## Contents

- **Classification**
- **Filtering Grids**
- **Opening the Program**
  - **Main Screen**
  - **Ribbon Bar**
  - **Additional Ribbon Bars**
  - **Hiding the Ribbon Bar**
- **Grids**
  - **Column Chooser**
  - **Grouping Data**
  - **Filtering Grids**
  - **Printing Grids**
  - **Exporting Grids**
  - **Vertical Grids**
  - **Conditional Formatting**
- **Navigation**
  - **Home Screen**
  - **Quick Access Buttons**
  - **Widgets**
  - **Quick Access Tabs**
  - **Patient Tab**
    - **Patient Tab Column Descriptions**
  - **Claims Tab**
  - **Reports Tab**
  - **Tasks Tab**
- **Quick Start for Premier Billing**
  - **Security**
  - **Payer Library**
    - **Edit Payer Information**
  - **Physician, Facility Library**
    - **General Information**
    - **Mark as Inactive**
    - **Physician/Facility Information**
    - **Additional Library Classifications**
  - **New Patient**
  - **Insurance Information**
    - **Primary Insurance**
    - **Additional Payers**
  - **New Claim**
    - **Creating the Claim**
  - **Next Steps**
- **Patients**
  - **Classification**
  - **Claim Templates**
  - **Account #**
  - **Update Claims Button**
  - **Additional Claim Information**
  - **Initial Claim Values**
  - **Other Patient Information**
  - **Additional Data**
  - **Statement Information**
  - **Reminder Note**
  - **Specific Field Information**
  - **Make Patient Inactive**
  - **Lock Patient Record**
  - **Delete Patient**
Copy Patient........................................................................................................... 39
Merging Patient Records.......................................................................................... 39

Patient Notes.......................................................................................................... 39
Note Editor.............................................................................................................. 40
Highlighting Notes................................................................................................. 40

FAQ on Patients.................................................................................................... 40

Patient Templates.................................................................................................. 42
Creating a Patient Template.................................................................................... 42
Using a Patient Template......................................................................................... 42
Editing a Patient Template....................................................................................... 43
Deleting a Patient Template..................................................................................... 43
Apply Template to Patient....................................................................................... 43
Automatic Patient Template.................................................................................... 43

Claims....................................................................................................................... 45
Overview.................................................................................................................. 45

Bill To....................................................................................................................... 46
Editing Claim Insured Information.......................................................................... 46
Edit All Claims for a Patient.................................................................................... 46
When does the claim’s ‘Bill To’ change?................................................................ 46
Claim Status Setting................................................................................................. 47

Claim Information Grid.......................................................................................... 47
Rows......................................................................................................................... 47
Categories.............................................................................................................. 48
Claim Status Information......................................................................................... 49

Prior Authorizations............................................................................................. 49
Authorizations and Claim Templates...................................................................... 50
Authorization Data Checks...................................................................................... 50

Diagnosis Codes.................................................................................................... 50
Diagnosis Code Lookup.......................................................................................... 51

Calendars................................................................................................................ 52

Service Line Grid................................................................................................... 52
Procedure Code Lookup........................................................................................ 53
Responsible Party..................................................................................................... 53
Line Item Notes........................................................................................................ 54
Drug Code Fields..................................................................................................... 54
Other Service Line Fields......................................................................................... 55

Claim Templates.................................................................................................... 55
Previous Claim........................................................................................................ 55
Previous Service..................................................................................................... 55
Custom Template.................................................................................................... 55
Previewing/Editing Claim Template Data............................................................... 56

Claim Notes............................................................................................................. 57
Note Editor............................................................................................................... 57
Highlighting Notes................................................................................................... 57

Recurring Claims.................................................................................................. 58
Recurring Claims Set-Up....................................................................................... 58
Edit a Recurring Claim........................................................................................... 58
Reviewing and Entering Recurring Claims........................................................... 58
Delete or Enter Multiple Recurring Claims........................................................... 58

Copy Claim............................................................................................................. 59

Other Fields........................................................................................................... 59
Locked (Claim)....................................................................................................... 59
CLIA Number......................................................................................................... 60
EDI Note................................................................................................................. 60
CMN....................................................................................................................... 60
Last Worked............................................................................................................ 61

FAQ on Claims..................................................................................................... 61

Printing Claims..................................................................................................... 62
Tips and Tricks........................................................................................................ 62
Printing Multiple Claims....................................................................................... 62
Filtering the Print Claims Screen.......................................................................... 63
Print Form with Data .................................................................................................................. 63
CMS-1500 Boxes ......................................................................................................................... 64
   Box 1 .................................................................................................................................. 64
   Box 9a ................................................................................................................................ 64
   Box 11b ............................................................................................................................... 64
   Box 11d ............................................................................................................................... 64
   Box 14 ................................................................................................................................ 64
   Box 15 ................................................................................................................................ 65
   Box 17 ................................................................................................................................ 65
   Box 26 ................................................................................................................................ 65
   Box 29 ................................................................................................................................ 66
   Box 30 ................................................................................................................................ 66
   Box 31 ................................................................................................................................ 66
   Box 32 ................................................................................................................................ 66
   Box 33 ................................................................................................................................ 66
   Box 33b ............................................................................................................................... 66

Printer Adjustment ...................................................................................................................... 67
   Print Form with Data.............................................................................................................. 68
   1500 Form Printer .................................................................................................................. 68
   1500 Form Version .................................................................................................................. 68
   Printer Alignment ................................................................................................................... 68
   Font Settings .......................................................................................................................... 68
   Bottom Margin ....................................................................................................................... 68
   Carrier Area Location Adjustment ....................................................................................... 68
   Vertical Shift Adjustment ....................................................................................................... 69
   Horizontal Shift Adjustment ................................................................................................. 69
   Formats ................................................................................................................................. 69

Troubleshooting Printer Adjustments .......................................................................................... 70

Payments ................................................................................................................................. 71
   Tips .................................................................................................................................... 71
   Enter a Payment .................................................................................................................. 72
   Payments Entry Options ..................................................................................................... 72
   Filtering Options ................................................................................................................... 73
   Entering Credits or Refunds ............................................................................................... 73
   Overpayment or Payments Not Fully Disbursed ............................................................... 75
   Pay and Auto Apply buttons ............................................................................................. 75
   Delete Payment .................................................................................................................... 76
   Checking for Duplicate Payments ..................................................................................... 76
   Patient Receipt ...................................................................................................................... 76
   Special Situations ............................................................................................................... 77
   Double Payment .................................................................................................................. 77
   Zero Dollar Payments ......................................................................................................... 77
   Fix an Incorrect Disbursement ......................................................................................... 78
   Collections .......................................................................................................................... 78
   Other Payment Options ...................................................................................................... 79
   Receive a payment at the time of service and print a receipt ............................................. 79

Adjustments ............................................................................................................................ 80
   Auto-Posting ....................................................................................................................... 80
   Payment Entry ..................................................................................................................... 80
   Claim Entry .......................................................................................................................... 80
   Deleting Adjustments ......................................................................................................... 81
   Tracking Adjustments ......................................................................................................... 82
   Write Offs and Bad Debts .................................................................................................... 82

Payment Modification ............................................................................................................... 84
   Opening an Existing Payment ............................................................................................. 84

Statements ............................................................................................................................... 86
   Statement Format ................................................................................................................. 86
   Filtering ................................................................................................................................. 86
   Monthly Statements ............................................................................................................ 87
   Statement Messages ............................................................................................................. 87
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Issues</td>
<td>87</td>
</tr>
<tr>
<td>Options</td>
<td>88</td>
</tr>
<tr>
<td>Tracking Adjustments</td>
<td>89</td>
</tr>
<tr>
<td>Addresses</td>
<td>89</td>
</tr>
<tr>
<td>Insurance and Patient Balances</td>
<td>90</td>
</tr>
<tr>
<td>BillFlash Electronic Statements</td>
<td>90</td>
</tr>
<tr>
<td>Requirements</td>
<td>90</td>
</tr>
<tr>
<td>Sending a Statement Batch</td>
<td>90</td>
</tr>
<tr>
<td>Electronic Statements by BillFlash</td>
<td>91</td>
</tr>
<tr>
<td>TriZetto Electronic Statements</td>
<td>91</td>
</tr>
<tr>
<td>Requirements</td>
<td>92</td>
</tr>
<tr>
<td>Sending a Statement Batch</td>
<td>92</td>
</tr>
<tr>
<td>Electronic Statements by TriZetto</td>
<td>92</td>
</tr>
<tr>
<td>Exporting Statements</td>
<td>93</td>
</tr>
<tr>
<td>FAQ on Statements</td>
<td>93</td>
</tr>
<tr>
<td>Electronic Claims</td>
<td>95</td>
</tr>
<tr>
<td>ANSI 837 Reference</td>
<td>95</td>
</tr>
<tr>
<td>Connections</td>
<td>95</td>
</tr>
<tr>
<td>Submitter/Receiver</td>
<td>96</td>
</tr>
<tr>
<td>Selecting Claims for Batching</td>
<td>96</td>
</tr>
<tr>
<td>Checking for Errors</td>
<td>96</td>
</tr>
<tr>
<td>Submitting a Batch of Claims</td>
<td>97</td>
</tr>
<tr>
<td>Resending Batches</td>
<td>98</td>
</tr>
<tr>
<td>Reprint an Exported Claims Report</td>
<td>98</td>
</tr>
<tr>
<td>Batch Sorting</td>
<td>98</td>
</tr>
<tr>
<td>Filtering Options</td>
<td>99</td>
</tr>
<tr>
<td>Workers Compensation</td>
<td>100</td>
</tr>
<tr>
<td>Anesthesia Claims</td>
<td>103</td>
</tr>
<tr>
<td>Service Line Description</td>
<td>103</td>
</tr>
<tr>
<td>Units</td>
<td>103</td>
</tr>
<tr>
<td>Secondary Claims</td>
<td>104</td>
</tr>
<tr>
<td>Payer Library – Step 1</td>
<td>104</td>
</tr>
<tr>
<td>Patient Information Screen – Step 2</td>
<td>104</td>
</tr>
<tr>
<td>Claim Screen – Step 3</td>
<td>105</td>
</tr>
<tr>
<td>Troubleshooting Secondary Claims</td>
<td>106</td>
</tr>
<tr>
<td>Common Secondary Claim Errors</td>
<td>106</td>
</tr>
<tr>
<td>Analyzed Secondary Claim</td>
<td>107</td>
</tr>
<tr>
<td>View EDI Reports</td>
<td>109</td>
</tr>
<tr>
<td>EDI Reports Features</td>
<td>109</td>
</tr>
<tr>
<td>EDI Reports Options</td>
<td>110</td>
</tr>
<tr>
<td>Searching for Electronic Billing Reports</td>
<td>110</td>
</tr>
<tr>
<td>Notes for EDI Reports</td>
<td>110</td>
</tr>
<tr>
<td>Adding EDI Reports</td>
<td>111</td>
</tr>
<tr>
<td>Downloading Reports</td>
<td>111</td>
</tr>
<tr>
<td>Manually Adding Reports</td>
<td>111</td>
</tr>
<tr>
<td>Compatible ANSI Formats</td>
<td>111</td>
</tr>
<tr>
<td>Auto Posting Payments</td>
<td>113</td>
</tr>
<tr>
<td>835 Adjustments Grid</td>
<td>114</td>
</tr>
<tr>
<td>Service Line Warning Messages</td>
<td>114</td>
</tr>
<tr>
<td>One or more service lines lack a Reference ID#</td>
<td>114</td>
</tr>
<tr>
<td>Payer Not Linked</td>
<td>116</td>
</tr>
<tr>
<td>Apply Payments and Adjustments</td>
<td>116</td>
</tr>
<tr>
<td>Applied Status Definitions</td>
<td>116</td>
</tr>
<tr>
<td>Payment and Adjustment Statuses</td>
<td>117</td>
</tr>
<tr>
<td>Reversal of Previous Payments</td>
<td>117</td>
</tr>
<tr>
<td>Denied Claims</td>
<td>117</td>
</tr>
<tr>
<td>Original Reference Number</td>
<td>117</td>
</tr>
<tr>
<td>Resubmission Code</td>
<td>117</td>
</tr>
<tr>
<td>835 Claim Status *Code</td>
<td>117</td>
</tr>
<tr>
<td>Denied or Rejected Claim Tasks</td>
<td>118</td>
</tr>
</tbody>
</table>
835 Reports ................................................. 118
Warning Messages on Report ................................ 119
Posting Options ............................................ 120
Available Actions ......................................... 120
Additional Options ....................................... 120
FAQ on Auto Posting ..................................... 121
Posting 835 Data Twice ................................... 122
Exporting 835 Data ....................................... 123
Reports .................................................... 124
Tips and Tricks ........................................... 124
Overview .................................................. 124
Report Criteria .......................................... 124
No Criteria Warning .................................. 125
Running Reports ........................................ 125
Exporting Reports ...................................... 126
Updating Reports ........................................ 126
Additional Reports ....................................... 127
Custom Reports ......................................... 127
Accounts Receivable .................................... 127
Description .............................................. 127
Adjustments .............................................. 128
Description .............................................. 128
Authorizations .......................................... 128
Description .............................................. 129
Claim List .................................................. 129
Description .............................................. 129
Disbursements .......................................... 129
Description .............................................. 129
Patient Demographics ................................. 129
Description .............................................. 130
Patient Ledger .......................................... 130
Description .............................................. 130
Patient List ................................................ 130
Description .............................................. 130
Patient Receipt .......................................... 131
Patient Services ........................................ 131
Description .............................................. 131
Payment List ............................................ 131
Description .............................................. 131
Troubleshooting ........................................ 132
Procedure Code Summary ............................. 132
Description .............................................. 132
Production Summary ................................... 132
Description .............................................. 132
Transaction List ......................................... 133
Description .............................................. 133
Tasks ..................................................... 134
Overview ................................................ 134
Assigned To ............................................ 134
Reminders .............................................. 134
Delete Tasks ............................................ 135
Document Linking ....................................... 137
About Document Linking ............................... 137
Configuration ........................................... 137
Add an Existing Document ............................. 137
Scanning a New Document ............................ 138
Working with Document Links ....................... 140
Libraries .................................................. 141
| View Last Statement | ................................................................. | 170 |
| Electronic Statements by TriZetto | ................................................................. | 170 |
| Institutional Claims Add-On | ................................................................. | 170 |
| **Eligibility** | ................................................................. | 172 |
| Eligibility Setup | ................................................................. | 172 |
| Checking Eligibility | ................................................................. | 172 |
| Troubleshooting Eligibility | ................................................................. | 174 |
| **Finding Data** | ................................................................. | 175 |
| Find Patient | ................................................................. | 175 |
| Other Actions | ................................................................. | 176 |
| Find Claim | ................................................................. | 176 |
| Other Actions | ................................................................. | 176 |
| Claim ID | ................................................................. | 177 |
| Find Service Line | ................................................................. | 177 |
| Other Actions | ................................................................. | 177 |
| Find Payment | ................................................................. | 178 |
| Other Actions | ................................................................. | 178 |
| Find Task | ................................................................. | 179 |
| Find Adjustment | ................................................................. | 179 |
| Other Actions | ................................................................. | 179 |
| Find Payer | ................................................................. | 180 |
| Other Actions | ................................................................. | 180 |
| Find Physician | ................................................................. | 181 |
| Find Disbursement | ................................................................. | 181 |
| **Import Appointments** | ................................................................. | 182 |
| Importing a Batch of Appointments | ................................................................. | 182 |
| Import and Edit a Single Appointment | ................................................................. | 182 |
| Claim Templates | ................................................................. | 182 |
| Rendering Provider | ................................................................. | 183 |
| Appointments Not Listed | ................................................................. | 183 |
| Import Appointments into Existing Claims | ................................................................. | 183 |
| Filters | ................................................................. | 184 |
| **Importing Data (via Interfaces)** | ................................................................. | 185 |
| Interface Setup | ................................................................. | 185 |
| Review Incoming Files | ................................................................. | 185 |
| Processing a File | ................................................................. | 186 |
| Import Batch | ................................................................. | 186 |
| Save for Later | ................................................................. | 186 |
| Delete Batch | ................................................................. | 186 |
| **Exporting Patient Data (via Interfaces)** | ................................................................. | 186 |
| Practice Fusion | ................................................................. | 187 |
| Duplicate Superbills | ................................................................. | 187 |
| Check Minutes | ................................................................. | 187 |
| Patient Payments | ................................................................. | 187 |
| ICD Codes | ................................................................. | 187 |
| Insured Information | ................................................................. | 187 |
| Disconnecting Practice Fusion and Premier | ................................................................. | 188 |
| WebPT | ................................................................. | 188 |
| Getting Started | ................................................................. | 188 |
| Premier Program Setup | ................................................................. | 188 |
| Importing WebPT Data | ................................................................. | 190 |
| **HL7 2.3.1** | ................................................................. | 190 |
| HL7 Duplicate Checking | ................................................................. | 190 |
| Technical Details | ................................................................. | 191 |
| Patient Matching | ................................................................. | 191 |
| Updating Patient Demographics | ................................................................. | 191 |
| Physician/Facility Library Matching | ................................................................. | 192 |
| Creating Claims | ................................................................. | 192 |
| Service Lines | ................................................................. | 192 |
| Procedure Code Lookup | ................................................................. | 192 |
# Program Setup
- Main Screen ................................................................. 193
- Patient ........................................................................... 193
- Patient Custom Fields .................................................... 195
  - Custom Field Types ..................................................... 195
- Claim ............................................................................. 196
- Claim Custom Fields ...................................................... 196
  - Custom Field Types ..................................................... 197
- Printing Claims ............................................................... 198
- Payment .......................................................................... 198
- Document Linking ......................................................... 198
- Company ........................................................................ 198
- Patient Eligibility .......................................................... 199

# Widgets........................................................................... 201
- Tile View ......................................................................... 201
- Classic View ..................................................................... 201
- Creating Widgets ............................................................. 201
- Displaying or Removing Widgets ...................................... 203
- Updating Widget Data ...................................................... 203

# Widget Descriptions.......................................................... 203
- Claims Over 120 Days ..................................................... 203
- Claims Over 90 Days ....................................................... 203
- Claims with a Credit Balance ........................................... 203
- Payments with Balance Remaining ................................... 203
- Undisbursed Payments .................................................... 204

# Manage Security Settings .................................................. 205
- Admin User ...................................................................... 205
- Security Modes ............................................................... 205
- Adding Users .................................................................... 205
- Permissions ...................................................................... 206

# Institutional Claims .......................................................... 207
- Payer Library .................................................................... 207
- Data Entry ........................................................................ 207
- Submitter/Receiver Library ............................................. 208
- Print Setup ....................................................................... 208
- Printing Claims ............................................................... 209
- UB-04 Boxes (Form Locator) ............................................ 209

# ICD-10............................................................................ 213
- FAQ on ICD-10 ................................................................ 214

# Company Files ................................................................ 217
- New Company ................................................................... 217
- Open Company ................................................................ 217

# Clearinghouse Reference................................................... 218
- Capario .......................................................................... 218
  - EDI Connection Library Settings for Claims and Reports .... 218
  - ANSI 270 (Eligibility) Submitter/Receiver Library Entry .... 218
- TriZetto EDI ..................................................................... 218
  - EDI Connection Library Settings for Claims and Reports .... 218
  - ANSI 837 (Claims) Submitter/Receiver Library Entry ....... 219
  - ANSI 270 (Eligibility) Submitter/Receiver Library Entry .... 220
- ZirMed ............................................................................ 220
  - EDI Connection Library Settings for Claims and Reports .... 220
  - Claim File Naming Convention ...................................... 220
  - ANSI 837 (Claims) Submitter/Receiver Library Entry ....... 221
  - ANSI 270 (Eligibility) Submitter/Receiver Library Entry .... 221
- Office Ally ........................................................................ 222
  - EDI Connection Library Settings for Claims and Reports .... 222
  - ANSI 837 (Claims) Submitter/Receiver Library Entry ....... 223
- Availity ........................................................................... 223
Frequently Asked Questions

Q – What features are available for ICD-10?
A – See “ICD-10” on page 213 for features related to ICD-10 and the ICD Indicator.

Q – How do I start using the new 1500 (02-12) form?
A – Select the new form version on the Printing Claims setup screen. See “1500 Form Version” on page 68.

Q – I updated the patient insurance information but the existing claims still show the old information.
A – Insurance information is stored with each claim. See “Editing Claim Insured Information” on page 46 for editing a single claim or “Update Claims Button” on page 34 for updating multiple claims.

Q – How do I enter a Refund?
A – Enter a negative payment. See ‘Entering Credits or Refunds’ on page 73 for more information.

Q – How do I enter Adjustments without entering in a payment?
A – Double click the adjustment amount in the claim service line, this will open the Adjustments window and allow you to add or edit line item adjustments.

Q – Are Custom Reports available?
A – Yes. Please contact EZClaim for pricing information.

Q – Are Custom Fields available? How are they configured?
A – Yes. The program contains 5 data fields on the Patient screen, 5 data fields on the Claim screen, and 3 custom fields for service lines. These fields can be any type of data…text, currency, date, yes/no box, etc. See “Patient Custom Fields” on page 195 for more information.

Q – Are other FAQs available?
“FAQ on Patients” on page 40
“FAQ on Claims” on page 61
“FAQ on Statements” on page 93
“FAQ on Auto Posting” on page 121
“FAQ on ICD-10” on page 214
Online Tutorials

Overview 2:29 minutes

Navigation and Grids 5:27 minutes

Create Claim 6:00 minutes

Send Claims 6:24 minutes

Rejected Claims Workflow 3:28 minutes

Payment Entry Basics 4:32 minutes

Report System 7:43 minutes

Downloading New and Updated Reports 0:29 minutes

BillFlash Electronic Statements 2:14 minutes

Practice Fusion and EZClaim Premier (PDF)
Data Entry Overview

The program will accept any characters for data entry. We suggest not using the following characters for data that will be sent electronically since they are used as delimiters and could cause a file to reject: ~ * :

Shortcut Keys

Most date fields will accept the letter ‘t’ to enter today’s date or ‘y’ to enter yesterday’s date.

Almost all buttons have a shortcut key. Press the Alt key on the keyboard to see which letter is used for each button.

Before pressing the Alt key

After pressing the Alt key

Notice that the ‘S’ is underlined. This means pressing Alt-S will act like the Save & Close button.

The Ribbon bar has the same features:

Other shortcut keys are available too:

- **t**  Enters current date
- **y**  Enters yesterday’s date
- **b** or **+** Enters ‘balance’ on Payment entry screen
- **F2** Creates a patient
- **F3** Creates a patient from a template
- **F4** Finds a patient
- **F5** Finds a claim
- **F6** New Claim
- **F11** Shuts the program down
- **Alt-Z** to activate the application menu
- **Alt-H** to show the home ribbon bar shortcuts
Opening the Program

Once the program has been installed, you will see a new icon on your desktop. Double click the icon to open Premier.

Main Screen

All primary billing functions can be handled from the Home Screen. Click on any Button, Tab or Grid to access information.
Ribbon Bar

The Ribbon Bar provides quick access to the many Premier Features. Click on the tab Home, Electronic Billing, Tools or Support, to display the Ribbon Bar categories under each heading.

A description below the Ribbon Bar defines the information available. Ex: File, Edit, Find, New etc.

Additional Ribbon Bars

Additional Ribbon Bar information will be available when opening a Patient record, Claim, or Tasks.

Hiding the Ribbon Bar

Click the ‘Home’ tab to hide the Ribbon bar, providing more room for the data entry screens. Click the ‘Home’ tab again to restore the Ribbon Bar.
Grids

EZClaim Premier makes extensive use of Grids. These grids are very powerful and offer capabilities beyond what you see on the screen.

**Column Chooser**

The ‘Column Chooser’ enables the user to add or remove columns from the data view. Most column chooser’s have a search field to help find the correct column. To show the column chooser, right click a column heading and select Column Chooser.

**Add** – Drag and drop columns into the header area at desired location.

**Remove** – Drag and drop a column outside the column heading area to remove it.

**Restored** – If you need to reset the grid to the original settings, right click any of the column headings and select ‘Restore Grid’.

**Grouping Data**

**Group Drop Zone** – Drag and Drop a column heading such as Classification, into the ‘group by this column’ area. Data will be sorted into the selected group. Multiple columns can be grouped at one time. To ‘Restore’ a column
heading, drag and drop back to column headings area. To ‘Hide’ this feature, Rt. click in the drop zone and select ‘Hide Group by Box’.

**Sort** – Click the column heading to sort A-Z and click again to sort Z-A. To sort more than one column, hold the Shift key and click additional column headings.

- Indicates the column is sorted A to Z
- Indicates the column is sorted Z to A

**Reorder** – Drag and drop a column heading to change the column order.

**Resize** – Click and drag the column separation bar to resize the column.

**Filtering Grids**

**Filter** – Click the icon (available when the mouse is hovering over the column heading) to bring up the filter list. Filtering is also possible from the filter row.

**Advanced Filtering** – By clicking the filter icon, you can select ‘(Custom)’ to open the advanced filtering window. This allows multiple filter criteria.

For text columns (such as name or account number columns), the % is used as a wild card. Entering s%l would match ‘Sim, Abigail’, ‘Strick, Darryl’, and ‘Sums, Manuel’
Filter Editor – Right click any of the column headings and select ‘Filter Editor’. The filter editor allows additional filter capabilities.

Printing Grids

Printed – Right click any of the column headings and select ‘Print Grid.’ The program will print ALL the data in the grid (even the data you need to scroll down to see).

If the grid has been filtered, only the filtered data will be printed.
Exporting Grids

Any grid can be exported to Excel or a variety of other formats. Right click a column header and select Export then the desired format.

Exporting Large Datasets

Exporting Reports or exporting data to formatted file types can cause your computer to run out of memory because it cannot handle the large amounts of data. To export extremely large datasets, use the 'CSV File (Bulk Data)' format. It’s been designed to handle large amounts of data without taxing your computer resources.

1. Right click a grid column heading
2. Select Export To >
3. Select CSV File (Bulk Data)
Vertical Grids

Vertical grids are used to show a single set of information. Examples of this would be on the claim screen. There is a vertical grid that contains the claim details.

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>Bill Date</th>
<th>Last Exported</th>
<th>Total Charge</th>
<th>Total Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sort Ascending</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td>Sort Descending</td>
<td>$50.00</td>
<td>$50.00</td>
<td>$50.00</td>
<td></td>
</tr>
<tr>
<td>Group By This Column</td>
<td>$150.00</td>
<td>$150.00</td>
<td>$150.00</td>
<td></td>
</tr>
<tr>
<td>Hide Group By Box</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td>Removes This Column</td>
<td>$150.00</td>
<td>$150.00</td>
<td>$150.00</td>
<td></td>
</tr>
<tr>
<td>Column Removes</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td>Best Fit</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td>Best Fit (all columns)</td>
<td>$170.00</td>
<td>$170.00</td>
<td>$170.00</td>
<td></td>
</tr>
<tr>
<td>Filter Editor</td>
<td>$50.00</td>
<td>$50.00</td>
<td>$50.00</td>
<td></td>
</tr>
<tr>
<td>Show Field Panel</td>
<td>$150.00</td>
<td>$150.00</td>
<td>$150.00</td>
<td></td>
</tr>
<tr>
<td>Hide Field</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td>Restore Grid</td>
<td>$150.00</td>
<td>$150.00</td>
<td>$150.00</td>
<td></td>
</tr>
<tr>
<td>Print Grid</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$100.00</td>
<td></td>
</tr>
</tbody>
</table>

Vertical grids can be customized as well. Each row can be repositioned or fields can be added or removed.

Right click the grid and select Customize Grid.
As you drag fields around the grid, two different icons will appear to help you place the fields in the correct location.

This icon: ![align-right] will place the field in line with the rest of the fields.

This icon: ![indent-right] will place the field indented to the field above (as shown below). Notice how the Invoice # field is indented below the Status field.

Moving fields around a vertical grid can get tricky. Remember you can always restore the grid to its original format by right clicking and selecting 'Restore Grid'.

**Conditional Formatting**

Most grids have the ability to conditionally format the cell based on the data. For example, you can have patients with a balance greater than $50 show up red.

To set the formatting rules, right click the column heading and select Conditional Formatting.

Follow the onscreen prompts to set your criteria. There are many different possibilities including icons, gradients, and data bars.
Navigation

Home Screen

Quick Access Buttons
Click on any Button to quickly access data or common tasks.

Widgets
Widgets are a customized list of information for quick access. See “Widget Library” on page 165 for setting up and using Widgets.

Quick Access Tabs
Use the following tabs for quick access to Patient, Claims, Reports and Tasks.
Patient Tab

The ‘Patient’ tab is primarily used to find and manage patients in the system. Features include the ability to filter lists, quick access to claim screen, customize columns and view more detail information about the patient.

Select a Patient and detailed information will then be available in the ‘Detail’ area below.

- **Add** additional columns by right clicking on any heading and select ‘Column Chooser’. Drag and Drop selection to column headings area.

- **Quickly find** patients by entering name in the filter field. Click on the x to clear filter field.

- **Open a new** claim screen by clicking on the icon next to the name. See “Column Chooser” on page 15.

- **Columns may be removed** by dragging the column header outside the search pane area.

- **To sort** information such as Classification, drag and drop the column header into the ‘group by that column’ area. To return column header, drag and drop back to column headings.

Patient Tab Column Descriptions

Some of the columns available on the grid are the following:

**Tot. Cla. Bal.** – Total Claim Balance – This represents the total balance of all the patient’s claims. If you went to the ‘Find Claim’ grid and filtered by that patient, the footer grand total for ‘Total Balance’ would match.

**Ins. Bal.** – Insurance Balance – This represents the amount not due by the patient.
**Pat. Bal.** – Patient Balance – This represents the amount due by the patient. It takes into account any undisbursed patient payments. For example, if a claim had a $100 patient balance and there was a $75 patient payment that was not disbursed, the patient balance would be $25.

**Pat. Cla. Bal.** – Patient Claim Balance – This represents the patient balance for all the patient’s claims. It does not take into account undisbursed patient payments. For example, if a claim had a $100 patient balance and there was a $75 patient payment that was not disbursed, the patient claim balance would still be $100.

**Pat. Unapplied Bal.** – Patient Unapplied Balance – This represents the total amount of patient payments that are waiting to be disbursed. For example, if the patient paid $100 and $75 was disbursed, this would show $25.

Here are some formulas for reference:


**Claims Tab**

Click on the ‘Claims’ tab for a list of active patient claims.

**Reports Tab**

Click on the ‘Reports’ tab for quick access to Reports. See “Reports” on page 124 for additional Report information.

