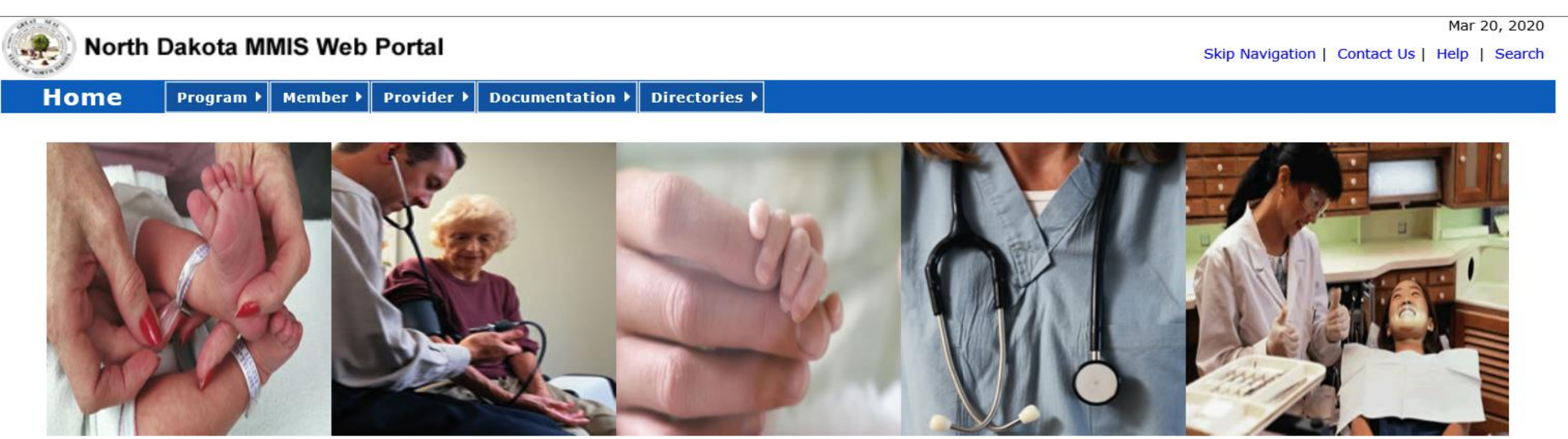
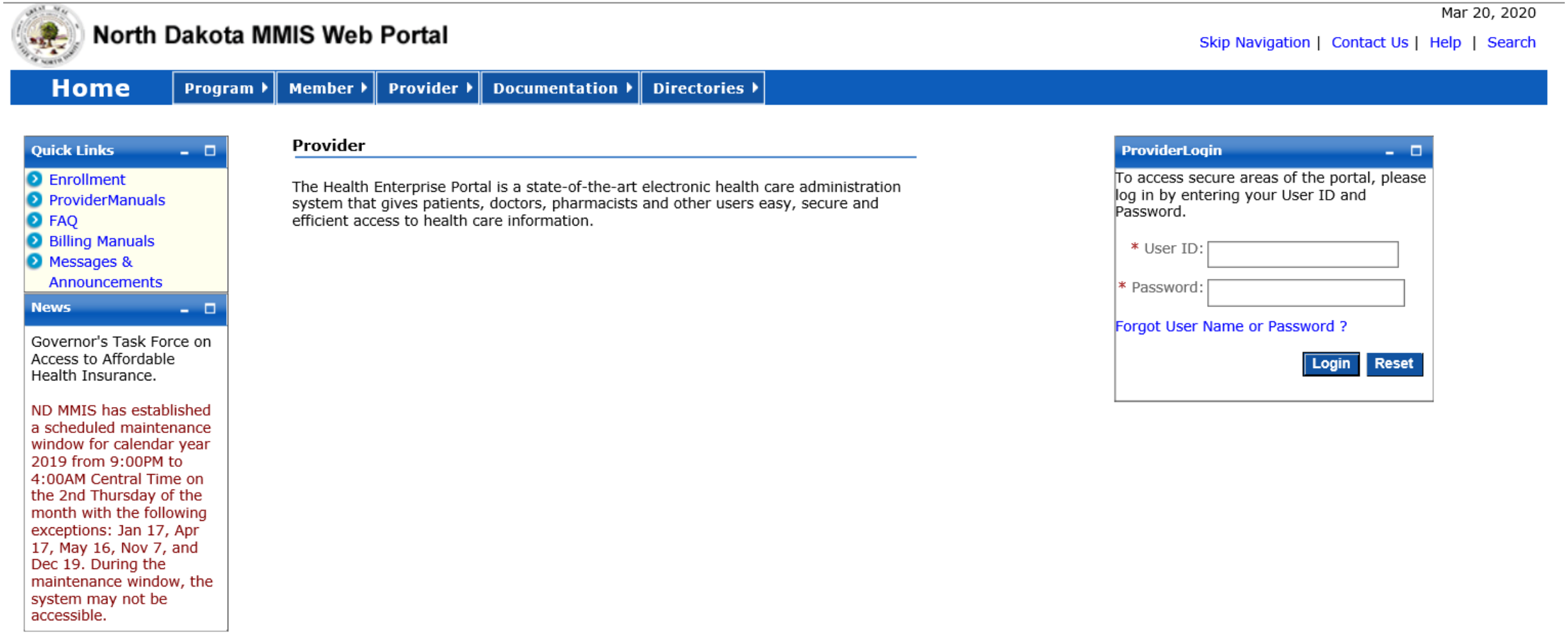
ND Health Enterprise Web Portal Professional Claim Form Submission Instructions

