DHS
Oregon Department of Human Services

Keys to Success—
Partnering with DMAP

Division of Medical Assistance Programs 2007

Oregon HEALTH PLAN

Department of Human Services
Division of Medical Assistance Programs
500 Summer Street NE, E-35
Salem, OR 97301

Welcome!

The Oregon Health Plan (OHP) serves nearly 400,000 Oregonians, and we couldn't do it without providers such as you! We look forward to a successful partnership.

Now that you have agreed to serve Medicaid clients through Oregon's Division of Medical Assistance Programs (DMAP*), you probably have some questions, such as:

- Who is an OHP client?
- What services will DMAP reimburse?
- Are there payers other than DMAP?
- How do I bill DMAP?
- What if I need help?

This material gives an overview to providing and billing for health care services to Oregon Health Plan (OHP) clients. We'll try to answer the big questions and point you to where to find answers to more specific inquiries.

Keys to Success does not take the place of provider Rulebooks or Supplemental Information. Complete rules and billing instructions are online at <http://www.dhs.state.or.us/policy/healthplan/guides/main.html>.

We've listed the Oregon Administrative Rules (OARs) on our Web pages by program. In addition, all our providers need the General Rules (OAR 410 Division 120).

You will find more tools to help you in this booklet and on the DMAP Web site at: <http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml>.

For more copies of this booklet, contact DMAP at 503-945-5772 or 1-800-527-5772, or download a copy from our Provider Tools page above.

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* The Department of Human Services recently changed our name from Office of Medical Assistance Programs (OMAP) to Division of Medical Assistance Programs (DMAP). Some of our material (and employees) still use the old acronym while we adjust to the new name.

Contents

I. Who is an OHP client?

Eligibility verification

When OHP clients seek your health care services, you'll need to first verify their eligibility for Oregon Health Plan (OHP) coverage on the date of service.

Every month, DMAP issues a new Medical Care Identification (ID) to eligible households. A sample of this letter-sized sheet of paper follows. Sometimes the local DHS office will issue a temporary ID, either handwritten or computer generated.

The Medical Care ID will tell you which household members are eligible; each person's recipient number and date of birth; on which dates they are eligible; whether they are enrolled in one or more managed care plans; if they must pay you a copayment; and what benefit package coverage they receive.

For a field-by-field explanation of how to read the ID, see the Supplemental Information for General Rules.

Sometimes, patients will tell you they forgot to bring their Medical Care ID to an appointment. Not to panic! We offer other ways to verify eligibility.

These methods can answer basic "who, when and where" eligibility questions as well as give you other service limitations for specific clients:

- The Automated Information System (AIS). You may access AIS, a free system, by touchtone phone or via the Web.
- Electronic Eligibility Verification Systems (EEVS) offers fee-based contractor services with additional features you may want.
- Electronic Data Interchange (EDI) 270/271 offers HIPAA-compliant, computerized answers to your eligibility questions either immediately (real-time) for one inquiry or next working day for multiple submissions.
- Coming soon: a Web "portal" to our new Medicaid Management Information System (MMIS).

Key to Success

Eligibility verification

- ✓ Ask clients to show you their Medical Care Identification (ID) at the time of service and make a photocopy for your records.
- ✓ Learn to use alternate ways of verifying eligibility (EDI 270/271, EEVS or AIS).

Resources

Eligibility verification

Rules and Supplemental Info <http://www.dhs.state.or.us/policy/healthplan/guides/main.html> or call 1-800-527-5772 for hard copies.

Eligibility verification tools: 270/271 transactions. See the "Introduction to Electronic Data Interchange (EDI)" at <http://www.oregon.gov/DHS/admin/hipaa/edi.shtml>.

Eligibility verification tools, EEVS & AIS <http://www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml>.

AIS phone number: 1-800-522-2508.

