

# Billing 101 Training for Providers

Presented by Loma Romero, Provider Relations Field Representative

# Roll Call

In chat, please share:

- Your name
- Company
- Who you are representing

# In this training...

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- Claim preparation
- Claims submissions
- MPATH Claims Setup
- MPATH Claims Solution
- MPATH Additional Portal Features
- Adjustments
- Most common billing errors
- Where do I go for help

# Preparation for Submitting claims

# What order should information be gathered?

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1. Verify member eligibility & service limits (if applicable)
2. Obtain & review member's prior authorization (if applicable)
3. Select the proper diagnosis code
4. Select place of service
5. Select the proper CPT code (service provided) & modifier
6. Verify Fee Schedule
7. EOB from primary insurance (if applicable)

# Automated System Information

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The MATH/MPATH portals and the IVR do not give services limits.

Always contact the Call Center to confirm service limits.

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

- It may say the member is eligible for eye exam & glasses. That only means that the member's coverage allows for this service.
- It may say that the member is eligible for vision or dental services when the member only has QMB. This is because Medicare may cover some services in medical setting.

# Prior Authorizations

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

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

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

# Prior Authorization Letter

DATE 02/25/21

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



# Diagnosis Codes

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ICD-10 is short for *International Classification of Diseases, 10<sup>th</sup> Revision*.

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

<https://icd10coded.com>

# Place of Service

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

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

# CPT Code

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

Provider manuals should be reviewed for service specifics.

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

<https://medicaidprovider.mt.gov>

# Rev Codes

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

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

# Modifiers & Other Coding Resources

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***Resources for coders*** – coding manuals, diagnosis code ICD-10 book & websites, provider manuals, general manual, & provider notices.

Modifier info – CMS newsletter, provider notices, Correct Procedural Coding Manual (appendix A = modifiers).

Montana Medicaid only accepts one modifier on the UB – 04 – use billing modifier first.

Montana Medicaid only accepts up to 3 modifiers on the CMS-1500.

The Call Center is not allowed to give billing advice.

# EOB for Primary Insurance

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

- The page that shows the member and all their charges. Must include date of service, CPT codes, amount billed, and amount paid by the primary insurance.
- The page that shows the Reason and Remark Code explanations for the codes listed on the EOB.
- If there is more than one patient on the page, please cross out the information for other patients.

# Claims Submission

# Electronic Claim Submission Setup

A clearinghouse, software, or billing agent that is contracted to submit claims with MT Medicaid can assist with claims submission.

A Montana DPHHS EDI Provider Enrollment Form can be filled out if you have a company that is not contracted. (Unless using MPATH)

The form can be found on the [Claims Instruction page of the Provider Information Website](#).

|   |
|---|
| Home  |
| <a href="#">COVID-19 Provider Information</a> |
| <a href="#">Online Services</a> ▼             |
| <a href="#">Resources by Provider Type</a>    |
| <a href="#">Provider Enrollment</a>           |
| <a href="#">Subscribe to Claim Jumper</a>     |
| <a href="#">Site Search</a>                   |
| <a href="#">Site Index</a> ▼                  |
| <a href="#">Announcements</a>                 |
| <a href="#">Archive</a>                       |
| <a href="#">Claim Instructions</a>            |



# Electronic Claim Submission

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

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

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

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

Please send an email to [MTPRHelpdesk@Conduent.com](mailto:MTPRHelpdesk@Conduent.com) if you have set up questions.

# Electronic Claims Submission Cont.

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- Electronic claims must be submitted by 2pm MST on Wednesdays in order process during that claim cycle. This is not a payment guarantee.
- Electronic claims process faster than paper claims.
- Electronic claims can also be submitted through a Billing Agency or a Clearing House.

# Paper Claim Submissions

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

# Paper Claim Submissions

## – CMS 1500


### Required Fields:

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

### Optional fields as applicable:

- Box 11 TPL information
- Box 17a Passport number
- Box 23 Prior Authorization
- Box 29 TPL Payment amount

CMS-1500 02/12



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

☐ FICA ☐ FICA

|   |  |   |  |
|---|--|---|--|
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> REGIONAL <input type="checkbox"/> OTHER <input type="checkbox"/><br><small>(Indicate by checkmark)</small>                     |  | 10. INSURED'S POLICY OR GROUP NUMBER<br><b>Possible Member ID</b>   |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br><b>Client last name, first name</b>  |  | 3. PATIENT'S BIRTH DATE<br>MM DD YY   |  |
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial)   |  | 5. INSURED'S ADDRESS (No. Street)   |  |
| 6. PATIENT'S ADDRESS (No., Street)  |  | 7. INSURED'S ADDRESS (No., Street)  |  |
| 8. PATIENT'S RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>   |  | 9. RESERVED FOR NUCC USE  |  |
| 11. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  |  | 12. INSURED'S DATE OF BIRTH<br>MM DD YY   |  |
| 13. OTHER INSURED'S POLICY OR GROUP NUMBER<br><b>Possible Member ID</b>   |  | 14. OTHER CLAIM ID (Designated by NUCC)   |  |
| 15. RESERVED FOR NUCC USE   |  | 16. INSURANCE PLAN NAME OR PROGRAM NAME<br><b>Possible TPL Information</b>  |  |
| 17. RESERVED FOR NUCC USE   |  | 18. IS THIS ADDITIONAL HEALTH BENEFIT PLAN?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If yes, complete items 19, 20, and 21)  |  |
| 19. PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO<br>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>PLATE (State)</small><br>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO |  | 20. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts and agrees below.<br>SIGNED: _____ DATE: _____ |  |
| 21. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)<br>MM DD YY   |  | 22. OTHER DATE<br>MM DD YY  |  |
| 23. NAME OF REFERRING PROVIDER OR OTHER SOURCE<br>17a. _____<br>17b. _____<br>17c. _____  |  | 24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY TO MM DD YY  |  |
| 25. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)   |  | 26. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (SAL))<br>A. ICD - 10 Diagnosis code<br>B. _____<br>C. _____<br>D. _____<br>E. _____<br>F. _____<br>G. _____<br>H. _____<br>I. _____<br>J. _____<br>K. _____<br>L. _____   |  | 28. PRIOR AUTHORIZATION NUMBER<br><b>4123456789</b>   |  |
| 29. A. DATE OF SERVICE FROM MM DD YY TO MM DD YY<br>B. PLACE OF SERVICE<br>C. PROCEDURE, SERVICE, OR SUPPLIER (Specify Unusual Circumstances)<br>D. DIAGNOSIS PORTION<br>E. CHARGES<br>F. AMOUNT PAID<br>G. PAYMENT PERCENTAGE<br>H. ID<br>I. RECEIVING PROVIDER ID #   |  | 30. FEDERAL TAX ID NUMBER<br>99-9999999   |  |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include and describe OR credentials & verify that the address on the reverse apply to this bill and are made a part thereof)<br><b>Dr. Provider, MD</b>   |  | 32. SERVICE FACILITY LOCATION INFORMATION<br><b>Dr. Provider, MD</b>  |  |
| 33. BILLING PROVIDER INFO & PH #<br><b>123 Main Street</b><br><b>Anywhere, MT 54321-1234</b>  |  | 34. BILLING PROVIDER ID #<br><b>2084N0400X</b>  |  |
| 35. BILLING PROVIDER NPI<br><b>1234567891</b>   |  | 36. BILLING PROVIDER TAXONOMY<br><b>2084N0400X</b>  |  |

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

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

# Additional Montana Medicaid CMS-1500 Info

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- Box 17a Passport referral and Box 23 Prior Authorization are different. The boxes they belong in are not interchangeable.
- Box 24J is for the rendering provider. The NPI and taxonomy must match an active provider file on the DOS.
- Box 29 is for TPL payment amounts except Medicare. When Medicare made a payment, submit the Medicare EOB with the claim without entering any Medicare payment information on the claim.
- Box 33 Billing provider information must match the physical location on file for the Billing NPI listed in box 33a and the Billing taxonomy listed in box 33b. Montana Medicaid does not edit on box 32 for servicing location.

