Electronic Patient Statement Registration Packet

August 2024

CGM webPRACTICE™
Fully Web-Based Practice Management Suite

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NOTICE

CompuGroup Medical US (CGM) believes the information contained in this documentation to be accurate at the time of publication and reserves the right to make improvements in the product described herein at any time and without notice.

ELECTRONIC STATEMENT SETUP

How does it work?

You create your patient statements and print them to a file. Within CGM webPRACTICE you can review and edit your statements. You also have options to; enter additional notes; discard statements from the file and to print individual statements to the printer. After you approve the statement file, you send the file to CGM US.

Setup Process

The setup process usually takes one week to complete and then you will be ready to send your patient statements to CGM US.

Step 1: This is an information gathering process that enables CGM US to customize the setup to meet your practice's needs, based on the available standard options. To begin this step, you will need to complete the Statement Registration Form, which is included on page five of this document.

Step 2: CGM US will install the statement programs, perform the setup and create a test batch of statements.

Step 3: The next step is to send the test batch of patient statements to CGM US. The statement mapping will be performed for your statements and a sample will be emailed to you for approval.

What happens to the statements at CompuGroup Medical?

When CGM US receives your patient statements, they are processed and mailed out no later than the next business day.

Prior to printing the statements, they are processed through special U.S. Postal Mailing software to add the zip + 4 and barcoding to ensure the accuracy of addresses so your statements can be delivered quickly and efficiently with fewer mail returns. These statements cost current postage rate plus .20 cents apiece w/ .10 cents for any additional pages.

Any patient statements that do not pass successfully through the mailing software are placed on the *Confirmation/Exception* report. You will be able to review this report via EMEDIX Online (which also includes the total number of statements mailed) every time you send statements to CGM US. The *Confirmation/Exception* report allows you to make the necessary corrections to your patient accounts.

STATEMENT REGISTRATION FORM

Complete the following and return to your Implementation Consultant. This information is required a minimum of one week prior to the estimated *go-live* date to ensure a smooth installation. If you have multiple databases that will be sending Electronic Patient Statements, complete a separate packet for each database. In addition, you will need to assign an individual to be responsible for all Electronic Patient Statement activity.

Client #	_____	Database #	_____
Practice Name	_____	Contact Person	_____
Address	_____	Contact Phone #	_____
City, ST, Zip	_____	Contact Email	_____
Phone #	_____	Fax #	_____

Setup Information

The name and address of the practice and/or physician that prints on the patient statement is taken directly from the statement file that you send to CGM US. This information can be found in the *Change Database Parameters* function (*System > Database Maintenance Menu*) for each database in your system. If you **need a different practice name** to be printed on the patient statement, fill out the following:

Practice Name: _____

Statement Type selected? ☐ 5 ☐ 6 **# of Days for Statement Cycle**: _____

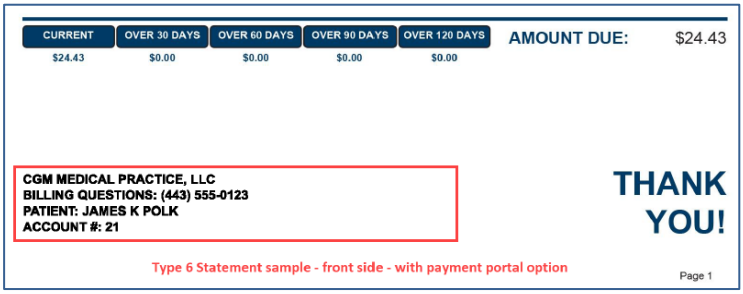
****Note** -** *For databases that are setup for Linking Billing, only Statement Type 6 can be used.*

Credit Cards our office accepts: ☐ MasterCard ☐ Visa ☐ Amex ☐ Discover ☐ None

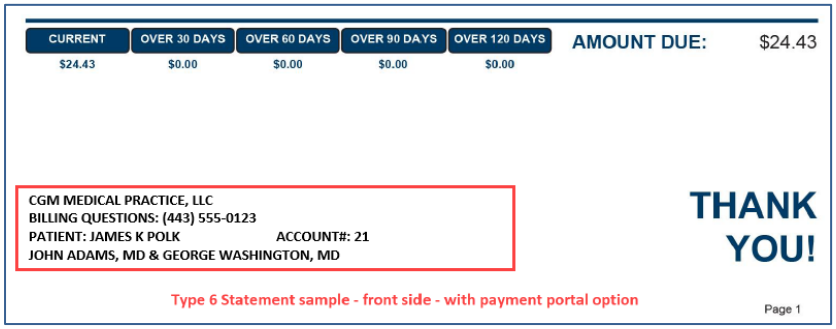
Billing Office Phone #: _____

Practice and Patient Information to print on each patient statement

You have four lines of data available that can print in the lower-left portion of the statement. Typically, this includes your Practice Name, Billing Questions Phone #, Patient Name and Patient Account # as shown in the sample below:



This area can be customized to meet your needs though. For example, if you want to include Doctor Names, the data can be shifted around to do so, as shown below:

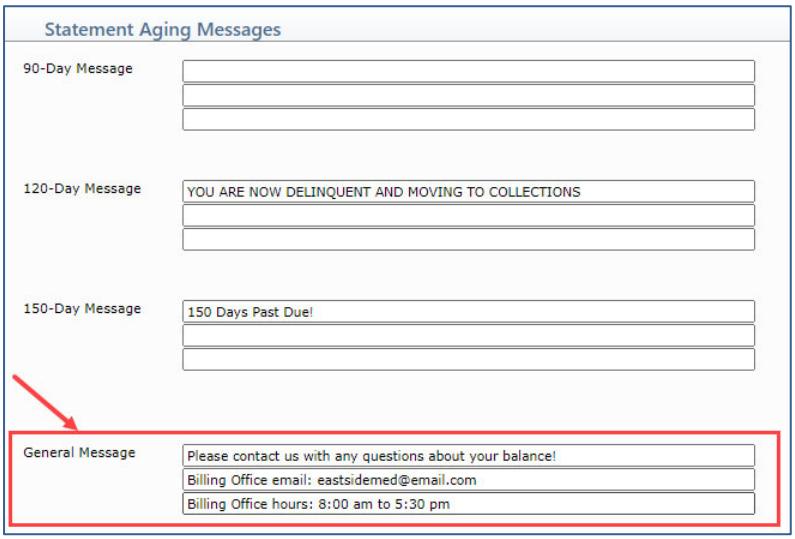


Indicate below if you want the standard data to print, otherwise complete the fields with the data you want to print on the four lines at the bottom of the statement:

Print Standard Data: ☐

Line 1: _____
Line 2: _____
Line 3: _____
Line 4: _____

If you need additional information to print on each patient statement, such as Billing office hours, Billing email address, etc., you should add that information to the **General Message** in the Statement Aging Messages (*Billing > Statement Aging Messages*). **Note**: *The additional information should only be entered in the **General Message** section and not each Aging Category Message, otherwise it will print multiple times on each statement.*



Statement Customization Options:

If you are using Statement Type 6, you can customize the statement program to meet your practice's needs with the following options. ****Note** -** *These options are only available for Statement Type 6.*

Statement Aging

The first option is to decide how you want the statement aging calculated. The standard format is to calculate the aging based on when the balance of the transaction was placed in the **Patient Balance** column. You can choose to have the aging calculated instead, by the **Accounting Date** of the transaction.

Balance Used to Create Statements

The next option is to decide which balance you want to use when you create statements. You can select either the **Whole Account Balance** or just the **Balance in the Patient Balance column**.

Indicate below which options you want:

Aging: ☐ Patient Balance ☐ Accounting Date

Balance Used to Create Statements: ☐ Patient Balance ☐ Whole Balance

Client Name	Date
Signature	Title

STATEMENT TYPE DESCRIPTIONS

Type 5 - Open Item Statement

This statement prints only the open items on a patient's account. Open items are charges still owing, and payments or adjustments that are not allocated. It will show the individual transactions with the charge amount, payments and adjustments applied against the charges and the balance owing on the charges.

- It prints any denial reasons for each charge right below the charge description.
- The aging displayed represents the entire account balance.
- The *whole account balance* is printed for the prompt "Pay this Amount".
- This statement can only be printed through *Billing, Print Patient Statements*.

Type 6 - Patient Balance Statement

This statement prints only the open items on a patient's account. Open items are charges still owing, and payments or adjustments not allocated. The individual charges will be printed, any payments and adjustments applied to the charges (in one column) and the breakdown of the balance owed in the insurance and patient balance columns.

