QR Code to Access Training Resources

Use your IOS, Android or any device to access all our MMIS Tools and Resources for your convenience.
John Selig, MPA

President and CEO, AFMC
MMIS Outreach Team

MMIS OUTREACH SPECIALISTS

HOURS OF OPERATION:
Monday–Friday • 8 A.M.–5 P.M.

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Poll Question

How many visits can a professional provider perform in an Arkansas Medicaid fiscal year without an extension of benefits?

| 10 visits | 5 visits | 16 visits | 12 visits |
Poll Question

Should you have specific questions concerning a requested prior authorization from AFMC such as denial, incorrect information submitted on request, etc. who would you contact?

<table>
<thead>
<tr>
<th>Provider Relations</th>
<th>MMIS Outreach Specialist</th>
<th>Gainwell Provider Assistance Center</th>
<th>Clinical Services</th>
</tr>
</thead>
</table>
Poll Question

When logged into the Arkansas Medicaid Healthcare Portal under the Billing Group Provider ID, choose the option to review all providers affiliated, or linked, with the billing group.

| My profile link | Manage accounts link | Characteristics link |
Poll Question

Manual updates are highlighted in what color?

<table>
<thead>
<tr>
<th>Red</th>
<th>Orange</th>
<th>Yellow</th>
</tr>
</thead>
</table>

Poll Question

Which tab on the Arkansas Medicaid Healthcare portal would you upload documents to Provider Enrollment?

<table>
<thead>
<tr>
<th>Case Management Tab</th>
<th>Files Exchange Tab</th>
<th>Claims Tab</th>
<th>Provider Functions Tab</th>
</tr>
</thead>
</table>
MMIS Outreach Team Map
Did You Know? Agenda

Provider Information
• Maintain current contact information

Third Party Liability (TPL)
• Coordination of Benefits policy enforcement

Ordering, Referring, and Prescribing
• CMS Directive

Medicare Advantage Plan
• Medicare EOMB attachment enforcement

New Medicare Crossover Form
• Professional and Inpatient

Timely Filing
• What is Timely Filing?

Things to Know
• Medicare Crossover Claims (DMS-600) coming soon!
• New Provider Workshop
• Medicaid 101 webinar
DID YOU KNOW?
Provider Contact Information
Provider Contact Information

Messages for Remittance Advices dated December 7, 2023 – December 14, 2023

<table>
<thead>
<tr>
<th>TO: ALL PROVIDERS</th>
<th>RE: IMPORTANCE OF MAINTAINING CURRENT CONTACT INFORMATION WITH DHS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For general business purposes, it is important that DHS can contact providers. Please note, it is the provider's responsibility to update their contact information with DHS. This may be done via the provider portal. Contact information includes mailing, billing, service location, and email addresses. Failure to update provider information may result in delay of business processes.</td>
</tr>
<tr>
<td></td>
<td>A provider remains subject to audit and recoupment when appropriate, even when their contact information is not up to date. Please remember to review provider demographic information via the portal periodically, and make changes as needed.</td>
</tr>
</tbody>
</table>
Third-Party Liability | Coordination of Benefits
Coordination of Benefits

"Medicaid beneficiaries are required to use third party sources of coverage that are available to them at no cost. By seeing an out-of-network provider, the Medicaid beneficiary was not using his or her available health care resources. Consistent with the general principle that Medicaid is the payer of last resort, Medicaid will not reimburse the provider or the beneficiary for any balance not paid by the commercial plan" (CMS, p.54, 2020).

If you provide services to a Medicaid eligible member but the services are denied by the member’s primary insurance, you can use either a Certificate of Benefits or a denial letter from insurance company (EOB with no payment to provider) or a payment to the provider (EOB with payment) as proof the primary insurance was billed. Keep this in the client file for auditing purposes. The Certificate of Benefits or Denial EOB is good for one year.

Please note that it is the provider’s responsibility to follow the billing policies of the liable third-party payer. Procedural denials from the liable third-party payer should be resolved prior to billing Medicaid. Failure to resolve procedural denials prior to billing Medicaid may result in delayed payments or denied claims. Additionally, the Medicaid filing deadline is not delayed while providers chase payment from potentially liable commercial third-party plans.

To show how this should be billed so the claim will bypass the TPL editing, the following example is provided.

The provider receives a denial letter from the insurance company (EOB with no payment to provider) dated 01/01/2019. The provider would say yes, primary insurance was billed using the denial date of 01/01/2019 and $0.00 payment amount in this example. Be sure to include the Claim Filing Indicator.

