

# PHDH-Public Health Dental Hygienist

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**Rhode Island Medicaid**

September 13<sup>th</sup>, 2023

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# Agenda

## Section One

- **Introduction to Medicaid**
- **Provider Enrollment**
- **Steps You Take to Get Set Up**
- **Enrolling for a Trading Partner number**
- **Navigate the Health Care Portal**
- **Questions and Answers**

## Section Two

- **Reminder: Steps You Take to Get Set Up**
- **Overview of Billing and Payment Basics**
- **Billing Policy and Procedure**
- **Questions and Answers**

# Gainwell Technologies Overview

The Rhode Island Executive Office of Health and Human Services (EOHHS) partners with Gainwell Technologies as its Fiscal Agent to process the state's Medicaid Program claims, to enroll and train providers, and perform other duties to fulfill State and Federal requirements. EOHHS has the sole responsibility for formatting program policy and procedures.

# Public Health Dental Hygienist (PHDH)

Provider Enrollment

# ENROLLMENT GUIDELINES

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- Rhode Island Medicaid is currently accepting applications from Public Health Dental Hygienist (PHDH) Providers.
- Active enrollment is required before a provider can begin seeing RI Medicaid members.
- Must have a PHDH license in order to enroll.

# HOW TO ENROLL

Enrollment is completed using the RI Medicaid Healthcare Portal (HCP).

➤ RI Medicaid Healthcare Portal

<https://www.riproviderportal.org>

➤ Step-by-step enrollment instruction can be found on the portal home page.

➤ Healthcare Portal Resource Page

<http://www.eohhs.ri.gov/ProvidersPartners/HealthcarePortal.aspx>

Executive Office of Health & Human Services  
Medicaid

Home

Home

Tuesday 02/15/2022 07:43 AM EST

**Login** ?

\*User ID

**Log In**

[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)

**Protect Your Privacy!**  
Always log off and close all of your browser windows

**Would you like to enroll as a Provider?**

[Provider Enrollment](#)

**Would you like to change or add electronic funds transfer?**

[Electronic Funds Transfer](#)

**Would you like to enroll as an Ordering, Prescribing or Referring (OPR) "Non-Billing" Provider?**

[Enroll as an OPR Provider](#)

**Would you like to enroll as a Trading Partner?**

[Click here to Enroll!](#)

**What can you do in the RI Medicaid Health Care Portal**  
Through this secure and easy to use internet portal:

- Healthcare providers and Billing Agents can **enroll as a Trading Partner** with RI Medicaid.
- Trading Partners can access eligibility, claim status, file exchange and other Interactive Web Services including the Electronic Health Record (EHR) Incentive Program - **MAPIR** - utilizing their Trading Partner ID as their User ID.

**Provider Enrollment User Guide**

**Trading Partner Enrollment User Guide**

**Trading Partner Agreement**

**OPR Provider User Guide**

[Website Requirements](#)

[Rhode Island Medicaid Providers](#)

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# INFORMATION NEEDED TO ENROLL

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- ▶ Address Information, including postal code + 4
- ▶ Tax ID – either EIN or SSN
- ▶ Completed W-9 as an attachment, including a live signature.
  - ▶ W9 needs to be dated for month/year application is being submitted
- ▶ You will need to complete the Federally Required Disclosures.

# ADDITIONAL ENROLLMENT INFORMATION

- ▶ Because PHDH services are only reimbursed through FFS Medicaid at this time, PHDH Providers should select “RI Medicaid Provider - Billing Claims Directly to RI Medicaid” as the Type of Provider Enrollment
- ▶ Under **Provider Enrollment Type**, select “Group” or “Individual”
- ▶ Provider Type is Public Health Dental Hygienist
- ▶ Effective date is the date you fill out the application

The screenshot shows the 'Provider Enrollment: Request Information' form. The header includes the logo for the Executive Office of Health & Human Services, State of Rhode Island, and the text 'Rhode Island Executive Office of Health and Human Services Medicaid'. The breadcrumb trail is 'Home > Provider Enrollment > Enrollment Request Information'. The date and time are 'Friday 09/01/2023 04:01 PM EST'. The form is divided into several sections: 'Request Information' (with a table of tabs), 'Type of Provider Enrollment' (with radio button options), 'Initial Enrollment Information' (with dropdowns and a date field), and 'Contact Information' (with text input fields and a dropdown). At the bottom right are 'Continue', 'Finish Later', and 'Cancel' buttons. The footer contains 'R4.4.02' and '© 2023 Gainwell Technologies. All rights reserved. | Privacy Notice'.

**EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES**  
STATE OF RHODE ISLAND

Rhode Island Executive Office of Health and Human Services  
Medicaid

Home

Home > Provider Enrollment > Enrollment Request Information Friday 09/01/2023 04:01 PM EST

**Provider Enrollment: Request Information** ?

<a href="#">Welcome</a>	You are initiating a new Enrollment application. Below is the initial enrollment screen. Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later".
<b>Request Information</b>	The contact person will potentially be contacted to answer any questions regarding the information provided in this enrollment application. Hospitals and Agencies should choose a Provider Enrollment Type of Facility. Health Plans should choose a Provider Enrollment Type of Atypical.
Specialties	
Provider Identification	* Indicates a required field.
Addresses	
Languages	
Other Information	
Disclosures	
Agreement	
Summary	

**Type of Provider Enrollment**

\* Please select type of Provider Enrollment:

RI Medicaid Provider - Billing Claims Directly to RI Medicaid.  
 MCO (Managed Care Organization) Provider - Providing services to RI Medicaid recipients; billing claims through an MCO.  
 MCO & RI Medicaid Provider - Billing Claims Directly to RI Medicaid and through an MCO.

**Initial Enrollment Information**

\* Provider Enrollment Type: Individual  
\* Provider Type: Public Health Dental Hygienist  
\* Requesting Enrollment Effective Date: 09/01/2023

**Contact Information**

\* Contact Name: \_\_\_\_\_  
\* Contact Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
\* Contact Email: \_\_\_\_\_  
\* Confirm Email: \_\_\_\_\_  
Preferred Method of Communication: Email

[Continue](#) [Finish Later](#) [Cancel](#)

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# YOU'RE ENROLLED! WHAT NEXT?

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- Once enrolled you will be receiving a letter in the mail letting you know that you're enrolled with RI Medicaid

## Revalidation

- Revalidation happens once every five years. When you will need to revalidate, we will be sending you a letter in the mail with all the information you need to complete this task.
- Failure to complete revalidation will result in termination of enrollment.

# STEPS YOU TAKE TO GET SET UP

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## Step One: Provider Enrollment

- ▶ Enroll as a PHDH provider
- ▶ Comply with revalidation

If you have questions reach out to our Provider Enrollment Department  
[rienrollment@gainwelltechnologies.com](mailto:rienrollment@gainwelltechnologies.com)

## Step Two: Health Care Portal

- ▶ Enroll to receive a Trading Partner ID
- ▶ Register your Trading Partner ID

If you have questions reach out to our EDI Department  
[riediservices@gainwelltechnologies.com](mailto:riediservices@gainwelltechnologies.com)

## Step Three: Billing

- ▶ Download the PES (Provider Electronic Solutions) Billing software.

If you have questions reach out to your Provider Representative  
[Andrea.rohrer@gainwelltechnologies.com](mailto:Andrea.rohrer@gainwelltechnologies.com)

# ENROLLING FOR A TRADING PARTNER NUMBER

- ▶ What is a Trading Partner number?
  - ▶ A trading partner number is how you would conduct business to access eligibility, claim status, file exchange and other Interactive Web Services, by using their Trading Partner ID as your User ID
- ▶ Enroll to receive a trading partner number so that you can utilize the Health Care Portal
- ▶ The information you will need:
  - ▶ Your Nation Provider Identification Number

## Initial Enrollment Information

\*Trading Partner/Billing Agency Full Name

\*FEIN (Tax ID)

This section is not required for Billing Agents. NPI must be entered for all healthcare providers (taxonomy is optional). If you do not qualify for an NPI, please provide your Medicaid Provider Number.

