

# MPATH Provider Services Billing 101

# MPATH Provider Services Portal

## Claims Entry

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The **MPATH Provider Services Claims Entry** solution is an online tool allowing providers to manually enter claims. Available features include:

- **Single submission claim forms** – The system allows direct claim form entry for claim submission.
- ***Claim form templates*** - The system allows users to create and save templates for common claim submissions. No need to start from scratch every time.
- ***Diagnosis and Procedure code look up*** - The system has code look-up features to assist with entering correct information.
- ***Ability to submit multiple claim types*** - including Professional, Facility and Dental claims.
- ***Electronic Claim Adjustments*** - Paper adjustment forms are no longer required. The system allows for online claim adjustments which process faster than paper adjustments.

# MPATH Provider Services Portal

## Electronic Claims Submission

Log in to the [Provider Services Portal](#)

1 Sign in with your Optum GovID

2 Continue

Optum GovID or Email Address  
testprovider@test.com

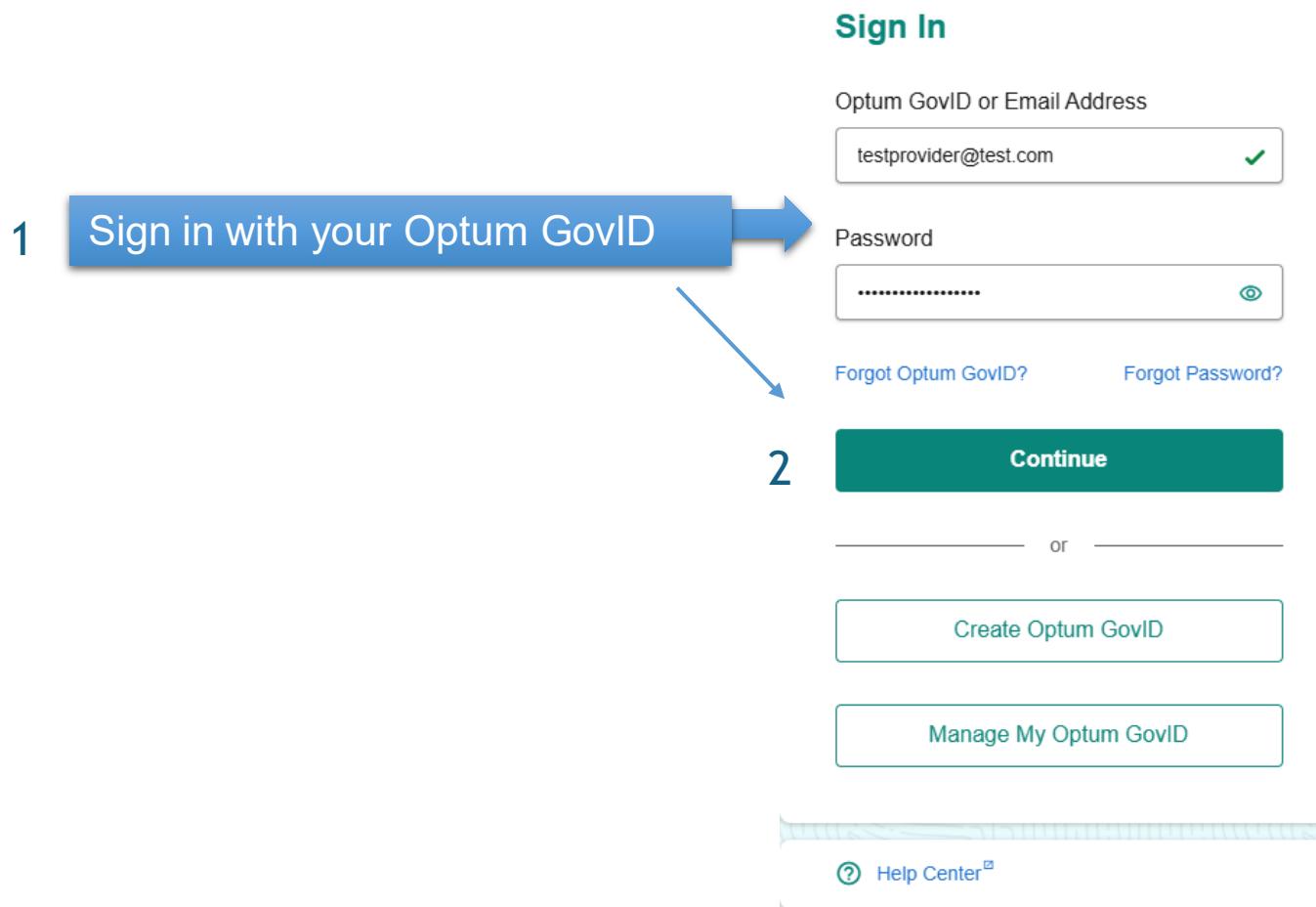
Password

Forgot Optum GovID?      Forgot Password?

Create Optum GovID

Manage My Optum GovID

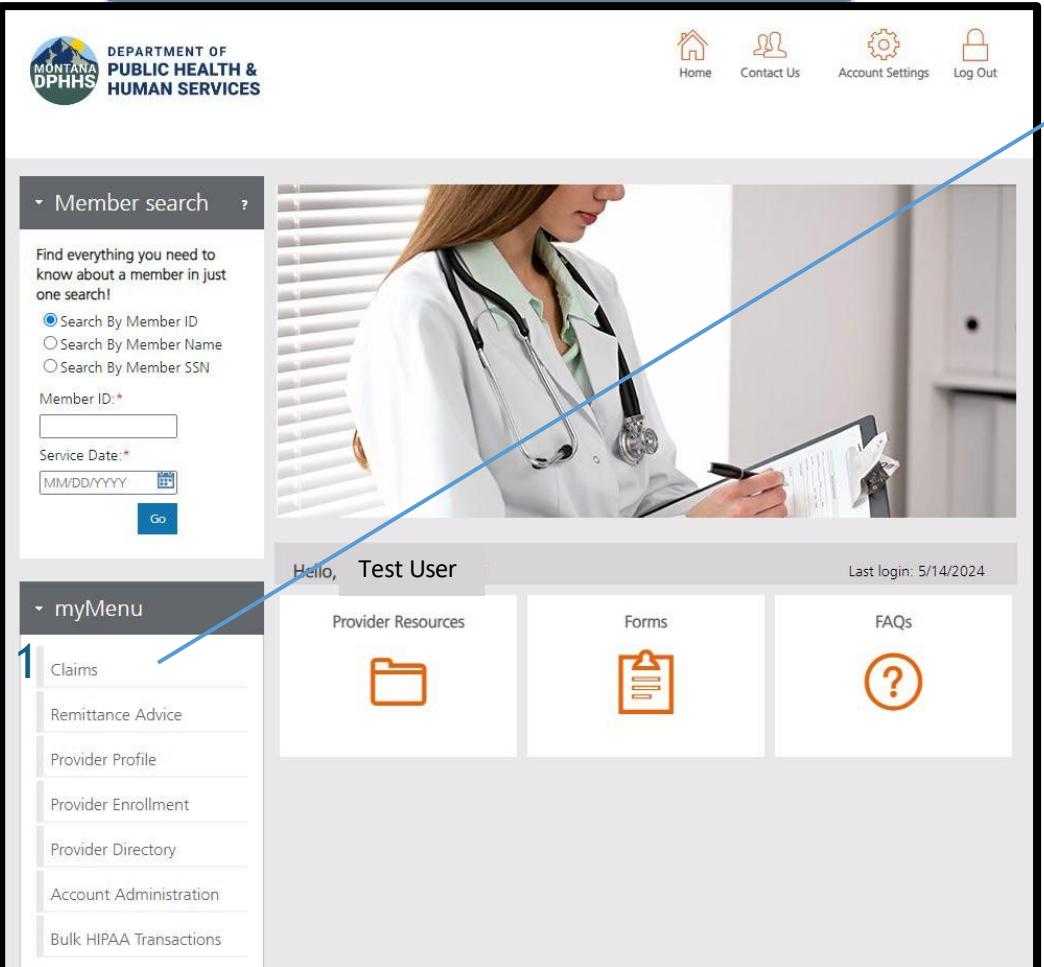
Help Center

The image shows a sign-in form for the Provider Services Portal. It is divided into two main sections by a vertical line. The left section, containing steps 1 and 2, is highlighted with a blue box and arrows. Step 1 is 'Sign in with your Optum GovID' with an arrow pointing to the 'Optum GovID or Email Address' field. Step 2 is 'Continue' with an arrow pointing to the 'Create Optum GovID' and 'Manage My Optum GovID' buttons. The right section contains the 'Sign In' header, the 'Forgot Optum GovID?' and 'Forgot Password?' links, and the 'Help Center' link at the bottom.

# MPATH Provider Services Portal

## Single Professional Claim Submission

Provider Services Portal Home Page



DEPARTMENT OF  
PUBLIC HEALTH &  
HUMAN SERVICES

Member search

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

Search By Member ID (radio button selected), Search By Member Name, Search By Member SSN

Member ID:

Service Date:  MM/DD/YYYY

Hello, Test User Last login: 5/14/2024

myMenu

- Claims
- Remittance Advice
- Provider Profile
- Provider Enrollment
- Provider Directory
- Account Administration
- Bulk HIPAA Transactions

Provider Resources  Forms  FAQs 

myMenu

Claims  

Remittance Advice

Provider Profile

Provider Enrollment

Provider Directory

Account Administration

Bulk HIPAA Transactions

Claim Submission History

Claim Submission in Progress

Claim Submission Templates

Professional Submission 

Facility Submission

Dental Submission

Hover the mouse over "Claims" in the myMenu section on the left navigation and select "Professional Claim Submission"

4

# MPATH Provider Services Portal

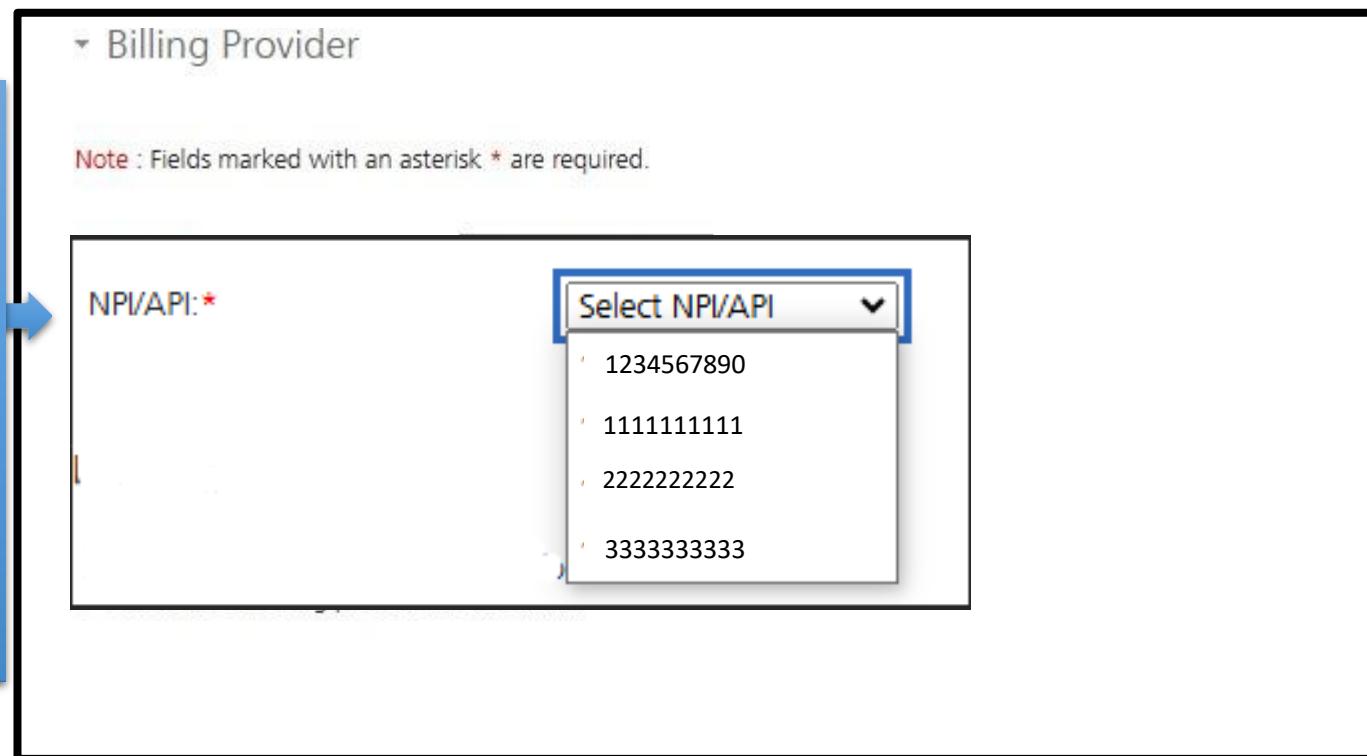
## Single Professional Claim Submission – Selecting correct PID/Team#

Select your provider NPI. All associated demographics including PID and Team# will be automatically populated after selecting Program/Specialty.

▼ Billing Provider

Note : Fields marked with an asterisk \* are required.

NPI/API:\*



1234567890

1111111111

2222222222

3333333333

# MPATH Provider Services Portal 2

## Single Professional Claim Submission – Selecting correct PID/Team# SDMI ALF

**Billing Provider**

**Note** : Fields marked with an asterisk \* are required.

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	<input type="button" value="Select Program/Waiver"/> 1 Select Program/Waiver Severe Disabling Mental Illness Waiver (SDMI) Big Sky Waiver

**Program/Waiver:\*** 2

Specialty:*	<input type="button" value="Select Specialty"/> 2 Select Specialty Assisted Living Facility Community/Behavioral Health/HCBS Waiver
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**Program/Waiver:\*** 3

**Specialty:\*** 4

**Taxonomy Team# PID/EU**

**Program/Waiver:\*** Severe Disabling Mental Illness Waiver (SI)

**Specialty:\*** Assisted Living Facility

**NPI/API:\*** 1234567890

**Provider Name:\*** Test Provider

**Program/Waiver:\*** Severe Disabling Mental Illness Waiver (SI)

**Specialty:\*** Assisted Living Facility

**Service Location Address 1:\*** 123 1<sup>st</sup> St

**Service Location Address 2:**

**City:\*** Billings

**State:\*** MT

**ZIP:\*** 59102-3320

**Taxonomy Code: \*** 310400000X

**Team Number:\*** TEAM S1

**Enrollment Unit:\*** 1111111

# MPATH Provider Services Portal 3

## Single Professional Claim Submission – Selecting correct PID/Team# SDMI HCBS

**Billing Provider**

Note : Fields marked with an asterisk \* are required.

