



Job Aid

Dental Claim Submission

This job aid provides step-by-step instructions on how to submit a Dental Claim in the MESA portal. Please thoroughly read and follow all directions.

Review the Steps to Submit a Dental Claim

Steps	Description
Step 1	<p>Login to the Portal. The Portal Home screen Displays.</p> 
Step 2	<p>The following steps will review how to submit a Dental Claim in MESA: Hover over the Claims tab on the menu bar. A list of claim types displays below.</p> <ul style="list-style-type: none"> Select Submit Claim Dental. 
Step 3	<p>The Portal displays the “Submit Dental Claim: Step 1” page.</p> <ul style="list-style-type: none"> Complete the Provider Information section.

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	<p>NOTE: There will be information already generated in this section. Complete additional fields if applicable to the claim being submitted.</p> <div data-bbox="272 323 1468 646"> <p>Submit Dental Claim: Step 1 ?</p> <p>* Indicates a required field.</p> <p>Provider Information</p> <table border="1"> <tr> <td>Billing Provider ID</td> <td>ID Type NPI</td> <td>Name</td> </tr> <tr> <td>Taxonomy</td> <td></td> <td></td> </tr> <tr> <td>Performing Provider ID <input type="text"/></td> <td>ID Type NPI</td> <td>Name <input type="text"/></td> </tr> <tr> <td>Taxonomy <input type="text"/></td> <td></td> <td></td> </tr> <tr> <td>Service Facility Location ID <input type="text"/></td> <td>ID Type NPI</td> <td>Name <input type="text"/></td> </tr> <tr> <td>Taxonomy <input type="text"/></td> <td></td> <td></td> </tr> </table> </div>	Billing Provider ID	ID Type NPI	Name	Taxonomy			Performing Provider ID <input type="text"/>	ID Type NPI	Name <input type="text"/>	Taxonomy <input type="text"/>			Service Facility Location ID <input type="text"/>	ID Type NPI	Name <input type="text"/>	Taxonomy <input type="text"/>		
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<p>Step 4</p>	<ul style="list-style-type: none"> Complete the Patient Information section. <p>NOTE: Once the Member ID is entered, the system will generate the remaining fields in this section. Verify the fields populate correctly.</p> <div data-bbox="272 779 1468 1052"> <p>Patient Information</p> <p>*Member ID <input type="text"/></p> <p>Last Name <input type="text"/> First Name <input type="text"/></p> <p>Birth Date <input type="text"/></p> <p>Address <input type="text"/></p> <p>Address Line 2 <input type="text"/></p> <p>City <input type="text"/></p> <p>State <input type="text"/> Zip Code <input type="text"/></p> </div>																		
<p>Step 5</p>	<ul style="list-style-type: none"> Complete the Claim Information section. <p>NOTE: The "Include Other Insurance" check box is not selected. If the member has other primary insurance check the "Include Other Insurance" box before selecting continue to step 2.</p> <p>NOTE: Everything with a red asterisk * must be completed.</p> <div data-bbox="272 1230 1468 1640"> <p>Claim Information</p> <p>Accident Related <input type="text"/> Accident Date <input type="text"/></p> <p>*Place of Treatment <input type="text"/> 11-Office</p> <p>Patient Number <input type="text"/> Authorization Number <input type="text"/></p> <p>Initial X-Ray/Photo Date <input type="text"/></p> <p>*Does the provider have a signature on file? <input type="radio"/> Yes <input type="radio"/> No</p> <p>*Does the provider accept assignment for claim processing? <input type="radio"/> Yes <input type="radio"/> No</p> <p>*Are benefits assigned to the provider by the patient or their authorized representative? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A</p> <p>*Does the provider have a signed statement from the patient releasing their medical information? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Include Other Insurance <input type="checkbox"/></p> <p>Total Charged Amount \$0.00</p> </div>																		
<p>Step 6</p>	<ul style="list-style-type: none"> Important - Complete the Medicare Crossover Details section if the claim is supposed to be a crossover Dental Claim. Make sure to check the "Include Other Insurance" box. Review all sections on the "Submit Dental Claim: Step 1" page. If all the information entered is correct select Continue to move on to Step 2. 																		

