



Home Enteral / Parenteral and IV Services

Supplemental information for
Oregon Medicaid providers

- ✓ Prior authorization
- ✓ Billing instructions and forms
- ✓ PA forms and cover sheet
- ✓ Electronic billing / EDI

November 5, 2010



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NOTE: DMAP provides the information and instructions contained in this booklet as a supplement to the program policies found in the current Home Enteral/ Parenteral and IV Services (EPIV) Oregon Administrative Rules (410 Division 148). See the current EPIV rulebook for official policies regarding billing.

Prior authorization

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/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.

Prior authorization (PA) and billing

Prior authorization does not guarantee payment. Remember:

- Always check eligibility on the date of service. This is especially important when services have been authorized beyond the current month of eligibility.
- Ensure the service to be provided is currently a covered medical service.
- Ensure the claim is for the actual service(s) and/or number of services provided even though the authorization may be for a higher number of units or dollars.
- Services and/or dollars billed in excess of the number of units or dollars authorized will not be reimbursed.

Services requiring PA

See OAR 410-148-0060 Authorization in the Home Enteral/Parenteral and IV Services rulebook for the services that require 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 contact information:

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, instructions and required information.

If you have questions about how to request PA, contact the appropriate office below.

Medically Fragile Children (MFC) clients	DHS Medically Fragile Children’s Unit 971-673-2974 for referrals and general information
All other clients	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 and oral nutritional supplements to:

Oregon Pharmacy Call Center
888-202-2126
Fax: 888-346-0178

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

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.” 9-digit PA numbers issued before December 2008 now have a leading zero as their 10th digit.

Description of the fields of the Notice of Prior Authorization:

If DMAP cannot produce a computer-generated notice, DMAP will complete the DMAP 1072 form (the PA number is below the provider's name).

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. HCPCS 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: A **ten digit number** beginning with the number "0."
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.



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 ③ 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		
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

Notice of Prior Authorization of Payment for Medical Services

Recipient

Date

ID Number	XX#####X
Other Information	

Provider

Provider Name
Street Name
City, State ZIP

Jane Doe
Street Name
City, State ZIP

Prior Authorization Number	#####	Dates Valid	10/1/05 through 10/31/05
Procedure/Drug/Diagnosis (ICD-9-CM) Code(s) Approved		Approved By	DHS Staff Name
Type of Service Code		Maximum Units of Service Approved	
Description		Maximum Dollars Approved	
		Referring Provider Number	#####

Client: Please contact the provider shown above to arrange for these services.

Provider: Your request for payment of medical/dental services to the Division of Medical Assistance Programs (DMAP) client named above has been approved providing:

- (1) The services authorized are provided within the "Dates Valid" listed above.
- (2) The client is eligible for DMAP payment of medical services on the date of service.
- (3) Any and all properly completed auxiliary documents are attached to the claim when submitted; examples are: Consent to Sterilization form, Consent to Hysterectomy form, Operative report.

This prior authorization DOES NOT supersede other rules, regulations, and policies of DMAP. Enter the Prior Authorization Number listed on the claim or payment will be denied or delayed. Give the Prior Authorization Number to other providers who will be billing DMAP for services related to this medical service. These ancillary providers (assisting surgeon, anesthesia, hospital) must enter the Prior Authorization Number on their claim when billing DMAP.

All prior resources must be explored and utilized before billing DMAP. (See General Rules, 410-120-1280—Full Use of Alternate Resources).

Providers having questions about prior authorization please refer to your provider guide.

State Office for Children, Adults and Families (CAF) clients must have consent for surgery obtained from the appropriate CAF office.

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.** HCPCS 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 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 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

National Provider Identifier

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

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/mpi.shtml.

Pharmaceutical claims

For information on electronic Point of Sale billing or how to complete the Universal Claim Form, refer to the Pharmaceutical Services provider guidelines at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html.

Professional claims

Use the CMS-1500, 837P or Professional Web claim format to bill for the following services:

- Home enteral/parenteral nutrition and IV services identified with a five-digit HCPCS
- Oral nutritional supplements identified with a five-digit HCPCS

Use the billing instructions found in this supplement. Make sure to include the National Drug Code (NDC) where applicable. See rule 410-148-0160 for billing clients with Medicare coverage.

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.