# Paper Claim Submissions – UB-04

## Required Fields:

- Box 1 Billing provider name and address
- Box 4 Type of Bill
- Box 6 Covered Days
- Box 7 Passport Referral
- Box 8b Member Name
- Box 12 Admit Date
- Box 17 Discharge Status
- Box 42 Revenue Code
- Box 44 HCPCS code
- Box 45 Service date
- Box 46 Units of Service
- Box 45 total Charges
- Creation Date

- Box 56 Billing NPI
- Box 60 Member ID
- Box 66 Diagnosis Codes
- Box 76 Attending Provider
- Box 81 Billing NPI Taxonomy

## Optional fields, as applicable:

- Boxes 18-26 Condition Codes
- Box 43 Description – Can be used for NDCs
- Box 50 TPL Payer Name
- Box 51 TPL Member ID
- Box 54 TPL payment amount
- Box 63 Prior Authorization
- Box 74 Surgical procedure Codes

|  |                       |  |         |
|--|-----------------------|--|---------|
| Provider Name<br>Physical Address<br>City, ST Zip+4  |                       | 131  |         |
| Member First Name Last Name  |                       | Passport#  |         |
| In/Out multi ER visits   |                       | 01 Condition Codes relate to copy overrides                |         |
| Occurrence codes are used to denote events relating to the bill that may effect payer processing |                       |  |         |
| Value Codes and Amounts reflect Medicare Payment Information                                     |                       |  |         |
| 250  |                       | 7/6/14   | 1       |
| 260  | 96365                 | 7/7/14   | 1       |
| 260  | 96366                 | 7/7/14   | 1       |
| 260  | 96367                 | 7/7/14   | 1       |
| 301  | 80048                 | 7/7/14   | 1       |
| 301  | 82055                 | 7/7/14   | 1       |
| 306  | 87040                 | 7/7/14   | 2       |
| 306  | 87804                 | 7/7/14   | 2       |
| 320  | 71020 TC              | 7/7/14   | 1       |
| 450  | 99284 25              | 7/7/14   | 1       |
| 636  | N4 63323047401 4 ML   | 7/7/14   | 4       |
| 636  | N4 50458016601 150 ML | 7/6/14   | 3       |
| PAGE OF  |                       | CREATION DATE  | 8/11/14 |
| Possible TPL Payer   |                       | 123456789  | 42.80   |
| Member Name  |                       | Member ID  |         |
| Prior Auth#  |                       | PAs are required in order for certain services to be paid. |         |
| ICD-10 codes   |                       |  |         |
| Billing Taxonomy   |                       | B3 282N00000X  |         |
| Attending Last Name  |                       | First Name   |         |

# Paper Claim Submissions ADA Dental

## Required Fields:

- Box 12 Member Name
- Box 15 Member ID
- Box 29 Procedure Code
- Box 29a Diagnosis Pointer
- Box 29b Unit of Service
- Box 31 Fee
- Box 32 Total Charge
- Box 48 Billing provider Name and Address
- Box 49 Billing NPI
- Box 52a Billing Taxonomy
- Box 54 Rendering NPI
- Box 56A Rendering Taxonomy

## Optional Fields, as applicable:

- Box 2 Prior Authorization
- Boxes 5-11 TPL Information
- Boxes 25-28 Tooth Number and Surfaces
- Box 33 Missing Teeth
- Box 35 Remarks (Used to indicate disabled members needing additional services or Once in Lifetime replacement)

**ADA American Dental Association® Dental Claim Form**

**HEADER INFORMATION**

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

2. Predetermination/Preauthorization Number

**DENTAL BENEFIT PLAN INFORMATION**

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

**POLICYHOLDER/SUBSCRIBER INFORMATION** (Assigned by Plan Named in #3)

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

13. Date of Birth (MM/DD/CCYY) 14. Gender ☐ M ☐ F ☐ J 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number 17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above  
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other 19. Reserved For Future Use

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

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

**RECORD OF SERVICES PROVIDED**

|    | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 29a. Diag. Pointer | 29b. City | 30. Description | 31. Fee |
|----|---------------------------------|-------------------------|------------------|----------------------------------|-------------------|--------------------|--------------------|-----------|-----------------|---------|
| 1  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 2  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 3  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 4  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 5  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 6  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 7  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 8  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 9  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 10 |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |

33. Missing Teeth Information (Place an "X" on each missing tooth.)  
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16  
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ (ICD-10 = AB)  
34a. Diagnosis Code(s) A \_\_\_\_\_ C \_\_\_\_\_  
34b. Primary diagnosis in "A" B \_\_\_\_\_ D \_\_\_\_\_

31a. Other Fee(s) \_\_\_\_\_  
32. Total Fee \_\_\_\_\_

35. Remarks

**AUTHORIZATIONS**

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

X Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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

X Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

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

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

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

52. Phone Number ( ) - \_\_\_\_\_ 52a. Additional Provider ID \_\_\_\_\_

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment (e.g. 11=Office, 22=OP Hospital) 39. Enclosures (Y or N)  
(Use "Place of Service Codes for Professional Claims")

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment ☐ No ☐ Yes (Complete 44) 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State \_\_\_\_\_

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

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

X Signed (Treating Dentist) \_\_\_\_\_ Date \_\_\_\_\_

54. NPI \_\_\_\_\_ 55. License Number \_\_\_\_\_

56. Address, City, State, Zip Code 56a. Provider Specialty Code \_\_\_\_\_

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

©2019 American Dental Association  
J430 (Same as ADA Dental Claim Form - J431, J432, J433, J434, J430D)

To reorder call 800.947.4746  
or go online at ADAcatalog.org

# MPATH Claims Setup



# Account Administration

All 3 Account Administration functions are located on one screen.

- Manage Portal Users
- Manage Billing Providers
- Manage Provider Enrollment Accounts

## Manage Portal Users

[? Help](#)

A maximum of 200 users will be displayed. Adjust your search criteria in the left navigation to refine your results.

Filter your results:

| ACTIONS | LOGIN NAME | FIRST NAME | LAST NAME | EMAIL | STATUS |
|---------|------------|------------|-----------|-------|--------|
|---------|------------|------------|-----------|-------|--------|

No matching users found.

Show  entries

Showing 0 to 0 of 0 entries [|<](#) [<](#) [>](#) [>|](#)

Add User Account

## Manage Billing Providers

[? Help](#)

Filter your results:

| ACTIONS | BILLING PROVIDER NAME | NPI/API ID |
|---------|-----------------------|------------|
|---------|-----------------------|------------|

|  |       |            |
|--|-------|------------|
|  | MPATH | 1003362864 |
|--|-------|------------|

Show  entries

Showing 1 to 1 of 1 accounts [|<](#) [<](#) [>](#) [>|](#)

Add Billing Provider

## Manage Provider Enrollment Accounts

[? Help](#)

Complete LINK Request Form

Complete UNLINK Request Form

Filter your results:

| ACTION | ATTACHMENT | DATE | STATUS |
|--------|------------|------|--------|
|--------|------------|------|--------|

No matching transactions found.

Show  entries

Showing 0 to 0 of 0 entries [|<](#) [<](#) [>](#) [>|](#)

Upload Request

# Manage Billing Providers

Add Billing NPIs to this section  
ONLY if,

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

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

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

Provider Name or Organization Name?\*

☐ Provider Name ☐ Organization Name

NPI or API?\*

☐ NPI ☐ API

TIN/FEIN:\*

Enter Provider ID Number:\*

Submit

Cancel

# Manage Affiliations

# Manage Affiliations

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This action is **needed** if you are a facility that employs Rendering Providers and/or you are billing on the Provider Services Portal.






The person completing this action will need the facility NPI on their Enrollment workbench.

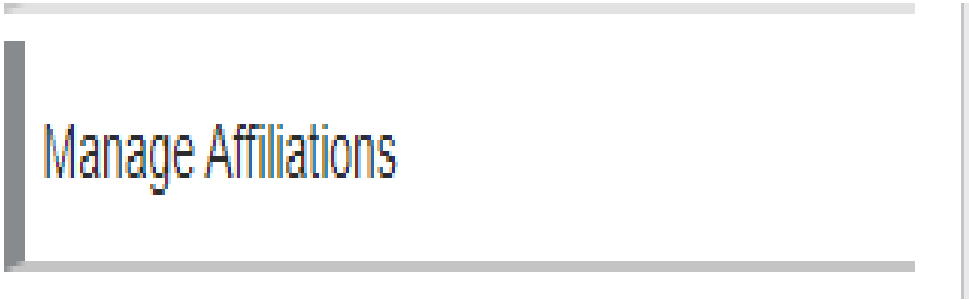
# Add an Affiliation

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

Click the **Radio button** on the Enrollment line of the facility.

Click the **Manage Affiliations** tab, now visible under the Enrollment Menu.

| Actions  | Type       | Status   |
|--|------------|----------|
| <input checked="" type="radio"/>      | Enrollment | Enrolled |



# Add an Affiliation Cont.

Search for Providers tab.

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

Click Search.

