Electronic Claims **Processing**™

RelayHealth Module

May 2008

Version 14

medisoft™

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Sales (800) 333-4747

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Preface

Electronic Claims Processing – RelayHealth Clearinghouse

Welcome to the world of electronic media claims. This module gives you the ability to transmit virtually all of your insurance claims (Medicare Part B, Medicaid, Blue Cross/Blue Shield and Commercials) through the RelayHealth Clearinghouse.

The RelayHealth module includes the software you need to submit insurance claims electronically using a broadband/high-speed internet connection. Your claims are transmitted to a central clearinghouse where they are formatted for each individual insurance carrier's requirements. Your claims are then forwarded electronically to the carriers.

Depending on the state in which you practice, claims can be submitted by RelayHealth to Medicare, Medicaid, Blue Cross/Blue Shield, and Commercial carriers throughout the country. For an up-to-date payor list, visit the RelayHealth Collaboration Compass™ site.

About This Manual

This manual is for use with all Medisoft programs, Version 14 and higher. If you have an older version, contact your local Value-Added Reseller for an update or call Medisoft directly at (800) 333-4747.

Broadband Internet Connection

If you are sending claims through the RelayHealth Broadband module, you need an active high speed internet connection, for instance a cable modem, to send claims.

Customer Support

For registration questions or technical support, contact Medisoft at (800) 689-4550 6 AM–5 PM MST. The Medisoft Knowledge Base at www.medisoft.com/kb is also available 24 hours a day.

Getting Started

After signing your sales contract, Medisoft will work with RelayHealth to complete much of the registration process. When this process is complete, you will receive a confirmation email that contains your Billing ID and Submitter ID. You will use both of these, when you create an EDI Receiver for RelayHealth in Medisoft. This process is detailed in the chapter Setting up Medisoft for RelayHealth.

The confirmation email also contains your User ID and Password for the RelayHealth Collaboration Compass™ site. The Collaboration Compass site is an important element in processing claims with RelayHealth. You will need to go to this site at http://collaborationcompass.com and login and register to use the site. You will receive another confirmation email that documents that your registration on the site is complete. After receiving this email you can return to the site and create other users, customize the way in which you view data on the site, view important updates, etc. This process is detailed in the chapter Using the Collaboration Compass Site.

Before you can process any claims, you will need to login to the Collaboration Compass Site and complete various payor agreements for carriers that your practice accepts. This process is detailed in the chapter Using the Payor Agreement Library.

As previously noted, you will also need to set up Medisoft to support the RelayHealth module. The chapter Setting up Medisoft for RelayHealth details this process. After setting up Medisoft, review the chapter Processing Electronic Claims in Medisoft. This chapter details claims processing and provides an overview along with step-by-step procedures.

Once you begin sending claims, you will want to take advantage of the robust reporting offered via the RelayHealth clearinghouse. The chapter Receiving Reports outlines reports offered, provides sample reports, and discussing when the reports are relevant and the type of data displayed.

Using the Collaboration Compass Site

Introduction

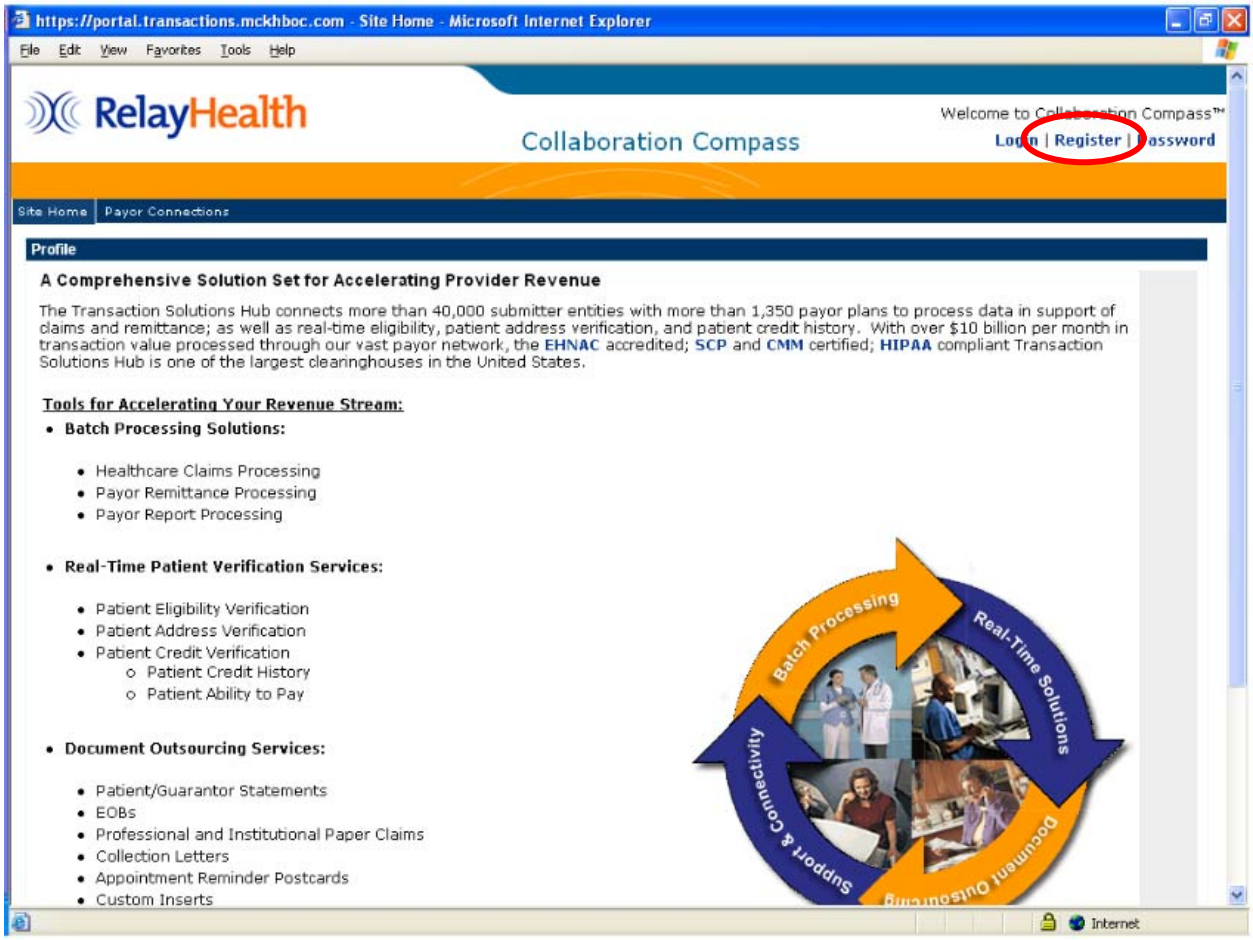
The purpose of this chapter is to overview, introduce, and provide instructions for using the RealyHealth Collaboration Compass™ site.

Of particular importance in this chapter is the section Self Registration. All users will need to complete this process before using the RelayHealth clearinghouse. This step is crucial since you will use the site to complete your payor agreements—detailed in the chapter Using the Payor Agreement Library.

Self Registration

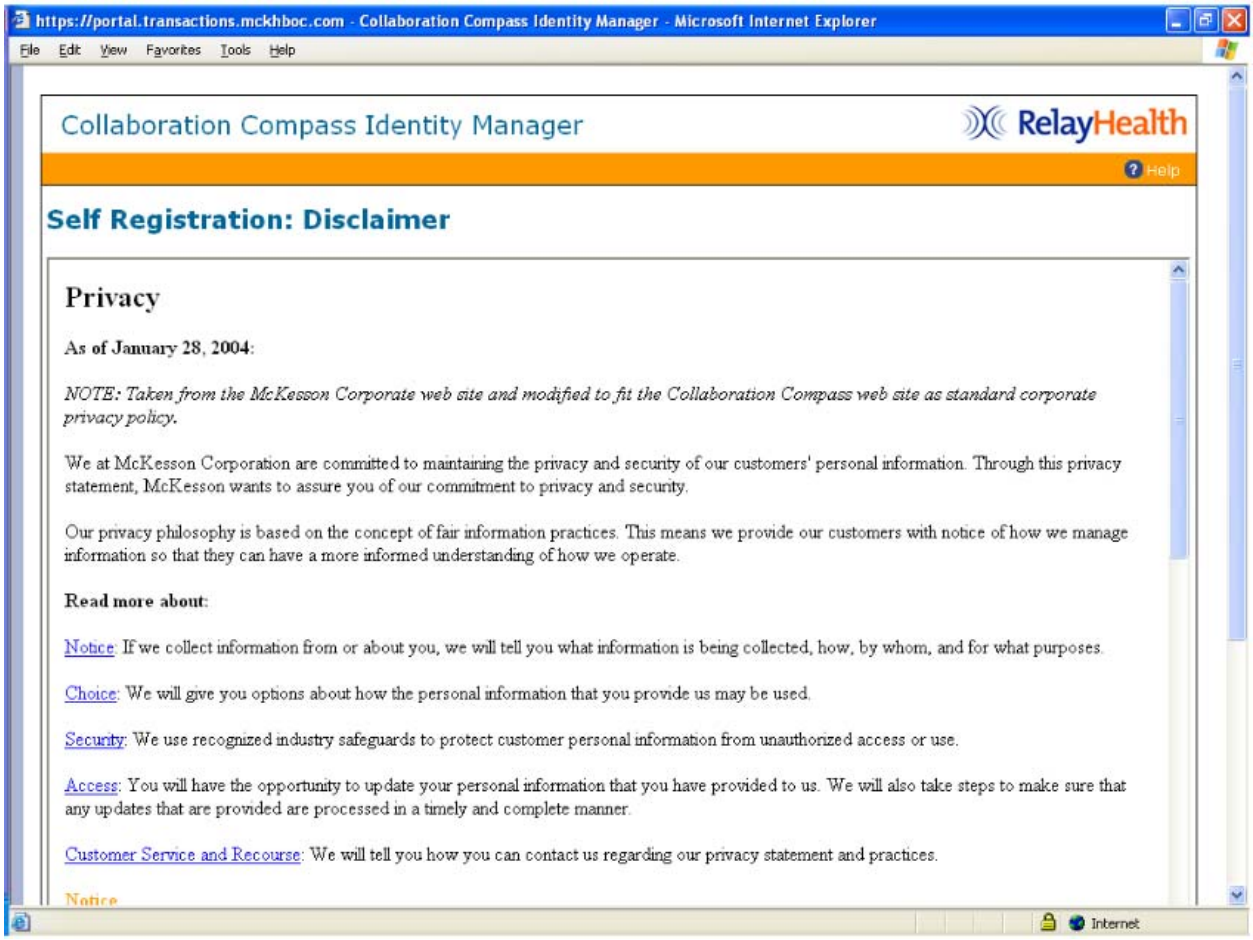
Self-Registration allows new users to register for access to Collaboration Compass™ and corresponding applications.

1. Access Collaboration Compass™ with the following url: http://collaborationcompass.com.
2. Click **Register**.



Note: Users who do not access their account for 180 consecutive days, may be removed from the system. In order to regain access to the Collaboration Compass™, the user must complete the registration process with a new user ID.

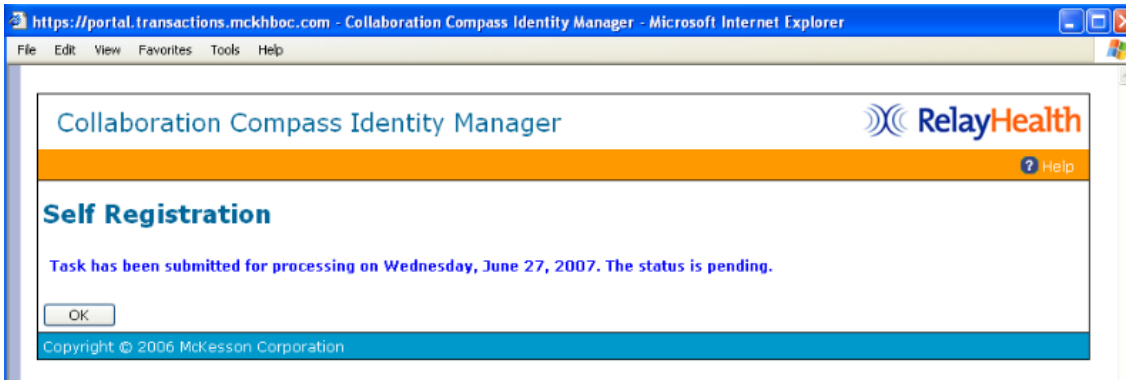
3. Review the disclaimer and click **Accept**, located at the bottom of the page.



4. Enter the required information indicated by the red asterisk, select news subscriptions by holding down the **Ctrl** key and clicking each subscription needed.
5. Click **Submit**, located at the bottom of the page.

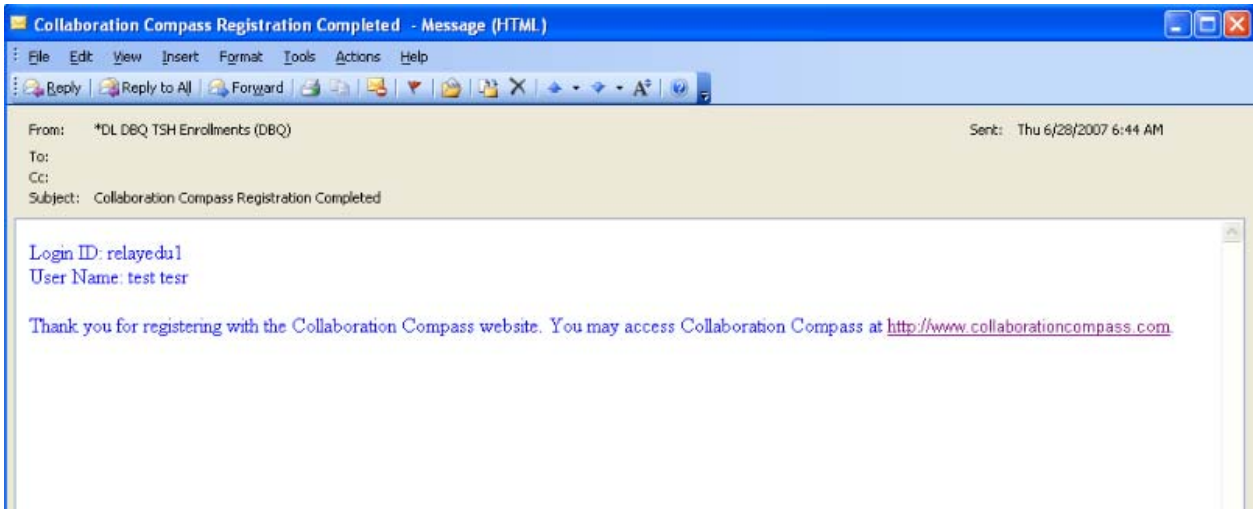
   Note: An invalid Submitter ID will delay approval. Your Submitter ID was send to you by the registration team after your initial enrollment.

6. A confirmation message will display, indicating your registration has been accepted; Click **OK** to return to Identity Manager home page.



7. Registration staff will review the user request within 24 hours. Users who are approved will receive an email from the team. Users with invalid Submitter IDs will be contacted for additional information.

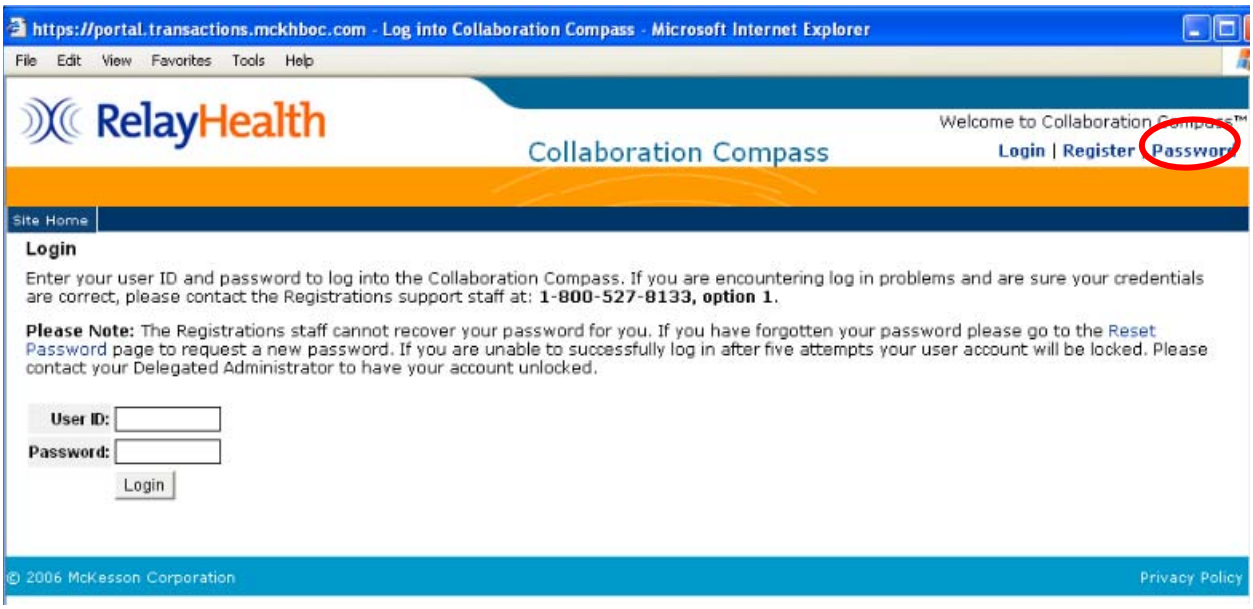
   Upon receipt of the Collaboration Compass Registration Completed email, users will have access to the Collaboration Compass™ and the RelayHealth Payor Agreement Library.



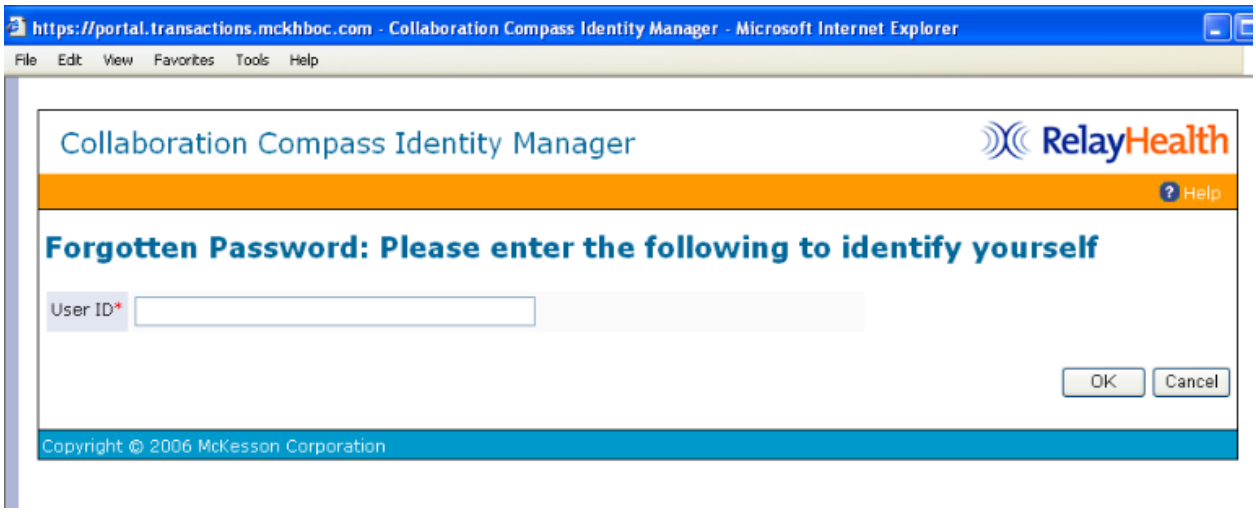
Forgotten Password

A temporary password can be generated by using the Forgotten Password function.

