

# MPATH Provider Services Billing 101

# MPATH Provider Services Portal

## Claims Entry

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The **MPATH Provider Services Claims Entry solution** is an online tool allowing providers to manually enter claims. Available features include:

- **Single submission claim forms** – The system allows direct claim form entry for claim submission.
- ***Claim form templates*** - The system allows users to create and save templates for common claim submissions. No need to start from scratch every time.
- ***Diagnosis and Procedure code look up*** - The system has code look-up features to assist with entering correct information.
- ***Ability to submit multiple claim types*** - including Professional, Facility and Dental claims.
- ***Electronic Claim Adjustments*** - Paper adjustment forms are no longer required. The system allows for online claim adjustments which process faster than paper adjustments.

# MPATH Provider Services Portal Electronic Claims Submission

Log in to the [Provider Services Portal](#)

1

Sign in with your Optum GovID



2

The screenshot shows a 'Sign In' form with the following elements:

- Sign In** (Section Header)
- Optum GovID or Email Address** (Label) with a text input field containing 'testprovider@test.com' and a green checkmark icon.
- Password** (Label) with a text input field containing masked characters and an eye icon.
- [Forgot Optum GovID?](#) (Link)
- [Forgot Password?](#) (Link)
- Continue** (Green Button)
- or (Text separator)
- [Create Optum GovID](#) (Text Button)
- [Manage My Optum GovID](#) (Text Button)
- [Help Center](#) (Link with question mark icon)

# MPATH Provider Services Portal Single Professional Claim Submission

## Provider Services Portal Home Page

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us Account Settings Log Out

Member search ?

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

Search By Member ID  
 Search By Member Name  
 Search By Member SSN

Member ID:\*

Service Date:\*

Go

Hello, Test User Last login: 5/14/2024

Provider Resources Forms FAQs

1 Claims

Remittance Advice

Provider Profile

Provider Enrollment

Provider Directory

Account Administration

Bulk HIPAA Transactions

myMenu

Claims

Remittance Advice

Provider Profile

Provider Enrollment

Provider Directory

Account Administration

Bulk HIPAA Transactions

Claim Submission History

Claim Submission in Progress

Claim Submission Templates

Professional Submission

Facility Submission

Dental Submission

Hover the mouse over "Claims" in the myMenu section on the left navigation and select "Professional Claim Submission"

# MPATH Provider Services Portal

## Single Professional Claim Submission – Selecting correct PID/Team#

Select your provider NPI. All associated demographics including PID and Team# will be automatically populated after selecting Program/Specialty.

▼ Billing Provider

Note : Fields marked with an asterisk \* are required.

NPI/API: \*

Select NPI/API ▼

- 1234567890
- 1111111111
- 2222222222
- 3333333333

# MPATH Provider Services Portal

## Single Professional Claim Submission – Selecting correct PID/Team# SDMI ALF

The screenshot displays a web form for claim submission. The form is divided into several sections:

- Billing Provider Section:** Includes fields for NPI/API (1234567890), Provider Name (Test Provider), and Program/Waiver. A dropdown menu for Program/Waiver is open, showing options: "Select Program/Waiver", "Severe Disabling Mental Illness Waiver (SDMI)", and "Big Sky Waiver". An arrow labeled '1' points to this dropdown.
- Program/Waiver and Specialty Section:** Includes fields for Program/Waiver (Severe Disabling Mental Illness Waiver (SDMI)), Specialty (Assisted Living Facility), Service Location Address 1 (123 1st St), Service Location Address 2, City (Billings), State (MT), ZIP (59102-3320), Taxonomy Code (310400000X), Team Number (TEAM S1), and Enrollment Unit (1111111). An arrow labeled '2' points to the Program/Waiver dropdown, and an arrow labeled '3' points to the Specialty dropdown.
- Specialty Dropdown:** A separate view of the Specialty dropdown menu is shown, with options: "Select Specialty", "Assisted Living Facility", and "Community/Behavioral Health/HCBS Waiver". An arrow labeled '4' points to the "Assisted Living Facility" option.

A blue box at the bottom center contains the text "Taxonomy Team# PID/EU" with an arrow pointing to the "Team Number" field in the main form.

# MPATH Provider Services Portal

## Single Professional Claim Submission – Selecting correct PID/Team# SDMI HCBS

The screenshot displays a web form for claim submission. The form is divided into sections: Billing Provider, Program/Waiver, and Specialty. Annotations 1, 2, 3, and 4 highlight specific fields and their dropdown menus. A callout box labeled 'Taxonomy Team# PID/EU' points to the 'Specialty' dropdown menu.

**Billing Provider Section:**

- Note: Fields marked with an asterisk \* are required.
- NPI/API: \* 1234567890
- Provider Name: \* Test Provider
- Program/Waiver: \* Select Program/Waiver (dropdown menu)

**Program/Waiver Section:**

- Program/Waiver: \* Severe Disabling Mental Illness Waiver (SDMI) (dropdown menu)
- Specialty: \* Select Specialty (dropdown menu)

**Specialty Section:**

- Specialty: \* Community/Behavioral Health/HCBS Waiver (dropdown menu)

**Form Fields:**

- NPI/API: \* 1234567890
- Provider Name: \* Test Provider
- Program/Waiver: \* Severe Disabling Mental Illness Waiver (SDMI)
- Specialty: \* Community/Behavioral Health/HCBS Waiver
- Service Location Address 1: \* 123 1st St
- Service Location Address 2:
- City: \* Billings
- State: \* MT
- ZIP: \* 59102-3320
- Taxonomy Code: \* 251S00000X
- Team Number: \* TEAM S1
- Enrollment Unit: \* 2222222

**Callout Box:** Taxonomy Team# PID/EU

# MPATH Provider Services Portal

## Single Professional Claim Submission – Selecting correct PID/Team# BSW ALF

**Billing Provider**

Note: Fields marked with an asterisk \* are required.

NPI/API:\* 1234567890

Provider Name:\* Test Provider

Program/Waiver:\*

1 → Select Program/Waiver

- Select Program/Waiver
- Severe Disabling Mental Illness Waiver (SDMI)
- Big Sky Waiver

Program/Waiver:\* Big Sky Waiver

Specialty:\*

2 → Select Specialty

- Select Specialty
- Assisted Living Facility
- Community/Behavioral Health/HCBS Waiver

3 → Program/Waiver:\* Big Sky Waiver

Specialty:\*

- Select Specialty
- Assisted Living Facility
- Community/Behavioral Health/HCBS Waiver

4 →

NPI/API:\* 1234567890

Provider Name:\* Test Provider

Program/Waiver:\* Big Sky Waiver

Specialty:\* Assisted Living Facility

Service Location Address 1:\* 123 1st St

Service Location Address 2:

City:\* Billings

State:\* MT

ZIP:\* 59102-3320

Taxonomy Code:\* 310400000X

Team Number:\* TEAM B1

Enrollment Unit:\* 1111111

**Taxonomy Team# PID/EU**

# MPATH Provider Services Portal

## Single Professional Claim Submission – Selecting correct PID/Team# BSW HCBS

▼ Billing Provider

Note : Fields marked with an asterisk \* are required.

NPI/API:\* 1234567890

Provider Name:\* Test Provider

Program/Waiver:\*

1 →

Program/Waiver:\* Big Sky Waiver

Specialty:\*

2 →

Specialty:

3 →

Specialty:

4 →

NPI/API:\* 1234567890

Provider Name:\* Test Provider

Program/Waiver:\* Big Sky Waiver

Specialty:\* Community/Behavioral Health/HCBS Wai

Service Location Address 1:\* 123 1<sup>st</sup> St

Service Location Address 2:

City:\* Billings

State:\* MT

ZIP:\* 59102-3320

Taxonomy Code: \* 251500000X

Team Number:\* TEAM B1

Enrollment Unit:\* 2222222

Taxonomy Team# PID/EU

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# MPATH Provider Services Portal

## Single Professional Claim Submission – Selecting correct PID/Team# DDP HCBS

The image shows a screenshot of the MPATH Provider Services Portal with several form fields and annotations. The form is titled "Billing Provider" and includes a note: "Note : Fields marked with an asterisk \* are required." The fields are:

- NPI/API: \* 1234567890
- Provider Name: \* Test Provider
- Program/Waiver: \* Select Program/Waiver
- Specialty: \* Select Specialty
- Service Location Address 1: \* 123 1<sup>st</sup> St
- Service Location Address 2:
- City: \* KALISPELL
- State: \* MT
- ZIP: \* 59901-1916
- Taxonomy Code: \* 251500000X
- Team Number: \* TEAM 01
- Enrollment Unit: \* 1111111

Annotations and callouts:

- 1**: Points to the "Program/Waiver" dropdown menu.
- 2**: Points to the "Specialty" dropdown menu.
- 3**: Points to the "Specialty" dropdown menu.
- 4**: Points to the "Specialty" dropdown menu.
- Taxonomy Team# PID/EU**: A blue callout box pointing to the "Team Number" field.

The "Program/Waiver" dropdown menu is open, showing the following options:

- Select Program/Waiver
- Severe Disabling Mental Illness Waiver (SDMI)
- Big Sky Waiver
- Developmentally Disabled Waiver (DDP)

The "Specialty" dropdown menu is open, showing the following options:

- Select Specialty
- Select Specialty
- Community/Behavioral Health/HCBS Waiver
- Community Based Residential Treatment Facility, Intellectual and/or Developmental Disabilities

The "Specialty" dropdown menu is highlighted with a blue bar, indicating the selected option is "Community/Behavioral Health/HCBS Waiver".

# MPATH Provider Services Portal

## Single Professional Claim Submission – Selecting correct PID/Team# DDP CBRT

The image shows a multi-step process for selecting the correct Program/Waiver and Specialty in the MPATH Provider Services Portal. The form is titled "Billing Provider" and includes a note: "Note : Fields marked with an asterisk \* are required." The form fields are as follows:

- Program/Waiver:** A dropdown menu with options: "Select Program/Waiver", "Severe Disabling Mental Illness Waiver (SDMI)", "Big Sky Waiver", and "Developmentally Disabled Waiver (DDP)". An arrow labeled "1" points to this dropdown.
- Specialty:** A dropdown menu with options: "Select Specialty", "Select Specialty", "Community/Behavioral Health/HCBS Waiver", and "Community Based Residential Treatment Facility, Intellectual and/or Developmental Disabilities". An arrow labeled "2" points to this dropdown.
- Program/Waiver:** A dropdown menu with options: "Developmentally Disabled Waiver (DDP)" and "Specialty". An arrow labeled "3" points to this dropdown.
- Specialty:** A dropdown menu with options: "Developmentally Disabled Waiver (DDP)" and "Community Based Residential Treatment Facility, Intellectual and/or Developmental Disabilities". An arrow labeled "4" points to this dropdown.

