


## Manual Claims Creation



RECENTLY VIEWED PATIENTS OR QUICK PATIENT SEARCH

Recently Viewed Patients	
Test, Anthea	
Test, Christina	

OR



Quick Patient Search	
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## STEPS

1. Scroll over Patient's Name > Create New Claim

**TEST, ANTHEA**  
[Patient Management](#)  
[View Health Record](#)  
[Comments](#)

Chart ID:  
WRS ID: **002-03-7153**  
SSN: **999-99-9999**  
DOB: **10/01/1990**  
Age: **29 year old**




123 Street  
SCHENECTADY, NY 12345  
(887) 123-4567  
antheatest@email.com

Primary Ins: **Medicare B, Policy #: PRIMARY INSURANCE, Group #:**  
Secondary Ins: **Anthem BCBS, Policy #: TEST, Group #:**


EMR:	Scheduling:	Billing:	Miscellaneous:
EMR All Notes	Make Appointment	Patient Account	Send Referral Letter
Create New Note	Appointment Recall	Most Recent Claim	Print Patient Forms
View Most Recent Note	Appointment Search	Patient Statement	Print Label
View Test Results		<b>Create New Claim</b>	
Continuity of Care Record		View Patient Claims	
Patient Health Maintenance			
Diet Calculator			

2. OR Right Click Patient's Name > Create New Claim

	Print Lab Requisition Make Appointment Appointment Recall Appointment Search View All Surgeries Schedule New Surgery Patient Account Patient Statement Billing Summary View Patient Claims Create New Claim Most Recent Claim Patient Health Maintenance Continuity of Care Record
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**Recently Viewed Patients**  
Test, Anthea   
Test, Christina

- This will populate a CMS 1500 with the patient's demographic and insurance information
- 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



Medicare B  
NGS  
PO BOX 4803  
SYRACUSE, NY 13221

CARRIER

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

PICA ☐ ☐

<b>1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA DLK LUNG OTHER</b> <input checked="" type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (TRICARE #) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)		<b>1a. INSURED'S I.D. NUMBER</b> (For Program in Item 1) 999999999A	
<b>2. PATIENT'S NAME</b> (Last Name, First Name, Middle Initial) TRAINING BILLING		<b>4. INSURED'S NAME</b> (Last Name, First Name, Middle Initial) TRAINING BILLING	
<b>3. PATIENT'S BIRTH DATE</b> MM DD YY SEX 01 01 1985 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		<b>7. INSURED'S ADDRESS</b> (No., Street) 2004 ROUTE 17M	
<b>5. PATIENT'S ADDRESS</b> (No., Street) 2004 ROUTE 17M		<b>6. PATIENT RELATIONSHIP TO INSURED</b> Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
<b>8. RESERVED FOR NUCC USE</b>		<b>7. INSURED'S ADDRESS</b> (No., Street) 2004 ROUTE 17M	
<b>9. OTHER INSURED'S NAME</b> (Last Name, First Name, Middle Initial) TRAINING BILLING		<b>11. INSURED'S POLICY GROUP OR FECA NUMBER</b>	
<b>10. OTHER INSURED'S POLICY OR GROUP NUMBER</b> XXX1234567890		<b>12. INSURED'S DATE OF BIRTH</b> MM DD YY SEX 01 01 1985 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
<b>11. RESERVED FOR NUCC USE</b>		<b>13. OTHER CLAIM ID</b> (Designated by NUCC) <input type="checkbox"/>	
<b>12. RESERVED FOR NUCC USE</b>		<b>14. INSURANCE PLAN NAME OR PROGRAM NAME</b> Medicare B	
<b>13. INSURANCE PLAN NAME OR PROGRAM NAME</b> Anthem BCBS		<b>15. CLAIM CODES</b> (Designated by NUCC)	

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 Signature on File DATE \_\_\_\_\_

SIGNED Signature on File

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

**EDIT PATIENT'S INSURANCE PROFILES**

CLAIM STATUS: NEW CLAIM [Print](#)

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

**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"/>	<a href="#">Detail</a>
Anthem BCBS PO Box 60007 Los Angeles, CA 90060-0007	Billing Training	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<a href="#">Detail</a>
AETNA 1 Debornshire Dr Easton, PA 18045-0001	Billing Training	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<a href="#">Detail</a>

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](#)

