

Dental (837D) Claim Level COB - Billing for Dental Services

[Revised: January 4, 2022](#)

Review [MHCP Billing Policy](#) for general billing requirements and guidance when submitting dental claims.

Refer to specific billing requirements in the following MHCP Provider Manual service sections [Dental Services](#), [Allied Oral Health Professional \(Overview\)](#), [Dental Benefits for Children and Pregnant Women](#), [Non-Dental Health Providers](#) or [Dental Benefits for Non-Pregnant Adults](#) before you submit the claim.

Intended Users: Federally qualified health center (FQHC), rural health clinic (RHC) and Indian Health Services (IHS) providers who receive encounter rates for services performed.

All fee-for-service (FFS) dental providers including FQHC, RHC and IHS providers billing for MinnesotaCare members with major program BB must bill using the [MN-ITS Direct Data Entry \(DDE\) User Guide – Dental \(837D\) Line Level COB](#).

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 Dental (837D)

Submit the Claim

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

[Billing Provider](#)
[Subscriber](#)
[Claim Information](#)
[Coordination of Benefits \(COB\)](#)
[Services](#)

Validate claim before you submit using X12 (formerly known as Washington Publishing Company) to make sure you:

- Completed all fields
- Can make corrections
- Can avoid denied claims

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. If changes are needed, use the [Change of Enrollment](#) to notify MHCP Provider Eligibility and Compliance.

Refer to the following table for instructions and information about each field on this screen. Refer to the Help link on each MN-ITS 837D claim screen for additional descriptions of the field and their valid values.

Field Name * (X12 Loop & element)	Field Description
Organization (Loop: 2010AA, NM103 (last or organization) NM104 (first))	<p>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 log in to MN-ITS.</p> <p>Providers who have one NPI for multiple locations are known as consolidated providers. Each location that is associated with the NPI used to log in to MN-ITS will display with each locations name, address, provider type and any associated Taxonomy information that provider has on file with MHCP in a table format.</p> <p>Consolidated providers must select the radio button next to the location that is associated with their claim. The Billing Provider Information will auto-populate with that locations address and taxonomy information into the billing provider information fields after the radio button associated with their claim is selected.</p>
Taxonomy (Loop: 2000A, PRV03)	<p>This field only displays information when a Health care provider specialty/location code has been added by the provider using the MN-ITS Taxonomy Code feature.</p> <p>If multiple taxonomy codes have been added, additional choices will display to determine</p>

	the location where services were provided. Select the radio button to identify the 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.
Select Locations	When using a consolidated NPI, a table will display showing the locations and taxonomy codes information on file with MHCP. Select the radio button next to the location for the pay-to provider
Screen Action Buttons	Select: <ul style="list-style-type: none"> • Cancel to cancel the claim entry • Continue to proceed to the next screen

Subscriber (member)

Use the Subscriber screen to report the member who received the services reported on this claim.

Refer to the following table for instructions and information about each field on this screen.

Field Name* (X12 loop & element)	Field Description
Subscriber ID (Loop: 2010BA, NM109)	Enter the 8-digit MHCP ID for the subscriber (member) indicated on the MHCP member identification card.
Birth Date (Loop: 2010BA, DMG02)	Enter the birth date of the subscriber. The birth date must match the birth date on the MHCP file. The format for entering the birth date is 2-digit month, 2-digit day, and 4-digit year (MMDDYYYY). 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 Subscriber 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 to remove the subscriber information if not correct.
Screen Action Buttons	Select: <ul style="list-style-type: none"> • Back to go back to the billing provider screen • Cancel to cancel the claim entry • Continue to proceed to the next screen

Claim Information

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

Refer to the following table for instructions and information about each field on this screen.

