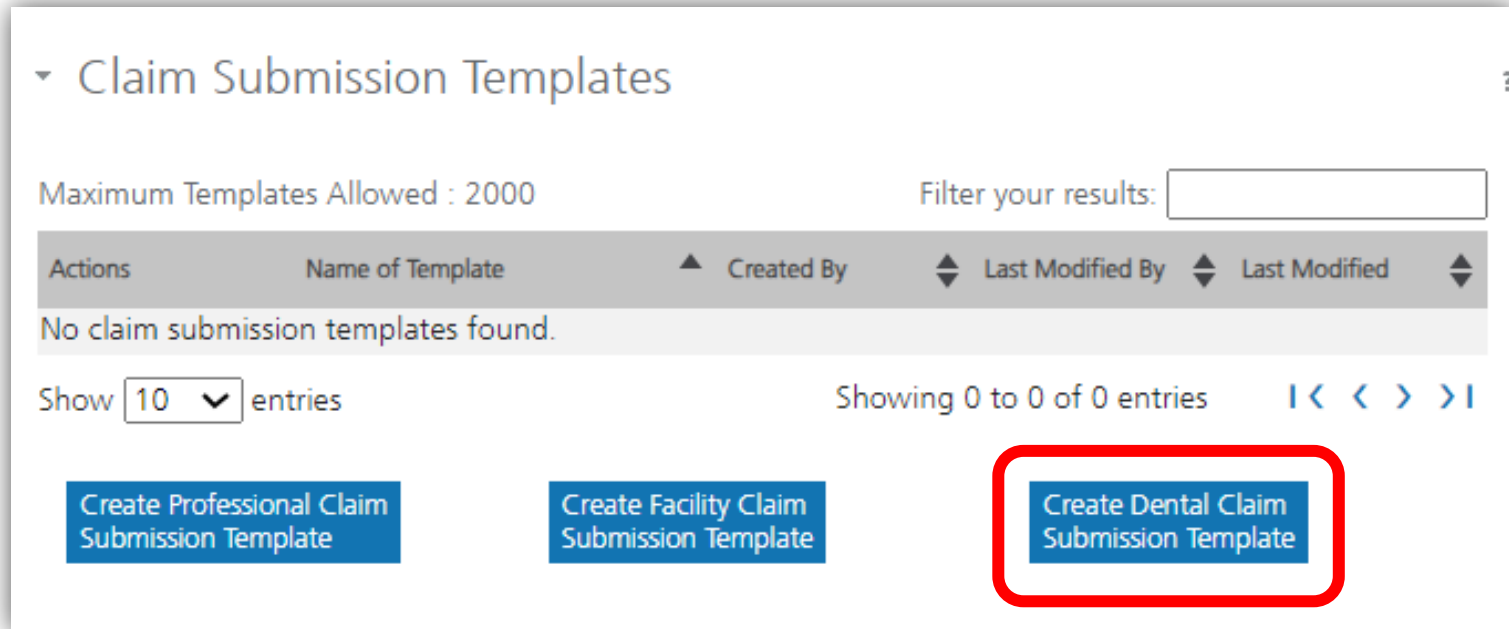
You see the same member for the same service on a consistent basis. You can create a template for that member with all the claim information except the date of service, and maybe the units & billed amount.

When it is time to submit their claim; select the billing provider NPI & Rendering Provider NPI (if applicable). Enter any additional required information on the Claim Information screen. Submit your claim.

Creating a Template

To create a template, select the **Claims Submission Templates** button.

Click the **blue button** for the claim form required.



Claim Submission Templates

Maximum Templates Allowed : 2000 Filter your results:

Actions	Name of Template	▲ Created By	◆ Last Modified By	◆ Last Modified
No claim submission templates found.				

