

Release 16.14.0 - July 20, 2026

Modified on 07/20/2026 1:49 pm EDT

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Highlights

New Features

Electronic Statement Configuration Improvements
Contracts: Support for Single Case Agreements
Enhanced Eligibility Reporting

Enhancements

Expanded Availability of Electronic Claim Status
New Payment Automations by Procedure Code
Patient Activity: "Show Net Amount" Option Relocated for Easier Access
Eligibility Now Shows More Details Within the Plan Number
Interface Tracker: New Optional "Fix User" & "Fix Date" Columns
Universal Import Updates

New features

Electronic Statement Configuration Improvements

Several enhancements have been made to Electronic Statement Configuration as part of our Electronic Statements Enhancements Project to provide practices with greater control and flexibility:

- Per-practice configuration:** E-Statement configuration is now set **per practice**, rather than per customer (consistent with how paper statement configuration already works). Each practice can now have its own Electronic Statement settings, instead of one setting applying across the entire customer account.

> General

Electronic Statement Options

Charge Breakdown (used for all practices)

☐ Summarized details for each charge

☒ Detailed activity listing

☒ Show Facility/Office

Send email replies to

Do not accept email replies

> General

Electronic Statement Options

Charge Breakdown

☒ Summarized ☐ Detailed Activity

☒ Show Facility/Office address

Send email replies to

Do not accept email replies

☐ Use patient comment (if exists) in place of the important message

- Default reply-to address:** The "**Send Email Reply to Address**" field will now automatically default to the practice's default email address. This can still be changed to a different address, or turned off entirely if you don't want to accept email replies. This can be done from the "**Send email replies from receipts & statements to**" new field in the practice section or directly within the electronic statement template options.

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 > Statements > Superbills > Labels > Customization... > Settings

Save Close Show History

Name
CMD FAMILY PRACTICE - EAST

☐ Make this practice inactive

Organization Type
Solo Practice

Taxonomy Specialty
174N00000X

Other Service Providers : Lactation Consultant, Non-RN

Sequence # 10003867 **Reference #** 1234 **TCN Prefix** **Statement TCN Prefix** **Code**

Primary Office

Address

Send email replies from receipts & statements to
Practice email address

Time Zone
Eastern

Phone (888) 348-8457 **Fax**

Email support@collaboratemd.com

Send email replies from receipts & statements to
Practice email address

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

- **Patient Comment in Payment Portal:** When the option "Use Patient Comment (if exists) in place of the Important Message" is selected, the Payment Portal's Important Message will now be populated using the patient's Patient Comment, when one exists.

General

Electronic Statement Options

Charge Breakdown (used for all practices)
☐ Summarized details for each charge
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Send email replies to
Do not accept email replies

Previously

General

Electronic Statement Options

Charge Breakdown
☒ Summarized ☐ Detailed Activity

☒ Show Facility/Office address

Send email replies to
Do not accept email replies

☒ Use patient comment (if exists) in place of the important message

Now

If you need help setting up Electronic Statement Templates, please visit our [Configure Manual Electronic Statements Help Article](#).

Contracts: Support for Single Case Agreements

Out-of-network providers are sometimes granted permission to treat an individual patient under special circumstances — such as continuing an existing course of care, or when no in-network provider is available in the area. This arrangement is formalized through a **Single Case Agreement**, which is a contract that

plies to just one patient, rather than to a payer relationship broadly.

To support this, a new "**Apply as a Single Case Agreement**" option has been added to Payer Associations within Contracts. When enabled, users can select a single patient to which the contract will apply. Once configured, the system will apply Single Case Agreement contracts in:

- **EOBs:** When automatically entering the allowed amount
- **ERAs:** When determining whether a contract warning should be shown
- **Reports:** In the Current/Primary/Secondary/Tertiary Contract Amount and Contract Name fields

This allows practices to accurately reflect and apply special one-patient contract arrangements throughout the billing workflow, rather than needing to work around the limitation manually.

