Administrative Medical Examinations and Reports

Supplemental information for Oregon Medicaid providers

- ✓ Procedure codes and rates
- ✓ Sample authorization forms
- ✓ Billing forms
- ✓ Electronic billing / EDI

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NOTE: DMAP provides Information and instructions contained in this booklet as a supplement to the program policies found in the current Administrative Medical Examinations and Reports (Admin Exam) Oregon Administrative Rules. (Chapter 410 Division 150). See current Admin Exam rulebook for official policies regarding billing.

Administrative medical examinations and reports

Administrative medical examinations and reports

An administrative medical examination is an evaluation required by the Department of Human Services (DHS) to help determine eligibility and casework planning for various programs. Only the client's DHS caseworker can request an administrative exam.

Instructions are in Section 8 of the Worker Guide on the OHP Web site at www.oregon.gov/DHS/healthplan/data_pubs/wguide/main.shtml. For rules on exam requests, see OAR 410-150-0040.

Procedure codes and fee schedule

Section 8 of the DMAP Worker Guide lists the procedure codes used for administrative exams. The Administrative Examinations rulebook (OAR Chapter 410, Division 150) also lists the procedure codes to be used by the following providers:

- Medical and Ancillary Services Providers (OAR 410-150-0120)
- Hospital Providers (OAR 410-150-0160)
- Licensed Polygraphers (OAR 410-150-0200)
- Copy Services Providers (OAR 410-150-0300)

Providers billing for administrative examinations and reports must use the procedure codes entered on the DMAP 729 form(s) received from the DHS caseworker. See the Billing Information section of this supplement for more information.

Administrative medical exams and reports **do not require** prior authorization.

For the most current fee schedule information, go to the OHP Fee Schedule Web page at www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml.

Fee schedule - Hospitals only

Revenue Center Code	Exam description	Fee
229	Medical records copying fee, administrative. Includes copies of Admitting History/ Physical, Admission Summary, Consultations, Operative and Other Reports, and Discharge Instruction Sheet and Discharge Summary for (date)_____ admission as checked on DMAP 729D.	Usual charge
309	Drug screen qualitative; multiple drug classes chromatographic method, each procedure or drug screen qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class. Only for Child Welfare and OYA clients.	$22.00
309	Drug confirmation, each procedure. Only for Child Welfare and OYA clients.	$45.00
309	Alcohol and/or other drug testing, collection and handling, only specimen other than blood. Only for Child Welfare and OYA clients.	$15.00
424	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.	Usual charge
434	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.	Usual charge
500	Work related or medical disability examination by the treating physician. See current CPT for details. OR Work related or medical disability examination by other than the treating physician. See current CPT for details.	Usual Charge
918	Description determined by testing requested by worker (see 96100).	Usual Charge
919	Description determined by examination requested by worker (see 90801 or H1011).	Usual Charge

Fee schedule - Professional services

Procedure code	Exam description	Fee
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes. Limited to 1 hour.	$21.98
99172	Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision, with completion of the report on eye examination (DMAP 729C). See current CPT for details.	$91.83
96101	Psychological testing with interpretation and report, per hour. See current CPT for details. Limited to 6 hours per day.	$53.98
90801	Psychiatric diagnostic interview, examination. See current CPT and CPT Assist Volume II, Issue 3, March 2001 for details. Narrative report (90889) per recommended outline in Comprehensive Psychiatric or Psychological Evaluation (DMAP 729A). OR Use for psychosexual evaluation including assessment of history and degree of offending behavior, cognitive distortions, empathy, hostility, compulsivity and impulsivity. Only for Child Welfare, OYA, and DD Services clients.	$222.60
99080	Special reports. See current CPT for details. Use for Physical Residual Function Capacity Report (DMAP 729E). Use for Mental Residual Function Capacity Report (DMAP 729F). Use for Rating of Impairment Severity Report (DMAP 729G). Used during examinations or based on existing records.	$33.45
S9981	Medical records copying fee, administrative. Include progress notes, laboratory reports, X-ray reports, and special study reports since (date)_______. Include recent hospital admission records if available.	$18.65
99455	Work related or medical disability examination by the treating physician. See current CPT for details. May be paid in addition to 99080.	$161.94

Procedure code	Exam description	Fee
99456	Work related or medical disability examination by other than the treating physician. See current CPT for details. May be paid in addition to 99080.	$161.94
96118	Neuropsychological testing battery (e.g., Halstead-Reitan Neuropsychological battery, Wechsler memory scales and Wisconsin card scoring test) per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing report.	$53.98
96111	Development testing, extended with interpretation and report, per hour, up to 5 hours. See current CPT for details.	$104.05
90889	Preparation of report of patient's psychiatric status, history, treatment or progress. See current CPT for details. Use in conjunction with 90801 only.	$53.61
PIN02	Polygraph testing by licensed polygrapher with narrative report.	$166.12
54240	Penile Plethysmography. Only for Child Welfare, OYA, and DD Services clients.	$221.49
80100	Drug screen qualitative, multiple drug classes, chromatographic method, each procedure. Only for Child Welfare and OYA clients.	$23.59
80101	Drug screen qualitative, single drug class method, each drug class. Only for Child Welfare and OYA clients.	$23.59
80102	Drug confirmation, each procedure. Only for Child Welfare or OYA clients.	$48.25
H0048	Alcohol and/or other drug testing; collection and handling, only specimen other than blood. Only for Child Welfare or OYA clients.	$16.08
H1011	Family assessment by licensed behavioral health professional for state defined purposes. Use in combination with 96100 if needed. Only for Child Welfare and OYA clients.	$268.07
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination and straightforward medical decision making.	$27.82

