

Billing 101 Training for Providers

Presented by Loma Romero, Provider Relations Field Representative

Roll Call

In chat, please share:

- Your name
- Company
- Who you are 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.

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](#).

Home
COVID-19 Provider Information
Online Services ▼
Resources by Provider Type
Provider Enrollment
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Site Index ▼
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Claim Instructions

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.

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) GROUP HEALTH PLAN (Group Health Plan) FECA (FECA) 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)
5. INSURED'S ADDRESS (No., Street)
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
7. OTHER INSURED'S ADDRESS (No., Street)
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

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

11. IS THIS POLICY GROUP OR FECA 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 THIS ADDRESS REAL? (Resident Point)
 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 governmental benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

17. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____

18. OTHER DATE MM DD YY

19. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD TO MM DD YY

20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD TO MM DD YY

21. OUTSIDE LAB? YES NO \$ CHARGES _____

22. RESUBMISSION ORIGINAL REC. NO. _____

23. PRIOR AUTHORIZATION NUMBER
4123456789

24. A. DATE(s) OF SERVICE FROM MM DD YY TO MM DD YY B. PLACE OF SERVICE C. D. PROCEDURE, SERVICE, OR SUPPLIER (Specify Unusual Circumstances) E. DIAGNOSIS PORTER F. \$ CHARGES G. DAYS OR PARTS H. I. J. RECEIVING PROVIDER ID #

1	07 01 14	07 01 14	11	99241		ABC	100 00	1	ZZ	2084N0400X	1234567891
2											
3											
4											
5											
6											

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. Filled for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDE AND CIRCLED OR IDENTICAL & verify that this address on the reverse apply to this bill and are made a part thereof.)
Dr. Provider, MD 07/01/14

32. SERVICE FACILITY LOCATION INFORMATION
Dr. Provider, MD 123 Main Street Anywhere, MT 54321-1234

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

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMB 0938-1197 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 sample UB-04 claim form with several fields highlighted in yellow and green. The form includes sections for provider information, member details, condition codes, diagnosis codes, and payment information. A table of condition codes is visible in the middle section.

Condition Code	Description	Units	Rate	Total
250				83.95
260	96365	7/6/14	1	326.72
260	96366	7/7/14	1	32.83
260	96367	7/7/14	1	63.50
301	80048	7/7/14	1	95.56
301	82055	7/7/14	1	121.37
306	87040	7/7/14	2	223.96
306	87804	7/7/14	2	259.56
320	71020 TC	7/7/14	1	209.83
450	99284 25	7/7/14	1	687.39
636	N4 63323047401 4 ML	7/7/14	4	159.30
636	N4 50458016601 150 ML	7/6/14	3	75.95

Other highlighted fields include: Provider Name, Physical Address, City, ST Zip+4; Member First Name Last Name; In/Out multi ER visits; Condition Codes relate to copay overrides; Occurrence codes are used to denote events relating to the bill that may effect payer processing; Value Codes and Amounts reflect Medicare Payment Information; Possible TPL Payer (123456789); Billing NPI; Member Name; Member ID; Prior Auth#; ICD-10 codes; Attending Last Name (123456789); Billing Taxonomy (B3 282N00000X).

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 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 Claims Setup

Account Administration

All 3 Account Administration functions are located on one screen.

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

Manage Portal Users

? Help

A maximum of 200 users will be displayed. Adjust your search criteria in the left navigation to refine your results.

Filter your results:

ACTIONS	LOGIN NAME	FIRST NAME	LAST NAME	EMAIL	STATUS
---------	------------	------------	-----------	-------	--------

No matching users found.

Show entries

Showing 0 to 0 of 0 entries |<<>>|

Add User Account

Manage Billing Providers

? Help

Filter your results:

ACTIONS	BILLING PROVIDER NAME	NP/API ID
	MPATH	1003362864

Show entries

Showing 1 to 1 of 1 accounts |<<>>|

Add Billing Provider

Manage Provider Enrollment Accounts

? Help

Complete LINK Request Form

Complete UNLINK Request Form

Filter your results:

ACTION	ATTACHMENT	DATE	STATUS
--------	------------	------	--------

No matching transactions found.

