

MPATH Provider Services Billing 101

MPATH Provider Services Portal

Claims Entry

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

Sign In

Optum GovID or Email Address

testprovider@test.com ✓

Password

..... 👁

[Forgot Optum GovID?](#) [Forgot Password?](#)

Continue

or

[Create Optum GovID](#)

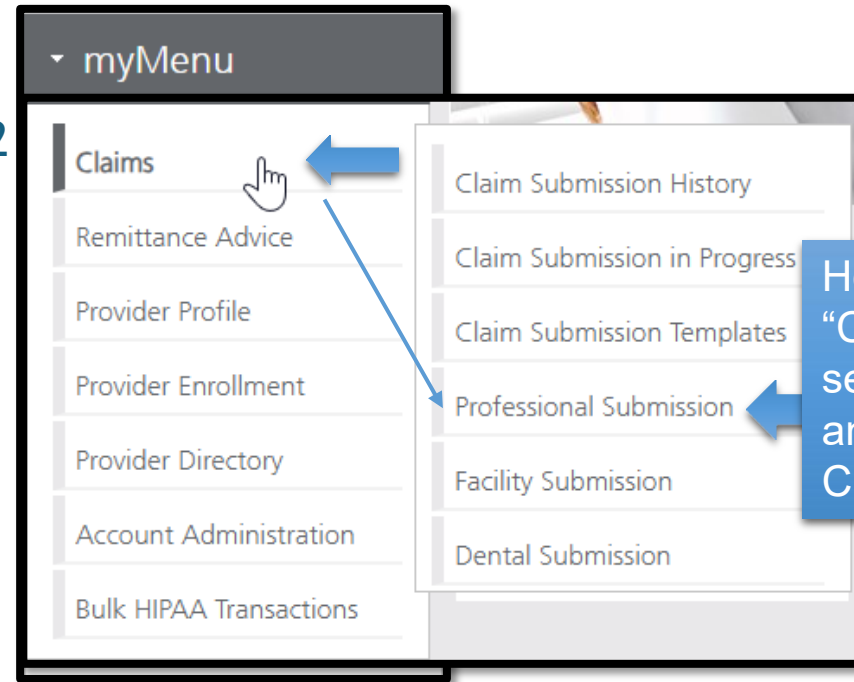
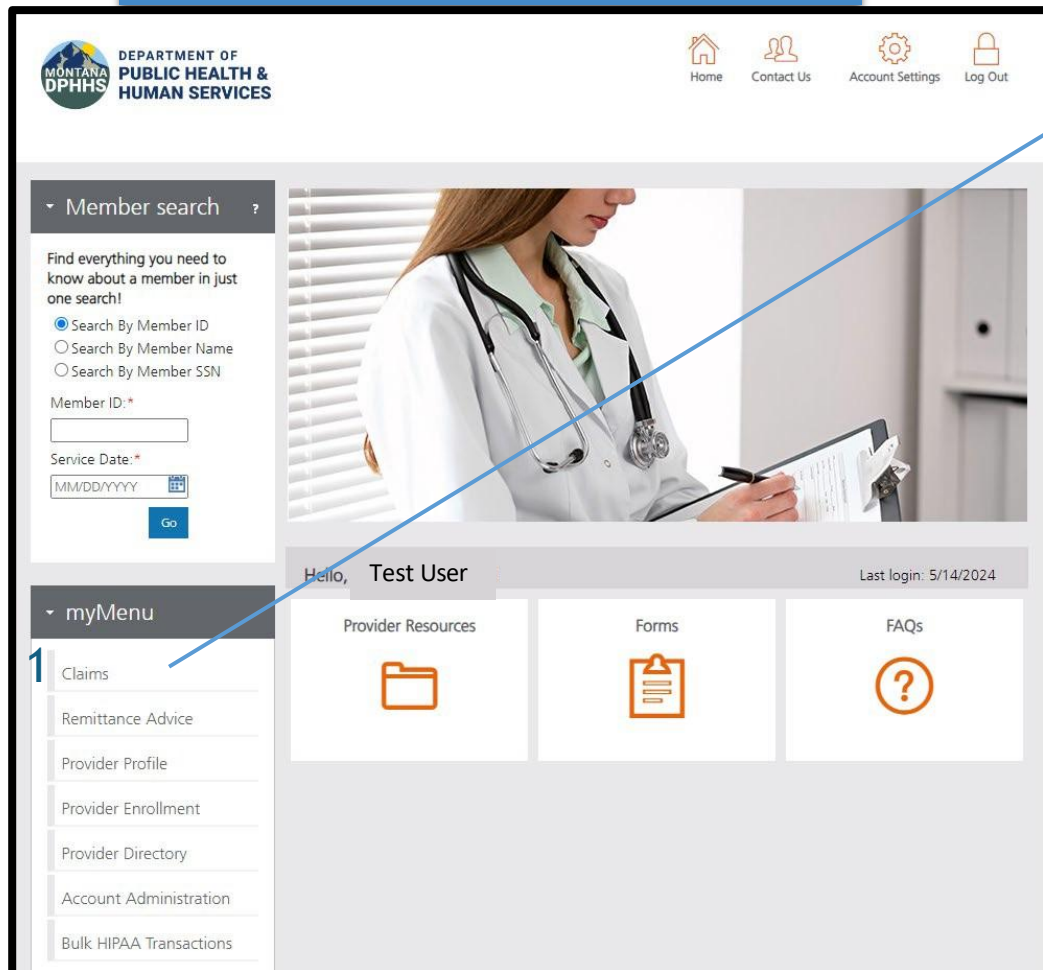
[Manage My Optum GovID](#)

[Help Center](#)

MPATH Provider Services Portal

Single Professional Claim Submission

Provider Services Portal Home Page



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: *

Select NPI/API ▼

- 1234567890
- 1111111111
- 2222222222
- 3333333333

MPATH Provider Services Portal 2

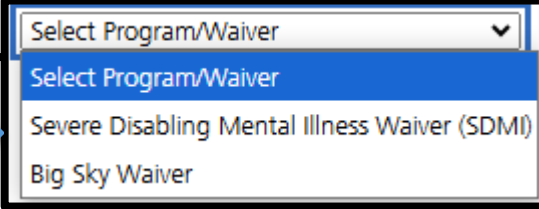
Single Professional Claim Submission – Selecting correct PID/Team# SDMI ALF

▼ Billing Provider

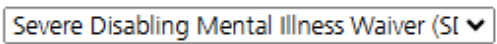
Note : Fields marked with an asterisk * are required.

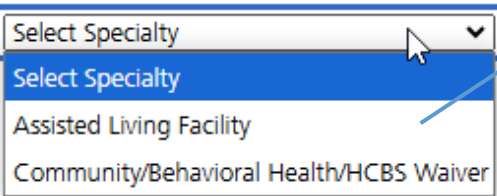
NPI/API: * 1234567890

Provider Name: * Test Provider

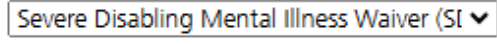
Program/Waiver: * 

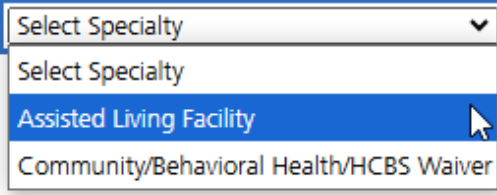
1 →

Program/Waiver: * 2 

Specialty: * 

3 →

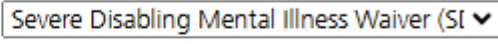
Program/Waiver: * 

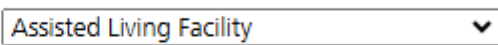
Specialty: * 

4 →

NPI/API: * 1234567890

Provider Name: * Test Provider

Program/Waiver: * 

Specialty: * 

Service Location Address 1: * 123 1st St

Service Location Address 2:

City: * Billings

State: * MT

ZIP: * 59102-3320

Taxonomy Code: * 310400000X

Team Number: * TEAM S1

Enrollment Unit: * 1111111

Taxonomy Team# PID/EU

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: *
 Select Program/Waiver
 Select Program/Waiver
 Severe Disabling Mental Illness Waiver (SDMI)
 Big Sky Waiver

Program/Waiver: * 2
 Severe Disabling Mental Illness Waiver (SI)
 Specialty: *
 Select Specialty
 Select Specialty
 Assisted Living Facility
 Community/Behavioral Health/HCBS Waiver

3
 Program/Waiver: * Severe Disabling Mental Illness Waiver (SI)
 Specialty: *
 Select Specialty
 Select Specialty
 Assisted Living Facility
 Community/Behavioral Health/HCBS Waiver

4
 NPI/API: * 1234567890
 Provider Name: * Test Provider
 Program/Waiver: * Severe Disabling Mental Illness Waiver (SI)
 Specialty: * Community/Behavioral Health/HCBS Wai
 Service Location Address 1: * 123 1st 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

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

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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: * 1234567890

Provider Name: * Test Provider

Program/Waiver: *

1 →

Select Program/Waiver

Select Program/Waiver

Severe Disabling Mental Illness Waiver (SDMI)

