

2025 Release Notes

at Modified on 01/04/2026 5:53 pm EST

Release 15.25.0 - December 22, 2025

Resolutions

Resolutions

Claim Scrubbing: Copy Configuration Issue Corrected

We previously introduced an option within the Claim Scrubbing configuration screen that allows customers to set up or change their specialty to receive more tailored edits for their specific claims. Billing services, in particular, need to be able to use the Copy Configuration option to easily set up all of their customers' claim scrubbing configurations. However, when Copy Configuration was recently used, it was not copying correctly, and we were not setting up Aptarro submitters for any of the customers that had it enabled. In this release, we updated the claim scrubbing configuration window. When a specific specialty is selected, and then the "Copy Configuration" button is clicked, the system will display the selected specialty for each customer in the list. (The normal logic will be used to select a default specialty if one has not been chosen.) Additionally, when a configuration is copied, the system will register all necessary submitters with Aptarro.

Claim Scrubbing for Customer

i Usage of this feature will result in additional charges to your invoice. [Click here](#) for complete pricing information.

☒ Enable Claim Scrubbing

Claim Scrubbing Settings

Specialty

Multi-Specialty



[Change](#) Select your specialty to tailor Claim Scrubbing to your Practice

Automatically scrub new claims as they are entered?

☒ Yes ☐ No

Automatically scrub existing claims when coding changes are made?

☒ Yes ☐ No

Only perform automatic claim scrubbing for claims that contain more than one charge?

☐ Yes ☒ No

Exclude procedure codes marked as Retail or Other Medical from the code scrubbing process?

☐ Yes ☒ No

Save

Copy Configuration

Cancel

Interface Tracker: Not all Columns Visible at Minimum Resolution

We corrected an issue within Interface Tracker causing some columns not to be visible when the monitor was at minimum resolution. With this update, users can now horizontally scroll to see all columns on all supported browsers/screen resolutions.

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

Release 15.24.0 - December 8, 2025

Highlights

New Features

New WebAPI Endpoint to Allow Setting a Claim To a Specific Status

Enhancements

New New Payment Plan Auto Pay Report Fields
New Report Field for New or Changed Today Claims
Claim Frequency Reset Enhancement

New features

New WebAPI Endpoint to Allow Setting a Claim To a Specific Status

This release introduces a new endpoint for all WebAPI customers who create claims. This endpoint allows customers who integrate with our API and work outside our system to set claim statuses. They can set claims to any custom status and most standard statuses. Please note that Paid, Send to Insurance, User Print, and Delete statuses are not supported. This new claim status option is available to all WebAPI customers, allowing integration customers to send claims to specific status buckets for processing.

Claim Status Update

POST v1/customer/{custno}/claim/{claimID}/status

Parameter Name	Parameter Type	Description	Example	Required
customer	Path	The CollaborateMD customer number (always 8 digits)	10001001	Y
claim	Path	The CollaborateMD claim number	279068067	Y

Example Request

`https://webapi.collaboratemd.com/v1/customer/10001011/claim/279068067/status`

Request Details

Claim status update object fields are:

Status: Required. Must be either a single character representing a default CMD [status](#) or an 8-character string representing the sequence number of a custom status within the given customer.

Enhancements

New Payment Plan Auto Pay Report Fields

In this release, we added new report fields under "Payment Plan Data" to allow users to report on the status of payment plans that are on Auto Pay. We first added a new "**AutoPay Status**" field that will show one of the following statuses (also usable in a Filter):

- **Not Set Up:** If AutoPay has never been set up for this payment plan
- **Active:** If AutoPay is currently set up for this payment plan
- **Disabled:** If AutoPay had been set up but was disabled by a specific user
- **Failed:** If AutoPay failed for this payment plan

We also added report fields for:

- **AutoPay Enable User:** Will show "Patient" if the patient did it from the Portal
- **AutoPay Enable Date:** Date/Time it was enabled
- **AutoPay Disable User:** Will show "CollaborateMD" (rather than "AUTO_DEBIT") if the system disabled it
- **AutoPay Disable Date:** Date: Date/Time it was disabled

For more information visit our [Payment Plan Data Help Article](#).

Report Fields

Search for fields

>

Payer Agreement Data

>

Payer Data

>

Payment Plan Data

Patient ID

Plan ID

Auto Pay Disable User

Auto Pay Enable User

Auto Pay Status

Description

Is Payment Plan Overdue?

Name

Status

Auto Pay Disable Date

Auto Pay Enable Date

Available Credit Amt

Balance

Total Amount

Total Paid

New Report Field for New or Changed Today Claims

This release also brings a new report field within Claim Data, **'Claim New or Changed Today,'** that efficiently reports on claims and charges that were added or changed today. This allows you to get data specifically on claims that have been added or changed the current day, allowing users to get the claim information that has changed since the last snapshot without having to wait for the next days snapshot.

Visit our [Claim Data Help Article](#) for more information.

Report Fields

Search for fields

CLAIM NEW OR UPDATED TODAY

>

Claim Data

New or Updated Today

Claim Frequency Reset Enhancement

Previously, when resubmitting claims to the primary payer, staff manually reset the claim frequency to 1 after posting the ERA/EOB and before sending to the secondary payer. In this release, we updated the system so that when a professional claim's status changes to "Send to Insurance via Clearinghouse" or "User Print & Mail" through the ERA or EOB screens, the claim frequency automatically resets from 7 to 1 before sending the claim to the next payer.

Statement Vendor Change Configuration Warning

To facilitate the completion of our Statement Vendor migration to DataMedia (DMA), we added a non-dismissible message to the login screen. This message will appear for users with permission to edit statement templates on accounts where Statement Automation is enabled but not yet configured with the new statement vendor for any statement type. The warning will inform users that they must configure and verify the new statement template in their account to continue sending statements. It will also include a "Verify Templates" button, which will direct users to the configuration screen to complete the setup process.

CollaborateMD is transitioning to a new statement vendor, DataMedia (DMA). This change is part of our ongoing commitment to improve the clarity and reduce the costs of your patient statements. You must configure and verify your new statement templates in your account in order to continue sending statements.

At least one practice has templates that are still not configured to work with the new vendor. Please verify your templates now.

[Verify Templates](#)

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

Release 15.23.0 - November 24, 2025

[New features](#) | [Enhancements](#) | [Resolutions](#)

Highlights

New Features

New "Claims Not Acknowledged by the Clearinghouse" Timeline Item

Enhancements

New Option to Calculate With Fixed Values on Reports

New Follow Up Management Payment Columns

Payment Automations: Customize Denial Status

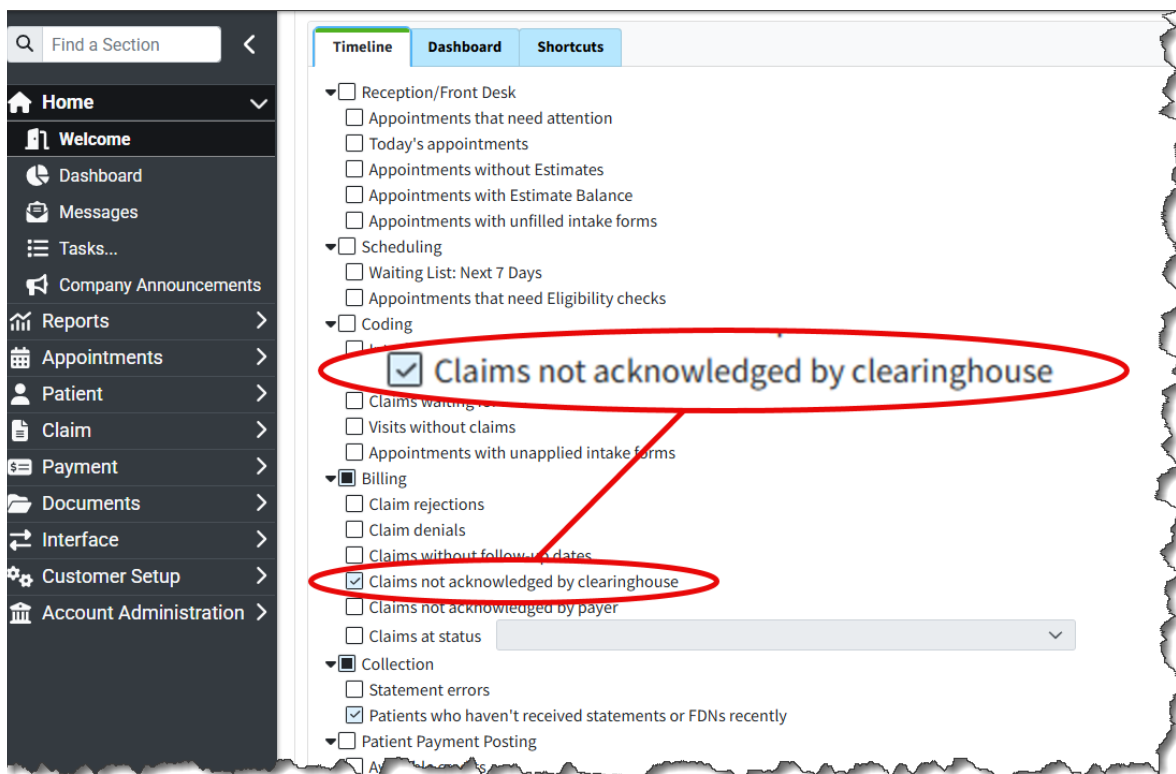
Incremental Snapshots Now Include Claim Status

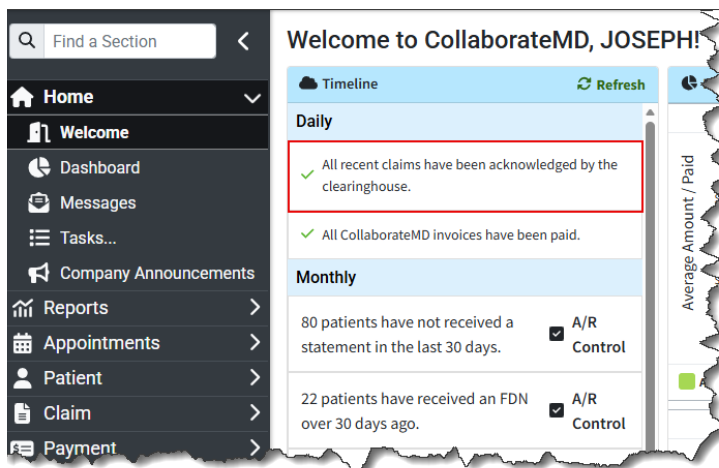
New features

New "Claims Not Acknowledged by the Clearinghouse" Timeline Item

This release introduces a new timeline item that checks for electronic claim submissions with an 'Unprocessed' status, submitted between 2 and 30 days prior. This new timeline item alerts users by identifying any claims not received by the clearinghouse. This enables users to quickly identify these claim and contact support to work with the clearinghouse to determine why they were not received. This new 'Claims Not Acknowledged by the Clearinghouse' timeline item will be displayed by default under the Billing role. It will also link to a "Claims Not Acknowledged by the Clearinghouse" report when clicked.

For more information on enabling this timeline item, visit our [Customize Your Timeline Help Article](#).





Enhancements

New Option to Calculate With Fixed Values on Reports

Previously, calculated columns on reports allowed users to select two numeric or date columns for calculations. However, certain reporting use cases require calculations based on a fixed number rather than another column. For instance, for some services, the number of units is a fraction of the time spent (e.g., each unit represents 15 minutes), so it can be useful to report on this.

In this release, we added a new option to both Column 1 and Column 2 for any calculated column with a "Number" calculation type. When "Fixed Value" is selected, a new option appears to enter the fixed value and choose the calculation method (Plus, Minus, Multiplied By, Divided, By). This field accepts a minimum value of -99,999,999, a maximum value of 99,999,999, and up to 10 decimal places.

New Calculated Column

Title

Calculation Type: ☒ Number ☐ Date

Column 1 Type

Fixed Value

Fixed Value 1

15.000

Calculation

Plus

Column 2 Type

Column

Column 2

Done

Cancel

For more information visit our [Add Calculated Columns Help Article](#).

New Follow Up Management Payment Columns

In this release, we added two optional columns to the follow-up management table, allowing users to view the total amount of applied payments. The new "Insurance Payment" and "Patient Payment" columns will be hidden by default and can be added using the "Select Columns" option or by right-clicking and selecting "Select Columns."

Select Columns

Available Columns

Last Note User +

First Billed Date +

Last Claim Status Check +

Insurance Payments +

Patient Payments +

Visible Columns

Checkbox

Alerts × ↓

Claim #

Balance

Patient Name

DOS

Done

Payment Automations: Customize Denial Status

In some cases, by the time users receive a denial, they have already addressed and resolved the issue. Therefore, it is not always helpful for the claims to automatically be marked as "Denied at Insurance." They may prefer to set their own custom status for these claims, for example, all issues with prior authorization could go to a specific status for review.

In this release, when the Processing Mode for a payment automation is set to either "Process as a Partial Denial" or "Process as a Total Denial," users will be able to select their own claim status, and when the automation runs for this Processing Mode, it will apply the selected status to the charges.

Please note that all existing automations with a "denied" status will be updated to set the claim status to "Denied at Remittance Payer," but the users are able to update the status as needed. For more information, visit our [Add a Payment Automation Help Article](#).

Incremental Snapshots Now Include Claim Status

One of the biggest tables for data snapshots is the Claim Status. In this release, we updated how we store the date when a claim status entry is marked as fixed or marked as not fixed to now support claim status on incremental snapshots. Incremental Data Snapshots minimize the time required for the snapshot process by including only changed items, rather than capturing a complete snapshot of the entire database daily. The Incremental Snapshot option exports smaller (incremental) files containing only data that has changed for the Patient, Claim, Charge, Credit, and Activity tables. All other datasets will receive the full data, ensuring your snapshot is prioritized and available sooner than full snapshots. So save time and money by switching to Incremental Snapshots today!

For more information on setting up your Incremental Snapshots, visit our [Manage Recurring Data Snapshots Help Article](#).

Resolutions

A/R Report Performance Improvements

We added an internal enhancement that allows AR reports (or any reports that look at charges with a balance) to run faster. This addresses performance issues with a long-running AR reports, enabling it to run within an acceptable timeframe.

Payment Automations: "All" Group Codes Now Includes Scenarios Where Group Code Isn't Listed

We corrected a Payment Automations issue where, if an automation was configured for all group codes (by selecting the "All" checkbox), the automation did not match when the code lacked a group code (e.g., a 197 remittance code without a group code like "CO"). This has been resolved, and the automation will now match even if no group code is present.

Therefore, if the automation is configured for all group codes, it will now match regardless of whether a group code exists.

Criteria

Remittance Codes

197 X

Group Codes

All ^

☒ Select All

☒ CO - Contractual Obligation

☒ OA - Other Adjustment

☒ PI - Payer Initiated Reduction

☒ PR - Patient Responsibility

Any v

As part of this release, we are continuing our ongoing work to assess, monitor, and address any security vulnerabilities.

Release 15.22.0 - November 10, 2025

Highlights

New Features

- New Intelligent Claim Rejections
- New Supervising Provider Default

Enhancements

- Incremental Data Snapshot Enhancements
- New Claim Type Column in Claim Control

New features

New Intelligent Claim Rejections

We previously released our "Intelligent Claim Rejections" feature, which we are systematically rolling out to more customers behind the scenes. We will complete a full roll out to all customers in the coming days. In this release, we are updating how rejection messages are shown in Claim Tracker to make them easier for customers to understand. If an intelligent claim rejection message is available, the confusing payer message will now be hidden by default and replaced with an AI-produced message that is easier for users to read, understand, and is better formatted. We also added extra space to the intelligent message so it is not confined to one line. Users can click "Show Details" to view the full list details of payer messages, if needed. Visit our [Track a Claim Help Articles](#) for more information.

Group By		Task Options		View Applied Filters		Expand	
(No Selection)							
<input type="checkbox"/> Claim # / TCN	DOS / Status Date	Patient / Status	Current Claim Status	Claim Amount / Billed Amount	Payer	Payer ID	Correl
<input type="checkbox"/> [REDACTED]	04/14/2025	REDACTED, REDACTED [REDACTED]	DELETED	\$0.00			
<input type="checkbox"/> [REDACTED]	10/21/2025	Submitted electronically		\$2,200.00	BLUE CROSS AND BLUE SHIEL...	TXBS	ab925f
<input type="checkbox"/>	10/22/2025	The billing NPI [REDACTED] is not registered with BCBS of Texas and is not authorized for the tax ID [REDACTED]. Contact BCBS to enroll the provider or verify credentials.			Show Details		

⚠ If you do not yet see intelligent claim rejections in Claim Tracker, we will be systematically rolling out this feature to all customers in the coming days.

New Supervising Provider Default

This release introduces a new patient claim default for customers who are required to bill with a supervising or operating provider. This automation enables users to set a default supervising provider on professional claims or an operating provider on institutional claims. Once configured, the system will automatically add the supervising/operating provider for claims entered manually in the application and for interface claims when a supervising/operating provider isn't sent over. For more information on enabling this default automation, visit our [Configure Patient Claim Defaults Help Article](#).

The screenshot shows the 'Patient Claim Defaults' configuration page for a patient named FOX MCCLOUD. The page is divided into several tabs: Patient Info, Insurance Info, Billing Info, and Claim Defaults. The 'Claim Defaults' tab is currently selected. Within this tab, there are several fields for setting defaults: Default Provider, Default Ordering Provider, Default Facility, Default Referring Provider, Default Sales Rep, and Supervising Provider. The 'Supervising Provider' field is highlighted with a red oval. A red arrow points from this field to the 'Supervising Provider' field in the 'Assignment' section at the bottom of the page. The 'Assignment' section also has a red oval around its 'Supervising Provider' field. The 'Supervising Provider' field in the 'Claim Defaults' section is currently empty, while the 'Default Provider' field is set to ABDUL, SAMANTHA L (10009890).

Search/Add FOX MCCLOUD X

Save Close Print Merge Eligibility Activity View All Appointments Show History

Last Name: MCCLOUD First Name: FOX MI Suffix: ☐ Make this patient inactive
Gender: Male Date of Birth: 09/23/1993 (32 y) Date of Death: SSN: ☐ Patient is complete

Patient Info Insurance Info Billing Info Claim Defaults

Default Provider: ABDUL, SAMANTHA L (10009890) [Search] [Add]

Hide Default Provider Details
NPI: 1346585296
Practice: ISOTOPE NUCLEAR MEDICINE - TEST (#1000599)
Office Location: ISOTOPE NUCLEAR MEDICINE - TEST 263 CENTRAL AVE [Dropdown]

Default Ordering Provider [Search] [Add]

Default Facility [Search] [Add]

Default Referring Provider [Search] [Add]

Default Sales Rep [Search] [Add]

Supervising Provider [Search] [Add]

Assignment
Assignment of Benefits

Enhancements

Incremental Data Snapshot Enhancements

This release introduces several enhancements to our Incremental Snapshots. Previously, our Incremental Recurring Data Snapshot feature produced a snapshot of all changes since the last recurring snapshot, typically one day. However, if users failed to download their incremental snapshot (e.g., due to system downtime), they would have to revert to a full snapshot.

In this release, when Incremental Snapshot is selected, we added the ability to specify the minimum number

of days to include in the incremental snapshot. The default will be one day, but the system will allow selection between one and seven days. This will include data that is new or has changed since the last recurring snapshot or within the selected number of days, whichever period is longer.

Recurring Data Snapshot for Account #462134 - CollaborateMD

ⓘ Usage of this feature will result in additional charges to your invoice. [Click here](#) for complete pricing information.

☒ Enable recurring (daily) data snapshots

Format
MySQL ▼ [Download Sample](#)

Incremental Snapshot ▼

Incremental Snapshot with data from the last 4 ⬆️⬆️ days

ⓘ [Click Here](#) for important information about incremental snapshots.

[View Audit History](#)

<input type="checkbox"/>	Customer #	Name
<input type="checkbox"/>	10028368	1BIOS INTERFACE TEST ACCOUNT
<input type="checkbox"/>	10004785	NOT USED - OLD QA
<input type="checkbox"/>	10006399	SALES DEMO 2009
<input type="checkbox"/>	10033727	SECOPS PENTEST ACCOUNT
<input type="checkbox"/>	10033728	BEST NOTES SECOND INTERFACE TEST ACCOUNT
<input type="checkbox"/>	10006872	***CLOSED*** **CLOSED*** CLAIMGEAR TRAINING 1
<input type="checkbox"/>	10032618	BIG WOO INTERFACE TEST ACCOUNT
<input type="checkbox"/>	10000000	SUPPLY TEST 123

Export multiple customers as
One File per Customer ▼

Save Cancel

Full Data Snapshots are typically delivered later in the day due to their large file size, which requires more time for download and integration into databases. In this release, a new warning message has been added for customers who select Full Snapshot as their recurring data snapshot option. This message informs them of the delivery implications and recommends choosing Incremental Snapshots to reduce file size and enable faster delivery. Consequently, users with incremental snapshots will receive their snapshots earlier in the day, as they will obtain a smaller file containing only new or changed data.

Recurring Data Snapshot for Account #462134 - CollaborateMD

Usage of this feature will result in additional charges to your invoice. [Click here](#) for complete pricing information.

☒ Enable recurring (daily) data snapshots

Format
MySQL
Download Sample

Full Snapshot

Choose Incremental Snapshots to reduce file size and enable faster delivery

[View Audit History](#)

<input type="checkbox"/>	Customer #	Name
<input type="checkbox"/>	10028368	1BIOS INTERFACE TEST ACCOUNT
<input type="checkbox"/>	10004785	NOT USED - OLD QA
<input type="checkbox"/>	10006399	SALES DEMO 2009
<input type="checkbox"/>	10033727	SECOPS PENTEST ACCOUNT
<input type="checkbox"/>	10033728	BEST NOTES SECOND INTERFACE TEST ACCOUNT
<input type="checkbox"/>	10006872	***CLOSED*** **CLOSED*** CLAIMGEAR TRAINING 1
<input type="checkbox"/>	10032618	BIG WOO INTERFACE TEST ACCOUNT
<input type="checkbox"/>	10004503	SYSTEM TESTING
<input type="checkbox"/>	10029111	DOCNOW INTERFACE TEST ACCOUNT
<input checked="" type="checkbox"/>	10029112	LEAPFROG BI INTERFACE TEST ACCOUNT

Export multiple customers as
One File per Customer

Save
Cancel

Previously, when customers set up recurring data snapshots, the system defaulted to a Full Snapshot, requiring them to manually select incremental snapshots from the available options. In this release, incremental Snapshots will become the default option for recurring data snapshots. This change is implemented because most customers primarily require incremental snapshots, which capture only changed items and offer a faster, more efficient solution. For more information visit our [Manage Recurring Data Snapshots](#) Help Article.

New Claim Type Column in Claim Control

A new column for the "Claim Type" has been added to the Claim Control table. This column will be hidden by default and can be accessed via the "Select Columns" option or the right-click "Select Columns" option. When added, this column will display the claim type as a visual identifier for customers who submit both professional and institutional claims.

Select Columns

Available Columns

Billing Provider +

Task Due Date +

Task Status +

Task Assign Date +

Task Assignee +

Claim Type +

Visible Columns

Check

Claim #

DOS

Current Payer

Patient

Review Status

Done

Resolutions

Added New Adjustment Action and Improved Overall Denial Processing Not Properly Reflected in Payment Automations

We resolved an issue that caused payment automation denials to not reflect properly. When processing a total or partial denial, several codes with a "Denied" action incorrectly displayed the adjustment action as "Do not Apply," even though the adjustment action should always be applied as an unpaid amount for partial or total denials. We also added a new adjustment action, "***Apply as an unpaid amount but exclude from allowed amount,***" to all automations. The existing action, "*Apply as an unpaid amount (due patient/next insurance),*" was updated to "***Apply as an unpaid amount and include in the allowed amount (due patient/next insurance),***" These updates ensure the Allowed Amount is set correctly and users can select a custom charge status when processing a denial.

Criteria

Remittance Codes

119 X

Group Codes

CO - Contractual Obligation

Payers

☒ Payer Types
 ☐ Specific Payers

Payer Action

All

Payment Amount

Any

Charge Amount

Any

Payer Types

All

Next Payer

All

Adjustment

Adjustment Method

Apply according to the payer's instructions

Apply according to the payer's instructions

Apply as an insurance adjustment

Apply as an unpaid amount but exclude from the allowed amount

Apply as an unpaid amount and include in the allowed amount (due patient/next insurance)

Apply as a payment

Don't apply

Add Issue

Release 15.21.0 - October 27, 2025

New features | Enhancements

Highlights

New Features	Enhancements
New Statement Vendor Change	ERA Secondary Claim Improvements

New features


New Statement Vendor Change

In this release, we will be transitioning to a new patient statement vendor, DataMedia (DMA), to enhance the customer experience and better serve your patients. This transition will occur behind a feature flag in

groups or waves, and customers will be notified when they have been switched to the new vendor. Once the feature flag is activated, your new statement template will be auto-filled based on your previous settings, requiring minimal effort for confirmation.

Please note that, at this time, the vendor change only applies to automated statements (statements, payment plans, and FDNs), not to enhanced user print statements.

The new statement templates will eliminate additional pages, making statements more concise and cost-effective. The new template also features a clearer statement activity listing, distinguishing charges, payments, and adjustments, and the balance for each individual charge. This new template will also separate insurance payments and adjustments, providing a clearer, more detailed, and organized statement at no additional cost, as the pricing for statement automation will remain the same.

 **Important** - Customers with automated statements enabled before the statement vendor change must complete the following after being transitioned to the new vendor:

- Configure your new statement templates (must be done for each practice).
- When opening the new templates, all required fields will be pre-populated from your previous template. However, the template still needs to be reviewed and saved.
- Please be aware that statements will not be sent until the templates are reviewed and saved.

Visit our [Configuring Statement Automations Demo](#) for an interactive, step-by-step demonstration on configuring your statement template, or refer to our [Configure Statement Automation Templates Help Articles](#) for more information.

STATEMENT

Your Logo
HereADD PRACTICE
1497 EAST HWY
ORLANDO FL 32811-1565

If you need to contact our Billing Department, please
call 800-555-2525 M-F 8AM-6PM or email us at
yourofficeemail@sample.com

JOHN PATIENT
123 MAIN ST
ANYTOWN US 12345-6789

COMPLETE AND RETURN IF PAYING BY CREDIT CARD



CARD NUMBER	SECURITY CODE
NAME ON CARD (PLEASE PRINT)	EXP. DATE
SIGNATURE	AMOUNT

STATEMENT DATE	ACCOUNT #	AMOUNT DUE
10/16/2025	10000001	\$110.00

MARK CHECK PAYABLE AND MAIL TO:

ADD PRACTICE
1497 EAST HWY
ORLANDO FL 32811-1565

DETACH FOR PORTION AND RETURN WITH PAYMENT IN ENCLOSED ENVELOPE

Date	Description	Charges	Payments	Adjustments	Balance
<i>Patient: JOHN PATIENT \ Account: 10000001</i>					
09/16/2025	OFFICE VISIT	\$400.00	\$200.00	\$100.00	\$100.00
10/09/2025	PAYMENT BY AETNA		-\$50.00		
10/09/2025	ADJUSTMENT BY AETNA			\$0.00	
10/09/2025	PAYMENT BY AETNA		-\$150.00		
10/09/2025	ADJUSTMENT BY AETNA			-\$100.00	
10/09/2025	DENIED BY AETNA		\$0.00		

Account Information

AMOUNT DUE

Total Charges:	\$430.00	\$110.00
Credits/Adjust:	\$100.00	
Ins Payments:	\$320.00	
Patient Payments:	\$0.00	
Patient Balance:	\$110.00	

Pay Online

www.paystatementonline.com
Account Number: 10000001
Or scan the QR code to the right.