Show entries

Showing 0 to 0 of 0 entries |<<>>|

Upload Request

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:*

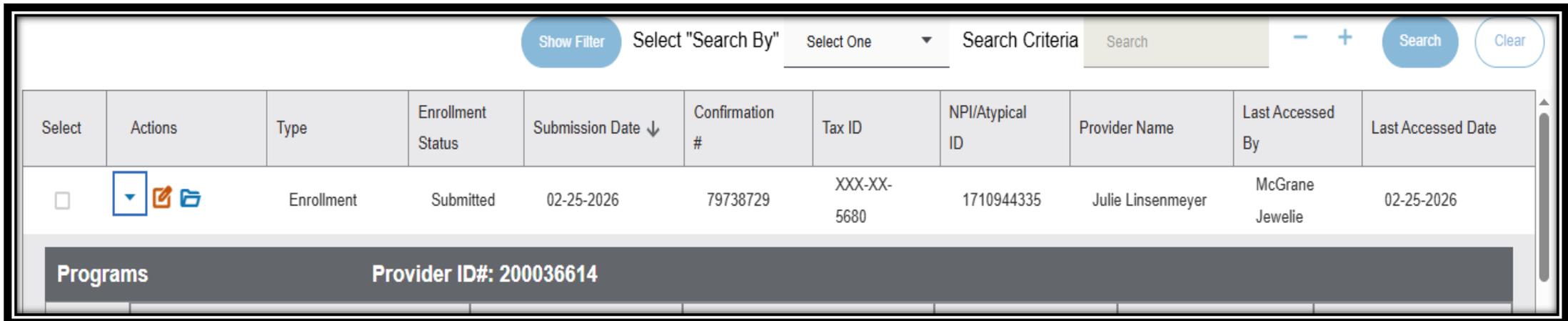
Submit

Cancel

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	XXX-XX-5680	1710944335	Julie Linsenmeyer	McGrane Jewelie	02-25-2026

Programs **Provider ID#: 200036614**

Manage Affiliations

Manage Affiliations

This action is **needed** if you are a facility that employs Rendering Providers and/or you are 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, 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.

User Guide

Search for Providers Pending Approval Requested Affiliations Existing Affiliations

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.

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

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
<input checked="" type="checkbox"/>	ROBERT	NITSCHM	1598719064	05/12/2022	<input type="text"/>		

Assigned Locations

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

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.

Manage Affiliations

Search for Providers | Pending Approval | Requested Affiliations | **Existing Affiliations** | Denied 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 ? Last Name ? NPI/Atypical ID ?

?

	First Name	Last Name	NPI/Atypical ID	Effective Date ↑	Terminate Date	Actions	File Name
<input type="radio"/>	Emma	Windauer	1144064783	06/24/2024	MM/DD/YYYY <input type="text"/>	<input type="button" value="↑"/> ?	

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 terminate.

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 ? Last Name ? NPI/Atypical ID ? ?

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

ANITA BEACH 1922064401 ?

Ending Affiliations Cont.

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

Click the **radio button** under **Deactivate**.

Enter the **termination date**.

Click the **Save and Continue** button.

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

Assign Locations ⓘ

Address Line	Active	Deactivate	Effective Date	Terminate Date	
1111 BAKER AVE	<input type="radio"/>	<input checked="" type="radio"/>	01/01/2006	05/11/2022	

Questions?

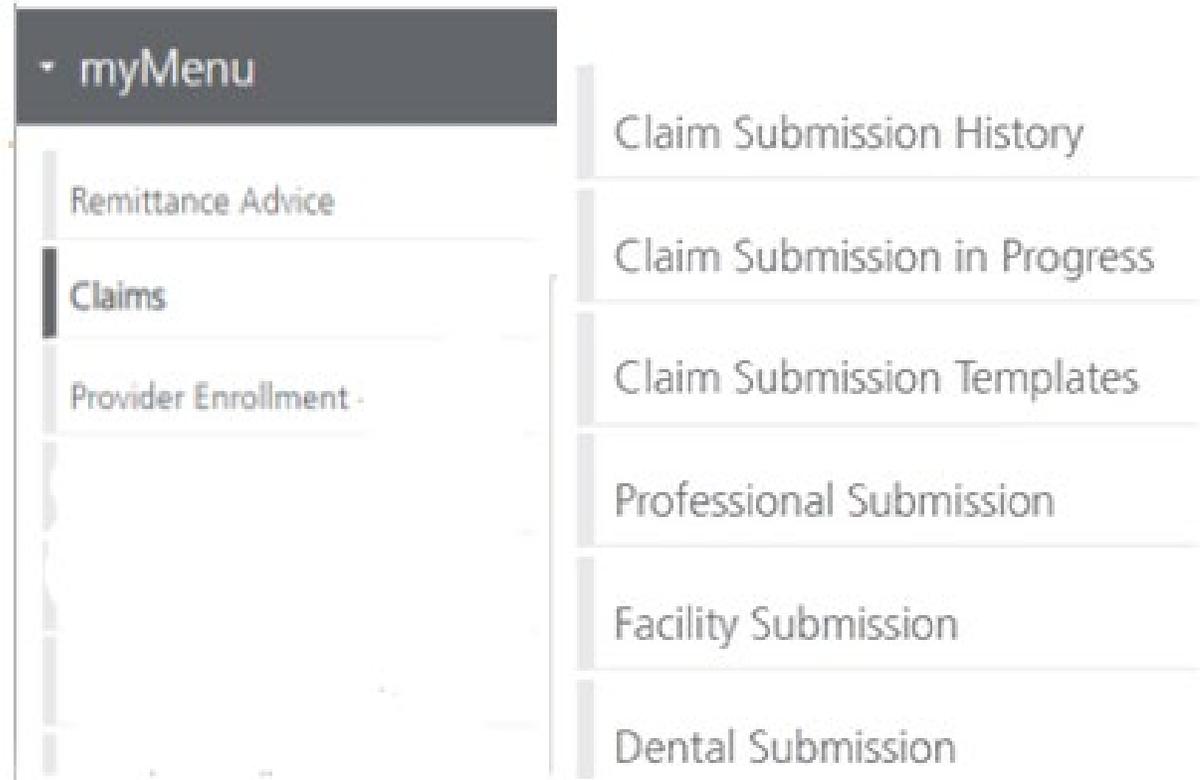
Provider Services Portal Claims Submission

Claim Submission Menu

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

A side menu with submission options will appear.

