

Provider Billing 101

Court Ordered Evaluation and Stabilization Near-Term Initiative

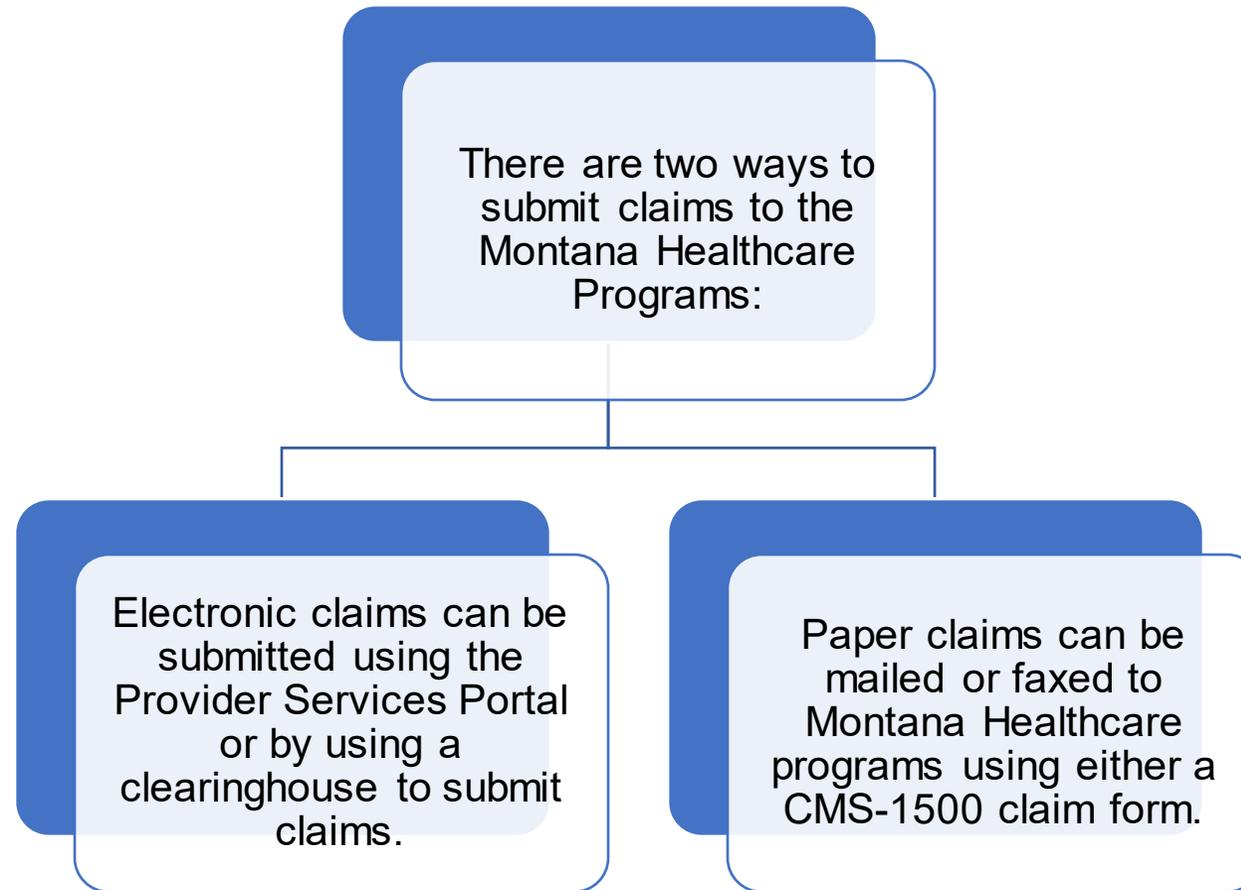
The [Community-Based COE and Stabilization near-term initiative \(NTI\)](#) launched on March 8, 2024 after receiving approval from Governor Greg Gianforte and the Behavioral Health System for Future Generations Commission (BHSFG).

A total of \$7.5 million in state funds is now available to incentivize community-based COEs and stabilization and restoration services to address a longstanding backlog in evaluations at the Montana State Hospital Forensic Mental Health Facility (FMHF, also known as Galen).

DPHHS has prepared a [detailed summary](#) that outlines the new process from the time a judge issues a COE to be conducted in the community to when a provider submits a claim for reimbursement.

This presentation is intended to provide instructions for providers interested in participating in this historic initiative.

