



Self-Pay claims are created in the same way as creating a claim manually or out of an EMR note. The only difference is the balance will be charged to the patient and not to the insurance carrier.

How to create a self-pay claim:

1. In BOX 11C, choose Self-Pay.

). OTHER INSURED'S NAME (Last Name, First Name, Middle Initiai)	10. IS PATIENT'S	CONDITION	RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	DINE
I. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMEN	-	-	a. INSURED'S DATE OF BIRTH MM DD YY 08 20 1990 M V F	INSURED
D. RESERVED FOR NUCC USE	b. AUTO ACCID	ENT?	NO PLACE (State	b. OTHER CLAIM ID (Designated by NUCC)	NI CN
RESERVED FOR NUCC USE	c. OTHER ACCI			C. INSURANCE PLAN NAME OR PROGRAM NAME	ATIENT
		YES	NO	*SELF PAY*	
1. INSURANCE PLAN NAME OR PROGRAM NAME	E OR PROGRAM NAME 100. CLAIM CODES (Designated by NUCC) BLUE CROSS BLUE SHIELD OF MICH Illinois Medicaid				10
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize to to process this claim. I also request payment of government benefits 				services described below.	_
signature on File	DATE			SIGNED	
below. signature on File 4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY		MM D		SIGNED 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	1
SIGNED Signature on File	DATE 15. OTHER DATE			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
SIGNED Signature on File	DATE 15. OTHER DATE QUAL			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM DD YY TO MM DD YY	

2. Click Verify and Print Patient Statement.

ATIENT'S ADDRESS (NO 1TWIN LAKE RD	a, Street) 6		STATEMENT	Print & Close Win	dow
AVERTON	STATE 8 MI			111111111111111111111111111111111111111	luow
P CODE 3612	TELEPHONE (Include Area Code) (999) 999 - 9999	MAKE CHECKS PAYABLE TO: WRS IMPLEMENTATION & TRAINING		FOR ACCOUNT QUESTIONS CALL: 973-928-5101	
OTHER INSURED'S NAME	E (Last Name, First Name, Middle Initial) 1			DUE DATE:	10/08/2020
OTHER INSURED'S POLI		PATIENT: DOB: 0	BONG TEST 3/20/1990		
RESERVED FOR NUCC U	SE	DATE	REASON	CHARGED/PAID	OWED
INSURANCE PLAN NAME	E OR PROGRAM NAME	02/19/2020	PROCEDURE 99204 OFFICE/OUTPATIENT VISIT NEW	\$322.00	
DC.	AD BACK OF FORM BEFORE COMPLETING &	02/19/2020	ADJUSTMENT: CONTRACTUAL	\$-153.53	
PATIENT'S OR AUTHORI to process this claim. I also	ZED PERSON'S SIGNATURE. I authorize the release o request payment of government benefits either to	03/25/2020	PAYMENT: CASH [PATIENT]	\$-30.00	
	nature on File	06/22/2020	PAYMENT: CASH [PATIENT]	\$-20.00	
DATE OF CURRENT ILLI	NESS, INJURY, or PREGNANCY (LMP) 15. O QUAL QUA	07/01/2020	PAYMENT: CASH [PATIENT]	\$-20.00	
NAME OF REFERRING P	ROVIDER OR OTHER SOURCE 17a.			A 00.00	