• Go to MMIS.ND.GOV to log into the provider web portal
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
Log into the system using the USER ID and Password
To submit a claim, go to the **Claims** tab;
Select **Create Claims**; then select **Create Professional Claim**
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.
- Enter the Facility Taxonomy Code
- Enter your Tax ID
- Enter the Location Number BI (Billing)
**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

<table>
<thead>
<tr>
<th>Pay-To Address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address 1</strong></td>
</tr>
<tr>
<td><strong>City</strong></td>
</tr>
<tr>
<td><strong>State</strong></td>
</tr>
<tr>
<td><strong>Zip and Extension</strong></td>
</tr>
<tr>
<td><strong>Country</strong></td>
</tr>
<tr>
<td><strong>Subdivision Code</strong></td>
</tr>
</tbody>
</table>

- 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?

- 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?

- 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

- **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**
  - 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

- Is this claim accident related?
  - Yes or No

- Service Authorization # - if applicable

- Referral # - if applicable
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 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
- **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 etc.
### New Line Item

- **Service Date Begin and Service Date End** - Use format: MM/DD/YYYY
- **Place of Service**
- **Procedure Code**
- **Procedure Description**
- **Modifiers**
- **Line Item Charge Amount**
- **Diagnosis Pointers** – Primary, secondary ect.
- **Unit Code and Units**
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
<table>
<thead>
<tr>
<th>Service Date Begin</th>
<th>Service Date End</th>
<th>Place of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<th>Procedure Code</th>
<th>Procedure Description</th>
<th>Modifiers</th>
</tr>
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<tbody>
<tr>
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<td></td>
<td>1.</td>
</tr>
<tr>
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<td></td>
<td>2.</td>
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<tr>
<td></td>
<td></td>
<td>3.</td>
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<tr>
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<td></td>
<td>4.</td>
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<table>
<thead>
<tr>
<th>Unit Code</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### Service Authorization

### Additional Service Line Information

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

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

<table>
<thead>
<tr>
<th>Line #</th>
<th>Adjustment Reason Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>204</td>
<td>This service/equipment/drug is not covered under the patient's current benefit plan</td>
</tr>
<tr>
<td>1</td>
<td>A1</td>
<td>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.)</td>
</tr>
<tr>
<td>1</td>
<td>26</td>
<td>Expenses incurred prior to coverage.</td>
</tr>
<tr>
<td>1</td>
<td>27</td>
<td>Expenses incurred after coverage terminated.</td>
</tr>
</tbody>
</table>

Remark Codes

<table>
<thead>
<tr>
<th>Line #</th>
<th>Remark Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No Data</td>
</tr>
</tbody>
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- Print and Save for your records