Procedure code	Exam description	Fee
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: An expanded problem focused history, an expanded problem focused examination and straightforward medical decision making.	$48.41
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A detailed history, a detailed examination and medical decision making of low complexity.	$70.94
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history, a comprehensive examination, and medical decision making of moderate complexity.	$108.78
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history, a comprehensive examination, and medical decision making of high complexity.	$137.15
99241	Office consultation for the new or established patient, which requires these three key components: a problem focused history, a problem focused examination and straightforward medical decision making.	$37.28
99242	Office consultation for the new or established patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination and straightforward medical decision making.	$69.55
99243	Office consultation for the new or established patient, which requires these three key components: a detailed history, a detailed examination and a medical decision making of low complexity.	$95.42
99244	Office consultation for the new or established patient, which requires these three key components: a comprehensive history, a comprehensive examination and a medical decision making of moderate complexity.	$140.77

Procedure code	Exam description	Fee
99245	Office consultation for the new or established patient, which requires these three key components: a comprehensive history, a comprehensive examination and a medical decision making of high complexity.	$173.88

Sample authorization forms

The following pages contain samples of administrative exam and report authorization forms. These are only to be completed by the client's DHS caseworker.

These forms are also available on the DMAP Web site at www.oregon.gov/DHS/healthplan/data_pubs/forms/main.shtml.

DHS
Oregon Department
of Human Services

"Caseworker, see instructions on back"

① Patient's Name	② Insured's ID (Prime No)
③ SSN	④ Date of Birth

Administrative Medical Examination/ Report Authorization

AgencyUseOnly

⑤ Program	⑥ Branch	⑦ Case Number	⑧ Wkr ID
⑨ Case Name			Filing Sect 5

⑪

A Release of Information is Enclosed

⑩ Provider Number ______________________

This individual and the Department ask your help in determining his/her medical condition. He/she is seeking assistance because of the following complaints: ⑫ ____

⑬ Procedure Code	⑭ Description of Service	⑮ Amount to be Billed

All medical reports must be written and must contain a diagnosis, prognosis, and supporting objective findings. Functional impairments (changes in physical/mental functioning as a result of illness, injury, medication or surgery) and expected duration should also be included. The reports will only be accepted from Medicaid enrolled licensed medical and osteopathic doctors, optometrists, licensed clinical psychologists, licensed clinical social workers, physical therapists or occupational therapists as requested by the local branch.

16. Attached forms to be completed and returned:

- ❐ Comprehensive Psychiatric or Psychological Evaluation — See attached form DMAP 729A
- ❐ Report on Eye Examination — Complete attached form DMAP 729C
- ❐ Medical Record Checklist — See attached form DMAP 729D
- ❐ Mental Residual Function Capacity Report - Complete attached form DMAP 729F
- ❐ Physical Residual Function Capacity Report - Complete attached form DMAP 729E
- ❐ Rating of Impairment Severity Report - Complete attached form DMAP 729G

17. Branch Name and Address	18. Worker's Name	
	19. Date Requested	20. Telephone

Billing Information: In order to expedite services to this patient and payment to you, please return the report within 15 days to the branch office listed above. Use the ICD-9-CM diagnosis code V68.89. Send the CMS-1500 billing form to DMAP, PO Box 14165, Salem OR 97309. Hospitals send UB 92 to DMAP, PO Box 14956, Salem OR 97309. Copying services send CMS-1500 to DMAP, PO Box 14165, Salem OR 97309. **Relay the V68.89 diagnosis code to the Medicaid enrolled ancillary providers if additional DMAP-covered outpatient diagnostic services (e.g. lab, X-ray, special studies) are needed.**

Distribution: 1 Copy, Provider TO RETAIN 1 Copy, Provider TO RETURN with report 1 Copy, Case Record

Caseworker Instructions for Completion of DMAP 729

All blanks must be completed

1. Patient's Name........................Name of client to be seen by medical provider
2. Insured's ID/Prime No ....Eight alpha/numeric character field
3. SSN..Client's Social Security Number
4. Date of Birth............................Patient's Date of Birth
5. Program...................................Program (A1, 2, B3, D4, 5, P2, etc)
6. Branch......................................Branch number (2401, etc)
7. Case Number ....Case number under which client is identified
8. Worker ID................................Worker Identification code
9. Case Name ....Case name under which client is identified
10. Provider Number...................Medical provider number assigned by DMAP, found on PRV1 (See Computer Guide for instructions on accessing PRV1)
11. Address Box ....Name and address of medical provider
12. Patient's Complaint Area ......List stated medical or mental conditions
13. Procedure Code......................Procedure code of selected exam or report
14. Description of Service...........Description for selected examination or report from guidelines
15. Amount to be Billed..............Amount to be billed for selected examination or report from guidelines
16. Needed Reports Boxes..........If other 729's are used, check the appropriate box
17. Branch Name and Address...Legible branch name and mailing address
18. Worker's Name.......................Legible name of worker requesting examination or report
19. Date Requested.......................Date 729 sent to medical provider
20. Telephone ....Legible telephone number of worker requesting report

State of Oregon
Department of Human Services
Division of Medical Assistance Programs

Comprehensive Psychiatric or Psychological Evaluation

Patient's Name			Insured's ID (Prime No)
			Date of Birth
Agency Use Only			
Program	Branch	Case Number	Wkr ID
Case Name			Filing Sect 5

Please use the following outline for the Comprehensive Psychiatric or Psychological Evaluation.

