



Wyoming
Department
of Health

Professional Claims

Professional Claims Submission

Course Content

- Professional Claims Overview
- Professional Claims Submissions
- Professional Claims Third-Party Liability (TPL)
- Professional Claims with Medicare Primary
- Professional Claims with Tertiary TPL
- Professional Claims Attachments



Professional Claims Overview

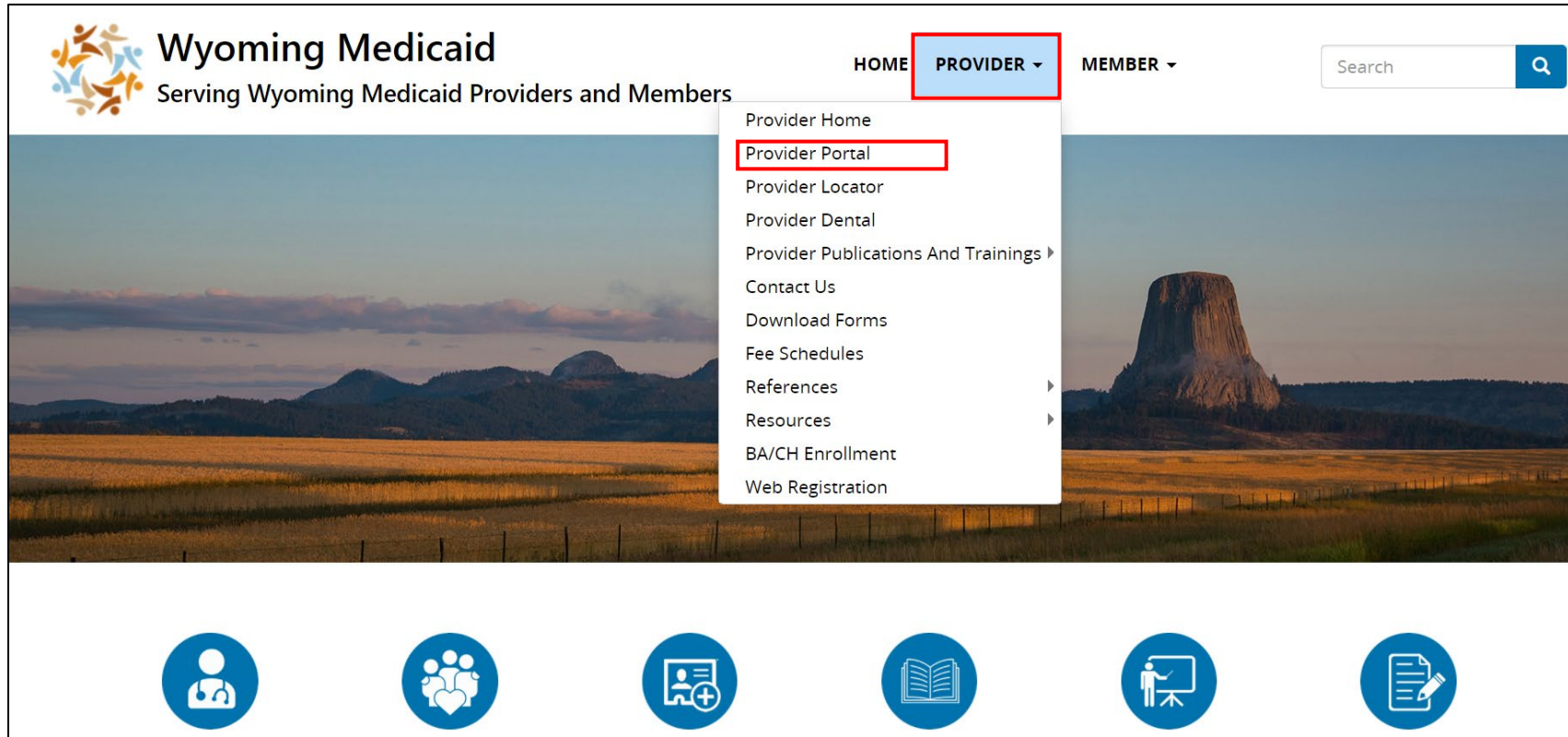
- Professional Claims are submitted by surgeons, nurses, and general practitioners
 - Member receives a service
 - Provider submits a claim
 - Claims include information about the Member, Provider, and service
 - The claim is submitted to the State Medicaid Agency
 - The claim is approved, paid, or denied.



Professional Claims

How to enter a Professional Claim (Medicaid Eligibility Only)

Professional 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**

Professional Claims Submission

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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.

