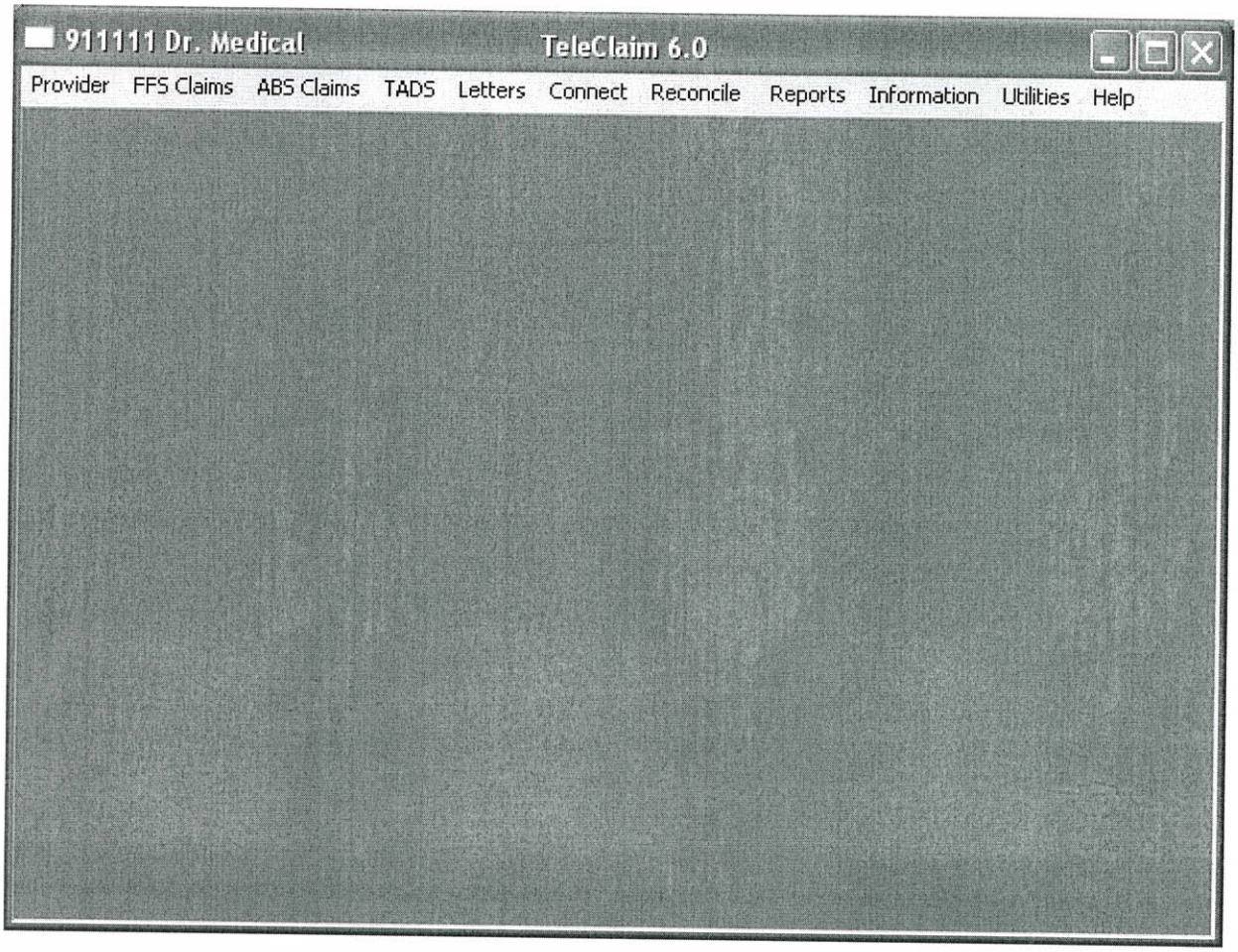
Main Menu

Main Menu



From this menu you can access all of the features of TeleClaim. All eleven (11) options on this menu have sub menus. To select an option, click on the heading and a list will appear under the chosen option. To select one of the sub menus, click on the desired one.

First time users should note that Provider defaults can be set before entering any claim information. See *Provider Defaults* on the *Information* Menu.

Menu Options:

- *Provider*
- *FFS Claims*
- *ABS Claims*
- *TADs*
- *Letters*
- *Connect*
- *Reconcile*
- *Reports*
- *Information*
- *Utilities*

INFORMATION MENU

- PROVIDER DEFAULTS
- PATIENTS
- FEE SCHEDULES
- COPY FEE SCHEDULES
- HOSPITALS
- DIAGNOSTIC CODES
- REMARKS CODES

Add/Remove Providers

If you have requested an update to your TeleClaim system to add or remove providers, an update file will be created by MCP and placed in your folder on our transmission system.

When you connect to MCP, this file will be automatically transmitted to your machine in the same manner as TAD and remittance files.

After receiving an update file, you must exit TeleClaim then open it again to apply the update. Messages will be displayed indicating providers being added and/or removed, and then the list of providers in your TeleClaim system will be displayed. Check the list to ensure it has been properly updated.

Listed below is the information required to add and remove providers.

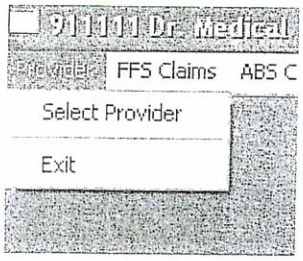
To add providers to your copy of TeleClaim:

An Electronic Billing Application must be completed for each provider being added to your TeleClaim software. An Electronic Claims Submission Application is available from MCP via mail or fax, or online at www.gov.nl.ca/mcp in the Forms section. The completed application(s) can be mailed or faxed to MCP.

To remove providers from your copy of TeleClaim:

To remove providers, call MCP Operations at 758-1530. Before any providers are removed, it is recommended that as much data as possible be purged that is specific to the provider, using the various purge options on the *Utilities Menu*. **Do not purge patients, as the patient records are shared by all providers in TeleClaim.**

Provider Menu



From this menu you can select a Provider or Exit the application. A brief description of each option is listed below. Each option is described in detail in the following sections.

Select Provider
Use this option to select a Provider.

Exit
Closes TeleClaim.

Patient Purge

This option is used to delete Patients from the Patient master file. Run this option occasionally to remove Patients who have not had a visit in some time.

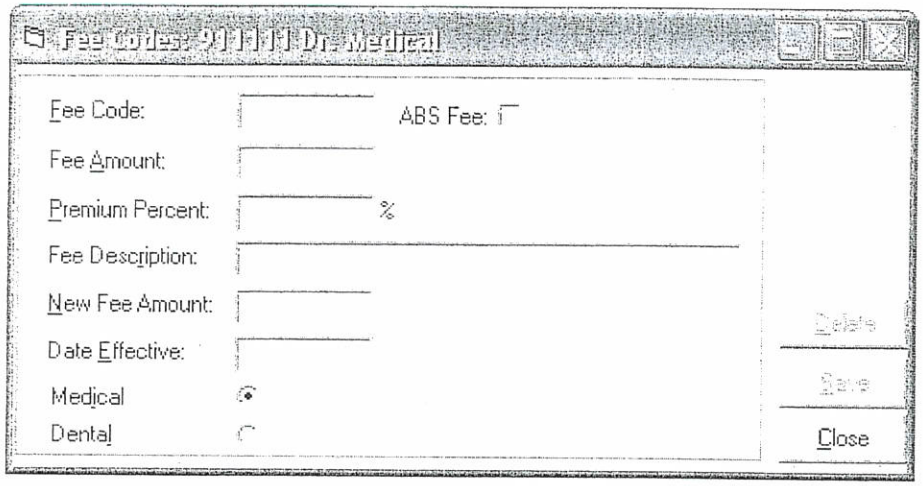
There is only one Patient master file in your TeleClaim system, which is shared by all Providers. It does not matter which Provider you are currently working with when you run this option.

Depending on the microcomputer you have and the number of records in your Patient master file, this option may take some time to run.

This option purges Patients based on the LAST SERVICE DATE of the patient. A default date of five (5) years will be used when this option is selected. This can be changed to any date. Any patient with a last service date before the date entered will be deleted.

To perform the purge, click on *Utilities - Patient Purge*. If there are no patients to be purged, a message box will appear to inform you. If there are patients to be purged a message box will appear asking you to enter a date or accept the default date. Next, you will be told how many patients will be deleted and asked to confirm that you would like to continue. If Yes is chosen, when the purge is complete, a message box will appear saying the purge is complete. If No is chosen, the purge will be canceled and a message box will appear to inform you the purge has been canceled.

Fee Schedule



This screen displays the Fee Code information and is used to add, change and/or delete Fee Codes and Fee Amounts.

Fields:

Fee Code: A unique number assigned to each service or procedure as shown in the *MCP Payment Schedule*.

Dental Providers please note that the two (2) digit High Frequency codes cannot be used in the TeleClaim system. Any claims containing these codes will be rejected.

Regular Fee Codes and premium/co-pay codes can be set. For Medical, SHV types may also be set in this option.

ABS Fee: Check this field if the fee code is a Alternate Billing Fee Code.

Fee Amount: The fee amount or the premium amount for one unit of this service. See the *MCP Payment Schedule* to determine which amount is appropriate for you.

Premium Percent: The premium percent for a specific procedure premium codes. A percentage, instead of an amount may be set for premium codes that are claimed as a percentage of a fee amount.

When a Fee Code and amount are entered on a claim screen, and a premium code that has a percentage are entered on the SAME claim, the premium amount is calculated, based on the fee amount, and automatically entered into the premium amount field. If the Premium amount has been set as an amount, that amount will be entered into the Premium amount field.

Fee Description: A description of the Fee. Note that the description does not have to match the Fee Code description in the *MCP Payment Schedule*. It can be user defined to something more meaningful, if appropriate.

New Fee Amount: If a new fee amount is coming into effect, you can update the Fee Code amount by putting the new amount in this field.

Date Effective: The date the new fee amount is in effect. This date is used to determine which fee amount to use when a new claim is added if a new fee amount is entered in the Fee Code file.

The date can be entered in several ways. For example, January 19, 2000 can be entered in

the following ways and default to the format YYYY/MM/DD:
20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

Medical: Click this field if the Fee Code is Medical. **Displayed only for a Provider who can bill both Medical and Dental claims.** A code can be medical OR dental, not both.

Dental: Click this field if the Fee Code is Dental. **Displayed only for a Provider who can bill both Medical and Dental claims**. A code can be medical OR dental, not both.

Command Buttons:

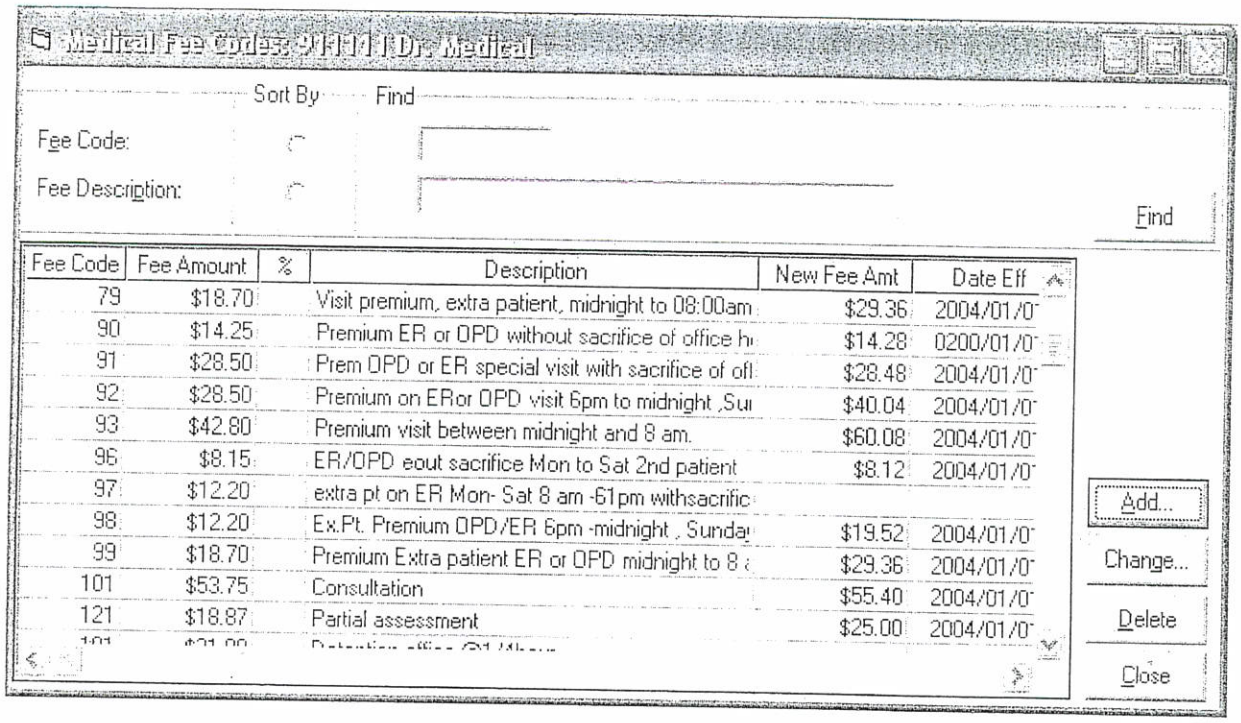
Delete allows you to remove the fee code shown on the screen. A dialogue box will appear asking you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

Save saves the information on the current screen and then clears the screen. This will be enabled when data is entered on the screen or a change is made to the screen.

Close closes the current screen. This will be enabled if no changes are made to the current screen.

Cancel does not save any changes to the current screen . A dialogue box will appear confirming whether or not you wish to cancel. This will be enabled when a change is made to the current screen.

Fee Schedules



This screen is used to add, change and/or delete Medical, Dental and Alternate Billing Fee Codes, including Premium and Co-Pay Codes. Medical users can also set subsequent hospital visit (SHV) types. A Fee Code file is not included with TeleClaim because of the large number of codes. Note that you will have to update these Fee Codes when a new payment (fee) schedule comes into effect. It is recommended that only the more frequently used codes be entered.

Each Provider has his/her own Fee Code file. Therefore, the Fee Codes must be set for each Provider individually. However, if you have more than one Provider that use mostly the same Fee Codes, you can copy the Fee Code file from one Provider to another. See the *Information Menu - Copy Fee Schedule* for more details

When codes are set in the Fee Code file and they are used in a claim, the fee claimed amount will automatically be entered on the claim for you when the number of units is entered. You can change the amount on an individual claim, if required. Some Premium codes can be set as a percentage, instead of a specific amount.

When entering claims you can also browse the *Fee Schedules* screen. See help on *Dental Claims* or *Medical Claims* for more details.

To Add a Fee, click Add... . To change or delete a Fee, highlight the fee in the grid list and click Change... or Delete .

Sort Criteria: A sort can be done on Fee Code or Fee Description. Sorts will be in ascending order.

When the screen is first displayed, it is sorted in Fee Code.

To change the sort order, click on the radio button ◉ next to the desired sort field.

Sort/Search Criteria: A search can be done on Fee Code and/or Fee Description.

If the Fee Code that you enter is not found, TeleClaim will display codes greater that or equal to the search criteria.

A search on Fee Description will display all records containing the search criteria. If no matches are found, the list will be empty.

To perform a search, enter the desired code or description in the associated text box and click Find.

When starting a new search, it is recommended you clear all the search fields and press Find to get a complete list.

Fields:

Fee Code: A unique number assigned to each service or procedure as shown in the *MCP Payment Schedules*.

Fee Amount: The fee or premium fee associated with a given Fee Code.

%: The Premium percent associated with selected Premium Codes.

Fee Description: A description Service or Procedure.

New Fee Amt: If a new fee amount is coming into effect, the new amount will be displayed here.

Date Eff:

The date the new fee amount is in effect. This date is used to determine which fee amount to use when a new claim is added if a new fee amount is entered in the Fee Code file. It can be entered in the format of YYYY/MM/DD, MM/DD (ex. 12/31 will default the current year and display as 1999/12/31) or M/D (ex. 3/18 will default the current year and display as 1999/03/18). Spaces are not allowed.

Command Buttons:

Find allows you to search for a desired search criteria in the grid list.

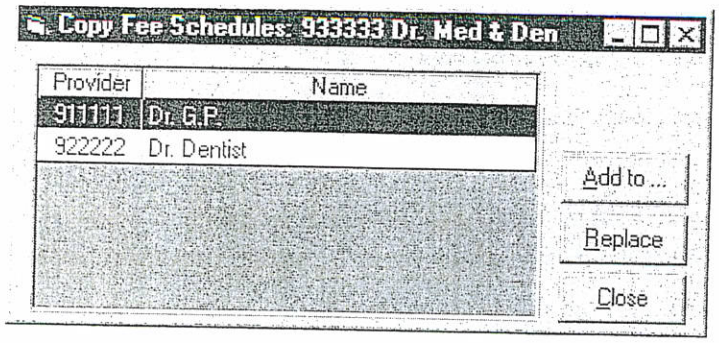
Add... brings you to the Fee entry screen.

Change... allows you to modify the highlighted fee.

Delete allows you to remove the highlighted fee code. A dialogue box will appear asking you to confirm the Delete.

Close closes the current screen.

Copy Fee Schedule



This screen lets you copy the Fee Code information from one Provider to another.

This is a useful option when you are setting up a new TeleClaim system that contains several Providers who use many of the same Fee Codes. You can set the Fee Codes for one of the Providers, and then copy the file to the other Provider.

This option is also useful when you are adding a new Provider to TeleClaim who uses many of the same Fee Codes as on of the Providers already set on your system.

When you select this option, a screen will appear showing a list of the Providers on this system. Highlight the Provider from whom you wish to copy the Fee Code file and either click Add to ... or Replace depending on the desired outcome.

If Add to ... is chosen, a message box will appear asking you to confirm if you would like to add the Fee Codes from the Provider chosen to your Fee Code file. If you click *Yes,* then TeleClaim will copy all the Fee Codes from the Provider selected, while leaving any Fee Codes that already exist in the current Provider's file. If you click *No,* the action of copying the Fee Code file will be canceled. After adding, you should check your fee schedule file to determine if you have the correct fee codes and fee amounts.

If Replace is chosen, a message box will appear asking you to confirm if you would like to replace your Fee Code file with the Fee Code file of the Provider chosen. If *Yes* is chosen, TeleClaim will replace all the Fee Code data for the current Provider with the Fee Code data of the Provider from whom you are copying. If *No* is chosen, the action of copying the Fee Code file will be canceled.

Columns:

Provider: The Provider number associated with the Fee Code file from which you are going to copy.

Name: The Provider name associated with the Fee Code file from which you are going to copy.

Command Buttons:

Add to ... Click *Add to* to add any Fee Codes from the highlighted Provider not already existing in the current Provider's list.

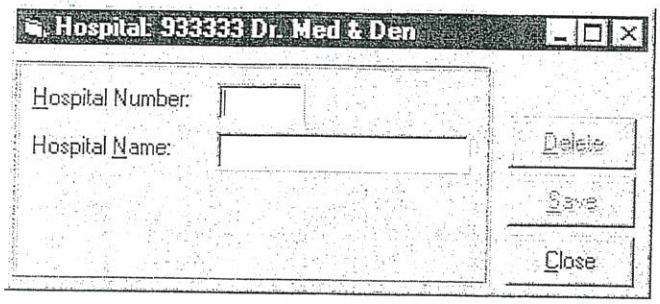
A message box will appear asking you to confirm if you would like to add the Fee Codes from the Provider chosen to your Fee Code file. If you click Yes, then TeleClaim will copy all the Fee Codes from the Provider selected, while leaving any Fee Codes that already exist in the current Provider's file. If you click No, the action of copying the Fee Code file will be canceled.

Replace Click Replace to remove any currently existing Fee Codes with all those of the highlighted provider.

A message box will appear asking you to confirm if you would like to replace your Fee Code file with the Fee Code file of the Provider chosen. If Yes is chosen, TeleClaim will replace all the Fee Code data for the current Provider with the Fee Code data of the Provider from whom you are copying. If No is chosen, the action of copying the Fee Code file will be canceled.

Close Click *Close* to exit this screen and go back to the main TeleClaim screen.

Hospital



This screen is used to add, change and/or delete hospital codes and hospital names.

Fields:

Hospital Number: A number assigned to each hospital or institution by MCP

Hospital Name: A name assigned to each hospital as provided in the *MCP Physicians Information Manual* or the *MCP Dentist Information Manual.*

Command Buttons:

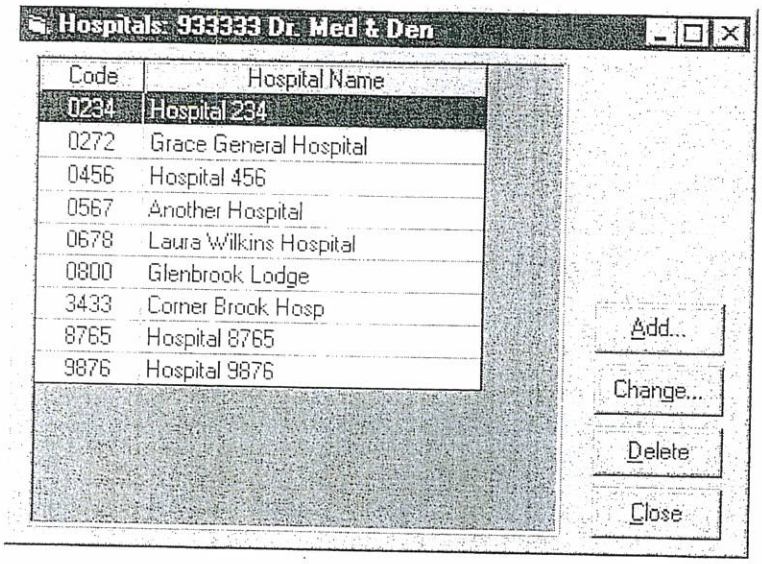
Delete allows you to remove the hospital shown on the screen. A dialogue box will appear asking you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

Save saves the information on the current screen and then clears the screen. This will be enabled when data is entered on the screen or a change is made to the screen.

Close closes the current screen. This will be enabled if no changes are made to the current screen.

Cancel does not save any changes to the current screen . A dialogue box will appear confirming whether or not you wish to cancel. This will be enabled when a change is made to the current screen.

Hospitals



Used to add, change and/or delete hospital numbers and hospital descriptions. These hospital numbers are not included with TeleClaim.

There is only one hospital file for this practice, which is shared by all Providers.

When entering claims you can also browse the *Hospitals* screen. See help on *Dental Claims* or *Medical Claims* for more details.

To Add a hospital, click Add... . To change or delete a hospital, highlight the hospital in the grid list and click Change... or Delete .

Columns:

(Hospital) Code: A unique number assigned to each Hospital or institution by MCP.

Hospital Name: A name assigned to each Hospital.

Command Buttons:

Find allows you to search for a desired search item in the grid list.

Add... brings you to the hospital entry screen.

