

HEALTHCARE IT

## **Exa® PACS/RIS**

# **Feature Summary**

**Printer Settings** 

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### Open printer settings

You can adjust the margins of your claim to suit your printer's requirements. To modify them, go to:

Burger > Billing...



Oldeb	Clairis		LOD	Report	octup
Printer Tem	nplate	s			
SETUP					
ADJUSTMENT CODES					
BILLING CODES					
BILLING CLASSES					
CLAIM STATUS					
COLLECTIONS PROCESS					
DELAY REASONS					
BILLING PROVIDERS					
PROVIDER ID CODE QUAL	IFIERS				
BILLING MESSAGES					
PAYMENT REASONS					
CAS GROUP CODES					
CAS REASON CODES					
STATUS COLOR CODES					
BILLING VALIDATIONS					
EDI/ERA TEMPLATES					
EDI CLEARINGHOUSES					
INSURANCE MAPPING					
PRINTER TEMPLATES					

### Modify printer margins

You can modify margins on individual printer templates. To edit a template, select the edit (pencil) button.

		TEMPLATE NAME
Ø	Ū	Red form
Ø	Ū	Invoice Template
Ø	Ū	Patient Invoice
Ø	Ū	Black & White Final

Modify margins separately for each printer template.

Name *	Black & White F	Final	🗌 🗆 Inactive 📄 Default
Margin Left *	12.0	Margin Top *	30.0
Margin Right *	0.0	Margin Bottom *	0.0
Page Height *	792	Page Width *	612

Name *	Red form		🗆 Inactive 📄 Default
Margin Left *	17.0	Margin Top *	34.0
Margin Right *	0.0	Margin Bottom *	0.0
Page Height *	792	Page Width *	612

You can deactivate printer forms or set them as the default when printing.

#### Modify printer setting in the print preview

Another way to modify the printer margins is by selecting the More Settings option when the print preview screen appears.