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

Search for Providers

Pending Approval

Requested Affiliations

Existing Affiliations

User Guide

Search for Provider

Help

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

First Name

Last Name

NPI/Atypical ID

Search

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

Assigned Locations

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

Items per page 10 1 - 1 of 1 < >

# Add an Affiliation Cont.

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

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

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


Click **Add and Continue**.




|                                     | First Name | Last Name  | NPI/Atypical ID | Effective Date ↓   | Last 4 digits of SSN/ITIN *   | Actions   | File Name |
|-------------------------------------|------------|------------|-----------------|--|---|---|-----------|
| <input checked="" type="checkbox"/> | ROBERT     | NITSCHHELM | 1598719064      | 05/12/2022  |  |   |           |



Assigned Locations 

|   | Address Line   |   |
|---|----------------|---|
| <input checked="" type="checkbox"/>  | 1111 BAKER AVE |  |

Items per page: 10 1 - 1 of 1

1111 BAKER AVE 

| Select  | Program Name                | Effective Date*  | Termination Date   |
|---|-----------------------------|--|--|
| <input checked="" type="checkbox"/>  | Montana Medicaid (HMK Plus) | 05/12/  | MM/DD/YYYY  |



# Manage Existing Affiliations

**Pending Approval** tab will show any providers that have submitted to be affiliated by your facility.

**Requested Affiliations** are providers who are requesting affiliation.

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

The screenshot displays the 'Manage Affiliations' interface. At the top, there's a dark header with the title 'Manage Affiliations'. Below it, a navigation bar contains five tabs: 'Search for Providers', 'Pending Approval', 'Requested Affiliations', 'Existing Affiliations' (which is selected and highlighted), and 'Denied Affiliations'. To the right of the tabs is a 'User Guide' icon. Below the navigation bar, there's a 'Search for Provider' section with a help icon. The text below the search section explains that the existing affiliation tab lists all affiliations linked to the organizational provider and provides instructions on how to manage them, including adding a new physical address or terminating an affiliation. Below this text are three input fields: 'First Name', 'Last Name', and 'NPI/Atypical ID'. The 'NPI/Atypical ID' field contains the value '1144064783'. To the right of these fields is a 'Search' button. Below the search section is a table with the following columns: 'First Name', 'Last Name', 'NPI/Atypical ID', 'Effective Date', 'Terminate Date', 'Actions', and 'File Name'. The table contains one row of data for Emma Windauer with NPI/Atypical ID 1144064783 and an effective date of 06/24/2024. The 'Terminate Date' column shows a placeholder 'MM/DD/YYYY' with a calendar icon. The 'Actions' column contains a blue up arrow icon and an information icon.

| First Name | Last Name | NPI/Atypical ID | Effective Date ↑ | Terminate Date | Actions   | File Name |
|------------|-----------|-----------------|------------------|----------------|---|-----------|
| Emma       | Windauer  | 1144064783      | 06/24/2024       | MM/DD/YYYY     |   |           |



# Ending Affiliations

Click the **Existing Providers** tab.

Click the **Search** button.

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

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

Search for ProvidersPending ApprovalRequested AffiliationsExisting Affiliations

User Guide

Search for Provider

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

First Name ⓘ

Last Name ⓘ

NPI/Atypical ID ⓘ

Search ⓘ

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

ANITABEACH1922064401

ⓘ

# Ending Affiliations Cont.

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

Click the **radio button** under **Deactivate**.  
Enter the **termination date**.

Click the **Save and Continue** button.

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

Assign Locations ⓘ

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

Questions?

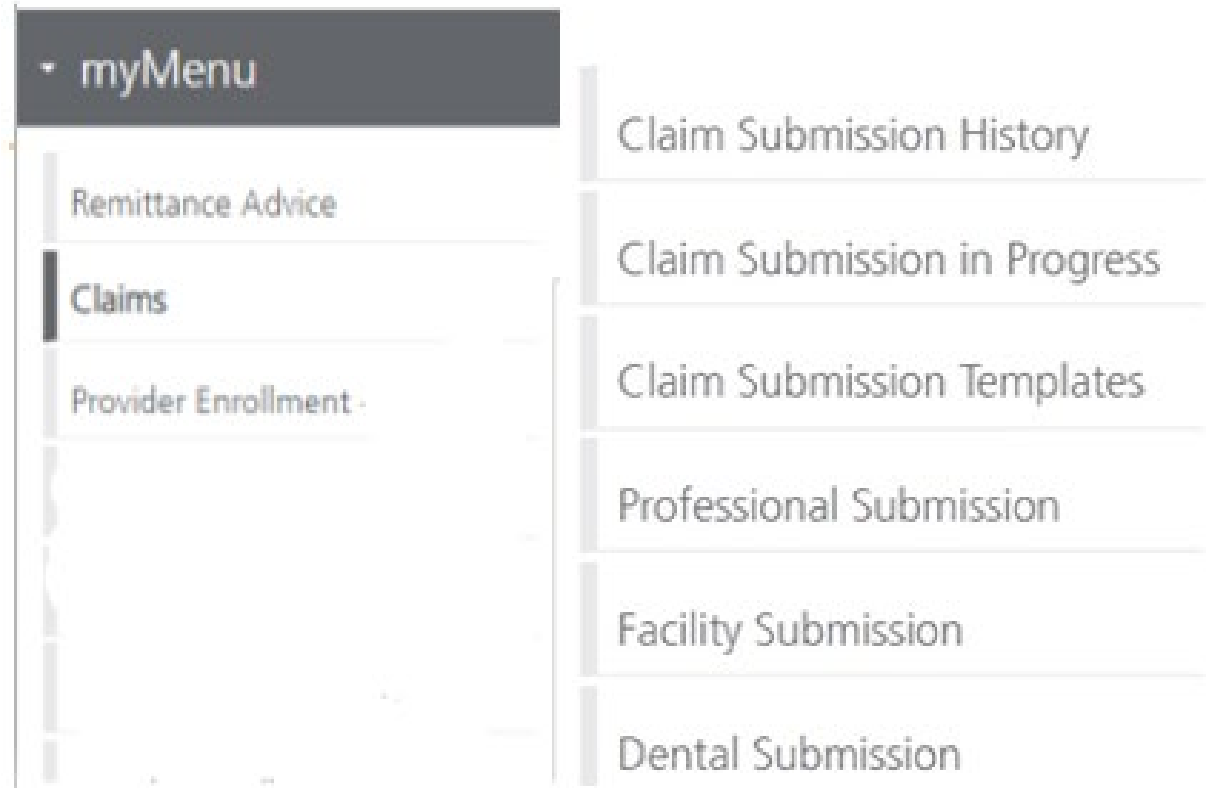
# Provider Services Portal Claims Submission

# Claim Submission Menu

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

A side menu with submission options will appear.

The following slides will describe each function.



# Claims Submission History

---

This option will show you the most recent claims SUBMITTED to Montana Medicaid for processing.

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

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

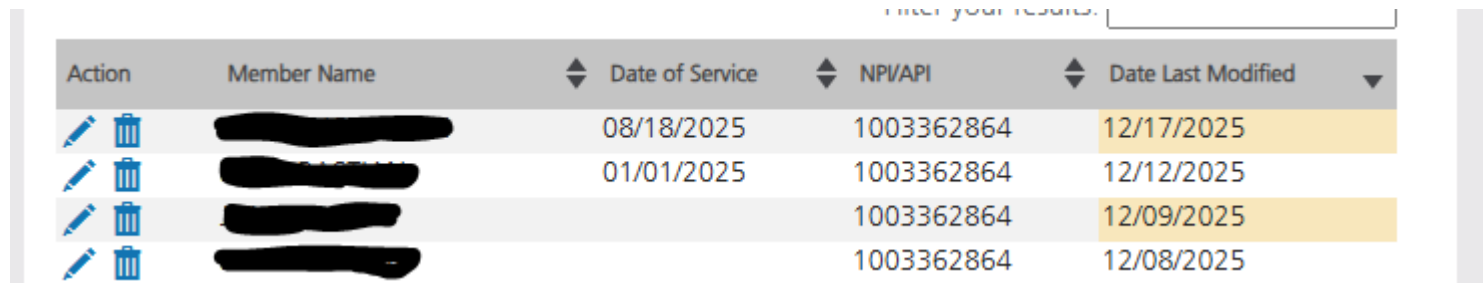
# Claims Submission in Progress









**This function is for claims started but not submitted.**

Example:

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

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



| Action  | Member Name | Date of Service | NPV/API    | Date Last Modified |
|---|-------------|-----------------|------------|--------------------|
|   | [REDACTED]  | 08/18/2025      | 1003362864 | 12/17/2025         |
|   | [REDACTED]  | 01/01/2025      | 1003362864 | 12/12/2025         |
|   | [REDACTED]  |                 | 1003362864 | 12/09/2025         |
|   | [REDACTED]  |                 | 1003362864 | 12/08/2025         |

# Claim Submission Templates



# Claim Submission Templates

---

**This function is a time saving tool for reoccurring claims.**

Example:

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

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

# Creating a Template

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









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

\*Section 6, of the Provider Portal User Guide.

Claim Submission Templates

Maximum Templates Allowed : 500

Filter your results:

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

Showing 1 to 4 of 4 templates

Create Professional Claim Submission Template

Create Facility Claim Submission Template

Create Dental Claim Submission Template

# Creating a template cont.

Select the Billing Provider file.

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

Select NPI.

Select Program/Waiver.

Select Specialty.

Click **Save and Continue**.

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

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

# Creating a template cont.

Select the Rendering Provider file.

If you have multiple NPIs listed under Affiliations, The NPI field will have a drop down.

Select NPI.

Select Specialty.

