

Instructions for submitting a secondary claim with Coordination of Benefits (COB) information using Office Ally

Step 1. Check the box in top left corner indicating that this is a secondary claim.

Health Insurance Claim Form

Load Stored Info

This is a SECONDARY Claim
 (Note: You must have EOB/ERA from Primary Insurance to complete this form)

Secondary Payer Name:	<input type="text"/>	...	OA Payers
Address / Payer ID:	<input type="text"/>		
2 nd Address:	<input type="text"/>		
City, State, Zip:	<input type="text"/>	<input type="text"/>	<input type="text"/>

HEALTH INSURANCE CLAIM FORM										
1. MEDICARE <input type="radio"/> (Medicare #)	MEDICAID <input type="radio"/> (Medicaid #)	CHAMPUS <input type="radio"/> (Sponsor's SSM)	CHAMPVA <input type="radio"/> (VA File #)	GROUP HEALTH PLAN <input type="radio"/> (SSN OR ID)	FECA BLK LUNG <input type="radio"/> (SSM)	OTHER <input checked="" type="radio"/> (ID)	1a. INSURED'S I.D. NUMBER <input type="text"/>			
2. PATIENT'S NAME (Last Name, First Name, Middle Init) Last: <input type="text"/> First: <input type="text"/> MI: <input type="text"/>			3. PATIENT'S BIRTHDATE <input type="text"/>		SEX M <input type="radio"/> F <input type="radio"/>	4. INSURED'S NAME (Last Name, First Name, Middle Init) Last: <input type="text"/> First: <input type="text"/> MI: <input type="text"/>				
5. PATIENT'S ADDRESS (No. Street): <input type="text"/>			6. PATIENT RELATIONSHIP TO INSURED Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other <input type="radio"/>		7. INSURED'S ADDRESS (No. Street) <input type="text"/>					
CITY <input type="text"/>		STATE <input type="text"/>	8. PATIENT'S STATUS Single <input type="radio"/> Married <input type="radio"/> Other <input type="radio"/>			CITY <input type="text"/>		STATE <input type="text"/>		
ZIP CODE <input type="text"/>		TELEPHONE <input type="text"/>			Employed <input type="radio"/> Full-Time Student <input type="radio"/> Part-Time Student <input type="radio"/>		ZIP CODE <input type="text"/>			
9. PRIMARY INSURED'S NAME (Last Name, First Name, Middle Init) Last: <input type="text"/> First: <input type="text"/> MI: <input type="text"/>			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="radio"/> Yes <input type="radio"/> No				11. INSURED'S POLICY GROUP OR FECA NUMBER <input type="text"/>			
PRIMARY INSURED'S ADDRESS (No. Street): <input type="text"/>			b. AUTO ACCIDENT? PLACE (State) <input type="radio"/> Yes <input type="radio"/> No <input type="text"/>				a. INSURED'S DATE OF BIRTH <input type="text"/>			
CITY <input type="text"/>		STATE <input type="text"/>	ZIP CODE <input type="text"/>			c. OTHER ACCIDENTS? <input type="radio"/> Yes <input type="radio"/> No		SEX M <input type="radio"/> F <input type="radio"/>		
a. PRIMARY INSURED'S POLICY OR GROUP NUMBER <input type="text"/>			b. EMPLOYER'S NAME OR SCHOOL NAME <input type="text"/>				b. EMPLOYER'S NAME OR SCHOOL NAME <input type="text"/>			
b. PRIMARY INSURED'S DATE OF BIRTH <input type="text"/>		SEX M <input type="radio"/> F <input type="radio"/>	c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>				c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>			
c. EMPLOYER'S NAME OR SCHOOL NAME <input type="text"/>			10d. RESERVED FOR LOCAL USE <input type="text"/>				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="radio"/> NO <input checked="" type="radio"/> If yes, return to and complete item 9 a-d			
d. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>							13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE <input type="text"/>			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <input type="text"/>										

Step 2. Complete all required fields and input stored information, including primary insurance information, in fields 9, 9a, 9b, 9c, 9d, and 11d.

Step 3. Complete the diagnosis, line items, and charges fields.

d. INSURANCE PLAN NAME OR PROGRAM NAME		10a. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="radio"/> NO <input checked="" type="radio"/> <i>If yes, return to and complete item 9 a-d</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
SIGNED <input checked="" type="radio"/> Yes <input type="radio"/> No DATE 06 06 2009		17a. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		SIGNED <input checked="" type="radio"/> Yes <input type="radio"/> No	
14. DATE OF CURRENT:		17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> TO <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> TO <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		20. OUTSIDE LAB? <input type="radio"/> YES <input checked="" type="radio"/> NO	
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)		22. MEDICAID RESUBMISSION CODE	
		1. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 5. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 7. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		ORIGINAL REF. NO	
		2. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 6. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 8. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		23. PRIOR AUTHORIZATION NUMBER	
				<input type="text"/>	
24. A.		B. C. D. PROCEDURES, SERVICES, OR SUPPLIES		E.	
From: DATE(S) OF SERVICE To:		Place Of Service EMG CPT/HCPCS A MODIFIER B C D DIAGNOSIS POINTER		\$ CHARGES Days Or Units EPSDT Family Plan ID QUAL RENDERING PROVIDER ID. #	
1 Line Level Note: <input type="text"/>		Anesthesia Times: Start <input type="text"/> Stop <input type="text"/> NDC Code: <input type="text"/>		PIN: <input type="text"/>	
<input type="text"/>		<input type="text"/>		NPI: <input type="text"/>	
2 Line Level Note: <input type="text"/>		Anesthesia Times: Start <input type="text"/> Stop <input type="text"/> NDC Code: <input type="text"/>		NPI: <input type="text"/>	
<input type="text"/>		<input type="text"/>		NPI: <input type="text"/>	
3 Line Level Note: <input type="text"/>		Anesthesia Times: Start <input type="text"/> Stop <input type="text"/> NDC Code: <input type="text"/>		NPI: <input type="text"/>	
<input type="text"/>		<input type="text"/>		NPI: <input type="text"/>	
4 Line Level Note: <input type="text"/>		Anesthesia Times: Start <input type="text"/> Stop <input type="text"/> NDC Code: <input type="text"/>		NPI: <input type="text"/>	
<input type="text"/>		<input type="text"/>		NPI: <input type="text"/>	
5 Line Level Note: <input type="text"/>		Anesthesia Times: Start <input type="text"/> Stop <input type="text"/> NDC Code: <input type="text"/>		NPI: <input type="text"/>	
<input type="text"/>		<input type="text"/>		NPI: <input type="text"/>	
6 Line Level Note: <input type="text"/>		Anesthesia Times: Start <input type="text"/> Stop <input type="text"/> NDC Code: <input type="text"/>		NPI: <input type="text"/>	
<input type="text"/>		<input type="text"/>		NPI: <input type="text"/>	
7 Line Level Note: <input type="text"/>		Anesthesia Times: Start <input type="text"/> Stop <input type="text"/> NDC Code: <input type="text"/>		NPI: <input type="text"/>	
<input type="text"/>		<input type="text"/>		NPI: <input type="text"/>	
8 Line Level Note: <input type="text"/>		Anesthesia Times: Start <input type="text"/> Stop <input type="text"/> NDC Code: <input type="text"/>		NPI: <input type="text"/>	
<input type="text"/>		<input type="text"/>		NPI: <input type="text"/>	
9 Line Level Note: <input type="text"/>		Anesthesia Times: Start <input type="text"/> Stop <input type="text"/> NDC Code: <input type="text"/>		NPI: <input type="text"/>	
<input type="text"/>		<input type="text"/>		NPI: <input type="text"/>	

Step 4. Complete the lower section with information from the primary EOB/ERA. If Medicare is not the primary EOB/ERA, leave “Insurance Type Code” as “select one.”

25. FEDERAL TAX I.D. NUMBER: SSN: EIN:

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE: \$

29. AMOUNT PAID: \$

30. BALANCE DUE: \$

Date Of Initial Treatment: (mm/dd/yyyy) / /

Date Last Seen: (mm/dd/yyyy) / /

Supervising Physician:

Supervising Physician NPI:

Supervising Physician ID:

Ordering Physician: (Last, First, MI)

Ordering Physician NPI:

Ordering Physician ID:

CLIA:

Accident Date: / /

Mammography Certificate:

32. SERVICE FACILITY LOCATION AND INFORMATION

Facility Name:

Address:

City:

State:

Zip:

33. BILLING PROVIDER INFO. & PHONE #

Billing Provider:

Address:

City:

State: Zip:

Telephone: ()

Rendering Provider:

(Last, First, MI)

Provider Specialty:

Provider PIN#: (please see box 24J)

a. NPI: b. Facility ID:

a. Billing/Group NPI: b. Billing/Group No.:

ID QUAL:

SECONDARY CLAIM: FILL IN INFORMATION FROM PRIMARY EOB/ERA HERE

PRIMARY PAYER NAME:

PRIMARY PAYER ID:

INSURANCE TYPE CODE: 12 - Medicare Secondary, Working Aged Beneficiary or Spouse with Employer Group Health Plan

LINE ITEMS INFORMATION

LINE NO.	ALLOWED AMOUNT	PRIMARY PAYER PAYMENT AMOUNT	ADJUDICATION DATE	REASONS (Enter exactly as they appear on ERA 835 report)			click [+] for more adjustments...
				GROUP CODE	AMOUNT	REASON CODE	
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
7	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
8	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
9	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
11	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
12	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...

Tip: If the primary insurance has an adjustment amount and a patient responsibility amount, you will need to click the plus sign to list more than one reason code field. Use the grey dotted boxes to bring up drop-down menus of code choices.

REASONS (Enter exactly as they appear on ERA 835 report)

GROUP CODE	AMOUNT	REASON CODE	
<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...
<input type="text"/>	<input type="text"/>	<input type="text"/>	click [+] for more adjustments...

Step 5. When all information is complete, click *update* to submit the form.