I. Summary history
  A. Social (including family, educational and significant life events)
  B. Mental illness (including development of psychiatric symptoms, hospitalizations and course of illness to date)

II. Mental status examination including
  A. General appearance and interview behaviors
  B. Thought processes
  C. Thought content — delusions, hallucinations
  D. Affects
  E. Judgment
  F. Risk of harm to self or others
  G. Intellectual functioning
  H. Indication of organic impairment, if any
  I. Current social functioning and activities of daily living
  J. Severity of functional limitations
    1. Restriction of activities of daily living
    2. Difficulties in maintaining social functioning
    3. Deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (in work settings or elsewhere).
    4. Episodes of deterioration or decompensation in work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration or adaptive behaviors).

III. Substance abuse history and current pattern of use/abuse

IV. Diagnosis (must be substantiated above by history and mental status examination, using American Psychiatric Association nomenclature according to current DSM)

V. Prognosis/expected duration

VI. Treatment recommendations including medications

VII. Physical/health problems and treatment (if any)

State of Oregon
Department of Human Services
Division of Medical Assistance Programs

Patient's Name	Insured's ID (Prime No)
SSN	Date of Birth

Agency Use Only			
Program	Branch	Case Number	Wkr ID
Case Name			Filing Sect 5

Report on Eye Examination

Diagnosis ______________________________

____

Legal Blindness —To meet the criteria of legal blindness, the answer must be "Yes" to *one* of the following four questions:

1. Is the impairment of central visual acuity in the better eye after best correction to 20/200 or less? ❑ Yes ❑ No
2. Is the contraction of peripheral visual fields in the better eye to 10 degrees or less from the point of fixation; or ❑ Yes ❑ No
3. Is the contraction of peripheral visual fields in the better eye so the widest diameter subtends an angle no greater than 20 degrees; or ❑ Yes ❑ No
4. Is the contraction of peripheral visual fields in the better eye to 20 percent or less visual field efficiency? ❑ Yes ❑ No

What is the prognosis?

____

____

Is the condition progressive? ❑ **Yes** ❑ **No**

What is the expected duration of the condition? (circle one)

❑ Less than 60 days ❑ 60 days or longer

Will the condition deteriorate without treatment? ❑ **Yes** ❑ **No**

Is treatment indicated? ❑ **Yes** ❑ **No**

If "yes," what is the recommended treatment?

____

____

____

Examiner's Name (Please type or print.)	Date of Examination
Address	
Signature	Telephone Number

State of Oregon
Department of Human Services
Division of Medical Assistance Programs

Patient's Name			Insured's ID (Prime No)
SSN			Date of Birth
Agency Use Only			
Program	Branch	Case Number	Wkr ID
Case Name			

Medical Record Checklist

Please send copies of existing records as noted below

Information to request from hospital

- ❑ Hospital Admitting History and Physical Examination
- ❑ Hospital Admission Summary
- ❑ Hospital Discharge Summary
- ❑ Hospital Discharge Instruction Sheet
- ❑ Copies of consultant reports done while in hospital
- ❑ Psychological examination and reports
- ❑ Operative and pathology reports or summaries
- ❑ History and physical examination including height and weight
- ❑ Lab reports
- ❑ X-ray reports

Optional information to request from hospital

- ❑ Progress notes since ________________________
- ❑ Other ____

Information to request from doctor or clinic

- ❑ Progress notes since ________________________
- ❑ History and physical examination including height and weight
- ❑ Recent hospital admission and discharge records
- ❑ Lab reports
- ❑ X-ray reports
- ❑ Functional Classification of heart disease according to the New York Heart Association Criteria
- ❑ Angiography interpretations
- ❑ EKG interpretations
- ❑ Treadmill interpretation
- ❑ Pulmonary function tests, pre and post bronchodilators
- ❑ Arterial blood gases
- ❑ Evidence of metastasis
- ❑ Neurological findings
- ❑ EEG interpretation
- ❑ IQ test results, including sub-test scores
- ❑ Psychological examinations or reports
- ❑ Mental status including: evidence of delusions, hallucinations, disorientation, impaired concentration and affect
- ❑ Other ____

Comments: ____

State of Oregon
Department of Human Services
Division of Medical Assistance Programs

Client Name (Last, First, M.I.)				Insured's ID (Prime No)
SSN				Date of Birth
Agency Use Only				
Program	Branch	Case Number		Wkr ID
Case Name			Date Completed	Filing Sec 5

Physical Residual Function Capacity Report

Exertional Limitations

See patient name above. Please indicate the patient's ability to perform the functions listed below without experiencing severe palpitation, pain, fatigue, nausea with vomiting or difficulty breathing. **Based on an 8-hour day.**

1. Occasionally (2 hours or less) lift and/or carry, maximum:
   - ❑ Less than 10 pounds ❑ 10 pounds ❑ 20 pounds ❑ 50 pounds ❑ 100 pounds or more
2. Frequently (6 hours or more) lift and/or carry, maximum:
   - ❑ Less than 10 pounds ❑ 10 pounds ❑ 25 pounds ❑ 50 pounds or more
3. Stand and/or walk (with normal breaks) for a total of:
   - ❑ less than 2 hours in an 8-hour workday
   - ❑ at least 2 hours in an 8-hour workday
   - ❑ about 6 hours in an 8-hour workday
   - ❑ medically required hand-held assistive device is necessary for ambulation
4. Sit (with normal breaks) for a total of:
   - ❑ less than about 6 hours in an 8-hour workday
   - ❑ about 6 hours in an 8-hour workday
   - ❑ must periodically alternate sitting and standing to relieve pain or discomfort
5. Push and/or pull (including operation of hand and /or foot controls)
   - ❑ unlimited, other than as shown for lift and/or carry
   - ❑ limited in upper extremities
   - ❑ limited in lower extremities

