



HCFA 02-12 GUIDE

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HCFA 1500 (02/12)


a) What is HCFA 1500?

A HCFA 1500 form is an official standard form that is used by physicians as well as other providers when submitting claims or bills for re-imbursement to Medicaid or Medicare for health services. It may also be used by private insurers as well as managed care plans.

The 1500 Claim Form instructions were initially approved by the NUCC in November 2005. The NUCC continues to research the type of data that are typically reported, as well as the required data elements that may apply to public and private payers. Therefore, the instructions have and will continue to evolve. Updated versions of this instruction manual are released each July. The ultimate goal of the NUCC is to develop standardized national instructions. The end result may require additional changes to the 1500 Claim Form in the future. Currently the version of HCFA 1500 form being used is 02/12; previously it was 08/05.

This guide will provide you an in-depth understanding of a HCFA 1500. It will help you populate a HCFA 1500 (02/12) form. Also, it will help you fill the details using CureMD's application by mapping the details in the form onto the application.

b) HCFA 1500 (02/12) FORM

												HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12												PICA <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1)												PICA <input type="checkbox"/> <input type="checkbox"/>											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>												4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>												7. INSURED'S ADDRESS (No., Street)											
CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()												8. RESERVED FOR NUCC USE												CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:												11. INSURED'S POLICY GROUP OR FECA NUMBER											
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>												a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>											
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)												b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>												c. INSURANCE PLAN NAME OR PROGRAM NAME											
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, complete items 9, 9a, and 9d.											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																							
SIGNED DATE												SIGNED																							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.												15. OTHER DATE MM DD YY QUAL.												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. NPI												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES												21. PRIOR AUTHORIZATION NUMBER											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																																			
A. B. C. D. E. F. G. H. I. J. K. L.																																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. PLACE OF SERVICE												C. EMG											
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)												E. DIAGNOSIS POINTER												F. \$ CHARGES											
G. DAYS OR UNITS												H. SPOT Family Plan												I. ID. QUAL.											
J. RENDERING PROVIDER ID. #												NPI												NPI											
25. FEDERAL TAX I.D. NUMBER												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>											
28. TOTAL CHARGE \$												29. AMOUNT PAID \$												30. Reserved for NUCC Use											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION												33. BILLING PROVIDER INFO & PH # ()											
SIGNED DATE												a. NPI												b. NPI											

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

To download in pdf, click http://www.nucc.org/images/stories/PDF/1500_claim_form_2012_02.pdf

c) Patient's Demographics

Inbox 0 Today's Patients

Home Patient Calendar Mail Clock Dollar Stethoscope Settings

Profile

Demographics Insurance Contacts Consents Preferences Restrictions

Messaging 0 Online

Save Mark Inactive Mark Red Flag Rx Eligibility Print Send Patient Portal Log

Registration Profile Materials Patient Notes Letters Provider Notes Clinical Messages Documents Appointment Billing

Title Mrs First Name SHIRLEY MI Last Name BERLIND Gender Female Status Unknown DOB 7/8/1925 SSN Mother's Maiden First Name Last Name Address 1 * 500 EAST MARYLYN AVE. Room 205 Address 2 City * STATE COLLEGE State * PA Zip * 16801 Country United States of America Location * 301 SOUTH ALLEN ST. Account No. 33 Chart No. 00101 Work Status Unemployed Ethnicity --Select-- MU Religion Unknown Preferred Language Search MU Race Search MU

Picture Upload Scan Webcam

WORKFLOW: Patient -> Profile -> Demographics

- We have shown this screenshot as it will be highlighted frequently in the following steps. Most of the information related to patient and his/her insurance is populated from this page.

d) Miscellaneous Item:**i. PICA:**

- The three boxes are used as a reference for OCR (Optical Character Recognition) Scanner. They have 3 X's in them and will auto populate with every HCFA generated using CureMD's PM/EMR.

1. SELECT PLAN:

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRIGARE <input type="checkbox"/> (ID#DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)
---	--	---	--	---	---	---

- The insurance type is mentioned using these boxes. The right box is marked based on the insurance type.

The screenshot shows the 'Settings' window in the CureMD application. The 'Billing' section is selected in the left sidebar, and the 'Plan' dropdown menu is open, displaying a list of insurance categories. The 'Plan' field is currently set to '1199 NATIONAL BENEFIT FUND'. The 'Details' section on the right provides additional information about the selected plan, including the insurer 'CI Commercial Insurance Co.', claim filing limits, and other policy details.

WORKFLOW: Settings->Billing->Plan

- In the application, select the category based on the chosen plan as shown above.

1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
---------------------------	-------------------------

- The subscriber ID of the insured party which is written on the insurance card should be entered in Subscriber Policy No.

Insurance	
Plan*	Aetna US Healthcare <input type="checkbox"/> Active <input checked="" type="checkbox"/> Default
Address*	PO BOX 14079 <input type="checkbox"/> Referral Required
Priority	Primary
Subscriber Policy No.*	W193675380
Group Number	87875203000033
Sign On File*	6/4/2014
Effective Date	
Exception Code	
Insurance Code (P)	C1 Commercial
Comments	

WORKFLOW: Patient-> Profile ->Insurance.

- Insured ID should be added and verified by running eligibility verification (if plan is offering).

2. PATIENT'S NAME:

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

- Patient's name should be entered in the given format.

Patient - Profile

Demographics | Insurance | Contacts | Consents | Preferences | Restrictions

Save | Mark Inactive | Mark Red Flag | Rx Eligibility | Print | Send | Patient Portal | Log

First Name * Michelle **MI** **Last Name *** Test

Gender * Male **Status** Single

DOB * 1/1/1900 **SSN** [Search]

Mother's Maiden First Name [Search] Last Name [Search]

Address 1 * [Search]

Address 2 [Search]

City * [Search] **State *** [Search]

Zip * [Search] **Country** United States of America

Home Ph [Search] **Location *** Carla J Cole DO PA

Email [Search] **Account No.** 15725

Work Status Unknown **Chart No.** [Search]

Ethnicity --Select-- **Religion** Unknown

Preferred Language Search **Race** Search

X English (US)

Picture
Upload | Scan | Webcam

WORKFLOW: Patient-> Profile ->Demographics.

- In the application, the name of the patient can be entered in the '**Demographics**' section as shown.

3. PATIENT'S BIRTHDATE AND GENDER:

- Patient's Date of Birth and Gender are to be mentioned in box 3.

WORKFLOW: Patient-> Profile ->Demographics.

- The patient's date of birth and gender can be entered in the '**Demographics**' as shown above.

4. INSURED'S NAME:

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

- Enter the name of insured party in the given format. An insured is the one whose insurance is used by the patient. Insured can be the patient or it can be any relative of the patient.

Insured Party				Self <input type="checkbox"/>	
Title	Mr	Relationship		Other Relationship	
First Name*	Michelle	MI	Last Name*	Test	
Gender	Male	DOB		1/1/1900	
SSN		Email			
Address1					
Address2					
City		State		Zip	
Home Ph					
Retirement		Spouse Retirement			
Employer		Employee ID			
Address					
City		State		Zip	

WORKFLOW: Patient-> Profile ->Insurance.

