



Wyoming
Department
of Health

Institutional Claims

Claim Submission

Course Content

- Institutional Claim Overview
- Institutional Claim Submissions
- Institutional Claim with Third-Party Liability (TPL)
- Institutional Claim with Tertiary Third-Party Liability (TPL)
- Institutional Claim Attachments



Institutional Claims Overview

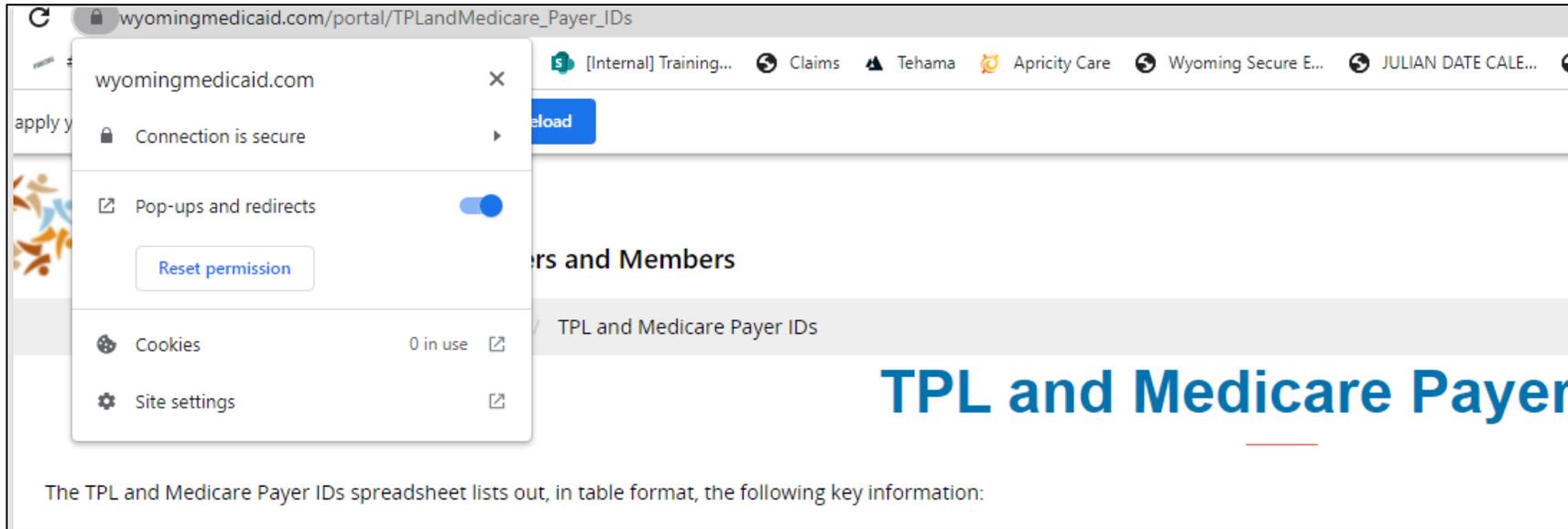
- Institutional Claims are submitted by hospitals, nursing homes, and hospice
 - Member receives a service
 - Provider submits a claim
 - Claims include information about the Member, Provider, and service
 - The claim is submitted to the State Medicaid Agency
 - The claim is approved and paid or denied



Institutional Claims

How to enter an Institutional Claim

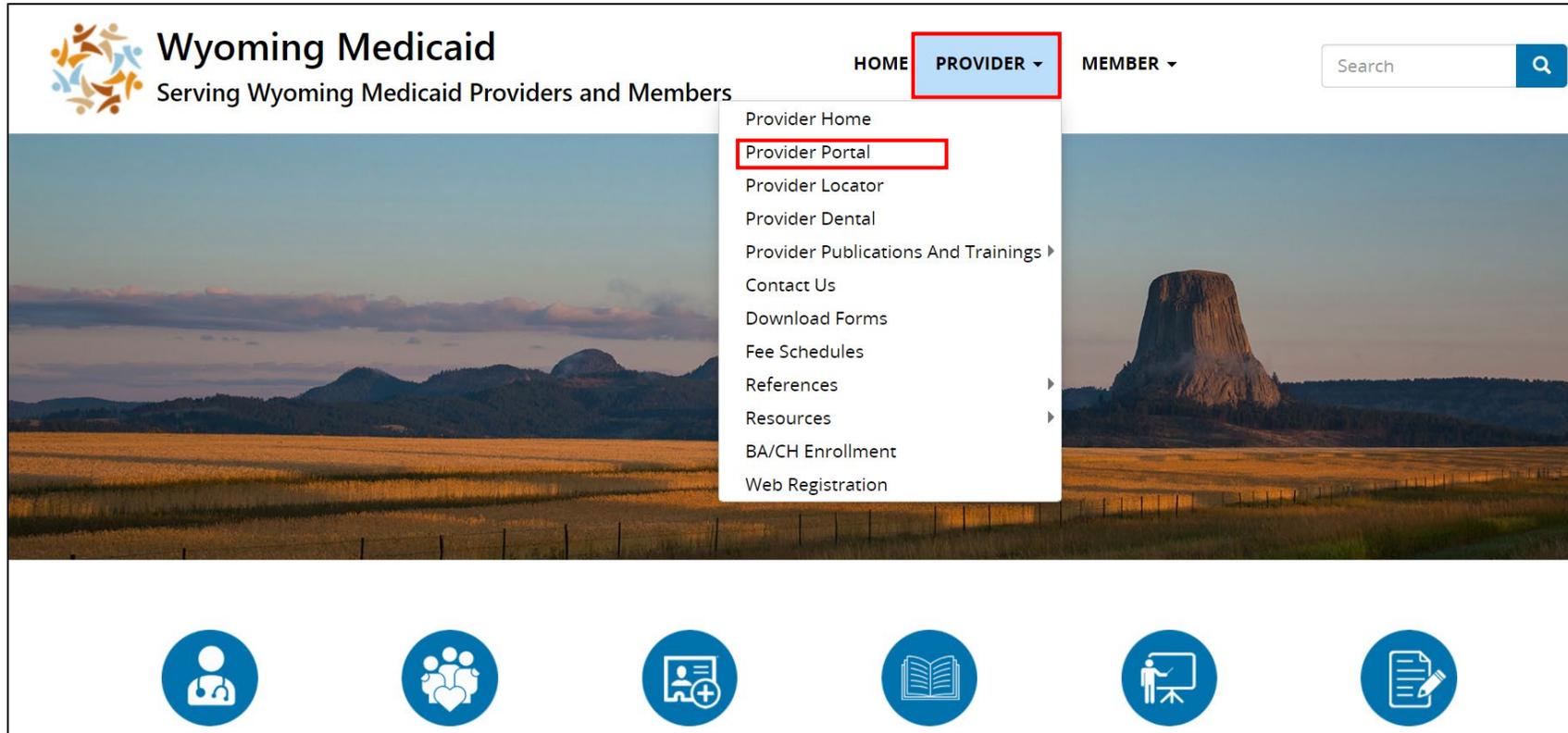
Institutional Claims Submission



Before Claim Submission Begins:

- Check that pop-up blocker will allow pop-ups from the BMS System
- Have all materials needed such as Explanation of Benefits (EOB), Claim Information, and Member Information

Institutional Claims Submission



- Access the Medicaid Website at:
<https://www.wyomingmedicaid.com/>
- Select **Provider** at the top of the page. A drop-down list displays
- Select **Provider Portal**

Institutional Claims Submission

Wyoming
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Sign In - Non Production

Username

Password

Remember me

Sign In

OR

New users click here

Need Help Signing In?

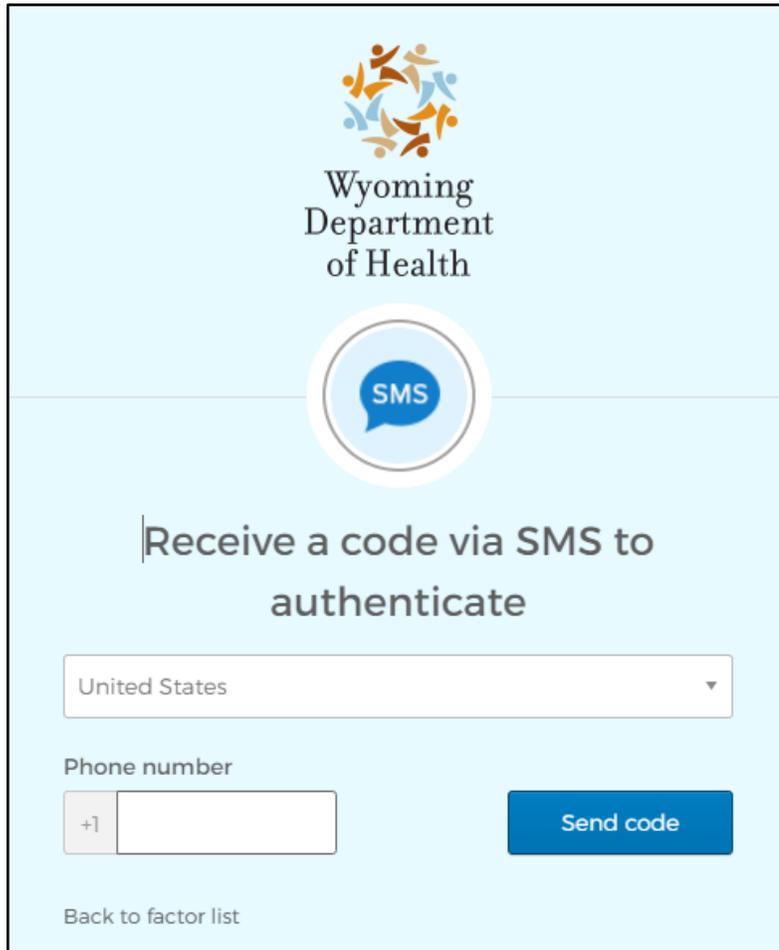
Log in with Credentials

Log in to the BMS system:

- Log in to the Provider Portal with your Single Sign-On (SSO) username and password

After logging in, an authentication screen displays to authenticate access to the system.

Institutional Claims Submission



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SMS

Receive a code via SMS to authenticate

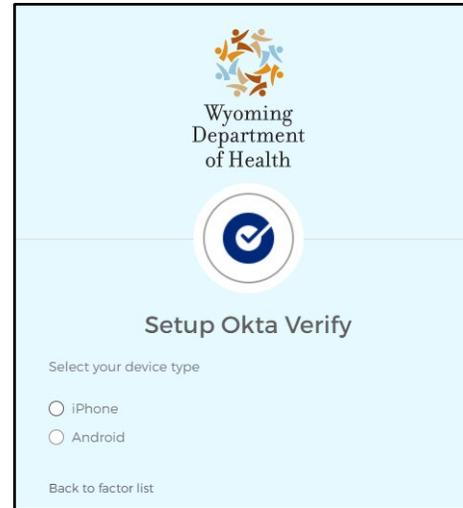
United States

Phone number

+1

Send code

Back to factor list



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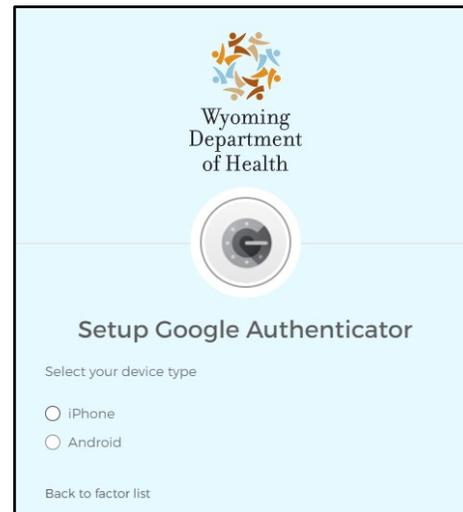
Setup Okta Verify

Select your device type

iPhone

Android

Back to factor list



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Setup Google Authenticator

Select your device type

iPhone

Android

Back to factor list

After logging in, the Multi-Factor Authentication (MFA) appears to authenticate access to the system:

Verify authentication based on your setup selection:

- Select **Send code** for SMS
- If you chose Google Authenticator, enter that code
- If you did an OKTA push, accept the push

