Oregon Health Plan
Provider Web Portal

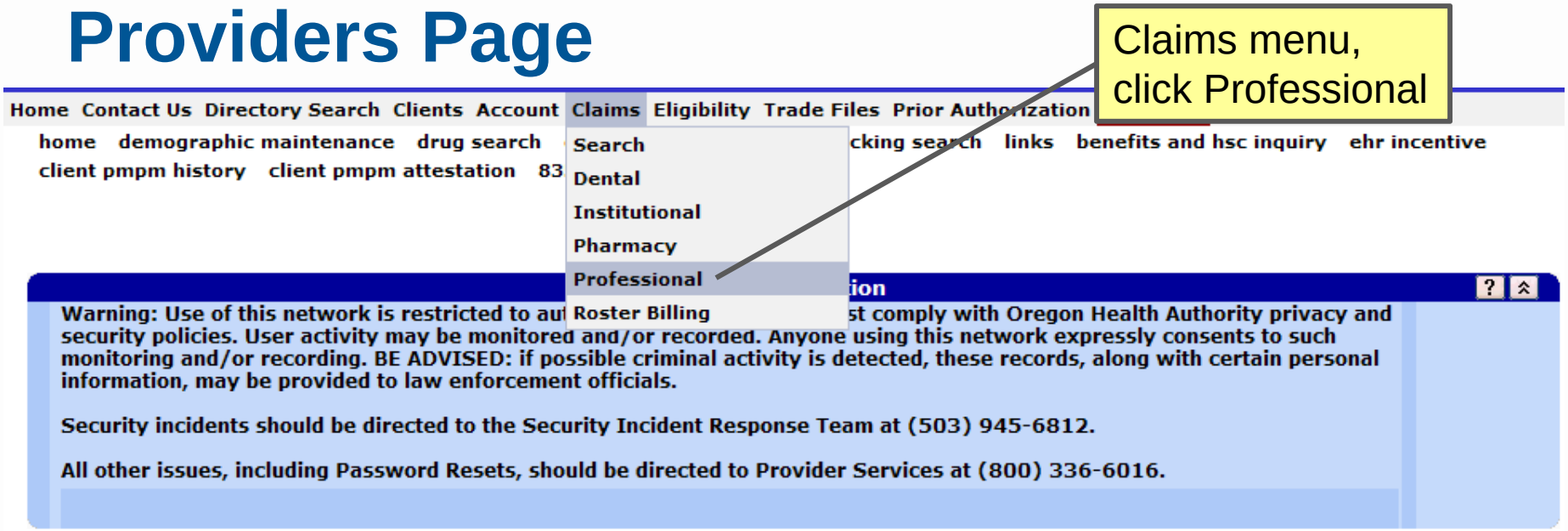
Professional Claim

Program-specific instructions are included in supplemental guides for each program