Click **Save and Continue**.

## Rendering Provider

|                  |  |
|------------------|--|
| NPI:             | <input type="text" value="1346773231"/>        |
| Provider Name: * | <input type="text" value="MPATH W Barton"/>    |
| Taxonomy Code: * | <input type="text" value="Select Taxonomy C"/> |

## Referring Provider

☐ There is a referring provider for this claim.

## Ordering Provider

☐ There is a ordering provider for this claim.

Save and Continue

Save and Exit

Cancel

# Creating a Template Cont.

Enter the member's MT  
Medicaid ID number and Date  
of Service.

Click **Search**.

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

The screenshot shows a web application interface for a 'Professional Claim Submission Form'. At the top right is a 'Help' link. Below the form title is a section for 'Member Details'. It contains three radio buttons for search criteria: 'Search By Member ID' (selected), 'Search By Member Name', and 'Search By Member SSN'. Below these are two required input fields: 'Enter Member ID: \*' with a text box, and 'Service Date: \*' with a date picker showing 'MM/DD/YYYY'. A blue 'Search' button is positioned below the date field. At the bottom right, there are four buttons: 'Save and Continue' (highlighted in blue), 'Previous', 'Save and Exit', and 'Cancel'.

# Creating a Template Cont.

Complete the fields that will not change.

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

## ▼ Claim Information

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



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

### Diagnosis Codes

Diagnosis Codes (ICD 10):

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

### Claim Details

**Note :**  or  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/<br>HCPCS<br>Code* | Modifier             | Diagnosis<br>Pointer* | Charges*             | Days<br>or<br>Units* | Type                 | COB                  | NDC                  | EPSDT                | Emergency<br>Service | Family<br>Planning   |
|----------------------|----------------------|----------------------|------------------------|----------------------|-----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   | <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   | <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   | <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   | <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   | <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   | <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   | <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   | <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   | <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Total Charges: \$

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

# Creating a Template Cont.

Answer all the questions at the bottom of the screen.

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

Click **Save and Continue**.

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

Save and Continue

# Creating a Template Cont.

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

Your template is now visible.

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

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

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

## Facility Claim Template

### Save Template









Please enter a claim submission template name.

Template Name: \*

Note(s):

Template Name must satisfy the following conditions:

- a. Minimum length: 3 characters.
- b. Maximum length: 35 characters.
- c. Cannot contain special characters other than: Space " " or Underscore "\_" or Dash "-".

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



Questions?

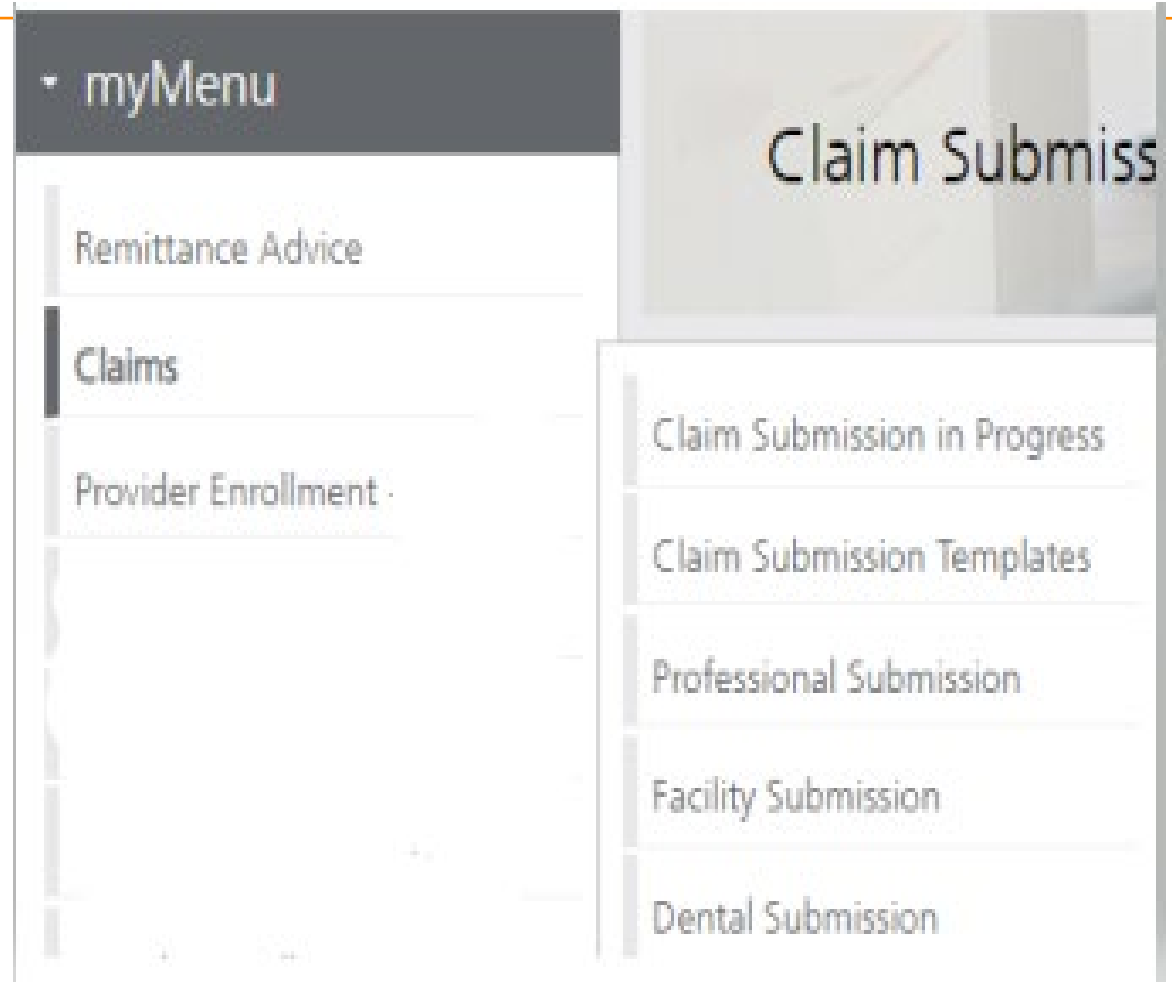
# Claim Submission

# Submitting a Claim

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

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

\*Section 6, of the Provider Portal User Guide.



# Billing Provider

Select the Billing Provider file.

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

Select NPI.

Select Program/Waiver.

Select Specialty.

Click **Save and Continue**.

NPI/API: \* 1245490713

Provider Name: \* NORTH WEST HOME CARE

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

Specialty: \* In Home Supportive Care ▼

Service Location Address 1: \* 818 W CENTRAL

Service Location Address 2: \*

City: \* MISSOULA

State: \* MT

ZIP: \* 59801-0000

Taxonomy Code: \* 253Z00000X

Enrollment Unit: \* 0000262208

NPI/API: \* 1033508080 ▼

Provider Name: \* LIBERTY PLACE, INC

Program/Waiver: \* Severe Disabling Mental Illness Waiver (SDMI) ▼

Specialty: \*

Service Location Address 1: \*

Service Location Address 2: \* BOOTSTRAP RANCH E

City: \* BELGRADE

State: \* MT

ZIP: \* 59714-8121

Taxonomy Code: \* 251S00000X

Enrollment Unit: \* 0000801034

# Billing Provider Cont.

If the Billing file you chose, requires a Rendering provider.

The Rendering Provider drop down will appear.

Select your rendering NPI from the drop down.

Click **Save and Continue.**

## Billing Provider

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

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

## Rendering Provider

|        |  |
|--------|--|
| NPI: * | <div>Select NPI<br/>1609484575<br/>1538253760<br/>1164561635</div> |
|--------|--|

## Referring Provider

☐ There is a referring provider for this claim.

## Ordering Provider

☐ There is a ordering provider for this claim.

