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OREGON MEDICAID
MANAGEMENT INFORMATION
SYSTEM

Institutional (UB-04)

Paper Billing

Instructions for

Fee-for-Service

Providers v1.2

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1 Introduction

The UB-04 (Uniform Bill -Version 04) Billing Instructions handbook is a guide to help Providers who bill for Medicaid services complete the UB-04 paper billing form.

1.1 About This Handbook

This handbook lists the requirements for claims completion and provides helpful hints on how to avoid common billing errors. It provides step-by-step instructions on how to submit a UB-04 paper claim.

Providers are encouraged to use this handbook, as applicable, with the Oregon Administrative Rules (OARs) and related supplemental information for billing.

The UB-04 Paper Billing Instructions are designed to assist the following Providers:*

- Freestanding Kidney Dialysis Centers
- Home Health Agencies
- Hospice Services
- Hospitals
- Mental Health
- Nursing Facilities

*This list may not include all Provider types that use the UB-04. If in doubt of which claim form to use or if you need assistance with claims, refer to your Provider guidelines or contact DHS Provider Services at:

- **Email:** DMAP.Providerservices@state.or.us
- **Phone:** 800-336-6016 (8:00 a.m. to 5:00 p.m PST, Monday through Friday)

2 Key Terms

Claim

- A request for payment of health care services to a DHS client.

Diagnosis Code

- A numeric code that documents the client's medical condition, symptom or complaint as determined by the Provider and is the basis for rendering service(s). The diagnosis coding structure uses the International Classification of Disease– Ninth Revision, Clinical Modification (ICD-9-CM).

Internal Control Number

- An Internal Control Number (ICN) is a unique 13-digit identification number assigned to every claim in order to distinguish it from all other claims received by the system. The ICN is comprised of multiple components that identify critical information about the claim.
 - The first two characters represent the region code that identifies the source (paper, electronic, claim adjustments, etc) of the claim submission.
 - The ICN also represents the date the claim was received in the year and Julian date portion of the field. This facilitates control reporting of claims for the receipt date, as well as other downstream processing, such as edit disposition.
 - The batch range portion identifies the claim type assigned to the claim, and the sequence number of its relative position within a process cycle.

Modifier

- A means by which the reporting physician can indicate that a service or procedure performed has been modified by some specific circumstance but the service has not changed in its definition or code.

Modifiers can be found in the Current Procedural Terminology (CPT) book.

Patient Status Code

- A two (2)-digit code to indicate the patient's status at the time of discharge from the hospital.

Payment Authorization

- Authorization is granted to a Provider to render specified services to a designated client. The authorization is given **after** the services are provided.

Prior Authorization

- A Prior Authorization (PA) is requested by a Provider in order to render specified services to a designated client. The authorization is given **prior** to the services being performed.

Procedure Code

- A CPT or a Healthcare Common Procedure Coding System (HCPCS) code is a five (5)-digit code that uniquely identify a service or procedure for a professional service from physicians, nurses, chiropractors, etc. Procedure codes are used on all professional claims to describe services performed.

Revenue Center Codes

- A four (4)-digit code that most accurately describes the service provided and identifies specific accommodation and/or ancillary charges.

Third-Party Liability

- Third-Party Liability (TPL) provides cost containment of the Medicaid program through the identification of services for which other insurance should be the primary payer. This includes, but is not limited to, private health insurance, any applicable Medicare coverage, worker's compensation, and accident-related liability insurance.

Type of Bill

- A three (3)-digit code that identifies the type of facility and type of care you are billing.

Value Codes

- A 2-digit alphanumeric code and the related dollar or unit amount identifies data of a monetary nature that are necessary for the processing of a claim.

3 Claims Processing

The federal government requires Medicaid claims to be processed through an automated claim processing system known as the Medicaid Management Information System (MMIS). This system is a combination of people and computers working together to process claims.

Most paper claims submitted by mail go first to the DHS Office of Document Management (ODM) Imaging Unit.

- The document is scanned through an Optical Character Recognition (OCR) machine and the claim is given an ICN.
- The scanned documents are then identified and sorted by form type and indexed by identifiers such as client name, prime identification number, the date of service, and Provider number.
- Finally, the data and images are stored on an Electronic Document Management System (EDMS).