**Tasks Tab**

Click on the ‘Tasks’ tab for quick access to previously set up Tasks. See “Tasks” on page 134 for more information.
<table>
<thead>
<tr>
<th>Due</th>
<th>Subject</th>
<th>Assigned</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filter</td>
<td>Filter</td>
<td>Filter</td>
<td>Filter</td>
</tr>
</tbody>
</table>
Quick Start for Premier Billing

This Quick Start will take you through the basics of the program and guide you through entering your first claim.

Security

One of the first tasks that should take place is the creation of the ADMIN password. This is the password used to access certain areas of the program when user security has not been enabled and serves as a backup admin account.

To set the ADMIN password, access an admin required area.

1. Click the Libraries icon

2. Select Add-On Services

3. A message will appear explaining that the ADMIN password needs to be set.

4. Enter the password twice and click OK.

5. The Add-On library will open.

6. Click the Close button to close the library

See “Manage Security Settings” on page 205 for more information on managing security settings.

Payer Library

Home tab > Payer

Payer information must be entered before entering ‘Physician Library’ data. See “Payer Library” on page 155 for more information.
1. Enter name and address of Payer.

2. Enter Payer ID number if submitting claims electronically (Contact your Payer or CH for Payer ID numbers)
   *It’s very important that the Payer ID be entered. Especially if you have multiple entries for the same payer (such as UHC having different mailing addresses, etc). This is critical in making the payment posting work smoothly. The program uses the Payer ID to link multiple payer library entries together when posting payments.*


4. Enter ‘Ins Type Code’ is submitting Medicare Secondary Claims.

5. Select ‘Claim Filing Indicator’ if submitting electronic claims.

6. All other fields are ‘Optional’.

7. Click on one of the ‘Save’ buttons.

8. Payer information is now listed in the box above.

**Edit Payer Information**

To edit Payer information once it has been entered, highlight the Payer, edit Payer information, click one of the ‘Save’ buttons.

**Physician, Facility Library**

*Home tab > Physician Facility*

**Physician/Facility Library information must be entered before entering Patient data.** Once entries are set-up in the Library, they will be selected on Premier data entry screens. Setting up Physician Library data correctly is important for error free claim submissions.

**General Information**

**Classification** - The ‘Classification’ determines in which Premier drop-down list the name will appear. For example, if you select ‘Billing’ as classification, the name will be displayed when selecting ‘Billing Provider’ information.
What is Rate Class? Rendering providers can be assigned a ‘Rate Class.’ A Rate Class is used in conjunction with the Procedure Code Library. Rate Class identifiers previously set up in the Procedure Code library will be displayed in the ‘Rate Class’ drop down box. (See “Procedure Code Library” on page 159 for setting up a ‘Rate Class’ in the Procedure Code Library)

Rate Class: Phy Assist

When using the Procedure Code Library to enter code data on a claim, the code list will be filtered based on the ‘Rate Class’ of the claim’s Rendering provider.

NPI numbers - NPI numbers will be validated during data entry. If the number looks invalid, a Tool tip message will appear warning you of an invalid NPI number. The warning does not prevent saving the library entry.

To find the NPI number of an entry, click on the Lookup NPI link next to the NPI field.

Additional ID Numbers - To enter Additional ID Numbers, select a Payer, press the tab key, select the type of ID from the list, press the tab key, enter the ID number, then press the tab key to save the entry.

Mark as Inactive

To hide a Library entry, mark the entry as ‘Inactive’. Do not delete the entry if being used on patient or claim records.

To view Inactive entries, select ‘All’ or ‘Inactive’ from the filter list.
Physician/Facility Information

1. Enter the Display Name of Provider, Agency or Business Name.

2. Select ‘Billing’ as Classification. The Classification determines in which drop-down list the name will appear when entering claim data. **Note:** If submitting an electronic ANSI 837 file, do not enter a PO Box number for **Billing Provider information.** Enter Physical Address and then click on the ‘Pay-to-Provider’ button to enter PO Box information.

3. Check ‘Signature on File’.

4. Select ‘Entity Type’ as ‘Person’ or ‘Non-Person’ if Agency or Business name.

5. Enter Last Name and First Name or Organization name.

6. Enter Address information and 9 digit zip code.

7. Enter ‘Individual’ or ‘Organizational NPI’ number and Tax ID Type and Number. Use Lookup NPI if needed.

8. Situational: Enter Taxonomy Code only if required by your Payer.

9. If required by your Payer, enter ‘Additional ID Number’ by clicking in the blank line.

10. Click on one of the ‘Save’ buttons.

**Additional Library Classifications**

Continue entering additional Provider/Facility information.

- **Rendering** – Last, First name and NPI number.
- **Facility** – Name and Address, 9 digit zip code, NPI if required.
- **Referring** – Last, First name and NPI number.
- **Ordering** – Last, First name, NPI and full physical address.
- **Supervising** - Last, First name and NPI number.
New Patient

- **Do not** use initials or credentials. MR., MS., DR., MD, INC. etc.
- **Do not** use words such as ‘SAME’ or ‘NONE’ or ‘N/A’.

Use expander buttons to view additional information.

1. Enter Patient information manually or select a ‘Patient Template’. See “Patient Templates” on page 42 for creating and using Patient Templates.

2. Optional; Classification, Claim Template (See “Claim Template Library” on page 143 for creating Claim Templates), Copay Amt or Percent.

3. Enter Diagnosis codes on Patient Information screen only if codes remain the same for all dates of service. For electronic claims, up to eight Diagnosis codes may be entered. Claim specific codes will be entered on the Charges screen.
4. Enter Patient Contact Information for your records. This information will not be sent with a claim.

5. Enter previously set up Physician/Facility information; Billing Provider, Rendering Provider, Facility, and/or Referring Provider as required by your Payer.

6. Use expander button to open Additional Claim Information.

7. Use expander buttons to add additional Patient information as required by your Payer.

**Insurance Information**

**Note:** Click on ‘Add Ins’ or ‘Lookup’ button to enter Insured’s information.

### Primary Insurance

1. If the Patient is the same as the Insured, click the ‘Copy Information from the Patient’ button or enter new information.

2. Using the drop-down arrow, select the Payer previously set-up in the Physician/Facility Library.

3. Enter the Insured’s ID.

4. Enter ‘Patient Rel to Insured’.

5. Enter ‘Accept Assignment’.

6. Enter ‘Claim Filing Indicator’ if submitting electronic claims.

7. All other fields are situational.
Additional Payers

1. Click on ‘Add Ins’ to add additional Payers.
2. Follow guideline above.

Note: To delete a Payer, click on the ‘Delete’ button.

New Claim

Home > Create Claim

Tip: To quickly open a new claim, click on the Claim icon next to Patient name in the search pane.

Creating the Claim

1. Click ‘Claim’ button on menu bar or ‘Create Claim’ from the Home screen. Click the ‘Select’ button beside the patient to add a claim.

2. Optional: Select ‘Previous Claim’, ‘Previous Service’ or a previously created Custom template. See “Claim Template Library” on page 143.

3. Enter Diagnosis codes if they had not been previously entered on the Patient Information screen.

4. Expand grids by clicking on the expander button to confirm additional information. To Edit claim information in the grid, click in the field to view additional options.
Note: DME claims will need to select an Ordering Provider. See “Claim Information Grid” on page 47, for adding the ‘Ordering Provider’ row under the ‘Physician Library Entries’ category.

5. To quickly enter service line dates, click on a Date on the calendar. Dates may also be entered manually.

6. Required - Place of Service, must use 2 digits: below are the most commonly used values. Contact your Payer for additional codes.

   11 - Office
   12 - Home
   21 - Inpatient Hospital
   22 - Outpatient Hospital
   23 - Emergency Room - Hospital
   24 - Ambulatory Surgical Center
   53 - Community Mental Health Center
   81 – Independent Laboratory
   99 – Other Unlisted Facility

7. Enter the diagnosis code line number (POINTER) on the charges line. Do not use the actual diagnosis code in this box, only pointers. Enter no more than four DX pointers on each service line.

8. Continue entering required data in Service Line.

Note: For additional Claim information see “Claim” on page 45.

Next Steps

“Printing Claims” on page 62

“Electronic Claims” on page 95

“Reports” on page 124
Patients

The Patient Information screen is for managing **Patient**, **Insurance**, **Provider** and **Statement** information. There are also fields for Reminder and Patient notes and the option of adding five Customized fields.

**Data Entry Tip:** When the patient screen is scrolled to the bottom, the Save & Close button may not be visible. Use Alt-S to save and close the window or use the ribbon bar buttons.

**Classification**

Classification designation is used as a means to organize patients. A patient’s classification is not printed on paper claims or sent with electronic claims. The list is maintained dynamically. As new entries are added, they are available in the drop down list.

Selecting a Classification is optional but useful for the user to sort or run reports based on patient’s Classification.

When entering Patient data, use the drop-down arrow to select a previously entered Classification or enter a new Classification name.

To remove entries from the list, use the List Library available under the Libraries icon on the ribbon bar.

The classification field can hold 30 characters.

**Claim Templates**
On the Patient Information screen, Claim Templates can be assigned to patients if the patient will use a specific ‘Claim Template’ for most or all claim charges.

If a Claim Template has been selected on the Patient Information screen, when creating a new claim, the template will be selected automatically. You can change the Claim Template at any time either on the Patient Info screen or on the Charges screen. Selecting a different Claim Template will not affect existing data. See “Claim Templates” on page 55 for selecting Claim Templates.

**Account #**

The program can be configured to automatically enter a patient account number or allow you to enter a number. See the Patient section in “Program Setup” on page 193 for setting account number options.

**Auto**

Account #: AUTO

**Manual**

Account #: 

**Update Claims Button**

The Update Claims button allows you to change 1 or more claims for a patient. This button is normally used when you’ve made a mistake with patient data entry and have already created multiple claims that need to be updated.
You can change the following information:

- Insurance Information
- Diagnosis Codes
- Physician / Facility Entries
- Initial Claim Values
- Bill To selection
- Service Line Responsible Party
- Claim Status

**Updating Claims**

1. Click the ‘Update Claims’ button
2. Select the claims to update
3. Place a check on the items to update and/or select from the drop down lists
4. Click the ‘Update Claims’ button

**Additional Claim Information**

Click on expander arrow to open ‘Additional Claim Information’. Select ‘Signature Source’ to print ‘Signature on File’ in boxes 12 and/or 13.
Initial Claim Values

Click on the 'Initial Claim Values' button to open data entry box and then 'Click here to add a new row'. Select items to add. Information entered in this area will be used when creating new claims only. Existing claims will not be affected. Initial claim value may still be edited on Charges screen after the new claim is created.

Claim specific information would be entered on the Charges screen in 'Claim Information' grid.

Other Patient Information

Additional Data

The EZClaim Premier program contains 5 data fields on the Patient screen, and 5 data fields on the Claim screen that may be customized. These fields can be any type of data…text, currency, date, yes/no box, etc. Go to Tools Ribbon Bar > Program Setup to customize fields. See “Program Setup” on page 193 for working with Custom Fields.

Statement Information

Premier will use the insured’s mailing address for patient statements. To use a different name and address enter information below. This information will be the statement mailing name and address for this Patient.

Statement Message is used to print a personalized message on statements.

Last Statement Date shows the last time a statement was printed for the patient.
Don’t Send Statements – Check this box if you do not want the patient to appear in the statement list.

Don’t Send Promotions – This field is not currently used by the program.

Reminder Note

Reminder Note is a message that is shown in the search pane in both the Billing and Scheduling programs. Also used as popup text when creating appointments or marking appointments as attended or not attended (KEPT or NOT KEPT) type statuses).

‘Reminder Note Prompts’ may only be used with the EZClaim Scheduler program.

Specific Field Information

- **Account #** - A field showing AUTO means the program will automatically set the account number when the patient is saved.

- **Diagnosis Codes** – The diagnosis code values are used when creating a new claim but can be modified on the claim screen. Double click or press Alt-L to open the Diagnosis Library screen.

- **Box 12: Print Current Date** – Prints the current date (or text of your choice) in box 12 of the 1500 form.

- **Box 13: Print Claim Bill Date** – Prints the original bill date in Box 31 of the 1500 form. The original bill date is the date the claim was first printed or exported.

- **Signature Source** – Used to print ‘Signature on File’ in Box 12 and/or 13 of the 1500 form. Also used in electronic billing.

- **Patient Member ID** – Only used in special electronic billing situations. Do not enter data unless required by the payer.

- **External ID** – Used with some interface formats. If using interfaces (or plan to), do not enter or modify data in this field unless directed to by EZClaim. Otherwise you can use this field as needed.

- **Statement Information** section – Used when printing Statements to direct the statement to another name and address.

- **Statement Message** – Used to print a Personalized Message on statements.

- **Last Statement Date** – Shows the last time a statement was printed for the patient.

- **Reminder Note** – A message that is shown in the search pane in the Billing and Scheduling program. Also used as popup text when creating appointments or marking appointments as attended or not attended (KEPT or NOT KEPT type statuses).
- **Copay Amt or Percent** – Stores the Copay Amount. If you would like the copay amount to be entered on the service line, be sure the ‘Set Pat. Amt. Due’ column is checked in the procedure code library. The program will enter the dollar amount into the Patient Amount Due field when the procedure code is used.

### Make Patient Inactive

To remove a Patient record from the Patient list, uncheck the [Active] checkbox. To reactivate the patient go to Home tab>Find. Use the drop-down and select ‘Find Patient’. Open patient record and check the ‘Active’ checkbox. User must have permission to edit patient records. User permissions are set under ‘Manage Security Settings’ on the Tools Ribbon bar.

### Lock Patient Record

Use the checkbox [Locked] to lock a patient record. If the Patient record has been ‘Locked’, the user will not be able to unlock the record unless user has been given permission by the Admin. User permissions are set under ‘Manage Security Settings’ on the Tools Ribbon bar.

### Delete Patient

Patients can only be deleted if there are no claims or payments associated with the patient. We recommend making patients inactive instead of deleting them.

To delete a patient, click the Delete button on the patient screen.

You will be presented with a confirmation box similar to the following:

![Confirmation Box](image)

**IMPORTANT:** When you delete a patient, all claims and payments associated with the patient will be deleted. We recommend marking a patient inactive instead of deleting.

You MUST check each box before the ‘Delete Patient’ button will become active. Once each check box has a check, click the ‘Delete Patient’ button to delete the patient.

Click Yes to the confirmation. Clicking Yes will delete the patient and all associated claims and payments.
Copy Patient

The Copy Patient function will copy the currently open patient to a new patient tab. It will not copy the insurance information. If you would like to copy the insurance information from another patient, use the Lookup button.

Merging Patient Records

This is an Admin level feature. You must know the admin password or have admin permissions to use it.

If you have duplicate patient records, you can move one patient’s claims and payments to another patient. The Merge Patient button appears when you have a patient record open.

All the records from the patient on the left will be moved to the patient on the right. The original patient will not be deleted. After you click Merge Patients, a confirmation will appear along with an operation completed message.

Patient Notes

Patient Notes will keep a history of when the Patient was created, when Patient information was edited and who edited the information.

If user logins are activated, notes created by one user cannot be deleted or edited by another user.

Tracking notes automatically entered by the system cannot be deleted or edited.

To expand notes click on expansion arrow in the upper right corner.
**Note Editor**

Notes can be shown in a pop-up window by right clicking in the note and selecting ‘Show in Pop-up.’ This will place the note into a large editing window allowing you more room for editing. You can also print the individual note by clicking the ‘Print’ button.

**Highlighting Notes**

Right click a note, select Highlight, then a color to highlight a patient note.

**FAQ on Patients**

Q. How do I automatically generate account numbers?

A. Turn on auto account numbers from Tools tab > Program Setup > Automatically Generate Account Numbers

Q. Where is the insured’s (subscriber) Social Security Number field?

A. The SSN field is normally hidden from the user. Close Patient screen if open. Go to ‘Program Setup’ (Tools>Program Setup) there is an option to ‘Show Subscriber SSN.’ Once checked, the field will appear in the subscriber insurance area of the patient screen.

Q. How do I handle Self Pay patients?
A. If a patient does not have insurance, simply leave the insurance area blank on the patient record. When a claim is created, the program will automatically mark the claim as being the patient’s responsibility. You can then create statements from the claim data.
Patient Templates

Patient Templates are used to pre-fill fields in order to reduce repetitive data entry. A Patient Template may be selected as a default setting to be used automatically every time a new patient is created. See the Tools Ribbon Bar > Program Setup section to set the default template.

If you bill to multiple insurance companies or bill for multiple doctors, patient templates can be very helpful. For example, for BC/BS patients, you could have a BC/BS template that has the BC/BS address information, Providers PIN#, etc. already entered so when a new patient is being billed, you can start with the BC/BS template then fill in the patient name and address. If you bill for multiple doctors, you could have a template set up with each Provider’s individual information.

Creating a Patient Template

1. From the Home menu bar, use the Patient drop-down arrow to select ‘Patient from a Template’. When the message asks if you like to would like to create a new template, click on Yes.

2. Enter a name to identify the template. Ex: Dr. Jones or Medicare etc.

3. The name ‘EZTEMPLATE’ will be entered in the Patient last name field and the name of your template will be in the Patient first name field. **DO NOT MODIFY THE FIRST OR LAST NAME.** The first and last name is used by EZClaim to track the template.

4. Enter data into fields you would like pre-filled. Ex: Provider Address and NPI number.

5. Click the ‘Save and Close’ button to save the template and clear the screen.

Using a Patient Template

1. From the Patient button, use the drop-down arrow to select ‘Patient from a Template’

2. Select a Template from the list.
3. Click the OK button.
4. Enter your new patient data.

**Editing a Patient Template**

1. Click the ‘Patient Template’ icon.
2. Select the Template you would like to edit.
3. Click the ‘Edit’ button.
4. Make any changes needed.
5. Click the ‘Save & Close’ button save the template and clear the screen.

**Deleting a Patient Template**

1. Click the ‘Patient Template’ icon.
2. Select the Template you would like to edit.
3. Click the ‘Edit’ button.
4. Click the ‘Delete’ button to delete the template.

**Apply Template to Patient**

If a patient record already exists, you can still apply a Template to the record. The program will only enter data into fields that are blank.

1. Select and open Patient record.
2. Click on the ‘Apply a Template’ from the Patient ribbon bar.
3. Select by highlighting a Template.
4. Click on OK. Template data will be applied but will not overwrite fields that have been modified from their initial value.

**Automatic Patient Template**

The program can be configured to use a patient template every time you create a new patient even if you do not use the ‘Patient from a Template’ option.

1. Create a patient template using the instructions.
2. Open the Program Setup window and set the Automatic Patient Template.
When creating a new claim, there are various ways to access the Claim screen. From the Home screen click on ‘Create Claim’ or from the Patient search pane, click on the Claim icon next to the patient’s name and a new Claim screen will open for the selected patient.

Overview

When creating a new claim, the following steps are performed by the program.

- A blank claim is created. Claim ID set to ‘New’. Status set to ‘Ready to Submit’
- The ‘Bill To’ list is populated based on the current Insurances entered on the patient record.
- The claim submission ‘Method’ is set based on the payer setting in the payer library (Paper or Electronic).
- The ‘Date of Current’ is populated with the date from the patient’s previously entered claim, the Initial Claim Value or left blank.
- The Diagnosis codes are set based on the codes entered on the patient record.
- The ‘Initial Claim Values’ from the patient record are read and the claim values set accordingly.
• If the patient has a ‘Claim Template’ defined, the claim template values are applied (possibly overriding the physician library entries and/or the diagnosis codes). See “Claim Template Library” on page 143.

• Service lines may also be added automatically if creating claims from appointments.

• A warning will appear when saving a claim with more than 50 service lines for professional claims and 999 for institutional claims.

Bill To

The ‘Bill To’ list is based on the Insurance information on the Patient record. The text of the selected ‘Bill To’ will contain information, ex: (1/2), so a user can see how many insurance records the claims has.

Editing Claim Insured Information

On the Claim screen, click on button to open the Insured's information.

Edit Insured's information and click on 'Save'.

Edit All Claims for a Patient

To edit Insured information for multiple claims for this patient, go to Patient Information screen, edit insurance information and click on 'Update Claims'.

When does the claim's ‘Bill To’ change?
The program will automatically change the ‘Bill To’ based on service line responsible parties.

Examples:

<table>
<thead>
<tr>
<th>Current Bill To</th>
<th>New RP for Service Line 1</th>
<th>New RP for Service Line 2</th>
<th>New Bill To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Secondary</td>
<td>Secondary</td>
<td>Primary</td>
</tr>
<tr>
<td>Primary</td>
<td>Primary</td>
<td>Secondary</td>
<td>Primary</td>
</tr>
<tr>
<td>Primary</td>
<td>Secondary</td>
<td>Secondary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Patient</td>
<td>Secondary</td>
<td>Secondary</td>
<td>Patient</td>
</tr>
<tr>
<td>Primary</td>
<td>Patient</td>
<td>Patient</td>
<td>Patient</td>
</tr>
<tr>
<td>Primary</td>
<td>Patient</td>
<td>Patient</td>
<td>(notice it skipped the secondary)</td>
</tr>
</tbody>
</table>

Claim Status Setting

If the claim ‘Bill To’ setting changes to another insurance company, the program will change the status back to ‘Ready to Submit’ so you know the claim is ready to submit to the next insurance company. The status will remain as ‘Submitted’ when you change the ‘Bill To’ to ‘Patient.’

If the payer listed as the ‘Bill To’ has the ‘Automatically Forwards Claims’ option checked in the Payer Library, the Claim Status will not change. This prevents claims from being sent if the primary payer automatically forwards the claims to the secondary.

When auto-posting, if the 835 claim status says forwarded to additional payers, then the status will remain at submitted.

Claim Information Grid

Rows

Claim information Grids displays all ‘Physician Library’ information along with additional Claim information. Not all fields are required and Grid categories may be customized to add additional fields.

Click on expander arrows to open Claim categories. Right click the grid and select ‘Customize Grid’ to add additional rows.
Drag and Drop additional row information to Category location. ‘Accident Date’ would be dropped under the ‘Date Information’ category.

To remove a row, open the Customization box, drag and drop the row back to Customization dialog box.

Categories

Additional ‘Categories’ may be added to the Grid. To add a customized Category, click on ‘New’.

Enter new Category name. Drag and drop to grid.
Claim Status Information

The Claim Status on new claims is automatically set to ‘Ready to Submit.’ Once the claim has been Exported or Printed, the claim status changes to ‘Submitted.’

Prior Authorizations

If authorizations are available for a Patient/Payer selection, the program will notify you on the charges screen. It is up to the user to select the correct authorization. See “Authorization” on page 142 for more information.

There is an informational Icon to the right of the authorization selector.

If the icon is ‘blue’ it indicates that there is a claim insurance that has an authorization available, but does not have any authorization number assigned, otherwise, the icon is ‘gray’.

Hovering over the icon shows a summary of the claims’ authorization information.

To select the Authorization number, click on the button. To open the Authorization Library click on the button.

If an authorization is not showing, be sure the authorizing payer (set in the authorization library) matches the bill to payer.

The list will only show authorizations that have units and/or dollars remaining. If you have used up all the available units, the auth will not appear in this list.
When selecting an authorization, if the <No Template> option is being used to create the claim, the auth’s procedure code will be added to the ‘preview’ line.

**Authorizations and Claim Templates**

When selecting an authorization, if the Claim Template is set to `<No Template>`, the program will pre-fill the service line preview row with the procedure code, modifier(s), and any other information such as charges from the procedure code library. NOTE: This only works if the template is set to `<No Template>`.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2023</td>
<td>21</td>
<td>91834</td>
<td>A2</td>
<td>B3</td>
<td>C4</td>
<td>D5</td>
<td>E6</td>
<td>F7</td>
<td>$50.00</td>
<td>1</td>
<td>0.00</td>
<td>50.00</td>
<td>10.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Authorization Data Checks**

When saving a claim, there are three authorization data checks the program performs.

**Dates between the start and end date.** If outside the date range, the following message will appear.

![Service DOS Outside of Authorized Unit Entry](image)

**Unit count is lower than Units Allowed.** If unit count is higher than allowed, the following message will appear.

![Units Exceeded Units Allowed in Authorized Unit Entry](image)

**Total dollar amount below the Dollars Allowed.** The program first checks for the service line allowed amount value. If the allowed amount value is $0.00 then it will use the charge amount to determine if a warning should be shown.

**Diagnosis Codes**

If submitting claims electronically, up to 12 Diagnosis codes may be entered.

<table>
<thead>
<tr>
<th>Diagnosis A1</th>
<th>B2</th>
<th>B3</th>
<th>B4</th>
<th>C5</th>
<th>C6</th>
<th>D7</th>
<th>E8</th>
<th>F9</th>
<th>G10</th>
<th>H11</th>
</tr>
</thead>
<tbody>
<tr>
<td>54321</td>
<td>8765</td>
<td>98765</td>
<td>65432</td>
<td>E10</td>
<td>F11</td>
<td>G12</td>
<td>H13</td>
<td>I14</td>
<td>J15</td>
<td>K16</td>
</tr>
</tbody>
</table>

When the mouse is hovering over a diagnosis field, the description from the code library will appear. If a description does not appear, make sure the code is entered properly in the library.
On the Service line, enter Diagnosis code corresponding number. All Diagnosis codes entered on the claim must have a corresponding number on a service line.

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Diagnosis Code</th>
<th>Service Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/08/2013</td>
<td>11</td>
<td>90834</td>
<td>ABCD</td>
<td>$50.00</td>
</tr>
<tr>
<td>11/15/2013</td>
<td>11</td>
<td>90834</td>
<td>ABCD</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

**Diagnosis Code Lookup**

Double click a diagnosis field to open the lookup library list. Use the ICD selector to change between the ICD-9 and ICD-10 code sets.

Another option is to use the ICD10Data.com web site to lookup codes. To access, right click the diagnosis field and select ‘Lookup ICD-10 on ICD10Data.com’

Once a code has been found, click the ‘Use’ button.
Calendars

Enter Service line dates by clicking on a calendar date. Use the < > arrows to move between months or years.

Special keys available after selecting the 'From Date':

- Holding the CTRL key down while clicking a date will set the 'To Date' on the newly added service line.
- Holding the CTRL and SHIFT key will set the ‘To Date’ and update the number of units to the number of days in the span on the newly added service line.
- Holding the SHIFT key down while clicking a date will add a service line for every date between the From and To date.

Service Line Grid

The Service Line holds all Charge and Payment information required for submitting a claim to the Payer. The Service Line may be customized by adding additional columns using the Column Chooser.

Right click on any column heading and select ‘Column Chooser’. Drag and drop column selection into the header area at desired location. See “Column Chooser” on page 15 for additional information on working with Column Headings.

The ‘Add’ button is only enabled when a Srvc Date has been entered. The ‘Add’ button can be used instead of clicking a calendar date.

When changing the number of Units on a service line, the Patient Amount Due, Cost and Adjustment columns are not changed. Only the Charge and Allowed columns are updated.

When changing the number of Units, the current charge is divided by the original units to get the ‘per unit’ amount; it is then multiplied by the new number of units.

\[ \text{<New Charge>} = \frac{\text{<Old Charge>} \times \text{<New Units>}}{\text{<Old Units>}} \]

If an adjustment is entered on the ‘Add’ line, it will be saved as a contract adjustment with a group code of CO and a reason code of 45.
Procedure Code Lookup

To open the ‘Procedure Code Lookup’ window, double **click** in the Procedure code field. The program will filter the code list based on the Bill To payer, the Billing Provider and Rate Class associated with the claim.

See “Procedure Code Library” on page 159 for more information about the procedure code library.

In the ‘Procedure Code Lookup’ window, double click on the Procedure Code to enter it into the service line.

The following fields are populated from the library: Procedure, Product, Modifiers 1-4, Charges, Units, Allowed, Adjustment, Cost, NDC (Drug) Code, Drug Unit Measurement, Drug Unit Count, and Revenue Code.

If the Set Description is checked in the library, the line item description will be set with the code description.

If the Set Patient Amount Due is checked in the library, the program will enter a patient amount due based on their patient record.

**Additional Information**

- If you select the same code from the lookup library that is already on the service line, nothing will happen.
- The combination of Procedure code and Product code determines which library entry to use. The product code column is not shown normally and is only used in special situations.

**Responsible Party**

The Resp. Party is used to determine who is responsible for the line item balance. The field is managed by EZClaim but can be manually set by the end user. Click in the ‘Resp. Party’ field to display the drop-down arrow.

The responsible party (RP) will change to the next party when a payer payment or adjustment is applied to the service line that matches the payer currently set as the responsible party.

Each time a service line responsible party changes, the program will re-evaluate the claim to determine if the ‘Bill To’ needs to be changed.

**Exceptions:**
• If the Bill To Insured’s Accept Assignment is ‘No’, then the program will not change the responsible party.

• If using tracking type Adjustments, the responsible party will not change.

Examples:

<table>
<thead>
<tr>
<th>Current Resp. Party</th>
<th>Payer used when entering a Payment or Adjustment</th>
<th>New Resp. Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Primary</td>
<td>Secondary</td>
<td>Primary (no change because the payers do not match)</td>
</tr>
<tr>
<td>Primary</td>
<td>Blank</td>
<td>Primary (no change because no payer was set)</td>
</tr>
</tbody>
</table>

**Line Item Notes**

Right click on any column heading to select ‘Column Chooser’ dialog box.

Scroll to ‘Service Line Description’ and drag and drop within the column headings or below the column headings.

Click in area below the service line and enter ‘Line Item’ notes.

837 Notes: Information entered into this area will be exported into Loop 2400 Segment NTE Field 2

![Service Line Notes](image)

**Drug Code Fields**

Additional fields are available if billing for drug administration.

837 Note: Drug information is only exported if the NDC code is entered.

These fields are:

• NDC Code – National Drug Code used in the 837 LIN02 segment.

• Drug Unit Count – Enter a unit count if different from the service units. Exported in the 837 into the CTP04 segment.

• Drug Unit Measurement – Enter the Unit Measurement Code. If left blank, ‘UN’ will be used in CTP05. Valid values include:
  
  o F2 – International Unit
  
  o GR – Gram
  
  o ME – Milligram
  
  o ML – Milliliter
- **UN - Unit**
  - Drug Unit Price – This field is no longer used in the ANSI 837 5010
  - Prescription Number – Used to report the prescription number. Exported in the 837 into the REF02 segment with a XZ qualifier. The REF’XZ segment will only be exported if an NDC Code is entered on the service line.

