

7. CLAIMS

In this section you will be able to Create (or Add) a Claim, Edit, Delete, Resubmit a Claim, and Work with Closed Claims. To access this section, it is best to do so through the Patient Record. Click on the “**Patients**” Icon on the Left Navigational Menu, or, from the Top Navigational Menu, select “**Patients Data**”. Double-click on the Patient Record that this claim is for to open that Patient’s data. Then click on the “**Add Claims**” button at the top of the opened record.

A. Creating (Adding) a Claim

1. Adding Claims Through the Patient Record

In the newly opened “**Edit New Claims Data**” window, enter the information requested in the following fields:

GENERAL INFORMATION (TOP PORTION):

- a) **Facility:** From the menu provided in this field, select the facility where the services were rendered, or click on the word “**Add**” in this field to add one. (Refer to **Section “II PROGRAM SETUP/ Facility”** for instruction on how to add a Facility). (Will appear on the HCFA/CMS 1500 Claim Form Box 32)

Note: If selecting an INPATIENT FACILITY (Place of Service codes 21, 31, 32, 34, 51, 52, 55, or 56), the HOSPITALIZED FROM/TO dates fields must be filled in so as to avoid a possible claim rejection by either the clearinghouse or the insurer.

- b) **Hospitalized From/To:** If the Patient was treated at the hospital, enter the dates they were hospitalized. (Will appear on the HCFA/CMS 1500 Claim Form Box 18)
- c) **Unable to Work From/To:** If the Patient is unable to work due to this injury or illness that your doctor is treating them for, enter the corresponding dates. (Will appear on the HCFA/CMS 1500 Claim Form Box 16)
- d) **Condition Related To, Which State, Date:** If you are treating the Patient for an accident related illness or injury, complete all three fields. All three of these fields **MUST** be completed in order to avoid claim denials when processing. (Condition Related To and State appear in box 10A – 10C of the HCFA/CMS 1500 Claim Form; the Date will appear in box 14)

Note: If the date of accident is different than the date of the Current Illness/Injury, then the date of the Current Illness/Injury will print in

Box 14 (Current Date of Injury/Illness) of HCFA Claim Form. The date of accident will not print.

- e) **Date of Current Illness, First Date if Illness is Same or Similar:** These dates will appear in box 14 and 15 of the HCFA/CMS 1500 Claim Form. Please complete these as necessary.

Note: If the date of the Current Illness/Injury is different than the date of accident, then the Current Illness/Injury date will print in Box 14 (Current Date of Injury/Illness) of HCFA Claim Form. The date of accident will not print.

- f) **Date Last Seen:** This is the date the Patient was last seen by the **Referring Physician** and **not** by your doctor. This date will appear on the top of the service date for the first procedure entered in box 24A of the HCFA/CMS 1500 Claim Form. Please complete as necessary.
- g) **Medicaid Resubmission Code/Original Reference #:** The code and reference number that is needed for this field will be provided to your office by Medicaid, and will appear in box 22 of the HCFA/CMS 1500 Claim Form. Enter as applicable.
- h) **Outside Lab:** If lab work was sent to an outside lab to process, but your office is billing for the service, select the “**Yes**” button, and enter the charge(s) in the field(s) provided. (Will appear on the HCFA/CMS 1500 Claim Form Box 20)

ANESTHESIA INFORMATION (MIDDLE PORTION):

- a) **First two boxes:** There are two boxes to the left and right immediately below the word “**Anesthesia**”. In the left box enter the **Start Time** of the Anesthesia Service. In the box on the right, enter the **End Time** of the Anesthesia Service. The time is entered in Military Time. (For example: 11:00am would be entered as 1100, 1:30pm would be entered as 1330). This will appear on the top of the first **Date of Service** entered on line 1, box 24A, of the HCFA/CMS 1500 Claim Form.
- b) **Anesthesia (Minutes into Units):** Calculates automatically 1 unit for every 15 minutes of time from the **Start Time** to the **End Time**, and is used to calculate the number of units in box 24G of the HCFA/CMS 1500 Claim Form for the Anesthesia procedure code billed.
- c) **Anesthesia (Total Minutes):** The program will calculate the total Anesthesia minutes from the **Start Time** and **End Time** entered. This amount appears at the top of the first **Place of Service** entered on line 1, box 24A, of the HCFA/CMS 1500 Claim Form, and if under **Section “II PROGRAM SETUP / INSURANCE”** you selected to have the Anesthesia minutes entered in box 24G of the HCFA/CMS Claim Form, this is the amount that will be entered in that box as well.

