

Billing for Medication Therapy Management Service

Revised: March 12, 2024

Review [MHCP Billing Policy](#) for general billing requirements and guidance when submitting claims. Refer to additional billing requirements in the item/service specific section of the MHCP Provider Manual before you submit the claim for services.

Log in to MN-ITS

1. [Log in](#) to MN-ITS
2. From the left menu:
 - a. Select **MN-ITS**
 - b. Select Claim Transactions
 - c. Select Professional (837P)

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 individual used to login to MN-ITS.
Taxonomy (Loop: 2000A, PRV03)	This field only displays information when a Health care provider specialty is selected. 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.
Screen Action Button	Select: 3. Cancel to cancel the claim entry 4. 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
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Subscriber ID (Loop: 2010BA, NM109)	Enter the 8-digit MHCP ID for the subscriber (recipient) indicated on the MH
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 dis date of birth entered. The remaining subscriber fields will auto-populate based on the information
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 informa
Screen Action Button	Select: 5. Back to go back to the previous screen 6. Cancel to cancel the claim entry 7. 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
Claim Frequency Code (Loop: 2300, CLM05-3)	Specifies if the claim is an original, replacement or void. The default is Original. If hand keying a claim to be replaced or voided, select the radio button in front of replacement or void. If the claim has been retrieved from the request status feature, the claim will display with the option selected.
Payer Claim Control Number (Loop: 2300, REF02)	Identifies the previously processed claim when the claim frequency code is replacement or void. The payer claim control field is protected until the replacement or void radio button is selected. Once selected, enter the payer claim control number to be replaced or voided. If the claim has been retrieved from a submit response or the request status feature, the payer claim number will display.
Place of Service (Loop: 2300 CLM05-1)	Select from the drop down, the code that identifies where the service was performed or the item will be used by the recipient.
Patient Control Number (Loop: 2300, CLM01)	Enter a unique identifier to help identify this claim for this recipient. The patient control number will be reported on the remittance advice.
Assignment/ Plan Participation (Loop: 2300, CLM07)	Code indicating whether the provider accepts payment from MHCP. Default is Assigned. Select the correct response if different that the default.
Benefits Assignment (Loop: 2300, CLM08)	The determination of the policy holder or person authorized to act on their behalf, to give MHCP permission to pay the provider directly. Default is Yes. Select the correct response if different that the default
Release of Information (Loop: 2300, CLM09)	The determination of whether the provider has a signed statement by the recipient on file, authorizing the release of medical data to other organizations. Default is Yes. Select the correct response if different that the default.

