

# IHS/Tribal 638 Workshop

New Mexico Medicaid

# Purpose

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The purpose of this workshop is to provide an overview on verifying eligibility, submitting claims, adjustments and voids using the New Mexico Medicaid Portal as well as discussing NM Medicaid policy and resources for IHS/Tribal 638 facilities.

# Ways to Check Eligibility

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- On-Line Eligibility Inquiry—Web Portal:  
<https://nmmedicaid.portal.conduent.com/static/index.htm>
- Automatic Voice Response System (AVRS) 800-820-6901
- Conduent Eligibility Help Desk: 800-705-4452  
**Monday – Wednesday & Friday (Mountain Time) 8:00 a.m. - 5:00 p.m.**  
**Thursday (Mountain Time) 8:00 a.m. - 4:00 p.m.**

# Medicaid Limited Benefit Categories of Eligibility

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- 029: Family Planning Benefits
- 041: QMB - Age 65 and Over
- 044: QMB - Under 65
- 301: Pregnancy Related Medicaid

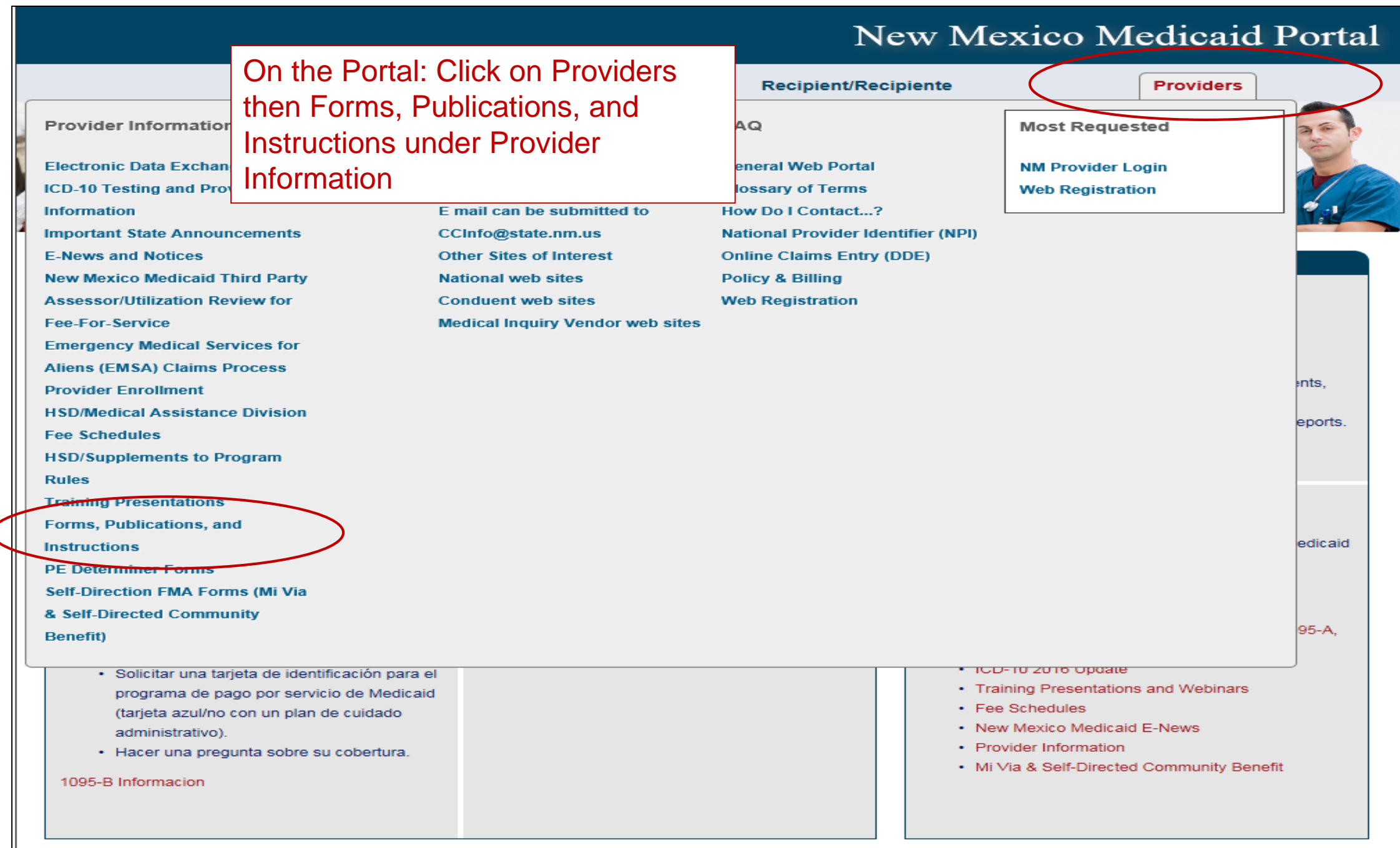
**For a Categories of Eligibility (COE) & description listing, go to:**

[http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Rules%20and%20Statutes/Medical%20Assistance%20Division/MAD%20NMAC%20Eligibility%20Program%20Manual/Eligibility%20Pamphlets/EP%20revised%206\\_17.pdf](http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Rules%20and%20Statutes/Medical%20Assistance%20Division/MAD%20NMAC%20Eligibility%20Program%20Manual/Eligibility%20Pamphlets/EP%20revised%206_17.pdf)

# Claim Form Instructions

# Where to get a copy of Claim Form Instructions

On the Portal: Click on Providers then Forms, Publications, and Instructions under Provider Information



The screenshot shows the New Mexico Medicaid Portal. At the top, there are two tabs: "Recipient/Recipiente" and "Providers", with "Providers" circled in red. On the left side, under "Provider Information", the link "Forms, Publications, and Instructions" is circled in red. A "Most Requested" dropdown menu is open, showing "NM Provider Login" and "Web Registration". At the bottom, there are two columns of text. The left column contains Spanish text: "Solicitar una tarjeta de identificación para el programa de pago por servicio de Medicaid (tarjeta azul/no con un plan de cuidado administrativo). Hacer una pregunta sobre su cobertura." and "1095-B Informacion". The right column contains a list of links: "ICD-10 2016 Update", "Training Presentations and Webinars", "Fee Schedules", "New Mexico Medicaid E-News", "Provider Information", and "Mi Via & Self-Directed Community Benefit".

# Where to get a copy of Claim Form Instructions

**Forms, Publications, and Instructions**  
 For more information on HSD program policies, refer to: [New Mexico Medical Assistance Division Program Policy Manual and Provider Packet Appendix](#) for specific policy manual sections which apply to your specific provider type and specialty.

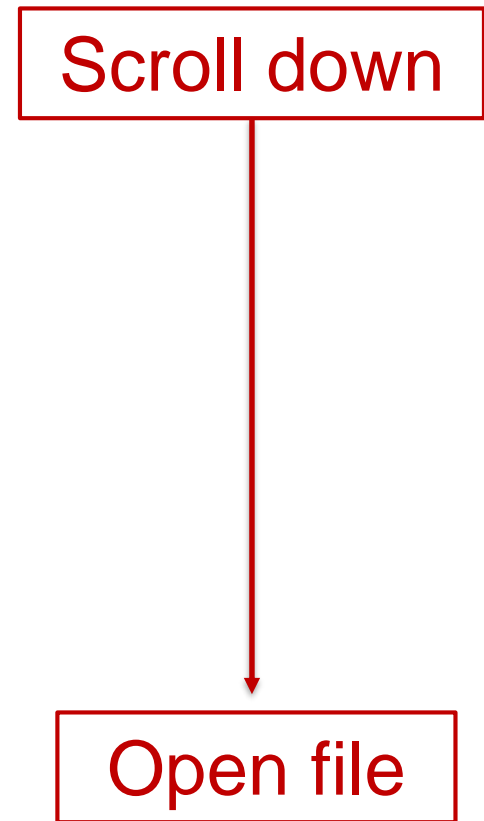
**Adjustments, Voids, and Inquiries**  
 The following publications contain detailed instructions for filling out the Adjustment/Void Request Form (AVR) and the claim inquiry form.

