

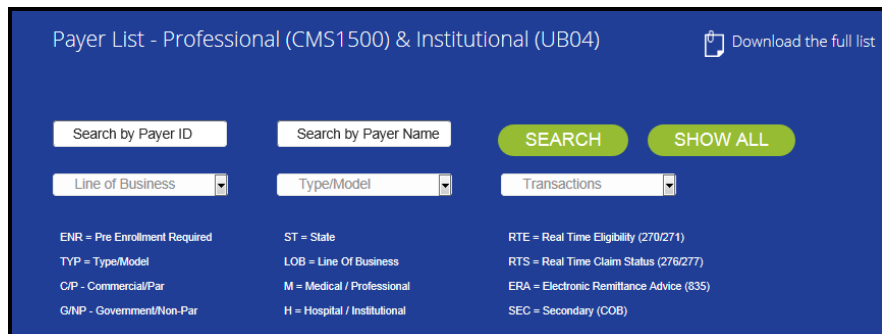


ONLINE CLAIM ENTRY

Professional (HCFA) Claims

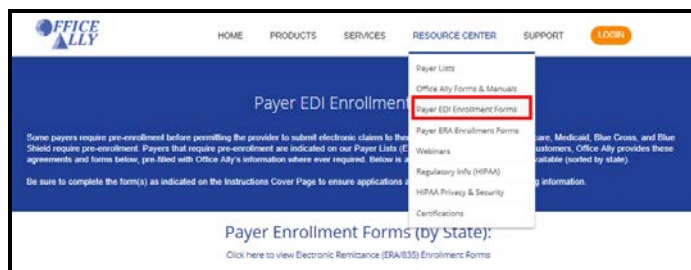
PAYER LIST LOOK UP

Office Ally has the ability to submit to thousands of insurance companies (payers). To review the list of payers we have a connection with, please visit our Payer List under Resource Center > Payer Lists, or by clicking [here](#).



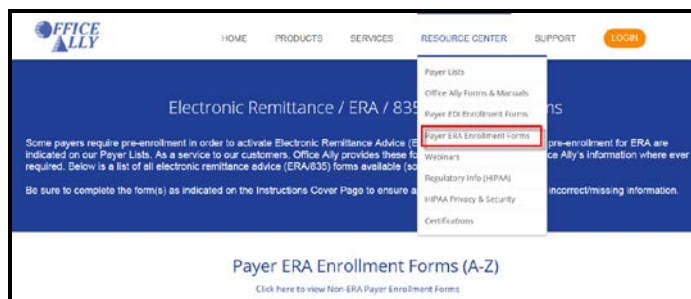
PRE-ENROLLMENT REQUIREMENTS

Certain payers require pre-enrollment to be completed before submitting claims electronically through a clearinghouse. If the necessary steps are not taken, your claims may be rejected back until pre-enrollment has been completed. You can find the necessary payer enrollment forms under Resource Center > Payer EDI Enrollment Forms, or by clicking [here](#).



Payer EDI enrollment forms will be separated based on the state they're for. If a payer is not state specific, it will be listed under the "ALL or Multiple States Payer Enrollment Forms" section.

Payers with the ability to return Electronic Remittance Advice (ERA/835) may also require enrollment be completed before ERA's will be returned. The ERA enrollment forms can be found under Resource Center > Payer ERA Enrollment Forms, or by clicking [here](#). ERA enrollment forms will be listed alphabetically.



If a payer is not able to receive electronic claims or we don't yet have them available on our payer list, Office Ally can send paper claims on your behalf. In order to activate this feature, the [Update Printing Option](#) form will need to be completed. This form is located under Resource Center > Office Ally Forms & Manuals > Account Management.

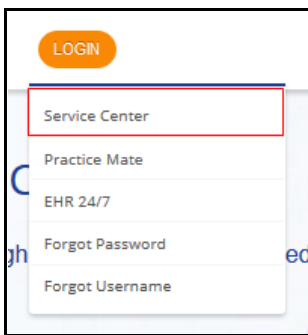
If you'd like to see a new payer connection made available on our payer list, you can send in a [New Payer Connection Request Form](#) and we will attempt to set the connection up (adding the requested connection is not guaranteed).

LOGGING INTO YOUR ACCOUNT

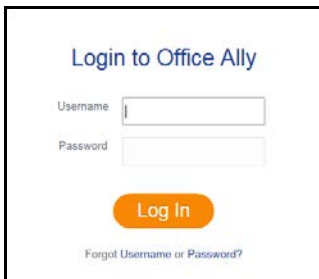
1. Go to www.officeally.com.



