

Provider Portal: How to Submit a Dental Claim

ARMedicaid

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Home

Home

Tuesday 08/02/2016 10:30 AM CST

Login

*User ID

Log In

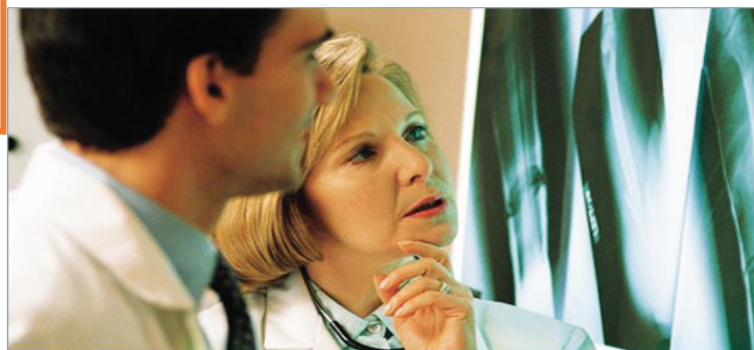
[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)

What can you do in the Provider Portal

Through this secure and easy to use internet portal, healthcare providers can submit claims and inquire on the status of their claims, inquire on a patient's eligibility, upload files containing 837 transactions, and search for another provider. In addition, healthcare providers can use this site to locate claim forms, provider participation materials and other health plan information and resources.



[FAQs](#)

[Links and Tools](#)

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[Website Requirements](#)

[Provider Manual](#)

Protect Your Privacy!

Always log off and close all of your browser windows

Would you like to enroll as a Provider or a Trading Partner?

[Provider](#)

[Trading Partner](#)

Looking for a Doctor or Hospital near you?

[Search Providers](#)

DHS-703 form

[Fill out Medical Eligibility Application](#)

[Check Status of Medical Eligibility](#)

1. 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.



2

[Home](#) [Eligibility](#) [Claims](#) [Care Management](#) [Provider Functions](#) [Files Exchange](#) [Resources](#)

Home Thursday 06/20/2024 09:52 AM CST

Provider Name DENTAL PROVIDER **Role IDs** Provider - In Network - 111111112 (NP ▼)

User Details

Welcome Dr. Dental DDS

[My Profile](#)

[Manage Accounts](#)

Provider

Name DENTAL PROVIDER

Provider ID 111111112 (NPI)

Revalidation Date 01/01/2022

[Characteristics](#)

Provider Services

[Search Payment History](#)

Welcome Health Care Professional!

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

[Help us provide better service to you! Click here to give us your feedback](#)

[Authenticare Demo - For Personal Care Providers required to participate in Electronic Visit Verification](#)

[Contact Us](#)

[Secure Correspondence](#)

All Claim Inquiries should be submitted to the following Address:

Claims
Gainwell Technologies
PO BOX 8034
LITTLE ROCK, AR 72203

- 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
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Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History | Maintain Favorite Providers | Saved Claims

Claims Thursday 03/25/2021 02:24 PM CST

Provider Name	PCP PROVIDER	Role IDs	Provider - In Network - 111111112 (NF ▼)
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Claims

- Search Claims
- Submit Claim Dental
- Submit Claim Inst
- Submit Claim Prof
- Search Payment History
- Maintain Favorite Providers
- Saved Claims

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.

4a

Provider Name DENTAL PROVIDER Role IDs

Submit Dental Claim: Step 1

The * (in red) indicates required fields. (Note: When the Add/Save button is present, all fields with * are only required when selecting Add/Save for that section.)

Provider Information

Billing Provider ID ID Type NPI Name DENTAL PROVIDER
Taxonomy DENTAL ASSISTANT

Select from Favorites No favorite providers available. ▾

Performing Provider ID ID Type Name Add to Favorites ☐
Taxonomy

Select from Favorites No favorite providers available. ▾

Referring Provider ID ID Type Name Add to Favorites ☐
Taxonomy

Select from Favorites No favorite providers available. ▾

Supervising Provider ID ID Type Name Add to Favorites ☐
Taxonomy

Service Facility Location ID ID Type Name
Taxonomy

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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NOTE: Enter the NPI number of the performing provider in the **Performing Provider ID** field.

