
DMAP 505 Billing Instructions

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

Division of Medical
Assistance Programs

Oregon
Health
Authority

Overview

- This presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid/Medicare services complete the DMAP 505 billing form correctly the first time.
- If applicable, this presentation is to be used in conjunction with General Rules, your 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.
- Claims process weekly. DMAP sends a Remittance Advice (RA) listing all claims adjudicated to the provider (with payment if appropriate).

When to use the DMAP 505 form

- When you submit professional claims to Medicare, Medicare transmits the billing information to DMAP. This transmission is called a “crossover.”
- The DMAP 505 billing form is unique. It is specifically used for clients who receive both Medicare and Medicaid services, when:
 - Medicare transmits incorrect crossover information to DMAP, or Medicare denied payment;
 - DMAP did not receive the crossover information; or
 - An out-of-state Medicare carrier or intermediary was billed.

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 the most current version of the DMAP 505 available at <https://apps.state.or.us/Forms/Served/OE505.pdf>.

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

- The DMAP 505 is available on the Web at <https://apps.state.or.us/Forms/Served/OE505.pdf>
- You order hard copy forms using the DMAP 2420 (Provider Form Request). Mail the DMAP 2420 to:
DHS Forms Distribution
550 Airport Rd. S.E.
Salem, OR 97310
- You can also use the Provider Web Portal at <https://www.or-medicaid.gov>.

Accepted versions

- DHS accepts DMAP 505 forms revised 2007 or later.
 - The 8/07 version has changes to the shading on the form for improved processing of DMAP 505 forms printed from the Web.

Top section

1. Patient's Name (Last, First, MI)		2. Patient's birthdate/sex MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		3. Insured's ID # (include all letters and numbers)	
4. Patient's address (number, street)		5. Patient's Relation to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		6. Insured's Name (Last, First, MI)	
City		State		8. Insured's address (number, street)	
Zip Code		Phone (Area Code)		City	
7. Was condition related to:		a. Patient's employment Y <input type="checkbox"/> N <input type="checkbox"/>		State	
9. Other insured's name (Last, First, MI)		b. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/>		Zip Code	
a. Other insured's Plan name		b. Other insured's policy number		Phone (Area Code)	
Other insured's Plan address (number, street)		10. Insured's group # (or group name)		12. I authorize payment of medical benefits to undersigned physician or supplier for services described below.	
City		State		Zip Code	
Phone (Area Code)		11. 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 (insured or authorized person)	
Signed		Date			

Red = Required

Yellow = Optional

Box 1 - Required

1. Patient's Name (Last, First, MI)

Client, Your

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

Box 3 - Required

3. Insured's ID # (include all letters and numbers)

X X # # # X # X

- Recipient ID Number
 - Enter the client's eight-character identification number.
 - Enter the number exactly as it appears on the Medical Care Identification.

Box 7 - Optional

7. Was condition related to:

a. Patient's employment Y N

b. Accident Auto Other

- Patient's Condition
 - Check the appropriate box only when an injury is involved.
 - Do not check any boxes if there is no injury to report.

Box 9 - Optional

9. Other insured's name (Last, First, MI)

UD

- Third Party Resource
 - If Medicare did not make a payment to you, enter the appropriate two-digit third party resource (TPR) explanation code.
 - A code is always required when the client has more than one other insurance carrier.
 - TPR codes can be found in your specific provider rulebook supplemental, or on the following slides.

Single carrier TPR codes

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 (MVAFF) 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 there was no payment from insurance)

Multiple carrier TPR codes

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 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)

Middle section

13. Date of current: MM DD YY	Illness (first symptom) or Injury (accident) or Pregnancy (LMP)	14. If emergency, check here <input type="checkbox"/>	15. First date patient had same or similar illness MM DD YY
16. Name of referring provider or other source	16a. _____ 16b. NPI	17. Dates patient unable to work in current occupation From MM DD YY To MM DD YY	
18. Outside lab? Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ Charges	19. Prior authorization number	20. Hospitalization dates related to current services From MM DD YY To MM DD YY
21. Diagnosis or nature of illness or injury (relate items 1, 2, 3, or 4 to item 22D by line) 1. _____ 2. _____ 3. _____ 4. _____			

Red = Required

Yellow = Optional

Box 14 - Optional

14. If emergency, check here



- Emergency Indicator
- If the service you provided was a result of an emergency, check this box.
- If this was not an emergent service, leave blank.

