
Oregon Health Plan Provider Web Portal

Professional Claim

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



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Roster Billing

Warning: Use of this network is restricted to authorized users. All users must comply with Oregon Health Authority privacy and security policies. User activity may be monitored and/or recorded. Anyone using this network expressly consents to such monitoring and/or recording. BE ADVISED: if possible criminal activity is detected, these records, along with certain personal information, may be provided to law enforcement officials.

Security incidents should be directed to the Security Incident Response Team at (503) 945-6812.

All other issues, including Password Resets, should be directed to Provider Services at (800) 336-6016.

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

The screenshot displays a web-based form for a Professional Claim, divided into several sections. The sections are numbered 1 through 7, corresponding to the list on the left:

- 1. Billing Information:** Includes fields for ICN, Provider ID (1891792313 NPI), Client ID, Last Name, First Name, MI, Date of Birth, Patient Account #, Referring Phys, Insurance Denied, Service Information (From Date, To Date, Expected Delivery Date, Medical Record Number), Accident Related To, and Charges (Total Charges, TPL Amount, Plan Payment Amount, CoPay Amount).
- 2. Diagnosis:** A table with columns for Sequence, Present on Admission, Diagnosis, and ICD Version.
- 3. TPL (Third-Party Liability):** A table with columns for Last Name, First Name, MI, Date of Birth, Relationship, Policy Number, Plan Name, Plan ID, Adjustment Reason Code, Adjustment Group Code, and Adjustment Amount.
- 4. Medicare Information:** A table with columns for Medicare Paid Date, Coinsurance Amount, Deductible Amount, Psychiatric Amount, and Paid Amount.
- 5. Detail:** A table with columns for Item, Procedure, Units, Charges, Status, Allowed Amount, and various other fields like From DOS, To DOS, Units Qualifier, Charges, Referring Physician, Taxonomy, Zip+4, Status, Diagnosis Code Pointer, Modifiers, POS, Procedure, NDC, NDC UOM, NDC Quantity, Tpl Amount, and Plan Payment Amount.
- 6. Hard-Copy Attachments:** A table with columns for Control Number, Transmission, Report Type, and Description.
- 7. Claim Status Information:** A section for Claim Status, currently showing "Not Submitted yet".

Professional Claim (Header)

- Required fields:
1. Client ID
 2. From Date
 3. To Date

Professional Claim		Billing Information		Mailbox and Filename	
ICN		Mailbox #		File Name	
Provider ID	1376854091 NPI	Service Information			
1 Client ID*	MJ301G5A [Search]	2 From Date*	10/15/2015	3 To Date*	10/15/2015
Last Name	CWMM	Expected Delivery Date		Medical Record Number	
First Name, MI	PATTEE	Accident Related To		Charges	
Date of Birth	01/15/1975	Total Charges			\$0.00
Patient Account #		TPL Amount			\$0.00
Referring Phys	[Search]	Plan Payment Amount			
Insurance Denied		CoPay Amount			\$0.00

Required *only* when the service requires a referral

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

Diagnosis

Diagnosis				
Sequence	Diagnosis	Description	ICD Version	Present on Admission
A	1	M71811	Other specified bursopathies, right shoulder	10

Type data below for new record.

2 Sequence* 1 3 Diagnosis* M71811 [Search]

Present on Admission Description Other specified bursopathies, right shoulder

ICD Version 10

delete add 1

- 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

TPL

Last Name	First Name	MI	Date of Birth	Relationship	Plan Name	Policy Number
			01/01/1900			

Select row above to update.

Last Name	<input type="text"/>	Plan Name	<input type="text"/>
First Name, MI	<input type="text"/>	Plan ID*	20125 [Search] ²
Date of Birth	01/01/1900	Adjustment Reason Code	1 [Search] ³
Relationship	<input type="text"/>	Adjustment Group Code	CO
Policy Number	<input type="text"/>	Adjustment Amount	\$0.00

delete add ¹

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

Medicare Information

Medicare Information					
1	Medicare Paid Date	Coinsurance Amount	Deductible Amount	Psychiatric Amount	Paid Amount
		\$0.00	\$0.00	\$0.00	\$0.00

Select row above to update.

Medicare Paid Date	<input type="text"/>	Coinsurance Amount	<input type="text"/>
Psychiatric Amount	<input type="text"/>	2 Deductible Amount	<input type="text"/>
Paid Amount	<input type="text"/>		

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

Detail

Item	Procedure	Units	Charges	Status	Allowed Amount
A	1	0	\$0.00		\$0.00

Item	1	Emergency	No
1 From DOS*	10/15/2015	Pregnancy	
2 To DOS*	10/15/2015	EPSDT Ref	None
3 Units*	1.00	EPSDT Family Planning	
Units Qualifier		Allowed Amount	\$0.00
4 Charges*	\$200.00	CoPay Amount	\$0.00
Rendering Physician	1376854091 [Search]	Adjustment Reason Code	[Search]
Taxonomy		Adjustment Amount	
Zip+4		Medicare Paid Date	
Status		Deductible Amount	\$0.00
Diagnosis Code Pointer	1	Coinurance Amount	\$0.00
Modifiers	[Search] [Search]	Medicare Paid Amount	\$0.00
	[Search] [Search]	Medicare Psych Amount	\$0.00
5 POS*	11 [Search]		
6 Procedure*	22840 [Search]		
NDC			
NDC UOM			
NDC Quantity	0		
Tpl Amount	\$0.00		
Plan Payment			

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

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

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

add

Hard-Copy Attachments

This section is *never* required

Hard-Copy Attachments	
*** No rows found ***	
Select row above to update -or- click Add button below.	
Control Number	<input type="text"/>
Transmission	<input type="text"/>
Report Type	<input type="text"/>
Description	<input type="text"/>
<input type="button" value="delete"/> <input type="button" value="add"/>	

Claim Status Information

Claim Status Information	
Claim Status	Not Submitted yet
Supporting documentation	

Not Submitted yet claim; provider may

- Submit
- Cancel

submit

cancel

Submits the claim for processing

Clears changes made during this session

Claim Status PAID

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

Claim Status Information	
Claim Status	PAID
Claim ICN	5012011705001
Paid Date	01/12/2012
Allowed Amount	\$90.00

Coversheet for supporting documentation

HIPAA Adjustment Reasons		
Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
1	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
2	45	Charge exceeds contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Clears changes made during this session

cancel adjust void copy claim

Adjusts the existing claim with changes made during this session

Cancel 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.

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