- d) **Anesthesia (Minutes \$)**: The amount calculated in this field uses the **Fee Schedules** initially set up for the doctor performing the service. (Refer to **Section “II PROGRAM SETUP / SET UP / Fee Schedules”** for more information on how to enter these amounts.)

PROCEDURAL INFORMATION (BOTTOM PORTION):

A. Adding the Procedures

To move from field to field when entering claim information, click the “Tab” button on your keyboard. To move from line to line, click the “Enter” button on your keyboard.

- a) Click the “**Add**” button under the word “**Procedures**” to open the “**Edit New Transaction Data**” form.
- b) **Dates of Service (From/To)**: Enter the date (or date range) that the services were rendered. If the **From** and **To** dates are the same, hit the **Tab** button on your keyboard after entering the **From** date to automatically enter the same date as the **To** date. (Will appear in box 24A under the **Date(s) of Service** column on the HCFA/CMS 1500 Claim Form)
- c) **Place of Service**: From the menu provided in this field, click on the number that represents the **Place of Service** where the services were rendered (i.e.: **11** Office, **21** Inpatient Hospital, **22** Outpatient Hospital, etc.). (Will appear under the **Place of Service** column in box 24B of the HCFA/CMS 1500 Claim Form)

Note: If selecting an INPATIENT FACILITY Place of Service (codes 21, 31, 32, 34, 51, 52, 55, or 56), the HOSPITALIZED FROM/TO dates fields must be filled in so as to avoid a possible claim rejection by either the clearinghouse or the insurer.

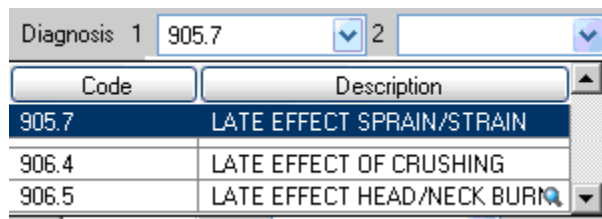
- d) **Type of Service**: From the menu that appears in this field, select the type of business entity that best describes your provider (*Is he a Solo Practice, Partnership, Professional Org., etc.?*). (Will appear in box 24C of the HCFA 1500 Claim Form, but not on the CMS 1500 Claim Form)
- e) **Diagnosis**: Enter (or select from the menu that appears in this field) the Diagnosis Code(s) to be billed on the claim. The field(s) will automatically populate if you entered a Diagnosis Code(s) under the **Default Tab** of the “**Edit Patient Data**” screen when creating the Patient Record. (Will appear in box 21 of the HCFA/CMS 1500 Claim Form)

NOTE: Although you can enter up to 6 Diagnosis Codes on the claim itself, if you send this claim ELECTRONICALLY,

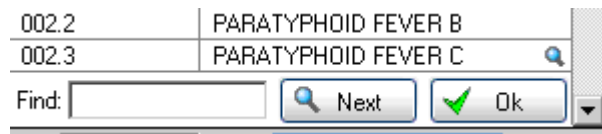
you can only have a MAXIMUM of 4 Diagnosis Codes per Procedure Code entered.

You can search for a diagnosis either by code or description by clicking on the drop down arrow in the “Diagnosis” field. This opens a list of Diagnosis Codes and their matching Descriptions. From here, select the code you want to use by double-clicking on it from the list that appeared.

If the list does not contain the code you need, click on the hourglass that appears on the bottom right of the Description column (see example below):



A FIND option field will appear as shown below:



In the field, type in the code number or the description of the diagnosis code that you are looking for and click on the NEXT button. Continue to click on the NEXT button until the one that you are looking for appears. When you find it, double-click on it to append it into the Diagnosis field.

