General Resources

May 06, 2026

Presented by Loma Romero,

Provider Relations Field Representative

Roll Call

- We want to get to know our Community in Chat or Introduce yourself
- Your name
- The name of your company
- Who are your representing

Objectives

- Website navigation
- Where to find forms and training materials
- How to fill out an individual adjustment request form
- How to read a remittance advice

General Website Resources

Website

https://medicaidprovider.mt.gov/

- Home Page
- Resources by Provider Type
- Provider Enrollment
- Subscribe to Claim Jumper
- Site Index

Home Page

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- Provider Services Portal
- Provider Information
- Online Training Availability
- Announcements
- Forms
- Claim Instructions
- Claim *Jumper* Newsletters

Welcome to the Montana Healthcare Programs Provider Information Website.

Provider Services Portal | COVID-19 Provider Information and Notices

To register for upcoming Online Training and access to previous Training PowerPoints, please visit the Training page at https://medicaidprovider.mt.gov/training.

Recent Website Posts | Announcements | Forms | Claim Instructions | *Claim Jumper* Newsletters

Resources by Provider Type

Providers are listed in alphabetical order

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- COVID-19 Provider Information
- Online Services
- Resources by Provider Type
- Provider Enrollment
- Subscribe to Claim Jumper
- Site Search
- Site Index

Select Your Provider Type

Provider types are listed in alphabetical order. Available resources include fee schedules, provider notices, provider manuals, and more.

A - C | D - F | G - K | L - O | P -Q | R - Z

Providers A - C

- Ambulance
- Ambulatory Surgical Center
- Applied Behavior Analysis Services
- Audiologist
- Big Sky Waiver
- Chiropractor (Children's)
- Chiropractor (QMB)
- Clinic (Public Health)
- Clinical Pharmacist
- Community First Choice Services and Personal Care Services (CFCS/PCS)

Providers D - F

Providers L - O

- Laboratory Services
- Licensed Addiction Counselor
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor
- Mental Health Center
- Mid-Level Practitioner
- Mobile Imaging
- Nursing Facility
- Nutritionist (EPSDT)
- Occupational Therapist
- Optician
- Optometric
- Oral Surgeon

Resources by Provider Type

Providers are listed in alphabetical order

Mental Health Center

Prior Authorization | Forms | *Claim Jumper* Newsletters

- Provider Manuals
- Medicaid Rules and Regulations
- Fee Schedules – 72-Hour Presumptive
- Fee Schedules – Medicaid Mental Health Adults 18 and Over
- Fee Schedule - Medicaid Mental Health Youth Under 18
- Fee Schedules – Mental Health Services Plan (MHSP) Adults 18 and Over
- Fee Schedules – Non-Medicaid Mental Health Adults 18 and Over
- Provider Notices
- Other Resources

Provider Enrollment

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Individual Providers

Montana Medicaid has three enrollment types for individual providers:

- Sole Proprietor Provider
- Rendering Provider
- Ordering/Referring/Prescribing Provider

These enrollment types have different functions and requirements.

Sole Proprietor Provider

A provider who owns their own business and the associated tax ID.

They will be used as the pay-to provider on a claim, and they are the direct recipient of payment from Montana Healthcare Programs.

This enrollment type is appropriate for individuals who own their own practice and do not employ other individuals. Providers who are sole proprietors can also work part-time at another organization and be used as a rendering provider on the organization's claims. However, they do not need to add a location to their sole proprietor enrollment for the other organization for whom they are working.

Individual providers who are sole proprietor providers are not allowed to share a tax ID with an organization NPI or another individual NPI. Any individual providers currently enrolled under a shared tax ID with an organization or individual would need to be disenrolled and reenrolled.

Enrollment Support Information

- Enrollment Support Forms
- Enrollment Training Materials and User Guides
- Enrollment FAQs
- New Provider Resources
- Revalidation

- COVID-19 Provider Information
- Online Services
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Subscribe to Claim Jumper

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COVID-19 Provider Information

Online Services

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Claim Jumper Registration

The ***Claim Jumper*** is published on or near the last day of each month. Registering your email will allow you to receive the publication directly to your inbox as well as occasional announcements applicable to most providers. Your email will not be shared or sold at any time.