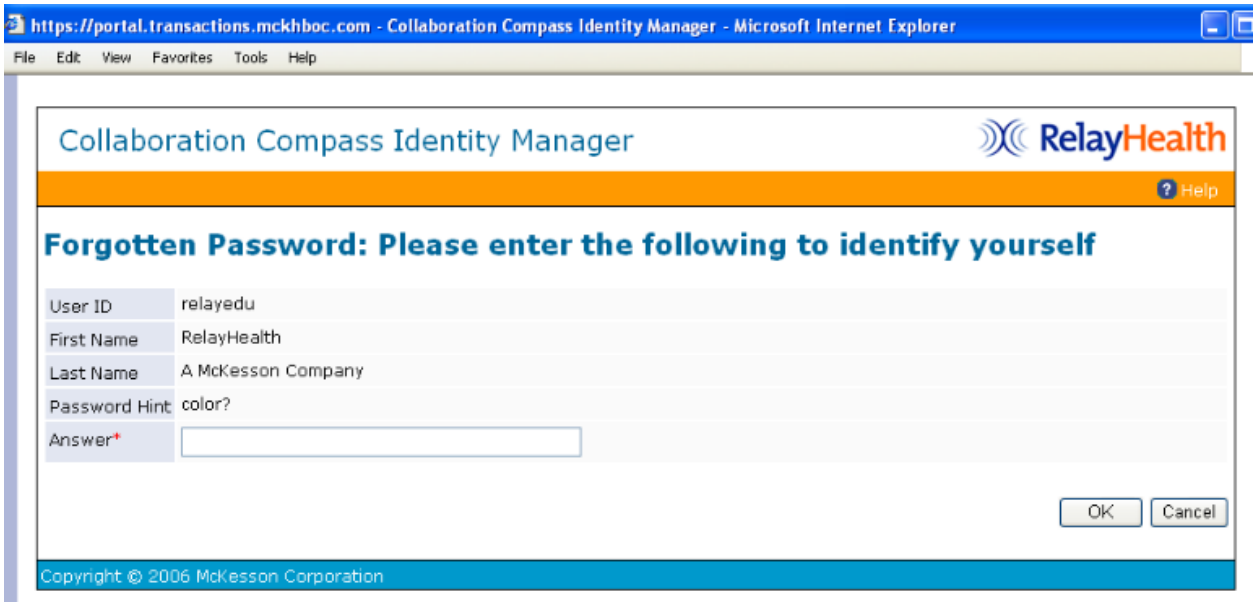
1. Click **Password**.



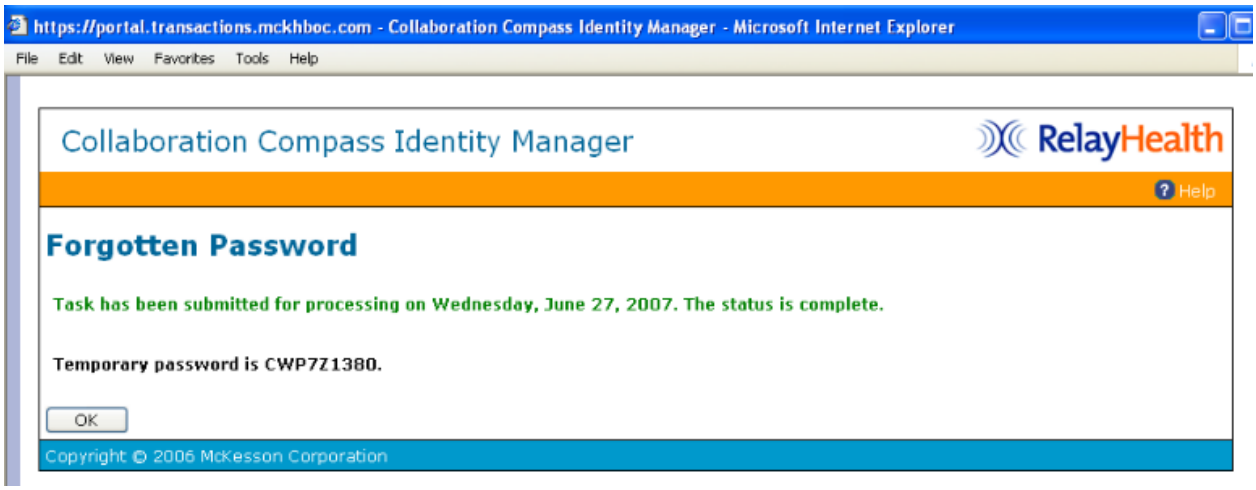
2. Enter the **User ID** and click **OK**.



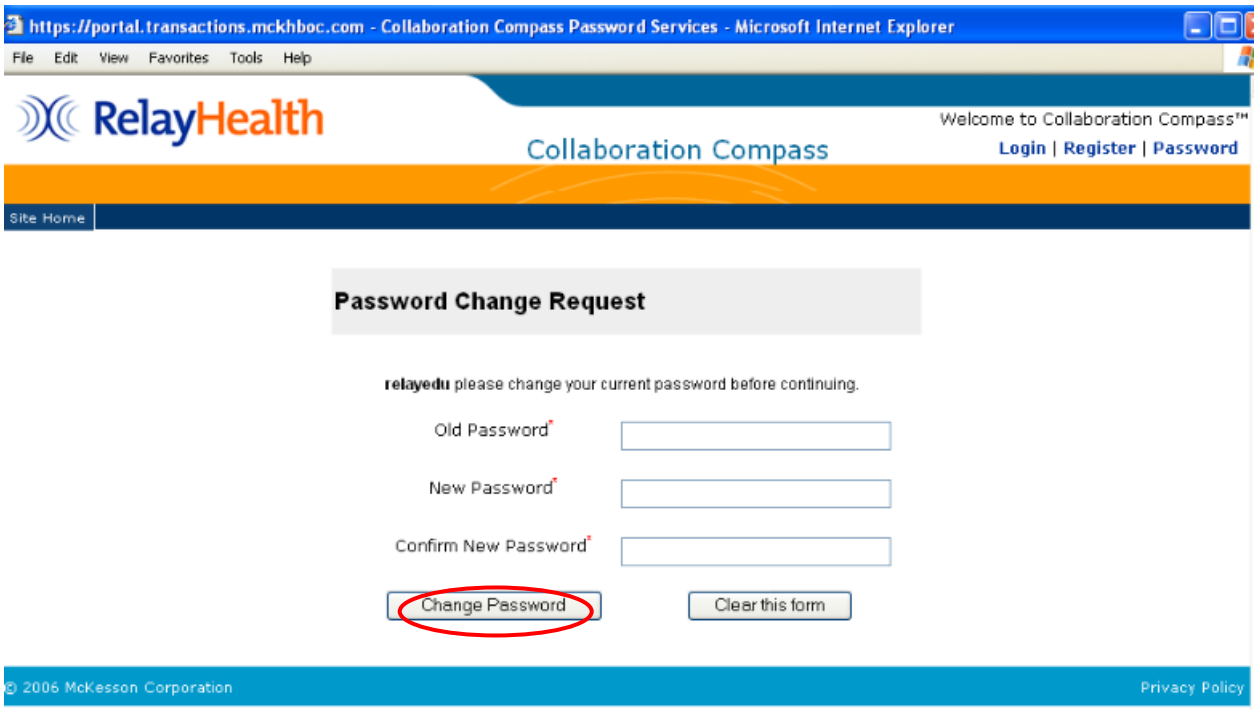
3. Answer the password hint and click **OK**.



4. A temporary password will be displayed; copy the password by pressing and holding down the **CTRL** key + **C**. The password will also be emailed to the address in the user profile.
5. Click **OK** to return to the Collaboration Compass™ login screen.



6. Use the temporary password to log in; once logged in, the user will be required to change their password.
7. After entering the new password, click **Change Password**.



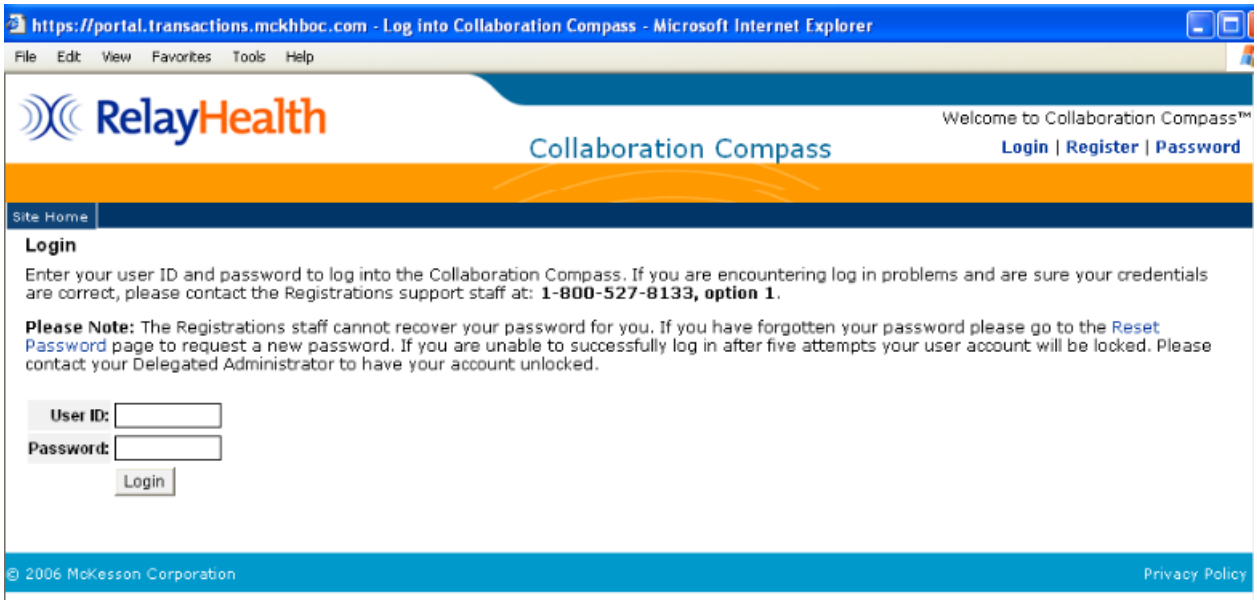
8. Click **Continue** on the next screen.

Accessing Identity Manager

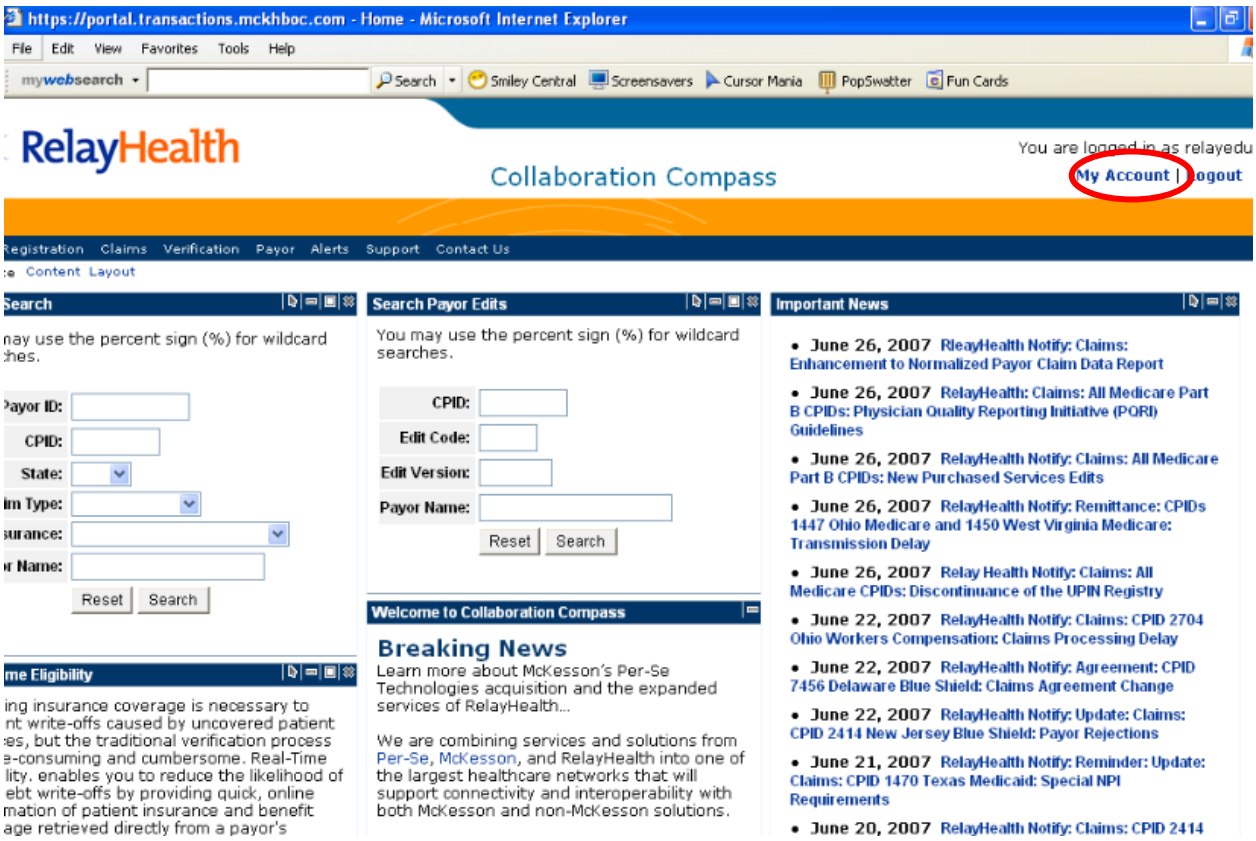
To access Identity Manager users will need to be logged into Collaboration Compass™. Access within Identity Manager is based on the roles assigned within each user's profile.

1. Access Collaboration Compass with the following url: http://.collaborationcompass.com.
2. Login to Collaboration Compass by clicking **Login**.

3. Enter the appropriate **User ID** and password; click **Login**.



4. Click **My Account** on the top right of the page to access Identity Manager.



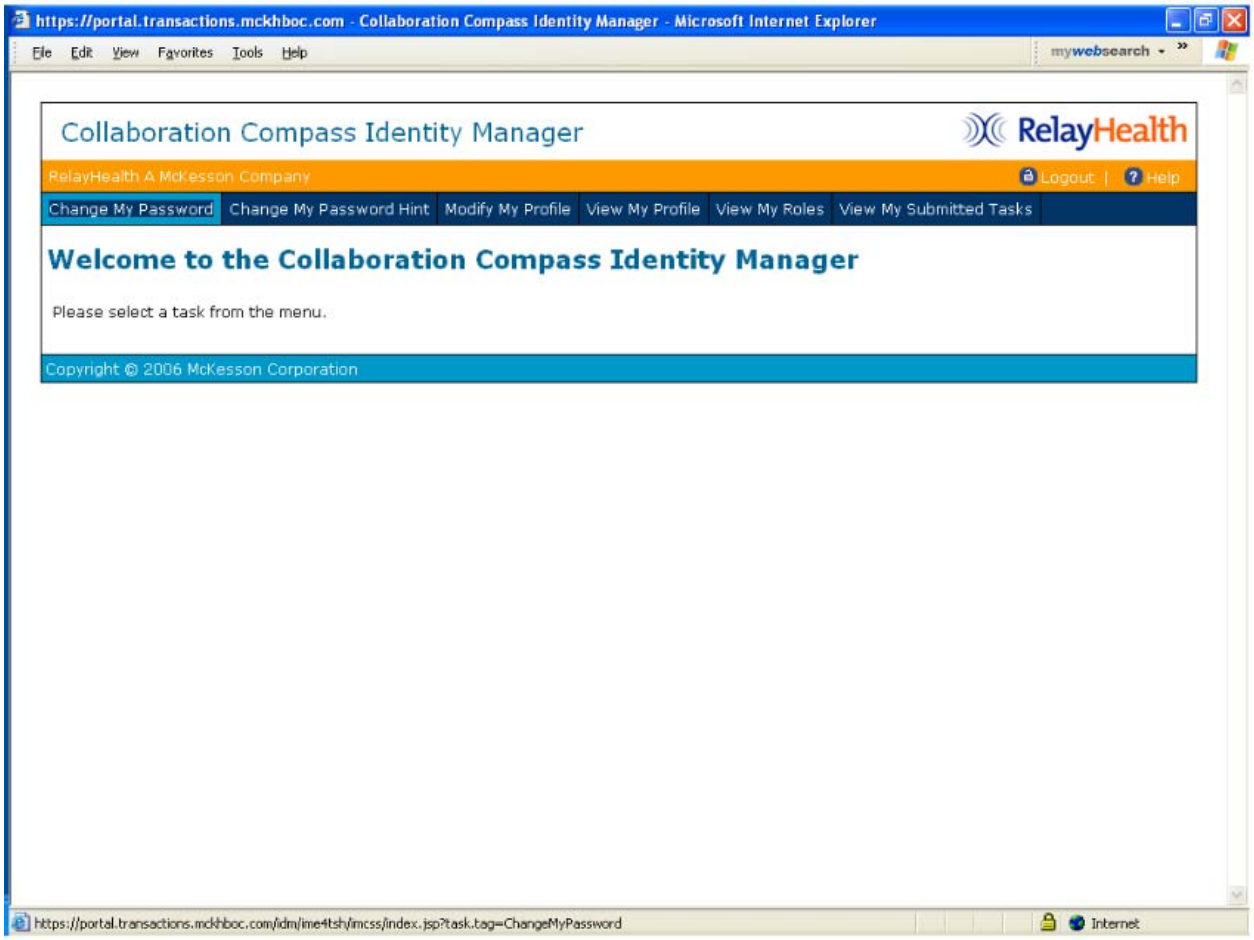
My Account

My Account allows users to view their roles and modify or view their profile and password. Clicking on My Account brings you to the following screen.

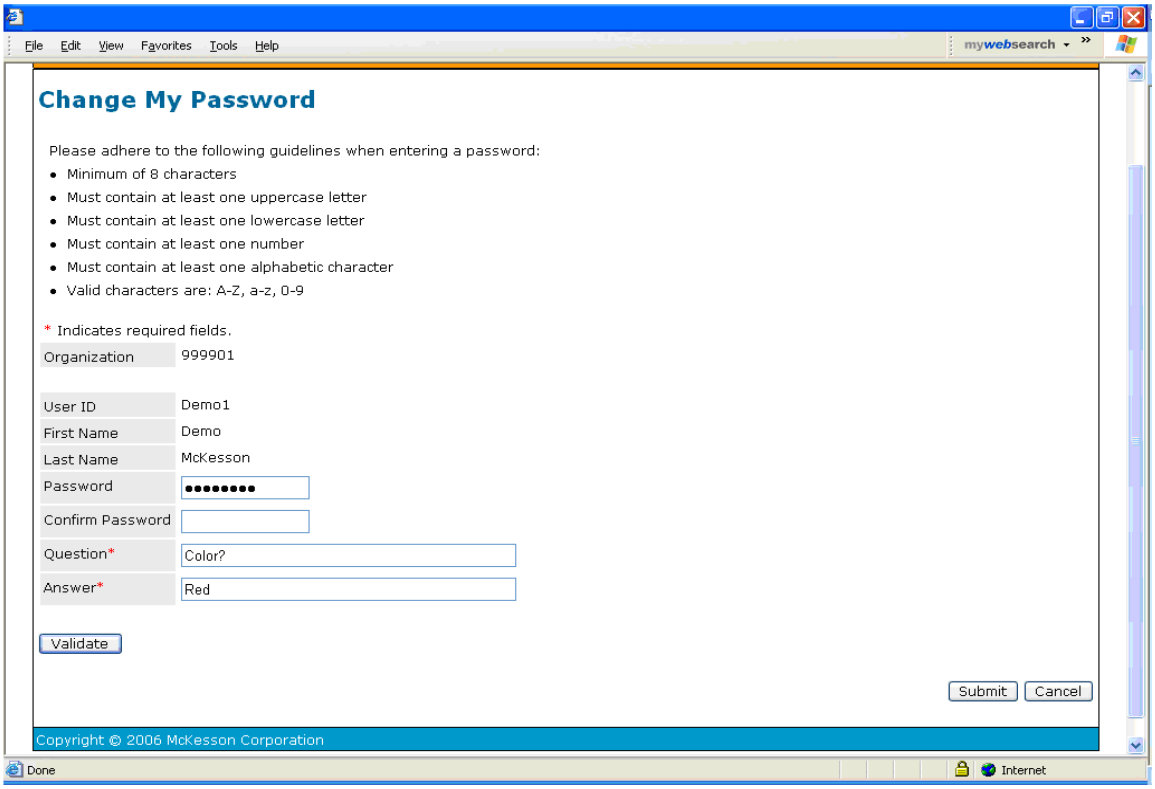
Change My Password

The Change My Password function allows users to change their password if they know their current password. *Change My Password* may only be accessed if the user is signed in to Identity Management.