The following slides will describe each function.



Claims Submission History

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

This function comes in handy if you have a big batch of claims to submit and lose track of who you have completed.

This section will not give you any charge line details or adjudication information.

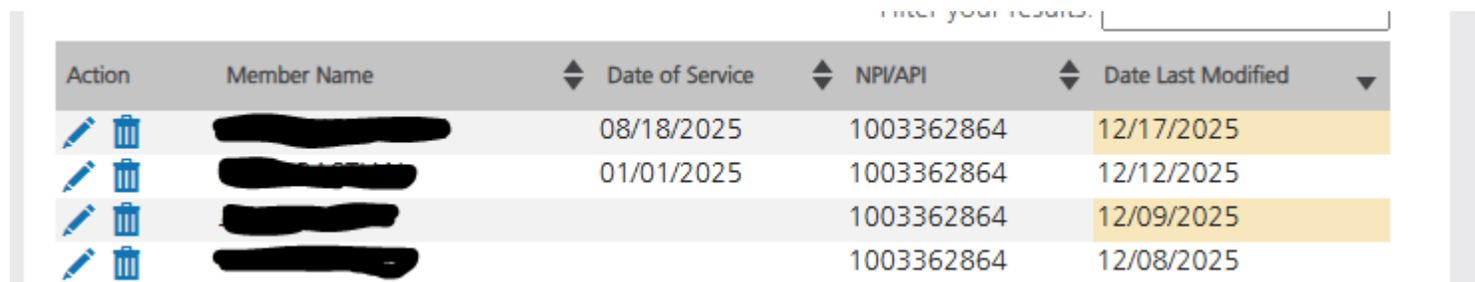
Claims Submission in Progress

This function is for claims started but not submitted.

Example:

You begin to complete the information for claim. You are interrupted and need to exit the system. When you click Save and Exit at the bottom of the current claim screen; your claim moves to this section.

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



The screenshot shows a table with a search bar at the top right labeled "Enter your results:". The table has five columns: Action, Member Name, Date of Service, NPVAPI, and Date Last Modified. There are four rows of data, each with a pencil icon and a trash can icon in the Action column. The Member Name column is redacted with black bars. The Date Last Modified column has a yellow background for the first and third rows.

Action	Member Name	Date of Service	NPVAPI	Date Last Modified
 	[REDACTED]	08/18/2025	1003362864	12/17/2025
 	[REDACTED]	01/01/2025	1003362864	12/12/2025
 	[REDACTED]		1003362864	12/09/2025
 	[REDACTED]		1003362864	12/08/2025

Claim Submission Templates

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 Template

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

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

*Section 6, of the Provider Portal User Guide.

Claim Submission Templates ? Help

Maximum Templates Allowed : 500 Filter your results:

Actions	Name	Date Last Modified
	<u>Member B</u>	12/08/2021
	<u>Ortho</u>	12/09/2021
	<u>Test 121</u>	12/01/2021
	<u>Tester22</u>	12/15/2021

Show entries Showing 1 to 4 of 4 templates

Create Professional Claim Submission Template

Create Facility Claim Submission Template

Create Dental Claim Submission Template

Creating a 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.**

The screenshot displays a web form with two sections. The first section, on the left, contains the following fields: NPI/API: * (text input: 1245490713), Provider Name: * (text input: NORTH WEST HOME CAI), Program/Waiver: * (dropdown menu: Montana Medicaid (HMK Plus)), Specialty: * (dropdown menu: In Home Supportive Care), Service Location Address 1: * (text input: 818 W CENTRAL), Service Location Address 2: (text input: empty), City: * (text input: MISSOULA), State: * (text input: MT), ZIP: * (text input: 59801-0000), Taxonomy Code: * (text input: 253Z00000X), and Enrollment Unit: * (text input: 0000262208). The second section, on the right, contains: NPI/API: * (dropdown menu: 1033508080), Provider Name: * (text input: LIBERTY PLACE, INC), Program/Waiver: * (dropdown menu: Severe Disabling Mental Illness Waiver (SDMI)), Specialty: * (dropdown menu: Big Sky Waiver), Service Location Address 1: * (text input: BOOTSTRAP RANCH E), Service Location Address 2: (text input: empty), City: * (text input: BELGRADE), State: * (text input: MT), ZIP: * (text input: 59714-8121), Taxonomy Code: * (text input: 251S00000X), and Enrollment Unit: * (text input: 0000801034). A mouse cursor is hovering over the Program/Waiver dropdown menu in the second section, which has opened to show options: Severe Disabling Mental Illness Waiver (SDMI) and Big Sky Waiver.

Creating a 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**.

Rendering Provider

NPI:	<input type="text" value="1346773231"/>
Provider Name: *	<input type="text" value="MPATH W Barton"/>
Taxonomy Code: *	<input type="text" value="Select Taxonomy C"/>

Referring Provider

There is a referring provider for this claim.

