



# Tenancy Support Training

## Part 2: Claims

Presented by Loma Romero and  
Maria Gonzales  
Provider Relations Field  
Representatives

# In this training...

---

- Claim preparation
- Claims submissions
- MPATH Claims Setup
- MPATH Claims Solution
- MPATH Additional Portal Features
- If you have questions

# Automated System Information

---

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.

Inconsistent waiver information on MATH portal.

# Preparation for submitting claims

# What information should be gathered?

---

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

# Prior Authorizations

---

Tenancy Support Requires a prior authorization.

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 NUMBER	AUTHORIZE FROM	DATES TO
00 [REDACTED]	[REDACTED]	10557 [REDACTED]	021521	021521

REASON: 999

LINE	----MAXIMUM----		FR-DTE	TO-DTE	PROC RANGE / MOD	DIAG	RANGE
ITEM	UNITS	DOLLARS			A0430 A0430		
01	1	0.00	021521	021521			
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----		FR-DTE	TO-DTE	PROC RANGE / MOD	DIAG	RANGE
ITEM	UNITS	DOLLARS			A0430 A0430		
01	1	0.00	021121	021121			
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

---

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

---

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

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

# CPT Codes

---

Billable CPT Codes for Tenancy Support:

Procedure Code	Modifier	Description
<b>H0043</b>	U1	TSS – ASSESSMENT AND PLANNING
<b>H0043</b>	U2	TSS – PRE-TENANCY SERVICES
<b>H0043</b>	U3	TSS – TENANCY SUSTAINING SERVICES
<b>H0044</b>	UA	TSS – APPLICATION FEE ASSISTANCE
<b>H0044</b>	UD	TSS- SECURITY DEPOSIT FEE ASSISTANCE

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

# Claims Submission

# Electronic Claim Submission

---

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.

---

- Electronic claims must be submitted by 2pm MST on Wednesdays in order process during that claim cycle.
- Electronic claims process faster than paper claims.
- Electronic claims can also be submitted through a Billing Agency or a Clearing House.

# Paper Claim Submissions

---

- 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 23 Prior Authorization
- 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

Note: 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.

CMS-1500 02/12

HEALTH INSURANCE CLAIM FORM  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/01

PIKA [REDACTED]

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN  FED. LUNG  OTHER   
[REDACTED]  (Medicaid)  (CHAMPVA)

2. PATIENT NAME (Last Name, First Name, Middle Initial)  
Client last name, first name

3. PATIENT'S BIRTH DATE  MM DD YY  MM DD YY  MM DD YY  
4. PATIENT RELATIONSHIP TO INSURED  Spouse  Child  Other

5. PATIENT ADDRESS (No., Street)  CITY  STATE  
ZIP CODE  TELEPHONE (Include Area Code) ( )

6. PATIENT'S ADDRESS (No., Street)  CITY  STATE  
ZIP CODE  TELEPHONE (Include Area Code) ( )

7. INSURED'S ADDRESS (No., Street)  CITY  STATE  
ZIP CODE  TELEPHONE (Include Area Code) ( )

8. INSURED'S POLICY GROUP OR FICA NUMBER  
Possible Member ID

9. INSURED'S DATE OF BIRTH MM DD YY  MM DD YY  MM DD YY  
10. IS PATIENT'S CONDITION RELATED TO:  
a. OTHER INSURED'S POLICY OR GROUP NUMBER  
Possible Member ID

11. EMPLOYMENT? (Current or Previous)  YES  NO  
b. AUTO ACCIDENT?  YES  NO  PLACE (State)

12. RESERVED FOR NUCC USE  c. OTHER ACCIDENT?  YES  NO

13. INSURANCE PLAN NAME OR PROGRAM NAME  14. CLAIM CODES (Designated by NUCC)

15. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  
16. PATIENT'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 assignment below.