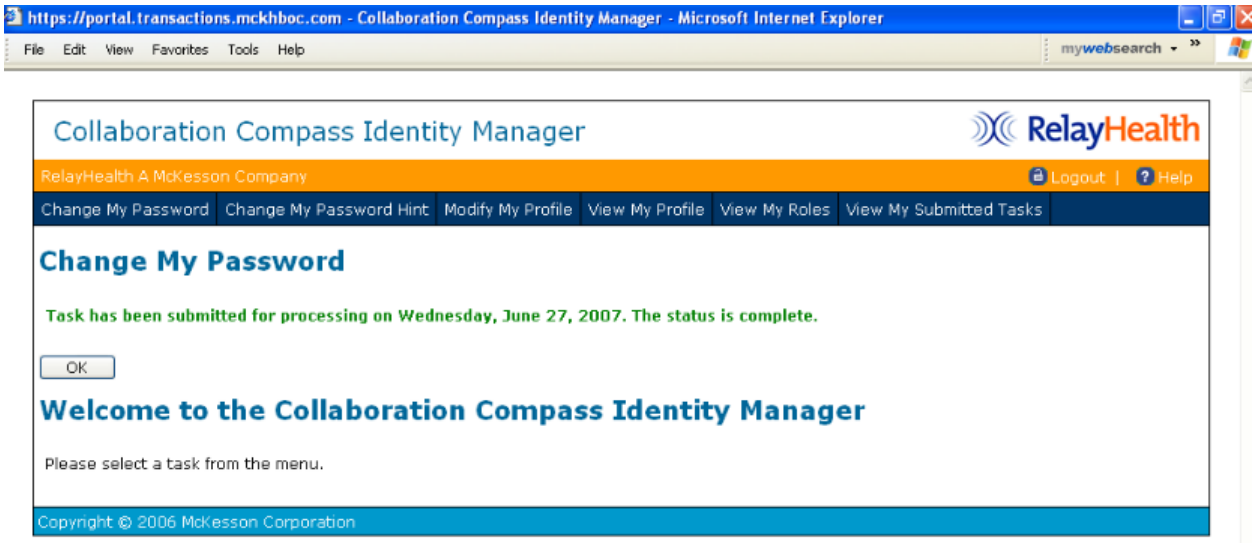
1. Click **Change My Password**.



2. Clear the password field, type in the new password, and retype to confirm.
3. Click **Submit**.



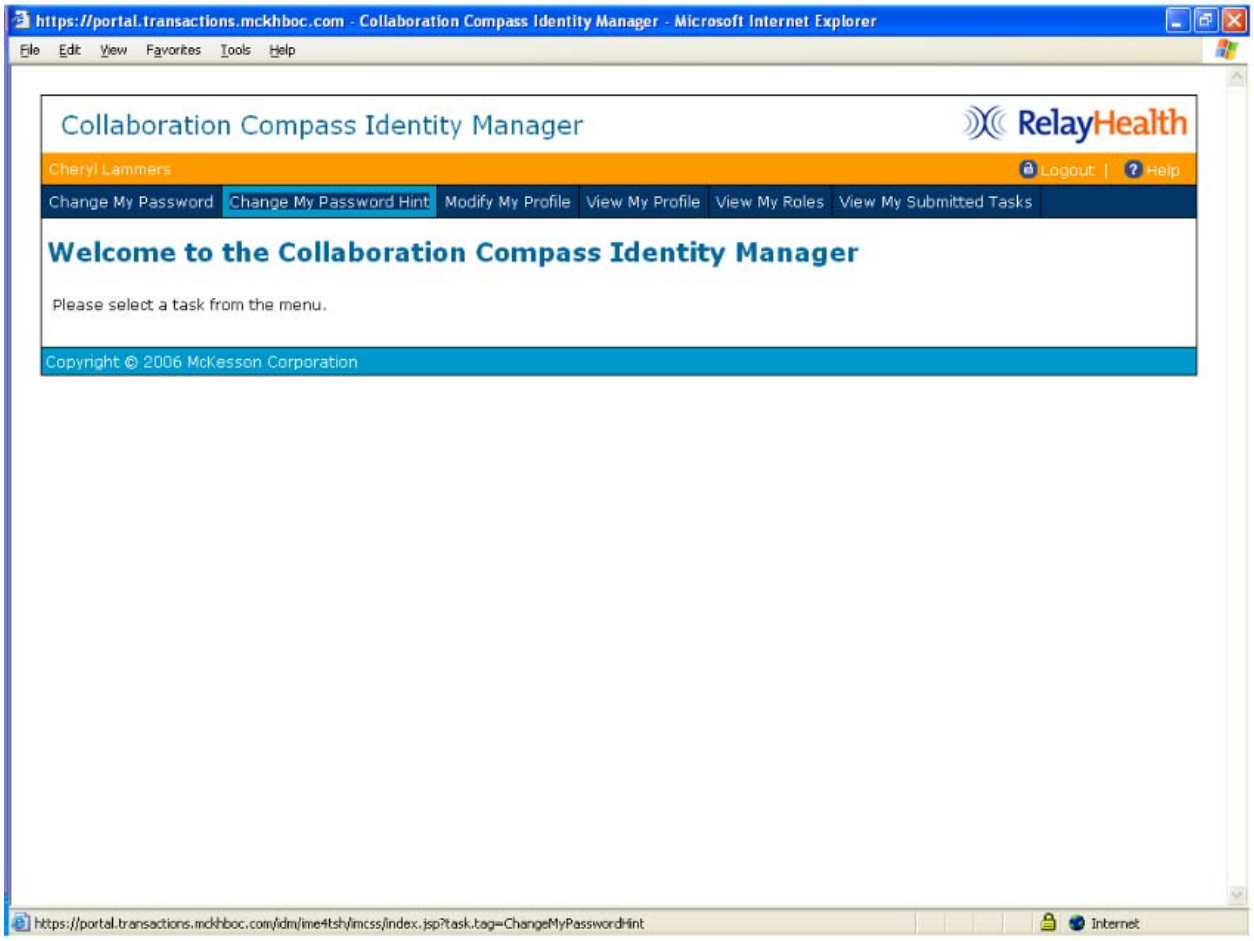
4. Click **OK** to return to the Identity Manager home page.



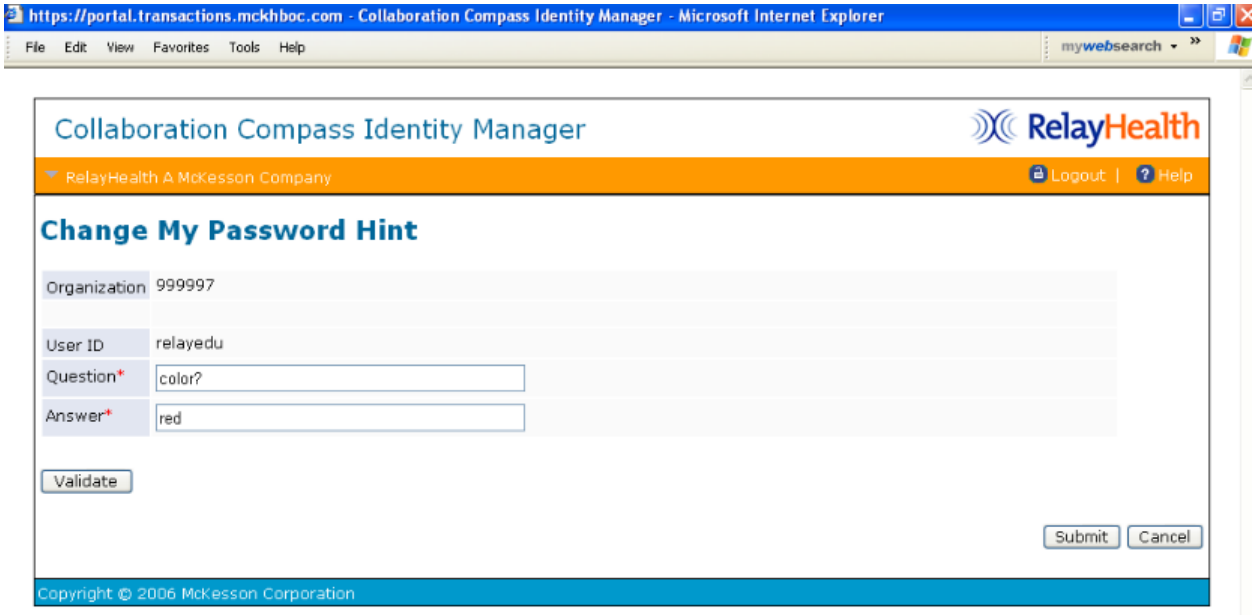
Change My Password Hint

Change My Password Hint allows users to change the Challenge question and answer, which is used for security purposes.

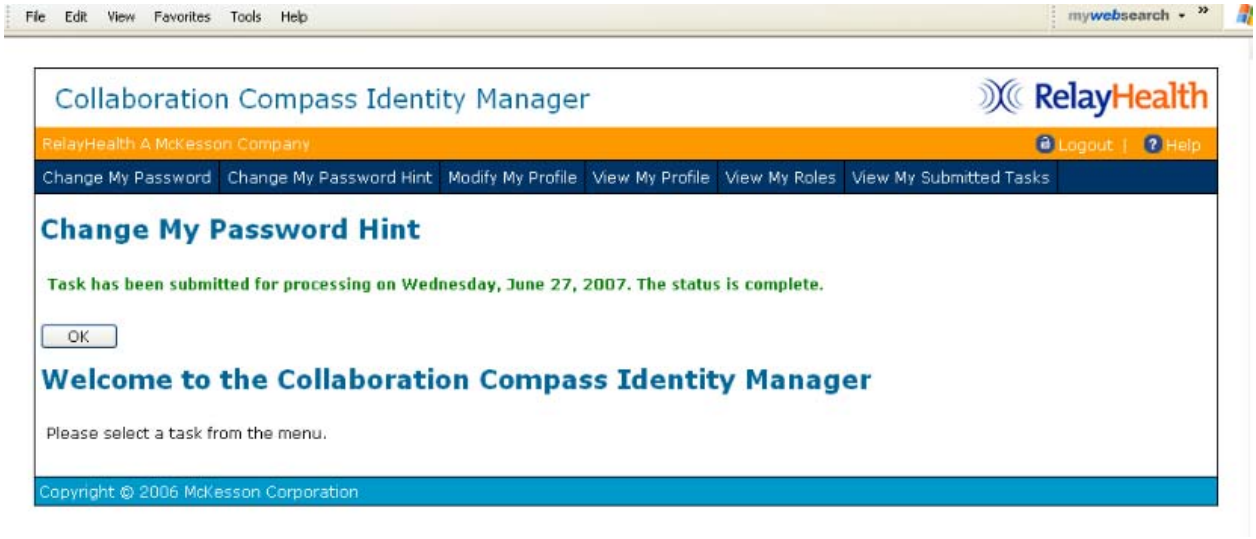
1. Click **Change My Password Hint**.



2. Update the question and/or answer and click **Submit**.



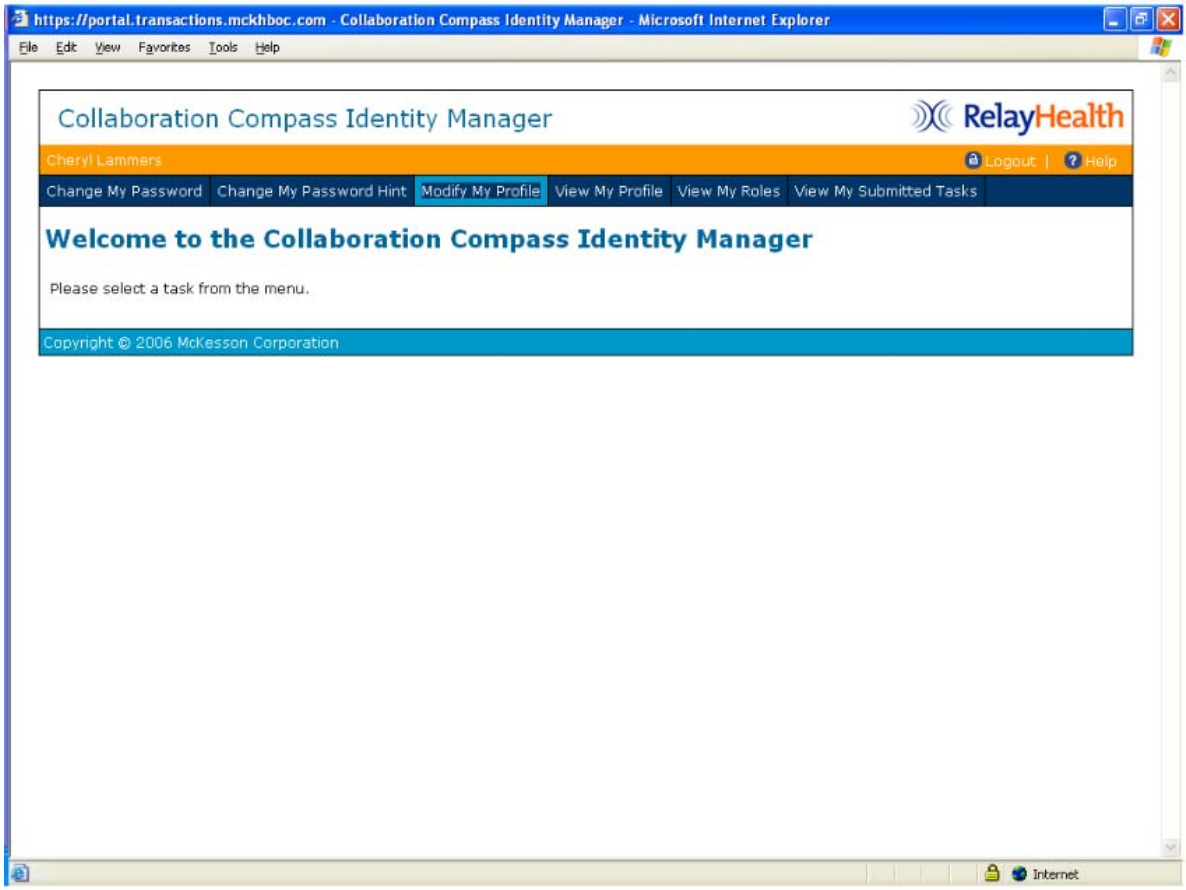
3. Click **OK**.



Modify My Profile

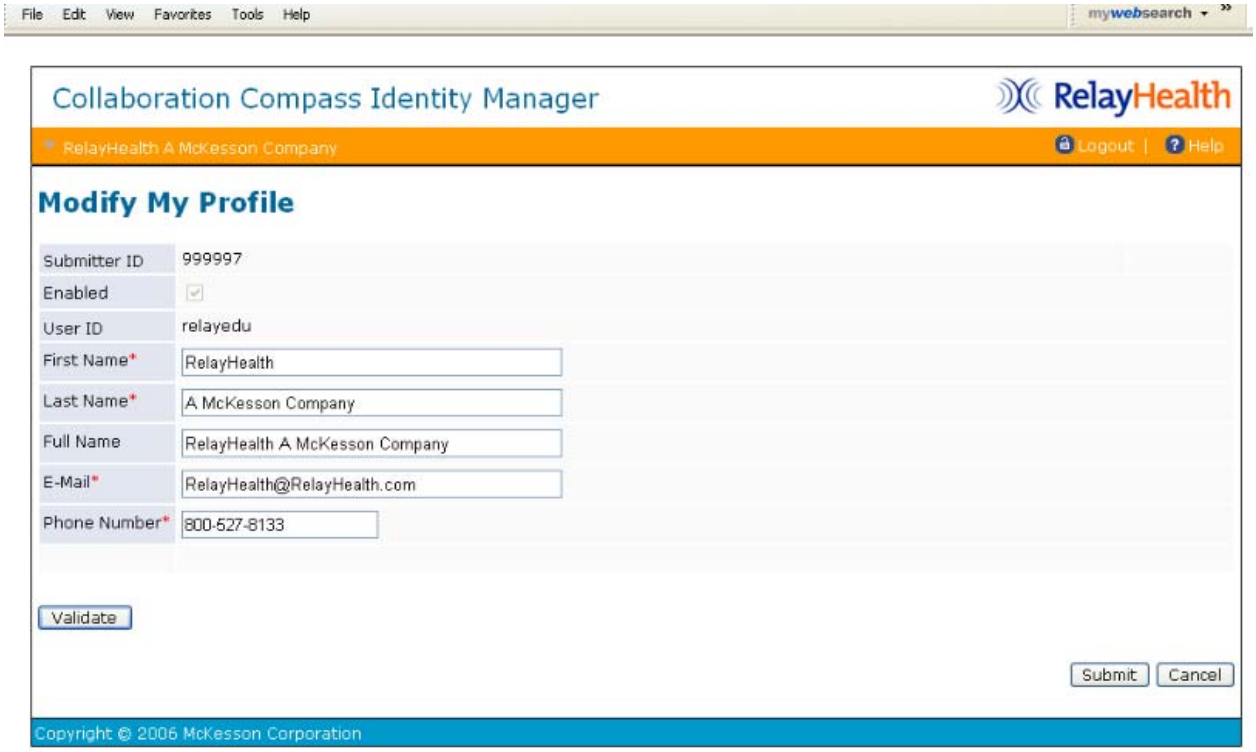
Modify My Profile allows users to change their demographic information, like the email address or phone number associated with their account.

1. Click **Modify My Profile**.

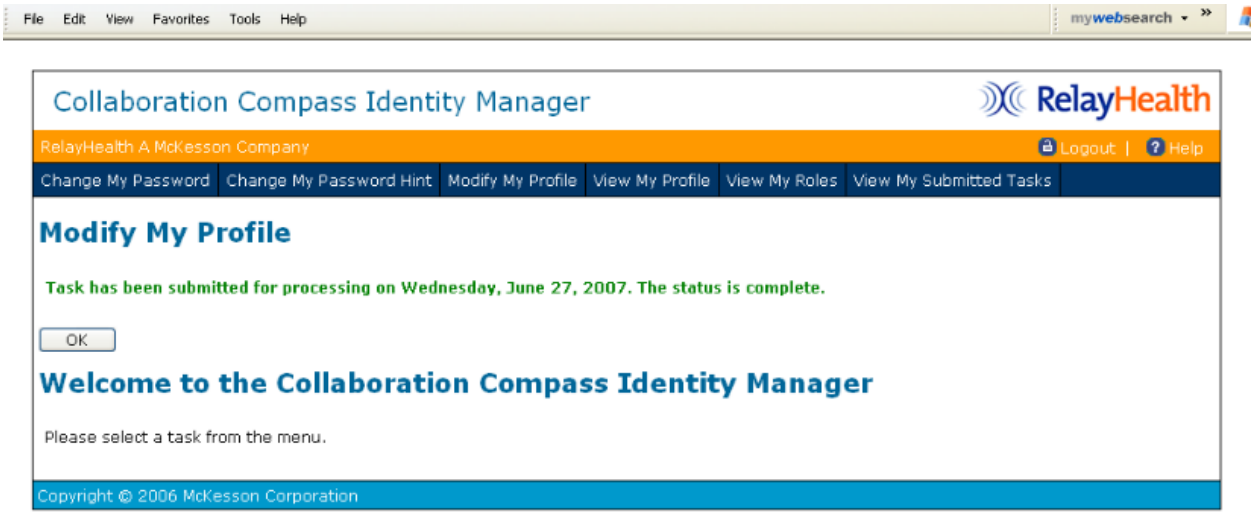


2. Update the necessary information and click **Submit**.

Note: Users may only change the submitter ID to another within their scope.



