

New MN-ITS Direct Data Entry (DDE) Screens Professional (837P)

This handout is intended to accompany the MN-ITS DDE Professional 837P Training Webinar session. It is not intended to replace the MN-ITS User Guides or specific billing instructions in the MHCP Provider Manual.

The document reflects the new layout and functionality of the MN-ITS Direct Data Entry (DDE) Professional (837P) claim screens. The screenshots below show examples of each 837P screen and the individual sections within each screen. Screens are shown in the order they will appear while entering a professional claim.

Refer to the appropriate MN-ITS User Guide for detailed instructions on completing a claim for a specific service.

The Professional 837P claim contains these five screens:

- Billing Provider
- Subscriber
- Claim Information
- COB – Coordination of Benefits
- Services

Billing Provider

The Billing Provider screen auto-populates with the information in the enrollment profile for the NPI/UMPI used to log in to MN-ITS.

Screenshot of the MN-ITS Billing Provider screen. The page title is "Professional(837P): Billing Provider". The form contains the following fields:

- Organization: MHCP Provider
- Taxonomy: [Empty]
- Address1: 1234 Main Street
- Address2: [Empty]
- City: Anytown
- State: MN
- Zip: 55155
- Telephone: 651-431-2700

Navigation buttons: Back, Cancel, Submit, Validate, Continue.

Right-hand sidebar:

- Application Progress**
 - Billing Provider
 - Subscriber
 - Claim Information
 - COB
 - Claim Services
- Related Links**
 - [MN-ITS User Guides](#)
 - [Provider Website](#)
 - [Electronic Claim Attachments](#)
 - [MHCP Payment Claim Calendars](#)
 - [Fee Schedule](#)
 - [Provider Training](#)
 - MHCP Provider Profile Change Forms**
 - [Individual Practitioner](#)
 - [Organization](#)
 - [Provider Enrollment](#)
 - [NDC Search](#)
 - [Washington Publishing Company](#)
- Questions or Comments?**
 - [Contact Us](#)

Billing Provider Continued - Consolidated Providers

Consolidated providers must select the appropriate location where the service was provided.

Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#)

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Professional(837P): Billing Provider

[Print Page](#)

⚠ If the Billing Provider information is inaccurate, complete the appropriate profile change form and fax to Provider Enrollment.

Billing Provider Information

Organization:

Taxonomy:

Address1:

Address2:

City: State: Zip:

Telephone:

Select Location:

	Location	Address	Provider Type	Taxonomy Information
<input type="radio"/>	MHCP Clinic 1	1234 Main Street Anytown MN 55155	OPTICIAN	332H00000X Eyewear Supplier Active
<input type="radio"/>	MHCP Clinic 2	1234 Main Street Anytown MN 55155	CHEMICAL HEALTH	261QR0405X Rehabilitation, Substance Use Disorder Active
<input type="radio"/>	MHCP Hospital	1234 Main Street Anytown MN 55155	HOSPITAL	262N00000X General Acute Care Hospital Active

[Back](#) [Cancel](#) [Submit](#) [Validate](#) [Continue](#)

Application Progress

- Billing Provider
- Subscriber
- Claim Information
- COB
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- MHCP Provider Profile Change Forms**
 - [Individual Practitioner](#)
 - [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

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Subscriber

Use the Subscriber screen to indicate the recipient who received the service(s) reported on this claim. Only the subscriber ID and birth date are required.

Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#) |  Minnesota Department of Human Services  minnesota north star [Help](#)

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Professional(837P): Subscriber [Print Page](#)

Billing Provider:

* Required fields

Subscriber

Subscriber ID* Birth Date*

Application Progress

- Billing Provider [Edit](#)
- Subscriber
- Claim Information
- COB
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- [MHCP Provider Profile Change Forms](#)
 - [Individual Practitioner](#)
 - [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

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- [Contact Us](#)

Claim Information

Use the Claim Information screen to report header (claim) level information that will identify the type of claim and details about the service(s). The Claim Information screen contains three sections:

- Claim Information
- Situational Claim Information
- Other Providers (Claim Level)

Claim Information Section

Use this section to report general required claim information, including:

- Claim Frequency Code (Original is default)
- Payer Claim Control Number (required for replacement or void [take back] claims)
- Place of Service (Office is default)
- Patient Control Number
- Assignment and Release Information
- Diagnosis Code

Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#) |

Minnesota Department of Human Services **MN-ITS: Home** minnesota north star

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Professional(837P): Claim Information [Print Page](#)

Billing Provider	MHCP Provider	Total Claim Charge Amount	
Subscriber	01044759- FIFTYTEN R TESTRECIPO2	Type of Claim	Original

=Required Field** *=situational: if applicable, complete all ** fields within a section**

Claim Information

Claim Frequency Code Original Replacement Void Payer Claim Control Number

Place of Service *

Patient Control Number *

Assignment/Plan Participation * Assigned Assignment Accepted Not Assigned

Benefits Assignment * Yes No Not Applicable

Release of Information * Yes Informed Consent

Provider Indicator * Signature on File Signature not on File

Enter Diagnosis Code:

Diagnosis Code * [Add](#)

Sequence	Diagnosis Code
No records found.	

Situational Claim Information

Other Providers (Claim Level)

[Back](#) [Cancel](#) [Submit](#) [Validate](#) [Continue](#)

Application Progress

- Billing Provider [Edit](#)
- Subscriber [Edit](#)
- Claim Information
- COB
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- [MHCP Provider Profile Change Forms](#)
 - [Individual Practitioner](#)
 - [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

Questions or Comments?
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Situational Claim Information Section

Use this section to report additional claim information, when required. This may include:

- Prior Authorization Number
- Medical Record Number
- Claim Note
- Attachment Control Number/Type
- Property/Casualty and Accident Information
- Ambulance Transport Information
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (C&TC Referral Code)



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Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#) | [Help](#)

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Professional(837P): Claim Information
[Print Page](#)

Billing Provider:

Subscriber:

Total Claim Charge Amount:

Type of Claim:

**=Required Field **=situational: if applicable, complete all ** fields within a section

Claim Information

Situational Claim Information

Prior Authorization Number:

Medical Record Number:

Claim Note:

Attachments

Attachment Control Number ** Type **

Control Number	Type ID	Attachment Type Description
No records found.		

Property and Casualty

Contact Name **

Telephone Number ** Extension

Accident Information

Related Causes **	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"><input type="checkbox"/></th> <th style="width: 20%;">Code</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td>AA</td> </tr> <tr> <td><input type="checkbox"/></td> <td>EM</td> </tr> <tr> <td><input type="checkbox"/></td> <td>OA</td> </tr> </tbody> </table>	<input type="checkbox"/>	Code	<input type="checkbox"/>	AA	<input type="checkbox"/>	EM	<input type="checkbox"/>	OA	Date of Accident ** <input type="text"/>
<input type="checkbox"/>	Code									
<input type="checkbox"/>	AA									
<input type="checkbox"/>	EM									
<input type="checkbox"/>	OA									

Ambulance Transport Information

Certification Condition

Certification Condition **

Condition Code **	<input type="text"/> <input type="button" value="Add"/>
-------------------	---

Code	Description
No records found.	

Reason ** Distance ** (miles)

Ambulance Pick-up

Pickup Address **

Address (contd)

City ** State ** Zip Code **

Ambulance Drop-off

Dropoff Address **

Address (contd)

City ** State ** Zip Code **

EPSDT

Certification Condition **

Condition Code **

Other Providers (Claim Level)

Application Progress

- Billing Provider Edit
- Subscriber Edit
- Claim Information
- COB
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- [MHCP Provider Profile Change Forms](#)
 - o [Individual Practitioner](#)
 - o [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

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- [Contact Us](#)

Other Providers (Claim Level) Section

Use this section to report the NPI of other providers associated with the claim or to report a service location. These may include the:

- Rendering provider
- Pay-to-provider
- Referring provider
- Service Facility Location

Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#)

Minnesota Department of Human Services **MN-ITS: Home** minnesota north star

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Professional(837P): Claim Information [Print Page](#)

Billing Provider	MHCP Provider	Total Claim Charge Amount	
Subscriber	01044759- FIFTYEN R TESTRECIP02	Type of Claim	Original

=Required Field** *=situational: if applicable, complete all ** fields within a section**

Claim Information

Situational Claim Information

Other Providers (Claim Level)

Rendering Provider

Provider Identifier

NPI/UMPI: [Add](#)

Name	Address	Taxonomy Information
No records found.		