Field Name (X12; Loop & Element)	Field Description
Claim Frequency Code (Loop: 2300, CLM05-3)	Specifies if you are filing an original (1) replacement (7) or void (8) claim. Select radio button in front of the appropriate claim frequency code. The

	<p>default is 1 – original.</p> <p>Note: If selecting replacement or void, you must enter your original payer claim number that you wish to replace or void in the Payer Claim Control Number field.</p> <p>If the claim has been retrieved from a submit response or from the request status feature, the payer claim number will auto-display.</p>
<p>Payer Claim Control Number (PCN) (Loop: 2300, REF02)</p>	<p>Identifies the previously processed claim when the claim frequency code is replacement or void.</p> <p>The payer claim control field is protected until replacement or void radio button is selected. Enter the payer claim control number of the claim that is to be replaced or voided after the radio button is selected.</p> <p>If the claim has been retrieved from a submit response or the request status feature the payer claim number will display.</p>
<p>Place of Service (Loop:2300, CLM05-1)</p>	<p>Select the appropriate code from the dropdown that identifies where the service was performed. Default is 11 (office).</p>
<p>Patient Control Number (Loop: 2300, CLM01)</p>	<p>Enter a unique identifier for this member. The patient control number can be numeric or alphanumeric.</p> <p>This number will be reported on your Remittance Advice.</p>
<p>Assignment/Plan Participation (Loop: 2300, CLM07)</p>	<p>Code indicating whether the provider accepts payment from MHCP. Default is Assigned.</p> <p>Select the correct response if different than the default.</p>
<p>Benefits Assignment (Loop: 2300, CLM08)</p>	<p>The determination of the policy holder or person authorized to act on their behalf to give MHCP permission to pay the individual provider directly.</p> <p>Default is Yes.</p> <p>Select the correct response if different than that the default.</p>
<p>Release of Information (Loop: 2300, CLM09)</p>	<p>The determination whether the provider has a signed statement by the member on file, authorizing the release of medical data to other organizations.</p> <p>Default is Yes.</p> <p>Select the correct response if different that the default.</p>
<p>Provider Indicator (Loop 2300, CLM06)</p>	<p>Identifies whether the provider's signature is on file, certifying services were performed by the provider.</p> <p>Default is Signature on File.</p> <p>Select the correct response if different that the default.</p>
<p>Diagnosis Type Code (Loop: 2300, H101-1)</p>	<p>Select from the dropdown menu whether the diagnosis code reported on this claim is in the ICD-9 or ICD-10 classification. (When required)</p>
<p>Diagnosis Code (Loop: 2300, H101-2, H102-2, H103-2, H104-2)</p>	<p>Enter the ICD or other industry-accepted codes that best describes the condition or reason the member needed the services. (When required)</p> <p>Next, select the Add action button in this section to include the diagnosis code on the claim. After a diagnosis code is entered, it will display in the table below. Repeat this procedure to report all diagnoses for the claim. Next to each entry, a Delete action button in this section will display. Select the Delete to remove an entry.</p>
<p>Situational Claim Information - Select the situational claim information accordion screen to report situational information when required.</p>	
<p>Prior Authorization Number (Loop: 2330B, REF02)</p>	<p>Enter the approved authorization number for the item or service when authorization is required.</p>

