

# Payerpath Dental Training



Nevada Medicaid Provider Training



**What will be covered...**



# What will be covered...

- Benefits of electronic claim submission
- Required enrollment forms
- Submission contact information
- Signing on to Allscripts-Payerpath
- Creating and viewing claims
- Submitting a Dental claim form
- Copy claims feature
- View the remittance advice



# Electronic Data Interchange (EDI)

- Eliminates supply costs
  - Preprinted forms
  - Envelopes and postage
  - Allscripts-Payerpath claim submission is free
- Eliminates time-consuming processes and reduces claim errors
  - Document sorting and filing
  - Built-in validation checks
- Quicker processing and notification
  - Check claim status within 48 hours of submission

# EDI Enrollment Documents

[www.medicaid.nv.gov](http://www.medicaid.nv.gov)

Scroll down to EDI Enrollment Forms

The screenshot shows the Nevada Department of Health and Human Services website. The header includes the state seal, the department name, and navigation links for 'Contact Us' and 'DHCFP Home'. A search bar is located in the top right. Below the header is a blue navigation bar with links for 'Providers', 'EVS', 'Pharmacy', 'Prior Authorization', 'Quick Links', and 'Calendar'. The main content area is divided into several sections:

- Announcements / Latest News:** Contains several web announcements with dates and titles, such as 'Reminders for Provider Types 64 and 65 Regarding Hospice Forms' and '2016 Annual Medicaid Conference Presentations and Survey'. A link 'View All Web Announcements' is provided.
- Electronic Claims / EDI:** A central section with a heading and a paragraph explaining that electronic billing speeds payment and eliminates costs. It includes contact information for the EDI Coordinator: Telephone: (775) 638-3472 and Fax: (775) 322-8502. A black arrow points from this section down to the 'EDI Enrollment Forms' section.
- EDI Enrollment Forms:** A section with a heading and a paragraph stating that EDI enrollment forms are for completion and submission by active or enrolling Nevada Medicaid and Nevada Check Up providers only. Below this is a table of forms.
- EDI Announcements:** A section with a heading and a table of recent announcements.
- Notifications:** A red-bordered box containing information about enrollment termination and revalidation requirements.
- Provider Links:** A blue-bordered box containing links for 'Billing Information', 'E-Prescribing Forms', 'Provider Enrollment', 'Provider Newsletters', and 'Provider Training'.

Form Number	Title
FA-35	Electronic Transaction Agreement for Service Centers
FA-36	Service Center Operational Information
FA-37	Service Center Authorization
FA-39	Payerpath Enrollment

Title	Date
Payerpath Claim Submission Training for November 2016	Oct. 24, 2016
Payerpath Claim Submission Training for October 2016	Sept. 29, 2016
Payerpath Claim Submission Training for September 2016	Sept. 1, 2016
Payerpath Claim Submission Training for August 2016	July 19, 2016
Payerpath Claim Submission Training for July 2016	June 24, 2016



# Allscripts-Payerpath Enrollment Documents

- Enrolled providers may submit electronic Nevada Medicaid and Nevada Check Up claims free of charge through Allscripts-Payerpath.
- Simply complete Service Center Authorization form (FA-37) and the Allscripts-Payerpath Enrollment form (FA-39) located on the Electronic Claims/EDI webpage and submit your documents for processing.



# Required Registration Forms

- Enrollment forms for Allscripts-Payerpath: [www.medicaid.nv.gov](http://www.medicaid.nv.gov)
  - Send in one FA-37 (Service Center Authorization) form for each Group National Provider Identifier/Atypical Provider Identifier (NPI/API) unless billing each rendering provider as an individual
- AND**
- Send in one FA-39 (Payerpath Enrollment) form and include the names of all those who will be using this Payerpath account



# Form Submission and Contact Information

- Completed registration forms are to be mailed to:  
Nevada Medicaid  
P.O. Box 30042  
Reno, Nevada 89520-3042
- Faxed to: 775-335-8502
- Emailed to: [NVMMIS.EDIsupport@dxc.com](mailto:NVMMIS.EDIsupport@dxc.com)
- Upload forms to: [www.medicaid.nv.gov](http://www.medicaid.nv.gov) then login to Electronic Verification System (EVS) website to upload documents
- For assistance, call 1-877-638-3472, option 2, select then option 0 and then select option 3 to speak with an EDI Coordinator





**Getting Started**

# Accessing Payerpath

On the Electronic Claims/EDI webpage, scroll down to the Allscripts-Payerpath link.

<a href="#">PayerPath Claim Submission Training for August 2014(Updated August 26, 2014)</a>	July 25, 2014
<a href="#">PayerPath Claim Submission Training</a>	July 10, 2014
<a href="#">EDI Announcement: Dual Use for 4010/5010 Formats Ends June 30, 2012</a>	June 5, 2012
<a href="#">Anesthesia Services Claims Submitted Electronically (Updated May 31, 2012)</a>	May 4, 2012
<a href="#">EDI Announcement: Nevada Medicaid Version 5010 Solution Limits Diagnosis Codes on 837P Transactions.</a>	Apr. 10, 2012
<a href="#">EDI Announcement: Prepare for March 31, 2012, End Date for Dual Use of 5010 and D.O Formats</a>	Jan. 5, 2012
<a href="#">Instructions for EDI Enrollment</a>	December 2011

**Payerpath**

Enrolled providers may submit electronic Nevada Medicaid and Nevada Check Up claims free of charge through [Allscripts-Payerpath](#).

**Service Center Directory**

The Service Center Directory is a list of commercial clearinghouses currently registered with Hewlett Packard Enterprise. The list contains links to each clearinghouse's web site.  
[Service Center Directory](#)

**Provider Billing Manual: EDI Chapter**

The EDI chapter in the Provider Billing Manual provides answers to commonly asked EDI questions.  
[Read the chapter...](#)

