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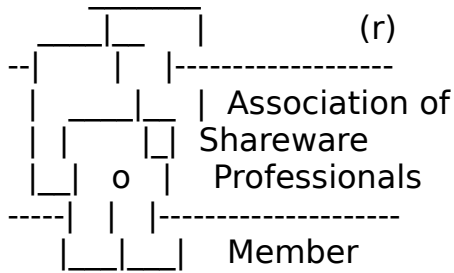
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#### ASP Ombudsman policy

This program is produced by a member of the Association of Shareware Professionals (ASP). ASP wants to make sure that the shareware principle works for you. If you are unable to resolve a shareware-related problem with an ASP member by contacting the member directly, ASP may be able to help. The ASP Ombudsman can help you resolve a dispute or problem with an ASP member, but does not provide technical support for members' products. Please write to the ASP Ombudsman at 545 Grover Road, Muskegon, MI 49442 or send a CompuServe message via CompuServe Mail to ASP Ombudsman 70007,3536."

\*\*\*\*\*|IMPORTANT WARRANTY INFORMATION|\*\*\*\*\*

Tolman Dental Program, Version 3.1

\*\*\* PLEASE READ THIS INFORMATION CAREFULLY \*\*\*

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TRIAL USE (SHAREWARE EVALUATION VERSION) WARRANTY:

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The Shareware evaluation (trial use) version is provided AS IS.

Peter T. Smith MAKES NO WARRANTY OF ANY KIND, EXPRESSED OR IMPLIED, INCLUDING WITHOUT LIMITATION, ANY WARRANTIES OF MERCHANTABILITY AND/OR FITNESS FOR A PARTICULAR PURPOSE.

REGISTERED VERSION ONLY WARRANTY:

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\*\*\*\*\* IMPORTANT WARRANTY INFORMATION \*\*\*\*\*



## Freely distributed versus registered versions

The Tolman Dental Program is a Clipper compiled application. The Freely Distributed and Registered versions of Tolman.exe are identical.

The Data files found with the freely distributed version contain sample data including a few families, patients, insurance companies, employers and some of the standard dental procedures. In the registered version, most of these files are emptied of data except one family (for testing by support) and the standard dental procedures without fees.

Do not consider Medicaid forms standard with the Tolman Dental program except in these states: NY, NJ, VA, WI. The form for each state is different so far and in every case the state provides pin-fed forms free to Providers. I would like to add as many as possible so if your state is not included, please send a copy of your state's Medicaid form and I will try to incorporate it into the program for you. I will need to know the length of a Medicaid number in your state and any other info that your state requires that a standard insurance form does not. The freely distributed version will prepare the WI Medicaid form. You may also contact the author if you would like a version of the program that does a different state from among those listed above. I would have included the NY version except that requires a wide printer.

To those of you who are not dentists, be aware of the difference between MediCAID and MediCARE: Medicaid is welfare and Medicare is for elderly. Medicare does not pay dental benefits.

To those of you who are in offices that do not accept Medicaid, ignore all of this; for you the program is complete as is.

The Freely distributed version contains a file called TESTVER.BAT. The presence of this file will cause the Main Menu screen to note that you are running a trial version of the program. When learning the program, even after it is registered, it is useful (and legal) to duplicate the program in a second directory and keep a copy of TESTVER.BAT in that directory. It will help the user "try things out" in one directory before running the Tolman Dental program with real data. Having TESTVER.BAT in that directory will allow the user to recognize the real vs. the trial version of the program. TESTVER.BAT in no way disables any feature of the program and has no effect on the request-for-registration startup screen.

Once the program has been registered, you will be assigned a serial number and provided with a means to install that number. Once installed, the introductory start up screens will be eliminated.

#### Hardware required:

The Tolman Dental program will run on most IBM or compatible computers with a hard disk, 640K RAM minimum with more advised. The program will run on Monochrome or color monitors. DOS 2.1 or higher is required as is a 9 or 24 pin dot matrix printer. In NY, if you wish to prepare Medicaid forms, you will need a wide carriage printer. If you are using a graphics card with a Monochrome monitor, use #38 Personal Office Data and change the display type.

#### Software suggested:

Although not absolutely required, a commercially available print spooler called PRINTQ from Software Directions (201-584-8566) is expected, strongly advised and highly recommended. I find this program invaluable on a single user setup (networks usually come with a spooler built in). Since some processing occurs during the printing of bills and insurance forms, the presence of a spooler eliminates the worry of paper jams interfering with record processing. The program will make calls to PRINTQ if it is available. I've seen PRINTQ priced at about \$85.00 in a number of different catalogs.

The Tolman Dental program will extract information for merging with a word-processor. The files are prepared in a format useable by MICROSOFT WORD.

#### Forms required:

Standard ADA insurance forms (Form #4358 can be purchased from COLWELL (800-637-1140). To overcome the problem of the patient's signature, signature labels are also available.

Statement forms can be purchased from Exactforms by calling Richard Bernstein at Exactforms (516-826-7700)

Labels used are 3.5" x 15/16" one across and can be purchased from most any stationary supply store.



with 1 and 21 being the most common.

On the left in the middle (7 thru 11) are options related to insurance transactions and the printing of forms. On the right, #27 is an option related to tracking claims once forms have been submitted.

Throughout these options, the line by line entries on the ins. forms are referred to as *transactions* and the form itself as a *claim*. Once the *claim* is prepared, the insurance *transactions* are marked for deletion so as not to be printed again.

Items 13 thru 20 are more utility in nature and will be used mostly during initial installation in the office. These options allow you to tell the computer your fees, who will be producing them, etc. However for ease of use, new insurance companies, employers and referrers will primarily be added on-the-fly as you add new families. "13 VIEW/UPDATE REFERRING DOCTORS", "14 VIEW/UPDATE EMPLOYERS" and "18 VIEW/UPDATE INSURANCE COMPANY" are provided here mainly to update any changes in that information.

Item 31 PATIENT LISTS is your opportunity to create customized lists. By entering the selection criteria, you will determine those accounts to be selected as well as the amount of information to be included on that report.

Items 29,30,35,36,37 and 39 take you to other menus.

Since you will be assigning account numbers to all family accounts and will need a way to know those numbers, an account number look-up screen is available with the touch of the F1 key at any point where an account number is required. In addition to Alt-H for Help, special look-up screens like that are available wherever needed throughout the program.

This manual will start with an overview of how the program is intended to be used at various stages of installation and use and will then give more detailed explanations for each menu item.

## PART ONE - GENERAL OVERVIEW AND USAGE

### PRELIMINARIES

When first installed, the installer will set a couple of permanent values related to Medicaid, and Medicaid #s which will be determined by the State in which you practice.

You then will have to add information about your office. Main Menu Item #38, PERSONALIZE OFFICE DATA, should be run and completed 1st. Complete the default Names and address lines but skip the Medicaid information for now. That can be updated after an insurance company number has been assigned for Medicaid and a separate fee schedule created.