To Subscribe:

- Enter your email in the box below.
- On the next screen, confirm your email.
- You will begin receiving the Claim Jumper on the next publication date.

To Unsubscribe:

- Enter the email address receiving the Claim Jumper in the box below.
- On the next screen choose "Subscriber Preferences".
- On the next screen choose "Check to Delete" Then "Submit" You will be immediately unsubscribed.

Email Updates

To sign up for updates or to access your subscriber preferences, please enter your contact information below.

*Email Address

Submit

MONTANA DPHHS

Claim Jumper

Montana Healthcare Programs Claim Jumper — February 2024 Volume XXXIX, Issue 2

In This Issue

Training for Caregivers of Those with Dementia

Training for Caregivers of Those with Dementia

Caregivers of people with Alzheimer's disease and related dementias often experience unique challenges.

The Office for the Study of Aging Arnold School of Public Health University of Carolina is offering a 5-module training course designed to educate vers (formal as well as informal) for person who exhibit signs and oms of Alzheimer's disease and related dementias (ADRD).

modules cover valuable information and contain recommendations ng an overview of dementia, effective communication strategies, standing the environment, and ways to promote independence. The es also cover how to address challenging behaviors and creative m solving. Dementia Dialogues is offered nationwide.

nformation can be found on the Office for the Study of Aging website.

Submitted by Michelle Christensen
Section Supervisor
Community Services Bureau

Site Index

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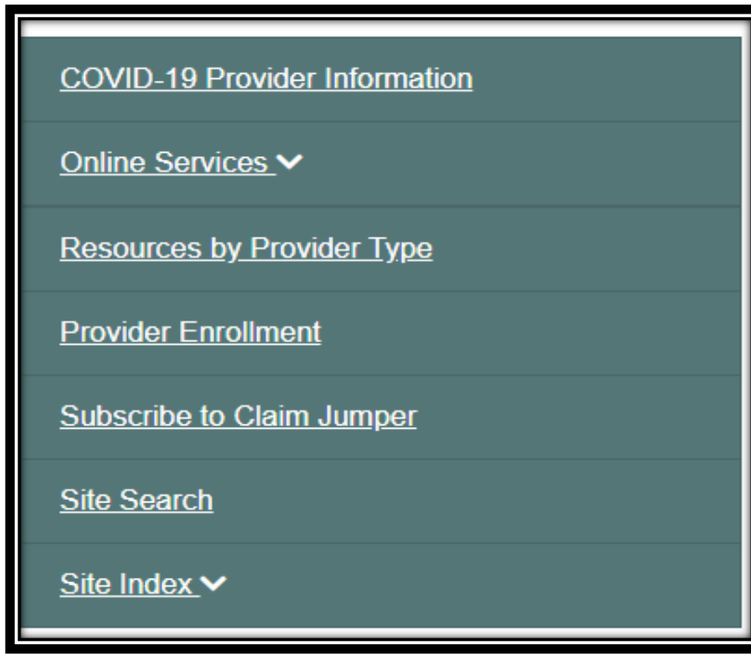
- Claim Instructions
- Contact Us
- FAQs
- Passport to Health
- Preferred Drug List
- Prior Authorization
- Provider Locator Search
- RBRVS



Questions?

Submitting Adjustments

When should I request an adjustment?

- Claim was overpaid or underpaid.
- Claim was paid but the information on the claim was incorrect (e.g., member ID, provider number, date of service, procedure code, diagnoses, units).
- Individual line is denied on a multiple-line UB-04 claim. The claim must be submitted as an adjustment rather than a rebill.
- Note: when doing an adjustment for rate changes, bill for the new total amount – not the difference between prior payment and new rate amount.

