

Federally Qualified Health Centers and Rural Health Clinics Provider Guide



Supplemental information for
Oregon Medicaid providers

- Billing for Medicare/Medicaid clients
- Billing for QMB-only clients
- Billing instructions and forms
- Electronic billing / EDI
- Remittance advice information



Revised Sep. 27, 2011

Contents

- Service eligibility..... 1
 - Client eligibility and enrollment..... 1
 - Prior authorization - *See OAR 410-147-0060 for more information*..... 2
- Billing information..... 4
 - Vaccines for Children Program - *See OAR 410-147-0180 for more information* 4
 - Billing references - *See OAR 410-147-0120 for more information*..... 4
 - National Provider Identifier (NPI) 5
 - Billing for Medicare/Medicaid clients 5
 - Billing for QMB-Only clients – *Refer to OAR 410-120-1210 for more information*..... 5
 - Claims with services that require prior authorization 6
 - When to bill on paper 6
 - Electronic claims submissions 7
 - Paper claim submissions 8
- Billing codes 17
 - Third Party Resource (TPR) Explanation Codes 17
 - Supplemental information qualifiers 19
- Remittance advice 20
- Forms 22

NOTE: DMAP provides the Information and instructions contained in this booklet as a supplement to the program policies found in the current Federally Qualified Health Centers and Rural Health Clinics (FQHC-RHC) Oregon Administrative Rules (Chapter 410 Division 147). See current FQHC-RHC rulebook for official policies regarding billing.

Service eligibility

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).

Resources

To determine client eligibility and enrollment, verify with one of the following. For more information about these options, go to www.oregon.gov/OHA/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 Web at <https://apps.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.

Prior authorization - *See OAR 410-147-0060 for more information*

The following services require prior authorization (PA):

- Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)
- Home health services
- Home Enteral/Parenteral and IV services
- Hospital dentistry and certain dental services
- Physical and occupational therapy
- Private duty nursing
- Speech and hearing services
- Certain pharmaceutical, medical-surgical, vision, and hospital services

Refer to the specific administrative rules and supplemental information for these programs for specific details and required forms.

For clients in a managed care plan, contact the managed care plan to request PA.

How to request prior authorization (PA)

For clients enrolled in an OHP managed care plan, contact the plan for their PA procedures. For OHP fee-for-service (“open card”) clients, use the following procedures:

Professional services

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.

Submit documentation for PA requests using the following fax numbers:

- Routine requests: 503-378-5814
- Immediate/urgent requests: 503-378-3435

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

If you have questions about how to request PA, contact DMAP:

DMAP – Medical Management Unit

500 Summer St NE, E44

Salem, OR 97301-1078

503-945-6821 (direct)

800-642-8635 (in-state only)

Pharmaceutical services and oral nutritional supplements

Submit all PA requests for fee-for-service prescriptions (including 7/11 carveout drugs for managed care plan clients) and oral nutritional supplements to:

Oregon Pharmacy Call Center

888-202-2126

Fax: 888-346-0178

Use the DMAP 3978 form (see Forms section for sample and instructions). Refer to the Pharmaceutical Services provider guidelines for more information about requesting PA.

Billing information

Vaccines for Children Program - *See OAR 410-147-0180 for more information*

The Vaccines for Children Program (VFC) supplies federally purchased free vaccines for immunizing eligible children in public and private practices - at no cost to participating private health care providers. Patients through age 18 are eligible if they are:

- Enrolled in Medicaid or the Oregon Health Plan;
- Uninsured; or
- American Indian/Alaskan Native.

For more information, go to the VFC Web site at <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/index.aspx>.

To enroll in the VFC program, call 971-673-0300 and request a “VFC Recruitment Packet.”

Billing references - *See OAR 410-147-0120 for more information*

FQHC/RHCs must bill according to the provider guidelines for the services requested, including the specific procedure codes, documentation or other requirements (*e.g.*, prior authorization) outlined for each program.

Refer to the provider guidelines for the following programs for information on the billing and documentation requirements for these services.

