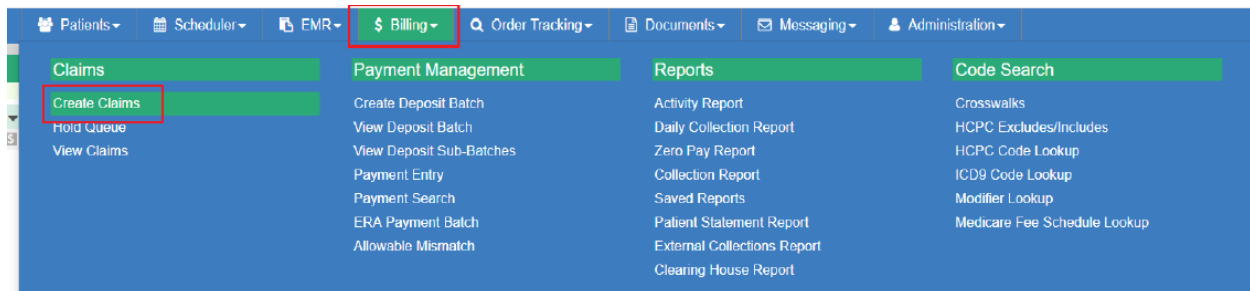


## Claims Creation



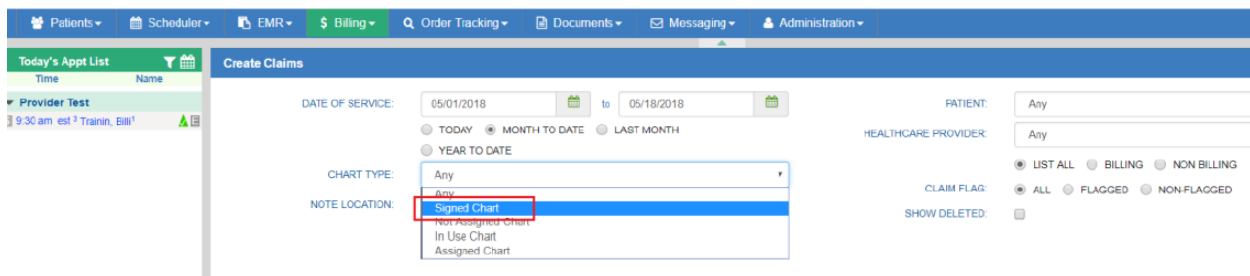
**GO TO**

BILLING> CLAIMS> CREATE CLAIMS



### STEPS

1. Choose the filters:
  - a. Date of Service
  - b. Chart Type – Choose SIGNED CHART
  - c. Note Location
  - d. Patient – you can search for one patient at a time
  - e. Healthcare Provider – you can search for one provider at a time
  - f. List All; Billing; Non-Billing
  - g. Claim Flag: All; Flagged; Non-Flagged
  - h. Show Deleted – checking the box will show the deleted line items



2. Select **SEARCH**

### 3. Select the V Button to pull the progress note

**WRS Implementation & Training**  
 123 Main, Goshen, NY 10924-1234  
 Tel: (845)222-5234 Fax: (845)531-4890  
**Training, Billing**  
 DOB: 01/01/1985, 33 year old Female  
 Note No.25050600, Date: May 18, 2018

Printed 7:57 AM May 18 2018, User Location: Goshen

**ASSESSMENT & PLAN**  
**Headache [RS1] (unchanged)**  
 Plan: [99205] Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history, a comprehensive examination, medical decision making of high complexity, counseling and/or coordination of

**SIGNATURE**  
 This note has not yet been signed.  
 If required, you can add an addendum to it.  
 If required, you can add a patient annotation to it.