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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

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Domain → []*

Claims Access []* ← Profile

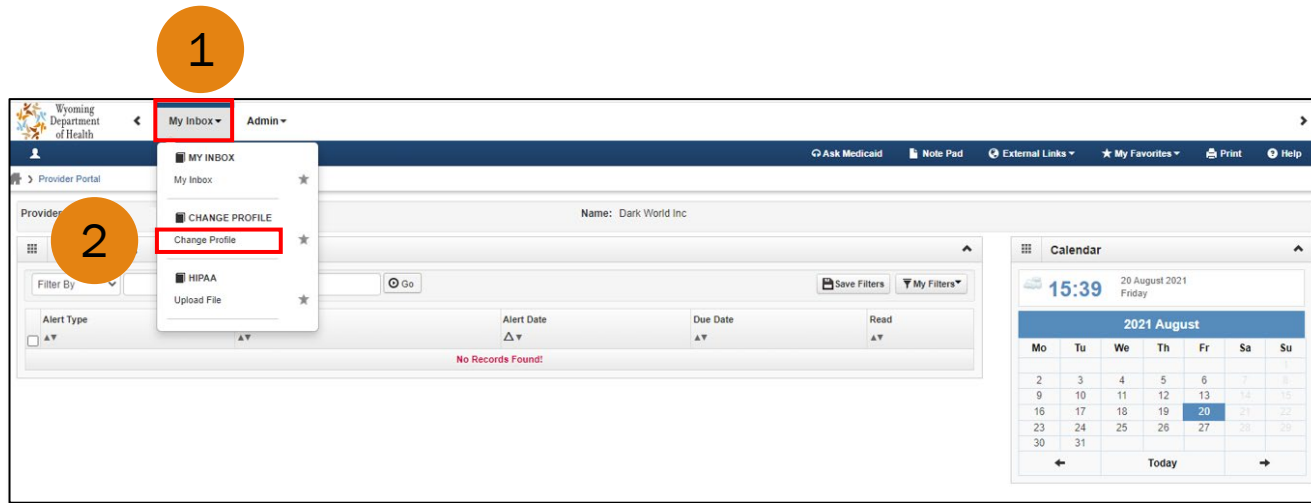
Select Favorite [] → Click Go

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**

Professional Claims Submission

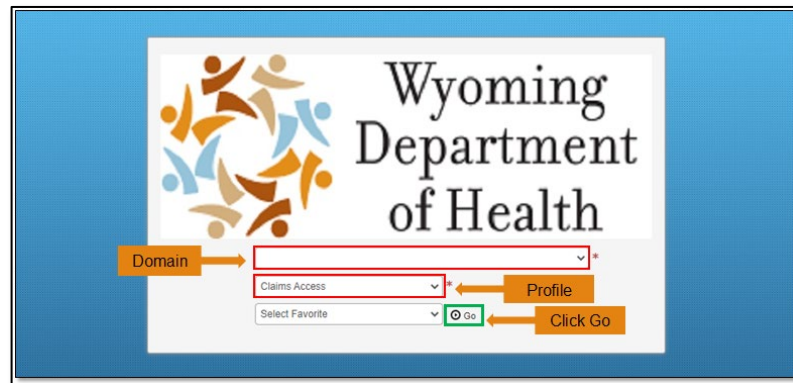


If you are already logged in to the Provider Portal, you can change your profile:

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**



Professional Claims Submission

1

2

The screenshot displays the Wyoming Department of Health Provider Portal. The 'Claims' menu is open, showing options under 'CLAIM SUBMISSION', 'MANAGE CLAIMS', 'INQUIRE CLAIMS', 'RA LIST', and 'INQUIRE PHARMACY CLAIMS'. The 'Submit Professional' option is highlighted. The main content area shows a search for 'Test BACH Test' with 'No Records Found!' displayed. A calendar for August 2021 is visible on the right side of the screen.

- To enter Professional Claims in BMS:
 1. Select **Claims**.
 2. Select **Submit Professional**.

Professional Claims Submission

Professional Claim

Note: Asterisks (*) denote required fields.

Basic Claim

PR... INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: 139206900 * Type: Provider ID * Taxonomy Code: * *

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

Address Line 2: *

Address Line 3: *

City/Town: OTHER *

State/Province: OTHER *

County: OTHER *

Country: UNITED STATES *

Zip Code: * - * * Validate Address

Is the Billing Location also the Service Facility Location? Yes No

Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: * Taxonomy Code: *

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

Annotations: 1 (circled) points to the Provider ID field. 2 (circled) points to the Taxonomy Code field. An orange arrow points to the 'Validate Address' button with the text 'Select Validate Address'.

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

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

Address Line 1: 580 Livingston Ave *
(Enter Street Address or PO Box Only)

Address Line 2: *

Address Line 3: *

City/Town: Cheyenne *

State/Province: WYOMING *

County: Laramie *

Country: UNITED STATES *

Zip Code: 82007 * - 1966 * Validate Address

Address validation successful

Address Validation Successful

Annotations: A red box highlights the 'Address validation successful' message. An orange arrow points from the 'Address Validation Successful' text to the red box.

