

Secondary Claims

Example of a Professional Secondary Claim For LOB other than Medicare Processed at Service Line Level

Please note that you will have to be signed up to transmit EDI Midwest commercial claims before you can transmit secondary claims for commercial carriers. In this example, the commercial payer is the line of business (LOB) being billed. This example shows how you would report a secondary claim with adjustment amounts at the line level instead of the claim level. You will need to verify with the secondary payer to determine if you need to report the adjustment amounts at the claim or the line levels.

The **LOB** selected will be the line of business you are submitting to for **this** claim.

Under the Patient Info & General tab: Must select **Y** for **COB**.

Professional Claim Form

Patient Info & General | Insured Information | Billing Line Items | Ext. Patient/General | Ext. Pat/Gen (2) | Ext. Payer/Insured

LOB: Billing Provider: 26 - Patient Control No.:

2 - Patient Last Name: First Name: MI: Gen: 3 - Birthdate: Sex: 8 - Pat. Status: Death Ind: 12 - Legal Rep.:

5 - Patient Address 1: Patient Address 2: Patient City: State: Patient Zip: Country: Patient Phone:

10 - Patient Condition Related To: Employment Accident ROI: ROI Date: Other Ins.: 14 - Date/Ind of Current: 15 - First Date: 16 - UTW/Disability Dates & Type: to

17 - Referring Phys Name (Last/Org, First, MI, Suffix): 17a - Referring Phys IDs/Types: 18 - Hospitalization Dates: to Y/N: 20 - Outside Lab/Chgs:

19 - Reserved For Local Use: 22 - Medicaid Resubmission Code & Ref No:

25 - Fed. Tax ID: SSN/EIN: 27 - Provider Accepts Assignment?: 33a - PIN No.:

31 - Provider SOF: Date: Facility?: Dental?: COB?: Frequency: 33b - GRP No.:

Click on **Insured Information** tab.

Professional Claim Form

Patient Info & General | **Insured Information** | Billing Line Items | Ext. Patient/General | Ext. Pat/Gen (2) | Ext. Payer/Insured

Sub	Payer ID	Payer Name	Insured's ID	P.Rel	Insured's Last Name	First Name	MI	Gen
<input type="checkbox"/>	47163	BCBS OF KANSAS	XSB123456789	19	DOE	JOHN	R	
<input type="checkbox"/>	12345	AETNA	456789123A	18	DOE	JANE	M	
<input type="checkbox"/>								

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Birthdate	Sex	Sig	AOB	Insured's Address 1	Insured's Address 2	Insured's City	State	Zip
01/28/1958	M	B	Y	1234 TEST WAY		TEST CITY	KS	12345-__
09/17/1930	F	B	Y	1234 TEST WAY		TEST CITY	KS	12345-__
/ /								

Country	Insured's Phone	ESC	Employer Name	Group Name	Group Number	
	()_-_-	9				<input type="button" value="Clear Payer"/>
	()_-_-					<input type="button" value="Clear Payer"/>
	()_-_-					<input type="button" value="Clear Payer"/>

Enter Primary Payer information on the first line. Enter the Secondary Payer information on the second line--this will be the payer being billed for the services.

NOTE: The check mark in the second Sub box will automatically populate once the claim has been saved.

Click on **Billing Line Items** tab.

Complete line item information and then select **MSP/COB (Line 1)**.

****Please note if there are multiple service lines on the claim, this screen will need to be completed for each service line.**

Complete **Service Line Adjudication Information** (Primary paid amount)

Complete **Line Level Adjustments**; i.e. Patient Responsibility; write-off/withhold amount; contractual obligation; bundled services, etc.

The Service Line Adjudication + The Line Adjustments = the submitted charges.

In this example: Paid \$55.00 + Patient Responsibility \$15.00 + \$20.00 + Contractual Obligation \$10.00 = \$100.00

Complete the **Adj/Payment Date**.

Claim Level Adjustments (S)					COB / MOA Amounts		
Num	Group	Reason	Amount	Units	Num	Code	Amount
1					1	D	55.00
2					2	B6	90.00
3					3		

****Repeat the above steps for any additional service lines.**

Click on the **Ext. Payer/Insured tab** and then click on the **COB Info (Primary)** tab.

Complete **COB/MOA Amounts** (This is the total processed on the entire claim by the Primary insurance). These fields may not be required by all payers but are available if needed.

Once the necessary information has been completed correctly, click on **Save**.

Example of a Professional Secondary Claim For LOB other than Medicare Processed at Claim Level

Please note that you will have to be signed up to transmit EDI Midwest commercial claims before you can transmit secondary claims for commercial carriers. This example shows how you would report a secondary claim with adjustment amounts at the claim level instead of the line level. This would be used when the Primary Payer processed and paid one amount for all services lines. You will need to verify with the secondary payer to determine if you need to report the adjustment amounts at the claim or the line levels.

The **LOB** selected will be the line of business you are submitting to for **this** claim.

Under the Patient Info & General tab: Must select **Y** for **COB**.

Professional Claim Form

Patient Info & General | Insured Information | Billing Line Items | Ext. Patient/General | Ext. Pat/Gen (2) | Ext. Payer/Insured

LOB: **BS** Billing Provider: 123456 25 - Patient Control No.: 123

2 - Patient Last Name: DOE First Name: JANE MI: R Gen: 3 - Birthdate: 03/31/1982 Sex: F 8 - Pat. Status: MS ES SS: S T N Death Ind: 12 SOF: B Legal Rep.: N

5 - Patient Address 1: 1234 TEST ST Patient Address 2: Patient City: TEST CITY State: KS Patient Zip: 12345- Country: Patient Phone: () -

10 - Patient Condition Related To: Employment: N Accident: N ROI: Y ROI Date: 01/01/2004 Other Ins.: 1 14 - Date/End of Current: 15 - First Date: 16 - UTW/Disability Dates & Type: to

17 - Referring Phys Name (Last/Orig, First, MI, Suffix): 17a - Referring Phys IDs/Types: 18 - Hospitalization Dates: to Y/N: 0.00

19 - Reserved For Local Use: 22 - Medicaid Resubmission Code & Ref No:

25 - Fed. Tax ID: 481234567 SSN/EIN: E 27 - Provider Accepts Assignment?: A 33a - PIN No.: 31 - Provider SOF: Y Date: 01/01/2005 Facility?: Dental?: COB?: **Y** Frequency: 33b - GRP No.: 123456

↑

Save Close

Click on the **Insured Information** tab.

Professional Claim Form

Patient Info & General | **Insured Information** | Billing Line Items | Ext. Patient/General | Ext. Pat/Gen (2) | Ext. Payer/Insured

Sub	Payer ID	Payer Name	Insured's ID	6 P.Rel	Insured's Last Name	First Name	MI	Gen
<input type="checkbox"/>	61101	HUMANA CLAIMS OFFICE	123456789	18	DOE	JANE	R	
<input checked="" type="checkbox"/>	47163	BLUE CROSS BLUE SHIELD O	XSB8831321251	01	DOE	JOHN		
<input type="checkbox"/>								

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Birthdate	Sex	Sig	AOB	Insured's Address 1	Insured's Address 2	Insured's City	State	Zip
03/31/1982	F	B	Y	1234 TEST ST		TEST CITY	KS	12345-
05/28/1980	M	B	Y	1234 TEST ST		TEST CITY	KS	12345-
/ /								

Country	Insured's Phone	ESC	Employer Name	Group Name	Group Number	
	() -					Clear Payer
	() -					Clear Payer
	() -					Clear Payer

Save Close

Enter the Primary Payer information on the first line. Enter the Secondary Payer information on the second line—this will be the payer being billed for the services.

NOTE: The check mark in the second Sub box will automatically populate once the claim has been saved.

Complete the line item information as needed and then click on the **Ext. Payer/Insured** tab.

Professional Claim Form

Patient Info & General | Insured Information | **Billing Line Items** | Ext. Patient/General | Ext. Pat/Gen (2) | Ext. Payer/Insured

Line Item Details | Extended Details (Line 1) | Ext Details 2 (Line 1) | Ext Details 3 (Line 1) | MSP/COB (Line 1)

Diagnosis Codes (1 - 8): 7395

LN	24a - Service Dates From	24a - Service Dates Thru	24b PS	24c EMG	24d Proc	24d - Modifiers 1	24d - Modifiers 2	24e Diagnosis	24f Charges	24g Units	24h EP	24h FP	24h AT	24j Rendering Phys.
1	10/01/2009	10/01/2009	11		99221			1	100.00	1.0				
2														
3														
4														
5														
6														

28 - Total Charge: 100.00 Recalculate 29 - Amount Paid: 0.00 30 - Balance Due: 100.00

Error List Save With Fatal Save Cancel

Click on the **COB Info (Primary)** tab to enter the information specific to the adjudication information received on the primary payer’s Remittance Advice

Professional Claim Form

Patient Info & General | Insured Information | Billing Line Items | Ext. Patient/General | Ext. Pat/Gen (2) | Ext. Payer/Insured

Primary Payer/Insured | Secondary Payer/Insured | Tertiary Payer/Insured | **COB Info (Primary)** | COB Info (Secondary)

Common Payer MSP Information

OTAF: 0.00 Zero Payment Ind:

Additional Adjustment / COB Amounts / MOA Information (ANSI-837 Only)

Claim Level Adjustments (CAS)					COB / MOA Amounts		
Num	Group	Reason	Amount	Units	Num	Code	Amount
1					★	B6	55.00
2					2	D	35.00
3					3	F2	20.00

Medicare Outpatient Adjudication (MOA) Remarks Codes

Claim Adjudication Date: 06/01/2008

Save Close

★ Complete the Claim Level Adjustments, if needed ie; patient Responsibility, Write-off/Withhold amount; Contractual Obligation; Bundled Services, etc.

★ Complete the **COB/MOA Amounts**

In this example, the amount charged was \$55.00. The primary payer allowed \$55.00, paid \$35.00, and applied \$20.00 to the patient's co-pay.

The information entered on this screen applies to the entire claim.

Enter the **Claim Adjudication Date**.

Once the necessary information has been completed correctly, click on **Save**.

Example of Institutional Secondary Claim For LOB other than Medicare

The following is an example where the COB information should be entered to send a secondary claim, other than Medicare.

The **LOB** selected will be the line of business you are submitting to for **this** claim.

Complete this screen as needed.

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Info | Diagnosis/Procedure | Diag/Proc (2) | Extended General | Ext. General (2) | Extended Payer

LOB: **BC** | FL 1 | FL 2 | Patient Control No.: 123456 | Type of Bill: 111

Patient Last Name: DOE | First Name: JANE | MI: R | Suffix: | Fed Tax ID: 456789123 | Statement Covers Period: 03/02/2009 - 03/05/2009

Patient Address 1: 1234 TEST WAY | Patient Address 2: | Patient City: TEST CITY | State: KS | Patient Zip: 12345- | Country: | Patient Phone: (123) 456-7891 | FL 38

Birthdate: 03/31/1962 | Sex: F | MS: S | Admission: 03/02/2009 | HR Type: 12 | SRC: 2 | D HR: 9 | Stat: 11 | 09 | Medical Record No.: 12345 | Condition Codes: | | | | | | | | | |

Occurrence		Occurrence		Occurrence		Occurrence		Occurrence Span		Occurrence Span			
Code	Date	Code	Date	Code	Date	Code	Date	Code	From	Thru	Code	From	Thru

Value		Value		Value		Value		Value		Value	
Code	Amount	Code	Amount	Code	Amount	Code	Amount	Code	Amount	Code	Amount

Save Cancel

Click on the **Billing Line Items** tab

Institutional Claim Form

Patient Info & Codes | **Billing Line Items** | Payer Info | Diagnosis/Procedure | Diag/Proc (2) | Extended General | Ext. General (2) | Extended Payer

Line Item Details | Extended Details (Line 1) | Ext Details 2 (Line 1) | MSP/COB (Line 1)

LN	42 Rev.Cd.	44 HCPCS	44 - Modifiers				44 Rate	45 - Service Date		46 Units/Days	47 Total Charges	48 Non-Cov Charges
			1	2	3	4		From Date	Thru Date			
1	0120						400.00	03/02/2009	03/05/2009	3	2170.00	0.00
2												
3												
4												
5												
6												
7												
8												

Recalculate Totals: 2170.00 0.00

Save Cancel

Complete the **Line Items Details** screen as needed with the appropriate information.

Click on the **Payer Information** tab.

Sub	Payer ID	Payer Name	Provider No.	ROI	AOB	Prior Payments	Amount Due	
<input type="checkbox"/>	12345	PRIMARY INSURANCE CO	456789123	Y	Y	0.00	0.00	Clear Payer
<input type="checkbox"/>	47163	BCBS OF KANSAS	123456	Y	Y	0.00		Clear Payer
<input type="checkbox"/>								Clear Payer

Due From Patient >> 0.00 0.00

P.Rel	Insured's Last/Org Name	First Name	MI	Suffix	Insured's ID	Group Name	Group Number
01	DOE	JOHN	S		123659870		
18	DOE	JANE	R		XSA123456789		

Authorization Code / Type	ESC	Employer Name

Save Cancel

Enter the primary payer provider and insured information on the first line, and then enter the provider and payer information for Blue Cross of Kansas on the second line.

NOTE: The check mark in the second Sub box will automatically populate once the claim has been saved.

Click on the **Diagnosis/Procedure** tab.

DX/PC Principal Diag.

Diagnosis Codes (1 - 17)

Admitting Diagnosis Patient's Reason For Visit Codes (1 - 3) External Cause of Injury Codes (1 - 3) PPS/DRG

Principal Proc Code/Date Other Procedure Codes/Dates (1 - 5) NPI Exempt POA Type COB2 LH, CR6?

Remarks

Type	Last/Org Name	First Name	MI	Suffix	Provider IDs / Types
ATT					
DPR					
OTH					

Save Cancel

Complete the **Diagnosis/Procedure** screen, as necessary with the appropriate information.

★ Make sure that you enter a 'Y' in the **COB?** field.

Click on the **Extended Payer** tab.

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Info | **Diagnosis/Procedure** | Diag/Proc (2) | Extended General | Ext. General (2) | **Extended Payer**

Primary Payer | Secondary Payer | Tertiary Payer | COB Info (Primary) | COB Info (Secondary)

Primary Payer | **Secondary Payer** | **Tertiary Payer** | **COB Info (Primary)** | **COB Info (Secondary)**

Payer Address & Miscellaneous

Address: []

City/St/Zip: [] [] []

Payer Source Code: [] Provider Accepts Assign: []

Provider SDF: []

ICN/DCN: []

Add'l Ref No/Type: [] []

Add'l Ref No/Type: [] []

Insured Address & Miscellaneous

Address: 1234 TEST WAY

City/St/Zip: TEST CITY KS 12345- []

Country: [] Birthdate: 06/01/1963 Sex: M

Patient ID: []

Investigational Device Exemption (IDE) Numbers

IDE No. 1: []

IDE No. 2: []

IDE No. 3: []

Save Cancel

Under the Primary Payer tab, the insured's birthdate and sex needs to be completed in the **Insured Address & Miscellaneous** section.

Select **COB Info (Primary)**

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Info | Diagnosis/Procedure | Diag/Proc (2) | Extended General | Ext. General (2) | Extended Payer

Primary Payer | Secondary Payer | Tertiary Payer | **COB Info (Primary)** | COB Info (Secondary)

Claim Adjustments / COB Amounts / MIA - MDA Information (ANSI-837 Only)

Claim Level Adjustments (CAS)

Num	Group	Reason	Amount	Units
★ 1	PR	3	700.00	1.000
2				
3				

COB / MIA / MDA Amounts

Num	Code	Amount
★ 1	B6	2170.00
2	C4	1470.00
3		

Medicare Inpatient Adjudication (MIA) Remarks Codes

Medicare Outpatient Adjudication (MOA) Remarks Codes

Claim Adjudication Date: 03/23/2009 ★

Save Cancel

From the **Extended Payer** screen, click on the **COB Info (Primary)** tab to enter the information specific to the adjudication information received on the primary payer's Remittance Advice.

In this example, the amount charged was \$2170.00. The primary payer allowed \$2170.00, paid \$1470.00, and applied \$700.00 to the patient's co-pay. The information entered on this screen will be for the entire claim and not for each line item.

Enter the **Claim Adjudication Date**.

Once the necessary information has been completed correctly, click on **Save**.