Pay-To Provider

Referring Provider

Service Facility Location

[Back](#) [Cancel](#) [Submit](#) [Validate](#) [Continue](#)

Application Progress

- Billing Provider [Edit](#)
- Subscriber [Edit](#)
- Claim Information
- COB
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- [MHCP Provider Profile Change Forms](#)
 - [Individual Practitioner](#)
 - [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

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- [Contact Us](#)

COB

Use the COB screen to report other payers, such as private insurance or Medicare, when they pay for all or a portion of the claim. This includes:

- Other Payer Name
- Other Payer Primary ID (Carrier ID, displays on eligibility response: Other Insurance)
- Claim Filing Indicator

Refer to [Medicare and Other Insurance](#) sections in Billing Policy of the MHCP Provider Manual for instruction on billing TPL at header/claim level.

Additional fields display based on the Claim Filing Indicator selection.

The screenshot displays the MN-ITS Home page for the Minnesota Department of Human Services. The user is logged in as ABiller@1234567890. The main content area is titled "Professional(837P): COB" and contains a form for entering claim information. The form includes fields for Billing Provider (MHCP Provider), Total Claim Charge Amount, Subscriber (01044759- FIFTYEN R TESTRECIPO2), and Type of Claim (Original). Below this, there is a section for "Other Payer" with fields for Other Payer Name, Other Payer Primary ID, and Claim Filing Indicator (a dropdown menu). A "1." label is present above the Other Payer section. The form also includes an "ADD" button and a "Print Page" link. The sidebar on the right contains "Application Progress" with checkboxes for Billing Provider, Subscriber, Claim Information, COB, and Claim Services. Below that are "Related Links" including Provider Website, Electronic Claim Attachments, MHCP Payment Claim Calendars, Fee Schedule, Provider Training, MHCP Provider Profile Change Forms (with sub-links for Individual Practitioner and Organization), Provider Enrollment, NDC Search, Washington Publishing Company, and Questions or Comments? (with a sub-link for Contact Us).

Commercial Insurance

Additional fields for commercial insurance:

- Other Payer Subscriber
- Claim Level Adjustments
- Other Payer Amounts
- Other Insurance Information



Minnesota Department of **Human Services**



Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#)

ABiller@1234567890 | [Logout](#)
[minnesota north star](#) | [Help](#)

Professional(837P): COB [Print Page](#)

Billing Provider: Total Claim Charge Amount:

Subscriber: Type of Claim:

*=Required Field **=situational: if applicable, complete all ** fields within a section

1. 123456 Commercial Insurance Co.

Other Payer

Other Payer Name ******: Other Payer Primary ID ******:

Claim Filing Indicator ******:

Other Payer Subscriber

Payer Responsibility ******: Insured ID ******: Relationship Code ******:

Claim Level Adjustments

Claim Adjustment Group Code **	Adj Reason Code **	Adj Amount **	Adj Quantity
<input type="text" value="Select One..."/> <input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="button" value="Add"/>			
Claim Adjustment Group Code	Adj Reason code	Adj Amount	Adj Quantity
No records found.			

Other Payer Amounts

Payer Paid Amount: Non-Covered Charge Amount:

Other Insurance Information

Benefits Assignment: Yes No Not Applicable

Release of Information: Yes Informed Consent

Application Progress

- Billing Provider [Edit](#)
- Subscriber [Edit](#)
- Claim Information [Edit](#)
- COB
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- [MHCP Provider Profile Change Forms](#)
 - o [Individual Practitioner](#)
 - o [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

Questions or Comments?

- [Contact Us](#)

Medicare Insurance

Additional fields for Medicare insurance:

- Other Payer Subscriber
- Medicare ICN and Payment Remark Codes
- Other Payer Amounts
- Other Insurance Information

Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#)

Minnesota Department of Human Services **MN-ITS: Home** minnesota north star

ABiller@1234567890 | [Logout](#) [Help](#)

Professional(837P): COB [Print Page](#)

Billing Provider: Total Claim Charge Amount:
Subscriber: Type of Claim:

=Required Field** *=situational: if applicable, complete all ** fields within a section**

1. 123456 Medicare

Other Payer

Other Payer Name ** Other Payer Primary ID **
Claim Filing Indicator **

Other Payer Subscriber

Payer Responsibility ** Insured ID ** Relationship Code **

Medicare

Other Payers Claim Control Number

Claim Payment Remark Code(s)

Payment Remark Code

Sequence	Code
No records found.	