Provider Indicator <i>(Loop: 2300, CLM06)</i>	<p>Identifies whether the provider's signature is on file, certifying services were performed by the provider.</p> <p>Default is Signature on File. Select the correct response if different than the default.</p>
Diagnosis Type Code <i>(Loop: 2300, HI01-1)</i>	<p>From the drop down menu, select whether the diagnosis code reported on this claim is in the ICD-9 or ICD-10 classification.</p>
Diagnosis Code <i>(Loop: 2300, HI01-2, HI02-2, HI03-2, HI04-2)</i>	<p>Enter the ICD or other industry accepted code(s) that best describes the condition/reason the recipient needs the service or item.</p> <p>Select the Add action button in this section to include the diagnosis code on the claim.</p> <p>Repeat this step to add additional codes. When entering multiple codes enter the codes in order of priority to identify the primary reason the service or item is needed.</p> <p>Once a diagnosis code is added a delete action button will display next to that entry in the display field below.</p> <p>Select Delete to remove an entry if incorrect.</p>
Situational Claim Information - Select this accordion panel to report additional information at the claim level when required	
Prior Authorization Number <i>(Loop: 2300, REF02)</i>	<p>When authorization is required, enter the approved authorization number for the item or service. Or if there are multiple authorizations to report, enter the authorization number(s) at the service line.</p> <p>You may report multiple authorizations on a claim, but once one authorization is entered all lines must either be on that authorization or have a service line specific authorization.</p>
Medical Record Number <i>(Loop: 2300, REF02)</i>	<p>This field is not required for the items and services types identified in this guide.</p> <p>A number to identify the actual medical record of the patient, assigned by the provider.</p>
Claim Note <i>(Loop: 2300, NTE02)</i>	<p>When required, enter a free form description to provide additional information about this claim.</p>
Attachment Control Number <i>(Loop: 2300, PWK06)</i>	<p>When sending a required attachment with the claim, enter a code/number assigned by the provider, identifying an attachment.</p> <p>MHCP uses only the first 30 characters when matching the attachments to the claim.</p>
Type <i>(Loop: 2300, PWK01)</i>	<p>When sending an attachment with the claim, select from the drop down, the code indicating the attachment type ID and description.</p> <p>Select the Add action button in this section to include the attachment information on the claim.</p>
Contact Name <i>(Loop: 2010CA, PER02)</i>	<p>This field is not required for the items and services types identified in this guide.</p> <p>The name of the provider's contact person who handles the property and casualty coverage related to this claim.</p>
Telephone Number <i>(Loop: 2010CA, PER04)</i>	<p>This field is not required for the items and services types identified in this guide.</p> <p>The telephone number of the provider's contact person who handles the property and casualty coverage related to this claim.</p>
Extension <i>(Loop: 2010CA, PER06)</i>	<p>This field is not required for the items and services types identified in this guide.</p> <p>The telephone number extension of the provider's contact person who handles the property and casualty coverage related to this claim.</p>
Related Causes <i>(Loop: 2300, CLM11-1)</i>	<p>This field is not required for the items and services types identified in this guide.</p> <p>Code identifying the type of accident that caused an illness or injury.</p>
Date of Accident	<p>This field is not required for the items and services types identified in this guide.</p>

<i>(Loop: 2300, DTP03)</i>	The date of the accident that caused an illness or injury.
Certification Condition <i>(Loop: 2300, CRC02)</i>	This field is not required for the items and services types identified in this guide. Code indicating whether or not the child needs further assessment, diagnosis or treatment which was identified during the C&TC screening.
Condition Code <i>(Loop: 2300, CRC03, CRC04, CRC05)</i>	This field is not required for the items and services types identified in this guide. Code used to define the status or nature of the referral as a result of the C&TC screening
Situational Ambulance Information- Select the Situational Ambulance Services accordion panel to report ambulance services information on the service line, if different than what was reported at the claim level.	
Certification Condition <i>(Loop: 2400, CRC02)</i>	This field is not required for the items and services types identified in this guide. When required, select the code indicating whether a value in the Condition Code field applies to the Ambulance Transportation Service.
Condition Code <i>(Loop: 2400, CRC03, CRC04, CRC05, CRC06, CRC07)</i>	This field is not required for the items and services types identified in this guide. Select the code indicating the status or nature of the recipient's condition for the Ambulance Transportation Service.
Patient Weight <i>(Loop 2400, CR102)</i>	This field is not required for the items and services types identified in this guide. Enter the weight of the patient.
Transport Distance <i>(Loop: 2300, CR106)</i>	This field is not required for the items and services types identified in this guide. The distance traveled during the Ambulance Transportation Service.
Transport Reason Code <i>(Loop 2400, CR104)</i>	This field is not required for the items and services types identified in this guide. Select the transport reason from the drop down menu.
Round Trip Purpose Description <i>(Loop: 2400, CR109)</i>	This field is not required for the items and services types identified in this guide. When required enter a free form description to provider additional information about the round trip.
Stretcher Purpose Description <i>(Loop: 2400, CR110)</i>	This field is not required for the items and services types identified in this guide. When required enter a free form description to provide additional information of why a stretcher was needed.
Pickup Address <i>(Loop: 2310E, N301)</i>	This field is not required for the items and services types identified in this guide. Physical location address where the Ambulance Transportation Service began.
Address (contd) <i>(Loop: 2310E, N302)</i>	This field is not required for the items and services types identified in this guide. The second address line of the physical location address where the Ambulance Transportation Service began.
City <i>(Loop: 2310E, N401)</i>	This field is not required for the items and services types identified in this guide. The city name for the address where the Ambulance Transportation Service began.
State <i>(Loop: 2310E, N402)</i>	This field is not required for the items and services types identified in this guide. The state where the Ambulance Transportation Service began.
Zip Code <i>(Loop: 2310E, N403)</i>	This field is not required for the items and services types identified in this guide. The zip code for the address where the Ambulance Transportation Service began.
Dropoff Address <i>(Loop: 2310F, N301)</i>	This field is not required for the items and services types identified in this guide. Physical location address where the Ambulance Transportation Service ended.
Address {contd} <i>(Loop: 2310F, N302)</i>	This field is not required for the items and services types identified in this guide. The second address line of the physical location address where the Ambulance Transportation Service ended.
City	This field is not required for the items and services types identified in this guide.

