

Hospice Services

Revised: March 1, 2024

Review [MHCP Billing Policy](#) for general billing requirements and in the [Hospice Services](#) section of the MHCP Provider Manual when submitting claims.

Log in to MN-ITS

1. Log in to [MN-ITS](#)
2. From the left menu:
 - a. Select **MN-ITS**
 - b. Select Submit DDE Claims (837)
 - c. Select Institutional (837I)

Submit the Claim

To submit the claim follow the instructions in the tables below for each of the following claim screens:

[Billing Provider](#)

[Subscriber](#)

[Claim Information](#)

[Coordination of Benefits \(COB\)](#)

[Services](#)

Billing Provider

The Billing Provider screen auto-populates with the information in the enrollment profile for the NPI/UMPI used to login to MN-ITS. If changes are needed, use the [Change of Enrollment Information](#) to notify MHCP Provider Enrollment.

Refer to the table below for instruction and information about each field on this screen.

Field Name * (X12 Loop & element)	Field Instruction
Organization (Loop: 2010AA, NM103 (last or organization) NM104 (first))	The name of the Billing Provider: This could be an Organization, business or the Name of an individual provider identified by the NPI used to login to MN-ITS.
Taxonomy (Loop: 2000A, PRV03)	This field only displays information when a Health care provider specialty/location code has been added to the provider file. If multiple taxonomy codes have been added, additional information will display. Select the radio button to identify appropriate location for this claim.
Address 1 (Loop: 2010AA, N301)	The first address line reported on the provider file.
Address 2 (Loop: 2010AA, N302)	The second address line reported on the provider file.
City (Loop: 2010AA, N401)	The city name for the address in address fields 1 and 2.
State (Loop: 2010AA, N402)	The state name for the address in address fields 1 and 2.
Zip (Loop: 2010AA, N403)	The zip code for the address in address fields 1 and 2.

Telephone (Loop: 2010AA, PER04)	Telephone number reported on the provider file.
Consolidated Provider Locations	Consolidated provider will have additional location populated. Select the location where the service was provided.
Action Buttons	Select Continue to proceed to the next screen.

Subscriber

Use the Subscriber screen to report the recipient who received the service(s) reported on this claim.

Refer to the table below for instruction and information about each field on this screen.

Field Name* (X12 loop & element)	Field Instruction
Subscriber ID (Loop: 2010BA, NM109)	Enter the 8-digit MHCP ID for the subscriber (recipient) indicated on the MHCP member identification card.
Birth Date (Loop: 2010BA, DMG02)	Enter the birth date of the subscriber. Select the Search action button in this section to have MN-ITS find and display the subscriber associated with the subscriber ID and date of birth entered.
The following fields auto-populate based on the information entered in the Subscriber ID and Birth Date fields.	
Subscriber First Name (Loop: 2010BA, NM104)	The first name of the subscriber.
Middle Initial (Loop: 2010BA, NM105)	The middle initial of the subscriber.
Last Name (Loop: 2010BA, NM103)	The last name of the subscriber.
Gender (Loop: 2010BA, DMG03)	The gender of the subscriber. Select Delete action button in this section to remove the subscriber information if not correct.
Action Button	Select Back to go back to the previous screen.
Action Button	Select Cancel to cancel the claim entry.
Action Button	Select Continue to proceed to the next screen.

Claim Information

Use the Claim Information screen(s) to report header (claim) level information that will identify the type of claim and details about the service(s). Information entered on the claim information screen will apply to all lines of the claim.

Refer to the table below for instruction and information about each field on this screen.

Field Name* (X12 Loop & element)	Field Instruction
TOB (Loop: 2300, CLM05)	Enter the appropriate Type of bill (TOB). The TOB is a 3-digit code which defines the type of facility, bill classification, and frequency.
Payer Claim Control Number (Loop: 2300, REF02)	The Payer Claim Control (PCN) Number field only appear when the TOB claim frequency code 7 (Replacement), or 8 (Void) is entered.

