DMAP 505

Claim form billing instructions for the Department of Human Services

DHS
Oregon Department of Human Services

Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid/Medicare services complete the DMAP 505 billing form correctly the first time. If applicable, this presentation is to be used in conjunction with General Rules, your provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~ DHS ~

MMIS

- The federal government requires DHS to process Medicaid claims through an automated claim processing system known as the Medicaid Management Information System (MMIS).
- This system is a combination of people and computers working together to process claims.
- This system performs daily edits for presence and validity of data.
- DHS staff only reviews claims that MMIS cannot make a payment decision on based on the information submitted.

Claims Processing

- Paper claims submitted by mail go to DHS Office of Document Management (ODM) Imaging Unit.
- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.
- Make sure your claim form meets OCR specifications.
- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).

Crossover

- When you submit your CMS 1500 claim form to Medicare, Medicare transmits the billing information to DMAP. This transmission is called a “crossover.”

- The DMAP 505 billing form is unique. It is specifically used for clients who receive both Medicare and Medicaid services, when:

  - Medicare transmits incorrect crossover information to DMAP, and the claim was denied payment; or
  - An out-of-state Medicare carrier or intermediary was billed.

Before you bill

- Read your provider guidelines.
- Verify client eligibility on the date of service.
- Make sure you bill all prior resources first. DHS is the payer of last resort.

A few tips!

- When submitting handwritten claim forms, you must use blue or black ink. Never use red ink.
- Make sure your handwriting is legible.
- If possible, submit no more than six lines of services per claim form.
- Do not use liquid whiteout.
- Check your printer alignment.

Form supplier

- The DMAP 505 is supplied by DHS.
- The form is also available on DMAP's Web site:
  www.oregon.gov/DHS/healthplan/forms/omapforms.shtml
- For a supply of forms, complete and submit a provider forms request card, DMAP 2420.
- Mail the DMAP 2420 to:

  DHS Forms Distribution
  550 Airport Rd. S.E.
  Salem, OR 97310

Who uses the DMAP 505

- Medical Professional Providers
- Physician's Assistants
- Nurse Practitioners
- Podiatrists
- Certified Registered Nurse Anesthetists
- Independent Laboratories
- Naturopaths
- Vision
- Chiropractors
- Durable Medical
- Physical Therapy
- Occupational Therapy
- Audiologists
- Home Enteral/Parenteral IV Services

This list may not include all provider types that us the DMAP 505.

Who uses the DMAP 505

- If you are not sure what claim form you are required to use, contact DMAP Provider Services. They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: DMAP.providerservices@state.or.us

Introducing the DMAP 505

DHS Oregon Department of Human Services

Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

1. Patient's Name (Last, First, MI)	2. Patient's birthdate/sex MM DD YY M F	3. Insured's ID # (include all letters and numbers)
4. Patient's address (number, street)	5. Patient's Relation to Insured Self Spouse Child Other	6. Insured's Name (Last, First, MI)
City / State	7. Was condition related to: a. Patient's employment Y N; b. Accident Auto Other	8. Insured's address (number, street)
Zip Code / Phone (Area Code)		City / State
9. Other insured's name (Last, First, MI)	a. Other insured's Plan name	Zip Code / Phone (Area Code)
Other insured's Plan address (number, street)	b. Other insured's policy number	10. Insured's group # (or group name)
City / State	Zip Code / Phone (Area Code)	12. I authorize payment of medical benefits to undersigned physician or supplier for services described below.
11. Patient's or authorized person's signature – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signed / Date		Signed (insured or authorized person)
13. Date of current: MM DD YY ◀ Illness (first symptom) or Injury (accident) or Pregnancy (LMP)	14. If emergency, check here	15. First date patient had same or similar illness MM DD YY
16. Name of referring provider or other source	16a. / 16b. NPI	17. Dates patient unable to work in current occupation From MM DD YY To MM DD YY
18. Outside lab? Yes No $ Charges	19. Prior authorization number	20. Hospitalization dates related to current services From MM DD YY To MM DD YY

21. Diagnosis or nature of illness or injury (relate items 1, 2, 3, or 4 to item 22D by line)
1. _____ 2. _____ 3. _____ 4. _____