After personalizing your office data, select Main Menu #19, VIEW/UPDATE PROVIDERS. Here you will enter information about the dentist(s) and hygienist(s). By entering the providers, you will be able to track who is producing what for the office. If you prefer not to know the breakdown by dentist, enter information for Provider #1 only.

Next, from the LISTS MENU, print out a list of the standard Procedures. Then use Main Menu #16 to enter your fees. The most common procedure codes are already entered, but all fees are set to zero. Do not change the names of any codes from 1 to 100 that are already entered. You may however add others in that range.

Procedures from 1 to 10 must be some form of payments and the following should not be changed:

- 1 Cash
- 2 Personal checks
- 3 Insurance checks

Procedures 11 to 50 are adjustments which can be either credits or charges such as "Professional courtesy" or "Bounced check charge." For these you must enter a "-" sign when the adjustment is to be a credit. That is the only time a "-" need be used. It need not be used for payments (procedures 1 to 10).

Procedures from 51 to 100 are charges that will not appear on insurance forms such as "Consultation."

Information about insurance companies and employers can be added on-the-fly as you add patients. Be sure to keep the distinction in mind as to what is an insurance company and what is an employer. A simple rule of thumb for your personnel to use is: "what company will send us the check (insurance company)" and "what company gives this patient his paycheck (employer)." It is surprisingly easy to mess that up.

It will be much easier for you if, right from the start, you are consistent in the way you enter

company and employer information. For example, Local Union 801 could be entered as:

Local 801

L.U. 801

Local Union 801

or the worst possible choice, 801

Whichever you choose, do Local 123 the same way. That way each will be next to the other on your alphabetical list and therefore easier to locate. Do not begin the name with a number if possible since that will really screw up alphabetizing.

At this point, you may begin entering patients. Gather all the information you can about a family before you begin keying in the data. You should have the following information readily available for every family member:

1. Complete name - especially if children's names differ
2. Complete address
3. Home and business phones of husband and wife
4. Dates of birth of all
5. Current recall dates
6. Social Security #s of any insured member
7. Medicaid #s
8. Name of referring Doctor or patient
9. Name and address of the insurance companies
10. Name and address of employers
11. % of insurance coverage of the Employers insurance plans if known and if you wish to estimate benefits. Remember that plan coverage is determined by the employer information, not the insurance company. For example, Aetna has many plans with varying coverage but NY Telephone has chosen only 1 of those plans for all it's employees.

We suggest that you enter first only those patients who currently have a balance due the office. You will enter all the background information about those families such as name, address, phone etc. but only when all families who have a balance have been entered will you enter the balance due. In this way you need not rush this process.

We also suggest you leave acct, #1 as Peter T. Smith. This will allow the programmer an account to use when testing any updates.

We also suggest you enter a "John Doe" account with an easy to remember acct. # such as "2." In this way you can enter transactions for those occasional walk-in-never-to-return-patients without adding unnecessary accounts to the system.

We also suggest you enter a "Collection Agency account" if you use one. We have found the following routine useful but not at all mandatory when posting a collection agency check. When a check is received from a collection agency, it can be posted to the "Collection Agency account. All entries to the patient account from whom the agency collected the payment should then be adjustments rather than payments. In this way you can not only keep track of the patient's financial information, you can also track the production of your collection agency.

You will find after but 1 or 2 family entries, that the better organized your prior system has been, the easier it will be to enter that information into the computer. Take your time here. Since you have not yet entered financial information, you can take as much time as you like getting this all done correctly.

If you make a minor error in entering a family such as a misspelled name, accept the data and use #2 CHG/DELETE A FAMILY to make your corrections rather than re-entering everything.

Keep aside the charts of patients that you enter. At the end of each day, use Main Menu #29, LABELS AND ROLODEX MENU and prepare chart labels for each patient. That will automatically advise you who is entered and who is not as well as getting the account # information onto the chart.

The easiest way to review your entries is to prepare a patient list from Main Menu #31, PATIENT LISTS. At the end of each day, prepare a list of those accounts entered that day and review the data.

Also at the end of each day, prepare a new Insurance Co. list and a new Employer list using Main Menu #30, LISTS AND REPORTS MENU. Although company and employer #s can be looked up as you need them, it is sometimes easier to refer to the printed list.

## GETTING IT ALL ROLLING

Once all the families that owe you money have been entered, you will, all at one time, enter a balance forward to each account by using #21 ENTER DAILY TRANSACTIONS. For more specifics on using that selection, refer to #21 ENTER DAILY TRANSACTIONS further on in this manual.

From that point on you will be on-the-computer. As patients appear for treatment, they will be entered into the computer just as the original families were.

The first few months will be hectic as most patients will need entering into the computer. However as patients already entered return, the data entry into the computer will diminish significantly.

## THINGS TO DO ON A DAY TO DAY BASIS

During the course of a normal day, new patients will be entered using #1 ADD NEW FAMILY. Charges and payments will be recorded using #21 ENTER DAILY TRANSACTIONS.

Before entering transactions, be sure to read the portion of this manual regarding #21 ENTERING DAILY TRANSACTIONS. You will learn more about handling double insurance. For now, understand that when you enter a charge to a family with double insurance, you will be asked if you wish to submit a form to the primary insurance company for that charge. You will also be asked if you wish to hold up submission of that same charge to the secondary insurance company until a future time. We suggest you accept the defaults.

Why? The system is designed to handle double insurance this way. First a claim will be prepared for the primary insurance company. The computer will figure out which company is primary based on the birthday rule.

Next, when you record an insurance payment, you will be prompted to release held transactions for the second claim. You need not print both forms initially and have to store a paper copy of the secondary claim. Simply prepare the secondary claim form after receiving payment from the primary company.

Will you forget to send the second form? Well when you record the payment, the computer will beep and blink at you and list all the transactions still outstanding for that account. Simply select the correct transactions and the computer will prepare the second form at the end of the day.

If that's not enough to remind you, a list is prepared monthly listing all as-yet-unsubmitted transactions. They can be reviewed and decisions made as to whether they should remain on hold or be submitted.

It should be harder to forget to prepare a computer stored insurance form than it would be to remember to find and submit an already but previously prepared paper form.

## WHY TODAY'S TRANSACTIONS DO NOT APPEAR IN THE FAMILY ACCOUNT

It is important to understand how the computer handles the transactions you enter. As you enter them during the day, the transactions are stored in a temporary DAILY file. Patient accounts as well as other files (such as the insurance, procedure and provider files) will not be updated until the information in the temporary DAILY file is reviewed, checked for accuracy and balanced against monies collected and charge slips prepared in the treatment rooms and collected in the business area.

To check that accuracy, an edit sheet is prepared using #21 PRINT EDIT SHEET. The cash and checks collected that day are then added and compared to the numbers listed on the edit sheet. If they do not balance, entry errors must be identified and corrected, and a new edit



sheet prepared. This can be done as many times as necessary until all monies balance and all charges equal the total of charge slips collected during the day.

