Release 16.14.0 - July 20, 2026

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

New features | **Enhancements**| **Resolutions**

Highlights

New Features

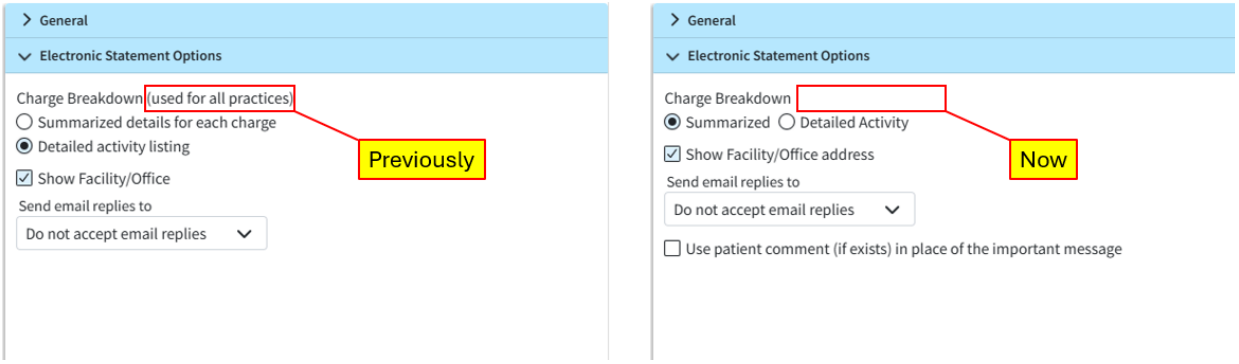
Enhancements

New features

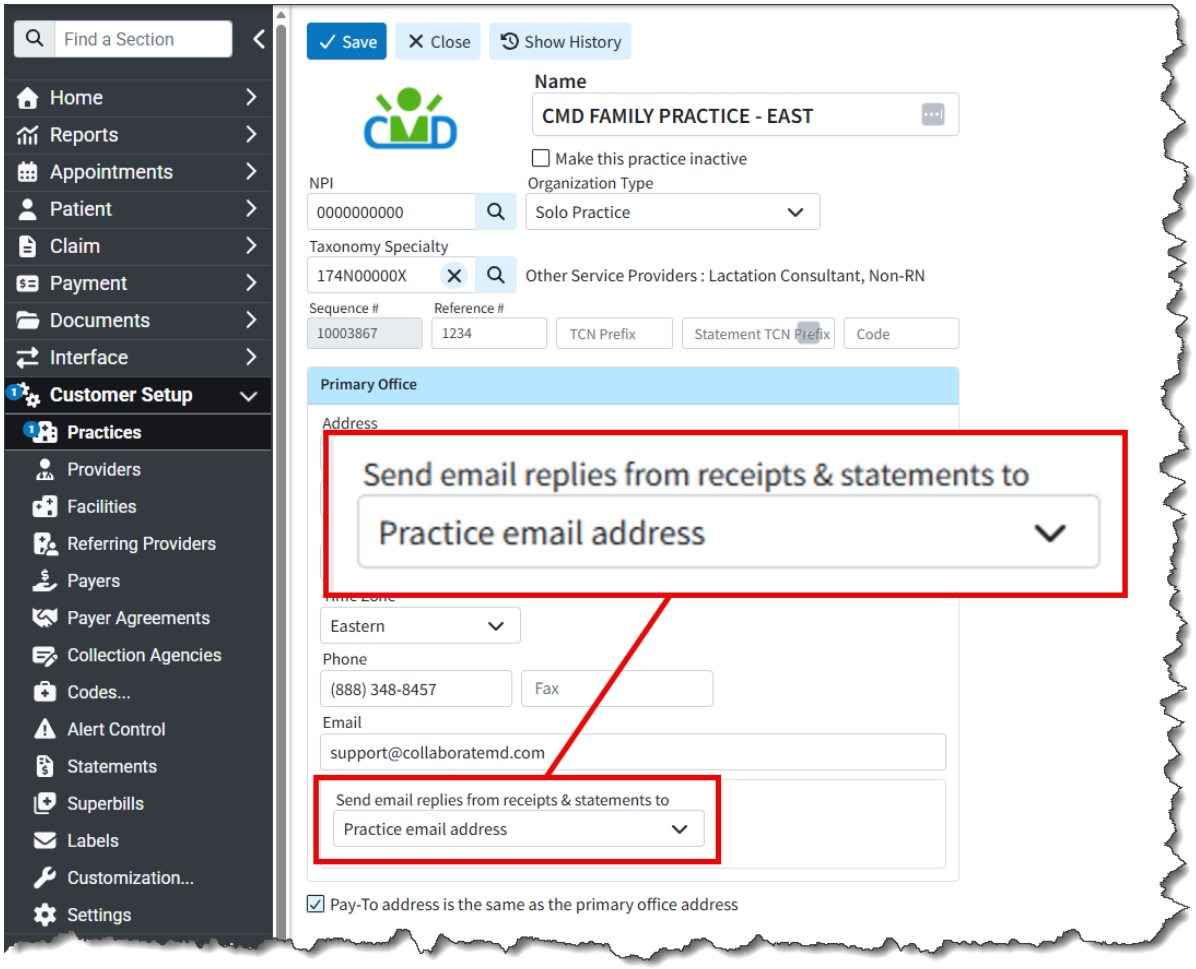
Electronic Statement Configuration Improvements