SCAN FOR
MOBILE
PAYMENT



Payment is due upon receipt. Prompt payment is appreciated.
Thank you!

ADD PRACTICE
1497 EAST HWY
ORLANDO FL 32811-1565

Please see payment options below or call our Billing Department to make
payment arrangements.

ERA Secondary Claim Improvements

Previously, charges paid by the primary payer were not automatically forwarded to the secondary payer on ERAs/EOBs. This release improves the handling of charge statuses in ERA/EOB claims processing, ensuring all applicable charges are correctly sent to the subsequent insurance payer. With this update, if at least one charge in an ERA/EOB is to be sent to the next payer, then all charges will be forwarded to the next payer, and their status will not be set to PAID. We also made an update when reviewing big ERAs to prevent any browser "Out Of Memory" errors.

Release 15.20.0 - October 13, 2025

New features | Enhancements

Highlights

New Features	Enhancements
New Payment Automations	Remove All Option for Claim/Patient Not Found
New Statement Automation Option to Send Based on Days Since Last Seen	ERA Errors
New Admitting Diagnosis Default	Refund Reversals Removed from Statements
	New Automatic TCN Prefix (For ERA Splits)

New features

New Payment Automations Feature

In this release, we added an exciting feature that allows users to build powerful custom automations to prevent manual work for ERAs. They can be configured to perform actions automatically based on the remittance codes received from the payer. These automations replace our existing "Remittance Actions" and significantly enhance the feature by expanding the criteria that payment automations can detect and improving the actions that automation rules can perform.

Our new Payment automations allow you to automatically mark payments as denials and move adjustments so they do not affect the balance. You can also create your own rules and criteria for moving adjustments, control how adjustments are applied, set specific status buckets where claims need to go, or even create and assign automatic tasks based on a remittance code.

Please note that this feature is available to all customers that use our ERA feature. Visit our [Payment Automations Demo](#) for an interactive, step-by-step demonstration on its use, or refer to our [Payment Automations Help Articles](#) for more information.

Find a Section	Payment Automations					
Home	Edit + New Automation <input type="checkbox"/> Show inactive automations					
Reports	Name	Remittance Codes	Adjustment Method	Processing	Additional Actions	Created On
Appointments	109 - CO - Contractual Obligation	109	Don't apply	Process the payment as a total denial		Collaboration
Patient	QA218 - Automobile Medical	QA218	Apply according to the payer's instructions	Forward to the next insurance		Collaboration
Claim	100 - Medicaid	100	Apply according to the payer's instructions	Write off the charge's remaining balance		Collaboration
Payment	23 - Forward Converted Remittance Action	23	Apply according to the payer's instructions	Write off the charge's remaining balance		Collaboration
Documents	N545 - Forward Converted Remittance Action	N545	Apply according to the payer's instructions	Set a specific status		Collaboration
Interface	N545 - Commercial Insurance Company	N545	Apply according to the payer's instructions	Set a specific status		Collaboration
Customer Setup	197 - Forward Converted Remittance Action	197	Don't apply	Process the payment as a total denial		Collaboration
Practices	16 - CO - Contractual Obligation	16	Don't apply	Process the payment as a total denial		Collaboration
Providers	N545 Medicare	N545	Apply according to the payer's instructions	Set a specific status	<ul style="list-style-type: none"> Assign Task to joetest1 	Collaboration
Facilities	Apply As Adjustment	142, 227, 274	Apply as an insurance adjustment	Write off the charge's remaining balance		Collaboration
Referring Providers	Deny claims with denial remittance codes	10, 107, 108 ... +160 more	Apply as an unpaid amount (due patient/next insurance)	Process the payment as a partial denial		Collaboration
Payers	Forward claims based on remittance code	MA07, MA18, N367 ... +1 more	Apply according to the payer's instructions	Forward to the next insurance		Collaboration
Payer Agreements	Do not apply secondary adjustments	1, 100, 101 ... +128 more	Don't apply	Process according to the payer's instructions	<ul style="list-style-type: none"> Add Issue: Adjustments from the secondary payer were not applied. 	Collaboration
Collection Agencies	Default Automation	All Remittance Codes	Apply according to the payer's instructions	Process according to the payer's instructions		Collaboration
Codes...						
Alert Control						
Statements						
Superbills						
Labels						
Customization...						
Settings						
Account Administration						

New Statement Automation Option to Send Based on Days Since Last Seen

For some institutional claim workflows, a patient may be admitted to the hospital for a period during which the provider sends multiple "interim" claims while the patient is still admitted. These claims may be paid and set to "Balance Due Patient" even before discharge. Many practices and hospitals prefer not to send statements until after a patient has been discharged.

In this release, we added a new option to Statement Automation to restrict patient statements until a specified number of days have passed since the patient's last visit. This setting, located under "Statement Options," allows users to set a hold on statements for 1 to 99 days based on the patient's last visit date. The new option is turned off by default and is included with our Statement Automation feature. For more information on enabling this feature visit our [Statement Options Help Article](#).

Statement Automation Settings

Enable automated statement generation for the following:

- ☒ Statements
- ☒ Final Demand Notices (FDN)
- ☒ Payment Plans

Automated statements are sent to the printing company at 5:30 AM ET.

Statements and FDNs

Send statements electronically?

☒ Yes ☐ No

Send statements on paper after the maximum number of electronic statements have been sent?

- ☒ Yes. Send the first statement days after the last electronic statement was sent, or immediately if electronic statements cannot be sent. [?](#)
- ☐ No. Patients who can't receive electronic statements [?](#) will not receive statements automatically.

Statement Options

Electronic Statements

Paper Statements

Minimum amount required for sending Statements and FDNs:

☐ Wait to send statements until days since the patient's last visit. [?](#)

Automatically send FDN to patient after the maximum number of statements (both electronic and paper) have been sent?

☐ Yes ☒ No

Prevent statements from being sent to patients with any outstanding account credit(s) set to due insurance?

☒ Yes ☐ No

New Admitting Diagnosis Default

We previously added a new "Institutional" Default Codes tab within the patient's Claim Defaults section, allowing users to set default Principal Diagnosis, POA, Other Diagnosis, CPT Codes, or Value Codes to be added to any new institutional claim for the patient. We then added the admitting diagnosis default in release 15.18 but immediately reverted it to fix a bug. In this release, we re-launching the "Admitting Diagnosis" as a patient claim default for institutional claims. When the default admitting diagnosis is set and the user has enabled the claim setting to "automatically apply the patient's default diagnosis codes on new claims," the admitting diagnosis will automatically be set on new claims created for that patient. For more information on default codes, visit our [Configure Patient Claim Defaults Help Article](#).

The screenshot shows a medical software interface for a patient named JOHNNY TEST. The interface includes a sidebar with navigation options like Home, Reports, Appointments, Patient, and various management tools. The main area displays patient details and tabs for Patient Info, Insurance Info, Billing Info, and Claim Defaults. Under the 'Default Codes' tab, there are sections for Professional and Institutional codes. The 'Admitting Diagnosis' field is highlighted with a red circle. Below this, the 'Other Diagnosis' section contains a table with columns for Code and Description, and another 'Admitting Diagnosis' field is also highlighted with a red circle.

Enhancements

Remove All Option for Claim/Patient Not Found ERA Errors

When posting ERAs, particularly for new customers, the ERA may have a large number of "Claim Not Found" issues if the ERA has claims that were sent from different systems. Some of these ERAs are huge, meaning that it can take an hour just to mark all of these payments as removed.

In this release, we added a **"Remove All"** option next to the "Unresolved Errors" displayed at the top of the ERA screen. When unresolved errors of the type "the claim or patient for this payment was not found" are present, the system will display the "Remove All" button. Clicking this button will remove all such errors simultaneously instead of having to remove them one by one. Please note that this option will only be visible if two or more of these errors ("the claim or patient for this payment was not found") exist. All other error types must be resolved individually. Visit our [ERA Errors, Warnings, Informational Messages & Alerts](#) Help Article for more information on errors and warnings.

Refund Reversals Removed from Statements

Whenever an insurance adjudicates a claim multiple times (e.g., paying, adjusting, and then issuing a refund/reversal), it creates a longer, confusing statement for patients. To enhance the patient experience and reduce clutter, we are removing all refunds/reversals from enhanced, automated, and electronic statements (payment portal). The system will now automatically detect reversed payments and adjustments. When this occurs, the original payment and adjustment, along with any associated information lines, will be excluded from the statement.

New Automatic TCN Prefix (For ERA Splits)

Previously, the TCN Prefix field in the Practice section was used by ePS when an ERA Split was necessary. This was not ideal because a Practice can be associated with multiple Providers (and therefore multiple submitters), which required significant extra work (e.g., creating multiple practices) and could lead to errors.

In this release, we added a new "TCN Prefix" field within the "Internal Use" area of the "Provider" section. This field will show the Practice TCN Prefix (if one exists), otherwise, a system-generated prefix will be created. We will automatically send this submitter-specific TCN prefix for submitters who lack a Practice-level TCN Prefix when an ERA split is required. This means that when entering an ERA split, ePS will look up that submitter in CMD and copy the TCN Prefix. The system-generated prefix will be consistent for all providers sharing the same Submitter ID.

Display Follow Up Note Count on Claim Side-Tab Header

We added a "Follow-Up Note Count" indicator to the side-tab header within the claim's "Follow-Up Activity" side panel. This indicator mirrors the existing functionality on the top-level side-tab header for "Patient Notes," "Tasks," and "Alerts" when viewing a claim.

Release 15.19.0 - September 29, 2025

[New features](#) | [Enhancements](#)

Highlights

New Features

New Onboarding Process for "In-App Credit Card Processing" (Beta Release)

Enhancements

Charge Totals now Visible from the Payment Plans
EIN The Defaulted Option when Adding a New Provider

New features

New Onboarding Process for "In-App Credit Card Processing" (Beta Release)

Onboarding customers to our in-app payment processing feature was a time-consuming, multi-step process. It required close collaboration between our Strategic Customer Success team, the customer, and GPI to submit customer information to GPI, secure approval, and integrate credentials into CMD. This limited the speed and ease with which new customers could sign up or existing customers could add new merchant accounts.

This release introduces a new process enabling customers to complete and sign their entire application within CMD without additional intervention. This streamlined workflow allows users to sign up and immediately fill out the application directly from the Services section, with auto-filled data from their office information. A new multi-step dialog screen facilitates entering all required information and provides status updates for pending applications within the IPP Settings.

Please note that this is a BETA (limited) release and will soon be available to all customers Visit our [Manage In-App Credit Card Processing](#) Help Article for more information.

In-App Credit Card Processing: New Merchant Account Request

Step 1: Location Information

Select the practice to add as a merchant

TEST PRACTICE (10021129)

x

Q

Office Location

TEST PRACTICE 5716 GRAND CANYON DR

Location Contact Information

TEST PRACTICE
5716 GRAND CANYON DR
ORLANDO, FL 32810-5454
Phone: (659) 656-5989
**To make changes to the location information, go to the Practice Section*

Doing Business As (DBA) Name (if different)

Location Primary Contact

First Name

JOE

Last Name

TEST

Email Address

test@test.com

Cancel

Next

Enhancements

Charge Totals now Visible from the Payment Plans

Previously, the total charge balance was not included when viewing a payment plan. Ideally, this information should be available to visually match the total charge balance with the payment plan balance, ensuring all charges have been added. In this release, we added a column to the main Payment Plan screen displaying the total charges and total balance of charges to help users visually confirm that all charges have been included in the payment plan. We also added these two values to the "Edit Payment Plan" screen.

+ New Payment Plan

✕ Close

⌵ Create Task

Current Payment Plan Balance:

\$241.90

Charge Balance Due Patient:

\$381.35

Next Installment Due Date:

09/26/2025

Charge Balance Due Insurance:

\$10360.61

Next Installment Amount:

\$

Payment Plan Listing

☐ Show P

Previously Deleted Payment Plans

Payment Plan 01/26/2026 (Active)

✎ Edit

⋮ More

Amount: \$241.90

Create Date: 09/26/2025

Balance: \$241.90

Create User: josephmuniz

Installments

Due Date	Description	Amount	Balance	Status	Last Stmt Date
09/26/2025	Installment 1 of 5	\$48.38	\$48.38	Unpaid	
10/26/2025	Installment 2 of 5	\$48.38	\$48.38	Unpaid	
11/26/2025	Installment 3 of 5	\$48.38	\$48.38	Unpaid	
12/26/2025	Installment 4 of 5	\$48.38	\$48.38	Unpaid	
01/26/2026	Installment 5 of 5	\$48.38	\$48.38	Unpaid	

Charges

DOS	Claim #	CPT	Status	Amount	Balance
01/22/2020	134407986	008F	BALANCE DUE PATIENT	\$291.90	\$241.90

+ New Payment Plan

✕ Close

⌵ Create Task

Current Payment Plan Balance:

\$241.90

Charge Balance Due Patient:

\$381.35

Next Installment Due Date:

09/26/2025

Charge Balance Due Insurance:

\$10360.61

Next Installment Amount:

\$

Payment Plan Listing

☐ Show

Now Deleted Payment Plans

Payment Plan 01/26/2026 (Active)

✎ Edit

⋮ More

Amount: \$241.90

Charges: \$291.90

Create Date: 09/26/2025

Balance: \$241.90

Charge Balance: \$241.90

Create User: josephmuni

Installments

Due Date	Description	Amount	Balance	Status	Last Stmt Date
09/26/2025	Installment 1 of 5	\$48.38	\$48.38	Unpaid	
10/26/2025	Installment 2 of 5	\$48.38	\$48.38	Unpaid	
11/26/2025	Installment 3 of 5	\$48.38	\$48.38	Unpaid	
12/26/2025	Installment 4 of 5	\$48.38	\$48.38	Unpaid	
01/26/2026	Installment 5 of 5	\$48.38	\$48.38	Unpaid	

Charges

DOS	Claim #	CPT	Status	Amount	Balance
01/22/2020	134407986	008F	PAID	\$291.90	\$241.90

EIN The Defaulted Option when Adding a New Provider

When creating a new Provider (either in the Provider section or in the New Account Wizard), the "Use which ID number?" field previously defaulted to the SSN. However, most billing is now done under the EIN. In this release, we have set this field to default to "Employer Identification# (EIN)" in both the Provider section and the New Account Setup Wizard, as it is more commonly used than SSN billing.

✓ Save

✕ Cancel

⚙️ Configure Eligibility

Last

First

MI

Credentials

This provider is an: ☒ Individual ☐ Organization

NPI

Taxonomy Specialty

Sequence #

NEW

Reference #

Code

Billing Information

Practice for this provider

Bill claims under

SELF

Check eligibility under

SELF

Use which ID number?

Employer Identification# (EIN) ▼

Employer Identification # (EIN)

Bill as

Individual ▼

☐ Bill professional claims (CMS-1500)
 ☐ Bill institutional claim (CMS-1500)

New Patient # Column within Statement Tracker

A new column for "Patient #" has been added to Statement Tracker. This column will be hidden by default and can be accessed via the "Select Columns" option or the right-click "Select Columns" option. When added, this column will display the patient account number.

Select Columns

Available Columns

Task Due Date

+

Task Status

+

Task Assign Date

+

Task Assignee

+

Patient #

+

Visible Columns

Selected

Icon

Patient

Invoice #

Date

Amount

Done

Release 15.18.0 - September 15, 2025

New features | Enhancements

Highlights

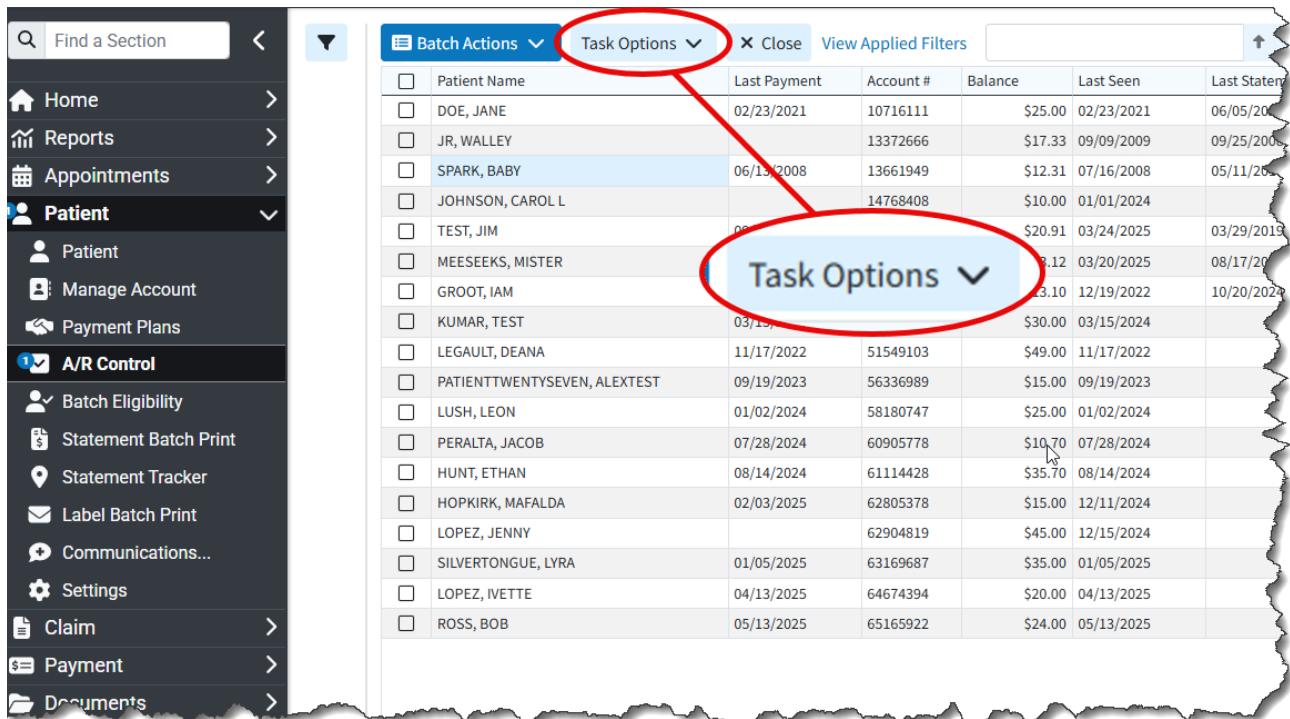
<div>New Features</div> <div>New Task Management in A/R Control</div>	<div>Enhancements</div> <div>New Admitting Diagnosis Default</div> <div>Duplicate Remittance Codes Now Allowed if Group Code is Different</div> <div>Custom Statuses Now Available as Report Filters</div>
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New features

New Task Management in A/R Control

We previously added the ability to add task reminders associated with specific records within more sections of the application (e.g., Claim Control, Claim Tracker, and Statement Tracker) to keep track of items that need to be completed. These tasks can have due dates, links, descriptions, statuses, and priorities, and can be assigned to yourself or to specific users/groups within your business. In this release, we added a new **"Task Options"** feature within the A/R Control section of the application. This feature allows users to create, manage, reassign, and delete tasks associated with a patient's A/R simply by

checking them off. These tasks can also be linked (batched) to multiple patients simultaneously. Please be aware that these task management options are available in Plan 3 and above. Visit our [A/R Control Task Options Help Article](#) for more information.



The screenshot displays the A/R Control interface. On the left is a sidebar with navigation options: Home, Reports, Appointments, Patient (selected), Patient, Manage Account, Payment Plans, A/R Control (selected), Batch Eligibility, Statement Batch Print, Statement Tracker, Label Batch Print, Communications..., Settings, Claim, Payment, and Documents. The main area shows a table of patients with columns: Patient Name, Last Payment, Account #, Balance, Last Seen, and Last Statement. A red circle highlights the 'Task Options' dropdown menu in the top right corner of the table. Another red circle highlights the 'Task Options' dropdown menu in the table's header row. The table contains 20 rows of patient data.

<input type="checkbox"/>	Patient Name	Last Payment	Account #	Balance	Last Seen	Last Statement
<input type="checkbox"/>	DOE, JANE	02/23/2021	10716111	\$25.00	02/23/2021	06/05/2021
<input type="checkbox"/>	JR, WALLEY		13372666	\$17.33	09/09/2009	09/25/2009
<input type="checkbox"/>	SPARK, BABY	06/13/2008	13661949	\$12.31	07/16/2008	05/11/2008
<input type="checkbox"/>	JOHNSON, CAROL L		14768408	\$10.00	01/01/2024	
<input type="checkbox"/>	TEST, JIM			\$20.91	03/24/2025	03/29/2019
<input type="checkbox"/>	MEESEKES, MISTER			\$9.12	03/20/2025	08/17/2025
<input type="checkbox"/>	GROOT, IAM			\$3.10	12/19/2022	10/20/2022
<input type="checkbox"/>	KUMAR, TEST	03/15/2024		\$30.00	03/15/2024	
<input type="checkbox"/>	LEGAULT, DEANA	11/17/2022	51549103	\$49.00	11/17/2022	
<input type="checkbox"/>	PATIENTTWENTYSEVEN, ALEXTES	09/19/2023	56336989	\$15.00	09/19/2023	
<input type="checkbox"/>	LUSH, LEON	01/02/2024	58180747	\$25.00	01/02/2024	
<input type="checkbox"/>	PERALTA, JACOB	07/28/2024	60905778	\$10.70	07/28/2024	
<input type="checkbox"/>	HUNT, ETHAN	08/14/2024	61114428	\$35.70	08/14/2024	
<input type="checkbox"/>	HOPKIRK, MAFALDA	02/03/2025	62805378	\$15.00	12/11/2024	
<input type="checkbox"/>	LOPEZ, JENNY		62904819	\$45.00	12/15/2024	
<input type="checkbox"/>	SILVERTONGUE, LYRA	01/05/2025	63169687	\$35.00	01/05/2025	
<input type="checkbox"/>	LOPEZ, IVETTE	04/13/2025	64674394	\$20.00	04/13/2025	
<input type="checkbox"/>	ROSS, BOB	05/13/2025	65165922	\$24.00	05/13/2025	

Enhancements

New Admitting Diagnosis Default

We previously added a new "Institutional" Default Codes tab within the patient's Claim Defaults section, allowing users to set default Principal Diagnosis, POA, Other Diagnosis, CPT Codes, or Value Codes to be added to any new institutional claim for the patient. In this release, we added the "Admitting Diagnosis" as a patient claim default for institutional claims. When the default admitting diagnosis is set and the user has enabled the claim setting to "automatically apply the patient's default diagnosis codes on new claims," the admitting diagnosis will automatically be set on new claims created for that patient. For more information on default codes, visit our [Configure Patient Claim Defaults Help Article](#).

Find a Section

Search/Add JOHNNY TEST

Save Close Print Merge Eligibility Activity View All Appointments Show History More

Last Name: TEST First Name: JOHNNY MI Suffix

Gender: Male Date of Birth: 01/16/1982 (43 y) Date of Death: SSN: 581-55-8885

Make this patient inactive Patient is complete

Patient Info Insurance Info Billing Info Claim Defaults

Default Codes

Professional Institutional

POA

Principal Diagnosis

Admitting Diagnosis

Other Diagnosis

Code	Description
Q	
Q	
Q	
Q	
Q	
Q	
Q	
Q	
Q	
Q	

Duplicate Remittance Codes Now Allowed if Group Code is Different

Previously, the system prevented adding duplicate adjustment codes on manual insurance payments. In this release, we updated the duplicate checking of remittance codes on insurance payments to account for differing group codes (e.g., OA-109 and PR-109). If a group code is present, the system will prevent a new code entry if that code already exists within the same group or without a group. However, entry is permitted if the group code is different.

Search **Payment from UNITED HEALTHCARE** X

Done Cancel Activity Actions Options

Payment - Check from UNITED HEALTHCARE received on 03/02/2017 for ADAMS, SAMUEL J (#10238335)

Claim # 93707879 | Rendering HOWSER, DOUGLAS MD

Action TCN

Processed (User) Sent to (paper) on 03/02/2017 (#697116867)

Status SEND TO UNITED HEALTHCARE VIA CLEARINGHOUSE Claim Control / Original Ref. #

DOS	Proc	Amount	Start Balance	Allowed	Paid	Remarks	Adj. Reasons	Adjusted	Unpaid Reasons	Unpaid	Deductible	Status
03/02/2017	99212	\$250.00	\$250.00	150.00	100.00		CO-45 X	100.00	PR-45 X QA-45 X	0.00	0.00	SEND TO UNITED ...
03/02/2017	0030T	\$50.00	\$50.00	0.00	0.00			\$0.00		\$0.00	0.00	SEND TO UNITED ...
03/03/2017	99212	\$44.00	\$44.00	0.00	0.00			\$0.00		\$0.00	0.00	SEND TO UNITED ...
03/03/2017	0030T	\$0.00	\$0.00	0.00	0.00			\$0.00		\$0.00	0.00	SEND TO UNITED ...
Total:		\$344.00	\$344.00	\$150.00	\$100.00			\$100.00		\$0.00	\$0.00	

Apply Discount Payment Memo
PAYMENT BY UNITED HEALTHCARE

Apply Credit Adjustment Adjustment Memo
ADJUSTMENT BY UNITED HEALTHCARE

Apply Debit Adjustment

Apply Account Credit (\$20.00) This charge uses the claim-level memo line.

Use Unapplied Copy

Custom Statuses Available as Report Filters

We added support to allow default filter selections and static filter selections on reports to work with custom statuses. This means that when selecting "Claim Status" as a filter on a report, you will be able to select from both standard and custom claim statuses as options for static or default filters.

