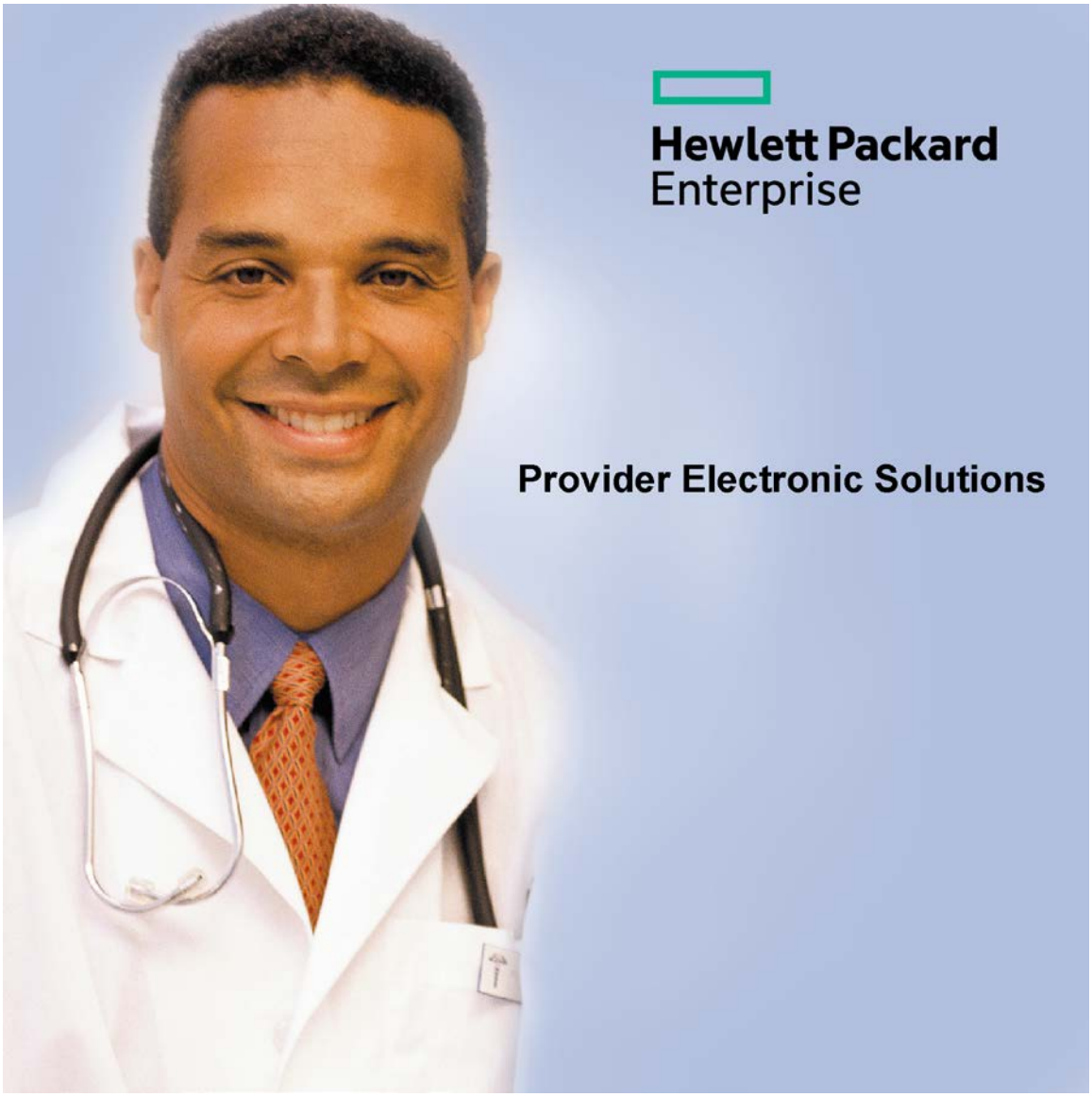
HPE Provider Electronic Solutions

Billing Instructions



Dental Claims

Important Update: **This software will not be supported after October 1, 2015. Current PES users are encouraged to transition to an alternative method of claim submission by October 1, 2015 to avoid a disruption in electronic claims processing.**

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INTRODUCTION

Now that you have installed and become familiar with the functionality of the Hewlett Packard Enterprise PROVIDER ELECTRONIC SOLUTIONS software, it's time to begin claims data entry.

The claim entry screen consists of six sections: Three Headers, Two Service and Other Insurance screens. The following instructions detail requirements and general information for each of these sections.

In the following sections, each data entry field is defined with the appropriate requirements. Edits have been built into the software to assist you in correct data entry, however, READ THESE SECTIONS CAREFULLY. Payment or denial of your claims depends on the data you supply to Hewlett Packard Enterprise.

Please reference your billing manual for detailed Connecticut Medical Assistance Program billing requirements unique to your provider type.

Important Update: **This software will not be supported after October 1, 2015. Current PES users are encouraged to transition to an alternative method of claim submission by October 1, 2015 to avoid a disruption in electronic claims processing.**

Provider Electronic Solutions contains reference lists of information that you commonly use when you enter and edit screens. For example, you can enter lists of common diagnosis codes, procedure codes, and modifiers. All of the lists are available from the data entry section as a drop-down list where you can select previously entered data to speed the data entry process and help ensure accuracy of the form.

There are several lists that you are required to complete prior to entering a transaction. Because this software uses the HIPAA compliant transaction format, there is certain information which is required for each transaction. To assist you in making sure that all required information is included and save time entering your information, some of the lists are required. These lists are:

- Client
- Billing Provider (and Other Provider, if applicable)
- Taxonomy
- Policy Holder

If these lists are not completed prior to keying your transaction, the list will open in the transaction form.

Some of the lists contain preloaded information that is available for auto-plugging as soon as you install Provider Electronic Solutions. Other lists require you to enter the information you will use for auto-plugging. You should enter your data in these lists soon after you set up Provider Electronic Solutions to take advantage of the auto-plug feature. To create or edit a list, select List from the Main Menu and then select the appropriate item.

WORKING WITH LISTS

From the Lists option on the menu bar, select the list you want to access.

Perform one of the following:

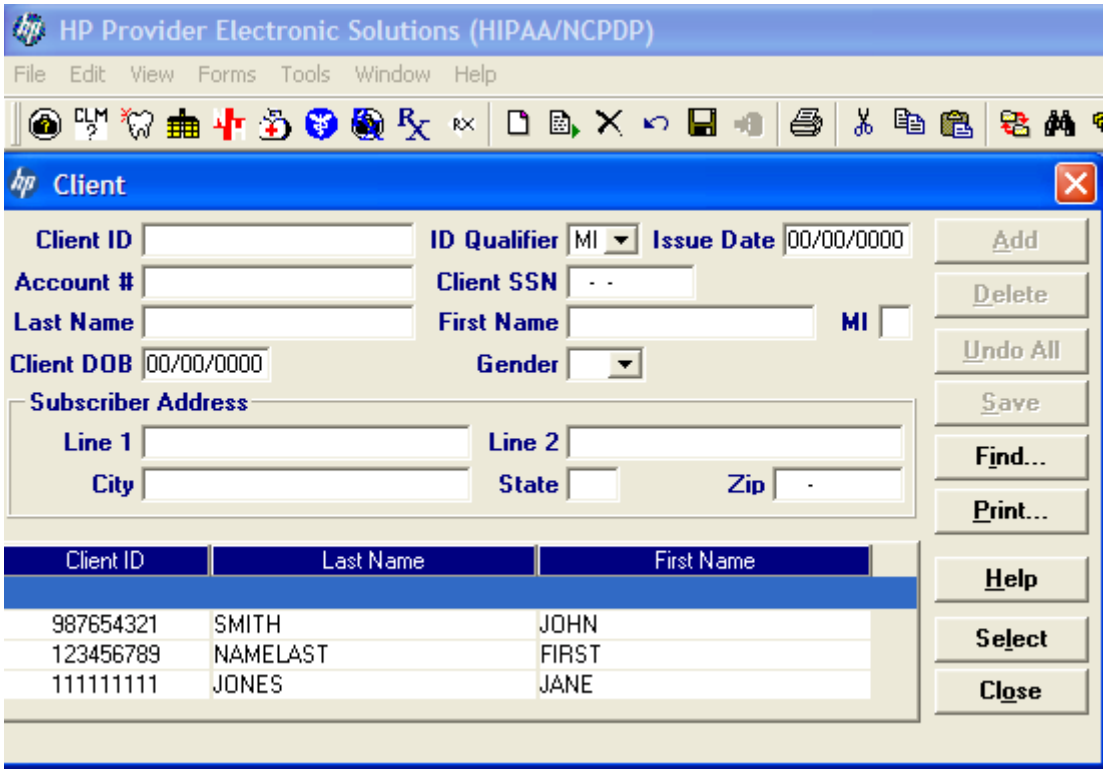
· To add a new entry, select Add.