The form also includes the following fields:

- NPI/API:** 1234567890
- Provider Name:** Test Provider
- Service Location Address 1:** 123 1st St
- Service Location Address 2:** (empty)
- City:** KALISPELL
- State:** MT
- ZIP:** 59901-1916
- Taxonomy Code:** 320900000X
- Team Number:** TEAM 01
- Enrollment Unit:** 2222222

A blue callout box at the bottom center contains the text: "Taxonomy Team# PID/EU".

# MPATH Provider Services Portal

## Single Professional Claim Submission – Selecting correct PID/Team# IHSC

**Billing Provider**

Note: Fields marked with an asterisk \* are required.

NPI/API:\* 1234567890

Provider Name:\* Test Provider

Program/Waiver:\* Select Program/Waiver

1 → Severe Disabling Mental Illness Waiver (SDMI)  
Big Sky Waiver  
Montana Medicaid (HMK Plus)

Program/Waiver:\* Montana Medicaid (HMK Plus)

Specialty:\* Select Specialty  
Select Specialty  
In Home Supportive Care  
Nursing Care

2 → In Home Supportive Care

3 → In Home Supportive Care

4 → In Home Supportive Care

**Service Location**

Program/Waiver:\* Montana Medicaid (HMK Plus)

Specialty:\* In Home Supportive Care

NPI/API:\* 1234567890

Provider Name:\* Test Provider

Program/Waiver:\* Montana Medicaid (HMK Plus)

Specialty:\* In Home Supportive Care

Select Address

Service Location Address 1:\* 123 1<sup>st</sup> St

Service Location Address 2: APT A

City:\* Billings

State:\* MT

ZIP:\* 59102-3200

Taxonomy Code: \* 253Z00000X

Team Number: \* TEAM AB

Enrollment Unit:\* 1234567

**Taxonomy Team# PID/EU**

# MPATH Provider Services Portal

## Single Professional Claim Submission

Enter Member ID (Card#/SSN) and click "Search" - Enter Patient Account Number (optional).

Professional Claim Submission Form

1

Member Details

Note : Fields marked with an asterisk \* are required.

Enter Member ID:\*

1234567 Search

Enter Member ID:\*

1234567 Search

2

Member ID: 1234567

Patient Account Number:

First Name: Test

Middle Name:

Last Name: Member

Date of Birth:

Gender: Male

Mailing Address 1:

Mailing Address 2:

City:

State: MT

ZIP: 59521-0000

Member demographics are automatically populated when entering a valid Member ID

Select Save and Continue

Save and Continue Previous Save and Exit Cancel

# MPATH Provider Services Portal

## Single Professional Claim Submission

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"/>					
7	8	9	10	11	12
<input type="text"/>					

**Claim Details**

Note : **COB** or **NDC** indicates all required fields for COB or NDC 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
MM/DD/YYYY	MM/DD/YYYY	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$

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

Click the “?Help” link on any page for more information

Enter at least one Diagnosis Code

Enter required fields: Service Dates, Place of Service Code, Diagnosis Pointer(s), Charge, and Units .

# MPATH Provider Services Portal

## Single Professional Claim Submission

Enter the Diagnosis Code. The magnifying glass will allow users to search for the specific Diagnosis Code if unknown.

Enter at least first three (3) characters of a Diagnosis to search code list.

**Diagnosis Codes** 1

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
F20					
7	8	9	10	11	12

**Diagnosis Codes** 3

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
F200					
7	8	9	10	11	12

**Search Results** ✕

Code	Description
F20	Schizophrenia
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F208	Other schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified

Cancel

# MPATH Provider Services Portal

## Single Professional Claim Submission

Enter the CPT/HCPCS Code. The magnifying glass will allow users to search for the specific Code if unknown.

Enter at least first three (3) characters of a CPT/HCPCS to search code list.

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
03/08/2024	03/08/2024	11	9079			\$ 150.00	1.0C	COB	NDC		<input type="checkbox"/>	1 <input type="checkbox"/>

**Claim Details**

Note: or indicates all required fields for COB or NDC 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
03/08/2024	03/08/2024	11	90791		1	\$ 150.00	1.0C	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ 150.00

**Search Results**

Code	Description
90791	PSYCH DIAGNOSTIC EVALUATION
9079122	PSYCH DIAGNOSTIC EVALUATION;Increased Procedural Services
9079123	PSYCH DIAGNOSTIC EVALUATION;Unusual Anesthesia
9079151	PSYCH DIAGNOSTIC EVALUATION;Multiple Procedures
9079152	PSYCH DIAGNOSTIC EVALUATION;Reduced Services
9079153	PSYCH DIAGNOSTIC EVALUATION;Discontinued Procedure
9079158	PSYCH DIAGNOSTIC EVALUATION;Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
9079159	PSYCH DIAGNOSTIC EVALUATION;Distinct Procedural Service

# MPATH Provider Services Portal

## Single Professional Claim Submission

Total Charges: \$ 150.00

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

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

Select Yes/No radio buttons for required "\*" fields

Select Save and Continue

# MPATH Provider Services Portal

## Single Professional Claim Submission

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Professional Claim Submission Form ? Help

Terms and Agreements

Note : Fields marked with an asterisk \* are required.

Provider Name:\*

NPI/API:\*

\* I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof.

Submit Previous Save and Exit Cancel

**Agree to Terms and Conditions** →

**Select Submit** →

# MPATH Provider Services Portal

## Single Professional Claim Submission

Print/Save PDF of claim submission (optional).

1

Thank you for your Submission

Your Claim was successfully submitted: OC240308P0517496.

Print

Continue

2

Print

Claim: OC240308P0517496

Claim Type: Professional

Provider Detail:

Billing Provider: NPI/API: 1234567890

3

Print 2 pages

Destination

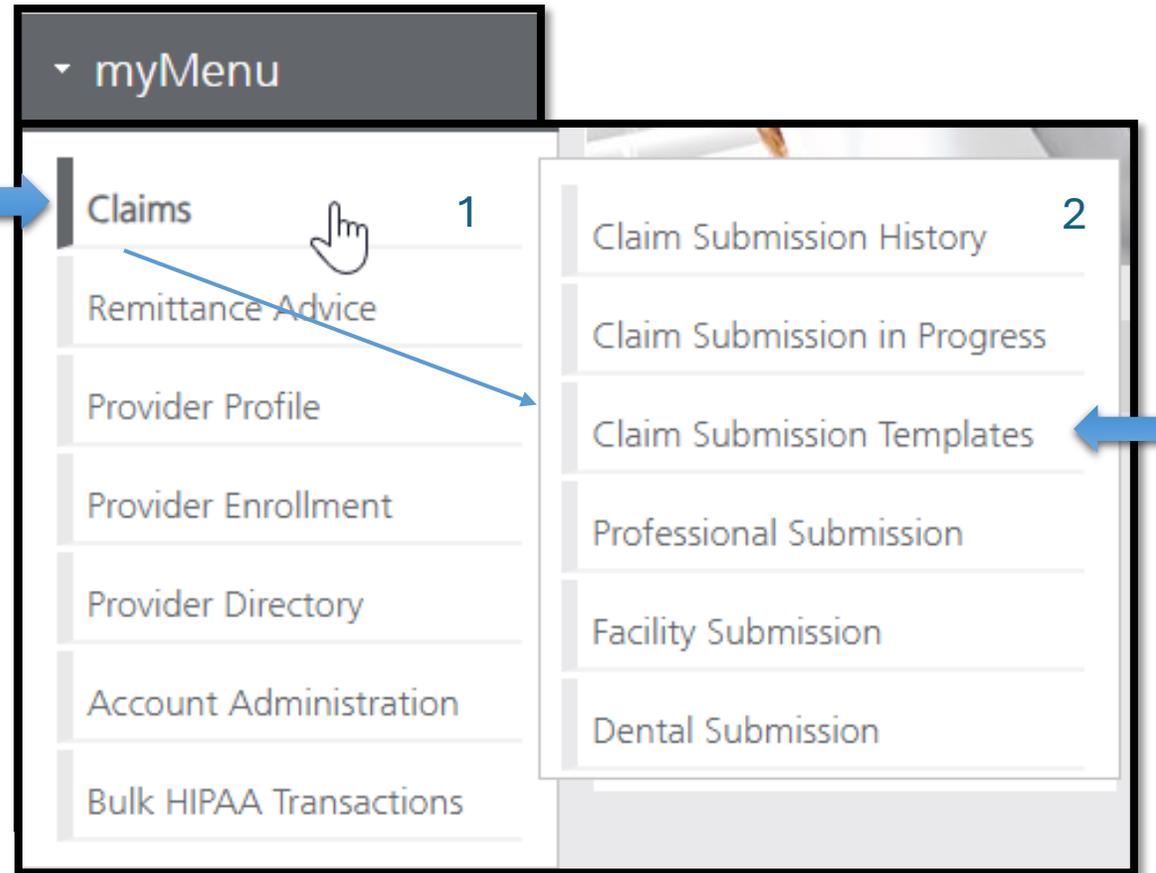
Save as PDF

Save Cancel

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

Hover the mouse over "Claims" in the myMenu section on the left navigation and select "Claim Submission Templates"



# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

To create a template, click the blue button to Create Professional Claim Submission. Templates may be Member or Service (without member) specific.

Claim Submission Templates <sup>1</sup>

Claim Submission Templates ? Help

Maximum Templates Allowed : 2000

Filter your results:

Actions	Name	Date 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

Select "Create Professional Claim Submission Template"

Professional Claim Template ? Help

Member Details

Enter Member ID:  Search

Select Save and Continue

Save and Continue Cancel

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

Professional Claim Template ? 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"/>					
7	8	9	10	11	12
<input type="text"/>					

**Claim Details**

**Note :** COB or NDC indicates all required fields for COB or NDC 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"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Total Charges: \$  Add

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

Click the “?Help” link on any page for more information

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

Dynamic data (Date of Service, Diagnosis) is entered when submitting the template.

Enter static data for the template

**Diagnosis Codes**

Diagnosis Codes (ICD 10):

1  2  3  4  5  6   
7  8  9  10  11  12

**Claim Details**

From Date	To Date	POS	CPT/HCPCS Code	Modifier	Diagnosis Pointer	Charges	Days or Units	COB	NDC	Emergency Service	Family Planning
<input type="text"/>	<input type="text"/>	11	90791		1	\$ 150.00	1.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>			\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>			\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>			\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>			\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>			\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>			\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>			\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>			\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ 150.00

Enter static data for the template

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

Select Save and Continue

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

Save Template, naming service specific template for quick reference

Professional Claim Template ? Help 1

Save Template

Please enter a claim submission template name.

Template Name: \* Psych Eval Prof

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 "-".