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 submission

DHS accepts professional claims in the following electronic formats:

Batch claim format

If you want to submit claims electronically using the 837P 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

Phone: 888-690-9888

Web site: www.oregon.gov/DHS/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 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 Professional Companion Guide - Fee-for-Service* at 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.

Individual claim format

Enrolled DHS providers authorized to access the Provider Web Portal can submit individual professional or pharmacy claims at <https://www.or-medicaid.gov>.

For more information, go to www.oregon.gov/DHS/healthplan/webportal.shtml.

Paper claim submissions

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

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

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

Health Insurance Claim Form (CMS-1500)

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

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

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

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

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 DHS Medical Care ID. <i>Left-align</i>
2.	The client’s name as it appears on the DHS Medical Care ID. <i>Left-align</i>
9.	Use Third Party Resource codes (pages 26-27) 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-10c.	Complete as appropriate when an injury is involved.
17.	Enter the name of the referring physician.
17a.	Enter the 6- or 9-digit DHS 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). ◆ The service being billed requires a referral (<i>e.g.</i>, Physical, Occupational, or Speech Therapy services). ◆ This service is the result of a Prepaid Health Plan (PHP) referral. In this case, enter the PHP’s DHS provider number (not the practitioner’s).
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).

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER 1a (For Program in Item 1)									
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					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY STATE									
ZIP CODE TELEPHONE (Include Area Code) ()					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					c. EMPLOYER'S NAME OR SCHOOL NAME					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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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 _____										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									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____ 17b. NPI _____					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					18. 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 24E by Line) 1. _____ 21 3. _____ 2. _____ 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
1 24A		24B		24D			24E	24F		24G	NPI	24J							
2											NPI								
3											NPI								
4											NPI								
5											NPI								
6											NPI								
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) <input type="checkbox"/> YES <input type="checkbox"/> NO									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____					28. TOTAL CHARGE \$ 28 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 30									
										33. BILLING PROVIDER INFO & PH # () 33									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

23.	If the service being billed requires prior authorization, and DMAP has authorized the service, enter the 10-digit PA number here.
24	<p>In the shaded area across Fields 24A through 24H, enter supplemental information (<i>e.g.</i>, NDC) 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. ◆ When entering supplemental information for NDC, add in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas. ◆ See pages 22 and 26 for additional information.
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. <i>Left-align for line item 1</i>
24B.	<p>Enter the appropriate code for the place service was provided (use standard CMS Place of Service codes):</p> <ul style="list-style-type: none"> ◆ 12 – Client’s Home ◆ 13 - Assisted Living Facility ◆ 31 - Skilled Nursing Facility ◆ 32 - Nursing Facility
24C.	Put a “Y” in this field if the service was an emergency.
24D.	Enter the most appropriate HCPCS code as described in the Home Enteral/ Parenteral Nutrition and IV Services rulebook (OAR 410 Division 148).
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 include a qualifier on the line for the DHS provider number, the system reads the qualifier as part of the provider number and denies the claim due to invalid provider number.

24J.	In the shaded half of this field, enter the 6- or 9-digit DHS provider number of the provider who rendered the service. Do not enter an NPI.
26.	(Optional) Enter your unique patient account number here (up to 12 characters). It will be printed on your remittance advice.
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 “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.	<p>If you have an NPI, enter it in part “a” of this field. In part “b,” enter your DHS 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). ◆ If you leave part “b” blank, DHS will use the NPI in part “a” to process your claim, which may result in DHS processing the claim under the wrong DHS provider number. ◆ Do not enter qualifiers in these fields. If you enter a qualifier, the system will read it as part of the provider number and deny for invalid provider number.

DMAP 505 - Medicaid - Medicare Billing Invoice

This form is used to submit claims for services to Medicare-Medicaid clients.

- To order this form, complete and submit the DMAP 2420 (Provider Forms Request) to DHS 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 Web site at <http://dhsforms.hr.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 DHS Medical Care ID.
3	Enter the eight-digit number found on the DHS Medical Care ID.
8	Enter the Medicare claim number as it appears on the client's Medicare card.
9	If no payment was received from Medicare, this space must be used to explain why no payment was made. Enter the 2-digit Third Party Resource code first, followed by the name of the TPR ("Medicare"). <ul style="list-style-type: none">◆ See pages 26-27 for accepted TPR codes.◆ 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.
16a	Enter the 6- or 9-digit DHS provider number of the referring (requesting) practitioner. If this service is the result of a Prepaid Health Plan (PHP) referral, the DHS provider number of the PHP (not the practitioner) must be entered here.
16b	Enter the 10-digit National Provider Identifier (NPI) of the referring practitioner.



Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

1

3

1. Patient's Name (Last, First, MI)			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)				
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</i> _____ <i>Date</i> _____										
13. Date of current: MM DD YY			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 1. 2. 3. 4.)										
22. A. Date(s) of service MM YY To MM DD		B. Place of service	C. Procedures, services or supplies (exp. usual circumstances) CPT/HCPC Modifier		D. Diagnosis	E. Days or units	F. EPSDT Family Plan	G. Charges and Medicare	H. Medicare's covered charges	I. Rendering DHS Provider Number
22A		22B	22C		22D	22E	22G	22H		
DHS: _____										
NPI: _____										
DHS: _____										
NPI: _____										
DHS: _____										
NPI: _____										
DHS: _____										
NPI: _____										
DHS: _____										
NPI: _____										
DHS: _____										
NPI: _____										
23. Federal tax ID #			24. Total charges			25. Total Medicare payment				
			SSN <input type="checkbox"/> EIN <input type="checkbox"/>							
26. Patient's account #			27. Accept assignment? Y <input type="checkbox"/> N <input type="checkbox"/>			28. Ins (not Medicaid/Medicare)		29. Balance		
30. Service facility location information					31. Billing provider information and phone number					
NPI #:					DHS #:					

21

24

29

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.
22A	Use a six-digit numeric date (MM/DD/YY). If a “From-To” date range is used, the claim must not be submitted to DMAP prior to the “to” date.
22B	Enter where service was provided (use standard CMS Place of Service codes): <ul style="list-style-type: none"> ◆ 12 – Client’s Home ◆ 13 - Assisted Living Facility ◆ 31 - Skilled Nursing Facility ◆ 32 - Nursing Facility
22C	Enter the most appropriate HCPCS code as described in the Home Enteral/ Parenteral Nutrition and IV Services rulebook (OAR 410 Division 148).
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	If not used in Field 31, enter your performing provider number information here. <ul style="list-style-type: none"> ◆ In the top half of this field, enter the 6- or 9-digit DHS 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	If you have an NPI, enter it in the “NPI #” part of this field.. In the “DMAP #” part of this field, enter your DHS billing provider number. <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 examples

How to bill units

When billing for enteral or parenteral nutrition services, a “thru” date of service is not required. If a “thru” date is entered, the claim must not be submitted to DMAP prior to the “thru” date.

24	A DATE(S) OF SERVICE						B PLACE OF SERVICE		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E DIAGNOSIS POINTER	F \$ CHARGES		G DAYS OR UNITS	H ID. QUAL	J RENDERING PROVIDER ID. #	K FOR SUPPLIER INFORMATION
	From MM DD YY	To MM DD YY	EMG	CPT/HCPCS	MODIFIER													
1	03	06	06			4		B4150	4000	Cal/Day	1	XX	XX	800	NPI	#####		
2	03	06	06			4		B4150	4000	Cal/Day	1	XX	XX	800	NPI	#####		
3														NPI				
4														NPI				

Item	Qty	Unit(s)
Parenteral Nutrition Supply Kit	1 kit	1 unit
Parenteral Solution (500 ml)	1 unit x 30 days	30 units
Parenteral Solution (1000 ml)	2 units x 30 days	60 units
Pump Rental (Home IV)	1 day	1 unit
100 calories per day	100 calories	1 unit
1200 calories per day	1200 divided by 100= 12 units x 30 days	360 units
◆ Units exceeding 999 units per month must be billed using two lines with different dates of service as shown below.		
4000 calories per day	4000 divided by 100= 40 units x 30 days	1200 units

Supplemental information qualifiers

In Field 24 of the CMS-1500, and Field 22 of the DMAP 505, you can enter supplemental information about the service rendered. Enter the appropriate qualifier(s), followed by the information.

The following examples show how to enter different types of supplemental information as listed on page 28. They are not meant to provide direction on how to code for specific services.

- 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.