2. Hover your mouse over the **Login** button and select **Service Center**.

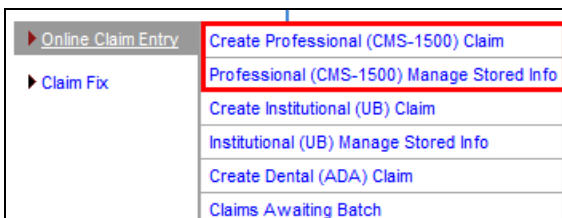


3. Enter your **Username** and **Password** (password is case sensitive) and click **Log In**.



ONLINE CLAIM ENTRY (DIRECT DATA ENTRY)

Once logged into the Office Ally website, hover your mouse over **Online Claim Entry**. There will be multiple claim form options to choose from. The **Create Professional (CMS-1500) Claim** option will allow you to begin completing the online claim form immediately. The **Professional (CMS-1500) Managed Stored Info** option will allow you to build and store data for future claim use so that you will not have to manually enter that specific data for each claim you create.



ONLINE CLAIM ENTRY – CREATE PROFESSIONAL (CMS-1500) CLAIM

After selecting **Create Professional (CMS-1500) Claim**, a blank CMS-1500 (HCFA) claim form will appear. Enter the payer (insurance company), patient, provider information, etc. into the appropriate fields before clicking on **Update** to submit the claim electronically. Once the claim is submitted, the payer, patient, and provider information will automatically store within **Managed Stored Info**.

CMS 1500 02/12 Form

[Load Stored Info](#)

Payer Name: [OA Payers](#)
 Address / Payer ID:
 2nd Address:
 City, State, Zip:

