



ND MMIS DENTAL WEB PORTAL TRAINING  
LAURA HOLZWORTH, MEDICAL SERVICES DIVISION

NORTH  
**Dakota**  
Be Legendary.

Health & Human Services

# ND MMIS Web Portal Dental Claim Form Submission Instructions



Go to

<https://mmis.nd.gov/portals/wps/portal/EnterpriseHome>



**Home**

[Program](#) ▶

[Member](#) ▶

[Provider](#) ▶

[Documentation](#) ▶

[Directories](#) ▶



**Welcome** [Print](#) | - □

Welcome to the North Dakota MMIS Web Portal.

ND MMIS has established a scheduled maintenance window for calendar year 2019 from 9:00PM to 4:00AM Central Time on the 2nd Thursday of the month with the following exceptions: Jan 17, Apr 17, May 16, Nov 7, and Dec 19. During the maintenance window, the

**Provider Registration** - □

To obtain a user id and password, Providers and Trading Partners must have an approved enrollment with North Dakota and have received their Provider or Trading Partner ID.

[Register](#)

**Quick Links** - □

- [FAQ](#)
- [Find a Healthcare Provider](#)
- [Benefits Overview](#)
- [Provider Enrollment](#)
- [Report Fraud & Abuse](#)

**Sign In** - □

Log into the system based upon your role:

- [Providers](#)
- [Internal Users](#)

# ➤ Sign In - Provider



**Home** | Program ▶ | Member ▶ | **Provider ▶** | Documentation ▶ | Directories ▶

**Quick Links**

- ▶ Enrollment
- ▶ ProviderManuals
- ▶ FAQ
- ▶ Billing Manuals
- ▶ Messages & Announcements

**News**

Governor's Task Force on Access to Affordable Health Insurance.

ND MMIS has established a scheduled maintenance window for calendar year 2019 from 9:00PM to 4:00AM Central Time on the 2nd Thursday of the month with the following exceptions: Jan 17, Apr 17, May 16, Nov 7, and Dec 19. During the maintenance window, the system may not be accessible.

## Provider

The Health Enterprise Portal is a state-of-the-art electronic health care administration system that gives patients, doctors, pharmacists and other users easy, secure and efficient access to health care information.

**ProviderLogin**

To access secure areas of the portal, please log in by entering your User ID and Password.

\* User ID:

\* Password:

[Forgot User Name or Password ?](#)

- **Provider Login**
  - **USER ID** and **Password**



[Home](#) | 
 [Member](#) ▾ | 
 [Provider](#) ▾ | 
 **Claims** ▾ | 
 [EDI](#) ▾ | 
 [Authorizations](#) ▾ | 
 [My Account](#) ▾ | 
 [FES](#) ▾

Quick Links [Print](#) | -

- [Add Service Location](#)
- [Trading Partner Enrollment](#)
- [Provider Manuals](#)
- [Provider Inquiry/Update Request](#)
- [Provider Training Registration](#)
- [Provider FAQ](#)
- [Provider Resources](#)
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- [EFT Enrollment](#)
- [ERA Enrollment](#)

News - □

Governor's Task Force on Access to Affordable Health Insurance

Provider Message

[Create Claims](#) ▸ | 
 [Manage Claims](#) ▸ | 
 [Create Templates](#) ▸ | 
 [Manage Templates](#) ▸ | 
 [Claim Status Inquiry](#) | 
 [Payment Inquiry](#) | 
 [1099 Inquiry](#) | 
 [Pharmacy Claims](#) ▸

Create Professional Claim | 
 Create Institutional Claim | 
 **Create Dental Claim** | 
 Create Claim from Template | 
 Create Claim from Processed Claim | 
 Travel/Lodging Claim | 
 HCBS/DD Claim

0-0 of 0

If you are unable to view PDFs, please [download Adobe Reader](#).

## ➤ Submit a Claim

- Claims
- Create Claims
- Create Dental Claim

\* Required Field

Basic Claim Info

Other Claim Info

[Provider](#) [Member](#) [Claim](#) [Basic Line Items](#)

? Is this a Service Authorization?

 Yes  No**NOTE:** Please use the [Service Authorization](#) form.