Select Submit

Submit Previous Cancel

Claim Submission Templates ? Help 2

Maximum Templates Allowed : 2000 Filter your results:

Actions	Name	Date Last Modified
 	<u>Psych Eval Prof</u>	03/08/2024

Show 10 entries Showing 1 to 1 of 1 templates |< < > >|

Create Professional Claim Submission Template Create Facility Claim Submission Template Create Dental Claim Submission Template

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

Hover the mouse over "Claims" in the myMenu section on the left navigation and select "Claim Submission Templates" to access saved Templates

myMenu

- Claims
- Remittance Advice
- Provider Profile
- Provider Enrollment
- Provider Directory
- Account Administration
- Bulk HIPAA Transactions

- Claim Submission History 1
- Claim Submission in Progress
- Claim Submission Templates
- Professional Submission
- Facility Submission
- Dental Submission

### Claim Submission Templates

Maximum Templates Allowed : 2000

Filter your results:

Actions	Name	Date Last Modified
	<u>Psych Eval Prof</u>	03/08/2024

Show 10 entries      Showing 1 to 1 of 1 templates

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

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

Select your provider NPI. All associated demographics will be automatically populated.

Enter other optional provider data as needed.

▼ Billing Provider

**Note :** Fields marked with an asterisk \* are required.

NPI/API:\*

Provider Name:\*

Program/Waiver:\*

Specialty:\*

Service Location Address 1:\*

Service Location Address 2:

City:\*

State:\*

ZIP:\*

Team Number:\*

Enrollment Unit:\*

Referring Provider

There is a referring provider for this claim.

Ordering Provider

There is a ordering provider for this claim.

Select Save and Continue

Optional Rendering Provider selection is available when affiliated providers are added.

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

Enter Member ID and click "Search" - Enter Patient Account Number (optional).

Professional Claim Submission Form

Member Details 1

Note : Fields marked with an asterisk \* are required.

Enter Member ID:\*

Enter Member ID:\*

2

Member ID:

Patient Account Number:

First Name:

Middle Name:

Last Name:

Date of Birth:

Gender:

Mailing Address 1:

Mailing Address 2:

City:

State:

ZIP:

Select Search

Select Save and Continue

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

**Diagnosis Codes**

Diagnosis Codes (ICD 10):

1 \* 2 3 4 5 6

7 8 9 10 11 12

**Claim Details**

Note : COB or NDC indicates all required fields for COB or NDC 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
MM/DD/YYYY	MM/DD/YYYY	11	90791		1	\$ 150.00	1.00	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ 150.00 Add

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

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

**Diagnosis Codes (ICD 10):**

1 \* 2 3 4 5 6

F200

7 8 9 10 11 12

**Claim Details**

Note : COB or NDC indicates all required fields for COB or NDC 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
03/08/2024	03/08/2024	11	90791		1	\$ 150.00	1.00	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ 150.00 Add

5 Select Save and Continue

Save and Continue Previous Save and Exit Cancel

Template retains the static data entered allowing for dynamic data entry

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

---

Professional Claim Submission Form ? Help

Terms and Agreements

**Note :** Fields marked with an asterisk \* are required.

Provider Name:\* [ Test Provider ]

NPI/API:\* [ 1234567890 ]

\* I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof.

**Select Submit** [ Submit ] [ Previous ] [ Save and Exit ] [ Cancel ]

Agree to  
Terms and  
Conditions



Select Submit



# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

Print/Save PDF of claim submission (optional).

1 Professional Claim Submission Form ? Help

Thank you for your Submission

Your Claim was successfully submitted: OC240308P0517496.

Print

2 Print

Claim: OC240308P0517496

Claim Type: Professional

Provider Detail:

Billing Provider: NPI/API: 1234567890

3 Print 2 pages

Destination Save as PDF

Save Cancel

# MPATH Provider Services Portal Single Facility Claim Submission

## Provider Services Portal Home Page

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us Account Settings Log Out

Member search

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

Search By Member ID  
 Search By Member Name  
 Search By Member SSN

Member ID:\*

Service Date:\*

Go

Hello, Test User Last login: 5/14/2024

myMenu

- Claims
- Remittance Advice
- Provider Profile
- Provider Enrollment
- Provider Directory
- Account Administration
- Bulk HIPAA Transactions

Provider Resources Forms FAQs

myMenu

- Claims 2
- Remittance Advice
- Provider Profile
- Provider Enrollment
- Provider Directory
- Account Administration
- Bulk HIPAA Transactions

- Claim Submission History 3
- Claim Submission in Progress
- Claim Submission Templates
- Professional Submission
- Facility Submission
- Dental Submission

Hover the mouse over "Claims" in the myMenu section on the left navigation and select "Facility Claim Submission"

# MPATH Provider Services Portal Single Facility Claim Submission

Select your provider NPI, all other associated demographics will be automatically populated.

Enter other optional provider data as needed.

▼ Billing Provider

Note : Fields marked with an asterisk \* are required.

NPI/API:\* 1234567890

Provider Name:\* Test Provider

Program/Waiver:\* Montana Medicaid (HMK Plus) ▼

Specialty:\* In Home Supportive Care ▼

**Service Location**

Service Address 1:\* 1120 CEDAR ST

Service Address 2:

City:\* MISSOULA

State:\* MT

ZIP:\* 59802-3911

Taxonomy Code:\* 261QR0405X

Team Number:\* TEAM AB

Enrollment Unit:\* 1234567

**Other Provider(s)**

**Attending Provider**

There is an attending provider for this claim.

**Operating Provider**

There is an operating provider for this claim.

**Other Provider 1**

There is an other provider for this claim.

**Other Provider 2**

There is an other provider for this claim.

Save and Continue Save and Exit Cancel

Optional Rendering Provider selection is available when affiliated providers are added.

Select Save and Continue

# MPATH Provider Services Portal Single Facility Claim Submission

Enter Member ID (Card#/SSN) and click "Search" - Enter Patient Account Number (optional).

The screenshot displays the 'Professional Claim Submission Form' with a 'Member Details' section. A blue callout box labeled '1' points to the 'Enter Member ID:\*' field, which contains the value '1234567'. A blue callout box labeled 'Select Search' points to the 'Search' button. A second blue callout box labeled '2' points to the 'Search' button in the 'Enter Member ID:\*' section of the 'Member Demographics' form. This form is populated with the following information: Member ID: 1234567, Patient Account Number: (empty), First Name: Test, Middle Name: (empty), Last Name: Member, Date of Birth: (empty), Gender: Male, Mailing Address 1: (empty), Mailing Address 2: (empty), City: (empty), State: MT, and ZIP: 59521-0000. A blue callout box on the right states: 'Member Demographics are automatically populated when entering a valid Member ID'. At the bottom, a blue callout box labeled 'Select Save and Continue' points to the 'Save and Continue' button, which is highlighted in blue. Other buttons include 'Previous', 'Save and Exit', and 'Cancel'.

Professional Claim Submission Form 1

Member Details

Note : Fields marked with an asterisk \* are required.

Enter Member ID:\* 1234567 Search

Enter Member ID:\* 1234567 Search 2

Member ID: 1234567

Patient Account Number:

First Name: Test

Middle Name:

Last Name: Member

Date of Birth:

Gender: Male

Mailing Address 1:

Mailing Address 2:

City:

State: MT

ZIP: 59521-0000

Member Demographics are automatically populated when entering a valid Member ID

Select Save and Continue

Save and Continue Previous Save and Exit Cancel

# MPATH Provider Services Portal Single Facility Claim Submission

Facility Claim Submission Form ? Help

Claim Information

**Note :** Fields marked with an asterisk \* are required.

**Note :** Type of Bill value field is 4 character code with the first value always being zero. To void or replace a claim, enter the original submitted Type of Bill, change the last digit to 8 (Void) or 7 (Replacement) and enter the 17-digit MMIS ICN in the Original MMIS ICN field.

Type of Bill:\*  Inpatient or Outpatient:\*  Select Statement Period From:\*  MM/DD/YYYY  MM/DD/YYYY  Statement Period Through:\*  MM/DD/YYYY

Admission Date:  MM/DD/YYYY  Admission Hour:  Select Admission Type: \*  Source of Admission: \*  Discharge Hour:  Select Member Discharge Status: \*

**Note :** Changing only the Type of Bill on the claim cannot be done via electronic adjustment. This must be done using the Individual Adjustment Request.

Condition Codes ?

Accident State:  Select

Click the ?Help link on any page for more information

Enter required fields: Type of Bill, Inpatient/Outpatient, From/Through Date(s), Admit Type/Source/Status

Other fields may be required based on selections

Hover over any "?" to see a quick list of common values

Condition Codes ?

Condition Codes:

Accident State:  Select

Common Condition Codes are:  
A1 - EPSDT, A4 - Family Planning,  
B3 - Pregnancy, AI - Sterilization.  
Refer to the current applicable coding manual for more information.

# MPATH Provider Services Portal Single Facility Claim Submission

**Occurrence Codes**

Occurrence Code:	Date:	Occurrence Code:	Date:
<input type="text"/>	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY

**Occurrence Span Codes**

Occurrence Span Code:	From:	Through:	Occurrence Span Code:	From:	Through:
<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY

**Value Codes ?**

Value Code:	Amount/Days:	Value Code:	Amount/Days:	Value Code:	Amount/Days:
1	<input type="text"/>	5	<input type="text"/>	9	<input type="text"/>
2	<input type="text"/>	6	<input type="text"/>	10	<input type="text"/>
3	<input type="text"/>	7	<input type="text"/>	11	<input type="text"/>
4	<input type="text"/>	8	<input type="text"/>	12	<input type="text"/>

Hover over any "?" to see a quick list of common values

Enter optional fields as necessary: Occurrence Codes, Occurrence Span codes, Value Codes.

**Value Codes ?**

Value Code: Am t/Days:

1

To report Personal Resource Amount for a skilled Nursing Facility claim enter Value Code 31 and enter the dollar amount into the Amount/Days field.

# MPATH Provider Services Portal

## Single Facility Claim Submission

### Claim Details

Note :  indicates all required fields for NDC have been entered.

Note : Use a comma "," if multiple values are needed in Modifier field.

Enter Revenue Code, Optional HCPCS Code, Optional Modifier, Date(s) of Service, Units, and Charges

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					

Total Charges: \$

# MPATH Provider Services Portal Single Facility Claim Submission

Enter the Revenue Code. The magnifying glass will allow users to search for the specific Revenue Code if unknown.

Enter at least first three (3) characters of a Revenue Code to search code list.