Anesthesia Services – Payment based on 15-minute units

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

Anesthesia Services – Payment based on minutes as units

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

Unspecified Code

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.						
From To		EMG		(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	EPSCOT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #						
MM	DD	YY	MM	DD	YY												
ZZ Kaye Walker																	
06	01	07	06	01	07	4	E1399				1	### ##	1		NPI	123456	1234567890

NDC Code

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.						
From To		EMG		(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	EPSCOT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #						
MM	DD	YY	MM	DD	YY												
N41234567890 UN2																	
MM	DD	YY	MM	DD	YY	I	J####	UD [for 340B drugs]			1	### ##	20		NPI	123456789	1234567890

Vendor Product Number

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.						
From To		EMG		(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	EPSCOT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #						
MM	DD	YY	MM	DD	YY												
VPA122BIC5D6E7G																	
06	01	07	06	01	07	1	A6410				1	### ##			NPI	123456	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, go to www.oregon.gov/DHS/healthplan/tools_prov/read-ra.shtml.

Electronic remittance advice

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

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

To sign up for the 835 transaction, contact DHS EDI Support Services (see page 13).

Web portal claim search

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

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

Correcting claims

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

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

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

Billing codes

Third Party Resource (TPR) explanation codes

Use in Field 9 on the CMS-1500 and DMAP 505 forms. 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 DMAP 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 DMAP 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: See page 23 for examples.

Qualifier	Information Type
7	Anesthesia duration in hours and/or 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

Forms

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

DMAP 1036 - Individual Adjustment Request

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

- Use the DMAP 1036 only to request adjustments for *adjudicated* claims. Do not use the DMAP 1036 for *denied* claims. If DMAP denied a claim that you think DMAP should have paid, you must correct and re-submit the claim for processing.
- To order the Individual Adjustment Request (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 the Individual Adjustment Request (DMAP 1036)

Most required information is printed on the RA. You must have an RA for the claim in order to fill out the form. You can also 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

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>.

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 "Index Field & Values" 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 "Index Field & Values" 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 "Index Field & Values" section of the coversheet.

DHS 3971 - Oregon DHS Prior Authorization Request

Use this form when submitting professional PA requests to DMAP. Submit with required documentation and a completed EDMS Coversheet (see previous page). This form is also available on the DHS Web site at <http://dhsforms.hr.state.or.us/Forms/Served/DE3971.pdf>.

Information needed to request PA

DMAP may automatically deny requests that do not include one or more of the following pieces of information. Fields in **bold** are required for processing the form.

Information needed	New PA	Existing PA	
		Continue	Change
Section I	X		
◆ Provider number - Enter your NPI.			
Section II	X		
◆ Type of PA request - Mark "Home EPIV"			
Section III	X	X	X
◆ Client ID - The 8-digit Medicaid ID.			
◆ Client's name			
Section IV	X		
◆ Frequency of service			
◆ ICD-9-CM Diagnosis Code – to the highest specificity, obtained from the prescribing practitioner, for each service requested – The code must be the reason chiefly responsible for the service being provided as shown in the medical records.			
Section V	X		
◆ Procedure codes; units of service			
Section VIII	X		
◆ Performing provider number - Enter the NPI.			
Section IX	X		
◆ Date of request;			
◆ Expected service begin/end dates			
Notes	X		X
◆ New PA: Explanation of medical necessity, other options considered and why they cannot be used			
◆ Existing PA: The needed change and reason for change			
Attachments	X	X	X
Describe and attach a proper written order from the prescribing practitioner			



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							
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 Web site at <http://dhsforms.hr.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. ◆ FQHC/RHC and AI/AN providers - Also enter the pharmacy or clinic NPI for your facility.
Section II	Type of PA Request: Mark "Home EPIV." ◆ FQHC/RHC and AI/AN providers -Mark "Other," followed by provider type (FQHC, RHC, IHS or Tribal 638).
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 codes and cost information: Complete for EPIV and oral nutritional supplements only.
Section VIII	Patient Questionnaire: Complete for oral nutritional supplements only.



Print

Clear Form

For Internal Use Only: PA Number

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.

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

I Requesting Provider

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

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: _____

DMAP Forms Request

Instructions:

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

Provider Name		
Street Address (NOT PO Box)		
City	State	ZIP

Area Code & Phone

Forms available in packages of 50

CMS 1500 billing forms are available through business forms suppliers.

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

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

DMAP 2420 (Rev. 02/08)

Place
Postage
Here

DAS Distribution Center
550 Airport Rd SE
Salem OR 97310