## ➤ New Dental Claim

- Is this a Service Authorization
  - ✓ Defaults to "No"
  - ✓ Select "Yes" if you are submitting a Service Authorization – click on the link **Service Authorization** form

## ➤ Service Authorization Instructions

<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/dental-training-materials.pdf>

? Is this a void/replacement?

Yes  No

Claim Resubmission Information

\*Resubmission Type Code

Replacement  
Void

\*TCN to Void/Replace

Note: For Void/Replacement of a Claim, prior claim data (if available) will populate once the user has either a) tabbed out of the TCN field, or b) selected another field on this page.

## ➤ New Dental Claim

- Is this a void/replacement?
- Defaults to "No"
  - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim.
  - ✓ Resubmission Type Code – Replacement or Void
  - ✓ TCN to Void/Replace

## Submitter Information

Submitter ID

## Provider Information

Go to [Other Claim Info](#) to enter information for other providers.

### Billing Provider

**NOTE:** Healthcare Providers are required to submit National Provider ID

Medicaid Provider ID

National Provider ID

Taxonomy Code


Tax ID

SSN

Location Number

- **Enter** - Billing Provider Taxonomy Code
- **Enter** - Billing Provider Tax ID or SSN Number



 **Additional Billing Provider Information**

<b>*Entity Qualifier</b> <input type="text" value=""/>	Currency Code <input type="text" value=""/>					
<b>*Org/Last Name</b> <input type="text" value=""/>	First Name <input type="text" value=""/>	MI <input type="text" value=""/>	Suffix <input type="text" value=""/>			
<b>*Address 1</b> <input type="text" value=""/>	<b>*City</b> <input type="text" value=""/>	State <input type="text" value=""/>	Zip and <input type="text" value=""/>	Extension <input type="text" value=""/>	Country <input type="text" value=""/>	Subdivision Code <input type="text" value=""/>
Address 2 <input type="text" value=""/>						

## ➤ **Additional Billing Provider Information**

- **REQUIRED**
- **Select** - Entity Qualifier – non-person or person
- **Enter** – Org/Last Name, Address, City, State and Zip Code

? Is the Billing Provider Address also the Pay-To Address?

Yes  No

### Pay-To Address

\*Address 1

\*City

State

Zip and Extension

Country

Subdivision Code

Address 2

## ➤ Is the Billing Provider also the Pay-To Address?

- **Required** - Defaults to "Yes"
- Pay-To Address is **different**, select "**No**"
  - ✓ Complete the Pay-To Address section with the Billing Provider Name, Address, City, State and Zip Code

? Is the Billing Provider also the Rendering Provider?

Yes  No

#### Rendering (Performing) Provider

Medicaid Provider ID

National Provider ID

Taxonomy Code

Location Number

## ➤ Is the Billing Provider also the Rendering Provider?

- **Required** - Default to "Yes"
- Rendering (Performing) Provider is **different** select "**No**"
  - ✓ **Enter** – Rendering (Performing) Provider Medicaid Provider ID
  - ✓ **Enter** – Rendering (Performing) Provider NPI Number
  - ✓ **Enter** – Rendering (Performing) Provider Taxonomy Code

## Member Information

*Member ID	*Last Name	First Name	MI	Suffix	*Date of Birth	*Gender	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Property Casualty Number							
<input type="text"/>							

## ➤ Member Information

- **REQUIRED**
- **Enter** - Member's 9-digit ID number
- **Enter** - Member's Last Name
- **Enter** - Member's First Name
- **Enter** - Member's Date of Birth
  - ✓ Use format: MM/DD/YYYY
- **Enter** - Member's Gender
  - ✓ F = Female
  - ✓ M = Male

[Member Address](#)

\*Address 1      \*City      State      Zip and      Extension      Country      Subdivision Code

Address 2

## ○ Member Address

- **REQUIRED**
- **Enter** - Member's Address, City, State and Zip Code

## Other Insurance Information

? \*Does the member have other insurance?

Yes  No

- **Does the member have other insurance?**
  - **Yes or No**
- **If “No” - member does not have other insurance – proceed to slide 22**
- **If “Yes” - member has other insurance– proceed to slide 15**

## Other Insurance Information

? \*Does the member have other insurance?