	<p>Enter the 17-digit PCN number to identify the previously paid claim to be replaced or void.</p> <p>If the claim has been retrieved from a submit response, or the request status feature, the payer claim number will display.</p>
Statement Date (From) <i>(Loop: 2300, DTP03)</i>	Enter the start date of the services for this claim.
Statement Date (To) <i>(Loop 2300, DTP03)</i>	Enter the last date of services for this claim.
Patient Control Number (Loop: 2300, CLM01)	Enter a unique identifier to help identify the claim for this recipient. This is a unique identifier the provider chooses the patient control number will be reported on the remittance advice.
Assignment/Plan Participation <i>(Loop: 2300, CLM07)</i>	<p>Code indicating whether the provider accepts payment from MHCP.</p> <p>Defaulted is Assigned.</p> <p>Select the correct response if different than the default.</p>
Benefits Assignment <i>(Loop: 2300, CLM08)</i>	<p>The determination of the policy holder or person authorized to act on their behalf, to give MHCP permission to pay the provider directly.</p> <p>Default is Yes.</p> <p>Select the correct response if different than the default.</p>
Release of Information <i>(Loop: 2300, CLM09)</i>	<p>The determination of whether the provider has a signed statement by the recipient on file, authorizing the release of medical data to other organizations.</p> <p>Default is Yes.</p> <p>Select the correct response if different than the default.</p>
Admission Type <i>(Loop: 2300, CL101)</i>	Select the drop down arrow and choose the appropriate response to identify the priority of the admission.
Admission Source <i>(Loop: 2300, CL102)</i>	Select the drop down arrow and choose the appropriate source code indicating the point of location/origin for this admission.
Patient Status <i>(Loop: 2300, CL103)</i>	Select the drop down arrow and choose the appropriate code indicating the disposition or discharge status of the recipient on the date entered in the statement Date (To) field.
Admission Date <i>(Loop: 2300, DTP02)</i>	Enter the date of the admission to the facility.
Admission Time <i>(Loop: 2300, DTP03)</i>	Enter the time of admission to the facility.
Discharge Time <i>(Loop: 2300, DTP03)</i>	Enter the time the patient was discharged from the facility.
Diagnosis Type Code <i>(Loop: 2300, HI01-1)</i>	From the drop down menu, select whether the diagnosis code reported on this claim is in the ICD-9 or ICD-10 classification.
Principal Diagnosis Code <i>(Loop: 2300, HI01-2)</i>	Enter the highest level of ICD or other industry accepted code(s) that best describes the condition/reason the recipient needed the services.
Present on Admission (POA) <i>(Loop: 2300, HI01-9)</i>	Select the Present on Admission (POA) indicator for the Principal Diagnosis code to indicate if the Principal Diagnosis code was present on admission.
Admitting Diagnosis Code <i>(Loop: 2300, HI01-1)</i>	Enter the ICD or other industry accepted code(s) that best describes the condition/reason the recipient needed the service(s).