Once the claim is scanned through the OCR, DHS staff can immediately access submitted claim information by checking certain MMIS screens. The fewer edits and audits the claim goes through, the more quickly the system can process the claim.

The system performs daily edits for presence and validity of data. Once a week, the system audits all claims to ensure that they conform to medical policy. Every weekend, a payment cycle runs and the system produces checks for claims that successfully pass all edits and audits.

DHS staff can view all claims, however they must routinely access claims if the MMIS cannot make a payment decision based on the information submitted. The system directs the claim to DHS staff for specific medical or administrative review. This type of claim is a suspense claim or a claim that has been suspended.

DHS does not return denied claims to Providers. Instead, DHS mails or sends an electronic, per the Provider's choice, listing of all claims paid, denied and/or suspended to the Provider (with payment if appropriate). The listing is called a Remittance Advice (RA).

4 Eligibility Verification

It is the responsibility of the provider to verify that the individual receiving medical services is, in fact, an eligible individual on the date of service (DOS) for the service provided and whether a managed care plan or DHS is responsible for reimbursement. The provider assumes full financial risk in serving a person not identified as eligible for the service provided on the date(s) of service.

The Medical Care ID card and household's comprehensive coverage letter do not guarantee eligibility or payment and should not be used as proof of eligibility.

The Medical Care ID card will not include eligibility or enrollment information. Providers can verify eligibility in the following ways:

- The secure provider Web portal
- The Automated Voice Response (AVR), which replaces the Automated Information System (AIS)
- Electronic Eligibility Verification Service (EEVS) through a vendor
- Batch and real-time verification method through EDI 270/271 transactions

Current and past client eligibility information is available through any of these methods. Future eligibility information is not available. Eligibility information is subject to change at any time.

Clients enrolled with an OHP managed care organization (MCO) must be billed to the appropriate MCO identified.

Note: It is always a good idea to keep track of when and how you verified eligibility. In addition, it is recommended to record all client eligibility information for the date of service verified, including any eligibility verification numbers.

For more information on client eligibility verification, please refer to the MMIS Provider Overview training module at:

www.oregon.gov/DHS/mmis/training-info.shtml

5 UB-04 Claim Form

5.1 Where to get the UB-04 claim form

Providers billing institutional services on paper must use the standard UB-04 claim form. DHS does not supply the UB-04 form. The federal UB-04 form is available through:

- Local business forms suppliers
- Standard Register Company, Forms Division (800-755-6405)

DHS processes paper claims using OCR scanning. When purchasing your claim forms use commercially available “red form” versions of the UB-04. When claim forms are submitted on the standard “red form”, the red ink drops out and the OCR technology scans the claim data (black ink) directly into the claims processing system, which increases the accuracy and efficiency of claims processing. Do not make copies of the red forms for use in billing DHS.

5.2 Valid Claim Formats

DHS only accepts the current UB-04 claim form. Claims submitted on the previous version (UB-92 form) will be returned with a request to resubmit the claim on the correct form.

5.3 Completing the UB-04 Claim Form

Shaded fields are required in order to process the claim. The claim may suspend or deny if information in this field is missing or incomplete.

1	2	34 PRT CNTL #	35 MED REC #	3	4
5	6	7	8	9	10
11	12	13	14	15	16
17	18	19	20	21	22
23	24	25	26	27	28
29	30	31	32	33	34
35	36	37	38	39	40
41	42	43	44	45	46
47	48	49	50	51	52
53	54	55	56	57	58
59	60	61	62	63	64
65	66	67	68	69	70
71	72	73	74	75	76
77	78	79	80	81	82
83	84	85	86	87	88
89	90	91	92	93	94
95	96	97	98	99	100

UB-04 CMS-1450 APPROVED OMB NO. NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

5.3.1 Field Descriptions and Required Fields

Shaded boxes are always mandatory. Non-shaded boxes are mandatory, if applicable to the client's claim.

