PNM Billing Guide for Dental Claims

For full step-by-step guidance of how to enter a dental claim in the Provider Network Management (PNM) system, access the Dental Claims User Guide by selecting the 'Learning' page from the PNM homepage/dashboard.

Fields marked with an asterisk (*) require an entry. Sections/panels marked with an asterisk, indicate that a field within that section/panel requires entry. Sections/panels that are situational, may not display an asterisk (*) but can be expanded by clicking (+) in the section/panel header. Fields with an asterisk (*) listed under a section/panel without an asterisk, are only required if data is entered within that section/panel.

Information entered in a field must be 'recorded' before the PNM system can accept and use it. (This is a similar concept to clicking <Enter> after entering information in a cell on a spreadsheet for the data to be accepted). After typing in information in a field, and clicking outside of that field, the data entered will be 'locked' into that field.

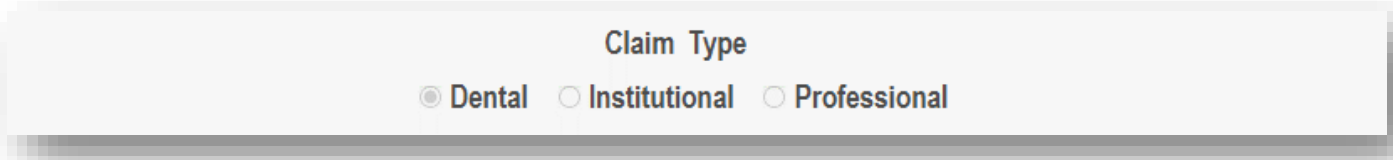
Certain fields have a "Search" hyperlink located next to this. This search function allows the user to look up information if they do not know it at the time of submission. Some examples of this include provider NPIs and diagnosis codes, among others.

Within certain sections/panels, there is an 'Add' button that needs to be selected to add new information. This occurs in sections/panels where multiple lines of data can be entered. Select a display row and click "Edit" to update/change information, "Copy" to copy the line details or "Delete" to remove the information for an existing line item.

Once all data points for the claim submission are entered, the "Submit" button needs to be selected. If there is missing information in any section or panel, PNM displays error messages in red text at the top of the page. If there are errors in the adjudication process with the Fiscal Intermediary (FI), the error messages display in a pop-up message.

After a claim is submitted, information relating to the claim including the Claim Status, ICN, Paid Amount, and Adjudication date appear in an area at the top-right of the claim submission page in PNM.

Ohio Department of Medicaid



*PAYER INFORMATION

*Destination Payer Name

<Blank> (default)
Ohio Department of Medicaid

- Select the payer entity to receive the claim.

*Destination Payer ID

<Blank> (default)
MMISODJFS – Ohio Department of Medicaid

- Select the Destination Payer identification code.
- NOTE: Some Destination Payers only have a single ID. When those Destination Payers are selected, PNM will automatically list the ID in this field.

*Destination Payer Responsibility Sequence

<Blank> (default)
P – Primary
S – Secondary
T – Tertiary
A – Payer Responsibility Four
B – Payer Responsibility Five
C – Payer Responsibility Six
D – Payer Responsibility Seven
E – Payer Responsibility Eight
F – Payer Responsibility Nine

G – Payer Responsibility Ten
H – Payer Responsibility Eleven

- Select a code to indicate the Destination Payer's level of responsibility for the payment of the claim being submitted.

Once these 3 selections are made, the rest of the claim submission page will populate with the panel/sections listed below.

*RECIPIENT INFORMATION

***Medicaid Billing Number**

- Enter the 12-digit Billing Number from the recipient's medical card or the online eligibility system.

***Date of Birth**

- Enter the Medicaid recipient's date of birth in the following format (MM/DD/YYYY).
- The date of birth must match the birth date on file for the recipient's Medicaid Billing Number entered in the previous field. Make sure that both the recipient's Medicaid Billing Number and date of birth are entered correctly; if they do not correspond, you will not be able to proceed.

Last Name *(populated automatically from FI)*

First Name *(populated automatically from FI)*

Middle Name *(populated automatically from FI if one is part of the recipient's record)*

***Patient Control Number**

- Enter the patient control number/account number assigned by the provider to identify the individual. If a control/account number is not available, enter '0' in this field.

