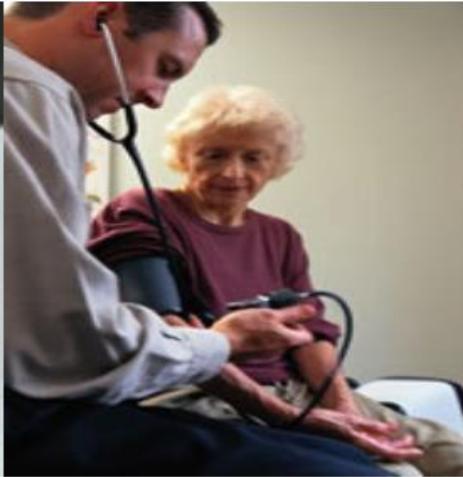


# ND Health Enterprise Web Portal Professional Claim Form Submission Instructions

- Go to [MMIS.ND.GOV](http://MMIS.ND.GOV) to log into the provider web portal



- [Home](#)
- [Program](#)
- [Member](#)
- [Provider](#)
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**Welcome** [Print](#) | - □

Welcome to the North Dakota MMIS Web Portal.

ND MMIS has established a scheduled maintenance window for calendar year 2019 from 9:00PM to 4:00AM Central Time on the 2nd Thursday of the month with the following exceptions: Jan 17, Apr 17, May 16, Nov 7, and Dec 19. During the maintenance window, the

**Provider Registration** - □

To obtain a user id and password, Providers and Trading Partners must have an approved enrollment with North Dakota and have received their Provider or Trading Partner ID.

[Register](#)

**Quick Links** - □

- [FAQ](#)
- [Find a Healthcare Provider](#)
- [Benefits Overview](#)
- [Provider Enrollment](#)
- [Report Fraud & Abuse](#)

**Sign In** - □

Log into the system based upon your role:

- [Providers](#)
- [Internal Users](#)

# Sign In - Provider



**Home** | [Program](#) | [Member](#) | [Provider](#) | [Documentation](#) | [Directories](#)

**Quick Links**

- ▶ [Enrollment](#)
- ▶ [ProviderManuals](#)
- ▶ [FAQ](#)
- ▶ [Billing Manuals](#)
- ▶ [Messages & Announcements](#)

**News**

Governor's Task Force on Access to Affordable Health Insurance.

ND MMIS has established a scheduled maintenance window for calendar year 2019 from 9:00PM to 4:00AM Central Time on the 2nd Thursday of the month with the following exceptions: Jan 17, Apr 17, May 16, Nov 7, and Dec 19. During the maintenance window, the system may not be accessible.

**Provider**

The Health Enterprise Portal is a state-of-the-art electronic health care administration system that gives patients, doctors, pharmacists and other users easy, secure and efficient access to health care information.

**ProviderLogin**

To access secure areas of the portal, please log in by entering your User ID and Password.

\* User ID:

\* Password:

[Forgot User Name or Password ?](#)

Log into the system using the **USER ID** and **Password**



Home

Member ▾

Provider ▾

Claims ▾

EDI ▾

Authorizations ▾

My Account ▾

FES ▾

- Quick Links Print | -
- Add Service Location
  - Trading Partner Enrollment
  - Provider Manuals
  - Provider Inquiry/Update Request
  - Provider Training Registration
  - Provider FAQ
  - Provider Resources
  - Messages & Announcements

News - □

Provider Message

Status ▾



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Create Claims ▸

Manage Claims ▸

Create Templates ▸

Manage Templates ▸

Claim Status Inquiry

Payment Inquiry

1099 Inquiry

Pharmacy Claims ▸

Create Professional Claim

Create Institutional Claim

Create Dental Claim

Create Claim from Template

Create Claim from Processed Claim

Travel/Lodging Claim

HCBS/DD Claim

Subject ▾

New Document for Online Viewing:

New Document for Online Viewing:

New Document for Online Viewing:

Delete

Print | Help - □If you are unable to view PDFs, please [download Adobe Reader](#).