Find a Section <

Save Cancel

Title Description

Category Claim Reports

Report Fields

Search for fields CLAIM STATUS

Columns

TCN

Activity Claim ID

Claim Activity Patient ID

Claim Submitted Date

Claim From Date

Patient Full Name

Groups

Drag & drop fields here to add report groups

Customer Field

Default Filter Value Selection

Search for charge statuses

- ☐ Rejected At Clearinghouse
- ☐ Rejected At Insurance
- ☐ Denied At Insurance
- ☐ Appeal At Insurance
- ☐ Incomplete
- ☐ On Hold
- ☐ Pending Patient
- ☐ Pending Physician
- ☐ Paid
- ☐ User Print & Mail To Insurance
- ☐ Collection
- ☐ Deleted
- ☐ Test Claim Status
- ☐ Hold For Patient
- ☐ Pending Review

Select All or None

Done Cancel

New features | Enhancements

Highlights

New Features

New Statement Option for Continuing Visits
New "Card on File" Indicator when Posting Payments
ANSI (837) Import via WebAPI

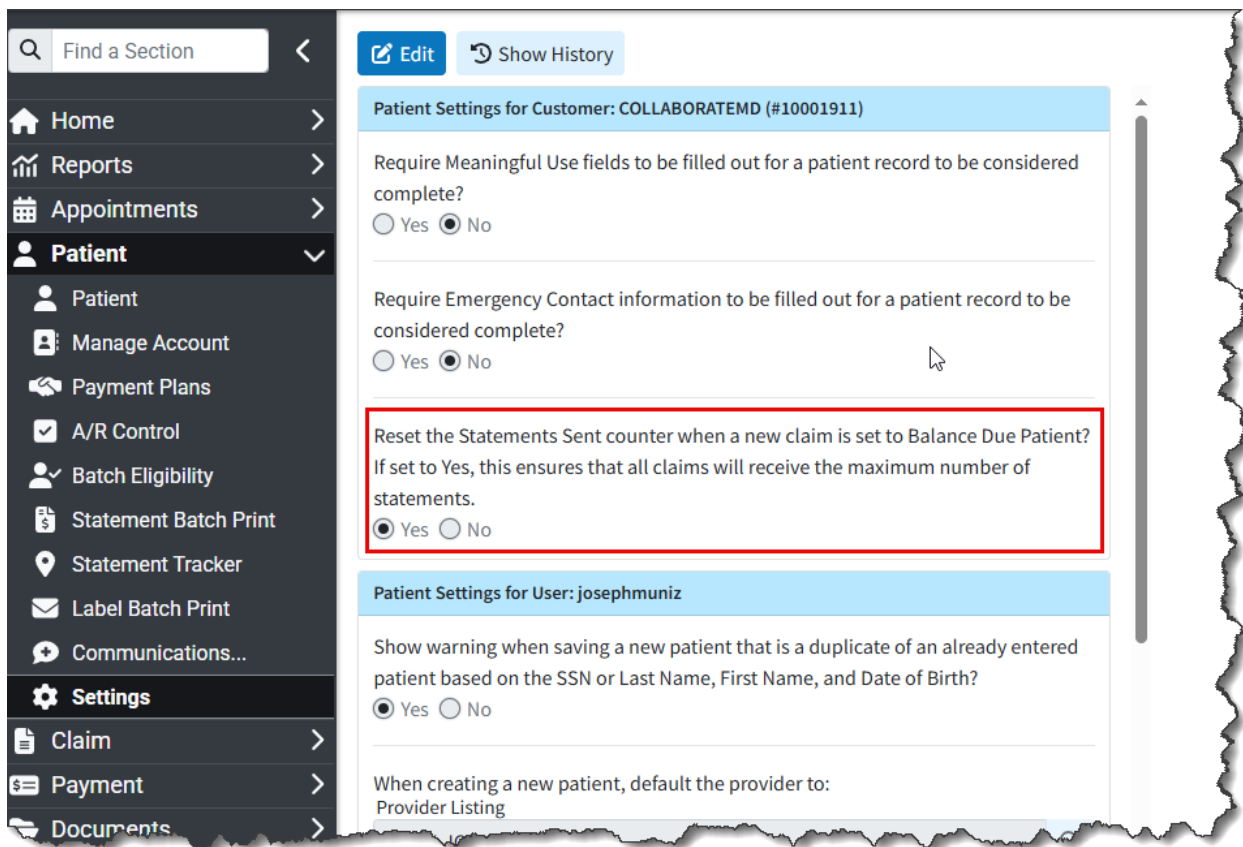
Enhancements

"Tracking" Tasks Enhancement

New features

New Statement Option for Continuing Visits

CollaborateMD's Statement Automation has always allowed setting a maximum number of statements threshold, ensuring patients receive one only if their statement count is below this limit. However, this was not very effective for institutional inpatient, long-term care, or physical therapy settings, where numerous claims are billed in a short period of time. Consequently, if a patient failed to pay initial claims, they would not receive statements for subsequent ones. To accommodate these use cases, we added a new setting that will reset the "Number of Statements Sent" counter when a balance is newly set to "Due Patient." When set to "Yes," this new patient setting will reset the patient's "Statements Sent" counter to 0 when a claim is changed from another status to "Balance Due Patient" for the first time. For more information, visit our [Configure Patient Settings for Customer Help Article](#).



New "Card on File" Indicator when Posting Payments

We added a new indicator to show if a patient has a credit card on file when using the In-App Payment Processing feature. If the "save payment information for next time" checkbox is selected, users will see the saved card(s) at the bottom of the payment screen. This is viewable when posting a payment from the Payment Post, Claim Payment tab, or Appointment Scheduler Payment tab.

New Payment

Credit Account (Apply Later)

Apply Automatically ▼

Apply Manually ▼

Clear Payment

☒ Patient Payment
 ☐ Insurance Payment

Patient

MCCLLOUD, FOX (25017512)

x

Q

Payment Amount

20.00

☐ Send Receipt

Received/Check Date

08/27/2025

Deposit Date

08/27/2025

Check #

Type

☐ Copay

☒ Payment

Source

☐ Check

☐ Cash

☒ Credit Card

Other ▼

Merchant Account

SecOps Testing ▼

Credit card information (card #, expiration date, etc) will be collected when saving the payment.

VISA

Credit Card is on file: Visa Card ending in 1111 (expires 5/26)

Memo

PATIENT PAYMENT - CREDIT CARD

ANSI (837) Import via WebAPI

We added the ability to import ANSI (837) files via new WebAPI endpoints, a feature previously exclusive to the Interface File Import. This enhancement also includes support for the "View Message Content" option within the interface tracker for ANSI 837 files from both API and File Import, enabling users to identify matching fields and better understand issues and errors.

	▶	Success	08/26/2025 08:08:33 PM	CLAIM
	▶	Success	08/26/2025 08:08:32 PM	CLAIM
<input type="checkbox"/>	▶	Warning	08/26/2025 08:08:31 PM	CLAIM
<input type="checkbox"/>	▼	Warning	08/26/2025 08:08:30 PM	CLAIM
		INFC	Copy	Patient: ()
		WAR	Mark as Fixed	atch the given payer to a n
		WAR	View Message Content	; not found. Both the Patien
		INFC	Open Patient	ID:272505668
	▶	Success	08:28 PM	CLAIM
	▶	Success	08:26 PM	CLAIM
	▶	Success	08:24 PM	CLAIM
	▶	Success	08:22 PM	CLAIM
<input type="checkbox"/>	▶	Warning	08/26/2025 08:08:21 PM	CLAIM
<input type="checkbox"/>	▶	Warning	08/26/2025 08:08:19 PM	CLAIM

For more information how to view the 837 message content, visit our [Retrieve Interface Messages Help Article](#).

Enhancements

Tracking Tasks Enhancement

We recently added new task types for Statement Tracking and Claim Tracking. In this release, we updated the "Create Task" right-click option for consistency with task options in corresponding locations. These task types will now be used when creating tasks via the right-click option (this means that Claim Tracking now creates a claim tracking task & Statement Tracking now creates a statement task).

▶	<input type="checkbox"/>	239111944	07/16/2024	REDACTED, REDACTED (#37190993)	SEND TO AMERIC
▶	<input type="checkbox"/>	242777502	08/30/2024	REDACTED, REDACTED (#37190993)	SEND TO AMERIC
▼	<input type="checkbox"/>	246654189	10/18/2024	REDACTED, REDACTED (#62097812)	ON HOLD
▶	<input type="checkbox"/>	131		ed by user	
	<input type="checkbox"/>	129	Copy	: Submitted electronically	
	<input type="checkbox"/>	129	Open Patient	: Submitted electronically	
	<input type="checkbox"/>	128	Open Claim	: Submitted electronically	
	<input type="checkbox"/>	129	Create Task	: Submitted electronically	
	<input type="checkbox"/>	129	Find Payer Batch Reports	: Submitted electronically	
	<input type="checkbox"/>	128	View Claim	: Submitted electronically	
	<input type="checkbox"/>	129	Print Proof of Timely Filing Letter	: Submitted electronically	
	<input type="checkbox"/>	129	Print Appeal Letter	: Submitted electronically	
	<input type="checkbox"/>	1289531952	01/04/2025	(Test): Submitted electronically	
	<input type="checkbox"/>	1294928344	01/19/2025	(Test): Submitted electronically	
	<input type="checkbox"/>	1295365969	01/20/2025	(Test): Submitted electronically	

Appointment Text Improvements

Updated the appointment text messages so that when users click "Confirm" or "Cancel" it now requires an additional button press. This will prevent accidental confirmations or cancellations from text message previews on some smartphones.

Release 15.16.0 - August 18, 2025

[New features](#) | [Enhancements](#)

Highlights

New Features	Enhancements
Post Payments and Copays from Practice Fusion	Enhancements to Claim Tasks
New Timeline Option for Due and Overdue Tasks	
New Dynamic Support PIN	

New features

Post Payments and Copays from Practice Fusion

We added support for transmitting and posting payments and copayments applied in PracticeFusion to the claim in CMD after the claim has been created, based on information received from PF. Now, if "copay" is selected in PF, it is posted as a copay credit in CMD and can be applied automatically based on your copay settings. If "Payment on account" is selected, it will be posted as an account credit in CMD, reducing the manual work required to post these payments. A new Interface Setting has also been created that will allow these payments to transmit to CMD. This new "Allow interface to post Payments?" setting is enabled by default but can be disabled manually. For more information, visit our [Manage PF Payments & Copays Help Article](#).

Find a Section

Home >

Reports >

Appointments >

Patient >

Claim >

Payment >

Documents >

Interface >

Interface Tracker

Import

Settings

Customer Setup >

Account Administration >

✓ Save X Cancel ↺ Show History

PRACTICEFUSION Interface Settings

Interface Status
Active ▾

Allow interface to update existing patient information (address, insurance info, etc)?
New patients will still be created as needed regardless of this setting.
☒ Yes ☐ No

Allow interface to archive patient insurance information? Insurance information will still be updated as needed regardless of this setting.
☐ Yes ☒ No

Allow interface to receive Appointments? If disabled, appointment messages will not be processed and will not appear in Interface Tracker.
☒ Yes ☐ No

Allow interface to post payments?
☒ Yes ☐ No

Time Zone (For Appointments)
Eastern ▾

Practice Fusion Practice GUID

Set charges pricing based on whether received in message? By default, the

New Timeline Option for "Due and Overdue" Tasks

Two new Timeline items have been added to the Welcome Screen, that will provide all due and overdue tasks for the day. The new "**Overdue Tasks**" and "**Tasks Due Today**" options are automatically displayed for users with the Management role. Other users, or those with custom welcome screens, can manually select these options. When selected, the Task Search report will automatically apply the appropriate filters and pull up the report displaying all the due or overdue tasks for the day. For more information on adding these timeline options, visit our [Customize Your Timeline](#) Help Article.

▼ ☐ Reception/Front Desk

- ☐ Appointments that need attention
- ☐ Today's appointments
- ☐ Appointments without Estimates
- ☐ Appointments with Estimate Balance
- ☐ Appointments with unfilled intake forms

▼ ☐ Scheduling

- ☐ Waiting List: Next 7 Days
- ☐ Appointments that need Eligibility checks

▼ ☐ Coding


- ☐ Interface errors
- ☐ Incomplete claims
- ☐ Claims waiting for review
- ☐ Visits without claims
- ☐ Appointments with unapplied intake forms

▼ ☐ Billing

- ☐ Claim rejections
- ☐ Claim denials
- ☐ Claims without follow-up dates
- ☐ Claims not acknowledged by payer
- ☐ Claims at status ▼

▼ ☐ Collection

- ☐ Statement errors
- ☐ Patients who haven't received statements or FDNs recently

▼ ☐ Patient Payment Posting 

- ☐ Available credits

▼ ☒ Accounting

- ☐ Open charges set to PAID
- ☒ Invoice due
- ☒ Run reports [Configure](#)
- ☐ Hard close Quarterly ▼

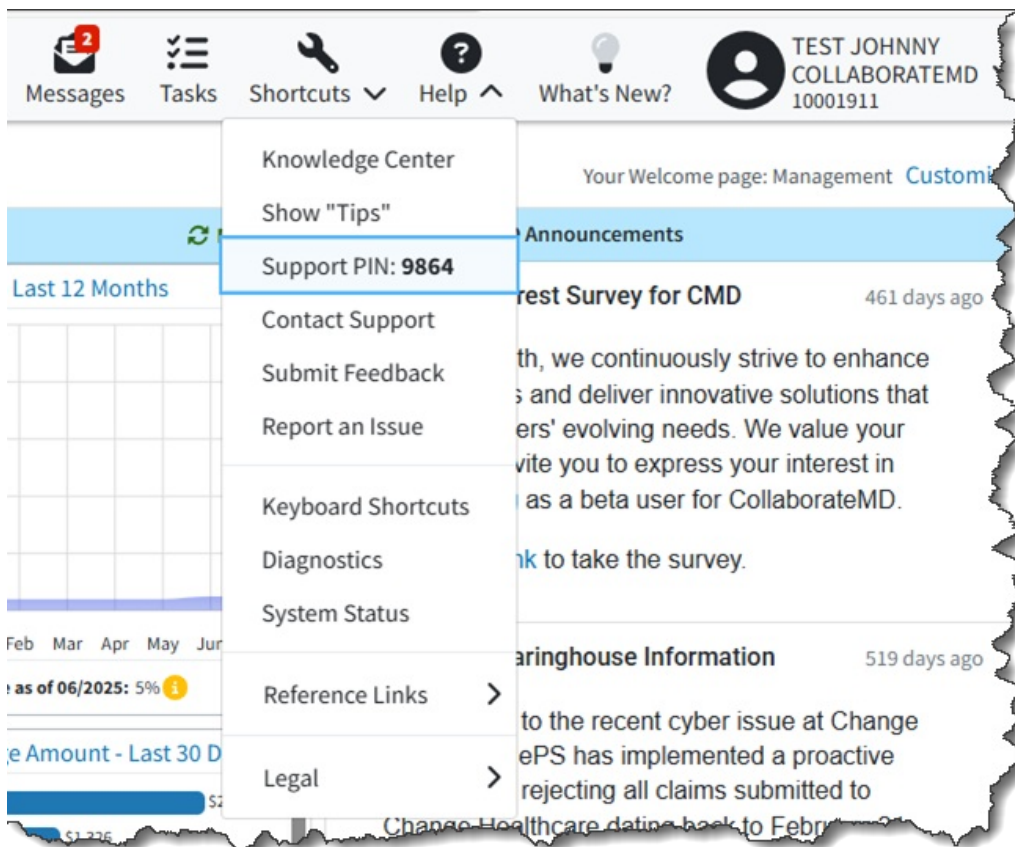
▼ ☒ Tasks

- ☒ Overdue Tasks
- ☒ Tasks Due Today

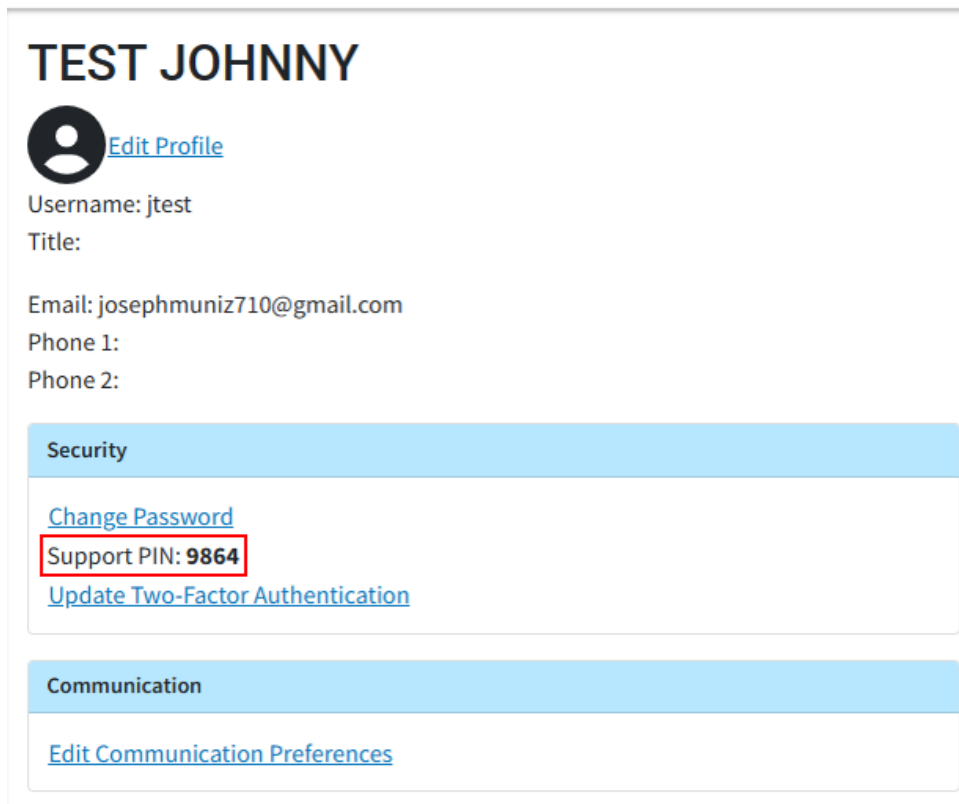
New Dynamic Support PIN

We added a new auto-generated user-level dynamic PIN within the application in order to meet all HIPAA & RA requirements. This Dynamic Support PIN must be provided by users to validate their identity when contacting support via phone or live chat, and will automatically reset every 30 days or when verified by support. You can access your Support PIN two different ways:

1. Locate your Support PIN by going to "Help" in the User Bar and selecting "Show Support PIN."



2. Alternatively, you can access it by navigating to your User Profile and selecting "Show Support PIN.".



For more information visit our [Show Support PIN](#) Help Article.

Default Value Codes by Revenue Codes

A new Claim Defaults tab has been added to the Revenue Codes screen, enabling users to set a default Value Code for claims based on the revenue code. Once configured within a Revenue Code, the selected Value Codes are automatically added to claims utilizing that revenue code. This functionality applies to claims entered in CMD as well as interface claims. For more information on enabling this default, visit our [Revenue Codes Claim Defaults Help Article](#).

Revenue Code

✓ Save

✕ Close

🕒 Show History

Code

0901

☐ Make this code inactive

Price

0.00

☐ Exclude this code from duplicate service checks

Description

BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X AN EXTENSION OF 090X) - ELECTROSHOCK TREATMENT

81 characters left.

Statement Options

Statement Description

> Fee Schedules

✓ Claim Defaults

Default Value Codes

Code	Amount	Description
10	Q 25.00	Lifetime Reserve Amount in the Second Calendar Year
32	Q 15.00	Multiple Patient Ambulance Transport
	Q 0.00	

Default Diagnosis Codes by Procedure

We also added a new option to the Procedure Codes screen that allows users to set default diagnosis code for claims based on the procedure code. The new Diagnosis Codes field within the Procedure Codes section allows users to enter diagnosis code(s), ensuring that when a procedure code is entered on a claim, the related diagnosis will populate automatically. For more information on enabling this default, visit our [Add CPT/HCPCS Codes Help Article](#).

Procedure Codes

✓ Save

✕ Close

↺ Show History

Modifiers

Global 1



Global 2



Global 3



Global 4



+ Create situational modifiers

Diagnosis Codes

ICD #1

A02.24



ICD #2



ICD #3



ICD #4



Billing Alerts

Global Surgery Period



Default (0 days)



Same or Similar Codes



Codes

Period

Delete

+ Add New Same/Similar Code List

Enhancements

Enhancement to Claim Tasks

We added the ability to filter tasks associated with claims via a new dropdown from the "Tasks" side-bar. There are 3 different claim tasks that are created in the application:

- **Claim Tasks:** Tasks created in the Claim section
- **Follow Up Tasks:** Tasks created in the Follow Up Management section
- **Submission Tasks:** Tasks created in the Claim Tracker section

This new dropdown allows users to filter their tasks in the Follow Up Management and Claim sections by *Claim Tasks*, *Follow Up Tasks*, or *Claim Submission Tasks* allowing you to manage all 3 from the same screen. Your task type preferences will then be remembered for each section when opened in the future.

> Claim Summary

> Estimate

> Patient Notes

> Follow Up Activity

> Alerts

▼ Tasks

+ Create Task

☐ Show Completed Tasks

Claim Tasks ^

☐ Select All

☒ Claim Tasks

☐ Follow-Up Tasks

☐ Submission Tasks

> Documents

> Payment

Release 15.15.0 - August 4, 2025

New features | Enhancements

Highlights

New Features	Enhancements
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New Features

Task Management for Statements
New Post Only Payment Permission
New Payer-Level Authorization Billing Alert

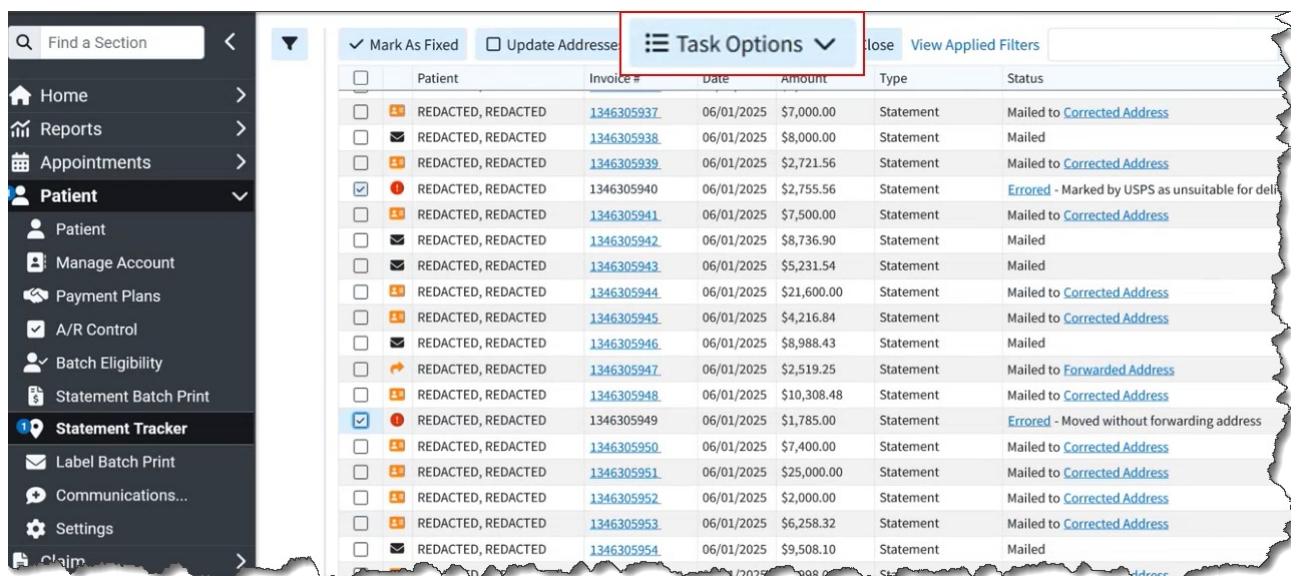
Enhancements

AR Aging By Net Amount
New Electronic Statements Report Fields

New features

Task Management for Statement Tracker

As part of our Task workflow improvements project, we added the ability for users to create and manage Patient Tasks based on specific statements within Statement Tracker. Similar to previous enhancements that added tasks to Claim Tracker, Claim Control, and Follow-Up Management, this enhancement allows customers to track statements requiring attention. These tasks include due dates, links, descriptions, statuses, and priorities, and can be assigned to individuals or specific user groups within your organization. Please note that some task management options are exclusive to Plan 3 and above. For more information, visit our [Add a Diagnosis Code Help Article](#)



<input type="checkbox"/>	Patient	Invoice #	Date	Amount	Type	Status
<input type="checkbox"/>	REDACTED, REDACTED	1346305937	06/01/2025	\$7,000.00	Statement	Mailed to Corrected Address
<input type="checkbox"/>	REDACTED, REDACTED	1346305938	06/01/2025	\$8,000.00	Statement	Mailed
<input type="checkbox"/>	REDACTED, REDACTED	1346305939	06/01/2025	\$2,721.56	Statement	Mailed to Corrected Address
<input checked="" type="checkbox"/>	REDACTED, REDACTED	1346305940	06/01/2025	\$2,755.56	Statement	Errored - Marked by USPS as unsuitable for delivery
<input type="checkbox"/>	REDACTED, REDACTED	1346305941	06/01/2025	\$7,500.00	Statement	Mailed to Corrected Address
<input type="checkbox"/>	REDACTED, REDACTED	1346305942	06/01/2025	\$8,736.90	Statement	Mailed
<input type="checkbox"/>	REDACTED, REDACTED	1346305943	06/01/2025	\$5,231.54	Statement	Mailed
<input type="checkbox"/>	REDACTED, REDACTED	1346305944	06/01/2025	\$21,600.00	Statement	Mailed to Corrected Address
<input type="checkbox"/>	REDACTED, REDACTED	1346305945	06/01/2025	\$4,216.84	Statement	Mailed to Corrected Address
<input type="checkbox"/>	REDACTED, REDACTED	1346305946	06/01/2025	\$8,988.43	Statement	Mailed
<input type="checkbox"/>	REDACTED, REDACTED	1346305947	06/01/2025	\$2,519.25	Statement	Mailed to Forwarded Address
<input type="checkbox"/>	REDACTED, REDACTED	1346305948	06/01/2025	\$10,308.48	Statement	Mailed to Corrected Address
<input checked="" type="checkbox"/>	REDACTED, REDACTED	1346305949	06/01/2025	\$1,785.00	Statement	Errored - Moved without forwarding address
<input type="checkbox"/>	REDACTED, REDACTED	1346305950	06/01/2025	\$7,400.00	Statement	Mailed to Corrected Address
<input type="checkbox"/>	REDACTED, REDACTED	1346305951	06/01/2025	\$25,000.00	Statement	Mailed to Corrected Address
<input type="checkbox"/>	REDACTED, REDACTED	1346305952	06/01/2025	\$2,000.00	Statement	Mailed to Corrected Address
<input type="checkbox"/>	REDACTED, REDACTED	1346305953	06/01/2025	\$6,258.32	Statement	Mailed to Corrected Address
<input type="checkbox"/>	REDACTED, REDACTED	1346305954	06/01/2025	\$9,508.10	Statement	Mailed

We also added a new "Statement" Task Type that allows users to specifically search for statement tasks. For more information, visit our [Statement Tracker Task Options Help Article](#)

The screenshot shows a web application interface. At the top, there is a 'Customer' section with a dropdown menu currently set to 'All Customers'. To the right of this are two buttons: 'Advanced Search' and 'Show Tasks for Others'. Below the 'Customer' section, there is a search bar labeled 'Task Title or Description'. Underneath the search bar is a dropdown menu titled 'Task Linked To'. This menu is open, showing a list of options: 'All', 'Claim (including Claim Follow Ups)', 'Claim Tracker', 'Patient', 'Appointment', 'Statement', 'Payer', and 'Facility'. The 'Statement' option is highlighted with a red rectangular border. The entire interface is presented on a background that looks like a piece of torn paper.