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

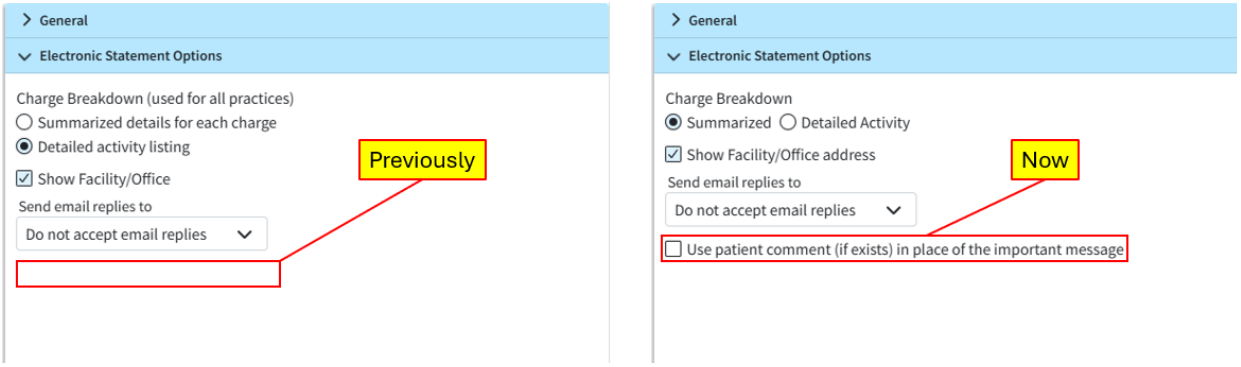
- **Per-practice configuration:** E-Statement configuration is now set**per practice**, rather than per customer (consistent with how paper statement configuration already works). Each practice can now have its own Electronic Statement settings, instead of one setting applying across the entire customer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



- **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 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.



- **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.



f you need help setting up Electronic Statement Templates, please visit ourConfigure Manual Electronic tatements Help Article.

