

ND Health Enterprise Web Portal Professional Claim Form Submission Instructions

- Go to MMIS.ND.GOV to log into the provider web portal



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



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 ▾
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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 InformationGo 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 <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"/>	

○ 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"/>	

Service Authorization

Additional Service Line Information

? 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