Ordering Provider

There is a ordering provider for this claim.

Save and Continue

Save and Exit

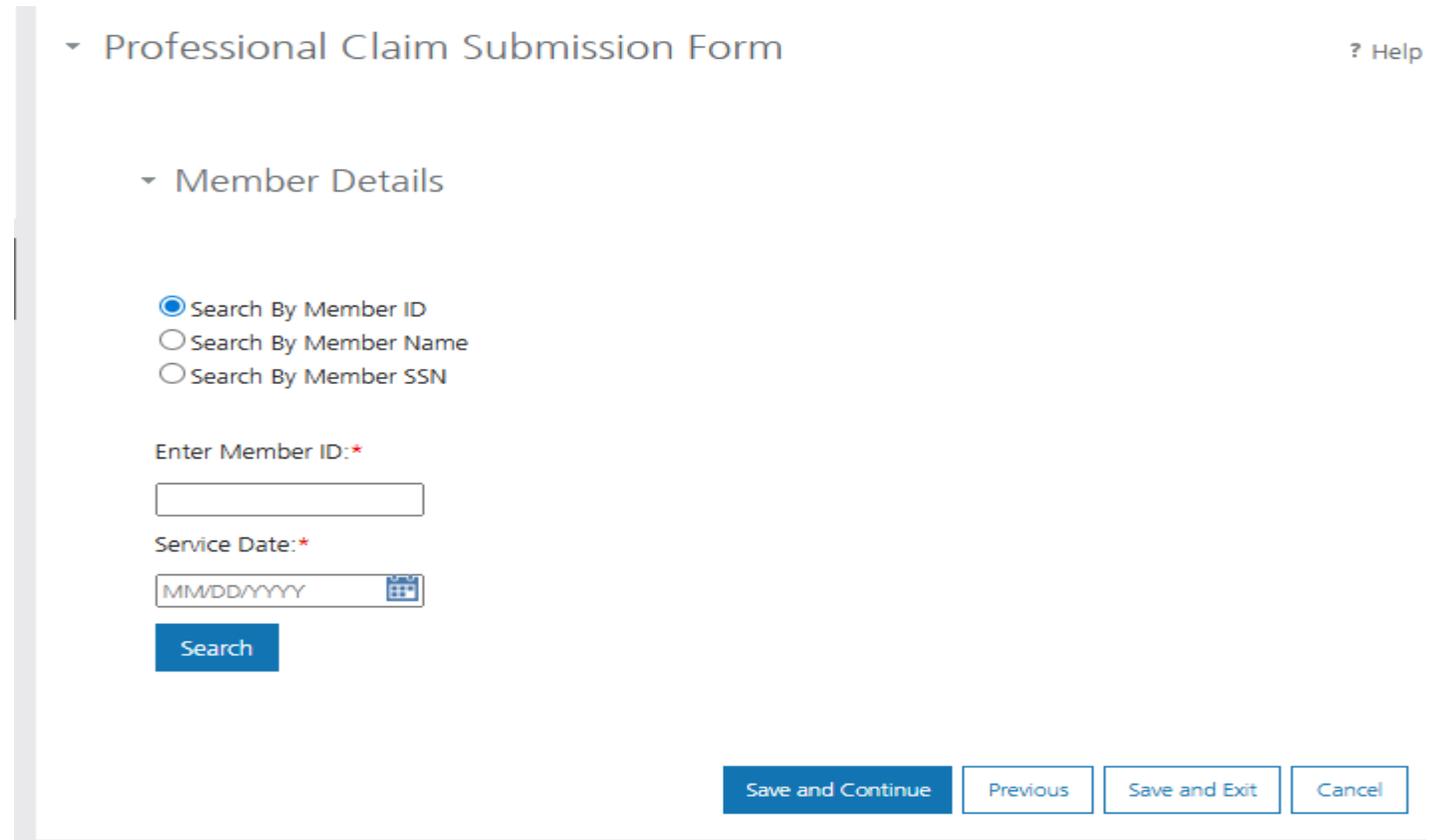
Cancel

Creating a 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" link 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 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"/>					
7	8	9	10	11	12
<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 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

Is there a Referral for this claim? Yes No

Do you have attachments for this claim? Yes No

Save and Continue

Creating a Template Cont.

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

Your template is now visible.

To submit a claim, click on the **Name**.

To edit a template, click on the **Pencil** icon.

To delete a template, click on the **Garbage can** icon.

Facility Claim Template

Save Template

Please enter a claim submission template name.

Template Name: *

Note(s):

Template Name must satisfy the following conditions:

- a. Minimum length: 3 characters.
- b. Maximum length: 35 characters.
- c. Cannot contain special characters other than: Space " " or Underscore "_" or Dash "-".

Actions	Name	Date Last Modified
 	<u>Member B</u>	12/08/2021
 	<u>Ortho</u>	12/09/2021
 	<u>Test 121</u>	12/01/2021
 	<u>Tester22</u>	12/15/2021

Questions?

