

# Hospice Services Provider Guide



Supplemental information for  
Oregon Medicaid providers

- Billing instructions
- Billing forms
- Electronic billing / EDI



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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 Hospice Services Oregon Administrative Rules (Chapter 410 Division 142). See current Hospice Services 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](http://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 DHS/OHA Web site 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.

# Billing information

## How to enter CBSA codes on hospice claims

To ensure timely claim processing and payment, include the Cost-Based Statistical Area (CBSA) code for your county. Enter it as a dollar amount in the value code field. See page 7 for examples.

The CBSA code tells DMAP the amount to pay for your claim. **Claims will process without payment (“zero pay”) if this information is missing or invalid.**

<b>For paper claims:</b>	Enter the following values in FL 39, 40, or 41 of the UB-04: <ul style="list-style-type: none"><li>◆ Code - 61</li><li>◆ Amount - In the dollar section, enter the Cost-Based Statistical Area (CBSA) code for your county as a dollar amount (<i>e.g.</i>, code 38 will display as 38.00).</li></ul>
<b>For Web claims:</b>	Click on the “Value” link. Enter the following values: <ul style="list-style-type: none"><li>◆ Sequence - 1</li><li>◆ Code - 61</li><li>◆ Amount - Enter the CBSA code as a dollar amount (<i>e.g.</i>, code 38 will display as \$38.00).</li></ul>

## National Provider Identifier

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/npi.shtml](http://www.oregon.gov/OHA/healthplan/tools_prov/npi.shtml).

## 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

DMAP accepts institutional claims in the following electronic formats:

### Batch claim format

If you want to submit claims electronically using the 837I 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](mailto:DHS.EDIsupport@state.or.us)  
Phone: 888-690-9888  
Web site: [www.oregon.gov/OHA/edi](http://www.oregon.gov/OHA/edi)

### Coordination of Benefits (COB)

The 837I 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 Management Information System (OR-MMIS) Technical Specifications 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 *OR-MMIS 837 Institutional Technical Specifications - Fee-for-Service* at [www.oregon.gov/OHA/edi/resources.shtml](http://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 institutional claims at <https://www.or-medicaid.gov>.

For more information about submitting claims on the Web portal, go to [www.oregon.gov/OHA/healthplan/webportal.shtml](http://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.

### Uniform Billing (UB) claim form

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

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

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

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

### Multi-page UB claims

DMAP cannot process multi-page UB claims. If the claim exceeds one page, complete the claim as follows, or submit using the Provider Web Portal:

- **Outpatient Claims:** Separate the charges into two claims. Do not duplicate Revenue Center Codes or HCPCS codes unless you are billing for different dates of service and the different dates of service are shown in FL 45.
  - ✓ For example, if a specific Revenue Center Code appears on one claim, it must not appear on the second claim unless different dates of service show for each claim.
- **Inpatient Claims:** Do not use more than 22 Revenue Center Codes or line items on a single claim, and do not separate the charges into two claims. If needed, combine services under a single Revenue Center Code to reduce the total number of line items to 22 or fewer.

## Billing for multiple dates of service

For each procedure, list each Date of Service in FL 45. In FL 6, enter a date range that covers all dates entered in FL 45 in which services were provided.

- Example: Outpatient physical therapy services provided from October 1 through October 31. Three separate services were provided.
- Dates of service (FL 6): 10/01/10 - 10/31/10

FL 42	FL 45	FL 46	FL 47
420	100110	1	53.00
420	101510	1	40.00
420	103110	1	40.00

## Billing for multiple units of service

For each procedure, list the number of units of service provided in FL 46. In FL 6, enter the date range during which services were provided.

- Example: Outpatient physical therapy services provided from October 1 through October 31. 12 separate services were provided.
- Dates of service (FL 6): 10/01/10 - 10/31/10

FL 42	FL 45	FL 46	FL 47
420	100110	12	600.00

## Field Locators 50-66: Information listed by payer (A, B, C)

DMAP is secondary to all other insurance. When billing DMAP, enter DMAP information on line C.