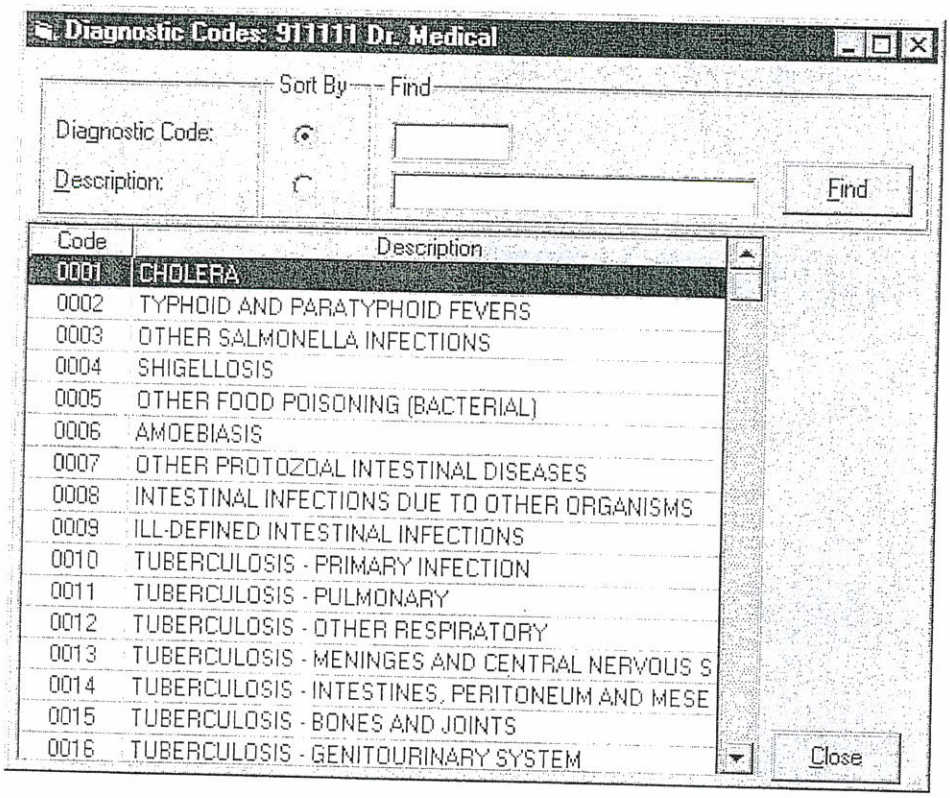
Change... allows you to modify the hospital highlighted in the grid list.

Delete allows you to remove the highlighted hospital code. A dialogue box will appear

asking you to confirm the Delete.

closes the current screen.

Diagnostic Codes



This screen displays diagnostic codes and descriptions.

A diagnostic code file is provided with TeleClaim. There is only one diagnostic file, which is shared by all providers in this practice. These codes cannot be edited, added or deleted.

Sort Criteria: A sort can be done on Diagnostic Code or Description. Sorts will be in ascending order.

When the screen is first displayed, it is sorted by Diagnostic Code.

To change the sort order, click on the radio button next to the sorted field

Search Criteria: A search can be done on Diagnostic Code and/or Description.

If a search is done on diagnostic code, it will display a code greater than or equal to the search criteria.

A search on diagnostic description will display all records containing the search criteria. If no matches are found, the list will be empty.

To perform a search, enter the desired code or description in the associated text box and click Find.

When starting a new search, it is recommended you clear all the search fields and press Find

Find to get a complete list.

Fields:

Diagnostic Code: A unique number as per the Diagnostic Code Manual.

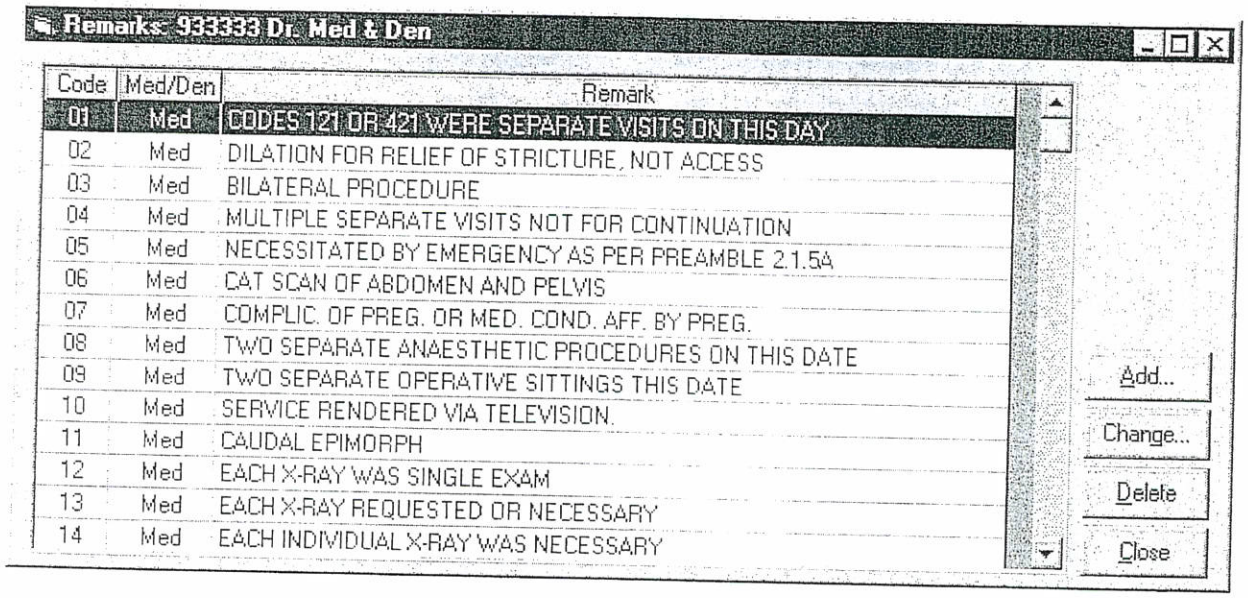
Description: A condensed description of the Diagnostic Code

Command Buttons:

Find allows you to search for a desired search item in the grid list.

Close closes the current screen.

Remark Codes



Used to add, change and/or delete remark codes and remark descriptions.

Remark codes are included with TeleClaim. However, you will have to maintain any changes made to the remark codes.

There is only one remark code file in your TeleClaim system, which is shared by all Providers.

Note that remarks descriptions are abbreviated versions of the complete descriptions. You can change these descriptions to something more meaningful if desired. See the *MCP Physicians Information Manual* or the *MCP Dentist Information Manual* for complete descriptions.

When entering claims you can browse the remark file. See help on Medical Claims or Dental Claims for more details.

To Add a remark, click Add... . To change or delete a remark, highlight the remark in the grid list and click Change... or Delete .

Fields:

Code: A unique number assigned to convey specific messages by MCP. Listed in the *Physician/Dentist Manual.*

Med/Den: Med - Medical Remark; Den - Dental Remark.

Remarks: A description of the Remark Code. Listed in the *Physician/Dentist Manual.*

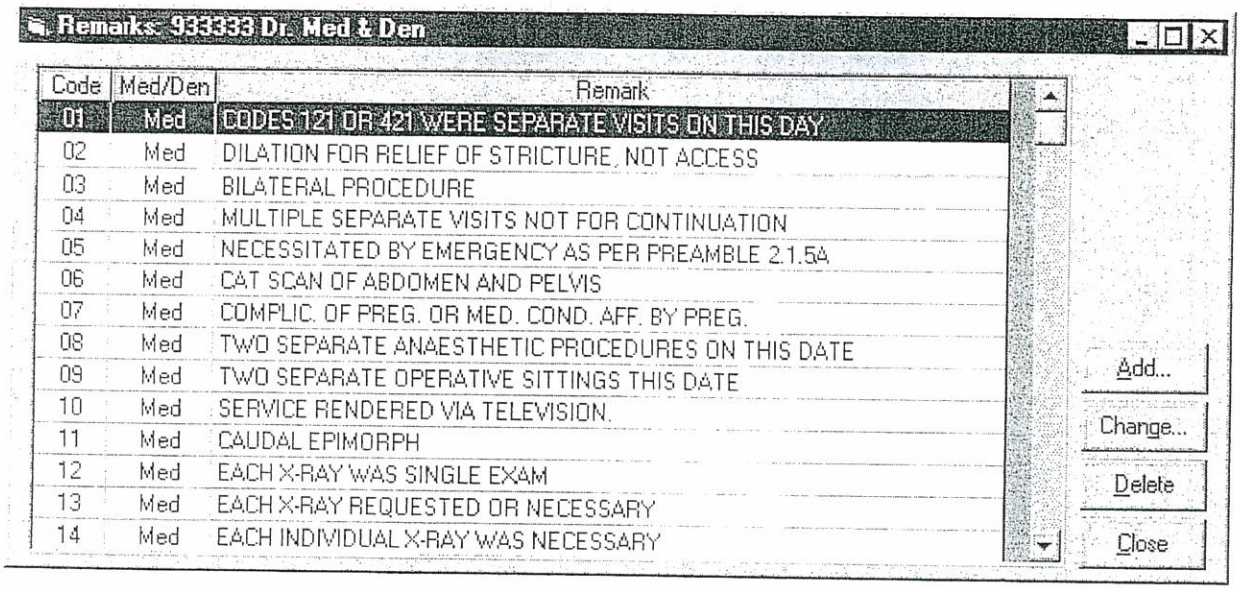
Command Buttons: Add... brings you to the remark entry screen.

Change... allows you to modify highlighted remark in the grid list.

Delete allows you to remove the highlighted remark code. A dialogue box will appear asking you to confirm the Delete.

Close closes the current screen.

Remark Codes



Used to add, change and/or delete remark codes and remark descriptions.

Remark codes are included with TeleClaim. However, you will have to maintain any changes made to the remark codes.

There is only one remark code file in your TeleClaim system, which is shared by all Providers.

Note that remarks descriptions are abbreviated versions of the complete descriptions. You can change these descriptions to something more meaningful if desired. See the *MCP Physicians Information Manual* or the *MCP Dentist Information Manual* for complete descriptions.

When entering claims you can browse the remark file. See help on Medical Claims or Dental Claims for more details.

To Add a remark, click Add... . To change or delete a remark, highlight the remark in the grid list and click Change... or Delete .

Fields:

Code: A unique number assigned to convey specific messages by MCP. Listed in the *Physician/Dentist Manual.*

Med/Den: Med - Medical Remark; Den - Dental Remark.

Remarks: A description of the Remark Code. Listed in the *Physician/Dentist Manual.*

Command Buttons: Add... brings you to the remark entry screen.

Change... allows you to modify highlighted remark in the grid list.

Delete allows you to remove the highlighted remark code. A dialogue box will appear asking you to confirm the Delete.

Close closes the current screen.

To change the sort order, click on the radio button next to the desired sort field.

Search Criteria:

A search can be done on Patient Id and/or Last Name and/or Last Service Date

If the Patient Id or Name you enter is not found, the list will be empty. If the Last Service Date you enter is not found, TeleClaim will take you to the next date greater than the search date.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:
20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

To perform a search, enter the desired PIN, Last Name and/ Last Service Date in the associated text box and click Find.

When starting a new search, it is recommended you clear all the search fields and press Find to get a complete list.

Fields:

Patient Id: Patient Identity Number.

Patient Name: The Patient's Surname and Given Names.

Last Service Date: The last date a service was billed for the patient.

Birth Date: The Patient's Birth Date

Sex: The Patient's Sex

Province: The Patient's Province.

Command Buttons:

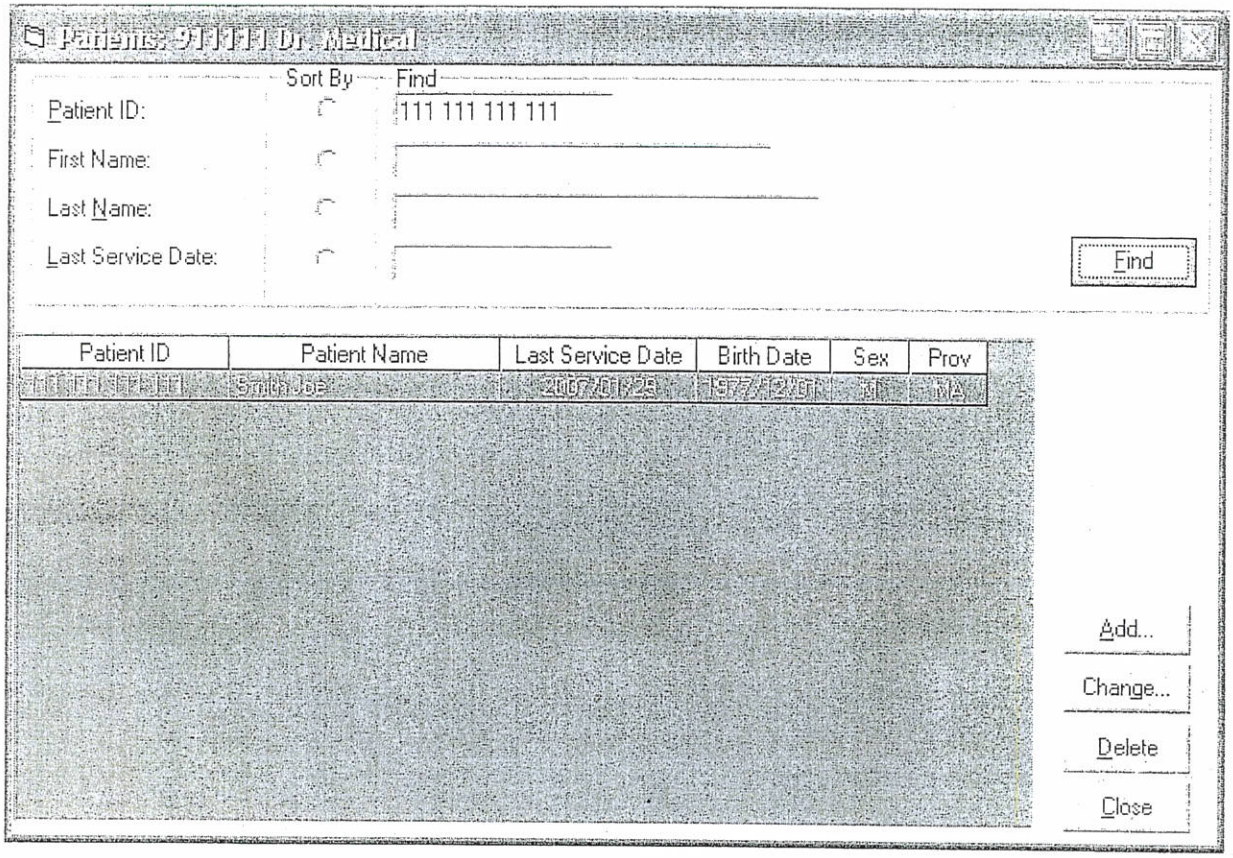
Add... brings you to the Patient information entry screen

Change... allows you to modify the highlighted Patient.

Delete allows you to remove the highlighted patient. A dialogue box will appear asking you to confirm the Delete.

Close closes the current screen.

Patients



Displays a list of all Patients. Used to add, change and/or delete Patient information in the Patient master file.

If the *Use Patient Master File* default is set to Y, the Patient master file is used for all Patients. See the *Claims - Provider* for details on this default.

There is only one Patient master file in your TeleClaim system, which is shared by all Providers.

Note that the Patient ID number (PIN) cannot be changed or removed from the Patient master file if there are any records in the Outstanding/History file or claims work files for that PIN.

To Add a Patient, click Add... . To change or delete a Patient, highlight the Patient in the grid list and click Change... or Delete .

When the screen first appears, there will be no data in the grid. To find a patient, either type in the Patient ID, Last Name or Last Service Date and click FIND. To view the entire patient file, click on one of the sort buttons.

Sort Criteria: A sort can be done on Patient Id ascending or Last Name or Last Service Date. Sorts will be in ascending order.

Phone No:

The Patient's telephone number.

OOP:

OOP indicator. This will be checked if the patient id is not a valid Newfoundland number..

Patient History Data:

Claim #:

A seven (7) digit number given to a claim during batching.

Item #:

A two (2) digit number given to a claim during batching.

Service Date:

The date the Patient was seen by the Provider.

Fee Code:

A unique number assigned to each service or procedure as shown in the *MCP Payment Schedule*

Fee Claimed:

The amount claimed for the service.

Prem/Co-Pay Code:

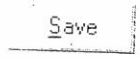
The premium or co-pay code.

Prem/Co-Pay Claimed:

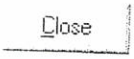
The premium or co-pay claimed.

Command Buttons:

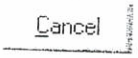
allows you to remove the patient shown on the screen. A dialogue box will appear asking you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.



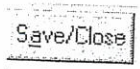
saves the information on the current screen and then clears the screen. This will not be visible when this screen is displayed for a claim that is being entered for a patient that is not in the patient master file.



closes the current screen. This will be enabled if no changes are made to the current screen.



does not save any changes to the current screen . A dialogue box will appear confirming whether or not you wish to cancel. This will be enabled when a change is made to the current screen.



saves the information on the current screen. This will be visible when this screen is displayed for a claim that is being entered for a patient that is not in the patient master file.

allows you to browse History for the Patient currently displayed. You cannot browse or maintain the history file of another Patient from here. See *FFS Claims - History* on the main menu.

If the number entered is a valid Newfoundland number, the birth date, sex and prov code for the Patient is automatically entered on the screen.

If the number entered is a Newfoundland number and the OOP indicator is checked, verify that the Patient ID number entered is the same as on the Patient's MCP card. If they are the same, have the Patient contact MCP to have the number corrected.

The Patient's surname, given names, birth date, sex and prov code must be entered for both NF Patients and OOP (host) Patients.

Note that you cannot change the Patient ID number on a Patient record if there are claims in the Outstanding/History or the claims work files for that Patient ID number.

Surname: The Patient's Surname.

Given Names: The Patient's Given Names.

Birth Date: The Patient's birth date. Automatically entered if the Patient Id is a valid Newfoundland number.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:
20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

Sex Code: The Patient's Sex. Automatically entered if the Patient Id is a valid Newfoundland number.

Prov Code: The Province Code where the Patients MCP number was issued. If the Patient Id is a valid Newfoundland number, this field will be automatically entered.

File No: This field is provided to add file or chart numbers or other information about the patient.

If you wish to Terminate a Patient Id, enter the word "TERM" in this field. If this PIN is then used on a claim, a message will be displayed warning the user that the patient id is terminated.

Last Service Date: This is not a data entry field. This field is updated by TeleClaim when a claim is batched for a Patient. It will always show the service date of the last claim batched. When you initially set up a Patient on this screen, this field will be blank.

Address Line 1: The Patient's Address. Only required for mothers or guardians of Neonatal patients.

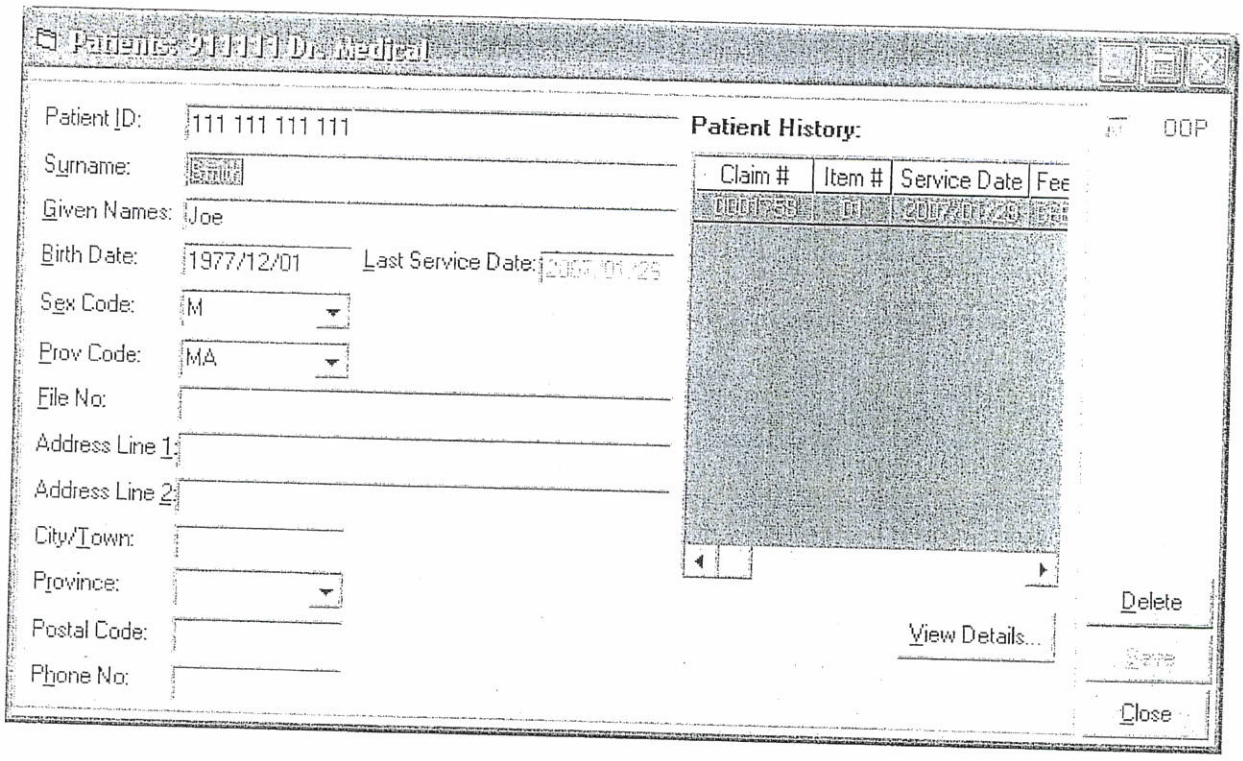
Address Line 2: The Patient's Address. Only required for mothers or guardians of Neonatal patients.

City/Town The Patient's City or Town. Only required for mothers or guardians of Neonatal patients.

Province: The Patient's Province. Only required for mothers or guardians of Neonatal patients.

Postal Code: The Patient's Postal Code. Only required for mothers or guardians of Neonatal patients.

Patient



This screen is used to add, change and/or delete Patient information. Also used to view a Patient's history.

Note that the Patient ID number (PIN) cannot be changed or removed from the Patient master file if there are records in History or claims work files for that PIN.

If the Patient is a Newfoundland Patient, then the birth date, sex and prov code for the Patient is automatically entered on the screen. You should verify if this information is accurate at time of entry. The PIN, surname, given name(s), birth date and sex code are mandatory and must be entered for Out of Province patients.

If the Patient is OOP, (from another province, not a valid Newfoundland PIN), you will be notified and an OOP indicator will be checked on the screen. OOP numbers cannot be used on Dental Claims.

To view the current Patient's history, highlight a claim in the grid list and click the View Details... button. This brings you to the history claim that Patient. To maintain the Patient's history, see *FFS Claims - History* on the main menu.

Fields:

Patient Id: Patient Identity Number.

TeleClaim will check the number entered to see if it is a valid Newfoundland number. An invalid Newfoundland number will be considered to be an Out of Province Patient and a message box will be displayed informing you, after data entry. A valid Newfoundland MCP number is 12 digits in length and passes a check digit routine performed by TeleClaim.