· To edit an existing entry, select the entry and then enter your changes.

· The command buttons for Delete, Undo All, Find, Print, and Close work as titled.

Note: The Select Command button is not visible on the List window unless it has been invoked by double-clicking an autoplug field from a claim screen. Once a List entry has been either added or edited, the Select button ***must*** be clicked in order for the data to populate the claim screen with the selected List entry.

CLIENT SCREEN



The Client list requires you to collect detailed information about your clients, which are then automatically entered into forms. All of the fields are required except Issue Date, Middle Initial and Subscriber Address Line 2.

CLIENT ENTRY INSTRUCTIONS

Client ID:
Enter the Client identification number assigned by the Connecticut Medical Assistance Program.

ID Qualifier:
This field has been preloaded with the information which identifies the type of client. This field will be by-passed.

Issue Date:
Enter the issue date found on the patient's Medical Assistance Program Identification Card.

Account #:
Enter the unique number assigned by your facility to identify a client.

Client SSN:
Enter the client's social security number.

Last Name:
Enter the last name of the client who received services.

First Name:

Enter the first name of the client who received services.

MI:

Enter the middle initial of the client who received services.

Client DOB:

Enter the date the client was born.

Gender:

Select the appropriate value from the drop-down list to enter the client's gender.

Code	Description
F	Female
M	Male
U	Unknown

Subscriber Address Line 1:

Enter the street address of the party being referenced. The address is required for providers, clients and policyholders.

Line 2:

Enter additional address information of the party being referenced, such as suite or apartment number if applicable.

City:

Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

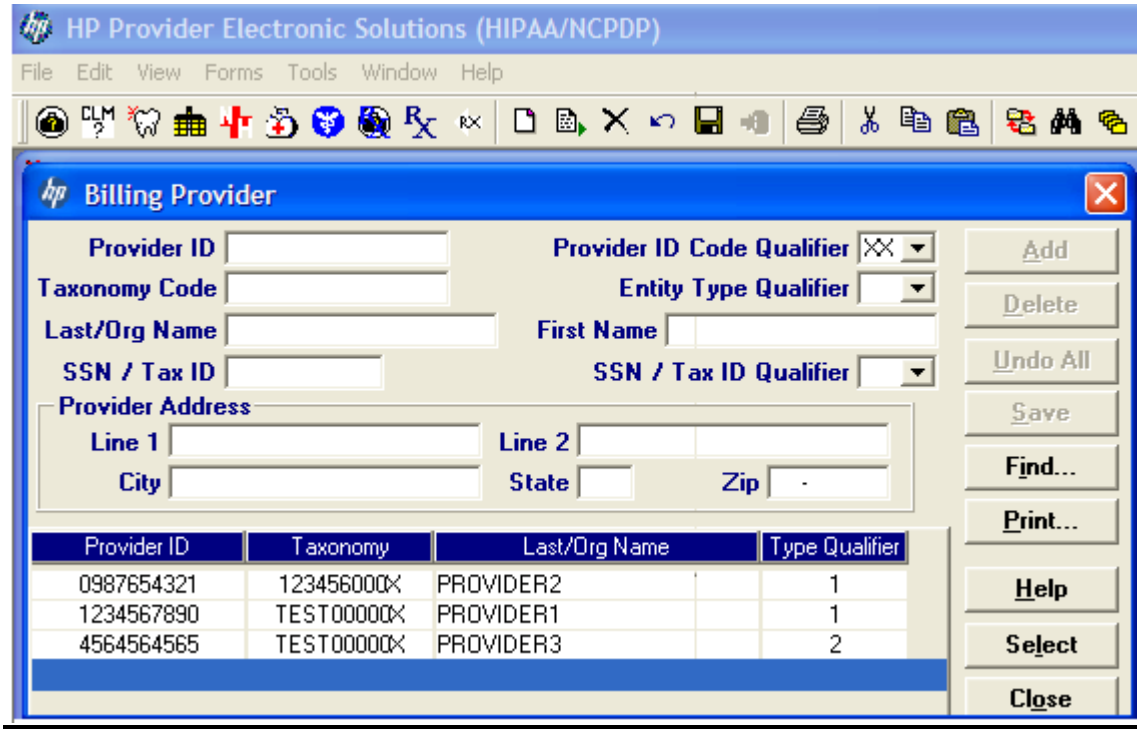
State:

Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip:

Enter the 9-digit zip code of the party being referenced. The address is required for providers, clients and policyholders.

BILLING PROVIDER SCREEN



The Provider lists require you to collect information about service providers, which are then automatically entered into forms. These can be individual providers or organizations. Use the Billing Provider list to enter all billing, rendering and facility identification provider numbers. Use the Other Provider list to enter referring provider numbers. All fields are required except Provider Address Line 2 and First Name when the Entity Type Qualifier is a 2 (Facility).

BILLING/OTHER PROVIDER ENTRY INSTRUCTIONS

Provider ID:

Enter the National Provider Identifier (NPI) or the Connecticut Medical Assistance Program billing provider number with two leading zeros if the provider is a Non-Covered Entity (NCE). (An NCE is a Medicaid service provider who is not included in the National Provider Identifier requirement.)

Provider ID Code Qualifier:

Enter the code that identifies if the Provider ID submitted is the Medical Assistance Provider number or the Health Care Financial Administration (HCFA) National Provider Identifier (NPI).

Taxonomy Code:

An alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Entity Type Qualifier

Select the appropriate value to indicate if the provider is an individual performer or corporation.

Last/Org Name:
Enter the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

First Name:
Enter the first name of the provider when the provider is an individual. Required when the Entity Type Qualifier is a 1. Field will not be available when the Entity Type Qualifier is a 2.

SSN / Tax ID:
Enter the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) of the provider being referenced.

SSN / Tax ID Qualifier:
Select the appropriate code from the drop-down box that identifies what value is being submitted in the SSN/Tax ID field.

Provider Address Line 1:
Enter the street address of the party being referenced. The address is required for providers, subscribers and policyholders.

