

What's New in 9.5.48- 9.5.52



This document was developed by Genius Solutions to introduce users to the features/modifications that have been released in versions 9.5.48 to 9.5.52 of eTHOMAS. Click on the text or page numbers within the Contents page to be brought to that specific item within the document.

eTHOMAS

Contents

Service History Report 3

Second Appointment Type..... 3

Statements..... 3

 Bad Address 3

 Doctor Name on Statements 3

 Statement Notes 3

 Claim Specific Statement Notes..... 4

 Running Total Statements..... 6

 Open Item Statements..... 6

 Claim Detail Statements..... 6

 Electronic Claim Detail 7

 \$0.00 Insurance Payments..... 7

Claims..... 7

 Paper Claims NDC 7

 Dental Claims 7

Service History Report

Changes were made to the Enhanced Service History Report to include a header on each page and additional spacing between diagnoses to make the report more legible.

Second Appointment Type

Previously, if the second appointment type was filled out on an appointment, the user could not change it back to blank. This has been changed so a blank appointment type can now be selected.

Statements

Bad Address

Patients whose Guarantor address is incomplete will now appear on the statement prebiling report as an error of "Bad Address". The address must be completed before statements can be sent for the patient.

Doctor Name on Statements

The claim doctor will now print on Claim Detail patient statements.

PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT. RETAIN THE BOTTOM PORTION FOR YOUR RECORDS.					
DATE	PATIENT	DESCRIPTION		ACCOUNT ACTIVITY	
				INSURANCE	PATIENT
01/01/2018	JOHANSEN, BETTY B	99213 GENERAL OFFICE VISIT	Clm: 1234699 ROBERT BROWN	85.00	15.00

Statement Notes

Within the Statement Notes feature an adjustment code can now be selected to indicate the reason for the note. This reason will default in the "remarks" section to be printed on the patient statement. This allows users to easily create notes for common situations in their office.

To add an adjustment code, go to Code Files | Procedure | Adjustments. Click the  to add a new code.

- **Code:** Enter 2 characters to identify this adjustment code.
- **Description:** Enter a description used to define the adjustment code.
- **Statement Note:** Enter the message to appear on the patient statement.

Adjustment Codes

Code: CB

Description: COORDINATION OF BENEFITS

Statement Note: YOUR CLAIM HAS BEEN REJECTED DUE TO A COORDINATION OF BENEFITS ISSUE. PLEASE CONTACT YOUR INSURANCE CARRIER TO NOTIFY THEM OF ANY ADDITIONAL INSURANCE POLICIES THAT YOU HAVE.

Click  to save the code.

To add a statement note to a patient, click on Patient | Notes | Stmt Notes.

Selecting a Code from the drop-down will automatically populate the information from that code into the Remarks field. You can type in additional text in the field as well. Just be sure to select the Code first before typing any additional text, since choosing a code after you have typed into the Remarks field will override the verbiage to the text defined in the code.

The note will appear on the statement as shown below (as long as “Show on Statement” was checked when the note was created).

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY	
			INSURANCE	PATIENT
	JOHANSEN, BETTY B			
01/01/2018	99213	GENERAL OFFICE VISIT	Clin: 1234699 ROBERT BROWN	85.00
12/12/2018		STATEMENT NOTES		15.00
		(COORDINATION OF BENEFITS) YOUR CLAIM HAS BEEN REJECTED DUE TO A COORDINATION OF BENEFITS ISSUE. PLEASE CONTACT YOUR INSURANCE CARRIER TO NOTIFY THEM OF ANY ADDITIONAL INSURANCE POLICIES THAT YOU HAVE.		

Claim Specific Statement Notes

Statement notes can now be attached to a specific claim. This will allow the note to print on the patient statement with the claim that it pertains to. This feature works a little differently depending on which statement type is used, and is detailed below.

A statement note can be attached to a claim two different ways. The first method is on the insurance payment posting screen. Clicking on “Stmt Note” will bring up the statement note screen and the claim number will automatically fill out and cannot be changed to a different claim.