Show entries Showing 0 to 0 of 0 entries | < < > > |

[Create Professional Claim Submission Template](#) [Create Facility Claim Submission Template](#) [Create Dental Claim Submission Template](#)

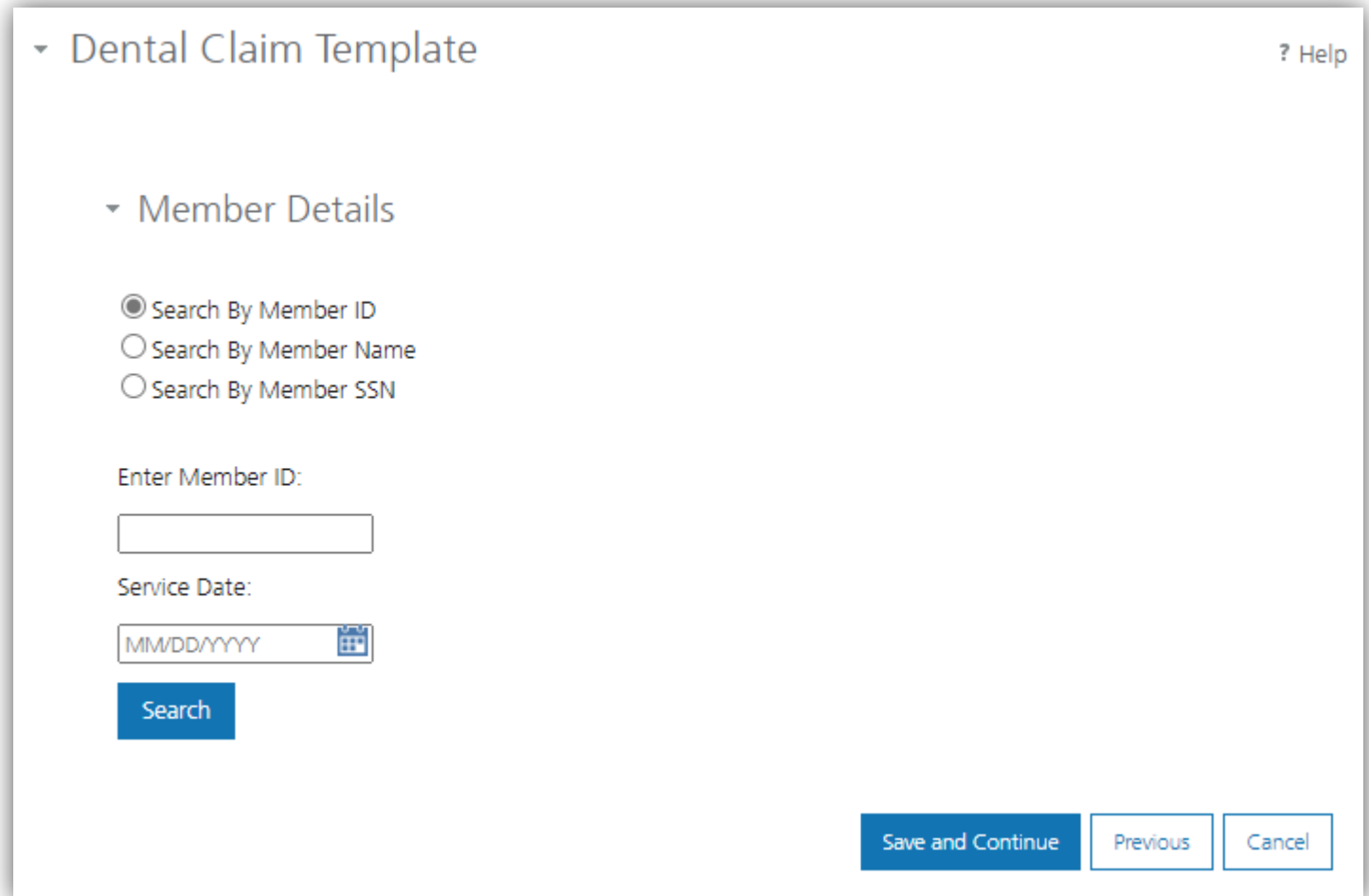
*Section 6, of the Provider Portal User Guide.

Creating a Template Cont.

Enter the member's MT Medicaid ID number.

Click **Search**.

When the member information populates, verify and click **Save and Continue**.



The screenshot shows a web form titled "Dental Claim Template" with a "? Help" link in the top right corner. Under the "Member Details" section, there are three radio button options: "Search By Member ID" (selected), "Search By Member Name", and "Search By Member SSN". Below these options is a text input field labeled "Enter Member ID:". Underneath that is a date input field labeled "Service Date:" with a placeholder "MM/DD/YYYY" and a calendar icon. A blue "Search" button is positioned below the date field. At the bottom right of the form, there are three buttons: "Save and Continue" (highlighted in blue), "Previous", and "Cancel".

Creating a Template Cont.

Complete the fields that will not change.

