

Tenancy Support Training

Part 2: Claims

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Provider Relations Manager

In this training...

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

Automated System Information

The MATH/MPATH portals and the IVR do not give services limits.

Always contact the Call Center to confirm service limits.

The verbiage on the IVR can be confusing when it comes to covered services.

It may say the member is eligible for eye exam & glasses. That only means that the member's coverage allows for this service.

It may say that the member is eligible for vision or dental services when the member only has QMB. This is because Medicare may cover some services in medical setting.

Inconsistent waiver information on MATH portal.

Preparation for submitting claims

What information should be gathered?

1. Verify member eligibility & service limits (if applicable)
2. Obtain & review member's prior authorization (if applicable)
3. Select the proper diagnosis code
4. Select place of service
5. Select the proper CPT code (service provided) & modifier

Prior Authorizations

Tenancy Support Requires a prior authorization.

Prior Authorization letters are mailed by Conduent any time a prior authorization has been entered into our system.

Letters may contain multiple members. Each member will have their own prior authorization number.

If you do not receive your prior authorizations in time for billing, contact the Call Center.

Prior Authorization Letter

DATE 02/25/21

RECIP ID	NAME		PRIOR AUTH NUMBER		AUTHORIZE FROM	DATES TO		
00			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 for Providers manual, located on every Provider Type page of the Provider Information website.

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

CPT Codes

Billable CPT Codes for Tenancy Support:

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

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

Claims Submission

Electronic Claim Submission

We currently support one free billing program. The MPATH claims solution is a function on the Provider Services Portal.

The MPATH system is a web-based program. Therefore, it can be used on any computer.

The Provider Portal User Guide is available under the Claims Page of the Provider Information Website.

The Call Center can only assist with submission questions on the EDI line. They are not available to walk you through the entire process.

Please send an email to MTPRHelpdesk@Conduent.com if you have set up questions.

Electronic Claims Submission Cont.

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

Paper Claim Submissions

- Paper claims can only be submitted via fax or US Mail.
- Claims may not be emailed.
- Paper claims can take several weeks longer to process than electronic claims as these claims must be manually keyed into our system.
- Claim forms can be purchased through most office supply stores and through Amazon.
- Information must be legible and in the correct fields. Please avoid using copies of copies.
- Instructions can also be found at www.nucc.org and www.nubc.org

Paper Claim Submissions

– CMS 1500

Required Fields:

- Box 1a Member ID
- Box 2 Member Name
- Box 21 Diagnosis Codes
- Box 23 Prior Authorization
- Box 24 Lines of Service
- Box 28 Total Charges
- Box 31 Provider's signature and date
- Box 33 Billing Provider Information
- Box 33a Billing NPI
- Box 33b Billing taxonomy

Note: Box 33 Billing provider information must match the physical location on file for the Billing NPI listed in box 33a and the Billing taxonomy listed in box 33b. Montana Medicaid does not edit on box 32 for servicing location.

