Once information has been entered on Hdr 1 per the 837 Dental claim instructions, proceed to Hdr 2. Enter any required information and change the Other 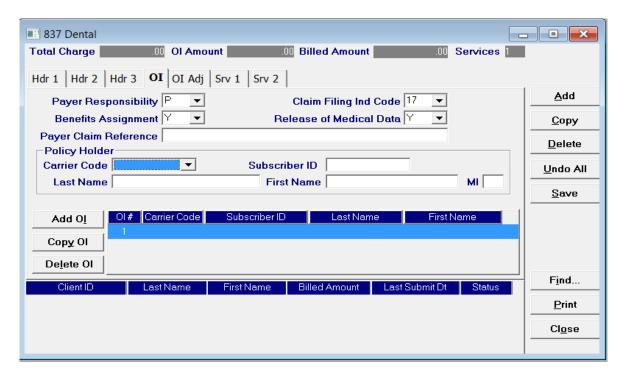Insurance Indicator from the default "N" to "Y" as shown below. Two additional tabs will now be visible between Hdr 3 and Srv 1.
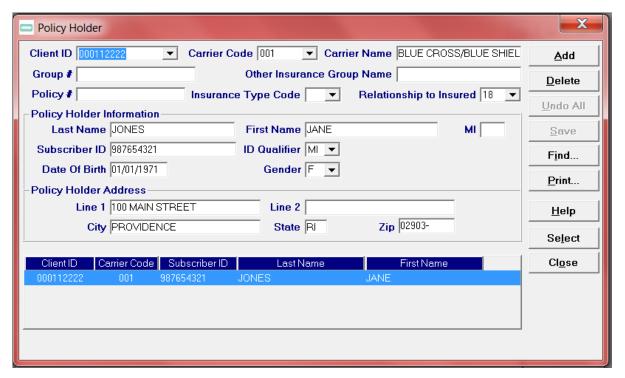

Click on the OI Tab after entering required information on Hdr 3 per the 837 Dental claim instructions. Within the OI Tab, the Payer Responsibility Field is defaulted to "P" and does not change. Select the appropriate value for the Claim Filing Indicator from the drop down box.

Once this step is complete, Tab to the Carrier Code field. If this is the first entry for this recipient, double click in the Carrier Code field and go to the second screen shot example below and complete the required information as indicated. If this is not the first entry for this recipient, select the recipient information from the drop-down menu of the Carrier Code field.
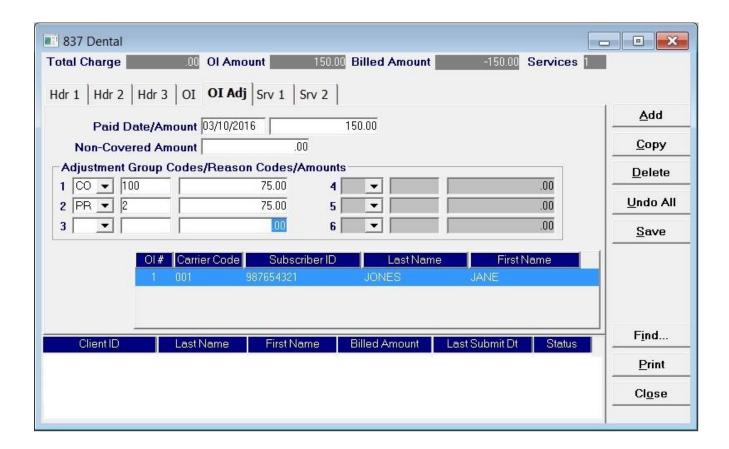

Enter the Medicaid ID in the Client ID field. Select the valid value for the Carrier Code of the primary insurer from the drop down box, click the tab button and the carrier name will be populated. Select the relationship to the insured. Enter policy holder information. When all information is entered select save then chose Select to populate the carrier information on the OI tab.

When the Carrier/Client information has been completed on the OI Tab, click on the OI Adj Tab and enter the following required information; Provide other insurance payment information in the <u>Paid Date</u> and <u>Amount Paid</u> fields. This amount will be deducted from your billed amount.

Enter the valid value for the <u>Adjustment Group Code</u> along with the <u>Reason Code</u> as reported on the primary payers EOB.

All of the dollar amounts entered must equal the total dollar amount being billed to Medicaid. The Non-Covered Amount field is not required. This field can only be used <u>without</u> Adjustment Group and Reason Codes.

837 Dental	— ▢ ✕

Total Charge `.00` **OI Amount** `150.00` **Billed Amount** `-150.00` **Services** `1`

Hdr 1 | Hdr 2 | Hdr 3 | OI | **OI Adj** | Srv 1 | Srv 2

Paid Date/Amount `03/10/2016` `150.00`   Add

Non-Covered Amount `.00`   Copy

Adjustment Group Codes/Reason Codes/Amounts

1 `CO` ▼ `100` `75.00`   4 ▼ `.00`   Delete

2 `PR` ▼ `2` `75.00`   5 ▼ `.00`   Undo All

3 ▼ `.00`   6 ▼ `.00`   Save

OI #	Carrier Code	Subscriber ID	Last Name	First Name
1	001	987654321	JONES	JANE

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status

Find...

Print

Close

Required information for the SRV 1 and SRV 2 tabs should be completed per the instructions for the 837 Dental claim.