



ND MMIS HCBS/DD WEB PORTAL TRAINING

LAURA HOLZWORTH, MEDICAL SERVICES DIVISION

NORTH  
**Dakota**  
Be Legendary.

Health & Human Services



# ND MMIS HCBS/DD Web Portal Claim Form Submission Instructions



Go to

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



Home

Program ▶

Member ▶

Provider ▶

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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



**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**



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[Create Claims](#) | 
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 [Create Institutional Claim](#) | 
 [Create Dental Claim](#) | 
 [Create Claim from Template](#) | 
 [Create Claim from Processed Claim](#) | 
 [Travel/Lodging Claim](#) | 
 **[HCBS/DD Claim](#)**

Provider Messages			<a href="#">Print</a>   <a href="#">Help</a>   <a href="#">-</a> <a href="#">□</a>
Status	Date	Subject	<a href="#">Delete</a>
0-0 of 0	No Data		

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



## ➤ **Submit a Claim**

- Claims
- Create Claims
- Create HCBS/DD Claim



\* Required Field

Void/Replace

? Is this a void/replacement?

Yes  No

## ➤ New HCBS/DD Claim

- Is this a void/replacement?
  - ✓ Defaults to "No."
  - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim.

\* Required Field

Void/Replace

? 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 HCBS/DD Claim

- Is this a replacement/void?
  - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim (TCN).
  - ✓ Resubmission Type Code – Replacement or Void
  - ✓ TCN to Replace/Void – Must be the last TCN in the chain of TCN's

\* Required Field

### Void/Replace

? Is this a void/replacement?

Yes  No

### Claim Resubmission Information

\*Resubmission Type Code

\*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.

### Billing Provider

Please enter either a Provider Organization Name or Provider Last Name and First Name.

\*Provider Number

Provider Organization Name

OR

Last Name

First Name

MI

## ➤ Billing Provider

- **Required**
- Enter - Provider Organization Name or Last Name, First Name and MI



Member

Numeric field only, do not include hyphens, slashes or spaces.

\*Member ID Number

\*Member's Last Name

\*First Name

MI

## ➤ Member Information

- **REQUIRED**
- **Enter** - Member's 9-digit Medicaid ID number
- **Enter** - Member's Last Name
- **Enter** - Member's First Name
- **Enter** - Member's Middle Initial

## Member

Numeric field only, do not include hyphens, slashes or spaces.

\*Member ID Number

\*Member's Last Name

\*First Name

MI

## Billing Period

\*Begin Date



\*End Date




## ➤ Billing Period

- **REQUIRED**
- **Enter** – Begin Date – Use format: MM/DD/YYYY
- **Enter** – End Date – Use format: MM/DD/YYYY


## Line Items

Total Submitted Charges:\$0.00

LI	Service Begin Date	Service End Date	Procedure Code	Units	Billed Amount	Action
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	

## ➤ Line Items

- **REQUIRED**

- **Enter** – Service Begin Date – Use format: MM/DD/YYYY
- **Enter** – Service End Date – Use format: MM/DD/YYYY
- Enter – Procedure Code
- Enter – Units
- Enter – Billed Amount
- Click plus sign to add the line - 

Action


## Line Items

Total Submitted Charges:\$100.00

LI	Service Begin Date	Service End Date	Procedure Code	Units	Billed Amount	Action
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	
1	04/01/2023	04/01/2023	S5136	1	\$100.00	

## ➤ Line Items – Repeat if more than 1 line

- **REQUIRED**

- **Enter** – Service Begin Date – Use format: MM/DD/YYYY
- **Enter** – Service End Date – Use format: MM/DD/YYYY
- Enter – Procedure Code
- Enter – Units
- Enter – Billed Amount
- Click plus sign to add the line - 

Action



Claim e-Attachments

Add e-Attachment

Date Added

Added By

File Name

Description

Add e-Attachment

Save Reset Delete Cancel

\* File Name

Choose File No file chosen

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 Choose File

- Insert/select file that is saved on your computer

## ➤ Description

- Content of attachment

## ➤ SAVE

## Claim e-Attachments

Add e-Attachment

System successfully saved the Information.

Date Added ▾	Added By ▾	File Name ▾	Description ▾
<a href="#">05/31/2023</a>	MSNERD	Test document.pdf	Test Document

1 - 1 of 1

Submit Claim Save Claim Reset Cancel

- **System successfully saved the Information**
- **Save Claim**
- **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: 04/01/2023 - 04/01/2023  
 Provider # [REDACTED]  
 Member ID [REDACTED]

Claim Status: S - Suspended

Total Charge: \$100.00

\*To Be Paid Amount: \$0.00

\*Co-Payment: \$0.00

\*Total Recipient Liability: \$0.00

Submission Date/Time: Wed May 31 16:38:55 CDT 2023

\*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	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
0	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.)
0	206	National Provider Identifier - missing.
0	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification

**➤ Print and Save for your records**