Field	Field Name	Description
1	Billing Provider Information	Enter the name and address of the entity that is requesting to be paid for the services rendered.
3a	Patient Control No.	If a client account number is provided in this field it will print on the Remittance Advice (RA). The patient account number is for the biller's internal billing purposes and is not used by DHS for claims processing.
4	Type of Bill	Enter the appropriate three (3)-digit code that identifies the type of service you are billing. Refer to Appendix " Type of Bill Codes " for specific codes by Provider type.
6	Statement Covers Period From/Through Date	Enter the beginning and ending dates of service covered by this claim. This field is for billing accommodation day only! Use MMDDYY numeric format (example: 102806). Total days in this field must correspond to the number of units in field 46. <ul style="list-style-type: none"> • "From" date is the date services began. • "Through" date is the date services ended.
8b	Patient Name	Enter the client name exactly as it is printed on the Medical Care Identification Card. DO NOT use "nicknames."
12	Admission Date	Enter the actual admission date. Use MMDDYYYY format.

Field	Field Name	Description
13	Admission Hour	For inpatient and outpatient services, enter the hour of admission. Use numbers from 00 to 24 (01 = 1 a.m., 10 = 10 a.m., 13 = 1 p.m. 23 = 11 p.m., etc.)
14	Type of Admission or Service	For inpatient services, enter the one (1)-digit code to indicate type of service. Use one of the following codes (see OAR 410-125-0401 for definitions): <ul style="list-style-type: none"> • 1 - Emergent • 2 - Urgent • 3 - Elective • 4 - Newborn
16	Discharge Hour	For inpatient and outpatient services, enter the hour of discharge. Use military time formats e.g. 00 to 24 (01 = 1 a.m., 10 = 10 a.m., 13 = 1 p.m. 23 = 11 p.m., etc.).
17	Patient Status	For inpatient services, enter the two (2)-digit code to indicate patient status at time of discharge. See Appendix patient status codes.
42	Revenue Center Codes	Enter the four (4)-digit code that most accurately describes the service provided. For a complete list of Revenue Codes for your Provider type, refer to OARs and, as applicable, related supplemental information for billing. Enter “0001” in line 23 of this field to indicate the claim’s total charges (entered in field 47).

Field	Field Name	Description
44	HCPCS/Rates	<p>Enter the five (5)-digit code for each Revenue Code requiring CPT/HCPCS. Refer to OARs and, as applicable, related supplemental information for revenue codes requiring CPT/HCPCS.</p> <ul style="list-style-type: none"> • Inpatient services do not require CPT/HCPCS.
46	Service Units	<p>Enter total days or units of service for each Revenue Center Code listed.</p> <ul style="list-style-type: none"> • One visit equals one unit of service. • One supply item equals one unit of service.
47	Total Charges	<p>Enter the usual and customary charge for each Revenue Center Code listed. Enter the sum of all charges in line 23 of this field.</p>
50	Payer Name	<p>Enter the name(s) of the payer organizations you are billing (up to three payers).</p> <ul style="list-style-type: none"> • If DHS is the only payer, enter DHS/Medicaid on Line A. <p>Note: DHS is the payer of last resort. Any resources billed prior to billing DHS should be listed first.</p>
54	Prior Payments	<p>Enter the actual amount of any payments you received from Third Party Resources (TPR). Use the line that corresponds to the line used for DHS in field 50.</p> <ul style="list-style-type: none"> • If Medicare paid, show the actual Medicare payment. • Do not list write-offs, any previous payment received from Medicaid, or co-payments.
56	NPI	<p>Enter your ten (10)-digit National Provider Identifier.</p>

Field	Field Name	Description
57	Other Provider ID	<p>Enter the six (6) or (9)-digit Provider number on the line that corresponds to the line used for DHS in Field 50. DHS will pay this Provider.</p> <ul style="list-style-type: none"> Existing Medicaid Providers will have a six (6)-digit Provider number. After the replacement MMIS goes live, newly enrolled Medicaid Providers will have a nine (9)-digit Provider number.
60	Insured's Unique ID	<p>Enter the eight (8)-digit Medicaid Client Identification Number. Use the line that corresponds to the line used for DHS in field 50.</p> <ul style="list-style-type: none"> The client ID number is printed on the Medical Care Identification card.
63	Treatment Authorization Codes	<p>If the service was prior authorized, enter the nine (9)-digit Prior Authorization number that DHS issued for the service. Use the line that corresponds to the line used for DHS in field 50.</p> <ul style="list-style-type: none"> For all services except inpatient: DO NOT bill prior-authorized and non-authorized services on the same claim form. You must submit separate UB-04 claim forms. Bill all inpatient services (both prior-authorized and non-authorized) on a single claim.