Big Sky Waiver

2 →

Program/Waiver: * Big Sky Waiver

Specialty: *

Select Specialty

Select Specialty

Assisted Living Facility

Community/Behavioral Health/HCBS Waiver

3 →

Program/Waiver: * Big Sky Waiver

Specialty: *

Select Specialty

Select Specialty

Assisted Living Facility

Community/Behavioral Health/HCBS Waiver

4 →

NPI/API: * 1234567890

Provider Name: * Test Provider

Program/Waiver: * Big Sky Waiver

Specialty: * Community/Behavioral Health/HCBS Waiver

Service Location Address 1: * 123 1st St

Service Location Address 2:

City: * Billings

State: * MT

ZIP: * 59102-3320

Taxonomy Code: * 251500000X

Team Number: * TEAM B1

Enrollment Unit: * 2222222

Taxonomy Team# PID/EU

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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)

2 →

Program/Waiver: * Developmentally Disabled Waiver (DDP)

Specialty: * Select Specialty

3 →

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 Wai

Service Location Address 1: * 123 1st St

Service Location Address 2:

City: * KALISPELL

State: * MT

ZIP: * 59901-1916

Taxonomy Code: * 251500000X

Team Number: * TEAM 01

Enrollment Unit: * 1111111

Taxonomy Team# PID/EU

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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

Severe Disabling Mental Illness Waiver (SDMI)

Big Sky Waiver

Developmentally Disabled Waiver (DDP)

2 →

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

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 Based Residential Treatment

Service Location Address 1:* 123 1st St

Service Location Address 2:

City:* KALISPELL

State:* MT

ZIP:* 59901-1916

Taxonomy Code:* 320900000X

Team Number:* TEAM 01

Enrollment Unit:* 222222

Taxonomy Team# PID/EU

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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

▼

Severe Disabling Mental Illness Waiver (SDMI)

Big Sky Waiver

Montana Medicaid (HMK Plus)

1 →

Program/Waiver:*
Montana Medicaid (HMK Plus)

▼

Specialty:*
Select Specialty

▼

Select Specialty

In Home Supportive Care

Nursing Care

2 →

Program/Waiver:*
Montana Medicaid (HMK Plus)

▼

Specialty:*
In Home Supportive Care

▼

Select Specialty

In Home Supportive Care

Nursing Care

3 →

NPI/API:*
1234567890

Provider Name:*
Test Provider

Program/Waiver:*
Montana Medicaid (HMK Plus)

▼

Specialty:*
In Home Supportive Care

▼

Select Address

Service Location Address 1:*
123 1st St

Service Location Address 2:
APT A

City:*
Billings

State:*
MT

ZIP:*
59102-3200

Taxonomy Code: *
253Z00000X

Team Number: *
TEAM AB

Enrollment Unit: *
1234567

4 →

Taxonomy Team# PID/EU

→

MPATH Provider Services Portal

Single Professional Claim Submission 1

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 Search

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

7 8 9 10 11 12

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 |
|------------|------------|--------|-----------------|----------|--------------------|----------|----------------|-----|-----|-------|-------------------|-----------------|
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |

Total Charges: \$ Add

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

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

Enter at least one Diagnosis Code

Enter required fields: Service Dates, Place of Service Code, Diagnosis Pointer(s), Charge, and Units.

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.

Diagnosis Codes 1

Diagnosis Codes (ICD 10):

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

Diagnosis Codes 3

Diagnosis Codes (ICD 10):

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

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.

| 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"/> |

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 | 90791 | | 1 | \$ 150.00 | 1.00 | 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 Add

| 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

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

Select Yes/No radio buttons for required "*" fields

Select Save and Continue

MPATH Provider Services Portal

Single Professional Claim Submission 6



Professional Claim Submission Form Help

Terms and Agreements

Note : Fields marked with an asterisk * are required.

Provider Name:*

NP/ABI:*

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

Select Submit →

Agree to Terms and Conditions →

MPATH Provider Services Portal

Single Professional Claim Submission 7

Print/Save PDF of claim submission (optional).

1

Professional Claim Submission Form

Thank you for your Submission

Your Claim was successfully submitted: OC240308P0517496.

Continue

Print

2

Print

Claim: OC240308P0517496

Claim Type: Professional

Provider Detail:

Billing Provider: NPI/API: 1234567890

3

Print

2 pages

Destination

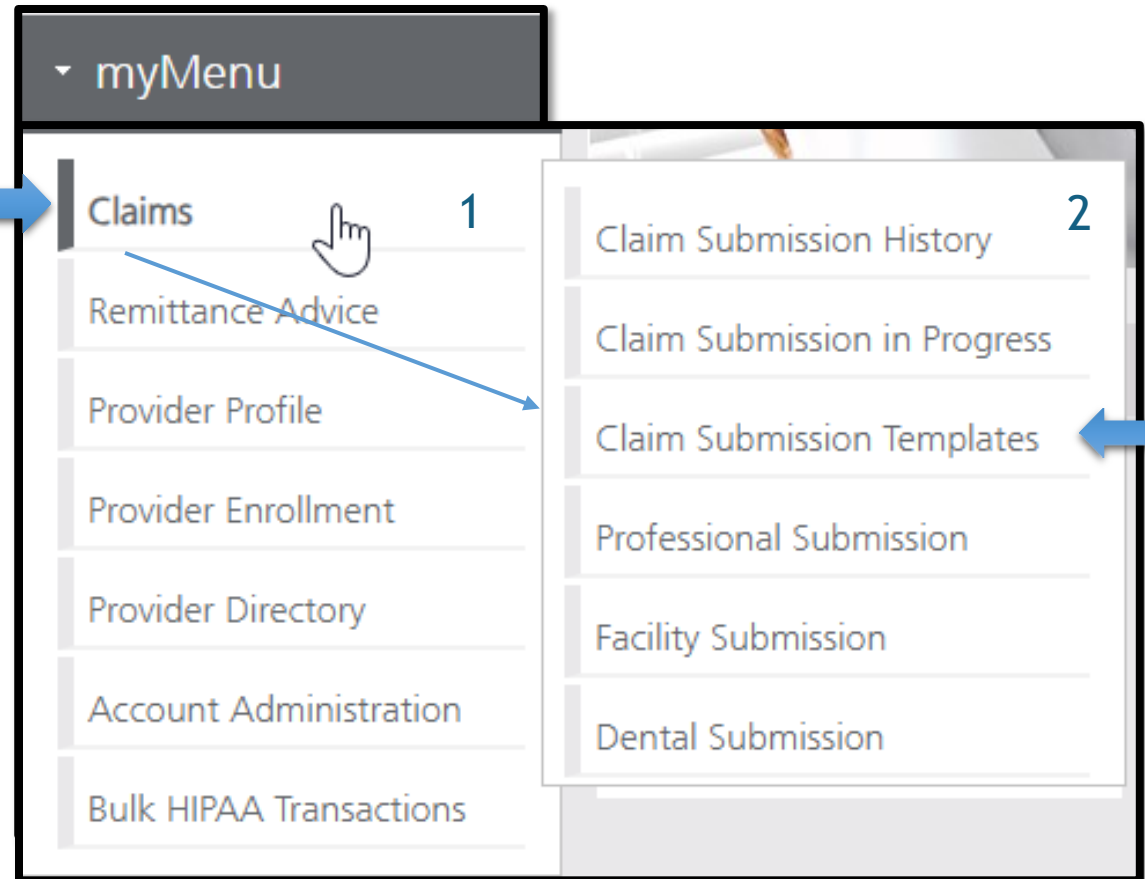
Save as PDF

Save Cancel

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 ? Help

Maximum Templates Allowed : 2000

Filter your results:

| Actions | Name | Date Last Modified |
|--------------------------------------|------|--------------------|
| No claim submission templates found. | | |

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

Create Professional Claim Submission Template Create Facility Claim Submission Template Create Dental Claim Submission Template

Professional Claim Template ² ? Help

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

7

8



9

10

11

12

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 |
|---|---|-------------------------------------|-------------------------------|-------------------------------|-------------------------------|---------------------------------|-------------------------------|----------------------------------|----------------------------------|-------------------------------|-------------------------------|-------------------------------|
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="\$"/> | <input type="text" value=""/> | <input type="text" value="COB"/> | <input type="text" value="NDC"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="\$"/> | <input type="text" value=""/> | <input type="text" value="COB"/> | <input type="text" value="NDC"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="\$"/> | <input type="text" value=""/> | <input type="text" value="COB"/> | <input type="text" value="NDC"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="\$"/> | <input type="text" value=""/> | <input type="text" value="COB"/> | <input type="text" value="NDC"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="\$"/> | <input type="text" value=""/> | <input type="text" value="COB"/> | <input type="text" value="NDC"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="\$"/> | <input type="text" value=""/> | <input type="text" value="COB"/> | <input type="text" value="NDC"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="\$"/> | <input type="text" value=""/> | <input type="text" value="COB"/> | <input type="text" value="NDC"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="\$"/> | <input type="text" value=""/> | <input type="text" value="COB"/> | <input type="text" value="NDC"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="\$"/> | <input type="text" value=""/> | <input type="text" value="COB"/> | <input type="text" value="NDC"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="\$"/> | <input type="text" value=""/> | <input type="text" value="COB"/> | <input type="text" value="NDC"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |

Total Charges:

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

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

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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.