CMS-1500 02/12

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

FICA FICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (Department) (Member ID#) (Date) (Plan) (Other)</small>			9. INSURED'S POLICY OR GROUP OR FICA NUMBER Possible Member ID		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client last name, first name			4. INSURED'S NAME (Last Name, First Name, Middle Initial) Possible Member ID		
3. PATIENT'S BIRTH DATE <input type="checkbox"/> SEX <input type="checkbox"/> MM DD YY M F			7. INSURED'S ADDRESS (No. Street) Possible Member ID		
5. PATIENT'S ADDRESS (No., Street) Possible Member ID			8. RESERVED FOR NUCC USE		
CITY STATE ZIP CODE TELEPHONE (Include Area Code) Possible Member ID			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLAGE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
6. OTHER INSURER'S NAME (Last Name, First Name, Middle Initial) Possible Member ID			11. INSURED'S DATE OF BIRTH <input type="checkbox"/> SEX <input type="checkbox"/> Possible Member ID		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (IMP) Possible Member ID			12. OTHER CLAIM ID (Designated by NUCC) Possible Member ID		
15. 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: _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: _____		
16. OTHER DATE MM DD YY Reserved for Passport #			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES Reserved for IHS Ref. ID		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Reserved for IHS Ref. ID			19. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below) (ICD Code) ICD - 10 Diagnosis code			22. BILL NUMBER ORIGINAL PCT. NO. 4123456789		
24. A. DATE OF SERVICE FROM MM DD YY TO MM DD YY 07 01 14 07 01 14			B. PLACE OF SERVICE 11		
C. PROCEDURE, SERVICE, OR SUPPLIER (Specify Universal Procedure Code) 99241			D. DIAGNOSIS PORTER ABC		
E. CHARGES \$ 100 00			F. DAYS OR PARTS 1		
G. QUALITY ZZ			H. RECEIVING PROVIDER ID # 2084N0400X		
I. BILL NUMBER 1234567891			J. TAX 1234567891		
K. BILL NUMBER 1234567891			L. BILL NUMBER 1234567891		
M. BILL NUMBER 1234567891			N. BILL NUMBER 1234567891		
O. BILL NUMBER 1234567891			P. BILL NUMBER 1234567891		
Q. BILL NUMBER 1234567891			R. BILL NUMBER 1234567891		
S. BILL NUMBER 1234567891			T. BILL NUMBER 1234567891		
U. BILL NUMBER 1234567891			V. BILL NUMBER 1234567891		
W. BILL NUMBER 1234567891			X. BILL NUMBER 1234567891		
Y. BILL NUMBER 1234567891			Z. BILL NUMBER 1234567891		
26. FEDERAL TAX ID NUMBER 99-9999999			28. PATIENT'S ACCOUNT NO. 123456789		
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			29. TOTAL CHARGE \$ 100 00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include and describe on separate lines all services that the physician or supplier apply to this bill and are made a part thereof.) Dr. Provider, MD 07/01/14			30. Amount Paid \$ 25 00		
32. SERVICE FACILITY LOCATION INFORMATION Dr. Provider, MD 123 Main Street Anywhere, MT 54321-1234			33. BILLING PROVIDER INFO & PFI # (406) 555-1234		

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMB 9938-1197 FORM 1500 02-12

If Atypical Provider, 33a will be blank and 33b will have G2 prefix—> G2 Atypical ID

MPATH Claims Setup

Manage Billing Providers

Add Billing NPIs to this section
ONLY if,

- You will be submitting claims through MPATH
- You need access to the weekly Remittances for this NPI