Field	Field Name	Description
67	Principal Diagnosis Code	<p>Enter the primary diagnosis/condition of the client by entering the current ICD-9-CM code. The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records.</p> <ul style="list-style-type: none"> • Enter up to four (4) diagnosis codes in priority order. Carry out codes to their highest degree of specificity. • DO NOT enter the decimal point.
67A - 67D	Other Diagnosis Codes	<p>Enter up to four (4) additional diagnosis ICD-9-CM codes, as appropriate. You can enter additional diagnosis codes for conditions that:</p> <ul style="list-style-type: none"> • Coexist at the time of admission. • Develop subsequently. • Affect treatment received and/or length of treatment.
74	Principal Procedure Code and Date	<p>This box is required if a procedure was performed. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes. Enter the ICD-9-CM which best identifies the procedure.</p>
78	Other Physician ID	<p>For Primary Care Manager (PCM) or Physician Care Organization (PCO) clients, list the ten (10)-digit NPI, followed by the six (6)-digit or (9) digit DHS Provider number of the PCM/PCO.</p> <ul style="list-style-type: none"> • Existing Medicaid Providers will have a six (6)-digit Provider number. • After the replacement MMIS goes live, newly enrolled Medicaid Providers will have a nine (9)-digit Provider number.

Field	Field Name	Description
80	Remarks	If the client has other medical coverage, enter the appropriate two (2)-digit third party resource (TPR) explanation code. See Appendix, TPR explanation codes.

6 Helpful Billing Tips

- READ** your Provider guidelines!
- MAKE SURE** you have the most current OARs rulebook.
- VERIFY** client eligibility on the date services are provided.
- VERIFY** that the client's name and ID number on the claim matches the name and number shown on the Medical Care ID card.
- USE** only commercially available "red form" of the UB-04.
- DO NOT USE** black and white claim forms or copies.
- USE** blue or black ink and print clearly if you are hand writing your claim. **DO NOT** use red ink.
- DO NOT USE** liquid white out on the claim form.
- DO NOT** bold data on the claim form.
- CHECK** your printer alignment. All data on a claim form must be correctly aligned within the designated data fields. CMS recommends using Arial 10 pt font type and size.
- BILL** other resources (Medicare/Third-party resources) before billing Medicaid and reported the correct dollar amount in Field 54.
- USE** the correct 2-digit third party resource (TPR) explanation code when the client has other insurance. Always enter a code if the client has more than one TPR available.
- REPORT** the correct TPL dollar amount on the claim.

- USE** the correct combination of procedure code and modifier appropriate for the service billed.
- USE** only one prior authorization number in Field 63.
- Unless you are billing for inpatient services, **DO NOT** bill authorized services and services that do not require authorization on the same claim form.
- ENTER** the Provider ID number you want DHS to send payment to in Field 57. An invalid or missing Provider ID number could delay your payment, make payment to a wrong Provider or deny your payment.
- DO NOT** carry over totals from one UB-04 form to the other.
- For inpatient services, **BILL** all procedures provided on the same date of service on a single claim.
- BILL** multiple surgical procedures on one claim form.
- DO NOT** attach third-party resources explanation of benefits (EOB) to your claim form.
- READ** the EOB codes on the claims status screen or RA to determine the error.
- CONTACT** DHS Provider Services at 800-336-6016 or e-mail at DMAP.Providerservices@state.or.us for assistance.
- VISIT** www.oregon.gov/DHS/healthplan for additional information.

7.1 Type of Bill Codes

Use the Type of Bill Code in Field 4 of the UB-04.

Type of Bill codes provide specific information about the bill. The first digit identifies the type of facility (e.g., hospital). The second digit identifies the type of care (e.g., Inpatient). The first and second digit are also referred to as the "Claim Form Bill Type".

