



# Dental Services

## Supplemental information for Oregon Medicaid providers

- ✓ Prior Authorization
- ✓ Billing Instructions
- ✓ Billing Forms
- ✓ Electronic Billing / EDI

January 7, 2011



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**NOTE: Information and instructions contained in this booklet are provided as a supplement to the program policies found in the current Dental Services Oregon Administrative Rules (Chapter 410 Division 123). See current Dental Services rulebook for official policies regarding billing.**

# **Prior authorization**

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## General information

The Dental Services Administrative Rulebook outlines the services requiring prior authorization and specific requirements for submitting prior authorizations to the Division of Medical Assistance Programs (DMAP).

**All hospital dentistry requires prior authorization.** See OAR 410-123-1490 for administrative rule on hospital dentistry and specific instructions on obtaining prior authorization.

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## How to get prior authorization (PA) – *see OAR 410-123-1160 for more information*

The following procedures mainly apply to fee-for-service clients whose prior authorizations are authorized by DMAP. For clients in a managed care plan, refer to the plan for their PA procedures as appropriate.

- **Hospital dentistry is authorized by the client’s medical plan.** If the client does not have a medical managed care plan (type FCH or PCO on the Managed Care section of the Web portal Eligibility Verification response screen), then DMAP authorizes hospital dentistry for that client.
- **Dental services are authorized by the client’s dental plan.** If the client does not have a dental managed care plan (type DCO on the Managed Care section of the Web portal Eligibility Verification response screen), then DMAP authorizes dental services for that client.

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## Information needed to request PA

Use the DHS 3971 form or the Provider Web Portal to submit PA requests. For information on how to submit PA requests using the Provider Web Portal, go to [www.oregon.gov/DHS/healthplan/webportal.shtml#authorization](http://www.oregon.gov/DHS/healthplan/webportal.shtml#authorization).

Submit documentation for prior authorization requests for OHP fee-for-service (“open card”) clients to the following fax numbers. Both numbers are in Salem:

- Routine requests: 503-378-5814
- Immediate/urgent requests: 503-945-9908

Fax required documentation accompanied by the EDMS Coversheet (DHS 3970). See Forms section for sample forms and instructions.

The following procedures are for services authorized by DMAP.

### Hospital dentistry requests

You must submit prior authorization requests for hospital dentistry on the DHS 3971 (DHS Prior Authorization Request) form. See Forms section for DHS 3971 instructions.

## All other PA requests

In addition to the DHS 3971, attach a completed ADA 2006 claim form as indicated below. Refer to the ADA claim form instructions on pages 8-10 for more information.

Required information	Field
Type of transaction: Request for Preauthorization	1
Patient's name	20
Patient's ID	15
Patient's date of birth	13
Billing Dentist's name	48
Billing Dentist's NPI	49
Billing Dentist's DHS Provider ID	52A
Auto accident box (as applicable)	45
Tooth number or letter, per service (as applicable)	27
5-digit ADA procedure code, per service	29
Description, per service	30
Remarks for unusual services (attach additional information if needed)	35
Treating Dentist's signature and date of request	53
Treating Dentist's NPI	54
Treating Dentist's DHS Provider ID	58

## Contacts for Prior Authorization requests

### Managed care plan members

Refer to the following chart to determine who to contact for PA. Check eligibility using the Provider Web Portal to determine the client's managed care coverage.

Web portal eligibility information (see Managed Care section)	PA Authority	
	Hospital Dentistry	Other Dental Services
DCO coverage only	DMAP	Dental Plan
FCHP or PCO coverage only	Medical Plan	DMAP
Both DCO and FCH/PCO coverage	Medical Plan	Dental Plan

When the plan is the PA authority for the service being requested, contact the plan to determine their procedures.

## Fee-for-service clients

Services will be authorized by:

DMAP Dental Coordinator  
2575 Bittern St NE  
Salem, OR 97301

Phone: 503-945-9891

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## Prior Authorization Notices

DMAP issues the following types of Prior Authorization Notices:

- Notice of Prior Authorization: The PA number is in Field 11.
- Notice of Denial.
- Other notices that inform the provider that information is needed to complete the PA request, or that no PA is required.

The PA number will always be a **ten digit number** beginning with the number “0.” For nine-digit numbers issued before December 2008, a leading zero will be the tenth digit. When appropriate, place this number in Field 2 of the ADA claim form.

