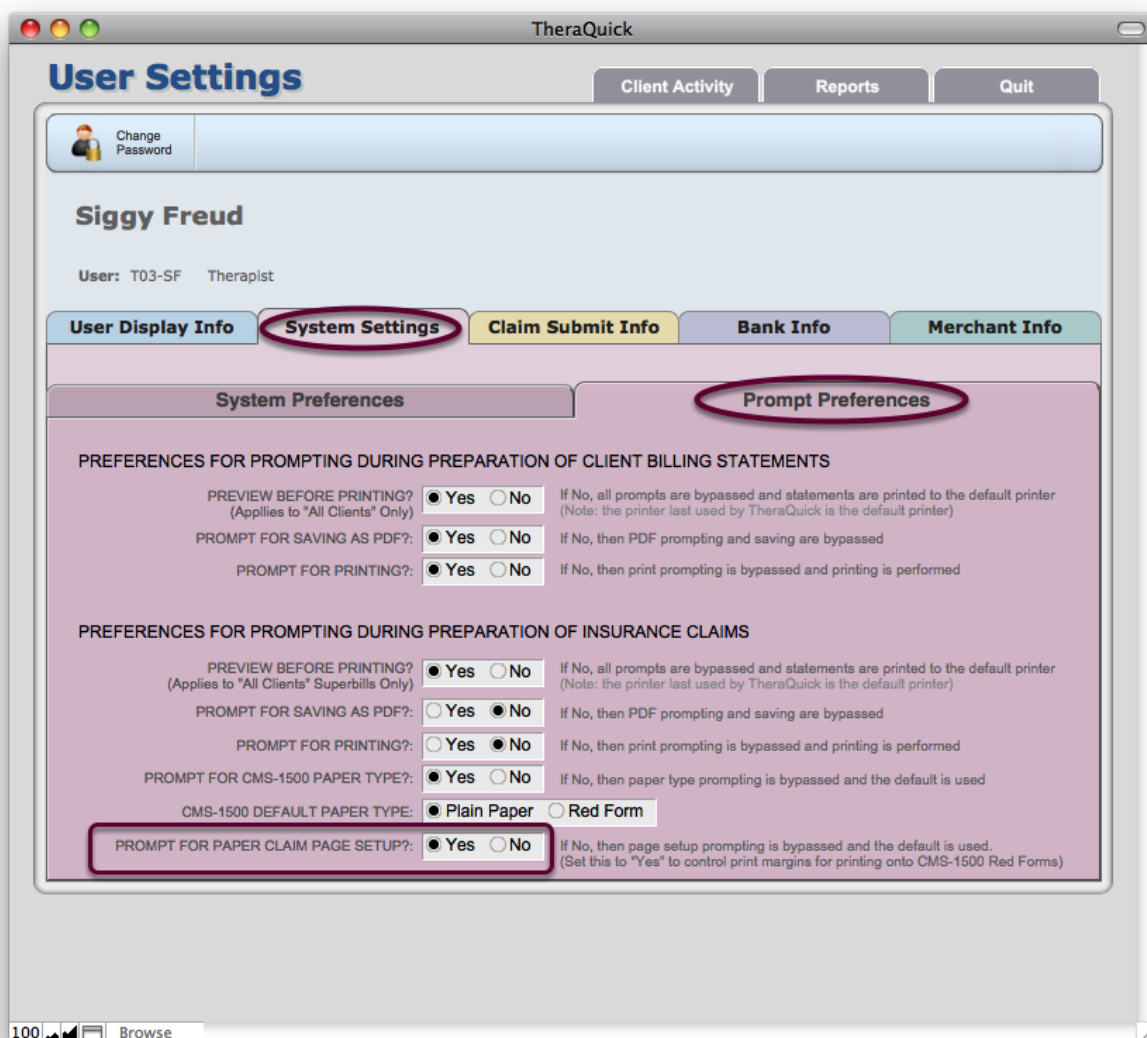


Applying Custom Page Margins for Aligning CMS-1500 Data Onto Pre-Printed Red Forms (for Paper Claims)

How to use the Paper Claim Page Setup prompt preference to allow selection of a custom page size with custom margins to control alignment of the CMS-1500 text when printing Paper Claims onto pre-printed red forms.

The new prompt is on the User Settings > System Settings > Prompt Preferences tab



Navigate to the User Settings > System Settings > Prompt Preferences tab. The Paper Claim Page Setup prompt preference setting is at the bottom of the list. Set it to "Yes" to activate the display of the Page Setup (Windows: Print Setup) dialog during printing of the CMS-1500 onto pre-printed red forms.

