



# Electronic Adjustments for Providers

Presented by Loma Romero, Provider Relations Field Representative

# In this instruction:

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What and why of adjustments.

Some adjustment particulars.

Where to request adjustments.

Submitting an Adjustment Request (Professional).

Submitting an Individual Adjustment Request (Facility).

Submitting an Adjustment Request (Dental).

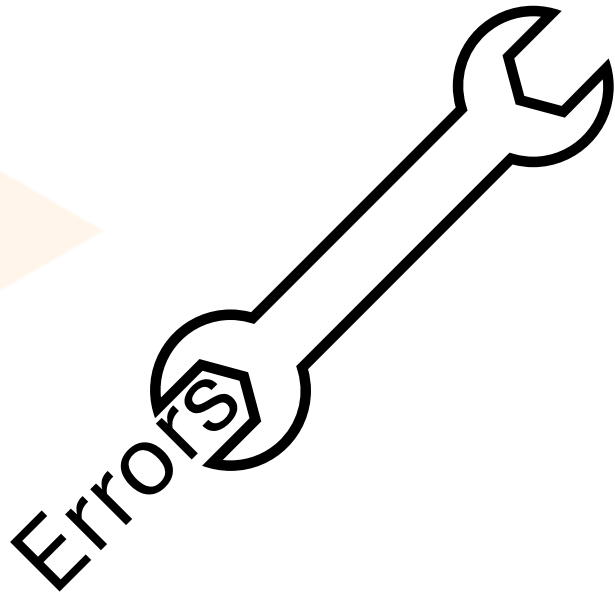
Adjustments For Clearinghouses

When to revert to paper.

When adjustments are rejected.

# What is an adjustment?

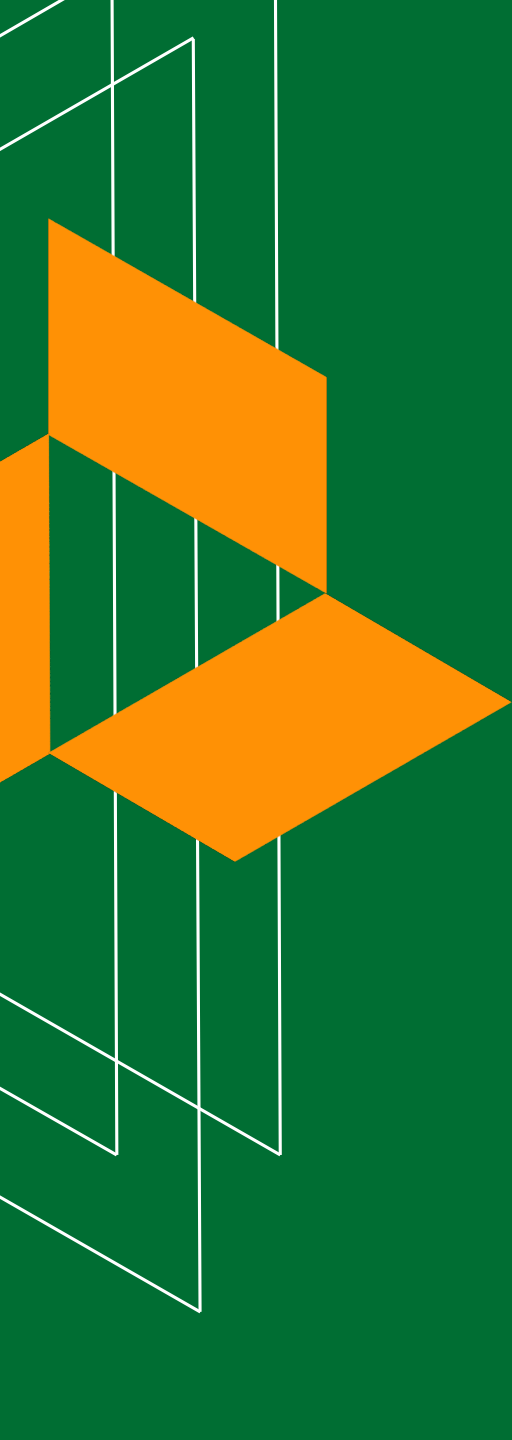
---



OR



Mandates



Some adjustment particulars

# Adjustment particulars

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Paid



No denied



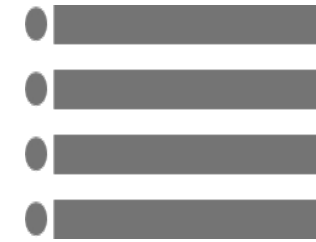
12 months

# More adjustment particulars

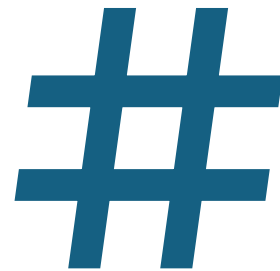
---

0 39118 11 505 002300

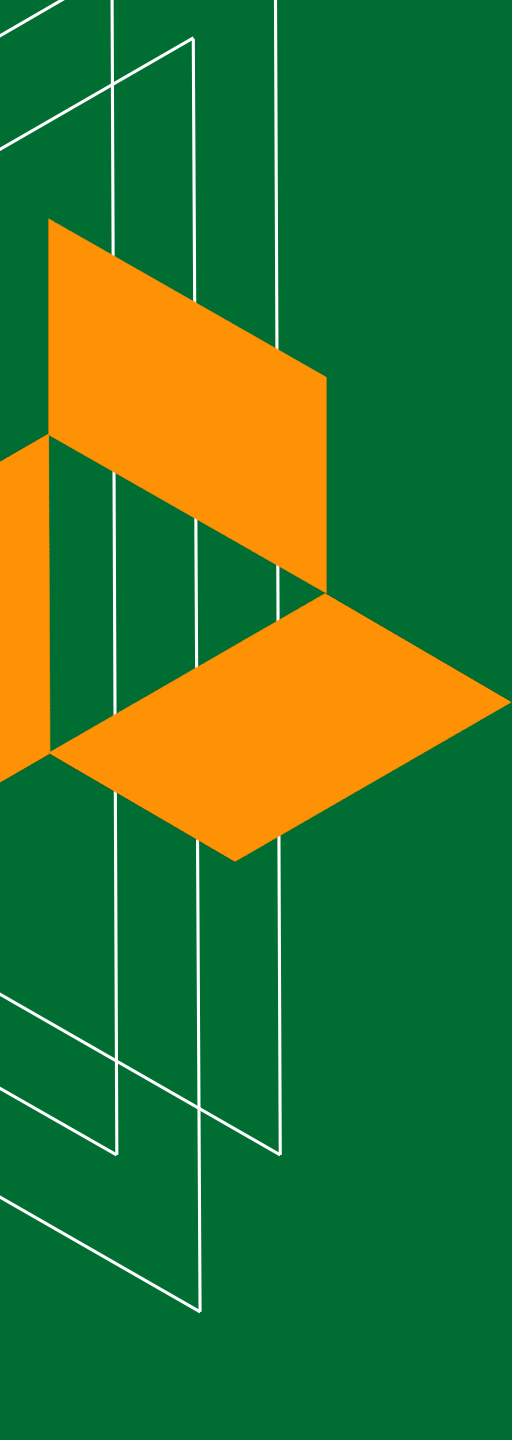
Only ICN



All charges



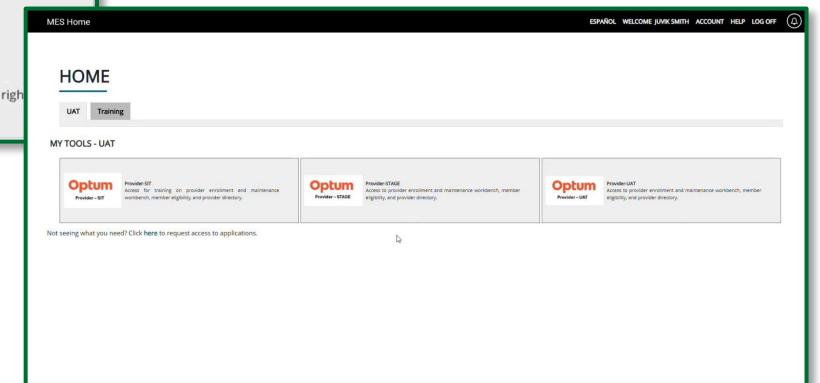
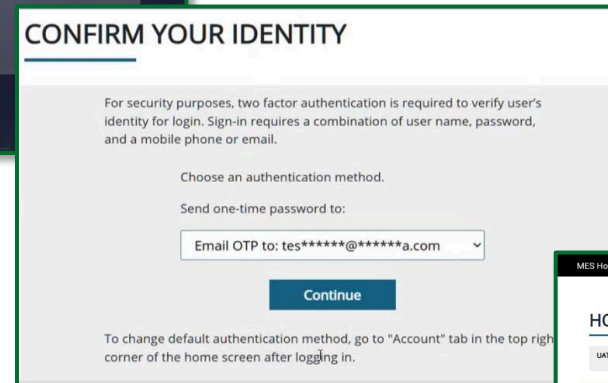
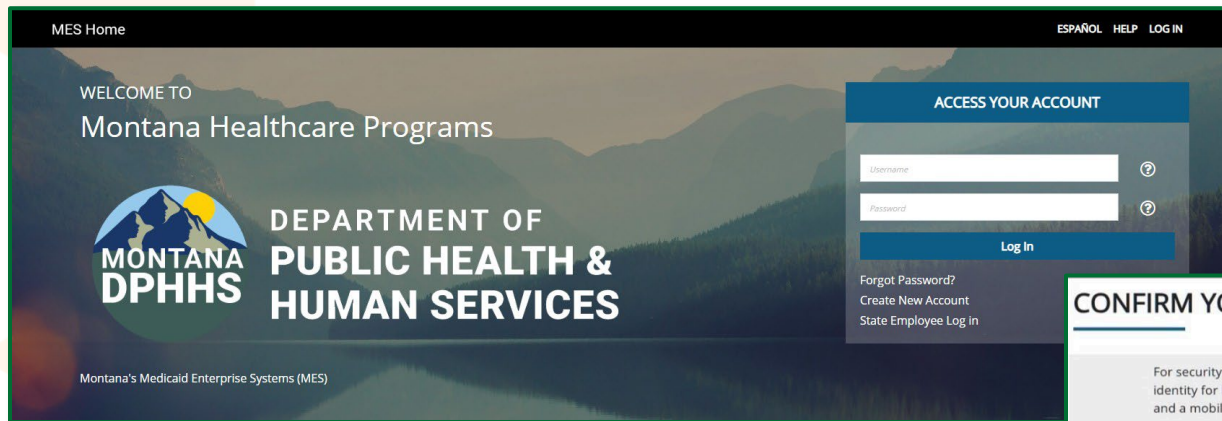
Newest ICN