- It prints any denial reasons for each charge right below the charge description.
- There is a section that displays any payments received in last 30 days.
- The aging displayed is broken down between insurance and patient balances.
- The *patient balance* is printed for the prompt "Pay this Amount".
- This statement can only be printed through *Billing, Print Patient Statements.*

CGM MEDICAL PRACTICE, LLC
10901 STONELAKE BLVD
AUSTIN, TX 78759

Statement Date	Account Number	Pay This Amount
04/02/24	21	$24.43

Show Amount Paid Here _____

☐ MasterCard ☐ Discover
☐ Visa ☐ American Express

CC # _____ CVV _____ Expiration ____/____

Signature _____

JAMES K POLK
1111 POLK PLACE
PITTSBURGH, PA 15111-1111

CGM MEDICAL PRACTICE, LLC
10901 STONELAKE BLVD
AUSTIN, TX 78759

Please Pay: $24.43 **Account Number: 21**

To pay online, scan the QR code or go to: https://paymentportal.emedixus.com and enter the access code: 111-1ABC-DEF2-G3HI

DATE	CODE #	DESCRIPTION	CHARGES	PAYMENTS CREDITS	INSURANCE BALANCE	PATIENT BALANCE
03-07-24	99213	OV LEVEL 3	100.00	75.57		24.43(2)
		DED - APPLIED TO PATIENT DEDUCTIBLE				
		Payments received in last 30 days:				
03-07-24	COCRD	COPAYMENT CREDIT CARD		30.00		
03-11-24	AETNA	AETNA PAYMENT		16.43		
TOTALS					0.00	24.43

(2) - This item is the patients responsibility

THANK YOU FOR CHOOSING CGM MEDICAL PRACTICE FOR YOUR MEDICAL CARE!
CONTACT OUR BILLING OFFICE AT 443-555-0123 WITH QUESTIONS.

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	AMOUNT DUE:	$24.43
$24.43	$0.00	$0.00	$0.00	$0.00		

CGM MEDICAL PRACTICE, LLC
BILLING QUESTIONS: (443) 555-0123
PATIENT: JAMES K POLK
ACCOUNT #: 21

THANK YOU!

Type 6 Statement sample - front side - with payment portal option

PLEASE COMPLETE IF THERE ARE ERRORS OR CHANGES IN ADDRESS OR INSURANCE INFORMATION:

Responsible Person's Name	Home Phone Number ( )	Work Phone Number ( )	e-Mail Address

Address	City	State	Zip	MARITAL STATUS ☐ SEPARATED ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED

Primary Insurance Coverage	Policy Holder (Subscriber) Name	Subscriber Birth Date	Effective Date	Subscriber Identification Number	Group/Plan Number
	Insurance Company Name	Insurance Company Address		City State Zip	
	Employer Name	Insurance Phone Number ( )	Plan Name	Relationship of Patient to Subscriber ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	
Secondary Insurance Coverage	Policy Holder (Subscriber) Name	Subscriber Birth Date	Effective Date	Subscriber Identification Number	Group/Plan Number
	Insurance Company Name	Insurance Company Address		City State Zip	
	Employer Name	Insurance Phone Number ( )	Plan Name	Relationship of Patient to Subscriber ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	

Type 6 Statement sample - back side of page 1

CGM MEDICAL PRACTICE, LLC
10901 STONELAKE BLVD
AUSTIN, TX 78759

Statement Date	Account Number	Pay This Amount
04/02/24	21	$24.43

Show Amount Paid Here
_____

☐ MasterCard ☐ Discover
☐ Visa ☐ American Express

CC # _____ CVV _____ Expiration ____/____

Signature _____

JAMES K POLK
1111 POLK PLACE
PITTSBURGH, PA 15111-1111

CGM MEDICAL PRACTICE, LLC
10901 STONELAKE BLVD
AUSTIN, TX 78759

Please Pay: $24.43 **Account Number: 21**

DATE	CODE #	DESCRIPTION	CHARGES	PAYMENTS CREDITS	INSURANCE BALANCE	PATIENT BALANCE
03-07-24	99213	OV LEVEL 3	100.00	75.57		24.43(2)
		DED - APPLIED TO PATIENT DEDUCTIBLE				
		Payments received in last 30 days:				
03-07-24	COCRD	COPAYMENT CREDIT CARD		30.00		
03-11-24	AETNA	AETNA PAYMENT		16.43		
TOTALS					0.00	24.43