**Other Service Line Fields**

- **Print/Export** – If unchecked, the service line will not be printed or exported.

- **Cost** – This field is for your reference only. It is not used when printing or exporting claims. It is available in the procedure code library and will be populated when using the procedure code lookup. The amount is not recalculated when changing the number of units.

- **Expected Pmt.** – This field is for your reference only. It is not used when printing or exporting claims.

**Claim Templates**

![Claim Template](image)

**Previous Claim**

The ‘Previous Claim’ template will perform the following when opening the new claim screen (or switching to the <Previous Claim> template):

- Load the previous Diagnosis Codes values
- Load the previous Date of Current
- Load the previous Physician Library Entries
- Disable the service line preview row

When you click a Calendar date, the previous claims service line(s) will be entered. The Previous Claim is the claim most recently entered for the patient. It may not necessarily be the claim with the most recent date of service.

**Previous Service**

The ‘Previous Service’ line data from the last claim will be carried over to Charges screen. If needed, you can change the information in the Preview line before clicking the calendar dates.

**Custom Template**

![Custom Template](image)
A ‘Custom Template’ will allow a user to save specific claim information that is entered on a regular basis. For example, if the same two or more services are performed every time on the first visit, the user can save those services under the name ‘Initial Visit’. When a patient comes in for an initial visit, the user can bring up the ‘Initial Visit’ template, select a date and the claim is complete.

1. Open a claim and enter the service line items to save for the Template. Click on ‘Save as a Template’ from the Claim ribbon bar. When asked to ‘Save’ changes, click ‘Yes’.

2. Enter a Name for the Template.

3. The template will now be in the ‘Template Library’ and available to select on all new claims.

When a custom template is applied, the program will do a procedure code lookup to obtain the charge and other information. A custom template procedure code lookup does not operate the same as a normal manual entry procedure code lookup. For claim templates, the procedure code lookup will set the following fields from data found in the Procedure Code Library:

- Charge
- Allowed
- Adjustment
- Cost
- NDC (Drug) Code, Drug Unit Measurement, and Drug Unit Count – If the claim template does not have a value, then all three of these fields will be populated from the procedure code library.
- Revenue Code – If the claim template does not have a value.
- Patient Amount Due - If the Set Patient Amount Due is checked in the procedure code library, the program will enter a patient amount due based on their patient record.
- Attach CMN

The lookup will not set the following fields. These fields must be set in the claim template:

- Service Line Description
- Modifiers
- Product Code

**Previewing/Editing Claim Template Data**

Click on ![Template Library](image) to open the ‘Template Library’. Select Template to edit or preview, click on ‘Save & Close’ to save changes.

**Note:** See “Claim Template Library” on page 143 for additional information.
Claim Notes

Click in the ‘Click here to add a new note’ field at bottom of Claim screen to enter the Claim note.

Hide, Show, Expand or Shrink Claim Notes

Click on the ‘Hide Notes’ button. Click the button a second time to ‘Show Notes’.

Use drop-down button to select ‘Expand’ or ‘Shrink’ notes.

To delete a note, click on the next to the note. Only the user who entered the note will be allowed to delete the note. Notes which are automatically entered by the program may not be deleted.

Note Editor

Notes can be shown in a pop-up window by right clicking in the note and selecting ‘Show in Pop-up.’ This will place the note into a large editing window allowing you more room for editing. You can also print the individual note by clicking the ‘Print’ button.

Highlighting Notes

Right click a note, select Highlight, then a color to highlight a claim note.
Recurring Claims

Claims entered into the system can be set to recur any number of times. When the program is opened, EZClaim can check for any claims that are due to be entered and automatically enter the claims.

Recurring Claims Set-Up

Navigate to the claim that you would like to recur. On the Claim ribbon bar select ‘Make Recurring’. Use drop-down arrows to select criteria for claim to recur.

![Screenshot of the Recurring Claim setup window]

Use drop-down arrow to select a date to ‘Add’

To delete a date, select by highlighting and click ‘Delete Selected Date’.

When viewing a Recurring claim, the ‘Make Recurring’ on the ribbon bar will now read ‘Edit Recurring’.

Edit a Recurring Claim

Select recurring claim to edit, click on ‘Edit Recurring’ on the menu bar. Edit data and ‘Save’.

Reviewing and Entering Recurring Claims

If recurring claims are ready to be entered when opening the program, the ‘Recurring Claims’ window will open automatically.

Delete or Enter Multiple Recurring Claims

From the ‘Home’ ribbon bar, select ‘Review and Enter Recurring Claims’ from the ‘Claim’ icon dropdown.
Check box to ‘Enter Selected Claims’ or ‘Delete Selected Claims’.

Copy Claim

To copy Claim data to a different Patient record, select a claim, click on ‘Copy Claim’ on the ribbon bar.

Click ‘Select’ button or double click on the Patient record where the claim is to be copied.

The new claim will contain a note ‘Claim created by copying Claim ID XX’

Other Fields

Locked (Claim)

The locked check box prevents accidental changes to a claim. To edit a locked claim, uncheck the box.

A locked claim does not prevent disbursements or adjustment from being added, removed, or edited.

Claim user notes can be added or edited on locked claims.

The ‘Bill To’ selection can be changed but the claim insured information cannot.

The Locked check box can be used in conjunction with security options to prevent users from unlocking and editing claims.

When printing or exporting claims, the check box can automatically check if the ‘Automatic Lock Claims After Print or Export’ option is turned on in the Program Setup > Claim screen.
**CLIA Number**

The CLIA number can be entered one of two ways:

- Use the CLIA Number field on the claim screen (you may need to add the field into the grid).

- Use the Additional ID numbers area in the physician library for a Rendering or Billing Provider.

When the program is exporting data for electronic billing, the program will look for a CLIA number if the following places and use the first one it finds:

1. CLIA Number field on the claim
2. Claim Rendering provider
3. Claim Billing provider

**EDI Note**

If required by your payer, claim level notes can be included in the ANSI 837. These notes are entered into the ‘EDI Note’ field on the claim information grid. The field is not normally visible. Use the grid customization feature to add the ‘EDI Note’ field. See “Claim Information Grid” on page 47 for more information on customizing the grid.

837 Notes: Information entered into this field will be exported into Loop 2300 Segment NTE Field 2

**CMN**

If your claims require a CMN to be attached, you will need to add the field to the grid. The field is not normally visible. Use the grid customization feature to add the ‘CMN Form’ field. See “Claim Information Grid” on page 47 for more information on customizing the grid.
Last Worked

This field is used for Workers Comp claims. The data will be exported into Loop 2300 Segment REF*297. It is not used to designate when a claim was last followed up with.

FAQ on Claims

Q - How do I add sales tax or interest to a claim?

A - Open the claim to edit, add a new service line, enter TAX or INT into the procedure code field, enter the total dollar amount you want to tax or charge interest, enter the tax or interest amount into the units field. The program will calculate the correct tax/interest amount and update the charge column. For example, to charge 6% tax on $100, enter $100 into the charge column then enter .06 into the units column. The program will recalculate the charge to $6.00.
Printing Claims

Home Screen > Print

Note: To adjust your printer to the CMS 1500 form, see “Printer Adjustment” on page 67.

Tips and Tricks

- The responsible party does not affect which service lines are printed on the claim.
- If the ‘Bill To’ is set to Final (Patient), then the claim will print as a primary claim.
- Uncheck the ‘Print/Export’ service line check box on the Claim screen (available in the column chooser) to prevent an individual line item from printing. One or more service lines must be checked to save the claim.
- If a claim is not showing up on the ‘Print Claims’ list, make sure the submission method is set to paper, the ‘Bill To’ is set to a payer (not the patient), and the status is ‘Ready to Submit’. You can also change the filter to ‘All’ and all claims will be displayed regardless of the claim status settings.
- To ‘Lock’ a claim check the ‘Locked’ checkbox on the Claim screen under Claim Information.

To set the default for Locking all claims when printing or exporting, go to Tools>Program Setup>Claims.

Printing Multiple Claims

To print multiple claims, click on ‘Print Claims’ from the Home screen or select ‘Print Claims’ from Home tab > Print icon.

Select claims to print by entering a check in the checkbox next to claim or select ‘Check All’. Click on ‘Print Claims’ to quickly print claims or use the drop-down arrow to select ‘Print Claim’ which will open your printer dialog box, or ‘Print Preview’ to preview claims.
Filtering the Print Claims Screen
The print claims screen has three filter options:

- **Ready to Submit** shows claims that:
  - Status = ‘Ready to Submit’
  - Method = ‘Paper’
  - Bill To <> Patient

- **All Paper** shows claims that:
  - Status = Anything
  - Method = ‘Paper’
  - Bill To = Anything

- **All** shows all claims that:
  - Status = Anything
  - Method = Anything
  - Bill To = Anything

Print Form with Data
TIP: If using the ‘red’ forms, use either ‘Preview Only’ or ‘Never’. Otherwise, a black form will print on top of the red form.

If using plain paper and need to print the form and you are using the ‘Print Claims’ window, select the ‘Always’ option in the ‘Print Form with Data’ selector.
If printing from a claim window, the program will use the option set in program setup. See “Print Form with Data” on page 68.

**CMS-1500 Boxes**

Below is the program logic used for printing data in the following boxes:

**Box 1**

```
1. MEDICARE   MEDICAID   TRICARE   CHAMPUS   CHAMPVA   GROUP   FECA/BLACK      OTHER
    Medicare #  Medicaid #  Sponsor’s SSN  (Member ID)  Health Plan ID  (SSN or ID)  FECA/Black Lung  (ID)
```

Selected in the ‘Payer Library’.

**Box 9a**

When printing a Primary claim, this box will be populated by the secondary Group # field. When printing a Secondary (or Tertiary) claim, this box will contain both the primary insured’s ID and the primary group number.

```
4. OTHER INSURED’S POLICY OR GROUP NUMBER
```

**Box 11b**

```
b. OTHER CLAIM ID (Designated by NUCC)
```

This box is populated with the ‘Workers Compensation Claim Number’. This field is available as a custom column on the claim screen’s vertical grid. If a WC Claim Number is entered, the qualifier will automatically be set to ‘Y4’. There is no option to change the qualifier.

**Box 11d**

```
a. IS THERE ANOTHER HEALTH BENEFIT PLAN?
   YES   NO
```

If there are 2 or more payers attached to the claim, the program will automatically check the ‘Yes’ box. Otherwise, the box is checked ‘No’.

**Box 14**

In the 02-12 version of the 1500 form, different dates can be represented by this box. The qualifier will print in the QUAL box to the right of the date. The program has the following qualifiers and dates available. If both dates are entered, the Date of Current will take precedence.
• 431 – Date of Current
  Date of Curr: 04/04/2012

• 484 – Last Menstrual Period – This field can be added to the claim grid as needed using the Customize Grid feature.

Box 15

1500 08-05 Version: Similar Illness Date will print in box 15. This field will need to be added to the grid on the claim screen.

Box 17

If multiple providers are entered, only the Referring Provider will be printed. For printed claims, the Referring Provider must be removed for the Ordering or Supervising Provider to print in Box 17.

If both the Ordering and Supervising Provider data is entered, the ‘Ordering Provider’ information would be printed.

Box 26

The patient account number typically contains the patient account number found on the patient screen. This setting can be changed in the Program Setup > Printing Claims section.

See “Account Number (Box 26)” on page 69 for more information.
Box 29

Box 29 normally shows payments only. If the option ‘Include Adjustments with Payments in Box 29’ is checked in the Payer Library, both payments AND adjustments will appear in Box 29. Uncheck ‘Include Adjustments with Payments in Box 29’ in Payer Library to edit.

There is also an option on the claim screen ‘Ignore Applied Amount’ which will cause $0.00 to print in box 29. This is an optional field that can be added to the claim vertical grid.

Box 30

Box 30 is not normally printed per CMS rules. If your payer requires the balance in Box 30, check the ‘Print Box 30’ option in the Payer Library. See “Payer Library” on page 155 for more information.

Box 31

The Rendering provider name displayed on the Claims screen will print in Box 31 if the Payer selected on the claim does not have the ‘Ignore Rendering Provider’ option checked in the Payer library.

SIGNATURE ON FILE will print if the claim’s Billing Provider has the ‘Signature on File’ option checked in the ‘Physician/Facility Library’. See “Signature on File” on page 157 for more information. The signature on file setting is stored with the billing provider and not the rendering provider because a rendering provider may not be set on the claim.

Bill Date will print when the ‘Print Claim Bill Date’ is checked on the patient record.

Box 32

The claim facility will print in Box 32. If the ‘Address Line 2’ is populated in the physician library, it will print in box 32.

Box 33

The claim billing provider will print in Box 33. If the ‘Address Line 2’ is populated in the physician library, it will print in box 33.

Box 33b

Box 33b can come from two different location. Typically, this field contains the ‘Additional ID Number’ found in the Billing Provider record in the Physician/Facility library. There is also a field available on the claim grid called ‘Box 33b Override’ which allows the user to enter a value into Box 33b.
Printer adjustment is only required if you are using pre-printed red CMS 1500 forms. If you are billing electronically or the program is printing the black and white form for you, no printer adjustment is required.

EZClaim will work with any printer that works with Windows Vista (or newer). Follow the steps below and your forms will print out correctly.

Note: After setting printer values you must click on ‘Save’ to set values

1. Click on Home tab and using the ‘Print’ drop-down select ‘Printer Adjustment’.
2. Load your printer with CMS-1500 forms.
3. Click the ‘Print Test Page’ button.
4. Following Printer Adjustment steps, change values until the X is positioned in the center of the Medicare check box at the top of the CMS-1500 form. (Suggestion: Continue using the same CMS-1500 form until adjusted)
5. When adjustment is correct, click on ‘Save’.
Print Form with Data

TIP: If using the ‘red’ forms, use either ‘Preview Only’ or ‘Never’. Otherwise, a black form will print on top of the red form.

This option allows you to print a black and white form with the data. There are three options:

- **Preview Only** – The form will only be visible when previewing the claim. When printed, only the data will print. This option is when printing on pre-printed forms only.

- **Always** – Both the form and data will print. This option should be used when printing on plain paper.

- **Never** – Only the data will be visible in print preview mode. This option is when printing on pre-printed forms only.

1500 Form Printer

This option allows you to select the printer used for 1500 form printing. Select <Default Printer> to have the program use your default printer.

1500 Form Version

Select 1500 (02-12) for the form to be used starting January 1st, 2014 or select 1500 (08-05) for the old 1500 form.

Printer Alignment

If the print needs to be shifted up, down, left, or right, use the Printer Alignment settings.

Font Settings

<table>
<thead>
<tr>
<th>Font Setting</th>
<th>Font</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Font</td>
<td>Courier New</td>
<td>12</td>
</tr>
</tbody>
</table>

To change the font face or size, select from the options available.

Bottom Margin

Some printers are unable to print at the very bottom of the paper. If your printer is cutting off the text at the bottom of the page, check this box to have EZClaim use a smaller font in boxes 31, 32, and 33.

Carrier Area Location Adjustment

This will adjust the location of the insurance address printed at the top of the 1500 form. Sometimes adjustments need to be made to align the Payer address to a windowed envelope.
Vertical Shift Adjustment

If data at the top of the 1500 form starts in the correct position but slowly shifts out of the boxes toward the bottom of the form, use this adjustment to correct.

Horizontal Shift Adjustment

If data on the left of the 1500 form starts in the correct position but slowly shifts out of the boxes on the right side of the page, use this adjustment to correct.

Formats

<table>
<thead>
<tr>
<th>Formats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Box 24 – Date of Service</td>
</tr>
<tr>
<td>MMDDYYYY</td>
</tr>
<tr>
<td>All Other Dates:</td>
</tr>
<tr>
<td>MMDDYYYY</td>
</tr>
<tr>
<td>Account Number</td>
</tr>
<tr>
<td>Account #</td>
</tr>
</tbody>
</table>

Dates

Select ‘Date of Service’ and ‘All Other Dates’ format using the drop-down arrow. Date formats selected will apply to ALL claims.

Most Payers require the 8 digits in this format MMDDYYYY.

Account Number (Box 26)

If you would like a different number format for Box 26, select from the account number drop down list. The available options are:

- Account # – Prints the ‘Account #’ field from the Patient screen.
- Invoices # – Prints the ‘Invoice #’ field from the Claim screen.
- Claim ID – Prints the ‘Claim ID’ from the Claim screen. This is an internal database number automatically assigned by the program and cannot be changed.
- Account #-Claim ID – Prints both the patient account # and Claim ID separated by a dash.
- Claim ID-Account # – Prints both the Claim ID and patient account # separated by a dash.
Note: If you have entered a 4-digit year in the program and it switches back to 2 digits, your Windows Regional settings have the M/D/YY display setting. To change the setting open the Windows Control Panel>Regional Settings>Click the Date tab>Change the Short Date Style field to M/D/YYYY.

Troubleshooting Printer Adjustments

Home tab> Print >Printer Adjustment

Printing problems can be frustrating. Every printer has different issues. The following trouble shooting tips try to address the common printing issues, why they happen and what can be done to fix them.

Try 11pt or 10pt Courier New Font. If the data is close but still on the lines in some places, you can try a smaller font.

If Box 33a and 33b numbers are printing on the line, confirm you are using ‘Normal Spacing’ for the ‘Bottom Margin Setting.’ Both ‘Tight Spacing’ and ‘Smaller Font’ will force the numbers to move up and print on or above the line.

Vertical Adjustment may be used as well (see below).

The date is printing on the hash marks. This is normal if using a 4 digit year in the format MMDDYYYY. Most insurance companies require a 4 digit year and if so, it must be in the MMDDYYYY format.

Data prints ok on the top of the form but is too low or high on the bottom of the form. Check the Vertical Adjustment. Most users can have a setting of 0 in this field. If a value is required, it is usually between -25 and 25.
This section is for manually entering payments. For auto posting see “Auto Posting Payments” on page 113.

Tips

- To quickly enter a Patient payment, use “Column Chooser” on page *, to include a ‘Payment’ button on the Patients search pane. Clicking on the Payment button will open the Payment Entry screen with the patient’s data already selected.

- Use ‘t’ (today) or ‘y’ (yesterday) to quickly enter a date in the payment date field.

- Use the letter ‘b’ to quickly enter the balance due in a payment or adjustment amount cell in the grid.

- If you are on a patient’s claim and need to enter a quick payment, you can use the ‘Payment’ button at the top of the screen to enter a Patient or Payer payment.
Enter a Payment

1. Click the Enter Payment button on the home screen.

2. Select a Payment Source. If the payment or check came from the patient, select patient. If the payment came from the insurance company, select Payer.

3. Select the payer or patient. Once selected, the program will load all service lines with a balance associated with the payer or patient.

4. Enter the payment details such as check amount, date, method and reference information.

5. In the apply payment grid, enter the dollar amount to apply to the service lines. You can also enter adjustment amounts.

6. When the remaining balance is $0.00, you know you have applied the full payment amount.

7. Save and Close the payment when finished.

Payments Entry Options

Use the to add or remove additional Adjustment columns.

Check this box to include a ‘Reason Code’s column heading.
Check this box to include a ‘Remark Codes’ column heading.

Check this box to include a ‘Payment Reason Codes’ column heading.

Check this box to include a ‘Disbursement Note’ field on the payment line.

**Filtering Options**

Service lines on the payment screen are normally visible if the claim service line ‘Responsible Party’ matches the selected Payer or Patient, and the service line on the claim has a balance due.

Use the available filtering options to change which service lines appear.

Check this box to view all service lines showing a balance with the selected Payer.

Check this box to show all service lines that match a Payer ID set up in the Payer Library. This box is normally checked.

Check this box to view service lines with a $0.00 balance. The service lines shown are limited by the date set in the date field.

**Entering Credits or Refunds**

Enter a negative amount in the Payment Amount field and then enter a negative disbursement on the service lines.

If the service line to credit has a $0.00 balance, be sure to check the option to ‘Include $0.00 Balance Service Lines From DOS’. See ‘Filtering Options’ for more information.

Note: The ‘Pay’ button does not work when applying credits or refunds.
Payments from the selected patient with a balance (double click to disburse):

<table>
<thead>
<tr>
<th>Name</th>
<th>DOS</th>
<th>Proc</th>
<th>Change</th>
<th>Applied</th>
<th>Balance</th>
<th>Ant</th>
<th>Ant Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>BROOKS, PATIENT D</td>
<td>03/06/2013</td>
<td>99599</td>
<td>$50.00</td>
<td>$20.00</td>
<td>$30.00</td>
<td>($30.00)</td>
<td></td>
</tr>
<tr>
<td>BROOKS, PATIENT D</td>
<td>03/16/2013</td>
<td>90684</td>
<td>$50.00</td>
<td>$0.00</td>
<td>$50.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BROOKS, PATIENT D</td>
<td>04/03/2013</td>
<td>90684</td>
<td>$50.00</td>
<td>$0.00</td>
<td>$20.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BROOKS, PATIENT D</td>
<td>04/16/2013</td>
<td>90684</td>
<td>$50.00</td>
<td>$30.00</td>
<td>$20.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remaining: $0.00  ($30.00)
Overpayment or Payments Not Fully Disbursed

If a patient makes an overpayment or if a payment is not fully disbursed, the remaining balance will be saved within the system and can be fully disbursed at a later time. When saving a payment that has not been fully disbursed, the program will show a message making sure you want to save the remaining balance.

To disburse an overpayment or a payment with a remaining amount:

1. Click the Enter Payment button on the home screen.

2. Select a Payment Source

3. Select the patient or payer the payment is from. The program will load any payments with a remaining balance on the right side grid.

4. Double click the existing payment shown in the grid. The payment will be loaded and allow you to disburse the remaining amount.

Pay and Auto Apply buttons

Note: The ‘Auto Apply’ button will not apply credits. Credits must be entered manually.

- The Payment Entry screen provides two features that help speed up the payment entry process. The ‘Auto Apply’ and ‘Pay’ buttons.
- The ‘Auto Apply’ button will apply dollar amounts to the service lines in order until the payment amount is used or there are no additional service lines.
- The ‘Pay’ button will apply a dollar amount to the single service line.
- When entering a patient payment, the ‘Pay’ button will enter the full balance amount or the patient amount due minus any existing patient payments.
- The ‘Amount Applied’ varies depending on the payment type (patient or payer) and if allowed amounts have been entered on the service line.
- When entering a payer payment, the ‘Pay’ button will enter the allowed amount if it is not $0.00 otherwise, it will enter the full balance amount. Note: If the allowed amount is more than the balance amount, the balance amount will be entered.
- When clicking the ‘Pay’ button on an individual service line, if a dollar amount is already in the amount field, the amount will be changed to the allowed amount (if the allowed amount is not $0).
- When clicking the ‘Auto Pay’ button, if a dollar amount is already in the amount paid field, nothing will be changed.
Delete Payment

A payment can be deleted from the Payment Modification screen. Use the Find Payment window to find the payment then click the Delete button. Deleting a payment will automatically delete all the disbursements associated with the payment.

Checking for Duplicate Payments

The program will check if an existing payment once the dollar amount and reference number is entered. A message will appear showing the details of the existing payment. Only the dollar amount and reference number are used to check for duplicates.

Potential Duplicate Payment

A payment posted on 06/20/2013 seems to match the one you are entering:

Amount: $50.00
Ref #: 3847
Add Ref #:
Note:

Click OK to continue.

Patient Receipt

When entering a patient payment, there is an optional setting that allows a receipt to be printed from the payment entry screen.

To enable this button:

1. Download the Patient Receipt report. See “Patient Receipt” on page 131 for more information.
2. Enable the receipt report in Program Setup. See “Payment” on page 198 for more information.

Additional options are available by using the arrow next to the button:
Special Situations

Double Payment

Sometimes a service line will be paid twice by the payer. If the service line appears on the Payment Entry screen when you select the payer, enter the second payment amount. This may cause the service line balance to become negative. This is OK. When the payer takes back the overpayment, you will enter a refund to correct the balance. See Entering Credits or Refunds for more information.

OPTIONAL: If you do not want the service line balance to change when entering the double payment, you will need to enter a negative adjustment for the same amount. When you enter the refund, be sure to adjust the same amount.

Entering double payment with a reversing adjustment:

<table>
<thead>
<tr>
<th>Charge</th>
<th>Applied</th>
<th>Balance</th>
<th>Amt</th>
<th>Amt</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filter</td>
<td>Filter</td>
<td>Filter</td>
<td>Filter</td>
<td>Filter</td>
<td>Filter</td>
</tr>
<tr>
<td>$100.00</td>
<td>$50.00</td>
<td>Pay</td>
<td>$50.00</td>
<td>$50.00</td>
<td>($50.00)</td>
</tr>
</tbody>
</table>

Crediting the double payment with a reversing adjustment:

<table>
<thead>
<tr>
<th>Charge</th>
<th>Applied</th>
<th>Balance</th>
<th>Amt</th>
<th>Amt</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filter</td>
<td>Filter</td>
<td>Filter</td>
<td>Filter</td>
<td>Filter</td>
<td>Filter</td>
</tr>
<tr>
<td>$100.00</td>
<td>$100.00</td>
<td>Pay</td>
<td>$50.00</td>
<td>($50.00)</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

Zero Dollar Payments

Occasionally, in primary/secondary situations you need to indicate that the primary paid $0.00.

When manually posting a $0.00 payment, you MUST enter $0.00 onto the service line disbursement area. Do not leave it blank. In the screen shot below, only the first two services lines will indicate a $0.00 payments.

When auto-posting payments, you can turn on the option to 'Apply zero dollar disbursements.' See “Posting Options” on page 120 for more information.
Fix an Incorrect Disbursement

If you have applied a payment to the wrong patient or service line, you can fix it by deleting the disbursement and re-applying the remaining payment to the correct patient or service line.

1. Open the payment using the ‘Find Payment’ window. This should open the Payment Modification screen.

2. Delete the incorrect disbursements by clicking the button on the incorrect disbursement and save the changes. The payment will now have a remaining balance that can be re-applied to the correct patient or service line.

3. Follow the instructions for “Overpayment or Payments Not Fully Disbursed” on page 75.

Collections

If using a collections agency to collect on outstanding claims, you will need to record the amounts collected by the agency. One solution is to treat the collection agency as a payer.

1. Create a Payer Library entry for the collection agency
2. Open the claim that was sent to collections
3. Click the … button on the Bill To field

Bill To: Final - Patient - SMITH, JOHN D
4. Click the New button to add another responsible party (in this case the collection agency) to the available payers. Save your changes.

5. Change the ‘Bill To’ to the collection agency and save the claim.

6. You will now be able to enter the payment you have received from the collection agency on the Payment Entry screen.

**Other Payment Options**

**Receive a payment at the time of service and print a receipt**

The simplest way to receive payment and print a receipt is through the EZClaim Scheduling program. Double click on the appointment to open the details window, enter the payment information, and click the ‘Print Receipt’ button. If you would like 2 copies of the receipt, click the ‘2’ button instead. This will create a patient payment within the billing system as well. The biller will still need to disburse the payment and apply to individual service lines.
Adjustments

Adjustments are typically entered during payment posting. Either during the auto-posting process or manual payment entry. You can also enter adjustments directly on the service line.

Auto-Posting

For posting adjustments during the auto-posting process, see “835 Adjustments Grid” on page 114.

Payment Entry

When entering a payment using the Payment Entry screen, you can use the available Adjustment columns. See “Payments” on page 71.

Claim Entry

If you need to enter an adjustment directly to a service line, you can do so using the Adjustments window.

1. Open the claim.
2. Double click the Adjustment cell on the service line.

3. Enter the adjustment(s) as needed. Press ‘B’ on the keyboard to enter the service line balance. Useful if you are writing off the balance.

4. Click OK when finished.

Deleting Adjustments

Adjustments can be deleted two ways: from the Claim screen or the Find Adjustment window.

Claim Screen

1. Double click the Adjustment cell to open the Adjustment window.

2. Click the X button on the left side of the adjustment record.

3. Click ‘Yes’ on the confirmation window.
Find Adjustment Window

1. Open the Find Adjustment window.

2. Highlight the adjustments to be deleted. You can use the Ctrl or Shift key to select multiple rows.

3. Right click a highlighted row and select Delete Adjustments.

Tracking Adjustments

EZClaim uses a concept called ‘Tracking Adjustments’ to help follow-up with claims that were denied for one reason or another. A tracking adjustment is simply an adjustment with a $0.00 amount.

When auto-posting, select ‘Track’ for any of the adjustments you want to follow-up with. See “835 Adjustments Grid” on page 114. You can then use “Find Adjustment” on page 179 to easily find the claim and/or create tasks to remind yourself later.

To enter a tracking adjustment manually, simply enter a $0.00 in the amount field. We also suggest entering a reason code so you know what the issue is. This can be done during payment entry or on the Adjustment window from the Claim screen. See “Adjustments” on page 80.

See Also: ‘Other Actions’ in the “Find Adjustment” on page 179 section.

Write Offs and Bad Debts

Premier allows you write off claims or service lines in bulk using the ‘Find Claim’ and ‘Find Service’ screens.
We suggest first creating reason codes to represent write offs or bad debts for later tracking. This is done in the Reason Code Library. See “Code Library” on page 144 for information on adding codes.

Once you have the codes in place, use the Find windows to zero out the claims or service lines. See “Find Claim” on page 176 or “Find Service Line” on page 177 and look in the ‘Other Actions’ section for more information.
Payment Modification

On the Payment Modification screen, you can perform the following:

- Edit the payment details such as Amount, Date, References and Note information.
- Change the amount applied (disbursed) to a service line.
- Remove a Disbursement from a service line.
- You cannot apply payments to additional service lines. This must be done from the ‘Payment Entry’ screen.

Opening an Existing Payment

There are two primary ways to open the ‘Payment Modification’ screen.

- From ‘Find Payment’ or
- From an existing claim.

From the Home tab, use the ‘Find’ drop-down and select Find Payment.

On the ‘Find Payment’ screen click on ‘Open’ or double click on payment line to open a selected payment. If needed, use the Filter area to search by selected criteria.

From a ‘Claim’ screen, click on the plus sign to open service line details. Double click the detail line to open ‘Payment Modification’.
On the 'Payment Modification' screen, Edit or Delete payment.
Statements

Home Screen

Statements are run by clicking the 'Patient Statements' button on the home screen or 'Statement' on the Home Ribbon bar.

When the 'Statement' window opens, the grid will show a list of patients that have a balance greater than $0.01. You can change the filter options to see additional patients based on the available criteria.

Statement Format

Chose the various statement formats.

**Statement** – Standard plain paper statement.


**Note: BillFlash Options** are set in the Add-On Library under Libraries Icon>Add-On Services> Electronic Statements by Bill Flash. See “Add-On Services” on page 167 for additional BillFlash information.