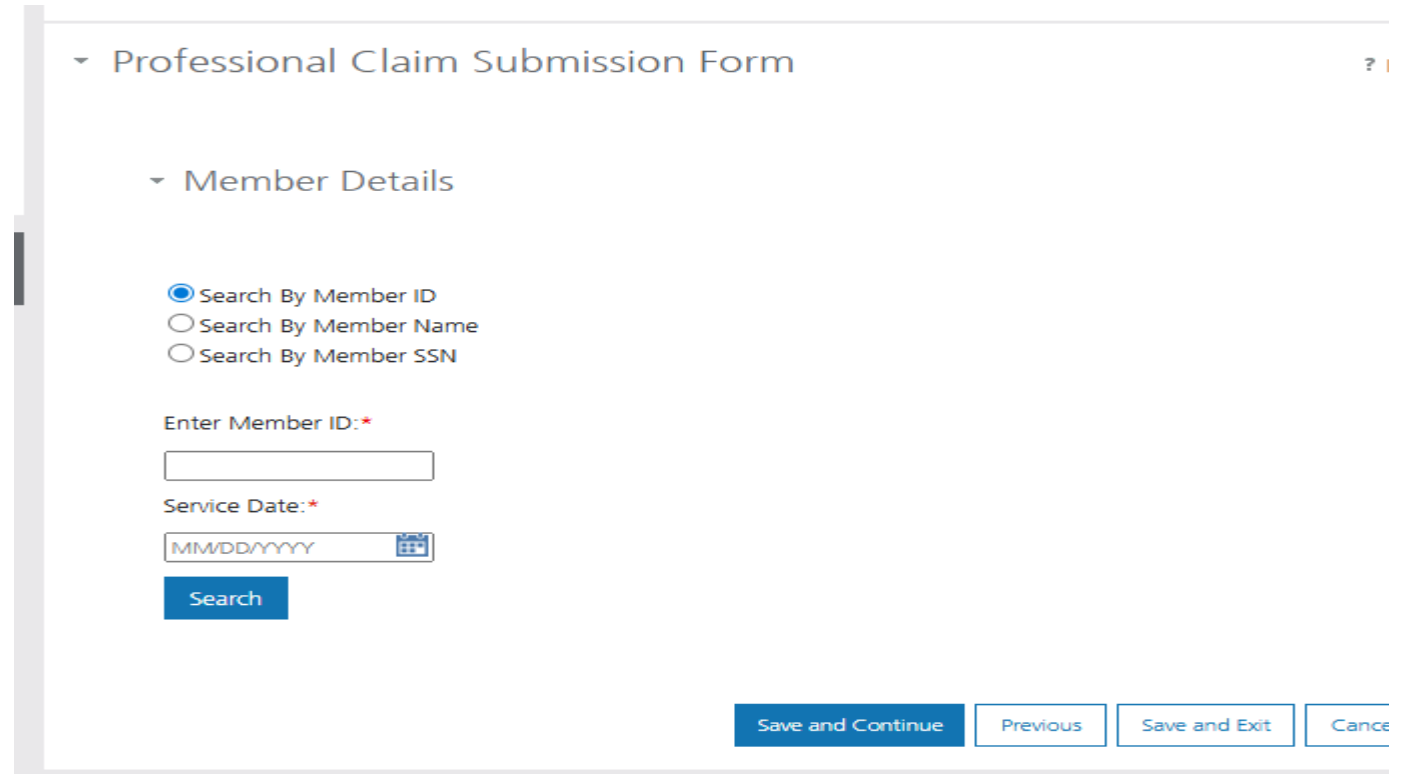
# Member Details

Enter the member's MT  
Medicaid ID number.

Click **Search**.

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

Click **Save and Continue**.



The screenshot shows a web form titled "Professional Claim Submission Form". Under the "Member Details" section, there are three radio button options: "Search By Member ID" (which is selected), "Search By Member Name", and "Search By Member SSN". Below these options is a text input field labeled "Enter Member ID: \*" and a "Service Date: \*" field with a date picker icon. A blue "Search" button is positioned below the input fields. At the bottom right of the form, there are four buttons: "Save and Continue" (in blue), "Previous", "Save and Exit", and "Cancel".

# Claim Information

Complete all required fields and questions.

Required information is denoted with a red asterisk \*

Professional Claim Submission Form Help

Claim Information

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

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

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 \* 2 3 4 5 6

7 8 9 10 11 12

Claim Details

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

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

Total Charges: \$  Add

# Claim Information Questions

Complete all required fields and questions.

Required information is denoted with a red asterisk \*

Click **Save and Continue**.

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:

Select ▼

First date related to Member's condition:

Select ▼

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



# Claim Adjustment Question

Select Yes to complete a claim adjustment.

Select Replacement or Void claim.

Enter Original ICN.

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

Select the Medicaid Resubmission Code:\*

Enter the Original MMIS ICN:\*

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

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

# Primary Insurance EOB

- Answer Yes to this question, only if you have received payment from a primary insurance. Do not use for Medicare payments.
- If you have a primary EOB but they did not pay, do not use this screen.
- For Medicare payments or Zero payment EOBs, skip this step and proceed to the attachment question.

Are you submitting COB at the claim level?

☒ Yes ☐ No

| Primary Payer           |            |        | Secondary Payer         |            |        |
|-------------------------|------------|--------|-------------------------|------------|--------|
| Insurance Type:*        | Select     | ▼      | Insurance Type:         | Select     | ▼      |
| Carrier Name:*          |            |        | Carrier Name:           |            |        |
| Carrier Code:           |            |        | Carrier Code:           |            |        |
| Subscriber First Name:* |            |        | Subscriber First Name:  |            |        |
| Subscriber Middle Name: |            |        | Subscriber Middle Name: |            |        |
| Subscriber Last Name:*  |            |        | Subscriber Last Name:   |            |        |
| Allowed:                | \$         |        | Allowed:                | \$         |        |
| Copay:                  | \$         |        | Copay:                  | \$         |        |
| Deductible:             | \$         |        | Deductible:             | \$         |        |
| Coinsurance:            | \$         |        | Coinsurance:            | \$         |        |
| Paid Amount:*           | \$         |        | Paid Amount:            | \$         |        |
| Group                   | Reason     | Amount | Group                   | Reason     | Amount |
|                         |            | \$     |                         |            | \$     |
|                         |            | \$     |                         |            | \$     |
|                         |            | \$     |                         |            | \$     |
| EOB Payment Date:*      | MM/DD/YYYY |        | EOB Payment Date:       | MM/DD/YYYY |        |

# Electronic Claim Attachments

Do you have attachments for this claim? \*

☒ Yes ☐ No

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

Report Code Type: \*

Transmission Code: \*

Control Number: \*

Select ▼

Select ▼

Attachments

Add

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

**Transmission Code:** Select Electronic submission.

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

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

Report Code Type: \*

Transmission Code: \*

Control Number: \*

EB-Explanation of Benefi ▼

FT-Electronic Attachmen ▼

Attachments



Add

# Final Submission

Check the box to certify that you have read the 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.

Submit

Previous

Save and Exit

Cancel

# Bulk HIPAA Transactions

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

## ▼ Bulk HIPAA Transactions activity

[? Help](#)

Filter your results:

ACTIONS

TRANSACTION DATE



FILE NAME



No matching transactions found.

Show  entries

Showing 0 to 0 of 0 entries

| < > |

Upload

# Bulk HIPAA Transactions Cont.

File Upload



NPI/API: 1427003862

File Type: Claim Submission (837) ▼

Browse

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

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

Upload

Cancel

Questions?