Box 16a - Optional

16a.

#

- Referring Provider Number
 - Enter the six (6)-or nine (9)-digit DMAP provider number of the referring provider.
 - This may be required if the client has a Primary Care Manager (PCM) or the service requires a referral (e.g., Physical Therapy, Occupational Therapy or Speech Therapy).

Box 16b - Optional

16b.	NPI	# # # # # # # # # #
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- Referral National Provider Identifier (NPI)
 - If information was entered in box 16a (Primary Care Manager, or other referral) the corresponding NPI is entered here.
 - Enter the ten-digit NPI of the referring provider.

Box 19 - Optional

19. Prior authorization number

#####

- **Prior Authorization Number**
 - If the service you provided requires 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.
 - Do not bill prior authorized and non-authorized services on the same claim form.

Box 21 - Required

21. Diagnosis or nature of illness or injury (relate items 1, 2, 3, or 4 to item 22D by line)
1. **786 59** 2. **414 01** 3. **250 61** 4. **465 9**

- Diagnosis Code
 - Enter the client's diagnosis/condition.
 - The diagnosis code must be the reason chiefly responsible for the service being provided as shown in medical records.
 - You may enter up to four codes and each code must be carried out to its highest degree of specificity.
 - Do not use the decimal point.

Supplemental qualifiers

Use when reporting the following services:

Qualifier	Description
7	Anesthesia
ZZ	Narrative description of unspecified codes
VP	Vendor Product Number
OZ	Health Care Uniform Code
CTR	Contract rate
N4	National Drug Code. Also use the following units of measure: <ul style="list-style-type: none">• F2 - International unit• GR - Gram• ML - Milliliter• UN - Unit

Supplemental information examples

National Drug Code

22. A. Date(s) of service						B. Place of service	C. Procedures, services or supplies (explain unusual circumstances)		D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering DHS Provider Number
From	To	Place of service	CPT/HCPCS		Modifier	Diagnosis code	Days or units	EPSDT Family Plan	Charges billed Medicare	Medicare's allowed charges	Rendering DHS Provider Number			
MM DD YY	MM DD YY		1	J#####	UD [for 340B drugs]						1	20	###	##
N412345678901 UN1234.567														

Anesthesia Services, in 15-minute units

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To	PLACE OF SERVICE	EMG	CPT/HCPCS		MODIFIER		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY	MM DD YY			1	00770	P2	1						###	##	6	NPI	123456
7Begin 1245 End 1415 Time 90 Minutes																	

Unspecified Code

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To	PLACE OF SERVICE	EMG	CPT/HCPCS		MODIFIER		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY	MM DD YY			4	E1399								1	###	##	1	NPI
ZZ Kaye Walker																	

Vendor Product Number

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To	PLACE OF SERVICE	EMG	CPT/HCPCS		MODIFIER		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY	MM DD YY			1	A6410								1	##	##	NPI	123456
VPA122BIC5D6E7G																	

Box 22A - Required

22.	A. Date(s) of service					
	From			To		
	MM	DD	YY	MM	DD	YY
	12	01	08			
	12	03	08			
	12	05	08	12	06	08

- Date of Service
 - This box must list numeric dates of service.
 - If billing for one day, complete only the “from” column.
 - If the “from and to” dates are used, a Service must be on consecutive days and provided no more than once per day.

Box 22B - Required

B. Place of service
11
11
11

- Place of Service
 - Enter the two-digit CMS code for where the service was provided.
 - Place of service codes are in CPT/HCPCS codebooks or on the CMS Web site at www.cms.hhs.gov/placeofservicecodes/downloads/posdatabase.pdf.

Box 22C - Required

C. Procedures, services or supplies (explain unusual circumstances)				
CPT/HCPCS	Modifier			
99213	21			
99213	21			
99213	21			

- Procedure Code
 - Enter the five-digit/character CPT or HCPCS code(s) for the specific service provided.
 - Optional - Enter up to four two-digit national modifiers that relate to this service.
 - For procedure codes that indicate “unlisted,” you must attach an operative/medical report.

Box 22I - Optional

I. Rendering provider number	
DMAP:	#####
NPI:	#####
DMAP:	#####
NPI:	#####
DMAP:	#####
NPI:	#####
DMAP:	
NPI:	
DMAP:	
NPI:	
DMAP:	
NPI:	

- Rendering Provider ID
 - This box is only required when clinics or group practices use a specific billing provider number in box 31. This identifies who rendered the service.
 - Shaded - Enter the six (6)-or nine (9)-digit DMAP provider number of the individual rendering the service.
 - Non-shaded - Enter the ten-digit NPI of the rendering provider that was identified in the shaded area.