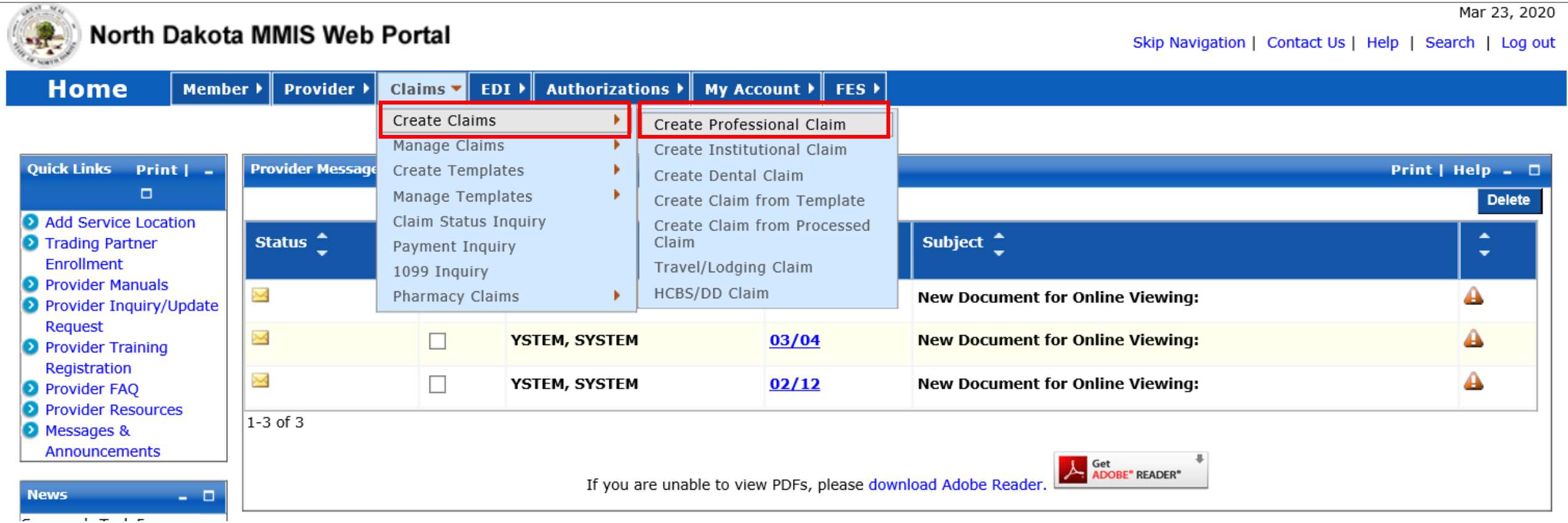
- Go to MMIS.ND.GOV to log into the provider web portal