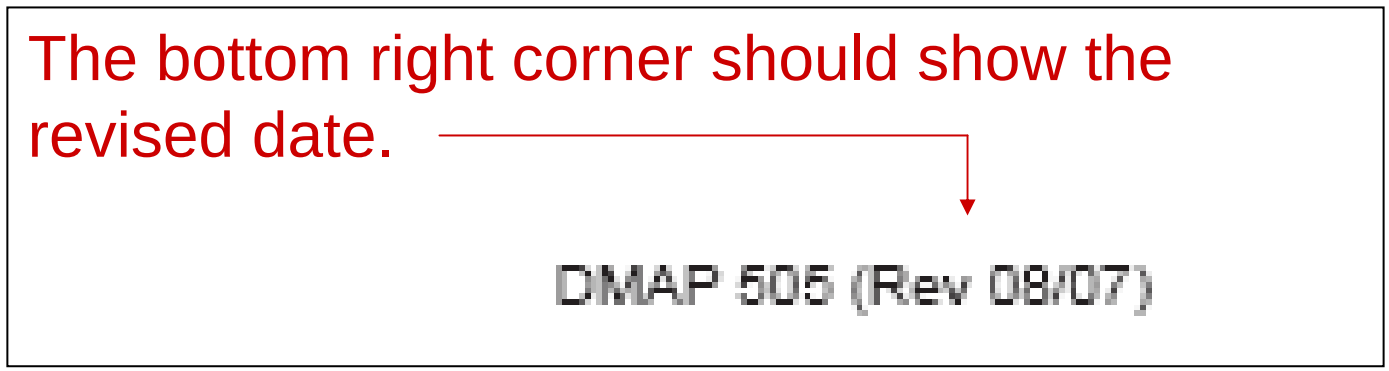
22. A. Date(s) of service From MM DD YY To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
									DMAP: / NPI:
									DMAP: / NPI:
									DMAP: / NPI:
									DMAP: / NPI:
									DMAP: / NPI:
									DMAP: / NPI:

23. Federal tax ID # SSN EIN	24. Total charge	25. Total Medicare payment
26. Patient's account #	27. Accept assignment? Y N	28. Ins (not Medicaid/Medicare) / 29. Balance due
30. Service facility location information	31. Billing provider information and phone number	
NPI #: / DMAP #:	NPI #: / DMAP #:	

Revised form

- Not sure if you are using the correct form?

The bottom right corner should show the revised date.



- DHS will also accept the 2/07 version of this form.
- The 8/07 version has changes to the shading on the form for improved processing of DMAP 505 forms printed from the DHS Web site.

Top section

1. Patient's Name (Last, First, MI)	2. Patient's birthdate/sex MM | DD | YY M ☐ F ☐	3. Insured's ID # (include all letters and numbers)
4. Patient's address (number, street)	5. Patient's Relation to Insured Self ☐ Spouse ☐ Child ☐ Other ☐	6. Insured's Name (Last, First, MI)
City / State	7. Was condition related to: a. Patient's employment Y ☐ N ☐ b. Accident Auto ☐ Other ☐	8. Insured's address (number, street)
Zip Code / Phone (Area Code)		City / State
9. Other insured's name (Last, First, MI)	a. Other insured's Plan name	Zip Code / Phone (Area Code)
Other insured's Plan address (number, street)	b. Other insured's policy number	10. Insured's group # (or group name)
City / State	Zip Code / Phone (Area Code)	12. I authorize payment of medical benefits to undersigned physician or supplier for services described below.
11. Patient's or authorized person's signature – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. *Signed* *Date*		*Signed (insured or authorized person)*

Red = Required

Yellow = Optional

Box 1 - Required

1. Patient's Name (Last, First, MI)
   Client, Your

Patient’s Name

- Enter the client’s name exactly as it is printed on the Medical Care Identification.
- Use your client’s last name first.
- Do not use nicknames.

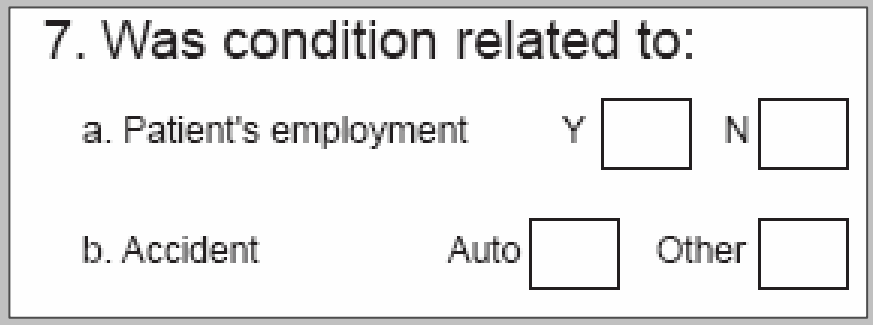
Box 3 - Required

3. Insured's ID # (include all letters and numbers)
X X # # # X # X

Recipient ID Number

- Enter the client's eight-character prime identification number.
- Enter the number exactly as it appears on the Medical Care Identification.