# Where to request adjustments

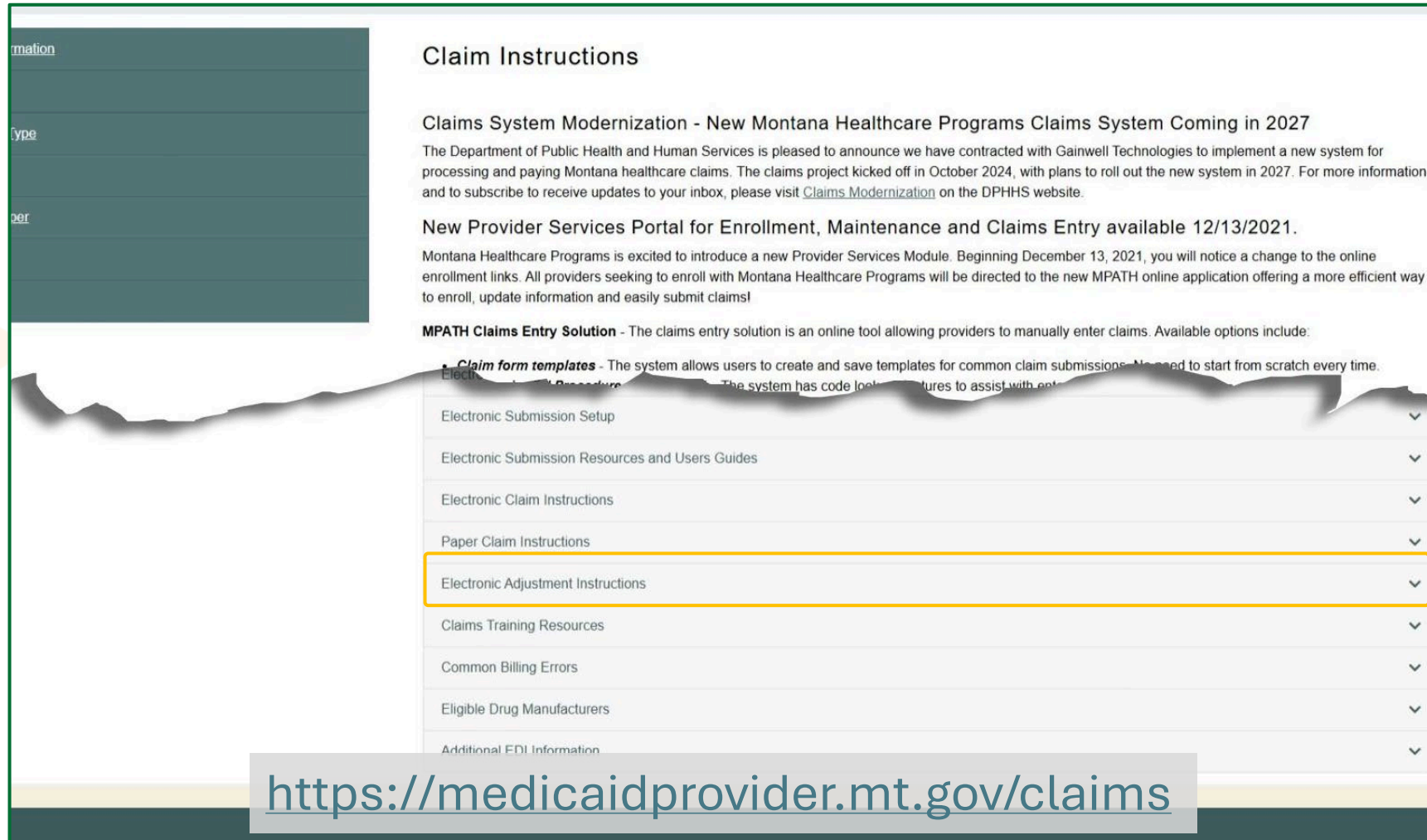
# Where to Request

## Montana Medicaid Enterprise Systems Portal (MES)



<https://medicaidprovider.mt.gov/providerenrollment>

# Where Else to Request



Information

Type

per

## Claim Instructions

### Claims System Modernization - New Montana Healthcare Programs Claims System Coming in 2027

The Department of Public Health and Human Services is pleased to announce we have contracted with Gainwell Technologies to implement a new system for processing and paying Montana healthcare claims. The claims project kicked off in October 2024, with plans to roll out the new system in 2027. For more information and to subscribe to receive updates to your inbox, please visit [Claims Modernization](#) on the DPHHS website.

### New Provider Services Portal for Enrollment, Maintenance and Claims Entry available 12/13/2021.

Montana Healthcare Programs is excited to introduce a new Provider Services Module. Beginning December 13, 2021, you will notice a change to the online enrollment links. All providers seeking to enroll with Montana Healthcare Programs will be directed to the new MPATH online application offering a more efficient way to enroll, update information and easily submit claims!

**MPATH Claims Entry Solution** - The claims entry solution is an online tool allowing providers to manually enter claims. Available options include:

- Claim form templates** - The system allows users to create and save templates for common claim submissions. No need to start from scratch every time.
- Electronic Submission Setup** - The system has code look-up features to assist with entry.

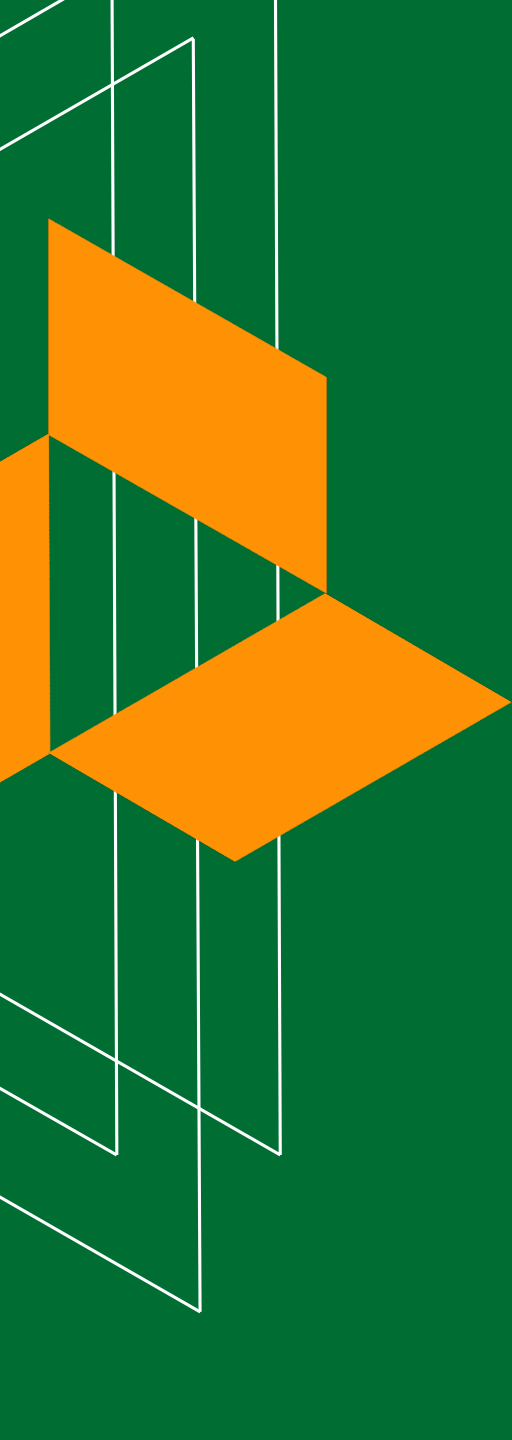
- Electronic Submission Setup
- Electronic Submission Resources and Users Guides
- Electronic Claim Instructions
- Paper Claim Instructions
- Electronic Adjustment Instructions**
- Claims Training Resources
- Common Billing Errors
- Eligible Drug Manufacturers
- Additional FDI Information

<https://medicaidprovider.mt.gov/claims>

Professional

Facility

Dental



# Submitting an Adjustment Request

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## Professional Submission

# Claim Status — Professional

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us 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, Conduent Test Last login: 4/28/2026

myMenu

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

Provider Resources

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

Forms

FAQs

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home > Claim Submission History

Home Contact Us Log Out

Member search Hi Conduent Test

Claim Submission History

Claims Detail

Submission Date Range

From Date: To Date:

Search

Claim search results

You are viewing: Claims for NPV/API 1003362864 and time period from 03/29/2026 to 04/28/2026.