- Selecting '**Insurance**' from the patient module will give the required information on the insured. If the checkbox '**Self**' is marked then it means that the patient is also the insured party as mentioned earlier. Otherwise, the details of the insured can be entered as shown above.

5. PATIENT'S ADDRESS:

5. PATIENT'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ()

- The patient's address must be entered in the given format including the city, state, zip code and the telephone number.

Patient - Profile

Demographics Insurance Contacts Consents Preferences Restrictions

Messaging 12 Online Save Mark Inactive Mark Red Flag Rx Eligibility Print Send Patient Portal Log

Registration
Provider Notes
Clinical
Messages
Interoperability
Documents
Appointment
Billing

Title: Mr
First Name: Michelle MI
Last Name: Test
Gender: Male
Status: Single
DOB: 1/1/1900
SSN:
Mother's Maiden: First Name: Last Name:
Address 1: 31 - Kenilworth Road, New York
Address 2:
City: New York City
State: NY
Zip: 10003
Home Ph:
Country: United States of America
Location: Carla J Cole DO PA

Picture
Upload
Scan
Webcam

WORKFLOW: Patient-> Profile ->Demographics.

- In the application, the **'Demographics'** section contains all the address details of the patient.

6. PATIENT'S RELATIONSHIP TO INSURED:

6. PATIENT RELATIONSHIP TO INSURED

Self ☐ Spouse ☐ Child ☐ Other ☐

- If the patient is also the insured party then **'Self'** checkbox must be checked. Otherwise, the patient's relationship to the insured must be mentioned using one of the other three options.

Insured Party

Self ☐

Title: Mr

First Name: Liam MI

Gender: Male

SSN:

Address1: 26 mary circle

Address2:

City: Richardson

Home Ph: (214) 534-1550

Retirement:

Employer:

Address:

City:

Relationship: Other Relationship

Other Relationship:

- Adopted Child
- Cadaver Donor
- Child
- Child Where Insured Has
- Dependent of a Minor Dep
- Emancipated Minor
- Employee
- Father
- Foster Child
- Grandfather or Grandmoth
- Grandson or Granddaught
- Handicapped Dependent
- Injured Plaintiff
- Life Partner
- Mother
- Nephew or Niece
- Other Adult
- Employee
- Organ Donor
- Other Relationship
- Significant Other
- Stepson or Stepdaughter
- Sponsored Dependent
- Spouse
- Unknown
- Ward

WORKFLOW: Patient-> Profile ->Insurance.

- The application gives more options of the relationship with patient compared to the ones mentioned on HCFA form. These are all covered under **'Other Relationship'** in the HCFA form.

7. INSURED'S ADDRESS:

7. INSURED'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ()

- The insured's address details are also entered the same way as patient's details are entered. The city, the state, the zip and phone number must be entered. **Do not use any punctuation like commas/periods.**

Insured Party
Self ☐

Title	Mr ▼		Relationship	Other Relationship ▼
First Name*	Michelle	MI <input type="checkbox"/>	Last Name*	Test
Gender	Male ▼		DOB	1/1/1900 📅
SSN			Email	
Address1	PO BOX 200555			
Address2				
City	New York City		State	NY Zip 10003
Home Ph ▼				
Retirement			Spouse Retirement	
Employer			Employee ID	
Address				
City			State	Zip

WORKFLOW: Patient-> Profile ->Insurance.

- The application has a separate space for the insured's address details. If the patient is also the insured than the address details will be the same as patients' and **'Self'** box will be checked. Otherwise, the address details of the insured can be entered separately as mentioned in above workflow.

8. RESERVED FOR NUCC USE:

8. RESERVED FOR NUCC USE

- This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

9. OTHER INSURED'S NAME:

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

- If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2.

If the insured uses a last name suffix (**e.g., Jr, Sr**), enter it after the last name and before the first name. Titles (**e.g., Sister, Capt, and Dr**) and professional suffixes (**e.g., PhD, MD, and Esq.**) should not be included with the name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

- The "Other Insured's Policy or Group Number" identifies the policy or group number for coverage of the insured as indicated in Item Number 9.

b. RESERVED FOR NUCC USE

- This field is reserved for NUCC use.

c. RESERVED FOR NUCC USE

- This field is reserved for NUCC use.

d. INSURANCE PLAN NAME OR PROGRAM NAME

- The "Insurance Plan Name or Program Name" identifies the name of the plan or program of the other insured.

Patient Test		Balance \$ 70.00		Unapplied 0.00		Plan Balance \$ 225.00	
Insurance - Appointment - Provider		Place of Service 11. Office					
Primary Plan	Aetna	Referral		PAN		Copay	0.00
Secondary	1199 NATIONAL BEI	Referral		PAN		Adv.	--Reason--
Location	332 Harrison Avenue	Start DOS	06/17/2014	End DOS	06/17/2014	Transaction	6/17/2014
Claim Type	Original	Original Ref #					
Admission		Discharge					
Rendering		Billing	<input type="checkbox"/>	--Select--	Referring		Dates
							Add New Date

WORKFLOW: Patient-> Billing -> Quick Charge

Insurance	
Plan*	Aetna
Address*	PO Box 27267
Priority	Secondary
Subscriber Policy No.*	4444444a
Group Number	1234
Sign On File*	5/6/2013
Effective Date	
Exception Code	
Insurance Code (P)	HM Health Maintenance Organization (HMO)
Comments	
Insured Party	Self <input checked="" type="checkbox"/>

WORKFLOW: Patient-> Profile ->Insurance.

- **Group Name** will appear in Box 9d as shown in above screenshot.

Inbox Provider Note 1355

Settings

Plan Edit

Save Delete Unmap

☒ Active
 ☒ Accept Assignment ☒ Electronic

Details

Plan: BCBS-NY FEDERAL EMPIRE * BL Blue Cross/Blue Shield

Display Name: AARP * 180 days claim filing limit

Desc (HCFA top right): Desc BCBS-NY FEDERAL EMPIRE * 60 days reconsideration limit

Category: Commercial *

Rendering Provider: Situational (Electronic Claims Only)

NPI: (Real Time Transactions)

☒ Send Paper Claims Electronically

Batch 00803 Real Time 303

Address

PO BOX 740819, ATLANTA, GA 30374 Office 8005235800

PO BOX 5020, ct, CT 10001

PO BOX 11810, ALBANY, NY 12211

Messaging 5 Online
 Practice
 EHR
 Billing
 Claims Status
 Collection Agencies
 Diagnosis
 Drug
 Fee Schedule
 Financial Closing
 Inpatient Billing
 Modifier
 Payment Comments
 Payment Reason
 Plan
 Plan Category
 Procedure
 Provider Preferred Codes
 Relative Value Unit
 Reports

Same value will be printed on HCFA 11C and 9D unless different value is provided in Patient Insurance > Group Name.

WORKFLOW: Settings-> Billing -> Plan

- If the **Group Name** is missing, then the information added as shown in the screenshot will appear in Box 9d.

10. PATIENT'S CONDITION:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

☐ YES ☐ NO

b. AUTO ACCIDENT? **PLADE (State)**

☐ YES ☐ NO

c. OTHER ACCIDENT?

