

Billing 101 Training for Providers

Presented by Loma Romero and Maria Gonzales
Provider Relations Field Representatives

Roll Call

- We want to get to know our Community. You can either unmute yourself or place in chat:
- Your name
- The name of your company
- Who are you representing

In this training...

- 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?

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

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

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			10557		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			10557		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

ICD-10 is short for *International Classification of Diseases, 10th 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 in the Provider manuals, located on every Provider Type page of the Provider Information website.

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

CPT Code

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

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

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

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.

Electronic 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](#).

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Provider Enrollment
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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 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. 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.

Electronic Adjustment Submission through Clearinghouse

Electronic Adjustments are now accepted by Montana Medicaid. They can be submitted through Provider Services Portal and Clearinghouses.

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.

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 and 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

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHAMPVA (Champion VA) GROUP HEALTH PLAN (Group Health Plan) REG. LONG TERM CARE (Reg. Long Term Care) OTHER (Other)

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

5. PATIENT'S RELATIONSHIP TO INSURED
Self Spouse Child Other

6. RESERVED FOR NUCC USE

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

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S POLICY OR GROUP NUMBER
Possible Member ID

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT (Current or Previous) YES NO
b. AUTO ACCIDENT? YES NO PLAGE (State) _____
c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY OR GROUP OR MEDICARE NUMBER
Possible Member ID

12. INSURED'S DATE OF BIRTH MM DD YY SEX M F

13. OTHER CLAIM ID (Designated by NUCC)

14. INSURANCE PLAN NAME OR PROGRAM NAME
Possible TPL Information

15. IS TRANSFERRED HEALTH BENEFIT PLAN? YES NO (If yes, complete items 9, 3a, and 3b.)

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 _____

17. IS PATIENT UNABLE TO WORK IN CURRENT OCCUPATION?
FROM MM DD TO MM DD
YES NO

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD TO MM DD
YES NO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (I-ICD-10)
A. ICD - 10 Diagnosis code _____ B. _____ C. _____ D. _____
E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____

22. BILLING NUMBER ORIGINAL POC NO.
4123456789

23. PRIOR AUTHORIZATION NUMBER
123456789

24. A. DATE OF SERVICE FROM MM DD YY	24. B. PLACE OF SERVICE TO MM DD YY	24. C. PROCEDURE, SERVICE, OR SUPPLIER CODES (ICD-10, CPT, HCPCS)	24. D. DIAGNOSIS PORTER	24. E. CHARGES	24. F. DAYS OR PERCENT	24. G. UNIT	24. H. RENDERING PROVIDER ID #
07 01 14	07 01 14	11	99241	ABC	100.00	1	ZZ 2084N0400X 1234567891

25. FEDERAL TAX ID NUMBER SSN EIN 99-9999999

26. PATIENT'S ACCOUNT NO. 123456789

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE 100.00

29. AMOUNT PAID 25.00

30. Reserved for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDE AND CERTIFY ON ONE IDENTICAL COPY; THE SIGNATURES ON THE REVERSE APPLY TO THIS SET) AND DATE
Dr. Provider, MD 07/01/14

32. BILLING PROVIDER INFO & PII # (406) 555-1234
Dr. Provider, MD 123 Main Street Anywhere, MT 54321-1234

33. BILLING PROVIDER INFO & PII # (406) 555-1234
1234567891 ZZ 2084N0400X

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMB 9938-1197 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

- 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

The image shows a UB-04 claim form with several fields highlighted in yellow and green. The yellow highlights include: Provider Name/Address, Member First Name Last Name, In/Out multi ER visits, Possible TPL Payer (123456789), Member Name, Member ID, ICD-10 codes, Billing Taxonomy (B3 282N0000X), and Billing NPI. The green highlights include: Condition Codes (01), Occurrence codes, and Value Codes and Amounts reflect Medicare Payment Information. A table of services is also visible, showing columns for ICD-10 code, date, units, and charges.

ICD-10 CODE	DATE	UNITS	CHARGE
250	7/6/14	1	83.95
260	7/7/14	1	326.72
260	7/7/14	1	32.83
260	7/7/14	1	63.50
301	7/7/14	1	95.56
301	7/7/14	1	121.37
306	7/7/14	2	223.96
306	7/7/14	2	259.56
320	7/7/14	1	209.83
450	7/7/14	1	687.39
636	7/7/14	4	159.30
636	7/6/14	3	75.95

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)

OTHER COVERAGE (Mark applicable box and complete items 5-11, if none, leave blank.)

4. Dental? Medical? (If both, complete 5-11 for dental only)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender M F J 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number 10. Patient's Relationship to Person named in #5
 Self Spouse Dependent Child Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

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 _____
 (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 _____

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11-office, 22-OP Hospital) 39. Enclosure (Y or N)

(Use "Place of Service Code 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 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

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dental 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

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

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

©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 Electronic Claims Setup

Sign in to the Provider Services Portal



- Go to the MT Medicaid Website.

TIP: save this website as a favorite. Also, save ICAP as a favorite.

- Click the Provider Services Portal Link. It will take you to the ICAP Login

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



[ICAP Portal](#)

Sign in to the Provider Services Portal Continued



- Sign into the ICAP Portal

TIP: your Username is your email you are registered with on the Provider Services Portal.

A screenshot of the login page for the Montana Healthcare Programs. The page has a dark blue background with a mountain landscape. On the left, it says "WELCOME TO Montana Healthcare Programs" and "DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES" with the Montana DPHHS logo. Below that, it says "Montana's Medicaid Enterprise Systems (MES)". On the right, there is a white box titled "ACCESS YOUR ACCOUNT" containing a "Username" field, a "Password" field, and a "Log In" button. Below the fields are links for "Forgot Password?", "Create New Account", and "State Employee Log in".

WELCOME TO
Montana Healthcare Programs

MONTANA DPHHS

DEPARTMENT OF
**PUBLIC HEALTH &
HUMAN SERVICES**

Montana's Medicaid Enterprise Systems (MES)

ACCESS YOUR ACCOUNT

Username

Password

Log In

[Forgot Password?](#)
[Create New Account](#)
[State Employee Log in](#)

Account Administration

All 3 Account Administration functions are located on one screen.

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

The screenshot displays the Account Administration interface with three main sections:

- Manage Portal Users:** Features a search filter, a table with columns for ACTIONS, LOGIN NAME, FIRST NAME, LAST NAME, EMAIL, and STATUS. It shows "No matching users found." and includes a "Show 10 entries" dropdown and a "Showing 0 to 0 of 0 entries" status. A blue "Add User Account" button is present.
- Manage Billing Providers:** Features a search filter, a table with columns for ACTIONS, BILLING PROVIDER NAME, and NP/API ID. It shows one entry with "MPATH" and "1003362864". It includes a "Show 10 entries" dropdown and a "Showing 1 to 1 of 1 accounts" status. A blue "Add Billing Provider" button is present.
- Manage Provider Enrollment Accounts:** Features two buttons: "Complete LINK Request Form" and "Complete UNLINK Request Form", followed by a search filter. It has a table with columns for ACTION, ATTACHMENT, DATE, and STATUS. It shows "No matching transactions found." and includes a "Show 10 entries" dropdown and a "Showing 0 to 0 of 0 entries" status. A blue "Upload Request" button is present.

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:*

Manage Billing Providers Cont.

To find Provider ID

- Click on blue arrow
- Provider ID# will show in gray box

Select	Actions	Type	Enrollment Status	Submission Date ↓	Confirmation #	Tax ID	NPI/Atypical ID	Provider Name	Last Accessed By	Last Accessed Date
<input type="checkbox"/>	  	Enrollment	Submitted	02-25-2026	79738729					02-25-2026

Programs **Provider ID#: 200036614**

Manage Affiliations

Manage Affiliations

This action is **needed** if a facility that employs Rendering Providers and/or the facility is 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 on the left, now visible under the Enrollment Menu.

Actions	Type	Status
     	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 i Last Name i NPI/Atypical ID i

i

	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	<input type="text"/>	i	

Assigned Locations i

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

Items per page 10 1 - 1 of 1 < >

Add an Affiliation Cont.

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

2. 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**.

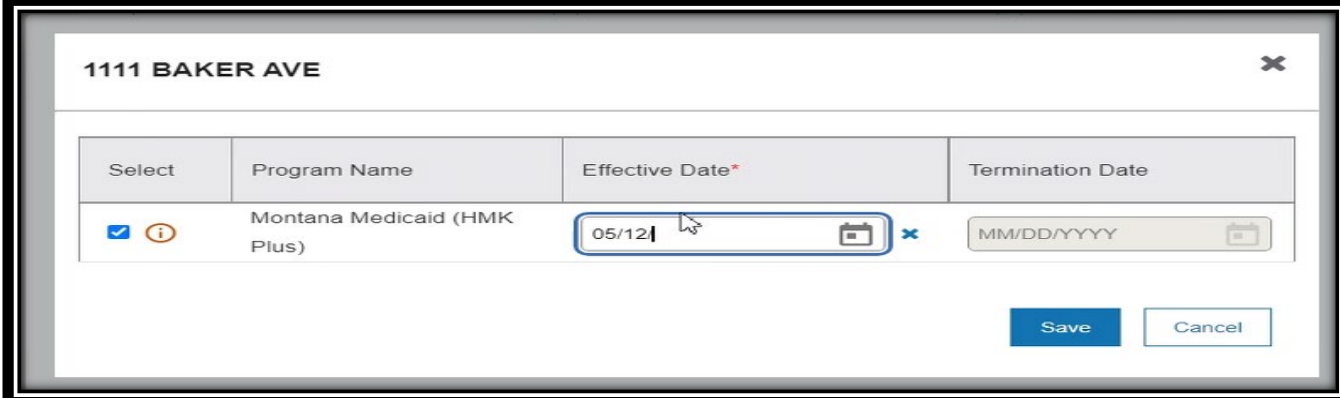


First Name	Last Name	NPI/Atypical ID	Effective Date ↓	Last 4 digits of SSN/TIN	Actions	File Name
ROBERT	NITSCHELM	1598719064	05/12/2022			

Assigned Locations

Address Line	
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 are five tabs: 'Search for Providers', 'Pending Approval', 'Requested Affiliations', 'Existing Affiliations' (which is selected and highlighted), and 'Denied Affiliations'. A 'User Guide' icon is located in the top right corner. Below the tabs is a 'Search for Provider' section with a help icon. The search section includes a text box for 'First Name', a text box for 'Last Name', and a text box for 'NPI/Atypical ID' containing the value '1144064783'. A 'Search' button is positioned to the right of the NPI/Atypical ID field. 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: 'Emma Windauer', '1144064783', '06/24/2024', and a 'Terminate Date' field with a calendar icon and a placeholder 'MM/DD/YYYY'. The 'Actions' column for this row contains an upward 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 end affiliation.

Search for Providers Pending Approval Requested Affiliations Existing Affiliations User Guide

Search for Provider Help

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 i Last Name i NPI/Atypical ID i i

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

ANITA BEACH 1922064401 i

Ending Affiliations Cont.

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

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



Address Line	Active	Deactivate	Effective Date	Terminate Date	
1111 BAKER AVE	<input type="radio"/>	<input checked="" type="radio"/>	01/01/2008	05/11/2022	<input type="text"/>

Click the **Save and Continue** button.

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

Questions?

Provider Services Portal Claims Submission

Provider Services Portal

[Provider Portal User Guide](#)

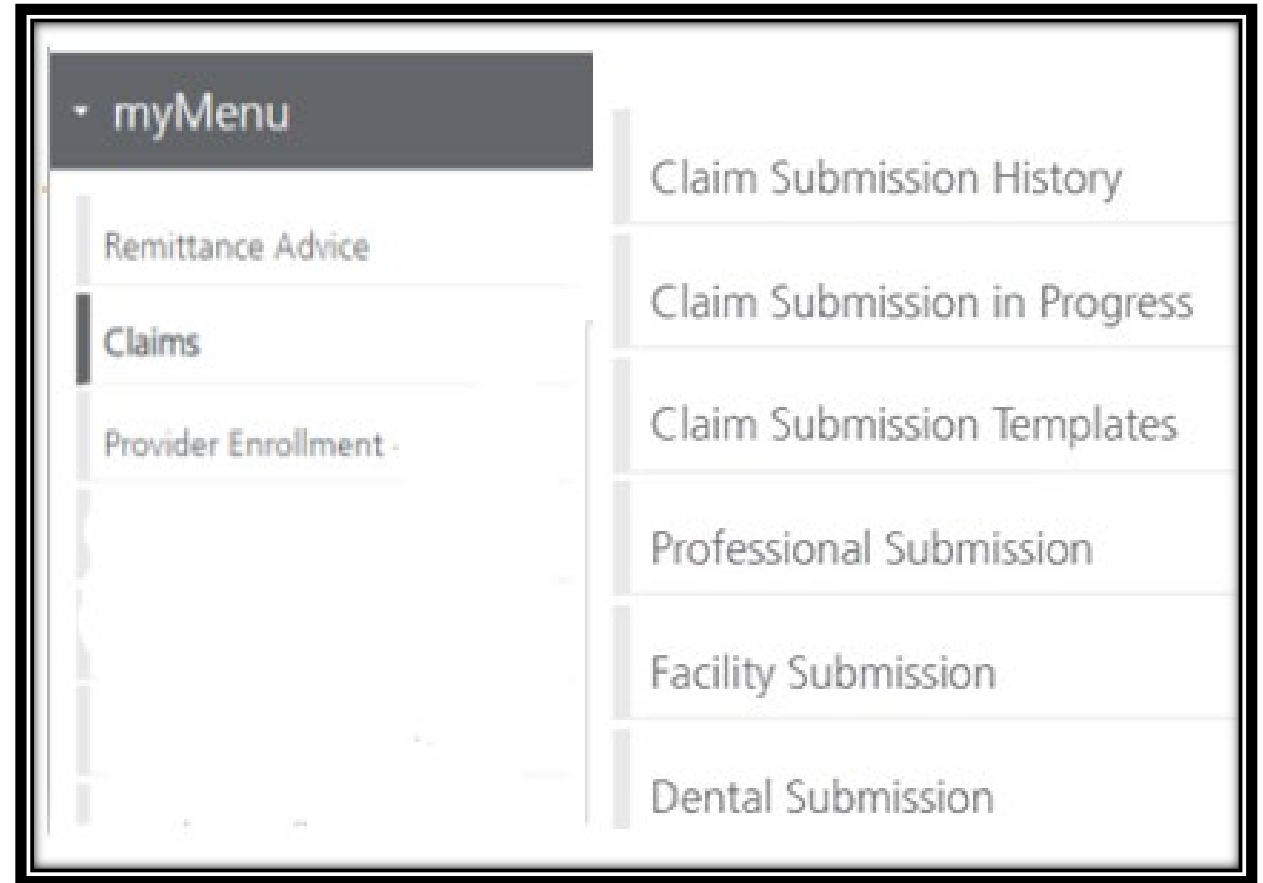
This is a resource to go step by step for claim submission.