New "Post Only" Payment Permission

Some larger practices or billing services allow certain users to collect patient payments but want to restrict their ability to choose which charges to apply them to. In this release, we added a new **"Post Only"** level to the existing **Patient Payments** permission, that will allow the user to post new payments as credits but will prevent them from being able to apply payments, account credits, discounts, or credit/debit adjustments. We also renamed the existing **"Allow"** level for this permission to **"Apply"** which will still allow users to post patient payments and apply discounts, credit/debit adjustments, and account credits.

Permissions

COLLABORATEMD

☐ Assign to an existing permission role

Select a role

☒ Set custom permissions

Search for permissions

Select Category to View Permissions

Payment

☐ Show Permission Descriptions

Patient Payments	Post Only	
Insurance Payments	Deny	
ERA Auto Apply	Post Only	
ERA File (835) Download	Deny	
ERA Upload	Deny	
Patient Activity	Deny	
Tracking	Deny	
Hard Close	Deny	

> Customer Access

> Access Hours

> Department Access

New Payer-Level Authorization Billing Alert

We previously added code-level authorization alerts to set a prior authorization requirement as a default for the code. On this release, we added the ability to add payer-level authorization alerts, which will help users ensure claims have the proper authorization information before submission. The new *Require prior authorization for this payer* option will set the requirement for all claims that have that payer set as primary.

> Clearinghouse Connection

> Notes

> Alerts

> Tasks

▼ Billing Options

General

Provider

Patient

ERA

☐ Automatically set Follow Up Date when billing to this payer

☐ Require prior authorization for this payer

☐ Use the provider name as the pay-to name

☐ Only send the pay-to address

☐ Use the office address as the pay-to address

☐ Print CMS-1500 as NY Workers' Compensation Form (C-4, C-4.2, C-4.3, or OT/PT-4)

☐ Override billing provider with rendering provider

Professional

When the new payer level option is enabled, a warning will be issued during the claim review since a pre-authorization is required and no authorization number is set on a claim. For more information visit our [General Billing Options Help Article](#).

Results

✖

Claim reviewed for Billing Alerts. An issue was found.

The following payers or procedures require prior authorization:

- Payer AETNA (#10564976).

⚠

Claim not analyzed by CollaborateMD Edits.

⚠

Claim not processed by the code scrubbing engine because the service is not turned on.

📄

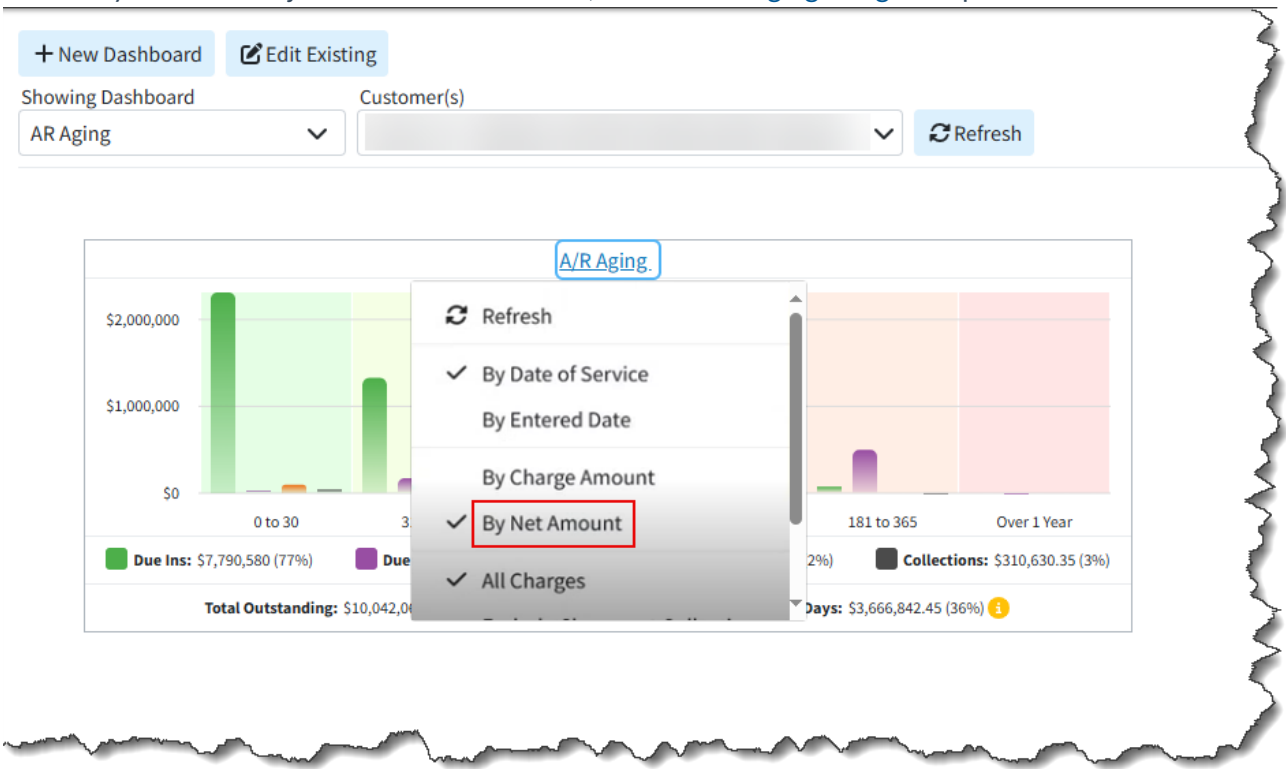
The claim was not analyzed by Clearinghouse Edits. Either this claim has no charges set to send to the clearinghouse or Real-Time Claim Submission is not enabled.

JOB ID: N/A

Enhancements

AR Aging By Net Amount

We added a new option within the A/R Aging Gadget that allows users to see A/R by Net Amount (expected payment) received from the payer instead of charge amount. This option will show the expected revenue before any insurance adjustments. For more info, visit our [AR Aging Gadget Help Article](#).



Drilling down to the Charge Aging Report from the gadget now also allows you to add columns to your report for Charge Net Amount and Charge Net Balance.

Select Columns

Available Columns	Visible Columns
Charge Net Amount +	Patient ID
Charge Total Transfers +	Patient Full Name
Total Payments & Transfers +	Charge Claim ID
Charge Net Balance +	Charge Entered Date

Done

New Electronic Statements Report Fields

We added 2 new report fields under **Patient Data > Electronic Statements** for Patient Email Address and Patient Phone Number that allow users to report on where patients are set to receive their electronic statements. Visit our [Electronic Statements Report Fields Help Article](#) for more information.

Report Fields

Search for fields

✓ Electronic Statements

A Email Address

A Phone Number

> Emergency Contact

> Flexeon - Custom

> Guarantor

> Miscellaneous Info

> Payment Portal

> Primary Insured (Default)

> Primary Payer (Default)

Release 15.14.0 - July 21, 2025

New features | Enhancements

Highlights

New Features

- Diagnosis Code Default Procedures
- New Task Automation For Appointment Cancellation
- New Basic Appeal & Timely Filing Letters

Enhancements

- Copay Max Increased
- New Eligibility Report Fields

New features

Diagnosis Code Default Procedures

We added the ability to automate procedure codes based on diagnosis codes, particularly for diagnoses that consistently require a specific procedure. When set, if a claim is created or a diagnosis code is manually entered, the corresponding procedure code will automatically populate as a charge line item. This new feature allows users to assign up to six default procedure codes per diagnosis code. For more information, visit our [Add a Diagnosis Code Help Article](#)

Diagnosis Codes

✓ Save

✕ Close

Show History

Code

M25.562

Code Type

ICD-10

☐ Make this code inactive

Description

PAIN IN LEFT KNEE

Effective Date

Termination Date

Default Procedure Codes

CPT #1

CPT #2

CPT #3

CPT #4

CPT #5

CPT #6

Superbill Options

☐ Print code on Superbill

Superbill description

▼ Alerts

+ Add Alert

New Task Automation for Appointment Cancellation

We recently added a new Task Automation tab allowing customers to configure their practice to automatically create a new task for any payment failures during the daily AutoPay process. In this release, we are expanding this tab to include a new task automation option to *Create a task when a patient cancels their appointment via appointment reminder*. When a patient cancels an appointment via an appointment reminder, a user or group can receive an automated task notification, enabling them to immediately fill the slot with another patient. Visit our [Task Automations](#) Help Article for more info on setting up this automation.

> Notes

> Other Offices

> Options

▼ Task Automations

☒ Create a task when a patient cancels their appointment via appointment reminder

Assign appointment task to

DANIEL GOLDSMITH (danielgoldsmith) X

Select User

☐ Create a task when a patient's AutoPay payment fails

New Basic Appeal & Timely Filing Letters

Previously, users needed to create their own appeal and timely filing letters when they needed to provide those letters to payers. In this release, we added the ability for users to print timely filing and appeal letter directly from the Claim, Claim Tracker, and Claim Follow Up sections of the application. This allows customers to print basic appeal and timely filing letters for payers who don't have their own required format.

Printing Letter From the Claim Section

Save

Close

Delete

Print

Review

Activity

Show History

More

Claim

Charges

Additional Information

Claim #

228132888

Reference #

Patient

TEST, JOHNNY (33397993)

Rendering Provider

DAVID, BOYER (10063327)

Billing Provider

CLARK, TODD A (10066781)

Supervising Provider

Ordering Provider

Referring/PCP Provider

Sales Rep

DUCK, DONALD (11714163)

Facility

Office Location

DR. SEUSS 1234 MAIN ST

Primary Insurance

AETNA (12848326)

Save and Print Claim

Show Preview

Copy

Save and Print with Form

Claim Transaction History

EOB

Letters

Frequency

1 - Original Claim

Open Negotiations Form

Proof of Timely Filing

Appeal

Printing Letter From the Follow Up Management section

Save

Close

Claim Status

Print

Activity

More

Editing follow up information for Claim #265981033

Set all charges to

NO CHANGE

Follow Up Date

Follow Up Notes

+ Add Note

Proof of Timely Filing

Appeal

Reference Information

DOS

06/02/2025

Last Billed

Status

Claim At Insurance

Amount Billed

Balance

\$3,800.00

TCN

Type

Institutional

Patient Info

Patient #

65295621

Patient Name

REDACTED, REDACTED

Patient DOB

01/01/2000

Payer Info

Name

ANTHEM BLUE CROSS OF COLORADO

Priority

PRIMARY

Phone

Website

Payment Info

Ins Payments

\$0.00

Pat Payments

\$0.00

Other Info

Printing Letter From the Claim Tracker Section

Group By

✖ Mark as Fixed
















(No Selection) ▾

☰ Task Options ▾

✕ Close

View Applied Filters

↑ ↓

<input type="checkbox"/> Claim # / TCN	DOS / Status Date	Patient / Status	Current Claim Status	Claim Amount / Billed Amount	Payer
▶ <input type="checkbox"/>  239709883	10/17/2024	REDACTED, REDACTED (#60866578)	REJECTED AT CLEARINGHOUSE	\$24.00	
▶ <input type="checkbox"/>  239709911	11/17/2024	REDACTED, REDACTED (#60866578)	REJECTED AT CLEARINGHOUSE	\$24.00	
▶ <input type="checkbox"/>  239709982	12/17/2024	REDACTED, REDACTED (#60866578)	REJECTED AT CLEARINGHOUSE	\$24.00	
▶ <input type="checkbox"/>  240651263	07/01/2025	REDACTED, REDACTED (#60993345)	CLAIM AT HUMANA MEDICARE	\$24.00	
▶ <input type="checkbox"/>  240673201	07/02/2025	REDACTED, REDACTED (#60995967)	CLAIM AT TEXAS MEDICARE D...	\$24.00	
▶ <input type="checkbox"/>  240700728	07/02/2025	REDACTED, REDACTED (#60999248)	CLAIM AT MEDICARE DMERC R...	\$24.00	
▶ <input type="checkbox"/>  240712109	07/02/2025	REDACTED, REDACTED (#29558550)	CLAIM AT TRICARE - EAST REG...	\$24.00	
▶ <input type="checkbox"/>  240806484	07/02/2025	REDACTED, REDACTED (#61026356)	CLAIM AT UNITED HEALTHCARE	\$24.00	
▶ <input type="checkbox"/>  240828854	07/02/2025	REDACTED, REDACTED (#61002552)	CLAIM AT UNITED HEALTHCAR...	\$24.00	
▶ <input type="checkbox"/>  241117534	07/02/2025	REDACTED, REDACTED (#61072615)	CLAIM AT TRICARE - EAST REG...	\$24.00	
▼ <input type="checkbox"/>  242446777	07/02/2025	REDACTED, REDACTED (#61397274)	CLAIM AT UNITED HEALTHCAR...	\$24.00	
▼ <input type="checkbox"/>  1359	Copy	tted electronically		\$24.00	UNITED HEALTHCARE
<input type="checkbox"/>	Open Patient	nt to CLEARINGHOUSE (BATCH)			
<input type="checkbox"/>	Open Claim	knowledge/Receipt-The claim/encounter has been received. This does not mean that the claim has been ...			
<input type="checkbox"/>	Open Claim	knowledge/Receipt-The claim/encounter has been received. This does not mean that the claim has been ...			
<input type="checkbox"/>	Create Task	knowledge/Receipt-The claim/encounter has been received. This does not mean that the claim has been ...			
<input type="checkbox"/>	Find Payer Batch Reports	knowledge/Receipt-The claim/encounter has been received. This does not mean that the claim has been ...			
<input type="checkbox"/>	View Claim	aim/encounter has been forwarded to Payer.			
<input type="checkbox"/>	Print Proof of Timely Filing Letter	ayer - Accepted for processing.			
<input type="checkbox"/>	Print Appeal Letter	ity acknowledges receipt of claim/encounter.			
<input type="checkbox"/>		ayer acknowledges receipt of claim/encounter.			
▶ <input type="checkbox"/>  242560887	07/02/2025	REDACTED, REDACTED (#61412129)	CLAIM AT ULTIMATE HEALTH P...	\$24.00	
▶ <input type="checkbox"/>  242599610	02/23/2025	REDACTED, REDACTED (#61417204)	CLAIM AT WELLMED	\$24.00	
<input type="checkbox"/>  242599652	03/23/2025	REDACTED, REDACTED (#61417204)	CLAIM AT WELLMED	\$24.00	

Knowledge base articles

- [Print Proof of Timely Filing Letter from Claim Help Article](#)
- [Print Appeal Letter From Claim Help Article](#)
- [Print Proof of Timely Filing Letter From Follow Up Help Article](#)
- [Print Appeal Letter From Follow Up Help Article](#)
- [Track a Claim Help Article](#)
- [Proof of Timely Filing Letter Sample](#)
- [Appeal Letter Sample](#)

Enhancements

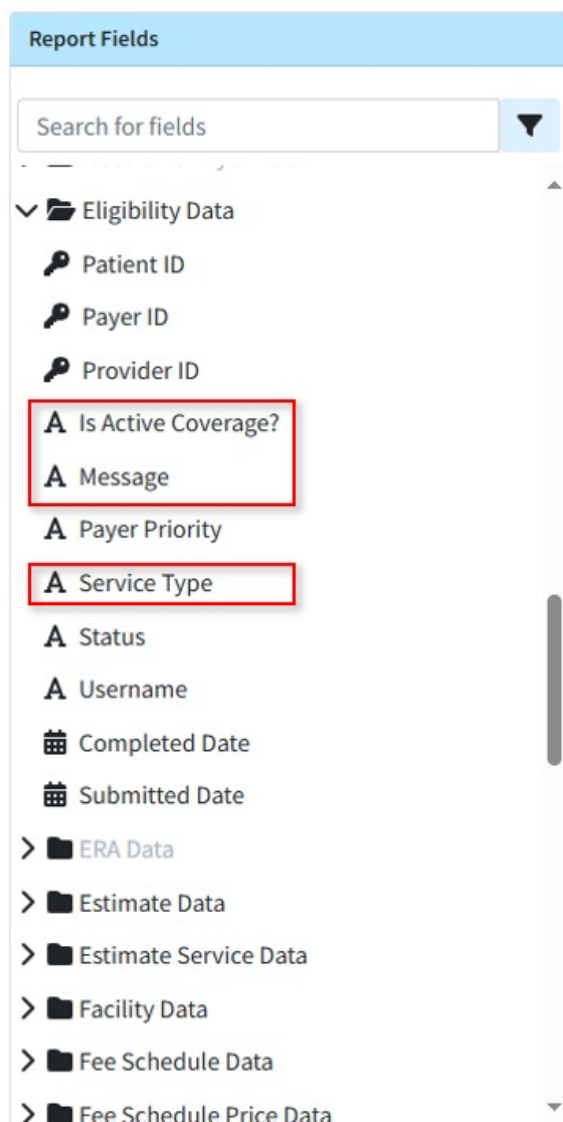
Copay Max Increased

As healthcare costs increase, more costs are being shifted to the patient. Previously, the Copay field allowed for up to \$999.99, which is generally sufficient for professional services but not for inpatient hospital or maternity copays. (Typically, plans use a coinsurance model for hospital claims, but not all plans do this.) Since the insurance policies table already has a limit of \$9,999.99 (based on being a numeric(6,4) column), we expanded the width of the in-app copay fields in the patient section to allow entering values up to \$9,999.99.

New Eligibility Report Fields

In this release, we added the following Eligibility Data report fields for better reporting on Eligibility requests:

1. **Is Active Coverage?** - This field displays if there is active coverage based on the Eligibility.Active field uses Yes or No filter values.
2. **Message** - (text field) This field displays any eligibility messages (error messages).
3. **Service Type** - (filter values are full name) This field displays the service type with values as the full name (i.e., "Medical Care" rather than the code "01") based on the Eligibility.Servicetype field.



Visit our [Eligibility Data Help Article](#) for more information on the new report fields.

Estimates Automation (Charge Detail)

We updated patient estimates for appointments to no longer require re-entering charge details when creating a new estimate for an appointment that already has one. The charge details that were previously entered are now shown by default, eliminating the need for users to re-enter them.

Report Performance Enhancement

We added performance improvements of several reports including the Rev. Claims Billed Charges Report and the Claim Details Report (particularly the Charge Last Billed Date filter) to minimize slowness when

unning these reports.

Show HL7 Location for Users

A new checkbox was added to the bottom left of the **View Message** Interface Tracker dialog to display the HL7 location. This checkbox will only be shown for HL7 messages and when checked, the HL7 segment location will be displayed to the user (previously only available with Engineering permissions).

Release 15.13.0 - July 7, 2025

[New features](#) | [Enhancements](#)

Highlights

New Features	Enhancements
EOB Info Available in Claim & Follow Up Sections	WebAPI Enhancements

New features

EOB Information Now Available in Claim & Follow Up Sections

When working claim appeals and denials, users were previously having to juggle multiple windows to see the claim EOB details. In this release, we added a new tab that allows customers to quickly access this information directly within the Claim and Follow Up Management sections so that users can access this information without the need to leave the current screen. The new EOB Info tab is available from the side-panel dropdown (in the Claim and Follow Up sections) and will allow users to view the EOB details including remittance code information.

- Home
- Reports
- Appointments
- Patient
- Claim
- Claim Tracker
- Claim Control
- Follow Up Management
- Claim Batch Print
- Settings
- Payment
- Documents
- Interface
- Customer Setup
- Account Administration

Save

Close

Delete

Print

Review

Activity

Show History

More

Claim

Charges

Additional Info

Ambulance Info

Claim #

228132888

Reference #

Claim is complete

Frequency

1 - Original Claim

Patient

TEST, JOHNNY (33397993)

Rendering Provider

DAVID, BOYER (10063327)

Billing Provider

CLARK, TODD A (10066781)

Supervising Provider

Ordering Provider

Referring/PCP Provider

CAT, LUNA (11846012)

Sales Rep

Facility

Office Location

DR. SEUSS 1234 MAIN ST

Primary Insurance

MEDICARE (12170165)

Hide Primary Policy Details

Member ID

123456789

Policy Type

Other

Copay Due

30.00

Group Number

Claim Control / Original Ref. #

Referral Type

Claim Summary

Estimate

Patient Notes

Follow Up Activity

Alerts

Tasks

Documents

Payment

Claim Payment

EOB Info

Check #:

From:

Received On:

Payment Type:

Processing Type:

Allowed (this claim):

Paid (this claim):

Adjusted (this claim):

MEDICARE

03/21/2024

Check

Processed as primary payer

\$71.04

\$55.69

\$230.10

Check #:

From:

Received On:

Payment Type:

Processing Type:

Allowed (this claim):

Paid (this claim):

Adjusted (this claim):

AARP

04/19/2024

Check

Processed as tertiary payer

\$0.00

\$14.21

\$0.00

To view the EOB details, click the desired check information to open the EOB details window.

EOB Details

Procedure Code	Amount	Allowed	Paid	Remarks	Adjustments	Unpaid
99308	\$300.00	\$71.04	\$55.69		CO-253: \$1.14 CO-45: \$228.96	PR-2: \$14.21

Close

This new tab applies to manually posted insurance payments and applied ERAs. For more info on viewing the EOB Info from a claim or Follow Up, visit our [View EOB Info On Claim](#) or [View EOB From Follow Up](#) Help Articles.

Enhancements

Web API Enhancements

We added some updates and improvements to the WebAPI so that the following data that was previously only supported either on HL7 or XML is now supported on both.

- **Last Menstrual Period:** Added Support for receiving the Last Menstrual Period field on inbound claim messages (HL7 claims). This was previously supported only on XML.
- **Accident/Illness Date:** Added Support for receiving the Accident/Illness Date field on inbound claim messages (XML claims). This vital information for PT and Worker's Comp providers was previously supported only on HL7.
- **Race, Ethnicity, Language:** Added Support for receiving the Meaningful Use fields for Race, Ethnicity,

and Language on inbound claim messages (XML claims). This Meaningful Use information was previously supported on HL7 but undocumented on XML.

Please note that customers need to update the data they send to CMD to take advantage of these new available fields.

We also added a **Provider Matching Warning**. This means that if a provider name is sent in the interface message and the system selects a provider where the first and last name (or just organization name) is not an exact match, the system will create the claim as usual. However, it will post a Warning message to Interface Tracker stating that the provider was selected based on ID even though the name does not match.

Increased Maximum Length of TCN Prefix

Currently users can enter a TCN Prefix in the Practice section. This is typically done by Support and used by the clearinghouse, but some users may set their own if they do not share an NPI across multiple CMD customers.

Previously, this field was limited to 4 characters. Based on customer requests and considering that our TCNs are 11 characters long and the maximum TCN length in ANSI is 20 characters, we increased the length of the TCN Prefix and Statement TCN Prefix fields to 6 characters.

✓ Save Save TCN Prefix Only ✕ Close ↺ Show History

Name

MEDICAL PRACTICE

⋮

☐ Make this practice inactive

NPI

1234567890

Q

Organization Type

Solo Practice

▼

Taxonomy Specialty

332BP3500X

✕ Q

Suppliers : Durable Medical Equipment & Medical Supplie...

Sequence #

10007631

Reference #

123456

TCN Prefix

Statement TCN Prefix

Code

TE

Primary Office

Address

201 PINE ST SUITE 1

City

APOPKA

State

FL

ZIP Code

32703-1000

⋮

Time Zone

Eastern

▼

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☒ Pay-To address is the same as the primary office address

Release 15.12.0 - June 23, 2025

New features | Enhancements

Highlights

New Features	Enhancements
Tasks Available in Multiple New Sections	Net Amount now Available in Activity Report
New Enhanced Auditing (Show History) for Contracts	Incremental Data Snapshot Option

New features

Tasks Added to Multiple Sections

We added the ability to add tasks reminders associated with specific records within more sections of the application in order to keep track of items that need to be completed. Tasks can have due dates, links, descriptions, statuses, and priorities. Please be aware that some of these task management options are available in plan 3 and above. You can now assign the following tasks to yourself or to specific users/group within your business:

Report Snapshot Tasks

A new option was added to create tasks from a Report Snapshot, allowing you to assign a user or group to review specific report results. Creating a task from a report will have the report snapshot linked to it and will be available for 90 days. For more information on saving and creating a task on a report, visit our [Create Task for a Report Help Article](#)

Snapshot Details

Title

Daily/Monthly Net Charges - 06/18/2025

Note

Save & Create Task

Cancel

Appointment Tasks

We also added the ability to create and link tasks to specific appointments. Users can access this feature via the right-click menu within the scheduler or the new tasks side panel option. Visit our [Appointment Tasks Help Articles](#) for more information on adding and managing appointment tasks.

Save

Close

Print

Eligibility

Activity

View All Appointments

Show History

More

Appointment

Patient

Payment

Patient

TEST, JOHNNY (33397993)

Appointment Date

06/20/2025

at

03 : 00 PM

for

30

Minutes

Find a time

Appointment Reminder

☐ Allow appointment to overbook with another appointment

Appt Status

Rescheduled

Appt Type

CAT CHECK

Resource

[PC] CHEN, PAUL MD

Facility

NORTH COUNTY LASER EYE ASSOC. (#10012415) 1905 CALLE BARCELONA, # 208

Office Location

NORTH COUNTY LASER EYE ASSOCIATES, APC 1905 CALLE BARCELONA, #208

Chief Complaint

☐ Repeat appointment every

Comment

6mon cat iop JL 12/20/24

Account Summary

Estimate

Notes

Appointments

Alerts

Tasks

+ Create Task

Show Completed Tasks

Documents / Forms

Tasks From Claim Control

We added new Task Options within the Claim Control screen, allowing users to create and manage tasks associated with specific claims. This new option allows users to create and link tasks to multiple claims at once, as well as reassign and delete them simply by checking them off. For more info on creating tasks from Claim Control, visit our [Claim Control Task Options Help Article](#).