Institutional Claims Submission

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Domain → []*

Claims Access ↓* ← Profile

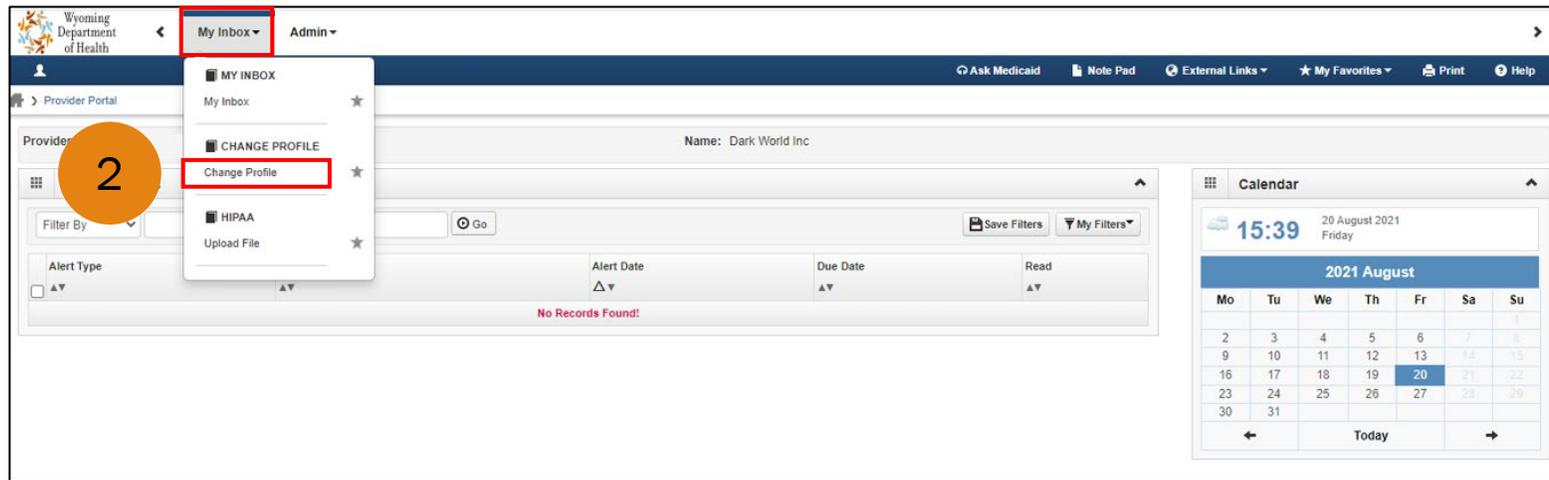
Select Favorite ↓ [Go] ← Select Go

Next, select the domain and role:

- Select the applicable domain from the **Domain** drop-down list
- Select **Claims Access** from the **Profile** drop-down list
- Select **Go**

Institutional Claims Submission

1

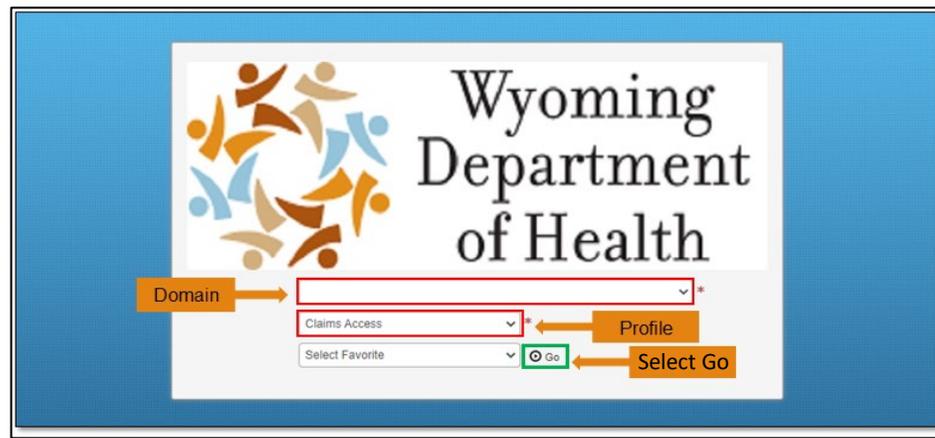


If you are already logged in to the Provider Portal, you can change your profile:

1. Select **My Inbox**.
2. Select **Change Profile**.

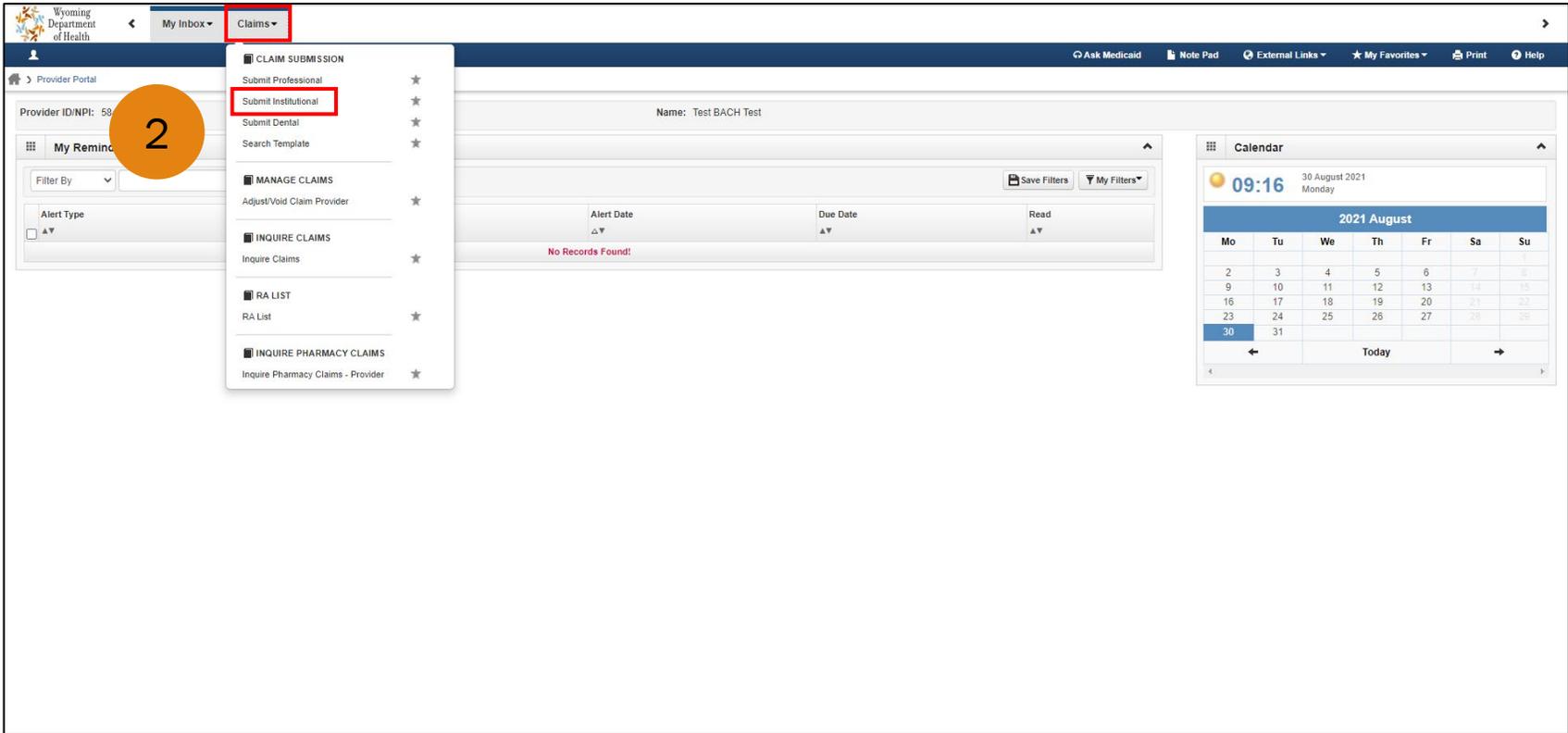
Next, select the domain and role:

- Select the applicable domain from the **Domain** drop-down list
- Select **Claims Access** from the **Profile** drop-down list
- Select **Go**



Institutional Claims Submission

1



To enter Institutional Claims in BMS:

1. Select **Claims**.
2. Select **Submit Institutional**.

Institutional Claims Submission

The screenshot shows the 'Institutional Claim' form with the following elements and annotations:

- Annotation 1:** A red box highlights the 'Provider ID' field containing '900000390'.
- Annotation 2:** A red box highlights the 'Taxonomy Code' field, which is currently empty.
- Annotation 3:** A red box highlights the 'ATTENDING PROVIDER INFORMATION' section at the bottom, which includes 'Provider ID', 'Type', and 'Taxonomy Code' fields.
- Address Validation:** A blue message 'Address validation successful' is displayed. Below it, address fields are populated: 'Address Line 1: 504 W 17th St Ste 100', 'City/Town: Cheyenne', 'County: Laramie', and 'Zip Code: 82001 - 4347'. A 'Validate Address' button is highlighted with a red box and an orange arrow pointing to it from the text 'Select Validate Address'.

To enter Provider Information:
Required fields are indicated with an *.

1. National Provider Identifier (NPI) auto-populates in the **Provider ID** field. Confirm this is the correct NPI.
2. Enter in all caps the applicable **Taxonomy Code** associated with Provider.

The address auto-populates.

- Select **Validate Address**
3. Enter **Attending Provider Information**.

Institutional Claims Submission

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My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

Institutional Claim

Note: Asterisks (*) denote required fields.

Basic Claim Info

Provider Beneficiary Claim Service Line

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: * Type: NPI * Taxonomy Code: *

Address Line 1: 508 Livingston Ave *
(Enter Street Address or PO Box Only)

Address Line 2: *

Address Line 3: *

State/Province: WYOMING *
Country: UNITED STATES *

City/Town: Cheyenne *
County: Laramie *
Zip Code: 82007 * - 1966 * Validate Address

Address validation successful

BMS validates the address information and displays the following message “Address validation successful”

- If a message displays “International Address,” change **Country** to **United States** and re-validate

Institutional Claims Submission

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My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

ATTENDING PROVIDER INFORMATION

Provider ID: * Type: * Taxonomy Code:

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *
Last Name: * First Name: Middle Initial: Suffix:
Date of Birth: mm dd yyyy * Gender: *

Complete the required **Beneficiary Information** (Member data), required fields are indicated with an asterisk *:

- Beneficiary (Member) ID
- Last Name
- First Name
- Date of Birth
- Gender

Institutional Claims Submission

In order to process your claim, BMS also requires claim data about the patient.

Wyoming Department of Health
My Inbox > Claims >
Ask Medicaid | Note Pad | External Links | My Favorites | Print | Help
Provider Portal > Submit Institutional Claim
Close | Submit Claim | Save as Template | Reset

CLAIM INFORMATION

CLAIM DATA

Patient Control No.: *

Medical Record No.:

Type of Bill: *

Statement Dates: From: (Enter 4 digits with leading zero.) * To: *

Admission Date/Hour: *

Admission Type:

Admission Source: *

Discharge Hour: *

Patient Status: *

Principal Diagnosis Code: * POA: Auto Accident State/Province:

Diagnosis Code Category: *

Complete the required fields indicated with an *:

- **Patient Control No** identifies the Medicaid Member
- **Type of Bill** is a 4-digit number
- **Statement Start and End Dates**
- **Admission Source** is needed
- **Patient Status**
- **Principal Diagnosis Code**
- **Diagnosis Code Category** defaults to **ICD-10**

Institutional Claims Submission

The screenshot shows a form with four sections: CONDITION INFORMATION, OCCURRENCE INFORMATION, OCCURRENCE SPAN INFORMATION, and VALUE INFORMATION. Section 1 (CONDITION INFORMATION) has a field for '1.Condition Code:' with an asterisk and an 'Add Another' button. Section 2 (OCCURRENCE INFORMATION) has a field for '1.Occurrence Code:' with an asterisk, a date field for 'Occurrence Date:' with sub-fields for mm, dd, and yyyy, and an 'Add Another' button. Section 3 (OCCURRENCE SPAN INFORMATION) has a field for '1.Occurrence Span Code:' with an asterisk, a date field for 'From Date:' with sub-fields for mm, dd, and yyyy, and a date field for 'Through Date:' with sub-fields for mm, dd, and yyyy, and an 'Add Another' button. Section 4 (VALUE INFORMATION) is currently empty. Three orange circles with numbers 1, 2, and 3 are placed above the 'Add Another' buttons in sections 1, 2, and 3 respectively.

Under **Condition Information**, **Occurrence Information**, and **Occurrence Span Information**, required fields are indicated with an *:

1. Enter **Condition Code**. If there is more than one, select **Add Another**.
2. Enter **Occurrence Code** and **Occurrence Date**. If there is another code, select **Add Another**.
3. Enter **Occurrence Span Information**. If there is another span, select **Add Another**.

