

# 1025 Release Notes

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 Aptarrc

## Claim Scrubbing for Customer

**Info** 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

## New features | Enhancements

### Highlights

New Features	Enhancements
New WebAPI Endpoint to Allow Setting a Claim To a Specific Status	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
- A Auto Pay Disable User**
- A Auto Pay Enable User**
- A Auto Pay Status**
- A Description
- A Is Payment Plan Overdue?
- A Name
- A 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

- A 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.

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Release 15.23.0 - November 24, 2025

## 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

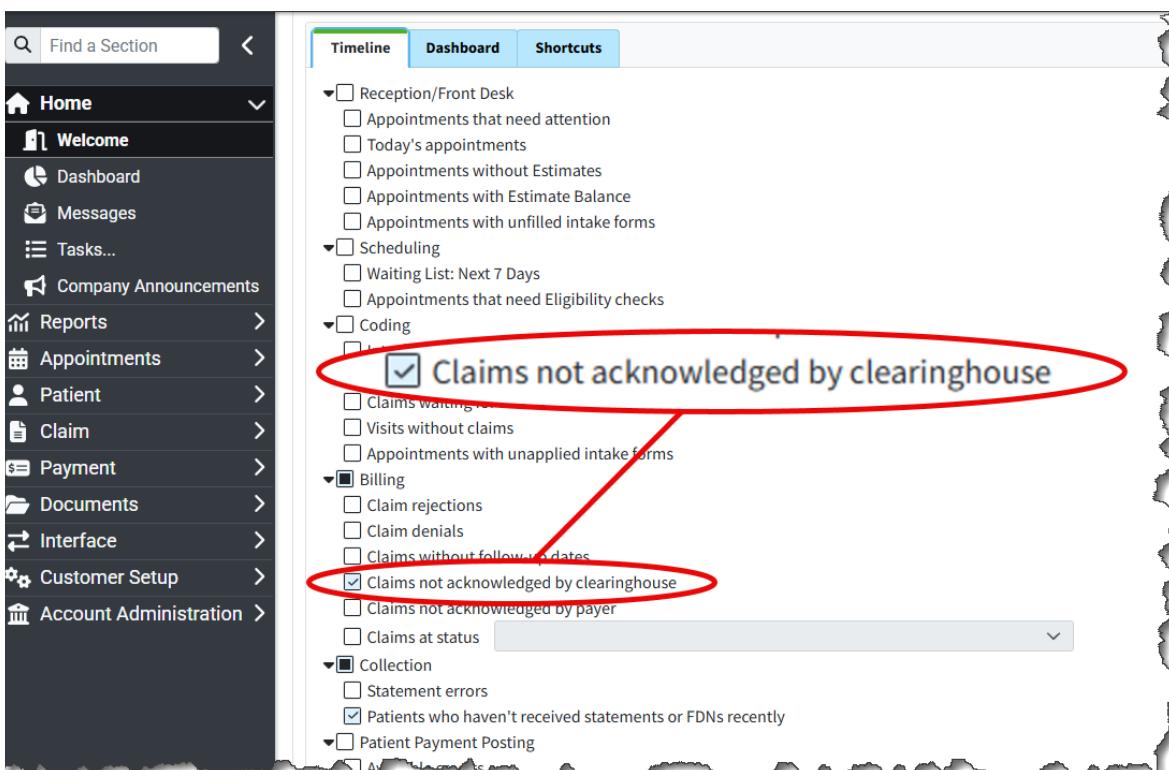
Incremental Snapshots Now Include Claim Status

## New features

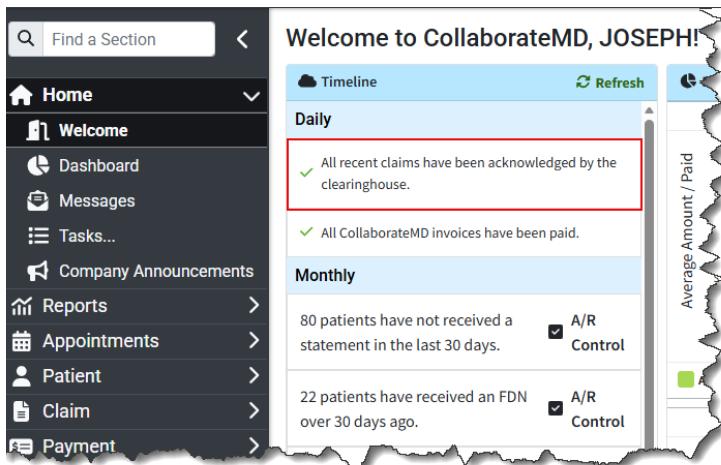
### New "Claims Not Acknowledged by the Clearinghouse" Timeline Item

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](#).



The screenshot shows the 'Timeline' settings page. On the left is a sidebar with various menu items. The main area is titled 'Timeline' and contains a list of timeline items. The 'Claims not acknowledged by clearinghouse' item is circled in red, indicating it is selected. Other items in the list include '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', 'Claims waiting for clearinghouse', 'Visits without claims', 'Appointments with unapplied intake forms', 'Billing', 'Claim rejections', 'Claim denials', 'Claims without follow-up dates', 'Claims not acknowledged by clearinghouse' (which is circled in red), 'Claims not acknowledged by payer', 'Claims at status', 'Collection', 'Statement errors', 'Patients who haven't received statements or FDNs recently', and 'Patient Payment Posting'.



## 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

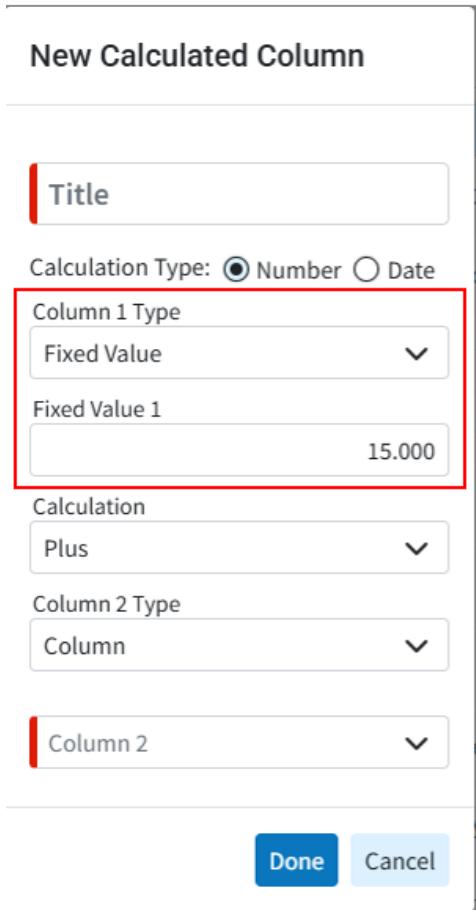
Plus

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	Visible Columns
Last Note User +	Checkbox
First Billed Date +	Alerts <span style="float: right;">x ↓</span>
Last Claim Status + Check	Claim #
Insurance Payments +	Balance
Patient Payments +	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 in 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 <input type="button" value="X"/>
Group Codes All <input type="button" value="^"/>
<input checked="" type="checkbox"/> Select All
<input checked="" type="checkbox"/> CO - Contractual Obligation
<input checked="" type="checkbox"/> OA - Other Adjustment
<input checked="" type="checkbox"/> PI - Payer Initiated Reduction
<input checked="" type="checkbox"/> PR - Patient Responsibility
Any <input type="button" value="▼"/>

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

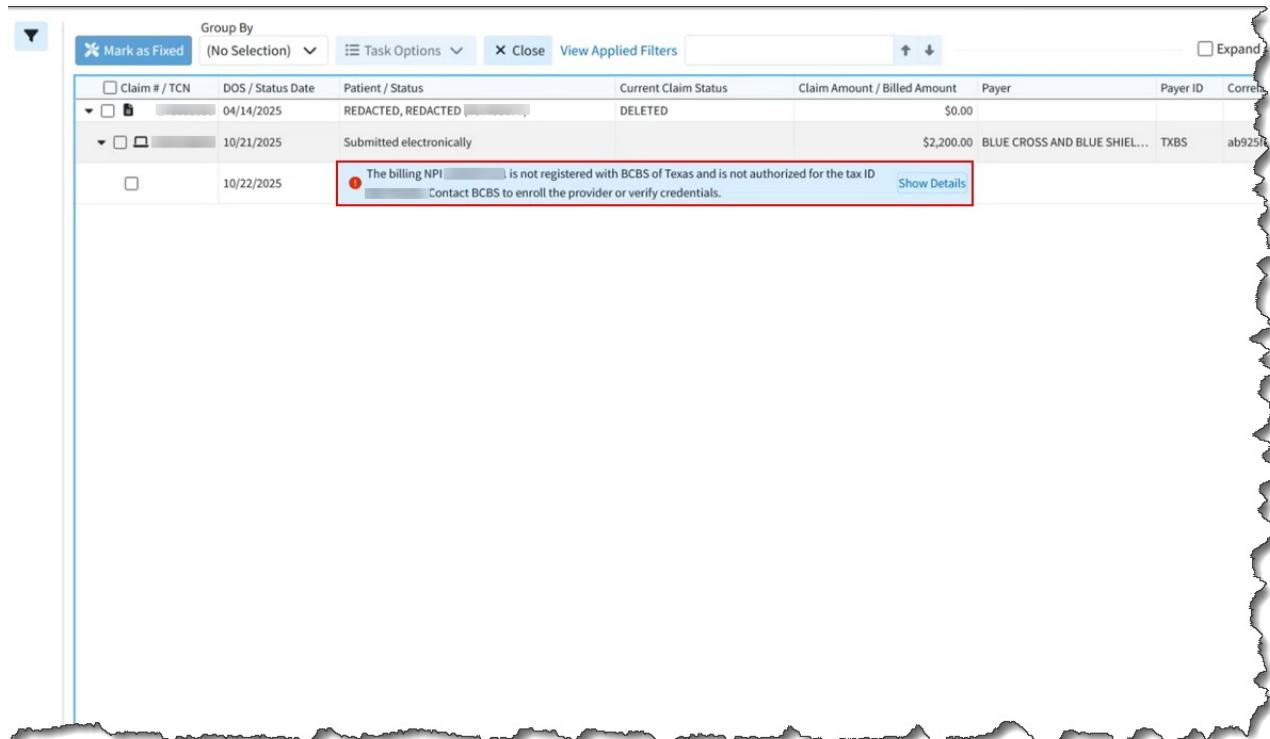
### Enhancements

- 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.



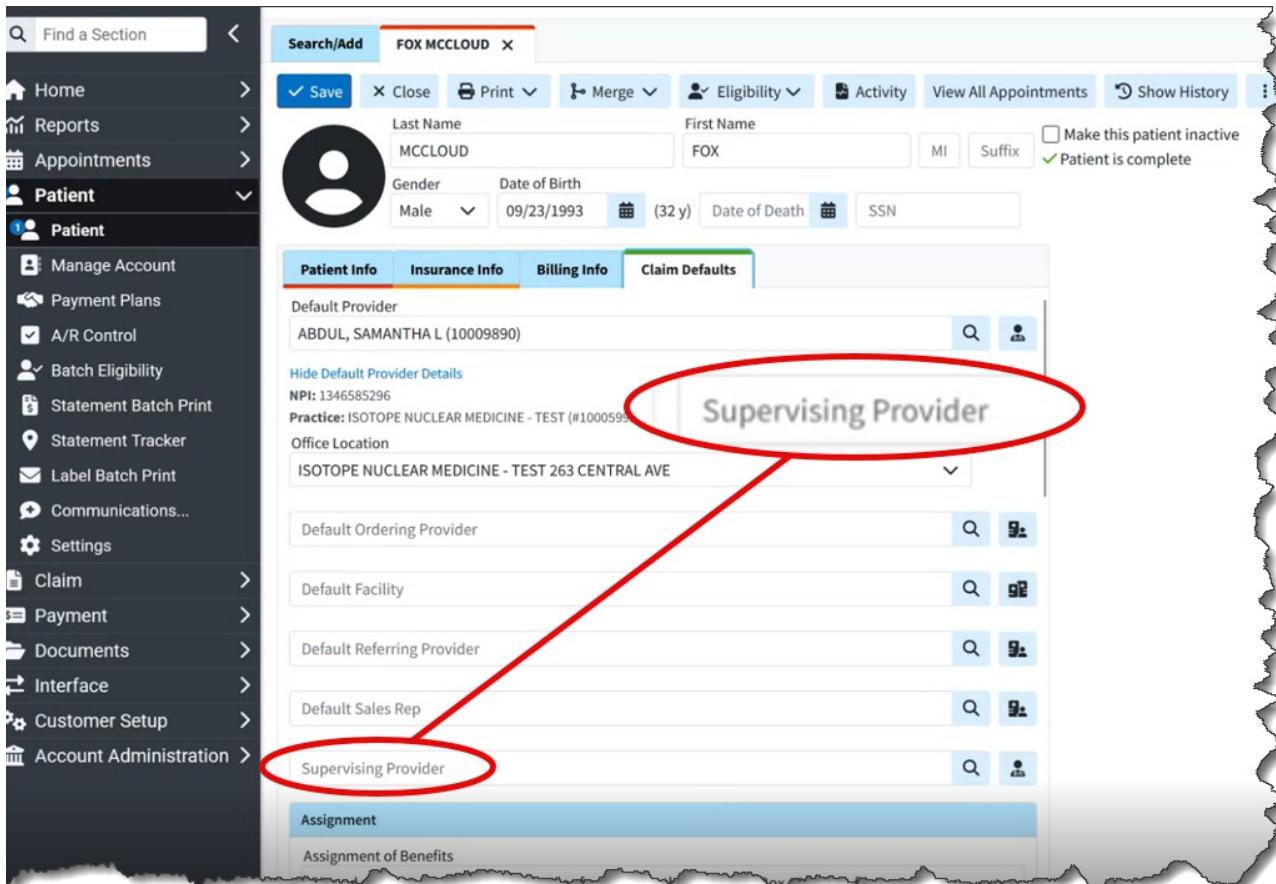
The screenshot shows a table in the Claim Tracker interface with the following data:

Claim # / TCN	DOS / Status Date	Patient / Status	Current Claim Status	Claim Amount / Billed Amount	Payer	Payer ID	Correl
	04/14/2025	REDACTED, REDACTED	DELETED	\$0.00			
	10/21/2025	Submitted electronically		\$2,200.00	BLUE CROSS AND BLUE SHIEL...	TXBS	ab9257
	10/22/2025		<p>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.</p> <p>Show Details</p>				

 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](#).



## 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**

**Info** 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 [View Audit History](#)

Incremental Snapshot with data from the last  days

**Info** [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"/> 10006399	SALES DEMO 2009

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"/>	1006872	***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		Visible Columns
Billing Provider	+	Check
Task Due Date	+	Claim #
Task Status	+	DOS
Task Assign Date	+	Current Payer
Task Assignee	+	Patient
Claim Type	+	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

Group Codes  
CO - Contractual Obligation

Payers  
 Payer Types  Specific Payers

Payer Action  
All  Next Payer

Payment Amount  
Any

Charge Amount  
Any

**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

New Statement Vendor Change

##### Enhancements

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 need 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  
Here

ADD 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

COMPLETE AND RETURN IF PAYING BY CREDIT CARD



CARD NUMBER

SECURITY CODE

NAME ON CARD (PLEASE PRINT)

EXP. DATE

SIGNATURE

AMOUNT

STATEMENT DATE

10/16/2025

ACCOUNT #

10000001

AMOUNT DUE

\$110.00



JOHN PATIENT  
123 MAIN ST  
ANYTOWN US 12345-6789



ADD PRACTICE  
1497 EAST HWY  
ORLANDO FL 32811-1565

DETACH TOP PORTION AND RETURN WITH PAYMENT IN ENCLOSED ENVELOPE

Date	Description	Charges	Payments	Adjustments	Balance
<b>Patient: JOHN PATIENT \ Account: 10000001</b>					
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	<b>\$110.00</b>
Credits/Adjust:	\$100.00	
Ins Payments:	\$320.00	
Patient Payments:	\$0.00	
<b>Patient Balance:</b>	<b>\$110.00</b>	

**Pay Online**

[www.paystatementonline.com](http://www.paystatementonline.com)

Account Number: 10000001

Or can 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.

PAGE 1 OF 2

Enhancements

## 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

- New Payment Automations
- New Statement Automation Option to Send Based on Days Since Last Seen
- New Admitting Diagnosis Default

### Enhancements

- Remove All Option for Claim/Patient Not Found
- ERA Errors
- 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.

Payment Automations						
<input checked="" type="checkbox"/> Edit <input type="button" value="New Automation"/> <input type="checkbox"/> Show inactive automations		Name	Remittance Codes	Adjustment Method	Processing	Additional Actions
109 - CO - Contractual Obligation	109	Don't apply	Process the payment as a total denial		Collaborator	
QA218 - Automobile Medical	QA218	Apply according to the payer's instructions	Forward to the next insurance		Collaborator	
100 - Medicaid	100	Apply according to the payer's instructions	Write off the charge's remaining balance		Collaborator	
23 - Forward Converted Remittance Action	23	Apply according to the payer's instructions	Write off the charge's remaining balance		Collaborator	
NS45 - Forward Converted Remittance Action	NS45	Apply according to the payer's instructions	Set a specific status		Collaborator	
NS45 - Commercial Insurance Company	NS45	Apply according to the payer's instructions	Set a specific status		Collaborator	
197 - Forward Converted Remittance Action	197	Don't apply	Process the payment as a total denial		Collaborator	
16 - CO - Contractual Obligation	16	Don't apply	Process the payment as a total denial		Collaborator	
NS45 Medicare	NS45	Apply according to the payer's instructions	Set a specific status	• Assign Task to joetest1	Collaborator	
Apply As Adjustment	142, 227, 274	Apply as an insurance adjustment	Write off the charge's remaining balance		Collaborator	
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		Collaborator	
Forward claims based on remittance code	MA07, MA18, NS67 ... +1 more	Apply according to the payer's instructions	Forward to the next insurance		Collaborator	
Do not apply secondary adjustments	1, 100, 101 ... +128 more	Don't apply	Process according to the payer's instructions	• Add Issue: Adjustments from the secondary payer were not applied.	Collaborator	
Default Automation	All Remittance Codes	Apply according to the payer's instructions	Process according to the payer's instructions		Collaborator	

## 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 info on enabling this feature visit our [Statement Options Help Article](#).

