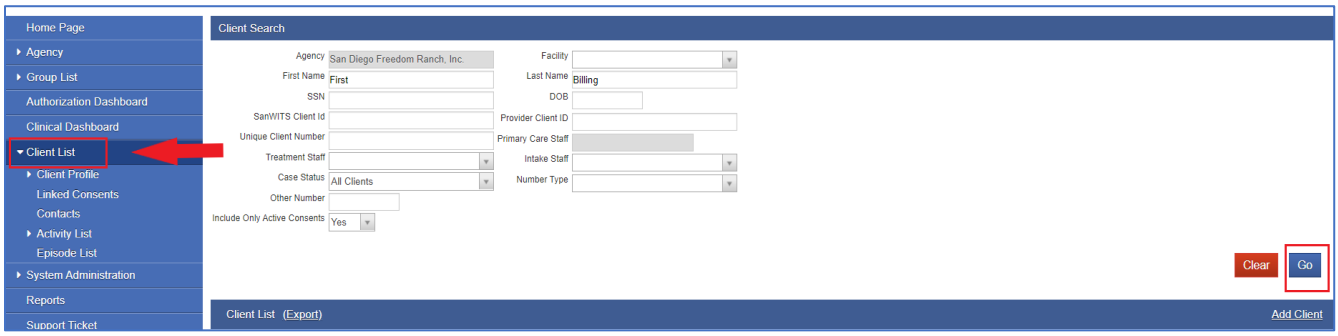
TIP SHEET ON HOW TO RELEASE THE OUTPATIENT SERVICES TO OHC AND HOW TO PRINT THE OHC CMS-1500 FORM USING SANWITS

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

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

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



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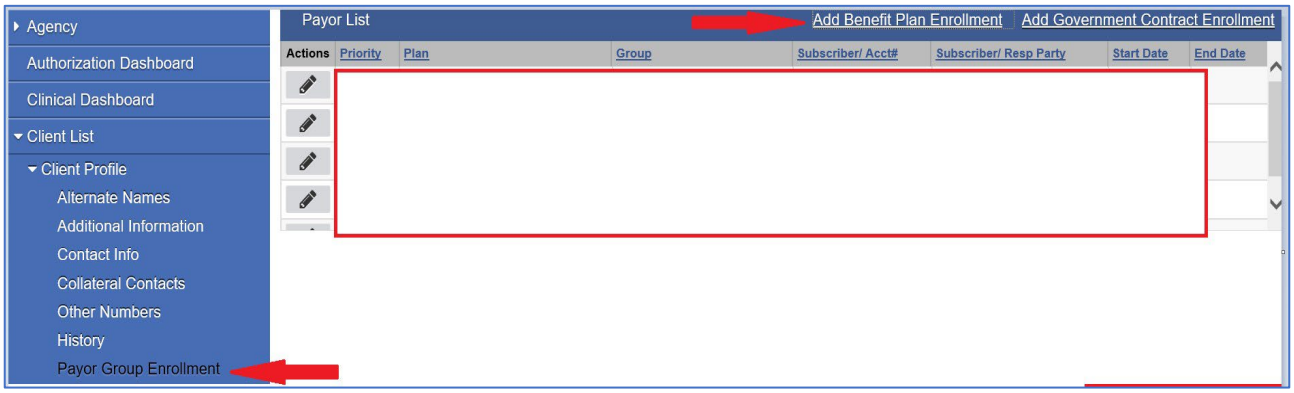
4. Go to Payor Group Enrollment (PGE). Click Add Benefit Plan Enrollment.

Payor Group Enrollment screen

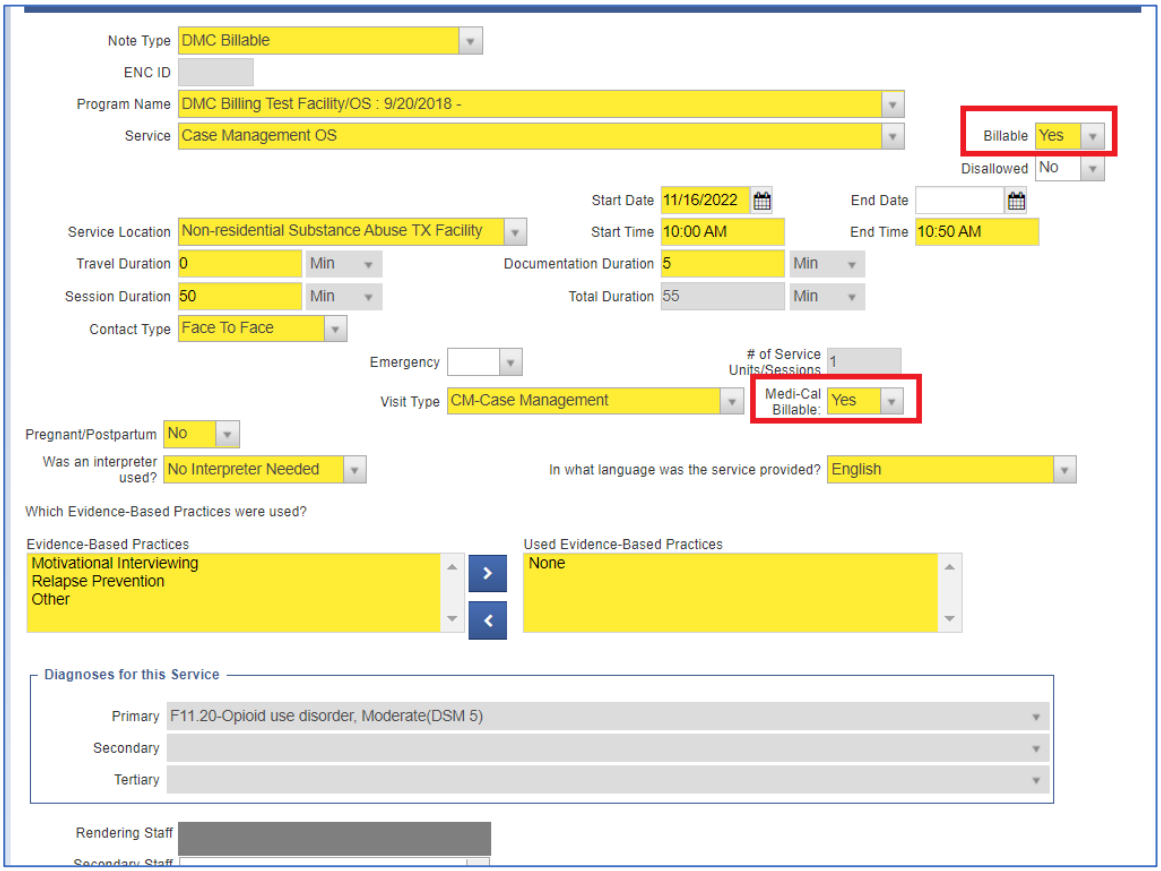


5. Select Payor-Type (Group Insurance) and Plan Group (Other Health Coverage (OHC) General. Select Relationship to Subscriber (Self). Enter Coverage Start (e.g., 03/01/2020)
   Enter Subscriber # or 000 if not available.
   Enter the OHC Policy # on the Policy # field when available.
   NOTE: If client is DMC Billable, please create a DMC PGE as well.

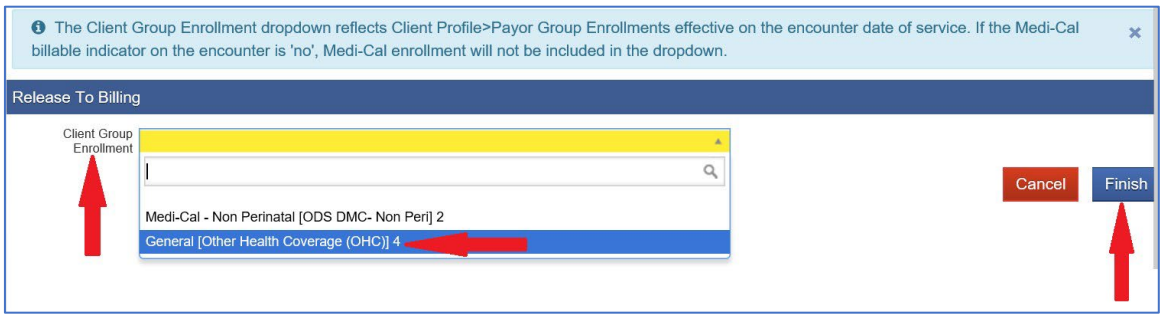
6. Go to Encounters (Outpatient services). Click Release to Billing.

Note: The Medi-Cal Billable box should have a "Yes" response.

Encounter screen



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



8. Go to Claim Item List. Select Plan Other Health Coverage. Item Status All Awaiting Review. Select your Facility -> Enter Service Date (e.g., 07012020:07312020) -> Click Go.

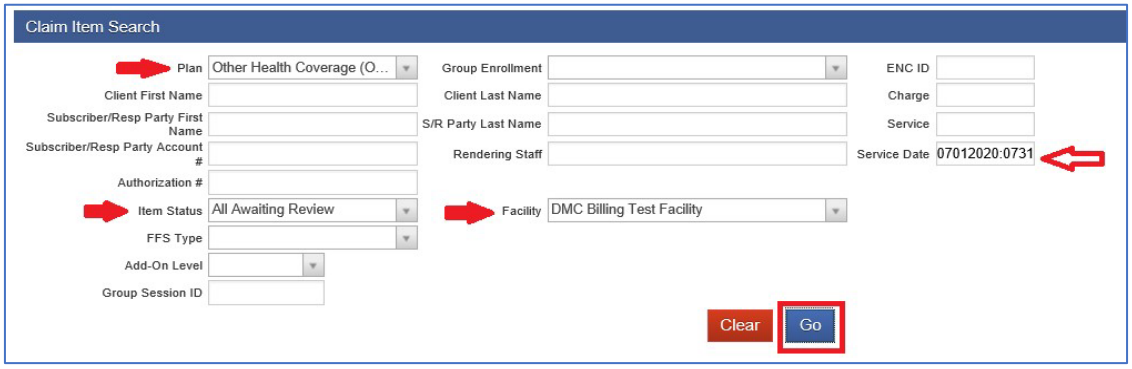
   Note: You can put the OHC claims on hold if you are not yet billing DMC and waiting for the insurance Explanation of Benefits (EOB). Please remember to check the OPTUM BHS Resources, Billing folder regarding rules on hold OHC claims for over 90 days.

   Drug Medi-Cal Organized Delivery System (optumsandiego.com)

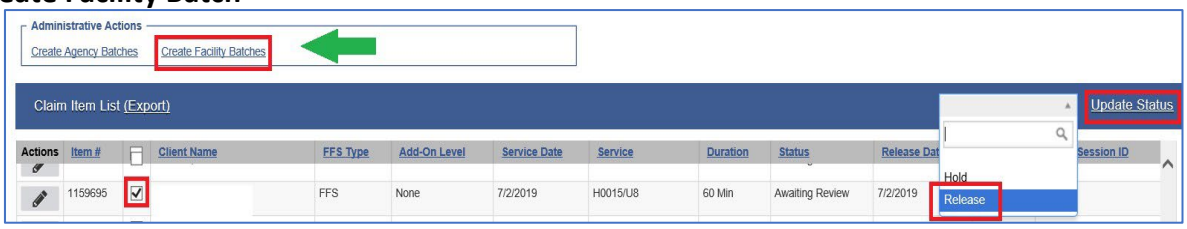
SUD Billing Announcement: Other Health Coverage Rules for Outpatient Providers (msg).	Email announcement regarding OHC Rules

9. Check the box next to Item # then click Release & Update Status. Click ***Create Facility Batches.***

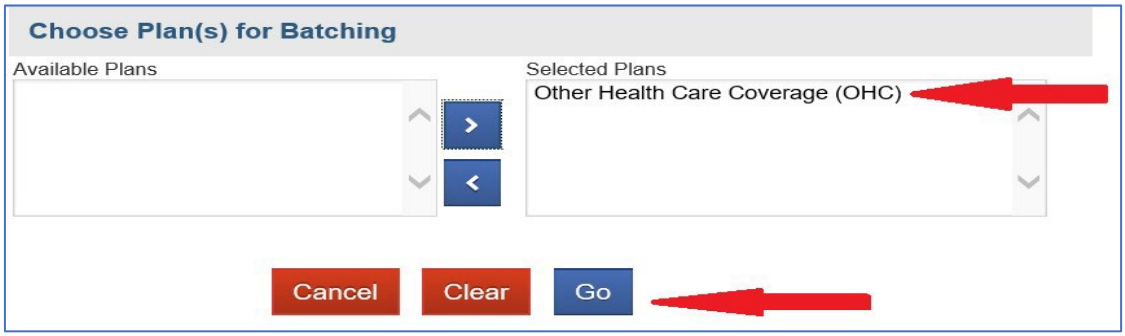
Claim Item List screen



Create Facility Batch

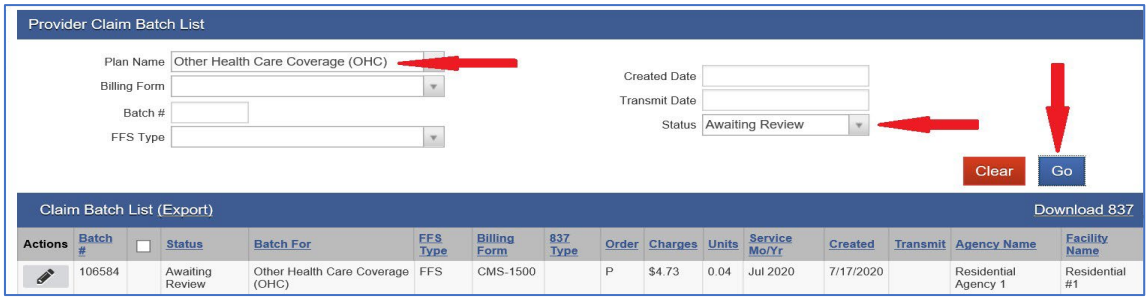


10. Move the Available Plans to the right. Click Go.



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

Claim Batch List screen



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

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

Admin Action: Release

Admin Action: Bill It

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

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

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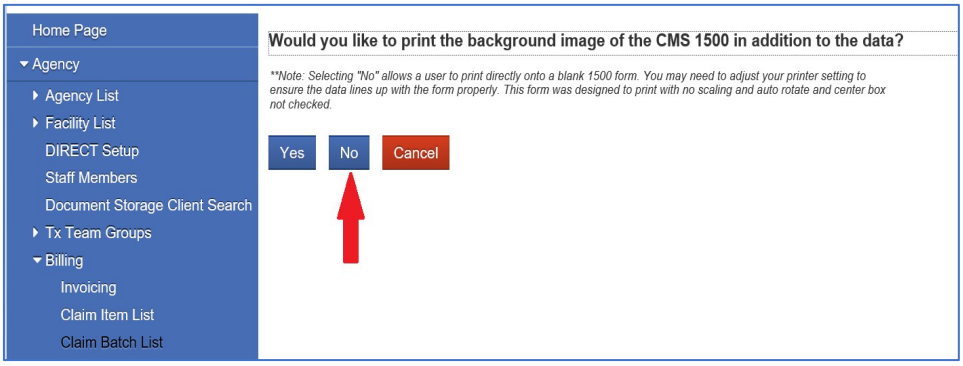
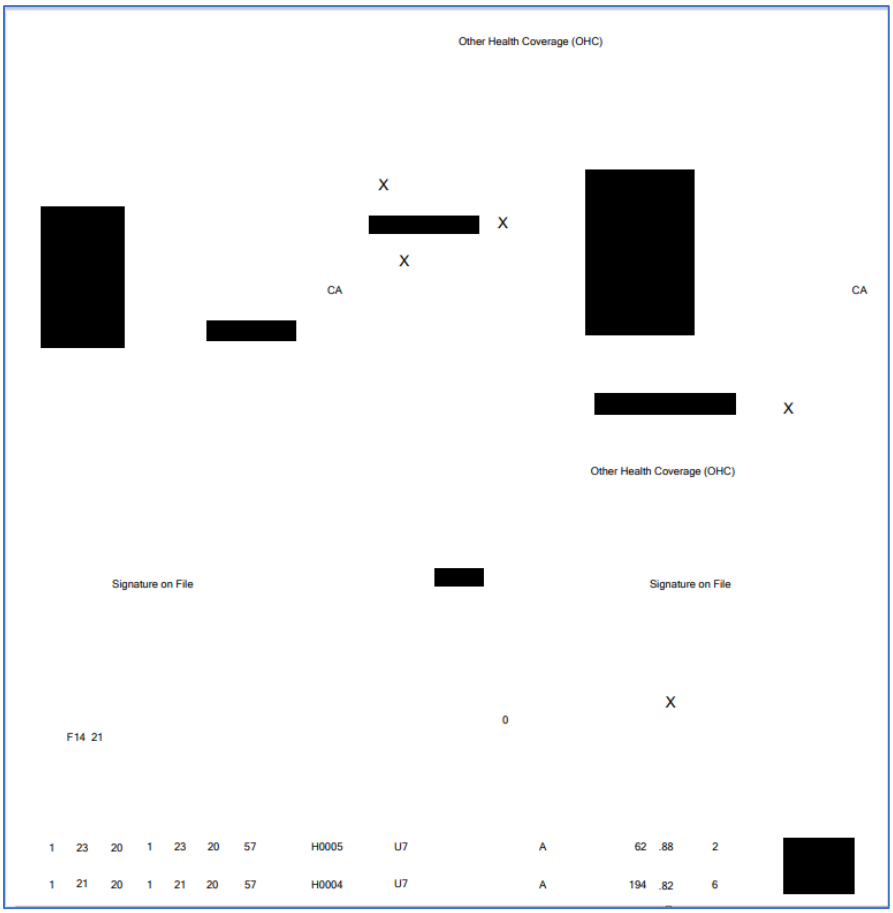


- The CMS 1500 form's print view will be in black and white, with no lines and field titles.

Here is how the CMS 1500 print preview looks like:



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

Benefit Plan/Private Pay Billing Information

Payor-Type: Group Insurance
Plan-Group: Other Health Coverage (OHC)-Ge
Payor Priority Order: 3
Policy #: POLNO1
Coverage Start: 03/02/2020
End:
Payment Scale:
Aid Code:
Relationship to Subscriber/ Responsible Party: Self

Subscriber/ Responsible Party:

First Name: First
Middle: Day
Last Name: Billing
Birthdate: 01/01/1988
Gender: 2-Female
Subscriber #: SUBSCRN02
Address 1: 123 Not Real Address St.
Address 2:
City: san Diego
State: California
Zip: 92125

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M [X] F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

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

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [X] F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME Other Health Coverage (OHC)

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

CARF

PATIENT AND INSURED INFORMATION

Quick Tips:

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

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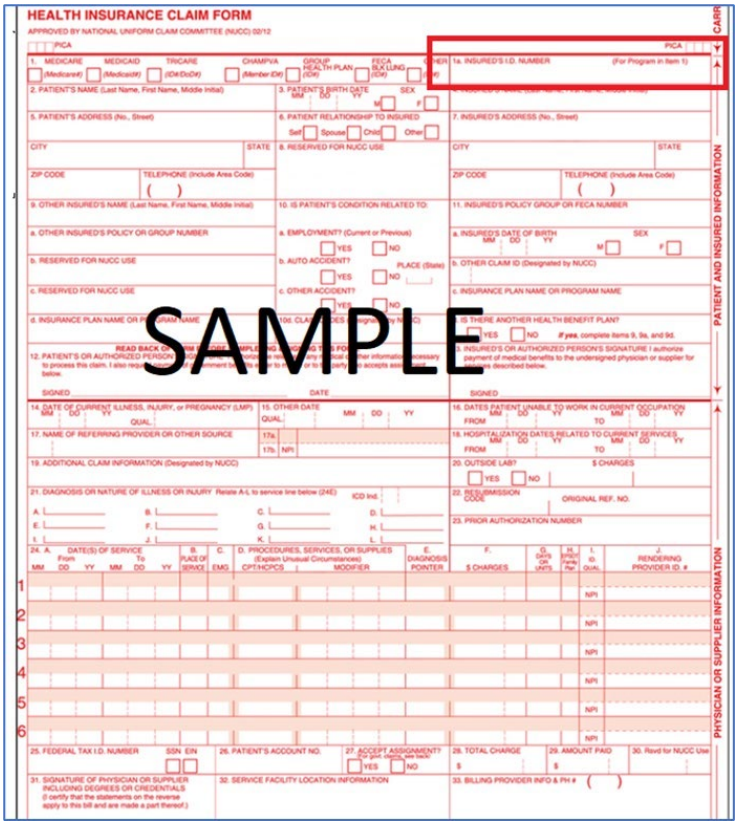
Sample: Red/white CMS 1500 Form



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