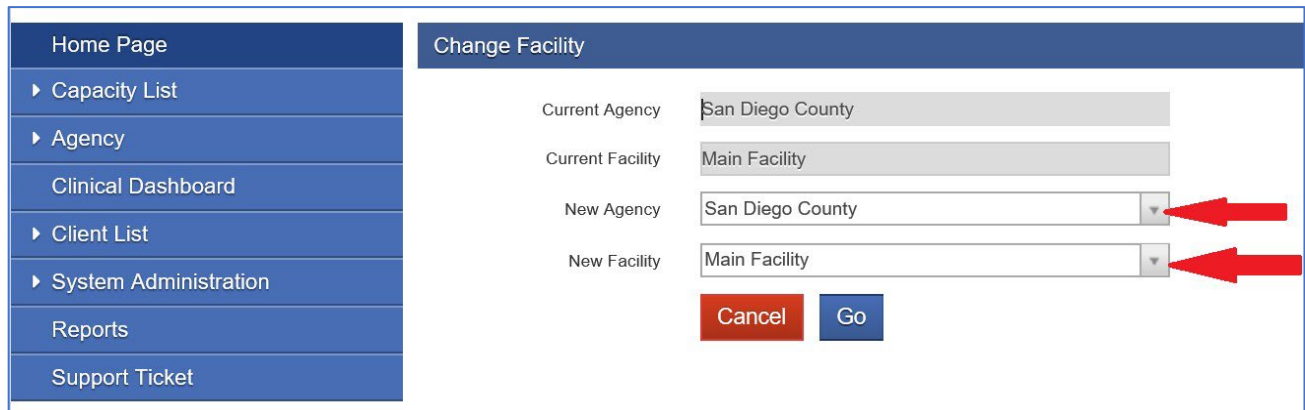


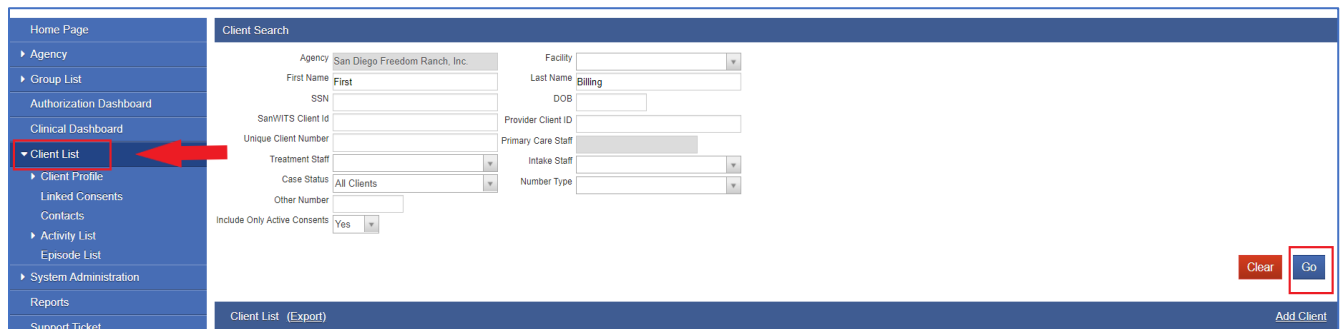
TIP SHEET ON HOW TO RELEASE THE OUTPATIENT SERVICES TO OHC AND HOW TO PRINT THE OHC CMS-1500 FORM USING SANWITS

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.



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

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

Payor Group Enrollment screen

- 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.

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

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

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

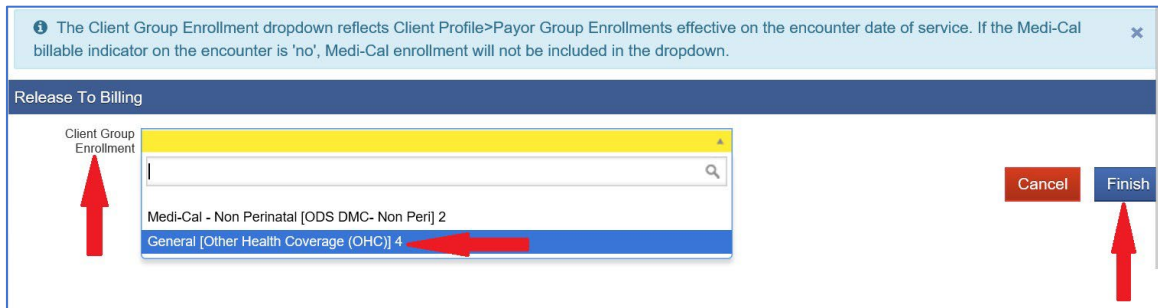
Encounter screen

The screenshot shows the 'Encounter screen' with the following fields and values:

- Note Type: DMC Billable
- ENC ID: [Empty]
- Program Name: DMC Billing Test Facility/OS : 9/20/2018 -
- Service: Case Management OS
- Billable: Yes (highlighted with a red box)
- Disallowed: No
- Start Date: 11/16/2022
- End Date: [Empty]
- Start Time: 10:00 AM
- End Time: 10:50 AM
- Service Location: Non-residential Substance Abuse TX Facility
- Travel Duration: 0 Min
- Documentation Duration: 5 Min
- Session Duration: 50 Min
- Total Duration: 55 Min
- Contact Type: Face To Face
- Emergency: [Empty]
- # of Service Units/Sessions: 1
- Visit Type: CM-Case Management
- Medi-Cal Billable: Yes (highlighted with a red box)
- Pregnant/Postpartum: No
- Was an interpreter used?: No Interpreter Needed
- In what language was the service provided?: English
- Which Evidence-Based Practices were used?:
 - Evidence-Based Practices: Motivational Interviewing, Relapse Prevention, Other
 - Used Evidence-Based Practices: None
- Diagnoses for this Service:
 - Primary: F11.20-Opioid use disorder, Moderate(DSM 5)
 - Secondary: [Empty]
 - Tertiary: [Empty]
- Rendering Staff: [Empty]
- Secondary Staff: [Empty]

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

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



The Client Group Enrollment dropdown reflects Client Profile>Payor Group Enrollments effective on the encounter date of service. If the Medi-Cal billable indicator on the encounter is 'no', Medi-Cal enrollment will not be included in the dropdown.

Release To Billing

Client Group Enrollment

Medi-Cal - Non Perinatal [ODS DMC- Non Per] 2

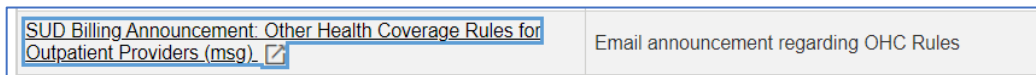
General [Other Health Coverage (OHC)] 4

Cancel 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 \(optumsandiego.com\)](http://optumsandiego.com)

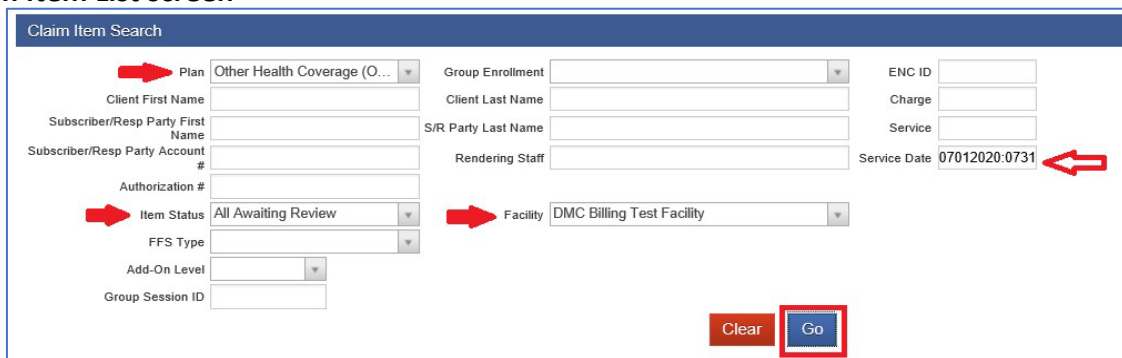


SUD Billing Announcement: Other Health Coverage Rules for Outpatient Providers (msg)