Contracts

✓ Save ✕ Close 📄 Export ⌚ Show History

Name
AETNA ☐ Make this contract inactive

Type
FFS ☒ Allow users posting payments to update price

Sequence #
10106767

Find in table

Code	Price	Description	Type
00001	0.00	Testing	Proced
0001F	0.00	test adfsd	Proced
0001U	0.00		Proced
0003T	0.00	cervicography	Proced
0005F	0.00	OSTEOARTHRITIS ASSESSED	Proced
00100	20.73	ANESTHESIA FOR PROC ON SALIVARY GLANDS WBX	Proced
001099	0.00	asdfsasdfsdf	Proced
00120	20.73	ANES XTRNL MID&INNR EAR W/BX NOS	Proced
00124	20.73	test test	Proced
00126	20.73		Proced
00140	20.73	ANES EYE NOS	Proced
00140-2	0.00	asdfsasdfsasdfsdf	Proced
00142	20.73	ANES EYE LENS SURG	Procedure ☐
00145	20.73	ANES EYE VITREORTA SURG	Procedure ☐
00147	20.73		Procedure ☐
00148	20.73	ANES EYE OPSCPY	Procedure ☐

Create Payer Association

Payers

☐ Apply based on the claim's date of service

☐ Apply based on the location or provider

☐ Apply based on place of service

☐ Apply based on modifier

☐ Apply based on value code

☒ **Apply as Single Case Agreement**

Patient

Patient

TEST, JOHNNY (33397993)

ⓘ This contract will only apply to the selected patient

Done Cancel

For more information on setting up a Single Case Agreement, please visit our [Managing Payer Associations Help Article](#).

Enhanced Eligibility Custom Reporting

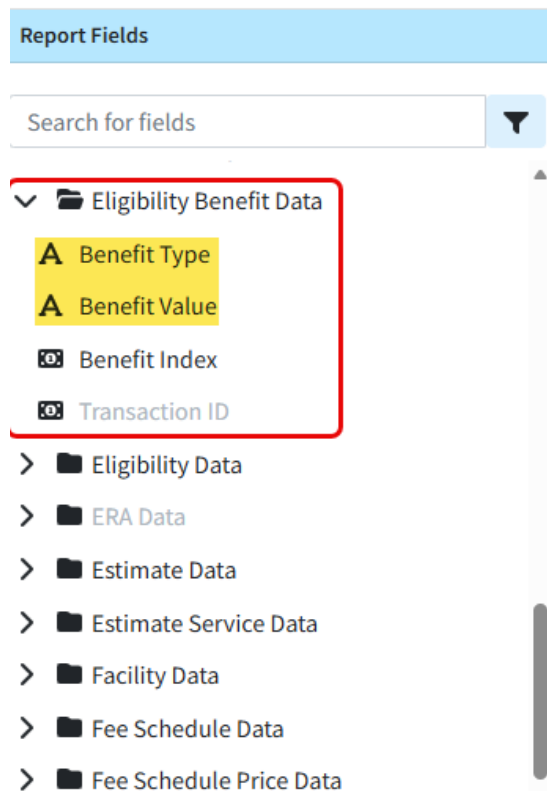
You can now build custom reports on detailed insurance eligibility and benefit information — going far beyond simply confirming whether a patient has active coverage.

What's new: Previously, eligibility checks returned rich benefit details (coverage levels, copays, deductible and more), but this information wasn't accessible for reporting and viewing any specific detail required opening each patient individually and reviewing their eligibility report one at a time.

With this release, that data is now automatically captured and organized so you can report on it directly, cross patients. A new "**Eligibility Benefit Data**" report category is now available, with two main configurable fields:

- **Benefit Type:** Allows you to filter by the type of eligibility benefit (e.g., **Deductible**, copay, out-of-pocket max), covering roughly 35 standard benefit types returned by payers.
- **Benefit Item Value:** Allows you to drill into a specific service type within that benefit (e.g., *Health Benefit Plan Coverage*), with roughly 150 possible values to choose from.