Note Sign off  
☒ Private Visit ☒ Patient Portal Access  
 Sign Note

HEALTHCARE PROVIDER	PRIMARY INSURANCE	LOCATION	V	S	R	+
SN: 444-44-4444	Medicare B	Goshen				
SSN 999-99-9999	BCBS-NY Empire BCBS	Goshen				
999-99-9999	BCBS	Goshen				
Mr. SSN 999-99-9999	Medicare B	Goshen				

1 - 20 21 - 40 41 - 44

### 4. Select the S button to pull the superbill

**Training, Billing**  
 123 Main, Goshen, NY 10924-1234  
 Tel: (845)222-5234 Fax: (845)531-4890  
 Date: May 18, 2018  
 DOB: 01/01/1985, 33 year old, Female  
 Note No.25050600  
 Printed 7:50 AM May 18 2018

**Procedures:**  
 OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED HISTORY, A DETAILED EXAMINATION, MEDICAL DECISION MAKING OF MODERATE COMPLEXITY, COUNSELING AND/OR

**Diagnoses:**  
 RS1 Headache  
 Fax number:

HEALTHCARE PROVIDER	PRIMARY INSURANCE	LOCATION	V	S	R	+
Mr. SSN 444-44-4444	Medicare B	Goshen				
Mr. SSN 999-99-9999	BCBS-NY Empire BCBS	Goshen				
SSN 999-99-9999	BCBS	Goshen				
Female, SSN 999-99-9999	Medicare B	Goshen				

1 - 20 21 - 40 41 - 44

### 5. Select the R button to pull the referral note template

**Edit Referral Note**

Referring Provider:  Fax:  Phone:

Referral Note:

Date: May 18, 2018

Dear Dr. Referring Physician Name

Thank you for referring Billing Training ( DOB: 01/01/1985) to me for evaluation. The following are my findings:

**Diagnosis/Plan**  
 Diagnosis Headache [RS1] (unchanged)  
 Plan: [99205] Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history, a comprehensive examination, medical decision making of high complexity, counseling and/or coordination of

HEALTHCARE PROVIDER	PRIMARY INSURANCE	LOCATION	V	S	R	+
Mr. SSN 444-44-4444	Medicare B	Goshen				
Mr. SSN 999-99-9999	BCBS-NY Empire BCBS	Goshen				
SSN 999-99-9999	BCBS	Goshen				
Female, SSN 999-99-9999	Medicare B	Goshen				

1 - 20 21 - 40 41 - 44

- Select the **trash bin** button to delete non-billable line item

- Select **CREATE CLAIM** to pull CMS 1500 / 837P / Claim Form
- Box 11C** – Primary Insurance; if you need to change the primary insurance or update the member ID, click BOX 11C > Edit Patient's Insurance Profiles
- Box 9D** – Secondary Insurance; if you need to change the secondary insurance or update the member ID, click BOX 9D > Edit Patient's Insurance Profiles

#### CMS 1500

Print Message Type: 837P Fee Schedule: default \*DEFAULT

CLAIM STATUS: NEW CLAIM

INSURANCE PLAN AND ADDRESS:  
Medicare B  
NGS  
PO BOX 4803  
SYRACUSE, NY 13221

HEALTH INSURANCE CLAIM FORM  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER  
☒ (Medicare #) ☐ (Medicaid #) ☐ (ID#) ☐ (ID#) ☐ (ID#) ☐ (ID#) ☐ (ID#) ☐ (ID#)

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

3. PATIENT'S BIRTH DATE SEX  
MM DD YY M F  
01 01 1985 M ☒ F

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

5. PATIENT'S ADDRESS (No., Street)  
2004 ROUTE 17M

6. PATIENT RELATIONSHIP TO INSURED  
Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)  
2004 ROUTE 17M

8. RESERVED FOR NUCC USE

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

10. IS PATIENT'S CONDITION RELATED TO:  
a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO  
b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)  
c. OTHER ACCIDENT? ☐ YES ☒ NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

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 Signature on File DATE

13. INSURED'S DATE OF BIRTH SEX  
MM DD YY M F  
01 01 1985 M ☐ F ☒

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


15. OTHER DATE  
MM DD YY

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

17. INSURED'S PLAN NAME OR PROGRAM NAME  
Medicare B  
Medicare B  
Anthem BCBS  
AETNA  
\*SELF PAY\*

18. OTHER CLAIM ID (Designated by NUCC)

19. EDIT PATIENT'S INSURANCE PROFILES

CLAIM STATUS: NEW CLAIM  


INSURANCE PLAN AND ADDRESS  
Medicare B  
NGS  
PO BOX 4803  
SYRACUSE, NY 13221

HEALTH INSURANCE CLAIM FORM  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6/2/12