If yes is the default, then you will be required to enter data for each Patient the first time you enter a claim for the Patient. This is useful when you have a practice where the same Patients are being seen on a regular basis. Then each time a claim is entered for a Patient that has been set, the Patient's Name, Sex, Birth date and Province will be automatically entered on the claim screen. The Patient master file is prompted from the Patient Id when entering claims. If the Patient is not found, the Patient Information screen appears in order for you to add the new Patient to the Patient Master file.

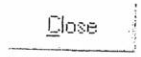
If the default is set to No, the Patient Master file is prompted from the Patient id when entering claims. If the Patient is found, the Patient's Name, Sex, Birth Date and Province are displayed. If the Patient is not found, you may add the Patient to the Patient Master file by entering the Patient's name, Birth Date, Sex and Province Code on the Patient Information screen. OOP numbers cannot be used on Dental claims.

Starting Claim No: This is set in your software program by MCP. Sometimes it is necessary to change the starting claim number when problems occur. It is recommended that you not change the claim number unless you check with MCP first. Never change the claim number so that it is lower than either the number that is set in your system, or any number you have already used electronically. This could result in duplicate claim numbers, rejected claims and problems with the outstanding file.

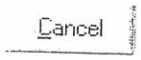
Starting Sequence No: The first sequence number you wish to use for batching. The default Starting Sequence No will only be used the first batch of each day.

Command Buttons:

saves the information on the current screen to a file in the database. This will be enabled when data is entered on the screen or a change is made to the screen.

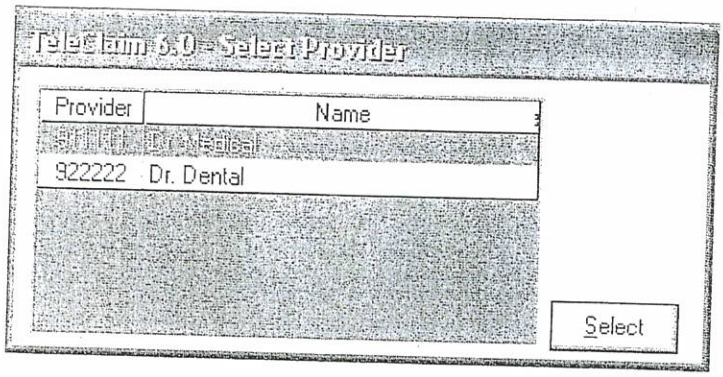


closes the current screen. This will be enabled if no changes are made to the current screen.



does not save any changes to the current screen. A dialogue box will appear confirming whether or not you wish to cancel. This will be enabled when a change is made to the current screen.

Select Provider



Purpose: Displays a list of Providers in your system. If the Provider list does not contain all the Providers for your practice, contact MCP to request an update.

To select a Provider, highlight the desired Provider and press Select.

By clicking the Select button, the screen closes and the main menu is displayed. Once a Provider is selected, any subsequent inquiries or processing will relate to that Provider only.

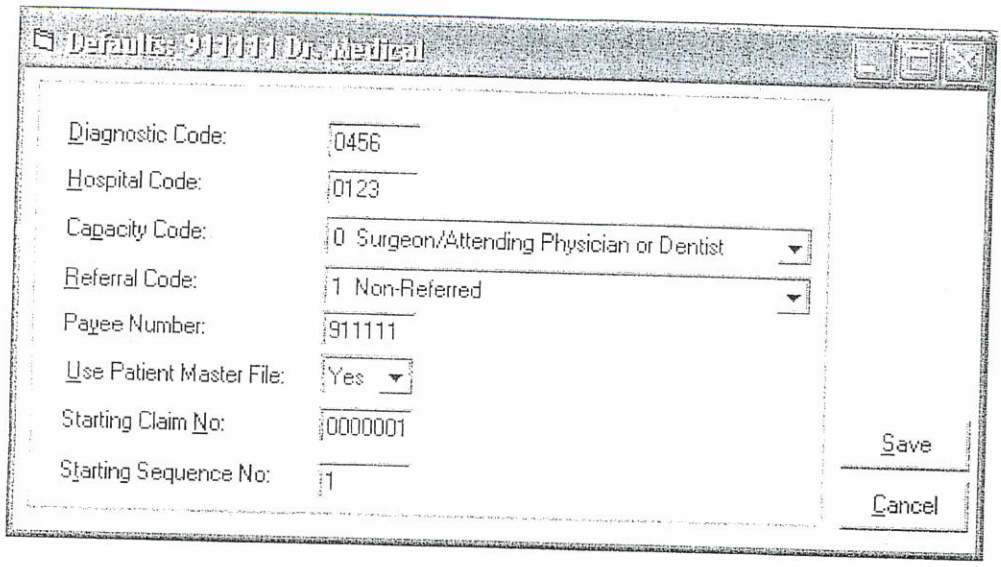
Fields:

Provider: The number assigned by MCP.

Provider Name: The name of the Provider.

Command Buttons: Select selects a Provider and closes the current screen.

Provider Defaults



Used to add and/or change a Provider's defaults.

Defaults can be set for a Provider for certain system values. These defaults can be changed at any time. Defaults must be set individually for each Provider in the system.

Setting up certain Fee-for-Service defaults can save you time if certain values are used consistently when entering claims.

Diagnostic Code, Hospital Code, Capacity, Referral Code, Payee Number, Use Patient Master File, Starting Claim Number and Starting Sequence Number are all claims values that can be set as defaults. The default values will show up on every new Fee-for-Service Claim. You can set whichever defaults are appropriate for your practice. These values can be changed on any individual Fee-for-Service Claim, as required.

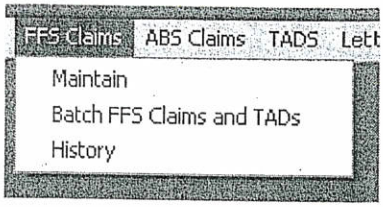
Fields:

Diagnostic Code:	A unique number as per the Diagnostic Code Manual. Should only be set for Radiologists. All other providers leave blank.
Hospital Code:	A unique number assigned to each Hospital by MCP. Only use if all you services are for a specific hospital, such as Radiologists.
Capacity Code:	A code associated with the capacity of the Provider. Valid values are 0, 1 and 3.
Referral Code:	A code indicating if the Patient was referred Valid values are 1 and 2.
Payee:	A number assigned by MCP which is used to allow payment to another Provider or Institution.
Use Patient Master File:	This default must be set to either Yes or No. Note that the Patient master file is shared by all Providers on your TeleClaim system.

Fee-for-Service Claims (FFS—Dental)

- Claim menu
- Dental Claim
- Maintain
- Batch FFS Claims and TADs
- Claims History
- Dental History
- TADs—Retrieve
- TADs—Maintain
- TADs—Dental
- TADs—Dental History
- TADs File Purge
- TADS History Purge

FFS Claims Menu



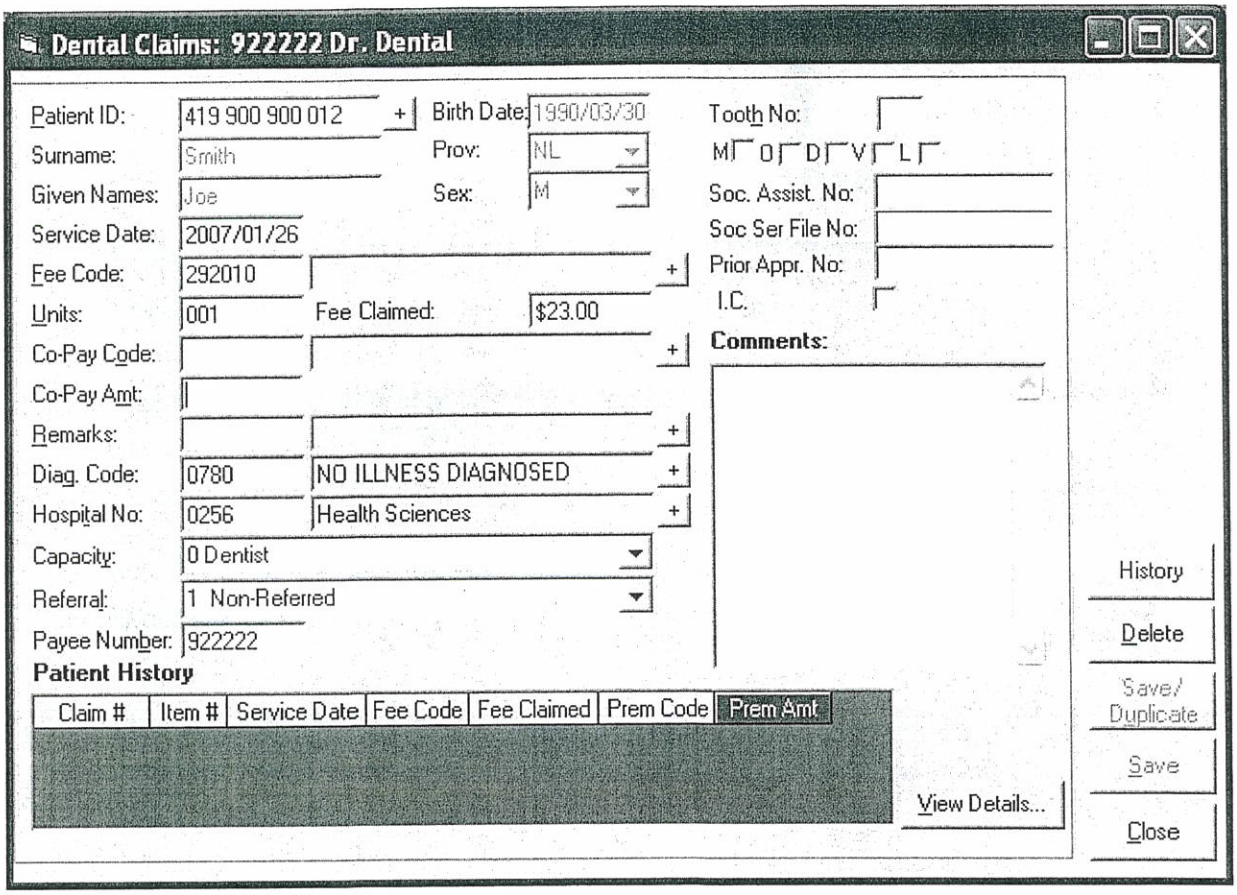
From this menu you can perform all of the functions necessary for entering and updating Fee-for-Service Claims, batching Fee-for-Service Claims and TADs and viewing Fee-for-Service history. A brief description of each option is listed below. Each option is described in their individual sections.

Maintain
Select this option to add new Fee-for-Service claims and to change, delete and browse claims which have been keyed into the claims work files but have not been batched.

Batch FFS Claims and TADs
Select this option to batch Fee-for-Service claims and TADs for submission to MCP.

History
Select this option to browse outstanding and paid Fee-for-Service Claims, including reconciliation information, and to delete individual claims as required.

Dental Claim



This screen allows you to view, add, change or delete a Dental claim and to view a patient's history.

The *Patient History* grid will appear if you are changing a claim and if you click the History Button on an *Add.* To view a claim in the Patient's history, highlight the claim in the *Patient History* grid and click View History.

To maintain a Patient's claim history see *Dental Claim History* on the *FFS Claims* Menu.

Fields:

Patient Id: The Patient Identity Number (PIN). Only Newfoundland PINs can be keyed. Out-of-Province PINS can not be keyed for *Dental Claims.*

If you know the PIN of the patient you can key it here. If the Patient is a Newfoundland Patient and the PIN already exists in *Patients* information screen - the *Surname, Given Names, Birth Date, Sex* and *Prov* for the Patient fields will be automatically filled once you Tab out of the *Patient Id* field.

If you do not know the PIN, you need to add a new Patient, or you wish to view further patient information (i.e. address) you can click the Plus Sign + next to *Patient Id* to access the *Patients* screen. For more information on this screen see the Patient topic in Help.

Once the PIN has been entered you should verify that *Surname, Given Names, Birth Date, Sex* and *Prov* automatically filled in is accurate. As well you should click on the Plus Sign next to Patient Id to pop up the *Patients* screen to ensure patient contact information is up to date.

Birth Date, Surname, Prov, Given Names, and Sex:

The *Surname, Given Names, Birth Date, Sex* and *Prov* fields are automatically filled in when a Newfoundland PIN already in *Patients* information screen is entered in the Patient Id field and the user Tabs from the field. These fields are also automatically filled in when the user clicks the Plus Sign next to the Patient Id field, opens the Patients screen and then selects or adds a new PIN. For more information on this screen see the Patients topic in Help.

Service Date:

The date the Patient was seen by the Provider. The default is the current date. This field can be overwritten but must be less than or equal to the current date.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:
20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

Only claims with a Service Date less than 90 days old should be submitted to MCP. However, if a Provider does wish to submit an old claim enter comments explaining why the claim is late. These claims will be reviewed by MCP staff to determine if claims will be accepted. If you have a number of older claims to submit, contact the Edit department at MCP for further information before entering claims.

Fee Code:

A unique number assigned to each service or procedure as shown in the *MCP Payment Schedules*. If the Fee Code entered is in the *Fee Schedules* screen, the description associated with the Fee Code will automatically be displayed. See *Fee Schedules* on the *Information Menu*. You can click the Plus Sign next to this field to access the *Fee Schedules* screen. If the Fee Code is not in the *Fee Schedules* screen you can add it to the file or simply add the Fee Code directly on the screen. Premium Codes must not be entered in this field.

Units:

Number of units claimed. Used to calculate the Fee Claimed. Default is one (1) but you can overwrite this field.

Fee Claimed:

The amount claimed for the service. If the Fee Code entered is in the *Fee Schedules* screen, this will be calculated upon pressing TAB on Units. This calculation will multiply the Units by the Fee Amount associated with the Fee Code and the result will show in this field. If the Fee Code entered is not in the *Fee Schedules* screen, you must enter the Fee Claimed directly on the screen. If the Fee Code is in the *Fee Schedules* screen but you wish to enter a fee amount different from the one associated with the code, you can do so directly on the Dental Claims screen.

If Fee Claimed is calculated by TeleClaim from the Fee Schedule file, and the claim is modified later by changing the number of units, TeleClaim will **not** recalculate the Fee Claimed. The new Fee Claimed will have to be recalculated manually and reentered.

Co-Pay Code:	A unique number assigned as per the *Dental MCP Payment Schedule*. If the Co-Pay Code entered is in the *Fee Schedules* screen, the description associated with the Co-Pay Code will automatically be displayed. See *Fee Schedules* on the *Information Menu*. You can click the Plus Sign  next to this field to access the *Fee Schedules* screen. If the Co-Pay Code is not in the *Fee Schedules* screen you can add it to the file or simply add the Co-Pay Code directly on the screen.
Co-Pay Amt:	The Co-Pay Amount for the service. If the Co-Pay Code entered is in the *Fee Schedules* screen, this will be calculated upon pressing TAB on the Co-Pay Code field.
Remarks:	A unique number assigned to convey specific messages to MCP. Listed in the *Physician/Dentist Information Manual.* If the Remarks Code entered is in the Remark Code file, a brief description associated with the Remark code will automatically be displayed. See *Remark Codes* on the *Information Menu*. You can click the Plus Sign  next to this field to access the *Remark Codes* screen. If the Remark is not in the Remark Code file you can add it to the file or simply add the Remark Code directly on the screen.
Diag Code:	A unique number as per the Diagnostic Code Manual. If you have set a default Diagnostic Code in *Provider Defaults* on the *Information Menu*, this field will automatically be filled in. You can overwrite this field with a different Diagnostic Code. If the Diagnostic Code entered is in the Diagnostic Codes screen, the name associated with the Diagnostic Code will automatically be displayed. See *Diagnostic Codes* on the *Information Menu*. You can click the Plus Sign  next to this field to access the Diagnostic Codes screen. If the Diagnostic Code is not in the Diagnostic Codes screen you cannot add it to the file.
Hospital Code:	A unique number assigned to each Hospital and Institution by MCP. If you have set a default Hospital Code in the *Provider Defaults* on the *Information Menu*, this field will automatically be filled in. You can overwrite this field with a different Hospital Code. If the Hospital Code entered is in the *Hospitals* screen, the name associated with the Hospital Code will automatically be displayed. See *Hospitals* on the *Information Menu*. You can click the Plus Sign  next to this field to access the Hospital Code file. If the Hospital Number is not in the Hospitals screen you can add it to the file or simply add the Hospital Number directly on the screen.
Capacity:	A code associated with the Capacity of the Provider. If you have set a default Capacity Code in *Provider Defaults* on the *Information Menu*, this field will be automatically be filled in. You can overwrite this field with a different Capacity Code. To change the Capacity Code, click on  and highlight the desired code.
Referral:	A code indicating if the Patient was referred. If you have set a default Referral Code in the *Provider Defaults* on the *Information Menu*, this field will automatically be filled in. You can overwrite this field with a different Referral Code To change the Referral code, click on  and highlight the desired code.
Payee:	The provider number or institution number to whom you wish to assign payment for this claim. If a Payee other than the Provider is always used it is wise to set that Payee Number as the default. Use *Provider Defaults* on the *Information* Menu to do this. Default to provider number if you want to assign payment to the provider.
	The two (2) digit tooth code for services such as fillings and extractions.

Tooth No:	The alpha coding of tooth surfaces. Click the surface codes used for this service.
M,O,D,V,L	
Soc. Assist No:	The Patient's Social Assistance Identification Number valid at the time of service, if applicable.
Soc. Ser. File No:	The Patient's Social Services File Number valid at the time of service, if applicable. Required when a social assistance number is entered.
Prior Appr. No:	The six (6) digit number issued on the Prior Approval Notice.
I.C.	Indicates whether the claim is being submitted for Independent Consideration. If it is to be processed as an IC claim then click this field. If the explanation is brief you can avail of the Comments section on the claim. If the explanation is lengthy then you must submit paper documentation to support the claim.
Comments:	Additional information to help to process a claim.

Patient History Data:	This grid will only show in the Dental Claims screen when viewing a claim that was previously entered. If adding a new claim, the grid will not be visible.
Claim #:	A seven (7) digit number given to the claim during batching.
Item #:	A two (2) digit number given to the item during batching.
Service Date:	The date the Patient was seen by the Provider.
Fee Code:	A unique number assigned to each service or procedure as shown in the *MCP Payment Schedules.*
Fee Claimed:	The amount claimed for the service.
Prem Code:	A unique number assigned to each premium fee as shown in the *MCP Payment Schedules.*
Prem Amt:	The premium amount claimed for the service.

Command Buttons:

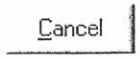
Delete allows you to remove the claim shown on the screen. A dialogue box will appear which will ask you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

Save/ Duplicate saves the information on the current screen and then clears the Fee Code, Fee Code Description, Fee Claimed, Prem Code, Prem Description and Prem Claimed fields. Use this option to enter additional services for the same patient. This will be enabled when data is entered or a change is made to the screen.

Save saves the information on the current screen and then clears the screen. This will be enabled when data is entered or a change is made to the screen.

Close Click *Close* to exit this screen and go back to the main TeleClaim screen. This

will be enabled if no changes are made to the current screen.

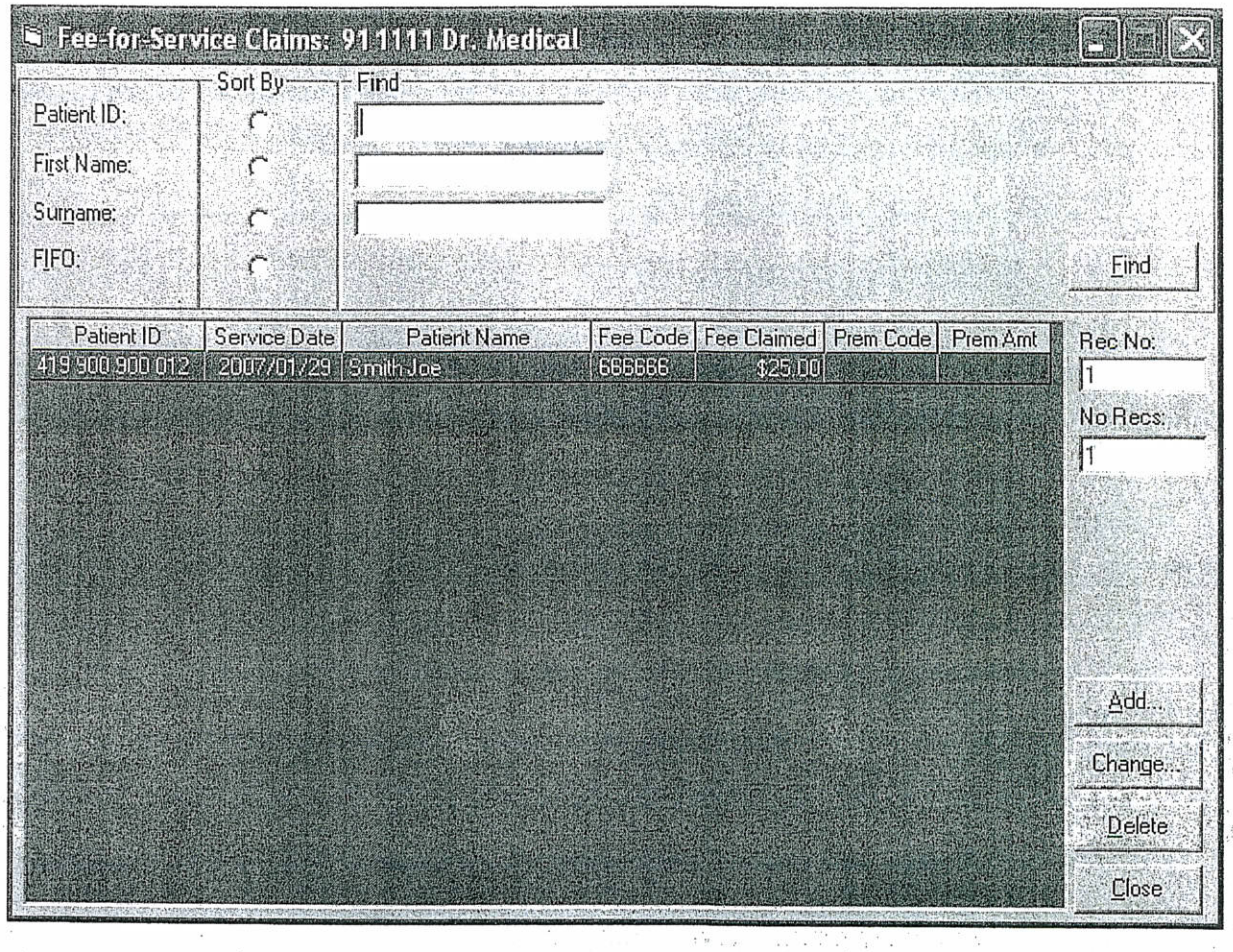


does not save any changes to the current screen . A dialogue box will appear confirming whether or not you wish to cancel. This will be enabled when a change is made to the current screen.

allows you to browse History for the Patient currently displayed. This grid will only be displayed when viewing a claim that was previously entered. Highlighting a claim on the grid and selecting this will make the Dental screen appear. From here you can either delete or close the screen. Then the claims screen reappears. You cannot browse or maintain the history file of another Patient. (See *History* on the *Claims* Menu)

this button will display the entire patient history for the PIN entered on the claim.