Enter static data for the template

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 2 3 4 5 6

7 8 9 10 11 12

Claim Details

| From Date | To Date | POS | CPT/ HCPCS Code | Modifier | Diagnosis Pointer | Charges | Days or Units | COB | NDC | Emergency Service | Family Planning |
|----------------------|----------------------|--------|-----------------------|----------|----------------------|-----------|---------------------|---------------------|---------------------|--------------------------|--------------------------|
| <input type="text"/> | <input type="text"/> | 11 | 90791 | | 1 | \$ 150.00 | 1.00 | COB | NDC | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | Select | <input type="text"/> | | | \$ | | COB | NDC | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | Select | <input type="text"/> | | | \$ | | COB | NDC | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | Select | <input type="text"/> | | | \$ | | COB | NDC | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | Select | <input type="text"/> | | | \$ | | COB | NDC | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | Select | <input type="text"/> | | | \$ | | COB | NDC | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | Select | <input type="text"/> | | | \$ | | COB | NDC | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | Select | <input type="text"/> | | | \$ | | COB | NDC | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | Select | <input type="text"/> | | | \$ | | COB | NDC | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | Select | <input type="text"/> | | | \$ | | COB | NDC | <input type="checkbox"/> | <input type="checkbox"/> |

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

Enter static data for the template

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

Select Save and Continue

Save and Continue

Previous

Cancel

MPATH Provider Services Portal

(Service specific) Professional Claim Template 5

Save Template, naming service specific template for quick reference

Professional Claim Template ? Help

1

Save Template

Please enter a claim submission template name.

Template Name: * Psych Eval Prof

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

Claim Submission Templates ? Help

2

Maximum Templates Allowed : 2000

Filter your results:

| Actions | Name | Date Last Modified |
|---|------------------------|--------------------|
|   | <u>Psych Eval Prof</u> | 03/08/2024 |

Show 10 entries

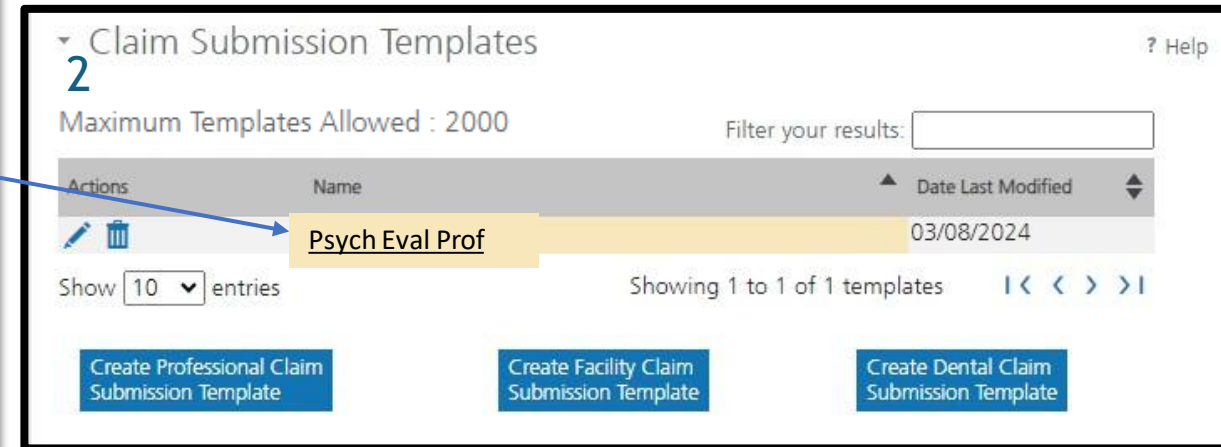
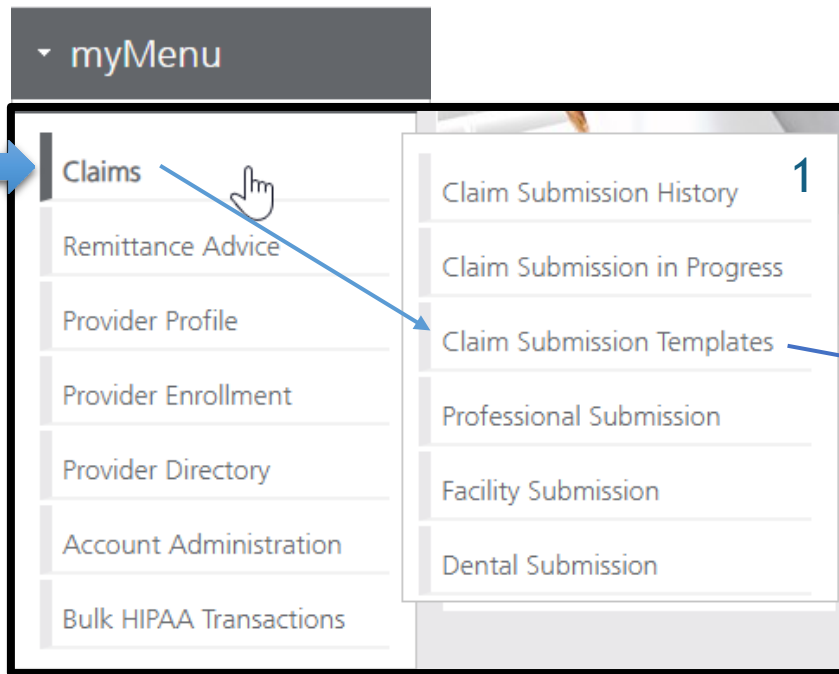
Showing 1 to 1 of 1 templates

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



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.

▼ 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.

Save and Continue Save and Exit Cancel

Select Save and Continue

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

MPATH Provider Services Portal

(Service specific) Professional Claim Template 8

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

Professional Claim Submission Form

Member Details 1

Note : Fields marked with an asterisk * are required.

Enter Member ID:*

1234567 Search

Enter Member ID:*

1234567 Search

2

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

Select Save and Continue

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

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 : 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 | EPSTD | Emergency Service | Family Planning |
|------------|------------|------|------------------------|----------|-----------------------|-----------|----------------------|-----|-----|-------|--------------------------|--------------------------|
| MM/DD/YYYY | MM/DD/YYYY | 11 | 90791 | | 1 | \$ 150.00 | 1.00 | COB | NDC | | <input type="checkbox"/> | <input type="checkbox"/> |

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:

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

Diagnosis Codes (ICD 10):

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

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 | EPSTD | Emergency Service | Family Planning |
|------------|------------|------|------------------------|----------|-----------------------|-----------|----------------------|-----|-----|-------|--------------------------|--------------------------|
| 03/08/2024 | 03/08/2024 | 11 | 90791 | | 1 | \$ 150.00 | 1.00 | COB | NDC | | <input type="checkbox"/> | <input type="checkbox"/> |

Total Charges: \$ 150.00 Add

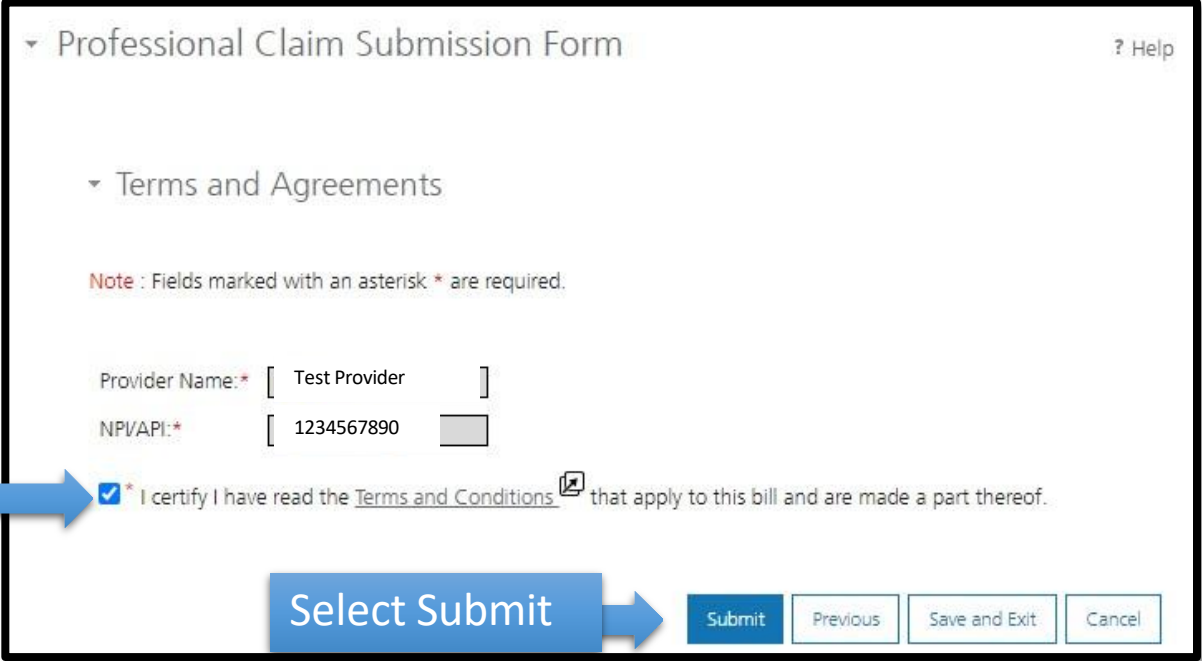
5

Select Save
and
Continue

| | | | |
|-------------------|----------|---------------|--------|
| Save and Continue | Previous | Save and Exit | Cancel |
|-------------------|----------|---------------|--------|

MPATH Provider Services Portal

(Service specific) Professional Claim Template 10



Professional Claim Submission Form [? Help](#)

Terms and Agreements

Note : Fields marked with an asterisk * are required.