Professional 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

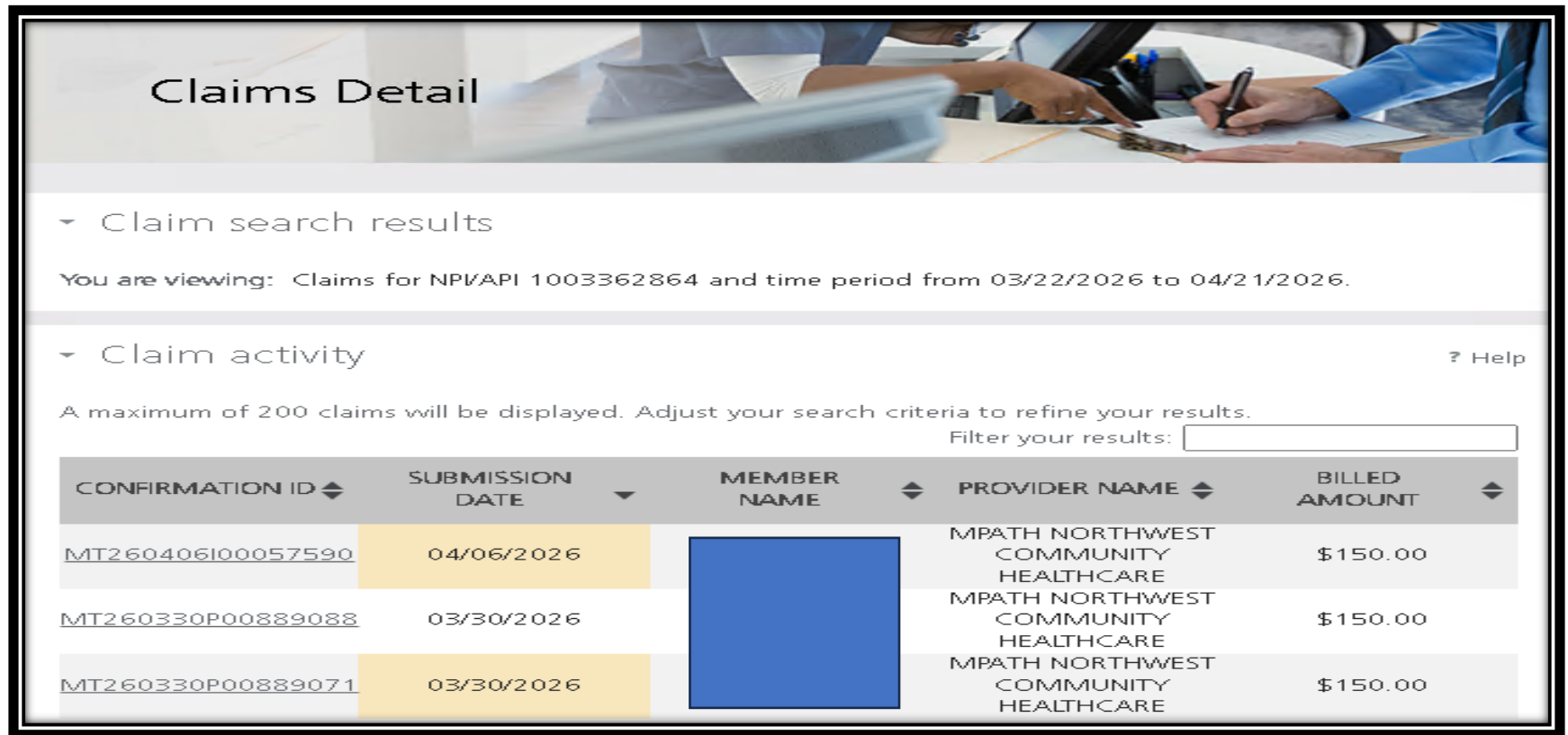
This option will show you the most recent claims SUBMITTED to Montana Medicaid for processing.

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 History Cont.

The last claims submitted will show here.



The screenshot displays a web interface titled "Claims Detail". It includes a section for "Claim search results" with a filter for NPI/API 1003362864 and a time period from 03/22/2026 to 04/21/2026. Below this is a "Claim activity" section with a "Filter your results:" input field. A table lists three claims with columns for Confirmation ID, Submission Date, Member Name, Provider Name, and Billed Amount. The Member Name column is obscured by a blue box.

CONFIRMATION ID	SUBMISSION DATE	MEMBER NAME	PROVIDER NAME	BILLED AMOUNT
MT260406I00057590	04/06/2026	[REDACTED]	MPATH NORTHWEST COMMUNITY HEALTHCARE	\$150.00
MT260330P00889088	03/30/2026	[REDACTED]	MPATH NORTHWEST COMMUNITY HEALTHCARE	\$150.00
MT260330P00889071	03/30/2026	[REDACTED]	MPATH NORTHWEST COMMUNITY HEALTHCARE	\$150.00

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.

Claims Submission in Progress Cont.

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

The screenshot shows a web application interface for managing claims. At the top, there is a header image with the text "Claim Submission in Progress". Below the header, there is a navigation menu with a dropdown arrow and the text "Claim Submission in Progress". To the right of the menu is a "? Help" link. Below the menu, there is a message: "A maximum of 200 in-progress claims will be displayed." To the right of this message is a search box labeled "Filter your results:". Below the search box is a table with the following columns: "Action", "Member Name", "Date of Service", "NPI/API", and "Date Last Modified". The table contains 10 rows of data. The first row has a pencil icon and a trash can icon in the "Action" column, a blue redaction box in the "Member Name" column, and the values "1003362864" and "04/07/2026" in the "NPI/API" and "Date Last Modified" columns respectively. The subsequent rows have similar data, with the "Date Last Modified" values being "04/07/2026", "04/06/2026", "04/06/2026", "04/02/2026", "04/02/2026", "04/02/2026", "04/02/2026", "04/02/2026", and "04/02/2026". At the bottom of the table, there is a "Show 10 entries" dropdown menu and a pagination control showing "Showing 1 to 10 of 59 in-progress claims" with navigation arrows.

Action	Member Name	Date of Service	NPI/API	Date Last Modified
	[Redacted]		1003362864	04/07/2026
	[Redacted]		1003362864	04/07/2026
	[Redacted]		1003362864	04/06/2026
	[Redacted]		1003362864	04/06/2026
	[Redacted]		1003362864	04/02/2026
	[Redacted]		1003362864	04/02/2026
	[Redacted]		1003362864	04/02/2026
	[Redacted]		1003362864	04/02/2026
	[Redacted]		1003362864	04/02/2026
	[Redacted]		1003362864	04/02/2026

Professional Claim Submission Templates

Professional 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 Professional Claim Template

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

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

*Section 6, of the Provider Portal User Guide.

The screenshot displays the 'Claim Submission Templates' interface. At the top, it shows the title 'Claim Submission Templates' and a help icon. Below the title, it indicates 'Maximum Templates Allowed : 2000' and a search filter 'Filter your results:'. The main content is a table with columns for 'Actions', 'Name of Template', 'Created By', 'Last Modified By', and 'Last Modified'. The table lists nine templates, each with a blue button for editing, a blue button for creating a new template, and a trash icon for deletion. Below the table, there is a 'Show 10 entries' dropdown and 'Showing 1 to 9 of 9 templates' with navigation arrows. At the bottom, three blue buttons are highlighted with red boxes: 'Create Professional Claim Submission Template', 'Create Facility Claim Submission Template', and 'Create Dental Claim Submission Template'.

Actions	Name of Template	Created By	Last Modified By	Last Modified
	<u>Fred</u>	Test, Conduent	Test, Conduent	12/08/2025
	<u>H0043 U1</u>	Test, Conduent	Test, Conduent	10/16/2024
	<u>Maria</u>	Test, Conduent	Test, Conduent	11/26/2025
	<u>Maria G</u>	Test, Conduent	Test, Conduent	09/24/2025
	<u>office visit</u>	Test, Conduent	Test, Conduent	06/12/2025
	<u>Sarah E</u>	Test, Conduent	Test, Conduent	08/12/2025
	<u>Template 2</u>	Test, Conduent	Test, Conduent	05/01/2025
	<u>test</u>	Test, Conduent	Test, Conduent	07/02/2025
	<u>Threeirons A</u>	Test, Conduent	Test, Conduent	02/26/2026

Show 10 entries Showing 1 to 9 of 9 templates < < > >

[Create Professional Claim Submission Template](#) [Create Facility Claim Submission Template](#) [Create Dental Claim Submission Template](#)

Creating a Professional 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.**

NPI/API:*	1245490713
Provider Name:*	NORTH WEST HOME CAI
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:*	Select Program/Waiver
Service Location Address 1:*	Severe Disabling Mental Illness Waiver (SDMI)
Service Location Address 2:	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 Professional Template cont.

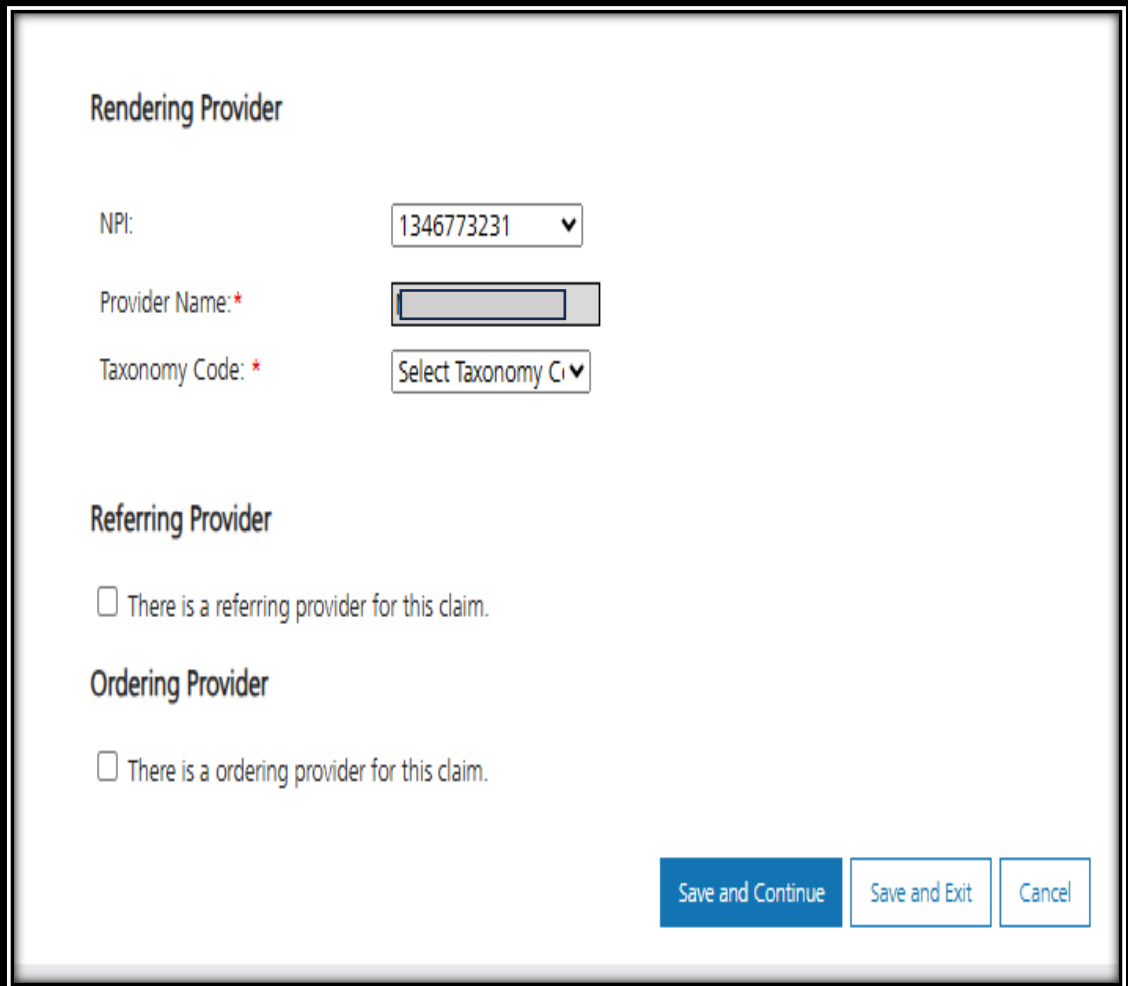
Select the Rendering Provider file.