Claim activity 7 Help

ICN: 22608900255001217 Optum Claim number: MT260330P00889071

Member: FARNSWORTH, KEVIN  
Date of service: 01/13/26-01/13/26  
Patient account: Date processed: 03/30/26

Total amount billed:	\$313.50
Total amount paid:	\$181.50

Payment details

Member ID: 517157458	Payment number: 564123
Claim status: F2:Finalized/Denial	Payment date: 04/06/26
	Payment amount: \$181.50

Line 1

Provider name: MPATH NORTHWEST COMMUNITY HEALTHCARE	Cost for this service	Amount billed: \$313.50
Provider NPV/API: 1003362864		Amount paid by plan: \$181.50
Date of service: 01/13/26-01/13/26		
Procedure code: 90791		

# Search for Remittance — Professional

**DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES**

Home Contact Us 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:\*

MMDDYYYY

Go

myMenu

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

Hello, Conduent Test Last login: 4/27/2026

Provider Resources Forms FAQs

**Member search**

**Remittance advice search**

Note : Fields marked with \* are required. Only remittances with Date Issued on or after September 01, 2021, can be viewed and/or downloaded.

PID/EU: Select PID/EU

I want to search by:

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

From Date:\*

06/01/2025

To Date:\*

07/31/2025

Search

myMenu

Privacy

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Hi Conduent Test

**Remittance Advice**

**!** If you experience a blank PDF Remittance Advice or 835 EDI, there may be no claims processed for the time frame you are inquiring on or the file is not available yet. Please check back at a later time.


**Remittance advice search results**




To view remittance advice, use the remittance advice search portlet.

**Remittance advice activity** ? Help

To view remittance advice, use the remittance advice search portlet.

# Remit Search Results — Professional



 Home
  Contact Us
  Log Out

Home > Remittance Advice

Member search > Hi Conduent Test

Remittance advice search >

**Note** : Fields marked with \* are required.  
Only remittances with Date issued on or after September 01, 2021, can be viewed and/or downloaded.

PID/EU:

I want to search by:

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

From Date:\*

To Date:\*

Remittance Advice

**!** If you experience a blank PDF Remittance Advice or 835 EDI, there may be no claims processed for the time frame you are inquiring on or the file is not available yet. Please check back at a later time.

Remittance advice search results

Provider NPI/API: 1003362864  
You are viewing: Remittance Advice for NPVAPI 1003362864 and time period from 06/01/2025 to 07/31/2025.

Remittance advice activity ? Help

Filter your results

REMITTANCE ADV NBR	DATE ISSUED	PID/EU	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	835 EDI
085925	06/30/2025	0001668862	000000000	EFT	\$181.50	<a href="#">View</a> <a href="#">Download</a>
091450	07/07/2025	0001668862	000000000	EFT	\$0.00	<a href="#">View</a> <a href="#">Download</a>

Show  entries      Showing 1 to 2 of 2 forms      |<< >>|

myMenu

[Privacy](#)

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AS OF 01/21/2026      HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

FRED'S FAMILY CLINIC  
123 E HIGHWAY RD  
BUTTE MT 59701

VENDOR # 0001719771 REMIT ADVICE # 244219 EFT/CHK #020024060 DATE 01/26/2026 PAGE 5  
NPI #: 1871685198 TAXONOMY: 193200000X

RECIPIENT ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	CO-ALLOWED PAY	REASON & REMARK CODES
DENIED CLAIMS - MISCELLANEOUS CLAIM								
***CLAIM TOTAL*****						207.00	0.00	31
ICN 22600700255001990	DAVIS, HANNAH	01062026	01062026	1.000	99213	158.00	0.00	177 N30
0000706004	LOUISE EDEN PA-C	01062026	01062026	1.000	G2211	28.00	0.00	
***CLAIM TOTAL*****						186.00	0.00	31 MA61
5441982	FARNSWORTH, KEVIN	06302025	06302025	1.000	90791	178.50	101.48	
ICN 22601500255003376	PATIENT NUMBER=78749							
0001720381	EVE SVARINSKI	06302025	06302025	1.000	90832	135.00	80.02	
***CLAIM TOTAL*****						313.50	181.50	22 MA04
CLAIMS PENDING: MISCELLANEOUS CLAIM								
5167204	SMITH, HEATH	01162026	01162026	1.000	99213	158.00	0.00	
ICN 22601900255002927	PATIENT NUMBER=82982							
0001804777	YESSA NORRBERG							

# Provider Services Portal Home Page

**MONTANA DPHHS** 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

myMenu

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

Hello, Conduent Test Last login: 3/30/2026

Provider Resources

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

Forms

FAQs

# Provider Identification

Member search

Hi Conduent Test

View Templates

MPATH NORTHWEST  
COMMUNITY  
HEALTHCARE  
NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

Professional Claim Submission Form ? Help

Billing Provider

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

NPI/API:\* 1003362864

Provider Name:\* MPATH NORTHWEST (<

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

Specialty:\* Clinic/Center, Federally Qualified Health Cer

Service Location Address 1:\* 8 J Street

Service Location Address 2:

City:\* Helena

State:\* MT

ZIP:\* 59601-0000

Taxonomy Code: \* 261 QF0400X

Enrollment Unit:\* 0001861613

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

# Member Identification

**MONTANA DPHHS** DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home > Professional Submission

Home Contact Us Account Settings Log Out

Member search ?

MPATH NORTHWEST COMMUNITY HEALTHCARE  
NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

Hi Conduent Test

View Templates

Professional Claim Submission Form ? Help

Member Details

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

Enter Member ID: \*  
1234567

Service Date: \*  
01/20/2026

Search

Save and Continue Previous Save and Exit Cancel

[Privacy](#)  
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HEALTHCARE  
NPI#: 1003362864

Professional Claim Submission Form ? Help

Member Details

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

Enter Member ID: \*  
1234567

Service Date: \*  
01/20/2026

Search

Member ID: 1234567

Patient Account Number: [Empty] ←

First Name: KEVIN

Middle Name: [Empty]

Last Name: FARNSWORTH

Date of Birth: 05/19/1992

Gender: Male

Mailing Address 1: 5646 Last Chance

Mailing Address 2: [Empty]

City: HELENA

State: MT

ZIP: 59601-0000

Save and Continue Previous Save and Exit Cancel →

# Diagnosis Codes

**NORTHWEST COMMUNITY HEALTHCARE**  
 NPI#: 1003362864

Provider Details  
 Member Details  
 Claim Information  
 Terms and Agreements

myMenu

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  
 F200 [Q] [ ] [ ] [ ] [ ] [ ]  
 7 8 9 10 11 12  
 [ ] [ ] [ ] [ ] [ ] [ ]

Claim Details

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

From Date*	To Date*	POS*	CPT/HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	Type	COB	NDC	EPSDT	Emergency Service	Family Planning
MM/DD/YYYY	MM/DD/YYYY	Select	[Q]			\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	[Q]			\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	[Q]			\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	[Q]			\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	[Q]			\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	[Q]			\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	[Q]			\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	[Q]			\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ [ ] Add

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

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

# Professional Claim Details

**NORTHWEST COMMUNITY HEALTHCARE**  
NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

## 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
F200					
7	8	9	10	11	12

#### Claim Details

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

From Date*	To Date*	POS*	CPT/HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	Type	COB	NDC	EPSDT	Emergency Service	Family Planning
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$  Add

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

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

Cancel

# Completed Professional Details

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	Type	COB	NDC	EPSDT	Emergency Service	Family Planning
01/13/2026	01/13/2026	11	90791		1	\$ 150.00	1.00	UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
01/14/2026	01/14/2026	11	90832		1	\$ 135.00	1.00	UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: **\$ 285.00** **Add**

# More Claim Information

MM/DD/YYYY	MM/DD/YYYY	Select	Q			\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	Q			\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	Q			\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	Q			\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	Q			\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	Q			\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	Q			\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select	Q			\$		UN	COB	NDC	<input type="checkbox"/>	<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.

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

Select the Medicaid Resubmission Code:\*

Enter the Original MMIS ICN:\*

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



# Terms and Agreements —Professional

**MONTANA DPHHS** DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us Account Settings Log Out

Home > Professional Submission

Member search ?

**MPATH NORTHWEST COMMUNITY HEALTHCARE**  
NPI#: 1003362864

- Provider Details
- Member Details
- Claim Information
- Terms and Agreements

myMenu

Hi Conduent Test

View Templates

Professional 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.

[Privacy](#)

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# Thank You — Professional

The image shows a screenshot of a web application interface for the Montana Department of Public Health & Human Services. The main content area displays a confirmation message: "Thank you for your Submission" and "Your Claim was successfully submitted: MT260330P00889071." A blue "Continue" button is located at the bottom of this message. A print icon is visible next to the message. An orange arrow points from this icon to a print dialog box on the right. The dialog box is titled "Print" and shows "Total: 2 pages". It includes options for "Printer" (set to "Save as PDF"), "Layout" (Portrait selected), and "Pages" (All selected). At the bottom of the dialog, there are "Save" and "Cancel" buttons. Another orange arrow points from the "Save" button back to the main application window.