Update Status

Review Claims

Update Claims

Combine Claims

Task Options

Create Task

Reassign Task

Delete Task

More

Close

Show charge details

<input type="checkbox"/>	Claim #	DOS	Current Payer	Patient	Review Status	First Billed Date	Last Billed Date	Charge Amour
<input type="checkbox"/>		05/21/2025	PRIORITY HEALTH MEDICARE (Primary)	REDACTED	<div></div> No Issues Found	06/09/2025	06/09/2025	\$195
<input type="checkbox"/>		05/28/2025	PRIORITY HEALTH MEDICARE (Primary)	REDACTED	<div></div> No Issues Found	06/09/2025	06/09/2025	\$195
<input type="checkbox"/>		06/02/2025	MCLAREN HEALTH PLAN MEDICAID (Primary)	REDACTED	<div></div> No Issues Found	06/10/2025	06/10/2025	\$98
<input type="checkbox"/>		06/03/2025	UHC MEDICARE DUAL COMPLETE SPECIAL NEEDS (Pr...	REDACTED	<div></div> No Issues Found	06/09/2025	06/09/2025	\$195
<input type="checkbox"/>		06/04/2025	PRIORITY HEALTH OF MICHIGAN - PRIMARY (Primary)	REDACTED, REDACTED REDACTED	<div></div> No Issues Found	06/10/2025	06/10/2025	\$140
<input type="checkbox"/>		06/04/2025	MICHIGAN MEDICARE (Primary)	REDACTED, REDACTED REDACTED	<div></div> No Issues Found	06/10/2025	06/10/2025	\$140
<input type="checkbox"/>		06/04/2025	UNITED HEALTHCARE (Primary)	REDACTED, REDACTED REDACTED	<div></div> No Issues Found	06/10/2025	06/10/2025	\$195

We also added new Task Options within the Claim Tracker screen, allowing users to create, manage, reassign, and delete tasks associated with specific claims simply by checking them off. Tasks can also be linked to multiple claims simultaneously. Visit our [Claim Tracker Task Options](#) Help Article for more information.

New Enhanced Auditing (Show History) for Contracts

In this release, we are expanding our Enhanced Auditing functionality to **Contracts**, enabling users to track modifications, changes, and updates made to contracts for better auditing and accountability. With the new **"Show History"** feature, you can now determine which user changed/updated a specific contract in the software and when by providing an auditing table with all updates or changes made to a record, including the user, date, time, and the record changed.

Contracts

✓ Save
✕ Close
📄 Export
🕒 Show History

Name

☐ Make this contract inactive

Type

☒ Allow users posting payments to update prices

Sequence #

↑ ↓

Code	Price	Description	Type	Exclude
0044T	100.00	WHBDY INTEG PHTGRPHY DYSPLSTC NEVUS FAMIL MLNMA	Procedure	<input type="checkbox"/>
00450	150.00	ANES CLAV/SCAPLA NOS	Procedure	<input type="checkbox"/>
00452	50.00	ANES CLAV/SCAPLA RAD SURG	Procedure	<input type="checkbox"/>
00454	80.00	ANES CLAV/SCAPLA BX CLAV	Procedure	<input type="checkbox"/>
0046T	45.00	CATH LVG MAM DUX COLLJ CYTOL SPEC EA BRST 1 DUX	Procedure	<input type="checkbox"/>
00470	65.00	ANES PRTL RIB RESCJ NOS	Procedure	<input type="checkbox"/>
00472	225.00	ANES PRTL RIB RESCJ THORACOPLASTY	Procedure	<input type="checkbox"/>
00474	300.00	ANES PRTL RIB RESCJ RAD	Procedure	<input type="checkbox"/>
0047T	25.00	CATH LVG MAM DUX COLLJ CYTOL SPEC EA BRST EA DUX	Procedure	<input type="checkbox"/>
0048T	42.00	IMPLTJ VENTR ASSIST DEV XTRCORP PRQ T-SEPTAL	Procedure	<input type="checkbox"/>
0049T	122.00	PROLNG XTRCORP PRQ T-SEPTAL VENTR DEV 24HR	Procedure	<input type="checkbox"/>
00500	145.00	ANES ALL PX ESOPH	Procedure	<input type="checkbox"/>
0050T	200.00	RMVL VENTR DEV XTRCORP PRQ T- SEPTAL 1/DUAL	Procedure	<input type="checkbox"/>
0051T	100.00	IMPLTJ TOT RPLCMT HRT SYS W/RCP CARDIECTOMY	Procedure	<input type="checkbox"/>
00520	85.00	ANES CLSD CH PX NOS	Procedure	<input type="checkbox"/>

These new auditing records are also included in our existing User Audit Report, making it an even stronger tool for auditing multiple records simultaneously. The Show History capability will be systematically added to other sections of the application. For more information visit our [Enhanced Auditing \(Show History\) Help Article](#).

Enhancements

Net Amount now Available in Activity Report

We added a new user-level setting to the Patient Settings to display the Net Amount (based on the allowed or contracted amount) in the Patient Activity section. When set to "Yes" (the default is "No"), the Net Amount and Net Balance will be shown in the Claim listing in the Patient Activity.

set) whenever creating a new Payment Plan?

☒ Yes ☐ No

Show an alert when opening patient records for patients older than 65?

☐ Yes ☒ No

Display an option in the Patient screen to copy the patient's default Facility as their primary address? (This can be useful for practices that work directly with nursing homes and other residential treatment facilities.)

☐ Yes ☒ No

Show whether a claim is professional or institutional in the Patient Activity?

☐ Yes ☒ No

Show the Net Amount and balance (based on the allowed or contracted amount) in Patient Activity?

☒ Yes ☐ No

Set margins to use when printing the addresses on the Enhanced Statement payment slip.

i Changes to these margins will only adjust that that address.
Each unit represents 1/72 of an inch.

Return Address label:

Left Margin Top Margin

Patient Address label:

Left Margin Top Margin

This option was added to allow users to view claims on a net basis. When this option is selected, the Balance column will no longer be displayed. Instead, users can utilize the Net Amount and Net Balance columns to see the expected revenue, regardless of whether a contractual adjustment has been entered yet.

Procedure	DOS/Received	Entered	Description	Units	Charge	Net Amount	Payment	Adjustment	Net Balance
99212	02/01/2024	02/01/2024	OFFICEOP VISIT EST PT KEY COMPONENTS ...	1	\$250.00				
SEND TO BLUE CROSS AND BLUE SHIELD OF FLORIDA VIA CLEARINGHOUSE as of 11/12/2024						\$138.99	\$0.00	\$0.00	\$138.99
11055	02/01/2024	02/01/2024	TRIM SKIN LESION	1	\$208.00				
SEND TO BLUE CROSS AND BLUE SHIELD OF FLORIDA VIA CLEARINGHOUSE as of 11/12/2024						\$0.00	\$0.00	\$0.00	\$0.00
Claim Totals					\$458.00	\$138.99	\$0.00	\$0.00	\$138.99

For more info on enabling this setting, visit our [Configure Patient Settings Help Article](#).

New Incremental Data Snapshots

In this release, we added a new option for Recurring Data Snapshots to minimize processing time. This option captures only changed items in larger tables, rather than a complete daily database snapshot. When configuring this new "Incremental Snapshot" option, the initial snapshot (or the first snapshot after adding a new customer to a combined snapshot) will be a full snapshot. Subsequent snapshots will export smaller files containing only changed data for **Patient, Claim, Charge, Credit, and Activity tables**; all other datasets will receive full data. This ensures your snapshot is prioritized and available sooner than full snapshots. Visit our [Recurring Data Snapshot Help Article](#) for more info on setting up an Incremental recurring snapshot.

✓ Patient Payment Portal

✓ Enhanced User Print Statement

✓ Claim Attachments

✓ Intake Forms

Add-On Services

Manage the per transaction

✓ C

✓ R

✓ A

✓ M

✗ A

✗ Data Sync

✓ Broadcast Communications

Recurring Data Snapshot for Account #462134 - CollaborateMD

Usage of this feature will result in additional charges to your invoice. [Click here](#) for complete pricing information.

☒ Enable recurring (daily) data snapshots

Format

MySQL

Download Sample

Incremental Snapshot

Click Here

for important information about incremental snapshots.

Incremental snapshots include data that is new or changed since the last recurring snapshot. Customers who do not have a recent recurring snapshot will receive a full snapshot first, and then subsequent days will be incremental.

If you select One Combined File below and add any customer who hasn't recently received a recurring data snapshot, the first recurring snapshot after your change will be a full snapshot. Subsequent snapshots will be incremental.

Not all tables are delivered as an incremental snapshot. The following tables only include incremental data. All other tables contain complete data.

- Patient
- Claim
- IClaim
- Claim ICD Code
- Charge
- Credit
- Activity

T

IMGEAR TRAINING 1

UNT

UNT

CCOUNT

ST ACCOUNT

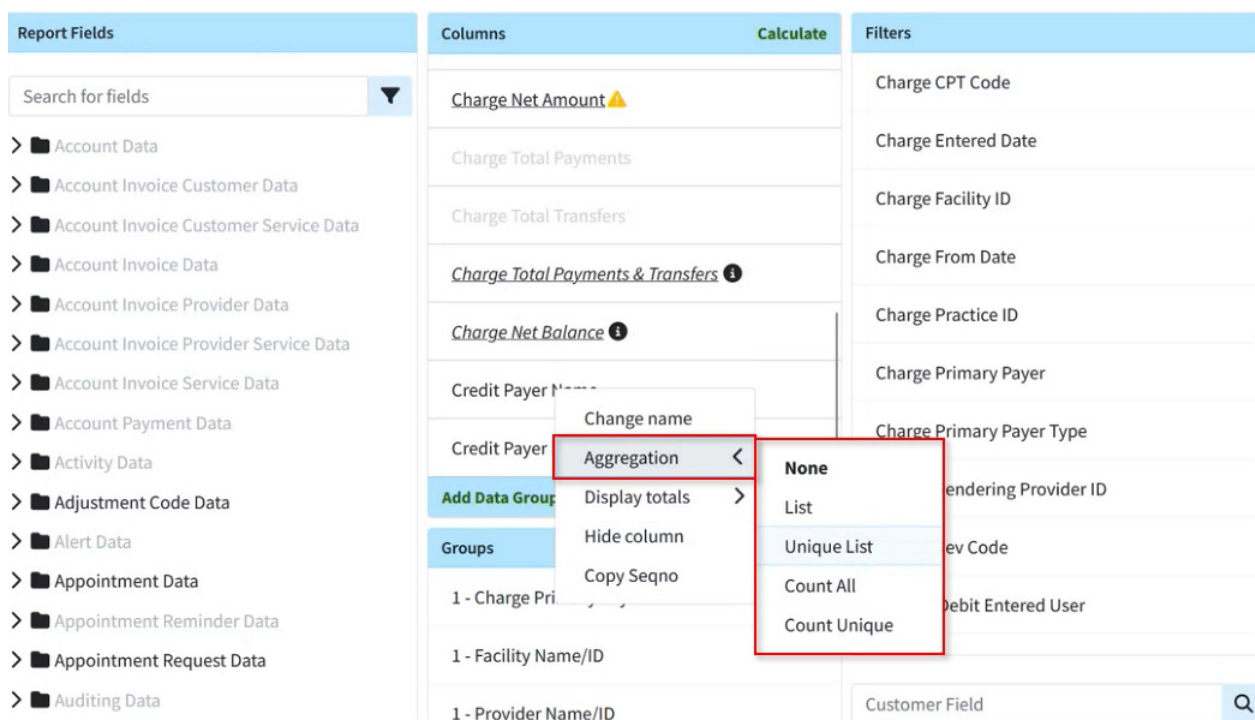
COUNT

Save

Cancel

New Aggregation of Text Columns on Reports

We updated the Report Builder to allow aggregations of text columns (in addition to numeric and date) into List, Unique List, Count, and Count Unique. This allows users to create reports detailing payment information, such as a list of payers for a specific claim, a report of all remittance codes, or a summary of distinct check numbers, in order to prevent duplicate lines.



Release 15.11.0 - June 10, 2025

New features | Enhancements

Highlights

New Features

Claim Workflow Enhancements: New Combining Claims Feature

Claim Workflow Enhancements: New Institutional Defaults

New Task Automation for AutoPay

Custom Claim Scrubbing Edits

Enhancements

Claim Workflow Enhancements: New Situational Modifier Options

New features

New Claim Workflow Enhancements: Combining Claims

We added a new feature within Claim Control section that allows users to find and combine claims (as long as the claims are for the same patient/payer/provider). CollaborateMD's new **Combine Claims** feature allows users to merge two or more separate claims into one, consolidating all charges and removing the

duplicate claims automatically. This is useful for customers who need to combine encounters into a single claim due to the EHR separating the encounter into multiple claims, payer bundling requirements, or any other reason. Simply select your claims and click the *Combine Claims* button to start the process.

<input checked="" type="checkbox"/> Update Status ▾ <input type="button" value="Submit Claims"/> <input type="button" value="Review Claims"/> <input type="button" value="Update Claims"/> <input checked="" type="button" value="Combine Claims"/> <input type="button" value="Close"/>				
<input type="checkbox"/>	Claim #	DOS	Current Payer	Patient
<input type="checkbox"/>	253287625	01/10/2025	SEDGWICK (Primary)	TEST, COURTNEY
<input checked="" type="checkbox"/>	264008360	05/05/2025	AETNA (Primary)	DASS, SYLVESTER
<input checked="" type="checkbox"/>	264008583	05/06/2025	AETNA (Primary)	DASS, SYLVESTER
<input type="checkbox"/>	254274882	01/22/2025	AARP (Primary)	PIERRE, AARON
<input type="checkbox"/>	254274900	01/22/2025	AARP (Primary)	PIERRE, AARON

You will be presented with a list of charges that will be combined into the new claim where you can reorder the charges before combining them into a new claim.

Below is the list of charges that will be combined into a new claim.

After the combine claim process is completed, all the original claims will be deleted.

	From	To	Procedure	POS	TOS	Mod 1	Mod 2	Mod 3	Mod 4	Unit Price	Units	Amount	Status	Inventory							
=	05/05/2025	05/05/2025	99213	Q	11	Q	1	Q	52	Q	Q	Q	200.00	1.00	200.00	SEND TO AETNA VIA CLEARINGHOUSE	Q				
=	05/05/2025	05/05/2025	99214	Q	12	Q	3	Q	1	Q	2	Q	3	Q	4	Q	50.00	1.00	50.00	SEND TO AETNA VIA CLEARINGHOUSE	Q
=	05/06/2025	05/06/2025	99213	Q	11	Q	1	Q	52	Q	Q	Q	200.00	1.00	200.00	SEND TO AETNA VIA CLEARINGHOUSE	Q				
=	05/06/2025	05/06/2025	99214	Q	12	Q	3	Q	1	Q	2	Q	3	Q	4	Q	50.00	1.00	50.00	SEND TO AETNA VIA CLEARINGHOUSE	Q

Combine Claims

Cancel

Once combined, you can save the new claim, and only the new combined claim will exist, while the individual ones will be deleted. For more information on combining claims, visit our [Combine Claims Help Article](#).

New Claim Workflow Enhancements: New Institutional Defaults

In this release, we have added updates to the patient and payer claim defaults for institutional claims. First we separated the Patient Claim defaults into Professional and Institutional categories. The availability of Professional or Institutional claim default options depends on whether the default provider for the patient sends professional claims, institutional claims, or both. The claim default options for Professional Claims include **ICD** and **CPT Codes**. For Institutional Claims, the options are **Principal Diagnosis**, **POA**, **Other Diagnosis**, **CPT Codes**, and **Value Codes** to provide more flexibility when setting your defaults. For more information on setting up institutional patient claim defaults, visit our [Patient Claim Defaults Help Article](#).

Patient Info **Insurance Info** **Billing Info** **Claim Defaults**

Default Codes

Institutional

Principal Diagnosis: M25.561 POA: N-No

Other Diagnosis

Code	Description	POA
M25.562	PAIN IN LEFT KNEE	<input type="button" value="v"/> <input type="button" value="x"/>

CPT #1: 99212 CPT #2: J3475 CPT #3: CPT #4:

We also added 2 payer billing options for claims. Within the General Billing Options tab, we introduced a new option to select a **Default Value Code** to be included on institutional claims for this payer. Additionally, under the Provider Billing Options, we added an option to select a Default Referring Provider for every claim under this provider. Visit our [General Billing Options](#) and [Provider Billing Options](#) Help Articles for more information.

Billing Options

General **Provider** **Patient** **ERA**

☐ Send patient address in Box 32 for Place of Service 12

☐ Remove the insured's ID# from Box 1A

Print the following supplemental info in Box 24

Narrative Notes

☐ Print ICD code for first diagnosis pointer in Box 24E

☒ Send minutes instead of units on anesthesia claims

☒ Send anesthesia start/stop times in a line note.

Institutional

Print the following in Box 38

Print payer's address

Print the following in Box 80

Print remarks

☐ Print referring physician in Box 76

☐ Print Taxonomy Code in Box 76

☐ Print Taxonomy Code in Box 81CC a

Default Value Codes

Code	Amount	Description
	0.00	

Billing Options

General **Provider** **Patient** **ERA**

Search for providers

The provider billing options allow you to customize certain configuration settings for one or more providers specific to this payer. Providers not listed below will bill claims based on their general settings/configuration in the provider screen.

Customize for Additional Providers

☐ Show separate configurations for each office location

▼ ABDUL, SAMANTHA BEST, TEST [RAD] (#10009890)

Status: Active Individual ID:

Bill Mode: Individual Group ID: 9999999

☒ Accept this Insurance

☐ **Default Referring Provider**

☐ Override Billing Provider

▼ BARNES, KYLE MD [KB] (#10002227)

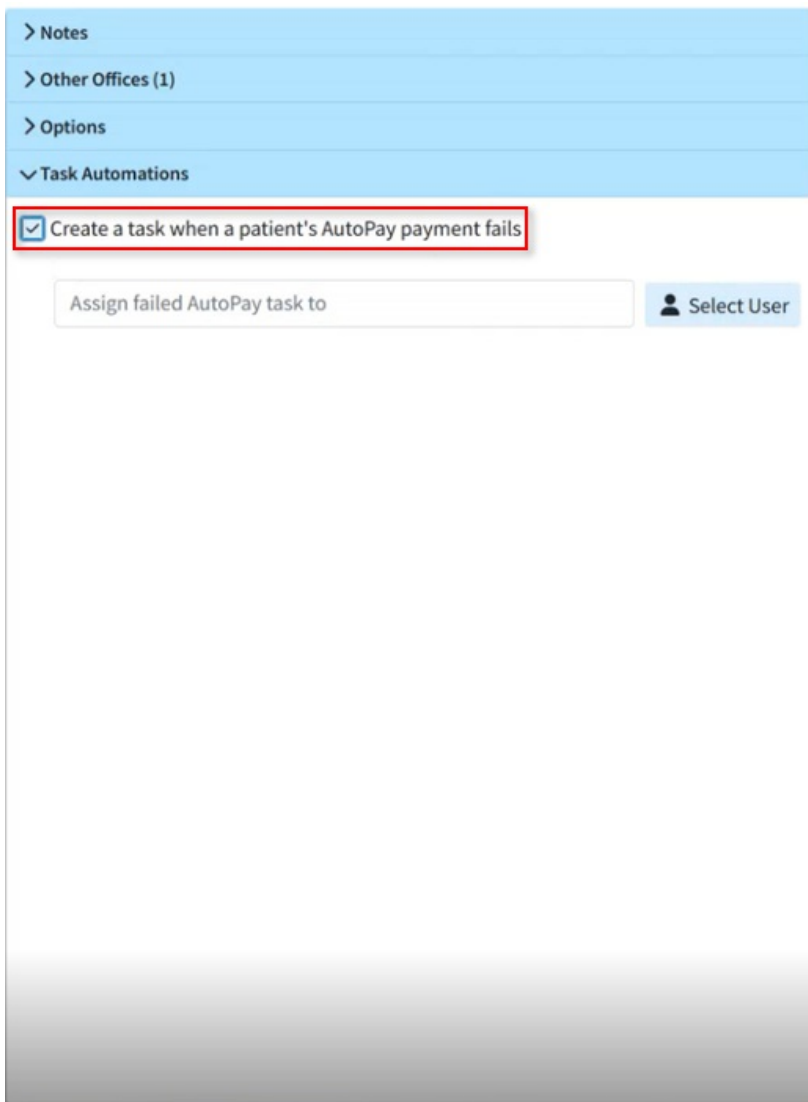
Status: Active Individual ID:

Bill Mode: Group ID: 123456

☒ Accept this Insurance

New Task Automation for AutoPay

We added a new Task Automation feature allowing customers to configure their practice to automatically create a new task for any payment failures during the daily AutoPay process. This task will be linked to the patient and assigned to a pre-selected user or group. Customers that use the AutoPay feature can now set up the "Create a task when a patient's AutoPay payment fails" task automation from the practices right-hand side panel. Visit our [Task Automations](#) Help Article for more info on setting up this automation.



The screenshot shows a sidebar menu on the left with the following items: > Notes, > Other Offices (1), > Options, and ✓ Task Automations. The 'Task Automations' section is expanded, showing a checkbox labeled 'Create a task when a patient's AutoPay payment fails', which is checked and highlighted with a red border. Below this checkbox is a text input field labeled 'Assign failed AutoPay task to' and a button labeled 'Select User' with a user icon.

Custom Claim Scrubbing Edits & Claim Scrubbing Specialty

In this release, we added two significant enhancements to our Claim Scrubbing. First, we introduced an option within the Claim Scrubbing configuration screen that allows customers to set up (or change) their specialty to receive more tailored edits for their specific claims. Visit our [Manage Claim Scrubbing](#) Help Article for more information on setting your Specialty.

Claim Scrubbing for Customer

Usage of this feature will result in additional charges to your invoice. [Click here](#) for complete pricing information.

☒ Enable Claim Scrubbing

Claim Scrubbing Settings

Specialty
Multi-Specialty ▼ [Change](#) Select your specialty to tailor Claim Scrubbing to your Practice

Automatically scrub new claims as they are entered?
☒ Yes ☐ No

Automatically scrub existing claims when coding changes are made?
☒ Yes ☐ No

Only perform automatic claim scrubbing for claims that contain more than one charge?
☐ Yes ☒ No

Exclude procedure codes marked as Retail or Other Medical from the code scrubbing process?
☐ Yes ☒ No

[Save](#) [Copy Configuration](#) [Cancel](#)

Secondly, we introduced a new **Claim Scrubbing Custom Edits & Analytics** service that provides customer access to the ClaimStaker® application, allowing them to review existing claim scrubbing edits, create new ones, and review detailed analytics. This is a paid service that can be requested from **Services > Other Services** and includes one initial training session on how to use ClaimStaker® to create custom edits and review analytics.

Other Services

Submit a request for one of the following services which can be purchased for a one-time fee ([pricing information](#)):

Interfaces	Request
One-on-One Training	Request
Claim Scrubbing Custom Edits & Analytics	Request
Custom Report	Request
Data Copy	Request
Data Move	Request
Data Conversion (Import)	Request
One-Time Data Snapshot	Request

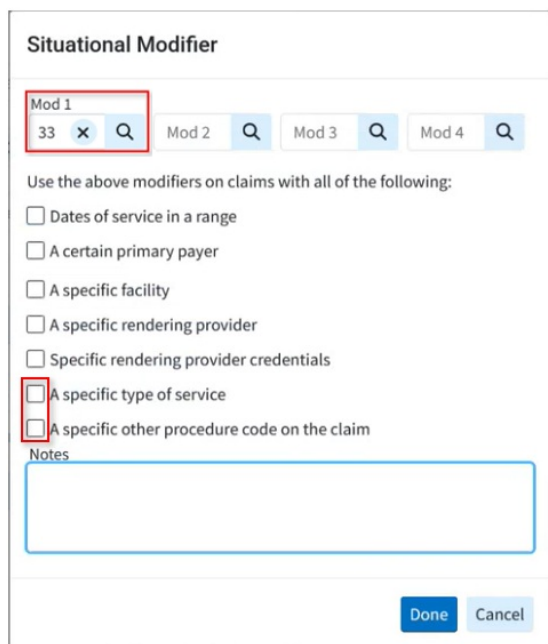
For more information on requesting this service, visit our [Request Claim Scrubbing Custom Edits &](#)

Enhancements

New Claim Workflow Enhancements: New Situational Modifier Options

In this release, we have added a couple of updates to the situational modifiers for procedure codes. First, we introduced two new options within the Procedure Codes to set Situational Modifiers.

1. A new option to create a situational modifier based on "**A specific type of service**" to set a specific TOS code that the modifier should apply to.
2. A new option to create a situational modifier based on "**A specific other procedure code on the claim**" to select a procedure code that will trigger the modifier only when this other procedure is present on claim.

A screenshot of the 'Situational Modifier' form. At the top, there's a header 'Situational Modifier'. Below it, there are four input fields labeled 'Mod 1', 'Mod 2', 'Mod 3', and 'Mod 4'. The 'Mod 1' field is highlighted with a red box and contains the text '33' followed by an 'x' icon and a search icon. Below these fields, there's a section titled 'Use the above modifiers on claims with all of the following:' followed by a list of checkboxes: 'Dates of service in a range', 'A certain primary payer', 'A specific facility', 'A specific rendering provider', 'Specific rendering provider credentials', 'A specific type of service', and 'A specific other procedure code on the claim'. The 'A specific type of service' checkbox is highlighted with a red box. At the bottom of the form, there's a 'Notes' section with a text area and two buttons: 'Done' and 'Cancel'.

We also updated the **Dates of Service**, **Primary Payer**, **Facility**, **Rendering Provider**, **Rendering Provider Credentials**, and **TOS** situational modifier options to be multi-select, making it easier for practices with a large number of records to manage these modifiers. For more information on adding these modifiers, visit our [Add Situational Modifiers](#) Help Article.

New Claim Workflow Enhancements: Claim Status Updates

We updated our Real-Time Claim Status results window to allow users to update the claim charge status directly from the results screen. Users can now also enter any follow-up notes pertaining to the claim, as well as any expected payment information from the status result (paid amount, check date, and check number). This update will automatically override any existing data in Expected Payment Info with information from the Claim Status if the payer made a payment. For more information visit our [Claim Status](#) Help Article.

Claim Status Results

Claim Status

Follow Up Notes

Expected Payment Info

Claim Status Response from UNITED COMMUNITY HEALTH PLAN

Status Category:

Finalized/Payment-The claim/line has been paid.

Status:

Claim/line has been paid.

Detailed Status

Date of Denial/Approval:

03/15/2025

Check Issued/Funds Available:

03/22/2025

Check/EFT #:

Claim Payment Amount:

\$183.01

> Charge-Level Info

Payload ID:

Set all charges to

NO CHANGE

This information will be available from the Claim Tracking section for future reference.

Done

Cancel

Release 15.10.0 - May 27, 2025

[New features](#) | [Enhancements](#) | [Resolutions](#)

Highlights

New Features

[New Task Assignment to Contact Groups](#)
[New Prior Auth Requirement & Billing Alerts](#)
[Update](#)
[New Appointment Types Default Codes](#)

Enhancements

[New Taxonomy Specialty Report Fields](#)

New features

New Task Assignment to Contact Groups

Capitalizing on our recently released Shared Contact Groups feature, users can now assign tasks to individuals within a Contact Group. You can create Contact Groups for teams (denials, billing, specific offices, payments, etc.) and assign tasks to those groups to ensure work is completed. All users in the group will see the tasks assigned to the group, and once completed, the system will track which user completed

the task via the User Productivity by Tasks Completed Report, allowing you to monitor user productivity. For more information creating Shared contact groups, visit our [Create a Shared Contact Group](#) Help Article. For info on assigning tasks to a contact group, visit our [Assign a Task to a Contact Group](#) Help Article.