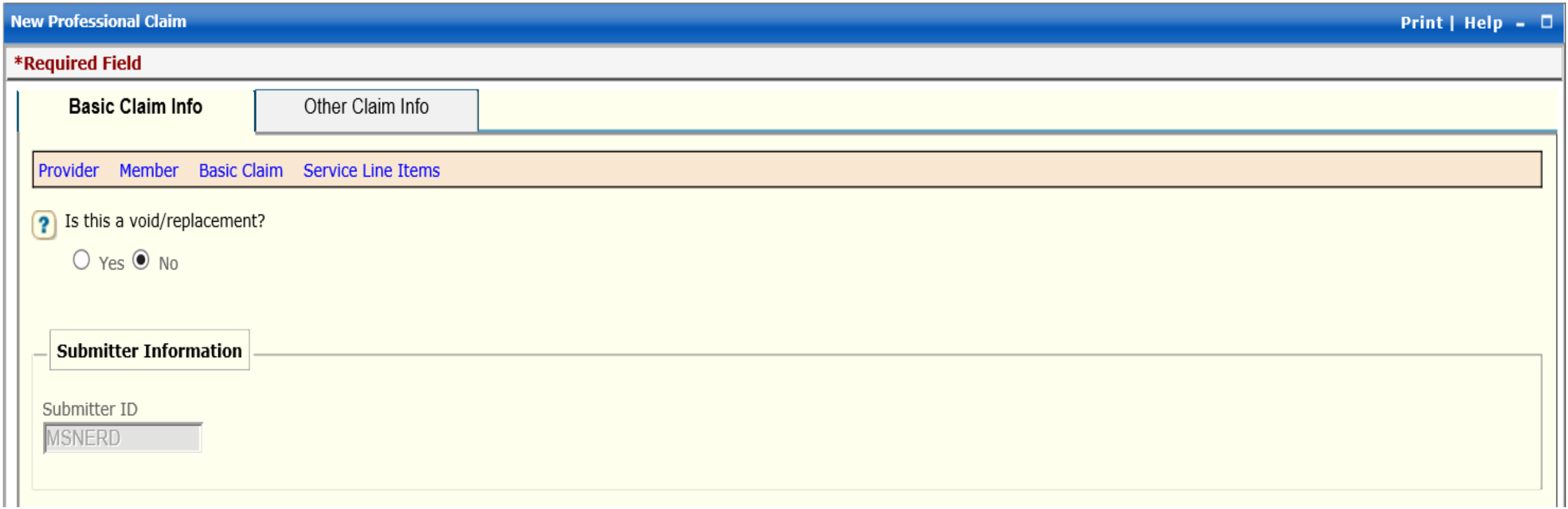
Sign In - Provider



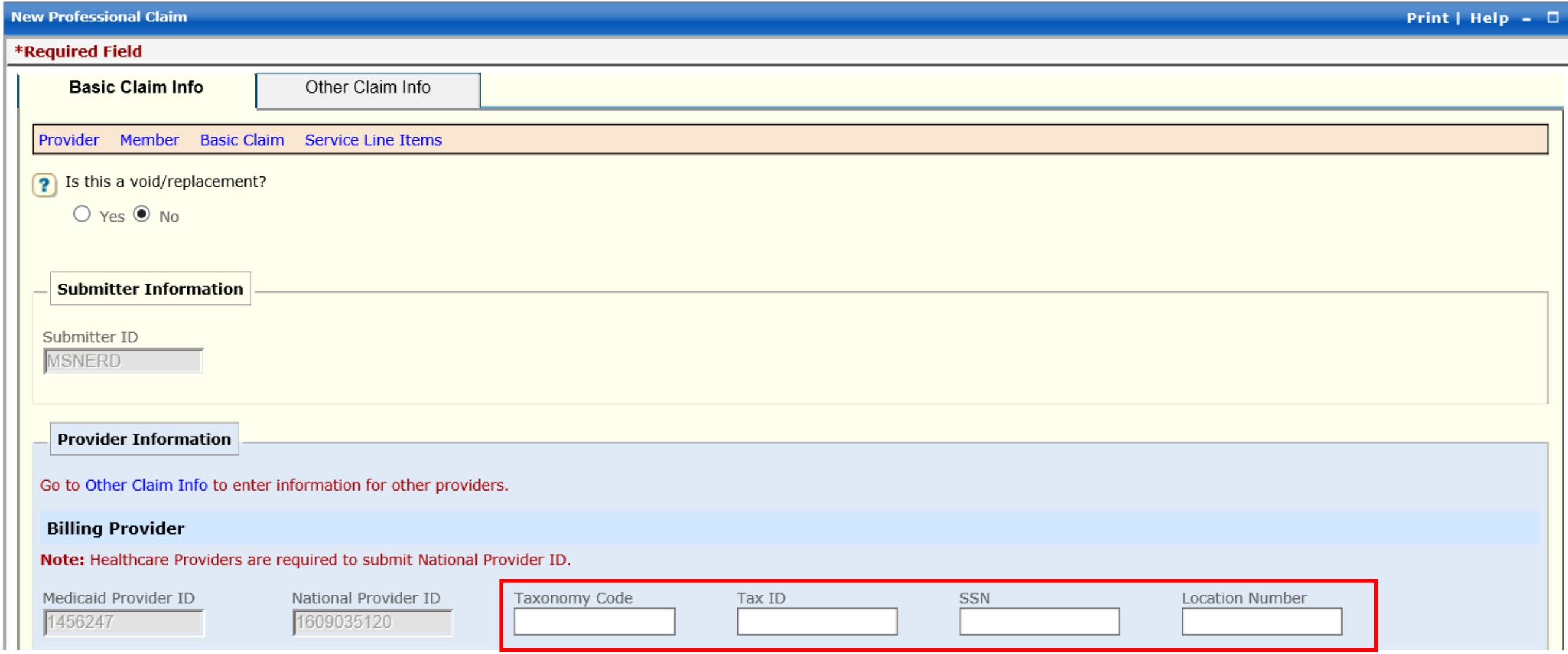
Log into the system using the **USER ID** and **Password**



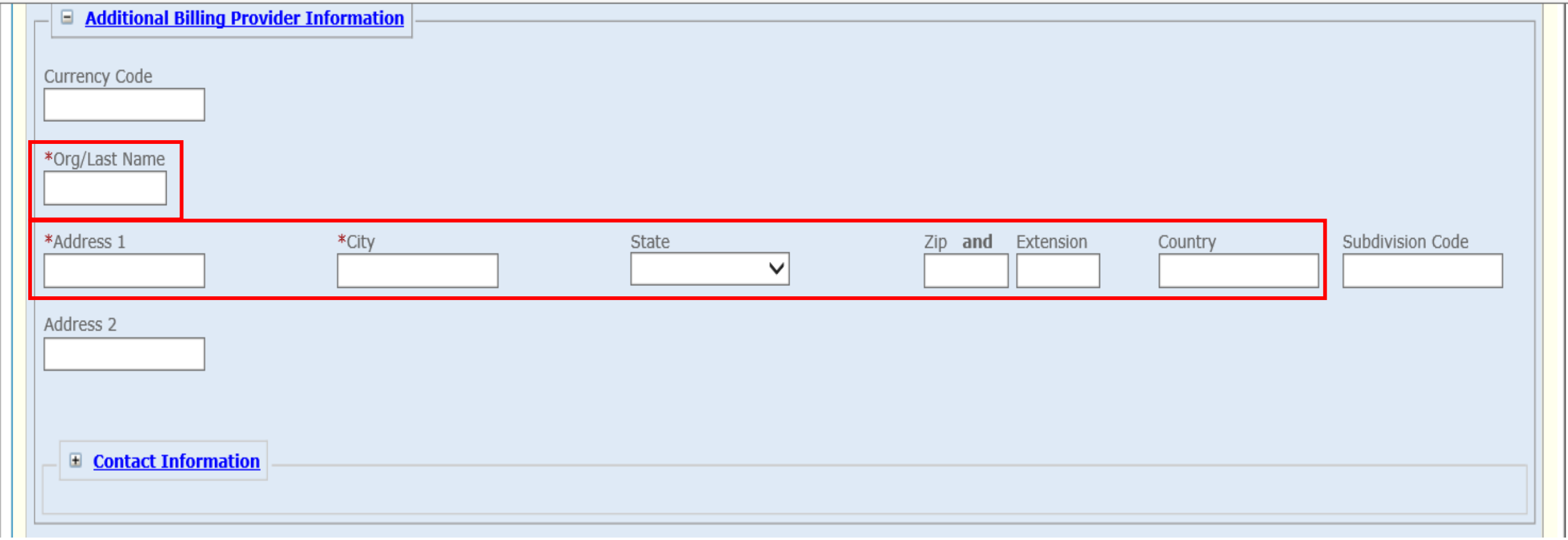
To submit a claim, go to the **Claims** tab;
Select **Create Claims**; then select **Create Professional Claim**