1

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
012			06/14/2024	06/14/2024	1	NDC	\$ 150.00

3

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
0120			06/14/2024	06/14/2024	1	NDC	\$ 150.00

Search Results

Code	Description
2 0120	Room & Board Semiprivate (Two Beds)-General Classification
0121	Room & Board Semiprivate (Two Beds)-Medical/Surgical/GYN
0122	Room & Board Semiprivate (Two Beds)-Obstetrics (OB)
0123	Room & Board Semiprivate (Two Beds)-Pediatric
0124	Room & Board Semiprivate (Two Beds)-Psychiatric
0125	Room & Board Semiprivate (Two Beds)-Hospice
0126	Room & Board Semiprivate (Two Beds)-Detoxification
0127	Room & Board Semiprivate (Two-Beds)-Oncology
0128	Room & Board-Semiprivate (Two-Beds)-Rehabilitation

Cancel

# MPATH Provider Services Portal Single Facility Claim Submission

Optional: Enter the HCPCS Code. The magnifying glass will allow users to search for the specific HCPCS Code if unknown.

Enter at least first three (3) characters of a HCPCS to search code list.

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
9079	1		06/14/2024	06/14/2024	1	NDC	\$ 150.00

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
0120	90791	3	06/14/2024	06/14/2024	1	NDC	\$ 150.00

Code	Description
90791	PSYCH DIAGNOSTIC EVALUATION
2 9079122	PSYCH DIAGNOSTIC EVALUATION;Increased Procedural Services
9079123	PSYCH DIAGNOSTIC EVALUATION;Unusual Anesthesia
9079151	PSYCH DIAGNOSTIC EVALUATION;Multiple Procedures
9079152	PSYCH DIAGNOSTIC EVALUATION;Reduced Services
9079153	PSYCH DIAGNOSTIC EVALUATION;Discontinued Procedure
9079158	PSYCH DIAGNOSTIC EVALUATION;Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
9079159	PSYCH DIAGNOSTIC EVALUATION;Distinct Procedural Service

Cancel

# MPATH Provider Services Portal Single Facility Claim Submission

Enter Primary Diagnosis Code. The magnifying glass will allow users to search for the specific Diagnosis Code if unknown.

Enter at least first three (3) characters of a Diagnosis to search code list.

**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.

Primary Diagnosis Code: \* Present on Admission: \* Diagnosis Related Groups(DRG):

F20

**1**

Primary Diagnosis Code: \* Present on Admission: \* Diagnosis Related Groups(DRG):

F200

**3**

**2**

Code	Description
F20	Schizophrenia
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F208	Other schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified

# MPATH Provider Services Portal Single Facility Claim Submission

**Other Diagnosis Codes**

**Note :** When you add Other Diagnosis Code, you are required to select Present on Admission.

Other Diagnosis Codes:	Present on Admission:
<input type="text"/>	Select

**Add Diagnosis Code**

Admitting Diagnosis Code:  Member's Reason for Visit Diagnoses:

**Note :** When you add External Cause of Injury Codes, you are required to select Present on Admission.

External Cause of Injury Codes:	Present on Admission:
<input type="text"/>	Select
<input type="text"/>	Select
<input type="text"/>	Select

Principal Procedure Code:  Date:

**Other Procedure Codes**

Other Procedure Codes:	Date:
<input type="text"/>	MM/DD/YYYY

Enter optional information, then select save and continue

Prior Authorization Number:  Referral Number:  Service Authorization Exception Code:

[Advanced Search](#)

Are you submitting COB at the claim level?  Yes  No

Do you have attachments for this claim?  Yes  No

**Notes:**

**Select Save and Continue**

Enter optional information

Select Save and Continue

# MPATH Provider Services Portal Single Facility Claim Submission

The screenshot shows a web form titled "Facility Claim Submission Form" with a "? Help" link in the top right corner. Below the title is a section for "Terms and Agreements". A red note states: "Note : Fields marked with an asterisk \* are required." There are two input fields: "Provider Name:\*" containing "Test Provider" and "NPI/API:\*" containing "1234567890". Below these is a checkbox labeled "I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof." which is checked. At the bottom right are four buttons: "Submit", "Previous", "Save and Exit", and "Cancel".

Annotations on the screenshot include:

- A blue box on the left containing the text "Agree to Terms and Conditions" with an arrow pointing to the checked checkbox.
- A blue box at the bottom containing the text "Select Submit" with an arrow pointing to the "Submit" button.

# MPATH Provider Services Portal Single Facility Claim Submission

Print/Save PDF of claim submission (optional).

1

Facility Claim Submission Form

Thank you for your Submission

Your Claim was successfully submitted: OC220301I0158541

Print

2

Print

Claim: OC220301I0158541

Claim Type: Facility

Provider Detail:

Billing Provider: NPI/API: 1234567890

3 2 pages

Print

Destination

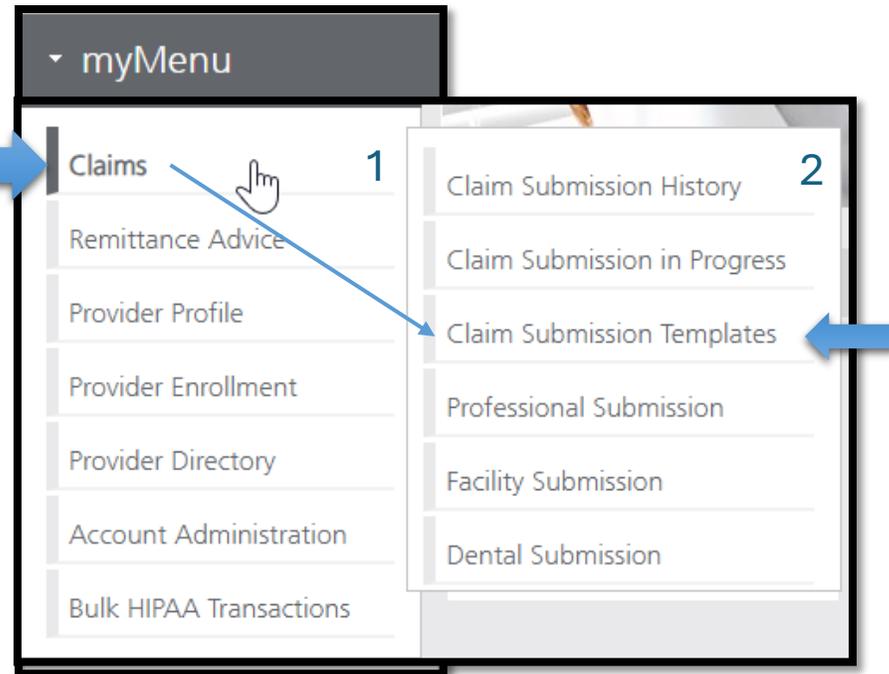
Save as PDF

Save Cancel

# MPATH Provider Services Portal

## Developing a (Service specific) Facility Claim Template

Hover the mouse over “Claims” in the myMenu section on the left navigation and select “Claim Submission Templates”



# MPATH Provider Services Portal

## (Service specific) Facility Claim Template

To create a template, select Create Facility Claim Template. Templates may be Member or Service (without member) specific.

1

### Claim Submission Templates

Claim Submission Templates ? Help

Maximum Templates Allowed : 2000 Filter your results:

Actions	Name	Date Last Modified
No claim submission templates found.		

Show 10 entries Showing 0 to 0 of 0 entries |< < > >|

Select "Create Facility Claim Submission Template"

Create Facility Claim Submission Template Create Dental Claim Submission Template

2 ? Help

### Facility Claim Template

Member Details

Enter Member ID:  Search

Select Save and Continue

Save and Continue Cancel

# MPATH Provider Services Portal

## (Service specific) Facility Claim Template

Facility Claim Template ? Help

Claim Information

**Note :** Type of Bill value field is 4 character code with the first value always being zero. To void or replace a claim, enter the original submitted Type of Bill, change the last digit to 8 (Void) or 7 (Replacement) and enter the 17-digit MMIS ICN in the Original MMIS ICN field.

Type of Bill:  Inpatient or Outpatient?:  Select Statement Period From:  MM/DD/YYYY Statement Period Through:  MM/DD/YYYY

Admission Date:  MM/DD/YYYY Admission Hour:  Select Admission Type:  Source of Admission:  Discharge Hour:  Select Member Discharge Status:

**Note :** Changing only the Type of Bill on the claim cannot be done via electronic adjustment. This must be done using the Individual Adjustment Request.

Condition Codes ?

Condition Codes:

Accident State:  Select

Occurrence Codes

Occurrence Code:	Date:	Occurrence Code:	Date:
<input type="text"/>	<input type="text"/> MM/DD/YYYY	<input type="text"/>	<input type="text"/> MM/DD/YYYY
<input type="text"/>	<input type="text"/> MM/DD/YYYY	<input type="text"/>	<input type="text"/> MM/DD/YYYY
<input type="text"/>	<input type="text"/> MM/DD/YYYY	<input type="text"/>	<input type="text"/> MM/DD/YYYY
<input type="text"/>	<input type="text"/> MM/DD/YYYY	<input type="text"/>	<input type="text"/> MM/DD/YYYY

Click the “?Help” link on any page for more information

# MPATH Provider Services Portal (Service specific) Facility Claim Template

Dynamic data (Date of Service, Diagnosis) is entered when submitting the template.

Enter static data for the template

1

Type of Bill: 0120 Inpatient or Outpatient?: Inpatient Statement Period From: MM/DD/YYYY Statement Period Through: MM/DD/YYYY

Admission Date: MM/DD/YYYY Admission Hour: Select Admission Type: 1 Source of Admission: 1 Discharge Admission Hour: Select Member Discharge Status: 02

Note: Changing only the Type of Bill on the claim cannot be done via electronic adjustment. This must be done using the Individual Adjustment Request.

Condition Codes ?

Condition Codes: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Accident State: Select

Occurrence Codes

Occurrence Code:	Date:	Occurrence Code:	Date:
[ ]	MM/DD/YYYY	[ ]	MM/DD/YYYY
[ ]	MM/DD/YYYY	[ ]	MM/DD/YYYY
[ ]	MM/DD/YYYY	[ ]	MM/DD/YYYY
[ ]	MM/DD/YYYY	[ ]	MM/DD/YYYY

2

Claim Details

Note: Use a comma "," if multiple values are needed in Modifier field.

Revenue Code:	HCPCS Code:	Modifier:	From Date:	To Date:	Service Units:	NDC:	Total Charges:
0120	[ ]	[ ]	MM/DD/YYYY	MM/DD/YYYY	1	NDC	\$ 150.00
[ ]	[ ]	[ ]	MM/DD/YYYY	MM/DD/YYYY	[ ]	NDC	\$ [ ]

Select Save and Continue

3

Save and Continue Previous Cancel

# MPATH Provider Services Portal (Service specific) Facility Claim Template

Save Template, naming service specific template for quick reference

Facility Claim Template 1 ? Help

Save Template

Please enter a claim submission template name.

