

2026 Release Notes

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Release 16.6.0 - March 30, 2026

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

Highlights

New Features

[Universal Import](#)

Enhancements

[New Rich Text Editor](#)

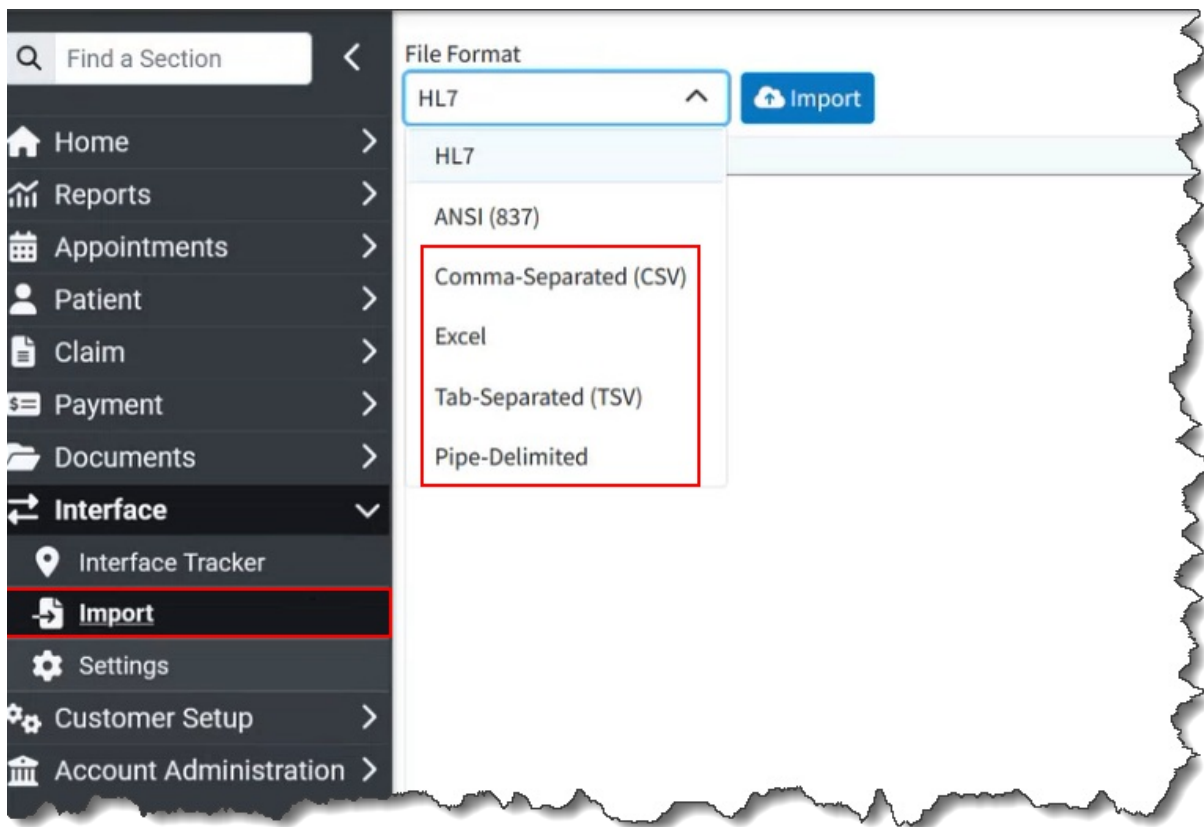
[New Automation for Value Code 80](#)

New features

Universal Import

This release introduces the beta version of CollaborateMD's Universal Import feature. Many Electronic Health Record (EHR) systems now include interfaces designed to export data, often in HL7 standard format, offering greater flexibility to their users. However, a common issue is that numerous EHRs lack interfaces for external systems. This deficiency creates substantial additional work for medical practices and billing services, as they are forced to manually input claims and patient data into CMD.

Our Universal Interface Import allows users with an EMR/EHR that has not built an interface with us to import encounter, claim, and patient data from any external system. Customers can now upload CSV, Excel, TSV, and pipe-delimited files using our Interface Import section. This new feature uses AI-powered field mapping to automatically interpret the structure of CSV/Excel files from other systems and map them into CMD. This feature allows customers who do not use our WebAPI to automatically import claims, and patients from any EMR/EHR via a report or export from their software.



Customers can still manually import claims into our system in the HL7 format or from an 837 ANSI file into CollaborateMD.

For more information visit our [Universal Import Help Articles](#) or visit our [Universal Import Interactive Demo](#).

Enhancements

New Rich Text Editor

This release includes an update to our Rich Text Editor, used in sections such as alerts and messaging. Although the editor functions similarly, you will notice some changes to the toolbar's appearance and its items. Icons for bold, italics, underline, and insert link remain largely the same, while others, such as Font Color and Font Size, have a new look. The previous Text Color and Highlight Color icons were combined into one. The Indent, Insert Ordered List, Insert Unordered List, and Insert Table icons are now visible in the toolbar. This new editor reduces clutter and increases visibility directly from the toolbar.

Creating alert for Provider

Font

Font Size

Text & Fill Color



Lists, Indent & Tables

Display Options

Global

- Show Alert in Patient Section
- Show Alert in Claim Section
- Show Alert in Appointment Section
- Show Alert in Payment Section

Effective Date Range

Alert Start Date  Alert End Date 

Done **Cancel**

New Automation for Value Code 80

We previously added the ability to default value codes at the payer and patient level for institutional claim as part of our claim workflow enhancements. Value codes are specific billing details on institutional claims—for example, value code 80, "Covered Days," represents the number of days covered by the bill. This value will vary per claim, so it should not be set as a default amount.

In this release, we added an automation for value code 80. When value code 80 is used, leaving the amount blank in the default value codes section for the payer or patient will change the value field to "number of days" instead of "dollar amount." Subsequently, when a claim is received via interface, the value code's amount will be automatically set based on the number of covered days.

> Clearinghouse Connection

> Notes

> Alerts

> Tasks

▼ Billing Options

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

Send patient address in Box 32 for Place of Service 12

Remove the insured's ID# from Box 1A

Print the following supplemental info in Box 24

Narrative Notes ▼

Print ICD code for first diagnosis pointer in Box 24E

Send minutes instead of units on anesthesia claims

Send anesthesia start/stop times in a line note.

Institutional

Print the following in Box 38

Print payer's address ▼

Print the following in Box 80

Print remarks ▼

Print referring physician in Box 76

Print Taxonomy Code in Box 76

Print Taxonomy Code in Box 81CC a

Default Value Codes

Code	Amount	Description	
80	# of days	Covered Days	X
	0.00		

Resolutions

ERA Reversal Matching Improvement

We resolved an issue that prevented some ERA reversals from applying correctly. The affected ERAs received a "we couldn't apply the reversal because there was no prior reversal to apply to" warning message. With this update, the system now looks at the previous payment to determine how the payment and adjustment should be posted. This ensures consistent application, allowing reversals to be matched appropriately.

Corrected GPI Onboarding Issues

We fixed several issues with the GPI onboarding when setting up In-App Payment Processing. The 'Percentage of Processing Methods' field will now have improved validation to prevent progression with invalid or null information. Additionally, the "Title" field for the **Authorized Signer** will now be a dropdown

menu with allowed options, preventing errors, as GPI expects specific values.

Intake Forms: Unmatched Forms Option Fixed

We corrected an issue with our Intake Forms' **Unmatched** forms feature. A previous release accidentally created a bug that prevented the option to fix unmatched intake forms from appearing when clicking on an "Unmatched" form. This has been corrected in this release and is working again.

Incorrect Net Amount Issue

We resolved an issue where a net amount could be calculated incorrectly for patients. This issue prevented the charge-level allowed and net amounts from calculating correctly in the daily/monthly net charges report. Although this issue will be fixed going forward, existing patients may still have invalid values. If that's the case, opening and saving the patient will solve the issue.

Multiple Universal Import Beta Fixes

Since releasing the Beta version of our Universal Import feature, we have updated and corrected some issues. First, we updated the Universal Import user interface to simplify the process and improve readability. We also updated how Universal Import files are read to better determine header and value rows. This means users do not need to remove blank or additional rows before the file header.

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

Release 16.5.0 - March 16, 2026

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

Highlights

New Features

[New Plan Name Details Within the Eligibility Plan Number](#)

Enhancements

[ERA Name Mismatch Warning Will Now Ignore the Middle Name](#)

New features

Eligibility Will Now Show Extra Details Within the Plan Number

This item has been delayed due to a bug but will be released soon.

When an eligibility response is received, the "Plan Number" field, located under the "Subscriber/Plan Information" tab, previously displayed only the plan number. This number is the unique identifier assigned by the payer to a specific insurance plan, helping the customer distinguish which of the many available plans a patient has. It is used to identify the precise benefits, coverage, and cost-sharing amounts associated with the patient's policy.

Accurately identifying a patient's plan is important for any practice, but it is critical for California IPA plans. In California, Independent Physician Associations (IPAs) are often tied to specific medical groups and PCP networks. The plan number acts as a code to identify the exact health plan and managed care plan network which directly dictates patient benefits, PCP assignment, and required authorization procedures for services. When we receive an eligibility response message, it sometimes includes an additional segment with the name of the Group, Plan, or Network associated with the plan number.

In this release, when the eligibility response message includes an additional segment with the group, plan, or network name, we will now include the plan name when it is provided with the plan number in the response. This will assist practices that handle California IPAs by offering an additional reference point to minimize errors.

✓ Active Coverage

Subscriber/Plan Information	Eligibility/Benefit Details	Request ANSI	Response ANSI
Type	Insured or Subscriber		
Last Name	[REDACTED]		
First Name	[REDACTED]		
Member Identification Number	[REDACTED]		
Group Number	VHPCOMM ⚠		
Plan Number	7 [HSS COMMERCIAL PREFERRED - SCCIPA]		
Address	[REDACTED]		
City	[REDACTED]		
State	CA ⚠		
Zip	[REDACTED]		
Date of Birth	[REDACTED]		
Gender	[REDACTED]		
Plan	07/01/2018 - 12/31/2078		
Type	Payer		
Name	VALLEY HEALTH PLAN		

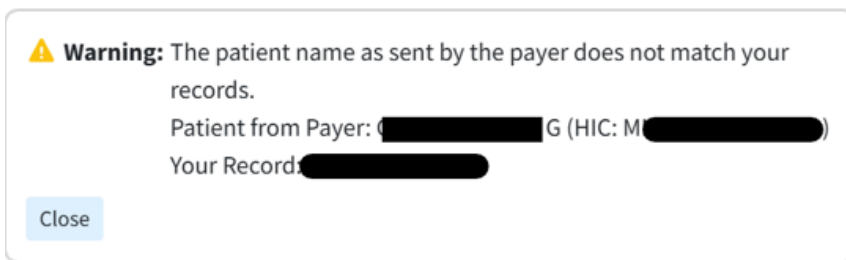
Enhancements

ERA: Name Mismatch Warning Will Now Ignore The Middle Name

When reviewing an ERA, if a patient had a mismatched middle initial, the system would always display the "Name Mismatch" warning. This scenario could occur if the ERA and CMD records have a discrepancy in the middle initial, such as one record including it while the other does not, or if the initials themselves differ.

The purpose of this warning is to identify instances where the payer may have a completely different patient. A missing middle initial is not critical and was generating numerous warnings for correct patients due to unmatched or missing initials.

In this release, we updated this process to no longer show this warning based on the middle initial. Instead, it will only check if the first and last name do not match, regardless of whether the middle initial is present. This will reduce the time spent reviewing unnecessary warnings.



Resolutions

Missing Tooltip in Dashboards

A bug affecting the A/R Dashboards has been fixed. The bug, introduced in the last release, prevented the hover-over feature from displaying the amount represented by a bar or graph point. This functionality has been restored.



Copy Configuration Issues Within Claim Scrubbing

When an authorized representative adds additional services, particularly for billing service customers, they can copy existing service configurations of certain services from one customer to another. This feature is crucial for billing services that frequently onboard new customers, as it significantly reduces data entry and setup times.

The problem was that the copy configuration feature was not working correctly for the "Claim Scrubbing" feature. When Copy Configuration was used for claim scrubbing, the selected specialty was not set up correctly, and the Aptarro submitters were not set up for the enabled customers.

In this release, we corrected this issue so that when the "Copy Configuration" option is used, the system copies and displays the selected specialty and registers the required submitters with Aptarro.

Copy Configuration Issues Within Interface Automation Settings

We also corrected an issue where, the copy configuration option was not working for interface automation settings. This meant that when copying the configuration to other customers, applicable interface automation settings, within features such as address verification and eligibility, were not being copied over.

In this release, we resolved this so that if there are any interface automation options selected, they are also copied over as part of the process.

Address Verification for Customer #10001911 - COLLABORATEMD

This service is included in your account's price plan

Enable Address Verification

Address Verification Settings

Automatically scrub the following when changes are made:

- Patient Address
- Insured Address
- Guarantor Address
- Statement Recipient Address
- Payer Address

Automatically scrub addresses when the above changes are made via Interface?

Yes No

Claim Tracker: Mark as Fixed Issue

We also corrected an issue stemming from our 16.3 release, where Claim Tracker inconsistently marked some rejections as fixed. When checking the claim-level checkbox next to a claim without expanding it in Claim Tracker, the row would remain checked, but the "Mark as Fixed" and "Task" options would remain grayed out or unavailable. This was causing issues by selecting (checking) "Mark as Fixed" at the claim level instead of the issue level.

Global Period Alert Issue

The Global Period alert ensures the correct modifiers are used for post-surgery procedures. These procedure codes typically have a follow-up period during which charges for normal post-operative care are bundled into the global surgery fee. Therefore, when a claim is saved with a Date of Service (DOS) that falls within the global period of a code on a previous claim, the Global Period alert will appear to warn the user.

In this release, we fixed an issue where the global period alert was not appearing as expected under specific circumstances where, based on the modifier, it should have triggered the alert. We corrected the issue, and

The feature now activates when any relevant modifiers are used.

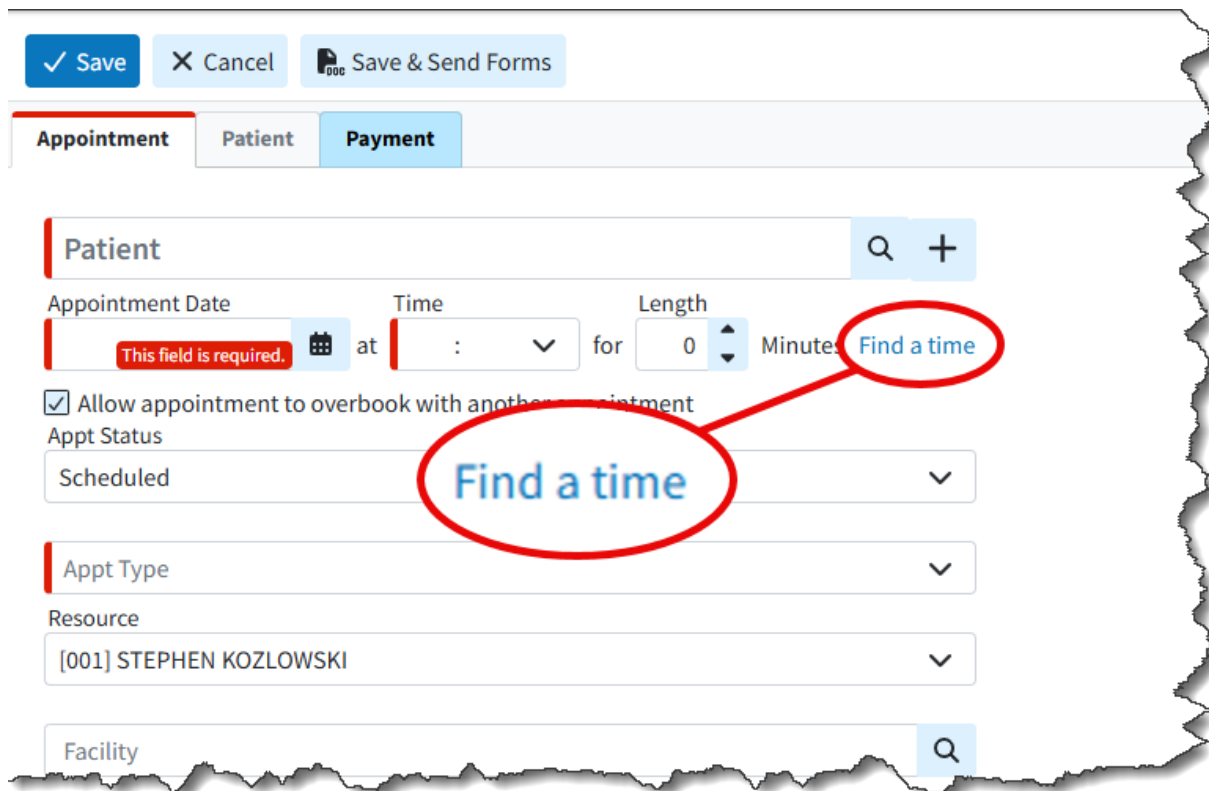
Report Performance Improvements

A change was implemented in our report processor to significantly improve the performance of certain reports, depending on the filters used. Due to the nature of this change, it is difficult to predict which specific reports will experience performance improvements, but we should see better overall performance. It is important to note that this enhancement does not target a specific slow report. Instead, it addresses a pattern of report slowness issues observed within the application environment.

'Find a Time' Option Issue Within the Scheduler

We corrected an issue where the "Find a time" feature in the appointment scheduler did not consider appointment blocks. Appointment blocks are intended to prevent appointments from being scheduled within the blocked time. However, the "Find a time" feature was providing a list of available appointment slots that included times that should have been blocked.

This issue has been resolved in this release, ensuring that the appointment time-slot list provided via the "Find a time" option does not show appointment slots within blocks that disallow appointments.



The screenshot shows the appointment scheduler interface with the following elements:

- Buttons: Save, Cancel, Save & Send Forms
- Navigation tabs: Appointment, Patient, Payment
- Search bar: Patient
- Appointment Date: This field is required. at
- Time: :
- Length: 0 Minutes
- Buttons: Find a time (circled in red)
- Checkboxes: Allow appointment to overbook with another appointment
- Appt Status: Scheduled
- Buttons: Find a time (circled in red)
- Appt Type: (dropdown)
- Resource: [001] STEPHEN KOZLOWSKI
- Facility: (dropdown)

Updated Sending All Charges to Secondary Payer After a Payment

Previously, several changes and updates were implemented to ensure all charges are sent to the secondary payer after a primary payer payment. Although this is correct when there are other unpaid charges on a claim, it caused the system to send claims to the secondary payer even when all charges had been paid. In these scenarios, the secondary payer would have no action to take because the charges had already been paid by the primary. The secondary payer would then issue a \$0.00 payment, rendering the claim

submission inefficient.

In this release, we updated the system to ensure claims are not sent to the secondary payer if all charges are paid. This update will only send charges to the secondary payer if at least one charge has a balance greater than zero dollars (\$0.00).

Family Statements: Printing Issue

When printing family statements, selecting "Family Statement" from the master account will generate a statement (Enhanced or Plain Text) for the entire family. However, if printing from a dependent's account with the "Family" option selected, only that dependent's statement will be printed.

In this release, we updated the system so that a family statement can now be printed from the dependent's account. This eliminates the need for users to switch to the master account to print a family statement.

Fee Schedule: Round Prices Up to The Next Whole Dollar Option Not Working

In this release, we updated the option to round prices to the next whole dollar amount (available when updating prices), which was previously not working correctly. With this update, when selecting the "Round prices up to the next whole dollar amount" option, procedure prices will now be correctly rounded up.

The screenshot shows the 'Update Prices' interface. It has several sections: 'Use your ZIP code' with a text input field and a dropdown arrow; 'Enter the carrier and locality' with 'Carrier' and 'Locality' input fields; 'Pricing Method' with radio buttons for 'Non-facility pricing' (selected), 'Facility pricing', and a checkbox for 'Include prices for codes that are not applicable for non-facility'; 'Adjust Prices' with radio buttons for 'Do not adjust the prices of the new Fee Schedule', 'Increase prices by' (selected, with a value of 0.00%), 'Decrease prices by' (with a value of 0.00%), and 'Adjust prices to' (with a value of 1.0000 times or 100.00% of the selected prices); and a checkbox for 'Round prices up to the next whole dollar amount' which is highlighted with a red box. At the bottom, there are radio buttons for 'Set prices based on a Contract' and 'Set prices based on charges entered', and 'Update Prices' and 'Cancel' buttons.

Copay Credits Applied to Incomplete Claims

When copays are configured to auto-apply to claims created via interfaces, they should never auto-apply to incomplete claims. We previously found some instances where this occurred, so in this release, we updated the process to prevent copay credits from being auto-applied to claims with an incomplete status.

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

Release 16.4.0 - March 2, 2026

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

Highlights

New Features

Universal Import - BETA

Enhancements

New Option to Stop Showing the All-Inclusive Code Warning

New features

Universal Import Updated UI - BETA

Please be aware that the new universal import options are currently in BETA testing and will be available to all customers soon!

Our last release introduced the beta version of CollaborateMD's Universal Import feature, allowing users with an EMR/EHR that has not built an interface with us to import encounter, claim, and patient data from any external system. Customers can upload CSV, Excel, TSV, and pipe-delimited files using our Interface Import section. This new feature uses AI-powered field mapping to automatically interpret the structure of CSV/Excel files from other systems and map them into CMD. This allows customers who do not use our WebAPI to automatically import claims and patient data from any EMR/EHR via a report or export from their software.

In this release, we updated the Universal Import user interface to simplify the process and improve readability. We enhanced it by removing unnecessary fields and clutter, renaming file naming conventions, automating the matching of existing templates, and converting mapped preview data into a table. This facilitates scanning either the header or CMD field to ensure accurate field matching.

Universal Import: Template Selection



Universal Import detected that you haven't imported a file that looks like this yet. You'll be able to use the below information to select this template the next time you import this kind of file.

EHR / Other System Name

Export / Report Name

Did you expect this file to match a template? Your EHR or other system may have changed its export format. [Show Other Templates](#)

[Next](#) [Cancel](#)

For more information visit our [Universal Import Help Article](#).

Enhancements

Claim: New Option to Stop Showing the All-Inclusive Code Warning

All-inclusive codes are common in Rural Health Clinics and Federally-Qualified Health Centers. In our system, entering a claim with an all-inclusive code triggers a warning. This notification indicates that an all-inclusive code has been selected and explains the impact on other charges. These charges will either not be billed or will be billed with a nominal amount, such as \$0.00 or \$0.01, depending on system configuration.

Because this all-inclusive code prevents users from editing other charges on the claim, the pop-up informs them that these are non-editable amounts. The problem is that this is inconvenient for some customers that work thousands of claims, when it happens for every claim.

To address this, a "Don't show this again" checkbox has been added to the All-Inclusive Code warning message in this release. Checking this box allows users to suppress the All-Inclusive Code warning dialog for the same user when editing or creating a new claim with an inclusive code.

You have selected an all inclusive code.
 All other charges on the claim will be sent with an amount of \$0.00

Don't show me this again

OK

We also added a tooltip under the procedure description so that the information is still available without disrupting or prompting the user to close the warning.

Save Cancel Print Review Activity More

Claim Charges Additional Info Ambulance Info

ICD A ICD B
 M25.561 M25.562 ICD C ICD D
 ICD E ICD F ICD G ICD H
 ICD I ICD J ICD K ICD L

Charge Options
 Update patient ICD & Procedure Code defaults
 Create a new charge panel from procedure(s)
 Set all charges to
 NO CHANGE

From	To	Procedure	POS	TOS	Mod 1	Mod 2	Mod 3	Mod 4	DX Pointers	Unit Price	Units		
02/19/2026	02/19/2026	80048	54	1					AB	50.00	1.00	50.00	SEND
02/19/2026	02/19/2026									0.00	1.00	0.00	DELE
02/19/2026	02/19/2026									0.00	1.00	0.00	SEND
										0.00	1.00	0.00	SEND

2 Charges

Description:
 BASIC METABOLIC PANEL

Note:
 This is an all-inclusive code. All other charges on the claim will be sent with an amount of \$0.00

Claim Summary
 Estimate
 Patient Notes
 Follow Up Activity
 Alerts
 Tasks
 Documents
 Payment

TCN Search Now Ignores the TCN Prefix

We recently added the submitter-level TCN Prefix feature to help the clearinghouse ensure that ERAs are routed correctly and to facilitate ERA splits.

This feature has been very helpful, but it could be inconvenient for some users depending on their workflow because if the full TCN, including the prefix, was copied from a payer report or EOB, users could not search for the correct claim or patient within the application. They would have to carefully copy the number while omitting the prefix, which could be difficult due to the small font on some reports.

In this release, the submitter-level TCN Prefix was updated so the system ignores it when searching by TCN in the claim, claim tracker, patient, insurance check, and ERA searches. This means that copying a TCN number from an EOB will no longer require partial selection for the search to function. This update allows the system to locate claims that include the prefix when copied.

Resolutions

WebAPI: Payer & Patient Default Value Codes Not Set on Claims

We have systematically implemented the ability to use more default codes from interface claims (such as value codes from revenue codes), but patient default codes and payer default value codes were still missing. In this release, we are adding both Patient and Payer default value codes. When a claim is received via the WebAPI, the system will now add the default value codes in the following priority order:

1. Value Codes from the interface message (if sent)
2. Payer Defaults
3. Patient Defaults
4. Revenue Code Defaults

At each priority step, the system will only add value codes that have not already been included. For example, if the interface message sends value code 16, and the patient defaults include value code 16 and value code 18, then the message's amount for value code 16 will be used, followed by the patient's amount for value code 18.

Practice email address is automatically set as the "Reply-To" address for electronic statements

Previously, the practice email address was automatically set as the Reply-To address for electronic statements. Users were often unaware that the practice email was used as the default Reply-To email address when setting up their electronic statements, as this option is part of the electronic statement options. To prevent user error, we updated this release to default the Reply-To address to "No Reply," even when a practice email address is available. This will ensure that any Reply-To address set for electronic statements is added intentionally by the customer. Please note that existing configurations will not change. This applies only to electronic statement setups moving forward.

ERA: Incorrect Claim Status

Resolved an ERA issue that caused a charge balance with no additional payers to display an incorrect claim status. It showed a "PAID" status instead of "BALANCE DUE PATIENT," despite an existing balance and no other payers.

ERA & EOB: Incorrect allowed amount on refund/reversal

We corrected an issue within our ERA/EOBs causing an incorrect auto-calculation of the allowed amount on some refund/reversals.

Universal Import: Support First and Last Names with Spaces

We corrected an issue within our universal import detected during testing where names containing spaces but no hyphens, apostrophes, or symbols (e.g., "De La Cruz," "Van Dyke," "Mary Jane") were not recognized correctly during import.

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

Release 16.3.0 - February 19, 2026

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

Highlights

New Features

Universal Import - BETA

Enhancements

New Option to Ignore Modifiers Received From The WebAPI

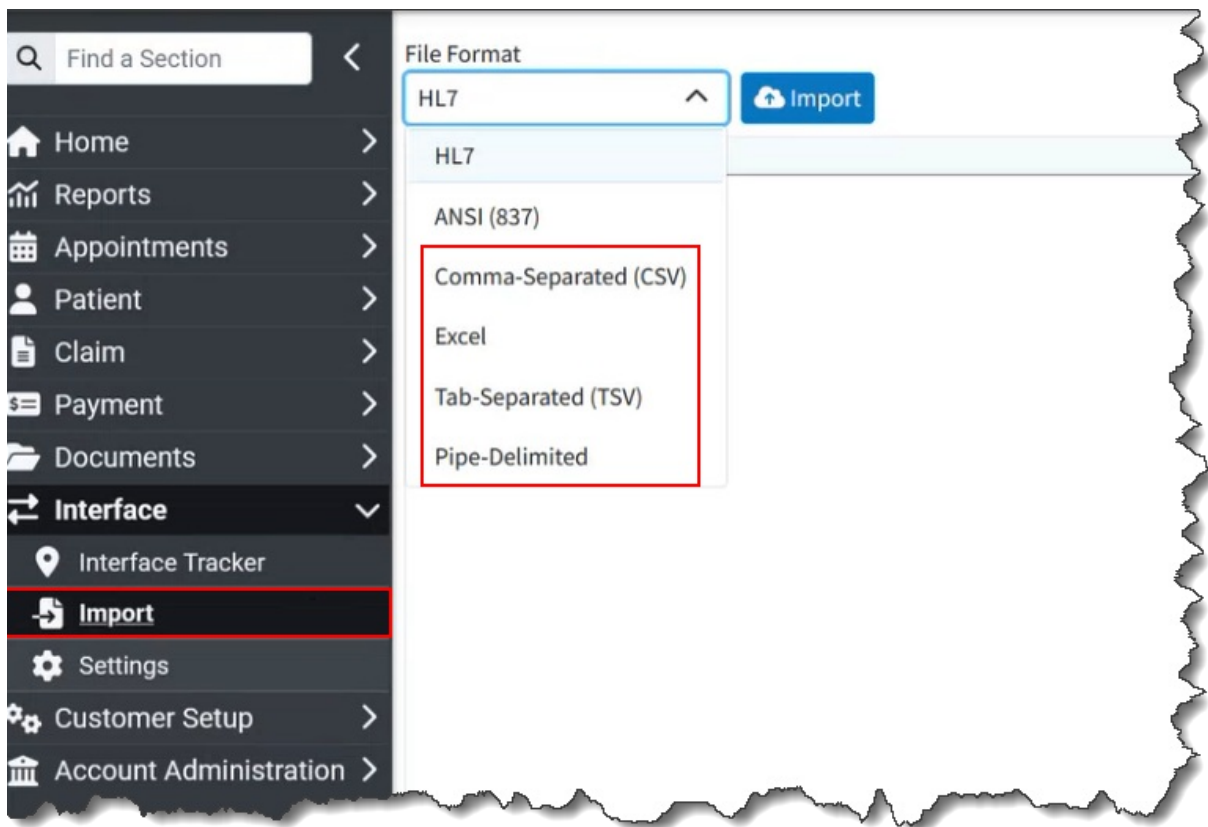
New features

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These new import options are currently in BETA testing and will be available to all customers soon!

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Customers can also manually import claims into our system in the HL7 format or claims from an 837 ANSI file format into CollaborateMD.

For more information visit our [Universal Import Help Article](#).

Enhancements

New Option to Ignore Modifiers Received From The WebAPI

When configuring interfaces, we can currently set up the interface to ignore the price that comes over in the message and use our own pricing instead. This is necessary because CMD, as the billing system, houses the fee schedules and contracts. We also have many defaults & automations around modifiers (specifically situational modifiers), but those rules are not used if modifiers are received from your EMR. Some users do not want this since if the modifiers entered in the EMR are wrong, automations will not work.

In this release, we added new options to the Interface Settings screen (for WebAPI Interfaces) that allows you to ignore modifiers sent via the interface. The new setting "**Set modifiers based on the modifiers received from the Interface?**" will default to **Yes** to allow setting the modifiers based on the modifiers received from the interface (just like it does today). Even if this is set to Yes, default and situational modifiers will be used if they are not received from the Interface. When set to **No** it will ignore the modifiers sent from the interface.

WEBAPI Interface Settings

Interface Status
Active ▼

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

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

Set charge pricing based on unit price received in interface message? By default, the pricing information within the message is ignored and the charge amount is determined based on the pricing information in CollaborateMD (code default price or fee schedule price).
 Yes No

Set modifiers based on the modifiers received from the Interface? Even if this is set to Yes, default and situational modifiers will be used if they are not received from the Interface.
 Yes No

Specify the vendor associated to this WebAPI interface:
Alex WebAPI ▼

For more information visit our [Configure Interface Settings Help Article](#).

New Option To Get Current Claim Status Through The WebAPI

We previously introduced an API endpoint request that allows users to set the claim status. To allow API vendors to continue building on this capability, we added the ability to retrieve the current claim status. This will return an XML response that includes the Claim Status ID, Claim Location ID, and Claim Status Display value.

Resolutions

Report Performance Issue When Combining Results

We resolved an issue in our Report Viewer where reports, run for multiple customers with the "combine results" option selected, took longer to process compared to running the same report with separate result

Mark as Fixed Issue in Claim Tracker

Corrected an issue within claim tracker where, when checking the Mark As Fixed checkbox on Intelligent Claim Rejection messages should also mark all of the hidden issues as fixed but instead was flagging issues as "Not Fixed."

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

Release 16.2.0 - February 3, 2026

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

Highlights

New Features

[New Interface Automations](#)

New features

New Interface Automations

Our CollaborateMD interface provides a powerful bridge to automatically create patients, appointments, and claims in the CMD application via interface messages (ADT, SIU, DFT). Previously, after a patient appointment or claim was received & created via the interface, users still had to perform manual work such as checking eligibility, reviewing/scrubbing claims, or address verification. Powerful add-on features like Eligibility, Claim Scrubbing, and Address Verification had to be used either through a separate integration with our WebAPI (for Eligibility only) or manually in the application. In this release, these actions can now be automated to occur as soon as the claim, patient, or appointment is received. For more information visit our [Manage Interface Automations Help Article](#).

We added the following new automations that can be enabled and configured within the services section for Auth Reps:

Eligibility Interface Automation

We created 2 new eligibility settings to allow eligibility to be automatically checked when a patient, appointment, or claim is created via the interface:

- **Automatically check eligibility when an appointment or claim is created over an Interface?**

- Select **Yes** if you want an automatic eligibility check when creating an appointment or claim, from an SIU or DFT message received via the interface.

- **Automatically check eligibility when a patient is created or updated over an Interface?**

- Select **Yes** if you want an automatic eligibility check when creating a patient from an ADT message received via the interface.

Eligibility for Customer #10001911 - COLLABORATEMD

i This service is included in your account's price plan

Enable eligibility checking

Eligibility Settings

Automatically check eligibility when saving appointment?
 Yes No

Automatically check eligibility when an appointment or claim is created over an Interface?
 Yes No

Automatically check eligibility when a patient is created or updated over an Interface?
 Yes No

Limit automatic eligibility checking to:
Once Every 30 Days

Show user an alert if they lack permissions to check eligibility when saving an appointment that otherwise would have run eligibility automatically?
 Yes No

Save Copy Configuration Cancel

For more information visit our [Manage Real-Time Eligibility Help Article](#).

Claim Scrubbing Interface Automation

We created a new claim scrubbing setting to automatically review claims created via the interface:

- **Automatically review and scrub new claims as they are entered through an Interface?**

- Select **Yes** if you want to automatically scrub new claims created from a DFT message received via the interface.

Claim Scrubbing for Customer #10001911 - COLLABORATEMD

This service is included in your account's price plan

Enable Claim Scrubbing

Claim Scrubbing Settings

Specialty

Dermatology

Automatically scrub new claims as they are entered in through the claim section?

Yes No

Automatically review and scrub new claims as they are entered through an interface?

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

For more information visit our [Manage Claim Scrubbing Help Article](#).

Address Verification Interface Automation

We created a new Address Verification setting to automatically scrub addresses when creating/editing a patient record via the interface:

- **Automatically scrub addresses when the above changes are made via Interface?**
 - Select **Yes** if you want to automatically scrub addresses (based on your pre-selected options) when creating or editing a patient record from an ADT/DFT message received via the interface.

Address Verification for Customer #10001911 - COLLABORATEMD

This service is included in your account's price plan

Enable Address Verification

Address Verification Settings

Automatically scrub the following when changes are made:

Patient Address

Insured Address

Guarantor Address

Statement Recipient Address

Payer Address

Automatically scrub addresses when the above changes are made via Interface?

Yes No

Save

Copy Configuration

Cancel

For more information visit our [Manage Address Verification Help Article](#).

Coming Soon - Patient Estimates Interface Automation

The ability to automatically generate patient estimates upon appointment or claim creation via the interface will be added soon!

Resolutions

Claim Control for Large Batches

We resolved an issue within Claim Control that could prevent users from changing the status of more than one thousand claims at once. This action would cause a "Maximum call stack size exceeded" console error when updating the claim status. With this new update, when a user updates claim statuses, it is performed in batches of 1,000 and pre-selects all the remaining claims that exceed 1000 after in initial claim status update. If more than 1,000 claims are selected for saving, a modal will appear stating: *"Only 1,000 claims can be saved at once. After the save is complete, the remaining X claims will be selected in the table and can then be saved."* Following the save, the selections in the table will be updated accordingly.

Intelligent Claim Rejections Enabled by Default

The Intelligent Claim Rejection feature was enabled for most customers, but an issue prevented its automatic enablement for new submitters. This issue marked the submitter in CMD with the feature turned on without changing the submitter request sent to ePS. In this release, we corrected this issue to ensure that submitter registrations sent to ePS turns this feature flag on.

Intelligent Claim Rejections Enabled by Default

In this release, we corrected some appointment reminder issues where some appointments were not sent and others had expired confirmation tokens. This issue was causing the confirm & cancel links in the appointment reminder to stop working after an additional reminder was sent to the patient.

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

Enhancements

Highlights

Enhancements

New "To Date" Optional Column

New ERA Warning when Patient Name Doesn't Match

Enhancements

New "To Date" Optional Column

We have always displayed the "From" Date (Date of Service) as a column in our Claim Control, Claim Tracking, and Follow-Up Management tables. This represents the first date of service on the claim. Customers who treat patients for extended periods (especially those using Institutional claims) could not view the complete range of service dates in these tables. In this release, we added the "To" Date (representing the last date of service on the claim) as an optional, hidden-by-default column.

Select Columns

Available Columns	Visible Columns
First Billed Date +	Check
Last Billed Date +	Claim #
Follow Up Date +	DOS
Patient # +	Patient
Billing Provider +	Primary Payer
To DOS +	Review Status

Done

New ERA Warning when Patient Name Doesn't Match

A new ERA Warning has been implemented for instances where the patient's first or last name on the ERA (EraClaim.plast and EraClaim.pfirst) does not match the name recorded in our application. The warning

message, "Warning: The patient name as sent by the payer does not match your records," will alert users to this discrepancy.

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

Release 16.0.0 - January 5, 2026

Enhancements

Highlights

Enhancements

New Referring Provider Note Report Field

New Optional Columns in Claim Control &

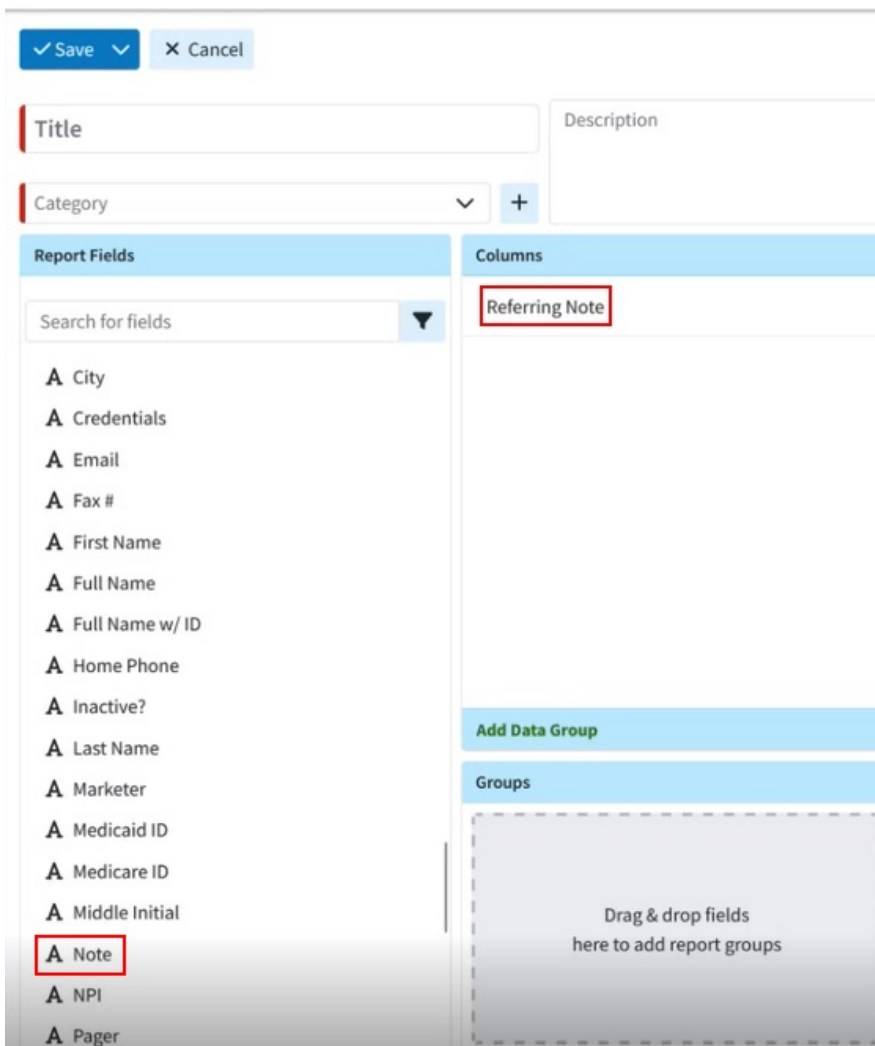
Follow Up Management

ERA Claim-level Payments Now Evenly Applied

Enhancements

New Referring Provider Note Report Field

In this release, we added a new report field for the Referring Provider's Note text field. This new report field (available under Referring Data) is useful for recording various information. For example, users can note the name of the facility a referring provider is from, allowing them to report on the number of lab samples received from each facility.



New Optional Columns in Claim Control & Follow Up Management

Some customers use the **Account Type** and **Reference #** fields in CMD to store information that does not fit elsewhere in the application. While integrating fields for workflows across different specialties would be ideal, many customer issues can be resolved by allowing them to view this information in various places. In this release, we added these two columns as optional (not visible by default) in both Follow Up Management and Claim Control.

Select Columns

Available Columns	Visible Columns
Last Claim Status Check +	Checkbox
Insurance Payments +	Alerts
Patient Payments +	Claim #
Patient Account Type +	Patient Name
Patient Reference # +	DOS
	Current Payer

[Done](#)

ERA Claim-level Payments are Now Evenly Applied

Some payers (particularly for institutional claims) send only a claim-level payment rather than line-item payments. Previously, our system applied these payments by distributing as much of the paid amount on each charge as possible, and then as much of the adjusted amount on each charge as possible, resulting in uneven claim application, and requiring users to manually correct the ERAs for institutional claims. With this release, these payments will now be applied evenly.

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