Postural Limitations

❑ None established

Limitation	Frequently	Occasionally	Never
1. Climbing (ramp, stairs, ladder, rope, scaffolds)	❑	❑	❑
2. Balancing	❑	❑	❑
3. Stooping	❑	❑	❑
4. Kneeling	❑	❑	❑
5. Crouching	❑	❑	❑
6. Crawling	❑	❑	❑

Manipulative Limitations

☐ None established

Limitation	Frequently	Occasionally	Never
1. Reaching all directions (including overhead)	☐	☐	☐
2. Handling (gross manipulation)	☐	☐	☐
3. Fingering (fine manipulation)	☐	☐	☐
4. Feeling (skin receptors)	☐	☐	☐

Environmental Limitations

☐ None established

Limitation	No Restriction	Avoid Frequent Exposure	Avoid Occasional Exposure	Avoid All Exposure
1. Extreme cold	☐	☐	☐	☐
2. Extreme heat	☐	☐	☐	☐
3. Wetness	☐	☐	☐	☐
4. Humidity	☐	☐	☐	☐
5. Noise	☐	☐	☐	☐
6. Vibration	☐	☐	☐	☐
7. Fumes, odors, dusts, gases, poor ventilation, etc.	☐	☐	☐	☐
8. Hazards (machinery, heights, etc.)	☐	☐	☐	☐

Diagnosis

Prognosis

How long do you expect this condition to last?

Date of disability onset

Is patient compliant with treatment? ☐ **Yes** ☐ **No**

Would you recommend a psychological evaluation? ☐ **Yes** ☐ **No**

Additional Comments

Physician Name (Please type or print)

Address

Signature

Date

State of Oregon
Department of Human Services
Division of Medical Assistance Programs

Patient's Name				Insured's ID (Prime No)	
SSN				Date of Birth	
Agency Use Only					
Program	Branch	Case Number			Wkr ID
Case Name			Date Completed		Filing Sec **5**

Mental Residual Function Capacity Report

Mental Residual Function Capacity is evaluated using the following criteria based on the basic mental skills necessary to engage in competitive employment. A marked limitation would impair functioning to a greater extent than a moderate limitation.

In responding to the designated ratings of the following categories of mental functioning, it is essential that your responses and comments be based on your clinical assessment of the individual's current and past mental limitations and not on non-medical factors. For example, your assessment should not be based on such non-medical factors as the availability of job openings, the hiring practices of employers, cyclical economic conditions, technological changes in the work industry since the individual last worked, or upon the individual's preference not to do a particular type of work. (See, 20 CFR §§ 404.1566(c) and 416.966 (c)).

In responding to the ratings on this form, please do not include any limitations which you believe the individual has as a result of his or her alcoholism or drug addiction, if any. In other words, do not include limitations which would go away if the individual stopped using drugs or alcohol.

The following assessment form reflects the four criteria in Social Security Administration regulations concerning the basic mental demands of work. (See, 20 CFR §§ 404.1521 & 416.921). These four criteria, as well as those for other than "basic" mental abilities and aptitudes, are to be documented and evaluated in terms of the individual's maximum remaining ability to perform sustained work on a regular and continuing basis, i.e, 8 hours a day, for 5 days a week, or an equivalent work schedule.

DEFINITIONS OF RATING TERMS

Not Significantly Limited: No significant limitation in this area.

Moderately Limited: A limitation which seriously interferes with the individual's ability to perform the designated activity on a regular and sustained basis, i.e., 8 hours a day, 5 days a week, or an equivalent work schedule.

Markedly Limited: A limitation which precludes the ability to perform the designated activity on a regular and sustained basis, i.e., 8 hours a day, 5 days a week, or an equivalent work schedule.

Unable to Determine: Insufficient evidence to assess.

Using the above-listed DEFINITIONS OF RATING TERMS please assess the degree of limitation the individual experiences in the categories of mental functioning set out below by placing a check mark or X in the corresponding boxes.

Understanding and Memory

Limitation	Not Significantly Limited	Moderately Limited	Markedly Limited	Unable to Determine
1. The ability to remember locations and work-like procedures.	❑	❑	❑	❑
2. The ability to understand and remember very short and simple instructions.	❑	❑	❑	❑
3. The ability to understand and remember detailed instructions.	❑	❑	❑	❑

Sustained Concentration and Persistence

Limitation	Not Significantly Limited	Moderately Limited	Markedly Limited	Unable to Determine
4. The ability to carry out very short and simple instructions.	☐	☐	☐	☐
5. The ability to carry out detailed instructions.	☐	☐	☐	☐
6. The ability to maintain attention and concentration for extended periods.	☐	☐	☐	☐
7. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	☐	☐	☐	☐
8. The ability to sustain an ordinary routine without special supervision.	☐	☐	☐	☐
9. The ability to work in coordination with or proximity to others without being distracted by them.	☐	☐	☐	☐
10. The ability to make simple work related decisions.	☐	☐	☐	☐
11. The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods	☐	☐		☐