Adjustment Requirements

- Adjustments may be submitted electronically or using Individual Adjustment Request (IAR) form. (Electronically is more efficient and reliable)
- Only be submitted on paid claims; denied claims cannot be adjusted.
- Always use most recent paid ICN on adjustments.
- Always require a remit from the paid claim when using **paper adjustment form**.
- Claims Processing must receive individual claim adjustments within 15 months from the date of Payment for **paper** adjustments. After this time, gross adjustments are required via DPHHS.

Using the IAR form

- Separate adjustment request form for each ICN.
- If correcting more than one error per ICN, use only one adjustment request form and include each error on the form.
- If there is not enough space on the form to detail the corrections needed, use box 8 to indicate processed attached claim and attach a new claim to the IAR form.

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Electronic Claim Submission through Clearinghouse

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 **PAID** 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.

Adjustment Request Form

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One adjustment form per Internal Control Number

Section A – Must be completely filled out

Section B – Only the info that needs changing

MONTANA DPHHS

Montana Healthcare Programs

Medicaid • Mental Health Services Plan • Healthy Montana Kids

Individual Adjustment Request

Instructions:

This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A with information about the paid claim from your remittance statement. Complete **only** the items in Section B that represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in the *General Information for Providers* manual or call Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1837 (Helena).

A. Complete all fields using the remittance advice for information.

1. Provider Name, Address, and Telephone Number
   - Name
   - Street or P.O. Box
   - City State ZIP
   - Telephone Number
2. Member Name
3. Internal Control Number (ICN)
4. NPI/API
5. Member ID Number
6. Date of Payment
7. Amount of Payment $

B. Complete only the items which need to be corrected.

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			

8. Other/Remarks (Be specific.)

Signature _____ Date _____

When the form is completed and signed, attach a copy of the remittance advice and a copy of the corrected claim, and mail to Claims, P.O. Box 8000, Helena, MT 59604, or fax to 406.442.4402.

Adjustment Request Form - Section A

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Completing an Individual Adjustment Request Form – Section A

Field	Description
1. Provider Name and Address	Provider’s name and address (and mailing address if different).
2. Name	The member’s name
3. Internal Control Number (ICN)	There can be only one ICN per Adjustment Request Form. When adjusting a claim that has been previously adjusted, use the ICN of the most-recent claim.
4. Provider number	The provider’s NPI/API.
5. Member Medicaid Number	Member’s Medicaid ID number.
6. Date of Payment	Date claim was paid.
7. Amount of Payment	The amount of payment from the remittance advice.

Adjustment Request Form - Section B

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Completing an Individual Adjustment Request Form – Section B

Field	Description
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/NDC Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (DOS)	If the date of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Facility)	If the member's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the member's insurance credit amount is incorrect, complete this line.
7. Net (Billed - TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply or if unsure what caused the payment error, complete this line.

Questions?

How to Read a Remittance Advice

Remittance Advice- e!Sor

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- Remits can be found on the MPATH portal for rolling 12 months.
- Information about upcoming events and provider type specific updates.
- Sections for paid claims, denied claims, and pending claims.
- Includes any takebacks or credit balance claims.
- Includes the Internal Claim Number(ICN).

Remittance

AS OF 05/08/2025 HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

Provider·Name¶
Address·line·1¶
Address·line·2¶
City,·State·Zip¶

VENDOR # EU¶ REMIT ADVICE # ### EFT/CHK # ####¶ DATE 05/12/2025 PAGE 1
NPI #: XXXXXXXXXX¶ TAXONOMY: 193400000X

- NEWSLETTER UPDATE -

DDP AND DPHHS ARE MAKING A FREE TRAINING OPPORTUNITY AVAILABLE FOR MEDICAID PROVIDERS INTERESTED IN BETTER UNDERSTANDING THE SPECIAL HEALTH CARE NEEDS OF MEMBERS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. TRAINING IS SELF-PACED. EARN CME OR CEU CREDITS. FOR DETAILS, SEE THE BHDD WEBPAGE, HTTPS://DPHHS.MT.GOV/BHDD/DISABILITYSERVICES/DEVELOPMENTALDISABILITIES/DDPTRAINING.