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us Account Settings Log Out

Home > Professional Submission

Member search ?

MPATH NORTHWEST COMMUNITY HEALTHCARE NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

Hi Conduent Test

View Templates

Professional Claim Submission Form ? Help

Thank you for your Submission

Your Claim was successfully submitted: MT260330P00889071.

Continue

Print

Print

Total: 2 pages

Printer

Save as PDF

Layout

Portrait  
Landscape

Pages

All  
Odd pages only  
Even pages only  
e.g. 1-5, 8, 11-13

More settings v

Print using system dialog... (Ctrl+Shift+P)

Save Cancel

# Original vs Adjusted — Professional

**ADJUSTED**

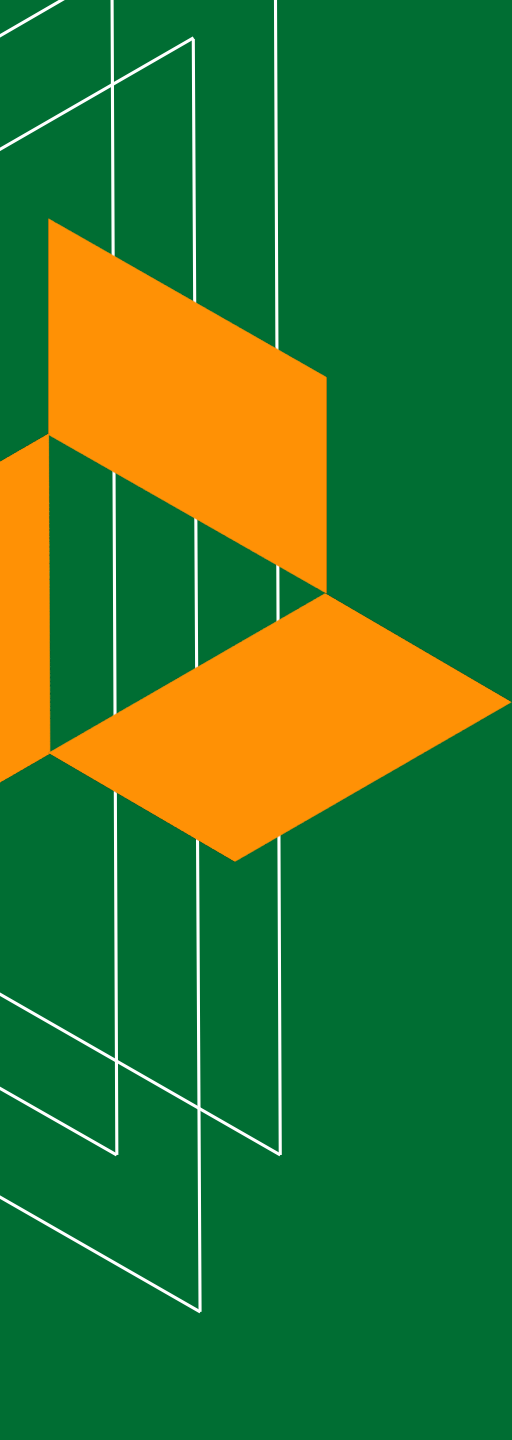
From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	Type	COB	NDC	EPSDT	Emergency Service	Family Planning
01/13/2026	01/13/2026	11	90791		1	\$ 150.00	1.00	UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
01/14/2026	01/14/2026	11	90832		1	\$ 135.00	1.00	UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$		UN	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ 285.00

Return

Facility

Dental



# Submit an Adjustment Request

---

## Facility Submission

# Claim Status — Facility

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us 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

myMenu

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

Provider Resources

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

Forms

FAQs

Hello, Conduent Test Last login: 4/28/2026

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home > Claim Submission History

Home Contact Us Log Out

Member search Hi Conduent Test

Claim Submission History

Submission Date Range

From Date: To Date:

Search

Claims Detail

Claim search results

You are viewing: Claims for NP/API 1003362864 and time period from 03/29/2026 to 04/28/2026.

Claim activity

ICN: 22608900255001217 Optum Claim number: MT260330P00889071

Member: KLINGER, MAXWELL	Total amount billed:	\$852.75
Date of service: 01/13/26-01/13/26	Total amount paid:	\$501.38
Patient account:	Date processed: 03/30/26	
Member: KLINGER, MAXWELL	Payment details	
Member ID: 517157458	Payment number:	0
Claim status: F2:Finalized/Denial	Payment date:	04/06/26
	Payment amount:	\$0

Line 1

Provider name: MPATH NORTHWEST COMMUNITY HEALTHCARE	Cost for this service	Amount billed:	\$852.75
Provider NP/API: 1003362864		Amount paid by plan:	\$501.38
Date of service: 01/13/26-01/13/26			
Procedure code: 90791			

# Search for Remittance — Facility

**DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES**

Home Contact Us 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:\*

MMDDYYYY

Go

Hi Conduent Test

**Remittance Advice**

**Note** : Fields marked with \* are required.  
Only remittances with Date Issued on or after September 01, 2021, can be viewed and/or downloaded.

PID/EU: Select PID/EU

I want to search by:

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

From Date:\*

06/01/2025

To Date:\*

07/31/2025

Search

**myMenu**

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

Hello, Conduent Test Last login: 4/27/2026

Provider Resources Forms FAQs

**Remittance advice search results**

To view remittance advice, use the remittance advice search portlet.

**Remittance advice activity** ? Help

To view remittance advice, use the remittance advice search portlet.

**myMenu**

[Privacy](#)

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# Remit Search Results — Facility

Home Contact Us Log Out

Home > Remittance Advice

Member search > Hi Conduent Test

Remittance advice search >

Note: Fields marked with \* are required. Only remittances with Date Issued on or after September 01, 2021, can be viewed and/or downloaded.

PID/EU:

I want to search by:

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

From Date: \*

To Date: \*

Provider NPI/API: 1003362864  
You are viewing: Remittance Advice for NPVAPI 1003362864 and time period from 06/01/2025 to 07/31/2025.

Remittance advice activity Help

Filter your results

REMITTANCE ADV NBR	DATE ISSUED	PID/EU	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	835 EDI
085925	06/30/2025	0001668862	000000000	EFT	\$501.38	<a href="#">View</a> <a href="#">Download</a>
091450	07/07/2025	0001668862	000000000	EFT	\$0.00	<a href="#">View</a> <a href="#">Download</a>

Show  entries Showing 1 to 2 of 2 forms

SHERMAN'S MASH HOSPITAL  
4077 UIJBONGBU PLC STE 1  
HELENA MT 59602

VENDOR # 0000396962 REMIT ADVICE # 231596 EFT/CHK #035208217 DATE 01/12/2026 PAGE 4  
NFI #: 1346642262 TAXONOMY: 282N0000DX

RECIPIENT ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	CO-ALLOWED PAY	REASON & REMARK CODES	
PAID CLAIMS - INPATIENT CLAIM									
12292025	12302025	1.000	301	182.00	0.00				
12292025	12302025	10.000	302	1248.00	0.00				
12292025	12302025	1.000	305	142.00	0.00				
12292025	12302025	1.000	450	948.75	0.00				
12292025	12302025	4.000	920	4377.00	0.00				
***CLAIM TOTAL*****						15462.63	2365.04		
6184982	KLINGER, MAXWELL	11102025	11112025	2.000	170	390.00	0.00		
ICN 22600200256000695 PATIENT NUMBER=42303269									
DRG CODE 885 DRG									
11102025 11112025						3.000	302	462.75	0.00
***CLAIM TOTAL*****						852.75	501.38		
1560865	O'REILLY, WALTER	12222025	12272025	6.000	110	19491.00	0.00		
ICN 22600700256001792 PATIENT NUMBER=42397491									
DRG CODE 0280-2 DRG									
12222025 12272025						76.000	250	4928.56	0.00
12222025 12272025						12.000	272	0.12	0.00
12222025 12272025						6.000	300	238.50	0.00
12222025 12272025						24.000	301	3834.25	0.00
12222025 12272025						4.000	302	775.75	0.00
12222025 12272025						19.000	305	1819.25	0.00
12222025 12272025						2.000	306	1427.75	0.00
12222025 12272025						1.000	350	2106.25	0.00
12222025 12272025						1.000	390	639.75	0.00
12222025 12272025						1.000	402	1397.50	0.00
12222025 12272025						1.000	450	2599.75	0.00
12222025 12272025						1.000	483	2283.75	0.00
12222025 12272025						1.000	921	1473.75	0.00
***CLAIM TOTAL*****						43015.93	5661.00		
6128886	STRAMINSKY, IGOR	06132025	06132025	1.000	170	2256.75	0.00		
ICN 22600200256000700 PATIENT NUMBER=42305564									
DRG CODE 0640-1 DRG									

# Provider Portal Home Page

**MONTANA DPHHS** 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

myMenu

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

Hello, Conduent Test Last login: 3/31/2026

Provider Resources	Forms	FAQs
<ul style="list-style-type: none"><li>Claim Submission History</li><li>Claim Submission in Progress</li><li>Claim Submission Templates</li><li>Professional Submission</li><li><b>Facility Submission</b></li><li>Dental Submission</li></ul>		

# Facility Identification

Terms and Agreements

myMenu

▼ Billing Provider

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

NPI/API:\* 1003362864

Provider Name:\* IMPATH NORTHWEST

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

Specialty:\* Clinic/Center, Federally Qualified Health Cer

Service Location

Service Address 1:\* 8 J Street

Service Address 2:

City:\* Helena

State:\* MT

ZIP:\* 59601-0000

Taxonomy Code: \* 261QF0400X

Enrollment Unit:\* 0001861613

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

# Member Identification

**MONTANA DPHHS DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES**

Home Contact Us Account Settings Log Out

Home > Facility Submission

Member search ?