## POA Indicators

If you have claims that require these indicators for Medicare, please make sure that there is a space between the diagnosis code and the POA indicator. OCR will pick up the POA code from the shaded area.

## Where to send claims

DMAP  
PO Box 14956  
Salem, Oregon 97309

## UB-04 claim form instructions

Fields on the UB claim form are called Field Locators (FLs). Information on how to obtain the UB-04 Manual can be found on the NUBC Web site at [www.nubc.org/First\\_Final\\_UB-04.pdf](http://www.nubc.org/First_Final_UB-04.pdf).

- 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.

FL	Description															
1.	Provider Identification: Enter provider name, mailing address and ZIP code.															
3a.	Patient Control Number (optional): Enter the number you assign to the account. If you enter the patient account number here, DMAP will print this information (up to 12 characters) on your Remittance Advice.															
4.	<p>Type of Bill: Enter the appropriate numeric code identified in the UB-04 Users Manual. <b>Left-align</b></p> <p>DMAP accepts the following codes:</p> <table border="0"> <thead> <tr> <th><i>Non-Hospital- Based Code</i></th> <th><i>Hospital- Based Code</i></th> <th><i>Description</i></th> </tr> </thead> <tbody> <tr> <td>811</td> <td>821</td> <td><b>Admission through discharge claim:</b> Encompasses an entire course of hospice treatment and no further bills will be submitted for this client (<i>i.e.</i>, client revokes or expires within the first billing period).</td> </tr> <tr> <td>812</td> <td>822</td> <td><b>First claim:</b> Use this code for the first of an expected series of payment bills for course of treatment.</td> </tr> <tr> <td>813</td> <td>823</td> <td><b>Interim-continuing claim:</b> Use when a bill has been submitted and further bills are expected to be submitted</td> </tr> <tr> <td>814</td> <td>824</td> <td><b>Last billing:</b> Use for a bill which is the last of series for a hospice course of treatment. The through date of this bill (Form Locator 6) is the discharge date or the date of death.</td> </tr> </tbody> </table>	<i>Non-Hospital- Based Code</i>	<i>Hospital- Based Code</i>	<i>Description</i>	811	821	<b>Admission through discharge claim:</b> Encompasses an entire course of hospice treatment and no further bills will be submitted for this client ( <i>i.e.</i> , client revokes or expires within the first billing period).	812	822	<b>First claim:</b> Use this code for the first of an expected series of payment bills for course of treatment.	813	823	<b>Interim-continuing claim:</b> Use when a bill has been submitted and further bills are expected to be submitted	814	824	<b>Last billing:</b> Use for a bill which is the last of series for a hospice course of treatment. The through date of this bill (Form Locator 6) is the discharge date or the date of death.
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6.	Statement Covers Period: Use MMDDYY (month, day, and year) numeric format (example: 102808). Total days in this field must correspond to the units entered in FL 46. <b>Left-align</b>															
8b.	Patient’s Name: Enter the patient’s name as it appears on the Medical Care ID. <b>Left-align</b>															