Box 7 - Optional



Patient's Condition

- Check the appropriate box only when an injury is involved.
- Do not check any boxes if there is no injury to report.

Box 9 - Optional

9. Other insured's name (Last, First, MI)
UD

Third Party Resource

- If Medicare did not make a payment to you, enter the appropriate two-digit third party resource (TPR) explanation code.
- A code is always required when the client has more than one other insurance carrier.
- TPR codes can be found in your specific provider rulebook supplemental, or on the following slides.

Single carrier TPR codes

UD	Service under deductible
NC	Service not covered by insurance policy
PN	Patient not covered by insurance policy
IC	Insurance coverage canceled/terminated
IL	Insurance lapsed or not in effect on date of service
IP	Insurance payment went to policyholder
PP	Insurance payment went to patient
NA	Service not authorized or prior authorized by insurance
NE	Service not considered emergency by insurance
NP	Service not provided by primary care provider/facility

Single carrier TPR codes continued on next slide

Single carrier TPR codes

MB	Maximum benefits used for diagnosis/condition
RI	Requested information not received by insurance from patient
RP	Requested information not received by insurance from policyholder
MV	Motor Vehicle Accident Fund (MVAF) maximum benefits exhausted
AP	Insurance mandated under administrative/court order through an absent parent and not paid within 30 days
OT	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance)

Multiple carrier TPR codes

MP	Primary insurance paid – secondary paid
SU	Primary insurance paid – secondary under deductible
MU	Primary and secondary under deductible
PU	Primary insurance under deductible – secondary paid
SS	Primary insurance paid – secondary service not covered
SC	Primary insurance paid – secondary patient not covered
ST	Primary insurance paid – secondary canceled/terminated
SL	Primary insurance paid – secondary lapsed or not in effect
SP	Primary insurance paid – secondary payment went to patient

Multiple carrier TPR codes continued on next two slides

Multiple carrier TPR codes

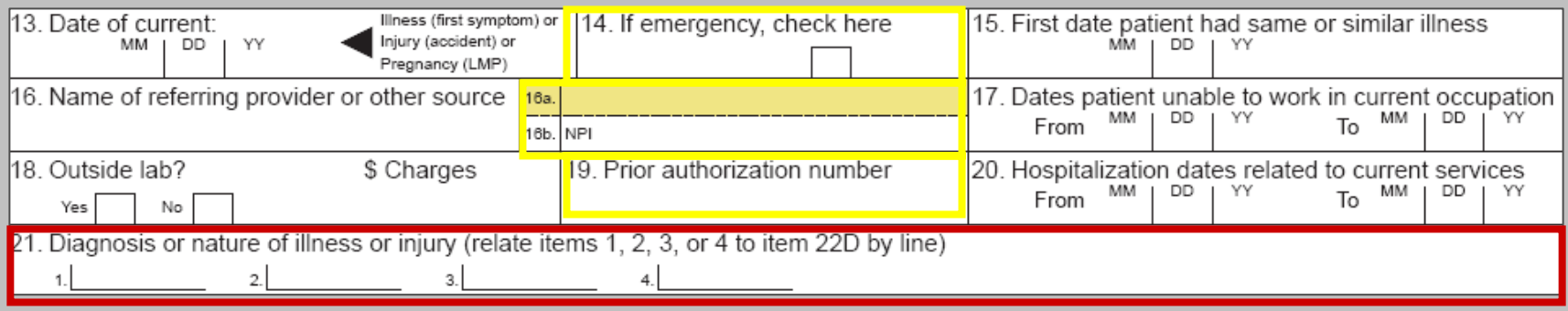
SH	Primary insurance paid – secondary payment went to policyholder
SA	Primary insurance paid – secondary denied – service not authorized
SE	Primary insurance paid – secondary denied – service not considered emergency
SF	Primary insurance paid – secondary denied – service not provided by primary care provider/facility
SM	Primary insurance paid – secondary denied – maximum benefits used for diagnosis/condition
SI	Primary insurance paid – secondary denied – requested information not received from policyholder