☐ YES ☐ NO

10d. CLAIM CODES (Designated by NUCC)

- This box must be checked if the patient's condition is related to Employment, Auto Accident or any Other Accident. Also, the claim codes in Item Number 10d are given for specific cases for a few insurances.

The screenshot shows the CureMD application interface. On the left, the 'Clinical' menu is expanded, and 'Case Review' is selected. The 'Profile' tab is active in the main content area. The 'Name' field is 'Office Visit', and the 'Open' date is '12/15/2011'. The 'Type' dropdown is set to 'Accident'. The 'Insurance' section shows 'Primary', 'Secondary', and 'Tertiary' dropdowns, all set to '--Select--'. The 'Accident Details' section shows 'Condition Related To' with a dropdown menu open, listing options: NA. Not Applicable, AA. Auto Accident, EM. Employment, and OA. Other Accident.

WORKFLOW: Patient->Clinical->Case Review->Profile

- In the application, go to Patient > Clinical > Case Review and first add a case. Case type must be selected as '**Accident**' for the '**Accident Details**' to appear. We can select the related condition as shown above before saving the case.

Add/Edit Charges

Save Receipt

Patient Test Balance \$ 70.00 | Unapplied 0.00 | Plan Balance \$ 225.00

Insurance Place of Service 11. Office

Primary Plan Aetna Referral PAN Copay 0.00 Paid Allocate

Secondary 1199 NATIONAL BE Referral PAN Adv. --Reason--

Tertiary --Select-- Referral PAN Dates Add New Date

Appointment

Location 332 Harrison Avenue Start DOS 06/17/2014 End DOS 06/17/2014 Transaction 6/17/2014

CLIA Reason (None) Resource --Resource--

Case --Select-- Special Prog --Select Special Program Code-- UT Status --Select--

APG --Select-- Delay Reason --Select Delay Reason Code--

Outside Lab Office Visit SAEC --Select Service Authorization Exception Code--

Claim Type Original Original Ref # Admission Discharge

Provider

Rendering Billing --Select-- Referring

Supervising --Select-- Pay-to --Select--

WORKFLOW: Patient-> Billing -> Quick Charge

- The same **Case** has to be selected from under the '**Appointment**' that appears after clicking the expand tab beside the '**Insurance**'. Select the same case name from quick charge, '**Office Visit**', and save.

Patient Test Balance \$ 70.00 | Unapplied 0.00 | Plan Balance \$ 225.00 June 17, 2014 09:54 AM

Insurance - Appointment - Provider Place of Service 11. Office ☒ Accept Assignment

Primary Plan Aetna Referral PAN Copay 0.00 ☐ Paid Allocate
 Secondary 1199 NATIONAL BENEFIT REFUNDATION PLAN Referral PAN Adv. --Reason--
 Location 332 Harrison Avenue Start DOS 06/17/2014 End DOS 06/17/2014 Transaction 6/17/2014
 Claim Type Original Original Ref#
 Admission **Original** Discharge
 Replacement
 Void
 W3 Level 1 appeal
 W4 Level 2 appeal
 W5 Level 3 appeal
 Billing --Select-- Referring Dates Add New Date
 Preferred Last Visit Template

Diagnosis 2. 3. 4.

Procedures Start DOS End DOS Modifier Dx. Ptr * Units Patient \$ Plan \$ Ordering Provider
 --Select-- --Select-- --Select-- 0 1 UN \$ 0.00 0.00 --Select--
 Rendering Provider --Select-- Referring Provider Primary PAN
 Supervising Provider --Select-- Purchased Services --Select-- Secondary PAN
 Outsource Location CLIA Tertiary PAN
 NDC Unit UN APG
 EPSDT Ref. Code ☐ EPSDT Service ☐ CHCUP Ref. ☐ Emergency ☒ Active
 Prescription No Prescription Date Enter Dates for
 Line Note
 Total: 0.00 0.00 0.00

Notes & Comments
 Claim Status 7. Never been billed Responsible Plan P.Aetna
 Comments
 Print on HCFA [F-19]

WORKFLOW: Patient-> Billing -> Quick Charge

- In box 10d, provide W3-W5 codes under the Claim Type field if there is a Worker's compensation form attached with the charge. If user selects 'Void' from the claim type field, HCFA will print W2 and if any option from W3-W5 is selected; HCFA will populate same code however EDI will print 7 - Replacement.

11. INSURED'S POLICY GROUP:

11. INSURED'S POLICY GROUP OR FECA NUMBER

- This is an alphanumeric identifier for the health, auto or other insurance plan coverage.

Insurance			
Plan*	Aetna US Healthcare	<input checked="" type="checkbox"/> Active	<input checked="" type="checkbox"/> Default
Address*	PO BOX 14079	<input type="checkbox"/> Referral Required	
Priority	Primary	Copay	0.00
Subscriber Policy No.*	W193675380	Patient Policy No.	
Group Number	87875203000033	Group Name	
Sign On File*	6/4/2014	Release Information	Yes
Effective Date		Termination Date	
Exception Code		Person Code	
Insurance Code (P)	C1 Commercial		
Comments			
Insured Party			Self <input checked="" type="checkbox"/>

WORKFLOW: Patient-> Profile ->Insurance.

- In the application, the Group Number of the mentioned group is the Insured's policy group or FECA number.

a. INSURED'S DATE OF BIRTH			SEX	
MM	DD	YY	M	F
			<input type="checkbox"/>	<input type="checkbox"/>

- Insured's date of birth must be entered in the given format along with Gender.

Insured Party		Clarence Abrahams		Self <input type="checkbox"/>	
Title	Mr	Relationship	Other Relationship		
First Name*	Clarence	MI	<input type="checkbox"/>	Last Name*	Abrahams
Gender	Male	DOB	7/24/1938		
SSN	130-40-7127		Email		
Address1	2435 north lake ridge drive				
Address2					
City	Palm City	State	FL	Zip	34990
Home Ph	(718) 231-7563				
Retirement		Spouse Retirement			
Employer		Employee ID			
Address					
City		State		Zip	

WORKFLOW: Patient-> Profile ->Insurance.

- If the 'Self' box is unchecked then the Insured's Date of Birth can be entered in space shown above. If the 'Self' box is checked then the patient's date of birth will be used for this box.

b. OTHER CLAIM ID (Designated by NUCC)

- Other Claim ID must be entered in the space given. Applicable claim identifiers are designated by NUCC. You need to leave it as blank in CureMD.

c. INSURANCE PLAN NAME OR PROGRAM NAME

- This box must be filled with insurance plan's name to which the claim is being billed to. It will be populated from Group Name highlighted in below screenshot. If it is missing, plan name can be added under Settings > Billing > Plan will be shown.

Insurance

Plan*	Aetna US Healthcare	<input checked="" type="checkbox"/> Active <input checked="" type="checkbox"/> Default
Address*	PO BOX 14079	<input type="checkbox"/> Referral Required
Priority	Primary	Copay
Subscriber Policy No.*	W193675380	Patient Policy No.
Group Number	87875203000033	Group Name
Sign On File*	6/4/2014	Release Information
Effective Date		Termination Date
Exception Code		Person Code
Insurance Code (P)	C1 Commercial	
Comments		

Insured Party Self ☒

WORKFLOW: Patient-> Profile ->Insurance.