SIGNED DATE SIGNED DATE

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  17a. Reserved for Passport #  17b. Reserved for IHS Ref. ID

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY  20. OTHER DATE MM DD YY  21. OTHER DATE MM DD YY  
QUAL.  22. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY  TO MM DD YY  
FROM MM DD YY  23. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY  TO MM DD YY  
FROM MM DD YY  24. OUTCOME LATE  & CHARGES  
YES  NO  25. EMISSIONS  
CPT  26. PRIOR AUTHORIZATION NUMBER  
ORIGINAL REC. NO. 4123456789

27. ICD - 10 Diagnosis code  28. A. DATES OF SERVICE From MM DD YY To MM DD YY  B. PLACE OF SERVICE  C. D. PROCEDURAL, SERVICE, OR SUPPLIER  
(Specify Unusual Circumstances)  E. DIAGNOSIS CODES  
1 07 01 14 07 01 14 11 99241 ABC 100 00 1 ZZ 2084N0400X  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13. FEDERAL TAX ID NUMBER 58R 58N  14. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?  YES  NO  
99-9999999 123456789 X YES ND  
15. TOTAL CHARGE \$ 100 00 16. AMOUNT PAID \$ 25 00 17. Paid for NUCC Use  
18. BILLING PROVIDER INFO & PH # (406) 555-1234  
Dr. Provider, MD 123 Main Street Anywhere, MT 54321-1234  
19. NPI 22. 2084N0400X  
20. APPROVED CMB 0938-1197 FORM 1500 (02-12)  
NUCC Instruction Manual available at: www.nucc.org  
If Atypical Provider, 33a will be blank and 33b will have G2 prefix—> G2 Atypical ID

# MPATH Claims Setup

# 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

**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:\*

**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.**

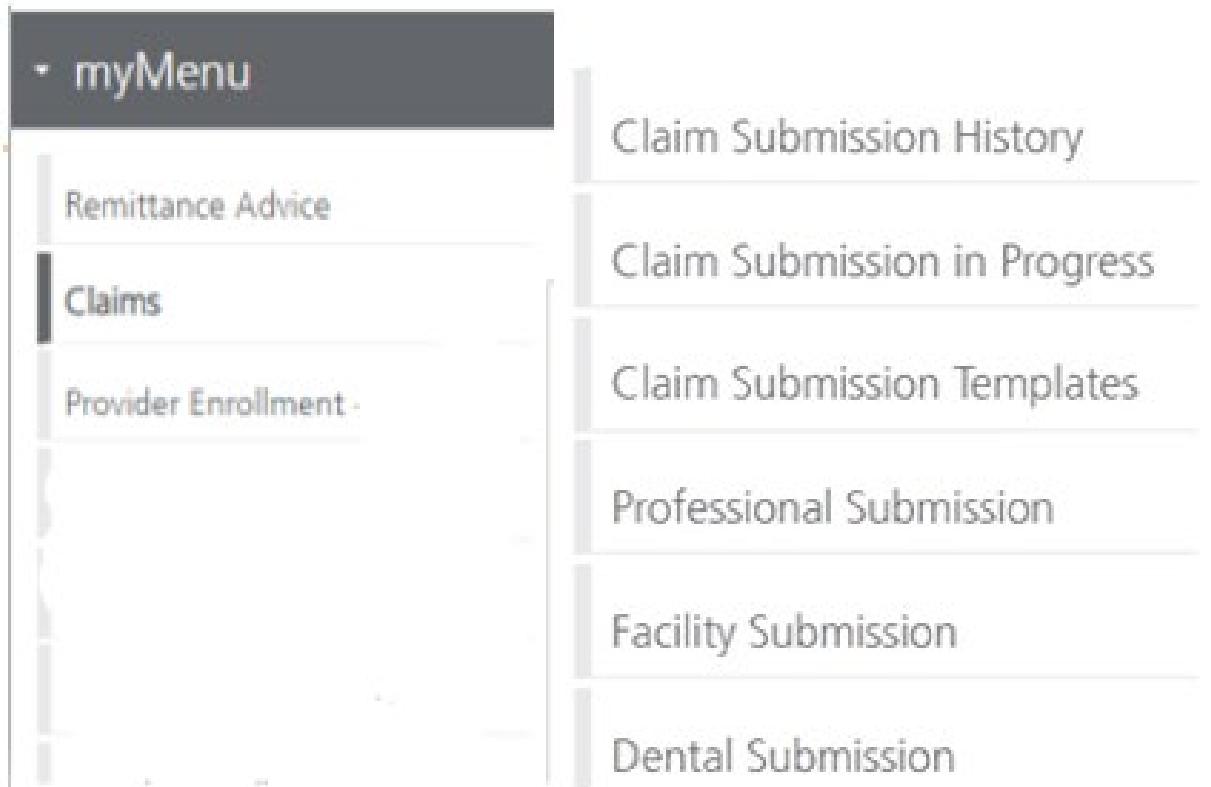
# MPATH Claims Solution

# Claim Submission Menu

Under myMenu, without clicking, place your cursor 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.

