Options

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Claim Defaults

Claim Defaults contain fields that are automatically carried over to your newly created claims. They can be changed at any time to a new default setting; once changed, the defaults will only take effect for newly created claims. Defaults can also be changed on a claim itself for a one-time change.

Follow the steps below to set your Claim Defaults for a specific office.

1. Select **Customer Setup** > **Practices**.
2. Use the **Show All** button to view all practices. Or use the **Search field** to further drill down your search.
3. Select the **Practice.**
4. Locate and click on the **Defaults tab** from the right-hand side panel.
5. Click the **Claim tab.**
6. Make your selections referencing the **Claim Default Descriptions** below.
7. Click **Save**.

Claim Default Descriptions

- **Default Place of Service**: Click on the magnifying glass to select a default place of service.
- **Default Type of Service**: Click on the magnifying glass to select a default type of service.
- **Payer Address Location on Claim Form**: Click the drop-down to select if the payer address will print on the left or the right side on the claim. Note: By default, Right is selected.
- **Print Anesthesia start/stop time on CMS-1500 box 24**: Check this box to print the anesthesia start and stop time on Box 24 (of the CMS 1500 form).
- **Auto decrement authorized visits on claim entry**: Check this box to auto-decrement the visits authorized on claim entry. This will automatically decrease the visits left once the claim is saved.
- **Include accident and illness information on claims for all patients** Check this box to automatically populate the Injury/Accident date shown in the Patient section under the Claim Defaults tab on all future claims created once checked.
- **Exclude the Facility when sending claims to insurance** Check this box to automatically populate the

facility on claims, but exclude it when sending to the payer.

The following are **Institutional Claim Defaults only.**

- **Type of Bill**: Click on the magnifying glass to set a default bill type for institutional claims. It will also set a default three-digit bill type for institutional (UB-04) claims. Choose your options by clicking the drop-down on each of the following:
    - **Type of Facility**: The type of facility represents the first digit of the bill type.
    - **Type** of Care: The type of care represents the second digit of the bill type and is dependent on the type of facility.
    - **Frequency**: The frequency represents the third digit of the bill type.
- **Admission Type**: Select the drop down to set a default Admission Type for institutional claims.
- **Admission Source**: Select the drop down to set a default Admission Source for institutional claims.
- **Patient Status**: Select the drop down to set a default Patient Status for institutional claims.

Patient Defaults

Configuring your Patient Defaults can help streamline how you create new patient records. They can be changed at any time to a new default setting; once changed, the defaults will only take effect for newly created patients. Defaults can also be changed on a per-patient basis in the Patients section.

> ⚠ Once updated, defaults will only effect newly created patients.

Follow the steps below to set your Patient Defaults for a specific office:

1. Select **Customer Setup** > **Practices**.
2. Use the **Show All** button to view all practices. Or use the **Search field** to further drill down your search.
3. Select the **Practice.**
4. Locate and click on the **Defaults** tab right-hand side panel.
5. Click the **Patient tab**.
6. Make your selections referencing the **Patient Default Descriptions** below.
7. Click **Save**.

Patient Defaults Descriptions

- **Marital Status**: Select new patients marital status.
- **Employment status**: Select new patients employment status.
- **Student status**: Select new patients student status.
- **Residence status**: Select new patients residence status.
- **Statement type**: Select new patients statement type.
    - If **Single** is selected, statements will print charges and credits for this patient only.
    - If **Family** is selected, statements will print charges and credits for this patient as well as all linked dependents. This will combine all charges and balances due on one statement and list the patien and all dependents at the header of the statement.
- **Mail statement to**: Select whom statements are mailed to. By default, this field is set to Insured; you can change this selection to Patient or one of the other choices at any time on the patient's record.
- **Send statement**: Select if statements should be sent to new patients.
- **Language**: Select new patients preferred language.
- **Accept Assignment**: Select the default accept assignment. This information will populate on Box 27 (the CMS 1500 form) and/or on the electronic ANSI file
- **Gender**: Upon creating a new patient the Gender field will default to blank. You will have to select a Gender for all new patients unless a Gender is specified in the Defaults.

ERA (Payment) Defaults

Payment Defaults contain options that will automatically be set when posting payments. They can be changed at any time to a new default setting; once changed, the default will only take effect for new payments posted.

Follow the steps below to set your Payment Defaults for a specific office.

1. Select **Customer Setup** > **Practices**.
2. Use the **Show All** button to view all practices. Or user the **Search field** to further drill down your search.

3. Select the **Practice**.
4. Locate and click on the **Defaults tab** from the right-hand side panel.
5. Click the **Payment tab**
6. Make your selections referencing the **Payment (ERA) Default Descriptions** below.
    1. **Allow automatic patient payment redistribution:** This option is selected by default and is used to set whether the patient or the payer gets an account credit due to the over-payment of a charge, regardless of the source of the over-payment.
        1. The patient makes a payment on a $100 charge at the time of service (this could be a patient payment or a patient co-pay).
        2. The claim is submitted to the payer for processing.
        3. When we receive the ERA check from the payer they include an $80 payment and a $20 adjustment.
        4. User auto-applies the check and the following actions take place:
            1. The non-insurance payments are removed from the charge (i.e., patient payment/patient co-pay).
            2. The insurance payments are adjustments are applied to each charge.
            3. The system will verify if there are any outstanding balances on the claim.
            4. If so, the system will apply the payment amount (patient payment) that was removed; to bring the charge to $0 or until all money is used.
        5. If there is any money left, the system will set this money as an account credit due to the patient (in this case $20).
            1. When Allow automatic patient payment redistribution is not checked, all the steps remain the same, except for #5 which will then be the following: If there's any money left, the system will set the money as an account credit due to the payer (in this case $20).
    2. **Include the sequence amount (adj code 253) in the allowed amount:** Selecting this option will include the sequestration amount (shown under adjustment reason code 253) within the Allowe amount on ERAs received by Medicare.
7. Click **Save**.

Payment Defaults

Payment Defaults contain options that will automatically be set when sanding patient payment receipts. They can be changed at any time to determine if you want to allow email, text, or printed receipts as well as what to include on them.

Follow the steps below to set your Patient Defaults for a specific office.

1. Select **Customer Setup** > **Practices**.
2. Use the **Show All** button to view all practices. Or use the **Search field** to further drill down your search.
3. Select the **Practice.**
4. Locate and click on the **Options tab** from the right-hand side panel.
5. Click the **Payment tab.**
6. Make your selections referencing the **Payment Default Descriptions** below.
7. Click **Save**.

Payment Default Descriptions

- **Send Receipts Via**: Click on the dropdown to select the default options allowed for receipts:
  - **Print**: Select this option to allow users to print patient receipts.
  - **Email**: Select this option to allow users to send patient receipts via email.
  - **Text**: Select this option to allow users to send patient receipts via text.
  - **Select All**: Select this option to allow users to print, email, and text patient receipts.
- **Configure Allowed Text Time**: If the Text option is selected, choose the start and end times during which text receipts are allowed to be sent.

  Important: Please note that only **Auth Reps** can turn on text receipts.

- **Send replies to**: Click the drop-down to select where any email replies to the receipt email messages should be sent to:
  - **Practice email address**: Select this option to route any email replies to the practice email.

    - **Other email address**: Select this option to route any email replies to an alternate email.
    - **Do not accept email replies**: Select this option if you don't want to accept any email replies associated with the emailed receipts.
- **Include next appointment**: Check this box to include the patient's next appointment on the receipt.
- **Include last seen date**: Check this box to include the patient's last seen date on the receipt.
- **Include current account balance**: Check this box to include the patient's current account balance on the receipt.
- **Include the provider's tax ID**: Check this box to include the provider's tax ID on the receipt.
- **Include payment plan information if applicable**: Check this box to include any applicable payment plan information on the receipt.
- **Include a QR code to access a digital copy of the receipt** Check this box to include a QR code that wi provide the patient with a digital copy of the receipt.
- **Show the procedure code on HSA/FSA receipts** Check this box to include he procedure code on the HSA/FSA receipt.

Estimates Defaults

Estimates Defaults contain options that will automatically apply to patient estimates. They can be changed at any time to a new default setting; once changed, the default will only take effect for new estimates created.

Follow the steps below to set your Estimates Defaults for a specific office.

1. Select **Customer Setup** > **Practices**.
2. Use the **Show All** button to view all practices. Or user the **Search field** to further drill down your search.
3. Select the **Practice**.
4. Locate and click on the **Defaults tab** from the right-hand side panel.
5. Click the **Estimates tab**
6. Check the ***Show new estimates in the Payment Portal Automatically*** checkbox to show any patient estimates in the payment portal by default.
7. Create new estimates using:

1. **Auto**: Select this option to create new estimates based on eligibility by default.
2. **Quick**: Select this option to create new estimates based on copay by default.

8. Click **Save**.

> ⚠ Configure these settings before configuring the patient estimates interface automation. For more information on configuring our patient estimates interface automation, visit our "Manage Patient Estimates" help article.