- f) **Procedure (1-6):** Enter (or select from the menu that appears in this field) the Procedure Code(s) to be billed. (Will appear in box 24D of the HCFA/CMS 1500 Claim Form under the heading “CPT/HCPCS”)
- g) **Pointers:** If more than one Diagnosis Code has been entered, but not applicable to each Procedure Code billed, uncheck the box(es) next to the number(s) of the Diagnosis Pointer(s) that do(es) not apply. Each Pointer will appear in box 24E of the HCFA/CMS 1500 Claim Form, unless in **Section “II PROGRAM SETUP/ Insurance”** you selected the option “**Only Print 1st Pointer**”, which will then only show the first Diagnosis Code Pointer on the Claim Form.
- h) **Modifiers:** In the two fields provided, using the menu(s) provided in these fields, select the Modifier Code(s) as needed for the

Procedure Code entered. (Will appear in box 24D of the HCFA/CMS 1500 Claim Form under its own heading)

- i) **Units:** If the Procedure Code was set up correctly (refer to **Section “II PROGRAM SETUP/ Procedure Codes”**), the number of units will automatically populate in this field. If the number of units that appears is not what you want to use for this service, you may override the amount by highlighting the amount shown and typing in the corrected amount. If the “**Units**” field remains empty, enter the number of units here.
- j) **Dollars:** If the Procedure Code was set up correctly (refer to **Section “II PROGRAM SETUP/ Procedure Codes”**), the total charge for this Procedure Code will automatically populate in this field. If the total charge that appears is not what you want to use for this service, you may override this amount by highlighting the amount shown and typing in the corrected amount. If the “**Dollars**” field remains empty, enter the total charge here.
- k) **Family Plan (EPSDT):** (Will appear in the shaded portion of the field in block 24H of the HCFA 1500 Claim Form). For Early & Periodic Screening, Diagnosis, and Treatment related services, in the field provided, enter the appropriate two character code response (identifying certain services that may be covered under some state plans) as either:

AV Available – Not Used (Patient refused referral.)

S2 Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.)

ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)

NU Not Used (Used when no EPSDT patient referral was given.)

- l) **COB (Coordination of Benefits):** For paper claims, enter the appropriate code from the list below. If none of the following conditions apply, leave this item blank:

1 = An insurance carrier other than Medicare made payment.

2 = Commercial HMO fixed co-pay only. Item 24F should be the fixed co-pay amount only.

3 = An insurance carrier other than Medicare applied the charges to the deductible.

4 = Both Medicare and another carrier made payment.

5 = Medicare only made payment.

- 6** = Medicare risk HMO co-pay only. Item 24F should be the fixed co-pay amount only.
- 7** = Medicare applied all charges to the deductible.
- 8** = The patient has other insurance (other than Medicare) and this service is not covered OR the patient's other insurance is terminated or expired. Indicate the reason for nonpayment in Box 19. The policy number of the other insurance must be reported in box 11 even if the other insurance is terminated or expired.
- 9** = Spend-down liability. Enter the spend-down liability of the patient in item 24K.

Note: Do not bill Medicare covered and excluded services on the same claim. The Medicare EOB and/or the other insurance EOB must be submitted with the paper claim if you entered 1, 3, 4, 5, or 7.

- m) **EMG (Emergency):** Enter “Y” if this was an emergency visit, or “N” if not. (Will appear in box 24I of the HCFA 1500 Claim Form, or in box 24C of the CMS 1500 Claim Form)
- n) **Prior Authorization:** If previously entered, (refer to **Section “III PATIENTS / Default Tab”**), select it from the menu provided in this field. You may also enter it by selecting “**Edit**” from the menu provided in this field, then selecting “**Add**” in the “**Prior Authorization For**” box that appears in the “**Edit New Prior Authorization Code**” window. In the fields provided, enter the **Prior Authorization Number**, select the **Number of Visits** from the menu provided, and enter the date the authorization **Expires**. Click the “**Save**” button when done and then the “**Close**” button to return to the “**Edit New Transaction Data**” screen.

***** Note regarding Prior Authorizations:** When more than one service date requires a Prior Authorization to be printed on the claim, each service date must be entered as a separate claim in order to apply the Prior Authorization correctly.

*If you more than 6 lines of services to bill for this patient, click the “**Save and Add**” button on the bottom left side of this screen to open a new “**Edit New Transaction Data**” screen to enter more charges.*

*If there are no additional services, click the “**Save**” button on the bottom right side of this screen to return to the “**Edit New Claims Data**” screen. Click the “**Save**” button to exit out of this screen and return to the “**Edit Patient Data**” screen, then “**Save**” to exit and return to the “**Patient Data**” screen.*

B. Editing the entered Procedures

- a) From the opened “**Edit New Claims Data**” window, left click on the line entry you want to edit, and then click on the “**Edit**” button under the word “**Procedures**” to open the “**Edit New Transaction Data**” form.
- b) Make the appropriate changes, then click the “**Save**” button to return to the “**Edit New Claims Data**” window.
- c) Click the “**Save**” button to return to the “**Edit Patient Data**” window.