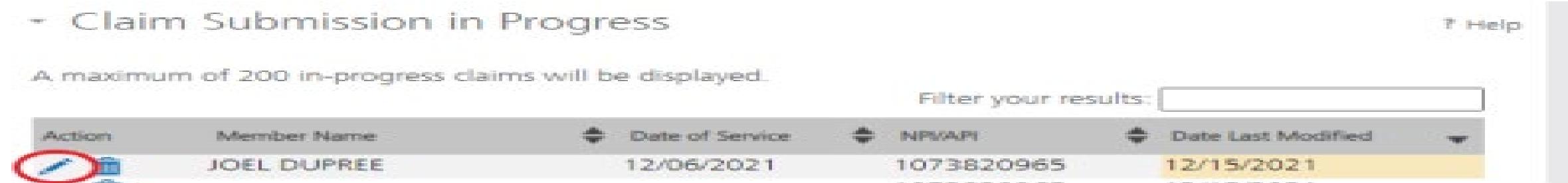
# Claims Submission in Progress

**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	INPAPI	Date Last Modified
	JOEL DUPREE	12/06/2021	1073820965	12/15/2021

# Claim Submission Templates

---

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

**Example:**

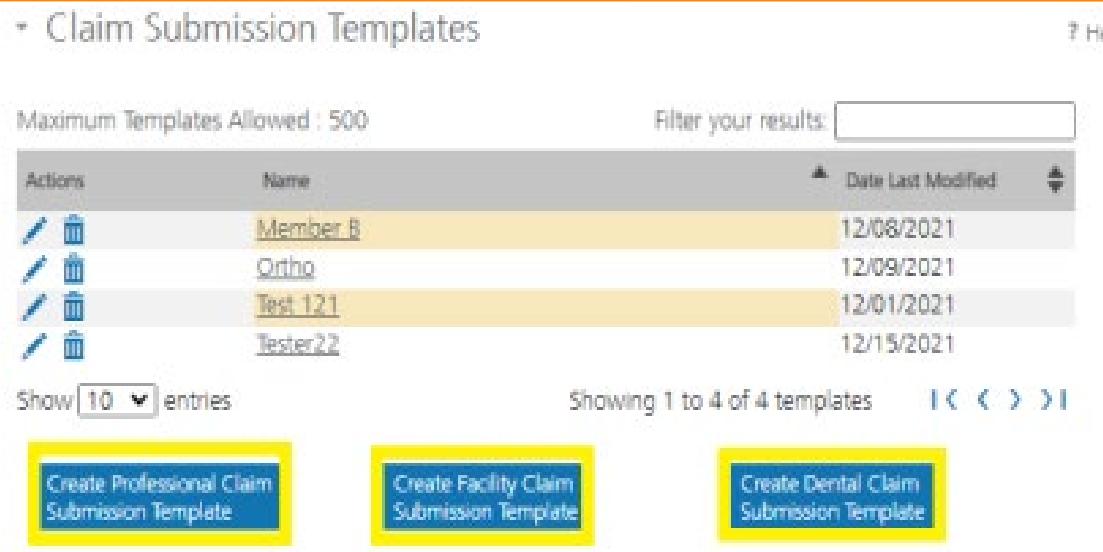
You see the same member for the same service on a consistent basis. You can create a template for that member with all the claim information except the date of service, and maybe the units & billed amount.

When it is time to submit their 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.



The screenshot shows a list of existing claim submission templates. The columns are 'Actions', 'Name', and 'Date Last Modified'. The templates listed are 'Member\_B' (12/08/2021), 'Ortho' (12/09/2021), 'Test\_121' (12/01/2021), and 'Tester22' (12/15/2021). Below the table, there are three blue buttons with yellow outlines, each labeled 'Create [Claim Type] Claim Submission Template'. The claim types are 'Professional', 'Facility', and 'Dental'.

Actions	Name	Date Last Modified
	Member_B	12/08/2021
	Ortho	12/09/2021
	Test_121	12/01/2021
	Tester22	12/15/2021

Show 10 entries

Showing 1 to 4 of 4 templates

Create Professional Claim Submission Template

Create Facility Claim Submission Template

Create Dental Claim Submission Template

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

# Creating a Template Cont.

Enter the member's MT Medicaid ID number.