(Loop: 2310F, N401)	The city name for the address where the Ambulance Transportation Service ended.
State (Loop: 2310F, N402)	This field is not required for the items and services types identified in this guide. The state where the Ambulance Transportation Service ended.
Zip Code (Loop: 2310F, N403)	This field is not required for the items and services types identified in this guide. The zip code for the address where the Ambulance Transportation Service ended.
Other Providers (Claim Level) – Select this accordion panel to report other provider when required	
Rendering Provider	
NPI/UMPI (Loop: 2310B, NM109)	If different than the billing or rendering provider: <ul style="list-style-type: none"> • Enter the NPI of the MTMS pharmacist 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 (Loop: 2010AB, NM109)	If different than the billing provider: <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
Referring Provider	
NPI/UMPI (Loop: 2310A, NM109)	If different than the billing provider: <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>Some of the services identified in this guide require a referral for the item or service. Enter the NPI of the health care professional who referred the MHCP subscriber to receive the service.</p> <p>Other items may require an order/prescription. Report the ordering provider on the services screen.</p>
Service Facility Location	
NPI/UMPI (Loop: 2310C, NM109)	This field is not required for the items and services types identified in this guide. If different than the billing provider: <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
Supervising Provider	
NPI/UMPI (Loop: 2310D, NM109)	If different than the billing provider: <ul style="list-style-type: none"> • Enter the NPI of the provider who supervised the service • Select the Add action button in this section to add the other provider information <p>Select the radio button to add the other provider to the claim</p>
Screen Action Buttons	Select: <ol style="list-style-type: none"> 8. Back to go back to the previous screen 9. Cancel to cancel the claim entry 10. 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:

[Third Party Liability \(TPL\)/Other insurance \(non-Medicare\)](#)

[Medicare/HMO Medicare Risk](#)