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	<div style="border: 1px solid black; padding: 2px;"> <span>Select Program/Waiver</span> <ul style="list-style-type: none"> <li>Severe Disabling Mental Illness Waiver (SDMI)</li> <li>Big Sky Waiver</li> </ul> </div>
Program/Waiver:*	<div style="border: 1px solid black; padding: 2px;"> <span>Severe Disabling Mental Illness Waiver (SI)</span> <ul style="list-style-type: none"> <li>Select Specialty</li> <li>Assisted Living Facility</li> <li>Community/Behavioral Health/HCBS Waiver</li> </ul> </div>

Program/Waiver:*	Severe Disabling Mental Illness Waiver (SI)
Specialty:*	<div style="border: 1px solid black; padding: 2px;"> <span>Select Specialty</span> <ul style="list-style-type: none"> <li>Assisted Living Facility</li> <li>Community/Behavioral Health/HCBS Waiver</li> </ul> </div>
NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	<div style="border: 1px solid black; padding: 2px;"> <span>Severe Disabling Mental Illness Waiver (SI)</span> <ul style="list-style-type: none"> <li>Select Specialty</li> <li>Assisted Living Facility</li> <li>Community/Behavioral Health/HCBS Waiver</li> </ul> </div>
Specialty:*	<div style="border: 1px solid black; padding: 2px;"> <span>Select Specialty</span> <ul style="list-style-type: none"> <li>Assisted Living Facility</li> <li>Community/Behavioral Health/HCBS Waiver</li> </ul> </div>
Service Location Address 1:*	123 1 <sup>st</sup> St
Service Location Address 2:	
City:*	Billings
State:*	MT
ZIP:*	59102-3320
Taxonomy Code: *	251S00000X
Team Number:*	TEAM S1
Enrollment Unit:*	1111111

**Taxonomy**  
**Team#**  
**PID/EU**

# MPATH Provider Services Portal 4

## Single Professional Claim Submission – Selecting correct PID/Team# BSW ALF

**Billing Provider**

**Note** : Fields marked with an asterisk \* are required.

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	<input type="button" value="Select Program/Waiver"/> Select Program/Waiver Severe Disabling Mental Illness Waiver (SDMI) Big Sky Waiver

**1** 

Program/Waiver:*	<input type="button" value="Select Specialty"/> Select Specialty Assisted Living Facility Community/Behavioral Health/HCBS Waiver
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**2** 

**Taxonomy Team# PID/EU**

Program/Waiver:*	<input type="button" value="Big Sky Waiver"/> Big Sky Waiver
Specialty:*	<input type="button" value="Select Specialty"/> Select Specialty Assisted Living Facility Community/Behavioral Health/HCBS Waiver

**3** 

Program/Waiver:*	<input type="button" value="Big Sky Waiver"/> Big Sky Waiver
Specialty:*	<input type="button" value="Assisted Living Facility"/> Assisted Living Facility
NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	<input type="button" value="Big Sky Waiver"/> Big Sky Waiver
Specialty:*	<input type="button" value="Assisted Living Facility"/> Assisted Living Facility
Service Location Address 1:*	123 1 <sup>st</sup> St
Service Location Address 2:	
City:*	Billings
State:*	MT
ZIP:*	59102-3320
Taxonomy Code:*	310400000X
Team Number:*	TEAM B1
Enrollment Unit:*	1111111

**4** 

# MPATH Provider Services Portal 5

## Single Professional Claim Submission – Selecting correct PID/Team# BSW HCBS

**Billing Provider**

**Note** : Fields marked with an asterisk \* are required.

NPI/API:\*

Provider Name:\*

Program/Waiver:\*

1 

2 

**Taxonomy Team# PID/EU**

Program/Waiver:\*

Specialty:\*

NPI/API:\*

Provider Name:\*

Program/Waiver:\*

Specialty:\*

Service Location Address 1:\*

Service Location Address 2:

City:\*

State:\*

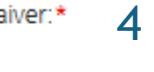
ZIP:\*

Taxonomy Code: \*

Team Number:\*

Enrollment Unit:\*

3 

4 

Big Sky Waiver

Select Specialty

Select Specialty

Assisted Living Facility

Community/Behavioral Health/HCBS Waiver

123 1<sup>st</sup> St

Billings

MT

59102-3320

251S00000X

TEAM B1

2222222

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# MPATH Provider Services Portal 6

## Single Professional Claim Submission – Selecting correct PID/Team# DDP HCBS

**Billing Provider**

**Note** : Fields marked with an asterisk \* are required.

NPI/API: \* 1234567890

Provider Name: \* Test Provider

Program/Waiver: \* Select Program/Waiver

**1** → **Select Program/Waiver**  
Severe Disabling Mental Illness Waiver (SDMI)  
Big Sky Waiver  
Developmentally Disabled Waiver (DDP)

Program/Waiver: \* Developmentally Disabled Waiver (DDP)

Specialty: \* Select Specialty

**2** → **Select Specialty**  
Community/Behavioral Health/HCBS Waiver  
Community Based Residential Treatment Facility, Intellectual and/or Developmental Disabilities

**3** → **Program/Waiver: \*** Developmentally Disabled Waiver (DDP)  
**Specialty: \*** Select Specialty  
Select Specialty  
Community/Behavioral Health/HCBS Waiver  
Community Based Residential Treatment Facility, Intellectual and/or Developmental Disabilities

**4** → **NPI/API: \*** 1234567890  
**Provider Name: \*** Test Provider  
**Program/Waiver: \*** Developmentally Disabled Waiver (DDP)  
**Specialty: \*** Community/Behavioral Health/HCBS Waiver  
**Service Location Address 1: \*** 123 1<sup>st</sup> St  
**Service Location Address 2:**  
**City: \*** KALISPELL  
**State: \*** MT  
**ZIP: \*** 59901-1916  
**Taxonomy Code: \*** 251S00000X  
**Team Number: \*** TEAM 01  
**Enrollment Unit: \*** 1111111

**Taxonomy  
Team#  
PID/EU**

# MPATH Provider Services Portal 7

## Single Professional Claim Submission – Selecting correct PID/Team# DDP CBRT

**Billing Provider**

**Note** : Fields marked with an asterisk \* are required.

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	Select Program/Waiver

1. Select Program/Waiver: Developmentally Disabled Waiver (DDP)

2. Select Specialty: Community/Behavioral Health/HCBS Waiver

3. Program/Waiver: Developmentally Disabled Waiver (DDP)

4. Specialty: Community Based Residential Treatment Facility, Intellectual and/or Developmental Disabilities

**Taxonomy Team# PID/EU**

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	Developmentally Disabled Waiver (DDP)
Specialty:*	Community Based Residential Treatment
Service Location Address 1:*	123 1 <sup>st</sup> St
Service Location Address 2:	
City:*	KALISPELL
State:*	MT
ZIP:*	59901-1916
Taxonomy Code: *	320900000X
Team Number:*	TEAM 01
Enrollment Unit:*	2222222

# MPATH Provider Services Portal 8

## Single Professional Claim Submission – Selecting correct PID/Team# IHSC

**Billing Provider**

**Note** : Fields marked with an asterisk \* are required.

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	Select Program/Waiver

1 → **Severe Disabling Mental Illness Waiver (SDMI)**  
Big Sky Waiver  
Montana Medicaid (HMK Plus)

2 → **Montana Medicaid (HMK Plus)**  
Select Specialty  
Select Specialty  
In Home Supportive Care  
Nursing Care

**Program/Waiver:\***  
**Specialty:\***

3 → **Montana Medicaid (HMK Plus)**  
In Home Supportive Care  
Select Specialty  
In Home Supportive Care  
Nursing Care

4 → **123 1<sup>st</sup> St**  
APT A  
Billings  
MT  
59102-3200  
253Z00000X  
TEAM AB  
1234567

**Taxonomy Team# PID/EU**

Program/Waiver:\*

Specialty:\*

NPI/API:\*

Provider Name:\*

Program/Waiver:\*

Specialty:\*

Service Location Address 1:\*

Service Location Address 2:

City:\*

State:\*

ZIP:\*

Taxonomy Code: \*

Team Number:\*

Enrollment Unit:\*

# MPATH Provider Services Portal

## Single Professional Claim Submission 1

Enter Member ID (Card#/SSN) and click “Search” - Enter Patient Account Number (optional).

1

Member Details

Note : Fields marked with an asterisk \* are required.

Enter Member ID:\*

1234567

Search

Select Search

2

Enter Member ID:\*

1234567

Search

Member ID: 1234567

Patient Account Number:

First Name: Test

Middle Name:

Last Name: Member

Date of Birth:

Gender: Male

Mailing Address 1:

Mailing Address 2:

City:

State: MT

ZIP: 59521-0000

Member demographics are automatically populated when entering a valid Member ID

Select Save and Continue

Save and Continue

Previous

Save and Exit

Cancel

# MPATH Provider Services Portal

## Single Professional Claim Submission 2

Professional Claim Submission Form

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

Claim Details

**Note :**  or  indicates all required fields for COB or NDC 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
MM/DD/YYYY <input type="button" value="Calendar"/>	MM/DD/YYYY <input type="button" value="Calendar"/>	Select <input type="button" value="Select"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="button" value="Calendar"/>	MM/DD/YYYY <input type="button" value="Calendar"/>	Select <input type="button" value="Select"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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MM/DD/YYYY <input type="button" value="Calendar"/>	MM/DD/YYYY <input type="button" value="Calendar"/>	Select <input type="button" value="Select"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="button" value="Calendar"/>	MM/DD/YYYY <input type="button" value="Calendar"/>	Select <input type="button" value="Select"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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MM/DD/YYYY <input type="button" value="Calendar"/>	MM/DD/YYYY <input type="button" value="Calendar"/>	Select <input type="button" value="Select"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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MM/DD/YYYY <input type="button" value="Calendar"/>	MM/DD/YYYY <input type="button" value="Calendar"/>	Select <input type="button" value="Select"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox

# MPATH Provider Services Portal

## Single Professional Claim Submission 3

Enter the Diagnosis Code. The magnifying glass will allow users to search for the specific Diagnosis Code if unknown.

Enter at least first three (3) characters of a Diagnosis to search code list.

1

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
F20	Q	Q	Q	Q	Q
7	8	9	10	11	12
Q	Q	Q	Q	Q	Q

3

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
F200	Q	Q	Q	Q	Q
7	8	9	10	11	12
Q	Q	Q	Q	Q	Q

2

Search Results

Code	Description
F20	Schizophrenia
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F208	Other schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified

Cancel

# MPATH Provider Services Portal

## Single Professional Claim Submission 4

Enter the CPT/HCPCS Code. The magnifying glass will allow users to search for the specific Code if unknown.

Enter at least first three (3) characters of a CPT/HCPCS to search code list.

Claim Details

Note : **COB** or **NDC** indicates all required fields for COB or NDC 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	
03/08/2024	03/08/2024	11	9079			\$ 150.00	1.00	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	1	
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>		
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>		
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>		
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>		
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>		
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>		
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>		
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>		
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>		
MM/DD/YYYY	MM/DD/YYYY	Select				\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>		

Total Charges: \$ 150.00

Search Results

Code	Description
90791	PSYCH DIAGNOSTIC EVALUATION
9079122	PSYCH DIAGNOSTIC EVALUATION;Increased Procedural Services
9079123	PSYCH DIAGNOSTIC EVALUATION;Unusual Anesthesia
9079151	PSYCH DIAGNOSTIC EVALUATION;Multiple Procedures
9079152	PSYCH DIAGNOSTIC EVALUATION;Reduced Services
9079153	PSYCH DIAGNOSTIC EVALUATION;Discontinued Procedure
9079158	PSYCH DIAGNOSTIC EVALUATION;Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
9079159	PSYCH DIAGNOSTIC EVALUATION;Distinct Procedural Service

# MPATH Provider Services Portal

## Single Professional Claim Submission 5

Total Charges: \$ 150.00 [Add](#)

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

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  Select

First date related to Member's condition:  Select  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

**Select Save and Continue** → [Save and Continue](#) [Previous](#) [Save and Exit](#) [Cancel](#)

Select Yes/No radio buttons for required “\*” fields

# MPATH Provider Services Portal

## Single Professional Claim Submission 6

---

Agree to Terms and Conditions



Professional Claim Submission Form ? Help

Terms and Agreements

**Note :** Fields marked with an asterisk \* are required.

Provider Name: \*

NPI/API: \*

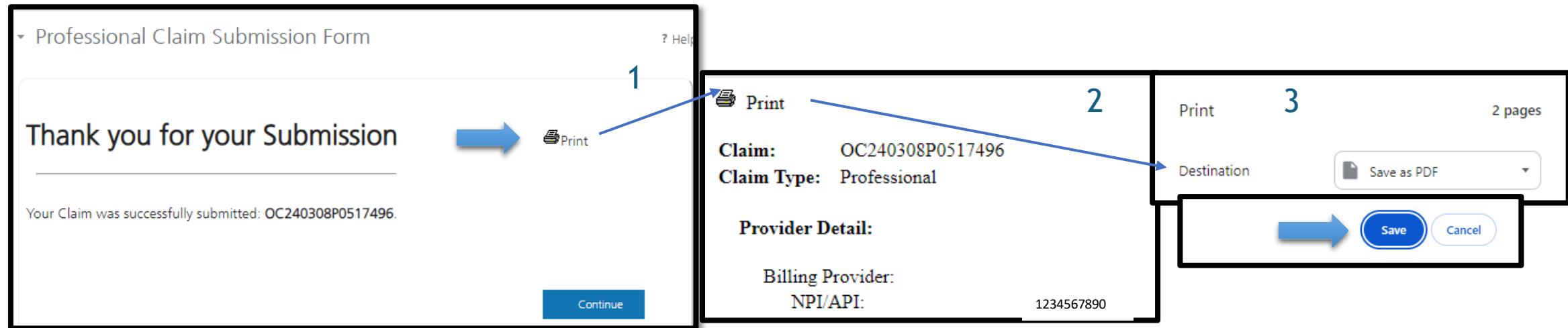
\* I certify I have read the [Terms and Conditions](#)  that apply to this bill and are made a part thereof.