DMAP mails the following notices to the requesting provider’s main mailing address.

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## **Description of the fields of the Notice of Prior Authorization:**

1. The date DMAP generated this notice.
2. Provider's name and address as they appear on DMAP records.
3. The client's name.
4. Description of the type of service authorized.
5. CDT codes for the authorized service.
6. Procedure code descriptions for the authorized service.
7. The amount and units requested by the provider on the original PA request.
8. The amount and units approved by DMAP.
  - ◆ If a specific dollar amount is printed here, that means DMAP will not pay more than this limit. DMAP may pay less depending on the actual services billed.
  - ◆ "DMAP Rate": Is printed when DMAP sets no specific dollar limit. This means DMAP will pay up to its maximum allowable rate, depending on services billed. In both cases, if there is TPR, DMAP's payment is reduced by the TPR payment.
9. Name of servicing provider.
10. The client's 8-digit ID number (for billing DMAP).
11. PA Number: When billing for the authorized service, place this number in Field 2 on the ADA 2006, Field 23 on the CMS-1500 or in Field 19 on the DMAP 505 claim form, when appropriate.
12. The valid date range for the authorized service. The date of service must fall between these two dates, and the client must also be eligible on the actual date of service.
13. When the prescribing or referring provider's name is listed in this field, it must be used when billing DMAP. Your billing may require a referring provider number when the client is restricted to a Primary Care Manager (PCM) or the service requires referral.
14. Additional notes: A space for notes entered by the reviewer for the provider.
15. The client's name and address.
16. The DHS branch office serving the client.
17. The DHS office and reviewer who approved the PA.
18. If DMAP sends copies of this notice to other entities, such as the the client's branch office, that information will display here.



# Oregon

Theodore R. Kulongoski, Governor

Department of Human Services

500 Summer St NE  
Salem, OR 97301-1079



Date of Notice: 12/09/2008 ①

Provider Name ②

### Street Name

City, State ZIP

### Notice of Prior Authorization

DHS authorizes the following item(s) or service(s) to Jane Doe for the dates of service listed below.

PROVIDER: Prior authorization (PA) does not guarantee payment. All rules for service must be met. See your program's Oregon Administrative Rules (OARs). In addition:

- The client must be eligible on the date(s) of service.
- The client must receive service(s) within the dates approved below.
- When you bill DHS, any third-party payments will reduce the billable amount. You must make full use of any other resource before billing DHS.
- CAF-Child Welfare clients must receive consent for surgery from the CAF-Child Welfare branch.
- Attach all required reports and forms to your claim. See your provider rules.

*This letter contains protected health information (PHI) from DHS and is covered by the Electronic Communications Privacy Act, 18 U.S.C. Sec. 2510-2521 and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, which is intended only for the use of the individual or entity named in the letter. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.*

PA Assignment:	Physical Therapy Services ④			
CODES ⑤	DESCRIPTION ⑥	REQUESTED AMT/UNITS ⑦	APPROVED AMT/UNITS ⑧	SERVICING PROVIDER NAME ⑨
97110	THERAPEUTIC PROC, ONE OR MORE AR	\$181.44/009	\$181.44/009	THEO THERAPIST
CLIENT ID # ⑩	AA####A			
PRIOR AUTH # ⑪	0123456789			
Dates Valid: From ⑫	12/09/2008	Through	01/31/2009	
Requesting/Referring Providers ⑬	REFERRER, MD			

### Additional Notes: ⑭

<Notes entered by the reviewer for the provider may be entered here>

Jane Doe ⑮

### Street Name

City, State ZIP

DHS Branch:	Anytown ⑰		
Address: ⑱	### Street Name	Division:	DMAP - Medical Unit 800-642-8635
City/ZIP:	City, ZIP	Reviewer:	Reviewer, RN

CC: DHS Branch, Referring Provider ⑲

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## **Description of the fields of the Notice of Denial (PAU-0111-D):**