Oregon Health Authority

September 2015

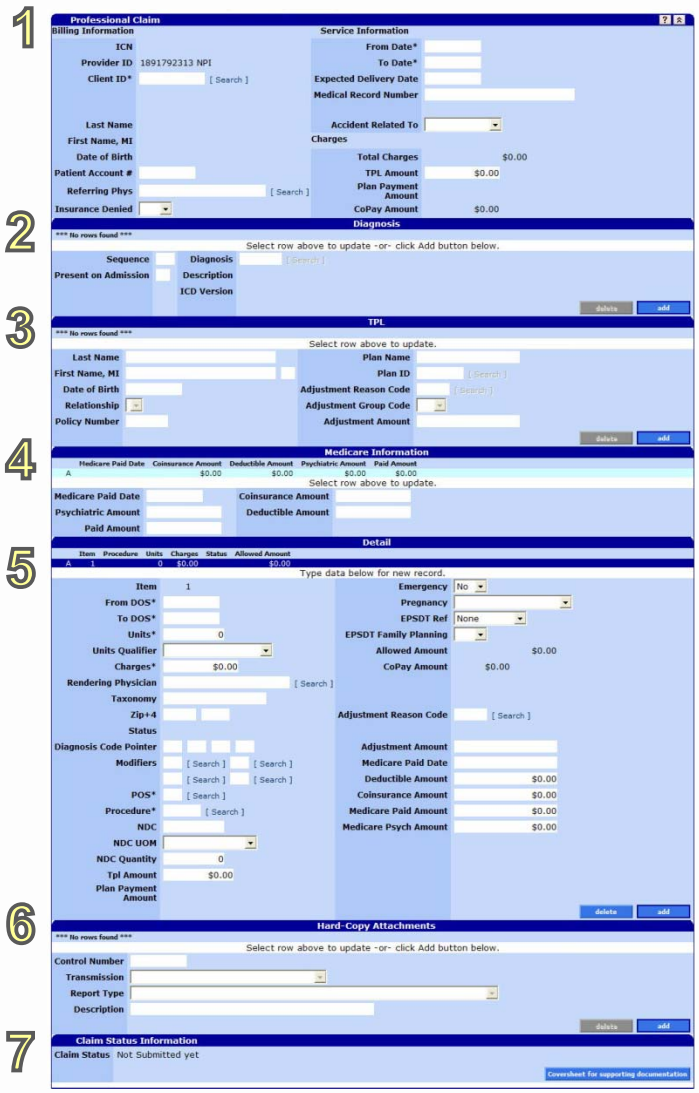
Providers Page



Professional Claim Form

Sections:

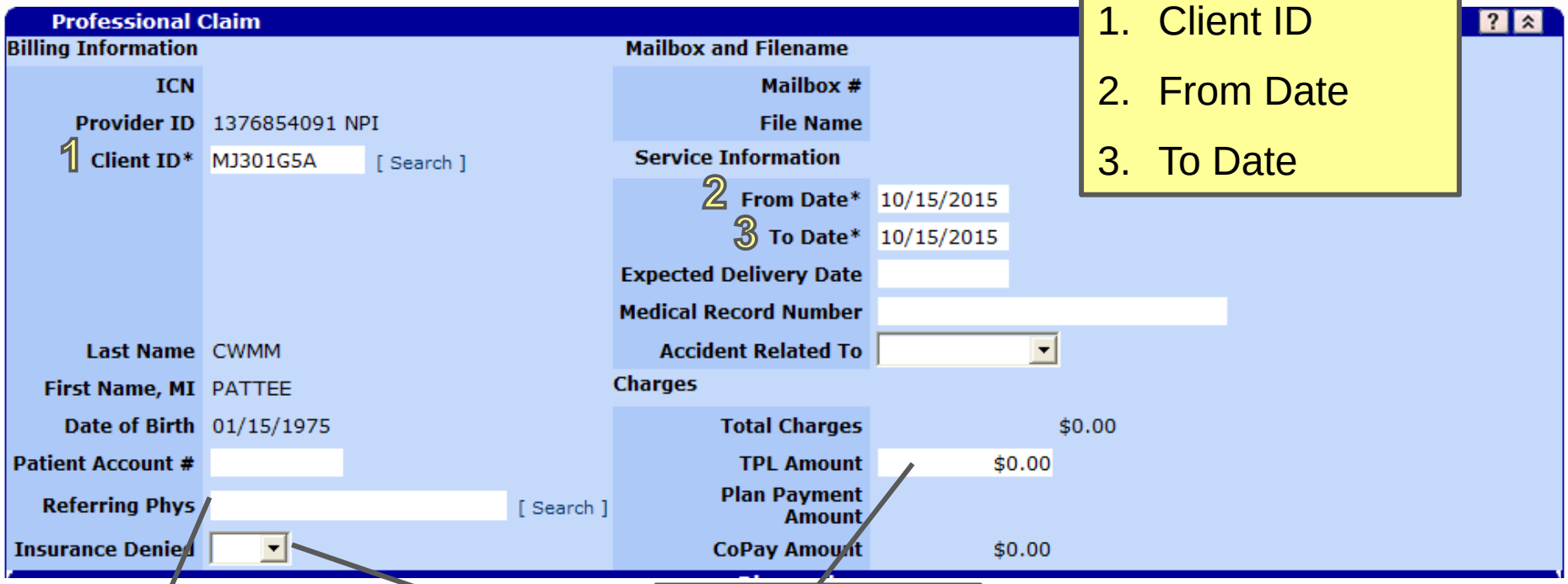
1. Professional Claim (header)
2. Diagnosis
3. TPL: Third-Party Liability
4. Medicare Information
5. Detail
6. Hard-Copy Attachments
7. Claim Status Information