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

Select NPI.

Select Specialty.

Click **Save and Continue**.



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

- Rendering Provider**
 - NPI: A dropdown menu with the value "1346773231" selected.
 - Provider Name: * A text input field.
 - Taxonomy Code: * A dropdown menu with the value "Select Taxonomy C" selected.
- Referring Provider**
 - There is a referring provider for this claim.
- Ordering Provider**
 - There is a ordering provider for this claim.

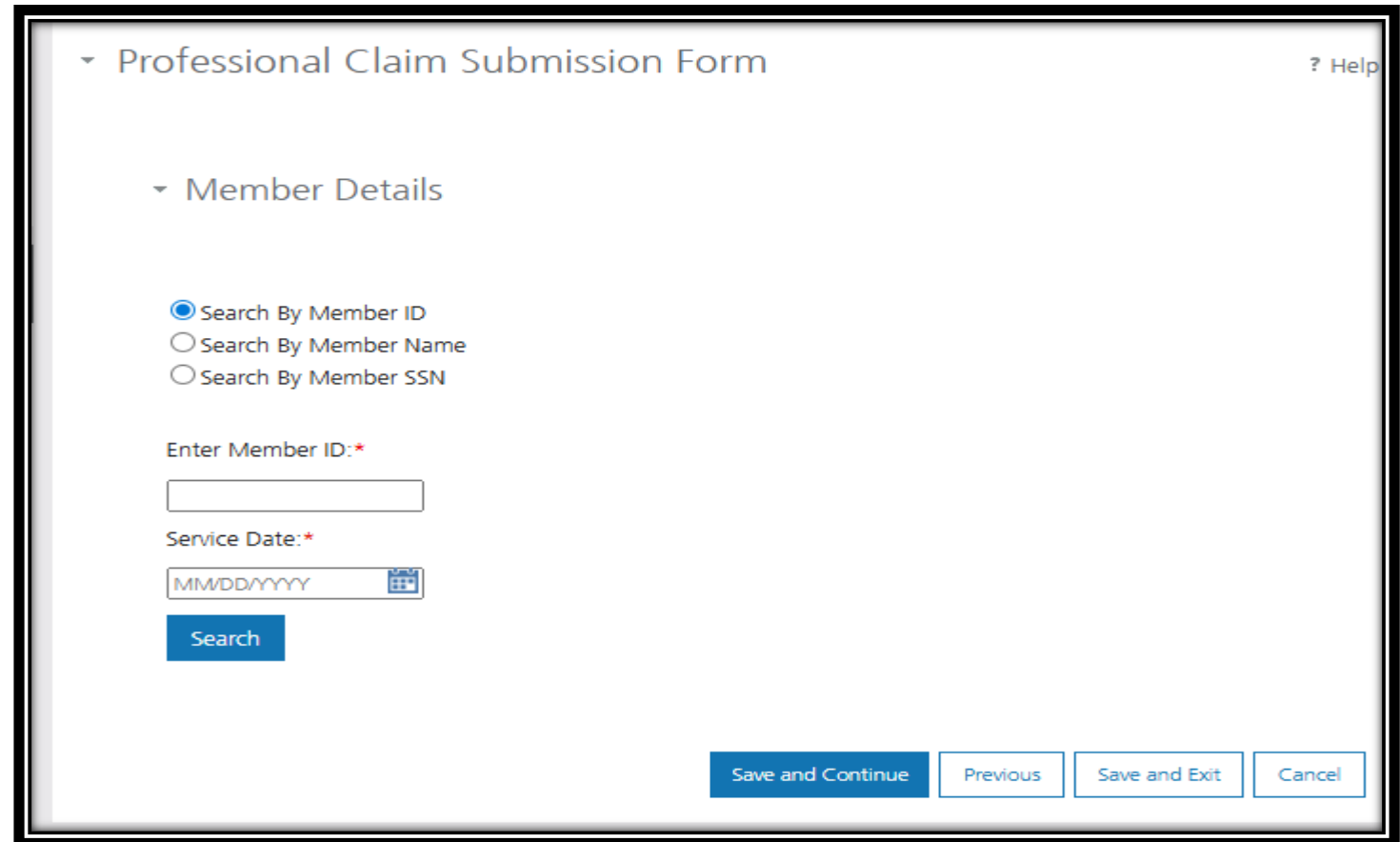
At the bottom right, there are three buttons: "Save and Continue" (highlighted in blue), "Save and Exit", and "Cancel".

Creating a Professional 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 displays a web form titled "Professional Claim Submission Form" with a help icon in the top right corner. Under the "Member Details" section, there are three radio button options: "Search By Member ID" (selected), "Search By Member Name", and "Search By Member SSN". Below these options, there is a text input field labeled "Enter Member ID: *" and a date input field labeled "Service Date: *" with a calendar icon and the placeholder "MMDD/YYYY". A blue "Search" button is positioned below the date field. At the bottom right of the form, there are four buttons: "Save and Continue" (highlighted in blue), "Previous", "Save and Exit", and "Cancel".

Creating a Professional Claim 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 : **COB** or **NDC** indicates all required fields for COB or NDC have been entered.

Note : Use a comma "," if multiple values are needed in Modifier or Diagnosis Pointer fields.

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

Total Charges: \$

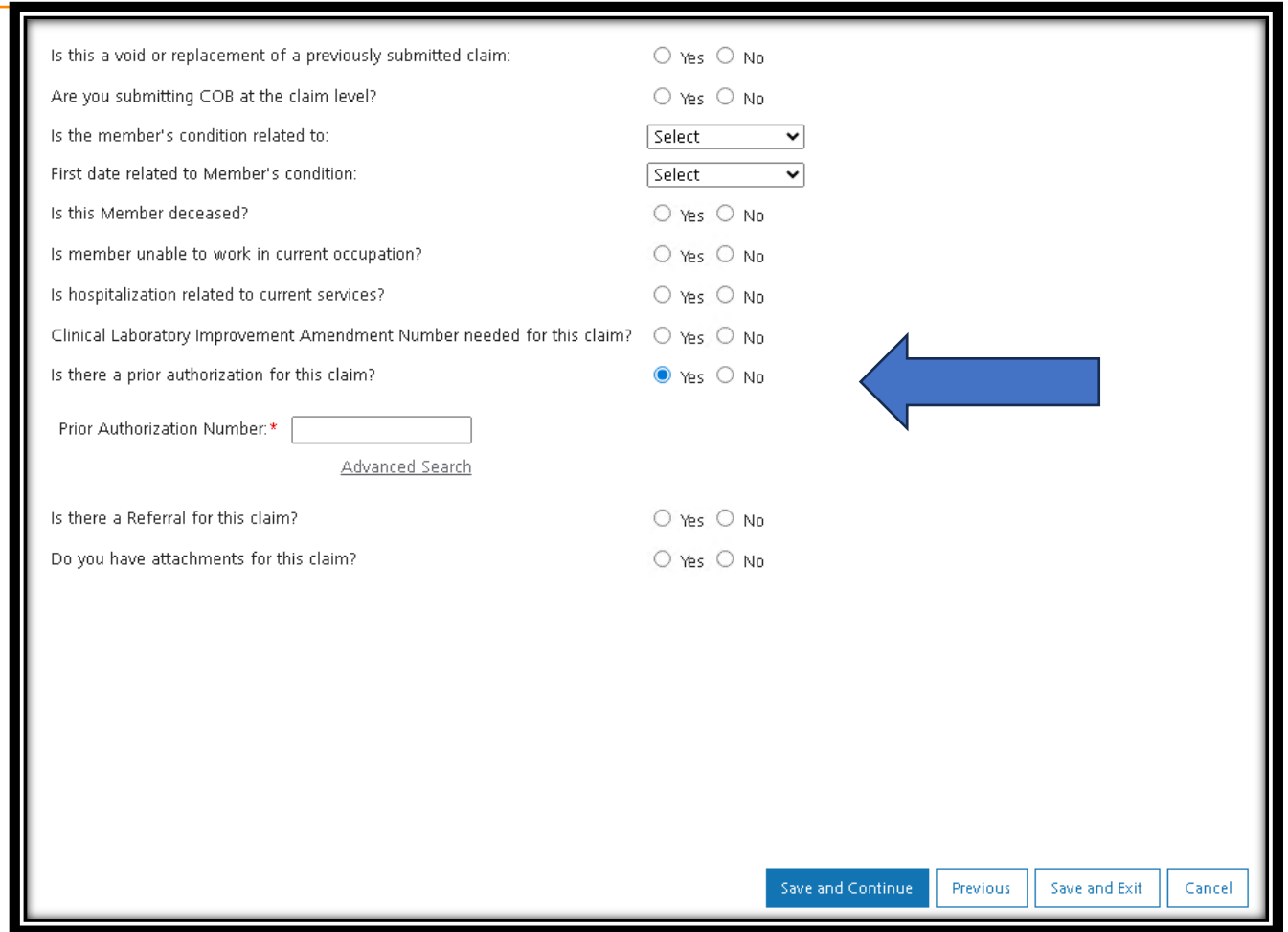
Note : Total Claim Lines are limited to a maximum of 50 for each submission.

Creating a Professional Claim 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:

First date related to Member's condition:

Is this Member deceased? Yes No

Is member unable to work in current occupation? Yes No

Is hospitalization related to current services? Yes No

Clinical Laboratory Improvement Amendment Number needed for this claim? Yes No

Is there a prior authorization for this claim? Yes No

Prior Authorization Number: *

[Advanced Search](#)

Is there a Referral for this claim? Yes No

Do you have attachments for this claim? Yes No

Save and Continue Previous Save and Exit Cancel

Creating a Professional Template Cont.

The last step is to name the Template.

Your template is now visible.



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.

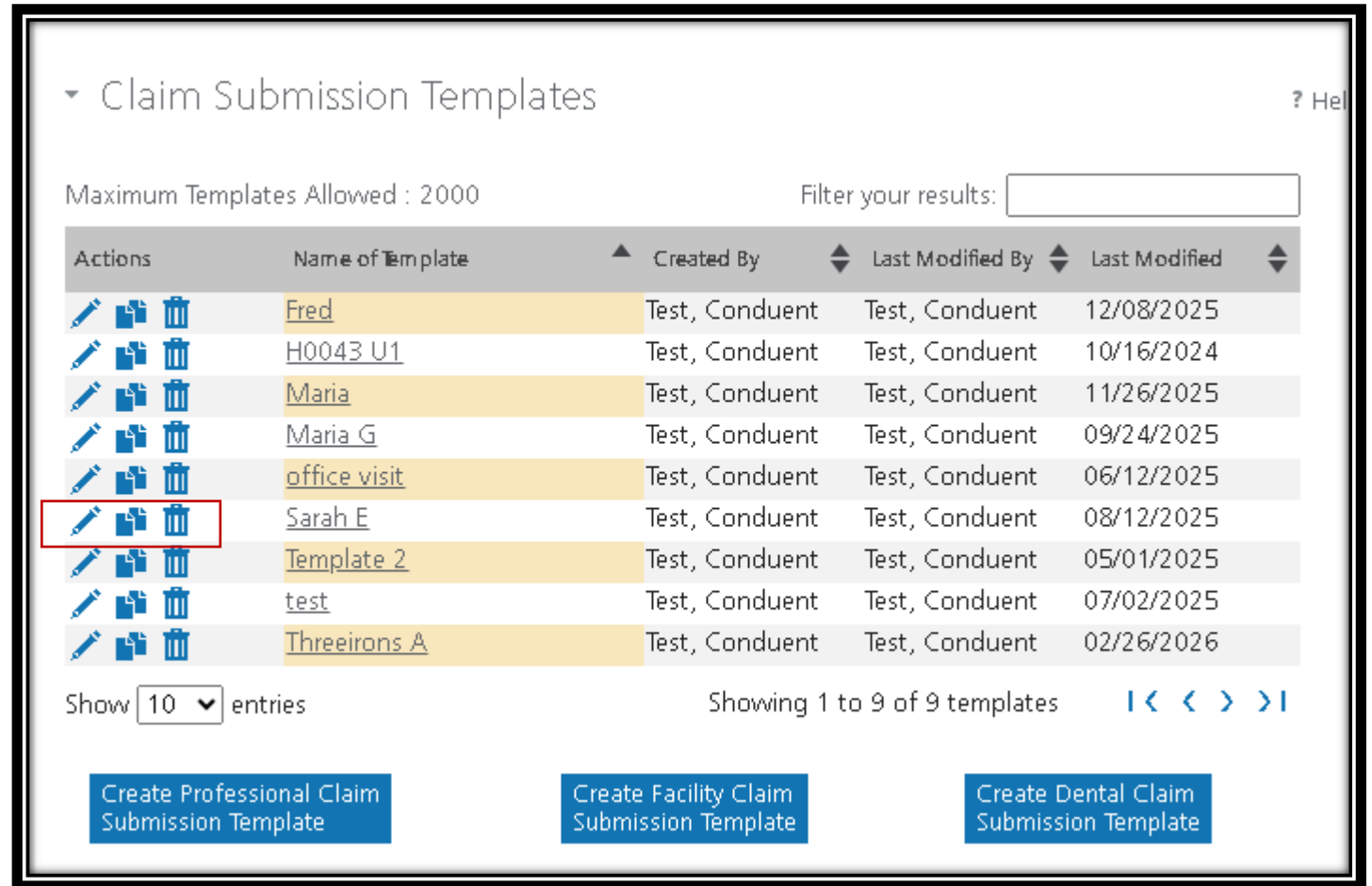
Creating a Professional Template Cont.