## Statement Automation Settings

Save  Cancel  Show History

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:

25.00

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?

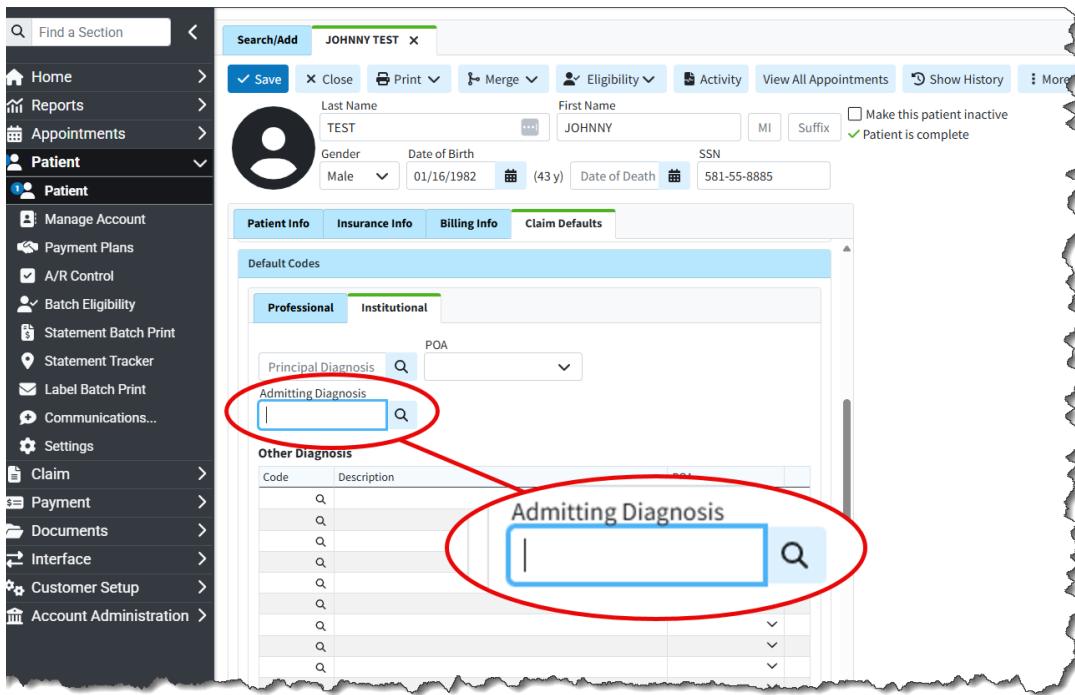
Yes  No

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.

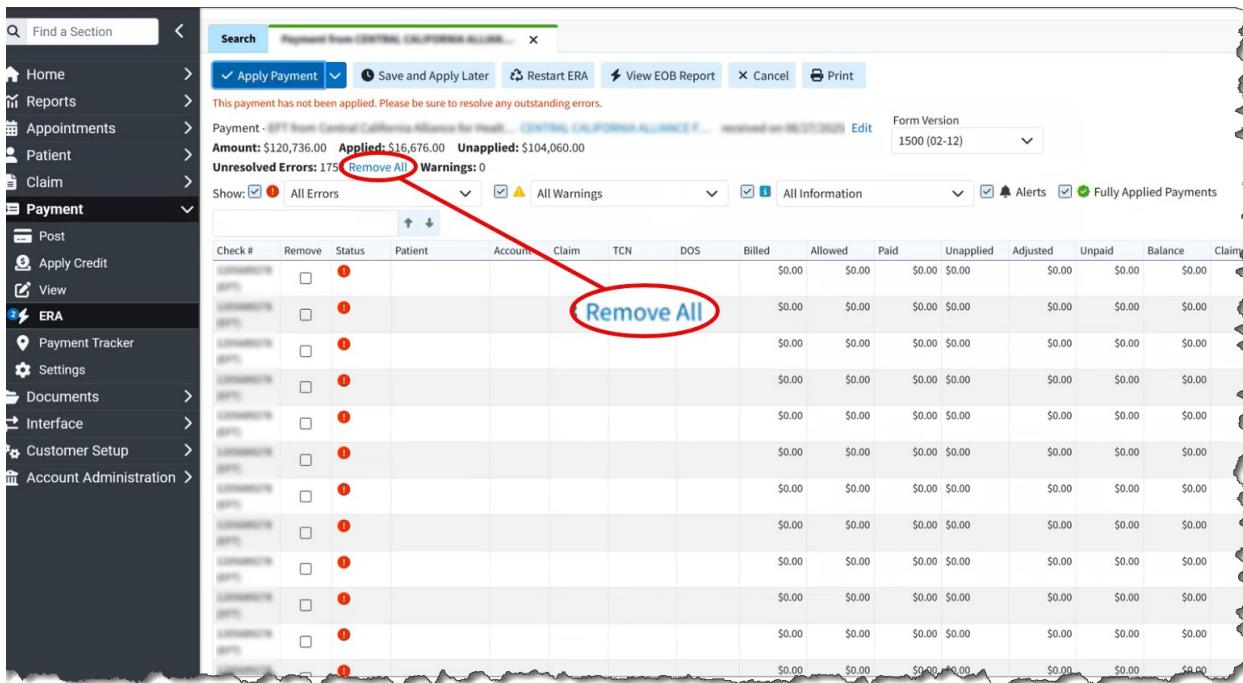


## Enhancements

### 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.

Find a Section  Save  Close  Configure Eligibility  Register Submitter  Show History

Bill claims under  
SELF

Check eligibility under  
ABDUL, SAMANTHA L (10009890)

Use which ID number? Social Security # (SSN)  
Social Security# (SSN) 555-55-5555  Change

Bill as  
Individual

Bill professional claims (CMS-1500) TEST

Bill institutional claims (CMS-1450) TEST

Internal Use

Submitter #

Submitter Request has NOT been sent electronically for this provider.  
Clearinghouse: eProvider Solutions  
ePS Registration Date: Mar 11, 2021

TCN Prefix

Use Submitter's TCN Prefix in an ePS ERA split  
(the Practice TCN Prefix will not be used)

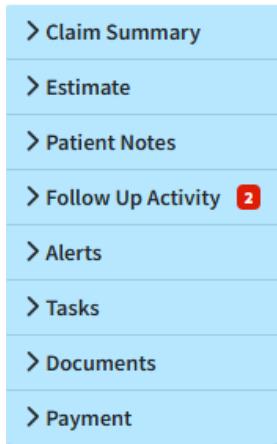
Contact Information

Home Phone  Cell Phone

Fax #  Pager #

## 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.



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Release 15.19.0 - September 29, 2025

## Highlights

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

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  Last Name   
Email Address

## 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.

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: \$241.90

Payment Plan Listing  Show Previously Deleted Payment Plans

Payment Plan 01/26/2026 (Active)

**Amount: \$241.90 Create Date: 09/26/2025**  
**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	BALANCE DUE PATIENT	\$291.90	\$241.90

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: \$241.90

Payment Plan Listing  Show Now Deleted Payment Plans

Payment Plan 01/26/2026 (Active)

**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?

Bill as  
Individual

Bill professional claims (CMS-1500)

University of California

## 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		Visible Columns
Task Due Date	+	Selected
Task Status	+	Icon
Task Assign Date	+	Patient
Task Assignee	+	Invoice #
Patient #	+	Date
		Amount

**Done**

## Release 15.18.0 - September 15, 2025

### New features | Enhancements

#### Highlights

##### New Features

New Task Management in A/R Control

##### Enhancements

New Admitting Diagnosis Default

Duplicate Remittance Codes Now Allowed if Group Code is Different

Custom Statuses Now Available as Report Filters

## 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

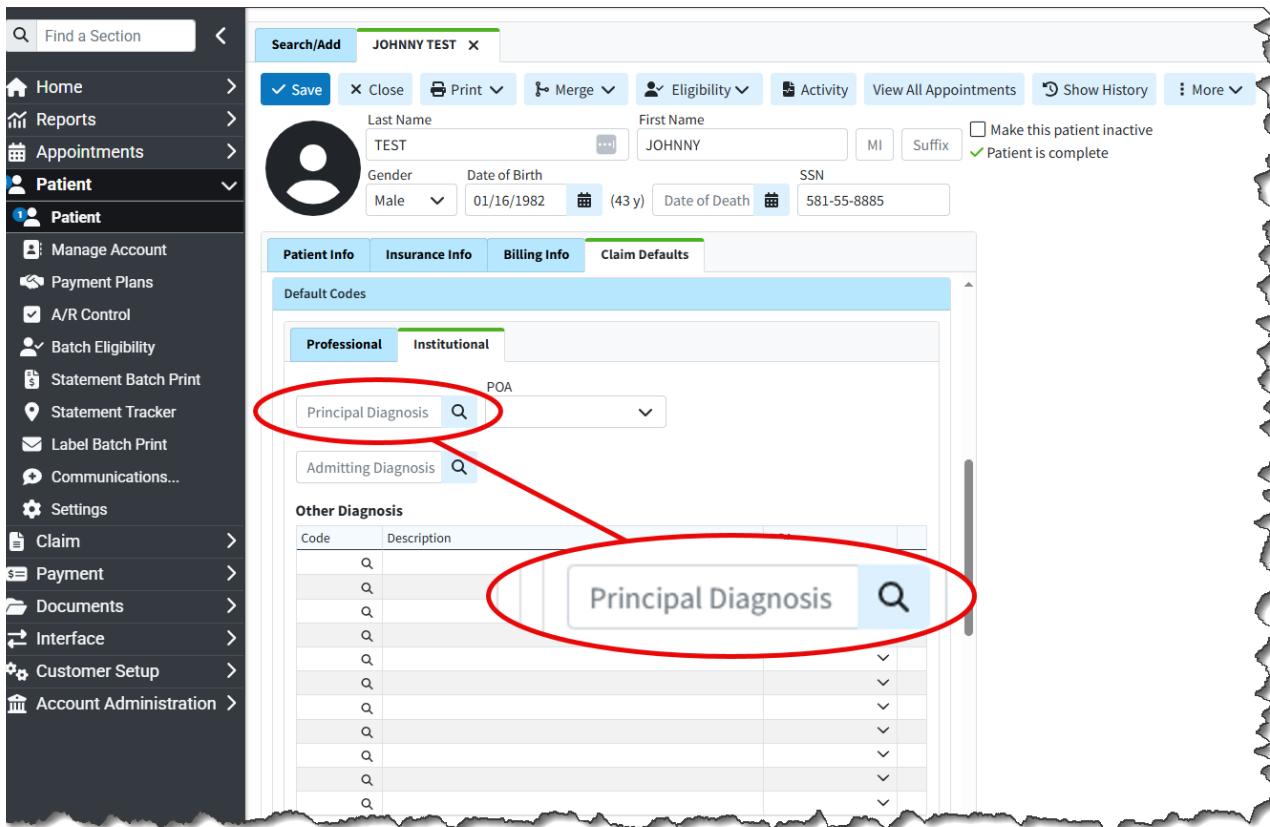
Checking them off. These tasks can also be linked (batched) to multiple patients simultaneously. Please be aware that these task management options are available in Plan 3 and above. Visit our [A/R Control Task Options Help Article](#) for more information.

Patient Name	Last Payment	Account #	Balance	Last Seen	Last Statement
DOE, JANE	02/23/2021	10716111	\$25.00	02/23/2021	06/05/2024
JR, WALLEY		13372666	\$17.33	09/09/2009	09/25/2024
SPARK, BABY	06/15/2008	13661949	\$12.31	07/16/2008	05/11/2024
JOHNSON, CAROL L		14768408	\$10.00	01/01/2024	
TEST, JIM			\$20.91	03/24/2025	03/29/2019
MESEEKS, MISTER			\$8.12	03/20/2025	08/17/2024
GROOT, IAM			\$3.10	12/19/2022	10/20/2024
KUMAR, TEST	03/15/2024		\$30.00	03/15/2024	
LEGUAULT, DEANA	11/17/2022	51549103	\$49.00	11/17/2022	
PATIENTTWENTYSEVEN, ALEXTEST	09/19/2023	56336989	\$15.00	09/19/2023	
LUSH, LEON	01/02/2024	58180747	\$25.00	01/02/2024	
PERALTA, JACOB	07/28/2024	60905778	\$10.70	07/28/2024	
HUNT, ETHAN	08/14/2024	61114428	\$35.70	08/14/2024	
HOPKIRK, MAFALDA	02/03/2025	62805378	\$15.00	12/11/2024	
LOPEZ, JENNY		62904819	\$45.00	12/15/2024	
SILVERTONGUE, LYRA	01/05/2025	63169687	\$35.00	01/05/2025	
LOPEZ, IVETTE	04/13/2025	64674394	\$20.00	04/13/2025	
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 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](#).



## 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.

## 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.

## 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](#).

Find a Section

Home Reports Appointments Patient Payment Plans A/R Control Batch Eligibility Statement Batch Print Statement Tracker Label Batch Print Communications... Settings Claim Payment Documents

Patient Settings for Customer: COLLABORATEMD (#10001911)

Require Meaningful Use fields to be filled out for a patient record to be considered complete?

Yes  No

Require Emergency Contact information to be filled out for a patient record to be considered complete?

Yes  No

Reset the Statements Sent counter when a new claim is set to Balance Due Patient?  
If set to Yes, this ensures that all claims will receive the maximum number of statements.

Yes  No

Patient Settings for User: josephmuniz

Show warning when saving a new patient that is a duplicate of an already entered patient based on the SSN or Last Name, First Name, and Date of Birth?

Yes  No

When creating a new patient, default the provider to:  
Provider Listing

## 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**  
MCLOUD, FOX (25017512)

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

i 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.

<input type="checkbox"/>	► <span style="color: green;">✓</span> Success	08/26/2025 08:08:33 PM	CLAIM
<input type="checkbox"/>	► <span style="color: green;">✓</span> Success	08/26/2025 08:08:32 PM	CLAIM
<input type="checkbox"/>	► <span style="color: orange;">⚠</span> Warning	08/26/2025 08:08:31 PM	CLAIM
<input type="checkbox"/>	► <span style="color: orange;">⚠</span> Warning	08/26/2025 08:08:30 PM	CLAIM
	<a href="#">Copy</a>		Patient: ( [REDACTED] )
	<a href="#">Mark as Fixed</a>		Match the given payer to a re
	<a href="#">View Message Content</a>		not found. Both the Patient
	<a href="#">Open Patient</a>		ID:272505668
	<a href="#">Open Claim</a>		08:28 PM CLAIM
	<a href="#">Open Appointment</a>		08:26 PM CLAIM
	<a href="#">View Raw Message</a>		08:24 PM CLAIM
<input type="checkbox"/>	► <span style="color: orange;">⚠</span> Warning	08/26/2025 08:08:21 PM	CLAIM
<input type="checkbox"/>	► <span style="color: orange;">⚠</span> 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).

File #	Entered Date	Entered By	Status
239111944	07/16/2024	REDACTED, REDACTED (#37190993)	SEND TO AMERICAN
242777502	08/30/2024	REDACTED, REDACTED (#37190993)	SEND TO AMERICAN
246654189	10/18/2024	REDACTED, REDACTED (#62097812)	ON HOLD
<input checked="" type="checkbox"/> <input type="checkbox"/> 131	<input type="button" value="Copy"/>	Entered by user	
<input type="checkbox"/> <input type="checkbox"/> 129		: Submitted electronically	
<input type="checkbox"/> <input type="checkbox"/> 129	<input type="button" value="Open Patient"/>	: Submitted electronically	
<input type="checkbox"/> <input type="checkbox"/> 128	<input type="button" value="Open Claim"/>	: Submitted electronically	
<input type="checkbox"/> <input type="checkbox"/> 129	<input type="button" value="Create Task"/>	: Submitted electronically	
<input type="checkbox"/> <input type="checkbox"/> 129	<input type="button" value="Find Payer Batch Reports"/>	: Submitted electronically	
<input type="checkbox"/> <input type="checkbox"/> 128	<input type="button" value="View Claim"/>	: Submitted electronically	
<input type="checkbox"/> <input type="checkbox"/> 128		: Submitted electronically	
<input type="checkbox"/> <input type="checkbox"/> 129	<input type="button" value="Print Proof of Timely Filing Letter"/>	: Submitted electronically	
<input type="checkbox"/> <input type="checkbox"/> 129	<input type="button" value="Print Appeal Letter"/>	: Submitted electronically	
<input type="checkbox"/> <input type="checkbox"/> 1289531952	01/04/2025	(Test): Submitted electronically	
<input type="checkbox"/> <input type="checkbox"/> 1294928344	01/19/2025	(Test): Submitted electronically	
<input type="checkbox"/> <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 reviews on some smartphones.

