

Tenancy Support Training

Part 2: Claims

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In this training...

- Claim preparation
- Claims submissions
- MPATH Claims Setup
- MPATH Claims Solution
- MPATH Additional Portal Features
- If you have questions

Automated System Information

The MATH/MPATH portals 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.

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.

Preparation for submitting claims

What information should be gathered?

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) & modifier

Prior Authorizations

Tenancy Support Requires a prior authorization.

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

DATE 02/25/21

RECIP ID	NAME	PRIOR AUTH NUMBER	AUTHORIZE FROM	DATES TO			
00 [REDACTED]	[REDACTED]	10557 [REDACTED]	021521	021521			
REASON: 999							
LINE ----MAXIMUM----							
ITEM	UNITS	DOLLARS	FR-DTE	TO-DTE	PROC RANGE / MOD	DIAG	RANGE
01	1	0.00	021521	021521	A0430 A0430		
TOOTH NUM / SURFACE:			THERA CLASS: STATUS: APPROVED				
REASON:							
02	106	0.00	021521	021521	A0435 A0435		
TOOTH NUM / SURFACE:			THERA CLASS: STATUS: APPROVED				
REASON:							
RECIP ID	NAME	NUMBER	FROM	TO			
00 [REDACTED]	[REDACTED]	10557 [REDACTED]	021121	021121			
REASON: 999							
LINE ----MAXIMUM----							
ITEM	UNITS	DOLLARS	FR-DTE	TO-DTE	PROC RANGE / MOD	DIAG	RANGE
01	1	0.00	021121	021121	A0430 A0430		
TOOTH NUM / SURFACE:			THERA CLASS: STATUS: APPROVED				
REASON:							
02	182	0.00	021121	021121	A0435 A0435		
TOOTH NUM / SURFACE:			THERA CLASS: STATUS: APPROVED				
REASON:							

Diagnosis Codes

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

There are many websites out there to obtain this information. This is a very user-friendly site.

<https://icd10coded.com>

Place of Service

The Place of Service List is in Appendix B, of the General Information for Providers manual, located on every Provider Type page of the Provider Information website.

<https://medicaidprovider.mt.gov/manuals/generalinformationforprovidersmanual>

CPT Codes

Billable CPT Codes for Tenancy Support:

Procedure Code	Modifier	Description
H0043	U1	TSS – ASSESSMENT AND PLANNING
H0043	U2	TSS – PRE-TENANCY SERVICES
H0043	U3	TSS – TENANCY SUSTAINING SERVICES
H0044	UA	TSS – APPLICATION FEE ASSISTANCE
H0044	UD	TSS- SECURITY DEPOSIT FEE ASSISTANCE

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

Claims Submission

Electronic Claim Submission

We currently support one free billing program. The MPATH claims solution is a function on the Provider Services Portal.

The MPATH system is a web-based program. Therefore, it can be used on any computer.

The Provider Portal User Guide is available under the Claims Page of the Provider Information Website.

The Call Center can only assist with submission questions on the EDI line. They are not available to walk you through the entire process.

Please send an email to MTPRHelpdesk@Conduent.com if you have set up questions.

Electronic Claims Submission Cont.

- Electronic claims must be submitted by 2pm MST on Wednesdays in order process during that claim cycle.
- Electronic claims process faster than paper claims.
- Electronic claims can also be submitted through a Billing Agency or a Clearing House.

Paper Claim Submissions

- Paper claims can only be submitted via fax or US Mail.
- Claims may not be emailed.
- Paper claims can take several weeks longer to process than electronic claims as these claims must be manually keyed into our system.
- Claim forms can be purchased through most office supply stores and through Amazon.
- Information must be legible and in the correct fields. Please avoid using copies of copies.
- Instructions can also be found at www.nucc.org and www.nubc.org

Paper Claim Submissions


– CMS 1500

Required Fields:

- Box 1a Member ID
- Box 2 Member Name
- Box 21 Diagnosis Codes
- Box 23 Prior Authorization
- Box 24 Lines of Service
- Box 28 Total Charges
- Box 31 Provider's signature and date
- Box 33 Billing Provider Information
- Box 33a Billing NPI
- Box 33b Billing taxonomy

Note: Box 33 Billing provider information must match the physical location on file for the Billing NPI listed in box 33a and the Billing taxonomy listed in box 33b. Montana Medicaid does not edit on box 32 for servicing location.

