

# Instructions to customize claim form template – self pay invoice

Action / Instruction	Screen Shot																																																								
<p>1. FINANCIAL – Billing – Claim Form Template Library: select an existing template to edit by clicking the hyperlink in the Template name column (or create a new one). Once selected, the claim form-specific customization fields are displayed in lower portion of screen.</p>	<p>Template name: Insurance_1500   ID#: 48   Status: Active</p> <p><b>Claim Form Template Library</b></p> <table border="1"> <thead> <tr> <th>Template Name</th> <th>Claim Form</th> <th>Processing Type</th> <th>Status</th> <th>Version</th> <th>Version Eff Da</th> <th>Creation Date</th> <th>Created By</th> </tr> </thead> <tbody> <tr> <td>Insurance_UB92</td> <td>UB-92 HCFA-145</td> <td>Commercial</td> <td>Active</td> <td>1</td> <td>01/01/2003</td> <td>09/26/2005</td> <td>abc</td> </tr> <tr> <td>Insurance_1500</td> <td>CMS-1500(12/90)</td> <td>GROUP HEALTH PL</td> <td>Active</td> <td>1</td> <td>01/01/2003</td> <td>01/01/2003</td> <td>abc</td> </tr> <tr> <td>Self Pay - Full Fee</td> <td>Laser-Plain Paper</td> <td>Self Pay</td> <td>Active</td> <td>1</td> <td>01/01/2003</td> <td>01/01/2003</td> <td>abc</td> </tr> <tr> <td>Medicare - PPS UB-92</td> <td>UB-92 HCFA-145</td> <td>MEDICARE</td> <td>Active</td> <td>1</td> <td>01/01/2004</td> <td>08/10/2005</td> <td>abc</td> </tr> <tr> <td>Medicaid UB92</td> <td>UB-92 HCFA-145</td> <td>MEDICAID</td> <td>Active</td> <td>1</td> <td>01/01/2003</td> <td>01/01/2003</td> <td>abc</td> </tr> <tr> <td>Medicaid CMS1500</td> <td>CMS-1500(12/90)</td> <td>MEDICAID (Medic</td> <td>Active</td> <td>1</td> <td>01/01/2003</td> <td>01/01/2003</td> <td>abc</td> </tr> </tbody> </table> <p>1 of 1    Prev Next</p> <p><a href="#">Create New Template</a></p> <p><b>Claim Definition / Information</b></p> <p>* Template Name: Insurance_1500    ID#: 48</p> <p>* Claim Form: CMS-1500 (12/90)</p> <p>* Effective Date: 1/1/2003</p> <p><a href="#">Create New Version and Effective</a></p> <hr/> <p>Item 1: <input type="radio"/> MEDICARE (Medicare HIC#)    <input type="radio"/> CHAMPUS (Sponsor's SSN)    <input checked="" type="radio"/> GROUP HEALTH PLAN (SSN or ID#)</p> <p><input type="radio"/> MEDICAID (Medicaid ID#)    <input type="radio"/> CHAMPVA (VA file#)    <input type="radio"/> FECA BLACK LUNG (SSN)</p> <p><input type="radio"/> OTHER (ID#)</p> <p>Item 12: <input checked="" type="checkbox"/> Print "Signature on File"</p> <p>Item 16: <input checked="" type="checkbox"/> Prompt For DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION In Patient Payer/Policy Assignment</p> <p>Item 18: <input checked="" type="checkbox"/> Prompt For HOSPITALIZATION DATES RELATED TO CURRENT SERVICES In Patient Payer/Policy Assignment</p> <p>Item 24:</p> <p>Visits - <input checked="" type="radio"/> Print one visit per line    <input type="radio"/> Group visits by discipline and consecutive service date</p> <p>Supplies - <input checked="" type="radio"/> Print one supply item per line    <input type="radio"/> Group supply items by discipline and consecutive service date</p> <p>Item 24B: 12-Home,Location, other than a hospital or other facility, where the patient receives care in</p> <p>Item 24D: <input checked="" type="checkbox"/> Include HCPCS</p> <p>Item 24G: <input type="radio"/> DAYS    <input checked="" type="radio"/> UNITS    Unit = 1    Visits    <input type="checkbox"/> Increment Starts at</p> <p>Item 33: <input checked="" type="radio"/> Use AGENCY INFO For Billing Name, Address, Zip Code and Telephone #</p> <p><input checked="" type="checkbox"/> Include EIN</p> <p><input type="radio"/> Use REGIONAL OFFICE INFO For Billing Name, Address, Zip Code and Telephone #</p> <p><input type="checkbox"/> Include EIN</p> <p>* Required Fields</p> <p><b>Reference Documentation</b></p> <p>Click Button to Display Blank Claim Form in PDF Format</p> <p><a href="#">CMS-1500 (12/90)</a></p> <p>Note: Some of the files on this page are available only in Adobe Acrobat - Portable Document Format (PDF). To view PDF files, you must have the Adobe Acrobat Reader (minimum version 5, version 6 suggested). If you do not already have the Acrobat Reader installed, please go to Adobe's Acrobat download page now.</p> <p><a href="#">Save</a>    <a href="#">Save / Exit</a>    <a href="#">Cancel/Exit</a></p>	Template Name	Claim Form	Processing Type	Status	Version	Version Eff Da	Creation Date	Created By	Insurance_UB92	UB-92 HCFA-145	Commercial	Active	1	01/01/2003	09/26/2005	abc	Insurance_1500	CMS-1500(12/90)	GROUP HEALTH PL	Active	1	01/01/2003	01/01/2003	abc	Self Pay - Full Fee	Laser-Plain Paper	Self Pay	Active	1	01/01/2003	01/01/2003	abc	Medicare - PPS UB-92	UB-92 HCFA-145	MEDICARE	Active	1	01/01/2004	08/10/2005	abc	Medicaid UB92	UB-92 HCFA-145	MEDICAID	Active	1	01/01/2003	01/01/2003	abc	Medicaid CMS1500	CMS-1500(12/90)	MEDICAID (Medic	Active	1	01/01/2003	01/01/2003	abc
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**Action / Instruction**