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## Release 15.16.0 - August 18, 2025

### New features | Enhancements

## Highlights

### New Features

- Post Payments and Copays from Practice Fusion
- New Timeline Option for Due and Overdue Tasks
- New Dynamic Support PIN

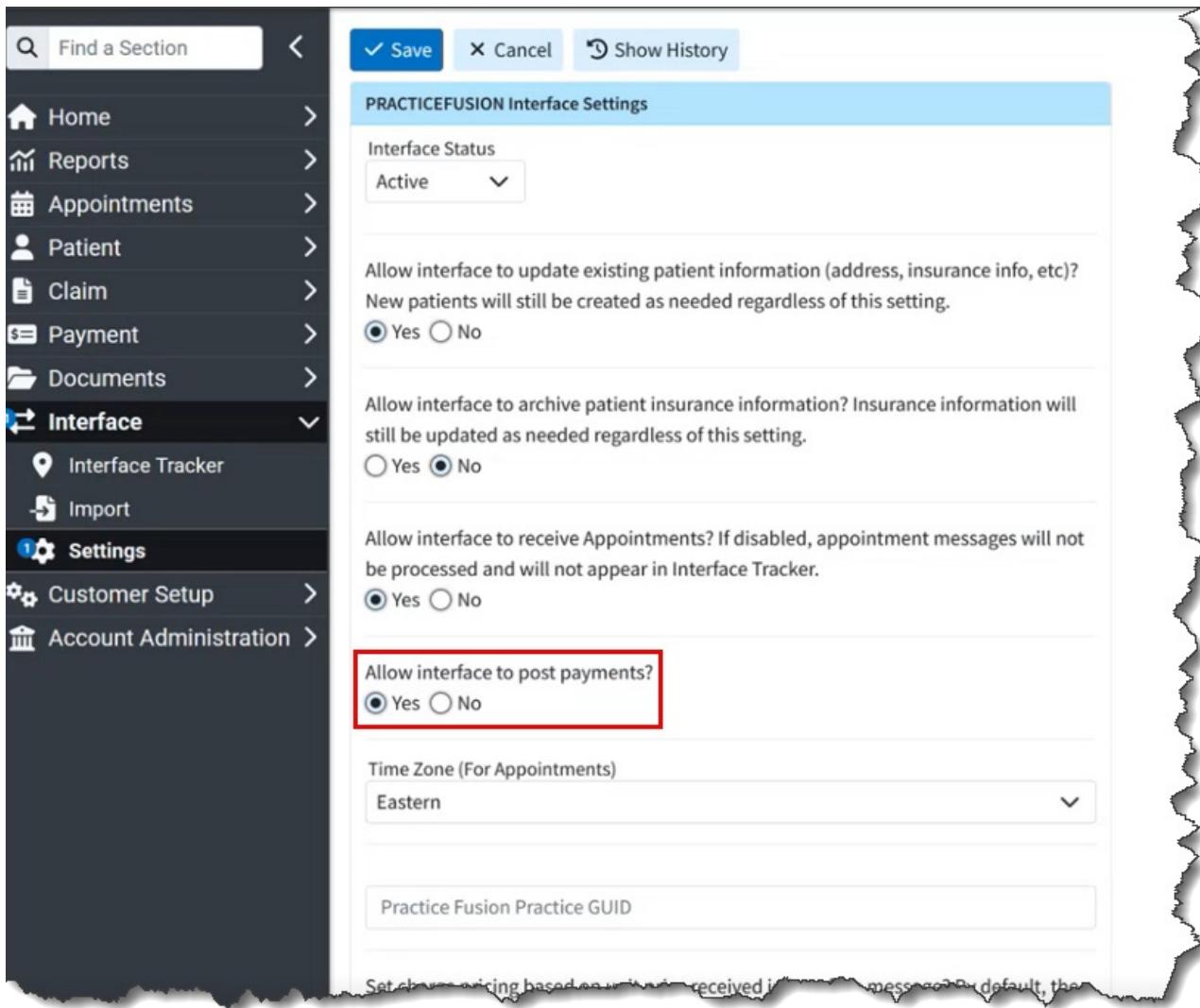
### Enhancements

- Enhancements to Claim Tasks

## New features

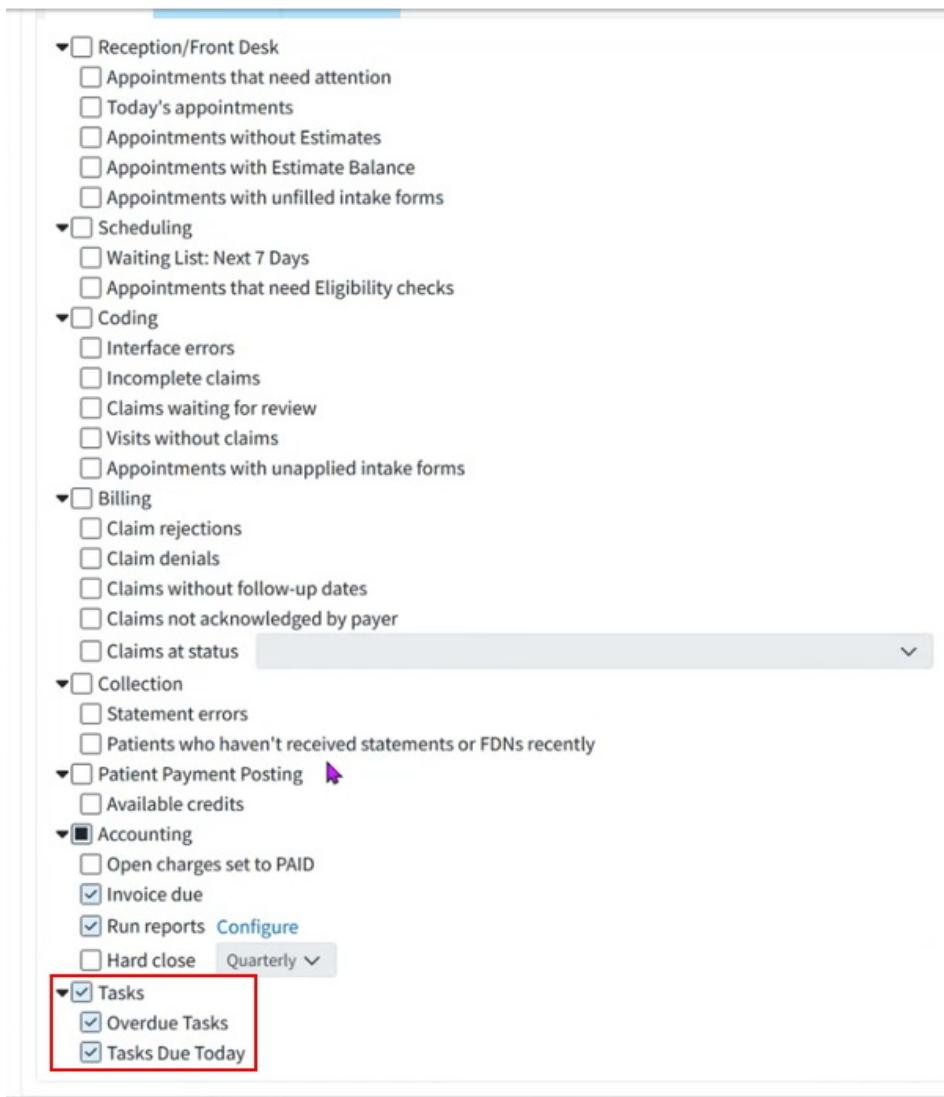
### Post Payments and Copays from Practice Fusion

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.



## 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](#).



The screenshot shows a software interface with a sidebar containing a list of tasks and filters. The tasks are organized into categories: Reception/Front Desk, Scheduling, Coding, Billing, Collection, Patient Payment Posting, Accounting, and Tasks. Under the Tasks category, three sub-options are listed: Overdue Tasks and Tasks Due Today, both of which are checked. The interface includes a 'Configure' button and a dropdown menu for 'Quarterly'.

- ▼  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 SRA 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:

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

The screenshot shows the CollaborateMD dashboard. At the top, there are icons for Messages (2 notifications), Tasks, Shortcuts, Help, and a What's New? button. To the right is a user profile for TEST JOHNNY COLLABORATEMD with the ID 10001911. Below the header, a sidebar on the left lists 'Last 12 Months' with a grid and a progress bar showing 'Last as of 06/2025: 5%'. The main content area has a 'Knowledge Center' menu with options like 'Show "Tips"', 'Support PIN: 9864' (which is highlighted with a red box), 'Contact Support', 'Submit Feedback', 'Report an Issue', 'Keyboard Shortcuts', 'Diagnostics', 'System Status', 'Reference Links', and 'Legal'. To the right, there are 'Announcements' and 'Survey for CMD' posts. The 'Survey for CMD' post is dated 461 days ago and encourages users to take the survey.

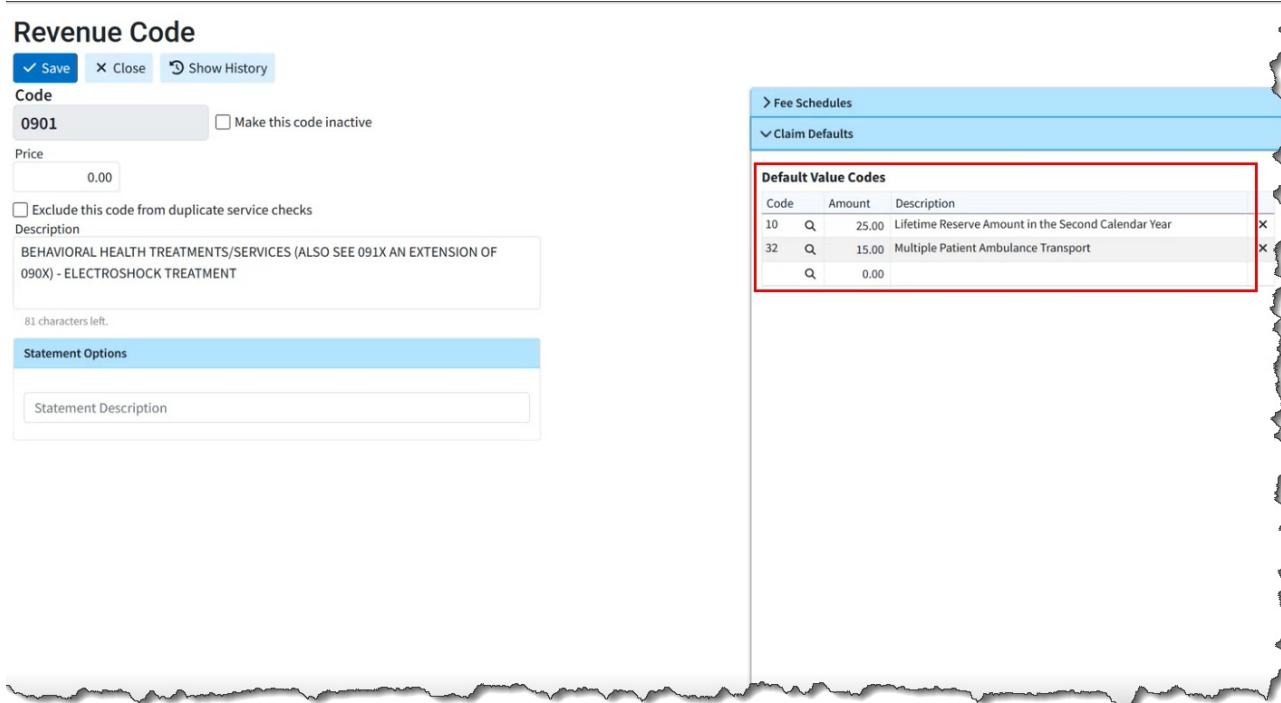
2. Alternatively, you can access it by navigating to your User Profile and selecting "Show Support PIN.".

The screenshot shows the User Profile page for TEST JOHNNY. At the top, there is a 'Edit Profile' button and a placeholder for a profile picture. Below that, the user's information is listed: Username: jtest, Title: (empty), Email: josephmuniz710@gmail.com, Phone 1: (empty), and Phone 2: (empty). The page is divided into sections: 'Security' and 'Communication'. The 'Security' section contains links for 'Change Password', 'Support PIN: 9864' (which is highlighted with a red box), and 'Update Two-Factor Authentication'. The 'Communication' section contains a link for 'Edit Communication Preferences'.

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](#).



The screenshot shows the Revenue Code screen with the Claim Defaults tab selected. On the left, the Revenue Code details are shown: Code 0901, Price 0.00, and a description of BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X AN EXTENSION OF 090X) - ELECTROSHOCK TREATMENT. On the right, the Default Value Codes table is displayed, showing three entries: 10 (Q, 25.00, Lifetime Reserve Amount in the Second Calendar Year), 32 (Q, 15.00, Multiple Patient Ambulance Transport), and a blank row (Q, 0.00). The table is highlighted with a red border.

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   ICD #2  ICD #3  ICD #4

**Billing Alerts**

Global Surgery Period [i](#)  
Default (0 days)

Same or Similar Codes [i](#)

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

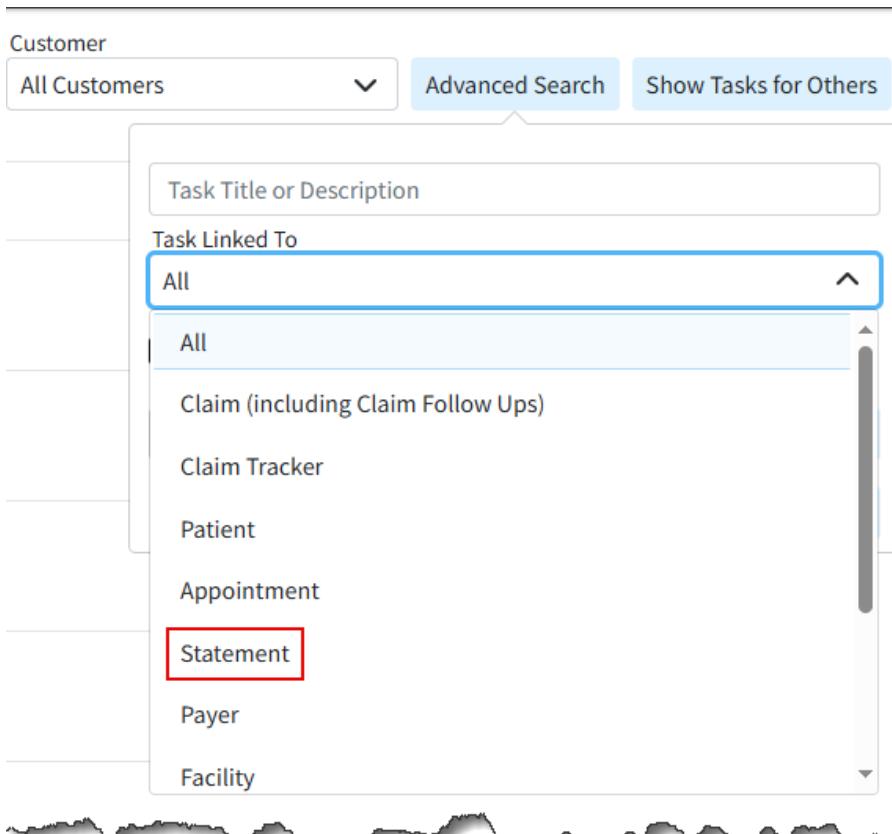
[New features](#) | [Enhancements](#)

## Highlights

### New Features

### Enhancements





## 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

Set custom permissions

Search for permissions

Select Category to View Permissions

Payment   Show Permission Descriptions

Patient Payments	Post Only	<input type="button" value="^"/>	<input type="button" value="⌚"/>
Insurance Payments	Deny	<input type="button" value="⌚"/>	<input type="button" value="⌚"/>
ERA Auto Apply	Post Only	<input type="button" value="⌚"/>	<input type="button" value="⌚"/>
ERA File (835) Download	Apply	<input type="button" value="▼"/>	<input type="button" value="⌚"/>
ERA Upload	Deny	<input type="button" value="▼"/>	<input type="button" value="⌚"/>
Patient Activity	Deny	<input type="button" value="▼"/>	<input type="button" value="⌚"/>
Tracking	Deny	<input type="button" value="▼"/>	<input type="button" value="⌚"/>
Hard Close	Deny	<input type="button" value="▼"/>	<input type="button" value="⌚"/>

> 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 on 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

Billings 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

Default POS

Default Claim Note

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.

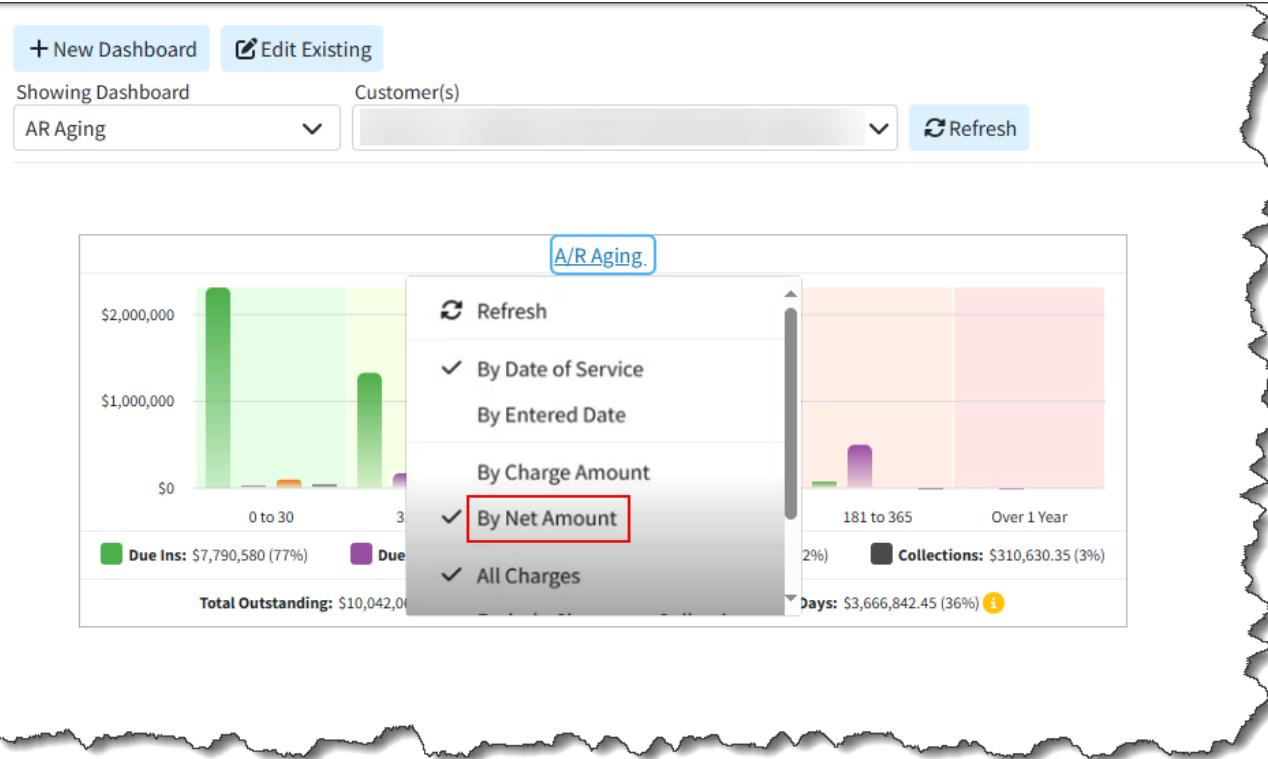
JOB ID: N/A

ⓘ 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.