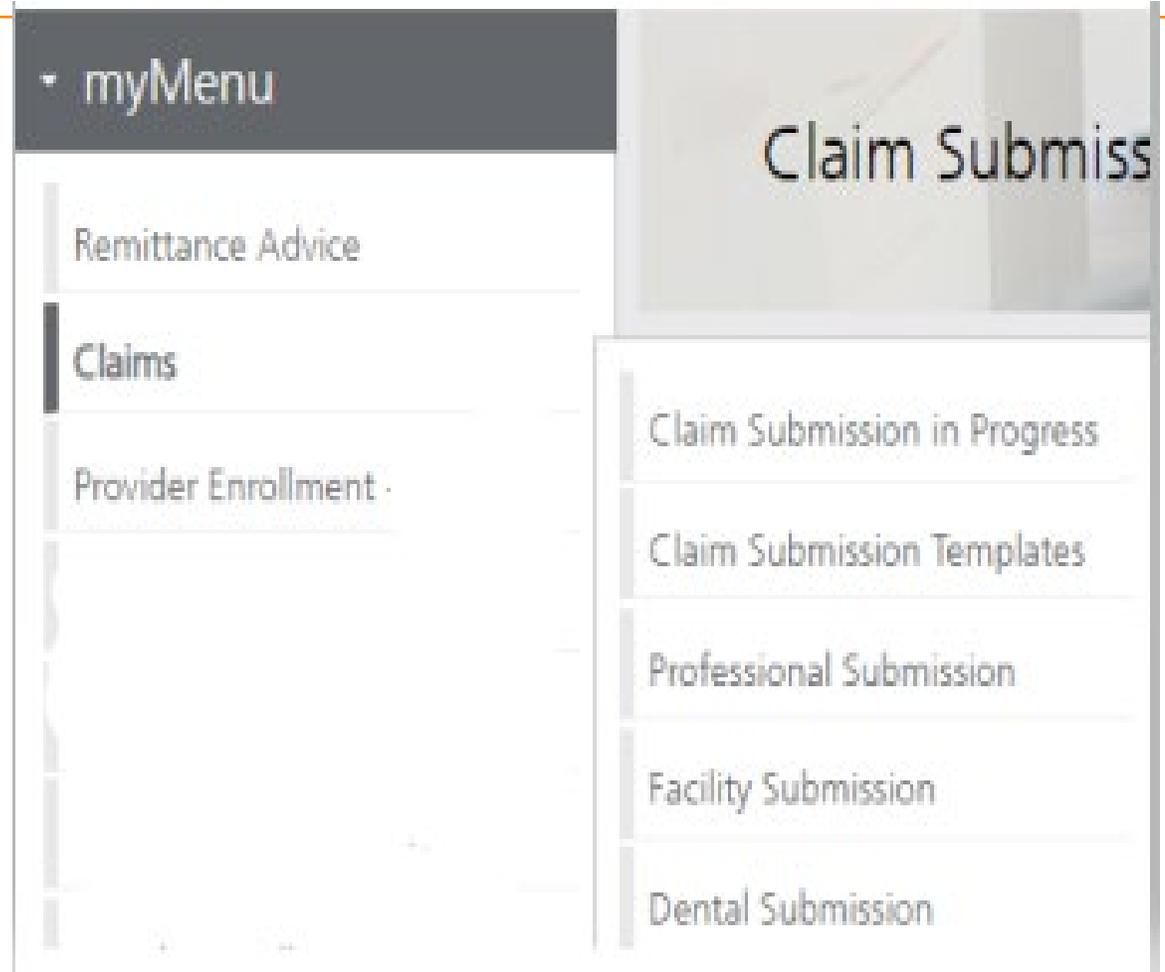
Claim Submission

Submitting a Claim

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

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

*Section 6, of the Provider Portal User Guide.



Billing Provider

Select the Billing Provider file.

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

Select NPI.

Select Program/Waiver.

Select Specialty.

Click **Save and Continue**.

The image shows a screenshot of a web form for adding a Billing Provider. It contains two identical forms side-by-side. The first form has the following values: 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: (empty); City: MISSOULA; State: MT; ZIP: 59801-0000; Taxonomy Code: 253Z00000X; Enrollment Unit: 0000262208. The second form has: NPI/API: 1033508080 (dropdown); Provider Name: LIBERTY PLACE, INC; Program/Waiver: Severe Disabling Mental Illness Waiver (dropdown menu open); Specialty: (empty); Service Location Address 1: (empty); Service Location Address 2: BOOTSTRAP RANCH E; City: BELGRADE; State: MT; ZIP: 59714-8121; Taxonomy Code: 251S00000X; Enrollment Unit: 0000801034. The dropdown menu for Program/Waiver in the second form shows options: 'Severe Disabling Mental Illness Waiver (SDMI)', 'Severe Disabling Mental Illness Waiver (SDMI)', and 'Big Sky Waiver'.

Billing Provider Cont.

If the Billing file you chose, requires a Rendering provider.

The Rendering Provider drop down will appear.

Select your rendering NPI from the drop down.

Click **Save and Continue**.

- Billing Provider

Note : Fields marked with an asterisk * are required.