# MPATH Portal Additional Features

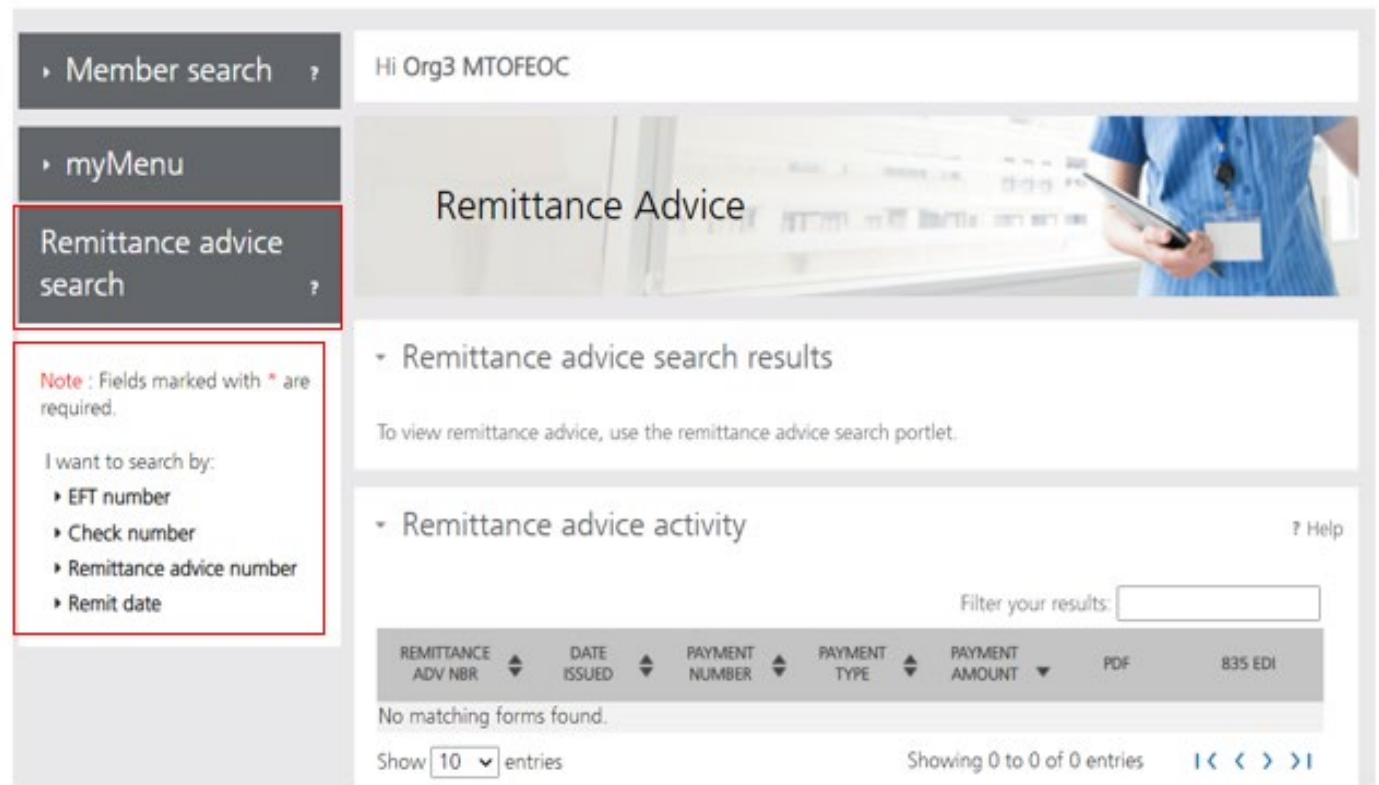
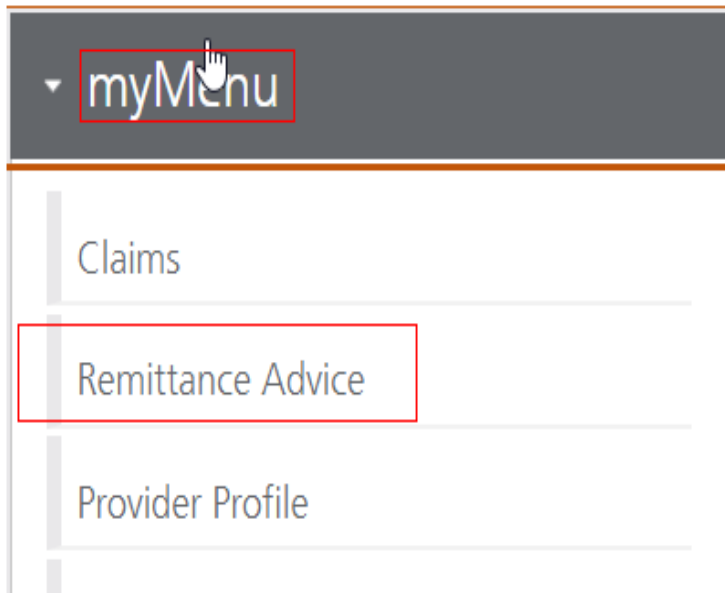


# Remittance Advice- e!Sor

---

- Remits can be found on the Provider Services Portal back rolling 12 month
- Information about upcoming events and provider type specific updates.
- Sections for paid claims, denied claims, and pending claims.
- Includes any adjusted claims, voids or credit balance claims.
- Includes the Internal Claim Number(ICN).

# Remittance Advice



# Remits Search

I want to search by:

▼ EFT number

Enter EFT number: \*

▼ Check number


Enter check number: \*

▼ Remittance advice number


Enter remittance advice number: \*

▼ Remit date

From Date(mm/dd/yyyy): \*

09/02/2021 

To Date(mm/dd/yyyy): \*

12/01/2021 

Search

# Remits Results

Filter your results:

| REMITTANCE ADV NBR | DATE ISSUED | PAYMENT NUMBER | PAYMENT TYPE | PAYMENT AMOUNT | PDF                  | 835 EDI                  |
|--------------------|-------------|----------------|--------------|----------------|----------------------|--------------------------|
| C                  | 09/27/2021  | 01             | Check        | \$1150550.83   | <a href="#">View</a> | <a href="#">Download</a> |
| O                  | 09/27/2021  | 01             | Check        | \$246077.51    | <a href="#">View</a> | <a href="#">Download</a> |
| O                  | 09/27/2021  | 01             | Check        | \$94875.42     | <a href="#">View</a> | <a href="#">Download</a> |
| O                  | 09/20/2021  | 01             | Check        | \$14843.00     | <a href="#">View</a> | <a href="#">Download</a> |
| O                  | 09/27/2021  | 01             | Check        | \$7195.51      | <a href="#">View</a> | <a href="#">Download</a> |
| O                  | 09/06/2021  | 01             | Check        | \$1572.51      | <a href="#">View</a> | <a href="#">Download</a> |
| O                  | 09/13/2021  | 01             | Check        | \$520.36       | <a href="#">View</a> | <a href="#">Download</a> |

Show  entries

Showing 1 to 7 of 7 forms

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

VENDOR # 0001 REMIT ADVISE # 81 EFT/CHK #01 DATE 09/27/2021 PAGE 2  
NPI #: 121 TAXONOMY:

| RECIP ID                          | NAME    | SERVICE FROM | DATES TO | UNIT OF SVC | PROCEDURE REVENUE NDC | TOTAL CHARGES | ALLOWED | CO-PAY | REASON & REMARK CODES |
|-----------------------------------|---------|--------------|----------|-------------|-----------------------|---------------|---------|--------|-----------------------|
| PAID CLAIMS - MISCELLANEOUS CLAIM |         |              |          |             |                       |               |         |        |                       |
| ICN 22                            | PATIENT | 07012021     | 07312021 | 1.000       | S5141                 | 2453.93       | 2453.93 |        |                       |
| TEAM NUMBER 01                    |         |              |          |             |                       |               |         |        |                       |
| ***CLAIM TOTAL*****               |         |              |          |             |                       | 2453.93       | 2453.93 |        |                       |
| ICN 221                           | PATIENT | 08012021     | 08312021 | 1.000       | S5141                 | 2453.93       | 2453.93 |        |                       |
| TEAM NUMBER 01                    |         |              |          |             |                       |               |         |        |                       |
| ***CLAIM TOTAL*****               |         |              |          |             |                       | 2453.93       | 2453.93 |        |                       |
| ICN 221                           | PATIENT | 07012021     | 07312021 | 1.000       | T2032                 | 767.70        | 767.70  |        |                       |
| TEAM NUMBER 01                    |         |              |          |             |                       |               |         |        |                       |
| ***CLAIM TOTAL*****               |         |              |          |             |                       | 767.70        | 767.70  |        |                       |
| ICN 221                           | PATIENT | 07012021     | 07312021 | 5.000       | S5135                 | 115.50        | 115.50  |        |                       |
| TEAM NUMBER 01                    |         |              |          |             |                       | 883.20        | 883.20  |        |                       |
| ***CLAIM TOTAL*****               |         |              |          |             |                       | 883.20        | 883.20  |        |                       |
| ICN 221                           | PATIENT | 08012021     | 08312021 | 1.000       | T2032                 | 767.70        | 767.70  |        |                       |
| TEAM NUMBER 01                    |         |              |          |             |                       |               |         |        |                       |
| ***CLAIM TOTAL*****               |         |              |          |             |                       | 767.70        | 767.70  |        |                       |
| ICN 2212                          | PATIENT | 08012021     | 08312021 | 5.000       | S5135                 | 115.50        | 115.50  |        |                       |
| TEAM NUMBER 01                    |         |              |          |             |                       | 883.20        | 883.20  |        |                       |
| ***CLAIM TOTAL*****               |         |              |          |             |                       | 883.20        | 883.20  |        |                       |
| ICN 2212                          | PATIENT | 07012021     | 07312021 | 8.000       | T2021                 | 782.48        | 782.48  |        |                       |
| TEAM NUMBER 01                    |         |              |          |             |                       |               |         |        |                       |
| ***CLAIM TOTAL*****               |         |              |          |             |                       | 782.48        | 782.48  |        |                       |

# Remittance

|   |                      |                  |                        |
|---|----------------------|------------------|------------------------|
| AS OF 02/08/2024  |                      | HELENA, MT 59604 |                        |
| REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP  |                      |                  |                        |
|   |                      | Provider Name    |                        |
|   |                      | Address          |                        |
| VENDOR #  | REMIT ADVICE #       | EFT/CHK #        | DATE 02/12/2024 PAGE 1 |
| NPI #:  | TAXONOMY: 282N00000X |                  |                        |
| - NEWSLETTER UPDATE -   |                      |                  |                        |
| PLEASE CHECK OUT THE PROVIDER INFORMATION WEBSITE,<br>HTTPS://MEDICAIDPROVIDER.MT.GOV/, FOR NEW AND UPDATED PROVIDER<br>NOTICES, CLAIM JUMPER NEWSLETTERS, FEE SCHEDULES, PROVIDER MANUALS,<br>TRAINING, AND OTHER RESOURCES.                                   |                      |                  |                        |
| WE ARE SEEING A HIGH VOLUME OF CLAIMS POSTING DUPLICATE CLAIM ERRORS.<br>PLEASE MAKE SURE YOU DO NOT HAVE MULTIPLE CLAIMS FOR THE SAME MEMBER,<br>DATE OF SERVICE, AND SERVICE(S). ATTENTION TO THIS LEVEL OF DETAIL WILL<br>HELP REDUCE CLAIM PROCESSING TIME. |                      |                  |                        |