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

☐ YES ☐ NO *If yes, complete items 9, 9a, and 9d.*

- If there is any other insurance plan, then 'YES' will be checked and box 9, 9a and 9d will be populated with other insurance details. If there is no other insurance, then 'NO' will be checked and box 9, 9a and 9d will be kept as blank.

Patient Test Balance \$ 70.00 | Unapplied 0.00 | Plan Balance \$ 225.00

Insurance - Appointment - Provider Place of Service 11. Office

Primary Plan	Aetna	Referral		PAN		Copay	0.00	<input type="checkbox"/> Paid	Allocate
Secondary	1199 NATIONAL BEN	Referral		PAN		Adv.		--Reason--	
Location	332 Harrison Avenue	Start DOS	06/17/2014	End DOS	06/17/2014	Transaction	6/17/2014		
Claim Type	Original	Original Ref #							
Admission		Discharge							
Rendering		Billing	<input type="checkbox"/>	--Select--	Referring		Dates	Add New Date	

WORKFLOW: Patient-> Billing -> Quick Charge

12. PATIENT'S SIGNATURE:

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ **DATE** _____

- Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit (MM|DD|YY) or 8-digit format (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File."

The "Patient's or Authorized Person's Signature" indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

13. INSURED'S SIGNATURE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

- Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."

The "Insured's or Authorized Person's Signature" indicates that there is a signature on file authorizing payment of medical benefits.

14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)			
MM	DD	YY	QUAL

- The given box requires the Onset of Current Illness, Injury or pregnancy. Enter the applicable qualifier to identify which date is being reported.

Add Dates
Save

Name*			
Admission		Discharge	
Unable To Work From		Unable To Work To	
Disability Start		Disability End	
Initial Treatment		Date Last Seen	
Current Problem	Illness	Onset of Current Illness	
Had Similar Illness?	No	Similar Illness 1	
Last Worked		Authorized Return to Work	
Last X-ray		Last Menstrual Period	
Acute Manif. 1		Assumed Care	
Hearing & Vision Prescription		Can Work	Yes
Condition Related To	NA. Not Applicable	Disability Type	Short Term
Accident State		Accident Date	
Code			

WORKFLOW: Patient-> Profile -> Clinical-> Dates

- If we select the 'Current Problem' as Illness, then the 'Onset of current Illness' must be provided and the qualifier for it.

Add Dates

Save

Name*			
Admission	<input type="text"/>	Discharge	<input type="text"/>
Unable To Work From	<input type="text"/>	Unable To Work To	<input type="text"/>
Disability Start	<input type="text"/>	Disability End	<input type="text"/>
Initial Treatment	<input type="text"/>	Date Last Seen	<input type="text"/>
Current Problem	Pregnancy	Onset of Current Illness	<input type="text"/>
Had Similar Illness?	No	Similar Illness 1	<input type="text"/>
Last Worked	<input type="text"/>	Authorized Return to Work	<input type="text"/>
Last X-ray	<input type="text"/>	Last Menstrual Period	<input type="text"/>
Acute Manif. 1	<input type="text"/>	Assumed Care	<input type="text"/>
Hearing & Vision Prescription	<input type="text"/>	Can Work	Yes
Condition Related To	NA. Not Applicable	Disability Type	Short Term
Accident State	<input type="text"/>	Accident Date	<input type="text"/>
Code	<input type="text"/>		

WORKFLOW: Patient-> Profile -> Clinical-> Dates

- If the 'Current Illness' is selected as Pregnancy then the Last Menstrual Period must be mentioned and the respective qualifier for the problem.

15. OTHER DATE:

16. OTHER DATE			
QUAL	MM	DD	YY

- The **“Other Date”** identifies additional date information about the patient’s condition or treatment. This will cover one of the following:
 - Accident Date (Highest priority)
 - Initial Treatment
 - Date Last Seen
 - Acute Manifestation 1
 - Last X-ray
 - Hearing & Vision Prescription

Add Dates
Save

Name			
Admission		Discharge	
Unable To Work From		Unable To Work To	
Disability Start		Disability End	
Initial Treatment		Date Last Seen	
Current Problem	Pregnancy	Onset of Current Illness	
Had Similar Illness?	No	Similar Illness 1	
Last Worked		Authorized Return to Work	
Last X-ray		Last Menstrual Period	
Acute Manif. 1		Assumed Care	
Hearing & Vision Prescription		Can Work	Yes
Condition Related To	NA. Not Applicable	Disability Type	Short Term
Accident State		Accident Date	
Code			

WORKFLOW: Patient-> Billing-> Quick Charge-> Dates

- All of the dates except for Accident date can be added from the workflow shown above.

Case **Office Visit**

Save Close Delete

Profile Notes Complaints ROS Vitals Physical Exam Diagnoses Prescription Attachments

Name * Office Visit Open * 7/1/2008

Provider --Select-- Ref. Provider + -

Type Accident Referral No. + -

Deliver Statement To Patient

Insurance

Primary --Select-- Secondary --Select-- Tertiary --Select--

Accident Details

Condition Related To AA. Auto Accident

Accident Date to State

Disability Yes No

Disability

Type No Disability

Period to

Unable to Work to

Can Work Yes No

WORKFLOW: Patient-> Profile -> Clinical-> Case Review

- If it is an **Accident date** then it must be added from the workflow shown.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION:

18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

FROM	MM	DD	YY	TO	MM	DD	YY

- “Dates: Patient Unable to Work in Current Occupation” is the time span the patient is or was unable to work.

Patient - Case Review | Case | Add | Save

Messaging 5 Online

- Registration
- Provider Notes
- Clinical
- Messages
- Interoperability
- Documents
- Appointment
- Billing

Name = Open = 6/17/2014

Provider = Ref. Provider

Type = Accident Referral No.

Deliver Statement To = Patient

Insurance

Primary = Secondary = Tertiary =

Accident Details

Condition Related To = EM. Employment

Accident Date

Disability ☒ Yes ☐ No

Disability

Type = Short Term

Period to

Unable to Work to

Can Work ☐ Yes ☒ No

WORKFLOW: Patient -> Clinical -> Case Review -> Case

- Using this workflow, the dates can be added for the inability to work.

18. HOSPITALIZATION DATES:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
FROM		MM	DD	YY	TO	
MM	DD	YY	MM	DD	YY	

- The “Hospitalization Dates Related to Current Services” would refer to an inpatient stay and indicates the admission and discharge dates associated with the service(s) on the claim.

Insurance - Appointment - Provider		Place of Service		11. Office	
Primary Plan	Aetna	Referral		PAN	
Secondary	Unisys Corporation	Referral		PAN	
Location	332 Harrison Avenue	Start DOS	06/17/2014	End DOS	06/17/2014
Claim Type	Original	Original Ref #		Transaction	6/17/2014
Admission		Discharge			
Rendering	Palmieri, Ponciano	Billing	<input checked="" type="checkbox"/>	Palmieri, Pon	Referring
				Dates	Add New Date

WORKFLOW: Patient-> Profile -> Clinical-> Dates

- Admission and Discharge dates can be added by expanding the Insurance – Appointment – Provider window in a quick charge.