Template Name: \* Psych Eval Facil

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 "-".

Select Submit

Submit Previous Cancel

Claim Submission Templates 2 ? Help

Maximum Templates Allowed : 2000 Filter your results:

Actions	Name	Date Last Modified
 	<u>Psych Eval Facil</u>	03/08/2024

Show 10 entries Showing 1 to 1 of 1 templates |< < > >|

Create Professional Claim Submission Template Create Facility Claim Submission Template Create Dental Claim Submission Template

# MPATH Provider Services Portal (Service specific) Facility Claim Template

Hover the mouse over "Claims" in the myMenu section on the left navigation and select "Claim Submission Templates" to access saved Templates

The screenshot shows a 'myMenu' dropdown menu. The 'Claims' item is highlighted with a mouse cursor. A blue arrow points from the text box to this item. A secondary dropdown menu is visible under 'Claims', with 'Claim Submission Templates' highlighted by another blue arrow.

- myMenu
  - Claims
  - Remittance Advice
  - Provider Profile
  - Provider Enrollment
  - Provider Directory
  - Account Administration
  - Bulk HIPAA Transactions

  - Claim Submission History 1
  - Claim Submission in Progress
  - Claim Submission Templates
  - Professional Submission
  - Facility Submission
  - Dental Submission

The screenshot shows the 'Claim Submission Templates' page. It includes a table with one entry, 'Psych Eval Facil', and three buttons at the bottom: 'Create Professional Claim Submission Template', 'Create Facility Claim Submission Template', and 'Create Dental Claim Submission Template'.

Maximum Templates Allowed : 2000 Filter your results:

Actions	Name	Date Last Modified
	<u>Psych Eval Facil</u>	03/08/2024

Show 10 entries Showing 1 to 1 of 1 templates |< < > >|

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

# MPATH Provider Services Portal (Service specific) Facility Claim Template

Select your provider NPI. All other associated demographics will be automatically populated.

Enter other optional provider data as needed.

Select Save and Continue

▼ Billing Provider

Note : Fields marked with an asterisk \* are required.

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	Montana Medicaid (HMK Plus)
Specialty:*	Montana Medicaid (HMK Plus) ▼
Service Location	In Home Supportive Care ▼
Service Address 1:*	1120 CEDAR ST
Service Address 2:	
City:*	MISSOULA
State:*	MT
ZIP:*	59802-3911
Taxonomy Code: *	261QR0405X
Team Number:*	TEAM AB
Enrollment Unit:*	1234567

**Other Provider(s)**

**Attending Provider**

There is an attending provider for this claim.

**Operating Provider**

There is an operating provider for this claim.

**Other Provider 1**

There is an other provider for this claim.

**Other Provider 2**

There is an other provider for this claim.

Save and Continue Save and Exit Cancel

# MPATH Provider Services Portal (Service specific) Facility Claim Template

Enter Member ID and click "Search" Enter Patient Account Number (optional) if necessary.

Professional Claim Submission Form **1**

Member Details

Note : Fields marked with an asterisk \* are required.

Enter Member ID:\*

Select Search

Enter Member ID:\* **2**

Member ID:

Patient Account Number:

First Name:

Middle Name:

Last Name:

Date of Birth:

Gender:

Mailing Address 1:

Mailing Address 2:

City:

State:

ZIP:

Select Save and Continue

# MPATH Provider Services Portal (Service specific) Facility Claim Template

Template retains the static data entered allowing for dynamic data entry.

1

Type of Bill: 0120 Inpatient or Outpatient? Inpatient Statement Period From: MM/DD/YYYY Statement Period Through: MM/DD/YYYY

Admission Date: MM/DD/YYYY Admission Hour: Select Admission Type: 1 Source of Admission: 1 Discharge Hour: Select Member Discharge Status: 02

Note: Changing only the Type of Bill on the claim cannot be done via electronic adjustment. This must be done using the Individual Adjustment Request.

Condition Codes ?

Condition Codes: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Accident State: Select

Occurrence Codes

Occurrence Code:	Date:	Occurrence Code:	Date:
[ ]	MM/DD/YYYY	[ ]	MM/DD/YYYY
[ ]	MM/DD/YYYY	[ ]	MM/DD/YYYY
[ ]	MM/DD/YYYY	[ ]	MM/DD/YYYY
[ ]	MM/DD/YYYY	[ ]	MM/DD/YYYY

2

Note: Use a comma "," if multiple values are needed in Modifier field.

Revenue Code:	HCPCS Code:	Modifier:	From Date:	To Date:	Service Units:	NDC:	Total Charges:
0120			MM/DD/YYYY	MM/DD/YYYY	1	NDC	\$ 150.00
			MM/DD/YYYY	MM/DD/YYYY		NDC	\$

3

Note: NDC indicates all required fields for NDC have been entered.

Note: Use a comma "," if multiple values are needed in Modifier field.

Revenue Code:*	HCPCS Code:	Modifier:	From Date:	To Date:	Service Units:*	NDC:	Total Charges:*
0120			06/14/2024	06/14/2024	1	NDC	\$ 150.00

Total Charges: \$ 150.00 Add

Hover over any "?" to see a quick list of common values

4  
Select Save and Continue

Save and Continue Previous Cancel

# MPATH Provider Services Portal (Service specific) Facility Claim Template

Agree to  
Terms and  
Conditions

Facility Claim Submission Form ? Help

Terms and Agreements

Note : Fields marked with an asterisk \* are required.

Provider Name:\*

NP/ANI:\*

\* I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof.

Select Submit

# MPATH Provider Services Portal (Service specific) Facility Claim Template

Print/Save PDF of claim submission (optional).

1

Facility Claim Submission Form

Thank you for your Submission

Your Claim was successfully submitted: OC220301I0158541

Print

2

Print

Claim: OC220301I0158541

Claim Type: Facility

Provider Detail:

Billing Provider: NPI/API: 1234567890

3

Print 2 pages

Destination

Save as PDF

Save Cancel

# MPATH Provider Services Portal

## Claim status

### Provider Services Portal Home Page

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us Account Settings Log Out

1

Member search ?

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

Search By Member ID  
 Search By Member Name  
 Search By Member SSN

Member ID: \*  
1234567

Service Date: \*  
06/14/2024

Go

myMenu

- Claims
- Remittance Advice
- Provider Profile
- Provider Enrollment
- Provider Directory
- Account Administration
- Bulk HIPAA Transactions

Hello, AaronProd MPATH Last login: 5/14/2024

Provider Resources Forms FAQs

Enter Member ID (Card#/SSN) and click "Go"

Member search ?

2

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

Search By Member ID  
 Search By Member Name  
 Search By Member SSN

Member ID: \*  
1234567

Service Date: \*  
06/14/2024

Go

Select "Claims Inquiry" and click "Search"

Member search ?

3

Member found!

You are currently viewing:  
Test Member 1234567

Clear Search

Claims Inquiry  
 Eligibility

Search

# MPATH Provider Services Portal

## Claim status

Select/Enter Search criteria as necessary

Member search ? Hi AaronProd MPATH

Claim search ?

NPI/API: 1234567890

I want to view:

Claims for

Test Member (06/14/2000)

Time period

From Date: 06/14/2024

To Date: 06/14/2024

Claim number

Patient account number

Search

myMenu

### Claims Detail

Claim search results

Member: Test Member 1234567

You are viewing: Claims for NPI/API 1234567890 and time period from 06/14/2024 to 06/14/2024.

Claim activity [Download](#) [Print](#) [? Help](#)

Filter your results:

ICN	OPTUM CLAIM NUMBER	SERVICE DATE	MEMBER NAME	PROVIDER	STATUS	BILLED AMOUNT	PLAN PAYS
22419900255	OC2241	06/14/2024	Test Member	Test Provider	F1	\$100.00	\$50.00

Show 10 entries Showing 1 to 1 of 1 Claims

# MPATH Provider Services Portal

## Claim status

Select ICN to view detail

Claim activity 1 [Download](#) [Print](#) [? Help](#)

Filter your results:

ICN	OPTUM CLAIM NUMBER	SERVICE DATE	MEMBER NAME	PROVIDER	STATUS	BILLED AMOUNT	PLAN PAYS
22419900255	OC2241	06/14/2024	Test Member	Test Provider	F1	\$100.00	\$50.00

Claim activity 2 [Download](#) [Print](#) [? Help](#)

ICN: 22419900255008999 OC2241I0158541 [Return to search](#)

Member: Test Member  
Date of Service: 6/14/24  
Patient Account  
Member ID: 1234567

Date Processed: 6/14/24

Claim status: F1:Finalized/Payment

Total amount billed:	\$100.00
Total amount paid:	\$50.00

Payment details

Payment number:	00000942396
Payment date:	6/14/23
Payment amount:	\$50.00

Line 1

Provider name:	Test Provider
Provider Tax ID:	
Date of service:	6/14/24
Procedure code:	90791

Cost for this service	Amount billed:	\$100.00
	Amount paid by plan:	\$50.00

[Return to search](#)

# MPATH Provider Services Portal Remittance Advice

## Provider Services Portal Home Page

Member search ?

Member search  
Enter Member ID \*

Go

myMenu

- Claims 1
- Remittance Advice
- Provider Profile
- Provider Enrollment
- Provider Directory
- Account Administration
- Bulk HIPAA Transactions

Hello, Test Provider Last login: 3/7/2024

Provider Resources Forms FAQs

Privacy

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Select "Remittance Advice" in the myMenu section on the left navigation.

myMenu

- Claims 2
- Remittance Advice

# MPATH Provider Services Portal

## Remittance Advice Retrieval

Member search ? Hi Test User

Remittance advice search ?

Note : Fields marked with \* are required.

NPV/API: 1234567890  
PID/EU: 1234567

I want to search by:

- EFT number
- Check number
- Remittance advice number
- Remit date

From Date: \*  
11/02/2002

To Date: \*  
11/03/2002

Search

Remittance Advice

Remittance advice search results

Provider NPV/API: 1234567890  
You are viewing: Remittance Advice for NPV/API 1234567890 and time period from 11/02/2002 to 11/03/2002.

Remittance advice activity ? Help

Filter your results:

REMITTANCE ADV NBR	DATE ISSUED	PID/EU	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	PDF	835 EDI
11	03/07/2022	1234567		Check	\$29633.82	<a href="#">View</a>	<a href="#">Download</a>
11	03/14/2022	1234567		Check	\$20182.56	<a href="#">View</a>	<a href="#">Download</a>
150000	03/14/2022	1234567		Check	\$398.30	<a href="#">View</a>	<a href="#">Download</a>

Show 10 entries

Showing 1 to 4 of 4 forms

Select NPI and PID/EU (if necessary). Select Remit Date and select from/to date. Click Search.