Yes  No

**Note:** Please go to the [Other Claim Info Tab](#) in the Coordination of Benefits Section.

## ➤ Other Insurance Information

- **REQUIRED**
- Does the member have other insurance?
- Select "Yes"
- Click and complete the **Other Claim Info Tab** with the Other Insurance information

## Coordination of Benefits

Go to [Basic Claim Info](#) to enter basic claim information.

### Other Insurance

Add Other Insurance

Sequence Number ▾

Subscriber ID ▾

Payer / Carrier ID ▾

Payer/Insurance Org Name ▾

Payer Paid Amount ▾

No Data Available

Submit Claim

Save Claim

Reset

Cancel

## ➤ Coordination of Benefits

- **REQUIRED**
- Other Insurance
- Add Other Insurance



## Other Subscriber

\*Entity Qualifier

\*Subscriber ID

\*Last Name

First Name

MI

Suffix

SSN

## ➤ New Other Insurance

- **REQUIRED**
- **Other Subscriber**
- Entity Qualifier – Non-Person
- Subscriber ID – Member's Primary Insurance ID number
- Last Name – Member's Last Name

Other Insurance Coverage

\*Release of Information Code

Informed Consent to Release Information  
Yes, Provider has signed statement

## ➤ Other Insurance Coverage

- **REQUIRED**
- Release of Information Code
- Select appropriate value

Informed Consent to Release Medical Information for Conditions or Diagnosis  
Regulated by Federal Statutes

Yes, Provider has a Signed Statement Permitting Release of Medical Billing  
Data Related to a Claim

## Other Payer

\*Payer / Carrier ID Qualifier

Health Care Fin Admin National PlanID  
Payor Identification

\*Payer / Carrier ID

\*Payer / Insurance Organization Name

## ➤ **Other Payer**

- Payer/Carrier ID Qualifier – Select Payer Identification
- Payer/Carrier ID – Insurance Payer/Carrier ID number
- Payer/Insurance Organization Name – Insurance Name

## Other Subscriber

\*Entity Qualifier

\*Subscriber ID

\*Last Name

First Name

MI

Suffix

SSN

➤ **New Other Insurance**

- **REQUIRED**

- Scroll to the top of New Other Insurance section

➤ **SAVE**

## Coordination of Benefits

Go to [Basic Claim Info](#) to enter basic claim information.

### Other Insurance

System successfully saved the Information.

Add Other Insurance

Sequence Number ▾	Subscriber ID ▾	Payer / Carrier ID ▾	Payer/Insurance Org Name ▾	Payer Paid Amount ▾
1				

1 - 1 of 1

Submit Claim

Save Claim

Reset

Cancel

## ➤ System successfully saved the Information

- Verify the Insurance was added
- Sequence Number
- Subscriber ID
- Payer/Carrier ID
- Payer/Insurance Org Name
- **Save Claim – System will take you back to the Basic Claim Info Tab**

## Claim Information

Go to [Other Claim Info](#) to include the following claim level information:  
Orthodontics, Tooth Status, Service Facility, Claim Adjustment and Other Insurance Information.

 \*Is this claim accident related?

Yes  No

## ➤ Claim Information

- Is this claim accident related?
  - ✓ Yes or No

## Claim Data

\*Patient Account #

\*Service Date

\*Place of Service

 ▼

\*Benefits Assignment Certification

 ▼

\*Assignment Code

 ▼

\*Release of Information Code

 ▼

## ➤ Claim Data

- Patient Account # - Acct # will print on remittance advice
- Service Date
- Place of Service - Office
- Benefits Assignment Certification – No, Not Applicable or Yes
- Assignment Code – Assigned or Not Assigned
- Release of Information Code – Informed Consent to Release Information or Yes, provider has signed statement

## Service Authorization

Service Authorization #

Referral #

- **Service Authorization**
  - Enter Service Authorization number if applicable
- **Referral Number**
  - Enter Referral number if applicable



## Claim Note

Note

80 Characters Remaining

## ➤ Claim Note

- Add any pertinent information
  - ✓ Example Note: Proving the One-Year Timely Filing Limit Policy Remittance Advice (RA) Date and TCN Number

# Faxing in an Attachment

Yes  No

Claim Attachments

[Add Attachment](#)