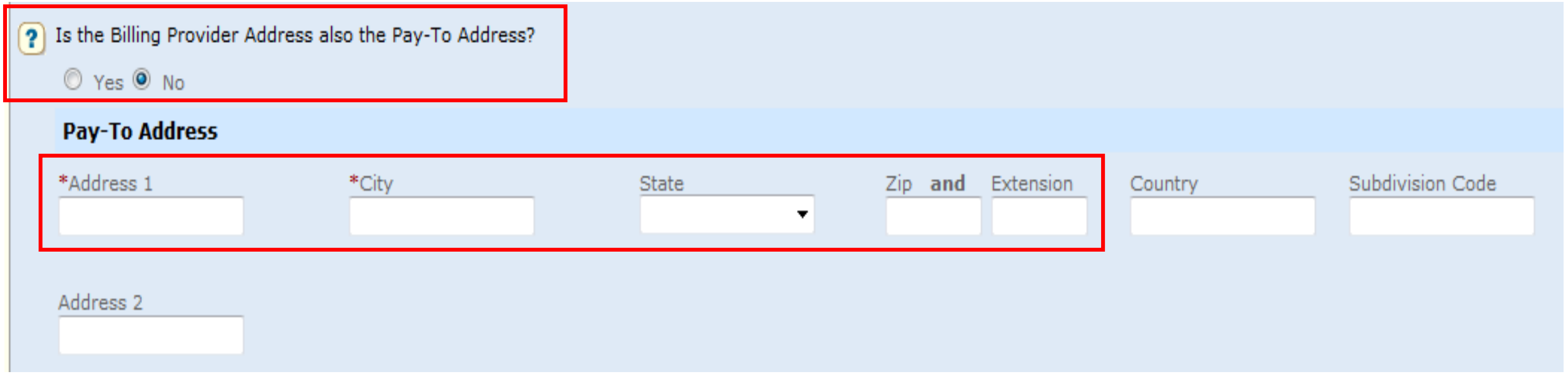
- The "New Professional Claim" screen will appear
  - Is this a void/replacement?
  - This field will default to "No." Select "Yes" only if you are voiding or replacing a previously processed claim.



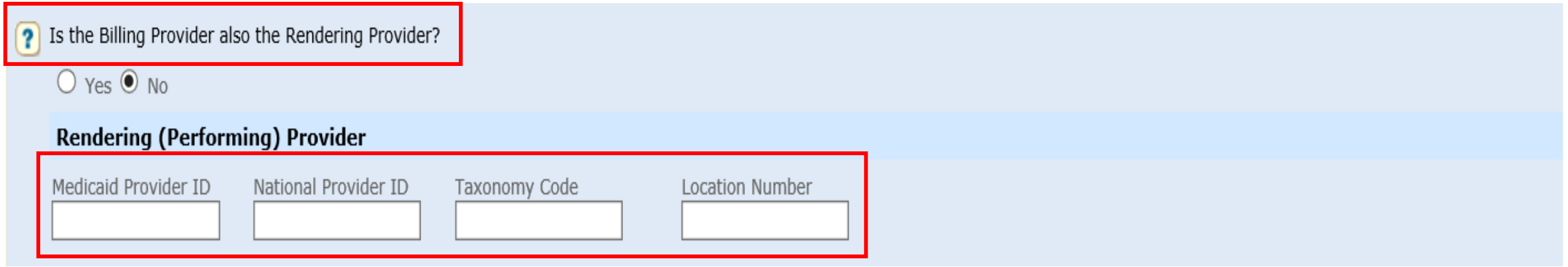
- Enter the Facility Taxonomy Code
- Enter your Tax ID
- Enter the Location Number BI (Billing)