**Click Search.**

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

- Professional Claim Template
- Member Details

Enter Member Card ID:



# 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.

- Professional Claim Submission Form ? Help

Claim Information

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

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

Diagnosis Codes

Diagnosis Codes (ICD 10):

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

Claim Details

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

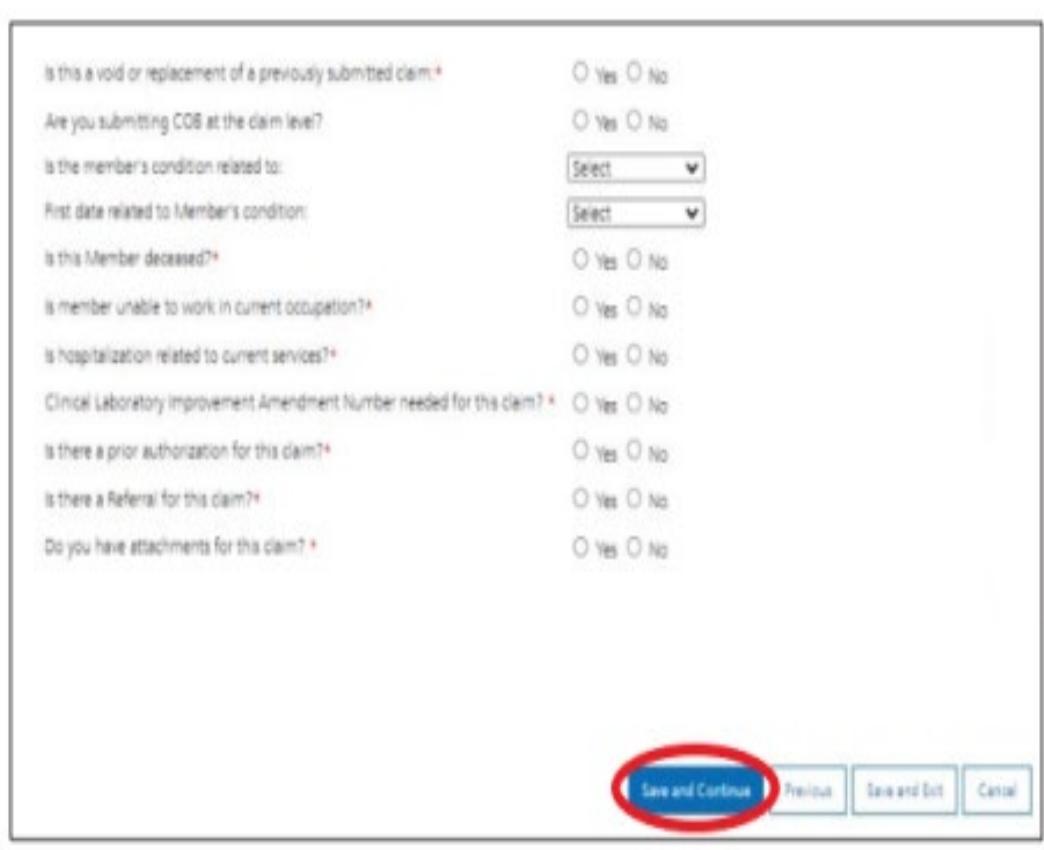
From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>									

# Creating a Template Cont.

Answer all the questions at the bottom of the screen.

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

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

**Save and Continue**

# Creating a Template

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

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 "-".

