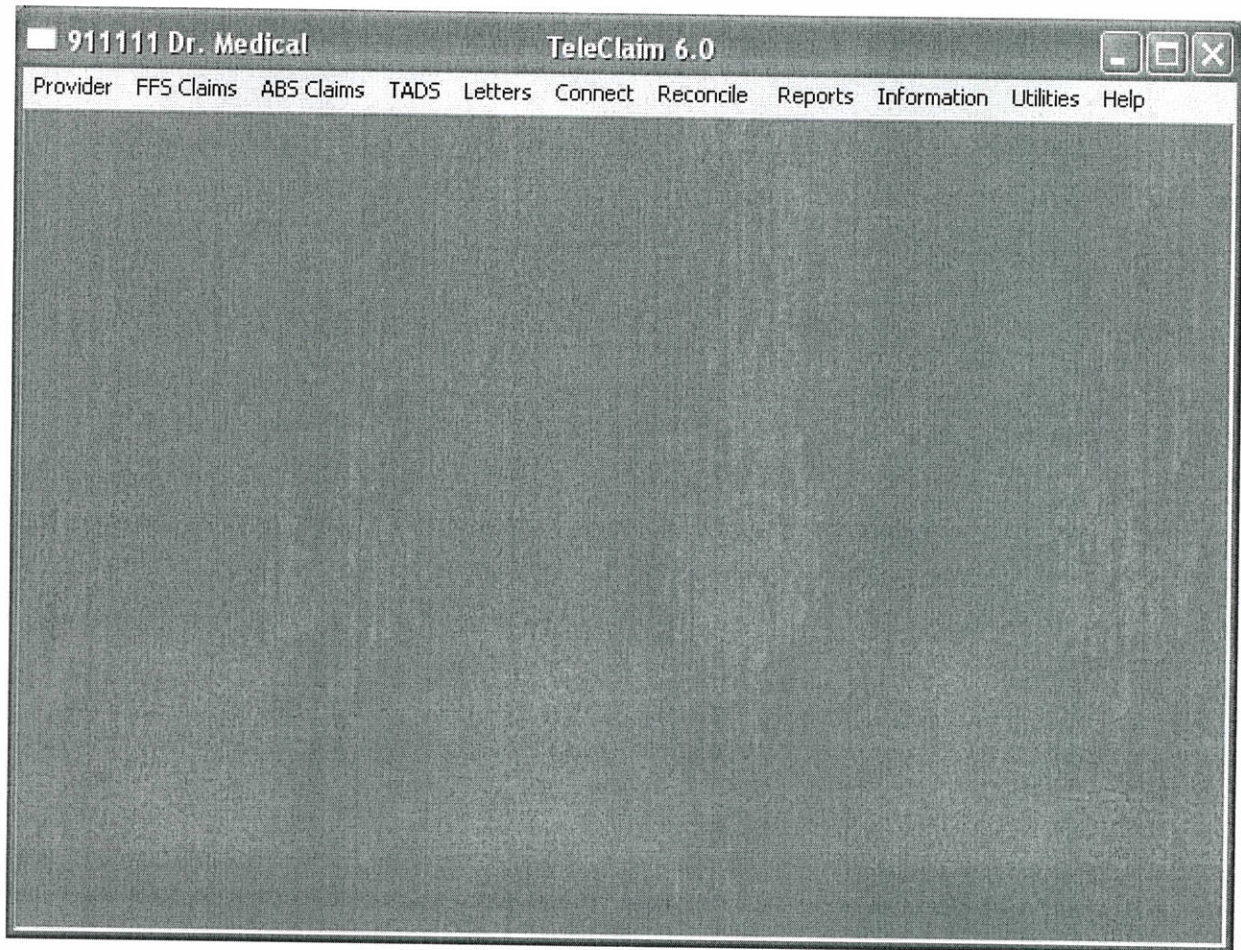


MAIN MENU

Main Menu



From this menu you can access all of the features of TeleClaim. All eleven (11) options on this menu have sub menus. To select an option, click on the heading and a list will appear under the chosen option. To select one of the sub menus, click on the desired one.

First time users should note that Provider defaults can be set before entering any claim information. See [Provider Defaults](#) on the [Information Menu](#).

Menu Options:

- [Provider](#)
- [FFS Claims](#)
- [ABS Claims](#)
- [TADS](#)
- [Letters](#)
- [Connect](#)
- [Reconcile](#)
- [Reports](#)
- [Information](#)
- [Utilities](#)

INFORMATION MENU

➤ PROVIDER DEFAULTS

➤ PATIENTS

➤ FEE SCHEDULES

➤ COPY FEE SCHEDULES

➤ HOSPITALS

➤ DIAGNOSTIC CODES

➤ REMARKS CODES

Add/Remove Providers

If you have requested an update to your TeleClaim system to add or remove providers, an update file will be created by MCP and placed in your folder on our transmission system.

When you connect to MCP, this file will be automatically transmitted to your machine in the same manner as TAD and remittance files.

After receiving an update file, you must exit TeleClaim then open it again to apply the update. Messages will be displayed indicating providers being added and/or removed, and then the list of providers in your TeleClaim system will be displayed. Check the list to ensure it has been properly updated.

Listed below is the information required to add and remove providers.

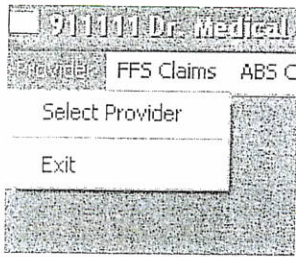
To add providers to your copy of TeleClaim:

An Electronic Billing Application must be completed for each provider being added to your TeleClaim software. An Electronic Claims Submission Application is available from MCP via mail or fax, or online at www.gov.nl.ca/mcp in the Forms section. The completed application(s) can be mailed or faxed to MCP.

To remove providers from your copy of TeleClaim:

To remove providers, call MCP Operations at 758-1530. Before any providers are removed, it is recommended that as much data as possible be purged that is specific to the provider, using the various purge options on the *Utilities Menu*. **Do not purge patients, as the patient records are shared by all providers in TeleClaim.**

Provider Menu



From this menu you can select a Provider or Exit the application. A brief description of each option is listed below. Each option is described in detail in the following sections.

Select Provider

Use this option to select a Provider.

Exit

Closes TeleClaim.

Patient Purge

This option is used to delete Patients from the Patient master file. Run this option occasionally to remove Patients who have not had a visit in some time.

There is only one Patient master file in your TeleClaim system, which is shared by all Providers. It does not matter which Provider you are currently working with when you run this option.

Depending on the microcomputer you have and the number of records in your Patient master file, this option may take some time to run.

This option purges Patients based on the LAST SERVICE DATE of the patient. A default date of five (5) years will be used when this option is selected. This can be changed to any date. Any patient with a last service date before the date entered will be deleted.

To perform the purge, click on *Utilities - Patient Purge*. If there are no patients to be purged, a message box will appear to inform you. If there are patients to be purged a message box will appear asking you to enter a date or accept the default date. Next, you will be told how many patients will be deleted and asked to confirm that you would like to continue. If Yes is chosen, when the purge is complete, a message box will appear saying the purge is complete. If No is chosen, the purge will be canceled and a message box will appear to inform you the purge has been canceled.

Fee Schedule

The screenshot shows a window titled "Fee Codes: 911111 Dr. Medical". Inside the window, there are several input fields and buttons. The fields are: "Fee Code:" with a text box, "Fee Amount:" with a text box, "Premium Percent:" with a text box followed by a "%" symbol, "Fee Description:" with a large text area, "New Fee Amount:" with a text box, and "Date Effective:" with a text box. To the right of the "Fee Code:" field is a checkbox labeled "ABS Fee:". Below the "Date Effective:" field are two radio buttons, one labeled "Medical" and one labeled "Dental". On the right side of the window, there are three buttons: "Delete", "Save", and "Close".

This screen displays the Fee Code information and is used to add, change and/or delete Fee Codes and Fee Amounts.

Fields:

Fee Code: A unique number assigned to each service or procedure as shown in the *MCP Payment Schedule*.

Dental Providers please note that the two (2) digit High Frequency codes cannot be used in the TeleClaim system. Any claims containing these codes will be rejected.

Regular Fee Codes and premium/co-pay codes can be set. For Medical, SHV types may also be set in this option.

ABS Fee: Check this field if the fee code is a Alternate Billing Fee Code.

Fee Amount: The fee amount or the premium amount for one unit of this service. See the *MCP Payment Schedule* to determine which amount is appropriate for you.

Premium Percent: The premium percent for a specific procedure premium codes. A percentage, instead of an amount may be set for premium codes that are claimed as a percentage of a fee amount.

When a Fee Code and amount are entered on a claim screen, and a premium code that has a percentage are entered on the SAME claim, the premium amount is calculated, based on the fee amount, and automatically entered into the premium amount field. If the Premium amount has been set as an amount, that amount will be entered into the Premium amount field.

Fee Description: A description of the Fee. Note that the description does not have to match the Fee Code description in the *MCP Payment Schedule*. It can be user defined to something more meaningful, if appropriate.

New Fee Amount: If a new fee amount is coming into effect, you can update the Fee Code amount by putting the new amount in this field.

Date Effective: The date the new fee amount is in effect. This date is used to determine which fee amount to use when a new claim is added if a new fee amount is entered in the Fee Code file.

The date can be entered in several ways. For example, January 19, 2000 can be entered in

the following ways and default to the format YYYY/MM/DD:

20000119

0119

2000/01/19

01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

Medical:

Click this field if the Fee Code is Medical. **Displayed only for a Provider who can bill both Medical and Dental claims.** A code can be medical OR dental, not both.

Dental:

Click this field if the Fee Code is Dental. **Displayed only for a Provider who can bill both Medical and Dental claims.** A code can be medical OR dental, not both.

Command
Buttons:

Delete

allows you to remove the fee code shown on the screen. A dialogue box will appear asking you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

Save

saves the information on the current screen and then clears the screen. This will be enabled when data is entered on the screen or a change is made to the screen.

Close

closes the current screen. This will be enabled if no changes are made to the current screen.

Cancel

does not save any changes to the current screen. A dialogue box will appear confirming whether or not you wish to cancel. This will be enabled when a change is made to the current screen.

Fee Schedules

Medical Fee Codes - 9/11/11 Dr. Medical

Sort By: Find

Fee Code:

Fee Description:

Find

Fee Code	Fee Amount	%	Description	New Fee Amt	Date Eff
79	\$18.70		Visit premium, extra patient, midnight to 08:00am	\$29.36	2004/01/01
90	\$14.25		Premium ER or OPD without sacrifice of office h	\$14.28	0200/01/01
91	\$28.50		Prem OPD or ER special visit with sacrifice of off	\$28.48	2004/01/01
92	\$28.50		Premium on ER or OPD visit 6pm to midnight, Sui	\$40.04	2004/01/01
93	\$42.80		Premium visit between midnight and 8 am.	\$60.08	2004/01/01
96	\$8.15		ER/OPD eout sacrifice Mon to Sat 2nd patient	\$8.12	2004/01/01
97	\$12.20		extra pt on ER Mon- Sat 8 am -61pm withsacrific		
98	\$12.20		Ex.Pt. Premium OPD/ER 6pm -midnight, Sunda	\$19.52	2004/01/01
99	\$18.70		Premium Extra patient ER or OPD midnight to 8	\$29.36	2004/01/01
101	\$53.75		Consultation	\$55.40	2004/01/01
121	\$18.87		Partial assessment	\$25.00	2004/01/01

This screen is used to add, change and/or delete Medical, Dental and Alternate Billing Fee Codes, including Premium and Co-Pay Codes. Medical users can also set subsequent hospital visit (SHV) types. A Fee Code file is not included with TeleClaim because of the large number of codes. Note that you will have to update these Fee Codes when a new payment (fee) schedule comes into effect. It is recommended that only the more frequently used codes be entered.

Each Provider has his/her own Fee Code file. Therefore, the Fee Codes must be set for each Provider individually. However, if you have more than one Provider that use mostly the same Fee Codes, you can copy the Fee Code file from one Provider to another. See the [Information Menu - Copy Fee Schedule](#) for more details.

When codes are set in the Fee Code file and they are used in a claim, the fee claimed amount will automatically be entered on the claim for you when the number of units is entered. You can change the amount on an individual claim, if required. Some Premium codes can be set as a percentage, instead of a specific amount.

When entering claims you can also browse the [Fee Schedules](#) screen. See help on [Dental Claims](#) or [Medical Claims](#) for more details.

To Add a Fee, click . To change or delete a Fee, highlight the fee in the grid list and click or .

Sort Criteria: A sort can be done on Fee Code or Fee Description. Sorts will be in ascending order.

When the screen is first displayed, it is sorted in Fee Code.

To change the sort order, click on the radio button  next to the desired sort field.

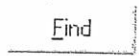
**Sort/Search
Criteria:**

A search can be done on Fee Code and/or Fee Description.

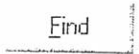
If the Fee Code that you enter is not found, TeleClaim will display codes greater than or equal to the search criteria.

A search on Fee Description will display all records containing the search criteria. If no matches are found, the list will be empty.

To perform a search, enter the desired code or description in the associated text box and click



When starting a new search, it is recommended you clear all the search fields and press



to get a complete list.

Fields:

Fee Code: A unique number assigned to each service or procedure as shown in the *MCP Payment Schedules*.

Fee Amount: The fee or premium fee associated with a given Fee Code.

%: The Premium percent associated with selected Premium Codes.

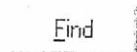
Fee Description: A description Service or Procedure.

New Fee Amt: If a new fee amount is coming into effect, the new amount will be displayed here.

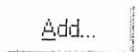
Date Eff:

The date the new fee amount is in effect. This date is used to determine which fee amount to use when a new claim is added if a new fee amount is entered in the Fee Code file. It can be entered in the format of YYYY/MM/DD, MM/DD (ex. 12/31 will default the current year and display as 1999/12/31) or M/D (ex. 3/18 will default the current year and display as 1999/03/18). Spaces are not allowed.

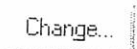
**Command
Buttons:**



allows you to search for a desired search criteria in the grid list.



brings you to the Fee entry screen.



allows you to modify the highlighted fee.

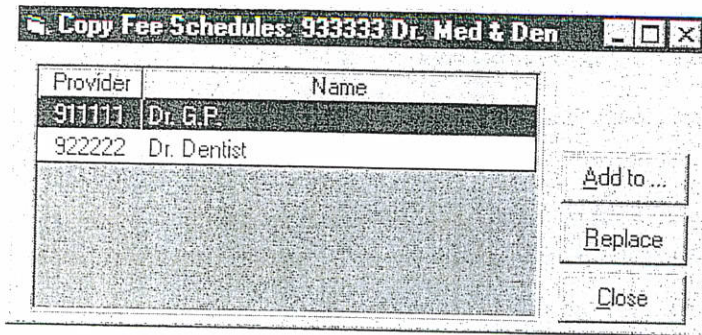


allows you to remove the highlighted fee code. A dialogue box will appear asking you to confirm the Delete.



closes the current screen.

Copy Fee Schedule



This screen lets you copy the Fee Code information from one Provider to another.

This is a useful option when you are setting up a new TeleClaim system that contains several Providers who use many of the same Fee Codes. You can set the Fee Codes for one of the Providers, and then copy the file to the other Provider.

This option is also useful when you are adding a new Provider to TeleClaim who uses many of the same Fee Codes as on of the Providers already set on your system.

When you select this option, a screen will appear showing a list of the Providers on this system. Highlight the Provider from whom you wish to copy the Fee Code file and either click Add to ... or Replace depending on the desired outcome.

If Add to ... is chosen, a message box will appear asking you to confirm if you would like to add the Fee Codes from the Provider chosen to your Fee Code file. If you click Yes, then TeleClaim will copy all the Fee Codes from the Provider selected, while leaving any Fee Codes that already exist in the current Provider's file. If you click No, the action of copying the Fee Code file will be canceled. After adding, you should check your fee schedule file to determine if you have the correct fee codes and fee amounts.

If Replace is chosen, a message box will appear asking you to confirm if you would like to replace your Fee Code file with the Fee Code file of the Provider chosen. If Yes is chosen, TeleClaim will replace all the Fee Code data for the current Provider with the Fee Code data of the Provider from whom you are copying. If No is chosen, the action of copying the Fee Code file will be canceled.

Columns:

Provider: The Provider number associated with the Fee Code file from which you are going to copy.

Name: The Provider name associated with the Fee Code file from which you are going to copy.

Command

Buttons: Add to ... Click Add to to add any Fee Codes from the highlighted Provider not already existing in the current Provider's list.

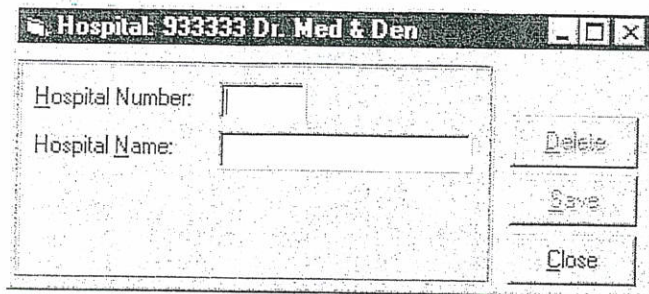
A message box will appear asking you to confirm if you would like to add the Fee Codes from the Provider chosen to your Fee Code file. If you click Yes, then TeleClaim will copy all the Fee Codes from the Provider selected, while leaving any Fee Codes that already exist in the current Provider's file. If you click No, the action of copying the Fee Code file will be canceled.

 Click *Replace* to remove any currently existing Fee Codes with all those of the highlighted provider.

A message box will appear asking you to confirm if you would like to replace your Fee Code file with the Fee Code file of the Provider chosen. If Yes is chosen, TeleClaim will replace all the Fee Code data for the current Provider with the Fee Code data of the Provider from whom you are copying. If No is chosen, the action of copying the Fee Code file will be canceled.

 Click *Close* to exit this screen and go back to the main TeleClaim screen.

Hospital



The screenshot shows a window titled "Hospital: 933333 Dr. Med & Den". Inside the window, there are two input fields: "Hospital Number:" and "Hospital Name:". To the right of these fields are three buttons: "Delete", "Save", and "Close".

This screen is used to add, change and/or delete hospital codes and hospital names.

Fields:

Hospital Number: A number assigned to each hospital or institution by MCP

Hospital Name: A name assigned to each hospital as provided in the *MCP Physicians Information Manual* or the *MCP Dentist Information Manual*.

Command Buttons:

Delete allows you to remove the hospital shown on the screen. A dialogue box will appear asking you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

Save saves the information on the current screen and then clears the screen. This will be enabled when data is entered on the screen or a change is made to the screen.

Close closes the current screen. This will be enabled if no changes are made to the current screen.

Cancel does not save any changes to the current screen. A dialogue box will appear confirming whether or not you wish to cancel. This will be enabled when a change is made to the current screen.

Hospitals

Code	Hospital Name
0234	Hospital 234
0272	Grace General Hospital
0456	Hospital 456
0567	Another Hospital
0678	Laura Wilkins Hospital
0800	Glenbrook Lodge
3433	Corner Brook Hosp
8765	Hospital 8765
9876	Hospital 9876

Buttons: Add..., Change..., Delete, Close

Used to add, change and/or delete hospital numbers and hospital descriptions. These hospital numbers are not included with TeleClaim.

There is only one hospital file for this practice, which is shared by all Providers.

When entering claims you can also browse the Hospitals screen. See help on Dental Claims or Medical Claims for more details.

To Add a hospital, click Add.... To change or delete a hospital, highlight the hospital in the grid list and click Change... or Delete.

Columns:

(Hospital) Code: A unique number assigned to each Hospital or institution by MCP.

Hospital Name: A name assigned to each Hospital.

Command Buttons:

Find allows you to search for a desired search item in the grid list.

Add... brings you to the hospital entry screen.

Change... allows you to modify the hospital highlighted in the grid list.

Delete allows you to remove the highlighted hospital code. A dialogue box will appear

asking you to confirm the Delete.

Close closes the current screen.

Diagnostic Codes

Code	Description
0001	CHOLERA
0002	TYPHOID AND PARATYPHOID FEVERS
0003	OTHER SALMONELLA INFECTIONS
0004	SHIGELLOSIS
0005	OTHER FOOD POISONING (BACTERIAL)
0006	AMOEBIASIS
0007	OTHER PROTOZOAL INTESTINAL DISEASES
0008	INTESTINAL INFECTIONS DUE TO OTHER ORGANISMS
0009	ILL-DEFINED INTESTINAL INFECTIONS
0010	TUBERCULOSIS - PRIMARY INFECTION
0011	TUBERCULOSIS - PULMONARY
0012	TUBERCULOSIS - OTHER RESPIRATORY
0013	TUBERCULOSIS - MENINGES AND CENTRAL NERVOUS S
0014	TUBERCULOSIS - INTESTINES, PERITONEUM AND MESE
0015	TUBERCULOSIS - BONES AND JOINTS
0016	TUBERCULOSIS - GENITOURINARY SYSTEM

This screen displays diagnostic codes and descriptions.

A diagnostic code file is provided with TeleClaim. There is only one diagnostic file, which is shared by all providers in this practice. These codes cannot be edited, added or deleted.

Sort Criteria: A sort can be done on Diagnostic Code or Description. Sorts will be in ascending order.

When the screen is first displayed, it is sorted by Diagnostic Code.

To change the sort order, click on the radio button  next to the sorted field

Search Criteria: A search can be done on Diagnostic Code and/or Description.

If a search is done on diagnostic code, it will display a code greater than or equal to the search criteria.

A search on diagnostic description will display all records containing the search criteria. If no matches are found, the list will be empty.

To perform a search, enter the desired code or description in the associated text box and click .

When starting a new search, it is recommended you clear all the search fields and press .

Find to get a complete list.

Fields:

Diagnostic Code: A unique number as per the Diagnostic Code Manual.

Description: A condensed description of the Diagnostic Code

Command

Buttons: Find allows you to search for a desired search item in the grid list.

Close closes the current screen.

Remark Codes

Code	Med/Den	Remark
01	Med	CODES 121 OR 421 WERE SEPARATE VISITS ON THIS DAY
02	Med	DILATION FOR RELIEF OF STRICTURE, NOT ACCESS
03	Med	BILATERAL PROCEDURE
04	Med	MULTIPLE SEPARATE VISITS NOT FOR CONTINUATION
05	Med	NECESSITATED BY EMERGENCY AS PER PREAMBLE 2.1.5A
06	Med	CAT SCAN OF ABDOMEN AND PELVIS
07	Med	COMPLIC. OF PREG. OR MED. COND. AFF. BY PREG.
08	Med	TWO SEPARATE ANAESTHETIC PROCEDURES ON THIS DATE
09	Med	TWO SEPARATE OPERATIVE SITTINGS THIS DATE
10	Med	SERVICE RENDERED VIA TELEVISION
11	Med	CAUDAL EPIMORPH
12	Med	EACH X-RAY WAS SINGLE EXAM
13	Med	EACH X-RAY REQUESTED OR NECESSARY
14	Med	EACH INDIVIDUAL X-RAY WAS NECESSARY

Used to add, change and/or delete remark codes and remark descriptions.

Remark codes are included with TeleClaim. However, you will have to maintain any changes made to the remark codes.

There is only one remark code file in your TeleClaim system, which is shared by all Providers.

Note that remarks descriptions are abbreviated versions of the complete descriptions. You can change these descriptions to something more meaningful if desired. See the *MCP Physicians Information Manual* or the *MCP Dentist Information Manual* for complete descriptions.

When entering claims you can browse the remark file. See help on Medical Claims or Dental Claims for more details.

To Add a remark, click . To change or delete a remark, highlight the remark in the grid list and click  or .

Fields:

Code: A unique number assigned to convey specific messages by MCP. Listed in the *Physician/Dentist Manual*.

Med/Den: Med - Medical Remark; Den - Dental Remark.

Remarks: A description of the Remark Code. Listed in the *Physician/Dentist Manual*.

Command Buttons:  brings you to the remark entry screen.

Change... allows you to modify highlighted remark in the grid list.

Delete allows you to remove the highlighted remark code. A dialogue box will appear asking you to confirm the Delete.

Close closes the current screen.

Remark Codes

Remarks: 933333 Dr. Med & Den

Code	Med/Den	Remark
01	Med	CODES 121 OR 421 WERE SEPARATE VISITS ON THIS DAY
02	Med	DILATION FOR RELIEF OF STRICTURE, NOT ACCESS
03	Med	BILATERAL PROCEDURE
04	Med	MULTIPLE SEPARATE VISITS NOT FOR CONTINUATION
05	Med	NECESSITATED BY EMERGENCY AS PER PREAMBLE 2.1.5A
06	Med	CAT SCAN OF ABDOMEN AND PELVIS
07	Med	COMPLIC. OF PREG. OR MED. COND. AFF. BY PREG.
08	Med	TWO SEPARATE ANAESTHETIC PROCEDURES ON THIS DATE
09	Med	TWO SEPARATE OPERATIVE SITTINGS THIS DATE
10	Med	SERVICE RENDERED VIA TELEVISION.
11	Med	CAUDAL EPIMORPH
12	Med	EACH X-RAY WAS SINGLE EXAM
13	Med	EACH X-RAY REQUESTED OR NECESSARY
14	Med	EACH INDIVIDUAL X-RAY WAS NECESSARY

Used to add, change and/or delete remark codes and remark descriptions.

Remark codes are included with TeleClaim. However, you will have to maintain any changes made to the remark codes.

There is only one remark code file in your TeleClaim system, which is shared by all Providers.

Note that remarks descriptions are abbreviated versions of the complete descriptions. You can change these descriptions to something more meaningful if desired. See the *MCP Physicians Information Manual* or the *MCP Dentist Information Manual* for complete descriptions.

When entering claims you can browse the remark file. See help on Medical Claims or Dental Claims for more details.

To Add a remark, click . To change or delete a remark, highlight the remark in the grid list and click or .

Fields:

Code: A unique number assigned to convey specific messages by MCP. Listed in the *Physician/Dentist Manual*.

Med/Den: Med - Medical Remark; Den - Dental Remark.

Remarks: A description of the Remark Code. Listed in the *Physician/Dentist Manual*.

Command Buttons: brings you to the remark entry screen.

Change... allows you to modify highlighted remark in the grid list.

Delete allows you to remove the highlighted remark code. A dialogue box will appear asking you to confirm the Delete.

Close closes the current screen.

To change the sort order, click on the radio button  next to the desired sort field.

**Search
Criteria:**

A search can be done on Patient Id and/or Last Name and/or Last Service Date

If the Patient Id or Name you enter is not found, the list will be empty. If the Last Service Date you enter is not found, TeleClaim will take you to the next date greater than the search date.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:

20000119

0119

2000/01/19

01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

To perform a search, enter the desired PIN, Last Name and/ Last Service Date in the associated text box and click .

When starting a new search, it is recommended you clear all the search fields and press  to get a complete list.

Fields:

Patient Id: Patient Identity Number.

Patient Name: The Patient's Surname and Given Names.

Last Service Date: The last date a service was billed for the patient.

Birth Date: The Patient's Birth Date

Sex: The Patient's Sex

Province: The Patient's Province.

**Command
Buttons:**

 brings you to the Patient information entry screen

 allows you to modify the highlighted Patient.

 allows you to remove the highlighted patient. A dialogue box will appear asking you to confirm the Delete.

 closes the current screen.

Patients

Patients: 911111 Dr. Medical

Sort By: Find

Patient ID: 111 111 111 111

First Name:

Last Name:

Last Service Date:

Find

Patient ID	Patient Name	Last Service Date	Birth Date	Sex	Prov
111 111 111 111	Smith Joe	2007/01/25	1977/12/01	M	MA

Add...

Change...

Delete

Close

Displays a list of all Patients. Used to add, change and/or delete Patient information in the Patient master file.

If the *Use Patient Master File* default is set to Y, the Patient master file is used for all Patients. See the *Claims - Provider* for details on this default.

There is only one Patient master file in your TeleClaim system, which is shared by all Providers.

Note that the Patient ID number (PIN) cannot be changed or removed from the Patient master file if there are any records in the Outstanding/History file or claims work files for that PIN.

To Add a Patient, click Add.... To change or delete a Patient, highlight the Patient in the grid list and click Change... or Delete.

When the screen first appears, there will be no data in the grid. To find a patient, either type in the Patient ID, Last Name or Last Service Date and click FIND. To view the entire patient file, click on one of the sort buttons.

Sort Criteria: A sort can be done on Patient Id ascending or Last Name or Last Service Date. Sorts will be in ascending order.

Phone No:

The Patient's telephone number.

OOP:

OOP indicator. This will be checked if the patient id is not a valid Newfoundland number..

Patient

History Data:

Claim #:

A seven (7) digit number given to a claim during batching.

Item #:

A two (2) digit number given to a claim during batching.

Service Date:

The date the Patient was seen by the Provider.

Fee Code:

A unique number assigned to each service or procedure as shown in the *MCP Payment Schedule*

Fee Claimed:

The amount claimed for the service.

Prem/Co-Pay

Code:

The premium or co-pay code.

Prem/Co-Pay

Claimed:

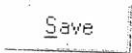
The premium or co-pay claimed.

Command

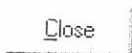
Buttons:

Delete

allows you to remove the patient shown on the screen. A dialogue box will appear asking you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

Save

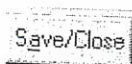
saves the information on the current screen and then clears the screen. This will not be visible when this screen is displayed for a claim that is being entered for a patient that is not in the patient master file.

Close

closes the current screen. This will be enabled if no changes are made to the current screen.

Cancel

does not save any changes to the current screen. A dialogue box will appear confirming whether or not you wish to cancel. This will be enabled when a change is made to the current screen.

Save/Close

saves the information on the current screen. This will be visible when this screen is displayed for a claim that is being entered for a patient that is not in the patient master file.

View Details...

allows you to browse History for the Patient currently displayed. You cannot browse or maintain the history file of another Patient from here. See *FFS Claims - History* on the main menu.

If the number entered is a valid Newfoundland number, the birth date, sex and prov code for the Patient is automatically entered on the screen.

If the number entered is a Newfoundland number and the OOP indicator is checked, verify that the Patient ID number entered is the same as on the Patient's MCP card. If they are the same, have the Patient contact MCP to have the number corrected.

The Patient's surname, given names, birth date, sex and prov code must be entered for both NF Patients and OOP (host) Patients.

Note that you cannot change the Patient ID number on a Patient record if there are claims in the Outstanding/History or the claims work files for that Patient ID number.

Surname: The Patient's Surname.

Given Names: The Patient's Given Names.

Birth Date: The Patient's birth date. Automatically entered if the Patient Id is a valid Newfoundland number.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:
20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Sex Code: Spaces are NOT allowed.

Prov Code: The Patient's Sex. Automatically entered if the Patient Id is a valid Newfoundland number.

The Province Code where the Patients MCP number was issued. If the Patient Id is a valid Newfoundland number, this field will be automatically entered.

File No: This field is provided to add file or chart numbers or other information about the patient.

If you wish to Terminate a Patient Id, enter the word "TERM" in this field. If this PIN is then used on a claim, a message will be displayed warning the user that the patient id is terminated.

Last Service Date: This is not a data entry field. This field is updated by TeleClaim when a claim is batched for a Patient. It will always show the service date of the last claim batched. When you initially set up a Patient on this screen, this field will be blank.

Address Line 1: The Patient's Address. Only required for mothers or guardians of Neonatal patients.

Address Line 2: The Patient's Address. Only required for mothers or guardians of Neonatal patients.

City/Town: The Patient's City or Town. Only required for mothers or guardians of Neonatal patients.

Province: The Patient's Province. Only required for mothers or guardians of Neonatal patients.

Postal Code: The Patient's Postal Code. Only required for mothers or guardians of Neonatal patients.

Patient

Patients: 911111 Dr. Medical

Patient ID: 111 111 111 111

Surname: SMITH

Given Names: Joe

Birth Date: 1977/12/01 Last Service Date: 2007/01/25

Sex Code: M

Prov Code: MA

File No:

Address Line 1:

Address Line 2:

City/Town:

Province:

Postal Code:

Phone No:

Patient History:

Claim #	Item #	Service Date	Fee
000123	1	2007/01/25	123

View Details...

Delete

Save

Close

OOP

This screen is used to add, change and/or delete Patient information. Also used to view a Patient's history.

Note that the Patient ID number (PIN) cannot be changed or removed from the Patient master file if there are records in History or claims work files for that PIN.

If the Patient is a Newfoundland Patient, then the birth date, sex and prov code for the Patient is automatically entered on the screen. You should verify if this information is accurate at time of entry. The PIN, surname, given name(s), birth date and sex code are mandatory and must be entered for Out of Province patients.

If the Patient is OOP, (from another province, not a valid Newfoundland PIN), you will be notified and an OOP indicator will be checked on the screen. OOP numbers cannot be used on Dental Claims.

To view the current Patient's history, highlight a claim in the grid list and click the **View Details...** button. This brings you to the history claim that Patient. To maintain the Patient's history, see FFS Claims - History on the main menu.

Fields:

Patient Id: Patient Identity Number.

TeleClaim will check the number entered to see if it is a valid Newfoundland number. An invalid Newfoundland number will be considered to be an Out of Province Patient and a message box will be displayed informing you, after data entry. A valid Newfoundland MCP number is 12 digits in length and passes a check digit routine performed by TeleClaim.

If yes is the default, then you will be required to enter data for each Patient the first time you enter a claim for the Patient. This is useful when you have a practice where the same Patients are being seen on a regular basis. Then each time a claim is entered for a Patient that has been set, the Patient's Name, Sex, Birth date and Province will be automatically entered on the claim screen. The Patient master file is prompted from the Patient Id when entering claims. If the Patient is not found, the Patient Information screen appears in order for you to add the new Patient to the Patient Master file.

If the default is set to No, the Patient Master file is prompted from the Patient id when entering claims. If the Patient is found, the Patient's Name, Sex, Birth Date and Province are displayed. If the Patient is not found, you may add the Patient to the Patient Master file by entering the Patient's name, Birth Date, Sex and Province Code on the Patient Information screen. OOP numbers cannot be used on Dental claims.

Starting
Claim No:

This is set in your software program by MCP. Sometimes it is necessary to change the starting claim number when problems occur. It is recommended that you not change the claim number unless you check with MCP first. Never change the claim number so that it is lower than either the number that is set in your system, or any number you have already used electronically. This could result in duplicate claim numbers, rejected claims and problems with the outstanding file.

Starting
Sequence
No:

The first sequence number you wish to use for batching. The default Starting Sequence No will only be used the first batch of each day.

Command
Buttons:

 saves the information on the current screen to a file in the database. This will be enabled when data is entered on the screen or a change is made to the screen.

 closes the current screen. This will be enabled if no changes are made to the current screen.

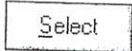
 does not save any changes to the current screen. A dialogue box will appear confirming whether or not you wish to cancel. This will be enabled when a change is made to the current screen.

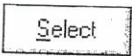
Select Provider

Provider	Name
922222	Dr. Dental

Select

Purpose: Displays a list of Providers in your system. If the Provider list does not contain all the Providers for your practice, contact MCP to request an update.

To select a Provider, highlight the desired Provider and press .

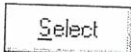
By clicking the  button, the screen closes and the main menu is displayed. Once a Provider is selected, any subsequent inquiries or processing will relate to that Provider only.

Fields:

Provider: The number assigned by MCP.

Provider Name: The name of the Provider.

Command

Buttons:  selects a Provider and closes the current screen.

Provider Defaults

Defaults: 911111 Dr. Medical

Diagnostic Code: 0456

Hospital Code: 0123

Capacity Code: 0 Surgeon/Attending Physician or Dentist

Referral Code: 1 Non-Referred

Payee Number: 911111

Use Patient Master File: Yes

Starting Claim No: 0000001

Starting Sequence No: 1

Save

Cancel

Used to add and/or change a Provider's defaults.

Defaults can be set for a Provider for certain system values. These defaults can be changed at any time. Defaults must be set individually for each Provider in the system.

Setting up certain Fee-for-Service defaults can save you time if certain values are used consistently when entering claims.

Diagnostic Code, Hospital Code, Capacity, Referral Code, Payee Number, Use Patient Master File, Starting Claim Number and Starting Sequence Number are all claims values that can be set as defaults. The default values will show up on every new Fee-for-Service Claim. You can set whichever defaults are appropriate for your practice. These values can be changed on any individual Fee-for-Service Claim, as required.

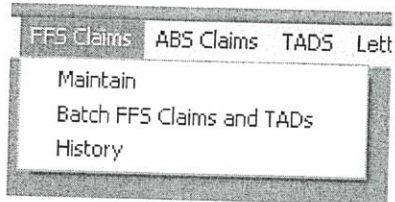
Fields:

- | | |
|--------------------------|--|
| Diagnostic Code: | A unique number as per the Diagnostic Code Manual. Should only be set for Radiologists. All other providers leave blank. |
| Hospital Code: | A unique number assigned to each Hospital by MCP. Only use if all your services are for a specific hospital, such as Radiologists. |
| Capacity Code: | A code associated with the capacity of the Provider. Valid values are 0, 1 and 3. |
| Referral Code: | A code indicating if the Patient was referred. Valid values are 1 and 2. |
| Payee: | A number assigned by MCP which is used to allow payment to another Provider or Institution. |
| Use Patient Master File: | This default must be set to either Yes or No. Note that the Patient master file is shared by all Providers on your TeleClaim system. |

FEE-FOR-SERVICE CLAIMS (FFS)

- **CLAIM MENU**
- **MEDICAL CLAIM**
- **MAINTAIN**
- **BATCH FFS CLAIMS AND TADS**
- **CLAIM HISTORY**
- **TADS—RETRIEVE**
- **TADS—MAINTAIN**
- **MEDICAL TAD**
- **TAD HISTORY**
- **TADS FILE PURGE**
- **TADS HISTORY PURGE**

FFS Claims Menu



From this menu you can perform all of the functions necessary for entering and updating Fee-for-Service Claims, batching Fee-for-Service Claims and TADS and viewing Fee-for-Service history. A brief description of each option is listed below. Each option is described in their individual sections.

Maintain

Select this option to add new Fee-for-Service claims and to change, delete and browse claims which have been keyed into the claims work files but have not been batched.

Batch FFS Claims and TADS

Select this option to batch Fee-for-Service claims and TADS for submission to MCP.

History

Select this option to browse outstanding and paid Fee-for-Service Claims, including reconciliation information, and to delete individual claims as required.

Medical Claim

Medical Claims: 911111 Dr. Medical

Patient ID: + OOP ☒ SHV ☐ Neonatal ☐

Surname: Birth Date: Surname:

Given Names: Prov: Birth Date:

Service Date: Sex: Sex:

I.C.

Diag. Code: +

Fee Code: +

Units: Fee Claimed: +

Prem Fee Code: +

Prem Fee Claimed:

Remarks: +

Capacity: +

Referral: +

Hospital No: +

Admission Date:

Payee Number:

Comments:

Patient History

Claim #	Item #	Service Date	Fee Code	Fee Claimed	Prem Code	Prem Amt

[View Details...](#)

[History](#)

[Delete](#)

[Save/Duplicate](#)

[Save](#)

[Close](#)

This screen is used to add, change or delete a Medical claim and to view a patient's history.

The Patient History grid will appear if you are changing a claim and if you click the button on an Add. To view a claim in the Patient's History, highlight the claim in the Patient History grid and click [History](#).

To maintain a Patient's history see [FFS Claims History](#) on the [FFS Claims Menu](#).

Fields:

Patient Id: The Patient Identity Number (PIN).

If you know the PIN of the patient you can key it here.

- If the Patient doesn't have a Newfoundland PIN you will be alerted that the PIN is for an Out of Province Patient.
- If the PIN already exists in [Patients](#) - the *Surname*, *Given Names*, *Birth Date*, *Sex* and *Prov* for the Patient fields will be automatically filled once you Tab out of the *Patient Id* field.
- If the PIN doesn't exist in the database you will receive an alert that more information is needed and the Patient screen will popup automatically.

If you do not know the PIN, you need to add a new Patient, or you wish to view further patient information (i.e. address) you can click the Plus Sign  next to *Patient Id* to access the [Patients](#) screen. For more information on this screen see the [Patients](#) topic in Help.

Once the PIN has been entered you should verify that *Surname, Given Names, Birth Date, Sex* and *Prov* automatically filled in is accurate. As well you should click on the Plus Sign  next to Patient Id to pop up the [Patients](#) screen to ensure patient contact information is up to date.