Institutional Claims Submission

1 VALUE INFORMATION

1.Value Code: *

Value Amount: *

2 DELAY REASON

Delay Reason Code: *

3

OTHER INSURANCE

Other Subscriber

Payer Responsibility

Payer ID Number

Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

1.Reason Code: Amount:

2.Reason Code: Amount:

Remittance Date: mm dd yyyy

Subscriber Member ID:

First Name: [State Code]: Suffix:

Beneficiary's Relationship:

Total COB Payer Paid Amount: *

Adjustment Quantity:

Adjustment Quantity:

Under **Value Code**, required fields are indicated with an *:

1. Enter **Value Code**.
2. Enter **Value Amount**. If there is another, select **Add Another**.
3. Select the applicable **Delay Reason**.

Institutional Claims Submission

OTHER INSURANCE INFORMATION

Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: *

Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

1.Reason Code: Amount:

2.Reason Code: Amount:

Remittance Date:

Subscriber Member ID:

First Name: [State Code]: Suffix:

Beneficiary's Relationship:

Total COB Payer Paid Amount:

Adjustment Quantity:

Adjustment Quantity:

If the Member has other insurance besides Medicaid, this can be Commercial or Medicare:

1. **Payer Responsibility** will be primary or secondary or tertiary in some cases.
2. **Payer ID Number** can default to 99999, or you can find the Payer ID Number at: [Payer ID List](#).
3. Enter **Insured's Group or Policy number** and **Claim Filing Indicator**, along with **Total COB Payer Paid Amount**. This is the amount that the Primary Insurance paid.

Institutional Claims Submission

Wyoming Department of Health
My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

PRIOR AUTHORIZATION/PRO/REFERRAL NUMBER

Prior Authorization Number: Agency PA: Yes No PRO Number:

Referral Number:

DIAGNOSIS INFORMATION (Do not use decimals or spaces)

PROCEDURE INFORMATION

OPERATING PHYSICIAN INFORMATION

OTHER OPERATING PHYSICIAN INFORMATION

RENDERING PHYSICIAN INFORMATION

REFERRING PHYSICIAN INFORMATION

CLAIM NOTE

Does this claim have backup documentation? Yes No

If your claim requires a Prior Authorization (PA), complete the fields for the **Prior Authorization/Pro/Referral Number**:

- **Prior Authorization Number**
- For **Agency PA**, select **Yes** or **No**.

This is all the information you will need. *PRO number and Referral number are not needed*

PAs are not needed for every claim.

Institutional Claims Submission

The screenshot shows a form titled "DIAGNOSIS INFORMATION (Do not use decimals or spaces)". It contains several input fields and buttons. Three orange circles with numbers 1, 2, and 3 are overlaid on the form to indicate key steps:

- 1**: A red box highlights the "Admitting Diagnosis Code" input field.
- 2**: A red box highlights the "Add Another" button located below the "Reason For Visit" section.
- 3**: A red box highlights the "Add Another" button located below the "Other Diagnosis Information" section.

The form fields include:

- Admitting Diagnosis Code: [Input field]
- Reason For Visit: 1: [Input field], 2: [Input field], 3: [Input field]
- E-Code: [Input field]
- PPS/DRG: [Input field]
- POA: [Dropdown menu]
- Other Diagnosis Information: 1. Other Diagnosis Code: [Input field] *
- POA: [Dropdown menu]

Under **Diagnosis Information**:

1. Enter **Admitting Diagnosis Code**.

Do not place a "." when adding information, as the system will not recognize it.

Example: Enter F402 instead of F4.20.

2. Select **Add Another** to add other diagnosis codes.

3. To add more of the Admitting or Other Diagnosis codes, select **Add Another**.

Diagnosis codes may not always be applicable.

Institutional Claims Submission

<input type="checkbox"/> OPERATING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> OTHER OPERATING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> RENDERING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> REFERRING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *

Operating, Rendering, and Referring Physician Information:

If applicable, complete the required fields indicated with an *.

In **Provider ID** field, use NPI or Provider ID for Identification Number.

Not all claims require this information.

Institutional Claims Submission

1

The screenshot shows the 'SERVICE LINE ITEM INFORMATION' form. At the top, a red box highlights the question 'Does this claim have backup documentation?' with radio buttons for 'Yes' and 'No'. Below this, the form contains several fields: 'Revenue Code' (with a red box and annotation '2'), 'HCPCS Code', 'Service Date', 'Last Date of Service', 'Service Units' (with a red box and annotation '3'), 'Total Line Charges', 'Operating Physician ID', 'Other Operating Physician ID', 'Rendering Physician ID', 'Referring Physician ID', 'National Drug Code', 'Quantity', 'Unit', 'Qualifier', and 'Prescription/Link No'. There are also 'Modifiers' (1-4), 'HCPCS Description', 'Non-covered Line Charges', and 'Type' dropdowns. At the bottom, a red box highlights the 'Add Service Line Item' button, with an orange arrow pointing to it from a label 'Add Service Line Item' below the form.

Add Service Line Item

Service Line Item Information is required to process the claim, all required fields are indicated with an *:

1. Select **Yes** for **Does this claim have backup documentation** for items such as OP notes or sterilization forms. This suspends the claim for 30 days for processing attachments.
2. Enter **Revenue Code**.
3. Enter **Service Units** and **Total Line Charges**.
4. Select **Add Service Line Item**. Repeat for additional revenue codes.
5. Other fields can be completed, if applicable.

Institutional Claims Submission

Close
Submit Claim

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code:	<input type="text"/>	*			
HCPCS Code:	<input type="text"/>		Modifiers:	1: <input type="text"/>	2: <input type="text"/>
Service Date:	mm <input type="text"/>	dd <input type="text"/>	yyyy <input type="text"/>	3: <input type="text"/>	4: <input type="text"/>
Last Date of Service:	mm <input type="text"/>	dd <input type="text"/>	yyyy <input type="text"/>	HCPCS Description: <input style="width: 100%;" type="text"/> Characters Remaining: <input style="width: 50px;" type="text" value="80"/>	
Service Units:	<input type="text"/>				
Total Line Charges:	<input type="text"/>				
Operating Physician ID: (If different from header):	<input type="text"/>		Non-covered Line Charges:	<input type="text"/>	
Other Operating Physician ID: (If different from header):	<input type="text"/>		Type:	<input type="text"/>	
Rendering Physician ID: (If different from header):	<input type="text"/>		Type:	<input type="text"/>	
Referring Physician ID: (If different from header):	<input type="text"/>		Type:	<input type="text"/>	
National Drug Code:	<input type="text"/>	Quantity:	<input type="text"/>	Unit:	<input type="text"/>
			Qualifier:	<input type="text"/>	
			Prescription/Link No:	<input type="text"/>	

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$0.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non covered Charges
			1	2	3	4	Service Date	Last DOS			

- At the bottom of the **Claims** page, Service Line items must be entered before Claim Submission.
- After all lines of the claim are entered at the bottom of the claim submission form, if no primary insurance is being billed, select **Submit Claim**.

Institutional Claims Attachment

Submitted Professional Claim Details

TCN:	Billing Provider ID:	Beneficiary ID:
Total Number of Lines:	Billing Provider Name:	Beneficiary Name:
Total Claim Charge:	Date of Service:	

Cover Sheet

Please select the document(s) to be mailed/faxed:

<input type="checkbox"/> Hysterectomy Forms	<input type="checkbox"/> Medical Documentation	<input type="checkbox"/> Forms
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Predictive Modeling	<input type="checkbox"/> NDC Drug Dosing and Cost Info
<input type="checkbox"/> Reports	<input type="checkbox"/> Anesthesia Records	<input type="checkbox"/> Voluntary Sterilization Forms
<input type="checkbox"/> EOB Insurance	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Diagnostic Tests
<input type="checkbox"/> Notes		
<input type="checkbox"/> Other <input type="text"/>		

Once your claim is submitted, the BMS system displays the **Submitted Professional Claim Details**:

- Scroll down until you reach the **Additional Documents** section.

Institutional Claims Attachment

Print Help

Submitted Professional Claim Details

TCN: Billing Provider ID: Beneficiary ID:
Total Number of Lines: Billing Provider Name: Beneficiary Name:
Total Claim Charge: Date of Service:

Cover Sheet

Please select the document(s) to be mailed/faxed:

Hysterectomy Forms Medical Documentation Forms
 History and Physical Predictive Modeling NDC Drug Dosing and Cost Info
 Reports Anesthesia Records Voluntary Sterilization Forms
 EOB Insurance Ambulance Diagnostic Tests
 Notes
 Other

Generate Coversheet Reset

Additional Documents

Save Delete

Document Type *	Document Name *	File Name * (Size < 30 MB) ⓘ	Remarks	TCN
--Select--	--Select--	Choose File 	<input type="text"/>	

Close

Select the type of electronic document to attach from the options listed or select a file from your computer:

Documents size is limited to 25 pages per attachment.

1. Select the **paper clip** icon to search for and select the file to upload from your computer.
2. Select **Save** to save the file. The message “File Uploaded Successfully” displays.

Repeat these steps if you have multiple documents to attach to a claim.

Institutional Claims with TPL

How to bill Third-Party Liability (TPL) with an Institutional Claim

Institutional Claims Submission

- TPL (Third-Party Liability) is: Other insurance, other health insurance, other medical coverage, or other insurance coverage
- Medicare, Medicare replacement, Medicare supplemental plans, commercial companies like Blue Cross Blue Shield or Cigna, Disability, and Workman's comp are all examples of TPL.
- HMS is our TPL vendor and can be reached at 1-888-996-6223
 - Within the IVR say **Report TPL** or **Update insurance** to speak with someone.
- TPL can be direct billed, through a clearing house or from a Medicare if applicable
- An EOB or Explanation of Benefits is a document that is acquired from a primary insurance that explains what was paid and what reason or adjustment codes were applied to the over all payment

Institutional Claims Submission

1

The screenshot shows the Wyoming Department of Health BMS interface. At the top, there is a navigation bar with 'My Inbox' and 'Claims' (highlighted with a red box and a circled '1'). A dropdown menu is open under 'Claims', with 'Submit Institutional' highlighted by a red box and a circled '2'. Other options in the menu include 'Submit Professional', 'Submit Dental', 'Search Template', 'MANAGE CLAIMS', 'INQUIRE CLAIMS', 'RA LIST', and 'INQUIRE PHARMACY CLAIMS'. The main content area shows a search for 'Test BACH Test' with 'No Records Found!' displayed. A calendar widget on the right shows the date 30 August 2021.

To enter Institutional Claims in BMS:

1. Select **Claims**.
2. Select **Submit Institutional**.

Institutional Claims Submission

The screenshot shows the 'Institutional Claim' form with the following elements and annotations:

- Annotation 1:** A red box highlights the 'Provider ID' field containing '990000390'.
- Annotation 2:** A red box highlights the 'Taxonomy Code' field, which is currently empty.
- Annotation 3:** A red box highlights the 'ATTENDING PROVIDER INFORMATION' section at the bottom, which includes 'Provider ID', 'Type', and 'Taxonomy Code' fields.
- Address Validation:** A blue message 'Address validation successful' is displayed. Below it, address fields are populated: 'Address Line 1: 504 W 17th St Ste 100', 'City/Town: Cheyenne', 'County: Laramie', and 'Zip Code: 82001 - 4347'. A 'Validate Address' button is highlighted with a red box and an orange arrow pointing to it, with the text 'Select Validate Address' below.

To enter Provider Information:
Required fields are indicated with an *.

1. National Provider Identifier (NPI) auto-populates in the **Provider ID** field. Confirm this is the correct NPI.
2. Enter in all caps the applicable **Taxonomy Code** associated with Provider.

The address auto-populates.

- Select **Validate Address**
3. Enter **Attending Provider Information**.

Institutional Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

Institutional Claim

Note: Asterisks (*) denote required fields.

Basic Claim Info

Provider | Beneficiary | Claim | Service Line

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: * Type: NPI * Taxonomy Code: *

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

State/Province: *

City/Town: *

Country: *

County:

Zip Code: * -

Address validation successful

BMS validates the address information and displays the following message “Address validation successful”

- If a message displays “International Address,” change **Country** to **United States** and re-validate

Institutional Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

ATTENDING PROVIDER INFORMATION

Provider ID: * Type: * Taxonomy Code:

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *
Last Name: * First Name: Middle Initial: Suffix:
Date of Birth: mm dd yyyy * Gender: *

Complete the required **Beneficiary Information** (Member data), required fields are indicated with an asterisk *:

- Beneficiary (Member) ID
- Last Name
- First Name
- Date of Birth
- Gender

Institutional Claims Submission

In order to process your claim, BMS also requires claim data about the patient.