TPL Documentation/Billing Guidelines

If you are a provider of services to a Medicaid-eligible member, but the services you provide are not covered by the member’s primary insurance company, please see below for documentation and billing guidelines:

▪ A provider can use either a Certificate of Benefits or a denial letter from insurance company (EOB with no payment to provider) or a payment to the provider (EOB with payment). They will need to keep this in the client file for auditing purposes.

▪ It will be good for one year for either the Certificate of Benefits or Denial EOB.

▪ Example: Get certificate or denial dated 01/01/2024. The provider could use it through 12/31/2024. They would say “yes” they billed the insurance using a denial date of, in this example, 01/01/2024 and $0.00 payment amount. Be sure to include Claim Filing Indicator.
Submitting a Third-Party Liability (TPL) Claim on the Portal

### Submit Professional Claim: Step 1

The * (in red) indicates required fields when the ADD button is selected.

<table>
<thead>
<tr>
<th>#</th>
<th>Carrier Name</th>
<th>Carrier ID</th>
<th>Policy ID</th>
<th>Paid Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SOUTHWARE AND AFFILIATES</td>
<td>CI1</td>
<td>321694</td>
<td>[Field]</td>
<td>[Field]</td>
</tr>
</tbody>
</table>

- **Carrier Name**: SOUTHWARE AND AFFILIATES
- **Policy ID**: 321694
- **Paid Amount**: [Field]
- **Action**: [Field]

#### Claim Details

- **Policy ID**: 321694
- **Policy Holder Name**: Puffy
- **Policy Holder Address**: 1234 Main Street
- **City**: Little Rock
- **State**: AR
- **Zip Code**: 72205
- **Responsibility**: [Unknown]
- **Patient Relationship**: [Self]
- **Paid Amount**: [Field]

### Claim Submission Options

- **Save Insurance**
- **Cancel Insurance**

Click to add a new other insurance.
Claims

Image of a Claim Form with the word "Claims" written on it.
Provider Numbers

- Nine-digit provider ID
- National provider ID (NPI)
- Atypical providers (NPI not required)
Ordering, Referring, and Prescribing
Definition of Ordering, Referring, and Prescribing

**Ordering** — The Ordering Provider is the individual who requested the services or items being reported on this service line.

**Referring** — The Referring Provider is the Primary Care Provider (PCP) of a client. Please note, the PCP can also be the person who orders a service for a client but the ordering and referring do not have to be the same.

**Prescribing** — The Prescribing Provider is the individual who advised and authorized the use of a medicine or treatment for someone, especially in writing.
Completion of Claim Form

**Professional (1500)**

The following are examples of providers who would complete a CMS 1500 form:

- Physicians/Other practitioners
- Transportation providers
- Vision providers
- Surgeons
- Supply providers
- HCBS/Waiver providers

**Institutional (UB-04)**

The following are examples of providers who would complete a UB-04 form:

- Inpatient/Outpatient hospital
- Nursing facility
- Home health/PDN
- Hospice
- Dialysis center
- Residential treatment center
- Rural health clinics
Rendering Versus Billing Provider Professional Claim (CMS 1500)

Rendering Provider (Individual within a Group)
Individual who performs services for an Arkansas Medicaid client

Billing Provider
Entity billing and receiving payment for service
Sample of the Professional Claim

Provider Information

Billing Provider ID: 1111111112
Taxonomy: FAMILY MEDICINE

ID Type: NPI
Name: PCP PROVIDER

Performing Provider ID
Select from Favorites
Taxonomy

ID Type: _
Name: _
Add to Favorites

Referring Provider ID
Select from Favorites
Taxonomy

ID Type: _
Name: _
Add to Favorites
Institutional Claim Form

Service Details

Select the row number to edit the row. Click the Remove link to remove the entire row.

Instructions:
If values are required for submission, please fill in the required fields. Otherwise, you may leave the field blank and proceed. These fields are required when the ADD button is selected.

<table>
<thead>
<tr>
<th>Svc #</th>
<th>From Date</th>
<th>To Date</th>
<th>Place Of Service</th>
<th>Procedure Code</th>
<th>Charge Amount</th>
<th>Units</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From Date

To Date

Place Of Service

Procedure Code

Charge Amount

Units

Action

1. Procedure Code
2. Modifiers
3. Unit Type
4. Unit

Diagnosis Pointers

Family Plan

NDCs for Svc. # 1

Add
Reset
Attending Versus Billing Provider
Institutional Claim (CMS 1450 or UB-04)

Attending Provider
Individual who performs services for an Arkansas Medicaid client

Billing Provider
Entity billing and receiving payment for service
Medicare Advantage Plans
Medicare Advantage Plans Claims

These claims do not automatically crossover to Medicaid.