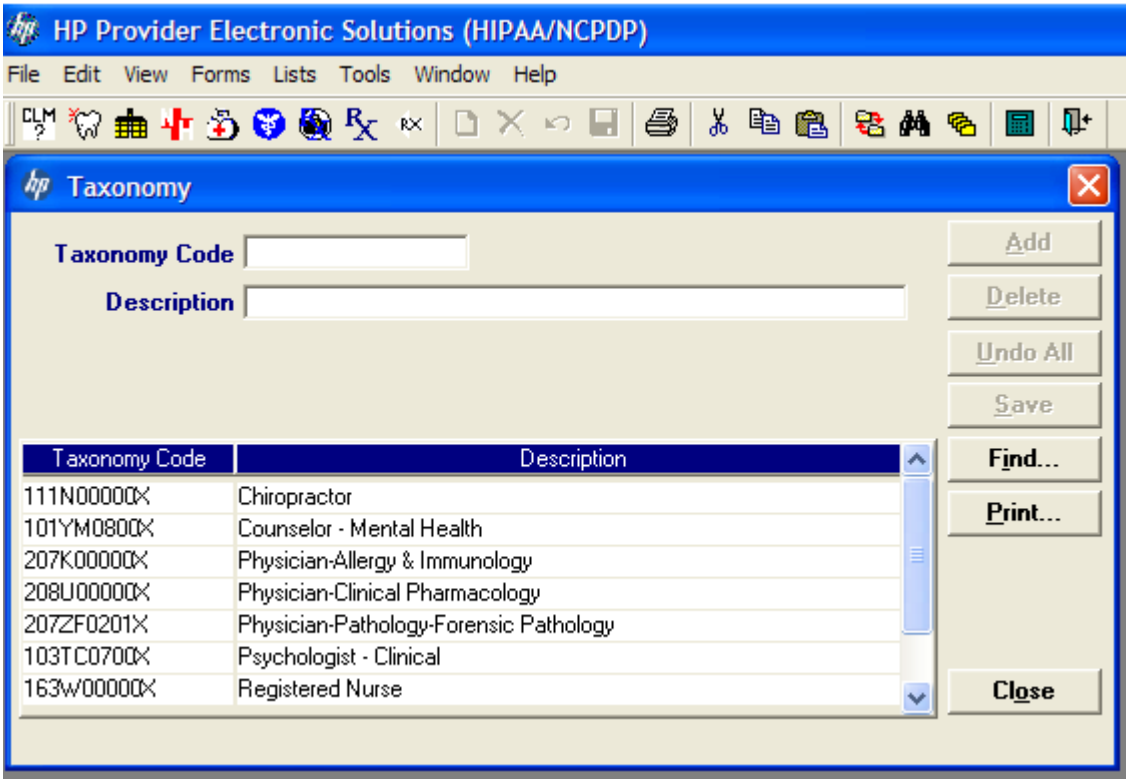
Line 2:
Enter additional address information of the party being referenced, such as suite or apartment number, if applicable.

City:
Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip Code:
Enter the 9-digit zip code of the party being referenced. The address is required for providers, clients and policyholders.

TAXONOMY SCREEN



The Taxonomy list requires you to list the taxonomy code, which is then automatically entered into the Provider List. All fields are required.

TAXONOMY BILLING INSTRUCTIONS

Taxonomy Code:

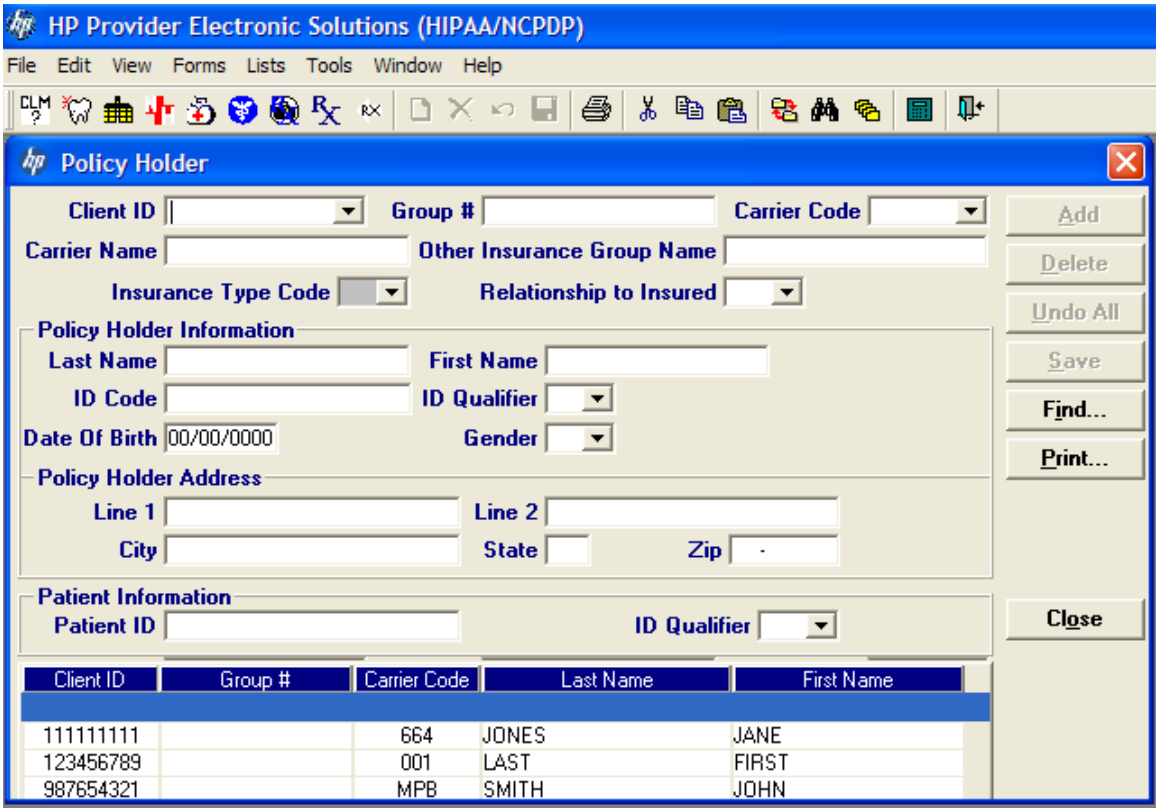
Enter the alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Description:

Enter the description of the code listed.

POLICY HOLDER SCREEN



The Policy Holder list requires you to list the information for the policyholder of the other insurance policies and Medicare policies. As with the provider and client lists, this list must be completed before completing a claim with other insurance or Medicare. Complete a separate list for each policy when a client has both other insurance and Medicare. Like the other lists, once the code is entered into the list, it may be accessed by the drop-down window and will automatically populate into the claim. All fields are required except Policy Holder Address Line 2.

POLICY HOLDER ENTRY INSTRUCTIONS

This tab is required if an indicator of "Y" is entered in the other insurance indicator field on the Header Three screen. The information on this screen must be entered before you enter the Group Number from the Other Insurance screen.

Client ID:
Enter the Client identification number assigned by the Connecticut Medical Assistance Program.

Group Number:
Enter group number for the other insurance or Medicare. If a group number is not applicable, please enter the policy number of the client. For Medicare clients, please enter the client's Health Insurance Claim (HIC) number.

Carrier Code:
Select the three-digit other insurance carrier code from the drop-down box.

Note: Provider must maintain an Explanation of Benefits (EOB) on file for audit purposes.

Carrier Name:
This field is auto-plugged by the system once the carrier code is entered and contains the name of the other insurance company listed for the client.

Other Insurance Group Name:
Enter the name of the group that the other insurance is listed under and coincides with Group number.

Insurance Type Code:
Select the appropriate value from the drop-down box that identifies the type of insurance listed.

Relationship to Insured:
Select the appropriate value from the drop-down box that identifies the client's relationship to the policy-holder for the other insurance or Medicare listed. If the client is the policyholder, self will be listed.

Last Name:
Enter the last name of the policyholder of the other insurance or Medicare.

First Name:
Enter the first name of the policyholder of the other insurance or Medicare.

ID Code:
Enter the policyholder's identification number assigned by the other insurance company.

ID Qualifier:
Select the appropriate value from the drop-down box that identifies the ID that is being used.

Date of Birth:
Enter the date the policyholder was born.

Gender:
Select the appropriate value from the drop-down box that identifies the sex of the individual.

Policy Holder Address Line 1:
Enter the street address of the party being referenced. The address is required for providers, clients and policyholders.

Line 2:
Enter additional address information of the party being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip Code:

Enter the zip code of the party being referenced. The address is required for providers, clients and policyholders.

Patient ID:

Enter the other insurance identification number of the Connecticut Medical Assistance Program client to whom services were rendered.

ID Qualifier:

Select the appropriate value from the drop-down box that identifies the ID that is being used.