Once everything balances, then and only then are accounts updated. But first, BACK IT UP!!

### BACK IT ALL UP - YOUR BEST FIRE INSURANCE

Simply put, backing up is making a copy of everything. It is your best possible fire insurance. With a backup, you can use any compatible computer and restore your entire data without losing a beat. IT CANNOT BE OVEREMPHASIZED THAT YOU SHOULD BACKUP YOUR DATA EVERY DAY.

Why backup now - before posting? Because the next step, #25 POST THE DAY does a lot. It will update the family account balances, update the provider and procedure files. It will also move copies of needed transactions into the insurance file where they will then be ready for the printing of insurance forms. Finally, the temporary DAILY file will be emptied and made ready for the next day.

If during this process, your computer should shut down (such as occurs with electrical surges) it would be impossible to know what has been updated and what has not. However with a backup, all you need do is restore from that backup and run the POST THE DAY option again. If you waited until after running the POST THE DAY option, your most recent backup would probably be from the same point the day before. Therefore, when you restored from that backup, you would need to re-enter everything you did today.

### POST THE DAY

Once everything is backed-up, it is time to select Main Menu #25, POST THE DAY. This will prepare a final posting report, a report to be kept in a binder. These are truly paper backups and what you would hand Uncle Sam in the event of an audit.

### PREPARE INSURANCE AND MEDICAID FORMS

Once the day has been posted, you can then print your insurance forms and/or Medicaid forms.

We strongly advise that you prepare all your insurance forms at one time at the end of the day. We recommend peel-off signature labels available from SYCOM to handle the patient signature line on the forms.

### PREPARING PRETREATMENT INSURANCE FORMS

Preparing pretreatment insurance forms is as easy as entering transactions. Select Main Menu #9, PRETREATMENTS RESUBMISSIONS. You will then be viewing a screen that looks exactly like #21 ENTER DAILY TRANSACTIONS screen. The only difference will be a message that

advises you that what you are about to enter will not be charged to the patients account but will only be entered into the insurance file. Simply enter the pretreatment transactions exactly as you do when entering transactions.

There will be two differences on each transaction line: first, the insurance claim field will default to a "P" for pretreatment rather than a "Y" or an "H" and second, the date field at the end of the line normally used for a recall date is now used for the transaction date and will be blank (as is normal on pretreatment forms).

If however you are resubmitting a form because the insurance company claims never to have received it (read they lost it!!), simply change the "P" to a "Y" and fill in the date with the date the procedure was actually performed. A new form will be prepared at the day's end and no charges will be made to the patient's account.

### WHY WE RECOMMEND SUBMITTING INSURANCE DAILY

Strangely enough, one of the things a new computer user seems to have to get over is the "Do-we-have-to-use-so-much-paper" outlook. The paper is cheap and the advantages of submitting forms daily is substantial. If you need motivation, think about it this way: the sooner the form goes out, the sooner you get your money - or - if you don't submit first, the orthodontist down the street will and use up the patient's maximum before you get paid. But most of all, submitting forms daily makes tracking claims much easier. It is also easy with a computer - not the dread it was without one.

### WHY NOT SUPER BILLS

In a manual system, Super bills become quickie insurance forms. Just check off what you did and the patient can submit it to his company. However, since insurance forms from a computer are effortless (or almost so - certainly no more so than a super-bill), there seemed no need to duplicate the process. They could however be custom prepared for you if you wish.

### HOW TO GET AT THE INFORMATION YOU KNOW IS IN THERE SOMEWHERE

#### Patient Balance Information

Probably the information you need most often is a patient's balance. You can locate that a few ways. You can choose #3 DISPLAY FAMILY DATA. Here a lot of information about the Family account can be viewed along with the current balance. You must remember however, that any transactions entered today before POSTING, will not be reflected yet in the family account.

You can also choose, #4 PRINT FAMILY HISTORY to find the current balance. Here you will get a complete list of all transactions entered in addition to the balance. This is most useful if there is any question as to charges or payments recorded. You will also be given an opportunity to print-out this history on paper. We find that handing a patient a print-out is very useful in

answering their questions regarding charges and payments.

If you happen to be using #21 ENTER DAILY TRANSACTIONS, the balance will be displayed on the top. You can also prepare a receipt from this program. This is the only place you can print-out a balance that DOES include today's charges and payments.

However if you do prepare a receipt, you will not be allowed to make any changes to those transactions already entered for the account that day. If later, you notice an error in those transactions, you will have to enter an adjusting transaction rather than correcting the incorrect entry.

## Answers to questions about insurance

Patients frequently ask about their insurance. Most commonly they want to know if you sent a form or did you get paid by the company yet. Well if you follow our suggested routine, you should almost automatically be able to say, "Yes we submitted the form." They should be submitted every day.

Double insurance changes things only slightly. You will be sending out the primary insurance form on the day of treatment but will only be sending the other when you receive payment from the first company. The computer will keep track of that for you and remind you to release the secondary form any time you record an insurance check payment.

But for now, here's where to go to look up those claims you have already submitted.

If you simply need to know the total dollars of all outstanding claims, you can use #3 DISPLAY FAMILY DATA. Look at the bottom three lines for Claims information. You will see the amount of claims outstanding for the Head-of-Household (1), Spouse (2) and Bill-to party (3) as well as the total of all three. If you entered plan information, you can also see the amount estimated that you expect to receive from those claims.

For more detailed information, select Main Menu #27 UPDATE INSURANCE CLAIMS. After entering the account #, you will get a list of all claims submitted for that account. By checking the claim dates and company #s, as well as the amount and date paid fields, you will have what you need. If the date-paid field is blank, the claim is still outstanding. If the date paid field is not blank, than the amount-paid field will tell you how much was paid for that claim. If the date is not blank, but the amount-paid is zero, then you know that the company notified you that they were paying nothing for whatever reason (ex. deductible not met).

## THINGS TO DO ONCE A MONTH

We have organized the monthly things-to-do on one menu. The month has ended when you have posted the last day of the month and prepared any insurance and/or medicaid forms.

Then select Main Menu #36 MONTH END MENU. Simply run each selection in the order listed. Each selection is explained more fully later in this manual. For now just a little review.

Are your expected insurance claim returns realistic?

If you submit a claim to an insurance company and receive nothing for 6 months, it is very unlikely that you will ever receive anything. For that reason, one of the options run each month will clear out outdated and satisfied claims. The program will allow you to track claims for as long as you wish however we recommend that you delete claims 4 or more months old. You will be given an opportunity to print a list of those claims before you delete them in case you wish to resubmit any as yet unpaid.

A lot will depend on your philosophy of practice. In the author's office, we believe that a balance due is the responsibility of the patient, not the insurance company. We will happily prepare and submit our standard ADA forms for all companies but if these companies fail to pay for whatever reason, then we expect payment from the patient. Therefore, we do not hesitate to delete outdated claims and continue to bill the patient.