19. ADDITIONAL CLAIM INFORMATION:

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

- Enter the comments related to the procedure used. This is claim level comments.

Diagnosis & Procedure										Preferred			Last Visit			Template				
Diagnosis		1. <input type="text"/>		2. <input type="text"/>		3. <input type="text"/>		4. <input type="text"/>												
Procedures		Start DOS	End DOS	Modifier	Dx. Ptr *	Units	Patient \$	Plan \$	Ordering Provider											
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	0	1	UN	\$ 0.00	0.00	--Select--										
Rendering Provider		--Select--		Referring Provider		Primary PAN														
Supervising Provider		--Select--		Purchased Services		--Select--		Secondary PAN												
Outsource Location				CLIA		Tertiary PAN														
NDC				Unit		UN		APG												
EPSDT Ref. Code				<input type="checkbox"/> EPSDT Service		<input type="checkbox"/> CHCUP Ref.		<input type="checkbox"/> Emergency		<input checked="" type="checkbox"/> Active										
Prescription No				Prescription Date		<input type="text"/>		Enter Dates for												
Line Note																				
							Total:	0.00	0.00	0.00										
Notes & Comments																				
Claim Status		7. Never been billed			Responsible Plan		P.Highmark													
Comments		<input type="text"/>																		
Print on HCFA [F-19]		<input type="checkbox"/>																		

WORKFLOW: Patient-> Billing -> Quick Charge

- The workflow mentioned above shows how to insert claim level comments. The checkbox has to be marked before entering the comments otherwise they would not appear on the HCFA form.

20. OUTSIDE LAB AND CHARGES:

20. OUTSIDE LAB?		\$ CHARGES
<input type="checkbox"/> YES	<input type="checkbox"/> NO	

- Complete this field when billing for purchased services by entering an X in “YES.” A “YES” mark indicates that the reported service was provided by an entity other than the billing provider. A “NO” mark or blank indicates that no purchased services are included on the claim. If “Yes” is annotated, enter the purchase price under “\$Charges”.

The screenshot shows the 'Quick Charge' form in the CureMD application. The left sidebar lists various navigation options, with 'Quick Charge' highlighted. The main form area displays patient information (Liam Frater) and financial details (Balance \$ 0.00, Unapplied 10.00, Plan Balance \$ 795.00). The 'Insurance' section shows 'Primary Plan' as 'Aetna US Healthcare' and 'Place of Service' as '11. Office'. The 'Appointment' section includes fields for Location, Start DOS, End DOS, and Transaction. The 'Billing' section contains the 'Outside Lab' checkbox, which is checked, and a field for the charge amount, currently set to '0.00'. Other fields include 'Claim Type' (Original), 'Admission', and 'Discharge'.

WORKFLOW: Patient-> Billing -> Quick Charge

- In the application, the space shown in the figure can be used to enter details of the Outside lab used. If the checkbox is marked then the charge field provided must be filled with the total charges of the Outside lab.

21. DIAGNOSIS CODES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. _____	B. _____	C. _____	D. _____
E. _____	F. _____	G. _____	H. _____
I. _____	J. _____	K. _____	L. _____


- Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.

9: ICD-9-CM

0: ICD-10-CM

ICD Code	Name	Short Name
002.9	PARATYPHOID FEVER UNSPECIFIED	
003.0	SALMONELLA GASTROENTERITIS	
003.1	SALMONELLA SEPTICEMIA	
003.20	LOCALIZED SALMONELLA INFECTION UNSPECIFIED	
003.21	SALMONELLA MENINGITIS	
003.22	SALMONELLA PNEUMONIA	
003.23	SALMONELLA ARTHRITIS	
003.24	SALMONELLA OSTEOMYELITIS	
003.29	OTHER LOCALIZED SALMONELLA INFECTIONS	
003.8	OTHER SPECIFIED SALMONELLA INFECTIONS	
003.9	SALMONELLA INFECTION UNSPECIFIED	

Message from webpage

 Maximum limit reached for diagnosis

OK

Diagnosis & Procedure					
1.	00.67	Intravascular pressure measurement of ir	2.	00.49	SuperSaturated oxygen therapy
3.	00.58	INSERTION OF INTRA-ANEURYSM SAC F	4.	00.59	Intravascular pressure measurement of c
5.	00.68	Intravascular pressure measurement of p	6.	001.0	CHOLERA DUE TO VIBRIO CHOLERAE
7.	001.1	CHOLERA DUE TO VIBRIO CHOLERAE E	8.	001.9	CHOLERA UNSPECIFIED
9.	002.0	TYPHOID FEVER	10.	002.1	PARATYPHOID FEVER A
11.	002.2	PARATYPHOID FEVER B	12.	002.3	PARATYPHOID FEVER C

WORKFLOW: Patient-> Billing -> Quick Charge

- In the application, there are initially 4 'Diagnosis' spaces given. When you click on **Diagnosis** highlighted in the figure above, another window opens up showing all the diagnosis and procedures available. When you click on any code it is automatically added to the list. When you add 4 codes, mores fields will appear. Maximum of 12 ICD codes can be entered within one claim after which the application gives a maximum limit warning as shown above.

22. RESUBMISSION CODE:

22. RESUBMISSION CODE	ORIGINAL REF. NO.

- “Resubmission” means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

Appointment			
Location	Carla J Cole DO PA	Start DOS	06/11/2014
CLIA		Reason	(None)
Case	--Select--	Special Prog	--Select Special Program Code--
APG		Delay Reason	--Select Delay Reason Code--
Outside Lab	<input type="checkbox"/> 0.00	SAEC	--Select Service Authorization Exception Code--
Claim Type	Original	Original Ref #	
Admission	Original	Discharge	
	Replacement		
	Void		
	W3 Level 1 appeal		
	W4 Level 2 appeal		
	W5 Level 3 appeal		
Billing	<input checked="" type="checkbox"/>	Cole, Carla	Referring
Pay-to	--Select--		

WORKFLOW: Patient-> Billing -> Quick Charge

- Under the **Appointment** sub-heading, the details of box 22 can be added in the highlighted portion shown in figure above.

23. PRIOR AUTHORIZATION NUMBER (PAN):

23. PRIOR AUTHORIZATION NUMBER

- The “Prior Authorization Number” is the payer assigned number authorizing the service(s), PAN in short.

* Insurance		Place of Service		11. Office			
Primary Plan	Aetna US Healthcare ▼	Referral		PAN		Copay	0.00
Secondary	--Select-- ▼	Referral		PAN		Adv.	--Reason-- ▼
Tertiary	--Select-- ▼	Referral		PAN		Dates	Add New Date ▼

WORKFLOW: Patient-> Billing -> Quick Charge

- PAN can be added directly into the box without clicking on the PAN name and finding the PAN in list of numbers (which is another possibility too). For each insurance Primary, Secondary or Tertiary, PAN is provided using this workflow.