Identifier Type

Identifier

Taxonomy

**Login** ?

\*User ID

**Log In**

[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)

**Protect Your Privacy!**  
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[Provider Enrollment](#)

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[Electronic Funds Transfer](#)

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**Provider Enrollment User Guide** **Trading Partner Enrollment User Guide** **Trading Partner Agreement**

**OPR Provider User Guide**

[Website Requirements](#)

[Rhode Island Medicaid Providers](#)

# TRADING PARTNER NUMBER

- ▶ Once your trading partner application has been accepted. You will then receive your trading partner number through an email.
- ▶ **Register your Trading Partner Number**
- ▶ The information you will need
  - ▶ Trading Partner Number
  - ▶ Trading Partner Number Name
  - ▶ Tax-ID
  - ▶ ID- Type (NPI)
  - ▶ Your NPI
- ▶ Your Trading Partner number will be your user ID that you use to log into the Healthcare Portal.
- ▶ You will be prompted on the next screen to pick your security questions and answers. It's very important that you write that information down.
- ▶ Your Password must be exactly 8 characters in length. At least one uppercase, one lowercase, and one number, and *no* special characters

### Login

\*User ID

[Log In](#)


[Forgot User ID?](#)

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[Provider Enrollment User Guide](#)   [Trading Partner Enrollment User Guide](#)   [Trading Partner Agreement](#)

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[Website Requirements](#)

[Rhode Island Medicaid Providers](#)

[Enroll as an OPR Provider](#)

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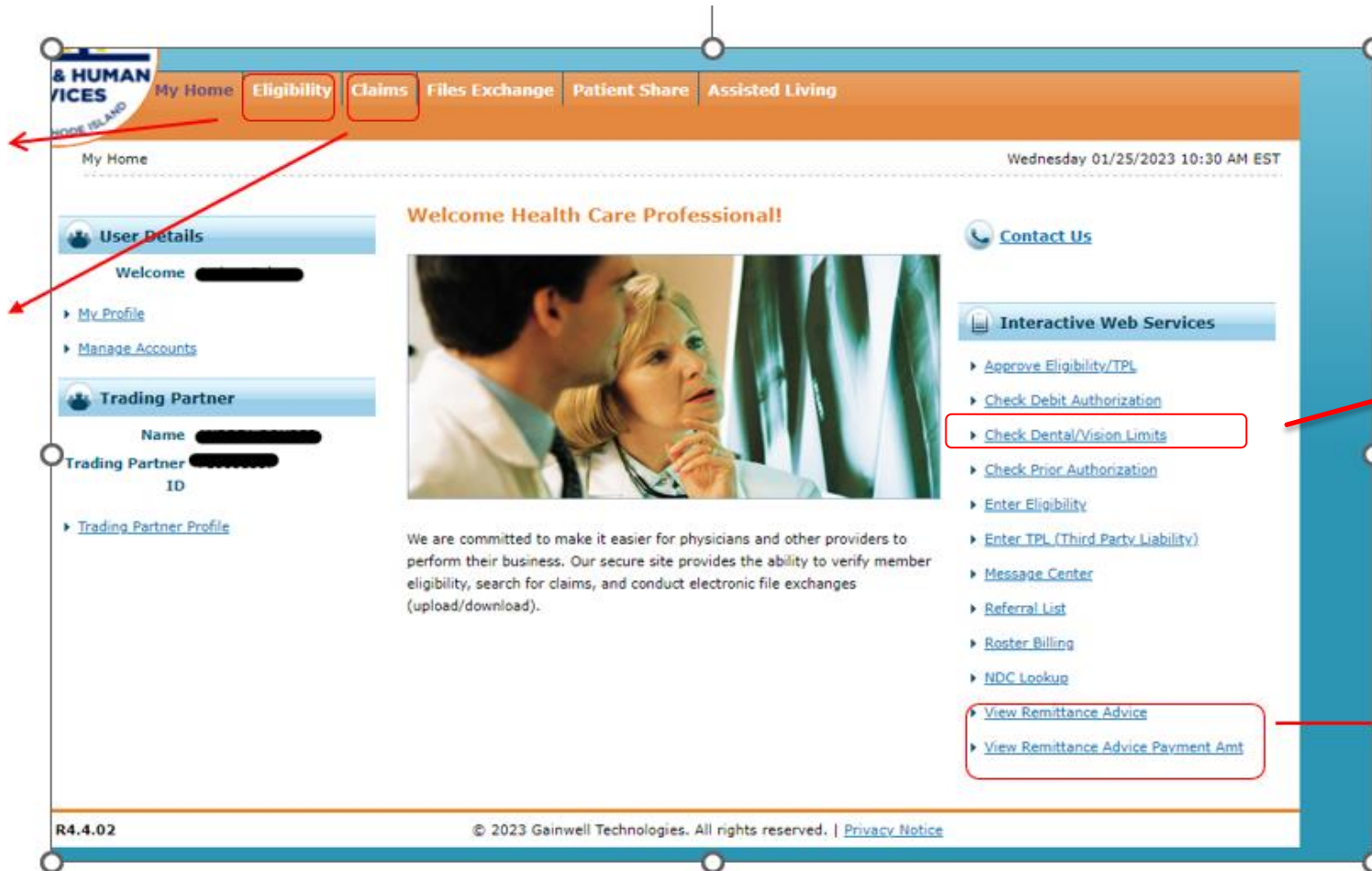
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[Electronic Funds Transfer](#)

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[Enroll as an OPR Provider](#)

# RI MEDICAID PROVIDER PORTAL



Check Patient Eligibility

Check claim status

Check Dental Limits

View your remittance advice

# STEPS YOU TAKE TO GET SET UP

## Step One: Provider Enrollment

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# BILLING AND PAYMENT BASICS



Claim

# YOUR ROLE AS A BILLING PROVIDER

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## Verify

Verify Beneficiary RI  
Medicaid Eligibility

## Adhere

Adhere to Timely  
Filing Guidelines

## Claims

Claim Submission

# VERIFY ELIGIBILITY

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- ❑ Member eligibility must be verified on each date of service
- ❑ Eligibility information is available 24/7 in the health care portal
- ❑ Access to the HCP is obtained as part of the enrollment process



# TIMELY FILING GUIDELINES

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- ❑ The Rhode Island Executive Office of Health and Human Services has a claim submission restriction of **twelve (12)** months from the date the service that was provided to Medicaid recipients.
- ❑ Gainwell Technologies must receive a claim for services for Medicaid clients within 12 months of the date of service in order to process claims for adjudication.
- ❑ Any claim with a service date over one year and a remittance advice date from Gainwell Technologies over ninety (90) days will be denied for timely filing. Denials must be for reasons other than timely filing to be considered.



# ELECTRONIC VS. PAPER CLAIMS

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## Electronic

- Faster turnaround time
- No original signature required
- Quicker corrections
- Free Provider Electronic Solutions (PES) Software for Billing
- Cost savings

## Paper

- Slower Turnaround Time due to Manual Processing
- Requires an original signature
- Cost of postage and forms

# BILLING FORMATS

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- ❑ Electronic claims are the preferred method for claim submission. PHDH services are submitted using HIPAA compliant software and electronic claim type 837 Dental.
- ❑ To submit claims electronically, providers have access to the free Provider Electronic Solutions (PES) software. [The software along with written instructions for download and setup can be found on the EOHHS website.](#)
- ❑ Paper claims are to be submitted using the 2012 ADA Dental claim form, which providers will need to purchase. Claim forms can be purchased at medical supply stores. [Step-by-step instruction document for completing the paper claim form is available on the EOHHS website.](#)

# ADA Dental Claim Form Example

## ADA American Dental Association® Dental Claim Form

**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

**POLICYHOLDER/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  M  F    15. Policyholder/Subscriber ID (SSN or ID#)

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

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

**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

**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. Point	29b. SN	30. Description	31. Fee
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

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	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32			

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

34a. Diagnosis Code(s)    A \_\_\_\_\_    C \_\_\_\_\_    31a. Other Fee(s) \_\_\_\_\_  
 (Primary diagnosis in "A")    B \_\_\_\_\_    D \_\_\_\_\_    32. Total Fee \_\_\_\_\_

35. Remarks

**AUTHORIZATIONS**

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 dental benefits, 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.

