



Medical Transportation Services

Supplemental information for
Oregon Medicaid providers

- ✓ Billing instructions
- ✓ Billing forms
- ✓ Billing codes
- ✓ 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 Medical Transportation Oregon Administrative Rules (Chapter 410 Division 136). See the current Medical Transportation rulebook for official policies regarding billing.

Billing information

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. See page 4 for more EDI information.

Benefit plan coverage

The OHP Standard (“KIT”) benefit package does not cover non-emergent medical transportation. DMAP covers non-emergent medical transportation services for the following OHP benefit packages:

- OHP Plus (“BMH”)
- OHP Plus with Limited Drug (“BMD”)
- QMB with OHP with Limited Drug (“BMM”)
- CAWEM Plus (“CWX”)

Payment authorization

All medical transportation services require authorization of payment prior to billing. See OAR 410-136-0300 for complete information.

National Provider Identifier

To ensure accurate and timely processing 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.

Medicare-Medicaid billing for ambulance services -See OAR 410-136-0340

Bill Medicare first using the professional claim format (CMS-1500 or 837P). Medicare will process your claim for ambulance services and automatically forward it to DMAP for processing.

If Medicare has not made a final payment determination on your claim

- DMAP will automatically deny payment and instruct you by Explanation of Benefit (EOB) to resubmit your claim to Medicare.
- If Medicare resubmits the claim for you, it will again be transmitted to DMAP for adjudication.
- If you resubmit a paper claim to Medicare, your claim will **not** be sent to DMAP automatically, and you will need to resubmit to DMAP on an DMAP 505.

If Medicare has made a final payment determination on your claim

DMAP will make payment for covered services using the lesser of Medicare's allowed or DMAP's maximum allowable amount.

If Medicare denied payment for services covered by DMAP

Resubmit your claim on the DMAP 505 with a copy of Medicare's EOB attached. Follow the DMAP 505 billing instructions.

Electronic claims submissions

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.

Emergency flag

Make sure to indicate in the appropriate loop of your 837 transaction whether the claim is an emergency transport or not. The DHS 837 Professional Companion Guide provides information on available loops.

This information is also available in the HIPAA EDI Implementation Guides available for purchase at the Washington Publishing Company Web site at www.wpc-edi.com/hipaa.

Individual claim format

Enrolled DHS providers authorized to access the Provider Web Portal can submit individual professional claims at <https://www.or-medicaid.gov>. For more information about submitting claims on the Web portal, go to www.oregon.gov/DHS/healthplan/webportal.shtml.

Place of Service (POS) coding

All professional claims for transportation services must include a HIPAA-compliant, CMS-defined 2-digit POS code to indicate the type of transportation service used:

- 41 - Ambulance Land: A land vehicle specifically designed, equipped and staffed lifesaving and transporting the sick or injured.
- 42 - Ambulance Air or Water: An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
- 99 - Other Place of Service: For non-ambulance transportation providers

Modifiers/Destination coding

The combination of modifier and procedure code is very important. This combination of codes will tell where a client was picked up and dropped off on a billed trip.

- Use the appropriate pair of 1-digit HCPCS modifiers to indicate the client's pick-up point and destination. The first digit for the service indicates the pick-up point; the second digit indicates the drop-off point.
- Enter the pickup point and destination as a single 2-digit modifier. Do not enter the pickup point and destination as two separate 1-digit modifiers.
- For a full list of accepted transportation modifiers, see page 14 of this supplement.

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 following 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.	This information is listed on the DHS Medical Care ID. Use Third Party Resource codes listed on pages 17-18 to indicate response received from other resources. <ul style="list-style-type: none"> ◆ 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.
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.	Enter the appropriate 2-digit code for the place of service: <ul style="list-style-type: none"> ◆ 41 – Ambulance - Land ◆ 42 – Ambulance - Air or water ◆ 99 – Other Place of Service (for non-ambulance providers)
24C.	Put a “Y” in this field if the service was an emergency.
24D.	Enter the most appropriate CPT or HCPCS code as described in the Medical Transportation Services Rulebook (OAR Chapter 410, Division 136), <ul style="list-style-type: none"> ◆ Modifiers/Destination Codes: Enter the 2-digit modifier that best describes the service provided. Only use one modifier space. See page 14 for accepted modifiers.
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.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLKLUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										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			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:			11. INSURED'S POLICY GROUP OR FECA NUMBER																						
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			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? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____			b. EMPLOYER'S NAME OR SCHOOL NAME																						
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME																						
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <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. 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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____			22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____			23. PRIOR AUTHORIZATION NUMBER _____																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										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		24F		24G		NPI																	
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			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