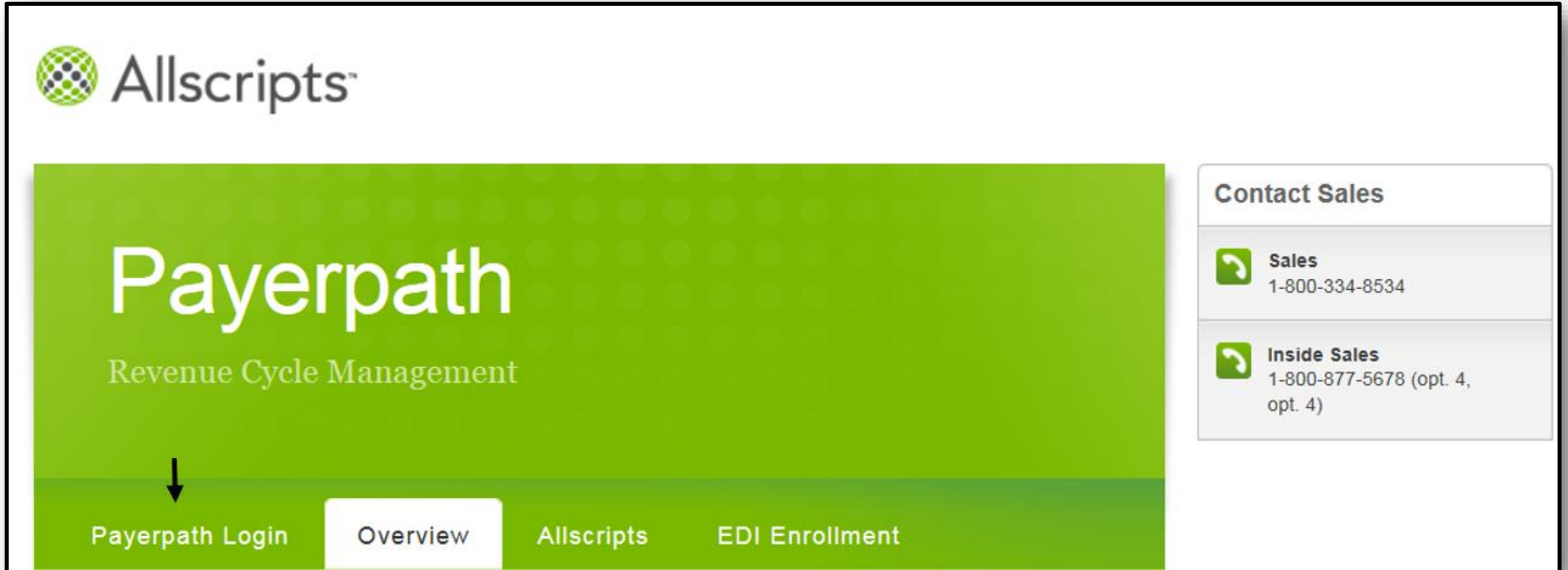
**Service Center User Manual**

The Service Center User Manual contains technical instructions for submitting and retrieving electronic transactions. This includes SFTP guidelines, transaction testing and handling login problems. EDI registration instructions are also included.  
[Service Center User Manual](#)

**EDI Companion Guides**

Title	Date
<a href="#">Transaction 270/271 - Health Care Eligibility Inquiry and Response</a>	February 2015
<a href="#">Transaction 271U - Unsolicited Transaction - HIPAA Version 5010</a>	February 2013
<a href="#">Transaction 277U - Unsolicited 277 Claims Status Response - HIPAA Version 5010</a>	October 2012
<a href="#">Transaction 820 - Health Care Premium Payment - HIPAA Version 5010</a>	October 2012
<a href="#">Transaction 834 - Benefit Enrollment and Maintenance - HIPAA Version 5010</a>	October 2012
<a href="#">Transaction 835 - Health Care Payment/Advice</a>	February 2015

# Payerpath Login Screen



The screenshot displays the Payerpath login interface. At the top left is the Allscripts logo. The main content area has a green background with the text "Payerpath" in large white font and "Revenue Cycle Management" in smaller white font below it. A dark green arrow points down to the "Payerpath Login" button in the bottom navigation bar. To the right of the main content is a "Contact Sales" sidebar with two entries: "Sales" with phone number 1-800-334-8534 and "Inside Sales" with phone number 1-800-877-5678 (opt. 4, opt. 4).

Allscripts<sup>™</sup>



# Payerpath

Revenue Cycle Management

↓

Payerpath Login Overview Allscripts EDI Enrollment

### Contact Sales

-  **Sales**  
1-800-334-8534
-  **Inside Sales**  
1-800-877-5678 (opt. 4, opt. 4)

[www.payerpath.com](http://www.payerpath.com)  
Select Payerpath Login

# Login Page

Enter Customer Name

Enter User Name

Enter Password

Allscripts Allscripts Payerpath Login

Customer Name:

User Name:

Password:

Remember My Credentials

[Access Allscripts Payerpath](#)

[Page Help](#)

[Forgot your Password?](#)

[Forgot your Username?](#)

[Change your Password.](#)

# Welcome Page

The screenshot shows the Allscripts Welcome Page. At the top left is the Allscripts logo. A green header bar contains the word "Welcome". Below this is a navigation bar with links for Claims, Patients, Reports, Maintenance, Help, and Tools. On the left side, there is a "Resources" section with a "Knowledge Center" link. The main content area features a "Quick Links" section with three icons: "New Messages" (with a '0' badge), "Payer Reports" (with a '0' badge), and "Remit Reports" (with a '0' badge). Below this is a "My Filters" section with a "Claims Filters" dropdown menu and a message: "You have not set up any Claims filters." with a "Create Filter" button. Two black callout boxes with white text are overlaid on the image: one pointing to the "New Messages" icon with the text "Select New Messages", and another pointing to the "Remit Reports" icon with the text "Select New Remit Reports".

Select New Messages

Select New Remit Reports

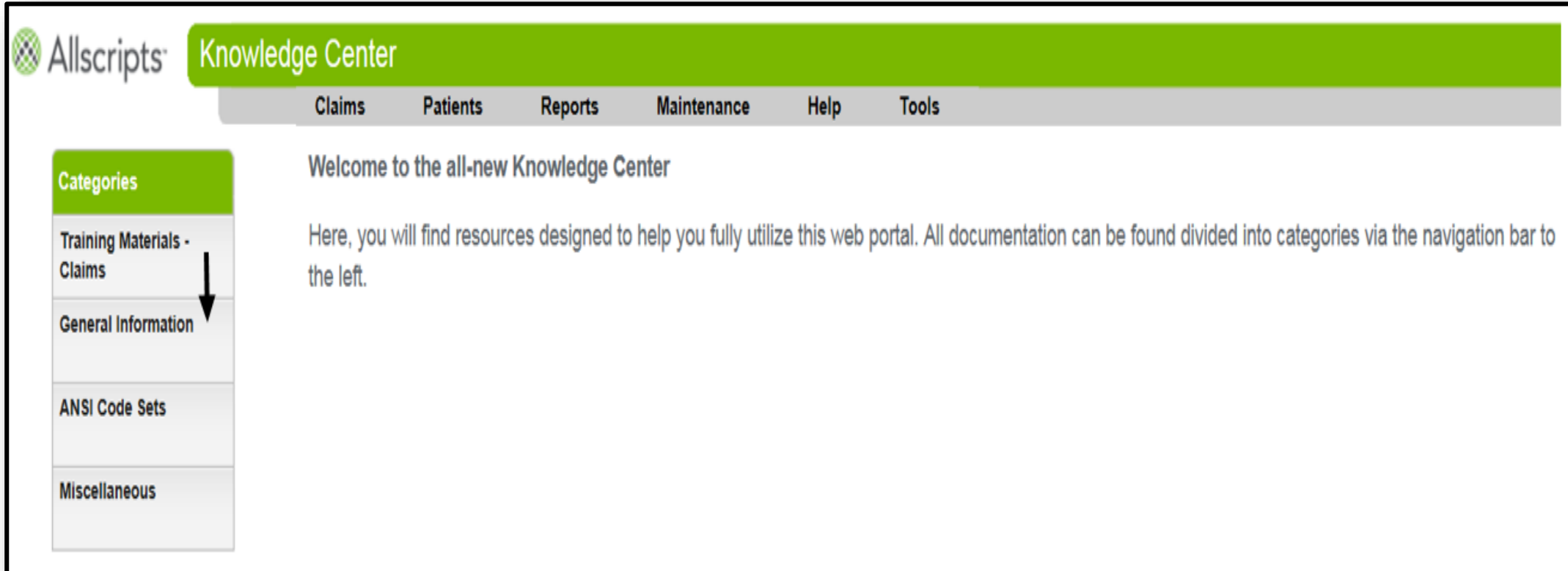
# Welcome Page

Please select Knowledge Center.