CMS-1500 02/12



HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

☐ FICA ☐ FICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> REGIONAL <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Indicate by checkmark)</small>		3. INSURED'S POLICY OR GROUP NUMBER Possible Member ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client last name, first name		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE	
5. PATIENT'S BIRTH DATE 6. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. RESERVED FOR NUCC USE 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Possible Member ID	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S DATE OF BIRTH 12. OTHER CLAIM ID (Designated by NUCC) Possible TPL Information	
13. INSURANCE PLAN NAME OR PROGRAM NAME 14. CLAIM CODES (Designated by NUCC)		15. IS TRANSFERRED HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If yes, complete items 16, 17, and 18.)	
16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		19. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 21. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 23. NAME OF REFERRING PROVIDER OR OTHER SOURCE 24. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		25. RESUBMISSION ORIGINAL REC. NO. 4123456789	
26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (S40) A. ICD - 10 Diagnosis code B. ICD - 10 Procedure code C. ICD - 10 Procedure code D. ICD - 10 Procedure code E. ICD - 10 Procedure code F. ICD - 10 Procedure code G. ICD - 10 Procedure code H. ICD - 10 Procedure code I. ICD - 10 Procedure code J. ICD - 10 Procedure code K. ICD - 10 Procedure code L. ICD - 10 Procedure code			
27. DATE OF SERVICE FROM 07 01 14 TO 07 01 14 11		28. PROVIDER, SERVICE, OR SUPPLIER 29. DIAGNOSIS PORTION 30. CHARGES 31. AMOUNT PAID 32. BILLING PROVIDER INFO & PFI # Dr. Provider, MD 123 Main Street Anywhere, MT 54321-1234 1234567891 22 2084N0400X	
33. SIGNATURE OF PHYSICIAN OR SUPPLIER Dr. Provider, MD 07/01/14		34. SERVICE FACILITY LOCATION INFORMATION 35. BILLING PROVIDER INFO & PFI # Dr. Provider, MD 123 Main Street Anywhere, MT 54321-1234 1234567891 22 2084N0400X	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMB 0938-1197 FORM 1500 02/12

If Atypical Provider, 33a will be blank and 33b will have G2 prefix—> G2 Atypical ID

