ND MMIS WEB portal
Check Member Eligibility Training
LAURA HOLZWORTH, MEDICAL SERVICES DIVISION

NORTH
Dakota | Health & Human Services
Be Legendary.

ND MMIS WEB portal
Check Member Eligibility Training

Go to
https://**mmis**.nd.gov/**portals**/wps/**portal**/EnterpriseHome

➢ **Sign In - Provider**

> **Provider Login**
> - **USER ID** and **Password**

> **Member**
> - Check Eligibility

* Required Field

Eligibility Inquiry

Requester

Provider ID	Provider Name	Payer ID	Payer Name
			North Dakota Medicaid

To inquire about a specific member's eligibility, you must enter at least 3 of the following criteria:
1. Member ID
2. Date of Birth
3. Last Name
4. First Name

Use of member SSN, gender and middle initial is optional.

Note: If the Service From Date and Service To Date are left blank, the dates will be defaulted to current date.

Member Information

	Member ID	Date of Birth	Last Name	First Name	MI	Gender	SSN	Service From Date	Service To Date	Service Type	Action
1						⌄				30-Health Benefit ⌄	➕ 🗑

Search   Reset

➤ Check Eligibility

- Eligibility Inquiry – Must enter at least 3 criteria
  - ✓ Member ID
  - ✓ Date of Birth
  - ✓ Last Name
  - ✓ First Name

➤ Member Information

- Member ID
- Date of Birth – MM/DD/YYYY
- First Name
- Service From Date
- Service to Date
- Search

Search Results

Please click on a row to view the member's eligibility detail.

Member ID	Date of Birth	Last Name	First Name	MI	Gender	SSN	Service From Date	Service To Date	Service Type Code	TPL
XXXXXXXXX	XXXXXXXX	XXXXXXXXX	XXXXXXXXX	X	X		03/01/2019	03/31/2019	30-Health Benefit	Y

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➢**Search Results**

➤ **Eligibility Confirmation**
- Service From Date
- Service To Date
- Confirmation Number
- Eligibility As of Date
- Eligibility Status

* Required Field   Close

Service From Date: 03/01/2019   Service To Date: 03/31/2019   Confirmation Number: 55912911
Eligibility As of date: 03/01/2019   Eligibility Status: Yes   Last EPSDT Date:

Member Information

Name: XXXXXXXXX   Suffix: Date of Birth: XXXXXXXXX   Date of Death:12/31/9999   Member ID: XXXXXXXXX

Street Address XXXXXXXX   P.O.Box: XXXXXXXXX   City: XXXXXXXXX   State: XX   Zip: XXXXXXXXX

Eligibility Status

Program Code ⬍	Case Number ⬍	Case Head Of Household ⬍
04DF	XXXXXXXXX	XXXXXXXXX

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➢ **Eligibility Confirmation Member Information**
- Member Name
- Date of Birth/Date of Death
- Member ID
- Street Address/PO Box
- City, State and Zip

> **Eligibility Confirmation Eligibility Status**
> - Program Code
> - Case Number
> - Case Head of Household

Eligibility Status

Program Code ⇕	Case Number ⇕	Case Head Of Household ⇕
04DF	XXXXXXXXX	XXXXXXXXXXXXX

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Benefit Plan

Plan Description ⇕	Copay ⇕	Coinsurance ⇕	Base Deductible ⇕	Remaining Deductible ⇕	Plan From ⇕	Plan To ⇕
Medicaid Fee For Service	$0.00	0%	$0.00	$0.00	03/01/2019	03/31/2019

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Service Type

Copay details are available on DHS Website

Service Type Code ⇕	Service Type Code Description ⇕	Service Type ⇕	Copay ⇕	Coinsurance ⇕	Base Deductible ⇕	Remaining Deductible ⇕

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Primary Care Provider

Provider ID ⇕	Provider Name ⇕	Plan Description ⇕	Organization Name ⇕

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TPL Spans

Carrier ID	Carrier Name	Insurance Type	Policyholder ID	Policyholder Name	Policy Number	Policy Begin Date	Policy End Date
						03/01/2019	03/31/2019
						03/01/2019	03/31/2019
						03/01/2019	03/31/2019
	XXXXXXXXXXXX	MB		XXXXXXXXXXX	XXXXXXXXXXXX	03/01/2019	03/31/2019
		MA				03/01/2019	03/31/2019
		M-Part D				03/01/2019	03/31/2019

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Lock-in Spans

Begin Date	End Date	Provider ID	Provider Name	Lockin Type

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Other General Information

Is There Any Recipient Liability Involved?	Is there any Long Term Care involved?	Has the Recipient Liability Amount been met?	Recipient Liability Amount
Yes	**No**	**Yes**	**0.00**

Choose a Different Member