3. Click **OK** to return to the Identity Manager home page.



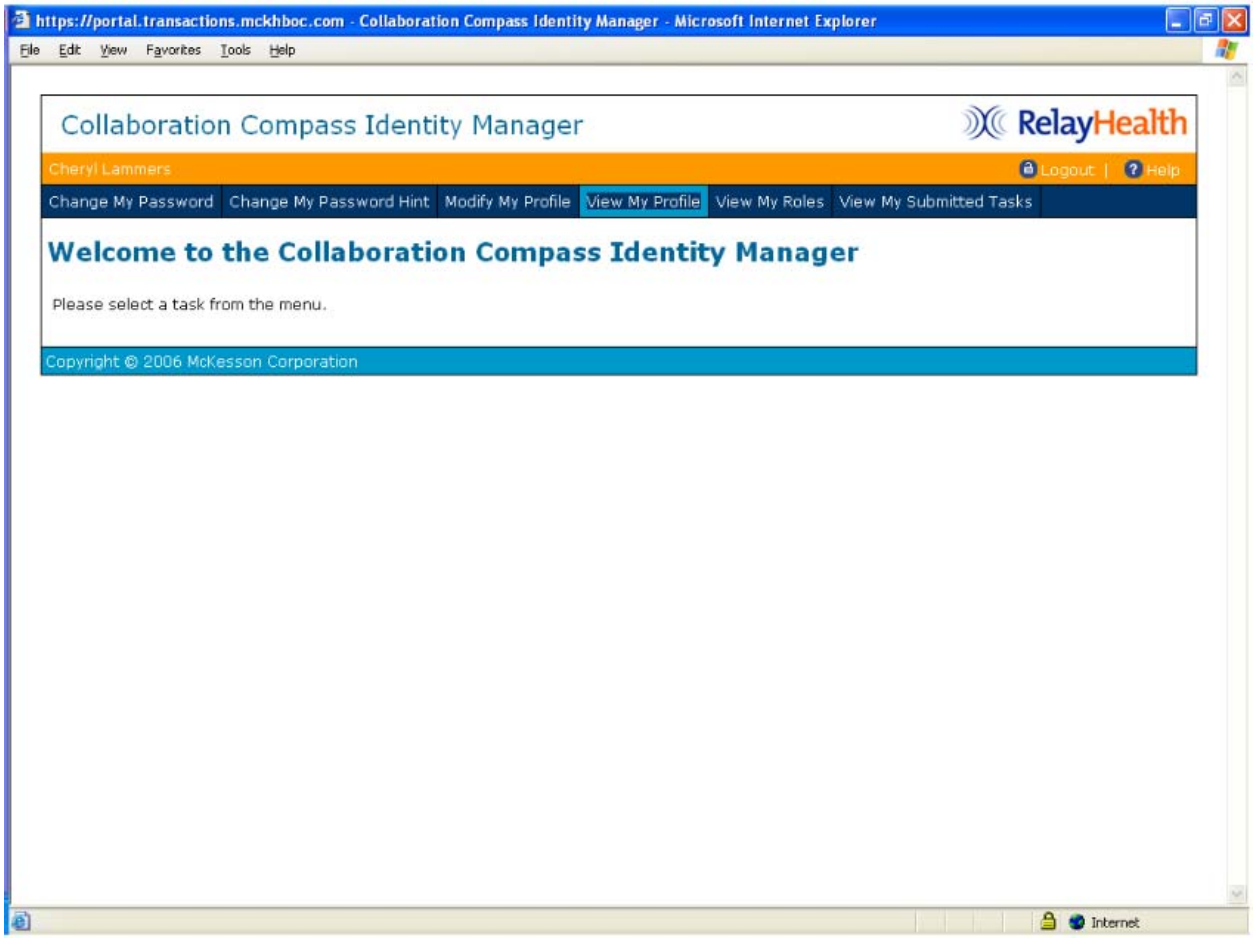
View My Profile

View My Profile displays the user's current demographic information and any Access or Admin roles associated with the user setup.

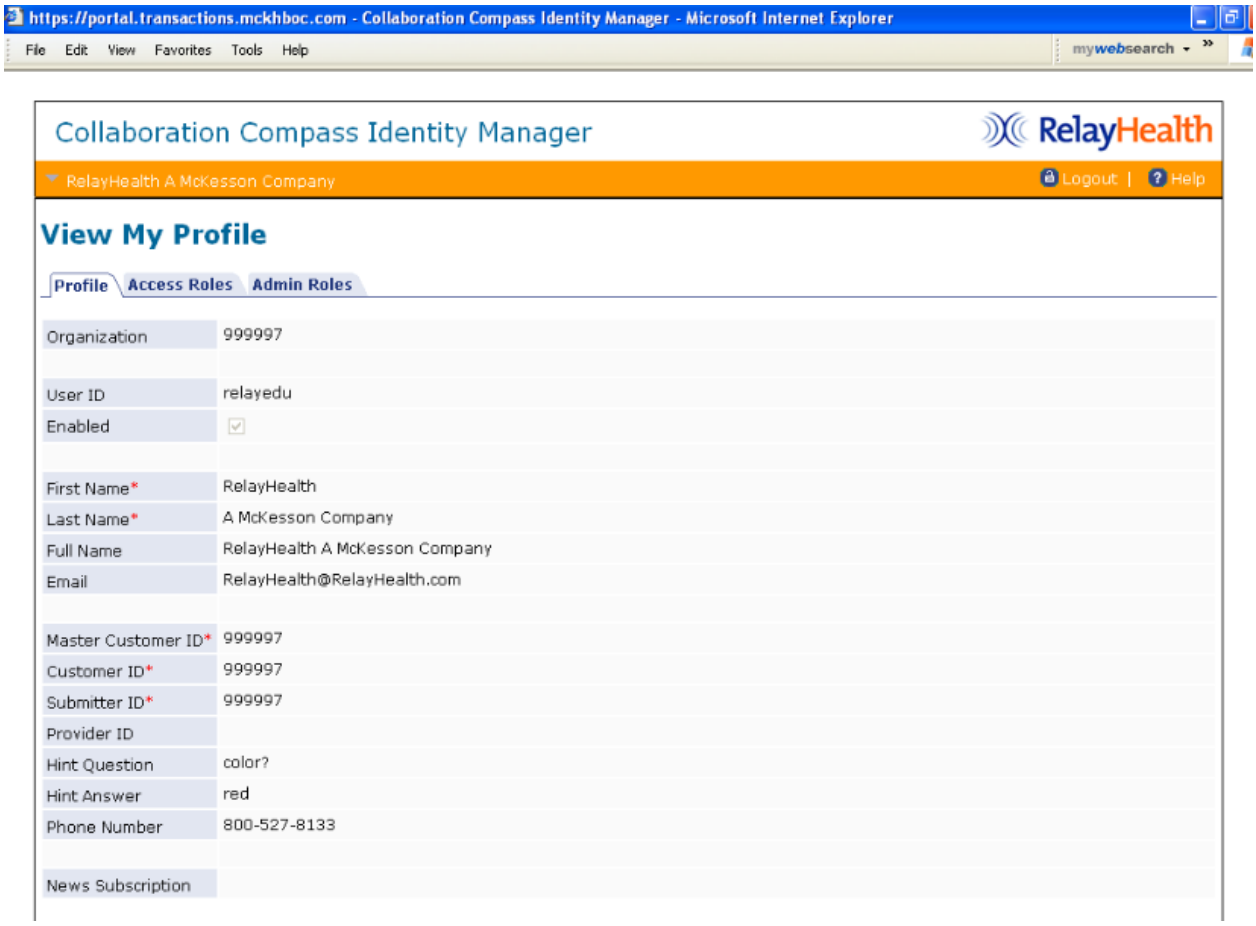
Access Roles grant users access to RelayHealth applications, like the ASP Eligibility application or the Agreements Website.

Admin Roles allow a user to view and modify other users within their established scope. For example, it allows Business Partners to view and modify their customers' users.

1. Click **View My Profile**.

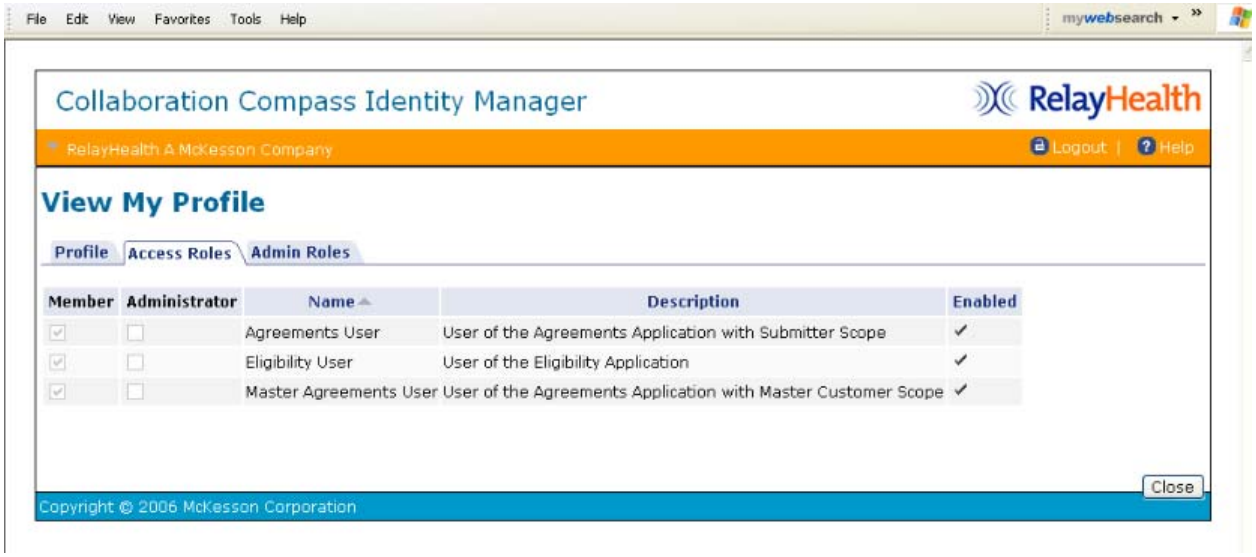


2. The Profile tab allows users to view their demographic information and News Subscriptions, as well as the Submitter ID associated with their user ID.



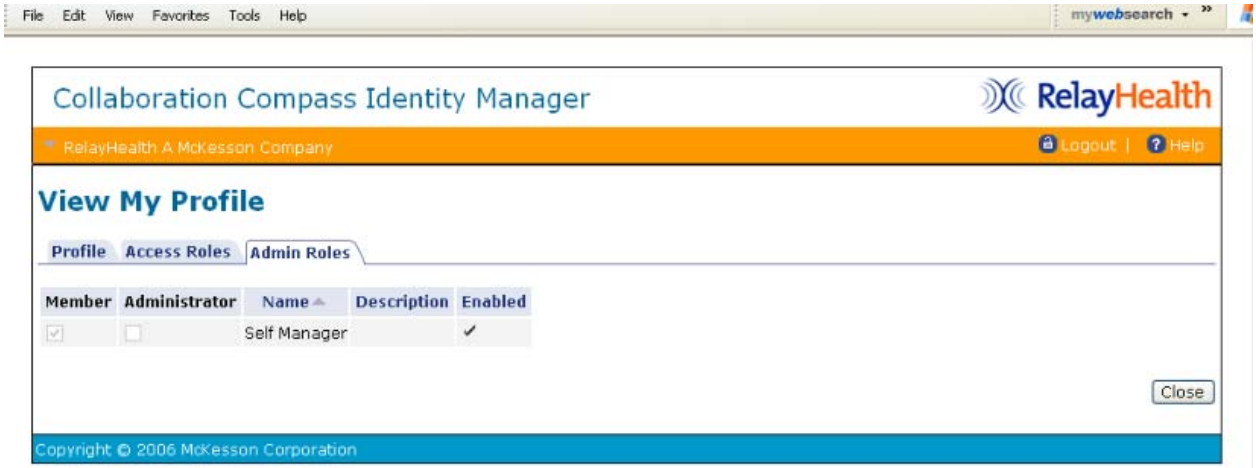
3. To view Access Roles, click the **Access Roles** tab.

    - Members of a role are granted the rights associated with a role
    - Administrators of a role may assign it to other users



4. To view Admin Roles, click the **Admin Roles Tab**.

   - Members of a role are granted the rights associated with a role
   - Administrators of a role may assign it to other users



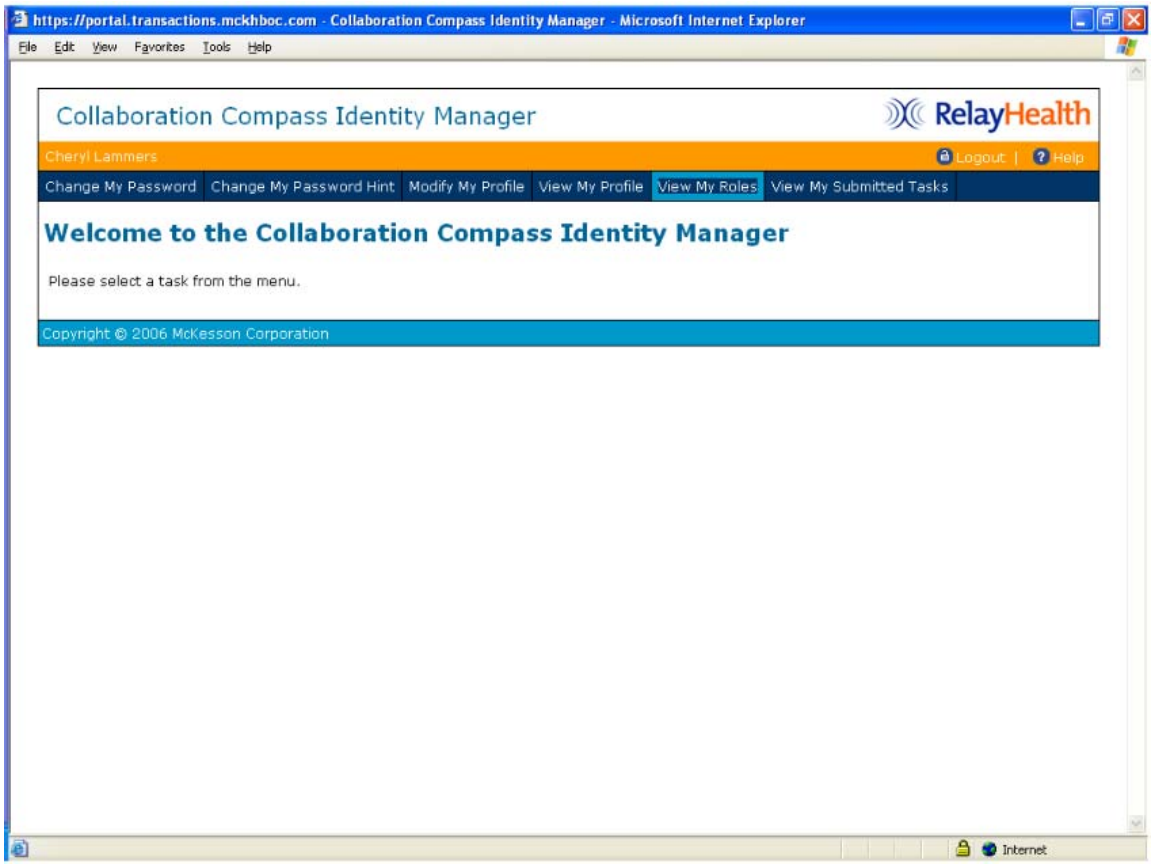
5. Click **Close** to return to the Identity Manager home screen.

View My Roles

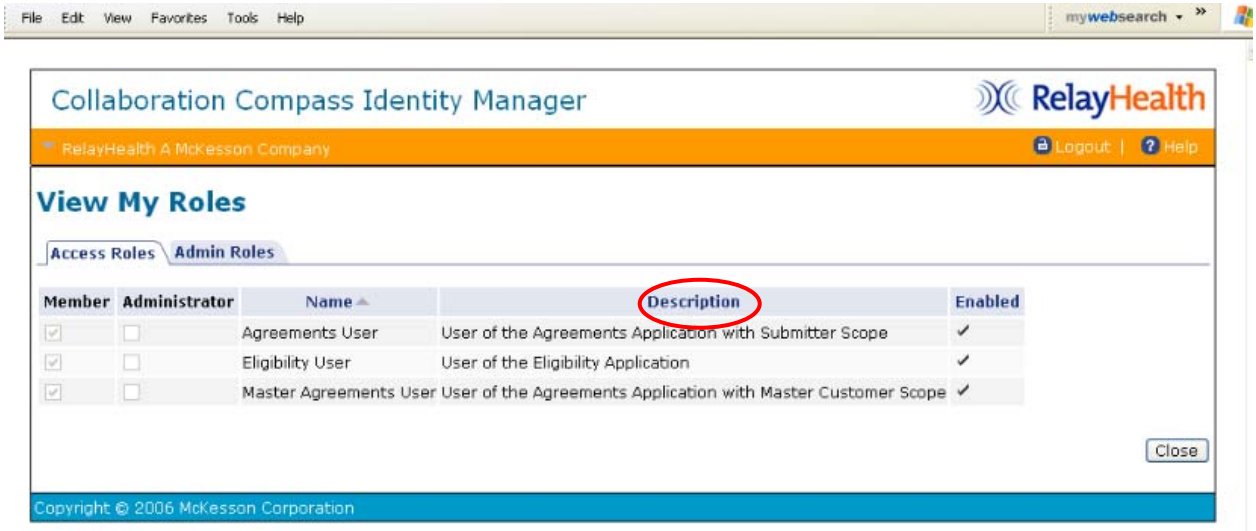
View My Roles displays a list of Access and Admin roles associated with a user account.

Access Roles grant users access to RelayHealth applications, like the ASP Eligibility application or the Agreements Website.
Admin Roles allow a user to view and modify other users within their established scope. For example, it allows Business Partners to view and modify their customers' users.

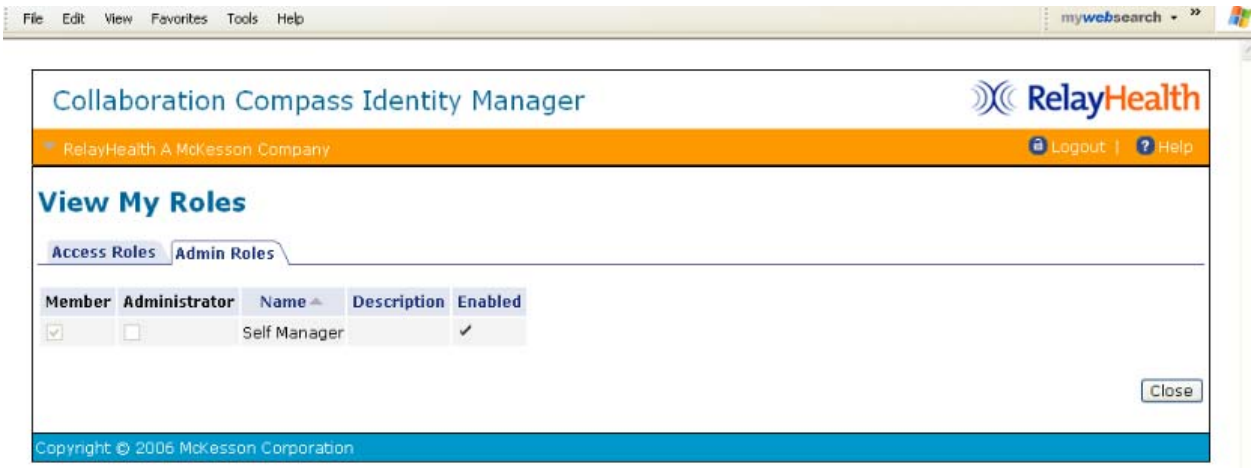
1. Click **View My Roles**.