Your template is now under Claim Submission Templates.




























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.



The screenshot displays the 'Claim Submission Templates' interface. At the top, it shows the title 'Claim Submission Templates' and a help icon. Below the title, it indicates 'Maximum Templates Allowed : 2000' and a search filter 'Filter your results:'. The main content is a table with columns for 'Actions', 'Name of Template', 'Created By', 'Last Modified By', and 'Last Modified'. The table lists nine templates, each with a pencil icon for editing and a trash can icon for deletion. The 'Sarah E' row is highlighted with a red box. At the bottom, there are three buttons: 'Create Professional Claim Submission Template', 'Create Facility Claim Submission Template', and 'Create Dental Claim Submission Template'. The page also shows 'Showing 1 to 9 of 9 templates' and a pagination control.

Actions	Name of Template	Created By	Last Modified By	Last Modified
  	Fred	Test, Conduent	Test, Conduent	12/08/2025
  	H0043 U1	Test, Conduent	Test, Conduent	10/16/2024
  	Maria	Test, Conduent	Test, Conduent	11/26/2025
  	Maria G	Test, Conduent	Test, Conduent	09/24/2025
  	office visit	Test, Conduent	Test, Conduent	06/12/2025
  	Sarah E	Test, Conduent	Test, Conduent	08/12/2025
  	Template 2	Test, Conduent	Test, Conduent	05/01/2025
  	test	Test, Conduent	Test, Conduent	07/02/2025
  	Threeirons A	Test, Conduent	Test, Conduent	02/26/2026

Questions?

Professional Claim Submission

Creating a Professional Claim

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 CAI
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:*	Select Program/Waiver
Service Location Address 1:*	Severe Disabling Mental Illness Waiver (SDMI)
Service Location Address 2:	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 Professional Claim cont.

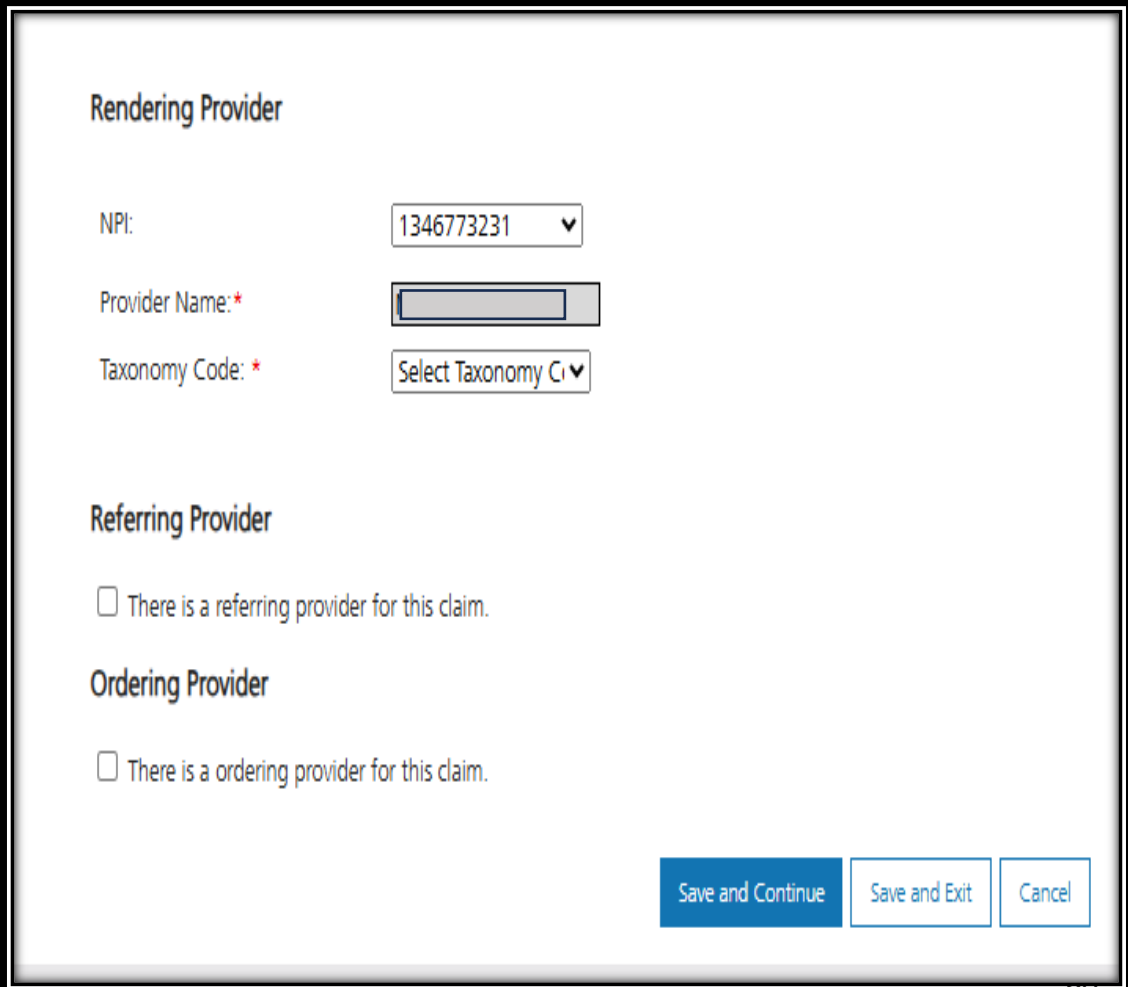
Select the Rendering Provider file.

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

Select NPI.

Select Specialty.

Click **Save and Continue**.



The screenshot shows a web form titled "Creating a Professional Claim cont." with the following sections and fields:

- Rendering Provider**
 - NPI: A dropdown menu with the value "1346773231".
 - Provider Name: * A text input field.
 - Taxonomy Code: * A dropdown menu with the value "Select Taxonomy C".
- Referring Provider**
 - There is a referring provider for this claim.
- Ordering Provider**
 - There is a ordering provider for this claim.

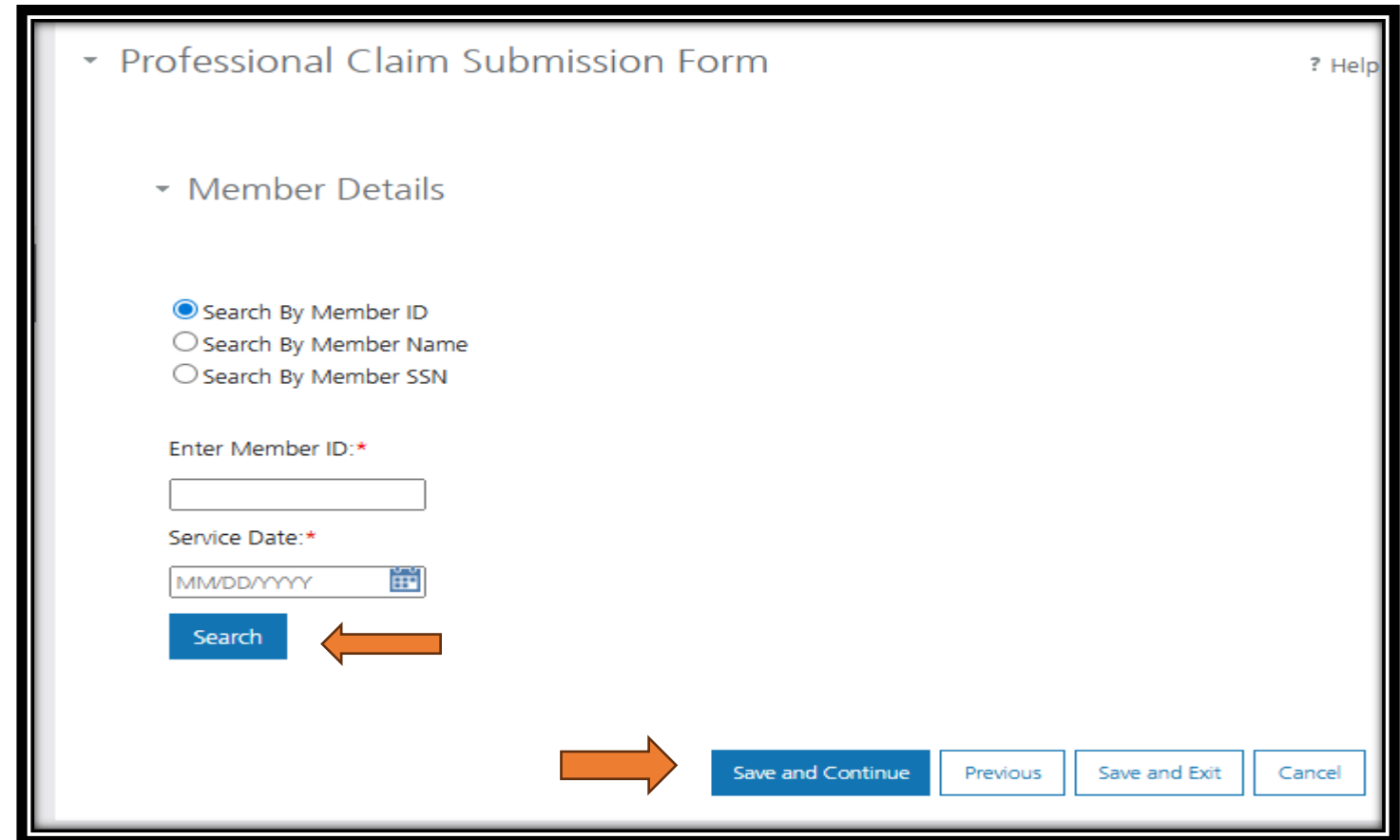
At the bottom right, there are three buttons: "Save and Continue" (highlighted in blue), "Save and Exit", and "Cancel".

Creating a Professional Claim 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 form titled "Professional Claim Submission Form" with a help icon in the top right. Under the "Member Details" section, there are three radio button options: "Search By Member ID" (selected), "Search By Member Name", and "Search By Member SSN". Below these is a text input field labeled "Enter Member ID: *" and a "Service Date: *" field with a date picker icon and the format "MMDD/YYYY". A blue "Search" button is positioned below the date field, with an orange arrow pointing to it from the left. At the bottom right of the form, there are four buttons: "Save and Continue" (highlighted with an orange arrow from the left), "Previous", "Save and Exit", and "Cancel".

Creating a Professional Claim Cont.

Complete the fields.

For instance, the diagnosis code, place of service, CPT code, modifier & diagnosis pointer, charges, units.

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 : **COB** or **NDC** indicates all required fields for COB or NDC have been entered.

Note : Use a comma "," if multiple values are needed in Modifier or Diagnosis Pointer fields.

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

Total Charges: \$

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

Creating a Professional Claim Cont.

TIP: Any time there is a magnifying glass icon you can put in the beginning of the Diagnosis or CPT and it will give you options.

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"/>

Search Results

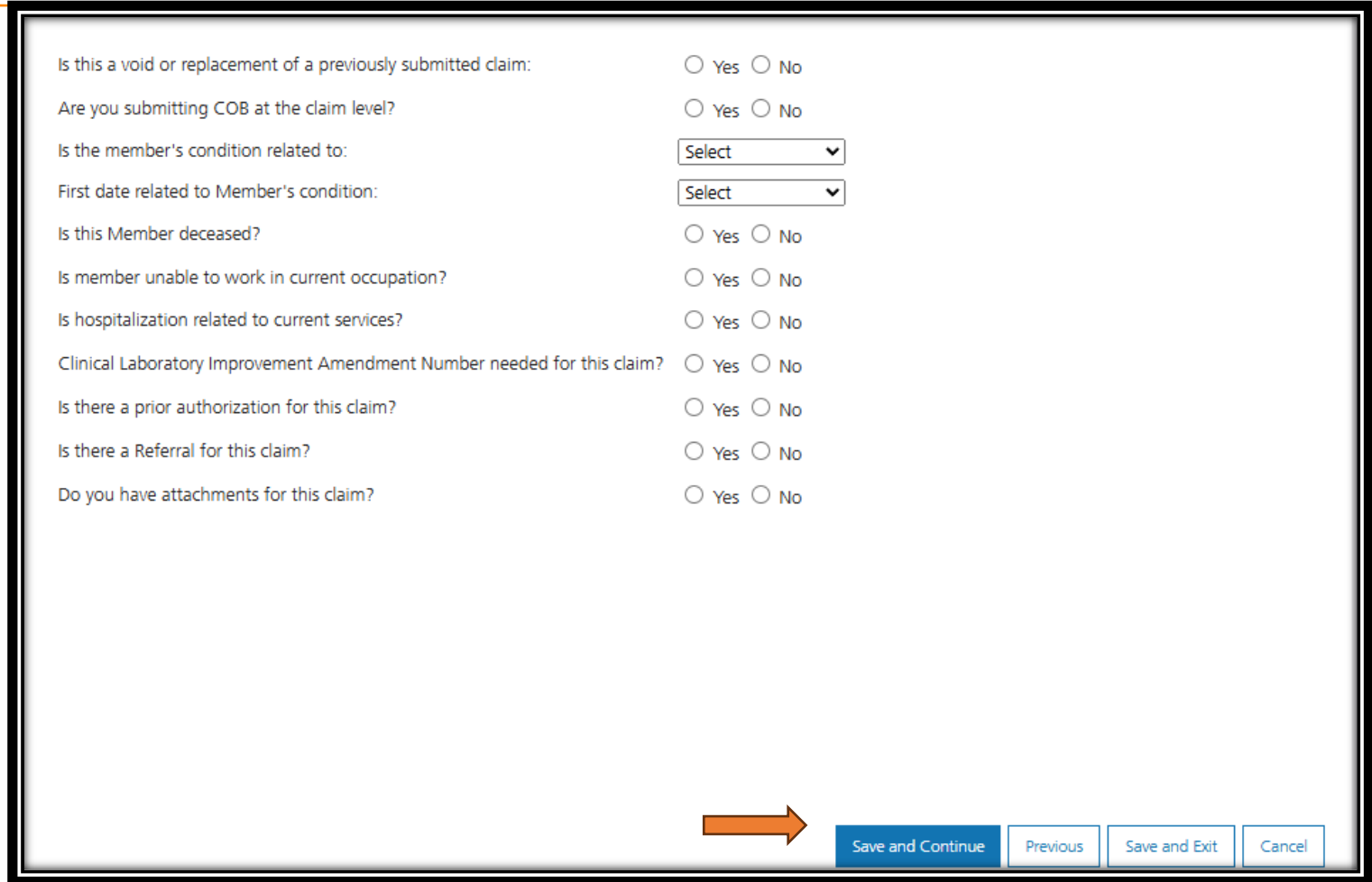
Code	Description
<u>F41</u>	Other anxiety disorders
<u>F410</u>	Panic disorder [episodic paroxysmal anxiety]
<u>F411</u>	Generalized anxiety disorder
<u>F413</u>	Other mixed anxiety disorders
<u>F418</u>	Other specified anxiety disorders
<u>F419</u>	Anxiety disorder, unspecified

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

Creating a Professional Claim Cont.