X 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 or dental entity.

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

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment  (e.g. 11=office; 22=O/P Hospital)    39. Enclosures (Y or N)   
 (Use "Place of Service Codes for Professional Claims")

40. Is Treatment for Orthodontics?  No (Skip 41-42)     Yes (Complete 41-42)    41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment    43. Replacement of Prosthesis  No     Yes (Complete 44)    44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from  Occupational Illness/Injury     Auto accident     Other accident

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

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI    50. License Number    51. SSN or TIN

52. Phone Number ( ) -    52a. Additional Provider ID    57. Phone Number ( ) -    58. Additional Provider ID

**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.

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

54. NPI    55. License Number

56. Address, City, State, Zip Code    56a. Provider Specialty Code

# PAYMENT

- Payment for services is made by EFT (electronic funds transfer) only. You will set this up during enrollment.
- Payment frequency is determined by the State Fiscal Year (SFY) Claims Payment and Processing Schedule. The schedule can be found [here](#) on the EOHHS website.
- Providers are required to retrieve the claims remittance advice from the Healthcare Portal (HCP) every payment date. “Claims remittance advice” is the explanation to the provider about status. For example, the claims remittance advice will tell you whether the claim was paid or denied; how much was paid if paid; reason for denial if denied.

MONTH	LTC CLAIMS Due at Noon	EMC CLAIMS Due by 5:00PM	EFT PAYMENT
July	7/06/2023	7/07/2023	7/14/2023
		7/21/2023	7/28/2023
August		8/4/2023	8/11/2023
	8/10/2023	8/11/2023	8/18/2023
September		8/25/2023	9/01/2023
	9/07/2023	9/08/2023	9/15/2023
October		9/22/2023	9/29/2023
	10/05/2023	10/06/2023	10/13/2023
November		10/20/2023	10/27/2023
		11/03/2023	11/10/2023
December	11/09/2023	11/10/2023	11/17/2023
		11/24/2023	12/01/2023
January	12/07/2023	12/08/2023	12/15/2023
		12/22/2023	12/29/2023
February		1/05/2024	1/12/2024
	1/11/2024	1/12/2024	1/19/2024
March		1/26/2024	2/02/2024
	2/08/2024	2/09/2024	2/16/2024
April		2/23/2024	3/01/2024
	3/07/2024	3/08/2024	3/15/2024
May		3/22/2024	3/29/2024
	4/04/2024	4/05/2024	4/12/2024
June		04/19/2024	04/26/2024
	5/09/2024	5/03/2024	5/10/2024
July		5/10/2024	5/17/2024
	6/06/2024	5/24/2024	5/31/2024
August		6/07/2024	6/14/2024
		6/21/2024	6/28/2024
September		7/05/2024	7/12/2024
	7/11/2024	7/12/2024	7/19/2024
October		7/26/2024	8/02/2024

# BILLING POLICY AND PROCEDURES



# Covered Procedure Codes

Procedure Codes	Description
D0191	ASSESSMENT OF A PATIENT
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)
D0220	INTRAORAL-PERIAPICAL-FIRST FILM
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM
D0240	INTRAORAL-OCCLUSAL FILM
D0250	EXTRAORAL-FIRST FILM
D0270	BITEWING-SINGLE FILM
D0272	BITEWINGS-TWO FILMS
D0273	BITEWINGS, THREE FILMS
D0274	BITEWINGS-FOUR FILMS
D0275	BITEWINGS-EACH ADDITIONAL FILM
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF LOW RISK
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF MODERATE RISK
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF HIGH RISK
D1110	PROPHYLAXIS-ADULT
D1120	PROPHYLAXIS-CHILD
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS
D1208	TOPICAL APPLICATION OF FLUORIDE
D1351	SEALANT-PER TOOTH
D1354	SILVER DIAMINE FLUORIDE, 8 TEETH PER YEAR
D4341	PERIODONTAL SCALING AND ROOT PLANING-PER QUADRANT
D4342	PERIODONTAL SCALING AND ROOT PLANNING- ONE TO THREE TEETH PER QUADRANT
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION Â- FULL MOUTH, AFTER ORAL EVALUATION
D9410	HOUSE/EXTENDED CARE FACILITY CALL

