

# Entering Claims into nhxsPricer

## Electronic Claims

The transaction set for batch claim data is the ASC X12N 837 (v4010 or higher) file. The file contains all of the data necessary to process a medical claim for payment. These files can be uploaded through a secure web interface or transmitted using secure over the internet FTP. Contact NHXS support for FTP instructions.

## Manually Entered Claims

Claims are entered manually using a web form based on an enhanced CMS 1500 claim form. There are a few required fields in the 837 files that are not available on the CMS 1500. (i.e. Claim Filing Indicator (PPO, EPO, HMO), etc.). The Claim Filing Indicator has been added by NHXS to the CMS 1500 form. Required fields are highlighted to speed data entry. Claims with more than six services can be entered into a single claim.

**QUICK KEYS:**  
TAB/SPACEBAR  
SPEED DATA  
ENTRY OF THE  
REQUIRED FIELDS

**DROP DOWN LISTS  
REDUCE DATA ENTRY  
ERRORS**

**REQUIRED FIELDS  
ARE HIGHLIGHTED  
IN YELLOW**

**HEALTH INSURANCE CLAIM FORM**

INSURER NAME: Aetna  
 151 FARMINGTON AVENUE  
 HARTFORD CT 06155

1. PRODUCT TYPE: PPO  
 2. PATIENT'S NAME: Lechner, Rudy  
 3. PATIENT'S BIRTH DATE: 10/7/1987  
 4. INSURED'S I.D. NUMBER: 012458922  
 5. PATIENT'S ADDRESS: 151 FARMINGTON AVENUE, HARTFORD, CT 06155  
 6. PATIENT RELATIONSHIP TO INSURED: Self  
 7. INSURED'S ADDRESS: 151 FARMINGTON AVENUE, HARTFORD, CT 06155  
 8. PATIENT STATUS: Single  
 9. OTHER INSURED'S NAME: [Blank]  
 10. IS PATIENT'S CONDITION RELATED TO: [Blank]  
 11. INSURED'S POLICY GROUP OR FECA NUMBER: [Blank]  
 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: [Blank]  
 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: [Blank]  
 14. DATE OF CURRENT ILLNESS OR INJURY: 8/13/2007  
 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: [Blank]  
 16. DATES PATIENT UNABLE TO WORK: [Blank]  
 17. NAME OF REFERRING PHYSICIAN: [Blank]  
 17a. I.D. NUMBER OF REFERRING PHYSICIAN: [Blank]  
 18. HOSPITALIZATION DATES: [Blank]  
 19. RESERVED FOR LOCAL USE: [Blank]  
 20. OUTSIDE LAB? [Blank]  
 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:  
 1. 173.8  
 2. 173.8  
 3. 702.0  
 4. [Blank]  
 22. MEDICARE RESUBMISSION CODE: [Blank]  
 23. PRIOR AUTHORIZATION NUMBER: [Blank]  
 24. TABLE OF SERVICES:  

A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE FROM	DATE(S) OF SERVICE TO	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (CPT, HCPCS, ICD9-CM)	DIAGNOSIS CODE	\$ CHARGES	DAYS EPISODE OR FAMILY PER	EMG	COB	RESERVED FOR LOCAL USE
8/13/2007	8/13/2007	11		17282	1 2 3	500.00	1			
8/13/2007	8/13/2007	11		17281	59 1 2 3	375.00	1			
8/13/2007	8/13/2007	11		17000	59 1 2 3	185.00	1			
8/13/2007	8/13/2007	11		17003	1 2 3	110.00	3			

 25. FEDERAL TAX ID NUMBER: 123456789  
 26. PATIENT'S ACCOUNT NO: [Blank]  
 27. ACCEPT ASSIGNMENT? YES  
 28. TOTAL CHARGE: \$ 1,150.00  
 29. AMOUNT PAID: \$ 1,150.00  
 30. BALANCE DUE: \$ 0.00  
 31. SIGNATURE OF PHYSICIAN OR SUPPLIER: SMITH, JAMES  
 32. NAME AND ADDRESS OF FACILITY: [Blank]  
 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE: [Blank]