**Downloading Tips**

Topic	PowerPoint	Adobe
Adjustment or Void Request Form	Word Format	PDF Format
Reconsideration Request Form	Word Format	PDF Format

**Box by Box Instructions for Completing Claim Forms**

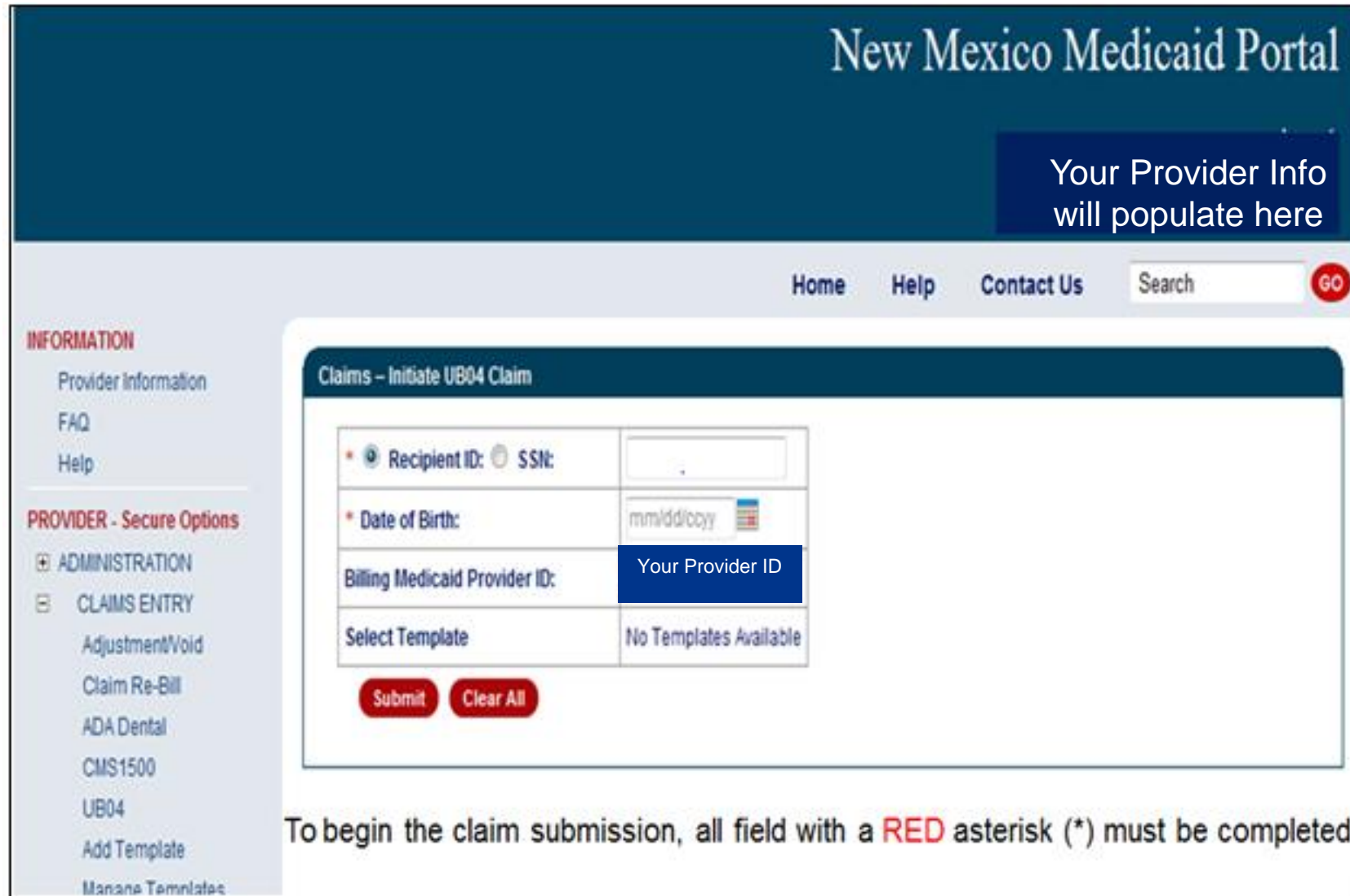
Topic	Word	Adobe
CMS-1500 Professional Claim Form	Not Available	PDF Format
UB-04 Institutional Claim Form	Not Available	PDF Format
ADA 2012 Dental Claim Form	Not Available	PDF Format



# Medicaid Online Primary Claim Submission



# Online Claims Entry



The screenshot shows the 'New Mexico Medicaid Portal' interface. At the top right, a dark blue box contains the text 'Your Provider Info will populate here'. Below this is a navigation bar with links for 'Home', 'Help', and 'Contact Us', along with a search bar and a 'GO' button. On the left side, there is a sidebar menu with sections for 'INFORMATION' (Provider Information, FAQ, Help) and 'PROVIDER - Secure Options' (ADMINISTRATION, CLAIMS ENTRY, AdjustmentVoid, Claim Re-Bill, ADA Dental, CMS1500, UB04, Add Template, Manual Templates). The main content area is titled 'Claims - Initiate UB04 Claim' and contains a form with the following fields:

* Recipient ID: SSN:	<input type="text"/>
* Date of Birth:	<input type="text" value="mm/dd/yyyy"/>
Billing Medicaid Provider ID:	Your Provider ID
Select Template	No Templates Available

At the bottom of the form are two red buttons: 'Submit' and 'Clear All'.

To begin the claim submission, all field with a **RED** asterisk (\*) must be completed

# Online Claims Entry Primary Claim *Continued*

New Mexico Medicaid Portal

Your Provider Info will populate here

Home Contact Us Search  GO

**INFORMATION**  
Provider Information  
FAQ

**PROVIDER - Secure Options**

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

**WEB REGISTRATION**

**ASK SERVICE REPRESENTATIVE**

**PROVIDER ENROLLMENT**  
Enroll Online  
Check Enrollment Status  
Download Enrollment Application

**UB04 Form**

\* 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:			
Provider Taxonomy (required if NPI matches multiple Medicaid provider numbers.):			
<input type="text"/>			

**Ordering or Referring Provider**

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

**Rendering (Performing) Provider**

Medicaid Provider ID	<input type="text"/>	Current NPI	<input type="text"/>
<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.

Click on the Red Text for the UB-04 Claim form instructions

# Additional Information Option *Continued*


<b>Attending Provider</b>			
Medicaid Provider ID	<input type="text"/>	Current NPI	<input type="text"/>
<input checked="" type="checkbox"/> Additional Attending Information			
Provider Name	<input type="text"/>		
Provider First Name	<input type="text"/>		
<b>Recipient Information</b>			
Recipient ID:	<input type="text"/>	Name:	Doe, Jane
<input checked="" type="checkbox"/> Additional Recipient Information			
Recipient's Birth Date	4/8/1984	Gender	F
Address	1720 Randolph Rd SE Albuquerque, NM 87106		
Telephone	505-555-5555		

Sections can be expanded by selecting all sections with Red Text

# Online Claims Entry Primary Claim *Continued*





















Recipient Information	
Recipient ID:	Name:
<input checked="" type="checkbox"/> <b>Additional Recipient Information</b>	
Recipient's Birth Date	Gender
Address	
Telephone	

Other Insurance Info
<p>* Please identify if there is another health benefit plan whether services were paid or denied:</p> <p><input type="radio"/> Medicare</p> <p><input type="radio"/> Medicare Advantage</p> <p><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</p> <p><input type="radio"/> PPO/HMO (Other than a Medicaid Managed Care Organization)</p> <p><input type="radio"/> Other insurance</p> <p><input type="radio"/> Workers' Compensation</p> <p><input type="radio"/> None</p> <p>Other payer payment or denial date: <input type="text" value="mm/dd/ccyy"/> </p> <p>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.</p>