Patient Reason For Visit (Loop: 2300, HI01-2)	Enter the ICD or other industry accepted diagnosis code describing the recipient's reason for visit at the time of outpatient registration.
External Cause of Injury Code (Loop: 2300, HI01-2)	Code indicating a code from a specific industry code list.
POA (Loop: 2300 HI101-9)	Enter the Present on Admission (POA) indicator for External Cause of Injury Code to Indicate if the External Cause of Injury Code was present at time of admission.
Other Diagnosis Code (Loop: 2300, HI01-2)	Enter the ICD or other industry accepted code(s) that best describes the additional condition/reason the recipient needed the service(s) and select add. Repeat this process to add all other diagnosis codes
POA (Loop: 2300 HI01-1)	Select the Present on Admission (POA) indicator for the Other Diagnosis code to indicates if the Other Diagnosis Code was present at time of admission.
Situational Claim Information- Select the situational claim information accordion screen to report situational information when required	
Principal Procedure Code (Loop: 2300, HI01-2)	When appropriate, enter the Code (ICD) identifying the procedure. Reminder if you are submitting more than one Q code with the same revenue code you will have to submit on two claims.
Date (Loop: 2300, HI01-4)	Date the principal procedure was performed. Required if Principal Procedure Code is reported.
Other Procedure Code (Loop: 2300, HI01-2)	When appropriate, enter additional code (ICD) identifying the other procedure.
Date (Loop: 2300, HI01-3)	Date the Other Procedure Code was performed. Required if Other Procedure Code was performed.
Prior Authorization Number (Loop: 2300, REF02)	When appropriate, enter the service agreement or authorization number.
Medical Record Number (Loop: 2300, REF02)	Enter the number to identify the actual medical record of the patient, assigned by the provider.
Reference (Loop: 2300, NTE01)	Select the code identifying the functional area or purpose for which the claim note applies.
Text (Loop: 2300, NTE02)	Use this field only when required for claim adjudication to report claim information/ clarification about the product or service provided for the entire claim relating to the Reference Code. Adding note causes the claim to become complex and allows 90 days to process.
Attachment Control Number (Loop: 2400, PWK06)	Enter the Code/number assigned by the provider, identifying an attachment for this claim. Review the Electronic Claim Attachments page for MHCP Attachment Criteria and additional information.
Attachment Type (Loop: 2400, PWK01)	Enter the code indicating the type ID and description of the attachment.
Situational Services – (Continued) Claim Information	
Occurrence Code (Loop: 2300, HI102-2-HI12)	Enter the code defining a significant event relating to this bill that may affect payer processing.
Date	Enter the date associated with the Occurrence Code.

<i>(Loop: 2300, HI01-4)</i>	
Occurrence Span Code <i>(Loop: 2300, HI01-2)</i>	Enter the code that identifies an event, occurring over a span of days that relates to payment of the claim.
From Date <i>(Loop: 2300, HI01-3)</i>	Enter the beginning date associated with the Occurrence Span.
To Date <i>(Loop: 2300, HI01-4)</i>	Enter the end date associated with the Occurrence Span.
Value Code <i>(Loop: 2300, HI01-2)</i>	Enter a value code that identifies data necessary for processing this claim as required by the payer organization.
Amount <i>(Loop: 2300, HI101-1)</i>	Enter the dollar amount associated with the value code.
Condition Code <i>(Loop: 2300, HI01-2)</i>	Enter the code to identify a condition/event related to the bill that may affect processing of the claim.
Patient Responsibility <i>(Loop: 2300, AMT02)</i>	Enter the amount determined to be the recipient's responsibility for payment.
Auto Accident State or Province <i>(Loop: 2300, REF01)</i>	Enter the State or Province where auto accident occurred.
Delay Reason <i>(Loop: 2300, CLIM20)</i>	Enter the code indicating the reason why an auto accident request was delayed.
Other Providers (Claim Level) – Select the Other Providers accordion screen when required to report other provider information	
Rendering Provider	
NPI/UMPI <i>(Loop: 2310B, NM109)</i>	<p>If different than the billing provider:</p> <ul style="list-style-type: none"> • Enter the NPI of the provider who provided the service • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Pay-To Provider	
NPI/UMPI <i>(Loop: 2010AB, NM109)</i>	<p>If different than the billing provider:</p> <ul style="list-style-type: none"> • Enter the NPI of the provider who should be paid for the item or service • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim <p>The services identified in this guide do not require a pay-to provider for the services.</p>
Referring Provider	
NPI/UMPI <i>(Loop: 2310A, NM109)</i>	<p>If different than the billing provider:</p> <ul style="list-style-type: none"> • Enter the NPI of the provider who referred the recipient for the item or service • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim <p>The services identified in this guide do not require a referring provider for the services.</p>
Attending Provider	
NPI/UMPI	Enter the NPI/UMPI of the provider who is attending the service:

<i>(Loop: 2310A, NM 101)</i>	<ul style="list-style-type: none"> • Select Add to add the Attending Provider NPI • Select the radio button to add the Attending Provider to the claim • To delete, select Delete <p>OR</p> <p>If NPI entered is Consolidated:</p> <ul style="list-style-type: none"> • Select Add to add the Attending Provider • Select the location for Attending Provider • Select the radio button to add the Attending Provider to the claim • To delete, select Delete
Operating Provider	
NPI/UMPI <i>(Loop: 2330D, REF02)</i>	<p>Enter the NPI/UMPI of the provider who did the operating for the service.</p> <p>The services identified in this guide do not require an operating provider for the services.</p>
Service Facility Location	
NPI/UMPI <i>(Loop: 2310E, NM101)</i>	<p>If different than the billing provider:</p> <ul style="list-style-type: none"> • Enter the NPI of the provider where the services were actually provided • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim <p>The services identified in this guide do not require a service facility location for the services</p>
Action Button	Select Back to go back to the previous screen
Action Button	Select Cancel to cancel the claim entry
Action Button	Select Continue to proceed to the next screen

Coordination of Benefits (COB)

Use the COB screen to report other payers, private insurance (TPL) or Medicare's financial responsibility for all or a portion of the claim. If no other payers are involved with this claim, select the action button at the bottom of this screen to proceed to the next screen.

To report each type of other payer information at the claim/header level use the tables below.

Medicare/HMO Medicare Risk

Third Party Liability (TPL)/Other insurance (non-Medicare)

TPL/Private Insurance

Complete the following field to report adjustment, payments and denials from the private insurance (Non-Medicare) carrier.

If reporting MB-Medicare Part B or 16-Health Maintenance Organization, HMO Medicare Risk insurance use the instructions in the Medicare/HMO Medicare Risk table below.

Field Name*	Field Instruction
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<i>(X12 Loop & Element)</i>	
Other Payer Name <i>(Loop: 2330B, NM103)</i>	Other Payer: Enter the full name of the insurance carrier. Do not use symbols such as slashes, dashes, periods or plus signs.
Other Payer Primary ID <i>(Loop: 2330B, NM109)</i>	Enter the Identifier of the insurance carrier. (This is available on the eligibility response for this recipient). Do not use symbols such as slashes, dashes, periods or plus signs.
Claim Filing Indicator <i>(Loop: 2320, SBR09)</i>	From the drop down select the code identifying type of insurance. Once the claim filing indicator is selected, additional fields will display for reporting TPL/private insurance.
Payer Responsibility <i>(Loop: 2320, SBR01)</i>	Other Payer Subscriber: From the drop down select the code identifying the insurance carrier's level of responsibility for payment of a claim.
Insured ID <i>(Loop: 2330A, NM109)</i>	Enter the policy holder's identification number as assigned by the payer. For Medicare this would be the Medicare health insurance claim number (HICN) or the Medicare beneficiary identifier (MBI) number.
Relationship Code <i>(Loop: 2320, SBR02)</i>	From the drop down select the relationship of the MHCP subscriber (recipient) to the policy holder. If reporting adjustments at the claim (header) level for TPL complete the remaining Claim Level Adjustments. If reporting adjustment at the line level select the Save action button in this section and then scroll to down to the Other Insurance Information section of this screen.
Claim Adjustment Group Code <i>(Loop: 2320, CAS01)</i>	Claim Level Adjustments: This field is used only when reporting TPL/private insurance at the claim (header) level rather than at the service line. From the drop down select the adjustment code as reported on the other payers EOB identifying the general category of payment adjustment.
Adj Reason Code <i>(Loop: 2320, CAS02, CAS05, CAS08, CAS11, CAS14, CAS17)</i>	This field is used only when reporting TPL/private insurance at the claim (header) level rather than at the service line. Enter the code identifying the reason the claim paid differently than originally billed to the other payer by this by the provider.
Adj Amount <i>(Loop: 2320, CAS03, CAS06, CAS09, CAS12, CAS15, CAS18)</i>	This field is used only when reporting TPL/private insurance at the claim (header) level rather than at the service line. Enter the dollar amount of the adjustment.