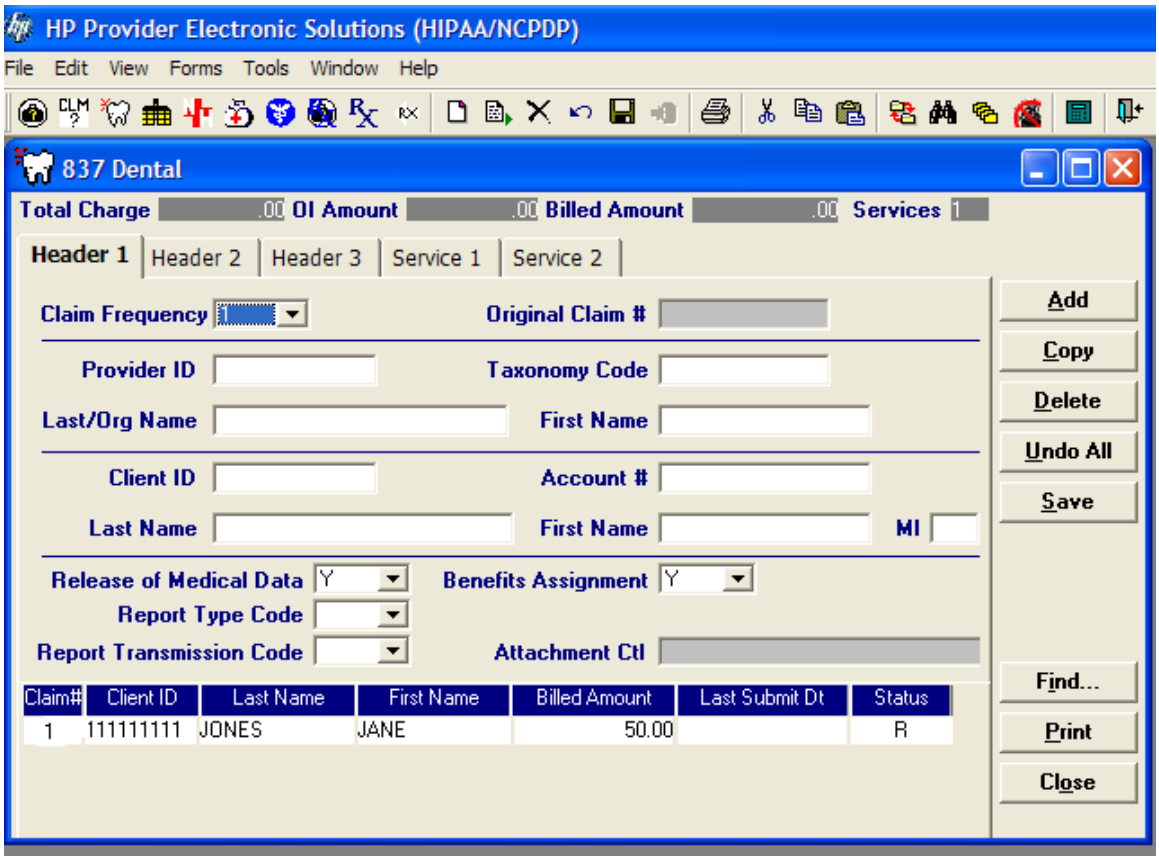
CLAIM ENTRY INSTRUCTIONS

Use the following instructions to complete the claim screens. When data entry is complete, click **SAVE.** The saved claim will appear in the list below the data entry screen. If the claim data hits edits, a message window will appear with error messages. Click **SELECT** to move to the highlighted error and correct the data. Once all error messages have been resolved, you can save the claim.

Newly saved claims are in Status R (Ready). Status R claims can be edited and saved multiple times prior to submission. Be sure to click **ADD** before beginning to enter the data for each new claim.

Note: The Select Command button is not visible on the List window unless it has been invoked by double-clicking an autoplug field from a claim screen. Once a List entry has been either added or edited, the Select button ***must*** be clicked in order for the data to populate the claim screen with the selected List entry.

DENTAL HEADER ONE



DENTAL HEADER ONE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
CLAIM FREQUENCY	1	R	N
ORIGINAL CLAIM #	13	S	N
PROVIDER ID	10	R	N
TAXONOMY CODE	10	R	X
LAST/ORG NAME	35	R	A
FIRST NAME	25	R	A
CLIENT ID	16	R	X
ACCOUNT #	38	R	X
LAST NAME	35	R	A
FIRST NAME	25	S	A
MI	1	O	A
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
REPORT TYPE CODE	2	O	X
REPORT TRANSMISSION CODE	2	O	A

ATTACHMENT CTL	30	S	X

A = ALPHA N = NUMERIC X = ALPHANUMERIC

DENTAL HEADER ONE ENTRY INSTRUCTIONS

Special Note: All data entry will default to capital letters.

Header Field Definition

$$ = Dollars
cc = Cents
A = Alpha
N = Numeric
X = Alphanumeric

Claim Frequency:

Select the appropriate code specifying the frequency of the claim to identify original, adjustment or void.

Code	Description
1	Original (Admit thru discharge claim)
7	Replacement (Replacement of prior claim)
8	Void (Void/Cancel of prior claim)

Note: If the claim frequency is a "7" or "8", the Original Claim field will be required.

Remarks: Required
Format: N

Original Claim #:

This field is populated when the claim frequency is a "7" or "8". When a claim is replaced or voided, indicate the original Internal Control Number as it appears on the remittance advice.

Remarks: Situational
Format: NNNNNNNNNNNNN

Provider ID:

Enter your NPI or Connecticut Medical Assistance Program Provider Number with two leading zeros.

Remarks: Required
Format: NNNNNNNNN

Alternatively, click the down arrow at the right side of the field to display the list of saved providers, and select the desired provider from the list. Double click the Provider ID field to open the provider list and add a new entry if needed.

Taxonomy Code:

This field will be auto-plugged once you enter your provider number and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Required
Format: NNNANNNNNA

Last/Org Name:

This field will be auto-plugged once you enter your provider number and contains the provider's name or the first two letters of the provider's last name as enrolled in the Connecticut Medical Assistance Program.

Example: THOMPSON or 'TH'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA or AA

First Name:

This field will be auto-plugged once you enter your provider number and contains the provider's name or the first letter of the provider's first name as enrolled in the Connecticut Medical Assistance Program. Required when the Entity Type Qualifier is a 1. There are no spaces allowed in this field.

Example: THOMPSON or 'T'
Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAA or A

Client ID:

Enter the client's nine-digit Connecticut Medical Assistance Program identification number.

Remarks: Required
Format: XXXXXXXXXXXXXXX

Account #:

This field will be auto-plugged once you enter the client's Connecticut Medical Assistance Program identification number and contains the patient's account number. Provider assigned, this field may be alphabetic or numeric and is used for the provider's own accounting purposes.

Remarks: Required
Format:
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Last Name:

This field will be auto-plugged once you enter the client's Connecticut Medical Assistance Program identification number. This field contains the client's last name or the first two characters of the client's last name.

Example: THOMPSON or 'TH'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA or AA

First Name:

This field will be auto-plugged once you enter the client's Connecticut Medical Assistance Program identification number. This field contains the client's first name or the first character of the client's first name. There are no spaces allowed in this field.

Example: JOHN or 'J'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAA or A

MI:

This field will be auto-plugged once you enter the client's Connecticut Medical Assistance Program identification number. This field contains the first character of the client's middle name.

Example: JOHN or 'J'
Remarks: Optional
Format: A

Release of Medical Data:

This code indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. Enter the value that corresponds to the release of medical data. (Yes is the default value.)

Y – Yes
N - No

Remarks: Required
Format: A

Benefits Assignment:

Code identifying that the client, or authorized person, authorizes benefits to be assigned to the provider. Enter one of the values below to indicate assignment of benefits.

Y – Yes
N - No

Remarks: Required
Format: A

Report Type Code:

Code indicating the title or contents of a document, report or supporting item for this claim.
Enter the two-digit value that corresponds to the report type.

Code	Description
B4	Referral form
DA	Dental models
DG	Diagnostic report
EB	Explanation of benefits
OB	Operative Notes
OZ	Support data for claim
P6	Periodontal charts
RB	Radiology films
RR	Radiology reports

Remarks: Optional
Format: XX

Report Transmission Code:

Code defining timing, transmission method or format by which reports are to be sent. Enter the two-digit value that defines the transmission method under which reports will be sent:

Code	Description
AA	Available on request at provider's site
BM	By mail
EL	Electronically only
EM	E-mail
FX	By fax

Note: If the values BM, EL, EM or FX, are used the Attachment Control field will be required.

