Provider Portal: How to Submit a Dental Claim

ARMedicaid

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 Go to the portal landing page and log in with the User ID and password previously created. If you do not have a User ID and password, click Register Now or see the JOB+AID "Registering on the Portal." (https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx)

If you have already logged in, skip to step 2.







For more information call 1-800-457-4454



2. From the "Welcome Health Care Professional" Home page, select the Claims tab.







For more information call 1-800-457-4454

Home	Eligibility	Claims	Care Management	Provider Functions	Files Exchange	Resources
Search Cl	aims Submit	Claim Den	ntal Submit Claim Inst	Submit Claim Prof Sea	rch Payment History	Maintain Favorite Providers Saved Claims
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3. Select "Submit Claim Dental."

You can also click **Search Claims** to search through claims you have previously submitted, or **Search Payment History** to search through your submitted claims that have already been paid.

NOTE: To find a claim that was previously entered, use the ICN or use the Member ID and Date of Service (DOS) options.

Maintain Favorite Providers: The providers on this list will be available for selection as the Facility or Servicing provider when you are creating a claim. Up to 20 providers can be stored on your favorites list.

Saved Claims: This function allows you to save a claim for later and resume where you left off. The claim will be saved for 90 days.





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Provider Name DENTAL PROVIDER	Note IDs			
Submit Dental Claim: Step 1				
The * (in red) indicates required fields.	(Note: When the Add/Save button i	s present, all fields	with * are only requi	ired when selecting Add/Save for that section.)
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Tuxonomy	0	ID Type		Name
Service Facility Location ID				

4a. • After selecting your claim type, enter the following information for **Step 1** as shown on the **Submit a Claim** screen.

Provider Information (enter all applicable information):
 Performing Provider ID and ID Type, Referring Provider ID and ID Type, Supervising
 Provider ID and ID Type, Service Facility Location ID and ID Type







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Provider Information	Claim Type						
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	Accident	Related	~	Accident Date 0	
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		EPSDT	No 🗸		
			*Does the provider have a signature on t	file? O Yes O No	
	*Do	es the prov	vider accept assignment for claim processi	ing? O Yes O No	
	*Are benefits as	signed to t	he provider by the patient or their author representat	ized Ores ONo ON/A	
	*Does the provider I	nave a sign	ed statement from the patient releasing t medical informati	heir Oyes ONo ion?	
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If you choose the "Include Other Insurance" option and select "Continue" on Step 1, it will bring you to the bottom of Step 2 which shows the panel for "Other Insurance Details."

If not applicable, proceed to Step #5.

Othe	r Insurance Details					E
Click	the Remove link to remove the en	bire row.				
circit					Refresh Other	Insurance
	Carrier Name	Carrier ID	Policy ID	Paid Amount	Paid Date	Action
1	SOUTHWIRE AND AFFILIATES	CI1	321654		-	Remove
• c	lick to add a new other insurance.					
	Back to Step 1			Continue Finish I	Later Cancel	I

Click on the number next to the correct primary payor to enter all of the other insurance information. If you do not see the correct carrier listed, simply click the + to add the appropriate carrier and other insurance details.

Otl	her Insurance Details						-
Clic	k the Remove link to remove t	ne entire row.					
						Refresh Other	Insurance
#	Carrier Name	Carrier ID	Policy ID		Paid Amount	Paid Date	Action
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	Carrier Name	SOUTHWIRE AND AFFILIATES	Carrier ID	CI1			
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	Policy Holder Last Name	PUFF	First Name	PATTI		MI _	
	Policy Holder Address	1234 MAIN STREET					
		-					
	City	LITTLE ROCK	State	ARKANS	SAS		
	Zip Code	72255					
	Policy Holder ID						
	Policy ID	321654					
	Group Name						
	Responsibility	U-Unknown	Patient Relationship to	18-Self			
	Paid Amount		*Paid Date 0		[TTT]		
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	*Claim Filing Indicator		~				
	Release of Information						
	Assignment of Benefits	~ · · · · ·					
	Save Insurance	Cancel Insurance					
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Once the information has been entered and all questions have been answered, select **Save Insurance**.