Contracts: Support for Single Case Agreements

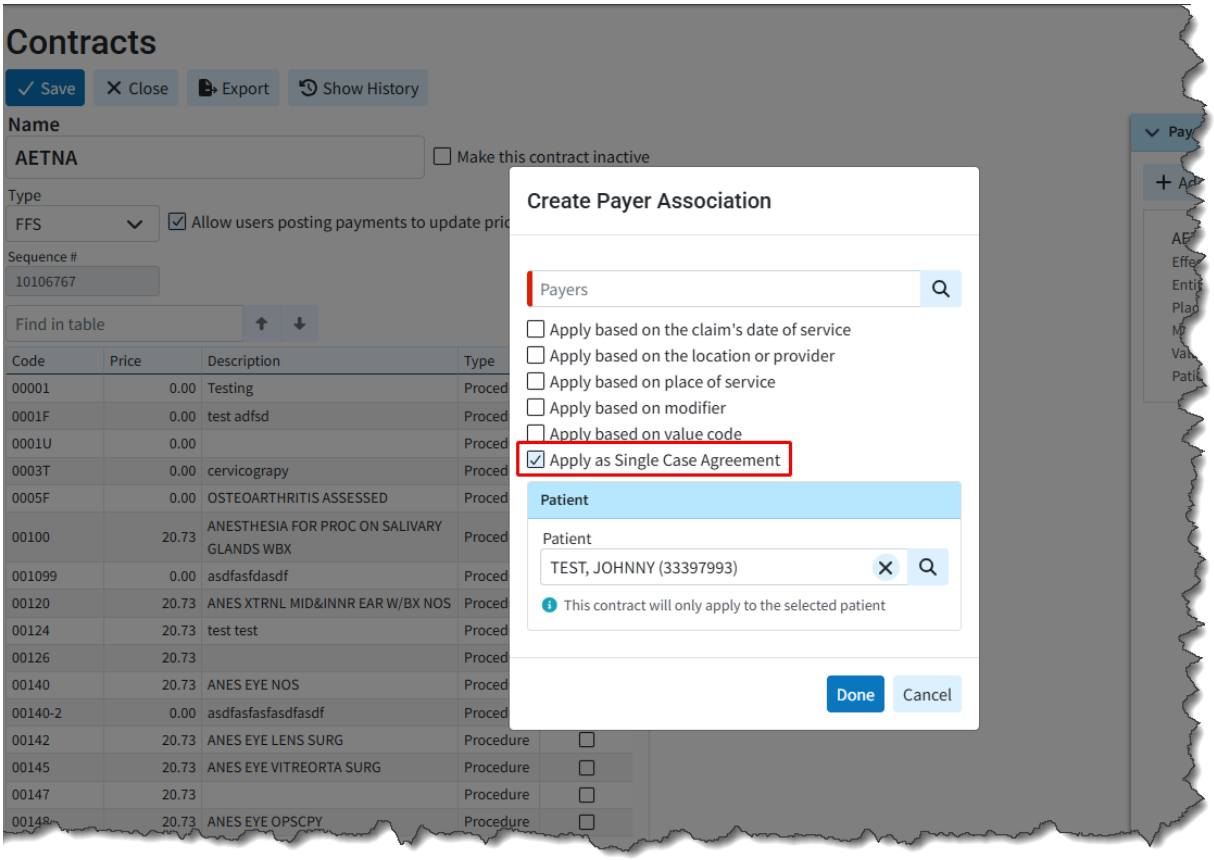
Out-of-network providers are sometimes granted permission to treat an individual patient under special ircumstances — such as continuing an existing course of care, or when no in-network provider is available n the area. This arrangement is formalized through a **Single Case Agreement,** which is a contract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

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

o support this, a new **"Apply as a Single Case Agreement"** option has been added to Payer Associations ithin Contracts. When enabled, users can select a single patient to which the contract will apply. Once onfigured, 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

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



For more information on setting up a Single Case Agreement, please visit ou Managing Payer ssociations Help Article.

nhanced Eligibility Custom Reporting

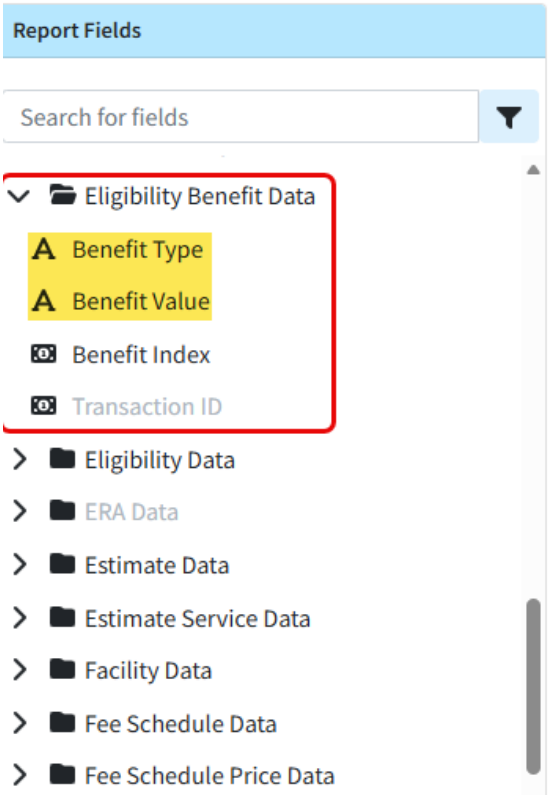
ou can now build custom reports on detailed insurance eligibility and benefit information — going far eyond simply confirming whether a patient has active coverage.