TPL/Private Insurance

Complete the following fields 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* (X12 Loop & Element)	Field Instruction
Other Payer Name (Loop: 2330B, NM103)	Other Payer: Enter the full name of the insurance carrier.
Other Payer Primary ID (Loop: 2330B, NM109)	Enter Payer Identifier for the TPL/Other insurance. This information is available on the MN-ITS Eligibility Response screen for this recipient for the TPL/Other Insurance
Claim Filing Indicator (Loop: 2320, SBR09)	Select from the drop down, the code identifying the type of insurance. Once the claim filing indicator is selected, additional fields will display for reporting TPL/Other Insurance
Payer Responsibility (Loop: 2320, SBR01)	Other Payer Subscriber: Select from the drop down, the code identifying the insurance carrier's level of responsibility for the claim.
Insured ID (Loop: 2330A, NM109)	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 (Loop: 2320, SBR02)	Select from the drop down, the code identifying the relationship of the MHCP subscriber to the policy holder. If reporting adjustments at the claim (header) level for TPL complete the remaining Claim Level Adjustments . Or: If reporting adjustments at the line level, scroll to down to the Other Insurance Information section.
Claim Adjustment Group Code (Loop: 2320, CAS01)	Claim Level Adjustments: This field is used only when reporting TPL/private insurance at the claim (header) level. If reporting adjustments at the line level, do not complete the claim level adjustment fields. If reporting at the claim level: Select from the drop down, the adjustment code as reported on the other payers EOB. Select the general category of payment adjustment and complete the claim level adjustments.
Adj Reason Code (Loop: 2320, CAS02, CAS05, CAS08, CAS11, CAS14, CAS17)	This field is used only when reporting TPL/private insurance at the claim (header) level. Enter the code identifying the reason the claim paid differently than originally billed to the carrier.
Adj Amount (Loop: 2320, CAS03, CAS06, CAS09, CAS12, CAS15, CAS18)	This field is used only when reporting TPL/private insurance at the claim (header) level. Enter the dollar amount of the adjustment.
Adj Quantity (Loop: 2320, CAS04, CAS07, CAS10, CAS13, CAS16, CAS19)	This field is used only when reporting TPL/private insurance at the claim (header) level. Enter the number of not units paid, if different than the number of units submitted on the EOB from other payer. Select the Add action button that is displayed next to the filed to add the adjustment entry. Repeat the Claim Adjustment entries to report all adjustments as noted on the EOB from the private insurance. Once an adjustment entry is entered and added, a delete button will display next to the entry. Select the Delete action button to remove the entry from the claim.

Payer Paid Amount (Loop: 2320, AMT02)	Other Payer Amounts : This field is used only when reporting TPL/private insurance at the claim (header) level. The total dollar amount paid by the other payer.
Non-Covered Charge Amount (Loop: 2320, AMT02)	This field is used only when reporting TPL/private insurance at the claim (header) level. The total dollar amount the other payer did not pay.
Benefits Assignment (Loop: 2320, O103)	Other Insurance Information: The determination of the policy holder or person authorized to act on their behalf, to give permission to pay the provider directly. Default is Yes. Select the correct response if different than the default.
Release of Information (Loop 2320, O106)	The determination of whether the provider has a signed statement by the recipient of the release of medical data to other organizations. Default is Yes. Select the correct response if different than the default.
Section Action Button	Select the Delete action button at the bottom of this section to remove the payer that is on the screen.
Section Action Button	Select the Save action button at the bottom of this section to save this payer information.
Screen Action Button	Once the Other Payer Information is saved an ADD button will display below this section. Select the ADD action button to enter additional payers. Repeat the same Other Payer and Claim Adjustments step for additional payers.
Screen Action Buttons	Select: 11. Back to go back to the previous screen 12. Cancel to cancel the claim entry 13. Continue to proceed to the next screen

Medicare and HMO Medicare Risk

Recipient eligible for Medicare Part D are not eligible for this service through MA or Minnesota Care.

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

Field Name* (X12 Loop & Element)	Field Instruction
Other Payer Name (Loop: 2330B, NM103)	Other Payer: Enter the full name of the insurance carrier. Do not use symbols, such as slashes, dashes, and etc.
Other Payer Primary ID (Loop: 2330B, NM109)	Enter the Payer ID of the Medicare contractor or Medicare Risk (Advantage) plan. <ul style="list-style-type: none"> For Medicare: Refer to the CMS Provider Compliance Group Map for contractor information. For HMO/Medicare Risk/Advantage (Coverage Type: 07): Refer to the carrier information displayed in the Carrier ID field.
Claim Filing Indicator (Loop: 2320, SBR09)	Select from the drop down, the code identifying type of insurance. Once the claim filing indicator is selected, additional fields will display for reporting.
Payer Responsibility (Loop: 2320, SBR01)	Other Payer Subscriber: Select from the drop down, the code identifying the payers level of responsibility.
Other Payer Primary ID (Loop: 2330A, NM109)	Enter the policy holder's identification number as assigned by the payer.
Relationship Code (Loop: 2320, SBR02)	Select from the drop down, the relationship of the MHCP subscriber (recipient).
Other Payers Claim Control Number (Loop: 2330B, REF02)	Medicare: Enter the claim number reported on the Medicare EOMB.
Payment Remark Code (Loop: 2320, MOA03-MOA07)	Claim Payment Remark Code(s): When reported on the Medicare EOMB, enter the payment remark code(s) and description. Select the Add action button that is displayed next to the entry to add the remark code.