Answer all the questions at the bottom of the screen if applicable.

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:

First date related to Member's condition:

Is this Member deceased? Yes No

Is member unable to work in current occupation? Yes No


Is hospitalization related to current services? Yes No

Clinical Laboratory Improvement Amendment Number needed for this claim? Yes No

Is there a prior authorization for this claim? Yes No

Is there a Referral for this claim? Yes No

Do you have attachments for this claim? Yes No



Creating a Professional Claim Cont.

The last step is to certify that you have read the terms and agreement.

Click Submit.



The screenshot shows a web form titled "Professional Claim Submission Form" with a "? Help" link in the top right. Below the title is a dropdown menu for "Terms and Agreements". A red note states: "Note : Fields marked with an asterisk * are required." There are two input fields: "Provider Name: *" containing "MPATH NORTHWEST" and "NPI/API: *" containing "1003362864". Below these is a checkbox labeled "I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof." The checkbox is checked. At the bottom right, there are four buttons: "Submit", "Previous", "Save and Exit", and "Cancel". A large orange arrow points from the left towards the "Submit" button.

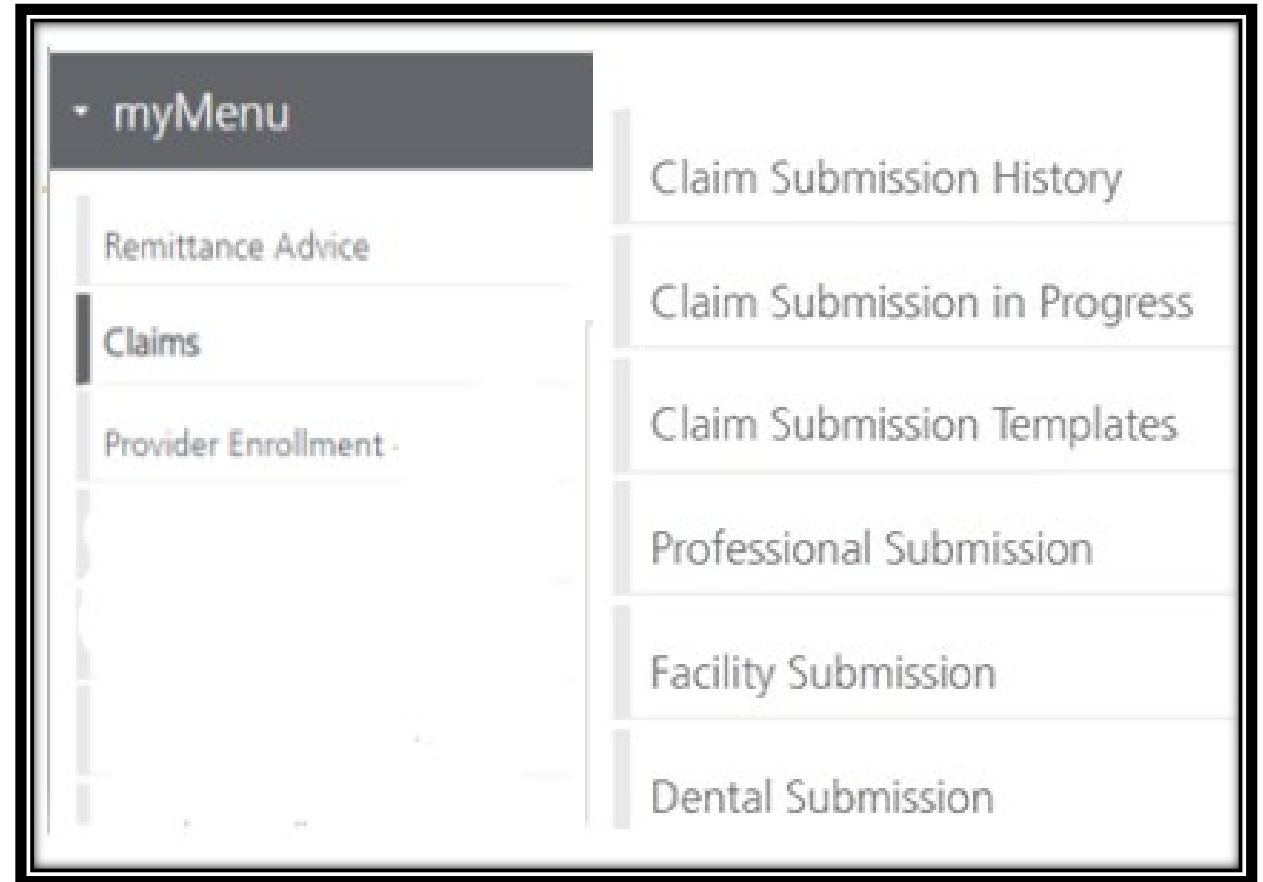
Facility Claim Submission

Facility Claim Submission Menu

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

A side menu with submission options will appear.

Choose the **Facility Submission** Option



Facility Claim Submission

The first step is choosing your Billing Provider, Program and Specialty.

If the facility has multiple specialities at the location, you will have a drop down to choose from.

Tip: Review what you have selected.

Facility Claim Submission Form ? Help


▼ Billing Provider

Note : Fields marked with an asterisk * are required.

NPI/API:*	<input type="text" value="1003362864"/>
Provider Name:*	<input type="text" value="MPATH NORTHWEST C"/>
Program/Waiver:*	<input type="text" value="Montana Medicaid (HMK Plus)"/>
Specialty:*	<input type="text" value="Clinic/Center; Federally Qualified Health Cen"/>

Service Location

Service Address 1:*	<input type="text" value="8 J Street"/>
Service Address 2:	<input type="text"/>
City:*	<input type="text" value="Helena"/>
State:*	<input type="text" value="MT"/>
ZIP:*	<input type="text" value="59601-0000"/>
Taxonomy Code:*	<input type="text" value="261QF0400X"/>
Enrollment Unit:*	<input type="text" value="0001861613"/>



Facility Claim Submission Continued

The second step is clicking type of providers to add.

Put in the NPI, click GO.

Save and continue.

Other Provider(s)

Attending Provider

There is an attending provider for this claim.

Enter Provider NPI: *

NPI:

Provider Name:

Operating Provider

There is an operating provider for this claim.

Other Provider 1

There is an other provider for this claim.

Other Provider 2

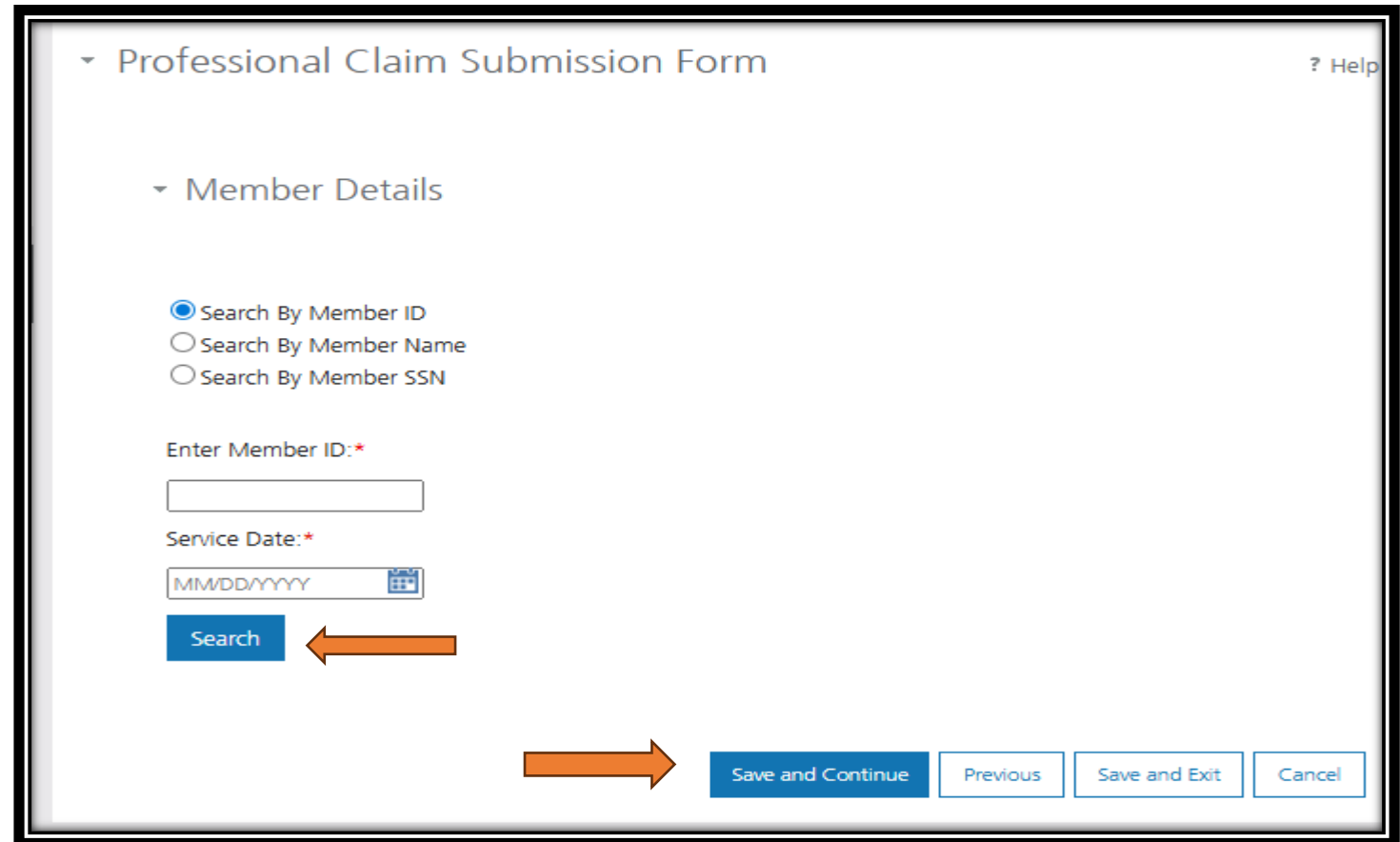
There is an other provider for this claim.

Creating a Facility Claim 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 displays the 'Professional Claim Submission Form' interface. At the top, there is a title bar with a dropdown arrow and the text 'Professional Claim Submission Form', and a 'Help' link on the right. Below the title bar, there is a section titled 'Member Details' with a dropdown arrow. Under 'Member Details', 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, there are two required fields: 'Enter Member ID: *' with an empty text input box, and 'Service Date: *' with a date picker showing 'MMDD/YYYY' and a calendar icon. A blue 'Search' button is located below the date picker, with an orange arrow pointing to it from the right. At the bottom of the form, there are four buttons: 'Save and Continue' (highlighted with an orange arrow from the left), 'Previous', 'Save and Exit', and 'Cancel'.

Creating a Facility Claim Cont.

Answer all the questions with the red asterisk.

Read the notes about the bill types and adjustments.

Fill out appropriate required information.

Facility Claim Submission Form ? Help

Claim Information

Note : Fields marked with an asterisk * are required.

Note : Type of Bill value field is 4 character code with the first value always being zero. To void or replace a claim, enter the original submitted Type of Bill, change the last digit to 8 (Void) or 7 (Replacement) and enter the 17-digit MMIS ICN in the Original MMIS ICN field.

Type of Bill:*	Inpatient or Outpatient:*	Statement Period From:*	Statement Period Through:*		
<input type="text"/>	Select ▼	MM/DD/YYYY	MM/DD/YYYY		
Admission Date:	Admission Hour:	Admission Type: *	Source of Admission:*	Discharge Hour:	Member Discharge Status:*
MM/DD/YYYY	Select ▼	<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>

Note : Changing only the Type of Bill on the claim cannot be done via electronic adjustment. This must be done using the Individual Adjustment Request.

Creating a Facility Claim Cont.

Fill out the optional fields where applicable.

Tip: if you click on the ? The application give you helpful info.

Condition Codes ?