<p>Adj Quantity (Loop: 2320, CAS04, CAS07, CAS10, CAS13, CAS16, CAS19)</p>	<p>This field is used only when reporting TPL/private insurance at the claim (header) level rather than at the service line.</p> <p>Use this field to enter the number of units not paid when the units paid are different than the number of units submitted on the claim sent to the other payer.</p> <p>Select the Add action button in this section to include the adjustment entries on the claim. The information entered will display in the field below.</p> <p>Repeat the Claim Adjustment Adjustments entries to report all adjustments as noted on the EOB from the TPL/private insurance.</p> <p>Once the adjustment entry is added to the claim, a Delete button will display next to each entry. Select the Delete action button in this section next to an adjustment to remove that specific entry.</p>
<p>Payer Paid Amount</p>	
<p>Non-Covered Charge Amount</p>	
<p>Benefits Assignment (Loop: 2320, O103)</p>	<p>Other Insurance Information: The determination of the policy holder or person authorized to act on their behalf, to give the other payer permission to pay the provider directly.</p> <p>Default is Yes. Select the correct response if different than the default.</p>
<p>Release of Information (Loop 2320, O106)</p>	<p>The determination of whether the provider has a signed statement by the recipient on file, authorizing the release of medical data to other organizations.</p> <p>Default is Yes. Select the correct response if different than the default.</p> <p>Note: Select the Delete action button in this section next to remove this payer from the claim level and at the line level.</p> <p>Select the Save action button in this section to include the TPL/private insurance information on the claim.</p> <p>Select the ADD action button in this section to enter additional payers.</p> <p>If no other payers, select the Action Button Continue at the bottom of the screen to proceed to the next screen.</p>
<p>Action Button</p>	<p>Select Back to return to the previous screen.</p>
<p>Action Button</p>	<p>Select Cancel to the entire claim entry.</p>
<p>Action Button</p>	<p>Select Continue to proceed to the next screen.</p>

Medicare and HMO Medicare Risk

Complete the following field to report adjustment, payments and denials from Medicare or an HMO Medicare Risk plan.

Field Name* <i>(X12 Loop & Element)</i>	Field Instruction
Other Payer Name <i>(Loop: 2330B, NM103)</i>	Other Payer: Enter the full name of the insurance carrier. Do not use symbols such as slashes, dashes, periods or plus signs.
Other Payer Primary ID <i>(Loop: 2330B, NM109)</i>	Enter the Identifier of the insurance carrier. (This is available on the eligibility response for this recipient). Do not use symbols such as slashes, dashes, periods or plus signs.
Claim Filing Indicator <i>(Loop: 2320, SBR09)</i>	From the drop down select the code identifying type of insurance. Once the claim filing indicator is selected, additional fields will display for reporting Medicare/HMO Medicare Risk.
Payer Responsibility <i>(Loop: 2320, SBR01)</i>	Other Payer Subscriber: From the drop down select the code identifying the payers level of responsibility for payment of a claim.
Insured ID <i>(Loop: 2330A, NM109)</i>	Enter the policy holder's identification number as assigned by the payer.
Relationship Code <i>(Loop: 2320, SBR02)</i>	From the drop down select the relationship of the MHCP subscriber (recipient) to the policy holder.
Payer Paid Amount <i>(Loop: 2320, AMT02)</i>	This field is not used when reporting Medicare or HMO Medicare risk insurance COB. This information should be reported at the service line. The total dollar amount paid by the other payer.
Non-Covered Charge Amount <i>(Loop: 2320, AMT02)</i>	This field is not used when reporting Medicare or HMO Medicare risk insurance COB. This information should be reported at the service line. The total dollar amount the other payer did not pay.
Other Payers Claim Control Number <i>(Loop: 2330B, REF02)</i>	Medicare: Enter the claim number reported on the Medicare EOMB.
Benefits Assignment <i>(Loop: 2320, O103)</i>	Other Insurance Information: The determination of the policy holder or person authorized to act on their behalf, to give the other payer permission to pay the provider directly. Default is Yes. Select the correct response if different than the default.
Release of Information <i>(Loop 2320, O106)</i>	The determination of whether the provider has a signed statement by the recipient authorizing the release of medical data to other organizations on file. Default is Yes. Select the correct response if different than the default.
Inpatient Adjudication Information (MIA)	
MIA Count Type <i>(Loop: 2320, MIA01)</i>	Select from the drop down menu for the counts. This field is not required for the services identified in this guide.
MIA Count	Report only if on the Medicare EOMB. This field is not required for the services identified in this guide.
Claim Payment Remark Codes	Enter the code returned by Medicare.