Prepare the Paper Claim normally



Use the Reports > Insurance layout and select the time interval and desired group of clients. (Note: only the printing of claims for clients with "Paper Claim" selected will be affected by the prompt preference described above.)

Continue to the printing options

Paper Claim

Page 1 of 1

Cancel **Continue**

1500
Missing Clue Health Associates

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

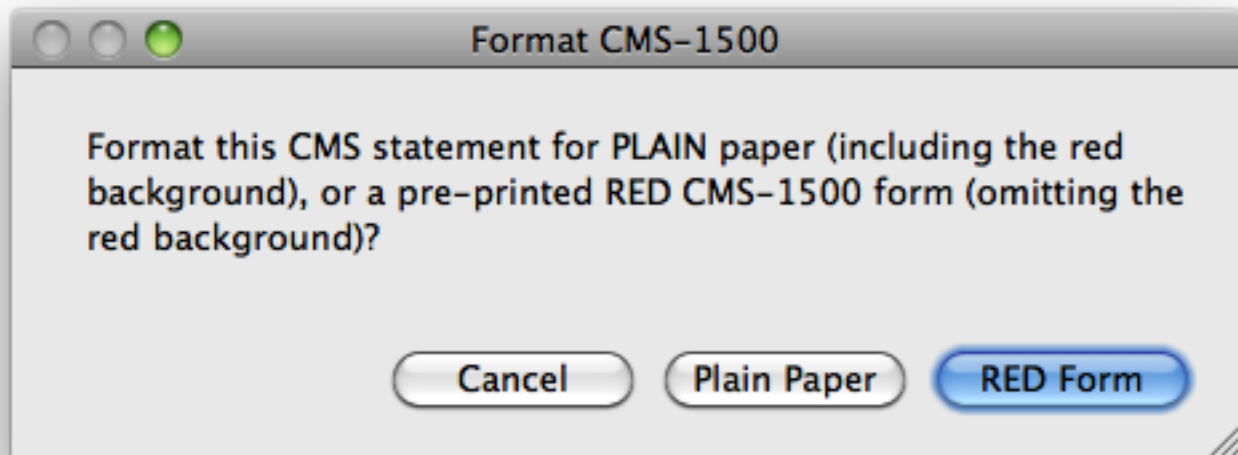
PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPVA <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) SHERLOCK123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Holmes, Sherlock M.		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Holmes, Sherlock	
3. PATIENT'S BIRTH DATE MM DD YY 01 01 75 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. INSURED'S ADDRESS (No., Street) 13 Shady Lane	
5. PATIENT'S ADDRESS (No., Street) 13 Shady Lane		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
7. INSURED'S ADDRESS (No., Street) 13 Shady Lane		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10a. RESERVED FOR LOCAL USE	
8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER Detective PPO	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		12. INSURED'S DATE OF BIRTH MM DD YY 01 01 75 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10a. RESERVED FOR LOCAL USE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature on File DATE 8/7/10	
11. INSURED'S POLICY GROUP OR FECA NUMBER Detective PPO		14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 09 01 09	
12. INSURED'S DATE OF BIRTH MM DD YY 01 01 75 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature on File DATE 8/7/10		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 09 01 09		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Self-Referral	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		18. RESERVED FOR LOCAL USE	
16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. RESERVED FOR LOCAL USE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Self-Referral		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
18. RESERVED FOR LOCAL USE		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 300 3 3. _____	
19. RESERVED FOR LOCAL USE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES		23. PRIOR AUTHORIZATION NUMBER AuthIndividual	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 2. V62 2 4. _____		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPTHCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. ICD-9-CM PROC. CODE I. ID. QUAL. J. RENDERING PROVIDER ID. #	
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		25. FEDERAL TAX I.D. NUMBER SSN EIN 11-222333 <input checked="" type="checkbox"/> <input type="checkbox"/>	
23. PRIOR AUTHORIZATION NUMBER AuthIndividual		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPTHCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. ICD-9-CM PROC. CODE I. ID. QUAL. J. RENDERING PROVIDER ID. #		28. TOTAL CHARGE \$ 450 00 29. AMOUNT PAID \$	
25. FEDERAL TAX I.D. NUMBER SSN EIN 11-222333 <input checked="" type="checkbox"/> <input type="checkbox"/>		30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Sigmund Freud PhD	
26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		31. SERVICE FACILITY LOCATION INFORMATION PsychoHealth, Inc. 123 Healthy Mind Ave. Mentalville, CA 99999	
28. TOTAL CHARGE \$ 450 00 29. AMOUNT PAID \$		32. BILLING PROVIDER NAME & PHONE # (800) 555-9999	
30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Sigmund Freud PhD		33. BILLING PROVIDER NAME & PHONE # (800) 555-9999	
31. SERVICE FACILITY LOCATION INFORMATION PsychoHealth, Inc. 123 Healthy Mind Ave. Mentalville, CA 99999		34. SIGNED DATE 8/7/10 a. 11-2345678 b. 11-2345678	
32. BILLING PROVIDER NAME & PHONE # (800) 555-9999		35. SIGNED DATE 8/7/10 a. 11-2345678 b. 11-2345678	