✓ Save

✕ Cancel

Task Title

Review Follow ups for BCBS today

Due Date

05/27/2025

Status

Not Started

Priority

Normal

Description

Please Review all BCBS follow ups before EOD today.

Task Links

+ Add Link

No links have been added yet.

Assign this task to

Billing ✕

Select User

New Prior Authorization Requirements & Billing Alerts Update

In this release, we have added a couple of updates to the billing alerts for procedure codes. First, we introduced a new option within the Procedure Codes setup window to set a Prior Authorization Requirement as a default on the code. You can set the Prior Authorization Requirement on a code for all payers or a list of specific payers. When there is a pre-authorization requirement and no authorization number is set on a claim, you will now receive a warning during the claim review. For more information on setting up a prior authorization requirement, visit our [Add CPT/HCPCS Codes](#) Help Article.

Find a Section

Home >

Reports >

Appointments >

Patient >

Claim >

Payment >

Documents >

Interface >

Customer Setup >

Practices

Providers

Facilities

Referring Providers

Payers

Payer Agreements

Collection Agencies

Codes...

Alert Control

Procedure Codes

SaveCloseShow History

Narrative Notes

Modifiers (Global & Situational)

Global 1Global 2Global 3Global 4

Create situational modifiers

Billing Alerts

Global Surgery Period

Default (0 days)

Same or Similar Codes

Codes	Period	Delete
Add New Same/Similar Code List		

Prior Authorization Requirements

☐ None

☒ All Payers

☐ Certain Payers Only

Drug Information

We also updated the placement of billing alert warnings within the application. Billing alerts will now be displayed not only in the claim section, but also in the claim control area when running the claim review process. This change is intended to help our interface customers more easily access these billing alerts, as they are now integrated into the claim review workflow.

Claim Review Result

Claim ID **228334650** Run Date 05/21/2025 12:11 PM

Results

✗ Claim reviewed for Billing Alerts. An issue was found.

The following procedures require prior authorization:

- 11055 - TRIM SKIN LESION.

⚠ Claim not analyzed by CollaborateMD Edits.

✗ Claim processed by the code scrubbing engine. Issues were found.

❗ *Reject Claim*

9999999999 (PROV) The billing provider NPI is either missing, contains invalid characters or is malformed. The billing provider NPI is required.

❗ *Line Item Rejected*

00001 (CPT/HCPCS) The CPT/HCPCS code is not valid for the date of service.

ℹ *Actionable*

11055 (MN-PROP) This CPT/HCPCS and diagnosis code combination may be clinically questionable for medical necessity and might benefit from clinical review.

Run date: May 21, 2025, 12:11:35 PM JOB ID: 1637578969

✗ Claim analyzed by Clearinghouse Edits. An issue was found.

Errors were found that will prevent this claim from being successfully processed at the

New Appointment Type Default Codes

We previously added claim defaults for POS and TOS within the Appointment Types configuration. In this release, we introduced Appointment Type Default Codes, allowing users to set default procedure codes or appointment types. When creating claims from the appointment scheduler, these default codes will be used. New estimates created from the appointment scheduler will also use default procedures from the Appointment Type, making estimates faster and easier than ever.

Please note that these default codes apply only to claims created from an appointment. Patient Default Procedure Codes won't be used if the Appointment Type has a default procedure, though patient default diagnosis codes will still be used. Claims created from the claim section will not use these Appointment Type default codes, only Patient Defaults if available. Visit our [Add New Appointment Type](#) Help Article for more info on adding default codes to an Appointment Type.

Appointment Types

✓ Save
✕ Close
🕒 Show History

Code

NEW PT

☐ Make this type inactive

Description

NEW PATIENT

Icon

Color

Length (minutes)

45

Make Appointment Type Available in:

☒ All Departments (Global)
 ☐ Specific Department(s)

☐ Disable automatic appointment reminders for this appointment type

☐ Specify the hours of operation for this appointment type

▼ Claim Defaults

Place of Service

Type of Service

Default Codes

CPT #1	CPT #2	CPT #3
01420	A4770	G0483
CPT #4	CPT #5	CPT #6

> Intake Forms

Enhancements

New Report Fields

Previously, users could add fields related to the taxonomy specialty and the taxonomy specialty description for Providers and Practice, but not for Referring Providers. In this release, we added fields to report on taxonomy codes (specialties) and its description for Referring Providers.

- Referring Data → Taxonomy Specialty
- Referring Data → Taxonomy Specialty Description

Report Fields

Search for fields

TAXONOMY

> Facility Data

> Practice Data

> Provider Data

✓ Referring Data

Taxonomy Specialty

Taxonomy Specialty Description

View Prior Claim Status Checks

We have long supported viewing prior claim status checks from the Claim section, but this ability was not available for claim follow-ups. In this release, we added this capability to the Claim Follow-Up Management section.

▼

+ Add Note

📅 Set Follow Up

⚡ Check Claim Status

☰ Task Options ▼

📄 Export

✕ Close

View Applied Filters

↑ ↓

DOS	Last Note	Claim Follow Up Date	Current Payer	Last Note C	Task Assignr	Last Billed Date	Task Status	Status	Task Due Date	+
12/04/2024		02/25/2025	AARP			02/10/2025		CLAIM AT AARP		
12/06/2019		05/06/2025	AETNA	04/09/2020		05/01/2025		CLAIM AT AETNA		
02/11/2024		03/05/2025	BCBS			02/03/2025		CLAIM AT BCBS		

Web API Updates

In this release, we made a few enhancements to our WebAPI. On professional claims, we support the "Charge To Date" to represent charges over a period of time. This "to date of service" can be sent in the FT1.5 segment. However, on institutional claims, there is no location on the claim form for the "To Date of Service" for any particular charge, so we do not support it. Since some payers require sending one charge with multiple units to cover multiple days, and individual charges are the only way to send dates, and institutional claims don't support the "To Date of Service," it becomes difficult to set a "Statement Covers To" date that extends beyond the last charge's date of service. In this release, we updated our WebAPI to internally store a "To Date" of service and use it to determine the claim's statement covers "To" and "From" dates when a single charge covers multiple days.

We also added the ability to add payments via the WebAPI. Previously, when we received payments from the WebAPI, they were applied as a credit, and users had to access the application to apply the payment. In this release, we updated the WebAPI to allow users to apply a patient payment directly to specific claims instead of as a credit. Users can now use the Activity or Charge History APIs to get charge details and use that information to choose where to apply new payments (only new payments, not existing credits).

Resolutions

ERA Secondary OA-23 Adjustments Update

The process of applying a secondary adjustment on an ERA has been updated to no longer allow the OA-23 adjustment. This adjustment, related to prior payers' payments and adjustments, should never be applied as it can incorrectly affect the balance and cause an incorrect account credit.

Update from Release 15.9 (Net Amount available in the Activity Report)

We recently added a new user-level setting to the Patient Settings to display the Net Amount (based on the allowed or contracted amount) in the Patient Activity section. When set to "Yes," the Net Amount and Net Balance would be shown in the Claim listing in the Patient Activity. In this release, we removed this setting due to an issue found with the feature. We will correct this and re-release it in the June-July timeframe.

✓ Save

✕ Cancel

↺ Show History

set) whenever creating a new Payment Plan?

☒ Yes ☐ No

Show an alert when opening patient records for patients older than 65?

☐ Yes ☒ No

Display an option in the Patient screen to copy the patient's default Facility as their primary address? (This can be useful for practices that work directly with nursing homes and other residential treatment facilities.)

☐ Yes ☒ No

Show whether a claim is professional or institutional in the Patient Activity?

☐ Yes ☒ No

Show the Net Amount and balance (based on the allowed or contracted amount) in Patient Activity?

✕

☒ Yes ☐ No

Set margins to use when printing the addresses on the Enhanced Statement payment slip.

i Changes to these margins will only adjust that that address.
Each unit represents 1/72 of an inch.

Return Address label:

Left Margin

Top Margin

0

0

Patient Address label:

Left Margin

Top Margin

0

0

Release 15.9.0 - May 12, 2025

[New features](#) | [Enhancements](#) | [Resolutions](#)

Highlights

New Features

New Split Claim Feature
Enhanced Auditing for Fee Schedules &
Customer-level Settings

Enhancements

A/R Control Payer Filter Renamed

New features

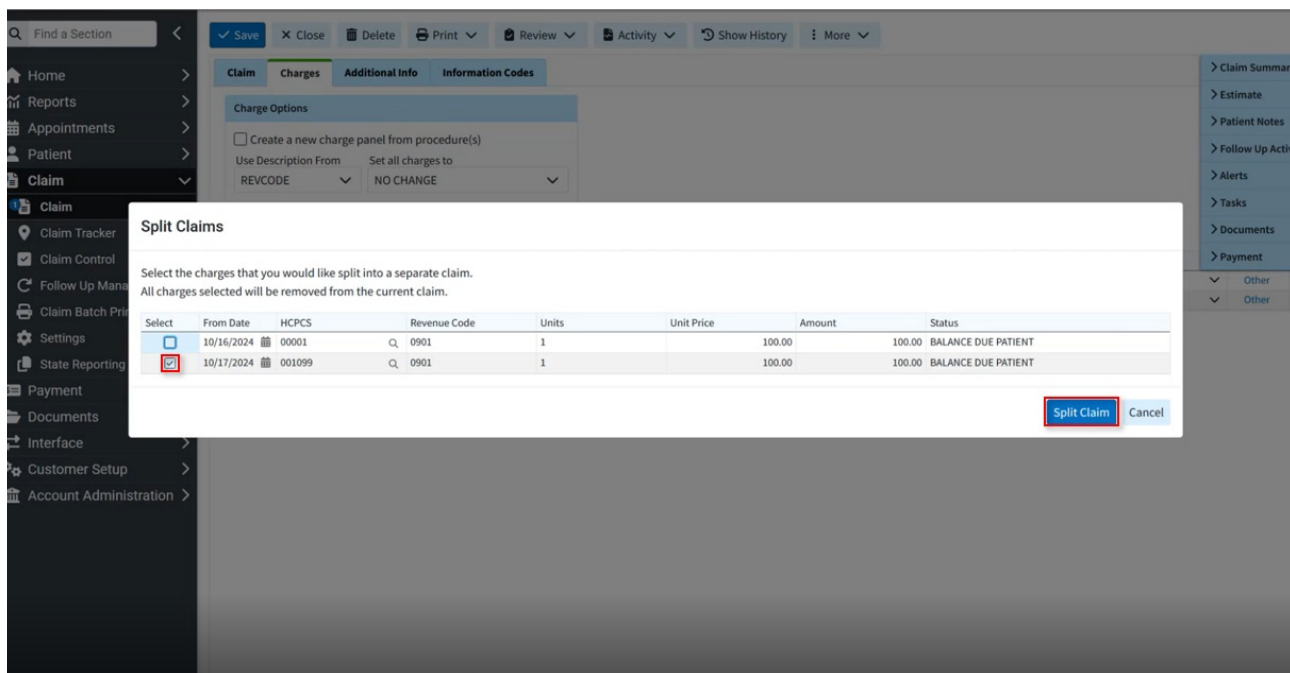
New Split Claim Feature

There are certain scenarios where claims need to be split. This could occur when an interface sends a single visit that should have been billed as multiple claims, or when a secondary payer has different bundling requirements than the primary payer. In these cases, users previously had to delete and re-enter payments or completely recreate the claim and duplicate the payments. To streamline this process, we released a new **Split Claim feature** that allows users to take a single claim and quickly split it into multiple claims. This option within the **More** menu in a claim enables users to move selected charges, including any existing payments, to a new claim, saving a significant amount of time.

The screenshot displays a software interface for managing claims. At the top, there is a toolbar with buttons: Save, Close, Delete, Print, Review, Activity, Show History, and a More menu. The 'More' menu is open, showing options: Convert Claim to Professional, Copy Claim, Split Claim (highlighted with a red box), Check Claim Status, Track Claim Submission History, View Charge History, Preview Electronic Claim, Update Other Claims w/ Insurance Info, and Update Patient w/ Insurance Info. The main area has tabs: Claim, Charges, Additional Info, and Information Codes. The 'Charges' tab is active, showing a 'Charge Options' section with a checkbox 'Create a new charge panel from procedure(s)', a dropdown 'Use Description From' set to 'REVCODE', and a dropdown 'Set all charges to' set to 'NO CHANGE'. Below this is a table with columns: Service Date, HCPCS, Mod 1, Mod 2, Mod 3, Mod 4, Rev Code, and Description. The table contains two rows of charges. At the bottom left, there is a '+ Add Charges' button and a '2 Charges' indicator. On the right side, there is a vertical sidebar with links: Claim Summary, Estimate, Patient Notes, Follow Up Activity, Alerts, Tasks, Documents, and Payment.

Service Date	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	Rev Code	Description
10/16/2024	00001	Q	Q	Q	Q	0901	BEHAVIORAL HEALTH TRE
10/17/2024	001099	Q	Q	Q	Q	0901	BEHAVIORAL HEALTH TRE

This new option allows users to select which charges will transfer to the new claim simply by checking them. Once moved, any associated payment history is automatically transferred, even if the claim has already been submitted. Please note that you are only able to split one claim into two. If you wish to split it further, you can reopen the claim after splitting it once.



Knowledge base articles

- [Split a Claim \(Prof\)](#)
- [Split Claim \(Inst\)](#)

New Enhanced Auditing (Show History) for Fee Schedules & Customer-level Settings

CollaborateMD has been working on a new enhanced auditing project that will provide offices with an easy and transparent way of auditing changes made in the application. We previously released our new Enhanced User Auditing feature in the Customer Setup, Patient, Claim, Appointment, Payment Profiles, and Interface Settings sections of the application, allowing users to see a detailed list of changes made to specific records throughout the application.

In this release, we are expanding our Enhanced Auditing functionality to the **Fee Schedules** and all **Customer-level Payment, Claim, and Patient settings**, enabling users to track modifications, changes, and updates made to fee schedules and settings for better auditing and accountability. With the new "**Show History**" feature, you can now determine which user changed/updated a specific setting or fee schedule in the software and when by providing an auditing table with all updates or changes made to a record, including the user, date, time, and the record changed.

The screenshot displays the application's user interface. On the left is a dark sidebar with a search bar labeled 'Find a Section' and a list of navigation items: Home, Reports, Appointments, Patient, Claim (expanded), Settings, State Reporting, Payment, Documents, Interface, Customer Setup, and Account Administration. The 'Claim' section is expanded, showing sub-items: Claim, Claim Tracker, Claim Control, Follow Up Management, and Claim Batch Print. The 'Settings' section is also expanded, showing: State Reporting, Payment, Documents, Interface, Customer Setup, and Account Administration. The main content area on the right has a top bar with 'Edit' and 'Show History' buttons. The 'Show History' button is highlighted with a red rectangle. Below this, the 'Claims Settings for Customer: COLLABORATEMD (#10001911)' section is visible, containing text about claim processing and a dropdown for 'HCPSC Code'. The 'Claims Settings for User: danielgoldsmith' section is also visible, containing settings for margins and print units.

These new auditing records are also included in our existing User Audit Report, making it an even stronger tool for auditing multiple records simultaneously. The Show History capability has currently been deployed in the Customer Setup, Patient, Claim, Appointments, Payment Profiles, Interface Settings, Fee Schedules, and Customer-level Setting sections, and we will be systematically adding it to other sections of the application.

Knowledge base articles

- [Enhanced Auditing \(Show History\)](#)

Enhancements

A/R Control Payer Filter Renamed

Previously, the existing A/R Control "Payer" filter could potentially confuse users who might expect it to "show any claims with this payer on it" instead of "showing claims currently at this payer," which is what it actually checks. In this release, we updated the filter name from "Payer" to "**Current Payer**" to better reflect its actual use. Please note that only the name has changed; the filter itself remains the same.

Claim Search Options

Old Filter Name

Payer

Charge Balance

Any

Charge Status

Balance Due Patient, Pending Patient, Collection, Claim At Insu...

Rendering Provider

Referring Provider

Claim Search Options

New Filter Name

Current Payer

Charge Balance

Any

Charge Status

Balance Due Patient, Pending Patient, Collection, Claim At Insu...

Rendering Provider

Referring Provider

Knowledge base articles

- Search for Patient Balances

Resolutions

ERA Contract Updates

When a contract warning appears in the ERA section, we will no longer allow users to update the contract from the ERA warning if the allowed amount is \$0.00. Previously, this could allow users to incorrectly update their contracts based on a \$0.00 allowed amount, when it was actually a claim denial or rejection and not a reflection of a contract needing to be updated. The warning itself, if your contract amount doesn't match the allowed amount, will still show (alongside informational items stating that the payer did not pay). However, the system will not allow you to update the contract directly from the warning.

Release 15.8.0 - April 28, 2025

[New features](#) | [Enhancements](#) | [Resolutions](#)

Highlights

New Features

New Re-Order charges on claims option
Enhanced Auditing for Payment Profiles & Interface Settings

Enhancements

New Shared Contact Groups

New features

New claim option to Re-Order charges

We added a new option that allows customers to quickly reorder charges on claims without completely re-entering them. This new column enables customers to change the order of charges on a claim in seconds for payers with specific requirements, even between primary and secondary payers. With this new drag-and-drop option, it's never been easier to change the order of charges on claims.

The screenshot displays the 'Claim Charges' interface. At the top, there are tabs for 'Claim', 'Charges', 'Additional Info', and 'Ambulance Info'. Below these are search fields for ICD A, ICD B, ICD C, ICD D, ICD E, ICD F, ICD G, ICD H, ICD I, and ICD J. A 'Charge Options' panel on the right includes a checkbox for 'Create a new charge panel from procedure(s)' and a dropdown for 'Set all charges to' with 'NO CHANGE' selected. A red box highlights a drag-and-drop handle (three horizontal lines) on the first row of the charges table, with a callout box stating 'Drag and drop to the Desired location/order'. The charges table has columns: From, To, Procedure, POS, TOS, Mod 1, Mod 2, Mod 3, Mod 4, DX Pointers, Unit Price, Units, Amount, Status, Other, and Delete. The first row shows a charge for J3475, POS 11, TOS 1, Mod 1 Q, Mod 2 Q, Mod 3 Q, Mod 4 Q, DX Pointers AB, Unit Price 0.00, Units 1.00, Amount 0.00, Status PAID. The second row shows a charge for J0610, POS 11, TOS 1, Mod 1 Q, Mod 2 Q, Mod 3 Q, Mod 4 Q, DX Pointers AB, Unit Price 0.00, Units 1.00, Amount 0.00, Status PAID. The third row shows a charge for 99212, POS 11, TOS 1, Mod 1 Q, Mod 2 Q, Mod 3 Q, Mod 4 Q, DX Pointers AB, Unit Price 250.00, Units 1.00, Amount 250.00, Status PAID. At the bottom, there is a '+ Add Charges' button and a '3 Charges' indicator.

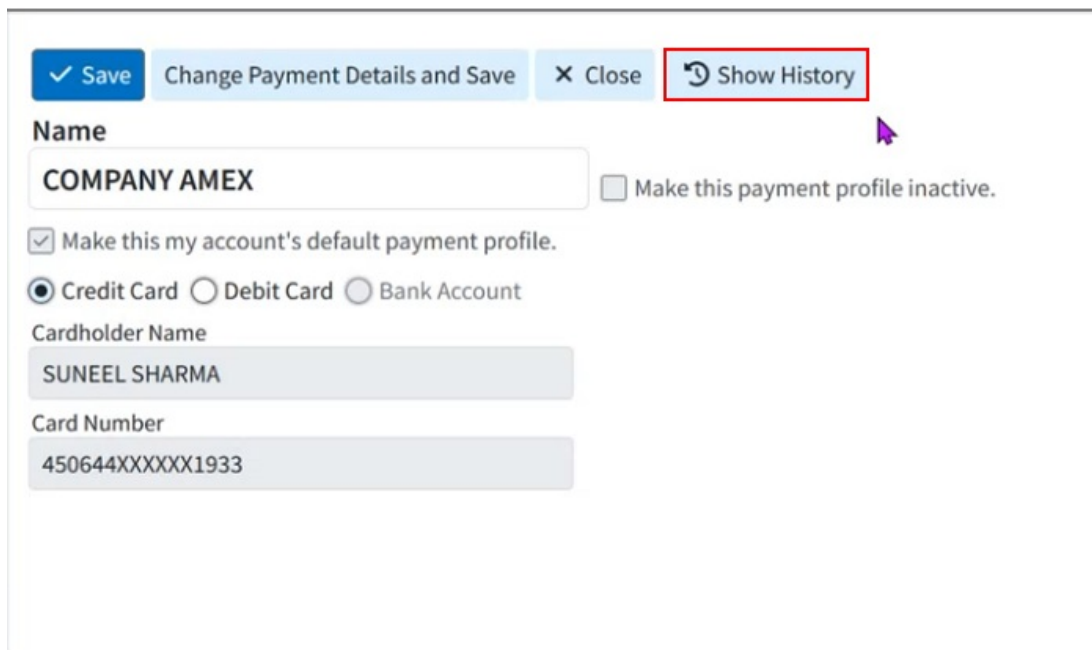
Knowledge base articles

- [Re-Order Charges On a Claim](#)
- [Add Diagnosis and Procedure Codes to Professional Claims](#)

New Enhanced Auditing (Show History) for Payment Profiles & Interface Settings

CollaborateMD has been working on a new enhanced auditing project that will provide offices with an easy and transparent way of auditing changes made in the application. We previously released our new Enhanced User Auditing feature in the Customer Setup, Patient, Claim, and Appointment sections of the application, allowing users to see a detailed list of changes made to specific records throughout the application.

In this release, we are expanding our Enhanced Auditing functionality to the **Payment Profiles** and **Interface Settings**, enabling users to track modifications, changes, and updates made to these 2 sections within CMD for better auditing and accountability. With the new "Show History" feature, you can now determine which user changed/updated a specific payment profile or interface setting in the software and when by providing an auditing table with all updates or changes made to a record, including the user, date, time, and the record changed.



The screenshot shows a web form for managing a payment profile. At the top, there are four buttons: 'Save' (blue with a checkmark), 'Change Payment Details and Save' (light blue), 'Close' (light blue with an 'X'), and 'Show History' (light blue with a circular arrow icon, highlighted with a red rectangle). Below the buttons, the 'Name' field contains 'COMPANY AMEX'. To the right of the name field is a checkbox labeled 'Make this payment profile inactive.' Below the name field is another checkbox labeled 'Make this my account's default payment profile.' which is checked. Underneath are three radio buttons: 'Credit Card' (selected), 'Debit Card', and 'Bank Account'. The 'Cardholder Name' field contains 'SUNEEL SHARMA'. The 'Card Number' field contains '450644XXXXXX1933'.

Please note that when auditing changes to a payment profile's credit card #, only the first and the last digit of the card will be visible. These new auditing records are also included in our existing User Audit Report, making it an even stronger tool for auditing multiple records simultaneously. The Show History capability has currently been deployed in the Customer Setup, Patient, Claim, Appointments, Payment Profiles, and Interface Settings sections, and we will be systematically adding it to other sections of the application.

[Knowledge base articles](#)

- [Enhanced Auditing \(Show History\)](#)

Enhancements

New Shared Contact Groups

We added a Shared Contact Groups option within CMD Messaging, enabling users to send messages to groups and share those groups across their organization. This new option is controlled by an additional permission level within the existing Contacts permission. It allows users to create and share contact groups for those employees working on specific tasks (e.g., denials or collections) to ensure timely notifications are sent to the appropriate individuals.

New Group

Group Name

+ Add Contacts

☒ Share this group

☐ All Users
 ☒ Admins Only
 ☐ Auth Reps Only

i Shared groups are accessible to users who can contact all members.

Username	First Name	Last Name	Type	Remove
You have no members added to this contact group. Try adding a new member.				

Save

Cancel

Knowledge base articles

- [Create a Shared Contact Group](#)

Resolutions

Text not highlighted within tables when a field was selected

Corrected a minor visual issue that prevented text from being highlighted in tables for some Chrome users when an input field was selected. This affected all sections but did not impact keyboard functionality when typing to replace content in the field.



Release 15.7.0 - April 14, 2025

[View features](#) |
 [Enhancements](#) |
 [Resolutions](#)

New features

New Pay Over Time with Sunbit feature integration

CollaborateMD now has an integrated partnership with Sunbit's buy now, pay later (BNPL) technology. Trusted healthcare practices and medical billing platforms can now choose Sunbit as a patient-friendly solution for post-care payment plans. Sunbit helps eliminate the stress of managing in-house payment plans by offering a pay-over-time option for patient invoices.

Providers can now offer their patients financing without assuming any financial risk themselves, as they receive the full amount within a few days. Sunbit manages all patient billing, enabling providers to reduce time in accounts receivable and minimize effort on collections. Patients can easily request financing directly from the payment portal, benefiting from a 90% approval rate and a 0% financing option for 3 months. Additionally, there are 6, 12, and 18-month plans with competitive interest rates.

Important Note: You must have the **In-App Credit Card Processing** and the **Patient Payment Portal** features enabled and configured so your patients can use Pay Over Time with Sunbit from the portal.

Pay Over Time with sunbit

 This service is included in your account's price plan

The average American can't afford a \$400 unexpected expense, resulting in patients partially paying or delaying payment and an overall hardship on your patients. CollaborateMD and Sunbit have partnered to help you increase your collection rate, create office efficiency and build better patient relationships, with buy now, pay-over-time flexible payment options embedded into your CollaborateMD patient experience.


Why Sunbit

Sunbit is the preferred buy now, pay-over-time consumer financing technology for everyday needs, offering access to fast, fair, and transparent payment options to 90% of patients.

- 90% of patients approved (no late fees)
- 0% APR option presented to all approved patients
- Providers are paid upfront and in full no later than 5 business days after patient selection (non-recourse)

[Learn More](#)

[Activate Now](#)

 Subject to approval based on creditworthiness. Payment is due at checkout. 0-35.99% APR. Maximum loan amounts may vary based on merchant. Account openings and payment activity are reported to a major credit bureau. See [Rates and Terms](#) for loan requirements and state restrictions. Sunbit is licensed under the CT Laws Relating to Small Loans (lic. # SLC-1760582 & SLC-BCH-1844702).