MPATH NORTHWEST COMMUNITY HEALTHCARE  
NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

Hi Conduent Test

View Templates

Facility Claim Submission Form ? Help

Member Details

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

Enter Member ID: \*  
1234567

Service Date: \*  
01/20/2026

Search

Save and Continue Previous Save and Exit Cancel

[Privacy](#)  
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HEALTHCARE  
NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

Facility Claim Submission Form ? Help

Member Details

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

Enter Member ID: \*  
1234567

Service Date: \*  
01/20/2026

Search

Member ID: 1234567

Patient Account Number: [Empty] ←

First Name: MAXWELL

Middle Name: [Empty]

Last Name: KLINGER

Date of Birth: 05/19/1992

Gender: Male

Mailing Address 1: 8063 S KOREAST

Mailing Address 2: [Empty]

City: SEOUL

State: MT

ZIP: 59642-0101

Save and Continue Previous Save and Exit Cancel →



# Optional Fields

**Claim Information**  
Terms and Agreements

**myMenu**

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

Original MMIS ICN\*  
22419900255008999

**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"/>	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"/>				

**Value Codes ?**

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.

Value Code: An  t/Days:

1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	6 <input type="text"/>
3	<input type="text"/>	7 <input type="text"/>
4	<input type="text"/>	8 <input type="text"/>



# Completed Facility Details

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			01/13/2026	01/21/2026	7	<a href="#">NDC</a>	\$ 341.25
0434			01/13/2026	01/21/2026	3	<a href="#">NDC</a>	\$ 462.75
			MM/DD/YYYY	MM/DD/YYYY		<a href="#">NDC</a>	\$
			MM/DD/YYYY	MM/DD/YYYY		<a href="#">NDC</a>	\$
			MM/DD/YYYY	MM/DD/YYYY		<a href="#">NDC</a>	\$
			MM/DD/YYYY	MM/DD/YYYY		<a href="#">NDC</a>	\$
			MM/DD/YYYY	MM/DD/YYYY		<a href="#">NDC</a>	\$
			MM/DD/YYYY	MM/DD/YYYY		<a href="#">NDC</a>	\$
			MM/DD/YYYY	MM/DD/YYYY		<a href="#">NDC</a>	\$

Total Charges: \$ 804.00

# Diagnosis Information

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

Primary Diagnosis Code:\* Present on Admission:\* Diagnosis Related Groups(DRG):  
F200 [Search] Y-Yes [Dropdown]

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

**Other Diagnosis Codes**

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

Other Diagnosis Codes: Present on Admission:  
[Text] [Search] [Select] [Dropdown]  
[Text] [Search] [Select] [Dropdown]  
[Text] [Search] [Select] [Dropdown]  
[Text] [Search] [Select] [Dropdown]  
[Text] [Search] [Select] [Dropdown]  
[Add Diagnosis Code]

Admitting Diagnosis Code: Member's Reason for Visit Diagnoses:  
[Text] [Search] [Text] [Search] [Text] [Search] [Text] [Search]

**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:  
[Text] [Select] [Dropdown]  
[Text] [Select] [Dropdown]  
[Text] [Select] [Dropdown]

Principal Procedure Code: Date:  
[Text] [Search] [MMDD/YYYY] [Calendar]

**Other Procedure Codes**

Other Procedure Codes: Date:  
[Text] [Search] [MMDD/YYYY] [Calendar]  
[Text] [Search] [MMDD/YYYY] [Calendar]  
[Text] [Search] [MMDD/YYYY] [Calendar]  
[Text] [Search] [MMDD/YYYY] [Calendar]

**Search Results** [Close]

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]

# Other Procedure Codes

The screenshot shows a web form with the following fields and sections:

- Principal Procedure Code: [Text Field] [Select] [Date: MM/DD/YYYY]
- Other Procedure Codes**
- Other Procedure Codes: [Text Field] [Date: MM/DD/YYYY]
- [Text Field] [Date: MM/DD/YYYY]
- [Text Field] [Date: MM/DD/YYYY]
- [Text Field] [Date: MM/DD/YYYY]
- [Text Field] [Date: MM/DD/YYYY]
- Prior Authorization Number: [Text Field] Referral Number: [Text Field] Service Authorization Exception Code: [Select]
- [Advanced Search](#)
- Are you submitting COB at the claim level?  Yes  No
- Do you have attachments for this claim?  Yes  No
- Notes: [Text Area]
- Buttons: **Save and Continue** (highlighted with an orange arrow), Previous, Save and Exit, Cancel

# Terms and Agreements—Facility

The screenshot displays the Montana Department of Public Health & Human Services (DPHHS) web portal. The top navigation bar includes links for Home, Contact Us, Account Settings, and Log Out. The breadcrumb trail shows 'Home > Facility Submission'. The left sidebar contains a 'Member search' dropdown, a profile card for 'MPATH NORTHWEST COMMUNITY HEALTHCARE' (NPI#: 1003362864) with tabs for Provider Details, Member Details, Claim Information, and Terms and Agreements, and a 'myMenu' dropdown. The main content area is titled 'Hi Conduent Test' and features a 'View Templates' button. Below this is the 'Facility Claim Submission Form' section, which includes a 'Terms and Agreements' subsection. A note states: 'Note : Fields marked with an asterisk \* are required.' The form contains two required fields: 'Provider Name:\*' with a dropdown menu showing 'MPATH NORTHWEST' and 'NPI/API:\*' with a text input field containing '1003362864'. A checkbox is checked, indicating agreement with the terms and conditions. At the bottom of the form are buttons for 'Submit', 'Previous', 'Save and Exit', and 'Cancel'. Two orange arrows point from the bottom towards the 'Terms and Conditions' link and the 'Submit' button. The footer includes a 'Privacy' link and the copyright notice '©2026 Optum, Inc. All rights reserved.'

# Thank You — Facility

The image shows a screenshot of a web application interface. The main content area displays a confirmation message: "Thank you for your Submission" followed by "Your Claim was successfully submitted: MT260330P00889071." and a "Continue" button. A "Print" icon is visible next to the message. An orange arrow points from this icon to a print dialog box on the right. The dialog box is titled "Print" and shows "Total: 2 pages". It includes a "Printer" dropdown menu set to "Save as PDF", "Layout" options for "Portrait" (selected) and "Landscape", and "Pages" options for "All" (selected), "Odd pages only", "Even pages only", and a range input field. At the bottom of the dialog are "Save" and "Cancel" buttons. An orange arrow points from the "Print" icon in the main window to the "Print" button in the dialog. Another orange arrow points from the "Print" button in the dialog back to the "Print" icon in the main window.

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us Account Settings Log Out

Home > Facility Submission

Member search ?

MPATH NORTHWEST COMMUNITY HEALTHCARE NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

Hi Conduent Test

View Templates

Facility Claim Submission Form ? Help

Thank you for your Submission

Your Claim was successfully submitted: MT260330P00889071.

Continue

Print

Print

Total: 2 pages

Printer

Save as PDF

Layout

Portrait  
Landscape

Pages

All  
Odd pages only  
Even pages only  
e.g. 1-5, 8, 11-13

More settings v

Print using system dialog... (Ctrl+Shift+P)

Save Cancel

# Original vs Adjusted — Facility

**ADJUSTED**

Note: \* indicates an required field that has not been entered.  
Note: Use a comma ", " if multiple values are needed in Modifier field.

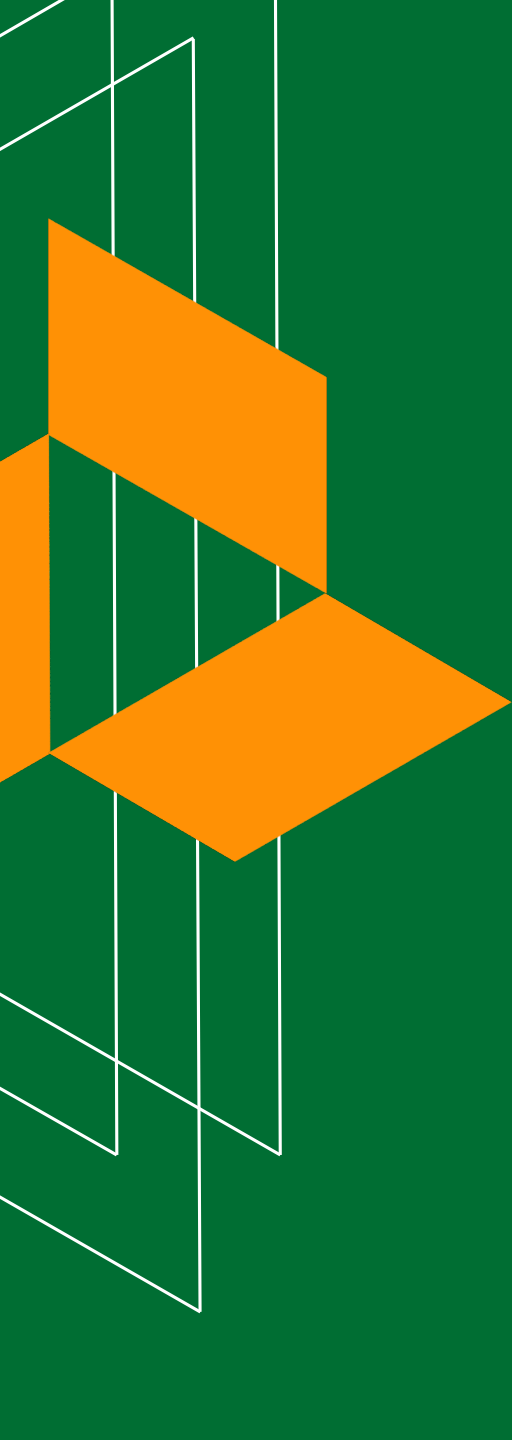
Revenue Code:*	HCPCS Code:	Modifier:	From Date:	To Date:	Service Units:*	NDC:	Total Charges:*
0120			01/13/2026	01/21/2026	7	NDC	\$ 341.25
0434			01/13/2026	01/21/2026	3	NDC	\$ 462.75
			MM/DD/YYYY	MM/DD/YYYY		NDC	\$
			MM/DD/YYYY	MM/DD/YYYY		NDC	\$
			MM/DD/YYYY	MM/DD/YYYY		NDC	\$
			MM/DD/YYYY	MM/DD/YYYY		NDC	\$
			MM/DD/YYYY	MM/DD/YYYY		NDC	\$
			MM/DD/YYYY	MM/DD/YYYY		NDC	\$
			MM/DD/YYYY	MM/DD/YYYY		NDC	\$
			MM/DD/YYYY	MM/DD/YYYY		NDC	\$