1. MEDICARE  
2. PATIENT'S IN TRAINING  
3. PATIENT'S A 2004 ROUT  
4. CITY  
GOSHEN  
5. ZIP CODE  
10924  
6. OTHER INEL TRAINING  
7. OTHER INEL XXX123456  
8. RESERVED  
9. RESERVED 1  
10. INSURANCE  
Anthem BC  
11. PATIENT'S 1  
12. PATIENT'S 1  
13. DATE OF C  
14. NAME OF P  
15. ADDITIONAL

Edit Patient's Insurance Profiles

INSURANCE PLAN & ADDRESS	INSURED NAME	P	S	T	DETAIL
Medicare B	Billing Training	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Detail
Anthem BCBS PO Box 80007 Los Angeles, CA 90060-0007	Billing Training	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	Detail
AETNA 1 Debornshire Dr Easton, PA 18045-0001	Billing Training	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Detail

Other Public Insurance ☐ CHIP/S-CHIP ☐

Pharmacy Coverage  
No pharmacy coverage information available.

Add New Insurance

IS THE PATIENT THE INSURANCE POLICY HOLDER? ☒ YES

Search Insurance Package

https://ehr.wrshealth.com/patient\_full/QuickRegistrationInsuranceSelectInsuranceGr...

Secure | https://ehr.wrshealth.com/patient\_full/QuickRegistrationInsuranceSelectInsuranceGr...

Health Insurance Question

Please select the option that describes your insurance plan

☐ Medicare (Non-managed care)  
☐ Medicaid (Non-managed care)  
☒ Other

Continue

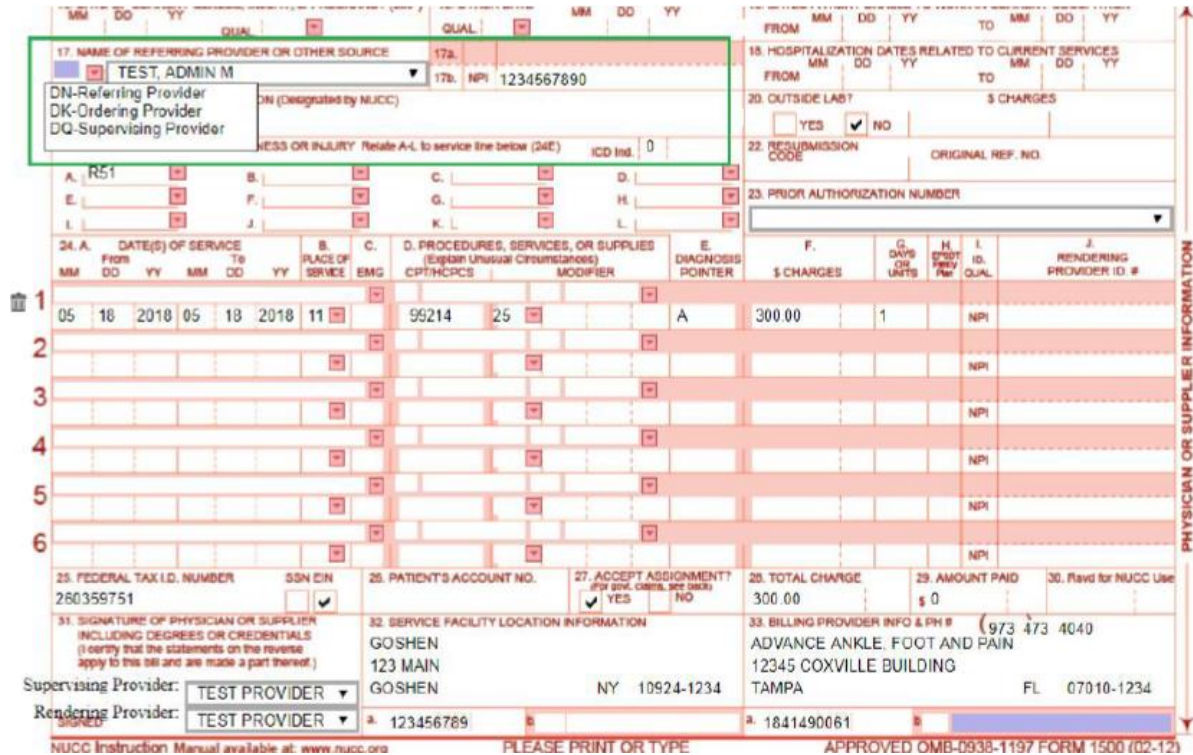
Cancel

10. **Box 10D** – If Medicare is Secondary > click BOX 10D to indicate the reason as to why Medicare is secondary