The screenshot shows the 'Submit Institutional Claim' form in the Wyoming Department of Health Provider Portal. The 'CLAIM DATA' section is highlighted with a red box. The fields in this section are:

- Patient Control No.: *
- Medical Record No.:
- Type of Bill: *
- Statement Dates: From: mm dd yyyy * To: mm dd yyyy *
- Admission Date/Hour: mm dd yyyy - hh : mm
- Admission Type:
- Admission Source: *
- Discharge Hour: hh : mm
- Patient Status: *
- Principal Diagnosis Code: * POA: Auto Accident State/Province:
- Diagnosis Code Category: *

Complete the required fields indicated with an *:

- **Patient Control No** identifies the Medicaid Member
- **Type of Bill** is a 4-digit number
- **Statement Start and End Dates**
- **Admission Source** is needed
- **Patient Status**
- **Principal Diagnosis Code**
- **Diagnosis Code Category** defaults to **ICD-10**

Institutional Claims Submission

The screenshot shows a form with four sections: CONDITION INFORMATION, OCCURRENCE INFORMATION, OCCURRENCE SPAN INFORMATION, and VALUE INFORMATION. Each section has an 'Add Another' button. Callout 1 points to the 'Add Another' button in the CONDITION INFORMATION section. Callout 2 points to the 'Add Another' button in the OCCURRENCE INFORMATION section. Callout 3 points to the 'Add Another' button in the OCCURRENCE SPAN INFORMATION section. The 'Add Another' buttons are highlighted with red boxes.

Under **Condition Information**, **Occurrence Information**, and **Occurrence Span Information**, required fields are indicated with an *:

1. Enter **Condition Code**. If there is more than one, select **Add Another**.
2. Enter **Occurrence Code** and **Occurrence Date**. If there is another code, select **Add Another**.
3. Enter **Occurrence Span Information**. If there is another span, select **Add Another**.

Institutional Claims Submission

1 VALUE INFORMATION

1.Value Code: *

Value Amount: *

2 DELAY REASON

Delay Reason Code: *

3

OTHER INSURANCE

Other Subscriber

Payer Responsibility

Payer ID Number

Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

1.Reason Code: Amount:

2.Reason Code: Amount:

Remittance Date: mm dd yyyy

Subscriber Member ID:

First Name: [State Code]: Suffix:

Beneficiary's Relationship:

Total COB Payer Paid Amount: *

Adjustment Quantity:

Adjustment Quantity:

Under **Value Code**, required fields are indicated with an *:

1. Enter **Value Code**.
2. Enter **Value Amount**. If there is another, select **Add Another**.
3. Select the applicable **Delay Reason**.

Institutional Claims Submission

OTHER INSURANCE INFORMATION

Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: *

Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

1.Reason Code: Amount:

2.Reason Code: Amount:

Remittance Date:

Subscriber Member ID:

First Name: [State Code]: Suffix:

Beneficiary's Relationship:

Total COB Payer Paid Amount: *

Adjustment Quantity:

Adjustment Quantity:

If the Member has other insurance besides Medicaid, this can be Commercial or Medicare:

1. **Payer Responsibility** will be primary or secondary or tertiary in some cases.
2. **Payer ID Number** can default to 99999, or you can find the Payer ID Number at: [Payer ID List](#).
3. Enter **Insured's Group or Policy number** and **Claim Filing Indicator**, along with **Total COB Payer Paid Amount**. This is the amount that the Primary Insurance paid.

Institutional Claims Submission

Wyoming Department of Health
My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

PRIOR AUTHORIZATION/PRO/REFERRAL NUMBER

Prior Authorization Number: Agency PA: Yes No PRO Number:

Referral Number:

DIAGNOSIS INFORMATION (Do not use decimals or spaces)

PROCEDURE INFORMATION

OPERATING PHYSICIAN INFORMATION

OTHER OPERATING PHYSICIAN INFORMATION

RENDERING PHYSICIAN INFORMATION

REFERRING PHYSICIAN INFORMATION

CLAIM NOTE

Does this claim have backup documentation? Yes No

If your claim requires a Prior Authorization (PA), complete the fields for the **Prior Authorization/Pro/Referral Number**:

- **Prior Authorization Number**
- For **Agency PA**, select **Yes** or **No**.

This is all the information you will need. *PRO number and Referral number are not needed*

PAs are not needed for every claim.

Institutional Claims Submission

1

DIAGNOSIS INFORMATION (Do not use decimals or spaces)

Admitting Diagnosis Code:

Reason For Visit:

1: PPS/DRG: **2**

2: 3:

E-Code: POA:

3

Other Diagnosis Information

1. Other Diagnosis Code: * POA:

Under **Diagnosis Information**:

1. Enter **Admitting Diagnosis Code**.

Do not place a “.” when adding information, as the system will not recognize it.

Example: Enter F402 instead of F4.20.

2. Select **Add Another** to add other diagnosis codes.

3. To add more of the Admitting or Other Diagnosis codes, select **Add Another**.

Diagnosis codes may not always be applicable.

Institutional Claims Submission

<input type="checkbox"/> OPERATING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> OTHER OPERATING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> RENDERING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> REFERRING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *

Operating, Rendering, and Referring Physician Information:

If applicable, complete the required fields indicated with an *.

In **Provider ID** field, use NPI or Provider ID for Identification Number.

Not all claims require this information.

Institutional Claims Submission

1

Does this claim have backup documentation? Yes No

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: 2

HCPCS Code:

Service Date: mm dd yyyy

Last Date of Service: mm dd yyyy

Service Units: 3

Total Line Charges:

Operating Physician ID: (If different from header):

Other Operating Physician ID: (If different from header):

Rendering Physician ID: (If different from header):

Referring Physician ID: (If different from header):

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Modifiers: 1: 2: 3: 4:

HCPCS Description: Characters Remaining: 80

Non-covered Line Charges:

Type:

Type:

Type:

Type:

Add Service Line Item

Service Line Item Information is required to process the claim, all required fields are indicated with an *:

1. Select **Yes** for **Does this claim have backup documentation** for items such as OP notes or sterilization forms. This suspends the claim for 30 days for processing attachments.
2. Enter **Revenue Code**.
3. Enter **Service Units** and **Total Line Charges**.
4. Select **Add Service Line Item**. Repeat for additional revenue codes.
5. Other fields can be completed, if applicable.

Institutional Claims Submission

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$200.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pointer				Submitted Charges	Units	Prior Auth Number	
	From	To		1	2	3	4	1	2	3	4				
1	03/02/2022	03/02/2022	T2027								200.00	1		Enter Insurance Info <input type="button" value="Copy"/> <input type="button" value="Delete"/>	

[Enter Insurance Info](#)

At the bottom of the **Claims** page, enter each Claim Line's insurance information:

1. Select **Insurance Info** to enter the other insurance payments and adjustments.

Institutional Claims Submission

Payee: Dr. Sample	Date: 01/21/2022
123 Anywhere Dr	TIN: 12345679
Cheyenne, Wyoming	Reference ID: 98765452
82009	Amount: \$5682.05
Payer: WY Medicare	
900 42 nd Street South	
Fargo ND, 58103	
Claims: (1)	Claim Status: 19 Claim Amount: 189.00
Patient Name: John Smith	Paid Amount: 86.29
Patient ID: 3GR2W94GE64	Pt Responsibility: 27.17
Payer Claim ID: 6548061301856241850	
Provider Claim ID: 315487	
Received Date: 01/11/2022	
Outpatient: MA0 MA04	
Adjudication: MA18	

Claim Status Description : Processed as Primary, Forwarded to Additional Payer(s). Forwarded to : UNITEDHEALTH
GROUP : 30002

Serv Date	Units	Serv Code	Billed	Paid	Allowed Adjustments
08/25/2021 - 08/25/2021	1	HC:99214	\$189.00	\$88.69	\$110.86 CO-45: \$78.14 PR-2: \$22.17

Adjustment Group Codes
CO : Contractual Obligations
PR : Patient Responsibility

Adjustment Reason Codes
1 : Deductible Amount
2 : Coinsurance Amount
45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
49 : This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
144 : Incentive adjustment, e.g. preferred product/service.

Remark Codes
MA01 : Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA07 : Alert: The claim information has also been forwarded to Medicaid for review.
MA18 : Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
N429 : Not covered when considered routine.
N782 : Alert: No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance.
N807 : Payment adjustment based on the Merit-based Incentive Payment System (MIPS).

Proprietary codes and their descriptions are shown in this sample Explanation of Benefits (EOB), this is used for adjustment reasons. Also, what is shown on the EOBs.

Institutional Claims Submission

The screenshot displays a web form for a Professional Claim. At the top, there are buttons for 'Close', 'Basic Claim Form', and 'Reset'. A red warning message reads: 'Warning: Insurance Detail Reason Code(s) is invalid.' with a red dashed arrow pointing to the reason code fields. Below the warning, the form is titled 'Professional Claim' and includes a note: 'Note: asterisks (*) denote required fields.' The 'INSURANCE INFORMATION' section contains a question: 'Does the Beneficiary have insurance other than Medicaid?' with radio buttons for 'Yes' (selected) and 'No'. The 'OTHER INSURANCE INFORMATION' section is titled '1. Service Line Other Payer Information' and contains the following fields:

Field	Value	Notes
Primary Payer Responsibility:	1#P#99999#CI-Commercial Insuran	Required field (*)
Amount Paid:	\$100.00	Required field (*)
Remittance Date:	mm dd yyyy	mm: [input], dd: [input], yyyy: [input]
1.Reason Code:	CO45	Highlighted in yellow, red dashed arrow points to it.
Amount:	\$50.00	
Adjustment Quantity:	[input]	
2.Reason Code:	PR2	Highlighted in yellow, red dashed arrow points to it.
Amount:	\$150.00	
Adjustment Quantity:	[input]	

Buttons for 'Add Another Reason Code' and 'Add Another Payer' are also visible.

- If you see the error code “Warning: Insurance Detail Reason Code(s) is Invalid”
- Check to make sure you did not enter the letters of the reason code as shown in the example

Institutional Claims Submission

Note: asterisks (*) denote required fields.

INSURANCE INFORMATION

To save the information, Click 'Basic Claim Form' button.

Does the Beneficiary have insurance other than Medicaid? Yes No

OTHER INSURANCE INFORMATION

1. Service Line Other Payer Information

Primary Payer Responsibility:	1#P#4444444#MB-Medicare Part I *	Amount Paid:	\$95.00 *	Remittance Date:	mm dd yyyy
1.Reason Code:	45	Amount:	\$385.00	Adjustment Quantity:	
2.Reason Code:	1	Amount:	\$20.00	Adjustment Quantity:	

1 (points to Primary Payer Responsibility and Amount Paid)

2 (points to Add Another Reason Code)

3 (points to Add Another Payer)

At the bottom of the **Claims** page, enter each Claim Line's insurance information:

1. Select **Insurance Info** to enter the other insurance payments and adjustments.
 - Complete the required fields indicated with an *.
2. Select **Add Another Reason Code** to add additional reason code and amount.
3. Reason codes must be entered with only the number. Do not enter "PR" or "CO".
 - Total + Adjustment Reason = Total amount billed to Medicaid.
4. After all primary insurance information is entered, select **Basic Claim Form** to return to the claim for submission.

Institutional Claims Submission



1



2

Adjustment codes must be proprietary and not from the commercial insurance. Go to x12.org

Filter by code:

Filter codes by status:

1	Deductible Amount <small>Start: 01/01/1995</small>
2	Coinsurance Amount <small>Start: 01/01/1995</small>
3	Co-payment Amount <small>Start: 01/01/1995</small>
4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 03/01/2020</small>
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 03/01/2018</small>
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
12	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>

3

1. Go to **Reference**, in the top right-hand corner.
2. Go to **Claim Adjustment Reason Codes**.
3. Scroll down to the proprietary code list and select a remark code that most accurately compares to the commercial code.
4. Enter this for the **Reason Code** on the other insurance form.