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: *



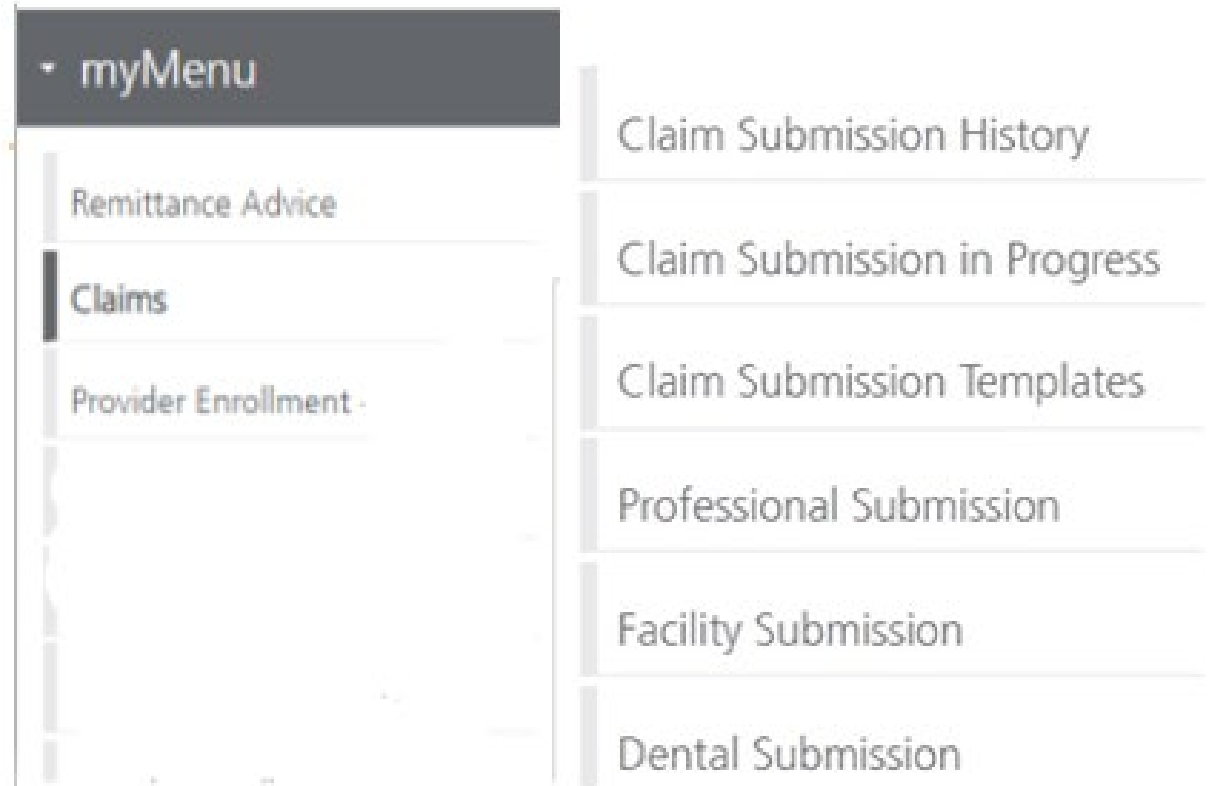
MPATH Claims Solution

Claim Submission Menu

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

A side menu with submission options will appear.

The following slides will describe each function.



Claims Submission History

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

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

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

Claims Submission in Progress

This function is for claims started but not submitted.

Example:

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

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

Claim Submission in Progress ? Help

A maximum of 200 in-progress claims will be displayed.

Filter your results:

Action	Member Name	Date of Service	NP/APR	Date Last Modified
	JOEL DUPREE	12/06/2021	1073820965	12/15/2021

Claim Submission Templates

This function is a time saving tool for reoccurring claims.

Example:

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

When it is time to submit their claim; select the billing provider NPI & Rendering Provider NPI (if applicable). Enter any additional required information on the Claim Information screen. Submit your claim.

Creating a Template

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

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

Claim Submission Templates ? Help

Maximum Templates Allowed : 500 Filter your results:

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

Show 10 entries Showing 1 to 4 of 4 templates

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

*Section 6, of the Provider Portal User Guide.

Creating a Template Cont.

Enter the member's MT
Medicaid ID number.

Click **Search**.

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

Professional Claim Template

Help

Member Details

Enter Member Card ID:

Creating a Template Cont.

Complete the fields that will not change.

For instance, the diagnosis code, place of service, CPT code, modifier & diagnosis point fields will most likely not change for reoccurring visits.

Professional Claim Submission Form ? Help

Claim Information

Note: Fields marked with an asterisk * are required.


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

Diagnosis Codes

Diagnosis Codes (ICD 10):