HEALTH INSURANCE CLAIM FORM										CLARK
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12										
PICA										PICA
1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA	BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)	
<input type="checkbox"/> (Medicare #)	<input type="checkbox"/> (Medicaid #)	<input type="checkbox"/> (IDMIDCODE)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)	<input checked="" type="checkbox"/> (ID#)	XXX1234567890		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
TRAINING BILLING				MM DD YY		M F		TRAINING BILLING		
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
2004 ROUTE 17M				Self <input checked="" type="checkbox"/> spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				2004 ROUTE 17M		
CITY		STATE		8. RESERVED FOR NUCC USE		CITY		STATE		
GOSHEN		NY				GOSHEN		NY		
ZIP CODE		TELEPHONE (Include Area Code)		10. IS PATIENT'S CONDITION RELATED TO:		ZIP CODE		TELEPHONE (Include Area Code)		
10924		(990) 999 - 9999				10924		(990) 999 - 9999		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				11. INSURED'S POLICY GROUP OR FECA NUMBER						
TRAINING BILLING										
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH		
9999999999A				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				MM DD YY		
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? PLACE (State)				01 01 1905 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)		
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				Anthem BCBS		
d. INSURANCE PLAN NAME OR PROGRAM NAME				10g. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
Medicare B				12 - Medicare Secondary Worker				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.		
<p>READ BACK OF FORM BEFORE COMPLETING</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the use of this claim. I also request payment of government benefits either below.</p> <p>SIGNED: Signature on File</p> <p>12 - Medicare Secondary Working Ages Beneficiary or Spouse with Employer Group Health Plan</p> <p>13 - Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan</p> <p>14 - Medicare Secondary, No-fault Insurance including Auto is Primary</p> <p>15 - Medicare Secondary Worker's Compensation</p> <p>16 - Medicare Secondary Public Health Service (PHS) or Other Federal Agency</p> <p>41 - Medicare Secondary Black Lung</p> <p>42 - Medicare Secondary Veteran's Administration</p> <p>43 - Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)</p> <p>47 - Medicare Secondary, Other Liability Insurance is Primary</p>										
<p>14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)</p> <p>MM DD YY</p> <p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</p> <p>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</p>										

# 11. Box 17 – choose the correct provider qualifier

DN – Rendering Provider; DK – Ordering Provider; DQ – Supervising Provider



17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
 DN-Rendering Provider  
 DK-Ordering Provider  
 DQ-Supervising Provider

17a. NPI 1234567890

17b. NPI 1234567890

17c. NPI 1234567890

17d. NPI 1234567890

17e. NPI 1234567890

17f. NPI 1234567890

17g. NPI 1234567890

17h. NPI 1234567890

17i. NPI 1234567890

17j. NPI 1234567890

17k. NPI 1234567890

17l. NPI 1234567890

17m. NPI 1234567890

17n. NPI 1234567890

17o. NPI 1234567890

17p. NPI 1234567890

17q. NPI 1234567890

17r. NPI 1234567890

17s. NPI 1234567890

17t. NPI 1234567890

17u. NPI 1234567890

17v. NPI 1234567890

17w. NPI 1234567890

17x. NPI 1234567890

17y. NPI 1234567890

17z. NPI 1234567890

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

19. OUTSIDE LAB? \$ CHARGES

20. YES ☐ NO ☒

21. RESUBMISSION CODE ORIGINAL REF. NO.

22. PRIOR AUTHORIZATION NUMBER

23. DATE(S) OF SERVICE  
 FROM MM DD YY TO MM DD YY

24. PLACE OF SERVICE  
 A. R51 B. C. D. E. F. G. H. I. J. K. L.

25. PROCEDURES, SERVICES, OR SUPPLIES  
 CPT/HCPCS MODIFIER

26. DIAGNOSIS POINTER

27. \$ CHARGES

28. C. DAYS OR UNITS

29. H. ID. QUAL.

30. J. RENDERING PROVIDER ID #

31. FEDERAL TAX I.D. NUMBER SSN EIN

32. PATIENT'S ACCOUNT NO.

33. ACCEPT ASSIGNMENT? (If gov. claim, see back)

34. TOTAL CHARGE

35. AMOUNT PAID

36. Rev'd for NUCC Use

37. 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.)