	Repeat the remark code entries until all remark codes are entered. Once a Select the Delete action button in this section to remove that entry.
Payer Paid Amount (Loop: 2320, AMT02)	Other Payer Amounts : This field is not used when reporting Medicare or HMO Medicare risk insura The total dollar amount paid by the other payer.
Non-Covered Charge Amount (Loop: 2320, AMT02)	This field is not used when reporting Medicare or HMO Medicare risk insura The total dollar amount the other payer did not pay.
Benefits Assignment (Loop: 2320, O103)	Other Insurance Information: The determination of the policy holder or person authorized to act on their b provider directly. Default is Yes. Select the correct response if different than the default.
Release of Information (Loop 2320, O106)	The determination of whether the provider has a signed statement by the re organizations on file. Default is Yes. Select the correct response if different than the default
Section Action Button	Select the Delete action button at the bottom of this section to remove the p
Section Action Button	Select the Save action button at the bottom of this section to save this paye
Screen Action Button	Once the Other Payer Information is saved an ADD button will display below Select the ADD action button to enter additional payers. Repeat the same Other Payer and Claim Adjustments step for additional pa
Screen Action Buttons	Select: 14. Back to go back to the previous screen 15. Cancel to cancel the claim entry 16. Continue 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* (X12 Loop and element)	Field Instruction
Date of Service (From) (Loop: 2400, DTP03)	Enter the date the item or service was provided, dispensed or delivered to
Date of Service (To) (Loop: 2400, DTP03 * RD8* required in DTP02 when TO date is reported)	Enter the last date of a consecutive date range, the service was provided o
Place of Service (Loop: 2400, SV105)	Select from the drop down, the place where the service was provided or w than what was reported on the Claim Information screen.
Procedure Code (Loop: 2400, SV101-2)	Enter the CPT or HCPCS code identifying the product or service.
Procedure Code Modifier(s) (Loop: 2400, SV101-3, SV101-4, SV101-5, SV101-6)	Enter the modifier that clarifies or further identifies the service indicated in Use modifier GT if the service was provided via Interactive Video.
Diagnosis Pointer (Loop: 2400, SV107-1, SV107-2, SV107-3, SV107-4)	Select from the drop down fields the diagnosis code(s) in the order of impo
Line Item Charge (Loop: 2400, SV102)	Enter your usual and customary charge for this line item or service. If other payers were involved with the determination of this claim/service li other payer.