Social Interaction

Limitation	Not Significantly Limited	Moderately Limited	Markedly Limited	Unable to Determine
12. The ability to interact appropriately with the general public.	☐	☐	☐	☐
13. The ability to ask simple questions or request assistance.	☐	☐	☐	☐
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	☐	☐	☐	☐
15. The ability to get along with co-workers or peers without distracting them or exhibiting behavioral extremes.	☐	☐	☐	☐
16. The ability to maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness.	☐	☐	☐	☐

Adaptation

Limitation	Not Significantly Limited	Moderately Limited	Markedly Limited	Unable to Determine
17. The ability to respond appropriately to changes in the work setting.	☐	☐	☐	☐
18. The ability to be aware of normal hazards and take appropriate precautions.	☐	☐	☐	☐
19. The ability to travel in unfamiliar places or use public transportation.	☐	☐	☐	☐
20. The ability to set realistic goals or make plans independently of others.	☐	☐	☐	☐

Diagnosis **Prognosis**

Has or will this person's condition last at least 12 months? ☐ **Yes** ☐ **No**

If NO, how long do you expect this condition to last?

Date of Disability Onset: **Is patient compliant with treatment?** ☐ **Yes** ☐ **No**

Would you recommend physical evaluation? ☐ **Yes** ☐ **No**

Additional Comments:

Physician Name **Address**

(Please print or type)

Signature **Date**

State of Oregon
Department of Human Services
Division of Medical Assistance Programs

Rating of Impairment Severity Report

Patient's Name	Insured's ID (Prime No)
SSN	Date of Birth

Agency Use Only			
Program	Branch	Case Number	Wkr ID
Case Name		Date Completed	Filing Sec 5

Rating of Impairment Severity

1. Restriction of Activities of Daily Living (ADLs)

Activities of daily living include adaptive behaviors such as cleaning, shopping, cooking, using public transportation, paying bills, maintaining a residence, attending to grooming and hygiene, using a phone book, or using a post office, etc. Functioning in this area will be evaluated by determining the extent to which these tasks can be performed independently, appropriately, and effectively. A marked limitation is not the number of activities restricted, but the nature and overall degree of interference with function.

❑ None ❑ Mild ❑ Moderate ❑ Marked ❑ Extreme

Please cite evidence for this assessment rating: ______________________________

____

____

2. Social Functioning (SF)

Social functioning refers to the capacity to interact appropriately, independently, and effectively with other individuals on a sustained basis. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Social functioning in work situations may involve interacting with the public, responding appropriately to persons in authority, or cooperating with coworkers. A marked limitation in social functioning is not the total number of areas impaired, but the nature and overall degree of interference with function.

❑ None ❑ Mild ❑ Moderate ❑ Marked ❑ Extreme

Please cite evidence for this assessment rating: ______________________________

____

____

3. Concentration, Persistence, or Pace (CPP)

Concentration, persistence, or pace refer to the ability to sustain focused attention and concentration sufficiently long to permit the timely appropriate completion of tasks commonly found in work and other settings. Major impairment in this area can often be assessed through direct psychiatric and/or psychological testing, although test results should be supplemented with other relevant information when available. A marked limitation in concentration, persistence or pace is not the total number of areas impaired, but the nature and overall degree of interference with function.

❑ None ❑ Mild ❑ Moderate ❑ Marked ❑ Extreme

Please cite evidence for this assessment rating:______________________________

____

____

4. Episodes of Decompensation (DC)

Episodes of decompensation are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning. An episode is defined as lasting for at least two weeks.

The frequency of episodes is measured over an inclusive 12-month period prior to assessment. More frequent episodes of shorter duration (less than 2 weeks) or less frequent episodes of longer duration (more than 2 weeks) may also be considered in addressing the degree of impairment. Episodes of decompensation may be inferred from medical records or other relevant information concerning the nature and extent of the claimant's impairment related signs and symptoms.

❑ Never ❑ Once or twice ❑ Three ❑ Four or more

Please cite evidence for this assessment rating:________________________________

5. Is the client demonstrating a residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate?

❑ Yes ❑ No

If yes, please explain: ________________________________

6. If this person uses drugs or alcohol, would you expect any difference in your ratings of numbers 1-4 above if there were no drug or alcohol use?

❑ Yes ❑ No ❑ Doesn't apply

If yes, please state what you think each rating would be without the use of drugs or alcohol.

1. ADL	❑ None	❑ Mild	❑ Moderate	❑ Marked	❑ Extreme
2. SC	❑ None	❑ Mild	❑ Moderate	❑ Marked	❑ Extreme
3. CPP	❑ None	❑ Mild	❑ Moderate	❑ Marked	❑ Extreme
4. DC	❑ Never	❑ Once or twice	❑ Three	❑ Four or more	

Diagnosis	Prognosis

Will this person's condition last at least 12 months from the date of assessment? ❑ Yes ❑ No

Is patient compliant with treatment? ❑ Yes ❑ No

Would you recommend a physical evaluation? ❑ Yes ❑ No

Additional Comments ________________________________

Physician Name (Please type or print)	Address
Signature	Date

Billing information

National Provider Identifier

To ensure accurate claims processing, DHS requires all providers to register their National Provider Identifier (NPI) and taxonomy code(s) with DMAP.

To find out if you need a National Provider Identifier, or how to obtain one, go to the DHS NPI Web page at www.oregon.gov/DHS/healthplan/tools_prov/npi.shtml.

Billing for administrative exams and reports

Send the completed administrative examination and/or reports to the DHS branch office listed on the DMAP 729. Do not attach the DMAP 729 or any documents to the claim.