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

Claim Details

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

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

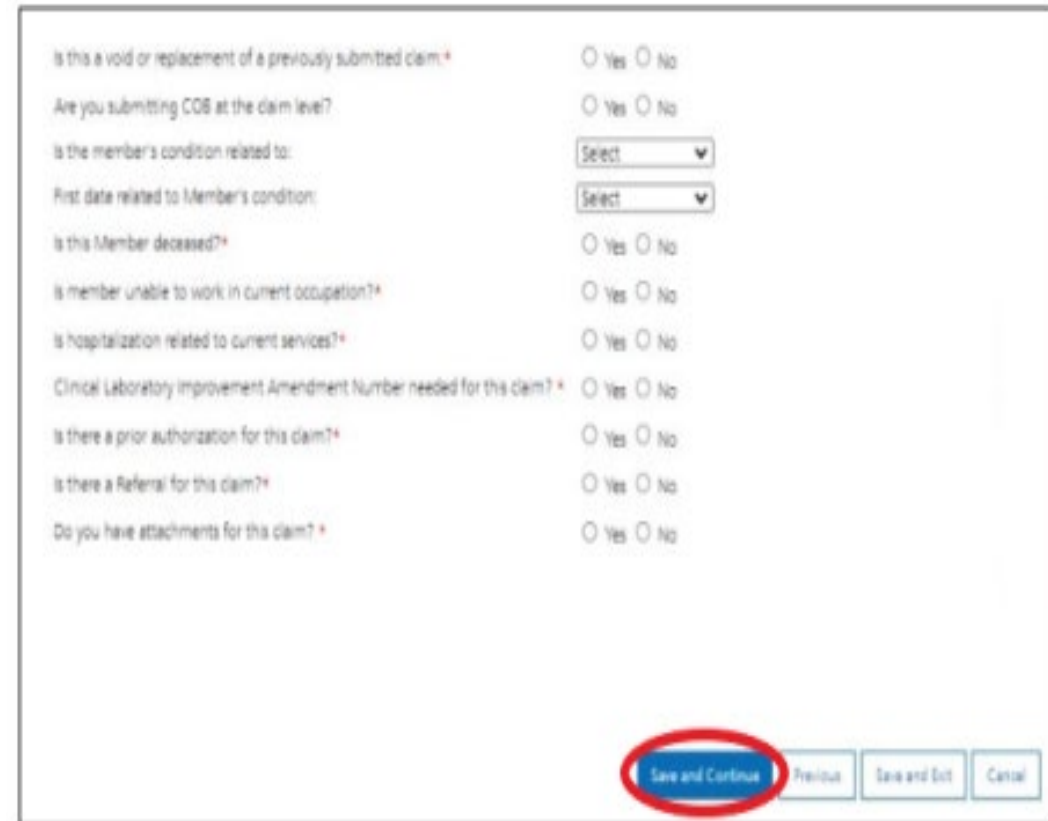
Total Charges: \$

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**.



The screenshot shows a form with the following questions and options:

- 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

At the bottom right, there are four buttons: **Save and Continue** (circled in red), Previous, Save and Exit, and Cancel.

Creating a Template

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

Your template is now visible.

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

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

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

Facility Claim Template

Save Template









Please enter a claim submission template name.

Template Name: *

Note(s):

Template Name must satisfy the following conditions:

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

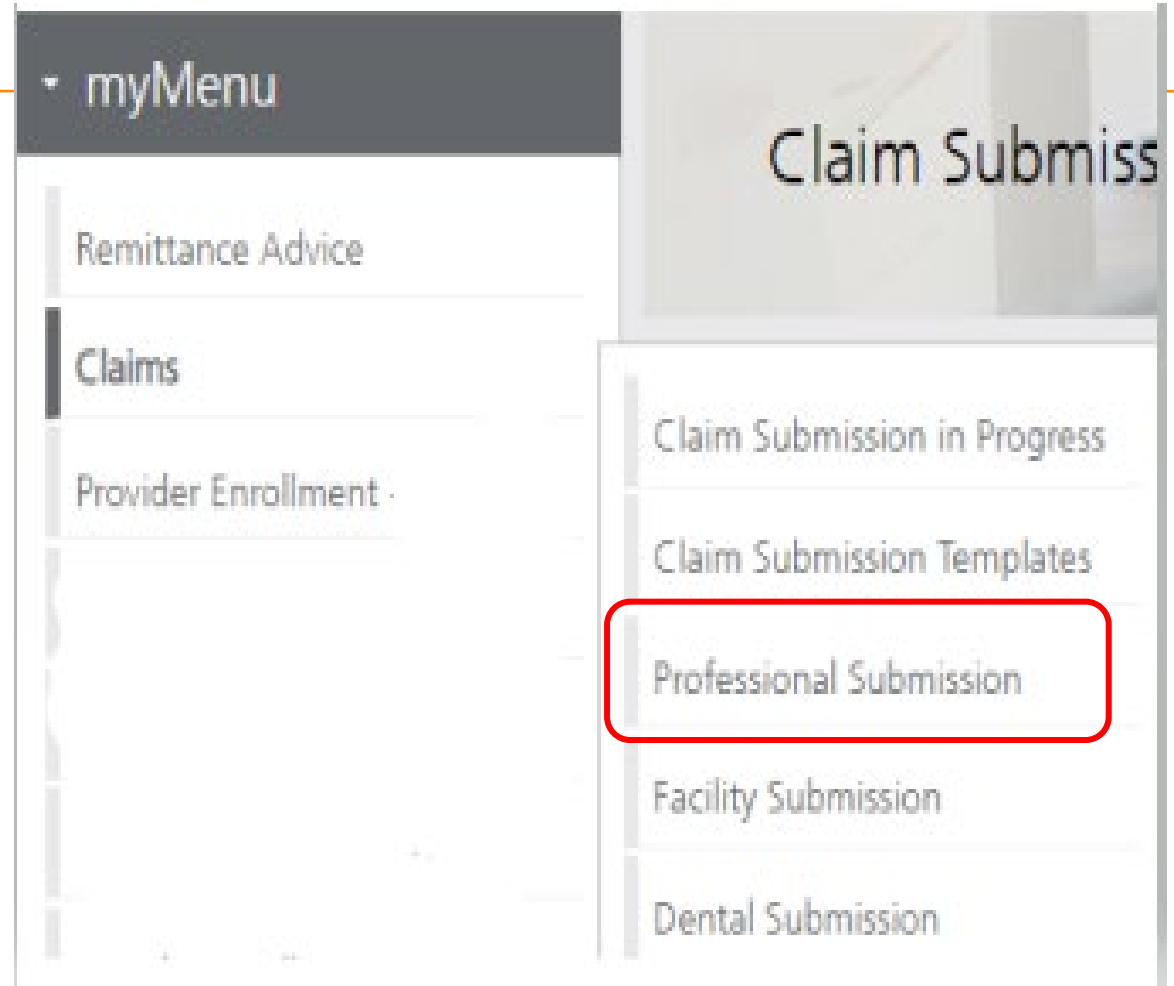
Actions	Name	Date Last Modified
 	<u>Member B</u>	12/08/2021
 	<u>Ortho</u>	12/09/2021
 	<u>Test 121</u>	12/01/2021
 	<u>Tester22</u>	12/15/2021

Submitting a Claim

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

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

*Section 6, of the Provider Portal User Guide.



Billing Provider

Select the Billing Provider file.

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

Select NPI.

Select Program/Waiver.

Select Specialty.

Click **Save and Continue**.

NPI/API: * 1245490713

Provider Name: * NORTH WEST HOME CAI

Program/Waiver: * Montana Medicaid (HMK Plus) v

Specialty: * In Home Supportive Care v

Service Location Address 1: * 818 W CENTRAL

Service Location Address 2:

City: * MISSOULA

State: * MT

ZIP: * 59801-0000 NPI/API: * 1033508080 v

Taxonomy Code: * 253Z00000X Provider Name: * LIBERTY PLACE, INC

Enrollment Unit: * 0000262208 Program/Waiver: * Severe Disabling Mental Illness Waiver (v

Specialty: * Select Program/Waiver

Service Location Address 1: * Severe Disabling Mental Illness Waiver (SDMI)

Service Location Address 2: * Big Sky Waiver

City: * BOOTSTRAP RANCH E

State: * BELGRADE

ZIP: * MT

Taxonomy Code: * 59714-8121

Enrollment Unit: * 251S00000X

0000801034

Member Details

Enter the member's MT Medicaid ID number.

Click **Search**.

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

Click **Save and Continue**.