**Select Submit**  Submit Previous Save and Exit Cancel

# MPATH Provider Services Portal

## Single Professional Claim Submission 7

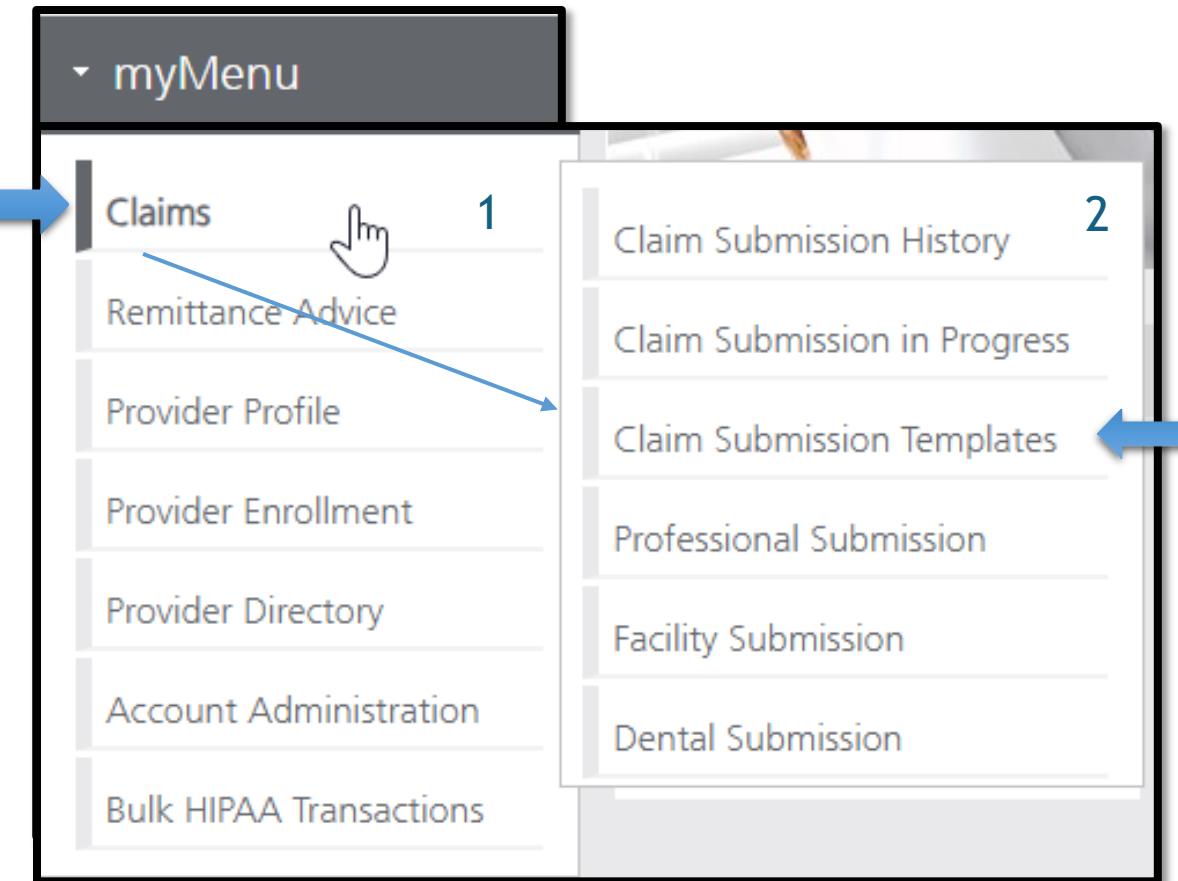
Print/Save PDF of claim submission (optional).



# MPATH Provider Services Portal

## (Service specific) Professional Claim Template

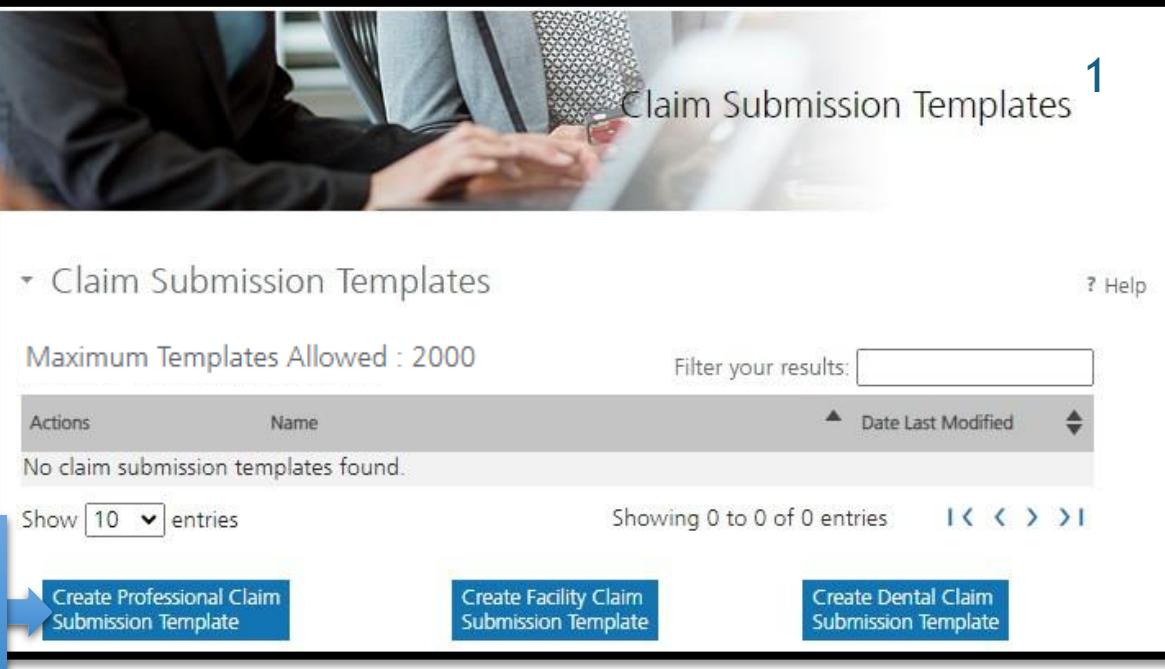
Hover the mouse over “Claims” in the myMenu section on the left navigation and select “Claim Submission Templates”



# MPATH Provider Services Portal

## (Service specific) Professional Claim Template 2

To create a template, click the blue button to ~~s may be Member or Service~~ (without member) specific.



Claim Submission Templates 1

Claim Submission Templates

Maximum Templates Allowed : 2000

Filter your results:

Actions	Name
No claim submission templates found.	

Show 10 entries

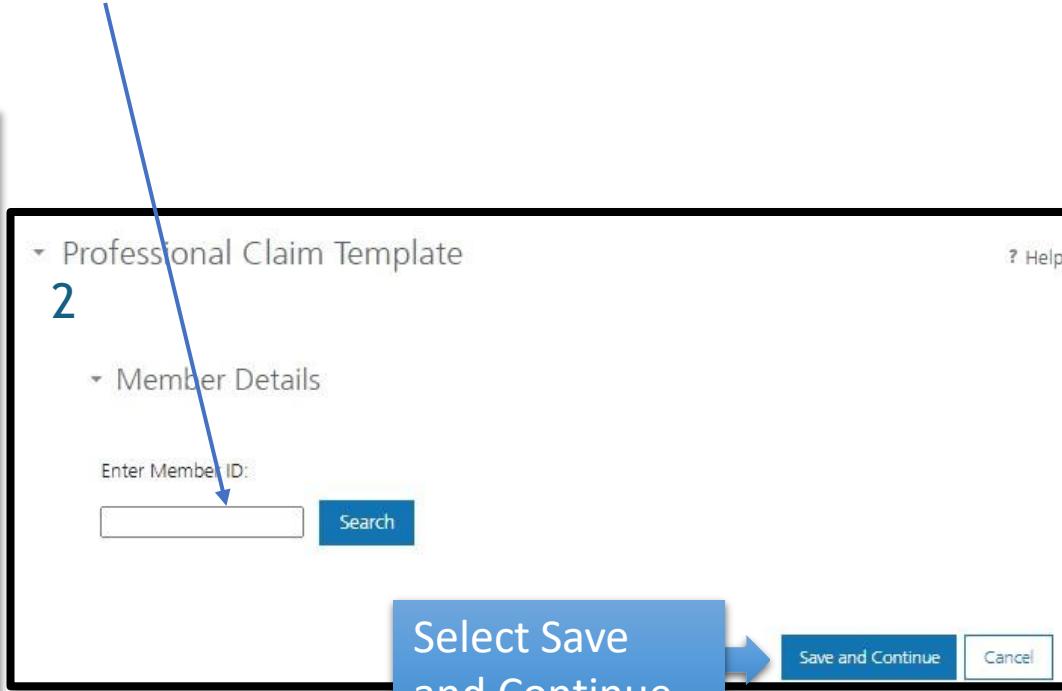
Showing 0 to 0 of 0 entries

[Create Professional Claim Submission Template](#)

[Create Facility Claim Submission Template](#)

[Create Dental Claim Submission Template](#)

Select “Create Professional Claim Submission Template”



Professional Claim Template 2

Member Details

Enter Member ID:

Search

Select Save and Continue

Save and Continue

Cancel

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template 3

Professional Claim Template [? 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 :** **COB** or **NDC** indicates all required fields for COB or NDC 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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
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# **MPATH Provider Services Portal**

## **(Service specific) Professional Claim Template 4**

Dynamic data (Date of Service, Diagnosis) is entered when submitting the template.

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template 5

Save Template, naming service specific template for quick reference

**Screenshot 1: Professional Claim Template**

1

Professional Claim Template

Save Template

Please enter a claim submission template name.

Template Name: **Psych Eval Prof**

Name template

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 "-".

Select Submit

Submit Previous Cancel

**Screenshot 2: Claim Submission Templates**

2

Claim Submission Templates

Maximum Templates Allowed : 2000

Filter your results:

Actions Name Date Last Modified

Psych Eval Prof 03/08/2024

Show 10 entries

Showing 1 to 1 of 1 templates

Create Professional Claim Submission Template

Create Facility Claim Submission Template

Create Dental Claim Submission Template

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template 6

Hover the mouse over “Claims” in the myMenu section on the left navigation and select “Claim Submission Templates” to access saved Templates

The screenshot illustrates the navigation and functionality for creating professional claim templates. On the left, a blue box provides instructions: "Hover the mouse over ‘Claims’ in the myMenu section on the left navigation and select ‘Claim Submission Templates’ to access saved Templates". The main interface shows the 'myMenu' with 'Claims' selected, opening a dropdown menu (1) containing 'Claim Submission History', 'Claim Submission in Progress', 'Claim Submission Templates' (which is highlighted), 'Professional Submission', 'Facility Submission', and 'Dental Submission'. A blue arrow points from the 'Claims' menu item to the 'Claim Submission Templates' option. The 'Claim Submission Templates' page (2) displays a table with one entry: 'Psych Eval Prof'. The table includes columns for 'Actions' (with edit and delete icons) and 'Name'. The page also features a 'Create Professional Claim Submission Template' button, a 'Create Facility Claim Submission Template' button, and a 'Create Dental Claim Submission Template' button. The page header includes a 'Help' link, a 'Filter your results:' input field, and a date range selector for 'Date Last Modified'.

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template 7

Select your provider NPI. All associated demographics will be automatically populated.

Enter other optional provider data as needed.

Optional Rendering Provider selection is available when affiliated providers are added.

**Billing Provider**

Note : Fields marked with an asterisk \* are required.

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	Montana Medicaid (HMK Plus)
Specialty:*	Community/Behavioral Health/SDMI HCB
Service Location Address 1:*	1120 CEDAR ST
Service Location Address 2:	
City:*	MISSOULA
State:*	MT
ZIP:*	59802-3911
Team Number:*	TEAM AB
Enrollment Unit:*	1234567

**Referring Provider**

There is a referring provider for this claim.

**Ordering Provider**

There is a ordering provider for this claim.

Select Save and Continue →

Save and Continue   Save and Exit   Cancel

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template 8

Enter Member ID and click “Search” - Enter Patient Account Number (optional).

1

2

Select Search

Select Save and Continue

Enter Member ID:\*

Member ID: 1234567

Patient Account Number:

First Name: Test

Middle Name:

Last Name: Member

Date of Birth:

Gender: Male

Mailing Address 1:

Mailing Address 2:

City:

State: MT

ZIP: 59521-0000

Save and Continue Previous Save and Exit Cancel

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template 9

Template retains the static data entered allowing for dynamic data entry

1

Diagnosis Codes

Diagnosis Codes (ICD 10):

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

Claim Details

Note :  or  indicates all required fields for COB or NDC 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
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	11 <input type="text"/>	90791 <input type="text"/>	<input type="text"/>	<input type="text"/>	\$ 150.00 <input type="text"/>	1.00 <input type="text"/>	<input type="checkbox"/> COB	<input type="checkbox"/> 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.