- Dental Services (division 123)
- Home Enteral/Parenteral Nutrition and IV Services (division 148)
- Home Health Services (division 127)
- Hospice Services (division 142)

- Hospital Services (division 125)
- Medical-Surgical Services (division 130)
- Medical Transportation Services (division 136)
- Physical and Occupational Therapy Services (division 131)
- Private Duty Nursing Services (division 132)
- Speech-Language Pathology, Audiology and Hearing Aid Services (division 129)
- Visual Services (division 140)

You can access the most recent administrative rulebook and supplemental information for all programs by going to the DMAP Web site at www.dhs.state.or.us/policy/healthplan/guides/main.html.

National Provider Identifier (NPI)

To ensure accurate and timely claims processing, DMAP 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 DMAP NPI Web page at www.oregon.gov/OHA/healthplan/tools_prov/mpi.shtml.

Billing for Medicare/Medicaid clients

To ensure your clinic's Medicare/Medicaid claims are paid correctly, do not submit CMS-1500 paper claims for dual-eligible clients. Instead, submit 837P, professional Web claim or DMAP 505 paper claim form for the services not covered by Medicare.

Billing for QMB-Only clients – *Refer to OAR 410-120-1210 for more information*

The Benefit Plan section of the Web portal Eligibility Verification Screen identifies QMB-only clients using the code "MED." These clients are Medicare beneficiaries who have limited income, but do not meet the income or resource standard for Medicaid coverage.

- **The QMB medical assistance program pays only for Medicare premiums, coinsurance and deductibles for Medicare-covered services.** Providers can bill DMAP for a QMB-only client's coinsurance and deductibles related to a Medicare-covered service. They cannot bill the client.
- The provider may bill QMB-only clients for services not covered by Medicare in accordance with OAR 410-120-1280(3). Medicaid will not cover these services.
- QMB-only clients always have a third party resource that must be billed first – Medicare. When billing DMAP, bill as a Medicaid-Medicare claim using the DMAP 505, professional Web claim or 837P transaction. See pages 12-15 for DMAP 505 instructions.

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 DMAP. Even though the system does not use this field during claim processing, this number helps DMAP staff resolve the claim when the system cannot find a matching PA.

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.

Electronic claims submissions

DMAP accepts claims in the following electronic formats:

Batch claim format

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

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

Phone: 888-690-9888

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

Coordination of Benefits (COB)

The 837 professional 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 EDI Support Services (see above).

Transaction information for EDI submitters

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

- For specific instructions on how to submit an electronic claim, refer to the *Oregon Medicaid 837 Professional Companion Guide* at www.oregon.gov/OHA/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.

Individual claim format

Enrolled Oregon Medicaid providers authorized to access the Provider Web Portal can submit individual professional, dental and institutional claims at <https://www.or-medicaid.gov>.

For more information, go to www.oregon.gov/OHA/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 1-866-202-512-1800.

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.

Where to mail claims

Send all completed CMS-1500 forms to:

DMAP
PO Box 14955
Salem, OR 97309

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 on next page). 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 Medical Care ID. <i>Left-align</i>
2.	The client’s name as it appears on the Medical Care ID. <i>Left-align</i>
9.	Use Third Party Resource (TPR) codes (pages 12-13) to indicate response received from other resources. Be sure that this code is the first entry in Field 9, followed by the name of the TPR. <ul style="list-style-type: none"> ◆ If the client has other health insurance coverage, and no payment was received from that resource, this space must be used to explain why no payment was made. ◆ If using TPR code “MO” or “OT,” write “Review TPR code” at the top of the claim. Attach additional pages if needed to explain use of the code. Mail claim to Provider Services, 500 Summer St NE E44, Salem OR 97301.
10a-c.	Complete as appropriate when an injury is involved.
17.	Enter the name of the referring physician.
17a.	Enter the 6- or 9-digit Oregon Medicaid provider number for the referring physician. This information may be required if: <ul style="list-style-type: none"> ◆ Your client has a Primary Care Manager (PCM), or ◆ The service being billed requires a referral (<i>e.g.</i>, Physical, Occupational, or Speech Therapy services).
17b.	Enter the PCM or referring physician’s 10-digit National Provider Identifier (NPI).
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. <ul style="list-style-type: none"> ◆ Carry the codes out to their highest degree of specificity (fourth or fifth digit). ◆ For multiple encounters on same date of service, refer to OAR 410-147-0140.
23.	If the service being billed requires prior authorization, and DMAP has authorized the service, enter the 10-digit PA number here.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA										PICA							
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>						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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)					
CITY			STATE			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 <input type="checkbox"/> NO <input type="checkbox"/>						a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____						b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>						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 <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.					
<p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> 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 _____					
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 <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____				22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 21						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. #						
24A		24B		24D		24E	24F	24G		24J							
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		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.)						32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH # () 33					
SIGNED _____ DATE _____						a. NPI _____		b. _____		a. NPI _____		b. _____					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