To submit a claim, go to the **Claims** tab;  
 Select **Create Claims**; then select **Create Professional Claim**

**\*Required Field**

Basic Claim Info

Other Claim Info

[Provider](#) [Member](#) [Basic Claim](#) [Service Line Items](#) Is this a void/replacement? Yes  No**Submitter Information**

Submitter ID

MSNERD

- The “New Professional Claim” screen will appear
  - Is this a void/replacement?
  - This field will default to “No.” Select “Yes” only if you are voiding or replacing a previously processed claim.

**\*Required Field****Basic Claim Info**

Other Claim Info

Provider Member Basic Claim Service Line Items

? Is this a void/replacement?

 Yes  No**Submitter Information**

Submitter ID

MSNERD

**Provider Information**Go to [Other Claim Info](#) to enter information for other providers.**Billing Provider****Note:** Healthcare Providers are required to submit National Provider ID.

Medicaid Provider ID

1456247

National Provider ID

1609035120

Taxonomy Code

Tax ID

SSN

Location Number

- Enter the Facility Taxonomy Code
- Enter your Tax ID
- Enter the Location Number BI (Billing)

 **Additional Billing Provider Information**

Currency Code

**\*Org/Last Name**

**\*Address 1**

**\*City**

State

Zip **and**

Extension

Country

Subdivision Code

Address 2

 **Contact Information**

○ Additional Billing Provider Information

- REQUIRED
- Enter your Facility Name, Address, City, State and Zip Code

? Is the Billing Provider Address also the Pay-To Address?

Yes  No

### Pay-To Address

\*Address 1

\*City

State

Zip and Extension

Country

Subdivision Code

Address 2

- Is the Billing Provider also the Pay-To Address?
  - Will default to “Yes”
  - Required - if Pay-To Address is different, select “No”
  - Complete the Pay-To Address section with the Facility Name, Address, City, State and Zip Code

? Is the Billing Provider also the Rendering Provider?

Yes  No

**Rendering (Performing) Provider**

Medicaid Provider ID

National Provider ID

Taxonomy Code

Location Number

- Is the Billing Provider also the Rendering Provider?
  - Default to “Yes”
  - Required - if Rendering Provider is different select “No”
  - Complete the Rendering (Performing) Provider
  - Enter Rendering Provider Medicaid Provider ID
  - Enter Rendering Provider NPI Number
  - Enter Rendering Provider Taxonomy Code
  - Enter Rendering Provider Location Code

? Is this service the result of a referral?

Yes  No

? Is this service the result of a referral?

Yes  No

### Referring Provider

Medicaid Provider ID

National Provider ID

### Additional Referring Provider Information

\*Org/Last Name

First Name

MI

Suffix

- Is this service the result of a referral?
  - Default “No”
  - Referring Provider Medicaid Provider ID and NPI (National Provider ID)
  - Org/Last Name and First Name
  - MI and Suffix – if applicable

## Member Information

*Member ID	*Last Name	First Name	MI	Suffix	*Date of Birth	*Gender	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Property Casualty Number							
<input type="text"/>							

### ○ Member Information

- REQUIRED
- Enter the Member's 9-digit ID number
- Enter the Member's Last Name
- Enter the Member's First Name
- Enter the Member's Date of Birth
  - Use format: MM/DD/YYYY
- Enter the Member's Gender
  - F = Female
  - M = Male

[Member Address](#)

\*Address 1      \*City      State      Zip and      Extension      Country      Subdivision Code

Address 2

- Member Address
  - REQUIRED
  - Enter the Member's Address, City, State and Zip Code

## Other Insurance Information

 \*Does the member have other insurance?

Yes  No

- Select “No” if the member does not have other insurance

## Claim Information

Go to [Other Claim Info](#) to include the following claim level information:  
Specialized Line Information, Line Providers , Other Payer Service Line information, Test Result and Form Identification Information.

? \*Is this claim accident related?