(1) (2)

5503 XX#### EF P2
P.O. BOX 14520
SALEM, OR
97309-5044
DO NOT FORWARD: RETURN IN 3 DAYS

(3)

OMAP Medical Care Identification (ID)

(4) Branch Name	Division	(5) Worker	(6) Phone
OHP Branch	AFS	EF	(503) 378-2666 1-800-699-9075

John Doe
Street Name

City State Zip

(7a) Copy Requirements
A $3 for outpatient services not paid for by your Plan (listed in 8a)
B $2 Generic/$3 Brand – for drugs not paid for by your Medical Plan (listed in 8a)

(8a) Managed Care/TPR
A OMAP MEDICAL PLAN MEDICAL PLAN NAME PH # 1-800-555-1234 GRP #
B OMAP DENTAL PLAN DENTAL PLAN NAME PH # 1-800-555-1234 GRP #
C OMAP MENTAL HEALTH PLAN MENTAL HEALTH PLAN NAME PH # 1-800-555-1234 GRP #
D PRIVATE MAJOR MED/DRUGS MEDICAL PLAN NAME PH # 1-800-555-1234 GRP #
E PRIVATE VISION COVERAGE VISION PLAN NAME PH # 1-800-555-1234 GRP #
F MEDICARE PART A AND B MEDICARE PLAN NAME PH # 1-800-555-1234 GRP #
G MEDICARE PART D HAS PART D
H
I

(9a) Benefit Package

A – OHP Plus	**D – OHP with limited drug**
B – OHP Standard	**E – CAWEM Emergency Medical**
C – QMB	

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 8a. See OMAP General Rules OAR 410-120-1210 for specific benefit package limitations. All OMAP administrative rules can be found on the OMAP website at: www.oregon.gov/DHS/healthplan/

(10) Name of Eligible Person(s)	(11) Recipient ID	(12) Date of Birth	(13) Dates of Coverage	(7b) Copay Req	(8b) ManagedCare/TPR	(9b) Benefit Package
DOE, JOHN	XX#####X	10/13/62	6/01-6/30/06	AB	FG	CD
DOE, JANIE	XX#####X	08/10/74	6/01-6/30/06	NO COPAYS	ABC	B
DOE, JACOB	XX#####X	01/26/99	6/01-6/30/06	NO COPAYS	ABCDE	A

IMPORTANT:

- **This is your new OMAP Medical Care ID. Issued on:** 6/1/06
- **Show this ID to all providers, even if you have a Managed Care Plan card.**
- **Not valid outside the United States or US Territories.**

(14)

Agency Message - 45 characters - 6 Lines - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message

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State of Oregon Department of Human Services Office of Medical Assistance Programs OMAP 1417 (Rev 09/05)

Managed care

The Oregon Health Plan uses "managed care" as a tool to help control health care costs.

Managed care plans and Primary Care Managers (PCMs) contract with DMAP to provide health services to OHP clients. These organizations or providers "manage" each enrolled client's health care on behalf of DMAP.

DMAP contracts with five types of managed care organizations (MCOs):

- Fully Capitated Health Plan (FCHP) —physical health & in-patient care
- Physician Care Organization (PCO) — physical health; no in-patient care
- Dental Care Organization (DCO)
- Mental Health Organization (MHO)
- Chemical Dependency Organization (CDO)

The monthly Medical Care ID indicates which MCOs the member is enrolled in (see Fields 8a and 8b). A client may be enrolled in more than one plan for different types of services. If the Managed Care/TPR fields are blank, the client receives care on a fee-for-service (FFS or "open card")basis.

The Department of Human Services (DHS) requires enrollment in managed care, but gives exceptions to some clients. These clients might have continuity of care issues, such as a woman in the last trimester of pregnancy. Or some clients live in areas of the state where managed care enrollment is not an option. The affected OHP clients receive services on a fee-for-service basis.