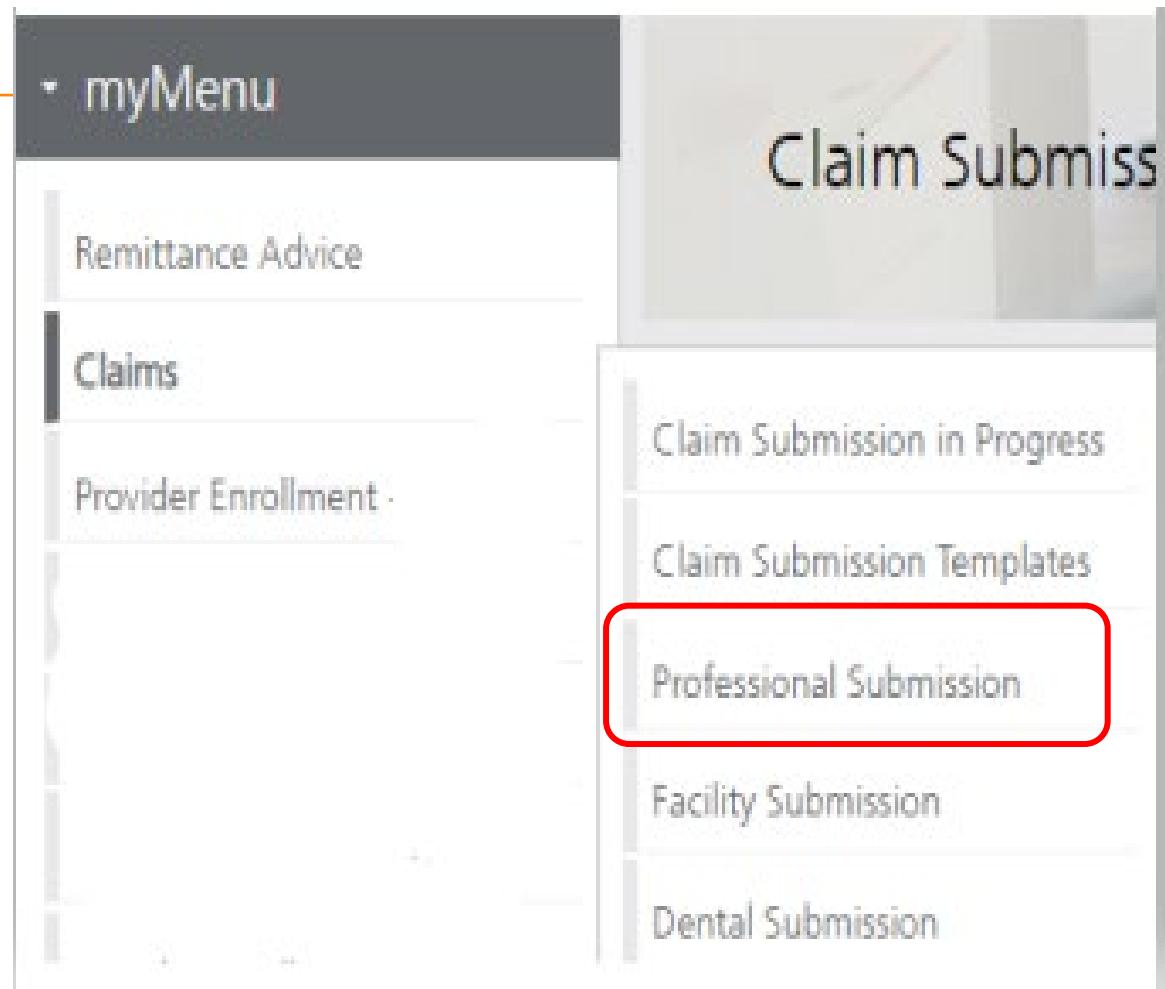
**Submit** Previous Cancel

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

# Submitting a Claim

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

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



\*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 CAF		
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	NPI/API:*	1033508080
Taxonomy Code: *	253Z00000X	Provider Name:*	LIBERTY PLACE, INC
Enrollment Unit:*	0000262208	Program/Waiver:*	Severe Disabling Mental Illness Waiver (SDMI)
		Specialty:*	Select Program/Waiver
		Service Location Address 1:*	Severe Disabling Mental Illness Waiver (SDMI)
		Service Location Address 2:	Big Sky Waiver
		City:*	BOOTSTRAP RANCH E
		State:*	BELGRADE
		ZIP:*	MT
		Taxonomy Code: *	59714-8121
		Enrollment Unit:*	251S00000X
			0000801034

# Member Details

Enter the member's MT Medicaid ID number.

Click **Search**.

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

- Professional Claim Template
- Member Details

Enter Member Card ID:



Search

Save and Continue Cancel

Click **Save and Continue**.

