

## UTAH MEDICAID SPECIFIC DENTAL COB TEMPLATE

### UHINt 2.5 Tool

All EDI must pass through the Utah Health Information Network (UHIN), an independent, not-for-profit, value added network serving all payers in Utah. Contact UHIN at [www.uhin.org](http://www.uhin.org) or call 801-466-7705.

Telephone Number for Medicaid EDI customer support is 801-538-6155 or 800-662-9651 menu 3, menu 5. Hours of operation are Monday through Wednesday (7 am to 12 noon and 1 pm to 6 pm) and Thursday (11 am to 12 noon and 1 pm to 6 pm). Closed on Fridays.

UHINt 2.5 is an internet based product offered by UHIN that can be used to interface between a medical billing system and UHINet (UHIN's internet portal). It can also be used to directly type in claims, eligibility inquires, etc. This is not a Medicaid product. The user guide is on the internet [https://www.uhinet.com/uhint/install/UHINt\\_2.5\\_User\\_Guide.pdf](https://www.uhinet.com/uhint/install/UHINt_2.5_User_Guide.pdf). For help installing, security, or any technical question contact UHIN.

Submitter Maintenance and Provider Maintenance will need to be set up to submit claims. Providers submitting to HT000004-001 need to be set up with NPI and (EIN) Tax ID. Required fields by the UHINt tool are in **Red**. There are some Utah Medicaid specific fields in addition to those that will need to be filled out to process the claim.

Transmit claims for all Medicaid programs (Non-Traditional Medicaid, Primary Care Network, Select Access, Baby Your Baby, etc.) to Medicaid Fee-For-Service (FFS), HT000004-001.

If Primary Insurance paid \$0.00 or denied the claim, send the claim electronically. When you receive the denial from Medicaid, send the Primary Insurance EOB to the Office of Recovery Services at fax number 801-536-8513.

For additional information please refer to the Utah Medicaid Companion Guides <http://health.utah.gov/hipaa/guides.htm>.

The screenshot shows the 'Dental' form in the UHINt 2.5 application. The form includes sections for 'Monitor', 'Submission', and 'Production (Butch)'. The 'Monitor' section contains fields for 'Bill Type' (set to 'Original Claim'), 'Original Ref #', and 'Option' (with 'COB' selected). The 'Submission' section includes 'Carrier' information (Name: 'Utah Medicaid - FFS', ID: 'HT000004-001 : Utah Medicaid') and 'Carrier Address' (Address, City, State, Zip Code). The 'Production (Butch)' section includes 'Patient Information' (Last Name, First Name, Middle Initial, Birthdate, Patient ID #, Address, City, State, Zip Code, Gender, Phone Number) and 'Relationship to Subscriber/Employer' (Self, Spouse, Child, Other).

- **Bill Type:** Use drop-down list to select the bill type. If a Replacement or Cancel of a Prior PAID Claim enter the TCN of the Original Medicaid Paid Claim to be replaced/cancelled in the Original Ref# box. Enter all 17 digits with no hyphens or spaces.
- **Option:** Select the radio button COB if the patient is covered by another plan and reporting Coordination of Benefit information.
- Dental Pre-Treatment Estimate option is currently not available.
- Type the Prior Authorization Number if applicable.
- **Relationship to Subscriber:** Select the radio button that indicates self.
- **Box 10. Patient Information** auto populates when using Patient Demography Repository.
- **Box 16** is the Patients Medicaid ID number or SSN number.

The screenshot shows the UHINt 2.5 software interface. The main window is titled 'UHINt 2.5' and has a menu bar with 'File', 'Tools', 'View', and 'Help'. Below the menu bar are tabs for 'Monitor', 'Professional', 'Institutional', and 'Dental'. The 'Dental' tab is selected. On the left side, there is a sidebar with buttons for 'Preferences', 'Submission', 'Queries', 'Files', and 'Reports'. Below these is a 'Production (Butch)' button. The main form area contains several sections:

- Subscriber Information:** Fields for 19. ID#/SSN, 21. Group #, 22. Subscriber/Employee Name (Last, First, Middle Initial, Suffix), 23. Address, 24. Phone (NOT USED), 25. \* City, 26. \* State (UT), 27. \* Zip Code, 28. \* Birthdate (mm/dd/yy), 29. Marital Status (NOT USED), 30. Gender (M, F), 38. Employment Status (NOT USED).
- Payer Information:** 31. Other coverage type (Dental or Medical), 32. Policy Number, 33. \* Last Name, \* First Name, Middle Initial, Address, City, State (UT), Zip Code, 34. \* Birthdate (mm/dd/ccyy), 35. Gender (M, F), 36. \* Responsibility Seq (Primary), 37. \* Relationship to Subscriber.
- Authorization:** 39. 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 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 under applicable law, I authorize release of any information relating to this claim. (X) Yes.
- Other Payer:** 40. Other Payer, \* Plan Name, \* Plan ID.
- Release of Information:** 41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. Signed (X) Yes ( ) No.