For instance, the diagnosis code, place of service, CPT code, modifier & diagnosis point fields will most likely not change for reoccurring visits.

Professional Claim Submission Form ? Help

Claim Information

Note: Fields marked with an asterisk * are required.

Note: Do not include any decimals when entering Diagnosis Code information. Enter at least first three (3) characters of a Diagnosis and/or Procedure code before utilizing the search icon.

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7	8	9	10	11	12
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Claim Details

Note: COB indicates all required fields of COB have been entered.

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NOC	EPSDT	Emergency Service	Family Planning
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>

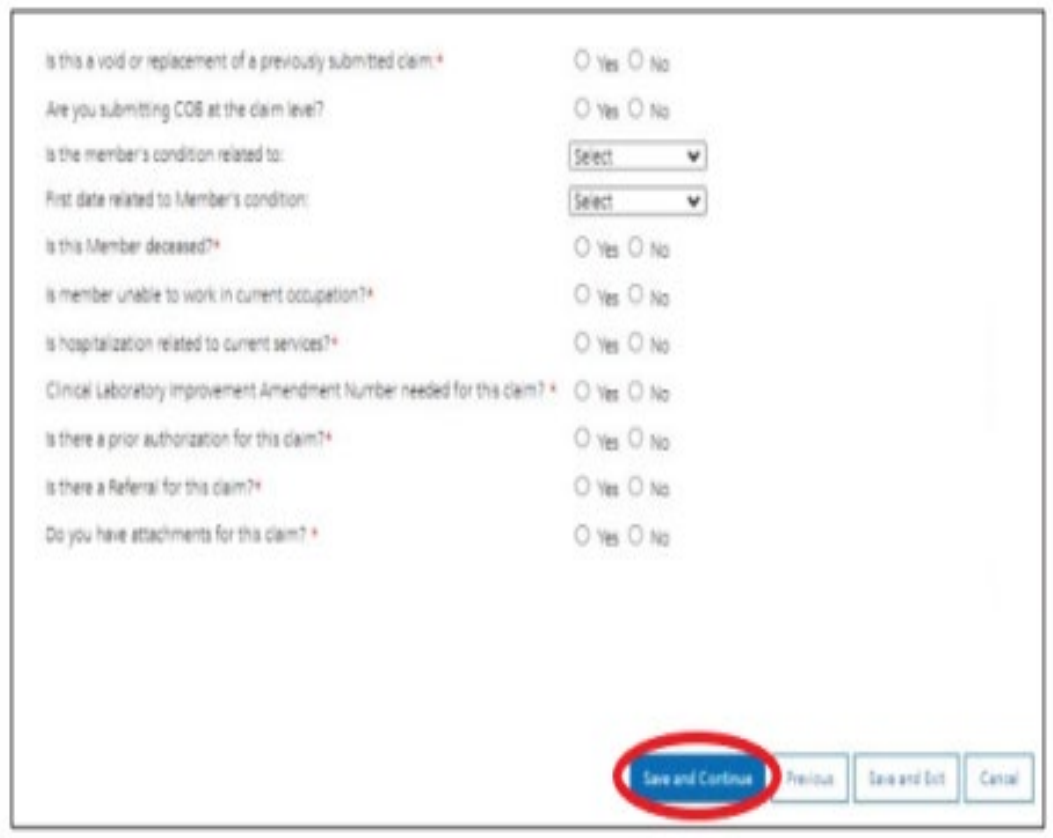
Total Charges: \$

Creating a Template Cont.

Answer all the questions at the bottom of the screen that will not change.

If your claim requires a Prior Authorization, make sure to add that number to your template.

Click **Save and Continue**.



The screenshot shows a form with the following questions and options:

- Is this a void or replacement of a previously submitted claim? Yes No
- Are you submitting COB at the claim level? Yes No
- Is the member's condition related to:
- First date related to Member's condition:
- Is this Member deceased? Yes No
- Is member unable to work in current occupation? Yes No
- Is hospitalization related to current services? Yes No
- Clinical Laboratory Improvement Amendment Number needed for this claim? Yes No
- Is there a prior authorization for this claim? Yes No
- Is there a Referral for this claim? Yes No
- Do you have attachments for this claim? Yes No

At the bottom right, there are four buttons: **Save and Continue** (circled in red), Previous, Save and Exit, and Cancel.

Creating a Template

The last step is to name the template. Then click **Save**.