Professional Claim Template

Help

Member Details

Enter Member Card ID:

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

Claim Details

Note :  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"/>

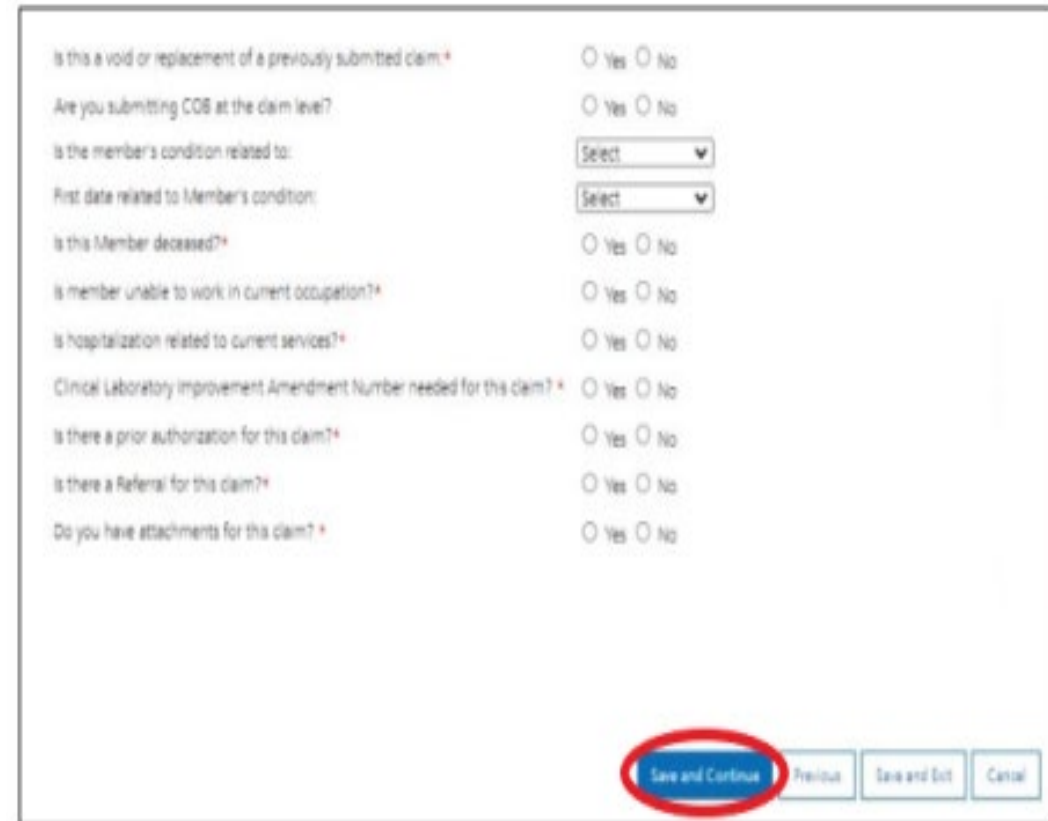
Total Charges: \$

Claim Information Questions

Complete all required fields and questions.

Required information is denoted with a red asterisk *

Click **Save and Continue**.



The screenshot shows a form with the following questions and options:

- 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

At the bottom right, there are four buttons: **Save and Continue** (circled in red), Previous, Save and Exit, and Cancel.

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

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 | < < > > |

[Upload](#)

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

Bulk HIPAA Transactions Cont.

File Upload



Note: Only .edi formats are supported for uploading

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

Claims Inquiry

Member search ?


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

Member search

Enter Member Card ID *

Go

Member search ?

 **Member found!**

You are currently viewing:

Member's Name

[Clear Search](#)

Claims Inquiry
 Eligibility

Search

Claims Inquiry Cont.