- **Medical providers, ancillary service providers, licensed polygraphers, and copy services providers** must bill using the professional claim format. See page 21 for instructions on how to complete CMS-1500 claim forms.
- **Hospital services** must be submitted using the institutional claim format. See page 28 for instructions on how to complete UB claim forms.

Where to mail claims

Send completed UB and CMS-1500 claim forms for administrative exams to:

DMAP
PO Box 14165
Salem, OR 97309

Electronic claims submissions

DHS accepts claims in the following electronic formats:

Batch claim format

If you want to submit claims in the 837 Professional or Institutional formats, you must become an approved Electronic Data Interchange (EDI) provider. To begin the authorization process, contact DHS EDI Support Services:

E-mail: DHS.EDIsupport@state.or.us

Phone: 888-690-9888

Web site: www.oregon.gov/DHS/edi

Individual claim format

Enrolled DHS providers authorized to access the Provider Web Portal can submit indiviual professional and institutional claims at https://www.or-medicaid.gov.

For more information about submitting claims on the Web portal, go to www.oregon.gov/DHS/healthplan/webportal.shtml.

Paper claim submissions

DMAP only accepts current, commercially available versions of paper claim forms. DMAP will return all other formats with a request to resubmit the claim in a valid claim format (Web, EDI, or commercially available form).

The information listed on the following pages is necessary for processing paper claims. You can enter information in more than the required fields, but **only** the information in the required fields is absolutely necessary (unless otherwise noted).

- Check your claim for missing, incorrect or misaligned information before it's mailed. Claim processing depends upon how well your claim is completed.
- **Each claim is a complete billing document.** Do not submit multi-page claims. If you do not have enough space on the form to bill all procedures provided, complete a new billing form for the rest of the procedures, or use the Provider Web Portal. Do not "carry over" totals from one claim to another.
- Use a separate claim form for each client.

Health Insurance Claim Form (CMS-1500)

DMAP does not supply this form. This federal form is available through local business forms suppliers, the Oregon Medical Association, or by calling the U.S. Government Printing Office at 1-866-512-1800.

Make sure information is left-aligned in the following fields:

- 1a - Client ID
- 2 - Patient Name
- 24A - Dates of Service - For detail line 1 only

If your forms are not to scale, or if the fields on your form are not correctly aligned, DMAP will manually enter your claim, which may delay processing of the claim.

8/05 CMS-1500 claim form instructions

General instructions for this form can be found on the National Uniform Claim Committee (NUCC) Web site at www.nucc.org/content/view/33/42/.

- Shaded boxes indicate the fields DMAP uses to process your claim (shaded at right). Your claim may suspend or deny if one or more these fields are empty or incorrectly completed. Unshaded fields are optional or required only in certain circumstances.
- Make sure information is left-aligned and correctly placed in fields marked ***"Left-align."*** Misaligned information in these fields will delay processing.

1a.	The eight-digit number found on the DMAP 729. ***Left-align***
2.	The client's name as it appears on the DMAP 729. ***Left-align***
21.	Enter the principal diagnosis/condition of the client indicated by current ICD-9-CM code number. Enter up to four codes in priority order. ♦ **Medical, ancillary, and copy services providers and licensed polygraphers:** Enter diagnosis code V68.89.
24A.	Enter the date (or first and last dates if consecutive days) that the service was provided. ***Left-align for line item 1*** ♦ **Medical providers, ancillary service providers and licensed polygraphers:** Enter the date the examination was done. ♦ **Copy services providers:** Enter the date the records were copied.
24B.	Enter "11" for the place service was provided.
24D.	Enter the procedure code as indicated on the DMAP 729.
24E.	Enter "1" to indicate the primary diagnosis from Field 21 for each service billed.
24F.	Enter the charge for the service listed on that line.
24G.	Enter "1." This number must match the number of days in Field 24A.
24I	**Leave this field blank.** If you include a qualifier on the line for the DHS provider number, the system reads the qualifier as part of the provider number and denies the claim due to invalid provider number.
24J.	In the shaded half of this field, enter the 6- or 9-digit DHS provider number of the provider who rendered the service. Do not enter an NPI.
26.	(Optional) Enter your unique patient account number here. It will be printed on your remittance advice.
28.	Enter the total of all of the charges listed in column F.
30.	Re-enter the total of all the charges listed in column F.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) — 1a

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — 2

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS — Single, Married, Other; Employed, Full-Time Student, Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. AUTO ACCIDENT? YES NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) — 21

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 24A	24B		24D	24E	24F	24G		NPI	24J
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ — 28

29. AMOUNT PAID $

30. BALANCE DUE $ — 30

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) — 33

a. NPI b.

33.	If you have an NPI, enter it in part "a" of this field. In part "b," enter your DHS provider number. ♦ These numbers identify the provider to whom the check should be sent (actual service provider *or* the provider's billing service). ♦ If you leave part "b" blank, DHS will use the NPI in part "a" to process your claim, which may result in DHS processing the claim under the wrong DHS provider number. ♦ Do not enter qualifiers in these fields. If you enter a qualifier, the system will read it as part of the provider number and deny for invalid provider number.

Uniform Billing (UB) Claim Form

DMAP does not supply this form. This form is available through local business forms suppliers, or by calling the Standard Register Company, Forms Division at 800-755-6405.

Make sure information is left-aligned in the following fields:

- 4 - Type of Bill
- 6 - Statement From and Through Dates
- 8b - Patient Name

If your forms are not to scale, or if the fields on your form are not correctly aligned, DMAP will manually enter your claim, which may delay processing of the claim.