The third digit is the sequence of this bill in the particular episode of care (e.g., Admit Through Discharge Claim). The third digit is also referred to as the "Frequency Code".

The tables below outline the Type of Bill codes accepted by DHS.

DHS accepts the following codes:

7.1.1 Home Health Services

321	Admit through Discharge Claim: Encompasses an entire home health span of service for which the agency expects reimbursement.
322	First Claim: Use for the first of an expected series of payment claims for the same home health start of care.
323	Interim-Continuing Claim: Use when one or more claims for the same home health start of care have already been submitted, and further claims are expected to be submitted at a later date.
324	Interim-Last Claim: Use for a claim which is the last of a series for a home health start of care. The "through" date of this claim (FL 6) is the discharge date or date of death for this service span.

7.1.2 Hospice Services

Codes beginning in “81” indicate non-hospital based hospice services; codes beginning in “82” indicate hospital-based hospice services.

811	821	Admit through Discharge Claim: Encompasses an entire course of hospice treatment. Use when no further bills will be submitted for this client (<i>i.e.</i> , client revokes or expires within the first billing period).
812	822	First Claim: Use this code for the first of an expected series of payment bills for course of treatment.
813	823	Interim-Continuing Claim: Use when a bill has been submitted and further bills area expected to be submitted.
814	824	Last Claim: Use for a bill which is the last of a series for a hospice course of treatment. The through date of this bill (FL 6) is the discharge date or date of death.

7.1.3 Hospital Services – Inpatient

111	Use for most inpatient billings, including clients with Medicare Part A coverage only.
121	Use for clients with Medicare Part B coverage only.

7.1.4 Hospital Services – Outpatient

131	Use for most outpatient billings.
141	Referenced Diagnostic Services
831	Hospital-based ambulatory surgery

7.1.5 Kidney Dialysis Services

721	Independent End Stage Renal Dialysis Facilities
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7.1.6 Nursing Facility/Long-Term Care

DHS accepts many Type of Bill codes for Nursing Facility/Long-Term Care services. Use the tables below to select the most appropriate combination of numbers for your Type of Bill code.

Select the first two digits from the following table.

Claim Form Bill Type (1st & 2nd Digit)	Description
18	Hospital swing bed
21	SNF In-patient
22	SNF In-patient (Part B)
23	SNF Out-patient
28	SNF swing bed

Then, select the third digit from the following table.

Frequency Code (3rd Digit)	Description
1	Admit Through Discharge Claim
2	Interim - First Claim
3	Interim - Continuing Claims
4	Interim - Last Claim
8	Void/Cancel of a Prior Claim

Always select values that are most appropriate for the associated claim.

7.2 Patient Status Codes

This information is required for inpatient hospital claims only. Use in Field 17 of the UB-04 form.

01	Discharged to home or self care (routine discharge)
02	Discharged or transferred to another acute care hospital
03	Discharged or transferred to skilled nursing facility (SNF)
04	Discharged or transferred to an intermediate care facility (ICF)
05	Discharged or transferred to another type of institution (not another acute care hospital)
06	Discharged or transferred to home under care of home health service organization
07	Left against medical advice
08	Discharged to home under care of Home Enteral/Parenteral Provider
20	Expired
50	Hospice discharged to home
51	Hospice discharged to medical facility
63	Discharged/transferred to a long-term care facility

7.3 Third Party Resource (TPR) Explanation Codes

Use in field 80 on the UB-04 form.

7.3.1 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-and Not Paid Within 30 Days
OT	Other (if above codes do not apply, include detailed explanation of why no TPR payment was made)

7.3.2 Multiple Insurance Coverage

Use in Field 80 on the UB-04 form. 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 Canceled/Terminated
SL	Primary Insurance Paid – Secondary Lapsed or Not in Effect
SP	Primary Insurance Paid – Secondary Payment Went to Patient
SH	Primary Insurance Paid – Secondary Payment Went to Policyholder
SA	Primary Insurance Paid – Secondary Denied - Service Not Authorized
SE	Primary Insurance Paid – Secondary Denied - Service Not Considered Emergency
SF	Primary Insurance Paid – Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Insurance Paid – Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Insurance 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)

7.4 Claims Address Mailing List

Below is the DHS claims address mailing list.