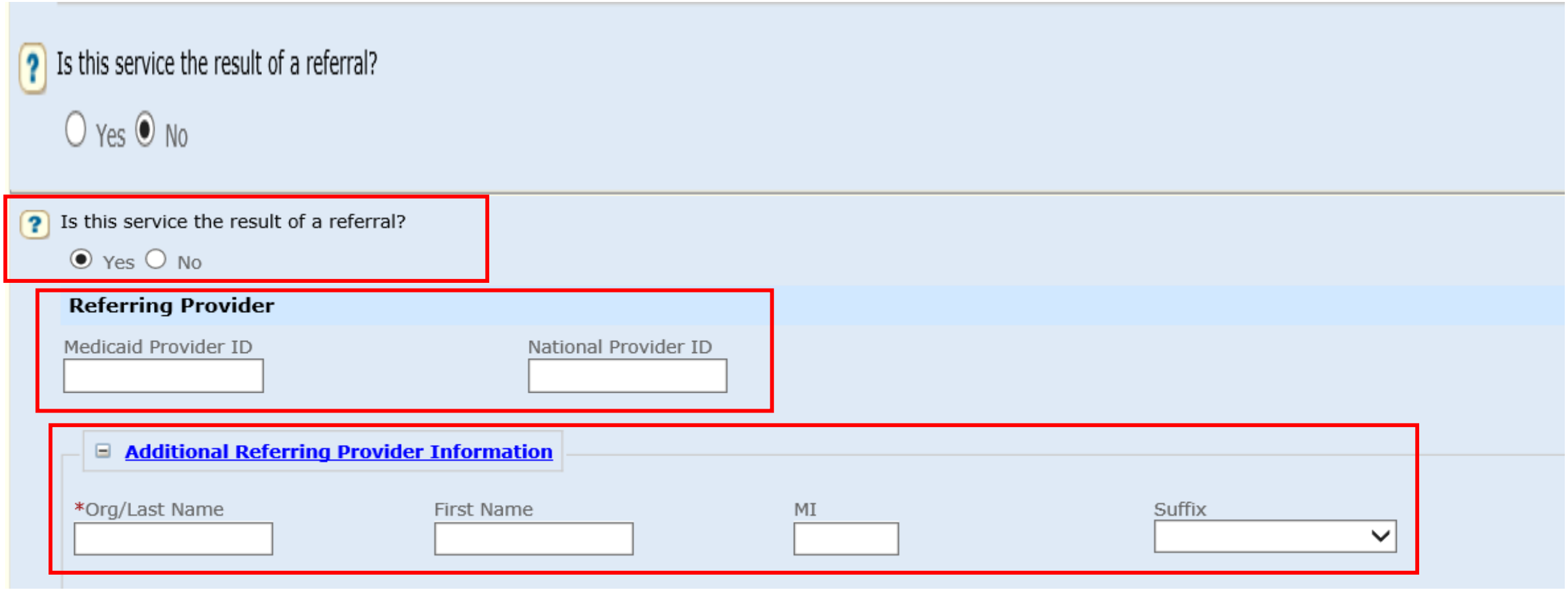
- Additional Billing Provider Information
  - REQUIRED
  - Enter your Facility Name, Address, City, State and Zip Code



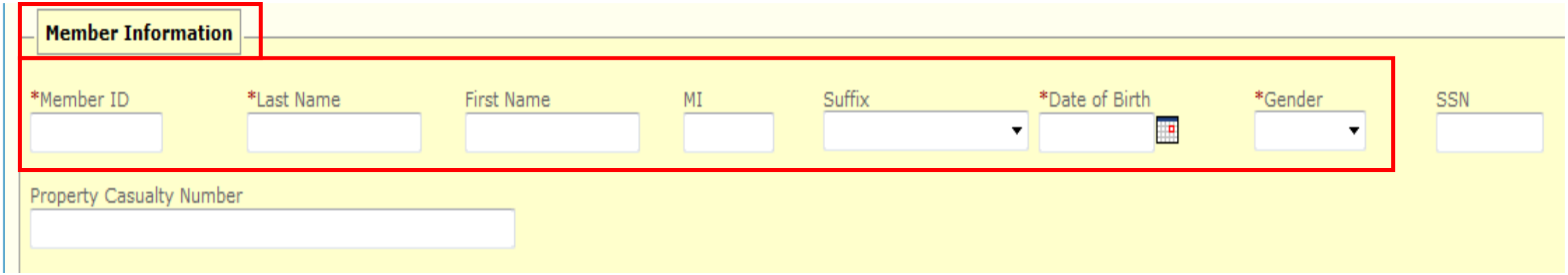
- Is the Billing Provider also the Pay-To Address?
  - Will default to “Yes”
  - Required - if Pay-To Address is different, select “No”
  - Complete the Pay-To Address section with the Facility Name, Address, City, State and Zip Code



- 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

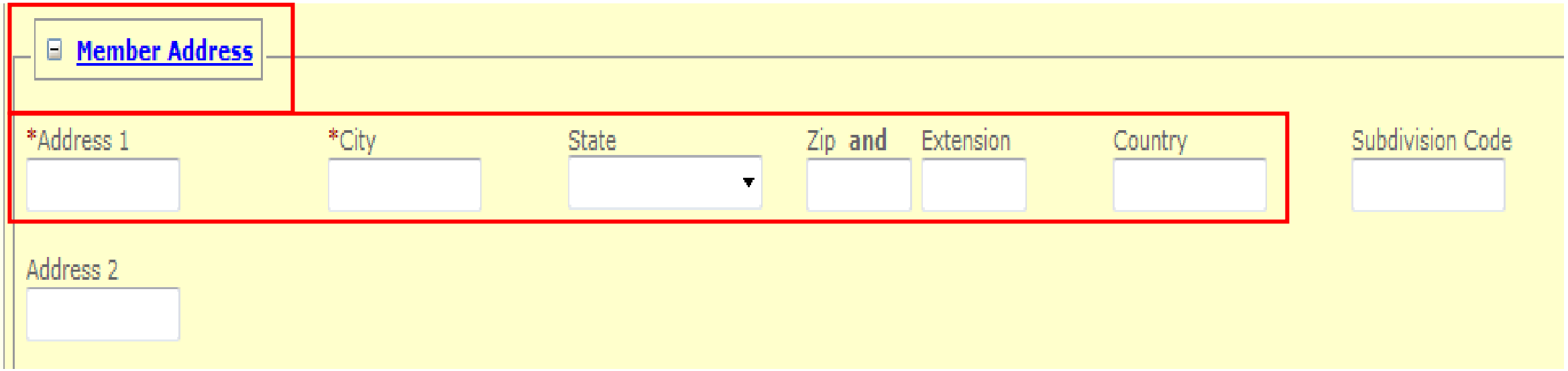


- Is this service the result of a referral?
  - Default “No”
  - Referring Provider Medicaid Provider ID and NPI (National Provider ID)
  - Org/Last Name and First Name
  - MI and Suffix – if applicable