Occasionally the patient will call and ask us to resubmit a claim, something that can easily be done. At the worst, deleting an outdated claim will bring to the attention of the patient that his insurance company has not paid. We encourage our patients to contact their company (in fact we usually volunteer to do so for them) to find out why payment was not made however we also ask that they pay the as-yet-unpaid balance.

No matter what your attitude toward handling insurance, the information you will need is available using #27 VIEW/UPDATE INSURANCE CLAIMS.

### Bill Messages

Bills are prepared for all accounts with a balance due - even those with a credit. Credit accounts however will receive a bill only in the month their account becomes a credit balance. Thereafter no bill will be prepared if there is no activity in that account.

You can prevent a bill from being prepared for any account by answering "N" to the Bill (Y/N) field in any family account (Main Menu #2 UPDATE FAMILY DATA). The default for Medicaid accounts will be "N".

When bills are prepared, various messages appear depending on account balances and outstanding insurance claims. This is yet another reason to keep the outstanding claims realistic. Each month, the amount of the outstanding claims is updated and the amount listed on the bill. The patient will then have reason to believe that at least a portion of that amount will be paid by the insurance company.

Using the information you've got.

### Incompleted Patients

Some reports need reviewing or the stored information is useless. A good example is the "Incomplete Patients List." This report is included not only on the LIST AND REPORTS MENU but also on the MONTH END MENU. By running every item on the Month end menu every month, you can stay on top of those patients who in many practices, slip through the cracks. Consider the patients who cancel in the course of treatment and do not make a new appointment. Of course they call at the busiest time of day and their record does not get updated. With this list, those patients can be spotted and appointed to finish needed treatment. That has to be good for everybody, patient and dentist alike.

### Aged Accounts Receivable

The same holds true of an aged accounts receivable report. If it is prepared and reviewed regularly, the overdue accounts can be held to a minimum. Combined with a word-processor, the Tolman program can help you track overdue accounts, extract personal information from the family account and prepare customized letters to help out with those collections (Main Menu #35, COLLECTION AIDS).

### As Yet Unsubmitted Insurance Transactions

We have spent a lot of time working out a way to handle double insurance. To double check that all forms are being submitted properly, all transactions on hold can be listed. Usually the only reason they should be on hold is because they are going to be submitted to a secondary carrier for accounts that have double insurance and you are still awaiting payment from the primary carrier. However, if they've been stored here too long, as you can tell from the transaction date, it is time to check out why and either release or delete them.

### Using Production reports

By knowing what procedures are performed most often, you have a great aid in setting fees. If a procedure is performed 1000 times a year, raising that fee \$10 will likely increase your gross income by \$10,000. This puts much more predictability into your fee changes. Needless to say, many other decisions about your practice can be aided by knowing both the count and Dollars-produced on a procedure by procedure basis.

Let's now look at the program on an menu item by menu item basis.

PART TWO - PROGRAM DESCRIPTION BY MENU SELECTION

MAINMENU            1 ADD NEW FAMILY  
                       2 UPDATE A FAMILY  
                       3 DISPLAY FAMILY DATA

Most items here are self-explanatory. The screens for all three choices are the same. These directions assume you have chosen the ADD NEW FAMILY option however wherever an entry is allowed, the rules will be the same.

```

(1)                    (2)                    (3)
ACCT # 1      Head of Household    Spouse                    Bill-To
First Name    : DECLAN                    PATRICIA
Last Name     : MCMULLEN                    MCMULLEN
Street Address: 204 LINCOLN RD.      204 LINCOLN RD.
Town          : PORT JEFF,                    PORT JEFF,
State/Zip     : NY 11777                    NY 11777
Home Phone    : 473-9106                    473-9106
Work Phone    : 744-2104
S.S.N / DOB   : 100-32-5453 12/04/42 079-34-3097 12/05/44
Ins # / Empl #: 001 001                    005 005
=====
Referred by   : Dr. #: 1 Pat. # ___ FN Fred      LN Courtney
=====
Bill (Y/N)    : Y : Bill-to (1/2/3): 1 :      User Codes: ___ __ __
Fee Schedule : 00 : Mail-to (1/2/3): 1 : Document Number: __
=====
Last Per Pmt : 30.00: Cur-chrg Cur-pmt 30 days 60 days 90 days Balance
Payment Date : 11/06/88: 100.00 434.75 0.00 0.00 0.00 534.75
=====
Last Ins Pmt : 25.00: Outstanding Claims: 50.00 50.00 0.00 100.00
Payment Date : 11/06/88: Ins Due Estimates: 45.00 45.00 0.00 90.00
              :        : Ins Pmts this yr: 0.00 50.00 0.00 50.00
                              **** Due now from patient **** 444.75
                              DISPLAY FAMILY MEMBERS (Y/N)
  
```

If you enter no acct # or no first name (just hit return) you will leave the option and return to the Main Menu.

The computer will assign the next available acct. number. Note it and write in on the patients record. Later the computer will prepare labels for your charts which will include significant information taken from the account.

When you enter a ZIP Code, the computer will insert the TOWN and STATE for the most local zips. If none appear, you must type them in and thereafter the computer will do it for you. Right now, try 11951 to see what I mean.

Phone numbers will appear on an overdue accts. receivable list so enter as many as you can find. It makes collections much easier.

If the patient has insurance, enter the company number in the INSURANCE CO # field and the EMPLOYER # in the EMPL # field. Use of the F1 key will provide help and allow the computer to locate those #s for you.

If you use the next available number for either the insurance company or employer (as listed in the prompt at the bottom of the screen), you will then be able to add a new company or employer without leaving this module to do so.

Send Bill (Y/N) will default to "Y." It can be overridden by changing the Bill(Y/N) to N.

We recommend peel-off signature labels that the patients sign as they leave. The labels are affixed to the forms on the signature line. Many insurance companies are not accepting "SIGNATURE ON FILE" in place of an actual signature. This way you are able to prepare all insurance forms at one time at the end of the day.

If you enter a first name for a Spouse, most of the fields in the Spouse column will be prepared for you. You may change them if you wish. You need to add the spouse's work phone, insurance co # and Social Security Number.

Under referred by, enter the name of the person who referred this family as you wish it to appear on a mailing label to that person. Enter that person's acct # if the referrer is a current patient or the Referring Dr. # if the referrer is another dentist or physician. Help is available for locating those numbers. The acct # field will change from an acct # to "sent" when the label is prepared. When the referrer is a Dr., a record of referrals by that Dr. will automatically be updated each time a new patient is added to the system. A list of patient referrals by any referring Dr. can be printed up elsewhere in the program.

Here again you can add a new referring Dr. on-the-fly by using the next available number listed in the prompt. You need not leave this module to add new Doctor information.

Fee schedule must be a number from 0 to 99. You can choose the standard fees by skipping this field. The number for the standard fee schedule is 0 (not 1).