Post Insurance Payment P5-430 DENTON, JOSEPH
Cash: 105.00 Ins: 120.00

Check No: Check Date:
 ICN: Bill Method:
 Post Date: 02/15/2019 Claim Status: Billed
 Method: Check

No Alert Information
No Note Information

Claim: 1136 Insurance: BC - BLUE CROSS BLUE SHIELD
 Location: GSDocor: 01 Financial: BC - BLUE CROSS

Patient Paid:	0.00	Pol	FC	Insurance
Ins Paid:	0.00	1	BC	BC
Ins Bal:	60.00	2		
Total Paid:	0.00	3		
Total Adjusted:	0.00			
Total Approved:	75.00			

Prep Claim Prep Stmt
 Done Exit

Ins Adj Inquiry Rgt Note Claim Note Stmt Note


DOS	Proc	Charge	To Pat	PTD	Approved	Amt Paid	Deductible	Copay	ParAdj	BT	M	Xfer Reason
02/15/2019	99213	75.00	15.00	0.00	75.00	0.00	0.00	75.00	0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Benefits denied

PgD: Done F4: Medicaid F6: Claim Status Totals: 75.00 0.00 0.00 75.00 0.00
 F3: Interest F5: Grid F7: Check No

Add Statement Note P5 - 430 DENTON, JOSEPH
Cash: 105.00 Ins: 120.00


Date: 02/18/2019 Date To: 02/18/2019
 Doctor:
 Location:
 Code:
 Remarks:

Claim No: 1136
☒ Show On Statement

The second method is by going to Patient | Notes | Stmt Notes. To attach the note to a specific claim, click the  next to the claim number field. This will bring a list of patient claims to choose from.

Add Statement Note P5 - 430 DENTON, JOSEPH
Cash: 105.00 Ins: 120.00

Date: 02/18/2019 Date To: 02/18/2019
 Doctor:
 Location:
 Code: NO INSURANCE COVERAGE
 Remarks: (NO INSURANCE COVERAGE) IT APPEARS THAT YOUR INSURANCE IS NOT ACTIVE. PLEASE REMIT PAYMENT OR CONTACT YOUR INSURANCE COMPANY.

Claim No: 0  ☒ Show On Statement

Running Total Statements

For Running Total statements, the statement note will show on the patient statement when the claim it is attached to has a balance. In order for the note to display below the outstanding claim, the date of the note should be the same as the transfer balance.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY	
			INSURANCE	PATIENT
	DENTON, JOSEPH			
		Date Statement from 01/20/2019 to 02/19/2019		
		Previous Balance		15.00
02/01/2019		99213 OFFICE VISIT		
02/01/2019		TRANSFER BALANCE		75.00
		(\$75.00 BENEFITS DENIED) 02/01/2019 OFFICE VISIT		
02/01/2019		STATEMENT NOTE		
		(NO INSURANCE COVERAGE) IT APPEARS THAT YOUR INSURANCE IS NOT ACTIVE. PLEASE REMIT PAYMENT OR CONTACT YOUR INSURANCE COMPANY.		
02/15/2019		99213 OFFICE VISIT		15.00

Open Item Statements

For Open Item statements, the statement note will show on the patient statement when the claim it is attached to has a balance. In order for the note to display below the outstanding claim, the date of the note should be the same as the date of service.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY	
			INSURANCE	PATIENT
	DENTON, JOSEPH			
01/18/2019		99213 OFFICE VISIT		15.00
02/01/2019		99213 OFFICE VISIT (BENEFITS DENIED)		75.00
02/01/2019		STATEMENT NOTE		
		(NO INSURANCE COVERAGE) IT APPEARS THAT YOUR INSURANCE IS NOT ACTIVE. PLEASE REMIT PAYMENT OR CONTACT YOUR INSURANCE COMPANY.		
02/15/2019		99213 OFFICE VISIT		15.00