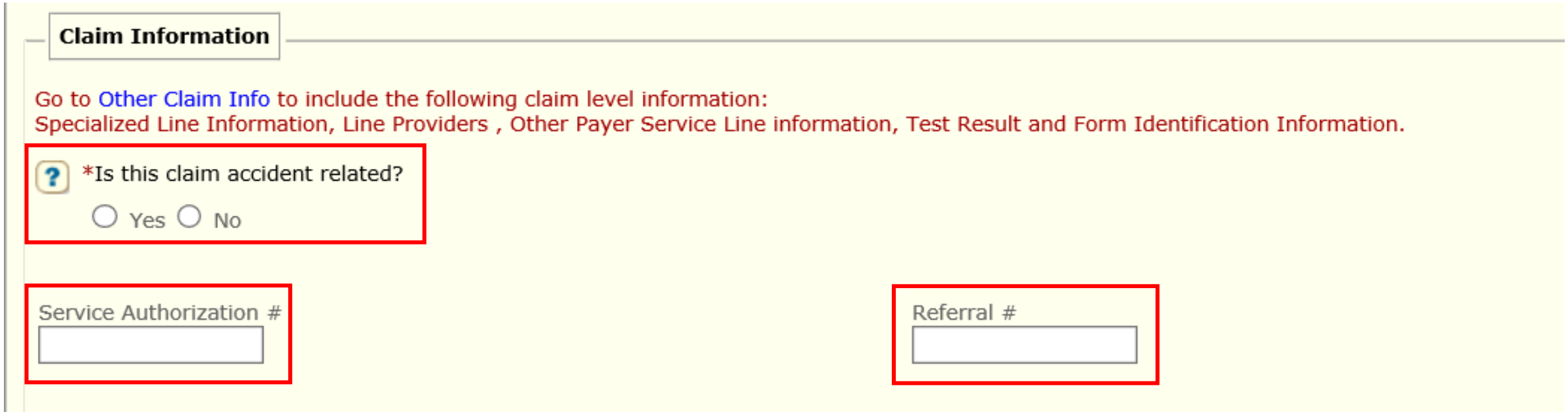
- Member Information

  - 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



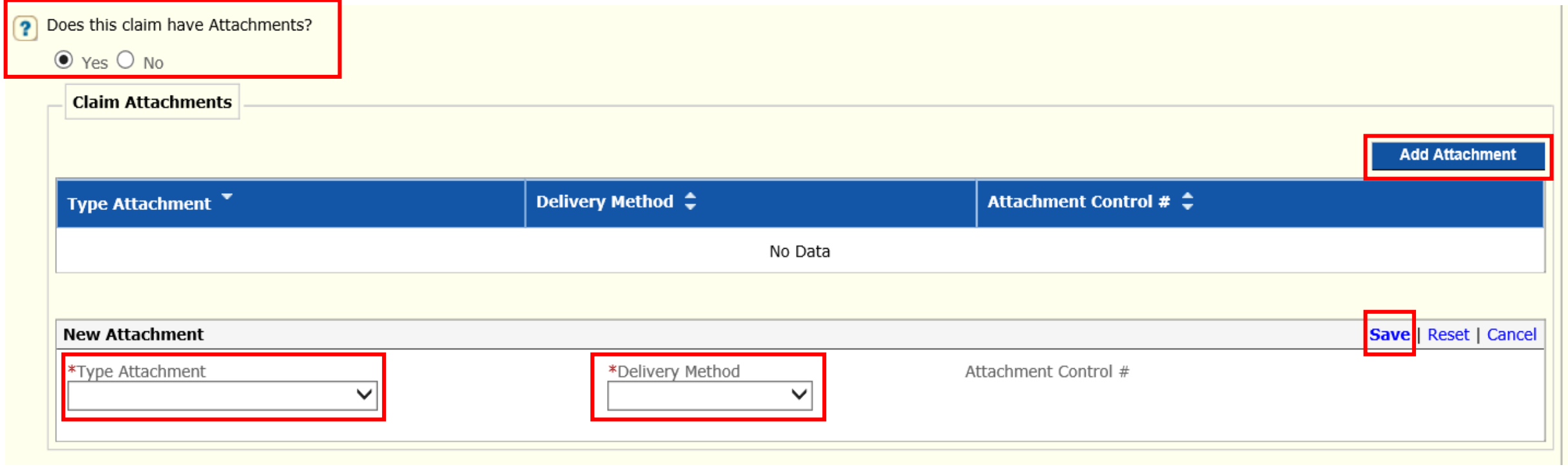
- Member Address
  - REQUIRED
  - Enter the Member's Address, City, State and Zip Code