Professional Claim (Header)

Required fields:

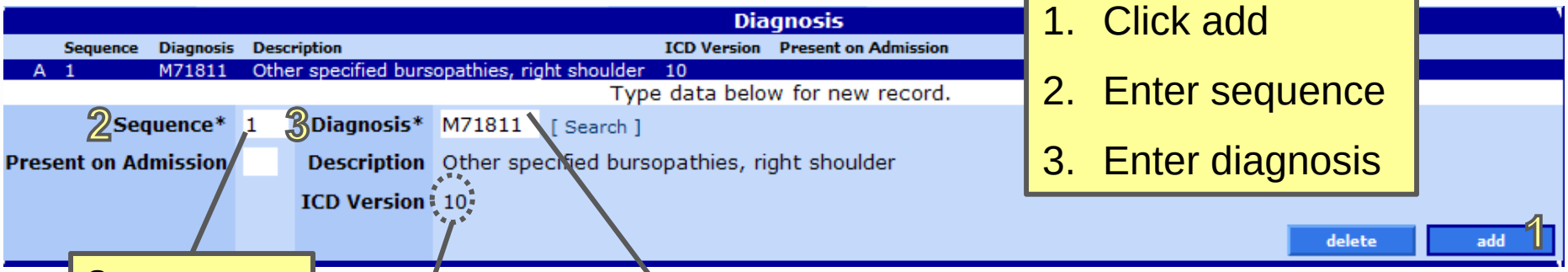
1. Client ID
2. From Date
3. To Date



Required *only* when the service requires a referral

Required *only* if TPL is listed on client eligibility; does not include Medicare

Diagnosis



For each diagnosis:

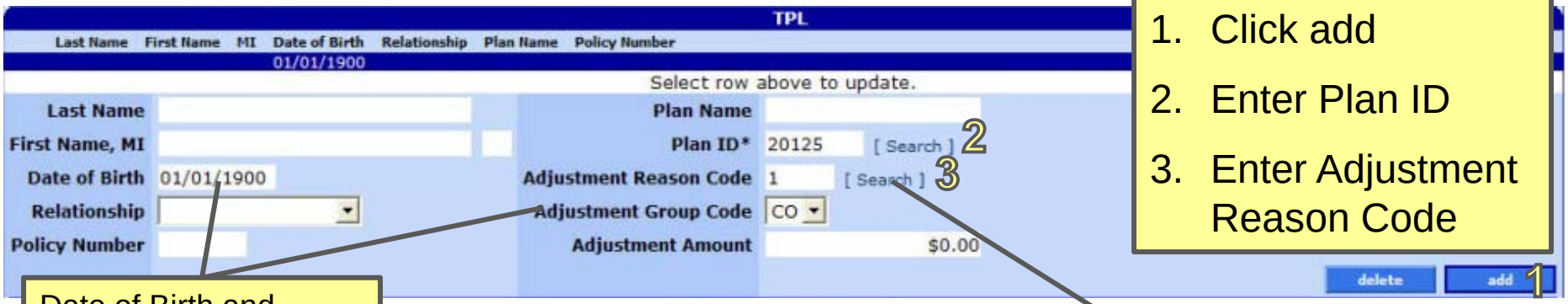
1. Click add
2. Enter sequence
3. Enter diagnosis

Sequence:
1 for first;
2 for second;
3 for third; etc.