Type Attachment ▾	Delivery Method ⇅	Attachment Control # ⇅
No Data		

## ➤ Does this claim have Attachments?

- Yes or No
  - ✓ Yes
  - ✓ Add Attachment

## New Attachment

Save | Reset | Cancel

\*Type Attachment

\*Delivery Method

Attachment Control #

\*Type Attachment

Dental Models  
Diagnostic Report  
Explanation Of Benefits  
Periodontal Charts  
Radiology Films  
Radiology Reports  
Referral Form  
Support Data for Claim

## ➤ Type Attachment

- Select the appropriate type of attachment
  - ✓ Example: Periodontal Charts

**New Attachment** **Save** | Reset | Cancel

\*Type Attachment \*Delivery Method Attachment Control #

- Available on Request
- By Mail
- E-mail
- Electronic Only
- Facsimile**
- File Transfer

## ➤ **Delivery Method**

- Select the Facsimile
- Faxed documentation needs to have a SFN177 cover form
- SFN 177 link: <https://www.nd.gov/eforms/Doc/sfn00177.pdf>

## ➤ **SAVE**

➤ **Claim Submitted Confirmation Page may be substituted for the SFN 177**

# MMIS ATTACHMENT COVER SHEET – SFN 177



MMIS ATTACHMENT COVER SHEET  
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
MEDICAL SERVICES DIVISION  
SFN 177 (6-2015)

Clear Fields

Complete this form and include it as the cover sheet for all attachments or additional documentation being submitted to the North Dakota Department of Human Services Medicaid.

Provider NPI or Medicaid Number
Member Medicaid Number
Corresponding Record Number

Type of Attachment (select only one)

<input type="checkbox"/> Claim	Transaction Control Number (TCN)	Fax To: 701-328-0374
<input type="checkbox"/> Service Authorization (SA)	Service Authorization (SA) Number	Fax To: 701-328-1544
<input type="checkbox"/> Referral	Referral Number	Fax To: 701-328-1544
<input type="checkbox"/> Other	Description	Fax To: 701-328-1544



## Required

- Provider NPI or Medicaid Number
- Member Medicaid Number
- Type of Attachment – **Select only one**
  - ✓ Claim - Transaction Control Number (TCN)
  - ✓ Service Authorization (SA) – SA Number
  - ✓ Referral – Referral Number
  - ✓ Other - Description

Mail to:

North Dakota Department of Human Services  
MMIS Attachments  
600 East Blvd Ave.  
Bismarck, ND 58505

Telephone Number: 1-877-328-7098

# Electronic Only in an e-Attachment

**?** Does this claim have Attachments?  
 Yes  No

Claim Attachments

**Add Attachment**

Type Attachment ▾	Delivery Method ⇅	Attachment Control # ⇅
No Data		

## ➤ Does this claim have Attachments?

- Yes or No
  - ✓ Yes
  - ✓ Add Attachment

## New Attachment

Save | Reset | Cancel

\*Type Attachment

\*Delivery Method

Attachment Control #

\*Type Attachment

Dental Models  
Diagnostic Report  
Explanation Of Benefits  
Periodontal Charts  
Radiology Films  
Radiology Reports  
Referral Form  
Support Data for Claim

## ➤ Type Attachment

- Select the appropriate type of attachment
  - ✓ Example: Periodontal Charts

\*Type Attachment

\*Delivery Method

Attachment Control #

- Available on Request
- By Mail
- E-mail
- Electronic Only**
- Facsimile
- File Transfer

## ➤ **Delivery Method**

- Select the Electronic Only

## ➤ **Save**



? Does the claim have Attachments?

Yes  No

Claim Attachments

System successfully saved the Information.

Add Attachment

Type Attachment ▼	Delivery Method ⇅	Attachment Control # ⇅
<a href="#">Periodontal Charts</a>	Electronic Only	9972

1 - 1 of 1

➤ **System successfully saved the Information**

? Does the claim have Attachments?

Yes  No

### Claim Attachments

System successfully saved the Information.

Add Attachment

Type Attachment	Delivery Method	Attachment Control #
<a href="#">Periodontal Charts</a>	Electronic Only	9972

1 - 1 of 1

### Claim e-Attachments

Add e-Attachment

Date Added	Added By	File Name	Description
No Data			

## ➤ Does this claim have Attachments?

- Yes or No
  - ✓ Yes
  - ✓ Add e-Attachment

**Add e-Attachment** [Save](#) [Reset](#) [Delete](#) [Cancel](#)

\* File Name

\* Description

Please upload your file, enter a Description, and click the Save link; repeat this for as many attachments as needed. Once all e-Attachments have been Saved, ensure you click the Submit button.