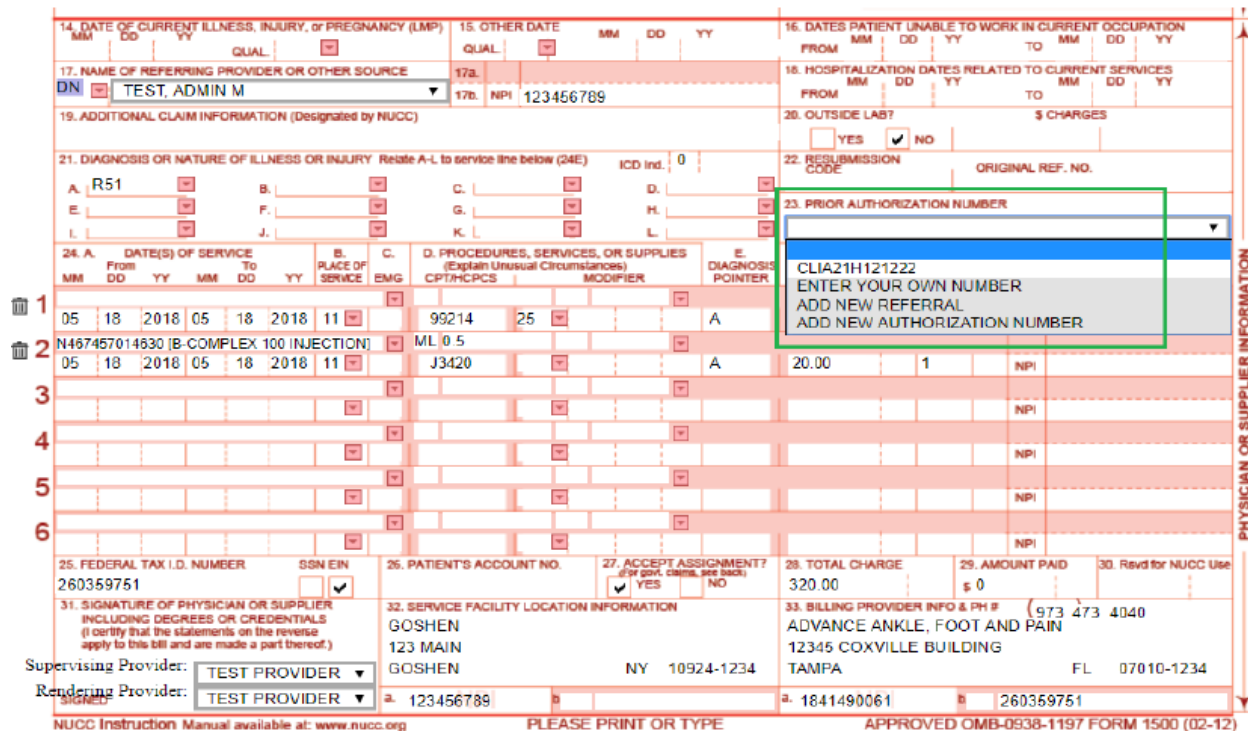
38. SERVICE FACILITY LOCATION INFORMATION  
 GOSHEN  
 123 MAIN  
 GOSHEN NY 10924-1234

39. BILLING PROVIDER INFO & PH # (973 473 4040)  
 ADVANCE ANKLE, FOOT AND PAIN  
 12345 COXVILLE BUILDING  
 TAMPA FL 07010-1234

Supervising Provider: TEST PROVIDER  
 Rendering Provider: TEST PROVIDER

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

# 12. Box 23 – you can enter the REFERRAL; AUTHORIZATION; CLIA# in this box



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

15. OTHER DATE  
 QUAL. MM DD YY

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  
 DN-Rendering Provider  
 DK-Ordering Provider  
 DQ-Supervising Provider

