
ADA 2006 Billing Instructions

Line-by-line paper billing instructions
for Oregon Medicaid providers

Division of Medical Assistance Programs

Oregon
Health
Authority

Overview

- This presentation provides instructions on how to complete the ADA 2006 billing form when billing the Division of Medical Assistance Programs (DMAP) for dental services.
- If applicable, this presentation is to be used in conjunction with General Rules, program-specific provider guidelines and supplemental information.
- We hope you find this tutorial helpful.

Claims processing

- Paper claims are scanned into the claims processing system using Optical Character Recognition (OCR).
 - For OCR, you must use commercial “red form” claim forms and make sure certain fields are left-aligned.
- Electronic claims (Web and electronic data interchange) do not require specific claim forms or field alignment. Make sure you bill electronically whenever possible.
- Claims process weekly. DMAP sends a Remittance Advice (RA) listing all claims adjudicated to the provider (with payment if appropriate).

Before you bill

- Verify client eligibility on the date of service.
- Make sure you bill all prior resources first. Medicaid (DMAP) is the payer of last resort.
- Bill electronically if possible. You only need to bill on paper if you need to submit attachments with your claim, the claim is over a year old, and other certain instances.
- If you must bill on paper, use commercially available versions of the ADA 2006.

Paper billing tips

- When submitting handwritten claim forms:
 - Use blue or black ink; never use red ink.
 - Make sure your handwriting is legible. Zeroes should look different from the letter “O,” the number one (“1”) different from the letter “l,” etc.
 - Don’t use liquid paper/whiteout to make corrections.
- If possible, submit no more than six lines of services per claim form.
 - If you need to bill more than six lines on a single claim, bill electronically. Then you don’t need to complete multiple paper claim forms.
- Check your printer alignment.

Form suppliers

- DMAP does not supply the ADA 2006 form.
- You can purchase forms by contacting one of the following:
 - Local business forms suppliers
 - American Dental Association (800-947-4746) or on the Web at www.adacatalog.org
- If you don't want to purchase claim forms, you can use the Provider Web Portal for free!

ADA Dental Claim Form

MSA 07-0
Attachment

A
D
A

2
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0
6

HEADER INFORMATION												
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prauthorization <input type="checkbox"/> EPSDT/Title XIX												
2. Predetermination/Prauthorization Number					POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)							
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION												
3. Company/Plan Name, Address, City, State, Zip Code												
13. Date of Birth (MM/DD/CCYY)					14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)					
OTHER COVERAGE					16. Plan/Group Number		17. Employer Name					
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)												
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)												
PATIENT INFORMATION												
6. Date of Birth (MM/DD/CCYY)					7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)					
9. Plan/Group Number					10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other			18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other				
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code												
19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS					20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code							
21. Date of Birth (MM/DD/CCYY)					22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)					
RECORD OF SERVICES PROVIDED												
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description					31. Fee	
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
MISSING TEETH INFORMATION										32. Other Fee(s)		
34. (Place an 'X' on each missing tooth)										33. Total Fee		
35. Remarks												
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION							
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.					38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other					39. Number of Enclosures (00 to 99) Radiographs Oral Images Models <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
X Patient/Guardian signature _____ Date _____					40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)					41. Date Appliance Placed (MM/DD/CCYY)		
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.					42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		
X Subscriber signature _____ Date _____					44. Date Prior Placement (MM/DD/CCYY)					45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident		
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)					TREATING DENTIST AND TREATMENT LOCATION INFORMATION					46. Date of Accident (MM/DD/CCYY)		
48. Name, Address, City, State, Zip Code					53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.					47. Auto Accident State		
49. NPI					X Signed (Treating Dentist) _____ Date _____					54. NPI		
50. License Number					55. License Number					56A. Provider Specialty Code		
51. SSN or TIN					56. Address, City, State, Zip Code					57. Phone Number () -		
52. Phone Number () -					58A. Additional Provider ID					58. Additional Provider ID		

ADA Version 2006

- Not sure if you are using the correct form?

The bottom left corner will look like this.

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Top section

ADA Dental Claim Form		
HEADER INFORMATION		
1. Type of Transaction (Mark all applicable boxes)		
<input type="checkbox"/> Statement of Actual Services	<input type="checkbox"/> Request for Predetermination/Preauthorization	
<input type="checkbox"/> EPSDT/Title XIX		
2. Predetermination/Preauthorization Number		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		
3. Company/Plan Name, Address, City, State, Zip Code		
OTHER COVERAGE		
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender <input type="checkbox"/> M <input type="checkbox"/> F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	
PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender <input type="checkbox"/> M <input type="checkbox"/> F	23. Patient ID/Account # (Assigned by Dentist)

Red = Required

Yellow = Required if applicable

Box 1 - Optional

1. Type of Transaction (Mark all applicable boxes)

- Statement of Actual Services Request for Predetermination/Preauthorization
 EPSDT/Title XIX

- Type of Transaction
 - Indicate whether the claim is for pre-treatment or for actual services.