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

Claim Details

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

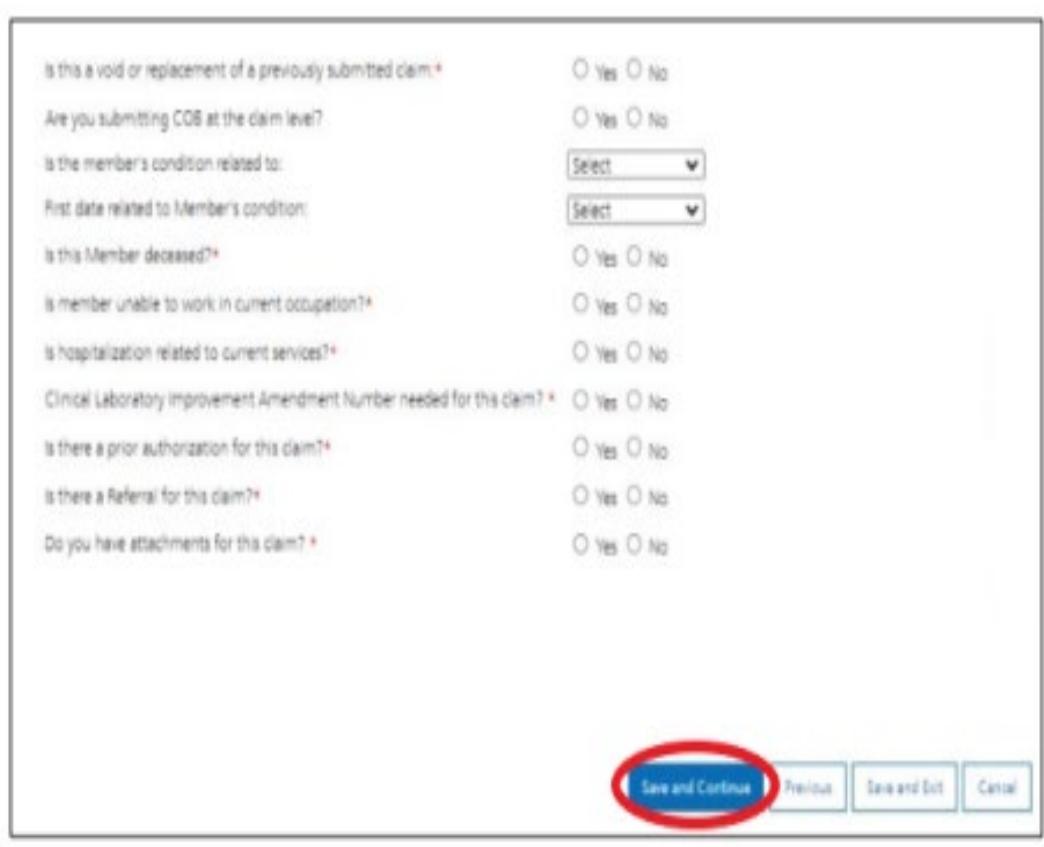
From Date*	To Date*	POS*	CPT/HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/> Total Charges: \$ <input type="text"/> <input type="button" value="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

**Save and Continue**

# 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 Sheets](#) 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: *
<input type="button" value="Select"/>	<input type="button" value="Select"/>	<input type="text"/>
<input type="button" value="Attachments"/> <input type="button" value="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: *
<input type="button" value="EB-Explanation of Benefit"/>	<input type="button" value="FT-Electronic Attachmen"/> <input type="button" value=""/>	<input type="button" value="Attachments"/> <input type="button" value=""/>
<input type="button" value="Add"/>		

# Bulk HIPAA Transactions

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

▼ Bulk HIPAA Transactions activity ? Help

ACTIONS	TRANSACTION DATE	FILE NAME
No matching transactions found.		

Filter your results:

Show 10 entries Showing 0 to 0 of 0 entries 1 < < > > 1

[Upload](#)

Click the “Help” link and you’ll be taken to that section of the manual

# Bulk HIPAA Transactions

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

▼ Bulk HIPAA Transactions activity ? Help

ACTIONS	TRANSACTION DATE	FILE NAME
No matching transactions found.		

Filter your results:

Show 10 entries Showing 0 to 0 of 0 entries 1 < < > > 1

[Upload](#)

Click the “Help” link and you’ll be taken to that section of the manual

Questions?

# MPATH Portal Additional Features

# Claims Inquiry

Member search ?

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

Member search

Enter Member Card ID \*

Go

Member search ?

Member found!

You are currently viewing:

**Member's Name**

[Clear Search](#)

Claims Inquiry  
 Eligibility

Search

# Claims Inquiry Cont.

Member search

myMenu

Claim search ?

I want to view:  
Claims for

Time period  
From Date: 09/01/2021   
To Date: 12/01/2021

Claim number

Patient account number

Search

Hi Org3 MTOFEOC

Claims Detail 

Claim search results

Member:   
You are viewing: Claims for NPI/API 1 and time period from 09/01/2021 to 12/01/2021.

