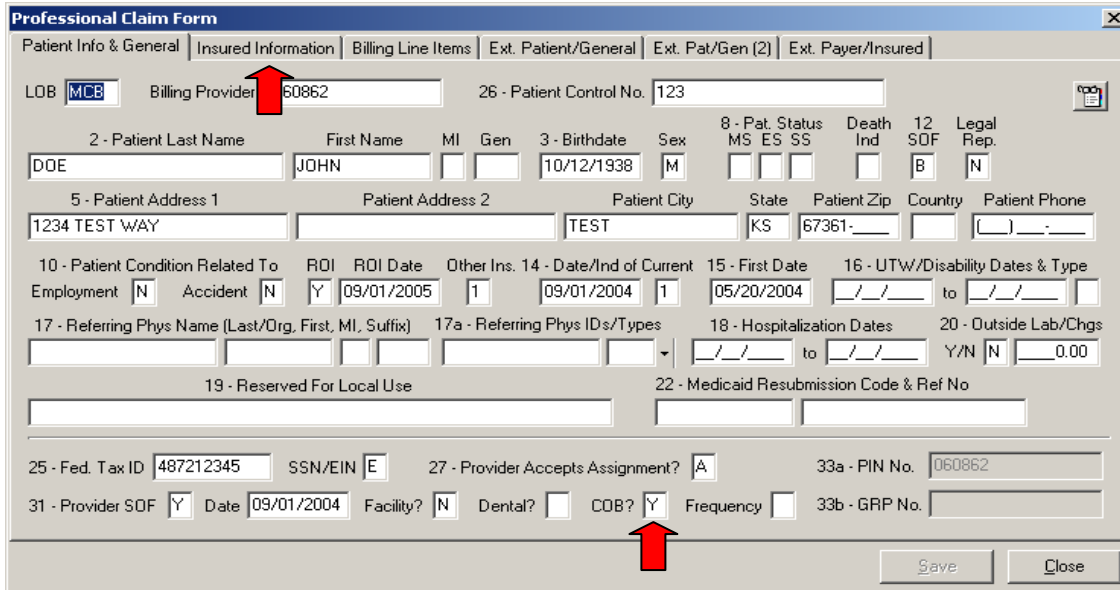


Secondary Claims

Example of an MSP Claim (Professional-Processed at Service Line Level)



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: MS ES SS Death Ind: 12 SOF: 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:

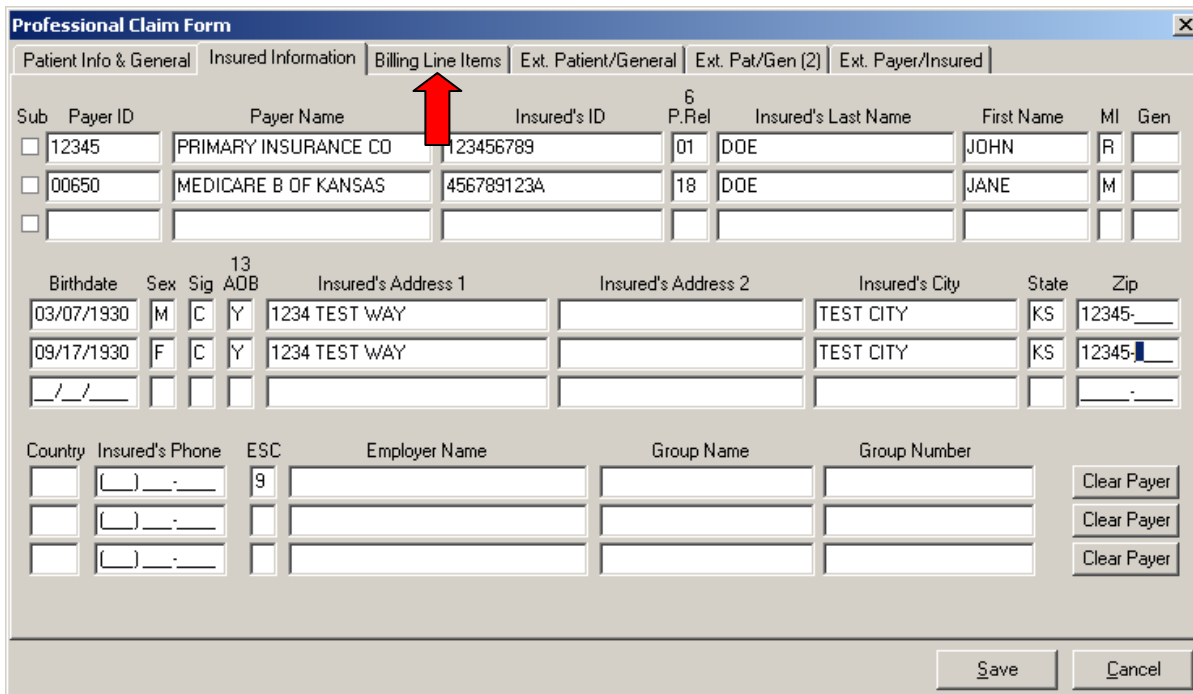
19 - Reserved For Local Use: 22 - Medicaid Resubmission Code & Ref No:

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

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

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

Must select **Y** for **COB**. 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	6 P.Rel	Insured's Last Name	First Name	MI	Gen
<input type="checkbox"/>	12345	PRIMARY INSURANCE CO	123456789	01	DOE	JOHN	R	
<input type="checkbox"/>	00650	MEDICARE B OF KANSAS	456789123A	18	DOE	JANE	M	
<input type="checkbox"/>								

13

Birthdate	Sex	Sig	AOB	Insured's Address 1	Insured's Address 2	Insured's City	State	Zip
03/07/1930	M	C	Y	1234 TEST WAY		TEST CITY	KS	12345-
09/17/1930	F	C	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 Medicare information on the second line.

Click on **Billing Line Items** tab.

LN	24a - Service Dates From	24a - Service Dates Thru	24b PS	24c TS	24d Proc	24d - Modifiers 1	24d - Modifiers 2	24e Diagnosis	24f Charges	24g Units	EP	FP	EM	CB	AT	Rendering Physician
1	08/01/2004	09/01/2004	11		98941			1	32.00	1.0						
2	09/01/2004	09/01/2004	11		98941			1	32.00	1.0						
3	/ /	/ /														
4	/ /	/ /														
5	/ /	/ /														
6	/ /	/ /														

28 - Total Charge: 64.00 Recalculate 29 - Amount Paid: 0.00 30 - Balance Due: 64.00

Complete line item information and then select **MSP/COB (Line 1)**. Please note--if there are multiple service lines on the claim, these screens will need to be completed for each service line.

Common Line MSP Amounts

Approved: 50.00

OTAF: 50.00

Additional Line-level Adjudication / COB Information (ANSI-837 Use Only)

Service Line Adjudication (SVD) Information

SVD	P/S	Proc. Qual / Code	Modifiers 1 thru 4	Paid Amount	Paid Units	B/U Line
1	P	HC 90791		100.98	1.000	
2						
3						

Line Adjustment (CAS) & Miscellaneous Adjudication Info (for SVD 1 above)

Procedure Code Description: [] Line Level Adjustments (CAS)

Num	Group	Reason	Amount	Units
1	CO	45	23.00	1.000
2				
3				

Adj/Payment Date: 08/01/2015

Remaining Owed: 0.00

Complete **Approved** (Allowed or Approved amount from Primary EOB), **OTAF** (Obligated to accept field)

Complete **Service Line Adjudication Information** (Primary paid amount). If no payment was made, please enter a zero dollar amount in this field to indicate no payment made.

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 \$23.00 + Patient Responsibility \$5.00 + Contractual Obligation \$4.00 = \$32.00

Complete the **Adj/Payment Date**.

****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.

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

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					1	D	241.93
2					2		
3					3		

Medicare Outpatient Adjudication (MOA) Remarks Codes

Claim Adjudication Date

Save Close

Complete the **Insurance Type** and the **Zero Payment Ind** fields.

Complete **COB/MOA Amounts** (Enter the total amount paid on the entire claim).