## ➤ File Name

- **Cannot** be more than 55 characters
- **Cannot** have special characters: example !@#\$

## ➤ Select Browse

- Insert/select file that is saved to your computer

## ➤ Description

- Content of attachment: example Periodontal Chart

## ➤ SAVE

\* File Name  
TEST.pdf Browse...

\* Description  
Periodontal Chart

## ➤ File Name

- **Cannot** be more than 55 characters
- **Cannot** have special characters: example !@#\$

## ➤ Select Browse

- Insert/select file that is saved to your computer

## ➤ Description

- Content of attachment: example Periodontal Chart

## ➤ SAVE

? Does the claim have Attachments?

Yes  No

### Claim Attachments

System successfully saved the Information.

Add Attachment

Type Attachment	Delivery Method	Attachment Control #
<a href="#">Periodontal Charts</a>	Electronic Only	7998

1 - 1 of 1

### Claim e-Attachments

System successfully saved the Information.

Add e-Attachment

Date Added	Added By	File Name	Description
<a href="#">05/05/2022</a>		TEST.pdf	Periodontal Chart

1 - 1 of 1

- **SAVE – System successfully saved the Information**
- **Claim Attachments and Claim e-Attachments must be completed**
- **NOTE:** If resubmitting/adjusting a claim, all documents need to be attached again

## Basic Line Item Information

System successfully deleted the Information

Add Service Line Item



Total Claim Charge Amount:\$0.00

Line #	Procedure Code	Modifiers				Line Item Charge Amount	Oral Cavity Designation					Units	Service Date	Orthodontic Banding Date	Tooth/Surface
		1	2	3	4		1	2	3	4	5				
No Data Available															

## ➤ Basic Line Item Information

- Add Service Line Item

**New Line Item** Save | Save & Add Other Svc Info/TPL | Reset | Cancel

<b>*Procedure Code</b> <input type="text"/>	Procedure Description <input type="text"/>	<b>*Line Item Charge Amount</b> \$ <input type="text"/>	Place of Service <input type="text" value="▼"/>
Modifiers 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>		Oral Cavity Designation 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/> 5. <input type="text"/>	
Procedure Count <input type="text"/>			
Service Date <input type="text"/> 	Orthodontic Banding Date <input type="text"/> 		

## ➤ New Line Item

- Procedure Code
- Line Item Charge Amount
- Place of Service – Office
- Oral Cavity Designation – if applicable
- Procedure Count - Unit
- Service Date
- Orthodontic Banding Date – if applicable

Tooth Number ▾	Tooth Surface				
	1 ⇅	2 ⇅	3 ⇅	4 ⇅	5 ⇅
No Data Available					

- **Tooth Information**
  - Add Tooth Information



## New Tooth Information

Save | Reset | Cancel

\*Tooth Number

Tooth Surface

1.

2.

3.

4.

5.

Tooth Surface

1.
- Buccal
  - Distal
  - Facial
  - Incisal
  - Lingual
  - Mesial
  - Occlusal

## ➤ Tooth Information

- Tooth Number
- Tooth Surface – if applicable - enter all applicable surfaces
- **SAVE**

 [Service Authorization](#)

Service Authorization #

Referral #

➤ **Service Authorization – if applicable**

- Service Authorization #
- Referral #

**Additional Service Line Information**

Replacement Date

Prior Placement Date

Line Item Control Number

Prosthesis, Crown or Inlay Code

Sales Tax Amount

Prosthesis, Crown or Inlay Code

Treatment Start date

Treatment Completion Date

Initial placement  
Replacement

➤ **Additional Service Line Information – if applicable**

- Replacement Date
- Prior Placement Date
- Prosthesis, Crown or Inlay Code
- Treatment Start Date
- Treatment Completion Date

**New Line Item** Save [Save & Add Other Svc Info/TPL](#) | [Reset](#) | [Cancel](#)

? Is there additional line-specific information/TPL to be entered?  
 Yes  No

Submit Claim Save Claim [Reset](#) [Cancel](#)