CMS-1500	All professional Provider and AMH claims	DMAP, PO Box 14955 Salem, OR 97309
	Speech/language pathology, audiology & hearing services; private duty nursing claims	DMAP, PO Box 14018 Salem, OR 97309
	Contract RN claims	DMAP, PO Box 14957 Salem, OR 97309
DMAP 505	Medicare/Medicaid claims	DMAP, PO Box 14015 Salem, OR 97309
UCF (Universal Claim Form)	Drug claims	DMAP, PO Box 14951 Salem, OR 97309
Any form used in conjunction with Death with Dignity	Death with Dignity claims	DMAP, PO Box 992 Salem, OR 97308-0992
ADA 2006	Dental claims	DMAP, PO Box 14953 Salem, OR 97309
UB-04	Hospital, Home Health, Hospice, NF/LTC claims	DMAP, PO Box 14956 Salem, OR 97309
DMAP 741 OMAP 742	Consent to hysterectomy Consent to sterilization	DMAP, PO Box 14958 Salem, OR 97309
Out-of-state claims (all claim types)	For Providers more than 75 miles beyond the Oregon border.	DHS Provider Services (Out-of-State Claims) 500 Summer St. NE - E44 Salem, OR 97301

Administrative exams	Exams requested by DHS offices. Send reports to requesting DHS office; Mail only claims to DMAP.	DMAP, PO Box 14165 Salem, OR 97309
DMAP/DHS forms	To order DMAP or DHS forms	DHS Distribution Center 550 Airport Rd Salem, OR 97310
DMAP 1036 – Individual adjustment request	To use if you have received an incorrect payment (overpayment or underpayment) for a CMS-1500 claim	DMAP, PO Box 14952 Salem, OR 97309
Problem claims including administrative errors and claims over one year old.	<ol style="list-style-type: none"> 1. Send copy of claim with letter explaining the problem 2. Attach a copy of the RA related to the claim 3. Include complete documentation 	DHS Provider Services 500 Summer St NE, E44 Salem, OR 97301-1079
Appeals (Reconsideration of Non-covered services, CAWEM denials, and other appeals).	<ol style="list-style-type: none"> 1. Send a letter stating reasons for the appeal. 2. Attach the claim for denied services. 3. Include supporting medical record documentation. 	DHS Provider Services 500 Summer St NE, E44 Salem, OR 97301-1079
Addictions and Mental Health Division (AMH)	For General Correspondence	Addictions and Mental Health Division 500 Summer St. NE - E86 Salem, OR 97301-1118

7.5 Prior Authorization/Plan of Care Contact List

Below are the Fee-for-Service Prior Authorization (PA)/Plan of Care (POC) contact phone numbers.

PA/POC Contacts for FFS or open card Clients	
Use the appropriate agency listed below to authorize services in each section.	
Programs	Agency Authorizing Service
DME Equipment/Supplies Hearing Aid Services Home Health (Nursing only) Home Enteral /Parenteral Services (see below for Oral Nutritional Supplements) Physical/Occupational Therapy Private Duty Nursing Speech/Hearing/Audiology Vision Services	<p>Medically Fragile Children’s (MFC) Unit:</p> <ul style="list-style-type: none"> • 971-673-2985 • 971-673-3000 <p>FFS high cost/high risk clients- Innovative Care Management 10117 SE Sunnyside Road, Box F409 Clackamas, OR 97015</p> <ul style="list-style-type: none"> • 800-862-3338 • 503-654-9447 <p>All other clients—DMAP Medical Unit:</p> <ul style="list-style-type: none"> • 800-642-8635 • 503-945-6821
Addictions and Mental Health Plan of Care	<p>Addictions and Mental Health Division:</p> <ul style="list-style-type: none"> • 503-945-5763 • 800-375-2863 TTY • 503-947-5546 Fax
Long term care and waived services for Seniors and People with Physical Disabilities (SPD).	All PA requests must go through the local office.
Dental Services	<p>DMAP Dental Coordinator:</p> <ul style="list-style-type: none"> • 800-527-5772 • 503-945-6506

**PA/POC Contacts
for FFS or open card Clients**

Use the appropriate agency listed below to authorize services in each section.