2. The Access Roles tab will appear when clicking the **View My Roles** link.



3. To view Admin Roles, click the **Admin Roles** tab.

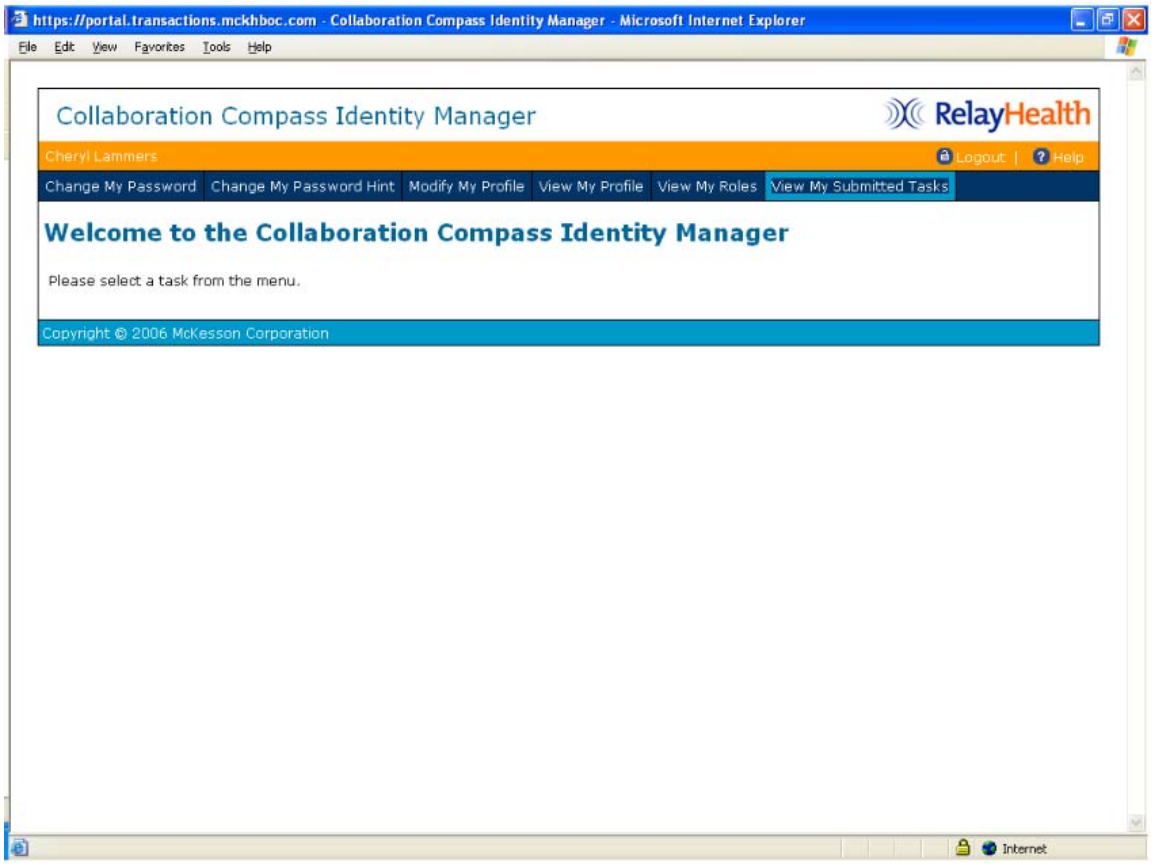


4. Click **Close** to return to the Identity Manager home screen.

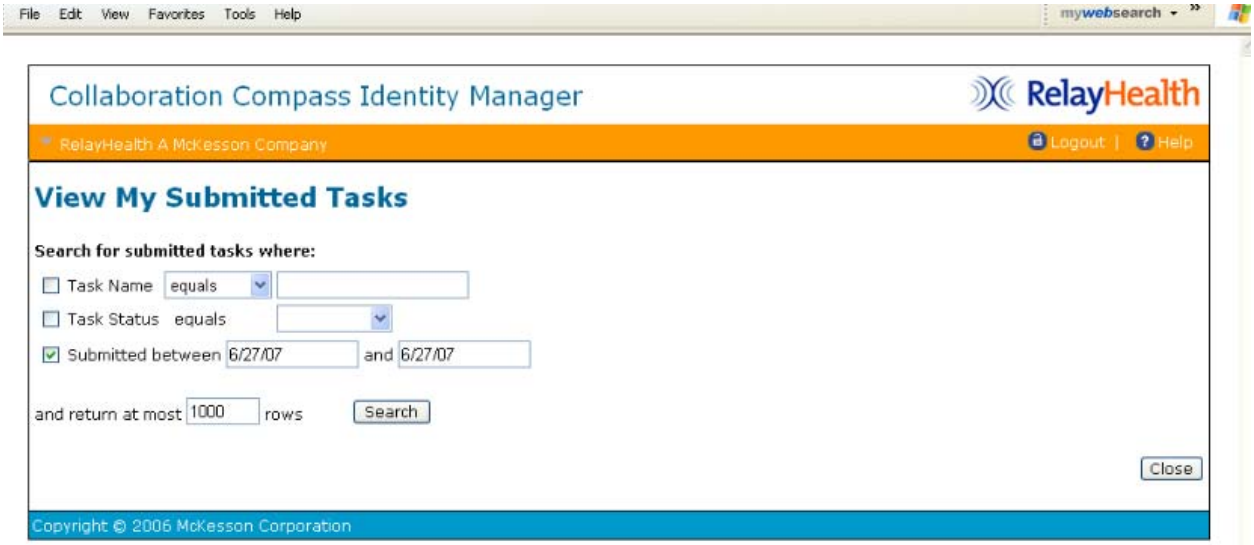
View My Submitted Tasks

View My Submitted Tasks enables users to view tasks that they have submitted for processing; it is an audit of any changes made by the user.

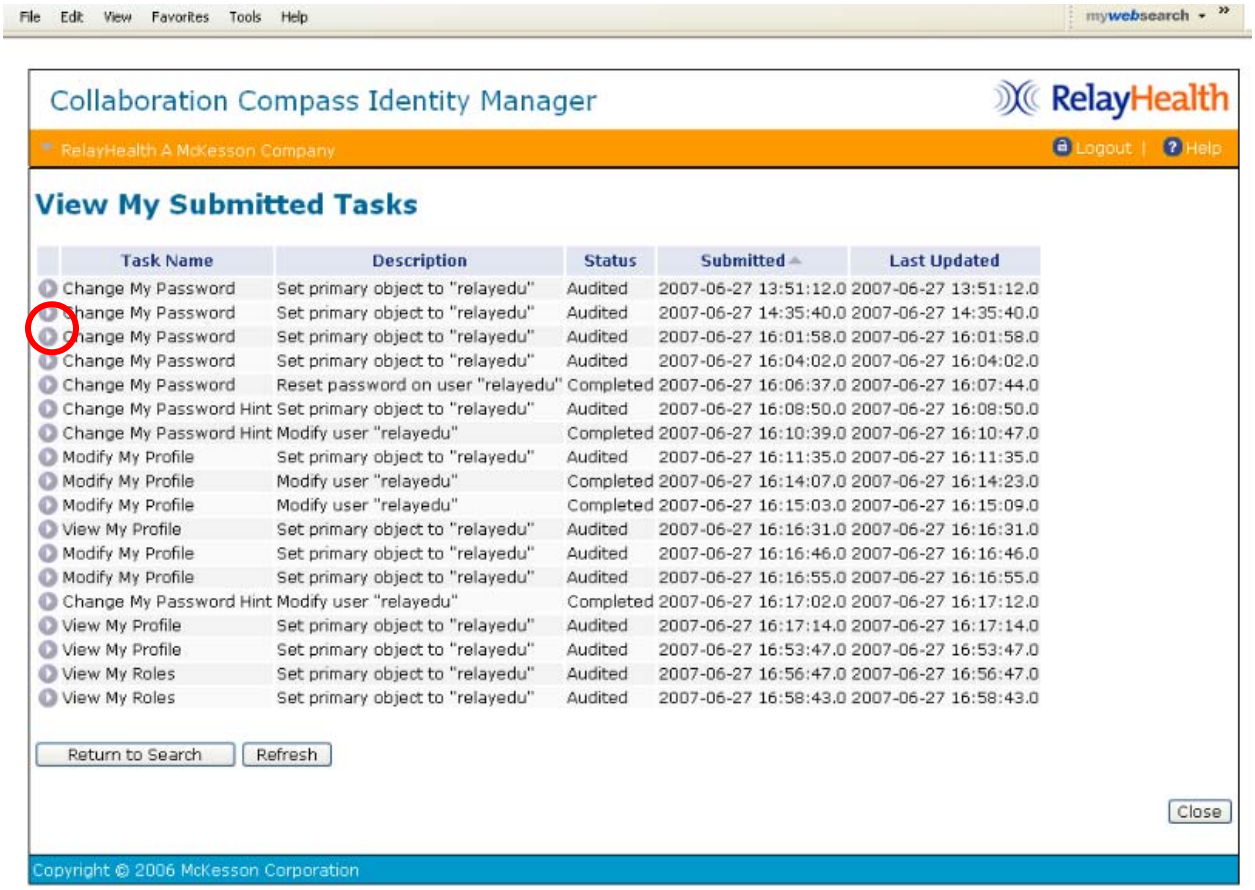
1. Click **View My Submitted Tasks**.



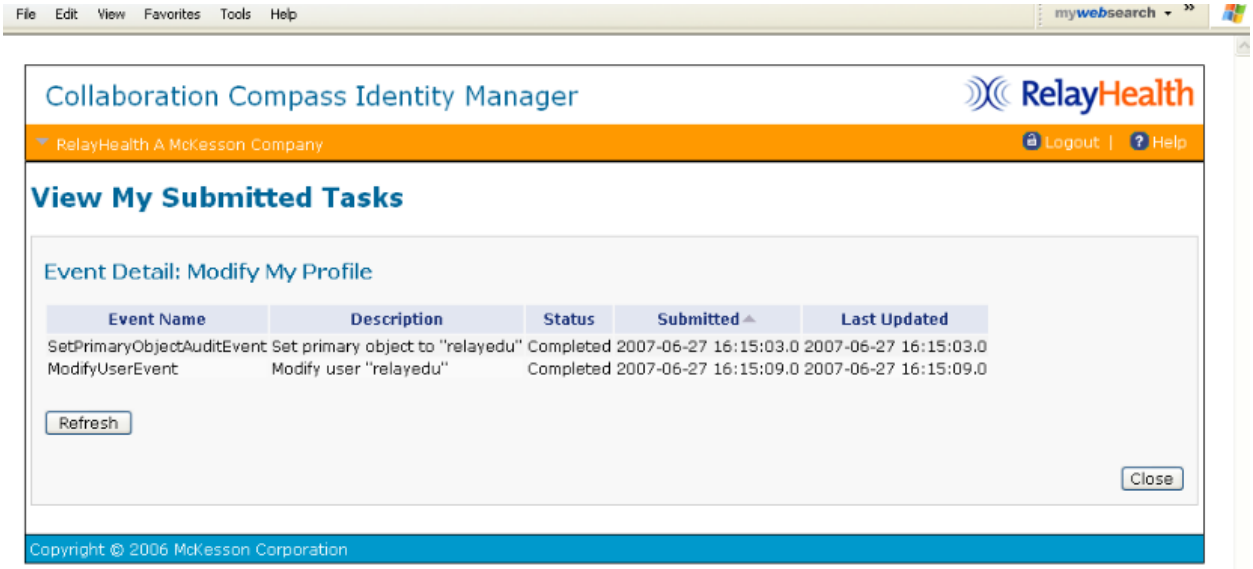
2. Enter search criteria.
3. Click **Search**.



4. Click the **Edit** icon to view the desired task.



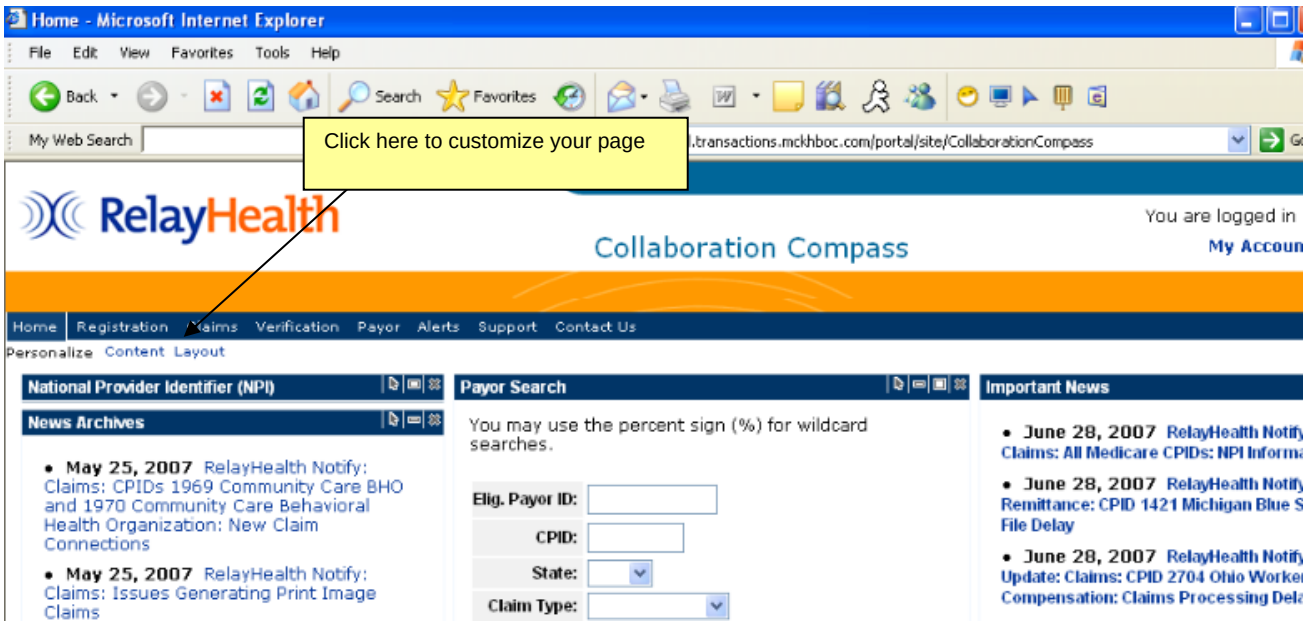
Note: Users will see Completed or Audited in the Status column for each task. Completed tasks are changes submitted to the application and completed. Audited tasks were viewed but no change was submitted. An audit entry is inserted each time an item is viewed.



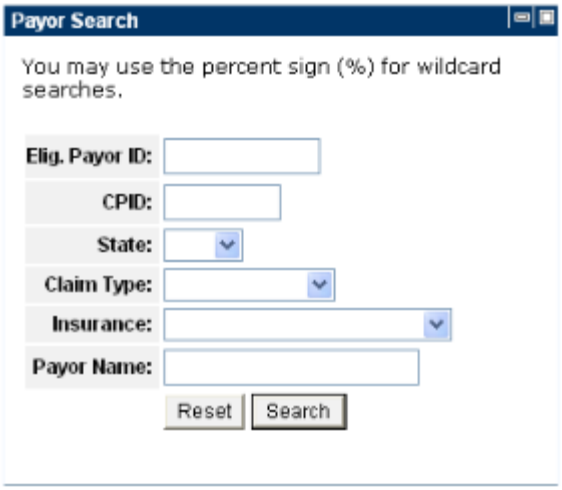
5. Click **Close** to return to the Identity Manager home page.

Customizing Your Pages

You have the ability to customize the content and layout of your Home page. On other pages, you have the ability to minimize and maximize portlets.



The following is an example of what is meant by a portlet:

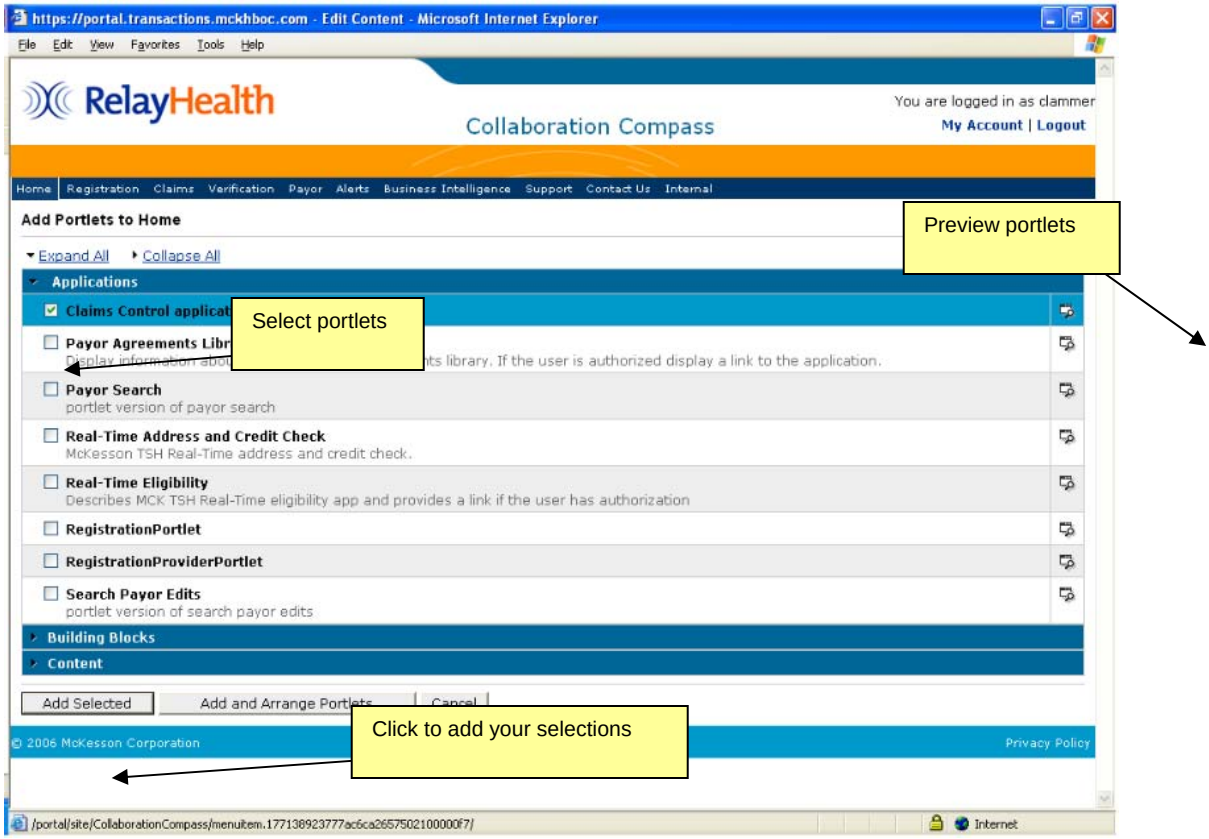


Adding Content

To add content to your Home page, complete the following steps:

Main Path

1. Click the **Content** link at the top left of the page.
2. Select the portlets you wish to add to your page by clicking the check box for each portlet.
3. Click the **Add Selected** or **Add and Arrange Portlets** button.