C. Deleting the entered Procedures

- a) From the opened “**Edit New Claims Data**” window, left click on the line entry you want to edit, and then click on the “**Delete**” button under the word “**Procedures**”.
- b) If you are certain that you want to delete this Procedure, click “**Yes**”.
- c) Continue to either add a new Procedure (by clicking on the “**Add**” button under the word “**Procedures**”), or finish by clicking the “**Save**” button to return to the “**Edit Patient Data**” window.

D. Using the “Repeat Procedures” Feature

If you have already entered a claim for a Patient and your doctor is treating the Patient for the **same conditions** using the **same Procedure Codes and Diagnosis Codes** as the last service date the doctor saw this Patient, you can save time in entering future claims for this Patient by doing the following from the opened “**Edit Patient Data**” screen:

- a) Click on the “**Add Claim**” button.
- b) In the opened “**Edit New Claims Data**” screen, complete the General Information (Top Portion), and the Anesthesia Information (Middle Portion), as needed.
- c) Click on the “**Repeat Procedures**” button, and in the “**Repeat Procedures, New Claim**” screen, change the Date of Service (**DoS**) field to reflect the correct service date.
- d) Click the “**Save**” button when done to return you to the “**Edit New Claims Data**” screen.
- e) Review the entered Procedures. Click the “**Edit**” button to edit any entries made, or the “**Delete**” button to remove an entry made. If everything is correct as entered, click the “**Save**” button to return you back to the “**Edit Patient Data**” screen.

2. Adding Claims From the “Charges” Icon

Another way to enter claims for a Patient is thru the “Charges” Icon located on the **Left Navigational Menu**.

- a) Click on the “Charges” Icon to open the “Claims Data” screen.
- b) Click the “Add” button to open an empty “Edit New Claims Data” screen.
- c) Click the browser button (☰) to the right of the empty “Name” field to open the “Select Patient” list.
- d) From this list, double-click on the name of the Patient you are creating the claim for. The name you chose will be inserted in the “Name” field along with their Patient Account Number which will appear to the left of their name.
- e) Proceed to fill out the rest of this form following the “Adding Claims” instructions presented in this section.
- f) Click the “Save” button when done to return to the “Claims Data” screen.
- g) Click the “Close” button when done.

3. Adding Claims From the “Claims” selection (Top Navigational Menu)

Another way to enter claims for a Patient is from the **Top Navigational Menu**.

- a) Click on the word “Claims” and then choose the word “Claims” again from the menu that opens.
- b) From the opened “Claims Data” screen, click on the “Add” button to open an empty “Edit New Claims Data” screen.
- c) Follow steps “c” – “g” (under the above **Section “2. From the “Charges” Icon”**) to enter your Patient’s claim.

B. Editing an Open Claim

1. Through the Patient Record

- a) After you’ve selected your Patient from the “Patients Data” screen, click on the “Claims” box to open the “Claims Data For” screen showing all of your Patient’s existing opened Claims.
- b) Double-click on the claim you want to edit to open the “Edit Claims Data” screen.
- c) Make your changes to the claim as needed.

- d) Click on the **“Save”** button to return you to the **“Claims Data For”** screen, then click the **“Close”** button to return you to the **“Patients Data”** screen.

2. From the **“Charges”** Icon

- a) From the **Left Navigational Menu**, click on the **“Charges”** Icon to open the **“Claims Data”** screen.
- b) Double-click on the Patient’s Name and Claim you want to edit to open the **“Edit Claims Data”** screen.
- c) Make your changes to the claim as needed.
- d) Click on the **“Save”** button to return you to the **“Claims Data”** screen, then click the **“Close”** button when done.

3. From the **“Claims”** selection on the Top Navigational Menu

- a) From the **Top Navigational Menu**, click on the word **“Claims”** and then choose the word **“Claims”** again from the menu that opens.
- b) From the opened **“Claims Data”** screen, double-click on the Patient’s Name and Claim you want to edit to open the **“Edit Claims Data”** screen.
- c) Make your changes to the claim as needed.
- d) Click on the **“Save”** button to return you to the **“Claims Data”** screen, then click the **“Close”** button when done.