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



Claim Item Search

Plan Other Health Coverage (OHC)

Client First Name

Client Last Name

Subscriber/Resp Party First Name

Subscriber/Resp Party Last Name

Subscriber/Resp Party Account #

Authorization #

Item Status All Awaiting Review

FFS Type

Add-On Level

Group Session ID

Group Enrollment

Client Last Name

S/R Party Last Name

Rendering Staff

Facility DMC Billing Test Facility

ENC ID

Charge

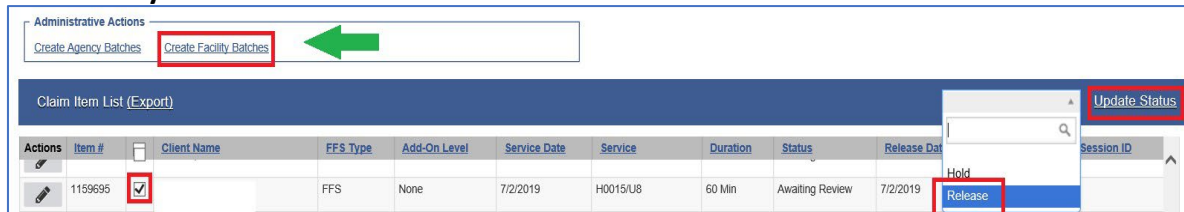
Service

Service Date 07012020:0731

Clear Go

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

Create Facility Batch



Administrative Actions

Create Agency Batches Create Facility Batches

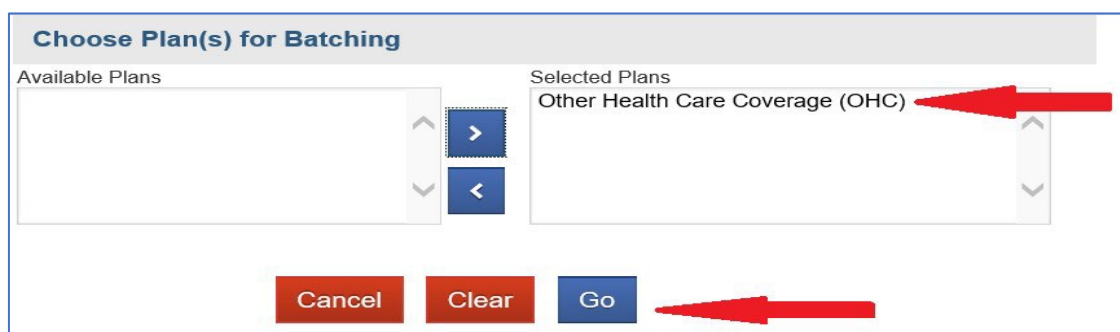
Claim Item List (Export)

Actions	Item #	Client Name	FFS Type	Add-On Level	Service Date	Service	Duration	Status	Release Date	Session ID
	1159695		FFS	None	7/2/2019	H0015/U8	60 Min	Awaiting Review	7/2/2019	

Hold Release

Update Status

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



Choose Plan(s) for Batching

Available Plans

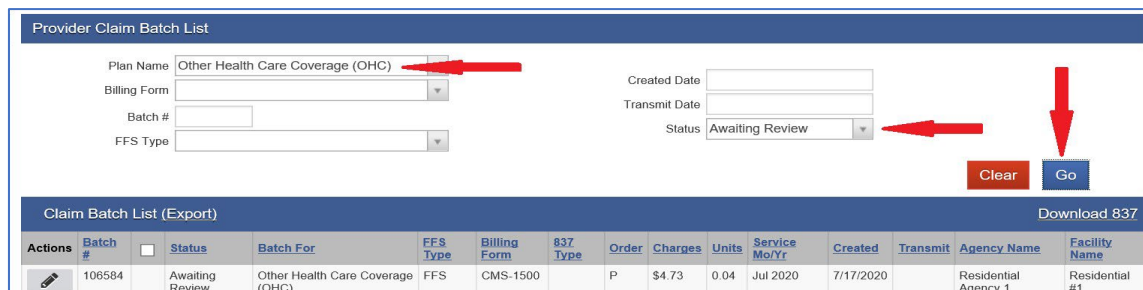
Selected Plans

Other Health Care Coverage (OHC)

