DMAP 1036 Instructions

Line-by-Line Individual Adjustment Request instructions for Oregon Medicaid providers

Division of Medical Assistance Programs

Oregon Health Authority

Overview

- This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the DMAP 1036 individual adjustment request form correctly the first time.
- If applicable, this presentation is to be used in conjunction with General Rules, provider guidelines and supplemental information.
- We hope you find this tutorial helpful.

Claims processing

- Claims process weekly. DMAP sends a Remittance Advice (RA) listing all claims adjudicated to the provider (with payment if appropriate).
- If you see that DMAP has overpaid or underpaid a claim, you should submit an adjustment request.
  - Only paid claims can be adjusted.
  - Denied claims must be re-billed on a new claim form.
- You can submit adjustment requests for any paid claim using the Provider Web Portal at https://www.or-medicaid.gov!

Form suppliers

- You can download the DMAP 1036 form at https://apps.state.or.us/Forms/Served/oe1036.pdf.
- If you don't want to use forms, you can use the Provider Web Portal for free!
- The RA for the original claim provides most of the information needed to file an adjustment.
- Adjustment requests must show specifically what needs to be changed, with both incorrect and correct information.

What happens at DMAP

- When DMAP receives the completed DMAP 1036 form, staff review the form to ensure all information entered on the form is complete and accurate.
- A new Internal Control Number (ICN) is assigned to the request and entered into the computer system, which then checks and cross-references the original claim against the adjustment.
- DMAP staff then processes the request.

Adjustment results

- Once the adjustment request passes all reviews, DMAP then takes steps to reconcile the underpayment or overpayment.
  - If the original claim was underpaid, DMAP's next regular payment to the provider will include the adjustment.
  - If the original claim was overpaid, DMAP's next regular payment to the provider will deduct the amount of the overpayment from the total amount due to the provider.

Print | Clear Form | "Save As" to desk top

State of Oregon — Oregon Health Authority — Division of Medical Assistance Programs

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
☐ Place of Service				
☐ Procedure Code/NDC/Rev Code				
☐ Modifier				
☐ Quantity/Unit				
☐ Diagnosis				
☐ Prescribing/Rendering Provider				
☐ Billed Amount/Total Billed				
☐ Medicare Payment				
☐ Other Insurance/Patient Liability				
☐ Co-Insurance				
☐ Other				

(16) **Remarks**

(17) **Requester's Name** | **Phone #** | **Date**

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Top section

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

Red = Required

Box 1 - Required

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

- Type of Adjustment
  - Check the box that applies to the claim you are requesting an adjustment be made to.
  - Check underpayment if DMAP paid too little.
  - Check overpayment if DMAP paid too much.

Box 2 - Optional

(2) **Attach the following:**

- ✓ Claim (corrected copy)
- ✓ Remittance Advice (copy)
- ✓ Financial planner (NH only)

- Attachments
  - You may attach additional information to help facilitate the processing of your request.

Box 3

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

Return <u>all other</u> adjustment requests to:
DMAP
PO Box 14952
Salem, OR 97309

- Mailing address
  - Mail your completed DMAP 1036 form to the address listed in this box.

Middle section

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	

Red = Required

Box 4 - Required

4 Internal Control Number	#	#	#	#	#	#	#	#	#	#	#	#	#

- Internal Control Number
  - List the most recent thirteen-digit Internal Control Number (ICN) of the claim that you are applying an adjustment to.
  - The ICN is located on your Remittance Advice (RA).
  - If you tried to adjust the claim on the Provider Web Portal, use the new ICN from the Web adjustment, and not the ICN on your paper RA.

Box 5 - Required

(5) RA Date ## / ## / ##

- Remittance Advice (RA) Date
  - Enter the date printed on the RA.
  - The date is located at the top of your RA.

Box 6 - Required

⑥ Recipient Name **Patient, Your**

- Recipient Name
  - Enter the recipient name as it appears on the RA.
  - Enter the last name first.