Loans made by TAB bank. All figures are provided by Sunbit

[Close](#)

Knowledge base articles

- [Pay Over Time with Sunbit](#)
- [Manage Pay Over Time with Sunbit](#)
- [Create a Payment Plan with Sunbit](#)
- [Refund a Sunbit \(Pay Over Time\) Patient Payment](#)

- [Merchant Payments Report](#)
- [Manage your Patient Payment Portal](#)

New Clinical Laboratory Fee Schedule

We added the Centers for Medicare and Medicaid Services (CMS) "**Clinical Laboratory Fee Schedule**" for customers who are not physicians or who perform services not covered by the Medicare Physician Fee Schedule but can still be paid by Medicare. Lab customers or any customer who orders lab tests can now take advantage of fee schedules and contracts based on the Medicare Clinical Laboratory Fee Schedule (CLFS). When creating a fee schedule or contract using the Medicare Fee Schedule in CMD, it will include the Medicare Physician Fee Schedule and the Medicare Clinical Laboratory Fee Schedule. The Clinical Laboratory Fee Schedule will price procedure codes associated with a lab or test, while the Medicare Physician Fee Schedule will price other procedures.

The Medicare Clinical Laboratory Fee Schedule will be updated quarterly and consists of a single price, either local or national, in contrast to the Medicare Physician Fee Schedule, which is determined based on the specific ZIP code location.

Medicare Clinical Laboratory Fee Schedule

Code: 81400

Year

2025

Medicare Allowables

Pricing Indicator: National

CLIA Waived: No

Price: \$63.96

Knowledge base articles

- [Add a Fee Schedule](#)
- [Procedure Code Fee Schedule](#)
- [Add a Contract](#)

New Payer Agreement Signature option

We added a new feature for completing payer agreements that require a physical signature but allow for electronic submission of the agreement with the wet signature. This option enables the provider to print, sign, and scan the form, then upload the scanned PDF within the application as part of the Submit Facility NPI Enrollment Form API, similar to the electronic signature process.

New Agreement for: ABDALLA, YOOSIF MD (#10134970)

✓ ☐ ☐ ☐

TEXAS MEDICARE

Product: Institutional Claims ID: TXMC

This payer requires a physical signature for this agreement, but allows for electronic submission. Please print, sign, scan, and upload the form.

Note: Please ensure that the uploaded form has been correctly signed to prevent agreement processing delays.

Knowledge base articles

- [New ePS Payer Agreement](#)

Enhancements

New Option to allow sending Clearinghouse Notifications via email

Previously, clearinghouse notifications could only be subscribed to using the CMD Messaging option. In this release, we added the ability to receive Clearinghouse notifications via email, in addition to CMD Messaging. The default will remain CMD Messaging, but users can now configure Clearinghouse notifications to be sent via email within their User Profile > Communication Preferences.

Communication Preferences

[✓ Save](#)[✕ Cancel](#)

Communication Type	Email	Text	Messaging	None
Approval(s).				
Payer Agreement Denial Sent when CollaborateMD has received your Payer Agreement Denial(s).	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Maintenance Notification CMD initiated communication related to upcoming planned maintenance windows (application downtime).	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
System Issue CMD initiated communication related to ongoing or resolved system issues impacting critical services (claims, statements, etc) or application availability.	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
Pricing Changes CMD initiated communication related to upcoming changes to pricing.	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
Other Announcement CMD initiated communication related to other general announcements (new application release, office closure, etc).	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
User Permissions Changed Sent when a user's permissions are changed.	<input type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Clearinghouse Notifications CMD initiated communication related to clearinghouse notifies.	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Knowledge base articles

- [Communication Preferences](#)

New Option to set non-all-inclusive charges as Paid after billing

We recently added a new feature to the Codes section that allows users to bill other charges when there is an "all-inclusive" charge on the claim, while still sending other charges as \$0.00 or \$0.01. These charges are then sent as information to the payer but will not be paid. Users would then need to manually adjust, delete, or mark these charges as paid, which created extra work. In this release, we introduced a new option on the Procedure Codes screen to automatically set non-all-inclusive charges as paid after billing. After selecting one of the options to send all other charges on the claim as \$0.00 or \$0.01, you can choose to automatically mark the other charges as paid after billing, which will set all other charges to PAID rather than AT INSURANCE when claims are submitted.

Procedure Codes

Code

Type

☐ Make this code inactive

Description

Claim Defaults

☐ Exclude this code from duplicate service checks
☒ This is an all inclusive code

☒ Automatically mark other charges as PAID after billing
☐ This code is a percentage of the claim total

Default Price
Default Units
Default Charge Status

Rev Code
Place of Service

Narrative Notes

Modifiers (Global & Situational)

Knowledge base articles

- [Add CPT/HCPCS Codes](#)

New "Current Status" column on EOB/ERA

When posting an insurance payment (manual or ERA) and viewing an individual EOB, the current claim status (not the status that will be set when the payment is posted) is available when hovering over the status column. In this release, we added a new optional column, hidden by default, to the individual EOB screen. The new "Current Status" column will show the current claim status for better visibility in some workflows.

Search

Payment from AMERICHoice of New York Inc. (Medicaid NY) X

Done

Cancel

Activity

Actions

Options

Payment - Check from AMERICHoice of New York Inc. (Medicaid NY) received on 03/21/2024 for MUNIZ, JOSEPH (#37190993)

Claim # 177121295 | Rendering STRANGE, DOCTOR

Action

Processed

TCN

Status

SEND TO AMERICHoice of New York Inc. (Medicaid NY)

Claim C

DOS	Proc	Amount	Start Balance	Allowed	Paid
03/04/2022	001F	\$400.00	\$400.00	300.00	200.00
03/04/2022	44388	\$370.00	\$352.00	0.00	0.00
03/04/2022	00174	\$250.00	\$250.00	0.00	0.00
Total:		\$1,020.00	\$1,002.00	\$300.00	\$200.00

Transaction ID

Unapplied Copay is Available

Current Status

DOS

Proc

Amount

Start Balance

Allowed

Paid

Done

Apply Discount

Apply Credit Adjustment

Apply Debit Adjustment

Payment Memo

ADJUSTMENT BY AMERICHoice of New York Inc. Medicaid NY

New Search option when searching in specific dropdown select fields

We added the ability to search and filter dropdowns with a visual confirmation when typing or searching in the Charge Status, Account Type, and Eligibility Service Type dropdown fields so users can see when they search for dropdown items.

Search/Add

JOHNNY TEST X

Save

Close

Print

Merge

Eligibility

Activity

View All Appointments

Show History

Last Name

TEST

First Name

JOHNNY

MI

Suffix

Gender

Male

Date of Birth

01/16/1982

(43 y)

SSN

581-55-8885

Date of Death

☐ Make this patient inactive

☒ Patient is complete

Patient Info

Insurance Info

Billing Info

Claim Defaults

Type

Payment Plan

Account #

33397993

Reference #

Q Search

Self Pay

Courtesy

Collection

Pre-Collection

Type I

Type II

Payment Plan

Copy Insured Address

State

FL

ZIP Code

32703

Phone

(1) 277-0617

Work Phone

Ext

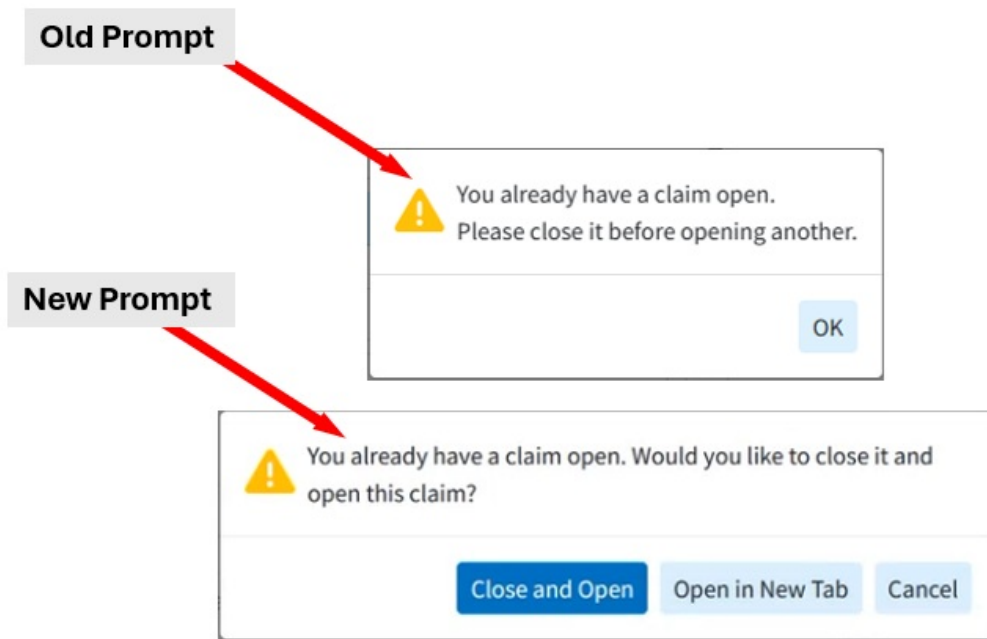
Email

joseph.muniz@collaboratemd.com

Resolutions

The "Close and Open Claim" option is missing from Patient > View All Claims

Corrected an issue preventing users from opening a claim from **Patient > More > View All Claims** when a claim is already open. We previously added this prompt to other sections where claims could be opened, allowing the user to open the claim in a new tab or close the existing claim and open a new one from the prompt. In this release, we updated this screen to prompt the user to close the current claim before opening a new one, as it does on other screens.



Release 15.6.0 - March 31, 2025


Enhancements

Enhancements

Provider Adjustments Details screen update

Updated the Help Text for the Provider Adjustment Details screen at the top to include links pointing directly to help pages that will aid customers in understanding what provider-level adjustments are and how to post them. The text will now provide a brief description of what provider adjustments are and include links to help articles on associating and applying provider adjustments on claims, as well as automatically posting interest amounts as payments.

Provider Adjustment Details

 Provider adjustments are payments that are not associated with a specific claim or service. To apply provider adjustments to claims, see our help articles:

- Associate and apply provider adjustments to claims
- Automatically post interest amounts as payments

Date	Reason	Reference #	Amount	Claims	Remove
Total			\$0.00		

+ Add Provider Adjustment

Done

Cancel

Knowledge base articles

- Associate and apply provider adjustments to claims
- Configure Payment Settings for Users

Referring Provider filter updated in multiple locations

The Referring Provider filter has been modified to function as a search field instead of a dropdown menu when the number of referring providers exceeds 20. This change aligns the behavior of the Referring Provider filter with that of the Rendering Provider and Payer search fields across the Control, Tracking, and Batch sections of the application. This search field offers enhanced searching and improved performance for accounts with more than 20 referring providers while maintaining the simplicity of a dropdown menu for customers with fewer than 20.

All Referring Providers

Search for referring providers

Selected	Name	Reference #	NPI	Address	+
<input type="checkbox"/>	ACTIVE, RADIO (#10589394)	CHAS		FL	
<input type="checkbox"/>	AHOV, CHIIPS (#11805299)			123 COOKIE WAY, IL	
<input type="checkbox"/>	BELL, EDITH (#10404204)		3773978330	UT	
<input type="checkbox"/>	BELL, EDITH (#11172899)		3773978330	FL	
<input type="checkbox"/>	BELL - MD, EDITH (#11218397)		3773978330	UT	
<input type="checkbox"/>	BILLY, BOB (#11714164)			TX	
<input type="checkbox"/>	BIRD, ITSA (#11291637)	123	1651984613	42039 ITS A PLANE PLACE, ORLANDO, FL 32817	
<input type="checkbox"/>	BLUE, DR (#11813529)			FL	
<input type="checkbox"/>	BOWLER, DONNY (#11324581)			857-10 PIN LANE, LOS ANGELES, CA 12345-5845	
<input type="checkbox"/>	BRAD TEST ORG (#11712702)			FL	
<input type="checkbox"/>	BRADSHAW - REF TEST, KEVIN (#1171554)		0646465406	123 MAIN STREET, ORLANDO, FL 32805	
<input type="checkbox"/>	BRADSHAW - TEST, KEVIN (#1171455)		6546546540	123 MAIN STREET, ORLANDO, FL 32805	
<input type="checkbox"/>	BRAIN, PINKY (#10170578)		1223334444	12 SNARF WAY, ORLANDO, FL 32801	
<input type="checkbox"/>	BROWN, ERIC (#12076905)		1417622671	439 S UNION ST UNIT 2104, LAWRENCE, MA 01843-2800	
<input type="checkbox"/>	BURKE, DARLENE (#11218440)		5231532236	TX	
<input type="checkbox"/>	BURNS, TEST (#11295403)		3546846263	AZ	
<input type="checkbox"/>	BURR, JADE (#11233476)		0060964643	GA	
<input type="checkbox"/>	CAKES, NATTIE (#10039281)	78674	5214693585	654 CATS MEOW LANE SUITE #3, KITTY, PA 71254	
<input type="checkbox"/>	CAT, LUNA (#11846012)		0000000001	REF PROV AVE, TAMPA, FL 00000-1111	
<input type="checkbox"/>	CHANG, JOHN (#11759319)		1073516027	169 N MIDDLETOWN RD, PEARL RIVER, NY 10965-	

☐ Select All

Select

Close

Release 15.5.0 - March 17, 2025

New Features and Updates

General

Appointments

- New Enhanced Auditing (Show History) for Appointments** CollaborateMD has been working on a new enhanced auditing project that will provide offices with an easy and transparent way of auditing changes made in the application. We previously released our new Enhanced User Auditing feature in the Customer Setup, Patient, and Claim sections of the application, allowing users to see a detailed list of changes made to specific records throughout the application.

In this release, we are expanding our Enhanced Auditing functionality to the Appointments section, enabling users to track modifications, changes, and updates made to appointments within CMD for better auditing and accountability. With the new "Show History" feature, you can now determine which user changed/updated specific appointment information in the software and when by providing an auditing table with all updates or changes made to a record, including the user, date and time, and the record changed.

The screenshot displays the 'Appointment' form in the CollaborateMD application. The left sidebar contains navigation options like Home, Reports, Appointments, Scheduler, and Patient. The main form area is titled 'Appointment' and includes tabs for 'Patient' and 'Payment'. The 'Patient' tab is active, showing details for 'TEST, JOHNNY (33397993)'. The form fields include Appointment Date (03/13/2025), Time (01:00 PM), Length (45 Minutes), Appt Status (Scheduled), Appt Type (CARDIOLOGY), Resource ([01] JESSICA DUKE), Facility (A UNIQUE FACILITY(#10203231)), Office Location (ABC MEDICAL GROUP 123 ABC STREET), Chief Complaint, and a checkbox for 'Repeat appointment every'. A 'Show History' button is highlighted in the top right. The right sidebar shows an 'Account Summary for JOHNNY TEST' with various financial and administrative details.

These new auditing records are also included in our existing User Audit Report, making it an even stronger tool for auditing multiple records simultaneously. The Show History capability has currently been deployed in the Customer Setup, Patient, Claim, and Appointments sections, and we will be systematically adding it to other sections of the application.

For more information on using our new Add New Same/Similar Code List feature, please visit our [Enhanced Auditing Help Articles](#).

Release 15.4.0 - March 3, 2025

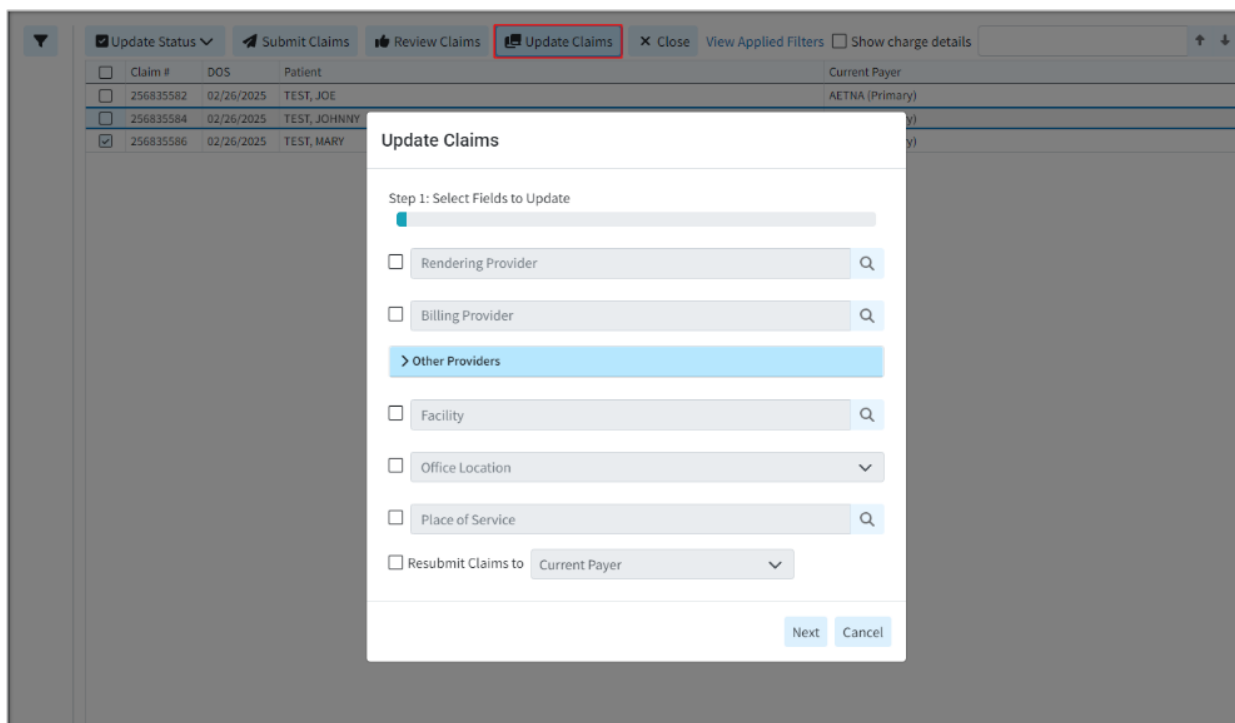
New Features and Updates

General

Claims

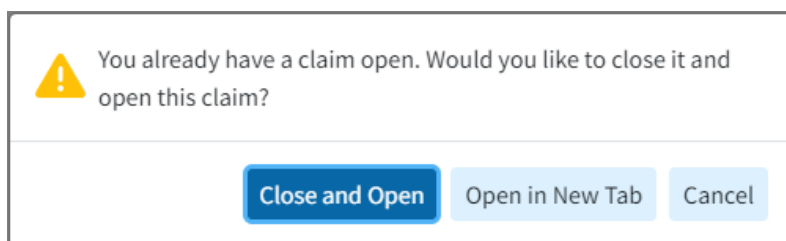
- New Mass Claim Updates Feature:** CollaborateMD has always provided powerful tools for working with individual claims, but the platform's ability to make changes to multiple claims at once was limited. With this release, users no longer have to open each claim individually when correcting minor mistakes, such as setting the wrong rendering provider or place of service code on claims. We added a new Mass Claim Updates feature that enhances the existing Status Control screen with capabilities to modify multiple claims. The Status Control screen has been renamed Claim Control, where users can now manage the review of incoming claims from their EHR, submit or resubmit claims, and make updates to multiple claims at once, such as updating the Rendering and Billing Providers, the Facility,

the Office Location, or the Place of Service by simply selecting the claim(s) and choosing the Update Claims option.



For more information on updating multiple claims at once, please visit our [Update Multiple Claims Help Article](#).

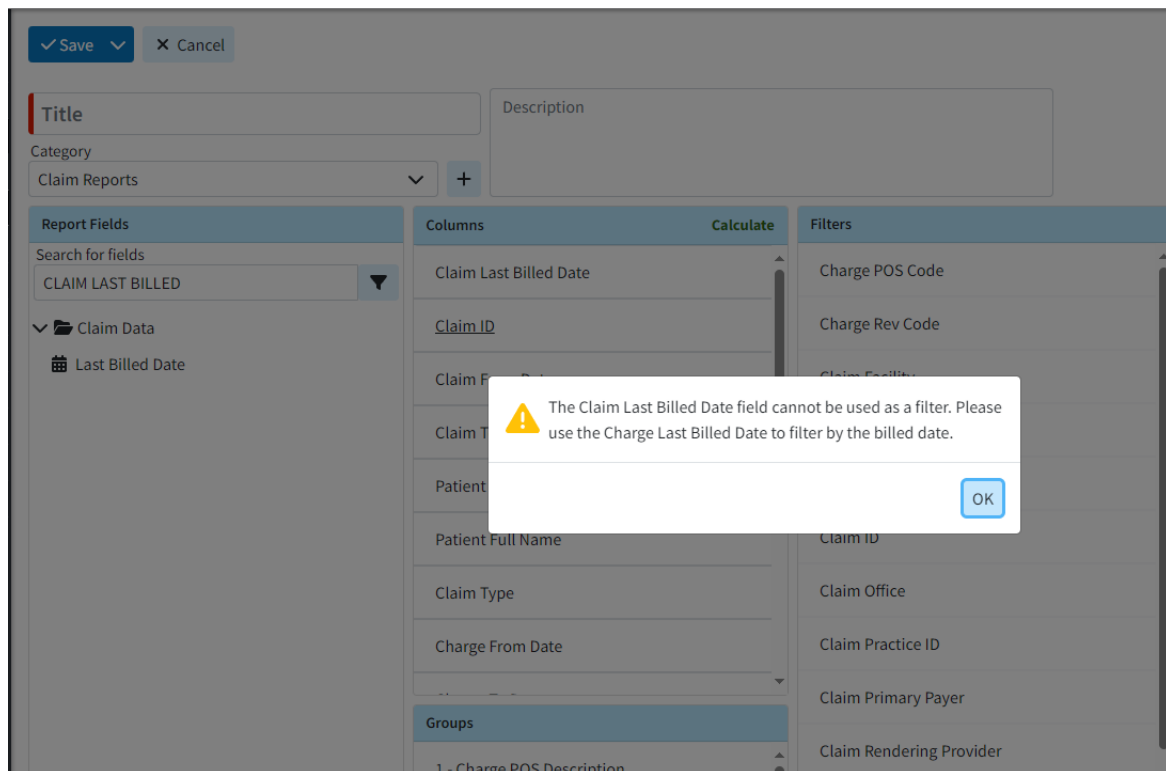
- **Alternate Option To Open A Claim In a Separate Tab When Another Claim Is Already Open:** We have introduced a new dialog box option that appears when a user attempts to open a claim from any section within the CMD while a claim is already open. This feature will now provide the user with the following options:
 - **Close and Open** - Closes the open claim and opens a new one (it will display the usual unsaved changes warning and allow the user to save if there are unsaved changes).
 - **Open in New Tab** - Opens a new window/tab with the correct URL/claim
 - **Cancel** - Closes the dialog and keeps the claim open.



Reports

- **Update to the Report Builder to Prevent the "Claim Last Billed Date" Field from Being Added as a Filter:** Updated the Report Builder to prevent adding the "Claim Last Billed Date" report field as a

Report Filter. While some customers may still try using this field as a filter, we've added a warning message directing them to use the "Charge Last Billed Date" instead, which provides the same results is much faster, and can potentially be improved further via an index.



Patient

- **New Appointment View Option From The Patient Section:** Previously, the "View All Appointments" button directed users to the Appointment section to view a patient's appointment details, requiring them to leave the current section even if they only needed the dates of past appointments. In this release, we added a new "Appointments" option in the patient side panel that displays a list of all appointments (categorized into Past Appointments and Future Appointments) for the patient without leaving the screen. The section will still provide an option for users to access the "View All Appointments" button, directing them to the Appointment section where they can see patient appointment details.

Search/Add

JOE TEST

Save

Close

Print

Merge

Eligibility

Activity

Show History

More

TEST

JOE

MI

Suffix

Make this patient inactive

Patient is complete

Gender

Male

Date of Birth

01/16/1982

(43 y)

Date of Death

987-65-4321

Patient Info

Insurance Info

Billing Info

Claim Defaults

Type

Payment Plan

Account #

37190993

Reference #

Contact Information

Address

1100 E WASHINGTON ST

City

ORLANDO

State

FL

ZIP Code

32801-2128

International Address

This address was successfully verified.

Home Phone

(407) 555-2121

Cell Phone

(321) 277-5555

Work Phone

Ext

Email

fake.email@gmail.com

Communications

Account Summary

Notes

Appointments

View All Appointments

Past Appointments

10/10/2024 at 3:00 PM (45 minutes)

[01] JESSICA DUKE

06/06/2024 at 11:00 AM (45 minutes)

[01] JESSICA DUKE

06/03/2024 at 11:00 AM (45 minutes)

[01] JESSICA DUKE

09/07/2023 at 12:45 PM (45 minutes)

[01] JESSICA DUKE

06/15/2023 at 12:00 PM (45 minutes)

[001] STEPHEN KOZLOWSKI

06/12/2023 at 10:00 AM (45 minutes)

[1212] DR DISNEY

06/09/2023 at 10:45 AM (30 minutes)

[001] STEPHEN KOZLOWSKI

Alerts

For more information on our new Appointments dropdown, please visit our [View Appointments From Patient Section Help Articles](#).

Customer Setup

- New Option to Open Contracts and Fee Schedules From Procedure & Revenue Codes Section:** We added the ability for users to open contracts and fee schedules directly from the Procedure and Revenue Codes sections. This new functionality enables users to click on the Fee Schedule/Contract Name (which is now a clickable link) within the Contracts and Fee Schedules side panel, allowing them to access and view the associated contracts and fee schedules.

Procedure Codes

Save

Close

Show History

Code

0005F

Type

CPT®/HCPCS

Dept.