Box 2 – Required if applicable

2. Predetermination/Preauthorization Number

#####

- Preauthorization Number
 - If the service you provided required prior authorization (PA), enter the ten-digit prior authorization number that was issued for the service.
 - Only use one prior authorization number per claim form.

Box 15 - Required

15. Policyholder/Subscriber ID (SSN or ID#)

X X # # # X # X

- Recipient ID Number
 - Enter the recipient's eight-character identification number.
 - Enter the number exactly as it appears on the Medical Care Identification.
 - Do not use the recipient's Social Security Number.

Box 20 - Required

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Patient, Your

- Recipient Name
 - Enter the recipient's name exactly as it is printed on the Medical Care Identification.
 - Use your recipient's last name first.
 - Do not use nicknames.

Middle section

RECORD OF SERVICES PROVIDED																													
1	24. Procedure Date (MM/DD/CCYY)		25. Area of Oral Cavity		26. Tooth System		27. Tooth Number(s) or Letter(s)				28. Tooth Surface		29. Procedure Code		30. Description			31. Fee											
	2																												
3																													
4																													
5																													
6																													
7																													
8																													
9																													
10																													
MISSING TEETH INFORMATION		Permanent															Primary										32. Other Fee(s)		
34. (Place an 'X' on each missing tooth)		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	
35. Remarks																													

Red = Required

Yellow = Required if applicable

Box 24 - Required

24. Procedure Date (MM/DD/YYYY)
12/01/2008

- Procedure Date
 - This box must list numeric dates of service for each line item.

Box 25 – Required if applicable

25. Area of Oral Cavity

- Area of Oral Cavity
 - If appropriate, use one of the codes at right for each line item.