- 1.** The date DMAP generated this notice.
- 2.** Provider's name and address as they appear on DMAP records.
- 3.** The client's name.
- 4.** Description of the type of service authorized.
- 5.** Date the service was denied.
- 6.** CDT codes for the authorized service..
- 7.** Procedure code descriptions for the authorized service.
- 8.** The amount and units requested by the provider on the original PA request.
- 9.** Name of servicing provider.
- 10.** The reason DMAP denied the PA request, with Oregon Administrative Rule references as appropriate.
- 11.** The client's 8-digit ID number (for billing DMAP).
- 12.** Request number: The 10-digit number referencing the PA denial..
- 13.** The name of the prescribing/referring provider.
- 14.** Additional notes: A space for notes entered by the reviewer for the provider. For example, if the reason for denial specifies incomplete documentation, the reviewer can use this space to explain the specific documentation required.
- 15.** The client's name and address.
- 16.** The DHS branch office serving the client.
- 17.** The DHS office and reviewer who approved the PA.
- 18.** If DMAP sends copies of this notice to other entities, such as the the client's branch office, that inforamtion will display here.



Date of Notice: 12/09/2008 ①

Provider Name ②  
### Street Name  
City, State ZIP

**Notice of Denial**

*This letter contains protected health information (PHI) from DHS and is covered by the Electronic Communications Privacy Act, 18 U.S.C. Sec. 2510-2521 and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, which is intended only for the use of the individual or entity named in the letter. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.*

DHS has denied the prior authorization (PA) request to provide the following item(s) or service(s) to Jane Doe: ③

PA Assignment:	Physical Therapy Services ④	Denial Date: ⑤	12/09/2008
CODES ⑥	DESCRIPTION ⑦	REQUESTED AMT/UNITS ⑧	SERVICING ⑨ PROVIDER NAME
97110	THERAPEUTIC PROC, ONE OR MORE AR	\$181.44/009	THEO THERAPIST
REASON FOR DENIAL ⑩	The information submitted does not substantiate the medical appropriateness for the service provided/requested. (OAR 410-120-0000, OAR 410-120-1200, OAR 410-120-1320, DME OAR 410-122-0080)		
CLIENT ID # ⑪	AA####A		
REQUEST # ⑫	0123456789		
Requesting/ Referring Providers ⑬	REFERRER, MD		

**Additional Notes: ⑭**

<Notes entered by the reviewer for the provider may be entered here>

Jane Doe ⑮  
### Street Name  
City, State ZIP

DHS Branch:	Anytown		
Address: ⑯	### Street Name	Division: ⑰	DMAP - Medical Unit 800-642-8635
City/ZIP:	City, ZIP	Reviewer:	Reviewer, RN

CC: DHS Branch, Referring Provider ⑱

## **Billing information**

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## Client eligibility and enrollment

[DMAP General Rule 410-120-1140](#) Verification of Eligibility and Coverage requires all enrolled providers to verify eligibility on the date of service.

- DMAP will not pay claims for clients who are not eligible on the date of service.
- For clients enrolled in an OHP managed care plan, DMAP will not pay for services covered by the managed care plan, except as provided by statute and included in Oregon Administrative Rule (OAR).

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## Resources

To determine client eligibility and enrollment, verify with one of the following. For more information, go to [www.oregon.gov/DHS/healthplan/tools\\_prov/electronverify.shtml](http://www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml).

- Automated Voice Response (AVR): Call 866-692-3864. A quick reference for verifying client eligibility via AVR is available on the DHS Web site at <http://dhsforms.hr.state.or.us/Forms/Served/OE3162.pdf>.
- Provider Web Portal: Go to <https://www.or-medicaid.gov>.
- 270/271 transaction: Available to approved Electronic Data Interchange (EDI) providers.

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## How to verify eligibility for OHP Plus dental benefits

Remember that most dental services, including hygiene and restorative services, are covered for all OHP Plus clients. OHP Plus children, and OHP Plus adults with the *OHP Plus - Supplemental Benefits* plan (BMP) get additional dental services. Refer to the Covered/Non-Covered Services table for a list of the services affected.

To verify eligibility for the additional OHP Plus dental services:

- For OHP Plus clients under age 21: Verify the client's date of birth is later than [today's date], 1990 and client has the BMM, BMD or BMH benefit plan.
- For OHP Plus clients age 21 or older: Verify the client has the BMP benefit plan and the BMM, BMD or BMH benefit plan.

You can verify benefit plan and date of birth using the Provider Web Portal, Automated Voice Response or the 270/271 transaction.

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## Fee schedule and billing

DMAP's complete Fee Schedule is now located on the Web at [www.oregon.gov/DHS/healthplan/data\\_pubs/feeschedule/main.shtml](http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml). Please refer to the Dental Services Administrative Rulebook for current payment policies.

