

Reporting "Other Insurance" in CHAMPS

Commercial Insurance – Billing Co-Insurance Amount

Total Submitted Charges = \$79.00

Does the beneficiary have insurance other than Medicaid? Yes No

OTHER INSURANCE INFORMATION

Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: *

Subscriber Last Name:

Date of Birth:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

Subscriber Member ID:

First Name: MI: Suffix:

Gender:

Beneficiary's Relationship:

Total COB Payer Paid Amount: \$ * [Add Another](#)

[Add Service Line Item](#) [Update Service Line Item](#)

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.
Click on Insurance Info to enter each Line's Insurance Information.

Total Submitted Charges: \$79.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	
	From	To		1	2	3	4	1	2	3	4			
1	01/12/2010	01/12/2010	99213					1				79.00	1	

[Insurance Info](#) [Copy](#) [Delete](#)

Click here for line level Other Insurance information

OTHER INSURANCE INFORMATION

1. Service Line Other Payer Information

Primary Payer Responsibility: * Amount Paid: \$ *

1. Reason Code: Amount: \$ Adjustment Quantity: [Add Another Reason Code](#)

2. Reason Code: Amount: \$ Adjustment Quantity:

[Add Another Payer](#)

Medicare Deductible

Total Submitted Charges = \$327.00

Yes No Does the beneficiary have insurance other than Medicaid?

OTHER INSURANCE INFORMATION

Other Subscriber Information

Payer Responsibility Code: *
 Payer ID Number: * Subscriber Member ID:
 Subscriber Last Name: First Name: MI: Suffix:
 Date of Birth: / / Gender: *
 Insured's Group or Policy Number: * Beneficiary's Relationship: *
 Claim Filing Indicator: * Total COB Payer Paid Amount: \$ * [Add Another](#)

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.
 Click on Insurance Info to enter each Line's Insurance Information.

Total Submitted Charges: \$327.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units		
	From	To		1	2	3	4	1	2	3	4				
1	01/01/2010	01/01/2010	99284	UD					1	2			327.00	1	Insurance Info <input type="button" value="Copy"/> <input type="button" value="Delete"/>

Click here for line level Other Insurance Information



OTHER INSURANCE INFORMATION

1. Service Line Other Payer Information

Primary Payer Responsibility: * Amount Paid: \$ *

1. Reason Code: Amount: \$ Adjustment Quantity: [Add Another Reason Code](#)

2. Reason Code: Amount: \$ Adjustment Quantity:

[Add Another Payer](#)

Other Insurance Not Covered

Total Submitted Charges = \$1,050.00

? Does the beneficiary have insurance other than Medicaid? Yes No

OTHER INSURANCE INFORMATION
Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: * Subscriber Member ID:

Subscriber Last Name: First Name: MI: Suffix:

Date of Birth: Gender:

Insured's Group or Policy Number: * Beneficiary's Relationship:

Claim Filing Indicator : * Total COB Payer Paid Amount: \$ * [Add Another](#)

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Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.
 Click on Insurance Info to enter each Line's Insurance Information.

Total Submitted Charges: \$1,050.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Ptrs				Submitted Charges	Units	
	From	To		1	2	3	4	1	2	3	4			
1	01/02/2010	01/02/2010	59426					1				1050.00	1	

Click here for line level Other Insurance information



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OTHER INSURANCE INFORMATION
1. Service Line Other Payer Information

Primary Payer Responsibility: * Amount Paid: \$ *

1. Reason Code: Amount: \$ Adjustment Quantity: [Add Another Reason Code](#)

2. Reason Code: Amount: \$ Adjustment Quantity:

[Add Another Payer](#)

Reporting Primary and Secondary Insurance other than Medicaid

Total Submitted Charges = \$920.00

Does the beneficiary have insurance other than Medicaid? Yes No

OTHER INSURANCE INFORMATION

Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: *

Subscriber Last Name:

Date of Birth:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

Subscriber Member ID:

First Name: MI: Suffix:

Gender:

Beneficiary's Relationship:

Total COB Payer Paid Amount: \$ * [Add Another](#)

2.Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: *

Subscriber Last Name:

Date of Birth:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

Subscriber Member ID:

First Name: MI: Suffix:

Gender:

Beneficiary's Relationship:

Total COB Payer Paid Amount: \$ * [Delete](#)

[Add Service Line Item](#) [Update Service Line Item](#)

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.
Click on Insurance Info to enter each Line's Insurance Information.

Total Submitted Charges: \$920.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	Insurance Info	Copy	Delete	
	From	To		1	2	3	4	1	2	3	4						
1	01/05/2010	01/05/2010	00832	AA					1				920.00	50			

Click here for line level Other Insurance information



OTHER INSURANCE INFORMATION

1. Service Line Other Payer Information

Primary Payer Responsibility: * Amount Paid: \$ *

1. Reason Code: Amount: \$ Adjustment Quantity: [Add Another Reason Code](#)

2. Reason Code: Amount: \$ Adjustment Quantity:

[Add Another Payer](#)

2. Service Line Other Payer Information

Primary Payer Responsibility: * Amount Paid: \$ * [Delete Payer](#)

1. Reason Code: Amount: \$ Adjustment Quantity: [Add Another Reason Code](#)

2. Reason Code: Amount: \$ Adjustment Quantity:

3. Reason Code: Amount: \$ Adjustment Quantity: [Delete](#)