The screenshot shows the Allscripts Welcome Page. At the top left is the Allscripts logo. A green header bar contains the word "Welcome". Below this is a navigation bar with links for Claims, Patients, Reports, Maintenance, Help, and Tools. On the left side, there is a "Resources" menu with "Knowledge Center" selected and indicated by a downward arrow. The main content area is divided into three sections: "Quick Links" with three cards for "New Messages" (0), "Payer Reports" (0), and "Remit Reports" (0); "My Filters" with a dropdown menu set to "Claims Filters" and a message stating "You have not set up any Claims filters." with a "Create Filter" button below it.

# Knowledge Center

Please select General Information.



Allscripts Knowledge Center

Claims Patients Reports Maintenance Help Tools

**Categories**

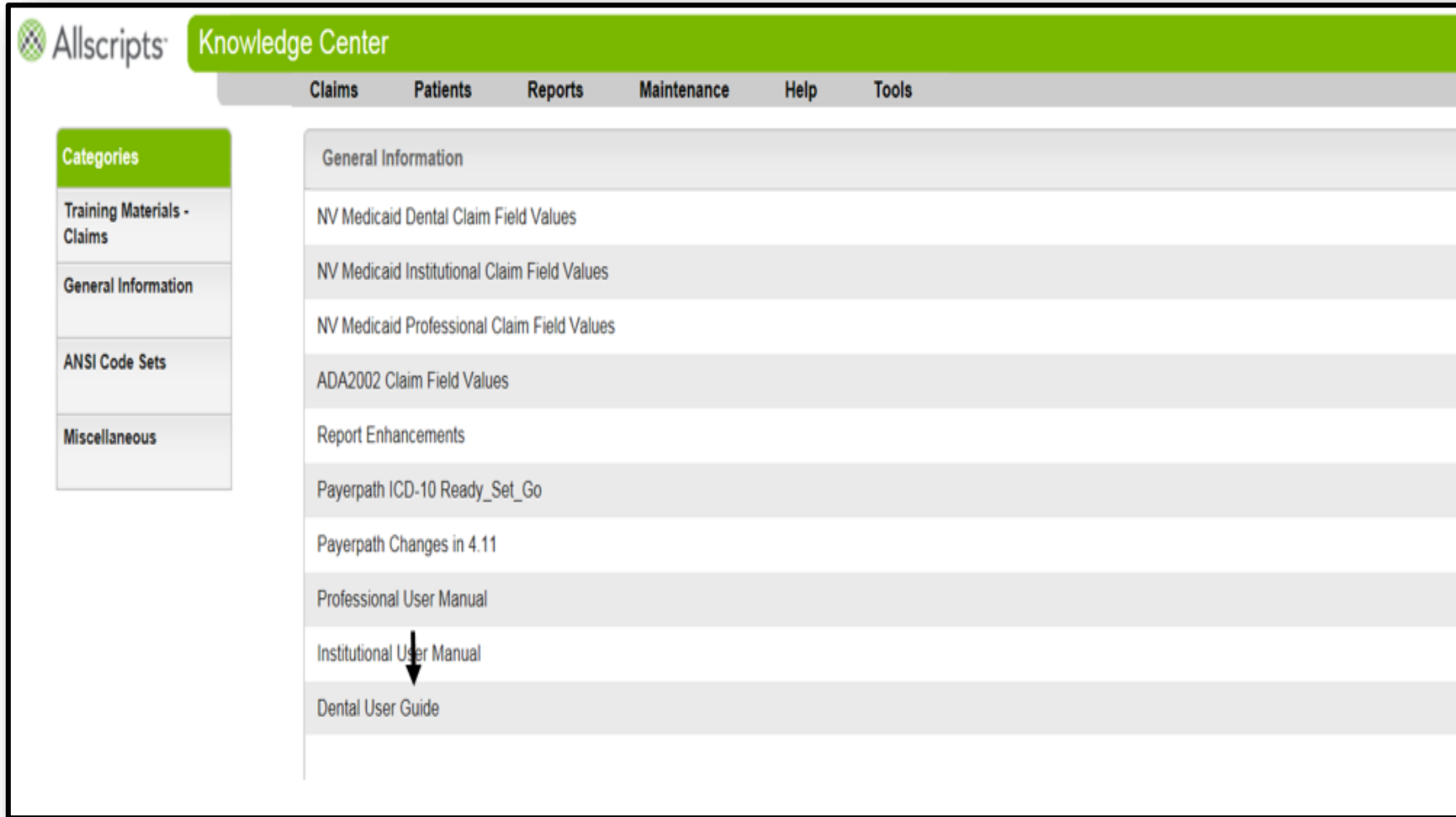
- Training Materials - Claims
- General Information**
- ANSI Code Sets
- Miscellaneous

Welcome to the all-new Knowledge Center

Here, you will find resources designed to help you fully utilize this web portal. All documentation can be found divided into categories via the navigation bar to the left.