Gender *(populated automatically from FI)*

Address Line 1 *(populated automatically from FI)*

City *(populated automatically from FI)*

State *(populated automatically from FI)*

Zip Code *(populated automatically from FI)*

*SERVICE INFORMATION

Special Program Code

<Blank> (default)
EPSDT or CHAP
Physically Handicapped Children's Program
Special Federal Funding
Disability

- Select a program code, if applicable.

*Release of Information

<Blank> (default)
Yes
No

- This field indicates whether the provider has the authorization for the release of medical data.

Patient Paid Amount

- Enter the amount of recipient spenddown collected or applied.
- NOTE: Do NOT enter the Medicaid co-pay amount for any service subject to co-payment (explained in rule 5160-1-09 of the Ohio Administrative Code). Such a co-pay amount is automatically deducted from the Medicaid payment made to a provider. Entering a Medicaid co-pay amount in this field will result in a duplicate deduction.

*Place of Service

- Enter (or use the [Search] function to select) the code that best describes the place of service.

Date of Service *(populated automatically when the claim is successfully submitted)*

- If there are multiple detail lines with multiple dates of service, this field will show the earliest Date of Service entered at the detail level.

Predetermination Claim ID

- Enter the ICN for the predetermination claim.

ACCIDENT INFORMATION

*Accident Related To *(1st field)*

<Blank> (default)
AA – Auto Accident
EM – Employment
OA – Other Accident

- If the service is related to an accident, choose the category most appropriate to the circumstances.

Accident Related To *(2nd field)*

<Blank> (default)
AA – Auto Accident
EM – Employment
OA – Other Accident

- If the Accident Related To *(1st field)* is selected, options, other than what was selected in the 1st field, will populate. Choose the subcategory most appropriate to the circumstances.

Accident State

<Blank> (default)
(50 states and District of Columbia, listed individually)

- If the service is related to an automobile accident, identify the state or territory in which the accident occurred.

Accident Date

- If the service is related to an automobile accident, enter the date (format MM/DD/YYYY) on which the accident occurred.

Accident Country

<Blank> (default)
(239 countries, listed individually)

- If the service is related to an automobile accident, enter the country in which the accident occurred.

PRIOR AUTHORIZATION & REFERRAL INFORMATION

Prior Authorization Number

- Complete this field only if prior authorization is required and has been approved by ODM for a service listed on the claim. Use the ODM prior authorization number assigned for the service.

Referral Number

- Complete this field only if there is a provider referral number related to this claim.

REFERRING PROVIDER INFORMATION

*Referring Provider NPI

- If a physician or dentist authorized a referral, enter (or use the [Search] function to select) the NPI of the referring provider. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

*Primary Care Provider NPI

- This field will be grayed out until a Referring Provider is entered. If a physician or dentist is the primary care provider, enter (or use the [Search] function to select) the NPI of the primary care provider. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

RENDERING PROVIDER INFORMATION

*NPI

- If a physician or dentist rendered care, enter (or use the [Search] function to select) the NPI of the rendering provider. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

SERVICE FACILITY LOCATION INFORMATION

***NPI**

- If services were rendered at a facility, enter (or use the [Search] function to select) the NPI of the facility. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Name *(populated automatically)*

Address1 *(populated automatically)*

Address2 *(populated automatically)*

City *(populated automatically)*

State *(populated automatically)*

Zip *(populated automatically)*

ASSISTANT SURGEON

***NPI**

- If a physician or dentist actively assisted the physician in charge of a case in performing a surgical procedure, enter (or use the [Search] function to select) the NPI of the assistant surgeon. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

SUPERVISING PROVIDER

***NPI**

- If an individual provided oversight of the Rendering Provider, enter (or use the [Search] function to select) the NPI of the supervising provider. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

OTHER PAYER INFORMATION

After entering data in this section/panel, press the 'Add' button to specify that another source, such as commercial insurance or Medicare, is the primary payer for the recipient.

NOTE: Information for each payer (other than Medicaid) must be entered separately. For example, if a recipient has both Medicare and commercial insurance, then create a different entry for each carrier.

*Other Payer Name

- Enter the name of the payer that adjudicated the claim prior to submission.

*Health Plan ID

- Enter the Health Plan ID of the other payer (Medicare plan or insurance company).
  - The Health Plan ID may be obtained from the individual's Medicare or private insurance card, an explanation of benefits (EOB) or electronic remittance advice (ERA) issued by the payer, or the payer itself. Each payer defines its own Health Plan ID. ODM does not maintain a list of Health Plan IDs.