To enter Professional Claims information, required fields are indicated with an asterisk *:

1. Provider ID, National Provider Identifier (NPI), or Provider # 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.
3. Enter **Address Line 1** and **Zip Code**. If it is incorrect, enter the correct address.

- Select **Validate Address**

BMS validates the address information and displays the message “Address Validation Successful”.

Professional Claims Submission

If the Rendering Provider is not the Billing Provider, enter information as follows:

1. Enter the **Provider ID**.
2. Select the **Type** from the drop-down list.
3. Enter the **Taxonomy Code**.
4. Complete the required **Beneficiary Information** (Member data):
 - Beneficiary (Member) ID
 - Last Name
 - First Name
 - Date of Birth
 - Gender

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

RENDERING

Provider ID: * Type: * Taxonomy Code: *

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: * Middle Initial: Suffix:

Date of Birth: mm dd yyyy * Gender: *

Onset of Current Illness/symptom Date: mm dd yyyy

Does the beneficiary have insurance other than Medicaid? Yes No

Professional Claims Submission

CLAIM INFORMATION

RELEVANT DATES

PRIOR AUTHORIZATION/REFERRAL/CLIA

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

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date From: mm dd yyyy * Service To Date: mm dd yyyy *

Place of Service: Procedure Description: Characters Remaining: 80

Procedure Code: * Submitted Charges: * Units/Quantity: * Modifiers: 1: 2: 3: 4:

EPSDT/Family Planning: * Diagnosis Pointers: 1: * 2: 3: 4:

EMG: Claim Note: Characters Remaining: 80

Prior Authorization Number: Agency PA: Yes No Referral Number: CLIA:

If your claim requires a Prior Authorization (PA), and the PA is for all Service Line Items, complete the fields for the PA information:

1. Enter the **Prior Authorization Number**.
2. Select **Yes** or **No** for **Agency PA**.

If you have a PA that corresponds to only one of the Procedure Codes you are billing for, enter the PA number in the **Basic Service Line Items** section.

or

3. If you have multiple PAs, enter the PA numbers in the **Basic Service Line Items** section for the corresponding Procedure Code.
4. Select **Yes** or **No** for the questions under the **Claim Note** section.

Professional Claims Submission

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

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date From: * *
Service To Date: *
Place of Service:
Procedure Code: *
Submitted Charges: *
Units/Quantity:
EMG:
Procedure Description: Characters Remaining: 80
Modifiers: 1: 2: 3: 4:
Diagnosis Pointers: 1: * 2: 3: 4:
Claim Note: Characters Remaining: 80
Prior Authorization Number: Agency PA: Yes No Referral Number: CLIA:
Rendering Provider ID: (If different from header) Type: Taxonomy Code:
Ordering Provider ID: Type:
Referring Provider ID: (If different from header) Type:
Primary Care Referring Provider ID: (If different from header) Type:
Is the Header Service Facility Location also the Service Line Facility Location? Yes No
National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No.:
Prescription Date:
AMBULANCE INFORMATION

Complete the required **Basic Line Item Information** indicated with an asterisk *:

1. Enter the **Service Date From**.
2. Enter the **Service To Date**.
3. Enter the **Procedure Code, Submitted Charges, and Units/Quantity**.
4. Enter **Diagnosis Pointers**.

Professional Claims Submission

BASIC SERVICE LINE ITEMS

Service Date From:	<input type="text"/> <small>mm</small> <input type="text"/> <small>dd</small> <input type="text"/> <small>yyyy</small> *	Service To Date:	<input type="text"/>
Place of Service:	<input type="text"/>	Procedure Description:	<input type="text"/>
Procedure Code:	<input type="text"/> *	Modifiers:	<input type="text"/>
Submitted Charges:	<input type="text"/> *	Diagnosis Pointers:	<input type="text"/>
Units/Quantity:	<input type="text"/> *	Claim Note:	<input type="text"/>
EPSDT/Family Planning:	<input type="text"/>		
EMG:	<input type="text"/>		

Prior Authorization Number: Agency PA: Yes No Referral Number: CLIA:

Rendering Provider ID:(If different from header) Type: Taxonomy Code:

Ordering Provider ID: Type:

Referring Provider ID:(If different from header) Type:

Primary Care Referring Provider ID:(If different from header) Type:

Is the Header Service Facility Location also the Service Line Facility Location? Yes No

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

Prescription Date: mm dd yyyy

+ AMBULANCE INFORMATION

Continue completing the **Basic Service Line Items** information.

Be sure to complete any Line Items with an asterisk *. These indicate required data needed to process your claim.

Complete other information as appropriate.