Institutional Claims Submission

Close
Submit Claim
Submit Claim

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code:

Service Date: mm dd yyyy

Last Date of Service: mm dd yyyy

Service Units: *

Total Line Charges: *

Operating Physician ID: (If different from header):

Other Operating Physician ID: (If different from header):

Rendering Physician ID: (If different from header):

Referring Physician ID: (If different from header):

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Modifiers: 1: 2: 3: 4:

HCPCS Description:

Characters Remaining:

Non-covered Line Charges:

Type:

Type:

Type:

Type:

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$0.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non covered Charges
			1	2	3	4	Service Date	Last DOS			

- At the bottom of the **Claims** page, Service Line items must be entered before Claim Submission
- After all lines of the claim are entered at the bottom of the claim submission form, if no primary insurance is being billed, select **Submit Claim**

Institutional Claims Attachment

The screenshot shows a web interface for submitting professional claim details. The top section, titled "Submitted Professional Claim Details", is highlighted with a red box. Below this title bar, there are three columns of input fields for TCN, Billing Provider ID, and Beneficiary ID. The TCN column includes fields for "Total Number of Lines" and "Total Claim Charge". The Billing Provider ID column includes fields for "Billing Provider Name" and "Date of Service". The Beneficiary ID column includes a field for "Beneficiary Name". Below these fields is a section titled "Cover Sheet" with a sub-header "Please select the document(s) to be mailed/faxed:". This section contains a grid of checkboxes for various document types: Hysterectomy Forms, History and Physical, Reports, EOB Insurance, Notes, Other (with an adjacent text input field), Medical Documentation, Predictive Modeling, Anesthesia Records, Ambulance, Forms, NDC Drug Dosing and Cost Info, Voluntary Sterilization Forms, and Diagnostic Tests. At the bottom right of the form, there are two buttons: "Generate Coversheet" and "Reset".

Once your claim is submitted, the BMS system displays the **Submitted Professional Claim Details**:

- Scroll down until you reach the **Additional Documents** section.

Institutional Claims Attachment

Print Help

Submitted Professional Claim Details

TCN: Billing Provider ID: Beneficiary ID:
Total Number of Lines: Billing Provider Name: Beneficiary Name:
Total Claim Charge: Date of Service:

Cover Sheet

Please select the document(s) to be mailed/faxed:

- Hysterectomy Forms
- History and Physical
- Reports
- EOB Insurance
- Notes
- Other
- Medical Documentation
- Predictive Modeling
- Anesthesia Records
- Ambulance
- Forms
- NDC Drug Dosing and Cost Info
- Voluntary Sterilization Forms
- Diagnostic Tests

Generate Coversheet Reset

Additional Documents

Save Delete

Document Type *	Document Name *	File Name * (Size < 30 MB)	Remarks	TCN
<input type="checkbox"/> --Select--	<input type="text" value="--Select--"/>	Choose File	<input type="text"/>	

Close

Select the type of electronic document to attach from the options listed or select a file from your computer:

Documents size is limited to 25 pages per attachment.

1. Select the **paper clip** icon, then search for and select a file to upload from your computer.
2. Select **Save** to save the file. A message displays “File Uploaded Successfully”.

Repeat these steps if you have multiple documents to attach to a claim.

Institutional Claims with Medicare Primary

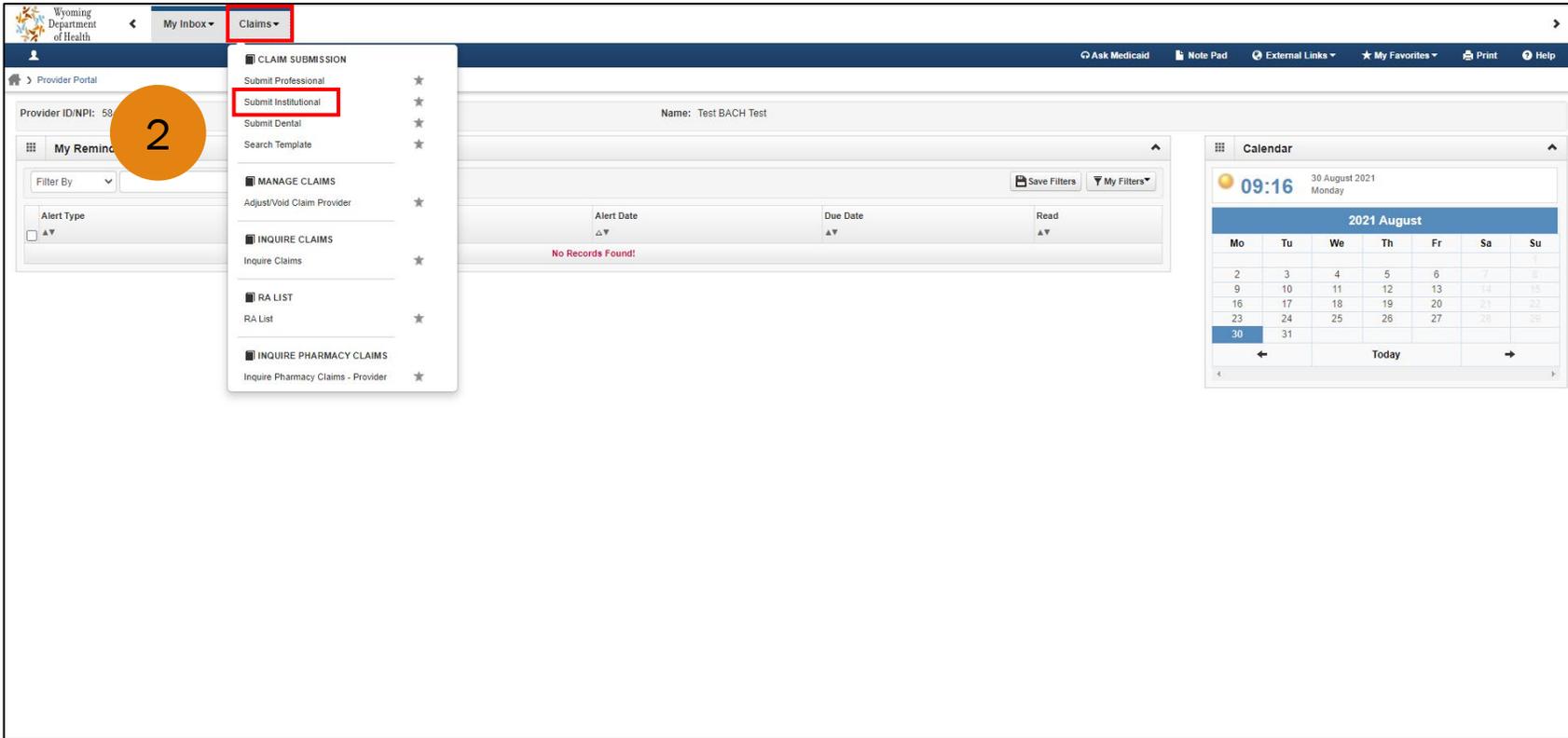
How to bill a Medicare Primary Claim

Institutional Claims Submission

- TPL (Third-Party Liability) is: Other insurance, other health insurance, other medical coverage, or other insurance coverage
- Medicare, Medicare replacement, Medicare supplemental plans, commercial companies like Blue Cross Blue Shield or Cigna, Disability, and Workman's comp are all examples of TPL.
- HMS is our TPL vendor and can be reached at 1-888-996-6223
 - Within the IVR say **Report TPL** or **Update insurance** to speak with someone.
- TPL can be direct billed, through a clearing house or from a Medicare if applicable
- An EOB or Explanation of Benefits is a document that is acquired from a primary insurance that explains what was paid and what reason or adjustment codes were applied to the over all payment

Institutional Claims Submission

1



To enter Institutional Claims in BMS:

1. Select **Claims**.
2. Select **Submit Institutional**.

Institutional Claims Submission

The screenshot shows the 'Institutional Claim' form with the following elements and annotations:

- Annotation 1:** A red box highlights the 'Provider ID' field containing '990000390'.
- Annotation 2:** A red box highlights the 'Taxonomy Code' field, which is currently empty.
- Annotation 3:** A red box highlights the 'ATTENDING PROVIDER INFORMATION' section at the bottom, which includes fields for 'Provider ID', 'Type', and 'Taxonomy Code'.
- Address Validation:** A blue message 'Address validation successful' is displayed. Below it, address fields are populated: 'Address Line 1: 504 W 17th St Ste 100', 'City/Town: Cheyenne', 'County: Laramie', and 'Zip Code: 82001 - 4347'. A 'Validate Address' button is highlighted with a red box and an orange arrow pointing to it from the text 'Select Validate Address'.

To enter Provider Information:
Required fields are indicated with an *.

1. National Provider Identifier (NPI) auto-populates in the **Provider ID** field. Confirm this is the correct NPI.
2. Enter in all caps the applicable **Taxonomy Code** associated with Provider.

The address auto-populates.

- Select **Validate Address**
3. Enter **Attending Provider Information**.

Institutional Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

Institutional Claim

Note: Asterisks (*) denote required fields.

Basic Claim Info

Provider | Beneficiary | Claim | Service Line

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: * Type: NPI * Taxonomy Code: *

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

State/Province: *

City/Town: *

Country: *

County:

Zip Code: * -

Address validation successful

BMS validates the address information and displays the following message “Address validation successful”.

- If a message displays “International Address,” change **Country** to **United States** and re-validate

Institutional Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

ATTENDING PROVIDER INFORMATION

Provider ID: * Type: * Taxonomy Code:

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: Middle Initials: Suffix:

Date of Birth: mm / dd / yyyy * Gender: *

Complete the required **Beneficiary Information** (Member data), required fields are indicated with an asterisk *:

- Beneficiary (Member) ID
- Last Name
- First Name
- Date of Birth
- Gender

Institutional Claims Submission

In order to process your claim, BMS also requires claim data about the patient.

The screenshot shows the 'Submit Institutional Claim' form in the Wyoming Department of Health Provider Portal. The 'CLAIM DATA' section is highlighted with a red box. The fields in this section are:

- Patient Control No.: *
- Medical Record No.:
- Type of Bill: *
- Statement Dates: From: mm dd yyyy * To: mm dd yyyy *
- Admission Date/Hour: mm dd yyyy - hh : mm
- Admission Type:
- Admission Source: *
- Discharge Hour: hh : mm
- Patient Status: *
- Principal Diagnosis Code: * POA: Auto Accident State/Province:
- Diagnosis Code Category: *

Complete the required fields indicated with an *:

- **Patient Control No** identifies the Medicaid Member
- **Type of Bill** is a 4-digit number
- **Statement Start and End Dates**
- **Admission Source** is needed
- **Patient Status**
- **Principal Diagnosis Code**
- **Diagnosis Code Category** defaults to **ICD-10**

Institutional Claims Submission

The screenshot shows a form with four sections: CONDITION INFORMATION, OCCURRENCE INFORMATION, OCCURRENCE SPAN INFORMATION, and VALUE INFORMATION. Three orange circles with numbers 1, 2, and 3 are placed above the form. Circle 1 is above the '1.Condition Code' field and its 'Add Another' button. Circle 2 is above the '1.Occurrence Code' and 'Occurrence Date' fields and their respective 'Add Another' buttons. Circle 3 is above the '1.Occurrence Span Code' field and its 'Add Another' button. Asterisks (*) indicate required fields.

Under **Condition Information**, **Occurrence Information** and **Occurrence Span Information**, required fields are indicated with an *:

1. Enter **Condition Code**. If there is more than one, select **Add Another**.
2. Enter **Occurrence Code** and **Occurrence Date**. If there is another code, select **Add Another**.
3. Enter **Occurrence Span Information**. If there is another span, select **Add Another**.

Institutional Claims Submission

1 VALUE INFORMATION

1.Value Code: *

Value Amount: *

2 DELAY REASON

Delay Reason Code: *

3 OTHER INSURANCE

11-Other
2-Litigation
15-Natural Disaster
3-Authorization Delays
4-Delay in Certifying Provider
7-Third Party Processing Delay
5-Delay in Supplying Billing Forms
8-Delay in Eligibility Determination
1-Proof of Eligibility Unknown or Unavailable
6-Delay in Delivery of Custom-made Appliances
9-Orgnl Cim Rjctd/Denied Due Unrelated Bling Lmttn
10-Administration Delay in the Prior Approval Process

Other Subscriber
Payer Responsibility
Payer ID Number
Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

1.Reason Code: Amount:
2.Reason Code: Amount:

Remittance Date: mm dd yyyy

Subscriber Member ID:
First Name: [State Code]: Suffix:

Beneficiary's Relationship:

Total COB Payer Paid Amount: *

Adjustment Quantity:
Adjustment Quantity:

Under **Value Code**, required fields are indicated with an *:

1. Enter **Value Code**.
2. Enter **Value Amount**. If there is another, select **Add Another**.
3. Select the applicable **Delay Reason**.

Institutional Claims Submission

OTHER INSURANCE INFORMATION

Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: *

Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

1.Reason Code: Amount:

2.Reason Code: Amount:

Remittance Date:

Subscriber Member ID:

First Name: [State Code]: Suffix:

Beneficiary's Relationship:

Total COB Payer Paid Amount: *

Adjustment Quantity:

Adjustment Quantity:

If the Member has other insurance besides Medicaid, this can be Commercial or Medicare:

- 1. Payer Responsibility** will be primary or secondary or tertiary in some cases.
- 2. Payer ID Number** can default to 99999, or you can find the Payer ID Number at: [Payer ID List](#).
- 3. Enter Insured's Group or Policy number and Claim Filing Indicator**, along with **Total COB Payer Paid Amount**. This is the amount that the Primary Insurance paid.

Institutional Claims Submission

Wyoming Department of Health
My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

PRIOR AUTHORIZATION/PRO/REFERRAL NUMBER

Prior Authorization Number: Agency PA: Yes No PRO Number:

Referral Number:

DIAGNOSIS INFORMATION (Do not use decimals or spaces)

PROCEDURE INFORMATION

OPERATING PHYSICIAN INFORMATION

OTHER OPERATING PHYSICIAN INFORMATION

RENDERING PHYSICIAN INFORMATION

REFERRING PHYSICIAN INFORMATION

CLAIM NOTE

Does this claim have backup documentation? Yes No

If your claim requires a Prior Authorization (PA), complete the fields for the **Prior Authorization/Pro/Referral Number**:

- **Prior Authorization Number**
- For **Agency PA**, select **Yes** or **No**.

This is all the information you will need. *PRO number and Referral number are not needed*

PAs are not needed for every claim.

Institutional Claims Submission

The screenshot shows a form titled "DIAGNOSIS INFORMATION (Do not use decimals or spaces)". It contains several input fields and buttons. Three orange circles with numbers 1, 2, and 3 are overlaid on the form to indicate key steps:

- 1**: A red box highlights the "Admitting Diagnosis Code" input field.
- 2**: A red box highlights the "Add Another" button located below the "Reason For Visit" section.
- 3**: A red box highlights the "Add Another" button located below the "Other Diagnosis Information" section.

Under **Diagnosis Information**:

1. Enter **Admitting Diagnosis Code**.

Do not place a "." when adding information, as the system will not recognize it.

Example: Enter F402 instead of F4.20.

2. Select **Add Another** to add other diagnosis codes.
3. To add more of the Admitting or Other Diagnosis codes, select **Add Another**.

Diagnosis codes may not always be applicable.

Institutional Claims Submission

<input type="checkbox"/> OPERATING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> OTHER OPERATING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> RENDERING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> REFERRING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *

Operating, Rendering, and Referring Physician Information:

If applicable, complete the required fields indicated with an *.

In **Provider ID** field, use NPI or Provider ID for Identification Number.

Not all claims require this information.

Institutional Claims Submission

1

Does this claim have backup documentation? Yes No

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: 2

HCPCS Code:

Service Date:

Last Date of Service:

Service Units: 3

Total Line Charges:

Operating Physician ID: (If different from header):

Other Operating Physician ID: (If different from header):

Rendering Physician ID: (If different from header):

Referring Physician ID: (If different from header):

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Modifiers: 1: 2: 3: 4:

HCPCS Description: Characters Remaining: 80

Non-covered Line Charges:

Type:

Type:

Type:

Type:

Add Service Line Item

Service Line Item Information is required to process the claim, all required fields are indicated with an *:

1. Select **Yes** for **Does this claim have backup documentation** for items such as OP notes or sterilization forms. This suspends the claim for 30 days for processing attachments.
2. Enter **Revenue Code**.
3. Enter **Service Units** and **Total Line Charges**.
4. Select **Add Service Line Item**. Repeat for additional revenue codes.
5. Other fields can be completed, if applicable.

Institutional Claims Submission

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$200.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pointer				Submitted Charges	Units	Prior Auth Number	
	From	To		1	2	3	4	1	2	3	4				
1	03/02/2022	03/02/2022	T2027								200.00	1		Enter Insurance Info <input type="button" value="Copy"/> <input type="button" value="Delete"/>	

[Enter Insurance Info](#)

At the bottom of the **Claims** page, enter each Claim Line's insurance information:

- Select **Insurance Info** to enter the other insurance payments and adjustments.

Institutional Claims Submission

Payee: Dr. Sample 123 Anywhere Dr Cheyenne, Wyoming 82009	Date: 01/21/2022 TIN: 12345679 Reference ID: 98765452 Amount: \$5682.05
Payer: WY Medicare 900 42 nd Street South Fargo ND, 58103	
Claims: (1)	Claim Status: 19 Claim Amount: 189.00
Patient Name: John Smith	Paid Amount: 86.29
Patient ID: 3GR2W94GE64	Pt Responsibility: 27.17
Payer Claim ID: 6548061301856241850	
Provider Claim ID: 315487	
Received Date: 01/11/2022	
Outpatient: MA0 MA04	
Adjudication: MA18	

Claim Status Description : Processed as Primary, Forwarded to Additional Payer(s). Forwarded to : **UNITEDHEALTH**
GROUP : 30002

Serv Date	Units	Serv Code	Billed	Paid	Allowed Adjustments
08/25/2021 - 08/25/2021	1	HC:99214	\$189.00	\$88.69	\$110.86 CO-45: \$78.14 PR-2: \$22.17

Adjustment Group Codes
CO : Contractual Obligations
PR : Patient Responsibility

Adjustment Reason Codes
1 : Deductible Amount
2 : Coinsurance Amount
45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
49 : This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
144 : Incentive adjustment, e.g. preferred product/service.

Remark Codes
MA01 : Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA07 : Alert: The claim information has also been forwarded to Medicaid for review.
MA18 : Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
N429 : Not covered when considered routine.
N782 : Alert: No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance.
N807 : Payment adjustment based on the Merit-based Incentive Payment System (MIPS).

This is an example of a Medicare EOB.

- Details on payment from Medicare
- Remark and Adjustment Codes
- Member information

Institutional Claims Submission

The screenshot displays a web form for a Professional Claim. At the top, there are buttons for 'Close', 'Basic Claim Form', and 'Reset'. A red warning message reads: "Warning: Insurance Detail Reason Code(s) is invalid." with a red dashed arrow pointing to the reason code fields. Below the warning, the form is titled "Professional Claim" and includes a note: "Note: asterisks (*) denote required fields." The "INSURANCE INFORMATION" section contains a question: "Does the Beneficiary have insurance other than Medicaid?" with radio buttons for "Yes" (selected) and "No". The "OTHER INSURANCE INFORMATION" section is titled "1. Service Line Other Payer Information" and includes the following fields:

Field	Value	Notes
Primary Payer Responsibility:	1#P#99999#CI-Commercial Insuran	Required field (*)
Amount Paid:	\$100.00	Required field (*)
Remittance Date:	mm dd yyyy	mm: [input], dd: [input], yyyy: [input]
1.Reason Code:	CO45	Highlighted in yellow, red dashed arrow points to it.
Amount:	\$50.00	
Adjustment Quantity:	[input]	
2.Reason Code:	PR2	Highlighted in yellow, red dashed arrow points to it.
Amount:	\$150.00	
Adjustment Quantity:	[input]	

Buttons for "Add Another Reason Code" and "Add Another Payer" are also visible.

- If you see the error code “Warning: Insurance Detail Reason Code(s) is Invalid”
- Check to make sure you did not enter the letters of the reason code as shown in the example

Institutional Claims Submission

Provider Portal > Submit Professional Claim

Close Basic Claim Form Select Basic Claim Form

Professional Claim

Note: asterisks (*) denote required fields.

INSURANCE INFORMATION

To save the information, Click 'Basic Claim Form' button.

Does the Beneficiary have insurance other than Medicaid? Yes No

OTHER INSURANCE INFORMATION

1. Service Line Other Payer Information

Primary Payer Responsibility:	1#P#44444444#MB-Medicare Part I *	Amount Paid:	\$88.69 *	Remittance Date:	mm dd yyyy
1.Reason Code:	45	Amount:	\$78.14	Adjustment Quantity:	<input type="text"/>
2.Reason Code:	2	Amount:	\$22.17	Adjustment Quantity:	<input type="text"/>

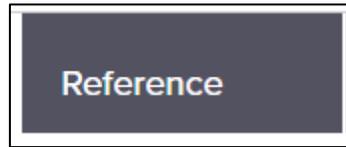
Add Another Reason Code

Add Another Payer

At the bottom of the **Claims** page, enter each Claim Line's insurance information:

1. Select **Insurance Info** to enter the other insurance payments and adjustments.
 - Fill in all the required fields indicated with an *.
2. Select **Add Another Reason Code** to add additional reason code and amount.
 - Reason codes must be entered with only the number. Do not put "PR" or "CO".
 - Total + Adjustment Reason = Total amount billed to Medicaid.
3. After all primary insurance information is entered select **Basic Claim Form** to return to the claim for submission.

Institutional Claims Submission



1



2

Adjustment codes must be proprietary and not from the commercial insurance. Go to x12.org

Filter by code:

Filter codes by status:

1	Deductible Amount <i>Start: 01/01/1995</i>
2	Coinsurance Amount <i>Start: 01/01/1995</i>
3	Co-payment Amount <i>Start: 01/01/1995</i>
4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 01/01/1995 Last Modified: 03/01/2020</i>
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 01/01/1995 Last Modified: 03/01/2018</i>
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 01/01/1995 Last Modified: 07/01/2017</i>
7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 01/01/1995 Last Modified: 07/01/2017</i>
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 01/01/1995 Last Modified: 07/01/2017</i>
9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 01/01/1995 Last Modified: 07/01/2017</i>
10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 01/01/1995 Last Modified: 07/01/2017</i>
11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 01/01/1995 Last Modified: 07/01/2017</i>
12	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 01/01/1995 Last Modified: 07/01/2017</i>

3

1. Go to **Reference**, in the top right-hand corner.
2. Go to **Claim Adjustment Reason Codes**.
3. Scroll down to the proprietary code list and select a remark code that most accurately compares to the commercial code.
4. Enter this for the **Reason Code** on the other insurance form.

Institutional Claims Submission

Close Submit Claim Submit Claim

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code: Modifiers: 1: 2: 3: 4:

Service Date: mm dd yyyy
 HCPCS Description:

Last Date of Service: mm dd yyyy
 Characters Remaining:

Service Units: *

Total Line Charges: *

Operating Physician ID: (If different from header):

Other Operating Physician ID: (If different from header):

Rendering Physician ID: (If different from header):

Referring Physician ID: (If different from header):

Non-covered Line Charges:

Type:

Type:

Type:

Type:

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$0.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non covered Charges
			1	2	3	4	Service Date	Last DOS			

- At the bottom of the **Claims** page, Service Line items must be entered before Claim Submission
- After all lines of the claim are entered at the bottom of the claim submission form, if no primary insurance is being billed, select **Submit Claim**

Institutional Claims Attachment

The screenshot shows a web interface for submitting professional claim details. The top section, titled "Submitted Professional Claim Details", is highlighted with a red box. Below this title bar, there are three columns of input fields for "TCN:", "Billing Provider ID:", and "Beneficiary ID:". Each column contains three sub-fields: "Total Number of Lines:", "Total Claim Charge:", "Billing Provider Name:", and "Date of Service:". Below the input fields is a section titled "Cover Sheet" with a sub-header "Please select the document(s) to be mailed/faxed:". This section contains a grid of checkboxes for various document types: Hysterectomy Forms, History and Physical, Reports, EOB Insurance, Notes, Other (with an adjacent text input field), Medical Documentation, Predictive Modeling, Anesthesia Records, Ambulance, Forms, NDC Drug Dosing and Cost Info, Voluntary Sterilization Forms, and Diagnostic Tests. At the bottom right of the form, there are two buttons: "Generate Coversheet" and "Reset".

Once your claim is submitted, the BMS system displays the **Submitted Professional Claim Details**:

- Scroll down until you reach the **Additional Documents** section.