NPI/API: *	1316521222
Provider Name: *	WHICKER GROUP
Program/Waiver: *	Montana Medicaid (HMK Plus)
Specialty: *	Single Specialty
Service Location Address 1: *	2600 WILSON ST STE 4
Service Location Address 2:	
City: *	MILES CITY
State: *	MT
ZIP: *	59301-5094
Taxonomy Code: *	193400000X
Enrollment Unit: *	0000734214

Rendering Provider

NPI: *	<div style="border: 1px solid black; padding: 2px;"><p>Select NPI</p><p>1609484575</p><p>1538253760</p><p>1164561635</p></div>
--------	--

Referring Provider

There is a referring provider for this claim.

Ordering Provider

There is a ordering provider for this claim.

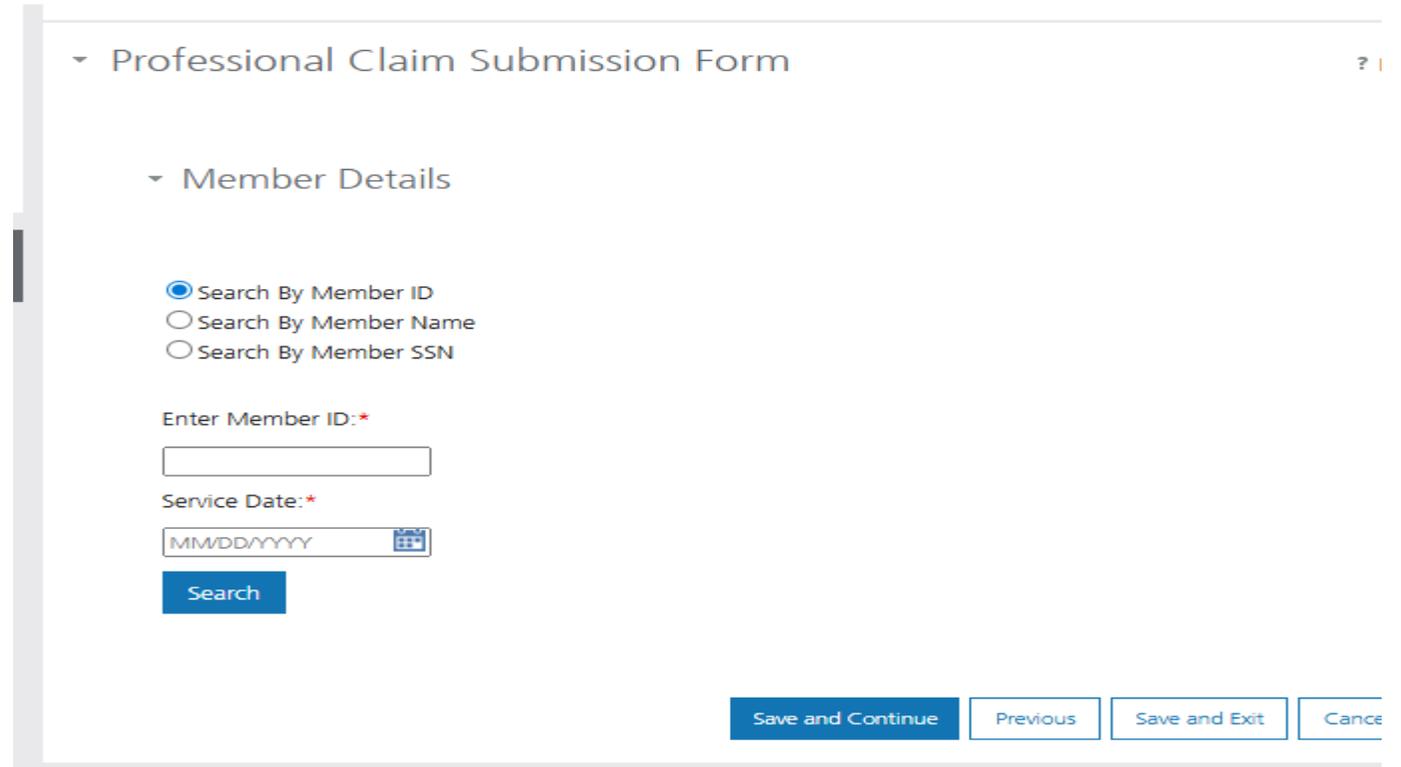
Member Details

Enter the member's MT Medicaid ID number.

Click **Search**.

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

Click **Save and Continue**.



The screenshot shows a web form titled "Professional Claim Submission Form" with a "Member Details" section. The "Search By Member ID" radio button is selected. Below the radio buttons are input fields for "Enter Member ID:*" and "Service Date:*" (with a date picker icon). A blue "Search" button is positioned below the "Service 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".

Claim Information

Complete all required fields and questions.

Required information is denoted with a red asterisk *

Professional Claim Submission Form ? Help

Claim Information

Note : Fields marked with an asterisk * are required.

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

Diagnosis Codes

Diagnosis Codes (ICD 10):

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

Claim Details

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

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

Total Charges: \$

Claim Information Questions

Complete all required fields and questions.

Required information is denoted with a red asterisk *

Click **Save and Continue**.

Is this a void or replacement of a previously submitted claim:

Yes No

Are you submitting COB at the claim level?