24	<ul style="list-style-type: none"> ◆ If entering more than one item of information on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space from other items on the same line. See page 19 for more information about entering supplemental information. ◆ If billing for anesthesia services: Enter 7, followed by the anesthesia duration (in 15-minute increments). ◆ If billing for physician-administered drugs: Enter National Drug Code (NDC) information in the following order: N4, 11-digit NDC in 5-4-2 format, one space, unit of measure, NDC quantity (limited to 8 digits before the decimal and 3 digits after the decimal). If entering a whole number, do not use a decimal. Do not use commas. See the example below:
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24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSTD Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER					
N4	12345678901	UN	1234.567			J#####	UD [for 340B drugs]	1	### ##	20	NPI	123456789
MM	DD	YY	MM	DD	YY							

24A.	Enter the date (or first and last dates if consecutive days) that the service was provided. Must be numeric (100308). If “From-To” dates are used, a service must have been provided on each consecutive day but not more than once per day. Left-align for line item 1
24B.	Enter the appropriate code for the place service was provided: Use current Medicare place of service codes (available on the CMS Web site at www.cms.hhs.gov/PlaceofServiceCodes/ or CPT/HCPCS book).
24C.	Put a “Y” in this field if the service was an emergency. ◆ Labor and delivery services for Citizen/Alien-Waived Emergency Medical (CAWEM) women are considered an emergency..
24D.	Enter the most appropriate code as described in 410-147-0160 and individual program rules. Use required modifiers when appropriate. ◆ For drugs purchased for Medicaid clients through a 340B entity: Include UD modifier with HCPCS and NDC.
24E.	Enter the one-digit line number which refers to the primary diagnosis from Field 21 for each service billed.
24F.	Enter the charge for each service billed.
24G.	Enter the number of days or units. This number must correspond with the number of days in Field 24A.
24H.	Enter a “Y” if the service is related to family planning.

24I.	Leave this field blank. If you enter a qualifier for the Oregon Medicaid provider number in this field, the system will read it as part of your Oregon Medicaid provider number.
24J.	In the shaded half of this field, enter the 6- or 9-digit Oregon Medicaid provider number of the provider who rendered the service. Do not enter an NPI. <ul style="list-style-type: none"> ◆ If an FQHC or RHC has received written approval for multiple clinic numbers, list the performing clinic number in this Field and the FQHC/RHC billing provider number in Field 33.
26.	(Optional) Enter your unique patient account number here (up to 12 characters). It will be printed on your remittance advice. <ul style="list-style-type: none"> ◆ This area can also be used to identify the clinic site.
28.	Enter the total of all of the charges listed in column 24F.
29.	Enter the total amount paid by any other insurance or resource. Do not include DMAP copayments in this Field. If the client has other insurance and this amount is zero, there must be a 2-digit TPR reason code in Field 9.
30.	Enter the amount due after subtracting the Amount Paid from the Total Charge (Field 28 minus Field 29). Do not include insurance write-off amounts.
33.	If you have an NPI, enter it in part “a” of this field. In part “b,” enter your Oregon Medicaid provider number. Do not enter qualifiers for these numbers. <ul style="list-style-type: none"> ◆ 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, DMAP will use the NPI in part “a” to process your claim, which may result in DMAP processing the claim under the wrong Oregon Medicaid 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.

DMAP 505 - Medicaid - Medicare Billing Invoice

To order this form, complete and submit the DMAP 2420 (Provider Forms Request) to DHS/OHA Forms Distribution, 550 Airport Rd SE, Salem, OR 97310. You will find a copy of the DMAP 2420 at the end of this supplement.

This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE0505.pdf>.

Where to mail claims

Send all completed DMAP 505 forms to:

DMAP
PO Box 14015
Salem, OR 97309

How to complete the DMAP 505

Shaded boxes indicate the fields DMAP uses to process your claim (shaded on next page). 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	Enter the client's name as printed on the Medical Care ID.
3	Enter the 8-digit number found on the Medical Care ID.
8	The Medicare Claim Number as it appears on the client's Medicare Card.
9	If no payment was received from Medicare, use this space to explain why no payment was made. Enter a 2 digit "reason" code from the Third Party Resource (TPR) codes on pages 18-19, followed by the name of the TPR (Medicare). ◆ If there is any other TPR, be sure to use a code that shows what both insurances did. ◆ If using TPR code "MO" or "OT," write "Review TPR code" at the top of the claim. Attach additional pages if needed to explain use of the code. Mail claim to Provider Services, 500 Summer St NE E44, Salem OR 97301.
7	Complete ONLY when an injury is involved.
14	Complete if the service was performed as an emergency. Labor and delivery services for Citizen/Alien-Waived Emergency Medical (CAWEM) women are considered an emergency.
16a	Enter the 6- or 9-digit Oregon Medicaid provider number of the referring (requesting) practitioner.
16b	Enter the 10-digit National Provider Identifier (NPI) of the referring practitioner.

Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

1. Patient's Name (Last, First, MI) 1		2. Patient's birthdate/sex MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		3. Insured's ID # (include all letters and numbers) 3	
4. Patient's address (number, street)		5. Patient's Relation to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		6. Insured's Name (Last, First, MI)	
City	State	7. Was condition related to: a. Patient's employment Y <input type="checkbox"/> N <input type="checkbox"/> b. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/>		8. Insured's address (number, street)	
Zip Code	Phone (Area Code)			City	State
9. Other insured's name (Last, First, MI)		a. Other insured's Plan name		Zip Code	Phone (Area Code)
Other insured's Plan address (number, street)		b. Other insured's policy number		10. Insured's group # (or group name)	
City	State	Zip Code	Phone (Area Code)	12. I authorize payment of medical benefits to undersigned physician or supplier for services described below. <i>Signed (insured or authorized person)</i>	
11. 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. <i>Signed _____ Date _____</i>					
13. Date of current: MM DD YY		Illness (first symptom) or Injury (accident) or Pregnancy (LMP)	14. If emergency, check here <input type="checkbox"/>		15. First date patient had same or similar illness MM DD YY
16. Name of referring provider or other source		16a. _____	16b. NPI	17. Dates patient unable to work in current occupation From MM DD YY To MM DD YY	
18. Outside lab? Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ Charges	19. Prior authorization number		20. Hospitalization dates related to current services From MM DD YY To MM DD YY	
21. Diagnosis or nature of illness or injury (relate items 1, 2, 3, or 4 to item 22D by 21) 1. _____ 2. _____ 3. _____ 4. _____					
22. A. Date(s) of service MM 22A To MM DD 22B	B. Place of service	C. Procedures, services or supplies (exp. usual circumstances) CPT/HC 22C Modifier 22D	D. Diagnosis 22E	E. Days or units	F. EPSDT Family Plan 22G
					G. Charges and Medicare 22H
					H. Medicare's covered charges
					I. Rendering DHS Provider Number
					DHS: _____
					NPI: _____
					DHS: _____
					NPI: _____
					DHS: _____
					NPI: _____
					DHS: _____
					NPI: _____
					DHS: _____
					NPI: _____
23. Federal tax ID #		SSN <input type="checkbox"/> EIN <input type="checkbox"/>	24. Total charges 24		25. Total Medicare payment
26. Patient's account #		27. Accept assignment? Y <input type="checkbox"/> N <input type="checkbox"/>	28. Ins (not Medicaid/Medicare)	29. Balance 29	
30. Service facility location information			31. Billing provider information and phone number		
NPI #:	DHS #:	NPI #:	DHS #:	31	