**Health Insurance Question**  
Please select the option that describes your insurance plan

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

[Continue](#) [Cancel](#)

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

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

PICA ☐ ☐ ☐

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (IDM/DOOM) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)	2. PATIENT'S NAME (Last Name, First Name, Middle Initial) TRAINING BILLING	3. PATIENT'S BIRTH DATE MM DD YY 01 01 1985	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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) 2004 ROUTE 17M	8. RESERVED FOR NUCC USE
CITY GOSHEN	STATE NY	CITY GOSHEN	STATE NY
ZIP CODE 10924	TELEPHONE (Include Area Code) (990) 999 - 9999	ZIP CODE 10924	TELEPHONE (Include Area Code) (990) 999 - 9999
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	11. INSURED'S POLICY GROUP OR FECA NUMBER	12. MEDICARE SECONDARY WORKING AGES BENEFICIARY OR SPOUSE WITH EMPLOYER GROUP HEALTH PLAN
13. OTHER INSURED'S POLICY OR GROUP NUMBER 999999999A	14. MEDICARE SECONDARY END-STAGE RENAL DISEASE BENEFICIARY IN THE MANDATED COORDINATION PERIOD WITH AN EMPLOYER'S GROUP HEALTH PLAN	15. MEDICARE SECONDARY WORKER'S COMPENSATION	16. MEDICARE SECONDARY PUBLIC HEALTH SERVICE (PHS) OR OTHER FEDERAL AGENCY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	18. MEDICARE SECONDARY BLACK LUNG	19. MEDICARE SECONDARY VETERAN'S ADMINISTRATION	20. MEDICARE SECONDARY DISABLED BENEFICIARY UNDER AGE 65 WITH LARGE GROUP HEALTH PLAN (LGHP)
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	21. MEDICARE SECONDARY OTHER LIABILITY INSURANCE IS PRIMARY	22. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	

**Signature on File**

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

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7. **Box 17** – choose the correct provider qualifier

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE TEST, ADMIN M DN-Referring Provider DK-Ordering Provider DQ-Supervising Provider												17a. NPI 1234567890		15. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		22. RESUBMISSION CODE		ORIGINAL REF. NO.							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 05 18 2018 05 18 2018 11												B. PLACE OF SERVICE 11		C. EMG 59214		D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS 25		E. DIAGNOSIS POINTER A		F. \$ CHARGES 300.00		G. DAYS ON UNITS 1		H. EP/OT 1		I. ID. QUAL. NPI		J. RENDERING PROVIDER ID #	
25. FEDERAL TAX I.D. NUMBER 260359751												SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE 300.00		29. AMOUNT PAID \$ 0		30. Paid for NUCC Use							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Supervising Provider: TEST PROVIDER Rendering Provider: TEST PROVIDER												32. SERVICE FACILITY LOCATION INFORMATION GOSHEN 123 MAIN GOSHEN NY 10924-1234		33. BILLING PROVIDER INFO & PH # (973 473 4040) ADVANCE ANKLE, FOOT AND PAIN 12345 COXVILLE BUILDING TAMPA FL 07010-1234															
NUCC Instruction Manual available at: www.nucc.org												PLEASE PRINT OR TYPE																	
APPROVED OMB-0938-1197 FORM 1500 (02-12)																													

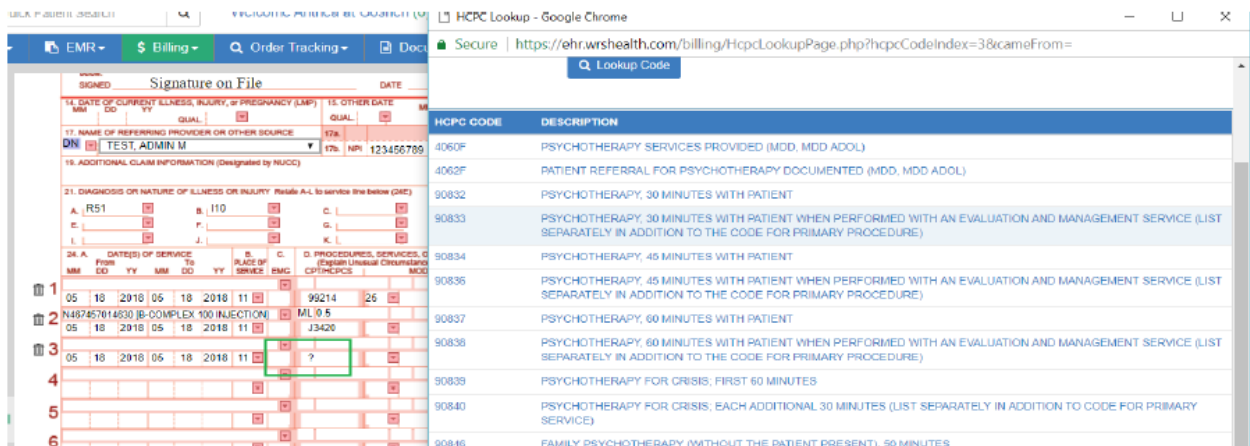
8. **Box 23** – you can enter the REFERRAL; AUTHORIZATION; CLIA# in this box
9. **Box 24** – above the Date of Service; click the dropdown above the DOS for the NDC Code

SIGNED _____ Signature on File												DATE _____												SIGNED _____ Signature on File											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL <input type="checkbox"/>												15. OTHER DATE QUAL <input type="checkbox"/> 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 <input type="checkbox"/> TEST, ADMIN M												17a. NPI 123456789												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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES												22. RESUBMISSION CODE ORIGINAL REF. NO.											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R51 B. C. D. E. F. G. H. I. J. K. L.												22. PRIOR AUTHORIZATION NUMBER												23. PRIOR AUTHORIZATION NUMBER											
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) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPOT Rev Pw I. ID. QUAL J. RENDERING PROVIDER ID. #																																			
1 05 18 2018 05 18 2018 11												99214 25 A 300.00 1 NPI																							
2 N467457014630 [B-COMPLEX 100 INJECTION] ML 0.5												J3420 A 20.00 1 NPI																							
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25. FEDERAL TAX I.D. NUMBER 260359751 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
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 GOSHEN 123 MAIN GOSHEN NY 10924-1234												33. 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												a. 123456789 b. 1841490061 c. 260359751											
NUCC Instruction Manual available at: www.nucc.org												PLEASE PRINT OR TYPE												APPROVED OMB-0938-1197 FORM 1500 (02-12)											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES												22. RESUBMISSION CODE ORIGINAL REF. NO.											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R51 B. C. D. E. F. G. H. I. J. K. L.												23. PRIOR AUTHORIZATION NUMBER												23. PRIOR AUTHORIZATION NUMBER											
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) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPOT Rev Pw I. ID. QUAL J. RENDERING PROVIDER ID. #																																			
1 05 18 2018 05 18 2018 11												99214 25 A 320.00 1 NPI																							
2 N467457014630 [B-COMPLEX 100 INJECTION] ML 0.5												J3420 A 20.00 1 NPI																							
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25. FEDERAL TAX I.D. NUMBER 260359751 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
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 GOSHEN 123 MAIN GOSHEN NY 10924-1234												33. 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												a. 123456789 b. 1841490061 c. 260359751											
NUCC Instruction Manual available at: www.nucc.org												PLEASE PRINT OR TYPE												APPROVED OMB-0938-1197 FORM 1500 (02-12)											



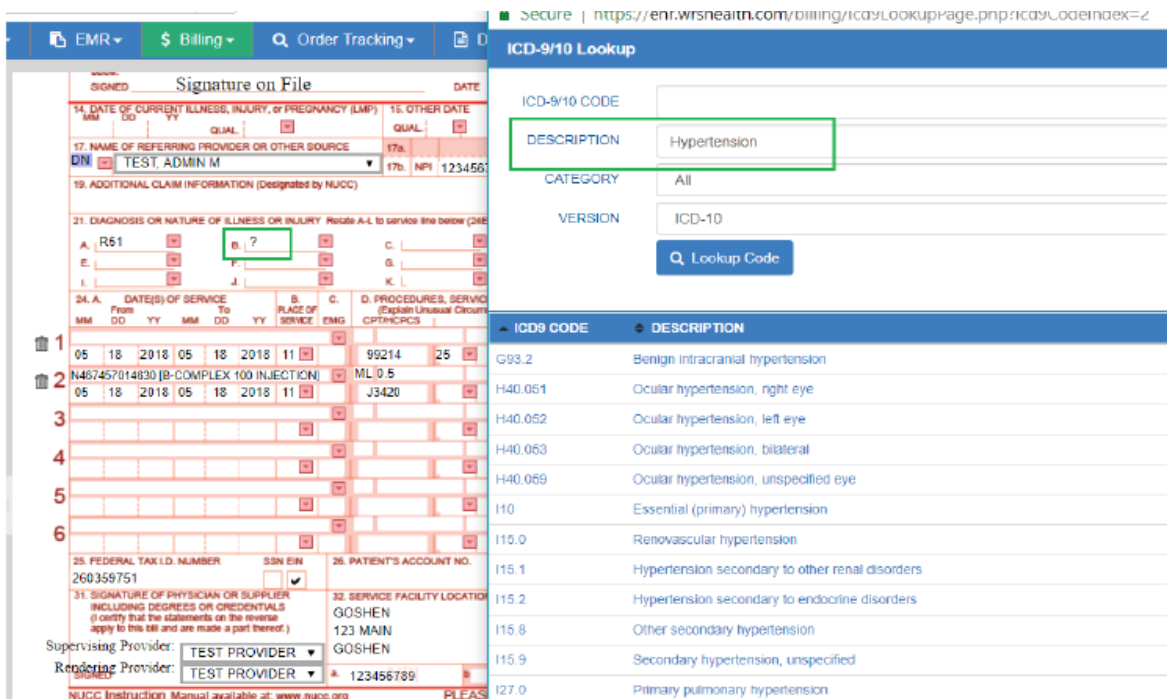
10. **Box 21** – ICD Code; type “?” to pull the ICD 9/10 Lookup

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



HCPC CODE	DESCRIPTION
4060F	PSYCHOTHERAPY SERVICES PROVIDED (MDD, MDD ADOL)
4062F	PATIENT REFERRAL FOR PSYCHOTHERAPY DOCUMENTED (MDD, MDD ADOL)
90832	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT
90833	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90834	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT
90835	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90837	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT
90838	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90839	PSYCHOTHERAPY FOR CRISIS, FIRST 60 MINUTES
90840	PSYCHOTHERAPY FOR CRISIS, EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)
90846	FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT), 50 MINUTES

12. Click **Verify and Submit Electronically** the system will ‘Verify’ by doing an LCD Check or Local coverage decision. This checks that the inputted CPT code can be used with the entered ICD code. It also puts the claim through the CCI (Correct Coding Initiative) edits and then submits it electronically send the claim to the clearinghouse



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

13. Click **Verify and Drop to Paper** It will print a black and white version of the CMS 1500 (You can also load the Red & White paper into your printer).

14. Click **Send to Hold Queue** to put claim on hold

25. FEDERAL TAX I.D. NUMBER 260359751	SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 10220570	27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE 320.00	29. AMOUNT PAID \$ 0	30. Revid 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.) Supervising Provider: TEST PROVIDER Rendering Provider: TEST PROVIDER		32. SERVICE FACILITY LOCATION INFORMATION GOSHEN 123 MAIN GOSHEN NY 10924-1234		33. BILLING PROVIDER INFO & PH # (973 473 4040) ADVANCE ANKLE, FOOT AND PAIN 12345 COXVILLE BUILDING TAMPA FL 07010-1234		
NUCC Instruction Manual available at: <a href="http://www.nucc.org">www.nucc.org</a>		PLEASE PRINT OR TYPE		APPROVED OMB-0938-1197 FORM 1500 (02-12)		

Verify and Submit Electronically

Verify and Drop To Paper

Send To Hold Queue

15. **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

6						PHYSI
25. FEDERAL TAX I.D. NUMBER 260359751	SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 10220570	27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE 320	29. AMOUNT PAID \$ 0	30. Revid 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.) Supervising Provider: TEST PROVIDER Rendering Provider: TEST PROVIDER		32. SERVICE FACILITY LOCATION INFORMATION GOSHEN 123 MAIN GOSHEN NY 10924-1234		33. BILLING PROVIDER INFO & PH # (973 473 4040) ADVANCE ANKLE, FOOT AND PAIN 12345 COXVILLE BUILDING TAMPA FL 07010-1234		
NUCC Instruction Manual available at: <a href="http://www.nucc.org">www.nucc.org</a>		PLEASE PRINT OR TYPE		APPROVED OMB-0938-1197 FORM 1500 (02-12)		

Claim #10220570 has been created and will be sent to the clearinghouse

Submit another claim



## NOTES

- All claims submitted during the day will be sent over to the clearinghouse at midnight