Key to Success

Managed care

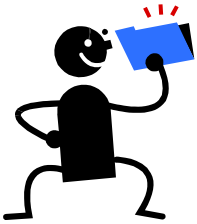
- ✓ Always check the client's ID to see if they are in managed care.
- ✓ Refer clients to their plan or PCM for services if you are not sub-contracted with the plan; or call the PCM for a referral.
- ✓ Bill the plan if you are authorized to provide services to their members.
- ✓ Check with the plan about their claim filing timelines.
- ✓ Some services require securing prior authorization from the plan.
- ✓ Only bill DMAP for services to clients ***not*** covered by a managed care plan *(i.e.*, fee-for-service clients).

Resources

Managed care

Rules and Supplemental Information <http://www.dhs.state.or.us/policy/healthplan/guides/main.html> or call 1-800-527-5772 for hard copies.

Eligibility verification tools (AIS & EEVS) <http://www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml>.



Eligibility flow chart
for fee-for-service OHP clients

1. Is client enrolled in OHP managed care for your type of service?

Yes. Either refer the client to the managed care plan or secure authorization from the plan or PCM to treat the client.

No. Continue to Step 2.

2. Is client eligible for OHP services on this date of service?

No. Inform client they are responsible to pay the bill if you proceed.

Yes. Continue to Step 3.

3. Does client's OHP benefit package cover your service?

No. Does client have other health insurance to cover this service?

No. Inform client they are responsible to pay for not-covered services.

Yes. Proceed with services and bill other insurance.

Yes. Continue to Step 4.

4. Is this service currently funded on the Prioritized List?

No. Inform client they are responsible to pay for not-covered services.

Yes. Continue to Step 5.

5. Does this service require prior authorization?

Yes. Secure PA before providing services.

No. Proceed with services.

II. What services will DMAP reimburse?

Client benefit packages

An OHP client's benefit package will define the medical, dental or mental health services for which they are eligible.

You can determine a client's benefit package by checking Fields 9a and 9b on the Medical Care ID or by using one of the electronic eligibility verification methods mentioned earlier.

DMAP offers five benefit packages:

- OHP Plus
- OHP Standard
- OHP with Limited Drug
- Qualified Medicare Beneficiary (QMB)
- Citizen-Alien Waived Emergency Medical (CAWEM)

The chart on the next page shows at a glance the types of services each benefit package covers.

CAUTION: This table is ***not*** comprehensive, and some services have coverage limitations. Please check the General Rules, OAR 410-120-1200, and your program's Rulebook for specific services that DMAP will and will not pay you to provide.

Key to Success

Client benefit packages

- ✓ Determine the client's OHP benefit package type.
- ✓ If the client has a limited benefit package, do not provide the service until you know exactly what the limitations are.
- ✓ Refer to General Rules, OAR 410-120-1210, for benefit package definitions.
- ✓ Refer to your provider type's Rulebook for specific limitations.

Resources

Client benefit packages

Rules and Supplemental Information
<www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html>
or call 1-800-527-5772 for hard copies.

OHP offers more services and places more limitations than we can list here. This chart is meant to be a guide, not OHP policy. Definitive answers appear in Oregon Administrative Rules online at <http://www.dhs.state.or.us/policy/healthplan/guides/main.html>.

Covered Services	OHP Standard	OHP Plus	OHP with Limited Drug
Acupuncture	Limited	✓	✓
Chemical dependency services	✓	✓	✓
Dental	Limited	✓	✓
Emergency medical	✓	✓	✓
Hearing aids & hearing aid exams		✓	✓
Home health		✓	✓
Hospice care	✓	✓	✓
Hospital care	Limited	✓	✓
Immunizations	✓	✓	✓
Labor & delivery	✓	✓	✓
Laboratory & X-ray	✓	✓	✓
Medical equipment & supplies (DME)	Limited	✓	✓
Medical transportation	Limited	✓	✓
Mental health services	✓	✓	✓
Occupational therapy		✓	✓
Physical therapy		✓	✓
Physician services	✓	✓	✓
Prescription drugs	✓	✓	Limited
Private duty nursing		✓	✓
Speech therapy		✓	✓
Vision care	Limited	✓	✓

Qualified Medicare Beneficiary (QMB) pays Medicare premiums, copayments (except drugs) and deductibles. Some clients may have more than one benefit package. For example, QMB clients may also have OHP with Limited Drug benefits.