The following describes each of the elements found on the Add Content page:

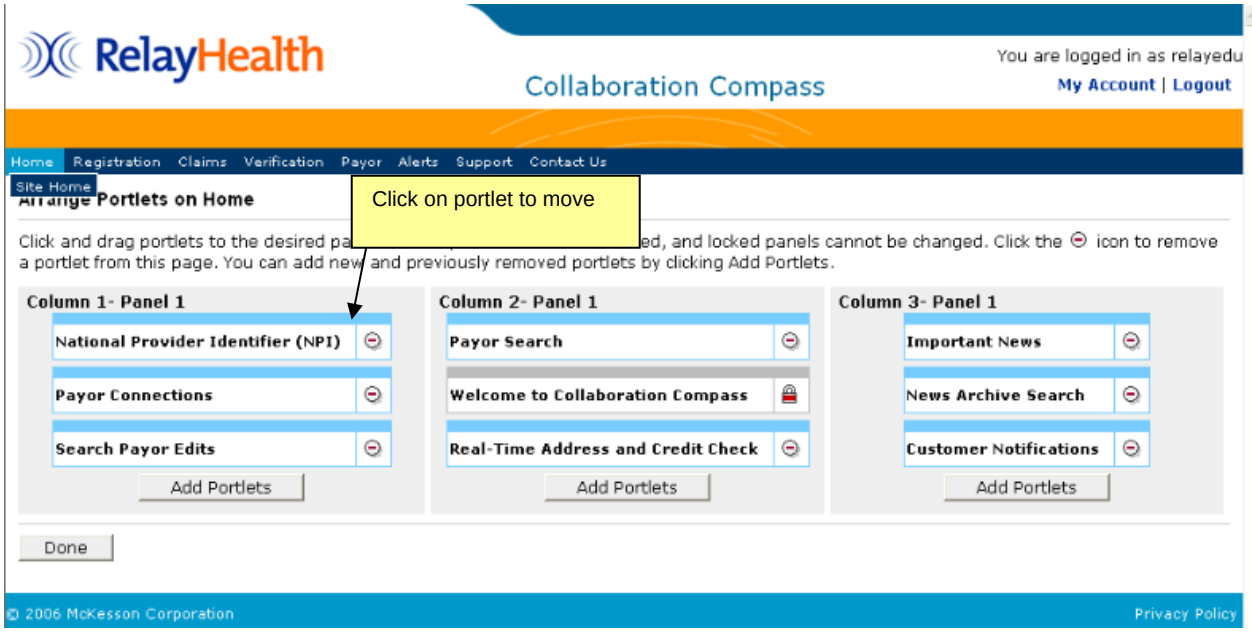
Expand All	Clicking this link expands all sections to display all portlets.
Collapse All	Clicking this link collapses all sections and only the section headings will appear.
Preview Icon	Clicking this icon displays a preview of the content of that portlet.
Portlet List	Each portlet contains a description of the portlet and a check box for selection.
Add Selected	Clicking this button displays either your Home page or the Applications page with the selected portlets added to the page.
Add and Arrange Portlets	Clicking this button displays adds the selected portlets and displays the Layout page.

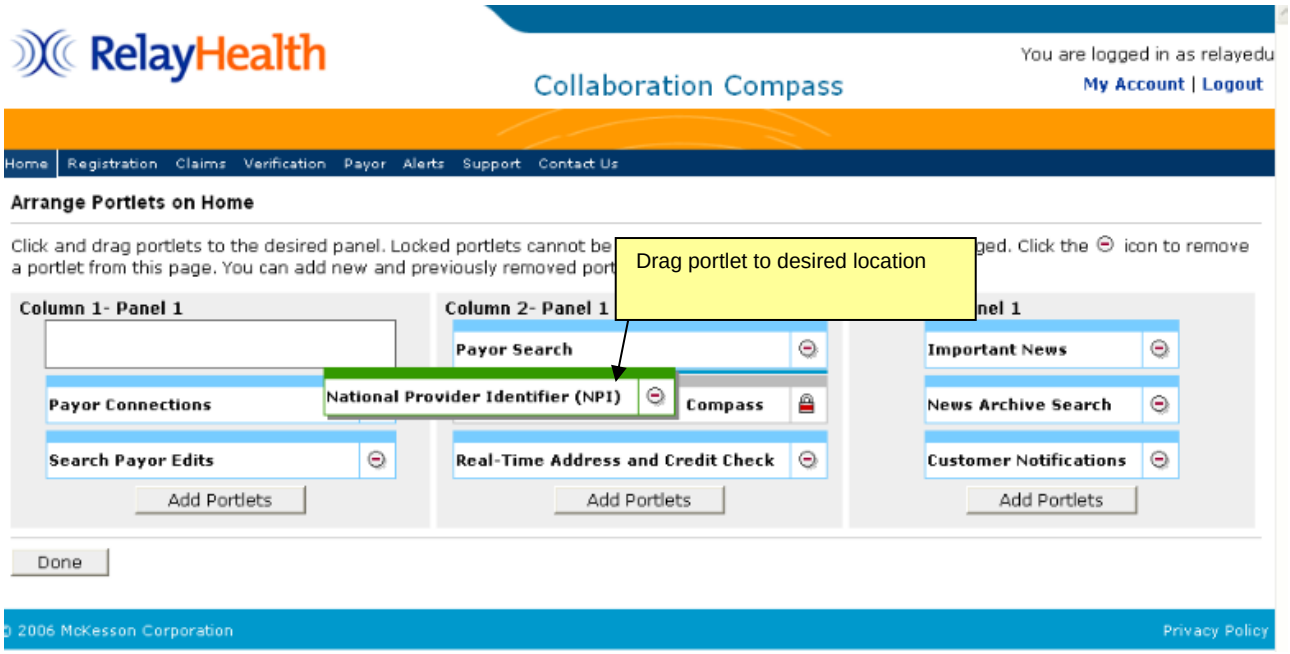
Layout

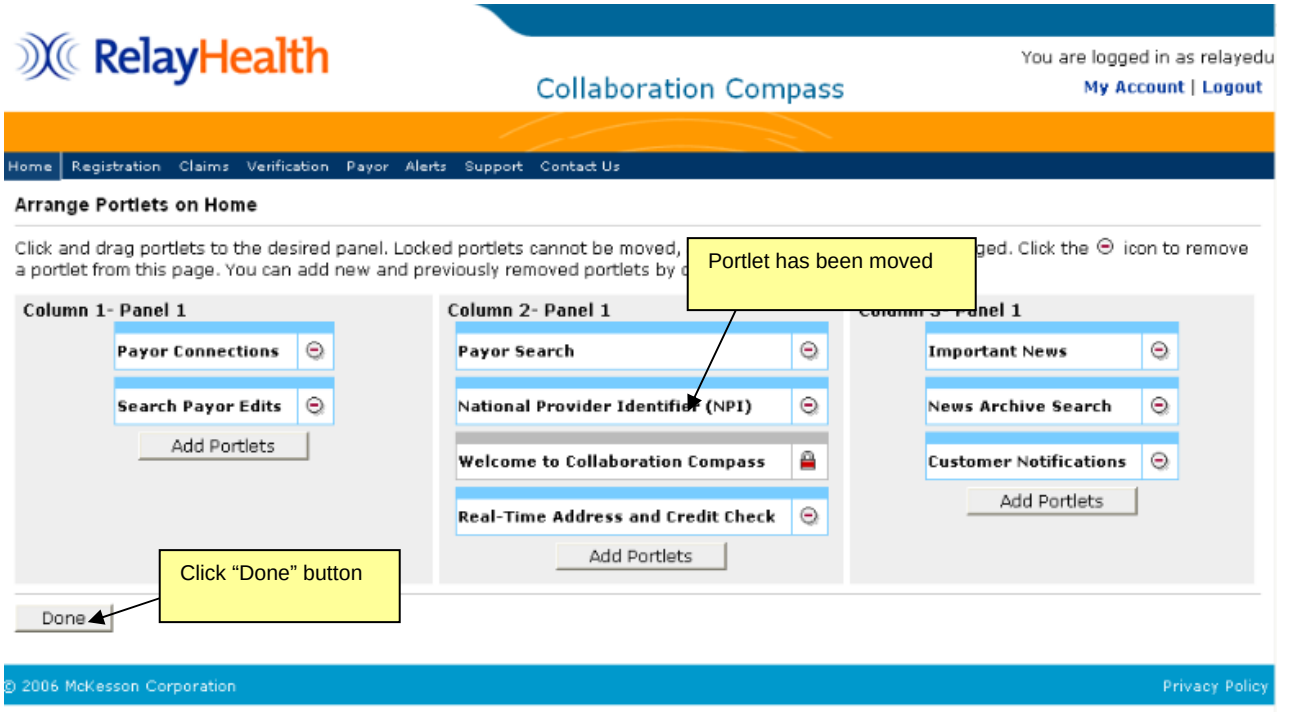
To arrange the layout of portlets on your Home page, complete the following steps:

Main Path

1. Click the **Layout** link at the top left of the page.
2. Click on the portlet you would like to move and drag it to the desired location.
3. Click the **Done** button.

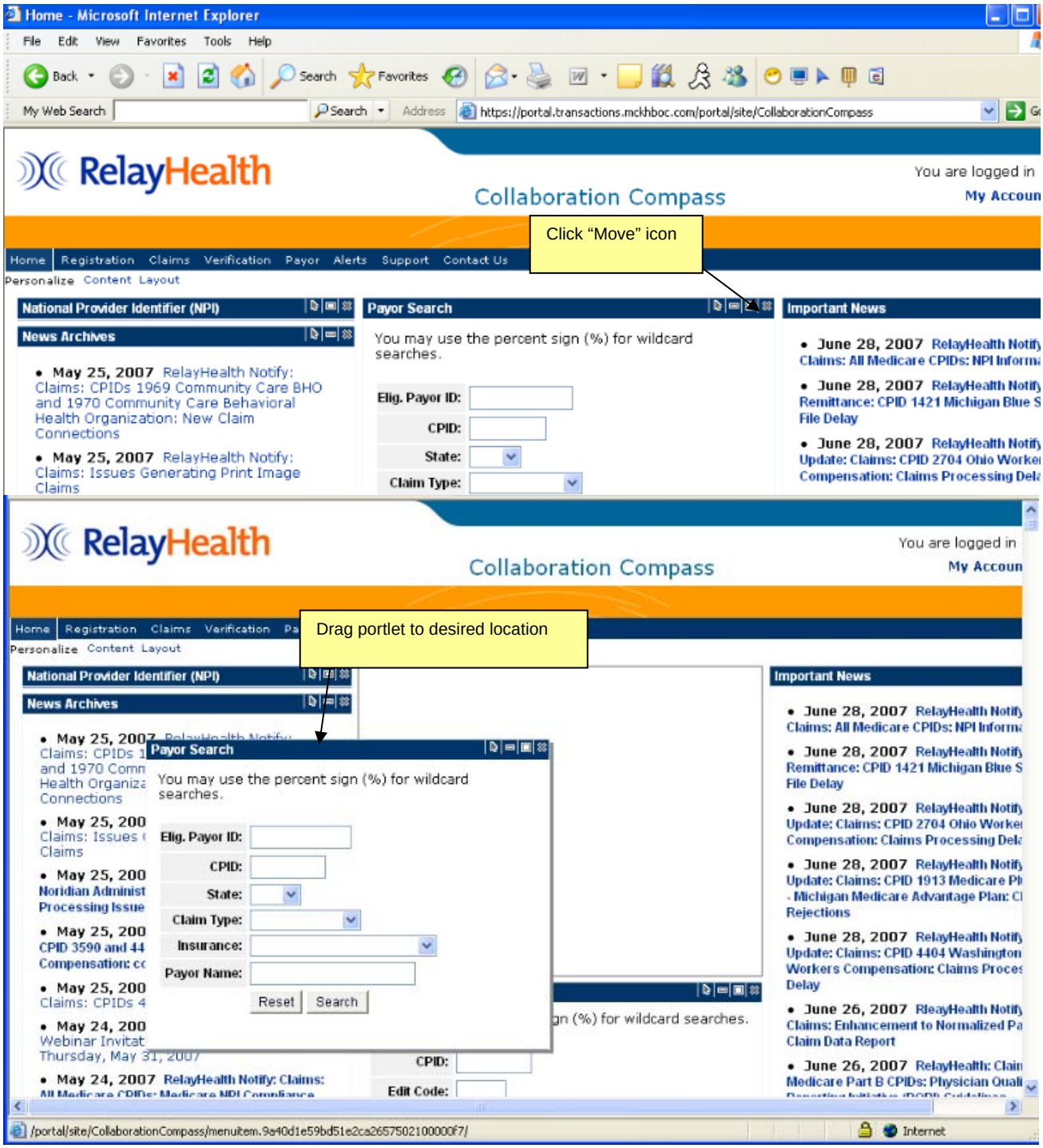


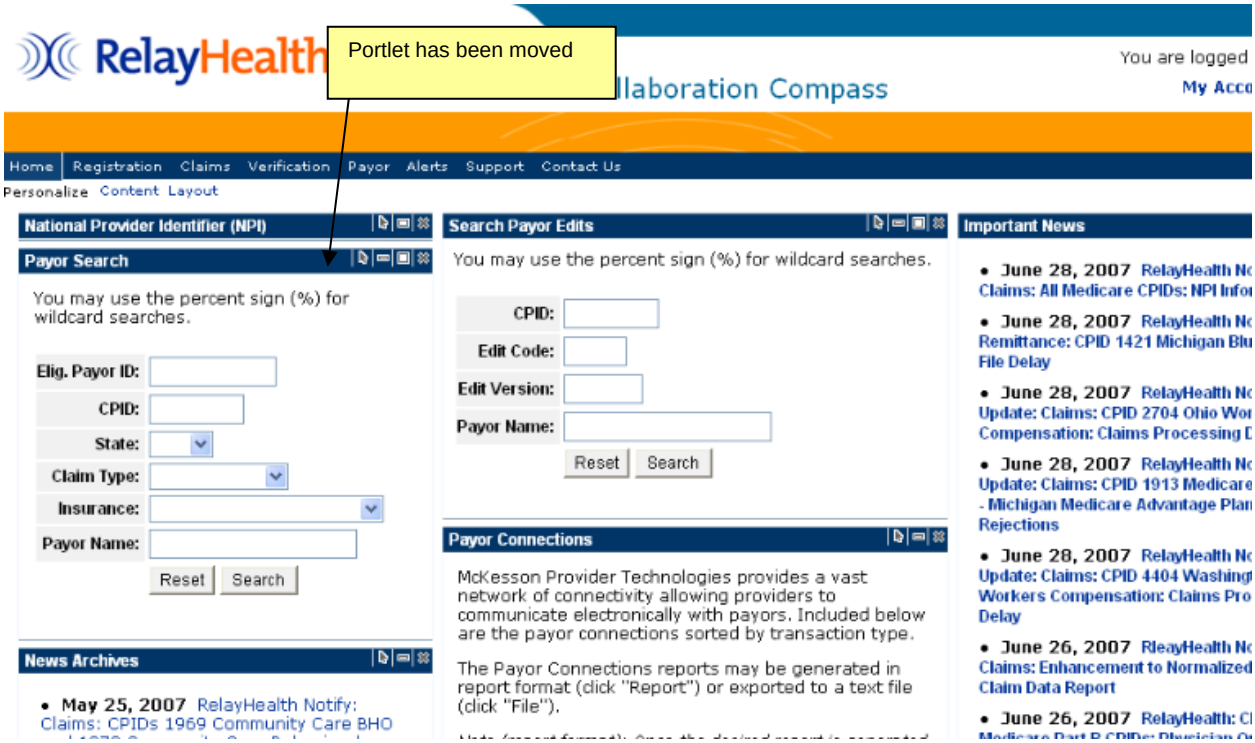




Alternate Path

- On your Home page, click the **Move** icon for the portlet you wish to move and drag it to the desired location.


Home - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites
My Web Search Search Address https://portal.transactions.mckhboc.com/portal/site/CollaborationCompass
RelayHealth
Collaboration Compass
You are logged in
My Accoun
Click “Move” icon
Home Registration Claims Verification Payor Alerts Support Contact Us
Personalize Content Layout
National Provider Identifier (NPI)
News Archives
Payor Search
You may use the percent sign (%) for wildcard searches.
Elig. Payor ID:
CPID:
State:
Claim Type:
Important News
May 25, 2007 RelayHealth Notify: Claims: CPIDs 1969 Community Care BHO and 1970 Community Care Behavioral Health Organization: New Claim Connections
May 25, 2007 RelayHealth Notify: Claims: Issues Generating Print Image Claims
June 28, 2007 RelayHealth Notify Claims: All Medicare CPIDs: NPI Informa
June 28, 2007 RelayHealth Notify Remittance: CPID 1421 Michigan Blue S File Delay
June 28, 2007 RelayHealth Notify Update: Claims: CPID 2704 Ohio Worke Compensation: Claims Processing Dela
RelayHealth
Collaboration Compass
You are logged in
My Accoun
Drag portlet to desired location
Home Registration Claims Verification
Personalize Content Layout
National Provider Identifier (NPI)
News Archives
Payor Search
You may use the percent sign (%) for wildcard searches.
Elig. Payor ID:
CPID:
State:
Claim Type:
Insurance:
Payor Name:
Reset
Search
Important News
June 28, 2007 RelayHealth Notify Claims: All Medicare CPIDs: NPI Informa
June 28, 2007 RelayHealth Notify Remittance: CPID 1421 Michigan Blue S File Delay
June 28, 2007 RelayHealth Notify Update: Claims: CPID 2704 Ohio Worke Compensation: Claims Processing Dela
June 28, 2007 RelayHealth Notify Update: Claims: CPID 1913 Medicare Ph - Michigan Medicare Advantage Plan: Cl Rejections
June 28, 2007 RelayHealth Notify Update: Claims: CPID 4404 Washington Workers Compensation: Claims Proces Delay
June 26, 2007 RleayHealth Notify Claims: Enhancement to Normalized Pa Claim Data Report
June 26, 2007 RelayHealth: Clain Medicare Part B CPIDs: Physician Quali
May 24, 2007 RelayHealth Notify: Claims:
CPID:
Edit Code:
/portal/site/CollaborationCompass/menuitem.9a40d1e59bd51e2ca2657502100000f7/
Internet

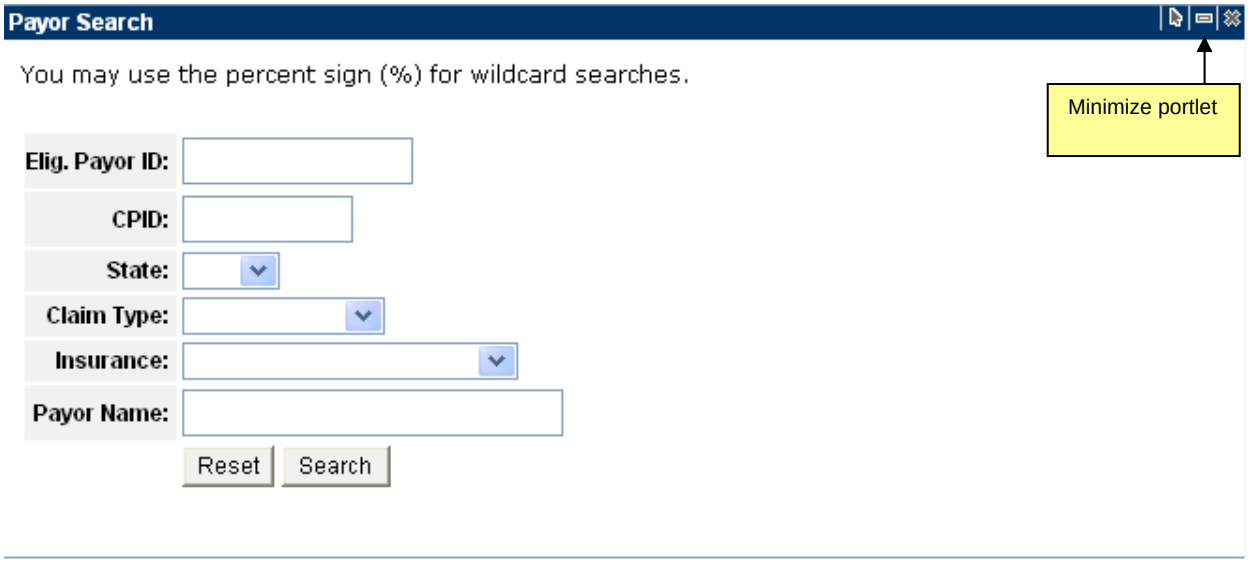


The following describes each of the elements found on the Layout page:

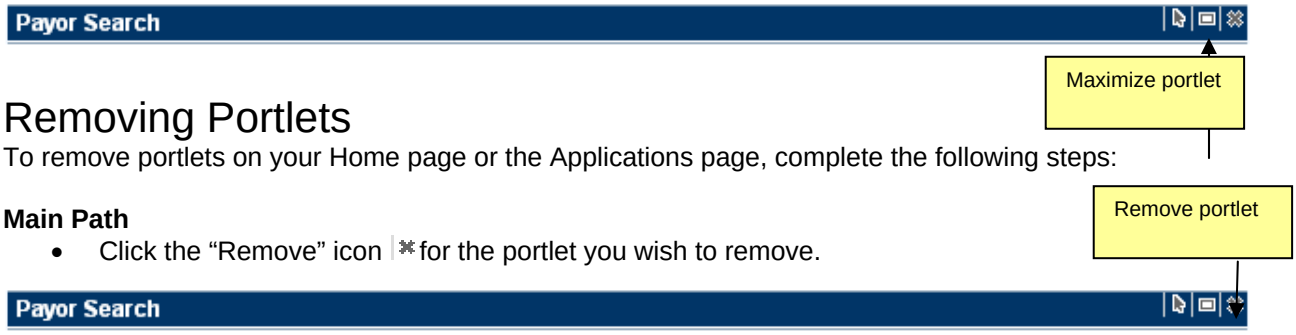
Instructional Text	Gives instruction on arranging portlets on a page.
Portlet	Each portlet will be displayed in it's location on the page. Clicking on the portlet will allow you to drag it to a new location on the page.
Remove Icon	Clicking this icon removes the portlet from the page.
Portlet List	Each portlet contains a description of the portlet and a check box for selection.
Add Portlets	Clicking this button displays the Add Content page.
Done	Clicking this button displays either your Home page or the Applications page with your layout changes.