# Paid Claims

|                               |                 |                      |          |                    |                       |               |            |        |                       |
|-------------------------------|-----------------|----------------------|----------|--------------------|-----------------------|---------------|------------|--------|-----------------------|
| VENDOR #                      |                 | REMIT ADVICE #       |          | EFT/CHK #018077531 |                       | DATE          | 02/12/2024 | PAGE   | 2                     |
| NPI #:                        |                 | TAXONOMY: 282N00000X |          |                    |                       |               |            |        |                       |
| RECIP ID                      | NAME            | SERVICE FROM         | DATES TO | UNIT OF SVC        | PROCEDURE REVENUE NDC | TOTAL CHARGES | ALLOWED    | CO-PAY | REASON & REMARK CODES |
| PAID CLAIMS - INPATIENT CLAIM |                 |                      |          |                    |                       |               |            |        |                       |
| ICN                           |                 | 01042024             | 01252024 | 6.000              | 124                   | 17359.50      | 0.00       |        |                       |
|                               | PATIENT NUMBER= |                      |          |                    |                       |               |            |        |                       |
| DRG CODE 0753-2 DRG           |                 |                      |          |                    |                       |               |            |        |                       |
|                               |                 | 01042024             | 01252024 | 16.000             | 204                   | 59332.00      | 0.00       |        |                       |
|                               |                 | 01042024             | 01252024 | 347.000            | 259                   | 3999.87       | 0.00       |        |                       |
|                               |                 | 01042024             | 01252024 | 11.000             | 300                   | 1817.75       | 0.00       |        |                       |
|                               |                 | 01042024             | 01252024 | 1.000              | 306                   | 112.00        | 0.00       |        |                       |
|                               |                 | 01042024             | 01252024 | 1.000              | 450                   | 1942.25       | 0.00       |        |                       |
|                               |                 | 01042024             | 01252024 | 9.000              | 636                   | 261.00        | 0.00       |        |                       |
|                               |                 | ***CLAIM TOTAL*****  |          |                    |                       | 84824.37      | 5578.90    |        |                       |

# Claims Pending

|                     |                 |                      |          |             |                       |                 |         |         |                       |
|---------------------|-----------------|----------------------|----------|-------------|-----------------------|-----------------|---------|---------|-----------------------|
| VENDOR #            |                 | REMIT ADVICE #       |          | EFT/CHK #   |                       | DATE 02/12/2024 |         | PAGE 21 |                       |
| NPI #:              |                 | TAXONOMY: 282N00000X |          |             |                       |                 |         |         |                       |
| RECIP ID            | NAME            | SERVICE FROM         | DATES TO | UNIT OF SVC | PROCEDURE REVENUE NDC | TOTAL CHARGES   | ALLOWED | CO-PAY  | REASON & REMARK CODES |
| CLAIMS PENDING:     |                 | INPATIENT CLAIM      |          |             |                       |                 |         |         |                       |
| ICN                 |                 | 10172023             | 10222023 | 1.000       | 120                   | 2038.50         | 0.00    |         |                       |
|                     | PATIENT NUMBER= |                      |          |             |                       |                 |         |         |                       |
| DRG CODE 0560-3 DRG |                 | 10172023             | 10222023 | 4.000       | 122                   | 8154.00         | 0.00    |         |                       |
|                     |                 | 10172023             | 10222023 | 72.000      | 259                   | 1232.42         | 0.00    |         |                       |
|                     |                 | 10172023             | 10222023 | 2.000       | 270                   | 472.50          | 0.00    |         |                       |
|                     |                 | 10172023             | 10222023 | 1.000       | 271                   | 124.25          | 0.00    |         |                       |
|                     |                 | 10172023             | 10222023 | 19.000      | 300                   | 2229.00         | 0.00    |         |                       |
|                     |                 | 10172023             | 10222023 | 1.000       | 351                   | 2067.75         | 0.00    |         |                       |
|                     |                 | 10172023             | 10222023 | 1.000       | 611                   | 2341.25         | 0.00    |         |                       |
|                     |                 | 10172023             | 10222023 | 1.000       | 615                   | 2143.50         | 0.00    |         |                       |
|                     |                 | 10172023             | 10222023 | 101.000     | 636                   | 2125.94         | 0.00    |         |                       |
|                     |                 | 10172023             | 10222023 | 1.000       | 720                   | 4088.50         | 0.00    |         |                       |
|                     |                 | 10172023             | 10222023 | 22.000      | 721                   | 5263.50         | 0.00    |         |                       |
| ***CLAIM TOTAL***** |                 |                      |          |             |                       | 32281.11        | 0.00    |         | 133                   |

# Denied Claims

| RECIP ID                         | NAME            | SERVICE FROM        | DATES TO | UNIT OF SVC | PROCEDURE REVENUE NDC | TOTAL CHARGES | ALLOWED | CO-PAY | REASON & REMARK CODES |
|----------------------------------|-----------------|---------------------|----------|-------------|-----------------------|---------------|---------|--------|-----------------------|
| DENIED CLAIMS - OUTPATIENT CLAIM |                 |                     |          |             |                       |               |         |        |                       |
| ICN                              | PATIENT NUMBER= | 12122022            | 12122022 | 2.000       | 259                   | 40.00         | 0.00    |        |                       |
|                                  |                 | OUTPATIENT GROUP 00 |          |             |                       |               |         |        |                       |
| ICN                              | PATIENT NUMBER= | 12122022            | 12122022 | 4.000       | 310                   | 1500.00       | 0.00    |        |                       |
|                                  |                 | 12122022            | 12122022 | 7.000       | 310                   | 2625.00       | 0.00    |        | 119 M53               |
|                                  |                 | 12122022            | 12122022 | 1.000       | 312                   | 290.50        | 0.00    |        |                       |
|                                  |                 | 12122022            | 12122022 | 6.000       | 312                   | 1743.00       | 0.00    |        |                       |
|                                  |                 | 12122022            | 12122022 | 60.000      | 636                   | 95.19         | 0.00    |        |                       |
|                                  |                 | 12122022            | 12122022 | 1.000       | 750                   | 2273.00       | 0.00    |        |                       |
|                                  |                 | ***CLAIM TOTAL***** |          |             |                       | 8566.69       | 0.00    |        | 29                    |
|                                  |                 | 01212024            | 01212024 | 1.000       | 300                   | 78.25         | 0.00    |        |                       |
| ICN                              | PATIENT NUMBER= | OUTPATIENT GROUP 00 |          |             |                       |               |         |        |                       |
|                                  |                 | 01212024            | 01212024 | 1.000       | 300                   | 85.00         | 0.00    |        |                       |
| ICN                              | PATIENT NUMBER= | ***CLAIM TOTAL***** |          |             |                       | 163.25        | 0.00    |        | 31                    |



# Total Warrant Amount

| VENDOR #  |                 | REMIT ADVICE #  |          | EFT/CHK #     |                       | DATE 02/12/2024     |                | PAGE 631 |                       |
|---|-----------------|---|----------|---------------|-----------------------|---------------------|----------------|----------|-----------------------|
| NPI #:  |                 | TAXONOMY: 282N00000X  |          |               |                       |                     |                |          |                       |
| RECIP ID  | NAME            | SERVICE FROM  | DATES TO | UNIT OF SVC   | PROCEDURE REVENUE NDC | TOTAL CHARGES       | ALLOWED        | CO-PAY   | REASON & REMARK CODES |
| CLAIMS PENDING: MEDICARE OUTPATIENT CROSSOVER                           |                 |   |          |               |                       |                     |                |          |                       |
| ICN   | PATIENT NUMBER= | 06192023  | 06192023 | 1.000         | 300                   | 27.00               | 0.00           |          |                       |
|   |                 | 06192023  | 06192023 | 1.000         | 510                   | 129.44              | 0.00           |          |                       |
|   |                 | *** MEDICARE PAYMENT*****   |          |               |                       |                     | 101.47         |          |                       |
|   |                 | ***CLAIM TOTAL*****   |          |               |                       | 156.44              | 0.00           |          | 133                   |
| OUR RECORDS INDICATE THAT THE RECIPIENT LISTED ABOVE HAS INSURANCE WITH |                 |   |          |               |                       |                     |                |          |                       |
|   |                 | UNITED HEALTHCARE<br>SPRINGFIELD SERVICE CENTER<br>P O BOX 740800<br>ATLANTA, GA<br>30374-0800<br>POLICY #:<br>SUBSCRIBER NAME: |          |               |                       |                     |                |          |                       |
|   |                 |   |          | GROUP CERT #: |                       | SUBSCRIBER SSN:     |                |          |                       |
| ICN   | PATIENT NUMBER= | 11102023  | 11102023 | 1.000         | 510                   | 129.44              | 0.00           |          | 133                   |
|   |                 | *** MEDICARE PAYMENT*****   |          |               |                       |                     | 101.47         |          |                       |
|   |                 | ***CLAIM TOTAL*****   |          |               |                       | 129.44              | 0.00           |          | 133                   |
| ICN   | PATIENT NUMBER= | 01092024  | 01092024 | 1.000         | 300                   | 67.25               | 0.00           |          |                       |
|   |                 | 01092024  | 01092024 | 1.000         | 300                   | 70.75               | 0.00           |          |                       |
|   |                 | 01092024  | 01092024 | 1.000         | 300                   | 60.75               | 0.00           |          |                       |
|   |                 | *** MEDICARE PAYMENT*****   |          |               |                       |                     | 31.23          |          |                       |
|   |                 | ***CLAIM TOTAL*****   |          |               |                       | 198.75              | 0.00           |          | 133                   |
| **CLAIMS PENDING TOTALS -MEDICARE OUTPATIENT                            |                 |   |          |               |                       | **NUMBER OF CLAIMS- | 47** 145357.81 | 0.00     |                       |
| ***TOTAL WARRANT AMOUNT***  |                 |   |          |               |                       |                     | 522768.96      |          |                       |