Claim activity

Filter your results:

ICN	OPTUM CLAIM NUMBER	SERVICE DATE	MEMBER NAME	PROVIDER	STATUS	BILLED AMOUNT	PLAN PAYS
221	221	09/01/21	INC	F1		\$177.44	\$177.44

Show 10 entries  Showing 1 to 1 of 1 Claims

# Claims Inquiry Results

I want to view:  
Claims for

Time period  
From Date:   To Date:

Claim number   
Patient account number

**Claim search results**

Member: You are viewing: Claims for NPI/API 1 and time period from 09/01/2021 to 12/01/2021.

**Claim activity**

ICN: 221 Optum Claim number:

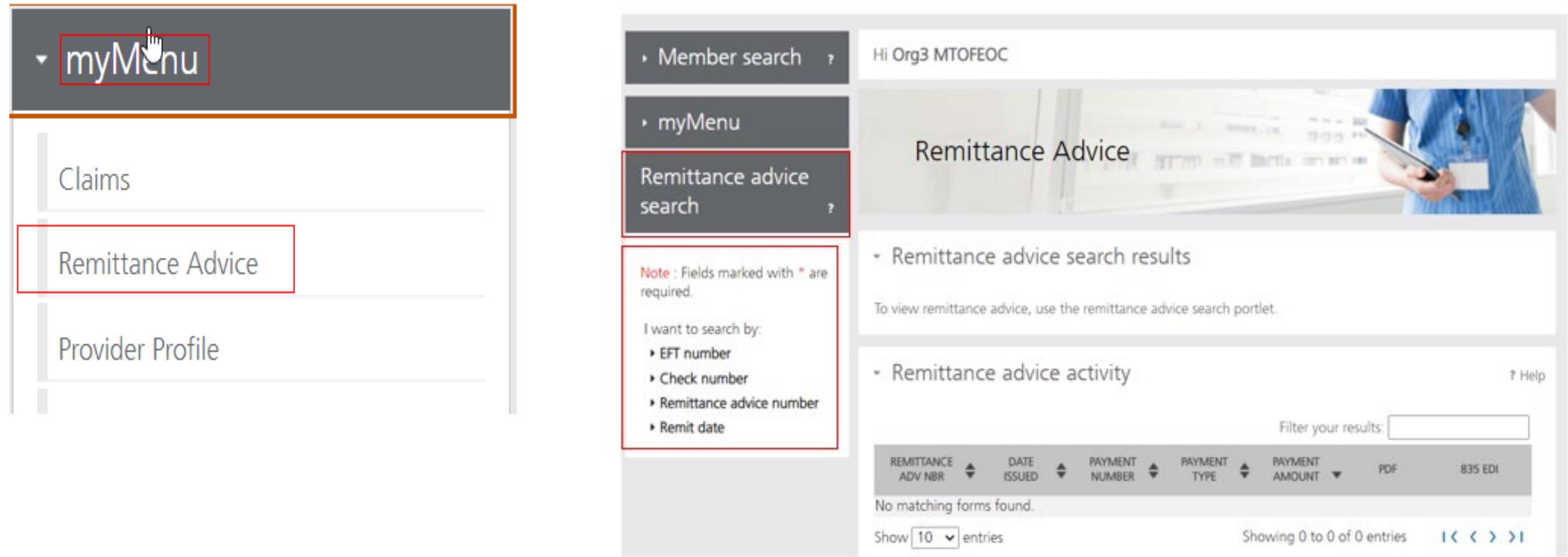
Member: <input type="text"/>	Date of service: 09/01/21-09/30/21	Total amount billed: \$177.44
Patient account: <input type="text"/>	Date processed: 10/04/21	Total amount paid: \$177.44
Member: <input type="text"/>	Member ID: <input type="text"/>	Payment details
Claim status: F1:Finalized/Payment	Payment number: 00000261657	Payment date: 10/11/21
	Payment amount: \$177.44	

**Line 1**

Provider name: <input type="text"/>	Provider NPI/API: 1234567890	INC	Cost for this service	Amount billed: \$177.44
Date of service: 09/01/21-09/30/21	Procedure code: T2041			Amount paid by plan: \$177.44