Multiple carrier TPR codes continued on next slide

Multiple carrier TPR codes

SR	Primary insurance paid – secondary denied – requested information not received from patient
MC	Service not covered by primary or secondary insurance
MO	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurances)

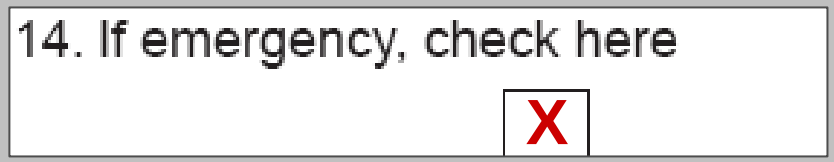
Middle section



Red = Required

Yellow = Optional

Box 14 - Optional



Emergency Indicator

- If the service you provided was a result of an emergency, check this box.
- If this was not an emergent service, leave blank.

Box 16a - Optional

16a.	# # # # # #

Referring Provider Number

- Enter the six-digit (DHS-issued) provider number of the referring provider.
- This may be required if the client has a Primary Care Manager (PCM) or the service requires a referral (*e.g.,* Physical Therapy, Occupational Therapy or Speech Therapy).

Box 16b - Optional

16b.	NPI	# # # # # # # # # #

Referral National Provider Identifier (NPI)

- If information was entered in box 16a (Primary Care Manager, or other referral) the corresponding NPI is entered here.
- Enter the ten-digit NPI of the referring provider.

Box 19 - Optional

Prior Authorization Number

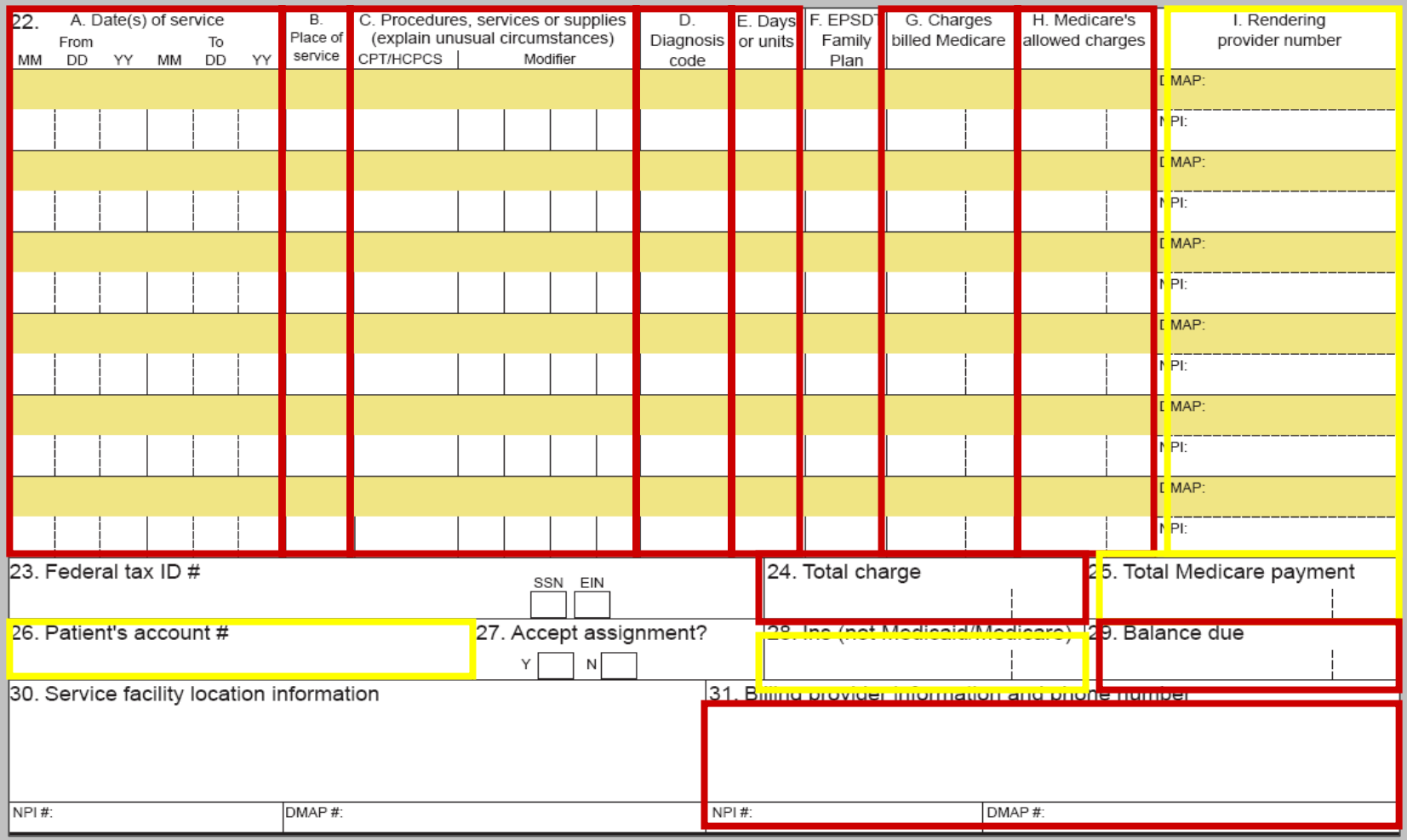
- If the service you provided requires prior authorization (PA), enter the nine-digit prior authorization number that was issued for the service.
- Only use one prior authorization number per claim form.
- Do not bill prior authorized and non-authorized services on the same claim form.