Filtering

Minimum Patient Balance – Used to filter out patients that do not owe anything. Can also be used to prevent statements going out to patients that owe small amounts.

Minimum Statement Cycle – Will only show patients that have not received a statement in the last 30 days. This feature allows you to send out statements every week but patients will only receive them once a month.

Include $0 Patient Balance Claims – This option is only valid when you set the Minimum Patient Balance to $0.00. By checking this box and setting the minimum balance to $0.00, you will see every patient in the system.

- **Checked** – When loading the statement grid, EZClaim will take into account all claims. Some users want to send a statement to all patients regardless of their balance. In this case, they would check the box and set the minimum patient balance to $0 so the grid would list all patients.

- **Unchecked** – When loading the statement grid, EZClaim will take into account only claims that have a patient balance. Some users will want to send a statement to a patient if there is a credit on one claim and an amount due on the other but the total patient due is $0. In this case, they would NOT check the box but set the
minimum patient balance to $0. This would cause the list to include patients that have a $0 balance across all their claims.

**Note:** Any changes to these values are not saved until you print statements.

**Monthly Statements**

If you would like to send statements even if the patient does not owe anything, change the Min. Pat. Bal. to $0.00 and click Refresh.

**Statement Messages**

There are two levels of statement messages; patient and global. The patient message will only print on a statement to that patient. The message is viewed and/or edited in the grid under the Pat. Msg. column. You can pre-set the patient statement message on the patient record. See “Statement Information” on page 36 for patient statement settings.

The Global Message located at the bottom of the statement screen will appear on every statement. Use the drop down arrow to select from the message list. The list is maintained in the ‘List’ Library. See “List Library” on page 154 for more information.

**Note:** Any changes to the ‘Global Message’ are not saved until you print statements.

**Common Issues**

**The service description is incorrect**

The description for procedures come from the ‘Procedure Code’ library. If there is no description entered, then the statement will show the work ‘PROCEDURE’. To fix this, add the procedure code and description to the ‘Procedure Code’ library. See “Procedure Code Library” on page 159.

**The adjustment description needs to be changed**

The adjustment description comes from the reason code library found in the ‘Code Library’. To change the description printed on the statement, edit the description in the ‘Code Library’. See “Code Library” on page 144.

**Show additional messages at the service line level**

This technique is useful when you want to show an explanation of the patient balance. Tracking adjustments allow you to show messages on statement service lines. Tracking adjustments appear with the date and description. This option must be turned on before tracking adjustment messages will appear. See “Tracking Adjustments” on page 89 for instructions on turning on the option.
The Diagnosis code is not showing

If the diagnosis code is not showing, there are two possible reasons. The first is the ‘Hide Diagnostic Codes’ option is turned on. The second is the diagnosis pointer on the service line points to a code that does not exist. This also will happen when no diagnosis pointer is entered (Box 24E on the 1500 form).

Options

Click on the Patient Statements ‘Options’ button to use the options screen for configuring statement information. The following screen shot shows the initial values for new companies.

- **Return Address** – The address shown in the top left of the statement for windowed envelopes.
- **Use Patient’s Billing Provider’s Address Instead** – Checking this option disables the Return Address fields and causes the statements to use the address of the Billing Provider found on the Patient’s record. Warning: If a billing provider is not selected on the patient record, the return address will be blank.
- **Use a ‘Pay to Address’ different than the ‘Return Address’** - Click checkbox to use this feature.
- **Hide Diagnostic Codes** – Check this box to hide the Diagnostic Code information from the statement
- **Hide Procedure Codes** – Check this box to hide the Procedure Code information from the statement
- **Hide Aging Section** – Check this box to hide the Aging amounts at the bottom of the statement
- **Include Insurance Balances in Aging** – Check this box to shows the insurance amounts in the aging sections.
- **Show Payment Reason Descriptions** - If a Payment Reason Code was entered during payment entry, the description will print on statement. Payment reason codes can only be entered during manual payment entry. Typically they are used to record the type of patient payment, 1 for deductible or 2 for co-pay. See “Payments Entry Options” on page 72 for more information.
- **Include $0 Balance Service Lines** - Service lines with a $0 balance will show on statement. Use this option to show service lines that have been fully paid.
- **Include $0 Patient Balance Service Lines** - Service lines with a $0 patient balance will show on statement. Use this option to show service lines that are the responsibility of insurance (not the patient).
- **Include $0 Patient Balance Claims** – Check this box to include $0 patient balance claims on Statements.
- **Days of History** – Determines how many days of history will be shown on the statement. The time frame is calculated from the most recent date of service. For example. If you are printing statements in March 31st showing 30 days of history and the most recent date of service is January 31st, then the statement will show
services from January 1st to 31st (Not March 1st to 31st). All other balances (if any) will be shown on a 'Previous Balance' line at the top of the report.

- **Show Last Payment Information** – Statement will include a line describing the last payment received and the date range of services.

  Last payment of $60.00 made 05/15/2013 applied to services on 03/15/2012 to 03/16/2012

- **Show Tracking Adjustments with the following Reason Codes** – Use this option to show descriptions of tracking adjustments. This is useful when trying to explain why the patient has a balance. Common selections in this option are reason code 1 (deductible) and 3 (co-payment).

  ![Show Tracking Adjustments with the Following Reason Codes:

  1, 3](image)

**Tracking Adjustments**

Tracking adjustments are a great way to show messages to customers about the bill (See “Tracking Adjustments” on page 82 for more information on manually entering Tracking Adjustments). Once the option is turned on and configured (see above), the program will show the reason code description on the statement. If the description needs to be changed, edit the description in the Code Library.

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Diag</th>
<th>Proc</th>
<th>Transaction Amount</th>
<th>Insurance Balance</th>
<th>Patient Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/13</td>
<td>45 Min Therapy</td>
<td>3004</td>
<td>90834</td>
<td>$60.00</td>
<td>$0.00</td>
<td>$20.00</td>
</tr>
<tr>
<td>6/20/13</td>
<td>BLUE CROSS Pmt</td>
<td></td>
<td></td>
<td>-$20.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/20/13</td>
<td>Contractual Obligation</td>
<td></td>
<td></td>
<td>-$10.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Addresses**

The program uses different addresses depending on what is available

Return Address (top left):

1. Statement Options – Return Address

2. Company Description (standard statement only)

Mailing Address (left side of statement): The program does not use the insured info since it may not be filled in on the patient Information screen:

1. Statement Address from ‘Patient Information’ screen.

2. Patient Name and Address

Pay to Address: Only available on Nelco and BillFlash formats, shown on the right side address for return envelopes.

1. Statement Options – Pay To Address

2. Statement Options – Return Address
Insurance and Patient Balances

The program takes into account the Charges, Payments, Responsible parties, and Patient Amount Due values to calculate the balances. Here are the formulas used:

Line item Responsible Party not set to ‘Patient’

**Insurance Balance** = Charges
minus Insurance Payments
minus Adjustments
minus Patient Amount Due (or Patient Payments if amount due is $0)

**Patient Balance** = Patient Amount Due – Patient Payments (or $0 if Patient Amount Due is $0)

Line item Responsible Party is set to ‘Patient’

**Insurance Balance** = 0

**Patient Balance** = Line Item Balance

<table>
<thead>
<tr>
<th>Responsible Party</th>
<th>Charges</th>
<th>Patient Payments</th>
<th>Insurance Payments</th>
<th>Adjustments</th>
<th>Patient Amount Due (Optional)</th>
<th>Patient Balance</th>
<th>Insurance Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance</td>
<td>$100.00</td>
<td></td>
<td></td>
<td></td>
<td>$20.00</td>
<td>$20.00</td>
<td>$80.00</td>
</tr>
<tr>
<td>Patient</td>
<td>$100.00</td>
<td>$60.00</td>
<td>$20.00</td>
<td></td>
<td>$20.00</td>
<td>$20.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Patient</td>
<td>$100.00</td>
<td>$10.00</td>
<td>$60.00</td>
<td>$20.00</td>
<td>$20.00</td>
<td>$20.00</td>
<td>$10.00</td>
</tr>
<tr>
<td>Patient</td>
<td>$100.00</td>
<td>$20.00</td>
<td>$60.00</td>
<td>$20.00</td>
<td>$20.00</td>
<td>$20.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**BillFlash Electronic Statements**

When using the BillFlash Electronic Statement service, there is very little difference in the statement process. Be sure to set the Statement Format to ‘BillFlash’.

**Requirements**

The Add-On MUST be configured before sending statements to BillFlash.

See “Add-On Services” on page 141 for information on setting up Add-Ons.

If you have not setup the Add-On, you will receive the following message when trying to send statements:

Before using BillFlash, it must be setup in the Add-On library.

OK

**Sending a Statement Batch**

1. Click the ‘Patient Statements’ button on the home screen.
2. Set the ‘Statement Format’ to ‘BillFlash’

   **Statement Format:**
   
   BillFlash

3. Click the ‘Check All’ button or place a check mark next to the patient’s to receive a statement

   ![Check All button]

4. Click the ‘Send’ button

   ![Send button]

5. You will receive a confirmation that the file was uploaded successfully

**Electronic Statements by BillFlash**

Upload statements from EZClaim and let BillFlash mail them to your customers.

Let patients pay online with eBill and ePay. Call BillFlash for more information.

Enroll online at [http://www.billflash.com](http://www.billflash.com) Reseller ID: 80488 or call 435-940-9123.

---

**Activation Code:** Code provided by EZClaim

**Username:** BillFlash username.

**Password:** BillFlash password.

**Statement Color:** Select the statement color. Contact BillFlash for information on statement options.

**Cards Accepted:** Select the credit cards accepted. Contact BillFlash for information on statement options.

---

**TriZetto Electronic Statements**

When using the TriZetto Electronic Statement service, there is very little difference in the statement process. Be sure to set the Statement Format to ‘TriZetto’.
Requirements

The Add-On MUST be configured before sending statements to TriZetto.

See “Electronic Statements by TriZetto” on page 170

If you have not setup the Add-On, you will receive the following message when trying to send statements:

Sending a Statement Batch

1. Click the ‘Patient Statements’ button on the home screen.

2. Set the ‘Statement Format’ to ‘TriZetto’

3. Click the ‘Check All’ button or place a check mark next to the patient’s to receive a statement

4. Click the ‘Send’ button

5. You will receive a confirmation that the file was uploaded successfully

Electronic Statements by TriZetto

As an alternative to printing statements, upload statements from EZClaim and let TriZetto send them to your customers.

Activation Code: Code provided by EZClaim

Username: TriZetto statement username. This is the same username used when logging into the TriZetto web portal.
Password: TriZetto statement password. This is the same password used with your Secure FTP account.

Statement Color: Select the statement color. Contact TriZetto for information on statement options.

Cards Accepted: Select the credit cards accepted. Contact TriZetto for information on statement options.

Exporting Statements

Since statements are reports just like any other Premier report, they can be exported to a variety of formats. When previewing the statements, click the arrow on the Export icon and select the desired format.

![Export Formats](image)

When you close the Preview window, the following message will appear asking if you want to treat the export as if the statements were printed. If you click Yes, the ‘Last Statement’ date and ‘Statement Printed’ notes will be attached to the patient’s record.

FAQ on Statements

Q - Why do the statements show ‘PROCEDURE’ as the description?

A - If the procedure code library does not have a description for the procedure code, the program will use a generic description. See “Procedure Code Library” on page 159 for information on entering codes and descriptions.

Q - Why doesn’t the statement screen list patients with a credit balance?

A. Statements are to collect money from patients and not to refund money. The Patient Ledger report could be used when providing refunds.

Q - Why does entering a negative minimum remaining balance not show patients with credits?

A - The statement screen will only show patients that owe money. It will not show patients with a credit balance.
Q - How do I prevent a patient from receiving a statement?

A - If you do not want to send statements to a patient even if they owe a balance, open the patient record and check the 'Don't Send Statements' check box in the Statement Information area.
Electronic Claims

Home Screen

The ‘Send Claim’ screen is used for Electronic claim submission. It provides for Batching claims, generating a file, and sending the file to a Payer or Clearinghouse.

Clicking on the ‘Send Claims’ button from the ‘Home’ screen will open the ‘Send Claims’ dialog box listing claims ready to be sent electronically.

Claims Missing from the List?

If claims are not appearing in this grid, it means they are being filtered out. A couple things to check:

- Is the claim ‘Status’ set to ‘Ready to Submit’?
- Is the claim ‘Method’ set to ‘Electronic’?
- If the Submitter/Receiver library entry is for Professional claims, is the claim’s Bill To payer’s Claim Type ‘Professional’?
- If the Submitter/Receiver library entry is for Institutional claims, is the claim’s Bill To payer’s Claim Type ‘Institutional’?
- Is the grid filtered? If so, right click the column heading and select ‘Clear Filter’

ANSI 837 Reference

A reference guide for the ANSI 837 Professional is available online.

Connections

The Connection drop down selection determines how the batch file is handled once the file has been created.

The ‘Just Export the File’ will allow you to save the file to your computer desktop or drive. Additional connection types will determine how the file will be batched to send to the Payer or Clearinghouse. See “EDI Connection Library” on page 145 for setting up your Connection Library.
Submitter/Receiver

The Submitter/Receiver drop down allows you to select the Payer information previously set up in the Submitter/Receiver Library and includes the ANSI 837 header information, ISA, GS, Loop 1000A and Loop 1000B. See “Submitter/Receiver Library” on page 164 for setting up the Submitter/Receiver Library.

Selecting Claims for Batching

Only claims which have been checked will be included in the batch. Select claims individually or use the ‘Check All’, ‘Uncheck All’, ‘Check Selected’, or ‘Uncheck Selected’ buttons to check claims.

There is also an option for selecting a previous batch of claims. This option is useful when resubmitting a batch of claims. Click on ‘Select Previous Batch’ and select by highlighting a previous submission. See “Resending Batches” on page 98 for re-submitting previous batches of claims.

Checking for Errors

EZClaim Premier has the capability of checking for missing data in ANSI 837 files. This functionality is not a complete claim scrubbing system and will not catch all errors. If you are looking for more complete code scrubbing capabilities, please see the section on “Coding Advisor & Claim Scrubbing” on page 167 for additional information.

Select claims from the ‘Send Claims’ dialog box and click the ‘Check for Errors’ button. A report will appear showing missing or incorrect ANSI 837 data. The following example is showing that Susan Secondary has a missing place of service code in the claim with the first date of service of 8/16/2011.

If no errors are found, you will receive a confirmation:

If you would like a detailed report of the ANSI 837, click the down arrow on the ‘Check for Errors’ button and select Detailed Report. This will provide the ANSI 837 formatted for easy reading.
Submitting a Batch of Claims

Depending on the Connection type, the steps to create and submit a batch will vary. Some Connection types require the file to be saved; others create the file for you automatically. The ‘Create Batch’ button text will vary, sometimes it will say ‘Create Batch’ and sometimes ‘Create and Send Batch’. The ‘Create Batch’ button may be disabled until you have selected your Connection type.

The following steps are for the ‘Just Export File’ connection type:

1. Select ‘Connection’ type. Ex: Just Export File
2. Select ‘Submitter/Receiver’ name.
3. Select claims to send by using checkbox for individual claims or ‘Check All’.
4. Click the ‘Check for Errors’ button. **Note: Checks for structure of an ANSI file. Does not verify data.**
5. Click the ‘Create Batch’ button
6. Enter the Filename into the ‘Save As’ box and click ‘Save’. **Important:** Some Clearinghouses and/or Payers require special filenames, be sure to check with your payer for any special requirements.
7. Once the claims are exported a confirmation will appear
8. Click ‘Yes’ to preview (and/or Print) an exported claims report.
Resending Batches

1. To resend a batch of previously submitted claims, go to ‘Send Claims’ and click on the button.

2. From the list of “Previous Submissions”, highlight or double click on the batch to be resent and click on OK.

3. All claims from the selected batch are now listed in the ‘Send Claims’ dialog box.

4. Check the claims to be resubmitted or click the ‘Check All’ button and resubmit claims.

Reprint an Exported Claims Report

Click ‘Select Previous Batch’ button and select by highlighting the batch to reprint, click the ‘Print Report’ button. Note: The Exported Claims report WILL NOT match the original report if any claim data has been changed.

Batch Sorting

EZClaim will create multiple batches (transaction sets) within the ANSI 837. Transaction sets are defined with ST (header) and SE (footer) segments. A new transaction set will be created on each change of the following:

- Billing Provider Additional ID Number Type
- Billing Provider Additional ID Number
- Billing Provider Selection

The batch sort value can be seen on the Send Claims screen by adding the ‘Batch Sort’ column to the grid. In the screen shot below, if all claims were selected for export, there would be two transaction sets in the file with 3 claims each. In this example, there are no additional ID numbers but there are two different billing providers (internal ID 6 and 20).
Filtering Options

The screen uses the following filter rules:

- **‘Ready to Submit’** shows claims that:
  - **Status** = ‘Ready to Submit’
  - **Method** = ‘Electronic’
  - **Bill To <> Patient**

At least one service line is flagged for export.

- **‘All Electronic’** shows claims that:
  - **Status** = Anything
  - **Method** = ‘Electronic’
  - **Bill To** = Anything

At least one service line is flagged for export.

- **‘All’** shows all claims that:
  - **Status** = Anything
  - **Method** = Anything
  - **Bill To** = Anything
Workers Compensation

Workers Compensation is a specialized type of billing and requires additional fields for data entry. The information below covers the most common required fields but each insurance company has payer specific guidelines. Contact your Payer for their workers compensation billing guidelines.

**Patient's Information**
9. Last Name, First Name, Address and Phone number
10. Patient’s Date of Birth, and Sex
11. Continue entering Patient/Billing Provider information as required by your Payer

**Other Patient Information**

*Note:* The Patient SSN number has priority over the Patient Member ID. If both numbers are entered, only the SSN number will be exported

- Enter Patient SSN.

**Insured Information**
1. Enter the Employer Name in the Last Name field only. (WC claims the Employer is always the Subscriber) DO NOT ENTER A FIRST NAME
2. Employer Address Information
3. Select the workers compensation ‘Payer’ previously set up in the Payer Library
4. Enter the Workers Compensation claim number in the ‘Insured ID Number’ field
5. Enter Employer Name in the ‘Plan or Program Name’ field
6. Patient Relationship to Insured is ‘Other’
7. Select Claim Filing Indicator ‘Workers’ Compensation Health Claim’
**Claim Information**

- Enter **Workers Comp Claim Number** (Field may need to be added to the Grid)

**Misc Information**

**Note:** To add this information as default values, see Patient Information screen>Additional Claim Information>Initial Claim Values

- Enter ‘**Accident Date**’ (Field may need to be added to the Grid)
- Select ‘**Employment**’ for ‘Condition Related To’

**Paperwork Information** (Attachments)

- Enter data for your Attachments as required by your Clearinghouse or Payer
<table>
<thead>
<tr>
<th>Paperwork Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission Code</td>
</tr>
<tr>
<td>Control Number</td>
</tr>
<tr>
<td>Report Type</td>
</tr>
</tbody>
</table>
Anesthesia Claims

Anesthesia claims sometimes require additional information required by the payer. Please refer to the payer’s companion guide for specific instructions on where to enter additional information.

Service Line Description

If the payer requests additional information to be entered into the Service Line Description field, the field can be added to the service line grid.

Note: The Start Time and End Time columns available on the service line grid are not used for paper or electronic claims. The fields are for reference only.

Units

Anesthesia claims typically require minutes to be reported in the units field. When the procedure code is between 00100 and 01999, EZClaim will automatically use ‘MJ’ as the units qualifier to designate minutes in the ANSI 837 file (Loop 2400, Segment SV1, Field 03).
Secondary Claims

Payer Library – Step 1
Confirm the following:

- Payer ID #’s: Both Primary and Secondary Payer’s MUST have correct ‘Payer ID’ numbers.
- If the Secondary payer is Medicare, confirm that Medicare secondary ‘Ins.Type Code’ is selected.

Patient Information Screen – Step 2
Confirm the following:

- Secondary Insured’s Name, DOB and Gender are entered.
- Secondary and Primary Insurance with Payer ID and Claim Filling Ind is selected.
- Secondary Insured’s ID# is entered in the ‘Insured’s ID’ field.
- If Medicare or Medicaid claims, Group field must be blank.
- For Medicare secondary Plan or Program Name must be blank.
- Secondary subscriber ‘Relationship Code’ is selected.
- SSN and Patient Member ID number must be blank. See ‘Other Patient Information’.
Claim Screen – Step 3

If your payments were not previously auto-posted using the Auto-Posting feature, manually enter payment information from your Primary EOB. Go to Home > Enter Payment screen.

Confirm the following:

Payment Entry Screen

- Line Item payments and/or adjustments with a date have been entered on the Payments screen.
- Every service line has an Insurance payment entered; even a $0.00 amount must be entered as a payment.

Claim Information Screen

- ‘Bill To’ has been set to ‘Secondary Insurance’.
- ‘Ready to Submit’ is selected under ‘Claim Information’.
Troubleshooting Secondary Claims

Before submitting your secondary claims, confirm the following or errors may be generated.

Payer Library (Step 1)

- In the Payer Library, if the Secondary payer is Medicare, confirm that Medicare secondary ‘Ins.Type Code’ is selected.

Patient Information screen (Step 2)

- Secondary Insured’s Name, DOB and Gender are entered.
- If Medicare/Medicaid Other Insured Policy or Group number field is blank.
- Secondary (and Primary) Insurance with Payer ID is entered.
- SSN, Patient Member ID and Additional ID number are blank. See Additional Information.
- Secondary/Other Insured’s ID# is entered in the ‘Insured’s ID’ field.
- Secondary subscriber ‘Patient Rel to Insured’ is selected.

Charges screen (Step 3)

- Confirm Payment information entered matches the EOB.
- Confirm each service line has an Insurance payment entered even if it is a $0.00
- Line Item payments and/or adjustments with a date have been entered.
- Confirm ‘Bill To:’ has been set to ‘Secondary Insurance’.

Your claim is now ready for submission or printing.

Common Secondary Claim Errors

2320 COB CLAIM BALANCING FAILED. (Balancing error) Step 3

- All service lines did not have payment entered and/or payment amounts were incorrect.
OTHER SUBSCRIBER INFORMATION IS MISSING OR INVALID

- Patient Information screen – Confirm ‘Secondary Insured’s’ information is entered. Step 2
- Patient Information – Confirm BOTH insurances have a Payer ID Step 1. Also make sure the ‘Insured’s ID’ field has the secondary ID. Step 2

OTHER PAYER SUBSCRIBER PRIMARY IDENTIFICATION NUMBER IS MISSING OR INVALID

- Patient Information screen – Confirm ‘Secondary Insured’s ID’ field has secondary subscriber ID entered. Step 2
- Patient Information screen – Confirm ‘Insured’s Policy or Group’ number field is blank. Step 2

INSURANCE TYPE CODE MISSING OR INVALID

- Payer Library – In the ‘Insurance Type’ drop down box choose one of the numbers for Medicare secondary Insurance ‘Type Code’. Step 1

INSURANCE TYPE CODE IS MISSING OR INVALID. (Bad Data: MB)

- Payer Library – Usually this is for a Medicare claim when MB is indicated as the bad data. In the ‘Ins Type’ drop down box choose one of the numbers for ‘Medicare Secondary Claims’. Step 1

**Analyzed Secondary Claim**

Use this sample of an analyzed Secondary claim to confirm data. See sample below.

**How to Analyze a Claim**

1. Go to ‘Electronic Billing’.
2. Select ‘Send Claims’.
3. Select by checking the claim to be analyzed.
4. Use the Check for Errors dropdown box and choose ‘Detailed Report’.
5. Compare to sample below. (Sample is for a Medicare secondary claim your claim may include different data depending on your payer.)
Loop 2000B - Subscriber Hierarchical Level
----------------------------------------
0011 HI*2:1=2230
0012 SER*5:13=**MB
Checking Claim For Insured ID - SECONDARYID

Loop 2010BA - SUBSCRIBER NAME
----------------------------------------
0013 NMI*IL*1=SECONDARY*SUSAN*3=SECONDARYID
0014 N3*123 MAIN STREET
0015 N4*CITY*MN*99999
0016 DEG*D6*19670221*F

Loop 2010BB - PAYER NAME
----------------------------------------
0017 NMI*PR*2=SECONDARY*PI=SECONDARYPAYERID

Loop 2300 - Claim Information
----------------------------------------
0018 CLM*173-12345*300**11:B:1:Y*Y*Y
0019 B*HI*BE*:54321

Loop 2320 - Other Subscriber Information
----------------------------------------
0020 SER*18**BLUE CROSS*****BL
0021 AMT*150
0022 0I***Y***Y

Loop 2330A - OTHER SUBSCRIBER NAME
----------------------------------------
0023 NMI*IL*1=SECONDARY*SUSAN*5=PRIMARYID
0024 N3*123 MAIN STREET
0025 N4*CITY*MN*99999

Loop 2330B - OTHER PAYER NAME
----------------------------------------
0026 NMI*PR*2=BLUE CROSS*****PI=PRIMARYPAYERID

Loop 2400 - Service Line
----------------------------------------
0027 LX*1
0028 SV1*HC:90800*200*UM*1***1:2
0029 DTP*472*D8*20121010
0030 REF*6R*F37CF540064D7314DF65EB2CF1CB

Loop 2430 - Line Adjudication Information
----------------------------------------
0031 SV1*PRIMARYPAYERID:103*HC:90800**1
0032 CAS*CO*45*40*1
0033 CTR*15**3000
0034 DTP*573*D8*20121016

Loop 2400 - Service Line
----------------------------------------
0035 LX*2
0036 SV1*HC:90801*100*UM*1***1
0037 DTP*472*D8*20121010
0038 REF*6R*2F47BC42C9429040D99B52A26695

Loop 2430 - Line Adjudication Information
----------------------------------------
0039 SV1*PRIMARYPAYERID:50*HC:90801**1
0040 CAS*CO*45*25*1
0041 CTR*25**2500
0042 DTP*573*D8*20121016
The ‘EDI Reports’ screen is for viewing and managing EDI reports. EDI Reports are stored with the company file.

- The EDI Reports window is opened by clicking ‘View EDI Reports’ on the home screen or from the ‘Home’ tab.
- Double click a report in the list to view it.

**Quick View** – The program provides a quick view in the lower half of the window if a quick view is available. If the file needs to be processed before viewing, the quick view window will instruct you to double click the file to view the contents. The Quick View will only show the first 500KB of data. If this happens, you will see ‘[FILE TOO LARGE TO PREVIEW ENTIRELY - DOUBLE CLICK FILE TO ANALYZE]’ in the Quick View area.

**EDI Reports Features**

**Connection Selector** - Use this drop down box to select the correct Connection to download reports. Connections are managed in the EDI Connection library, see “EDI Connection Library” on page 145.
**Report Grid** – This grid shows all the reports stored in the company file. If a Report is shown in bold, it is a new report and has not been viewed yet. The grid can be sorted and filtered as needed. There is a Note column that is available for you to type in a note about that particular EDI report. If you enter a Note, click the ‘Save Notes’ button to save your notes.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date Created</th>
<th>Type</th>
<th>Size</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>e5f3f70d80c6e4d5</td>
<td>11/29/2011</td>
<td>Text Document</td>
<td>1 KB</td>
<td>Updated Notes</td>
</tr>
</tbody>
</table>

**EDI Reports Options**

- **Open** - Open and analyze the highlighted file.
- **Save Notes** – Saves any notes that have been entered for reports.
- **Export File** – Extracts the file from the company and saves it to your computer.
- **Get Reports** – Only active if a connection has been selected. This button will activate the connection and download reports into the company file.
- **Add Reports** – Add reports from your computer into the company file. When clicked, a browse window will appear allowing you to select a file.
- **Refresh Reports** – If others have downloaded reports, this button will reload the grid and show any new reports.
- **Close** – Closes the EDI Reports window.
- **Check All** – Checks all the reports in the grid.
- **Uncheck All** – Unchecks any checked reports.
- **Show Archived** – When checked, will show reports that have been archived.
- **Archive** – Archives the checked reports.
- **Un-Archive** – Moves the checked reports from the archives to the active reports area.
- **Delete** – Deletes any checked reports. Reports cannot be undeleted so be very careful when deleting reports!

**Searching for Electronic Billing Reports**

**Enter Keyword here** **Search for Keyword** **Clear**

Use the EDI Reports search feature to quickly find reports. Enter a keyword such as a Provider or Patient Name or other report data and click on ‘Search for Keyword’.

**Notes for EDI Reports**

Notes can be attached to a report. Place the cursor in the Notes cell and type your note. Use the Save Notes button to save any changes. The field will hold 255 characters.
Adding EDI Reports

There are two methods for adding EDI reports.

**Downloading Reports**

Confirm or select an entry from the ‘Connection’ drop down box. If you need to configure a connection, see “EDI Connection Library” on page 145.

Click the button to download available reports.

You will receive a confirmation when the process completes.

**Manually Adding Reports**

If the report file already exists on your computer, you can manually add it to EZClaim.

Click the buttons to open a browse dialog box.

Find the report file and double click or click the Open button.

The report will be added to the list of available reports.

**Compatible ANSI Formats**

Premier can generate or parse and display the following ANSI formats:
- 270 – Eligibility Benefit Inquiry
- 271 – Eligibility Benefit Response
- 277CA – Claims Acknowledgement
- 835 – Health Care Claim Payment/Advice
- 837 – Health Care Claim: Professional
- 837 – Health Care Claim: Institutional
- 864 – Text Message
- 999 – Implementation Acknowledgement
Auto Posting Payments

Home Screen

From the ‘Home’ screen, click on ‘View EDI Reports’. Or from the Electronic Billing tab click on the ‘EDI Reports’ button.

For information on adding EDI reports, see “Adding EDI Reports” on page 111.

1. Double click an 835 file from the EDI Reports screen and the program will analyze the 835 file.

2. If the 835 has multiple payments, the program will display the following screen that shows individual payment information.

3. Select – Click ‘Select’ button to process the single payment or

4. Split into Individual Reports – Click this button to split the 835 into individual reports making it easier to manage payments and reports.

5. Once a payment has been selected, the program will ask to confirm the correct payer. The program will attempt to find the matching payer based on the Payer ID if available. It is possible that the payer name in the 835 does not match the name in the drop down since the payer IDs will match.

6. Confirm the correct payer is selected and click OK.
The following screen will be displayed.

835 Adjustments Grid

Before applying the payments and adjustments, select the appropriate action for each adjustment reason code.

Apply - Adjustments will be posted with the dollar amount.