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	<div data-bbox="272 260 1469 506" style="border: 1px solid black; padding: 5px;"> <p>Medicare Crossover Details</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Allowed Medicare Amount \$0.00</td> <td style="width: 50%;">Co-insurance Amount <input type="text" value="0.00"/></td> </tr> <tr> <td>Deductible Amount <input type="text" value="0.00"/></td> <td>Psychiatric Services Amount <input type="text" value="0.00"/></td> </tr> <tr> <td>Medicare Payment Amount <input type="text" value="0.00"/></td> <td>Medicare Payment Date <input type="text" value=""/></td> </tr> <tr> <td>Copay Amount <input type="text" value="0.00"/></td> <td></td> </tr> </table> <p style="text-align: right;"> <input type="button" value="Continue"/> <input type="button" value="Cancel"/> </p> </div>	Allowed Medicare Amount \$0.00	Co-insurance Amount <input type="text" value="0.00"/>	Deductible Amount <input type="text" value="0.00"/>	Psychiatric Services Amount <input type="text" value="0.00"/>	Medicare Payment Amount <input type="text" value="0.00"/>	Medicare Payment Date <input type="text" value=""/>	Copay Amount <input type="text" value="0.00"/>													
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<p>Step 7</p>	<p>The Portal displays the “Submit Dental Claim: Step 2” page. The previous information that was entered in step 1 will display at the top of the page in step 2.</p> <ul style="list-style-type: none"> Review the previously submitted information and scroll down. <div data-bbox="272 632 1469 1150" style="border: 1px solid black; padding: 5px;"> <p>Submit Dental Claim: Step 2 ?</p> <p><small>* Indicates a required field.</small></p> <p>Provider Information</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Billing Provider ID</td> <td style="width: 33%;">ID Type NPI</td> <td style="width: 33%;">Name</td> </tr> <tr> <td colspan="3">Taxonomy</td> </tr> </table> <p>Patient and Claim Information</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Member ID</td> <td style="width: 50%;">Gender</td> </tr> <tr> <td>Member</td> <td></td> </tr> <tr> <td>Birth Date</td> <td>Total Charged Amount</td> </tr> </table> <p>Medicare Crossover Details</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Allowed Medicare Amount \$0.00</td> <td style="width: 50%;">Co-insurance Amount \$0.00</td> </tr> <tr> <td>Deductible Amount \$0.00</td> <td>Medicare Payment Date _</td> </tr> <tr> <td>Medicare Payment Amount \$0.00</td> <td></td> </tr> <tr> <td>Copay Amount \$0.00</td> <td></td> </tr> </table> <p style="text-align: right;">Expand All Collapse All</p> </div>	Billing Provider ID	ID Type NPI	Name	Taxonomy			Member ID	Gender	Member		Birth Date	Total Charged Amount	Allowed Medicare Amount \$0.00	Co-insurance Amount \$0.00	Deductible Amount \$0.00	Medicare Payment Date _	Medicare Payment Amount \$0.00		Copay Amount \$0.00	
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<p>Step 8</p>	<ul style="list-style-type: none"> Enter the Diagnosis Code then select Add. <p>NOTE: Everything with a red asterisk * must be complete if the section is applicable to the claim.</p> <div data-bbox="272 1251 1469 1556" style="border: 1px solid black; padding: 5px;"> <p>Diagnosis Codes -</p> <p>Select the row number to edit the row. Click the Remove link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;">#</th> <th style="width: 30%;">Diagnosis Type</th> <th style="width: 55%;">Diagnosis Code</th> <th style="width: 10%;">Action</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>1 *Diagnosis Type <input type="text" value="ICD-10-CM"/> *Diagnosis Code <input type="text" value=""/></p> <p style="text-align: left;"> <input type="button" value="Add"/> <input type="button" value="Reset"/> </p> </div>	#	Diagnosis Type	Diagnosis Code	Action	1															
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<p>Step 9</p>	<p>Disclaimer: If the “Include Other Insurance” checkbox was checked on “Submit Dental Claim: Step 1” then there will be an “Other Insurance Details” section on “Submit Dental Claim: Step 2”. If the Other Insurance box was not checked then skip to Step 15.</p> <p>Scroll down to the Other Insurance Detail panel.</p> <p>NOTE: If there is other insurance information already populated that is out of date, select the Remove button under the Action column.</p> <ul style="list-style-type: none"> Select the plus sign to add any other insurance. 																				