Your template is now visible.

To submit a claim, click on the **Name**.

To edit a template, click on the **Pencil** icon.

To delete a template, click on the **Trash can** icon.









Facility Claim Template

Save Template

Please enter a claim submission template name.

Template Name: *

Note(s):
Template Name must satisfy the following conditions:
a. Minimum length: 3 characters.
b. Maximum length: 35 characters.
c. Cannot contain special characters other than: Space " " or Underscore "_" or Dash "-".

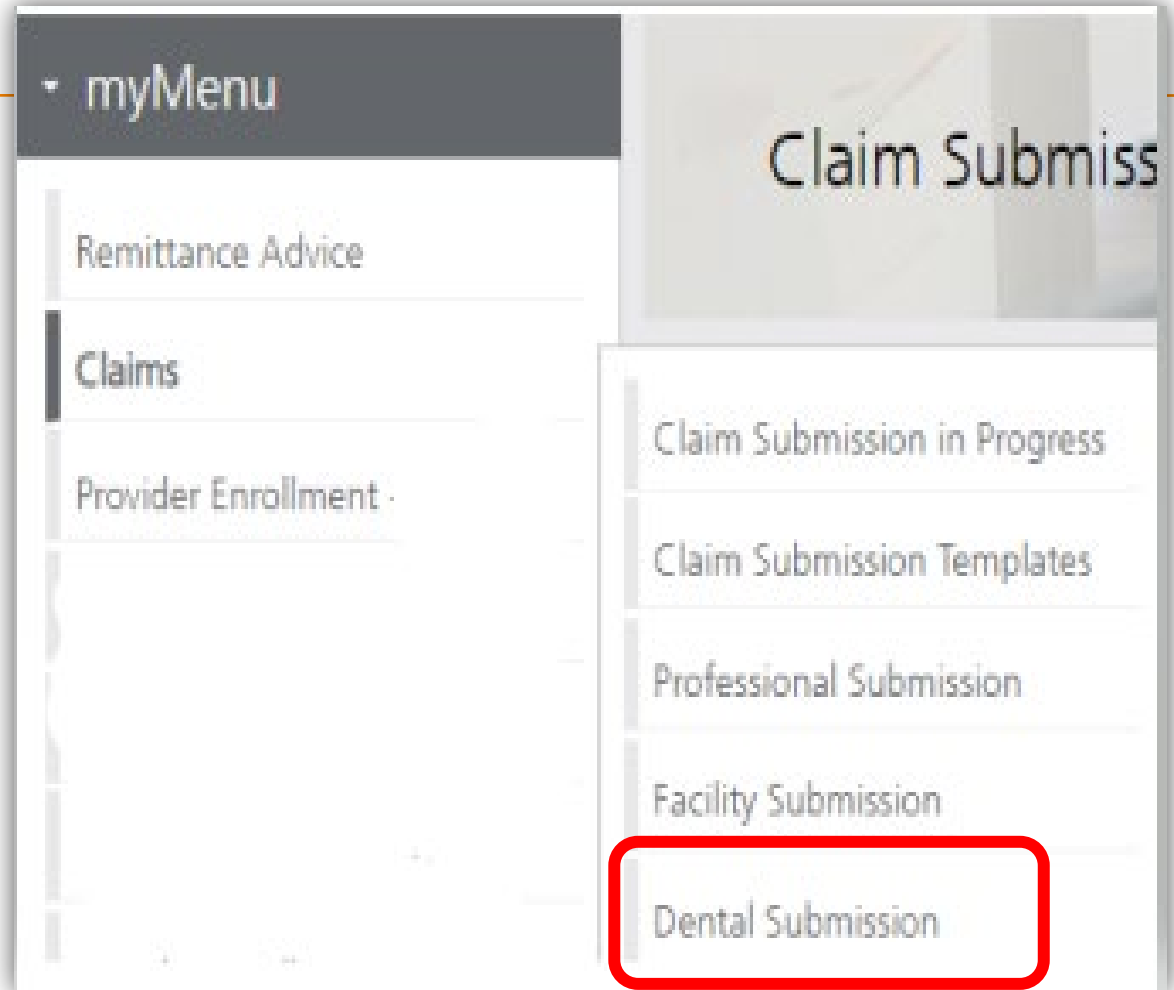
Actions	Name	Date Last Modified
 	<u>Member B</u>	12/08/2021
 	<u>Ortho</u>	12/09/2021
 	<u>Test 121</u>	12/01/2021
 	<u>Tester22</u>	12/15/2021

Submitting a Claim

To submit a claim using a template, place your cursor on the **Claims** tab.

Select **Dental Submission** for one-time claims or **Claim Submission Templates** to submit a claim from a template.

*Section 6, of the Provider Portal User Guide.



Billing Provider

Select the Billing Provider file.

If you have multiple NPIs listed under Manage Billing Providers, The NPI/API field will have a drop down.

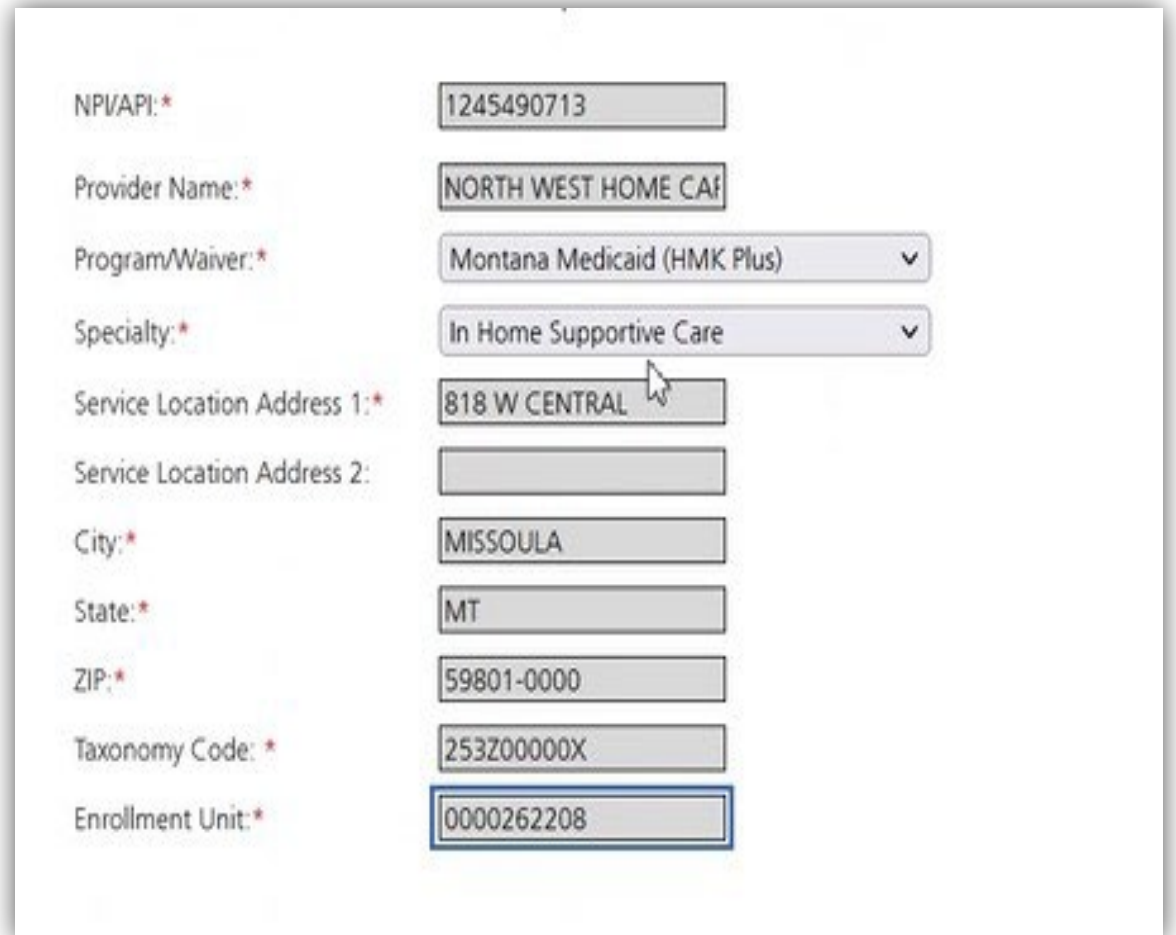
Select NPI.

Select Program/Waiver (as applicable).

Select Specialty (as applicable).

Select Service Location Address (as applicable).

Click **Save and Continue**.