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

Vith 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 onfigurable 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.

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



Vhy it matters:
very payer can return similar information in slightly different ways, and the range of possible benefit etails is extensive. Rather than requesting a custom report each time you need a new data point, you can ow 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).

or more information on adding these report fields, visit ourEligibility Benefit Data Fields Help Article.

Enhancements

Expanded Availability of Electronic Claim Status

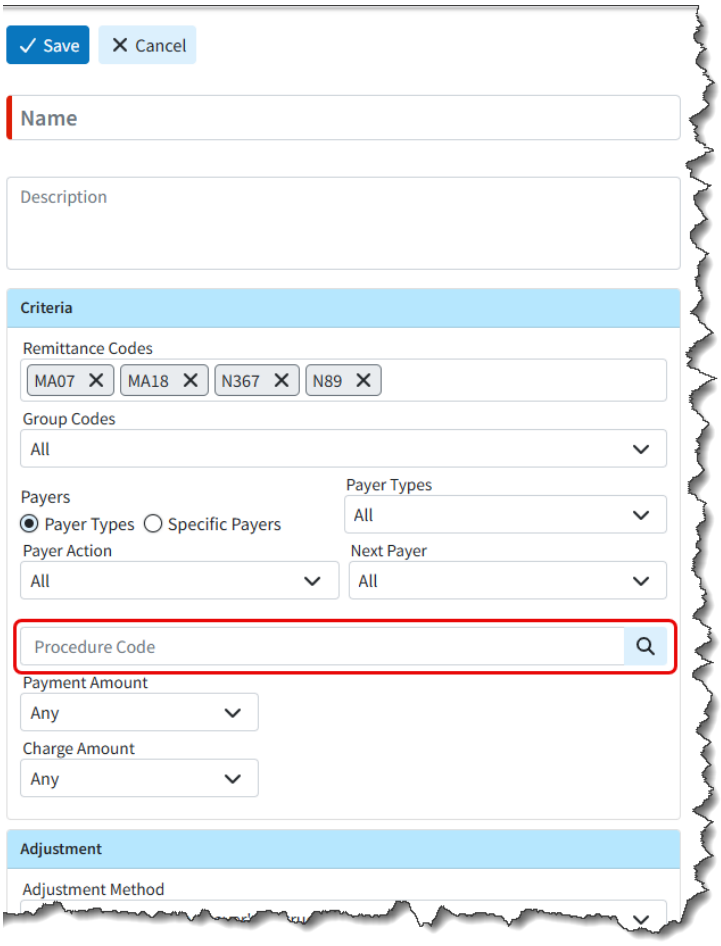
Previously, Electronic Claim Status could only be checked when a claim's status was **"At Insurance."** Once a customer updated a claim to a different status while working it (including custom statuses), they lost the ability to check status electronically (even if the claim was still legitimately pending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



