

How to print Supervising Provider details on the HCFA-1500 form

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Adding Supervising Provider Details on the HCFA-1500 Form

If you need to activate a supervising physician for your office, please reach out to your Account Manager or [support](#). Once activated, you can print those details on your HCFA-1500 form by following the directions below.

1. From the appointment window, either from the calendar or within the Live Claims Feed, you will see an option for Supervising Provider. Selecting from either the calendar view or the Live Claims Feed will update the information in both places.

From the appointment window:

The screenshot shows the 'Schedule Appointment' form with the following details:

- Appointment Type:** Appointment (selected), Video Visit, Break, Walk-in, Transition of Care, New Patient, Referral.
- Provider:** [Dropdown menu]
- Supervising:** - If different to provider - (highlighted with a red arrow)
- Patient:** [Dropdown menu]
- Reason:** [Text area]
- Scheduled:** [Time and Date fields]
- Duration:** [Minutes field] and [Allow overlapping checkbox]
- Notes:** [Text area]
- Consent Forms:** x HIPAA Data Use Agreement (default)
- Billing:** - If different to provider -
- Office:** Primary Office
- Profile:** [Dropdown menu]
- Eligibility Profile:** [Dropdown menu]
- Exam:** Exam 1
- Color:** [Color selection bar]
- Status:** [Dropdown menu]
- Buttons:** View Clinical Note, View All Appointments
- Footer:** Recurring Appointment, Arrange a Follow-up Reminder, View Active Reminders, Delete, Save & Close, Save, Save & Pay, Cancel

From the Live Claims Feed:

Institutional Claim No

Billing Status

ICD Version

Primary Insurer

Secondary Insurer

Billing Provider:

Supervising Provider:

1. Once the provider is selected from the dropdown, please save the appointment.
2. When you open the HCFA 1500, the supervising details will show in box #17 along with the qualifier DQ.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL 15. OTHER DATE MM DD YY QUAL

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. E00.2 B. C. D. E. F. G. H. I. J. K. L.

24. A.	DATE(S) OF SERVICE	B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES	E.
	From To	PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)	DIAGNOSIS POINTER
	MM DD YY MM DD YY	SERVICE		CPT/HCPCS MODIFIER	