

## SWF Billing Procedure

Welcome to the SWF Provider Network! The next few pages are written directions for the SWF billing procedure. Please note, all claim forms must be **submitted within 60 days** of the date you are billing us for. **Please be sure to include the SWF ROI/Waiver when billing for your first session.**

### **\*\*Disclaimer**

All claims are submitted for each referral and are broken out by month of service. This helps SWF associate which months have the highest therapy fees. Additionally, each **“Claim Detail”** indicates the type of service that was administered during the session. This means you will need to add multiple **“Claim Details”** for sessions that include travel, SIQs, and SWF ROI/Waiver.

Please watch this [demonstration video](#) before completing the form on your own.

### **Step 1:**

- Please click on the link below to access the SWF Claim Form via our secured database, Zoho...

<https://zfrmz.com/njgBx5g3451KnBumxsfM>

### **Step 2:**

- At the top of the page, in the first box, please input the SWF#00000.  
\*Please note, this referral number must include **SWF#**

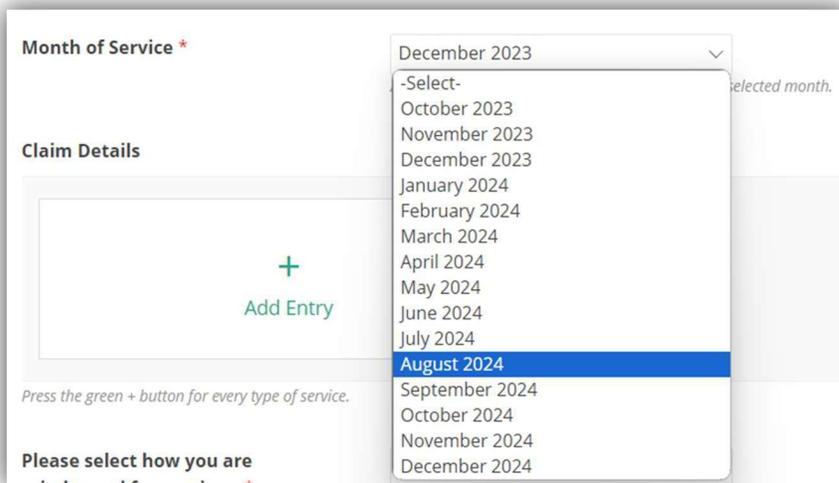


Referral Number \*

Please input SWF# before typing the referral number.

### **Step 3:**

- Select the month of service.  
\*All sessions for each client in one month will go on **one** claim form. Please reference the video for clarification.



Month of Service \*

December 2023

-Select-  
October 2023  
November 2023  
December 2023  
January 2024  
February 2024  
March 2024  
April 2024  
May 2024  
June 2024  
July 2024  
**August 2024**  
September 2024  
October 2024  
November 2024  
December 2024

selected month.

Claim Details

+  
Add Entry

Press the green + button for every type of service.

Please select how you are reimbursed for services \*

**Step 4:**

- Select the green "+ Add Entry". This will populate a pop-out page.

**Step 5:**

- Select the type of service.  
\*Please note, only one type can be selected at a time and "Cost" will populate automatically.
- Select the therapy mode.
- Select the date of service for the type of service.
- Please number the session 1-12.  
\*If a client **NS/CA** the session number will be **0**, regardless of what session it would have been.

### Claim Details

Press the green + button for every type of service.

**Type of Service \***

Therapy  Travel (please enter address below)

Cancellation / No Show  SIQ (please upload below)

**Cost**  \$

**Therapy Mode \***

In person  Teletherapy

Date of Service / No Show    
dd-MMM-yyyy

*All claims for this SWF Referral must be within the selected month.*  
\*

Session Number

If this is a NS/CA, please use session 0.  
If this is for session 1, please upload the SWF ROI/Waiver below.  
\*

**Step 6:**

- Repeat step 5 for travel and input the address at the bottom of the pop-out page.
- Repeat step 5 for SIQ and upload the file directly into the pop-out page.
- Press "Done"

Upload Survey(s) if SIQ is selected above  

If you are submitting a claim for session 1 upload SWF ROI/Waiver of Liability  

If travel is selected above, input the address or school name of off-site-visit only. Must travel a minimum of 2 miles. No home therapy allowed.

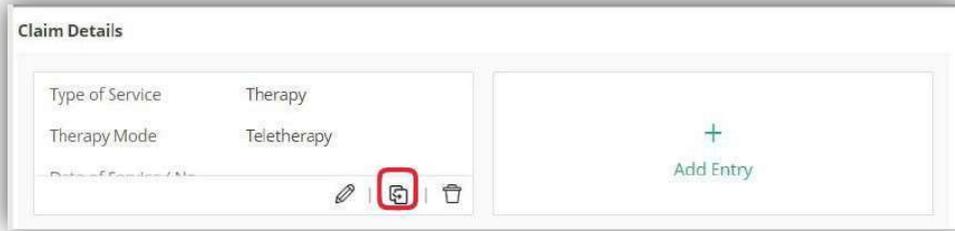
School Name

Street Address

City Zip Code

**Step 7:**

- Repeat steps 4-6 for all sessions in the same month as indicated on step 3.



**\*Helpful Tip\*** if you are submitting multiple claim details for the same month, you can also duplicate (circled in red) the claim detail and change the date and session number instead of selecting the green + button each time.

**Step 8:**

- If there are no more claims to submit for that referral for that month, you can move onto the bottom part of the page.  
**\*Reminder\*** If you are submitting for your first session with a SWF youth, **please make sure the SWF ROI/Waiver is uploaded to receive reimbursement.**
  - Select Reimbursement Option
    - Input your name
    - Organization (type N/A if not part of group practice)
  - Enter Provider's Email Address
  - Enter Provider's Phone Number
  - Enter Provider's Address (this address should match your W9)

Please select how you are reimbursed for services. \*

Organization/Practice Name

*If you are reimbursed using an EIN select organization. if you are reimbursed through your SSN select individual. If you are unsure look at the W9 submitted to SWF.*

Provider's Name \*

First Last

Organization Name \*

*If you are not part of an organization covered by a Services Agreement, please input N/A*

Provider's Email Address \*

Phone \*  -  -

### ### ####

Provider's Address \*

Street Address

Address Line 2

City State

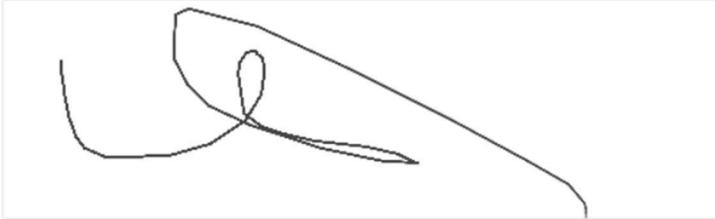
Zip Code

**Step 9:**

- Sign it and press Submit Claim.

If this claim includes **Session Number 1** for this referral please ensure you have uploaded the **SWF ROI/Waiver of Liability** in the claim details section! We are unable to pay claims until the completed ROI/Waiver is received.

**Provider's Signature \***



[Clear](#)

**Date \***



dd-MMM-yyyy

[Submit Claim](#)

**Step 10:**

- Complete steps 1-9 for the same referral but different months.
- Complete steps 1-9 for other SWF referrals.

If you have any questions, please email [program@thesecondwindfund.org](mailto:program@thesecondwindfund.org).