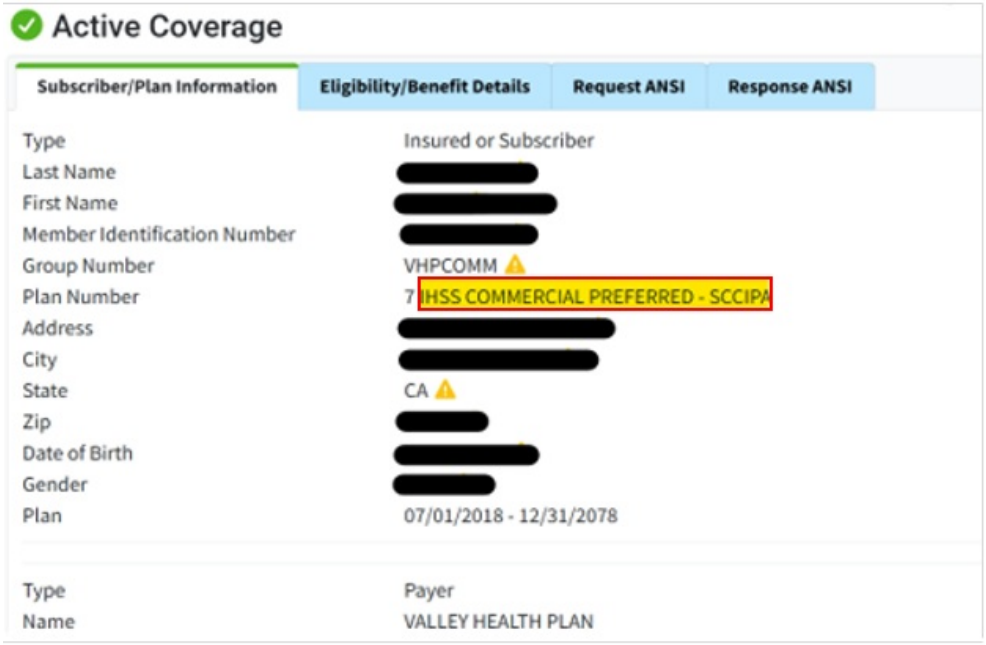
Visit our Add Payment Automations Help Article for more information.

:ligibility Now Shows More Details Within the Plan Number

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

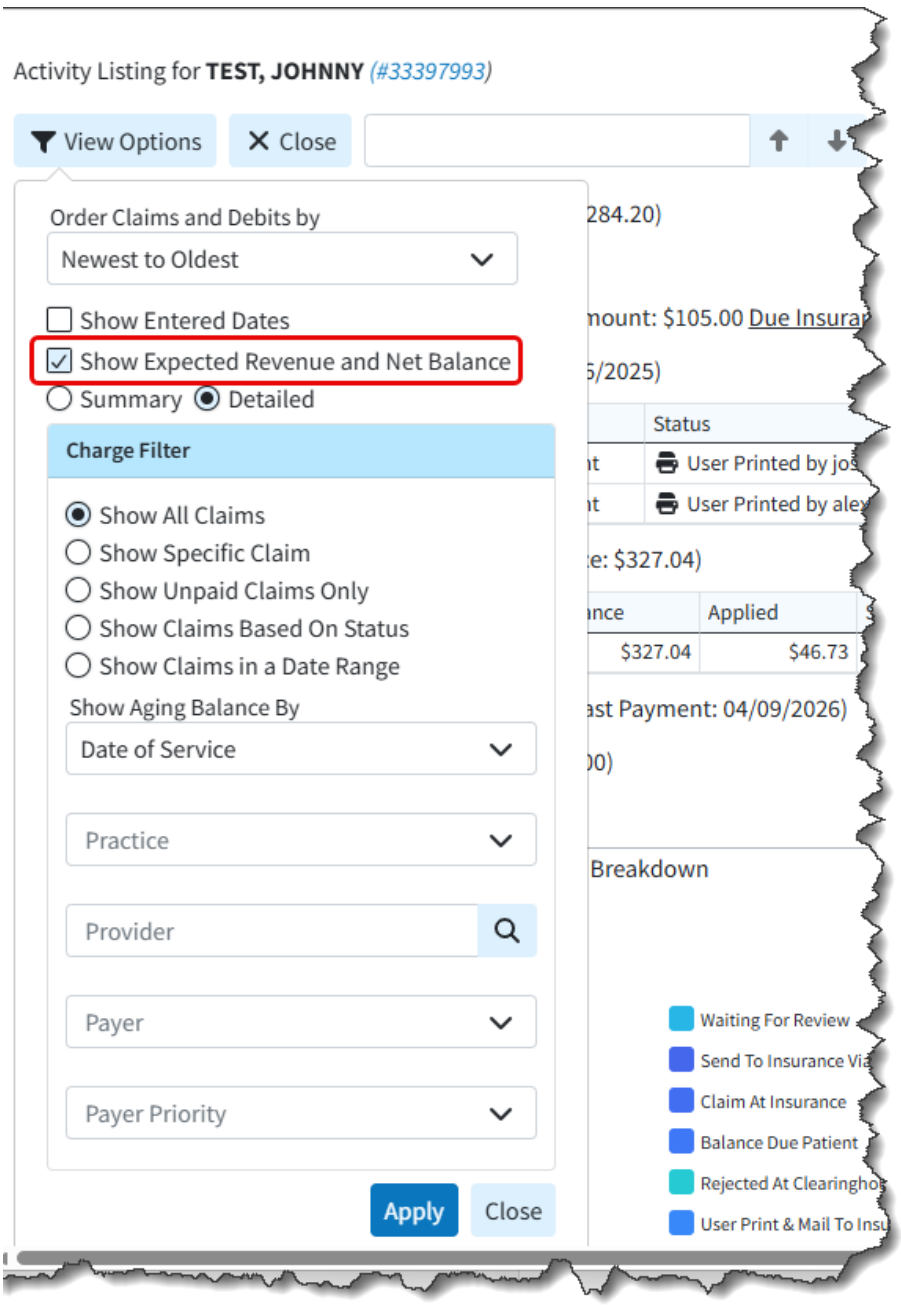
ccurately identifying a patient's plan is important for any practice, but it is critical for California IPA plans. n California, Independent Physician Associations (IPAs) are often tied to specific medical groups and PCP etworks. The plan number acts as a code to identify the exact health plan and managed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