Head-of-Household is column 1, Spouse is column 2, and Bill-To is column 3. In the Bill-To and Mail-To fields, enter the # of the appropriate column. If you enter "3", then you will be

requested to enter data in column 3 otherwise column 3 will be skipped.

User codes are for any codes you care to create. You will be able to extract a list of patients based on your user codes.

The Document # field is used to create a merge file to be merged with Word Processing letters. It is currently being used for collection letters. A list of codes currently in use and the letters that go with them is also available. This field can be automatically incremented by 1 (assuming you use numbers) when the account is selected for correspondence so as to be ready for the next in a series of letters without the user having to change each one individually.

Money fields should be self explanatory and are updated by the computer at day's end posting.

### ENTERING FAMILY MEMBERS (PART 2)

	(1)	(2)	(3)	
ACCT #	1			Bill-To
First Name	: DECLAN		PATRICIA	
Last Name	: McMULLEN		McMULLEN	
Street Address:	204 LINCOLN RD.		204 LINCOLN RD.	
Town	: PORT JEFF,		PORT JEFF,	
State/Zip	: NY 11777		NY 11777	
Home Phone	: 473-9106		473-9106	

-----  
S=Sex : Stg=Stage of treatment Cm=Completion (Y/N)  
P=Primary Ins: R=Relation - Select (H)ead (S)pouse (C)hild or (O)ther  
-----

#	First Nm	Last Name	S/P/R	D.O.B.	MMI#	Recall	Lst	Vst	Nxt	Vst	Stg/Cmp
1	DECLAN	McMULLEN	M 1	H 12/04/39		10/01/89	07/21/89	/	/	1	N
2	PATRICIA	McMULLEN	F 2	S 07/05/40		12/01/89	08/26/89	/	/	1	Y
3	DECKY	McMULLEN	M 2	C 06/08/67		12/01/89	06/28/89	/	/	2	N
4	TONY	McMULLEN	M 2	C 08/02/69		01/01/90	04/28/89	/	/	3	Y
5											

Press any key to continue...



When you enter a First Name, some information is assumed and will be entered for you. It can be changed if needed. To exit the option, just hit return instead of a First Name.

.c.:::Selecting primary insurance carrier

P stands for Primary Insurance. In most instances, the computer will determine the correct entry for this field. It will be a number from 1 to 3 based on whose insurance is primary for this member, 1-Head-of-Household, 2-Spouse or 3-Bill-To party such as a father who is now divorced from the current Head-of-Household.

In the event of double insurance coverage, in many states, the primary insurance for a dependent is usually the company of the parent whose birthday falls earlier in the year. In the above example, the spouse's insurance is primary for the children since her birthday occurs in July whereas her husband's birthday is in December. Please notice that although the husband is older, his birthday does not fall earlier than his wife's during the current year.

.c.:::Relationship field

The relationship field (R) is necessary for insurance forms and must be the relationship to the Head-of-Household. Once again, the computer will, in most instances, determine the correct entry for this field. The computer will also automatically adjust the insurance forms for secondary insurance. Your choices are (H) - Head of the Household, (S) - Spouse, (C) - Child, (O) - Other.

Date of birth is usually required by the insurance company so an entry is advised. Birthday card labels are also selected by this field.

.c.:::Medicaid number

The MMI# field is for a Medicaid #. Medicaid requires a Medicaid number on Medicaid forms or no money!!

The recall date is automatically set for 6 months from the current date but can be changed if desired.

Last Visit is updated by the computer as treatment is performed.

Cmpl refers to whether or not this patient's work is complete. It is updated every time a transaction is posted to this member. This field in conjunction with the last-visit field can be used to locate patients whose treatment has been interrupted and has no current appointment. The report is prepared by choosing "7 Incompleted Patients" from the MONTH END MENU.

EMPLOYER INFORMATION (PART III)

(1)

(2)

(3)

```

ACCT # 1      Head of Household  Spouse      Bill-To
First Name   : DECLAN           PATRICIA
Last Name    : MCMULLEN        MCMULLEN
Street Address: 204 LINCOLN RD.  204 LINCOLN RD.
Town        : PORT JEFF,      PORT JEFF,
State/Zip    : NY 11777       NY 11777
=====
Insurance Co. : NEW YORK LIFE    AETNA LIFE INS CO
Employer     : A&P             A&P
Group       : RETAIL CLERKS     RETAIL CLERKS
Street Address: MONTAUK HWY      MONTAUK HWY
Town        : MASTIC           MASTIC
State/Zip    : NY 11950        NY 11950
Group #      : A-S234-233-1234  A-S234-233-1234
=====
: Ded:50  Max:1000  Ded:50  Max:1000
Deductible and: Exam: 90      Exam: 90
insurance %   : Oper: 90 Peri: 50 Oper: 90 Peri: 50
of coverage by: Endo: 90 Surg: 80 Endo: 90 Surg: 80
treatment type: Pros: 80 Orth: 50 Pros: 80 Orth: 50
:
=====

```

Press any key to continue...

This screen simply displays Insurance and Employer information that you entered earlier.

The computer will automatically calculate an estimate of the insurance companies portion of the bill based on the percentages you enter here. If you leave these fields blank, the estimate will be zero.

The categories correlate with groups of procedures as follows:

```

Basic           Procedures 100-1999
Fillings       Procedures 2000-2999
Endo            Procedures 3000-3999
Perio          Procedures 4000-4999
Prosthetics    Procedures 5000-6999
Surgery        Procedures 7000-7999
Orthodontics   Procedures 8000-9000

```

That should be it for adding patients. The more you include the better for both collection and insurance purposes.



MAINMENU            7 PRINT INSURANCE FORMS  
                         8 PRINT MEDICAID FORMS

Although printing of your state's Medicaid forms may be unavailable in the Demo version, these do just what they say. A Spooling program can be used which saves the printed insurance forms on disk before actual printing is allowed. This allows a way to adjust the paper at the start of printing without the worry of jammed forms or other printer errors interfering with processing of the forms.

When entering transactions (MAINMENU #21), you will be asked whether to submit a procedure to the insurance carrier or not or, in the case of double insurance, to place it on Hold. You will also be asked for a Doctor number.

A form will prepared for each company though transactions placed on hold will only print up after they are released by you.

A different form will also be prepared for each Doctor. If you wish all forms to be submitted under one Doctor's name, simply assign that Doctor's number to all the other providers as explained later under MAINMENU #19 VIEW/UPDATE PROVIDER. Unless salaries are determined by income, it is recommended that all insurance be submitted under one name. This will reduce the number of claims and make updating claims a simpler task.

We recommend peel-off labels that are left out during the day that patients with insurance sign before they leave. The labels are later put on their insurance forms. We have found too many insurance companies will not accept "SIGNATURE ON FILE" as a substitute for an actual signature.

Medicaid forms look different from regular insurance. Some states use a form that requires a wide (132 column) printer and special forms supplied by the Medicaid office, a fact that needs knowing when purchasing a printer. All other reports prepared by this program can be printed on a printer that handles 9.5 inch wide paper.

MAINMENU 9 PRETREATMENTS/RESUBMISSIONS

ENTER ACCT # 1 NO CHARGES - INS. ONLY  
DECLAN McMULLEN  
204 LINCOLN RD.  
PORT JEFF, NY 11777

BALANCE: 139.75 FEE SCH: 0 ACCT TYPE:

-----  
Head of House: 5 NEW YORK LIFE |SSN:100-32-5453  
Spouse: 13 J.J. NEWMAN & CO. INC. |SSN:079-34-3097

-----  
Member Trans Description Fee Tooth/Surf Claim Date  
1 TONY 3330 ROOT CANAL - 3 CANAL 200.00 3 P P / /  
2 TONY 2891 POST AND CORE 100.00 3 P P / /  
3 TONY 2750 PORC ON METAL CROWN 400.00 3 P P / /

DECLAN PATRICIA DECKY TONY

IS THIS LINE CORRECT (Y/N) Y

This option is exactly like #21 ENTER DAILY TRANSACTIONS. Therefore a more thorough explanation of its use can be found under that topic. It differs only in that transactions entered are not charged to the family account but move directly to the insurance transaction file. It is assumed that you are entering pretreatment transactions therefore under Claim, the default is P for pretreatment. It can be changed to Y in the event that you are resubmitting an insurance form for whatever reason.

The default date is blank as it should be for a pretreatment. However, if you are resubmitting an insurance form, you can enter a date that will be included on the form as the treatment date.



MAINMENU

10 UPDATE INSURANCE TRANSACTIONS

ACCT # 1

Ln	Co. Name	Transaction	Fee	Tooth/Surf	Clm	Date	MMI#	Del
1	5 TONY	2160 3 SURFACE AMALGA	45.00	3	MOD	Y 10/01/91		
2	13 TONY	2160 3 SURFACE AMALGA	45.00	3	MOD	H 10/01/91		
3	5 TONY	2337 A.E 1 SURF COMPO	35.00	8	F	P 10/01/91		
4	13 TONY	2337 A.E 1 SURF COMPO	35.00	8	F	D 10/01/91		

ENTER # OF LINE TO UPDATE 11 TO CLEAR THE DATE, ENTER 11/11/11

Families with double insurance must submit to the primary carrier, await payment and then submit to the secondary carrier. To facilitate that process, the program will allow you to (H)old secondary transactions and release them when payment is received from the primary carrier. When recording an insurance payment, #21 Enter Daily Transaction will automatically call up this module to allow you to change the Clm column to "Y" for any transactions on (H)old. You may however select #10 UPDATE INSURANCE TRANSACTIONS directly to accomplish the same thing.

This option also allows correction to incorrectly entered insurance transactions. To delete one altogether, enter a 'D' in the DelCode field. Some data can not be changed (since it is not checked for accuracy) and therefore you must delete the transaction and start again.







Orthodontics Procedures 8000-9000

Since this is information that is used to calculate estimates of insurance benefits, it is strongly advised that you keep it as accurate and up to date as possible.



the computer whether the procedure applies to a permanent or deciduous tooth or both. This determines whether the user is required to enter that data when entering procedures.

When reviewing the status of a procedure, you will also see a second portion to the screen. Here you can see the number of times the procedure has been used for the month or year and how many dollars can be accounted for by the procedure for the month or year. The month to date field will be cleared by running the PROCEDURE REPORT found on the reports menu. It should be done at the end of each month.

MAINMENU

17 VIEW/UPDATE ALTERNATE FEES

With the Tolman Dental program, you can create up to 99 different fee schedules. If you accept Medicaid or participate in any insurance programs, their fees can be entered in a separate schedule. The fee schedule is then assigned to the appropriate families and will then automatically be used when charges are made to their accounts

This option is used to add or change the additional fee schedules. Again a fee of \$9999.99 will disallow this procedure with this fee schedule. For example, in the Medicaid fee schedule, we include 5110, the allowable standard procedure for a denture. In the Medicaid fee schedule however, we give it the fee of \$9999.99 so that the user will not be able to use 5110 if the patient is a Medicaid patient.







Each user can be assigned his/her own password. Each password is assigned a level of security. The highest is 6. I'll provide you with a list of which options require Passwords and how high a level. In the demo version you need only hit return.



MAINMENU

21 ENTER DAILY TRANSACTIONS

This is the most used option in the package. Like most, it begins with the acct #. To leave the option just hit return instead of entering a #.

First you must verify that you have chosen the correct account. **THIS IS PROBABLY THE SINGLE MOST IMPORTANT CHOICE YOU WILL MAKE.**

Although this option does a great deal of error checking of the user's inputs, there is virtually no way to catch a mistake if you charge the wrong account. The patient will complain about an incorrect charge at bill time, and although you can adjust his account, it will be difficult at best to determine if someone else should have been charged.

If you credit the wrong account, the patient who receives the credit will never call but the patient who sent the check certainly will!!

ENTER ACCT # 1	Day/bal	Day/est
DECLAN McMULLEN	0.00	75.00
204 LINCOLN RD.	Run/bal	Est/ins
PORT JEFF, NY 11777	139.75	200.00

BALANCE: 139.75 FEE SCH: 0 ACCT TYPE: Prior recall:01/01/88

-----

Head of House: 5 NEW YORK LIFE	SSN:100-32-5453
Spouse: 13 J.J. NEWMAN & CO. INC.	SSN:079-34-3097

-----

Member	Trans	Description	Fee	Tooth/Surf	Claim	Dr	Cmpl	Recall
1 TONY	110	INITIAL ORAL EXAM	25.00		H Y	5	Y	08/08/88
2 TONY	210	F.M.S. X-RAYS	25.00		H Y	5	N	
3 TONY	2150	2 SURFACE AMALGAM	25.00	3	MO	H Y	1	Y
4	2	PAYMENT - CHECK	75.00					

:F2-Adlt Init :F3-Adlt Recall :F4-Unused :F5-Unused :F6-Unused :  
:F7-Child Exam :F8-Sealants :F9-Unused :F10-Unused :F11-Unused :

The function key message at the bottom of the screen advises you of the batch entries possible. This will allow you to enter multiple procedures with the press of one key. The cursor will stop on the first line of each batch to allow you to enter the Doctor number and completion status of the patient. You can create these groupings by selecting Main Menu #33  
VIEW/UPDATE BATCH TRANSACTIONS

At the point when you are asked if you wish to enter a transaction, a different message will appear that will read:

F2-Receipt : F3-Super Bill :F4-Insurance form :F5-Stage  
Enter Transaction (Y/N)

At this point, you may choose any of the three hotkey choices rather than enter Y or N to the Enter transaction question. Although we still recommend processing all insurance forms in a batch at the end of the day, this will allow you to prepare forms immediately upon entering the transactions. If either a receipt or an insurance form is prepared in this manner, changes to the days entries for that account will not be allowed. If an error is found, it will have to be corrected with an offsetting adjustment entry rather than a change in the incorrect entry. This is done for accounting safeguard reasons.

During your entry of each procedure, various messages may appear at the bottom of the screen as each part of each entry is checked for accuracy.

Payments can be credited without a MEMBER NAME as well as adjustments up to number 50. After that a MEMBER NAME is required. Procedures 1-10 are payments. 11-50 are adjustments (credit adjustments must be entered with a negative sign preceding them - you need not do that for payments). 51-99 are charges that will not appear on insurance forms and 100 on up are standard insurance codes.

Procedures in the 8000s will appear on insurance forms but will list with a procedure of "0000". This is to allow for new procedures that do not yet have codes assigned to them.

Procedure 9500 is a special one. With a document # of 50 in the family account, you can charge a total case with Procedure 9500 rather than procedure by procedure entries. In fact, no other procedures except payments will be allowed as long as the document # remains 50. The older uninsured patients seem to prefer this method.

Your choices under Claim are Y/N/H for Yes, No or Hold. If a family has 2 or more insurance coverages, you will be asked if this procedure should be submitted, not-submitted, or held for each company. This way, especially with double insurance, you can hold the secondary company claim till you have received payment from the first. You need not print both insurance forms the same day and then worry about storing the secondary form for the future. When payment from the primary carrier is recorded, the program will alert you (with a beep and message). You can then release the secondary form.

After you enter your choice for the Claim field, the computer will calculate the estimated insurance benefit based on the information you provided when entering Employer information. The running totals on the top of the screen will be updated accordingly. Procedures put on Hold will be considered in the estimate. The program will also take into account double insurance and you will notice that with double insurance, the estimate will never exceed the fee. The estimate will also consider which carrier is primary and which secondary for each patient based on information you entered in the Family members section.

Under Dr, you enter a number from 1-99. If you enter nothing, it will default to 1.

Cmpl refers to whether or not the patient's treatment is complete. It is a choice any time a procedure greater than 100 is entered. It can also be adjusted with Procedure 22-Reset Completion.

Recall appears with those procedures related to examinations and prophylaxis. It is automatically updated to 6 months hence but can be changed. It can also be adjusted with Procedure 23-Reset Recall. Neither Procedure 22 nor 23 will appear on the Edit or Final Posting sheets prepared at day end.

All entries here are stored in a separate file until the end of day posting. The family account will not reflect these entries until #25 POST THE DAY is run. This is done for very specific accounting safeguard reasons as well as to allow changes to any errors found.

Whenever an insurance check is recorded, the program will automatically list all claims for that account and give you an immediate opportunity to update the appropriate claim. It will present all the claims in the bottom half of the screen and allow the update without leaving this module. For further details regarding updating claims, review the section in this manual pertaining to #27 Update Insurance Claims.

In a like manner, whenever an insurance check is recorded, if the account is one with double insurance, all transactions being held for release to a secondary company will appear in the bottom half of the screen. You may then release any that you wish, for submission to the secondary company. They will be included in the next batch of insurance forms prepared.

MAINMENU            22 PRINT EDIT SHEET  
                         23 CORRECT DAILY TRANSACTIONS  
                         24 DAILY BACK-UP

The report prepared here allows the user to compare checks/cash received to the amount listed. It is also the time to compare the charges to whatever buck slips have been used to advise the front desk what treatment has been performed.

If errors are found, they can be corrected with # 23. Some data may not be able to be changed but only deleted and then re-entered. This is done to assure checking the accuracy of the data entered.

Once things balance, then #24 Daily Back-up is performed. Selecting #24 DAILY BACKUP will cause a file called DAILY.BAT to be run. Any backup routine that can be called from a DOS prompt can be entered in DAILY.BAT and then run from the Tolman program. One suggestion: create an archive file of all the data files with a program such as ZIP and then backup the archive file. In this way you automatically have a double backup up each day - one on your hard disk and one on tape or floppy disk. Programs such as ZIP or PKZIP are shareware and are available from many bulletins boards, CompuServe or the author.

MAINMENU            25 POST THE DAY

This will prepare the final posting sheet that you save for the IRS. At the same time, many other files will be updated with the days activity such as the Family File, Procedures File, Providers File, Insurance File. In addition, procedures are cleared from the Daily File and added to the Monthly file.

A lot of work is accomplished here and that is why a backup is performed just prior to choosing it. If something goes wrong here, such as a fluctuation in the electrical current, you can restore from the backup and start again.

MAINMENU

27 UPDATE INSURANCE CLAIMS

Update Insurance Claims (CHGCLAIMS.PRG)

Ln	Name	Whose	Ins	Clm-Date	Est-Ben	Clm-Amt	Pay-Dt	Amt-Pd	Cd/Ty/DI
1	DECLAN	McMullen	1	5 05/18/91	0.00	420.00	08/29/91	223.50	2
2	DECLAN	McMullen	2	13 06/01/91	0.00	420.00	06/25/91	196.50	2
3	DECLAN	McMullen	1	5 07/21/91	0.00	35.00	08/10/91	28.00	2
4	PATRICIA	McMullen	1	5 05/05/91	0.00	375.00	05/18/91	175.00	2
5	PATRICIA	McMullen	1	5 05/06/91	1300.00	1455.00	/ /	0.00	1
6	PATRICIA	McMullen	1	5 05/06/91	40.00	45.00	/ /	0.00	2

ENTER # OF LINE TO UPDATE

It is here that you will post Insurance checks after posting them as payments to the family account. Simply match up the date of the claim with the treatment date noted on the insurance check stub and select that line as the claim to update. Since forms are to be prepared every day, it is not difficult to match up the dates.

As you update a claim, you will notice that the Estimated benefit will be reduced to 0.00 since once a claim is paid, the estimate no longer applies. This will be reflected in the family account automatically for you.

If a payment is denied by the carrier for any reason, update the correct line by entering the date of notification but leave the Amt Pd as 0.00. This way the computer will not consider this claim to be outstanding any longer.

Information about claims will be stored as long as you like and will not be removed till you run the option - CLEAR OUT/RESET CLAIMS file found on the MONTH END MENU. Since the estimated benefits and outstanding claims portion of the family account is based on information stored here, it is strongly advised that these fields be updated daily as insurance checks are received. It is also advised that outstanding unpaid claims be deleted when it becomes obvious that so much time has passed that it is not reasonable to expect further payment. It is suggested that a second form be submitted for that work if payment can still be anticipated. This can easily be done by listing the family history and resubmitting using MAINMENU #9. PRETREATMENT/RESUBMISSIONS.

Here you can create your own customized patient lists. The program begins by assuming that you want a list of all records. You then limit that list by the items you complete on the following screen.