Other Payer Amounts

Payer Paid Amount Non-Covered Charge Amount

Other Insurance Information

Benefits Assignment Yes No Not Applicable
Release of Information Yes Informed Consent

Application Progress

- Billing Provider [Edit](#)
- Subscriber [Edit](#)
- Claim Information [Edit](#)
- COB
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- [MHCP Provider Profile Change Forms](#)
 - [Individual Practitioner](#)
 - [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

Questions or Comments?

- [Contact Us](#)

Services

Use the Services screen to report details for each service being billed. Information reported on a service line will override information reported at the header (claim) level for that line. The Services screen has four different sections used to report information at the line level:

- Services
- Other Payer
- Situational Services
- Other Providers

Services

Use this section to report service specific information, including:

- Date of Service From/To
- Place of Service
- Procedure Code
- Procedure Code Modifiers, if applicable
- Diagnosis Pointers
- Line Item Charge Amount
- Service Unit Count

Minnesota Department of Human Services



Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#) | [Help](#)

ABiller@1234567890 | [Logout](#)minnesota north star

Professional(837P): Services

[Print Page](#)

Billing Provider	MHCP Provider	Total Claim Charge Amount	
Subscriber	01044759- FIFTYTEN R TESTRECIPO2	Type of Claim	Original

*=Required Field **=situational: if applicable, complete all ** fields within a section

Line 1

Services

Date of Service (From)*	<input type="text"/>	Date of Service (To)	<input type="text"/>
Place of Service*	<input type="text" value="11-OFFICE"/>		
Procedure Code*	<input type="text"/>	Procedure Code Modifiers	
		1st Modifier <input type="text"/>	2nd Modifier <input type="text"/>
		3rd Modifier <input type="text"/>	4th Modifier <input type="text"/>
Diagnosis Pointer(s)	<input type="text" value="390.0"/> <input type="text" value="select -one-"/> <input type="text" value="select -one-"/> <input type="text" value="select -one-"/>		
Line Item Charge Amount*	<input type="text"/>	Service Unit Count*	<input type="text"/>

Other Payer

Situational Services

Other Providers

Application Progress

- Billing Provider [Edit](#)
- Subscriber [Edit](#)
- Claim Information [Edit](#)
- COB [Edit](#)
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- [MHCP Provider Profile Change Forms](#)
 - [Individual Practitioner](#)
 - [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

Questions or Comments?

- [Contact Us](#)

Other Payer Section

Use this section to report other payer information for the service line:

- Other Payer Primary Identifier
- Service Line Paid Amount
- Adjudication Payment Date
- Paid Unit Count
- COB Line Adjustment Group Code
- Adjustment Reason Code
- Adjustment Amount
- Adjustment Quantity

Refer to [Medicare and Other Insurance](#) section in Billing Policy of the MHCP Provider Manual for instruction on billing TPL at the service/line level.


Minnesota Department of Human Services
 ABiller@1234567890 | Logout



Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#)

Professional(837P): Services
[Print Page](#)

Billing Provider	MHCP Provider	Total Claim Charge Amount	
Subscriber	01044759- FIFTYEN R TESTRECIP02	Type of Claim	Original

**=Required Field
**=situational: if applicable, complete all ** fields within a section

Line 1

Services

Other Payer

Other Payer **	<input type="text"/>			
Primary Identifier **	<input type="text"/>	Adjudication -	<input type="text"/>	Paid Unit Count**
Service Line **	<input type="text" value="0.00"/>	Payment Date	<input type="text"/>	<input type="text"/>

COB Line Adjustments Entry			
Claim Adjustment Group Code **	Adj Reason code **	Adj Amount **	Adj Quantity
<input type="text" value="Select One..."/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="button" value="Add"/>			

Claim Adjustment Group Code	Adj Reason code	Adj Amount	Adj Quantity
No records found.			