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

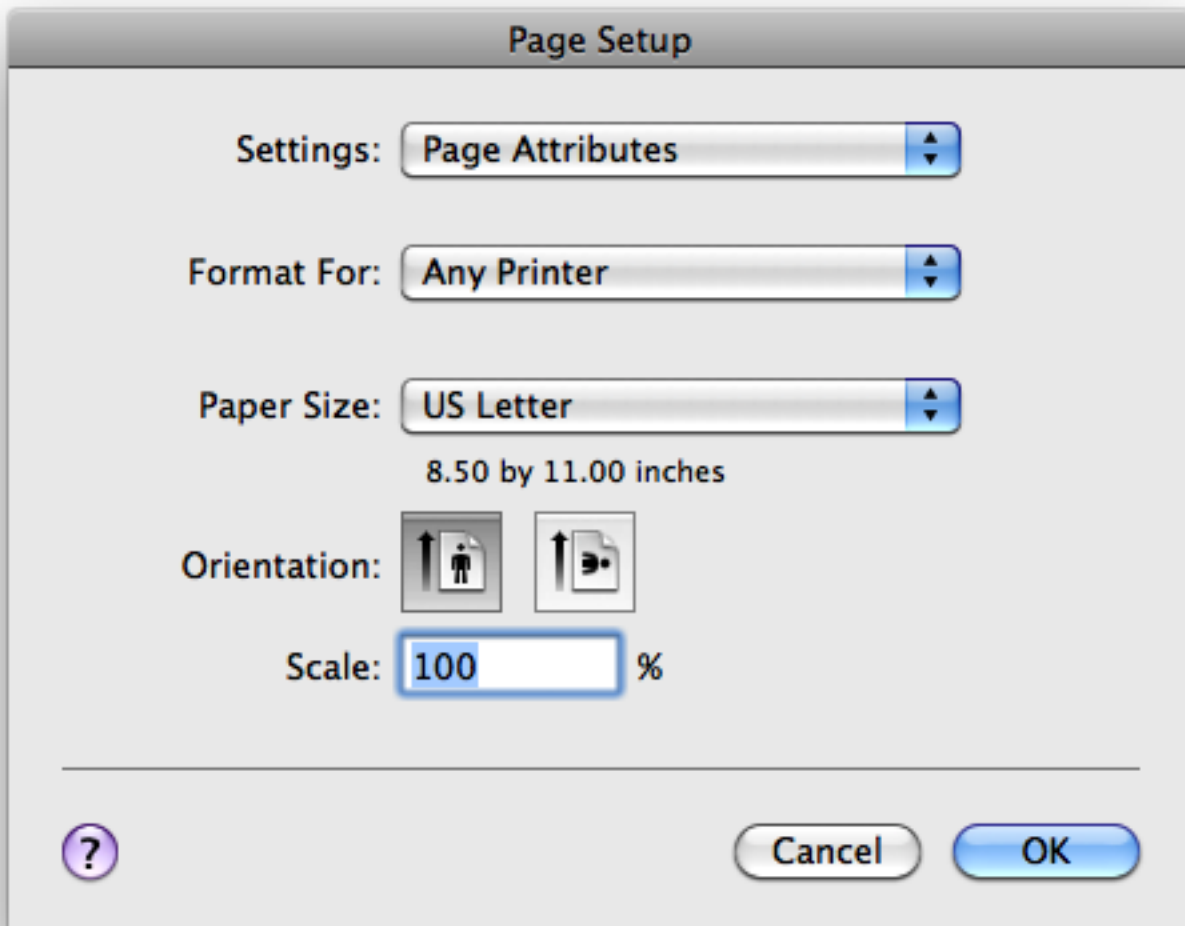
When the preview of the claim is presented, click "Continue" to proceed to the printing options.

Choose the "RED Form" for the printing format



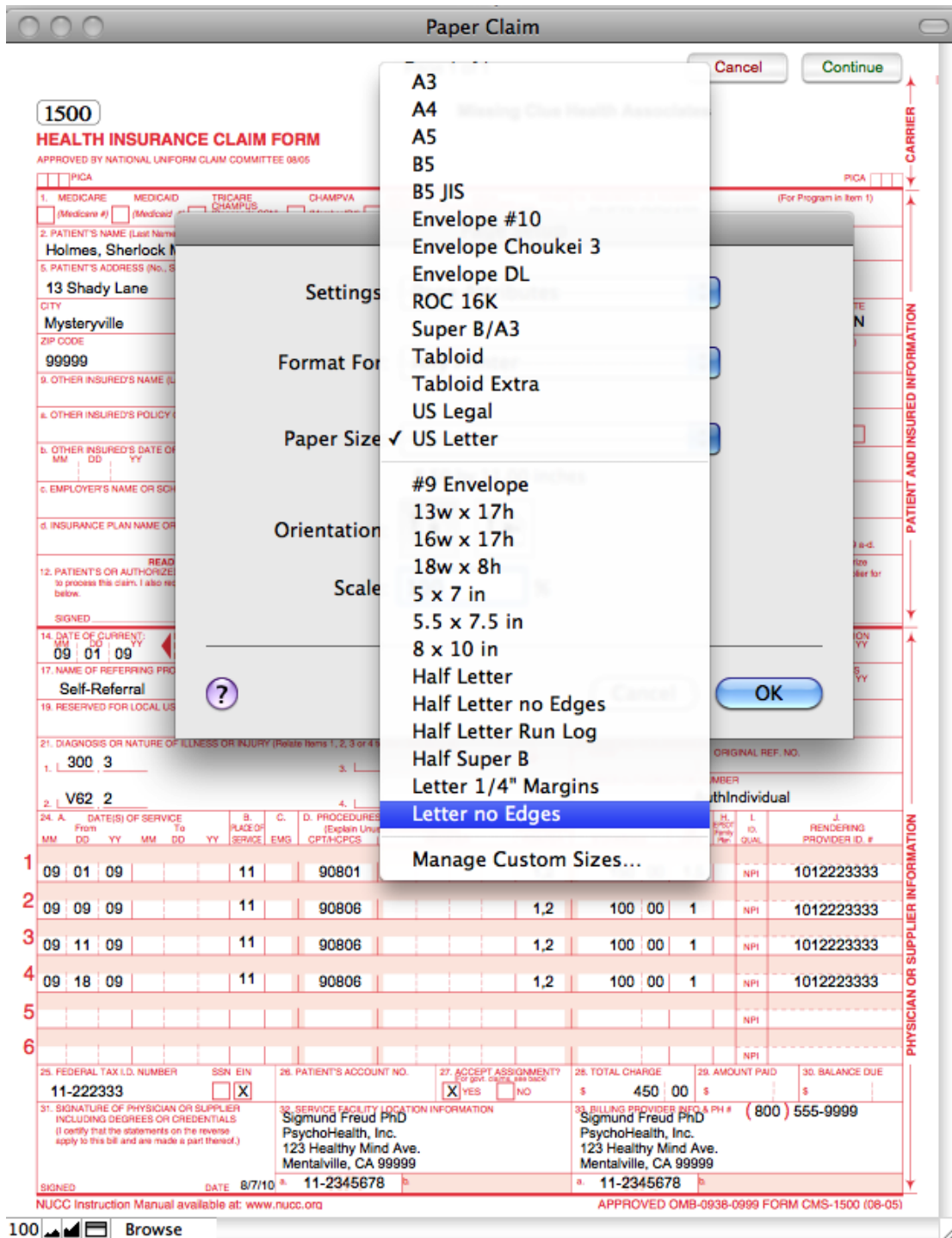
When the dialog appears for the printing format, choose the "RED Form" option. (Note: this dialog may be suppressed and the RED Form option can be pre-selected in your prompt preferences.)

The Page Setup (Windows: Print Setup) dialog will appear



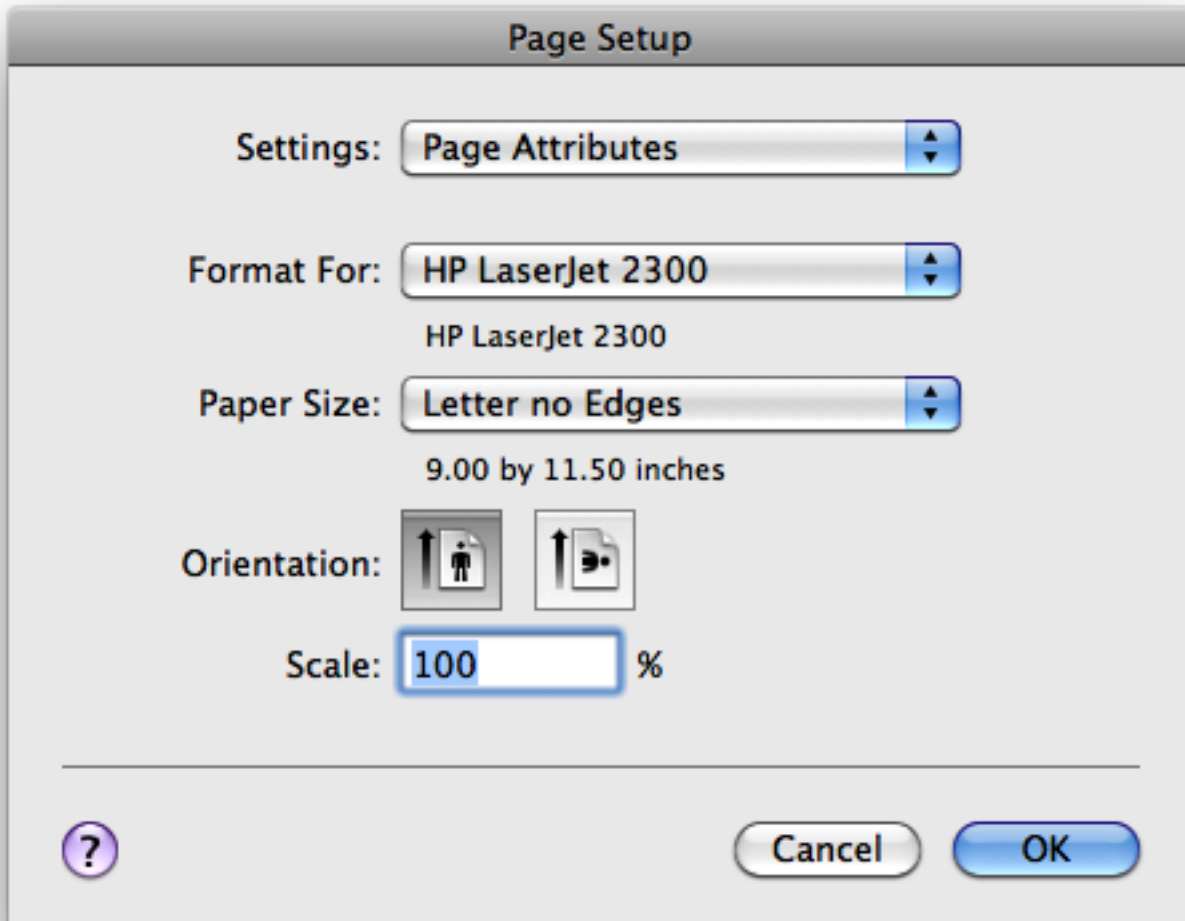
The Page Setup (Windows: Print Setup) dialog will appear to allow you to choose the printer and paper size that works for your printer. Note that you may have to create a custom paper size with custom margins through trial and error in order to get the alignment correct.

Choose the printer and/or paper size that you have customized to work with your printer



Choose a custom paper size that you have created with the dimensions and margins that work for your printer. (Hint: On a Mac, you would use the "Manage Custom Sizes..." process. As a starting point, set the margins to 0 and increment from there since the form is designed to be printed on a full page.)

Select the printer also, if necessary (you may have to do this first, before selecting the paper size)



You may first have to select the specific printer to gain access to the page size options that work for that printer. Click OK and the print dialog will appear. Be sure to select the correct printer (and to have a sheet of the pre-printed red form loaded into it.)

Note that this dialog will appear for each form that is printed. There is currently no way within FileMaker Pro to force it to "remember" a particular page setup if the page setup is under the control of the user.