Professional Claims Submission

2

Submit Claim

1

Add Service Line Item

Previously Entered Line Item Information

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pointer	Submitted Charges	Units	Prior Auth Number
	From	To		1	2	3	4				

To submit the Professional Claim, add any services that were rendered:

1. Select **Add Service Line Item**.
2. Select **Submit Claim** only after all lines for this claim have been entered.

The BMS system validates the information entered.

Professional 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 has been submitted, the BMS system displays the **Submitted Professional Claim Details**:

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

Professional 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:

- 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		

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 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.

Professional Claims TPL

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

Professional 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 clearinghouse 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

Professional Claims Submission

1

2

The screenshot displays the Wyoming Department of Health Provider Portal. The 'Claims' dropdown menu is open, showing options under 'CLAIM SUBMISSION', 'MANAGE CLAIMS', 'INQUIRE CLAIMS', 'RA LIST', and 'INQUIRE PHARMACY CLAIMS'. The 'Submit Professional' option is highlighted with a red box. 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 Professional Claims in BMS:
 1. Select **Claims**.
 2. Select **Submit Professional**.

Professional Claims Submission

Professional Claim

Note: Asterisks (*) denote required fields.

Basic Claim

PR... INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: 139206900 * Type: Provider ID * Taxonomy Code: * *

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

Address Line 2: *

Address Line 3: *

City/Town: OTHER *
County: OTHER *
State/Province: OTHER *
Country: UNITED STATES *

Zip Code: * - * * Validate Address

Is the Billing Location also the Service Facility Location? Yes No
Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: * Taxonomy Code: *

Is the Billing Provider also the Supervising Provider? Yes No
Is this service the result of a referral? Yes No
Is this service the result of a Primary Care Referral? Yes No

Annotations: 1 (circled) points to the Provider ID field. 2 (circled) points to the Taxonomy Code field. An orange arrow points to the 'Validate Address' button with the text 'Select Validate Address'.

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

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

Address Line 1: 580 Livingston Ave *
(Enter Street Address or PO Box Only)

Address Line 2: *

Address Line 3: *

City/Town: Cheyenne *
County: Laramie *
State/Province: WYOMING *
Country: UNITED STATES *

Zip Code: 82007 * - 1966 * Validate Address

Address validation successful

Address Validation Successful

Annotations: A red box highlights the 'Address validation successful' message. An orange arrow points from the 'Address Validation Successful' text to the red box.

To enter Professional Claims information, required fields are indicated with an asterisk *:

1. Provider ID, National Provider Identifier (NPI), or Provider # 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.
3. Enter **Address Line 1** and **Zip Code**. If it is incorrect, enter the correct address.

- Select **Validate Address**

BMS validates the address information and displays the message “Address Validation Successful”.

Professional Claims Submission

If the Rendering Provider is not the Billing Provider, enter information as follows:

1. Enter the **Provider ID**.
2. Select the **Type** from the drop-down list.
3. Enter the **Taxonomy Code**.
4. Complete the required **Beneficiary Information** (Member data):
 - Beneficiary (Member) ID
 - Last Name
 - First Name
 - Date of Birth
 - Gender

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

RENDERING

Provider ID: * Type: * Taxonomy Code: *

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: * Middle Initial: Suffix:

Date of Birth: mm dd yyyy * Gender: *

Onset of Current Illness/symptom Date: mm dd yyyy

Does the beneficiary have insurance other than Medicaid? Yes No

Professional 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 *

[Add Another](#)

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

Professional Claims Submission

CLAIM INFORMATION

RELEVANT DATES

PRIOR AUTHORIZATION/REFERRAL/CLIA

Prior Authorization Number:

Agency PA: Yes No

Referral Number:

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date From: mm dd yyyy *

Service To Date: mm dd yyyy *

Place of Service:

Procedure Description: Characters Remaining: 80

Procedure Code: *

Submitted Charges: *

Units/Quantity: *

EMG:

Prior Authorization Number:

Agency PA: Yes No

Referral Number: CLIA:

If your claim requires a Prior Authorization (PA), and the PA is for all Service Line Items, complete the fields for the PA information:

1. Enter the **Prior Authorization Number**.
2. Select **Yes** or **No** for **Agency PA**.

If you have a PA that corresponds to only one of the Procedure Codes you are billing for, enter the PA number in the **Basic Service Line Items** section.

or

3. If you have multiple PAs, enter the PA numbers in the **Basic Service Line Items** section for the corresponding Procedure Code.
4. Select **Yes** or **No** for the questions under the **Claim Note** section.