19	If the service requires prior authorization (PA), enter the 10-digit PA number issued by DMAP or the branch/unit.
21	Enter the primary diagnosis/condition of the client indicated by appropriate ICD-9-CM code number. Enter up to four codes in priority order. Carry the codes out to their highest degree of specificity.
22	<p>In the shaded area across Fields 22A through 22I, enter supplemental information (<i>e.g.</i>, NDC, anesthesia) about the service. Enter the appropriate qualifier(s), followed by the information.</p> <ul style="list-style-type: none"> ◆ If entering more than one item of information on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space from other items on the same line. See page 19 for more information about entering supplemental information. ◆ If billing for anesthesia services: Enter 7, followed by the anesthesia duration (in 15-minute increments). ◆ If billing for physician-administered drugs: Enter National Drug Code (NDC) information in the following order: N4, 11-digit NDC in 5-4-2 format, one space, unit of measure, NDC quantity (limited to 8 digits before the decimal and 3 digits after the decimal). If entering a whole number, do not use a decimal. Do not use commas. See the example below:

22.	A. Date(s) of service		B. Place of service	C. Procedures, services or supplies (explain unusual circumstances)		D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering DHS Provider Number
	From MM DD YY	To MM DD YY		CPT/HCPCS	Modifier						
	N412345678901 UN1234.567										DHS: 123456789
	MM DD YY	MM DD YY	1	J#####	UD [for 340B drugs]	1	20		### #	### #	NPI: 1234567890

22A	Use a 6-digit numeric date (MM/DD/YY). If a “From-To” range is used, all services must be on consecutive days and the quantity in Field 24E must equal the number of days.
22B	Enter where service was provided. Use the standard CMS codes available in your CPT or HCPCS book or the CMS Web site at www.cms.hhs.gov/PlaceofServiceCodes/Downloads/2007_POSDataBase.pdf .
22C	Enter the appropriate procedure code plus any appropriate two-digit modifier(s).
22D	Enter a single diagnosis reference number on each line as shown in Field 21.
22E	Enter the number of services or units you are billing for.
22G	Enter the total dollar amount billed to Medicare for each service.
22H	Enter the dollar amount allowed by Medicare for each service.

22I	<p>If not used in Field 31, enter your performing provider number information here.</p> <ul style="list-style-type: none"> ◆ In the top half of this field, enter the 6- or 9-digit Oregon Medicaid provider number. ◆ In the bottom half of this field, enter the 10-digit NPI.
24	Add the charges in Field 22G and enter the total dollar amount Medicare was billed.
25	Enter the total dollar amount paid by Medicare for the services. Do not show Medicare or other insurance write-offs.
26	Optional. If your patient account number is entered here, DMAP will print the account number on the Remittance Advice.
28	Enter any amount paid by any health insurance resource, other than Medicare. If the amount is zero, put in a “0”.
29	Subtract the amounts in Fields 25 and 28 from Field 24 and enter the balance in this field. You must enter an amount in this field.
31	<p>In the “NPI #” part of this field, enter your NPI. In the “DMAP #” part of this field, enter your Oregon Medicaid billing provider number.</p> <ul style="list-style-type: none"> ◆ These numbers identify the provider to whom the check should be sent (actual service provider <i>or</i> the provider’s billing service).

Billing codes

Third Party Resource (TPR) Explanation Codes

Use in Field 9 on the CMS-1500 or DMAP 505 form. These codes can only be used on paper claims. They cannot be used on electronic claims submissions.

Single Insurance Coverage

Use a single insurance code when the client has only one insurance policy in addition to Medical Assistance Program coverage

- UD Service Under Deductible
- NC Service Not Covered by Insurance Policy
- PN Patient Not Covered by Insurance Policy
- IC Insurance Coverage Cancelled/Terminated
- IL Insurance Lapsed or Not in Effect on Date of Service
- IP Insurance Payment Went to Policyholder
- PP Insurance Payment Went to Patient
- NA Service Not Authorized or Prior Authorized by Insurance
- NE Service Not Considered Emergency by Insurance
- NP Service Not Provided by Primary Care Provider/Facility
- MB Maximum Benefits Used for Diagnosis/Condition
- RI Requested Information Not Received by Insurance from Client
- RP Requested Information Not Received by Insurance from Policyholder