Claim Note Entry <i>(Loop: 2300, NTE02)</i>	<p>Enter a free form description to provide additional information about this claim. Use only when additional information is required.</p> <p>Note: If you are a FQHC, RHC or IHS provider who is billing for a denture or partial denture; use</p> <p>D5899 for appointments before or after the delivery of the denture or partial denture. Enter in the claim note field one of the following:</p> <ul style="list-style-type: none"> • Encounter in preparation for denture • Encounter in preparation for partial • Encounter for denture adjustment <p>The claim note must exactly match one of the notes mentioned above. Refer to MHCP Provider Manual Clinics Billing MHCP Directly in the Pharmacy Copays section for billing requirements.</p> <p>If a note was added, select the Add action button in this section to include the claim note on the claim. After the claim note is entered, it will display in the claim note table.</p>
Attachments – Control Number <i>(Loop: 2300, PWK06)</i>	<p>A unique alphanumeric number assigned by the provider that matches the AUC cover sheet for Health Care Claims that is faxed with the supporting documentation for this claim.</p> <p>Follow the steps listed on the Electronic claim attachments webpage when you need to submit an electronic claim with an attachment.</p> <p>Note: Complete the AUC cover sheet matching the attachment control number, billing provider ID number and name, as well as the member's name that is on the claim. Indicate the total number of pages and a contact name and phone number. If these identifiers do not match, your claim will be denied.</p> <p>You must fax the cover sheet and supporting documentation within 48 hours of submitting your electronic claim.</p>
Attachments – Type <i>(Loop: 2300, PWK01)</i>	<p>From the dropdown, select the appropriate code indicating the type ID and description of the attachment. Select OZ as the attachment type.</p> <p>Next, select the Add action button in this section to include the attachment control number and type on the claim. The attachment information will display in the control number and Type ID table after it is added.</p>
Accident Information – Related Causes <i>(Loop: 2300, CLM11-1)</i>	<p>If service is related to an accident, select the box for the code that best identifies the type of accident that caused an illness or injury.</p>
Accident Information – Date <i>(Loop: 2300, DTP03)</i>	<p>If the service is related to an accident, enter the date of the accident that caused an illness or injury.</p>
Other Providers (Claim Level)	
Rendering Provider – Provider Identifier NPI/UMPI <i>(Loop: 2310B, NM109)</i>	<ul style="list-style-type: none"> • Enter the NPI of the provider who performed the service. If consolidated, you will get a dropdown box. Choose location or service. <p>Next, select the Add action button in this section to have MN-ITS find and display the provider associated with the NPI/UMPI.</p>
Pay-To-Provider	
Pay-to-Provider – Provider Identifier NPI/UMPI <i>(Loop: 2010AA, NM109)</i>	<p>If the pay-to-provider is different from the NPI displayed on the Billing Provider screen, enter the NPI of the provider who will receive the payment.</p> <p>Next, select the Add action button in this section to have MN-ITS find and display the provider associated with the NPI/UMPI.</p>
Referring Provider	
Referring Provider – Provider Identifier	<ul style="list-style-type: none"> • (Optional) Enter the NPI of the provider who made the referral for the service. If consolidated, you will get a dropdown box. Choose location or

NPI/UMPI (Loop: 2310A, NM109)	<ul style="list-style-type: none"> • service. <p>Next, select the Add action button in this section to have MN-ITS find and display the provider associated with the NPI/UMPI.</p>
Service Facility Location	
Service Facility Location – Provider Identifier NPI/UMPI (Loop: 2310C, NM109)	<p>If you have one NPI for multiple locations, you must select the a location using the following guidelines to identify the NPI of one of the following:</p> <ul style="list-style-type: none"> • Where the service was actually provided • The member's or provider's home or clinic location when the location of health care service is different than the billing provider <p>Next, select the Add action button in this section to have MN-ITS find and display the service facility location associated with the NPI/UMPI.</p>
Assistant Surgeon Provider	
Assistant Surgeon Provider – Provider Identifier (Loop: 2310D, NM109)	<ul style="list-style-type: none"> • (Optional) Enter the NPI of the assistant surgeon who performed the service. If consolidated, you will get a dropdown box. Choose location or service. <p>Next, select the Add action button in this section to have MN-ITS find and display the assistant surgeon associated with the NPI/UMPI.</p>
Screen Action Button	<p>Select:</p> <ul style="list-style-type: none"> • Back to go back to the subscriber screen • Cancel to cancel the claim entry • Continue to proceed to the next screen

Coordination of Benefits (COB)

Use the COB screen to report other payers, private insurance (TPL) payer information. **Important:** This user guide instructs providers how to complete the COB payments and adjustments so the claim will be processed at the claim level. The other payers line payment amounts will be prorated using a percentage of the total charged amount and total paid amount over all of the lines.

Refer to the following table for instructions and information about each field on this screen.