Yes No

Is the member's condition related to:

Select ▼

First date related to Member's condition:

Select ▼

Is this Member deceased?

Yes No

Is member unable to work in current occupation?

Yes No

Is hospitalization related to current services?

Yes No

Clinical Laboratory Improvement Amendment Number needed for this claim?

Yes No

Is there a prior authorization for this claim?

Yes No

Is there a Referral for this claim?

Yes No

Do you have attachments for this claim?

Yes No

Claim Adjustment Question

Select Yes to complete a claim adjustment.

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 <input type="text"/>	Insurance Type:	Select <input type="text"/>
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

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

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.

Submit

Previous

Save and Exit

Cancel

Bulk HIPAA Transactions

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

▼ 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

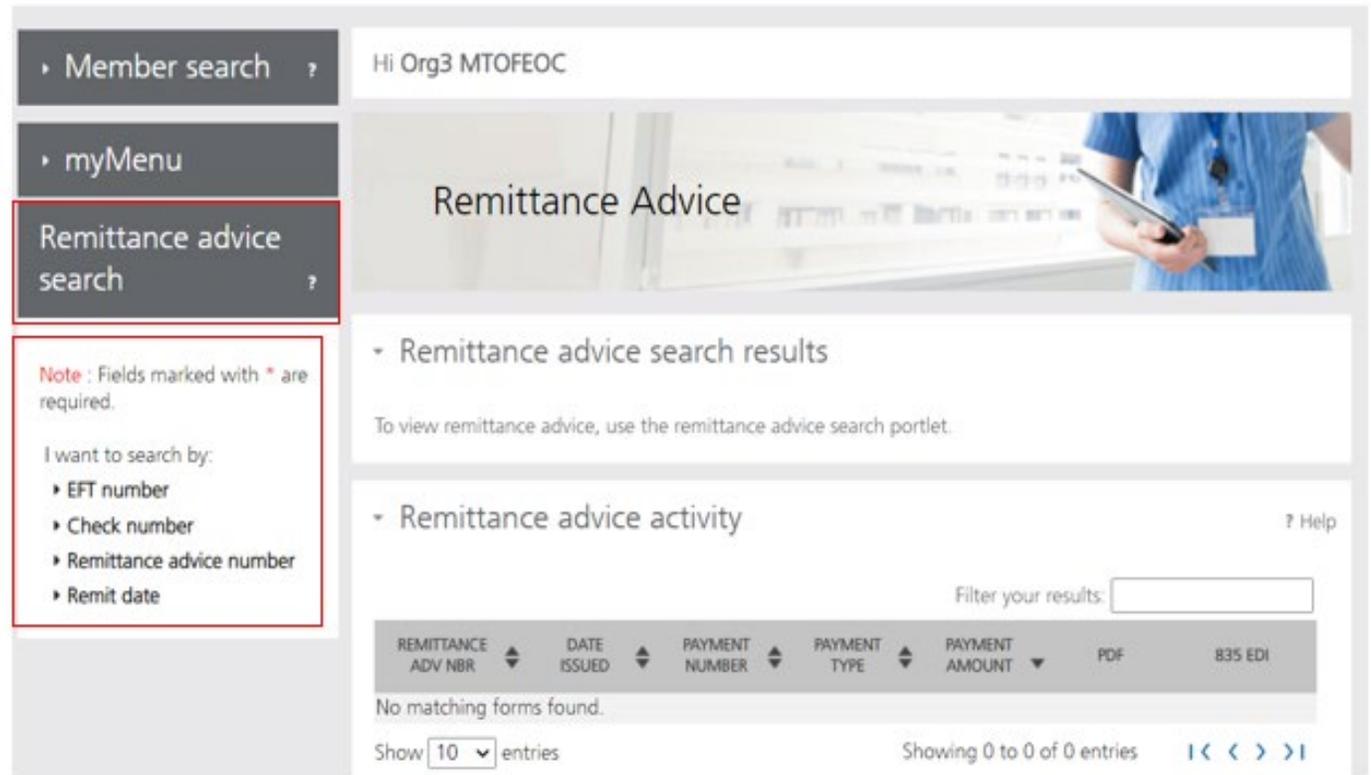
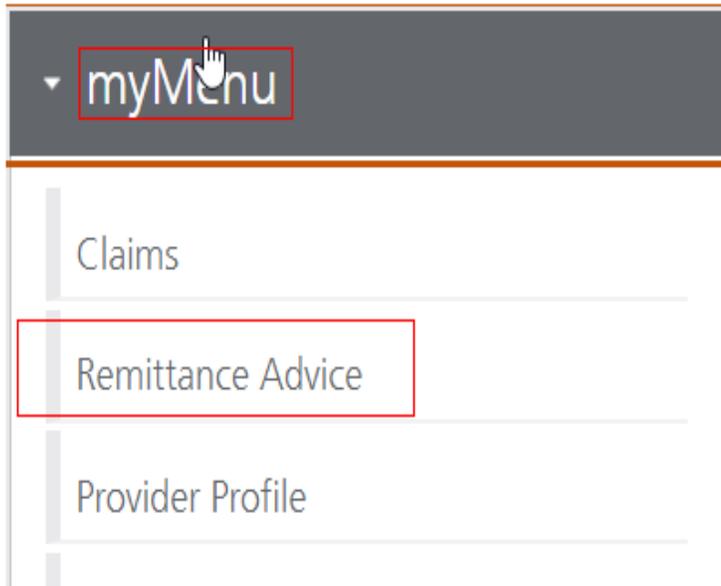
Questions?