Submit Professional Claim: Step 1


* Indicates a required field.

Claim Type

Provider Information

Billing Provider ID ID Type

Taxonomy

Performing Provider ID  ID Type

Taxonomy

Referring Provider ID ID Type

Taxonomy

Supervising Provider ID ID Type

Taxonomy

Service Facility Location ID ID Type Name

Taxonomy

If there are multiple nine-digit provider IDs associated with the NPI, click the **magnifying glass** to select the correct one.

Provider ID Search

Back to Claim

Search By ID Search By Name Search By Organization

The * (in red) indicates required fields when the ADD button is selected.

*Provider ID Provider ID Type

Search Cancel

Search Results:

Provider ID	Provider Name	Provider Type	Zip Code
(NPI)		Physician MD	
(01/01/2017 - 12/31/2299)			
(Atypical/Medicaid ID)			
(01/01/2017 - 12/31/2299)			
(NPI)		Skilled nursing facility	
(04/01/2017 - 12/31/2299)			
(Atypical/Medicaid ID)			
(04/01/2017 - 12/31/2299)			
(NPI)		Hospital	
(04/01/2017 - 12/31/2299)			
(Atypical/Medicaid ID)			
(04/01/2017 - 12/31/2299)			

To select the **provider ID**, click on the NPI number in the first column.



For more information call 1-800-457-4454





4b

Claim Information

Accident Related	<input type="text"/>	Preauthorization	<input type="text"/>
*Place of Treatment	11-OFFICE	Accident Date	<input type="text"/>
EPSDT	No	Patient Number	<input type="text"/>
*Does the provider have a signature on file?		<input type="radio"/> Yes <input type="radio"/> No	
*Does the provider accept assignment for claim processing?		<input type="radio"/> Yes <input type="radio"/> No	
*Are benefits assigned to the provider by the patient or their authorized representative?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
*Does the provider have a signed statement from the patient releasing their medical information?		<input type="radio"/> Yes <input type="radio"/> No	
Include Other Insurance <input type="checkbox"/>		Total Charged Amount \$0.00	

4b. • **Beneficiary Information:** Beneficiary ID, Last Name, First Name, Birth Date

- **Claim Information** (enter all applicable information available): **Preauthorization, Accident Related, Accident Date, Place of Treatment, Patient Number, EPSDT (only if an EPSDT screening has been completed),** four “yes/no” questions.

Note: If the beneficiary has other insurance, check this box before clicking **Continue**. If there is no other insurance to enter, click **Continue** to complete this step.

Fields marked with a red asterisk are required.



For more information call **1-800-457-4454**



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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.

Other Insurance Details

Click the **Remove** link to remove the entire row.

Refresh Other Insurance

#	Carrier Name	Carrier ID	Policy ID	Paid Amount	Paid Date	Action
1	SOUTHWIRE AND AFFILIATES	CI1	321654		-	Remove

Click to add a new other insurance.

Back to Step 1**Continue****Finish Later****Cancel**

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.

Other Insurance Details

Click the **Remove** link to remove the entire row.

Refresh Other Insurance

#	Carrier Name	Carrier ID	Policy ID	Paid Amount	Paid Date	Action
1	SOUTHWIRE AND AFFILIATES	CI1	321654		-	Remove

Carrier Name SOUTHWIRE AND AFFILIATES

Carrier ID CI1

Policy Holder is Person

Policy Holder Last Name PUFF

First Name PATTI

MI -

Policy Holder Address 1234 MAIN STREET

City LITTLE ROCK

State ARKANSAS

Zip Code 72255

Policy Holder ID

Policy ID 321654

Group Name

Responsibility U-Unknown

Patient Relationship to Insured 18-Self

Paid Amount

***Paid Date**

***Claim Filing Indicator**

Release of Information

Assignment of Benefits

Save Insurance**Cancel Insurance**

Once the information has been entered and all questions have been answered, select **Save Insurance**.

Fields marked with a red asterisk are required.



For more information call **1-800-457-4454**





Submit Professional Claim: Step 2 ?

The * (in red) indicates required fields when the ADD button is selected.