These new fields connect directly to your existing **Eligibility Data** reports, so you can build on reporting you already use today.



Why it matters:

Every payer can return similar information in slightly different ways, and the range of possible benefit details is extensive. Rather than requesting a custom report each time you need a new data point, you can now filter and report on the specific benefit information that matters to your practice.

 Please note that this applies to **new eligibility checks only**. Eligibility results processed *before* this release are not included (there is no retroactive backfill of historical data).

For more information on adding these report fields, visit our [Eligibility Benefit Data Fields Help Article](#).

Enhancements

Expanded Availability of Electronic Claim Status

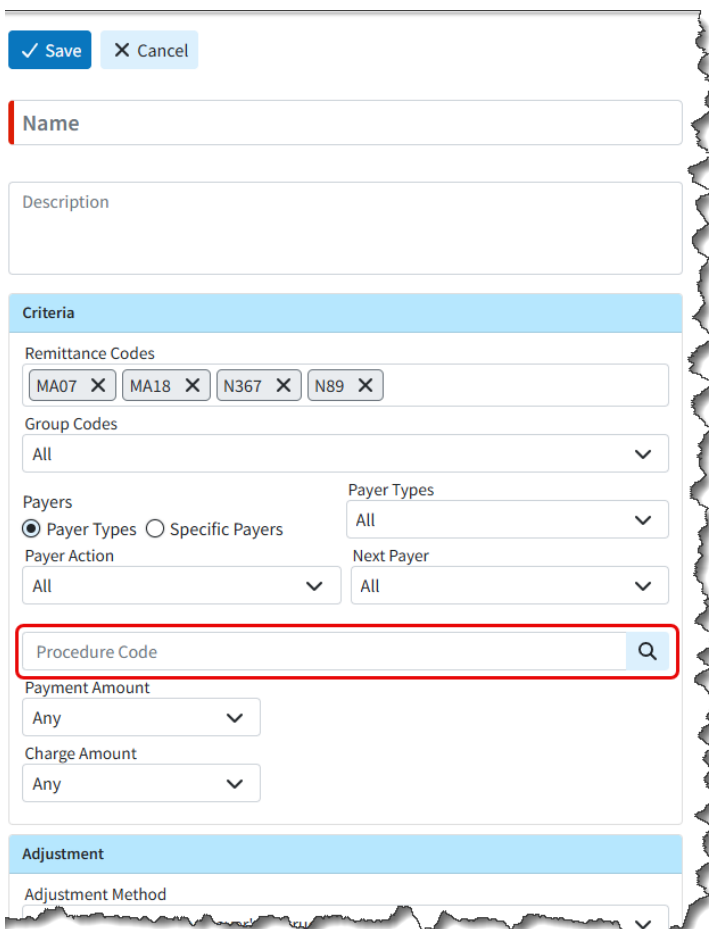
Previously, Electronic Claim Status could only be checked when a claim's status was **"At Insurance."** Once a customer updated a claim to a different status while working it (including custom statuses), they lost the ability to check status electronically (even if the claim was still legitimately pending with the payer).

In this release, we have updated this so that Electronic Claim Status is now available for claims in most statuses, with restrictions applying only to statuses marked as "Not billed" (collections, denied, rejected, or balance due patient). Customers using custom statuses to track claims through Insurance AR can now continue checking Claim Status electronically as they work a claim, instead of losing that ability as soon as the status changes.

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

New Payment Automations by Procedure Code

We added a new Procedure Code option to the Payment Automation criteria (above Payment Amount), allowing a single procedure code to be selected so the automation only runs when it matches the charge's procedure code.



