General Resources

September 2, 2026

Presented by:
Loma Romero

Provider Relations Field Representative

Conduent Government Health Service
Presented on behalf of Montana DPHHS

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

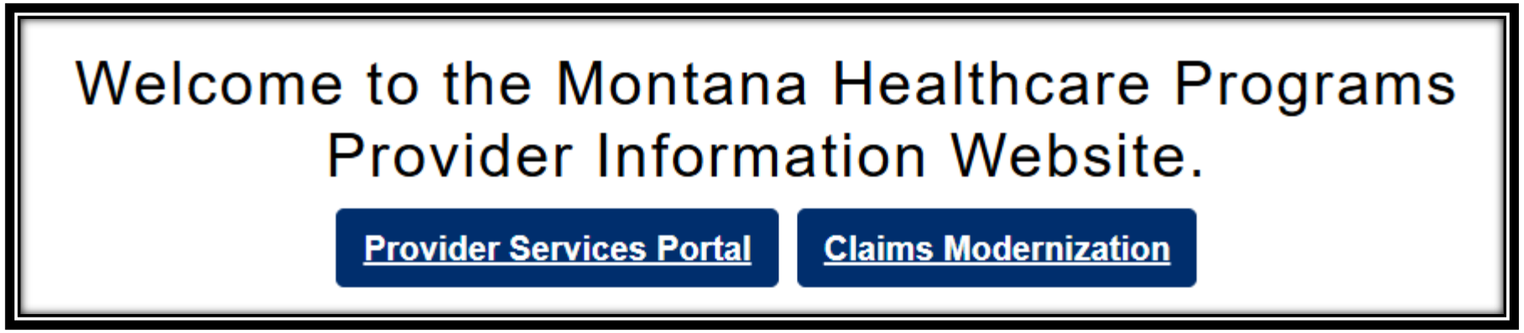
Website

https://medicaidprovider.mt.gov/

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

Home Page

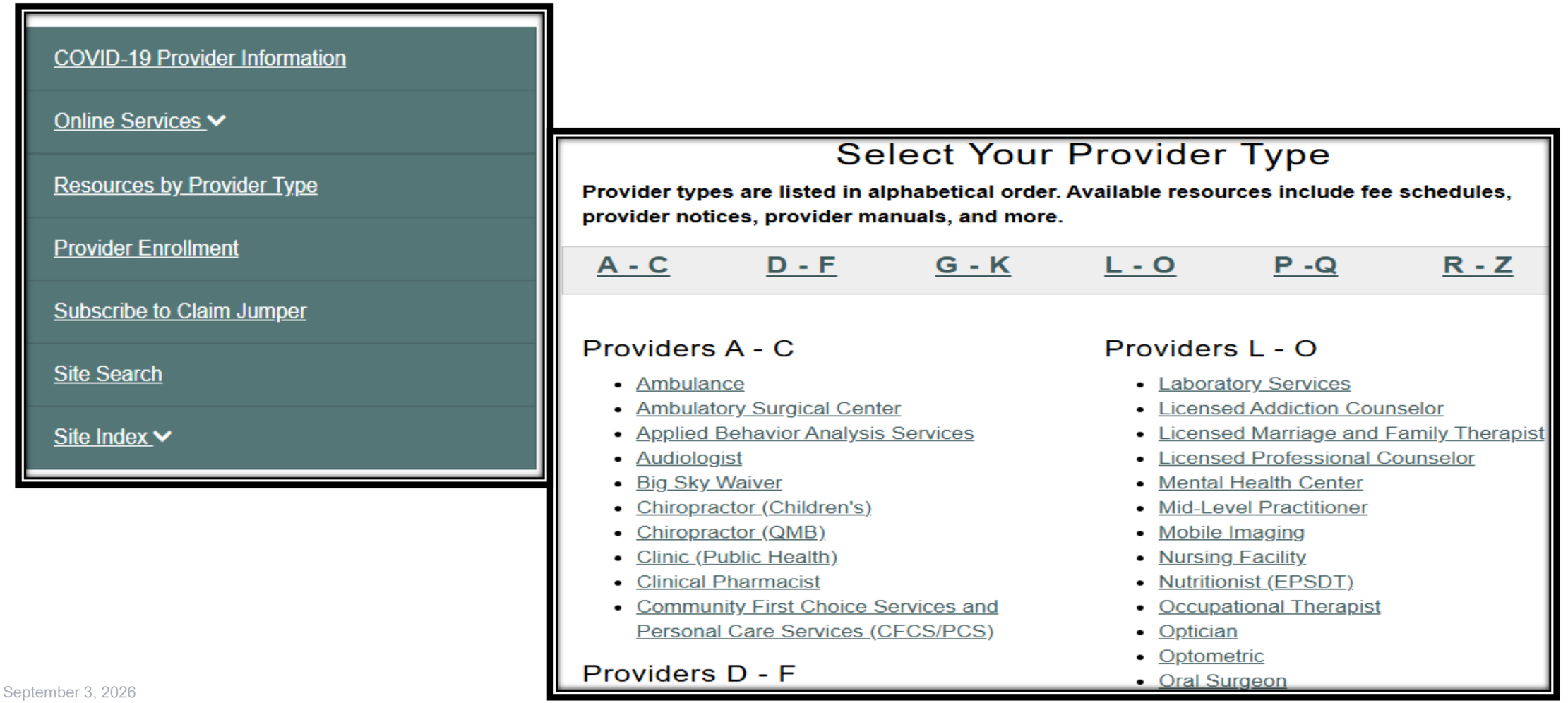
- Provider Services Portal
- Provider Information
- Online Training Availability
- Announcements
- Forms
- Claim Instructions
- Claim *Jumper* Newsletters