Box 21 - Required

Diagnosis Code

- Enter the client's diagnosis/condition.
- The diagnosis code must be the reason chiefly responsible for the service being provided as shown in medical records.
- You may enter up to four codes and each code must be carried out to its highest degree of specificity.
- Do not use the decimal point.

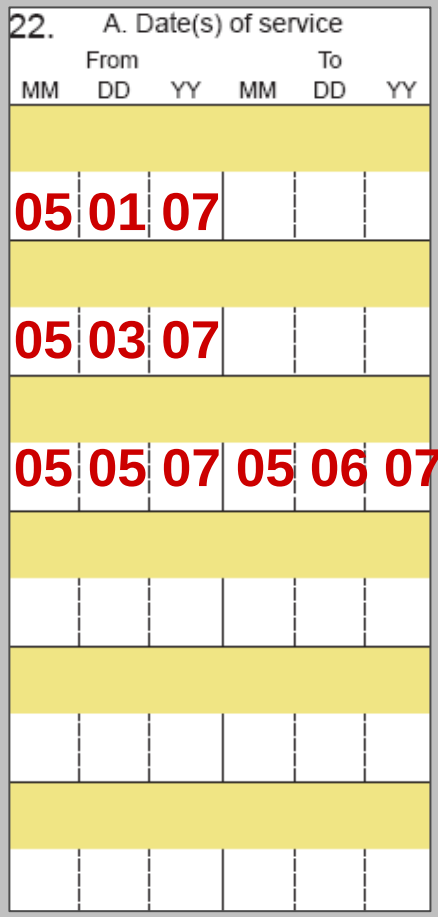
Bottom section



Red = Required

Yellow = Optional

Box 22A - Required



Date of Service

- This box must list numeric dates of service.
- If billing for one day, complete only the “from” column.
- If the “from and to” dates are used, a service must be on consecutive days and provided no more than once per day.