Sections can be expanded by selecting all sections with Red Text

# Online Claims Entry Primary Claim *Continued*

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 TCN:	<input type="text"/>
<input type="checkbox"/> Admission Information (Required for inpatient claims)	←		
<input type="checkbox"/> Condition Codes	←		
<input type="checkbox"/> Occurrence Code Date	←		
<input type="checkbox"/> Value Codes	←		
Diagnosis Codes (At least one entry required)			
Admission Diagnosis:	<input type="text"/>		
*Principal Diagnosis:	<input type="text"/>	POA:	Select 
Code	POA	Code	POA
1: <input type="text"/>	Select 	2: <input type="text"/>	Select 
3: <input type="text"/>	Select 	4: <input type="text"/>	Select 
5: <input type="text"/>	Select 	6: <input type="text"/>	Select 
7: <input type="text"/>	Select 	8: <input type="text"/>	Select 
9: <input type="text"/>	Select 	10: <input type="text"/>	Select 
11: <input type="text"/>	Select 	12: <input type="text"/>	Select 
13: <input type="text"/>	Select 	14: <input type="text"/>	Select 
15: <input type="text"/>	Select 	16: <input type="text"/>	Select 
17: <input type="text"/>	Select 		
<input type="checkbox"/> Other Procedures			







Sections can be expanded by selecting all sections with Red Text

Decimal point is not required for diagnosis. Using a decimal point will result in the error message below.  
"Diagnosis Code (1-17) does not allow decimals"

Note: The web portal has been formatted to allow 12 diagnosis codes which matches the CMS-1500. UB-04 allows for 17 diagnosis codes.

# Online Claims Entry -- Attachments

**Other Procedures**

Principle Surgical Procedure:	<input type="text"/>	Date:	<input type="text" value="mm/dd/ccyy"/> 
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"/> 		

\* Does the Claim have Attachments?  Yes  No

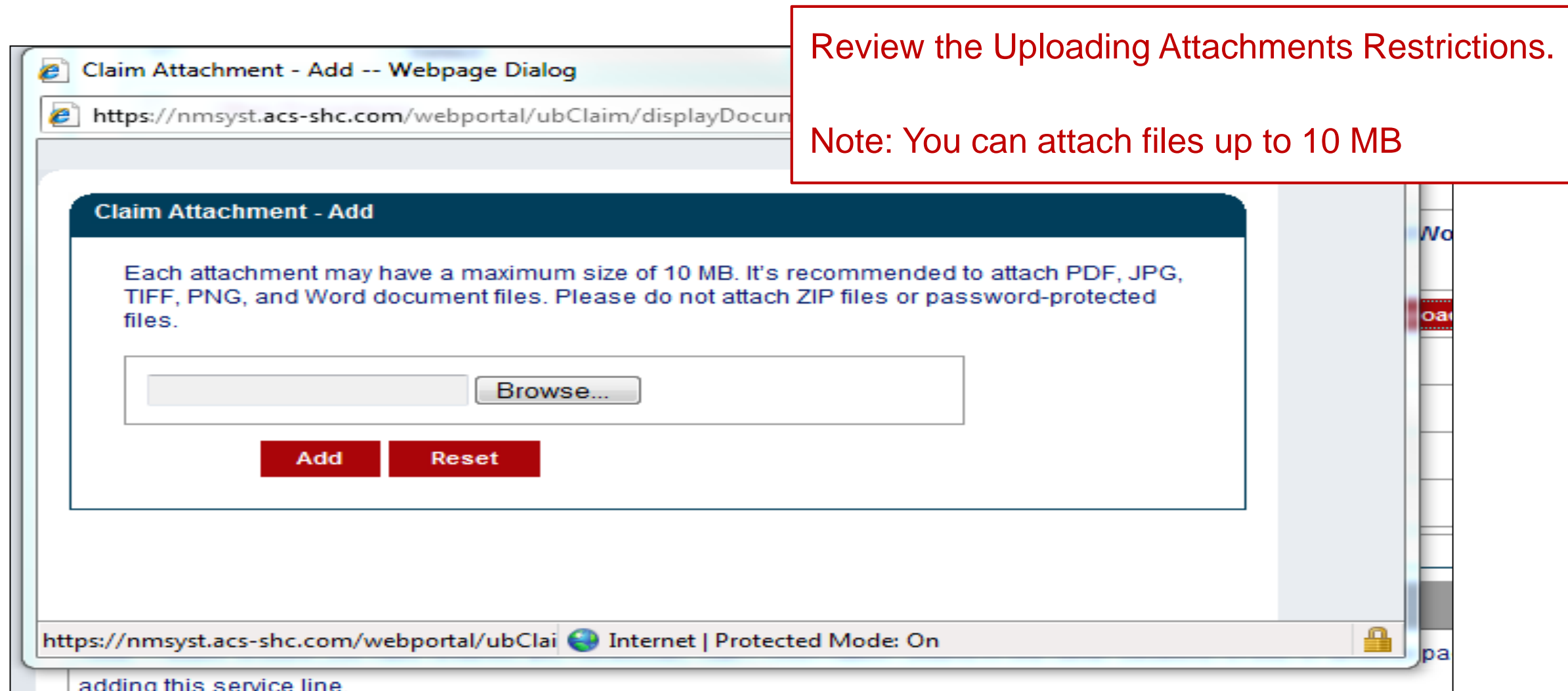
Each attachment may have a maximum size of 10 MB. It's recommended to attach PDF, JPG, TIFF, PNG, and Word document files. Please do not attach ZIP files or password-protected files.

*Type	Select	Select	* Attachment 1	<input type="button" value="Upload"/>
Type	Select		Attachment 2	
Type	Select		Attachment 3	
Type	Select		Attachment 4	
Type	Select		Attachment 5	

- Select
- Select
- Acknowledgement of Hysterectomy
- All other Documents
- Children's Medical Services (CMS) Authorization
- Insurance EOB if co-pay, coinsurance, or deductible ARE due
- Insurance EOB if co-pay/co-ins/deductible ARE NOT due
- Invoice for Hearing Aids, DME, or Vision Instruments
- Long Term Care Assessment or Abstract
- MAD 310 (Approval of Recipient for EMSA (Services for Aliens)
- MAD 311 (Utilization Review EMSA Approval)
- Managed Care Organization EOB including recoupments
- Medicaid Eligibility Card
- Medical Necessity Documentation
- Medical Services Authorization (ISD-309)
- Medicare Explanation of Benefits
- Presumptive Eligibility Form
- Prior Authorization (all others)
- Reconsideration Request Form
- Report of Vision Exam/Acuity or Loss of Glasses
- Reports or Notes from ER/OR

**Click upload** ←

# Online Claims Entry – Attachments *Continued*



The screenshot shows a web browser window titled "Claim Attachment - Add -- Webpage Dialog". The address bar displays "https://nmsyst.acs-shc.com/webportal/ubClaim/displayDocum". The main content area has a dark blue header "Claim Attachment - Add" and a text box stating: "Each attachment may have a maximum size of 10 MB. It's recommended to attach PDF, JPG, TIFF, PNG, and Word document files. Please do not attach ZIP files or password-protected files." Below this text is a file selection field with a "Browse..." button. At the bottom of the form are two red buttons: "Add" and "Reset". A red-bordered callout box in the upper right of the screenshot contains the text: "Review the Uploading Attachments Restrictions. Note: You can attach files up to 10 MB". The browser's status bar at the bottom shows "https://nmsyst.acs-shc.com/webportal/ubClai" and "Internet | Protected Mode: On".

Do not upload ZIP Files, Excel Spreadsheets or Password Protected Files.

# Online Claims Entry Primary Claim *Continued*

**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		

**Add Service Line Item** ✕

\* denotes required field(s)

**New Covered Individual**

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

All fields with a Red Asterisk (\*) are REQUIRED fields

Diagnosis codes do not require a period(.)