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

Resources by Provider Type

Providers are listed in alphabetical order



Resources by Provider Type

Providers are listed in alphabetical order

Provider Enrollment

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.

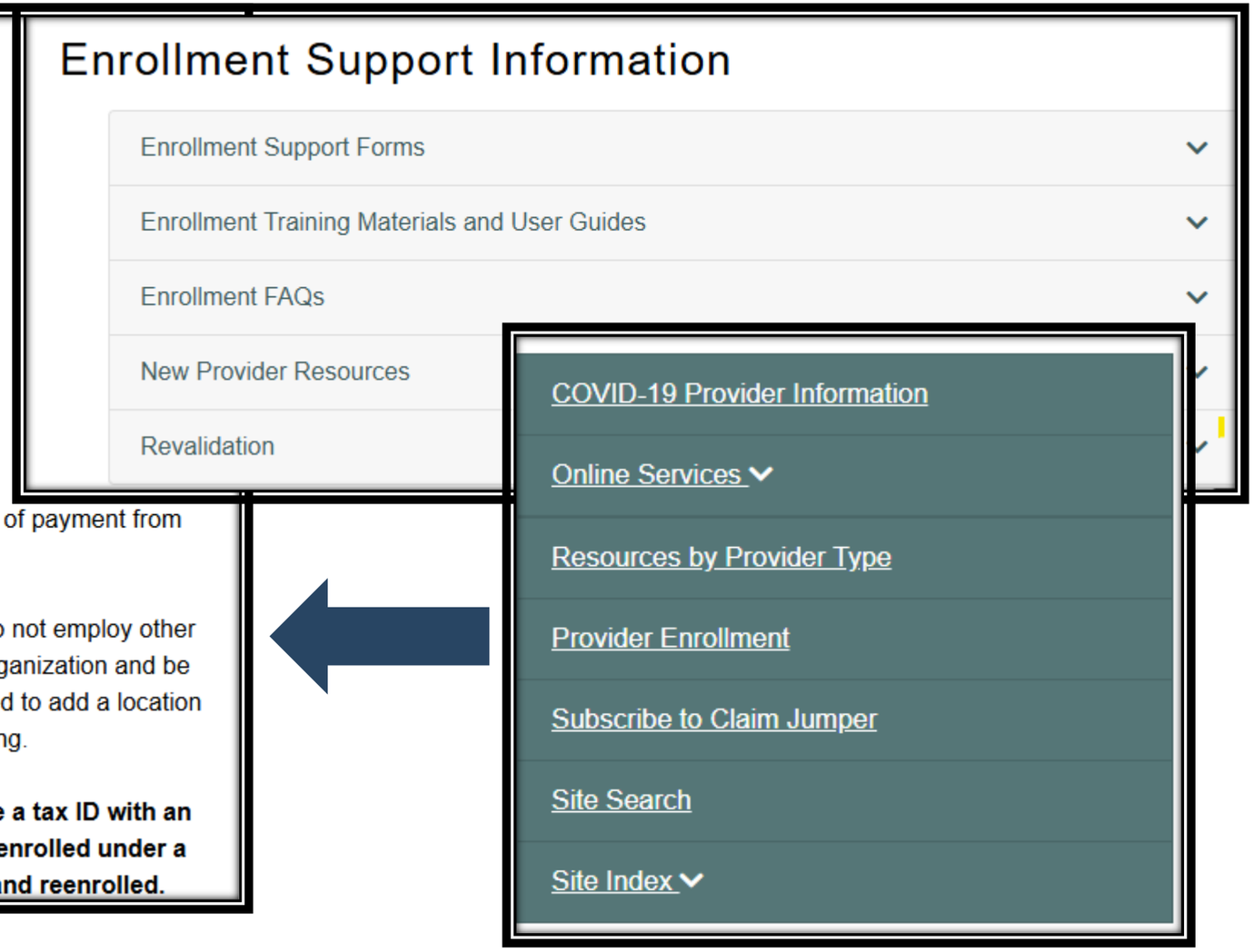