Member search | Hi Org3 MTOFEOC

myMenu

Claim search

I want to view:
Claims for

Time period
From Date: 09/01/2021
To Date: 12/01/2021
Claim number
Patient account number
Search

Claims Detail

Claim search results

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

Claim activity

Download | Print | Help

Filter your results:

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

Show 10 entries | Showing 1 to 1 of 1 Claims

Claims Inquiry Results

I want to view:
Claims for

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

Claim number
Patient account number

Search

- Claim search results

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

- Claim activity

ICN: 221 Optum Claim number: [redacted] [Download](#) [Print](#) [Help](#) [Return to search](#)

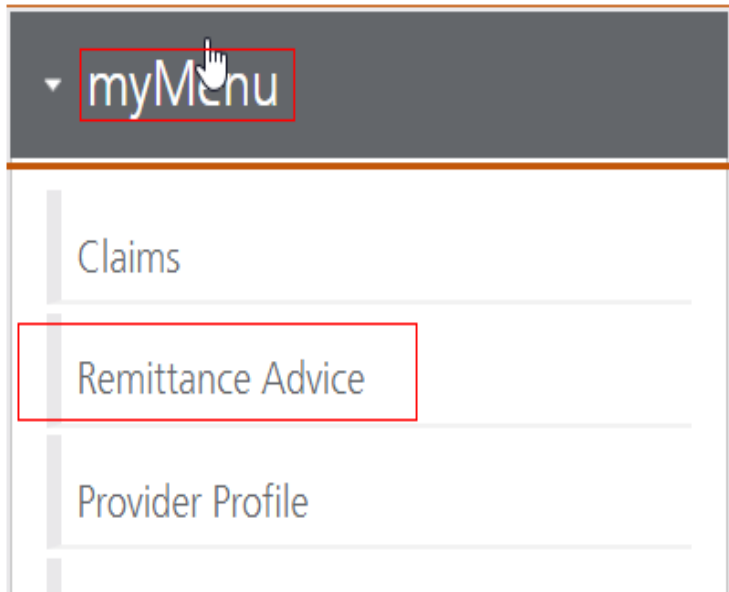
Member: [redacted]	Total amount billed: \$177.44
Date of service: 09/01/21-09/30/21	Total amount paid: \$177.44
Patient account: [redacted]	Date processed: 10/04/21
Member ID: [redacted]	Payment details
Claim status: F1:Finalized/Payment	Payment number: 00000261657
	Payment date: 10/11/21
	Payment amount: \$177.44

Line 1

Provider name: [redacted]	INC	Cost for this service	Amount billed: \$177.44
Provider NPI/API: 12-[redacted]			Amount paid by plan: \$177.44
Date of service: 09/01/21-09/30/21			
Procedure code: T2041			