Track - Adjustment will be posted with a $0.00 dollar amount to allow adjustment tracking and easy claim follow-up. The posted adjustment description will contain the dollar amount in the format $X.XX from the 835. This setting is normally used when there is a denial and you want to flag the service line for follow-up.

Ignore - Adjustment is ignored. This setting is normally used when the EOB has an adjustment amount but it should not be posted because the monies will be coming from another party such as copay or deductible type adjustments.

Service Line Warning Messages

Occasionally, when an 835 is processed, there are issues when matching payments to service lines. This is normally due to the 835 not containing the reference IDs that link the payment to the service line. This will sometimes occur if the claim was sent on paper or sent with a different billing system. The follow two message types are as follows:

- One or more service lines lack a Reference ID#
- Payer Not Linked

One or more service lines lack a Reference ID#

When analyzing a file, you may receive the following message ‘One or more service lines lack a Reference ID#’.

This warning typically happens when a Payer has not returned the linking codes EZClaim uses to link payments to service lines.

The 835 preview screen will then have red cells with the words **SRVC LINE NOT FOUND**.
Double click on the warning message [**SRVC LINE NOT FOUND**] and click on ‘Select’ to match the payment with an existing service line. A Reference ID# will be automatically entered. You can use the filter row to find other service lines if the one shown is not correct.
Payer Not Linked

When opening an 835 file, the program will check if all the claims have a matching Payer (based on the payer ID). If the 835 payer or its payer ID does not exist on a claim, the following message will appear.

The 835 preview screen will then have red cells with the words PAYER NOT LINKED.

This typically happens when the payer library is not populated with payer IDs. If you have duplicate payers in your library, make sure the duplicates all have matching payer IDs. Otherwise the program will not understand that the payers are the same entity.

This may also happen in automatic crossover situations when the secondary payer was not entered on the claim. To fix this issue, open the claim by double clicking the Claim Invoice number to open the claim, add the payer then save and close the claim.

Once you’ve added the payer IDs or added a payer to the claim, click the Recheck Payer Links button to recheck the links. The PAYER NOT LINKED message will disappear.

Apply Payments and Adjustments

Click on the ‘Apply Payment and Adjustments’ button. Confirm line item information is green. If not, click on the button to drill down to view warning status.

Applied Status Definitions

After the program has applied payments and adjustments, the Options grid will reflect the status of each Payment and Adjustment;
Payment and Adjustment Statuses

- MATCHED (Green): The payment or adjustment already exists.
- APPLIED (Green): The payment or adjustment dollar amount was applied
- TRACKED (Green): The payment or adjustment was entered with a $0.00 dollar amount
- IGNORED (Green): The payment or adjustment was not entered
- MISMATCH (Red): The program found an existing value but it does not match the incoming 835 data.
- SRVC LINE NOT FOUND (Red): Service Line ID returned in the 835 (REF*6R) is invalid or missing.

Reversal of Previous Payments

Claims with a status of 22 (Reversal of Previous Payment) will be posted unless the option to not post them is turned on. See “Posting Options” on page 120 for more information on posting options.

Denied Claims

Claim payments with a status of 4 (Denied) are not posted. The claim posting status will be flagged as ‘PROCESSED’ but the payment posting status will be set to ‘IGNORED.’

Any adjustments from claims with a status of 4 will be listed on the adjustment posting grid so they can be tracked for follow-up purposes.

Original Reference Number

The original reference number found in segment CLP07 (Payer Claim Control Number) of the 835 will populate the claim field ‘Original Ref Number’ if the field is currently blank. This facilitates secondary billing with some payers who require a reference number or for claim resubmission.

Resubmission Code

Enter only if required by your Payer.

835 Claim Status ‘Code

When auto posting 835 data, the program uses the claim status returned in the CLP segment to determine if a claim should be marked as ‘Ready to Submit’ or ‘Submitted.’

The 835 claim status can be one of the following:

1 = Processed as Primary
2 = Processed as Secondary
3 = Processed as Tertiary
19 = Processed as Primary, Forwarded to Additional Payer(s)
20 = Processed as Secondary, Forwarded to Additional Payer(s)
21 = Processed as Tertiary, Forwarded to Additional Payer(s)

If the claim has additional payers AND the 835 claim status is 1, 2, or 3, the program will change the ‘Bill To’ to the next payer in line and mark the claim as ‘Ready to Submit’

If the claim has additional payers AND the 835 claim status is 19, 20, or 21, the program will change the ‘Bill To’ to the next payer in line and mark the claim as ‘Submitted’

**Denied or Rejected Claim Tasks**

When working with ANSI 835 ERAs, there may be denied or rejected claims within the 835 that you need to fix and resubmit. This is managed by creating tasks through the Adjustment grid.

Right click the adjustment row and select ‘Create Tasks Linked to Claims’.

You can then enter a description, assign to a particular user and even set a reminder popup.

See “Tasks” on page 134 for more information about tasks.

**835 Reports**

Once payments have been applied, you will have the option of printing reports from the ‘Reports’ dialog box.
Use the ‘Run Report’ drop-down arrow to select a report.

**All Data** - This report will show all data from the downloaded 835 file.

**Denied Claims Only** - This report will only show denied claims.

**Items With Transfer Warnings** – This report will only show claims with Transfer Warnings.

### Warning Messages on Report

**Not Transferred** – The payment or adjustment has not been transferred.

**Mismatched Payment/Adjustment Entered** – This is reported when a payment or adjustment exists in EZClaim Premier but does not match the amount in the 835 file.

**Service Line Already Paid** – The service line already has a balance of $0.00 (or a negative balance).

**Option Set to Skip Adjustment** – The adjustment has been skipped because the posting option was set to not apply the adjustment.

**Could Not Find Service Line** – The service line to apply the payment or adjustment could not be found. The Analyzer will attempt to find the service line by matching the Claim ID, Procedure Code, and Date.
Posting Options

- These are company level options. If a user changes these options, they apply to all users.
- Use this screen to automatically select the appropriate action when applying an 835
- Click on the 'Options' button to select options for posting payments.
- Options are set to 'Ignore' by default.
- To select multiple Reason codes hold down the Ctrl key to select individual options. Once highlighted, click on 'Apply Selected', 'Track Selected' or 'Ignore Selected' to apply.
- Options that have been changed will be displayed in Pink

Available Actions

Apply - Adjustments will be posted with the dollar amount.

Track - Adjustment will be posted with a $0.00 dollar amount to allow adjustment tracking and easy claim follow-up. The description will contain the dollar amount in the format $X.XX from the 835. This setting is normally used when there is a denial and you want to flag the claim for follow-up.

Ignore - Adjustment is ignored. This setting is normally used when the EOB has an adjustment amount but it should not be posted because the monies will be coming from another party. Such as copay or deductible amounts.

Additional Options

Overwrite existing allowed amounts when posting the 835
Checked - Existing allowed amounts will be overwritten with the 835 allowed amount if the 835 value is greater than $0.00.

Unchecked - 835 Allowed amounts will be applied if the existing allowed amount is $0.00 and the 835 allowed amount is greater than $0.00.

**Use 835 Payment Date as Posting Date**

Checked - The program will use the 835 Payment Date as the posting date for payments and adjustments contained in the 835.

Unchecked – The program will use the current date.

**Apply Zero Dollar Disbursements** - Note: Zero dollar payments from denied claims will not be posted.

Checked – The program will apply payments with a $0.00 dollar amount.

Unchecked – The program will ignore $0.00 payments.

**Allow Payments and Adjustments greater than the balance to be applied**

Checked – The program will apply payments and/or adjustments even if it would cause the service line to have a negative balance.

Unchecked – The program will not apply payments and/or adjustments that would cause the service line to have a negative balance.

**Don’t apply reversals of previous payments and adjustments**

Checked – The program will not apply payments or adjustments from claims with a status of 22 (Reversal of Previous Payment).

Unchecked – The program will apply payments from claims with a status of 22 (Reversal of Previous Payment). Adjustments may also be applied depending on the Apply, Track, or Ignore setting.

**FAQ on Auto Posting**

**Q. What happens if the secondary payment is posted before the primary?**

A. The payment will still post properly. The responsible party will not change unless the service line balance is zero at which point the responsible party will be set to ‘Patient.’

**Q. What happens if an 835 file is posted twice?**

A. No new payment will be created and no new disbursements will be created since all of them will find ‘matching’ disbursements. If you select adjustments to apply, they will either find a matching adjustment or the adjustment will be applied. If you apply adjustments that were previously tracked, the tracking adjustment will be removed and the adjustment will be applied.

**Q. What happens if an 835 is posted for a payment that was manually entered with the same ref number?**

A. No new payment will be created and no new disbursements will be created since all of them will find ‘matching’ disbursements. If you select adjustments to apply, they may be applied if there is no matching reference number.

**Q. What happens if an 835 is posted for a payment that was manually entered with a different ref number?**
A. The program will create a payment based on the 835 data. The program will post disbursements from the 835 since there are no 'matching' disbursements. If the option to over pay is turned on, the claim will have a credit balance, otherwise posting may cause a 'BALANCE EXCEEDED' message.

**Posting 835 Data Twice**

There may be times when you would like to post 835 payment data but there are issues with service lines not found or payers not linked to claims and you do not have time to link all the service lines or edit the claims for the correct payer. This is OK. EZClaim will not double post payments or adjustments.

If you post an 835 and the complete payment amount is not disbursed, the program will provide a warning letting you know that the payment was not fully disbursed.

---

If you preview the report, you will see in the Status column the items that were not posted and why.

When you have time to match the service line not found or edit the claims for the correct payer, you can post the 835 again. Double click the 835 file in the EDI reports screen to start the process again. You will receive a notification that the payment already exists. Click Yes to continue.

When you match the service lines and/or edit the claim payers to match, you can post the file again. You can also change adjustment settings from Track to Apply. When you review the report after posting, you will notice that the previously posted disbursements show 'MATCHED' and the previously tracked adjustments show 'APPLIED' which means they were not double posted.
Exporting 835 Data

The program will export the 835 data to Excel and a variety of other formats. Use the ‘Export’ button to export the 835 data.
Reports

Tips and Tricks

- Reports are searchable in preview mode.

- Any Report can be exported to a variety of formats by clicking the icon in preview mode.

- If data is not showing up on a report, that’s because it has been filtered out. Double check your criteria to make sure Filters are not being applied to the report.

- If Payments have been entered but not disbursed (applied) to service lines, reports will not reflect the disbursed information. It’s very important that payments be disbursed to service lines.

- In general, inactive patients will appear on reports. Some reports have a patient active status criteria that can be applied if needed.

Overview

EZClaim provides a set of Reports using data pulled from your EZClaim Premier program. When clicking on a Report name, a brief description will be displayed at the bottom of the list.

Report Criteria

Report data may be filtered by changing the report criteria in the tab below the report list.
If the criteria selected prevents the report from showing any data, you will receive the following notice.

No Criteria Warning

Some reports can be very large if run without some type of limiting criteria. If you attempt to print or preview a large report without criteria, a warning will appear to confirm your action.

Running Reports

Double click the report name to Preview the report

Click the button to Print the report

Click the button to Preview the report
Exporting Reports

All reports can be exported to a variety of formats from the Print Preview screen. When previewing a report, click the arrow on the Export icon and select the desired format.

Updating Reports

Ribbon Bar > Support > Download Reports

To download new or updated reports:

1. Click on the 'Download Reports' button to open the Download Reports window.
2. Updated or New reports will be in bold.
3. Select individual reports or use the Check New and Updated button.
4. Click the 'Download Checked Reports' button to download the reports into your system.
Additional Reports

There are additional reports that are available for download that are not part of the standard report installation. When viewing the Download Reports window, click the ‘Show Additional Reports’ check box. The report grid will reload and show the list of additional reports.

1. Place a check next to the individual reports to download.

2. Click the ‘Download Checked Reports’ button to download the reports into your system.

Custom Reports

Custom Reports are available, please contact EZClaim for pricing.

Accounts Receivable

The Accounts Receivable (AR) report shows accounts that have a balance and shows the aging of the amounts. The report utilizes an ‘Aging as of Date’ to calculate aging bucket values and to serve as a cutoff date for transactions. Transactions taking place after the aging as of date will not be included on the report. Transaction dates are defined as the service line ‘from date’, payment date, or adjustment date. EZClaim does not use the ‘Original Bill Date’ as a transaction date. This means if the claim was billed after the ‘Aging as of Date’, service lines with dates before or on the ‘Aging as of Date’ will still be included.

HELPFUL TIP: If a patient is showing up on the AR report but the program is showing a zero balance, that means a payment or adjustment has been entered with a future date (a date after the ‘Aging as of Date’). The easiest way to find this entry is to use the Find Adjustment or Find Payment grids and sort by the date field. You will then be able to find the transaction and fix the incorrect date.

The report lists patients and payers which are listed alphabetically under the patient name because each claim can have a different set of payers with different sequences (primary, secondary, etc.). Example: Joe could have Medicare
as the primary on claim 1 but as the secondary on claim 2. Since we don’t want to list Joe twice (or more) on the AR report, the payers are simply listed alphabetically.

Aging is calculated using the formula ‘Aging as of Date’ – ‘Original Bill Date’ = Days aged. ‘Original Bill Date’ is the date the claim was first printed or exported. It is available on the ‘Claim’ screen for editing. If the Original Bill Date is blank, then the date of service is used as the bill date to calculate aging. If you are comparing an AR report from EZClaim Premier to Advanced, then this may account for the different amounts in the aging buckets. The total open balance will still match.

One important concept to remember is that the AR report does not take into account credits that may be available to patients or payer. Credits are created when payments are not completely applied to service line charges.

If you are seeing patients with a zero balance due on the report, it is because the patient has service lines that do not have a zero balance (even though the claim does). Example: Service line 1 has a balance of $20 and service line 2 has a balance of -$20. The report will show the patient with a $0.00 balance due.

The report only filters out service lines with a zero balance.

**Adjustments**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>DOS</th>
<th>Proc.</th>
<th>Charge</th>
<th>Adj Date</th>
<th>Adj Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO REASON CODE SELECTED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$5.00</td>
</tr>
<tr>
<td>SAMPLE, MIKE &amp;</td>
<td>04/03/13</td>
<td>46</td>
<td>90</td>
<td>10/03/13</td>
<td>$5.00</td>
</tr>
</tbody>
</table>

**Description**

The Adjustments Report includes Patient Name, DOS, Charges, Adj Date and Adj Amount. To customize your report, enter data into the ‘Report Criteria’ fields.

**Authorizations**

<table>
<thead>
<tr>
<th>Authorizations</th>
<th>Auth Number</th>
<th>Start Date</th>
<th>End Date</th>
<th>Procedure</th>
<th>Mod</th>
<th>Units Used</th>
<th>Allowed</th>
<th>Remain</th>
<th>Use Allowed</th>
<th>Remain</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLUE CROSS</td>
<td>JONES, SALLY</td>
<td>02/01/2013</td>
<td>03/31/2013</td>
<td>90806</td>
<td>1.00</td>
<td>4.00</td>
<td>5.00</td>
<td>$0.00</td>
<td>$180.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
Description

NOTE: Authorization information entered on charges screen must match information in Auth Library for correct calculations. If you use Product Codes in service lines, the product codes must match those used in the Authorization Library.

The Authorization report will show how many units have been used, how many were allowed and how many remain.

Claim List

Claim List

<table>
<thead>
<tr>
<th>Active Status</th>
<th>Active</th>
<th>Show All</th>
<th>Show By Name</th>
<th>Show Service Line</th>
<th>Show Unpaid Only</th>
<th>Criteria</th>
<th>Name</th>
<th>Invoice # ID</th>
<th>Ph</th>
<th>Bill Date</th>
<th>Paid Date</th>
<th>Charges</th>
<th>Pat Pay</th>
<th>Ins Pay</th>
<th>Adj</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Description

The claim list report shows lists of claims for each patient. It also has the ability to show service lines for each of the claims listed. This report is useful for showing paid claims, claims not paid, claims that were created 6 months ago but have not been paid, etc. To customize your report, enter data into the ‘Report Criteria’ fields.

Disbursements

Disbursements

<table>
<thead>
<tr>
<th>Group by None</th>
<th>DOS</th>
<th>Proc.</th>
<th>Charge</th>
<th>Disb Amt</th>
<th>Print Date</th>
<th>Print Amt</th>
<th>Print Ref 1</th>
<th>Print Ref 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAMPLE, PATIENT 0</td>
<td>03/04/13</td>
<td>00886</td>
<td>80.00</td>
<td>20.00</td>
<td>02/08/13</td>
<td>60.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAMPLE, PATIENT 0</td>
<td>03/04/13</td>
<td>00886</td>
<td>90.00</td>
<td>50.00</td>
<td>02/08/13</td>
<td>50.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Disbursements: 60.00

Description

Displays payment disbursements and service line data. To customize your report, enter data into the ‘Report Criteria’ fields.

Patient Demographics

<table>
<thead>
<tr>
<th>Group by None</th>
<th>DOS</th>
<th>Proc.</th>
<th>Charge</th>
<th>Disb Amt</th>
<th>Print Date</th>
<th>Print Amt</th>
<th>Print Ref 1</th>
<th>Print Ref 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient Demographics report includes Patient, Primary Insurance, Secondary Insurance, Emergency and Reminder Information. To customize your report, enter data into the 'Report Criteria' fields.

Patient Ledger

The patient ledger report is used to show a patient history of services, applied payments, and adjustments. If a patient or payer payment has not been applied to a service charge, it will not show up on the report. To customize your report, enter data into the 'Report Criteria' fields.

The address shown in the upper right is the Company Description entered into the Program Setup > Company area.

Patient List

The Patient List shows a list of patients with the patient balance, claim balance and some patient details.

The patient balance shows the true patient balance which includes undisbursed payments. This is important because the patient could have a $100 claim that is set to patient responsibility but has paid $100 that has not been disbursed (applied) to the claim yet. This would show up on the report as Pat. Bal. = $0 and Cla. Bal. = $100. To customize your report, enter data into the 'Report Criteria' fields.
Patient Receipt

The patient receipt is a special report not included in the standard report list. See “Additional Reports” on page 127 for more information on how to download the Patient Receipt report.

Once the report is in your report list, you can configure the program to allow printing a patient receipt from the Enter Payment window. See the Program Section “Payment” on page 198 for information on selecting this report as the receipt report for the payment entry screen.

<table>
<thead>
<tr>
<th>Patient Receipt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Counseling</td>
</tr>
<tr>
<td>555 Main Street, Suite 100</td>
</tr>
<tr>
<td>Anytown, MI 55555</td>
</tr>
<tr>
<td>BROOKS, PATIENT</td>
</tr>
<tr>
<td>12312 S MAIN AVE</td>
</tr>
<tr>
<td>ANYWHERE, NY 33033</td>
</tr>
<tr>
<td>Payment Date</td>
</tr>
<tr>
<td>10/06/2015</td>
</tr>
</tbody>
</table>

Patient Services

Description

The Patient Services report shows Patient name, Date, Procedure and Modifier, Units, Charges, Disbursements, Adjustments, Balances, and Visit count. To change group options or criteria, use the ‘Report Criteria’ fields.

Payment List

Description

The Payment List report shows all the Patient and Payer payments in the system. This report is useful for showing a patient’s or payer’s payments over time. To customize your report, enter data into the ‘Report Criteria’ fields.
The Amount column represents the total amount of the payment.

The Remain. (short for Remaining) column represents the portion of the payment that has not been disbursed to service lines. For example: If you received a check for $100 and applied $80 to services lines. The remaining balance would be $20 and would show in the Remain. column.

Troubleshooting

If grouping by ‘Patient Classification’, all payer payments will be grouped under the classification ‘NONE’ since only patient payments have a classification.

Procedure Code Summary

The Procedure Code Summary shows a list of procedure codes and the subtotals for each of the columns. This report is useful to see which codes are not getting paid nor have adjustments. We suggest exporting the report to Excel for deeper data analysis. To customize your report, enter data into the ‘Report Criteria’ fields.

Production Summary

Shows the production breakdown of Charges, Adjustments and Disbursements. Displays the percent of total for each grouping. To customize your report, enter data into the ‘Report Criteria’ fields.

The Day Count represents the number of unique dates. Therefore, if running the report by Rendering provider, the Day Count in the ‘Charges’ section would represent the number of days the provider was in the office performing services. The number is not very relevant in the other sections.

The Day Count counts the unique dates over the group. This means the total Day Count may be less than the total of each group. If Doctor A saw patients on 10/1 and 10/2, the Day Count would be 2. If Doctor B saw patients on 10/1 and 10/3, the Day Count would be 2. The total Day Count will be 3 (not 4) since patients were seen on 10/1, 10/2, and 10/3.

Transactions shown on the report
- Charges - Trans Date = From Date
- Contract Adjustments - Trans Date = Adjustment Date
- Disbursements - Trans Date = Payment Date. Disbursements are used instead of payments because the report can be grouped by claim related data and payments are not linked to claims until disbursed.
- Other Adjustments - Trans Date = Adjustment Date

**Transaction List**

![Transaction List Image]

<table>
<thead>
<tr>
<th>Transaction List</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPANY NAME</td>
</tr>
<tr>
<td>Group By: None, Hide Detail: Unchecked</td>
</tr>
<tr>
<td>Name</td>
</tr>
</tbody>
</table>

**Description**

Shows a list of transactions

The company information is printed in the top right corner. To set the company name, use the ‘Company’ section in “Program Setup” on page 193.

Transactions listed include:

- **Charges**
  - Reference = Procedure/HCPCS Code
  - Trans Date = From Date
- **Adjustments** – Adjustments are split into Contract Adjustments and Other Adjustments
  - Reference = Reason Code
  - Trans Date = Adjustment Date
- **Insurance Payments** – These are not disbursement amounts, the report shows the total payment amount.
  - Reference = Ref # on payment entry screen
  - Trans Date = Payment Date
- **Patient Payments** – These are not disbursement amounts, the report shows the total payment amount.
  - Reference = Ref # on payment entry screen
  - Trans Date = Payment Date
Tasks

Overview

Click on the ‘Task’ button on the Home ribbon bar or right click on a Patient or Claim in the Search Pane and select ‘Add Task’. Tasks may be assigned to an Individual, associated with a Patient, Claim or Payer and have a Reminder date and time selected.

Once tasks are created, view tasks under the tab ‘Tasks’ on the search pane. Double click to open a Task or view ‘Task Details’ in the lower tab. To filter which tasks to be viewed, you can mark a task as ‘Completed’ or ‘Assigned to Others’.

Assigned To

Tasks can be assigned to individual users. Once assigned, they can only be re-assigned by a user with Admin privileges. See “Manage Security Settings” on page 205 for more information.

Reminders

Reminders can be set on a Task to pop up a message at a certain date and time. In addition to the popup, the ribbon bar shows reminders as well.

NOTE: Only 10 reminders will appear at a time. As tasks with reminders are completed, additional reminders will appear.
The reminder can be 'snoozed' from the ribbon bar as needed.

The program will check for task reminders every minute. If you close the reminder, it will pop up again in 1 minute.

The database server time is used to determine when a pop up should appear. If your clock does not match the server, the reminders may be delayed or early depending on the time difference between your computer and the server.

A Task reminder will only pop up if the following criteria are matched:

- Task is assigned to current user (logins enabled) or the general user (not assigned or logins disabled)
- Task is not marked as completed
- Reminder time has passed

The Reminders icon on the ribbon bar will show reminder counts based on the following criteria:

- Task is assigned to current user or the general user
- Task is not marked as completed
- Reminder time has passed

If multiple Tasks have the same reminder, the program will show pop ups stacked on top of one another.

Pop ups will continue to appear until the task is marked as complete or the reminder is turned off.

**Delete Tasks**

To delete a task, double click to open the task and click the Delete button. User must have permissions to delete a Task. The following rules are used to determine if a task can be deleted:
• If you have 'ADMIN' level permissions, you can delete any task at any time.
• If you created the task, you can delete the task.
• If the task was created by 'USER', anyone can delete the task.
• If you are logged in as 'USER', you can delete any task. This situation can only happen if; security was enabled, ‘Joe’ logged in and created the task, then security was disabled. When opening the program without security enabled, you will be able to delete tasks created by other users. Note: Only Admin level users can disable security.
Document Linking

About Document Linking

Any type of document can be linked, or the user can scan the image directly into the base directory by right clicking in the document area and choosing ‘scan’.

Documents ARE NOT stored in the company database. The documents are stored in a central network location setup by your IT department. The EZClaim program simply stores ‘links’ to the documents that are on your server.

WARNING: Backing up the Premier Company file does NOT back up the folder where documents are stored. Please backup the documents folder using your normal backup procedures. Contact your IT department for more information.

Configuration

Cloud Users: Please contact EZClaim to create your Documents folder on the cloud servers.

Tools > Program Setup

Before using document linking, the option needs to be turned on and configured.

<table>
<thead>
<tr>
<th>Options</th>
<th>Document Linking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Screen</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td></td>
</tr>
<tr>
<td>Patient Custom Fields</td>
<td></td>
</tr>
<tr>
<td>Claim</td>
<td></td>
</tr>
<tr>
<td>Claim Custom Fields</td>
<td></td>
</tr>
<tr>
<td>Printing Claims</td>
<td></td>
</tr>
<tr>
<td>Document Linking</td>
<td></td>
</tr>
<tr>
<td>Company</td>
<td></td>
</tr>
<tr>
<td>Show Document Links:</td>
<td></td>
</tr>
<tr>
<td>Base Document Link Path:</td>
<td></td>
</tr>
</tbody>
</table>

Show Document Links – Turns on the document link feature.

Base Document Link Path – Set this to the path that will store linked documents. The setting is user and machine specific since different computers may have different UNC paths or shared drives to the same location.

Once configured, a ‘Documents’ tab will appear in the search pane:

The program stores links to documents associated with patient records.

Add an Existing Document

There are multiple ways to add a document to a patient record. When an existing document is added to the system, you have the opportunity to copy or move the file. If you no longer want a copy on your computer, select Move.

1. In EZClaim Premier, select the Patient from the left search pane.

2. Click on the Documents tab. There are two methods to add an existing document:
a. Drag documents into the document area of the patient record creates the link.

b. Right click and select ‘Add Document Link’

Browse to the location of the document that you would like to link, (for EZClaim Premier Remote customers, your documents will be on your ‘local’ drives) and double click a file to add.

3. EZClaim will ask you if you want to ‘Move’, ‘Copy’ or ‘Cancel’, in most cases you would want to click on ‘Copy’. If you no longer want a copy on your computer, select Move.

4. Once complete, you will receive a notification that your link has been added

5. Your document will then appear in the list

Scanning a New Document

NOTE: Not all scanners are compatible with scanning directly into EZClaim Premier. You may need to scan and save the document, then drag and drop it into the patient document area.

1. In EZClaim Premier, select the Patient from the left search pane.

2. Click on the Documents tab. Right click and select ‘Scan and Add Document Link’
3. You will now see the Scan Document menu, make sure your Device shows up in the left hand corner under 'Device'.

4. Click the Scan button and wait for your Scanned Document to show up under Scan Result

5. Click on Save and Link Document to save the Document to the folder we have created on the server and link the document to the patient. You will be prompted to name your document.

6. Once complete, you will receive a notification that your link has been added

7. Your document will then appear in the list
Working with Document Links

Right click an existing document and a menu appears with the options to open, print or save as. You can also set the document category to organize your documents. Document Categories are managed in the List Library.
Libraries

Libraries are accessed through the 'Libraries' icon on the Home ribbon bar.

Library Security

Not all libraries are accessible to everyone. Some libraries require 'ADMIN' or 'Full access' level permissions. See “Manage Security Settings” on page 205 for more information.

- Add-On Services – ‘Full access’ permission required to access or edit
- Authorization – Anyone can access, but ‘Manage Payer/Physician/Auth’ permission to edit
- Claim Template – Anyone can access, but ‘Manage data entry’ permission to edit
- Code Library – Anyone can access, but ‘Manage data entry’ permission to edit
- EDI Connection – Anyone can access, but ‘Submit claims and retrieve reports’ permission to edit
- Interface – ‘Full access’ permission required to access or edit
- List – Anyone can access, but ‘Manage data entry’ permission to edit
- Note Template – Anyone can access, but ‘Manage data entry’ permission to edit
- Payer – Anyone can access, but ‘Manage Payer/Physician/Auth’ permission to edit
- Physician Facility – Anyone can access, but ‘Manage Payer/Physician/Auth’ permission to edit
- Procedure Code – Anyone can access, but ‘Manage data entry’ permission to edit
- Submitter / Receiver – Anyone can access, but ‘Submit claims and retrieve reports’ permission to edit
- Widget - Anyone can access, but ‘Print, Preview, and Export’ reports permission to edit

Add-On Services

Add-On Services is access through the library menu in the ribbon bar.
Authorization

The ‘Authorization Library’ in the billing program is used to track authorized services. If you need to track authorized visits, please use the EZClaim Scheduling software ‘Authorized Visits Library’.

How it Works

- Authorization limits are only checked when entering new claims. The program will not check for authorization limits when changing data on existing claims.

- Authorizations are assigned at the claim level. It is not possible to assign Authorizations to individual service lines. If different authorizations are needed for different services, create additional claims.

- Units and Dollars remaining are calculated using only service lines that fall within the date range.

Entering Authorizations

1. Click in ‘Add New Entry’ field.

2. Select Patient using drop-down arrow. Required.

3. Select Payer using drop-down arrow. Optional. ‘None’ is a valid option if you want the authorization to be available to any payer listed on the claim.


**Note:** To customize column headings, Right click on any column heading and select ‘Column Chooser’. Drag and Drop selection to heading. See “Column Chooser” on page 15 for more information.

Advanced Techniques

**Rendering Phy** – There is a Rendering Phy column that can be added into the grid. When used, the authorization will only appear when the correct rendering provider is selected on the claim. Authorizations without a rendering provider will appear regardless of the claims’ rendering provider.

**Wildcard** - If there are multiple procedure codes within the same family of codes, you can use the wildcard character % at the end of the procedure code fragment. For example, entering 98% will count any procedure code that starts with 98.

**Multiple Entries** – If the same authorization number applies to different procedure codes, you can enter the same authorization number multiple times, one for each procedure code.

**Modifiers** – If your authorization is for both the procedure AND modifier, you can enter modifiers into the Mod 1 through Mod 4 columns. This will cause the program to count down authorizations only if the procedure code and modifiers match. If you leave the auth modifier fields blank, the program will look at the procedure code only when...
calculating the units (it will not matter if there are modifiers entered on the service line or not, the units will still count down).