Condition Codes:

Accident State:

Occurrence Codes

Occurrence Code:	Date:	Occurrence Code:	Date:
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>

Occurrence Span Codes

Occurrence Span Code:	From:	Through:	Occurrence Span Code:	From:	Through:
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="MM/DD/YYYY"/>
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="MM/DD/YYYY"/>
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="MM/DD/YYYY"/>
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="MM/DD/YYYY"/>

To report Personal Resource Amount for a skilled Nursing Facility claim enter Value Code 31 and enter the dollar amount into the Amount/Days field.

Value Codes ?


Creating a Facility Claim Cont.

Fill out the body of the claim. The asterisk fields are required.

Please read notes for tips.

Tip: if you are unsure of the exact information for each field. Click on the **Magnifying Glass Icon**, and the application give you helpful info.

Claim Details

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

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NDC	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NDC	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NDC	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NDC	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NDC	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NDC	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NDC	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NDC	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NDC	\$ <input type="text"/>

Total Charges: \$

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

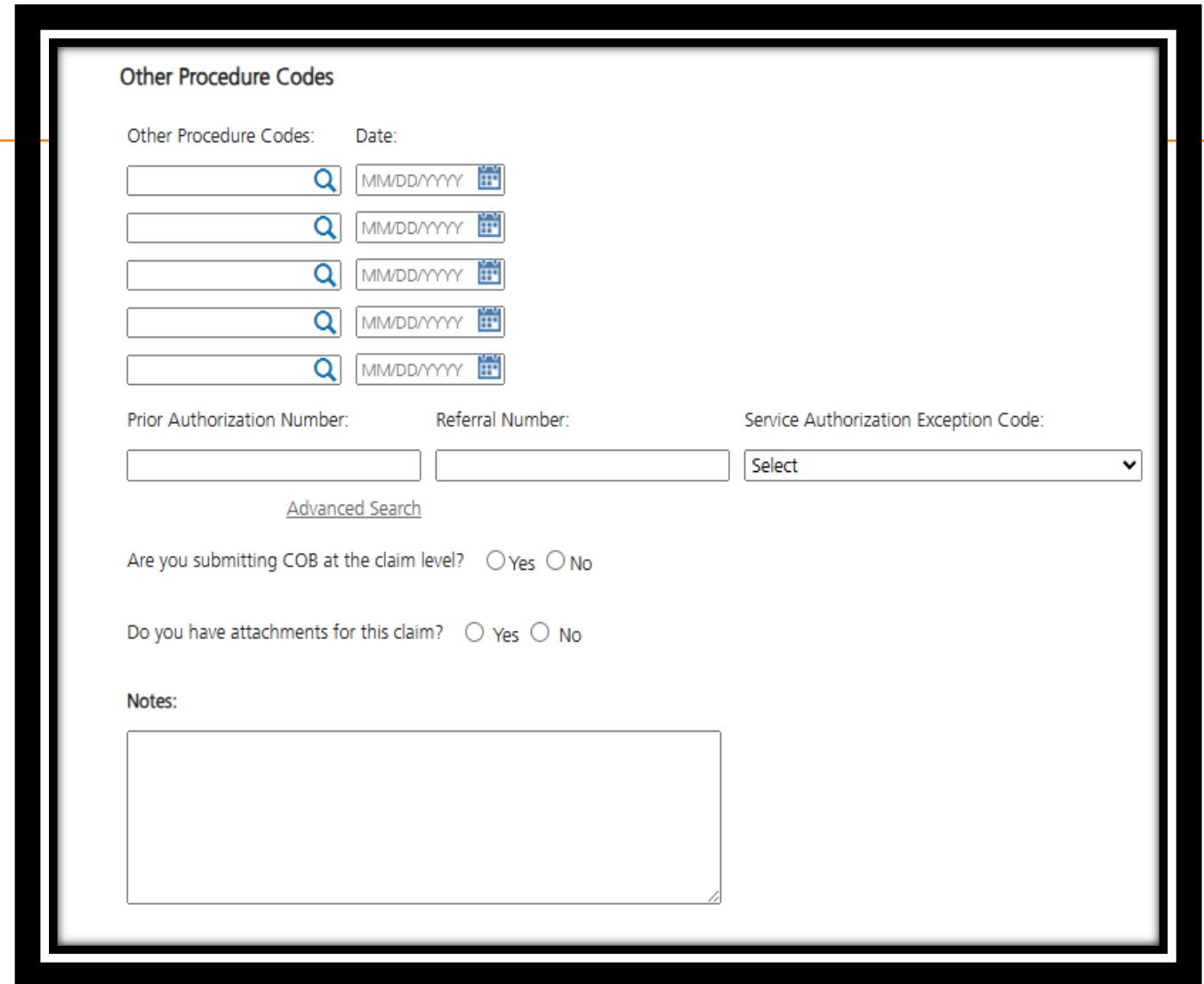
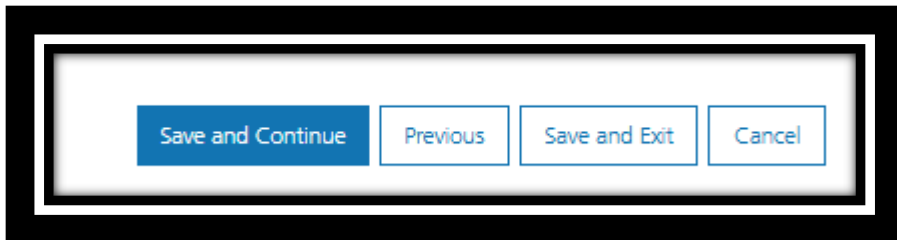
Primary Diagnosis Code: * Present on Admission: * Diagnosis Related Groups(DRG):

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

Creating a Facility Claim Cont.

Fill out the other procedure codes and other fields.

Save and continue.

A screenshot of a web form titled 'Other Procedure Codes'. The form contains several input fields and a dropdown menu. At the top, there are two columns: 'Other Procedure Codes:' and 'Date:'. Below each column are five rows of input fields. Each row has a search icon (magnifying glass) to the right of the 'Other Procedure Codes' field and a date picker icon (calendar) to the right of the 'Date' field. Below these rows are three more input fields: 'Prior Authorization Number:', 'Referral Number:', and 'Service Authorization Exception Code:'. The 'Service Authorization Exception Code' field is a dropdown menu with 'Select' and a downward arrow. Below these fields is a link for 'Advanced Search'. There are two radio button questions: 'Are you submitting COB at the claim level?' with 'Yes' and 'No' options, and 'Do you have attachments for this claim?' with 'Yes' and 'No' options. At the bottom is a 'Notes:' section with a large text area.

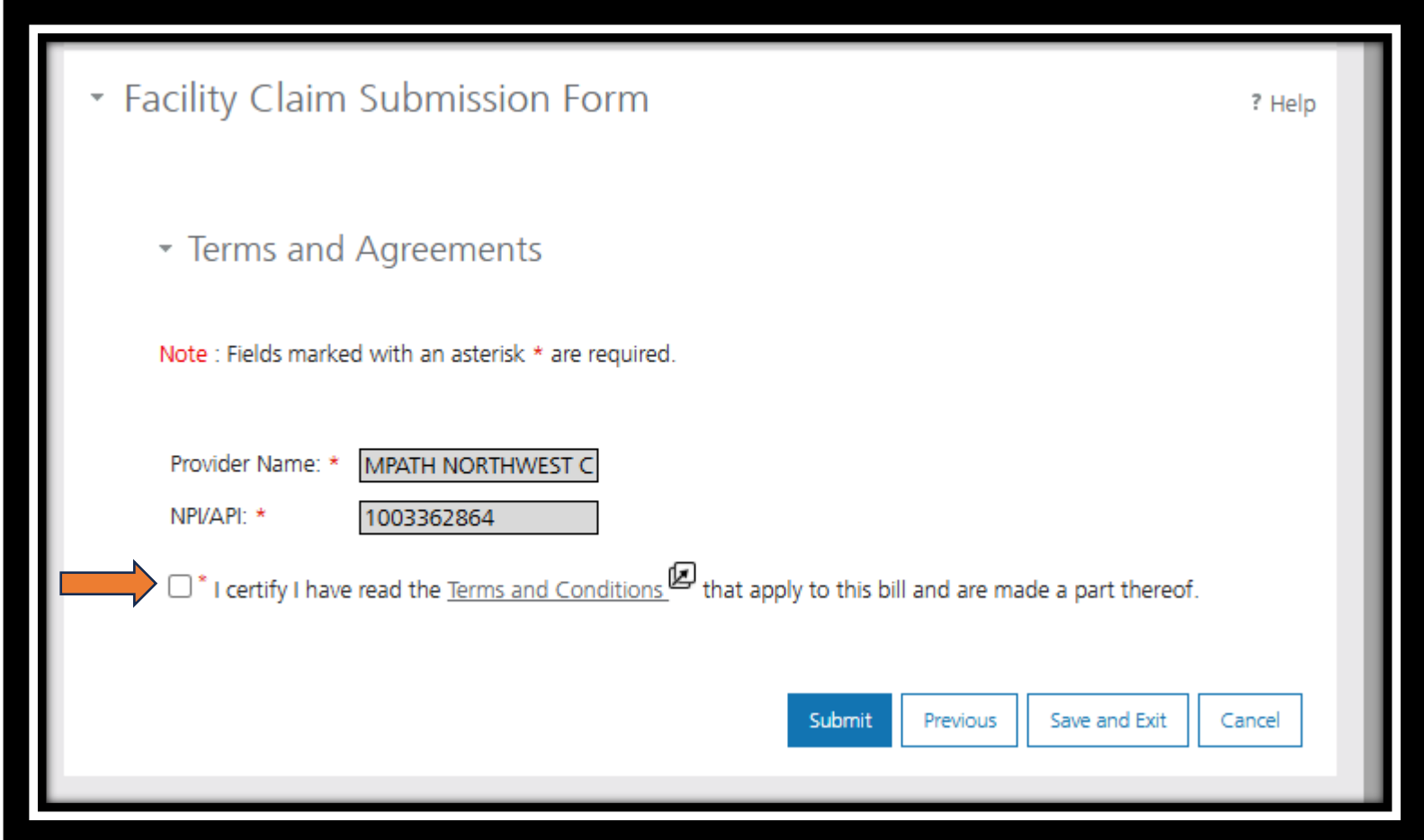
Creating a Facility Claim Cont.

The last step is to click the I certify box. Click the Terms and Conditions if you would like to read the Terms and agreements.

Submit.

After submitting your claim, there will be a thank you for submitting and confirmation number and a print icon.

Print or save.



Facility 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.

Questions?

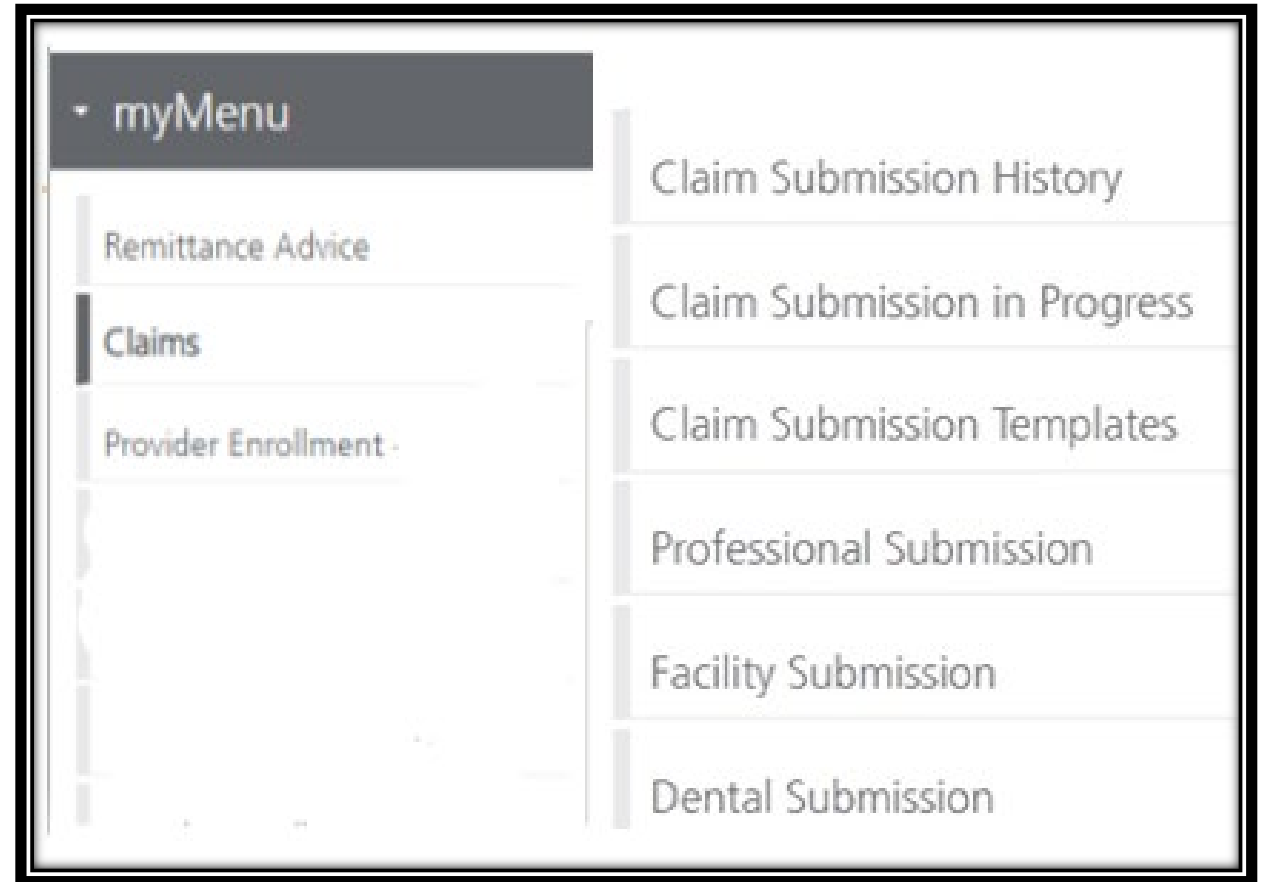
Dental Claim Submission

Dental Claim Submission Menu

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

A side menu with submission options will appear.

Choose the **Dental Submission** Option



Creating a Dental Claim

Select the Billing Provider file.

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

Select NPI.

Select Program/Waiver.

Select Specialty.



Enrollment Unit.

▼ Dental Claim Submission Form

▼ Billing Dentist

Note : Fields marked with an asterisk * are required.

NPI:*	<input type="text" value="1003362864"/>
Provider Name:*	<input type="text" value="MPATH NORTHWEST C"/>
Program/Waiver:*	<input type="text" value="Montana Medicaid (HMK Plus)"/>
Specialty:*	<input type="text" value="Clinic/Center; Federally Qualified Health Cen"/>
Service Location Address 1:*	<input type="text" value="8 J Street"/>
Service Location Address 2:	<input type="text"/>
City:*	<input type="text" value="Helena"/>
State:*	<input type="text" value="MT"/>
ZIP Code:*	<input type="text" value="59601-0000"/>
Taxonomy Code:*	<input type="text" value="261QF0400X"/>
Enrollment Unit:*	<input type="text" value="0001861613"/>



Creating a Dental Claim cont.

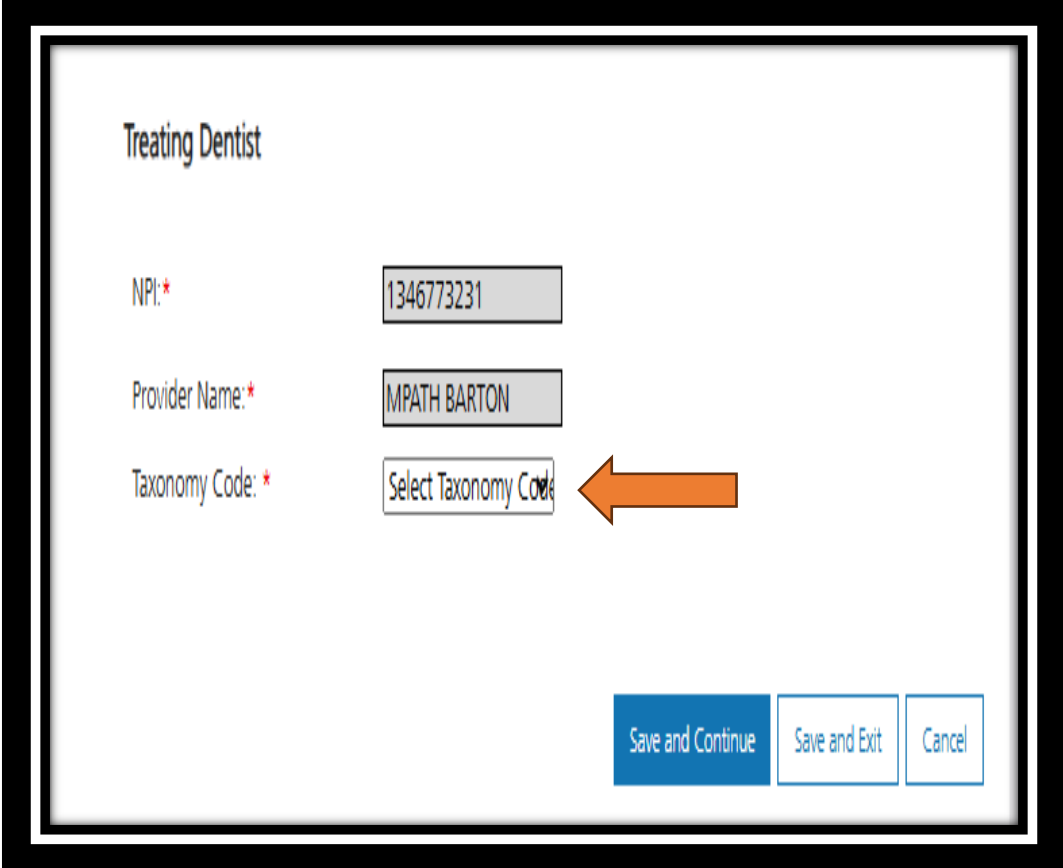
Select the Treating Provider.

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

Select NPI.

Select Specialty.

Click **Save and Continue**.



Treating Dentist

NPI: * 1346773231

Provider Name: * MPATH BARTON

Taxonomy Code: * Select Taxonomy Code ←

Save and Continue Save and Exit Cancel

Creating a Dental Claim 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**.

Member Details

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

Enter Member ID: *

Service Date: *

Search

Save and Continue Previous Save and Exit Cancel

Creating a Dental Claim cont.

Read the notes for tips in completing the claim.

Complete required fields, Procedure Date, Procedure Code, Quantity, and Fee.

▼ Claim Information

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

Note : Fields marked with an asterisk * are required.

Record of services provided

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

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

Procedure Date*	Area of Oral Cavity	Tooth Number(s) or Letter(s)	Tooth Surface	Procedure Code*	Diagnosis Code Pointer	Quantity*	COB	Fee*
MM/DD/YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COB	<input type="text"/>
MM/DD/YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COB	<input type="text"/>
MM/DD/YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COB	<input type="text"/>
MM/DD/YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COB	<input type="text"/>
MM/DD/YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COB	<input type="text"/>
MM/DD/YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COB	<input type="text"/>
MM/DD/YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COB	<input type="text"/>
MM/DD/YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COB	<input type="text"/>
MM/DD/YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COB	<input type="text"/>

Total Charges: \$

Creating a Dental Claim Cont.

The Diagnosis and Missing teeth sections have no asterisk.

Answer the required information with red asterisk in Ancillary Claim/Treatment Information.

Click **Save and Continue**.

Diagnosis Codes

Diagnosis Codes (ICD 10): 1 2 3 4

Missing Teeth Information

Click to highlight 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

Ancillary Claim/Treatment Information

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

Are there EPSDT services for this claim? Yes No

Are you submitting COB at the claim level? Yes No

Place of Treatment:*

Is this Treatment or Orthodontics:*

Replacement of Prosthesis: Yes No

Treatment Resulting From:

Predetermination Number:

Prior Authorization Number:

[Advanced Search](#)

Do you have attachments for this claim? Yes No

Notes:

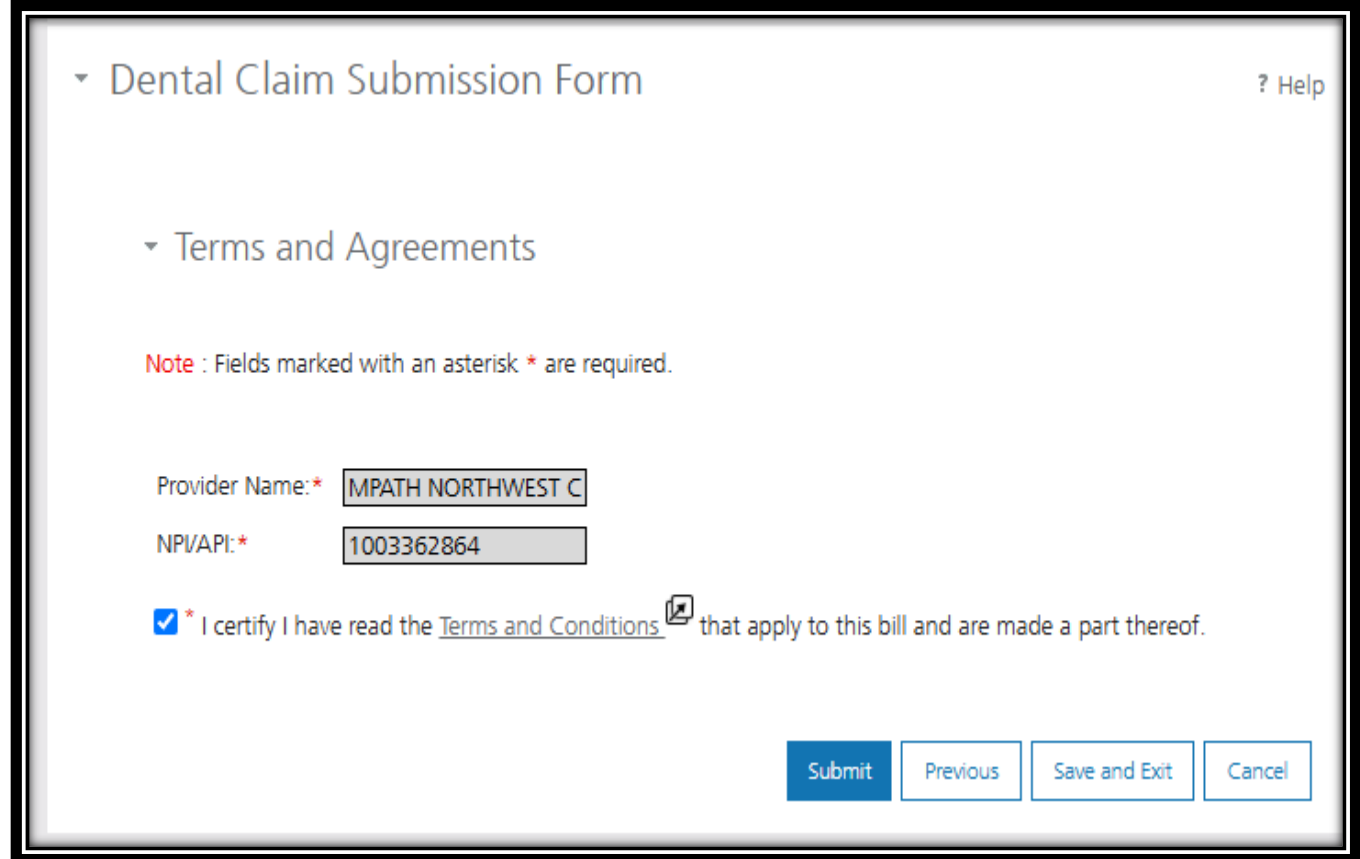
Creating a Dental Claim Cont.

The last step is to click the I certify box. Click the Terms and Conditions if you would like to read the Terms and agreements.

Submit.

After submitting your claim, there will be a thank you for submitting and confirmation number and a print icon.

Print or save.



The screenshot shows a web form titled "Dental Claim Submission Form" with a "? Help" link in the top right corner. Below the title is a section for "Terms and Agreements". A red note states: "Note : Fields marked with an asterisk * are required." There are two input fields: "Provider Name:*" containing "MPATH NORTHWEST C" and "NPV/API:*" containing "1003362864". Below these is a checkbox that is checked, followed by the text: "* I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof." At the bottom right, there are four buttons: "Submit" (blue), "Previous", "Save and Exit", and "Cancel".

Claims Body Questions

Claim Information Questions

The next slides are a highlight of the question that might be applicable to your claim.

There is a section for Adjustments later in the PowerPoint

Claim Adjustment Question

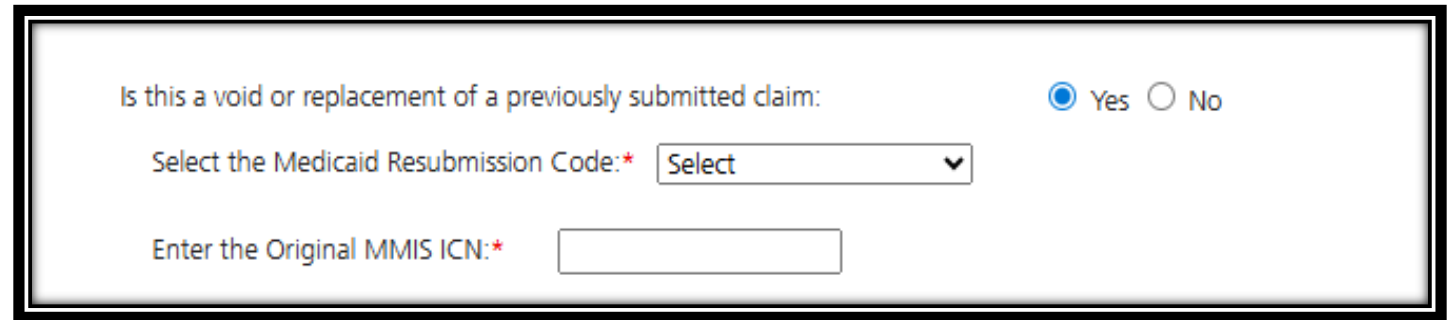
Select Yes to complete a claim adjustment.

TIP: An adjustment can only be done on a **PAID** claim.

A denied claim resubmit a clean claim.

Select Replacement or Void claim.

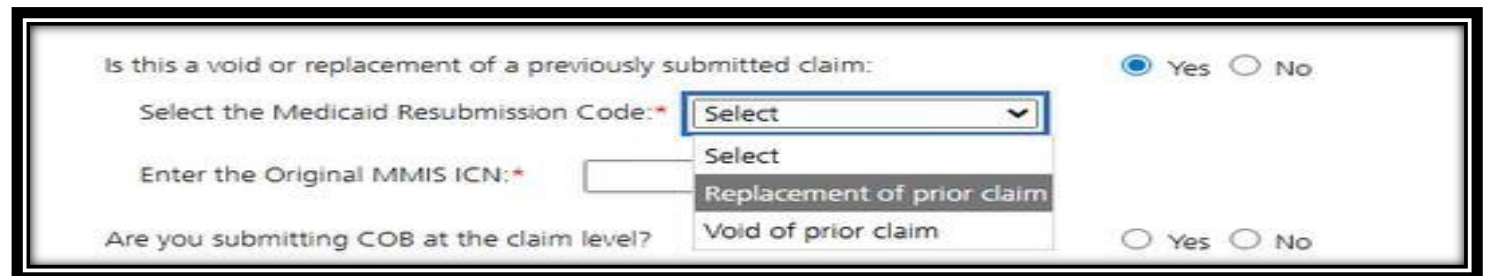
Enter Original ICN.



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:*	<input type="text"/>		Carrier Name:	<input type="text"/>	
Carrier Code:	<input type="text"/>		Carrier Code:	<input type="text"/>	
Subscriber First Name:*	<input type="text"/>		Subscriber First Name:	<input type="text"/>	
Subscriber Middle Name:	<input type="text"/>		Subscriber Middle Name:	<input type="text"/>	
Subscriber Last Name:*	<input type="text"/>		Subscriber Last Name:	<input type="text"/>	
Allowed:	\$	<input type="text"/>	Allowed:	\$	<input type="text"/>
Copay:	\$	<input type="text"/>	Copay:	\$	<input type="text"/>
Deductible:	\$	<input type="text"/>	Deductible:	\$	<input type="text"/>
Coinsurance:	\$	<input type="text"/>	Coinsurance:	\$	<input type="text"/>
Paid Amount:*	\$	<input type="text"/>	Paid Amount:	\$	<input type="text"/>
Group	Reason	Amount	Group	Reason	Amount
<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"/>
EOB Payment Date:*	MM/DD/YYYY <input type="text"/>		EOB Payment Date:	MM/DD/YYYY <input type="text"/>	

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.

After Final Submission


Check the box to certify that you have read the Terms and Conditions. Click Submit and you will have the option to Print or Save.

▾ Terms and Agreements

Note : Fields marked with an asterisk * are required.

Provider Name:*

NPV/API:*

* I certify I have read the [Terms and Conditions](#)  that apply to this bill and are made a part thereof.

Bulk HIPPA Claim Submission

Bulk HIPAA Transactions

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

The screenshot displays a web interface for "Bulk HIPAA Transactions activity". At the top right, there is a yellow "Help" button. Below the title, there is a search filter labeled "Filter your results:" with an empty input box. A table header is visible with columns: "ACTIONS", "TRANSACTION DATE", and "FILE NAME". The table body contains the text "No matching transactions found." Below the table, there is a pagination control showing "Showing 0 to 0 of 0 entries" and navigation arrows. On the left, there is a "Show 10 entries" dropdown menu. At the bottom left, there is a blue "Upload" button.

▼ 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 | < < > > |

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

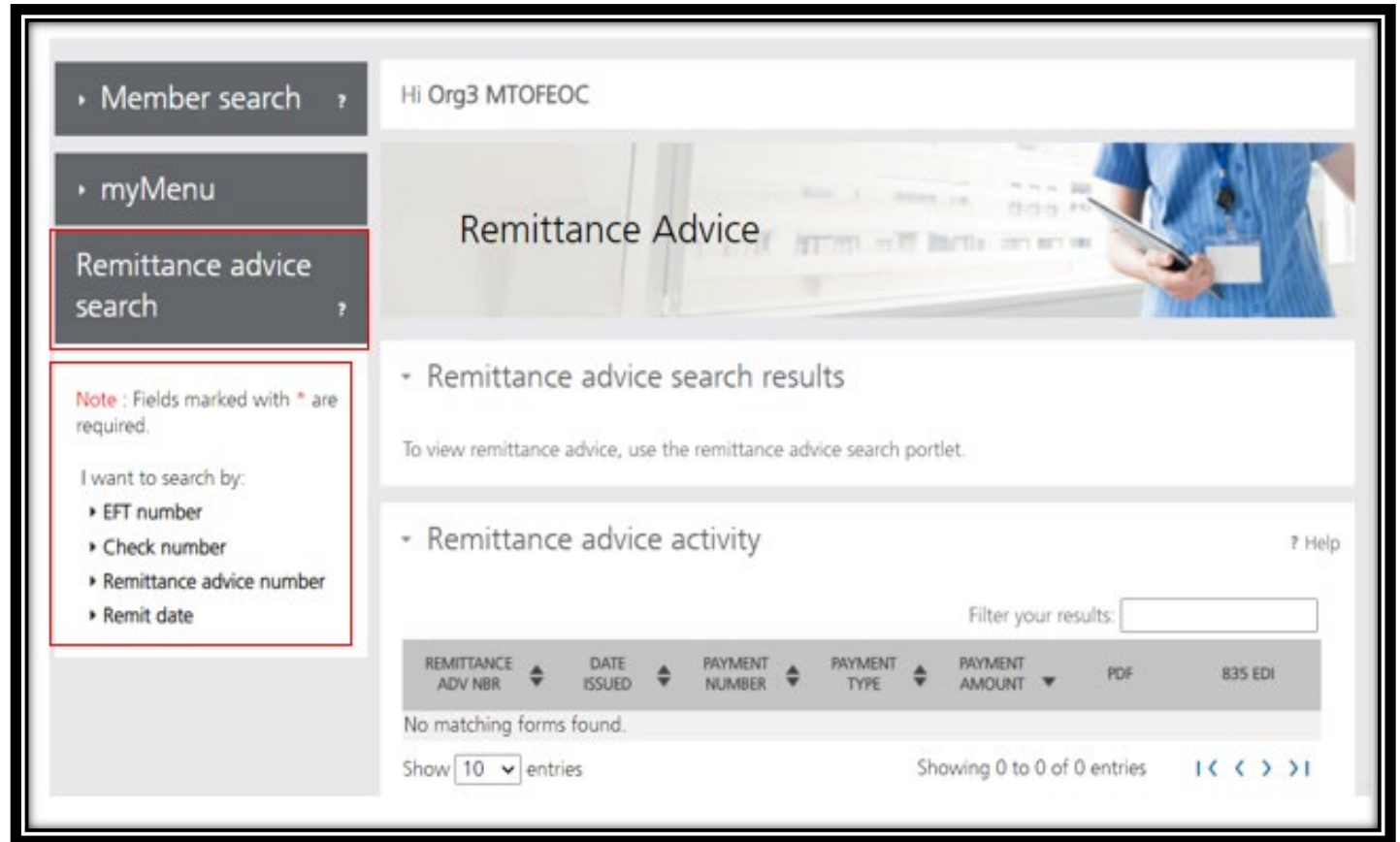
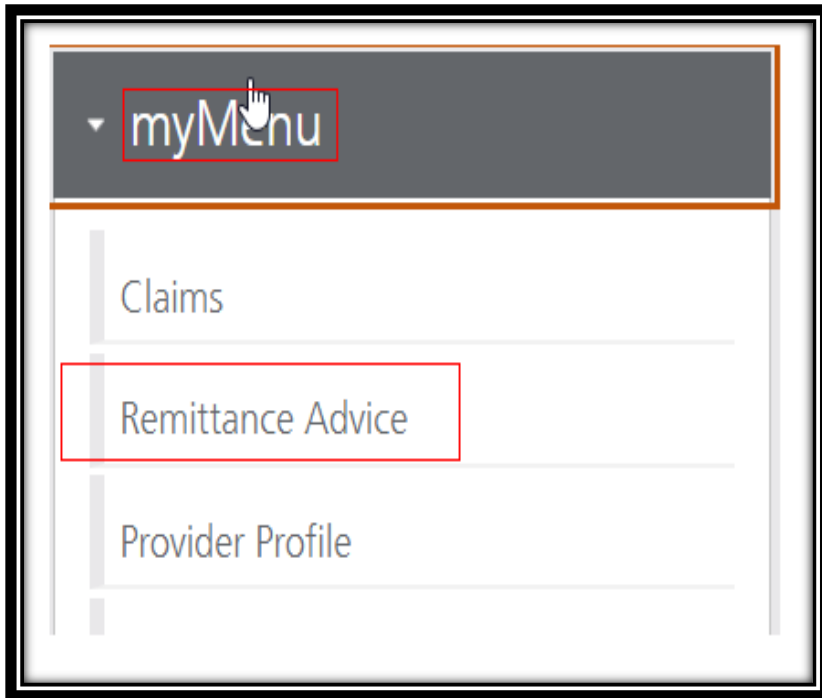
Questions?

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): *

To Date(mm/dd/yyyy): *

Remits Results

Filter your results:

REMITTANCE ADV NBR	DATE ISSUED	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	PDF	835 EDI
C	09/27/2021	00	Check	\$1150550.83	View	Download
O	09/27/2021	00	Check	\$246077.51	View	Download
O	09/27/2021	00	Check	\$94875.42	View	Download
O	09/20/2021	01	Check	\$14843.00	View	Download
OL	09/27/2021	00	Check	\$7195.51	View	Download
OE	09/06/2021	00	Check	\$1572.51	View	Download
O	09/13/2021	01	Check	\$520.36	View	Download

Show entries Showing 1 to 7 of 7 forms

VENDOR # 0001 REMIT ADVISE # 81 EFT/CHK #01 DATE 09/27/2021 PAGE 2
 NPI #: 12 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		07012021	07312021	1.000	S5141	2453.93	2453.93		
TEAM NUMBER 01		PATIENT NUMBER=00							
		CLAIM TOTAL**				2453.93	2453.93		
ICN 221		08012021	08312021	1.000	S5141	2453.93	2453.93		
TEAM NUMBER 01		PATIENT NUMBER=00							
		CLAIM TOTAL**				2453.93	2453.93		
ICN 221		07012021	07312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01		PATIENT NUMBER=00							
		07012021	07312021	5.000	S5135	115.50	115.50		
		CLAIM TOTAL**				883.20	883.20		
ICN 221		08012021	08312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01		PATIENT NUMBER=00							
		08012021	08312021	5.000	S5135	115.50	115.50		
		CLAIM TOTAL**				883.20	883.20		
ICN 2212		07012021	07312021	8.000	T2021	782.48	782.48		
TEAM NUMBER 01		PATIENT NUMBER=00							

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,
[HTTPS://MEDICAIDPROVIDER.MT.GOV/](https://medicaidprovider.mt.gov/), FOR NEW AND UPDATED PROVIDER
NOTICES, CLAIM JUMPER NEWSLETTERS, FEE SCHEDULES, PROVIDER MANUALS,
TRAINING, AND OTHER RESOURCES.

WE ARE SEEING A HIGH VOLUME OF CLAIMS POSTING DUPLICATE CLAIM ERRORS.
PLEASE MAKE SURE YOU DO NOT HAVE MULTIPLE CLAIMS FOR THE SAME MEMBER,
DATE OF SERVICE, AND SERVICE(S). ATTENTION TO THIS LEVEL OF DETAIL WILL
HELP REDUCE CLAIM PROCESSING TIME.

Paid Claims

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
VENDOR # REMIT ADVICE # EFT/CHK #018077531 DATE 02/12/2024 PAGE 2 NPI #: TAXONOMY: 282N00000X									
PAID CLAIMS - INPATIENT CLAIM									
ICN	PATIENT NUMBER=	01042024	01252024	6.000	124	17359.50	0.00		
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 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		12122022	12122022	2.000	259	40.00	0.00		
	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
ICN		01212024	01212024	1.000	300	78.25	0.00		
	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	PAGE	631				
NPI #:	TAXONOMY: 282N00000X		02/12/2024						
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 SPRINGFIELD SERVICE CENTER P O BOX 740800 ATLANTA, GA 30374-0800									
		POLICY #:			GROUP CERT #:	SUBSCRIBER SSN:			
		SUBSCRIBER NAME:			SUBSCRIBER INITIAL:				
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:*

Select



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"/>	<input type="text"/>		
Admission Date:	Admission Hour:	Admission Type:*	Source of Admission:*	Discharge Hour:	Member Discharge Status:*
<input type="text"/>	<input type="text" value="Select"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="Select"/>	<input type="text"/>
Original Reference Number:*					
<input type="text"/>					

Questions?

Common Billing Errors

Common Billing Errors

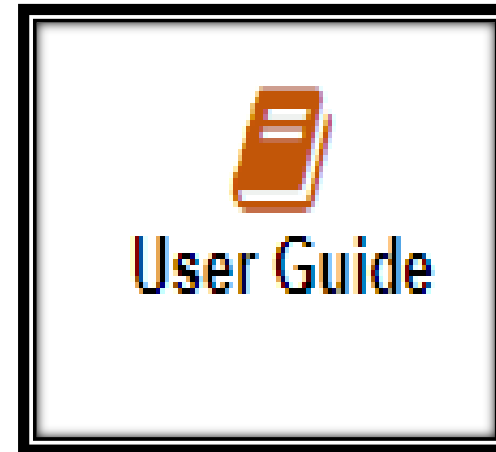
- Missing/Invalid Information
- Prior Authorization Number Missing or Invalid
- Exact Duplicate
- Proc. Code or Rev Code Not Covered/Not Allowed for Provider Type
- Recipient Not Eligible DOS
- Missing primary EOB
- Using the incorrect modifier for a provider type (HCBS vs SDMI)

Additional Resources

Need Help with MPATH?

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

Email Assistance

- The 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. Make sure to include the NPI, name, and confirmation number of the enrollment in question.
- Secured emails are not accepted.

MPATH Portal Help

For technical assistance with the Provider Services portal (MPATH)

Email the following to 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 for the care and support of
Montana Healthcare Programs members
that you provide.