# Training Materials Claims

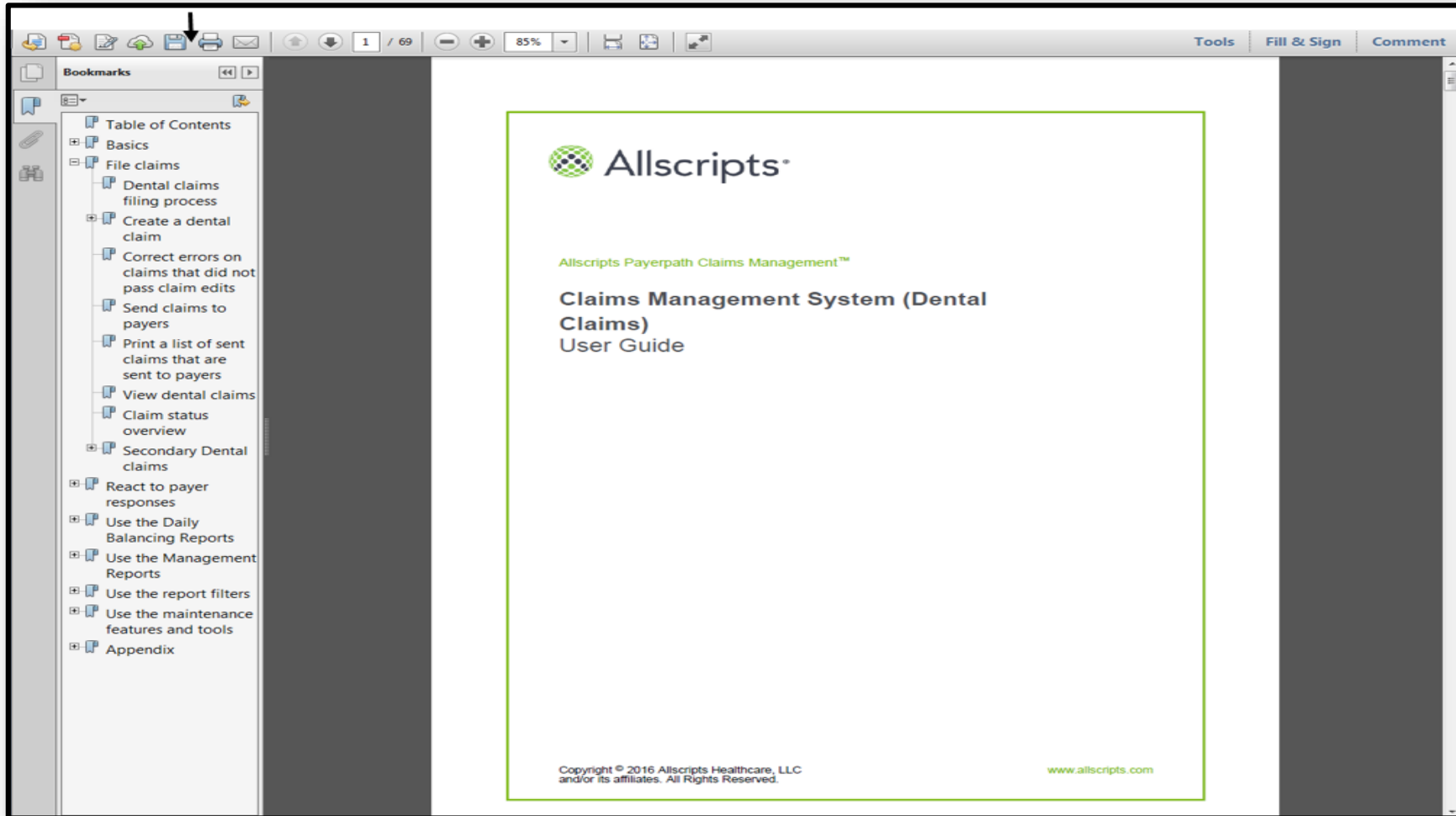
Please select Dental User Guide.



The screenshot shows the Allscripts Knowledge Center interface. At the top left is the Allscripts logo. To its right is a green header bar with the text "Knowledge Center". Below this header is a horizontal navigation bar with the following tabs: "Claims", "Patients", "Reports", "Maintenance", "Help", and "Tools". On the left side, there is a vertical "Categories" menu with the following items: "Training Materials - Claims" (highlighted in green), "General Information", "ANSI Code Sets", and "Miscellaneous". The main content area on the right displays a list of links under the heading "General Information". The links are: "NV Medicaid Dental Claim Field Values", "NV Medicaid Institutional Claim Field Values", "NV Medicaid Professional Claim Field Values", "ADA2002 Claim Field Values", "Report Enhancements", "Payerpath ICD-10 Ready\_Set\_Go", "Payerpath Changes in 4.11", "Professional User Manual", "Institutional User Manual", and "Dental User Guide". A black arrow points down from the "Institutional User Manual" link to the "Dental User Guide" link.



# Payerpath Dental Claims User Guide



This is the Dental Claims User Guide.

Please select the Save icon or Print icon in the top left corner.



# Learning Check

- 1. What is the website address you would use to directly login to Allscripts-Payerpath?**
- 2. What is one of the first things you should do when getting started with Allscripts-Payerpath?**
  - a. Print your remittance advice
  - b. Submit a claim
  - c. Copy a claim
  - d. Visit the Knowledge Center
- 3. Which documents should you review and/or print?**
  - a. Payerpath Dental COB Instructions
  - b. Payerpath Dental User Guide
  - c. All of the above

# Submitting Dental Claim Form

The screenshot displays the Allscripts web application interface. At the top left is the Allscripts logo. A green navigation bar contains the text 'Welcome' and a menu with items: 'Claims', 'Patients', 'Reports', 'Maintenance', 'Help', and 'Tools'. An arrow points to the 'Claims' menu item, which has a sub-menu 'View Claims' visible below it. On the left side, there are three main sections: 'News' with a 'View' button for 'OPR Information! Please Read!'; 'Resources' with a 'Knowledge Center' link; and 'Quick Links' with icons for 'New Messages' (4), 'Payer Reports' (0), and 'Remit Reports' (0). Below 'Quick Links' is a 'My Filters' section with a 'Claims Filters' dropdown menu and a message: 'You have not set up any Claims filters.' with a 'Create Filter' button. At the bottom, there is a 'Customer Support' section with contact information for Nevada: 'In Nevada Call (877) 638 3472 opt. 2, then opt. 0, then opt. 3 | Mon-Fri 8:00 AM to 5:00 PM PT | Email - [nvmmis.edisupport@hp.com](mailto:nvmmis.edisupport@hp.com)'.

- Creating a new claim:
- Please select Claims, then scroll down to View Claims.

# Claims List Filter

The screenshot shows the Allscripts Claims List Filter interface. The top navigation bar includes 'Allscripts' and 'Claims List Filter', with sub-menus for 'Claims', 'Patients', 'Reports', 'Maintenance', 'Help', and 'Tools'. The main form is titled 'My Claim Filters' and contains several sections:

- Select:** A dropdown menu.
- Name:** A text input field with 'Save' and 'Manage My Filters' buttons.
- Selection Criteria:**
  - Form Type:** A dropdown menu set to 'Dental 2012'.
  - Payer Group:** A dropdown menu with 'ALL' and 'NV Dental' options.
  - Payer Name:** A text input field.
  - Billing Provider:** A dropdown menu with 'ALL', 'NPI 1326125055', 'NPI 1548240443', and 'NPI 1548247281' options.
- Claim Status:**
  - Radio buttons for 'Untransmitted' (selected) and 'Transmitted'.
  - A dropdown menu with 'ALL', 'Deleted', 'Failed', and 'Warning' options.
- Claim Type:** Radio buttons for 'Primary', 'Secondary', and 'Both' (selected).
- Date and Code Fields:** A table with columns 'From' and 'Through' for 'Create Date', 'Date Of Service', 'Procedure Code', 'Patient Account #', and 'Patient Last Name'.

Callouts provide additional instructions:

- A callout pointing to the 'Form Type' dropdown says: "Select Dental 2012".
- A callout pointing to the 'Untransmitted' radio button and the 'Claim Status' dropdown says: "Choose from Untransmitted (claims not yet sent) or Transmitted (claims that have been sent)".
- A callout pointing to the 'Apply Filter' button at the bottom says: "Select Apply Filter".