<i>(Loop 2320, MIA20-23)</i>	You may add up to four remark codes. Report only if on the Medicare EOMB.
MIA Amount Type	Report only if on the Medicare EOMB. This field is not required for the services identified in this guide.
MIA Amount	Report only if on the Medicare EOMB. This field is not required for the services identified in this guide.
Action Button	Select the Delete action button to remove the Medicare information you entered if not needed.
Action Button	Select the Save action button in this section to include the Medicare A information on the claim.
Action Button	Select the Back action button to return to the previous screen.
Action Button	Select the Cancel action button to the entire claim entry.
Action Button	Select the Continue action button to proceed to the next screen.

Services

Use the Services screen to describe details for each service being billed. Information reported on a service line will override information reported at the header (claim) level for that line.

Refer to the table below for instruction and information about each field on this screen.

Field Name* <i>(X12 Loop and element)</i>	Field Instruction
Date of Service (From) <i>(Loop: 2400, DTP03)</i>	Enter the first date the service was provided to the recipient for this claim.
Date of Service (To) <i>(Loop: 2400, DTP03 * RD8* required in DTP02 when TO date is reported)</i>	Enter the last date of a consecutive date range, the service was provided.
Revenue Code <i>(Loop: 2400, SV201)</i>	Enter the NUBC code used to specify the service line item detail for a health care institution.
Line Item Charge <i>(Loop: 2400, SV102)</i>	Enter the total charge for the service. The total charges for the number of days entered for this line on the claim.
Unit Code <i>(Loop: 2400, SV204)</i>	Select from the drop down menu the unit code.
Service Unit Count <i>(Loop: 2400, SV104)</i>	Enter the number of units, for the services.
Procedure Code <i>(Loop: 2400, SV101-2)</i>	Enter the CPT or HCPCS code identifying the product or service. Note: bill only one Q code on a claim with revenue codes 0651 and 0652 if you have additional Q codes bill on separate claims.
Procedure Code Modifier(s) <i>(Loop: 2400, SV101-3, SV101-4, SV101-5, SV101-6)</i>	Enter the modifier that clarifies or further identifies the service indicated in the procedure code field.
NDC <i>(Loop: 2410, LIN03)</i>	National Drug Code. (NDC) required when government regulation mandates that prescribed drugs and biologics are reported with NDC numbers. Drugs and biologics reported in this segment are a further specification of service(s) described in the SV1 segment of this

	<p>Service Line Loop ID-2400.</p> <p>For the services intended for this guide this field is not used.</p>
<p>NDC Count (Loop: 2410, CPT04)</p>	<p>National Drug Unit Count– A numeric value used to specify pricing information.</p> <p>For services intended for this guide this field is not used.</p>
<p>CODE Qualifier (Loop: 2410, CTP05-1)</p>	<p>Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.</p> <p>For the services intended for this guide this field is not used.</p>
<p>Prescription Number (Loop: 2400, REF02)</p>	<p>Not used by MHCP.</p>
<p>Facility Tax Amount (Loop: 2400, ATM02)</p>	<p>Required when a facility tax or surcharge applies to the service being reported.</p>
	<p><i>When no other payer, situational services, or other provider information required for this line:</i></p> <p>Select the Copy action button in this section to when you have additions lines to report. The service line information will be copied to a new service line. You may then change the information for the next line.</p> <p>Select the Delete action button in this section to remove the line item that is displayed from the claim.</p> <p>Select the Add action button in this section to add a new service line to the claim or proceed to the Other Payer accordion screen to add the COB service line information.</p> <p>Select Save at the bottom of the screen when all service lines have been entered.</p> <p>Note: When reporting line level services there are options in performing this task.</p> <ol style="list-style-type: none"> 1. Enter all information for the individual service line, including Other payer, Situation Services and Other Providers <ul style="list-style-type: none"> • If you choose this option and use the Copy feature to copy the information for addition service line entries, all service line information will be copied from the line that was copied • If you choose Add to enter addition service lines, information from the previous line will not be copied 2. Enter all information for all service lines and then go back to add the Other Payer, Situational and Other Provider information for each service line <ul style="list-style-type: none"> • If you choose this option, you will have to select each service line accordion screen to enter the Other Payer information, Situational or Other provider for each service line
	<p>Other Payer – Use this accordion screen when reporting other payers (Medicare and/or TPL) payments or denials for the line item or service</p>
<p>Other Payer Primary</p>	<p>From the drop down select the identifier of the TPL/private insurance</p>