00	Entire Oral Cavity
01	Maxillary Arch
02	Mandibular Arch
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant

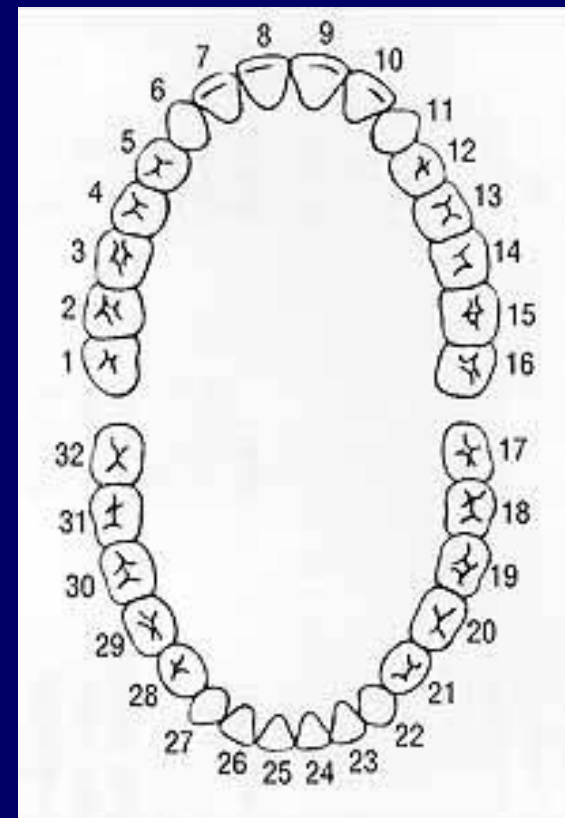
Box 27 – Required if applicable

27. Tooth Number(s) or Letter(s)

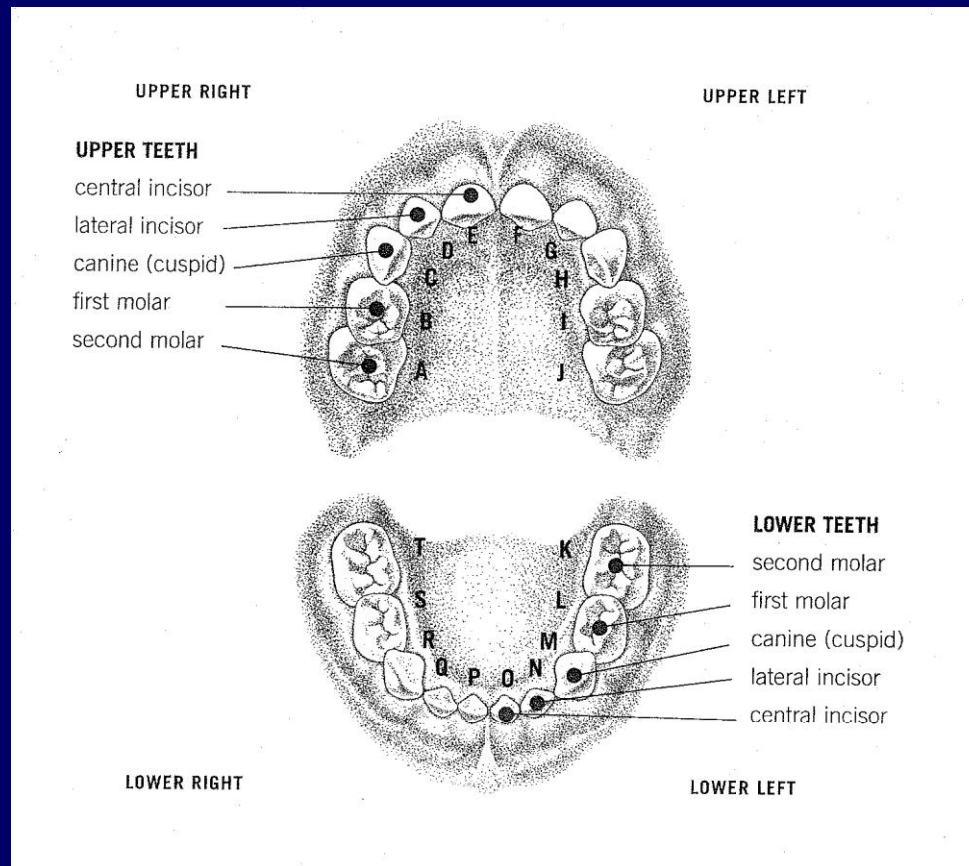
- Tooth Numbers or Letters
 - If appropriate, enter the tooth number or letter.
 - Leave blank if the procedure does not directly involve a tooth or range of teeth.
 - Refer to tooth chart appearing on the following pages.
 - A-T Deciduous teeth
 - 1-32 Permanent teeth
 - 51-82 Supernumerary permanent teeth
 - AS-TS Supernumerary primary teeth

Permanent Tooth Chart

- | | |
|---------------------------------|---------------------------------|
| 1. 3rd Molar (wisdom tooth) | 17. 3rd Molar (wisdom tooth) |
| 2. 2nd Molar (12-year molar) | 18. 3rd Molar (wisdom tooth) |
| 3. 1st Molar (6-year molar) | 19. 2nd Molar (12-year molar) |
| 4. 2nd Bicuspid (2nd premolar) | 20. 1st Molar (6-year molar) |
| 5. 1st Bicuspid (1st premolar) | 21. 2nd Bicuspid (2nd premolar) |
| 6. Cuspid (canine/eye tooth) | 22. 1st Bicuspid (1st premolar) |
| 7. Lateral incisor | 23. Cuspid (canine/eye tooth) |
| 8. Central incisor | 24. Lateral incisor |
| 9. Central incisor | 25. Central incisor |
| 10. Lateral incisor | 26. Central incisor |
| 11. Cuspid (canine/eye tooth) | 27. Lateral incisor |
| 12. 1st Bicuspid (1st premolar) | 28. Cuspid (canine/eye tooth) |
| 13. 2nd Bicuspid (2nd premolar) | 29. 1st Bicuspid (1st premolar) |
| 14. 1st Molar (6-year molar) | 30. 2nd Bicuspid (2nd premolar) |
| 15. 2nd Molar (12-year molar) | 31. 1st Molar (6-year molar) |
| | 32. 2nd Molar (12-year molar) |
| | 33. 3rd Molar (wisdom tooth) |



Primary Tooth Chart



Box 28 – Required if applicable

28. Tooth Surface

- Tooth Surface
 - If appropriate, list the tooth surface code(s) for each service.

B	Buccal
M	Mesial
D	Distal
O	Occlusal
L	Lingual
I	Incisal
F	Facial

Box 29 - Required

29. Procedure Code
D0120

- Procedure Code
 - For each line, list the five-character ADA procedure code for each individual service that was provided.
 - ADA procedure codes always begin with D.

Box 33 - Required

33.Total Fee		23	23
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- Total Fee
 - Enter the total for all fees listed in Box 31.

Box 35 - Optional

35. Remarks

- Remarks
 - If appropriate, enter “Payment by other plan” information, if any; or leave blank and attach a copy of plan’s Remittance Advice (RA).
 - You can also use this area for documentation when requesting prior authorization, or for unusual circumstances when filing a claim.