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

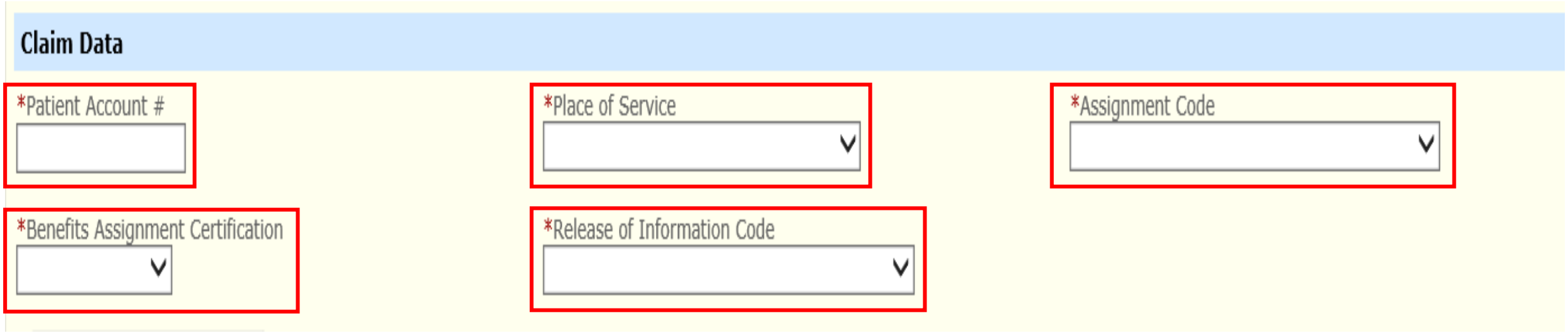


- Is this claim accident related?
  - Yes or No
- Service Authorization # - if applicable
- Referral # - if applicable

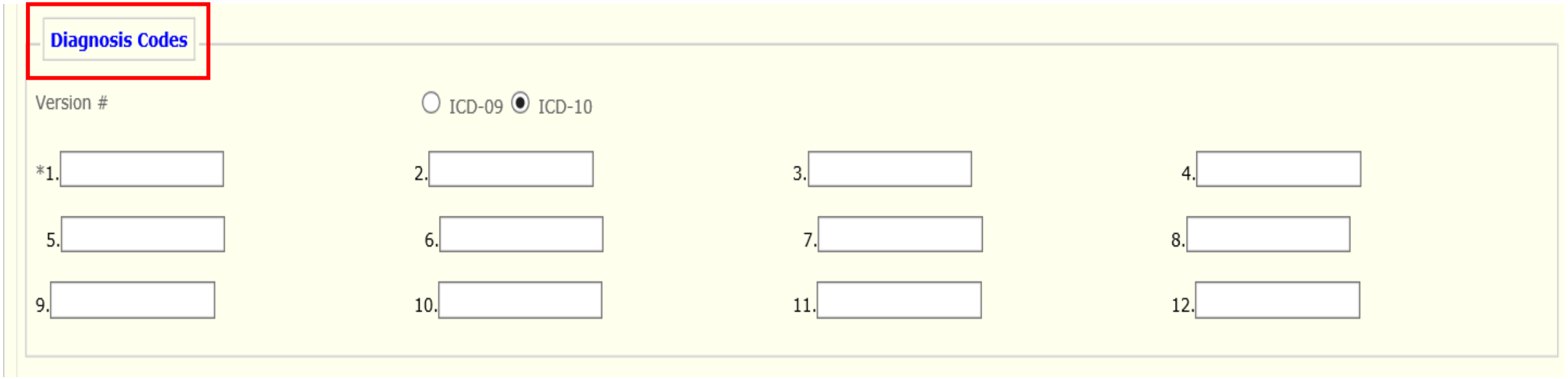
- Claim Note
  - Add any pertinent information for example proving the one year filing limit policy RA Date and TCN number



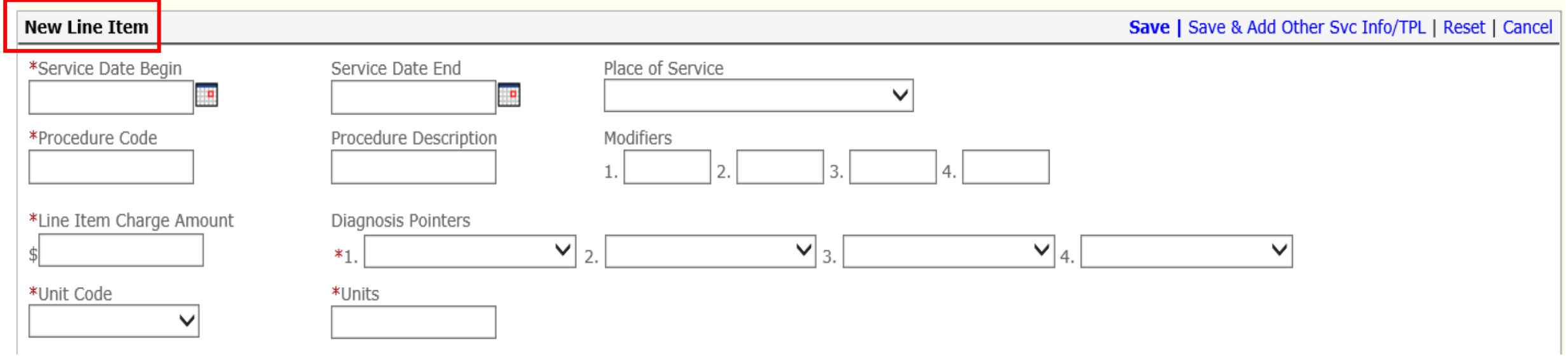
- Does this claim have Attachments? Yes or No
  - Yes
  - Add Attachment
  - Type Attachment
  - Delivery Method
  - Save



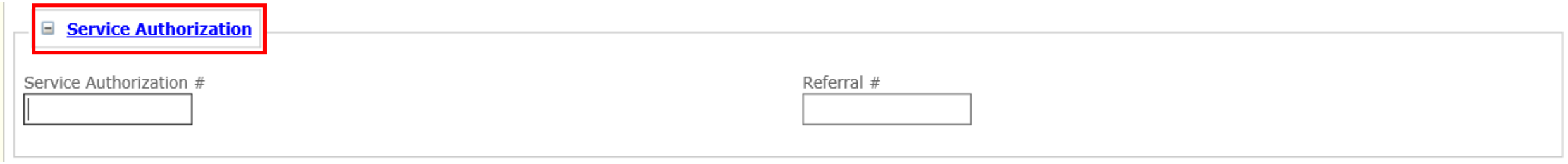
- Claim Data
  - Patient Account #
  - Place of Service
  - Assignment Code
  - Benefits Assignment Certification
  - Release of Information Code