## Enhancements

### A/R 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](#).

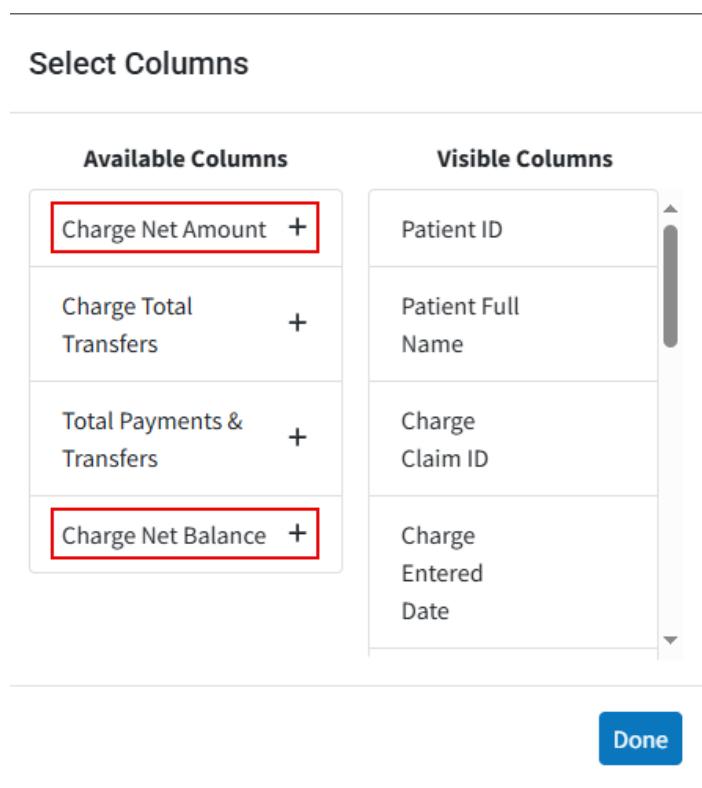


Drilling down to the Charge Aging Report from the gadget now also allows you to add columns to your report for Charge Net Amount and Charge Net Balance.

**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**



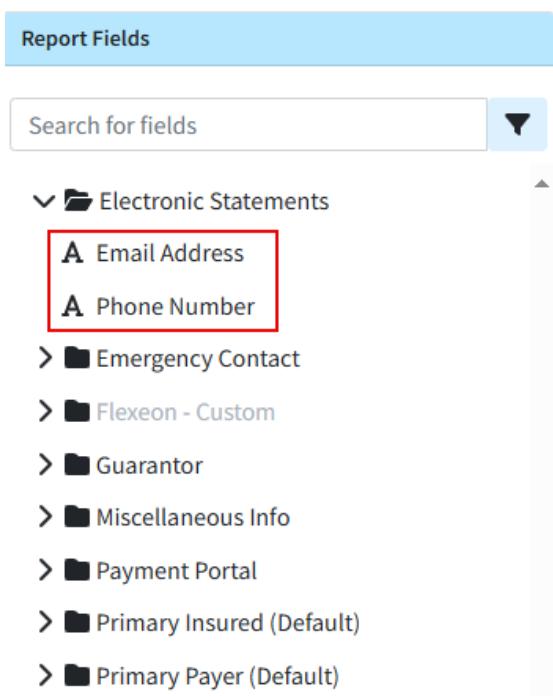
## New Electronic Statements Report Fields

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

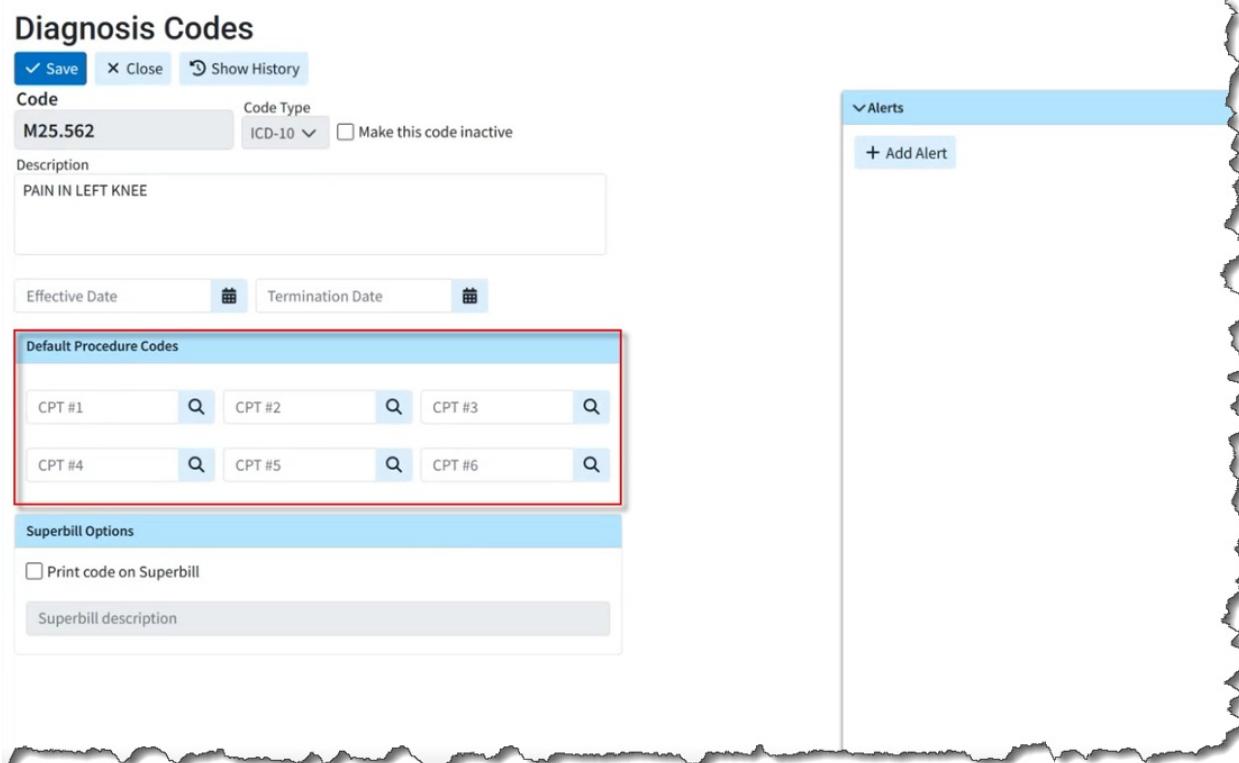
#### Enhancements

- Copay Max Increased
- New Eligibility Report Fields

## New features

### Diagnosis Code Default Procedures

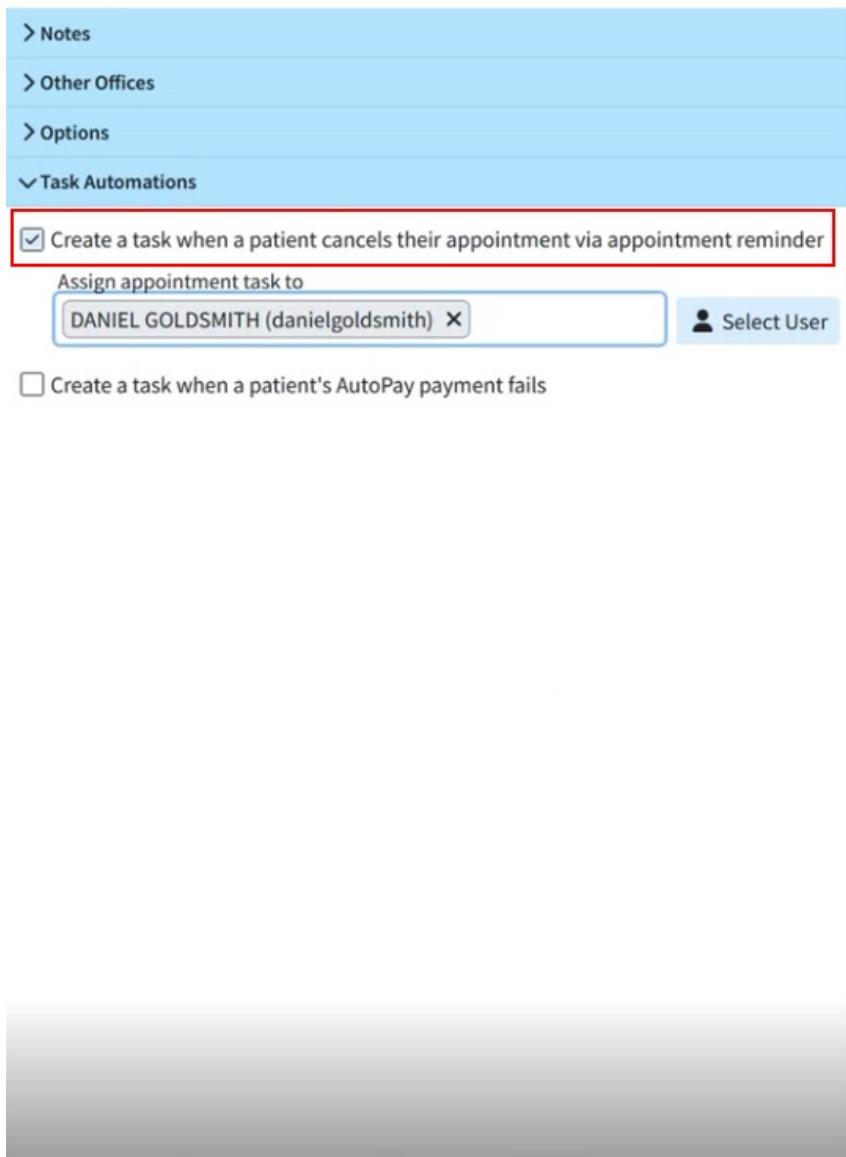
We added the ability to automate procedure codes based on diagnosis codes, particularly for diagnoses that consistently require a specific procedure. When set, if a claim is created or a diagnosis code is manually entered, the corresponding procedure code will automatically populate as a charge line 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](#)



The screenshot shows the 'Diagnosis Codes' screen. At the top, there are buttons for 'Save', 'Close', and 'Show History'. Below that, the 'Code' field contains 'M25.562' and the 'Code Type' dropdown is set to 'ICD-10'. There is a checkbox 'Make this code inactive' and a text area 'Description' with 'PAIN IN LEFT KNEE'. Below these are 'Effective Date' and 'Termination Date' fields. The main section is titled 'Default Procedure Codes' and contains six input fields for CPT codes, each with a search icon. This section is highlighted with a red box. Below this is a 'Superbill Options' section with a checkbox 'Print code on Superbill' and a text area 'Superbill description'. To the right, there is a sidebar titled 'Alerts' with a '+ Add Alert' button.

### 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.



## 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

Claim # 228132888 Reference # TEST, JOHNNY (33397993)

Patient DAVID, BOYER (10063327)

Rendering Provider CLARK, TODD A (10066781)

Billing Provider

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 Close Print Review Activity Show History More

Save and Print Claim  
Show Preview  
Copy  
Save and Print with Form  
Claim Transaction History  
EOB  
Letters  
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

Follow Up Date Set all charges to NO CHANGE

Follow Up Notes + Add Note

Proof of Timely Filing  
Appeal

Reference Information

DOS	06/02/2025	Last Bill
Status	Claim At Insurance	Amount Billed
Balance	\$3,800.00	TCN
Type	Institutional	

Patient Info

Patient #	65295621
Patient	REDACTED, REDACTED
Name	REDACTED
Patient	01/01/2000
DOB	

Payer Info

Name	ANTHEM BLUE CROSS OF COLORADO
Priority	PRIMARY
Phone	
Website	

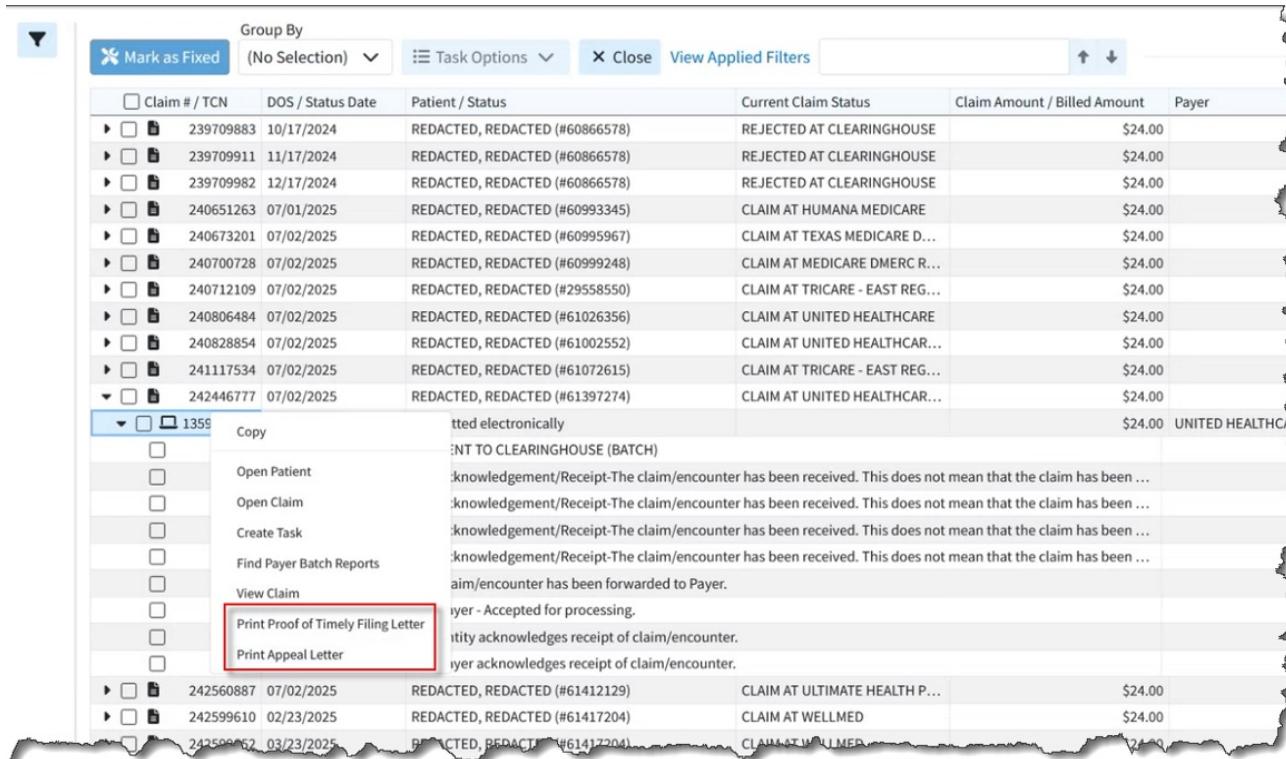
Payment Info

Ins Payments	\$0.00
Pat Payments	\$0.00

Other Info

Info	
------	--

## Printing Letter From the Claim Tracker Section



The screenshot shows a software interface for managing claims. At the top, there are buttons for 'Mark as Fixed' (with a red asterisk), 'Group By' (set to 'No Selection'), 'Task Options' (with a dropdown arrow), 'Close', and 'View Applied Filters'. Below this is a table with columns: 'Claim # / TCN', 'DOS / Status Date', 'Patient / Status', 'Current Claim Status', 'Claim Amount / Billed Amount', and 'Payer'. The table lists several claims, mostly with 'REDACTED' status. A context menu is open for the 135th claim, showing options: 'Copy', 'Open Patient', 'Open Claim', 'Create Task', 'Find Payer Batch Reports', 'View Claim', 'Print Proof of Timely Filing Letter' (which is highlighted with a red box), and 'Print Appeal Letter'.

<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"/> 135		Copy	tted electronically	\$24.00	UNITED HEALTHCA
<input type="checkbox"/>		Open Patient	ENT TO CLEARINGHOUSE (BATCH)		
<input type="checkbox"/>		Open Claim	cknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been ...		
<input type="checkbox"/>		Create Task	cknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been ...		
<input type="checkbox"/>		Find Payer Batch Reports	cknowledgement/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"/> 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.

Report Fields

Search for fields

Eligibility Data

- Patient ID
- Payer ID
- Provider ID
- A Is Active Coverage?**
- A Message**
- A Payer Priority**
- A Service Type**
- Status
- Username
- Completed Date
- Submitted Date

ERA Data

Estimate Data

Estimate Service Data

Facility Data

Fee Schedule Data

Fee Schedule Price Data

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

running 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).