Fields marked with a red asterisk are required.







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	essional Claim: Step 2					
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		Claim	туре			
Provider Inf	ormation					
	Billing Provider ID	1111111112	ID Type NPI	Name		
	Taxonomy					
Patient and	Claim Information					
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	Beneficiary	PATTI PUFF	Ger	nder Female		
	Birth Date	07/15/1963	Total Charged Ame	ount \$0.00		
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Please note th	at the 1st diagnosis ent	ered is considered to be	the principal (primary) Diagnosis Code.			
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# 	*Diagnosis Type (Add Reset	ICD-10-CM ¥	*Diagnosis Code 🔒 📃			
# 1	*Diagnosis Type [ICD-10-CM V	*Diagnosis Code e			

- 5. Continue filling out claim information for Step 2 as shown on the Submit a Claim screen (information at the top of the screen will auto-populate based on what you entered in Step 1):
- **Diagnosis Codes (when adding a Diagnosis row):** Select **Diagnosis Type** (required) and enter a **Diagnosis Code** (required).
- Once the Diagnosis fields have been populated, click **Add**. Click **Reset** to remove diagnosis codes and start over.





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ine	(in red) indicates required fields	when the ADD button is sel	ected.			
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	Beneficiary ID					
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6. Click **Continue** to advance to Step 3. Click **Finish Later** if you want to save your claim. Click **Cancel** to cancel the claim or **Back to Step 1** to return to the first step.





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- Continue filling out claim information for Step 3 as shown on the Submit a Claim screen (information at the top of the screen will auto-populate based on what you entered in steps 1 and 2). Note: Not all fields are mandatory; please fill in only those marked with a red asterisk and any other relevant fields.
- Service Details: Use this screen to add, edit, or remove services rendered to the beneficiary. To edit information previously entered, click on the numbered link appearing in the Svc # column. To remove information previously entered, click **Remove** in the action column.

To add a detail, populate any data that applies for the following fields and click "Add": Svc Date; Oral Cavity Area, Tooth#/Letter, Tooth Surface, Procedure Code, Modifiers, Units, Charge Amount, Performing Provider ID, ID Type State License #, Supervising Provider ID, ID Type State License #. To remove data populated for a detail, but not yet added, click Reset.

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- **8.** Attachments: Click the + to upload any attachments/documents that apply to the claim. Skip this step if there are no attachments.
- 9. Click Submit to move to the next step of the claim submission process. Click Back to Step 1 or Back to Step 2 to revisit previous steps.
 Click Finish Later if you want to save your claim.
 Click Cancel to cancel the claim submission process.







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For more information call 1-800-457-4454

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	Does	the provider	hàvé à s	gnature on file?	Yes					
Does th	e provider ac	cept assignme	ent for cl	aim processing?	Yes					
Are benefits assigne	d to the prov	ider by the pa	tient or	their authorized	Yes					
				representative?						
Does the provider	have a signed	statement fr	om the p	atient releasing	Yes					
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 Review the information that has been keyed/submitted. Click Back to Step 1, Back to Step 2 or Back to Step 3 to correct or add any additional information. Click Print Preview to preview the claim details entered. Click Confirm to submit your claim. Click Cancel to cancel the claim submission process.



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For more information call 1-800-457-4454

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Dental Claim Receipt
Your Dental Claim was successfully submitted. The claim status is Deny.
The Claim ID is
Click Print Preview to view the claim details as they have been saved on the payer's system
Click Copy to copy member or claim data.
Click Edit to resubmit the claim.
Click New to submit a new claim.
Click View to view the details of the submitted claim.

- **11.** Once a claim is confirmed/submitted, the system will provide a claim receipt along with a 13-digit Claim ID.
- 12. Click Print Preview to preview the claim details entered. Click Copy to copy claim. Click Edit to edit denied claim. Click New to submit a new claim. Click View to view the details of your submitted claim. Note: Edit may also be used to adjust a paid claim.







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For more information call 1-800-457-4454