- MV Motor Vehicle Accident Fund Maximum Benefits Exhausted
- AP Insurance mandated under administrative/court order through an absent parent not paid within 30 days
- OT Other (if above codes do not apply, include detailed information of why no TPR payment was made)

Multiple Insurance Coverage

Use a multiple insurance code when the client has more than one insurance policy in addition to Medical Assistance Program coverage

- MP Primary Insurance Paid-Secondary Paid
- SU Primary Insurance Paid - Secondary Under Deductible
- MU Primary and Secondary Under Deductible
- PU Primary Insurance Under Deductible - Secondary Paid
- SS Primary Insurance Paid - Secondary Service Not Covered
- SC Primary Insurance Paid - Secondary Patient Not Covered
- ST Primary Insurance Paid - Secondary Insurance Cancelled/Terminated
- SL Primary Paid - Secondary Lapsed or Not in Effect
- SP Primary Paid - Secondary Payment Went to Patient
- SH Primary Paid - Secondary Payment Went to Policyholder
- SA Primary Paid - Secondary Denied - Service Not Authorized or Prior Authorized
- SE Primary Paid - Secondary Denied - Service Not Considered Emergency
- SF Primary Paid - Secondary Denied - Service Not Provided by Primary Care Provider/
Facility
- SM Primary Paid - Secondary Denied - Maximum Benefits Used for Diagnosis/
Condition
- SI Primary Paid - Secondary Denied - Requested Information Not Received from
Policyholder
- SR Primary Paid - Secondary Denied - Requested Information Not Received from
Patient
- MC Service Not Covered by Primary or Secondary Insurance
- MO Other (if above codes do not apply, include detailed information of why no TPR payment was made)

Supplemental information qualifiers

DMAP accepts the following types of supplemental information, accompanied by the appropriate qualifier:

Qualifier	Information Type
7	Anesthesia duration in minutes with start and end times
ZZ	Narrative description of unspecified codes
N4	National Drug Codes (NDC). In addition, use the following qualifiers when reporting NDC units: <ul style="list-style-type: none"> ◆ F2 – International Unit ◆ GR – Gram ◆ ML – Milliliter ◆ UN - Unit
VP	Vendor Product Number – Health Industry Business Communications Council (HIBCC)
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC)
CTR	Contract rate

The following examples show how to enter different types of supplemental information as listed above. They are not meant to provide direction on how to code for specific services.

Anesthesia Services – Payment based on 15-minute units

24.	A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPISOD Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From	To	MM	DD	YY	MM			DD	YY	CPT/HCPCS		MODIFIER					
7	Begin	1245	End	1415	Time	90	Minutes											123456
06	01	07	06	01	07	1		00770	P2			1	###	##	6		NPI	1234567890

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/OHA/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 at 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 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/OHA/healthplan/webportal.shtml.

Correcting claims

You have three options to adjust a claim that you submitted and DMAP 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 DMAP 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/OHA/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 paid 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/OHA Forms Distribution, 550 Airport Rd SE, Salem, OR 97310.
- This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE1036.pdf>.

How to complete the 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.
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 boxes 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.

DHS 3970 - EDMS Coversheet

This sheet is required 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 DMAP 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/OHA Web site at <https://apps.state.or.us/Forms/Served/DE3970.pdf>.

How to complete the DHS 3970

This sheet allows DMAP 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.

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.

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 when submitting PA requests for professional services. Fax to one of the following numbers. Include required documentation and a completed EDMS Coversheet (see previous page).

- Routine requests: 503-378-5814
- Immediate/urgent requests: 503-378-3435

To ensure appropriate processing of your PA request, make sure to complete the following required fields on new PA requests.

- Section I: Provider Number
- Section II: Type of PA Request
- Section III: Client ID
- Section IV: Revenue Center Code (if applicable)
- Section V: Procedure Code and Units (if applicable)
- Section VII: NDC (if applicable)
- Section IX: Date of Request, Service Begin and End Dates

This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/DE3971.pdf>.



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 _____		

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							
Total Units					Total Cost		\$

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 3978 - Pharmacy Prior Authorization Request

Prescribers should submit their PA requests for fee-for-service prescriptions and oral nutritional supplements with required documentation to:

Oregon Pharmacy Call Center

888-202-2126

Fax: 888-346-0178

This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE3978.pdf>.