*Claim Filing Indicator

<Blank> (default)
11 – Other Non-Federal Programs
12 – Preferred Provider Organization (PPO)
13 – Point of Service (POS)
14 – Exclusive Provider Organization (EPO)
15 – Indemnity Insurance
16 – Health Maintenance Organization (HMO) Medicare Risk
17 – Dental Maintenance Organization
AM – Automobile Medical
BL – Blue Cross/Blue Shield
CH – Champus
CI – Commercial Insurance Co.
DS – Disability
FI – Federal Employees Program
HM – Health Maintenance Organization

LM – Liability Medical
MA – Medicare Part A
MB – Medicare Part B
MC – Medicaid
OF – Other Federal Program
TV – Title V
VA – Veterans Affairs Plan
WC – Workers' Compensation Health Claim
ZZ – Mutually Defined

- Never select “MEDICAID’. (It appears on this list because it is included in the 5010 version of the 837 transaction.)
- For third-party insurance other than Medicare, select ‘CI – Commercial Insurance Co.’.

***Payer Responsibility Sequence**

<Blank> (default)
P – Primary
S – Secondary
T – Tertiary
A – Payer Responsibility Four
B – Payer Responsibility Five
C – Payer Responsibility Six
D – Payer Responsibility Seven
E – Payer Responsibility Eight
F – Payer Responsibility Nine
G – Payer Responsibility Ten
H – Payer Responsibility Eleven
U – Unknown

- Select the payer’s claim adjudication order. The value selected at the top of the claim submission page (Destination Payer Responsibility Sequence) will not display because it is already in use.

*Subscriber's Number

- Enter the cardholder's subscriber number assigned by the other payer.

Policy Number

- Enter the unique ID number the other payer uses to verify coverage and arrange payment for services.

- NOTE: If PNM requires information in this field, but you do not have a Policy Number for the other payer, enter the same number listed under Subscriber Number (the Medicaid Billing Number).

Group Name

- Enter the group name the other payer uses to identify the specific benefits associated to the cardholder's employer's plan.

- NOTE: If you do not have a group name for the other payer, this field can be left blank, if a number is listed in the Policy Number field.

Insurance Type Code

<Blank> (default)
Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employers Group Health Plan
Medicare Secondary, No-fault Insurance including Auto is Primary
Medicare Secondary Worker's Compensation
Medicare Secondary Public Health Service (PHS)or Other Federal Agency
Medicare Secondary Black Lung
Medicare Secondary Veteran's Administration
Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
Medicare Secondary, Other Liability Insurance is Primary

- Select the proper code to identify the type of insurance.

***Patient Relationship To Subscriber**

<Blank> (default)
Spouse
Self
Child
Employee
Unknown
Organ Donor
Cadaver Donor
Life Partner
Other Relationship

- If the policy holder or subscriber is the recipient, select 'SELF'.

***Subscribers First Name**

- If the 'Patient Relationship to Subscriber' is specified as 'SELF", this field will be automatically populated. Otherwise, enter the information.

***Subscriber Last Name**

- If the 'Patient Relationship to Subscriber' is specified as 'SELF", this field will be automatically populated. Otherwise, enter the information.

Subscriber's Middle Name

- If the 'Patient Relationship to Subscriber' is specified as 'SELF", this field will be automatically populated. Otherwise, enter the information.

Subscriber's Address Line 1

- Enter the subscriber's address.

Subscriber's Address Line 2

- Enter the subscriber's address line 2.

Subscriber's City

- Enter the subscriber's city.

Subscriber's State

- Enter the subscriber's state.

Subscriber's Zip

- Enter the subscriber's zip.

Claim Adjudication Level

<Blank> (default)
Header
Detail

- Select the indicator to identify the other paid claim level.
- PNM grays out this field if the other payer responsibility sequence is greater than the destination payer responsibility sequence.

Claim Number

- Enter the claim number assigned by the other payer.

Paid Date

- Enter the claim adjudication date by the other payer using the MM/DD/YYYY format.

Paid Amount

- Enter the paid amount by the other payer.

Non Covered Amount

- Enter the COB Total Non-Covered Amount.

DIAGNOSIS CODES

Decimals are not allowed on claim submissions. Be sure to enter the diagnosis code without decimals.