Provider Name:* [Test Provider]

NP/ABI:* [1234567890]

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

Select Submit →

Agree to Terms and Conditions →

MPATH Provider Services Portal

(Service specific) Professional Claim Template 11

Print/Save PDF of claim submission (optional).

1 Professional Claim Submission Form ? Help

Thank you for your Submission

Your Claim was successfully submitted: OC240308P0517496.

Continue

Print

2

Print

Claim: OC240308P0517496

Claim Type: Professional

Provider Detail:

Billing Provider: NPI/API: 1234567890

3 2 pages

Print

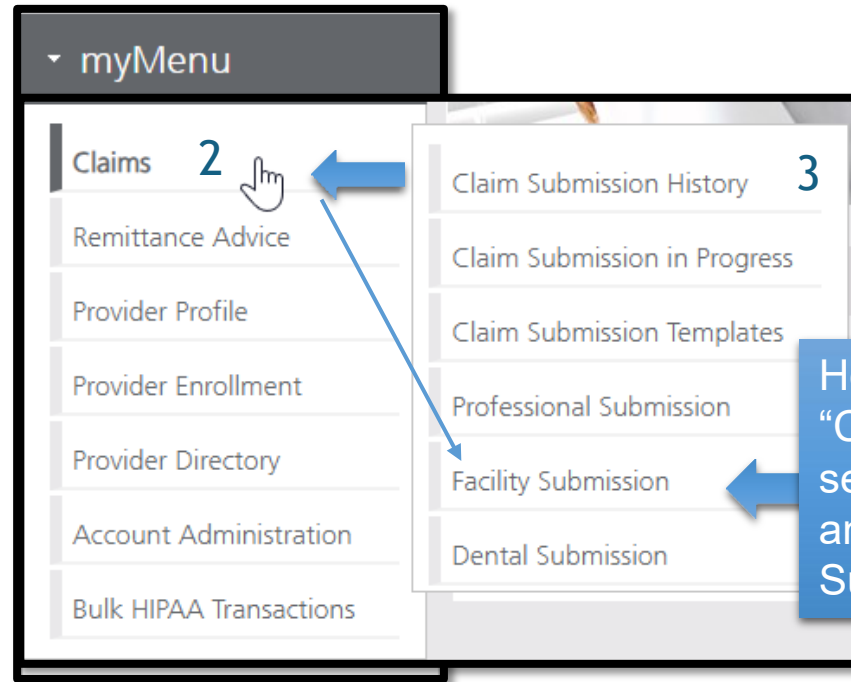
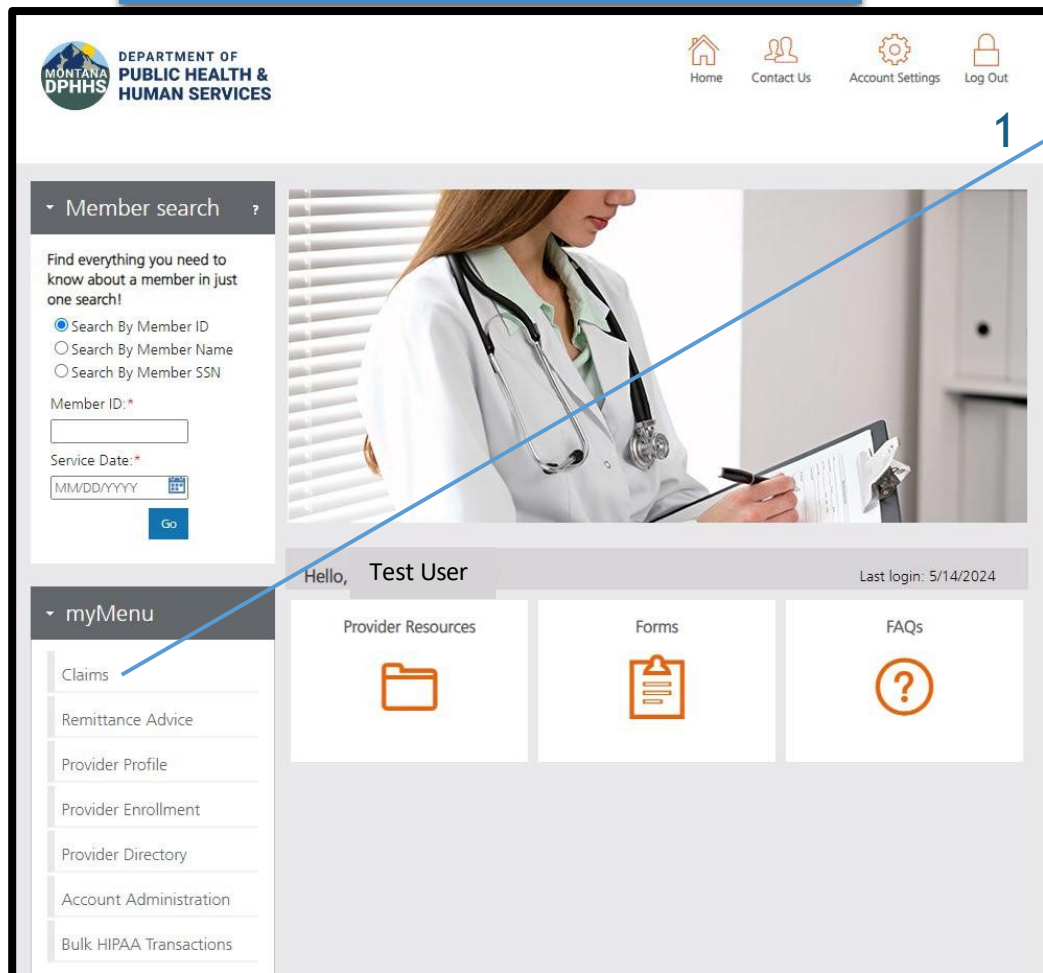
Destination

Save as PDF

Save Cancel

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 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: * In Home Supportive Care ▼

Service Location

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

☐ 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.

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).

The image shows two screenshots of the MPATH Provider Services Portal. The first screenshot, labeled '1', shows the 'Professional Claim Submission Form' with a 'Member Details' section. It includes a 'Note' that fields marked with an asterisk are required. There is an input field for 'Enter Member ID:*' with the value '1234567' and a 'Search' button. A blue callout box labeled 'Select Search' points to the 'Search' button. The second screenshot, labeled '2', shows the 'Member Demographics' form. It has a header 'Enter Member ID:*' with the value '1234567' and a 'Search' button. Below this are various fields: 'Member ID:', 'Patient Account Number:', 'First Name:', 'Middle Name:', 'Last Name:', 'Date of Birth:', 'Gender:', 'Mailing Address 1:', 'Mailing Address 2:', 'City:', 'State:', and 'ZIP:'. The 'Member ID' field is populated with '1234567', 'First Name' with 'Test', 'Last Name' with 'Member', 'Gender' with 'Male', 'State' with 'MT', and 'ZIP' with '59521-0000'. A blue callout box labeled 'Member Demographics are automatically populated when entering a valid Member ID' points to the populated fields. At the bottom of the second screenshot, there is a blue callout box labeled 'Select Save and Continue' pointing to the 'Save and Continue' button. Other buttons at the bottom include 'Previous', 'Save and Exit', and 'Cancel'.

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 Search

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 [? Help](#)

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: 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:

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

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

Condition Codes ?

Condition Codes:

Accident State:

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

MPATH Provider Services Portal

Single Facility Claim Submission 5

Occurrence Codes

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

Occurrence Span Codes

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

Value Codes ?

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

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 :  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"/> | <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"/> | <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"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Total Charges: 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 displays the MPATH Provider Services Portal interface for Single Facility Claim Submission. It features a form for entering claim details and a search results table.

Form Fields:

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

Search Results Table:

| 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 |

Annotations:

- 1: Points to the magnifying glass icon in the Revenue Code field.
- 2: Points to the selected code 0120 in the search results table.
- 3: Points to the first three characters (012) entered in the Revenue Code field.

Buttons:

- Cancel

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

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

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.

