

TIP SHEET ON HOW TO RELEASE THE OUTPATIENT SERVICES TO OHC AND HOW TO PRINT THE OHC CMS-1500 FORM USING SANWITS

The CMS 1500 form is the Health Insurance Claim Form used to bill a private insurance for rendered services.

1. Log in to **SanWITS**.
2. Select your Agency and Facility

Home Page

- ▶ Capacity List
- ▶ Agency
- Clinical Dashboard
- ▶ Client List
- ▶ System Administration
- Reports
- Support Ticket

Change Facility

Current Agency: San Diego County

Current Facility: Main Facility

New Agency: San Diego County

New Facility: Main Facility

Cancel Go

3. Go to Client List -> Enter First Name and Last Name -> Click Go -> click Client Profile.

Home Page

- ▶ Agency
- ▶ Group List
- Residential Unit Dashboard
- ▶ Residential Unit Mgmt
- Clinical Dashboard
- ▶ Client List
- ▶ Client Profile
- Linked Consents
- Contacts
- ▶ Activity List
- Episode List

Client Search

Agency: San Diego County

Facility: [dropdown]

First Name: first

Last Name: Billing

SSN: [input]

DOB: [input]

SanWITS Training Client Id: [input]

Provider Client ID: [input]

Unique Client Number: [input]

Primary Care Staff: [input]

Treatment Staff: [dropdown]

Intake Staff: [input]

Case Status: All Clients

Number Type: [dropdown]

Other Number: [input]

Include Only Active Consents: Yes

Clear Go

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4. Go to Payor Group Enrollment (PGE). Click Add Benefit Plan Enrollment.

Payor Group Enrollment screen

5. Select Payor-Type (Group Insurance) and Plan Group (Other Health Coverage (OHC) General).
 Select Relationship to Subscriber (Self).
 Enter Coverage Start (e.g. 03/01/2020)
 Enter Subscriber # or 000 if not available.
 Enter the OHC Policy # on the Policy # field when available.

NOTE: If client is DMC Billable, please create a DMC PGE as well.

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6. Go to Encounters (Outpatient services). Click Release to Billing.

Encounter screen

7. Select General [Other Health Coverage (OHC)]. Click Finish.

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8. Go to Claim Item List. Select Plan Other Health Coverage. Item Status All Awaiting Review. Select your Facility -> Enter Service Date (e.g. 07012020:07312020) -> Click Go.
9. Check the box next to Item # then click Release & Update Status. Click **Create Facility Batches**.

Claim Item List screen

The screenshot shows the 'Claim Item Search' form. Red arrows point to the following fields: Plan (Other Health Coverage (O...)), Item Status (All Awaiting Review), Facility (DMC Billing Test Facility), and Service Date (07012020:0731). A red box highlights the 'Go' button. Other fields include Client First Name, Client Last Name, Subscriber/Resp Party First Name, S/R Party Last Name, Subscriber/Resp Party Account #, Authorization #, FFS Type, Add-On Level, Group Session ID, Group Enrollment, ENC ID, Charge, and Service.

Create Facility Batch

The screenshot shows the 'Administrative Actions' menu with 'Create Facility Batches' highlighted by a green arrow. Below is the 'Claim Item List (Export)' table. A red box highlights the 'Release' button in the context menu for the first row.

Actions	Item #	Client Name	FFS Type	Add-On Level	Service Date	Service	Duration	Status	Release Date	Session ID
<input checked="" type="checkbox"/>	1159695		FFS	None	7/2/2019	H0015/U8	60 Min	Awaiting Review	7/2/2019	

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10. Move the Available Plans to the right. Click Go.

Choose Plan(s) for Batching

Available Plans: [Empty list with navigation arrows]

Selected Plans: Other Health Care Coverage (OHC)

Buttons: Cancel, Clear, Go

11. Go to Claim Batch List. Select Plan OHC. Click Go. Hover over the pencil and click the Batch Profile.

Claim Batch List screen

Provider Claim Batch List

Plan Name: Other Health Care Coverage (OHC)

Billing Form: [Dropdown]

Batch #: [Text]

FFS Type: [Dropdown]

Created Date: [Text]

Transmit Date: [Text]