After entering data in this section/panel, press the ‘Add’ button to add diagnosis codes. A maximum of 4 diagnosis codes can be entered.

***Diagnosis Code**

- If a diagnosis code needs to be added to the claim, enter (or use the [Search] function to select) the diagnosis code. Omit the decimal point.

***ICD Version**

<Blank> (default)
ICD 10
ICD 9

- Select the ICD version of the diagnosis code.

Diagnosis Description *(populated automatically after a diagnosis code is entered)*

OUTPATIENT ADJUDICATION INFORMATION

Reimbursement Rate (Percentage as decimal)

- Enter the reimbursement rate as a decimal.

HCPCS Payable Amount

- Enter the HCPCS payable amount.

Claim Remark Code (MOA 03)

- Enter the claim remark code.

Claim Remark Code (MOA 04)

- Enter the claim remark code.

HEADER OTHER PAYER ADJUSTMENT INFORMATION

If another payer has been entered in the 'Other Payer Information' panel, the claim adjudication level is 'Header', and the other payer responsibility sequence is prior to the destination payer, Health Plan ID will be available in the drop-down menu.

After entering data in this section/panel, press the 'Add' button to indicate adjustments at the header level. Each payer can have up to 30 adjustment lines.

*Health Plan ID

- Select the Health Plan ID of the other payer.

*Adjustment Group

<Blank> (default)
CO – Contractual Obligations
CR – Correction and Reversals
OA – Other Adjustments
PI – Payer Initiated Reductions
PR – Patient Responsibility

- Select the Claim Adjustment Segment (CAS) Group Code received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

*Reason Code

- If information is added to this section/panel, enter (or use the [Search] function to select) the claim-level Adjustment Reason Code (ARC) (for which there is a corresponding dollar amount) received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

***Amount**

- Enter the amount, in dollars, corresponding to a particular claim-level ARC received from the carrier on the explanation of benefits, remittance advice or 835 transaction.

Quantity

- Enter the quantity adjusted by the other payer.

*SERVICE DETAILS

In the ‘Service Detail’ section/panel, each service is represented as a line item. Each line is numbered in the order in which it is entered. Display rows are arranged in ascending order; meaning later line items are displayed below earlier line items.

After entering data in this section/panel, press the ‘Add’ button to add the service line. A maximum of 50 service lines can be added.

*Procedure Code

- In this field, enter (or use the [Search] function to select) the five character/digit Current Dental Terminology (CDT) code which corresponds to the service.

*Date of Services

- Enter the date (format MM/DD/YYYY) on which the service was provided.

Line Control Number

- Enter a reference number for the service detail.

Prior Authorization Number

- Complete this field only if prior authorization is required and has been approved by ODM for a service listed on the claim. Use the ODM prior authorization number assigned for the service.

Referral Number

- Complete this field only if there is a provider referral number related to this claim.

Place of Service

- In this field, enter (or use the [Search] function to select) the two character/digit place code for the place where the service was completed.

Modifier

- When applicable, enter each two-character procedure code modifier associated with the supply or service; up to four modifiers may be specified.
- NOTE: Modifiers are not shown in the display rows for the service lines at the top of the section/panel. Select ‘Edit’ for a service line to see the modifiers that have been entered in the data fields.

Diagnosis Pointer

<Blank> (default)
1 through 8

- Enter the diagnosis pointer for the procedure code. Up to 4 values can be added per procedure.

Oral Cavity

<Blank> (default)
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

- Select the appropriate oral cavity associated with the procedure code.

Prosthesis, Crown, or Inlay Code

<Blank> (default)
Initial Placement
Replacement

- Select the appropriate prosthesis, crown, or inlay code associated with the procedure code.

Status *(populated automatically from FI. If the claim has not been submitted, 'Pending Submission' displays.)*

***Charges**

- Enter the usual and customary charge for the service.

Paid Amount *(populated automatically from FI after the claim is adjudicated)*

***Billed Units**

- Enter the number of units appropriate to the service.

Paid Units *(populated automatically from FI after the claim is adjudicated)*

TOOTH & TOOTH SURFACE INFORMATION

In the ‘Tooth & Tooth Surface Information’ section/panel, each tooth is linked to a service line item. After entering data in this section/panel, press the ‘Add’ button to add the service line. A maximum of 50 records can be added.