FL	Description
12.	Admission Date: Use MMDDYY format. Enter the actual admission date, even if the patient was not eligible on that date.
13.	Admission Hour: Enter the hour of admission, using numbers from 00 to 24. (01 = 1 a.m., 10 = 10 a.m., 13 = 1 p.m. 23 = 11 p.m., etc.).
16.	Discharge Hour: Use numbers from 00 to 24 (as in FL 13).
18-28.	Condition Codes: Enter “A1 EPSDT/CHAP (Medicheck)” when billing for EPSDT services.
31-35.	Occurrence Codes and Dates of Occurrence : Enter one of the appropriate codes and date of occurrence: <ul style="list-style-type: none"> <li>◆ 01 (Auto accident)</li> <li>◆ 04 (Employment-related accident)</li> </ul>
39-41.	Value Code: For the code, enter “61.” Then enter the Cost-Based Statistical Area (CBSA) code for your geographic location as a dollar amount: <ul style="list-style-type: none"> <li>◆ <b>Bend</b> (includes Deschutes County) - 13460 (enter as \$13,460.00)</li> <li>◆ <b>Corvallis</b> (includes Benton County) - 18700 (enter as \$18,700.00)</li> <li>◆ <b>Eugene-Springfield</b> (includes Lane County) - 21660 (enter as \$21,660.00)</li> <li>◆ <b>Medford</b> (includes Jackson County) - 32780 (enter as \$32,780.00)</li> <li>◆ <b>Portland-Beaverton</b> (includes Clackamas, Columbia, Multnomah, Washington and Yamhill counties) - 38900 (enter as \$38,900.00)</li> <li>◆ <b>Salem</b> (includes Marion and Polk counties) - 41420 (enter as \$41,420.00)</li> <li>◆ <b>All other areas</b> - 38 (enter as \$38.00)</li> </ul>
42.	Revenue Center Codes: Enter “0001” in line 23 of this field. For each remaining line on the claim, enter the Revenue Center Code which most accurately describes the service provided. <ul style="list-style-type: none"> <li>◆ 651 – Routine Home Care</li> <li>◆ 652 – Continuous Home Care (billed in <i>hours</i>, not days)</li> <li>◆ 655 – Inpatient Respite Care</li> <li>◆ 656 – General Inpatient Care</li> <li>◆ 659 – Other Hospice (use for in-home respite care)</li> </ul>
44.	HCPCS/Rates: Enter the five-digit code for each Revenue Center Code. Do not enter a daily rate in this field; this will cause the claim to deny for an invalid procedure code. <ul style="list-style-type: none"> <li>◆ Refer to the Hospice Rates Table at <a href="http://www.dhs.state.or.us/policy/healthplan/guides/hospice/main.html">www.dhs.state.or.us/policy/healthplan/guides/hospice/main.html</a> for codes requiring HCPCS.</li> <li>◆ Check CMS Web site at <a href="http://www.cms.gov">www.cms.gov</a> for HCPCS modifiers, if applicable</li> </ul>

FL	Description
45.	Service Date: Enter in MMDDYY format. See page 5 for how to bill for a series of services based on dates of service.
46.	<p>Units of Service: Enter total units of service (days or hours). If you provide outpatient services over a period of time, you may bill for more than one service on a single claim form.</p> <ul style="list-style-type: none"> <li>◆ List the units of service for each Revenue Center Code in FL 46.</li> <li>◆ From and Through dates (FL 6) must reflect the range of dates on which services were provided.</li> </ul>
47.	<p>Total Charges: Enter the total charges for each line item. When billing for hospice services, the provider must bill the usual charge or the rate based upon the geographic location (CBSA) in which the care is furnished, <i>whichever is lower</i>.</p> <ul style="list-style-type: none"> <li>◆ For current rates by CBSA, refer to the Hospice Rates posted at <a href="http://www.dhs.state.or.us/policy/healthplan/guides/hospice/main.html">www.dhs.state.or.us/policy/healthplan/guides/hospice/main.html</a>.</li> <li>◆ Enter the sum of all charges in Line 23 of this field. Do NOT include charges for non-covered services in this column.</li> </ul>
50.	<p>Payer Name: Enter the name(s) of the payer organizations you are billing (up to three payers). Do not include DMAP copayments in this field.</p> <ul style="list-style-type: none"> <li>◆ Enter Medicare on line A.</li> <li>◆ Enter other TPL (including Medicare supplement/replacement plan) on line B.</li> <li>◆ Enter “Medicaid” on line C (for DMAP).</li> </ul>
54.	<p>Prior Payments: Enter the actual amount of any payments you have received from a third party resource such as Medicare Part A, Part B, or other insurance on the line which corresponds to that payer’s line in FL 50. Show the actual Medicare payment. Do NOT adjust the prior payment amount.</p>
56.	<p>NPI: Enter your 10-digit National Provider Identifier.</p>
57.	<p>Other Provider ID: Enter your 6- or 9- digit Oregon Medicaid provider number on line C. Do not put other payer identifiers (<i>e.g.</i>, Medicare) in this field.</p>
60.	<p>Insured’s Unique ID: On line C, enter the patient’s Client ID number as it appears on the client’s Medical Care Identification.</p>
67.	<p>Principal Diagnosis Code: Enter the ICD-9-CM diagnosis code best describing the principal diagnosis (the condition established after study to be chiefly responsible for causing this service).</p>
67A-67D	<p>Other Diagnosis Codes : Enter the ICD-9-CM diagnosis codes (up to four) for conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received.</p>