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: *



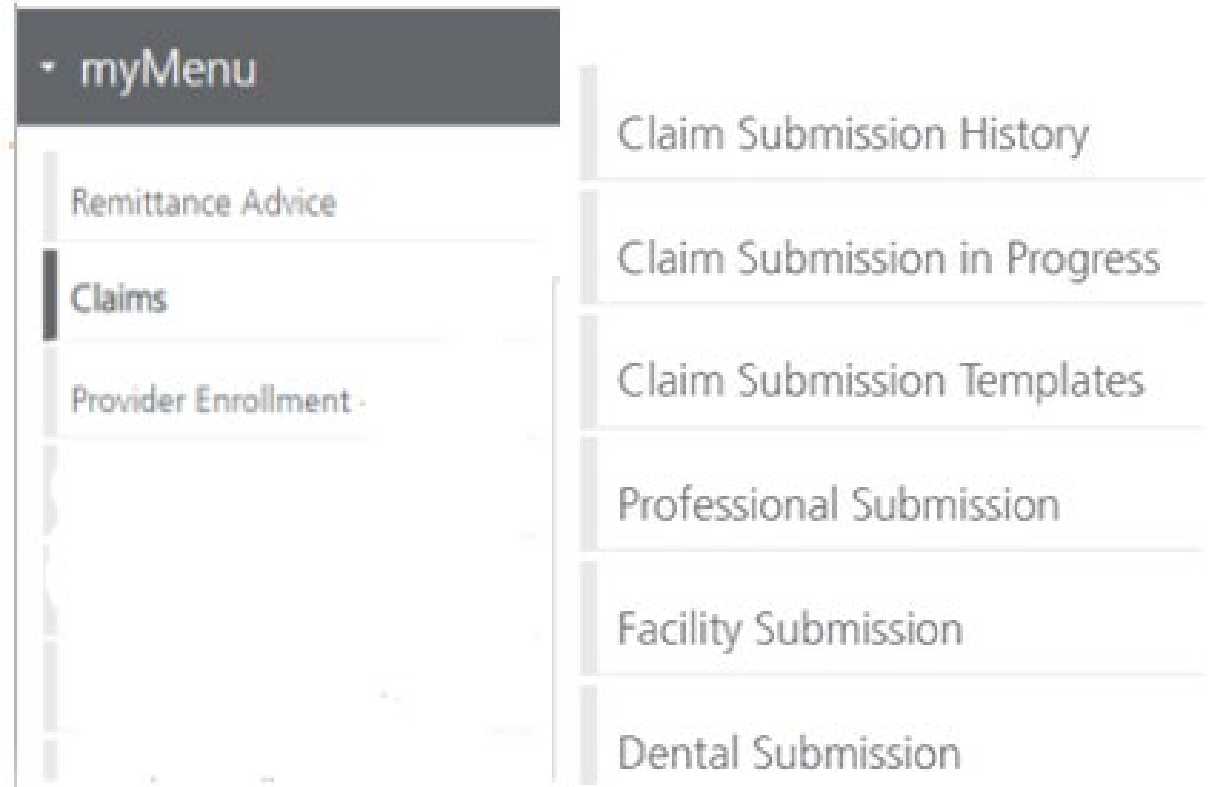
MPATH Claims Solution

Claim Submission Menu

Under myMenu, without clicking, place your curser 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 to Montana Medicaid for processing.

This function comes in handy if you have a big batch of claims to submit and lose track of who you have completed.

This section will not give you any charge line details or adjudication information.

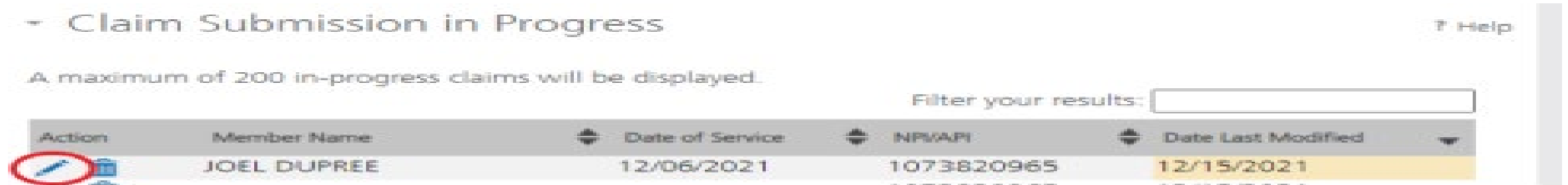
Claims Submission in Progress


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.



Claim Submission in Progress					Help
A maximum of 200 in-progress claims will be displayed.					
Filter your results:					
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** tab.

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

*Section 6, of the Provider Portal User Guide.

The screenshot displays the 'Claim Submission Templates' section of a web application. At the top, there is a header with a plus icon, the text 'Claim Submission Templates', and a help icon. Below the header, it states 'Maximum Templates Allowed : 500' and a search bar labeled 'Filter your results:'. A table lists four existing templates, each with an 'Actions' column containing edit and delete icons, a 'Name' column, and a 'Date Last Modified' column. Below the table, there is a 'Show 10 entries' dropdown and a pagination indicator 'Showing 1 to 4 of 4 templates'. At the bottom, three blue buttons are highlighted with yellow boxes: 'Create Professional Claim Submission Template', 'Create Facility Claim Submission Template', and 'Create Dental Claim Submission Template'.

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

Buttons:
Create Professional Claim Submission Template
Create Facility Claim Submission Template
Create Dental Claim Submission Template

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.

Professional Claim Template

Help

Member Details

Enter Member Card ID:

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:  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	NDC	EPSDT	Emergency Service	Family Planning
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>