**Product Code** – If product codes are utilized during data entry, it may be necessary to enter the product code into the authorization library entry. The product code column is not typically visible and will need to be added using the Column Chooser. If a product code is entered, only service line that have both the procedure code and product code will be counted for units and dollars used.

**Claim Template Library**

*Home tab > Libraries > Claim Template*

The Claim Template Library is used to group services together to reduce data entry time.

- Only the Template name and at least 1 service line is required. All other fields are optional.
- Enter Claim Template data using drop-down arrows for selecting template data. Click ‘Initial Claim Values’ to add additional criteria.
- Claim Templates can be made available to all patients or to a specific patient only. Use drop-down to make Available To: selected patient.
- All dollar amounts are obtained from the previously set up Procedure Code Library. Confirm the Library is configured properly before using a claim template.
- Claim Templates are selected on the Charges screen during data entry. Once a Template is selected, click the calendar dates to apply the template values to the claim.
The Code Library is used to maintain the following code sets:

**Reason Codes** (Adjustment reason codes) - The program will load the reason codes automatically if none exist in the library. The user can add, edit, or remove codes as needed. Any field that uses a reason code will have a drop down box showing the code and description.

**Remark Codes** – The program will load the remark codes automatically if none exist in the library. The user can add, edit, or remove codes as needed. Remark codes are used when auto posting ERAs.

**Diagnosis Codes** – The program does not come pre-filled with diagnosis codes. Enter codes as needed. Double click (or press Alt-L) on any of the diagnosis code fields to open the ‘Diagnosis Code Lookup’. If you enter a keyword into the diagnosis field before opening the lookup window, the program will search the code list for you.

**Diagnosis Codes ICD-10** – The program does not come pre-filled with ICD-10 diagnosis codes. Enter codes as needed. Double click (or press Alt-L) on any of the diagnosis code fields to open the ‘Diagnosis Code Lookup’. If you enter a keyword into the diagnosis field before opening the lookup window, the program will search the code list for you.

**Place of Service** – The program does not come pre-filled with place of service codes. Enter codes as needed. Double click (or press Alt-L) in Place of Service field to open the ‘Place of Service Lookup’.

**Modifiers** – The program does not come pre-filed with modifiers. Enter modifier codes as needed. Double click in the modifier field to open the ‘Modifier Lookup’.

**Importing Codes**

You can import your code libraries. We do not support converting codes into the correct format. The following describes the format a text file must follow to be imported into the code libraries:

Column 1 is the code, followed by a tab, followed by the description in column 2. For example:

```
Code1(TAB)Description1
Code2(TAB)Description2
```
EDI Connection Library

The EDI Connection Library is used to maintain electronic Connection methods to your various clearinghouses or payers.

Each connection Type has different requirements.

- Enter the name of the connection.
- Select the Type.
- Enter additional data as required.

Using the EDI Connections

The EDI Connections are selected on the ‘Send Claims’ screen and the ‘View EDI Reports’ window. Refer to “Electronic Claims” on page 95 and “View EDI Reports” on page 109 for additional information.

Secure File Transfer (SFTP)

This is the most popular type of connection. It allows uploading of claims and downloading of reports with the click of a button. No additional software is required.

The values for each field are provided by the clearinghouse.

User Login: The SFTP login provided by your clearinghouse or payer.

User Password: The SFTP password provided by your clearinghouse or payer.
**Host Name**: Enter the host name (i.e. ftp.somesite.com) or IP address (i.e. 192.168.0.1) provided by your clearinghouse or payer. If you receive a ‘Connect’ Failed during a test connection, double check that the host name is correct.

**Port**: Typically SFTP communicates over port 22 but other ports can be used. If you receive a ‘Connect’ Failed during a test connection, double check that the port is opened on your firewall.

**Upload Directory**: Enter the SFTP upload directory provided by your clearinghouse or payer. This directory will be used to upload ANSI 837 claim files.

**Download Directory**: Enter the SFTP download directory provided by your clearinghouse or payer. This directory will be checked for EDI reports.

**Download File Pattern (Optional)**: If you want to limit the download of files using a regular expression, enter it here.

**Automatically Name and Save Upload Files**: Check this box if you would like the program to automatically name the file and upload it. The saved file is temporary and will be deleted upon successful upload. The filename will be in the format yyMMdd_HHmmssff (year, month, day, hour, minute, second, hundredth). There is no file extension.

**Allow SFTP Site to Move or Delete Files**: Check this box if the server will handle the removal of downloaded report files.

**Other Connection Types**

**Availity**

Uses secure FTP protocol. Enter user login and password provided by Availity. When using this connection type, the program will automatically name and upload the claim file and show a progress bar on the screen.

The following values are used for the Availity connection type:

- Site: ftp.availity.com
- Upload Directory: SendFiles
- Download Directory: /ReceiveFiles
- Port: 9922

**BCBS of Michigan Secure File Transfer**

Used with BCBS of Michigan only. Enter the information provided by BCBS of Michigan’s EDI services.

**Capario Secure File Transfer**

Used for Capario clearinghouse services. Enter the information provided by EZClaim’s EDI services.

**TriZetto Secure File Transfer**

Used for TriZetto clearinghouse services. Enter the information provided by TriZetto’s EDI services.

The download pattern allows you to enter a file name pattern with wildcards ("*" ) to filter the files downloaded. Example. Entering 12345* would only download files that start with 12345. This is useful if you are working with multiple company files.
**Program**

If you would like an external program to open after the file has been exported, enter the filename here. Once the claim file is saved, the program will be opened. The claim filename is placed in the clipboard.

This option would be used if there is special transmission software that your clearinghouse uses to upload claim files.

NOTE: This connection type cannot be used with EZClaim Remote due to security restrictions. If you are using EZClaim remote, use the ‘Just Export File’ option to save the file to your local computer and open the program required to upload the file.

**Website**

If your clearinghouse uses a website to transfer files, enter the website URL here and the program will open the website in your default browser. The claim filename is placed in the clipboard.

NOTE: This connection type cannot be used with EZClaim Remote due to browser security restrictions. If you are using EZClaim remote, use the ‘Just Export File’ option to save the file to your local computer and use your web browser to upload the file.

**Zyantus Secure File Transfer**

Used for Zyantus clearinghouse services. Enter the information provided by Zyantus' EDI services.

<table>
<thead>
<tr>
<th>Submitter Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitter Telephone</td>
</tr>
<tr>
<td>Client Code</td>
</tr>
<tr>
<td>Site ID (Optional)</td>
</tr>
</tbody>
</table>

If entering the optional Site ID, the program will automatically format it to a 4 digit site ID. Entering 1 will become 0001 automatically. Be sure to confirm with Zyantus that your account is setup to name the files with a site ID. Once configured by Zyantus, your files will have s0001 appended to the end of the name. For example, an audit report filename will look like this: cXXXXXXXXd20150112t125720_1.submitter.s0001.html. If a file does not have the site ID format, it will still be downloaded into the company file.

**Interface Library**

Accessing this library requires ‘ADMIN’ or ‘Full access’ level permissions. See “Manage Security Settings” on page 205 for more information.

**Importing Data**

See “Importing Data (via Interfaces)” on page 185 for instructions on importing data.

**Available Interfaces**

- Amazing Charts Preferred 1500 Format
- EZClaim Import Ver 1
- EZClaim Import Ver 2 – Specifications
- HL7 2.3.1 Export
• HL7 2.3.1 Import (ADT^A08 and DFT^P03 message types) – Specifications
• iCRco
• LabDirector
• Practice Fusion Premium Import

How an Interface Works

• Interfaces that import data will only run when the program is open.

• Some interfaces are machine and user specific. This means the interface will only run when the user is logged into the machine that the interface was configured on. This is due to the fact that some parameters are machine/user specific such as mapped drives, etc.

• Interfaces are predefined within Premier. All available interfaces are listed in the ‘Interface Library’.

• Interfaces can be managed by the administrator only.

• Import/Export Interfaces are only active if the Premier program is running on the machine that the interface is configured on.

• Incoming data must be reviewed before being saved to the Premier database.

• Interfaces can be configured on multiple computers.

All interfaces require an Activation code; please contact EZClaim to obtain the activation code. The interfaces available may be different than shown on this screen shot. Contact EZClaim for specific information on available interfaces.

Amazing Charts Preferred 1500 Format

• Activation Code: Code provided by EZClaim to enable the interface
- **Import Directory**: Location of directory containing the files to be imported.
- **Check Minutes**: How often the program will check the directory for new files to be added to the interface review screen.
- **Active**: If unchecked, the program will not check for new files.
- **Update Patient Demographics**: New incoming patient data will overwrite existing data.
- **Backup Files**: If checked, copies of the files will be saved in a backup directory in the import directory. The filename will contain the date and time it was brought into the company file.

**EZClaim Import Ver 1**

<table>
<thead>
<tr>
<th>EZClaim Import Ver 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activation Code:</td>
</tr>
<tr>
<td>Import Directory:</td>
</tr>
<tr>
<td>Check Minutes: 10</td>
</tr>
<tr>
<td>Active:</td>
</tr>
<tr>
<td>Backup Files:</td>
</tr>
</tbody>
</table>

- **Activation Code**: Code provided by EZClaim to enable the interface
- **Import Directory**: Location of directory containing the files to be imported.
- **Check Minutes**: How often the program will check the directory for new files to be added to the interface review screen.
- **Active**: If unchecked, the program will not check for new files.
- **Backup Files**: If checked, copies of the files will be saved in a backup directory in the import directory. The filename will contain the date and time it was brought into the company file.

**EZClaim Import Ver 2**

<table>
<thead>
<tr>
<th>EZClaim Import Ver 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activation Code:</td>
</tr>
<tr>
<td>Import Directory:</td>
</tr>
<tr>
<td>Check Minutes: 10</td>
</tr>
<tr>
<td>Active:</td>
</tr>
<tr>
<td>Update Patient Demographics</td>
</tr>
<tr>
<td>Backup Files:</td>
</tr>
</tbody>
</table>

- **Activation Code**: Code provided by EZClaim to enable the interface
• **Import Directory**: Location of directory containing the files to be imported.

• **Check Minutes**: How often the program will check the directory for new files to be added to the interface review screen.

• **Active**: If unchecked, the program will not check for new files.

• **Update Patient Demographics**: New incoming patient data will overwrite existing data.

• **Backup Files**: If checked, copies of the files will be saved in a backup directory in the import directory. The filename will contain the date and time it was brought into the company file.

**HL7 2.3.1 Export**

<table>
<thead>
<tr>
<th>HL7 2.3.1 Export</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activation Code:</td>
</tr>
<tr>
<td>Export Directory:</td>
</tr>
<tr>
<td>Check Minutes: 10</td>
</tr>
<tr>
<td>Create ADT-A04 After: Don't create</td>
</tr>
<tr>
<td>Create ADT-A08 After: Don't create</td>
</tr>
<tr>
<td>Active: □</td>
</tr>
</tbody>
</table>

- **Activation Code**: Code provided by EZClaim to enable the interface
- **Export Directory**: Directory the exported files will be saved to.
- **Check Minutes**: How often the program will check for new information to be exported.
- **Create ADT-A04 After**: Don’t Create, Patient record created, or Patient record updated. The ADT-A04 is a ‘Register Patient’ message type.
- **Create ADT-A08 After**: Don’t Create, Patient record created, or Patient record updated. The ADT-A08 is a ‘Patient Update’ message type.
- **Active**: If unchecked, the program will not check for new files.

The ‘Create ADT-A04’ button is used to create a one time export of your existing patients. This could be used to do an ‘initial load’ into another system. You have the option of exporting an ADT-A04 or ADT-A08 using the button drop down.

Once clicked, you will be presented with a list of existing patients to export. Check the box next to the name to select for export or use the check buttons available on the right of the screen.
The single file containing the selected patients will be exported to the directory selected in the 'Export Directory' field. You will receive a confirmation once the export is complete.

HL7 2.3.1 Import

- **Activation Code**: Code provided by EZClaim to enable the interface
- **Active**: If unchecked, the program will not check for new files.
- **Update Patient Demographics**: New incoming patient data will overwrite existing data.

The HL7 2.3.1 Import has the capability of checking either a locally accessible directory or a SFTP (Secure FTP) site. One of two options can be activated: ‘Check Import Directory’ or ‘Check SFTP’

**Check Import Directory Options**

- **Import Directory**: Location of directory containing the files to be imported.
- **Check Minutes**: How often the program will check the directory for new files to be added to the interface review screen.
- **Backup Files**: If checked, copies of the files will be saved in a backup directory in the import directory. The filename will contain the date and time it was brought into the company file.

**Check SFTP Options**
SFTP Site – This is a list of EDI Connection entries of the type Secure File Transfer. See “EDI Connection Library” on page 145 for more information on setting up EDI Connection entries. Please note, only the following Secure File Transfer settings are used during the HL7 SFTP import:

- User Login
- User Password
- Host Name
- Port
- Download Directory
- Download File Pattern (Optional)

**iCRco**

<table>
<thead>
<tr>
<th>iCRco</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activation Code:</strong></td>
</tr>
<tr>
<td><strong>Import Directory:</strong></td>
</tr>
<tr>
<td><strong>Check Minutes:</strong></td>
</tr>
<tr>
<td><strong>Active:</strong></td>
</tr>
<tr>
<td><strong>Backup Files:</strong></td>
</tr>
</tbody>
</table>

- **Activation Code:** Code provided by EZClaim to enable the interface
- **Import Directory:** Location of directory containing the files to be imported.
- **Check Minutes:** How often the program will check the directory for new files to be added to the interface review screen.
- **Active:** If unchecked, the program will not check for new files.
- **Backup Files:** If checked, copies of the files will be saved in a backup directory in the import directory. The filename will contain the date and time it was brought into the company file.

**LabDirector**

<table>
<thead>
<tr>
<th>LabDirector</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activation Code:</strong></td>
</tr>
<tr>
<td><strong>Import Directory:</strong></td>
</tr>
<tr>
<td><strong>Check Minutes:</strong></td>
</tr>
<tr>
<td><strong>Active:</strong></td>
</tr>
<tr>
<td><strong>Backup Files:</strong></td>
</tr>
</tbody>
</table>

- **Activation Code:** Code provided by EZClaim to enable the interface
• **Import Directory**: Location of directory containing the files to be imported.

• **Check Minutes**: How often the program will check the directory for new files to be added to the interface review screen.

• **Active**: If unchecked, the program will not check for new files.

• **Backup Files**: If checked, copies of the files will be saved in a backup directory in the import directory. The filename will contain the date and time it was brought into the company file.

### Practice Fusion Premium Import

<table>
<thead>
<tr>
<th>Practice Fusion Premium Import</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activation Code:</td>
</tr>
<tr>
<td>Practice Id:</td>
</tr>
<tr>
<td>Check Minutes: 10</td>
</tr>
<tr>
<td>Active:</td>
</tr>
<tr>
<td>Update Patient Demographics</td>
</tr>
<tr>
<td>Process Each Superbill</td>
</tr>
<tr>
<td>Individually</td>
</tr>
</tbody>
</table>

• **Activation Code**: Code provided by EZClaim to enable the interface.

• **Import Directory**: Location of directory containing the files to be imported.

• **Check Minutes**: How often the program will check the directory for new files to be added to the interface review screen.

• **Active**: If unchecked, the program will not check for new files.

• **Update Patient Demographics**: New incoming patient data will overwrite existing data.

• **Process Each Superbill Individually**: If unchecked, available superbills will be brought into EZClaim as one file for review. If checked, every superbill will show as individual review files. See “Review Incoming Files” on page 185 for more information about reviewing incoming data.

### Test Connection

Click this button to confirm all the settings are correct and the system is registered properly with EZClaim. This will only test the configuration on EZClaim’s side, it will not test Practice Fusion’s configuration. If successful, you will receive the following message:

```
Connection succeeded

The connection was successful and your Practice Id is registered with EZClaim.

OK
```
If you receive a 'Practice Id not registered' message, this means the Practice Id entered does not match the one registered with EZClaim's servers. Please contact EZClaim to confirm.

List Library

The list library is used to manage items used in drop down boxes throughout the program. The available lists are shown in the List Type section.

Find & Replace

You can use the Find & Replace feature to change the name or replace one entry with another. The ADMIN password is required to use this feature.

What to replace: This drop down is populated with the existing data found in the company file. It does not show the current list entries.

Replace with: This drop down shows the current list entries. If you are changing the name of the entry, you will first need to add it to the list. Once the Find & Replace process is complete, you can delete the incorrect entry.
**Note Template Library**

Home tab > Libraries > Note Template

Note Templates may be set up for easy data entry in the various note fields.

Once created, note templates can be accessed by right clicking on a note area, and selecting the appropriate template.

Click on 'Add new note template' and enter data for template.

---

**Payer Library**

Home tab > Payer Library

The ‘Payer Library’ is used to maintain Payer information and customizing Payer options.

<table>
<thead>
<tr>
<th>Field</th>
<th>Payer Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer Name</td>
<td></td>
</tr>
<tr>
<td>Payer ID</td>
<td></td>
</tr>
<tr>
<td>Street Address 1:</td>
<td></td>
</tr>
<tr>
<td>Street Address 2:</td>
<td></td>
</tr>
<tr>
<td>City, State, zip:</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
</tr>
<tr>
<td>Website</td>
<td></td>
</tr>
<tr>
<td>Office Number:</td>
<td></td>
</tr>
<tr>
<td>Box 1:</td>
<td></td>
</tr>
<tr>
<td>Ins. Type Code:</td>
<td>Class Type: Professional</td>
</tr>
<tr>
<td>Claim Filing End:</td>
<td>Classification:</td>
</tr>
<tr>
<td>Initial ICD End:</td>
<td>Eligibility Provider:</td>
</tr>
<tr>
<td></td>
<td>Use value from Program Setup</td>
</tr>
</tbody>
</table>

**Payer Library Fields:**

- **Payer Name** and Address information

- **Payer ID** – The code provided by the payer or clearinghouse to designate this payer. *It's very important that the Payer ID be entered. Especially if you have multiple entries for the same payer (such as UHC having different mailing addresses, etc). This is critical in making the payment posting work smoothly. The program uses the Payer ID to link multiple payer library entries together when posting payments.*
• **Method** – Select the method of transmission. Paper or Electronic

• **Ins. Type Code** - Insurance Type Code is used when submitting Medicare Secondary Payer electronic claims.

• **Claim Filing Indicator** – A code identifying the source or type of payment for the claim.

• **Classification** – Sometimes for reporting and grouping purposes, it’s easier to use a classification instead of the payer name. For example, you may have multiple Blue Cross entries for various reasons. Setting the Classification to ‘BCBS’ would help run reports on all the Blue Cross entries without having to select each entry individually. Note that the payer classification criteria is only available on certain reports.

• **Initial ICD Ind** – This is used for setting the ICD indicator on new claims that use this payer. This setting overrides the ICD indicator setting in Program Setup.

**Payer Library Options**

• **Ignore Rendering Provider** – When using the selected Payer, EZClaim Premier will ignore the Rendering Provider information when claim is submitted.

• **Automatically Forwards Claims** – This setting is used when the primary payer automatically forwards claims to the secondary (or secondary to tertiary). When checked, claims that switch from primary to secondary will be marked as ‘Submitted’ so they are not printed or exported by the user since they have automatically been forwarded. IMPORTANT: When auto-posting, the 835 claim status determines if the secondary (or tertiary) claim will be set to ‘Ready to Submit’ or ‘Submitted’. Example: If the 835 says the claim was ‘Processed as Primary, Forwarded to Additional Payer(s)’, then the status of the secondary claim will be ‘Submitted’. If the 835 says the claim was ‘Processed as Primary’, then the secondary claim will be set to ‘Ready to Submit’

• **Export billing provider taxonomy code even if using a rendering provider** – When checked, the billing provider taxonomy code will be exported in Loop 2000A Segment PRV Field 02 even if a rendering provider is selected on a claim.

• **Export/Print patient info in Facility loop when Place of service is 12** – Primarily used for Home Health providers

• **Export Subscriber SSN** – If the payer requires the subscriber SSN in the ANSI 837 file, check this box.

• **Include Adjustments with Payments in Box 29** – When checked, the amount printed in Box 29 will include adjustments.

• **Print Box 30 on the 1500 (02-12)** – Check this box to print the balance due in box 30 for the 02-12 version of the 1500 form. This box is normally left blank.

• **Suppress payer address when printing claims** – Check this box to prevent the payer address from printing at the top of the 1500 form.

• **Mark as Inactive** – Check to prevent the Payer from being displayed in the Payer List.

• **Automatically create a reminder task** – Use this feature to have the system automatically create a task with a due date for X number of days after the claim has been billed. When a claim has been printed or exported, a task will be created with a due date X number of days after the claim has been billed.

• **Eligibility Provider** – Sometimes, the provider registered with the payer is different than the one selected in the program setup. Use this field to override the program setup option.

See “Payer Library” on page 25 for additional information on setting up the Payer Library.
Deleting a Payer Entry

You cannot delete a payer entry if it is currently in use. If you try to delete an entry and it is currently being used, a message will appear showing where the entry is used. Use the Find tools to open the appropriate record and change payer selected. If the entry is being used and you no longer want it to show up in selection lists, mark the entry as inactive instead.

![Cannot Delete Payer dialog box]

**Physician/Facility Library**

The ‘Physician/Facility Library’ is used to maintain a list of Providers and Facilities used in patient and claim records. See “Physician, Facility Library” on page 26 for additional information on setting up the Physician Library.

![Physician/Facility Library image]

**Classification**

Each entry is classified with one of the following classifications:

- Billing – Address and Tax ID is required for this type of entry.
- Facility
- Ordering – Address is required for this type of entry.
- Referring
- Rendering
- Supervising

**Signature on File**

This field is only available for ‘Billing’ type providers. It will be disabled for all other classifications. If checked, the program will print ‘Signature on File’ in box 31 of the 1500 form. It is also used in the ANSI 837 file in the CLM segment field 6 (Provider or Supplier Signature Indicator). See “Box 31” on page 66 for more information.

The billing provider is selected on the claim screen in the ‘Billing Provider’ field.
Rate Class

Rendering providers may be assigned a ‘Rate Class’ previously set-up in the Procedure Code Library. The Physician/Facility Library drop down box is populated with the rate class names used in the Procedure Code Library. See “Procedure Code Library” on page 159.

Data Entry Tips

NPI number is validated during data entry. If the number looks invalid, a tooltip message will appear warning you of an invalid number. The warning does not prevent you from saving the library entry.

You can quickly jump through the list of providers by clicking into the list and typing in a few letters of the name.

If you do not know the NPI number of an entry, click the Lookup NPI link next to the NPI field.

Additional ID Numbers

Additional ID Numbers print in Box 33b of the 1500 form and are used in the ANSI 837 export typically in REF segments.

To enter Additional ID Numbers, select the provider, then, in the Additional ID Numbers section, select a Payer if the ID number is only used for a specific payer. If not, leave the setting at ‘All Payers’, press the tab key, select the type of ID from the list, press the tab key, enter the ID number, then press the tab key to save the entry.

Inactive

To hide a library entry, check the entry as inactive. The library entry will not be available in the selection list when entering data. **Do not delete the entry if being used on patient or claim records!**

Physician Notes

The physician notes can be enlarged by right clicking in the notes area and selecting Show in Pop-up. This allows a larger editing area and you can print the notes using the ‘Print’ button.

Deleting a Physician/Facility Entry

You cannot delete a physician/facility entry if it is currently in use. If you try to delete an entry and it is currently being used, a message will appear showing where the entry is used. Use the Find tools to open the appropriate record and change physician selected. If the entry is being used and you no longer want it to show up in selection lists, mark the entry as inactive instead.
Procedure Code Library

Home tab > Libraries > Procedure Code

The ‘Procedure Code Library’ allows you to maintain procedure (or HCPCS) codes along with rates and additional information for each code. Maintaining the Procedure Code Library is optional and not required.

- When changing the number of units on a service line, the cost column and adjustment column is not changed. Only the Charge and Allowed columns are updated.
- When changing the number of units, the current charge is divided by the original units to get the ‘per unit’ amount, and then multiplied by the new number of units.
  \[ \text{<New Charge>} = \frac{\text{<Old Charge>}}{\text{<Old Units>} } * \text{<New Units>} \].
- The combination of procedure code and product code determines which library entry to use. The product code column is not shown normally and is only used in special situations.

To add additional columns, right click on any column heading and select ‘Column Chooser’. Drag and Drop custom column to desired location.

Available Columns

Only the most common columns are shown in the grid. Use the Column Chooser to add or remove columns.
Standard Columns

Procedure – Enter the CPT or HCPCS code here

Mod 1 – If a modifier is commonly used with this procedure code you can enter it here.

Charge – Normally contains the unit charge (the amount you charge for 1 unit)

Allowed – The amount allowed by the payer. Typically this is $0.00 but some users like to track the allowed amount before receiving the ERA (EOB)

Payer – If this code is specific to a payer, select the payer. This will allow the program to filter the available codes based on the payer being billed.

Rate Class – If there are different rates for different classes of service (MD, PA, RN, etc.), you can define rate classes here then use them with rendering providers in the Physician Library.

Description – Description of the code. Used on patient statements.

Additional Columns

To add additional columns, right click the current column heading and select Column Chooser.

Adjust – Typically left at $0.00. If you would like a contract adjustment entered at the time of service line data entry, enter the adjustment amount.

Attach CMN – If this code requires a CMN to be attached, you can check this box to cause the ‘Attach CMN’ box on the service line to be checked.

Billing Phy – If this code record is for a specific billing provider, you can enter it here. Sometimes used for different contracted rates for different providers.

Category – User defined category. Can be used in custom reports.

Cost – Used to fill in the cost amount when entering service lines.

Mod 2 – Modifier 2

Mod 3 – Modifier 3

Mod 4 – Modifier 4

NDC Code – Used to fill in the NDC code when entering service lines

Note – General note field for your reference

Product – Product code used when generic CPT or HCPCS codes to differentiate codes.

Revenue Code – Code used to describe the service.

Set Desc – If checked, the line item description will be filled in with the code description.

Set Pat Amt Due – If checked, the service line patient amount due field will be filled in with the patient’s co-pay amount.

Subcategory - User defined subcategory. Can be used in custom reports.
**Units** – If the charge amount cannot be a single unit charge, you can enter the units here. For example, you may charge $35 for 3 units. If so, enter $35 as the charge amount and 3 in the Units field. If only 1 unit is used, the program will round to the nearest cent.

**Start and End** – If the procedure code is only valid for a specific date range, use the Start and End fields to enter the start and end dates.

**Work RVU** – Used to track the Work Relative Value Unit. Can be used in custom reports.

**Malpractice RVU** – Used to track the Malpractice Relative Value Unit. Can be used in custom reports.

**Modify or Create New**

New code sets can easily be created using the ‘Modify’ or ‘Create New’ button. Select the codes to modify and click the ‘Modify or Create New’ button. This will open the Modify or Create New Procedure Code window.

- Check the properties you wish to apply and enter the appropriate values.
- To modify the selected codes, click the ‘Apply to Checked Items’ button.
- To create new codes based on the selected codes, click the ‘Create New from Checked Items’ button.

**Importing Procedure Codes**

You can import your code libraries. Import only works with tab delimited text files. We do not support converting codes into the correct format. The following shows the format a text file must follow to be imported into the code libraries:

```
Code|Charge|Allowed|Adjust|Description|Product
Code|Modifier|Category|Subcategory|WorkRVU|MalpracticeRVU
```

**Procedure Code Library Usage (Advanced Topic)**

EZClaim ‘Procedure Code Library’ is a powerful tool that if configured properly, can ease data entry and provide accurate charge information. Utilizing rate codes and assigning payers provides a method to maintain and store multiple rate schedules.
This section provides detailed information on how the program uses the Procedure Code Library to find charges during data entry. See ‘Procedure Code Lookup’ on page 53 for additional information on using the Procedure Code library.

At the time of data entry, the program uses a decision tree to determine the available library entries for the claim. The code list used by the program is determined by matching the following criteria:

- Billing Physician
- Bill To Payer
- Rate Class

If duplicate procedure codes match the criteria, only 1 will be returned. This provides consistency during data entry when not using the lookup tool.

Priority is given to codes that match:

- Billing Physician, Bill To Payer, and Rate Class
- Bill To Payer and Rate Class
- Rate Class only
- Codes that do not have the Billing Physician, Bill To Payer, or Rate Class assigned.

Additional Information:

- The combination of procedure code and product determine uniqueness.
- The existing Allowed amount is overwritten by library data when changing the procedure code.
- The existing Adjustment amount is overwritten IF a contract adjustment does not already exist for the service line.
- If the charge is $0.00 in the library, it will not overwrite an existing charge.
- If the allowed is $0.00 in the library, it will not overwrite an existing allowed.

### Product Codes

Product codes are used with generic procedure codes. Sometimes you may have the same code but with a different charge, you can use the Product Code column to differentiate between the two duplicate codes. This column is not normally shown and will need to be added using the column chooser.

![Product Code Table]

### Start and End Dates

If you are using procedure codes that have start and end dates, the following rules will apply when accessing the lookup library:

- The program will use the current date as filter criteria when accessing the lookup library from the Claim Template screen.
- The lookup library will not contain any codes with a start or end date when accessing the library from the claim’s service line preview row if the ‘From’ date is blank.
- The program will use the ‘From’ date as filter criteria when accessing the library from a service line.

**Fee Schedules**

If you maintain fee schedules for each of your payers, be sure to use the ‘Payer’ column to select the payer the code/fee applies to. The screen shot below shows the same code with different Charge amounts each assigned to a different payer. When looking up a code on a claim, the program will only show codes that match the claim’s payer.

**Not Otherwise Classified (NOC) Codes**

**Definition:** An NOC code is a procedure code that is defined as ‘Not Otherwise Classified’ and requires a description of the procedure code. Consult your coding references to determine the procedure code classification and description that may be required.

If your office uses NOC codes and bills electronically using the ANSI 837 format, you must configure the procedure code library properly:

1. Add the Category column into the Procedure Code library using “Column Chooser” on page 15.
2. Enter the word NOC into the Category field
3. Enter the NOC description into the procedure Description field.

This will enable the program to automatically export the description into the SV101-7 field in the ANSI 837 file.

If you need to use different descriptions for different products, use the Product Codes feature. More information can be found in “Product Codes” on page 162

NOC codes and descriptions can be payer specific by selecting a payer in the procedure code library entry. A payer is not required for the NOC code feature to work properly.

**Revenue Code Entries**

If you need to use the procedure code library for entries that use the revenue code column only, you will need to enter the word BLANK into the procedure code field since a procedure code is required. For the program to use the correct charge when doing a code lookup, you may need to utilize the product code.