# View Claims

Allscripts Untransmitted Claims List

Claims Patients Reports Maintenance Help Tools

Sorted By: (X)Pat Name ? Filtered

	Status	Location	Pat Name	Pat Acct	Payer	NPI	Created	Sent	Ack	Rcvd	Remitted	Charges	Paid	
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		04/16/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		04/16/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		04/16/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		04/16/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		04/16/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		04/16/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		04/12/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		04/05/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		03/16/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		02/17/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		02/09/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		02/02/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100		01/20/16					\$0.00	\$0.00	<a href="#">V</a> <a href="#">H</a>
<input type="checkbox"/>	P	NV TRAINING HILL, THOMA	HILLTHOMA NV MEDIC	100100100			04/05/16					\$535.00	\$0.00	<a href="#">V</a> <a href="#">H</a>

Jump To: 1 - 2016-04-16 Displaying Items 1 - 15 of 26

\*\*\*Claims not modified within 90 days will be deleted\*\*\*  
\*\*\*Claims in Blue are assigned to Print Mail or Unassigned Payer\*\*\*

Select "V"  
for view

Previously entered claims will be displayed on the Untransmitted Claims List. Claims must be in a "P" (Passed) status before they can be sent.

Untransmitted claims are retained in the system for 90 days.

# How to Create a Claim Template

Allscripts ADA Dental - NV Dental

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (27) Electronic Fields (1)

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)  
 Statement of Actual Services  Request for Predetermination / Preauthorization  EPSDT/Title XIX

2. Predetermination / Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code  
NEVADA MEDICAID

**POLICY HOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number 17. Employer Name

**OTHER COVERAGE**

4. Other Dental or Medical coverage? (If both, complete 5-11 for dental only.)  
None  Dental?  Medical?  Both

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number 10. Patient's Relationship to Person named in #5  
Self  Spouse  Dependent  Other

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12  
Self  Spouse  Dependent Child

20. Name (Last, First, Middle Initial, Suffix), Address

21. Date of Birth (MM/DD/CCYY) 22. Gender

23. Patient ID/Account# (Assigned Dentist)

PATIENT INFORMATION

Patient Name: Account: CLAIM TEMPLATE

Select Edit

New Copy Hold Print Undo Changes Save & Run Edits

# How to Create a Claim Template

The screenshot displays the Allscripts ADA Dental - NV Dental software interface. The top navigation bar includes 'Claims', 'Patients', 'Reports', 'Maintenance', 'Help', and 'Tools'. The main content area is titled 'Form Fields (20)' and 'Electronic Fields'. The form is divided into several sections: 'HEADER INFORMATION', 'INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION', 'OTHER COVERAGE', 'POLICY HOLDER/SUBSCRIBER INFORMATION', and 'PATIENT INFORMATION'. A confirmation dialog box titled 'Message from webpage' is overlaid on the form, asking 'Are you sure you want to copy the current claim?' with 'OK' and 'Cancel' buttons. A black callout box with the text 'Select OK' points to the 'OK' button. The bottom status bar shows 'Patient Name: . Account: CLAIM TEMPLATE' and 'Claim 1 of 16'. The bottom right corner contains icons for 'New', 'Copy', 'Hold', 'Print', 'Undo Changes', and 'Save & Run Edits'.

# How to Create a Claim Template

2. Predetermination / Preauthorization Number [ ]		<b>POLICY HOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)</b>									
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>		12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code [REDACTED]									
3. Company/Plan Name, Address, City, State, Zip Code NV MEDICAID [ ]		13. Date of Birth (MM/DD/CCYY) [REDACTED]	14. Gender M <input checked="" type="radio"/> F <input checked="" type="radio"/> U <input checked="" type="radio"/>								
<b>OTHER COVERAGE</b>		15. Policyholder/Subscriber ID (SSN or ID#) [REDACTED]									
4. Other Dental or Medical coverage? (If both, complete 5-11 for dental only.) None <input type="radio"/> Dental? <input type="radio"/> Medical? <input type="radio"/> Both <input type="radio"/>		16. Plan/Group Number [ ]	17. Employer Name [ ]								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) [ ]		<b>PATIENT INFORMATION</b>									
6. Date of Birth (MM/DD/CCYY) [ ]	7. Gender M <input type="radio"/> F <input type="radio"/> U <input type="radio"/>	8. Policyholder/Subscriber ID (SSN or ID#) [ ]	18. Relationship to Policyholder/Subscriber in #12 Above Self <input checked="" type="radio"/> Spouse <input type="radio"/> Dependent Child <input type="radio"/> Other <input type="radio"/>								
9. Plan/Group Number [ ]	10. Patient's Relationship to Person named in #5 Self <input type="radio"/> Spouse <input type="radio"/> Dependent <input type="radio"/> Other <input type="radio"/>		19. Reserved For Future Use [ ]								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code [ ]		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code [REDACTED]									
[ ]		21. Date of Birth (MM/DD/CCYY) [ ]	22. Gender M <input type="radio"/> F <input type="radio"/> U <input type="radio"/>								
[ ]		23. Patient ID/Account# (Assigned by Dentist) CLAIM TEMPL									
[ ]		[ ]									
<b>RECORDS OF SERVICES PROVIDED</b>											
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag Pointer	29b. Qty	30. Description	31. Fee (Includes 31a)	31a. Other Fee	DEL
[REDACTED]	[ ]	[ ]	[ ]	[ ]	[REDACTED]	[ ]	[ ]	[ ]	[REDACTED]	[ ]	<input type="checkbox"/>

Key in all of the Red highlighted sections on the ADA claim form



# How to Create a Claim Template

Allscripts ADA Dental - NV Dental

Claims Patients Reports Maintenance Help Tools

2. Predetermination / Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code  
NV MEDICAID

**POLICY HOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
ALE GINGER  
150 SOUTH FIRST STREET  
RENO NV 895020000

13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)  
01/01/1960 M F U 300000000

**OTHER COVERAGE**

4. Other Dental or Medical coverage? (If both, complete 5-11 for dental only.)  
None  Dental?  Medical?  Both

16. Plan/Group Number 17. Employer Name

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

**PATIENT INFORMATION**

6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)  
M F U

18. Relationship to Policyholder/Subscriber in #12 Above  
Self  Spouse  Dependent Child  Other

19. Reserved For Future Use

9. Plan/Group Number 10. Patient's Relationship to Person named in #5  
Self  Spouse  Dependent  Other

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
ALE GINGER

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account# (Assigned by Dentist)  
M F U CLAIM TEMPL

**RECORDS OF SERVICES PROVIDED**

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag Pointer	29b. Qty	30. Description	31. Fee (Includes 31a)	31a. Other Fee	DEL
04/04/2016					D0120				\$100.00		<input type="checkbox"/>

Patient Name: Account: CLAIM TEMPLATE  
Select Edit  
Claim 3 of 16

New Copy Hold Print Undo Changes Save & Run Edits

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

# How to Create a Claim Template

2. Predetermination / Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT**

3. Company/Plan Name, Address, City, State, Zip Code  
NV MEDICAID

**OTHER COVERAGE**

4. Other Dental or Medical coverage? (If both, complete both for dental only.)  
None  Dental?  Medical?  Both

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender M  F  U  8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number 10. Patient's Relationship to Person named in #5  
Self  Spouse  Dependent  Other