Institutional Claims Attachment

Print Help

Submitted Professional Claim Details

TCN: Billing Provider ID: Beneficiary ID:
Total Number of Lines: Billing Provider Name: Beneficiary Name:
Total Claim Charge: Date of Service:

Cover Sheet

Please select the document(s) to be mailed/faxed:

<input type="checkbox"/> Hysterectomy Forms	<input type="checkbox"/> Medical Documentation	<input type="checkbox"/> Forms
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Predictive Modeling	<input type="checkbox"/> NDC Drug Dosing and Cost Info
<input type="checkbox"/> Reports	<input type="checkbox"/> Anesthesia Records	<input type="checkbox"/> Voluntary Sterilization Forms
<input type="checkbox"/> EOB Insurance	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Diagnostic Tests
<input type="checkbox"/> Notes		
<input type="checkbox"/> Other <input type="text"/>		

Generate Coversheet Reset

Additional Documents

Save Delete

Document Type *	Document Name *	File Name * (Size < 30 MB)	Remarks	TCN
<input type="checkbox"/> --Select--	<input type="text" value="--Select--"/>	Choose File	<input type="text"/>	

Close

Select the type of electronic document to attach from the options listed or select a file from your computer:

Documents size is limited to 25 pages per attachment.

1. Select the **paper clip** icon, then search for and select a file to upload from your computer.
2. Select **Save** to save the file. A message displays “File Uploaded Successfully”.

Repeat these steps if you have multiple documents to attach to a claim.

Institutional Claims with Tertiary TPL

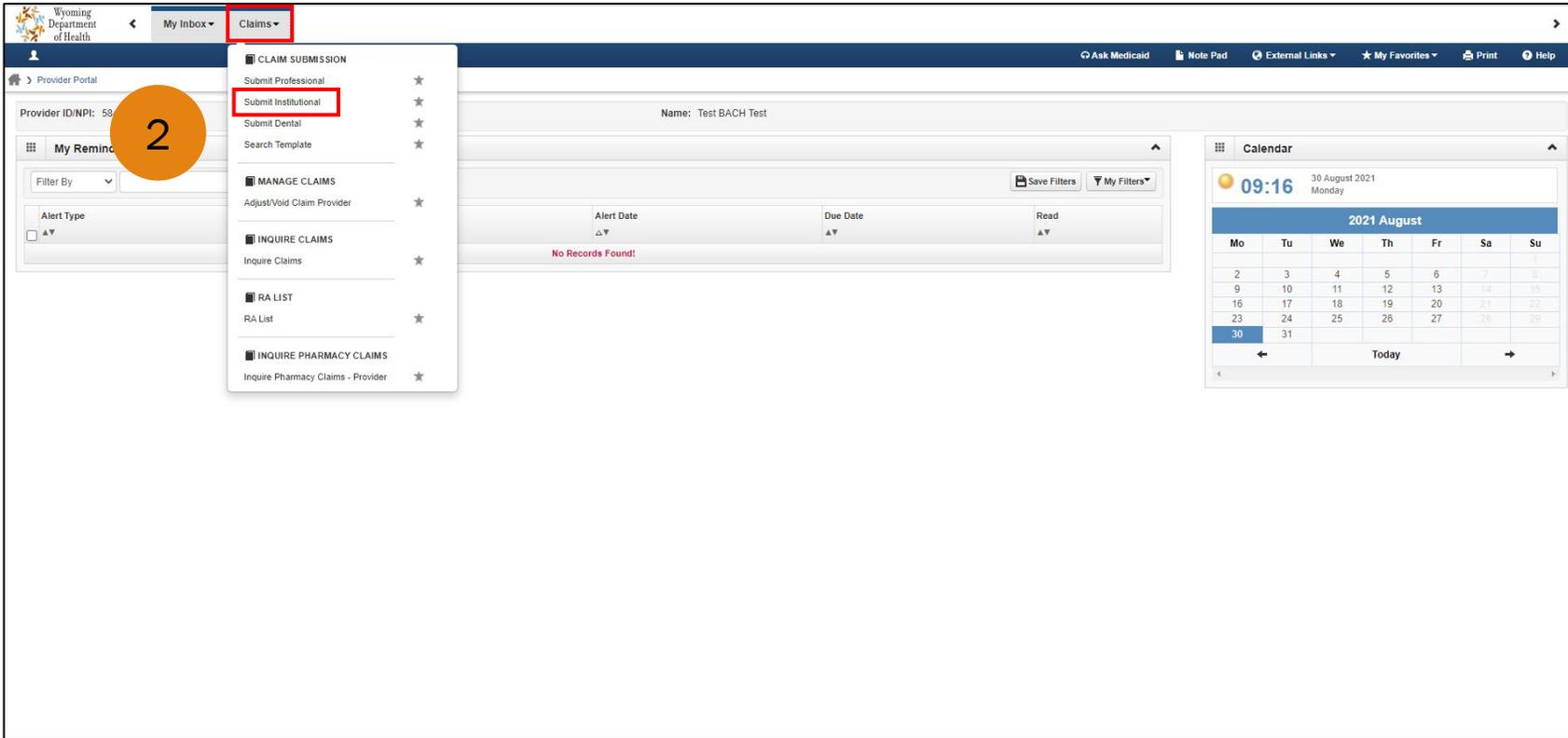
How to bill a Tertiary Third-Party Liability (TPL) Claim

Institutional Claims Submission

- TPL (Third-Party Liability) is: Other insurance, other health insurance, other medical coverage, or other insurance coverage
- Medicare, Medicare replacement, Medicare supplemental plans, commercial companies like Blue Cross Blue Shield or Cigna, Disability, and Workman's comp are all examples of TPL.
- HMS is our TPL vendor and can be reached at 1-888-996-6223
 - Within the IVR say **Report TPL** or **Update insurance** to speak with someone.
- TPL can be direct billed, through a clearing house or from a Medicare if applicable
- An EOB or Explanation of Benefits is a document that is acquired from a primary insurance that explains what was paid and what reason or adjustment codes were applied to the over all payment

Institutional Claims Submission

1



To enter Institutional Claims in BMS:

1. Select **Claims**.
2. Select **Submit Institutional**.

Institutional Claims Submission

The screenshot shows the 'Institutional Claim' form with the following elements and annotations:

- 1**: A red box highlights the 'Provider ID' field containing the value '900000390'.
- 2**: A red box highlights the 'Taxonomy Code' field, which is currently empty.
- 3**: A red box highlights the 'ATTENDING PROVIDER INFORMATION' section at the bottom of the form, which includes fields for 'Provider ID', 'Type', and 'Taxonomy Code'.
- An orange arrow points to the 'Validate Address' button, with a callout box containing the text 'Select Validate Address'.
- The form also displays 'Address validation successful' in blue text.

To enter Provider Information:
Required fields are indicated with an *.

1. National Provider Identifier (NPI) auto-populates in the **Provider ID** field. Confirm this is the correct NPI.
2. Enter in all caps the applicable **Taxonomy Code** associated with Provider.

The address auto-populates.

- Select **Validate Address**
3. Enter **Attending Provider Information**.

Institutional Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

Institutional Claim

Note: Asterisks (*) denote required fields.

Basic Claim Info

Provider | Beneficiary | Claim | Service Line

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: * Type: NPI * Taxonomy Code: *

Address Line 1: 508 Livingston Ave *
(Enter Street Address or PO Box Only)

Address Line 2: *

Address Line 3: *

State/Province: WYOMING *
Country: UNITED STATES *

Address Line 2: *

City/Town: Cheyenne *
County: Laramie *
Zip Code: 82007 * - 1966 * Validate Address

Address validation successful

BMS validates the address information and displays the following message “Address validation successful”

- If a message displays “International Address,” change **Country** to **United States** and re-validate

Institutional Claims Submission

Does the beneficiary have insurance other than Medicaid? Yes No

OTHER INSURANCE INFORMATION

Other Subscriber Information

Payer Responsibility Code:	P-Primary *	Remittance Date:	mm dd yyyy
Payer ID Number:	99999 *	Subscriber Member ID:	
Subscriber Last Name:		First Name:	[State Code]:
		Suffix:	
Insured's Group or Policy Number:	1234568798af *	Beneficiary's Relationship:	
Claim Filing Indicator:	CI-Commercial Insurance Co. *	Total COB Payer Paid Amount:	\$0.00 *

- Select **Yes** to **Does the beneficiary have insurance other than Medicaid**
- **Payer Responsibility Code** for one TPL will be **Primary**
- **Payer ID** can be found at [Primary Payer ID list](#)
- **Insured's Group or Policy Number** is the Primary ID number
- **Claim Filing Indicator** is the type of insurance (such as Medicare or Commercial)
- **Total COB Payer Paid Amount** is the Total amount TPL paid

Institutional Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

ATTENDING PROVIDER INFORMATION

Provider ID: * Type: * Taxonomy Code:

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: Middle Initials: Suffix:

Date of Birth: mm / dd / yyyy * Gender: *

Complete the required **Beneficiary Information** (Member data), required fields are indicated with an asterisk *:

- Beneficiary (Member) ID
- Last Name
- First Name
- Date of Birth
- Gender

Institutional Claims Submission

In order to process your claim, BMS also requires claim data about the patient.

The screenshot shows the 'Submit Institutional Claim' form in the Wyoming Department of Health Provider Portal. The 'CLAIM DATA' section is highlighted with a red box. The fields in this section are:

- Patient Control No.: *
- Medical Record No.:
- Type of Bill: * (Enter 4 digits with leading zero.)
- Statement Dates: From: mm dd yyyy * To: mm dd yyyy *
- Admission Date/Hour: mm dd yyyy - hh : mm
- Admission Type:
- Admission Source: *
- Discharge Hour: hh : mm
- Patient Status: *
- Principal Diagnosis Code: * POA:
- Diagnosis Code Category: *
- Auto Accident State/Province:

Complete the required fields indicated with an *:

- **Patient Control No** identifies the Medicaid Member
- **Type of Bill** is a 4-digit number
- **Statement Start and End Dates**
- **Admission Source** is needed
- **Patient Status**
- **Principal Diagnosis Code**
- **Diagnosis Code Category** defaults to **ICD-10**

Institutional Claims Submission

The screenshot shows a form with four sections: CONDITION INFORMATION, OCCURRENCE INFORMATION, OCCURRENCE SPAN INFORMATION, and VALUE INFORMATION. The first three sections have 'Add Another' buttons. Callout 1 is above the '1.Condition Code' field and its 'Add Another' button. Callout 2 is above the '1.Occurrence Code' and 'Occurrence Date' fields and their 'Add Another' button. Callout 3 is above the '1.Occurrence Span Code', 'From Date', and 'Through Date' fields and their 'Add Another' button.

Under **Condition Information**, **Occurrence Information**, and **Occurrence Span Information**, required fields are indicated with an *:

1. Enter **Condition Code**. If there is more than one, select **Add Another**.
2. Enter **Occurrence Code** and **Occurrence Date**. If there is another code, select **Add Another**.
3. Enter **Occurrence Span Information**. If there is another span, select **Add Another**.

Institutional Claims Submission

1 VALUE INFORMATION

1.Value Code: *

Value Amount: *

2 DELAY REASON

Delay Reason Code: *

3

OTHER INSURANCE

Other Subscriber

Payer Responsibility

Payer ID Number

Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

1.Reason Code: Amount:

2.Reason Code: Amount:

Remittance Date: mm dd yyyy

Subscriber Member ID:

First Name: [State Code]: Suffix:

Beneficiary's Relationship:

Total COB Payer Paid Amount: *

Adjustment Quantity:

Adjustment Quantity:

Under **Value Code**, required fields are indicated with an *:

1. Enter **Value Code**.
2. Enter **Value Amount**. If there is another, select **Add Another**.
3. Select the applicable **Delay Reason**.

Institutional Claims Submission

OTHER INSURANCE INFORMATION

Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: *

Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

1.Reason Code: Amount:

2.Reason Code: Amount:

Remittance Date:

Subscriber Member ID:

First Name: [State Code]: Suffix:

Beneficiary's Relationship:

Total COB Payer Paid Amount: *

Adjustment Quantity:

Adjustment Quantity:

If the Member has other insurance besides Medicaid, this can be Commercial or Medicare:

- 1. Payer Responsibility** will be primary or secondary or tertiary in some cases.
- 2. Payer ID Number** can default to 99999, or you can find the Payer ID Number at: [Payer ID List](#).
- 3. Enter Insured's Group or Policy number and Claim Filing Indicator**, along with **Total COB Payer Paid Amount**. This is the amount that the Primary Insurance paid.

Institutional Claims Submission

Wyoming Department of Health
My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Institutional Claim

Close Submit Claim Save as Template Reset

PRIOR AUTHORIZATION/PRO/REFERRAL NUMBER

Prior Authorization Number: Agency PA: Yes No PRO Number:

Referral Number:

DIAGNOSIS INFORMATION (Do not use decimals or spaces)

PROCEDURE INFORMATION

OPERATING PHYSICIAN INFORMATION

OTHER OPERATING PHYSICIAN INFORMATION

RENDERING PHYSICIAN INFORMATION

REFERRING PHYSICIAN INFORMATION

CLAIM NOTE

Does this claim have backup documentation? Yes No

If your claim requires a Prior Authorization (PA), complete the fields for the **Prior Authorization/Pro/Referral Number**:

- **Prior Authorization Number**
- For **Agency PA**, select **Yes** or **No**.