- **Subscriber Information auto populates when using Patient Demography Repository.**
- **Payer Responsibility Sequence: select Primary from the drop-down list.**
- **Box 31: Select the radio button Dental.**
- **Box 36 Responsibility Sequence: select Primary from the drop-down list.**

The screenshot shows the UHINt 2.5 software interface. The top menu bar includes 'File', 'Tools', 'View', and 'Help'. The main area is divided into several sections:

- Provider Information:** Includes fields for 'Other Payer Provider', 'Provider Type', 'Entity Type', and 'Provider ID'.
- Other Payer Rendering Provider:** Includes fields for 'Entity Type' and 'Provider ID'.
- Claim Amount Information:** Includes fields for 'Payer Paid Amount', 'Approved Amount', 'Allowed Amount', 'Patient Responsibility Amount', 'Covered Amount', 'Discount Amount', and 'Patient Paid Amount'.
- Claim Level Adjustment Information:** Includes a grid of input boxes with 'Edit' and 'X' buttons. A callout box states: "To add additional line information, type over Service Line Number and tab. This opens the fields to report TPL for the Line Number entered."
- Line Level Adjustment Information:** Includes fields for 'Service Line#', 'Bundled Line Number', 'Line Adjudication Date', 'Service Line Paid Amount', 'Paid Service Unit Count', 'Product/Service ID', 'Procedure Code Description', and 'Procedure Modifier'.

A sidebar on the left contains 'Preferences', 'Submission', 'Queries', 'Files', 'Reports', and 'Production (Butch)'. The 'Dental' tab is selected at the top.

- **Patient Responsibility must be reported at both Claim Level and Line Level. Report Write-off Amounts as reported by other Payer.**
- **The tool requires Line Level information. Claim level payment information can be reported on the first line. No other line level information needs to be submitted as Medicaid will pay based on claim level information. The claim will pay at the claim level. Patient Responsibility is what Medicaid reviews to pay the provider.**

The screenshot shows the UHINT 2.5 software interface. The top menu bar includes 'File', 'Tools', 'View', and 'Help'. A sidebar on the left contains 'Preferences', 'Submission', 'Queries', 'Files', and 'Reports'. A 'Production (Butch)' button is also present. The main form area is titled 'Dental' and contains several sections:

- 42. \* Billing Dentist or Dental Entity:** A dropdown menu.
- 44. \* Provider ID #:** A dropdown menu with 'Electronic Ide' and 'National Provider' options. A callout box points to this field with the text '44. EIN (TAX ID) or SSN No hyphens'.
- 45. \* Dentist SSN/TIN:** A dropdown menu with 'National Provider' option. A callout box points to this field with the text '45. NPI'.
- 46. \* Address:** Fields for \*Last Name, First Name, Middle Initial, and Address.
- 47. Dentist License #:** A text input field.
- 49. Place of Treatment:** Fields for \* Facility Name and ID.
- 50. \* City:** A text input field.
- 51. \* State:** A dropdown menu with 'UT' selected.
- 52. \* Zip Code:** A text input field.
- 53. Radiographs or models enclosed?:** A dropdown menu with 'NOT USED' selected.
- 55. Pay-to-Provider Information if different:** Fields for Last/Organization, First, Middle, ID, and Secondary ID.
- 56. Related Causes:** Fields A, B, C, and Date (mmddccyy).
- 57. If auto accident is related cause, indicate location of accident:** Fields for State and Country.
- 54. Is Treatment for Orthodontics?:** Radio buttons for Yes and No (No is selected).
- Orthodontics:** Fields for 'If service already commenced: Date appliances placed', 'Total Months of treatment', and 'Total Months of remaining treatment'.

- **Box 42 Billing Dentist:** select the Billing Dentist from the drop-down list.
- **Box 44 Provider ID#:** select Electronic Identification Number from the drop-down list. Type the Tax ID or SSN no hyphen or spaces. The identification number must match the NPI. For more information, please contact Provider Enrollment at 800-662-9651 or 801-538-6155 option 3 option 4.
- **Box 45 Dentist SSN/TIN:** select National Provider ID (NPI) from the drop-down list. Type the NPI Number of the Dentist.

- **Service Date:** Enter the first Date of Service as the Claim Service Date. The date is returned on the 277FE.
- **Box 59.** Click ADD for additional lines. For each line enter a Date of Service in the Date Field. Procedure Codes are the approved ADA codes. Fee is the money amount billed. This field cannot have a comma but can have a decimal for cents.
- **Note:** Do not delete a line located in the middle of charges. Type over the line to correct the information. Only the last line can be deleted, otherwise it causes an error at Medicaid. The claim is rejected.

UHINt 2.5

File Tools View Help

Monitor Professional Institutional Dental

Leave Blank if the Rendering Provider is the same as the Billing Provider

Is Rendering Provider different than Billing Provider?  
 No  Yes

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed  Yes  No

Provider List

Last Name/Organization Name

First Name

Treating Dentist ID Type

Payer Assigned Rendering ID EIN/SSN Taxonomy Code

Treatment Location

63. Address where treatment was performed  
NOT USED

64. City  
NOT USED

65. State  
NOT USED

66. Zip  
NOT USED

Download Status

Print Fill Test Data Clear All Submit

- Click Submit when finished to send the claim.
- Watch for Window that indicates that transmission was completed.