11. Other Insurance Company/Dental Benefit

**POLICY HOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
ALE GINGER  
150 SOUTH FIRST STREET  
RENO NV 895020000

13. Date of Birth (MM/DD/CCYY) 14. Gender M  F  U  15. Policyholder/Subscriber ID (SSN or ID#)  
000000000

16. Plan/Group Number 17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above  
Self  Spouse  Dependent Child  Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
ALE GINGER

21. Date of Birth (MM/DD/CCYY) 22. Gender M  F  U

23. Patient ID/Account# (Assigned by Dentist)  
CLAIM TEMPL

**RECORDS OF SERVICES PROVIDED**

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag Pointer	29b. City	30. Description	31. Fee (Includes 31a)	31a. Other Fee	DEL
1	04/04/2016					D0120				\$100.00		<input type="checkbox"/>

All the updates will be saved to the document and will no longer be highlighted in Red

Scroll down to the next Red highlighted fields

Update Field 23 and enter new Patient ID/Account #

# How to Create a Claim Template

Allscripts ADA Dental - NV Dental

Claims Patients Reports Maintenance Help Tools

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

21. Date of Birth (MMDDCCYY)

22. Gender M  F  U

23. Patient ID/Account# (Assigned by Dentist)  
ALEG01

RECORDS OF SERVICES PROVIDED

24. Procedure Date (MMDDCCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag Pointer	29b. Qty	30. Description	31. Fee (Includes 31a)	31a. Other Fee	DEL
04/04/2016					D0120	1	1		\$100.00		<input type="checkbox"/>
											<input type="checkbox"/>
											<input type="checkbox"/>
											<input type="checkbox"/>
											<input type="checkbox"/>
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											<input type="checkbox"/>
											<input type="checkbox"/>

33. Missing Teeth Information (Place an 'X' on each missing tooth)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier (ICD-9 = B, ICD-10 = AB)

34a. Diagnosis Code(s)  
1 [Redacted] 3  
(Primary diagnosis in "1")  
2 4

31a. Other Fee(s)

32. Total Fee \$100.00

Patient Name: ALE, GINGER Account: CLAIM TEMPLATE  
Select Edit

Claim 4 of 17

New Copy Hold Print Undo Change Save & Run Edits

Scroll down to the bottom of the page and select Save & Run Edits to save all changes.

# How to Create a Claim Template

Use the drop-down menu in Field 34 and Select ICD-10

Key in all of the Red highlighted sections on the ADA claim form

# How to Create a Claim Template

Allscripts ADA Dental - NV Dental

Claims Patients Reports Maintenance Help Tools

33. Missing Teeth Information (Place an 'X' on each missing tooth)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. Diagnosis Code List Qualifier ICD-10 (ICD-9 = B, ICD-10 = AB)

34a. Diagnosis Code(s)

1	Z741	3	Z742
(Primary diagnosis in "1")		4	Z748
2	Z742		

31a. Other Fee(s)

32. Total Fee \$100.00

35. Remarks

**AUTHORIZATION**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Y  N

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist of dental entity.

Y  N

Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

**BILLING DENTIST OR DENTAL ENTITY**

48. Name (Last, First), Address, City, State, Zip Code

SERVICE \_\_\_\_\_ BILLING \_\_\_\_\_

100 1ST ST \_\_\_\_\_

RENO NV 895200000

49. NPI 1001001001 50. License Number \_\_\_\_\_ 51. SSN or TIN 100100100

52. Phone Number \_\_\_\_\_ 52a. Additional Provider ID \_\_\_\_\_

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment 11 (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures No  Yes

40. Is Treatment for Orthodontics? No (Skip 41-42)  Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY) \_\_\_\_\_

42. Months of Treatment Remaining \_\_\_\_\_ 43. Replacement of Prosthesis? No  Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY) \_\_\_\_\_

45. Treatment Resulting from Occupational illness/injury  Auto accident  Other accident  None

46. Date of Accident (MM/DD/CCYY) \_\_\_\_\_ 47. Auto Accident State \_\_\_\_\_

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

Y  N

Signed (Treating Dentist) \_\_\_\_\_ Date \_\_\_\_\_

54. NPI 1001001001 55. License Number \_\_\_\_\_

56. Address, City, State, Zip Code \_\_\_\_\_ 56a. Provider Speciality Code \_\_\_\_\_

57. Phone Number \_\_\_\_\_ 58. Additional Provider ID \_\_\_\_\_

Patient Name: ALE, GINGER Account: ALEG01

Select Edit

Claim 4 of 17

New Copy Hold Print Undo Changes **Save & Run Edits**

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

# How to Create a Claim Template

**1. Scroll down to the bottom of the page to confirm the claim has no additional edits by locating No Errors**

**2. Scroll down to the bottom of the page and select Send to mark the claim for processing. Once the claim has been sent you are unable to make any changes to the claim form.**

Patient Name: ALE, GINGER Account: ALEG01  
No Errors  
Claim 4 of 17

# How to Print & Save Your Claim

Allscripts ADA Dental - NV Dental

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields Electronic Fields

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)  
 Statement of Actual Services  Request for Predetermination / Preauthorization  EPSDT/Title XIX

2. Predetermination / Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code  
NV MEDICAID

**POLICY HOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
ALE GINGER  
150 SOUTH FIRST STREET  
RENO NV 895020000

13. Date of Birth (MM/DD/YYYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)  
01/01/1960 M  F  U 000000000

**OTHER COVERAGE**

4. Other Dental or Medical coverage? (if both, complete 5-11 for dental only.)  
None  Dental?  Medical?  Both

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/YYYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number 10. Patient's Relationship to Person named in #5  
Self  Spouse  Dependent  Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**PATIENT INFORMATION**

16. Plan/Group Number 17. Employer Name

18. Relationship to Policyholder/Subscriber in #12 Above  
Self  Spouse  Dependent Child  Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
ALE GINGER

21. Date of Birth (MM/DD/YYYY) 22. Gender 23. Patient ID/Account# (Assigned by Dental)

ALEG01

← Patient Name: ALE, GINGER Account: ALEG01  
No Errors  
Claim 4 of 17

New Copy Hold Send **Print** Undo Changes Save & Run Edits

Scroll down to the bottom of the page and select the Print button to print a copy of claim form

# How to Print & Save Your Claim

The screenshot shows the Allscripts ADA Dental - NV Dental claims entry interface. The form is titled "ADA Dental - NV Dental" and includes a navigation bar with "Claims", "Patients", "Reports", "Maintenance", "Help", and "Tools". The main form area is divided into sections: "HEADER INFORMATION", "INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION", and "OTHER COVERAGE". A pop-up window titled "Select your print option" is displayed in the center, with two radio button options: "J430D Form (ICD10) - With Form" (which is selected and highlighted with a green box) and "J430D Form (ICD10) - Without Form". Below the options are "Print" and "Cancel" buttons. The background form contains various fields for patient and policyholder information, including name, address, date of birth, gender, and relationship. The status bar at the bottom indicates "Patient Name: ALE, GINGER" and "Account: ALEG01".