Do not include DMAP copayments when billing for dental services.

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## Billing for clients with other insurance

Remember that DMAP is the payer of last resort; you must bill all other prior resources before billing DMAP.

- When patients have other insurance, and the private insurance payment equals DMAP's maximum allowable rate, DMAP considers this payment in full. Do not bill clients for covered services.
- When billing DMAP as the secondary payer, make sure to attach the primary payer's Explanation of Benefits (EOB) to the claim.

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## National Provider Identifier (NPI)

To ensure accurate and timely 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](http://www.oregon.gov/DHS/healthplan/tools_prov/npi.shtml).

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## Claims with services that require prior authorization

**Make sure all services requiring prior authorization are billed on a single claim.** If a service is later billed for the same date range, DMAP will deny the claim as a duplicate service already paid.

Do not bill prior-authorized and non-prior-authorized services on the same claim form.

The system does not look at the PA number field on claims to find the PA. Instead, it looks for PAs that have an exact match to the following on the claim (if applicable):

- Diagnosis code
- Procedure code
- Performing provider

If the system cannot find an approved PA that matches these items on your claim, or if the degree of specificity does not match for any item on a potential match, the claim will deny.

To avoid this, look up the existing PA on the Provider Web Portal before you bill. Then you can make sure you bill for the service using the same criteria listed in the PA.

**Please continue to record the 10-digit PA number in the PA number field of claims submitted to DHS.** Even though the system does not use this field during claim processing, this number helps DHS staff resolve the claim when the system cannot find a matching PA.

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## When to bill on paper

You must bill on paper for claims that require attachments, reports or manual pricing (e.g., unlisted procedure codes). Submit the paper claim with a cover letter and required documentation attached.

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## Electronic claim submissions

DHS accepts claims in the following electronic formats:

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### Batch claim format

If you want to submit claims electronically using the 837 D format, 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](mailto:DHS.EDIsupport@state.or.us)

Phone: 888-690-9888

Web site: [www.oregon.gov/DHS/edi](http://www.oregon.gov/DHS/edi)

### Coordination of Benefits (COB)

The 837 transaction will allow you to send COB/secondary payer claims. This means that if you have a claim that Medicare, or any other insurer, has paid as primary, you can use the 837 transaction to report the other insurance and bill DMAP as secondary.

For more information, contact DHS EDI Support Services (see above).

### Transaction information for EDI submitters

The DHS Companion Guides contain information on how registered EDI submitters need to set up and code their transactions for appropriate processing by DHS.

- For specific instructions on how to submit an electronic claim, refer to the *DHS 837 Dental Companion Guide* at [www.oregon.gov/DHS/edi/resources.shtml](http://www.oregon.gov/DHS/edi/resources.shtml).
- If you bill for multiple service locations, submit your taxonomy and the complete ZIP+4 code in your 837 submission to ensure payment to the appropriate service location.

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### Individual claim format

Enrolled DHS providers authorized to access the Provider Web Portal can submit individual dental 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](http://www.oregon.gov/DHS/healthplan/webportal.shtml).

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## 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.

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.

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## Where to mail claims

Mail completed claim forms to:

DMAP  
PO Box 14956  
Salem, OR 97309

## ADA 2006 Claim Form instructions

For additional information about this form, go to the ADA Web site at [www.ada.org/prof/resources/topics/claimform.asp](http://www.ada.org/prof/resources/topics/claimform.asp).

- 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.