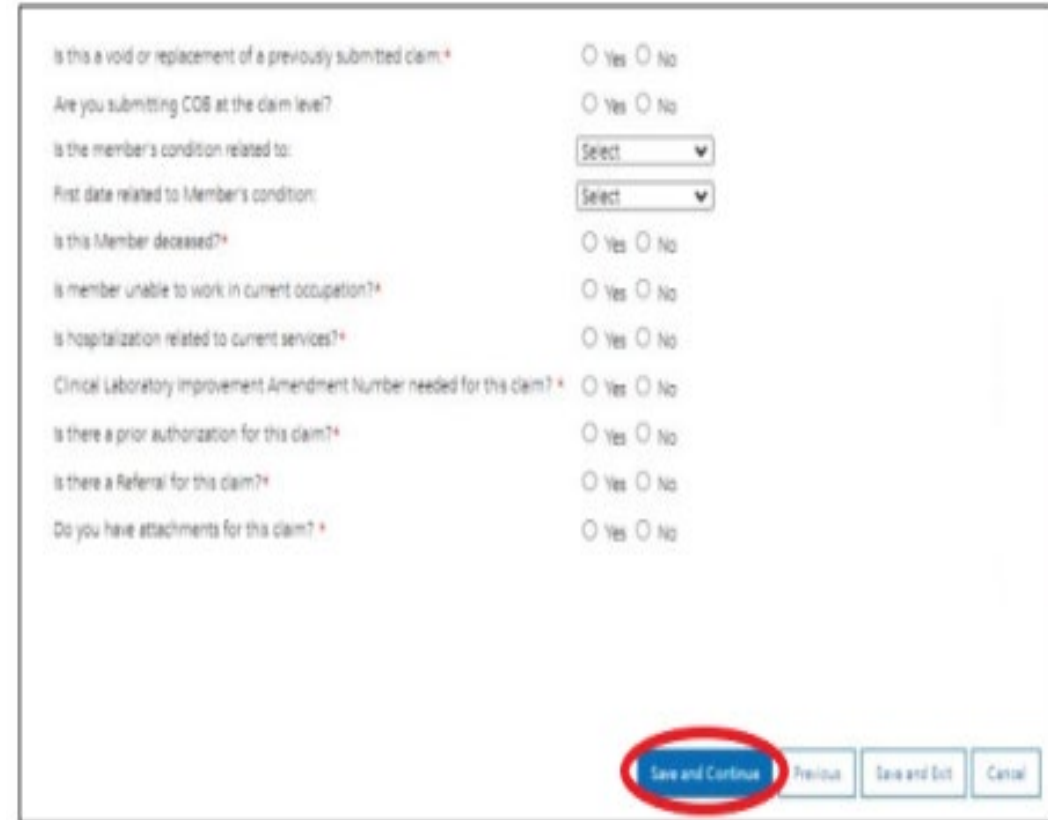
Total Charges: \$

Creating a Template Cont.

Answer all the questions at the bottom of the screen.

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

Click **Save and Continue**.



The screenshot shows a web form for creating a claim template. It contains several questions with radio button or dropdown answers. The questions are:

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

At the bottom right, there are four buttons: "Save and Continue" (highlighted with a red circle), "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 **Garbage 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 "-".