17a. NPI 1234567890

17b. NPI 1234567890

17c. NPI 1234567890

17d. NPI 1234567890

17e. NPI 1234567890

17f. NPI 1234567890

17g. NPI 1234567890

17h. NPI 1234567890

17i. NPI 1234567890

17j. NPI 1234567890

17k. NPI 1234567890

17l. NPI 1234567890

17m. NPI 1234567890

17n. NPI 1234567890

17o. NPI 1234567890

17p. NPI 1234567890

17q. NPI 1234567890

17r. NPI 1234567890

17s. NPI 1234567890

17t. NPI 1234567890

17u. NPI 1234567890

17v. NPI 1234567890

17w. NPI 1234567890

17x. NPI 1234567890

17y. NPI 1234567890

17z. NPI 1234567890

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

19. OUTSIDE LAB? \$ CHARGES

20. YES ☐ NO ☒

21. RESUBMISSION CODE ORIGINAL REF. NO.

22. PRIOR AUTHORIZATION NUMBER

23. CLIA21H121222  
 ENTER YOUR OWN NUMBER  
 ADD NEW REFERRAL  
 ADD NEW AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE  
 FROM MM DD YY TO MM DD YY

25. PLACE OF SERVICE  
 A. R51 B. C. D. E. F. G. H. I. J. K. L.

26. PROCEDURES, SERVICES, OR SUPPLIES  
 CPT/HCPCS MODIFIER

27. DIAGNOSIS POINTER

28. \$ CHARGES

29. C. DAYS OR UNITS

30. H. ID. QUAL.

31. J. RENDERING PROVIDER ID #

32. FEDERAL TAX I.D. NUMBER SSN EIN

33. PATIENT'S ACCOUNT NO.

34. ACCEPT ASSIGNMENT? (If gov. claim, see back)

35. TOTAL CHARGE

36. AMOUNT PAID

37. Rev'd for NUCC Use

38. 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.)

39. SERVICE FACILITY LOCATION INFORMATION  
 GOSHEN  
 123 MAIN  
 GOSHEN NY 10924-1234

40. BILLING PROVIDER INFO & PH # (973 473 4040)  
 ADVANCE ANKLE, FOOT AND PAIN  
 12345 COXVILLE BUILDING  
 TAMPA FL 07010-1234

Supervising Provider: TEST PROVIDER  
 Rendering Provider: TEST PROVIDER

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13. **Box 24** – above the Date of Service; click the dropdown above the DOS for the NDC Code

SIGNED Signature on File DATE										SIGNED Signature on File									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)										15. OTHER DATE									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI 123456789									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE										24. B. PLACE OF SERVICE									
24. C. EMG										24. D. PROCEDURES, SERVICES, OR SUPPLIES									
24. E. DIAGNOSIS POINTER										24. F. \$ CHARGES									
24. G. DAYS OR UNITS										24. H. SPOT Fee/ Pay									
24. I. Q. QUAL										24. J. RENDERING PROVIDER ID. #									
25. FEDERAL TAX I.D. NUMBER										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT?										28. TOTAL CHARGE									
29. AMOUNT PAID										30. Rev'd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH#										34. BILLING PROVIDER INFO & PH#									

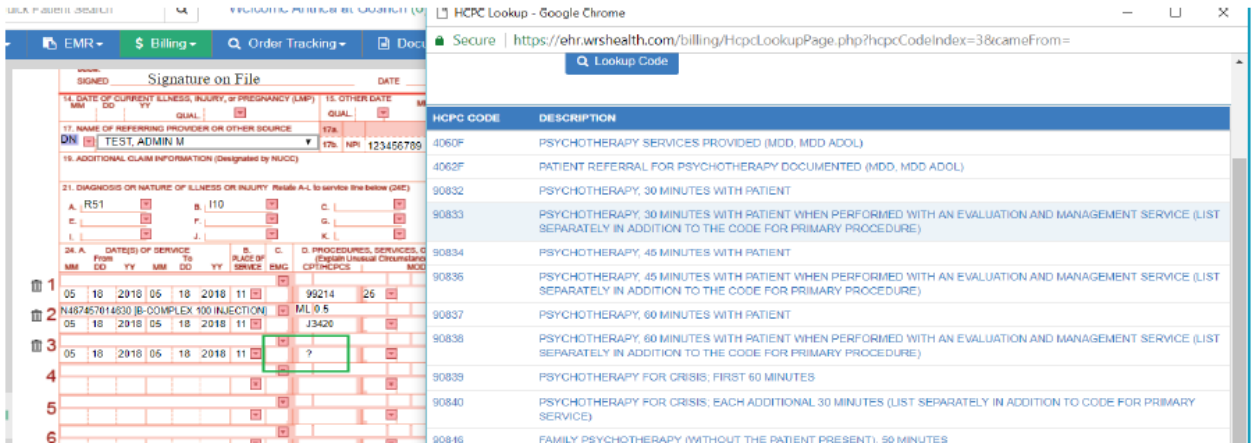
Supervising Provider: TEST PROVIDER  
 Rendering Provider: TEST PROVIDER