Citizenship/Alien Waived Emergency Medical (CAWEM) pays only labor and delivery or emergency services.

Prioritized List of Health Services

The Oregon Health Services Commission (HSC) created and maintains the Prioritized List of Health Services. They rank pairs of health conditions and treatments by clinical effectiveness (most effective to least) and cost of treatment based on public values.

The list contains 710 lines of paired diagnoses and treatments. The primary diagnosis is the condition, and the treatment is the procedure or service provided for the condition.

Services that help prevent illness rank higher on the list than treatments for conditions in progress. Services lower on the list describe illnesses that get better on their own, are cosmetic in nature or for which no effective treatments are available.

The Oregon Legislative Assembly decides how many lines are funded each biennium. Currently, the state funds services on lines 1-530.

Key to Success

Prioritized List of Health Services

- ✓ If in doubt, providers should check to see if their proposed treatments are currently funded on the Prioritized List.
- ✓ Contact the DMAP Benefit RN Hotline for specific questions about condition/treatment, pair line placement and guidelines:
  - o Have the ICD-9-CM code(s) ready
  - o Have the CPT/HCPCS code(s) ready

Resources

Prioritized List of Health Services

The Health Services Commission maintains the list online at <http://www.oregon.gov/DAS/OHPPR/HSC/current_prior.shtml>.

Contact the DMAP Benefit RN Hotline at 1-800-393-9855 toll-free, or in Salem the number is 503-945-5939.

Prior Authorization

Some treatments or items covered by DMAP require prior authorization (PA):

- Audiology
- Co-morbid conditions
- Dental
- Durable Medical Equipment and supplies
- Home Enteral/Parenteral and IV services
- Hearing Aid services
- Hospital (some inpatient services/outpatient therapies)
- Home Health services
- Pharmacy Managed Access Program (MAP)
- Physical Therapy/Occupational Therapy
- Physician (some medical/surgical procedures)
- Private Duty Nursing
- Out-of-state services
- Speech therapy
- Surgery
- Transplants
- Transportation (non-emergent)
- Vision (lenses, frames, contacts, etc.)

DMAP will authorize payment only for services that are medically appropriate and for which you have supplied the required documentation. Documentation must support the medical justification for the service.

Key to Success

Prior Authorization

- ✓ Determine if PA is required before rendering services.
- ✓ Verify a service is currently funded on the Prioritized List before requesting PA.
- ✓ Contact the client's plan or appropriate office for PA (see page 9).
- ✓ Use the appropriate forms and submit proper documentation at the time you are making a PA request.
- ✓ Include the specific PA number for each client when billing DMAP.

Resources

Prior Authorization

Check the administrative rules for the type of service you provide for guidance. You will find PA contact phone numbers and addresses plus sample PA request forms in your provider-specific Supplemental Information. Both the Rulebooks and supplements are posted online at <http://www.dhs.state.or.us/policy/healthplan/guides/main.html>.

See the next page for where to request prior authorization (PA).

To verify the status of your PA request, contact DMAP Provider Services:

1-800-336-6016 toll-free
503-378-3697 Salem
<dmap.providerservices@state.or.us>

Prior Authorization Contacts for Fee-for-Service (FFS or open card) Clients

Use the appropriate agency listed below to authorize services in each section.

Programs	Agency authorizing service
DME Equipment/Supplies **Hearing Aid Services** **Home Health Service**s **Home Enteral/Parenteral Services** (except Oral Nutritional Supplements; see Drugs/Pharmacy MAP) **Physical/Occupational Therapy** **Private Duty Nursing** **Speech/Hearing/Audiology** **Vision Services**	MFC Clients—Medically Fragile Children's Unit 971-673-3000 FFS high cost/high risk clients—Innovative Care Management 800-862-3338 All other clients—DMAP Medical Unit 800-642-8635 or 503-945-6821
Dental Services	DMAP Dental Coordinator 800-527-5772 or 503-945-6506
Drugs/Pharmacy - Managed Access Program (MAP) **Home Enteral/Parenteral –** Oral meds & Nutritional Supplements **only**	First Health 800-344-9180
Surgical Procedures **PET scans**	Accumentra Health* 800-452-1250 or 503-279-0159 Outside Oregon—non-emergent services 800-325-8933 FFS high cost/high risk clients—Innovative Care Management 800-862-3338
Transplants **Out-of-State Services**	DMAP Medical Director's Unit 800-527-5772 or 503-945-6488 FFS high cost/high risk clients—Innovative Care Management 800-862-3338
Non-Emergent Transportation	Local brokerage or branch office

FAX numbers and address

DMAP Medical Unit	FAX 503-378-5814
DMAP Medical Director's Unit	FAX 503-373-7689
First Health	FAX 800-250-6950
Medically Fragile Children's Unit	FAX 971-673-2971
* Accumentra Health (formerly OMPRO) 2020 SW Fourth St., Suite 520 Portland, OR 97201-4960	FAX 503-279-0190

III. Are there payers other than DMAP?

Client copayments

DMAP requires fee-for-service clients with OHP Plus or OHP with Limited Drug benefit packages to make a copayment for prescription drugs and outpatient services.

Copayments do not apply to children or pregnant women. People with the OHP Standard benefit package do not have to pay copayments either.

Affected clients pay their copayments directly to the provider.

Providers cannot deny services to a client solely because of an inability to pay a copayment. This does not relieve the client of the responsibility to pay, nor does it prevent the provider from attempting to collect any applicable copayments from the client.

Copayment amounts:

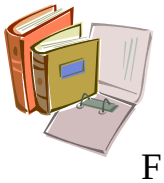
- $2 for generic drugs
- $3 for brand name drugs
- $3 for outpatient services (see OARs)

Fields 7a and 7b on the DMAP Medical Care ID will tell you what copayment amount, in any, applies to each household member. If this field says NO COPAYS, then don't collect a copayment.

Key to Success

Client copayments

- ✓ Verify which of your services require copayments.
- ✓ Determine which clients are exempt from copayments.
- ✓ Collect copayments only from affected clients.
- ✓ Do not deduct the copayment amount from the usual and customary fee when you submit your claim.
- ✓ Your remittance advice will show the copayment amount that has been automatically deducted from the amount paid.



Resources

Client copayments

For copayment information, see General Rules, OAR 410-120-1230. <http://www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html>.

Also, check the specific Rulebook for your provider type at <http://www.dhs.state.or.us/policy/healthplan/guides/main.html>.

Third party resources

Some OHP clients may also have other health insurance, otherwise known as a Third Party Resource (TPR). Fields 8a and 8b on the Medical Care ID will show the name(s) of any other coverage.

DMAP requires providers to pursue all other payers before billing us. Such resources include any individual, entity or program that is liable to pay all or part of the medical cost of any health care services furnished to an OHP client.

Just remember that DMAP is the payer of last resort.

Occasionally, a client neglects to tell us they have other insurance for themselves or one of their children. If you discover another payer that we didn't list on the client's Medical ID, please tell us. The location of the notification form (DHS 8708) is listed in the next column under Resources.

Key to Success

Third Party Resources

- ✓ If the client has another insurance source, including Medicare, bill them first.
- ✓ Indicate on your claim form how much the other payer paid.
- ✓ If other insurance denied the claim, enter a two-digit TPR explanation code on the paper claim form or a three-character adjustment reason code on electronic claims.

Resources

Third Party Resources

See General Rule OAR 410-120-1280 (4) and Table 1280 for two-digit TPR codes: <http://www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html>. or call 1-800-527-5772 for hard copies.

