

## UTAH MEDICAID SPECIFIC DENTAL 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 inquiries, 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.

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

- **Bill Type:** Use drop down arrow to identify 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.
- **Box 10. Patient Information** auto populates when using Patient Demography Repository.

**UHINt 2.5** [Window Title Bar]

File Tools View Help [Menu Bar]

Monitor Professional Institutional **Dental** [Tab Bar]

Preferences  
**Submission**  
 Queries  
 Files  
 Reports [Left Navigation]

**Production (Butch)** [Callout Box]

19. ID#/SSN [Text Box] 21. Group # [Text Box]

22. Subscriber/Employee Name  
 \* Last [Text Box] First [Text Box]  
 Middle Initial [Text Box] Suffix [Text Box]

\* Payer Responsibility Seq [Text Box] [Primary] [Dropdown]

Subscriber Information  
 23. Address [Text Box] 24. Phone [Text Box] [NOT USED]

25. \* City [Text Box] 26. \* State [UT] [Dropdown] 27. \* Zip Code [Text Box] 28. \* Birthdate (mmddcc) [Text Box]

29. Marital Status [NOT USED] [Dropdown] 30. Gender [M] [Radio] [F] [Radio] 38. Employment Status [NOT USED] [Dropdown]

31. Is Patient covered by another plan?  
 No  Yes:  Dental or  Medical

32. Policy Number [Text Box]

Other Subscriber  
 33. Last Name [Text Box] First Name [Text Box] Middle Initial [Text Box]

Address [Text Box]

City [Text Box] State [UT] [Dropdown] Zip Code [Text Box]

Member ID [Text Box]

34. Birthdate (mmddccyy) [Text Box] 35. Gender [M] [Radio] [F] [Radio]

37. Relationship to Subscriber [Dropdown] 36. Responsibility Seq [Dropdown]

Benefits Assignment  Yes  No Release of Information  Yes  No

40. Other Payer  
 Plan Name [Text Box] Plan ID [Text Box]

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.  
 Yes  No Signed

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.  
 Yes

Download Status [Text]

Print [Text] Fill Test Data [Text] Clear All [Text] Submit [Text] [Buttons]

- Subscriber Information auto populates when using the Patient Demography Repository.

The screenshot shows the UHINt 2.5 software interface. The top menu bar includes 'File', 'Tools', 'View', and 'Help'. The main window has a sidebar with 'Preferences', 'Submission', 'Queries', 'Files', and 'Reports'. The 'Submission' section is active, showing a form for dental provider enrollment. The form is divided into several sections: 'Billing Dentist or Dental Entity' (42), 'Provider ID #' (44) and 'Dentist SSN/TIN' (45), 'Address' (46), 'Dentist License #' (47), 'Place of Treatment' (49), 'Orthodontics' (54), and 'Related Causes' (56). Callouts point to fields 44 and 45 with instructions: '44. EIN (TAX ID) or SSN No hyphens' and '45. NPI'. A 'Production (Butch)' button is visible on the left sidebar.

- **Box 42 is the Billing Dentist. Select from the Provider Maintenance List.**
- **Box 44 is 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 is the National Provider ID (NPI).**

- 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.
- Box 59. 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

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

64. City

65. State

66. Zip

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.