Claims Submission



MPATH Provider Services Portal

Claims Entry

The **MPATH Provider Services Claims Entry solution** is an online tool allowing providers to manually enter claims.

Available options include:

- **Single submission claim forms** – The system allows direct claim form entry for claim submission.
- ***Claim form templates*** - The system allows users to create and save templates for common claim submissions. No need to start from scratch every time.
- ***Diagnosis and Procedure code look up*** - The system has code look up features to assist with entering correct information.
- ***Ability to submit multiple claim types*** - including Professional, Facility and Dental claims.
- ***Electronic Claim Adjustments*** - Paper adjustment forms are no longer required. The system allows for online claim adjustments which process faster than paper adjustments.

MPATH Provider Services Portal Electronic Claims Submission

To Access the Provider Services Portal login to the [Provider Services Portal](#)
Sign in with your Optum GovID



Sign In With Your Optum GovID

Optum GovID or email address

Password

SIGN IN

[Forgot Optum GovID](#) | [Forgot Password](#)

Additional options:
[Create Optum GovID](#)
[Manage your Optum GovID](#)
[What is Optum GovID? !\[\]\(18fd2a0f353d5d90e55e8dbe7a395dc2_img.jpg\)](#)

As a security enhancement, we are removing Security questions as an account recovery and authentication method. Users will have the option to use other available methods.

Warning! This system contains U.S Government information. By using this information system, you are consenting to system monitoring for law enforcement and other purposes. Unauthorized or improper use of, or access to, this computer system may subject you to state and federal criminal prosecution and penalties as well as civil penalties. At any time, the government may intercept, search, and seize any communication or data transiting or stored on this information system.

If you'd like assistance, contact MTPRHelpdesk@conduent.com

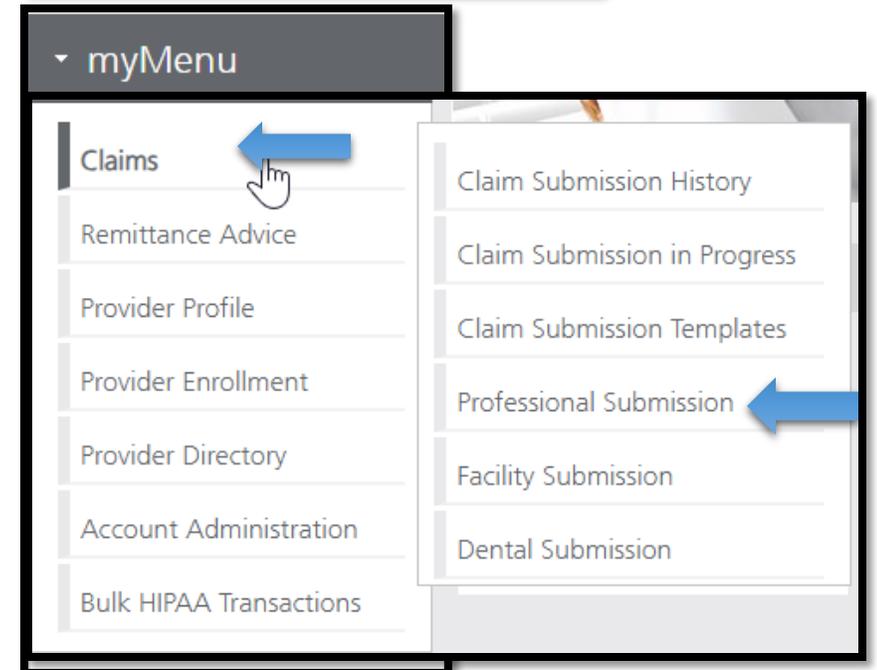
MPATH Provider Services Portal

Single Claim Submission

Provider Services Portal Home Page



Hover the mouse over "Claims" in the myMenu section on the left navigation and select "Professional Claim Submission"



MPATH Provider Services Portal

Single Claim Submission

Enter your provider NPI, all other associated demographics will be automatically populated.

▼ Billing Provider

Note : Fields marked with an asterisk * are required.

NPI/API:* [1234567890]

Provider Name:* Test Provider

Program/Waiver:* Montana Medicaid (HMK Plus)

Specialty:* Community/Behavioral Health/SDMI HCB ▼

Service Location Address 1:* 1120 CEDAR ST

Service Location Address 2:

City:* MISSOULA

State:* MT

ZIP:* 59802-3911

Taxonomy Code:* 251500000X

Enrollment Unit:* 1234567

Referring Provider

There is a referring provider for this claim.

Ordering Provider

There is a ordering provider for this claim.

Save and Continue Save and Exit Cancel

Select Save and Continue

MPATH Provider Services Portal

Single Claim Submission

Enter Member ID (SSN) and click “Search” Enter Patient Account Number (optional) as desired.

Professional Claim Submission Form

Member Details

Note : Fields marked with an asterisk * are required.

Enter Member ID:*

1234567 Search

Enter Member ID:*

1234567 Search

Member ID: 1234567

Patient Account Number:

First Name: Test

Middle Name:

Last Name: Member

Date of Birth:

Gender: Male

Mailing Address 1:

Mailing Address 2:

City:

State: MT

ZIP: 59521-0000

Member Demographics will be automatically populated when entering a valid Member ID

Save and Continue Previous Save and Exit Cancel

MPATH Provider Services Portal

Single Claim Submission

Professional Claim Submission Form Help

Claim Information

Note: Fields marked with an asterisk * are required.

Note: Do not include any decimals when entering Diagnosis Code Information. Enter at least first three (3) characters of a Diagnosis and/or Procedure code before utilizing the search icon.

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 * 2 3 4 5 6
[] [] [] [] [] []
7 8 9 10 11 12
[] [] [] [] [] []

Claim Details

Note: COB or NDC indicates all required fields for COB or NDC have been entered.

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
MM/DD/YYYY	MM/DD/YYYY	Select	[]	[]	[]	\$	[]	COB	NDC	[]	[]	[]
MM/DD/YYYY	MM/DD/YYYY	Select	[]	[]	[]	\$	[]	COB	NDC	[]	[]	[]
MM/DD/YYYY	MM/DD/YYYY	Select	[]	[]	[]	\$	[]	COB	NDC	[]	[]	[]
MM/DD/YYYY	MM/DD/YYYY	Select	[]	[]	[]	\$	[]	COB	NDC	[]	[]	[]
MM/DD/YYYY	MM/DD/YYYY	Select	[]	[]	[]	\$	[]	COB	NDC	[]	[]	[]
MM/DD/YYYY	MM/DD/YYYY	Select	[]	[]	[]	\$	[]	COB	NDC	[]	[]	[]
MM/DD/YYYY	MM/DD/YYYY	Select	[]	[]	[]	\$	[]	COB	NDC	[]	[]	[]
MM/DD/YYYY	MM/DD/YYYY	Select	[]	[]	[]	\$	[]	COB	NDC	[]	[]	[]
MM/DD/YYYY	MM/DD/YYYY	Select	[]	[]	[]	\$	[]	COB	NDC	[]	[]	[]

Total Charges \$ [] Add

Note: Total Claim Lines are limited to a maximum of 50 for each submission.

Enter at least one
Diagnosis Code

Enter required fields: Service Dates,
Place of Service Codes, Modifiers,
Diagnosis Pointer, Charges, and Units .

MPATH Provider Services Portal

Single Claim Submission

Users can either enter the full Diagnosis Code. The magnifying glass will allow users to search for the specific Diagnosis Code.

Enter at least first three (3) characters of a Diagnosis to search code list.

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
F20					
7	8	9	10	11	12

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
F200					
7	8	9	10	11	12

Search Results	
Code	Description
<u>F20</u>	Schizophrenia
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F208	Other schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified

Cancel

MPATH Provider Services Portal

Single Claim Submission

Enter Date of Service, select [Place of Service](#), CPT/HCPCS (Enter at least first three (3) characters of a CPT/HCPCS to search code list), Modifier (optional), Diagnosis Pointer, Charges, and Unit(s).

Claim Details

Note: or indicates all required fields for COB or NDC have been entered.

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
03/08/2024	03/08/2024	11	90791		1	\$ 150.00	1.00				<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$					<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$					<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$					<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$					<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$					<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$					<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$					<input type="checkbox"/>	<input type="checkbox"/>
MM/DD/YYYY	MM/DD/YYYY	Select				\$					<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ 150.00

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
03/08/2024	03/08/2024	11	9079		1	\$ 150.00	1.00				<input type="checkbox"/>	<input type="checkbox"/>

Search Results

Code	Description
90791	PSYCH DIAGNOSTIC EVALUATION
9079122	PSYCH DIAGNOSTIC EVALUATION;Increased Procedural Services
9079123	PSYCH DIAGNOSTIC EVALUATION;Unusual Anesthesia
9079151	PSYCH DIAGNOSTIC EVALUATION;Multiple Procedures
9079152	PSYCH DIAGNOSTIC EVALUATION;Reduced Services
9079153	PSYCH DIAGNOSTIC EVALUATION;Discontinued Procedure
9079158	PSYCH DIAGNOSTIC EVALUATION;Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
9079159	PSYCH DIAGNOSTIC EVALUATION;Distinct Procedural Service

MPATH Provider Services Portal Single Claim Submission

Click Yes/No radio buttons for required “*” fields, then select save and continue.

Total Charges: \$ 150.00

Note : Total Claim Lines are limited to a maximum of 50 for each submission.

Is this a void or replacement of a previously submitted claim: * Yes No

Are you submitting COB at the claim level? Yes No

Is the member's condition related to:

First date related to Member's condition:

Is this Member deceased? * Yes No

Is member unable to work in current occupation? * Yes No

Is hospitalization related to current services? * Yes No

Clinical Laboratory Improvement Amendment Number needed for this claim? * Yes No

Is there a prior authorization for this claim? * Yes No

Is there a Referral for this claim? * Yes No

Do you have attachments for this claim? * Yes No

MPATH Provider Services Portal

Single Claim Submission

Agree to Terms and Conditions and Submit.

Professional Claim Submission Form ? Help

Terms and Agreements

Note : Fields marked with an asterisk * are required.

Provider Name:*

NPI/API:*

* I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof.

MPATH Provider Services Portal

Single Claim Submission

Print/Save PDF of claim submission (optional).

Professional Claim Submission Form ? Help

Thank you for your Submission

Your Claim was successfully submitted: OC240308P0517496.

[Continue](#)

Print

Claim: OC240308P0517496
Claim Type: Professional

Provider Detail:

Billing Provider:
NPI/API:

Print 2 pages

Destination

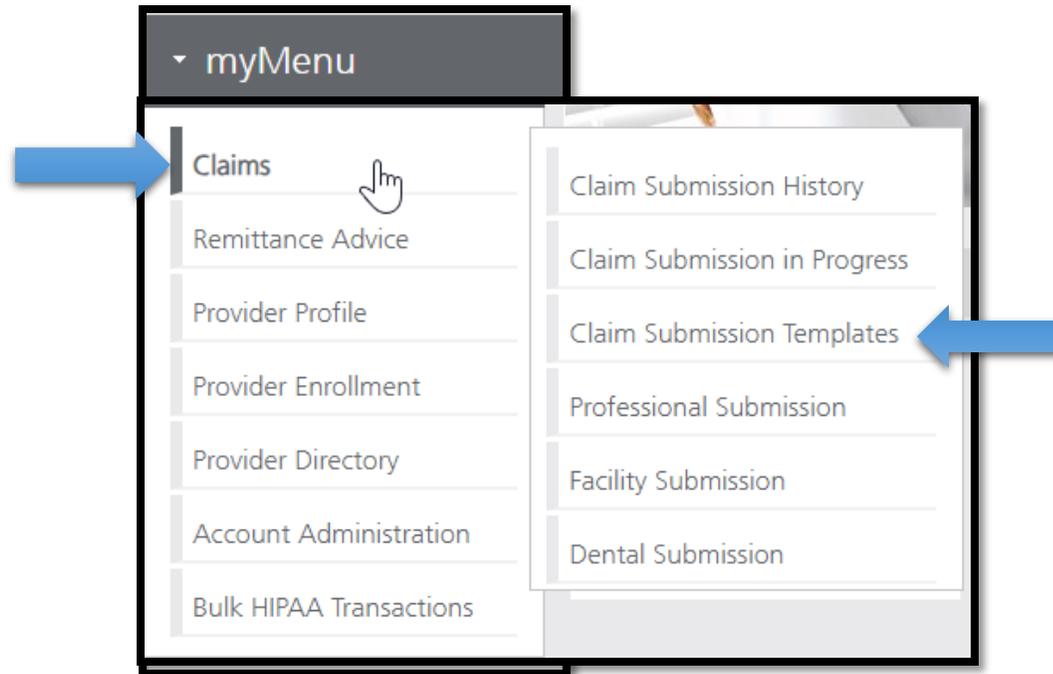
Save as PDF

[Save](#) [Cancel](#)

Provider Services Portal

Developing a Claim Template

Hover the mouse over “Claims” in the myMenu section on the left navigation and select “Claim Submission Template”



Provider Services Portal

Claim Template

To create a template, click the blue button to Create Professional Claim Submission. Templates may be Member or Service (without member) specific.