1.	Type of Transaction – Indicate whether the claim is for pre-treatment or actual services.
2.	PA Number – If claim is for actual services and services have been pre-authorized, place the 10-digit DMAP prior authorization number here.
4.	If patient covered by another plan, check “Yes” box.
5-11.	Enter patient’s other insurance information, if any.
15.	Patient ID # – Enter enter the patient’s 8-digit Client ID number as it appears on the Medical Care ID. <b>Do not use patient’s Social Security Number.</b>
18.	Patient’s relationship to subscriber.
20.	Patient Name – Enter patient’s last name, first name, and middle name as shown on the patient’s Medical Care ID.
21.	Date of Birth – Enter patient’s date of birth.
23.	Patient ID/Account # (Optional) – Enter your unique patient account number here. It will be printed on your remittance advice.
24.	Procedure Date – Enter date of service (MM/DD/YYYY format) for each line item.
25.	Area of Oral Cavity – Use the following codes, if applicable, for each line item: <ul style="list-style-type: none"> <li>◆ 00 – Entire oral cavity</li> <li>◆ 01 – Maxillary arch</li> <li>◆ 02 – Mandibular arch</li> <li>◆ 10 – Upper right quadrant</li> <li>◆ 20 – Upper left quadrant</li> <li>◆ 30 – Lower left quadrant</li> <li>◆ 40 – Lower right quadrant</li> </ul>
27.	Tooth Numbers or Letters – Enter for each line item as appropriate. Leave blank if procedure does not directly involve a tooth or range of teeth. List teeth in order. Use tooth numbers or letters from tooth chart. <ul style="list-style-type: none"> <li>◆ A-T – Deciduous/primary teeth</li> <li>◆ 1-32 – Permanent teeth</li> <li>◆ 51-82 – Supernumerary permanent teeth</li> <li>◆ AS-TS - Supernumerary primary teeth</li> </ul>



28.	<p>Tooth Surface – Use the following surface codes for each line item as appropriate:</p> <ul style="list-style-type: none"> <li>◆ B – Buccal</li> <li>◆ M – Mesial</li> <li>◆ D – Distal</li> <li>◆ O – Occlusal</li> <li>◆ L – Lingual</li> <li>◆ I – Incisal</li> <li>◆ F – Facial</li> </ul>
29.	Procedure Code – For each line item, list the 5-digit ADA Procedure Code (code starting with “D” required).
30.	Description – Description of service performed, for each line item.
31.	Fee – Enter the total usual and customary charge, for each line item.
33.	Total Fee – Enter the total for all fees listed in field 31.
35.	Remarks – Enter “Payment by other plan” information, if any; or leave blank and attach the plan’s RA. You can also use this area for documentation when requesting PA, or for unusual circumstances when filing a claim.
36.	Assignment of Benefits signature – Do not put “Signature on File” in this field.
38.	Place of Treatment – Check appropriate box.
39.	Entering the number of radiographs is helpful as an internal audit figure.
43.	Prosthesis information – Required when seeking PA for prosthetics.
45.	Indicate whether treatment is the result of occupational injury or illness or accident, as applicable.
48.	Billing Provider Name – Enter last name first, first name, middle initial. The billing provider is the provider to whom the check should be sent (actual service provider <i>or</i> the provider’s billing service).
49.	Billing Provider NPI – Enter your 10-digit National Provider Identifier (NPI).
52	Billing Provider Phone Number – This information can often speed assistance for problems with claims or PA.
52A.	Additional Billing Provider ID # – Enter your six- or nine-digit DHS billing provider number. Claims cannot be processed without this number. <b>Do not enter your license or TIN number.</b>
53.	Signature of provider and date of submission.
54.	Treating Provider NPI – If you are a billing clinic, enter the 10-digit NPI of the treating dentist.
58.	Additional Treating Provider ID # – If you are a billing clinic, enter the DHS performing provider number in this space.

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## 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](http://www.oregon.gov/DHS/healthplan/tools_prov/read-ra.shtml).

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## 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/](http://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.

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## 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](http://www.oregon.gov/DHS/healthplan/webportal.shtml).

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## 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](http://www.oregon.gov/DHS/healthplan/forms/omapforms.shtml).

## DMAP 1036 - Individual Adjustment Request

The adjustment process can resolve overpayments, underpayments, and payments received after DMAP has paid a claim.

- 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 (DMAP 1036) 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 an Individual Adjustment Request (DMAP 1036)

Most required information is printed on the Remittance Advice (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 National Provider Identifier (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 <b>Internal Control Number</b>		⑤ <b>RA Date</b>	
⑥ <b>Recipient Name</b>	⑦ <b>Recipient ID Number</b>		
⑧ <b>Provider Name</b>	⑨ <b>Provider Number</b>		
⑩ <b>NPI</b>			

⑪ <b>Description of original error</b>	⑫ <b>Line No.</b>	⑬ <b>Service Date</b>	⑭ <b>Wrong Information</b>	⑮ <b>Right Information</b>
<input type="checkbox"/> Place of Service				
<input type="checkbox"/> Procedure Code/NDC/Rev Code				
<input type="checkbox"/> Modifier				
<input type="checkbox"/> Quantity/Unit				
<input type="checkbox"/> Diagnosis				
<input type="checkbox"/> Prescribing/Rendering Provider				
<input type="checkbox"/> Billed Amount/Total Billed				
<input type="checkbox"/> Medicare Payment				
<input type="checkbox"/> Other Insurance/Patient Liability				
<input type="checkbox"/> Co-Insurance				
<input type="checkbox"/> Other				