# GENERAL POLICY AND CLAIM GUIDELINES

- At this time United Rite Smiles does not cover PHDH Services. This is subject to change in the future. You should only be billing FFS RI Medicaid.

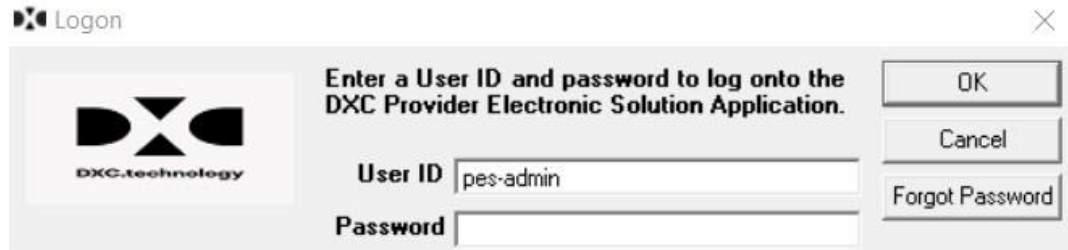
## House/Extended Care Facility Call

- Use of procedure code D9410, House/Extended Care Facility Call, continues to require billing with a CDT code and cannot be billed alone. The code D9410 continues to have a maximum number per day per facility and will be monitored through post-procedural review.
- Mobile services provided by fee-for-service providers to long term care/home care residents may only be reimbursed for a maximum of five visits per day, per facility, per provider. Providers may not bill the D9410- House/Extended Care Facility Call for each recipient seen during a single nursing home visit beyond five even when a reimbursable Medicaid Service is being rendered to multiple recipients.
- D9410 code is essentially meant to support the effort of getting to a location and setting up, etc. PHDH can see more than five individuals, but should not bill the D9410 code beyond the fifth patient.

Provider  
Electronic  
Solutions  
Software (PES)