Claim Submission Templates

Claim Submission Templates ? Help

Maximum Templates Allowed : 500 Filter your results:

Actions	Name	Date Last Modified
No claim submission templates found.		

Show entries Showing 0 to 0 of 0 entries |< < > >|

[Create Professional Claim Submission Template](#) [Create Facility Claim Submission Template](#) [Create Dental Claim Submission Template](#)

Professional Claim Template ? Help

Member Details

Enter Member ID: [Search](#)

[Save and Continue](#) [Cancel](#)

Provider Services Portal (Service specific) Claim Template

Professional Claim Template ? Help

Claim Information

Note : Fields marked with an asterisk * are required.

Note : Do not include any decimals when entering Diagnosis Code Information. Enter at least first three (3) characters of a Diagnosis and/or Procedure code before utilizing the search icon.

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
<input type="text"/>					
7	8	9	10	11	12
<input type="text"/>					

Claim Details

Note : or indicates all required fields for COB or NDC have been entered.

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Total Charges: \$

Note : Total Claim Lines are limited to a maximum of 50 for each submission.

Provider Services Portal (Service specific) Claim Template

Enter static data for the template. Dynamic data (Date of Service, Diagnosis) can be entered when submitting the template. Search functions work the same in a template.

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 2 3 4 5 6
7 8 9 10 11 12

Claim Details

From Date	To Date	POS	CPT/HCPCS Code	Modifier	Diagnosis Pointer	Charges	Days or COB	NDC	EPSDT	Emergency Service	Family Planning
<input type="text"/>	<input type="text"/>	11	90791	<input type="text"/>	1	\$ 150.00	1.00	COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB	NDC	<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ 150.00

Is this a void or replacement of a previously submitted claim: Yes No

Are you submitting COB at the claim level? Yes No

Is the member's condition related to:

First date related to Member's condition:

Is this Member deceased? Yes No

Is member unable to work in current occupation? Yes No

Is hospitalization related to current services? Yes No

Clinical Laboratory Improvement Amendment Number needed for this claim? Yes No

Is there a prior authorization for this claim? Yes No

Is there a Referral for this claim? Yes No

Provider Services Portal (Service specific) Claim Template

Save Template, naming service specific template for quick reference
(Optional)

Professional Claim Template ? Help

Save Template

Please enter a claim submission template name.

Template Name: *

Note(s):
Template Name must satisfy the following conditions:
a. Minimum length: 3 characters.
b. Maximum length: 35 characters.
c. Cannot contain special characters other than: Space " " or Underscore "_" or Dash "-".

Claim Submission Templates ? Help

Maximum Templates Allowed : 500 Filter your results:

Actions	Name	Date Last Modified
 	Psych Eval	03/08/2024

Show entries Showing 1 to 1 of 1 templates | < > >> <<

Provider Services Portal

Claim Template

Hover the mouse over “Claims” in the myMenu section on the left navigation and select “Claim Submission Template” to access saved Templates

The image shows a two-step process for navigating to the Claim Submission Templates page. On the left, a 'myMenu' dropdown is open, with 'Claims' highlighted by a blue arrow and a hand cursor. A sub-menu is visible, with 'Claim Submission Templates' highlighted by another blue arrow. On the right, the 'Claim Submission Templates' page is shown. It features a table with one entry: 'Psych Eval' with a date of '03/08/2024'. A blue arrow points from the 'Claim Submission Templates' menu item to the table. Below the table are three buttons: 'Create Professional Claim Submission Template', 'Create Facility Claim Submission Template', and 'Create Dental Claim Submission Template'.

myMenu

- Claims
- Remittance Advice
- Provider Profile
- Provider Enrollment
- Provider Directory
- Account Administration
- Bulk HIPAA Transactions

- Claim Submission History
- Claim Submission in Progress
- Claim Submission Templates
- Professional Submission
- Facility Submission
- Dental Submission

Claim Submission Templates ? Help

Maximum Templates Allowed : 500 Filter your results:

Actions	Name	Date Last Modified
	Psych Eval	03/08/2024

Show 10 entries Showing 1 to 1 of 1 templates |< < > >|

Create Professional Claim Submission Template Create Facility Claim Submission Template Create Dental Claim Submission Template

MPATH Provider Services Portal Template Claim Submission

Enter provider NPI. Provider demographic information will be automatically populated

▼ Billing Provider

Note : Fields marked with an asterisk * are required.