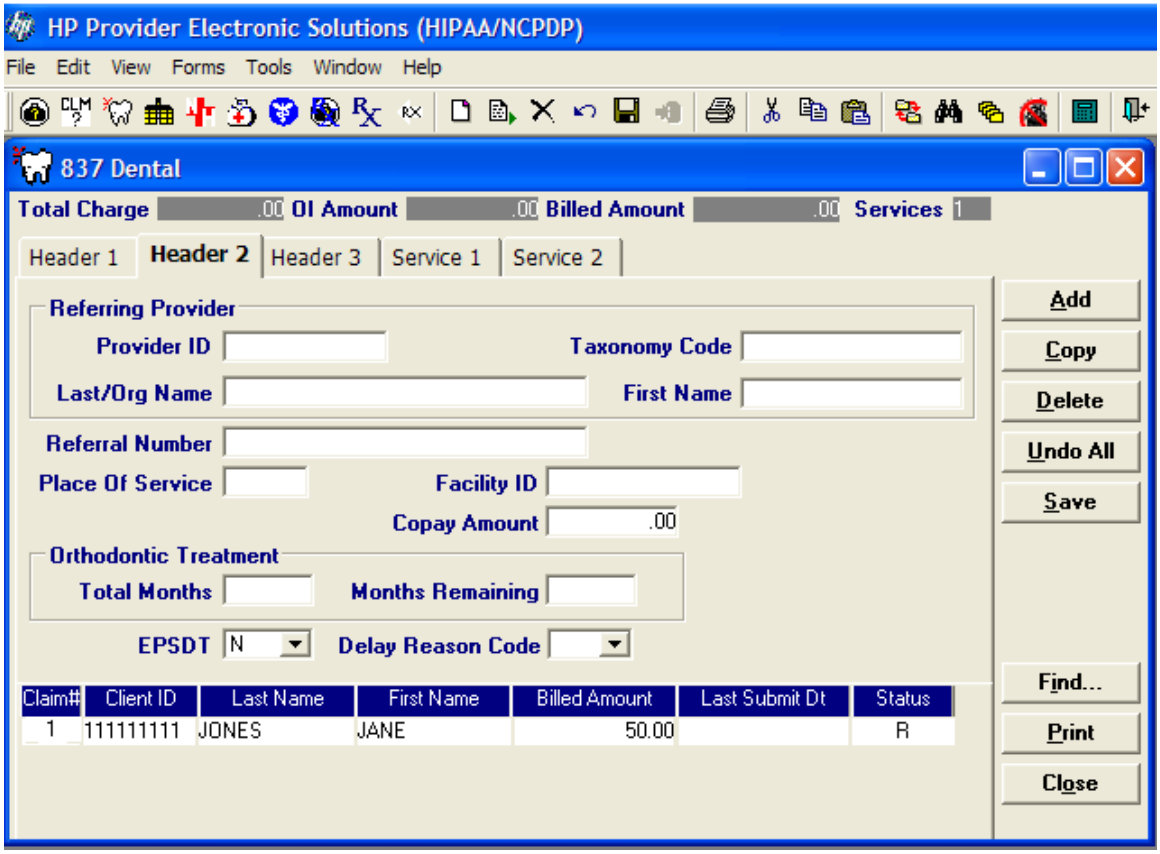
Remarks: Optional
Format: AA

Attachment Ctl:

This field is enabled when the Report Transmission Code is a "BM", "EL", "EM", or "FX". Enter the control number of the attachment.

Remarks: Situational
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

DENTAL HEADER TWO



HEADER TWO INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
REFERRING PROVIDER ID	10	O	N
REFERRING TAXONOMY CODE	10	O	X
REFERRING LAST/ORG NAME	35	O	A
REFERRING FIRST NAME	25	O	A
REFERRAL NUMBER	30	O	X
PLACE OF SERVICE	2	R	N
FACILITY ID	9	O	N
COPAY AMOUNT	9	S	N
TOTAL MONTHS	2	S	N
MONTHS REMAINING	2	S	N
EPSDT	1	R	A
DELAY REASON CODE	2	O	N

A = ALPHA N = NUMERIC X = ALPHANUMERIC

DENTAL HEADER TWO ENTRY INSTRUCTIONS

Referring Provider ID

Select the NPI or Connecticut Medical Assistance Program identification number from the drop-down list for the referring physician.

Remarks: Optional
Format: NNNNNNNNN

Taxonomy Code:

This field will be auto-plugged once you enter your provider number and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Optional
Format: NNNANNNNNA

Last/Org Name:

This field will be auto-plugged once you enter the provider number. This field contains the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

Remarks: Optional
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

First Name:

This field will be auto-plugged once you enter the provider number. This field contains the first name of the provider when they are an individual. Required when the Entity Type Qualifier is a 1. Cannot be used when the Facility Type Qualifier is a 2.

Remarks: Optional
Format: AAAAAAAAAAAAAAAAAAAAAA

Referral Number:

Enter the referral number if applicable.

Remarks: Optional
Format: AAAAAAAAAAAAAAAAAAAAAAA

Place of Service:

Enter the appropriate code from the drop-down list that reflects where the services for this claim were performed.

Code	Description	Code	Description
03	School	33	Custodial care facility
04	Homeless Shelter	34	Hospice
05	Indian health service free-standing facility	41	Ambulance – land
		42	Ambulance –air
06	Indian health service provider-based facility	50	Federally qualified health center
		51	Inpatient psychiatric facility

07	Tribal 638 free-standing facility	52	Psychiatric facility partial hospital
08	Tribal 638 provider based facility	53	Community mental health center
11	Office	54	Intermediate care facility/mentally retarded
12	Home	55	Psychiatric substance abuse treatment facility
13	Assisted Living Services	56	Psychiatric residential treatment center
15	Mobile unit	60	Mass immunization center
16	Temporary lodging	61	Comprehensive inpatient rehabilitation
20	Urgent care facility	62	Comprehensive outpatient rehabilitation
21	Inpatient	65	End stage renal disease treatment facility
22	Outpatient	71	State or local public health clinic
23	Emergency room	72	Rural health clinic
24	Ambulatory surgical center	81	Independent laboratory
25	Birthing center	99	Other unlisted facility
26	Military treatment facility		
31	Skilled nursing facility		

Remarks: Required
Format: XX

Facility ID:

Select the appropriate facility provider identification number from the drop-down list. Required when Place of Service values are 21, 22, 31 or 25.

Remarks: Optional
Format: NNNNNNNNN

Copay Amount:

Enter the copay amount if applicable.

Remarks: Situational
Format: $$$$$$$cc

Total Months:

Enter the number of months for the orthodontia treatment plan, if applicable.

Remarks: Situational
Format: NN

Months Remaining:

Enter the number of months remaining in the orthodontia treatment plan, if applicable.