FFS Claims - Maintain



This screen displays a list of all FFS claims which have been entered, but not batched. Used to add, change and/or delete claims before batching. Once this process is complete, the claims are batched into a submission file using *Batch FFS Claims and TADs* on the *FFS Claims Menu*.

Claims can be modified or deleted at any time before they are batched.

Providers that are allowed to submit both Medical and Dental claims should note that both types of claims will be listed on this screen.

To Add a claim click Add... . To change or delete a claim, highlight the claim in the grid list and click Change... or Delete .

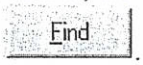
Sort Criteria: Can sort by Patient Id, Patient First Name or Patient Surname, all of which will sort in ascending order. Can also sort by FIFO - first in first out (i.e. the order the records were keyed in).

To change the sort order, click on the radio button next to the desired sort field.

Search Can search by Patient Id and/or Patient First Name and/or Patient Surname.

Criteria:

If using the Patient Id as the search criteria and the Patient Id you are searching is not found, the list will be blank. If using the Patient First Name or Surname as the search criteria and the name you are searching for is not found, TeleClaim will take you to the first record that is closest to the record for which you are searching and show that record in addition to all the records following in the list.

To perform a search, enter the Patient Id, the Patient's First Name or the Patient's Surname in the appropriate text box and click 

.

When starting a new search, it is recommended that you clear all the search fields and press 

to get a complete list.

Columns:

Patient Id: Patient Identity Number (PIN).

Service Date: The date the Patient was seen by the Provider.

Patient Name: The Patient's Surname and Given Name.

Fee Code: A number assigned to each service or procedure as shown in the *MCP Payment Schedules*.

Fee Claimed: The amount claimed for the service.

Prem Code: For Medical claims, this will be the Premium Code. For Dental claims, this will be the Co-pay Code.

Prem Amt: For Medical claims, this will be the Premium Claimed. For Dental claims, this will be the Co-pay Claimed.

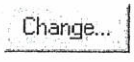
Rec No: The number of the record that is highlighted in the grid.

No Recs: The total number of records (claims entered) that can be listed in the grid. This count does not take into consideration any search criteria that may have been performed to eliminate certain records. This count assumes no search criteria has been performed.

Command Buttons:

allows you to perform a search for a desired item in the grid list.

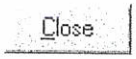
brings you to the *Medical Claim* Entry screen for a Medical Provider and the *Dental Claim* Entry screen for a Dental Provider. If the Provider can claim both Medical and Dental services, a message box will appear prompting you to select Medical or Dental claim entry. The selected claim entry screen will be displayed.



allows you to modify the claim highlighted on the grid list.

allows you to remove the highlighted claim. A dialogue box will appear asking you to

confirm the Delete.



closes the current screen.

FFS Claims - Batch FFS Claims and TADs

This option:

1) batches all Fee-for-Service (FFS) Claims that are currently in the claims work files and performs the following:
   - applies claim and item numbers to each FFS Claim entered
   - writes the numbered claims to the FFS Claims History
   - writes the numbered claims to a FFS Claims submission file
   - clears the FFS Claims work files
2) batches all Turn-Around Documents (TADs) that are currently ready for submission and performs the following:
   - writes the TADs to the FFS Claims History
   - writes the TADs to a FFS Claims submission file
   - clears the TADs work files that are ready for submission

The submission files created can then be transmitted to MCP using *Connect - Connect to MCP* on the *Main Menu*.

It is recommended that FFS Claims and TADs be batched and submitted to MCP at least twice a week. Do not wait until cut-off to batch and submit claims.

You can batch up to nine (9) FFS Claim files (containing FFS Claims and TADs) a day. When nine (9) have been batched, a message box will appear to inform you. To batch a total of nine (9) files, ensure your default Starting Sequence Number is set up as one (1) in the Provider Defaults file. See *Information - Provider Defaults* on the main menu.

If problems are encountered during batching, contact your vendor immediately! Ignoring problems that occur during batching can result in bigger problems later on.

If billing from more than one location, you must ensure that the sequence number is unique.

The Batching Process:

Before you select the batch option, ensure that all modifications have been made to the Fee-for-Service (FFS) Claims and TADs entered. Once they have been batched, they cannot be changed.

If you are using TeleClaim on a network, you should have exclusive use of the files for the Provider for whom you are batching claims. If someone else is doing work for the Provider that you are trying to batch, you will receive a message. You can either wait until the other person is finished or ask the other person to quit until you have finished batching.

When you select the *Batch FFS Claims and TADs* option on the *FFS Claims Menu*, TeleClaim will check to see if there are any FFS Claims or TADs to batch. If there are no FFS Claims or TADs to batch, a message box will appear to inform you. Press 'OK' and you will be brought back to the main menu. If there are FFS Claims or TADs to batch, a message box will appear to inform you of the next sequence number that will be used when building the file name for submission to MCP. The sequence number for the first batch of the day is retrieved from the Provider Defaults file. For each subsequent batch done that day, the sequence number is automatically incremented.

When the batch process is finished, a message box will appear telling you how many FFS Claims (including TADs) have been batched, the total amount claimed for the batch and the Submission File name. Click 'OK' and you will be brought back to the main menu.

Batching Notes:

1) You will determine how often the claims are batched. However, it is recommended that batching be done at least twice a week. Normally you would batch and transmit once per day.

The more often you batch, the less likely it will be that you will lose data due to PC problems, power failures, file corruption, etc. TeleClaim will allow you to create up to a maximum of nine (9) batches a day for each Provider.

2) The Claim Summary contains the name of the submission file, starting and ending claim numbers, number of records in the file and file total. See *Reports - Submission - Summaries* on the main menu.

It is not necessary to print this report unless you wish to keep it for your records.

3) It is a good habit to browse a submission file right after batching. Check the claim numbers used to see that they are correct, and that the data in the file looks reasonable.

4) Claim numbers are assigned sequentially, and are used in combination with item numbers. Each claim number has 99 items associated with it. For example, if the starting claim number for the batch is 0000001, the first Fee-for-Service Claim that you batch will be numbered 0000001-01, the second 0000001-02, up to 0000001-99 at which point the claim number changes to 0000002, and the numbering continues with 0000002-01, 0000002-02, etc.

Note that each new submission file starts with a new claim number. The new claim number should be one greater than the last claim number that used in the previous batching process.

If submitting from different locations, claim number cannot be duplicated.

5) TeleClaim gives every submission file a unique name. Each file name must be unique, or the file will be rejected by MCP as a duplicate file.

An example of a FFS Claims and TADs file name is 99990110.169. The file name is structured as follows:
99990110.169
The first 6 digits are the Provider number (ex. 999901)
9999011***0***.169
The seventh digit is a sequence number, starting with one (1), and going up to nine (9). The first file you batch in a day will use the sequence number that is specified in the *Provider Defaults* screen under the *Information Menu* and incremented by one (1) for every file you batch after that on that day. For more information on the Sequence Number see *Information - Provider Defaults*.
9999011***0***.169
The eight digit represents the year (ex. 0 for 2000)
99990117.169
Following the eighth digit is a period or dot.
99990110.***169***
A three (3) digit extension ends the file name and represents the Julian date of the day the file was batched. The Julian calendar numbers every day of the year from 1 to 366. The Julian date 169 represents June 17, because June 17 is the 169th day of the year. See help on *Julian Conversion* for more information.

Note that the Julian calendar used by MCP assumes every year has 366 days. In years that are not leap years, the Julian date for February 29, which is 060, is not used.

6) As part of the batching process, the submission file name is written to the pending file list under *Connect - Connect to MCP*.

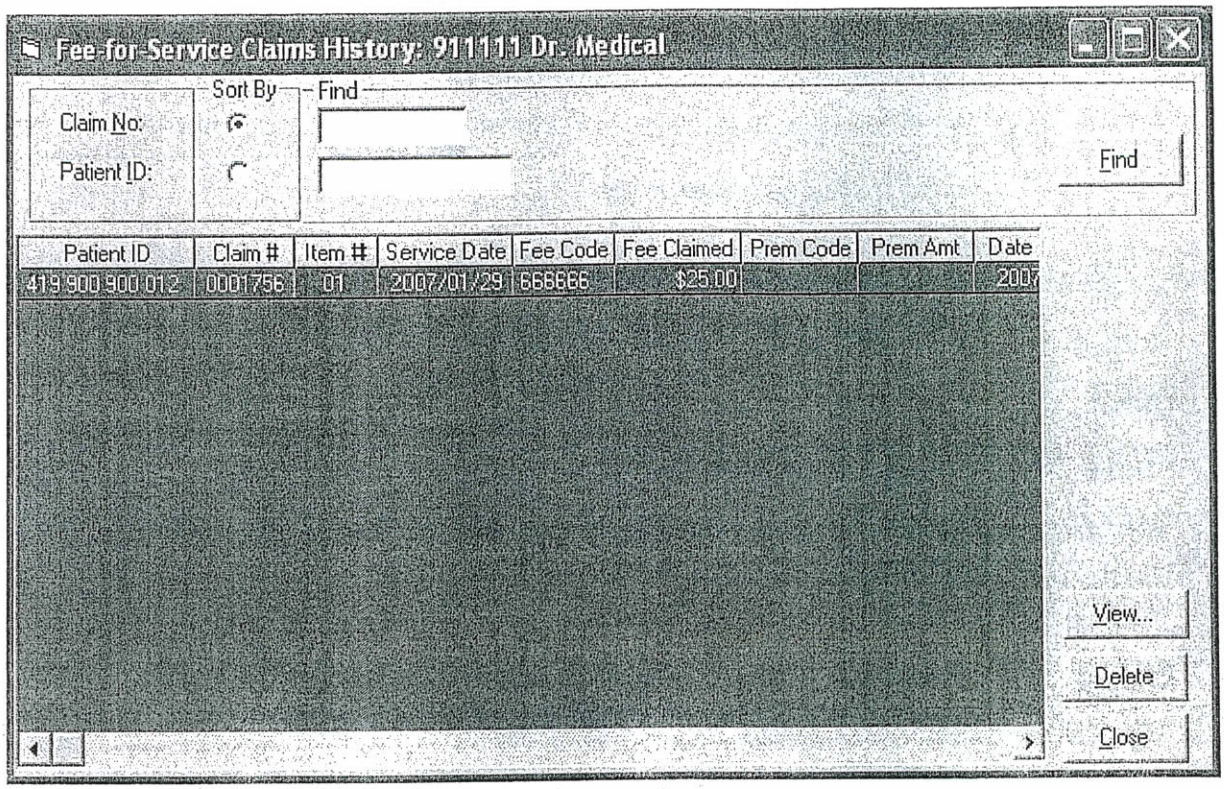
7) Submission files do not have to be transmitted right after they are batched. For example, if you are batching more that one file for a Provider on one day, or files for different Providers, you could wait and transmit all the files at the same time. It is recommended that after you have batched all files for all providers in your office that you then go to the connect option and transmit those files to MCP as soon as possible.

8) The MCP telephone transmission system is up 24 hours a day, 7 days a week, so you can transmit files at any time.

9) Do not wait until cut-off to transmit all your submission files.

Cut-off is the busiest day on the telephone transmission system in the two week payment cycle, and you may not be able to get through to MCP. It is better to transmit the bulk of files over the two weeks between cut-off days, and, if necessary, send a smaller file on cut-off day. This way, if you have a problem transmitting that file, you will still have the majority of claims submitted for payment.

FFS Claims - History



This screen is used to view and/or delete history claims.

As claims are batched, they are added to History. They will remain in this file until they are deleted or purged.

Using this option you can browse the file , look at the claim detail, including the reconciliation data, and delete individual claims.

To view or delete a claim, highlight the claim in the grid list and click View... or Delete.

When cancellation notices are received from MCP, and the claim is not going to be paid, the claim should be deleted from History. This will enable you to keep better track of unpaid claims. See the *Report* Menu - *Outstanding - FFS Claims* for more information on unpaid claims.

Note that if the claim has not been reconciled, the reconciliation code will be displayed as XX - Unreconciled.

Sort Criteria: Can sort by Claim Number or Patient ID. Sorts will be in ascending order.

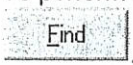
To change the sort order, click on the radio button next to the desired sort field.

Search Criteria: Can search by Patient Id and/or Claim Number.

If the Patient Id being searched for is not found, TeleClaim will bring you to the Patient Id most

resembling the search Id.

If the Claim Number being searched for is not found, the grid list will be blank.

To perform a search, enter the Patient Id or Claim Number in the appropriate text box and click 

.

When starting a new search, it is recommended you clear all the search fields and press 

to get a complete list.

Fields:

Patient Id: Patient Identity Number.

Claim #: A seven (7) digit number given to a claim during batching.

Item #: A two (2) digit number given to a item during batching.

Service Date: The date the Patient was seen by the Provider.

Fee Code: A unique number assigned to each service or procedure as shown in the *MCP Payment Schedules*.

Fee Claimed: The amount claimed for the service.

Prem Code: The Premium Code or Co-Pay Code, depending on if the claim is Medical or Dental.

Prem Claimed: The Premium or Co-Pay amount Claimed.

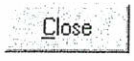
Date Batched: The date the claim was batched.

Command Buttons:

allows you to search for a desired search item in the grid list.

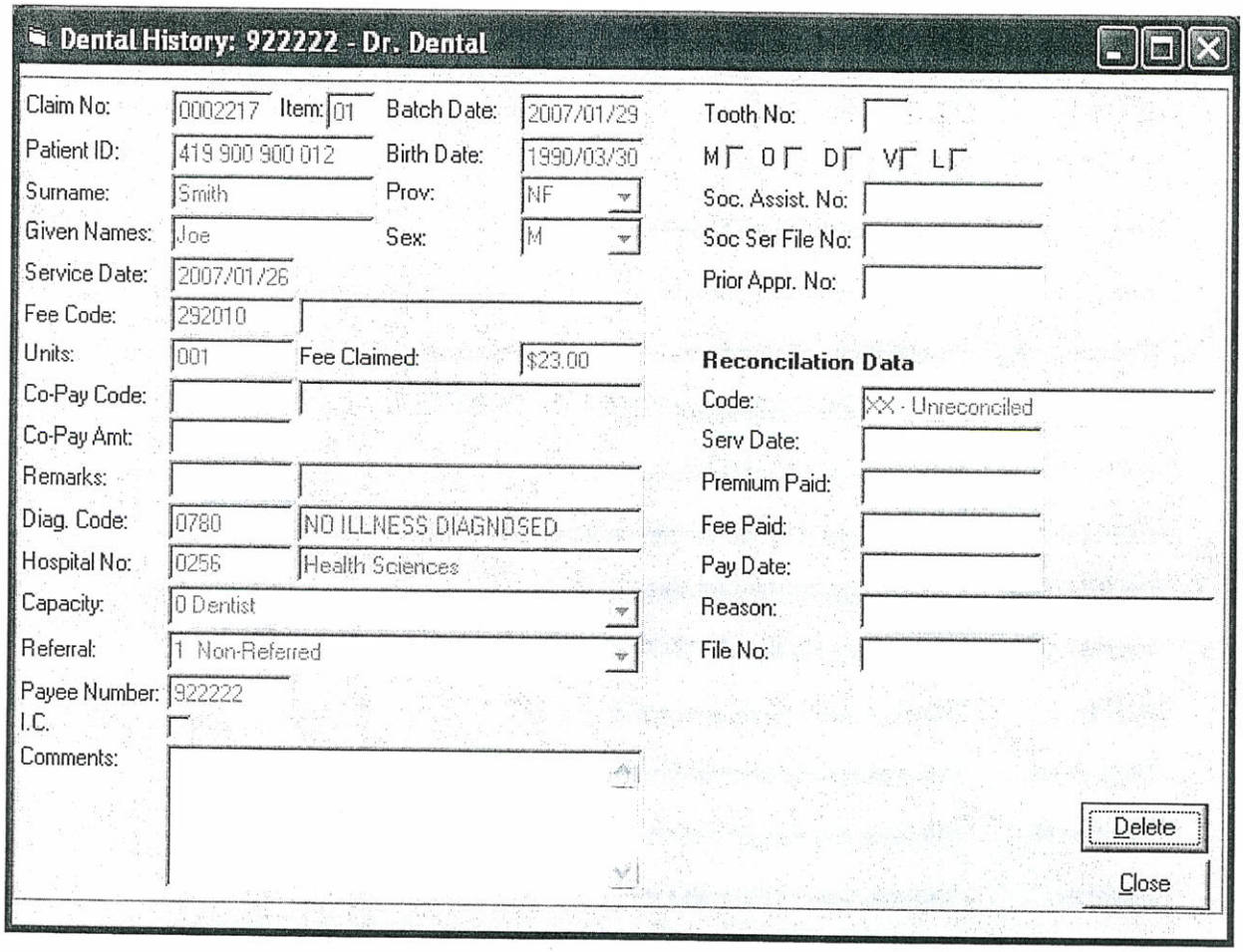
allows you to browse the chosen claim but not make any changes to the claim.

allows you to remove the highlighted claim. A dialogue box will appear which will ask you to confirm the Delete.



allows you to close the current screen.

Dental History



This screen displays the details of a Dental claim which has been batched by the user for submission to MCP. From this screen, the claim can also be deleted.

As claims are batched, they are added to History. They will remain in this file until they are deleted or purged.

Using this option you can browse the file, look at the claim detail, including the reconciliation data, and delete individual claims.

When cancellation notices are received from MCP, unless you take further action to have these claims reactivated, they should be deleted from History. This will enable you to keep better track of unpaid claims. See the *Report Menu - Outstanding - FFS* for more information on unpaid claims.

Note that if the claim has not been reconciled, the reconciliation code will be displayed as XX - Unreconciled.

All fields on this screen are disabled. No updates are allowed.

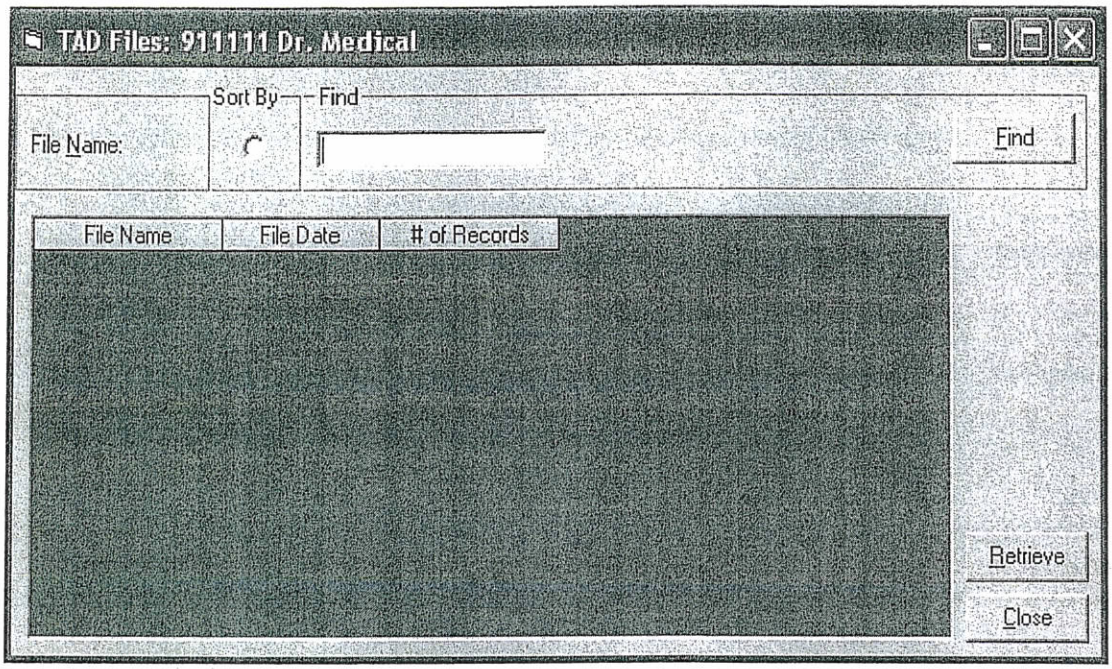
Fields:

Claim No: A seven (7) digit claim number.

Item:	A two (2) digit item number.
Batch Date:	The Date the claim was batched.
Patient Id:	Patient Identity Number.
Birth Date:	The Patient's Birth Date.
Surname:	The Patient's Surname.
Prov:	The Patient's Province Code.
Given Names:	The Patient's Given Names.
Sex:	The Patient's Sex Code.
Service Date:	The Date the Patient was seen by the Provider.
Fee Code:	The Fee Code submitted.
Units:	The number of units claimed.
Fee Claimed:	The amount claimed for the service.
Co-Pay Code:	The Co-Pay Code submitted.
Co-Pay Amt:	The Co-Pay amount claimed for the service.
Remarks:	The Remarks Code submitted.
Diag. Code:	The Diagnostic Code submitted.
Hospital No:	The Hospital Number submitted.
Capacity:	The Capacity of the Provider.
Referral:	The Referral Code submitted for this patient.
Payee No:	The Payee assigned to this service.
I.C.	Indicates whether the claim was submitted for Independent Consideration.
Comments:	Additional information submitted to help process this claim.
Tooth No:	The Tooth Code for services such as fillings and extractions.
M,O,D,V,L:	The alpha coding of Tooth Surfaces.
Soc. Assist No:	The Patient's Social Assistance Identification Number.
Soc. Serv. File No.:	The Patient's Social Services File Number.
Prior Appr.	Prior Approval No submitted.

No.:	Prior Approval No submitted.
Reconciliation Data	
Code:	The Reconciliation Code. See help on *Reconcile FFS and ABS Claims*.
Service Date:	The date of service of the paid claim.
Premium Paid:	The premium/co-pay amount paid for claim.
Fee Paid:	The amount paid for this claim.
Pay Date:	The date the fee and/or the premium was paid by MCP.
Reason:	Code to explain any changes to a claim as a result of an assessment by MCP.
File No:	Remittance file name for this claim.
Command Buttons:	Delete allows you to remove the claim shown on the screen. A dialogue box will appear asking you to confirm the Delete.
	Close closes the current screen.

TADS - Maintain - Retrieve FFS and ABS TADs



Used to retrieve FFS and ABS TAD files into the TeleClaim database and delete FFS and ABS TAD files.

To retireve a TAD file, highlight the file name in the grid and click Retrieve. If a TAD file has already been retrieved, there will be information displayed in the File Date and No TADs columns.

Search Criteria:

A search can be done on File Name.

To perform a search, enter the desired File Name in the File Name text box and click Find.

When starting a new search, it is recommended the user clear all the search fields and press Find to get a complete list.

Fields:

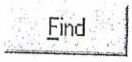
File Name — The name of the TAD file.

File Date: — The date the TAD file was created by MCP.

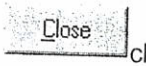
No TADs: — The number of TADs in the file.

Command Buttons:

Retrieve retrieves the highlighted file to the TeleClaim database.

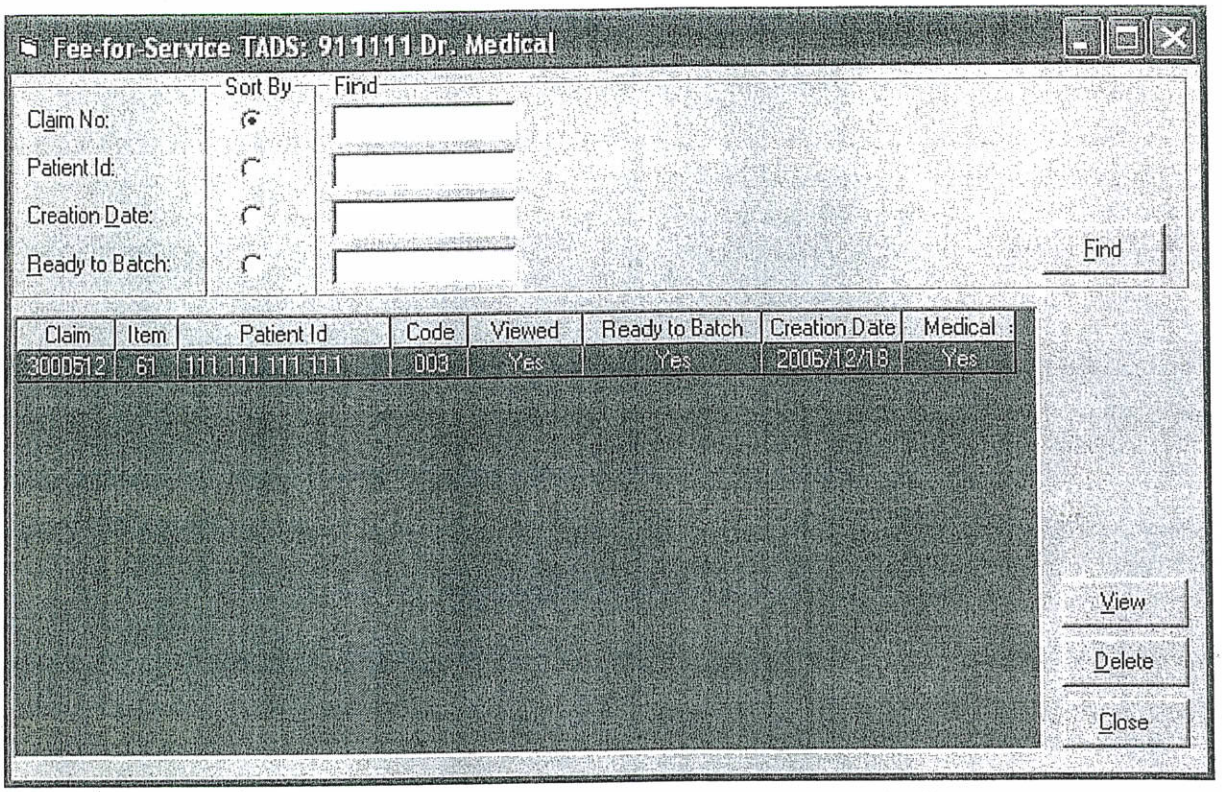


allows the user to search for a desired search item in the grid list.



closes the current screen.

TADS - Maintain - FFS TADs



This screen displays a list of FFS TADs available for Processing.

There are five (5) types of TADs:

- 001 First Notice - Request for Additional Information
- 002 Final Notice - Request for Additional Information
- 003 Cancellation
- 006 History Request for Additional Information
- 007 Final History Request for Additional Information

A FFS TAD may or may not have to be corrected and sent back to MCP.

To view a FFS TAD, highlight the FFS TAD in the grid list and click 

.

Sort Criteria:

Can sort by Creation Date, Code, Patient Id, Claim Number or Ready to Submit. Sorts ascending order.

When the screen is first displayed, it is sorted by Creation Date.

To change the sort order, click on the radio button  next to the desired sort field.

Search Criteria:

Can search by Creation Date, Notice Type (Code) and/or Claim Number.

If you search by Creation Date and none are found with that exact date, the list will cc claims whose are dates after the date entered.

If you search by Patient Id and none are found, the list will be blank.

If you search by Code and none are found, the list will be blank.

If you search by Claim Number and none are found, the list will be blank.

You must enter either 'Yes' or 'No' in the Ready to Submit search.

To perform a search, enter the Creation Date, Notice Type or Claim Number in the app text box and click Find.

The date can be entered in several ways. For example, January 19, 2000 can be enter following ways and default to the format YYYY/MM/DD:
20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

When starting a new search, it is recommended you clear all the search fields and pre Find to get a complete list.

Fields:

Claim: The claim number of the original claim.

Item: The item number of the original claim.

Patient ID: Patient Identity Number submitted on the original claim.

Code (Notice Type): The type of FFS TAD sent to you by MCP concerning the claim.

Viewed: Indicator to show if the FFS TAD has been viewed. If 'Yes', then the claim has been vi 'No', the claim has not been viewed.

Ready to Submit: Indicator to show if the FFS TAD has been viewed and fixed and thus is ready to be se to MCP for processing. If 'Yes', then the claim has been fixed and will be selected duri next batching process that is executed. If 'No', the claim is not ready to be sent back t and will not be selected during the next batching process that is executed.

Creation Date: The date the FFS TAD was created by MCP.

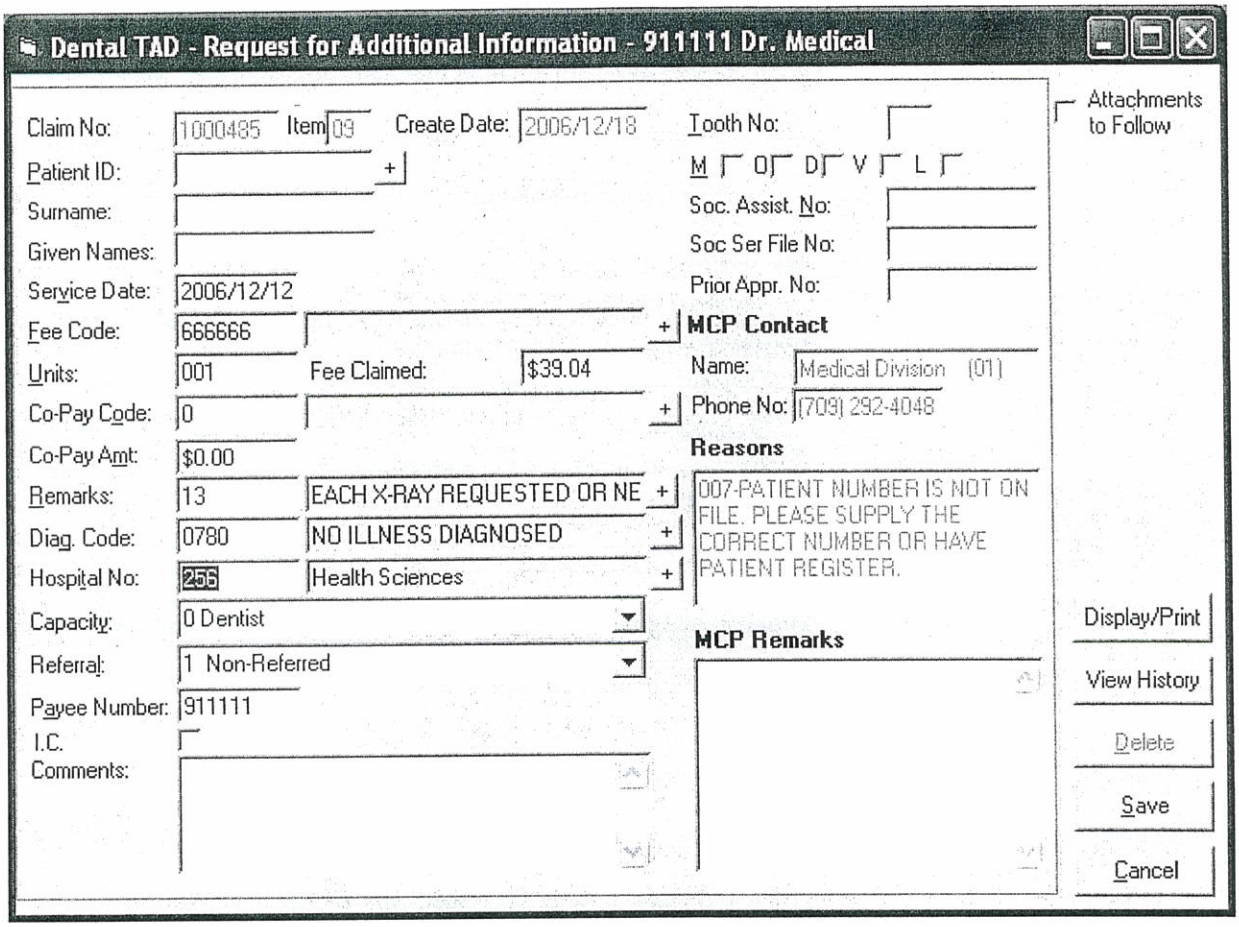
Command Buttons:

Find allows you to perform searches.

View... allows you to view and process the highlighted FFS TAD.

Close closes the current screen.

TADS Dental



This screen is used to change or delete a Dental TAD (Turn Around Document), to view and/or print a TAD or to view Claims History.

The reason the claim was sent back to you as a TAD is displayed under the field Reasons. This lists the first error encountered on the claim.

The TAD type is displayed at the top of the screen.
There are 5 types:
001 First Notice - Request for Additional Information
002 Final Notice - Request for Additional Information
003 Cancellation
006 History Request for Additional Information
007 Final History Request for Additional Information.

To display the report, click Display/Print. To view the claim history click View History.

Fields:

Claim No: The claim number of the original claim.

Item: The item number of the original claim.

Create Date:	The Date the TAD was created by MCP.
Patient Id:	Patient Identity Number submitted on the original claim.
Surname:	The Surname submitted on the original claim.
Given Names:	The Given Names submitted on the original claim.
Service Date:	The date of service submitted on the original claim.
Fee Code:	The Fee Code submitted on the original claim.
Units:	The number of Units claimed on the original claim.
Fee Claimed:	The Fee Amount claimed on the original claim.
Co-Pay Code:	The Co-Pay Code submitted on the original claim
Co-Pay Amt:	The Co-Pay Amount claimed on the original claim.
Hospital No:	The Hospital Number submitted on the original claim.
Diag. Code:	The Diagnostic Code submitted on the original claim.
Remarks:	The Remarks Code submitted on the original claim.
Capacity:	The Capacity Code submitted on the original claim.
Referral:	The Referral Code submitted on the original claim.
I.C.	Indicates whether the original claim was submitted for Independent Consideration.
Payee Number:	The Payee number submitted on the original claim.
Comments:	Additional information submitted on the original claim to help process the claim.
Tooth No:	The Tooth Number submitted on the original claim.
M,O,D,V,L:	The alpha coding of Tooth Surfaces submitted on the original claim.
Soc. Assist No:	The Patient's Social Assistance Identification Number submitted on the original claim.
Soc. Serv. File No.:	The Patient's Social Services File Number submitted on the original claim.
Prior Appr. No.:	Prior Approval No submitted on the original claim.
Name:	The contact name or division at MCP.
Phone:	The contact phone number at MCP.
Reasons:	The reason the claim was rejected and sent back to you.

Attachments to Follow: Check this if you wish to send supporting documentation via postal mail for this TAD to MCP for review before processing this claim.

Command Buttons:

Display/Print allows you to view and print the TAD displayed on the screen.

View History displays the Claims History browse screen. The patient id on the individual tad will carry over to the Patient Id search field on the FFS Claims History Browse screen.

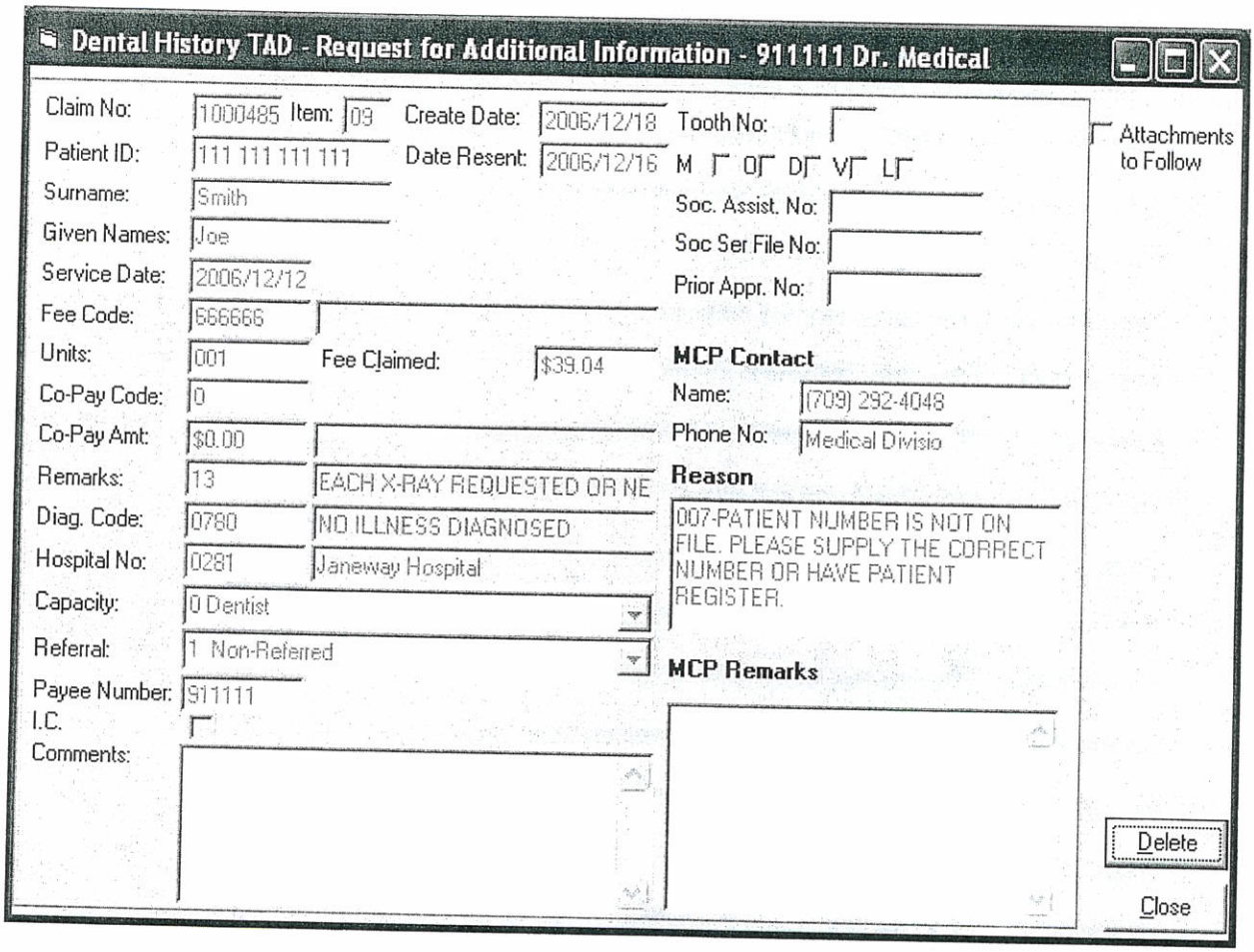
Delete allows you to remove the TAD shown on the screen. A dialogue box will appear asking you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

Save saves the information on the current screen. This will be enabled when data is entered on the screen or a change is made to the screen. A message box will appear asking you if this TAD is ready to be submitted to MCP. If Yes is chosen, this TAD will be included when the next batch is prepared for MCP.

Close closes the current screen. This will be enabled if no changes are made to the current screen.

Cancel does not save any changes to the current screen . A dialogue box will appear asking you to confirm the Cancel. This will be enabled when a change is made to the current screen.

TADS Dental History



This screen is used to view and/or delete a Patient's Dental TAD in History.

As claims are batched, they are added to History. They will remain in this file until they are deleted or purged.

Using this option you can browse the file, look at the claim detail, including the reconciliation data, and delete individual claims.

When cancellation notices are received from MCP, and the claim is not going to be paid, the claims should be deleted from History. This will enable you to keep better track of unpaid claims. See the *Report* Menu - *Outstanding - TADS* for more information on unpaid claims.

All fields on this screen are disabled. No updates are allowed.

The TAD type is displayed at the top of the screen.
There are 5 types:

- 001 First Notice - Request for Additional Information
- 002 Final Notice - Request for Additional Information
- 003 Cancellation
- 006 History Request for Additional Information
- 007 Final History Request for Additional Information.

Fields:

Claim No:	The Claim Number of the original claim.
Item:	The Item Number of the original claim.
Create Date:	The Date the TAD was created by MCP.
Patient Id:	Patient Identity Number submitted.
Date Resent:	The Date the claim was resent to MCP.
Surname:	The Surname submitted.
Given Names:	The Given Names submitted.
Service Date:	The Date of Service submitted.
Payee No:	The Payee Number assigned to this service.
Fee Code:	The Fee Code submitted.
Units:	The number of Units claimed.
Fee Claimed:	The Amount claimed for the service.
Co-Pay Code:	The Co-Pay Code submitted.
Co-Pay Amt:	The Co-Pay Amount claimed for the service.
Hospital No:	The Hospital Number submitted.
Diag. Code:	The Diagnostic Code submitted.
Remarks:	The Remark Code submitted.
Capacity:	The Capacity Code submitted for this provider.
Referral:	The Referral Code submitted for this patient.
I.C.	Indicates whether the claim was submitted for Independent Consideration.
Comments:	Additional information submitted to help process this claim.
Tooth No:	The Tooth Code submitted.
M,O,D,V,L:	The alpha coding of Tooth Surfaces submitted.
Soc. Assist No:	The Patient's Social Assistance Identification Number submitted.
Soc. Serv. File No.:	The Patient's Social Services File Number submitted.
Prior Appr. No.:	The Prior Approval no submitted.

Name:	The contact name or division at MCP.
Phone:	The contact phone number at MCP.
Reasons:	The reason the claim was rejected and sent back to you.
Attachments to Follow:	This will be checked if you checked this field on the TAD entry screen before batching the TAD.

Command Buttons:

Delete allows you to remove the claim shown on the screen. A dialogue box will appear asking you to confirm the Delete.

Close closes the current screen.

FFS TADs File Purge

This option will purge (delete) Fee For Service (FFS) TAD files received from MCP.

This purge is done based on the *File Date*. This is the date the file was created for the user by MCP. Any FFS TAD files with a *File Date* previous to and including the date entered will be purged.

To run the purge, click on the *Utilities Menu*, then *FFS TADs File Purge*. A date of one year previous to the current date will be entered in the date field. This can be changed to any date. Enter the date in the format YYYY/MM/DD. Click *OK*.

A message will be displayed stating how many FFS TAD files will be deleted and asking you if you are sure that you would like to continue.

If you click *Yes* to run the purge, a message will be displayed when the purge is complete.

If you click *No*, the purge will be cancelled.

FFS TADs History Purge

This option will purge (delete) Fee For Service (FFS) TADs from the *FFS TAD History*.

This purge is done based on the *Batch Date* of a TAD. This is the date the TAD was batched for submission to MCP. Any FFS TADs batched previous to and including the date entered will be purged.

To run the purge, click on the *Utilities Menu*, then *FFS TADs History Purge*. A date of one year previous to the current date will be entered in the date field. This can be changed to any date. Enter the date in the format YYYY/MM/DD/ Click *OK*.

A message will be displayed stating how many FFS TADs will be deleted and asking you if you are sure that you would like to continue.

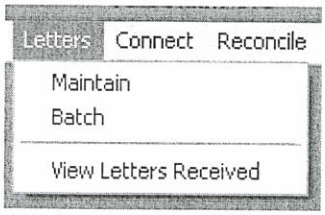
If you click *Yes* to run the purge, a message will be displayed when the purge is complete.

If you click *No*, the purge will be cancelled.

LETTERS

- MENU
- LETTER
- MAINTAIN
- BATCH
- VIEW LETTERS RECEIVED
- PURGE

Letters Menu



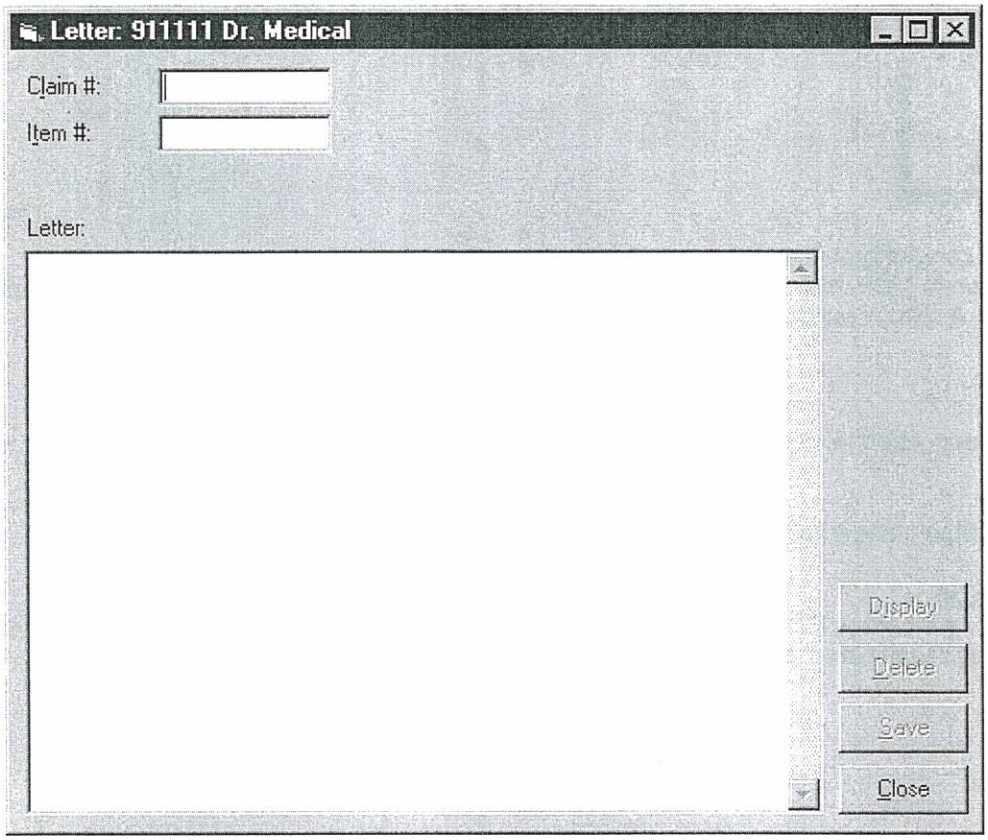
From this menu you can perform all of the functions necessary for entering letters to send to MCP, batching letters written to MCP, maintaining Outstanding/History Letters and viewing informational letters received from MCP. A brief description of each option is listed below. Each option is described in the individual sections.

Maintain
Select this option to add, change, delete and browse Letters which are in the Letters work files History.

Batch
Select this option to Batch letters written to MCP.

View Letters Received
Select this option to View Letters Received from MCP. There are two (2) types of letters sent to the Provider from MCP: (1) Notification of PIN change; (2) Notification of Canceled Claims.

Letter



This screen is used to add and/or change a Letter written by the Provider to be sent to MCP.

Letters may or may not be related to a specific claim.

Fields:

Claim #: A seven (7) digit number given to a claim during batching. This is optional and need only be filled in if the Letter relates to a specific claim.

Item #: A two (2) digit number given to a item during batching. This is optional and need only be filled in if the Letter relates to a specific item.

Letter: The text written by the Provider.

Batch Date: The date the letter was batched. **Only visible if the letter has been batched.**

Command Buttons:

Display allows you to display the letter.

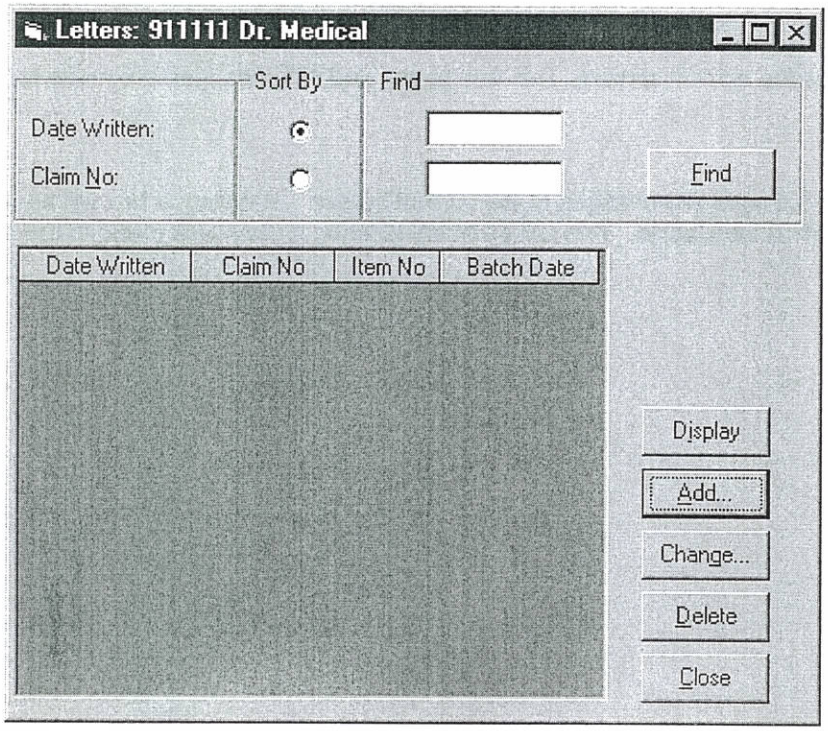
Delete allows you to remove the letter shown on the screen. A dialogue box will appear asking you to confirm the Delete. This will be enabled if there is already data on the screen when it is displayed or when you enter data on the screen.

Save saves the information on the current screen. This will be enabled when data is entered or a change is made to the screen.

Close closes the current screen. This will be enabled if no changes are made to the current screen.

Cancel does not save any changes to the current screen . A dialogue box will appear asking you to confirm the Cancel. This will be enabled when a change is made to the current screen.

Letters - Maintain



This screen displays a list of all Letters written. Used to print, add, view, change and/or delete Letters before batched. Also used to view letters which have been batched.

To Add a letter, click Add... . To display a letter , change or delete a letter, highlight the letter in the grid and click Display or Change... or Delete .

Search Criteria: Can search by Date Written.

To perform a search, enter the desired date in the associated text box and click Find .

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:
20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

If the Date you enter is not found, TeleClaim will take you to the next date greater than the search date.

When starting a new search, it is recommended you clear all the search fields and press

Find to get a complete list.

Fields:

Date Written: The date the letter was written by the Provider.

Claim No: A seven (7) digit claim number. This is optional and needed only if the Letter relates to a specific claim.

Item No: A two (2) digit item number. This is optional and needed only if the Letter relates to a specific item.

Batch Date: The date the letter was batched. If there is no date displayed, then the letter has not been batched and has not been sent to MCP.

Command Buttons:

Find allows you to search for the desired search criteria in the grid list.

Display allows you to view and print the highlighted letter.

Add... brings you to the Letters Entry screen.

Change... allows you to modify the letter highlighted in the grid list.

Close closes the current screen.

Delete allows you to remove the highlighted letter. A dialogue box will appear asking you to confirm the Delete.

Letters - Batch

This option takes all Letters written to MCP that are currently in the letters work files adds them to History and writes them to a submission file.

The submission files created can then be transmitted to MCP using the *Connect - Connect to MCP* option.

A user can only batch 1 Letter file for each Provider per day.

If problems are encountered during batching, contact your vendor immediately! Ignoring problems that occur during batching can result in bigger problems later on.

Letters cannot be batched from separate locations on the same day.

The Batching Process:

Before you select the batch option, ensure that all modifications have been made to the Letters entered. Once they have been batched, they cannot be changed.

When you select the *Letters - Batch* option TeleClaim will check to see if there are any Letters to batch. If there are no Letters to batch, a message box will appear to inform you. Press OK and you will be brought back to the main menu. If there are Letters to batch, then the batching process continues. You will be asked if you would like to print a copy of the letters for you files before they are batched. The letters will still be in the system after they are batched. When the process is finished, a message box will appear telling you how many Letters have been batched and the file name. Press OK and you will be brought back to the main menu.

If you are using TeleClaim on a network, you should have exclusive use of the files for the Provider for whom you are batching letters. If someone else is doing work for the Provider you are trying to batch, you will receive a message. You can either wait until the other person is finished or ask the other person to quit until you have finished batching.

Batching Notes:

1) TeleClaim gives every submission file a unique name. Each file name must be unique, or the file will be rejected by MCP as a duplicate file.

An example of a Letters file name is 999901L0.169. The file name is structured as follows:
999901L0.169
The first 6 digits are the Provider number, eg. 999901.
999901**L**0.169
The 7th digit is an L.
999901L**0**.169
The eight digit represents the year,eg. 0 for 200**0**.
999901L0**.**169
Following the eighth digit is a period or dot.
999901L0.***169***
A three (3) digit extension ends the file name and represents the Julian date of the day the file was batched. The Julian calendar numbers every day of the year from 1 to 366. The Julian date 169 represents June 17, because June 17 is the 169th day of the year. See help on Julian Conversion for more information.

Note that the Julian calendar used by MCP assumes every year has 366 days. In years that are not leap years, the Julian date for February 29, which is 060, is not used.

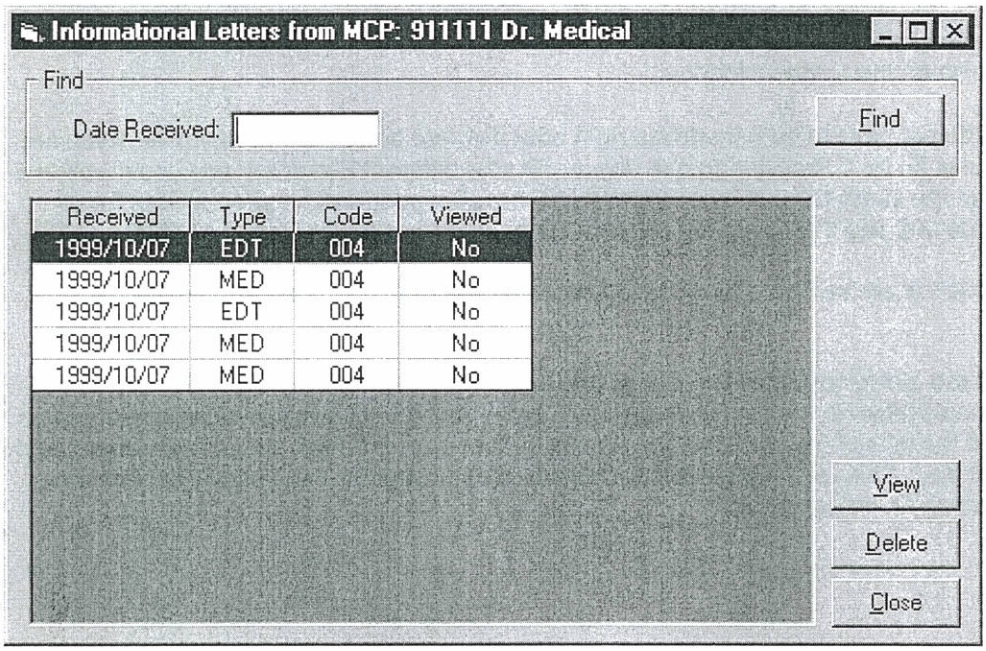
2) As part of the batching process, the submission file name is written to the pending file list in the *Connect to MCP* option on the *Connect* Menu.

3) Submission files do not have to be transmitted right after they are batched. For example, if you are batching more that one file for a Provider on one day, or files for different Providers, you could wait and transmit all the files at the same time. It is recommended that after you have batched all files for all providers in your office that you then go to the connect option and transmit those files to MCP.

4) The MCP telephone transmission system is up 24 hours a day, 7 days a week, so you can transmit files at any time.

5) Do not wait until cut-off to transmit all your submission files. Cut-off is the busiest day on the telephone transmission system in the two week payment cycle, and you may not be able to get through. It is better to transmit the bulk of files over the two weeks between cut-off days, and, if necessary, send a smaller file on cut-off day. This way, if you have a problem transmitting that file, you will still have the majority of claims submitted for payment.

View Letters Received



This screen is used to view, print and/or delete *Informational Letters* sent to the Provider from MCP.

To view or delete a letter, highlight the letter in the grid list and click View... or Delete.

Search Criteria: Can search by Date Received.

To perform a search, enter the Date Received in the appropriate text box and click Find.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:
20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

When starting a new search, it is recommended you clear all the search fields and press Find to get a complete list.

Fields:

Date Received: The date the letter was received from MCP.

Type: The type of informational letter. There are three types: MED (from the Medical department at MCP), DNT (from the Dental department at MCP) or EDT (from the Edit department at MCP).

Code: A three (3) digit code associated with the type of informational letter. Currently, '004' is the only Code used for those letters.

Command Buttons:

Find allows you to search for a desired search item in the grid list.

View... allows you to view the highlighted letter.

Delete allows you to remove the highlighted letter. A dialogue box will appear asking you to confirm the Delete.

Close closes the current screen.

Letter Purge

This option is used to delete letters you sent to MCP and Informational letters received from MCP.

This option should be run on a regular basis so that you can free up some hard disk space. The age of the letters and informational letters to be deleted can be specified, so that some letters and informational letters can be retained if desired.

Depending on the microcomputer you have and the number of letters and informational letters you have, this option may take some time to run.

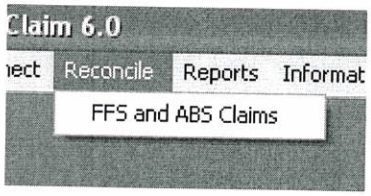
This option purges Letters written to MCP based on the BATCH DATE and Letters from MCP based on the DATE RECEIVED from MCP. A default date of one (1) year will be used when this option is selected. This can be changed to any date. Any Letters batched to MCP or any Letters received from MCP before the date entered will be deleted.

To perform the purge, click on *Utilities - Letter Purge*. If there are no files to be purged, a message box will appear informing you of this. If there are files to be purged a message box will appear asking you to enter a date or accept the default date. Next, you will be told how many Letters written to MCP will be deleted and asked to confirm that you would like to continue. If Yes is chosen, when the purge is complete, a message box will appear saying the purge is complete. If No is chosen, the purge will be canceled and a message box will appear informing you the purge has been canceled. The process is then repeated for Letters received from MCP.

RECONCILE

- MENU
- FEE-FOR-SERVICE AND ALTERNATE BILLING CLAIMS
- RECONCILED CLAIMS PURGE
- UNRECONCILED CLAIMS PURGE

Reconcile Menu

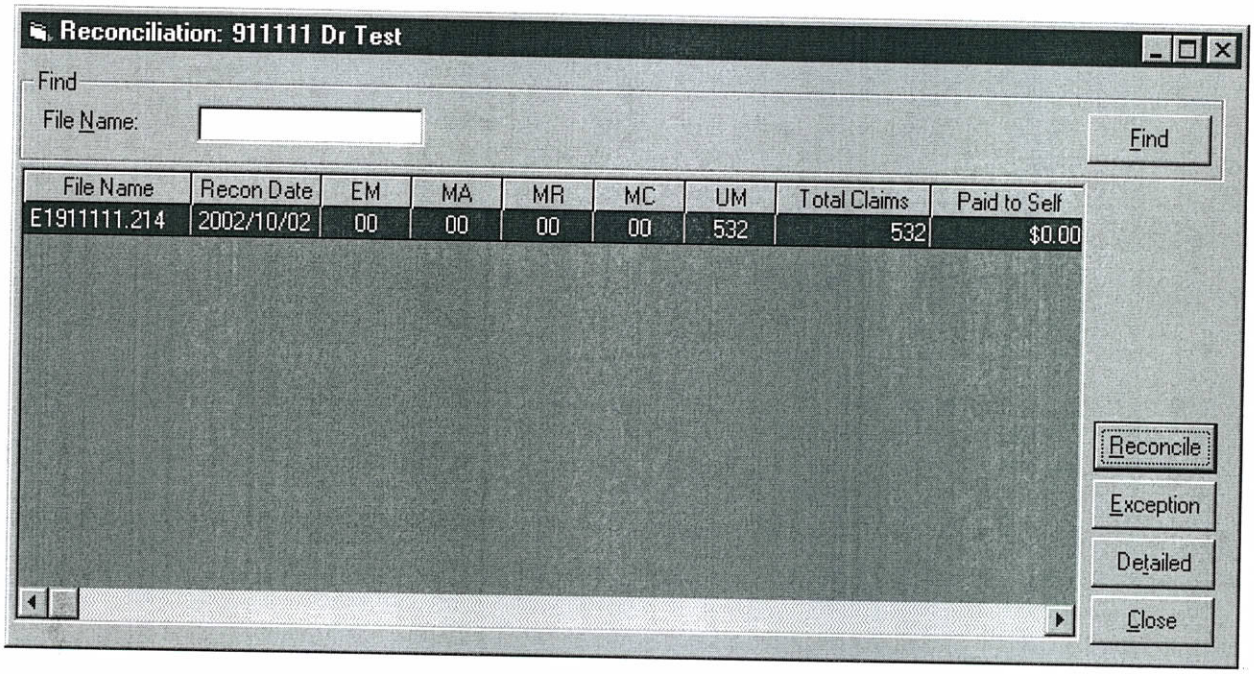


FFS and ABS Claims
Select this option to reconcile the paid Fee-for-Service and Alternate Billing Claims in the Remittance files you received from MCP with the corresponding outstanding (unpaid) Fee-for-Service and Alternate Billing Claims your History.

Select this option to view and print the Detailed and Exception reports for a file that has been reconciled.

Must be done for each provider.

Reconcile - FFS and ABS Claims



This screen is used to reconciled remittance data, view Detail and Exception reports and Delete remittance files.

Electronic remittance files are made available for pickup by MCP every two weeks, a couple of days before payday. The first time you connect to MCP's telephone transmission system after these files have been made available, the remittance files will be transmitted to your system.

When this occurs, in your messages from MCP, you will see one similar to "*Remittance file E19999901.013 received and Remittance file TX999901.013 received.*" The *E1*, or *claims detail* file contains the detail of all claims (Fee-for-Service and Alternate Billing) that are being paid. The *TX*, or *text file* contains a summary, including messages from MCP, reason codes, financial adjustments and the total paid.

Once these files have been received, you can reconcile (match) paid claims in the *remittance detail* file with the corresponding unpaid claims in History for Fee-for-Service Claims and Alternate Billing Claims.

If a file has already been reconciled, the reconciliation date will be displayed. The columns following the reconciled date display reconciliation codes. The numbers in the columns indicate how many claims in the remittance file have these codes associated with them.

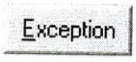
The reconciliation codes are:

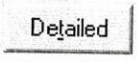
- EM - Exact Match: A claim was found in history with the same claim and item number as on the remittance file and all the fields matched exactly.
- MA - Matched With Amount Changed: A claim was found in history with the same claim and item number as on the remittance record but the amount paid is different from the amount claimed.
- MR - Matched With Reason Code: A claim was found in history with the same claim and item number as on the remittance record but there is a reason code on the remittance record. The reason code description is included in the remittance text file.
- MC - Matched With Record Changed: A claim was found in history with the same claim and item number as on the remittance record, but some field other than the amount field was changed and the record does not contain a reason code

- UM - Unmatched: There was no claim in history to match the claim on the remittance file. This could happen if the claim was submitted on paper, if the claim was deleted from history, or if the claim was submitted from another location.

To reconcile a file, highlight the file in the grid list and click 

.

To view a detail or exception report for a file that has already been reconciled, highlight the file in the grid list and click 

or 

. The Exception report will show you only those claims that have any reconciliation code other than EM - Exact Match. The Detailed report will show you all claims.

To view the *TX* or *Text* report, see *Reports - Remittance* on the main menu.

Search Criteria:

A search can be done on File Name.

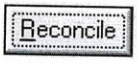
If the file name you are searching for is not found, the list will be blank.

To perform a search, enter the File Name in the associated text box and click 

.

The Reconcile Process:

Select *Reconcile - FFS and ABS Claims* on the main menu.

1) Highlight the file you wish to Reconcile and click 

. If you select a file that has already been reconciled, you will receive a message. You can rerun the reconciliation again and get the same results as the first time, as long as you have not purged the paid claims included in this remittance file from your history.

2) You will be asked if you wish to reconcile for all payees or selected payees. Refer to the *Reconciliation Notes* in this section for a detailed explanation of this option.

If you select all payees, the reconciliation process will continue.

If you choose selected payees, a list of payees included in this remittance file will be displayed. Highlight the payee you wish to reconcile and click select.

3) TeleClaim will match up the paid claims (Fee-for-Service and Alternate Billing Claims) in the remittance file with the corresponding claims in history, using the claim and item numbers.

4.) When the process is finished, you will receive a message.

Reconciliation Notes:

1) You should reconcile remittance files as soon as possible after you receive them and follow up on any claims with reason codes, etc. This keeps the History up to date, making it easier to track unpaid claims and makes the Patient claim history current and more useful.

2) The matching of paid claims with outstanding claims is done by checking the claim fields in a particular order. As a claim can only have one reconciliation code associated with it, the reconciliation code will be the one first encountered when checking the claim. The order in which the codes are assigned is UM, MR, MA, MC and EM.

3.) Remittance files can be reconciled more than once, as long as the paid claims included in the file you want to reconcile again have not been purged from history.

4.) Only the *E1* or *claims detail* information can be displayed and printed in the reconcile option. To see the summary contained in the *TX*, or *text file*, use the *Reports - Remittance* option on the main menu.

5) The file name extension on the *E1* and *TX* files indicates which pay period's data the files contain. There are 26 pay periods in the MCP fiscal year, which runs from April 1 to March 31. The pay periods are numbered sequentially from 1 to 26. Therefore, the first pay date occurring in April will be pay period one (1), the next pay date will be pay period two (2), etc.

The first digit in the three-digit file extension indicates the fiscal year and the second and third digits indicate the pay period. Therefore, the file extension 001 represents the first pay period of the 2000 fiscal year, zero (0) indicating the year and 01 indicating pay period one (1).

6.) Reconciling for selected payees.

If you are reconciling a provider's remittance file that contains more than one payee, you can run the reconciliation for certain payees only.

Example: A provider is billing claims from his own office, plus a hospital is billing claims for work he performs there, using the hospital number as a payee. When the provider's remittance file is produced by MCP, it contains claims received from both locations. The remittance file can only be sent to one location.

If the provider receives the remittance file on his own system in his office, he can reconcile his remittance for only those claims for which he is the payee, excluding the claims billed by the hospital. He can give a copy of the file to the hospital and reconcile his remittance for only those claims for which the hospital is the payee.

If the doctor or the hospital reconciled the full remittance file, they would have the claims that they did not bill showing on their reconciliation listing as UM or *Unmatched*, as these claims do not exist in their history.

7.) A file must be reconciled before any reports can be displayed.

Reconciled Claims Purge

This option will delete/purge reconciled Fee-for-Service Claims and Alternate Billing Claims from History.

This option should be run on a regular basis so that you can free up some hard disk space. The age of the claims to be deleted can be specified, so that some claim history can be retained if desired. Only claims that have been reconciled will be deleted. All outstanding claims will remain in the file.

Depending on the microcomputer you have and the number of records in your History, this option may take some time to run.

This option purges reconciled Fee-for-Service Claims and Alternate Billing Claims based on the BATCH DATE. A default date of one year will be used when this option is selected. This can be changed to any date. Any reconciled Fee-for-Service Claims and Alternate Billing Claims batched before that date will be deleted.

To perform the purge, click on *Utilities - Reconciled Claims* Purge. If there are no files to be purged, a message box will appear informing you of this. If there are files to be purged a message box will appear asking you to enter a date or accept the default date. TeleClaim will then search for Reconciled Medical Claims (for Medical Providers). If there are files to delete, you will be told how many will be deleted and asked to confirm that you wish to continue. If Yes is chosen, when the purge is complete, a message box will appear saying the purge is complete. If No is chosen, the purge will be canceled and a message box will appear to inform you. The process is then repeated for Reconciled Dental Claims (for Dental Providers) and Reconciled Alternate Billing Claims (for Medical Providers).

Unreconciled Claims Purge

This option will delete/purge unreconciled Fee-for-Service Claims and Alternate Billing Claims from History.

Fee-for-Service Claims and Alternate Billing Claims should normally be reconciled on a regular basis using the *Reconcile - FFS and ABS Claims* option and then purged when desired using the *Utilities - Reconciled Claims Purge* option.

Depending on the microcomputer you have and the number of records in History, this option may take some time to run.

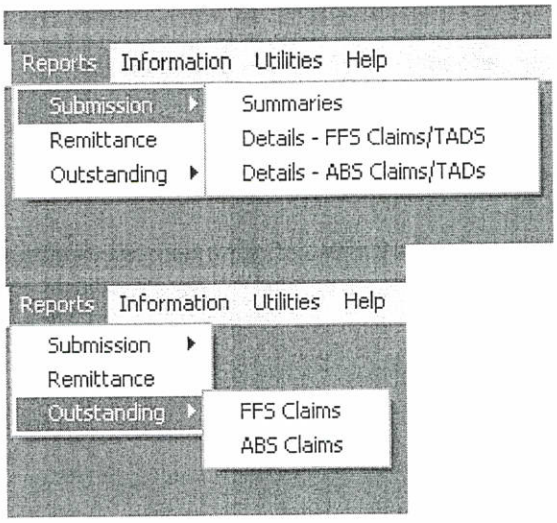
This option purges unreconciled Fee-for-Service Claims and Alternate Billing Claims based on the BATCH DATE. A default date of one year will be used when this option is selected. This can be changed to any date. Any unreconciled Fee-for-Service Claims and Alternate Billing Claims batched before that date will be deleted.

To perform the purge, click on *Utilities - Unreconciled Claims Purge*. If there are no files to be purged, a message box will appear informing you of this. If there are files to be purged a message box will appear asking you to enter a date or accept the default date. TeleClaim will then search for Unreconciled Medical Claims (for Medical Providers). If there are files to delete, you will be told how many will be deleted and asked to confirm that you wish to continue. If Yes is chosen, when the purge is complete, a message box will appear saying the purge is complete. If No is chosen, the purge will be canceled and a message box will appear to inform you. The process is then repeated for Unreconciled Dental Claims (for Dental Providers) and Unreconciled Alternate Billing Claims (for Medical Providers).

REPORTS

- MENU
- PREVIEW
- SUBMISSION—SUMMARIES
- SUBMISSION—DETAILS—FFS CLAIMS/TADS
- SUBMISSION—DETAILS—ABS CLAIMS/TADS
- SUBMISSION PURGE
- REMITTANCE
- REMITTANCE—PURGE
- OUTSTANDING

Reports Menu



These options are used to browse and/or print a submission claims summary, a submission file, remittance file, and/or outstanding (unpaid) Fee-for-Service and Alternate Billing Claims. See the individual options for more information.

Submission

- Summaries
- Details - FFS Claims/TADS
- Detail - ABS Claims/TADs

Remittance

Outstanding

- FFS Claims
- ABS Claims

Report Preview

When you choose to view a report the report preview screen appears. This screen shows exactly how the printed report will look. There are a number of icons on the tool bar to assist you, these are listed below.

 This is the close button. It takes you from print preview back to the report criteria screen.

 This button will show the first page of the report.

 This button will show the previous page of the report. For example if you are currently on page three and you push this button, page two will display.

 This button will show the next page of the report. For example if you are currently on page three and you push this button, page four will display.

 This button will show the last page of the report.

 This is the Stop button, It is used to stop a report from loading.

 This is the Export button, it allows you to save the output of the report as another file. You can export reports into the following formats:

HTML (*.htm; *.html)
Text (*.txt)
Unicode HTML (UTF-8) (*.HTM; *.HTML)
Unicode Text (*.text)

 This button displays a drop down list from which you can choose to view the screen in either an enlarged or decreased state. You can view the reports in the following sizes: 200%, 150%, 100%, 75%, 50%, 25%, 10%

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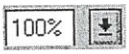
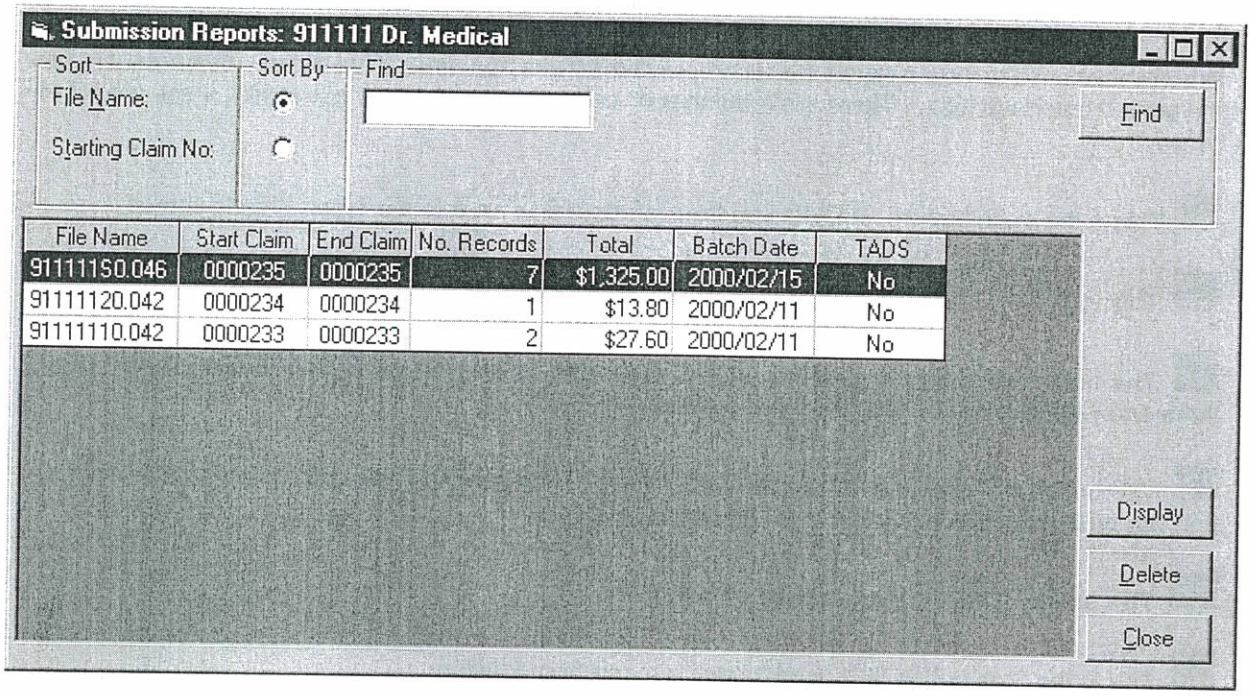
HTML (*.htm; *.html)
Text (*.txt)
Unicode HTML (UTF-8) (*.HTM; *.HTML)
Unicode Text (*.text)



This button displays a drop down list from which you can choose to view the screen in either an enlarged or decreased state. You can view the reports in the following sizes: 200%, 150%, 100%, 75%, 50%, 25%, 10%

Reports - Submission - Summaries



This option displays and prints the claims summary report produced when Claims, TADs, Alternate Billings and Letters are batched.

This is a one page report showing the details of the batch.

To display the report, click Display. To delete a file, highlight the file in the grid list and click Delete.

Sort Criteria: Can be sorted by File Name - Newest to Oldest, or Starting Claim Number - Lowest to Highest.

When first displayed, the display order is in File Name Newest to the Oldest.

To change the sort order, click on the radio button next to the desired sort field.

Search Criteria: Can search by File Name.

If the file name that you are searching for is not found, the list will be empty

To perform a search, enter the file name in the associated text box and click Find.

When starting a new search, it is recommended you clear all the search fields and press Find to get a complete list.

Fields:

Fields:

File Name: A unique name given to each file.

Start Claim: The starting claim number in this file.

End Claim: The ending claim number in this file.

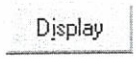
No. Records: The total number of records submitted in this file.

Total: The total amount claimed in this file.

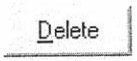
Batch Date: The date this file was batched.

TADS: Indicates whether there are TADs in the submission file.

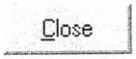
Command Buttons:



allows you to view and print the claims summary report.



allows you to remove the highlighted submission file. A dialogue box will appear asking you to confirm the Delete.

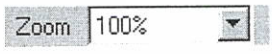


closes the current screen.

The following command buttons are found on the individual reports (See help on *Report Preview*):

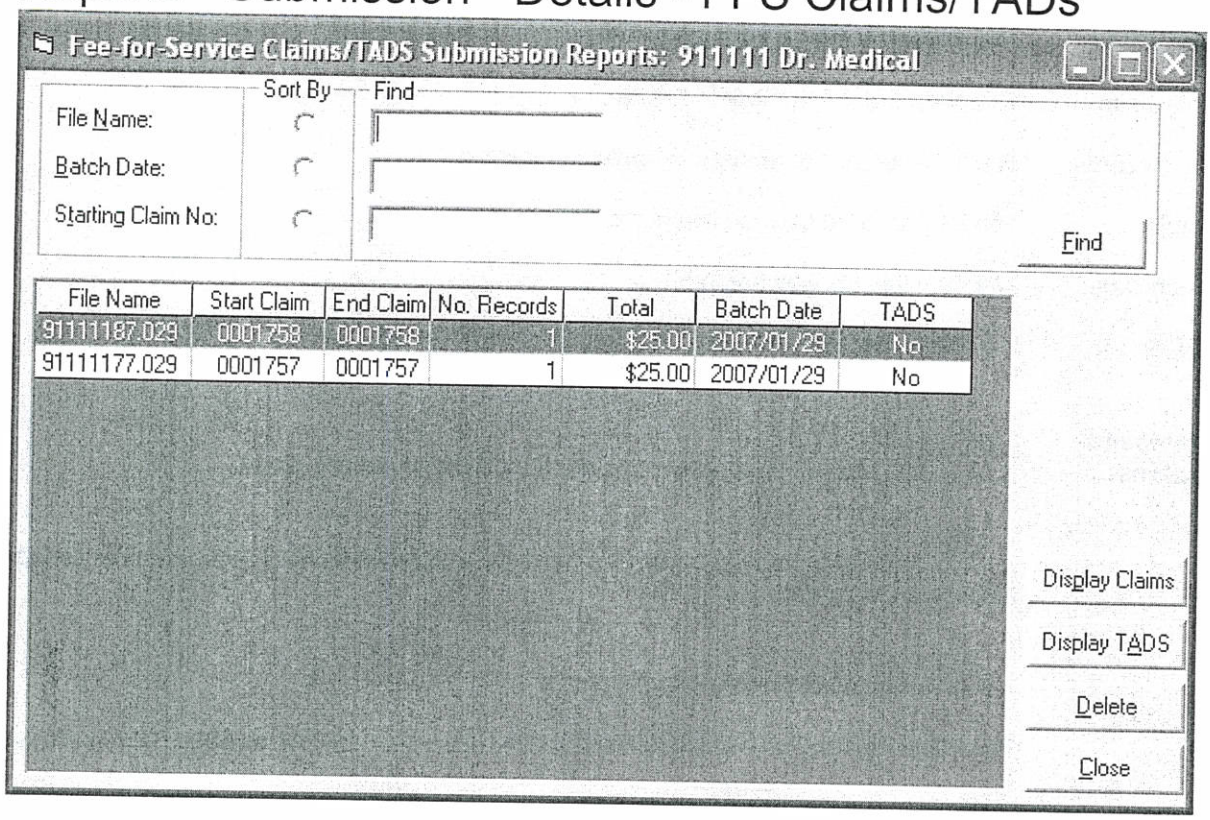

allows you to print the report.


allows you to export the report.



allows you to view the report at different sizes.

Reports - Submission - Details - FFS Claims/TADs



This option displays and prints Fee-for-Service Claims and TADs in a submission file.

The Display Claims option shows you all the Fee-for-Service Claim detail that was entered in the file, the total number of claims entered and a dollar total at the end of the listing.

The Display TADs option shows you all the TADs detail that was entered in the file, the total number of TADs entered and a dollar total at the end of the listing.

To delete a submission file, highlight the file in the grid list and click Delete.

Sort Criteria:

Can be sorted by File Name - Newest to Oldest, Batch Date - Oldest to Newest or Star Claim Number - Lowest to Highest.

When first displayed, the display order is in File Name, Newest to the Oldest.

To change the sort order, click on the radio button next to the desired sort field.

Search Criteria:

Can search by File Name and/or, Batch Date and/or Starting Claim number.

If the file name or starting claim number that you are searching for is not found the list empty. If the batch date you are looking for is not found, TeleClaim will take you to the record that is closest to the record for which you are searching.

The date can be entered in several ways. For example, January 19, 2000 can be enter

following ways and default to the format YYYY/MM/DD:
20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

To perform a search, enter the file name and/or batch date and/or starting claim numb associated text box and click Find.

When starting a new search, it is recommended you clear all the search fields and pre Find to get a complete list.

Fields:

File Name: A unique name given to each file.

Start Claim: The starting claim number in this file.

End Claim: The ending claim number in this file.

No. Records: The total number of records submitted in this file.

Total: The total amount claimed in this file.

Batch Date: The date this file was batched.

TADS: Indicates whether there are TADs in the submission file.

Command Buttons:

Find allows you to search for the desired search criteria in the grid list.

Display Claims allows you to view and print the Fee-for-Service Claims in this file.

Display TADs allows you to view and print the TADS in this file.

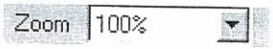
Delete allows you to delete the highlighted submission file. A dialogue box will app asking you to confirm the Delete.

Close closes the current screen.

The following command buttons are found on the individual reports (See help on *Repo Preview.)*:

 allows you to print the report.

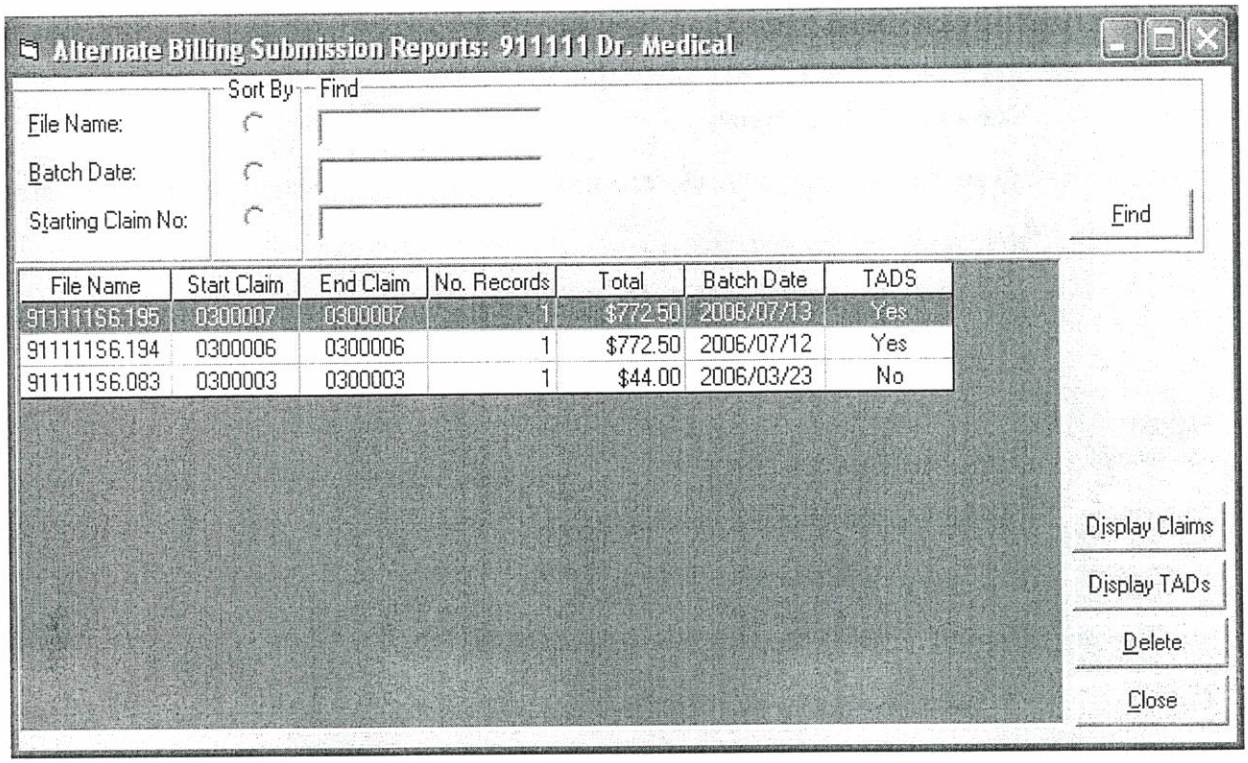
 allows you to export the report.



allows you to view the report at different sizes.

*** The submission report is a report of claims in the database submitted for the highlighted submission file. If you delete claims from your Claims History that were submitted in the highlighted file, they will not be displayed in the report.

Reports - Submission - Details - ABS Claims/TADs



This option displays and prints Alternate Billing System (ABS) Claims in a submission file.

The Display Claims option shows you all the ABS claim detail that was entered in the file, the total number of ABS claims entered and a dollar total at the end of the listing.

The Display TADs option shows you all the ABS TADs in the file.

To delete a submission file, highlight the file in the grid list and click Delete.

Sort Criteria: Can be sorted by File Name - Newest to Oldest, Batch Date - Oldest to Newest or Starting Claim Number - Lowest to Highest.

When first displayed, the display order is in File Name, Newest to the Oldest.

To change the sort order, click on the radio button next to the desired sort field.

Search Criteria: Can search by File Name and/or, Batch Date and/or Starting Claim number.

If the file name or starting claim number that you are searching for is not found, the list will be empty. If the batch date you are looking for is not found, TeleClaim will take you to the first record that is closest to the record for which you are searching.

The date can be entered in several ways. For example, January 19, 2000 can be entered in the following ways and default to the format YYYY/MM/DD:

20000119
0119
2000/01/19
01/19 (assuming 2000 is the current year. If 2001 is the current year, this will default to 2001/01/19)

Spaces are NOT allowed.

To perform a search, enter the file name and/or batch date and/or starting claim number the associated text box and click Find.

When starting a new search, it is recommended you clear all the search fields and press Find to get a complete list.

Fields:

File Name: A unique name given to each file.

Start Claim: The starting claim number in this file.

End Claim: The ending claim number in this file.

No. Records: The total number of records submitted in this file.

Total: The total amount claimed in this file.

Batch Date: The date this file was batched.

Command Buttons:

Display Claims allows you to view and print the ABS Claims.

Display TADs allows you to view and print the ABS TADs in this file.

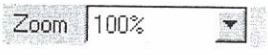
Delete allows you to delete the highlighted submission file. A dialogue box will appear asking you to confirm the Delete.

Close closes the current screen.

The following command buttons are found on the individual reports:

 allows you to print the report.

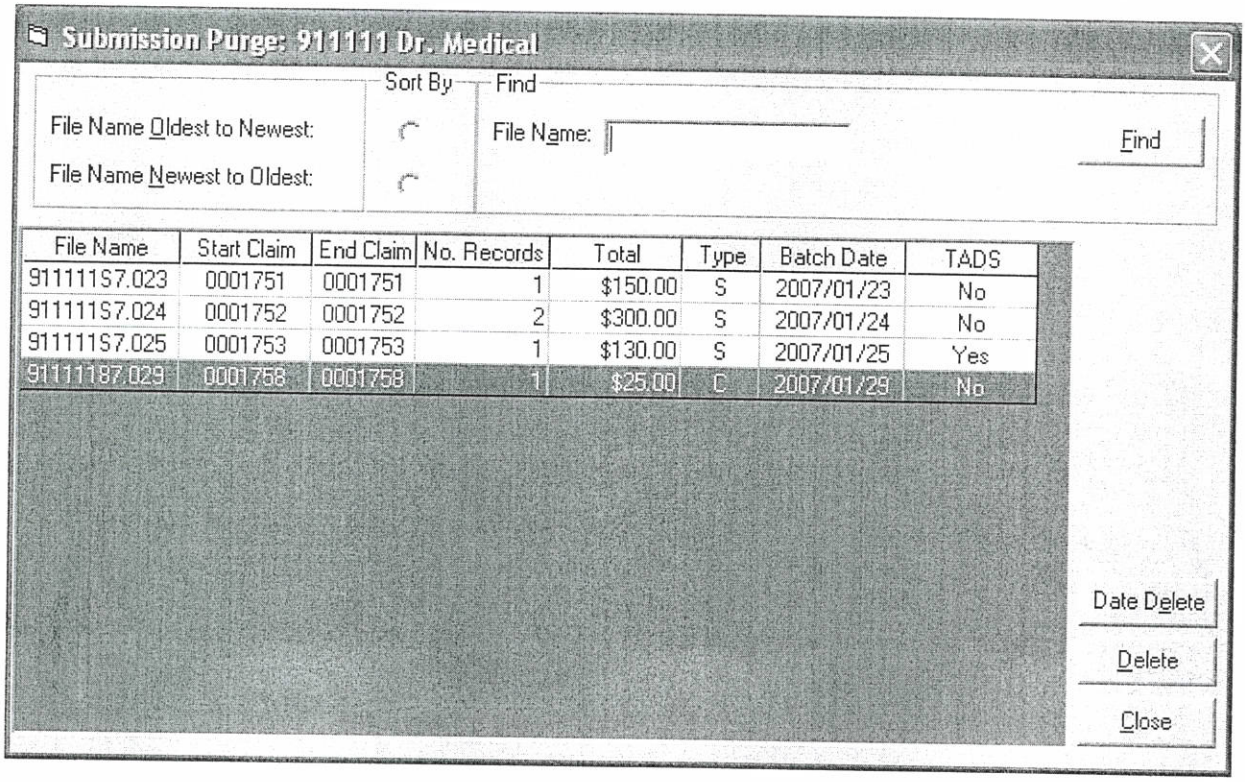
 allows you to export the report. See help on *Report Preview.*



allows you to view the report at different sizes. See help on *Report Preview.*

*** The submission report is a report of claims in the database submitted for the highlighted submission file. If you delete claims from your Alternate Billing Claims History that were submitted in the highlighted file, they will not be displayed in the report.

Submission Purge



This option is used to delete submission files from TeleClaim and your hard drive.

It is recommended that you wait until the Fee-for-Service Claims, TADs and Alternate Billing Claims in a submission file have been processed and paid before deleting the file.

If you are using TeleClaim on a network, you will not encounter any conflicts running this option, unless the file you are deleting is being used by another user.

You can delete an individual submission file or a group of submission files.

To delete an individual submission file, highlight the file you wish to delete and click the Delete button. A message box will appear asking you to confirm that you wish to delete this record.

To delete a group of submission files, click the Date Delete button. You will be prompted to enter a date. Files will be deleted based on the BATCH DATE. All files batched previous to and including the date entered will be deleted.

Sort Criteria: A sort can be done on File Name - Oldest to Newest or File Name - Newest to Oldest.

When the screen is first displayed, the files are displayed by file name, from the Oldest to the Newest.

To change the sort order, click on the radio button next to the desired sort field.

Search Criteria: A search can be done on File Name. If the file name you are searching for is not found, the list will be blank.

To perform a search, enter the desired File Name in the associated text box and click Find.

When starting a new search, it is recommended you clear all the search fields and press Find to get a complete list.

Fields:

File Name: A unique name given to each file.

Start Claim: The starting claim number in this file.

End Claim: The ending claim number in this file.

No. Records: The total number of records submitted in this file.

Total: The total amount claimed in this file.

Type: Type of Submission File. S - Alternate Billing Claims; C - Fee-for-Service Claims and TADs.

Batch Date: The date the file was batched.

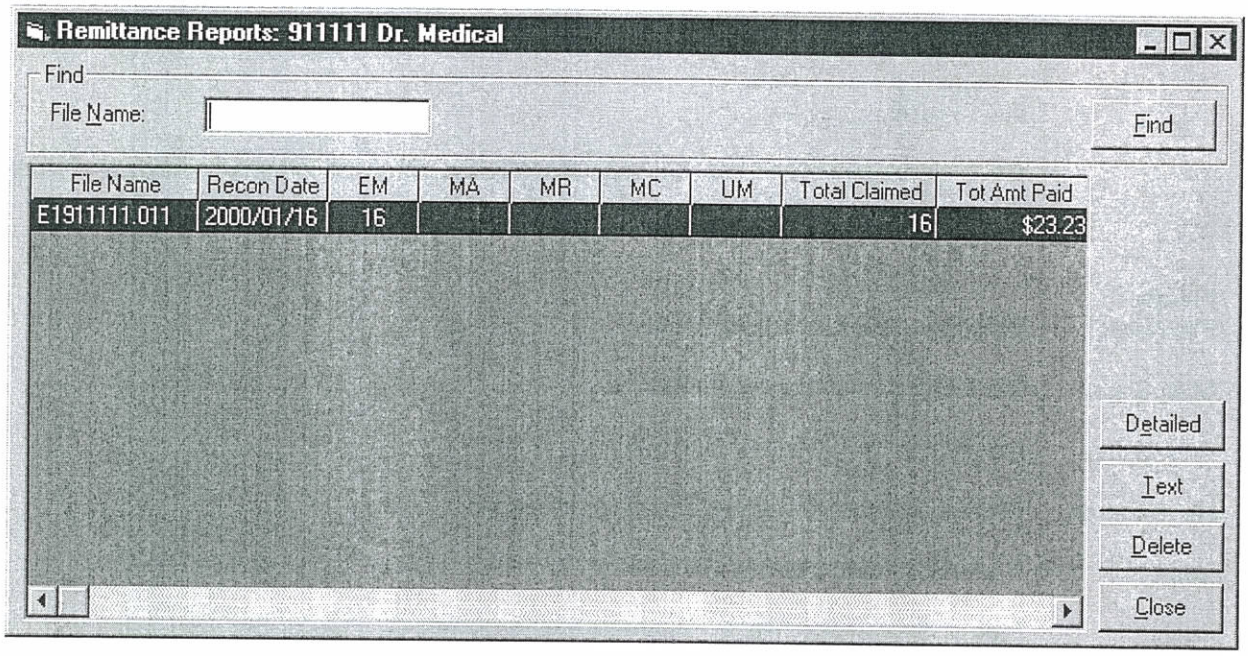
TADS: Indicates whether there are TADs in the submission file.

Command Buttons: Date Delete To delete a group of submission files, click the Date Delete button. You will be prompted to enter a date. Files will be deleted based on the BATCH DATE. All files batched previous to and including the date entered will be deleted.

Delete allows you to delete the highlighted submission file. A message box will appear asking you to confirm that you wish to delete this file.

Close closes the current screen.

Reports - Remittance



This option displays and prints remittance reports.

You can display and print two types of reports - Detail and/or Text

A Detail report will give you the detail for each Fee-for-Service Claim and Alternate Billing Claim item in this remittance file.

A Text report will give you a summary for the pay period, including messages from MCP, reason codes, financial adjustments and the total paid.

Note that although you do not see the *TX* or *Text* file name listed here, you can select the text file you wish to display or print by selecting the *E1* file for the pay period desired and click Text.

To print the Detail report, highlight the file in the grid list and click Detailed. To print the Text report, highlight the file in the grid list and click Text.

Notes

- if a file has not been reconciled under the option *Reconcile - FFS and ABS Claims*, there will be no Detail report to display.
- if a file has been reconciled by SELECTED PAYEES under the option *Reconcile - Claims and Alternate Billings,* the Detail report will not be the full Detail report. To display the full Detail report, go to *Reconcile - FFS and ABS Claims*, click Reconcile and when the option is displayed to choose ALL or SELECTED payees, choose ALL payees.
- a *TX* or *Text* file may not have an associated *E1* file. In this case, there will be no Detail report.

Search Criteria: Can search by File Name.

Search Criteria:

Can search by File Name.

If the file name that you are searching for is not found the grid list will be empty.

To perform a search, enter the file name in the associated text box and click Find.

When starting a new search, it is recommended you clear all the search fields and press Find to get a complete list.

Fields:

File Name: A unique name given to each file.

Recon Date: The date the file was reconciled.

EM: The number of claims with a Reconciliation Code of Exact Matched. An exact match is a Claim that was found in history with the same claim and item number as on the remittance file and all the fields matched exactly.

MA: The number of claims with a Reconciliation Code of Matched With Amount Changed. A match with amount changed is a claim that was found in history with the same claim and item number as on the remittance record but the amount paid is different from the amount claimed.

MR: The number of claims with a Reconciliation Code of Matched With Reason Code. A match with reason code is a claim that was found in history with the same claim and item number as on the remittance record but there is a reason code on the remittance record. The reason code description is included in the remittance text file.

MC: The number of claims with a Reconciliation Code of Matched With Record Changed. A match with record changed is a claim that was found in history with the same claim and item number as on the remittance record but some field other than the amount field was changed and the record does not contain a reason code.

UM: The number of claims with a Reconciliation Code of Unmatched. An unmatched is when there was no claim in history to match the claim on the remittance file. This could happen if the claim was submitted on paper, if the claim was deleted from history, or if the claim was submitted from another location.

Total Claimed: Number of claim items paid in a file.

Paid to Self: Amount of claims paid for services performed by this provider.

Paid by Others: Amount of claims paid to this provider, on assigned payment, for services performed by other providers.

Paid to Others: Amount of claims paid to other providers for services performed by this provider.

Command Buttons:

Find allows you to search for the desired search criteria in the grid list.

Detailed allows you to view and print the Detail report.

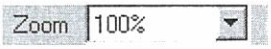
Text allows you to view and print the Text report.

Close closes the current screen.

The following command buttons are found on the individual reports (See help on *Report Preview*.)

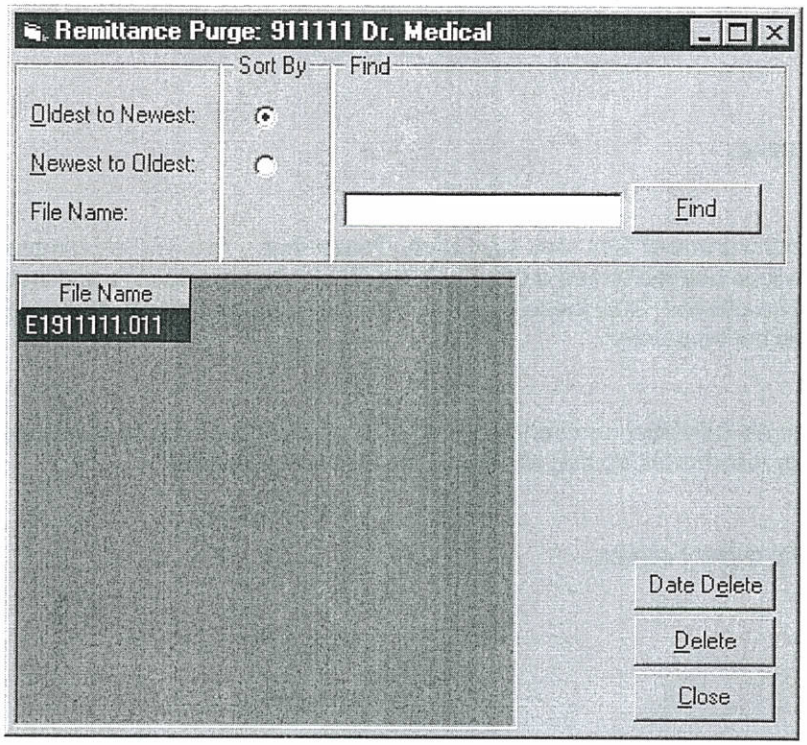
 allows you to print the report.

 allows you to export the report.



allows you to view the report at different sizes.

Remittance Purge



This option is used to delete remittance files from TeleClaim and your hard drive.

If you are using TeleClaim on a network, you will not encounter any conflicts running this option, unless the file you are deleting is being used by another user.

It is recommended that all remittance files be reconciled before deletion. If the file is not reconciled, the paid claims in that remittance file will not be deleted from History, unless they are deleted using the *FFS Claims - History* option.

You can delete an individual remittance file or a group of remittance files.

To delete an individual remittance file, highlight the file you wish to delete and click the Delete button. You will be asked to confirm that you wish to delete the file.

To delete a group of files click the Date Delete button. You will be prompted to enter a date. Files will be deleted based on the PAY DATE. All files previous to and including the date entered will be deleted. Only those files that have been reconciled will be deleted. Unreconciled files will not be deleted.

Sort Criteria: A sort can be done on File Name - Newest to Oldest or File Name - Oldest to Newest.

When the screen is first displayed, it is sorted by File Name - Oldest to Newest. To change the sort order, click on the radio button next to the desired sort field.

Search A search can be done on File Name. If the file name you are searching for is not found, the list

Search Criteria: will be blank.

To perform a search, enter the desired File Name in the associated text box and click Find.

Fields:

File Name: The remittance file name.

Command Buttons:

Date Delete To delete a group of files click the Delete Date button. You will be prompted to enter a date. Files will be deleted based on the PAY DATE. All files previous to and including the date entered will be deleted. Only those files that have been reconciled will be deleted. Unreconciled files will not be deleted.

Delete To delete an individual remittance file, highlight the file you wish to delete and click the delete button. It is recommended that all remittance files be reconciled.

Close closes the current screen.

Reports - Outstanding

This option displays and prints unpaid Fee-for-Service Claims and Alternate Billing Claims in History.

To display unpaid Fee-for-Service Claims, chose *Reports - Outstanding - FFS Claims* option.

To display unpaid Alternate Billings, chose *Reports - Outstanding - ABS Claims* option.

Using this option allows you to check for older Fee-for-Service and Alternate Billing Claims that are still in your system unpaid so you can investigate why they are still there. In some cases they may be canceled claims that you have not deleted from the outstanding file or claims from the remittance file you received but did not reconcile.

Use the *FFS Claims - History*, or *ABS Claims - History* options to delete canceled Fee-for-Service Claims or Alternate Billing Claims, or any Fee-for-Service Claim, or Alternate Billing Claims that will not be paid. Keeping your Outstanding/History file well maintained will help TeleClaim to run more efficiently and make it easier for you to maintain your system overall.

These options default to selecting Fee-for-Service Claims or Alternate Billing Claims that are 30 days old, or older, but you can change this to be any number of days from 0 to 999. The date used to select Fee-for-Service Claims or Alternate Billing Claims is the BATCH DATE. The Fee-for-Service Claims and Alternate Billing Claims are listed in batch date order from Oldest to Newest on each report.

At the end of each report is a total dollar amount and total number of outstanding Fee-for-Service Claims or outstanding Alternate Billing Claims, depending on the report printed.

Command Buttons:

 allows you to print the report.

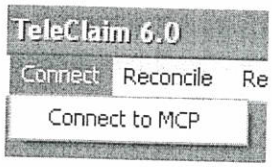
 allows you to export the report. See help on *Report Preview* for more information.

allows you to view the report at different sizes. See help on *Report Preview* for more information..

TECHNICAL SUPPORT AND MISCELLANEOUS

- CONNECT MENU
- FILES SENT TO AND RECEIVED FROM MCP
- BACKUPS
- COMPACT DATABASE
- RESTORE ABS SUBMISSION FILES
- RESTORE FFS SUBMISSION FILES
- JULIAN CALENDAR

Connect Menu



Select this option to transmit the submission files that were created by the batching process to MCP. These files will be sent to MCP via modem using your MCP file transmission software.

As part of the transmission, any files created for you by MCP (for example, TAD files, Remittance files), will be automatically transmitted to your computer.

For further information about this program see the documentation provided with your transmission software.

Connect to MCP

Select this option to transmit the submission files that were created by the batching process to MCP. These files will be sent via modem using your MCP file transmission software, to your folder on the MCP computer network.

As part of the transmission, any files created for you by MCP (for example, TAD files, Remittance files), will be automatically transmitted to your computer.

For further information about this program see the documentation provided with your transmission software.

Files sent to and received from MCP

Files sent to MCP by the Provider

- Fee-for-Service Claims and TADs (for example 91111139.328)
- Letters written by the provider to send to MCP (for example 911111L9.328)
- Alternate Billing Claims (for example 911111S9.328)

Where: 911111 is the provider number
3 is the sequence number of the FFS batch, L = Letters, S = Alternate Billing System (ABS) Claims
9 is the fourth digit of the year
328 is the Julian Date

Files sent to the Provider by MCP

- Remittance Detail (for example E1911111.918)
- Remittance Text (for example TX911111.918)
- Alternate Billing TADs (for example S9111119.328)
- Fee-for-Service TADs (for example T9111119.328)

Where: E1 = Remittance Detail, TX = Remittance Text, S = Alternate Billing System (ABS) TADs, T =
Fee-for-Service TADs
911111 is the provider number
9 is the sequence number (Fee-for-Sevice TADs)
918 is fourth digit of the year (9) and pay period (18) and 328 is the Julian Date

Backups

A backup is a duplicate copy of a file or files, which is stored on tape, writable CD or DVD or other storage device as a protective means against the accidental loss or destruction of the data. Crucial data and programs should be backed up regularly.

Backups should be done on a regular basis. This will enable you to restore data in the event of a hard disk failure, re-installation, corrupted data files, or other problems. The data can be restored from the latest backup, minimizing the amount of data reentry required.

For all backups, it is strongly recommended that copies be stored off site in case of fire or other building disaster.

It is up to the provider(s) to determine how often backups are required, deciding on a schedule that suits their particular practice.

There are no backup options in the system. For details on how to do backups, copies and restores, refer to the backup, copy and restore commands in your Windows documentation or online help.

Database File

This backup would include **MCP.MDB**. Ideally this backup would be done daily, though this may not be practical for some practices.

It is recommended that you compact your database after you backup the database. On the menu, go to *Utilities - Compact Database*.

For this backup, it is recommended that you retain several sets of backups (CDs, DVDs or tapes). For example, you could have a set for each work day of the week, so that you would have a weeks worth of backups at any given time.

Submission Files

If you wish to backup submission files, copy or backup some or all of the files in the directory in which TeleClaim is installed that start with the provider's number. For example, backing up all files that start with 999901 will give you all submission files for provider 999901. You could also copy or backup individual files.

Remittance Files

To backup remittance files, backup files in the directory in which TeleClaim is installed that start with E1 and TX.

TAD Files

To backup TAD files, backup files in the directory in which TeleClaim is installed that start with S or T and then the Provider number. For example, backing up all files that start with S999901 will give you all the Sessional TAD files for provider 999901.

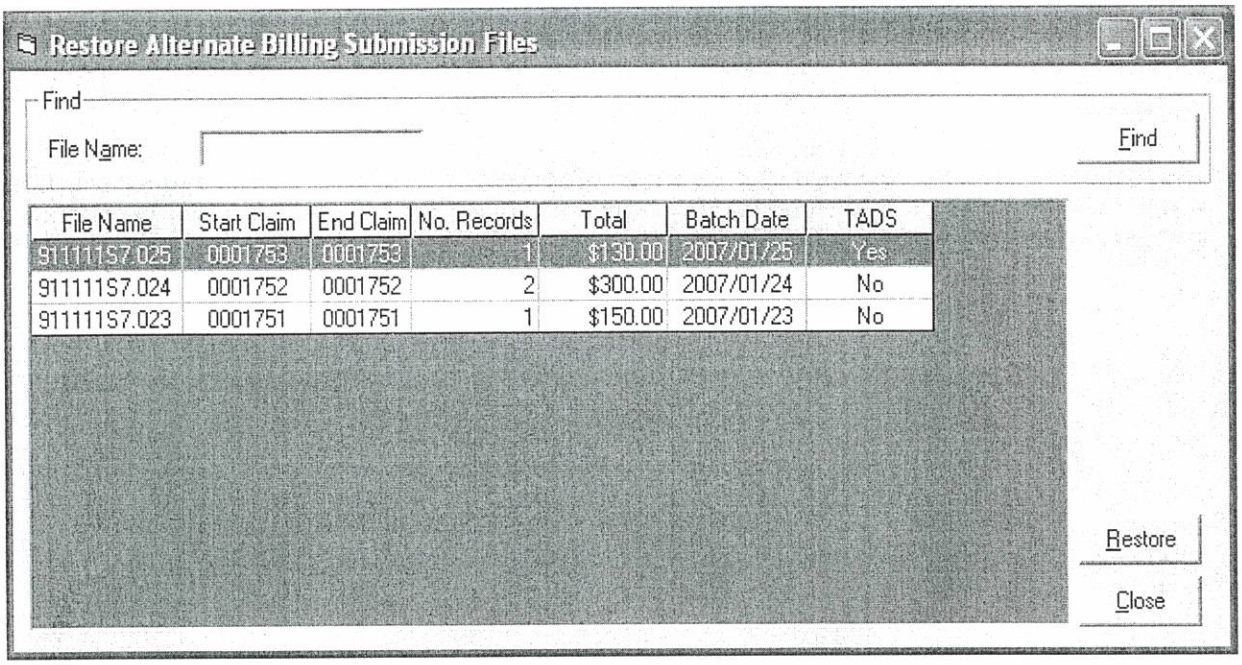
Software

It is recommended that the original software CD and/or diskette received from MCP be stored in a safe place, and not be reused for other purposes.

Full Backup

You may wish to do a full backup of your system on occasions. This will include all data files and software in your TeleClaim system. To do a full backup, include everything in the directory in which TeleClaim is installed. The default directory is C:\MCP.

Restore ABS Submission Files



This option will restore the Alternate Billing System (ABS) Claims and TADs in a selected ABS submission file back into the *ABS Claims Maintain* and *ABS TADs Maintain* options, and remove them from *ABS Claims History* and/or *ABS TADs History*.

This option should be used only when problems occur, and should be used with caution!

DO NOT RESTORE A FILE UNLESS ADVISED TO DO SO BY MCP.

Before running this option, ensure that there are no unbatched ABS claims entered. If there are, batch them before running this option.

To restore a file, highlight the file you wish to restore and click the Restore button. You will be asked to confirm that you wish to do a restore. If you select *NO,* you will be returned to the list of submission files.

If you select *YES,* and there are ABS claims entered but not batched, a message box will appear informing you that you have to batch all ABS claims before a restore can be done.

If you select *YES,* and there are no unbatched ABS claims, TeleClaim will continue with the restore.

TeleClaim will restore the ABS claims and/or TADs in the submission file to the ABS Claims and TADs *Maintain* options. You can then use the *ABS Claims - Maintain* option and/or the *TADS - Maintain - ABS TADs* option to make any necessary changes.

These claims and TADs can then be batched again when ready.

Note that the claims (not the TADs) will be assigned new claim numbers, i.e. the claim numbers assigned to these claims when they were originally batched will not be reused.

Search Criteria: A search can be done on *File Name*. If the file name you are searching for is not found, the list will be blank.

To perform a search, enter the desired *File Name* in the text box and click Find.

When starting a new search, it is recommended you clear all the search fields and click Find to get a complete list, and then enter the *File Name* for the new search.

Columns:

File Name: A unique name given to each file.

Start Claim: The starting claim number in this file.

End Claim: The ending claim number in this file.

No. Records: The total number of records in this file.

Total: The total amount claimed in this file.

Batch Date: The date this file was batched.

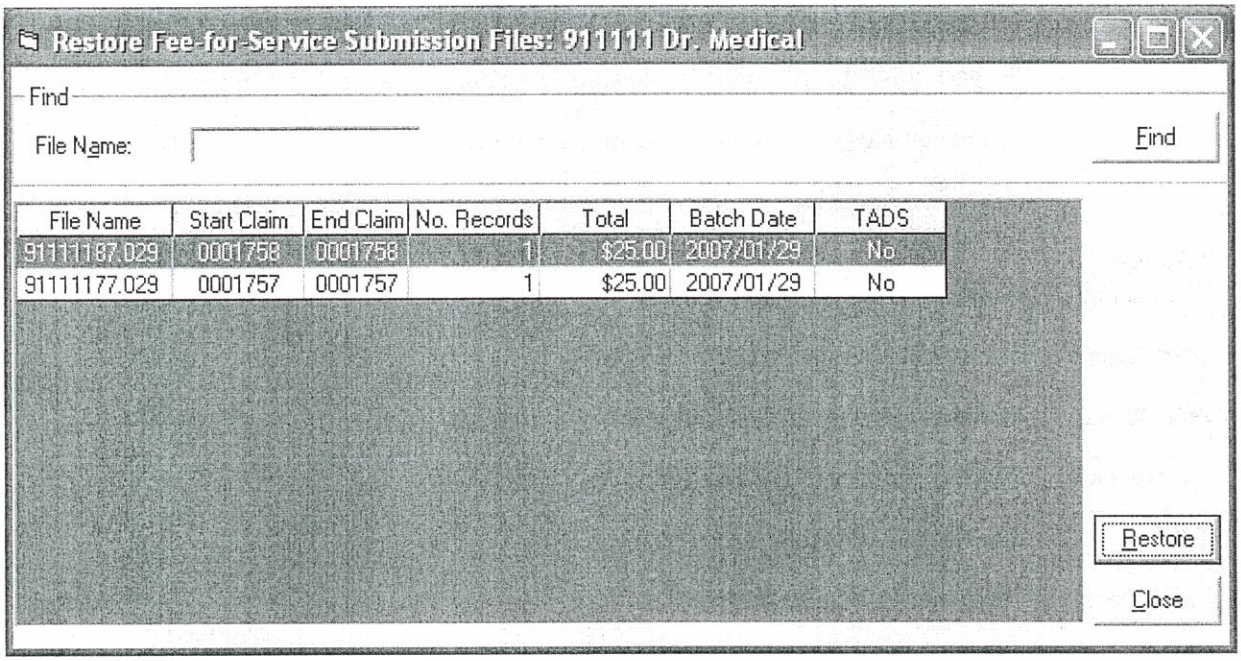
TADS: Indicates whether there are TADs in the submission file.

Command Buttons:

Restore To restore a file, highlight the file you wish to restore and click *Restore*.

Close Click *Close* to exit this screen and go back to the previous screen..

Restore FFS Submission Files



This option will restore the Fee-for-Service Claims and TADs in a selected submission file back into the claims and TADs work files, and remove them from history.

This option should be used only when problems occur, and should be used with caution! If you are not sure if it is appropriate to do a restore, contact your vendor or MCP for advice. **Do not restore a file that has already been transmitted to MCP unless advised to do so by MCP.**

This is an example of an appropriate situation for using the restore option. If claims were batched and assigned claim numbers that had already been used by the provider, you would investigate and correct the claim number problem. Then you would restore the submission file containing the claims with the duplicate claim numbers, and rebatch them so that new claim numbers are assigned to those claims.

Before running this option, ensure that there are no unbatched Fee-for-Service Claims entered. If there are, batch then before running this option.

To restore a file, highlight the file you wish to restore and press the Restore button. You will be asked to confirm that you wish to do a restore. If you select NO, you will be returned to the list of submission files.

If you select YES, and there are Fee-for-Service Claims entered but not batched, a message box will appear informing you that you have to batch all Fee-for-Service Claims before a restore can be completed. If you select YES, and there are no unbatched Fee-for-Service Claims entered, TeleClaim will continue with the restore.

TeleClaim will restore the Fee-for-Service Claims and the TADs in the submission file to the Fee-for-Service Claims and TADs work files. You can then use the *FFS Claims - Maintain* option to make any corrections to the Fee-for-Service Claims or the *FFS TADS - Maintain* option to make any corrections to the TADs. These Fee-for-Service Claims and TADs can then be batched again when ready.

Search Criteria:

A search can be done on File Name. If the file name you are searching for is not found will be blank.

To perform a search, enter the desired File Name in the associated text box and click Find.

When starting a new search, it is recommended you clear all the search fields and pre Find to get a complete list.

Fields:

File Name: A unique name given to each file.

Start Claim: The starting claim number in this file.

End Claim: The ending claim number in this file.

No. Records: The total number of records in this file.

Total: The total amount claimed in this file.

Batch Date: The date this file was batched.

TADS: Indicates whether there are TADs in the submission file.

Command Buttons:

Restore To restore a file, highlight the file you wish to restore and press this button

Delete allows you to delete the highlighted submission file. A message box will ap asking you to confirm that you wish to delete this submission file.

Close closes the current screen.

Julian Calendar

The Julian calendar used by MCP numbers every day of the year from 1 to 366. In years that are not leap years, the Julian date for February 29, which is 060, is not used.

Note that most Julian calendars, unlike the one used by MCP, number non-leap years from 1 to 365. If you have a Julian calendar be sure that it uses 366 days for every year.