C. Editing a Closed Claim

A closed claim is one whose balance has been cleared, either due a payment received or an adjustment, and nothing more is due. These claims are found under the **“Closed Claims”** Tab in the **“Edit Patient Data”** screen.

- a) From the **Left Navigational Menu**, click on the **“Patients”** Icon and double-click on the Patient’s Name or Account Number (PAN) in the **“Patient Data”** screen.
- b) From the opened **“Edit Patient Data”** screen, click on the **“Closed Claims”** Tab.
- c) From the list of claims appearing in this box, left click on the claim you want to edit to select it, and then click on the **“Edit”** button to the left to open the **“Edit Claims Data”** screen.
- d) Make your changes to the claim as needed.
- e) Click on the **“Save”** button to return you to the **“Closed Claims”** screen.

D. Deleting an Open Claim

1. Through the Patient Record

- a) After you've selected your Patient from the **"Patients Data"** screen, click on the **"Claims"** box to open the **"Claims Data For"** screen showing all of your Patient's existing opened Claims.
- b) Left click on the claim you want to delete to select it, and then click on the **"Delete"** button.
- c) If you are certain you want to delete this claim, click the **"Yes"** button in the **"Delete Claims"** box.
- d) Click the **"Close"** button to return you to the **"Patients Data"** screen.

Note: When attempting to delete a Claim, should a message appear stating *"Cannot Delete. Data in Use"*, follow the instructions below:

- a) Click the **"Ok"** button to close the message window.
- b) Click the **"Close"** button to close the **"Claims Data For"** screen.
- c) Click on the **"Transaction"** box to open the **"Patient Claims"** screen.
- d) Double-click on the claim you want to work with to open a new **"Transactions"** screen.
- e) For each line item that appears, left click on a line item and click the **"Delete"** button. Answer **"Yes"** to the **"Delete Item?"** question. Do the same until all the line items are deleted.
- f) Click the **"Close"** button to return to the **"Patient Claims"** screen.
- g) Click the **"Close"** button to return to the **"Edit Patient Data"** screen.
- h) Attempt to delete the claim again following the initial instructions.

2. From the "Charges" Icon

- a) From the **Left Navigational Menu**, click on the **"Charges"** Icon to open the **"Claims Data"** screen.
- b) Left click on the claim you want to delete to select it, and then click on the **"Delete"** button.
- c) If you are certain you want to delete this claim, click the **"Yes"** button in the **"Delete Claims"** box.
- d) Click the **"Close"** button to return you to the **"Claims Data"** screen.

Note: When attempting to delete a Claim, should a message appear stating *"Cannot Delete. Data in Use"*, follow the instructions below:

- a) Click the **"Ok"** button to close the message window.

- b) Click the **“Close”** button to close the **“Claims Data”** screen.
- c) Click on the **“Patients”** Icon on the **Left Navigational Menu** and double-click on the Patient Name or Patient Account Number to select your Patient and open the **“Edit Patient Data”** screen.
- d) Click on the **“Transaction”** box to open the **“Patient Claims”** screen.
- e) Double-click on the claim you want to work with to open a new **“Transactions”** screen.
- f) For each line item that appears, left click on a line item and click the **“Delete”** button. Answer **“Yes”** to the **“Delete Item?”** question. Do the same until all the line items are deleted.
- g) Click the **“Close”** button to return to the **“Patient Claims”** screen.
- h) Click the **“Close”** button to return to the **“Edit Patient Data”** screen.
- i) Attempt to delete the claim again following the initial instructions.

3. From the **“Claims”** selection on the **Top Navigational Menu**

- a) From the **Top Navigational Menu**, click on the word **“Claims”** and then choose the word **“Claims”** again from the menu that opens.
- b) From the opened **“Claims Data”** screen, left click on the Patient’s Name and Claim you want to delete, and then click the **“Delete”** button.
- c) If you are certain you want to delete this claim, click the **“Yes”** button in the **“Delete Claims”** box.
- d) Click the **“Close”** button to return you to the **“Claims Data”** screen.