n this release, when the eligibility response message includes an additional segment with the group, plan, c etwork name, we will now include the plan name when it is provided with the plan number in the response his will assist practices that handle California IPAs by offering an additional reference point to minimize rrors.



'atient Activity: "Show Net Amount" Option Relocated for Easier Access

he option to display the Net Amount (expected revenue) in the Patient Activity listing has been moved to nore accessible location. Previously, this option was located in Patient Settings, where it was difficult to nd. 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 xpected Revenue column in the Claim Activity window, as well as replace the Balance column for a Net alance Column.

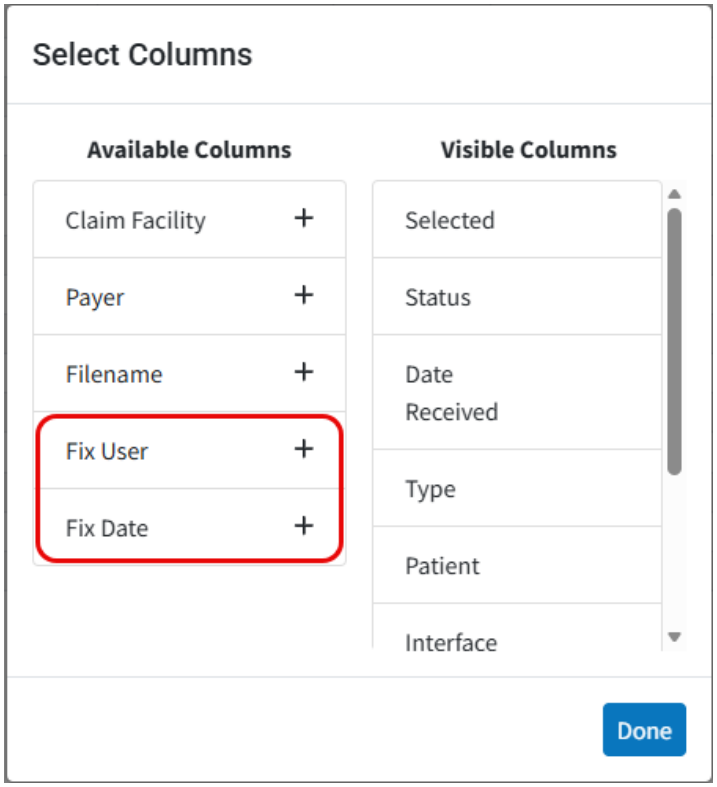


'isit our Patient Activity Help Article for steps to setting your Activity Listing View Options.