Yes  No

Service Authorization #

Referral #

- Is this claim accident related?
  - Yes or No
- Service Authorization # - if applicable
- Referral # - if applicable

**Claim Note**

\*Type Code

\*Note

80 Characters Remaining

- Claim Note

- Add any pertinent information for example proving the one year filing limit policy RA Date and TCN number

? Does this claim have Attachments?

Yes  No

Claim Attachments

Add Attachment

Type Attachment ▾

Delivery Method ⇅

Attachment Control # ⇅

No Data

New Attachment

Save | Reset | Cancel

\*Type Attachment

\*Delivery Method

Attachment Control #

- Does this claim have Attachments? Yes or No
  - Yes
  - Add Attachment
  - Type Attachment
  - Delivery Method
  - Save

## Claim Data

\*Patient Account #

\*Place of Service

\*Assignment Code

\*Benefits Assignment Certification

\*Release of Information Code

- Claim Data
  - Patient Account #
  - Place of Service
  - Assignment Code
  - Benefits Assignment Certification
  - Release of Information Code

## Diagnosis Codes

Version #

ICD-09  ICD-10

\*1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

### ○ Diagnosis Codes

- REQUIRED
- Version # - defaults to ICD-10, if date of service is older than 10/01/2015 select ICD-09
- Principal Diagnosis Code
  - Enter the diagnosis code for the member's primary, secondary condition ect.

*Service Date Begin	Service Date End	Place of Service
<input type="text"/> 	<input type="text"/> 	<input type="text"/>
*Procedure Code	Procedure Description	Modifiers
<input type="text"/>	<input type="text"/>	1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>
*Line Item Charge Amount	Diagnosis Pointers	
\$ <input type="text"/>	*1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>	
*Unit Code	*Units	
<input type="text"/>	<input type="text"/>	

### ○ New Line Item

- Service Date Begin and Service Date End - Use format: MM/DD/YYYY
- Place of Service
- Procedure Code
- Modifiers – if applicable
- Line Item Charge Amount
- Diagnosis Pointers – Primary, secondary ect.
- Unit Code and Units

**Service Authorization**

Service Authorization #

Referral #

- Service Authorization
  - Service Authorization – if applicable
  - Referral # - if applicable

**Additional Service Line Information**

EPSDT Indicator:

Family Planning Indicator:

Emergency Indicator:

Co-pay Status:

- Additional Service Line Information – if applicable
  - EPSDT Indicator
  - Family Planning Indicator
  - Emergency Indicator
  - Co-pay Status

**New Line Item** **Save** | Save & Add Other Svc Info/TPL | Reset | Cancel

*Service Date Begin <input type="text"/>	Service Date End <input type="text"/>	Place of Service <input type="text"/>
*Procedure Code <input type="text"/>	Procedure Description <input type="text"/>	Modifiers 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>
*Line Item Charge Amount \$ <input type="text"/>	Diagnosis Pointers *1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>	
*Unit Code <input type="text"/>	*Units <input type="text"/>	

Is there additional line-specific information/TPL to be entered?  
 Yes  No

**Submit Claim** **Save Claim** **Reset** **Cancel**

- All New Line Items completed
  - Save
  - Save Claim
  - Submit Claim

TCN: [REDACTED]

Your claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

### Claim Information

TCN: [REDACTED]

Date of Service: 03/20/2020 - 03/20/2020

Provider #: [REDACTED]

Member ID: [REDACTED]

Claim Status: C - To Be Dnd

Total Charge: \$200.00

\*To Be Paid Amount: \$0.00

\*Co-Payment: \$0.00

\*Total Recipient Liability: \$0.00

Submission Date/Time: Tue Mar 24 11:28:05 CDT 2020

\*This may not be the actual amount. Please refer to your remittance advice for detailed payment information.

### Adjustment Reason Codes

Line #	Adjustment Reason Code	Description
0	204	This service/equipment/drug is not covered under the patient's current benefit plan
1	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
1	26	Expenses incurred prior to coverage.
1	27	Expenses incurred after coverage terminated.

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### Remark Codes

Line #	Remark Code	Description
No Data		

- Print and Save for your records