Professional Claims Submission

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My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Professional Claim

Close Submit Claim Save as Template Reset

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date From: *

Service To Date: *

Place of Service:

Procedure Code: *

Submitted Charges: *

Units/Quantity:

EPSTD/Family Planning:

EMG:

Procedure Description: Characters Remaining: 80

Modifiers: 1: 2: 3: 4:

Diagnosis Pointers: 1: * 2: 3: 4:

Claim Note: Characters Remaining: 80

Prior Authorization Number: Agency PA: Yes No Referral Number: CLIA:

Rendering Provider ID: (If different from header) Type: Taxonomy Code:

Ordering Provider ID: Type:

Referring Provider ID: (If different from header) Type:

Primary Care Referring Provider ID: (If different from header) Type:

Is the Header Service Facility Location also the Service Line Facility Location? Yes No

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

Prescription Date:

AMBULANCE INFORMATION

Complete the required **Basic Line Item Information** indicated with an asterisk *:

1. Enter the **Service Date From**.
2. Enter the **Service To Date**.
3. Enter the **Procedure Code, Submitted Charges, and Units/Quantity**.
4. Enter **Diagnosis Pointers**.

Professional 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 Copy 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.

Professional 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 an Explanation of Benefits (EOB):

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

Professional Claims Submission

The screenshot shows a web-based form for submitting 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 is a section titled 'Professional Claim' with a note: 'Note: asterisks (*) denote required fields.' The main section is 'INSURANCE INFORMATION' and contains a question: 'Does the Beneficiary have insurance other than Medicaid?' with radio buttons for 'Yes' and 'No'. Below this is 'OTHER INSURANCE INFORMATION' with a sub-section '1. Service Line Other Payer Information'. It includes a dropdown for 'Primary Payer Responsibility' (selected as '1#P#99999#CI-Commercial Insuran *'), an 'Amount Paid' field (\$100.00 *), and a 'Remittance Date' field with mm, dd, and yyyy sub-fields. There are two rows of reason codes: '1.Reason Code: CO45' with an amount of \$50.00, and '2.Reason Code: PR2' with an amount of \$150.00. Red dashed arrows point to the 'CO45' and 'PR2' codes. An 'Add Another Reason Code' button is visible next to the first row. At the bottom left, there is an 'Add Another Payer' button.

- 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

Professional 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:	<input type="text" value="1#P#44444444#MB-Medicare Part I"/>	Amount Paid:	<input type="text" value="\$88.69"/>	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"/>	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"/>		

- 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.

Professional 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.

Professional 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#4444444#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

- Reason codes must be entered with only the number. Do not enter “PR” or “CO”.
- 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.

Professional Claims Submission

The screenshot shows a web application interface for submitting professional claims. At the top, there are navigation tabs for 'My Inbox' and 'Claims'. Below this, there are buttons for 'Close', 'Submit Claim', 'Save as Template', and 'Reset'. The 'Submit Claim' button is highlighted with a red box and a blue circle containing the number '2'. The main form area contains various input fields for claim details, including 'Units/Quantity', 'EPSTD/Family Planning', 'EMG', 'Diagnosis Pointers', 'Claim Note', 'Prior Authorization Number', 'Agency PA', 'Referral Number', 'CLIA', 'Rendering Provider ID', 'Ordering Provider ID', 'Referring Provider ID', 'Primary Care Referring Provider ID', 'National Drug Code', 'Quantity', 'Unit', 'Qualifier', 'Prescription/Link No.', and 'Prescription Date'. A section for 'AMBULANCE INFORMATION' is also present. At the bottom, there is a section for 'Previously Entered Line Item Information' with a table. The 'Add Service Line Item' button is highlighted with a red box and a blue circle containing the number '1'. An orange box labeled 'Add Service Line Item' has an arrow pointing to the 'Add Service Line Item' button.

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pointer	Submitted Charges	Units	Prior Auth Number
	From	To		1	2	3	4				

To submit the Professional Claim, add any services that were rendered:

1. Select **Add Service Line Item**.
2. Select **Submit Claim** only after all lines for this claim have been entered.

The BMS system validates the information entered.

Professional 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.

Professional 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:

- 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		

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 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.

Professional Claims with Medicare Primary

How to bill a Medicare Primary Claim

Professional 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 clearinghouse 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

Professional Claims Submission

1

2

The screenshot displays the Wyoming Department of Health Provider Portal interface. The top navigation bar includes 'My Inbox' and 'Claims' (highlighted with a red box and a '1' callout). A dropdown menu is open under 'Claims', with 'Submit Professional' (highlighted with a red box and a '2' callout) selected. Other options in the menu include 'Submit Institutional', '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 Professional Claims in BMS:
 1. Select **Claims**.
 2. Select **Submit Professional**.

Professional Claims Submission

Professional Claim

Note: Asterisks (*) denote required fields.