The screenshot shows a web-based configuration form for payment automation. At the top, there are 'Save' and 'Cancel' buttons. Below them are input fields for 'Name' and 'Description'. The 'Criteria' section is highlighted with a blue header and contains several filters: 'Remittance Codes' with buttons for MA07, MA18, N367, and N89; 'Group Codes' with a dropdown set to 'All'; 'Payers' with radio buttons for 'Payer Types' (selected) and 'Specific Payers'; 'Payer Types' with a dropdown set to 'All'; 'Payer Action' with a dropdown set to 'All'; and 'Next Payer' with a dropdown set to 'All'. The 'Procedure Code' field is highlighted with a red border and includes a search icon. Below this are 'Payment Amount' and 'Charge Amount' dropdowns, both set to 'Any'. The 'Adjustment' section, also highlighted with a blue header, contains an 'Adjustment Method' dropdown.

Visit our [Add Payment Automations](#) Help Article for more information.

Eligibility Now Shows More Details Within the Plan Number

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 plan 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 IHSS 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		

Patient Activity: "Show Net Amount" Option Relocated for Easier Access

The option to display the Net Amount (expected revenue) in the Patient Activity listing has been moved to a more accessible location. Previously, this option was located in Patient Settings, where it was difficult to find. It has now been moved to the **Activity View Options** popup, appearing as a checkbox directly under **Show Entered Dates.** When checked, the **"Show Expected Revenue and Net Balance"** option will display an expected Revenue column in the Claim Activity window, as well as replace the Balance column for a Net Balance Column.

Activity Listing for **TEST, JOHNNY** (#33397993)

Order Claims and Debits by

Newest to Oldest

☐ Show Entered Dates
☒ **Show Expected Revenue and Net Balance**
☐ Summary ☒ Detailed

Charge Filter

☒ Show All Claims
☐ Show Specific Claim
☐ Show Unpaid Claims Only
☐ Show Claims Based On Status
☐ Show Claims in a Date Range

Show Aging Balance By

Date of Service

Practice

Provider

Payer

Payer Priority

284.20)

Amount: \$105.00 Due Insurance

5/2025)

Status
User Printed by jos
User Printed by alex

re: \$327.04)

Balance	Applied
\$327.04	\$46.73

ast Payment: 04/09/2026)

00)

Breakdown

- Waiting For Review
- Send To Insurance Via
- Claim At Insurance
- Balance Due Patient
- Rejected At Clearinghouse
- User Print & Mail To Insu

Visit our [Patient Activity](#) Help Article for steps to setting your Activity Listing View Options.

Interface Tracker: New Optional "Fix User" & "Fix Date" Columns

Previously, marking a message as fixed within Interface Tracker provided no record of the user or the date, making follow-ups difficult. This release introduces two optional columns that are hidden-by-default to address this:

- **Fix User:** Displays the user who marked the message as fixed.
- **Fix Date:** Displays the date the message was marked as fixed.

Select Columns

Available Columns

Claim Facility	+
Payer	+
Filename	+
Fix User	+
Fix Date	+

Visible Columns

Selected
Status
Date Received
Type
Patient
Interface

Done

his provides users better visibility into who resolved an interface tracker message and when.

Universal Import Updates

Universal Import: Marital Status (and Similar Fields) Now Accept Text Values

Previously, Universal Import only accepted marital status as a numeric or single-letter code. Text values such as **"MARRIED"** were flagged as invalid, even though they represented a legitimate, recognizable value. This caused import failures for customers whose source files used text rather than codes.

In this release, Universal Import now accepts text values (case-insensitive) for marital status, in addition to the existing numeric/letter codes. This same improvement applies to similar fields that previously had the same limitation.

Universal Import: Added Support for Patient Account Type

Previously, Universal Import could not import the Patient Account Type field, resulting in incomplete patient records for customers who use this capability. In this release, we added support for mapping and importing Patient Account Type as part of the patient import process. Customers using custom account types can now bring in complete patient records through Universal Import, without needing to manually update Account Type after import.