Bottom section

AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION
<p>36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.</p>	<p>38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other</p> <p>39. Number of Enclosures (00 to 99) Radiograph(s) <input type="text"/> Oral Image(s) <input type="text"/> Model(s) <input type="text"/></p>
<p>X _____ Patient/Guardian signature Date</p>	<p>40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)</p> <p>41. Date Appliance Placed (MM/DD/CCYY) _____</p>
<p>37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.</p> <p>X _____ Subscriber signature Date</p>	<p>42. Months of Treatment Remaining <input type="text"/> 43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)</p> <p>44. Date Prior Placement (MM/DD/CCYY) _____</p> <p>45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident</p> <p>46. Date of Accident (MM/DD/CCYY) _____ 47. Auto Accident State _____</p>
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)	TREATING DENTIST AND TREATMENT LOCATION INFORMATION
<p>48. Name, Address, City, State, Zip Code</p> <p>_____</p>	<p>53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.</p> <p>X _____ Signed (Treating Dentist) Date</p>
<p>49. NPI <input type="text"/> 50. License Number <input type="text"/> 51. SSN or TIN <input type="text"/></p>	<p>54. NPI <input type="text"/> 55. License Number <input type="text"/></p> <p>56. Address, City, State, Zip Code _____ 56A. Provider Specialty Code <input type="text"/></p>
<p>52. Phone Number () - _____ 52A. Additional Provider ID <input type="text"/></p>	<p>57. Phone Number () - _____ 58. Additional Provider ID <input type="text"/></p>

Red = Required

Yellow = Required if applicable

Boxes 48, 49 and 52A - Required

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)		
48. Name, Address, City, State, Zip Code		
49. NPI	50. License Number	51. SSN or TIN
52. Phone Number () -	52A. Additional Provider ID	

- Billing Provider Information – Enter information for the provider number DMAP will direct payment to:
 - Box 48 - Enter the name and address of the billing provider.
 - Box 49 - Enter the NPI registered with the billing provider's DMAP ID number (listed in Box 52A).
 - Box 52A - Enter the billing provider's DMAP ID. (Do not enter license numbers in this box)

Boxes 54 and 58 – Required if applicable

TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.	
X _____ Signed (Treating Dentist) Date	
54. NPI	55. License Number
56. Address, City, State, Zip Code	56A. Provider Specialty Code
57. Phone Number () -	58. Additional Provider ID

- Treating Provider Information – If this is the same as the billing provider information, leave these fields blank:
 - Box 54 - Enter the NPI registered with the treating provider’s DMAP ID number (listed in Box 58).
 - Box 58 - Enter the treating provider’s DMAP ID. (Do not enter license numbers in this box.)

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E

ADA Dental Claim Form

HEADER INFORMATION																											
1. <input checked="" type="checkbox"/> Transaction (Mark all applicable boxes)																											
<input type="checkbox"/> Statement of Actual Service <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX																											
2. Predetermination/Preauthorization Number																											
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12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																											
13. Date of Birth (MM/DD/CCYY)				14. Gender <input type="checkbox"/> M <input type="checkbox"/> F				15. Policyholder/Subscriber ID (SSN or ID#) XX###X#X																			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																											
3. Company/Plan Name, Address, City, State, Zip Code																											
OTHER COVERAGE																											
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20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																											
Patient, Your																											
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1					D0120							23 23															
2																											
3																											
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7																											
8																											
9																											
10																											
MISSING TEETH INFORMATION																											
Permanent																											
Primary																											
34. (Place an 'X' on each missing tooth)																											
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	32. Other Fee(s)	
																											23 23
35. Remarks																											
AUTHORIZATIONS																											
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46. Date of Accident (MM/DD/CCYY)																											
47. Auto Accident State																											
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)																											
48. Name, Address, City, State, Zip Code Dental Clinic PO Box ### Anytown, OR 97###																											
49. NPI #####				50. License Number				51. SSN or TIN																			
52. Phone Number () -				53A. Additional Provider ID #####																							
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X _____ Signed (Treating Dentist) Date _____																											
54. NPI #####				55. License Number																							
56. Address, City, State, Zip Code				56A. Provider Specialty Code																							
57. Phone Number () -				58. Additional Provider ID #####																							

Resources

Where to mail your claim	DMAP PO Box 14956 Salem, OR 97309-4956
Help with paper billing	DMAP Provider Services 1-800-336-6016 E-mail: dmap.providerservices@state.or.us
Provider Web Portal – Free paperless Web billing (for individual claims)	https://www.or-medicaid.gov
Electronic business practices (billing, payment and more)	www.oregon.gov/OHA/healthplan/ebp.shtml
Provider training	www.oregon.gov/OHA/healthplan/tools_provider/training.shtml

THANK YOU!