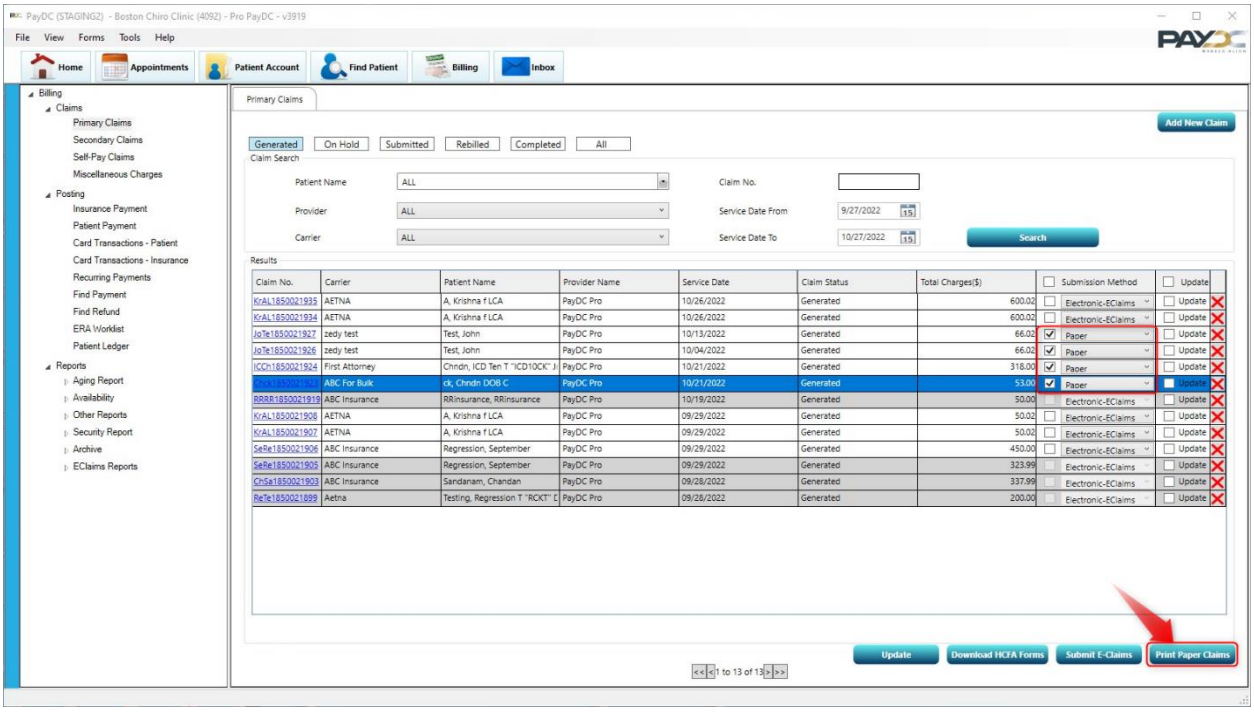
See What's New from PayDC!

Here's what's in this Release (October 28th, 2022)