Only enter the numeric value



# Online Claims Entry Primary Claim *Continued*

Summary	
* Total Charge	<input type="text"/>
Prior Payment Amount	<input type="text"/>
Amount Due	<input type="text"/>
<input checked="" type="checkbox"/> REQUIRED: I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures	
<input type="button" value="Submit"/>	<input type="button" value="Clear"/>

**Indicate the Total Charge**

**Verify Total Charge is correct**  
If Total charge is missing or does not match up with the line item provided on the claim, the claim will deny or post additional edits.

# Medicaid Third Party Liability (TPL) Claim

# Third Party Liability (TPL) Tips

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- TPL is commercial insurance
- TPL must be billed primary to Medicaid unless it is a tribal self insured policy
- Medicaid does not consider Medicare TPL

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# Third Party Liability (TPL) Tips *Continued*

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- Attach the TPL EOB showing the payment/denial with the claim.
- Always include the explanation page of the EOB along with the page of the EOB that shows payment/denial.


# Third Party Liability (TPL) Continued

**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

Medicare Claim Number:

\* Other payer payment or denial date:  

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.

When filling out a Medicaid claim indicate whether the Primary Insurance us a PPO/HMO or other insurance by selecting the appropriate option

When filling out a Medicaid claim where TPL is primary payer, be sure to fill in all required primary and secondary payer information

# Third Party Liability (TPL) *Continued*

\* Does the Claim have Attachments?  Yes  No

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

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

Attach a copy of the EOB along with the explanation of denials page

# Third Party Liability (TPL) *Continued*

Summary	
* Total Charge	<input type="text"/>
Prior Payment Amount	<input type="text"/>
Amount Due	<input type="text"/>

REQUIRED: I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures

Indicate the Total charge or OMB rate

TPL Payment

Difference between Total charge and TPL Payment

Verify Total Charge is correct, If total charge is missing or does not match up with the line item provided on the claim, the claim will deny or post additional edits.

# Medicare Primary Claims (Crossovers)









# Medicare Primary Claims *Continued*

Recipient Information			
Recipient ID:		Name:	
<input checked="" type="checkbox"/> <b>Additional Recipient Information</b>			
Recipient's Birth Date		Gender	F
Address			
Telephone			
Other Insurance Info			
* Please identify if there is another health benefit plan whether services were paid or denied:			
<input checked="" type="radio"/>	Medicare	<div style="border: 1px solid red; padding: 5px; display: inline-block;">                     Indicate "Medicare" for Medicare Crossover submissions                 </div>	
<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"/>			
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.			

*Continued on next page . . .*

# Medicare Primary Claims *Continued*

**Other Procedures**

Principle Surgical Procedure:	<input type="text"/>	Date:	<input type="text" value="mm/dd/ccyy"/> 
Code	Date (mm/dd/yyyy)	Code	Date (mm/dd/yyyy)
1 <input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 	2 <input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 
3 <input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 	4 <input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 
5 <input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 		

\* Does the Claim have Attachments?  Yes  No

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

*Type	Medicare Explanation of Benefits ▼	* Attachment 1	<b>Upload</b>
Type	Select ▼	Attachment 2	
Type	Select ▼	Attachment 3	
Type	Select ▼	Attachment 4	
Type	Select ▼	Attachment 5	



Attach a copy of the EOB along with the explanation of denials page

*Continued on next page . . .*

# Medicare Primary Claims *Continued*

**Add Service Line Item** x

\* denotes required field(s)

<b>New Covered Individual</b>			
* 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 
<b>Ordering or Referring Provider</b>			
Provider ID:	<input type="text"/>	Current NPI:	<input type="text"/>
Provider Taxonomy:	<input type="text"/>		
<b>Rendering Provider</b>			
Provider ID:	<input type="text"/>	Current NPI:	<input type="text"/>
Provider Taxonomy:	<input type="text"/>		
<b>Other Insurance Info</b>			
Co ins Amt:	<input type="text"/>	Deductible:	<input type="text"/>
Copay:	<input type="text"/>	Psych Reduction Amount:	<input type="text"/>
Prior Payment Allowed Amount:	<input type="text"/>	Prior Payment Paid Amount:	<input type="text"/>

Other Insurance Information can be input at the line item level here

# Medicare Primary Claims *Continued*

Summary		
* Total Charge	<input type="text"/>	Indicate Total charge for Medicare primary claims
Prior Payment Amount	<input type="text"/>	Leave the Prior Payment Amount blank
Amount Due	<input type="text"/>	Co-Pay, Deductible and Co-Insurance Amount
<input checked="" type="checkbox"/> <b>REQUIRED:</b> 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"/>		Box must be populated in order for claim to be submitted



# Inpatient Claims for Medicare Part B Only Clients

# Inpatient Claims for Medicare Part B Only Clients *Continued*


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Certain Medicaid/Medicare clients only have Medicare Part B coverage. Medicare may cross over the Part B claim with type of bill 121. The Crossover claim does not have an accommodation revenue code on it. The claim will deny and the provider will need to resubmit and include the following on the claim:

- Use type of bill “121”
- Attach a copy of the EOMB indicate Medicare paid amount in previous payment box.

*Continued on next page . . .*







# Inpatient Claims for Medicare Part B Only *Continued*

Recipient Information			
Recipient ID:		Name:	
<input checked="" type="checkbox"/> <b>Additional Recipient Information</b>			
Recipient's Birth Date:		Gender:	
Address:			
Telephone:			
Other Insurance Info			
* Please identify if there is another health benefit plan whether services were paid or denied:			
<input checked="" type="radio"/>	Medicare	<div style="border: 2px solid red; padding: 5px; display: inline-block;">                     Indicate "Medicare" for Inpatient Claims for Medicare Part B Only Recipients                 </div>	
<input type="radio"/>	Medicare Advantage		
<input type="radio"/>	Medicare but benefits have been exhausted or claims 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		
Medicare Claim Number:		<input type="text"/>	
*Other payer payment or denial date:		<input type="text" value="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.			
Co ins Amt:		Deductible:	
Copay:		*Prior Payer Allowed Amount:	
Psych Reduction Amount:		Prior Payer Paid Amount:	

*Continued on next page . . .*

# Inpatient Claims for Medicare Part B Only *Continued*

**Other Procedures**

Principle Surgical Procedure:	<input type="text"/>	Date:	<input type="text" value="mm/dd/ccyy"/> 
Code	Date (mm/dd/yyyy)	Code	Date (mm/dd/yyyy)
1 <input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 	2 <input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 
3 <input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 	4 <input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 
5 <input type="text"/>	<input type="text" value="mm/dd/ccyy"/> 		

\* Does the Claim have Attachments?  Yes  No

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

*Type	Medicare Explanation of Benefits <input type="text"/>	* Attachment 1	<input type="button" value="Upload"/>
Type	Select <input type="text"/>	Attachment 2	<input type="text"/>
Type	Select <input type="text"/>	Attachment 3	<input type="text"/>
Type	Select <input type="text"/>	Attachment 4	<input type="text"/>
Type	Select <input type="text"/>	Attachment 5	<input type="text"/>

Attach Copy of EOB



*Continued on next page . . .*



# Inpatient Claims for Medicare Part B-Only Continued

**Add Service Line Item** x

\* denotes required field(s)

<b>New Covered Individual</b>			
* 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 
<b>Ordering or Referring Provider</b>			
Provider ID:	<input type="text"/>	Current NPI:	<input type="text"/>
Provider Taxonomy:	<input type="text"/>		
<b>Rendering Provider</b>			
Provider ID:	<input type="text"/>	Current NPI:	<input type="text"/>
Provider Taxonomy:	<input type="text"/>		
<b>Other Insurance Info</b>			
Co ins Amt:	<input type="text"/>	Deductible:	<input type="text"/>
Copay:	<input type="text"/>	Psych Reduction Amount:	<input type="text"/>
Prior Payment Allowed Amount:	<input type="text"/>	Prior Payment Paid Amount:	<input type="text"/>

Other Insurance Information can be input at the line item level here

# Inpatient Claims for Medicare Part B-Only *Continued*

**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	0300	87185			06/07/2018	1	26.00	<input type="checkbox"/>	<input type="checkbox"/>
2	0306	87077	QW		06/07/2018	1	24.00	<input type="checkbox"/>	<input type="checkbox"/>
3	0306	87085			06/07/2018	1	15.00	<input type="checkbox"/>	<input type="checkbox"/>
4	0510	G0463			06/07/2018	1	117.00	<input type="checkbox"/>	<input type="checkbox"/>
5	0001				06/07/2018		182.00	<input type="checkbox"/>	<input type="checkbox"/>

**REQUIRED:** I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures

# Multiple Encounters

# Multiple Encounters

---

An encounter is a face-to-face visit between a client and an IHS provider. Multiple encounters can occur on the same date of service when the services are distinct.