Paid Claims

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VENDOR #            REMIT ADVICE #        EFT/CHK #018077531 DATE  02/12/2024    PAGE     2
NPI #:                TAXONOMY: 282N00000X

                                                UNIT   PROCEDURE
                                SERVICE   DATES   OF     REVENUE          TOTAL              CO-
RECIP ID        NAME              FROM     TO    SVC        NDC          CHARGES    ALLOWED  PAY  REASON & REMARK CODES

 PAID CLAIMS - INPATIENT CLAIM

                                01042024 01252024    6.000    124        17359.50       0.00
  ICN                     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

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```
VENDOR #            REMIT ADVICE #        EFT/CHK #          DATE  02/12/2024    PAGE    21
NPI #:                TAXONOMY: 282N00000X

                                                UNIT   PROCEDURE
                                SERVICE   DATES    OF     REVENUE        TOTAL            CO-
RECIP ID        NAME              FROM     TO     SVC        NDC        CHARGES   ALLOWED  PAY  REASON & REMARK CODES

 CLAIMS PENDING:     INPATIENT CLAIM

                                10172023 10222023    1.000    120       2038.50      0.00
  ICN                   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

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                                                UNIT   PROCEDURE
                                SERVICE   DATES   OF     REVENUE        TOTAL            CO-
RECIP ID        NAME              FROM     TO    SVC        NDC        CHARGES   ALLOWED  PAY  REASON & REMARK CODES

 DENIED CLAIMS - OUTPATIENT CLAIM

                                12122022 12122022    2.000    259         40.00       0.00
  ICN                   PATIENT NUMBER=

  OUTPATIENT GROUP 00
                                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
                                   ***CLAIM TOTAL***************         163.25       0.00         31
```

Total Warrant Amount

```
        VENDOR #              REMIT ADVICE #        EFT/CHK #          DATE   02/12/2024    PAGE    631
        NPI #:                  TAXONOMY: 282N00000X

                                                   UNIT    PROCEDURE
                                 SERVICE   DATES     OF      REVENUE          TOTAL                CO-
RECIP ID        NAME               FROM     TO      SVC         NDC         CHARGES    ALLOWED   PAY   REASON & REMARK CODES

 CLAIMS PENDING:     MEDICARE OUTPATIENT CROSSOVER

                                 06192023 06192023     1.000    300          27.00        0.00
   ICN                     PATIENT NUMBER=

                                 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
                                SPRINGFIELD SERVICE CENTER
                                P O BOX 740800
                                ATLANTA, GA
                                30374-0800
                                POLICY #:                GROUP CERT #:                SUBSCRIBER SSN:
                                SUBSCRIBER NAME:                   SUBSCRIBER INITIAL:

                                 11102023 11102023     1.000    510         129.44        0.00          133
   ICN                     PATIENT NUMBER=

                                    *** MEDICARE PAYMENT*****                            101.47
                                    ***CLAIM TOTAL***************           129.44        0.00          133

                                 01092024 01092024     1.000    300          67.25        0.00
   ICN                     PATIENT NUMBER=

                                 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

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                                                UNIT   PROCEDURE
                                SERVICE   DATES   OF     REVENUE          TOTAL              CO-
RECIP ID        NAME              FROM      TO    SVC        NDC        CHARGES    ALLOWED  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 i
              n a previous payment.
        B5    Coverage/program guidelines were not met or were exceeded.
        MA04  Secondary payment cannot be considered without the identity of or paymen
              t information from the primary payer. The information was either not rep
              orted 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 (ND
              C).
        M123  Missing/incomplete/invalid name, strength, or dosage of the drug furnish
              ed.
        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 service
              s.
        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 (
```

If You Have Questions…

Provider Relations Contact Information

Provider Relations Call Center:

- (800) 624-3958 or (406) 442-1837
- Monday through Friday
- 8 a.m. - 5 p.m. Mountain Time

IVR - Automated system available 24/7:

- (800) 624-3958

Helpdesk:

- MTPRHelpdesk@conduent.com
- General helpdesk cannot accept secured emails or PHI.

Thank you!