For information on Medicare to Medicaid crossover claims, read your Supplemental Information.

Notify the state via the Insurance Notification Form (DHS 8708) if you discover another TPR for any client. The form is online at <http://dhsforms.hr.state.or.us/Forms/Served/DE8708.pdf>.

IV. Billing DMAP

Billing DMAP electronically

When you are ready to submit your claim for payment processing, you have the choice of billing DMAP electronically or on paper.

Electronic data interchange (EDI) offers the faster, more secure and accurate choice.

When you transmit an electronic claim, it feeds directly into our provider payment system. You will need to buy software, or use a billing service or clearinghouse in order to participate in this type of health care information exchange with DMAP.

DHS will return rapid feedback about the acceptability of your claim format. If there is an error, you will receive a response indicating what data was missing or what was not formatted correctly. Once corrected, you can resubmit it right away. Payment for EDI claims follows faster than by paper billing.

When you submit claims by EDI for clients who are eligible for both Medicare and Medicaid, your claim will "cross over" automatically. You don't have to submit separate claims, as with paper billing.

DMAP offers providers a choice of receiving paper remittance advices (RAs) or electronic RAs in the CMS standard format.

Also, DMAP offers providers the choice of a direct deposit payment (*i.e.*, electronic funds transfer—EFT) or paper checks. (See "Exploring more resources" section.)

If you want to sign up for electronic data exchange with DMAP, complete a trading partner agreement and return it to us with original signature. (See Resources below.)

Then be sure to eSubscribe for "system alerts." (See "Exploring more resources.")

Key to Success

Billing DMAP electronically

- ✓ Secure the software, billing service or clearinghouse that will handle your transmissions.
- ✓ Register as an EDI trading partner with DMAP.
- ✓ Test your transmissions.
- ✓ Begin billing electronically.

Resources

Billing DMAP electronically

For help with electronic claims submission, see the Introduction to Electronic Business Practices at <http://www.oregon.gov/DHS/admin/hipaa/edi.shtml>

Start by reading *EDI 101* <http://www.oregon.gov/DHS/admin/hipaa/e-business/edi_101.pdf>.

Trading partner agreements are available online at <http://www.oregon.gov/DHS/admin/hipaa/testing_reg.shtml>. Then click on the EDI Registration Packet.

For specific questions or for help to register as an EDI trading partner, contact the EDI Support Team at 1-888-690-9888 or <dhs.hipaatesting@state.or.us>.

Billing flow chart
for fee-for-service OHP clients

1. Is client enrolled in OHP managed care for your type of service?

Yes. Bill the managed care plan.

No. Continue to Step 2.

2. Does client have a copayment requirement?

Yes. Collect copay and continue to Step 3.

No. Continue to Step 3.

3. Does client have other health insurance?

Yes. Bill all other payers before continuing to Step 4.

No. Continue to Step 5.

4. Does client have Medicare coverage for your services?

Yes. Bill Medicare and wait for payment, denial or automatic crossover before continuing to Step 5.

No. Continue to Step 5.

5. Bill DMAP following electronic or paper billing instructions for your provider type.

Billing DMAP via paper claims

If you're not prepared to do electronic billing, DMAP still accepts paper claims. You will find samples of the forms you need and instructions for completing them in the Supplemental Information for your specific provider type.

Mail your paper claim forms to a specific address based on the claim type. See the list of addresses on the next page.

It is crucial that you complete your claim form accurately and legibly. Data entry staff cannot alter the information on your claim form or take the time to read and answer notes attached to your claims. Address any questions to DMAP Provider Services.

Our computerized payment system may ask more than 900 potential questions about a claim before it can determine a payment approval or denial. Many claims are denied because of incomplete or incorrect patient or provider data.

DMAP will send you a paper remittance advice (RA) telling you that your claims were either paid or denied. Denied claims contain errors that need to be corrected and resubmitted.