(2) - This item is the patients responsibility

**THANK YOU FOR CHOOSING CGM MEDICAL PRACTICE
FOR YOUR MEDICAL CARE!
CONTACT OUR BILLING OFFICE AT 443-555-0123 WITH QUESTIONS.**

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS
$24.43	$0.00	$0.00	$0.00	$0.00

AMOUNT DUE: $24.43

CGM MEDICAL PRACTICE, LLC
BILLING QUESTIONS: (443) 555-0123
PATIENT: JAMES K POLK
ACCOUNT #: 21

THANK YOU!

Type 6 Statement sample - front side - without payment portal option

PLEASE COMPLETE IF THERE ARE ERRORS OR CHANGES IN ADDRESS OR INSURANCE INFORMATION:

Responsible Person's Name	Home Phone Number ( )	Work Phone Number ( )	e-Mail Address

Address	City	State	Zip	MARITAL STATUS ☐ SEPARATED ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED

Primary Insurance Coverage	Policy Holder (Subscriber) Name	Subscriber Birth Date	Effective Date	Subscriber Identification Number	Group/Plan Number
	Insurance Company Name	Insurance Company Address		City State Zip	
	Employer Name	Insurance Phone Number ( )	Plan Name	Relationship of Patient to Subscriber ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	
Secondary Insurance Coverage	Policy Holder (Subscriber) Name	Subscriber Birth Date	Effective Date	Subscriber Identification Number	Group/Plan Number
	Insurance Company Name	Insurance Company Address		City State Zip	
	Employer Name	Insurance Phone Number ( )	Plan Name	Relationship of Patient to Subscriber ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	

Type 6 Statement sample - back side of page 1

CGM MEDICAL PRACTICE, LLC
10901 STONELAKE BLVD
AUSTIN, TX 78759

Statement Date	Account Number	Pay This Amount
07/17/24	580	$215.77

Show Amount Paid Here _____

☐ MasterCard ☐ Discover ☐ Visa ☐ American Express

CC # _____ CVV _____ Expiration ____/____

Signature _____

JAMES K POLK
1111 POLK PLACE
PITTSBURGH, PA 15111-1111

CGM MEDICAL PRACTICE, LLC
10901 STONELAKE BLVD
AUSTIN, TX 78759

Please Pay: $215.77 **Account Number: 580**

DATE	CODE #	DESCRIPTION	CHARGES	PAYMENTS CREDITS	INSURANCE BALANCE	PATIENT BALANCE
08-14-23	99214	OFFICE/OUTPATI	140.00	115.00		25.00
		Co-payment Amount				
	J3304	ZILRETTA INJEC	960.00	892.81		67.19
		Coinsurance Amount				
08-28-23	20610	DRAIN/INJ JOIN	205.00	180.00		25.00
		Co-payment Amount				
	J3301	TRIAMCINOLONE	24.00	23.19		0.81
		Coinsurance Amount				
10-18-23	L1820	KO ELAS W/ CON	135.00	114.14		20.86
		Coinsurance Amount				
11-30-23	73560	X-RAY EXAM OF	100.00	90.75		9.25
		Co-payment Amount				
02-27-24	99214	OFFICE/OUTPATI	140.00	25.00	115.00	(1)
	20610	DRAIN/INJ JOIN	205.00	180.00		25.00
		Co-payment Amount				
03-07-24	99211	OFFICE/OUTPATI	50.00	58.70		-8.70(4)
04-17-24	J0702	BETAMETHASONE	7.50	6.14		1.36
		Coinsurance Amount				
06-07-24	99214	OFFICE/OUTPATI	140.00	115.00		25.00(1)
06-11-24	20610	DRAIN/INJ JOIN	205.00	180.00		25.00(1)
		Payments received in last 30 days:				
06-18-24	MED	HUMANA 6/18/24		68.22		
06-21-24	MED	HUMANA 6/21/24		33.44		
TOTALS					115.00	215.77

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS
$50.00	$0.00	$1.36	$-8.70	$173.11

AMOUNT DUE: $215.77

CGM MEDICAL PRACTICE, LLC
BILLING QUESTIONS: (443) 555-0123
PATIENT: JAMES K POLK
ACCOUNT #: 580

THANK YOU!

Type 6 Statement sample - front side - Continued sample

PLEASE COMPLETE IF THERE ARE ERRORS OR CHANGES IN ADDRESS OR INSURANCE INFORMATION:

Responsible Person's Name	Home Phone Number	Work Phone Number	e-Mail Address
	( )	( )	

Address	City	State	Zip	MARITAL STATUS
				☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED

Primary Insurance Coverage	Policy Holder (Subscriber) Name	Subscriber Birth Date	Effective Date	Subscriber Identification Number	Group/Plan Number
	Insurance Company Name	Insurance Company Address	City	State	Zip
	Employer Name	Insurance Phone Number ( )	Plan Name	Relationship of Patient to Subscriber ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	
Secondary Insurance Coverage	Policy Holder (Subscriber) Name	Subscriber Birth Date	Effective Date	Subscriber Identification Number	Group/Plan Number
	Insurance Company Name	Insurance Company Address	City	State	Zip
	Employer Name	Insurance Phone Number ( )	Plan Name	Relationship of Patient to Subscriber ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	

DATE	CODE #	DESCRIPTION	CHARGES	PAYMENTS CREDITS	INSURANCE BALANCE	PATIENT BALANCE

(1) - This item has been filed to your insurance
(4) - This payment has been credited to your account
YOUR ACCOUNT IS PAST DUE. PLEASE REMIT
PAYMENT IMMEDIATELY.

Type 6 Statement sample - back side - Continued sample

CGM MEDICAL PRACTICE, LLC
10901 STONELAKE BLVD
AUSTIN, TX 78759

Statement Date	Account Number	Pay This Amount
04/02/24	185	$302.82

Show Amount Paid Here
_____

☐ MasterCard ☐ Discover
☐ Visa ☐ American Express

CC # _____ CVV _____ Expiration ____/____

Signature _____

TEDDY ROOSEVELT
2626 SAGAMORE HILL
MANALAPAN, NJ 07262-2626

CGM MEDICAL PRACTICE, LLC
10901 STONELAKE BLVD
AUSTIN, TX 78759

Please Pay: $302.82 **Account Number: 185**

DATE	DESCRIPTION	AMOUNT	PAID	ADJ	BALANCE
01-08-24	PSYTX PT+/FAMILY 60	220.00	141.41	73.59	5.00(1)
01-29-24	PSYTX PT+/FAMILY 60	220.00		73.59	146.41(2)
	1 - Applied to insurance deductible				
02-05-24	PSYTX PT+/FAMILY 60	220.00		73.59	146.41(2)
	1 - Applied to insurance deductible				
03-04-24	PSYTX PT+/FAMILY 60	230.00	141.41	83.59	5.00(2)
	3 - Co-payment Amount				
03-18-24	PSYTX PT+/FAMILY 60	230.00			230.00(1)
	(1) - This item has been filed to your insurance				
	(2) - This item is the patient's responsibility				

CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS
$151.41	$151.41	$0.00	$0.00	$0.00

AMOUNT DUE: $302.82

CGM MEDICAL PRACTICE, LLC
BILLING QUESTIONS: (443) 555-0123
PATIENT: TEDDY ROOSEVELT
ACCOUNT #: 185

THANK YOU!

Type 5 Statement sample - front side - without payment portal option

PLEASE COMPLETE IF THERE ARE ERRORS OR CHANGES IN ADDRESS OR INSURANCE INFORMATION:

Responsible Person's Name	Home Phone Number ( )	Work Phone Number ( )	e-Mail Address

Address	City	State	Zip	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

Primary Insurance Coverage	Policy Holder (Subscriber) Name	Subscriber Birth Date	Effective Date	Subscriber Identification Number	Group/Plan Number
	Insurance Company Name	Insurance Company Address		City State Zip	
	Employer Name	Insurance Phone Number ( )	Plan Name	Relationship of Patient to Subscriber ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	
Secondary Insurance Coverage	Policy Holder (Subscriber) Name	Subscriber Birth Date	Effective Date	Subscriber Identification Number	Group/Plan Number
	Insurance Company Name	Insurance Company Address		City State Zip	
	Employer Name	Insurance Phone Number ( )	Plan Name	Relationship of Patient to Subscriber ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	

Type 5 Statement sample - back side - without payment portal option