Submit

Previous

Cancel

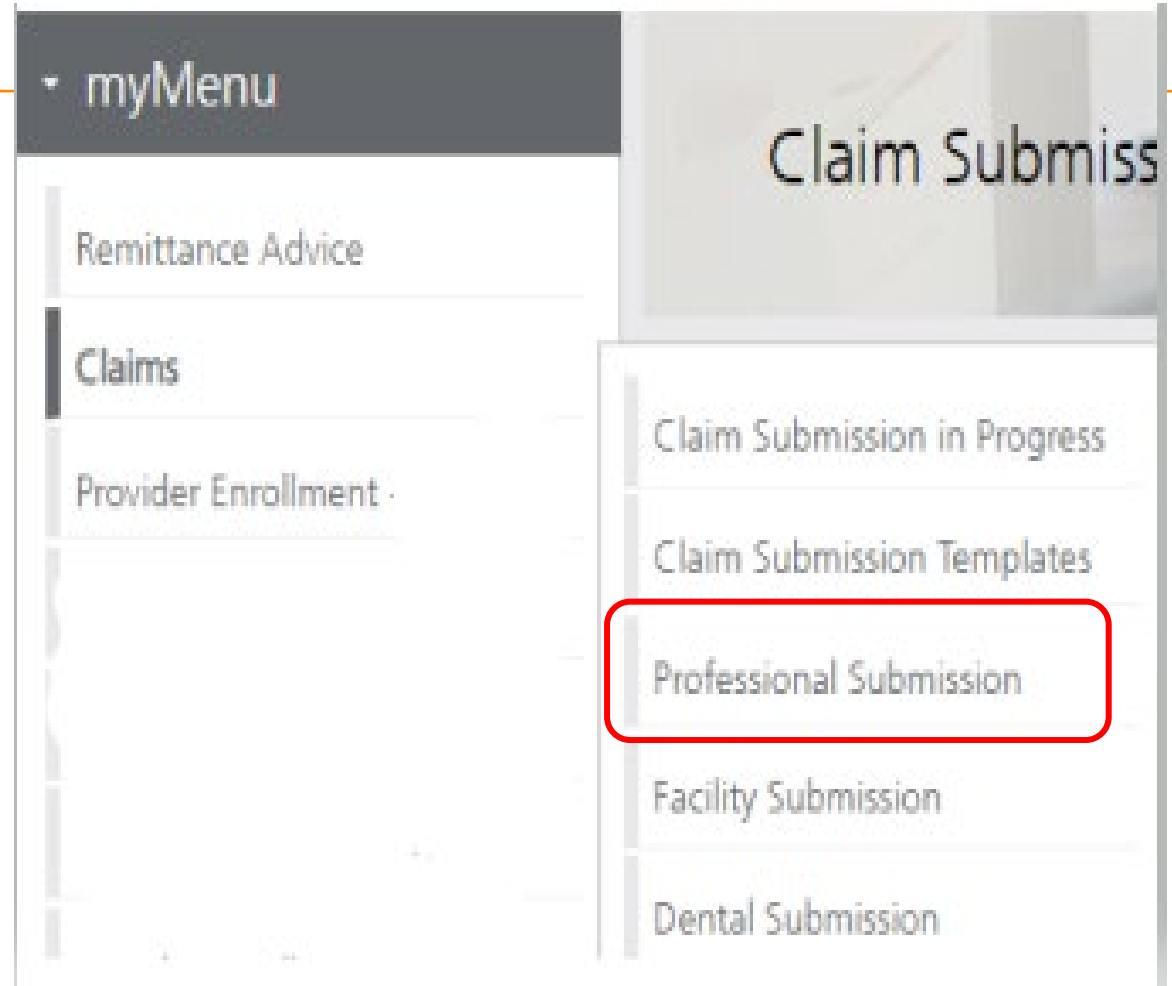
Actions	Name	Date Last Modified
 	<u>Member B</u>	12/08/2021
 	<u>Ortho</u>	12/09/2021
 	<u>Test 121</u>	12/01/2021
 	<u>Tester22</u>	12/15/2021

Submitting a Claim

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

Select **Claim Submission type** 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.

Select Specialty.

Click **Save and Continue**.

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

Field	Value
NPI/API:	1033508080
Provider Name:	LIBERTY PLACE, INC
Program/Waiver:	Severe Disabling Mental Illness Waiver (SDMI)
Specialty:	Severe Disabling Mental Illness Waiver (SDMI)
Service Location Address 1:	Big Sky Waiver
Service Location Address 2:	BOOTSTRAP RANCH E
City:	BELGRADE
State:	MT
ZIP:	59714-8121
Taxonomy Code:	251S00000X
Enrollment Unit:	0000801034

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**.

Professional Claim Template

Help

Member Details

Enter Member Card ID:

Claim Information

Complete all required fields and questions.

Required information is denoted with a red asterisk *

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

7 8 9 10 11 12

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"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>