A pop up window will appear. Select the J340D Form (ICD-10)-With Form, then select the Print button



# How to Print & Save Your Claim

TOC | Flags | Select Format | Download | **Preview** | Print | Help

### ADA American Dental Association® Dental Claim Form

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)  
 Statement of Actual Services  Request for Re-determination/Pre-authorization  
EMPHASIS REQUIRED

2. Provider/Supplier/Professional Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code  
NV MEDICAID

**POLICYHOLDER/SUBSCRIBER INFORMATION**

10. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix)  
ALE, GINGER  
150 SOUTH FIRST STREET  
RENO NV 8950200

11. Date of Birth (MM/DD/YYYY)  M  F 01/01/1960 000000000

12. Plan Group Number 17. Employee Name

**PATIENT INFORMATION**

14. Relationship to Policyholder/Subscriber in #10 Above  
 Self  Spouse  Dependent Child  Other

15. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
ALE, GINGER

21. Date of Birth (MM/DD/YYYY)  M  F ALEG01

**RECORD OF SERVICES PROVIDED**

16. Procedure Code (MM/DD/YYYY)	18. Area of Oral Care	19. Teeth Number	20. Teeth Surface	22. Procedure Code	23. Drug Codes	24. Fee
04042016				D0120	A	100.00

A pop up window will show the J340D Form (ICD-10)-With Form in a Report Viewer, then select the Preview button

# How to Print & Save Your Claim

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all that apply)

Statement of Actual Services  
 EPSDT / Title XIX

2. Pre-determination/Pre-authorization Number

INSURANCE COMPANY/DENTAL PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

NV MEDICAID

4. Other Coverage (Mark applicable box, and complete items 5-7 if none, leave blank.)

Dental  Medical  Other (complete 5-7 if other only)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MMDDCCYY)

7. Gender  M  F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5  
 Self  Spouse  Dependent  Other

11. Other Insurance Company/Dental Health Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

12. Relationship to Policyholder/Subscriber in #12 Above  
 Self  Spouse  Dependent Child  Other

13. Reserved For Future Use

14. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

ALE, GINGER

15. Date of Birth (MMDDCCYY)

16. Gender  M  F

17. Patient ID/Account # (Assigned by Dentist)

ALEG01

RENO NV 895020000

13. Date of Birth (MMDDCCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)

01/01/1988  X 000000000000

16. Plan/Group Number 17. Employer Name

# How to Print & Save Your Claim

https://www.payerpath.com/Reporting/PrintReport.aspx?Rptname=FormADAJ430 - Internet Explorer

Tools Fill & Sign Comment

### ADA American Dental Association® Dental Claim Form

HEADER INFORMATION		
1. Type of Transaction (Mark all applicable boxes)		
<input type="checkbox"/> Statement of Actual Services	<input type="checkbox"/> Request for Predetermination/Preauthorization	
<input type="checkbox"/> EPSDT / Title XIX		
2. Predetermination/Preauthorization Number		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		
3. Company/Plan Name, Address, City, State, Zip Code		
NV MEDICAID		
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)		
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input checked="" type="checkbox"/> Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
ALE, GINGER 150 SOUTH FIRST STREET RENO NV 895020000		
13. Date of Birth (MM/DD/CCYY)	14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	15. Policyholder/Subscriber ID (SSN or ID#)
01/01/1960		00000000000
16. Plan/Group Number	17. Employer Name	
PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
ALE, GINGER		
21. Date of Birth (MM/DD/CCYY)	22. Gender <input type="checkbox"/> M <input type="checkbox"/> F	23. Patient ID/Account # (Assigned by Dentist)
		ALEG01

To close the pop up window for the PDF document, select the Red X in the right hand corner of the window

# How to Print & Save Your Claim

ADA American Dental Association® Dental Claim Form

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services     Request for Predetermination/Prior Authorization

EPSDT / Title XIX

2. Predetermination/Prior Authorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code  
NV MEDICAID

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental?  Medical?  (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)    7. Gender  M  F    8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number    10. Patient's Relationship to Person named in #5  
 Self     Spouse     Dependent     Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**POLICYHOLDER/SUBSCRIBER INFORMATION** (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
ALE, GINGER  
150 SOUTH FIRST STREET  
RENO    NV    895020000

13. Date of Birth (MM/DD/CCYY)    14. Gender  M  F    15. Policyholder/Subscriber ID (SSN or ID#)  
01/01/1960    000000000000

16. Plan/Group Number    17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above  
 Self     Spouse     Dependent Child     Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
ALE, GINGER

21. Date of Birth (MM/DD/CCYY)    22. Gender  M  F    23. Patient ID/Account # (Assigned by Dentist)  
ALEG01

**RECORD OF SERVICES PROVIDED**

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag Pointer	29b. Qty	30. Description	31. Fee
04/04/2016					D0120	A	1		100.00

To close the pop up window for the Report Viewer document, select the Red X in the right hand corner of the window

# Back to Untransmitted Claims List

**Allscripts** ADA Dental - NV Dental

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields Electronic Fields

**HEADER INFORMATION**

1. Type of Transaction (Multiple applicable boxes)  
 Statement of Account  Request for Predetermination / Preauthorization  EPSDT/Title XIX

2. Predetermination/Authorization Number

**INSURANCE INFORMATION**

3. Company Name, Address, City, State, Zip Code

**DENTAL BENEFIT PLAN INFORMATION**

4. Plan Name, Address, City, State, Zip Code

5. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**POLICY HOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
 ALE GINGER  
 150 SOUTH FIRST STREET  
 RENO NV 895020000

13. Date of Birth (MM/DD/CCYY) 01/01/1960

14. Gender  M  F  U

15. Policyholder/Subscriber ID (SSN or ID#) 000000000

16. Plan/Group Number

17. Employer Name

**PATIENT INFORMATION**

6. Patient Name (Last, First, Middle Initial, Suffix)  
 ALE GINGER

7. Relationship to Policyholder/Subscriber in #12 Above  
 Self  Spouse  Dependent Child  Other

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5  
 Self  Spouse  Dependent  Other

11. Other insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

18. Relationship to Policyholder/Subscriber in #12 Above  
 Self  Spouse  Dependent Child  Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
 ALE GINGER

21. Date of Birth (MM/DD/CCYY)

22. Gender  M  F  U

23. Patient ID/Account# (Assigned by Dentist) ALEG01

Patient Name: ALE, GINGER Account: ALEG01  
 No Errors  
 Claim 4 of 17

New Copy Hold Send Print Undo Changes Save & Run Edits

# Untransmitted Claims List

The screenshot shows the Allscripts Untransmitted Claims List interface. The header includes the Allscripts logo and the title "Untransmitted Claims List". Below the header are navigation tabs: Claims, Patients, Reports, Maintenance, Help, and Tools. The main area displays a table of claims with columns for Status, Location, Account, Payer, NPI, Created, Sent, Ack, Rcvd, Remitted, Charges, and Paid. A dropdown menu is open over the table, showing options: Assign, Hold, New, and Send. Two callout boxes provide additional information:

- Other options available from the Untransmitted Claims List include selecting any claims to Print** (pointing to the Print icon in the dropdown menu).
- Other options available from the Untransmitted Claims List include selecting any claims in a Passed Status to Print or mark for Send** (pointing to the Send option in the dropdown menu).