The following are billable revenue codes:

0510 – Medicare Primary

0512 – Dental

0519 – Outpatient Physical Health

0529 – FQHC

0919 – Behavioral Health

# Multiple Encounters *Continued*

---

More than one OMB charge can be billed in a day if the recipient:

- has different distinct services such as going to a dentist then to an eye exam on the same day.
- goes a second time to the same facility on the same day with a different diagnosis.
- was seen for a condition and returned the same day due to condition progression.

# Billing Up to Three Encounters on the Same DOS

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	0519			427.00	05/18/2018	3	1281.00	<input type="checkbox"/>	<input type="checkbox"/>
2	0001						1281.00	<input type="checkbox"/>	<input type="checkbox"/>

# Billing Three Individual Lines

## 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	0519			427.00	05/18/2018	1	427.00	<input type="checkbox"/>	<input type="checkbox"/>
2	0519			427.00	05/18/2018	1	427.00	<input type="checkbox"/>	<input type="checkbox"/>
3	0519			427.00	05/18/2018	1	427.00	<input type="checkbox"/>	<input type="checkbox"/>
4	0001					3	1281.00	<input type="checkbox"/>	<input type="checkbox"/>

# Outpatient Services Billed on CMS-1500



# Outpatient Services

Some services are not part of the OMB rate and are billed on the CMS 1500 form and reimbursed at the fee schedule rate.

- Ambulatory surgical center facility services (ASC)
- Anesthesia (professional charges)
- Targeted case management
- Hearing aids (hearing testing is reimbursed at the OMB rate)
- Physician inpatient hospital visits and surgeries
- Smoking cessation
- Telehealth charge (telemedicine - HCPC code Q3014 (SEC 8.310.12.12))
- Transportation claims are paid at transportation rates
- Vision appliances - frames, lenses, dispensing glasses, contacts, etc. (The exam is in the OMB rate which is billed separately.)
- Pharmacy claims which are billed as a pharmacy transaction rather than the CMS 1500

# Outpatient Services Continued

- Note that it is incorrect to bill **laboratory** codes, **radiology** codes, **physician** office visit codes, and **physician emergency** room codes as additional lines on the claim with the OMB revenue codes.
- Note that the **OMB** rate can be billed when the physician is supervising the RN or LPN and signs the medical record (including after a nurse provides an EPSDT screening, or reviews a radiology image taken by a technician).

# Online Claims Entry for CMS-1500

CMS-1500 Claim Form

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:	<div style="background-color: black; height: 15px; width: 100%;"></div>	Current NPI:	<div style="background-color: black; height: 15px; width: 100%;"></div>
Address:	<div style="background-color: black; height: 15px; width: 100%;"></div> ALBUQUERQUE ,NM 87112		

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

Recipient Information

Recipient ID:	<div style="background-color: black; height: 15px; width: 100%;"></div>	Name:	<div style="background-color: black; height: 15px; width: 100%;"></div>
---------------	---	-------	---

Additional Recipient Information







Is Patient's Condition Related To	<input checked="" type="radio"/> None <input type="radio"/> Employment <input type="radio"/> Auto Accident <input type="radio"/> Other Accident
-----------------------------------	--

Accident Date	mm/dd/ccyy <input type="text"/>	Auto Accident State:	Select One <input type="text"/>
---------------	---------------------------------	----------------------	---------------------------------

Click on the RED text for the CMS 1500 Claim form instructions

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# Online Claims Entry for CMS-1500 –Relevant Dates

<input checked="" type="checkbox"/> Relevant Dates <div style="border: 2px solid red; padding: 5px; display: inline-block; color: red; font-weight: bold;">Expanded 'Relevant Dates' Section</div>	
Date of Current Illness, Injury, or Pregnancy	mm/dd/ccyy 
Date of Similar Illness	mm/dd/ccyy 
Dates Unable to Work	From: mm/dd/ccyy  To: mm/dd/ccyy 
Hospitalization Dates	From: mm/dd/ccyy  To: mm/dd/ccyy 

# Online Claims Entry for CMS-1500 – Line Item Information

## 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	Charges	Units				





← Click to add Line Items

*Continued on next page . . .*

# Online Claims Entry CMS-1500 – Line Item Information *Continued*

**Add Service Line Item** ✕

\* denotes required field(s)

<b>* Service Begin Date</b>	mm/dd/ccyy 	<b>Service End Date</b>	mm/dd/ccyy 
<b>* Procedure Code</b>	<input type="text"/>	<b>Modifiers</b>	<input type="text"/> <input type="text"/>
<b>Rendering Provider NPI</b>	<input type="text"/>	<b>Rendering Provider Taxonomy</b>	<input type="text"/>
<b>Rendering Provider ID</b>	<input type="text"/>		
<b>* Place Of Service</b>	Select 		
<b>* Units</b>	<input type="text"/>	<b>* EPSDT Indicator</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>* Family Planning</b>	<input type="radio"/> Yes <input type="radio"/> No		
<b>* Fee</b>	<input type="text"/>	<b>Diagnosis Pointers</b>	<input type="text" value="Select"/> <input type="text" value="Select"/> <input type="text" value="Select"/> <input type="text" value="Select"/>
<b>NDC</b>	<input type="text"/>	<b>NDC Quantity</b>	<input type="text"/>
<b>NDC Unit of Measure</b>	Select 	<b>NDC Units Qualifier</b>	<input type="text"/>
<b>Anesthesia Start Time</b>	<input type="text"/>	<b>Anesthesia Stop Time</b>	<input type="text"/>

**The fields with a red Asterisks (\*) are REQUIRED**

# Claim Summary

Summary	
* Total Charge	<input type="text"/>
Prior Payment Amount	<input type="text"/>
Amount Due	<input type="text"/>
<input checked="" type="checkbox"/> <b>REQUIRED:</b> 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"/>	

Indicate the Total Charge

Box must be populated in order for claim to be submitted

# Did you remember?

---

- ✓ Ensure the line item charges are correct and match the total charge.
- ✓ Include all appropriate EOB's for TPL, HMO, Medicare, etc.
- ✓ Rev codes, diagnosis codes, etc., are entered correctly.



# Adjustments, Voids and Claim Re-Bills

# Definitions of Adjustments, Voids and Claim Re-Bill

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**Adjustments** – for changes or updates to previously paid claims.

**Voids** – paid claims that need to be **FULLY** recouped.

**Re-Bill** – denied web portal submitted claims that can be resubmitted with corrected information in order for the claim to pay.