Basic Claim

PR... INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: 139206900 * Type: Provider ID * Taxonomy Code: * *

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

Address Line 2: *

Address Line 3: *

City/Town: OTHER *
County: OTHER *
State/Province: OTHER *
Country: UNITED STATES *

Zip Code: * - * * Validate Address

Is the Billing Location also the Service Facility Location? Yes No
Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: * Taxonomy Code: *

Is the Billing Provider also the Supervising Provider? Yes No
Is this service the result of a referral? Yes No
Is this service the result of a Primary Care Referral? Yes No

Annotations: 1 (circled) points to the Provider ID field. 2 (circled) points to the Taxonomy Code field. An orange arrow points to the 'Validate Address' button with the text 'Select Validate Address'.

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

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

Address Line 1: 580 Livingston Ave *
(Enter Street Address or PO Box Only)

Address Line 2: *

Address Line 3: *

City/Town: Cheyenne *
County: Laramie *
State/Province: WYOMING *
Country: UNITED STATES *

Zip Code: 82007 * - 1966 * Validate Address

Address validation successful

Address Validation Successful

Annotation: A red box highlights the 'Address validation successful' message, with an orange arrow pointing to it from a larger orange box labeled 'Address Validation Successful'.

To enter Professional Claims information, required fields are indicated with an asterisk *:

1. Provider ID, National Provider Identifier (NPI), or Provider # 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.
3. Enter **Address Line 1** and **Zip Code**. If it is incorrect, enter the correct address.

- Select **Validate Address**

BMS validates the address information and displays the message “Address Validation Successful”.

Professional Claims Submission

If the Rendering Provider is not the Billing Provider, you will enter information as follows:

1. Enter the **Provider ID**.
2. Select the **Type** from the drop-down list.
3. Enter the **Taxonomy Code**.
4. Complete the required **Beneficiary Information** (Member data):
 - Beneficiary (Member) ID
 - Last Name
 - First Name
 - Date of Birth
 - Gender

The screenshot shows the Wyoming Department of Health Professional Claims Submission form. The form is divided into two main sections: RENDERING PROVIDER and BENEFICIARY INFORMATION. The RENDERING PROVIDER section includes fields for Provider ID, Type, and Taxonomy Code, and three questions about the provider's role. The BENEFICIARY INFORMATION section includes fields for Beneficiary ID, Last Name, First Name, Middle Initial, Suffix, Date of Birth, and Gender, and a question about other insurance. Red boxes and orange circles highlight the required fields and sections.

1. Provider ID

2. Type

3. Taxonomy Code

4. Beneficiary Information (Member data):

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

Professional 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 *

[Add Another](#)

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

Professional Claims Submission

CLAIM INFORMATION

RELEVANT DATES

PRIOR AUTHORIZATION/REFERRAL/CLIA

Prior Authorization Number:

Agency PA: Yes No

Referral Number:

CLIA:

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date From: / / *
Place of Service:

Service To Date: / / *
Procedure Description: Characters Remaining: 80

Procedure Code: *
Submitted Charges: *
Units/Quantity: *
EPSDT/Family Planning:

EMG:

Modifiers: 1: 2: 3: 4:
Diagnosis Pointers: 1: * 2: 3: 4:
Claim Note: Characters Remaining: 80

Prior Authorization Number: Agency PA: Yes No Referral Number: CLIA:

If your claim requires a Prior Authorization (PA), and the PA is for all Service Line Items, complete the fields for the PA information:

1. Enter the **Prior Authorization Number**.
2. Select **Yes** or **No** for **Agency PA**.

If you have a PA that corresponds to only one of the Procedure Codes you are billing for, enter the PA number in the **Basic Service Line Items** section.

or

3. If you have multiple PAs, enter the PA numbers in the **Basic Service Line Items** section for the corresponding Procedure Code.
4. Select **Yes** or **No** for the questions under the **Claim Note** section.

Professional Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Professional Claim

Close Submit Claim Save as Template Reset

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date From: *

Service To Date: *

Place of Service:

Procedure Code: *

Submitted Charges: *

Units/Quantity:

EPSTD/Family Planning:

EMG:

Procedure Description: Characters Remaining: 80

Modifiers: 1: 2: 3: 4:

Diagnosis Pointers: 1: * 2: 3: 4:

Claim Note: Characters Remaining: 80

Prior Authorization Number: Agency PA: Yes No Referral Number: CLIA:

Rendering Provider ID: (If different from header) Type: Taxonomy Code:

Ordering Provider ID: Type:

Referring Provider ID: (If different from header) Type:

Primary Care Referring Provider ID: (If different from header) Type:

Is the Header Service Facility Location also the Service Line Facility Location? Yes No

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

Prescription Date:

AMBULANCE INFORMATION

Complete the required **Basic Line Item Information** indicated with an asterisk *:

1. Enter the **Service Date From**.
2. Enter the **Service To Date**.
3. Enter the **Procedure Code, Submitted Charges, and Units/Quantity**.
4. Enter **Diagnosis Pointers**.

Professional 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 Copy 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.