- First notice
- Second notice
- Findings Letter

Retrospective review audit of Edit 3383 — (ATTACHMENT REQUIRED FOR NON-COBA CROSSOVER CLAIMS).
Providers have received letters for paid claims requesting the required Explanation of Medicare Benefits (EOMB).
Providers should disregard any Edit 3383 Retrospective Review EOMB request if the claim reviewed is a COBA claim. Please continue to submit your EOMB for Non-COBA claims as requested.

If you have questions, please contact Utilization Review Department at 501-910-6536.
Medicare Advantage Sample Letter

Division of Medical Services
Utilization Review
P.O. Box 2457, Ste 5-113 Little Rock, AR 72203-2457
501-682-594-693 0E0 501-682-4709

SECOND NOTICE

PE: Retrospective Review of Paid Claims - Medicare Advantage Crossover Claims - Edit 3303
(ATTACHMENT REQUIRED FOR NON-CROSSOVER CLAIMS)

Provider ID:
Member Name:
ID #:
Claim ID:

As of July 1, 2022, Arkansas Medicaid began enforcing the Medicaid policy Section 18. Subsections 322.100 through 322.300 that require an Explanation of Medicare Benefits (EOMB) attachment for all Non-COA (Medicare Coordination of Benefits Agreement) Medicare crossover claims. Edit 3303 - (ATTACHMENT REQUIRED FOR NON-CROSSOVER CLAIMS) applies to claims without an EOMB attachment.

The Utilization Review (UR) department will implement a new Retrospective Review edit for Edit 3303 beginning April 1, 2022. To verify the EOMB, validate the Medicare information submitted on the Medicare Crossover claim. The Utilization Review Department, State of Arkansas, Department of Human Services, Division of Medical Services, reviews medical services provided to Medicaid recipients.

A copy of the complete Explanation of Medicare Benefits (EOMB) to include the crosswalk for the claim identified above must be submitted to:

CHS Division of Medical Services
P.O. Box 1457 Ste 5413
Little Rock, AR 72203

Via mail or electronically to the dedicated fax server at the following number (501) 522-0913.

Please attach this letter to the record and return within 15 business days from the request date.

This is the second and final notice.

If the EOMB submitted supports correct billing, no further notice or action will be required. However, if the EOMB does not support correct billing, a letter with findings will be sent to the provider.

If you have questions, please call (501) 910-0534 or email jessica.kieley@dhs.arkansas.gov.
Timely Filing
What is Timely Filing?

Section 302.000 of the AR Medicaid manual defines timely claims. The Code of Federal Regulations states, “The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.”

The 12-month (365 days) filing deadline applies to all claims, including:

- Claims for services provided to clients with joint Medicare/Medicaid eligibility
- Adjustment requests and resubmissions of claims previously considered
- Claims for services provided to individuals who acquire Medicaid eligibility retroactively

There are no exceptions to the 12-month filing deadline policy. The definitions and additional federal regulations in Section 3 will permit flexibility for those who adhere closely to them. All providers must submit claims within the 12-month (365 days) filing deadline to meet the timely filing policy.
Things to Know

- *New Crossover Claim Forms (DMS - 600) are coming soon!*
- Essential Health Benefits
- New Provider Workshops every quarter (In-Person)
- MyARMedicaid App
- Diabetic Supplies Update - [Helpful Information for Providers](#)
QR Code to Access Training Resources

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Any Questions?
Vendor Break
Poll Question

A request for an extension of benefits must be received within ________ calendar days of the date of the benefits-exhausted denial?

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>45</td>
<td>90</td>
<td>365</td>
</tr>
<tr>
<td>days</td>
<td>days</td>
<td>days</td>
<td>days</td>
</tr>
</tbody>
</table>
Poll Question

When searching claim status on the Arkansas Medicaid Healthcare portal, which panel do you open to see the denial reason of a claim?

| Adjudication Errors Panel | Service Details Panel | Diagnosis Code Panel |
Poll Question

Where do you find the Beneficiary Aid Category list?

| Section II of the Arkansas Medicaid Provider Manual | Section III of the Arkansas Medicaid Provider Manual | Section I of the Arkansas Medicaid Provider Manual |
Poll Question

What would you expect to find on a Procedure Code Table?