Remarks: Situational
Format: NN

EPSDT:

Select “N”; or select “Y” if the patient is part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

Remarks: Required
Format: A

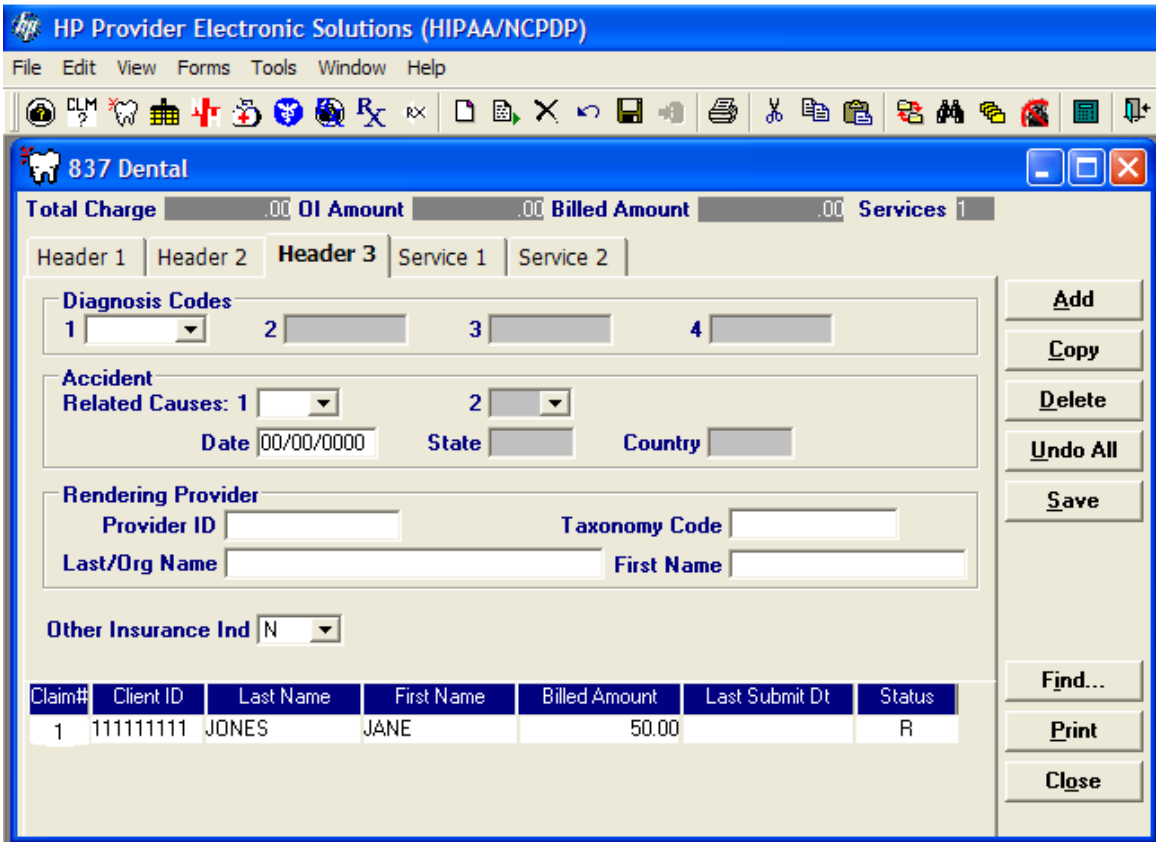
Delay Reason Code:

Select the appropriate code from the drop-down list to identify the reason for delay in submitting the claim.

Code	Description
1	Proof of eligibility unknown or unavailable
2	Litigation
3	Authorization delays
4	Delay in certifying provider
5	Delay in supplying billing forms

Remarks: Optional
Format: N

DENTAL HEADER THREE



DENTAL HEADER THREE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
DIAGNOSIS CODES 1-4	5	O	X
ACCIDENT RELATED CAUSES 1-2	2	S	A
DATE	8	S	N
STATE	2	S	A
COUNTRY	3	S	A

RENDERING PROVIDER PROVIDER ID	10	S	N
RENDERING PROVIDER TAXONOMY CODE	10	S	X
RENDERING PROVIDER LAST/ORG NAME	35	S	A
RENDERING PROVIDER FIRST NAME	25	S	A
OTHER INSURANCE INDICATOR	1	R	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

DENTAL HEADER THREE ENTRY INSTRUCTIONS

Diagnosis Code 1-4:

Enter the diagnosis code(s) from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) manual. Up to 4 diagnosis codes may be entered. NOTE: DO NOT key the decimal point. It is already assumed.

Remarks: Optional
Format: XXXXX

Accident Related Causes 1-2:

If this claim is the result of an accident, select the appropriate code to indicate the type of accident.

Remarks: Situational
Format: AA

Date:

Indicate the date of the accident. Required if the claim is the result of an accident.

Remarks: Situational
Format: MM/DD/CCYY

State:

Enter the state where the accident occurred. Use state postal codes (CT = Connecticut, etc). Required if Accident Related Causes value is "AA", Auto Accident.

Remarks: Situational
Format: AA

Country:

Enter the country in which the accident occurred. Required if an auto accident occurred outside of the United States.

Remarks: Situational
Format: AA

Rendering Provider ID:

Select the Connecticut Medical Assistance Program rendering provider number from the drop-down window. The other provider information will be populated once you select enter. Used only when the provider rendering services is different from the billing provider on the Header One tab.

Remarks: Situational
Format: NNNNNNNNN

Rendering Provider Taxonomy Code:

Enter an alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/training requirements. This field will be populated once you select a rendering provider, provider ID.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Situational
Format: NNNANNNNNA

Rendering Provider Last/Org Name:

Enter provider's name or the first two letters of the provider's last name as enrolled in the Connecticut Medical Assistance Programs. This field will be populated once you select a rendering provider, provider ID.

Example: THOMPSON or 'TH'
Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA or AA

Rendering Provider First Name:

Enter the first name of the provider when they are an individual. Required when the entity type qualifier is a 1. Cannot be used when the entity type qualifier is a 2. This field will be populated once you select a rendering provider, provider ID.

Example: THOMPSON or 'TH'
Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAA or AA

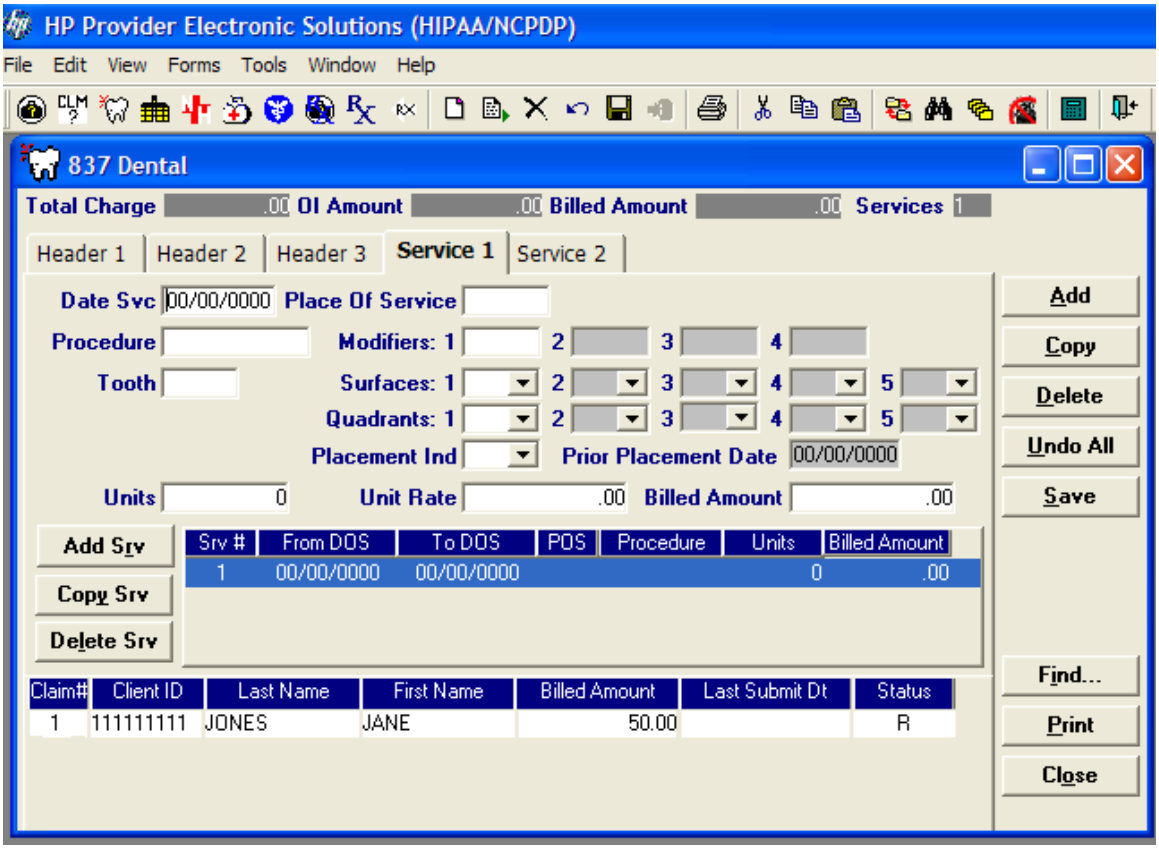
Other Insurance Indicator:

This field indicates whether the client has other insurance. This field is defaulted to "N" for no. When this is changed to a "Y" for yes, the Other Insurance Tab is added to the claim form for entry.