Situational Services

Other Providers

Application Progress

- Billing Provider [Edit](#)
- Subscriber [Edit](#)
- Claim Information [Edit](#)
- COB [Edit](#)
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- **MHCP Provider Profile Change Forms**
 - o [Individual Practitioner](#)
 - o [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

Questions or Comments?

- [Contact Us](#)

Situational Services Section

Use this section to report additional claim information, if needed. This may include:

- Prior Authorization Number (or Service Agreement Number)
- Ambulance Certification Condition Indicator and Ambulance Patient Count
- Line Note
- Fixed Form Information (tooth number, tooth surface or oral cavity designation)
- Description
- NDC Information reporting

Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#) |

Minnesota Department of Human Services  minnesota north star

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Professional(837P): Services  [Print Page](#)

Billing Provider: <input type="text" value="MHCP Provider"/>	Total Claim Charge Amount: <input type="text"/>
Subscriber: <input type="text" value="01044759- FIFTYTEN R TESTRECIP02"/>	Type of Claim: <input type="text" value="Original"/>

=Required Field** *=situational: if applicable, complete all ** fields within a section**

Line 1

Services

Other Payer

Situational Services

Prior Authorization Number: <input type="text"/>	Certification Condition Indicator: <input type="text" value=""/>	Ambulance Patient Count: <input type="text"/>
Line Note: <input type="text"/>		

Fixed Form Information

Qualifier ** <input type="text" value=""/>	Value ** <input type="text"/>	<input type="button" value="Add"/>
--	-------------------------------	------------------------------------

<input type="button" value="Qual"/> <input type="button" value="Fixed Form Information"/>
No records found.

Description:

NDC Information

NDC ** <input type="text"/>	NDC Count ** <input type="text"/>	CODE Qualifier ** <input type="text" value=""/>
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Other Providers

Application Progress

- Billing Provider [Edit](#)
- Subscriber [Edit](#)
- Claim Information [Edit](#)
- COB [Edit](#)
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- [MHCP Provider Profile Change Forms](#)
 - o [Individual Practitioner](#)
 - o [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

Questions or Comments?

- [Contact Us](#)

Other Providers Section

Use this section to report the NPI of other providers associated with the service line, or to report a service location, if different than reported on the Claim Information screen. These may include:

- Rendering Provider
- Referring Provider
- Service Facility Location
- Ordering Provider


Minnesota Department of **Human Services**
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Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#)

Professional(837P): Services [Print Page](#)

Billing Provider:

Subscriber:

Total Claim Charge Amount:

Type of Claim:

*Required Field **situational: if applicable, complete all ** fields within a section

Line 1

Services

Other Payer

Situational Services

Other Providers

Rendering Provider

Provider Identifier

NPI/UMPI:

Name	Address	Taxonomy Information
No records found.		

Referring Provider

Service Facility Location

Ordering Provider

Application Progress

- Billing Provider [Edit](#)
- Subscriber [Edit](#)
- Claim Information [Edit](#)
- COB [Edit](#)
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- [MHCP Provider Profile Change Forms](#)
 - [Individual Practitioner](#)
 - [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

Questions or Comments?

- [Contact Us](#)

Service Line Table

After a service line is saved, a summary table will display the following information for each line on the claim:

- Line number
- From and to date
- Procedure code
- Modifier
- Charge
- Place of service


Minnesota Department of **Human Services**
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Skip to: [Main content](#) | [Subnavigation](#) | [Quicklinks](#)

Professional(837P): Services

[Print Page](#)

Billing Provider	MHCP Provider	Total Claim Charge Amount	
Subscriber	01044759- FIFTYTEN R TESTRECIPO2	Type of Claim	Original

*=Required Field **=Situational: if applicable, complete all ** fields within a section

Line	From	To	Proc	Mod	Charges	POS	
1	10/01/2012	10/01/2012	T1013	U3	500	11	Edit

ADD

Back
Cancel

Submit
Validate
Continue

Application Progress

- Billing Provider [Edit](#)
- Subscriber [Edit](#)
- Claim Information [Edit](#)
- COB [Edit](#)
- Claim Services

Related Links

- [MN-ITS User Guides](#)
- [Provider Website](#)
- [Electronic Claim Attachments](#)
- [MHCP Payment Claim Calendars](#)
- [Fee Schedule](#)
- [Provider Training](#)
- **MHCP Provider Profile Change Forms**
 - [Individual Practitioner](#)
 - [Organization](#)
- [Provider Enrollment](#)
- [NDC Search](#)
- [Washington Publishing Company](#)

Questions or Comments?