Note: When attempting to delete a Claim, should a message appear stating *“Cannot Delete. Data in Use”*, follow the instructions below:

- a) Click the **“Ok”** button to close the message window.
- b) Click the **“Close”** button to close the **“Claims Data”** screen.
- c) Click on the **“Patients”** Icon on the **Left Navigational Menu** and double-click on the Patient Name or Patient Account Number to select your Patient and open the **“Edit Patient Data”** screen.
- d) Click on the **“Transaction”** box to open the **“Patient Claims”** screen.
- e) Double-click on the claim you want to work with to open a new **“Transactions”** screen.
- f) For each line item that appears, left click on a line item and click the **“Delete”** button. Answer **“Yes”** to the **“Delete Item?”** question. Do the same until all the line items are deleted.
- g) Click the **“Close”** button to return to the **“Patient Claims”** screen.

- h) Click the “**Close**” button to return to the “**Edit Patient Data**” screen.
- i) Attempt to delete the claim again following the initial instructions.

E. Editing a Diagnosis Code once a Claim Has Been Created

Once a claim has been created, the diagnosis code used in the claim is unable to be edited.

Here’s why: When a claim is created and sent to the insurance company, and the insurance company processes and rejects the service(s) due to an invalid or incomplete diagnosis code(s) submitted on the claim, the claim is now considered “**Paid**” or “**Processed**” by the insurance company, thus completing the processing cycle on their end.

In order for the provider to complete the billing cycle on his or her end, the charge would be posted as a zero payment with an adjustment for that line item, and a new claim would be created with the correct diagnosis code and resubmitted.

What Options do I Have? There are two options you can choose from to make things right:

Option 1: You can complete the billing cycle by processing the rejection under the “**Pay & Adjust**” section of the “**Edit Patient Data**” screen for the Patient Record that this is for, as a zero payment with an adjustment for that line item per the insurance report. Refer to **Section “VII. PAYMENTS & ADJUSTMENTS”** for further instructions.

Option 2: You can delete the originally created claim following the instructions provided in the preceding pages under the heading “**Deleting an Open Claim**”, and then create a new claim by following the instructions under the title “**Creating (Adding) a Claim**” at the beginning of this section of the User Manual. Then, submit the correct claim for processing.

F. Resubmitting an Open or Closed Claim

Once a claim has been edited, you can resubmit the claim to the Patient’s Insurance Carrier either as a Paper Claim or an Electronic Claim.

Refer to **Section “V. PRINTING CLAIMS”** for Paper Claim Resubmissions, or **Section “VI. FILING CLAIMS ELECTRONICALLY”** for Electronic Claim Resubmissions.

G. Billing a claim to an Insurance Company for a service that has already been paid for by the Patient (such as a pre-collected deductible, a non-assigned claim or a courtesy claim)?

In order to bill a claim to an Insurance Company for a service that has already been paid for by the Patient, such as a claim where your office collected the Patient's deductible in advance which was the same or more than the actual charge for the visit, or when you are sending the claim to an Insurance Company that will pay the Patient and not your office either because you are non-contracting with that insurance, or your office does not take assignment of the claim, or your office does not accept insurance payments, you will need to set up an Insurance Record for Non-Assigned Claims billing and then rebill the claim.

To do so, please take the following steps:

(A) Setting up the Insurance Record:

1. From the Top Navigational Menu, left click on the **“Set Up”** option and again on the **“Insurance”** option to open the **“Insurance Data”** screen.
2. Click on the **“Add”** button at the bottom of the opened screen to open the **“Edit New Insurance Data”** window.
3. Fill in the insurance data as applicable following the instructions in this User Manual under **Section “II Program Set Up”**, under the section titled **“Set Up: Insurance”**, then select **“Paper”** for the **“Type of Billing”** option, and select **“N”** for the **“Accept Assignment”** option. Click **“Save”** when done, and **“Close”** to exit the **“Insurance Data”** window.

(B) Setting up the Insurance under the Patient Record:

1. From the Left Navigational Menu, click on the **“Patients”** icon and from the opened **“Patients Data”** screen double click on the Patient Record to open it.
2. In the opened **“Edit Patient Data”** screen click on the **“Insurance”** tab and left click on the button to the left of the word **“Insurance”** to select it.
3. Immediately underneath, to the right of the word **“Primary”**, double click in the **“Insurance”** field to open the **“Edit Primary Patient Insurance”** screen.

4. Add the new Primary Insurance record (following the instructions in this User Manual under **Section “III Patients”**, under the section titled **“Patient: Insurance Tab”**). Click the **“OK”** button when done.