24. PROCEDURE CODES:

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPDPT Early Periodic Pin	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From	To	MM	DD	YY	MM			DD	YY	CPT/HCPCS	MODIFIER						
1																		
2																		
3																		
4																		
5																		
6																		

- In **24A**, enter date(s) of service, both the “From” and “To” dates. If there is only one date of service, enter that date under “From.”
- In **24B**, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed.
- In **24C**, enter Y for “YES” or leave blank if “NO” in the bottom, unshaded area of the field.
- **24 D and E** allows for the entry of the following: 5-6 characters in the unshaded area of the CPT/HCPCS field and four sets of 2 characters in the Modifier area as the maximum limit.
- **24 F** allows for the entry of charges up to 6 characters to the left of the vertical line and 2 characters to the right of the vertical line in the unshaded area.
- **24 G** allows for the entry of units/days up to 3 characters in the unshaded area.
- **24 H** allows for the entry of 1 character in the unshaded area. This refers to EPDPT (Early Periodic Screening Diagnosis and Treatment).
- **24 I** allows for the entry of a 2 character qualifier in the shaded area. This will identify the code mentioned in **24J**.
- **24 J** allows for the entry of maximum 11 characters in the shaded area and entry of a 10-digit NPI number of the unshaded area.
- The shaded area of the HCFA box **24a** to **24h** is for the line level comments that can be populated from the workflow shown below. Once we click on the tab provided, a box appears and comments can be added there.
- **24 I** shaded area will display ‘PIN Qualifier’ (which defines the code to be populated in **24 J** shaded area) against selected ‘Rendering Provider’ on quick charge. To create a ‘Provider Plan PIN’, please refer to Item number 32b mentioned below.
- **24 J** shaded area will display the code based on PIN qualifier entered in **24 K** shaded area. This can also

Add/Edit Charges

Save Receipt

Michael Test Balance \$ 20.00 | Unapplied 0.00 | Plan Balance \$ 20.00 August 13, 2014 04:09 PM

Insurance - Appointment - Provider Place of Service 21. Inpatient Hospital ☒ Accept Assignment

Primary Plan Aid Gwinnett Referral PAN Copay 0.00 ☐ Paid Allocate

Secondary Aetna Referral PAN Adv. --Reason--

Location Gwinnett Medical Ce Start DOS 08/13/2014 End DOS 08/13/2014 Transaction 8/13/2014

Claim Type Original Original Ref #

Admission Discharge

Rendering --Select-- Billing --Select-- Referring Dates Add New Date

Diagnosis & Procedure Preferred Last Visit Template

Diagnosis 1. 2. 3. 4.

Procedures	Start DOS	End DOS	Modifier	Dx. Ptr *	Units	Patient \$	Plan \$	Ordering Provider
<input checked="" type="checkbox"/> 0002M					1	0.00	0.00	--Select--
--Use when Non-Specific Code is reported--								
				0	1	0.00	0.00	0.00
Total:						0.00	0.00	0.00

Notes & Comments

Claim Status 7. Never been billed Responsible Plan P.Aid Gwinnett

Comments

Print on HCFA [F-19] ☐

WORKFLOW: Patient-> Billing -> Quick Charge

- Under the procedures, click on the '+' sign to expand the procedure options. From there you can select each detail of box 24. There are check boxes for 'Emergency' and 'EPSDT' which must be checked for appearance on the HCFA form if required.

25. FEDERAL TAX I.D. NUMBER:

25. FEDERAL TAX I.D. NUMBER	SSN EIN
	<input type="text"/> <input type="text"/>

- The “Federal Tax ID Number” is the unique identifier assigned by a federal or state agency. Either SSN or EIN must be provided.

Settings - Practice Provider | Profile | Schedule | Block Schedule | Provider Plan PIN

Messaging 4 Online | Save | Report | Delete

Practice

- My Practice
- My Practice Settings**
 - Appointment Reason
 - Appt Reason Group
 - Global Block Schedule
- Incentive Programs**
 - eSuperBill
 - Reminders & Confirmations
 - Appointment Chains
- Bank**
- Agency**
- Reference Data**
- Financial Aging**
- Provider**
 - Practice Provider**
 - Reference Provider
- Provider Groups**
 - Provider Taxonomy Codes
 - Outsource Location
 - Recall Reason
 - Resource
 - Title
 - Transport
 - Void Appointments
 - Zip-Code Library
 - Practice User
 - Patient Portal User
 - Patient Portal Settings
 - Role

Profile

☒ Active

Title* Dr Short Name DR JF

Name* Joe Apple

Tax Type EIN EIN 13 - 6547892 SSN* 987-52-1478

NPI* 1234567893 UPIN 9876543211 DEA AP5716329

License Type

State* NJ License # 88745111

☒ Auto Select on Patient's Profile

☒ Rendering/Attending ☒ Billing

☒ Pay-to ☐ Supervising

☐ Operating ☐ Assistant Surgeon

☐ Physician Assistant ☐ Purchased Service

☐ Atypical

☒ Billing as Rendering

Default Billing Provider --Select--

Billing Address

Address 1* 8969 BANANA ROAD

Address 2

City* Jersey City State* NJ Zip* 07302 3243

Office Ph (861) 995-6325 Office Fax

Specialty* Internal Medicine

Pay To Address (If different than Billing)

Address 1*

Address 2

City* State* Zip*

Email

WORKFLOW: Settings -> Practice -> Provider -> Practice Provider -> Profile

- User can select the **Tax Type** as either **EIN** or **SSN** using above workflow. The selected type will then be printed on **Box 25**. This scenario is valid if no billing group exists against selected **Provider**, **Plan** and **Location** on charge page. In case it exists, **Group EIN** will be populated workflow of which is shown in **Box 33**.
- Now consider a scenario in which no billing group exists (eliminating the need for Group EIN) and provider bills to most of insurances based on either Individual EIN (or SSN). The same option can be selected as highlighted above under **Tax Type**. For all the other insurances that require SSN (or EIN) as other option than selected **Tax Type**, we need to create **Provider Plan PIN** for same **Provider**, **Location** and **Plan**. Under Provider Plan PIN we can select other Tax Type and it will print it only for this particular insurance.

Inbox 0 Today's Patients

Settings - Reference Provider Profile Provider Plan PIN PIN Details

Messaging 1 Online Save

Practice

- My Practice
- My Practice Settings
 - Audit Trail
 - Billing
 - Clean Claim Checks
 - Device Integration
 - EDI
 - EHR
 - Reports
 - Scheduler
 - Security
 - Appointment Reason
 - Appt Reason Group
 - Global Block Schedule
- Incentive Programs
 - eSuperBill
 - Reminders & Confirmations
 - Appointment Chains
 - Bank
 - Reference Data
 - Financial Aging
- Provider
 - Practice Provider
 - Reference Provider
- Provider Groups
 - Provider Taxonomy Codes
 - Outsource Location
 - Recall Reason
 - Resource
 - Title
 - Transport
 - Void Appointments
 - Zip-Code Library
 - Practice User
 - Patient Portal User
 - Patient Portal Settings
 - Role

- EHR
- Billing
- Reports

Plan Name* (None) Location* Center for Advanced Neuro

HCFA

PIN Qualifier --Select-- PIN

Tax Type SSN Group SSN EIN Group EIN Other

Please Specify ☐ Print Billing Provider at Box 33

C4 Worker's Comp

Rating Code Authorization No.