Service Unit Count (Loop: 2400, SV104)	Enter the number of units for this line item or service. Select one or more of the collapsed accordion panel(s) to report: <ul style="list-style-type: none"> • Other Payer - when reporting other payers (Medicare and/or TPL) pay • Situational Services – to report additional information or if the service • Other Providers – if reporting a provider different than who was repor
Other Payer – Select this accordion panel when reporting other payers (Medicare and/or TPL) payments or denials for the line level.	
Other Payer Primary Identifier (Loop: 2430, SVD01)	Select from the drop down, the identifier of the TPL/private insurance carrier or contractor.
Service Line Paid Amount (Loop: 2430, SVD02)	Enter the total dollar amount paid by the other payer for this service line.
Adjudication - Payment Date (Loop: 2430, DTP03)	Enter the determination date of payment or denial 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.
Claim Adjustment Group Code (Loop: 2430, CAS01)	COB Line Adjustments Entry: Select from the drop down, the adjustment code as reported on the other payer's EOB for this adjustment.
Adjustment Reason Code (Loop: 2430, CAS02)	Enter the code identifying the reason the adjustment was made as reported on the other payer's EOB.
Adjustment Amount (Loop: 2430, CAS03)	Enter the total dollar amount of the adjustment for this service line as reported on the other payer's EOB.
Adjustment Quantity (Loop: 2430, CAS04)	Enter the number of not units paid, if different than the number of units submitted by the other payer EOB/EOMB.
Section Action Button	Select the Add action button in this section to include the adjustment entry. Repeat the Other Payer COB Line Adjustment Entries to report all adjustments for this service line.
Section Action Button	Once the line item adjustment entry is added to the claim, a Delete button will be displayed. Select the Delete action button to remove that specific entry.
Section Action Button	Select the Delete action button that is displayed below the adjustments table for this service line.
Section Action Button	Select the Save action button that is displayed below the adjustments table for this service line. Once saved, the COB Line Payments/Adjustments screen will appear with the following information: <ul style="list-style-type: none"> • Other Payer Primary identifier • Line Paid Amount • Total Adjustment for the service line
Section Action Button	Select Edit to go back and change you adjustment entries if corrections are needed. The totals on this screen should equal the total charge you sent to the primary payer.
Section Action Button	Select the Add action button that is display right below the COB Line Payments/ Adjustments in this section to report additional payer(s) if additional payers are used for this service line. Repeat the same steps used to report the primary payer service line adjustments for this service line.
Situational Services – Select this accordion panel to report additional information or if the service line information is different than the primary payer.	
Prior Authorization (Loop: 2400, REF02)	Enter the approved authorization number for the service line when different than the primary payer.
Certification Condition Indicator (Loop: 2400, SV111)	Not used by MHCP.
Ambulance Patient Count (Loop: 2400, QTY02)	This field is not required for the items and services types identified in this group. The number of patients, when more than one is transported in the same ambulance.
Line Note (Loop: 2400, NTE02)	When required, enter a free form description to provide additional information for this service line.
Qualifier	This field is not required for the items and services types identified in this group.

(Loop: 2400, K301)	CDT code indicating type of value entered for the service.
Value (Loop: 2400, K301)	This field is not required for the items and services types identified in this g Tooth number(s) or oral cavity designation(s) for the service.
Description (Loop: 2400, SV101-7)	Enter the hearing aid model number exactly as written in the hearing aid v aid as noted on an approved authorization.
NDC (Loop: 2410, LIN03)	This field is not required for the items and services types identified in this g National Drug Code (NDC) that further specifies the HCPCS code used fo
NDC Count (Loop: 2410, CPT04)	This field is not required for the items and services types identified in this g Number specifying the drug quantity.
CODE Qualifier (Loop: 2410, CTP05-1)	This field is not required for the items and services types identified in this g Code indicating type of measurement for the NDC count.
Situational Ambulance Information- Select the Situational Ambulance Services accordion panel to report ambulance services int at the claim level.	
Certification Condition (Loop: 2400, CRC02)	This field is not required for the items and services types identified in this g When required, select the code indicating whether a value in the Condition
Condition Code (Loop: 2400, CRC03, CRC04, CRC05, CRC06, CRC07)	This field is not required for the items and services types identified in this g Select the code indicating the status or nature of the recipient's condition f
Patient Weight (Loop 2400, CR102)	This field is not required for the items and services types identified in this g Enter the weight of the patient.
Transport Distance (Loop 2400, CR106)	This field is not required for the items and services types identified in this g Enter the distance traveled during the Ambulance Transportation Service.
Transport Reason Code (Loop 2400, CR104)	This field is not required for the items and services types identified in this g Select the transport reason from the drop down menu.
Round Trip Purpose Description (Loop: 2400, CR109)	This field is not required for the items and services types identified in this g When required enter a free form description to provider additional informat
Stretcher Purpose Description (Loop: 2400, CR110)	This field is not required for the items and services types identified in this g When required enter a free form description to provide additional informati
Pickup Address (Loop 2420G, N301)	This field is not required for the items and services types identified in this g Enter the physical location address where the Ambulance Transportation S
Address (contd) (Loop: 2420G, N302)	This field is not required for the items and services types identified in this g Enter the second address line of the physical location address where the A
City (Loop: 2420G, N401)	This field is not required for the items and services types identified in this g Enter the city name for the address where the Ambulance Transportation S
State (Loop: 2420G, N402)	This field is not required for the items and services types identified in this g Enter the state where the Ambulance Transportation Service began.
Zip Code (Loop: 2420G, N403)	This field is not required for the items and services types identified in this g Enter the zip code for the address where the Ambulance Transportation S
Dropoff Address (Loop: 2420H, N301)	This field is not required for the items and services types identified in this g Enter the physical location address where the Ambulance Transportation S
Address (contd) (Loop: 2420H, N302)	This field is not required for the items and services types identified in this g Enter the second address line of the physical location address where the A
City	This field is not required for the items and services types identified in this g