2. sample self-pay invoice

**Screen Shot**

PLEASE DO NOT STAPLE IN THIS AREA



**HEALTH INSURANCE CLAIM FORM**

1. MEDICARE  MEDICAID  CHAMPUS  CHAMPVA  GROUP HEALTH PLAN (SSN or ID)  FECA BLK LUNG (SSN)  OTHER (IC)

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

3. PATIENT'S BIRTH DATE MM DD YY 05 12 1978 M  F  SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial) Fox, Michael, T

5. PATIENT'S ADDRESS (No., Street) 2500 JOE JINGLES

6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other

7. INSURED'S ADDRESS (No., Street) 3008 Swiss Ave., North Tower

8. PATIENT STATUS Single  Married  Other  Employed  Full-Time Student  Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Fox, Michael, T

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES  NO b. AUTO ACCIDENT?  YES  NO c. OTHER ACCIDENT?  YES  NO

11. INSURED'S POLICY OR FECA NUMBER NONE

12. INSURED'S DATE OF BIRTH MM DD YY 03 08 1978 M  F  SEX

13. EMPLOYER'S NAME OR SCHOOL NAME Aetna

14. INSURANCE PLAN NAME OR PROGRAM NAME Aetna

15. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO

16. INSURED'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: Signature on File DATE 03-03-2005

17. INSURED'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: Signature on File DATE 03-03-2005

18. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 05 04 2004

19. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

20. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

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

22. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Hirsch, Tomczak

23. I.D. NUMBER OF REFERRING PHYSICIAN 084518

24. OUTSIDE LAB?  YES  NO \$ CHARGES

25. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

26. PRIOR AUTHORIZATION NUMBER

DATE(S) OF SERVICE	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPST Family Plan	EMG	COB	RESERVED FOR LOCAL USE
05 04 2004			G0154	1	91.57	1				
05 05 2004			G0155	1	92.00	1				
05 08 2004			G0152	1	100.00	1				
05 11 2004			G0155	1	0.00	1				
05 13 2004			G0155	1	80.00	1				
05 17 2004			G0152	1	45.00	1				

27. FEDERAL TAX I.D. NUMBER SSN EIN 051234567

28. PATIENT'S ACCOUNT NO. 2111111104

29. ACCEPT ASSIGNMENT? (For govt. claims, see back)  YES  NO

30. TOTAL CHARGE \$ 411.57

31. AMOUNT PAID \$ 0.00

32. BALANCE DUE \$ 411.57

33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: Michael J Jones None DATE 03-03-2005

34. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) Florida Sunshine Home Health 1415 Mockingbird Ln., Parkland Corporate Complex, Suite 245 Parkland, FL, 33067, (582) 521-4557

35. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PNM 051234567 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 888)

PLEASE PRINT OR TYPE

APPROVED OMB-0933-0008 FORM CMS-1500 (12/02), FORM RRB-1500, APPROVED OMB-1215-0055 FORM CWP-1500, APPROVED CMS-0720-0001 (CHAMPUS)

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION