

# Setting Up a Client for Insurance Billing (Paper Claim or Electronic Claim)

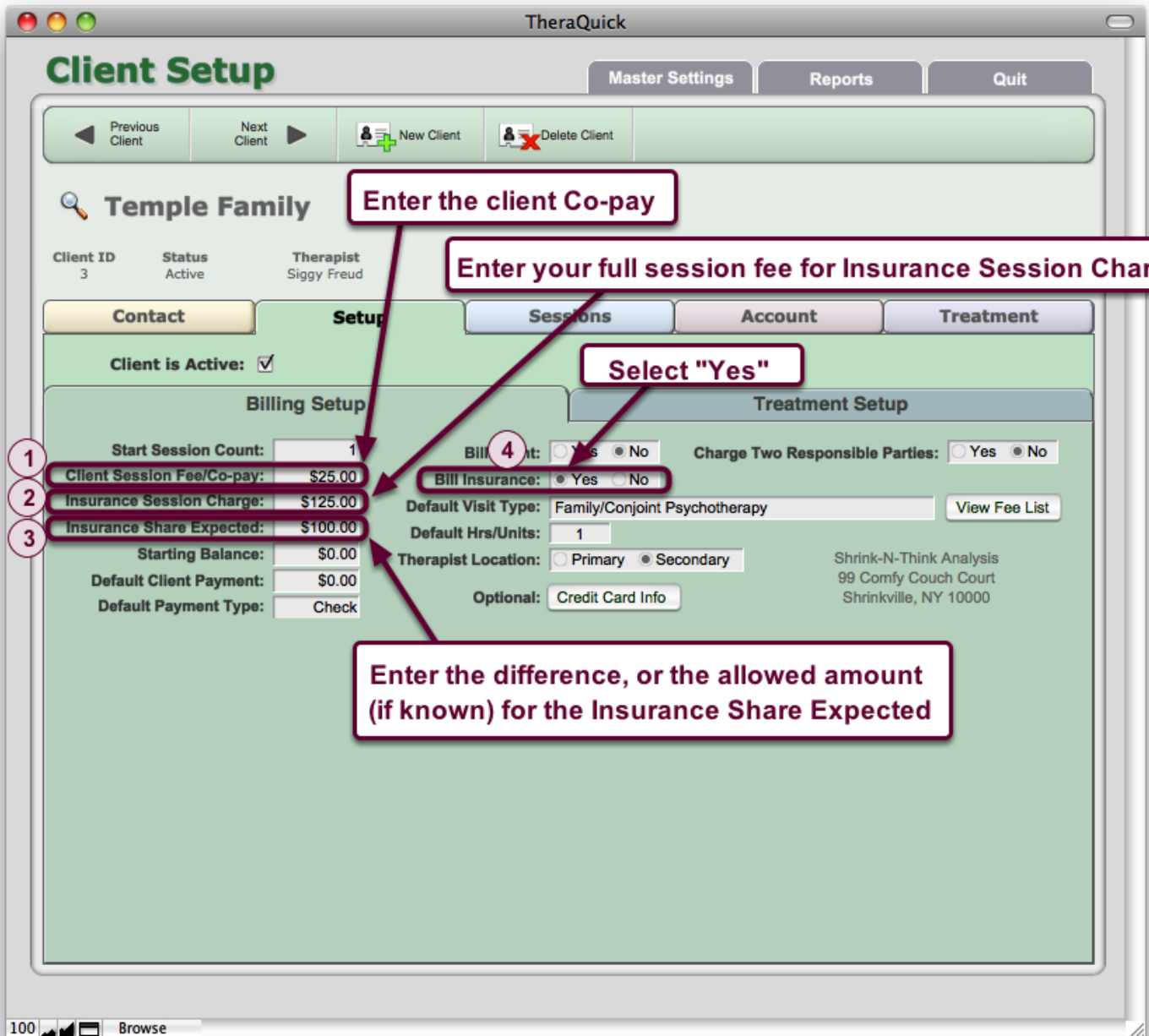
How to setup the billing information for a client who pays you a co-pay for the sessions, then you bill the insurance company for the remainder of your fee using a Paper Claim or an Electronic Claim.

**Navigate to the Client Biz Contact > Insurance Info > Current Insurance Policy tab.**



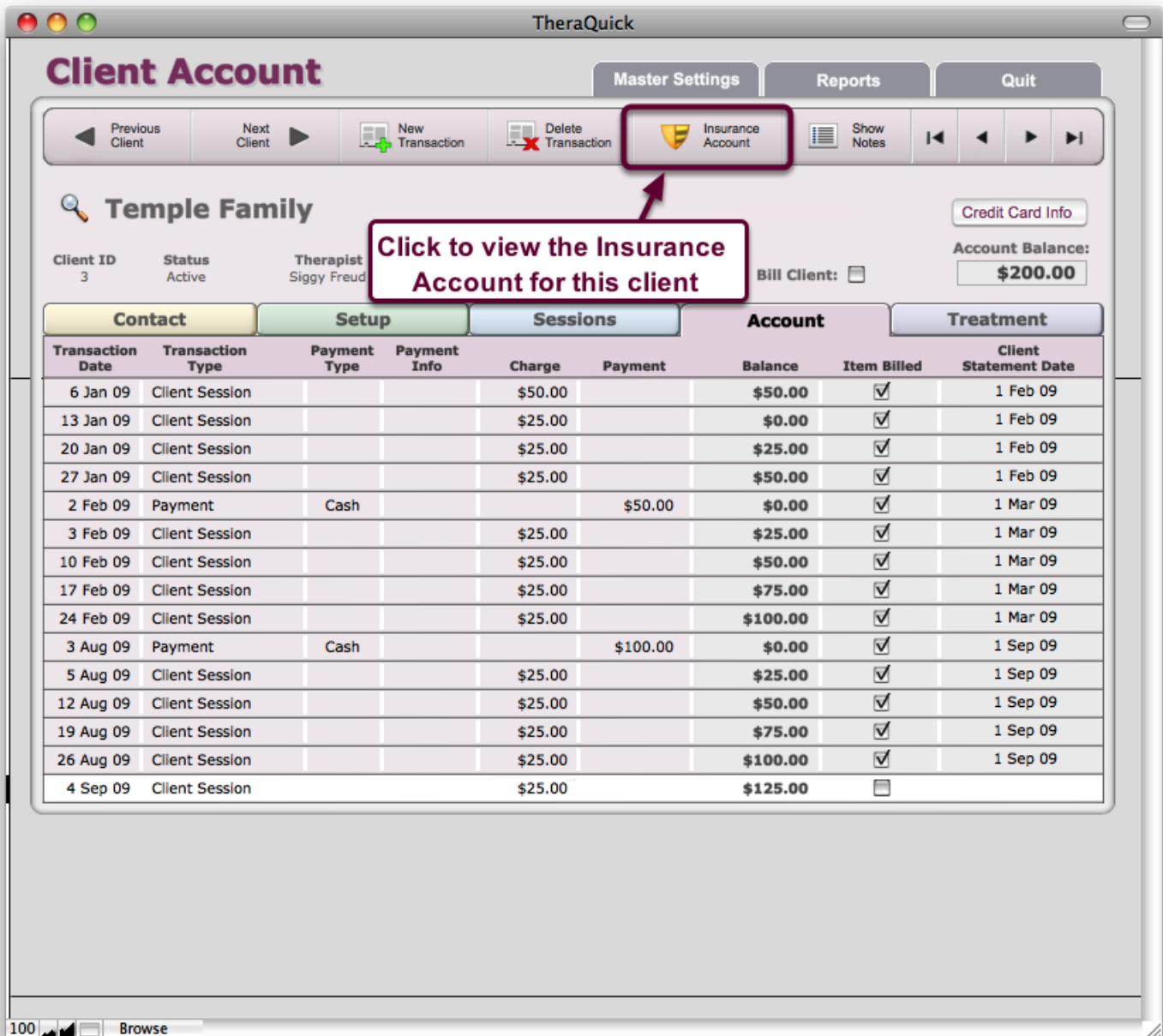
Fill in the required insurance policy information for the client and select the type of claim to produce. Note that if you select "Electronic Claim," you must have an account set up with a clearing house, and have the account information entered in your User Settings > Claim Submit Info settings.

Navigate to the Client Setup > Billing Setup layout for the client.



- (1) Enter the client co-pay amount in the Client Session Fee/Co-pay field, and (2) enter the full fee in the Insurance Session Charge field. (3) Enter the amount you expect to receive from the insurance company in the Insurance Share Expected field. (4) Select "Yes" for Bill Insurance to include this client when performing batch insurance billing. Be sure that you have entered a diagnosis under the Treatment Setup tab.

Navigate to the client's Account layout, then click on the Insurance Account toolbar button to view the client's Insurance Account.



The "Insurance Account" toolbar button lets you toggle between the client's account and the insurance account. It changes to "Client Account" when you are viewing the insurance account.

Review the insurance account and the dates for the transactions to be included in the insurance claim.

**Client's Insurance Account is being viewed**

### Insurance Account

Master Settings | Reports | Quit

Previous Client | Next Client | New Transaction | Delete Transaction | Client Account | Show Notes

**Temple Family** Re-create Insurance Charges

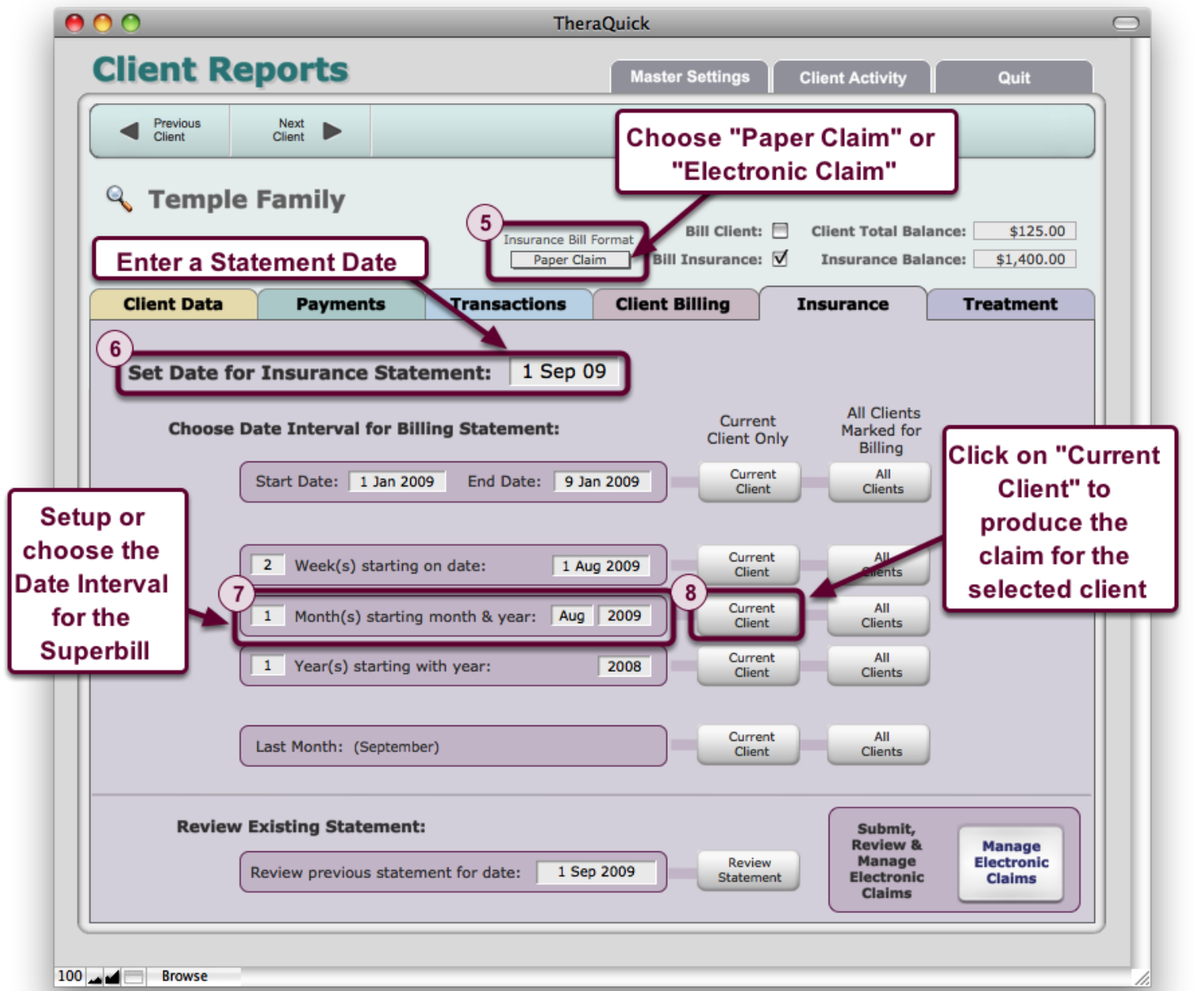
Client ID: 3 | Status: Active | Therapist: Siggy Freud | Bill Insurance:  | Insurance Balance: **\$1,400.00**

Contact		Setup	Sessions	Insurance	Treatment			
Transaction Date	CPT Code	Transaction Description	Check #	Total Charge	Insurance Share	Insurance Payment	Insurance Billed	Statement Date
6 Jan 09	90801	Diagnostic Interview Exam		\$250.00	\$200.00		<input checked="" type="checkbox"/>	1 Mar 09
13 Jan 09	90887	Consultation with Family		\$125.00	\$100.00		<input checked="" type="checkbox"/>	1 Mar 09
20 Jan 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input checked="" type="checkbox"/>	1 Mar 09
27 Jan 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input checked="" type="checkbox"/>	1 Mar 09
3 Feb 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input checked="" type="checkbox"/>	1 Mar 09
10 Feb 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input checked="" type="checkbox"/>	1 Mar 09
17 Feb 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input checked="" type="checkbox"/>	1 Mar 09
24 Feb 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input checked="" type="checkbox"/>	1 Mar 09
5 Aug 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input type="checkbox"/>	
12 Aug 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input type="checkbox"/>	
19 Aug 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input type="checkbox"/>	
26 Aug 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input type="checkbox"/>	
4 Sep 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input type="checkbox"/>	

**None of these transactions have been included in a billing statement yet**

The full session charge will be entered in the Total Charge column, with the amount you expect to receive in the Insurance Share column. A checkmark will appear for transactions that have already been billed. None have been billed yet in this example. Review the dates for the transactions to be included in the insurance claim. We will prepare a Paper Claim for the August transactions in this example. Note that the Insurance Balance reflects the balance based on the Insurance Share amounts.

Navigate to the Reports section, and choose the Insurance tab.



The screenshot shows the 'Client Reports' window for 'Temple Family' in the 'Insurance' tab. The interface includes navigation buttons for 'Previous Client' and 'Next Client', and tabs for 'Client Data', 'Payments', 'Transactions', 'Client Billing', 'Insurance', and 'Treatment'. The 'Insurance' tab is active, showing fields for 'Insurance Bill Format' (set to 'Paper Claim'), 'Bill Client' (unchecked), 'Bill Insurance' (checked), 'Client Total Balance' (\$125.00), and 'Insurance Balance' (\$1,400.00). A callout box (5) points to the 'Insurance Bill Format' dropdown. Below, the 'Set Date for Insurance Statement' is set to '1 Sep 09' (callout 6). The 'Choose Date Interval for Billing Statement' section has 'Start Date' (1 Jan 2009) and 'End Date' (9 Jan 2009). Underneath, there are options for 'Week(s)', 'Month(s)', and 'Year(s)'. Callout (7) points to the 'Month(s)' selection (1 month starting in August 2009). To the right, there are buttons for 'Current Client' and 'All Clients' for each interval. Callout (8) points to the 'Current Client' button for the month interval. A separate callout box (8) says 'Click on "Current Client" to produce the claim for the selected client'. At the bottom, there is a 'Review Existing Statement' section with a date field set to '1 Sep 2009' and buttons for 'Review Statement', 'Submit, Review & Manage Electronic Claims', and 'Manage Electronic Claims'. A callout box (7) says 'Setup or choose the Date Interval for the Superbill' pointing to the month interval selection.

(5) Be sure that "Paper Claim" or "Electronic Claim" is selected as the Insurance Bill Format. (6) Enter the statement date for the claim. (7) Choose the date interval that includes the desired transactions (August in this example). (8) Click on "Current Client" to prepare the insurance statement only for the selected client, or click on "All Clients" to perform batch billing for all clients marked for insurance billing.

**Review the Insurance Claim**

Paper Claim
Page 1 of 1
Cancel Continue

1500

**Child Actress Insurance Co.**  
 99 Show Biz Blvd.  
 Bizi City, CA 99999

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

PICA

PICA

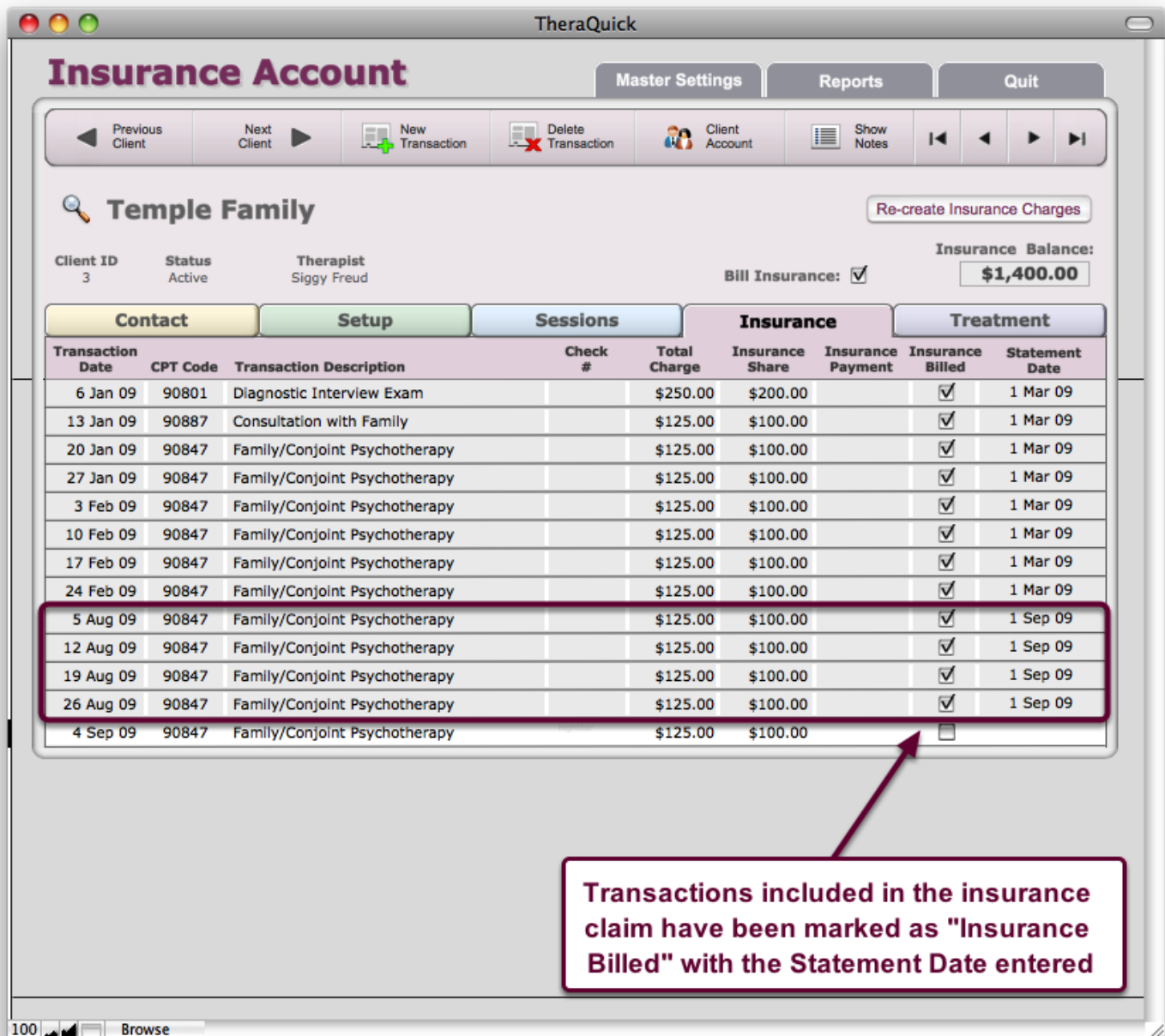
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (Other)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>XPD123ABE</b>																																																																																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Temple, Shirley A.</b>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Temple, George A</b>																																																																																
3. PATIENT'S BIRTH DATE MM DD YY <b>11 19 28</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. INSURED'S ADDRESS (No., Street) <b>7 Bloomsbury Lane</b>																																																																																
5. PATIENT'S ADDRESS (No., Street) <b>7 Bloomsbury Lane</b> CITY <b>Londonville</b> STATE <b>CN</b>	8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>																																																																																
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input checked="" type="checkbox"/> Other <input type="checkbox"/>	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																
7. PATIENT'S ZIP CODE <b>10101</b> TELEPHONE (Include Area Code) <b>(800) 555-3421</b>	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"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																																																
8. OTHER INSURED'S POLICY OR GROUP NUMBER	11. INSURED'S POLICY GROUP OR FECA NUMBER <b>B456789</b>																																																																																
9. OTHER INSURED'S DATE OF BIRTH MM DD YY _____ SEX <input type="checkbox"/> M <input type="checkbox"/> F	a. INSURED'S DATE OF BIRTH MM DD YY <b>01 01 10</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F																																																																																
10. EMPLOYER'S NAME OR SCHOOL NAME	b. EMPLOYER'S NAME OR SCHOOL NAME <b>Screen Actors Guild</b>																																																																																
11. INSURANCE PLAN NAME OR PROGRAM NAME	c. INSURANCE PLAN NAME OR PROGRAM NAME <b>PPO ACT</b>																																																																																
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 <b>Signature on File</b> DATE <b>9/1/09</b>	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																																																
13. 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 <b>Signature on File</b>	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 <b>Signature on File</b>																																																																																
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY/IMP _____ MM DD YY <b>01 06 09</b>	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY _____ 17a. _____ 17b. NPI _____																																																																																
16. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>Self-Referral</b>	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY _____ TO MM DD YY _____ 20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____																																																																																
19. 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. <b>299.1</b> 3. _____																																																																																
2. <b>309.4</b> 4. _____	22. MEDICAD RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____																																																																																
<table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th style="width: 10%;">A.</th> <th style="width: 15%;">B.</th> <th style="width: 10%;">C.</th> <th style="width: 15%;">D.</th> <th style="width: 10%;">E.</th> <th style="width: 10%;">F.</th> <th style="width: 10%;">G.</th> <th style="width: 10%;">H.</th> <th style="width: 10%;">I.</th> <th style="width: 10%;">J.</th> </tr> <tr> <th>DATE(S) OF SERVICE</th> <th>PLACE OF SERVICE</th> <th>EMG</th> <th>PROCEDURES, SERVICES, OR SUPPLIES</th> <th>DIAGNOSIS</th> <th>\$ CHARGES</th> <th>DATE OF URS</th> <th>PROF. FEE</th> <th>ID. QUAL.</th> <th>RENDERING PROVIDER ID #</th> </tr> </thead> <tbody> <tr> <td>08 05 09</td> <td>11</td> <td></td> <td>90847</td> <td>1,2</td> <td>125 00</td> <td>1</td> <td></td> <td></td> <td>NPI 1012223333</td> </tr> <tr> <td>08 12 09</td> <td>11</td> <td></td> <td>90847</td> <td>1,2</td> <td>125 00</td> <td>1</td> <td></td> <td></td> <td>NPI 1012223333</td> </tr> <tr> <td>08 19 09</td> <td>11</td> <td></td> <td>90847</td> <td>1,2</td> <td>125 00</td> <td>1</td> <td></td> <td></td> <td>NPI 1012223333</td> </tr> <tr> <td>08 26 09</td> <td>11</td> <td></td> <td>90847</td> <td>1,2</td> <td>125 00</td> <td>1</td> <td></td> <td></td> <td>NPI 1012223333</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> </tbody> </table>	A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	DATE(S) OF SERVICE	PLACE OF SERVICE	EMG	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS	\$ CHARGES	DATE OF URS	PROF. FEE	ID. QUAL.	RENDERING PROVIDER ID #	08 05 09	11		90847	1,2	125 00	1			NPI 1012223333	08 12 09	11		90847	1,2	125 00	1			NPI 1012223333	08 19 09	11		90847	1,2	125 00	1			NPI 1012223333	08 26 09	11		90847	1,2	125 00	1			NPI 1012223333										NPI										NPI	24. FEDERAL TAX I.D. NUMBER <b>11-222333</b> SSN EIN <input checked="" type="checkbox"/>
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25. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____	26. PATIENT'S ACCOUNT NO. _____ 27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																																																
28. SERVICE FACILITY LOCATION INFORMATION <b>Sigmund Freud PhD</b> Shrink-N-Think Analysis 99 Comfy Couch Court Shrinkville, NY 10000 a. <b>1012223333</b> b. _____	29. TOTAL CHARGE \$ <b>500 00</b> 29. AMOUNT PAID \$ _____ 30. BALANCE DUE \$ _____ 31. BILLING PROVIDER INFO & PH # <b>(866) 111-2222</b> <b>Sigmund Freud PhD</b> Shrink-N-Think Analysis 99 Comfy Couch Court Shrinkville, NY 10000 a. <b>1012223333</b> b. _____																																																																																

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

If you chose a Paper Claim, TheraQuick presents you with a sample of the insurance claim as it would look when printed (the buttons and page navigation information will not be printed). You can edit the entries for the Line 12 Signature and Date, and the Line 13 Signature on this layout. Click "Continue" to proceed with saving or printing the claim. You will be offered the choice of printing onto plain paper (TheraQuick will print the red form background in addition to the data), or onto

a pre-printed red CMS-1500 form (TheraQuick will print only the data and not the form background). If you created an electronic claim, the Manage Electronic Claims window will open, and the claim will be added to the Pending Claims list. You can review it by clicking on the claim number.

**Optional: Return to the client's insurance account to see the updated information.**



**Insurance Account**

Client: Temple Family  
 Client ID: 3, Status: Active, Therapist: Siggie Freud  
 Insurance Balance: \$1,400.00  
 Bill Insurance:

Transaction Date	CPT Code	Transaction Description	Check #	Total Charge	Insurance Share	Insurance Payment	Insurance Billed	Statement Date
6 Jan 09	90801	Diagnostic Interview Exam		\$250.00	\$200.00		<input checked="" type="checkbox"/>	1 Mar 09
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4 Sep 09	90847	Family/Conjoint Psychotherapy		\$125.00	\$100.00		<input type="checkbox"/>	

Transactions included in the insurance claim have been marked as "Insurance Billed" with the Statement Date entered

The transactions that were included in the claim are now marked as "Insurance Billed" in the insurance account and the Statement Date you selected has been entered in the transaction record.