**ANSI 837 Information**

When creating the SV1 segment, the program will use the procedure code library to find the NOC description based on the NOC code and payer (if needed) and place it into Loop 2400 Segment SV1 Field 01 Subfield 7.
Submitter/Receiver Library

The ‘Submitter/Receiver Library’ allows for entering Payer required information when submitting claims electronically. This information will be sent with your electronic claim file. Contact your Payer or Clearinghouse for Submitter/Receiver information.

Library Entry Name – Required and will be displayed for selection when sending claims.

Export Format – Select which electronic format to be used for the selected Payer

Version – Select Format version.

Claim Type – Chargeable or for Reporting only.

Submitter Information –

- Enter Type (Person or Non-Person)
- Business Name or Last and First Name (If Type 2 was selected, First Name field will be grayed out.)
- Submitter ID provided by Payer or Clearinghouse
- Contact Name, Type and Phone Number, Email or Other. Note: Some Payers require the Contact Name and Telephone number to be different than that found in the Billing Provider information on the claim.

Receiver Information – Enter Receiver Name and Receiver ID number provided by your Payer or Clearinghouse.

Header Information – Not all fields are required, contact your Payer for required information.

Select Test or Production to indicate if the electronic file is to be sent as Test or Production claims.

Strip extra characters from ID fields. Usually selected.

Zip export file. – Check only if required by your Payer. Usually left unchecked.
Widgets are available on the home screen to show snapshots of information. Any lookup Grid or Column heading can be turned into a widget. Widgets are stored with the company data and are available to all users of the company file.

The Show column determines if the widget will be visible on the home screen when using the ‘Tile View’ option. See “Widgets” on page 201 for more information on creating and using widgets.

Creating Widgets

See “Widgets” on page 201 for instructions on creating widgets.

Editing Widgets

Click the Edit button to edit an existing widget.

Widget Name – The names that are displayed in the available widget list.

Description – A description of the widget.

# of Rows – Limits the number of rows shown in the widget.

Click Action – When you double click an item in the widget list, what the action is: Show Claim, Show Patient, or Show Payment.

Layout – This is where you modify the visible columns and filter settings. This example filters the list to only show claims that are ready to submit.
Work Lists

Widgets are a great tool for creating work lists that help users manage claim follow-up.
Add-On Services

Home tab > Libraries

Accessing this library requires ‘ADMIN’ or ‘Full access’ level permissions. See “Manage Security Settings” on page 205 for more information.

If you do not have permissions to access the Add-On Services library, you will be required to enter the Admin password or have someone that has Full Access permissions log into the program and configure the settings for you.

Note: Contact EZClaim for Add-On-Services pricing and Activation.

Coding Advisor & Claim Scrubbing

The coding advisor and claim scrubbing add on will provides access to the complete Medical Code Solutions system. The system will scrub both Professional and Institutional claims.

Coding Advisor & Claim Scrubbing

Provided by Medical Coding Solutions.

Coding Advisor is much more than a code look-up tool. It’s a complete coding toolbox, enabling coders to work faster and smarter. Coding Advisor helps reduce denials by providing instant feedback throughout the entire coding process.

Claim Scrubbing find mistakes before the claim is saved. Check your claim codes in real time including CCI edits.

Click for more information

Activation Code:  
Username:  
Password:  
Change Password

- Scrub claim before every save
- If the claim being scrubbed has a diagnosis code that no service lines point to, consider the scrub a failure

Activation Code: Code provided by EZClaim
Username: Username provided by EZClaim.

Password: Password provided by EZClaim.

Scrub claim before every save: Checking this box will automatically scrub the claim every time a change is made and the claim is saved.

If the claim being scrubbed…: Check this box to make sure every diagnosis code on the claim has at least one pointer in the service lines.

**Searching for Codes**

To open the search window when doing data entry, hold the Ctrl key while double clicking the field. This will work on Diagnosis, Procedure Code, and Place of Service fields.

**Adding a Code to a Premier Library**

Hover over the code to add and click the Export Code button. If the Export Code button does not appear, that means the web site was not opened by Ctrl + Double Clicking on a valid field.

![Image of code selection](image)

**Coding Advisor Web Site**

When this Add-On is activated, a new button will appear on the Home screen.

Use this button to open the coding advisor web site where you can search the following code sets:

- LCD
- NCD
- CPT
- DSM IV
- HCPCS
- ICD-10
- ICD-10 Index
- ICD-10 PCS
- ICD-9
- ICD-9 Index
- ICD9-Vol 3
- Modifier
- Place of Service
Claim Status by Capario

Easily check the Capario claim status right from the Claim Screen. Contact EZClaim for ‘Claim Status’ setup.

Activation Code: Code provided by EZClaim

Client ID: The 8 digit client ID provided by Capario.

Username: Capario online portal username.

Password: Capario online portal password.

Electronic Statements by BillFlash

Upload statements from EZClaim and let BillFlash mail them to your customers.

Let patients pay online with eBill and ePay. Call BillFlash for more information.

Enroll online at [http://www.billflash.com](http://www.billflash.com) Reseller ID: 80488 or call 435-940-9123.

Activation Code: Code provided by EZClaim

Username: BillFlash username.

Password: BillFlash password.
Statement Color: Select the statement color. Contact BillFlash for information on statement options.

Cards Accepted: Select the credit cards accepted. Contact BillFlash for information on statement options.

**View Last Statement**

When the BillFlash add-on is activated, you can use the ‘View Last Statement’ button on the patient screen to open the web browser, automatically log into the BillFlash site, and view the last statement.

There is also a column that can be added to the Statements grid to view the last statement. The custom column is called ‘Last Statement’

**Electronic Statements by TriZetto**

As an alternative to printing statements, upload statements from EZClaim and let TriZetto send them to your customers.

**Activation Code:** Code provided by EZClaim

**Username:** TriZetto statement username. This is the same username used when logging into the TriZetto web portal.

**Password:** TriZetto statement password. This is the same password used with your Secure FTP account.

**Statement Color:** Select the statement color. Contact TriZetto for information on statement options.

**Cards Accepted:** Select the credit cards accepted. Contact TriZetto for information on statement options.

**Institutional Claims Add-On**

Print institutional claims and export using the ANSI 837 Institutional format with the Institutional Claim Add-On.
Activation Code: Code provided by EZClaim

When enabled, the ‘Institutional Claims’ add-on enables various features throughout the program.

EZClaim determines the type of claim (professional or institutional) based on the ‘Bill To’ payer.

See “Institutional Claims” on page 207 for more information.
Eligibility

The program has the ability to check patient eligibility through TriZetto, Capario, ZirMed, and others using the ANSI 270 format. Once setup, eligibility can be checked on the patient screen on the Insurance information tab.

Eligibility Setup

Eligibility is configured in the Program Setup screen. See “Patient Eligibility” on page 199 for more information.

Checking Eligibility

Click the ‘Check’ button to start the process. The program will connect with the clearinghouse and send the required data.
A typical response will look like this.

![Eligibility Response Form]

After clicking OK, the program will show in green they are active and the date the eligibility was checked.

Eligibility: Active 05/21/13  

Other possibilities are.

Eligibility: See Details  

Eligibility: Inactive  

Click the VIEW button at any time to view the existing eligibility results.

**Customizing the Results View**

If you primarily use the eligibility to view the co-pay amounts, you can filter the grid to only show the data you are interested in seeing. In this example, we've filtered the grid to show 'Professional (Physician) Visit' and 'Co-Payment' information. This reduces the amount of time it takes to find the relevant information.
Troubleshooting Eligibility

If you receive responses that include the words ‘Authorization/Access Restrictions’ or ‘Provider Ineligible for Inquiries’, that typically means the correct provider NPI number is not being used. See “Clearinghouse Reference” on page 218 for information on specific clearinghouses.
Finding Data

Most data can be found using the ‘Patient’ and ‘Claim’ search panes on the main screen. For access to additional search criteria, click on the ‘Find’ button from the Home Ribbon Bar and select the item to search.

Important: When viewing a ‘Find’ screen, Rt. Click on any column heading and select ‘Column Chooser’ to add additional search columns. See “Column Chooser” on page 15.

Find Patient

The ‘Find Patient’ window shows both active AND inactive patients.

Note: Use the ‘Column Chooser’ to select additional column headings.

1. Click on the ‘Find’ drop-down arrow and select ‘Find Patient’.
2. Enter patient name or other data in Filter box and patient data will be displayed.
3. Click ‘Open’ or double click which will open the patient information.
4. All Templates and Patients, active and inactive, will be available in the ‘Find Patient’ list.
Other Actions

Right clicking item(s) in the list will pop up a menu allowing you to create tasks.

![Create Tasks](image)

Find Claim

1. Click on the ‘Find’ drop-down arrow and select ‘Find Claim’.
2. Enter data into the filter row to filter the claim list.
3. Click on ‘Open’ or double click which will open the claim information.

Other Actions

Right clicking item(s) in the list will pop up a menu allowing you to select one of the following actions:

- Select All – Select all the items currently showing in the grid.
- Zero Selected Claim(s) – Will add an adjustment to each non-zero balance service line on the claim effectively zeroing out the claim balance.

- Create Tasks Linked to Claims – A task will be created for each selected claim.

Claim ID

To find a claim by Claim ID, enter the claim number in the filter box under ‘Claim ID’ to sort.

Find Service Line

1. Click on the ‘Find’ drop-down arrow and select ‘Find Service’.

2. Enter patient name or other data in filter box and patient data will be displayed. Click on any column heading to sort data.

3. Click on ‘Open’ or double click to open the service line information.

Other Actions

Right clicking item(s) in the list will pop up a menu allowing you to select one of the following actions:
- Zero Selected Service Lines(s) – Will add an adjustment to each non-zero balance service line effectively zeroing out the claim balance.

- Set Responsible Party – This allows you to change the responsible party on the service line.

**Find Payment**

1. Click on the ‘Find’ drop-down arrow and select ‘Find Payments’ to quickly find Payment information.

2. Use Filter boxes for sorting payments or click on any column heading to sort by selected column.

3. Click on ‘Open’ or double click to open the Payment information in the Payment Modification screen.

**Other Actions**

Right clicking item(s) in the list will pop up a menu allowing you to select one of the following actions:

- Change Payer Name – Allows you to change the name of the payer associated with the payment.

- Disburse Payment – This item is only enabled if the payment has not been fully disbursed. This will open Payment Entry window with the payment selected allowing you to disburse the remaining balance.
Find Task

1. Click on the 'Find' drop-down arrow and select 'Find Task'.
2. Enter patient name or other data in Filter box or click on any column heading to sort data. Task data will be displayed.
3. Click on ‘Open’ or double click to open the Task.

Find Adjustment

1. Click on the ‘Find’ drop-down arrow and select ‘Find Adjustment’.
2. Enter patient name or other data in Filter box or click on any column heading to sort data. Adjustment data will be displayed.
3. Click on ‘Open’ or double click to open the Adjustment information on a service line.

Other Actions

Right clicking item(s) in the list will pop up a menu allowing you to select one of the following actions:

- Select All – Select all the items currently showing in the grid.
- Zero Linked Service Lines(s) – Will add an adjustment to each non-zero balance service line effectively zeroing out the claim balance.

- Create Tasks Linked to Associated Claims – A task will be created for each claim that is associated to the adjustment.

- Delete Adjustments – Deletes the selected adjustments.

**Find Payer**

1. Click on the ‘Find’ drop-down arrow and select ‘Payer’ to quickly find payer information previously set up in the Payer Library.

2. Use Filter boxes for sorting payers or click on any column heading to sort by selected column.

3. Click on ‘Open’ or double click to open Payer information in the Payer Library.

**Other Actions**

Right clicking item(s) in the list will pop up a menu allowing you to select one of the following actions:
Create Tasks Linked to Payers – A task will be created for each payer selected.

Find Physician

1. Click on the ‘Find’ drop-down arrow and select ‘Physician’ to quickly find physician information previously set up in the ‘Physician/Facility Library’.

2. Use Filter boxes for sorting billing provider data or click on any column heading to sort by selected column.

3. Click on ‘Open’ or double click to open Physician information in the ‘Physician/Facility Library’.

Find Disbursement

1. Click on the ‘Find’ drop-down arrow and select ‘Disbursements’ to quickly find physician information previously set up in the ‘Physician/Facility Library’.

2. Use Filter boxes for sorting disbursement data or click on any column heading to sort by selected column.

3. Click on ‘Open’ or double click to open claim screen showing disbursements.
Import Appointments

Note: This section only applies if you are using EZClaim Premier’s Scheduling software.

The billing program will import appointments whose status is billable. Users can configure whether an appointment status is billable or not in the scheduling program setup.

Import Appointment Screen:

Importing a Batch of Appointments

1. Click the ‘Check All’ button or select the appointments to import.
2. Click the ‘Import Appointments’ button. You will receive a confirmation message that the appointments were imported.

Import and Edit a Single Appointment

If you would like to import the appointment and edit the claim immediately, use the ‘Import & Open’ button available on each appointment row. This will create the claim based on the appointment data and open the claim for editing.

Claim Templates

The claim will be create using the template shown in the ‘Template’ column. You can change this template before importing if needed.
Rendering Provider

The claim will be populated with the rendering provider shown on the grid. If you do not see the rendering provider column, restore the grid or add the column using the column chooser.

The rendering provider is set to the provider associated with the appointment resource or the claim template used. Scheduler resources and their associated rendering providers are configured in the scheduler setup.

If the Claim Template used to create the claim is changed on the import grid and the appointment rendering provider is blank, the rendering provider will be updated. If the rendering provider is already present, changing the claim template will not change the rendering provider.

Institutional Note: If the primary claim is an institutional claim, the program will look for an attending provider in the physician library that matching the rendering NPI. If found, the program will populate both the attending provider and the rendering provider. There is logic within the program that will prevent the rendering from being exported or printed if it is the same as the attending.

Appointments Not Listed

If an appointment is not showing in the list and the appointment status is 'billable', the most likely cause is the appointment has already been transferred. To determine if this is true, add the ‘Claim ID’ custom column to the appointment detail screen in the scheduler. You can then look up the claim in the billing system using the Find Claim window.

If the claim ID is 0, then the appointment has not been transferred. If the ID is -1, then the appt has been marked to not transfer.

Import Appointments into Existing Claims…

If this box is checked, the program will add the appointment service lines into an existing claim if the following conditions are met:

- The claim and appointment must have the same patient.
- The claim has not been printed or exported.
- The claim status is not “Submitted”.
- The claim must have the “Bill To” set to “Primary”.
- The claim and patient must have the same primary payer. This will catch situations where the patient has switched insurances since the last appointment.
• The claim and patient must have the same primary insured’s id #. This will catch situations where the patient has switched insurance plans since the last appointment.

• The claim and patient must have the same primary group #. This will catch situations where the patient has switched insurance plans since the last appointment.

• The claim’s primary authorization # must match the appointment’s authorization #.

• For professional claims, the claim must have the same rendering physician that is selected in the "Import Appointments" grid.

• For institutional claims, the claim must have the same attending provider that would be used on the claim. See “Rendering Provider” on page 183 for more information on attending provider selection.

Filters

If an appointment should not be imported for some reason and it continues to be shown on the list, check the box next to appointment and click the ‘Hide Checked Appointments’ button. If you need to import the appointment in the future, check the ‘Show Hidden Appointments’ check box.
Importing Data (via Interfaces)

Importing data is done through the Interface system. There are a variety of formats that EZClaim can accept. See “Available Interfaces” on page 147 for more information and specifications.

Interface Setup

Setting up the program to import data is done through the Interfaces Library. See ‘Interface Library’ on page 147 for more information and specifications. Please contact EZClaim for the latest information on Interface capabilities.

Review Incoming Files

Once the interface has been activated, the program will check for incoming data as needed. On the ribbon bar, there is a ‘Review Incoming’ item that you can use to review incoming data. When data is ready for review, the icon will change to show how many files are ready for processing.

Clicking the Review Incoming will open the Interface Data Review screen.

To force the program to check for new data files, click the ‘Check for New Data’ button.
Processing a File

Double click a file shown in the list to open the data review screen.

To view additional details of the incoming data, click any of the 'View Details' buttons.

Import Batch

If the summary information looks correct, click the 'Import Batch' button. The data will be imported, a confirmation window will be shown, and a log entry will be shown in the lower half of the screen.

Save for Later

If you would like to import the batch at a later time, click the 'Save for Later' button and the program will leave the file in the list.

Delete Batch

If the batch contains data you do not want to import, click the 'Delete Batch' button. The file will be removed from the list.

Exporting Patient Data (via Interfaces)

EZClaim can export patient data using HL7 2.3.1 ADT-A04 and ADT-A08 file formats. See "HL7 2.3.1 Export" on page 150 for more information on setting up the export system.

EZClaim data can also be exported using any of the available grids. See “Exporting Grids” on page 18 for more information.
Practice Fusion

Steps to Import a Superbill into Premier

1. **Practice Fusion user sets the super bill to ‘Ready for Biller’** – This sends the superbill to a holding area waiting to be picked up by Premier. The superbill history will say ‘Sent successfully’

2. **When Premier is opened and checks for new data, the waiting superbill will be placed into Premier’s interface system waiting for review and import.** The superbill history in Practice Fusion will say ‘Processing’

3. **When the super bill is reviewed and a claim is created, the superbill history in Practice Fusion will say ‘Info S01 The superbill was processed successfully.’**

**Duplicate Superbills**

If a claim has already been created with a superbill and the Practice Fusion user sets the same superbill as ‘Ready for Biller’, EZClaim will return the superbill to Practice Fusion and make a note in the interface log, no file will be available for review.

If a superbill is waiting in the Premier interface system (the superbill is in the ‘Review Incoming’ section but the claim is not yet created) and the Practice Fusion user sets the same superbill as ‘Ready for Biller’ again, the program will show two superbills waiting to be processed. The first one will process as normal, the second will show that there is already an existing claims. The claim will not be updated.

If the superbill is in between systems, meaning it has left Practice Fusion but has not yet been brought into Premier’s review system yet, the superbill will be replaced.

**Check Minutes**

When configuring the Practice Fusion interface, the ‘Check Minutes’ is set to 10 minutes. This causes Premier to check for new superbills and download them every 10 minutes. If the provider often makes changes to superbills after they have been marked as ‘Ready for Biller’, it may be beneficial to set the check minutes to 60 or higher. This gives the provider an opportunity to fix superbill before the biller has created a claim.

**Patient Payments**

Patient payments are transferred as undisbursed payments. Practice Fusion does not have the ability to ‘attach’ payments to service lines, therefore, EZClaim is unable to disburse the payment automatically.

**ICD Codes**

Practice Fusion sends both ICD-9 and ICD-10 codes to EZClaim. The ‘Initial ICD Indicator’ in Program Setup determines which diagnosis codes will be applied to the imported claim.
Insured Information

Practice Fusion provides different areas to record subscriber (insured) information. The subscriber is the person that has the insurance coverage.

When importing Practice Fusion data and populating Premier’s insured (subscriber) name and address information, the program will look at various sections of the incoming Practice Fusion data. There are three areas Premier will look: Subscriber Information, Guarantor Information, and Patient Information.

1. If the Subscriber information is available in Practice Fusion, Premier will use it to populate the Insured information.

2. If the Subscriber information is not available and the ‘Relationship to Insured’ IS NOT ‘Self’, then Premier will use the Guarantor to populate the Insured information.

3. If neither of the first two scenarios apply, Premier’s patient information is used to populate the Insured information.

Note: If that patient is new or ‘Update Patient Demographics’ interface option is checked, the patient demographics will reflect what’s in Practice Fusion. If the patient already exists, has been edited in Premier, and the ‘Update Patient Demographics’ interface option is unchecked, the patient information in Premier may not match what is in Practice Fusion.

Disconnecting Practice Fusion and Premier

To disable the connection between Practice Fusion and Premier, contact Practice Fusion. EZClaim does not have the ability to modify the practice settings.

WebPT

Getting Started

Before using the WebPT (HL7 2.3.1) interface within EZClaim Premier, you must contact WebPT and have the EZClaim interface activated. This will enable the HL7 files for EZClaim to import.

WebPT will provide you with the following information for the SFTP (Secure File Transfer) connection:

WebPT SFTP User Login: __________________

WebPT SFTP User Password: ________________

EZClaim will provide you with the HL7 2.3.1 Import Activation Code: __________

Premier Program Setup

1. Setup the SFTP EDI Connection Entry
1. Open the Libraries > EDI Connection window

![EDI Connection window](image)

b. Click ‘Add New Entry…’

![Add new entry](image)

c. Fill in the following details using the login and password provided by WebPT:

```
Name: WebPT
Type: Secure File Transfer

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>User Login</td>
<td>username</td>
</tr>
<tr>
<td>User Password</td>
<td>**********************</td>
</tr>
<tr>
<td>Host Name</td>
<td>partner.webpt.com</td>
</tr>
<tr>
<td>Port</td>
<td>22</td>
</tr>
<tr>
<td>Upload Directory</td>
<td></td>
</tr>
<tr>
<td>Download Directory</td>
<td></td>
</tr>
<tr>
<td>Download File Pattern (Optional)</td>
<td>HL7</td>
</tr>
<tr>
<td>Automatically Name and Save Upload</td>
<td>False</td>
</tr>
<tr>
<td>Allow SFTP Site to Move or Delete File</td>
<td>False</td>
</tr>
</tbody>
</table>
```

d. Click Save and Close.

2. Activate the HL7 Import Interface. NOTE: This process requires the ADMIN password.

a. Open the Libraries > Interface

![Interface section](image)
b. Select the HL7 2.3.1 Import item

c. Enter your Activation Code

d. Select 'Check SFTP'

e. Select 'WebPT' from the drop down list.

This completes the Program Setup procedure.

**Importing WebPT Data**

1. Click the Review Incoming button on the ribbon bar

2. Click the 'Check for New Data' button to download any waiting files

3. Review “Importing Data (via Interfaces)” on page 185 for more information on processing files and importing the claims.

**HL7 2.3.1**

Premier will import ADT^A08 and DFT^P03 message types.

**HL7 Duplicate Checking**

When HL7 based interface data is processed, the program checks to see if the services being described already exist in the company file. If a service appears to already exist, the program will not import a duplicate. Incoming service lines will be considered a duplicate an existing service line matches the following values:

- The patient
- The procedure code
- The product code
- The Service ‘From’ date
- All modifiers
- The rendering provider
- The referring provider

**Technical Details**

**Patient Matching**

Patients are matched based on first name, last name and DOB (middle name is not included in matching). If a patient is manually matched, the incoming patient ID number is matched to Premier’s internal patient ID and stored for future imports so a manual match does not need to take place on subsequent imports.

**Updating Patient Demographics**

Some interfaces have the ability to update the patient demographics. If available, a check box can be used to enable or disable the feature.

- Will not update the patient name (first, last) or DOB. Middle name can be updated.
- Will not update ‘Locked’ patients.
- Rules on updating patient insured records
  - If the incoming data does not have insured information, the existing data is not deleted.
  - If the incoming sequence (primary, secondary, etc.), payer name, insured ID, and group # matches an existing insured record, the program will update the existing insured record. *Technical Note: If the payer library contains duplicate payer names, it’s possible a match will not take place since the library payer found may not match the payer selected on the insured record.*
  - If the incoming payer name, insured ID, or group # do not match, the insured record is deleted and a new one is created. If the system is setup to use an automatic patient template, the insured record will be initialized with the template data first. For information on Automatic Patient Template, see “Patient” on page 194.
  - If an incoming data field is blank, the data is not removed from the insured record. *Technical Note: External software may not maintain every field required for a complete insured record. Once the partial data has been imported and the biller has manually filled in the missing data, the next import will not remove the data the biller had to fill in manually.*
  - If the incoming insured data is primary only and the existing insured data is primary and secondary, only the primary will be updated or replaced. The secondary will not be touched.
  - If the existing patient has both primary and secondary insureds and the incoming data only contains primary, the patient’s secondary insured will remain.
Physician/Facility Library Matching

The program will attempt to match to an existing ‘Physician Library’ entry by the incoming First name, Last name, NPI, and Type. If no match is found, a new Physician Library entry will be created. When matching a Facility, the first name field is not used. Some interfaces have slightly different logic. Please contact EZClaim for more information.

Creating Claims

When importing claim data, the program will set the claim status to the ‘Initial Claim Status’ setting found in the program setup. See “Claim” on page 196 for more information on initial claim values.

Service Lines

The place of service will be set to the ‘Initial Place of Service’ setting found in the program setup. If the incoming units field is 0, it will be imported as 1.

Procedure Code Lookup

If the incoming service line data does not contain a charge amount (either it is blank or $0.00), the program will perform a procedure code lookup and set the appropriate fields if they are blank (including the NDC code, co-pay amount due, etc.). This means incoming data takes precedent over a procedure code lookup. The fields that are populated from the lookup are the same as manually entering a claim and using the procedure code library.
Program Setup

Accessing the full program setup screen requires ADMIN level permissions. See “Manage Security Settings” on page 205 for more information. The program will ask for the ADMIN password if you are not logged into the system. If you do not provide the ADMIN password, only user level settings can be changed, all others will be disabled.

To access user settings only, click the User Settings button. The admin password is not required.

To access ALL settings, enter the admin password and click the All Settings button. The All Settings button will only enable once a password is entered.

Many different user settings can be customized in the program setup. Click an item in the Options list to view the different settings.

Main Screen

**Theme** – Change the colors and look of the program.

**Search Pane Location** – Move the search pane to the right or left side of the screen.

**Widget Layout** – Change the widget layout from Tile view to Classic

**Alternate Grid Row Colors** – Check this box if you like alternating rows to be different colors in the grids. The colors are dependent on the theme and cannot be changed.
Patient

<table>
<thead>
<tr>
<th>Options</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Screen</td>
<td>Automatic Account Numbers:</td>
</tr>
<tr>
<td></td>
<td>Next Account Number: 1010</td>
</tr>
<tr>
<td></td>
<td>Require Account Numbers:</td>
</tr>
<tr>
<td></td>
<td>Require Account Numbers Entered to be Unique</td>
</tr>
<tr>
<td></td>
<td>Automatic Patient Template: None</td>
</tr>
<tr>
<td></td>
<td>Show Subscriber SSN:</td>
</tr>
</tbody>
</table>

**Automatic Account Number** – Check this box to have the program automatically assign account numbers. Default is checked.

**Next Account Number** – Enter the next account number for the program to use. This setting is ignored if Automatic Account Number is unchecked. Default is 1000.

**Require Account Numbers** – Check this box to require the every patient record to have an account number entered. If you check this box and save, the program will check all the existing patient records. If any patient record does not contain an account number, the following message will appear:

Click OK to see a list of patients that need account numbers. Double click the patient name to open the patient and enter an account number. Once all the patients have account numbers, you will be able to save the Program Setup screen.

**Require Account Numbers Entered to be Unique** – If this box is checked, the program will make sure every patient record has a unique account number. If the patient account numbers are not unique, the following message will appear:

Click OK to see a list of patients with the same account number. Double click the patient name to open the patient and enter a unique account number. Once all the patients have unique account numbers, you will be able to save the Program Setup screen.

**Automatic Patient Template** – Select a patient template to be used when creating a new patient (also used when importing patients via an Interface). Default is None.

**Show Subscriber SSN** – Check this box to enable the Subscriber SSN field on the insurance tabs on the patient screen. Default is unchecked.
Patient Custom Fields

Of particular importance are the custom data fields. Users can choose the label and what type of data will be stored on the Patient screens.

Custom Field Types

TEXT – Will accept any type of text. The text will not be formatted by the program.

TEXT-LIST - - Shows a list box of previous entries. Will accept any type of text.

CURRENCY - $10.00 - Will accept currency characters (numbers, negative, etc). The entry will be formatted by the program.

DATE – Will provide a date selector drop down.

TIME - 8:30 AM - Will accept characters (numbers, colon, etc).

NUMBER - - Will only accept numbers and the period symbol.

YESNO - - Will show a check box. The check box has three values. Checked ✓, Unchecked □, and Blank □.
Claim

**Initial Claim Status** – When creating new claims, this status will be used.

**Initial Place of Service** – When adding new service lines, this place of service will be used.

**Initial ICD Indicator** – When creating new claims, the indicator value will be set accordingly. 9 = ICD-9 and 0 = ICD-10

**Automatic Lock Claims After Print or Export** – If checked, the program will check the 'Locked' check box on the claim which prevents changes to the claim. See “Locked (Claim)” on page 59 for more information.

**Check for duplicate service lines** – If checked, the program will check for duplicate service lines on the patient claims. The fields compared are service date, procedure code, product code, modifiers, and diagnosis pointer.

**Validate ICD Logic when saving a claim** – If checked, the program will check that the claim follows the following ICD rules:

- You cannot combine DOS before and after Oct 1st 2015
- ICD Indicator is a required field
- If any DOS is before 10/1/15, the indicator cannot be 0
- If any DOS is on or after Oct 1, 2015, the indicator cannot be 9
- If indicator is 0 then all diagnosis should start with a letter
- If indicator is 9 then all diagnosis should start with a number except for E or V

**Claim Custom Fields**

Custom fields are available for claims and service lines. Change the caption and data type as needed.

There are 5 custom fields available on the claim and 5 custom fields for each service line.
# Custom Field Types

**TEXT** - Will accept any type of text. The text will not be formatted by the program.

**TEXT-LIST** - Shows a list box of previous entries. Will accept any type of text.

**CURRENCY** - Will accept currency characters (numbers, negative, etc). The entry will be formatted by the program.

**DATE** - Will provide a date selector drop down.

**TIME** - Will accept characters (numbers, colon, etc).

**NUMBER** - Will only accept numbers and the period symbol.

**YESNO** - Will show a check box. The check box has three values. Checked ✅, Unchecked ☐, and Blank ☐.
Printing Claims

See “Printer Adjustment” on page 67 for more information.

Payment

Check for Duplicate Payments – When checked, the program will check for a existing payment that has the same dollar amount and reference number. If a match is found, an information message will appear with the matching payment information to determine if it really is a duplicate. This option is checked by default.

Receipt Report

The receipt report option lets you select a report to be used when printing a receipt from the Payment Entry Screen. The ‘Patient Receipt’ report must be downloaded before it will be available as a selection. See “Patient Receipt” on page 131 for instructions on downloading the patient receipt report.

Document Linking

See “Document Linking” on page 137 for detailed information.

Company
Company Description – Used in some reports in the header area.

Allow feature usage reporting – When checked, the program will send anonymous usage data to EZClaim which helps us make the program better!