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

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

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



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

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

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

Universal Import: Added Support for Patient Account Type

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

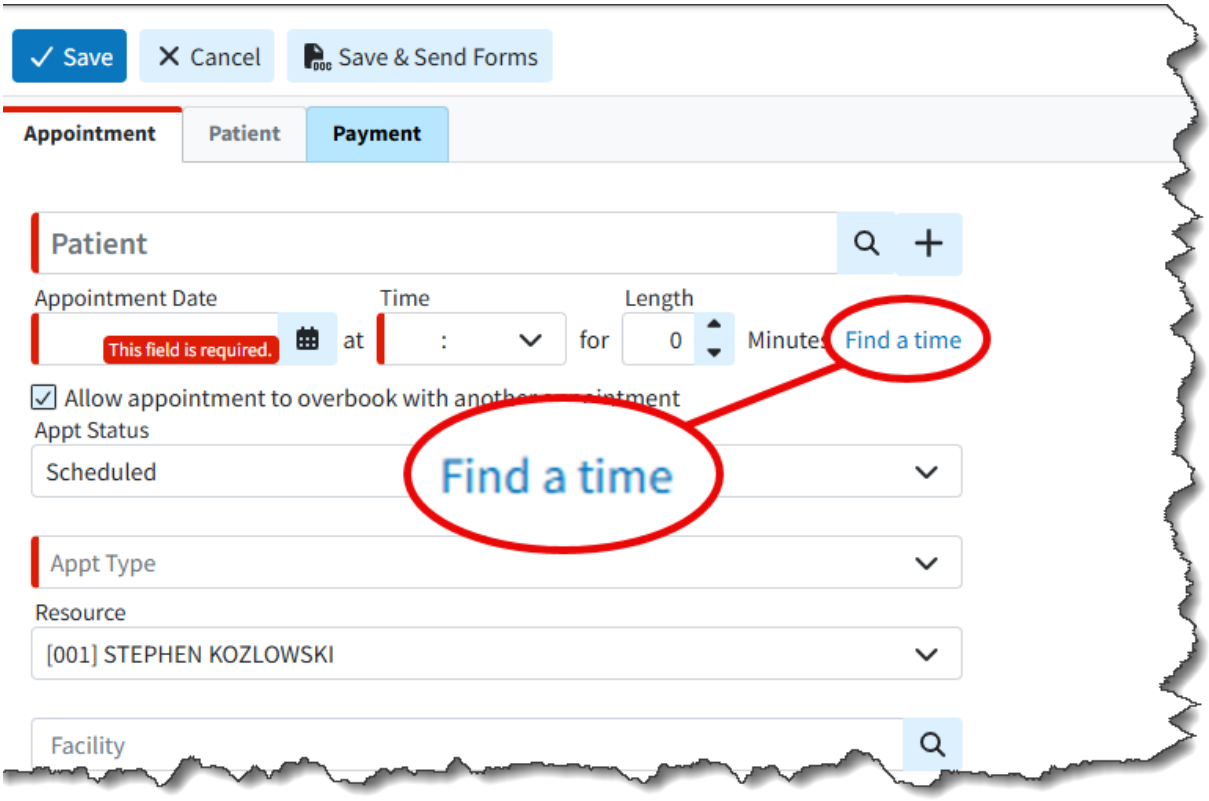
In this release, we corrected this so that the *"Days in AR"* dashboard now correctly counts all calendar days a charge remains outstanding between billing cycles, regardless of how frequently charges are entered.

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.



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 pdated as part of that change. Because the system uses this timestamp to detect updates, the cache did nc ecognize the procedure code as changed, meaning the update may not have appeared for other users or in laces that pull from the cached data until a later.

he "last modified" timestamp is now correctly updated whenever a procedure code is changed within a fee chedule, 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 uplicated as an **"other diagnosis"** on the combined claim (even in cases where both claims shared the same rincipal diagnosis). This issue has been resolved, along with related issues identified when combining nstitutional claims. Diagnosis codes are now combined correctly, without duplicating the principal diagnos s 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 ystem did not prompt the user to correct it, even though similar correction suggestions were already vorking for other fields, such as name and member ID.
he system now correctly evaluates Date of Birth as part of its correction-suggestion logic, alongside xisting checks for name and member ID. When a mismatch is detected, users will now be prompted to eview 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 **elf** on the Insurance Info tab, both the **Patient Info** and **Insurance Info** tabs were flagged with an address ssue. Correcting the address on the Patient Info tab resolved the flag there, but the Insurance Info tab emained 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 issu n the Patient Info tab now also clears the corresponding flag on the Insurance Info tab, since the two ddresses are the same.

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