At the bottom of the interface, there are two informational messages:

- \*\*\*Claims not modified within 90 days will be deleted\*\*\*
- \*\*\*Claims in Blue are assigned to Print Mail or Unassigned Payer\*\*\*



**Viewing Remittance Advice**

# Remittance Detail

Allscripts **Welcome**

Claims Patients **Reports** Maintenance Help Tools

Select Reports

Select Remittance

Resources  
Knowledge Center

**Quick Links**

New Messages Payer Reports Remit Reports

**My Filters** Claims Filters

You have not set up any Claims filters.

Create Filter



# Remittance Report Filter

The screenshot shows a web application interface for filtering remittance reports. At the top is a green header with the title "Remittance Report Filter". Below the header is a navigation menu with tabs for "Claims", "Patients", "Reports", "Maintenance", "Help", and "Tools". The main content area is divided into two sections: "Select Criteria" and a second filter section. The "Select Criteria" section includes radio buttons for "0-90 Days" (selected) and "91+ Days". Below this is a "From" and "Through" date range selector, where the "Report Date" is set from "04/16/2016" to "04/23/2016". Other options include "Payer" (set to "All Payers"), an empty "NPI" field, and "View" options for "Read", "Unread", and "Deleted" (all checked). There is also a checkbox for "Display Downloadable Reports Only". The second filter section has "From" and "Through" columns for "Check Amount", "Check Number", and "Check Date". At the bottom are two buttons: "Back To List" and "Apply Filter".

**Select Report Dates**

**Select Apply Filter**

# Remittance Detail List

**Allscripts** **Remittance Detail List**

Claims Patients Reports Maintenance Help Tools

Export to CSV

Check Data will be listed: Payer, NPI, Check No, Check Amount, Check Date, Received Date and Status

Select View

	Payer	NPI	Check No	Check Amt	Check Date	Received Date	Status			
<input type="checkbox"/>	NV Medicaid Professional		210002480194059	\$5,290.08	07/19/2013	7/14/2013 4:50:53 AM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480191411	\$5,744.88	07/12/2013	7/7/2013 5:03:00 AM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480188786	\$4,909.39	07/05/2013	6/30/2013 5:04:37 AM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480186066	\$4,660.83	06/28/2013	6/23/2013 4:56:53 AM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480183559	\$9,760.75	06/21/2013	6/16/2013 4:37:07 PM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480178481	\$4,435.92	06/07/2013	6/2/2013 4:51:43 AM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480175928	\$7,708.32	05/31/2013	5/26/2013 5:03:05 AM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480173295	\$2,000.59	05/24/2013	5/19/2013 4:55:41 AM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480170713	\$3,781.44	05/17/2013	5/12/2013 4:56:36 AM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480168121	\$1,599.84	05/10/2013	5/5/2013 4:56:22 AM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480165439	\$4,435.92	05/03/2013	4/28/2013 4:27:37 PM	R			<a href="#">View</a>
<input type="checkbox"/>	NV Medicaid Professional		210002480162845	\$2,181.60	04/26/2013	4/21/2013 4:54:13 AM	R			<a href="#">View</a>

Displaying items 1 - 12 of 12

Filter List

# Remittance Advice

Allscripts

NV Medicaid - 835 Remittances

Customer Name:

Claim Detail													
Patient Demographics				Claim Information									
Name:	CLAIM TEMPLET			Claim Status:	1	Total Billed:							\$145.44
Pat Acct:	CLAIM TEMPLET			Claim Num/ ICN:	2013193701488301	Total Prov Paid:							\$145.44
Ins Id:													
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	CoIns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	05 Jul - 06 Jul 2013	H2014			\$145.44							\$145.44	\$0.00
					-----							\$145.44	\$0.00
					\$145.44	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$145.44	\$0.00
Name:	CLAIM TEMPLET			Claim Status:	1	Total Billed:							\$363.60
Pat Acct:	CLAIM TEMPLET			Claim Num/ ICN:	2013193701488302	Total Prov Paid:							\$363.60
Ins Id:													
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	CoIns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	07 Jul - 11 Jul 2013	H2014			\$363.60							\$363.60	\$0.00
					-----							\$363.60	\$0.00
					\$363.60	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$363.60	\$0.00
Name:	CLAIM TEMPLET			Claim Num/ ICN:	2013193701489201	Total Billed:							\$145.44
Pat Acct:	CLAIM TEMPLET			Claim Num/ ICN:	2013193701489201	Total Prov Paid:							\$145.44
Ins Id:													
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	CoIns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	05 Jul - 06 Jul 2013	H2014			\$145.44							\$145.44	\$0.00
					-----							\$145.44	\$0.00
					\$145.44	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$145.44	\$0.00
Name:	CLAIM TEMPLET			Claim Num/ ICN:	2013193701489202	Total Billed:							\$363.60
Pat Acct:	CLAIM TEMPLET			Claim Num/ ICN:	2013193701489202	Total Prov Paid:							\$363.60
Ins Id:													
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	CoIns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	07 Jul - 11 Jul 2013	H2014			\$363.60							\$363.60	\$0.00
					-----							\$363.60	\$0.00
					\$363.60	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$363.60	\$0.00
Name:	CLAIM TEMPLET			Claim Num/ ICN:	2013193701489401	Total Billed:							\$145.44
Pat Acct:	CLAIM TEMPLET			Claim Num/ ICN:	2013193701489401	Total Prov Paid:							\$145.44
Ins Id:													
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	CoIns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	05 Jul - 06 Jul 2013	H2014			\$145.44							\$145.44	\$0.00
					-----							\$145.44	\$0.00
					\$145.44	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$145.44	\$0.00

Name of Insured  
Pat Account  
Insurance ID Number  
Service Date  
Procedure Code

Claim  
Number/ICN

Total Billed  
Amount  
Total Provider  
Paid Amount



# Learning Check

- 1. You should always copy the template before entering claim information.**
  - a. Yes
  - b. No
- 2. From the Welcome page, where do you go to start your submission of a claim?**
  - a. Tools
  - b. Reports
  - c. Claims
  - d. Help
- 3. Will your claim be automatically submitted once it's in a passed status?**
  - a. Yes
  - b. No



**Contact Us**



# Nevada Medicaid Contact Information

## EDI Help Desk

Phone: (877) 638-3472 (select option 2, then select option 0, then select 3)

Email [NVMMIS.EDIsupport@dxc.com](mailto:NVMMIS.EDIsupport@dxc.com)

## Mailing Address:

Nevada Medicaid

EDI Coordinator

P.O. Box 30042

Reno, NV 89520-3042

## Nevada Provider Training

Email [NevadaProviderTraining@dxc.com](mailto:NevadaProviderTraining@dxc.com)



**Thank You**