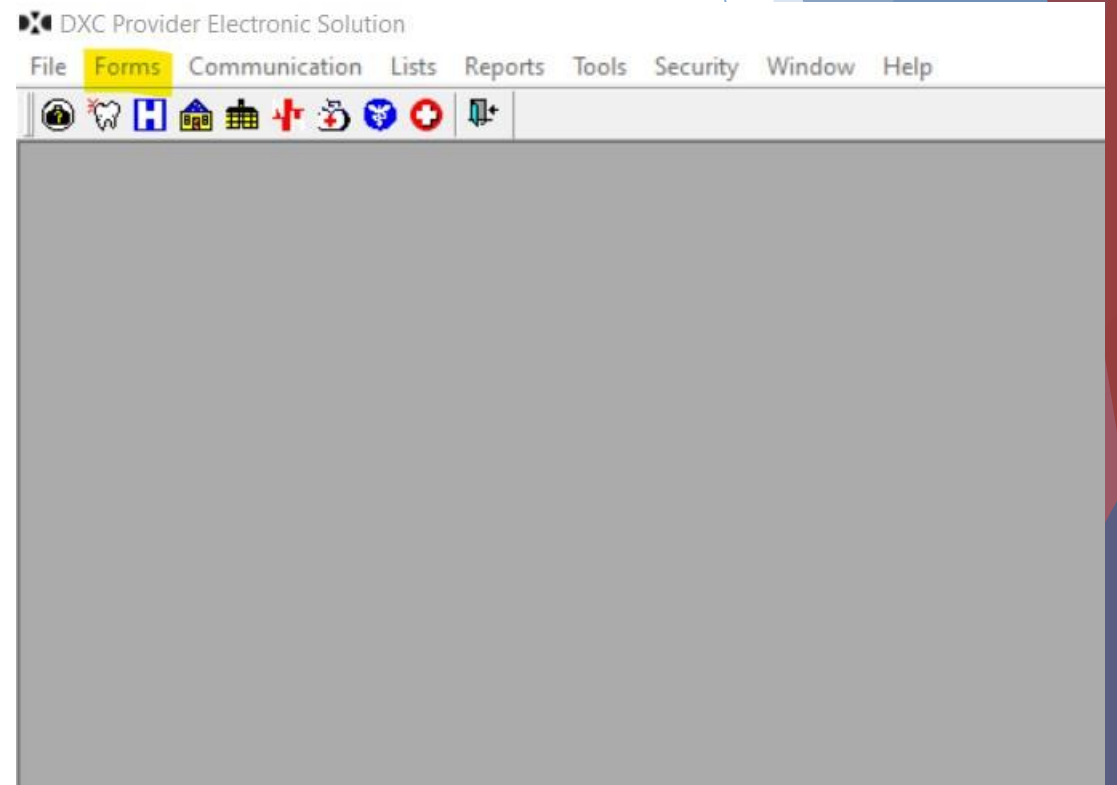
Billing

# Filling Out a Claim in PES



The screenshot shows a 'Logon' dialog box with the DXC Technology logo on the left. The main text reads: 'Enter a User ID and password to log onto the DXC Provider Electronic Solution Application.' Below this text are two input fields: 'User ID' containing 'pes-admin' and an empty 'Password' field. To the right of the input fields are three buttons: 'OK', 'Cancel', and 'Forgot Password'.

- Log into PES
- Click on Forms
- Then Click on 837 Dental



# Filling Out a Claim in PES

837 Dental

Total Charge 59.00 OI Amount .00 Billed Amount 59.00 Services 2

Hdr 1 | Hdr 2 | Hdr 3 | Srv 1 | Srv 2

Claim Frequency 1 Original Claim #

Provider ID 1234567890 Taxonomy Code 124Q00000X

Last/Org Name DENTAL GROUP First Name

Client ID 1234567890 Account # 1234567890

Last Name JANE First Name DOE MI

Signature on File Y Benefits Assignment Y Special Program Code

From DOS 05/12/2023 To DOS 00/00/0000 Release of Medical Data Y

Report Type Code Report Transmission Code

Attachment Ctl

Add  
Copy  
Delete  
Undo All  
Save

837 Dental

Total Charge 59.00 OI Amount .00 Billed Amount 59.00 Services 2

Hdr 1 | Hdr 2 | Hdr 3 | Srv 1 | Srv 2

Referring Provider

SSN/Tax ID Provider ID

Last/Org Name First Name MI

Orthodontic Treatment

Total Months Months Remaining Placement Date 00/00/0000

Accident

Related Causes Date 00/00/0000 State Country

Place Of Service 12 Other Insurance Ind N

Tooth Number Tooth Status Code

Add  
Copy  
Delete  
Undo All  
Save  
Find

# Filling Out a Claim in PES

837 Dental

Total Charge 59.00 OI Amount .00 Billed Amount 59.00 Services 2

Hdr 1 | Hdr 2 | **Hdr 3** | Srv 1 | Srv 2

**Service Facility Location**

Facility ID  Taxonomy Code

Facility Name

**Diagnosis codes**

Qualifier

Principal  Other: 1  2  3

**Rendering Provider**

Provider ID 1234567888 Taxonomy Code 124Q00000X

Last/Org Name DOE First Name JOHN MI

Add  
Copy  
Delete  
Undo All  
Save

837 Dental

Total Charge 59.00 OI Amount .00 Billed Amount 59.00 Services 2

Hdr 1 | Hdr 2 | Hdr 3 | **Srv 1** | Srv 2

Date SVC 05/12/2023 Treatment Start 00/00/0000 Treatment Stop 00/00/0000

Procedure D0190 Tooth  Modifiers: 1  2  3  4

Place Of Service  Surfaces: 1  2  3  4  5

Designation/Quadrants: 1 00 2  3  4  5

Placement Ind  Prior Placement Date 00/00/0000 Units 1

Billed Amount 20.00 Diag Ptr: 1  2  3  4

Add Srv	Srv #	Date Of Service	POS	Procedure	Units	Billed Amount
	1	05/12/2023		D0190	1	20.00
	2	05/12/2023		D9410	1	39.00

Copy Srv  
Delete Srv

Add  
Copy  
Delete  
Undo All  
Save

Find...