Y – Yes
N – No

Remarks: Required
Format: A

DENTAL SERVICE ONE SCREEN



SERVICE ONE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
DATE SVC	8	R	N
PLACE OF SERVICE	2	R	N
PROCEDURE	5	R	X
MODIFIERS 1-4	2	S	X
TOOTH	2	S	X
SURFACES 1-5	1	S	X
QUADRANTS 1-5	2	S	X
PLACEMENT IND	1	S	X
PRIOR PLACEMENT DATE	8	S	N
UNITS	8	R	N
UNIT RATE	9	R	N
BILLED AMOUNT	9	R	N

A = ALPHA N = NUMERIC X = ALPHANUMERIC

DENTAL SERVICE ONE ENTRY INSTRUCTIONS

Date Svc:

Enter the date of service on which services were provided for this claim in MM/DD/CCYY format.

Remarks: Required
Format: MM/DD/CCYY

Place of Service:

Select the appropriate code that reflects where the services for this claim were performed. This field is required if a place of service code is not entered on Header Two.

Code	Description	Code	Description
03	School	33	Custodial care facility
04	Homeless Shelter	34	Hospice
05	Indian health service free standing facility	41	Ambulance – land
		42	Ambulance –air
06	Indian health service provider-based facility	50	Federally qualified health center
		51	Inpatient psychiatric facility
07	Tribal 638 free-standing facility	52	Psychiatric facility partial hospital
08	Tribal 638 provider based facility	53	Community mental health center
11	Office	54	Intermediate care facility/mentally retarded
12	Home	55	Psychiatric substance abuse treatment facility
15	Mobile unit	56	Psychiatric residential treatment center
20	Urgent care facility	60	Mass immunization center
21	Inpatient	61	Comprehensive inpatient rehabilitation
22	Outpatient	62	Comprehensive outpatient rehabilitation
23	Emergency room	65	End stage renal disease treatment facility
24	Ambulatory surgical center	71	State or local public health clinic
25	Birthing center	72	Rural health clinic
26	Military treatment facility	81	Independent laboratory
31	Skilled nursing facility	99	Other unlisted facility
32	Nursing facility		

Remarks: Required
Format: NN

Procedure:

Enter the five (5) digit HCPCS or American Dental Association (ADA) service procedure code which best describes the services rendered.

Remarks: Required
Format: XXXXX

Modifiers:

Enter the modifier, if applicable. Up to four (4) modifiers may be entered for each detail.

Remarks: Situational
Format: XX

Tooth:

Select the appropriate tooth number (1-32, A-T) if applicable.

Remarks: Situational
Format: XX

Surfaces:

Enter the tooth surface, if applicable. Up to five (5) surfaces may be entered for each detail.

Remarks: Situational
Format: X

Quadrants:

Enter the quadrant, if applicable. Up to five (5) quadrants may be entered for each detail.

Remarks: Situational
Format: XX

Placement Ind:

Select the appropriate placement indicator code, if applicable.

Remarks: Situational
Format: X

Prior Placement Date:

Enter the date of the prior placement if services are for a replacement appliance. Required if Placement Ind. = "R"

Remarks: Situational
Format: MM/DD/CCYY

Units:

Enter the number of units performed for the service being billed.

Remarks: Required
Format: NNNNNNNN

Unit Rate:

Enter the rate per unit billed.

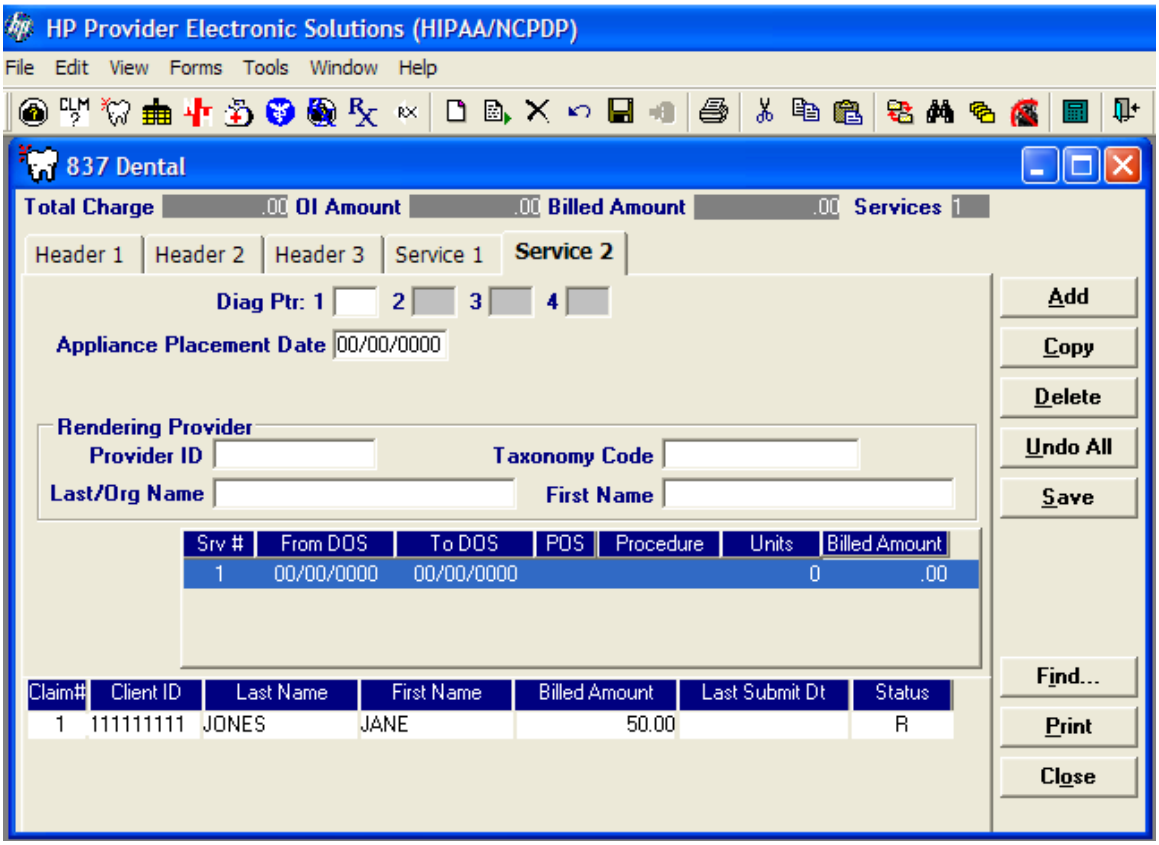
Remarks: Required
Format: $$$$$$$cc

Billed Amount

Enter the total amount for the services performed for this procedure. This should include the charge for all units listed.

Remarks: Required
Format: $$$$$$$cc

DENTAL SERVICE TWO SCREEN



SERVICE TWO INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
DIAG PTR 1-4	1	R	N
APPLIANCE PLACEMENT DATE	8	S	N
RENDERING PROVIDER PROVIDER ID	10	S	N
RENDERING PROVIDER TAXONOMY CODE	10	S	X
RENDERING PROVIDER LAST/ORG NAME	35	S	A

RENDERING PROVIDER FIRST NAME	25	S	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

DENTAL SERVICE TWO ENTRY INSTRUCTIONS

Diag Ptr:
Enter the diagnosis pointer that corresponds to the diagnosis code on the Header Three tab. Up to four (4) diagnosis pointers may be entered.

Remarks: Required
Format: N

Appliance Placement Date:
Enter the placement date of the appliance, if applicable.