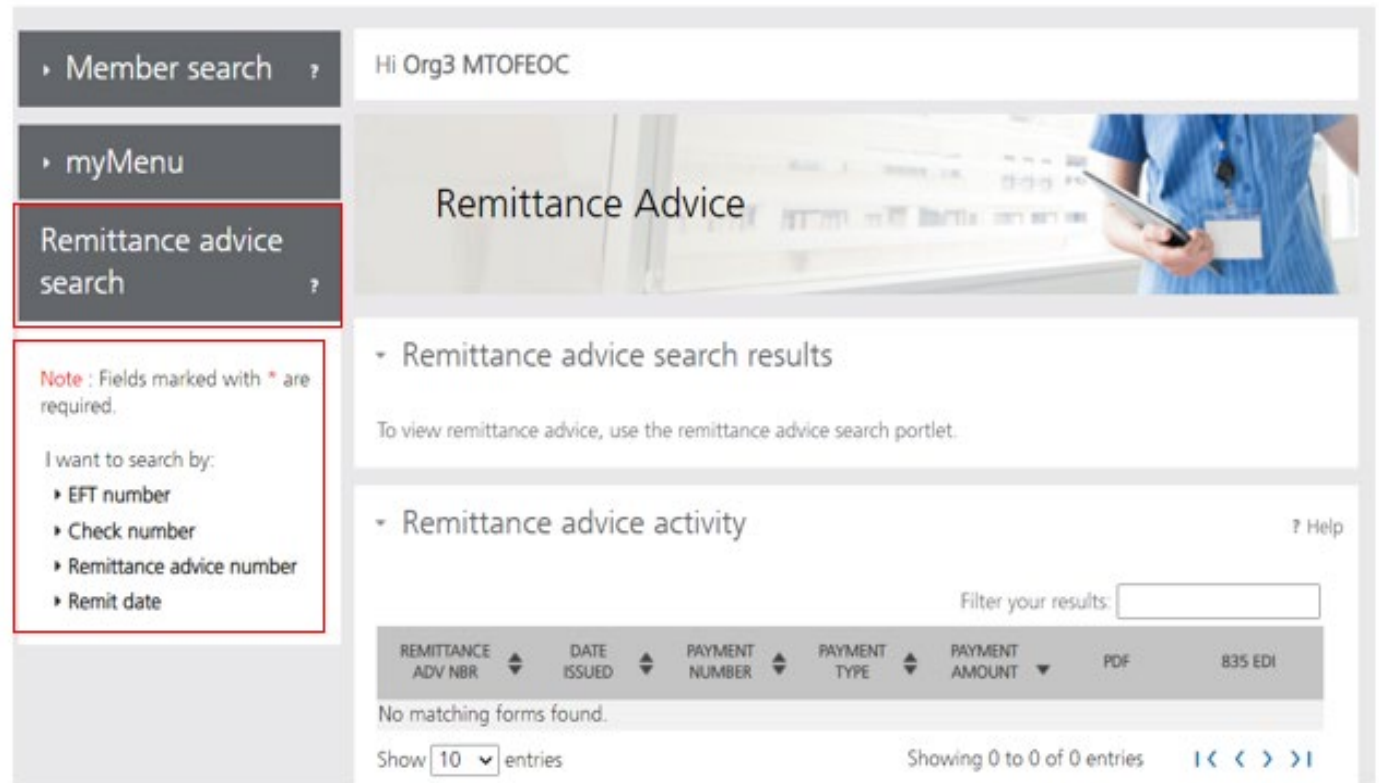
[Return to search](#)

Remittance Advice



myMenu

- Claims
- Remittance Advice
- Provider Profile



Member search > Hi Org3 MTOFEOC

myMenu

Remittance advice search ?

Note : Fields marked with * are required.

I want to search by:

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

Remittance Advice

Remittance advice search results

To view remittance advice, use the remittance advice search portlet.

Remittance advice activity ? Help

Filter your results:

REMITTANCE ADV NBR	DATE ISSUED	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	PDF	835 EDI
No matching forms found.						

Show 10 entries

Showing 0 to 0 of 0 entries

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

[|](#) [<](#) [>](#) [|](#)

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=00							
		CLAIM TOTAL**				2453.93	2453.93		
ICN 221	PATIENT	08012021	08312021	1.000	S5141	2453.93	2453.93		
TEAM NUMBER 01		PATIENT NUMBER=00							
		CLAIM TOTAL**				2453.93	2453.93		
ICN 221	PATIENT	07012021	07312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01		PATIENT NUMBER=00							
		CLAIM TOTAL**				767.70	767.70		
ICN 221	PATIENT	07012021	07312021	5.000	S5135	115.50	115.50		
TEAM NUMBER 01		PATIENT NUMBER=00							
		CLAIM TOTAL**				883.20	883.20		
ICN 221	PATIENT	08012021	08312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01		PATIENT NUMBER=00							
		CLAIM TOTAL**				767.70	767.70		
ICN 221	PATIENT	08012021	08312021	5.000	S5135	115.50	115.50		
TEAM NUMBER 01		PATIENT NUMBER=00							
		CLAIM TOTAL**				883.20	883.20		
ICN 2212	PATIENT	07012021	07312021	8.000	T2021	782.48	782.48		
TEAM NUMBER 01		PATIENT NUMBER=00							
		CLAIM TOTAL**				782.48	782.48		

If You Have Questions

Need Help with MPATH?

At the top of each screen is a **User Guide** icon.

When you click on the icon, the user guide will open to the section matching the screen you are on.



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

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

Questions?

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