Professional 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 Explanation of Benefits (EOB):

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

Professional Claims Submission

The screenshot displays a web-based form for submitting 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 main section is 'INSURANCE INFORMATION', which contains a question: 'Does the Beneficiary have insurance other than Medicaid?' with radio buttons for 'Yes' and 'No'. Underneath is the 'OTHER INSURANCE INFORMATION' section, specifically '1. Service Line Other Payer Information'. This section includes a dropdown for 'Primary Payer Responsibility' (selected as '1#P#99999#CI-Commercial Insuran'), an 'Amount Paid' field (\$100.00), and a 'Remittance Date' field with sub-fields for month (mm), day (dd), and year (yyyy). Below these are two rows for 'Reason Code' entries. The first row shows '1.Reason Code:' with 'CO45' selected, an 'Amount' of '\$50.00', and an 'Adjustment Quantity' field. The second row shows '2.Reason Code:' with 'PR2' selected, an 'Amount' of '\$150.00', and an 'Adjustment Quantity' field. A red dashed arrow points to the 'CO45' code. There are also buttons for 'Add Another Reason Code' and 'Add Another Payer'.

- 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

Professional 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:	<input type="text" value="1#P#44444444#MB-Medicare Part I"/>	Amount Paid:	<input type="text" value="\$88.69"/>	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"/>	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"/>		

- 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.

Professional 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.

Professional 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: *

Non-covered Line Charges:

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

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

Rendering Physician ID: (If different from header): Type:

Referring Physician ID: (If different from header): 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**.
- A pop-up displays with claim information and the option to attach documents if needed

Professional 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.

Professional 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:

- 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		

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 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.

Professional Claims with Tertiary TPL

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

Professional 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 clearinghouse 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

Professional Claims Submission

1

2

The screenshot displays the Wyoming Department of Health Provider Portal. The 'Claims' menu is open, and the 'Submit Professional' option is highlighted. The main content area shows a search for 'Test BACH Test' with 'No Records Found!' displayed. A calendar for August 2021 is visible on the right side of the screen.

- To enter Professional Claims in BMS:
 1. Select **Claims**.
 2. Select **Submit Professional**.

Professional 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:	1#P#4444444#MB-Medicare Part E *	1	Amount Paid:	\$86.89 *	2	Remittance Date:	mm dd yyyy
1.Reason Code:	45	3	Amount:	\$78.14	Adjustment Quantity:		<input type="button" value="Add Another Reason Code"/>
2.Reason Code:	2		Amount:	\$22.17	Adjustment Quantity:		

When Billing Medicare as Primary:

1. **Primary Payer Responsibility** will only have one choice, select **Medicare Part A/B**.
2. **Amount Paid** is total amount paid by Medicare.
3. Enter reason codes found on your Medicare EOB in the **Reason Code** fields.

The 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 balances the primary insurance.

Professional Claims Submission

If the Rendering Provider is not the Billing Provider, you will enter information as follows:

1. Enter the **Provider ID**.
2. Select the **Type** from the drop-down list.
3. Enter the **Taxonomy Code**.
4. Complete the required **Beneficiary Information** (Member data):
 - Beneficiary (Member) ID
 - Last Name
 - First Name
 - Date of Birth
 - Gender

The screenshot shows the Wyoming Department of Health Professional Claims Submission form. The form is divided into two main sections: RENDERING PROVIDER and BENEFICIARY INFORMATION. The RENDERING PROVIDER section includes fields for Provider ID, Type, and Taxonomy Code, and three questions about the provider's role. The BENEFICIARY INFORMATION section includes fields for Beneficiary ID, Last Name, First Name, Middle Initial, Suffix, Date of Birth, Gender, and Onset of Current Illness/Symptom Date, and a question about other insurance. Red boxes and orange circles highlight the required fields and sections.

Professional 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: 44444444 *	Subscriber Member ID:
Subscriber Last Name:	First Name: [State Code]: Suffix:
Insured's Group or Policy Number: 1234568798af *	Beneficiary's Relationship:
Claim Filing Indicator: MB-Medicare Part B *	Total COB Payer Paid Amount: \$86.89 * <input type="button" value="Add Another"/>

2. Other Subscriber Information

Payer Responsibility Code: S-Secondary *	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: 123456789asdfe *	Beneficiary's Relationship:
Claim Filing Indicator: CI-Commercial Insurance Co. *	Total COB Payer Paid Amount: \$50.00 * <input type="button" value="Delete"/>

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

Professional Claims Submission

CLAIM INFORMATION

RELEVANT DATES

PRIOR AUTHORIZATION/REFERRAL/CLIA

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

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date From: / / * Service To Date: / / *

Place of Service: Procedure Description: Characters Remaining: 80

Procedure Code: * Submitted Charges: * Units/Quantity: * Modifiers: 1: 2: 3: 4:

EPSTD/Family Planning: * Diagnosis Pointers: 1: * 2: 3: 4:

EMG: Claim Note: Characters Remaining: 80

Prior Authorization Number: Agency PA: Yes No Referral Number: CLIA:

If your claim requires a Prior Authorization (PA), and the PA is for all Service Line Items, complete the fields for the PA information:

1. Enter the **Prior Authorization Number**.
2. Select **Yes** or **No** for **Agency PA**.

If you have a PA that corresponds to only one of the Procedure Codes you are billing for, enter the PA number in the **Basic Service Line Items** section.

or

3. If you have multiple PAs, enter the PA numbers in the **Basic Service Line Items** section for the corresponding Procedure Code.
4. Select **Yes** or **No** for the questions under the **Claim Note** section.

Professional Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Professional Claim

Close Submit Claim Save as Template Reset

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date From: *

Service To Date: *

Place of Service:

Procedure Code: *

Submitted Charges: *

Units/Quantity:

EPSTD/Family Planning:

EMG:

Procedure Description: Characters Remaining: 80

Modifiers: 1: 2: 3: 4:

Diagnosis Pointers: 1: * 2: 3: 4: Characters Remaining: 80

Claim Note:

Prior Authorization Number: Agency PA: Yes No Referral Number: CLIA:

Rendering Provider ID: (If different from header) Type: Taxonomy Code:

Ordering Provider ID: Type:

Referring Provider ID: (If different from header) Type:

Primary Care Referring Provider ID: (If different from header) Type:

Is the Header Service Facility Location also the Service Line Facility Location? Yes No

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

Prescription Date:

AMBULANCE INFORMATION

Complete the required **Basic Line Item Information** indicated with an asterisk *:

1. Enter the **Service Date From**.
2. Enter the **Service To Date**.
3. Enter the **Procedure Code, Submitted Charges, and Units/Quantity**.
4. Enter **Diagnosis Pointers**.

Professional 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 Copy 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.

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

Add Another Payer

Enter information from the Explanation of Benefits (EOB):

1. The **Primary Payer Responsibility** information is your 1st insurance.
2. Enter total Amount Paid by the first payer only.
3. Enter your reason codes from the EOB in the **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**.

Professional Claims Submission

The screenshot shows a web form titled "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 divided into sections: "INSURANCE INFORMATION" and "OTHER INSURANCE INFORMATION". Under "INSURANCE INFORMATION", there is a question: "Does the Beneficiary have insurance other than Medicaid?" with radio buttons for "Yes" and "No". Under "OTHER INSURANCE INFORMATION", there is a section for "1. Service Line Other Payer Information". This section contains a table with the following data:

Primary Payer Responsibility:	Amount Paid:	Remittance Date:
1#P#99999#CI-Commercial Insuran *	\$100.00 *	mm dd yyyy
1.Reason Code: CO45	Amount: \$50.00	Adjustment Quantity: []
2.Reason Code: PR2	Amount: \$150.00	Adjustment Quantity: []

There are red dashed arrows pointing to the reason codes "CO45" and "PR2". A button "Add Another Reason Code" is visible next to the adjustment quantity fields. At the bottom left, there is a button "Add Another Payer".

- 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

Professional Claims Submission

Close Basic Claim Form Reset

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#99999#MB-Medicare Part B *	Amount Paid:	\$100.00 *	Remittance Date:	mm dd yyyy
1.Reason Code:	45	Amount:	\$50.00	Adjustment Quantity:	
2.Reason Code:	2	Amount:	\$50.00	Adjustment Quantity:	

Add Another Payer

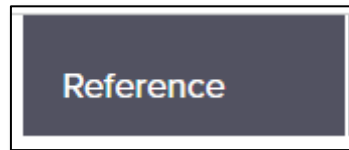
2. Service Line Other Payer Information

Primary Payer Responsibility:	2#S#99999#CI-Commercial Insuran *	Amount Paid:	\$25.00 *	Remittance Date:	mm dd yyyy
1.Reason Code:	45	Amount:	\$75.00	Adjustment Quantity:	
2.Reason Code:	23	Amount:	\$100.00	Adjustment Quantity:	

Delete Payer

- 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

Professional 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.

Professional 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: *

Non-covered Line Charges:

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

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

Rendering Physician ID: (If different from header): Type:

Referring Physician ID: (If different from header): 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**.
- A pop-up displays with claim information and the option to attach documents if needed

Professional 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:

- 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		

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 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.

Course Review

- Professional Claims Overview
- Professional Claims Submissions
- Professional Claims Third-Party Liability (TPL)
- Professional Claims with Medicare Primary
- Professional Claims with Tertiary TPL
- Professional Claims Attachments





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Department
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Thank you

Professional Claims Submission