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## Release 15.13.0 - July 7, 2025

### New features | Enhancements

## Highlights

### New Features

EOB Info Available in Claim & Follow Up Sections

### Enhancements

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.

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.

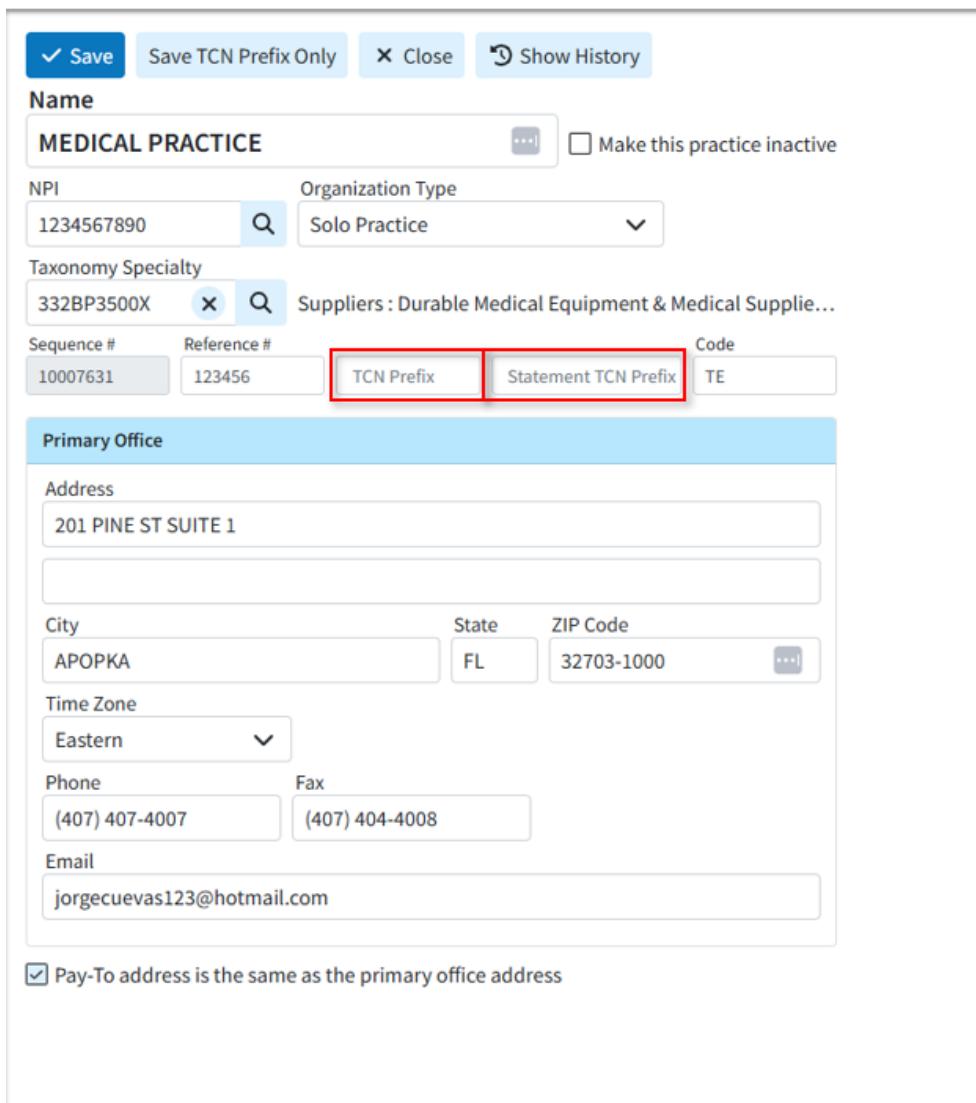
Please note that customers need to update the data they send to CMD to take advantage of these new available fields.

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.



The screenshot shows the 'Edit Practice' form. At the top, there are buttons for Save (highlighted in blue), Save TCN Prefix Only, Close, and Show History. The 'Name' field contains 'MEDICAL PRACTICE' with a dropdown arrow and a checkbox for 'Make this practice inactive'. The 'NPI' field is '1234567890' with a search icon. The 'Organization Type' dropdown is set to 'Solo Practice'. The 'Taxonomy Specialty' field shows '332BP3500X' with a search icon, and the dropdown shows 'Suppliers : Durable Medical Equipment & Medical Supplies...'. Below these are fields for 'Sequence #' (10007631), 'Reference #' (123456), 'TCN Prefix' (highlighted with a red box), 'Statement TCN Prefix' (highlighted with a red box), and 'Code' (TE). A 'Primary Office' section follows, containing fields for 'Address' (201 PINE ST SUITE 1), 'City' (APOPKA), 'State' (FL), 'ZIP Code' (32703-1000), 'Time Zone' (Eastern), 'Phone' ((407) 407-4007), 'Fax' ((407) 404-4008), and 'Email' (jorgecuevas123@hotmail.com). At the bottom, a checkbox is checked with the text 'Pay-To address is the same as the primary office address'.

# Release 15.12.0 - June 23, 2025

## New features | Enhancements

### Highlights

#### New Features

Tasks Available in Multiple New Sections  
New Enhanced Auditing (Show History) for Contracts

#### Enhancements

Net Amount now Available in Activity Report  
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 a 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 Article](#) for more information on adding and managing appointment tasks.

Save       

**Appointment**  **Patient**  **Payment**

**Patient**

TEST, JOHNNY (33397993)

Appointment Date  at  for  Minutes

**Appointment Reminder**

Allow appointment to overbook with another appointment

Appt Status

Appt Type

Resource

Facility

Office Location

Chief Complaint

Repeat appointment every

Comment

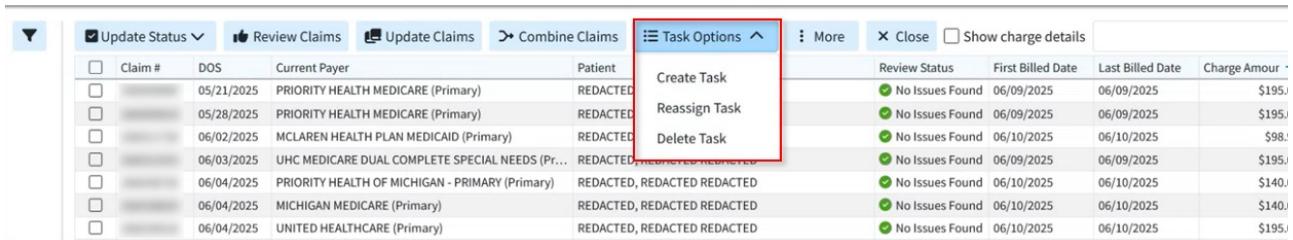
**Tasks**

Show Completed Tasks

**Documents / Forms**

### Tasks From Claim Control

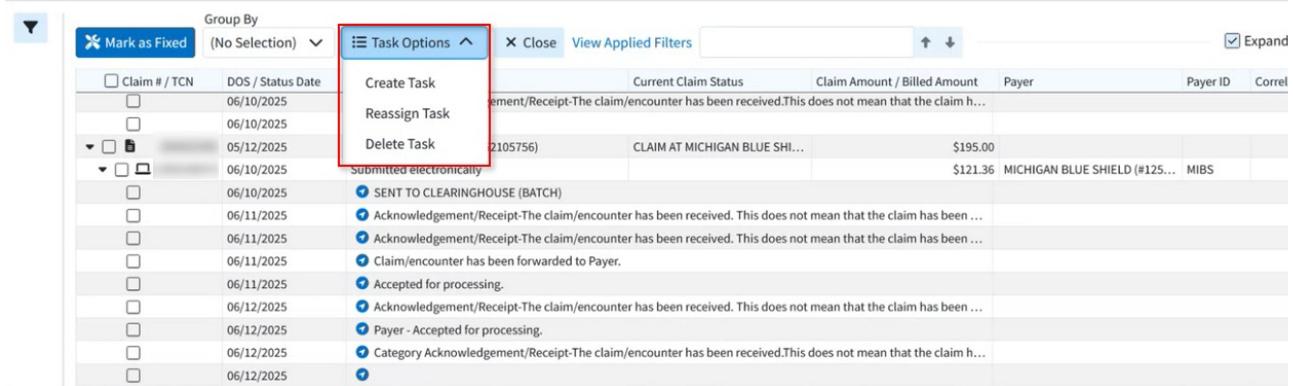
We added new Task Options within the Claim Control screen, allowing users to create and manage tasks associated with specific claims. This new option allows users to create and link tasks to multiple claims at once, as well as reassign and delete them simply by checking them off. For more info on creating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



A screenshot of the CollaborateMD Claim Tracker interface. At the top, there are several buttons: 'Update Status', 'Review Claims', 'Update Claims', 'Combine Claims', 'Task Options' (which is highlighted with a red box), 'More', 'Close', and 'Show charge details'. Below these buttons is a table with columns for 'Claim #', 'DOS', 'Current Payer', 'Patient', 'Review Status', 'First Billed Date', 'Last Billed Date', and 'Charge Amour'. The 'Task Options' menu, also highlighted with a red box, contains three items: 'Create Task', 'Reassign Task', and 'Delete Task'.

## Tasks From Claim Tracker

We also added new Task Options within the Claim Tracker screen, allowing users to create, manage, reassigned, 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.



A screenshot of the CollaborateMD Claim Tracker interface, similar to the one above but with more detailed data. The 'Task Options' menu is highlighted with a red box. Below the menu, a tooltip provides information about the 'Submitted electronically' status: 'Current Claim Status' (2105756), 'Claim Amount / Billed Amount' (\$195.00), 'Payer' (MICHIGAN BLUE SHIELD #125... MIBS), and a note: 'Element/Receipt-The claim/encounter has been received. This does not mean that the claim has been...'. The table below shows a list of claims with their 'DOS / Status Date' and a list of tasks associated with each claim.

## New Enhanced Auditing (Show History) for Contracts

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, Interface Settings, Fee Schedules, and all Customer-level Payment, Claim, and Patient 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 **Contracts**, enabling users to track notifications, 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: **BLUE CROSS AND BLUE SHIELD OF FLORIDA**  Make this contract inactive

Type: FFS   Allow users posting payments to update prices

Sequence #: 10031099

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"/>
00477	25.00	CATH LVG MAM DUX COLLJ CYTOL SPEC EA BRST EA DUX	Procedure	<input type="checkbox"/>
0048T	42.00	IMPLTJ VENTR ASSIST DEV XTRCOPR PRQ T-SEPTAL	Procedure	<input type="checkbox"/>
0049T	122.00	PROLNG XTRCOPR 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 XTRCOPR 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.

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.

*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
<b>Claim Totals</b>					<b>\$458.00</b>	<b>\$138.99</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$138.99</b>

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 number of tables delivered per transaction

One Combined File

Recurring Snapshot

Activity

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](#)

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

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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

uplicate 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.



The screenshot shows a software interface for managing claims. At the top, there are several buttons: 'Update Status' (with a dropdown arrow), 'Submit Claims', 'Review Claims', 'Update Claims', 'Combine Claims' (which is highlighted with a red box), and 'Close'. Below these buttons is a table with the following data:

	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.



The screenshot shows a table of charges that will be combined into a new claim. The columns are: From, To, Procedure, POS, TOS, Mod 1, Mod 2, Mod 3, Mod 4, Unit Price, Units, Amount, Status, and Inventory. The data is as follows:

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	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	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](#).

Code	Description	POA
M25.562	PAIN IN LEFT KNEE	1-Unreported
		Y-Yes
		N-No
		U-Unknown
		W-Undetermined

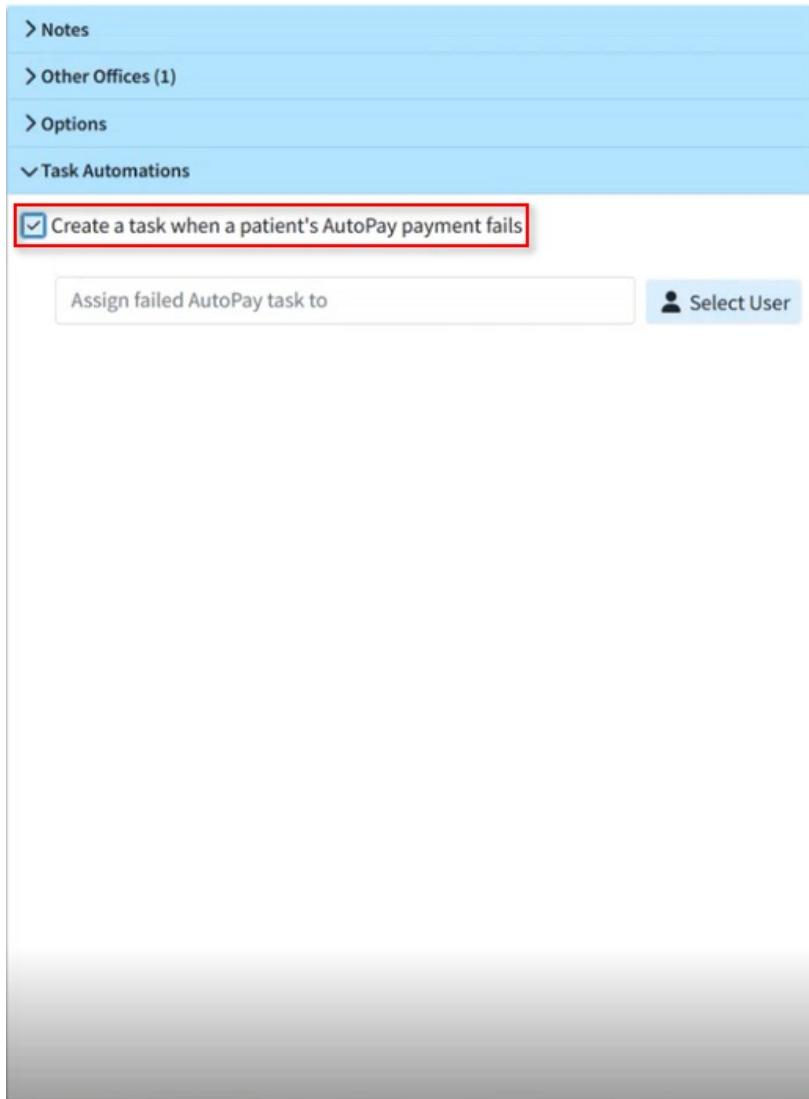
CPT #1: 99212    CPT #2: J3475    CPT #3    CPT #4

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.

Code	Amount	Description
	0.00	

## 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.



## 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 customers 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 the claim.

The screenshot shows a 'Situational Modifier' dialog box. At the top, there are four tabs labeled 'Mod 1', 'Mod 2', 'Mod 3', and 'Mod 4', each with a search icon. The 'Mod 1' tab is highlighted with a red box. Below the tabs, a note says 'Use the above modifiers on claims with all of the following:'. A list of checkboxes follows, with the first two ('A specific type of service' and 'A specific other procedure code on the claim') also highlighted with a red box. At the bottom, there is a 'Notes' text area with a blue border, and 'Done' and 'Cancel' buttons at the bottom right.

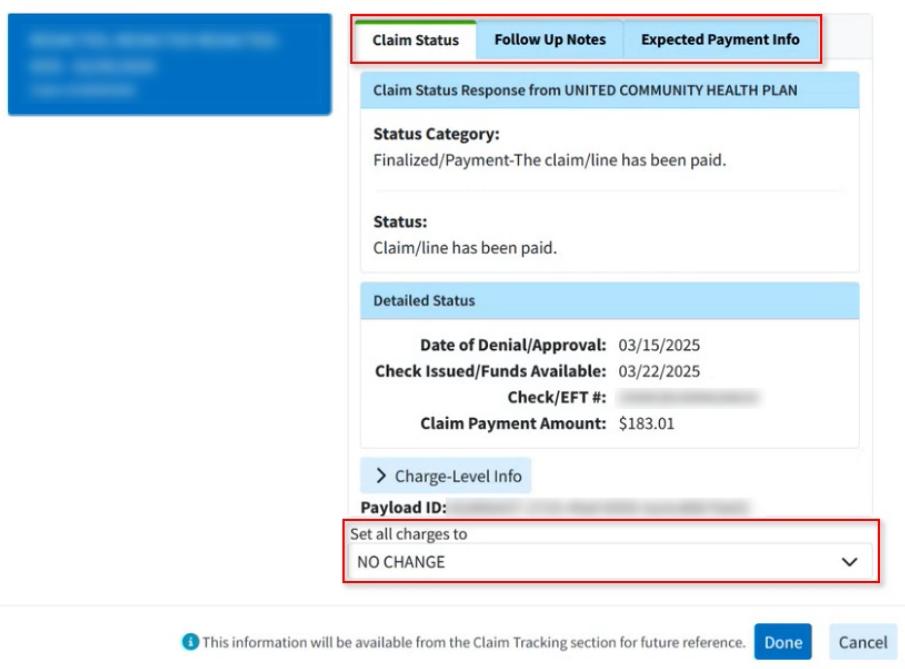
We also updated the **Dates of Service**, **Primary Payer**, **Facility**, **Rendering Provider**, **Rendering Provider Credentials**, and **TOS** situational modifier options to be multi-select, making it easier for practices with a large number of records to manage these modifiers. For more information 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.