Cancel Clear 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



Provider Claim Batch List

Plan Name Other Health Care Coverage (OHC)

Billing Form

Batch #

FFS Type

Created Date

Transmit Date

Status Awaiting Review

Clear Go

Claim Batch List (Export) Download 837

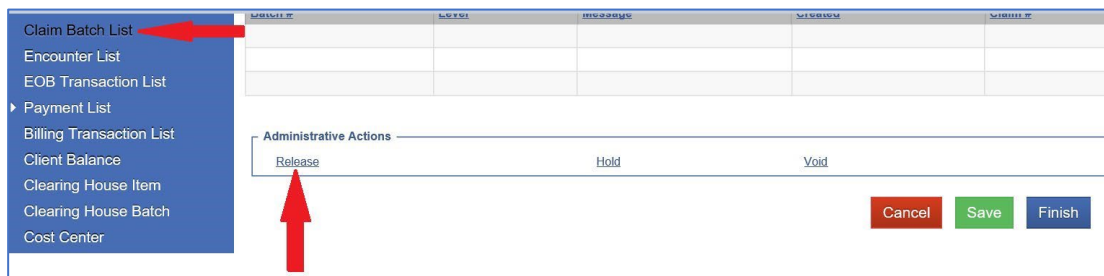
Actions	Batch #	Status	Batch For	FFS Type	Billing Form	837 Type	Order	Charges	Units	Service Mo/Yr	Created	Transmit	Agency Name	Facility Name
	106584	Awaiting Review	Other Health Care Coverage (OHC)	FFS	CMS-1500		P	\$4.73	0.04	Jul 2020	7/17/2020		Residential Agency 1	Residential #1

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

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.

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

Home Page

▼ Agency

▶ Agency List

▶ Facility List

DIRECT Setup

Staff Members

Document Storage Client Search

▶ Tx Team Groups

▼ Billing

Invoicing

Claim Item List

Claim Batch List

Would you like to print the background image of the CMS 1500 in addition to the data?

**Note: Selecting "No" allows a user to print directly onto a blank 1500 form. You may need to adjust your printer setting to ensure the data lines up with the form properly. This form was designed to print with no scaling and auto rotate and center box not checked.

Yes
No
Cancel

- 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:

Other Health Coverage (OHC)

X

CA

Signature on File

F14 21

X

CA

Signature on File

X

1 23 20 1 23 20 57 H0005 U7 A 62 .88 2

1 21 20 1 21 20 57 H0004 U7 A 194 .82 6

0

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

- 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)-Gen	
Payor Priority Order 3		<div style="border: 2px solid red; padding: 2px;">Policy # POLNO1</div>	
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	<div style="border: 2px solid red; padding: 2px;">Subscriber # SUBSCRN02</div>
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.

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

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

HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12</small>									
<input type="checkbox"/> PICA					<input type="checkbox"/> PICA				
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input checked="" type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (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 <input checked="" type="checkbox"/> F <input type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street) CITY _____ STATE _____					4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY _____ STATE _____				
ZIP CODE _____ TELEPHONE (Include Area Code) () _____					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)				
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 _____					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM / DD / YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) _____ c. INSURANCE PLAN NAME OR PROGRAM NAME Other Health Coverage (OHC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) _____					15. OTHER DATE _____				
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION _____									

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.

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

Sample: Red/white CMS 1500 Form

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

SAMPLE

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (Long Term Disability) <input type="checkbox"/>		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	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)		14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
15. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL. _____		16. OTHER DATE (MM DD YY) QUAL. _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Please A-L to service line below (24E) ICD-9-CM _____		22. SUBMISSION CODE ORIGINAL REF. NO. _____	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE (EMS) C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) D. MODIFIER E. DIAGNOSIS PORTER F. \$ CHARGES G. UNITS H. ICD-9-CM I. RENDERING PROVIDER ID # J. RENDERING PROVIDER ID #	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> (For Fee-For-Service)		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. BILLING PROVIDER INFO & PH #	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	

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.