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):

F20

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

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

F200

| 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 Facility Claim Submission 10

Other Diagnosis Codes

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

| Other Diagnosis Codes: | Present on Admission: |
|------------------------|-----------------------|
| <input type="text"/> | Select |
| <input type="text"/> | Select |
| <input type="text"/> | Select |
| <input type="text"/> | Select |
| <input type="text"/> | Select |

[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: |
|---------------------------------|-----------------------|
| <input type="text"/> | Select |
| <input type="text"/> | Select |
| <input type="text"/> | Select |

Principal Procedure Code: Date:

Other Procedure Codes

| Other Procedure Codes: | Date: |
|------------------------|------------|
| <input type="text"/> | MM/DD/YYYY |
| <input type="text"/> | MM/DD/YYYY |
| <input type="text"/> | MM/DD/YYYY |
| <input type="text"/> | MM/DD/YYYY |
| <input type="text"/> | MM/DD/YYYY |

Enter optional
information, then
select save and
continue

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:

[Save and Continue](#) [Previous](#) [Save and Exit](#) [Cancel](#)

Enter optional
information

Select Save
and Continue

MPATH Provider Services Portal

Single Facility Claim Submission 11

The screenshot shows a web form titled "Facility Claim Submission Form" with a "Help" link. Under the "Terms and Agreements" section, a note states: "Note : Fields marked with an asterisk * are required." There are two input fields: "Provider Name:*" containing "Test Provider" and "NPI/API:*" containing "1234567890". Below these is a checkbox labeled "I certify I have read the Terms and Conditions" which is checked. A blue callout box labeled "Agree to Terms and Conditions" has an arrow pointing to this checkbox. At the bottom, a blue callout box labeled "Select Submit" has an arrow pointing to the "Submit" button. Other buttons at the bottom include "Previous", "Save and Exit", and "Cancel".

Facility Claim Submission Form ? Help

Terms and Agreements

Note : Fields marked with an asterisk * are required.

Provider Name:* Test Provider

NPI/API:* 1234567890

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

Agree to Terms and Conditions

Select Submit

Submit Previous Save and Exit Cancel

MPATH Provider Services Portal

Single Facility Claim Submission 12

Print/Save PDF of claim submission (optional).

1

Facility Claim Submission Form

Thank you for your Submission

Your Claim was successfully submitted: OC220301I0158541

Continue

2

Print

Claim: OC220301I0158541

Claim Type: Facility

Provider Detail:

Billing Provider: NPI/API: 1234567890

3

Print 2 pages

Destination

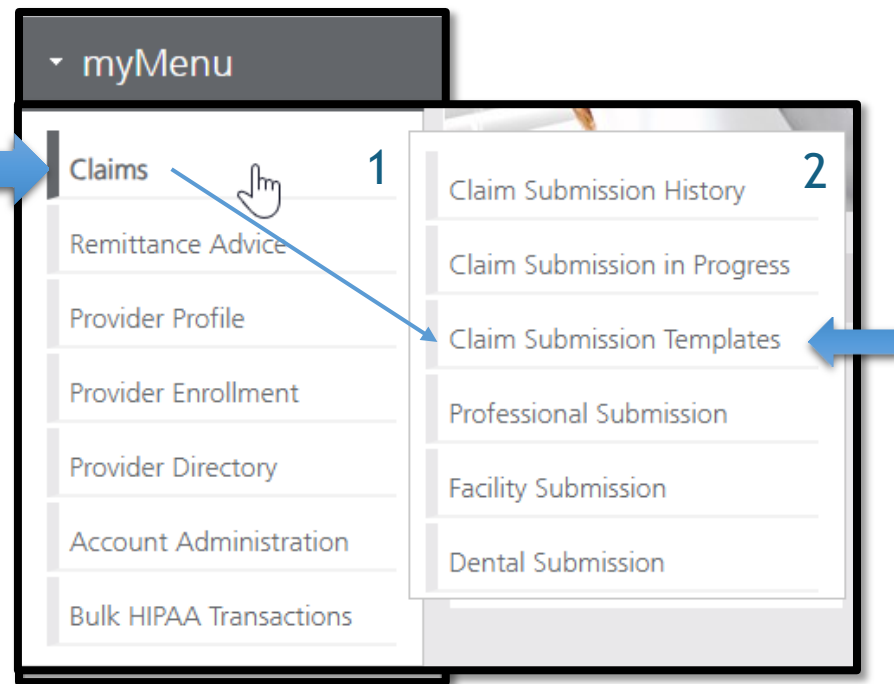
Save as PDF

Save Cancel

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.

1

Claim Submission Templates

Claim Submission Templates

Maximum Templates Allowed : 2000

Filter your results:

| Actions | Name | Date Last Modified |
|--------------------------------------|------|--------------------|
| No claim submission templates found. | | |

Show 10 entries

Showing 0 to 0 of 0 entries

Select "Create Facility Claim Submission Template"

Create Facility Claim Submission Template

Create Dental Claim Submission Template

2

Facility Claim Template

Member Details

Enter Member ID:

Search

Select Save and Continue

Save and Continue

Cancel

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:

Select

Admission Date:

Admission Hour:

Admission Type:

Source of Admission:

Discharge Hour:

Member Discharge Status:

Select

Select

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

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

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

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

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 | | | MM/DD/YYYY | MM/DD/YYYY | 1 | NDC | \$ 150.00 |
| | | | MM/DD/YYYY | MM/DD/YYYY | | NDC | \$ |

Select Save and Continue

3

Save and Continue Previous Cancel

MPATH Provider Services Portal

(Service specific) Facility Claim Template 4

Save Template, naming service specific template for quick reference

Facility Claim Template 1 ? Help

Save Template

Please enter a claim submission template name.

Template Name: * Psych Eval Facil

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

Claim Submission Templates 2 ? Help

Maximum Templates Allowed : 2000

Filter your results:

| Actions | Name | Date Last Modified |
|---|-------------------------|--------------------|
|   | <u>Psych Eval Facil</u> | 03/08/2024 |

Show 10 entries

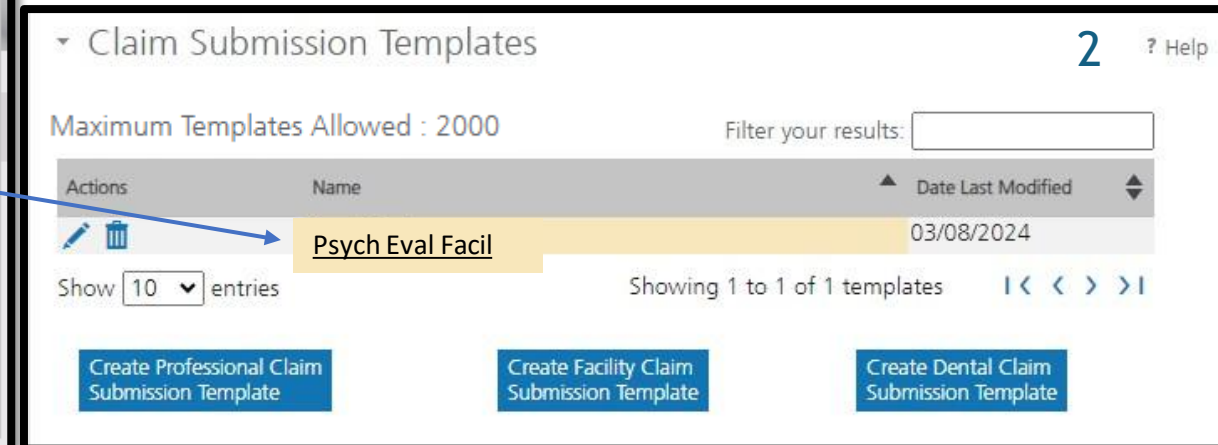
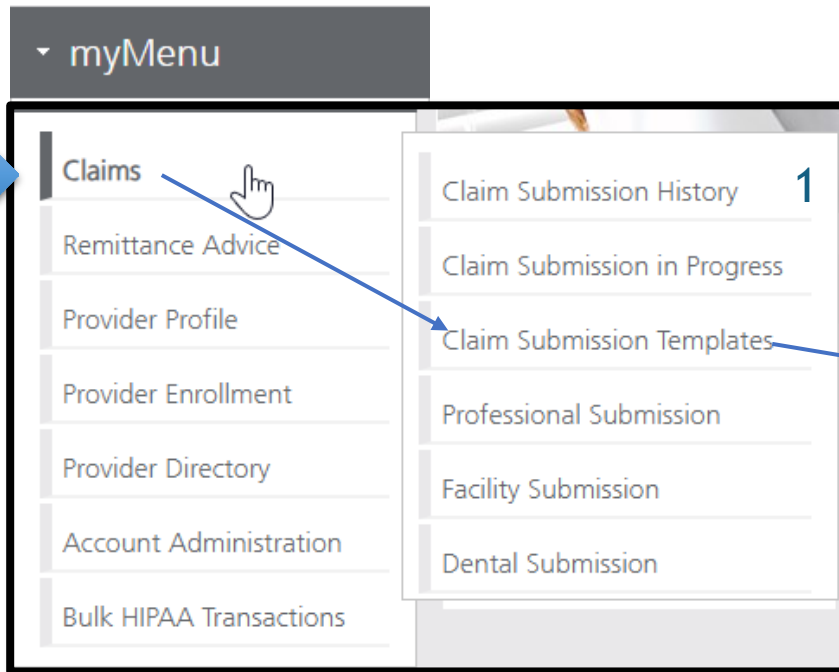
Showing 1 to 1 of 1 templates

Create Professional Claim Submission Template Create Facility Claim Submission Template Create Dental Claim Submission Template

MPATH Provider Services Portal

(Service specific) 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



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

☐ 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.

