

Online Claims Entry Adjustment, Void and Re-bill

Resources

When online use: **Ask Service Representative**

HIPAA.desknm@state.nm.us

NM.Providers@state.nm.us

Call Center 800-299-7304

New Mexico Web Portal

- Provider Information section
- Links and FAQ section
- Provider Login section

Important State Websites

STATE WEBSITE:

PROGRAM POLICY MANUAL

- <http://www.hsd.state.nm.us/mad/policymanual.html>

BILLING INSTRUCTIONS

- <http://www.hsd.state.nm.us/mad/billinginstructions.html>

REGISTERS AND SUPPLEMENTS:

- <http://www.hsd.state.nm.us/mad/registers/2012.html>

Adjustments

- A paid claim can be adjusted.
- Providers CAN NOT adjust a denied claim.
- ONLY Claims that have been processed through Online Claims Entry can be adjusted online. Claims processed through EDI or on paper CAN NOT be adjusted on the web portal.
- Attach any new attachments pertinent to the adjustment.

Adjustments – Filing Limit

Adjustments must be submitted within 90 days from the date on the RA, for the paid claim.

Submitting an Adjustment

Adjustments

New Mexico Medicaid Portal

Logout

User logged in as [testWaiver]

000D2601-SU VIDA SERVICES INC

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PROVIDER - Secure Options

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- CLAIMS ENTRY**
- Adjustment/Void
- Claim Re-Bill
- ADA Dental
- CMS1500
- UB04
- Add Template
- Manage Templates
- INQUIRIES
- REPORTS
- PROVIDER UPDATE

Claims – Adjustment/Void

* Recipient ID:	<input type="text"/>	←
Billing Medicaid Provider ID:	000D2601	
* TCN:	<input type="text"/>	←
* Action:	<input type="text" value="Select"/>	←
* Adj/Void Reason:	<input type="text" value="Select"/>	←

Enter the Recipient ID, TCN, Action & Adjustment Reason

Once this information is submitted, all data associated with the previously submitted TCN will appear.

Adjustments

New Mexico Medicaid Portal

Logout
User logged in as [testWaiver]
000D2601-SU VIDA SERVICES INC

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PROVIDER - Secure Options

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Claims – Adjustment/Void

* Recipient ID:	<input type="text"/>
Billing Medicaid Provider ID:	<input type="text"/>
* TCN:	<input type="text"/>
* Action:	Select <input type="button" value="v"/>
* Adj/Void Reason:	Select <input type="button" value="v"/>

Select Adjustment Reason from Drop Down



- Select
- 014-Prov Claim Filing Correction
- 017-Pos Prov Fil Corr/Health Insur
- 080-Prov Claim Fil Corr/Inc Recip
- 081-Prov Claim Corr/Clm Filed Err
- 087-TPL Recoup From Provider

CMS- 1500 Adjustment Form

Make any changes to the existing information provided

CMS-1500 Claim Form Adjustment of 91308400001000001

[Click here for CMS-1500 Professional Claim Form instructions](#)

* denotes required field(s)

If appropriate NPI or provider info is not listed, click here for Provider Enrollment contact information.

Billing Provider Information

Provider ID:		Current NPI:	
Address:			

* Is this service the result of a referral? Yes No

Recipient Information

Recipient ID:	-----	Name:	J
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Additional Recipient Information

Is Patient's Condition Related To	Select		
Accident Date	mm/dd/ccyy	Auto Accident State:	Select One

Other Insurance Info

* Please identify if there is another health benefit plan whether services were paid or denied:

- Medicare
- Medicare Advantage
- Medicare but benefits have been exhausted or claim is for medical equipment, supplies, or oxygen, or other service that Medicare does not cover
- PPO/HMO (Other than a Medicaid Managed Care Organization)
- Other insurance
- Workers' Compensation
- None

Other payer payment or denial date: mm/dd/ccyy

The following are not considered other health plans or insurance for New Mexico Medicaid recipients. You do not need to report coverage of a Medicaid Contracted Managed Care Organization, I.H.S., or a Medicaid/Medicaid Fiscal Agent.

All data associated with the previously submitted TCN will auto-populate.

CMS- 1500 Adjustment Form

Make any changes to the existing information provided

Claim Information			
Prior Authorization Number:	<input type="text"/>		
Timely Filing Justification – Prior TCN Number:	<input type="text"/>		
Patient Account#	<input type="text"/>		
<input type="checkbox"/> Relevant Dates			
Additional Claim data			
Diagnosis Codes (At least one entry required)			
* 1. <input type="text" value="799.9"/>	2. <input type="text"/>	3. <input type="text"/>	4. <input type="text"/>
* Does the Claim have Attachments? <input type="radio"/> Yes <input type="radio"/> No			

All data associated with the previously submitted TCN will populate.

Basic Line Item Information

Note: Please ensure you have entered any necessary claim information (found in the other sections of this or another page) before adding this service line.

If the appropriate NPI is not listed, please contact Provider Enrollment.

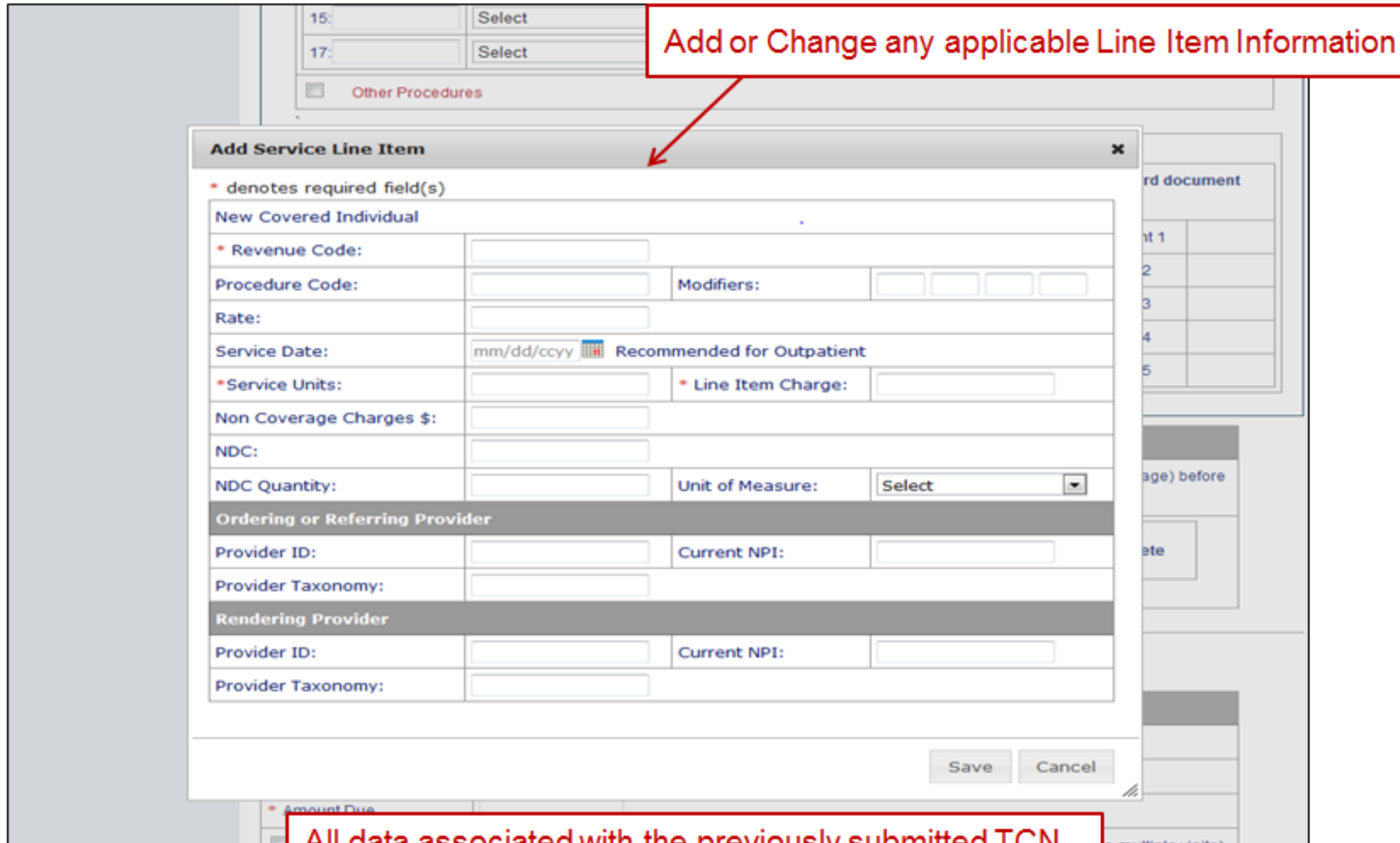
#	Service Dates		Procedure Codes	Rendering Provider		Modifiers				Diag Points		Submitted		Place of Service	NDC Code	Edit	Delete
	Begin	End		Id	NPI	1	2	3	4	1	2	3	4				
1	01/01/2013	01/31/2013	T2033										3159.11	31.00	12	<input type="checkbox"/>	<input type="checkbox"/>
2	01/01/2013	01/31/2013	T2033										3159.11	1.00	12	<input type="checkbox"/>	<input type="checkbox"/>

All data associated with the previously submitted TCN will auto-populate

Make any changes to the existing information provided

To add additional line items, select "Add Service Line Item"
Select "Edit" to make changes to lines already populated.

CMS- 1500 Adjustment Form




The screenshot shows a web-based form titled "Add Service Line Item". At the top, there are two dropdown menus labeled "15:" and "17:", both with "Select" as the current value. Below these is a checkbox labeled "Other Procedures". A red callout box with a white background and a red border contains the text "Add or Change any applicable Line Item Information" and has a red arrow pointing to the top section of the form.

Add Service Line Item

* denotes required field(s)

New Covered Individual

* Revenue Code:	<input type="text"/>					
Procedure Code:	<input type="text"/>	Modifiers:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Rate:	<input type="text"/>					
Service Date:	<input type="text" value="mm/dd/ccyy"/>		Recommended for Outpatient			
* Service Units:	<input type="text"/>	* Line Item Charge:	<input type="text"/>			
Non Coverage Charges \$:	<input type="text"/>					
NDC:	<input type="text"/>					
NDC Quantity:	<input type="text"/>	Unit of Measure:	Select <input type="text"/>			

Ordering or Referring Provider

Provider ID:	<input type="text"/>	Current NPI:	<input type="text"/>
Provider Taxonomy:	<input type="text"/>		

Rendering Provider

Provider ID:	<input type="text"/>	Current NPI:	<input type="text"/>
Provider Taxonomy:	<input type="text"/>		

Save Cancel

All data associated with the previously submitted TCN will populate.

CMS- 1500 Adjustment Form

Make any changes to the existing information provided

Summary	
* Total Charge	3159.11
Prior Payment Amount	0.00
Amount Due	3159.11

REQUIRED: I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction, and that the fees submitted are the actual fees I have charged and intend to collect for the payments.

Change Total Charge if line items have changed

Change Prior Payment if information has changed

Indicate Amount Due, if necessary

Once you submit Adjusted claim, you will received a new TCN #

UB-04 Adjustments

UB-04 Adjustments

* denotes required field(s)

[Click here for UB-04 Claim Form instructions](#)

If appropriate NPI or provider info is not listed, click here for Provider Enrollment contact information.

Billing Provider Information

Provider ID:		Current NPI:	
Address:			

Ordering or Referring Provider

Medicaid Provider ID		Current NPI	
<input type="checkbox"/> Additional Ordering or Referring Information			

Rendering (Performing) Provider

Medicaid Provider ID		Current NPI	
<input type="checkbox"/> Additional Rendering (Performing) Information			

Attending Provider
 Attending provider information is required for inpatient, nursing facility, and residential claims. Do not use in place of rendering provider for outpatient services.

Medicaid Provider ID		Current NPI	
<input type="checkbox"/> Additional Attending Information			



Make any changes to the existing information provided

All data associated with the previously submitted TCN will auto-populate

UB-04 Adjustments



Operating Provider			
Operating provider current NPI required for operative procedures.			
Medicaid Provider ID	<input type="text"/>	Current NPI	<input type="text"/>
<input type="checkbox"/> Additional Operating Information			
Other Operating Provider			
Medicaid Provider ID	<input type="text"/>	Current NPI	<input type="text"/>
<input type="checkbox"/> Additional Other Operatin;			
Recipient Information			
Recipient ID:	<input type="text"/>	Name:	<input type="text"/>
<input type="checkbox"/> Additional Recipient Information			
Other Insurance Info			
* Please identify if there is another health benefit plan whether services were paid or denied:			
<input type="radio"/> Medicare			
<input type="radio"/> Medicare Advantage			
<input type="radio"/> Medicare but benefits have been exhausted or claim is for medical equipment, supplies, or oxygen, or other service that Medicare does not cover			
<input type="radio"/> PPO/HMO (Other than a Medicaid Managed Care Organization)			
<input type="radio"/> Other insurance			
<input type="radio"/> Workers' Compensation			
<input type="radio"/> None			
Other payer payment or denial date: <input type="text" value="mm/dd/ccyy"/> <input type="text"/>			
The following are not considered other health plans or insurance for New Mexico Medicaid recipients. You do not need to report coverage of a Medicaid contracted Managed Care Organization, I.H.S., or a Medicaid/Medicaid Fiscal Agent.			

Make any changes to the existing information provided



All data associated with the previously submitted TCN will auto-populate


UB-04 Adjustments

Claim Information			
* Type of Bill:	<input type="text"/>		
Patient CNTL #:	<input type="text"/>	Medical Record #:	<input type="text"/>
Service Dates			
*From:	<input type="text" value="mm/dd/ccyy"/> 	*To:	<input type="text" value="mm/dd/ccyy"/> 
Treatment Authorization Code:	<input type="text"/>	Timely Filing Justification - Prior TCN Number:	<input type="text"/>

All data associated with the previously submitted TCN will auto-populate

Make any changes to the existing information provided













UB-04 Adjustments

<input checked="" type="checkbox"/> Admission Information (Required for inpatient claims)			
Date:	<input type="text" value="mm/dd/ccyy"/> 	HR:	<input type="text"/>
Type:	<input type="text" value="Select"/> ▼	Src:	<input type="text" value="Select"/> ▼
Discharge Hr.:	<input type="text"/>	Status:	<input type="text" value="Select"/> ▼
<input checked="" type="checkbox"/> Condition Codes			
1:	<input type="text"/>	2:	<input type="text"/>
3:	<input type="text"/>	4:	<input type="text"/>
5:	<input type="text"/>	6:	<input type="text"/>
7:	<input type="text"/>		

All data associated with the previously submitted TCN will auto-populate

Make any changes to the existing information provided

UB-04 Adjustments

<input checked="" type="checkbox"/> Occurrence Code Date			
Code	Date	Code	Date
<input type="text"/>	mm/dd/ccyy 	<input type="text"/>	mm/dd/ccyy 
<input type="text"/>	mm/dd/ccyy 	<input type="text"/>	mm/dd/ccyy 
<input type="text"/>	mm/dd/ccyy 	<input type="text"/>	mm/dd/ccyy 
<input type="text"/>	mm/dd/ccyy 	<input type="text"/>	mm/dd/ccyy 
Occurrence Spans			
	Code	From Date	To Date
<input type="text"/>	<input type="text"/>	mm/dd/ccyy 	mm/dd/ccyy 
<input type="text"/>	<input type="text"/>	mm/dd/ccyy 	mm/dd/ccyy 
<input checked="" type="checkbox"/> Value Codes			
Code	Amount	Code	Amount
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

All data associated with the previously submitted TCN will auto-populate

Make any changes to the existing information provided

UB-04 Adjustments


Diagnosis Codes (At least one entry required)






Admission Diagnosis:

*Principal Diagnosis: POA:

Code	POA	Code	POA
1: <input type="text"/>	<input type="text" value="Select"/>	2: <input type="text"/>	<input type="text" value="Select"/>
3: <input type="text"/>	<input type="text" value="Select"/>	4: <input type="text"/>	<input type="text" value="Select"/>
5: <input type="text"/>	<input type="text" value="Select"/>	6: <input type="text"/>	<input type="text" value="Select"/>
7: <input type="text"/>	<input type="text" value="Select"/>	8: <input type="text"/>	<input type="text" value="Select"/>
9: <input type="text"/>	<input type="text" value="Select"/>	10: <input type="text"/>	<input type="text" value="Select"/>
11: <input type="text"/>	<input type="text" value="Select"/>	12: <input type="text"/>	<input type="text" value="Select"/>
13: <input type="text"/>	<input type="text" value="Select"/>	14: <input type="text"/>	<input type="text" value="Select"/>
15: <input type="text"/>	<input type="text" value="Select"/>	16: <input type="text"/>	<input type="text" value="Select"/>
17: <input type="text"/>	<input type="text" value="Select"/>		

Other Procedures

Principle Surgical Procedure: Date: 

Code	Date (mm/dd/yyyy)	Code	Date (mm/dd/yyyy)
<input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 	<input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 
<input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 	<input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 
<input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 		

All data associated with the previously submitted TCN will auto-populate

Make any changes to the existing information provided

UB-04 Adjustments

Basic Line Item Information

Note: Please ensure you have entered any necessary claim information (found in the other sections of this or another page) before adding this service line.

#	Rev Code	Procedure	Modifiers	Rate	Service Date	Submitted		Edit	Delete
						Units	Charges		
1	529	99215	u4	10.00		1	10.00	<input type="checkbox"/>	<input type="checkbox"/>
2	529	99771	T4	10.00		1	10.00	<input type="checkbox"/>	<input type="checkbox"/>

[Add Service Line Item](#)

All data associated with the previously submitted TCN will auto-populate

To add additional line items, select "Add Service Line Items"
Select "Edit" to make changes to lines already populated.

Make any changes to the existing information provided

UB-04 Adjustments

* Does the Claim have Attachments? Yes No

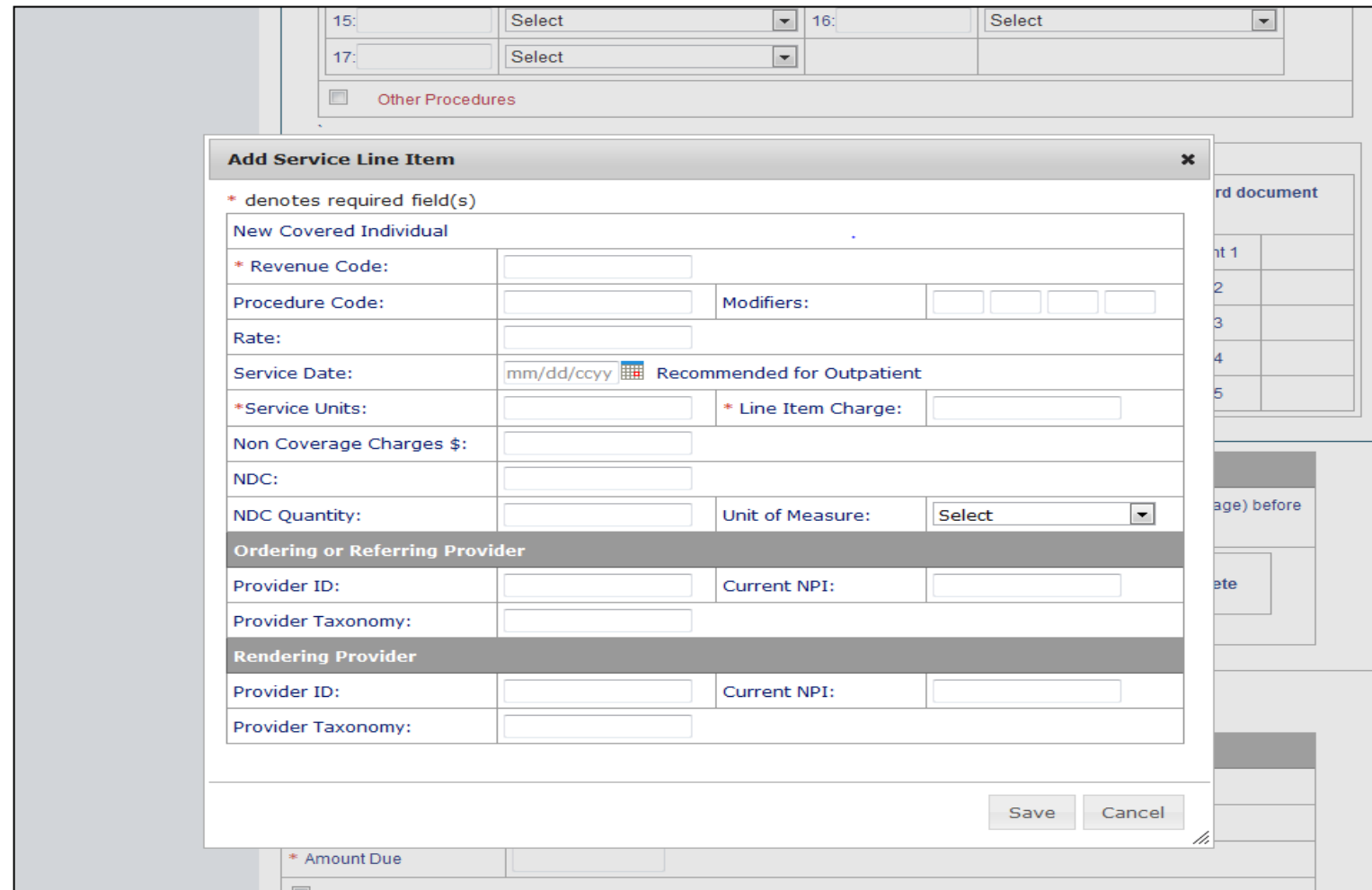
Each attachment may have a maximum size of 5 MB. It's recommended to attach PDF, JPG, TIFF, PNG, and Word document files. Please do not attach ZIP files or password-protected files.

*Type	Select	* Attachment 1
Type	Select	Attachment 2
Type	Select	Attachment 3
Type	Select	Attachment 4
Type	Select	Attachment 5

All data associated with the previously submitted TCN will auto-populate

Make any changes to the existing information provided

UB-04 Adjustments



15: Select 16: Select

17: Select

Other Procedures

Add Service Line Item ✕

* denotes required field(s)

New Covered Individual

* Revenue Code:

Procedure Code: Modifiers:

Rate:

Service Date: mm/dd/ccyy Recommended for Outpatient

* Service Units: * Line Item Charge:

Non Coverage Charges \$:

NDC:

NDC Quantity: Unit of Measure: Select

Ordering or Referring Provider

Provider ID: Current NPI:

Provider Taxonomy:

Rendering Provider

Provider ID: Current NPI:

Provider Taxonomy:

Save Cancel

* Amount Due

All data associated with the previously submitted TCN will auto-populate

Make any changes to the existing information provided

UB-04 Adjustments

Summary	
* Total Charge	<input type="text"/>
Prior Payment Amount	<input type="text"/>
Amount Due	<input type="text"/>
<input checked="" type="checkbox"/> REQUIRED: I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction, and that the fees submitted are the actual fees I have charged and intend to collect for the payments.	
<input type="button" value="Submit"/> <input type="button" value="Clear"/>	



All data associated with the previously submitted TCN will auto-populate

Make any changes to the existing information provided

Once adjusted claim is submitted, a new TCN will be generated.

Adjustments – Filing Guidelines Recap

- Make any changes to the existing information provided on the previously submitted TCN. Only make changes to data that will impact the adjustment.

Claim Information			
* Type of Bill:	<input type="text"/>		
Patient CNTL #:	<input type="text"/>	Medical Record #:	<input type="text"/>
Service Dates			
*From:	<input type="text" value="mm/dd/ccyy"/> 	*To:	<input type="text" value="mm/dd/ccyy"/> 
Treatment Authorization Code:	<input type="text"/>	Timely Filing Justification - Prior TCN Number:	<input type="text"/>

Submitting a Void

Void Request

New Mexico Medicaid Portal

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User logged in as [testnm]
000D2601-SU VIDA SERVICES INC

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WEB REGISTRATION

ASK SERVICE REPRESENTATIVE

PROVIDER ENROLLMENT

Claims – Adjustment/Void

* <input checked="" type="radio"/> Recipient ID: <input type="radio"/> SSN:	<input type="text"/>
COE:	<input type="text"/> If you are a waiver provider (PT 344 or 463), and this claim is for a waiver assessment, you must enter the clients' SSN and COE to submit the waiver assessment claim.
Billing Medicaid Provider ID:	000D2601
* TCN:	<input type="text"/>
* Action:	Void
* Adj/Void Reason:	Select

Submit Clear

Enter The Recipient ID, TCN, Action, & Void Reason

Void Request

New Mexico Medicaid Portal

Logout
User logged in as [testWaiver]

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- PROVIDER UPDATE

Claims – Adjustment/Void

* Recipient ID:	<input type="text"/>
Billing Medicaid Provider ID:	<input type="text"/>
* TCN:	<input type="text"/>
* Action:	Select <input type="button" value="v"/>
* Adj/Void Reason:	Select <input type="button" value="v"/>

Select Void Reason from Drop Down

- Select
- 014-Prov Claim Filing Correction
- 017-Pos Prov Fil Corr/Health Insur
- 080-Prov Claim Fil Corr/Inc Recip
- 081-Prov Claim Corr/Clm Filed Err
- 087-TPL Recoup From Provider

Void Request

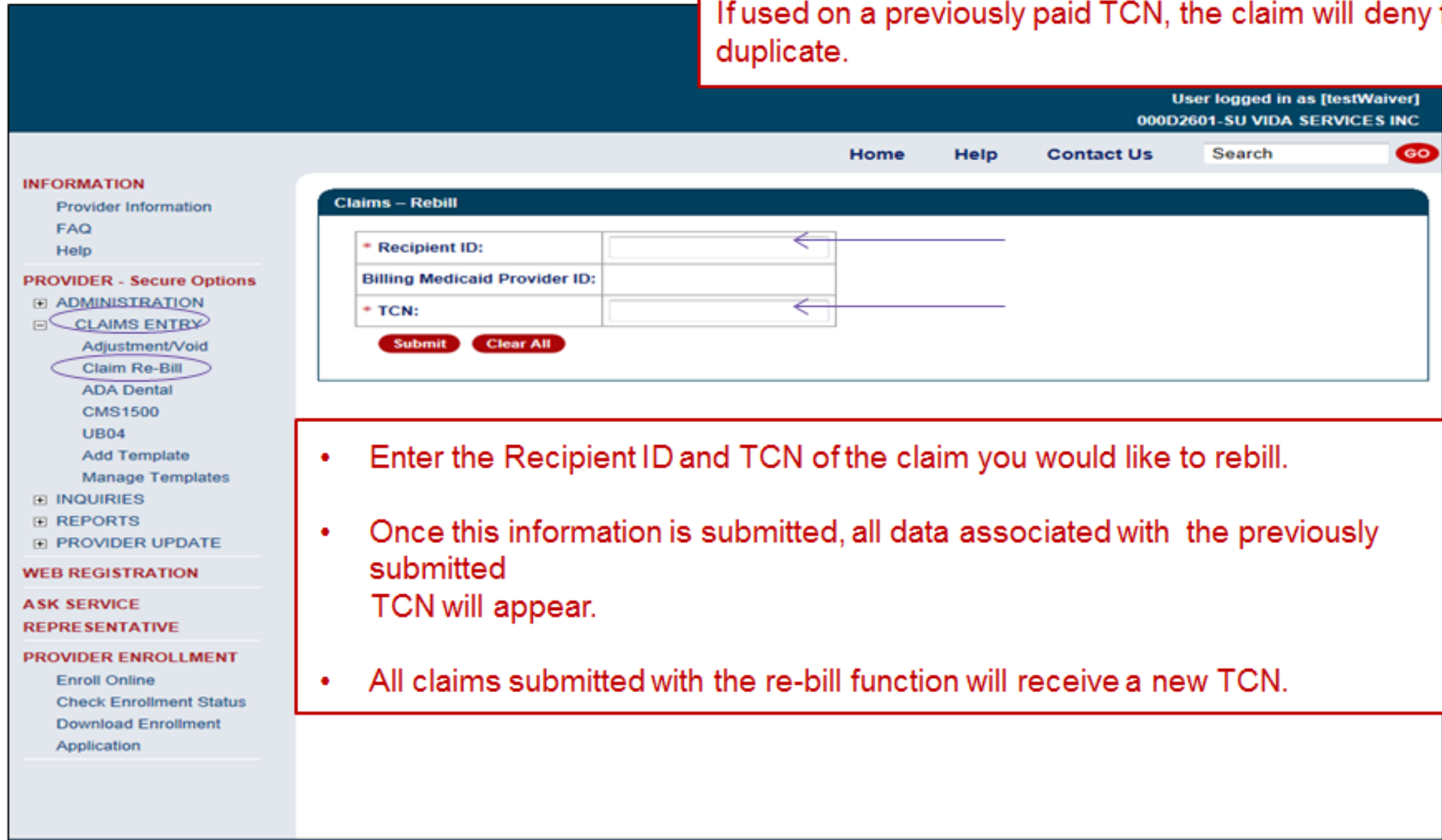
Summary	
* Total Charge	<input type="text" value="3159.11"/>
Prior Payment Amount	<input type="text" value="0.00"/>
Amount Due	<input type="text" value="3159.11"/>
<input checked="" type="checkbox"/> REQUIRED: I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction, and that the fees submitted are the actual fees I have charged and intend to collect for the payments.	
<input type="button" value="Submit"/> <input type="button" value="Clear"/>	

By selecting "Submit" the claim will be voided, a new TCN will be generated.

Claims Re-bill

Providers can make changes to existing claims that have **denied**, and rebill the claim.

If used on a previously paid TCN, the claim will deny for duplicate.



The screenshot displays the 'Claims - Rebill' section of a web application. On the left, a navigation menu includes sections for INFORMATION, PROVIDER - Secure Options (with sub-items like ADMINISTRATION, CLAIMS ENTRY, and Claim Re-Bill), INQUIRIES, REPORTS, PROVIDER UPDATE, WEB REGISTRATION, ASK SERVICE REPRESENTATIVE, and PROVIDER ENROLLMENT. The main content area features a form with three input fields: 'Recipient ID', 'Billing Medicaid Provider ID', and 'TCN'. Below these fields are 'Submit' and 'Clear All' buttons. The top of the page shows the user is logged in as 'testWaiver' for '000D2601-SU VIDA SERVICES INC' and includes navigation links for Home, Help, and Contact Us, along with a search bar.

- Enter the Recipient ID and TCN of the claim you would like to rebill.
- Once this information is submitted, all data associated with the previously submitted TCN will appear.
- All claims submitted with the re-bill function will receive a new TCN.

Claims Re-bill

What Questions Do You Have?



What take away message do you have to share with us?

Resources

When online use: **Ask Service Representative**

HIPAA.desknm@state.nm.us

NM.Providers@state.nm.us

Call Center 800-299-7304

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CONDUENT