The Service Line selections in the drop-down menu are dependent upon the number of service lines entered under the ‘Service Details’ panel. For example, if 3 service lines are added, the options of “1, 2, 3” will be available in the Service Line drop-down menu.

***Service Line**

- Select the appropriate service line relating to the tooth information.

***Tooth Number**

- Enter the appropriate tooth number or tooth letter.
  - 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 51, 52, 53, 54, 55, 56, 57,58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 99, A, AS, B, BS, C, CS, D, DS, E, ES, F, FS, G, GS, H, HS, I, IS, J, JS, K, KS, L, LS, M, MS, N, NS, O, OS, P, PS, Q, QS, R, RS, S, SS, T, TS

Tooth Surface

<Blank> (default)
B – Buccal
D – Distal
F – Facial
I – Incisal
L – Lingual
M – Mesial
O – Occlusal

- Select the appropriate tooth surface letter. Up to 5 values can be selected.

ADDITIONAL PROVIDER INFORMATION – SERVICE DETAIL

Line level provider information should only be entered if it is different than in the header level. After entering data in this section/panel, press the ‘Add’ button to add additional provider information. A maximum of 50 records can be added.

The Service Line selections in the drop-down menu are dependent upon the number of service lines entered under the ‘Service Details’ panel. For example, if 3 service lines are added, the options of “1, 2, 3” will be available in the Service Line drop-down menu.

***Service Line**

- Select the appropriate service line relating to the provider.

***Provider Type**

<Blank> (default)
Rendering Provider
Assistant Surgeon
Supervising Provider
Service Facility

- Select the appropriate provider type.

***Provider NPI**

- Enter (or use the [Search] function to select) the NPI of the provider. An NPI is the only acceptable identifier in this field.

Last Name *(populated automatically)*

First Name *(populated automatically)*

Middle Name *(populated automatically)*

OTHER PAYER PAID AMOUNT – SERVICE DETAIL SCREEN

Enter information in this section when there is an Other Payer, and the other payer adjudication level is 'Detail.' After entering data in this section/panel, press the 'Add' button.

If another payer has been entered in the 'Other Payer Information' panel, the claim adjudication level is 'Detail', and the other payer responsibility sequence is prior to the destination payer, Health Plan ID will be available in the drop-down menu.

***Service Line**

- Select the appropriate service line relating to the payer paid amount.

Procedure Code *(populated automatically based on the service line selected)*

***Health Plan ID**

- Select the Health Plan ID of the other payer.

***Amount Paid**

- Enter the amount paid by the other payer.

Paid Date *(populated automatically from the 'Other Payer Information' panel)*

***Paid Service Unit Count**

- Enter the number of the units paid by the other payer.

OTHER PAYER ADJUSTMENT INFORMATION – SERVICE DETAIL

Enter information in this section when there is an adjustment to the Other Payer amount. After entering data in this section/panel, press the 'Add' button.

If another payer has been entered in the 'Other Payer Information' panel, the claim adjudication level is 'Detail', and the other payer responsibility sequence is prior to the destination payer, Health Plan ID will be available in the drop-down menu.

***Service Line**

- Select the appropriate service line relating to the other payer adjustment.

Procedure Code *(populated automatically based on the service line selected)*

***Health Plan ID**

- Select the Health Plan ID of the other payer.

***Adjustment Group**

<Blank> (default)
CO – Contractual Obligations
CR – Correction and Reversals
OA – Other Adjustments
PI – Payer Initiated Reductions
PR – Patient Responsibility

- Select the Claim Adjustment Segment (CAS) Group Code received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

***Reason Code**

- If information is added to this section/panel, enter (or use the [Search] function to select) the claim-level Adjustment Reason Code (ARC) (for which there is a corresponding dollar amount) received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

***Amount**

- Enter the amount, in dollars, corresponding to a particular claim-level ARC received from the carrier on the explanation of benefits, remittance advice or 835 transaction.

Quantity

- Enter the quantity adjusted by the other payer.

ATTACHMENT

Press the ‘Choose File’ button to prepare an attachment for submission. Clicking ‘Choose File’ will access the folders on your computer where you can locate the document(s) to be uploaded to the claim submission. After adding a document and choosing a document type in this section/panel, press the ‘Add’ button. A maximum of 10 documents can be uploaded per claim with a maximum file size of 1.25 GB per file.

*Upload attachment

- Click ‘Choose File’ to attach a document to the claim submission.

*Document Type

Admission Summary (default)
Certification
Dental Models
Diagnostic Report
Discharge Summary
Explanation of Benefits
Models
Nursing Notes
Operative Note
Physical Therapy Certification
Physical Therapy Notes
Physician Order
Prescription
Prosthetics or Orthotic Certification
Radiology Films
Radiology Reports
Referral Form (Ohio 6653)
Report of Tests and Analysis Report
Support Data for Claim

- An attachment is required for the adjudication of certain claims. When a required attachment is submitted with a claim, the claim will be suspended for review. An attachment that is not required will not be reviewed; the accompanying claim will be processed as though there were no attachment listed. The mere presence of an attachment will not cause a claim to be suspended for review. Therefore, submit an attachment only when an attachment is required.
- The following file types are acceptable to upload:
    - Word: doc, docx
    - Excel: xls, xlsx, xlsm, xlsx
    - Image: mdi, jpe, jpeg, jpg, png, gif, bmp, tif, tiff
    - PDF: pdf
    - Other: pi, ec, zip, csv, acrbak, ms

PROVIDER NOTES

This selection allows for the addition of notes to be added to the claim submission. A note can be a maximum of 80 characters. After adding a note in this section/panel, press the 'Add' button. A maximum of 5 notes can be added.

If you are submitting a claim more than 365 days after the date of service because of either a hearing decision or a delay in a recipient's eligibility determination, enter a note.

***Note**

- Type in the note to be added to the claim submission.
- When a claim is submitted more than 365 days after the date of service because of either a hearing decision or a delay in a recipient's eligibility determination by the Ohio Department of Medicaid (ODM), the claim must be submitted within 180 days after the hearing decision or eligibility determination date.
    - Hearing decision note format: *APPEALS XXXXXXX CCYYMMDD* (XXXXXXX is the hearing number and CCYYMMDD is the date on the hearing decision letter.)
    - Eligibility determination note format: *DECISION CCYYMMDD* (CCYYMMDD is the date on the eligibility determination notice from ODM.)

REVIEWER NOTES

This section/panel remains blank until the claim is adjudicated. If the reviewer of the claim has notes to provide, those will be listed here.

DELAYED SUBMISSION/RESUBMISSION INFORMATION

The reasons listed are from the Electronic Data Interchange (EDI) and may relate to delay in Managed Care claim submissions. Fee-for-service claims usually indicate delays in the provider notes.

NOTE: A document needs to be uploaded under 'Attachments' to justify the use of this section/panel and data entered must be retained for future audit purposes.

Reason for Delay

<Blank> (default)
Proof of Eligibility Unknown or Unavailable
Litigation
Authorization Delays
Delay in Certifying Provider
Third Party Processing Delay
Delay in Eligibility Determination
Administration Delay in the Prior Approval Process
Other
Natural Disaster
Delay In Supplying Billing Forms
Delay in Delivery of Custom-made Appliances
Original Claim Rejected or Denied Due To a Reason Unrelated To The Billing Limitation Rules

CLAIM ADJUDICATION

Data in this section/panel appears only after the adjudication of the claim by the payer. This section/panel is view only and shows the status of the claim in the claim level.

Claim Status *(populated automatically by FI)*

Total Paid Amount *(populated automatically by FI)*

Claim Submission Date *(populated automatically by FI)*

Claim Paid Date *(populated automatically by FI)*

ICN *(populated automatically by FI)*

Adjudication Date *(populated automatically by FI)*

Total Charges *(populated automatically by FI)*

CoPay Amount *(populated automatically by FI)*

RELATED ICN SCREEN

Data in this section/panel appears only after the adjudication of the claim by the payer. This section/panel is view only and shows any ICN that is related to the current claim and the reason why the claims are related.

CARC & RARC INFORMATION

Data in this section/panel appears only after the adjudication of the claim by the payer. This section/panel is view only and shows CARC and RARC information. CARC and RARC information will be organized to be 10 lines per page.

ADJUDICATION ERRORS

Data in this section/panel appears only if there are errors in the claim adjudication process with FI.

MALICIOUS ATTACHMENTS

After the claim submission is reviewed, if an attached document is found to contain damaging macros, it will be flagged as a ‘malicious attachment.’ Malicious attachments for the claim submission will be listed in this section. To replace the malicious attachment documents, follow the steps outlined in the Dental Claims User Guide.

Select this checkbox for a predetermination claim.