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.

Professional Claim Submission Form

1

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

Select Save and Continue

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.

1

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

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

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 | | | MM/DD/YYYY | MM/DD/YYYY | 1 | NDC | \$ 150.00 |
| | | | MM/DD/YYYY | MM/DD/YYYY | | NDC | \$ |

3

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

Total Charges: \$ 150.00 Add

4

Select Save and Continue

Save and Continue Previous Cancel

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

MPATH Provider Services Portal

(Service specific) Facility Claim Template 9

The screenshot shows a web form titled "Facility Claim Submission Form" with a "Help" link. Under the "Terms and Agreements" section, a note states: "Note : Fields marked with an asterisk * are required." There are two input fields: "Provider Name:*" containing "Test Provider" and "NPI/API:*" containing "1234567890". Below these is a checkbox labeled "I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof." which is checked. At the bottom, there are four buttons: "Submit", "Previous", "Save and Exit", and "Cancel".

Annotations on the slide include:

- A blue box on the left with the text "Agree to Terms and Conditions" and a blue arrow pointing to the checked checkbox.
- A blue box at the bottom with the text "Select Submit" and a blue arrow pointing to the "Submit" button.

MPATH Provider Services Portal

(Service specific) Facility Claim Template 10

Print/Save PDF of claim submission (optional).

The diagram illustrates the process of printing or saving a PDF of a claim submission. It consists of three numbered steps:

- Step 1:** The "Facility Claim Submission Form" is displayed. It shows a "Thank you for your Submission" message and a confirmation: "Your Claim was successfully submitted: OC220301I0158541". A blue arrow points from the "Print" icon in this step to the "Print" option in Step 2.
- Step 2:** The "Print" menu is open, showing the following details:
 - Claim:** OC220301I0158541
 - Claim Type:** Facility
 - Provider Detail:**
 - Billing Provider:** NPI/API: 1234567890A blue arrow points from the "Print" option in this step to the "Destination" dropdown in Step 3.
- Step 3:** The "Print" menu is further expanded, showing the "Destination" dropdown set to "Save as PDF". A blue arrow points from the "Save" button in this step to the "Save" button in the final "Save as PDF" dialog.

The final "Save as PDF" dialog shows the "Save" button highlighted, indicating the successful completion of the process.

MPATH Provider Services Portal

Claim status

Provider Services Portal Home Page

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

1

2

3

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 1234567

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

MPATH Provider Services Portal

Claim status 3

Select
ICN to
view
detail

Claim activity 1 [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 |

Claim activity 2 [Download](#) [Print](#) [? Help](#)

ICN: [Return to search](#)

Member: Test Member
Date of Service: 6/14/24
Patient Account
Member ID: 1234567

Date Processed: 6/14/24

Total amount billed: \$100.00
Total amount paid: \$50.00

Payment details
Payment number: 00000942396
Payment date: 6/14/23
Payment amount: \$50.00

Claim status: F1:Finalized/Payment

Line 1

Provider name: Test Provider

Provider Tax ID:

Date of service: 6/14/24

Procedure code: 90791

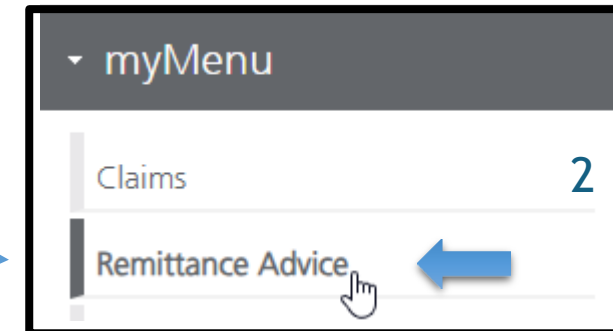
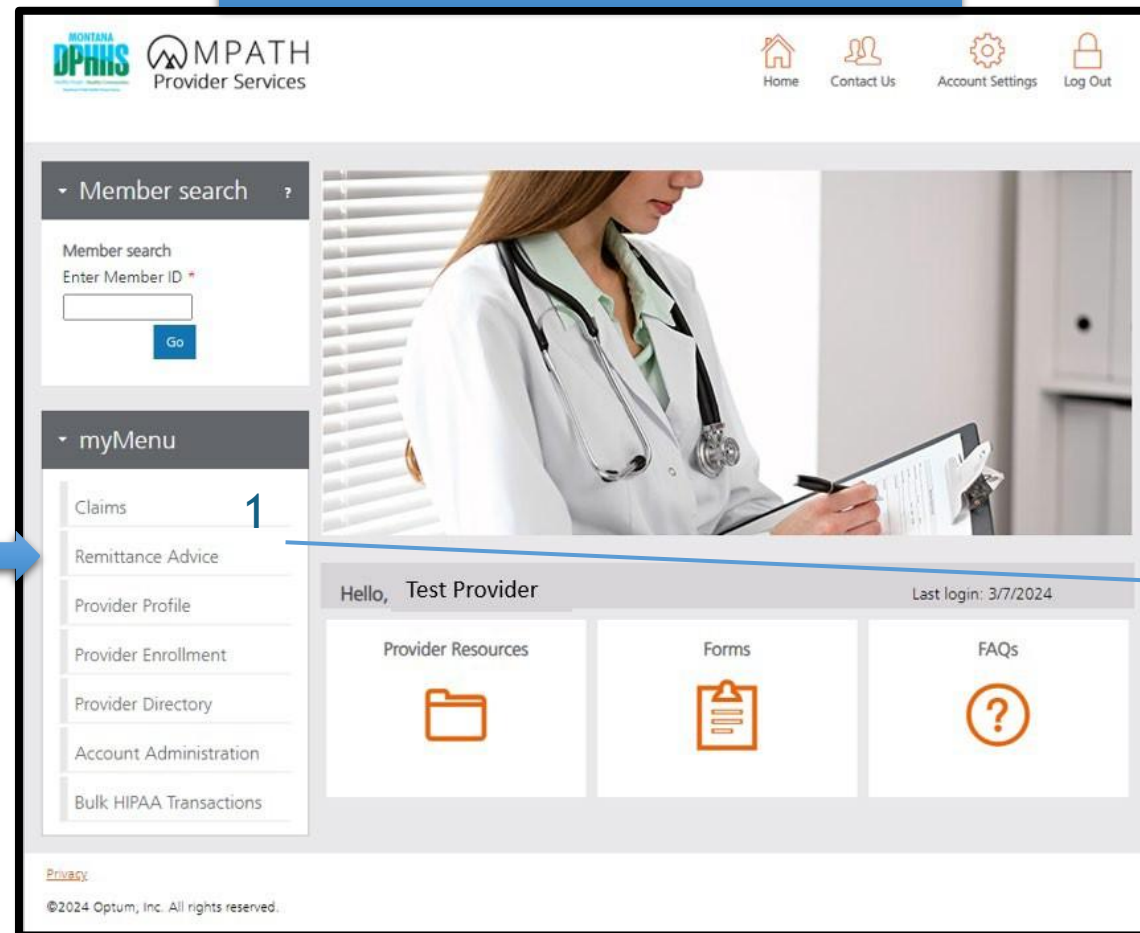
Cost for this service: Amount billed: \$100.00
Amount paid by plan: \$50.00

[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.



MPATH Provider Services Portal

Remittance Advice Retrieval

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: *
11/03/2002

Search

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 11/03/2002.

Remittance advice activity Help

Filter your results:

| REMITTANCE ADV NBR | DATE ISSUED | PID/EU | PAYMENT NUMBER | PAYMENT TYPE | PAYMENT AMOUNT | PDF | 835 EDI |
|--------------------|-------------|---------|----------------|--------------|----------------|----------------------|--------------------------|
| 1 | 03/07/2022 | 1234567 | | Check | \$29633.82 | View | Download |
| 1 | 03/14/2022 | 1234567 | | Check | \$20182.56 | View | Download |
| 1 | 03/21/2022 | 1234567 | | Check | \$398.30 | View | Download |

Show 10 entries

Showing 1 to 4 of 4 forms

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

Click "View" under the PDF header.

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

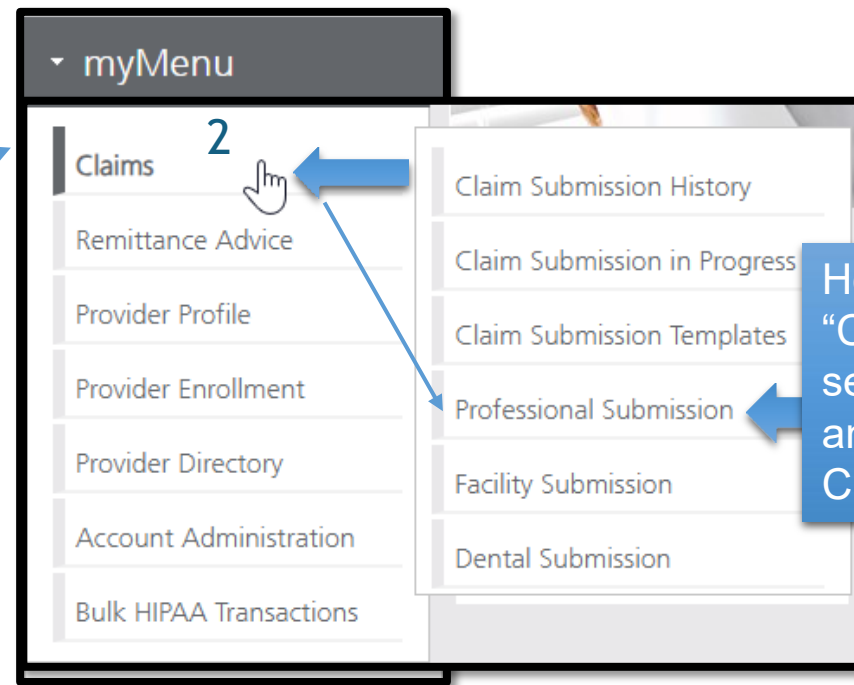
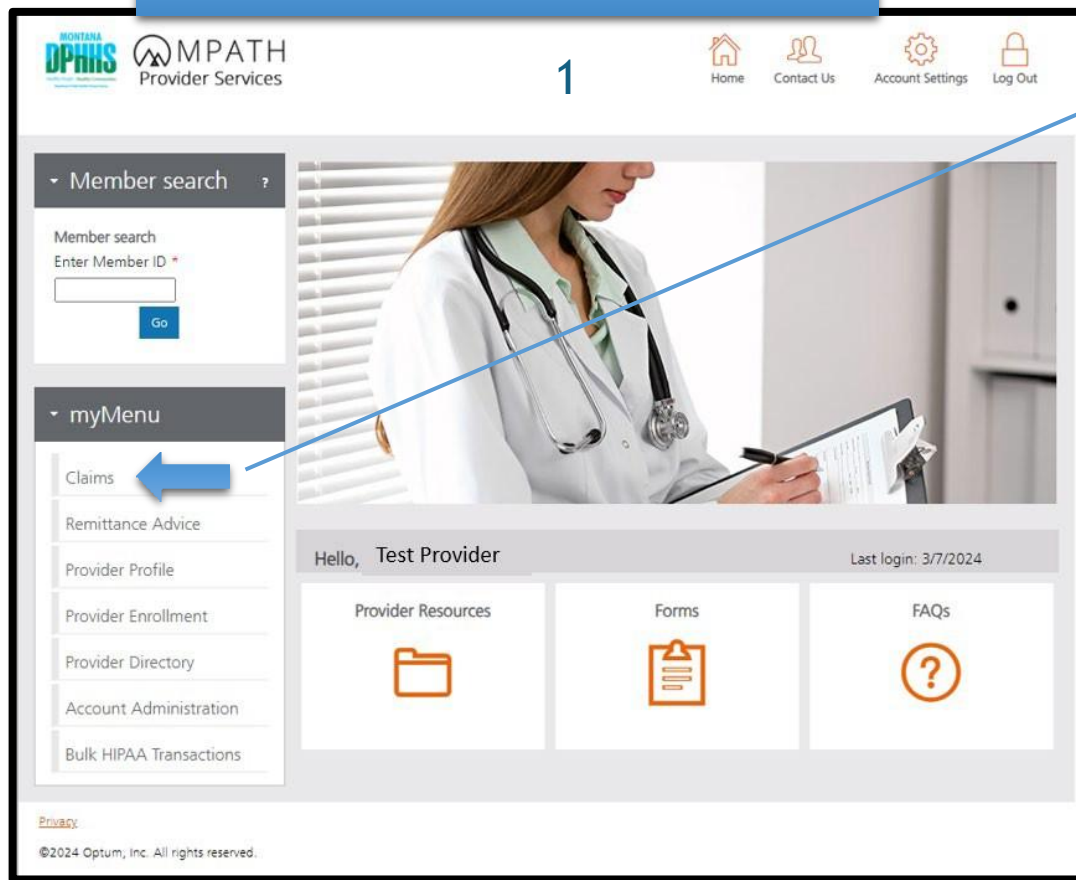
Electronic Adjustment (void/replace) 2

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



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:* 251S00000X

Enrollment Unit:* 1234567

Referring Provider

☐ There is a referring provider for this claim.

Ordering Provider

☐ There is a ordering provider for this claim.

Save and Continue Save and Exit Cancel

Select Save and Continue

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.

Professional Claim Submission Form 1

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 Search

Select Save and Continue

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

7 8 9 10 11 12

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 |
|------------|------------|--------|------------------------|----------|-----------------------|----------|----------------------|-----|-----|-------|----------------------|--------------------|
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |

Total Charges: \$ Add

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

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

Enter at least one
Diagnosis Code

Enter required fields: Service Date(s),
Place of Service Code, Diagnosis
Pointer(s), Charges, and Units .

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.

Diagnosis Codes

Diagnosis Codes (ICD 10):

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

Diagnosis Codes

Diagnosis Codes (ICD 10):

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

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

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).

Add New

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 1 \$ 150.00 1.00 COB NDC

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 | 90791 | | 1 | \$ 150.00 | 1.00 | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |
| MM/DD/YYYY | MM/DD/YYYY | Select | | | | \$ | | COB | NDC | | | |

Total Charges: \$ 150.00 Add

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 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: ☒ Yes ☐ No

Select the Medicaid Resubmission Code:* 1 ▼

Enter the Original MMIS ICN:* 2

Replacement of prior claim
Void of prior claim

Is this a void or replacement of a previously submitted claim: ☒ Yes ☐ No 2

Select the Medicaid Resubmission Code:* Replacement of prior c ▼

Enter the Original MMIS ICN:* 22419900255008999

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

Select Save and Continue

Save and Continue Previous Save and Exit Cancel

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

MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace) 10



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 →

Agree to Terms and Conditions → ☒

MPATH Provider Services Portal Professional Claim Electronic Adjustment (void/replace) 11

Print/Save PDF of claim submission (optional).

1

Professional Claim Submission Form

Thank you for your Submission

Your Claim was successfully submitted: OC240308P0517496.

Continue

Print

2

Print

Claim: OC240308P0517496

Claim Type: Professional

Provider Detail:

Billing Provider: NPI/API: 1234567890

3

Print 2 pages

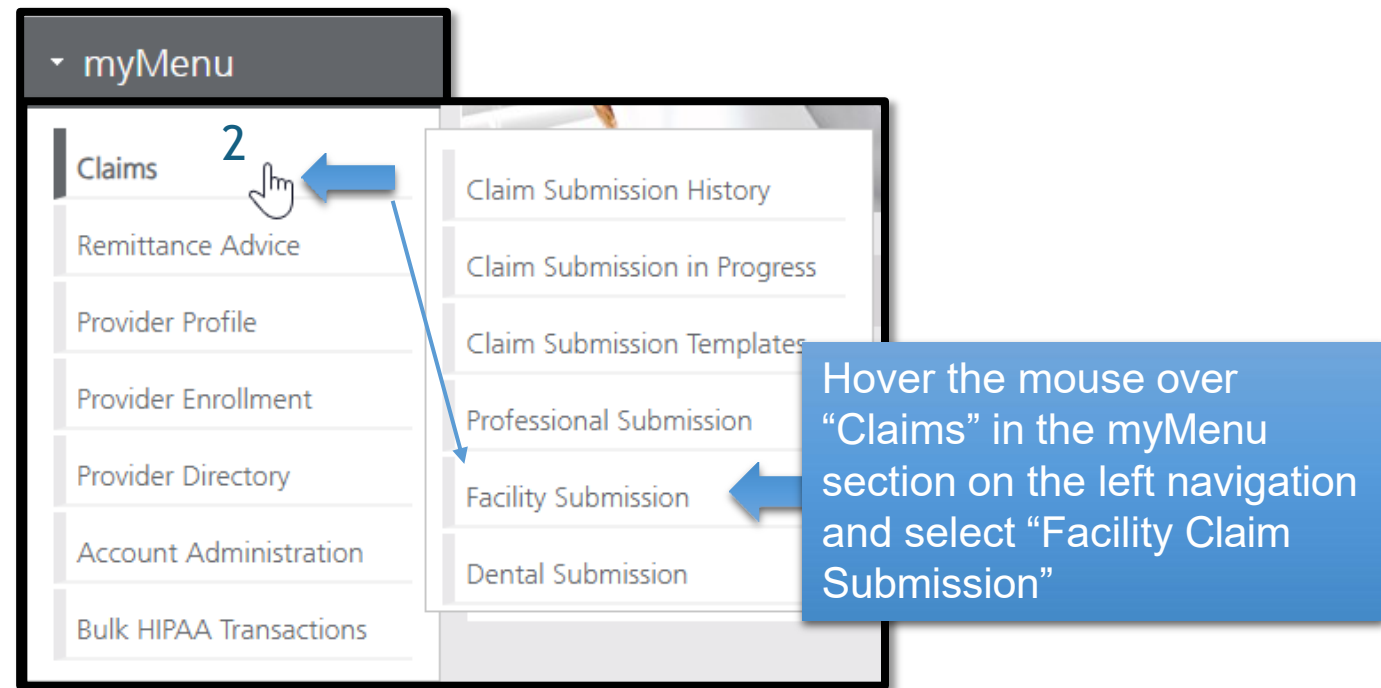
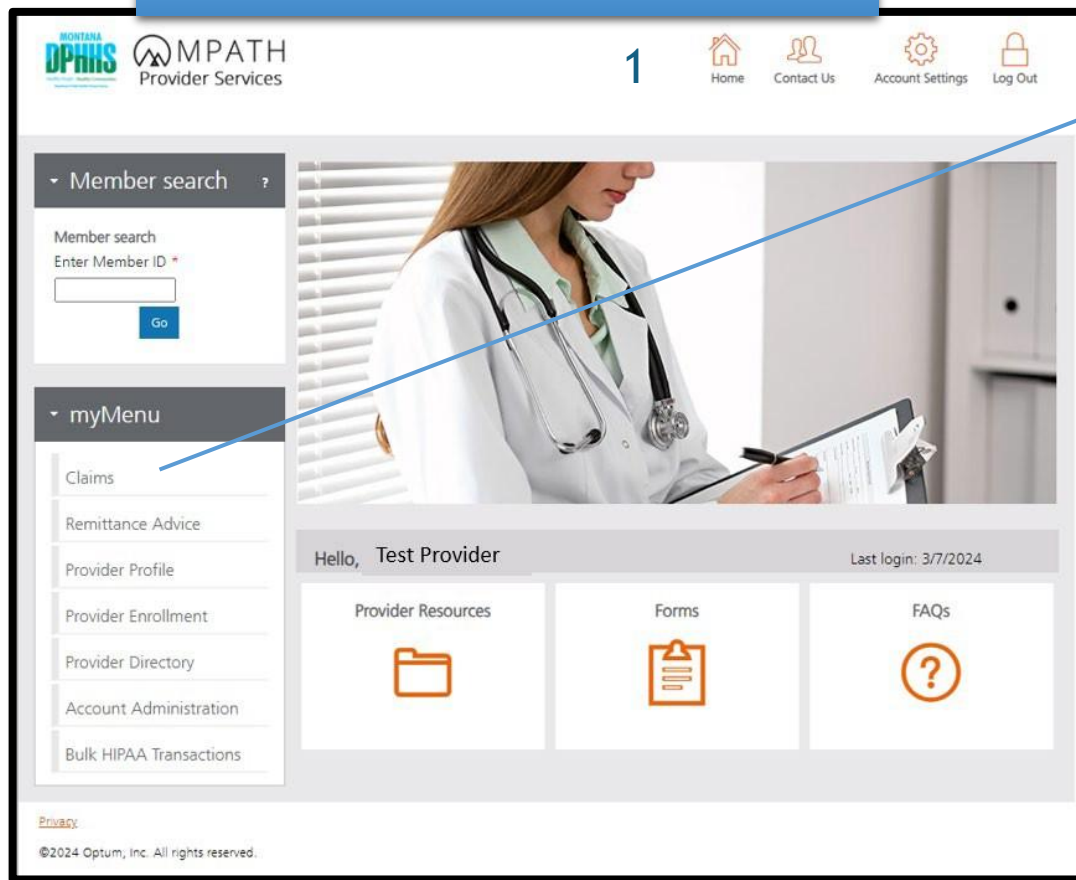
Destination

Save as PDF

Save Cancel

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

Provider Services Portal Home Page



MPATH Provider Services Portal Facility

Claim Electronic Adjustment (void/replace) 13

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:* Clinic/Center, Rehabilitation, Substance U ▼

Service Location

Service Address 1:* 1120 CEDAR ST

Service Address 2:

City:* MISSOULA

State:* MT

ZIP:* 59802-3911

Taxonomy Code:* 261QR0405X

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.

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 screenshot displays the MPATH Provider Services Portal Facility interface. On the left, a sidebar titled "Professional Claim Submission Form" contains a "Member Details" section. A blue callout box labeled "1" points to the "Enter Member ID:*" field, which contains the value "1234567". A blue button labeled "Search" is next to it. A blue callout box labeled "Select Search" points to this button. An arrow points from the "Search" button to the main form area on the right.

The main form area is titled "Enter Member ID:*" and is labeled with a blue callout box "2". It contains a "Search" button and a list of fields for member demographics. A blue callout box labeled "Member Demographics will be automatically populated when entering a valid Member ID" points to the "Member ID" field. The fields are as follows:

| Field | Value |
|-------------------------|------------|
| 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 |

At the bottom of the form, there are four buttons: "Save and Continue", "Previous", "Save and Exit", and "Cancel". A blue callout box labeled "Select Save and Continue" points to the "Save and Continue" button.

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:* | | |
| 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 | | | | | |

Enter all other claim data as required.

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.

MPATH Provider Services Portal Facility

Claim Electronic Adjustment (void/replace) 16

Facility Claim Submission Form [? Help](#)

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:* | | |
| <input type="text" value="0127"/> | <input type="text" value="Inpatient"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="MM/DD/YYYY"/> | | |
| Admission Date:* | Admission Hour:* | Admission Type:* | Source of Admission:* | Discharge Hour:* | Member Discharge Status:* |
| <input type="text" value="MM/DD/YYYY"/> | <input type="text" value="Select"/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value="Select"/> | <input type="text" value=""/> |
| Original MMIS ICN:* | | | | | |
| <input type="text" value="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:

| | | | | | | | | | | |
|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> | <input type="text" value=""/> |
|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

Accident State:

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" value="MM/DD/YYYY"/> | <input type="text"/> | <input type="text" value="MM/DD/YYYY"/> |
| <input type="text"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text"/> | <input type="text" value="MM/DD/YYYY"/> |
| <input type="text"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text"/> | <input type="text" value="MM/DD/YYYY"/> |
| <input type="text"/> | <input type="text" value="MM/DD/YYYY"/> | <input type="text"/> | <input type="text" value="MM/DD/YYYY"/> |

Occurrence Span Codes

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

Value Codes ?

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

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

Claim Details

Note :  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"/> | <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"/> | <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"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Total Charges: Add

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

| 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:* |
|----------------|-------------|-----------|-------------|------------|-----------------|------|-----------------|
| | 9079 | 1 | 06/14/2024 | 06/14/2024 | 1 | NDC | \$ 150.00 |

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

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.

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):

F20

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

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

F200

| 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 Facility

Claim Electronic Adjustment (void/replace) 22

Other Diagnosis Codes

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

| Other Diagnosis Codes: | Present on Admission: |
|------------------------|-----------------------|
| <input type="text"/> | Select |
| <input type="text"/> | Select |
| <input type="text"/> | Select |
| <input type="text"/> | Select |
| <input type="text"/> | Select |

[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: |
|---------------------------------|-----------------------|
| <input type="text"/> | Select |
| <input type="text"/> | Select |
| <input type="text"/> | Select |

Principal Procedure Code: Date:

Other Procedure Codes

| Other Procedure Codes: | Date: |
|------------------------|------------|
| <input type="text"/> | MM/DD/YYYY |
| <input type="text"/> | MM/DD/YYYY |
| <input type="text"/> | MM/DD/YYYY |
| <input type="text"/> | MM/DD/YYYY |
| <input type="text"/> | MM/DD/YYYY |

Enter optional
information

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](#)


[Save and Continue](#) [Previous](#) [Save and Exit](#) [Cancel](#)

Enter optional
information

Select Save
and Continue

MPATH Provider Services Portal Facility

Claim Electronic Adjustment (void/replace) 23



The screenshot shows a web form titled "Facility Claim Submission Form" with a "Help" link. Under the "Terms and Agreements" section, a note states: "Note : Fields marked with an asterisk * are required." The form contains two input fields: "Provider Name:*" with the value "Test Provider" and "NP/ABI:*" with the value "1234567890". Below these is a checkbox labeled "I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof." which is checked. At the bottom, there are four buttons: "Submit", "Previous", "Save and Exit", and "Cancel".

Annotations on the slide:

- A blue box on the left contains the text "Agree to Terms and Conditions" with a blue arrow pointing to the checked checkbox.
- A blue box at the bottom contains the text "Select Submit" with a blue arrow pointing to the "Submit" button.

MPATH Provider Services Portal Facility

Claim Electronic Adjustment (void/replace) 24

Print/Save PDF of claim submission (optional).

1

Facility Claim Submission Form

Thank you for your Submission

Your Claim was successfully submitted: OC220301I0158541

Continue

2

Print

Claim: OC220301I0158541

Claim Type: Facility

Provider Detail:

Billing Provider: NPI/API: 1234567890

3

Print 2 pages

Destination

Save as PDF

Save Cancel

Provider Relations Contact Information

Provider Relations Call Center:

(800) 624-3958

Monday through Friday 8am to 5pm MST

General, Claims, TPL, and EDI questions:

MTPRHelpdesk@conduent.com

Enrollment Questions and documents:

MTEnrollment@conduent.com

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

Provider Relations Contact Information (cont.)

MPATH Provider Services Helpdesk

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: