

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

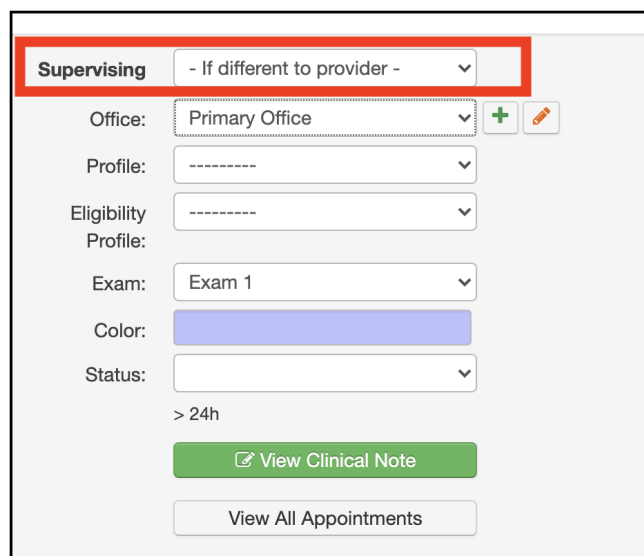
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Adding Supervising Provider Details on the HCFA-1500 Form

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 a form for adding supervising provider details. The 'Supervising' dropdown menu is highlighted with a red box and contains the text '- If different to provider -'. Below this are several other dropdown menus: 'Office' (set to 'Primary Office'), 'Profile' (set to '-----'), 'Eligibility Profile' (set to '-----'), 'Exam' (set to 'Exam 1'), and 'Status' (set to '-----'). There is also a color selection field (set to a light blue color) and a '> 24h' checkbox. At the bottom, there are two buttons: 'View Clinical Note' (green) and 'View All Appointments' (grey).

From the Live Claims Feed:

Billing Status	<input type="text"/>
ICD Version	ICD-10
Primary Insurer	- Default -
Secondary Insurer	- Default -
Supervising Provider:	- If different to provider -

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a and 9d.</i>
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 <u>Signature on File</u> DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED <u>Signature on File</u>
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY Q1 Q2 Q3 Q4	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. _____ 17b. NPI _____	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. _____	B. _____	C. _____
E. _____	F. _____	G. _____
I. _____	J. _____	K. _____
L. _____		L. _____
		23. PRIOR AUTHORIZATION NUMBER