EDI - Billing Provider

Billing	Rendering	Purchased Service	Supervising	Attending	Pay to Provider	Operating
eSubmitterID						
ePIN Qualifier	--Select--		ePIN			
<input type="checkbox"/> Use the same values for All						
Comments						

WORKFLOW: Settings -> Practice -> Provider -> Practice Provider -> Provider Plan PIN

- User needs to select **Tax Type** as **SSN or EIN** as shown above along with **Plan Name** and **Location**. For more than one Plan and multiple locations, you have to create PINs for all separate locations one by one.

26. PATIENT'S ACCOUNT NUMBER:



26. PATIENT'S ACCOUNT NO.

- Patient's Account No. is the **Claim Identifier** which is auto-generated by the system. It is indicated by **CLM** in the EDI File.

27. ACCEPT ASSIGNMENT:

- The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.

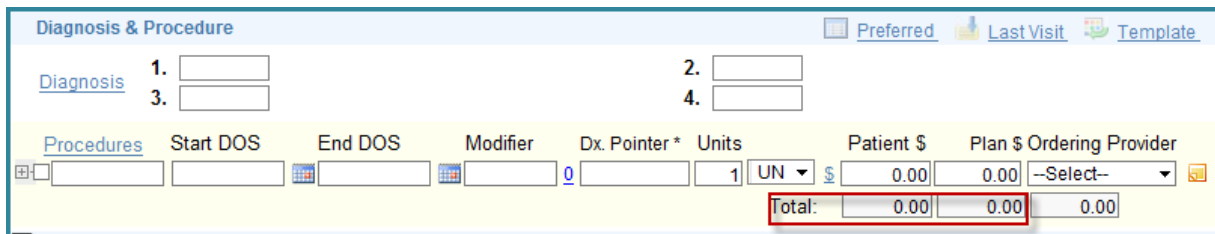
WORKFLOW: Patient-> Billing -> Quick Charge

- The checkbox given must be marked if the provider agrees to accept the terms of payer's program. It can be set to default under Plan Settings as well.

28. TOTAL CHARGE:



- Enter total charges for the services (i.e., total of all charges in 24F) and



Diagnosis & Procedure		Preferred	Last Visit	Template				
Diagnosis	1. <input type="text"/>	2. <input type="text"/>						
	3. <input type="text"/>	4. <input type="text"/>						
Procedures	Start DOS	End DOS	Modifier	Dx. Pointer *	Units	Patient \$	Plan \$	Ordering Provider
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0	1 UN	\$ 0.00	0.00	--Select--
Total:						0.00	0.00	0.00

WORKFLOW: Patient-> Billing -> Quick Charge

- The total sum is automatically added using the sum of individual CPT charges as shown in the figure.

29. AMOUNT PAID:



The “Amount Paid” is the payment received from the patient or other payers.

Diagnosis & Procedure										Preferred		Last Visit		Template	
<u>Diagnosis</u>		1.					2.								
		3.					4.								
<u>Procedures</u>		Start DOS	End DOS	Modifier	Dx. Pointer *	Units	Patient \$	Plan \$	Ordering Provider						
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
							Total:	<input type="text"/>	<input type="text"/>	<input type="text"/>					

WORKFLOW: Patient-> Billing -> Quick Charge

If the payments are entered against Procedures, they will be accumulated and appear in Box 29 as **Amount Paid**.

30. RESERVED FOR NUCC USE:

- This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

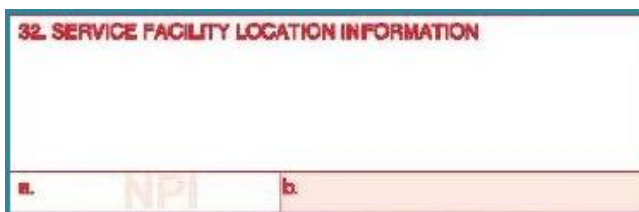
31. SIGNATURE OF PHYSICIAN:

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

SIGNED DATE

- Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, “Signature on File,” or “SOF.” Enter either the 6-digit date (MM|DD|YY), 8-digit date (MM|DD|YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.
- The “Signature of the Physician or Supplier Including Degrees or Credentials” refers to the authorized or accountable person and the degree, credentials, or title.

32. SERVICE FACILITY LOCATION:



- The name and address of facility where services were rendered.

Practice **Locations**

+ Add Location Save Delete

Location	Address	Status
Cresco	6272 Rt 191-390	Active
Marshalls Creek PT & Wellness	26 Fox Run Lane	Active
Tannersville PT and Wellness	2313 Route 715	Active

Location Profile

Location* Cresco

Location (EDI)* 6272Rt191-390

Address1* 6272 Rt 191-390

Address2

City* Cresco State* PA Zip* 18326 9998

Short Name* 36272Rt191

Phone (570) 595-3301

Fax (570) 629-9221

Email Tannersvillept@veriz

Contact Name Ken Todd

WORKFLOW: Settings -> Practice -> My Practice -> Locations

- The Service location can be entered in the Locations tab under My Practice as shown. The location NPI will also be added from location details which will appear in **32a**.

Practice **Locations**

+ Add Location Save Delete

Location	Address	Status
Cresco	6272 Rt 191-390	Active
Marshalls Creek PT & Wellness	26 Fox Run Lane	Active
Tannersville PT and Wellness	2313 Route 715	Active

Location Profile

Location* Cresco

Location (EDI)* 6272Rt191-390

Address1* 6272 Rt 191-390

Address2

City* Cresco State* PA Zip* 18326 9998

Short Name* 36272Rt191

Phone (570) 595-3301

Fax (570) 629-9221

Email Tannersvillept@veriz

Contact Name Ken Todd

Location Setting

Location NPI 1902872773 Group NPI 1902872773 Facility Code REF+LU

CLIA # Type* 77: Service Location Billing Provider --Select--

Place of Service* 11: Office Time Difference + 0 Minutes

☒ Active

☒ Print location address in claims (POS 13)

☐ Auto-Populate City, State and Zip in Patient Demo

eFax

Fax No User* Password* Fax Type Incoming & Outgoing

Fax No User Fax Type Default Applicable for all locations

WORKFLOW: Settings -> Practice -> My Practice -> Locations

- Information that appears in **32b** depends on **Billing Groups** added in the practice. Let's assume the first scenario in which a Billing Group exists for same **Provider**, **Location** and **Plan** as selected on Charge page. In this case, the system will print **License#** in **32b** which can be added in billing group using the below workflow.