# Adjustments Online


# Adjustments Online *Continued*

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- A paid claim **CAN** be adjusted
- Claims that have been processed originally via Online Claims Entry are the **ONLY** claims that **CAN** be adjusted online. Online Claim TCNs begin with a “9”
- Attach any new attachments pertinent to the adjustment
- Denied claims **CANNOT** be adjusted
- Claims processed via EDI or paper claims **CANNOT** be adjusted on the web portal

*Continued on next page . . .*

# Adjustments Online *Continued*



The screenshot displays the New Mexico Medicaid Portal interface. At the top, the title "New Mexico Medicaid Portal" is visible, along with a "Logout" link and the text "User logged in as [testnm]". Below this is a navigation bar with "Home" and "Contact Us" links, a search box, and a "GO" button. The main content area is divided into a left sidebar and a central "User Home" panel. The sidebar contains several sections: "INFORMATION" (Provider Information, FAQ), "PROVIDER - Secure Options" (ADMINISTRATION, CLAIMS ENTRY, Adjustment/Void, Claim Re-Bill, ADA Dental, CMS1500, UB04, Add Template, Manage Templates), "INQUIRIES", "REPORTS", "WEB REGISTRATION", "ASK SERVICE REPRESENTATIVE", and "PROVIDER ENROLLMENT" (Enroll Online, Check Enrollment Status, Download Enrollment Application). The "User Home" panel displays a welcome message for "testnm", the current date (Friday, June 29, 2018), and the last sign-in time (Wednesday, April 18, 2018 at 03:03 PM). A note at the bottom of the panel states: "Please note that after 15 minutes of inactivity you will be automatically logged out. You will be notified in advance so you can extend the session time." At the bottom of the page, there are links for "Terms of Usage", "Privacy Policy", and "Browser Compatibility", along with the build version "4025-2018-03-30\_10-10-41 - 162".

Select **Claims Entry** tab then click **Adjustment/Void**

# Adjustments Online *Continued*

New Mexico Medicaid Portal

Your Provider Info will populate here

Home Contact Us Search  GO

**INFORMATION**  
Provider Information  
FAQ

**PROVIDER - Secure Options**

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

**WEB REGISTRATION**

**ASK SERVICE REPRESENTATIVE**

**PROVIDER ENROLLMENT**

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**Claims – Adjustment/Void**

* <input checked="" type="radio"/> Recipient ID: <input type="radio"/> SSN:	<input type="text"/>
COE:	<input type="text"/> <small>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.</small>
Billing Medicaid Provider ID:	<input type="text"/>
* TCN:	<input type="text"/>
* Action:	<input type="text" value="Adjustment"/>
* Adj/Void Reason:	<input type="text" value="Select"/>

Enter Recipient ID, TCN of claim that needs to be adjusted, select "Adjustment" as the Action item, and the select the reason for your adjustment.

# UB-04 Adjustments Online

# UB-04 Adjustments Online *Continued*

\* 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			

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

Make any changes to the existing information provided





# UB-04 Adjustments Online *Continued*

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"/> 			
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

Make any changes to the existing information provided

# UB-04 Adjustments Online *Continued*

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

Indicate Timely Filing Justification TCN provided in the claim information section















# UB-04 Adjustments Online *Continued*

<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"/>	<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 Online *Continued*

<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 Online *Continued*

**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 Online *Continued*

\* 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 Online *Continued*

**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.

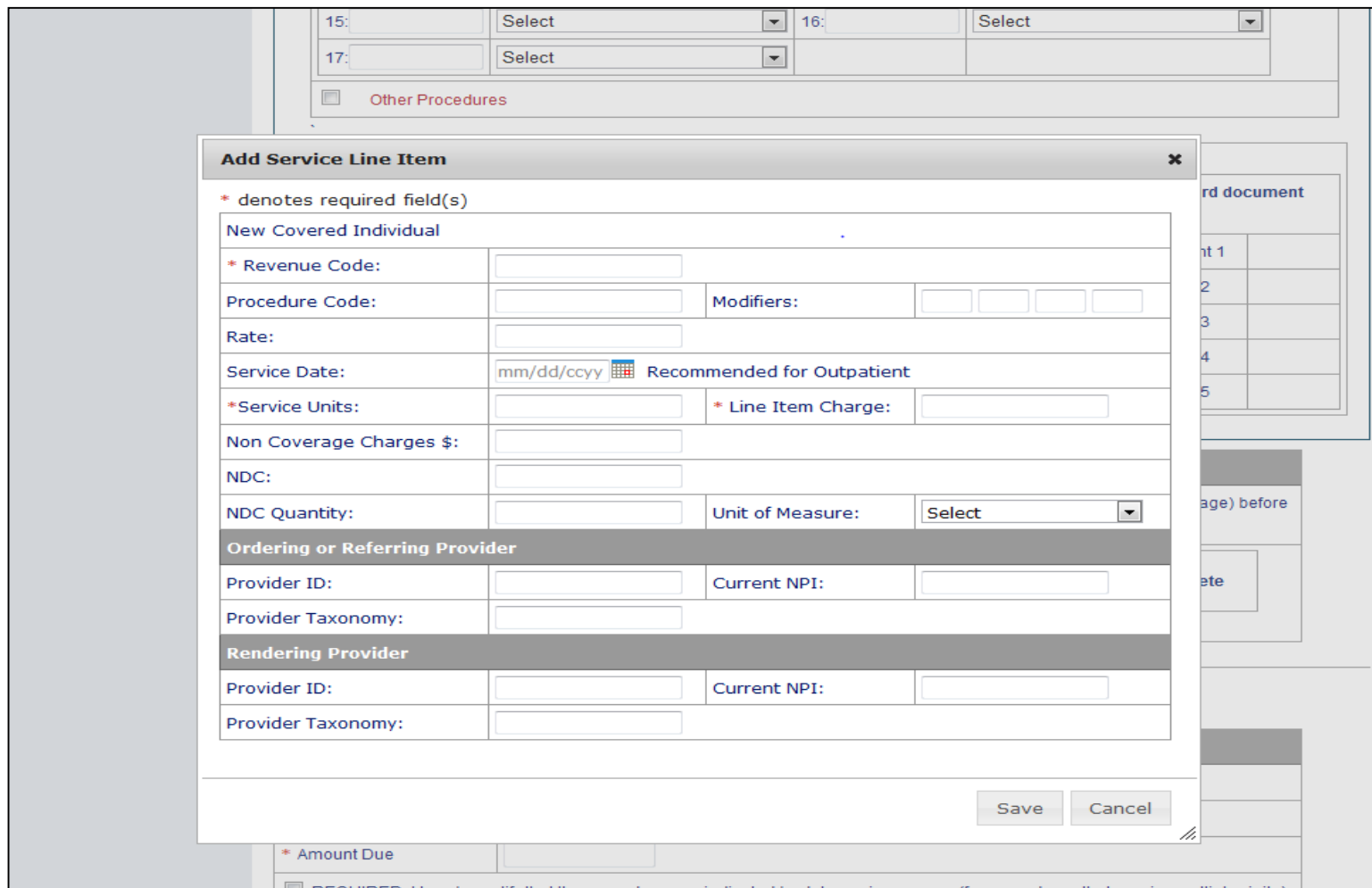
#	Rev Code	Procedure	Modifiers	Rate	Service Date	Submitted		Edit	Delete
						Units	Charges		
1	529	99215	u4	10.00		1	10.00	<input type="checkbox"/>	<input type="checkbox"/>
2	529	99771	T4	10.00		1	10.00	<input type="checkbox"/>	<input type="checkbox"/>

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 Items"  
Select "Edit" to make changes to lines already populated.

# UB-04 Adjustments Online *Continued*



The screenshot shows a web-based form titled "Add Service Line Item". At the top, there are dropdown menus for fields 15, 16, and 17, each with a "Select" option. Below these is a checkbox for "Other Procedures". The main form area is divided into several sections:

- New Covered Individual:**
  - \* Revenue Code: [Text Input]
  - Procedure Code: [Text Input] Modifiers: [Four Small Text Inputs]
  - Rate: [Text Input]
  - Service Date: [Date Picker (mm/dd/ccyy)] Recommended for Outpatient
  - \* Service Units: [Text Input] \* Line Item Charge: [Text Input]
  - Non Coverage Charges \$: [Text Input]
  - NDC: [Text Input]
  - NDC Quantity: [Text Input] Unit of Measure: [Dropdown Menu (Select)]
- Ordering or Referring Provider:**
  - Provider ID: [Text Input] Current NPI: [Text Input]
  - Provider Taxonomy: [Text Input]
- Rendering Provider:**
  - Provider ID: [Text Input] Current NPI: [Text Input]
  - Provider Taxonomy: [Text Input]

At the bottom of the form, there are "Save" and "Cancel" buttons. A note at the bottom left states: "\* denotes required field(s)".