Category	Range of Values
Acct #	Start: __1 End: __5
Zipcode	_____
Ins. Co. # / Employer #	____ _ Empl # __
Send Bill	(Y/N) _
User Code	_____
Document #	Start: __ End: __
Referring Dr./Patient #	Dr. # 001 Pat. #: __
Balance	Greater than: 0.00
60 day balance	Greater than: 0.00
90 day balance	Greater than: 0.00
Outstanding Claims	Greater than: 0.00
Last Personal Payment Date	More than __ days ago
Last Insurance Payment Date	More than __ days ago
Member Last Name	_____
Member Date of Birth	Born between: / / and / /
Member Recall Date	Due back between: / / and / /
Member Last Visit Date	More than __ days ago
Completion Status / Stage	(Y/N/H/B) _ Stage __

Hit Escape to return to Main Menu

After you make your limiting entries, you can then determine the amount of data you would like on your list by selections you make from the next menu.

Would you like

---

1. No report - just a total of matching accounts
2. Matching account numbers only
3. Brief one line per family report
4. A choice of fuller reports
5. Return to Main Menu

Enter selection:

If you select #4 for fuller reports, you can then choose from the following combinations of data to include on your list.

Should I Include

---

Head-of-Household/Spouse Data: Y

Family Member Data: Y

Head-of-Household/Spouse Employer Data: Y

---

Outstanding Insurance Transactions: N

Insurance Claims: N

---

As you can see, an almost infinite variety of lists becomes possible depending on your choices.

1. Accounts Receivable List
2. List accounts in Family File with Doc. # greater than 50
3. Enter Document Numbers
4. Extract account by Document # - Print List
5. List accounts in given merge file
6. Word Processor

Enter Selection:

All of the above are designed to aid you with collections. First you must identify those accounts which you feel need attention. The quickest source for that information is the Overdue Accounts Receivable Report. This will list those accounts which have a balance that are 60 or more days overdue. The number of days could be adjusted to any number you desire.

Pertinent information such as outstanding insurance claims etc., is included on this report to help you decide what action to take. You may, for example, not wish to contact a patient whose account is overdue but whose insurance company has not yet paid it's portion.

Identifying/marketing overdue accounts

Once you have decided which patients to contact, you can then prepare personalized letters to be sent to each of these accounts. Each letter can contain specific information about that account - information that will be different from one letter to the next.

To accomplish this, enter a number in the document # field using #3 - Enter Document numbers. The number you enter is up to you. You will create your own list of codes - codes for any use you like. One office we know prepares collection letters based on a series of letters identified by codes from 90 to 99.

Once marked, useful information that can be inserted into any letter you wish (such as Name, Address, Balance etc.) can be extracted by running #4 - Extract by Document number. This



option will also print you a list of the accounts selected.

The information extracted is then merged into an appropriate form letter that is customized and personalized by the inclusion of each member's personal data. Many excellent word processing programs are available for this purpose.

To improve your efficiency, the extracting option (#4 - Extract by Document numbers) will increment the number in the Document # field by 1 if you so desire. This will eliminate the need to manually increment the number if and when the time comes that the patient will be sent the next letter in a series.

If at any time you would like a list of accounts that have been marked (possibly to review collections received as a result of your efforts), simply run #2 - List Accounts in Family File with Doc. # greater than 50. Although we have set this program up with Doc. #s greater than 50, that could be adjusted to any number you wish.

MAINMENU

36 MONTH END MENU

MONTH END MENU

- 1 Backup - Run DAILY with Monthly disks
- 2 Clear out Ins. Transactions File
- 3 List Outstanding Insurance Transactions
- 4 List Outstanding Insurance Claims
- 5 Clear Out/Reset Insurance Claims
- 6 Accounts Receivable
- 7 Incompleted Patients List
- 8 Bills
- 9 Producer Activity Report
- 10 Procedure Activity Report

Enter selection: \_\_

Not all jobs need to be done every day. We have taken those that we feel need only monthly attention and placed them on a separate MONTH END MENU.

1 Monthly Backup: We recommend making a back up copy of all files just prior to monthly procedures are performed. This option will call a batch file named MONTHLY.BAT. Please refer to the section describing the Daily backup for suggestions with regard to backing up.

2 Clear Out Insurance Transaction File: After insurance forms are prepared, the procedures are marked for deletion. They do however remain in the file until this option is run. Clearing the file will increase performance and free disk space.

3 List Outstanding Insurance Transactions: Since the programs allows you to put insurance procedures on hold, it is good procedure to periodically review those procedures not yet printed up.

4 List Outstanding Insurance Claims: If you participate in one or more insurance plans you will

probably need to deal directly with the insurance carriers rather than just the patient. This list will allow selection of unpaid claims based on age and/or carrier.

5 Clear Out/Reset Insurance Claims: This option will automatically delete both satisfied and unsatisfied claims submitted prior to the date you choose. We figure that after a certain period of time, if a claim is not yet paid then it never will be! To include an outdated claim when considering the collectability of an account would be deceptive. You however decide how old is too old when running this option.

You may of course, list the Claims before deleting them.

6 Accounts Receivable: Prepares list of delinquent accounts.

7 Incompleted Patients: This report will help reduce "lost patients." It prepares a list of all patients who are listed as not yet complete but whose last visit has not been since a date that you select. It is designed to identify those patients who for whatever reason have interrupted treatment and enable you to reactivate them.

8 Bills: This does the obvious. Like other options, the bills are "spooled" to disk and can be printed at any time later. This option also updates the "aging" of all accounts.

10 Provider Activity Report: Prepares a report of who produced what and clears the Month-To-Date fields at the same time.

11 Procedure Activity Report: Prepares a report listing, procedure by procedure, the number of occurrences of each procedure as well as the production attributable to that procedure. It provides both Month-To-Date and Year-To-Date totals. Running this report also clears the Month-To-Date fields preparing for the next month.

BEFORE RUNNING THESE OPTIONS, RUN THE MONTHLY BILLS AS USUAL.

1. Create new PREVIOUS YEAR Files  
from CURRENT YEAR Files  
(FAMILY/PROCEDURE/HISTORY)
2. Kill current HISTORY FILE and  
create new HISTORY FILE with  
Balance Forward Transactions calculated  
from the current Family Accounts
3. ANNUAL BACKUP - Backup of new  
PREVIOUS YEAR Files
4. Backup new HISTORY FILE  
Use December History Disks

Enter Selection

The History files contain all the procedures entered for a given year. At the end of given year, a new history file must be created. These options, to be run in sequence, accomplish the housekeeping chores necessary to set that all up. All items on this menu should be run after the last transaction of the year ending and before entering any transaction for the new year.

#3 ANNUAL BACKUP will call a batch file named OLDYEAR.BAT and #4 Backup of new History file will call a batch file named NEWYEAR.BAT. This is probably a good time to back up your entire hard disk if you do not do so every day.

Suggestion: the year end is also a good time to perform other preventive maintenance tasks for your hardware: Tasks such as low level formatting (which can be done with a program like SPINRITE) and de-fragmenting files with a program like NORTON SPEED DISK.

Please refer to the section related to Daily backup for other suggestions regarding backup.