Enter diagnosis code without the decimal

Indicates the ICD version (9 or 10); ICD-10 is required as of 10/01/2014

TPL



For each third-party:

1. Click add
2. Enter Plan ID
3. Enter Adjustment Reason Code

Date of Birth and Adjustment Group Code are not required, but both auto-populate upon claim submission

TPL section required *only* when client has third-party insurance; does not include Medicare

Use Search links to search for appropriate ID or code

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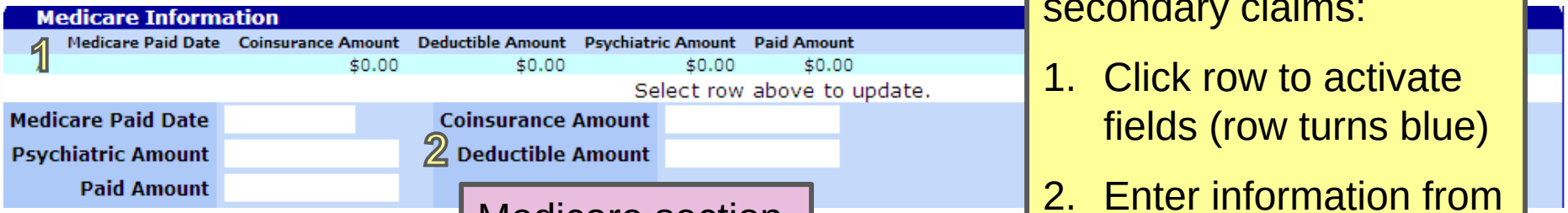
Medicare Information



Medicare section required *only* for Medicare clients

For Medicare/Medicaid secondary claims:

1. Click row to activate fields (row turns blue)
2. Enter information from Medicare

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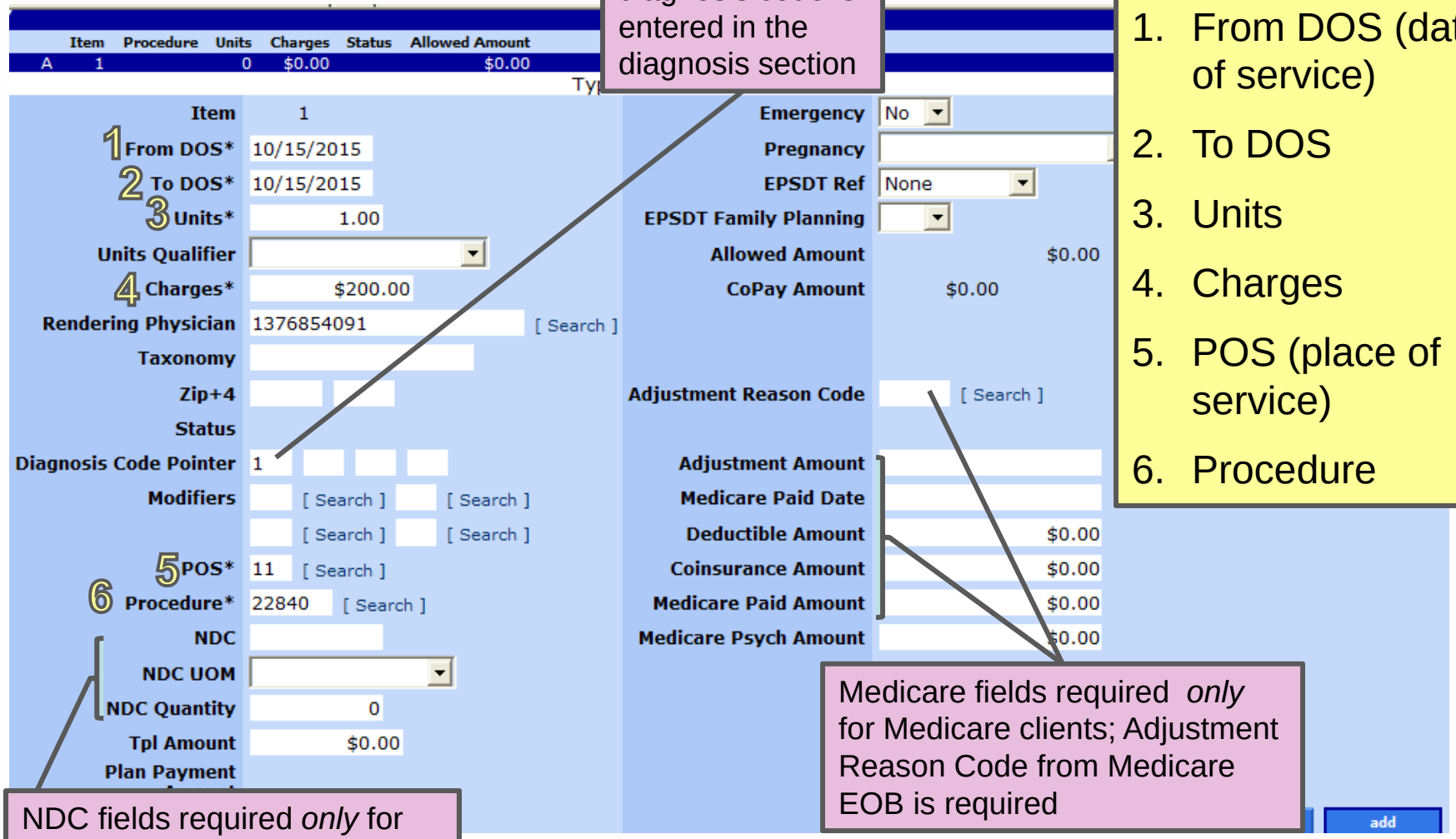
Detail