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

Make any changes to the existing information provided



# UB-04 Adjustments Online *Continued*

**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	0300	87185			06/07/2018	1	26.00	<input type="checkbox"/>	<input type="checkbox"/>
2	0306	87077	QW		06/07/2018	1	24.00	<input type="checkbox"/>	<input type="checkbox"/>
3	0306	87085			06/07/2018	1	15.00	<input type="checkbox"/>	<input type="checkbox"/>
4	0510	G0463			06/07/2018	1	117.00	<input type="checkbox"/>	<input type="checkbox"/>
5	0001				06/07/2018		182.00	<input type="checkbox"/>	<input type="checkbox"/>

**REQUIRED:** I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures

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.

# CMS-1500 Adjustments Online

# CMS-1500 Adjustments Online *Continued*

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:	000	Current NPI:	11
Address:	8501 ALBUQUERQUE ,NM 87112		

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

**Recipient Information**

Recipient ID:	00000522	Name:	THERESA .
---------------	----------	-------	-----------

**Additional Recipient Information**

Is Patient's Condition Related To:

Accident Date:  Auto Accident State:

**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:

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

Make any changes to the existing information provided

# CMS-1500 Adjustments Online

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 for Illness, Injury, Pregnancy, or Hospitalization			
Additional Claim data			
Diagnosis Codes (At least one entry required)			
* A. <input type="text"/>	B. <input type="text"/>	C. <input type="text"/>	D. <input type="text"/>
E. <input type="text"/>	F. <input type="text"/>	G. <input type="text"/>	H. <input type="text"/>
I. <input type="text"/>	J. <input type="text"/>	K. <input type="text"/>	L. <input type="text"/>

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

Make any changes to the existing information provided

# CMS-1500 Adjustments Online *Continued*

**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.

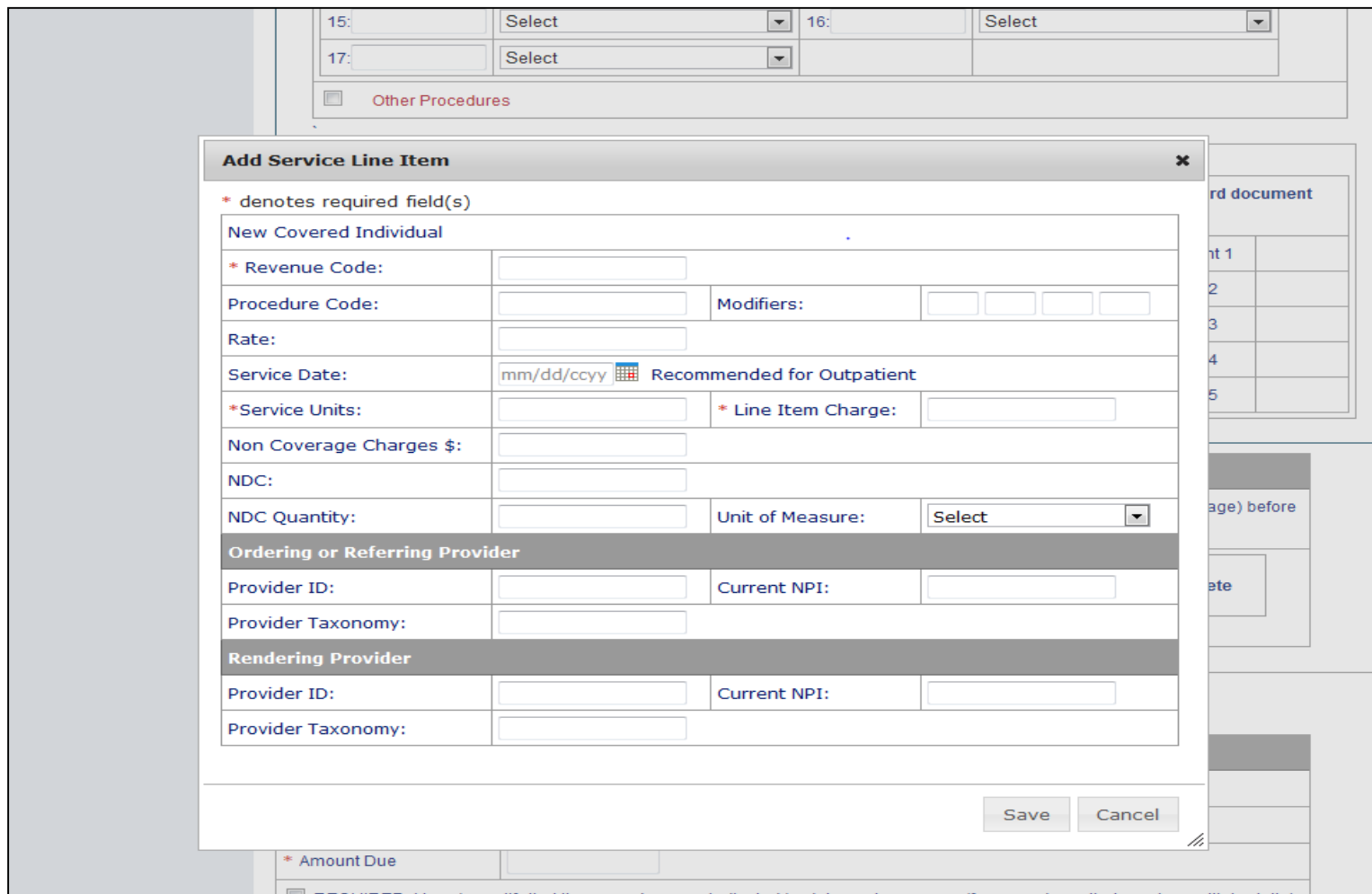
#	Service Dates		Procedure Codes	Rendering Provider		Modifiers				Diag Points				Submitted		Place of Service	NDC Code	Edit	Delete
	Begin	End		Id	NPI	1	2	3	4	1	2	3	4	Charges	Units				
1	01/01/2013	01/31/2013	T2033										3159.11	31.00	12		<input type="checkbox"/>	<input type="checkbox"/>	
2	01/01/2013	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 Items"  
 Select "Edit" to make changes to lines already populated.

# CMS-1500 Adjustments Online *Continued*



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

# CMS-1500 Adjustments Online *Continued*

Summary	
* Total Charge	3159.11
Prior Payment Amount	0.00
Amount Due	3159.11
<input checked="" type="checkbox"/> <b>REQUIRED:</b> 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.

# Voids Online



# Voids Online *Continued*



The screenshot shows the New Mexico Medicaid Portal interface. At the top right, there is a "Logout" link. Below the header, there are navigation links for "Home" and "Contact Us", and a search bar with a "GO" button. On the left side, there is a navigation menu with the following sections:

- INFORMATION**
  - Provider Information
  - FAQ
- PROVIDER - Secure Options**
  - ADMINISTRATION
  - CLAIMS ENTRY
    - Adjustment/Void
    - Claim Re-Bill
    - ADA Dental
    - MS1500
    - B04
    - dd Template
    - anage Templates

The main content area is titled "Claims - Adjustment/Void" and contains a form with the following fields:

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

At the bottom of the form, there are two buttons: "Submit" and "Clear".