OOP: Indicates if the claim is for an Out of Province (Host) Patient. Will automatically be checked if TeleClaim determines that the number is not a valid Newfoundland number.

SHV: Indicates if the claim is for a Subsequent Hospital Visit. If checked, Service Date changes to First Date, Fee Code changes to Type of Visit, Units changes to Visits, Last Day appears, Prem Fee Code disappears and Prem Fee Claimed disappears. Hospital number MUST be entered for SHV. You can click the Plus Sign  next to this field to access the [Hospitals](#) screen or simply enter the Hospital Number directly on the screen.

Surname: The Patient's Surname. Will automatically be filled in if the Patient is in the [Patients](#) screen.

Birth Date: The Patient's Birth date. Will automatically be filled in if the Patient is in the [Patients](#) screen.

Given Names: The Patient's Given Names. Will automatically be filled in if the Patient is in the [Patients](#) screen.

Prov: The Patient's Province. Will automatically be filled in if the Patient is in the Patient Master file.

Service Date: The date the Patient was seen by the Provider. The default is the current date. This field can be overwritten but it must be less than or equal to the current date.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:

20000119

0119

2000/01/19

01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

Only claims with a Service Date less than 90 days old should be submitted to MCP. However, if a Provider does wish to submit an old claim, enter comments explaining why the claim is late. These claims will be reviewed by MCP staff to determine if claims will be accepted. If you have a number of older claims to submit, contact the Edit department at MCP for further information before entering claims.

Sex: The Patient's Sex. Will automatically be filled in if the Patient is in the Patient Master file.

Diag.Code: A unique number as per the Diagnostic Code Manual. If you have set a default Diagnostic Code in [Provider Defaults](#) on the [Information Menu](#), this field will automatically be filled in. You can overwrite this field with a different Diagnostic Code. If the Diagnostic Code entered

is in the Diagnostic Codes screen, the name associated with the Diagnostic Code will automatically be displayed. See Diagnostic Codes on the Information Menu. You can click the Plus Sign  next to this field to access the Diagnostic Codes screen. If the Diagnostic Code is not in the Diagnostic Codes screen you cannot add it to the file.

- Fee Code: A unique number assigned to each service or procedure as shown in the *MCP Payment Schedules*. If the Fee Code entered is in the Fee Schedule file, the description associated with the Fee Code will automatically be displayed. See Fee Schedules on the Information Menu. You can click the Plus Sign  next to this field to access the Fee Schedules screen. If the Fee Code is not in the Fee Schedules file you can add it to the file or simply add the Fee Code directly on the screen. Premium Codes must not be entered in this field.
- Units: Number of units claimed. Used to calculate the Fee Claimed. Default is one (1) but this field can be overwritten.
- Fee Claimed: The amount claimed for the service. If the Fee Code entered is in the Fee Schedules screen, this will be calculated upon pressing TAB on Units. This calculation will multiply the Units by the Fee Amount associated with the Fee Code and the result will show in this field. If the Fee Code entered is not in the Fee Schedules screen, you must enter the Fee Claimed directly on the screen. If the Fee Code is in the Fee Schedules screen but you wish to enter a fee amount different from the one associated with the code, you can do so directly on the *Medical Claims* screen.
- If Fee Claimed is calculated by TeleClaim from the Fee Schedule, and the claim is modified later by changing the number of units, TeleClaim will **not** recalculate the Fee Claimed. The new Fee Claimed will have to be recalculated manually and reentered.
- Prem Fee Code: A unique number assigned to each premium service as per *Medical MCP Payment Schedule*. If the Premium Fee Code entered is in the Fee Schedules screen, the description associated with the Premium Fee Code will automatically be displayed. See Fee Schedules on the Information Menu. You can click the Plus Sign  next to this field to access the Fee Schedules screen. If the Premium Fee Code is not in the Fee Schedules screen you can add it to the file or simply add the Premium Fee Code directly on the screen.
- Prem Fee Claimed: The Premium Amount for the service. If the Premium Fee Code entered is in the Fee Schedules screen, this will be calculated upon pressing TAB on Prem Fee Claimed field. The calculation for the Premium Amount will depend on the type of Premium Fee Code entered.
- Remarks: A unique number assigned to convey specific messages to MCP. Listed in the *Physician/Dentist Information Manuals*. If the Remarks Code entered is in the Remark Code file, a brief description associated with the Remark code will automatically be displayed. See Remark Codes on the Information Menu. You can click the Plus Sign  next to this field to access the *Remark Codes* screen. If the Remark Code is not in the *Remark Codes* screen you can add it to the file or simply add the Remark Code directly on the screen.
- Capacity: A code associated with the Capacity of the Provider. If you have set a default Capacity Code in Provider Defaults on the Information Menu, this field will be automatically be filled in. You can overwrite this field with a different Capacity Code. To change the Capacity Code, click on  and highlight the desired code.
- A code indicating if the Patient was referred. If you have set a default Referral Code in the

Referral:	<u>Provider Defaults</u> on the <u>Information Menu</u> , this field will automatically be filled in. You can overwrite this field with a different Referral Code. To change the Referral code, click on ▼ and highlight the desired code.
Hospital No:	A unique number assigned to each Hospital or Institution by MCP. If you have set a default Hospital Code in the <u>Provider Defaults</u> on the <u>Information Menu</u>, this field will automatically be filled in. You can overwrite this field with a different Hospital Code. If the Hospital Code entered is in the Hospital Code file, the name associated with the Hospital Number will automatically be displayed. See <u>Information - Hospitals</u>. You can click the Plus Sign + next to this field to access the <u>Hospitals</u> screen. If the Hospital Number is not in the Hospitals screen you can add it to the file or simply add the Hospital Number directly on the screen.
Admission Date:	The date the Patient was admitted to the hospital. This has to be less than or equal to the service date. The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD: 20000119 0119 2000/01/19 01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19) Spaces are NOT allowed.
Payee:	The provider number or institution number to whom you wish to assign payment for this claim. If a Payee other than the Provider is always used, it is wise to set that Payee Number as the default. Use <u>Provider Defaults</u> on the <u>Information Menu</u> to do this. Default to provider number if you want to assign payment to the provider.
I.C.	Indicates whether the claim is being submitted for Independent Consideration. If it is to be processed as an IC claim then click this field. If the explanation is brief you can avail of the Comments section on the claim. If the explanation is lengthy then you must submit paper documentation to support the claim.
Comments:	Additional information to help process a claim.
SHV Data: First Date:	The first date of the SHV. Cannot be later than the last date. Only appears for SHV. The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD: 20000119 0119 2000/01/19 01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19) Spaces are NOT allowed.
Last Date:	The last date of the SHV. Cannot be earlier than the first date. Only appears for SHV. The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD: 20000119

0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

SHV Fee Code: Type of SHV visit. If the SHV type is entered in the Fee Code file, the description associated with the SHV type will automatically be displayed. You can click the Plus Sign  next to this field to open the *Fee Schedules* screen or simply enter the SHV type directly on the screen.
Types: 357 (1st to 35th day), 358 (36th to 91st day) and 359 (92nd day onward).

Visits: Number of SHV visits. Maximum number of visits allowed is calculated as First Date - Last Date + 1. Automatically calculated but you can overwrite this field. Only appears for SHV.

Neonatal Data:
Neonatal: Check this field if the service is for a Neonatal patient who does not have a Patient Id assigned to them by MCP. If this field is checked, the fields Surname, Birth Date and Sex are enabled for you to enter the information. An OOP patient cannot be neonatal.

Surname: Surname of the Neonatal Patient. Enabled when Neonatal field is checked.

Birth date: Birth date of the Neonatal Patient. Enabled when Neonatal is field checked.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:
20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Sex: Sex of the Neonatal Patient. Enabled when Neonatal is checked.

Sex: This grid will only show in the Medical Claims screen when viewing a claim that was previously entered. If adding a new claim, the grid will not be visible.

Patient History Data:
A seven (7) digit number given to the claim during batching.

Claim #: A two (2) digit number given to the item during batching.

Item #: The date the Patient was seen by the Provider.

Service Date: A unique number assigned to each service or procedure as shown in the *MCP Payment Schedules*.

Fee Code: The amount claimed for the service.

Fee Claimed: A unique number assigned to each premium service as shown in the *MCP Payments Schedule*.

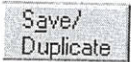
Prem Code: The premium amount claimed for the service.

Prem Amt:

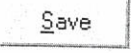
**Command
Buttons:**

Delete

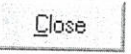
allows you to remove the claim shown on the screen. A dialogue box will appear which will ask you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

Save/
Duplicate

saves the information on the current screen and then clears the Fee Code, Fee Code Description, Fee Claimed, Co-Pay Code, Co-Pay Description and Co-Pay Claimed fields. Use this option to enter additional services for the same patient. This will be enabled when data is entered or a change is made to the screen.

Save

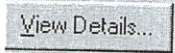
saves the information on the current screen and then clears the screen. This will be enabled when data is entered or a change is made to the screen.

Close

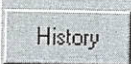
closes the current screen. This will be enabled if no changes are made to the current screen.

Cancel

does not save any changes to the current screen. A dialogue box will appear confirming whether or not you wish to cancel. This will be enabled when a change is made to the current screen.

View Details...

allows you to browse the History for the Patient currently displayed. This grid will only be displayed when viewing a claim that was previously entered. Highlighting a claim on the grid and selecting this will make the Medical History screen appear. You can either delete or close the screen. Then the claims screen reappears. You cannot browse or maintain the history file of another Patient from here. (See *History* on the *Claims* Menu)

History

this button will display the entire patient history for the PIN entered on the claim.

FFS Claims - Maintain

Fee-for-Service Claims: 911111 Dr. Medical

Patient ID: ☐ ☐ ☐ ☐ Find
 First Name: ☐ ☐ ☐ ☐
 Surname: ☐ ☐ ☐ ☐
 FIFO: ☐ ☐ ☐ ☐ Find

Patient ID	Service Date	Patient Name	Fee Code	Fee Claimed	Prem Code	Prem Amt	Rec No:
419 900 900 012	2007/01/29	Smith Joe	666666	\$25.00			1

No Recs: 1

Add...
 Change...
 Delete
 Close

This screen displays a list of all FFS claims which have been entered, but not batched. Used to add, change and/or delete claims before batching. Once this process is complete, the claims are batched into a submission file using Batch FFS Claims and TADs on the FFS Claims Menu.

Claims can be modified or deleted at any time before they are batched.

Providers that are allowed to submit both Medical and Dental claims should note that both types of claims will be listed on this screen.

To Add a claim click Add.... To change or delete a claim, highlight the claim in the grid list and click Change... or Delete.

Sort Criteria: Can sort by Patient Id, Patient First Name or Patient Surname, all of which will sort in ascending order. Can also sort by FIFO - first in first out (i.e. the order the records were keyed in).

To change the sort order, click on the radio button ☐ next to the desired sort field.

Search Can search by Patient Id and/or Patient First Name and/or Patient Surname.

Criteria:

If using the Patient Id as the search criteria and the Patient Id you are searching is not found, the list will be blank. If using the Patient First Name or Surname as the search criteria and the name you are searching for is not found, TeleClaim will take you to the first record that is closest to the record for which you are searching and show that record in addition to all the records following in the list.

To perform a search, enter the Patient Id, the Patient's First Name or the Patient's Surname in the appropriate text box and click .

When starting a new search, it is recommended that you clear all the search fields and press to get a complete list.

Columns:

Patient Id: Patient Identity Number (PIN).

Service Date: The date the Patient was seen by the Provider.

Patient Name: The Patient's Surname and Given Name.

Fee Code: A number assigned to each service or procedure as shown in the *MCP Payment Schedules*.

Fee Claimed: The amount claimed for the service.

Prem Code: For Medical claims, this will be the Premium Code. For Dental claims, this will be the Co-pay Code.

Prem Amt: For Medical claims, this will be the Premium Claimed. For Dental claims, this will be the Co-pay Claimed.

Rec No: The number of the record that is highlighted in the grid.

No Recs: The total number of records (claims entered) that can be listed in the grid. This count does not take into consideration any search criteria that may have been performed to eliminate certain records. This count assumes no search criteria has been performed.

Command Buttons:

allows you to perform a search for a desired item in the grid list.

brings you to the Medical Claim Entry screen for a Medical Provider and the Dental Claim Entry screen for a Dental Provider. If the Provider can claim both Medical and Dental services, a message box will appear prompting you to select Medical or Dental claim entry. The selected claim entry screen will be displayed.

allows you to modify the claim highlighted on the grid list.

allows you to remove the highlighted claim. A dialogue box will appear asking you to

confirm the Delete.

Close closes the current screen.

FFS Claims - Batch FFS Claims and TADs

This option:

- 1) batches all Fee-for-Service (FFS) Claims that are currently in the claims work files and performs the following:
 - applies claim and item numbers to each FFS Claim entered
 - writes the numbered claims to the FFS Claims History
 - writes the numbered claims to a FFS Claims submission file
 - clears the FFS Claims work files
- 2) batches all Turn-Around Documents (TADs) that are currently ready for submission and performs the following:
 - writes the TADs to the FFS Claims History
 - writes the TADs to a FFS Claims submission file
 - clears the TADs work files that are ready for submission

The submission files created can then be transmitted to MCP using Connect - Connect to MCP on the Main Menu.

It is recommended that FFS Claims and TADs be batched and submitted to MCP at least twice a week. Do not wait until cut-off to batch and submit claims.

You can batch up to nine (9) FFS Claim files (containing FFS Claims and TADs) a day. When nine (9) have been batched, a message box will appear to inform you. To batch a total of nine (9) files, ensure your default Starting Sequence Number is set up as one (1) in the Provider Defaults file. See Information - Provider Defaults on the main menu.

If problems are encountered during batching, contact your vendor immediately! Ignoring problems that occur during batching can result in bigger problems later on.

If billing from more than one location, you must ensure that the sequence number is unique.

The Batching Process:

Before you select the batch option, ensure that all modifications have been made to the Fee-for-Service (FFS) Claims and TADs entered. Once they have been batched, they cannot be changed.

If you are using TeleClaim on a network, you should have exclusive use of the files for the Provider for whom you are batching claims. If someone else is doing work for the Provider that you are trying to batch, you will receive a message. You can either wait until the other person is finished or ask the other person to quit until you have finished batching.

When you select the Batch FFS Claims and TADs option on the FFS Claims Menu, TeleClaim will check to see if there are any FFS Claims or TADs to batch. If there are no FFS Claims or TADs to batch, a message box will appear to inform you. Press 'OK' and you will be brought back to the main menu. If there are FFS Claims or TADs to batch, a message box will appear to inform you of the next sequence number that will be used when building the file name for submission to MCP. The sequence number for the first batch of the day is retrieved from the Provider Defaults file. For each subsequent batch done that day, the sequence number is automatically incremented.

When the batch process is finished, a message box will appear telling you how many FFS Claims (including TADs) have been batched, the total amount claimed for the batch and the Submission File name. Click 'OK' and you will be brought back to the main menu.

Batching Notes:

1) You will determine how often the claims are batched. However, it is recommended that batching be done at least twice a week. Normally you would batch and transmit once per day.

The more often you batch, the less likely it will be that you will lose data due to PC problems, power failures, file corruption, etc. TeleClaim will allow you to create up to a maximum of nine (9) batches a day for each Provider.

2) The Claim Summary contains the name of the submission file, starting and ending claim numbers, number of records in the file and file total. See Reports - Submission - Summaries on the main menu.

It is not necessary to print this report unless you wish to keep it for your records.

3) It is a good habit to browse a submission file right after batching. Check the claim numbers used to see that they are correct, and that the data in the file looks reasonable.

4) Claim numbers are assigned sequentially, and are used in combination with item numbers. Each claim number has 99 items associated with it. For example, if the starting claim number for the batch is 0000001, the first Fee-for-Service Claim that you batch will be numbered 0000001-01, the second 0000001-02, up to 0000001-99 at which point the claim number changes to 0000002, and the numbering continues with 0000002-01, 0000002-02, etc.

Note that each new submission file starts with a new claim number. The new claim number should be one greater than the last claim number that used in the previous batching process.

If submitting from different locations, claim number cannot be duplicated.

5) TeleClaim gives every submission file a unique name. Each file name must be unique, or the file will be rejected by MCP as a duplicate file.

An example of a FFS Claims and TADs file name is 99990110.169. The file name is structured as follows:

99990110.169

The first 6 digits are the Provider number (ex. 999901)

99990110.169

The seventh digit is a sequence number, starting with one (1), and going up to nine (9). The first file you batch in a day will use the sequence number that is specified in the Provider Defaults screen under the Information Menu and incremented by one (1) for every file you batch after that on that day. For more information on the Sequence Number see Information - Provider Defaults.

99990110.169

The eighth digit represents the year (ex. 0 for 2000)

99990117.169

Following the eighth digit is a period or dot.

99990110.169

A three (3) digit extension ends the file name and represents the Julian date of the day the file was batched. The Julian calendar numbers every day of the year from 1 to 366. The Julian date 169 represents June 17, because June 17 is the 169th day of the year. See help on Julian Conversion for more information.

Note that the Julian calendar used by MCP assumes every year has 366 days. In years that are not leap years, the Julian date for February 29, which is 060, is not used.

6) As part of the batching process, the submission file name is written to the pending file list under Connect - Connect to MCP.

7) Submission files do not have to be transmitted right after they are batched. For example, if you are batching more than one file for a Provider on one day, or files for different Providers, you could wait and transmit all the files at the same time. It is recommended that after you have batched all files for all providers in your office that you then go to the connect option and transmit those files to MCP as soon as possible.

8) The MCP telephone transmission system is up 24 hours a day, 7 days a week, so you can transmit files at any time.

9) Do not wait until cut-off to transmit all your submission files.

Cut-off is the busiest day on the telephone transmission system in the two week payment cycle, and you may not be able to get through to MCP. It is better to transmit the bulk of files over the two weeks between cut-off days, and, if necessary, send a smaller file on cut-off day. This way, if you have a problem transmitting that file, you will still have the majority of claims submitted for payment.

FFS Claims - History

Patient ID	Claim #	Item #	Service Date	Fee Code	Fee Claimed	Prem Code	Prem Amt	Date
419 900 900 012	0001756	01	2007/01/29	666666	\$25.00			2007

This screen is used to view and/or delete history claims.

As claims are batched, they are added to History. They will remain in this file until they are deleted or purged.

Using this option you can browse the file, look at the claim detail, including the reconciliation data, and delete individual claims.

To view or delete a claim, highlight the claim in the grid list and click View... or Delete.

When cancellation notices are received from MCP, and the claim is not going to be paid, the claim should be deleted from History. This will enable you to keep better track of unpaid claims. See the Report Menu - Outstanding - FFS Claims for more information on unpaid claims.

Note that if the claim has not been reconciled, the reconciliation code will be displayed as XX - Unreconciled.

Sort Criteria: Can sort by Claim Number or Patient ID. Sorts will be in ascending order.

To change the sort order, click on the radio button  next to the desired sort field.

Search Criteria: Can search by Patient Id and/or Claim Number.

If the Patient Id being searched for is not found, TeleClaim will bring you to the Patient Id most

resembling the search Id.

If the Claim Number being searched for is not found, the grid list will be blank.

To perform a search, enter the Patient Id or Claim Number in the appropriate text box and click

Find

When starting a new search, it is recommended you clear all the search fields and press

Find

to get a complete list.

Fields:

Patient Id: Patient Identity Number.

Claim #: A seven (7) digit number given to a claim during batching.

Item #: A two (2) digit number given to a item during batching.

Service Date: The date the Patient was seen by the Provider.

Fee Code: A unique number assigned to each service or procedure as shown in the *MCP Payment Schedules*.

Fee Claimed: The amount claimed for the service.

Prem Code: The Premium Code or Co-Pay Code, depending on if the claim is Medical or Dental.

Prem Claimed: The Premium or Co-Pay amount Claimed.

Date Batched: The date the claim was batched.

**Command
Buttons:**

Find

allows you to search for a desired search item in the grid list.

View...

allows you to browse the chosen claim but not make any changes to the claim.

Delte

allows you to remove the highlighted claim. A dialogue box will appear which will ask you to confirm the Delete.

Close

allows you to close the current screen.

Medical History

Medical History: 911111 Dr. Medical			
Claim No:	0001758	Item:	01
Patient ID:	111 111 111 111	Batch Date:	2007/01/29
Surname:	Smith	OOP	☒
Given Names:	Joe	Birth Date:	1977/12/01
Service Date:	2007/01/29	Prov:	MA
Diag. Code:	0780	Sex:	M
Fee Code:	666666	NO ILLNESS DIAGNOSED	
Units:	001	Fee Claimed:	\$25.00
Prem Fee Code:			
Prem Amt:			
Remarks:			
Capacity:	0 Surgeon/Attending Physician		
Referral:	1 Non-Referral		
Hospital No:	0256	Health Sciences	
Admission Date:			
Payee Number:	911111		
I.C.			
Comments:			

Subsequent Hospital Visits
 First Date:
 Last Date:

Neonatal
 Surname:
 Birthdate:
 Sex:

Reconciliation Data
 Code:
 Serv Date:
 Premium Paid:
 Fee Paid:
 Pay Date:
 Reason:
 File No:

This screen is used to view the detail of a Patient's Medical history claim. From this screen, the claim can also be deleted.

As claims are batched, they are added to FFS History. They will remain in this file until they are deleted or purged.

Using this option you can browse the file, look at the claim detail, including the reconciliation data, and delete individual claims.

When cancellation notices are received from MCP, unless you take further action to have these claims reactivated, they should be deleted from the History. This will enable you to keep better track of unpaid claims. See the [Report Menu - Outstanding - FFS](#) for more information on unpaid claims.

Note that if the claim has not been reconciled, the reconciliation code will be displayed as XX - Unreconciled.

All fields on this screen are disabled. No updates are allowed.

Fields:

Claim No: A seven (7) digit claim number.

Item: A two (2) digit claim number.

Batch Date: The date the claim was batched.

Patient Id: Patient Identity Number.

OOP: Indicator to show if this is an out-of-province (host) claim.

Surname: The Patient's Surname.

Birth Date: The Patient's Birth Date.

Given Names: The Patient's Given Names.

Prov: The Patient's Province Code.

Service Date: The Date the Patient was seen by the Provider.

Sex: The Patient's Sex Code.

Diag. Code: The Diagnostic Code submitted.

Fee Code: The Fee Code submitted.

Units: The number of units claimed.

Fee Claimed: The amount claimed for the service.

Prem Fee Code: The Premium Code submitted.

Prem Amt: The Premium amount claimed for the service.

Remarks: The Remarks Code submitted.

Capacity: The Capacity of the provider.

Referral: The Referral code submitted for this patient.

Hospital No: The Hospital number submitted.

Admission Date: The Date the Patient was admitted to the hospital.

Payee Number: The Payee assigned to this service.

I.C. Indicates whether the claim was submitted for Independent Consideration.

Comments: Additional information submitted to help process this claim.

**Subsequent
Hospital
Visits Data:**

First Date: The first date of the SHV.

Last Date: The last date of the SHV.

**Neonatal
Data:**

Surname: Surname of the Neonatal Patient.

Birth date: Birth date of the Neonatal Patient.

Sex: Sex of the Neonatal Patient.

**Reconciliation
Data:**

Code: The Reconciliation Code. See help on [Reconcile FFS and ABS Claims](#).

Service Date: The date of service of the paid claim.

Premium Paid: The premium/co-pay amount paid for claim.

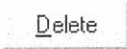
Fee Paid: The amount paid for this claim.

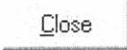
Pay Date: The date the fee and/or the premium was paid by MCP.

Reason: Code to explain any changes to a claim as a result of an assessment by MCP.

File No: Remittance file name for this claim.

**Command
Buttons:**

 allows you to remove the claim shown on the screen. A dialogue box will appear asking you to confirm the Delete.

 closes the current screen.

TADS - Maintain - Retrieve FFS and ABS TADs

TAD Files: 911111 Dr. Medical

Sort By: Find

File Name: Find

File Name	File Date	# of Records
-----------	-----------	--------------

Retrieve Close

Used to retrieve FFS and ABS TAD files into the TeleClaim database and delete FFS and ABS TAD files.

To retrieve a TAD file, highlight the file name in the grid and click Retrieve. If a TAD file has already been retrieved, there will be information displayed in the File Date and No TADs columns.

Search Criteria:

A search can be done on File Name.

To perform a search, enter the desired File Name in the File Name text box and click

Find

When starting a new search, it is recommended the user clear all the search fields and press

Find

to get a complete list.

Fields:

File Name

The name of the TAD file.

File Date:

The date the TAD file was created by MCP.

No TADs:

The number of TADs in the file.

Command Buttons:

Retrieve

retrieves the highlighted file to the TeleClaim database.

Find

allows the user to search for a desired search item in the grid list.

Close

closes the current screen.

TADS - Maintain - FFS TADs

Fee-for-Service TADS: 911111 Dr. Medical

Claim No: ☐ Find

Patient Id: ☐

Creation Date: ☐

Ready to Batch: ☐

Find

Claim	Item	Patient Id	Code	Viewed	Ready to Batch	Creation Date	Medical
3000512	61	111 111 111 111	003	Yes	Yes	2006/12/18	Yes

View

Delete

Close

This screen displays a list of FFS TADs available for Processing.

There are five (5) types of TADs:

- 001 First Notice - Request for Additional Information
- 002 Final Notice - Request for Additional Information
- 003 Cancellation
- 006 History Request for Additional Information
- 007 Final History Request for Additional Information

A FFS TAD may or may not have to be corrected and sent back to MCP.

To view a FFS TAD, highlight the FFS TAD in the grid list and click **View...**

Sort Criteria:

Can sort by Creation Date, Code, Patient Id, Claim Number or Ready to Submit. Sorts ascending order.

When the screen is first displayed, it is sorted by Creation Date.

To change the sort order, click on the radio button  next to the desired sort field.

Search Criteria:

Can search by Creation Date, Notice Type (Code) and/or Claim Number.

If you search by Creation Date and none are found with that exact date, the list will con claims whose are dates after the date entered.

If you search by Patient Id and none are found, the list will be blank.

If you search by Code and none are found, the list will be blank.

If you search by Claim Number and none are found, the list will be blank.

You must enter either 'Yes' or 'No' in the Ready to Submit search.

To perform a search, enter the Creation Date, Notice Type or Claim Number in the appropriate text box and click .

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:

20000119

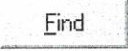
0119

2000/01/19

01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

When starting a new search, it is recommended you clear all the search fields and press



to get a complete list.

Fields:

Claim:

The claim number of the original claim.

Item:

The item number of the original claim.

Patient ID:

Patient Identity Number submitted on the original claim.

Code (Notice Type):

The type of FFS TAD sent to you by MCP concerning the claim.

Viewed:

Indicator to show if the FFS TAD has been viewed. If 'Yes', then the claim has been viewed. If 'No', the claim has not been viewed.

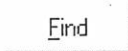
Ready to Submit:

Indicator to show if the FFS TAD has been viewed and fixed and thus is ready to be sent back to MCP for processing. If 'Yes', then the claim has been fixed and will be selected during the next batching process that is executed. If 'No', the claim is not ready to be sent back to MCP and will not be selected during the next batching process that is executed.

Creation Date:

The date the FFS TAD was created by MCP.

Command Buttons:



allows you to perform searches.



allows you to view and process the highlighted FFS TAD.



closes the current screen.

TADS Medical

Medical TAD - Cancellation - 911111 Dr. Medical

Claim No:	3000512	Item:	61	Create Date:	2006/12/18	Subsequent Hospital Visits	Attachments to Follow
Patient ID:	911111			OOP	☒	Admission Date:	
Surname:	Smith	Birth Date:	1977/12/01	Prov:	MA	Last Date:	
Given Names:	Joe	Sex:	M			MCP Contact	
Service Date:	2006/12/13					Name:	Medical Division (01)
Diag. Code:	0780	NO ILLNESS DIAGNOSED				Phone No:	(709) 292-4048
Fee Code:	666666					Reasons	
Units:	001	Fee Claimed:	\$2.75			405-SERVICE DATE IS AFTER PATIENT'S TERMINATION DATE	
Prem Fee Code:	0					MCP Remarks	
Prem Amt:	\$0.00						
Remarks:	13	EACH X-RAY REQUESTED OR N					
Capacity:	0	Surgeon/Attending Physician					
Referral:	1	Non-Referral					
Hospital No:	0256	Health Sciences					
Payee Number:	911111						
I.C.							
Comments:							

Display/Print View History Delete Save Close

Used to change or delete a Medical TAD (Turn Around Document), to view and/or print a TAD or to view Claims History.

The reason the claim was sent back to you as a TAD is displayed under the field Reasons. This lists the first error encountered on the claim.

The TAD type is displayed at the top of the screen. There are 5 types:

- 001 First Notice - Request for Additional Information
- 002 Final Notice - Request for Additional Information
- 003 Cancellation
- 006 History Request for Additional Information
- 007 Final History Request for Additional Information.

To display the report, click Display/Print. To view the claim history click View History.

Fields:

Claim No: The Claim Number of the original claim.

Item: The Item Number of the original claim.

Create Date: The Date the TAD was created by MCP.

Patient Id: Patient Identity Number submitted on the original claim.

Surname: The Surname submitted on the original claim.

Given Names: The Given Names submitted on the original claim.

Birth Date: The Birth date submitted on the original claim.

Prov: The Province submitted on the original claim.

Sex: The Sex submitted on the original claim.

Service Date: The date of service submitted on the original claim.

Fee Code: The Fee Code submitted on the original claim.

Units: The number of Units claimed on the original claim.

Fee Claimed: The Fee Amount claimed on the original claim.

Prem Fee Code: The Premium Code submitted on the original claim.

Prem Amt: The Premium Amount claimed on the original claim.

Hospital No: The Hospital Number submitted on the original claim.

Admission Date: The Admission Date submitted on the original claim.

Diag. Code: The Diagnostic Code submitted on the original claim.

Remarks: The Remark Code submitted on the original claim.

Capacity: The Capacity Code submitted on the original claim..

Referral: The Referral Code submitted on the original claim.

I.C. Indicates whether the original claim was submitted for Independent Consideration.

Comments: Additional information submitted on the original claim to help process the claim.

Payee Number: The Payee number submitted on the original claim.

OOP: Indicator to show if this is an Out of Province (Host) claim.

Last Date: The last day of the SHV submitted on the original claim.

Birth Date: The Patient's Birth date submitted on the original claim.

Prov: The Patient's Province submitted on the original claim.

Sex: The Patients Sex submitted on the original claim..

Name: The contact name or division at MCP.

Phone: The contact phone number at MCP.

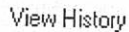
Reasons: The reason the claim was rejected and sent back to you.

Attachments to Follow: Check this if you wish to send supporting documentation via postal mail for this TAD to MCP for review before processing this claim.

Command Buttons:

The button is labeled "Display/Print".

allows you to view and print the TAD displayed on the screen.

The button is labeled "View History".

displays the Claims History browse screen. The patient id on the individual tad will carry over to the Patient Id search field on the Claims History Browse screen.

The button is labeled "Delete".

allows you to remove the TAD shown on the screen. A dialogue box will appear asking you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

The button is labeled "Save".

saves the information on the current screen to a file. This will be enabled when data is entered on the screen or a change is made to the screen. A message box will appear asking you if this TAD is ready to be submitted to MCP. If Yes is chosen, this TAD will be included when the next batch is prepared for MCP.

The button is labeled "Close".

closes the current screen. This will be enabled if no changes are made to the current screen.

The button is labeled "Cancel".

does not save any changes to the current screen . A dialogue box will appear asking you to confirm the Cancel. This will be enabled when a change is made to the current screen.

TADS Medical History

Medical TAD History - Request for Additional Information - 911111 Dr. Medical					
Claim No:	1000485	Item:	09	Create:	2006/12/18
Patient ID:	111 111 111 111	Resent:	2006/12/18	Subsequent Hospital Visits	
Surname:	Smith	OOP	☐	First Date:	
Given Names:	Joe	Birth Date:		Last Date:	
Service Date:	2006/12/12	Prov:		MCP Contact	
		Sex:	F	Name:	Medical Division (01)
Diag. Code:	0780	NO ILLNESS DIAGNOSED		Phone No:	(709) 292-4048
Fee Code:	886866				
Units:	001	Fee Claimed:	\$39.04	Reasons	
Prem Fee Code:	0	007-PATIENT NUMBER IS NOT ON FILE. PLEASE SUPPLY THE CORRECT NUMBER OR HAVE PATIENT REGISTER.			
Prem Amt:	\$0.00				
Remarks:	13	EACH X-RAY REQUESTED 0		MCP Remarks	
Capacity:	0 Surgeon/Attending Physician				
Referral:	1 Non-Referral				
Hospital No:	0281	Janeway Hospital			
Payee Number:	911111	I.C.	☐		
Comments:					
					Delete Close

Used to view and/or delete a Patient's Medical TAD in History.

As claims are batched, they are added to History. They will remain in this file until they are deleted or purged.

Using this option you can browse the file, view the claim detail, including the reconciliation data, and delete individual claims.

When cancellation notices are received from MCP, and the claim is not going to be paid, the claims should be deleted from History. This will enable you to keep better track of unpaid claims. See the Report Menu - Outstanding - TADS for more information on unpaid claims.

All fields on this screen are disabled. No updates are allowed.

The TAD type is displayed at the top of the screen. There are 5 types:

- 001 First Notice - Request for Additional Information
- 002 Final Notice - Request for Additional Information
- 003 Cancellation
- 006 History Request for Additional Information
- 007 Final History Request for Additional Information.

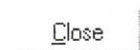
Fields:

Claim No: The Claim Number of the original claim.

Item:	The Item Number of the original claim.
Create:	The date the claim was created by MCP.
Patient Id:	Patient Identity Number submitted.
Resent:	The Date the claim was resent to MCP.
Surname:	The Surname submitted.
Given Names:	The Given Names submitted.
Service Date:	The Date of Service submitted.
Payee No:	The Payee Number assigned to this service.
Fee Code:	The Fee Code submitted.
Units:	The number of Units claimed.
Fee Claimed:	The Amount claimed for the service.
Prem Fee Code:	The Premium Code submitted.
Prem Amt:	The Premium Amount claimed for the service.
Hospital No:	The Hospital Number submitted.
Admission Date:	The Admission Date submitted.
Diag. Code:	The Diagnostic Code submitted.
Remarks:	The Remark Code submitted.
Capacity:	The Capacity Code submitted for this provider.
Referral:	The Referral Code submitted for this patient.
I.C.	Indicates whether the claim was submitted for Independent Consideration.
Comments:	Additional information submitted to help process this claim.
Last Date:	The last day of the SHV submitted.
Name:	The contact name or division at MCP.
Phone:	The contact phone number at MCP.
Reasons:	The reason the claim was rejected and sent back to you.
Attachments to Follow:	This will be checked if you checked this field on the TAD entry screen before batching the TAD.

**Command
Buttons:**

 allows you to remove the TAD shown on the screen. A dialogue box will appear asking you to confirm the Delete.

 closes the current screen.

TADS - History - FFS TADs

Fee-for-Service TADS History: 911111 Dr. Medical

Claim No: Sort By: Find: _____

Patient Id: ☐ _____

Creation Date: ☐ _____

Batch Date: ☐ _____

Find

Claim	Item	Patient Id	Batch Date	Code	Creation Date	Medical
0001364	08	329 721 265 505	2005/01/13	001	2004/12/23	Yes

View...
Delete
Close

This screen is used to view and/or delete FFS TADs (Turn Around Documents) History, which are FFS TADs which have already been batched for transmission to MCP.

To view or delete a TAD, highlight the TAD in the grid list and click View... or Delete.

Sort Criteria: Can sort by Creation Date, Code or Claim No. Sorts are in ascending order.

When the screen is first displayed, it is sorted by Creation Date.

To change the sort order, click on the radio button  next to the desired sort field.

Search Criteria:

Can search by Code and/or Creation Date and/or Claim No.

If the Code you are searching is not found, the list will be blank.

If the Creation Date you are searching is not found, the list will contain all claims whose dates are after the date entered.

If the Claim Number being searched for is not found, the grid list will be blank.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:

20000119

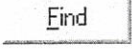
0119

2000/01/19

01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

To perform a search, enter the Notice Type and/or Creation Date and/or Claim No in the

appropriate text box and click .

Fields:

Claim: The Claim Number of the original claim.

Item: The Item Number of the original claim.

Patient ID: Patient Identity Number submitted.

Batch Date: The date the TAD was batched

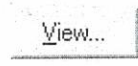
Code : The code sent by MCP to you concerning the claim.

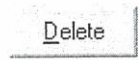
There are 5 types:

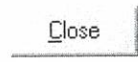
- 001 First Notice - Request for Additional Information
- 002 Final Notice - Request for Additional Information
- 003 Cancellation
- 006 History Request for Additional Information
- 007 Final History Request for Additional Information.

Creation Date: The date the TAD was created by MCP.

Command Buttons:

 allows you to view the highlighted TAD. No updates are allowed.

 allows you to remove the highlighted TAD. A dialogue box will appear asking you to confirm the Delete.

 closes the current screen.

FFS TADs File Purge

This option will purge (delete) Fee For Service (FFS) TAD files received from MCP.

This purge is done based on the *File Date*. This is the date the file was created for the user by MCP. Any FFS TAD files with a *File Date* previous to and including the date entered will be purged.

To run the purge, click on the Utilities Menu, then *FFS TADs File Purge*. A date of one year previous to the current date will be entered in the date field. This can be changed to any date. Enter the date in the format YYYY/MM/DD. Click *OK*.

A message will be displayed stating how many FFS TAD files will be deleted and asking you if you are sure that you would like to continue.

If you click *Yes* to run the purge, a message will be displayed when the purge is complete.

If you click *No*, the purge will be cancelled.

FFS TADs History Purge

This option will purge (delete) Fee For Service (FFS) TADs from the *FFS TAD History*.

This purge is done based on the *Batch Date* of a TAD. This is the date the TAD was batched for submission to MCP. Any FFS TADs batched previous to and including the date entered will be purged.

To run the purge, click on the [Utilities Menu](#), then *FFS TADs History Purge*. A date of one year previous to the current date will be entered in the date field. This can be changed to any date. Enter the date in the format YYYY/MM/DD/ Click *OK*.

A message will be displayed stating how many FFS TADs will be deleted and asking you if you are sure that you would like to continue.

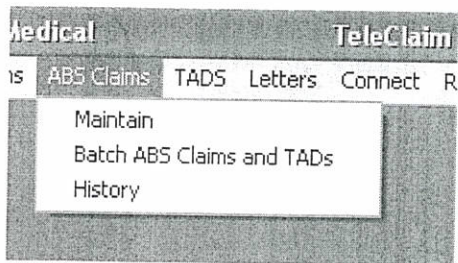
If you click *Yes* to run the purge, a message will be displayed when the purge is complete.

If you click *No*, the purge will be cancelled.

ALTERNATE BILLING SYSTEM CLAIMS (ABS)

- **MENU**
- **CLAIM**
- **MAINTAIN**
- **BATCH ABS CLAIMS AND TAD'S**
- **CLAIM HISTORY**
- **CLAIM HISTORY**
- **TADS—RETRIEVE**
- **TADS—MAINTAIN**
- **TAD**
- **TAD HISTORY**
- **TAD FILE PURGE**
- **TAD HISTORY PURGE**

ABS Claims Menu



From this menu you can access options for entering new ABS (Alternate Billing System) claims, batching ABS claims and TADs, and viewing and maintaining ABS claims history. A brief description of each option is listed below. Each option is described in more detail in their individual sections.

Maintain

Select this option to add new ABS claims and to change, delete and browse claims that have been entered, but not batched.

Batch ABS Claims and TADs

Select this option to batch ABS claims into a submission file for transmission to MCP.

History

Select this option to browse batched ABS claims, including reconciliation information, and to delete individual claims from History as required.

Alternate Billing Claim

Alternate Billing Claim: 911111 - Dr. Medical

ABS Code: +

Institution: +

Payee No:

Start Date: End Date:

Actual Start Time: Actual End Time:

Sched Start Time: Sched End Time:

Units: Fee Claimed:

Prem Code: + Prem Claimed:

Patient Totals

None Seen: ☐

New Patients: ☐

Not Kept: ☐

Diag Follow-up: ☐

Insured: ☐

Uninsured: ☐

Cancelled: ☐

Beds Not Used: ☐

Comments:

Patient Id	Patient Name	New	Not

This screen displays the details of an Alternate Billing System (ABS) claims before batching for submission to MCP. From this screen you can add, change and/or delete ABS claims that have not yet been batched.

This claim screen is used to accommodate a number of different types of ABS claims, and the fields required vary from one type to another. It is up to the provider to know which fields are required, based on the Provider Information Manual, and/or information received from MCP when approval is given to bill ABS claims.

Entering a new claims:

Enter the required claim information, and click **Save**. You will then be asked if you wish to enter a patient log. If you click **No** you will be returned to the list of claims that have been entered but not batched.

If you click **Yes**, you can then click **Add** in the patient log section of the screen, and the Add Alternate Billing Patient screen will be displayed. Click **Save** to save a patient's information, and another blank Add Alternate Billing Patient screen will be displayed.

After you have entered the information for all patients, close the Add Alternate Billing Patient screen. The **Patient Totals** section of the screen will be filled in. Close the claim. You will be returned to the list of claims that have been entered but not batched.

Field

Descriptions:

ABS Code: The ABS Code (Fee Code) for the service. If the ABS Code is set up in the [Fee Schedules](#) option on the [Information Menu](#), the description of the code entered will automatically be displayed when you Tab to the next field on the claim screen.

If you wish to access the [Fee Schedules](#) option from the *ABS Claim* screen, click the Plus

Sign  next to the *ABS Code* field. When you select a code or close the [Fee Schedules](#) screen, you will be returned to the *ABS Claim* screen.

Institution: A number assigned to an Institution/Hospital. If the Institution/Hospital is set up in the [Hospitals](#) option on the [Information Menu](#), the description of the number entered will automatically be displayed when you Tab to the next field on the claim screen.

If you wish to access the [Hospitals](#) option from the *ABS Claim* screen, click the Plus Sign  next to the *Institution* field. When you select a hospital, or close the [Hospitals](#) screen, you will be returned to the *ABS Claims* screen.

Payee Number: Number of another provider or institution to whom a provider assigns payment. If not assigning payment, this should be the provider's number.

Start Date: The date the service started in format YYYY/MM/DD.

To simplify key entry, dates can be entered in the format MMDD, and when you Tab to the next field the date will be converted to the proper format.

For example, for a service on May 29th of the current year, key in 0529, and when you Tab to the next field the date will display as YYYY/05/29, with the YYYY filled with the current year.

End Date: The date the service ended in format YYYY/MM/DD.

Actual Start Time: The time the service started in military time format HHMM, where HH represents the hour and MM represents the minutes. Military time ranges from 0000 (midnight) to 2359.

Actual End Time: The time the service ended in military time format HHMM.

Sched Start Time: The time the service was scheduled to start in military time format HHMM.

Sched End Time: The time the service was scheduled to end in military time format HHMM.

Units: Number of units being claimed. Will default to 1. Any other value must be entered by the user. If partial units are being entered, use two decimal spaces, i.e. for 3 1/4 units, enter 3.25.

Fee Claimed: The dollar amount claimed for the service. If the ABS Code is set up in the [Fee Schedules](#) option on the [Information Menu](#), the amount will be calculated automatically, based on the number of *Units*, when you Tab out of the *Units* field.

Prem Code: The Premium Code for the service.

If you wish to access the [Fee Schedules](#) option from the *ABS Claim* screen, click the Plus

Sign  next to the *ABS Code* field. When you select a code and/or close the *Fee Schedules* screen, you will return to the *ABS Claim* screen.

Prem Claimed: The dollar amount claimed for the premium. If the *Premium Code* is set up in the *Fee Schedules* option on the *Information Menu*, the amount will be inserted in the field automatically when you Tab out of the *Premium Code* field.

Comments: Additional information that the Provider may wish to include that will support or aid in the assessment of a claim. Can be up to 400 characters of text.

Patient Totals:

None Seen:

If there is no *Patient Log* (see below) entered for a claim, this will be checked automatically when the claim is saved.

New Patients:

The number of new patients seen by the provider. This will be automatically calculated based on the number of *New Patient* indicators checked in the patient log.

Not Kept:

The number of patients who did not keep appointments. This will be automatically calculated based on the number of *Not Kept* indicators checked in the patient log.

Diag Follow-up:

The number of patients who required a diagnostic follow-up. This will be automatically calculated based on the number of *Diagnostic Follow-up* indicators checked in the patient log.

Uninsured:

Insured:

The number of uninsured patients. This will be automatically calculated based on the number of patients in the patient log that do not have the *Insured* indicator checked.

Cancelled:

The number of insured patients. This will be automatically calculated based on the number of patients in the patient log that have the *Insured* indicator checked.

**Beds Not
Used:**

The number of patients who cancelled appointments. This will be automatically calculated based on the number of *Cancelled* indicators checked in the patient log.

Enter the number of *Beds Not Used* in this field.

Patient Log:

Some ABS claims require a patient log. After keying the claim information, click *Save*, and you will be asked if you wish to add a patient log. Click *Yes*, and then click *Add* in the patient log section of the screen to bring up the *Add Alternate Billing Patient* screen.

Add Alternate Billing Patient

Patient ID:

Surname:

Given Names:

New Patient: ☐

Not Kept: ☐

Diagnostic Follow-up: ☐

Insured: ☐

Cancelled: ☐

Patient Id:

Patient's MCP number. For Neonatal use Mother's number. Note that for a certain type of ABS claim, out of province numbers are to be included, but this is not the norm.

If you key a patient number that does not pass the MCP check digit routine, the message "This is an Out of Province Patient" will be displayed. Click OK. If the patient number is supposed to be an MCP number, check to ensure it was keyed correctly, or recorded correctly from the patient's MCP or hospital card.

Surname:

Given Names:

New Patient:

Not Kept:

Diagnostic
Follow-up:

Insured:

Cancelled:

**Command
Buttons:**

The patient's *Surname* (last name).

The patient's *Given Names*.

Check this box for new patients.

Check this box if the patient scheduled an appointment but did not keep the appointment.

Check this box for *Diagnostic Follow-up*.

Indicates whether or not the patient is insured. This will be automatically checked when an MCP number that passes the MCP check digit routine is entered.

Check this box if the patient canceled.

Click *Delete* to delete the displayed claim. A message will be displayed asking you to confirm the *Delete*.

Click *Save* to save the data on the current screen. This button is initially grayed out (i.e. can't be accessed), but will be enabled when data is entered or changed on the screen.

Click *Close* to close a screen that has no data entered or no changes made. Once data is entered or changes are made, the *Close* button will change to *Cancel*.

If you have entered claim information, but have not yet saved the claim, the claim can be cancelled by clicking *Cancel*. If you are making changes to a claim that has already

been saved, or to a patient log record, the changes made can be cancelled by clicking *Cancel*. A message will be displayed asking you to confirm the cancellation.

Add...

Click *Add* in the patient log area of the claim screen to add patients to the patient log for a claim. This button is initially grayed out (i.e. can't be accessed) when entering a new claim, but will be enabled when the claim data is saved.

Change...

To change a patient's information, highlight the patient on the patient log and click change.

ABS Claims - Maintain

ABS Code	Total Claimed	Start Date
666666	\$150.00	2007/01/20

This screen displays a list of ABS (Alternate Billing Claims) which have been entered, but not batched.

From this screen you can access screens to add new claims, and change or delete claims before batching. Once this process is complete, the claims are batched into a submission file using the Batch ABS Claims and TADs option on the ABS Claims Menu.

Note that once the claims and TADs are batched they will no longer be listed on this screen, and can no longer be changed or deleted.

Sort Criteria: Can sort by ABS Code or Start Date. Sorts will be in ascending order.

When the screen is first displayed, it is sorted by ABS Code.

To change the sort order, click the button  next to the desired sort.

Columns:

ABS Code: The ABS Code (Fee Code) for the service.

Total Claimed: The total dollar amount claimed for the ABS Claim.

Start Date: The start date of the ABS Claim.

Command Buttons:

 To add a new claim, click *Add*. A blank ABS claim will be displayed.

Change...

To change a claim, highlight the claim on the list and click *Change*. The claim detail will be displayed. Make any necessary changes and click *Save*.

Delete

To delete a claim, highlight the claim on the list and click *Delete*. A message will be displayed asking you to confirm the Delete.

Close

Click *Close* to exit this screen and go back to the main TeleClaim screen.

ABS Claims - Batch ABS Claims and TADs

This option batches all Alternate Billing (ABS) Claims that are currently entered in the ABS Claims - Maintain option and all ABS TADs that have a Ready To Batch status of Yes in the TADs - Maintain - ABS TADs option, into a submission file for transmission to MCP.

Only 1 ABS submission file can be batched per provider, per day.

If problems and/or error messages are encountered during batching, contact MCP immediately! Ignoring problems that occur during batching can result in bigger problems later on.

The Batching Process:

Before you run the batch option, ensure that all modifications have been made to the ABS Claims entered and the TADs that are ready to be batched. Once they have been batched, they cannot be changed.

If you are using TeleClaim on a network, you should have exclusive use of the files for the Provider for whom you are batching claims. If someone else is doing work for the Provider you are trying to batch, you will receive a message. You can either wait until the other person is finished or ask the other person to exit while you run the batch option.

When you click the Batch ABS Claims and TADs option, the message "Batching Alternate Billing Claims and TADs. Are you sure?" will be displayed. If you click *No*, you will be returned to the main TeleClaim screen.

If you click *Yes*, TeleClaim will check to see if there are any ABS claims and TADs to batch. If there is nothing to batch a message box will be displayed. Click *OK* and you will be brought back to the TeleClaim main menu.

If there are claims or TADs to batch, the batching process will continue.

When the batching is finished, a message will be displayed telling you how many ABS claims have been batched (this number includes the number of TADs), the total dollar amount in the batch and the submission file name. Click *OK* and you will be brought back to the main menu.

Batching Notes:

1) You will determine how often claims are batched. However, it is recommended that batching be done at least once or twice a week. The more often you batch, the less likely it will be that you will lose data due to PC problems, power failures, file corruption, etc.

2) It is a good habit to look at the submission file reports for claims and/or TADs in the file just batched. Check the claim numbers used to see that they are correct, and that the data on the reports looks reasonable.

See the Help topic Reports - Submission - Details - ABS Claims/TADs.

3) As part of the batching process, the submission file name is written to the list of files pending (awaiting transmission) in your transmission software.

4) Do not wait until cut-off to transmit all your submission files to MCP. The cut-off day for submission of claims is the busiest day on MCP's transmission system in the two week pay period, and you may not be able to get through.

It is better to transmit the bulk of files over the two weeks between cut-off days, and, if necessary, send a smaller file on cut-off day. This way, if you have a problem transmitting that file, you will still have the majority of claims for the period submitted for processing.

Also, transmitting submission files to MCP on a regular basis allows for a more timely processing of claims.

The MCP telephone transmission system is up 24 hours a day, 7 days a week, so you can transmit files at any time.

5) The batching process assigns a claim and item number to any new claims being batched, adds them to the *ABS Claims - History*, and removes them from the *ABS Claims - Maintain* screen.

Claim numbers are assigned sequentially, and are used in combination with item numbers. Each claim number has 99 items associated with it. For example, if the starting claim number for the batch is 0000001, the first Alternate Billing Claim that you batch will be numbered 0000001-01, the second 0000001-02, up to 0000001-99 at which point the claim number changes to 0000002, and the numbering continues with 0000002-01, 0000002-02, etc.

Note that each new submission file starts with a new claim number. The new claim number should be one greater than the last claim number that was used in the previous batching process.

6) The batching process adds any TADs being batched to the *TADs - History - ABS TADs* screen, and removes them from the *TADs - Maintain - ABS TADs* screen.

7) TeleClaim gives every submission file a unique name. Each file name must be unique, or the file will be rejected by MCP as a duplicate file.

An example of a Alternate Billing claims file name is 999901S0.169. The file name is structured as follows:

999901S0.169

The first 6 digits are the Provider number, eg. 999901.

999901S0.169

The 7th digit is an S.

999901S0.169

The eighth digit represents the year, eg. 0 for 2000.

999901S0.169

Following the eighth digit is a period or dot.

999901S0.169

A three (3) digit extension ends the file name and represents the Julian date of the day the file was batched. The Julian calendar numbers every day of the year from 1 to 366. The Julian date 169 represents June 17, because June 17 is the 169th day of the year. See help on Julian Conversion for more information.

Note that the Julian calendar used by MCP assumes every year has 366 days. In years that are not leap years, the Julian date for February 29, which is 060, is not used.

ABS Claims - History

Alternate Billing History: 911111 Dr. Medical

Claim No: Sort By: Find:

ABS Code:

Start Date:

Batch Date:

Claim No	Item	ABS Code	Total Claimed	Start Date	Batch Date
0001750	01	611111	\$35.00	2006/12/10	2006/12/11
0001751	01	666666	\$150.00	2007/01/20	2007/01/23

This screen displays a list of batched Alternate Billing System (ABS) Claims in history as it was originally submitted to MCP by the user. From this screen you can view and/or delete these claims by highlighting the claim in the list and clicking *View* or *Delete*.

Sort Criteria: Can sort by *Claim No.* (Number), *ABS Code* or *Start Date* or *Batch Date*. Sorts in ascending order.

When the screen is first displayed, it is sorted by *Claim No.*

To change the sort order, click the button  next to the desired sort.

Search Criteria: Can search by *Claim No.*, *ABS Code*, *Start Date* and/or *Batch Date*.

If the *Claim No.*, *ABS Code*, *Start Date* and/or *Batch Date* criteria you are searching for is not found, the list will be blank.

You can enter combinations for searching, i.e. a *Claim No.* and a *Start Date*.

To perform a search, enter the *Claim No.*, *ABS Code*, *Start Date* and/or *Ready to Batch* in the

appropriate text box and click  or click the button  next to the sort.

When starting a new search, it is recommended you clear all the search fields and press  to get a complete list, and then enter the information for a new search.

Columns:

Claim No: A seven (7) digit claim number assigned during batching.

Item: A two (2) digit item number assigned during batching.

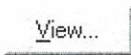
ABS Code: The *ABS Code* (Fee Code) on the claim.

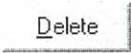
Total Claimed: The total amount claimed on the ABS claim.

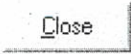
Start Date: The start date of the ABS claim.

Batch Date: The date the claim was batched.

**Command
Buttons:**

 To view the details of a claim, highlight the claim on the list, and click *View*.

 To delete a claim from the ABS Claims History, highlight the claim on the list, and click *Delete*. A message will be displayed asking you to confirm the delete.

 Click *Close* to exit this screen and go back to the main TeleClaim screen.

Alternate Billing Claim History

Alternate Billing Claim History 911111 Dr. Medical

ABS Cgde:	666666			Reconciliation Data							
Claim No:	0001752	Item:	02	Batch Date:	2007/01/24						
Institution:	0123			Code:	XX - Unreconciled						
Payee No:	911111			Serv Date:							
Start Date:	2007/01/20	End Date:	2007/01/20	Premium Paid:							
Actual Start Time:	0900	Actual End Time:	1500	Fee Paid:							
Sched Start Time:	0900	Sched End Time:	1500	Pay Date:							
Units:	001.00	Fee Claimed:	\$150.00	Reason:							
Prem Code:		Prem Claimed:		File No:							
Comments:				Patient Totals							
<table border="1"> <thead> <tr> <th>Patient Id</th> <th>Patient Name</th> <th>New</th> </tr> </thead> <tbody> <tr> <td>111 111 111 111</td> <td>Joe Smith</td> <td>Yes</td> </tr> </tbody> </table>				Patient Id	Patient Name	New	111 111 111 111	Joe Smith	Yes	None Seen:	☐
				Patient Id	Patient Name	New					
				111 111 111 111	Joe Smith	Yes					
				New Patients:	001						
				Not Kept:	000						
				Diag Follow-up:	000						
				Insured:	000						
Uninsured:	001										
Cancelled:	000	Delete									
Beds Not Used:	004	Close									

This screen shows the details of a batched Alternate Billing System (ABS) claim in history as it was originally submitted to MCP by the user. This screen also includes reconciliation (payment) information.

An individual claim can also be deleted from the *ABS Claim History* by using the *Delete* button on this screen.

Field

Descriptions: Most of the fields on the *ABS Claim History* screen are the same as those on the *ABS Claim* entry screen. See the Help topic [Alternate Billing Claim](#) for those field descriptions.

The extra fields on the *ABS TAD History* screen are described below:

- Claim No:** A seven (7) digit claim number assigned when the claim was originally batched for submission to MCP.
- Item:** A two (2) digit item number assigned when the claim was originally batched for submission to MCP.
- Batch Date:** The date the claim was batched by the user for submission to MCP.

Reconciliation

Data:

Code: Reconciliation Code. See the Help topic [Reconcile - FFS and ABS Claims](#) for explanations of the codes..

Serv Date: The date the claim was batched.

Premium Paid: The premium dollar amount paid for the claim.

Fee Paid: The *ABS Code* dollar amount paid for the claim.

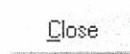
Pay Date: The date the claim was paid.

Reason: A *Reason Code* to explain any changes to a claim as a result of an assessment by MCP. *Reason Code Description* can be found in the [Remittance](#) Report for the pay period which the claim was paid. The *Text Report* can be accessed through the [Remittance](#) option on the [Reports Menu](#).

File No: The name of the remittance file received from MCP that contains the payment information for this claim.

Command Buttons:

 Click *Delete* to delete the claim displayed. A message will be displayed asking you to confirm the delete.

 Click *Close* to exit this screen and go back to the previous screen.

TADS - Maintain - Retrieve FFS and ABS TADs

TAD Files: 911111 Dr. Medical

Sort By Find

File Name: Find

File Name	File Date	# of Records
-----------	-----------	--------------

Retrieve Close

Used to retrieve FFS and ABS TAD files into the TeleClaim database and delete FFS and ABS TAD files.

To retrieve a TAD file, highlight the file name in the grid and click Retrieve. If a TAD file has already been retrieved, there will be information displayed in the File Date and No TADs columns.

Search A search can be done on File Name.

Criteria:

To perform a search, enter the desired File Name in the File Name text box and click Find.

When starting a new search, it is recommended the user clear all the search fields and press Find to get a complete list.

Fields:

File Name The name of the TAD file.

File Date: The date the TAD file was created by MCP.

No TADs: The number of TADs in the file.

Command Buttons:

Retrieve retrieves the highlighted file to the TeleClaim database.

Find

allows the user to search for a desired search item in the grid list.

Close

closes the current screen.

ABS TADs - Maintain

Alternate Billing TADS: 911111 Dr. Medical

Claim No: ☐

Start Date: ☐

Creation Date: ☐

Ready to Batch: ☐

Sort By ☐ Find

Find

ABS Code	Claim	Item	Claimed	Start Date	Viewed	Ready to Batch	Creation Date
000301	3000362	03	\$130.00	2006/12/29	Yes	Yes	2007/01/06

View

Delete

Close

This screen lists Alternate Billing System (ABS) TADs received from MCP. TADs are added to this list by using the Retrieve option on the TADs - Maintain Menu which retrieves data from ABS TAD files received from MCP.

A TAD can be viewed by highlighting the TAD on the list and clicking View.... Changes can be made and/or comments added.

TADs that have been changed and flagged as *Ready to Batch*, will be removed from this list when they are batched, and will be added to the ABS TADs History.

Sort Criteria: Can sort by *Claim No. (Number)*, *Start Date*, *Creation Date* and/or *Ready to Batch*. Sorts will be in ascending order.

When the screen is first displayed, it is sorted by *Claim No.*

To change the sort order, click the button  next to the desired sort.

Search Criteria: Can search by *Claim No.*, *Start Date*, *Creation Date* and/or *Ready to Batch*.

If you search by *Claim No* and none are found, the list will be blank.

If you search by *Start Date* or *Creation Date* and none are found with that exact date, the list will be blank.

To search by *Ready to Submit*, enter either *Yes* or *No*.

You can enter combinations for searching, i.e. a *Claim No.* and a *Start Date*.

To perform a search, enter the *Claim No.*, *Start Date*, *Creation Date* and/or *Ready to Batch* in the appropriate text box and click or click the button  next to the sort.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:

20000119

0119

2000/01/19

01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

When starting a new search, it is recommended you clear all the search fields and press

to get a complete list, and then enter the information for a new search..