Field Name* (X12 Loop & Element)	Field Description
Other Payer Name (Loop: 2330B, NM103)	Enter the full name of the insurance carrier.
Other Payer Primary ID (X12: Loop 2330B, NM109)	Enter the Identifier of the insurance carrier. This information is displayed on the MN-ITS eligibility response in the other insurance section as the 6-digit Carrier ID of the policyholder. Do not use symbols such as slashes, dashes, periods or plus signs.
Claim Filing Indicator (Loop: 2320, SBR09)	Select the appropriate code that identifies the type of insurance from the dropdown. CI – Commercial Insurance can be used for most general dental insurance plans. The following additional fields will display on the COB screen after the code is selected.
Payer Responsibility (Loop: 2320, SBR01)	Select the code that best identifies the insurance carrier's level of responsibility for payment on this claim.
Insured ID (Loop: 2330A, NM109)	Enter the policy holder's identification number as assigned by the insurance carrier. 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 the relationship code of the MHCP subscriber (member) to the policy holder from the dropdown list.
Claim Adjustment Group Code (Loop: 2320, CAS01)	Review the other payer explanation of benefits (EOB) adjustment group code. Select the appropriate HIPAA compliant adjustment group code from the dropdown that best matches what is shown on the other payers EOB. Use the X12 link on the right, to find the HIPAA-compliant code that matches the adjustment response on the other payer's EOB.
Adjustment Reason Code	Review other payer explanation of benefits (EOB) adjustment reason code. Enter the claim

<p>(Loop: 2320, CAS02, CAS05, CAS08, CAS11, CAS14, CAS17)</p>	<p>adjustment reason code that identifies why the adjustment was made; as shown on the other payer EOB.</p> <p>If the other payer EOB does not include HIPAA-compliant codes, refer to X12 code list to find the appropriate adjustment reason code. MHCP will not accept non-compliant codes.</p>
<p>Adjustment Amount (Loop: 2320, CAS03, CAS06, CAS09, CAS12, CAS15, CAS18)</p>	<p>Enter the total dollar amount of the adjustment related to the group code entered.</p> <p>Next, select the Add action button in this section to have MN-ITS display the COB line adjustments entry in the field below.</p> <p>IMPORTANT: Providers must report each Claim Adjustment Group Code shown on the other payers EOB until all COB adjustment entries are made. If additional codes, repeat the following fields:</p> <ul style="list-style-type: none"> • Claim Adjustment Group Code • Adjustment Reason Code • Adjustment Amount <p>Select Add after each entry.</p> <p>After all entries are made, select the Save action button to save the COB claim level adjustments.</p> <p>Select the Delete action button to remove the COB claim level adjustment entries.</p> <p>If more than one payer was entered, the COB screen entry must be repeated for all insurance carriers by selected the Add action button below the Save/View Line(s) action button.</p>
<p>Adjustment Quantity (Loop: 2320, CAS04, CAS07, CAS10, CAS13, CAS16, CAS19)</p>	<p>Not used by MHCP.</p>
<p>Payer Paid Amount (Loop: 2320, AMT02)</p>	<p>Enter the total dollar amount paid by the other payer for all service lines combined.</p>
<p>Non-Covered Charge Amount (Loop: 2320, AMT02)</p>	<p>Not used by MHCP.</p>
<p>Benefits Assignment (Loop: 2320, O103)</p>	<p>Select the radio button for the value that best indicates whether the policy holder or person authorized to act on their behalf, gave 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>Select the radio button for the value that best indicates whether the provider has a signed statement by the member on file, authorizing the release of medical data to other organizations for this claim.</p> <p>Default is Yes.</p> <p>Select the correct response if different than the default.</p> <p>Select the Save action button to save the claim level COB entry.</p> <p>Select the Delete action button to remove the claim level COB entry.</p> <p>Select the Add action button to open a new COB screen to add additional payers COB information, when there is more than one other payer that is primary to MHCP.</p>
<p>Screen Action Buttons</p>	<p>Select:</p> <ul style="list-style-type: none"> • Back to go back to the claims information screen • Cancel to cancel the claim entry • 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 following table for instructions and information about each field on this screen.