Select Claims Entry tab then click Adjustment/Void

# Voids Online *Continued*



New Mexico Medicaid Portal

Logout

Home Contact Us Search GO

**INFORMATION**  
Provider Information  
FAQ

**PROVIDER - Secure Options**

- ADMINISTRATION
- CLAIMS ENTRY
  - Adjustment/Void
  - Claim Re-Bill
  - ADA Dental
  - CMS1500
  - UB04
  - Add Template
  - Manage Templates

**Claims - Adjustment/Void**

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

Submit Clear

Enter Recipient ID, TCN of claim that needs to be adjusted, select "Void" as the Action item, and the select the reason for your adjustment.

# Voids Online

**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	0300	87186			06/07/2018	1	26.00	<input type="checkbox"/>	<input type="checkbox"/>
2	0306	87077	QW		06/07/2018	1	24.00	<input type="checkbox"/>	<input type="checkbox"/>
3	0306	87086			06/07/2018	1	15.00	<input type="checkbox"/>	<input type="checkbox"/>
4	0510	G0463			06/07/2018	1	117.00	<input type="checkbox"/>	<input type="checkbox"/>
5	0001				06/07/2018		182.00	<input type="checkbox"/>	<input type="checkbox"/>

**REQUIRED:** I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures

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



# Claim Re-Bill

# Claim Re-Bill *Continued*

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- All data associated with the previously submitted TCN will auto-populate
- Make any changes to the existing information
- Once claim you would like to re-bill is submitted, a new TCN will be generated
- The new TCN will show the claim to be in the 'O-To Be Paid' status once the re-bill is correctly submitted.

# Claim Re-Bill



New Mexico Medicaid Portal

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

Home Help Contact Us Search GO

**INFORMATION**  
Provider Information  
FAQ  
Help

**PROVIDER - Secure Options**

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

**WEB REGISTRATION**

**ASK SERVICE REPRESENTATIVE**

**PROVIDER ENROLLMENT**  
Enroll Online  
Check Enrollment Status  
Download Enrollment Application

**Claims - Rebill**

* Recipient ID:	<input type="text"/>
Billing Medicaid Provider ID:	<input type="text"/>
* TCN:	<input type="text"/>

Submit Clear All

Enter Recipient ID,  
Billing Provider ID,  
and previously  
denied TCN then  
Submit

# Paper Adjustment / Void

# Paper Adjustment / Void *Continued*

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New Mexico Medicaid has revised the Adjustment/Void Request Form to better assist providers and reduce the number of returns.

The Adjustment / Void Request Form have been consolidated into one form. Submission instructions for the revised Adjustment/Void Form are included on the form.

The form can be found on the New Mexico Medicaid Web Portal at:

<https://nmmedicaid.portal.conduent.com/static/ProviderInformation.htm#FormsPubs>

After **October 1st, 2017**, Conduent will no longer accept older versions of the Adjustment/Void Request Form and will return to provider.

Each Adjustment/Void request must be submitted with the form. Requests submitted without the form will be returned to the provider.



# Paper Adjustment / Void Continued

## ADJUSTMENT / VOID REQUEST NEW MEXICO MEDICAID

Must select one of the options below

**ADJUSTMENT**

Use this selection:

To make any changes to a claim that was paid incorrectly.

- Must be submitted with a corrected CMS-1500, UB-04 or Dental claim form and must include red-drop out ink and legal claim notice on the back.
- Always fill out the corrected claim (replacement claim) exactly as the claim was originally filed, with the exception of the information being changed.
- Adjustment requests must be submitted within 90 days from the date of the Remit Advice (RA) form the original paid claim.
- Submitting Adjustments via the web portal can only be done for claims submitted online. *i.e. Claims that were originally submitted through the web portal (these claims are indicated by TCNs that begin with a 9), can be adjusted via the web portal*
- For adjustment requests exceeding 5 claims or more, send your request via email to [NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us).

**VOID**

Use this selection:

For any paid claim that needs to be **fully** recouped.

- Only entire claims can be voided
- Paid claims that need lines or a line voided are to be considered as an adjustment, not a void.
- There is no time limit when a claim can be voided.
- Voids via web portal can only be done for online submitted claims. *i.e. Claims that were originally submitted through the web portal (these claims are indicated by TCNs that begin with a 9) can be voided via the web portal.*
- A claim form is not needed for a Void request
- For void requests exceeding 5 claims or more, send your request via email to [NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us).

**ALL FIELDS BELOW  
(SECTIONS A,B,C,D)  
ARE REQUIRED TO BE COMPLETED IN ORDER TO PROCESS THIS REQUEST**

**INCOMPLETE FORMS WILL BE RETURNED**

SECTION A: Provider Information	SECTION B: Claim Information
<b>Billing NPI (Must be 10 digits)</b> <input type="text"/> OR <b>Billing NM Provider ID</b> <input type="text"/>	<b>Client ID#</b> <input type="text"/>  <b>TCN (Must be 17 digits)</b> <input type="text"/>

SECTION C: Detailed Reason for Request

# Paper Adjustments / Void – Filing Guidelines

- Complete Adjustment / Void form
- A corrected claim is required for an Adjustment
- Complete the corrected claim with all information as it was previously submitted, with the exception of the changes being made (only for an Adjustment Request)
- **Mail to:**
  - Conduent, LLC
  - P.O. Box 26500
  - Albuquerque, NM 87125

# IHS Top 5 Denials

# IHS Top 5 Denials

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IHS Denials are on a revolving monthly list. The top five (5) denials generally remain the same. Most of the denials revolve around Eligibility for the Client.

# IHS Top 5 Denials *Continued*

Ranking Claim	Exception Code	Exception Code Description	Follow Up
1	0128	Svc dates within Centennial Care Enrollment Period	Verify eligibility via the Web Portal
2	0143	Client Not Eligible	Verify eligibility via the Web Portal
3	0029	Svc not Family Planning	Verify eligibility via the Web Portal
4	1361	Exact Duplicate	Verify if there are multiple encounters for the same DOS. If so, submit a Reconsideration Form
5	0900	Mcare denied for Admin Rsns-not following billing requirement	Review Mcare Explanation of Benefits(EOB)

# New Mexico Medicaid Resources

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- New Mexico Medicaid Online
  - Provider Information
  - Provider Login Screen Notices
  - Provider E-News Newsletters
- Medicaid Provider Relations Call Center
- Provider Communication Updates
- Provider Field Representative
- Provider Webinars
- Open Forums and Live Training Sessions

# New Mexico Medicaid Resources *Continued*

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**New Mexico Medicaid Portal** – <https://nmmedicaid.portal.conduent.com/static/index.htm>

Claim Inquiries, Eligibility Verification, Electronic Claim Submission, Provider Manuals, E-News

**NM Human Services Department** – <http://www.hsd.state.nm.us/mad/>

Supplements, Memos, Provider Billing Packets and Policy

**Consolidated Customer Service Center (CCSC) Helpdesk**– (800) 299 - 7304.

Claim Status, Eligibility, Prior Authorization, Medicaid Updates

**Consolidated Customer Service Center (CCSC) Helpdesk** – [NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us)

Claim research assistance, general Medicaid inquiries, Provider Enrollment Applications, Forms & Instructions

**HIPAA Helpdesk** – [HIPAA.desk@state.nm.us](mailto:HIPAA.desk@state.nm.us)

Assistance on NM Web Portal, EDI inquiries, and Online Claim Submission with DDE (Direct Data Entry)

**Consolidated Customer Service Center (CCSC) Helpdesk** – (800) 283-4465

Eligibility inquiries, Fee-for-Service Replacement Medicaid Identification Card, Enroll or change a Managed Care Organization and Eligibility application status

**Medical Assistance Division, Program Rules** – <http://www.hsd.state.nm.us/providers/rules-nm-administrative-code-.aspx>

NMAC for Programs administered by the Medical Assistance Division

**Yes New Mexico** - <https://www.yes.state.nm.us/yesnm/home/index>

Apply, check, update, or renew Medical Assistance (Medicaid) benefits

**CONDUENT**