Identifier (Loop: 2430, SVD01)	carrier, HMO Medicare Risk or the NPI of the Medicare contractor.
Service Line Paid Amount (Loop: 2430, SVD02)	Enter the total dollar amount paid for this service line by the other payer.
Adjudication - Payment Date (Loop: 2430, DTP03)	Enter the date of payment or denial determination by the Medicare payer for this service line. This field is not required for TPL/private insurance reporting.
Paid Unit Count (Loop: 2430, SVD05)	Enter the number of units identified as being paid from the other payer's EOB/EOMB.
Claim Adjustment Group Code (Loop: 2430, CAS01)	Enter the code identifying the general category of the payment adjustment for this line.
Adjustment Reason Code (Loop: 2430, CAS02)	Enter the code identifying the reason the adjustment was made.
Adjustment Amount (Loop: 2430, CAS03)	Enter the total dollar amount of the specific adjustment entered for this service line.
Adjustment Quantity (Loop: 2430, CAS04)	Only use this field to enter the number of units not paid when the units paid are different than the number of units submitted on the claim sent to the other payer. Select action button in this section Add to include the adjustment entries on the claim. Repeat the Other Payer COB Line Adjustment Entries to report all adjustments for this line as noted on the EOB /EOMB.
Other Providers - Select the Other Providers accordion panel when required to report other provider information on the service line, if different than what was reported at the claim level.	
Referring Provider	
NPI/UMPI (Loop: 2420D, NM109)	If different than the provider reported on the claim information screen: <ul style="list-style-type: none"> • Enter the NPI of the provider who provided the service • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Section Action Buttons	Select one of the following: Save/ View Line(s): to save the line item if only one line item is entered or if not using the Copy or Add action button for the next line. Copy: to save and copy the service line information that was just entered so that you can make changes to the copied service line. Delete: to remove the service line information that is displayed. Add: to add a new service line to the claim. A new service line will display for you to enter new information for your next service line.
Screen Action Button	Select Save once all entries are complete. Each time you select save/view line, a summary table will display providing a summary for each line, showing:

	<ul style="list-style-type: none"> • Line number • From and to Date • Procedure Code • Modifier • Charge • Units <p>Select the Edit button next to the line item if changes are needed to that service line.</p> <p>Select Add below the service line summary table to add additional service line(s).</p>
Screen Action Button	<p>Select one of the following:</p> <ul style="list-style-type: none"> • ADD to add additional payers • Back to return to the previous screen • Cancel to cancel the entire claim entry • Validate to determine if the claim entries have met HIPAA billing requirements and basic MHCP service specific requirements • Submit to send the claim to MHCP for adjudication

Copy, Replace or Void (take back) the Claim

After submitting the claim and receiving a claim response, an option to Copy, Replace or Void the claim is available. Use each of these features to do the following:

Copy - To correct an error of a denied claim or to copy information from other similar claims previously submitted

Replace - If the claim paid, but paid incorrectly or a line item was denied. The user may access the claim, correct the information and resubmit. The original paid amount will be taken back and replaced with the correct information on the replacement claim

Void (take back) - If the claim was submitted in error. This reverses the claim and takes the payment back

Review the [Copy, Replace, Void \(take back\), or Reverse a Claim](#) User Guide for step-by-step instructions when completing these transactions.