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

2

Diagnosis Codes (ICD 10):

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

3

4

Claim Details

Note :  or  indicates all required fields for COB or NDC 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
03/08/2024 <input type="text"/>	03/08/2024 <input type="text"/>	11 <input type="text"/>	90791 <input type="text"/>	<input type="text"/>	<input type="text"/>	\$ 150.00 <input type="text"/>	1.00 <input type="text"/>	<input type="checkbox"/> COB	<input type="checkbox"/> NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Charges

5 Select Save and Continue

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template 10

Agree to Terms and Conditions →

Professional Claim Submission Form ? Help

Terms and Agreements

**Note :** Fields marked with an asterisk \* are required.

Provider Name: \*   

NPI/API: \*   

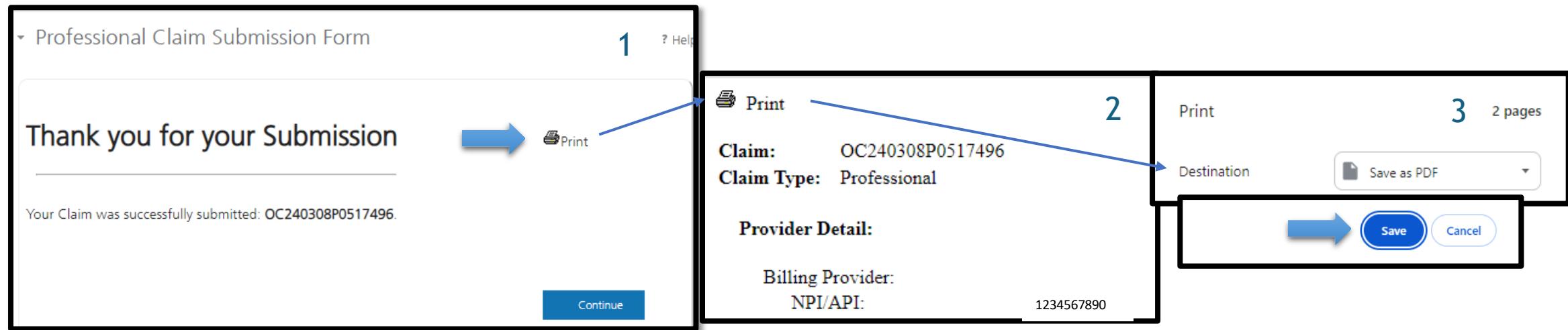
\* I certify I have read the [Terms and Conditions](#)  that apply to this bill and are made a part thereof.

Select Submit → Submit Previous Save and Exit Cancel

# MPATH Provider Services Portal

## (Service specific) Professional Claim Template 11

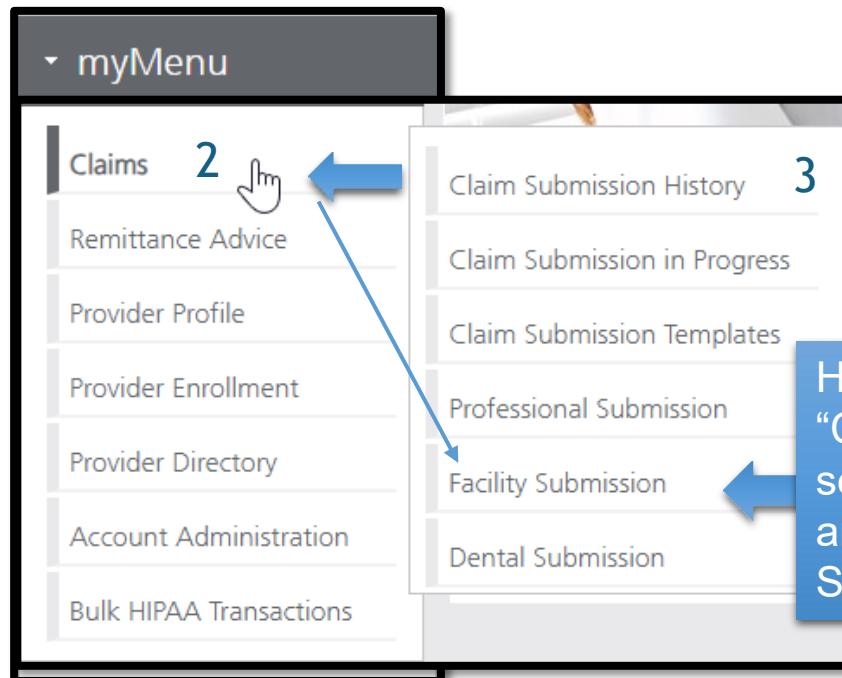
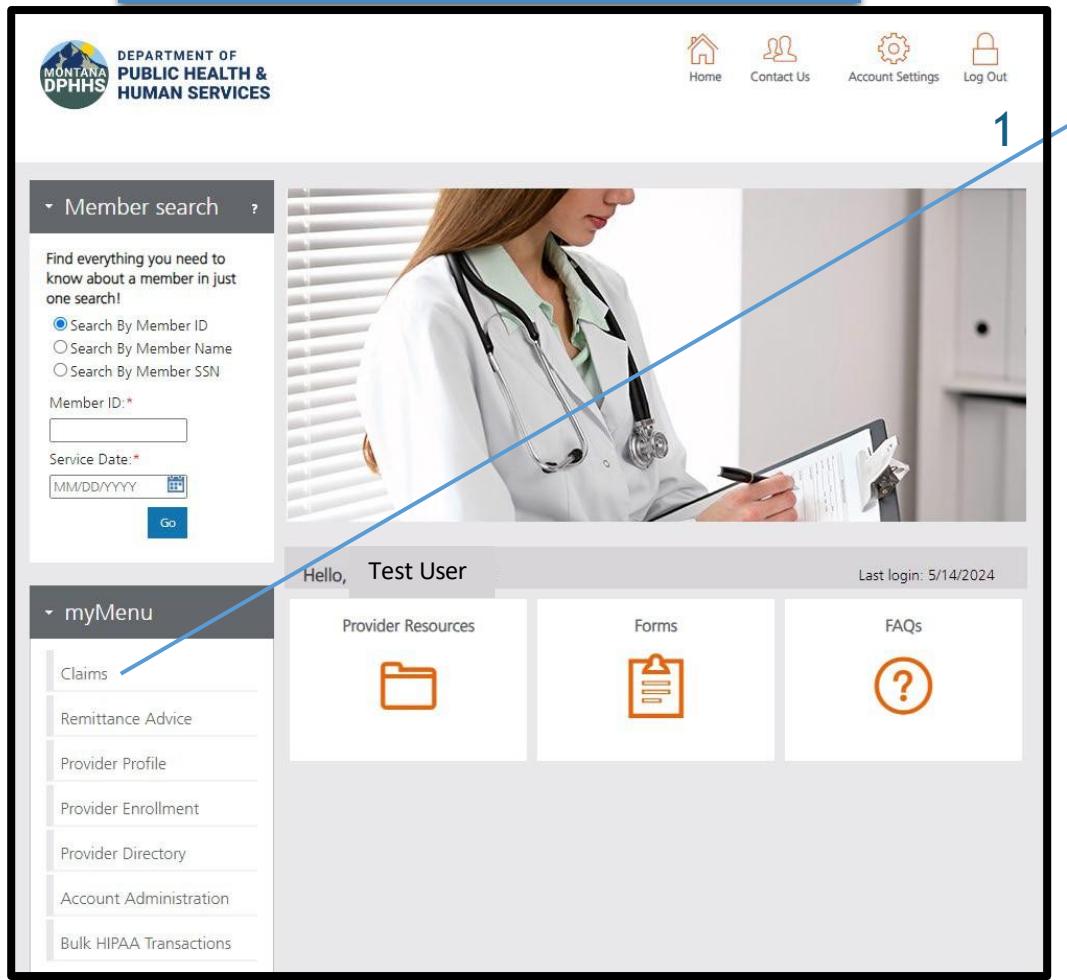
Print/Save PDF of claim submission (optional).



# MPATH Provider Services Portal

## Single Facility Claim Submission

Provider Services Portal Home Page



Hover the mouse over “Claims” in the myMenu section on the left navigation and select “Facility Claim Submission”

# MPATH Provider Services Portal

## Single Facility Claim Submission 2

Select your provider NPI, all other associated demographic s will be automatically populated.

Enter other optional provider data as needed.

**Billing Provider**

Note : Fields marked with an asterisk \* are required.

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	Montana Medicaid (HMK Plus)
Specialty:*	In Home Supportive Care
Service Location	
Service Address 1:*	1120 CEDAR ST
Service Address 2:	
City:*	MISSOULA
State:*	MT
ZIP:*	59802-3911
Taxonomy Code:*	Z61QR0405X
Team Number:*	TEAM AB
Enrollment Unit:*	1234567
Other Provider(s)	
Attending Provider	
<input type="checkbox"/> There is an attending provider for this claim.	
Operating Provider	
<input type="checkbox"/> There is an operating provider for this claim.	
Other Provider 1	
<input type="checkbox"/> There is an other provider for this claim.	
Other Provider 2	
<input type="checkbox"/> There is an other provider for this claim.	

Save and Continue Save and Exit Cancel

Optional Rendering Provider selection is available when affiliated providers are added.

Select Save and Continue

# MPATH Provider Services Portal

## Single Facility Claim Submission 3

Enter Member ID (Card#/SSN) and click “Search” - Enter Patient Account Number (optional).

**1**

Professional Claim Submission Form

Member Details

Note : Fields marked with an asterisk \* are required.

Enter Member ID:\*

1234567

Search

**2**

Enter Member ID:\*

1234567

Search

Member ID: 1234567

Patient Account Number:

First Name: Test

Middle Name:

Last Name: Member

Date of Birth:

Gender: Male

Mailing Address 1:

Mailing Address 2:

City:

State: MT

ZIP: 59521-0000

Member Demographics are automatically populated when entering a valid Member ID

Select Save and Continue

Save and Continue

Previous

Save and Exit

Cancel

# MPATH Provider Services Portal

## Single Facility Claim Submission 4

Facility Claim Submission Form

Claim Information

**Note :** Fields marked with an asterisk \* are required.

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

Type of Bill: \* Inpatient or Outpatient: \* Statement Period From: \* Statement Period Through: \*

Admission Date:  Select  Admission Hour:  Admission Type: \*  Source of Admission: \*  Discharge Hour:  Member Discharge Status: \*

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

Condition Codes ?

Condition Codes:

Accident State:  Select

Click the ?Help link on any page for more information

Enter required fields: Type of Bill, Inpatient/Outpatient, From/Through Date(s), Admit Type/Source/Status

Other fields may be required based on selections

Condition Codes ?

Condition Codes:

Accident State:  Select

Common Condition Codes are: A1 - EPSDT, A4 - Family Planning, B3 - Pregnancy, AI - Sterilization. Refer to the current applicable coding manual for more information.

Hover over any "?" to see a quick list of common values

# MPATH Provider Services Portal

## Single Facility Claim Submission 5

Hover over any  
“?” to see a  
quick list of  
common values

Occurrence Codes

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

Occurrence Span Codes

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

Value Codes ?

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

Enter optional fields as necessary:  
Occurrence Codes, Occurrence Span  
codes, Value Codes.

Value Codes ?

Value Code: 1	Amount/Days: <input type="text"/>
---------------	-----------------------------------

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

# MPATH Provider Services Portal

## Single Facility Claim Submission 6

Claim Details

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

Enter Revenue Code, Optional HCPCS Code, Optional Modifier, Date(s) of Service, Units, and Charges

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

# MPATH Provider Services Portal

## Single Facility Claim Submission 7

Enter the Revenue Code. The magnifying glass will allow users to search for the specific Revenue Code if unknown.

Enter at least first three (3) characters of a Revenue Code to search code list.

The screenshot illustrates the claim submission process. It shows two instances of a search interface and a results list.

**Search Interface 1:** Shows a Revenue Code field with '012' entered, a magnifying glass icon, and a search result '0120' highlighted with a blue box and a blue arrow pointing to the results list. The search interface also includes fields for HCPCS Code, Modifier, From Date, To Date, Service Units, NDC, and Total Charges (\$150.00).

**Search Interface 2:** Shows a Revenue Code field with '0120' entered, a magnifying glass icon, and a search result '0120' highlighted with a blue box and a blue arrow pointing to the results list. The search interface also includes fields for HCPCS Code, Modifier, From Date, To Date, Service Units, NDC, and Total Charges (\$150.00).

**Search Results:** A list titled 'Search Results' showing a table with 'Code' and 'Description' columns. The results for '0120' are listed, with the first result '0120' highlighted with a blue box and a blue arrow pointing to the search interface. The results are:

Code	Description
0120	Room & Board Semiprivate (Two Beds)-General Classification
0121	Room & Board Semiprivate (Two Beds)-Medical/Surgical/GYN
0122	Room & Board Semiprivate (Two Beds)-Obstetrics (OB)
0123	Room & Board Semiprivate (Two Beds)-Pediatric
0124	Room & Board Semiprivate (Two Beds)-Psychiatric
0125	Room & Board Semiprivate (Two Beds)-Hospice
0126	Room & Board Semiprivate (Two Beds)-Detoxification
0127	Room & Board Semiprivate (Two-Beds)-Oncology
0128	Room & Board-Semiprivate (Two-Beds)-Rehabilitation

**Buttons:** A 'Cancel' button is located in the bottom right corner of the search results window.

# MPATH Provider Services Portal

## Single Facility Claim Submission 8

Optional: Enter the HCPCS Code. The magnifying glass will allow users to search for the specific HCPCS Code if unknown.

Enter at least first three (3) characters of a HCPCS to search code list.

Revenue Code: \* HCPCS Code: Modifier: From Date: \* To Date: \* Service Units: \* NDC: Total Charges: \*

9079 1

0120 90791 3 06/14/2024 06/14/2024 1 NDC \$ 150.00

**Search Results**

Code	Description
90791	PSYCH DIAGNOSTIC EVALUATION
9079122	PSYCH DIAGNOSTIC EVALUATION;Increased Procedural Services
9079123	PSYCH DIAGNOSTIC EVALUATION;Unusual Anesthesia
9079151	PSYCH DIAGNOSTIC EVALUATION;Multiple Procedures
9079152	PSYCH DIAGNOSTIC EVALUATION;Reduced Services
9079153	PSYCH DIAGNOSTIC EVALUATION;Discontinued Procedure
9079158	PSYCH DIAGNOSTIC EVALUATION;Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
9079159	PSYCH DIAGNOSTIC EVALUATION;Distinct Procedural Service

Cancel

# MPATH Provider Services Portal

## Single Facility Claim Submission 9

Enter Primary Diagnosis Code. The magnifying glass will allow users to search for the specific Diagnosis Code if unknown.

Enter at least first three (3) characters of a Diagnosis to search code list.