Claim Type

Provider Information

Billing Provider ID 1111111112 ID Type NPI Name

Taxonomy

Patient and Claim Information

Beneficiary ID

Beneficiary PATTI PUFF Gender Female

Birth Date 07/15/1963 Total Charged Amount \$0.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes +

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Instructions:

If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1			
5	*Diagnosis Type <input type="text"/> ICD-10-CM <input type="text"/>	*Diagnosis Code <input type="text"/>	

5. Diagnosis codes are not required for dental claims. If opting to add diagnosis codes, follow the directions below:

- **Diagnosis Codes:** Select **Diagnosis Type** (required) and enter a **Diagnosis Code** (required).



Submit Dental Claim: Step 2

The * (in red) indicates required fields when the ADD button is selected.

Claim Type

Provider Information

Billing Provider ID

ID Type NPI

Name

Taxonomy

Patient and Claim Information

Beneficiary ID

Beneficiary

Gender Female

Birth Date

Total Charged Amount \$0.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Instructions:

If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1			
1	*Diagnosis Type <input type="text" value="ICD-10-CM"/>	*Diagnosis Code <input type="text"/>	
<div><div>Add</div><div>Reset</div><div>Submit Dental Claim: Step 2</div></div>			

Other Insurance Details

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Policy ID	Paid Amount	Paid Date	Action
1	SOUTHWIRE AND AFFILIATES	CI1	321654		-	Remove

[+](#) Click to add a new other insurance.

6

[Back to Step 1](#)

[Continue](#)

[Finish Later](#)

[Cancel](#)

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.



For more information call 1-800-457-4454





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7a

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Instructions:
If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.

Svc #	Svc Date	Oral Cavity Area	Tooth#/Letter	Procedure Code	Units	Charge Amount	Action
1							

1 *Svc Date Oral Cavity Area Tooth#/Letter

Tooth Surface

*Procedure Code Modifiers

*Units *Charge Amount Diagnosis

Performing Provider ID ID Type State License # Taxonomy

Supervising Provider ID ID Type State License # Taxonomy

[Add](#) [Reset](#)

7b

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Instructions:
If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.

Svc #	Svc Date	Oral Cavity Area	Tooth#/Letter	Procedure Code	Units	Charge Amount	Action
1							

1 *Svc Date Oral Cavity Area Tooth#/Letter

Tooth Surface

*Procedure Code Modifiers

*Units *Charge Amount Diagnosis

Performing Provider ID ID Type State License # Taxonomy

Supervising Provider ID ID Type State License # Taxonomy

[Add](#) [Reset](#)

00-ENTIRE ORAL CAVITY
01-MAXILLARY AREA
02-MANDIBULAR AREA
09-OTHER AREA OF ORAL CAVITY
10-UPPER RIGHT QUADRANT
20-UPPER LEFT QUADRANT
30-LOWER LEFT QUADRANT
40-LOWER RIGHT QUADRANT
L-LEFT
R-RIGHT

7c

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Instructions:
If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.

Svc #	Svc Date	Oral Cavity Area	Tooth#/Letter	Procedure Code	Units	Charge Amount	Action
1							

1 *Svc Date Oral Cavity Area Tooth#/Letter

Tooth Surface

*Procedure Code Modifiers

*Units *Charge Amount Diagnosis

Performing Provider ID ID Type State License # Taxonomy

Supervising Provider ID ID Type State License # Taxonomy

[Add](#) [Reset](#)

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #

[Click to add attachment.](#)

[Back to Step 1](#) [Back to Step 2](#) [Submit](#) [Finish Later](#) [Cancel](#)

1-3RD MOLAR-UR-PERMANENT
10-LATERAL INCISOR-UL-PERMANENT
11-CUSPID-UL-PERMANENT
12-1ST BICUSPID -UL-PERMANENT
13-2ND BICUSPID -UL-PERMANENT
14-1ST MOLAR -UL-PERMANENT
15-2ND MOLAR-UL-PERMANENT
16-3RD MOLAR-UL-PERMANENT
17-3RD MOLAR -LL-PERMANENT
18-2ND MOLAR-LL-PERMANENT
19-1ST MOLAR -LL-PERMANENT
2-2ND MOLAR-UR-PERMANENT
20-2ND BICUSPID -LL-PERMANENT
21-1ST BICUSPID -LL-PERMANENT
22-CUSPID-LL-PERMANENT
23-LATERAL INCISOR-LL-PERMANENT
24-CENTRAL INCISOR-LL-PERMANENT
25-CENTRAL INCISOR-LR-PERMANENT
26-LATERAL INCISOR-LR-PERMANENT