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## Claim Status Results



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 #:** [REDACTED]  
**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**

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## Release 15.10.0 - May 27, 2025

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### New features | Enhancements | Resolutions

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## Highlights

### New Features

- New Task Assignment to Contact Groups
- New Prior Auth Requirement & Billing Alerts Update
- New Appointment Types Default Codes

### Enhancements

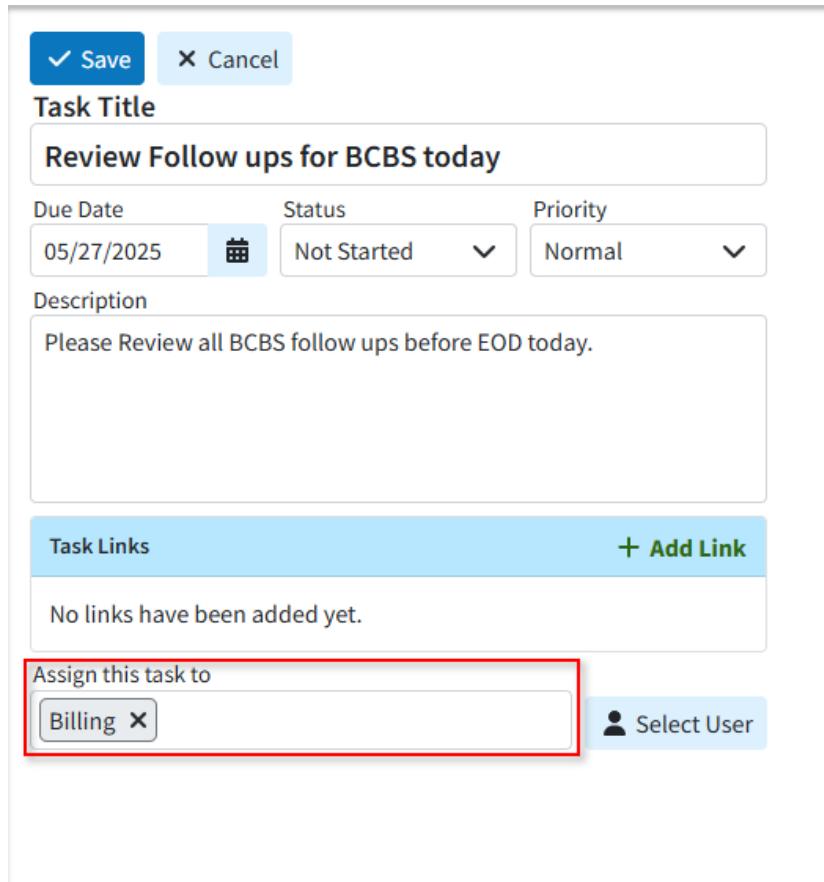
- New Taxonomy Specialty Report Fields

## 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.



The screenshot shows a task creation form. At the top are 'Save' and 'Cancel' buttons. The 'Task Title' field contains 'Review Follow ups for BCBS today'. Below it are 'Due Date' (05/27/2025), 'Status' (Not Started), and 'Priority' (Normal) fields. The 'Description' field contains the text 'Please Review all BCBS follow ups before EOD today.' A 'Task Links' section with a '+ Add Link' button shows 'No links have been added yet.' At the bottom is an 'Assign this task to' field containing 'Billing' with a delete 'X' button, and a 'Select User' button.

## 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

✓ Save × Close ⏪ Show History

Narrative Notes

Modifiers (Global & Situational)

Global 1 Global 2 Global 3 Global 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.

## Enhancements

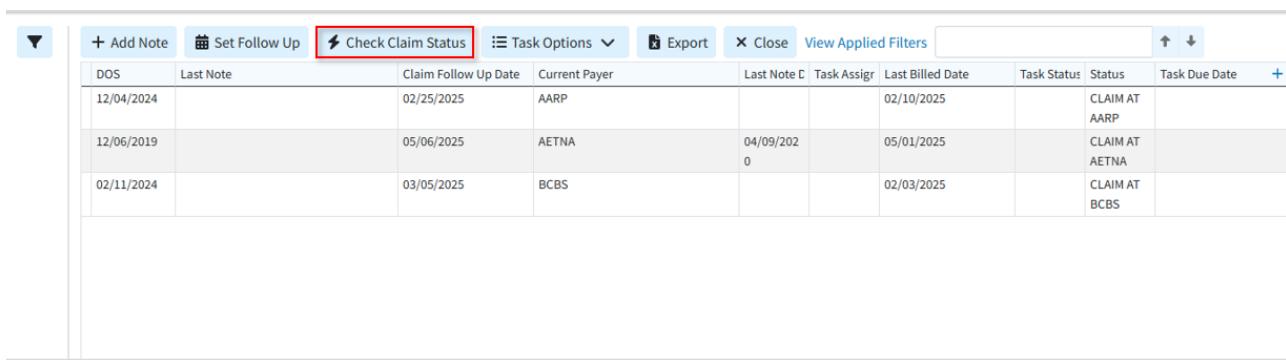
### New Report Fields

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**

### 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.



DOS		Last Note	Claim Follow Up Date	Current Payer	Last Note C	Task Assigr	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	04/09/202 0		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 "T1.5 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.

*Changes to these margins will only adjust 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

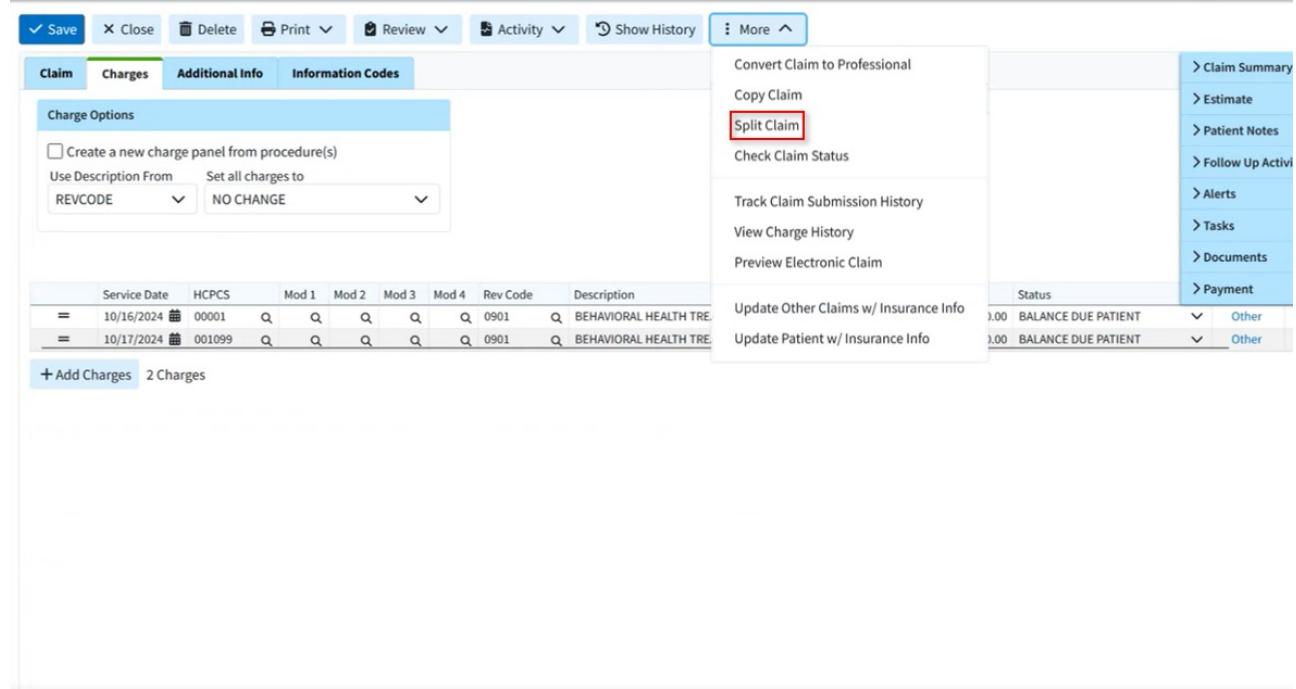
### Enhancements

A/R Control Payer Filter Renamed

## New features

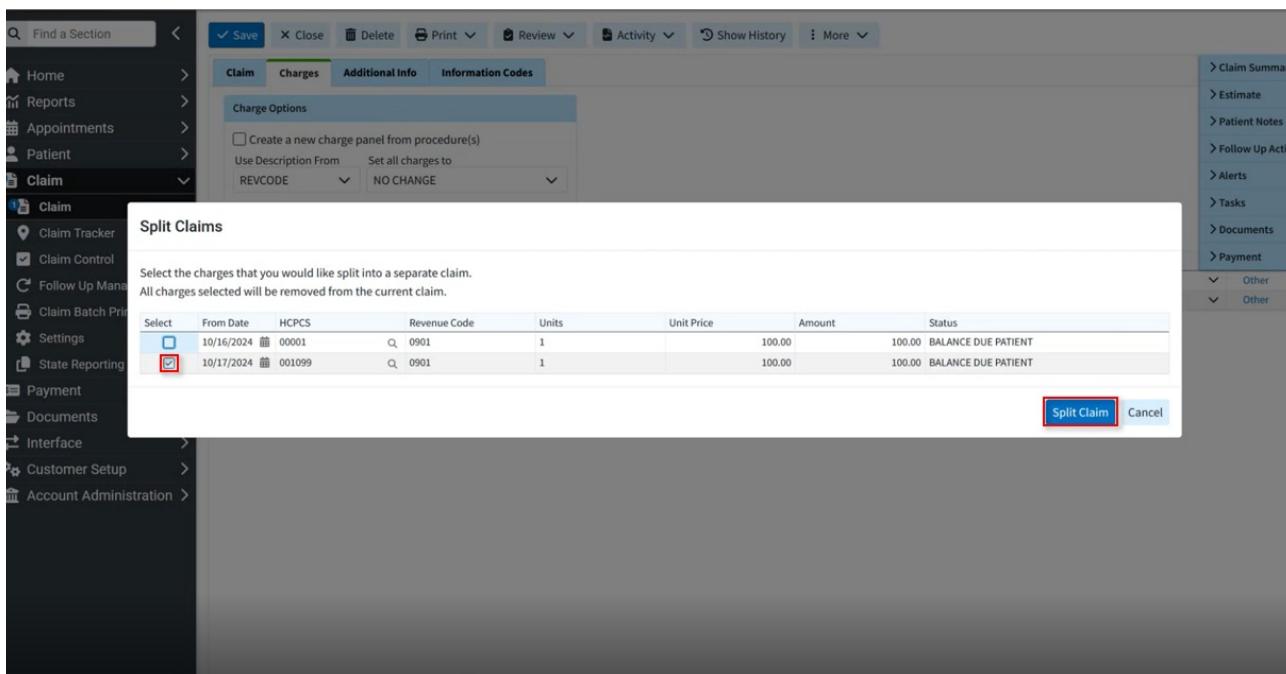
## New Split Claim Feature

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 shows a software interface for managing claims. At the top, there are buttons for Save, Close, Delete, Print, Review, Activity, Show History, and More. The 'Charges' tab is selected. Below the tabs, there is a 'Charge Options' section with a checkbox for creating a new charge panel from procedure(s), a dropdown for 'Use Description From' set to 'REVCODE', and a dropdown for 'Set all charges to' set to 'NO CHANGE'. A table below lists charges with columns for Service Date, HCPCS, Mod 1, Mod 2, Mod 3, Mod 4, Rev Code, and Description. Two rows are shown: one for 10/16/2024 with HCPCS 00001 and one for 10/17/2024 with HCPCS 001099. At the bottom left, there are buttons for '+ Add Charges' and '2 Charges'. On the right, a 'More' menu is open, showing options like Convert Claim to Professional, Copy Claim, Split Claim (which is 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 'Split Claim' option is located under the 'Copy Claim' section. The 'Status' section at the bottom right shows two entries: '0.00 BALANCE DUE PATIENT' and '0.00 BALANCE DUE PATIENT', both with dropdown menus for 'Other'.

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.



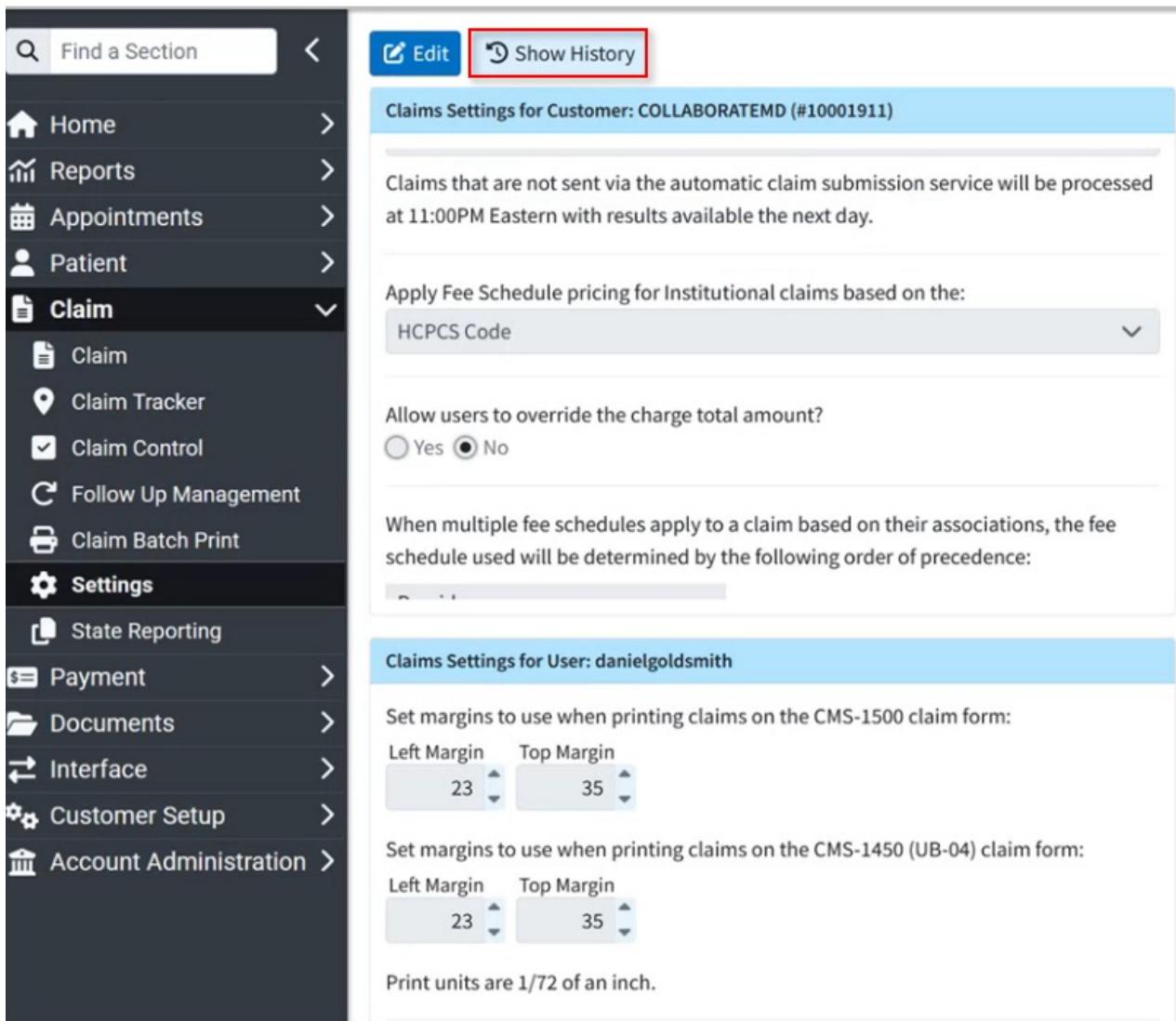
#### Knowledge base articles

- [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 shows a software interface with a left sidebar and a main content area. The sidebar contains a 'Find a Section' search bar and a list of menu items: Home, Reports, Appointments, Patient, Claim (selected), Claim, Claim Tracker, Claim Control, Follow Up Management, Claim Batch Print, Settings (selected), State Reporting, Payment, Documents, Interface, Customer Setup, and Account Administration. The main content area has a 'Show History' button highlighted with a red box. The 'Claims Settings for Customer: COLLABORATEMD (#10001911)' section contains a note about processing claims at 11:00PM Eastern. The 'Apply Fee Schedule pricing for Institutional claims based on the: HCPCS Code' section has a dropdown menu. The 'Allow users to override the charge total amount?' section has a radio button for 'Yes' selected. The 'When multiple fee schedules apply to a claim based on their associations, the fee schedule used will be determined by the following order of precedence:' section has a dropdown menu. The 'Claims Settings for User: danielgoldsmith' section contains settings for CMS-1500 and CMS-1450 claim forms, including left and top margin values of 23 and 35 respectively. A note at the bottom states 'Print units are 1/72 of an inch.'