Required *only* if a diagnosis code is entered in the diagnosis section

Required fields:

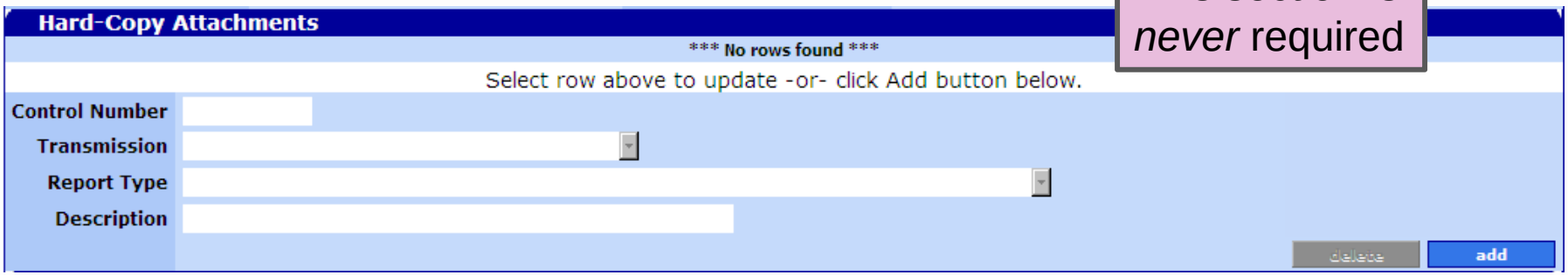
1. From DOS (date of service)
2. To DOS
3. Units
4. Charges
5. POS (place of service)
6. Procedure

Medicare fields required *only* for Medicare clients; Adjustment Reason Code from Medicare EOB is required

NDC fields required *only* for physician-administered drugs; enter NDC in 11-digit format