UB-04 claim form instructions

Fields on the UB claim form are called Field Locators (FLs).

- Shaded boxes indicate the fields DMAP uses to process your claim (shaded at right). Your claim may suspend or deny if one or more these fields are empty or incorrectly completed. Unshaded fields are optional or required only in certain circumstances.
- Make sure information is left-aligned and correctly placed in fields marked ***"Left-align."*** Misaligned information in these fields will delay processing.

1.	Provider Identification: Enter provider name, mailing address, and ZIP code.
3.	Patient Control Number (Optional): Enter the number you assign to the account. If you enter the patient account number here, DMAP will print this information (up to 12 characters) on your RA.
4.	Type of Bill: Enter 131.
6.	Statement Covers Period: Use MMDDYY (month, day, and year) numeric format (example: 102806). ♦ Both the "From" and "Through" date is the date the service was provided.
8b.	Patient's Name: Enter the name as it appears on the DMAP 729. ***Left-align***

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME a | b

9 PATIENT ADDRESS a | b | c | d | e

10 BIRTHDATE | 11 SEX | 12 ADMISSION 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														
b														

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE ____ OF ____	CREATION DATE		TOTALS			

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A							57
B							OTHER
C							PRV ID

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX | A | B | C | D | E | F | G | H | 68

I | J | K | L | M | N | O | P | Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL | LAST FIRST

77 OPERATING NPI QUAL | LAST FIRST

78 OTHER NPI QUAL | LAST FIRST

79 OTHER NPI QUAL | LAST FIRST

80 REMARKS | 81CC a | b | c | d

12.	Admission Date: Use MMDDYY format. Enter the actual admission date, even if the patient was not eligible on that date.
14.	Date of Birth: Use MMDDYY format. This information is not required but may help DMAP process the claim.
42.	Revenue Center Codes: Enter the code indicated on the DMAP 729. ♦ **Line 23 -** Enter 0001.
44.	HCPCS/Rates: If the Revenue Center Code entered requires a procedure code according to OAR 410-150-0160 (Procedure Code Table - Hospital Providers), enter the 5-digit code here. Do not enter a daily rate in this field; this will cause the claim to deny for an invalid procedure code.
46.	Units of Service: Enter total units of service.
47.	Total Charges: Enter the usual charge or the amount indicated per OAR 410-150-0160 (Procedure Code Table - Hospital Providers). ♦ **Line 23 -** Enter the sum of all charges here.
56.	NPI: Enter your 10-digit National Provider Identifier (NPI).
57.	Other Provider ID: Enter your DHS provider number on line C. Do not enter other numbers (*e.g.*, Medicare).
60.	Insured's Unique ID: On line C, enter the patient's Client ID number as found on the DMAP 729.
67.	Principal Diagnosis Code: Enter V68.89 (Encounters for other specified administrative purpose).
79.	Other Physician ID: Enter the NPI, DHS provider number, and name of the physician who rendered service. *To enter NPI:* Enter the 10-digit NPI of the physician who rendered service. *To enter DHS provider number:* Enter the six- or nine-digit DHS provider number or UPIN of the physician.

Remittance advice

The paper remittance advice (RA) tells you about payment, denial, or other actions taken on a claim. If you are expecting a paper check, you will find it on the third page of your RA. Claims "in process" (suspended) will also appear on your RA.

- The information you see on the RA is the information our system used to process your claim. If you receive an incorrect payment, you must adjust the claim using the Individual Adjustment Request (DMAP 1036) or Provider Web Portal. If DMAP made no payment, your RA will tell you to resubmit or adjust the claim.
- It is important to distinguish between a claim and an RA. You may receive one RA for many clients. Each line on the RA indicates an individual claim. One problem claim will not delay payment for the other claims listed on the RA.

For more information about the remittance advice, go to DMAP's Remittance Advice Web page at www.oregon.gov/DHS/healthplan/tools_prov/read-ra.shtml.

Electronic remittance advice

Providers who submit electronic claims in the 837 format can choose to receive the 835 Fee for Service Payment/Advice transaction. Like the paper RA, the 835 transaction displays the number of claims and the adjudication status of your claims in Oregon's Medicaid system. It does not contain suspended claim information.

The 835 contains HIPAA Claim Adjustment Reason Codes. A list of these codes can be found on the Washington Publishing Web site www.wpc-edi.com/content/view/180/223/. For more detailed codes, refer to the paper RA.

To sign up for the 835 transaction, contact DHS EDI Support Services.

Web portal claim search

Instead of waiting for the paper Remittance Advice to come in the mail, authorized providers can review previously submitted claims on the Provider Web Portal at https://www.or-medicaid.gov and adjust, void, or resubmit claims as needed.

For more information, go to the Provider Web Portal resources page at www.oregon.gov/DHS/healthplan/webportal.shtml.

Correcting claims

You have three options to adjust a claim that you submitted and DHS processed:

- Send a paper DMAP 1036 Individual Adjustment Request (see the Forms section);
- Adjust the claim electronically using the Provider Web Portal; or
- Submit the 837P transaction (refer to the 837 Companion Guide).

If DHS denied your claim, you can submit a corrected claim on paper, Web, or the 837.

Forms

All DMAP forms are available electronically on the Web at www.oregon.gov/DHS/healthplan/forms/omapforms.shtml.

DMAP 1036 - Individual Adjustment Request

Overpayments, underpayments and payments received after DMAP has paid a claim can be resolved through the adjustment process.