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

14. **Box 21** – ICD Code; type “?” to pull the ICD 9/10 Lookup

EMR		Billing		Order Tracking	
ICD-9/10 Lookup					
ICD-9/10 CODE					
DESCRIPTION					
CATEGORY					
VERSION					
Q Lookup Code					
ICD9 CODE					
DESCRIPTION					
G93.2					
Benign intracranial hypertension					
H40.051					
Ocular hypertension, right eye					
H40.052					
Ocular hypertension, left eye					
H40.053					
Ocular hypertension, bilateral					
H40.059					
Ocular hypertension, unspecified eye					
I10					
Essential (primary) hypertension					
I15.0					
Renovascular hypertension					
I15.1					
Hypertension secondary to other renal disorders					
I15.2					
Hypertension secondary to endocrine disorders					
I15.8					
Other secondary hypertension					
I15.9					
Secondary hypertension, unspecified					
I27.0					
Primary pulmonary hypertension					

15. **Box 24D – CPT Code; type “?” to pull the CPT Lookup**

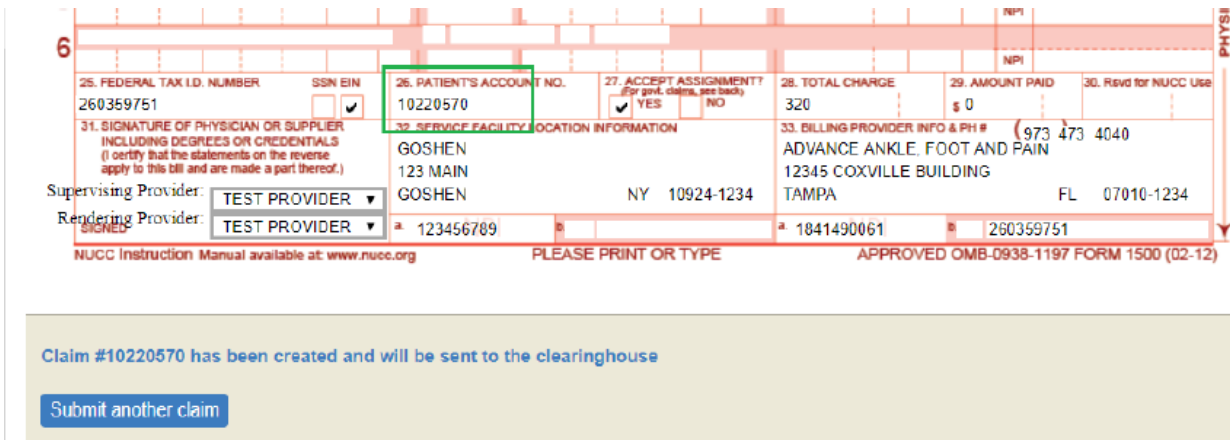


16. Click **Verify and Submit Electronically** to send the claim to the clearinghouse

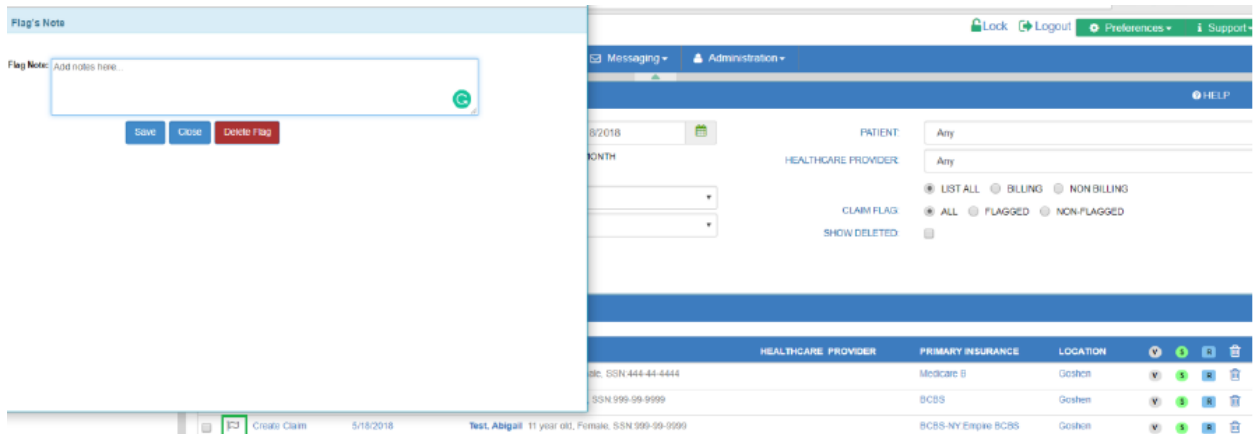
17. Click **Verify and Drop to Paper** to print a paper claim; send to HOLD Queue to put claim on hold



18. **Box 26 – a unique claim# gets generated in BOX 26 after a claim is created. The claim# used to pull up the claim in WRS**

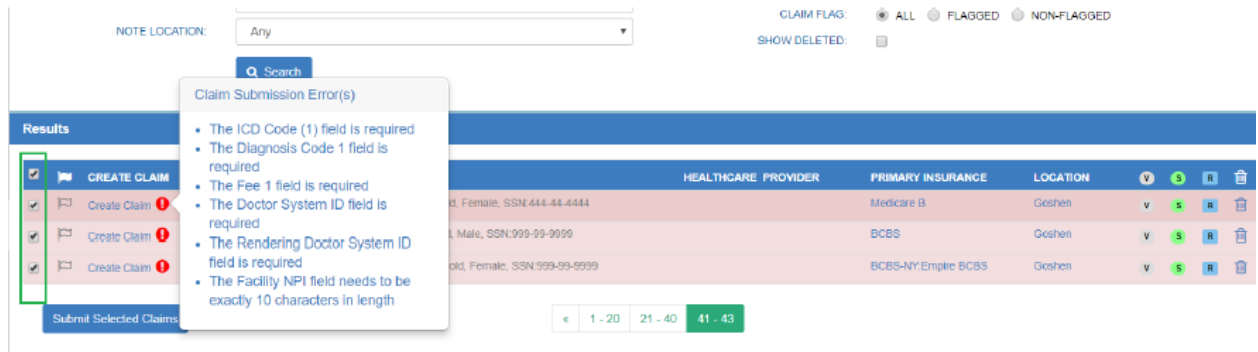


19. **FLAG** – Select the flag icon to pull the Flag Note. You can enter your notes here > click Save



The screenshot shows a 'Flag's Note' modal window on the left with a text input field and 'Save', 'Close', and 'Delete Flag' buttons. The background shows a patient list table with columns for Patient, Healthcare Provider, Primary Insurance, and Location. A patient named 'Test, Abigail' is highlighted.

20. You can submit multiple claims. Check the box beside the flag > Select **Submit Selected Claims**



The screenshot shows a 'Results' section with a 'CREATE CLAIM' button and a 'Submit Selected Claims' button. A 'Claim Submission Error(s)' dialog is open, listing several errors: 'The ICD Code (1) field is required', 'The Diagnosis Code 1 field is required', 'The Fee 1 field is required', 'The Doctor System ID field is required', 'The Rendering Doctor System ID field is required', and 'The Facility NPI field needs to be exactly 10 characters in length'.



## NOTES

- Review the appointment list. This contains the patients scheduled to specific providers and locations. Front Desk performs the check in and check out workflow
- When the option MOVE TO EXAM ROOM is clicked the system automatically prepares the EMR NOTE. The CPT, Modifier, ICD Codes entered in the superbill, in the EMR Note, will then automatically populate in the CMS 1500/claim Form
- Non-Billable line items are prescription notes, phone scripts; notes created for documentation purposes only
- The system will give you claim submission error warning message when there is something missing from the claim