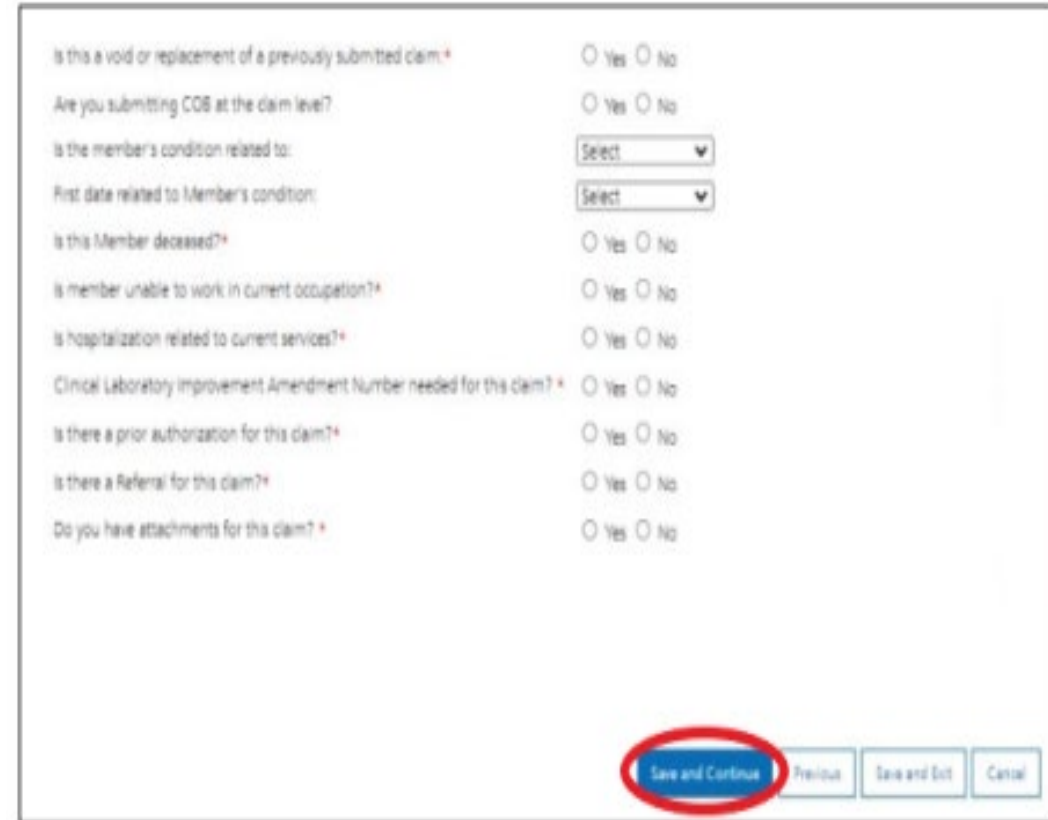
Total Charges: \$ Add

Claim Information Questions

Complete all required fields and questions.

Required information is denoted with a red asterisk *

Click **Save and Continue**.



The screenshot shows a web form titled "Claim Information Questions". It contains several questions, each followed by radio buttons for "Yes" and "No", or a dropdown menu. The questions are:

- Is this a void or replacement of a previously submitted claim? *
- Are you submitting COB at the claim level?
- Is the member's condition related to: (dropdown menu)
- First date related to Member's condition: (dropdown menu)
- Is this Member deceased? *
- Is member unable to work in current occupation? *
- Is hospitalization related to current services? *
- Clinical Laboratory Improvement Amendment Number needed for this claim? *
- Is there a prior authorization for this claim? *
- Is there a Referral for this claim? *
- Do you have attachments for this claim? *

At the bottom right of the form, there are four buttons: "Save and Continue" (highlighted with a red circle), "Previous", "Save and Exit", and "Cancel".

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 Benefi ▼

FT-Electronic Attachmen ▼

Attachments



Add

Bulk HIPAA Transactions

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

Bulk HIPAA Transactions activity

[? Help](#)

Filter your results:

ACTIONS	TRANSACTION DATE	FILE NAME
No matching transactions found.		

Show entries

Showing 0 to 0 of 0 entries

[|](#) [<](#) [>](#) [|](#)

Upload

Click the “Help” link and you’ll be taken to that section of the manual

Bulk HIPAA Transactions Cont.

File Upload



Note: Only .edi formats are supported for uploading

NPI/API: 1427003862

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?

MPATH Portal Additional Features

Claims Inquiry

▼ Member search ?

Find everything you need to know about a member with just one search!


Member search

Enter Member Card ID *

0000001

Go

▼ Member search ?

 **Member found!**

You are currently viewing:

Member's Name

[Clear Search](#)

☒ Claims Inquiry

☐ Eligibility

Search

Claims Inquiry Cont.

Member search

myMenu

Claim search

I want to view:
Claims for

Time period

From Date:
09/01/2021

To Date:
12/01/2021

Claim number

Patient account number

Search

Hi Org3 MTOFEOC

Claims Detail

Claim search results

Member:
You are viewing: Claims for NPV/API 12/01/2021 and time period from 09/01/2021 to 12/01/2021.