NPI/API:* ←

Provider Name:*

Program/Waiver:*

Specialty:*

Service Location Address 1:*

Service Location Address 2:

City:*

State:*

ZIP:*

Taxonomy Code: *

Enrollment Unit:*

Referring Provider

There is a referring provider for this claim.

Ordering Provider

There is a ordering provider for this claim.

→

Select Save and Continue

MPATH Provider Services Portal Template Claim Submission

Enter Member ID and click "Search" Enter Patient Account Number (optional) if necessary.

Professional Claim Submission Form

Member Details

Note : Fields marked with an asterisk * are required.

Enter Member ID:*

1234567 Search



Enter Member ID:*

1234567 Search

Member ID: 1234567

Patient Account Number:

First Name: Test

Middle Name:

Last Name: Member

Date of Birth:

Gender: Male

Mailing Address 1:

Mailing Address 2:

City:

State: MT

ZIP: 59521-0000

Save and Continue Previous Save and Exit Cancel



Select Save
and Continue

Provider Services Portal (Service specific) Claim Template

Template retains the static data entered allowing for dynamic data entry

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
<input type="text"/>					
7	8	9	10	11	12
<input type="text"/>					

Claim Details

Note : **COB** or **NDC** indicates all required fields for COB or NDC have been entered.

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSTD	Emergency Service	Family Planning
MM/DD/YYYY	MM/DD/YYYY	11	90791		1	\$ 150.00	1.00	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ 150.00 **Add**

Note : Total Claim Lines are limited to a maximum of 50 for each submission.

Is this a void or replacement of a previously submitted claim:* Yes No

Are you submitting COB at the claim level? Yes No

Is the member's condition related to:

First date related to Member's condition:

Is this Member deceased? * Yes No

Is member unable to work in current occupation? * Yes No

Is hospitalization related to current services? * Yes No

Clinical Laboratory Improvement Amendment Number needed for this claim? * Yes No

Is there a prior authorization for this claim? * Yes No

Is there a Referral for this claim? * Yes No

Do you have attachments for this claim? * Yes No

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
F200	<input type="text"/>				
7	8	9	10	11	12
<input type="text"/>					

Claim Details

Note : **COB** or **NDC** indicates all required fields for COB or NDC have been entered.

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSTD	Emergency Service	Family Planning
03/08/2024	03/08/2024	11	90791		1	\$ 150.00	1.00	COB	NDC		<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$ 150.00 **Add**

Select Save
and
Continue

Save and Continue

Previous

Save and Exit

Cancel

MPATH Provider Services Portal Template Claim Submission

Agree to Terms and Conditions and Submit.



Professional Claim Submission Form ? Help

Terms and Agreements

Note : Fields marked with an asterisk * are required.

Provider Name:* [Test Provider]

NPI/API:* [1234567890]

* I certify I have read the [Terms and Conditions](#) that apply to this bill and are made a part thereof.

The screenshot shows a web form titled "Professional Claim Submission Form" with a "Help" link. Under the "Terms and Agreements" section, there is a note that fields marked with an asterisk are required. Two text input fields are shown: "Provider Name" with the value "Test Provider" and "NPI/API" with the value "1234567890". Below these is a checkbox with a checkmark and the text "I certify I have read the Terms and Conditions that apply to this bill and are made a part thereof." A blue arrow points to this checkbox. At the bottom of the form, there are four buttons: "Submit", "Previous", "Save and Exit", and "Cancel". A blue arrow points to the "Submit" button.

Provider Relations Contact Information

Provider Relations Call Center:

(800) 624-3958

Monday through Friday 8am to 5pm MST

General, Claims, TPL, and EDI questions:

MTPRHelpdesk@conduent.com

Enrollment Questions and documents:

MTEnrollment@conduent.com

Note: the Conduent helpdesks cannot accept secured emails.

Email Assistance MTPRHelpdesk@conduent.com
and HHSMPathPS@mt.gov

When emailing the help desk, please provide the following so we can research & submit a help ticket to our Tech Team.

GovID:

Name:

Email registered:

NPI attempting/registered:

Phone number:

A screen shot of the error:

Thank you for participating in the
Court Ordered Evaluation and
Stabilization Services Near-Term
Initiative!