Box 7 - Required

⑦ Recipient ID Number	X	X	#	#	#	X	#	X

- Recipient ID Number
  - Enter the recipient's eight-digit alpha/numeric prime identification number that is located on the RA.

Box 8 - Required

⑧ Provider Name	Dr. Clinic

- Provider Name
  - Enter the provider name.
  - The name is located at the top of the RA

Box 9 - Required

9 Provider Number	#	#	#	#	#	#	#	#	#

- Provider Number
  - Enter your six (6)-or nine (9)-digit DHS provider number.
  - The provider number is located at the top of the RA.

Box 10 - Required

(10) NPI	#	#	#	#	#	#	#	#	#	#

- National Provider Identifier (NPI)
  - Enter the ten-digit NPI.

Bottom section

(11) Description of original error	(12) Line No.	(13) Service Date	(14) Wrong Information	(15) Right Information
❑ Place of Service				
❑ Procedure Code/NDC/Rev Code				
❑ Modifier				
❑ Quantity/Unit				
❑ Diagnosis				
❑ Prescribing/Performing Provider				
❑ Billed Amount/Total Billed				
❑ Medicare Payment				
❑ Other Insurance/Patient Liability				
❑ Co-Insurance				
❑ Other				

(16) **Remarks**

(17) Requester's Name	Phone #	Date

Red = Required   Yellow = Optional

Box 11 - Required

(11) **Description of original error**

- [ ] Place of Service
- [x] Procedure Code/NDC/Rev Code
- [ ] Modifier
- [ ] Quantity/Unit
- [ ] Diagnosis
- [ ] Prescribing/Performing Provider
- [ ] Billed Amount/Total Billed
- [ ] Medicare Payment
- [ ] Other Insurance/Patient Liability
- [ ] Co-Insurance
- [ ] Other

- Description of original error
  - Only check the box or boxes that you want corrected on your claim form.

Box 12 - Required

(12) Line No.
3

- Line number
  - List the line number for the service you are requesting wrong or right information for.
  - Count the line number from the claim as it appears on the RA.

Box 13 - Required

(13) Service Date

/ ## /

- Service Date
  - List the date of service for the service that was provided as indicated on the RA.

Box 14 - Required

14 Wrong Information
######

- Wrong Information
  - List the incorrect (wrong) information submitted as it appears on the RA.

Box 15 - Required

15 Right Information

#####

- Right Information
  - List the correct (right) information that is necessary to process your request.

Box 16 - Optional

(16) Remarks

- Remarks
  - Use this box as needed.
  - Provide us with any other information you think may be necessary to accurately adjust your request.

Box 17 - Required

(17) Requester's Name	Phone #	Date
Dr. Clinic	503-###-####	## / ## / ##

- Requester's Name
  - The provider or authorized representative must sign and date the request.
  - It is suggested that you list your phone number. DMAP staff may need to contact you for questions pertaining to your request.

C O M P L E T E D

E X A M P L E

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(4) **Internal Control Number** # # # # # # # # # # # # # # (5) **RA Date** ##/##/##

(6) **Recipient Name** Patient, Your (7) **Recipient ID Number** X X # # # X # X

(8) **Provider Name** Dr. Clinic (9) **Provider Number** # # # # # # # # #

(10) **NPI** # # # # # # # # # #

(11) Description of original error	(12) Line No.	(13) Service Date	(14) Wrong Information	(15) Right Information
☐ Place of Service				
X Procedure Code/NDC/Rev Code	3	##/##/##	#####	#####
☐ Modifier				
☐ Quantity/Unit				
☐ Diagnosis				
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☐ Other Insurance/Patient Liability				
☐ Co-Insurance				
☐ Other				

(16) **Remarks**

(17) **Requester's Name** *Dr. Clinic* **Phone #** 503-###-#### **Date** ##/##/##

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Resources

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 and adjustments (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_prov/training.shtml

THANK YOU!