

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>[screen 1] – click NEXT PAGE to proceed to second screen of form customizations</p>	<p>Claim Definition / Information</p> <p>* Template Name: Insurance_UB92 ID#:45</p> <p>* Claim Form: UB-92 HCFA-1450</p> <p>* Effective Date: 1/1/2003</p> <p>Create New Version and Effective</p> <p>Payer Processing Designation: <input type="radio"/> MEDICARE <input type="radio"/> MEDICAID <input type="radio"/> Blue Cross <input checked="" type="radio"/> Commercial <input type="radio"/> CHAMPUS</p> <p>FL 1: <input checked="" type="radio"/> Use AGENCY INFO For Billing Name, Address, Zip Code and Telephone #</p> <p><input type="radio"/> Use REGIONAL OFFICE INFO For Billing Name, Address, Zip Code and Telephone #</p> <p>FL 4: Type of Facility - 1st Digit: 3 - Home Health Bill Classification - 2nd Digit: 3 - Outpatient (include Patient Status - 3rd Digit: Ba</p> <p>FL 5: <input checked="" type="checkbox"/> Print Federal Tax Number</p> <p>FL 7: <input type="checkbox"/> Include Covered Days</p> <p>FL 8: <input type="checkbox"/> Include Non-Covered Days</p> <p>FL 16: <input checked="" type="checkbox"/> Include Marital Status</p> <p>FL 18: <input type="checkbox"/> Include Admission Hour</p> <p>FL 19: 2-Urgent</p> <p>FL 21: <input type="checkbox"/> Include Discharge Hour</p> <p>FLs 32-35: 32a 27 32b 33a 33b 34a 34b 35a 35b</p> <p>FL 36: 36a 36b</p> <p>FL 38: <input checked="" type="checkbox"/> Include Responsible Party Name and Address</p> <p>FLs 39-41: 39a 6: System 39b 39c 39d 40a 40b 40c 40d 41a 41b 41c 41d</p> <p>Continued... NEXT PAGE</p> <p>* Required Fields</p> <p>Reference Documentation</p> <p>Click Button to Display Blank Claim Form in PDF Format</p> <p>UB-92HCFA-1450</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>Save Save / Exit Cancel/Exit</p>

Action / Instruction	Screen Shot
2. [screen 2] – click PREVIOUS PAGE to proceed to first screen of form customizations	<p>Claim Definition / Information</p> <p>* Template Name: Insurance_UB92 ID #: 45 * Claim Form: UB-92 HCFA-1450</p> <hr/> <p>FL 42: <input type="checkbox"/> Use "0 - General Classification" as 4th Digit for Revenue Codes</p> <p>FL 43: <input checked="" type="checkbox"/> Use Standard Abbreviation as Description</p> <p>FL 44: <input checked="" type="checkbox"/> Include HCPCS / CPT-4 <input type="checkbox"/> Include Rate <input type="radio"/> Use HCPCS (HCFA Common Procedure Coding System) <input checked="" type="radio"/> Use CPT-4 (Current Procedural Terminology)</p> <p>FL 45: <input checked="" type="checkbox"/> Include Service Date</p> <p>FL 46: <input type="radio"/> DAYS <input checked="" type="radio"/> UNITS = Unit <input type="text" value="15"/> Minutes <input type="button" value="v"/> <input type="checkbox"/> Increment Starts at <input type="text"/></p> <p>FL 50: <input checked="" type="checkbox"/> Include Payer Name <input checked="" type="checkbox"/> Include Payer NAIC Number and Sub-code</p> <p>FL 51: <input checked="" type="checkbox"/> Include Provider Number Assigned to the Provider by the Payer</p> <p>FL 52: <input checked="" type="checkbox"/> Include Release of Information Certification Indicator</p> <p>FL 53: <input checked="" type="checkbox"/> Include Assignment of Benefits Certification Indicator</p> <p>FL 63: <input checked="" type="checkbox"/> Include Treatment Authorization Code <input checked="" type="radio"/> One Treatment Auth Code per Page <input type="radio"/> Up To Three Treatment Auth Codes per Page</p> <p>FL 64: <input checked="" type="checkbox"/> Include Employment Status Code of the Insured</p> <p>FL 65: <input type="checkbox"/> Include Employer Name of the Insured</p> <p>FL 66: <input type="checkbox"/> Include Employer Location of the Insured</p> <p>FL 79: CM <input type="radio"/> 4: CPT-4 (Current Procedural Terminology) <input type="radio"/> 5: HCPCS (HCFA Common Procedure Coding System) <input checked="" type="radio"/> 9: ICD-9-CM</p> <p>FL 82: <input checked="" type="checkbox"/> Include State Physician ID# in upper line</p> <p>FL 83A & B: <input checked="" type="checkbox"/> Include Other Physician ID# <input checked="" type="checkbox"/> Include State Physician ID# in upper line</p> <p>FL 84: <input checked="" type="checkbox"/> Include Remarks from Patient Payer/Policy Assignment</p> <p>FL 85: <input checked="" type="checkbox"/> Include Authorized Signature <input checked="" type="radio"/> Print AGENCY Primary Staff Contact Name <input type="radio"/> Print REGIONAL office Primary Staff Contact Name <input type="radio"/> Print OTHER Authorized Signature <input type="text"/></p> <p>FL 86: <input checked="" type="checkbox"/> Include Date Bill Submitted <input checked="" type="radio"/> Invoice 'END' Date <input type="radio"/> Invoice 'OUTPUT / PRINT' Date</p> <p style="text-align: right;">Continued... PREVIOUS PAGE</p> <p>* Required Fields</p> <p>Reference Documentation Click Button to Display Blank Claim Form in PDF Format</p> <p>UB-92HCFA-1450</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 style="text-align: right;">Save Save / Exit Cancel/Exit</p>

Action / Instruction

3. sample self-pay invoice

Screen Shot

Florida Sunshine Home Health 1415 Mockingbird Ln., Parkland Corporate Complex, Suite 245 Parkland, FL 32067 Tel: (904) 756-7587		2		APPROVED CMS NO. 0500-0275	
3 PATIENT CONTROL NO. 227891		301		301	
5 FED. TAX NO. 051234567		6 STAFF/STAFF COORDINATOR FROM 05012004 THROUGH 05312004		7 COV D. 8 N-C D. 9 C-I D. 10 L-R D. 11	
12 PATIENT NAME NINEEN MONTH, TEST		13 PATIENT ADDRESS 15703 CENTER DRIVE, Panama City, FL 32406			
14 BIRTHDATE 01/01/1931		15 SEX M		16 M2 M	
17 DATE 05/02/04		18 HR 1		19 TYPE 20000	
21 D-HR 30		22 STAT 30		23 MEDICAL RECORD NO. 241111111111	
24 25 26 27 28 29 30 31		27			
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