The screenshot shows a form for adding a Billing Provider. The fields and their values are as follows:

Field	Value
NPI/API: *	1245490713
Provider Name: *	NORTH WEST HOME CARE
Program/Waiver: *	Montana Medicaid (HMK Plus) ▼
Specialty: *	In Home Supportive Care ▼
Service Location Address 1: *	818 W CENTRAL
Service Location Address 2:	
City: *	MISSOULA
State: *	MT
ZIP: *	59801-0000
Taxonomy Code: *	253Z00000X
Enrollment Unit: *	0000262208

Billing Provider Cont.

If the Billing Enrollment Unit you chose, requires a Rendering provider.

The Rendering Provider drop down will appear (if you have affiliated your providers).

Select your rendering NPI from the drop down.

Click **Save and Continue**.

Billing Provider

Note : Fields marked with an asterisk * are required.

NPI/API: *	1316521222
Provider Name: *	WHICKER GROUP
Program/Waiver: *	Montana Medicaid (HMK Plus)
Specialty: *	Single Specialty
Service Location Address 1: *	2600 WILSON ST STE 4
Service Location Address 2:	
City: *	MILES CITY
State: *	MT
ZIP: *	59301-5094
Taxonomy Code: *	193400000X
Enrollment Unit: *	0000734214

Rendering Provider

NPI: *	Select NPI 1609484575 1538253760 1164561635
--------	--

Referring Provider

There is a referring provider for this claim.

Ordering Provider

There is a ordering provider for this claim.

Member Details

Enter the member's MT Medicaid ID number.

Click **Search**.

When the member information populates, verify you have the correct member.

Click **Save and Continue**.



The screenshot shows a web form titled "Professional Claim Template" with a "Help" link in the top right corner. Below the title is a section header "Member Details". Underneath, there is a label "Enter Member Card ID:" followed by a text input field and a blue "Search" button. The input field is highlighted with a yellow border, and the "Search" button is circled in red. At the bottom right of the form, there are two buttons: "Save and Continue" and "Cancel". The "Save and Continue" button is also circled in red.

Claim Information

Complete all required fields and questions.

Required information is denoted with a red asterisk *

▼ Dental Claim Submission Form


? Help

▼ Claim Information




























Note : Do not include any decimals when entering Diagnosis Code Information. Enter at least first three (3) characters of a Diagnosis and/or Procedure code before utilizing the search icon.

Note : Fields marked with an asterisk * are required.

Record of services provided

Note :  indicates all required fields of COB have been entered.

Note : Use a comma "," if multiple values are needed in Area of Oral Cavity, Tooth Number(s) or Letter(s), and Tooth Surface fields.

Procedure Date*	Area of Oral Cavity	Tooth Number(s) or Letter(s)	Tooth Surface	Procedure Code*	Diagnosis Code Pointer	Quantity*	COB	Fee*
MM/DD/YYYY 	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>	<input type="text"/>	COB	<input type="text"/> 
MM/DD/YYYY 	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>	<input type="text"/>	COB	<input type="text"/> 
MM/DD/YYYY 	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>	<input type="text"/>	COB	<input type="text"/> 
MM/DD/YYYY 	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>	<input type="text"/>	COB	<input type="text"/> 
MM/DD/YYYY 	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>	<input type="text"/>	COB	<input type="text"/> 
MM/DD/YYYY 	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>	<input type="text"/>	COB	<input type="text"/> 
MM/DD/YYYY 	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>	<input type="text"/>	COB	<input type="text"/> 
MM/DD/YYYY 	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>	<input type="text"/>	COB	<input type="text"/> 
MM/DD/YYYY 	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>	<input type="text"/>	COB	<input type="text"/> 

Total Charges: \$

Note : Total Claim Lines are limited to a maximum of 50 for each submission.

Claim Information Cont.

Required information is denoted with a red asterisk *

Enter DX code, missing teeth, and answer the questions as applicable.

Click **Save and Continue**.