(Loop: 2420H, N401)	Enter the city name for the address where the Ambulance Transportation Service ended.
State (Loop: 2420H, N402)	This field is not required for the items and services types identified in this group. Enter the state where the Ambulance Transportation Service ended.
Zip Code (Loop: 2420H, N403)	This field is not required for the items and services types identified in this group. Enter the zip code for the address where the Ambulance Transportation Service ended.
Other Providers – Select this accordion panel the if reporting a provider different than who was reported at the claim level	
Rendering Provider	
NPI/UMPI (Loop: 2420A, 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 action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Referring Provider	
NPI/UMPI (Loop: 2420F, 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 referred the recipient for this service • Select the action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Service Facility Location	
NPI/UMPI (Loop: 2420C, NM109)	This field is not required for the items and services types identified in this group. If different than the location reported on the claim information screen: <ul style="list-style-type: none"> • Enter the NPI of the provider who provided the service • Select the action button in this section to add the location information • Select the radio button to add the location to the claim
Ordering Provider	
NPI/UMPI (Loop: 2420E, NM109)	If reporting an ordering/prescribing provider: <ul style="list-style-type: none"> • Enter the NPI of the provider who wrote the order/prescription for the item • Select the action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Supervising Provider	
NPI/UMPI (Loop: 2420D, NM109)	If reporting a supervising provider: <ol style="list-style-type: none"> 17. Enter the NPI of the provider who is doing the supervising service 18. Select the Add action button in this section to add the supervising provider information 19. Select the radio button to add the supervising provider to the claim
Section Action Button	Select one of the following: <ol style="list-style-type: none"> 20. Save/ View Line(s): to save the line item if only one line item is entered 21. Copy: to save and copy the service line information that was just entered 22. Delete: to remove the service line information that is displayed 23. Add: to add a new service line to the claim. A new service line will display below the current service line.
Section Action Button	Select Save once all entries are complete. Each time you select save/view line, a service line table will display providing the following information: <ol style="list-style-type: none"> 24. Line number 25. From and to Date 26. Procedure Code 27. Modifier 28. Charge 29. Units Select the Edit button next to the line item if changes are needed to that service line. Select Add below the service line table to add additional service line(s).
Screen Action Button	Select: <ol style="list-style-type: none"> 30. Back to go back to the previous screen 31. Cancel to cancel the claim entry 32. Validate to determine if the claim has met the HIPAA-compliant and complete information. 33. Submit to submit the claim for adjudication. The submit response will display at the claim level and the line level of the claim.

	Use the Washington Publishing Company (WPC) health care codes lists to displayed on the claim response
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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.