DMAP offers providers the choice of a direct deposit payment (*i.e.*, electronic funds transfer—EFT) or paper checks.

If you're interested in receiving direct deposit payments, see "Exploring more resources" section.

Key to Success

Billing via paper claims

- ✓ Make sure all required fields are completed on your claim form.
- ✓ Remember to enter your provider number.
- ✓ Make sure your claim form is legible and accurate.
- ✓ Mail your claim to the appropriate address for your provider type.

Resources

Billing via paper claims

The list on the next page shows the addresses to which you will send your claims.

Your Supplemental Information includes sample forms and instructions for completing them. Go to your specific program type at <http://www.dhs.state.or.us/policy/healthplan/guides/main.html> or call 1-800-527-5772 to request a hard copy.

The DMAP Web pages also offer more tips at <http://www.oregon.gov/DHS/healthplan/tools_prov/tips/main.shtml>.

Provider Services can answer your questions at 1-800-336-6016 or mailto:DMAP.providerservices@state.or.us.

DMAP Mailing Addresses

Claim type	Service type	Address
CMS 1500	All medical provider claims	DMAP, PO Box 14955 Salem, OR 97309
	Speech/language pathology, audiology & hearing services; private duty nursing claims	DMAP, PO Box 14018 Salem, OR 97309
	Contract RN claims	DMAP, PO Box 14957 Salem, OR 97309
DMAP 505	Medicare/Medicaid claims	DMAP, PO Box 14015 Salem, OR 97309
UCF 5.1	Drug claims	DMAP, PO Box 14951 Salem, OR 97309
Any form used in conjunction with Death with Dignity	Death with Dignity claims	DMAP, PO Box 992 Salem, OR 97308-0992
ADA	Dental claims	DMAP, PO Box 14953 Salem, OR 97309
UB	Hospital, Home Health, Hospice claims	DMAP, PO Box 14956 Salem, OR 97309
TADS	Long-term nursing home care claims	DMAP, PO Box 14954 Salem, OR 97309
DMAP 741 DMAP 742	Consent to hysterectomy Consent to sterilization	DMAP, PO Box 14958 Salem, OR 97309
Cartridges or tapes	*DMAP no longer accepts electronic claims on cartridges or tapes*	
Out-of-state claims (all claim types)	For providers more than 75 miles beyond the Oregon border. If within 75 miles, use previous instructions for each form type.	DMAP CMU PO Box 14016 Salem, OR 97309
Administrative exams	Exams requested by DHS offices. Send reports to requesting DHS office; Mail only claims to DMAP.	DMAP, PO Box 14165 Salem, OR 97309
DMAP/DHS forms	To order DMAP or DHS forms	DHS Distribution Center 550 Airport Rd Salem, OR 97310
DMAP 1036 – Individual adjustment request	To use if you have received an incorrect payment (overpayment or underpayment) for a claim	DMAP, PO Box 14952 Salem, OR 97309
Problem claims including administrative errors and claims over one year old.	1. Send copy of claim with letter explaining the problem 2. Attach paper RAs related to claim 3. Include complete documentation	DMAP Prov Svcs 500 Summer St NE, E44 Salem, OR 97301-1079
Appeals (Reconsideration of non-covered services, CAWEM denials, and other appeals).	1. Send a letter stating reasons for the appeal. 2. Attach the claim for denied services. 3. Include supporting medical record documentation.	DMAP Prov Svcs 500 Summer St NE, E44 Salem, OR 97301-1079

Sending your claims to the wrong address will delay processing

V. Exploring more resources

Provider Services staff

Sometimes you may need our assistance to bill DMAP accurately. Whether you submit paper or electronic claims, we have trained staff to assist you.

- **For help with electronic data interchange (EDI) claims:**

Read *EDI 101* on the Introduction to Electronic Business Web page <http://www.oregon.gov/DHS/admin/hipaa/edi.shtml>.