Total Charges: \$ 804.00 Add

Return

Professional

Dental



# Submitting Adjustment Requests

---

## Dental Submission

# Claim Status — Dental

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us 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:\*  
[input field]

Service Date:\*  
[input field]

Go

myMenu

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

Hello, Conduent Test Last login: 4/28/2026

Provider Resources Forms FAQs

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

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Home Contact Us Log Out

Home > Claim Submission History

Member search ? Hi Conduent Test

Claim Submission History ?

Submission Date Range

From Date: [input field]

To Date: [input field]

Search

Claim search results

You are viewing: Claims for NPI/API 1003362864 and time period from 03/29/2026 to 04/28/2026.

Claim activity ? Help

ICN: 22608900255001217 Optum Claim number: MT260330P00889071 < Return to search

Member: WINCHESTER, CE	Total amount billed: \$322.00
Date of service: 01/13/26-01/13/26	Total amount paid: \$186.56
Patient account: [input field]	Date processed: 03/30/26
Member: WINCHESTER, CE	Payment details
Member ID: 517157458	Payment number: 0
Claim status: F2:Finalized/Denial	Payment date: 04/06/26
	Payment amount: \$0

Line 1

Provider name: MPATH NORTHWEST COMMUNITY HEALTHCARE	Cost for this service	Amount billed: \$322.00
Provider NPI/API: 1003362864		Amount paid by plan: \$186.56
Date of service: 01/13/26-01/13/26		
Procedure code: 90791		

# Search for Remittance — Dental

**DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES**

Home Contact Us 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:\*

MMDDYYYY

Go

Hi, Conduent Test Last login: 4/27/2026

Provider Resources Forms FAQs

**Remittance advice search**

Note : Fields marked with \* are required. Only remittances with Date Issued on or after September 01, 2021, can be viewed and/or downloaded.

PID/EU: Select PID/EU

I want to search by:

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

From Date:\*

06/01/2025

To Date:\*

07/31/2025

Search

**Remittance Advice**

Hi Conduent Test

**Remittance Advice**

**Remittance advice search results**

To view remittance advice, use the remittance advice search portlet.

**Remittance advice activity** ? Help

To view remittance advice, use the remittance advice search portlet.


**myMenu**

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




Privacy

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# Remit Search Results — Dental



**DEPARTMENT OF  
PUBLIC HEALTH &  
HUMAN SERVICES**

 Home
  Contact Us
  Log Out

Home > Remittance Advice

Member search >

Remittance advice search >

Note: Fields marked with \* are required.  
Only remittances with Date issued on or after September 01, 2021, can be viewed and/or downloaded.

PID/EU:


I want to search by:

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

From Date:\*

To Date:\*

Hi Conduent Test



Remittance Advice

! If you experience a blank PDF Remittance Advice or 835 EDI, there may be no claims processed for the time frame you are inquiring on or the file is not available yet. Please check back at a later time.

Remittance advice search results

Provider NPI/API: 1003362864  
 You are viewing: Remittance Advice for NPVAPI 1003362864 and time period from 06/01/2025 to 07/31/2025.

Remittance advice activity ? Help

Filter your results

REMITTANCE ADV NBR	DATE ISSUED	PID/EU	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	835 EDI
085925	06/30/2025	0001668862	000000000	EFT	\$186.56	<a href="#">View</a> <a href="#">Download</a>
091450	07/07/2025	0001668862	000000000	EFT	\$0.00	<a href="#">View</a> <a href="#">Download</a>

Show  entries      Showing 1 to 2 of 2 forms    << >> |

myMenu

[Privacy](#)

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REMITTANCE ADVICE FOR MEDICAID/CHIP/MBSP

DR. QUENTIN ROCKINGHAM, DMD  
612 MCDONALD RD  
POLSON MT 59860

VENDOR # 0001818219 REMIT ADVICE # 108357 EFT/CHK #019666017 DATE 07/28/2025 PAGE 3  
 NPI #: 1821981473 TAXONOMY: 193400000X

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	CO-ALLOWED PAY	REASON & REMARK CODES
PAID CLAIMS - DENTAL CLAIM								
		04	12	D	O			
		05	13	M	O			
***CLAIM TOTAL*****						1185.00	616.51	
H477637	HOULIHAN, MARGARET	07142025	07142025	1.000	02392	282.00	158.08	
ICN 22520300552000153 PATIENT NUMBER=001477637								
0001755233 WALTER WALDOWSKI								
		LINE NUM	TOOTH NUM	TOOTH SURFACE				
		01	03	M O				
***CLAIM TOTAL*****						282.00	158.08	
1136618	WINCHESTER, CE	04082026	04082026	1.000	00140	284.00	167.37	
ICN 22520200552000004 PATIENT NUMBER=517786269								
0001755208 QUENTIN ROCKINGHAM								
		06192025	06192025	1.000	00489	38.00	19.19	
		LINE NUM	TOOTH NUM	TOOTH SURFACE				
		02	02	O				
***CLAIM TOTAL*****						322.00	186.56	
1136618	YAMATO, KELLIIE	06232025	06232025	1.000	07140	210.00	84.41	
ICN 22520200552000008 PATIENT NUMBER=517786269								
0001755208 PHIL CARDOZO								
		LINE NUM	TOOTH NUM	TOOTH SURFACE				
		01	31					

# Home Page For Provider Portal

**MONTANA DPHHS** 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

**myMenu**

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

Hello, Conduent Test Last login: 3/31/2026

**Provider Resources**

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

**Forms**

**FAQs**

# Dental Provider Identification

Member search ?

MPATH NORTHWEST  
COMMUNITY  
HEALTHCARE  
NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

Hi Conduent Test

View Templates

Dental Claim Submission Form ? Help

Billing Dentist

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

NPI:\* 1003362864

Provider Name:\* MPATH NORTHWEST

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

Specialty:\* Clinic/Center

Service Location Address 1:\* B J Street

Service Location Address 2:

City:\* Helena

State:\* MT

ZIP Code:\* 59601-0000

Taxonomy Code: \* 261Q00000X

Enrollment Unit:\* 0001867467

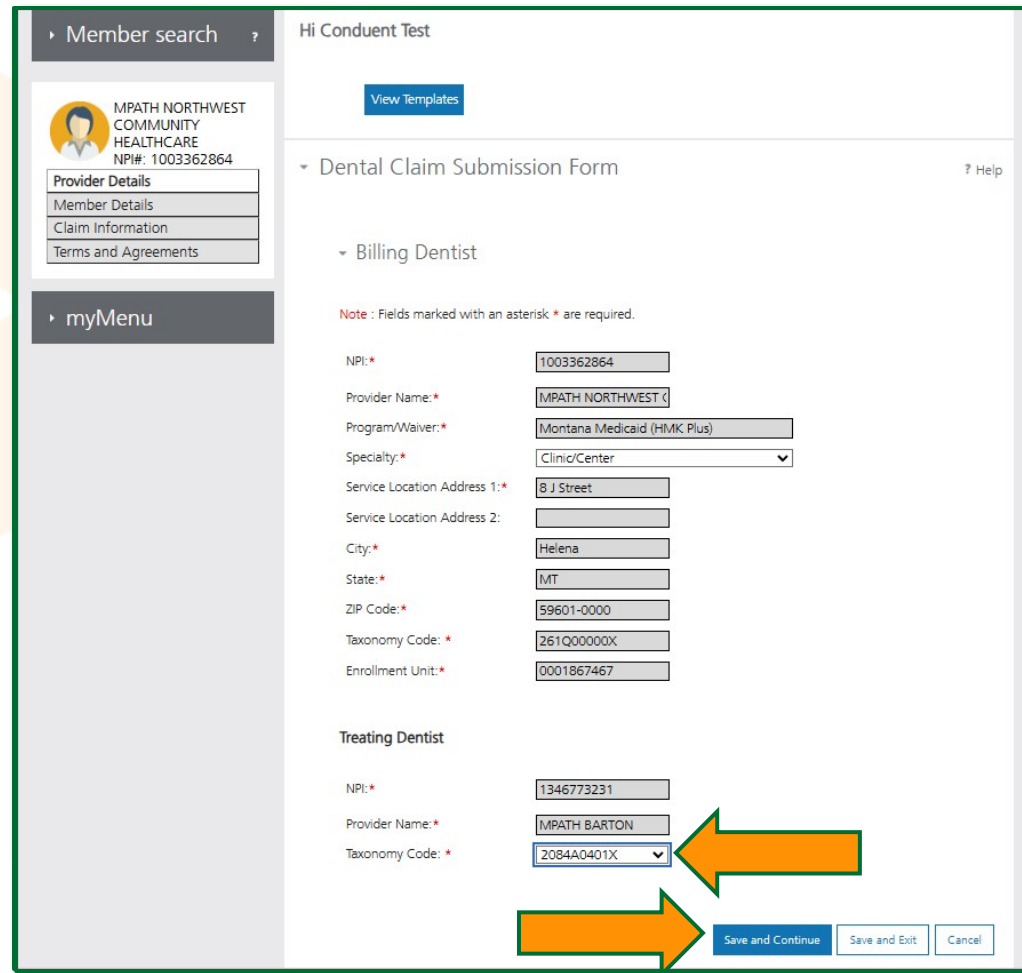
Treating Dentist

NPI:\* 1346773231

Provider Name:\* MPATH BARTON

Taxonomy Code: \* 2084A0401X

Save and Continue Save and Exit Cancel



# Member Identification — Dental

**MONTANA DPHHS DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES**

Home Contact Us Log Out

Home > Dental Submission

Member search

MPATH NORTHWEST COMMUNITY HEALTHCARE  
NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

Hi Conduent Test

View Templates

Dental Claim Submission Form

Member Details

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

Enter Member ID: \*  
1234567

Service Date: \*  
04/08/2026

Search

Save and Continue Previous Save and Exit Cancel

Privacy  
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COMMUNITY HEALTHCARE  
NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

Dental Claim Submission Form

Member Details

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

Enter Member ID: \*  
1234567

Service Date: \*  
04/08/2026

Search

Member ID: 1234567

Patient Account Number: [Empty]

First Name: CE

Middle Name: [Empty]

Last Name: WINCHESTER

Date of Birth: 05/19/1992

Gender: Male

Mailing Address 1: 12 UIJEONGBU LN

Mailing Address 2: [Empty]

City: WELSLY

State: MT

ZIP: 59797-0101

Save and Continue Previous Save and Exit Cancel

# Claim Information: Services Provided

Member search

MPATH  
NORTHWEST  
COMMUNITY  
HEALTHCARE  
NPI#: 1003362864

Provider Details

Member Details

**Claim Information**

Terms and Agreements

myMenu

Hi Conduent Test

[View Templates](#)

Dental Claim Submission Form ? Help

Claim Information

Note: Do not include any decimals when entering Diagnosis Code Information. Enter all characters of a Diagnosis and/or Procedure code before utilizing the search icon.

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

**Record of services provided**

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

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

Procedure Date*	Area of Oral Cavity	Tooth Number(s) or Letter(s)	Tooth Surface	Procedure Code*	Diagnosis Code Pointer	Quantity	COB	Remove
04/08/36				D33		1		
MM/DD/YYYY								
MM/DD/YYYY								
MM/DD/YYYY								
MM/DD/YYYY								
MM/DD/YYYY								
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	

Total Charges: \$262.00 [Add](#)

Search Results

Code	Description
D3310	endodontic therapy, anterior tooth (excluding final restoration)
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)
D3330	endodontic therapy, molar (excluding final restoration)
D3331	treatment of root canal obstruction; non-surgical access
D3332	incomplete endodontic therapy, inoperable, unrestorable or fractured tooth
D3333	internal root repair of perforation defects
D3346	retreatment of previous root canal therapy - anterior
\$262.00 D3347	retreatment of previous root canal therapy - bicuspid
D3348	retreatment of previous root canal therapy - molar

[Cancel](#)

# Completed Dental Line Details

Procedure Date*	Area of Oral Cavity	Tooth Number(s) or Letter(s)	Tooth Surface	Procedure Code*	Diagnosis Code Pointer	Quantity*	COB	Fee*
04/08/2026		10	F	D3310		1	COB	262.00
04/08/2026		02	O	D1353		1	COB	38.00
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	


Total Charges: \$ 300.00

# Diagnosis Codes

characters of a Diagnosis and/or Procedure code before utilizing the search icon.

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

**Record of services provided**

**Note :**  indicates all required fields of COB have been entered.  
**Note :** Use a comma "," if multiple values are needed in Area of Oral Cavity, Tooth Number(s) or Letter(s), and Tooth Surface fields.

Procedure Date*	Area of Oral Cavity	Tooth Number(s) or Letter(s)	Tooth Surface	Procedure Code*	Diagnosis Code Pointer	Quantity*	COB	Fee*
04/08/2026				D3331		1	COB	\$262.00
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	

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

**Diagnosis Codes**

Diagnosis Codes (ICD 10): 1  2  3

**Missing Teeth Information**

Click to highlight each missi

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

**Search Results**

Code	Description
K02	Dental caries
K023	Arrested dental caries
K025	Dental caries on pit and fissure surface
K0251	Dental caries on pit and fissure surface limited to enamel
K0252	Dental caries on pit and fissure surface penetrating into dentin
K0253	Dental caries on pit and fissure surface penetrating into pulp
K026	Dental caries on smooth surface
K0261	Dental caries on smooth surface limited to enamel
K0262	Dental caries on smooth surface penetrating into dentin
K0263	Dental caries on smooth surface penetrating into pulp
K027	Dental root caries

Cancel

# Ancillary Information

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

**Ancillary Claim/Treatment Information**

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

Select the Medicaid Resubmission Code:\*

Enter the Original MMIS ICN:\*

Are there EPSDT services for this claim?  Yes  No

Are you submitting COB at the claim level?  Yes  No

Place of Treatment:\*

Is this Treatment or Orthodontics:\*

Replacement of Prosthesis:  Yes  No

Treatment Resulting From:


Predetermination Number:

Prior Authorization Number:

[Advanced Search](#)

Do you have attachments for this claim?  Yes  No

**Notes:**



# Terms and Agreements — Dental

The screenshot displays the Montana Department of Public Health & Human Services (DPHHS) website interface. At the top left is the DPHHS logo. To the right are navigation icons for Home, Contact Us, and Log Out. Below the logo is the breadcrumb trail: Home > Dental Submission. The main content area is titled "Hi Conduent Test" and includes a "View Templates" button. A left sidebar contains a "Member search" dropdown, a profile card for "MPATH NORTHWEST COMMUNITY HEALTHCARE" (NPI#: 1003362864) with links for Provider Details, Member Details, Claim Information, and Terms and Agreements, and a "myMenu" dropdown. The main form area is titled "Dental Claim Submission Form" and includes a "Terms and Agreements" section. A note states: "Note : Fields marked with an asterisk \* are required." The form contains two required fields: "Provider Name:" with a dropdown menu showing "MPATH NORTHWEST" and "NPI/API:" with a text input field containing "1003362864". Below these is a checked checkbox with the text: "I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof." At the bottom of the form are four buttons: "Submit", "Previous", "Save and Exit", and "Cancel". Two orange arrows point from the bottom towards the "Terms and Conditions" link and the "Submit" button. The footer includes a "Privacy" link and the copyright notice "©2026 Optum, Inc. All rights reserved."

DEPARTMENT OF  
PUBLIC HEALTH &  
HUMAN SERVICES

Home > Dental Submission

Member search

MPATH NORTHWEST  
COMMUNITY  
HEALTHCARE  
NPI#: 1003362864

Provider Details  
Member Details  
Claim Information  
Terms and Agreements

myMenu

Hi Conduent Test

View Templates

Dental Claim Submission Form

Terms and Agreements

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

Provider Name: \* MPATH NORTHWEST

NPI/API: \* 1003362864

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

Privacy

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# Thank You — Dental

The image shows a screenshot of a web application interface for the Montana Department of Public Health & Human Services. The main content area displays a 'Thank you for your Submission' message, indicating that a dental claim was successfully submitted with ID MT260422D00091994. A 'Print' icon is visible next to the message, with an orange arrow pointing to it. A print dialog box is open on the right side of the screen, showing options for printer selection (set to 'Save as PDF'), layout (Portrait selected), and pages (All selected). An orange arrow points from the 'Print' icon in the main content area to the print dialog box. Another orange arrow points from the bottom right corner of the main content area to the 'Save' button in the print dialog box.

**DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES**

Home > Dental Submission

Member search

MPATH NORTHWEST COMMUNITY HEALTHCARE  
NPI#: 1003362864

- Provider Details
- Member Details
- Claim Information
- Terms and Agreements

myMenu

Hi Conduent Test

View Templates

Dental Claim Submission Form

Thank you for your Submission

Your Claim was successfully submitted: MT260422D00091994.