Print ?									
Total: 1 sheet of paper		HEALTH INSURAN				AARP ME	DICARE COMPLETE		
		APPROVED BY NATIONAL UNIF	DRM CLAIM COMMITTEE (NU	UCC)02/12		950 WINT	TER ST, SUITE 3800		
Printer		PICA	TRICARE	CHAMDVA	CROUP	WALTHEN	M MA 02451	(For Decorption in	PICA
Microsoft Print to PDF 🗸 🗸		(Medicare#) (Medicaid)		(Member ID#)		BLKLUNG (D#)	1a. INSURED'S I.D. NUMBER 345678	(For Program in	item 1)
		2.PATIENT'S NAME(Last Name, I TEST, BARRY	First Name, Middel Initial)	3.P/ M	TIENT'S BIRTH DATE	м 🗹 <sup>SEX</sup> F	4.INSURED'S NAME (Last Nat TEST, BARRY	ne, First Name, Middle Initial)	
Copies		5.PATIENT'S ADDRESS(No., Stree 101 MAIN ST	rt)	6.P/ Self	ATIENT'S RELATIONSH	IP TO INSURED hild Other	7.INSURED'S ADDRESS(No., S 101 MAIN ST	Areet)	
		CITY LAKE CHARLES		STATE 8.RI	ESERVED FOR NUCC U	SE	LAKE CHARLES		STATE SC
Layout		ZIP CODE 12321	TELEPHONE (Include Area Cod ( 456 ) 456-4564	de)			ZIP CODE 12321	TELEPHONE (Include Area ( )	a Code)
O Portrait		9.0THER INSURED'S NAME(Last	Name, First Name, Middel Initia	ial) 10.1	IS PATIENT'S CONDITIO	IN RELATED TO:	11.INSURED'S POLICY GROU	P OR FECA NUMBER	
_ Landscape		a.OTHER INSURED'S POLICY OR	GROUP NUMBER	a.D	VES	NO PLACE(State)	a.INSURED'S DATE OF BIRTH MM   DD   YY 10 10 2010	M 🖌 SEX	F
		b.RESERVED FOR NUCC USE			YES	✓ N0	b.OTHER CLAIM ID (Designat	ed by NUCC)	
Pages		C.RESERVED FOR NUCC USE		c. 0	YES	✓ NO	C.INSURANCE PLAN NAME O	R PROGRAM NAME	
O All		d.INSURANCE PLAN NAME OR F	ROGRAM NAME	10d	I.CLAIM CODES(Design	ated by NUCC)	d.IS THERE ANOTHER HEALT	H BENEFIT PLAN? If yes, complete items 9,9a,an	d 9d.
		12.PATIENTS OR AUTHORIZED PE to process this claim. I also reque assignment below.	READ BACK FORM COMPLETIN RSON'S SIGNATURE I authorize st payment of government bene	NG & SIGNING 1 te the release of tefits either to m	THIS FORM. f any medical or other in nyself or to the party with	nformation necessary ho accepts	13.INSURED'S OR AUTHORIZ of medical benefits to the uno described below.	2D PERSON'S SIGNATURE I au Jesigned physician or supplier	thorize payment for services
Color		SIGNED SIGNATURE ON FILE			DATE 05 02 202	3	SIGNED SIGNATURE	)N FILE	
		14.DATE OF CURRENT ILLNESS, MM   DD   YY QU/	NJURY, or PREGNANCY (LMP)	15.0THE	R DATE MM	I DD I YY	16.DATES PATIENT UNABLE FROM MM   DD	TO WORK IN CURRENT OCCUP YY To MM   DD	YY
		17.NAME OF REFERRING PROVI DN ANDREWS, NANCY	DER OR OTHER SOURCE	17a 17b NP	1427077	916	18.HOSPITALIZATION DATES MM   DD   FROM	RELATED TO CURRENT SERVI YY To MM   DD	ICES YY
		19.ADDITIONAL CLAIM INFORM	ATION(Designated by NUCC)				20.OUTSIDE LAB? YES NO	\$ CHARGES	
		21.DIAGNOSIS OR NATURE OF IL A. L A0100	LNESS OR INJURY Relate A-L to B. I	to service line b C. L	elow(24E) ICD Ind.	D.	22.RESUBMISSION CODE	ORIGINAL REF.NO.	
		E. L	F.	G. [ K. [		H. I	23.PRIOR AUTHORIZATION N	IUMBER	
		24. A. DATE(S) OF SERVICE From To MM DD YY MM DE	PLACE OF YY SERVICE EMG	D.PROCEDURI (Explain U CPT/HCPCS	ES,SERVICES,OR SUPP Inusual Circumstances I MODIFIE	LIES E. DIAGNOSIS R POINTER	F. G. DAYS OR UNITS	Family QUAL PROVIDE	ING. RID#
	1	05 02 2023 05 02	2023 49	73701		A	20 00 1	NPI	
	2	2	1 1 1 1					NPI	
	3							NPI	
	4							NPI	
Print Cancel	5							NPI	
				I					

These settings may vary by the type of printer.

#### Assign a printer template

Printer templates are user-specific; each user must assign templates that they want to use. On the **Claims** screen select the settings button.



In **User Settings**, select what form the printer points to.

llser Settings			
Column Order	Settings		SAVE
Study Date	Default Column	Study Date	~
Payer Type	Default Sort Order		~
Billing Method	Printer Templates		
Claim Status	Paper Claim (B&W)	Select	¥
Claim No	Paper Claim (RED)	Select Balck & White Final	
Submitted Date	Direct Invoice	Select	~
🖾 Claim Date	Patient Invoice	Select	
Patient Name		Select	
Clearing House	Special Form	Select	
Billing Provider			
C Account No.			
Date Of Birth			
Place Of Service			
Referring Providers			
Rendering Providers			
			CANCEL