(C) Reassigning the claim to the Insurance Company:

1. To the right of the MPM Office logo in the **“Edit Patient Data”** screen, click on the **“Transactions”** icon, and from the opened **“Patient Claims”** screen find and double click on the date of service in question.
2. In the bottom of the opened **“Transactions”** screen, click the **“Add”** button to open the **“Edit Pays and Bills”** screen, and do the following:
 - (a) In the **“Date”** field, enter today’s date.
 - (b) In the **“Payer”** field, select **“Primary”**.
 - (c) In the **“Transaction”** field, select **“Reassign”**.
 - (d) In the **“Amount”** field, enter the full original charge for the service.

Click the **“Save”** button when done with these changes.

3. Click the **“Close”** buttons on the opened **“Transactions”** and **“Patient Claims”** screens. Click the **“Save”** button in the opened **“Edit Patient Data”** screen as well.

(D) Billing the claim to the Insurance Company:

1. From the Left Navigational Menu, click on the **“Paper”** icon and from the opened **“1500 form: Claims Data”** find the Patient and click on the box to the left of their Patient Account Number (**PAN**) to select the claim for printing.
2. Click on the **“Print”** button at the bottom of this screen and again on the following window.
3. Once printed, mail the claim to the insurance.

FREQUENTLY ASKED QUESTIONS

Q1: When I print HCFA 1500 claims for Medicare patients, all the diagnosis code pointers will print in box 24E, but Medicare only wants the first diagnosis pointer printed. How do I make only the first diagnosis code pointer show?

A1: Select Setup - Insurance and double click on the Medicare insurance(s) to open it. To the bottom right of the Edit Insurance Data screen that opened, find the checkbox option that states: "Only Print 1st Pointer" and click in the box to the left of it. When done, click the Save Button. When you reprint, it should come out the way you want it to.

Q2: How can I get my Type of Practice (i.e.: "Solo Practice") to automatically populate in the Type of Service field when adding claims?

A2: The Type of Practice field defaults from the Provider set up. Select Setup – Providers and double click on the Provider(s) listed. In the top third of the Edit Provider Data screen, click on the drop down menu labeled Type of Service and select the correct one. When done, click the Save Button. When you go to add a new claim, the Type of Service field should automatically populate with the correct information.

Q3: How do I print a number in Box 24C (EMG) of the HCFA 1500 Claim Form?

A3: Box 24C (EMG) is controlled by the information you put into the EMG box found in the claims screen when you are creating a claim. It is located at the bottom left of the Edit New Transaction screen (the screen that opens when you click the ADD button) under Procedures in the Edit Claims Data screen.

Q4: Can I send secondary and tertiary claims electronically?

A4: Yes, the current version of MPM Office (4.5 063008 update and later) do allow for users to bill secondary and tertiary insurances after the primary insurance payment and adjustments have been entered. Please contact a support representative (at 707-226-1155 Monday thru Friday 8am - 4pm PST) for assistance in downloading this upgrade. Do keep in mind that MOST secondary and tertiary insurances want the EOB as well. For those, the claims must be printed and the eob attached and sent via US Mail.

Q5: I submitted a claim electronically and my clearinghouse rejected it with a cryptic response (such as "*rendering provider name (loop 2310b) is used. It's not required when segment prv (loop 2000a) is used*"). What do these rejections mean?

A5: As the biller, it is your responsibility to understand the reports you receive regardless of whom they are from. If you do not understand what you received, contact the company whom sent it to you (i.e.: the insurance payor, the clearinghouse, etc.), and

have someone there explain things to you using clear English terms both what it is you received, and what they expect you to do with it. If you still need further assistance, please contact a support representative (at 707-226-1155 Monday thru Friday 8am - 4pm PST) and explain to him or her what you received along with explanations given to you.

Q6: How do I get both the CLIA number and the PRIOR AUTHORIZATION number to print in Box 23 (Prior Authorization Number) of the HCFA 1500 Claim Form?

A6: You need to make sure that the CLIA number is entered in the CLIA field under the DEFAULT tab of the PATIENT RECORD, as well as making sure the PRIOR AUTHORIZATION NUMBER selected appears in the “Prior Authorization” field. Then, when creating the claim, make sure to have the PRIOR AUTHORIZATION NUMBER selected in the “Prior Authorization #” field before saving the claim.

The printed claim should have Box 23 completed as in the example below:

23. PRIOR AUTHORIZATION NUMBER	
CLIA 987987987	Pri.Auth 12312312312312312312