- Use the DMAP 1036 only to request adjustments for adjudicated claims. Do not use the DMAP 1036 for denied claims. If DMAP denied a claim that you think DMAP should have paid, you must correct and re-submit the claim for processing.
- To order the Individual Adjustment Request form, complete and submit the DMAP 2420 (Provider Forms Request) to DHS Forms Distribution, 550 Airport Rd SE, Salem, OR 97310.
- This form is also available on the DHS Web site at http://dhsforms.hr.state.or.us/Forms/Served/OE1036.pdf.

How to complete the Individual Adjustment Request

Most required information is printed on the RA. You must have an RA for the claim to complete this form. You may submit documentation to support your request.

1.	Check the appropriate box if this request is an underpayment (DMAP paid too little) or an overpayment (DMAP paid too much).
4.	Enter the 13-digit Internal Control Number (ICN).
5.	Enter the date printed at the top of the RA.
6.	Enter the client's name. Use the same name as is shown on the Medical Care ID.
7.	Enter the client's recipient ID number.
8.	This space is for your provider name.
9.	Enter your 6- or 9-digit provider number.
10.	Enter your 10-digit NPI, if available.
11.	This column contains possible areas you might want to correct. Only check the box you want to change. ♦ Other - Use this box if none of the above address your problems.
12.	Use the line number from the original claim you are adjusting.
13.	Enter the date you performed the service.
14.	Enter the incorrect information submitted on your original claim.
15.	Enter the corrected information.
16.	Give additional information or explain your request, if necessary.
17.	The signature of the provider or other authorized person must be in this space.

Individual Adjustment Request

DMAP Use Only

✓ Complete this form to request an adjustment.

✓ Please keep a copy and do not use red ink.

(1) **Type of Adjustment:** ❑ Underpayment – Request additional payment
❑ Overpayment – Please deduct from subsequent payment

(2) **Attach the following:**
- ✓ Claim (corrected copy)
- ✓ Remittance Advice (copy)
- ✓ Financial planner (NH only)

(3) **Return nursing home adjustment requests to:**
DMAP – NH
PO Box 14954
Salem, OR 97309

Return all other adjustment requests to:
DMAP
PO Box 14952
Salem, OR 97309

Enter the following data from your Remittance Advice (RA):

(4) **Internal Control Number** | (5) **RA Date**

(6) **Recipient Name** | (7) **Recipient ID Number**

(8) **Provider Name** | (9) **Provider Number**

(10) **NPI**

(11) Description of original error	(12) Line No.	(13) Service Date	(14) Wrong Information	(15) Right Information
☐ Place of Service				
☐ Procedure Code/NDC/Rev Code				
☐ Modifier				
☐ Quantity/Unit				
☐ Diagnosis				
☐ Prescribing/Rendering Provider				
☐ Billed Amount/Total Billed				
☐ Medicare Payment				
☐ Other Insurance/Patient Liability				
☐ Co-Insurance				
☐ Other				

(16) **Remarks**

(17) **Requester's Name** | **Phone #** | **Date**

Individual Adjustment Request Instructions

1. **Type of Adjustment** – Check the appropriate box.
4. **Internal Control Number (ICN)** – Enter the 13-digit ICN from the Remittance Advice (RA).
5. **RA Date** – Enter the date printed on the RA.
6. **Recipient Name** – Enter the recipient's name.
7. **Recipient ID Number** – Enter the recipient’s ID number.
8. **Provider Name** – Enter your provider name.
9. **Provider Number** – Enter your nine-digit DHS provider number.
10. **National Provider Identifier (NPI)** – Enter your NPI number.
11. **Description of original error** – This column lists possible errors to be corrected.
12. **Line Number** – Enter the line number from the RA.
13. **Service Date** – Enter the date, or date range, of service for the service provided.
14. **Wrong Information** – Enter the incorrect information submitted on your original claim.
15. **Right Information** – Enter the correct information.
16. **Remarks** – Enter any other information you think necessary to accurately adjust your claim.
17. **Requester’s Name** – Enter the provider or authorized representative’s name.

DHS
Oregon Department of Human Services

Division of Medical Assistance Programs

DMAP Forms Request

Instructions:

1. Fill in the Provider information at right (type or print clearly).
2. Order only those forms listed in the chart below. CMS 1500 Billing Forms are NOT available through DAS printing or DMAP.
3. Fill in the number of packages column.
4. Fold page in thirds, seal with adhesive strip, affix postage. Mail to:
   DAS Distribution Center
   550 Airport Rd SE
   Salem OR 97310

Provider Name		
Street Address **(NOT PO Box)**		
City	**State**	**ZIP**
Area Code & Phone		

Forms available in packages of 50

CMS 1500 billing forms are available through business forms suppliers.

Form #	Title	Qty	Packages
DMAP 2420	DMAP Forms Request cards (5 max)		
DMAP 405T	Med. Transportation Order		
DMAP 406	Med. Transport. Eligibility Screening & Med. Transportation Order		
DMAP 505	Medicare/Medicaid Billing Inv. (cont.)		
DMAP 741	Hysterectomy Consent English Spanish		
DMAP 742A	Consent to Sterilization English Spanish		
DMAP 742B	Ages 15-20 Consent to Sterilization English Spanish		
DMAP 1036	Individual Adjustment Request		

The above forms and other DMAP forms are available on DMAP's Web site at www.oregon.gov/DHS/healthplan

DMAP 2420 (Rev. 02/08)

____

____

____

Place
Postage
Here

DAS Distribution Center
550 Airport Rd SE
Salem OR 97310