Sole Proprietor Provider

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

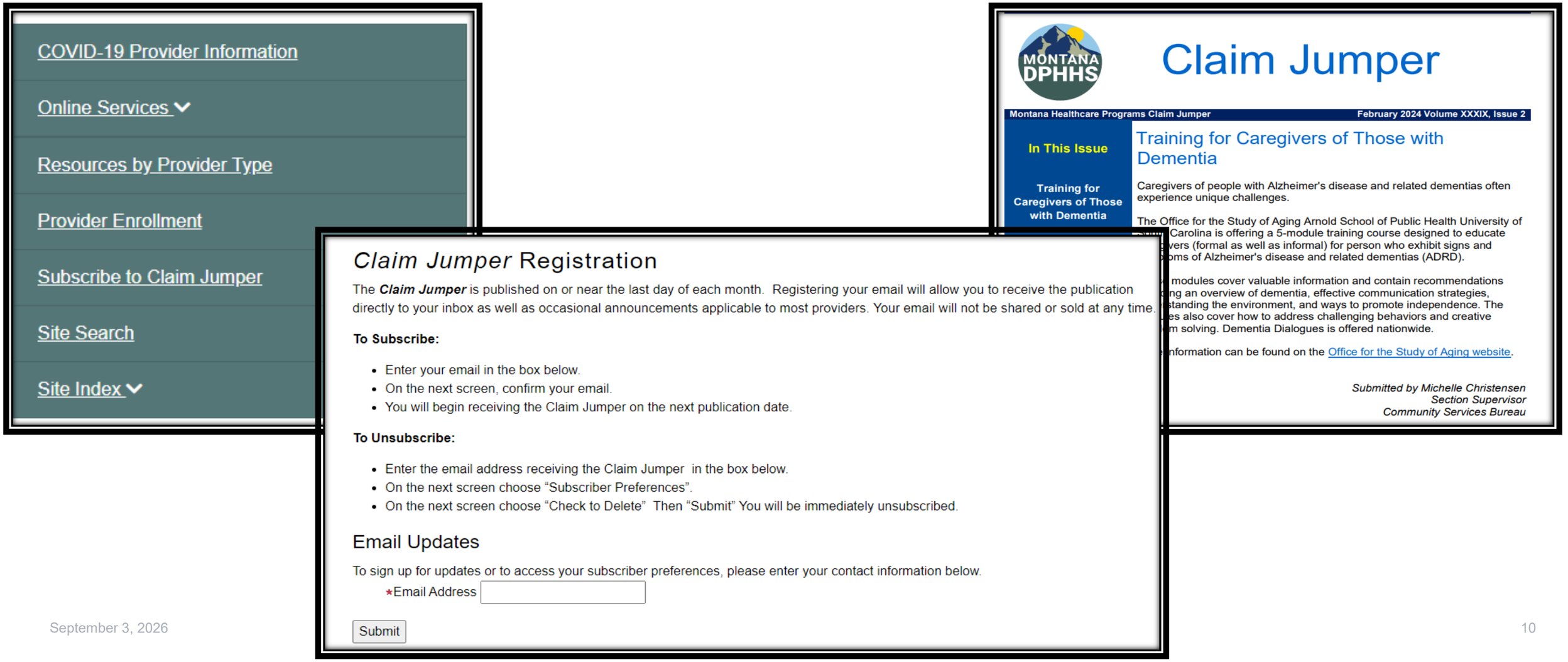
They will be used as the pay-to provider on a claim, and they are the direct recipient of payment from Montana Healthcare Programs.

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.

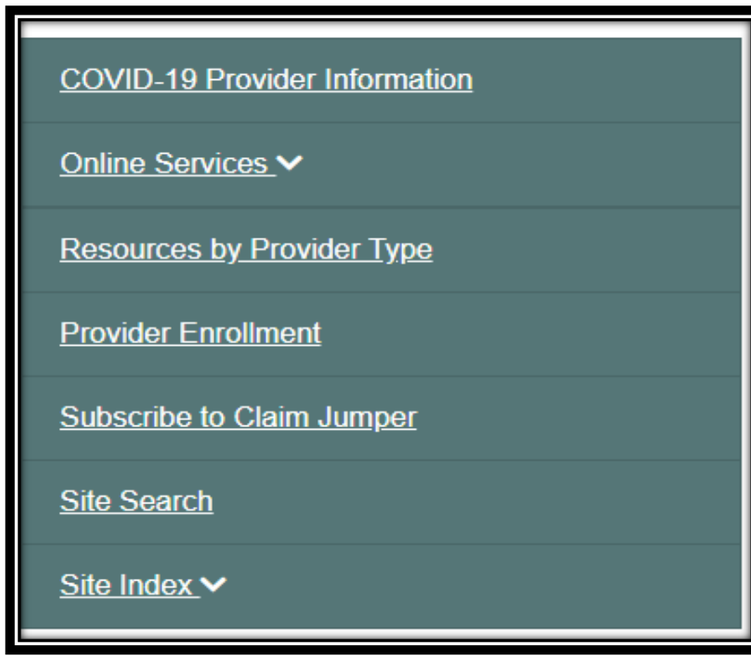


Subscribe to Claim Jumper



Site Index

- 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.

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

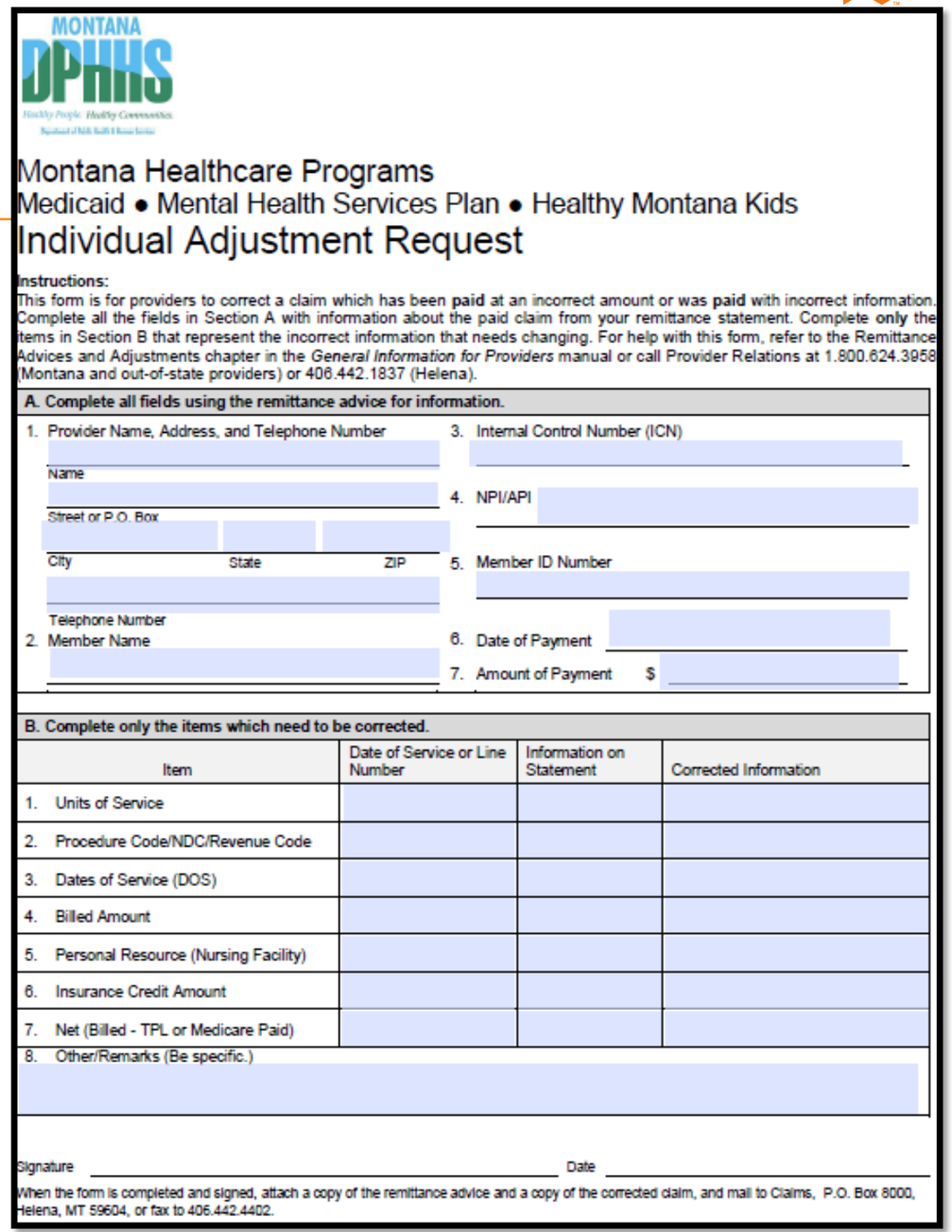
Loop 2300 - (CLM05-3) is the Claim Frequency Code. Enter 7 or 8.
REF*F8* - Enter the original ICN.

Adjustment Request Form

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

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

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

- 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

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								
	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

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								
		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

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									
		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

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        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
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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 (

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!