Programs	Agency Authorizing Service
Drugs/Pharmacy Home Enteral/Parenteral – (Oral meds & Nutritional Supplements only)	PBM Technical and Prior Authorization Center <ul style="list-style-type: none"> • 888-202-2126
Surgical Procedures	High cost/high risk clients—Innovative Care Management: <ul style="list-style-type: none"> • 800-862-3338 • 503-654-9447 All other clients- Acumentra Health: 2020 SW Fourth St. Ste 520 Portland, OR 97201-4960 <ul style="list-style-type: none"> • 800-452-1250 • 503-279-0159 Outside Oregon—non-emergent services: <ul style="list-style-type: none"> • 800-325-8933
Transplants Out-of –State Services	High-cost/high-risk clients- Innovative Care Management: <ul style="list-style-type: none"> • 800-862-3338 • 503-654-9447 All other clients- DHS Provider Services: <ul style="list-style-type: none"> • 800-336-6016 Mental Health- <ul style="list-style-type: none"> • 503-945-5763 • 800-375-2863 TTY • 503-947-5546 Fax
Non-Emergent Transportation	Contact the local branch office/brokerage

7.6 DHS Support Phone Numbers

Following is the DMAP Fee-for-Service PA and DHS contact phone numbers list.

Department	Phone Number	Hours
<p>Automated Voice Response (AVR)</p> <ul style="list-style-type: none"> ✓ Client eligibility, TPR, benefit packages, managed care, and more. ✓ Vision service history ✓ Claims & payment inquiry ✓ Prior Authorization 	866-692-3864	24 hours, 7 days a week
<p>RN Benefit Hotline</p> <ul style="list-style-type: none"> ✓ Information about OHP diagnosis/treatment pairs <p><i>If the patient is in a managed care plan and you have a question about whether the treatment is covered, call the patient's plan.</i></p>	800-393-9855	Mon-Fri – 8 a.m. to 5 p.m. PST
<p>Electronic Data Interchange Support Team</p> <ul style="list-style-type: none"> ✓ Information about submitting claims electronically 	888-690-9888	Mon-Fri – 8 a.m. to 5 p.m. PST
<p>PBM Technical and Prior Authorization Center</p> <ul style="list-style-type: none"> ✓ Prior Authorization for providers calling for prescriptions 	<p>888-202-2126</p> <p>Fax:</p> <p>888-346-0178</p>	24 hours per day, seven days per week, 365 days per year

<p>OHP Application Center</p> <ul style="list-style-type: none"> ✓ Patients may call to receive an OHP Application ✓ Provides general assistance in completing the OHP Application ✓ Patients may call to receive a Senior Prescription Drug Assistance Program Application 	<p>800-359-9517 or TTY 800-621-5260</p>	<p>Mon–Fri, 8 a.m. to 5 p.m. PST</p>
<p>Provider Services</p> <ul style="list-style-type: none"> ✓ Provides details of Medical programs ✓ Answers billing questions ✓ Information on claims payment ✓ To discuss claim status ✓ Out of state claims 	<p>800-336-6016</p>	<p>Mon–Fri, 8 a.m. to 5 p.m. PST</p>

7.7 DHS Fax Numbers

Document Type	Fax Number
<p><i>Immediate/Urgent Prior Authorizations</i></p> <ul style="list-style-type: none"> • PA • Supporting Docs <p>*A DHS approved cover sheet is required for <u>each</u> PA submitted.</p>	503-378-3435
<p><i>Routine Prior Authorizations</i></p> <ul style="list-style-type: none"> • PA • Supporting Docs <p>*A DHS approved cover sheet is required for <u>each</u> PA submitted.</p>	503-378-5814
<p>Contract RN Claims</p> <ul style="list-style-type: none"> • Claims <p>*Do not use a fax coversheet.</p>	503-373-1237
<p>Provider Enrollment</p> <ul style="list-style-type: none"> • Applications • Supporting Docs <p>*A DHS approved cover sheet is required.</p>	503-378-3074

Correspondence <ul style="list-style-type: none">• Solicited• Un-Solicited <p>*A DHS approved cover sheet is required.</p>	503-378-3086
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