Continue

Print

Print

Total: 2 pages

Printer: Save as PDF

Layout: Portrait (selected), Landscape

Pages: All (selected), Odd pages only, Even pages only, e.g. 1-5, 8, 11-13

More settings

Print using system dialog... (Ctrl+Shift+P)

Save Cancel

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# Original vs Adjusted — Dental

**ADJUSTED**

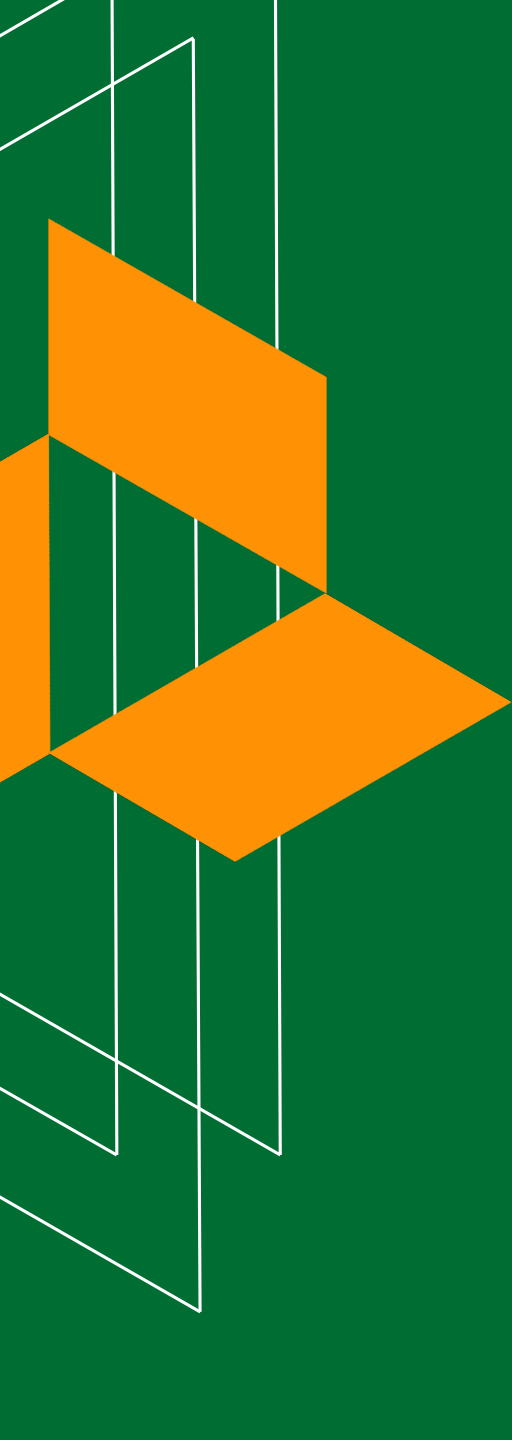
Procedure Date*	Area of Oral Cavity	Tooth Number(s) or Letter(s)	Tooth Surface	Procedure Code*	Diagnosis Code Pointer	Quantity*	COB	Fee*
04/08/2026		10	F	D3310		1	COB	262.00
04/08/2026		02	O	D1353		1	COB	38.00
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	
MM/DD/YYYY							COB	

Total Charges: \$ 300.00 Add

Return

Professional

Facility



# Clearinghouses

# Adjustment Settings — Clearinghouses

---

CMS 837 Format

Loop 2300

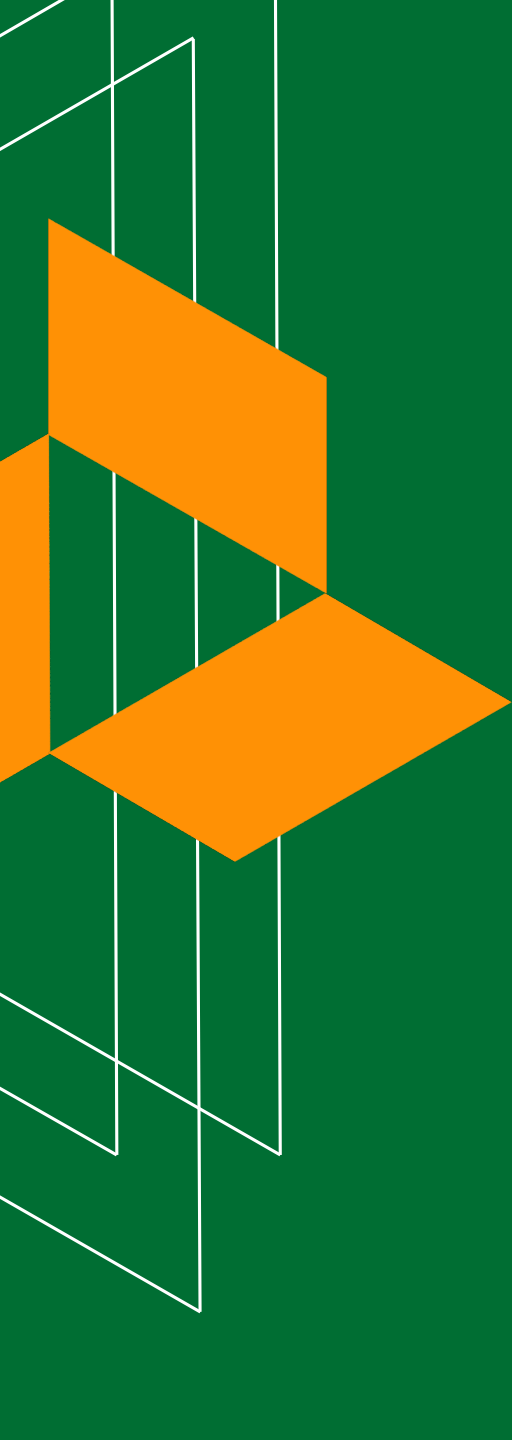
CLM Segment: Claim Info

CLM05-3: Frequency Type

7 = Replacement

8 = Void

REF\*F8\* = [Original ICN]



# When to Revert to Paper

# Reverting to Paper

---



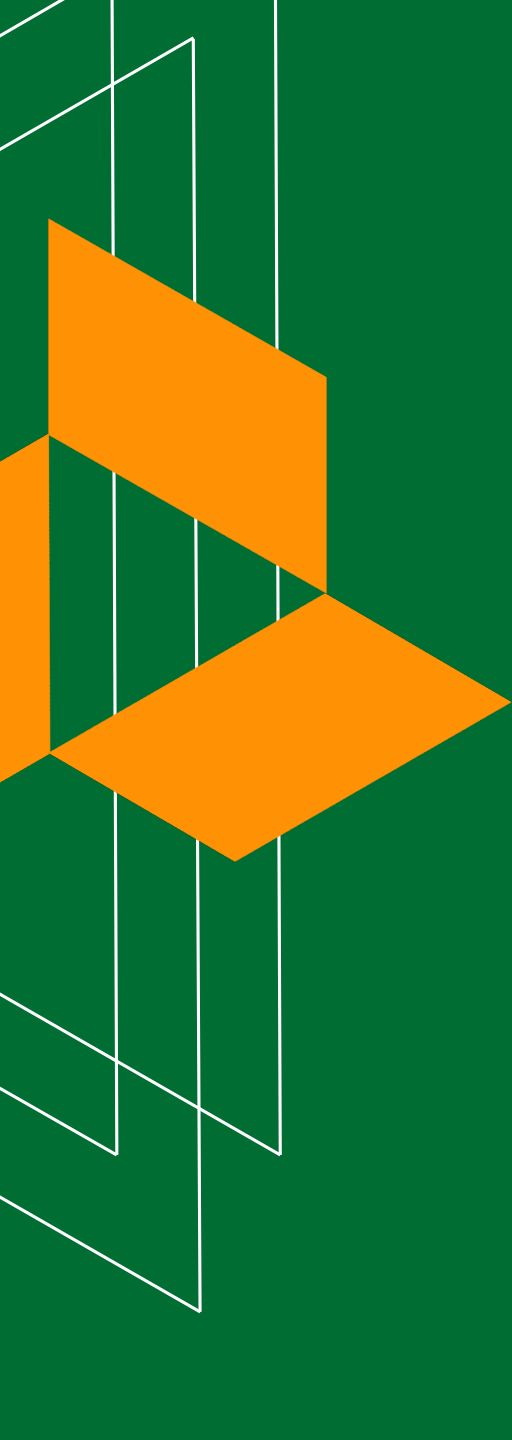
12 months



Splits



Attachments



When adjustments are rejected

# Which Claims Can Be Adjusted?

---

## Can be adjusted:

Only paid claims

Claims with an ICN

## Cannot be adjusted:

Older than 12 months.

Split or overflow claims

Denied claims

Suspended claims

Previously adjusted claims

Encounter claims

Pharmacy 837 claims

Financial (gross) adjustments

Medicaid Provider Website

<https://medicaidprovider.mt.gov/claims>

# Adjustment Rejection Codes — A3

---

<u>Code</u>	<u>Reason</u>	<u>Possible Cause</u>	<u>Fix</u>
A3	Already adjusted	Duplicate	Wait for final to submit
	Unprocessable	Split claim	Submit on paper
	Denied	Denied/non-covered charge	Resubmit as original

# Adjustment Rejection Codes — A4

---

<u>Code</u>	<u>Reason</u>	<u>Possible Cause</u>	<u>Fix</u>
A4	Not found	ICN is wrong	Correct ICN & resubmit
		Wrong claim type	Resubmit as correct type
		Too old	None

# Questions

---



# Media Credits

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Wrench icon MS Office Lic

Money icon MS Office Lic

Old man with a cane icon MS Office Lic

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Yellow paperclip icon by Jack Cai Freelmages Lic

Freckled woman looking puzzled by Windchime Freelmages Lic

MES screenshots ©State of Montana Used with permission

Medicaid Provider site screenshots ©State of Montana Used with permission



**CONDUENT**