Field Name* (X12 Loop and element)	Field Descriptions
Date of Service (From) (Loop: 2400, DTP03)	Enter the date that indicates the date the member was seen and the services were completed (must be the same date). Bill only for services provided within the same calendar month.
Date of Service (To) (Loop: 2400, DTP03)	Not used by MHCP for dental services.
Place of Service (Loop: 2400, SV303)	Select the code from the dropdown menu that identifies where the service was performed. Default is 11 (office). If you will be reporting multiple service lines with different places of service, change the Place of Service field code for the line item on the Services screen. Entries at the service line will override what is entered on the claim information screen.
Procedure Code (Loop: 2430, SV301-2)	Enter the CDT code identifying the service that was performed. (CDT codes should be entered included the D that precedes the code). Note: If you are a FQHC, RHC or IHS provider; bill: <ul style="list-style-type: none"> • The appropriate code for the denture or partial denture when the appliance is delivered to the member • Using D5899 for appointments prior to or after the delivery of the denture or partial denture. (This requires a claim note be added to the Situational Claim Information screen, as noted above.)
Procedure Code Modifier(s) (Loop: 2400, SV301-3, SV301-4, SV301-5, SV301-6)	This field is currently not required for the dental claim.
Diagnosis Pointer(s) (Loop: 2400, SV311-1, SV311-2, SV311-3, SV311-4)	From the dropdown menu, select whether the diagnosis code reported on this claim is in the ICD-9 or ICD-10 classification. (When required) If more than one diagnosis was entered, select the dropdown to add up to four diagnosis codes on the claim. After the diagnosis code is selected, it will display in the additional diagnosis pointer(s) fields. To remove an entry select the dropdown and select the words "select -one-."
Line Item Charge Amount (Loop: 2400, SV302)	Enter the provider's usual and customary charge for the service performed.
Procedure or Service Unit Count (Loop: 2400, SV306)	Enter a quantity of "1" unit for the service. Dental procedures only allow one unit.
Other Payer (COB Line Level Adjudication)	
Other Payer Primary ID (Loop: 2430, REF04-2)	Select the identifier of the TPL or private insurance carrier from the dropdown that was entered at the COB claim level.
Service Line Paid Amount (Loop: 2430, SVD02)	Enter the total dollar amount paid by the other payer for this specific service line.
Paid Unit Count (Loop: 2430, SVD05)	Enter the number of units paid from the other payer as 1. MHCP allows a unit of one for each service line.
Claim Adjustment Group Code (Loop: 2430, CAS01)	Review other payer explanation of benefits (EOB) adjustment group code. Then, from the dropdown, select the appropriate HIPAA compliant adjustment group code that best matches what is shown on the other payers EOB. Refer to X12 code list to find the appropriate claim adjustment group code.
Adjustment Reason Code (Loop: 2430, CAS02)	Review the other payer explanation of benefits (EOB) adjustment reason code. Enter the claim adjustment reason code that identifies why the adjustment was made; as shown on the other payer EOB. If the other payer EOB does not include HIPAA compliant codes, refer to X12 code list to find the appropriate adjustment reason code. MHCP will not accept non-compliant codes.
Adjustment Amount (Loop: 2430, CAS03)	Enter the total dollar amount of the adjustment related to the group code entered. Next, select the Add action button in this section to have MN-ITS display the COB line

	<p>adjustments entry in the field below.</p> <ul style="list-style-type: none"> • IMPORTANT: Providers must report each Claim Adjustment Group Code shown on the other payers EOB until all COB line adjustment entries are made. If additional codes, repeat the following fields: Claim Adjustment Group Code • Adjustment Reason Code • Adjustment Amount <p>Select the Add action button after each entry.</p> <p>Select the Save action button to save the COB line adjustment entries.</p> <p>Select the Delete action button to remove the COB line adjustment entries.</p> <p>If more than one payer was entered, the other payer accordion panel entry must be repeated for all insurance carriers by selected the Add action button below the Save/View Lines action button.</p>
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COB Line Payments Adjustment Summary Table	
	<p>After saved, the COB Line Payments/Adjustments Summary Table will display with the following COB service line information:</p> <ul style="list-style-type: none"> • Other Payer Primary identifier/Name • Line Paid Amount • Total Adjustment Amount <p>Select Edit to go back and change you adjustment entries if corrections are needed.</p> <p>The total payments and adjustments on this table should equal the total usual and customary charge for this service line.</p> <p>To report additional payers payments and adjustments (if additional payers were entered on the COB screen at the claim level); select the Add action button that displays below the COB Line.</p> <p>Repeat the same steps used to report the primary payer service line adjustments to report the secondary or additional payer information for this same service line.</p>