Status: Awaiting Review

Buttons: Clear, Go

Claim Batch List (Export) Download 837

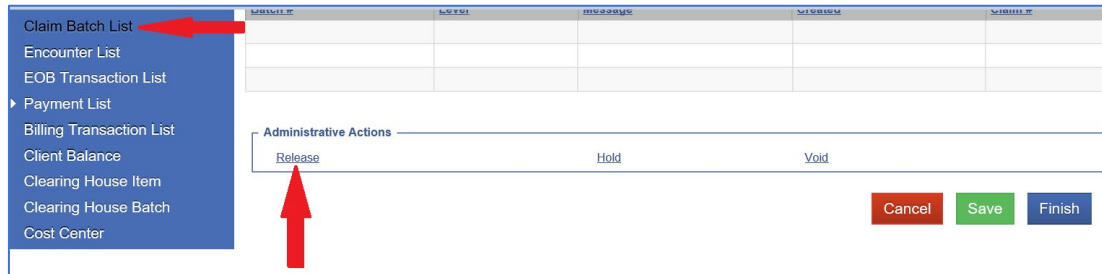
Actions	Batch #	Status	Batch For	FFS Type	Billing Form	837 Type	Order	Charges	Units	Service Mo/Yr	Created	Transmit	Agency Name	Facility Name
	106584	Awaiting Review	Other Health Care Coverage (OHC)	FFS	CMS-1500		P	\$4.73	0.04	Jul 2020	7/17/2020		Residential Agency 1	Residential #1

12. Click Release. Click Bill It. Save and Finish.

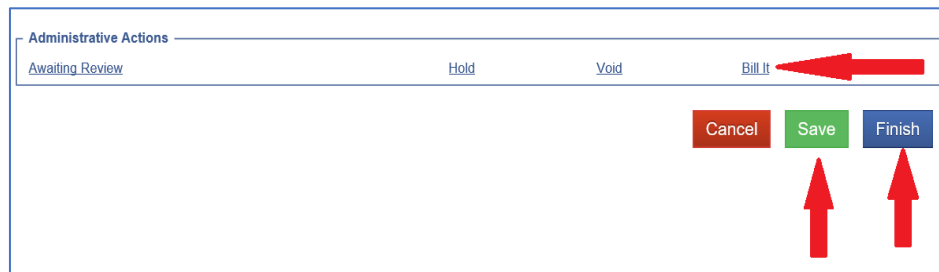
Note: Outpatient providers are requested to contact the Billing Unit to let us know that you have claims to be billed to OHC.

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Admin Action: Release

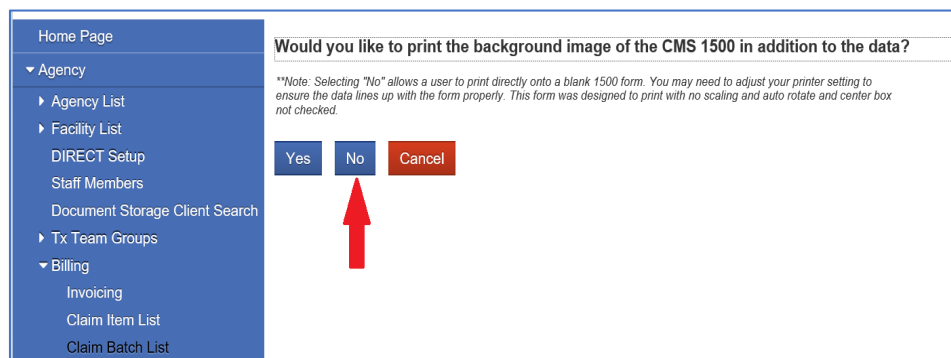


Admin Action: Bill It



13. You will get this message below. You would select **"NO"** and insert the red/white form into the printer.

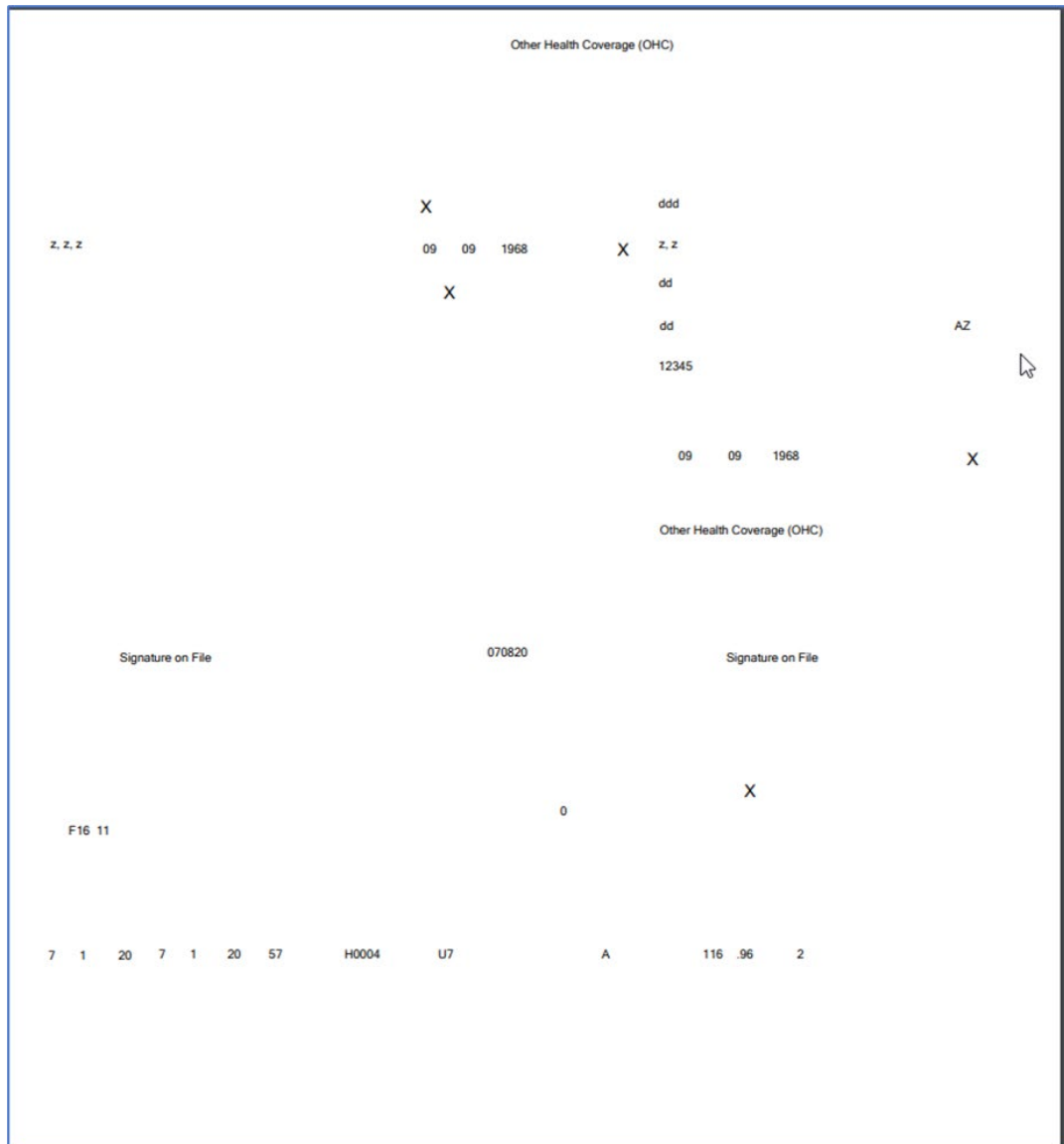
- If you click "Yes" it prints the form and the data. We have found that this print out is not acceptable but can be helpful to enter the data into an OHC billing system if they do accept the form.



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- The CMS 1500 form's print view will be in black and white, with no lines and field titles.

Here is how the CMS 1500 print preview looks like:



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- If provider is able to obtain a copy of the client's insurance card, please enter the insurance Policy # on the Payor Group Enrollment's Policy # field.

Benefit Plan/Private Pay Billing Information

Payor-Type: Group Insurance Plan-Group: OHC-Group 213

Payor Priority Order: 3 Policy #: POLNO1

Coverage Start: 1/1/2020 End: Payment Scale: Relationship to Subscriber/ Responsible Party: Self

Subscriber/ Responsible Party:

First Name: Middle: Last Name: Subscriber #: SUBSCRNO2

Birthdate: 8/18/1988 Gender: 2-Female

Address 1: 987 65th St

Address 2: City: San Diego State: California Zip: 11111

Buttons: Cancel Save

- On the CMS 1500 red/white ink. The subscriber number prints in line 1A while the OHC policy number prints in line 11. Please see the sample below.

Sample: Top portion of the CMS 1500 field 1a (Insured's ID #) and field 11 (Insured's Policy #)

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1): SUBSCRNO2

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [REDACTED]

3. PATIENT'S BIRTH DATE: 08 18 1988 SEX: F

5. PATIENT'S ADDRESS (No., Street): [REDACTED]

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

7. INSURED'S ADDRESS (No., Street): 987 65th St

CITY: San Diego STATE: CA

ZIP CODE: 11111 TELEPHONE (Include Area Code): ()

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: POLNO1

12. INSURED'S DATE OF BIRTH: 08 18 1988 SEX: F

13. OTHER CLAIM ID (Designated by NUCC):

14. INSURANCE PLAN NAME OR PROGRAM NAME:

Labels on right: CARF, VT AND INSURED INFORMATION

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Quick Tips:

- Some insurance (OHC) payers may accept a CMS-1500 form with a black-and-white background, other payers may reject your claims if you do not use the CMS 1500 red/white form. We do not suggest printing the CMS-1500 form in grayscale.
- When using the CMS 1500 red/white ink, make sure your printer setting is correct so the claims data will print properly on the assigned fields.

Sample: Red/white CMS 1500 Form

SAMPLE

Note:

For questions or comments, please contact the Billing Unit at phone # (619)338-2584 or email us at: ADSBillingUnit.HHSA@sdcounty.ca.gov.