# MPATH Portal Remittance Advice

# Remittance Advice



The screenshot shows a web-based application interface for managing remittance advice. The left side features a sidebar with a 'myMenu' button, a 'Claims' link, and a 'Remittance Advice' link which is highlighted with a red box. Below these are 'Provider Profile' and other unselected links. The main content area has a 'Member search' button and a 'myMenu' button. A red box highlights the 'Remittance advice search' button. A note below it states: 'Note: Fields marked with \* are required.' and lists search criteria: 'I want to search by: EFT number, Check number, Remittance advice number, Remit date'. The central part of the screen displays a 'Remittance Advice' search results page. The header says 'Hi Org3 MTOFEOC'. It shows a thumbnail of a person holding a smartphone, a title 'Remittance Advice', and a section for 'Remittance advice search results' with a note: 'To view remittance advice, use the remittance advice search portlet.' Below this is a 'Remittance advice activity' section with a 'Help' link and a 'Filter your results:' input field. A table header for the search results includes columns: REMITTANCE ADV NBR, DATE ISSUED, PAYMENT NUMBER, PAYMENT TYPE, PAYMENT AMOUNT, PDF, and 835 EDI. A message at the bottom says 'No matching forms found.' and includes pagination controls: 'Show 10 entries', 'Showing 0 to 0 of 0 entries', and navigation icons.

# 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

## Remittance advice search

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

PID/EU:

I want to search by:

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

From Date: \*

To Date: \*

▶ myMenu

## Remittance Advice

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

▼ Remittance advice search results

Provider NPI/API: 1316525603  
You are viewing: Remittance Advice for NPI/API 1316525603 and time period from 12/01/2025 to 01/12/2026.

▼ Remittance advice activity

? Help

Filter your results:

REMITTANCE ADV NBR	DATE ISSUED	PID/EU	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	PDF	835 EDI
	12/01/2025	0000743614		EFT	\$18823.57	<a href="#">View</a>	<a href="#">Download</a>
	12/29/2025	0000743614		EFT	\$14636.37	<a href="#">View</a>	<a href="#">Download</a>
	12/22/2025	0000743614		EFT	\$12642.69	<a href="#">View</a>	<a href="#">Download</a>
	12/08/2025	0000743614		EFT	\$12543.39	<a href="#">View</a>	<a href="#">Download</a>
	12/15/2025	0000743614		EFT	\$11129.01	<a href="#">View</a>	<a href="#">Download</a>
	01/05/2026	0000743614		EFT	\$11050.77	<a href="#">View</a>	<a href="#">Download</a>
	01/12/2026	0000743614		EFT	\$10685.67	<a href="#">View</a>	<a href="#">Download</a>
	12/15/2025	0001837853		EFT	\$6851.02	<a href="#">View</a>	<a href="#">Download</a>
	12/15/2025	0000743614		EFT	\$1795.57	<a href="#">View</a>	<a href="#">Download</a>
	12/08/2025	0000743614		EFT	\$1039.16	<a href="#">View</a>	<a href="#">Download</a>

44

Provider Name  
& Address

VENDOR # [REDACTED] REMIT ADVICE # 222548 EFT/CHK # [REDACTED] DATE 12/29/2025 PAGE 10  
NPI #: [REDACTED] TAXONOMY: 261QR0405X

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									
[REDACTED]	[REDACTED]	10292025	10292025	8.000	H0038	160.00	136.08		
ICN 42535500892206322	PATIENT NUMBER=AV-CWR-C10925065-1.1								
		10302025	10302025	14.000	H0038	280.00	238.14		
		11012025	11012025	8.000	H0038	160.00	136.08		
		***CLAIM TOTAL*****				600.00	510.30		
[REDACTED]	[REDACTED]	10032025	10032025	1.000	H0038	20.00-	16.54-		
ICN 42535500892105354	PATIENT NUMBER=AV-CWR-C10662282-1.3								
		***CLAIM TOTAL*****				20.00-	16.54-		
[REDACTED]	[REDACTED]	10032025	10032025	1.000	H0038	20.00	17.01		
ICN 42535500892205354	PATIENT NUMBER=AV-CWR-C10662282-1.3								
		***CLAIM TOTAL*****				20.00	17.01		
[REDACTED]	[REDACTED]	10082025	10082025	1.000	90837 59	200.00-	106.04-		
ICN 42535500892105568	PATIENT NUMBER=AV-CWR-C10721754-1.4								
		10112025	10112025	8.000	H0038	160.00-	132.32-		
		***CLAIM TOTAL*****				360.00-	238.36-		

# If You Have Questions

# Need Help with MPATH?

---

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

---

<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

---

Provider Relations Call Center:

(800) 624-3958

Monday through Friday  
8 AM to 5 PM Mountain Time

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

Note: The MTPR Help Desk does not accept PHI or secured emails.

Questions?

Thank you for the care and support  
that you provide to Montana  
Healthcare Programs Members!