⑯ **Remarks**

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⑰ <b>Requester's Name</b>	Phone #	Date
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## DHS 3970 - EDMS Coversheet

DHS now requires this sheet as the cover for most mailed or faxed correspondence sent to DMAP for processing. To avoid delays in processing:

- **Do not submit paper claims or adjustment requests with this coversheet.** Mail them to the appropriate PO Box with any required documentation attached.
- **Make sure to submit each request you send to DMAP with its own EDMS Coversheet.** This allows DHS to track each request as a separate document. You cannot send multiple requests under a single coversheet or combine document types.

This form is also available on the DHS Web site at <http://dhsforms.hr.state.or.us/Forms/Served/DE3970.pdf>.

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### How to complete the DHS 3970

This sheet allows DHS to scan your correspondence into the Electronic Document Management System (EDMS). To ensure appropriate processing of your PA request:

- **Always enter your National Provider Identifier and the client's ID number in the "Documentation Identification Numbers" section of this form.**
- **Always mark the "Prior Authorization" box in the "Document Type" section of this form for all PA-related submissions.** This is the only way the EDMS will recognize your PA request for automatic entry into the system.
- **For requests to revise existing PAs, enter the PA number in the "Documentation Identification Numbers" section of this form.** This is the only way EDMS will know to associate your revised PA request with an existing PA.

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### Requests for expedited PA

If you want to expedite your initial or revised PA request, mark the expedited timeframe you are requesting on the EDMS Coversheet and DHS 3971:

- "Urgent" processing (within 72 hours)
- "Immediate" processing (within 24 hours)

In addition to required information for the initial or revised request, submit written justification for expedited processing. A space to write this information is at the top of the EDMS Coversheet and DHS 3971.

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### Using the coversheet button in the Provider Web Portal

If you want to complete the coversheet while submitting your PA request on Provider Web Portal, make sure you click the "Submit" button before you complete the coversheet.

This enters your PA into the system and gives you the PA number you will need to enter in the "Documentation Identification Numbers" section of the coversheet.



## DHS 3971 - Oregon DHS Prior Authorization Request

Use this form, in addition to the ADA Dental Claim Form, when submitting hospital dentistry requests and other dental PA requests to DMAP.

- Submit your PA request with required documentation and a completed EDMS Coversheet (see previous page). To ensure appropriate processing of your PA request, make sure to complete the following required fields on new PA requests.
- This form is also available on the DHS Web site at <http://dhsforms.hr.state.or.us/Forms/Served/DE3971.pdf>.

### How to complete the DHS 3971

Information needed	Hospital Dentistry	Other PA
<b>Section I - Provider number (NPI)</b>	X	X
<b>Section II - Type of PA request</b> - Mark the “Dental Hospital Referral or “Other” box.	X	X
<b>Section III - Client ID</b> and client's name	X	X
<b>Section VI</b> <b>Tooth number and quadrant</b>	X	X
<b>Section IX</b> <b>Date of request</b> <b>Expected service begin date</b> - Beginning date of service <b>Expected service end date</b> - Ending date of service	X	
<b>Notes</b> Detailed explanation of why dental hospitalization is being requested, including whether oral sedation was used and the results.	X	
<b>Attachments</b> Describe and attach the following: ◆ Copy of treatment plan ◆ Completed ADA form for preauthorization (see page 3)	X	X



# Oregon DHS Prior Authorization Request Form

## For Internal Use Only: PA Number

**I**

Requesting Provider Name \_\_\_\_\_ Provider # \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone # \_\_\_\_\_

Contact Fax # \_\_\_\_\_ Processing Time Frame:  Routine  
 Urgent  
 Immediate

Supporting Justification for Urgent/Immediate Processing Time Frame:  
\_\_\_\_\_

**II**

### Type of PA Request

Assignment Code (check appropriate box)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Audiology                              | <input type="checkbox"/> Home Health            | <input type="checkbox"/> Physician                          |
| <input type="checkbox"/> Chemical Dependency Treatment Services | <input type="checkbox"/> Imaging                | <input type="checkbox"/> SPD – CIIS (MFCU, CHN and Nursing) |
| <input type="checkbox"/> Dental Hospital Referral               | <input type="checkbox"/> Inpatient Rehab        | <input type="checkbox"/> Speech Services                    |
| <input type="checkbox"/> DME                                    | <input type="checkbox"/> Medical Transportation | <input type="checkbox"/> Supplies                           |
| <input type="checkbox"/> Gambling Treatment Services            | <input type="checkbox"/> Mental Health          | <input type="checkbox"/> Surgery                            |
| <input type="checkbox"/> Hearing Aid                            | <input type="checkbox"/> Occupational Therapy   | <input type="checkbox"/> Transplant                         |
| <input type="checkbox"/> Home EPIV                              | <input type="checkbox"/> Pharmacy               | <input type="checkbox"/> Vision                             |
| <input type="checkbox"/> Other _____                            | <input type="checkbox"/> Physical Therapy       |   |

**III**

Client ID \_\_\_\_\_ DOB \_\_\_\_\_

Last Name \_\_\_\_\_ First Name, MI \_\_\_\_\_

**IV**

### Service Information

Estimated length of treatment \_\_\_\_\_ Frequency \_\_\_\_\_

Length of time per session \_\_\_\_\_

Primary diagnosis \_\_\_\_\_ Primary ICD-9 diagnosis code \_\_\_\_\_

Other pertinent diagnosis \_\_\_\_\_

**Facility:** Name \_\_\_\_\_ Provider # \_\_\_\_\_

Revenue Center Codes \_\_\_\_\_

*Please attach appropriate dental/medical/clinical justification for services requested (attach any plan of treatment, progress notes, invoices, etc. as needed).*

V							
Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1					\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
<b>Total Units</b>					<b>Total Cost</b>		\$

**VI** DENTAL

Tooth Number \_\_\_\_\_ Quad \_\_\_\_\_

**VII** *Fax all pharmacy PA requests to the Oregon Pharmacy Call Center at 888-346-0178.*

**Pharmacy:** Drug Name \_\_\_\_\_ Strength \_\_\_\_\_  
 Quantity \_\_\_\_\_ NDC \_\_\_\_\_

**Directions:**  
 \_\_\_\_\_

**VIII**

Performing Provider \_\_\_\_\_ Provider # \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone # \_\_\_\_\_

Contact Fax # \_\_\_\_\_ Billing Provider # \_\_\_\_\_

**IX** Date Information

Date of Request (MM/DD/CCYY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Expected Service Begin Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Expected Service End Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Notes:**

**Attachments:**

Document Control Number (DCN) \_\_\_\_\_

Report Type \_\_\_\_\_

**Description of attachments:**

## 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 ( <b>NOT PO Box</b> )		
<b>City</b>	<b>State</b>	<b>ZIP</b>
<b>Area Code &amp; Phone</b>		

### 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](http://www.oregon.gov/DHS/healthplan)

DMAP 2420 (Rev. 02/08)

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Place  
Postage  
Here

DAS Distribution Center  
550 Airport Rd SE  
Salem OR 97310

# Appendix

## Oregon Health Plan – Recommended Dental Periodicity Schedule

This schedule, effective for services rendered on or after 1/1/2010, is incorporated by reference in OAR 410-123-1260.

Frequency is based on the American Academy of Pediatric Dentistry’s Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children ([www.aapd.org/media/Policies\\_Guidelines/G\\_Periodicity.pdf](http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf)).