Minimizing/Maximizing Portlets

Minimizing a portlet will collapse the portlet and only display the header bar. To minimize a portlet, click the minimize icon.



Maximizing a portlet will restore the portlet to its normal size. To maximize a portlet, click the maximize icon. The maximize icon will only appear when a portlet is minimized.



Removing Portlets

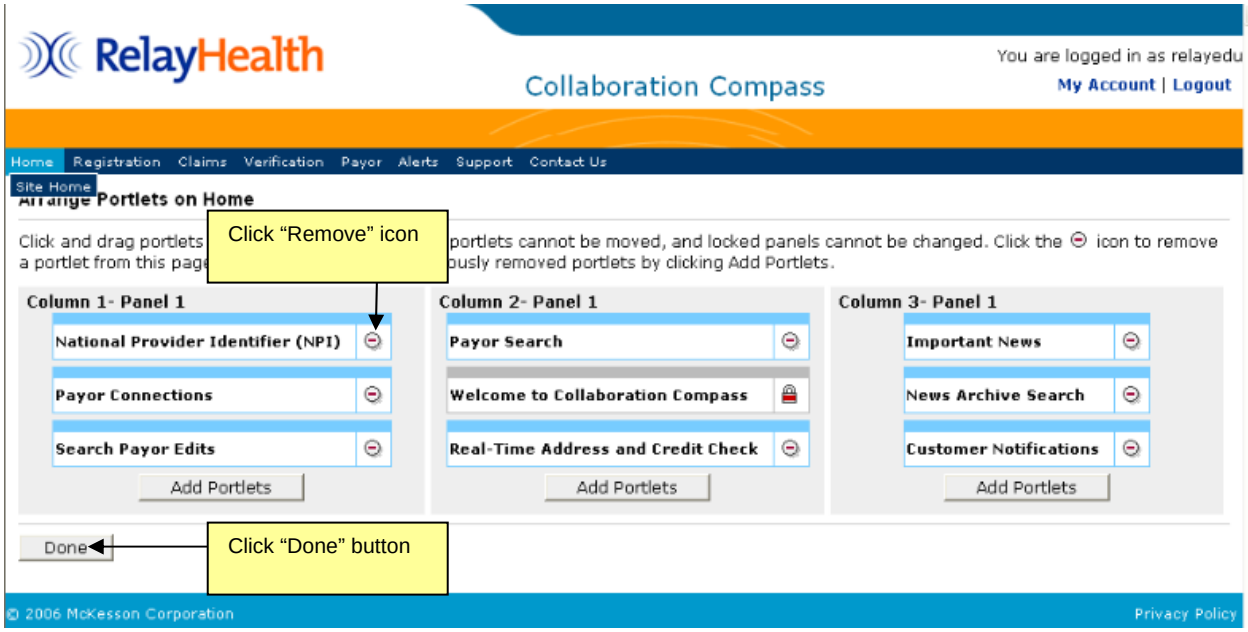
To remove portlets on your Home page or the Applications page, complete the following steps:

Main Path

- Click the "Remove" icon for the portlet you wish to remove.

Alternate Path

1. Click the **Layout** link at the top left of the page.
2. Click the **Remove** icon on the Layout page.
3. Click the **Done** button.



Home

Your Home page will contain whatever portlets you choose to appear on the page. You can have as many portlets as you wish on the page and arrange them in the layout of your choice.

Site Home

The Site Home page contains a description of the Transaction Services and the services provided.

Registration

From the Registrations item on the navigation menu, the following information is displayed:

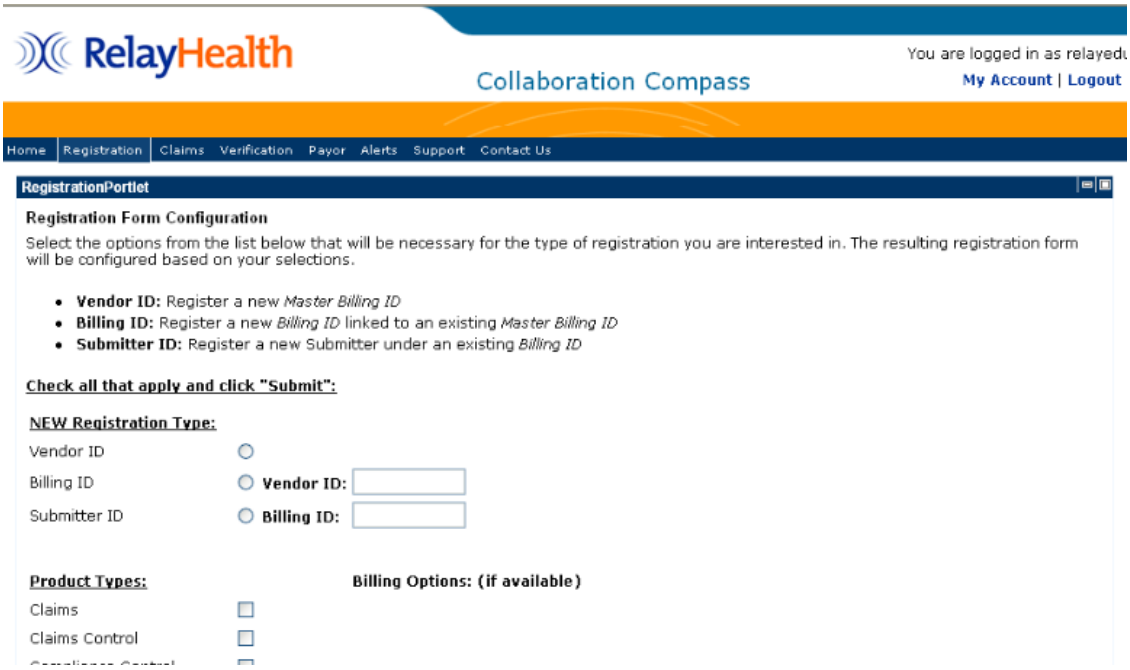
- Enrollment Services
- Enrollment Tools - Contains helpful documents regarding the Payor Agreement Library and the Online Viewer for Payor Agreements.

User(s)

From the Registration item on the navigation bar, hover over Registration and click **User(s)** to begin registration of additional users. This will display the User Registration form covered previously.

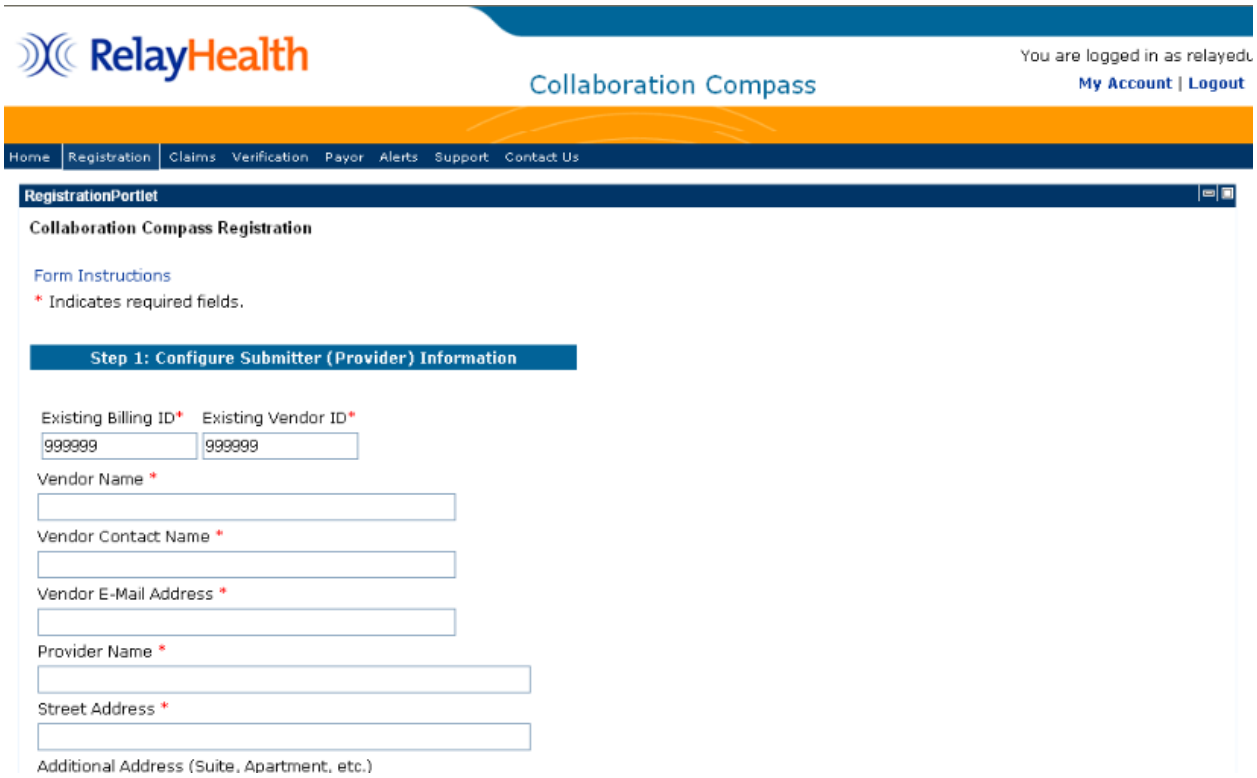
Submitter(s)

From the Registration item on the navigation bar, hover over Registration and click **Submitter(s)** to begin registration of submitters. This will display the Submitter Registration form seen below.



The following describes each of the elements found on the Submitter(s) Registration page:

Instructional Text	Gives instruction on submitter registration.
Function List	Contains a list of functions that you can request access to. Select all that apply.
Reset	Clicking this button clears any selections made.
Submit	Clicking this button displays the Registration Form(s) for the functions selected.

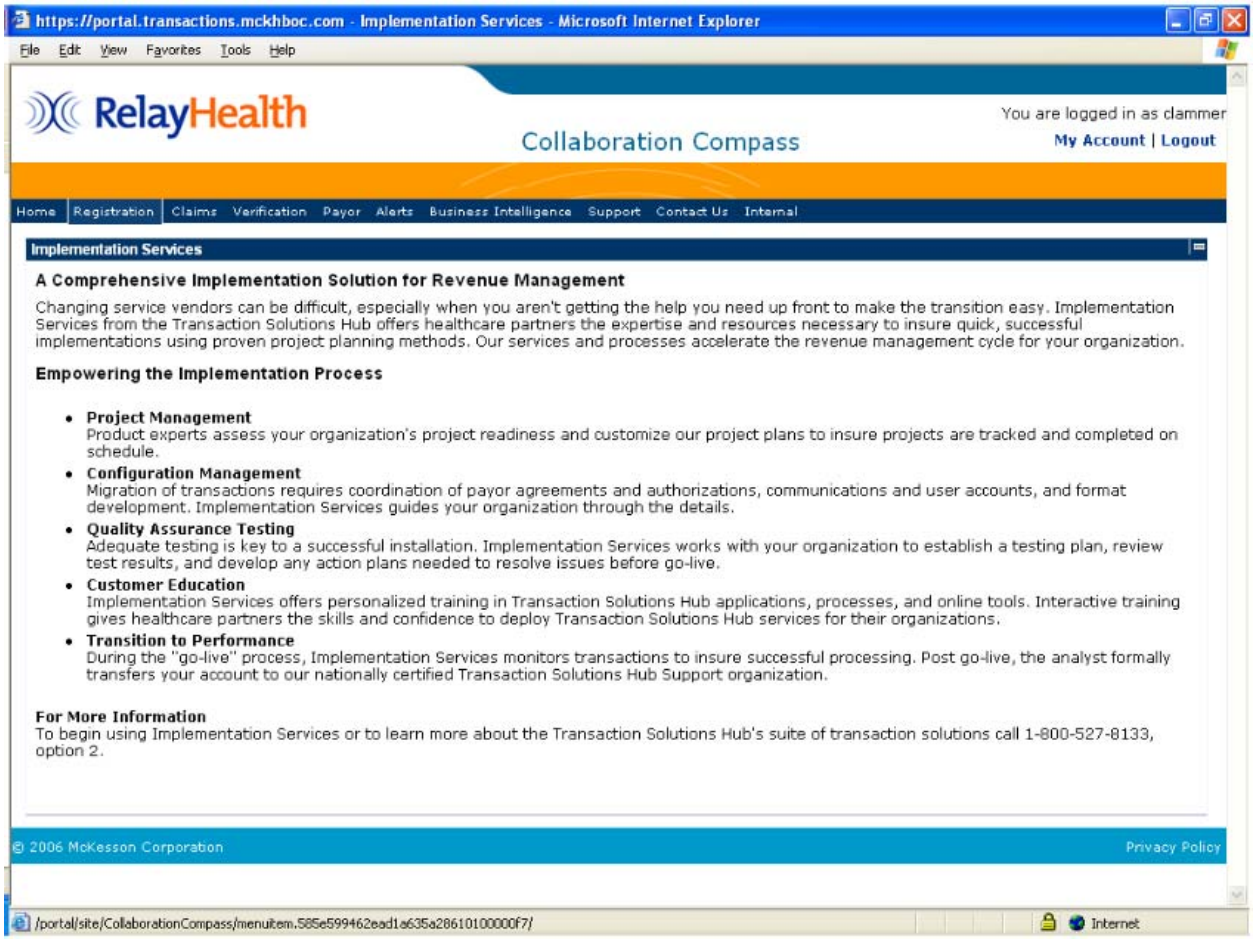


The following describes each of the elements found on the Submitter(s) Registration Form:

Form Instructions link	Displays the Registration Form Instructions in a new window.
Various Registration Fields	The fields that appear depend on the functions selected on the Submitter(s) Registration page.
Reset	Clicking this button clears all fields.
Submit	Clicking this button submits your registration.

Implementations

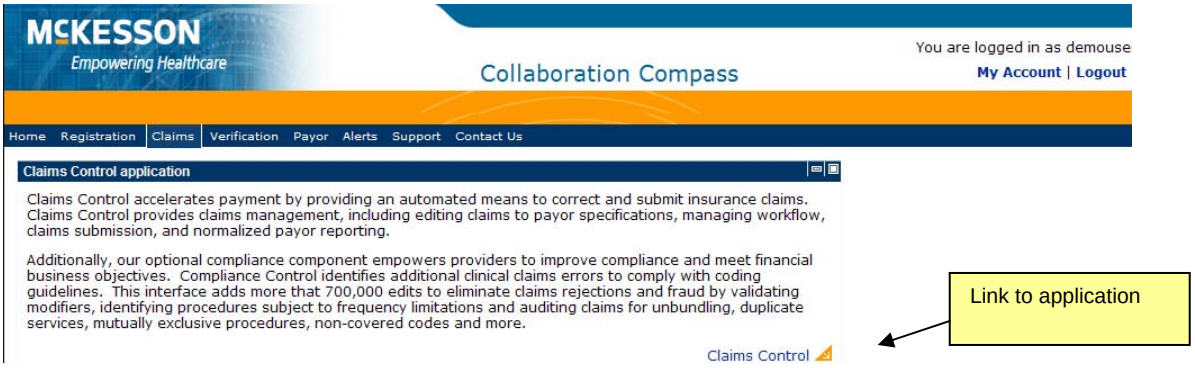
Implementation Services can be found under the Registration navigation item. Implementation Services describes the services and processes used to accelerate the revenue management cycle for your organization.



Claims

Claims Control

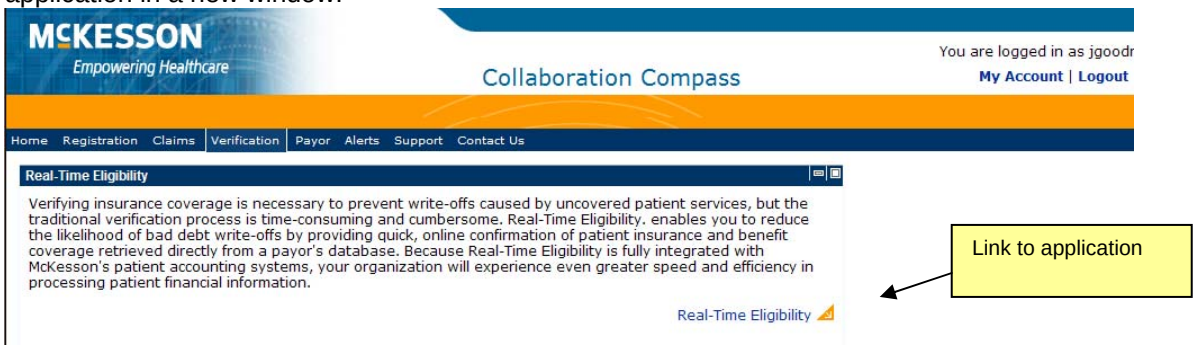
The Claims Control page displays a portlet with a description of the Claims Control application and if the user has the appropriate permissions, a link to the application is displayed. Clicking the link will open the application in a new window.



Verification

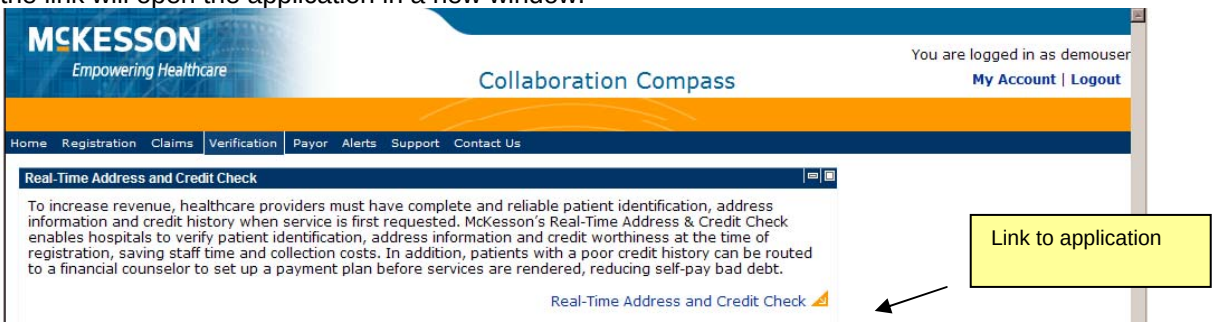
Eligibility

The Eligibility page displays a portlet with a description of the Real-Time Eligibility application and if the user has the appropriate permissions, a link to the application is displayed. Clicking the link will open the application in a new window.