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

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.

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: MS ES SS 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 SDF: Date: Facility?: Dental?: COB?: Frequency: 33b - GRP No.:

Must select **Y** for **COB**.

Click on **Insured Information** tab.

Professional Claim Form

Patient Info & General | **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"/>								

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				Clear Payer
	()__-__					Clear Payer
	()__-__					Clear Payer

Save Cancel

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.

Click on **Billing Line Items** tab.

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

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

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

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

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**.

****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.

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

Zero Payment Ind

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

Claim Level Adjustments (ANSI-837)					COB / MOA Amounts		
Num	Group	Reason	Amount	Units	Num	Code	Amount
1					1	D	241.93
2					2		
3					3		

Medicare Outpatient Adjudication (MOA) Remarks Codes

--	--	--	--	--

Claim Adjudication Date

Save Close

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.

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 | 26 - 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: S | 1 | N | Death Ind: | 12 SDF: 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/Org., First, MI, Suffix): | 17a - Referring Phys IDs/Types: | 18 - Hospitalization Dates: to | 20 - Outside Lab/Chgs: 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 SDF: Y | Date: 01/01/2005 | Facility?: | Dental?: | COB?: Y | Frequency: | 33b - GRP No.: 123456

Buttons: Save, Close

Select **Y** in the **COB** field.

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	P.Rel	Insured's Last Name	First Name	MI	Gen
<input type="checkbox"/>	51101	HUMANA CLAIMS OFFICE	123456789	18	DOE	JANE	R	
<input checked="" type="checkbox"/>	47163	BLUE CROSS BLUE SHIELD O	XSB831321251	01	DOE	JOHN		
<input type="checkbox"/>								

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
	() - -	<input type="checkbox"/>			
	() - -	<input type="checkbox"/>			
	() - -	<input type="checkbox"/>			

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.

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) | MSP/COB (Line 1)

Claim Diagnosis Codes: 1 78900 2 3 4 5 6 7 8

LN	24a - Service Dates From	24a - Service Dates Thru	24b PS	24c TS	24d Proc	24d - Modifiers 1	24d - Modifiers 2	24e Diagnosis	24f Charges	24g Units	EP	FP	EM	CB	AT	Rendering Physician
1	10/01/2005	10/01/2005	11		99213			1	55.00	1.0						654321
2	/ /	/ /														
3	/ /	/ /														
4	/ /	/ /														
5	/ /	/ /														
6	/ /	/ /														

28 - Total Charge 55.00 Recalculate

29 - Amount Paid 0.00 30 - Balance Due 55.00

Save Close

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 | **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

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	PR	3	20.00	1.000	1	D	241.93
2					2		
3					3		

Medicare Outpatient Adjudication (MOA) Remarks Codes

Claim Adjudication Date

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.

Complete the Claim Level Adjustments, 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 an MSP Paid claim (Institutional)

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

Institutional Claim Form

Patient Info & Codes | **Billing Line Items** | Payer Information | Diagnosis/Procedure | Extended Patient/General | Extended Payer

LOB: MCA | **FL 1** | FL 2 | 3 - Patient Control No. 123 | 4 - Type of Bill 121

12 - Patient Name (Last, First, MI): DOE | JOHN | 5 - Fed Tax ID: 123456789 | 6 - Statement Covers Period: 09/01/2004 - 09/03/2004 | Cov D: 2 | N-C-D: 0 | C-I-D: 0 | L-R-D: 0 | FL 11

13 - Patient Address 1: 231 APPLE ST | Patient Address 2: | Patient City: TOPEKA | State: KS | Patient Zip: 66611- | Country: | Patient Phone: () - - | FL 31 | FL 38

14 - Birthdate: 10/04/1931 | Sex: M | MS: M | Admission: 09/01/2004 | HR Type: 22 | SRC: 1 | D: 7 | HR Stat: 01 | 23 - Medical Record No.: 123456789 | 24 - Condition Codes: | | | | | | | | | |

32 - Occurrence Code	32 - Occurrence Date	33 - Occurrence Code	33 - Occurrence Date	34 - Occurrence Code	34 - Occurrence Date	35 - Occurrence Code	35 - Occurrence Date	36 - Occurrence Code	36 - Occurrence Span From	36 - Occurrence Span Thru	36 - Occurrence Code	36 - Occurrence Span From	36 - Occurrence Span Thru
11	09/01/2004												

39 - Value Code	39 - Value Amount	40 - Value Code	40 - Value Amount	41 - Value Code	41 - Value Amount	39 - Value Code	39 - Value Amount	40 - Value Code	40 - Value Amount	41 - Value Code	41 - Value Amount
47	75.00										

Save Cancel

You must fill out the necessary fields required within PC-ACE. This example just happens to be for an inpatient claim.

Click on **Billing Line Items** tab

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					
1	0809	99214					0.00	09/01/2004	1	150.00	0.00
2											
3											
4											
5											
6											
7											
8											

Recalculate Totals: 150.00 0.00

Save Cancel

You must fill out the service line information.

Click on **Payer Information** tab.

FL56

Sub	50 Payer ID	50 Payer Name	51 Provider No.	52 ROI	53 AOB	54 Prior Payments	55 Amount Due
<input type="checkbox"/>	60054	AETNA	123456	Y	Y	0.00	0.00
<input checked="" type="checkbox"/>	00150	MEDICARE A OF KANSAS	170001	Y	Y	0.00	0.00
<input type="checkbox"/>							

FL57 Due From Patient >> 0.00 0.00

P.Rel	58 - Insured's Name (Last, First, MI)	60 - Insured's ID	61 - Group Name	62 - Group Number
18	DOE JOHN	654123		080000
18	DOE JOHN	321456789A		

63 - Authorization Code / Type	ESC	65 - Employer Name	66 - Employer Address	City	State	Zip
	5					

Save Cancel

Enter Primary Payer information on the first line.

Enter Medicare Payer information on the second line.

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

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

Institutional Claim Form

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

DX/PC Principal Diag. _____ Other 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) _____ POA Type COB? Y H.H. CR6?

Remarks _____

Supporting Provider Information

Type	Last/Org Name	First Name	MI	Suffix	Provider IDs / Types
ATT	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
OPR	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTH	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Save Cancel

You must select a **Y** for a **COB**.

Select the **Extended Payer** tab.

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Information | Diagnosis/Procedure | Extended Patient/General | Extended Payer

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

Payer Address & Miscellaneous

Address _____

City/St/Zip _____

Cov D N-C D C-I D L-R D

Payer Source Code Claim Office Number _____

Payer Indicator Contractor ID _____

Provider SOF Provider Accepts Assign

37a - ICN/DCN _____

Reference Number/Type _____

Insured Address & Miscellaneous

Address 1234 TEST WAY

City/St/Zip TEST CITY KS 12345-____

Country _____ Birthdate 06/24/1958 Sex M

Patient ID _____

Extended Authorization / IDE Information (34 Record)

Set 1 | Set 2 | Set 3

Type Auth/IDE Num _____

Treatment Authorization Period _____ thru _____ Rev Code _____

HCPCS _____

Save Cancel

The primary insured's birth date 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 Information | Diagnosis/Procedure | Extended Patient/General | Extended Payer

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

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

Claim Level Adjustments (CAS)					COB / MIA / MOA Amounts		
Num	Group	Reason	Amount	Units	Num	Code	Amount
1	CO	2	50.00	1.0	1	C4	100.00
2					2		
3					3		

Medicare Inpatient Adjudication (MIA) Remarks Codes

Medicare Outpatient Adjudication (MOA) Remarks Codes

Claim Adjudication Date: 09/10/2004

Save Close

Complete **Claim Level Adjustments (CAS)** (Primary paid amount).

Complete **COB/MIA/MOA Amounts** (This is the total amount paid on all service lines by the Primary insurance).

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, then click on the **Billing Line Items** tab.

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Information | Diagnosis/Procedure | Extended Patient/General | Extended Payer

LOB FL 1 FL 2 3 - Patient Control No. 123456 4 - Type of Bill 111

12 - Patient Name (Last, First, MI) 5 - Fed Tax ID 6 - Statement Covers Period Cov D N-C-D C-I-D L-R-D
DOE JANE R 10/01/2005 10/07/2005 0 0 0 0 FL 11

13 - Patient Address 1 Patient Address 2 Patient City State Patient Zip Country Patient Phone
1234 TEST WAY TEST CITY KS 12345- Country () - () -

FL 31 FL 38

14 - Birthdate Sex MS Admission HR Type SRC D HR Stat 23 - Medical Record No. 24 - Condition Codes
03/31/1982 F S 10/01/2005 13 2 9 11 01 12345

32 - Occurrence Code	32 - Occurrence Date	33 - Occurrence Code	33 - Occurrence Date	34 - Occurrence Code	34 - Occurrence Date	35 - Occurrence Code	35 - Occurrence Date	36 - Occurrence Code	36 - Occurrence From	36 - Occurrence Thru	36 - Occurrence Code	36 - Occurrence From	36 - Occurrence Thru
	///		///		///		///		///	///		///	///
	///		///		///		///		///	///		///	///

39 - Value Code	39 - Value Amount	40 - Value Code	40 - Value Amount	41 - Value Code	41 - Value Amount	39 - Value Code	39 - Value Amount	40 - Value Code	40 - Value Amount	41 - Value Code	41 - Value Amount

Save Cancel

Institutional Claim Form

Patient Info & Codes | **Billing Line Items** | Payer Information | Diagnosis/Procedure | Extended Patient/General | Extended Payer

Line Item Details | Extended Details (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						310.00	10/01/2005	10/07/2005	7	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.

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Information | Diagnosis/Procedure | Extended Patient/General | Extended Payer

Sub	50 Payer ID	50 Payer Name	51 Provider No.	52 ROI	53 AOB	54 Prior Payments	55 Amount Due	
<input type="checkbox"/>	12345	PRIMARY INSURANCE CO	481234567	Y	Y	0.00	0.00	Clear Payer
<input checked="" type="checkbox"/>	47163	BLUE CROSS OF KANSAS	001234	Y	Y	0.00	0.00	Clear Payer
<input type="checkbox"/>								Clear Payer

FL56

Due From Patient >> 0.00 0.00

FL57

P.Rel	58 - Insured's Name (Last, First, MI)			60 - Insured's ID	61 - Group Name	62 - Group Number
19	DOE	JOHN	R	123659870		
18	DOE	JANE	R	XSA811511311		

63 - Authorization Code / Type	ESC	65 - Employer Name	66 - Employer Address	City	State	Zip

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.

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

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

Institutional Claim Form

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

DX/PC Principal Diag. Other 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) POA Type COB? H.H. CR6?

Remarks Supporting Provider Information

Type	Last/Org Name	First Name	MI	Suffix	Provider IDs / Types
ATT					
OPR					
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 Information | **Diagnosis/Procedure** | Extended Patient/General | **Extended Payer**

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

Payer Address & Miscellaneous Insured Address & Miscellaneous

Address City/St/Zip Cov D N-C D C-I D L-R D Payer Source Code Claim Office Number Payer Indicator Contractor ID Provider SOF Provider Accepts Assign 37a - ICN/DCN Reference Number/Type

Address City/St/Zip Country Birthdate Sex Patient ID

Extended Authorization / IDE Information (34 Record)

Set 1 Set 2 Set 3 Type Auth/IDE Num Treatment Authorization Period Rev Code HCPCS

Save Cancel

The primary insured's birthdate and sex needs to be completed in the **Insured Address & Miscellaneous** section.

Select **COB Info (Primary)**

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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)					COB / MIA / MDA Amounts		
Num	Group	Reason	Amount	Units	Num	Code	Amount
1	PR	3	700.00	1.0	1	B6	2170.00
2					2	C4	1470.00
3					3		

Medicare Inpatient Adjudication (MIA) Remarks Codes

Medicare Outpatient Adjudication (MDA) Remarks Codes

Claim Adjudication Date: 10/15/2005

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**.