➤ **Is there Additional line-specific information/TPL to be entered?**

- **No** – member does not have other insurance
- **Save – New Line Item**

➤ **SAVE CLAIM**

➤ **SUBMIT CLAIM**

**New Line Item** Save Save & Add Other Svc Info/TPL | [Reset](#) | [Cancel](#)

? Is there additional line-specific information/TPL to be entered?  
 Yes  No

**NOTE:** Click the Save & Add Other Svc Info/TPL link to enter line-level TPL amounts, and to include the following line-level information: Service Line Information, Service Line Provider Information and Other Payer Service Line Information

➤ **Is there Additional line-specific information/TPL to be entered?**

- **Yes** – Member has Other Insurance – proceed to **Slide 46** for instructions
- **Save & Add Other Svc Info/TPL**

TCN: [REDACTED]

Your claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

**Claim Information**

TCN: [REDACTED]  
 Date of Service: 03/20/2020 - 03/20/2020  
 Provider #: [REDACTED]  
 Member ID: [REDACTED]

Claim Status: C - To Be Dnd

Total Charge: \$200.00

\*To Be Paid Amount: \$0.00

\*Co-Payment: \$0.00

\*Total Recipient Liability: \$0.00

Submission Date/Time: Tue Mar 24 11:28:05 CDT 2020

\*This may not be the actual amount. Please refer to your remittance advice for detailed payment information.

**Adjustment Reason Codes**

Line #	Adjustment Reason Code	Description
0	204	This service/equipment/drug is not covered under the patient?s current benefit plan
1	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
1	26	Expenses incurred prior to coverage.
1	27	Expenses incurred after coverage terminated.

1 - 4 of 4

**Remark Codes**

Line #	Remark Code	Description
No Data		

➤ **Print and Save for your records**

\*Procedure Code

Procedure Description

\*Line Item Charge Amount  
\$

Place of Service

Modifiers  
1.  2.  3.  4.

Oral Cavity Designation  
1.  2.  3.  4.  5.

Procedure Count

Service Date

Orthodontic Banding Date

[Tooth Information](#)

[Service Authorization](#)

[Additional Service Line Information](#)

[? Is there additional line-specific information/TPL to be entered?](#)  
 Yes  No

**NOTE:** Click the Save & Add Other Svc Info/TPL link to enter line-level TPL amounts, and to include the following line-level information: Service Line Information, Service Line Provider Information and Other Payer Service Line Information

- **Is there Additional line-specific information/TPL to be entered?**
  - **Yes** – Member has Other Insurance
  - **Save & Add Other Svc Info/TPL**

\* Required Field

System successfully saved the Information.

Ln#1

Submit Claim

Save & Return to Basic Service Line Item

Save Claim

Reset

Cancel

Service Line Information

## ➤ New Dental Claim

- System successfully saved the Information
  - ✓ Line # 1
  - ✓ **Scroll down to the bottom of page - Other Payer Service Line Information section**

## Other Payer Service Line Information

Other Payer Service Line Information

Other Payer Service Information

Add Other Payer Service Information

Sequence Number ▾

Other Payer Primary ID ⚙

Procedure Code ⚙

Paid Service Unit Count ⚙

Service Line Paid Amount ⚙

Adjudicated or Pay Date ⚙

No Data Available

## ➤ Other Payer Service Line Information

- Add Other Payer Service Information



## Service Line Adjudication

Sequence Number

1 ▾

Other Payer Primary ID

\*Service Line Paid Amount

\$ 

\*Adjudicated or Pay Date

\*Paid Service Unit Count

\*Procedure Qualifier

 ▾

\*Procedure Code

Procedure Code Description Bundled Line Number Procedure Code Modifiers

1. 2. 3. 4. 

Remaining Patient Liability

\$ ➤ **New Other Payer Service Information**

- Service Line Adjudication
  - ✓ **REQUIRED**
  - ✓ Other Payer Primary ID
  - ✓ Service Line Paid Amount
  - ✓ Adjudicated or Pay Date
  - ✓ Paid Service unit Count
  - ✓ Procedure Qualifier - ADA
  - ✓ Procedure Code
  - ✓ Remaining Patient Liability

Line Level Adjustments

[Add Line Level Adjustments](#)