**1**

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

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



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

**3**

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



**2**

**Search Results**

Code	Description
F20	Schizophrenia
<b>F200</b>	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F208	Other schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified

**Cancel**

# MPATH Provider Services Portal

## Single Facility Claim Submission 10

Enter optional information, then select save and continue

**Other Diagnosis Codes**

*Note : When you add Other Diagnosis Code, you are required to select Present on Admission.*

Other Diagnosis Codes: Present on Admission:

**Add Diagnosis Code**

Admitting Diagnosis Code: Member's Reason for Visit Diagnoses:

*Note : When you add External Cause of Injury Codes, you are required to select Present on Admission.*

External Cause of Injury Codes: Present on Admission:

Principal Procedure Code: Date:

MM/DD/YYYY

**Other Procedure Codes**

Other Procedure Codes: Date:

MM/DD/YYYY    MM/DD/YYYY    MM/DD/YYYY    MM/DD/YYYY    MM/DD/YYYY

Prior Authorization Number: Referral Number: Service Authorization Exception Code:

[Advanced Search](#)

Are you submitting COB at the claim level?  Yes  No

Do you have attachments for this claim?  Yes  No

Notes:

Select Save and Continue

Enter optional information

# MPATH Provider Services Portal

## Single Facility Claim Submission 11

Facility Claim Submission Form [? Help](#)

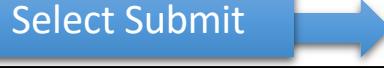
Terms and Agreements

**Note** : Fields marked with an asterisk \* are required.

Provider Name: \*

NPI/API: \*

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

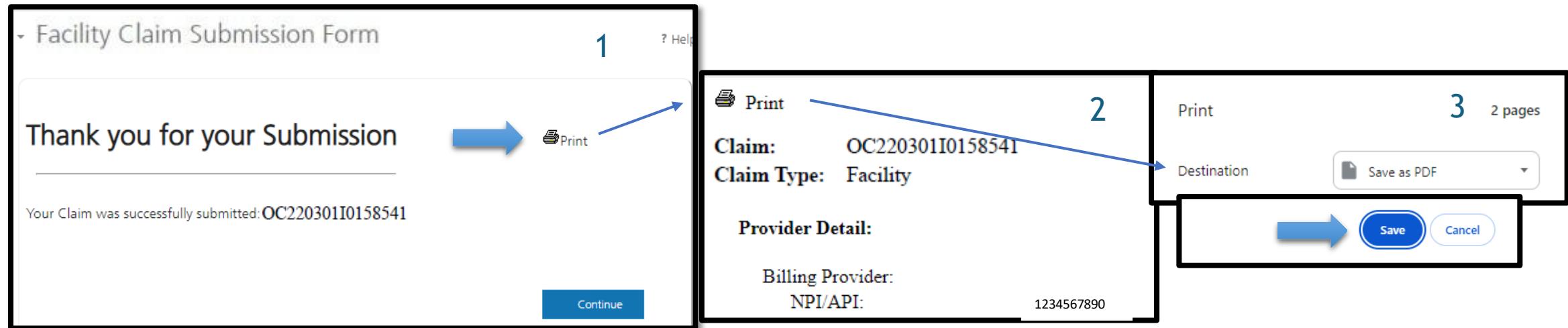
**Select Submit**  **Submit** [Previous](#) [Save and Exit](#) [Cancel](#)

Agree to Terms and Conditions 

# MPATH Provider Services Portal

## Single Facility Claim Submission 12

Print/Save PDF of claim submission (optional).

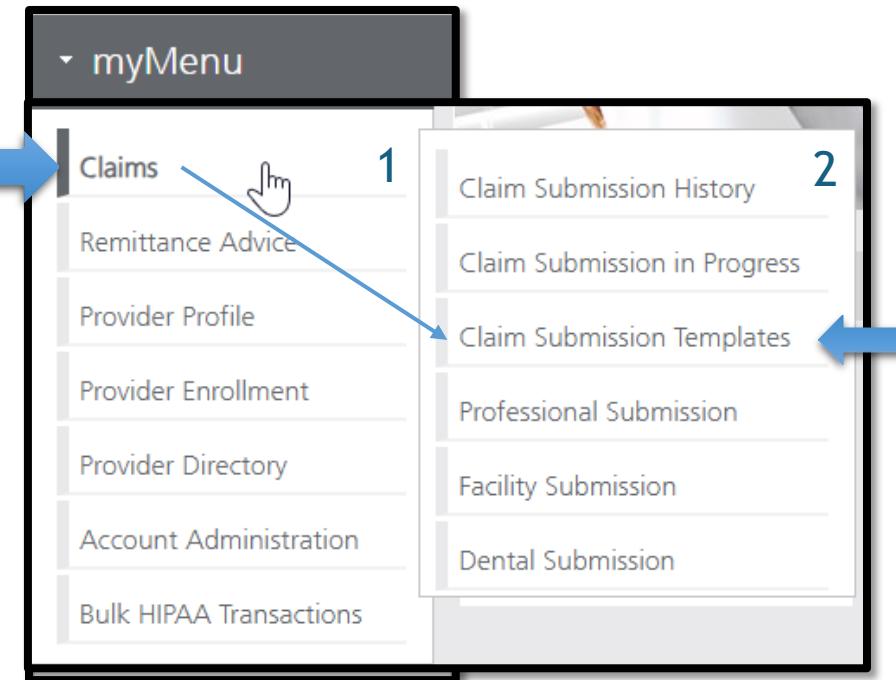


# MPATH Provider Services Portal

## Developing a (Service specific) Facility Claim Template

---

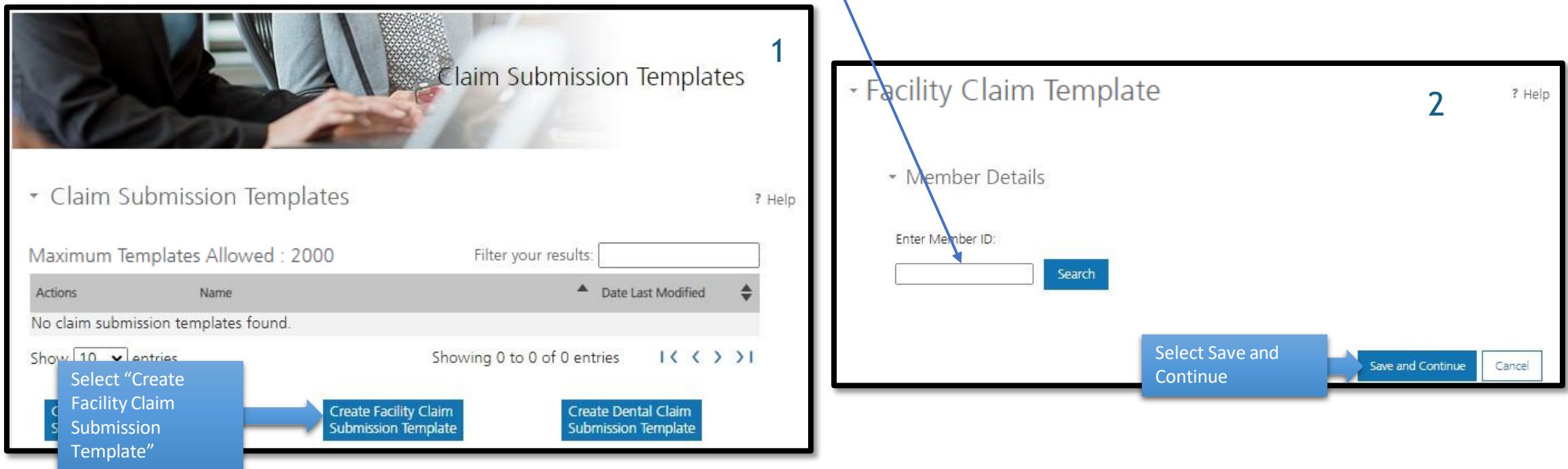
Hover the mouse over “Claims” in the myMenu section on the left navigation and select “Claim Submission Templates”



# MPATH Provider Services Portal

## (Service specific) Facility Claim Template

To create a template, select Create Facility Claim Template. Templates may be Member or Service (without member) specific.



# MPATH Provider Services Portal

## (Service specific) Facility Claim Template 2

Facility Claim Template

? Help

Claim Information

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

Type of Bill:  Inpatient or Outpatient?  Statement Period From:  Statement Period Through:

Admission Date:  Admission Hour:  Admission Type:  Source of Admission:  Discharge Hour:  Member Discharge Status:

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

Condition Codes ?

Condition Codes:

Accident State:

Occurrence Codes

Occurrence Code:  Date:  Occurrence Code:  Date:

Click the “?Help” link on any page for more information

# MPATH Provider Services Portal

## (Service specific) Facility Claim Template 3

Dynamic data (Date of Service, Diagnosis) is entered when submitting the template.

Enter static data for the template

1

2

3

Condition Codes ?

Occurrence Codes

Claim Details

Select Save and Continue

46

# MPATH Provider Services Portal

## (Service specific) Facility Claim Template 4

Save Template, naming service specific template for quick reference

**Screenshot 1: Facility Claim Template Creation**

The screenshot shows the 'Facility Claim Template' creation page. A blue arrow points from the 'Name template' field to the 'Template Name' input field, which contains the value 'Psych Eval Facil'. The 'Select Submit' button is highlighted with a blue arrow.

**Screenshot 2: Claim Submission Templates List**

The screenshot shows the 'Claim Submission Templates' list page. A blue arrow points from the 'Psych Eval Facil' template entry in the list to the 'Psych Eval Facil' entry in the list. The list includes three buttons: 'Create Professional Claim Submission Template', 'Create Facility Claim Submission Template', and 'Create Dental Claim Submission Template'.

# MPATH Provider Services Portal

## (Service specific) Facility Claim Template 5

Hover the mouse over “Claims” in the myMenu section on the left navigation and select “Claim Submission Templates” to access saved Templates

The screenshot illustrates the MPATH Provider Services Portal interface. On the left, a navigation menu titled 'myMenu' is displayed, featuring a list of links: Claims, Remittance Advice, Provider Profile, Provider Enrollment, Provider Directory, Account Administration, and Bulk HIPAA Transactions. A blue arrow points from the text in the blue box to the 'Claims' link. A mouse cursor is shown hovering over the 'Claims' link. A secondary navigation dropdown, labeled '1', appears over the 'Claims' link, containing: Claim Submission History, Claim Submission in Progress, Claim Submission Templates, Professional Submission, Facility Submission, and Dental Submission. A blue arrow points from the 'Claims' link in the main menu to the 'Claim Submission Templates' link in the dropdown. To the right, a main content area is titled 'Claim Submission Templates' and shows a table with one entry: 'Psych Eval Facil'. The table includes columns for 'Actions' (with edit and delete icons) and 'Name'. The table has a header row with 'Actions' and 'Name'. Below the table, there are three blue buttons: 'Create Professional Claim Submission Template', 'Create Facility Claim Submission Template', and 'Create Dental Claim Submission Template'. The page also includes a 'Maximum Templates Allowed : 2000' message, a 'Filter your results:' input field, a date filter for 'Date Last Modified' (set to 03/08/2024), and pagination controls for 'Showing 1 to 1 of 1 templates'.

# MPATH Provider Services Portal

## (Service specific) Facility Claim Template 6

Select your provider NPI. All other associated demographics will be automatically populated.

Enter other optional provider data as needed.

Select Save and Continue

**Billing Provider**

*Note : Fields marked with an asterisk \* are required.*

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	Montana Medicaid (HMK Plus)
Specialty:*	Montana Medicaid (HMK Plus)
Service Location	In Home Supportive Care
Service Address 1:*	1120 CEDAR ST
Service Address 2:	
City:*	MISSOULA
State:*	MT
ZIP:*	59802-3911
Taxonomy Code:*	261QR0405X
Team Number:*	TEAM AB
Enrollment Unit:*	1234567
Other Provider(s)	
Attending Provider	<input type="checkbox"/> There is an attending provider for this claim.
Operating Provider	<input type="checkbox"/> There is an operating provider for this claim.
Other Provider 1	<input type="checkbox"/> There is an other provider for this claim.
Other Provider 2	<input type="checkbox"/> There is an other provider for this claim.

**Save and Continue** **Save and Exit** **Cancel**

# MPATH Provider Services Portal

## (Service specific) Facility Claim Template 7

Enter Member ID and click “Search” Enter Patient Account Number (optional) if necessary.

1

2

Select Search

Select Save and Continue

Professional Claim Submission Form

Member Details

Note : Fields marked with an asterisk \* are required.

Enter Member ID:\*

1234567

Search

Enter Member ID:\*

1234567

Search

Member ID: 1234567

Patient Account Number:

First Name: Test

Middle Name:

Last Name: Member

Date of Birth:

Gender: Male

Mailing Address 1:

Mailing Address 2:

City:

State: MT

ZIP: 59521-0000

Save and Continue

Previous

Save and Exit

Cancel

# MPATH Provider Services Portal

## (Service specific) Facility Claim Template 8

Template retains the static data entered allowing for dynamic data entry.

Hover over any  
"?" to see a  
quick list of  
common  
values

1

Type of Bill: Inpatient or Outpatient? Statement Period From: Statement Period Through:  
0120 Inpatient MM/DD/YYYY MM/DD/YYYY

Admission Date: Admission Hour: Admission Type: Source of Admission: Discharge Hour: Member Discharge Status:  
MM/DD/YYYY Select 1 1 Select 02

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

Condition Codes ?

Condition Codes:

Accident State:

Occurrence Codes

Occurrence Code: Date: Occurrence Code: Date:  
 MM/DD/YYYY  MM/DD/YYYY  
 MM/DD/YYYY  MM/DD/YYYY  
 MM/DD/YYYY  MM/DD/YYYY  
 MM/DD/YYYY  MM/DD/YYYY

2

**Claim Details**

**Note:** Use a comma ", " if multiple values are needed in Modifier field.

Revenue Code:	HCPCS Code:	Modifier:	From Date:	To Date:	Service Units:	NDC:	Total Charges:
0120 <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	1 <input type="text"/>	NDC <input type="text"/>	\$ 150.00 <input type="button" value="Delete"/>
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	<input type="text"/>	NDC <input type="text"/>	\$ <input type="text"/> <input type="button" value="Delete"/>

**Claim Details**

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

Revenue Code:*	HCPCS Code:	Modifier:	From Date:	To Date:	Service Units:*	NDC:	Total Charges:*
0120 <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	06/14/2024 <input type="text"/>	06/14/2024 <input type="text"/>	1 <input type="text"/>	NDC <input type="text"/>	\$ 150.00 <input type="button" value="Delete"/>
Total Charges: <input type="text"/> <input type="button" value="Add"/>							

Select Save  
and  
Continue

4

# MPATH Provider Services Portal

## (Service specific) Facility Claim Template 9

Facility Claim Submission Form [? Help](#)

Terms and Agreements

**Note :** Fields marked with an asterisk \* are required.

Provider Name: \*

NPI/API: \*

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

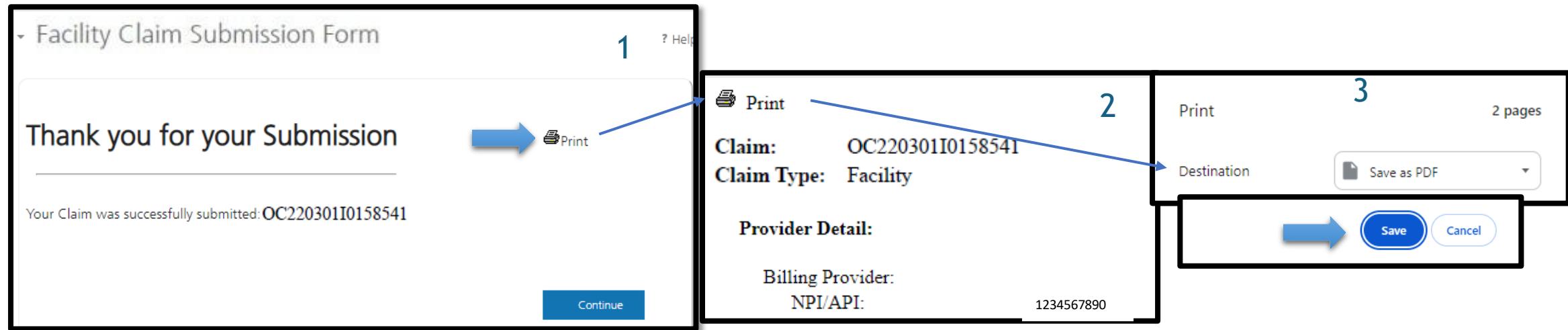
**Select Submit**  **Submit** **Previous** **Save and Exit** **Cancel**

Agree to Terms and Conditions 

# MPATH Provider Services Portal

## (Service specific) Facility Claim Template 10

Print/Save PDF of claim submission (optional).



# MPATH Provider Services Portal

## Claim status

Provider Services Portal Home Page

Enter Member ID (Card#/SSN) and click "Go"

1

2

3

Member search

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

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

Member ID:  \*

Service Date:  \*

Go

myMenu

Claims  
Remittance Advice  
Provider Profile  
Provider Enrollment  
Provider Directory  
Account Administration  
Bulk HIPAA Transactions

Provider Resources Forms FAQs

Hello, AaronProd MPATH

Last login: 5/14/2024

Member search

Member found!

You are currently viewing:  
Test Member **1234567**

Clear Search

Claims Inquiry  
 Eligibility

Search

Select "Claims Inquiry" and click "Search"

# MPATH Provider Services Portal

## Claim status 2

Select/Enter Search criteria as necessary

Member search ?

Claim search ?

NPI/API: 1234567890

I want to view:

Claims for

Test Member (06/14/2000)

Time period

From Date: 06/14/2024

To Date: 06/14/2024

Claim number

Patient account number

Search

myMenu

Hi AaronProd MPATH

Claims Detail

Claim search results

Member: Test Member 1234567890

You are viewing: Claims for NPI/API 1234567890 and time period from 06/14/2024 to 06/14/2024.

Claim activity

Download Print ? Help

Filter your results:

ICN	OPTUM CLAIM NUMBER	SERVICE DATE	MEMBER NAME	PROVIDER	STATUS	BILLED AMOUNT	PLAN PAYS
22419900255	OC2241	06/14/2024	Test Member	Test Provider	F1	\$100.00	\$50.00

Show 10 entries

Showing 1 to 1 of 1 Claims

1 < < > > 1

# MPATH Provider Services Portal

## Claim status 3

Select  
ICN to  
view  
detail

1

Claim activity

Download Print ? Help

Filter your results:

ICN	OPTUM CLAIM NUMBER	SERVICE DATE	MEMBER NAME	PROVIDER	STATUS	BILLED AMOUNT	PLAN PAYS
22419900255	OC2241	06/14/2024	Test Member	Test Provider	F1	\$100.00	\$50.00

2

Claim activity

Download Print ? Help

ICN: 22419900255008999 OC22410158541 [Return to search](#)

Member: Test Member	Total amount billed:
Date of Service: 6/14/24	Total amount paid:
Patient Account	\$100.00
Member ID: 1234567	\$50.00
Date Processed: 6/14/24	
Claim status: F1:Finalized/Payment	
Payment details	
Payment number:	00000942396
Payment date:	6/14/23
Payment amount:	\$50.00

Line 1

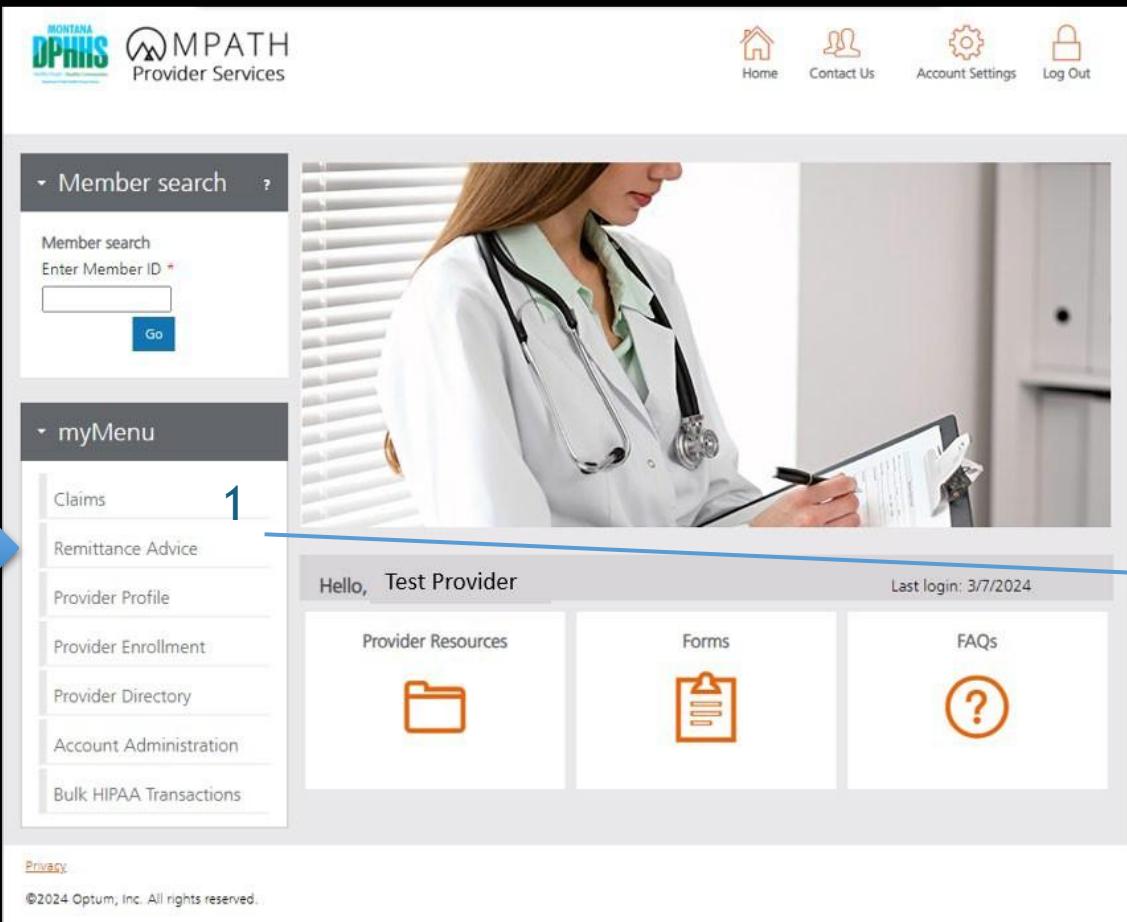
Provider name:	Test Provider	Cost for this service	Amount billed:	\$100.00
Provider Tax ID:			Amount paid by plan:	\$50.00
Date of service:	6/14/24			
Procedure code:	90791			

[Return to search](#)

# MPATH Provider Services Portal

## Remittance Advice

Provider Services Portal Home Page



Select “Remittance Advice” in the myMenu section on the left navigation.

1

2

myMenu

Claims

Remittance Advice

Provider Profile

Provider Enrollment

Provider Directory

Account Administration

Bulk HIPAA Transactions

Provider Resources

Forms

FAQs

Hello, Test Provider

Last login: 3/7/2024

Privacy

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# MPATH Provider Services Portal

## Remittance Advice Retrieval

Select NPI and PID/EU (if necessary). Select Remit Date and select from/to date. Click Search.

Click “View” under the PDF header.

Member search

Hi Test User

Remittance advice search

Note: Fields marked with \* are required.

NPI/API: 1234567890

PID/EU: 1234567

I want to search by:

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

From Date: \* 11/02/2002

To Date: \* 11/03/2022

Search

1

2

Remittance Advice

Remittance advice search results

Provider NPI/API: 1234567890  
You are viewing: Remittance Advice for NPI/API 1234567890 and time period from 11/02/2002 to 11/03/2022

Remittance advice activity

REMITTANCE ADV NBR	DATE ISSUED	PID/EU	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	PDF	835 EDI
1	03/07/2022	1234567	1	Check	\$29633.82	<a href="#">View</a>	<a href="#">Download</a>
1	03/14/2022	1234567	1	Check	\$20182.56	<a href="#">View</a>	<a href="#">Download</a>
2	03/21/2022	1234567	1	Check	\$398.30	<a href="#">View</a>	<a href="#">Download</a>
2	03/14/2022	1234567	1	Check	\$398.30	<a href="#">View</a>	<a href="#">Download</a>

Show 10 entries

Showing 1 to 4 of 4 forms

# MPATH Provider Services Portal

## Electronic Adjustment (void/replace)

---

Electronic Adjustment (void or void/replace) either voids a claim entirely or reverses and replaces a PAID claim.

The Adjustment is “as the claim should be” not only what is changed. What is sent is the entire new claim. Always include previous required information (Prior Authorization number, Paperwork Attachments, COB) to avoid denial.

The following claims cannot be adjusted electronically:

- Claims over 12 months from paid date (use paper form)
- Claims that have already been adjusted (use the ICN of the adjusted claim instead)
- Claims that are over lines (Split or Overflow claims)
- Financial adjustments (aka gross adjustment)
- Denied or in-process (suspended) claims

# MPATH Provider Services Portal

## Electronic Adjustment (void/replace) 2

---

Only PAID (even paid at \$0) can be adjusted. Only the 17-digit MMIS ICN from the remittance advice is valid for Adjustments – any other value (Optum claim#, Member ID, Account Number) will electronically reject as “not found.”

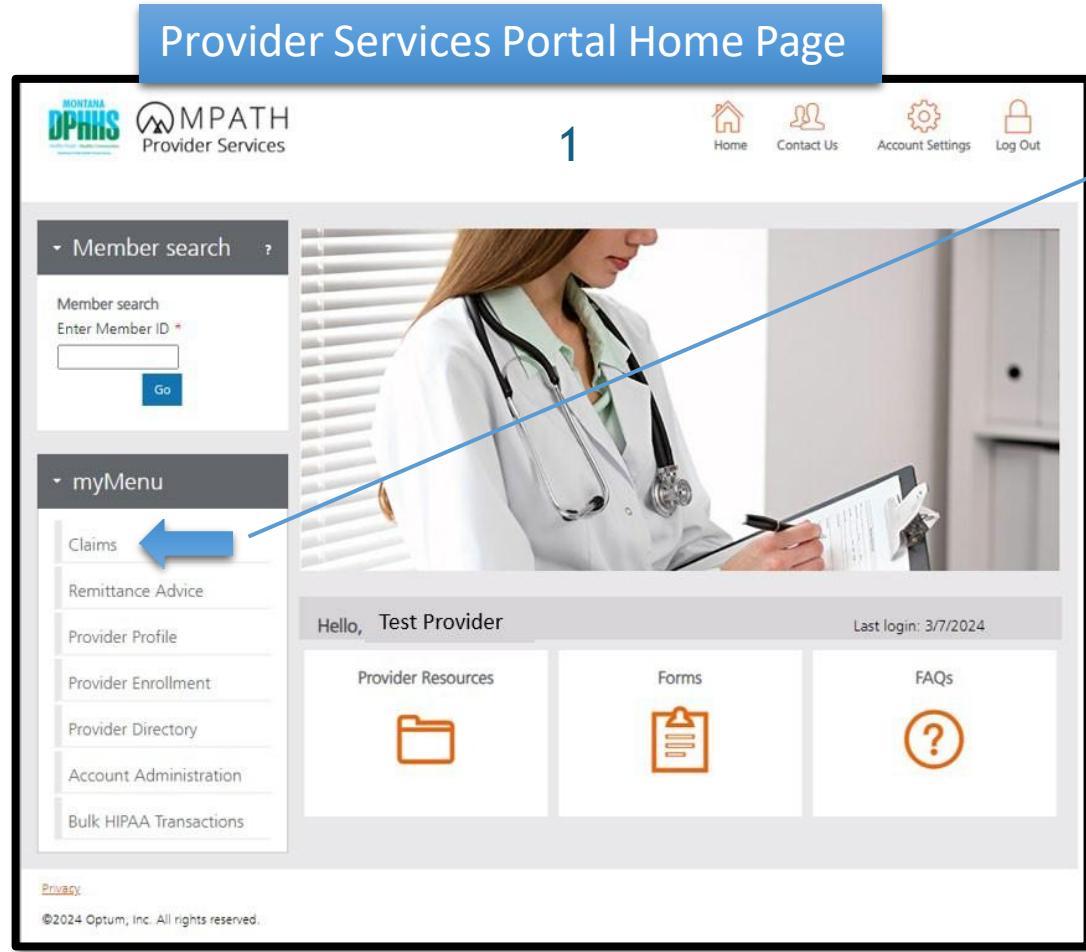


PAID CLAIMS - MISCELLANEOUS CLAIM							
1234567	Test Member	05222024	05222024	1.000	99394	347.00	149.27
ICN 22419900255008999	PATIENT NUMBER=1335317450						
1234567	Test Provider						

# MPATH Provider Services Portal Professional Claim

## Electronic Adjustment (void/replace) 3

Provider Services Portal Home Page



1

Member search

Enter Member ID #  Go

myMenu

- Claims
- Remittance Advice
- Provider Profile
- Provider Enrollment
- Provider Directory
- Account Administration
- Bulk HIPAA Transactions

Provider Resources

Forms

FAQs

Hello, Test Provider

Last login: 3/7/2024

Home Contact Us Account Settings Log Out

myMenu

2

Claims

Remittance Advice

Provider Profile

Provider Enrollment

Provider Directory

Account Administration

Bulk HIPAA Transactions

Claim Submission History

Claim Submission in Progress

Claim Submission Templates

Professional Submission

Facility Submission

Dental Submission

Claim Submission History

Claim Submission in Progress

Claim Submission Templates

Professional Submission

Facility Submission

Dental Submission

Hover the mouse over "Claims" in the myMenu section on the left navigation and select "Professional Claim Submission"

# MPATH Provider Services Portal Professional Claim

## Electronic Adjustment (void/replace) 4

Select your provider NPI, all other associated demographics will be automatically populated.