This is a SECONDARY Claim

HEALTH INSURANCE CLAIM FORM																																											
1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BLK LUNG		OTHER		18. INSURED'S I.D. NUMBER																													
<input type="radio"/> (Medicare #)		<input type="radio"/> (Medicaid #)		<input type="radio"/> (ICD/CDC)		<input type="radio"/> (VA File #)		<input type="radio"/> (ICF)		<input type="radio"/> (ICF)		<input type="radio"/> (ICF)		<input type="text"/>																													
2. PATIENT'S NAME (Last Name, First Name, Middle Init) Last: <input type="text"/> First: <input type="text"/> MI: <input type="text"/>				3. PATIENT'S BIRTH DATE MM/DD/YYYY: <input type="text"/>				SEX <input type="text"/>		4. INSURED'S NAME (Last Name, First Name, Middle Init) Last: <input type="text"/> First: <input type="text"/> MI: <input type="text"/> COp: <input type="text"/>				7. INSURED'S ADDRESS (No. Street) <input type="text"/>																													
5. PATIENT'S ADDRESS (No. Street) <input type="text"/>				6. PATIENT RELATIONSHIP TO INSURED Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other <input type="radio"/>				8. RESERVED FOR NUCC USE <input type="text"/>		7. INSURED'S ADDRESS (No. Street) <input type="text"/>				CITY: <input type="text"/> STATE: <input type="text"/>																													
CITY: <input type="text"/> STATE: <input type="text"/>				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Init) Last: <input type="text"/> First: <input type="text"/> MI: <input type="text"/>				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) Yes <input type="radio"/> No <input type="radio"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER <input type="text"/>				a. INSURED'S DATE OF BIRTH MM/DD/YYYY: <input type="text"/>																													
ZIP CODE: <input type="text"/> TELEPHONE: <input type="text"/>				b. AUTO ACCIDENT? PLACE (State): <input type="text"/>				b. OTHER CLAIM ID (Designated by NUCC) <input type="text"/>		b. OTHER CLAIM ID (Designated by NUCC) <input type="text"/>				c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>																													
9. OTHER INSURED'S POLICY OR GROUP NUMBER <input type="text"/>				c. OTHER ACCIDENTS? Yes <input type="radio"/> No <input type="radio"/>				c. OTHER ACCIDENTS? Yes <input type="radio"/> No <input type="radio"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>				6. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="radio"/> NO <input type="radio"/> If yes, complete items 9, 10 and 11.																													
d. RESERVED FOR NUCC USE <input type="text"/>				10. CLAIM CODES (Designated by NUCC) <input type="text"/>				10. CLAIM CODES (Designated by NUCC) <input type="text"/>		6. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="radio"/> NO <input type="radio"/> If yes, complete items 9, 10 and 11.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE <input type="text"/>																													
c. RESERVED FOR NUCC USE <input type="text"/>				12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <input type="text"/>				12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <input type="text"/>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE <input type="text"/>				SIGNED <input type="radio"/> Yes <input type="radio"/> No DATE: 4/19/2017																													
6. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>				14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP): MM/DD/YYYY: <input type="text"/> QUAL: <input type="text"/>				15. OTHER DATE QUAL: <input type="text"/>		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM: <input type="text"/> TO: <input type="text"/>				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: <input type="text"/> TO: <input type="text"/>																													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <input type="text"/>				17a. <input type="text"/>				17b. NPI: <input type="text"/>		20. OUTSIDE LAB? YES <input type="radio"/> NO <input type="radio"/>				CHARGES <input type="text"/>																													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) <input type="text"/>				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A: <input type="text"/> B: <input type="text"/> C: <input type="text"/> D: <input type="text"/> E: <input type="text"/> F: <input type="text"/> G: <input type="text"/> H: <input type="text"/> I: <input type="text"/> J: <input type="text"/> K: <input type="text"/> L: <input type="text"/>				ICD-10: <input type="text"/>		22. RESUBMISSION CODE <input type="text"/>				ORIGINAL REF NO <input type="text"/>																													
24. A				B				C				D. PROCEDURES, SERVICES, OR SUPPLIES				E				F				G				H				I				J							
DATE(S) OF SERVICE				Place Of Service				EMG				CPT/HCPCS				MODIFIER				DIAGNOSIS POINTER				\$ CHARGES				Days Or Units				EPSDT Family Plan				ID QUAL				RENDERING PROVIDER ID. #			
From: <input type="text"/> To: <input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>			
1				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
2				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
3				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
4				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
5				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
6				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
7				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
8				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
9				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
10				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
11				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
12				Anest Start: <input type="text"/> Stop: <input type="text"/>				NDCQual: <input type="text"/>				NDC Code: <input type="text"/>				NDC U Price: <input type="text"/>				NDC Qty: <input type="text"/>				NDC QtyQual: <input type="text"/>				NPI: <input type="text"/>															
25. FEDERAL TAX I.D. NUMBER <input type="text"/>				SSN: <input type="text"/> EIN: <input type="text"/>				26. PATIENT'S ACCOUNT NO. <input type="text"/>				27. ACCEPT ASSIGNMENT? YES <input type="radio"/> NO <input type="radio"/>				28. TOTAL CHARGE \$ <input type="text"/>				29. AMOUNT PAID \$ <input type="text"/>				30. Read for NUCC use																			
Date Of Initial Treatment: (mm/dd/yyyy) <input type="text"/>				Latest Visit or Consultation Date: (mm/dd/yyyy) <input type="text"/>				32. SERVICE FACILITY LOCATION AND INFORMATION Facility Name: <input type="text"/> Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip: <input type="text"/>				33. BILLING PROVIDER INFO. & PHONE # Billing Provider: <input type="text"/> Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip: <input type="text"/> Telephone: (<input type="text"/>) <input type="text"/> Billing Provider Specialty/Taxonomy: <input type="text"/>				Rendering Provider: <input type="text"/> (Last, First, MI) Rendering Provider Specialty/Taxonomy: <input type="text"/> Provider PIN#: <input type="text"/> (please see box 24J)																											
Ordering Physician: (Last, First, MI) <input type="text"/>				Ordering Physician NPI: <input type="text"/>				a. NPI: <input type="text"/>				b. Facility ID: <input type="text"/>				a. Billing Group NPI: <input type="text"/>				b. Billing Group No.: <input type="text"/>																							
Ordering Physician ID: <input type="text"/>				CLIA: <input type="text"/>				a. Billing Group NPI: <input type="text"/>				b. Billing Group No.: <input type="text"/>				ID QUAL: <input type="text"/>																											
Accident Date: <input type="text"/>				Mammography Certificate: <input type="text"/>																																							

[Update](#) [Cancel](#)

MANAGED STORED INFO

1. To Add, Edit, or Delete stored information, click on **Professional (CMS-1500) Managed Stored Info**. The below screen will appear.

Professional (CMS-1500) Manage Stored Info

Stored Information

Stored Payers: -- Select Payer -- Edit Delete Add

Stored Patients: -- Select Patient (click .. for more) ... Edit Delete Add

Stored Billing Providers: -- Select Provider -- Edit Delete Add

Stored Rendering Providers: -- Select Provider -- Edit Delete Add

Stored Facilities: -- Select Facility -- Edit Delete Add

Stored Templates: -- Select Template -- Edit Delete Add

To create a new claim using your stored information, please select from each of the pertinent categories then click "Create New Claim"

Create New Claim

2. Enter the Payer Name, Address (or Payer ID [preferred]), and City/State/Zip under the **Stored Payers** section.

Add Payer

Payer Information

Payer Name: * [Text Field] ... OA Payers

Address/Payer ID: [Text Field]

2nd Address: [Text Field]

City: [Text Field]

State: [Dropdown]

Zip: [Text Field]

Update Cancel

Note: Click on "OA Payers" to search through our available payer connections

3. Enter the Patient, Payer, Insured's, Other Insured's (COB) data, etc. under the **Stored Patients** section.

Patient Information

Payer Address

Name: [Text Field]

Address: [Text Field]

2nd Address: [Text Field]

City: [Text Field] State: [Dropdown] Zip: [Text Field]

1. Medicare Medicaid Champus ChampVA Group Health Plan FECA Bik Lunb Other
 (Medicare #) (Medicaid #) (sponsor's SSN) (VA File #) (SSN OR ID) (SSN) (ID)

2. Patient's Name (First, Middle Init, Last) [Text Field]

3. Patient's Birthday Sex [Text Field] [Dropdown]

4. Insured's Name (First, Middle Init, Last) [Text Field]

5. Patient's Address (No., Street) [Text Field]

6. Patient Relationship to Insured:
 Self Spouse Child Other

7. Insured's Address (No., Street) [Text Field]

8. Patient Status
 Single Married Other
 Employed Full-Time Student Part-Time Student

9. Other Insured's Name (First, Middle Init, Last) [Text Field]

10. Is Patient's Condition Related To:
a. Employment? (Current or Previous) YES NO
b. Auto Accident? YES NO [Dropdown] Place
c. Other Accident? YES NO

11. Insured's Policy or FECA Number [Text Field]

a. Date of Birth Sex [Text Field] [Dropdown]

b. Employer's Name or School Name [Text Field]

c. Insurance Plan or Program Name [Text Field]

d. Insurance Plan Name or Program Name [Text Field]

10d. Reserved For Local Use [Text Field]

d. Is there Another Health Benefit Plan?
 YES NO If yes, complete item 9 a-d.

Update Cancel

4. Enter the Billing Provider Name, Address, Tax ID, NPI, etc. under the **Stored Billing Providers** section.

Billing Provider Information

Billing Provider:

Address:

City:

State:

Zip Code:

Telephone: ()

Group No:

Federal Tax ID #:

Federal Tax ID Type: SSN EIN

NPI:

5. Enter the Rendering Provider Name and NPI under the **Stored Rendering Providers** section.

Rendering Provider Information

First:

Middle Initial:

Last:

Practice Id:

NPI:

6. Enter the Service Facility Name, Address, and NPI under the **Stored Facilities** section.

Facility Information

Facility Name:

Facility Id:

Facility Address:

Facility City:

Facility State:

Facility Zip:

NPI:

Stored Templates is an optional tool that can help you maximize efficiency when billing. It can be used for storing recurring Diagnosis codes (don't forget to select the ICD indicator), CPT codes, POS, Charges, etc. for a specific patient or for storing commonly used codes for certain types of visits that apply to various patients. Enter a name for the template and any information you would like to appear on the claim form whenever this template is selected.

Template Information

Template Name

14. Date of Current:

15. If Patient Has Had Same or Similar Illness, Give First Date:

16. Dates Patient Unable to Work in Current Occupation From: To:

17. Name of Referring Physician or Other Source (First, Middle Init, Last)

18. Hospitalization Dates Related To Current Services From: To:

19. Reserved For Local Use

20. Outside Lab? YES NO \$ Charges

21. Diagnosis or Nature of Illness or Injury (Relate Items A(1), B(2), C(3) or D(4) to item 24E by line)

A(1) B(2) C(3) D(4) ICD Ind.

E(5) F(6) G(7) H(8)

I(9) J(10) K(11) L(12)

22. Medicaid Resubmission Code Original Ref. No

23. Prior Authorization Number

24. A.	24. Date Of Service		B.	C.	D.	E.				F.	G.	H.	I.	J.	NDC	NDC
From	To	Place Of Service	EMG	CPT/ HCPCS	Modifier A B C D	Diag. Pointer	Charge	Days Or Units	EPSDT Family Plan	ID QUAL	Rendering Provider ID #	Rendering Provider NPI	NDC Qual	NDC Code		
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
11	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
12	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

25. Federal Tax I.D. Number SSN EIN

26. Patient's Account No.

27. Accept Assignment? YES NO

28. Total Charge

29. Amount Paid

30. Amount Balance

32. SERVICE FACILITY LOCATION AND INFORMATION

Facility Name:

Address:

City:

State:

Zip:

33. BILLING PROVIDER INFO. & PHONE #

Billing Provider:

Address:

City:

State:

Zip Code:

Telephone:

Rendering Provider: (Last, First, MI)

Provider Specialty:

PIN# (refer to 24J):

Please Note: When creating a new claim, you may select a Billing Provider, Rendering Provider, and Facility to use with the template.

**Grayed out fields must be completed upon creating a new claim.

a. NPI: b. Facility ID:

a. Billing/Group NPI: b. Billing/Group No

ID QUAL:

Update Cancel

Below is an example of how **Managed Stored Info** is used to create a claim with the stored data you have entered.

1. From each drop down list, you will select the data that you would like to be automatically filled in on the claim form. Once the information is selected, click on the **Create New Claim** button.

Stored Information

Stored Payers	Aetna	Edit	Delete	Add
Stored Patients	Smith, John [01/01/1980]	Edit	Delete	Add
Stored Billing Providers	JOHN SMITH, LLC []	Edit	Delete	Add
Stored Rendering Providers	Smith, John []	Edit	Delete	Add
Stored Facilities	John Smith Hospital	Edit	Delete	Add
Stored Templates	Office Visit - CPT 99213	Edit	Delete	Add

To create a new claim using your stored information, please select from each of the pertinent categories then click "Create New Claim"

Create New Claim

After you have created the claim form from **Managed Stored Info**, there will still be required fields needing to be completed that cannot be populated from the stored information (i.e. Date of Service).

After you enter all necessary claim data, review the claim for errors and then click the **Update** button at the bottom of the claim form. The program will alert you if you missed certain required fields. If all required fields were completed, clicking on **Update** will put your claim in the **Claims Awaiting Batch** section.

Form Validation Errors

- 24. LineItem 1: Missing From Date of Service.
- 27. Missing Patient Accept Assignment.

Close

CLAIMS AWAITING BATCH

After you've updated your claim, the process of submitting the claim has been completed. Your recently submitted claim is sent to the **Claims Awaiting Batch** (OLE submitters). Your claim(s) will sit in there until Office Ally picks them up for processing (occurs every 3 hours). From this section of Office Ally you can edit, print, or delete the claim before the claim is sent to the insurance company.

In order to access this section, hover over **Online Claim Entry** and select **Claims Awaiting Batch**.

Online Entry - Waiting to be Batched

Form Type	Processed	FileID	Claim ID	Patient Name	Total Charges	From DOS	Payer	Secondary	Print	Correct	Delete
HCFA	4/19/2017	ONLINE	237610446	Smith, John	50.00	4/18/2017		N		Correct	Delete

Don't forget to review the [reports](#) Office Ally sends back to ensure your claims were accepted.

If a claim [rejects](#), it is your responsibility to correct and resubmit the claim for processing.

CONTACT INFORMATION & SUPPORT OPTIONS

Business Hours: Monday thru Friday 6:00am PST to 5:00pm PST
After Hours Support is also available giving you 24/7 coverage!

Email: info@officeally.com or support@officeally.com

Customer Service:	(360) 975-7000	Option 1
Technical Support:	(360) 975-7000	Option 2
Enrollments:	(360) 975-7000	Option 3
Scheduling (FREE Training Appointments):	(360) 975-7000	Option 5

General Fax Number:	(360) 896-2151
Enrollments Fax Number:	(360) 314-2184
Accounting (Auto Pay) Fax Number:	(360) 953-8427

Live Chat Available (6am – 5pm PST): Click [HERE](#) or enter <https://support.officeally.com/> into your browser to access Live Chat, Claim Rejection Solutions, Troubleshooter, News and more!

Online Video Tutorials: Click [HERE](#) or enter <http://tv.officeally.com/> into your browser to access video tutorials covering Online Claim Entry, Inventory Reporting, Secondary Claims and more!

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