Situational Services	
Prior Authorization Number (Loop: 2400, REF02)	<p>Enter the approved authorization number for the service line when different than the authorization number reported at the claim level.</p> <p>Authorization numbers entered at the service level will override the authorization number entered at the claim information level.</p>
Fixed Form Information (X12 Loop, 2400, K301)	This field has no specific (X12 Loop) purpose, and is not used for dental claims at this time.
Tooth Code (Loop: 2400, TOO02)	Code identifying the tooth on which services were performed.
Tooth Surface (Loop: 2400 TOO03-1, TOO03-2, TOO03-3, TOO03-4, TOO03-5)	<p>Code identifying the surface area of the tooth that was treated.</p> <p>Select the Add action button in this section to save the Tooth Code or Tooth Surface for this service line.</p>
Oral Cavity Designation (Loop 2400, SV304-1)	<p>Code identifying an oral cavity designation involved in the service performed.</p> <p>Select the Add action button in this section to save the Oral Cavity Designation Code for this service line.</p>
Prosthesis Code (Loop: 2400, SV305)	Code identifying if the placement status of the prosthesis is initial or a replacement.
Prior Placement Date (Loop: 2400, DTP03)	Date prior prosthetic was received by the member (subscriber).
Orthodontic Banding Date (Loop: 2400, DTP02)	Date initial banding was performed on the member (subscriber).
Replacement Date (Loop: 2400, DTP03)	Date orthodontic appliance was replaced on the member (subscriber).

Other Providers (Line Level)	
Rendering Provider – Provider Identifier NPI/UMPI (Loop: 2420A, NM109)	<ul style="list-style-type: none"> NPI of the provider who performed the service. If consolidated, you will get a dropdown box. Choose location or service. <p>Select the Add action button in this section to have MN-ITS find and display the provider associated with the NPI/UMPI.</p>
Service Facility Location	
Service Facility Location – Provider Identifier NPI/UMPI (Loop: 2410C, NM109)	<p>NPI identifying one of the following:</p> <ul style="list-style-type: none"> Where the service was actually provided The member's or provider's home or clinic location when the location of health care service is different than the billing provider <p>Select the Add action button in this section to have MN-ITS find and display the service facility location associated with the NPI/UMPI.</p>
Supervising Provider	
Supervising Provider – Provider Identifier NPI/UMPI (Loop: 2420C, NM109)	<ul style="list-style-type: none"> (Optional) Enter the NPI of the provider who supervised the service. If consolidated, you will get a dropdown box. Choose location or service. <p>Next select the Add action button in this section to have MN-ITS find and display the provider associated with the NPI/UMPI.</p>
Assistant Surgeon Provider	
Assistant Surgeon Provider – Provider Identifier NPI/UMPI (Loop: 2420B, NM109)	<p>NPI of the assistant surgeon who performed the service. If consolidated you will get a dropdown box. Choose location or service.</p> <p>Select the Add action button in this section to have MN-ITS find and display the assistant surgeon associated with the NPI/UMPI.</p>
Screen Action Buttons	<p>Select:</p> <p>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.</p> <p>Copy: to save and copy the service line information that was just entered so that you can make changes to the copied service line.</p> <p>Delete: to remove the service line information that is displayed.</p> <p>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.</p>
Service(s) Line Summary Table	
<p>Select Save after all entries are complete.</p> <p>Each time you select save/view line, a service line table will display providing a summary for each line, showing:</p> <ul style="list-style-type: none"> Line number From Date Procedure Code (Proc) Modifier (Mod) Charges Place of Service (POS) <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 lines. Following the same entry process as the previous line.</p>	
Screen Action Buttons	<p>Select:</p> <ul style="list-style-type: none"> Back to go back to the claims services screen Cancel to cancel the claim entry Validate to determine if the claim has met the HIPAA-compliant and certain basic requirements at both the claim and line level information. Use the X12 health care codes to identify the claim status category and claim status codes displayed on the validate response Submit to identify if the claim will be paid, denied or suspended for review at the claim level and the line level of the claim. Use the X12 health care codes lists to identify the

	<ul style="list-style-type: none">• claim status category and claim status codes displayed on the claim response
Submit Response	
Effective with the new MN-ITS 837D Dental Claim Screens, providers now have the option to immediately Copy, Replace, or Void the claim that was just submitted.	

Copy, Replace or Void 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 - If the claim was submitted in error. This reverses the claim and takes the payment back.

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