

## 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>.

**UHInt 2.5**

File Tools View Help

Monitor Dental

Bill Type: Original Claim Original Ref #

1.  Dentist pre-treatment estimate Specialty  
 Dentist statement of actual service

2.  Medicaid Claim Prior Authorization #  
 EPSDT  
 None P&C  
 P&C

3. Carrier  
\* Name:  
\* ID:

Carrier Address  
4. Address  
5. City 6. State  
7. Zip Code

8. Relationship to Subscriber/Employer  
 Self  Spouse  Child  Other

9. Employer/School  
Name Address

Patient Information  
10. \* Patient Last Name \* First Name Middle Initial 15. \* Birthdate (mmddccyy) 16. \* Patient ID #  
11. \* Address  
12. \* City 13. \* State  
14. \* Zip Code  
17. Gender  
 M  F  
18. Phone Number

Download Status

Print Fill Test Data Clear All Submit

- **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**

File Tools View Help

**Click Yes for COB Option**

Monitor Professional Institutional **Dental**

Preferences  
**Submission**  
 Queries  
 Files  
 Reports

Production (Butch)

19. ID#/SSN 21. Group #

22. Subscriber/Employee Name  
 \* Last First \* Payer Responsibility Seq  
 Middle Initial Suffix Primary

Subscriber Information  
 23. Address 24. Phone NOT USED  
 25. \* City 26. \* State 27. \* Zip Code 28. \* Birthdate (mmdccc)  
 29. Marital Status 30. Gender 38. Employment Status  
 NOT USED M F NOT USED

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

32. Policy Number

Other Subscriber  
 33. \* Last Name \* First Name Middle Initial  
 Address  
 City State Zip Code  
 UT \* Member ID  
 34. \* Birthdate (mmdccyy) 35. Gender  
 M  F  
 37. \* Relationship to Subscriber 36. \* Responsibility Seq  
 Benefits Assignment Release of Information  
 Yes  No  Yes  No

40. Other Payer  
 \* Plan Name \* Plan ID

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

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

COB Option  
 Claim Filing Indicator Other Subscriber Secondary ID Other Payer Patient Member ID Other Payer Patient ID

Provider Information  
 Other Payer Provider  
 Provider Type Entity Type \* Provider ID  
 Primary Care Provider Person Provider Commercial Number  
 National Provider Number  
 Other Payer Rendering Provider  
 Entity Type Provider ID

- **Subscriber Information auto populates when using Patient Demography Repository.**
- **Must enter Provider Information under Other Payer Provider.**

The screenshot displays the UHInt 2.5 software interface. At the top, there is a blue header with the logo and text 'UHInt 2.5'. Below this is a menu bar with 'File', 'Tools', 'View', and 'Help'. On the left side, there is a vertical navigation menu with buttons for 'Preferences', 'Submission', 'Queries', 'Files', 'Reports', and 'Production (Butch)'. The main area is divided into several sections:

- Claim Amount Information:** This section has four tabs: 'Monitor', 'Professional', 'Institutional', and 'Dental'. Below the tabs are four columns of input fields: 'Payer Paid Amount', 'Approved Amount', 'Allowed Amount', and 'Patient Responsibility Amount'. Each column has a text input field and a label 'Amount'.
- Write-off Amounts Reported by Other Payer:** A callout box points to the 'Discount Amount' field in the 'Professional' tab.
- Claim Level Adjustment Information:** This section contains a table with columns: 'Group Code', 'Reason Code', 'Monetary Amount', and 'Adjustment Quantity'. The first row has 'Contractual Obligations' in the Group Code field, '42' in the Reason Code field, 'Amount' in the Monetary Amount field, and '1' in the Adjustment Quantity field.
- Line Level Adjustment Information:** This section contains fields for 'Line Adjustment Date', 'Service Line#', 'Bundled Line Number', 'Date', 'Service Line Paid Amount', 'Paid Service Unit Count', '\* Product/Service ID', 'Procedure Code Description', and 'Procedure Modifier'. The 'Service Line#' field contains the number '1'.
- PATIENT RESPONSIBILITY MUST BE LISTED:** A callout box points to the 'Patient Responsibility' dropdown menu in the 'Group Code' field of the 'Line Level Adjustment Information' section.

- Patient Responsibility must be entered for both Claim Level and Line Level.
- 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'. Below the menu is a navigation bar with tabs for 'Monitor', 'Professional', 'Institutional', and 'Dental'. A left sidebar contains buttons for 'Preferences', 'Submission', 'Queries', 'Files', and 'Reports'. A 'Production (Butch)' button is located on the left side of the main form area. The main form 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'.
- \* Last Name, First Name, Middle Initial:** Text input fields.
- 46. \* Address:** Text input field.
- 47. Dentist License #:** Text input field.
- 49. Place of Treatment:** A section with 'Office' and 'ID' dropdown menus.
- 50. \* City:** Text input field.
- 51. \* State:** A dropdown menu with 'UT' selected.
- 52. \* Zip Code:** Text input field.
- 53. Radiographs or models enclosed?:** A dropdown menu with 'NOT USED' selected.
- 55. Pay-to-Provider Information if different:** A section with 'Last/Organization', 'First', 'Middle', 'ID', and 'Secondary ID' fields.
- 56. Related Causes:** A section with 'A', 'B', and 'C' dropdown menus and a 'Date (mmddccyy)' field.
- 57. If auto accident is related cause, indicate location of accident:** A section with 'State' and 'Country' dropdown menus.
- 54. Is Treatment for Orthodontics?:** Radio buttons for 'Yes' and 'No'.
- If service already commenced:** Fields for 'Date appliances placed', 'Total Months of treatment', and 'Total Months of remaining treatment'.

- **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 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

Production (Butch)

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.