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	<div data-bbox="277 264 1468 583"> <p>Other Insurance Details</p> <p>Enter the carrier and policy holder information below.</p> <p>Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.</p> <p>NOTE: Please click Remove to discard any unrelated "Other Insurance", prior to submitting claim.</p> <p style="text-align: right;">Refresh Other Insurance</p> <table border="1"> <thead> <tr> <th>#</th> <th>Carrier Name</th> <th>Carrier Code</th> <th>Group #</th> <th>COB Payer Paid Amount</th> <th>Remittance Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="7"><input type="checkbox"/> Click to add a new other insurance.</td> </tr> </tbody> </table> </div>	#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date	Action	<input type="checkbox"/> Click to add a new other insurance.																				
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<p>Step 10</p>	<p>The required fields to be completed for the Other Insurance Details section depend on the selection in the Claim Filing Indicator dropdown.</p> <p>Select 16 (Medicare Part C) for the Claim Filing Indicator and the additional fields will not be displayed.</p> <p>Anything selected other than 16 will require additional fields to complete the Other Insurance Details section.</p> <p>NOTE: The Other Insurance Details section MUST have a Claim Filing Indicator of 16 (Medicare Part C) when submitting a Dental Claim with Other Insurance.</p> <ul style="list-style-type: none"> Select 16-Health Maintenance Organization (HMO) Medicare Risk from the Claim Filing Indicator dropdown. Select Add Insurance. <div data-bbox="277 978 1468 1402"> <p>Other Insurance Details</p> <p>Enter the carrier and policy holder information below.</p> <p>Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.</p> <p>NOTE: Please click Remove to discard any unrelated "Other Insurance", prior to submitting claim.</p> <p style="text-align: right;">Refresh Other Insurance</p> <table border="1"> <thead> <tr> <th>#</th> <th>Carrier Name</th> <th>Carrier Code</th> <th>Group #</th> <th>COB Payer Paid Amount</th> <th>Remittance Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="7"><input type="checkbox"/> Click to collapse.</td> </tr> <tr> <td colspan="7">*Claim Filing Indicator: 16-Health Maintenance Organization (HMO) Medicare Risk</td> </tr> <tr> <td colspan="7"> <input type="button" value="Add Insurance"/> <input type="button" value="Cancel Insurance"/> </td> </tr> </tbody> </table> </div>	#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date	Action	<input type="checkbox"/> Click to collapse.							*Claim Filing Indicator: 16-Health Maintenance Organization (HMO) Medicare Risk							<input type="button" value="Add Insurance"/> <input type="button" value="Cancel Insurance"/>						
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<p>Step 11</p>	<p>Other Insurance displays on line #1 for Health Maintenance Organization (HMO) Medicare Risk.</p> <ul style="list-style-type: none"> Select the plus sign to add another Other Insurance. <div data-bbox="277 1493 1468 1843"> <p>Other Insurance Details</p> <p>Enter the carrier and policy holder information below.</p> <p>Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.</p> <p>NOTE: Please click Remove to discard any unrelated "Other Insurance", prior to submitting claim.</p> <p style="text-align: right;">Refresh Other Insurance</p> <table border="1"> <thead> <tr> <th>#</th> <th>Carrier Name</th> <th>Carrier Code</th> <th>Group #</th> <th>COB Payer Paid Amount</th> <th>Remittance Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td>1</td> <td colspan="4">Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'</td> <td></td> <td>Remove</td> </tr> <tr> <td colspan="7"><input type="checkbox"/> Click to add a new other insurance.</td> </tr> </tbody> </table> </div>	#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date	Action	1	Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'					Remove	<input type="checkbox"/> Click to add a new other insurance.													
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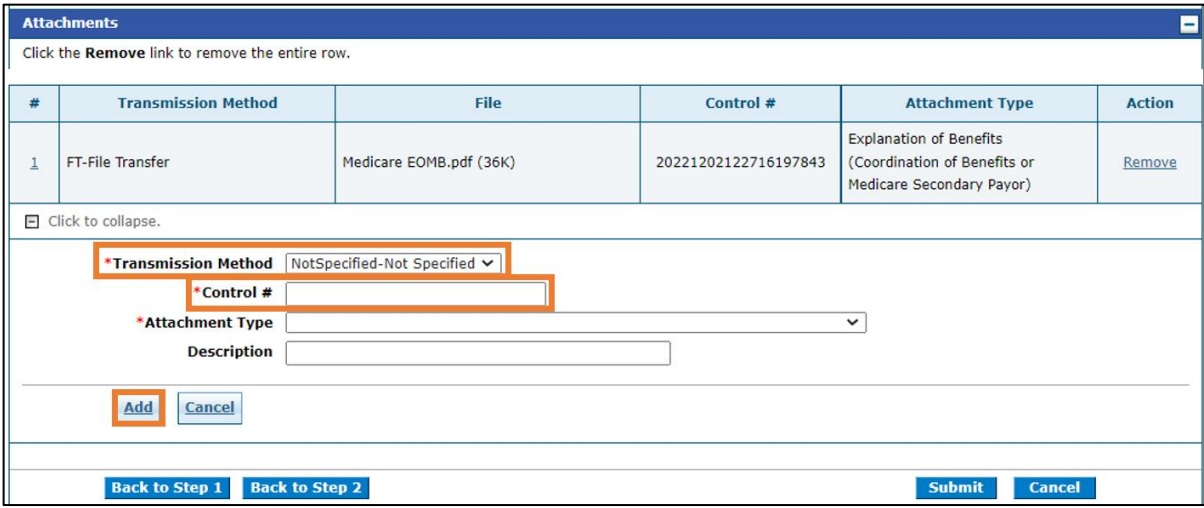
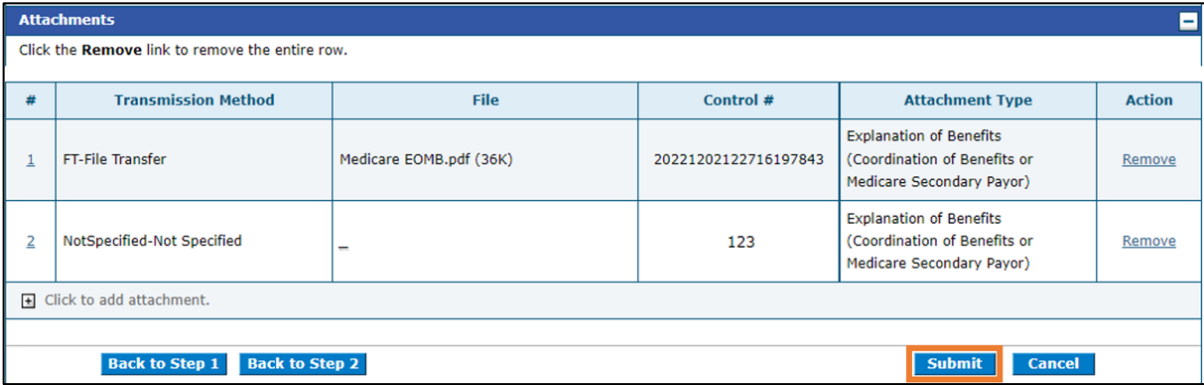
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<p>Step 12</p>	<ul style="list-style-type: none"> Select LM-Liability Medical for the Claim Filing Indicator. The additional fields display once the selection is made. Complete the additional other insurance fields that are required. <ul style="list-style-type: none"> Link to Carrier Codes Complete the Outpatient Adjudication Information section if applicable. Once all the information is entered select Add Insurance. <p>NOTE: Everything with a red asterisk * must be completed if the section is applicable to the claim.</p> <div data-bbox="272 516 1471 1614"> <table border="1"> <thead> <tr> <th>#</th> <th>Carrier Name</th> <th>Carrier Code</th> <th>Group #</th> <th>COB Payer Paid Amount</th> <th>Remittance Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td>1</td> <td colspan="5">Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'</td> <td>Remove</td> </tr> </tbody> </table> <p>Click to collapse.</p> <div style="border: 1px solid black; padding: 5px;"> <p>*Claim Filing Indicator LM-Liability Medical</p> <p>*Carrier Name <input type="text"/> *Carrier Code <input type="text"/></p> <p>*Subscriber Last Name <input type="text"/> *First Name <input type="text"/></p> <p>Subscriber Address <input type="text"/></p> <p>City <input type="text"/> State <input type="text"/></p> <p>Zip Code <input type="text"/> Country <input type="text"/></p> <p>*Subscriber ID <input type="text"/></p> <p>*Group # <input type="text"/></p> <p>Group Name <input type="text"/></p> <p>Insurance Type <input type="text"/></p> <p>*Payer Responsibility <input type="text"/> *Relationship to Subscriber <input type="text"/></p> <p>*COB Payer Paid Amount 0.00 *Remittance Date <input type="text"/></p> <p>Remaining Patient Liability <input type="text"/></p> <p>*Release of Information <input type="text"/></p> <p>Assignment of Benefits <input type="text"/></p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Outpatient Adjudication Information</p> <p>Reimbursement Rate <input type="text"/> Claim HCPCS Payable Amount <input type="text"/></p> <p>Remark CoMS 1 <input type="text"/></p> <p>Remark Code 2 <input type="text"/></p> <p>Remark Code 3 <input type="text"/></p> <p>Remark Code 4 <input type="text"/></p> <p>Remark Code 5 <input type="text"/> Non-payable Professional Component Amount <input type="text"/></p> <p>Claim ESRD Payment Amount <input type="text"/></p> <p>Add Insurance Cancel Insurance</p> <p>Back to Step 1 Continue Cancel</p> </div> </div>	#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date	Action	1	Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'					Remove
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<p>Step 13</p>	<ul style="list-style-type: none"> After the other insurance has been added, select the number 2 hyperlink in the # column to proceed to view the other insurance sub-panel. <p>NOTE: Users can only view the Other Insurance Reasons sub-panel if the Claim Filing Indicator is anything other than 16 (Medicare Part C), MA (Medicare Part A), or MB (Medicare Part B). The user MUST click on the number hyperlink after adding insurance to view it.</p>														