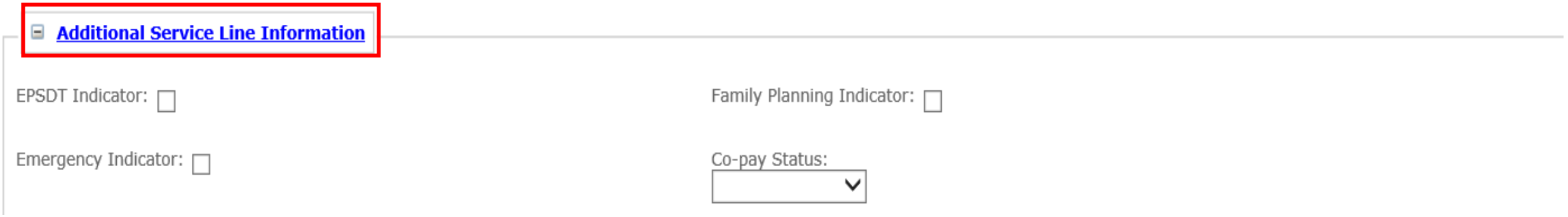
- Diagnosis Codes
  - REQUIRED
  - Version # - defaults to ICD-10, if date of service is older than 10/01/2015 select ICD-09
  - Principal Diagnosis Code
    - Enter the diagnosis code for the member's primary, secondary condition ect.



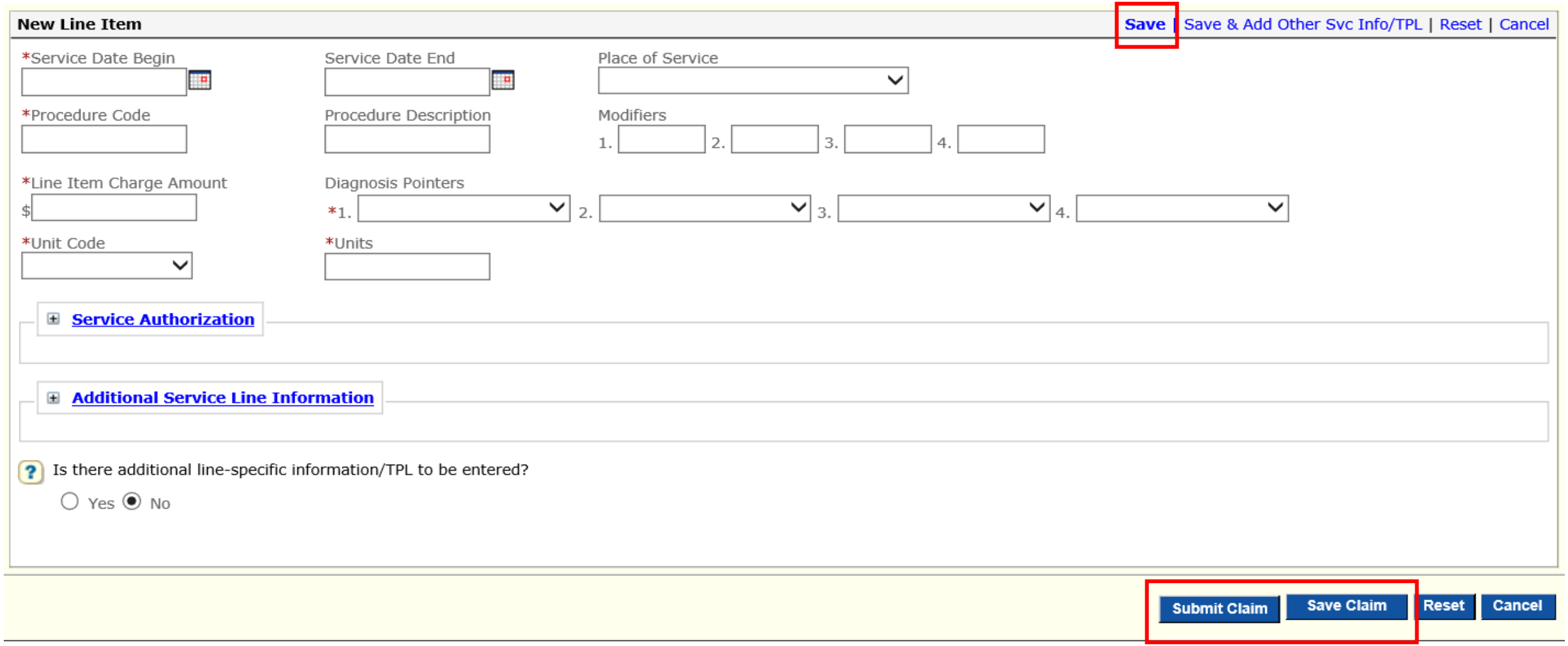
- New Line Item
  - Service Date Begin and Service Date End - Use format: MM/DD/YYYY
  - Place of Service
  - Procedure Code
  - Modifiers – if applicable
  - Line Item Charge Amount
  - Diagnosis Pointers – Primary, secondary ect.
  - Unit Code and Units



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



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



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

Claim Submitted

Print Help

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.

1 - 4 of 4

Remark Codes

Line #	Remark Code	Description
No Data		

- Print and Save for your records