Click "View" under the PDF header.

# MPATH Provider Services Portal

## Electronic Adjustment (void/replace)

---

Electronic Adjustment (void or void/replace) either voids a claim entirely or reverses and replaces a PAID claim.

The Adjustment is “as the claim should be” not only what is changed. What is sent is the entire new claim. Always include previous required information (Prior Authorization number, Paperwork Attachments, COB) to avoid denial.

The following claims cannot be adjusted electronically:

- Claims over 12 months from paid date (use paper form)
- Claims that have already been adjusted (use the ICN of the adjusted claim instead)
- Claims that are over lines (Split or Overflow claims)
- Financial adjustments (aka gross adjustment)
- Denied or in-process (suspended) claims

# MPATH Provider Services Portal

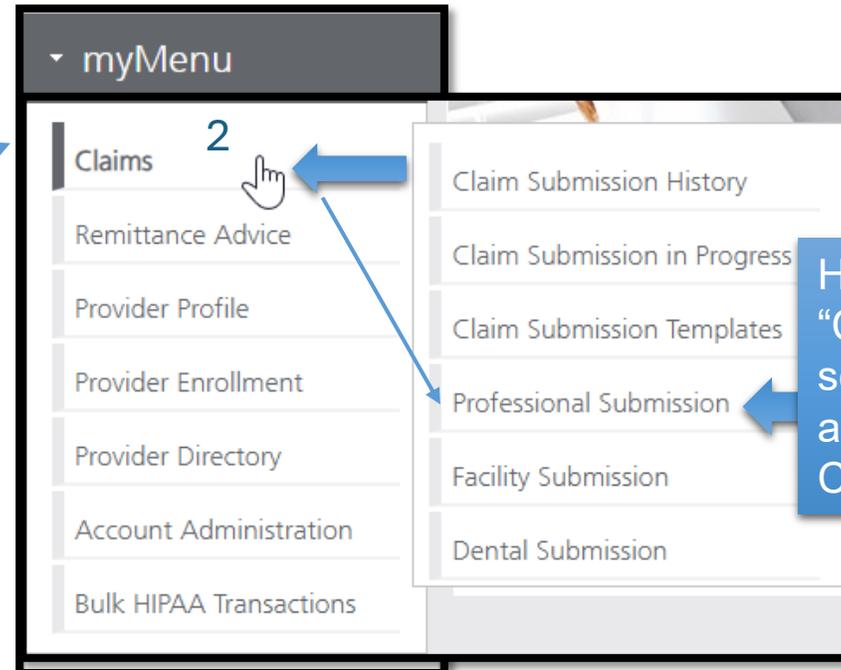
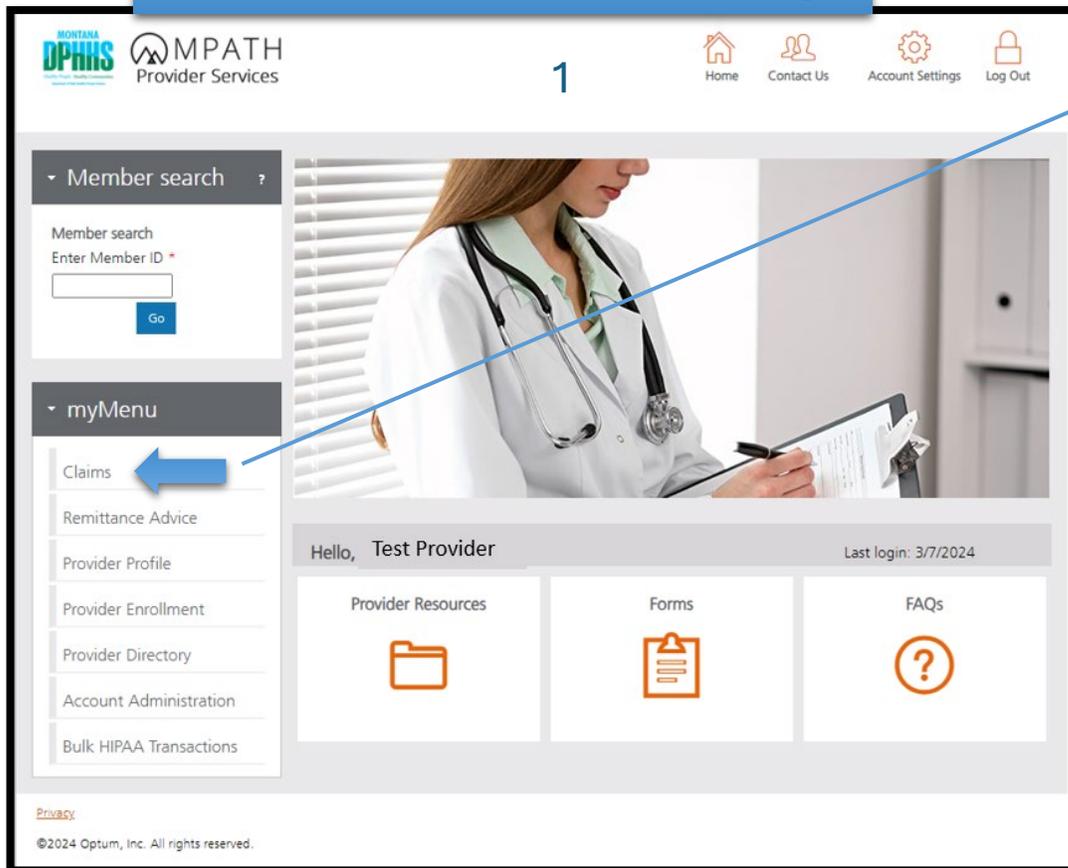
## Electronic Adjustment (void/replace)

Only PAID (even paid at \$0) can be adjusted. Only the 17-digit MMIS ICN from the remittance advice is valid for Adjustments – any other value (Optum claim#, Member ID, Account Number) will electronically reject as “not found.”

	PAID CLAIMS - MISCELLANEOUS CLAIM								
	1234567	Test Member		05222024	05222024	1.000	99394	347.00	149.27
	ICN 22419900255008999 . PATIENT NUMBER=1335317450								
	1234567	Test Provider							

# MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace)

## Provider Services Portal Home Page



Hover the mouse over "Claims" in the myMenu section on the left navigation and select "Professional Claim Submission"

# MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace)

Select your provider NPI, all other associated demographics will be automatically populated.

Enter other optional provider data as needed.

Select Save and Continue

▼ Billing Provider

Note : Fields marked with an asterisk \* are required.

NPI/API:\* | 1234567890

Provider Name:\* | Test Provider

Program/Waiver:\* | Montana Medicaid (HMK Plus)

Specialty:\* | Community/Behavioral Health/SDMI HCB ▼

Service Location Address 1:\* | 1120 CEDAR ST

Service Location Address 2: |

City:\* | MISSOULA

State:\* | MT

ZIP:\* | 59802-3911

Taxonomy Code: \* | 251S00000X

Enrollment Unit:\* | 1234567

**Referring Provider**

There is a referring provider for this claim.

**Ordering Provider**

There is an ordering provider for this claim.

Save and Continue | Save and Exit | Cancel

# MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace)

Enter Member ID (Card#/SSN) and click "Search" - Enter Patient Account Number (optional) as desired.

The screenshot displays the 'Professional Claim Submission Form' with the following elements:

- Professional Claim Submission Form 1** (Section Header)
- Member Details** (Section Header)
- Note:** Fields marked with an asterisk \* are required.
- Enter Member ID:\*** (Label) with an input field containing '1234567' and a **Search** button.
- Search** button (highlighted with a blue arrow and 'Select Search' callout).
- Enter Member ID:\*** (Label) with an input field containing '1234567' and a **Search** button (highlighted with a blue arrow and '2' callout).
- Member ID:** 1234567
- Patient Account Number:** (Empty field)
- First Name:** Test
- Middle Name:** (Empty field)
- Last Name:** Member
- Date of Birth:** (Empty field)
- Gender:** Male
- Mailing Address 1:** (Empty field)
- Mailing Address 2:** (Empty field)
- City:** (Empty field)
- State:** MT
- ZIP:** 59521-0000
- Member demographics are automatically populated when entering a valid Member ID** (Blue callout box).
- Select Save and Continue** (Blue callout box pointing to the **Save and Continue** button).
- Save and Continue** button
- Previous** button
- Save and Exit** button
- Cancel** button

# MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace)

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"/>					
7	8	9	10	11	12
<input type="text"/>					

**Claim Details**

**Note:** **COB** or **NDC** indicates all required fields for COB or NDC 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"/>	\$		<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		<input type="checkbox"/>				

Total Charges: \$

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

Click the “?Help” link on any page for more information

Enter at least one Diagnosis Code

Enter required fields: Service Date(s), Place of Service Code, Diagnosis Pointer(s), Charges, and Units .

# MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace)

Enter the Diagnosis Code. The magnifying glass will allow users to search for the specific Diagnosis Code if unknown.

Enter at least first three (3) characters of a Diagnosis to search code list.

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6	1
F20						
7	8	9	10	11	12	

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6	3
F200						
7	8	9	10	11	12	

Search Results

Code	Description
F20	Schizophrenia
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F208	Other schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified

Cancel

# MPATH Provider Services Portal Professional Claim

## Electronic Adjustment (void/replace)

Enter Date of Service, select [Place of Service](#), CPT/HCPCS (Enter at least first three (3) characters of a CPT/HCPCS to search code list), Modifier (optional), Diagnosis Pointer(s), Charges, and Unit(s).

The screenshot illustrates the process of adding a new line item to a claim. It shows the search interface, the search results, and the 'Claim Details' table.

**Search Interface:**

From Date*	To Date*	POS*	CPT/HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
03/08/2024	03/08/2024	11	9079	1	1	\$ 150.00	1.00	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>

**Search Results:**

Code	Description
90791	PSYCH DIAGNOSTIC EVALUATION
2 9079122	PSYCH DIAGNOSTIC EVALUATION;Increased Procedural Services
9079123	PSYCH DIAGNOSTIC EVALUATION;Unusual Anesthesia
9079151	PSYCH DIAGNOSTIC EVALUATION;Multiple Procedures
9079152	PSYCH DIAGNOSTIC EVALUATION;Reduced Services
9079153	PSYCH DIAGNOSTIC EVALUATION;Discontinued Procedure
9079158	PSYCH DIAGNOSTIC EVALUATION;Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
9079159	PSYCH DIAGNOSTIC EVALUATION;Distinct Procedural Service

**Claim Details:**

Note: COB or NDC indicates all required fields for COB or NDC have been entered.

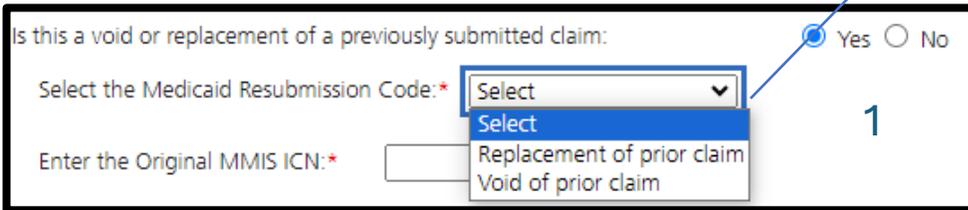
From Date*	To Date*	POS*	CPT/HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
03/08/2024	03/08/2024	11	90791		1	\$ 150.00	1.00	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ 150.00 Add

# MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace)

Click Yes on “Is this a void or replacement of a previously submitted claim?” radio button

Click Yes on “Is this a void or replacement of a previously submitted claim?” radio button. Select submission code . Enter the 17-digit MMIS ICN

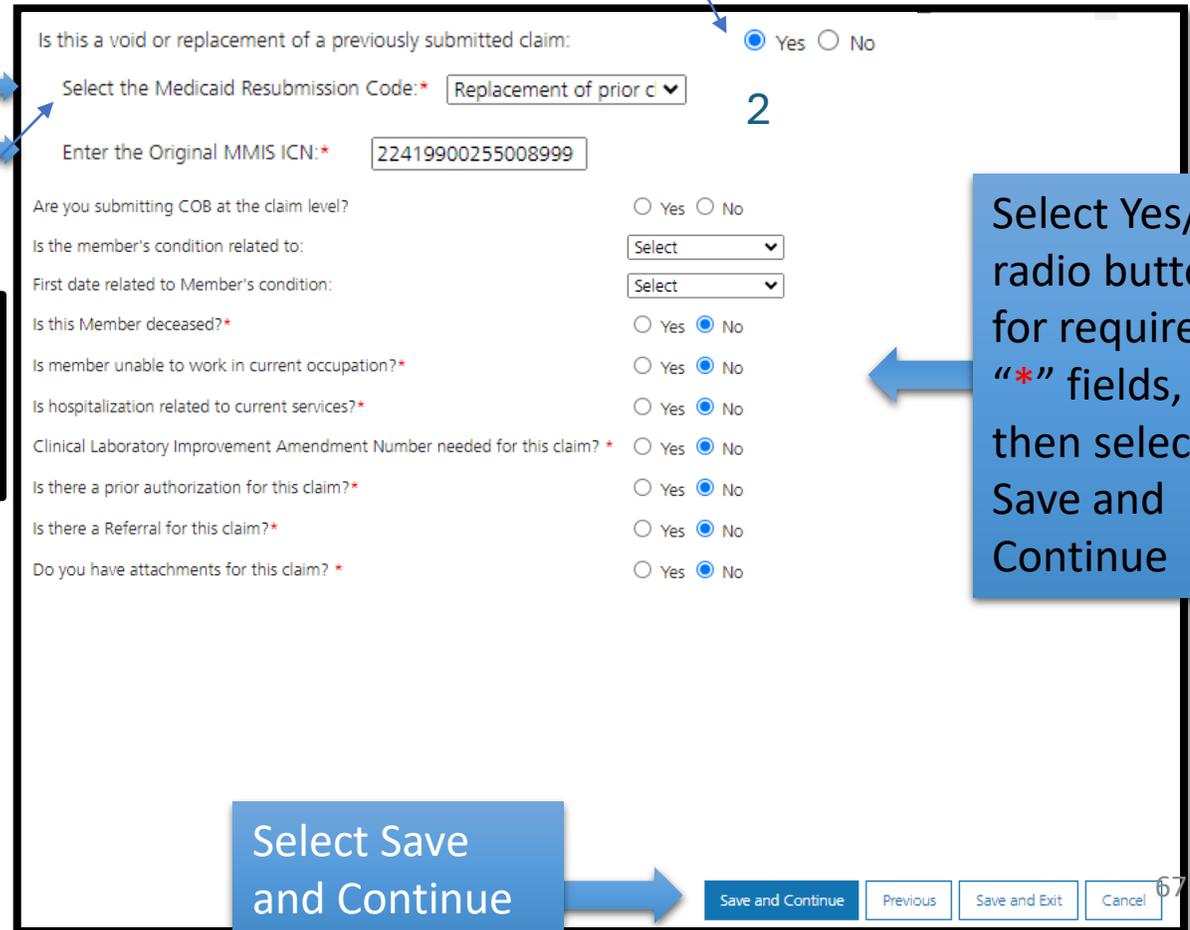


Is this a void or replacement of a previously submitted claim:  Yes  No

Select the Medicaid Resubmission Code:\* 1

- Select
- Select
- Replacement of prior claim
- Void of prior claim

Enter the Original MMIS ICN:\*



Is this a void or replacement of a previously submitted claim:  Yes  No 2

Select the Medicaid Resubmission Code:\* Replacement of prior claim

Enter the Original MMIS ICN:\* 22419900255008999

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

3

Select Save and Continue

Save and Continue Previous Save and Exit Cancel

Select Yes/No radio buttons for required “\*” fields, then select Save and Continue

# MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace)

Agree to  
Terms and  
Conditions

Professional Claim Submission Form ? Help

Terms and Agreements

**Note :** Fields marked with an asterisk \* are required.

Provider Name:\*

NPI/API:\*

\* I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof.

Select Submit

# MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace)

Print/Save PDF of claim submission (optional).

1

Professional Claim Submission Form

Thank you for your Submission

Your Claim was successfully submitted: OC240308P0517496.

Print

2

Print

Claim: OC240308P0517496

Claim Type: Professional

Provider Detail:

Billing Provider: NPI/API: 1234567890

3

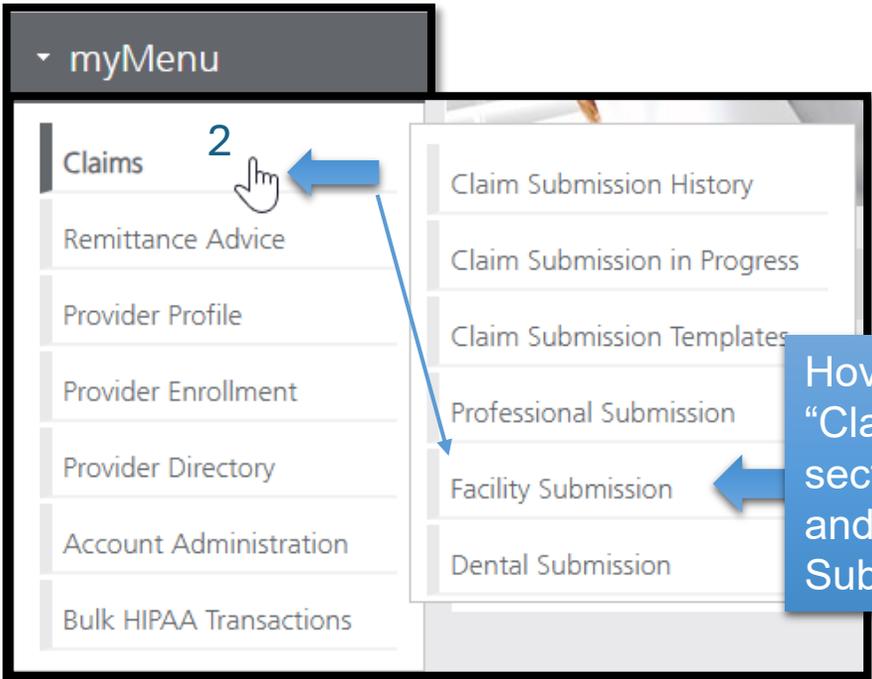
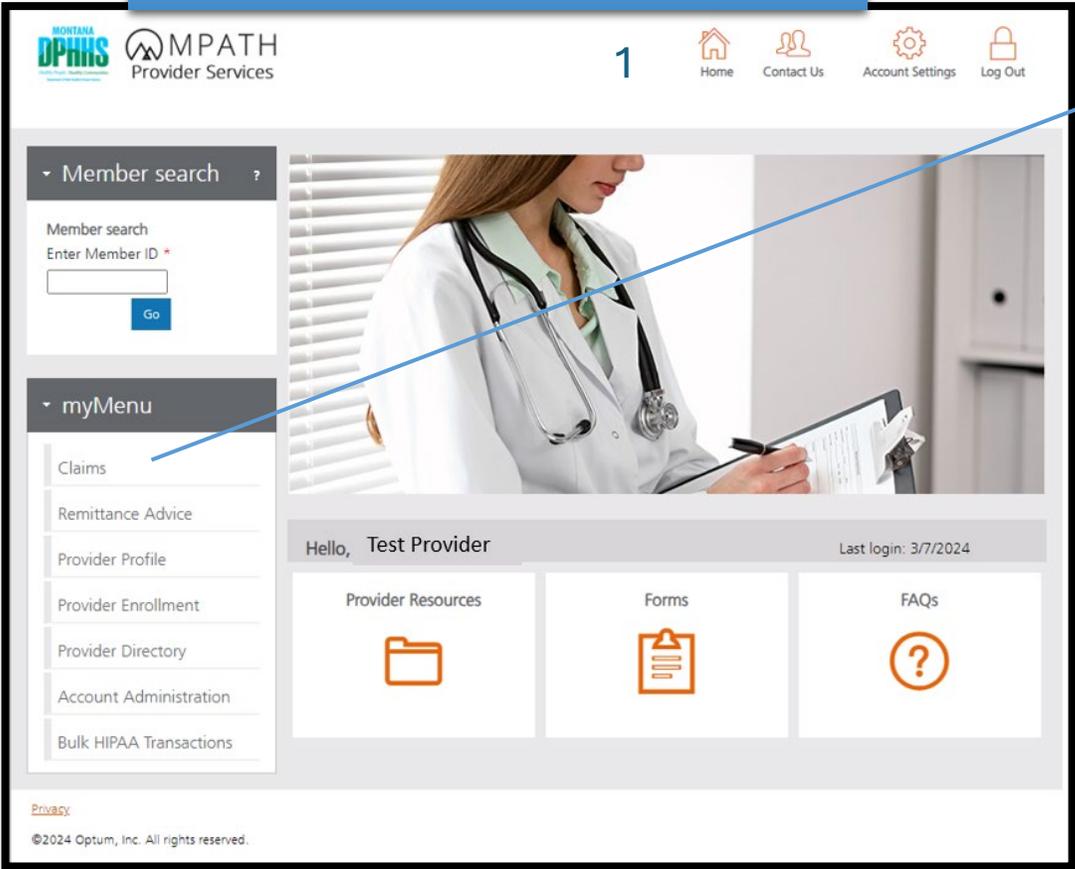
Print 2 pages

Destination Save as PDF

Save Cancel

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace)

Provider Services Portal Home Page



# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace)

Select your provider NPI, all other associated demographics will be automatically populated.