Make this code inactive

Description

OSTEOARTHRITIS ASSESSED

Claim Defaults

Exclude this code from duplicate service checks

This is an all inclusive code

This code is a percentage of the claim total

Default Price

100.00

Default Units

1.00

Default Charge Status

Rev Code

0020

Place of Service

11

CLIA Number

Type of Service

Narrative Notes

Modifiers (Global & Situational)

Global 1

Global 2

Global 3

Global 4

Modifiers

Applies To

Notes

25

Provider - ABDUL, SAMANTHA

1P

Payer - AARP

Add Situational Rule

Billing Alerts

Notes

Alerts

Fee Schedules

Fee Schedule

Price

REV101

0.00

AETNA093020

100.00

BCBS

100.00

COURT APPEARANCE FEES

100.00

COURTESY

100.00

MEDICARE

100.00

ERROL TEST

0.00

HORIZON

100.00

MEDICARE TEST MARY 123

100.00

PB CASH FEE 2022

23.00

PB CLINIC 2022 - INSURANCE

50.00

SDFGHJK

0.00

SELF PAY

100.00

T1016

0.00

TANYAS FEE SCHEDULE

0.00

TEST

600.00

TEST

100.00

TEST FEE

0.00

TEST FEE SCHED

100.00

TEST FS

0.00

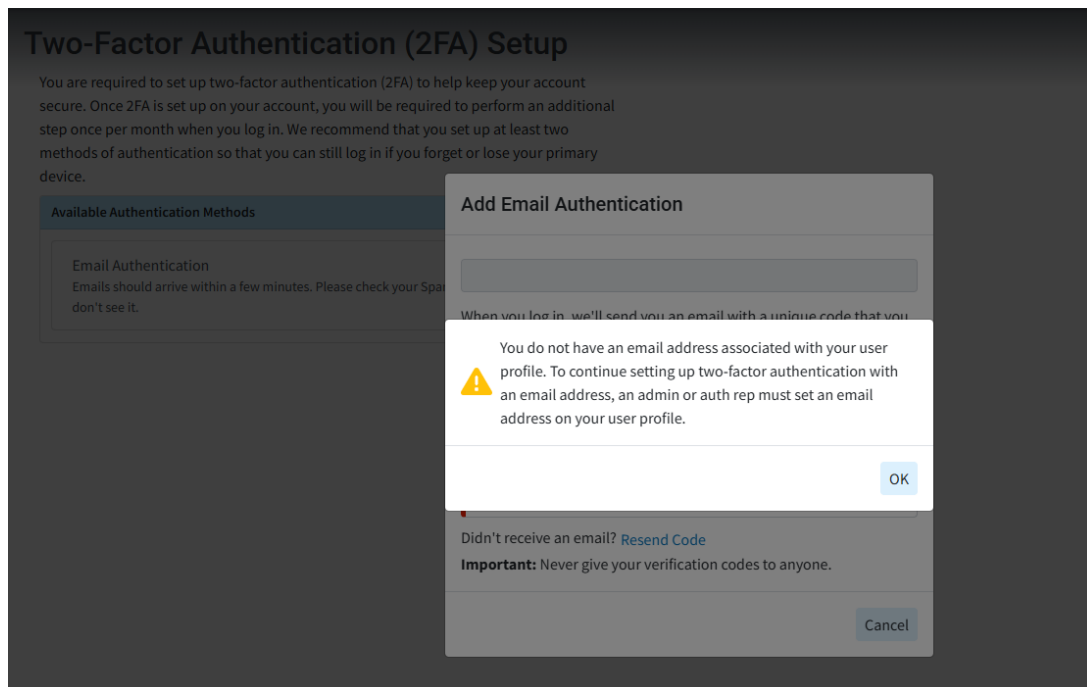
View Medicare Physician Fee Schedule (MPFS) Information

Contracts

For more information on accessing fee schedules/Contracts from procedure codes, please visit our [Procedure Codes Fee Schedules](#) or [Procedure Codes Contract](#) Help Articles. For information on accessing fee schedules/Contracts from revenue codes, please visit our [Revenue Codes Fee Schedule](#) or [Revenue Codes Contract](#) Help Articles.

User Profile

- **New Email Option For Two-Factor Authentication:** We updated our Two-Factor Authentication to now support email authentication. This option will send an email message with a 6-digit login code, similar to the SMS verification, and can only be set up with the email attached to the user's CMD profile. Please note that if an email address is used that does not match the one set in your user profile you will receive a warning.



Release 15.3.0 - February 18, 2025

New Features and Updates

General

Patient

- **New Balance Due Insurance Optional Column:** Some healthcare providers rarely bill patients

directly, instead focusing primarily on the balance owed by insurance companies rather than the patient's balance. The patient search screen (results dialog) already displayed the balance owed by insurance, but this information was not shown in the recently opened table. In this release, We added the Balance Due Insurance as an optional column (hidden by default) within the Patient Search screen's Recently Opened list.

Select Columns

Available Columns	Visible Columns
Reference # +	Account #
Facility +	Name
Rendering Provider +	Date of Birth
Balance due Ins. +	Insured
	Balance due Pat.
	Account Type

Done

- **New A/R Control Filters Related To Payment Portal Invites:** We recently added an option to Send Payment Portal Invites as a batch action from Patient A/R Control. In this release, we added new filters within A/R Control to determine whether or not a patient has enrolled with the payment portal. Customers can now search by a new Date Search Option "***Days Since Last Payment Portal Invite Sent***" or by the Claim Search Option "***Payment Portal Status***" (Invitation Not Sent, Invitation Sent but Not Registered, Registered).

Date Search Options

Filter search by: ☒ By # of days ☐ By date range

Days Since Last Seen
Any

Days Since Last Payment
Any

Days Since Last Statement
Any

Days Since Last FDN
Any

Days Since Last Collection
Any

Days Since Date of Service
Any

Days Since First Billed
Any

Days Since Set To Due Patient
Any

Days Since Last Statement Sent for Claim
Any

Days Since Last Payment Portal Invite Sent
Any

Claim Search Options

Payer

Charge Balance
Any

Charge Status
Balance Due Patient, Pending Patient, Collection, Claim At Insu...

Rendering Provider

Referring Provider

Paper Statements Sent
Any

Electronic Statements Sent
Any

Total Statements Sent
Any

Patient

Account Type

Set to Send Statement
Any

Set to Send FDN
Any

Payment Portal Status

For more information on determining if patients have enrolled in the payment portal, please visit our [Search For Patient Balances Help Article](#).

Claim

- Updated the Claim Search Capability:** When users receive communication from the payer about a claim, it often includes the payer's claim number: the ICN (Internal Control Number), Claim Control Number, or Original Reference #. These numbers are automatically populated on the claim after the ERA is applied, so the ability to find claims by the ICN is a great tool to have when working on appeals. In this release, we updated the Claim Search capability to include searching by all three claim control numbers, making it easier to locate specific claims during the appeals process.

Search by name, DOB, account#, member ID, claim ID, or TCN Number

+ Add Professional Claim
+ Add Institutional Claim
☐ Show exact matches only
☐ Show unpaid claims only

123456789

Recently Opened

Claim ID	DOS	Patient	Total Charges	Balance
----------	-----	---------	---------------	---------

Save
Close
Delete
Print
Review
Activity
Claim Status
Open Patient

Claim
Charges
Additional Info
Ambulance Info

Rendering Provider
DUKE, JESSICA (10128215)

Billing Provider
DUKE, JESSICA (10128215)

Supervising Provider

Ordering Provider

Referring/PCP Provider
Ref

Sales Rep

Facility

Office Location
ABC MEDICAL GROUP 123 ABC STREET

Primary Insurance
AMERICHoice OF NEW YORK INC. (MEDICAID NY) (10069010)

Hide Primary Policy Details

Member ID
36515

Policy Type
Other

Copay Due
0.00

Group Number
553

Claim Control / Original Ref. #
123456789

Authorization #

Referral Type
Prior Auth Number

Secondary Insurance
HUMANA (10102666)

Hide Secondary Policy Details

- New Optional Column For Document Count:** We added a new optional column (hidden by default) to the Claim, Patient, and Payment sections that display a count of the documents associated with each item. This column helps indicate if a patient, claim, or payment has a document association before opening it.

Please note that this column option will only appear on the search screen after a search is performed, not on the Recently Opened List.

Search Results												
Filter your results												
Searched By	Claim #	Type	Account #	Patient Name	Documents	Rendering	From	To	Lines	Charges	Payments	Adjustme
First: JOSEPH	256238298	Professional	37190993	MUNIZ, JOSEPH	1	DUKE	02/18/2025	02/18/2025	1	\$100.00	\$0.00	
First: JOSEPH	252696024	Professional	37190993	MUNIZ, JOSEPH	0	DUKE	01/03/2025	01/03/2025	2	\$294.00	\$0.00	
First: JOSEPH	246038322	Professional	37190993	MUNIZ, JOSEPH	2	DUKE	10/11/2024	10/11/2024	3	\$300.00	\$0.00	
First: JOSEPH	244816660	Professional	37190993	MUNIZ, JOSEPH	1	DUKE	09/26/2024	09/26/2024	2	\$100.00	\$0.00	
First: JOSEPH	242777502	Professional	37190993	MUNIZ, JOSEPH	0	DUKE	08/30/2024	08/30/2024	1	\$0.00	\$0.00	
First: JOSEPH	239111944	Professional	37190993	MUNIZ, JOSEPH	3	DUKE	07/16/2024	07/16/2024	1	\$100.00	\$0.00	
First: JOSEPH	237758587	Professional	37190993	MUNIZ, JOSEPH	0	DUKE	06/27/2024	06/27/2024	6	\$679.00	\$0.00	
First: JOSEPH	235925615	Professional	37190993	MUNIZ, JOSEPH	0	DUKE	06/03/2024	06/03/2024	1	\$100.00	\$0.00	
First: JOSEPH	203068504	Professional	37190993	MUNIZ, JOSEPH	1	DUKE	03/16/2023	03/16/2023	1	\$650.00	\$0.00	
First: JOSEPH	195211259	Professional	37190993	MUNIZ, JOSEPH	0	DUKE	11/21/2022	11/21/2022	3	\$300.00	\$50.00	\$2
First: JOSEPH	192053855	Professional	37190993	MUNIZ, JOSEPH	0	DUKE	10/04/2022	10/04/2022	2	\$850.00	\$0.00	
First: JOSEPH	185965232	Professional	37190993	MUNIZ, JOSEPH	0	DUKE	07/05/2022	07/05/2022	2	\$194.00	\$0.00	
First: JOSEPH	182987148	Professional	37190993	MUNIZ, JOSEPH	0	ABDUL	05/19/2022	05/19/2022	2	\$444.00	\$0.00	

Close

Payment

- Updated The Refund Receipts:** Previously, when refund receipts were generated, they appeared identical to a standard receipt, except that the refund amount was displayed within parentheses. To make these receipts more easily identifiable and comprehensible, we modified the refund receipt by adding the word "Refund" to the text and displaying negative numbers with a negative symbol instead of using parentheses, making it clearer.

**Receipt**

Receipt # 10002247

CMD FAMILY PRACTICE - WEST

PO BOX 555, ORLANDO, FL 32488-1111

<https://www.bestdoctorever.com> • (321) 251-7915**Payment Refund****-\$12.50**

Patient: MCCLOUD, FOX

Account: 25017512

Check received on 02/12/2025

Thank you for your payment.

Release 15.2.0 - February 4, 2025

New Features and Updates

General

Appointments

- **New Appointment Setting to Hide The Status of Received/Applied Intake Forms:** Some users who have tightly packed schedules (double/triple booked) may struggle to see the specifics of their appointments due to the two types of icons we show (the eligibility icon and the forms icon) taking up a lot of the appointment space. To help with this, we introduced a setting that allows users to hide the checkmark that indicates forms that have been submitted.

Appointment Settings for User: josephmuniz

Show a warning when opening a past appointment:
☒ Yes ☐ No

Prompt me to schedule requests from the waiting list when:
☒ Moving an appointment
☒ Deleting, canceling, or rescheduling an appointment

Enable drag-and-drop in the scheduler:
☒ Yes ☐ No

Hide the status of Intake Forms on the scheduler when intake forms have been received and applied?
☐ Yes ☒ No

Visit our [Configure User Appointment Settings Help Articles](#) for more information on how to turn on this setting.

Patient

- **New Patient Broadcast Communications Feature** Patient engagement is the collaborative process between healthcare providers and patients aimed at improving patient health. Over the past few years, the significance and prevalence of patient engagement have grown considerably. Research indicates that when patients feel involved and take an active role in their medical care, they achieve improved health results. Simultaneously, providers observe increased patient satisfaction and retention.

In order to meet the growing needs of both providers and patients, CollaborateMD has developed and introduced a new Patient Broadcast Communications feature. This feature allows providers to send targeted one-way communications to multiple patients using various methods (text, email, or phone). Customers can set campaigns with customized parameters to target specific patients, helping them with their healthcare needs and encouraging retention or usage of optional/elective medical services through intelligent marketing.

For more information on using our new Patient Broadcast Communications feature, please visit our [Broadcast Communications Help Articles](#). For instructions on how to enable and configure the feature, visit our [Manage Broadcast Communications Help Article](#).

- **New A/R Control Filters:** Some of our customers have very particular workflows and have requested to be able to search in A/R Control by Referring and Rendering providers. This would enable them to send out statements only for claims from a particular provider. To address this need, we added the ability to filter by Rendering or Referring Provider within A/R Control, allowing customers to send statements only for claims from a specific provider or referrer. These new filter options were added under a new header within the A/R Control Filters called "Claim Search Options." Additionally, the existing Payer, Charge Balance, and Charge Status filters have been moved under the Claim Search Options.

For more information on these new filters, please visit our [Search For Patient Balances Help Article](#).

Reports

- **New Report Fields For Contract Name:** We previously had a number of fields that could be used to show the contract price that applies to a charge. In this release, we added "**Contract Name**" as a report field under those same data sections. This new field is available under Charge/Debit Data > Charges > Current Payer (as well as Primary/Secondary/Tertiary Payers).

Report Fields

Search for fields

CONTRACT NAME

✓ Charge/Debit Data

✓ Charges

✓ Current Payer

A Contract Name

✓ Primary Payer

A Contract Name

✓ Secondary Payer

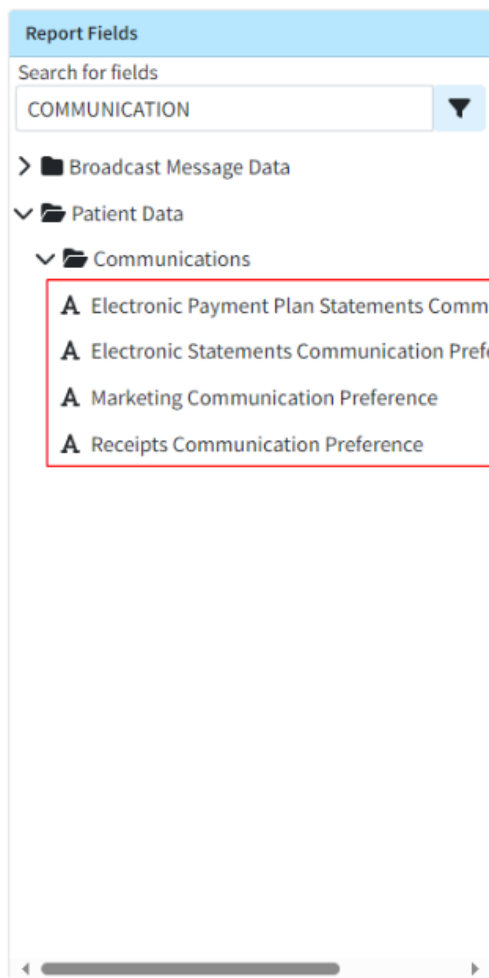
A Contract Name

✓ Tertiary Payer

A Contract Name

> Contract Data

- **New Report Fields For Patient Communication Preferences** We added the ability to include information about communication opt-ins in reports, enabling customers to conduct targeted outreach to patients to encourage them to opt-in. The following new communication preferences report fields have been added under **Patient Data > Communications**:
 - Electronic Payment Plan Statements Communication Preference
 - Electronic Statements Communication Preference
 - Marketing Communications Preference
 - Receipts Communication Preference



Release 15.1.0 - January 21, 2025

New Features and Updates

General

Patient

- **New Statement Batch Print Search Options:** We added the Default Provider and the Default Referring Provider as search (filter) options within Statement Batch Print, so only patients with the selected default referring or rendering providers are returned. This option will not affect the generated statement, which will continue to include all charges regardless of the rendering or referring provider on the claim.

- Home
- Reports
- Appointments
- Patient**
 - Patient
 - Manage Account
 - Payment Plans
 - A/R Control
 - Batch Eligibility
 - Statement Batch Print**
 - Statement Tracker
 - Label Batch Print
 - Communications...
 - Settings
 - Claim
 - Payment
 - Documents
 - Interface
 - Customer Setup
 - Account Administration

Filters Load Save

Search

Type

- ☒ Statement for outstanding charges
- ☐ Payment Plan statement
- ☐ Final Demand Notice

Statement Amount

Greater Than

0.00

Electronic Statements Sent

Any

Paper Statements Sent

Any

Total Statements Sent

Less Than

3

Days Since Last Statement

Greater Than

30

Account Type

Default Provider

Default Referring Provider

Statements to send

- ☒ Paper Statements
- ☐ Electronic Statements

Payment

- Updated The Default ACCOUNT CREDIT & APPLY ACCOUNT CREDIT Memos:** We updated the default account credit memo, created when an account credit is generated based on a payment or adjustment, to include more information about the credit. In this release, we also updated the APPLY ACCOUNT CREDIT memo line to include additional details (such as the source and check number) that will be visible in the Manage Account and Activity screens once the credit is applied.

Save
Close
Save & Re-Open
Activity
Create Task
Options

JOHNNY TEST (#33397993)

Patient Balance: \$898.04 Patient Credit: \$105.00 Insurance Balance: \$4,998.00 Insurance Credit: \$50.00

Debit Account

Credit Account

Refund Credits

Transaction Listing

DOS / Received Date	Procedure	Status / Memo	Amount	Applied	Balance
01/21/2025		APPLY ACCOUNT CREDIT - PATIENT PAYMENT - CHECK - 123456789	\$100.00	\$100.00	
08/16/2022			\$600.00	\$200.00	\$400
08/16/2022	00100	SEND TO HUMANA VIA CLEARINGHOUSE	\$600.00	\$200.00	\$400
10/05/2022		PAYMENT FROM AETNA	\$200.00	\$200.00	
10/05/2022		ADJUSTMENT BY AETNA	\$0.00	\$0.00	
08/16/2022	00600	CLAIM AT AETNA	\$0.00	\$0.00	\$0
10/05/2022		PAYMENT FROM AETNA	\$0.00	\$0.00	
10/05/2022		ADJUSTMENT BY AETNA	\$0.00	\$0.00	
08/11/2022			\$457.00	\$457.00	\$0
08/11/2022	85004	PAID	\$300.00	\$300.00	\$0

- **New ERA Auto Post:** Added a new ERA Auto-Post billing option that can be configured by Payer and pay priority (primary, secondary, etc.). Once enabled and configured, the Electronic Remittance Advice will automatically check for errors or warnings on most ERAs and, if the ERA is free of issues ("clean") will automatically apply the payments with no interaction or review required.

> Clearinghouse Connection

> Notes

> Alerts

> Tasks

▼ Billing Options

General Provider Patient **ERA**

Process PR-45 (patient responsibility amount in excess of fee schedule/maximum allowable) as an Adjustment when an ERA is posted, rather than as Unpaid?
☐ Yes ☒ No

Process PR-242 (services not provided by network/primary care providers) as an Adjustment when an ERA is posted, rather than as Unpaid?
☐ Yes ☒ No

Electronic Remittance Advice Automation

☒ Allow this payer's ERAs that fully apply with no errors to auto-post without review

☐ Show a dialog with the payment details before auto-posting

☐ Commit the payment after it has been applied

☐ Allow secondary payments to auto-post

☐ Allow payments that do not match the contract amounts to auto-post

☐ Allow payments with denials or \$0.00 allowed amounts to auto-post

☐ Allow duplicate payments (remit code 18) to auto-post

☐ Allow payments with refunds/reversals to auto-post

☐ Allow payments to patients/claims with Payment Alerts to auto-post

☐ Allow payments with Provider Adjustments that were not applied to claims to auto-post

For more information on configuring this new ERA Automation billing option, please visit our [ERA Billing Options Tab Help Article](#).

Release 15.0.0 - January 6, 2025

New Features and Updates

General

Appointments

- **Added UI Improvements To The Scheduler's Eligibility & Forms Icons:** We reduced the size of the Eligibility and Forms icons and allowed them to take up vertical space when available, enabling more

appointment information to be visible on the scheduler. We also changed the color of the "intake forms sent but not filled out" icon from yellow to gray, distinguishing it from the "intake forms not sent" icon.

12 pm	
15	
30	
45	
1 pm	✓ SILVERTONGUE, LYRA
15	- CONSULT 30
30	⌚ TEST, JOHNNY -
45	CARDIOLOGY
2 pm	
15	

Patient

- Updated The Statement Tracker "Status" Column:** Updated the Statement Trackers Status column to include the "user printed name." This allows users to see the print status, as well as the individual who printed the document, which improves the auditing process.

✓ Mark As Fixed







☐ Update Addresses

✕ Close

View Applied Filters

↑

↓

<input checked="" type="checkbox"/>	Patient	Invoice #	Date	Amount	Type	Status	+
	ALEXANDER, JONES	1262243014	10/20/2024	\$142.00	Statement	User Printed by alexramirez - Enhanced	
	BEAR, TORI	1262243019	10/20/2024	\$13.00	Statement	User Printed by alexramirez - Enhanced	
	TEST, ANGIE	1262243020	10/20/2024	\$837.00	Statement	User Printed by alexramirez - Enhanced	
	GROOT, IAM	1262243023	10/20/2024	\$13.10	Statement	User Printed by alexramirez - Enhanced	
	MCCLLOUD, FOX	1270798112	11/12/2024	\$20.00	Estimate Statement	User Printed by danielgoldsmith - Enhanced	
	TEST, JOHNNY	1289758024	01/06/2025	\$998.04	Statement	User Printed by josephmuniz - Plain Text	

Claim

- New Enhanced Auditing (Show History) for Claims** CollaborateMD has been working on a new enhanced auditing project that provides offices with an easy and transparent way of auditing changes made in the application. We previously released our new Enhanced User Auditing feature in the Customer Setup and Patient sections of the application, allowing users to see a detailed list of changes made to specific records throughout the application.

In this release, we are expanding our Enhanced Auditing functionality to the Claim section enabling users to track modifications, changes, and updates made to claims within CMD for better auditing and accountability. With the new "Show History" feature, you can now determine which user changed

specific Claim information in the software and when, by providing an auditing table with all updates or changes made to a record, including the user, date and time, and the item changed.

The screenshot shows the 'Claim' form in the software. The left sidebar contains a navigation menu with options like Home, Reports, Appointments, Patient, Claim, Claim Tracker, Status Control, Follow Up Management, Claim Batch Print, Settings, Payment, Documents, Interface, Customer Setup, and Account Administration. The main form area has tabs for Claim, Charges, Additional Info, and Ambulance Info. The 'Claim' tab is active, showing fields for Claim # (252696024), Reference #, Patient (MUNIZ, JOSEPH (37190993)), Rendering Provider (DUKE, JESSICA (10128215)), Billing Provider (BARNES, KYLE Y (10002227)), Supervising Provider, Ordering Provider, Referring/PCP Provider, Sales Rep, Facility, and Office Location (ABC MEDICAL GROUP 123 ABC STREET). A 'Show History' button is highlighted with a red box in the top right corner of the form.

These new auditing records are also included in our existing User Audit Report, making it an even stronger tool for auditing multiple records simultaneously. The Show History capability has currently been deployed in the Customer Setup, Patient, and Claim sections, and we will be adding it to other sections of the application systematically.

For more information on using our new Add New Same/Similar Code List feature, please visit our [Enhanced Auditing Help Articles](#).

- **Status Control's "Current Payer" Column Update:** Updated the Status Control results screen to show more details about which payer is displayed. The "Current / Primary Payer" column will now be "Current Payer," and will include the payer priority (primary, secondary, tertiary) in parentheses if the filtered charge status is a payer status.

The screenshot shows the Status Control results screen. It features a table with the following columns: Claim #, DOS, Patient, and Current Payer. The 'Current Payer' column is highlighted with a red box. The table contains the following data:

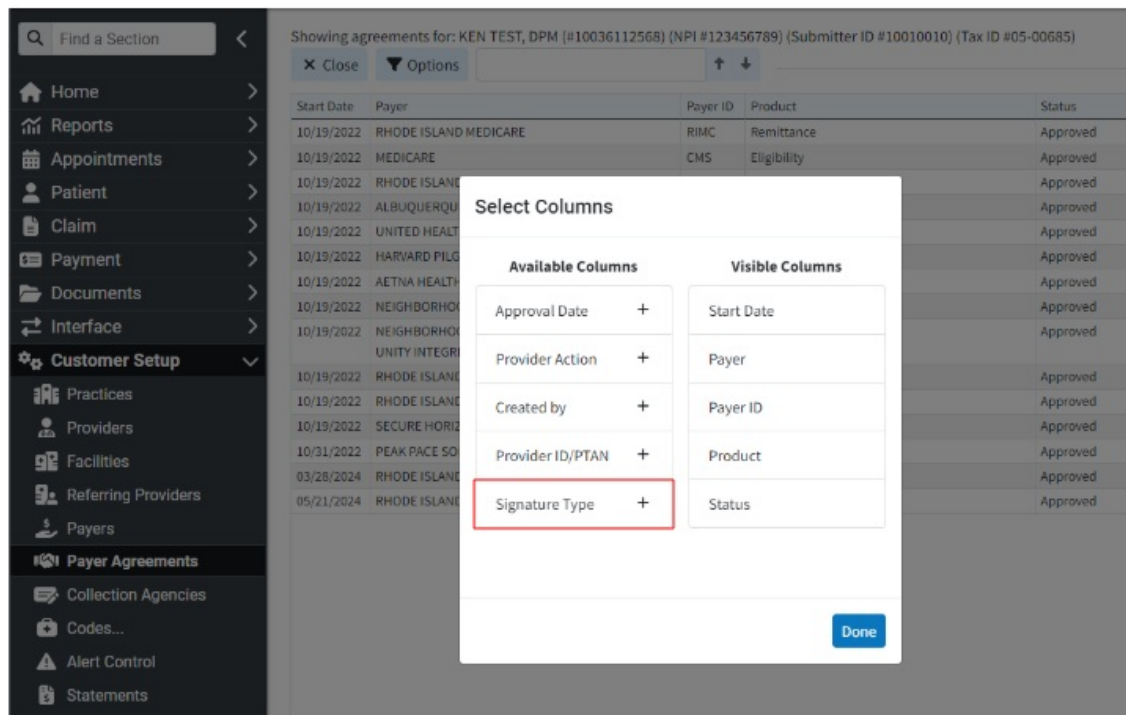
Claim #	DOS	Patient	Current Payer
252744839	12/09/2024	POPE, OLIVA	1199 NATIONAL BENEFIT FUND (Primary)
251048427	12/11/2024	DOE, JANE	ILLINOIS MEDICARE (Primary)
251048618	12/11/2024	SMITH, JIM	ILLINOIS MEDICARE (Primary)
251049522	12/11/2024	FLETCHER, JOHN	ILLINOIS MEDICARE (Primary)
251463320	12/17/2024	TEST, JOHNNY	AARP (Primary)
252800076	01/05/2025	SILVER, MARY	AMERIBEN SOLUTIONS (Primary)

Customer Support

- **New Signature Type Column Within Agreement Lookup:** Added a new column, hidden by default, to






the agreement lookup screen. This column will store and display the "Signature Type" (based on the Provider Action field received from ePS) and includes a new report field under Agreement Data. The possible actions for the "Signature Type" are:

- * Electronic Signature
- * Online Enrollment
- * Wet Signature
- * Other



Payment Portal

- **New UI Updates to The Payment Portal:** Added some UI enhancements to the Payment Portal relate to new colors and margins for better consistency and a better customer experience. We also updated the Payment Portals password requirements to now require at least 12 characters and disallow the reuse of any previous passwords.

-  **My Statement** >
-  Visit History
-  Payment History
-  Preferences
-  Sign Out

You owe \$877.00

Due **today**. Thank you!

Pay Now

Pay Over Time!

\$48.73 - \$146.17 per month.

Choose Your Plan

Account Summary

Total Charges	\$877.00
Insurance Payments	\$0.00
Insurance Adjustments	\$0.00

Recent Visit Summary