Box 22B - Required

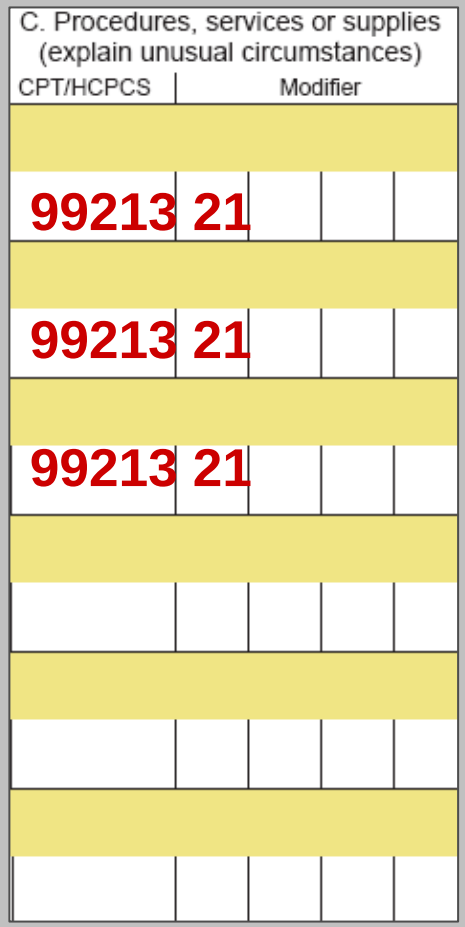
Place of Service

- Enter the two-digit place of service code of where the service was provided.
- Place of service codes can be found in CPT/HCPCS codebooks or on the CMS Web site at:
  www.cms.hhs.gov/placeofservicecodes/downloads/posdatabase.pdf
- One-digit place of service codes are also acceptable.
  (Refer to the following slide for DMAP place of service codes).

Place of service codes

1	Inpatient Hospital
2	Outpatient Hospital
3	Practitioner Office
4	Patient Home
5	Day Care Facility
6	Night Care Facility
7	Intermediate Care Facility
8	Skilled Nursing Facility
A	Independent Lab
B	Other Medical/Surgical Facilities/School District Facility
C	Residential Treatment Center
D	Specialized Treatment Center

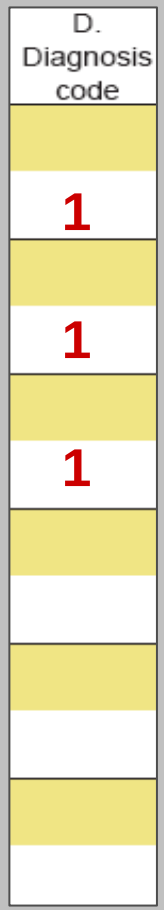
Box 22C - Required



Procedure Code

- Enter the five-digit/character CPT or HCPCS code(s) for the specific service provided.
- Optional - Enter up to four two-digit national modifiers that relate to this service.
- For procedure codes that indicate “unlisted,” you must attach an operative/medical report.

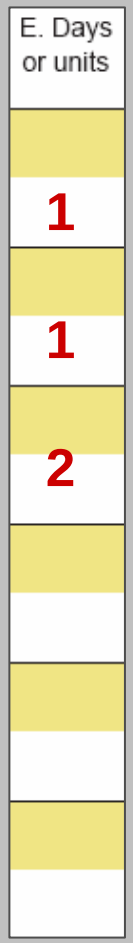
Box 22D - Required



Diagnosis Pointer

- Enter the one-digit diagnosis code reference number (pointer) as shown in box 21 that relates to the date of service and the procedure.
- Do not enter the actual ICD-9-CM code here.

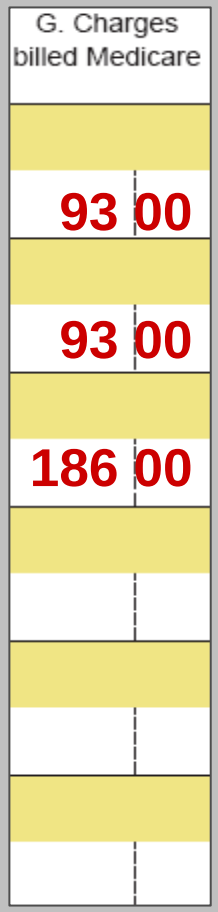
Box 22E - Required



Service Days or Units

- Enter the number of days or units for each number of consecutive days or services as indicated in box 22A.
- Some services are billed by units, depending upon the service provided.

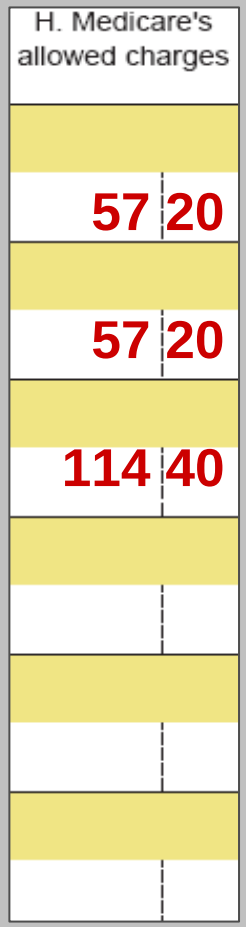
Box 22G - Required



Total Charges

- Enter the total usual and customary charge for each line.
- Do not list credits.
- Do not use dashes.
- DHS will not calculate your charge if billing for more than 1 item (unit).

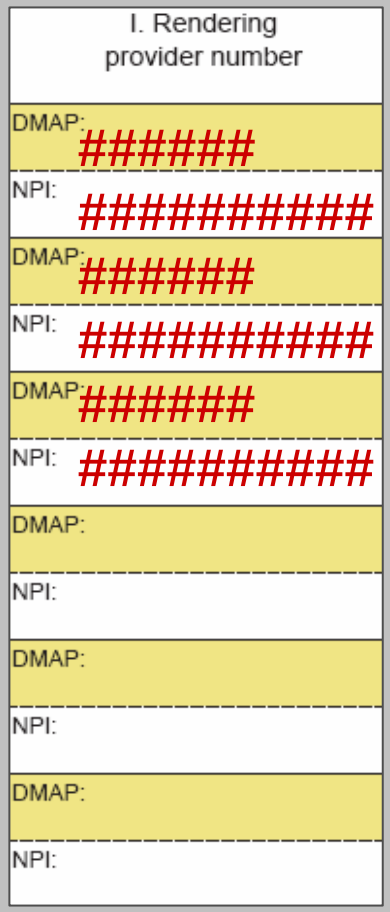
Box 22H - Required



Medicare Allowed Charges

- Enter the amount Medicare allowed for each service billed.

Box 22I - Optional



Rendering Provider ID

- This box is only required when clinics or group practices use a specific billing provider number in box 31. This identifies who rendered the service.
- Shaded - Enter the six-digit (DHS-issued) provider number of the individual rendering the service.
- Non-shaded - Enter the ten-digit NPI of the rendering provider that was identified in the shaded area.

Box 24 - Required

Total Charge

- Enter the total charge amount for all services listed in column 22G.
- Each claim form is a separate document, and is to be totaled as such.

Box 25 - Optional

Total Medicare Payment

- Enter the total amount paid by Medicare.
- Do not include write-offs.
- Do not include how much DHS previously paid.
- Do not include copayments.

Box 26 - Optional

Patient Account Number

- Enter your patient account number here.
- This box allows up to twelve characters.
- This number will appear on your Remittance Advice (RA).

Box 28 - Optional

Amount Paid

- Enter the total amount paid by any other resources.
- Do not include write-offs.
- Do not include how much DHS previously paid.
- Do not include copayments.

Box 29 - Required

Balance Due

- Enter the balance due.
- Box 24, minus box 25, minus box 28, must equal box 29.

Box 31 - Required

31. Billing provider information and phone number **Billing Provider** **PO Box ###** **Anytown, OR 97###**	
NPI #: **##########**	DMAP #: **######**

Billing Provider Information

- Enter the name and address of the provider that is requesting to be paid for the services rendered.
- (NPI#) Enter the ten-digit NPI of the billing provider.
- (DMAP#) Enter the six-digit (DHS-issued) provider number of the billing provider.

COMPLETED

EXAMPLE

DHS Oregon Department of Human Services

Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

1. Patient's Name (Last, First, MI): Client, Name	2. Patient's birthdate/sex (MM DD YY) M F	3. Insured's ID # (include all letters and numbers): XX###X#X
4. Patient's address (number, street)	5. Patient's Relation to Insured: Self Spouse Child Other	6. Insured's Name (Last, First, MI)
City / State	7. Was condition related to: a. Patient's employment Y N; b. Accident Auto Other	8. Insured's address (number, street)
Zip Code / Phone (Area Code)		City / State
9. Other insured's name (Last, First, MI): UD	a. Other insured's Plan name	Zip Code / Phone (Area Code)
Other insured's Plan address (number, street)	b. Other insured's policy number	10. Insured's group # (or group name)
City / State	Zip Code / Phone (Area Code)	12. I authorize payment of medical benefits to undersigned physician or supplier for services described below. Signed (insured or authorized person)
11. Patient's or authorized person's signature – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signed / Date		
13. Date of current: (MM DD YY) Illness (first symptom) or Injury (accident) or Pregnancy (LMP)	14. If emergency, check here	15. First date patient had same or similar illness (MM DD YY)
16. Name of referring provider or other source	16a. ###### / 16b. NPI ##########	17. Dates patient unable to work in current occupation From To
18. Outside lab? Yes No $ Charges	19. Prior authorization number	20. Hospitalization dates related to current services From To