Box 24 - Required

24. Total charge

372|00

- Total Charge
 - Enter the total charge amount for all services listed in column 22G.
 - Each claim form is a separate document, and is to be totaled as such.

Box 25 - Optional

25. Total Medicare payment

125|00

- Total Medicare Payment
 - Enter the total amount paid by Medicare.
 - Do not include write-offs.
 - Do not include how much DHS previously paid.
 - Do not include copayments.

Box 26 - Optional

26. Patient's account #

X123400

- Patient Account Number Enter your patient account number here.
 - This box allows up to twelve characters.
 - This number will appear on your Remittance Advice (RA).

Box 28 - Optional

28. Ins (not Medicaid/Medicare)

- Amount Paid
 - Enter the total amount paid by any other resources.
 - Do not include write-offs.
 - Do not include how much DHS previously paid.
 - Do not include copayments.

Box 29 - Required

29. Balance due

247|00

- Balance Due
 - Enter the balance due.
 - Box 24, minus box 25, minus box 28, must equal box 29.

Box 33 - Required

31. Billing provider information and phone number

Billing Provider

PO Box ###

Anytown, OR 97###

NPI # **#####**

DMAP # **#####**

- Billing Provider Information – Enter information for the provider number DMAP will direct payment to:
 - Box 31 - Enter the name and address of the billing provider.
 - NPI - Enter the NPI registered with the billing provider's DMAP ID number (listed in Box 33b).
 - DMAP # - Enter the billing provider's DMAP ID.
- Note: Non-medical services (e.g., taxis) do not require NPI.

Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

C
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L
E

1. Patient's Name (Last, First, MI) Client, Name		2. Patient's birthdate/sex MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		3. Insured's ID # (include all letters and numbers) XX###X#X	
4. Patient's address (number, street) City State		5. Patient's Relation to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		6. Insured's Name (Last, First, MI)	
7. Was condition related to: a. Patient's employment Y <input type="checkbox"/> N <input type="checkbox"/> b. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/>		8. Insured's address (number, street) City State		9. Other insured's name (Last, First, MI) UD	
10. Insured's Plan name Zip Code Phone (Area Code)		11. Insured's group # (or group name)		12. I authorize payment of medical benefits to undersigned physician or supplier for services described below. <i>Signed (insured or authorized person)</i>	
13. Date of current: MM DD YY		14. If emergency, check here <input type="checkbox"/>		15. First date patient had same or similar illness MM DD YY	
16. Name of referring provider or other source 10a. ##### 10b. NPI #####		17. Dates patient unable to work in current occupation From MM DD YY To MM DD YY		18. Outside lab? Yes <input type="checkbox"/> No <input type="checkbox"/> \$ Charges	
19. Prior authorization number		20. Hospitalization dates related to current services From MM DD YY To MM DD YY		21. Diagnosis or nature of illness or injury (relate items 1, 2, 3, or 4 to item 22D by line) 1. 786 59 2. 414 01 3. 250 61 4. 465 9	
22. A. Date(s) of service From MM DD YY To MM DD YY		B. Place of service		C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS Modifier	
D. Diagnosis code		E. Days or units		F. EPSDT Family Plan	
G. Charges billed Medicare		H. Medicare's allowed charges		I. Rendering provider number	
12 01 08		11 99213 21		1 1	
12 03 08		11 99213 21		1 1	
12 05 08 12 06 08		11 99213 21		1 2	
23. Federal tax ID # SSN EIN		24. Total charge 372.00		25. Total Medicare payment 125.00	
26. Patient's account # X123400		27. Accept assignment? Y <input type="checkbox"/> N <input type="checkbox"/>		28. Ins (not Medicaid/Medicare)	
29. Balance due 247.00		30. Service facility location information		31. Billing provider information and phone number Billing Provider PO Box ### Anytown, OR 97###	
NPI #		DMAP #		NPI # ##### DMAP # #####	

Resources

Where to mail your claim	DMAP PO Box 14015 Salem, OR 97309-4957
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/DHS/healthplan/ebp.shtml
Provider training	www.oregon.gov/DHS/healthplan/tools_pro v/training.shtml

THANK YOU!