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Age Restrictions</th>
<th>Diagnosis Groups</th>
<th>Prior Authorizations</th>
</tr>
</thead>
</table>

All of the above
Poll Question

How many digits are in a Medicaid Provider ID?

| Ten | Nine | Thirteen |
## Poll Question

What section of the Arkansas Medicaid Provider Manual is specific to your provider type?

<table>
<thead>
<tr>
<th>Section II of the Arkansas Medicaid Provider Manual</th>
<th>Section III of the Arkansas Medicaid Provider</th>
<th>Section IV of the Arkansas Medicaid Provider Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section II of the Arkansas Medicaid Provider Manual</td>
<td>Section III of the Arkansas Medicaid Provider</td>
<td>Section IV of the Arkansas Medicaid Provider Manual</td>
</tr>
</tbody>
</table>
Poll Question

What is the color of the MMIS Outreach Team banner on their map?

Blue  Orange
Poll Question

What is Not a covered service under the Preventative Screening/Essential Health Benefits?

<table>
<thead>
<tr>
<th>Lipid</th>
<th>Mammogram</th>
<th>Mole Removal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Poll Question

Arkansas Medicaid established a maximum benefit limit of $________ per SFY for diagnostic laboratory services and radiology.

1000  500  250
Poll Question

How often can you perform an EPSDT (Wellness) Screening on children 3 years through 20 years?

| Every 365 Days | Once per birth year | Anytime you want |
Eligibility Verification 101 — Deep Dive
Agenda

Eligibility Verification — Deep Dive

Training Tools to Determine Eligibility

Evaluations

Questions
# Beneficiary Aid Category List

Some categories provide a full range of benefits while others may offer limited benefits or may require cost sharing by a beneficiary. The following codes describe each level of coverage.

- **FR**: full range
- **LB**: limited benefits
- **AC**: additional cost sharing
- **MNLB**: medically needy limited benefits
- **QHP/AHP/MP**: Qualified Health Plan/assignment/medically frail

<table>
<thead>
<tr>
<th>Category</th>
<th>Category Name</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>ARKIDS B</td>
<td>CHIP Separate Child Health Program</td>
<td>LB, AC</td>
</tr>
<tr>
<td>06</td>
<td>ARHOME</td>
<td>New Adult Expansion Group</td>
<td>QHP, AC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IAP, AC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MF, FR</td>
</tr>
<tr>
<td>10</td>
<td>WD</td>
<td>Workers with Disabilities</td>
<td>FR, AC</td>
</tr>
<tr>
<td>11</td>
<td>Assisted Individual - Aged</td>
<td>Assisted Living Facility Individual is &gt;= 65 years old</td>
<td>FR</td>
</tr>
<tr>
<td>11</td>
<td>ARChoices - Aged</td>
<td>ARChoices waiver - Individual is &gt;= 65 years old</td>
<td>FR</td>
</tr>
<tr>
<td>13</td>
<td>SSI Aged Individual</td>
<td>SSI Medicaid</td>
<td>FR</td>
</tr>
<tr>
<td>14</td>
<td>SSI Aged Spouse</td>
<td>SSI Medicaid</td>
<td>FR</td>
</tr>
<tr>
<td>15</td>
<td>PACE</td>
<td>Program of All-Inclusive Care for the Elderly (PACE)</td>
<td>FR</td>
</tr>
<tr>
<td>16</td>
<td>AA-EC Aged Individual</td>
<td>Medically Needy, Exceptional Category Individual is &gt;= 65 years old</td>
<td>MNLB</td>
</tr>
<tr>
<td>17</td>
<td>AA-SD – Aged</td>
<td>Medically Needy Spend Down Individual is &gt;= 65 years old</td>
<td>MNLB</td>
</tr>
<tr>
<td>18</td>
<td>QMB</td>
<td>AA Aged Individual Qualified Medicare Beneficiary (QMB) Individual is &gt;= 65 years old</td>
<td>LB</td>
</tr>
<tr>
<td>19</td>
<td>ARSeniors</td>
<td>ARSeniors</td>
<td>FR</td>
</tr>
<tr>
<td>20</td>
<td>PCR</td>
<td>Parent Caregiver Relative</td>
<td>FR</td>
</tr>
<tr>
<td>25</td>
<td>TM</td>
<td>Transitional Medicaid</td>
<td>FR, AC</td>
</tr>
<tr>
<td>26</td>
<td>AFDC Medically Needy-EC</td>
<td>AFDC Medically Needy Exceptional Category</td>
<td>MNLB</td>
</tr>
<tr>
<td>27</td>
<td>AFDC Medically Needy-SD</td>
<td>AFDC Medically Needy Spend Down</td>
<td>MNLB</td>
</tr>
<tr>
<td>31</td>
<td>Pickle</td>
<td>Disregard COLA Increase</td>
<td>FR</td>
</tr>
<tr>
<td>33</td>
<td>SSI Blind Individual</td>
<td>SSI Medicaid</td>
<td>FR</td>
</tr>
<tr>
<td>34</td>
<td>SSI Blind Spouse</td>
<td>SSI Medicaid</td>
<td>FR</td>
</tr>
</tbody>
</table>
Tips for Healthcare Portal