For technical assistance when submitting electronically, call the EDI Support Team: (503) 947-5347 or 1-888-690-9888 or e-mail dhs.hipaatesting@state.or.us

- **For help with paper claims:**

When you contact DMAP Provider Services at 1-800-336-6016, a representative will walk you through the billing process or help you with any specific question you may have. DMAP offers two levels of representatives to assist you:

Level 1: Billing information, claim status, answers to simple questions.
Level 2: Extensive research, resolution to more complex issues.

- **To sign up for direct deposit:**

Complete a form (DMAP 3077), and return with original signature and a voided check.
<http://dhsforms.hr.state.or.us/Forms/Served/OE3077.pdf>

Tools on the Web site

DMAP provides a Web site with many helpful pages at <www.oregon.gov/DHS/healthplan/index.shtml>. From there you can navigate to wherever you need to go.

Provider Tools will be important for you (look on the left column and click on that title).

Please bookmark the **Oregon Administrative Rules (OARs)** that govern your medical specialty <http://www.dhs.state.or.us/policy/healthplan/guides/main.html> and the **Provider Announcements** <http://www.oregon.gov/DHS/healthplan/notices_providers/main.shtml>.

DHS is trying to eliminate mass mailings to save printing/postage costs, so updates are always posted at the address above faster than the post office can deliver the message. Make sure that you sign up for the free e-mail notification service known as "eSubscribe." By registering with us, you will receive an e-mail every time a new announcement is posted or a rule or supplement changes on the Web pages you select.

You can e-mail DMAP.info@state.or.us if you have questions about where to find something on the DMAP Web pages.

Register your National Provider Identifier with DHS at http://www.oregon.gov/DHS/admin/hipaa/npi/main.shtml>.

If you don't have Internet access, call DMAP at 1-800-527-5772 for hard copies of your Administrative Rules and Supplemental Information.

More assistance by phone

AIS 1-800-522-2508 *Sun – 12 a.m. to 8 p.m; Mon – 3 a.m. to 11 p.m; Tues-Sat – 12 a.m. to 11 p.m.*

- ✓ Patient eligibility, TPR, benefit packages, managed care
- ✓ Vision service history
- ✓ Reimbursement information for specific procedures

AIS Technical Support 1-800-884-7387 *24 hours/7 days a week*

- ✓ For assistance processing claims *(not for prior authorizations)*

Benefit RN Hotline 1-800-393-9855 *Mon-Fri – 8 a.m. to 5 p.m.*

- ✓ Information about OHP diagnosis/treatment pairs

If the patient is in a managed care plan and you have a question about whether the treatment is covered, call the patient's plan.

Claims Management Group 1-800-527-5772 *Mon-Fri – 8 a.m. to 5 p.m.*

- ✓ Information about out-of-state claims

Electronic Data Interchange Support Team 1-888-690-9888 *Mon-Fri – 8 a.m. to 5 p.m.*

- ✓ Information about submitting claims electronically

Managed Access Program 1-800-344-9180 or FAX 1-800 250-6950

- ✓ Prior Authorization for providers calling for prescriptions

Provider Enrollment 1-800-422-5047 (Option 1) *Mon–Fri, 8 a.m. to 5 p.m.*

- ✓ Call to change provider addresses or other enrollment information

Provider Services 1-800-336-6016 or 503-378-3697 in Salem *Mon–Fri, 8 a.m. to 5 p.m.*

- ✓ Provides details of Medical programs
- ✓ Answers billing questions
- ✓ Information on claims payment
- ✓ To discuss claim status

OHP Application Center 1-800-359-9517 or TTY 1-800-621-5260 *Mon–Fri, 8 a.m. to 5 p.m.*

- ✓ Patients may call to receive an OHP Application
- ✓ Provides general assistance in completing the OHP Application
- ✓ Patients may call to receive a Senior Prescription Drug Assistance Program Application

Department of Human Services
Division of Medical Assistance Programs
500 Summer Street NE, E-35
Salem, Oregon 97301