# Filling Out a Claim in PES

837 Dental

Total Charge 59.00 OI Amount .00 Billed Amount 59.00 Services 2

Hdr 1 | Hdr 2 | Hdr 3 | Srv 1 | **Srv 2**

Rendering Provider

Provider ID  Taxonomy Code

Last/Org Name  First Name  MI

Service Adjustment Ind  Line Item Control Nbr

Srv #	Date Of Service	POS	Procedure	Units	Billed Amount
1	05/12/2023	12	D0190	1	20.00
2	05/12/2023	12	D9410	1	39.00

Add  
Copy  
Delete  
Undo All  
Save

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837 Dental

Total Charge 59.00 OI Amount .00 Billed Amount 59.00 Services 2

Hdr 1 | Hdr 2 | Hdr 3 | **Srv 1** | Srv 2

Date SVC 05/12/2023 Treatment Start 00/00/0000 Treatment Stop 00/00/0000

Procedure D0190 Tooth Modifiers: 1 2 3 4

Place Of Service Surfaces: 1 2 3 4 5

Designation/Quadrants: 1 00 2 3 4 5

Placement Ind Prior Placement Date 00/00/0000 Units 1

Billed Amount 20.00 Diag Ptr: 1 2 3 4

Add Srv	Srv #	Date Of Service	POS	Procedure	Units	Billed Amount
Copy Srv	1	05/12/2023	D0190		1	20.00
Delete Srv	2	05/12/2023	D9410		1	39.00

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
1234567890	JANE	DOE	59.00	00/00/0000	R

Print

R= Ready  
I= Incomplete  
F= Finalized

[837 Dental \(ri.gov\)](http://837Dental.ri.gov)

# ADDITIONAL RESOURCES

- EOHHS Website
- The Dental Provider Manual
- Subscribe to receive the Provider Update

Official State of Rhode Island website

Settings & Language

THE EXECUTIVE OFFICE OF  
**Health and Human Services**  
State of Rhode Island

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Executive Office of Health and Human Services

Our mission is to ensure access to effective services that foster the independence of all Rhode Islanders.

Learn about EOHHS

# TERMINOLOGY

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- DOB –Date of Birth
- DOS –Date of Service
- EDI – Electronic Data Interchange
- EFT –Electronic Funds Transfer
- EOHHS – Executive Office of Health and Human Services
- ICD – 10 International Classification of Disease, new code set effective October 1, 2014
- ICN –Internal Control Number
- ID –Identification
- TPID- Trading Partner Number
- PHDH- Public Health Dental Hygienist
- HCP- Healthcare Portal
- CMS-Centers for Medicare & Medicaid Services
- PES-Provider Electronic Solutions
- NPI- National Provider Identification
- MCO- Manage Care Organization
- MID – Recipient Medicaid Identification
- POS –Place of Service
- RA –Remittance Advice

# CONTACT INFORMATION

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<b>Provider Enrollment</b>	<a href="mailto:rienrollment@gainwelltechnologies.com"><u>rienrollment@gainwelltechnologies.com</u></a>	
<b>Customer Service Help Desk</b>	401-784-8100 or Toll Free 1-800-964-6211	Monday through Friday 8:00 AM-5:00 PM
<b>Andrea Rohrer</b>	<a href="mailto:Andrea.rohrer@gainwelltechnologies.com"><u>Andrea.rohrer@gainwelltechnologies.com</u></a> 469-897-4389	Provider Representative



# Questions ?

- ▶ Please raise your hand if you have a question.