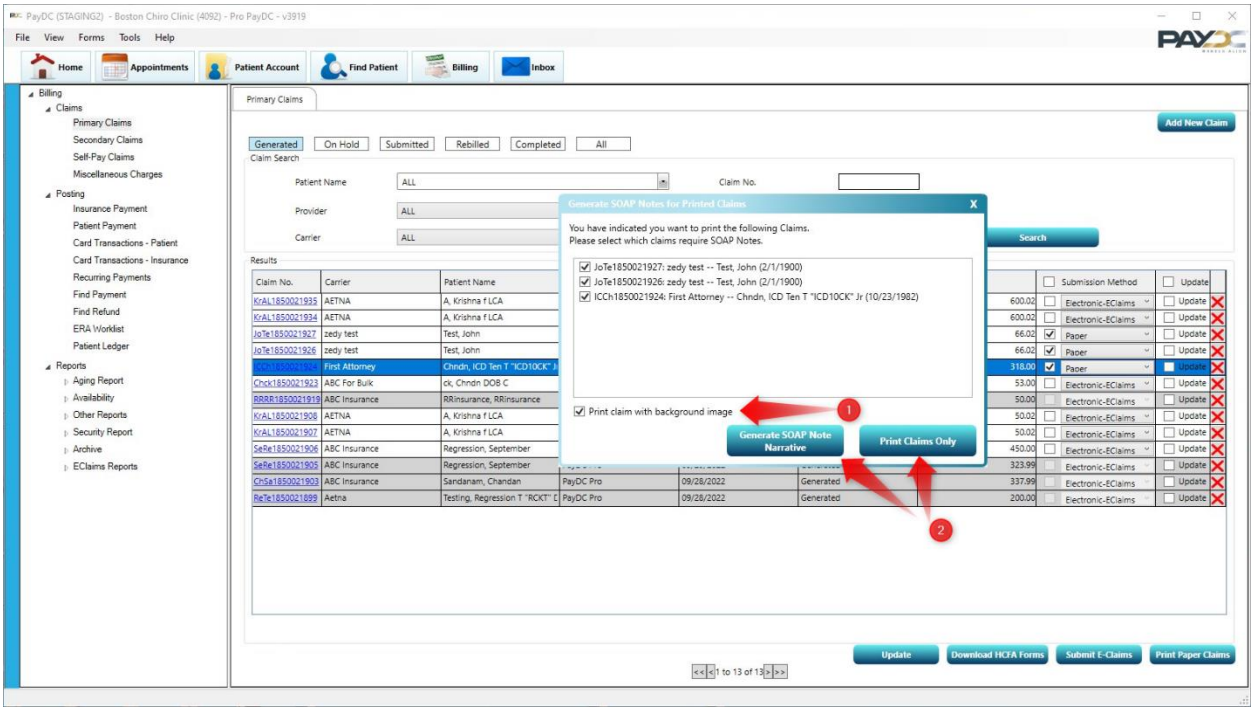
We've added the capability to print the background image of the CMS 1500 form along with the claim data when you print claims in our Native Billing platform.

Please Note: This will not replace a claim printed on a standard CMS 1500 form if submitted via USPS, but is meant to be faxed or emailed through secure channels.

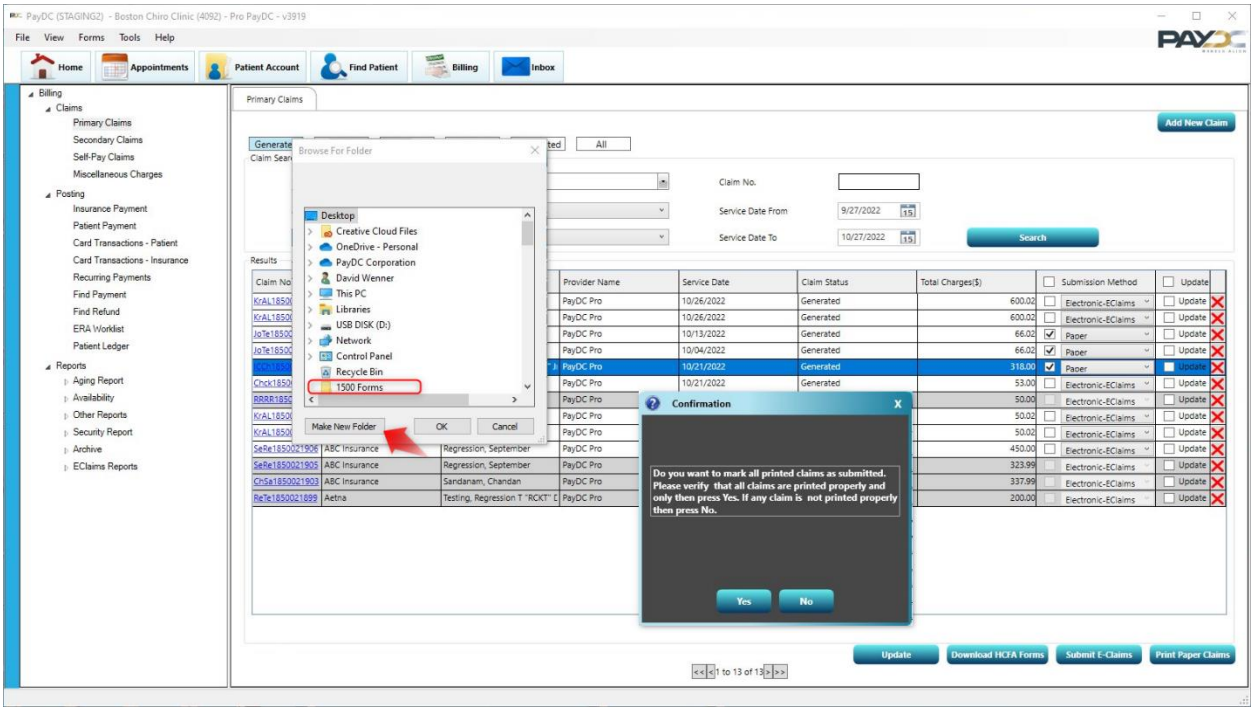
In the Generated Queue of the claims grid, select claims to print and click Print Paper Claims button as usual.

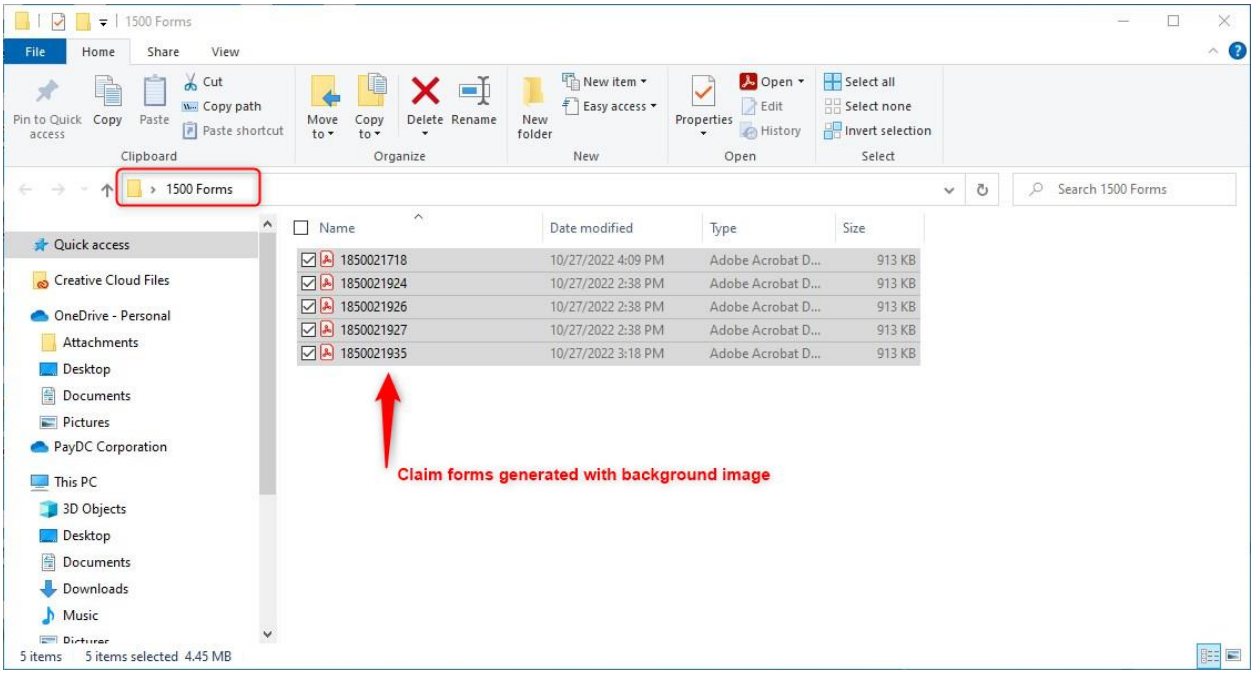


Then in the following Generate SOAP Notes for Printed Claims window, simply check the new checkbox labeled “Print claim with background image” (this will be unchecked by default) before clicking the Generate SOAP Note Narrative button OR Print Claims Only button.

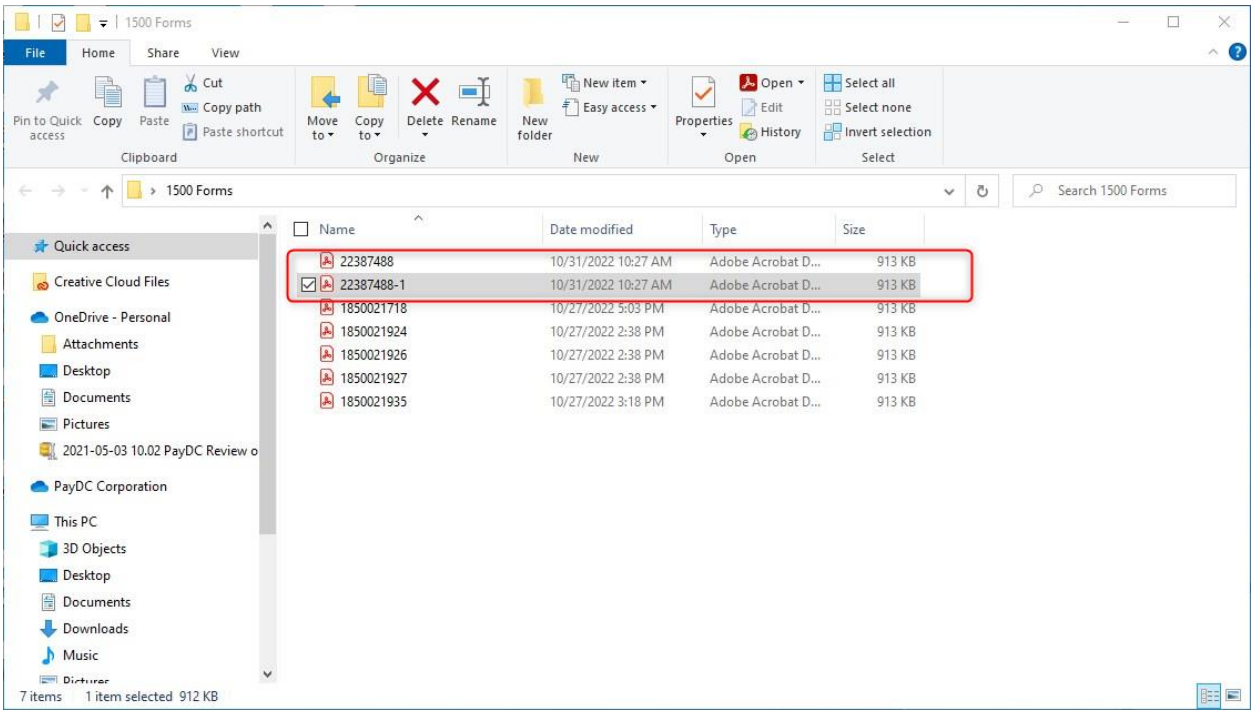


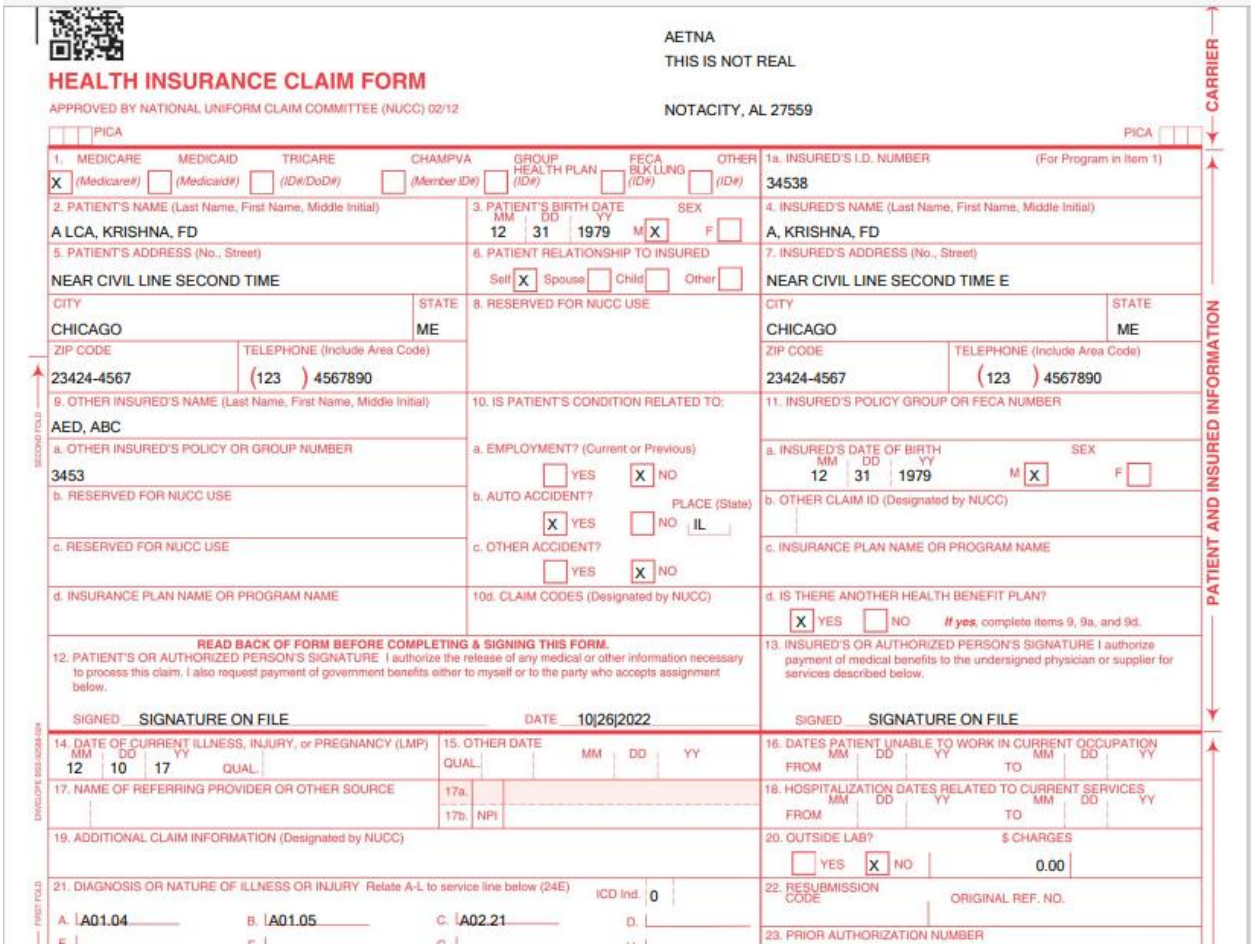
Then choose a Folder to generate the claim forms or “Make New Folder”. We suggest making a folder that’s easy to find with a name like 1500 Forms or CMS 1500 in an easily accessible area such as your Desktop or Documents Folder. The claim forms will be generated as .pdf files with the background image and the claim number will be the file name. Click Yes in the Confirmation dialogue box to confirm that All Claims have printed generated properly, which will mark the claims as Submitted and remove them from the Generated queue, OR press No, to keep the claims in the Generated queue.





Claim forms with more than 6 service lines will be created as multiple files as necessary and labeled with the original file number followed by a "-1, -2, -3," etc.





AETNA
THIS IS NOT REAL
NOTACITY, AL 27559

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [X] (Medicare#) — MEDICAID ( ) (Medicaid#) — TRICARE ( ) (ID#/DoD#) — CHAMPVA ( ) (Member ID#) — GROUP HEALTH PLAN ( ) (ID#) — FECA BLK LUNG ( ) (ID#) — OTHER ( ) (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 34538

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): A LCA, KRISHNA, FD

3. PATIENT'S BIRTH DATE: 12 31 1979 — SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): A, KRISHNA, FD

5. PATIENT'S ADDRESS (No., Street): NEAR CIVIL LINE SECOND TIME

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): NEAR CIVIL LINE SECOND TIME E

CITY: CHICAGO — STATE: ME

8. RESERVED FOR NUCC USE

CITY: CHICAGO — STATE: ME

ZIP CODE: 23424-4567 — TELEPHONE (Include Area Code): (123) 4567890

ZIP CODE: 23424-4567 — TELEPHONE (Include Area Code): (123) 4567890

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 3453

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 12 31 1979 — SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): IL

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE: 10|26|2022

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 12 10 17 — QUAL.

15. OTHER DATE — QUAL. — MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] — $ CHARGES: 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

A. A01.04 B. A01.05 C. A02.21 D.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

CARRIER

PATIENT AND INSURED INFORMATION

Thank you for trusting us as your software vendor!

Questions? You can always ask our Service Desk.

- If you are a PayDC customer, the phone number is **(888) 306-1257**; please choose option 4 for Service Desk.
- If you are an Advanced Provider Solutions customer, the phone number is **(855) 283-4940**; please choose option 4 for Service Desk.
- If you would like to contact the Service Desk via **e-mail**, please use the Contact Us form on our website. Please note: The Contact Us form is now secure, so you can include PHI in your description.