Claim Detail Statements

For Claim Detail statements, the statement note will show on the patient statement when the claim it is attached to has a balance. The note will display below the outstanding claim, regardless of the date of the note.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY		
			INSURANCE	PATIENT	
DENTON, JOSEPH					
01/18/2019	99213	OFFICE VISIT	Clm: 1134 MEREDITH GREY	60.00	15.00
02/01/2019	99213	OFFICE VISIT	Clm: 1135 MEREDITH GREY	75.00	
02/01/2019		TRANSFER BALANCE		-75.00	75.00
		(\$75.00 BENEFITS DENIED) 02/01/19 OFFICE VISIT			
02/01/2019		INSURANCE PAYMENT		0.00	
		BLUE CROSS BLUE SHIELD			
02/01/2019		STATEMENT NOTE			
		(NO INSURANCE COVERAGE) IT APPEARS THAT YOUR INSURANCE IS NOT ACTIVE. PLEASE REMIT PAYMENT OR CONTACT YOUR INSURANCE COMPANY.			
02/15/2019	99213	OFFICE VISIT	Clm: 1136 MEREDITH GREY	60.00	15.00



eTHOMAS NOTE

If you do not attach a specific claim to a statement note, the note will display on the statement during its date range. The note will appear on the statement

Electronic Claim Detail

Claim Detail patient statements can now be sent electronically.

\$0.00 Insurance Payments

Claim Detail statements have been updated to include \$0.00 insurance payment amounts.

Claims

Paper Claims NDC

Paper claims have been updated to properly report the narrative description on an NDC Code when it is required.

N400009028002	UN15	ZZDEPO	MEDROL	40MG
09	11	18	11	J1030

Dental Claims

The ADA Dental form has been updated to the 2012 edition.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark of applicable boxes)
☐ Statement of Actual Services ☐ Request for Preauthorization/Preauthorization
CPT/ICD-9 / ICD-10

2. Preauthorization/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (If no insurance company named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/YYYY) 14. Gender ☐ M ☐ F 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number 17. Employer Name

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Covered ☐ Medicaid ☐ If both, complete 5-11 for dental only

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/YYYY) 7. Gender ☐ M ☐ F 8. Policyholder/Subscriber ID (SSN or ID#)

9. Patient's Relationship to Person named in #5
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

10. Patient's Relationship to Person named in #5
☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

20. Date of Birth (MM/DD/YYYY) 21. Gender ☐ M ☐ F 22. Patient ID/Account # (Assigned by Dental)

RECORD OF SERVICES PROVIDED

24. Procedure Code (MM/DD/YYYY)	25. Date of Oral Care	26. Tooth Number (or surface)	27. Tooth Surface	28. Procedure Code	29. ICD-9-CM	30. Description	31. Fee
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

32. Missing Tooth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

34. Diagnostic Code List Qualifier ☐ (ICD-9-CM, ICD-10, AB)

35. Diagnostic Code(s) A: C: D: Total Fee: \$

36. Remarks

AUTHORIZATIONS

37. I have been advised of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with the plan prohibiting all or a portion of such charges. In the event permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

38. Patient/Subscriber Signature Date

39. I hereby authorize and consent payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

40. Subscriber Signature Date

41. Name, Address, City, State, Zip Code

ANCILLARY CLAIM/TREATMENT INFORMATION

42. Place of Treatment ☐ Inpatient (ICD-9-CM) ☐ Outpatient (ICD-9-CM) ☐ Other (Specify)

43. Exclusions (Y or N)

44. Is treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

45. Date of Placement (MM/DD/YYYY)

46. Number of Treatment ☐ One-time ☐ Multiple (Specify)

47. Date of Placement (MM/DD/YYYY)

48. Treatment Resulting from ☐ Occupational Injury ☐ Auto accident ☐ Other accident

49. Date of accident (MM/DD/YYYY)

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

50. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

51. Signature (Treating Dentist) Date

52. NPI 53. License Number

54. Address, City, State, Zip Code 55. Provider Specialty Code

56. Phone Number 57. Additional Provider ID

58. Additional Provider ID

©2012 American Dental Association
201201 (Name as ADA Dental Claim Form - J430, J431, J432, J433, J434)

To recorder call 800.947.4746 or go online at ada.org