Enter other optional provider data as needed.

▀ Billing Provider

Note : Fields marked with an asterisk \* are required.

NPI/API:*	1234567890	←
Provider Name:*	Test Provider	
Program/Waiver:*	Montana Medicaid (HMK Plus)	
Specialty:*	Community/Behavioral Health/SDMI HCB	▼
Service Location Address 1:*	1120 CEDAR ST	
Service Location Address 2:		
City:*	MISSOULA	
State:*	MT	
ZIP:*	59802-3911	
Taxonomy Code: *	251500000X	
Enrollment Unit:*	1234567	

Referring Provider

There is a referring provider for this claim.

Ordering Provider

There is a ordering provider for this claim.

Select Save and Continue →

Save and Continue   Save and Exit   Cancel

# MPATH Provider Services Portal Professional Claim

## Electronic Adjustment (void/replace) 5

Enter Member ID (Card#/SSN) and click “Search” - Enter Patient Account Number (optional) as desired.

1

2

Select Search

Select Save and Continue

Member demographics are automatically populated when entering a valid Member ID

Enter Member ID:\*

1234567

Search

Member ID: 1234567

Patient Account Number:

First Name: Test

Middle Name:

Last Name: Member

Date of Birth:

Gender: Male

Mailing Address 1:

Mailing Address 2:

City:

State: MT

ZIP: 59521-0000

Save and Continue

Previous

Save and Exit

Cancel

# MPATH Provider Services Portal Professional Claim

## Electronic Adjustment (void/replace) 6

Professional Claim Submission Form

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

Claim Details

**Note :**  or  indicates all required fields for COB or NDC 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
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY <input type="text"/>	MM/DD/YYYY <input type="text"/>	Select <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	COB <input type="checkbox"/>	NDC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type

# MPATH Provider Services Portal Professional Claim

## Electronic Adjustment (void/replace) 7

Enter the Diagnosis Code. The magnifying glass will allow users to search for the specific Diagnosis Code if unknown.

Enter at least first three (3) characters of a Diagnosis to search code list.

1

2

3

Cancel

Code	Description
F20	Schizophrenia
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F208	Other schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified

# MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace) 8

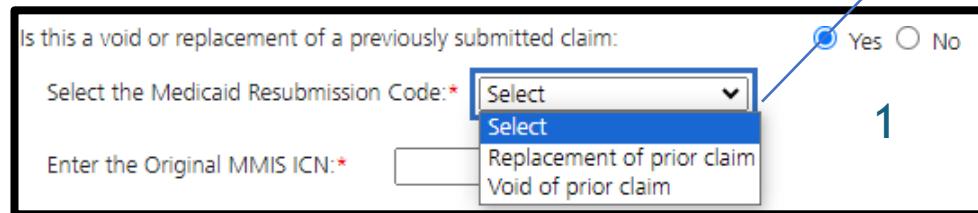
Enter Date of Service, select [Place of Service](#), CPT/HCPCS (Enter at least first three (3) characters of a CPT/HCPCS to search code list), Modifier (optional), Diagnosis Pointer(s), Charges, and Unit(s).

# MPATH Provider Services Portal Professional Claim

## Electronic Adjustment (void/replace) 9

Click Yes on “Is this a void or replacement of a previously submitted claim?” radio button

Click Yes on “Is this a void or replacement of a previously submitted claim?” radio button. Select submission code . Enter the 17-digit MMIS ICN

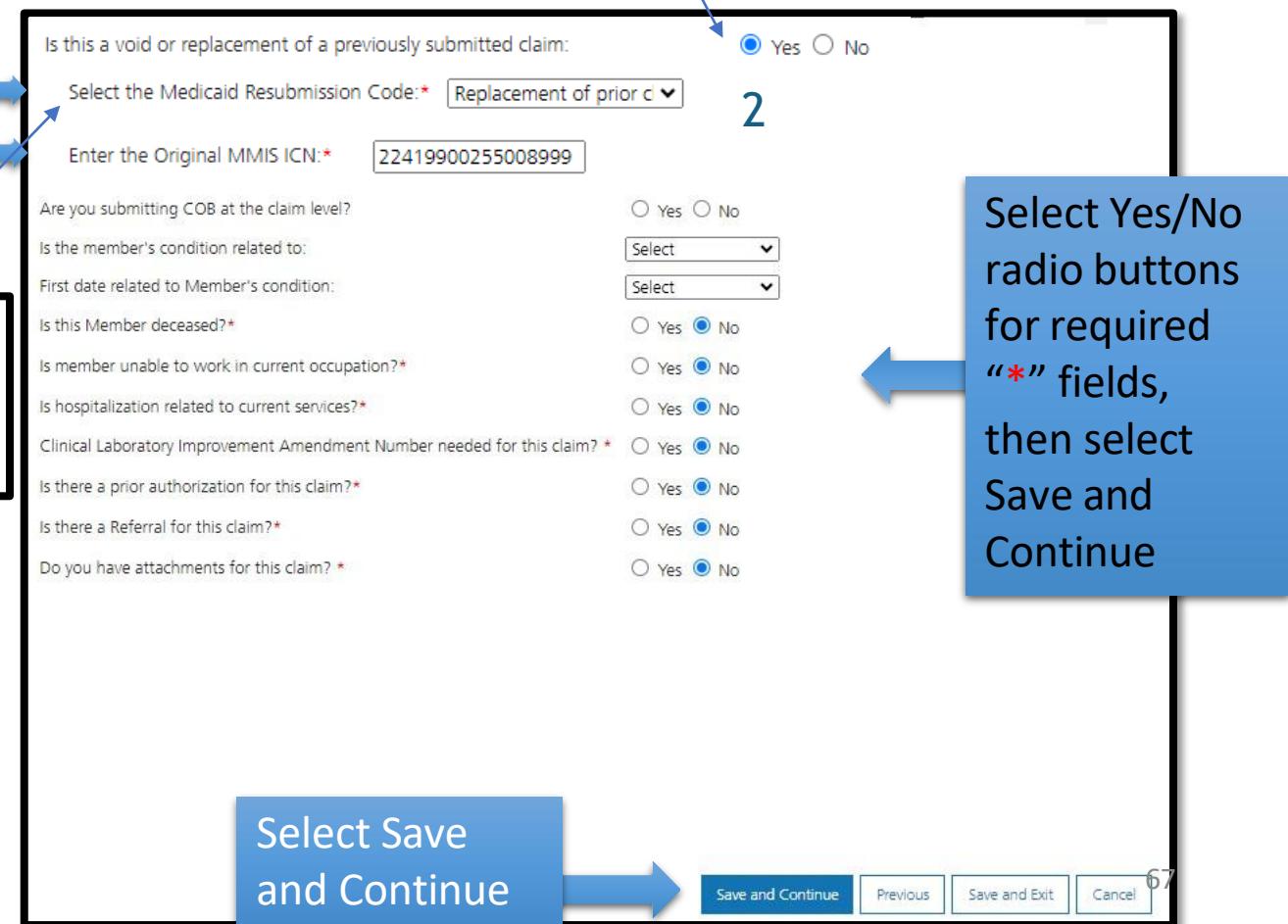


Is this a void or replacement of a previously submitted claim:

Select the Medicaid Resubmission Code:\*

Enter the Original MMIS ICN:\*

1



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

Select the Medicaid Resubmission Code:\*

Enter the Original MMIS ICN:\*

2

Are you submitting COB at the claim level?

Is the member's condition related to:

First date related to Member's condition:

Is this Member deceased?\*

Is member unable to work in current occupation?\*

Is hospitalization related to current services?\*

Clinical Laboratory Improvement Amendment Number needed for this claim?\*

Is there a prior authorization for this claim?\*

Is there a Referral for this claim?\*

Do you have attachments for this claim? \*

Select Yes/No radio buttons for required “\*” fields, then select Save and Continue

Select Save and Continue

Save and Continue Previous Save and Exit Cancel

67

# MPATH Provider Services Portal Professional Claim

## Electronic Adjustment (void/replace) 10

Agree to Terms and Conditions



Professional Claim Submission Form ? Help

Terms and Agreements

**Note :** Fields marked with an asterisk \* are required.

Provider Name: \*

NPI/API: \*

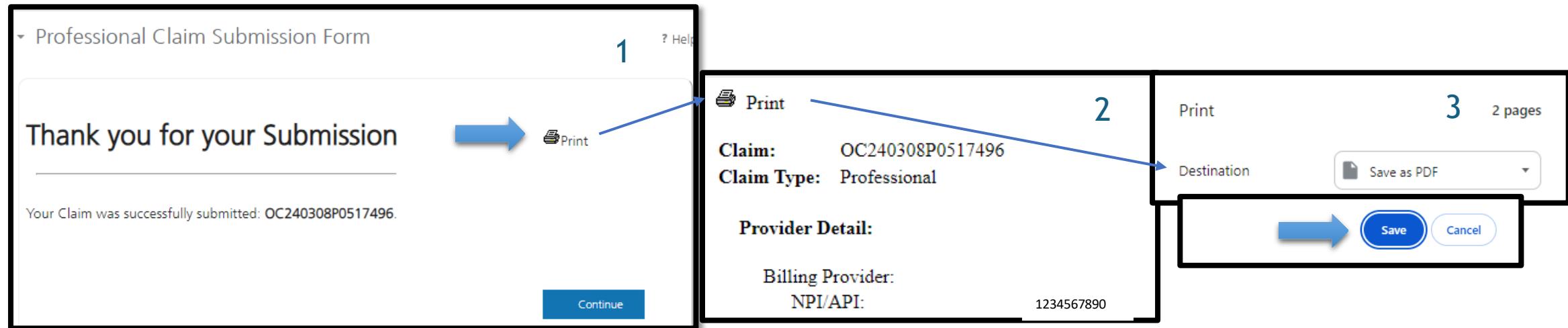
\* I certify I have read the [Terms and Conditions](#)  that apply to this bill and are made a part thereof.

**Select Submit**  Submit Previous Save and Exit Cancel

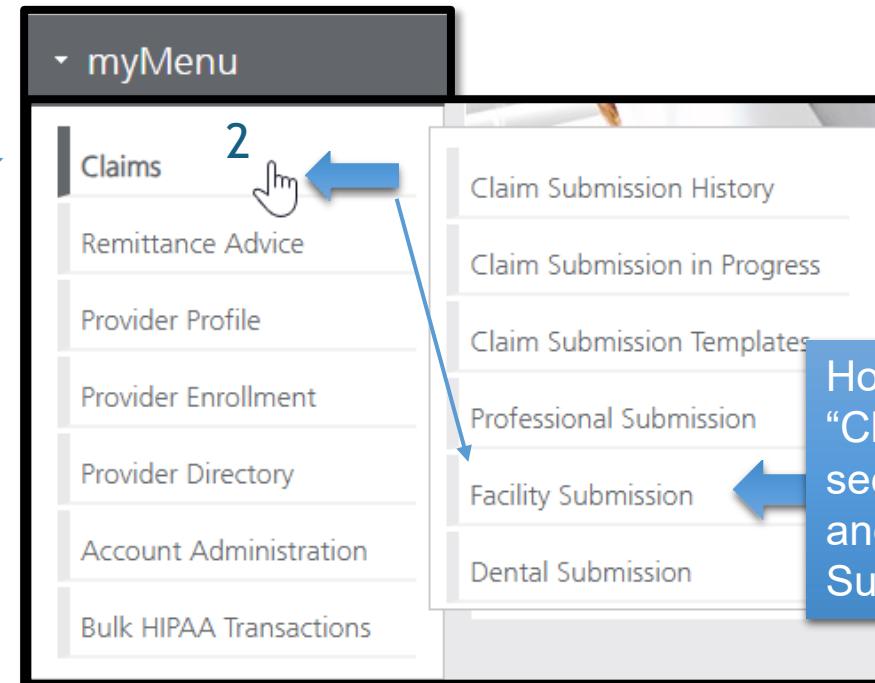
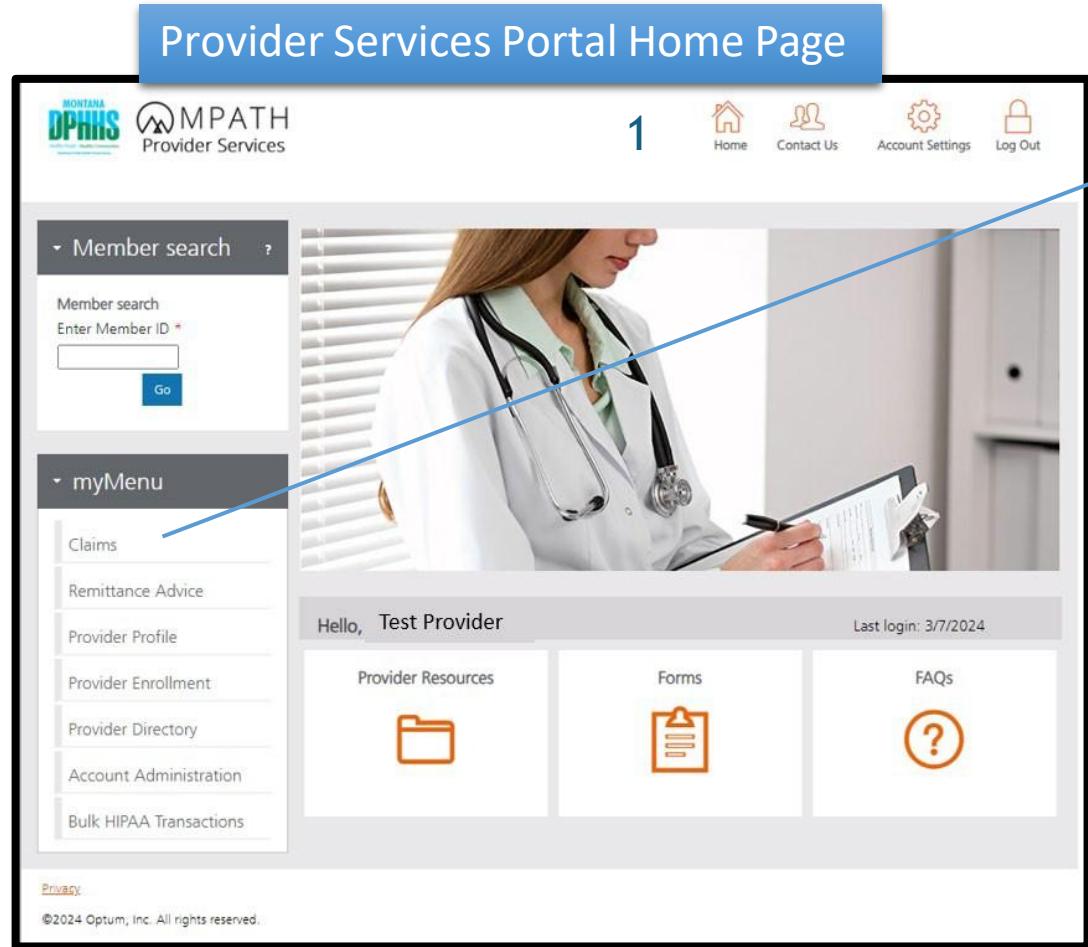
# MPATH Provider Services Portal Professional Claim