Billing Group **Group Detail**

Save Save For All Plans Attach Providers Delete

Group Details Fill Practice Info

Name* TANNERSVILLE PT & WELLNESS Plan* 1199 NATIONAL BENEFIT FUND

Location Cresco NPI* 1902872773 Tax ID(EIN)* 203056461

Specialty -- Select -- UPIN Licence#

ePIN -- Select --

Billing Address **Pay To Address (Required if different than Billing)**

Address1* 6272Rt191-390 Address1 PO BOX 221

Address2 Address2

City* Cresco State* PA Zip* 183269998 City REEDERS State PA Zip 183520221

Provider Details

Provider	Specialty	License No.	NPI	DEA
Todd, Georgine	Physical Therapist	PT013394L	1073656161	

Showing 1 - 1 of 1 Records << First < Previous Next > Last >>

WORKFLOW: Settings -> Practice -> Provider Groups -> Billing Provider

- If there is no Billing Group involved, then **Box 32b** will be populated from **Provider Plan PIN** using the following workflow. User has to once again make sure that the **Plan Name** and **Location** must be same as the ones selected on Charge while creating Provider Plan PIN for the same **Provider**. The PIN will be populated along with 2 digits qualifier as its prefix.

Profile **Provider Plan PIN** **PIN Details**

Save

Plan Name* AETNA Location* Tannersville PT and Wellness

HCFA

PIN Qualifier 0B State License Number PIN 2344322

Tax Type SSN Please Specify

Group 123123 ☒ Print Billing Provider at Box 33

C4 Worker's Compensation

Rating Code Authorization No.

EDI - Billing Provider

Billing Rendering Purchased Service Supervising Attending Pay to Provider Operating

eSubmitterID

ePIN Qualifier --Select-- ePIN

☐ Use the same values for All

Comments

WORKFLOW: Settings -> Practice -> Provider -> Practice Provider -> Provider Plan PIN

33. BILLING PROVIDER INFORMATION:

33. BILLING PROVIDER INFO & PH # ()

a. NPI b.

- The billing provider's or supplier's billing name, address, ZIP code, and phone number is the billing office location and telephone number of the provider or supplier.

Settings - Billing Group

Group Details

Name: Center for Advanced Neurological Su Plan: Medicaid of GA

Location: Center for Advanced Neuro NPI: 1871769521 Tax ID(EIN): 51-0543269

Specialty: -- Select -- UPIN: Licence#

ePIN: -- Select --

Billing Address

Address1: 500 Medical Center Blvd. Suite 200

Address2:

City: Lawrenceville State: GA Zip: 300463380

Pay To Address (Required if different than Billing)

Address1:

Address2:

City: State: Zip:

Provider Details

Provider	Specialty	License No.	NPI	DEA
Ehirim, Princewill	Neurological Surgery	048508	1902802515	BE6733035

Showing 1 - 1 of 1 Records

WORKFLOW: Settings -> Provider Groups -> Billing Provider

- Once again the information that appears in **Box 33** will also depend on **Billing Group** if it is added in the practice for the same **Provider**, **Plan** and **Location**. In case it exists, the system will first populate **Name** of Billing Group followed by **Pay-To-Address** details in **Box 33** and **Group NPI** in **33a**. If there is no Pay-To-Address added in the group, then **Billing Address** will be populated.

- If there is no Billing Group, then practice information will be shown in **Box 33** using following workflow:

Practice | Locations

Save | Report | Register Practice to CureCAM

Practice* Carla J. Cole, D.O., P.A.
 Address1 323 N. Shiloh Road
 Address2
 City Garland State TX Zip 75042
 Phone (972) 272-2777 Fax (972) 276-0932
 Email ccpediatrics@ymail.com URL
 HCFA Name HCFA_0805_copy Active ☒

Practice ID* CMDCJ
 Practice Type Practice
 eClaim ID* CM DCJ
 Tax ID (EIN) 752925518
 Case Workflow Single Open
 Licensed Users 120

EDI Vendor

Name CUREMD ENROLLMENT DESK
 Phone (718) 360-0597 Email ENROLLMENT@CUREM Fax (718) 301-7789

WORKFLOW: Settings -> Practice -> My Practice

- Box 33a** will then be extracted from **Billing Provider's** profile using below workflow:

Settings - Practice Provider | Profile | Schedule | Block Schedule | Provider Plan PIN

Save | Report | Delete

Practice
 My Practice
 My Practice Settings
 Appointment Reason
 Appt Reason Group
 Global Block Schedule
 Incentive Programs
 eSuperBill
 Reminders & Confirmations
 Appointment Chains
 Bank
 Agency
 Reference Data
 Financial Aging
 Provider
 Practice Provider
 Reference Provider
 Provider Groups
 Provider Taxonomy Codes
 Outsource Location
 Recall Reason
 Resource
 Title
 Transport
 Void Appointments
 Zip-Code Library
 Practice User
 Patient Portal User
 Patient Portal Settings
 Role

Active ☒
 Rendering/Attending ☒
 Billing ☒
 Pay-to ☒
 Operating ☐
 Assistant Surgeon ☐
 Physician Assistant ☐
 Purchased Service ☐
 Atypical ☐
 Billing as Rendering ☒
 Default Billing Provider --Select--

Title* Dr Short Name DR JF
 Name* Joe Apple
 Tax Type EIN EIN 13 - 6547892 SSN* 987-52-1478
 NPI* 1234567893 UPIN 9876543211 DEA AP5716329
 License Type
 State* NJ License # 88745111

Billing Address
 Address 1* 8969 BANANA ROAD
 Address 2
 City* Jersey City State* NJ Zip* 07302 3243
 Office Ph (861) 995-6325 Office Fax
 Specialty* Internal Medicine

Pay To Address (If different than Billing)
 Address 1*
 Address 2
 City* State* Zip*
 Email

WORKFLOW: Settings -> Practice -> Provider -> Practice Provider -> Profile

- **Box 33b** can be printed by using **Group** option under **Provider Plan PIN**. The highlighted checkbox must be marked for HCFA.

The screenshot shows the 'Provider Plan PIN' configuration page in the CureMD system. The page has tabs for 'Profile', 'Provider Plan PIN', and 'PIN Details'. The 'Provider Plan PIN' tab is active. Below the tabs is a 'Save' button. The form contains several sections:

- Plan Name**: AETNA (dropdown)
- Location**: Tannersville PT and Wellness (dropdown)
- HCFA** section:
 - PIN Qualifier**: 0B - State License Number (dropdown)
 - Tax Type**: SSN (dropdown)
 - Group**: 123123 (dropdown, highlighted with a red box)
 - PIN**: 2344322 (text field)
 - Please Specify**: (text field)
 - Print Billing Provider at Box 33**: ☒ (checkbox, highlighted with a red box)
- C4 Worker's Compensation** section:
 - Rating Code**: (text field)
 - Authorization No.**: (text field)
- EDI - Billing Provider** section:
 - Billing**: (selected tab)
 - Rendering**: (tab)
 - Purchased Service**: (tab)
 - Supervising**: (tab)
 - Attending**: (tab)
 - Pay to Provider**: (tab)
 - Operating**: (tab)
 - eSubmitterID**: (text field)
 - ePIN Qualifier**: --Select-- (dropdown)
 - ePIN**: (text field)
 - Use the same values for All**: ☐ (checkbox)
 - Comments**: (text area)

WORKFLOW: Settings -> Practice -> Provider -> Practice Provider -> Provider Plan PIN