- At least 5MB of upload and download speed
- All users have their own username and password
- Make sure staff that are no longer employed are changed to inactive on your profile
- Verify eligibility the day you provide service
- New Enhancement-claim attachments
Importance of Verifying Eligibility
Primary Care Provider

- Displays if the Medicaid client has a Primary Care Physician, Effective Dates and PCP Phone number.

- If the client has a PCP and a referral is required for your procedure code/services, please make sure that you have a referral form from the PCP listed on the eligibility verification.

- Enter the PCP Provider ID on the claim.

- Referral can be in paper form or verbal.

- If a verbal referral is given, ensure that you get: Name of the person that you spoke with who gave you the referral. *Documentation is key!*

- PCP referrals expire on the date specified by the PCP, upon receipt of the number of services specified by the PCP, or in six months, whichever occurs first.
Benefit Details

- This panel will display what coverage the client has (please refer to the Aid Category List) to determine if the client has:
  - **FR** — full range
  - **LB** — limited benefits
  - **AC** — additional cost sharing
  - **MN** — medically needy limited benefits
  - **QHP** — Qualified Health Plan/awaiting assignment

- Refer to Section 124.000 for full detail of each category.
Limit Details

- Displays the number of benefits that are left at the time you verify eligibility.
- Fiscal Year is July 1st – June 30th
- $500 Lab
- $500 Xray
- 12 Outpatient Visits
- 16 Office Visits — this is not limited to just Office visits, it includes....... 
- Benefits start over July 1st each year!
Managed Care Assignment Details

- Displays the Managed Care Provider for the Medicaid Client
- This can include:
  - Non-Emergency Transportation
  - Dental Managed Care — Delta Dental Smiles and MCNA
  - PASSE Providers — AR Total Care, CareSource, Empower, Summit
  - Primary Care Physician
  - AR Home — Qualified Health Plan (QHP) such as Ambetter, Blue Cross Blue Shield, Qualchoice, etc.

<table>
<thead>
<tr>
<th>Managed Care Assignment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>PCP NOT REQUIRED</td>
</tr>
</tbody>
</table>
Tier Level Details

- Displays assessment information to providers for members enrolled in the following categories:
  - Division of Aging and Adult Service (DAAS)
  - Provider Led Arkansas Shared Savings Entity (PASSE)
  - Division of Behavioral Health Services (DBHS)

- This will assist providers to give all information so that if an independent assessment is expiring that they have a mechanism to check this information.
Living Arrangement

- Displays the Living Arrangements and Level of Care for Medicaid clients in the following categories:
  - Hospice
  - Nursing Home
  - Patient Liability
Medicare/TPL

- **Medicare** — displays if a Medicaid client has Medicare Part A, Part B, Medicare A Buy-In or Medicare B Buy-In.

- **TPL** — displays if a Medicaid client has Third Party Liability (Other Insurance).
EPSDT Well Child Services Details

- Displays the Last and the Next Exam for **Medical**, **Dental**, **Vision**, and **Hearing** screening date for a Medicaid client.

<table>
<thead>
<tr>
<th>EPSDT Well Child Service Details</th>
<th>Last Exam</th>
<th>Next Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPSDT Medical Screening</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>EPSDT Dental Screening</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>EPSDT Vision Screening</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>EPSDT Hearing Screening</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
ARKids B Screening

- Displays the Last and the Next Exam for **Medical, Dental, Vision, and Hearing** screening date.