Information needed to request PA

Complete the form as follows. The Oregon Pharmacy Call Center may ask for some or all of the following information, depending upon the class of the drug requested:

DMAP 3978 section	Information needed
Section I:	Requesting provider name and National Provider Identifier.
Section II	Type of PA Request: Mark "Pharmacy."
Section III:	Client name and recipient ID number
Section IV:	Diagnosis code (ICD-9-CM)
Section V:	Drug name, strength, size and quantity of medication. ◆ Participating pharmacy: Include the dispensing pharmacy's name and phone number (if available).
Section VI:	Date of PA Request Begin and End Dates of Service
Section VII:	Procedure code(s) and cost information - Complete for EPIV and oral nutritional supplements only.
Section VIII	Patient questionnaire - Complete for oral nutritional supplements only.



Prior Authorization Request for Prescriptions & Oral Nutritional Supplements

To: Oregon Pharmacy Call Center
888-346-0178 (fax); 888-202-2126 (phone)

Confidentiality Notice:

The information contained in this Prior Authorization Request is confidential and legally privileged. It is intended only for use of the recipient(s) named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax document- except its direct delivery to the intended recipient - is strictly prohibited. If you have received this Prior Authorization Request in error, please notify the sender immediately and destroy all copies of this request along with its contents and delete from your system, if applicable.

Complete all fields marked with an asterisk (*), if applicable.

I Requesting Provider

* Name _____ * NPI _____
Contact Name _____ Contact Phone _____ - _____ - _____
Contact Fax _____ - _____ - _____ Processing Time Frame: Routine
Supporting Justification for Urgent/Immediate Processing: Urgent
_____ Immediate

II PA Request - Assignment Code (check appropriate box)

* Pharmacy Home EPIV Other _____

III Client Information

* Client ID _____ DOB _____ / _____ / _____
* Last Name _____ * First Name, MI _____

IV Service Information

Estimated length of treatment _____ Frequency _____
Primary diagnosis _____ * Primary ICD-9 diagnosis code _____
Other pertinent diagnosis
(For prescriptions and oral nutritional supplements, list all applicable ICD-9 codes or contributing factors)

V Drug/Product Information

* Name _____ * Strength _____
* Quantity _____ * NDC _____

Participating Pharmacy:

Name _____ Phone Number _____ - _____ - _____ Date _____ / _____ / _____

VI Date Information

* Date of Request _____ / _____ / _____ * Expected Service Begin Date _____ / _____ / _____
* Expected Service End Date _____ / _____ / _____

VII Code and Cost Information – Required for EPIV and oral nutritional supplements

Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1					0.00	0.00	0.00
2					0.00	0.00	0.00
3					0.00	0.00	0.00
4					0.00	0.00	0.00
5					0.00	0.00	0.00
			Total Units	0			\$0.00

VIII Patient Questionnaire – Complete for oral nutritional supplements only

Question	Yes	No
Is the patient fed via G-tube?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient currently on oral nutritional supplements? - If Yes, date product started: _____ - How is it supplied (e.g., self-pay, friends/family supply, etc)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have Failure to Thrive (FTT)?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a long history (more than one year) of malnutrition and cachexia?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient reside in a: - Long-term care facility? - Chronic home care facility? - If Yes, list name of residence: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Does the patient have: - Increased metabolic need from severe trauma (e.g., severe burn, major bone fracture)? - Malabsorption difficulties (e.g., Crohn’s Disease, cystic fibrosis, bowel resection/removal, Short Gut Syndrome, gastric bypass, renal dialysis, dysphagia, achalasia)? - A diagnosis that requires additional calories and/or protein intake (e.g., cancer, AIDS, pulmonary insufficiency, MS, ALS, Parkinson’s, cerebral palsy, Alzheimer’s)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Date of last MD assessment for continued use of supplements: _____

Date of Registered Dietician assessment indicating adequate intake is not obtainable through regular or liquefied pureed foods: _____

- Serum Protein level: _____ Date taken: _____
- Albumin level: _____ Date taken: _____
- Current weight: _____ Normal weight: _____

Written Justification and Attachments:

Requesting Physician’s signature: _____