Diagnosis Codes

Diagnosis Codes (ICD 10): 1 2 3 4

Missing Teeth Information

Click to highlight each missing tooth

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Ancillary Claim/Treatment Information

Is this a void or replacement of a previously submitted claim? Yes No

Are there EPSDT services for this claim? Yes No

Are you submitting COB at the claim level? Yes No

Place of Treatment:*

Is this Treatment or Orthodontics:*

Replacement of Prosthesis: Yes No

Treatment Resulting From:

Predetermination Number:

Prior Authorization Number:

[Advanced Search](#)

Do you have attachments for this claim? Yes No

Notes:

Primary Insurance EOB

Are you submitting COB at the claim level? Yes No

Primary Payer				Secondary Payer			
Insurance Type:*	<input type="text" value="Select"/>			Insurance Type:	<input type="text" value="Select"/>		
Carrier Name:*	<input type="text"/>			Carrier Name:	<input type="text"/>		
Carrier Code:	<input type="text"/>			Carrier Code:	<input type="text"/>		
Subscriber First Name:*	<input type="text"/>			Subscriber First Name:	<input type="text"/>		
Subscriber Middle Name:	<input type="text"/>			Subscriber Middle Name:	<input type="text"/>		
Subscriber Last Name:*	<input type="text"/>			Subscriber Last Name:	<input type="text"/>		
Allowed:	<input type="text" value="\$"/>			Allowed:	<input type="text" value="\$"/>		
Copay:	<input type="text" value="\$"/>			Copay:	<input type="text" value="\$"/>		
Deductible:	<input type="text" value="\$"/>			Deductible:	<input type="text" value="\$"/>		
Coinurance:	<input type="text" value="\$"/>			Coinurance:	<input type="text" value="\$"/>		
Paid Amount:*	<input type="text" value="\$"/>			Paid Amount:	<input type="text" value="\$"/>		
	Group	Reason	Amount		Group	Reason	Amount
	<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>		<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>
	<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>		<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>
	<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>		<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>
EOB Payment Date:*	<input type="text"/>			EOB Payment Date:*	<input type="text"/>		

Answer Yes to this question, only if you have received payment from a primary insurance. Do not use for Medicare payments.

If you have a primary EOB but they did not pay, do not use this screen.

For Medicare payments or Zero payment EOBs, skip this step and proceed to the attachment question.

Electronic Claim Attachments

Do you have attachments for this claim? * Yes No

Note: When uploading an attachment electronically, cover sheets are not required. For attachments that are being mailed or faxed, please download the [Paperwork Attachment Cover Sheet](#) for instructions on how to create a Paperwork Attachment Control Number. The Paperwork Attachment Control Number must be the same number as the Attachment Control Number on the corresponding electronic claim.

Report Code Type: * Transmission Code: * Control Number: *

Select Select Attachments

Add

Report Code Type: Select what type of document you are attaching.

Transmission Code: Select Electronic submission.

Control Number: The control number will auto-generate once the attachment is uploaded.

Add: Click add if you have more than one attachment type.

Report Code Type: * Transmission Code: * Control Number: *

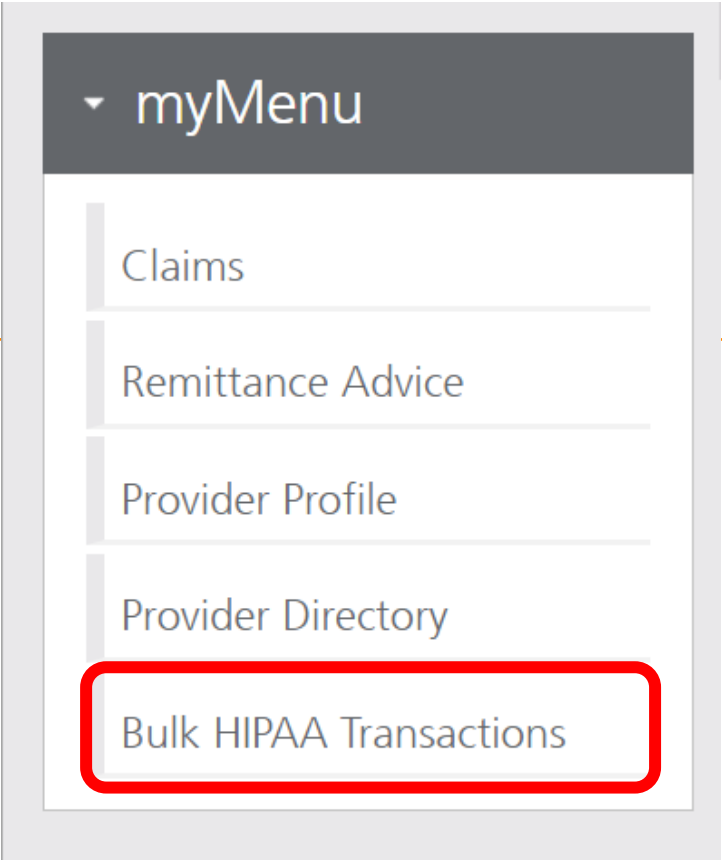
EB-Explanation of Benef FT-Electronic Attachmen Attachments

Add

Bulk HIPAA Transactions

Your file must be in an accepted format of either .edi or .bil.