Columns:

ABS Code: ABS Code (Fee Code) on the claim.

Claim: Claim number that was assigned to the original claim.

Item: Item number that was assigned to the original claim.

Claimed: The dollar amount claimed on the claim.

Date: The start date of the claim.

Viewed: States if the TAD has been viewed by the user.

Ready to Submit: Indicates if the TAD is ready to be batched for submission to MCP. Claims that are *Ready to Batch*, will be removed from this list when they are batched, and will be added to the ABS TADs History.

Creation Date: The date the TAD was created by MCP.

Command Buttons:

To view the details of a TAD, highlight the TAD on the list, and click *View*.

If you are not going to return a TAD to MCP; and want to delete it from the list of TADs, highlight the TAD on the list, and click *Delete*.

If you wish to view the details of a TAD before deleting it, use the *View* button as described above. The TAD screen displayed will have a *Delete* option.

Alternate Billing TAD

Alternate Billing TAD - 003 Cancellation - 911111 Dr. Medical

Claim No:	3000362	Item:	03	Created:	2007/01/06
ABS Code:	001	Consultation - Hospital in patient		+	
Institution:	0256	Health Sciences		+	
Payee Number:	911111				
Units:	024.00	Fee Claimed:	\$130.00		
Start Date:	2006/12/29	End Date:	2006/12/30		
Actual Start Time:	0800	Actual End Time:	0800		
Scheduled Start Time:		Scheduled End Time:			
Premium Code:		+	Premium Claimed:		

Patient Totals	
None Seen:	☐
New Patients:	001
Not Kept:	000
Diag Follow-up:	000
Insured:	000
Uninsured:	001
Cancelled:	000
Beds Not Used:	005

MCP Contact	
Name:	Medical Division
Phone No:	(709) 292-4048

Reasons	
B96-Overlapping of services with another provider for same dates and times.	

Patient Id	Patient Name
111 111 111 111	Joe Smith

Comments:

This screen shows the detail of an Alternate Billing System (ABS) TAD received from MCP, and allows the user to change or delete the TAD.

The TAD type is displayed at the top of the screen. The TAD type **001 - Request for Information** can be changed and returned to MCP. The TAD type **003 - Cancellation** cannot be returned.

The reason the claim was rejected and returned to the user is shown in the *Reasons* section. A contact name and phone number is on the TAD if you wish to contact MCP for further information. The claim information returned on the TAD is what was submitted by the user.

The user can change information and/or include comments that will support the claim, depending on what is appropriate for the reason for rejection. Changes can also be made to the patient log.

Once these changes have been made, click *Save*, the message "Is this TAD Ready to Batch?" will be displayed. If you have made all the necessary changes, and the TAD is ready to be returned to MCP, click *Yes*. If the TAD is not ready, or should not be returned to MCP, click *No*. You can come back to the TAD later.

Any TADs that have a *Ready to Submit* value of *Yes*, will be included in the next ABS Submission File

Close

Click *Close* to exit this screen and go back to the main TeleClaim screen.

batched using the [Batch ABS Claims and TADs](#) option on the [ABS Claims Menu](#).

If a TAD is not going to be returned to MCP, i.e. the claim was billed in error; you can delete the TAD by clicking *Delete*. A message will be displayed asking you to confirm the *Delete*.

A TAD can be printed by clicking *Display/Print*. Do not return the TAD to MCP on paper.

Field

Descriptions: The ABS TAD screen is the same as the *ABS Claim* entry screen, except for a few extra fields.

The extra fields are described below:

- Claim No: A seven (7) digit claim number that was assigned when claim was originally batched for submission to MCP.
- Item: A two (2) digit item number that was assigned when claim was originally batched for submission to MCP.
- Created: The date the TAD was created by MCP.
- MCP Contact Name: Person or department at MCP to whom all inquiries on this claim should be directed.
- Phone No: Phone number of the contact person or department at MCP.
- Reasons: The reason(s) the claim was rejected and returned to the user.

Command Buttons:

Display/Print

Click *Display/Print* to display the TAD report preview. Print the TAD by clicking the small printer button  in the upper left hand corner. A regular Windows Print screen will be displayed. Click *OK*.

View History

Click *View History* to display the *ABS History* (list of ABS claims in history).

Delete

Click *Delete* to delete the displayed TAD. A message will appear asking you to confirm the delete.

Save

Click *Save* to save the data on the current screen. This button is initially grayed out (i.e. can't be accessed), but will be enabled when data is entered or changed on the screen.

A message box will appear asking you if this TAD is ready to be submitted to MCP. If *Yes* is chosen, this TAD will be included in the next ABS Submission File batched for transmission to MCP.

Close

Click *Close* to close a screen that has no data entered or no changes made. Once data is entered or changes are made, the *Close* button will change to *Cancel*.

Cancel If you have entered or changed information, but have not yet saved the TAD, the changes made can be cancelled by clicking *Cancel*. A message will be displayed asking you to confirm the cancellation.

Add... Click *Add* in the patient log area of the claim screen to add patients to the patient log.

Change... To change a patient's information on the patient log, highlight the patient on the patient log and click *Change*.

Alternate Billing TAD History

Alternate Billing TAD History: 911111 Dr. Medical

Claim No:	3000362	Item:	03	Batch Date:	2007/01/25
ABS Code:	000301	Consultation - Hospital in patient			
Institution:	0256	Health Sciences			
Payee Number:	911111				
Units:	024.00	Fee Claimed:	\$130.00		
Start Date:	2006/12/29	End Date:	2006/12/30		
Actual Start Time:	0800	Actual End Time:	0800		
Scheduled Start Time:		Scheduled End Time:			
Premium Code:		Premium Claimed:			

Patient Totals

None Seen:	0
New Patients:	001
Not Kept:	000
Diag Follow-up:	000
Insured:	000
Uninsured:	001
Cancelled:	000
Beds Not Used:	005

MCP Contact

Name: Medical Division

Phone No: (709) 292-4048

Reasons

B96-Overlapping of services with another provider for same dates and times.

Comments:

Patient Id	Patient Name	New
111 111 111 111	Joe Smith	Yes

Delete

Close

This screen shows the details of a batched Alternate Billing System (ABS) TAD in history, as it was submitted to MCP.

An individual TAD can be deleted from the ABS TAD History by using the *Delete* button on this screen.

Field

Descriptions: Most of the fields on the *ABS TAD History* screen are the same as those on the *ABS Claim* entry screen. See the Help topic [Alternate Billing Claim](#) for those field descriptions.

The extra fields on the *ABS TAD History* screen are described below:

Claim No: A seven (7) digit claim number assigned when claim was originally batched for submission to MCP.

Item: A two (2) digit item number assigned when the claim was originally batched for submission to MCP.

Batch Date: The date the TAD was batched by the user for submission to MCP.

Person or department at MCP to whom all inquiries on this claim should be directed.

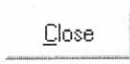
MCP Contact Name: Person or department at MCP to whom all inquiries on this claim should be directed.

Phone No: Phone number of the contact person or department at MCP.

Reasons: The reason(s) the claim was rejected and returned to the user.

**Command
Buttons:**

 Click *Delete* to delete the TAD displayed from TAD history. A message will be displayed asking you to confirm the delete.

 Click *Close* to exit this screen and go back to the previous screen.

ABS TADs History

Alternate Billing TADs History: 911111 Dr. Medical

Claim No: Sort By ☒ Find

Start Date:

Creation Date:

Batch Date: Find

ABS Code	Claim	Item	Claimed	Start Date	Creation Date	Batch Date
000301	3000362	03	\$130.00	2006/12/29	2007/01/06	2007/01/25

View...
Delete
Close

This screen lists Alternate Billing System (ABS) TADs that have been batch by the user and submitted to MCP. From this screen ABS TADs in history can be viewed or deleted by highlighting the ABS TAD in the list and clicking *View* or *Delete*.

Sort Criteria: Can sort by *Claim No.* (Number), *Start Date*, *Creation Date* or *Batch Date*. Sorts in ascending order.

When the screen is first displayed, it is sorted by *Creation Date*.

To change the sort order, click the button  next to the desired sort.

Search Criteria: Can search by *Claim No.*, *Start Date*, *Creation Date* and/or *Batch Date*.

If the *Claim No.*, *Start Date*, *Creation Date* and/or *Batch Date* criteria you are searching for is not found, the list will be blank.

You can enter combinations for searching, i.e. a *Claim No.* and a *Start Date*.

To perform a search, enter the *Claim No.*, *Start Date*, *Creation Date* and/or *Ready to Batch* in the appropriate text box and click Find or click the button  next to the sort.

When starting a new search, it is recommended you clear all the search fields and press

Find

to get a complete list, and then enter the information for a new search.

Columns:

ABS Code: The *ABS Code* (Fee Code) on the claim.

Claim: Claim number that was assigned to the original claim.

Item: Item number that was assigned to the original claim.

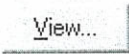
Claimed: The dollar amount claimed on the ABS claim.

Start Date: The start date of the ABS claim.

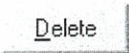
Creation Date: The date the ABS TAD was created by MCP.

Batch Date: The date the TAD was batched by the user for resubmission to MCP.

**Command
Buttons:**

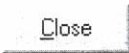
View...

To view the details of a TAD, highlight the TAD on the list, and click *View*.

Delete

To delete a TAD from the ABS TADs History, highlight the TAD on the list, and click *Delete*. A message will be displayed asking you to confirm the delete.

If you wish to view the details of a TAD before deleting it, use the *View* button as described above. The detail screen displayed will have a *Delete* option.

Close

Click *Close* to exit this screen and go back to the main TeleClaim screen.

ABS TADs File Purge

This option will purge (delete) Alternate Billing System (ABS) TAD files received from MCP.

This purge is done based on the *File Date*. This is the date the file was created for the user by MCP. Any ABS TAD files with a *File Date* previous to and including the date entered will be purged.

To run the purge, click on the Utilities Menu, then *ABS TADs File Purge*. A date of one year previous to the current date will be entered in the date field. This can be changed to any date. Enter the date in the format YYYY/MM/DD. Click *OK*.

A message will be displayed stating how many ABS TAD files will be deleted and asking you if you are sure that you would like to continue.

If you click *Yes* to run the purge, a message will be displayed when the purge is complete.

If you click *No*, the purge will be cancelled.

ABS TADs History Purge

This option will purge (delete) Alternate Billing System (ABS) TADs from the ABS TADs History.

This purge is done based on the *Batch Date* of a TAD. This is the date the TAD was batched for submission to MCP. Any ABS TADs batched previous to and including the date entered will be purged.

To run the purge, click on the Utilities Menu, then *ABS TADs History Purge*. A date of one year previous to the current date will be entered in the date field. This can be changed to any date. Enter the date in the format YYYY/MM/DD/ Click *OK*.

A message will be displayed stating how many ABS TADs will be deleted and asking you if you are sure that you would like to continue.

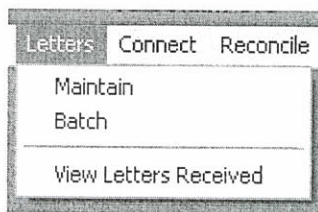
If you click *Yes* to run the purge, a message will be displayed when the purge is complete.

If you click *No*, the purge will be cancelled.

LETTERS

- **MENU**
- **LETTER**
- **MAINTAIN**
- **BATCH**
- **VIEW LETTERS RECEIVED**
- **PURGE**

Letters Menu



From this menu you can perform all of the functions necessary for entering letters to send to MCP, batching letters written to MCP, maintaining Outstanding/History Letters and viewing informational letters received from MCP. A brief description of each option is listed below. Each option is described in the individual sections.

Maintain

Select this option to add, change, delete and browse Letters which are in the Letters work files History.

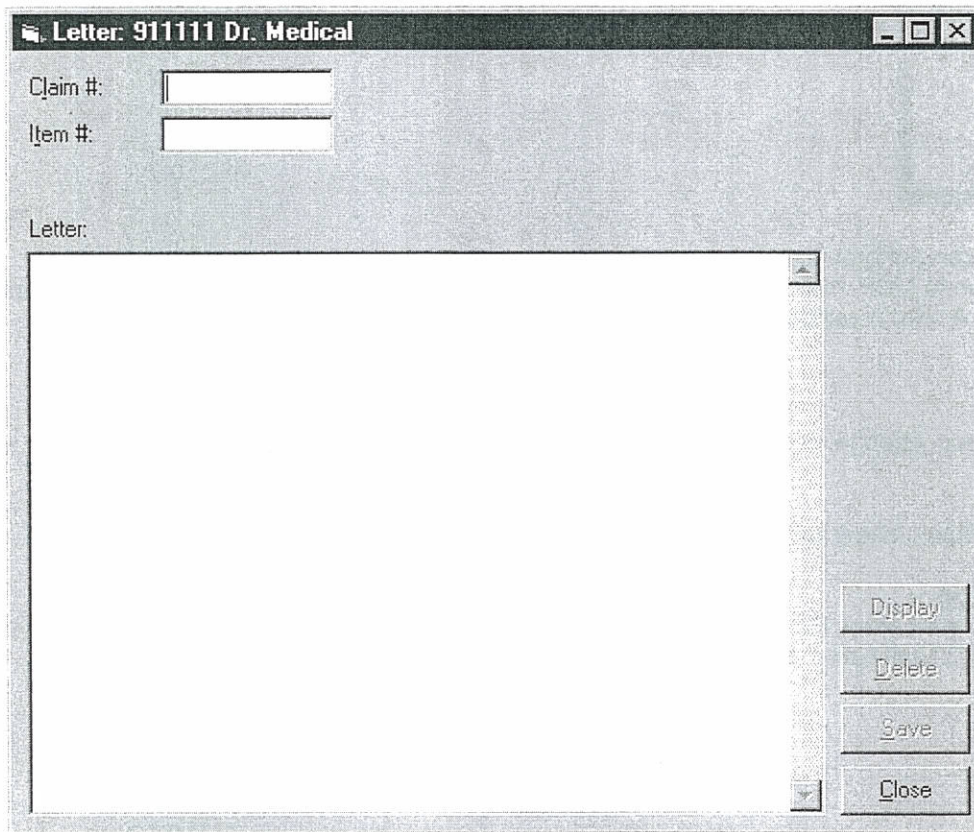
Batch

Select this option to Batch letters written to MCP.

View Letters Received

Select this option to View Letters Received from MCP. There are two (2) types of letters sent to the Provider from MCP: (1) Notification of PIN change; (2) Notification of Canceled Claims.

Letter



Letter: 911111 Dr. Medical

Claim #:

Item #:

Letter:

Display

Delete

Save

Close

This screen is used to add and/or change a Letter written by the Provider to be sent to MCP.

Letters may or may not be related to a specific claim.

Fields:

Claim #: A seven (7) digit number given to a claim during batching. This is optional and need only be filled in if the Letter relates to a specific claim.

Item #: A two (2) digit number given to a item during batching. This is optional and need only be filled in if the Letter relates to a specific item.

Letter: The text written by the Provider.

Batch Date: The date the letter was batched. **Only visible if the letter has been batched.**

Command Buttons:

Display allows you to display the letter.

Ddelete allows you to remove the letter shown on the screen. A dialogue box will appear asking you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

Save saves the information on the current screen. This will be enabled when data is entered or a change is made to the screen.

Close closes the current screen. This will be enabled if no changes are made to the current screen.

Cancel does not save any changes to the current screen . A dialogue box will appear asking you to confirm the Cancel. This will be enabled when a change is made to the current screen.

Letters - Maintain

Letters: 911111 Dr. Medical

Sort By: ☐ ☐ Find: Find

Date Written	Claim No	Item No	Batch Date
--------------	----------	---------	------------

Display Add.. Change.. Delete Close

This screen displays a list of all Letters written. Used to print, add, view, change and/or delete Letters before batched. Also used to view letters which have been batched.

To Add a letter, click Add... To display a letter, change or delete a letter, highlight the letter in the grid and click Display or Change.. or Delete.

Search Criteria: Can search by Date Written.

To perform a search, enter the desired date in the associated text box and click Find.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:

20000119

0119

2000/01/19

01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

If the Date you enter is not found, TeleClaim will take you to the next date greater than the search date.

When starting a new search, it is recommended you clear all the search fields and press

Find

to get a complete list.

Fields:

Date Written: The date the letter was written by the Provider.

Claim No: A seven (7) digit claim number. This is optional and needed only if the Letter relates to a specific claim.

Item No: A two (2) digit item number. This is optional and needed only if the Letter relates to a specific item.

Batch Date: The date the letter was batched. If there is no date displayed, then the letter has not been batched and has not been sent to MCP.

**Command
Buttons:**

Find

allows you to search for the desired search criteria in the grid list.

Display

allows you to view and print the highlighted letter.

Add...

brings you to the Letters Entry screen.

Change...

allows you to modify the letter highlighted in the grid list.

Close

closes the current screen.

Delete

allows you to remove the highlighted letter. A dialogue box will appear asking you to confirm the Delete.

Letters - Batch

This option takes all Letters written to MCP that are currently in the letters work files adds them to History and writes them to a submission file.

The submission files created can then be transmitted to MCP using the Connect - Connect to MCP option.

A user can only batch 1 Letter file for each Provider per day.

If problems are encountered during batching, contact your vendor immediately! Ignoring problems that occur during batching can result in bigger problems later on.

Letters cannot be batched from separate locations on the same day.

The Batching Process:

Before you select the batch option, ensure that all modifications have been made to the Letters entered. Once they have been batched, they cannot be changed.

When you select the *Letters - Batch* option TeleClaim will check to see if there are any Letters to batch. If there are no Letters to batch, a message box will appear to inform you. Press OK and you will be brought back to the main menu. If there are Letters to batch, then the batching process continues. You will be asked if you would like to print a copy of the letters for you files before they are batched. The letters will still be in the system after they are batched. When the process is finished, a message box will appear telling you how many Letters have been batched and the file name. Press OK and you will be brought back to the main menu.

If you are using TeleClaim on a network, you should have exclusive use of the files for the Provider for whom you are batching letters. If someone else is doing work for the Provider you are trying to batch, you will receive a message. You can either wait until the other person is finished or ask the other person to quit until you have finished batching.

Batching Notes:

1) TeleClaim gives every submission file a unique name. Each file name must be unique, or the file will be rejected by MCP as a duplicate file.

An example of a Letters file name is 999901L0.169. The file name is structured as follows:

999901L0.169

The first 6 digits are the Provider number, eg. 999901.

999901L0.169

The 7th digit is an L.

999901L0.169

The eight digit represents the year, eg. 0 for 2000.

999901L0.169

Following the eighth digit is a period or dot.

999901L0.169

A three (3) digit extension ends the file name and represents the Julian date of the day the file was batched. The Julian calendar numbers every day of the year from 1 to 366. The Julian date 169 represents June 17, because June 17 is the 169th day of the year. See help on Julian Conversion for more information.

Note that the Julian calendar used by MCP assumes every year has 366 days. In years that are not leap years, the Julian date for February 29, which is 060, is not used.

2) As part of the batching process, the submission file name is written to the pending file list in the *Connect to MCP* option on the *Connect* Menu.

3) Submission files do not have to be transmitted right after they are batched. For example, if you are batching more than one file for a Provider on one day, or files for different Providers, you could wait and transmit all the files at the same time. It is recommended that after you have batched all files for all providers in your office that you then go to the connect option and transmit those files to MCP.

4) The MCP telephone transmission system is up 24 hours a day, 7 days a week, so you can transmit files at any time.

5) **Do not wait until cut-off to transmit all your submission files.** Cut-off is the busiest day on the telephone transmission system in the two week payment cycle, and you may not be able to get through. It is better to transmit the bulk of files over the two weeks between cut-off days, and, if necessary, send a smaller file on cut-off day. This way, if you have a problem transmitting that file, you will still have the majority of claims submitted for payment.

View Letters Received

Received	Type	Code	Viewed
1999/10/07	EDT	004	No
1999/10/07	MED	004	No
1999/10/07	EDT	004	No
1999/10/07	MED	004	No
1999/10/07	MED	004	No

This screen is used to view, print and/or delete *Informational Letters* sent to the Provider from MCP.

To view or delete a letter, highlight the letter in the grid list and click or .

Search Can search by Date Received.

Criteria:

To perform a search, enter the Date Received in the appropriate text box and click .

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:

20000119

0119

2000/01/19

01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

When starting a new search, it is recommended you clear all the search fields and press

to get a complete list.

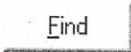
Fields:

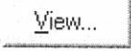
Date Received: The date the letter was received from MCP.

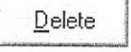
Type: The type of informational letter. There are three types: MED (from the Medical department at MCP), DNT (from the Dental department at MCP) or EDT (from the Edit department at MCP).

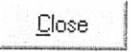
Code: A three (3) digit code associated with the type of informational letter. Currently, '004' is the only Code used for those letters.

**Command
Buttons:**

 **Find** allows you to search for a desired search item in the grid list.

 **View...** allows you to view the highlighted letter.

 **Delete** allows you to remove the highlighted letter. A dialogue box will appear asking you to confirm the Delete.

 **Close** closes the current screen.

Letter Purge

This option is used to delete letters you sent to MCP and Informational letters received from MCP.

This option should be run on a regular basis so that you can free up some hard disk space. The age of the letters and informational letters to be deleted can be specified, so that some letters and informational letters can be retained if desired.

Depending on the microcomputer you have and the number of letters and informational letters you have, this option may take some time to run.

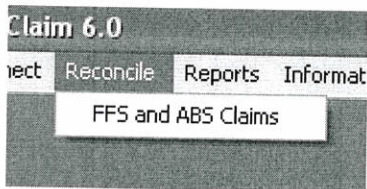
This option purges Letters written to MCP based on the BATCH DATE and Letters from MCP based on the DATE RECEIVED from MCP. A default date of one (1) year will be used when this option is selected. This can be changed to any date. Any Letters batched to MCP or any Letters received from MCP before the date entered will be deleted.

To perform the purge, click on *Utilities - Letter Purge*. If there are no files to be purged, a message box will appear informing you of this. If there are files to be purged a message box will appear asking you to enter a date or accept the default date. Next, you will be told how many Letters written to MCP will be deleted and asked to confirm that you would like to continue. If Yes is chosen, when the purge is complete, a message box will appear saying the purge is complete. If No is chosen, the purge will be canceled and a message box will appear informing you the purge has been canceled. The process is then repeated for Letters received from MCP.

RECONCILE

- **MENU**
- **FEE-FOR-SERVICE AND ALTERNATE
BILLING CLAIMS**
- **RECONCILED CLAIMS PURGE**
- **UNRECONCILED CLAIMS PURGE**

Reconcile Menu



FFS and ABS Claims

Select this option to reconcile the paid Fee-for-Service and Alternate Billing Claims in the Remittance files you received from MCP with the corresponding outstanding (unpaid) Fee-for-Service and Alternate Billing Claims your History.

Select this option to view and print the Detailed and Exception reports for a file that has been reconciled.

Must be done for each provider.

Reconcile - FFS and ABS Claims

File Name	Recon Date	EM	MA	MR	MC	UM	Total Claims	Paid to Self
E1911111.214	2002/10/02	00	00	00	00	532	532	\$0.00

This screen is used to reconcile remittance data, view Detail and Exception reports and Delete remittance files.

Electronic remittance files are made available for pickup by MCP every two weeks, a couple of days before payday. The first time you connect to MCP's telephone transmission system after these files have been made available, the remittance files will be transmitted to your system.

When this occurs, in your messages from MCP, you will see one similar to "Remittance file E19999901.013 received and Remittance file TX999901.013 received." The E1, or *claims detail file* contains the detail of all claims (Fee-for-Service and Alternate Billing) that are being paid. The TX, or *text file* contains a summary, including messages from MCP, reason codes, financial adjustments and the total paid.

Once these files have been received, you can reconcile (match) paid claims in the *remittance detail file* with the corresponding unpaid claims in History for Fee-for-Service Claims and Alternate Billing Claims.

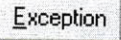
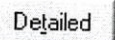
If a file has already been reconciled, the reconciliation date will be displayed. The columns following the reconciled date display reconciliation codes. The numbers in the columns indicate how many claims in the remittance file have these codes associated with them.

The reconciliation codes are:

- EM - Exact Match: A claim was found in history with the same claim and item number as on the remittance file and all the fields matched exactly.
- MA - Matched With Amount Changed: A claim was found in history with the same claim and item number as on the remittance record but the amount paid is different from the amount claimed.
- MR - Matched With Reason Code: A claim was found in history with the same claim and item number as on the remittance record but there is a reason code on the remittance record. The reason code description is included in the remittance text file.
- MC - Matched With Record Changed: A claim was found in history with the same claim and item number as on the remittance record, but some field other than the amount field was changed and the record does not contain a reason code

- ◆ **UM - Unmatched:** There was no claim in history to match the claim on the remittance file. This could happen if the claim was submitted on paper, if the claim was deleted from history, or if the claim was submitted from another location.

To reconcile a file, highlight the file in the grid list and click .

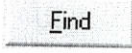
To view a detail or exception report for a file that has already been reconciled, highlight the file in the grid list and click  or . The Exception report will show you only those claims that have any reconciliation code other than EM - Exact Match. The Detailed report will show you all claims.

To view the *TX* or *Text* report, see *Reports - Remittance* on the main menu.

Search Criteria:

A search can be done on File Name.

If the file name you are searching for is not found, the list will be blank.

To perform a search, enter the File Name in the associated text box and click .

The Reconcile Process:

Select *Reconcile - FFS and ABS Claims* on the main menu.

1) Highlight the file you wish to Reconcile and click . If you select a file that has already been reconciled, you will receive a message. You can rerun the reconciliation again and get the same results as the first time, as long as you have not purged the paid claims included in this remittance file from your history.

2) You will be asked if you wish to reconcile for all payees or selected payees. Refer to the *Reconciliation Notes* in this section for a detailed explanation of this option.

If you select all payees, the reconciliation process will continue.

If you choose selected payees, a list of payees included in this remittance file will be displayed. Highlight the payee you wish to reconcile and click select.

3) TeleClaim will match up the paid claims (Fee-for-Service and Alternate Billing Claims) in the remittance file with the corresponding claims in history, using the claim and item numbers.

4.) When the process is finished, you will receive a message.

Reconciliation Notes:

1) You should reconcile remittance files as soon as possible after you receive them and follow up on any claims with reason codes, etc. This keeps the History up to date, making it easier to track unpaid claims and makes the Patient claim history current and more useful.

2) The matching of paid claims with outstanding claims is done by checking the claim fields in a particular order. As a claim can only have one reconciliation code associated with it, the reconciliation code will be the one first encountered when checking the claim. The order in which the codes are assigned is UM, MR, MA, MC and EM.

3.) Remittance files can be reconciled more than once, as long as the paid claims included in the file you want to reconcile again have not been purged from history.

4.) Only the *E1* or *claims detail* information can be displayed and printed in the reconcile option. To see the summary contained in the *TX*, or *text file*, use the Reports - Remittance option on the main menu.

5) The file name extension on the *E1* and *TX* files indicates which pay period's data the files contain. There are 26 pay periods in the MCP fiscal year, which runs from April 1 to March 31. The pay periods are numbered sequentially from 1 to 26. Therefore, the first pay date occurring in April will be pay period one (1), the next pay date will be pay period two (2), etc.

The first digit in the three-digit file extension indicates the fiscal year and the second and third digits indicate the pay period. Therefore, the file extension 001 represents the first pay period of the 2000 fiscal year, zero (0) indicating the year and 01 indicating pay period one (1).

6.) Reconciling for selected payees.

If you are reconciling a provider's remittance file that contains more than one payee, you can run the reconciliation for certain payees only.

Example: A provider is billing claims from his own office, plus a hospital is billing claims for work he performs there, using the hospital number as a payee. When the provider's remittance file is produced by MCP, it contains claims received from both locations. The remittance file can only be sent to one location.

If the provider receives the remittance file on his own system in his office, he can reconcile his remittance for only those claims for which he is the payee, excluding the claims billed by the hospital. He can give a copy of the file to the hospital and reconcile his remittance for only those claims for which the hospital is the payee.

If the doctor or the hospital reconciled the full remittance file, they would have the claims that they did not bill showing on their reconciliation listing as UM or *Unmatched*, as these claims do not exist in their history.

7.) A file must be reconciled before any reports can be displayed.

Reconciled Claims Purge

This option will delete/purge reconciled Fee-for-Service Claims and Alternate Billing Claims from History.

This option should be run on a regular basis so that you can free up some hard disk space. The age of the claims to be deleted can be specified, so that some claim history can be retained if desired. Only claims that have been reconciled will be deleted. All outstanding claims will remain in the file.

Depending on the microcomputer you have and the number of records in your History, this option may take some time to run.

This option purges reconciled Fee-for-Service Claims and Alternate Billing Claims based on the BATCH DATE. A default date of one year will be used when this option is selected. This can be changed to any date. Any reconciled Fee-for-Service Claims and Alternate Billing Claims batched before that date will be deleted.

To perform the purge, click on *Utilities - Reconciled Claims Purge*. If there are no files to be purged, a message box will appear informing you of this. If there are files to be purged a message box will appear asking you to enter a date or accept the default date. TeleClaim will then search for Reconciled Medical Claims (for Medical Providers). If there are files to delete, you will be told how many will be deleted and asked to confirm that you wish to continue. If Yes is chosen, when the purge is complete, a message box will appear saying the purge is complete. If No is chosen, the purge will be canceled and a message box will appear to inform you. The process is then repeated for Reconciled Dental Claims (for Dental Providers) and Reconciled Alternate Billing Claims (for Medical Providers).

Unreconciled Claims Purge

This option will delete/purge unreconciled Fee-for-Service Claims and Alternate Billing Claims from History.

Fee-for-Service Claims and Alternate Billing Claims should normally be reconciled on a regular basis using the Reconcile - FFS and ABS Claims option and then purged when desired using the *Utilities - Reconciled Claims Purge* option.

Depending on the microcomputer you have and the number of records in History, this option may take some time to run.

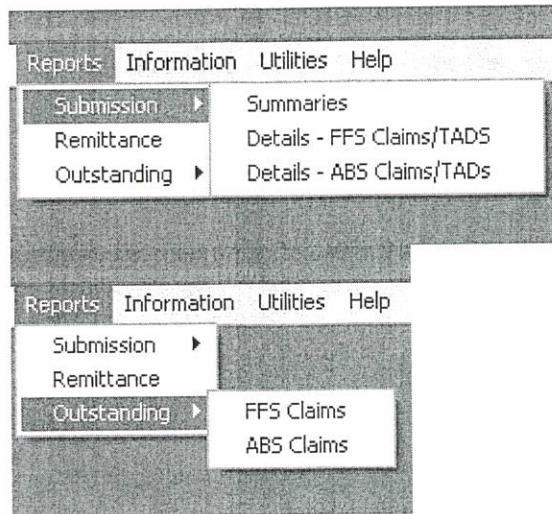
This option purges unreconciled Fee-for-Service Claims and Alternate Billing Claims based on the BATCH DATE. A default date of one year will be used when this option is selected. This can be changed to any date. Any unreconciled Fee-for-Service Claims and Alternate Billing Claims batched before that date will be deleted.

To perform the purge, click on *Utilities - Unreconciled Claims Purge*. If there are no files to be purged, a message box will appear informing you of this. If there are files to be purged a message box will appear asking you to enter a date or accept the default date. TeleClaim will then search for Unreconciled Medical Claims (for Medical Providers). If there are files to delete, you will be told how many will be deleted and asked to confirm that you wish to continue. If Yes is chosen, when the purge is complete, a message box will appear saying the purge is complete. If No is chosen, the purge will be canceled and a message box will appear to inform you. The process is then repeated for Unreconciled Dental Claims (for Dental Providers) and Unreconciled Alternate Billing Claims (for Medical Providers).

REPORTS

- **MENU**
- **PREVIEW**
- **SUBMISSION—SUMMARIES**
- **SUBMISSION—DETAILS—FFS CLAIMS/TADS**
- **SUBMISSION—DETAILS—ABS CLAIMS/TADS**
- **SUBMISSION PURGE**
- **REMITTANCE**
- **REMITTANCE—PURGE**
- **OUTSTANDING**

Reports Menu



These options are used to browse and/or print a submission claims summary, a submission file, remittance file, and/or outstanding (unpaid) Fee-for-Service and Alternate Billing Claims. See the individual options for more information.

Submission

[Summaries](#)

[Details - FFS Claims/TADS](#)

[Detail - ABS Claims/TADS](#)

Remittance

Outstanding

[FFS Claims](#)

[ABS Claims](#)

Report Preview

When you choose to view a report the report preview screen appears. This screen shows exactly how the printed report will look. There are a number of icons on the tool bar to assist you, these are listed below.



This is the close button. It takes you from print preview back to the report criteria screen.



This button will show the first page of the report.



This button will show the previous page of the report. For example if you are currently on page three and you push this button, page two will display.



This button will show the next page of the report. For example if you are currently on page three and you push this button, page four will display.



This button will show the last page of the report.



This is the Stop button, It is used to stop a report from loading.



This is the Export button, it allows you to save the output of the report as another file. You can export reports into the following formats:

- HTML (*.htm; *.html)

- Text (*.txt)

- Unicode HTML (UTF-8) (*.HTM; *.HTML)

- Unicode Text (*.text)



100%



This button displays a drop down list from which you can choose to view the screen in either an enlarged or decreased state. You can view the reports in the following sizes: 200%, 150%, 100%, 75%, 50%, 25%, 10%

Report Preview

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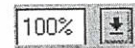
This is the Export button, it allows you to save the output of the report as another file. You can export reports into the following formats:

HTML (*.htm; *.html)

Text (*.txt)

Unicode HTML (UTF-8) (*.HTM; *.HTML)

Unicode Text (*.text)



This button displays a drop down list from which you can choose to view the screen in either an enlarged or decreased state. You can view the reports in the following sizes: 200%, 150%, 100%, 75%, 50%, 25%, 10%

Reports - Submission - Summaries

File Name	Start Claim	End Claim	No. Records	Total	Batch Date	TADS
911111S0.046	0000235	0000235	7	\$1,325.00	2000/02/15	No
91111120.042	0000234	0000234	1	\$13.80	2000/02/11	No
91111110.042	0000233	0000233	2	\$27.60	2000/02/11	No

This option displays and prints the claims summary report produced when Claims, TADs, Alternate Billings and Letters are batched.

This is a one page report showing the details of the batch.

To display the report, click Display. To delete a file, highlight the file in the grid list and click Delete.

Sort Criteria: Can be sorted by File Name - Newest to Oldest, or Starting Claim Number - Lowest to Highest.

When first displayed, the display order is in File Name Newest to the Oldest.

To change the sort order, click on the radio button  next to the desired sort field.

Search Criteria: Can search by File Name.

If the file name that you are searching for is not found, the list will be empty

To perform a search, enter the file name in the associated text box and click Find.

When starting a new search, it is recommended you clear all the search fields and press

Find to get a complete list.

Fields:

Fields:

File Name: A unique name given to each file.

Start Claim: The starting claim number in this file.

End Claim: The ending claim number in this file.

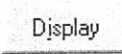
No. Records: The total number of records submitted in this file.

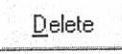
Total: The total amount claimed in this file.

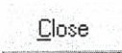
Batch Date: The date this file was batched.

TADS: Indicates whether there are TADs in the submission file.

Command Buttons:

 allows you to view and print the claims summary report.

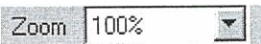
 allows you to remove the highlighted submission file. A dialogue box will appear asking you to confirm the Delete.

 closes the current screen.

The following command buttons are found on the individual reports (See help on *Report Preview*):

 allows you to print the report.

 allows you to export the report.

 allows you to view the report at different sizes.

Reports - Submission - Details - FFS Claims/TADs

Fee-for-Service Claims/TADS Submission Reports: 911111 Dr. Medical

File Name: Sort By: ☐ Find:

Batch Date:

Starting Claim No: Find

File Name	Start Claim	End Claim	No. Records	Total	Batch Date	TADS
91111187.029	0001758	0001758	1	\$25.00	2007/01/29	No
91111177.029	0001757	0001757	1	\$25.00	2007/01/29	No

Display Claims

Display TADS

Delete

Close

This option displays and prints Fee-for-Service Claims and TADS in a submission file.

The Display Claims option shows you all the Fee-for-Service Claim detail that was entered in the file, the total number of claims entered and a dollar total at the end of the listing.

The Display TADS option shows you all the TADS detail that was entered in the file, the total number of TADS entered and a dollar total at the end of the listing.

To delete a submission file, highlight the file in the grid list and click Delete.

Sort Criteria:

Can be sorted by File Name - Newest to Oldest, Batch Date - Oldest to Newest or Star Claim Number - Lowest to Highest.

When first displayed, the display order is in File Name, Newest to the Oldest.

To change the sort order, click on the radio button ☐ next to the desired sort field.

Search Criteria:

Can search by File Name and/or, Batch Date and/or Starting Claim number.

If the file name or starting claim number that you are searching for is not found the list empty. If the batch date you are looking for is not found, TeleClaim will take you to the record that is closest to the record for which you are searching.

The date can be entered in several ways. For example, January 19, 2000 can be enter

following ways and default to the format YYYY/MM/DD:

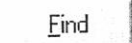
20000119

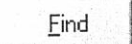
0119

2000/01/19

01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

To perform a search, enter the file name and/or batch date and/or starting claim number associated text box and click .

When starting a new search, it is recommended you clear all the search fields and press  to get a complete list.

Fields:

File Name:

A unique name given to each file.

Start Claim:

The starting claim number in this file.

End Claim:

The ending claim number in this file.

No. Records:

The total number of records submitted in this file.

Total:

The total amount claimed in this file.

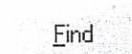
Batch Date:

The date this file was batched.

TADS:

Indicates whether there are TADs in the submission file.

Command Buttons:



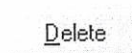
allows you to search for the desired search criteria in the grid list.



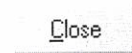
allows you to view and print the Fee-for-Service Claims in this file.



allows you to view and print the TADS in this file.



allows you to delete the highlighted submission file. A dialogue box will appear asking you to confirm the Delete.



closes the current screen.

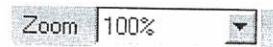
The following command buttons are found on the individual reports (See help on *Repo Preview.*):



allows you to print the report.



allows you to export the report.



allows you to view the report at different sizes.

*** The submission report is a report of claims in the database submitted for the highlighted submission file. If you delete claims from your Claims History that were submitted in the highlighted file, they will not be displayed in the report.

Reports - Submission - Details - ABS Claims/TADs

File Name	Start Claim	End Claim	No. Records	Total	Batch Date	TADS
911111S6.195	0300007	0300007	1	\$772.50	2006/07/13	Yes
911111S6.194	0300006	0300006	1	\$772.50	2006/07/12	Yes
911111S6.083	0300003	0300003	1	\$44.00	2006/03/23	No

This option displays and prints Alternate Billing System (ABS) Claims in a submission file.

The Display Claims option shows you all the ABS claim detail that was entered in the file, the total number of ABS claims entered and a dollar total at the end of the listing.

The Display TADs option shows you all the ABS TADs in the file.

To delete a submission file, highlight the file in the grid list and click Delete.

Sort Criteria: Can be sorted by File Name - Newest to Oldest, Batch Date - Oldest to Newest or Starting Claim Number - Lowest to Highest.

When first displayed, the display order is in File Name, Newest to the Oldest.

To change the sort order, click on the radio button  next to the desired sort field.

Search Criteria: Can search by File Name and/or, Batch Date and/or Starting Claim number.

If the file name or starting claim number that you are searching for is not found, the list will be empty. If the batch date you are looking for is not found, TeleClaim will take you to the first record that is closest to the record for which you are searching.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:

20000119

0119

2000/01/19

01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

To perform a search, enter the file name and/or batch date and/or starting claim number the associated text box and click .

When starting a new search, it is recommended you clear all the search fields and press  to get a complete list.

Fields:

File Name: A unique name given to each file.

Start Claim: The starting claim number in this file.

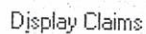
End Claim: The ending claim number in this file.

No. Records: The total number of records submitted in this file.

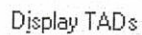
Total: The total amount claimed in this file.

Batch Date: The date this file was batched.

Command Buttons:



allows you to view and print the ABS Claims.



allows you to view and print the ABS TADs in this file.



allows you to delete the highlighted submission file. A dialogue box will appear asking you to confirm the Delete.



closes the current screen.

The following command buttons are found on the individual reports:



allows you to print the report.



allows you to export the report. See help on *Report Preview*.

 100%



allows you to view the report at different sizes. See help on *Report Preview*.

*** The submission report is a report of claims in the database submitted for the highlighted submission file. If you delete claims from your Alternate Billing Claims History that were submitted in the highlighted file, they will not be displayed in the report.

Submission Purge

File Name	Start Claim	End Claim	No. Records	Total	Type	Batch Date	TADS
911111S7.023	0001751	0001751	1	\$150.00	S	2007/01/23	No
911111S7.024	0001752	0001752	2	\$300.00	S	2007/01/24	No
911111S7.025	0001753	0001753	1	\$130.00	S	2007/01/25	Yes
91111187.029	0001758	0001758	1	\$25.00	C	2007/01/29	No

This option is used to delete submission files from TeleClaim and your hard drive.

It is recommended that you wait until the Fee-for-Service Claims, TADs and Alternate Billing Claims in a submission file have been processed and paid before deleting the file.

If you are using TeleClaim on a network, you will not encounter any conflicts running this option, unless the file you are deleting is being used by another user.

You can delete an individual submission file or a group of submission files.

To delete an individual submission file, highlight the file you wish to delete and click the Delete button. A message box will appear asking you to confirm that you wish to delete this record.

To delete a group of submission files, click the Date Delete button. You will be prompted to enter a date. Files will be deleted based on the BATCH DATE. All files batched previous to and including the date entered will be deleted.

Sort Criteria: A sort can be done on File Name - Oldest to Newest or File Name - Newest to Oldest.

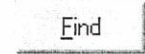
When the screen is first displayed, the files are displayed by file name, from the Oldest to the Newest.

To change the sort order, click on the radio button  next to the desired sort field.

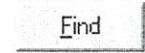
**Search
Criteria:**

A search can be done on File Name. If the file name you are searching for is not found, the list will be blank.

To perform a search, enter the desired File Name in the associated text box and click



When starting a new search, it is recommended you clear all the search fields and press



to get a complete list.

Fields:

File Name: A unique name given to each file.

Start Claim: The starting claim number in this file.

End Claim: The ending claim number in this file.

No. Records: The total number of records submitted in this file.

Total: The total amount claimed in this file.

Type: Type of Submission File. S - Alternate Billing Claims; C - Fee-for-Service Claims and TADs.

Batch Date: The date the file was batched.

TADS: Indicates whether there are TADs in the submission file.

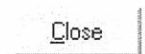
**Command
Buttons:**



To delete a group of submission files, click the Date Delete button. You will be prompted to enter a date. Files will be deleted based on the BATCH DATE. All files batched previous to and including the date entered will be deleted.



allows you to delete the highlighted submission file. A message box will appear asking you to confirm that you wish to delete this file.



closes the current screen.

Reports - Remittance

File Name	Recon Date	EM	MA	MR	MC	UM	Total Claimed	Tot Amt Paid
E1911111.011	2000/01/16	16					16	\$23.23

This option displays and prints remittance reports.

You can display and print two types of reports - Detail and/or Text

A Detail report will give you the detail for each Fee-for-Service Claim and Alternate Billing Claim item in this remittance file.

A Text report will give you a summary for the pay period, including messages from MCP, reason codes, financial adjustments and the total paid.

Note that although you do not see the *TX* or *Text* file name listed here, you can select the text file you wish to display or print by selecting the *E1* file for the pay period desired and click .

To print the Detail report, highlight the file in the grid list and click . To print the Text report, highlight the file in the grid list and click .

Notes

- if a file has not been reconciled under the option Reconcile - FFS and ABS Claims, there will be no Detail report to display.
- if a file has been reconciled by SELECTED PAYEES under the option Reconcile - Claims and Alternate Billings, the Detail report will not be the full Detail report. To display the full Detail report, go to Reconcile - FFS and ABS Claims, click Reconcile and when the option is displayed to choose ALL or SELECTED payees, choose ALL payees.
- a *TX* or *Text* file may not have an associated *E1* file. In this case, there will be no Detail report.

Search Criteria: Can search by File Name.

Search Criteria:

Can search by File Name.

If the file name that you are searching for is not found the grid list will be empty.

To perform a search, enter the file name in the associated text box and click

When starting a new search, it is recommended you clear all the search fields and press to get a complete list.

Fields:

File Name:

A unique name given to each file.

Recon Date:

The date the file was reconciled.

EM:

The number of claims with a Reconciliation Code of Exact Matched. An exact match is a Claim that was found in history with the same claim and item number as on the remittance file and all the fields matched exactly.

MA:

The number of claims with a Reconciliation Code of Matched With Amount Changed. A match with amount changed is a claim that was found in history with the same claim and item number as on the remittance record but the amount paid is different from the amount claimed.

MR:

The number of claims with a Reconciliation Code of Matched With Reason Code. A match with reason code is a claim that was found in history with the same claim and item number as on the remittance record but there is a reason code on the remittance record. The reason code description is included in the remittance text file.

MC:

The number of claims with a Reconciliation Code of Matched With Record Changed. A match with record changed is a claim that was found in history with the same claim and item number as on the remittance record but some field other than the amount field was changed and the record does not contain a reason code.

UM:

The number of claims with a Reconciliation Code of Unmatched. An unmatched is when there was no claim in history to match the claim on the remittance file. This could happen if the claim was submitted on paper, if the claim was deleted from history, or if the claim was submitted from another location.

Total Claimed:

Paid to Self:

Number of claim items paid in a file.

Paid by Others:

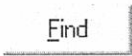
Amount of claims paid for services performed by this provider.

Paid to Others:

Amount of claims paid to this provider, on assigned payment, for services performed by other providers.

Amount of claims paid to other providers for services performed by this provider.

Command Buttons:

Find

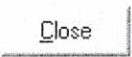
allows you to search for the desired search criteria in the grid list.

Detailed

allows you to view and print the Detail report.

Text

allows you to view and print the Text report.

Close

closes the current screen.

The following command buttons are found on the individual reports (See help on *Report Preview*.)



allows you to print the report.

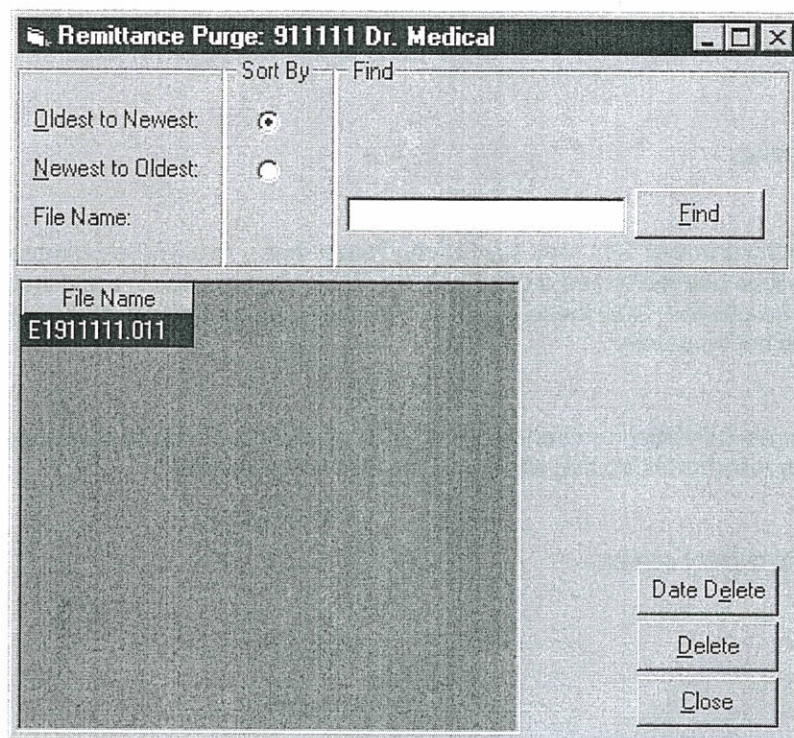


allows you to export the report.

Zoom 100% 

allows you to view the report at different sizes.

Remittance Purge



This option is used to delete remittance files from TeleClaim and your hard drive.

If you are using TeleClaim on a network, you will not encounter any conflicts running this option, unless the file you are deleting is being used by another user.

It is recommended that all remittance files be reconciled before deletion. If the file is not reconciled, the paid claims in that remittance file will not be deleted from History, unless they are deleted using the FFS Claims - History option.

You can delete an individual remittance file or a group of remittance files.

To delete an individual remittance file, highlight the file you wish to delete and click the Delete button. You will be asked to confirm that you wish to delete the file.

To delete a group of files click the Date Delete button. You will be prompted to enter a date. Files will be deleted based on the PAY DATE. All files previous to and including the date entered will be deleted. Only those files that have been reconciled will be deleted. Unreconciled files will not be deleted.

Sort Criteria: A sort can be done on File Name - Newest to Oldest or File Name - Oldest to Newest.

When the screen is first displayed, it is sorted by File Name - Oldest to Newest. To change the sort order, click on the radio button  next to the desired sort field.

Search A search can be done on File Name. If the file name you are searching for is not found, the list

**Search
Criteria:**

will be blank.

To perform a search, enter the desired File Name in the associated text box and click

Find

Fields:

File Name: The remittance file name.

**Command
Buttons:**

Date Delete

To delete a group of files click the Delete Date button. You will be prompted to enter a date. Files will be deleted based on the PAY DATE. All files previous to and including the date entered will be deleted. Only those files that have been reconciled will be deleted. Unreconciled files will not be deleted.

Delete

To delete an individual remittance file, highlight the file you wish to delete and click the delete button. It is recommended that all remittance files be reconciled.

Close

closes the current screen.

Reports - Outstanding

This option displays and prints unpaid Fee-for-Service Claims and Alternate Billing Claims in History.

To display unpaid Fee-for-Service Claims, chose *Reports - Outstanding - FFS Claims* option.

To display unpaid Alternate Billings, chose *Reports - Outstanding - ABS Claims* option.

Using this option allows you to check for older Fee-for-Service and Alternate Billing Claims that are still in your system unpaid so you can investigate why they are still there. In some cases they may be canceled claims that you have not deleted from the outstanding file or claims from the remittance file you received but did not reconcile.

Use the *FFS Claims - History*, or *ABS Claims - History* options to delete canceled Fee-for-Service Claims or Alternate Billing Claims, or any Fee-for-Service Claim, or Alternate Billing Claims that will not be paid. Keeping your Outstanding/History file well maintained will help TeleClaim to run more efficiently and make it easier for you to maintain your system overall.

These options default to selecting Fee-for-Service Claims or Alternate Billing Claims that are 30 days old, or older, but you can change this to be any number of days from 0 to 999. The date used to select Fee-for-Service Claims or Alternate Billing Claims is the BATCH DATE. The Fee-for-Service Claims and Alternate Billing Claims are listed in batch date order from Oldest to Newest on each report.

At the end of each report is a total dollar amount and total number of outstanding Fee-for-Service Claims or outstanding Alternate Billing Claims, depending on the report printed.

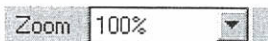
Command Buttons:



allows you to print the report.



allows you to export the report. See help on *Report Preview* for more information.

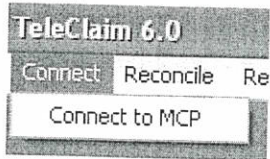


allows you to view the report at different sizes. See help on *Report Preview* for more information..

TECHNICAL SUPPORT AND MISCELLANEOUS

- **CONNECT MENU**
- **FILES SENT TO AND RECEIVED FROM MCP**
- **BACKUPS**
- **COMPACT DATABASE**
- **RESTORE ABS SUBMISSION FILES**
- **RESTORE FFS SUBMISSION FILES**
- **JULIAN CALENDAR**

Connect Menu



Select this option to transmit the submission files that were created by the batching process to MCP. These files will be sent to MCP via modem using your MCP file transmission software.

As part of the transmission, any files created for you by MCP (for example, TAD files, Remittance files), will be automatically transmitted to your computer.

For further information about this program see the documentation provided with your transmission software.

Connect to MCP

Select this option to transmit the submission files that were created by the batching process to MCP. These files will be sent via modem using your MCP file transmission software, to your folder on the MCP computer network.

As part of the transmission, any files created for you by MCP (for example, TAD files, Remittance files), will be automatically transmitted to your computer.

For further information about this program see the documentation provided with your transmission software.

Files sent to and received from MCP

Files sent to MCP by the Provider

- Fee-for-Service Claims and TADs (for example 91111139.328)
- Letters written by the provider to send to MCP (for example 911111L9.328)
- Alternate Billing Claims (for example 911111S9.328)

Where: 911111 is the provider number
3 is the sequence number of the FFS batch, L = Letters, S = Alternate Billing System
(ABS) Claims
9 is the fourth digit of the year
328 is the Julian Date

Files sent to the Provider by MCP

- Remittance Detail (for example E1911111.918)
- Remittance Text (for example TX911111.918)
- Alternate Billing TADs (for example S9111119.328)
- Fee-for-Service TADs (for example T9111119.328)

Where: E1 = Remittance Detail, TX = Remittance Text, S = Alternate Billing System (ABS)
TADs, T = Fee-for-Service TADs
911111 is the provider number
9 is the sequence number (Fee-for-Service TADs)
918 is fourth digit of the year (9) and pay period (18) and 328 is the Julian Date

Backups

A backup is a duplicate copy of a file or files, which is stored on tape, writable CD or DVD or other storage device as a protective means against the accidental loss or destruction of the data. Crucial data and programs should be backed up regularly.

Backups should be done on a regular basis. This will enable you to restore data in the event of a hard disk failure, re-installation, corrupted data files, or other problems. The data can be restored from the latest backup, minimizing the amount of data reentry required.

For all backups, it is strongly recommended that copies be stored off site in case of fire or other building disaster.

It is up to the provider(s) to determine how often backups are required, deciding on a schedule that suits their particular practice.

There are no backup options in the system. For details on how to do backups, copies and restores, refer to the backup, copy and restore commands in your Windows documentation or online help.

Database File

This backup would include **MCP.MDB**. Ideally this backup would be done daily, though this may not be practical for some practices.

It is recommended that you compact your database after you backup the database. On the menu, go to Utilities - Compact Database.

For this backup, it is recommended that you retain several sets of backups (CDs, DVDs or tapes). For example, you could have a set for each work day of the week, so that you would have a weeks worth of backups at any given time.

Submission Files

If you wish to backup submission files, copy or backup some or all of the files in the directory in which TeleClaim is installed that start with the provider's number. For example, backing up all files that start with 999901 will give you all submission files for provider 999901. You could also copy or backup individual files.

Remittance Files

To backup remittance files, backup files in the directory in which TeleClaim is installed that start with E1 and TX.

TAD Files

To backup TAD files, backup files in the directory in which TeleClaim is installed that start with S or T and then the Provider number. For example, backing up all files that start with S999901 will give you all the Sessional TAD files for provider 999901.

Software

It is recommended that the original software CD and/or diskette received from MCP be stored in a safe place, and not be reused for other purposes.

Full Backup

You may wish to do a full backup of your system on occasions. This will include all data files and software in your TeleClaim system. To do a full backup, include everything in the directory in which TeleClaim is installed. The default directory is C:\MCP.

Restore ABS Submission Files

File Name	Start Claim	End Claim	No. Records	Total	Batch Date	TADS
911111S7.025	0001753	0001753	1	\$130.00	2007/01/25	Yes
911111S7.024	0001752	0001752	2	\$300.00	2007/01/24	No
911111S7.023	0001751	0001751	1	\$150.00	2007/01/23	No

This option will restore the Alternate Billing System (ABS) Claims and TADS in a selected ABS submission file back into the ABS Claims Maintain and ABS TADS Maintain options, and remove them from ABS Claims History and/or ABS TADS History.

This option should be used only when problems occur, and should be used with caution!

DO NOT RESTORE A FILE UNLESS ADVISED TO DO SO BY MCP.

Before running this option, ensure that there are no unbatched ABS claims entered. If there are, batch them before running this option.

To restore a file, highlight the file you wish to restore and click the Restore button. You will be asked to confirm that you wish to do a restore. If you select **NO**, you will be returned to the list of submission files.

If you select **YES**, and there are ABS claims entered but not batched, a message box will appear informing you that you have to batch all ABS claims before a restore can be done.

If you select **YES**, and there are no unbatched ABS claims, TeleClaim will continue with the restore.

TeleClaim will restore the ABS claims and/or TADS in the submission file to the ABS Claims and TADS Maintain options. You can then use the ABS Claims - Maintain option and/or the TADS - Maintain - ABS TADS option to make any necessary changes.

These claims and TADS can then be batched again when ready.

Note that the claims (not the TADS) will be assigned new claim numbers, i.e. the claim numbers assigned to these claims when they were originally batched will not be reused.

**Search
Criteria:**

A search can be done on *File Name*. If the file name you are searching for is not found, the list will be blank.

To perform a search, enter the desired *File Name* in the text box and click .

When starting a new search, it is recommended you clear all the search fields and click to get a complete list, and then enter the *File Name* for the new search.

Columns:

- File Name:** A unique name given to each file.
- Start Claim:** The starting claim number in this file.
- End Claim:** The ending claim number in this file.
- No. Records:** The total number of records in this file.
- Total:** The total amount claimed in this file.
- Batch Date:** The date this file was batched.
- TADS:** Indicates whether there are TADs in the submission file.

**Command
Buttons:**

To restore a file, highlight the file you wish to restore and click *Restore*.

Click *Close* to exit this screen and go back to the previous screen..

Restore FFS Submission Files

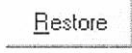
File Name	Start Claim	End Claim	No. Records	Total	Batch Date	TADS
91111187.029	0001758	0001758	1	\$25.00	2007/01/29	No
91111177.029	0001757	0001757	1	\$25.00	2007/01/29	No

This option will restore the Fee-for-Service Claims and TADS in a selected submission file back into the claims and TADS work files, and remove them from history.

This option should be used only when problems occur, and should be used with caution! If you are not sure if it is appropriate to do a restore, contact your vendor or MCP for advice. **Do not restore a file that has already been transmitted to MCP unless advised to do so by MCP.**

This is an example of an appropriate situation for using the restore option. If claims were batched and assigned claim numbers that had already been used by the provider, you would investigate and correct the claim number problem. Then you would restore the submission file containing the claims with the duplicate claim numbers, and rebatch them so that new claim numbers are assigned to those claims.

Before running this option, ensure that there are no unbatched Fee-for-Service Claims entered. If there are, batch then before running this option.

To restore a file, highlight the file you wish to restore and press the  button. You will be asked to confirm that you wish to do a restore. If you select NO, you will be returned to the list of submission files.

If you select YES, and there are Fee-for-Service Claims entered but not batched, a message box will appear informing you that you have to batch all Fee-for-Service Claims before a restore can be completed. If you select YES, and there are no unbatched Fee-for-Service Claims entered, TeleClaim will continue with the restore.

TeleClaim will restore the Fee-for-Service Claims and the TADS in the submission file to the Fee-for-Service Claims and TADS work files. You can then use the *FFS Claims - Maintain* option to make any corrections to the Fee-for-Service Claims or the *FFS TADS - Maintain* option to make any corrections to the TADS. These Fee-for-Service Claims and TADS can then be batched again when ready.

Search Criteria:

A search can be done on File Name. If the file name you are searching for is not found will be blank.

To perform a search, enter the desired File Name in the associated text box and click

Find

When starting a new search, it is recommended you clear all the search fields and pre-

Find

to get a complete list.

Fields:

File Name:

A unique name given to each file.

Start Claim:

The starting claim number in this file.

End Claim:

The ending claim number in this file.

No. Records:

The total number of records in this file.

Total:

The total amount claimed in this file.

Batch Date:

The date this file was batched.

TADS:

Indicates whether there are TADs in the submission file.

Command Buttons:

Restore

To restore a file, highlight the file you wish to restore and press this button

Delete

allows you to delete the highlighted submission file. A message box will ask you to confirm that you wish to delete this submission file.

Close

closes the current screen.

Julian Calendar

The Julian calendar used by MCP numbers every day of the year from 1 to 366. In years that are not leap years, the Julian date for February 29, which is 060, is not used.

Note that most Julian calendars, unlike the one used by MCP, number non-leap years from 1 to 365. If you have a Julian calendar be sure that it uses 366 days for every year.