Resolutions

Dashboard: Corrected "Days in AR" Calculation

A previous change caused the "Days in AR" dashboard to be calculated by counting only the days on which charges were entered, rather than all calendar days a charge remained outstanding. For practices that enter charges just a few times per week but bill on a regular schedule, this caused charges to appear to "age" only on entry days, significantly understating how long they had actually been outstanding.

In this release, we corrected this so that the "Days in AR" dashboard now correctly counts all calendar days a charge remains outstanding between billing cycles, regardless of how frequently charges are entered.

Payment (ERA): Unpaid Codes Not Applied When Processing Secondary Payer

Corrected an issue when processing a secondary payer's ERA, where the claim was incorrectly marked as paid, and the **PR-2** (patient responsibility) adjustment code from the remittance was not being captured. The PR-2 is now correctly being captured and applied when processing secondary payer remittances, ensuring the claim reflects the accurate payment and patient responsibility status.

Resolved Issue: "Find a Time" Option Not Returning All Available Appointments

We corrected an issue where the "Find a time" feature in the appointment scheduler did not consider appointment blocks correctly and returned very few results, failing to show all available appointment time slots.

The screenshot shows the 'Appointment' tab in a software interface. At the top are buttons for 'Save', 'Cancel', and 'Save & Send Forms'. Below are tabs for 'Appointment', 'Patient', and 'Payment'. The 'Appointment' section contains a 'Patient' search bar, 'Appointment Date' (with a calendar icon and a red 'This field is required.' message), 'Time' (with a dropdown arrow), 'Length' (with a spinner set to 0 and 'Minute' text), and a 'Find a time' button circled in red. Below these are checkboxes for 'Allow appointment to overbook with another appointment' and 'Appt Status' (set to 'Scheduled'), with another 'Find a time' button circled in red. Further down are 'Appt Type', 'Resource' (set to '[001] STEPHEN KOZLOWSKI'), and 'Facility' fields, each with a dropdown arrow or search icon.

Resolved Issues: Fee Schedules CPT Cache Not Updating After Procedure Code Changes

When a procedure code was updated within a fee schedule, the change was saved correctly to the database.

nd properly logged in the audit trail. However, the record's "last modified" timestamp was not being updated as part of that change. Because the system uses this timestamp to detect updates, the cache did not recognize the procedure code as changed, meaning the update may not have appeared for other users or in places that pull from the cached data until a later.

The "last modified" timestamp is now correctly updated whenever a procedure code is changed within a few minutes, ensuring the cache reliably picks up the change.

Claim Control: Fixed Diagnosis Duplication When Combining Institutional Claims

When combining institutional claims in Claim Control, the **principal diagnosis** was being incorrectly duplicated as an "**other diagnosis**" on the combined claim (even in cases where both claims shared the same principal diagnosis). This issue has been resolved, along with related issues identified when combining institutional claims. Diagnosis codes are now combined correctly, without duplicating the principal diagnosis as an other diagnosis.

Resolved Issue: Eligibility Date of Birth Correction Not Suggested When Mismatched

When an eligibility response returned a different Date of Birth than what was on file in CollaborateMD, the system did not prompt the user to correct it, even though similar correction suggestions were already working for other fields, such as name and member ID.

The system now correctly evaluates Date of Birth as part of its correction-suggestion logic, alongside existing checks for name and member ID. When a mismatch is detected, users will now be prompted to review and correct the DOB in CollaborateMD, consistent with how other field mismatches are handled.

Resolved Address Validation Issue

When a patient's address required correction (via the Address Correction service) and **Insured** was set to **Self** on the Insurance Info tab, both the **Patient Info** and **Insurance Info** tabs were flagged with an address issue. Correcting the address on the Patient Info tab resolved the flag there, but the Insurance Info tab remained flagged even though the insured's address was identical to the now-corrected patient address.

We resolved this so when the patient is set as their own insured (Insured = Self), correcting the address issue on the Patient Info tab now also clears the corresponding flag on the Insurance Info tab, since the two addresses are the same.

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