### Age Birth through 6 years

Examination/ Assessment	Counseling/ Parent or Patient Education	Treatment may include, but is not limited to:	Treatment Frequency:
<ul style="list-style-type: none"> <li>◆ The first dental examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age.</li> <li>◆ Clinical oral assessment and appropriate diagnostic tests and radiographs to assess oral growth and development and/or pathology</li> <li>◆ Assess the patient’s systemic and topical fluoride status</li> <li>◆ Assess patient’s risk for oral disease</li> <li>◆ Determine interval for periodic reevaluation</li> </ul> <p>(Oral screening included during an office visit by medical practitioners is encouraged.)</p>	<ul style="list-style-type: none"> <li>◆ Age-appropriate oral hygiene instructions, including implications of the oral health of the caregiver</li> <li>◆ Dietary and feeding practices counseling related to oral health</li> <li>◆ Non-nutritive oral habits such as pacifiers</li> <li>◆ Age-appropriate injury prevention</li> <li>◆ Anticipatory guidance</li> </ul>	<ul style="list-style-type: none"> <li>◆ Prophylaxis</li> <li>◆ Topical fluoride</li> <li>◆ Sealants for permanent teeth as indicated by individual patient’s needs</li> <li>◆ Diagnosis and required treatment and/or appropriate referral for any oral disease</li> </ul> <p>(Topical fluoride application by medical practitioner is encouraged)</p>	<ul style="list-style-type: none"> <li>◆ Exams twice every 12 months</li> <li>◆ Prophylaxis twice every 12 months, additional prophylaxis available for high risk oral conditions</li> <li>◆ Topical fluoride application twice every 12 months, or up to 4 treatments within 12-month period for high-risk conditions or oral health factors</li> <li>◆ Sealants (per permanent tooth) once every five years except for visible evidence of clinical failure</li> </ul> <p><b>Note: See OAR 410-123-1260 for reimbursement limitations.</b></p>

## Age 7 through 15 years

Examination/ Assessment	Counseling/ Parent or Patient Education	Treatment may include, but is not limited to:	Treatment Frequency:
<ul style="list-style-type: none"> <li>◆ Appropriate diagnostic tests and radiographic assessment of pathology and/or abnormal growth and development</li> <li>◆ Assess the patient's systemic and topical fluoride status</li> <li>◆ Assess patient's risk for oral disease</li> <li>◆ Determine interval for periodic reevaluation</li> </ul>	<ul style="list-style-type: none"> <li>◆ Age-appropriate oral hygiene instructions</li> <li>◆ Dietary counseling related to oral health</li> <li>◆ Age-appropriate injury prevention</li> <li>◆ Anticipatory guidance</li> <li>◆ Tobacco counseling</li> </ul>	<ul style="list-style-type: none"> <li>◆ Prophylaxis</li> <li>◆ Topical fluoride</li> <li>◆ Sealants for permanent teeth as indicated by individual patient's needs</li> <li>◆ Diagnosis and required treatment and/or appropriate referral for any oral disease</li> </ul>	<ul style="list-style-type: none"> <li>◆ Exams twice every 12 months</li> <li>◆ Prophylaxis twice every 12 months, additional prophylaxis available for high risk oral conditions</li> <li>◆ Topical fluoride application twice every 12 months, or up to 4 treatments within 12-month period for high-risk conditions or oral health factors</li> <li>◆ Sealants (per permanent tooth) once every five years except for visible evidence of clinical failure</li> </ul> <p><b>Note: See OAR 410-123-1260 for reimbursement limitations.</b></p>

## Age 16 through 21 years

Eligibility rules determine if covered through 18, 19, or 20 years.

Examination/ Assessment	Counseling/ Parent or Patient Education	Treatment may include, but is not limited to:	Treatment Frequency:
<ul style="list-style-type: none"> <li>◆ Appropriate diagnostic tests and radiographic assessment of pathology and/or abnormal growth and development</li> <li>◆ Assess the patient's systemic and topical fluoride status</li> <li>◆ Assess patient's risk for oral disease</li> <li>◆ Determine interval for periodic reevaluation</li> </ul>	<ul style="list-style-type: none"> <li>◆ Age-appropriate oral hygiene instructions</li> <li>◆ Dietary counseling related to oral health</li> <li>◆ Age-appropriate injury prevention</li> <li>◆ Anticipatory guidance</li> <li>◆ Tobacco counseling</li> </ul>	<ul style="list-style-type: none"> <li>◆ Prophylaxis</li> <li>◆ Topical fluoride</li> <li>◆ Diagnosis and required treatment and/or appropriate referral for any oral disease</li> </ul>	<ul style="list-style-type: none"> <li>◆ Exams twice every 12 months (under 19 years of age) or once every 12 months (age 19 and older)</li> <li>◆ Prophylaxis twice every 12 months (under 19 years of age) or once every 12 months (age 19 and older), additional prophylaxis available for high risk oral conditions</li> <li>◆ Topical fluoride application twice every 12 months (under 19 years of age) or once every 12 months (age 19 and older), or up to 4 treatments within 12-month period for high-risk conditions or oral health factors</li> </ul> <p><b>Note: See OAR 410-123-1260 for reimbursement limitations.</b></p>