


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: Self Pay - Full Fee ID#: 49 Status: Active</p> <p>Claim Form Template Library</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 PI</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>Create New Template</p> <p>Claim Definition / Information</p> <p>* Template Name: Self Pay - Full Fee ID#: 49</p> <p>* Claim Form: Self Pay</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 type="radio"/> Commercial <input type="radio"/> CHAMPUS <input checked="" type="radio"/> Self Pay</p> <p><input checked="" type="checkbox"/> Include Responsible Party Name and Address</p> <p><input checked="" type="checkbox"/> Include HCPCS In Service Description</p> <p><input checked="" type="checkbox"/> Include Admission Date(s) In Service Period / Comments Section</p> <p><input checked="" type="checkbox"/> Include Diagnosis Code/Description In Service Period / Comments Section</p> <p>Payment Due Date: <input type="text" value="10"/> Days after <input checked="" type="radio"/> Billing Cycle End Date <input type="radio"/> Invoice Print Date</p> <p>* Required Fields</p> <p>Reference Documentation</p> <p>Click Button to Display Blank Claim Form in PDF Format</p> <p>Self Pay</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>	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 PI	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

Screen Shot

2. sample self-pay invoice



REMIT TO:
 Florida Sunshine Home Health
 1415 Mockingbird Ln.
 Parkland Corporate Complex
 Suite 245
 Parkland, FL 33067 (582) 521-4587

INVOICE DATE: 03/03/2005
INVOICE #: 1
PATIENT ACCOUNT #: 8111111101
PAGE: 1 of 1
PAYMENT DUE DATE: 01/10/2004
AMOUNT DUE: 981.30

BILL TO / RESPONSIBLE PARTY:

TEST ONESELFYEAR
 9600 SUBURBAN CIRCLE
 Ponte Vedra Beach, FL 32004

PATIENT:

TEST ONESELFYEAR
 9600 SUBURBAN CIRCLE
 Ponte Vedra Beach, FL 32004

PLEASE MAKE CHECKS PAYABLE TO "FLORIDA SUNSHINE HOME HEALTH". WRITE INVOICE AND ACCOUNT NUMBER ON CHECKS.
DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

Date	Item	Description	Quantity	Basis	Unit Rate	Discount	Total
11/01/2003	RN, VST	Skilled Nursing (G0154)	1.0	Visit	110.00		110.00
11/01/2003	Wound Care, 1234557897	Coban™ Self-Adherent Wrap 2in.x10yd. Roll	6.0	Each	4.30		25.80
11/01/2003	Medical/Surgical, 1234567890	DuoDerm	5.0	Each	2.50		12.50
11/04/2003	OT, VST	Occupational Therapy (G0152)	1.0	Visit	75.00		75.00
11/06/2003	ST, HR	Speech Therapy, Language Pathology (G0153)	3.7	Hour	125.00		458.75
11/08/2003	HHA, HR	Home Health Aide (G0156)	5.3	Hour	25.00		133.25
11/10/2003	HHA, HR	Home Health Aide (G0156)	5.7	Hour	25.00		141.75
11/12/2003	HHA, HR	Home Health Aide (G0156)	1.0	Hour	25.00		24.25

Service Period / Comments: 01/01/2003 - 12/31/2003 : 11/1/2003 :

Previous Balance	- Payments	- Credits	+ Current Activity	+ / - Adjustments	= New Balance
0.00			981.30		981.30

If you think there is an error on your invoice, please write to us via e-mail at health@fshh.com or US mail at the address above within 30 days of the invoice date to dispute the erroneous charge. We'll be happy to clarify your invoice or correct any erroneous charges.

Current	30 Days Past Due	60 Days Past Due	90 Days Past Due	Over 90 Past Due	Total Due
981.30					981.30