Claim Adjustment Group Code ▾

Reason Code ⬆️⬆️

Amount ⬆️⬆️

Quantity ⬆️⬆️

No Data Available

0 - 0 of 0

- **Service Adjustment**
  - Add line Level Adjustments

**New Line Level Adjustments** Save Reset | Cancel

\*Claim Adjustment Group Code  
 Patient Responsibility ▼

*Reason Code 1	*Amount \$	Quantity
Reason Code 2 2	Amount 2 \$	Quantity 2
Reason Code 3	Amount 3 \$	Quantity 3
Reason Code 4	Amount 4 \$	Quantity 4

- New Line Level Adjustments**
- \*Claim Adjustment Group Code
  - Contractual Obligations
  - Correction and Reversals
  - Other Adjustments
  - Patient Responsibility
  - Payor Initiated Reductions

## ➤ New Line Level Adjustments

- Claim Adjustment Group Code – Patient Responsibility or Contractual Obligation
  - ✓ Only 1 Claim Adjustment Group Code may be selected at a time
  
- Reason Code and Amount - **(Do Not enter PR or CO in front of Reason Code)**
  - ✓ **Patient Responsibility** – up to 4 Reason Codes per detail line - **Save**
  - ✓ **Contractual Obligations** – up to 4 Reason Codes per detail line - **Save**

## Service Line Adjudication

Sequence Number

1

Other Payer Primary ID

[REDACTED]

\*Service Line Paid Amount

\$25.00

\*Adjudicated or Pay Date

06/30/2020

\*Paid Service Unit Count

1.00000

\*Procedure Qualifier

ADA

\*Procedure Code

D0120

Procedure Code Description Bundled Line Number Procedure Code Modifiers

1. [ ]

2. [ ]

3. [ ]

4. [ ]

Remaining Patient Liability

\$75.00

## Service Adjustment

## Line Level Adjustments

Add Line Level Adjustments

Claim Adjustment Group Code	Reason Code	Amount	Quantity
<a href="#">Patient Responsibility</a>	1	\$75.00	

1 - 1 of 1

## ➤ New Other Payer Service Information

- Additional Adjustments - Add Line Level Adjustments – if applicable
- Verify Line Level Adjustments
- **Save – New Other Payer Service Information**

**Other Payer Service Line Information**

**Other Payer Service Line Information**

**Other Payer Service Information**

**Add Other Payer Service Information**

Sequence Number	Other Payer Primary ID	Procedure Code	Paid Service Unit Count	Service Line Paid Amount	Adjudicated or Pay Date
1		D0120	1.00000	\$25.00	06/30/2020

1 - 1 of 1

Submit Claim **Save & Return to Basic Service Line Item** Save Claim Reset Cancel

➤ **If the member has 2 Insurance Policies**

- **Add Other Payer Service Information**

- ✓ Complete a 2<sup>nd</sup> Sequence Number – Repeat slides 40 – 45
- ✓ Primary is Sequence Number #1
- ✓ Secondary is Sequence Number #2

➤ **If the member has 1 insurance**

➤ **Save & Return to Basic Service Line Item**

Basic Line Item Information

Total Claim Charge Amount:\$100.00

Add Service Line Item

Line #	Procedure Code	Modifiers				Line Item Charge Amount	Oral Cavity Designation					Units	Service Date	Orthodontic Banding Date	Tooth/Surface
		1	2	3	4		1	2	3	4	5				
<u>1</u>	D0120					\$100.00						1.00000	06/24/2020		

1 - 1 of 1

Submit Claim

Save Claim

Reset

Cancel

➤ **Save Claim – Needs to be done before submitting the claim**

- In order to re-submit the claim from a processed claim if need be

➤ **Submit Claim**

TCN: [REDACTED]

Your claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

### Claim Information

TCN: [REDACTED]

Date of Service: 06/24/2020 - 06/24/2020

Provider #: [REDACTED]

Member ID: [REDACTED]

Claim Status: C - To Be Dnd

Total Charge: \$100.00

\*To Be Paid Amount: \$0.00

\*Co-Payment: \$0.00

\*Total Recipient Liability: \$0.00

Submission Date/Time: Mon Jul 20 14:39:13 CDT 2020

\*This may not be the actual amount. Please refer to your remittance advice for detailed payment information.

### Adjustment Reason Codes

Line #	Adjustment Reason Code	Description
0	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
1	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
1	170	Payment is denied when performed/billed by

➤ **Print and Save for your records**