Claim activity

Download Print Help

Filter your results:

ICN	OPTUM CLAIM NUMBER	SERVICE DATE	MEMBER NAME	PROVIDER	STATUS	BILLED AMOUNT	PLAN PAYS
221		09/01/21		INC	F1	\$177.44	\$177.44

Showing 1 to 1 of 1 Claims

Claims Inquiry Results

I want to view:
Claims for

Time period
From Date: 09/01/2021
To Date: 12/01/2021

Claim number
Patient account number

Search

Claim search results

Member:
You are viewing: Claims for NPI/API 1 and time period from 09/01/2021 to 12/01/2021.

Claim activity

ICN: 221 Optum Claim number:

< Return to search

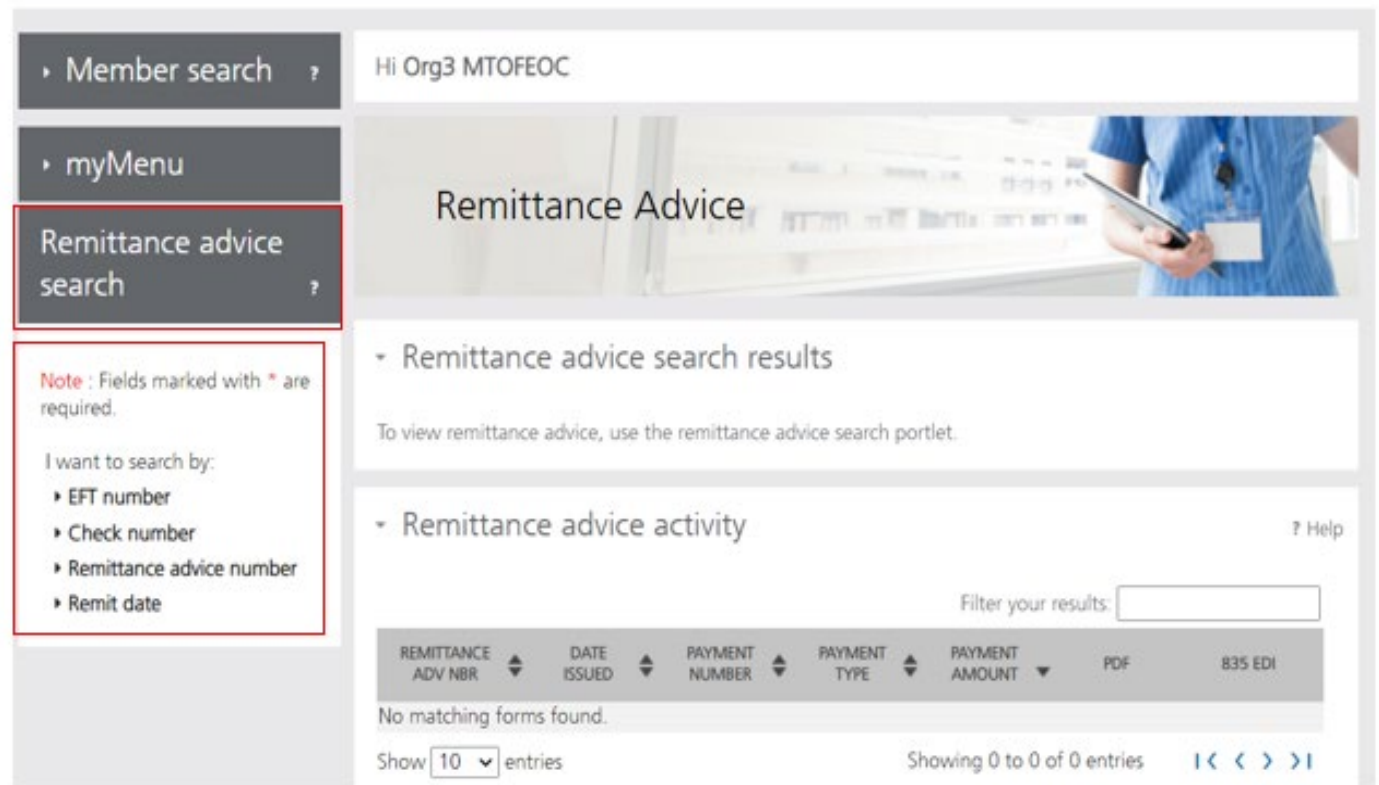
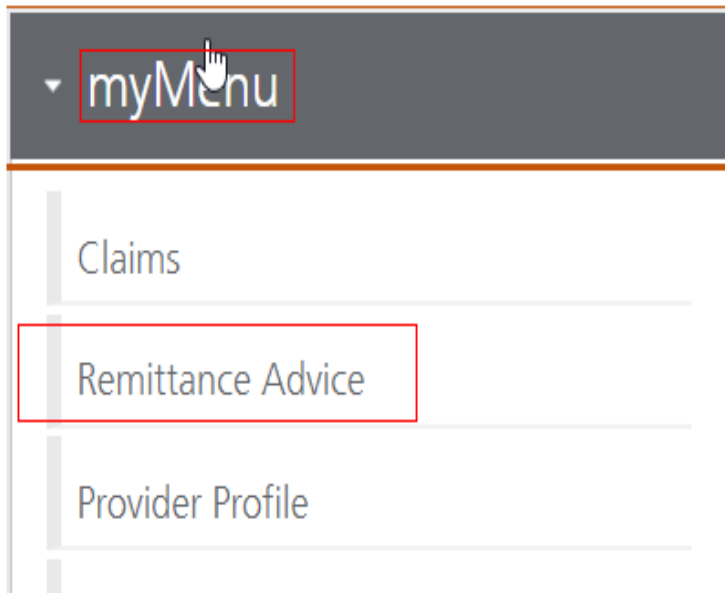
Member:		Total amount billed:	\$177.44
Date of service:	09/01/21-09/30/21	Total amount paid:	\$177.44
Patient account:		Date processed:	10/04/21
Member:		Payment details	
Member ID:		Payment number:	00000261657
Claim status:	F1:Finalized/Payment	Payment date:	10/11/21
		Payment amount:	\$177.44

Line 1

Provider name:	INC	Cost for this service	Amount billed:	\$177.44
Provider NPI/API:	12		Amount paid by plan:	\$177.44
Date of service:	09/01/21-09/30/21			
Procedure code:	T2041			

< Return to search

Remittance Advice



Remits Search

I want to search by:

▼ EFT number

Enter EFT number: *

▼ Check number


Enter check number: *

▼ Remittance advice number


Enter remittance advice number: *

▼ Remit date

From Date(mm/dd/yyyy): *

09/02/2021 

To Date(mm/dd/yyyy): *

12/01/2021 

Search

Remits Results

Filter your results:

REMITTANCE ADV NBR	DATE ISSUED	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	PDF	835 EDI
C	09/27/2021	01	Check	\$1150550.83	View	Download
O	09/27/2021	00	Check	\$246077.51	View	Download
O	09/27/2021	00	Check	\$94875.42	View	Download
O	09/20/2021	01	Check	\$14843.00	View	Download
O	09/27/2021	00	Check	\$7195.51	View	Download
O	09/06/2021	01	Check	\$1572.51	View	Download
O	09/13/2021	01	Check	\$520.36	View	Download

Show entries

Showing 1 to 7 of 7 forms

[1](#) [<](#) [>](#) [7](#)

VENDOR # 0000 REMIT ADVISE # 81 EFT/CHK #01 DATE 09/27/2021 PAGE 2
NPI #: 12 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									
ICN 22	PATIENT	07012021	07312021	1.000	S5141	2453.93	2453.93		
TEAM NUMBER 01									
CLAIM TOTAL**						2453.93	2453.93		
ICN 221	PATIENT	08012021	08312021	1.000	S5141	2453.93	2453.93		
TEAM NUMBER 01									
CLAIM TOTAL**						2453.93	2453.93		
ICN 221	PATIENT	07012021	07312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01									
CLAIM TOTAL**						767.70	767.70		
ICN 221	PATIENT	07012021	07312021	5.000	S5135	115.50	115.50		
TEAM NUMBER 01						883.20	883.20		
CLAIM TOTAL**						883.20	883.20		
ICN 221	PATIENT	08012021	08312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01									
CLAIM TOTAL**						767.70	767.70		
ICN 2212	PATIENT	08012021	08312021	5.000	S5135	115.50	115.50		
TEAM NUMBER 01						883.20	883.20		
CLAIM TOTAL**						883.20	883.20		
ICN 2212	PATIENT	07012021	07312021	8.000	T2021	782.48	782.48		
TEAM NUMBER 01									
CLAIM TOTAL**						782.48	782.48		

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.

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

MTPRHelpdesk@conduent.com

Note: The MTPR Help Desk does not accept PHI or secured emails.

Questions?

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