Hard-Copy Attachments

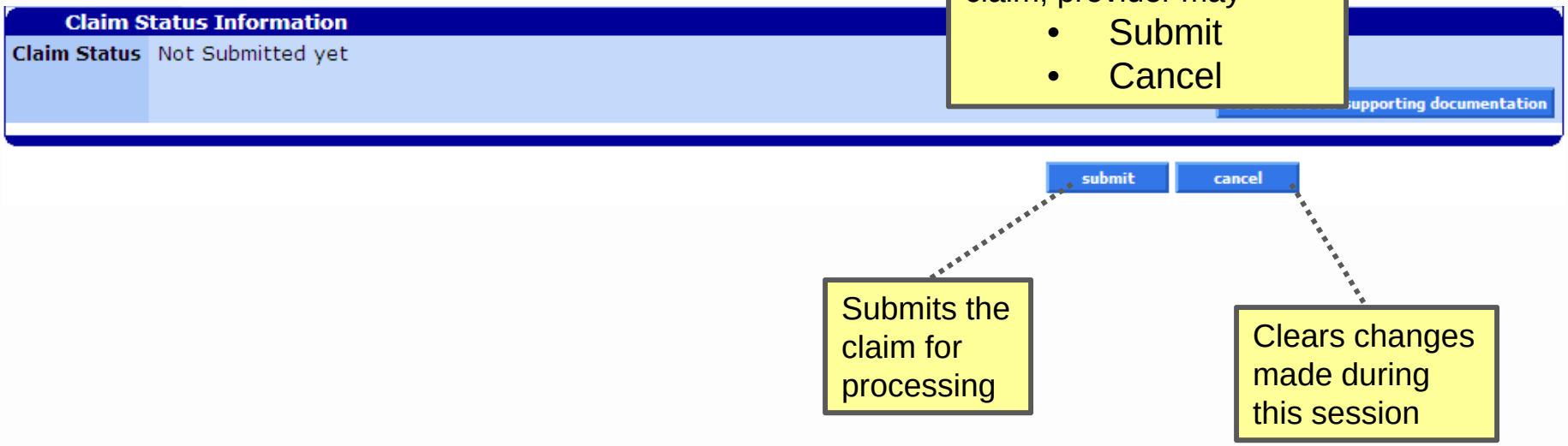
This section is *never* required



Claim Status Information

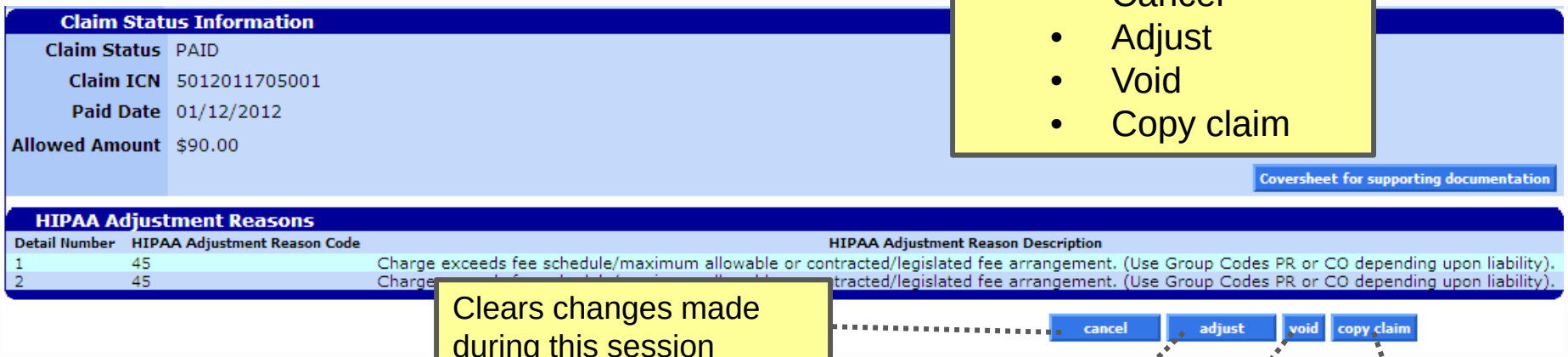
Not Submitted yet claim; provider may

- Submit
- Cancel



Claim Status PAID

PAID claim; provider may
- Cancel
- Adjust
- Void
- Copy claim



Clears changes made during this session

Adjusts the existing claim with changes made during this session

Cancels the existing claim; previous payments will be recouped

Duplicates the existing claim; status will change back to Not Submitted Yet

Claim Status DENIED

DENIED claim; provider may
- Re-submit
- Cancel

Claim Status Information

Claim Status	DENIED
Claim ICN	2213364000010
Denied Date	12/30/2013
Allowed Amount	$0.00

Coversheet for supporting documentation

HIPAA Adjustment Reasons

Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
0	146	Diagnosis was invalid for the date(s) of service reported.
1	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

re-submit cancel

Submits a new claim with changes made during this session

Clears changes made during this session

*Claim status SUSPENDED: In some cases, a claim may suspend for internal review when our system is unable to determine if a claim should pay or deny. Providers may take *no* action on suspended claims. Claims are given a PAID or DENIED status after internal review. This process should never take longer than two weeks.

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Do You Need Further Assistance?

Provider Services Unit

800-336-6016

dmap.providerservices@state.or.us

Medicaid Provider Training

Medicaid.Provider-Training@state.or.us