21. Diagnosis or nature of illness or injury (relate items 1, 2, 3, or 4 to item 22D by line)
1. 786 59 2. 414 01 3. 250 61 4. 465 9

22. A. Date(s) of service From MM DD YY	To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
										DMAP: ###### NPI: ##########
05 01 07		11	99213	21	1	1		93 00	57 20	
05 03 07		11	99213	21	1	1		93 00	57 20	DMAP: ###### NPI: ##########
05 05 07	05 06 07	11	99213	21	1	2		186 00	114 40	DMAP: ###### NPI: ##########
										DMAP: NPI:
										DMAP: NPI:
										DMAP: NPI:

23. Federal tax ID # SSN EIN	24. Total charge 372 00	25. Total Medicare payment 125 00	
26. Patient's account # X123400	27. Accept assignment? Y N	28. Ins (not Medicaid/Medicare)	29. Balance due 247 00
30. Service facility location information	31. Billing provider information and phone number: Billing Provider PO Box ### Anytown, OR 97###		
NPI #:	DMAP #:	NPI #: ##########	DMAP #: ######

DMAP 505 (Rev 08/07)

Supplemental information

Box 22A - 22H

- DMAP accepts the following types of supplemental information that can be entered in the shaded line across box 22A through box 22H:
  - Anesthesia duration in hours and/or minutes with start and end times
  - Narrative description of unspecified codes
  - National Drug Codes for drugs
  - Vendor Product Number
  - Health Care Uniform Code, formerly Universal Product Code
  - Contract rate

Supplemental qualifiers

- The following qualifiers are to be used when reporting these services:

Qualifier	Description
7	Anesthesia
ZZ	Narrative description of unspecified codes
VP	Vendor Product Number
OZ	Health Care Uniform Code
CTR	Contract rate
N4	National Drug Code, also use the following:
F2	▪ International unit
GR	▪ Gram
ML	▪ Milliliter
UN	▪ Unit

Supplemental items

- More than one supplemental item can be reported.
- Enter the first qualifier and number/code/information.
- After the first item, enter three blank spaces and then the next qualifier and number/code/information.
- The following three slides are examples of different types of supplemental information.

Anesthesia services

Billed based on 15-minute units

22. A. Date(s) of service From MM	DD	YY	To MM	DD	YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
7 Begin 1245 End Time 90 Minutes														DMAP: ######
05	**01**	**07**				**11**	**00770**	**P2**		**1**	**6**		### ##	## ##	NPI: ##########

Billed based on minutes as units

22. A. Date(s) of service From MM	DD	YY	To MM	DD	YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
7 Begin 1245 End 1415														DMAP: ######
05	**01**	**07**				**11**	**00770**	**P2**		**1**	**90**		### ##	## ##	NPI: ##########

Unspecified / NDC services

Unspecified Code

22. A. Date(s) of service From MM	DD	YY	To MM	DD	YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
ZZ Kaye Walker														DMAP: ######
05	**01**	**07**				**12**	**E1399**		**1**	**1**		### ##	## ##	NPI: ##########

National Drug Code

22. A. Date(s) of service From MM	DD	YY	To MM	DD	YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
N400026064871 Immune Globulin Intravenous UN2														DMAP: ######
05	**01**	**07**				**11**	**J1563**		**1**	**20**		### ##	## ##	NPI: ##########

Vendor / Uniform services

Vendor Product Number

22. A. Date(s) of service From MM	DD	YY	To MM	DD	YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
VPA122BIC5D6E7G														DMAP: ######
05	01	07				11	A6410		1	1		### ##	## ##	NPI: ##########

Health Care Uniform Code

22. A. Date(s) of service From MM	DD	YY	To MM	DD	YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
OZ00301134678906														DMAP: ######
05	01	07				11	A6410		1	1		### ##	## ##	NPI: ##########

Resources

Where to mail your claim

- Mail your DMAP 505 claim form to:

  DMAP
  PO Box 14015
  Salem, OR 97309-4957

Who to call if you need help

- Contact DHS' DMAP Provider Services if you need assistance or if you have questions concerning your DMAP 505 claim form.
- They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: DMAP.providerservices@state.or.us

Thank you!