24G.	<p>Enter the number of services, units or miles billed. If billing for a partial mile, round up to the next mile.</p> <p>◆ For taxi providers only: Bill a round trip on line with a quantity of two (2). Bill a three-way trip on one line with a quantity of three (3).</p>
26.	<p>(Optional) Enter your unique patient account number here (up to 12 characters). It will be printed on your remittance advice.</p>
28.	<p>Enter the total of all of the charges listed in column 24F.</p>
29.	<p>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.</p>
30.	<p>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.</p>
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). ◆ NPI is not required for non-medical services such as wheelchair coach or taxis, but ambulances do need an NPI. ◆ 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 - Medicare-Medicaid Billing Invoice

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

Submit completed DMAP 505 claim forms to:

DMAP
PO Box 14015
Salem, OR 97309

How to complete the DMAP 505 form

Shaded boxes indicate the fields DMAP uses to process your claim (shaded at right). Your claim may suspend or deny if one or more these fields are empty or incorrectly completed. Unshaded fields are optional or required only in certain circumstances.

1	Enter the client's name as printed on the DHS Medical Care ID.
3	Enter the 8-digit number found on the DHS Medical Care ID.
8	Enter the 10-digit Medicare number as it appears on the client's Medicare ID.
9	If no payment was received from Medicare, this space must be used to explain why no payment was made. Enter a 2 digit "reason" code from the Third Party Resource (TPR) codes on pages 15-16. ◆ 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.
22A	Use a six-digit numeric date (MM/DD/YY). If a "From-Through" date range is entered, a service must have been provided on each consecutive day but not more than once per day.
22B	Enter the appropriate 2-digit code for the place of service: ◆ 41 – Ambulance - Land ◆ 42 – Ambulance - Air or water ◆ 99 – Other Place of Service (for non-ambulance providers)

22C	Enter the most appropriate CPT or HCPCS code as described in the Medical Transportation Services Rulebook (OAR Chapter 410, Division 136). ◆ Modifiers/Destination Codes: Enter the 2-digit modifier that best describes the service provided. Only use one modifier space. See page 14 for accepted modifiers.
22E	Enter the number of services, units or miles billed. If billing for a partial mile, round up to the next mile.
22G	Enter the total dollar amount billed to Medicare for each service.
22H	Enter the dollar amount allowed by Medicare for each service.
24	Add the charges in Field 22G and enter the total dollar amount billed Medicare.
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 provider number. ◆ These numbers identify the provider to whom the check should be sent (actual service provider <i>or</i> the provider's billing service).

Remittance advice

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

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

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

Electronic remittance advice

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

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

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

Web portal claim search

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

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

Correcting claims

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

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

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

Billing codes

Modifiers (Destination Codes)

Use the appropriate 2-digit modifier to indicate the start and end destinations of a billed trip. Use in Field 24D of the CMS-1500, and Field 22C of the DMAP 505.

The first digit indicates pick-up; the second digit indicates the destination.

Position	Modifier	Description
1st or 2nd digit	D	Diagnostic or therapeutic site other than hospital or physician's office
	E	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
	G	Hospital-based dialysis facility (hospital or hospital-related)
	H	Hospital
	I	Site of transfer (<i>e.g.</i> , airport or helicopter pad) between types of ambulance
	J	Non-hospital-based dialysis facility
	N	Skilled nursing facility
	P	Physician's office (includes non-hospital facility, clinic, etc.)
	R	Residence
S	Scene of accident or acute event	
2nd digit only	X	Intermediate stop at physician's office en route to the hospital (includes non-hospital facility, clinic, etc)

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 Services 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 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 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
- C 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 Info Not Received from Policyholder
- SR Primary Paid - Secondary Denied - Requested Info Not Received from Patient
- MC Service Not Covered by Primary or Secondary Insurance
- MO Other (if above codes do not apply, include detailed info as to why no TPR payment was made)

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. Use the same name as is shown on the Medical Care ID.
7.	Enter the client's recipient ID number.
8.	This space is for your provider name.
9.	Enter your 6- or 9-digit provider number.
10.	Enter your 10-digit National Provider Identifier (NPI), if available.
11.	This column contains possible areas you might want to correct. Only check the box you want to change.
12.	Use the line number from the original claim (CMS-1500 or DMAP 505) you are adjusting.
13.	Enter the date you performed the service.
14.	Enter the incorrect information submitted on your original claim.
15.	Enter the corrected information.
16.	Give additional information or explain your request, if necessary.
17.	The signature of the provider or other authorized person must be in this space.

Individual Adjustment Request

DMAP Use Only

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

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

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

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

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

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

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

⑪ Description of original error	⑫ Line No.	⑬ Service Date	⑭ Wrong Information	⑮ Right Information
<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**

⑰ Requester's Name	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 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