## Electronic Adjustment (void/replace) 11

Print/Save PDF of claim submission (optional).



# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace) 12



Hover the mouse over “Claims” in the myMenu section on the left navigation and select “Facility Claim Submission”

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace) 13

Select your provider NPI, all other associated demographic s will be automatically populated.

Enter other optional provider data as needed.

Select Save and Continue

**Billing Provider**

*Note : Fields marked with an asterisk \* are required.*

NPI/API:*	1234567890
Provider Name:*	Test Provider
Program/Waiver:*	Montana Medicaid (HMK Plus)
Specialty:*	Clinic/Center; Rehabilitation, Substance L

**Service Location**

Service Address 1:*	1120 CEDAR ST
Service Address 2:	
City:*	MISSOULA
State:*	MT
ZIP:*	59802-3911
Taxonomy Code: *	Z61QR0405X
Enrollment Unit:*	1234567

**Other Provider(s)**

**Attending Provider**

There is an attending provider for this claim.

**Operating Provider**

There is an operating provider for this claim.

**Other Provider 1**

There is an other provider for this claim.

**Other Provider 2**

There is an other provider for this claim.

**Buttons**

Save and Continue   Save and Exit   Cancel

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace) 14

Enter Member ID (Card#/SSN) and click “Search” - Enter Patient Account Number (optional) as desired.

The image consists of two side-by-side screenshots of a web application. The left screenshot, labeled '1', shows a 'Professional Claim Submission Form' with a 'Member Details' section. It includes a note: 'Note : Fields marked with an asterisk \* are required.' Below this is a search field with '1234567' and a 'Search' button. A blue arrow points from this search field to the corresponding field in the right screenshot. The right screenshot, labeled '2', shows a search results page for 'Member ID: 1234567'. It displays the following demographic information:

Field	Value
Member ID	1234567
Patient Account Number	(empty)
First Name	Test
Middle Name	
Last Name	Member
Date of Birth	
Gender	Male
Mailing Address 1	
Mailing Address 2	
City	
State	MT
ZIP	59521-0000

A blue callout box on the right side of the right screenshot states: 'Member Demographics will be automatically populated when entering a valid Member ID'. At the bottom of the right screenshot, a blue arrow points to a 'Select Save and Continue' button, which is part of a row of buttons including 'Save and Continue', 'Previous', 'Save and Exit', and 'Cancel'.

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace) 15

Change the last digit of the originally submitted Type of Bill to 8 for Void and enter the 17-digit MMIS ICN.

Change the last digit of the originally submitted Type of Bill to 7 for Void /Replace and enter the 17-digit MMIS ICN.

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

Type of Bill:  Inpatient or Outpatient:  Statement Period From:  Statement Period Through:

Admission Date:  Admission Hour:  Admission Type:  Source of Admission:  Discharge Hour:  Member Discharge Status:

Original MMIS ICN:

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

Enter all other claim data as required.

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace) 16

Facility Claim Submission Form

Claim Information

**Note :** Fields marked with an asterisk \* are required.

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

Type of Bill: \* Inpatient or Outpatient: \* Statement Period From: \* Statement Period Through: \*

0127 Inpatient MM/DD/YYYY MM/DD/YYYY

Admission Date: \* Admission Hour: \* Admission Type: \* Source of Admission: \* Discharge Hour: \* Member Discharge Status: \*

MM/DD/YYYY Select Select

Original MMIS ICN: \*

22419900255008999

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

Condition Codes:

Accident State:  Select

? Help

Click the ?Help link on any page for more information

Enter required fields: Type of Bill, Inpatient/Outpatient, From/Through Date(s), Admit Type/Source/Status

Other fields may be required based on selections

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace) 17

Occurrence Codes

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

Occurrence Span Codes

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

Value Codes ?

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

Hover over any  
“?” to see a  
quick list of  
common values

Enter optional fields as necessary:  
Occurrence Codes, Occurrence Span  
codes, Value Codes.

Value Codes ?

Value Code: 1	Amount/Days: <input type="text"/>
---------------	-----------------------------------

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

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace) 18

Enter Revenue Code, Optional HCPCS Code, Optional Modifier, Date(s) of Service, Units, and Charges

Claim Details

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

Revenue Code:*	HCPCS Code:	Modifier:	From Date:*	To Date:*	Service Units:*	NDC:	Total Charges:*	
<input type="text"/>	<a href="#">NDC</a>	<input type="text"/>						
<input type="text"/>	<a href="#">NDC</a>	<input type="text"/>						
<input type="text"/>	<a href="#">NDC</a>	<input type="text"/>						
<input type="text"/>	<a href="#">NDC</a>	<input type="text"/>						
<input type="text"/>	<a href="#">NDC</a>	<input type="text"/>						
<input type="text"/>	<a href="#">NDC</a>	<input type="text"/>						
<input type="text"/>	<a href="#">NDC</a>	<input type="text"/>						
<input type="text"/>	<a href="#">NDC</a>	<input type="text"/>						
<input type="text"/>	<a href="#">NDC</a>	<input type="text"/>						
<input type="text"/>	<a href="#">NDC</a>	<input type="text"/>						
							Total Charges: <input type="text"/>	<a href="#">Add</a>

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace) 19

Enter the Revenue Code. The magnifying glass will allow users to search for the specific Revenue Code if unknown.

Enter at least first three (3) characters of a Revenue Code to search code list.

Revenue Code: \* HCPCS Code: Modifier: From Date: \* To Date: \* Service Units: \* NDC: Total Charges: \*

012

Revenue Code: \* HCPCS Code: Modifier: From Date: \* To Date: \* Service Units: \* NDC: Total Charges: \*

0120 3 06/14/2024 06/14/2024 1 NDC \$ 150.00

Search Results	
Code	Description
2 0120	Room & Board Semiprivate (Two Beds)-General Classification
0121	Room & Board Semiprivate (Two Beds)-Medical/Surgical/GYN
0122	Room & Board Semiprivate (Two Beds)-Obstetrics (OB)
0123	Room & Board Semiprivate (Two Beds)-Pediatric
0124	Room & Board Semiprivate (Two Beds)-Psychiatric
0125	Room & Board Semiprivate (Two Beds)-Hospice
0126	Room & Board Semiprivate (Two Beds)-Detoxification
0127	Room & Board Semiprivate (Two-Beds)-Oncology
0128	Room & Board-Semiprivate (Two-Beds)-Rehabilitation

Cancel

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace) 20

Enter the optional HCPCS Code. The magnifying glass will allow users to search for the specific HCPCS Code if unknown.

Enter at least first three (3) characters of a HCPCS to search code list.

Revenue Code: \* HCPCS Code: Modifier: From Date: \* To Date: \* Service Units: \* NDC: Total Charges: \*

1 9079 1 06/14/2024 06/14/2024 1 NDC \$ 150.00

2 90791 3 0120 90791 1 06/14/2024 06/14/2024 1 NDC \$ 150.00

Search Results

Code	Description
90791	PSYCH DIAGNOSTIC EVALUATION
9079122	PSYCH DIAGNOSTIC EVALUATION;Increased Procedural Services
9079123	PSYCH DIAGNOSTIC EVALUATION;Unusual Anesthesia
9079151	PSYCH DIAGNOSTIC EVALUATION;Multiple Procedures
9079152	PSYCH DIAGNOSTIC EVALUATION;Reduced Services
9079153	PSYCH DIAGNOSTIC EVALUATION;Discontinued Procedure
9079158	PSYCH DIAGNOSTIC EVALUATION;Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
9079159	PSYCH DIAGNOSTIC EVALUATION;Distinct Procedural Service

Cancel

# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace) 21

Enter the Diagnosis Code. The magnifying glass will allow users to search for the specific Diagnosis Code if unknown.

Enter at least first three (3) characters of a Diagnosis to search code list.

**1**

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

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



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

**3**

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



**2**

**Search Results**

Code	Description
F20	Schizophrenia
<b>F200</b>	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F208	Other schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified



# MPATH Provider Services Portal Facility

## Claim Electronic Adjustment (void/replace) 22

Enter optional information

**Other Diagnosis Codes**

*Note : When you add Other Diagnosis Code, you are required to select Present on Admission.*

Other Diagnosis Codes: Present on Admission:

Admitting Diagnosis Code: Member's Reason for Visit Diagnoses:

*Note : When you add External Cause of Injury Codes, you are required to select Present on Admission.*

External Cause of Injury Codes: Present on Admission:

Principal Procedure Code: Date:

Other Procedure Codes

Other Procedure Codes: Date:

Prior Authorization Number: Referral Number: Service Authorization Exception Code: Select

[Advanced Search](#)

Are you submitting COB at the claim level?  Yes  No

Do you have attachments for this claim?  Yes  No

Notes:

Select Save and Continue

Save and Continue Previous Save and Exit Cancel

Enter optional information

Select Save and Continue

80

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace) 23

Agree to Terms and Conditions →

Facility Claim Submission Form ? Help

▼ Terms and Agreements

**Note :** Fields marked with an asterisk \* are required.

Provider Name: \*

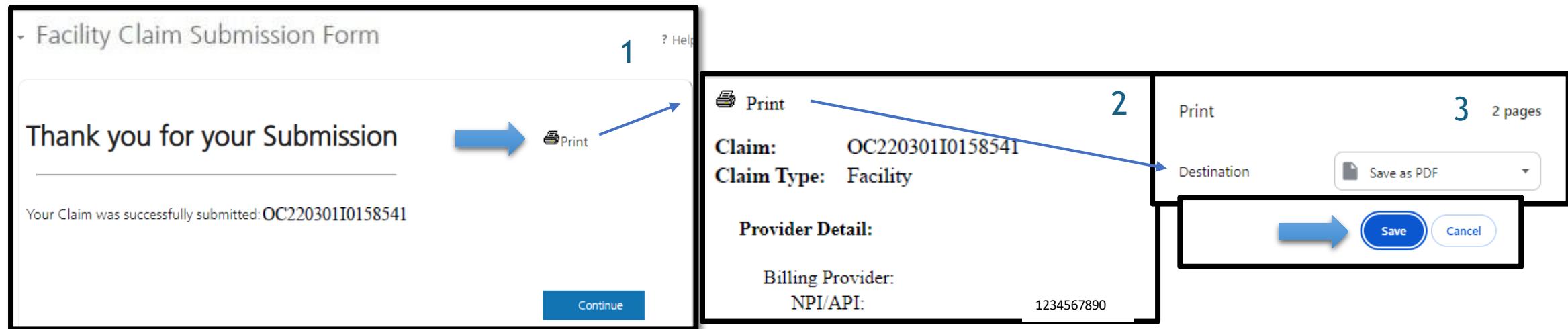
NPI/API: \*

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

**Select Submit** → Submit Previous Save and Exit Cancel

# MPATH Provider Services Portal Facility Claim Electronic Adjustment (void/replace) 24

Print/Save PDF of claim submission (optional).



# Provider Relations Contact Information

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Provider Relations Call Center:

(800) 624-3958

Monday through Friday 8am to 5pm MST

General, Claims, TPL, and EDI questions:

[MTPRHelpdesk@conduent.com](mailto:MTPRHelpdesk@conduent.com)

Enrollment Questions and documents:

[MTEnrollment@conduent.com](mailto:MTEnrollment@conduent.com)

Note: Conduent helpdesks cannot accept secured emails, please do not include HIPAA/PHI/PII.

# Provider Relations Contact Information (cont.)

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MPATH Provider Services Helpdesk

[MTEnrollment@conduent.com](mailto:MTEnrollment@conduent.com)

When emailing the Helpdesk, please provide the following so we can research & submit a help ticket to our Tech Team.

**GovID:**

**Name:**

**Email registered:**

**NPI attempting/registered:**

**Phone number:**

**A screen shot of the error:**