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): *

09/02/2021 

To Date(mm/dd/yyyy): *

12/01/2021 

Search

Remits Results

Filter your results:

REMITTANCE ADV NBR	DATE ISSUED	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	PDF	835 EDI
0000000000	09/27/2021	0000000000	Check	\$1150550.83	View	Download
0000000000	09/27/2021	0000000000	Check	\$246077.51	View	Download
0000000000	09/27/2021	0000000000	Check	\$94875.42	View	Download
0000000000	09/20/2021	0100000000	Check	\$14843.00	View	Download
0000000000	09/27/2021	0000000000	Check	\$7195.51	View	Download
0000000000	09/06/2021	0000000000	Check	\$1572.51	View	Download
0000000000	09/13/2021	0100000000	Check	\$520.36	View	Download

Show 10 entries

Showing 1 to 7 of 7 forms

Navigation icons: < << >> >

VENDOR # 0000 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 221	PATIENT	07012021	07312021	1.000	S5141	2453.93	2453.93		
TEAM NUMBER 01		PATIENT NUMBER=0000000000							
		CLAIM TOTAL**				2453.93	2453.93		
ICN 221	PATIENT	08012021	08312021	1.000	S5141	2453.93	2453.93		
TEAM NUMBER 01		PATIENT NUMBER=0000000000							
		CLAIM TOTAL**				2453.93	2453.93		
ICN 221	PATIENT	07012021	07312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01		PATIENT NUMBER=0000000000							
		CLAIM TOTAL**				767.70	767.70		
ICN 221	PATIENT	07012021	07312021	5.000	S5135	115.50	115.50		
TEAM NUMBER 01		PATIENT NUMBER=0000000000							
		CLAIM TOTAL**				883.20	883.20		
ICN 221	PATIENT	08012021	08312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01		PATIENT NUMBER=0000000000							
		CLAIM TOTAL**				767.70	767.70		
ICN 221	PATIENT	08012021	08312021	5.000	S5135	115.50	115.50		
TEAM NUMBER 01		PATIENT NUMBER=0000000000							
		CLAIM TOTAL**				883.20	883.20		
ICN 2212	PATIENT	07012021	07312021	8.000	T2021	782.48	782.48		
TEAM NUMBER 01		PATIENT NUMBER=0000000000							
		CLAIM TOTAL**				782.48	782.48		

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		01042024	01252024	6.000	124	17359.50	0.00			
	PATIENT NUMBER=									
	DRG CODE 0753-2 DRG									
		01042024	01252024	16.000	204	59332.00	0.00			
		01042024	01252024	347.000	259	3999.87	0.00			
		01042024	01252024	11.000	300	1817.75	0.00			
		01042024	01252024	1.000	306	112.00	0.00			
		01042024	01252024	1.000	450	1942.25	0.00			
		01042024	01252024	9.000	636	261.00	0.00			
		CLAIM TOTAL**					84824.37	5578.90		

Claims Pending

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES	
VENDOR # REMIT ADVICE # EFT/CHK # DATE 02/12/2024 PAGE 21 NPI #: TAXONOMY: 282N00000X										
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	PATIENT NUMBER=	12122022	12122022	2.000	259	40.00	0.00		
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	PATIENT NUMBER=	01212024	01212024	1.000	300	78.25	0.00		
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	CO-PAY ALLOWED	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

Adjustment Form

- Tips: Section A is filled out for the paid claim.
- Section B: Boxes 1-7 are used to change the information to be corrected
- Use Box 8 if you need to change more info. Or give instructions to use attached claim



**DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES**

Montana Healthcare Programs Individual Adjustment Request

Instructions
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your remittance statement. Complete only the items in Section B that represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in the General Information for Providers manual or call Provider Relations at (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

<p>1. Provider Name, Address, and Telephone Number</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"> <p>First and Last Name</p> </div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"> <p>Street or P.O. Box</p> </div> <div style="display: flex; justify-content: space-between; border: 1px solid black; padding: 2px; margin-bottom: 5px;"> City State ZIP Code </div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"> <p>Telephone Number</p> </div>	<p>3. Internal Control Number (ICN)</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"> <p> </p> </div> <p>4. NPI/API</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"> <p> </p> </div> <p>5. Member ID Number</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"> <p> </p> </div> <p>6. Date of Payment</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"> <p> </p> </div> <p>7. Amount of Payment \$ </p>
--	--

B. Complete only the items which need to be corrected.

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed – TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature Date

When the form is completed and signed, attach a copy of the remittance advice. A copy of the corrected claim is optional.
Mail to Claims, P.O. Box 8000, Helena, MT 59604, or fax to (406) 442-4402.

Updated 09/2024

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:*

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

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.



User Guide

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!