Select Upload.



A screenshot of a web application's navigation menu. The menu is titled 'myMenu' and contains several items: 'Claims', 'Remittance Advice', 'Provider Profile', 'Provider Directory', and 'Bulk HIPAA Transactions'. The 'Bulk HIPAA Transactions' item is highlighted with a red rounded rectangle.



A screenshot of the 'Bulk HIPAA Transactions activity' page. The page title is 'Bulk HIPAA Transactions activity' and there is a '? Help' link. Below the title is a search bar labeled 'Filter your results:'. A table header is visible with columns: 'ACTIONS', 'TRANSACTION DATE', and 'FILE NAME'. Below the header, it says 'No matching transactions found.' At the bottom left, there is a 'Show 10 entries' dropdown and a blue 'Upload' button highlighted with a red rounded rectangle. At the bottom right, it says 'Showing 0 to 0 of 0 entries' and navigation arrows.

Bulk HIPAA Transactions Cont.

Select Claims Submission (837) and then click browse to upload your .edi or .bil file.

File Upload [Close]

Note: Only .edi formats are supported for uploading

NPI/API: 1427005802

File Type: Claim Submission (837) ▾

Browse

Please upload file formats of .edi or contact customer service for assistance.

C:\fakepath\HSS Mar22 Pick-up.txt

Upload

Cancel

Questions?

Adjustments

Electronic vs Paper Claim Adjustments

When you submit a paper Individual Adjustment Request (IAR) form:

<https://medicaidprovider.mt.gov/docs/forms/adjustmentrequestindividual12192017.pdf>

1. Provide only the corrections needed.
2. Must attach the remittance advice showing the paid claim.
3. Call Center can see who submitted & any reason listed.

When submitting an electronic replacement claim:

1. Include all charge lines, including lines that paid correctly.
2. No additional paperwork is required.

* Note: the PR Call Center can NOT see who submitted & why.

Adjustment Tips

- Cannot adjust denied claims.
- Claims cannot be electronically adjusted more than 12 months from the paid date. These will reject. Claims needing to be adjusted past this time frame must be sent via a paper IAR form.
- If a claim was previously adjusted, you must use the most recent paid ICN.

Adjustments in MPATH

Create a new claim with the corrected information. If you are voiding the claim, claim information must match original claim.

Answer YES, to the first question at the bottom of the claim information screen asking if you are submitting a voided or replacement of a prior claim. The next two fields are now visible.

Select either ***Replacement of prior claim*** or ***Void of prior claim*** from the Medicaid Resubmission drop down.

Enter the most recent Paid ICN of the claim being adjusted in the Original Reference Number field.

Claim Adjustments Cont.

- Original Reference Number must be the most recent paid claim ICN.
- Cannot adjust denied claims.

Is this a void or replacement of a previously submitted claim:*

Yes No

Select the Medicaid Resubmission Code:*

Enter the Original Reference Number:*

Questions?

If You Have Questions

Need Help with MPATH?

At the top of each screen is a **User Guide** icon.

When you click on the icon, the user guide will open to the section matching the screen you are on.



User Guide

Online Resources

<https://medicaidprovider.mt.gov>

Claims Information Page

- Electronic Submission Setup
- Electronic Submission Resources and User Guides
- Claim instructions
- Adjustment instructions

Other Pages

- FAQs
- Provider Type pages (Provider notices, Provider manuals, Fee Schedules)
- Claim Jumper Newsletters

Provider Relations Contact Information

Provider Relations Call Center:

(800) 624-3958

Monday through Friday
8 AM to 5 PM Mountain Time

The MTPRhelpdesk@Conduent.com can be used for generic questions. Questions related to specific member information or specific claims must be directed to the Call Center. Emails must not contain PHI.

*Note: Secured emails are not accepted

Questions?

Thank you for the care you
provide to Montana Healthcare
Programs Members!