This is all the information you will need. *PRO number and Referral number are not needed*

PAs are not needed for every claim.

Institutional Claims Submission

1

DIAGNOSIS INFORMATION (Do not use decimals or spaces)

Admitting Diagnosis Code:

Reason For Visit:

1: PPS/DRG: **2**

2: 3:

E-Code: POA:

3

Other Diagnosis Information

1. Other Diagnosis Code: * POA:

Under **Diagnosis Information**:

1. Enter **Admitting Diagnosis Code**.

Do not place a “.” when adding information, as the system will not recognize it.

Example: Enter F402 instead of F4.20.

2. Select **Add Another** to add other diagnosis codes.
3. To add more of the Admitting or Other Diagnosis codes, select **Add Another**.

Diagnosis codes may not always be applicable.

Institutional Claims Submission

<input type="checkbox"/> OPERATING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> OTHER OPERATING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> RENDERING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *
<input type="checkbox"/> REFERRING PHYSICIAN INFORMATION	
Provider ID: <input type="text"/> *	Type: <input type="text"/> ▼ *

Operating, Rendering, and Referring Physician Information:

If applicable, complete the required fields indicated with an *.

In **Provider ID** field, use NPI or Provider ID for Identification Number.

Not all claims require this information.

Institutional Claims Submission

1

Does this claim have backup documentation? Yes No

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code: *

Service Date: mm dd yyyy

Last Date of Service: mm dd yyyy

Service Units: *

Total Line Charges: *

Operating Physician ID: (If different from header):

Other Operating Physician ID: (If different from header):

Rendering Physician ID: (If different from header):

Referring Physician ID: (If different from header):

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Modifiers: 1: 2: 3: 4:

HCPCS Description: Characters Remaining: 80

Non-covered Line Charges:

Type:

Type:

Type:

Type:

Add Service Line Item

Service Line Item Information is required to process the claim, all required fields are indicated with an *:

1. Select **Yes** for **Does this claim have backup documentation** for items such as OP notes or sterilization forms. This suspends the claim for 30 days for processing attachments.
2. Enter **Revenue Code**.
3. Enter **Service Units** and **Total Line Charges**.
4. Select **Add Service Line Item**. Repeat for additional revenue codes.
 - Other fields can be completed, if applicable.

Institutional Claims Submission

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$200.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pointer				Submitted Charges	Units	Prior Auth Number		
	From	To		1	2	3	4	1	2	3	4					
1	03/02/2022	03/02/2022	T2027									200.00	1			Enter Insurance Info <input type="button" value="Copy"/> <input type="button" value="Delete"/>

[Enter Insurance Info](#)

At the bottom of the **Claims** page, enter each Claim Line's insurance information:

1. Select **Edit Insurance Info** to enter the other insurance payments and adjustments.
 - Complete all required fields indicated with an *.
2. Select **Add Another Reason Code** to add additional reason code and amount.
3. Select **Add Another Payer** to items for Secondary/Tertiary Payer.
4. The **Amount Paid** for this line + Reason Amounts must = Billed Amount.

Institutional Claims Submission

Medicare Sample EOB

Payee: Dr. Sample
123 Anywhere Dr
Cheyenne, Wyoming
82009

Date: 01/21/2022
TIN: 12345679
Reference ID: 98765452
Amount: \$5682.05

Payer: WY Medicare
900 42nd Street South
 Fargo ND, 58103

Claims: (1)
Patient Name: John Smith
Patient ID: 3GR2W94GE64
Payer Claim ID: 6548061301856241850
Provider Claim ID: 315487
Received Date: 01/11/2022
Outpatient: MAO MAO4
Adjudication: MA18

Claim Status: 19
Claim Amount: 189.00
Paid Amount: 86.29
Pt Responsibility: 27.17

Claim Status Description : Processed as Primary, Forwarded to Additional Payer(s). Forwarded to : UNITEDHEALTH
GROUP : 30002

Serv Date	Units	Serv Code	Billed	Paid	Allowed Adjustments
08/25/2021 - 08/25/2021	1	HC:99214	\$189.00	\$88.69	\$110.86 CO-45: \$78.14 PR-2: \$22.17

Adjustment Group Codes
CO : Contractual Obligations
PR : Patient Responsibility

Adjustment Reason Codes
1 : Deductible Amount
2 : Coinsurance Amount
45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
49 : This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
144 : Incentive adjustment, e.g. preferred product/service.

Remark Codes
MA01 : Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA07 : Alert: The claim information has also been forwarded to Medicaid for review.
MA18 : Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
N429 : Not covered when considered routine.
N782 : Alert: No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance.
N807 : Payment adjustment based on the Merit-based Incentive Payment System (MIPS).

For a Tertiary Claim, you will have 2 EOBs:

- The secondary insurance will have an adjustment reason code of **23**. This is to signify payment of other payer
- Other payers' amount + adjustments will equal the total billed amount to Medicaid

Claim Status Description : Processed as Secondary

Serv Date	Units	Serv Code	Billed	Paid	Allowed Adjustments
08/25/2021 - 08/25/2021	0	HC:99214	\$189.00	\$11.09	\$110.86 OA-23: \$166.83 PR-2: \$11.08

Adjustment Group Codes
OA : Other adjustments
PR : Patient Responsibility

Adjustment Reason Codes
2 : Coinsurance Amount
23 : The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)

Institutional Claims Submission

To save the information, Click 'Basic Claim Form' button.

Does the Beneficiary have insurance other than Medicaid? Yes No

OTHER INSURANCE INFORMATION

1. Service Line Other Payer Information

Primary Payer Responsibility:	<input type="text" value="1#P#44444444#MB-Medicare Part E"/>	*	1	Amount Paid:	<input type="text" value="\$86.89"/>	*	2	Remittance Date:	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>
1.Reason Code:	<input type="text" value="45"/>		3	Amount:	<input type="text" value="\$78.14"/>			Adjustment Quantity:	<input type="text"/>	<input type="button" value="Add Another Reason Code"/>	
2.Reason Code:	<input type="text" value="2"/>			Amount:	<input type="text" value="\$22.17"/>			Adjustment Quantity:	<input type="text"/>		

Add Another Payer

Enter information from the EOB:

1. Enter your 1st insurance in **Primary Payer Information**.
2. Enter total **Amount Paid** by the first payer only.
3. Enter your reason codes from the EOB in **Reason Code** fields.

Your billed amount from Medicare must equal total amount billed to Medicaid.

In this example Total paid (\$86.89) + Adjustment Reason (\$78.17+22.17) = Total amount billed to Medicaid. \$189.00. This will balance the first line

4. Select **Add Another Payer**.

Institutional Claims Submission

The screenshot displays the 'Professional Claim' form. At the top, there are buttons for 'Close', 'Basic Claim Form', and 'Reset'. Below this is a section for 'INSURANCE INFORMATION' with a note: 'Note: asterisks (*) denote required fields.' A question asks 'Does the Beneficiary have insurance other than Medicaid?' with 'Yes' selected. The form is divided into two sections: '1. Service Line Other Payer Information' and '2. Service Line Other Payer Information'. Each section contains a 'Primary Payer Responsibility' dropdown, an 'Amount Paid' field, and a 'Remittance Date' field. Below these are two 'Reason Code' fields, each with an 'Amount' field. The first service line has a Primary Payer Responsibility of '1#P#99999#MB-Medicare Part B', an Amount Paid of '\$100.00', Reason Code 45 with Amount \$50.00, and Reason Code 2 with Amount \$50.00. The second service line has a Primary Payer Responsibility of '2#S#99999#CI-Commercial Insuran', an Amount Paid of '\$25.00', Reason Code 45 with Amount \$75.00, and Reason Code 23 with Amount \$100.00. Red boxes highlight the Primary Payer Responsibility, Amount Paid, Reason Code, and Amount fields for both service lines. A red arrow points to the 'Basic Claim Form' button at the top.

- Like your first line, the second line must balance.
- Your secondary insurance will have an adjustment code of **23** showing what the primary payer paid. You must enter this.
- Total + Adjustment Reason = Total amount billed to Medicaid.
- After all primary insurance information is entered, select **Basic Claim Form** to return to the claim for submission.

Institutional Claims Submission



1



2

Adjustment codes must be proprietary and not from the commercial insurance. Go to x12.org

Filter by code: Filter codes by status:

1	Deductible Amount <small>Start: 01/01/1995</small>
2	Coinsurance Amount <small>Start: 01/01/1995</small>
3	Co-payment Amount <small>Start: 01/01/1995</small>
4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 03/01/2020</small>
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 03/01/2018</small>
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
12	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>

3

1. Go to **Reference**, in the top right-hand corner.
2. Go to **Claim Adjustment Reason Codes**.
3. Scroll down to the proprietary code list and select a remark code that most accurately compares to the commercial code.
4. Enter this for the **Reason Code** on the other insurance form.

Institutional Claims Submission

Submit Claim

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code: Modifiers: 1: 2: 3: 4:

Service Date: mm dd yyyy
 HCPCS Description:

Last Date of Service: mm dd yyyy
 Characters Remaining:

Service Units: *

Total Line Charges: *

Operating Physician ID: (If different from header):

Other Operating Physician ID: (If different from header):

Rendering Physician ID: (If different from header):

Referring Physician ID: (If different from header):

Non-covered Line Charges:

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Type:

Type:

Type:

Type:

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$0.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non covered Charges
			1	2	3	4	Service Date	Last DOS			

- At the bottom of the **Claims** page, Service Line items must be entered before Claim Submission
- After all lines of the claim are entered at the bottom of the claim submission form, if no primary insurance is being billed, select **Submit Claim**

Institutional Claims Attachment

The screenshot shows a web interface for submitting professional claim details. The top section, titled "Submitted Professional Claim Details", is highlighted with a red box. Below this title bar, there are three columns of input fields for TCN, Billing Provider ID, and Beneficiary ID. The TCN column includes fields for "Total Number of Lines" and "Total Claim Charge". The Billing Provider ID column includes fields for "Billing Provider Name" and "Date of Service". The Beneficiary ID column includes a field for "Beneficiary Name". Below these fields is a section titled "Cover Sheet" with a sub-header "Please select the document(s) to be mailed/faxed:". This section contains a grid of checkboxes for various document types: Hysterectomy Forms, History and Physical, Reports, EOB Insurance, Notes, Other (with an adjacent text input field), Medical Documentation, Predictive Modeling, Anesthesia Records, Ambulance, Forms, NDC Drug Dosing and Cost Info, Voluntary Sterilization Forms, and Diagnostic Tests. At the bottom right of the form, there are two buttons: "Generate Coversheet" and "Reset".

Once your claim is submitted, the BMS system displays the **Submitted Professional Claim Details**:

- Scroll down until you reach the **Additional Documents** section.

Institutional Claims Attachment

Print Help

Submitted Professional Claim Details

TCN: Billing Provider ID: Beneficiary ID:
Total Number of Lines: Billing Provider Name: Beneficiary Name:
Total Claim Charge: Date of Service:

Cover Sheet

Please select the document(s) to be mailed/faxed:

- Hysterectomy Forms
- History and Physical
- Reports
- EOB Insurance
- Notes
- Other
- Medical Documentation
- Predictive Modeling
- Anesthesia Records
- Ambulance
- Forms
- NDC Drug Dosing and Cost Info
- Voluntary Sterilization Forms
- Diagnostic Tests

Generate Coversheet Reset

Additional Documents

Save Delete

Document Type *	Document Name *	File Name * (Size < 30 MB) ⓘ	Remarks	TCN
--Select--	--Select--	Choose File	<input type="text"/>	

Close

Select the type of electronic document to attach from the options listed or select a file from your computer:

Documents size is limited to 25 pages per attachment.

1. Select the **paper clip** icon, then search for and select a file to upload from your computer.
2. Select **Save** to save the file. A message displays “File Uploaded Successfully”.

Repeat these steps if you have multiple documents to attach to a claim.

Course Review

- Institutional Claim Overview
- Institutional Claim Submissions
- Institutional Claim with Third-Party Liability (TPL)
- Institutional Claim with Tertiary Third-Party Liability (TPL)
- Institutional Claim Attachments





Wyoming
Department
of Health

Thank you

Claim Transaction