For more information call 1-800-457-4454

THE ARKANSAS FOUNDATION FOR MEDICAL CARE INC. (AFMC) IS UNDER CONTRACT WITH GAINWELL TECHNOLOGIES AND THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (DHS), DIVISION OF MEDICAL SERVICES. THE CONTENTS PRESENTED MAY NOT BE THE SAME AS GAINWELL OR ARKANSAS DHS POLICY. ARKANSAS DHS IS IN COMPLIANCE WITH TITLES VI AND VII OF THE CIVIL RIGHTS ACT. REVISED 05/2024.



Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Instructions:
If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.

Svc #	Svc Date	Oral Cavity Area	Tooth#/Letter	Procedure Code	Units	Charge Amount	Action
1							

1 ***Svc Date** **Oral Cavity Area** **Tooth#/Letter**

Tooth Surface **Modifiers**

***Procedure Code** ***Charge Amount** **Diagnosis** **Pointers**

***Units** **ID Type** **State License #** **Taxonomy**

Performing Provider ID **ID Type** **State License #** **Taxonomy**

Supervising Provider ID **ID Type** **State License #** **Taxonomy**

Add **Reset**

7d

- 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**.

Please note: Limited orthodontic treatment services are NOT covered under codes D8020, D8030, or D8040. However, providers can bill Medicaid for limited orthodontic treatment under code D8999.

8

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

9 **Back to Step 1** **Back to Step 2** **Submit** **Finish Later** **Cancel**

- Attachments:** Click the + to upload any attachments/documents that apply to the claim. Skip this step if there are no attachments.
- 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.



Confirm Professional Claim

Select Print Preview before you Confirm if you want to assure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system.

Claim Type

Provider Information

Billing Provider ID <input type="text"/>	ID Type NPI	Name <input type="text"/>
Taxonomy <input type="text"/>		
Performing Provider ID <input type="text"/>	ID Type <input type="text"/>	Name <input type="text"/>
Taxonomy <input type="text"/>		
Referring Provider ID <input type="text"/>	ID Type <input type="text"/>	Name <input type="text"/>
Taxonomy <input type="text"/>		
Supervising Provider ID <input type="text"/>	ID Type <input type="text"/>	Name <input type="text"/>
Taxonomy <input type="text"/>		
Service Facility Location ID <input type="text"/>	ID Type <input type="text"/>	Name <input type="text"/>
Taxonomy <input type="text"/>		

Beneficiary Information

Beneficiary ID <input type="text"/>	Gender Female
Beneficiary <input type="text"/>	
Birth Date <input type="text"/>	

Claim Information

Date Type <input type="text"/>	Date of Current <input type="text"/>
Accident Related <input type="text"/>	Admission Date <input type="text"/>
Patient Number <input type="text"/>	Authorization Number <input type="text"/>
Transport Certification No	
Does the provider have a signature on file? Yes	
Does the provider accept assignment for claim processing? Yes	
Are benefits assigned to the provider by the patient or their authorized representative? Yes	
Does the provider have a signed statement from the patient releasing their medical information? Yes	
Total Charged Amount \$200.00	

[Expand All](#) | [Collapse All](#)

Diagnosis Codes

Service Details

#	From Date	To Date	Place Of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount
1	08/02/2016	08/02/2016	11		99203		1	1.000 Unit	<input type="checkbox"/>	<input type="checkbox"/>	\$200.00

No Other Insurance Details exist for this claim

No Attachments exist for this claim

[Back to Step 1](#) [Back to Step 2](#) [Back to Step 3](#) [Print Preview](#) [Confirm](#) [Cancel](#)

10

10. 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.



For more information call 1-800-457-4454





11

Submit Dental Claim: Confirmation

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.

12

[Print Preview](#) [Copy](#) [Edit](#) [New](#) [View](#)

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.*



For more information call **1-800-457-4454**