Remarks: Situational
Format: MM/DD/CCYY

Rendering Provider ID:
Select the Connecticut Medical Assistance Program rendering provider number from the drop-down window. The other provider information will be populated once you select enter. Used only when the provider rendering services is different from the billing provider on the Header One tab.

Remarks: Situational
Format: NNNNNNNNN

Rendering Provider Taxonomy Code:
Enter an alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/training requirements. This field will be populated once you select a rendering provider, provider ID.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Situational
Format: NNNANNNNNA

Rendering Provider Last/Org Name:
Enter provider's name or the first two letters of the provider's last name as enrolled in the Connecticut Medical Assistance Program. This field will be populated once you select a rendering provider, provider ID.

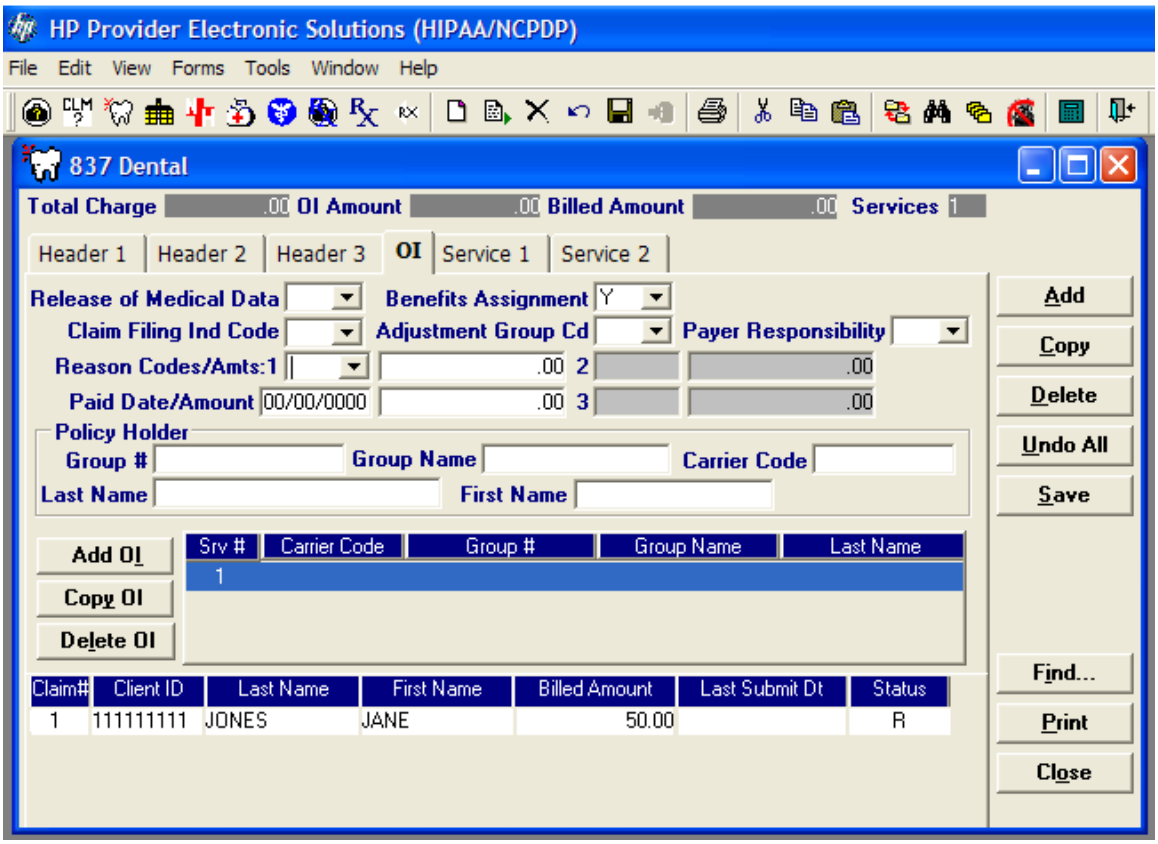
Example: THOMPSON or 'TH'
Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA or AA

Rendering Provider First Name:

Enter the first name of the provider when they are an individual. Required when the entity type qualifier is a 1. Cannot be used when the entity type qualifier is a 2. This field will be populated once you select a rendering provider, provider ID.

Example: THOMPSON or 'TH'
Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAA or AA

OTHER INSURANCE



OTHER INSURANCE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED/ OPTIONAL/ SITUATIONAL	ALPHA/ NUMERIC
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
CLAIM FILING IND CODE	2	R	X
ADJUSTMENT GROUP CD	2	R	X
PAYER RESPONSIBILITY	1	R	A
REASON CODES 1-3	3	R	X
REASON AMTS 1-3	9	R	N
PAID DATE	8	R	N

PAID AMOUNT	9	R	N
POLICY HOLDER GROUP #	17	O	X
POLICY HOLDER GROUP NAME	14	R	A
CARRIER CODE	3	R	X
POLICY HOLDER LAST NAME	35	R	A
POLICY HOLDER FIRST NAME	25	R	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

OTHER INSURANCE ENTRY INSTRUCTIONS

Providers are required to submit other insurance information when another payer is known to potentially be involved in paying or denying a claim.

The following fields are required when a "Y" is indicated in the Other Insurance Indicator field on the Header Three Screen.

Release of Medical Data:

Select the appropriate value from the drop-down box that indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations.

Remarks: Required
Format: A

Benefits Assignment:

Select the appropriate value from the drop-down box that identifies that the client, or authorized person, authorizes benefits to be assigned to the provider. This field defaults to 'Y'.

Remarks: Required
Format: A

Claim Filing Ind Code:

Select the appropriate value from the drop-down box that identifies the type of other insurance claim that is being submitted. Select MB when the denial is from Medicare.

Remarks: Required
Format: XX

Adjustment Group Cd:

Select the appropriate value from the drop-down box that identifies the general category of payment adjustment by the other insurance carrier.

Remarks: Required
Format: XX

Payer Responsibility:

Select the code that describes the order of insurance carrier's level of responsibility for a payment of a claim.

Remarks: Required
Format: A

Reason Codes 1-3:

Enter the code identifying the reason the adjustment was made by the other insurance carrier. At least one reason code and amount is required or use this field to indicate the reason Medicare denied the claim. Reason codes can be found in the Implementation Guide by clicking on the following site**:** www.wpc-edi.com http://www.wpc-edi.com Follow the instructions below to retrieve the reason codes.

- Click on HIPAA
- Click on Code Lists
- Click on Claim Adjustment Reason Codes

Use this list of codes to indicate if a payment was made by OI or denied by OI.

Remarks: Required
Format: XXXXX

Reason Amounts 1-3:

Enter the amount associated with each reason code. At least one reason code and amount is required.

Remarks: Required
Format: $$$$$$$cc

Paid Date:

Enter the date that the other insurance carrier paid the claim (remittance advice date). Use this field to enter the date Medicare denied the claim.

Remarks: Required
Format: MM/DD/CCYY

Paid Amount:

Enter the amount paid by the other insurance carrier. An amount of zero (0) may be entered. This field is required if a value is entered in the Reason Code field on the other insurance screen and a payment has been received towards the claim from a third party.

Remarks: Required
Format: $$$$$$$cc

Policy Holder Group #:

Select the group number for the other insurance from the drop-down list. If a group number is not applicable, please enter the policy number of the client. For Medicare clients, please enter the client's Health Insurance Claim (HIC) number.

Remarks: Optional
Format: XXXXXXXXXXXXXXXX

Policy Holder Group Name:

This field is auto-plugged when a group number is selected and contains the name of the group that the other insurance is listed under and coincides with Group number.

Remarks: Required

Format: AAAAAAAAAAAAAA

Policy Holder Carrier Code:
This field is auto-plugged when a group number is selected and contains the carrier code identifying the Other Insurance carrier from the drop-down list.

Remarks: Required
Format: XXX

Policy Holder Last Name:
This field is auto-plugged when a group number is selected and contains the last name of the policyholder of the other insurance.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAA

Policy Holder First Name:
This field is auto-plugged when a group number is selected and contains the first name of the policyholder of the other insurance.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAA