

Payerpath CMS-1500 Training

EDI Coordinator



Nevada Medicaid Provider Training



What will be covered...

- **Benefits of electronic claim submission**
- **Required enrollment forms**
- **Submission contact information**
- **Signing on to Allscripts-Payerpath**
- **Creating and viewing claims**
- **Submitting a CMS-1500 claim form**
- **Copy claims feature**
- **View the remittance advice**



Electronic Data Interchange (EDI)

- Eliminates supply costs
 - Preprinted forms
 - Envelopes and postage
 - Allscripts-Payerpath claim submission is free
- Eliminates time-consuming processes and reduces claim errors
 - Document sorting and filing
 - Built-in validation checks
- Quicker processing and notification
 - Check claim status within 48 hours of submission

EDI Enrollment Documents



Nevada Departments of Health and Human Services
Division of Health Care Financing and Policy Provider Portal

[Contact Us](#) [DHCFP Home](#)

[Home](#) [Providers](#) [EVS](#) [Pharmacy](#) [Prior Authorization](#) [Quick Links](#) [Calendar](#)

[Announcements](#) [Latest News](#)

[Web Announcement 1258](#)
Reminders for Provider Types 64 and 65 Regarding Hospice Forms

[Web Announcement 1257](#)
Outpatient Physician-Administered Drug Claims That Denied or Voided with Edit Code 0162 to be Reprocessed

[Web Announcement 1256](#)
Attention All Providers: New Form for Requesting Termination of Service with Existing Provider

[Web Announcement 1255](#)
Payerpath Claim Submission Training for November 2016

[Web Announcement 1254](#)
2016 Annual Medicaid Conference Presentations and Survey

[View All Web Announcements](#)

Featured Links

[Authorization Criteria](#)

[DHCFP Home](#)

[EDI Enrollment Forms and Information](#)

[EVS User Manual](#)

[Online Provider Enrollment](#)

[Provider Login \(EVS\)](#)

Electronic Claims / EDI

Electronic billing (also called Electronic Data Interchange or "EDI") speeds payment and eliminates costs associated with paper claims. You can submit electronic claims through a clearinghouse or through your existing, HIPAA-compliant business management software.

If you have any questions, please contact our EDI Coordinator at:
 Telephone: (775) 638-3472
 Fax: (775) 635-8502

EDI Enrollment Forms

EDI enrollment forms are for completion and submission by active or enrolling Nevada Medicaid and Nevada Check Up providers only.

Form Number	Title
FA-35	Electronic Transaction Agreement for Service Centers
FA-36	Service Center Operational Information
FA-37	Service Center Authorization
FA-39	Payerpath Enrollment

EDI Announcements

Title	Date
Payerpath Claim Submission Training for November 2016	Oct. 24, 2016
Payerpath Claim Submission Training for October 2016	Sept. 29, 2016
Payerpath Claim Submission Training for September 2016	Sept. 1, 2016
Payerpath Claim Submission Training for August 2016	July 19, 2016
Payerpath Claim Submission Training for July 2016	June 24, 2016

Notifications

[Enrollment Termination](#)
[Frequently Asked Questions \(FAQs\)](#) [\[Review\]](#)

If you are a Medicaid provider whose revalidation application has not been processed by your termination due date, you will not have access to the Provider Web Portal the day after your termination date. This will prevent any prior authorizations (PAs) from being submitted for approval. Please ensure that you have submitted your revalidation application to Hewlett Packard Enterprise at least 10 business days prior to your termination date to ensure that your application is processed on time.

Provider Links

[Billing Information](#)

[E-Prescribing](#)

[Forms](#)

[Provider Enrollment](#)

[Provider Newsletters](#)

[Provider Training](#)



Allscripts-Payerpath Enrollment Documents

- Enrolled providers may submit electronic Nevada Medicaid and Nevada Check Up claims free of charge through Allscripts-Payerpath.
- Simply complete Service Center Authorization form (FA-37) and the Allscripts-Payerpath Enrollment form (FA-39) located on the Electronic Claims/EDI webpage and submit your documents for processing.



Required Registration Forms

- Enrollment forms for Allscripts-Payerpath: www.medicaid.nv.gov
- Send in one FA-37 (Service Center Authorization) form for each Group National Provider Identifier/Atypical Provider Identifier (NPI/API) unless billing each rendering provider as an individual

AND

- Send in one FA-39 (Payerpath Enrollment) form and include the names of all those who will be using this Payerpath account

Form Submission and Contact Information

- Completed registration forms are to be mailed to:
Nevada Medicaid
P.O. Box 30042
Reno, Nevada 89520-3042
- Faxed to: 775-335-8502
- Emailed to: NVMMIS.EDIsupport@dxc.com
- Upload forms to: www.medicaid.nv.gov then login to Electronic Verification System (EVS) website to upload documents
- For assistance, call 1-877-638-3472, option 2, select then option 0 and then select option 3 to speak with an EDI Coordinator



Getting Started

Accessing Payerpath

On the Electronic Claims/EDI webpage, scroll down to the Allscripts-Payerpath link.

PayerPath Claim Submission Training for August 2014(Updated August 26, 2014)	July 25, 2014
PayerPath Claim Submission Training	July 10, 2014
EDI Announcement: Dual Use for 4010/5010 Formats Ends June 30, 2012	June 5, 2012
Anesthesia Services Claims Submitted Electronically (Updated May 31, 2012)	May 4, 2012
EDI Announcement: Nevada Medicaid Version 5010 Solution Limits Diagnosis Codes on 837P Transactions.	Apr. , 2012
EDI Announcement: Prepare for March 31, 2012, End Date for Dual Use of 5010 and D.0 Formats	Jan , 2012
Instructions for EDI Enrollment	December 2011

Payerpath

Enrolled providers may submit electronic Nevada Medicaid and Nevada Check Up claims free of charge through [Allscripts-Payerpath](#).

Service Center Directory

The Service Center Directory is a list of commercial clearinghouses currently registered with Hewlett Packard Enterprise. The list contains links to each clearinghouse's web site.
[Service Center Directory](#)

Provider Billing Manual: EDI Chapter

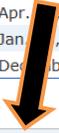
The EDI chapter in the Provider Billing Manual provides answers to commonly asked EDI questions.
[Read the chapter...](#)

Service Center User Manual

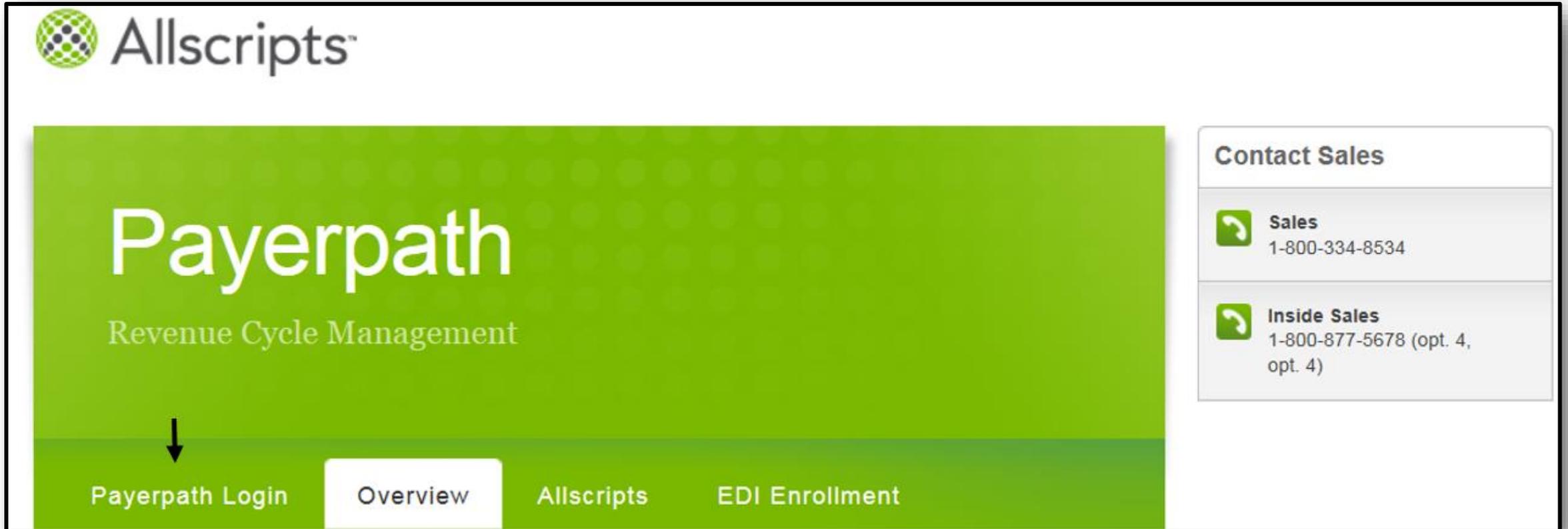
The Service Center User Manual contains technical instructions for submitting and retrieving electronic transactions. This includes SFTP guidelines, transaction testing and handling login problems. EDI registration instructions are also included.
[Service Center User Manual](#)

EDI Companion Guides

Title	Date
Transaction 270/271 - Health Care Eligibility Inquiry and Response	February 2015
Transaction 271U - Unsolicited Transaction - HIPAA Version 5010	February 2013
Transaction 277U - Unsolicited 277 Claims Status Response - HIPAA Version 5010	October 2012
Transaction 820 - Health Care Premium Payment - HIPAA Version 5010	October 2012
Transaction 834 - Benefit Enrollment and Maintenance - HIPAA Version 5010	October 2012
Transaction 835 - Health Care Payment/Advice	February 2015



Payerpath Login Screen



The screenshot shows the Payerpath login screen. At the top left is the Allscripts logo. The main content area has a green background with the text "Payerpath" in large white font and "Revenue Cycle Management" in smaller white font below it. At the bottom of this area is a navigation bar with four buttons: "Payerpath Login", "Overview", "Allscripts", and "EDI Enrollment". A black arrow points down to the "Payerpath Login" button. On the right side of the screen, there is a "Contact Sales" section with two entries: "Sales" with phone number 1-800-334-8534 and "Inside Sales" with phone number 1-800-877-5678 (opt. 4, opt. 4).

www.payerpath.com

Select Payerpath Login

Login Page

Allscripts Allscripts Payerpath Login



Customer Name:

User Name:

Password:

Remember My Credentials

[Access Allscripts Payerpath](#) ▶

- ▶ [Page Help](#)
- ▶ [Forgot your Password?](#)
- ▶ [Forgot your Username?](#)
- ▶ [Change your Password.](#)

Enter Customer Name
Enter User Name
Enter Password

Welcome Page

The screenshot shows the Allscripts Welcome Page. At the top left is the Allscripts logo. A green header bar contains the word "Welcome" and a navigation menu with links for "Claims", "Patients", "Reports", "Maintenance", "Help", and "Tools". On the left side, there is a "Resources" section with a "Knowledge Center" link. The main content area features a "Quick Links" section with three cards: "New Messages" (with an envelope icon and a '0' badge), "Payer Reports" (with a document icon and a '0' badge), and "Remit Reports" (with a document and dollar sign icon and a '0' badge). Below this is a "My Filters" section with a "Claims Filters" dropdown menu. A message states "You have not set up any Claims filters." with a "Create Filter" button below it. Two green callout boxes with blue borders are overlaid on the page: one on the left pointing to the "New Messages" card with the text "Select New Messages", and one on the right pointing to the "Remit Reports" card with the text "Select New Remit Reports".

Select New Messages

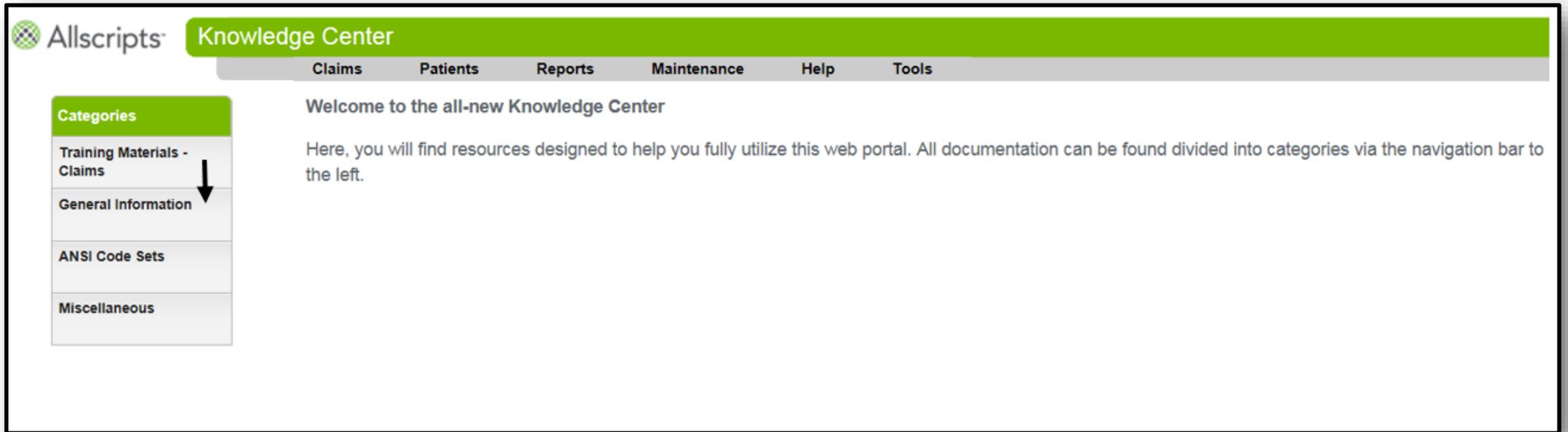
Select New Remit Reports

Welcome Page

The screenshot shows the Allscripts Welcome Page. At the top left is the Allscripts logo. A green header bar contains the word "Welcome" and a navigation menu with links for "Claims", "Patients", "Reports", "Maintenance", "Help", and "Tools". On the left side, there is a "Resources" section with a dropdown menu where "Knowledge Center" is selected, indicated by a black arrow. The main content area features a "Quick Links" section with three icons: "New Messages" (0), "Payer Reports" (0), and "Remit Reports" (0). Below this is a "My Filters" section with a dropdown menu set to "Claims Filters" and a message stating "You have not set up any Claims filters." with a "Create Filter" button.

Please select Knowledge Center.

Knowledge Center



Allscripts Knowledge Center

Claims Patients Reports Maintenance Help Tools

Categories

- Training Materials - Claims
- General Information
- ANSI Code Sets
- Miscellaneous

Welcome to the all-new Knowledge Center

Here, you will find resources designed to help you fully utilize this web portal. All documentation can be found divided into categories via the navigation bar to the left.

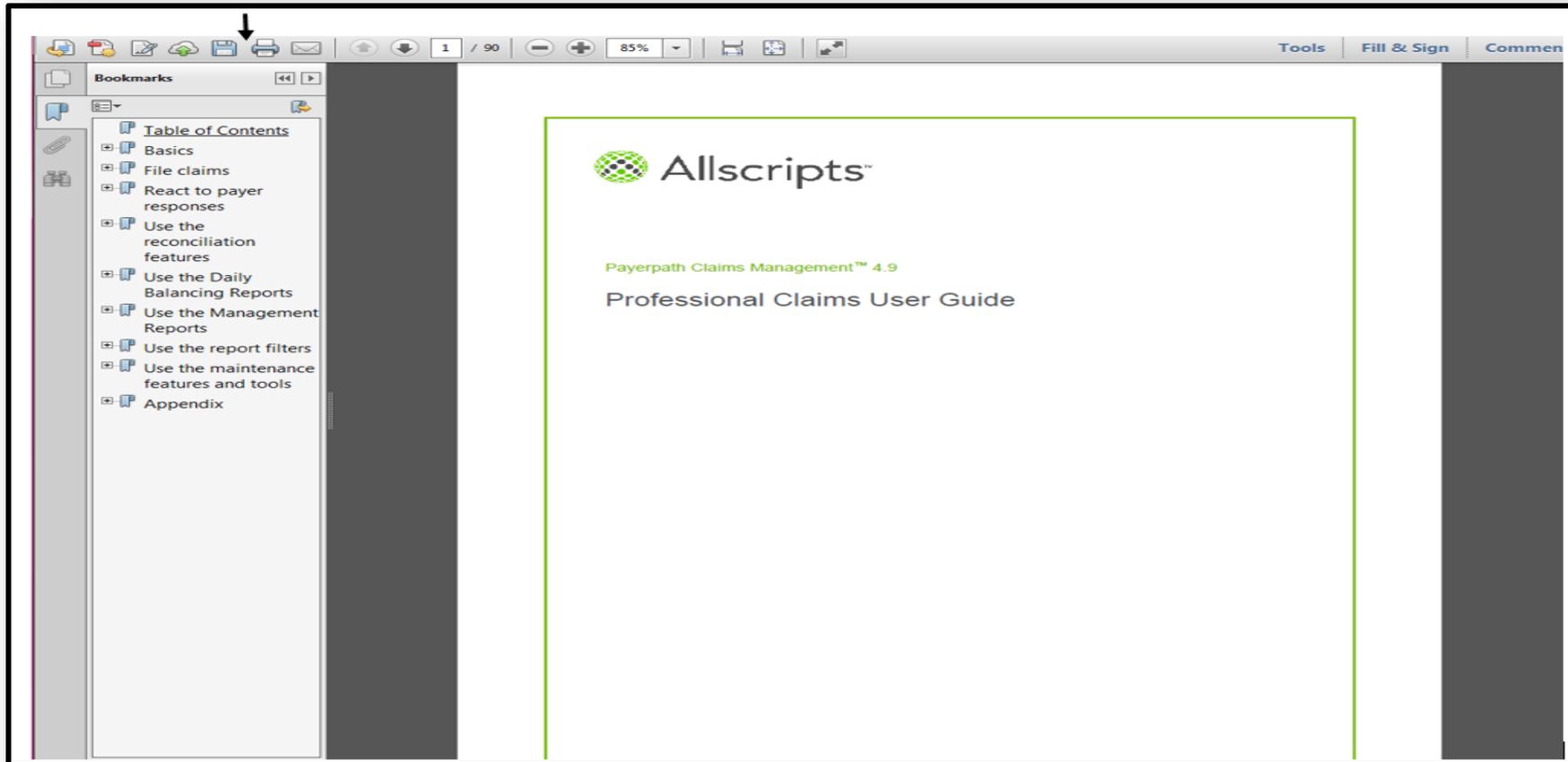
This is the Knowledge Center.
Please select General Information.

Training Materials Claims

The screenshot shows the Allscripts Knowledge Center interface. At the top, there is a green header with the Allscripts logo and the text 'Knowledge Center'. Below the header is a navigation bar with tabs for 'Claims', 'Patients', 'Reports', 'Maintenance', 'Help', and 'Tools'. On the left side, there is a 'Categories' sidebar with a green header and four items: 'Training Materials - Claims' (highlighted), 'General Information', 'ANSI Code Sets', and 'Miscellaneous'. The main content area displays a list of training materials under the 'General Information' section. The items are: 'NV Medicaid Dental Claim Field Values', 'NV Medicaid Institutional Claim Field Values', 'NV Medicaid Professional Claim Field Values', 'ADA2002 Claim Field Values', 'Report Enhancements', 'Payerpath ICD-10 Ready_Set_Go', 'Payerpath Changes in 4.11', 'Professional User Manual', 'Institutional User Manual', and 'Dental User Guide'. A black arrow points to the 'Professional User Manual' item.

This is the General Information.
Please select Professional User Manual.

Payerpath Professional Claims User Guide



This is the Professional Claims User Guide.

Please select the Save icon or Print icon in the top left corner.



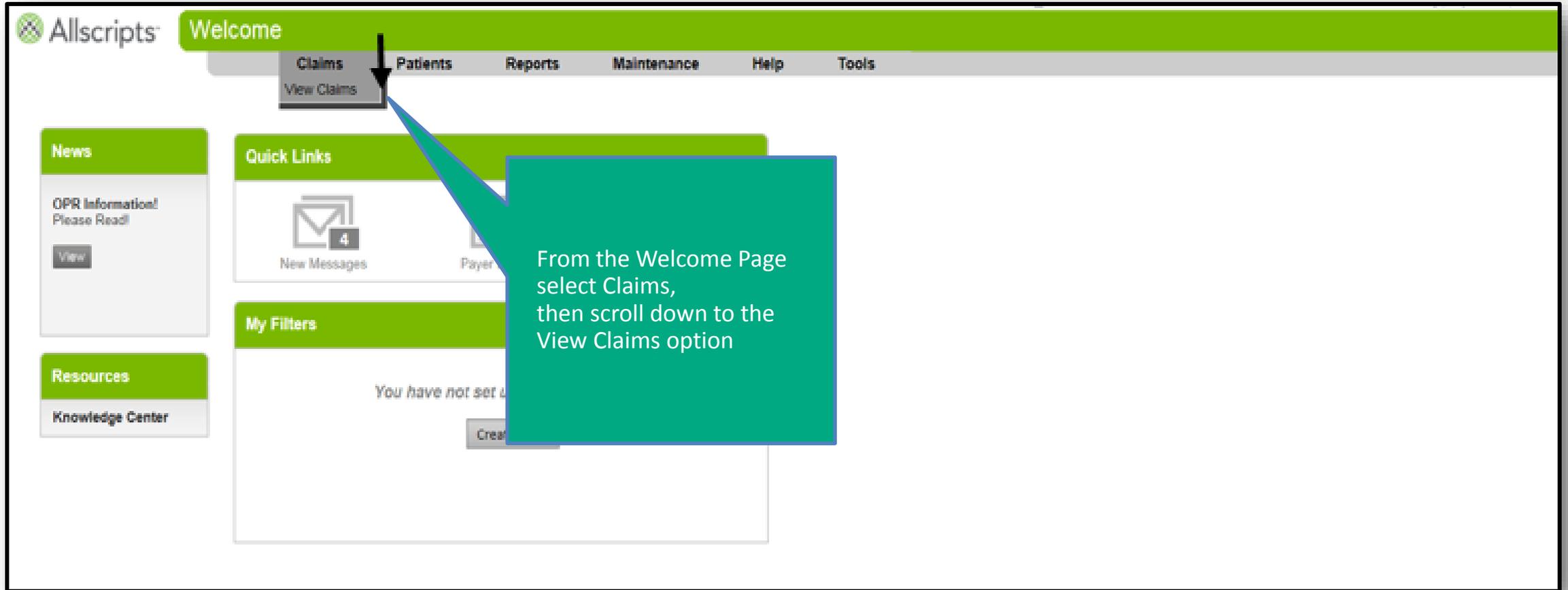
Learning Check

1. What is the website address you would use to directly login to Allscripts-Payerpath?
2. What is one of the first things you should do when getting started with Allscripts-Payerpath?
 - a. Print your remittance advice
 - b. Submit a claim
 - c. Copy a claim
 - d. Visit the Knowledge Center
3. Which documents should you review and/or print?
 - a. Payerpath Professional HCFA COB Instructions
 - b. Payerpath Professional User Guide
 - c. All of the above



CMS-1500 Claim Form Submission

Submitting Professional Claim Form CMS-1500



The screenshot displays the Allscripts web application interface. At the top left is the Allscripts logo. A green header bar contains the word "Welcome". Below this is a navigation menu with tabs for "Claims", "Patients", "Reports", "Maintenance", "Help", and "Tools". The "Claims" tab is selected, and a dropdown menu is open, showing the option "View Claims". A black arrow points from the "View Claims" option in the dropdown to a green callout box. The callout box contains the text: "From the Welcome Page select Claims, then scroll down to the View Claims option". The main content area includes sections for "News" (with "OPR Information! Please Read!" and a "View" button), "Quick Links" (with "New Messages" and a "4" notification), and "My Filters" (with the text "You have not set up").

Customer Support

Call 877-638-3472, option 2, then option 0, then option 3 | Mon-Fri 8 a.m. to 5 p.m. PT | Email: nvmmis.edisupport@dxc.com

Claims List Filter

The screenshot shows the 'Claims List Filter' interface in Allscripts. The top navigation bar includes 'Allscripts', 'Claims List Filter', and tabs for 'Claims', 'Patients', 'Reports', 'Maintenance', 'Help', and 'Tools'. The main content area is titled 'My Claim Filters' and contains several sections: 'Select' (a dropdown menu), 'Name' (a text input field with 'Save' and 'Manage My Filters' buttons), 'Selection Criteria' (with 'Form Type' set to 'Professional'), 'Payer Group' (set to 'NV Medicaid Professional'), 'Payer Name' (set to 'ALL'), 'Billing Provider' (set to 'ALL'), 'Claim Status' (with 'Untransmitted' selected and a dropdown menu showing 'ALL', 'Deleted', 'Failed', and 'Warning'), and 'Claim Type' (with 'Both' selected). Below these are date and text filters for 'Create Date', 'Date Of Service', 'Procedure Code', 'Patient Account #', and 'Patient Last Name', each with 'From' and 'Through' fields. A green box highlights the 'Apply Filter' button at the bottom. Three callout boxes provide instructions: 'Select Form: Type Professional' points to the 'Form Type' dropdown; 'Choose from Untransmitted (claims not yet sent) or Transmitted (claims that have been sent)' points to the 'Claim Status' radio buttons; and 'Select Apply Filter' points to the 'Apply Filter' button.

Select Form: Type Professional

Choose from Untransmitted (claims not yet sent) or Transmitted (claims that have been sent)

Select Apply Filter

Untransmitted Claims List

Allscripts Untransmitted Claims List

Claims Patients Reports Maintenance Help Tools

Sorted By: (x)Pat Name ? Filtered 0 selected

	Status	Location	Pat Name	Pat Acct	Payer	NPI	Created	Sent	Ack	Rcvd	Remitted	Charges	Paid	
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/12/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/05/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	03/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	02/17/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	02/09/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	02/02/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	01/20/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	P	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/05/16					\$535.00	\$0.00	V H

Jump To: 1 - 2016-04-16 Displaying Items 1 - 15 of 26

Claims not modified within 90 days will be deleted
Claims in Blue are assigned to Print Mail or Unassigned Payer

Select "V" for View

Previously entered claims will be displayed on the Untransmitted Claims List. Claims must be in a "P" (Passed) status before they can be sent.

Untransmitted claims are retained in the system for 90 days.

How to Create a Claim Template

Allscripts CMS-1500 Professional - NV Medicaid Professional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (19) Electronic Fields (5)

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP / FECA / OTHER		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code)		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. Accident Indicator 1:	
b. RESERVED FOR NUCC USE		c. Accident Indicator 2:	
c. RESERVED FOR NUCC USE		d. Accident Indicator 3:	
d. INSURANCE PLAN OR PROGRAM NAME		10d. CLAIM CODES	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNED Y DATE		a. INSURED'S DATE OF BIRTH SEX	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		b. OTHER CLAIM ID (Designated by NUCC)	
15. OTHER DATE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
17a. REFERRING ID QUAL / ID		Yes No If yes, complete items 9, 9a, and 9d.	
17b. REFERRING NP#		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
19. ADDITIONAL CLAIM INFORMATION		SIGNED Y	
		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
		FROM TO	
		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
		FROM TO	
		20. OUTSIDE LAB? \$ CHARGES	
		Yes No	

Patient Name: Account: CLAIM TEMPLATE

Select Edit

https://www.paycpath.com/US/Home/Welcome

New Copy Hold Inbound View Print Undo Changes Save & Run Edits

Scroll down to the bottom of the page and select Copy

How to Create a Claim Template

Allscripts CMS-1500 Professional - NV Medicaid Professional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (19) Electronic Fields (5)

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP / FECA / OTHER		1a. INSURED'S I.D. NUMBER (For Program in item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX M <input type="radio"/> F <input type="radio"/> U <input type="radio"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other <input type="radio"/>	7. INSURED'S ADDRESS (No., Street)
CITY STATE ZIP CODE TELEPHONE (Include Area Code)	8. RESERVED FOR NUCC USE	CITY STATE ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO PLACE (state)	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. Accident Indicator 1: Employment <input type="radio"/> Auto <input type="radio"/> Other <input type="radio"/> None <input checked="" type="radio"/>	a. INSURED'S DATE OF BIRTH SEX M <input type="radio"/> F <input type="radio"/> U <input type="radio"/>
b. RESERVED FOR NUCC USE	b. Accident Indicator 2: Employment <input type="radio"/> Auto <input type="radio"/> Other <input type="radio"/> None <input checked="" type="radio"/>	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. Accident Indicator 3: Employment <input type="radio"/> Auto <input type="radio"/> Other <input type="radio"/> None <input checked="" type="radio"/>	c. INSURANCE PLAN OR PROGRAM NAME
d. INSURANCE PLAN OR PROGRAM NAME	10d. CLAIM CODES 1. 2. 3. 4.	d. IS THERE ANOTHER CLAIM FOR THIS PATIENT?
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE SIGNED Y DATE		13. IS THERE ANOTHER CLAIM FOR THIS PATIENT?
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. ADDITIONAL CLAIM INFORMATION		20. OUTSIDE LAB? \$ CHARGES

Message from webpage: Are you sure you want to copy the current claim? OK Cancel

Select OK

Patient Name: Account: CLAIM TEMPLATE
Select Edit
Claim 1 of 26

New Copy Hold Inbound View Print Undo Changes Save & Run Edits

How to Create a Claim Template

Allscripts CMS-1500 Professional - NV Medicaid Professional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (19) Electronic Fields (5)

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP / FECA / OTHER		1a. INSURED'S I.D. NUMBER (For Program in item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	
CITY STATE		8. RESERVED FOR NUCC USE	
ZIP CODE TELEPHONE (Include Area Code)		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. Accident Indicator 1:	
b. RESERVED FOR NUCC USE		b. Accident Indicator 2:	
c. RESERVED FOR NUCC USE		c. Accident Indicator 3:	
d. INSURANCE PLAN OR PROGRAM NAME		10d. CLAIM CODES	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
SIGNED Y DATE		Yes No If yes, complete items 9, 9a, and 9d.	
		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
		SIGNED Y	

Key in all of the Red highlighted sections on the CMS-1500 claim form

How to Create a Claim Template

Allscripts CMS-1500 Professional - NV Medicaid Professional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (19) Electronic Fields (5)

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP / FECA / OTHER		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0000000000	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ALE GINGER		3. PATIENT'S BIRTH DATE SEX 01/01/1960 M F U	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) ALE GINGER		5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
8. RESERVED FOR NUCC USE		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO: PLACE (state) a. Accident Indicator 1: Employment Auto Other None b. Accident Indicator 2: Employment Auto Other None c. Accident Indicator 3: Employment Auto Other None		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH SEX b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME NV MEDICAID d. IS THERE ANOTHER HEALTH BENEFIT PLAN? Yes No If yes, complete items 9, 9a, and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE SIGNED Y DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE SIGNED Y	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. REFERRING ID QUAL / ID 17b. REFERRING NPI	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO		19. ADDITIONAL CLAIM INFORMATION	
20. OUTSIDE LAB? Yes No		\$ CHARGES	

Patient Name: , Account: CLAIM TEMPLATE
Select Edit

New Copy Hold Inbound View Print Undo Changes Save & Run Edits

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

How to Create a Claim Template

Back To List Form Fields **Electronic Fields**

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP / FECA / OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
ALE GINGER

3. PATIENT'S BIRTH DATE SEX
01/01/1960 M F U

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ALE GINGER

5. PATIENT'S ADDRESS (No., Street)
CITY STATE
STATE NV

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)
150 S FIRST STREET
CITY STATE
RENO NV

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE
d. INSURANCE PLAN OR PROGRAM NAME

10. CLAIM CODES
10d. CLAIM CODES
1. 2. 3. 4.

11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH SEX
b. OTHER CLAIM ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME
NV MEDICAID
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
Yes No *If yes, complete items 9, 9a, and 9d.*

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
SIGNED Y DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
SIGNED Y

All the updates will be saved to the document and will no longer be highlighted in Red.
Scroll down to the next Red highlighted fields.

How to Create a Claim Template

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate 1-12 to service line below (24E)												ICD IND: ICD-10		22. RESUBMISSION CODE		ORIGINAL REF NO	
1. [Red]	2. []	3. []	4. []	5. []	6. []	23. PRIOR AUTHORIZATION NUMBER		1		[]							
7. []	8. []	9. []	10. []	11. []	12. []	ENTER PA											
24. A. DATE(S) OF SERVICE		B. POS	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES				E. DIAGNOSIS POINTER			F. S Charges	G. Days or Units	H. EPSDT FP	J. Rendering Prov NPI	DEL		
FROM DATE	TO DATE			CPT/HCPCS	MOD1	MOD2	MOD3	MOD4									
[Red]	[Red]	[Red]	[]	[Red]	[]	[]	[]	[]	[]	[]	[]	[Red]	[Red]	[]	[]	[]	
[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	
[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	
[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	
[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	
[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO		27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE		29. AMOUNT PAID		30. RSVD FOR NUCC USE							
100100100		CLAIM TEMPLA		A <input checked="" type="radio"/> B <input type="radio"/> C <input type="radio"/>		\$0.00		[]		[]							
SSN <input type="radio"/> EIN <input checked="" type="radio"/>																	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS		32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # 7753358501											
SIGNED Y		[]				BILLING SERVICE											
DATE []		[]				100 1ST ST											
		[]				RENO NV 895200000											
		[]				[]											
32a. FACILITY NPI		32b. ID QUAL		FACILITY ID		33a. BILLING NPI		33b. ID QUAL		BILLING ID							
[]		[]		[]		1001001001		[]		[]							

Key in all of the Red highlighted sections on the CMS-1500 claim form

How to Create a Claim Template

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate 1-12 to service line below (24E) ICD IND: ICD-10

1. Z741 2. Z742 3. Z743 4. Z748 5. Z749 6.
 7. 8. 9. 10. 11. 12.

22. RESUBMISSION CODE ORIGINAL REF NO
 1

23. PRIOR AUTHORIZATION NUMBER
 0000000000

24. A. DATE(S) OF SERVICE		B. POS	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES				E. DIAGNOSIS POINTER				F. \$ Charges	G. Days or Units	H. EPSDT FP	J. Rendering Prov NPI	DEL	
FROM DATE	TO DATE			OPT/HCPCS	MOD1	MOD2	MOD3	MOD4									
04/01/2016	04/01/2016	11		99213	25				2	1	3	4	\$100.00	1			<input type="checkbox"/>
																	<input type="checkbox"/>
																	<input type="checkbox"/>
																	<input type="checkbox"/>
																	<input type="checkbox"/>
																	<input type="checkbox"/>

25. FEDERAL TAX I.D. NUMBER 100100100
 SSN EIN

26. PATIENT'S ACCOUNT NO SMITHJ01

27. ACCEPT ASSIGNMENT?
 A B C

28. TOTAL CHARGE \$100.00

29. AMOUNT PAID

30. RSVD FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
 SIGNED Y
 DATE

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # 7753358501
 BILLING SERVICE
 100 1ST ST
 RENO NV 895200000

32a. FACILITY NPI 32b. ID QUAL FACILITY ID
 33a. BILLING NPI 33b. ID QUAL BILLING ID
 1001001001

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

Patient Name: SMITH, JOHN Account: CLAIMTEMPLATE

Select Edit

Claim 1 of 26

New Copy Hold Inbound View Print Undo Change **Save & Run Edits**

How to Create a Claim Template

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate 1-12 to service line below (24E) ICD IND: ICD-10

1. Z741 2. Z742 3. Z743 4. Z748 5. Z749 6.

7. 8. 9. 10. 11. 12.

22. RESUBMISSION CODE ORIGINAL REF NO
1

23. PRIOR AUTHORIZATION NUMBER
0000000000

24. A. DATE(S) OF SERVICE		B. POS	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES				E. DIAGNOSIS POINTER				F. \$ Charges	G. Days or Units	H. EPSDT FP	J. Rendering Prov NPI	DEL	
FROM DATE	TO DATE			CPT/HCPCS	MOD1	MOD2	MOD3	MOD4	1	2	3	4					
04/01/2016	04/01/2016	11		99213	25				2	1	3	4	\$100.00	1			<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

25. FEDERAL TAX I.D. NUMBER 100100100
SSN EIN

26. PATIENT'S ACCOUNT NO SMITHJ01

27. ACCEPT ASSIGNMENT? A B C

28. TOTAL CHARGE \$100.00

29. AMOUNT PAID

30. RSVD FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
SIGNED Y
DATE

32. SERVICE FACILITY LOCATION INFORMATION

32a. FACILITY NPI 32b. ID QUAL 32c. FACILITY ID

33. BILLING PROVIDER INFO & PH # 7753358501
BILLING SERVICE
100 1ST ST

RENO NV 895200000

33a. BILLING NPI 1001001001 33b. ID QUAL 33c. BILLING ID

Once the page is saved, please scroll up to the top of the page and look for the tab that reads Electronic Fields

Patient Name: SMITH, JOHN Account: SMITHJ01

Select Edit

Claim 1 of 27

New Copy Hold Inbound View Print Undo Changes Save & Run Edits

How to Create a Claim Template

Allscripts CMS-1500 Professional - NV Medicaid Professional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields **Electronic Fields (5)**

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP / FECA / OTHER		1a. INSURED'S I.D. NUMBER (For Program in item 1) 0000000000
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH JOHN	3. PATIENT'S BIRTH DATE 01/01/1900	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SMITH JOHN
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="radio"/> Spouse <input type="radio"/> Other <input type="radio"/>	7. INSURED'S ADDRESS (No., Street) 1 FIRST STREET CITY STATE RENO NV ZIP CODE TELEPHONE (Include Area Code) 89502
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		INSURED'S POLICY, GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		INSURED'S DATE OF BIRTH SEX M <input type="radio"/> F <input type="radio"/> U <input type="radio"/>
b. RESERVED FOR NUCC USE		OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		INSURANCE PLAN NAME OR PROGRAM NAME / MEDICAID
d. INSURANCE PLAN OR PROGRAM NAME		IS THERE ANOTHER HEALTH BENEFIT PLAN? Yes <input type="radio"/> No <input type="radio"/> If yes, complete items 9, 9a, and 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE SIGNED Y DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE SIGNED Y
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. REFERRING ID QUAL / ID	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
	17b. REFERRING NPI	20. OUTSIDE LAB? \$ CHARGES Yes <input type="radio"/> No <input type="radio"/>
19. ADDITIONAL CLAIM INFORMATION		

Click on the Electronic Fields tab at the top of the page to enter the Rendering Provider's NPI

How to Create a Claim Template

Allscripts CMS-1500 Professional - NV Medicaid Professional

Claims Patients Reports Maintenance Help

Categories

- Rendering Provider (5)
- Ambulance
- Attending Provider
- Billing Provider
- Charge Reports
- Chiropractic
- Codes
- Coordination of Benefits - Payer A
- Coordination of Benefits - Payer B
- Coordination of Benefits - Payer C
- Coordination of Benefits Additional Adjustments B
- Coordination of Benefits Additional Adjustments C

Back To List Form Fields Electronic Fields

Rendering Provider

Rendering Provider First Name:	<input type="text"/>
Rendering Provider Middle Initial:	<input type="text"/>
Rendering Provider Last Name:	<input type="text"/>
Rendering Provider Taxid:	<input type="text"/>
Rendering Provider Qualifier:	<input type="text"/>
Rendering Provider Entity Type Qualifier:	<input type="text" value="1"/>
Rendering Provider 2ND ID Qualifier:	<input type="text"/>
Rendering Provider 2ND ID:	<input type="text"/>
Rendering Provider 3RD ID Qualifier:	<input type="text"/>
Rendering Provider 3RD ID:	<input type="text"/>
Rendering NPI:	<input type="text" value="ENTER NPI"/>

Enter the Rendering Providers First Name
Enter the Rendering Providers Last Name
Enter the Rendering Providers NPI

How to Create a Claim Template

Back To List Form Fields Electronic Fields (5)

Rendering Provider

Rendering Provider First Name:	TOOD
Rendering Provider Middle Initial:	
Rendering Provider Last Name:	SMITH
Rendering Provider Taxid:	
Rendering Provider Qualifier:	
Rendering Provider Entity Type Qualifier:	1
Rendering Provider 2ND ID Qualifier:	
Rendering Provider 2ND ID:	
Rendering Provider 3RD ID Qualifier:	
Rendering Provider 3RD ID:	
Rendering NPI:	1001001001

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

Patient Name: SMITH, JOHN Account: SMITHJ01

Select Edit

Claim 1 of 27

New Copy Hold Inbound View Print Undo Changes Save & Run Edits

How to Mark Your Claim for Send

The screenshot displays the Allscripts CMS-1500 Professional - NV Medicaid Professional interface. The top navigation bar includes 'Claims', 'Patients', 'Reports', 'Maintenance', 'Help', and 'Tools'. The main content area is divided into 'Categories' on the left and 'Form Fields' on the right. The 'Form Fields' section is titled 'Rendering Provider' and contains the following fields:

Field Name	Value
Rendering Provider First Name:	TOOD
Rendering Provider Middle Initial:	
Rendering Provider Last Name:	SMITH
Rendering Provider Taxid:	
Rendering Provider Qualifier:	
Rendering Provider Entity Type Qualifier:	1
Rendering Provider 2ND ID Qualifier:	
Rendering Provider 2ND ID:	
Rendering Provider 3RD ID Qualifier:	
Rendering Provider 3RD ID:	
Rendering NPI:	1001001001

At the bottom of the page, a status bar shows 'Patient Name: SMITH, JOHN Account: SMITHJ01', 'No Errors', and 'Claim 1 of 27'. A toolbar at the bottom right contains icons for 'New', 'Copy', 'Hold', 'Inbound View', 'Send', 'Print', 'Undo Changes', and 'Save & Run Edits'. The 'Send' icon is highlighted with a green box.

1. Scroll down to the bottom to confirm the claim has no additional edits by locating No Errors on claim.

2. Scroll down to the bottom of the page and select Send to mark the claim for processing. Once the claim has been sent you are unable to make any changes to the claim form.

How to Print & Save Your Claim

The screenshot displays the Allscripts CMS-1500 Professional - NV Medicaid Professional interface. The top navigation bar includes 'Claims', 'Patients', 'Reports', 'Maintenance', 'Help', and 'Tools'. The main content area is divided into three tabs: 'Back To List', 'Form Fields', and 'Electronic Fields'. The 'Form Fields' tab is active, showing a form for 'Rendering Provider' information. The form fields are as follows:

Field Name	Value
Rendering Provider First Name:	TOOD
Rendering Provider Middle Initial:	
Rendering Provider Last Name:	SMITH
Rendering Provider Taxid:	
Rendering Provider Qualifier:	
Rendering Provider Entity Type Qualifier:	1
Rendering Provider 2ND ID Qualifier:	
Rendering Provider 2ND ID:	
Rendering Provider 3RD ID Qualifier:	
Rendering Provider 3RD ID:	
Rendering NPI:	1001001001

A callout box with a green background and orange border points to the 'Print' button in the bottom toolbar. The text inside the callout box reads: "Scroll down to the bottom of the page and select the Print button to print a copy of claim form". The bottom toolbar also includes buttons for 'New', 'Copy', 'Hold', 'Inbound View', 'Send', 'Undo Changes', and 'Save & Run Edits'. The status bar at the bottom left shows 'Patient Name: SMITH, JOHN', 'Account: SMITHJ01', 'No Errors', and 'Claim 1 of 27'.

How to Print & Save Your Claim

The screenshot displays the Allscripts CMS-1500 Professional - NV Medicaid Professional interface. The top navigation bar includes 'Claims', 'Patients', 'Reports', 'Maintenance', 'Help', and 'Tools'. The left sidebar lists various categories such as 'Rendering Provider', 'Ambulance', 'Attending Provider', 'Billing Provider', 'Charge Reports', 'Chiropractic', 'Codes', and 'Coordination of Benefits'. The main content area shows the 'Rendering Provider' form with fields for 'Rendering Provider First Name' (TOOD), 'Rendering Provider Middle Initial', 'Rendering Provider Last Name' (SMITH), 'Rendering Provider Taxid', 'Rendering Provider Qualifier', 'Rendering Provider Entity Type Qualifier' (1), 'Rendering Provider 2ND ID Qualifier', 'Rendering Provider 2ND ID', 'Rendering Provider 3RD ID Qualifier', 'Rendering Provider 3RD ID', and 'Rendering NPI' (1001001001). The bottom toolbar contains icons for 'New', 'Copy', 'Hold', 'Inbound View', 'Send', 'Print', 'Undo Changes', and 'Save & Run Edits'. A green callout box with an orange border points to the 'Print' button, containing the text: 'Scroll down to the bottom of the page and select the Print button to print a copy of the claim form'.

Categories

- Rendering Provider
- Ambulance
- Attending Provider
- Billing Provider
- Charge Reports
- Chiropractic
- Codes
- Coordination of Benefits - Payer A
- Coordination of Benefits - Payer B
- Coordination of Benefits - Payer C
- Coordination of Benefits Additional Adjustments B
- Coordination of Benefits Additional Adjustments C

Back To List Form Fields Electronic Fields

Rendering Provider

Rendering Provider First Name:	TOOD
Rendering Provider Middle Initial:	
Rendering Provider Last Name:	SMITH
Rendering Provider Taxid:	
Rendering Provider Qualifier:	
Rendering Provider Entity Type Qualifier:	1
Rendering Provider 2ND ID Qualifier:	
Rendering Provider 2ND ID:	
Rendering Provider 3RD ID Qualifier:	
Rendering Provider 3RD ID:	
Rendering NPI:	1001001001

Scroll down to the bottom of the page and select the Print button to print a copy of the claim form

Patient Name: SMITH, JOHN Account: SMITHJ01
No Errors
Claim 1 of 27

New Copy Hold Inbound View Send Print Undo Changes Save & Run Edits

How to Print & Save Your Claim

A pop up window will appear. Select the CMS-1500 Form (ICD-10)-With Form, then select the Print button

Select your print option

- CMS-1500 Form (NPI) - With Form
- CMS-1500 Form (ICD10) - With Form
- CMS-1500 Form (ICD10) - Without Form

Print Cancel

Categories

- Ambulance
- Attending Provider
- Billing Provider
- Charge Reports
- Chiropractic
- Codes
- Coordination of Benefits - Payer A
- Coordination of Benefits - Payer B
- Coordination of Benefits - Payer C
- Coordination of Benefits Additional Adjustments B
- Coordination of Benefits Additional Adjustments C
- Coordination of Benefits- Additional

Back To List Form Fields Electronic Fields

Ambulance Service Lines

Service Line: 1 Date of Service: 04/04/2010 : 99213

1	Weight of Patient:	Hospital Admit:	Type Of Transport:	Bed Confined-Before:
2	Bed Confined-After:	Moved By Stretcher:	Unconscious/Shock:	Emergency Situation:
3				
4	Physical Restraints:	Visible Hemorrhaging:	Transported To/For:	Medically Necessary:
5				
	Miles:	Origin Information:	Ambulance Pick-up Address1:	Ambulance Pick-up Address2:
	Ambulance Pick-up City:	Ambulance Pick-up State:	Ambulance Pick-up Zip:	Destination Information:
	Ambulance Drop-off Name:	Ambulance Drop-off Address1:	Ambulance Drop-off Address2:	Ambulance Drop-off City:

How to Print & Save Your Claim

https://www.payerpath.com/?USERGUID={17bce7a2-4170-4522-90c4-fe48199cfc46}&ReportName=Form1500_ - Internet Explorer

Page 1 of 2 Sort By Select Format Download **Preview** Print Help

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

NV MEDICAID

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (IC#) FECA (FECA#) OTHER (ID#)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
ALE, GINGER

3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)
01 01 1960

4. INSURED'S I.D. NUMBER (For Program in Item 1)
00000000000

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ALE, GINGER

5. PATIENT'S ADDRESS (No., Street)
150 S FIRST STREET

6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other)

7. INSURED'S ADDRESS (No., Street)
150 S FIRST STREET

8. RESERVED FOR NUCC USE

8. RESERVED FOR NUCC USE

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. CLAIM CODES (Designated by NUCC)

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME
NV MEDICAID

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE DATE

SIGNED SIGNATURE ON FILE

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

15. OTHER DATE (MM DD YY) QUAL.

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAST \$ CHARGES

PATIENT AND INSURED INFORMATION

125%

How to Print & Save Your Claim

The screenshot shows a web browser window with the URL https://www.payerpath.com/Reporting/PrintReport.aspx?Rptname=Form1500_v0212. The browser toolbar includes icons for Home, Back, Forward, Stop, Refresh, Print, and Save. A green callout box with an orange border points to the Print and Save icons, containing the text: "A pop up window will show the CMS-1500 Form (ICD-10)-With Form in a PDF document. Select the Save button or Print button." The form itself is titled "HEALTH INSURANCE" and "NV MEDICAID". It contains various fields for patient information, insurance details, and medical history. The patient's name is ALE, GINGER, and the insurance plan is NV MEDICAID. The form is partially filled out with various codes and dates.

HEALTH INSURANCE
APPROVED BY NATIONAL UNIFORM CLAIMS ADMINISTRATION

NV MEDICAID

1. PATIENT'S NAME (Last Name, First Name)
ALE, GINGER

2. PATIENT'S ADDRESS (No., Street)
150 S FIRST STREET

3. CITY
RENO

4. STATE
NV

5. ZIP CODE
89502

6. INSURANCE PLAN NAME OR PROGRAM NAME
NV MEDICAID

7. INSURED'S I.D. NUMBER
0000000000

8. INSURED'S NAME (Last Name, First Name, Middle Initial)
ALE, GINGER

9. INSURED'S ADDRESS (No., Street)
150 S FIRST STREET

10. CITY
RENO

11. STATE
NV

12. ZIP CODE
89502

13. INSURED'S POLICY GROUP OR FECA NUMBER
NV MEDICAID

14. IS THERE ANOTHER HEALTH BENEFIT PLAN?
 YES NO

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

16. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)
MM DD YY

17. OTHER DATE
QUAL MM DD YY

18. NAME OF REFERRING PROVIDER OR OTHER SOURCE

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)
A. **Z741** B. **Z742** C. **Z743** D. **Z748**
E. **Z749** F. G. H. I. J. K. L.

21. DATE(S) OF SERVICE From To PLACE OF SERVICE

22. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)

23. DIAGNOSIS

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

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

26. OUTSIDE LAB? YES NO \$ CHARGES

27. RESUBMISSION CODE
1

28. ORIGINAL REF. NO.

29. PRIOR AUTHORIZATION NUMBER

How to Print & Save Your Claim

https://www.payerpath.com/Reporting/PrintReport.aspx?Rptname=Form1500_v0212 - Internet Explorer

1 / 1 93.5%

Tools Fill & Sign

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BEN (LNU) OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
ALE, GINGER

3. PATIENT'S BIRTH DATE
01 01 1960 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ALE, GINGER

5. PATIENT'S ADDRESS (No., Street)
150 S FIRST ST

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (Last Name, First Name, Middle Initial)
150 S FIRST ST

8. RESERVED FOR NUCC USE

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

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 OR GROUP NUMBER
0000000000

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: _____ DATE: _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: _____ DATE: _____

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

15. OTHER DATE
MM DD YY QUAL

16. IS THERE ANOTHER HEALTH BENEFIT PLAN?
 YES NO If yes, complete items 9, 9a, and 9d.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a. NAME 17b. NPI

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? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)
A. **Z741** B. **Z742** C. **Z743** ICD-9: **0**
D. **Z748**
E. **Z749** F. _____ G. _____ H. _____
I. _____ J. _____ K. _____ L. _____

22. RESUBMISSION CODE
1 ORIGINAL REF. NO. _____

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To B. PLACE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) E. DIAGNOSIS

Done

PATIENT AND INSURED

To close the pop up window for the PDF document, select the Red X in the right hand corner of the window

How to Print & Save Your Claim

https://www.payerpath.com/?USERGUID={17bce7a2-4170-4522-90c4-fe48199cf46}&ReportName=Form1500_ - Internet Explorer

Page 1 of 2 | Sort By | Select Format | Download | Preview | Print | Help

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

NV MEDICAID

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
ALE, GINGER

3. PATIENT'S BIRTH DATE
01 01 1960 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ALE, GINGER

5. PATIENT'S ADDRESS (No., Street)
150 S FIRST STREET

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)
150 S FIRST STREET

8. RESERVED FOR NUCC USE

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

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.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

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

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
17a. NPI
17b. NPI

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? \$ CHARGES

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNATURE ON FILE SIGNED DATE

SIGNATURE ON FILE SIGNED

125%

To close the pop up window for the Report Viewer document, select the Red X in the right hand corner of the window

Back to Untransmitted Claims List

The screenshot displays the Allscripts CMS-1500 Professional - NV Medicaid Professional interface. The top navigation bar includes 'Claims', 'Patients', 'Reports', 'Maintenance', 'Help', and 'Tools'. The main content area is divided into sections: 'Categories' on the left, 'Ambulance' form fields in the center, and 'Service Line: 1' details at the bottom. The 'Back to List' button is highlighted in a green box. A callout box points to the button with the text: 'Scroll up to the top of the page and select the button that reads Back to List'.

Categories

- Ambulance
- Attending Provider
- Billing Provider
- Charge Reports
- Chiropractic
- Codes
- Coordination of Benefits - I
- Coordination of Benefits - II
- Coordination of Benefits - III
- Coordination of Benefits A Adjustments B
- Coordination of Benefits A Adjustments C
- Coordination of Benefits- Additional

Ambulance

Back To List | Form Fields | Electronic Fields

Pickup Address 1:

Pickup Address 2:

Pickup City:

Pickup State:

Procedure Code:

Sub Div:

Notes:

Service Line: 1 | Date of Service: 04/04/2016 - 04/04/2016 | Proc Code: 99213

Weight of Patient:	Hospital Admit:	Type Of Transport:	Bed Confined-Before:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1			
Bed Confined-After:	Moved By Stretcher:	Unconscious/Shock:	Emergency Situation:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2			
Physical Restraints:	Visible Hemorrhaging:	Transported To/For:	Medically Necessary:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3			
Miles:	Origin Information:	Ambulance Pick-up Address1:	Ambulance Pick-up Address2:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4			
Ambulance Pick-up City:	Ambulance Pick-up State:	Ambulance Pick-up Zip:	Destination Information:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5			
Ambulance Drop-off Name:	Ambulance Drop-off Address1:	Ambulance Drop-off Address2:	Ambulance Drop-off City:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Untransmitted Claims List

Allscripts Untransmitted Claims List

Claims Patients Reports Maintenance Help Tools

Sorted By: (x)Created 7 Filtered

1 selected

	Status	Location	Pat Name	Pat Acct	Payer	NPI	Created	Sent	Ack	Rcvd	Remitted	Charges	Paid	
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	04/20/16					\$0.00	\$0.00	V H
<input checked="" type="checkbox"/>	P	NV TRAINING	ALE, GINGER	ALEG01	NV MEDIC	10010010C	04/20/16					\$625.00	\$0.00	V H
<input type="checkbox"/>	P	NV TRAINING	SMITH, JOHN	SMITHJ01	NV MEDIC	10010010C	04/18/16					\$100.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	04/12/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	P	NV TRAINING	HILL, THOMA	HILLTHO01	NV MEDIC	10010010C	04/12/16					\$695.00	\$0.00	V H
<input type="checkbox"/>	P	NV TRAINING	HILL, THOMA	HILLTHOMA	NV MEDIC	10010010C	04/05/16					\$535.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	04/05/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMP	NV MEDIC	10010010C	03/16/16					\$0.00	\$0.00	V H

Jump To: 1 - 04/20/16

Displaying items 1 - 15 of 27

Claims not modified within 90 days will be deleted
 Claims in Blue are assigned to Print Mail or Unassigned Payer

Other options available from the Untransmitted Claims List include selecting any claims in a Passed Status to Print or Mark for Send

Untransmitted Claims List

Other options available from the Untransmitted Claims List include selecting any claims to Print

Other options available from the Untransmitted Claims List include selecting any claims in a Passed Status to Print or Mark for Send

Claims not modified within 90 days will be deleted
Claims in Blue are assigned to Print Mail or Unassigned Payer

Status	Location	Account	Payer	NPI	Created	Sent	Ack	Rcvd	Remitted	Charges	Paid		
F	NV TRAIN	CLAIM TEMP NV M								\$0.00	\$0.00	Y	H
P	NV TRAIN	LEG000000000000								\$625.00	\$0.00	Y	H
P	NV TRAIN	WITHJ01								\$100.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV M								\$0.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV M								\$0.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV M								\$0.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV M								\$0.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV M								\$0.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV M								\$0.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV M								\$0.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV M								\$0.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV M								\$0.00	\$0.00	Y	H
P	NV TRAIN HILL, THOMA HILLTH001	NV MEDIC 100100100			04/12/16					\$695.00	\$0.00	Y	H
P	NV TRAIN HILL, THOMA HILLTHOMA	NV MEDIC 100100100			04/05/16					\$535.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV MEDIC 100100100			04/05/16					\$0.00	\$0.00	Y	H
F	NV TRAIN	CLAIM TEMP NV MEDIC 100100100			03/16/16					\$0.00	\$0.00	Y	H



Viewing Remittance Advice

Remittance Detail

The screenshot shows the Allscripts web application interface. At the top left is the Allscripts logo. A green header bar contains the word "Welcome". Below this is a navigation bar with tabs for "Claims", "Patients", "Reports", "Maintenance", "Help", and "Tools". The "Reports" tab is selected and highlighted with a green box, with an orange callout box labeled "Select Reports" pointing to it. A dropdown menu is open under "Reports", listing "Billing Summary", "Payer", "Remittance", "Payer Rejects", "Transmitted Claim", and "Payer Report Filter". The "Remittance" option is highlighted with a green box, with an orange callout box labeled "Select Remittance" pointing to it. On the left side, there is a "Resources" section with a "Knowledge Center" link. The main content area has a "Quick Links" section with three items: "New Messages" (with a 0 badge), "Payer Reports" (with a 0 badge), and "Remit Reports" (with a 0 badge). Below this is a "My Filters" section with a "Claims Filters" dropdown menu and a message: "You have not set up any Claims filters." with a "Create Filter" button.

Remittance Report Filter

Remittance Report Filter

Claims Patients Reports Maintenance Help Tools

Select Criteria

0-90 Days 91+ Days

From Through

Report Date: 04/16/2016 04/23/2016

Payer: All Payers

NPI:

View: Read Unread Deleted

Display Downloadable Reports Only

From Through

Check Amount:

Check Number:

Check Date:

Back To List Apply Filter

Select Report Dates

Select Apply Filter

Remittance Detail List

Export to CSV

Check Data will be listed: Payer, NPI, Check No, Check Amount, Check Date, Received Date and Status

Select View

	Payer	NPI	Check No	Check Amt	Check Date	Received Date	Status			
<input type="checkbox"/>	NV Medicaid Professional		210002480194059	\$5,290.08	07/19/2013	7/14/2013 4:50:53 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480191411	\$5,744.88	07/12/2013	7/7/2013 5:03:00 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480188786	\$4,909.39	07/05/2013	6/30/2013 5:04:37 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480186066	\$4,660.83	06/28/2013	6/23/2013 4:56:53 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480183559	\$9,760.75	06/21/2013	6/16/2013 4:37:07 PM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480178481	\$4,435.92	06/07/2013	6/2/2013 4:51:43 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480175928	\$7,708.32	05/31/2013	5/26/2013 5:03:05 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480173295	\$2,000.59	05/24/2013	5/19/2013 4:55:41 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480170713	\$3,781.44	05/17/2013	5/12/2013 4:56:36 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480168121	\$1,599.84	05/10/2013	5/5/2013 4:56:22 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480165439	\$4,435.92	05/03/2013	4/28/2013 4:27:37 PM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480162845	\$2,181.60	04/26/2013	4/21/2013 4:54:13 AM	R			View

Displaying items 1 - 12 of 12

Filter List

Remittance Advice

Allscripts

NV Medicaid - 835 Remittances

Customer Name:

Claim Detail														
Patient Demographics					Claim Information									
Name:					Claim Status:	1				Total Billed:	\$145.44			
Pat Acct:	CLAIM TEMPLET				Claim Num/ ICN:	2013193701488301			Total Prov Paid:	\$145.44				
Ins Id:														
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	Colns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due	
	05 Jul - 06 Jul 2013	H2014			\$145.44							\$145.44	\$0.00	
					-----							\$145.44	\$0.00	
					\$145.44	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$145.44	\$0.00	
Name:					Claim Status:	1				Billed:	\$363.60			
Pat Acct:	CLAIM TEMPLET				Claim Num/ ICN:	2013193701488302			Prov Paid:	\$363.60				
Ins Id:														
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	Colns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due	
	07 Jul - 11 Jul 2013	H2014			\$363.60							\$363.60	\$0.00	
					-----							\$363.60	\$0.00	
					\$363.60	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$363.60	\$0.00	
Name:					Claim Status:	1				Total Billed:	\$145.44			
Pat Acct:	C				Claim Num/ ICN:	2013193701489201			Total Prov Paid:	\$145.44				
Ins Id:														
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	Colns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due	
	05 Jul - 06 Jul 2013	H2014			\$145.44							\$145.44	\$0.00	
					-----							\$145.44	\$0.00	
					\$145.44	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$145.44	\$0.00	
Name:					Claim Status:	1				Total Billed:	\$363.60			
Pat Acct:	C				Claim Num/ ICN:	2013193701489202			Total Prov Paid:	\$363.60				
Ins Id:														
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	Colns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due	
	07 Jul - 11 Jul 2013	H2014			\$363.60							\$363.60	\$0.00	
					-----							\$363.60	\$0.00	
					\$363.60	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$363.60	\$0.00	
Name:					Claim Status:	1				Total Billed:	\$145.44			
Pat Acct:	CLAIM TEMPLET				Claim Num/ ICN:	2013193701489401			Total Prov Paid:	\$145.44				
Ins Id:														
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	Colns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due	
	05 Jul - 06 Jul 2013	H2014			\$145.44							\$145.44	\$0.00	
					-----							\$145.44	\$0.00	
					\$145.44	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$145.44	\$0.00	

Name of Insured
Pat Account
Insurance ID Number
Service Date
Procedure Code

Claim Number/ICN

Total Billed Amount
Total Provider Paid Amount



Learning Check

1. You should always copy the template before entering claim information?
 - a. Yes
 - b. No

2. From the Welcome page, where do you go to start your submission of a claim?
 - a. Tools
 - b. Reports
 - c. Claims
 - d. Help

3. Will your claim be automatically submitted once it's in a passed status?
 - a. Yes
 - b. No



Nevada Medicaid Contact Information

EDI Help Desk

Phone: (877) 638-3472 (select option 2, then select option 0, then select 3)

Email NVMMIS.EDIsupport@dxc.com

Mailing Address:

Nevada Medicaid

EDI Coordinator

P.O. Box 30042

Reno, NV 89520-3042

Nevada Provider Training

Email NevadaProviderTraining@dxc.com



Thank you