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  ▼

Charge Status  ▼

Rendering Provider  🔍  ⓘ

Referring Provider  🔍  ⓘ

**Claim Search Options**

**New Filter Name**

Current Payer  🔍

Charge Balance  ▼

Charge Status  ▼

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

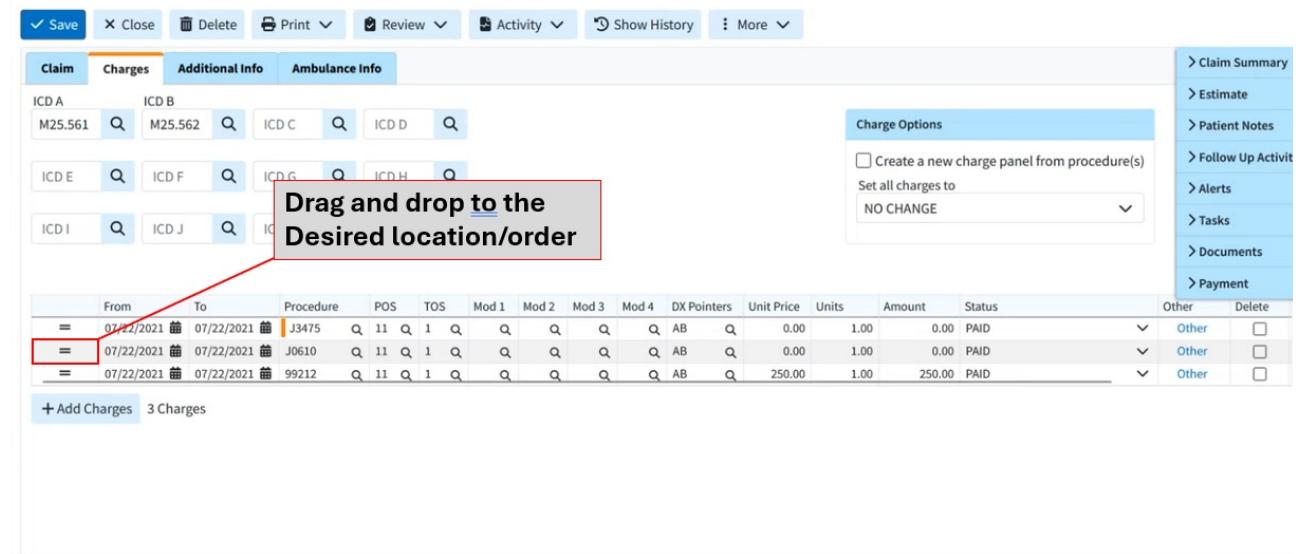
### Enhancements

- 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.



Drag and drop to the Desired location/order

From	To	Procedure	POS	TOS	Mod 1	Mod 2	Mod 3	Mod 4	DX Pointers	Unit Price	Units	Amount	Status	Other	Delete	
=	07/22/2021	J3475	Q	11	Q	1	Q	Q	Q AB Q	0.00	1.00	0.00	PAID	▼	Other	□
=	07/22/2021	J0610	Q	11	Q	1	Q	Q	Q AB Q	0.00	1.00	0.00	PAID	▼	Other	□
=	07/22/2021	99212	Q	11	Q	1	Q	Q	Q AB Q	250.00	1.00	250.00	PAID	▼	Other	□

### 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.

✓ Save Change Payment Details and Save × Close Show History

Name  
COMPANY AMEX  Make this payment profile inactive.

Make this my account's default payment profile.

Credit Card  Debit Card  Bank Account

Cardholder Name  
SUNEEL SHARMA

Card Number  
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

ⓘ 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

[New 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

***ⓘ 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

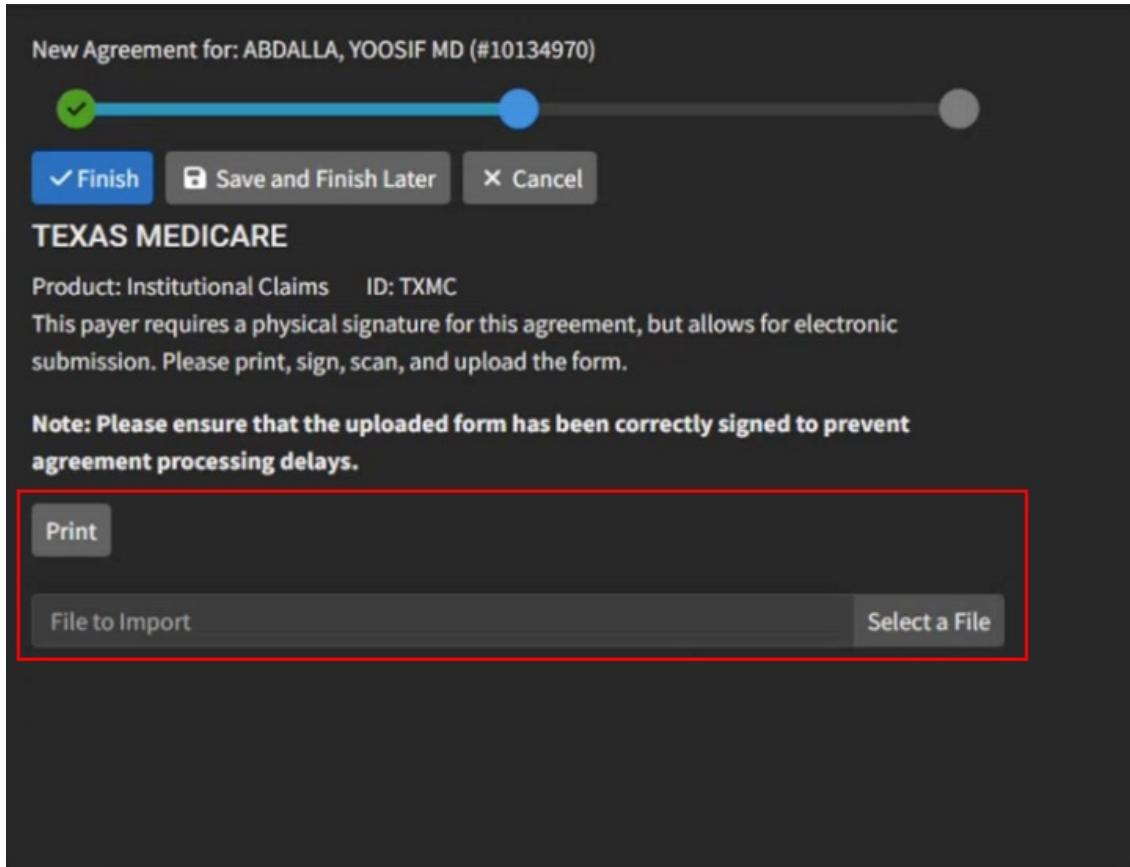
Price: \$63.96

### 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.



### 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

✓ Save    × Close    ⌂ Show History

**Code**  **Type**    Make this code inactive

**Description**  
OSTEOARTHRITIS ASSESSED

**Claim Defaults**

Exclude this code from duplicate service checks  
 This is an all inclusive code  
All other charges on the claim will be sent with an amount of \$0.01  
 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**

**CLIA Number**  **Type of Service**

**Narrative Notes**

**Modifiers (Global & Situational)**

Global 1  Global 2  Global 3  Global 4

### 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.

Payment - Check from AMERICOICE OF NEW YORK INC. (MEDICAID NY) received on 03/21/2024 for MUNIZ, JOSEPH (#37190993) [?](#)

Claim # 177121295 | Rendering STRANGE, DOCTOR

Action: Processed (User) Status: 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
<b>Total:</b>		<b>\$1,020.00</b>	<b>\$1,002.00</b>	<b>\$300.00</b>	<b>\$200.00</b>

Available Columns

- Transaction ID [+](#)
- Unapplied Copay is Available [+](#)
- Current Status [+](#)

Visible Columns

- DOS
- Proc
- Amount
- Start Balance
- Allowed
- Paid

Done

Apply Discount

Payment Memo: PAYMENT FROM AMERICOICE OF NEW YORK INC. MEDICAID NY

Apply Credit Adjustment

Adjustment Memo: ADJUSTMENT BY AMERICOICE OF NEW YORK INC. MEDICAID NY

Apply Debit Adjustment

## 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 X Close Print Merge Eligibility Activity View All Appointments Show History

Last Name: TEST First Name: JOHNNY MI: Suffix:  Make this patient inactive  Patient is complete

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

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

Type: Payment Plan Account #: 33397993 Reference #:

**Search**  Copy Insured Address

Self Pay

Courtesy

Collection

Pre-Collection

Type I

Type II

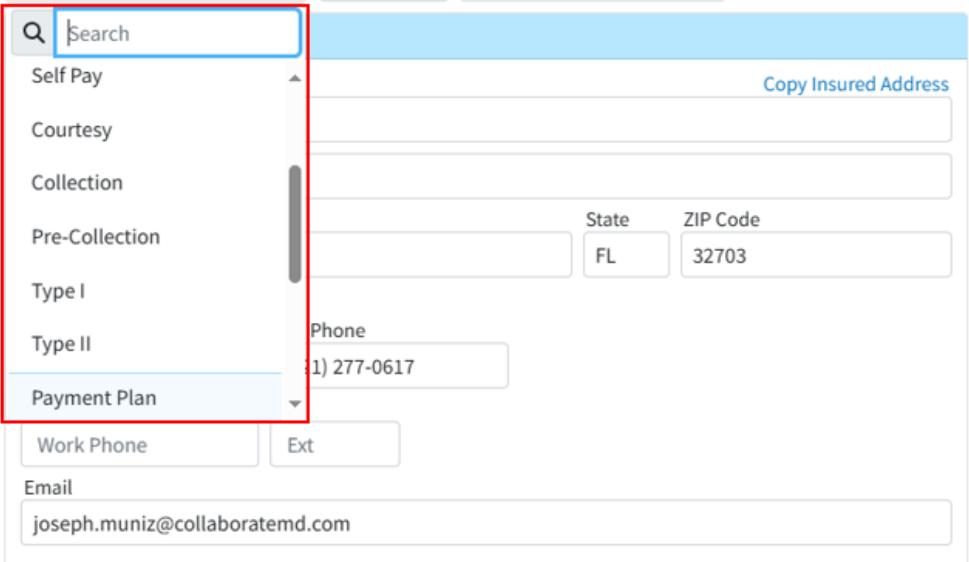
Payment Plan

State: FL ZIP Code: 32703

Phone: (1) 277-0617

Work Phone: Ext:

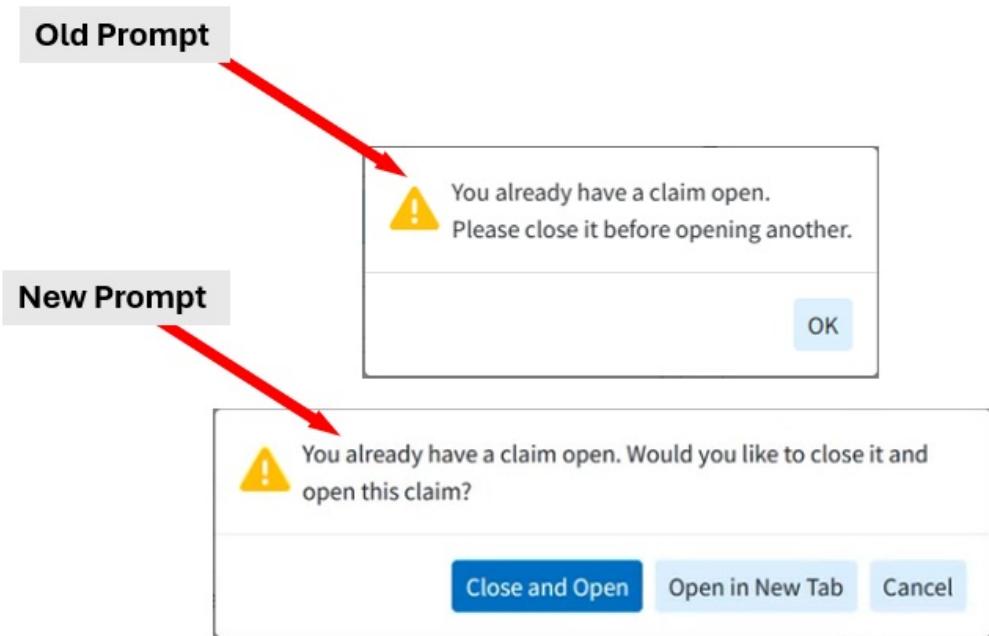
Email: joseph.muniz@collaboratemd.com



## 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.



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## 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
<b>Total</b>			<b>\$0.00</b>		

[+ 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"/>	AHOY, CHIPS (#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 (#11171554)		0646465406	123 MAIN STREET, ORLANDO, FL 32805	
<input type="checkbox"/>	BRADSHAW - TEST, KEVIN (#11171455)		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)		14117622671	439 S UNION ST UNIT 2104, LAWRENCE, MA 01843-2800	
<input type="checkbox"/>	BURKE, DARLENE (#111218440)		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 shows the CollaborateMD software interface. On the left is a dark sidebar with a navigation menu. The 'Appointments' section is expanded, showing sub-options like 'Scheduler', 'Manage Waiting List', 'Appointment Control', 'Superbill Batch Print', 'Configuration...', 'Patient', 'Claim', 'Payment', 'Documents', 'Interface', 'Customer Setup', and 'Account Administration'. The main workspace is titled 'Appointment' and shows a patient record for 'TEST, JOHNNY (33397993)'. The 'Patient' tab is selected. The appointment details include: Appointment Date: 03/13/2025, Time: 01 : 00 PM, Length: 45 Minutes. There is a checkbox for 'Allow appointment to overbook with another appointment'. Below these are dropdowns for 'Appt Status' (Scheduled), 'Appt Type' (CARDIOLOGY), 'Resource' (01) JESSICA DUKE, 'Facility' (A UNIQUE FACILITY(#10203231)), and 'Office Location' (ABC MEDICAL GROUP 123 ABC STREET). There are also fields for 'Chief Complaint' and 'Repeat appointment every'. On the right, a panel titled 'Account Summary for JOHNNY TEST' displays various patient statistics, such as 'Patient DOB', 'Family Account Type', 'Patient Balance', and 'Last Patient Payment'. A red box highlights the 'Show History' button in the top right corner of the main workspace.

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

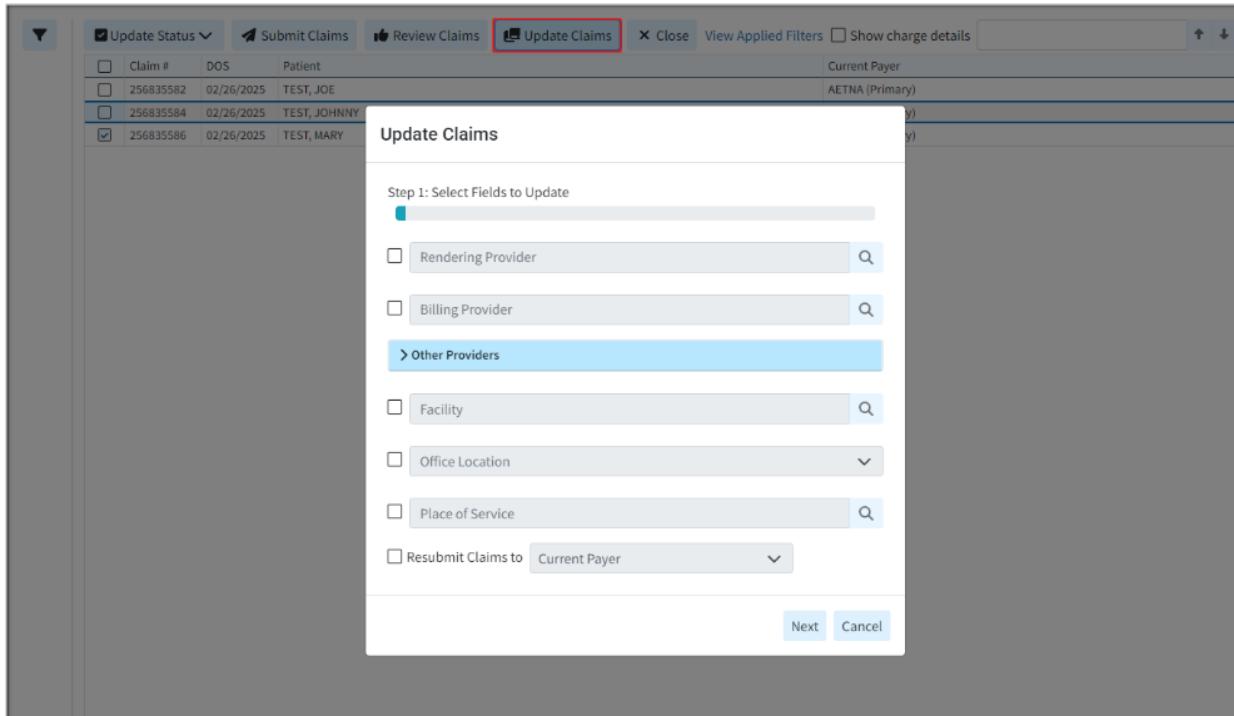
## New Features and Updates

### General

### Claims

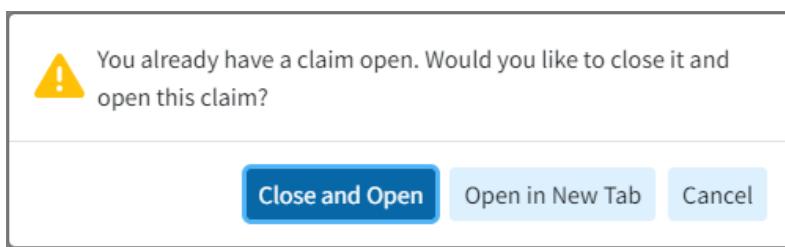
- **New Mass Claim Updates Feature:** CollaborateMD has always provided powerful tools for working with individual claims, but the platform's ability to make changes to multiple claims at once was limited. With this release, users no longer have to open each claim individually when correcting minor mistakes, 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](#).

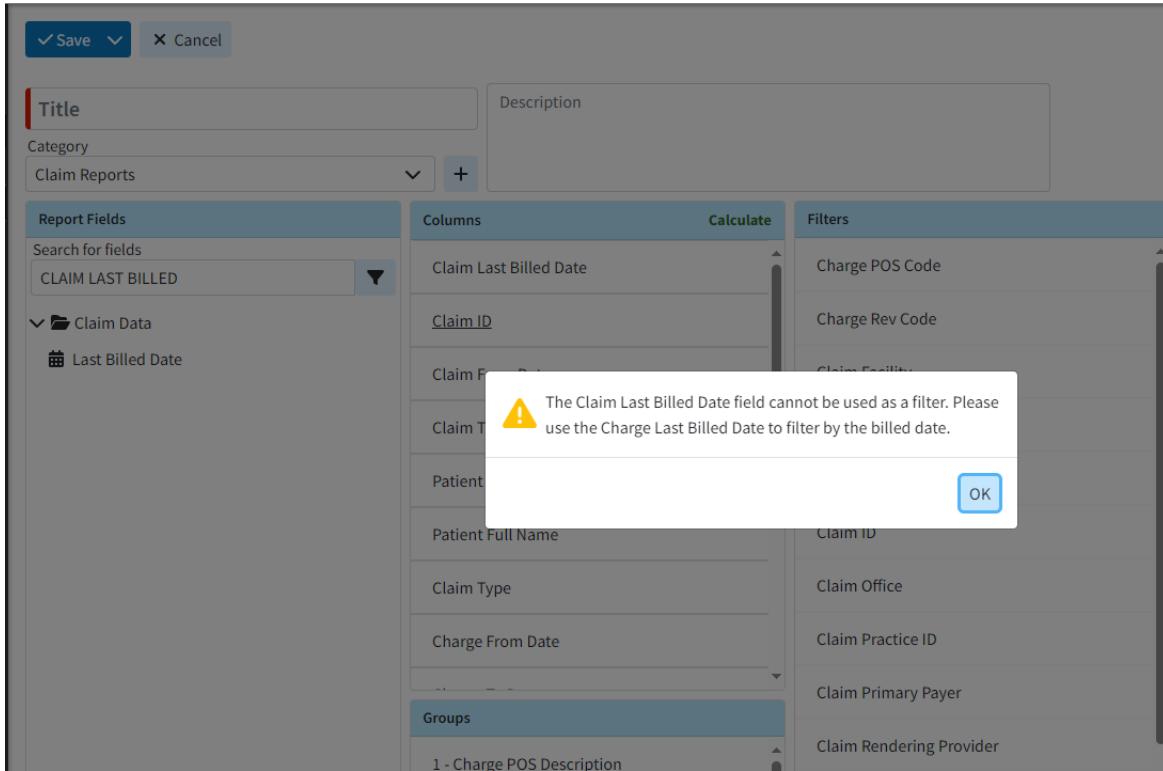
- **Alternate Option To Open A Claim In a Separate Tab When Another Claim Is Already Open:** We have introduced a new dialog box option that appears when a user attempts to open a claim from any section within the CMD while a claim is already open. This feature will now provide the user with the following 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.

The screenshot shows the 'Patient Record' screen for a patient named 'JOE TEST'. The main panel displays patient details like Last Name (TEST), First Name (JOE), Gender (Male), Date of Birth (01/16/1982), SSN (987-65-4321), and a contact address (1100 E WASHINGTON ST, ORLANDO, FL 32801-2128). The 'Appointments' panel on the right lists past appointments for 'JESSICA DUKE' and 'STEPHEN KOZLOWSKI' with various dates and times. A red box highlights the 'Past Appointments' section.

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

## Customer Setup

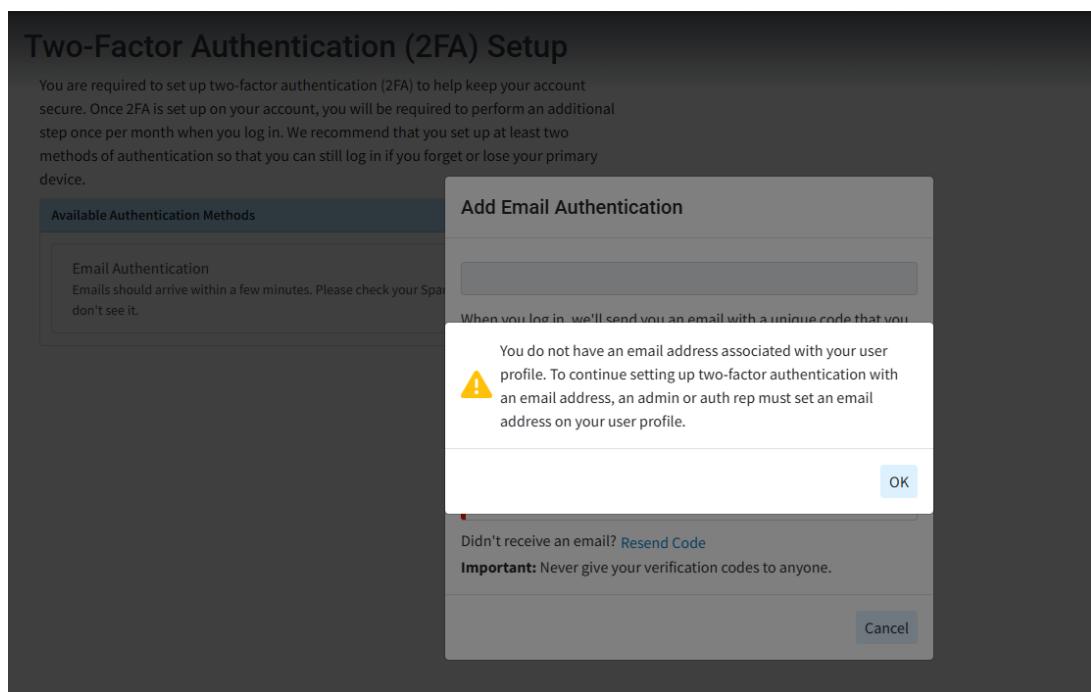
- New Option to Open Contracts and Fee Schedules From Procedure & Revenue Codes Section** We added the ability for users to open contracts and fee schedules directly from the Procedure and Revenue Codes sections. This new functionality enables users to click on the Fee Schedule/Contract Name (which is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

The screenshot shows the 'Procedure Codes' screen for code '0005F'. The main panel includes fields for Code, Type (CPT®/HCPCS), Dept., and a 'Make this code inactive' checkbox. The 'Fee Schedules' panel on the right lists various fee schedules with their names and prices, such as 'REV101' (0.00), 'AETNA093020' (100.00), and 'MEDICARE' (100.00). A red box highlights the 'MEDICARE' entry in the list.

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

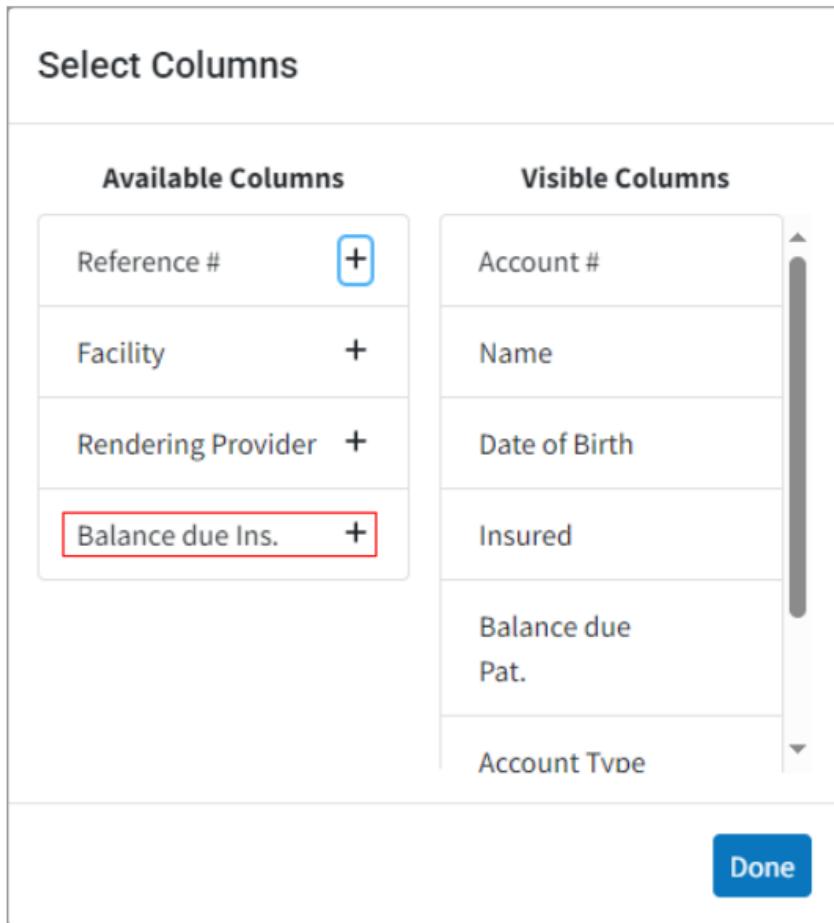
### New Features and Updates

#### 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.



- **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  Search

Charge Balance  
Any

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

Rendering Provider  Search Info

Referring Provider  More

Paper Statements Sent  
Any

Electronic Statements Sent  
Any

Total Statements Sent  
Any

Patient  Search

Account Type More

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
Search 123456789
Show exact matches only 
Show unpaid claims only 
Find for MUNIZ, JOSEPH
More

Recently Opened

Claim ID	DOS	Patient	Total Charges	Balance

Rendering Provider  
DUKE, JESSICA (10128215)

Billing Provider  
DUKE, JESSICA (10128215)

Supervising Provider

Ordering Provider

Referring/PCP Provider

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	Adjustments
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	\$250.00
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.

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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?

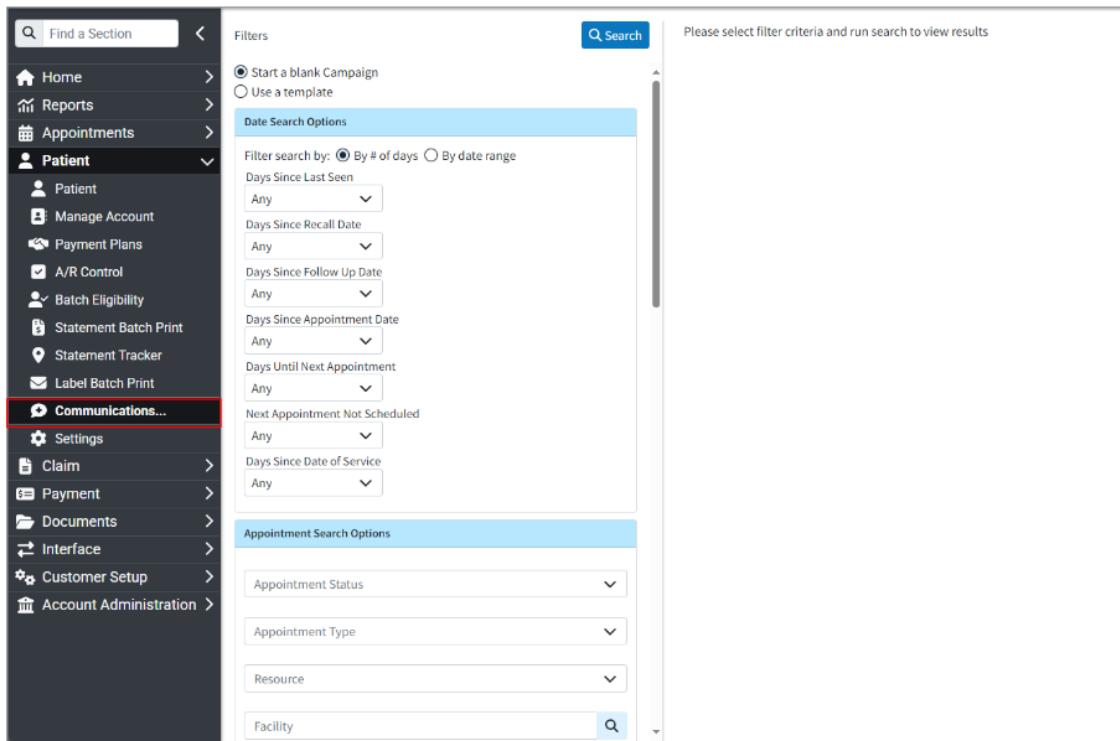
Yes  No

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

The screenshot shows a software interface for managing report fields. At the top, there's a search bar with the placeholder 'Search for fields' and a text input field containing 'CONTRACT NAME'. Below the search bar is a list of field categories, each with a small icon and a downward arrow indicating they are expandable. The categories are: 'Charge/Debit Data', 'Charges', 'Current Payer', 'Primary Payer', 'Secondary Payer', 'Tertiary Payer', and 'Contract Data'. Under the 'Current Payer' category, there are four sub-fields, each preceded by a bold letter 'A' and a red rectangular box. The sub-fields are: 'Contract Name' (under Primary Payer), 'Contract Name' (under Secondary Payer), 'Contract Name' (under Tertiary Payer), and 'Contract Name' (under Contract Data). The 'Contract Data' category is preceded by a right-pointing arrow and a red rectangular box.

- **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

Report Fields

Search for fields COMMUNICATION ▾

➤ Broadcast Message Data

➤ Patient Data

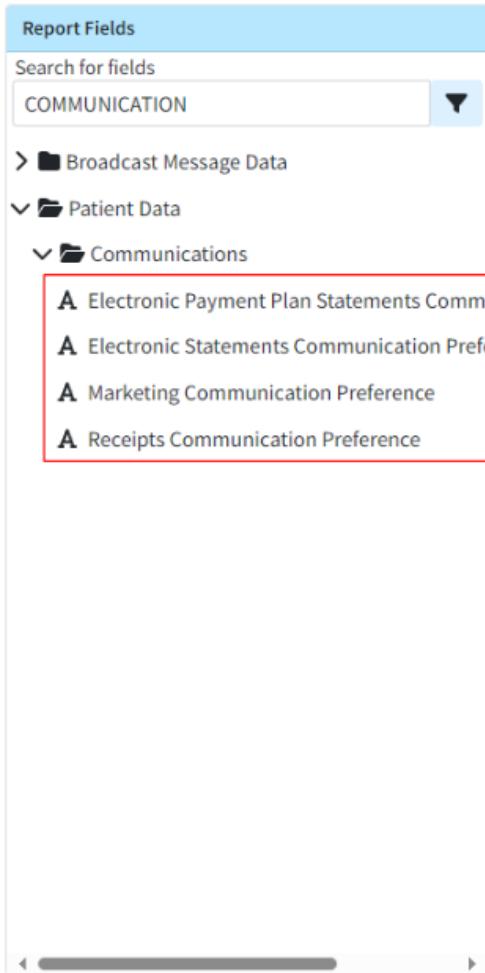
➤ Communications

A Electronic Payment Plan Statements Comm

A Electronic Statements Communication Pref

A Marketing Communication Preference

A Receipts Communication Preference



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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.

Find a Section  Search

Filters Load Save

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  Debit Account Credit Account Refund Credits

Insurance Balance: \$4,998.00 Insurance Credit: \$50.00

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.

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

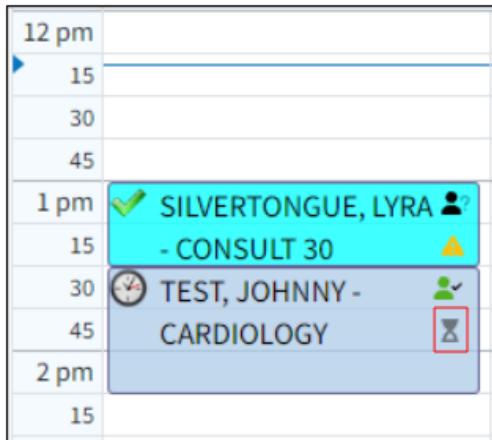
## New Features and Updates

### 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.



## 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.

<input checked="" type="checkbox"/> Mark As Fixed <input type="checkbox"/> Update Addresses <input type="checkbox"/> Close <input type="checkbox"/> View Applied Filters <input type="checkbox"/> <input type="checkbox"/>						
	Patient	Invoice #	Date	Amount	Type	Status
<input checked="" type="checkbox"/>	ALEXANDER, JONES	<a href="#">1262243014</a>	10/20/2024	\$142.00	Statement	User Printed by alexramirez - Enhanced
<input checked="" type="checkbox"/>	BEAR, TORI	<a href="#">1262243019</a>	10/20/2024	\$13.00	Statement	User Printed by alexramirez - Enhanced
<input checked="" type="checkbox"/>	TEST, ANGIE	<a href="#">1262243020</a>	10/20/2024	\$837.00	Statement	User Printed by alexramirez - Enhanced
<input checked="" type="checkbox"/>	GROOT, IAM	<a href="#">1262243023</a>	10/20/2024	\$13.10	Statement	User Printed by alexramirez - Enhanced
<input checked="" type="checkbox"/>	MCCLOUD, FOX	<a href="#">1270798112</a>	11/12/2024	\$20.00	Estimate Statement	User Printed by danielgoldsmith - Enhanced
<input checked="" type="checkbox"/>	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.

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.

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:

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

Showing agreements for: KEN TEST, DPM (#10036112568) (NPI #123456789) (Submitter ID #10010010) (Tax ID #05-00685)

Start Date	Payer	Payer ID	Product	Status
10/19/2022	RHODE ISLAND MEDICARE	RIMC	Remittance	Approved
10/19/2022	MEDICARE	CMS	Eligibility	Approved
10/19/2022	RHODE ISLAND			Approved
10/19/2022	ALBUQUERQUE			Approved
10/19/2022	UNITED HEALTH			Approved
10/19/2022	HARVARD PILGRIM			Approved
10/19/2022	AETNA HEALTH			Approved
10/19/2022	NEIGHBORHOOD			Approved
10/19/2022	NEIGHBORHOOD			Approved
10/19/2022	UNITY INTEGRITY			Approved
10/19/2022	RHODE ISLAND			Approved
10/19/2022	RHODE ISLAND			Approved
10/19/2022	SECURE HORIZON			Approved
10/31/2022	PEAK PACE SO			Approved
03/28/2024	RHODE ISLAND			Approved
05/21/2024	RHODE ISLAND			Approved

**Select Columns**

Available Columns	Visible Columns
Approval Date	Start Date
Provider Action	Payer
Created by	Payer ID
Provider ID/PTAN	Product
Signature Type	Status

**Done**

## 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