<table>
<thead>
<tr>
<th>Service</th>
<th>Last Exam</th>
<th>Next Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARKIDS B Medical Screening</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ARKIDS B Dental Screening</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ARKIDS B Vision Screening</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ARKIDS B Hearing Screening</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Adult Dental Service

- Displays the Last Date of Service for a Medicaid client’s dental services.
Demographic Details

- Displays the Medicaid client’s Street Address, City, State, Zip Code, and Gender according to the Medicaid system.

<table>
<thead>
<tr>
<th>Street Address</th>
<th>1234 MAIN STREET</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>LITTLE ROCK</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>State</td>
<td>ARKANSAS</td>
</tr>
<tr>
<td>Zip Code</td>
<td>72255</td>
</tr>
</tbody>
</table>
Other Insurance Detail Information

- Displays the Other Insurance Detail Information that we have on file. If this is incorrect, you have the option to Add New Other Insurance when you file the claim.

- You can also contact the Third-Party Liability Unit at the State to update TPL information.

(501) 537-1070
(501) 682-1644

DHS Division of Medical Services
TPL Unit
P.O. Box 1437, Slot S296
Little Rock, AR 72203-1437
Eligibility Verification Tips

Verify Eligibility the *day* you provide services

Refer to the Aid Category List

Make sure you have a referral for services that require a PCP referral

Pay close attention to Limit Details to ensure that have available benefits/visits.
Tools to Determine Eligibility

Beneficiary Aid Category List AND Section 1 (124.000) of your Provider Manual View or print the Client Aid Category list

Eligibility verification job aid — Eligibility Verification

Eligibility Verification Video — Eligibility Verification Video
Medicaid Tools and Resources

DHS/DMS website: Helpful Information for Providers

- Provider manuals
- Procedure code tables
- Fee schedule
- Frequently asked questions (FAQs)
- Vendor specifications
- Job aids
- Quick Track Training videos and guides
- MyARMedicaid Application
Download the MyARMedicaid App

**BENEFITS**
- View claims that Medicaid has paid for you
- View doctors or providers you have seen
- View medical visits or procedures you have had
- View your prescriptions and immunization records
- Access your digital Medicaid Card
- Search for providers
- Receive important notifications

**HOW TO SIGN UP**
- **On your smartphone**
  - Go to the Apple App Store or Google Play and download the MyARMedicaid app.
  - Create an account and log in to see the benefits.

- **Through the web**
  - Go to the MyARMedicaid website at https://mdp.mmls.arkansas.gov/
  - Create an account and log in to see the benefits.
# Medicaid Contacts

- **Division of Medical Services (DMS)**
  - [https://humanservices.arkansas.gov/offices](https://humanservices.arkansas.gov/offices)
- **County offices (DCO)**
  - [https://humanservices.arkansas.gov/find-a-county-office/](https://humanservices.arkansas.gov/find-a-county-office/)
- **AFMC**
  - [afmc.org](http://afmc.org)
    - MMIS outreach specialists — 501-906-7566, [afmc.org/mmis](http://afmc.org/mmis)
    - ConnectCare — 1-800-275-1131, [seeyourdoc.org](http://seeyourdoc.org)
    - Provider relations outreach specialists— [afmc.org/providerrelations](http://afmc.org/providerrelations)
    - AFMC Clinical Services — 479-649-8501, [clinicalservices@afmc.org](mailto:clinicalservices@afmc.org)
- **Accentra (formerly Kepro)** — Prior authorization and extension of benefits
  - Website: AR.EQHS.com
    - AR.PR@KEPRO.COM or 1-888-660-3831
- **Office of Medicaid Inspector General (OMIG)** — 1-855-527-6644
- **Magellan Medicaid Administration pharmacy help desk** — 1-800-424-7895, Option 2 for prescribers
- **Gainwell Technologies** — 1-800-457-4454
- **PASSE** — DHS PASSE provider call center — 1-888-889-6451
- **MCNA Dental** — 1-800-494-MCNA
- **Delta Dental Smiles Customer Service** — 1-866-864-2499
E-Blast Sign-Up Link

Sign-up for MMIS email updates

Name *
First
Last
Email *

Submit

AFMC MMIS E-Blast Sign-Up Link
QR Code to Access Training Resources

Use your IOS, Android or any device to access all our MMIS Tools and Resources for your convenience.
Evaluations

Your feedback is important to us!

A conference evaluation will be emailed to you. Please take time to complete it.

Upon completion of the evaluation, a printable attendance certificate will be available for you.

Thank you for attending today!
Afternoon Session
1:00 – 3:30 p.m.
Please be sure to come back!
TIME FOR A BREAK