FL	Description
78.	<p>Other Physician ID: Enter the NPI, DMAP number, and name of the physician who rendered service.</p> <ul style="list-style-type: none"> <li>◆ <i>To enter NPI:</i> Enter the 10-digit NPI of the physician who rendered service.</li> <li>◆ <i>To enter Oregon Medicaid provider number:</i> Enter the 6- or 9-digit Oregon Medicaid provider number or UPIN of the physician. For patients referred by a PCM or PCO, enter the PCM's Oregon Medicaid provider number.</li> </ul>
80.	<p>Remarks: Use this space for Third Party Resource (TPR) explanation codes (see pages 10-11 for accepted codes).</p> <ul style="list-style-type: none"> <li>◆ 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.</li> <li>◆ If the patient has Medicare Part B, but the service is not covered by Medicare, enter "NC" (Not Covered).</li> <li>◆ Using more than one TPR code on a claim can delay processing.</li> </ul>

## Third Party Resource (TPR) explanation codes

Enter in the “Remarks” Form Locator of the UB claim 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 Medicaid.

- UD Service under deductible
- NC Service not covered by insurance policy
- PN Patient not covered by insurance policy
- IC Insurance coverage canceled/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 patient
- 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 explanation of why no TPR payment as made.

### Multiple insurance coverage

Use a multiple insurance code when the client has more than one insurance policy in addition to Medicaid.

- 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 canceled/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 explanation of why no TPR  
payment was made)

## 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](http://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 [www.wpc-edi.com/content/view/180/223/](http://www.wpc-edi.com/content/view/180/223/). For more detailed codes, refer to the paper RA.

To sign up for the 835 transaction, contact 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-medicare.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](http://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

## 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/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 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.

<b>7.</b>	Enter the client's recipient ID number. .
<b>8.</b>	This space is for your provider name.
<b>9.</b>	Enter your 6- or 9-digit provider number.
<b>10.</b>	Enter your 10-digit National Provider Identifier (NPI), if available.
<b>11.</b>	This column contains possible areas you might want to correct. Only check the box you want to change.
<b>12.</b>	Use the line number from the original claim you are adjusting.
<b>13.</b>	Enter the date you performed the service.
<b>14.</b>	Enter the incorrect information submitted on your original claim.
<b>15.</b>	Enter the corrected information.
<b>16.</b>	Give additional information or explain your request, if necessary.
<b>17.</b>	The signature of the provider or other authorized person must be in this space.

# Individual Adjustment Request

DMAP Use Only

- ✓ Complete this form to request an adjustment.
- ✓ Please keep a copy and do not use red ink.

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

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

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

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

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

④ <b>Internal Control Number</b>		⑤ <b>RA Date</b>
⑥ <b>Recipient Name</b>	⑦ <b>Recipient ID Number</b>	
⑧ <b>Provider Name</b>	⑨ <b>Provider Number</b>	
⑩ <b>NPI</b>		

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

⑯ **Remarks**

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⑰ <b>Requester's Name</b>	Phone #	Date
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## 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 OHA Web site at  
[www.oregon.gov/OHA/healthplan](http://www.oregon.gov/OHA/healthplan)

DMAP 2420 (Rev. 7/11)

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