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Step 14	<p>Scroll down to the Other Insurance Reason section.</p> <ul style="list-style-type: none"> Fill out the Other Insurance Reasons section and select Add Reason. <p>NOTE: Everything with a red asterisk * must be completed if the section is applicable to the claim.</p> <ul style="list-style-type: none"> Once the Other Insurance Reasons are added select Save Insurance and move on to the next section. <div data-bbox="272 632 1471 1115" style="border: 1px solid black; padding: 5px;"> <p>Other Insurance Reasons -</p> <p>You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.</p> <p>Click the Remove link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Group Code</th> <th>Reason</th> <th>Amount</th> <th>Units of Service</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="6"><input type="checkbox"/> Click to collapse.</td> </tr> <tr> <td></td> <td>*Group Code</td> <td><input type="text"/></td> <td>*Reason</td> <td><input type="text"/></td> <td></td> </tr> <tr> <td></td> <td>*Amount</td> <td><input type="text" value="0.00"/></td> <td>Units of Service</td> <td><input type="text"/></td> <td></td> </tr> <tr> <td colspan="6" style="text-align: center;"> <input type="button" value="Add Reason"/> <input type="button" value="Cancel Reason"/> </td> </tr> <tr> <td colspan="6" style="text-align: center;"> <input type="button" value="Save Insurance"/> <input type="button" value="Cancel Insurance"/> </td> </tr> </tbody> </table> </div>	#	Group Code	Reason	Amount	Units of Service	Action	<input type="checkbox"/> Click to collapse.							*Group Code	<input type="text"/>	*Reason	<input type="text"/>			*Amount	<input type="text" value="0.00"/>	Units of Service	<input type="text"/>		<input type="button" value="Add Reason"/> <input type="button" value="Cancel Reason"/>						<input type="button" value="Save Insurance"/> <input type="button" value="Cancel Insurance"/>					
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Step 15	<ul style="list-style-type: none"> Scroll to the bottom of the page and select Continue. <div data-bbox="272 1178 1471 1262" style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;"> <input type="button" value="Back to Step 1"/> <input type="button" value="Continue"/> <input type="button" value="Cancel"/> </p> </div>																																				
Step 16	<p>The Portal displays the “Submit Dental Claim: Step 3” page. The previous information that was entered in step 1 and step 2 is displayed at the top of the page on step 3.</p> <ul style="list-style-type: none"> Scroll down to view the additional sections on this page. <p>NOTE: Select the plus and minus for each section to expand and collapse.</p>																																				

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	<div style="border: 1px solid black; padding: 5px;"> <p>Submit Dental Claim: Step 3 ?</p> <p>* Indicates a required field.</p> <p>Provider Information</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Billing Provider ID 1346510559</td> <td style="width: 33%;">ID Type NPI</td> <td style="width: 34%;">Name ST DOMINIC'S GYNECOLOGIC ONCOLOGY</td> </tr> <tr> <td colspan="3">Taxonomy 193200000X-Multi-Specialty</td> </tr> </table> <p>Patient and Claim Information</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Member ID 310721656</td> <td style="width: 33%;">Member FLORETTA MARTIN</td> <td style="width: 34%;">Gender Female</td> </tr> <tr> <td>Birth Date 01/04/1923</td> <td colspan="2">Total Charged Amount \$0.00</td> </tr> </table> <p>Medicare Crossover Details</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Allowed Medicare Amount \$0.00</td> <td style="width: 33%;">Co-insurance Amount \$0.00</td> </tr> <tr> <td>Deductible Amount \$0.00</td> <td>Medicare Payment Date _</td> </tr> <tr> <td>Medicare Payment Amount \$0.00</td> <td></td> </tr> <tr> <td>Copay Amount \$0.00</td> <td></td> </tr> </table> <p style="text-align: right;">Expand All Collapse All</p> <p>Diagnosis Codes -</p> <p>Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>#</th> <th>Diagnosis Type</th> <th>Diagnosis Code</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>ICD-10-CM</td> <td>R071-CHEST PAIN ON BREATHING</td> </tr> </tbody> </table> <p>Other Insurance Details -</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>#</th> <th>Carrier Name</th> <th>Carrier Code</th> <th>Group #</th> <th>COB Payer Paid Amount</th> <th>Remittance Date</th> </tr> </thead> <tbody> <tr> <td>1</td> <td colspan="5">Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'</td> </tr> <tr> <td>2</td> <td>test</td> <td>test</td> <td>test</td> <td>\$0.00</td> <td>12/07/2022</td> </tr> </tbody> </table> </div>	Billing Provider ID 1346510559	ID Type NPI	Name ST DOMINIC'S GYNECOLOGIC ONCOLOGY	Taxonomy 193200000X-Multi-Specialty			Member ID 310721656	Member FLORETTA MARTIN	Gender Female	Birth Date 01/04/1923	Total Charged Amount \$0.00		Allowed Medicare Amount \$0.00	Co-insurance Amount \$0.00	Deductible Amount \$0.00	Medicare Payment Date _	Medicare Payment Amount \$0.00		Copay Amount \$0.00		#	Diagnosis Type	Diagnosis Code	1	ICD-10-CM	R071-CHEST PAIN ON BREATHING	#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date	1	Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'					2	test	test	test	\$0.00	12/07/2022
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Step 17	<ul style="list-style-type: none"> • Fill out the required information for the Service Details section. • Complete the Medicare Crossover Details section if applicable. • Once all information has been completed, select Add. <p>NOTE: The system requires that the Medicare Crossover Details amounts at the header level (the section completed in Step 1) are balanced against the Medicare Crossover Details amounts at the service line level (the section displayed in Step 2). The amount for each corresponding field should balance out. An edit will be displayed when the amounts are not balanced.</p> <p>NOTE: If values are not completed at both the header level and the details level then the system will not try to balance them.</p>																																												

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	<div style="border: 1px solid black; padding: 5px;"> <div style="background-color: #0056b3; color: white; padding: 2px;">Service Details</div> <p>Select the row number to edit the row. Click the Remove link to remove the entire row.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Svc #</th> <th>Svc Date</th> <th>Oral Cavity Area</th> <th>Tooth#/Letter</th> <th>Procedure Code</th> <th>Units</th> <th>Charge Amount</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <div style="margin-top: 5px;"> <p>1 *Svc Date <input type="text"/> Oral Cavity Area <input type="text"/> Tooth#/Letter <input type="text"/></p> <p>Tooth Surface <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>*Procedure Code <input type="text"/> Modifiers <input type="text"/> <input type="text"/> <input type="text"/></p> <p>*Units <input type="text"/> Charge Amount <input type="text"/> *Diagnosis Pointers <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Authorization Number <input type="text"/></p> <p>Performing Provider ID <input type="text"/> ID Type NPI Taxonomy <input type="text"/></p> </div> <hr/> <div style="background-color: #e6f2ff; padding: 2px;">Medicare Crossover Details</div> <p>Allowed Medicare Amount \$0.00 Co-insurance Amount <input type="text" value="0.00"/></p> <p>Deductible Amount <input type="text" value="0.00"/> Medicare Payment Date <input type="text"/></p> <p>Medicare Payment Amount <input type="text" value="0.00"/></p> <p>Copay Amount <input type="text" value="0.00"/></p> <p style="text-align: center;"><input type="button" value="Add"/> <input type="button" value="Reset"/></p> </div>	Svc #	Svc Date	Oral Cavity Area	Tooth#/Letter	Procedure Code	Units	Charge Amount	Action	1															
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Step 18	<ul style="list-style-type: none"> Select the 1 hyperlink in the Svc # column to view the Other Insurance Details for Svc # 1 section. <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <div style="background-color: #0056b3; color: white; padding: 2px;">Service Details</div> <p>Select the row number to edit the row. Click the Remove link to remove the entire row.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Svc #</th> <th>Svc Date</th> <th>Oral Cavity Area</th> <th>Tooth#/Letter</th> <th>Procedure Code</th> <th>Units</th> <th>Charge Amount</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>12/07/2022</td> <td></td> <td></td> <td>D1110</td> <td>1</td> <td></td> <td>Remove</td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> </div>	Svc #	Svc Date	Oral Cavity Area	Tooth#/Letter	Procedure Code	Units	Charge Amount	Action	1	12/07/2022			D1110	1		Remove	2							
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Step 19	<p>If any insurance was added with a Claim Filing Indicator value other than 16, MA, or MB then the “Other Insurance Details for Svc # 1” section will be displayed.</p> <p>If the “Other Insurance Details for Svc # 1” section is displayed then the Other Carrier dropdown will only display the insurance carrier options with Claim Filing Indicator values other than 16, MA, or MB.</p> <ul style="list-style-type: none"> Complete the required information for the Other Insurance Details for Svc # 1 section if applicable. Select Add Insurance then select Save to save the service line detail if the information was added to this section. <p>NOTE: Everything with a red asterisk * must be completed if the section is applicable to the claim.</p>																								

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	<div data-bbox="277 254 1468 835"> <p>Other Insurance Details for Svc. # 1</p> <p>Click the row number to edit the row. Click the Remove link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Carrier Code</th> <th>Procedure Code</th> <th>Modifiers</th> <th>COB Payer Paid Amount</th> <th>Remittance Date</th> <th>Paid Units</th> <th>Remaining Patient Liability</th> <th>Bundled Line</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="10"> <input type="checkbox"/> Click to collapse. </td> </tr> <tr> <td colspan="2">*Other Carrier</td> <td colspan="2"> <input type="text"/> </td> <td colspan="2">Bundled into Line #</td> <td colspan="4"> <input type="text" value="0"/> </td> </tr> <tr> <td colspan="2">*Procedure Code</td> <td colspan="8"> <input type="text"/> </td> </tr> <tr> <td colspan="2">Modifiers</td> <td colspan="4"> <input type="text"/> </td> <td colspan="4"> <input type="text"/> </td> </tr> <tr> <td colspan="2">COB Payer Paid Amount</td> <td colspan="2"> <input type="text" value="0.00"/> </td> <td colspan="2">*Remittance Date</td> <td colspan="2"> <input type="text"/> </td> <td colspan="2">*Paid Units</td> </tr> <tr> <td colspan="2">Remaining Patient Liability</td> <td colspan="8"> <input type="text"/> </td> </tr> <tr> <td colspan="10"> <input type="button" value="Add Insurance"/> <input type="button" value="Cancel Insurance"/> </td> </tr> <tr> <td colspan="10"> <input type="button" value="Save"/> <input type="button" value="Reset"/> <input type="button" value="Cancel"/> </td> </tr> </tbody> </table> </div>	#	Carrier Code	Procedure Code	Modifiers	COB Payer Paid Amount	Remittance Date	Paid Units	Remaining Patient Liability	Bundled Line	Action	<input type="checkbox"/> Click to collapse.										*Other Carrier		<input type="text"/>		Bundled into Line #		<input type="text" value="0"/>				*Procedure Code		<input type="text"/>								Modifiers		<input type="text"/>				<input type="text"/>				COB Payer Paid Amount		<input type="text" value="0.00"/>		*Remittance Date		<input type="text"/>		*Paid Units		Remaining Patient Liability		<input type="text"/>								<input type="button" value="Add Insurance"/> <input type="button" value="Cancel Insurance"/>										<input type="button" value="Save"/> <input type="button" value="Reset"/> <input type="button" value="Cancel"/>									
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<p>Step 20</p>	<ul style="list-style-type: none"> Select the plus sign in the Attachments section to attach a copy of the EOMB. <p>NOTE: It is required to submit the Explanation of Medicare Benefits (EOMB) with all Medicare Crossover claims. For other TPL claims, Explanation of Benefits (EOB) is only required if the claim was denied or paid a \$0.00 amount.</p> <div data-bbox="277 999 1468 1230"> <p>Attachments</p> <p>Click the Remove link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Transmission Method</th> <th>File</th> <th>Control #</th> <th>Attachment Type</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="6"> <input type="checkbox"/> Click to add attachment. </td> </tr> <tr> <td colspan="6"> <input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/> </td> </tr> </tbody> </table> </div>	#	Transmission Method	File	Control #	Attachment Type	Action	<input type="checkbox"/> Click to add attachment.						<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/>																																																																													
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<p>Step 21</p>	<ul style="list-style-type: none"> Select FT-File Transfer- or NotSpecified-Not Specified from the Transmission Method dropdown. This selection affects the fields that display. Complete the additional required fields for this section and select Add. <p>NOTE: Everything with a red asterisk * must be completed if the section is applicable to the claim.</p> <div data-bbox="277 1398 1468 1818"> <p>Attachments</p> <p>Click the Remove link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Transmission Method</th> <th>File</th> <th>Control #</th> <th>Attachment Type</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="6"> <input type="checkbox"/> Click to collapse. </td> </tr> <tr> <td colspan="2">*Transmission Method</td> <td colspan="4"> <input type="text" value="FT-File Transfer"/> </td> </tr> <tr> <td colspan="2">*Upload File</td> <td colspan="4"> <input type="button" value="Choose File"/> No file chosen </td> </tr> <tr> <td colspan="2">*Attachment Type</td> <td colspan="4"> <input type="text"/> </td> </tr> <tr> <td colspan="2">Description</td> <td colspan="4"> <input type="text"/> </td> </tr> <tr> <td colspan="6"> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </td> </tr> <tr> <td colspan="6"> <input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/> </td> </tr> </tbody> </table> </div>	#	Transmission Method	File	Control #	Attachment Type	Action	<input type="checkbox"/> Click to collapse.						*Transmission Method		<input type="text" value="FT-File Transfer"/>				*Upload File		<input type="button" value="Choose File"/> No file chosen				*Attachment Type		<input type="text"/>				Description		<input type="text"/>				<input type="button" value="Add"/> <input type="button" value="Cancel"/>						<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/>																																															
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	<p>If NotSpecified-Not Specified was selected for the Transmission Method, an Attachment Control Number (ACN) needs to be added in the Control # field.</p> <p>NOTE: A unique Attachment Control Number (ACN) must be created for each claim if NotSpecified-Not Specified is selected as the Transmission Method. In addition, a Claim Attachment Form must accompany each EOMB and must identify the Provider's NPI and ACN as it was entered in the Attachments section. The Claim Attachment Form is located at: Forms - Mississippi Division of Medicaid.</p> 
Step 22	<p>The attachments display in the Attachments section.</p> <ul style="list-style-type: none"> Review the information entered for Step 3 and select Submit. 
Step 23	<p>The Portal displays the Confirm Dental Claim page.</p> <p>Review all the information entered for this claim. Select the plus and minus to expand and collapse each section. Expand All and Collapse All to expand and collapse all the sections at once.</p> <p>To go back and edit the information entered for this claim, select Back to Step 1,2 or 3 at the bottom of the page.</p> <ul style="list-style-type: none"> Once reviewing the claims information entered has been completed, select Confirm to confirm the claim submission.

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	<div style="border: 1px solid black; padding: 5px;"> <div style="background-color: #0070C0; color: white; padding: 2px;">Confirm Dental Claim ?</div> <p>Select Print Preview before you Confirm if you want to assure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system.</p> <div style="border: 1px solid #ADD8E6; padding: 2px; margin-top: 5px;">Provider Information</div> <table style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 33%;">Billing Provider ID</td> <td style="width: 33%;">ID Type NPI</td> <td style="width: 33%;">Name :</td> </tr> <tr> <td>Taxonomy</td> <td></td> <td></td> </tr> <tr> <td>Performing Provider ID _</td> <td>ID Type _</td> <td>Name _</td> </tr> <tr> <td>Taxonomy _</td> <td></td> <td></td> </tr> <tr> <td>Service Facility Location ID _</td> <td>ID Type _</td> <td>Name _</td> </tr> <tr> <td>Taxonomy _</td> <td></td> <td></td> </tr> </table> <div style="border: 1px solid #ADD8E6; padding: 2px; margin-top: 5px;">Patient Information</div> <table style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 60%;">Member ID</td> <td style="width: 40%;">Gender</td> </tr> <tr> <td>Member</td> <td></td> </tr> <tr> <td>Birth Date</td> <td></td> </tr> <tr> <td>Address</td> <td></td> </tr> <tr> <td>Address Line 2</td> <td></td> </tr> <tr> <td>City</td> <td></td> </tr> <tr> <td>State</td> <td>Zip Code</td> </tr> </table> <div style="border: 1px solid #ADD8E6; padding: 2px; margin-top: 5px;">Claim Information</div> <table style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 50%;">Accident Related _</td> <td style="width: 50%;">Accident Date _</td> </tr> <tr> <td>Place of Treatment 11-Office</td> <td></td> </tr> <tr> <td>Patient Number _</td> <td></td> </tr> <tr> <td>Initial X-Ray/Photo Date _</td> <td></td> </tr> <tr> <td colspan="2" style="text-align: right;">Does the provider have a signature on file? No</td> </tr> <tr> <td colspan="2" style="text-align: right;">Does the provider accept assignment for claim processing? No</td> </tr> <tr> <td colspan="2" style="text-align: right;">Are benefits assigned to the provider by the patient or their authorized representative? No</td> </tr> <tr> <td colspan="2" style="text-align: right;">Does the provider have a signed statement from the patient releasing their medical information? No</td> </tr> <tr> <td colspan="2" style="text-align: right;">Total Charged Amount \$0.00</td> </tr> </table> </div>	Billing Provider ID	ID Type NPI	Name :	Taxonomy			Performing Provider ID _	ID Type _	Name _	Taxonomy _			Service Facility Location ID _	ID Type _	Name _	Taxonomy _			Member ID	Gender	Member		Birth Date		Address		Address Line 2		City		State	Zip Code	Accident Related _	Accident Date _	Place of Treatment 11-Office		Patient Number _		Initial X-Ray/Photo Date _		Does the provider have a signature on file? No		Does the provider accept assignment for claim processing? No		Are benefits assigned to the provider by the patient or their authorized representative? No		Does the provider have a signed statement from the patient releasing their medical information? No		Total Charged Amount \$0.00	
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1	Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'																																				
2	test	test	test	\$0.00	12/07/2022																																
Svc #	Svc Date	Oral Cavity Area	Tooth#/Letter	Tooth Surface	Procedure Code	Mod	Units	Charge Amount																													
1	12/07/2022				D1110		1																														
Step 24	<p>The Portal returns the Submit Dental Claim: Confirmation page.</p> <p>NOTE: The confirmation page displays. ALL Crossover claims go to a PENDING status to verify the EOMB.</p> <p>NOTE: If the claim has an attachment with a not-specified transmission method then the Confirmation page has an Attachments Coversheet(s) button for the cover page.</p> <p>NOTE: It is required to mail the attachment after submitting the claim when a not-specified value is selected for the transmission method.</p> <div data-bbox="277 1234 1464 1612"> <p>Submit Dental Claim: Confirmation ?</p> <p>Dental Claim Receipt</p> <p>Your Dental Claim was successfully submitted. The claim status is Pending In Process.</p> <p>The Claim ID is 232234800001.</p> <p>Click Attachment Coversheet(s) to view the claim attachments coversheet(s).</p> <p>Click Print Preview to view the claim details as they have been saved on the payer's system.</p> <p>Click Copy to copy member or claim data.</p> <p>Click New to submit a new claim.</p> <p>Click View to view the details of the submitted claim.</p> <p style="text-align: center;"> Attachment Coversheet(s) Print Preview Copy New View </p> </div>																																				

Change History

The following change history log contains a record of changes made to this document:

Version #	Published/ Revised	Author	Section/Nature of Change
1.0	12/30/2022	Gainwell	Initial publication