- [Contact Us](#)

Validate Response

After completing the claim screens, select the "Validate" option before submitting.

Use the Validate Response to:

- Ensure you have completed all required HIPAA-compliant fields
- Verify with MHCP that your claim information will be submitted and returned to you with the appropriate edits, allowing changes or corrections to be made. Use the [Washington Publishing Company](#) link to the right to look up the HIPAA compliant codes
- Review the Claim Status Category and Claim Status codes to determine any errors on the claim

Validate Response Only: This claim has not been submitted for processing [Print Page](#)

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41-1674742
MHCP Provider Call Center
(651) 432-2700 or 1-(800)-366-5411

10/24/20YY 10:15

01 Patient: 01044759 Service Period: 10/01/2012-10/01/2012

Receiver
NPI/UMPI: 1234567890 Name: MHCP Provider

Provider
NPI/UMPI: 1234567890 Name: MHCP Provider

Subscriber
ID Number 01044759 Name: FIFTYTEN TESTRECIP02 Patient Control Number: 123456

Claim Information

Bill Type:	P	Service Period:	10/01/2012-10/01/2012				
Status Info Effective Date:	01/01/0001	Payer Claim Control Number:	10/01/2012				
Total Claim Charge Amount:	\$ 500.00	Pharmacy Prescription Number:					
Claim Payment Amount:	\$ 0.00	<table border="1"><thead><tr><th>Claim Status Category</th><th>Claim Status</th></tr></thead><tbody><tr><td>A1</td><td>400</td></tr></tbody></table>	Claim Status Category	Claim Status	A1	400	
Claim Status Category	Claim Status						
A1	400						
Adjudication Date:							
Remittance Date:							
Trace Number:	000000000						

Service Line Information

Line Number 01 - Procedure: T1013 Modifiers(s): U3 Charge: \$500.00 Units: 40.00

Service Dates:	10/01/2012-10/01/2012	<table border="1"><thead><tr><th>Claim Status Category</th><th>Claim Status</th></tr></thead><tbody><tr><td>A1</td><td>116</td></tr></tbody></table>	Claim Status Category	Claim Status	A1	116	
Claim Status Category	Claim Status						
A1	116						
Payment:	\$ 0.00						
Revenue code:							
Status Information Effective Date:	01/01/0001						

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Submission Response

Use the Submission Response to:

- Confirm your claim was successfully submitted for processing
- Obtain a claim number
- Review the Claim Status Category and Claim Status codes to determine any errors on the claim using the [Washington Publishing Company](#) link to the right to look up the HIPAA compliant codes

Submission Response: This claim has been submitted for processing [Print Page](#)

Minnesota Department of Human Services
41-1674742
MHCP Provider Call Center
(651) 432-2700 or 1-(800)-366-5411

10/24/20YY 10:15

01 Control #: 912298004000000XX Patient: 01044759 Service Period: 10/01/20XX-10/01/20XX

Receiver

NPI/UMPI: 1234567890 Name: MHCP Provider

Provider

NPI/UMPI: 1234567890 Name: MHCP Provider

Subscriber

ID Number 01044759 Name: FIFTYTEN TESTRECIP02 Patient Control Number: 123456

Claim Information

Bill Type:	P	Service Period:	10/01/20XX-10/01/20XX
Status Info Effective Date:	10/24/20XX	Payer Claim Control Number:	912298004000000XX
Total Claim Charge Amount:	\$ 500.00	Pharmacy Prescription Number:	
Claim Payment Amount:	\$ 0.00		
Adjudication Date:	10/24/20XX		
Remittance Date:			
Trace Number:	000000000		

	Claim Status Category	Claim Status
	F2	400

Service Line Information

Line Number 01 - Procedure: T1013 Modifiers(s): U3 Charge: \$500.00 Units: 40.00

Service Dates:	10/01/20XX-10/01/20XX	Claim Status Category	Claim Status
Payment:	\$ 0.00	F2	116
Revenue code:			
Status Information Effective Date:	10/24/20XX		

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