Patient Eligibility

<table>
<thead>
<tr>
<th>Options</th>
<th>Patient Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Screen</td>
<td>Source</td>
</tr>
<tr>
<td>Patient</td>
<td>None</td>
</tr>
<tr>
<td>Patient Custom Fields</td>
<td>Receiver</td>
</tr>
<tr>
<td>Claim</td>
<td>None</td>
</tr>
<tr>
<td>Claim Custom Fields</td>
<td>Provider</td>
</tr>
<tr>
<td>Printing Claims</td>
<td>Patient Billing Provider</td>
</tr>
<tr>
<td>Printing Institutional Claims</td>
<td>Username</td>
</tr>
<tr>
<td>Payment</td>
<td>Password</td>
</tr>
<tr>
<td>Document Linking</td>
<td>Server</td>
</tr>
<tr>
<td>Company</td>
<td></td>
</tr>
<tr>
<td>Patient Eligibility</td>
<td></td>
</tr>
</tbody>
</table>

Source – Lists the available companies that are compatible with EZClaim’s eligibility checking system. The following entries are available: Capario, TriZetto, ZirMed, and Practice Insight.

Receiver – The Submitter/Receiver library entry to use when checking eligibility. This drop down will only show Submitter/Receiver entries that use the ‘Eligibility Inquiry 270’ format. If one has not been created, use the … button to create one. The following links provide receiver library setup information

- Capario – See “ANSI 270 (Eligibility) Submitter/Receiver Library Entry” on page 218
- TriZetto – See “ANSI 270 (Eligibility) Submitter/Receiver Library Entry” on page 220
- ZirMed – See “ANSI 270 (Eligibility) Submitter/Receiver Library Entry” on page 221
- Navicure – See “ANSI 270 (Eligibility) Submitter/Receiver Library Entry” on page 225

Provider – This field may need to be set to a specific provider if the patient billing provider is not registered with the clearinghouse. We suggest leaving the field set to Patient Billing Provider unless instructed to change it. If you receive responses that include the words ‘Authorization/Access Restrictions’ or ‘Provider Ineligible for Inquiries’, that typically means the correct provider NPI number is not being used.

The choices are:

- Patient Billing Provider – The billing provider entered on the patient record
- Patient Rendering Provider – The rendering provider entered on the patient record
- An existing billing or rendering provider in the Physician library.

Note: If a payer use a different registered provider, you can select a specific provider for a specific payer in the payer library.

Username – Only required by certain Sources. The field will be enabled if required.

Password – Only required by certain Sources. The field will be enabled if required.
**Server** – Only required by certain Sources. The field will be enabled if required.
Widgets

Widgets allow you to customize the information shown on the home screen. You can create an unlimited number of widgets and show them on the home screen. Widgets are a great tool to manage your claims and find information at a glance.

Tile View

Tile View is the initial view when you install the program. This view offers the most information in an easy to understand layout. The tiles on the left can be re-ordered by dragging and dropping the tiles up or down. Each tile shows the name of the widget and the number of records within each widget.

Widgets are not automatically refreshed due to the potential workload they could produce. To refresh the widget data, click the refresh button below the tiles. There is also an indicator showing when the tiles were last refreshed.

Classic View

This view only allows 2 widgets to be available at a time and is not as flexible as the Tile View.

Creating Widgets

Widgets can be created from most any grid.

1. Filter a grid to show required data.
2. Right click the grid column headings and select ‘Add as Widget’
3. Edit the Widget properties as needed. See “Widget Library” on page 165 for more information.
Creating your first widget:

1. Click the Claims tab in the Quick Access area.

2. Click the filter icon to select claims with a status of ‘Ready to Submit’

3. Put a check on the ‘Ready to Submit’ item and click OK. This will filter the claim list and only show claims ready to submit.

4. Right click the column heading and select ‘Add as Widget’. This will open the Edit Widget window.

5. Enter ‘Claims Ready to Submit’ in the name field and set the click action to ‘Show Claim’ then click the OK button.

6. On the home screen, the widget will appear as a new tile.
Displaying or Removing Widgets

Home Screen

Widgets are automatically shown as a tile on the home screen. Tiles can be removed from the home screen by changing the ‘Show’ check box in the Widget Library.

<table>
<thead>
<tr>
<th>Show</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑</td>
<td>Claims Over 120 Days (Max 50)</td>
</tr>
<tr>
<td></td>
<td>Claims Over 90 Days (Max 50)</td>
</tr>
<tr>
<td>☑</td>
<td>Claims with a Credit Balance (Max 50)</td>
</tr>
<tr>
<td>☑</td>
<td>Payments with Balance Remaining (Max 50)</td>
</tr>
<tr>
<td>☑</td>
<td>Undisbursed Payments (Max 50)</td>
</tr>
</tbody>
</table>

Updating Widget Data

Widget data is updated when you click the ‘Refresh’ button on the Home screen below the tiles.

Widget Descriptions

Claims Over 120 Days

<table>
<thead>
<tr>
<th>Claims Over 120 Days (Max 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
</tbody>
</table>

Lists claims that have a balance and are over 120 days old based on the Original Bill Date. A maximum of 50 claims will be listed.

Claims Over 90 Days

<table>
<thead>
<tr>
<th>Claims Over 90 Days (Max 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
</tbody>
</table>

Lists claims that have a balance and are over 90 days old based on the Original Bill Date. A maximum of 50 claims will be listed.

Claims with a Credit Balance

<table>
<thead>
<tr>
<th>Claims with a Credit Balance (Max 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
</tbody>
</table>

Lists claims that have a credit balance. A maximum of 50 claims will be listed.

Payments with Balance Remaining

<table>
<thead>
<tr>
<th>Payments with Balance Remaining (Max 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
</tbody>
</table>

Lists payments that have not been fully disbursed. For example, if you entered a $100 payment but only applied $90 to claims, the payment would be on this list. It’s used as a reminder to go back and finish disbursing a payment. A maximum of 50 payments will be listed.
Undisbursed Payments

Lists payments that have no disbursements. This list will typically contain payments imported from other systems or payments that were entered in the scheduler. It’s used as a reminder for payments that need to be applied to claims. A maximum of 50 payments will be listed.
Manage Security Settings

Admin User
There is a built-in ‘ADMIN’ user that is always available for login. The first time a user tries to access an admin restricted area, the program will ask to create the admin password. DO NOT LOSE THIS PASSWORD.

Security Modes
EZClaim Premier has two security modes:

Don’t Require User Authentication

This setting allows the program to be opened without entering a password. While in this mode, the user has access to all data and areas of the program except for ADMIN only areas. When logging activities such as editing a patient record or creating a claim, the program will mark the activity as done by USER. When trying to access an ADMIN area of the program, the ADMIN password will be required before access is granted.

Require User Authentication

This setting will require the user to enter a login and password before opening the program. Depending on the access levels granted, different areas of the program will be accessible.

If ‘Require User Authentication’ is active but no users have been created, you must use ADMIN as the username to login.

Adding Users
To track and limit access to the program create User names for each user.
Permissions

There are numerous permissions that can be assigned to a user. Review the on-screen descriptions for more information about each setting.

**Full access to all areas of the program** – This is a special permission that overrides all other permissions. A user with this permission would be the equivalent of the ADMIN user but not be able to change the ADMIN password or enable/disable user authentication.

**Add, edit, and delete payments and adjustments** – If unchecked, the user will not be able edit payments in the billing system. This permission does not affect the ability to enter a payment in the scheduling system. Once the payment has been disbursed, regardless of the permission setting, the payment cannot be changed in the appointment.
Institutional Claims

These features are only available if the 'Institutional Claims' Add-On is activated.

This section contains information specific to institutional claims.

See "Institutional Claims Add-On" on page 170 for more information on activating.

Payer Library

IMPORTANT:

You must setup your payer library before billing institutional claims. If you are registered with a payer as an institutional organization, select 'Institutional' as the Claim Type. This is how the program knows which claim form to print or to show claims for exporting.

Data Entry

Once the Add-On is enabled, additional custom columns are available on the claim screen. Add additional columns as needed to both the service line grid and the claim grid. For more information on customizing grids, see “Grids” on page 15.

Adding additional columns to the Service Line grid:
The service line grid is normally sorted by Srvc Date. For Institutional claims, the Revenue Code should be included in the sort. To change the grid sort, click the Revenue Code column header to sort, hold the shift key down, and then click the Srvc Date field to add it to the sort order. The column headings will show triangles to indicate they are both included in the sort.

Adding the Institutional Group to the Claim grid:

Adding additional columns to the Claim grid:

Submitter/Receiver Library

A new format is available in the Submitter/Receiver library. **IMPORTANT:** You must setup a library entry with the ANSI 837 Institutional Export Format to send claims in the 837I format.

The send claims screen will show professional or institutional claims depending on the Submitter/Receiver library selected.

Print Setup

A new Program Setup options section is available for institutional claims. Click Tools > Program Setup then select Printing Institutional Claims to manage the options.
Printing Claims

When opening the print claims window, a new filter option is available allowing you to print the institutional claim. The list will filter based on the type of claim.

UB-04 Boxes (Form Locator)

Many of the fields for the UB-04 form need to be added manually to the grids. See “Grids” on page 15 for information on adding additional columns.

<table>
<thead>
<tr>
<th>Field No.</th>
<th>Field Name</th>
<th>Screen &gt; Field</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name and Address</td>
<td>Claim &gt; Billing Provider</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Service Facility</td>
<td>Claim &gt; Service Facility</td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td>Pat. Cntl #</td>
<td>Claim &gt; Claim ID (or Invoice #)</td>
<td>Will use the Invoice # if available otherwise, the Claim ID.</td>
</tr>
<tr>
<td>3b</td>
<td>Med Rec #</td>
<td>Patient &gt; Account #</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>Claim &gt; Type of Bill</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period</td>
<td></td>
<td>Min and Max of date of services OR the values contained in the ‘Statement From Override’ and ‘Statement Through Override’ columns available as custom columns on the claim vGrid.</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td>Not Available</td>
</tr>
<tr>
<td>8a</td>
<td>Patient’s Member ID</td>
<td>Patient &gt; Member ID</td>
<td></td>
</tr>
<tr>
<td>Field No.</td>
<td>Field Name</td>
<td>Screen &gt; Field</td>
<td>Notes</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>8b</td>
<td>Patient Name</td>
<td>Patient &gt; Name</td>
<td>Patient Last First MI (no extra punctuation)</td>
</tr>
<tr>
<td>9a</td>
<td>Patient’s Address</td>
<td>Patient &gt; Address</td>
<td>Patient’s address (not insured’s)</td>
</tr>
<tr>
<td>9b</td>
<td>Patient’s City</td>
<td>Patient &gt; City</td>
<td></td>
</tr>
<tr>
<td>9c</td>
<td>Patient’s State</td>
<td>Patient &gt; State</td>
<td></td>
</tr>
<tr>
<td>9d</td>
<td>Patient’s Zip</td>
<td>Patient &gt; Zip</td>
<td></td>
</tr>
<tr>
<td>9e</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Date of Birth</td>
<td>Patient &gt; DOB</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Sex</td>
<td>Patient &gt; Sex</td>
<td>M, F, or U for Unknown</td>
</tr>
<tr>
<td>12</td>
<td>Admission Date</td>
<td>Claim &gt; Admitted Date</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Admission Hour</td>
<td>Claim &gt; Admission Hour</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Admission Type</td>
<td>Claim &gt; Admission Type</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Admission Source</td>
<td>Claim &gt; Admission Source</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour (DHR)</td>
<td>Claim &gt; Admission Source</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Patient Status (STAT)</td>
<td>Claim &gt; Patient Status</td>
<td></td>
</tr>
<tr>
<td>18-21</td>
<td>Condition Codes</td>
<td>Claim Condition Code 1-4</td>
<td>Only 4 codes available</td>
</tr>
<tr>
<td>22-28</td>
<td>Condition Codes</td>
<td>Claim &gt; Condition Code 5-8</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Acct State</td>
<td>Claim &gt; Auto Accident State</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31a thru 34a</td>
<td>Occurrence Code Occurrence Date</td>
<td>Claim &gt; Occurrence Code 1-4</td>
<td></td>
</tr>
<tr>
<td>31b thru 34b</td>
<td>Occurrence Code Occurrence Date</td>
<td>Claim &gt; Occurrence Code 5-8</td>
<td></td>
</tr>
<tr>
<td>35a</td>
<td>Occurrence Span Code</td>
<td>Claim &gt; Occurrence Span Code 1</td>
<td>Only 1 span available</td>
</tr>
<tr>
<td>35a</td>
<td>Occurrence Span From-Through</td>
<td>Claim &gt; Occurrence Span From 1</td>
<td>Only 1 span available</td>
</tr>
<tr>
<td>35a</td>
<td></td>
<td>Claim &gt; Occurrence Span To 1</td>
<td></td>
</tr>
<tr>
<td>35b and 36a-b</td>
<td>Occurrence Span Code Occurrence Span From Throu</td>
<td>Claim &gt; Occurrence Span Code 5-8</td>
<td>Not Available</td>
</tr>
<tr>
<td>38</td>
<td>Responsible Party Name and Address (Claim Addressee)</td>
<td>Claim &gt; Bill To</td>
<td>Print the Bill To name and address. If the Bill To is 'Patient' then the patient's address will print in this box.</td>
</tr>
<tr>
<td>39a-41a</td>
<td>Value Codes Amounts</td>
<td>Claim &gt; Value Code 1-3</td>
<td>Only 3 value codes/amounts available</td>
</tr>
<tr>
<td>39b-41d</td>
<td>Value Codes and Amounts</td>
<td>Claim &gt; Value Code Amount 1-3</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Revenue Code</td>
<td>Claim &gt; Revenue Code</td>
<td>Available on each service line. Will print blank if left blank.</td>
</tr>
<tr>
<td>43</td>
<td>Description</td>
<td>Claim &gt; Service Line Description</td>
<td>Prints the service line description. Will print blank if left blank. No lookup is performed.</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/RATE/HIPPS CODE</td>
<td>Claim &gt; Procedure</td>
<td>Will print procedure code with up to 4 modifiers. All separated by a space.</td>
</tr>
<tr>
<td>45</td>
<td>Service Date</td>
<td>Claim &gt; Srvc Date</td>
<td>Lines sorted by revenue code then DOS</td>
</tr>
<tr>
<td>46</td>
<td>Service Units</td>
<td>Claim &gt; Units</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Total Charges</td>
<td>Claim &gt; Charges</td>
<td></td>
</tr>
<tr>
<td>Field No.</td>
<td>Field Name</td>
<td>Screen &gt; Field</td>
<td>Notes</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------</td>
<td>----------------</td>
<td>-------</td>
</tr>
<tr>
<td>48</td>
<td>Non Covered Charges</td>
<td></td>
<td>Not Available</td>
</tr>
<tr>
<td>Line 23</td>
<td>Creation Date</td>
<td>Claim &gt; Original Bill Date</td>
<td></td>
</tr>
<tr>
<td>Line 23</td>
<td>Total Charges</td>
<td></td>
<td>Calculated by the program. Total of all Charges</td>
</tr>
<tr>
<td>Line 23</td>
<td>Total Non-Covered Charges</td>
<td></td>
<td>Non Available</td>
</tr>
<tr>
<td>49</td>
<td></td>
<td></td>
<td>Not Available</td>
</tr>
<tr>
<td>50 A,B,C</td>
<td>Payer Name</td>
<td>Claim &gt; Bill To</td>
<td>Up to 3 payers listed A – Primary, B – Secondary, C – Tertiary</td>
</tr>
<tr>
<td>51 A, B,C</td>
<td>Health Plan ID</td>
<td>Claim &gt; Bill To</td>
<td>The ‘Payer ID’ from the payer library A – Primary, B – Secondary, C – Tertiary</td>
</tr>
<tr>
<td>52</td>
<td>Release of Information</td>
<td>Patient &gt; Patient Signature on File</td>
<td>Will print ‘Y’ if the Patient Signature on File is checked. Otherwise blank.</td>
</tr>
<tr>
<td>53</td>
<td>Assignment of Benefits</td>
<td>Patient &gt; Insured Signature on File</td>
<td>Will print ‘Y’ if the Insured Signature on File is checked. Otherwise blank.</td>
</tr>
<tr>
<td>54 A,B,C</td>
<td>Prior Payments</td>
<td></td>
<td>Not Available</td>
</tr>
<tr>
<td>55 A,B,C</td>
<td>Est Amt Due from Payer</td>
<td></td>
<td>Not Available</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Claim &gt; Billing Provider</td>
<td>Provider NPI from the physician library</td>
</tr>
<tr>
<td>57</td>
<td>Other Provider ID</td>
<td>Claim &gt; Billing Provider</td>
<td>Provider additional ID number (specific to payer). No qualifier is printed.</td>
</tr>
<tr>
<td>58</td>
<td>Insured’s Name</td>
<td>Claim &gt; Bill To &gt; Name</td>
<td>Insured information</td>
</tr>
<tr>
<td>59</td>
<td>P. Rel</td>
<td>Claim &gt; Bill To &gt; Patient Rel to Insured</td>
<td>Insured information</td>
</tr>
<tr>
<td>60</td>
<td>Insured’s Unique ID</td>
<td>Claim &gt; Bill To &gt; Insured’s ID #</td>
<td>Insured</td>
</tr>
<tr>
<td>61</td>
<td>Group Name</td>
<td>Claim &gt; Bill To &gt; Insured’s ID #</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Insurance Group No</td>
<td>Claim &gt; Bill To &gt; Group #</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Codes</td>
<td>Claim &gt; Prior Auth #</td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Document Control Number</td>
<td>Claim &gt; Original Ref Number</td>
<td>Original Ref Number from the claim screen. Will print in line A for primary claim, line B for secondary claim, and line C for Tertiary claim.</td>
</tr>
<tr>
<td>66</td>
<td>Diagnosis and Procedure Code Qualifier (ICD Version Indicator)</td>
<td>Claim &gt; ICD Indictor</td>
<td>9 for ICD-9 or 0 for ICD-10</td>
</tr>
<tr>
<td>67</td>
<td>DX: principal diagnosis code</td>
<td>Claim Diagnosis A1</td>
<td>Diag A1</td>
</tr>
</tbody>
</table>

**Field No.** | **Field Name** | **Screen > Field** | **Notes** |
<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
<th>Claim Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>74a-e</td>
<td>Other Procedure Code and Date</td>
<td>Claim &gt; Other Procedure Code and Date</td>
</tr>
<tr>
<td>75</td>
<td></td>
<td>Not Available</td>
</tr>
<tr>
<td>76 (NPI)</td>
<td>Attending Physician NPI</td>
<td>Claim &gt; Attending Provider NPI from the physician library</td>
</tr>
<tr>
<td>76 (QUAL and ID)</td>
<td>Attending Additional ID Numbers</td>
<td>Claim &gt; Attending Provider additional ID number from the physician library</td>
</tr>
<tr>
<td>76 (LAST and FIRST)</td>
<td>Attending Physician Last and First Name</td>
<td>Claim &gt; Attending</td>
</tr>
<tr>
<td>77</td>
<td>Operating Phy</td>
<td>Claim &gt; Operating Provider</td>
</tr>
<tr>
<td>78-79</td>
<td>Referring Phy and/or Rendering Phy</td>
<td>Claim &gt; Referring Provider and/or Rendering Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Will populate box 78 if only one provider is selected or 78 and 79 if two providers are selected. Rendering providers will have a qualifier of 82 and referring providers will have a qualifier of DN. The rendering and referring provider will not print if their NPI is the same as the Attending.</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>Claim &gt; Remarks</td>
</tr>
<tr>
<td>81CC a</td>
<td>Code-Code Field</td>
<td>Claim &gt; Billing Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prints the billing provider’s Taxonomy code. The prefix is B3 and the code is printed in the second column</td>
</tr>
</tbody>
</table>
ICD-10

EZClaim cannot answer questions about the use of ICD-10 codes. Please contact your payer for any questions related to the use of ICD-10 codes. This section points out features of EZClaim Premier that relate to the ICD indicator. This indicator is used to determine if the diagnosis codes should be treated as ICD-9 or ICD-10 codes by the payer.

CMS Web Site on ICD-10: http://www.cms.gov/icd10

You cannot mix ICD-9 and ICD-10 codes on one claim.

Claim ICD Indicator

The claim screen has an ICD indicator field located in the ‘Misc Information’ section of the grid. The field has two options; ICD-9 and ICD-10.

Initial Value

The program will automatically set the ICD Indicator to the value selected in program setup. See “Program Setup” > “Claim” on page 196 for information on changing the value.

Code Library

There are two code libraries available for diagnosis codes. Use ‘Diagnosis Codes’ for ICD-9 and ‘Diagnosis Codes ICD-10’ for ICD-10 codes. See “Code Library” on page 144 for information on the code libraries.
Diagnosis Code Library Lookup

When using the code library to look up a diagnosis code, a filter option is available. To look up a diagnosis code, double click in the diagnosis field.

Paper Claims

The ICD Indicator prints in Box 21 on the CMS-1500 form. The valid values are ‘9’ for ICD-9 or ‘0’ for ICD-10.

Electronic Claims

The ICD Indicator will affect the Code List Qualifier Code used in HI segments in Loop 2300. When ICD-10 is the indicator value, the qualifiers are prefixed with an ‘A’.

ICD-9 example: HI*BK:11111*BF:22222

ICD-10 example: HK*ABK:33333*ABF:4444

FAQ on ICD-10

EZClaim cannot answer questions about the use of ICD-10 codes. Please contact your payer for any questions related to the use of ICD-10 codes.

Q – What do I need to do to prepare for ICD-10?

- Confirm your program is at the latest release.
- Obtain access to ICD-10 codes. Codes are available from many sources and in many formats. EZClaim does not provide the ICD-10 codes.
- Populate the Premier ICD-10 diagnosis code library with your ICD-10 codes.

Q – Will EZClaim convert my ICD-9 codes to ICD-10 codes?

A – EZClaim will not convert your ICD-9 codes but you have the option of entering the ICD-10 codes into the Premier ICD-10 Library. You must obtain your own ICD-10 codes for populating your diagnosis code Library.
Q – Is there a crosswalk for ICD-9 to ICD-10 codes?

Q – Can I have both an ICD-9 and ICD-10 Diagnosis Library in my Premier Program?
A – Yes, there are two code libraries available for diagnosis codes. Use ‘Diagnosis Codes’ for ICD-9 and ‘Diagnosis Codes ICD-10’ for ICD-10 codes. Enter ICD-10 codes into your ICD-10 library and be ready for the October 1st deadline!

Q – How do I set the ICD indicator as a default for all future claims?
A – To set ICD-10 as a default setting, go to Tools > Program Setup> Claim. Select the ICD-10. All claims from this point will now default to ICD-10. To change the ICD Indicator for dates of service prior to October 1st, see below.

Q – Can I enter both ICD-9 and ICD-10 codes on the same claim?
A – No, you cannot mix both ICD-9 and ICD-10 codes on the same claim.
   - ICD-9 codes for dates of service before October 1
   - ICD-10 codes for dates of service on or after October 1

Q – Does EZClaim Premier offer ICD-10 code validation?
A – EZClaim does not offer code validation but does partner with [Medical Code Solutions](https://www.medicalcodesolutions.com) for claim scrubbing.
Q – How do I enter a claim with dates of service before October 1, 2015?

A – For dates of service prior to October 1st, continue to use your ICD-9 codes. To change the ICD indicator for a specific claim, the Claim screen has an ICD indicator field located in the ‘Claim Information’ section of the grid. The field has two options; ICD-9 and ICD-10. Select the correct indicator for the claim. If ICD-9 diagnosis codes are entered on a claim, the ICD Indicator must also be ICD-9.
Company Files

If you are a billing service or have additional clients to bill and want to keep data separate, additional Company files can be created. Click the Application icon in the upper left of the program to access the menu.

**New Company**

Use the New Company menu item to create a new separate company file. If you are unsure as to which Server you should select, contact your network administrator.

The Company Name can be anything. No spaces or special characters are allowed. Underscores are allowed.

**Open Company**

Select another company and/or server. If you are unsure as to which Server you should select, contact your network administrator.

Once selected, click ‘OK’ or ‘Enter’.

---

217
Clearinghouse Reference

Contact EZClaim for specific information about your clearinghouse or payer if it is not listed below.

Capario

EDI Connection Library Settings for Claims and Reports

Use the ‘Capario Secure File Transfer’ type when setting up the EDI connection library.

<table>
<thead>
<tr>
<th>Name: Capario</th>
<th>Type: Capario Secure File Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>User Login</strong></td>
<td><strong>Capario Client ID</strong></td>
</tr>
<tr>
<td><strong>User Password</strong></td>
<td><strong>Password</strong></td>
</tr>
<tr>
<td><strong>Submitter Name</strong></td>
<td><strong>Optional</strong></td>
</tr>
<tr>
<td><strong>Submitter ID</strong></td>
<td><strong>Optional</strong></td>
</tr>
</tbody>
</table>

ANSI 270 (Eligibility) Submitter/Receiver Library Entry

Enter your Capario Client ID into the ‘Authorization Information’ (ISA02) area and the password (ISA04) given to you by your EZClaim Representative.

TriZetto EDI

EDI Connection Library Settings for Claims and Reports

Use the ‘TRIZETTO’ Secure File Transfer’ Type when setting up the EDI connection library.
ANSI 837 (Claims) Submitter/Receiver Library Entry

- Submitter ID = TriZetto assigned Site ID number, 4 digits.
- Receiver ID (NM109) = 431420764
- Receiver ID (ISA07 and ISA 08) = 431420764000000
ANSI 270 (Eligibility) Submitter/Receiver Library Entry

The important fields are the ‘Authorization’ information in the ISA section. Use the same login and password you use for TriZetto SFTP access.

ZirMed

EDI Connection Library Settings for Claims and Reports

Use the ‘Secure File Transfer’ type when setting up the EDI connection library.

Contact ZirMed for the latest Secure FTP connection settings.

Claim File Naming Convention

The claim file name must end with .CLP example Claims05012013.CLP Do not use additional '.' in the file name.
ANSI 837 (Claims) Submitter/Receiver Library Entry

<Client Account ID*> If you are a billing service or are otherwise utilizing ZirMed’s parent/child account feature, you should send the Client Account ID of the CHILD account in this field.

ANSI 270 (Eligibility) Submitter/Receiver Library Entry

The important fields are the Authorization information in the ISA section. Use the same login and password you use to access the ZirMed web site.

Eligibility Payer IDs

The ZirMed eligibility payer ID may be different than the claim submission payer ID. If ZirMed’s payer name matching feature is used for claim submission, the payer ID sent in the 837 is ignored. Therefore, it is OK to enter the Eligibility Payer ID into EZClaim’s payer library.
Office Ally

EDI Connection Library Settings for Claims and Reports

- Use the ‘Secure File Transfer’ type when setting up the EDI connection library.

- Contact Office Ally for the latest Secure FTP connection settings.
  - Host Name: ftp.officeally.com
  - Port: 22
  - Upload Directory: inbound
  - Download Directory: outbound
  - DO NOT check the ‘Allow SFTP Site to Move or Delete Files’. Otherwise, you will receive duplicate report files.
ANSI 837 (Claims) Submitter/Receiver Library Entry

- Submitter ID = Office Ally assigned ID number.
- Receiver Name = OFFICE ALLY
- Receiver ID (NM109) = 330897513
- Receiver ID (ISA07) = 30
- Receiver ID (ISA 08) = 330897513
- Receiver Code (GS03) = 330897513

Availity

EDI Connection Library Settings for Claims and Reports

Uses secure FTP protocol. Enter user login and password provided by Availity. When using this connection type, the program will automatically name and upload the claim file and show a progress bar on the screen.

The following values are used for the Availity connection type:

- Host Name: ftp.availity.com
- Upload Directory: SendFiles
- Download Directory: /ReceiveFiles
- Port: 9922

**ANSI 837 (Claims) Submitter/Receiver Library Entry**

- Submitter ID = Availity assigned ID number.
- Receiver ID (NM109) = 030240928
- Receiver ID (ISA07) = 30
- Receiver ID (ISA 08) = 030240928
- Receiver Code (GS03) = 030240928
# ANSI 270 (Eligibility) Submitter/Receiver Library Entry

The important fields are the Authorization information in the ISA section. Use the username and password supplied by Navicure.

## Library Entry Name (Required):

- **Navicure Eligibility**

## Export Format:

- **Eligibility Inquiry 270**

## Version:

- **5010**

## Claim Type:

- **Chargeable**

## Submitter Information - Loop 1000A - NM1 and PER Segments

<table>
<thead>
<tr>
<th>Type</th>
<th>Business Name or Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>&lt;Submitter Name&gt;</td>
</tr>
</tbody>
</table>

## Receiver Information - Loop 1000B

<table>
<thead>
<tr>
<th>Receiver Name NM103</th>
<th>Receiver ID NM109</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Header Information - ISA and GS Segments

**Authorization Information ISA01 and ISA02:**

- **Username:**
  - 03: `<Username>`

**Password Information ISA03 and ISA04:**

- **Password:**
  - 01: `*******`

**Sender ID ISA05 and ISA06:**

- ZZ: [Input Field]

**Interchange Receiver ID ISA07 and ISA08:**

- ZZ: [Input Field]

**Acknowledge Requested ISA14:**

- [Input Field]

**Sender Code GS02:**

- [Input Field]

**Receiver Code GS03:**

- [Input Field]

**Test/Prod Indicator ISA15:**

- P: [Input Field]

*IMPORTANT:* Fields may remain blank if not required. Please contact the payer for required fields.
**Backup**

**Cloud Users**: Cloud users must email support@ezclaim.com to request a backup. Cloud data is automatically backed up daily but only available to users upon request.

Backups can be performed if you have Admin permissions and are not a cloud user. The backup icon is located on the Tools menu.

If you are not currently logged in as a user with Admin permissions, you will be prompted to enter the Admin password.

![Backup Window]

The backup window allows you to set the location of the backup file. Remember that the backup location is relative to the SQL server location, not your local computer.

**Data Backup**

This process will backup data from:

**Server: ezclaim-s01, Database: EZData_Demo_Company_Al**

IMPORTANT: Linked documents are not included in the backup.

Enter the location where the backup file is to be created. Please note that the file location entered must be relative to the server. If you are having trouble, perform the backup from the computer that hosts the database.

Backup data to:

D:\Backup\EZData_Company_2015_08_14.ezb

![Backup Window]

Restoring a company file can only be done through the Company Maintenance program.

**SQL Server Management Studio (SSMS)**

For offices that manage their own SQL server, backups should be managed and maintained through the tools provided by SQL Server Management Studio. There are no special requirements to backup or restore EZClaim Premier databases.