# Reason and Remark Codes

| RECIP ID   | NAME  | SERVICE FROM | DATES TO | UNIT OF SVC | PROCEDURE REVENUE NDC | TOTAL CHARGES | ALLOWED | CO-PAY | REASON & REMARK CODES |
|--|---|--------------|----------|-------------|-----------------------|---------------|---------|--------|-----------------------|
| *****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE ***** |   |              |          |             |                       |               |         |        |                       |
| B13  | Previously paid. Payment for this claim/service may have been provided in a previous payment.   |              |          |             |                       |               |         |        |                       |
| B5   | Coverage/program guidelines were not met or were exceeded.  |              |          |             |                       |               |         |        |                       |
| MA04   | Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. |              |          |             |                       |               |         |        |                       |
| MA30   | Missing/incomplete/invalid type of bill.  |              |          |             |                       |               |         |        |                       |
| MA66   | Missing/incomplete/invalid principal procedure code.  |              |          |             |                       |               |         |        |                       |
| M119   | Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).   |              |          |             |                       |               |         |        |                       |
| M123   | Missing/incomplete/invalid name, strength, or dosage of the drug furnished.   |              |          |             |                       |               |         |        |                       |
| M2   | Not paid separately when the patient is an inpatient.   |              |          |             |                       |               |         |        |                       |
| M20  | Missing/incomplete/invalid HCPCS.   |              |          |             |                       |               |         |        |                       |
| M50  | Missing/incomplete/invalid revenue code(s).   |              |          |             |                       |               |         |        |                       |
| M53  | Missing/incomplete/invalid days or units of service.  |              |          |             |                       |               |         |        |                       |
| M62  | Missing/incomplete/invalid treatment authorization code.  |              |          |             |                       |               |         |        |                       |
| M67  | Missing/incomplete/invalid other procedure code(s).   |              |          |             |                       |               |         |        |                       |
| M81  | You are required to code to the highest level of specificity.   |              |          |             |                       |               |         |        |                       |
| M86  | Service denied because payment already made for same/similar procedure within set time frame.   |              |          |             |                       |               |         |        |                       |
| N10  | Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.                          |              |          |             |                       |               |         |        |                       |
| N192   | Patient is a Medicaid/Qualified Medicare Beneficiary.   |              |          |             |                       |               |         |        |                       |
| N286   | Missing/incomplete/invalid referring provider primary identifier.   |              |          |             |                       |               |         |        |                       |
| N3   | Missing consent form.   |              |          |             |                       |               |         |        |                       |
| N30  | Patient ineligible for this service.  |              |          |             |                       |               |         |        |                       |
| N378   | Missing/incomplete/invalid prescription quantity.   |              |          |             |                       |               |         |        |                       |
| N45  | Payment based on authorized amount.   |              |          |             |                       |               |         |        |                       |
| N54  | Claim information is inconsistent with pre-certified/authorized services.   |              |          |             |                       |               |         |        |                       |
| 119  | Benefit maximum for this time period or occurrence has been reached.  |              |          |             |                       |               |         |        |                       |
| 125  | Submission/billing error(s). At least one Remark Code must be provided (  |              |          |             |                       |               |         |        |                       |

# Adjustments

# Electronic vs Paper Claim Adjustments

---

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

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

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

When submitting an electronic replacement claim:

1. Include all charge lines, including lines that paid correctly.
2. No additional paperwork is required.
3. Call Center can NOT see who submitted & why.

# Adjustment Tips

---

- Cannot adjust denied claims.
- Claims cannot be electronically adjusted more than 12 months from the paid date. These will reject. Claims needing to be adjusted past this time frame must be sent via a paper IAR form.
- If a claim was previously adjusted, you must use the most recent paid ICN.
- If you have a claim that is split, please use a Paper Adjustment form and put both ICN's on the adjustment form

# Electronic Claim Adjustments

Electronic Adjustments are now accepted by Montana Medicaid. There will be 2 options for submitting an electronic adjustment.

## **Acceptable frequency codes:**

- 1 Indicates the claim is an original claim.
- 7 Indicates the new claim is a replacement or corrected claim – the information present on this claim represents a complete replacement of the previously issued claim.
- 8 Indicates the claim is a voided/canceled claim

## ***All claim types***

Loop 2300 - (CLM05-3) is the Claim Frequency Code. Enter 7 or 8.

REF\*F8\* - Enter the original ICN.

# Electronic Claim Adjustments Cont.

---

## **MPATH Claims Solutions**

Create a new claim with the corrected information to include the correctly paid lines. If you are voiding the claim, claim information must match original claim.

## ***Professional Claims (CMS-1500) & Dental Claims***

Answer YES, to the first question at the bottom of the claim entry screen. The next two fields are now visible.

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

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

# Claim Adjustments Cont.

---

- Original Reference Number must be a valid paid claim ICN.
- Cannot adjust denied claims.

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

☒ Yes ☐ No

Select the Medicaid Resubmission Code:\*

▼

Enter the Original Reference Number:\*



# Claim Adjustments for Institutional Claims

## ***Institutional Claims (UB-04)***

When recreating the claim, change the last digit of the Type of Bill code to either **7 for replacement** or **8 for void**.

The Original Reference Number filed is now visible. Enter the Paid ICN of the claim being adjusted in the Original Reference Number field.

|                                   |                                     |                               |                               |                                     |                               |
|-----------------------------------|-------------------------------------|-------------------------------|-------------------------------|-------------------------------------|-------------------------------|
| Type of Bill:*                    | Inpatient or Outpatient:*           | Statement Period From:*       | Statement Period Through:*    |                                     |                               |
| <input type="text" value="0117"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> |                                     |                               |
| Admission Date:                   | Admission Hour:                     | Admission Type:*              | Source of Admission:*         | Discharge Hour:                     | Member Discharge Status:*     |
| <input type="text" value=""/>     | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="Select"/> | <input type="text" value=""/> |
| Original Reference Number:*       |                                     |                               |                               |                                     |                               |
| <input type="text" value=""/>     |                                     |                               |                               |                                     |                               |

Questions?

# Common Billing Errors

# Common Billing Errors

---

- Missing/Invalid Information
- Prior Authorization Number Missing or Invalid
- Exact Duplicate
- Proc. Code or Rev Code Not Covered/Not Allowed for Provider Type
- Recipient Not Eligible DOS
- Missing primary EOB
- Using the incorrect modifier for a provider type (HCBS vs SDMI)

# Additional Resources

# Need Help with MPATH?

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



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

# Online Resources

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<https://medicaidprovider.mt.gov>

## Claims Information Page

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

## Other Pages

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

# Provider Relations Contact Information

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Provider Relations Call Center:

(800) 624-3958

Monday through Friday

8 AM to 5 PM Mountain Time

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



# Email Assistance

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- The [MTPRhelpdesk@conduent.com](mailto:MTPRhelpdesk@conduent.com) can be used for generic questions. Questions related to specific member information or specific claims must be directed to the Call Center. Emails must not contain PHI.
- If you have specific questions regarding an enrollment in process or to follow up on missing documentation, please email [MTEnrollment@conduent.com](mailto:MTEnrollment@conduent.com). Make sure to include the NPI, name, and confirmation number of the enrollment in question.
- Secured emails are not accepted.

# MPATH Portal Help

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For technical assistance with the Provider Services portal (MPATH)

Email the following to [MTPRhelpdesk@conduent.com](mailto:MTPRhelpdesk@conduent.com) so we can submit a help ticket to our Tech Team.

**GovID:**

**Name:**

**Email registered:**

**NPI used to register:**

**Phone number:**

**A full screen, screen shot of the error:**

For issues registering, please provide screen shots of both the Details tab and Review tab showing all information entered and any error messages.

\*Include the issue and function you're attempting.

Questions?

# Thank you!