Enter other optional provider data as needed.

Select Save and Continue

▼ Billing Provider

Note : Fields marked with an asterisk \* are required.

NPI/API:\* 1234567890

Provider Name:\* Test Provider

Program/Waiver:\* Montana Medicaid (HMK Plus)

Specialty:\* Clinic/Center, Rehabilitation, Substance L

**Service Location**

Service Address 1:\* 1120 CEDAR ST

Service Address 2:

City:\* MISSOULA

State:\* MT

ZIP:\* 59802-3911

Taxonomy Code:\* 261QR0405X

Enrollment Unit:\* [ 1234567 ]

**Other Provider(s)**

**Attending Provider**

There is an attending provider for this claim.

**Operating Provider**

There is an operating provider for this claim.

**Other Provider 1**

There is an other provider for this claim.

**Other Provider 2**

There is an other provider for this claim.

Save and Continue Save and Exit Cancel

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace)

Enter Member ID (Card#/SSN) and click "Search" - Enter Patient Account Number (optional) as desired.

1

Professional Claim Submission Form

Member Details

Note : Fields marked with an asterisk \* are required.

Enter Member ID:\*

1234567 Search

2

Enter Member ID:\*

1234567 Search

Member ID: 1234567

Patient Account Number:

First Name: Test

Middle Name:

Last Name: Member

Date of Birth:

Gender: Male

Mailing Address 1:

Mailing Address 2:

City:

State: MT

ZIP: 59521-0000

Member Demographics will be automatically populated when entering a valid Member ID

Select Search

Select Save and Continue

Save and Continue Previous Save and Exit Cancel

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace)

Change the last digit of the originally submitted Type of Bill to 8 for Void and enter the 17-digit MMIS ICN.

Change the last digit of the originally submitted Type of Bill to 7 for Void /Replace and enter the 17-digit MMIS ICN.

**Note :** Type of Bill value field is 4 character code with the first value always being zero. To void or replace a claim, enter the original submitted Type of Bill, change the last digit to 8 (Void) or 7 (Replacement) and enter the 17-digit MMIS ICN in the Original MMIS ICN field.

Type of Bill:*	Inpatient or Outpatient:*	Statement Period From:*	Statement Period Through:*		
0127	Inpatient	MM/DD/YYYY	MM/DD/YYYY		
Admission Date:*	Admission Hour:*	Admission Type:*	Source of Admission:*	Discharge Hour:*	Member Discharge Status:*
MM/DD/YYYY	Select			Select	
Original MMIS ICN:*					
22419900255008999					

Enter all other claim data as required.

**Note :** Changing only the Type of Bill on the claim cannot be done via electronic adjustment. This must be done using the Individual Adjustment Request.

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace)

Facility Claim Submission Form [? Help](#)

Claim Information

**Note :** Fields marked with an asterisk \* are required.

**Note :** Type of Bill value field is 4 character code with the first value always being zero. To void or replace a claim, enter the original submitted Type of Bill, change the last digit to 8 (Void) or 7 (Replacement) and enter the 17-digit MMIS ICN in the Original MMIS ICN field.

Type of Bill:*	Inpatient or Outpatient:*	Statement Period From:*	Statement Period Through:*		
<input type="text" value="0127"/>	<input type="text" value="Inpatient"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="MM/DD/YYYY"/>		
Admission Date:*	Admission Hour:*	Admission Type:*	Source of Admission:*	Discharge Hour:*	Member Discharge Status:*
<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="Select"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="Select"/>	<input type="text"/>

Original MMIS ICN:\*

**Note :** Changing only the Type of Bill on the claim cannot be done via electronic adjustment. This must be done using the Individual Adjustment Request.

Condition Codes:

<input type="text"/>										
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Accident State:

Click the ?Help link on any page for more information

Enter required fields: Type of Bill, Inpatient/Outpatient, From/Through Date(s), Admit Type/Source/Status

Other fields may be required based on selections

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace)

**Occurrence Codes**

Occurrence Code:	Date:	Occurrence Code:	Date:
<input type="text"/>	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY

**Occurrence Span Codes**

Occurrence Span Code:	From:	Through:	Occurrence Span Code:	From:	Through:
<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY
<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY	<input type="text"/>	MM/DD/YYYY	MM/DD/YYYY

**Value Codes ?**

Value Code:	Amount/Days:	Value Code:	Amount/Days:	Value Code:	Amount/Days:
1	<input type="text"/>	5	<input type="text"/>	9	<input type="text"/>
2	<input type="text"/>	6	<input type="text"/>	10	<input type="text"/>
3	<input type="text"/>	7	<input type="text"/>	11	<input type="text"/>
4	<input type="text"/>	8	<input type="text"/>	12	<input type="text"/>

Hover over any "?" to see a quick list of common values

Enter optional fields as necessary: Occurrence Codes, Occurrence Span codes, Value Codes.

**Value Codes ?**

Value Code: An

1

t/Days:

To report Personal Resource Amount for a skilled Nursing Facility claim enter Value Code 31 and enter the dollar amount into the Amount/Days field.

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace)

### Claim Details

Note :  indicates all required fields for NDC have been entered.  
 Note : Use a comma "," if multiple values are needed in Modifier field.

Enter Revenue Code, Optional HCPCS Code, Optional Modifier, Date(s) of Service, Units, and Charges

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					
<input type="text"/>	NDC	\$ <input type="text"/>					

Total Charges: \$

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace)

Enter the Revenue Code. The magnifying glass will allow users to search for the specific Revenue Code if unknown.

Enter at least first three (3) characters of a Revenue Code to search code list.

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
012			06/14/2024	06/14/2024	1	1 NDC	\$ 150.00

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
0120		3	06/14/2024	06/14/2024	1	NDC	\$ 150.00

Search Results	
Code	Description
2 0120	Room & Board Semiprivate (Two Beds)-General Classification
0121	Room & Board Semiprivate (Two Beds)-Medical/Surgical/GYN
0122	Room & Board Semiprivate (Two Beds)-Obstetrics (OB)
0123	Room & Board Semiprivate (Two Beds)-Pediatric
0124	Room & Board Semiprivate (Two Beds)-Psychiatric
0125	Room & Board Semiprivate (Two Beds)-Hospice
0126	Room & Board Semiprivate (Two Beds)-Detoxification
0127	Room & Board Semiprivate (Two-Beds)-Oncology
0128	Room & Board-Semiprivate (Two-Beds)-Rehabilitation

Cancel

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace)

Enter the optional HCPCS Code. The magnifying glass will allow users to search for the specific HCPCS Code if unknown.

Enter at least first three (3) characters of a HCPCS to search code list.

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
	9079	1	06/14/2024	06/14/2024	1	NDC	\$ 150.00

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
0120	90791	3	06/14/2024	06/14/2024	1	NDC	\$ 150.00

Code	Description
90791	PSYCH DIAGNOSTIC EVALUATION
9079122	PSYCH DIAGNOSTIC EVALUATION;Increased Procedural Services
9079123	PSYCH DIAGNOSTIC EVALUATION;Unusual Anesthesia
9079151	PSYCH DIAGNOSTIC EVALUATION;Multiple Procedures
9079152	PSYCH DIAGNOSTIC EVALUATION;Reduced Services
9079153	PSYCH DIAGNOSTIC EVALUATION;Discontinued Procedure
9079158	PSYCH DIAGNOSTIC EVALUATION;Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
9079159	PSYCH DIAGNOSTIC EVALUATION;Distinct Procedural Service

Cancel

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace)

Enter the Diagnosis Code. The magnifying glass will allow users to search for the specific Diagnosis Code if unknown.

Enter at least first three (3) characters of a Diagnosis to search code list.

**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.

Primary Diagnosis Code: \* Present on Admission: \* Diagnosis Related Groups(DRG):

F20

**Note :** Primary Diagnosis Code should not be repeated within the listed Other Diagnosis Codes.

Primary Diagnosis Code: \* Present on Admission: \* Diagnosis Related Groups(DRG):

F200

Search Results	
Code	Description
F20	Schizophrenia
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F208	Other schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace)

**Other Diagnosis Codes**

**Note :** When you add Other Diagnosis Code, you are required to select Present on Admission.

Other Diagnosis Codes:	Present on Admission:
<input type="text"/>	Select

**Add Diagnosis Code**

Admitting Diagnosis Code:  Member's Reason for Visit Diagnoses:

**Note :** When you add External Cause of Injury Codes, you are required to select Present on Admission.

External Cause of Injury Codes:	Present on Admission:
<input type="text"/>	Select
<input type="text"/>	Select
<input type="text"/>	Select

Principal Procedure Code:  Date:

**Other Procedure Codes**

Other Procedure Codes:	Date:
<input type="text"/>	MM/DD/YYYY

Enter optional information

Prior Authorization Number:  Referral Number:  Service Authorization Exception Code:

[Advanced Search](#)

Are you submitting COB at the claim level?  Yes  No

Do you have attachments for this claim?  Yes  No

**Notes:**

**Select Save and Continue**

Enter optional information

Select Save and Continue

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace)

Agree to  
Terms and  
Conditions

Facility Claim Submission Form ? Help

Terms and Agreements

Note : Fields marked with an asterisk \* are required.

Provider Name:\*

NP/ABI:\*

\* I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof.

Select Submit

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace)

Print/Save PDF of claim submission (optional).

1

Facility Claim Submission Form

Thank you for your Submission

Your Claim was successfully submitted: OC220301I0158541

Print

2

Print

Claim: OC220301I0158541

Claim Type: Facility

Provider Detail:

Billing Provider: NPI/API: 1234567890

3 2 pages

Print

Destination

Save as PDF

Save Cancel

# Provider Relations Contact Information

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Provider Relations Call Center:

(800) 624-3958

Monday through Friday 8am to 5pm MST

General, Claims, TPL, and EDI questions:

[MTPRHelpdesk@conduent.com](mailto:MTPRHelpdesk@conduent.com)

Enrollment Questions and documents:

[MTEnrollment@conduent.com](mailto:MTEnrollment@conduent.com)

Note: Conduent helpdesks cannot accept secured emails, please do not include HIPAA/PHI/PII.

# Provider Relations Contact Information

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MPATH Provider Services Helpdesk

[MTEnrollment@conduent.com](mailto:MTEnrollment@conduent.com)

When emailing the Helpdesk, please provide the following so we can research & submit a help ticket to our Tech Team.

**GovID:**

**Name:**

**Email registered:**

**NPI attempting/registered:**

**Phone number:**

**A screen shot of the error:**