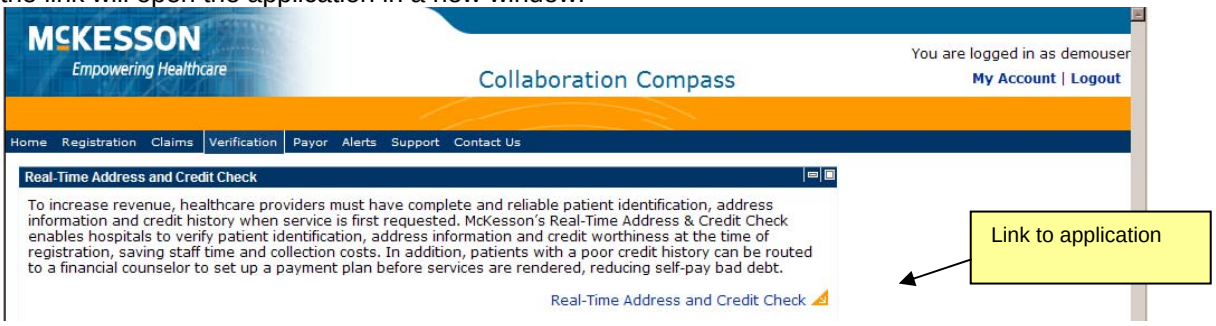
Address Check

The Address Check page displays a portlet with a description of the Real-Time Address and Credit Check application and if the user has the appropriate permissions, a link to the application is displayed. Clicking the link will open the application in a new window.



Credit Check

The Credit Check page displays a portlet with a description of the Real-Time Address and Credit Check application and if the user has the appropriate permissions, a link to the application is displayed. Clicking the link will open the application in a new window.



Payor

Payor Agreements

The Payor Agreements page displays a portlet with a description of the Payor Agreements Library application and if the user has the appropriate permissions, a link to the application is displayed. Clicking the link will open the application in a new window.

For more information on accessing, selecting, and completing various payor agreements, see the chapter, Using the Payor Agreement Library.

Alerts

What's New

To display the important news items and all customer notifications, choose the What's New item under the Alerts navigation item.

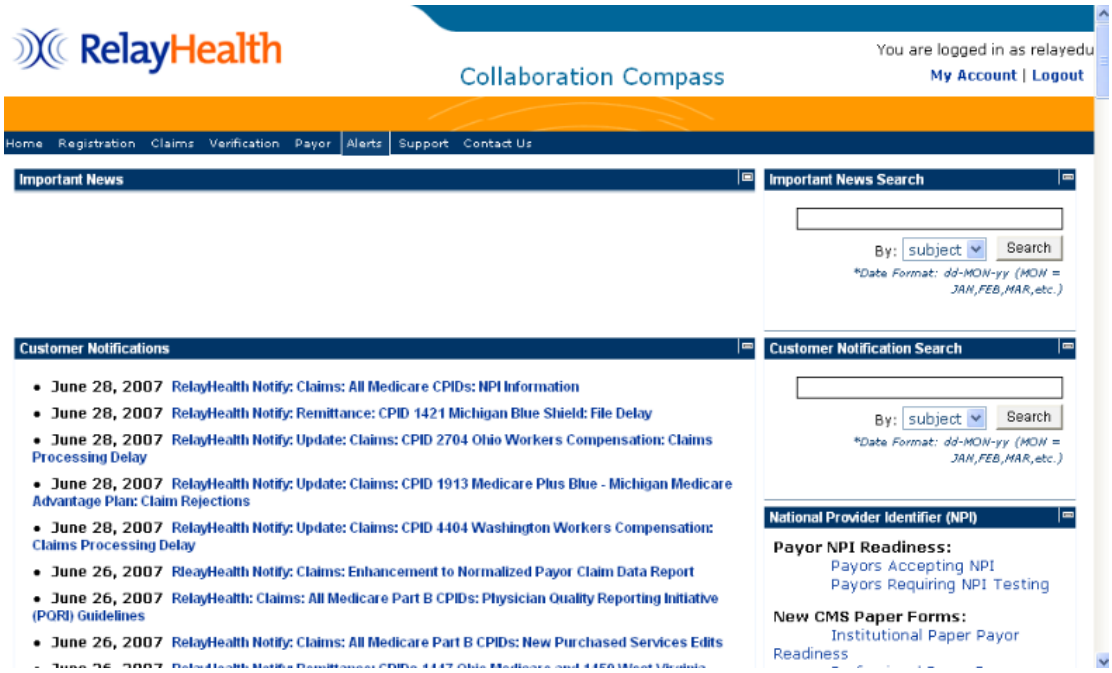
The What's New page contains the following information:

- Important News
- Important News Search

  To perform an Important News search, enter the criteria of your choice and click the **Search** button. The results of the search are displayed in a new window.

- Customer Notifications
- Customer Notification Search

  To perform a Customer Notification search, enter the criteria of your choice and click the **Search** button. The results of the search are displayed in a new window.



News Archive

To find past postings of customer notifications, click on the News Archive option under the Alerts item on the navigation menu.

The News Archive page contains the following information:

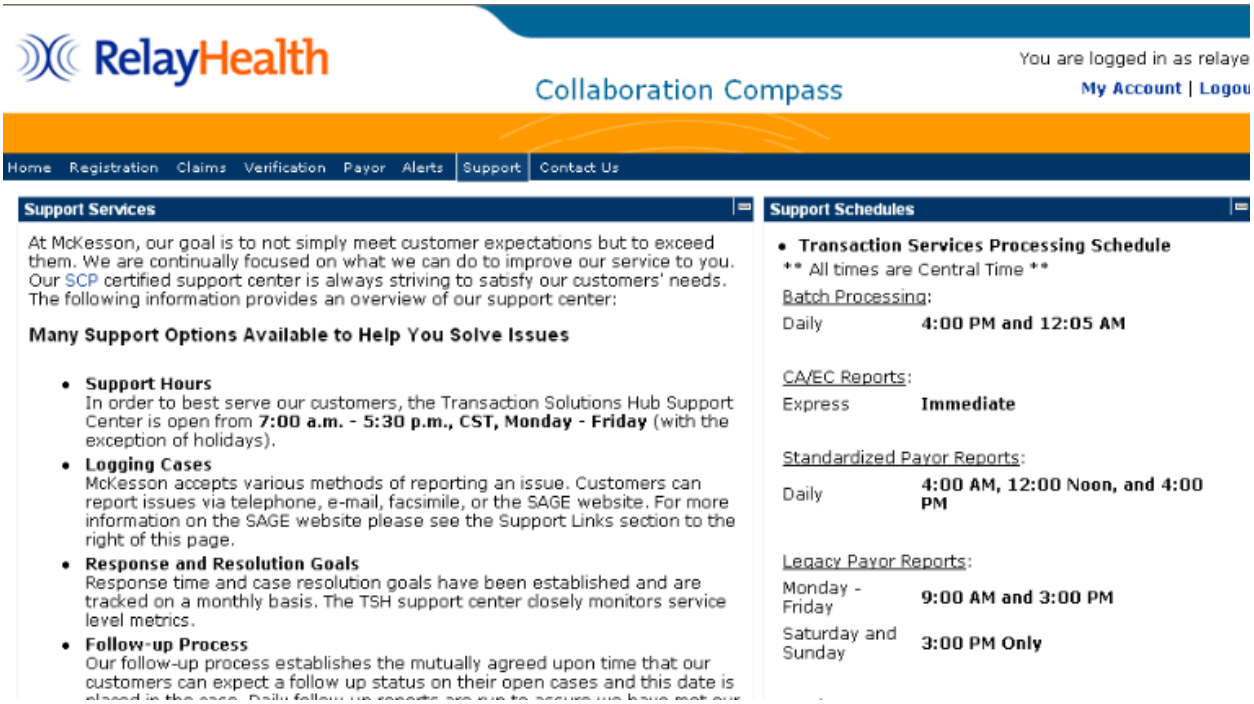
- News Archives
- News Archive Search

To perform a News Archive search, enter the criteria of your choice and click the **Search** button. The results of the search are displayed in a new window.

Support

To display the main Support page, click on the Support item on the navigation bar. The main Support page contains the following information:

- Support Services
- Support Schedules
- Case Standards
- Support Links



Payor

From the Support item on the navigation bar, click on the Payor option to display the Payor page. The Payor page contains the following information:

- Payor Connections

  Payor connections for existing and new professional and institutional claims (state and commercial) are accessible. Remittances, eligibility, upcoming formats, and ANSI formatted payors are also available.

  The payor connections reports may be generated in an online, report format (click **Report**) or exported to a text file (click **File**).

- Payor Search

  The Payor Search utility pulls together all of the payor information (edits, agreement requirements, guides, etc.) available on RelayHealth web site into a comprehensive payor data resource.

  To perform a Payor Search, enter the criteria of your choice and click the **Search** button. The results of the search are displayed in a new window. To clear all criteria fields, click the **Reset** button.

- Search Payor Edits

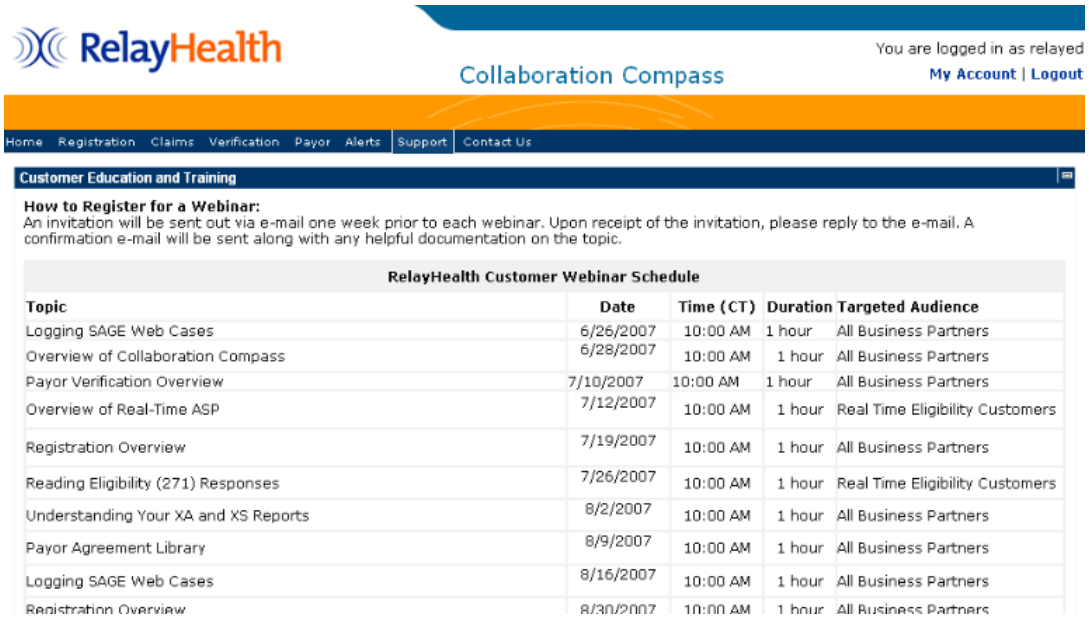
  The Payor Edits utility allows users to view ANSI payor-specific edits for any payors that currently have connections with RelayHealth and receive an ANSI claim file.

  To search Payor Edits, enter the criteria of your choice and click the **Search** button. The results of the search are displayed in a new window. To clear all criteria fields, click the **Reset** button.

Customer Education/Training

From the Support item on the navigation bar, click the Customer Education/Training option to display the Customer Education and Training page.

RelayHealth offers webinar training for clients on various topics. The Customer Education and Training page contains information about webinars and a list of upcoming webinars.



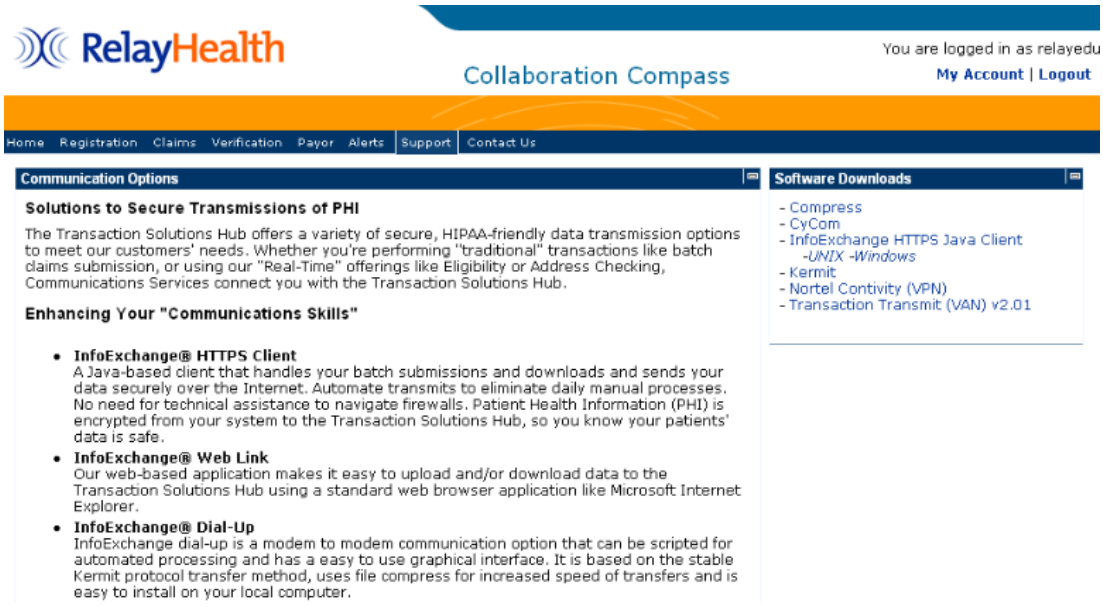
Communication Options

From the Support item on the navigation bar, click on the Communication Options option to display the Communication Options page.

RelayHealth offers a variety of secure, HIPAA-friendly data transmission options to meet our customers' needs. Whether you're performing traditional transactions like batch claims submission, or using our real-time offerings like Eligibility or Address and Credit, our communications services connect you with RelayHealth.

The Communication Options page contains the following information:

- Communication Options
- Software Downloads



Documentation

From the Support item on the navigation bar, click the Documentation item to display the Documentation page. The Documentation page contains the following information:

- Frequently Asked Questions

  Get most of your Frequently Asked Questions answered here. Please feel free to e-mail us with any additional questions that would be beneficial.

- EDI Specifications

  There are four extremely valuable tools to enable successful electronic data exchange to RelayHealth.

Contact Us

From the main navigation menu, click the Contact Us item to contact RelayHealth support regarding enrollment, testing, or support issues.

Using the Payor Agreement Library

Introduction

The purpose of this chapter is to provide instruction to users of the Payor Agreement Library.

Application Prerequisites

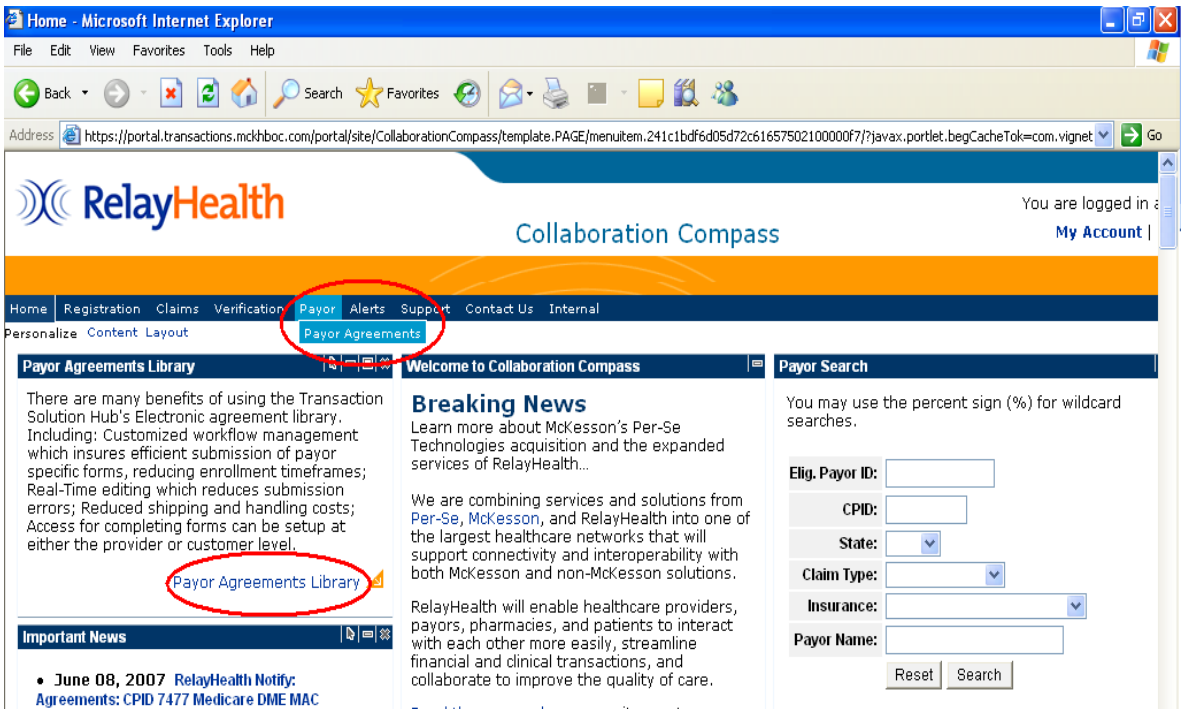
Each RelayHealth customer must designate a Master Customer User Manager. The Master Customer User Manager sets up any users at their facility needing access to the Payor Agreement Library.

Adobe Reader 7.0 or higher must be installed on all machines used by Agreement Users.

Accessing the Payor Agreement Library

To access the Payor Agreement Library, users will need to be logged into Collaboration Compass™. Access Collaboration Compass™ with the following url: http://www.collaborationcompass.com/

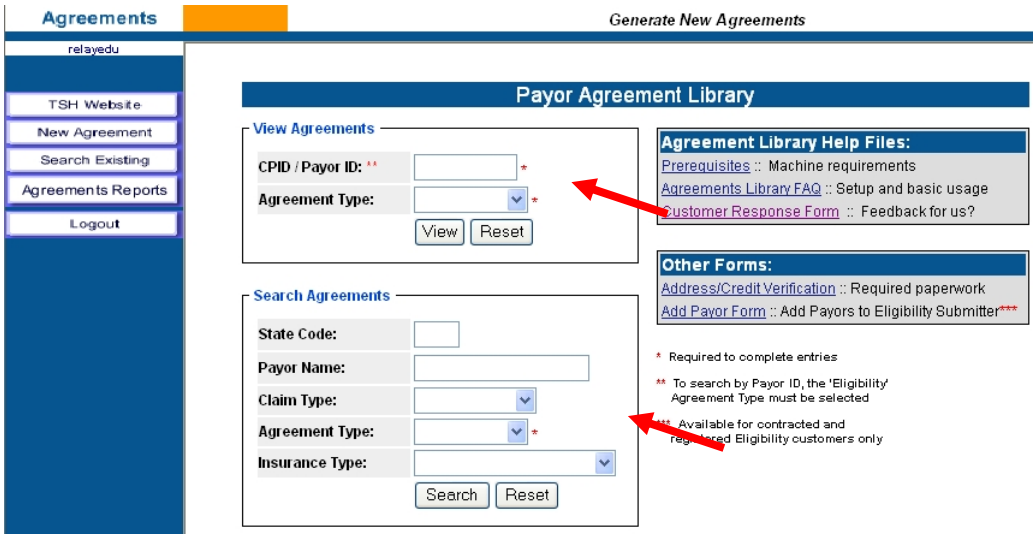
1. Login to Collaboration Compass™ by clicking **Login**
2. Enter the appropriate **User ID** and **password**; click **Login**.
3. Select the link to the **Payor Agreement Library** under the **Payor** menu.
4. Another way is to add the Payor Agreement Library portlet to the homepage.



Search for an Agreement

The library may be searched in two ways:

1. If users know the correct payor CPID or Payor ID, they may search for the agreement by completing the first section and selecting the agreement type.
2. If users do not know the CPID or Payor ID, they may search for the agreement in the second section by agreement type and a payor's state, name, etc…

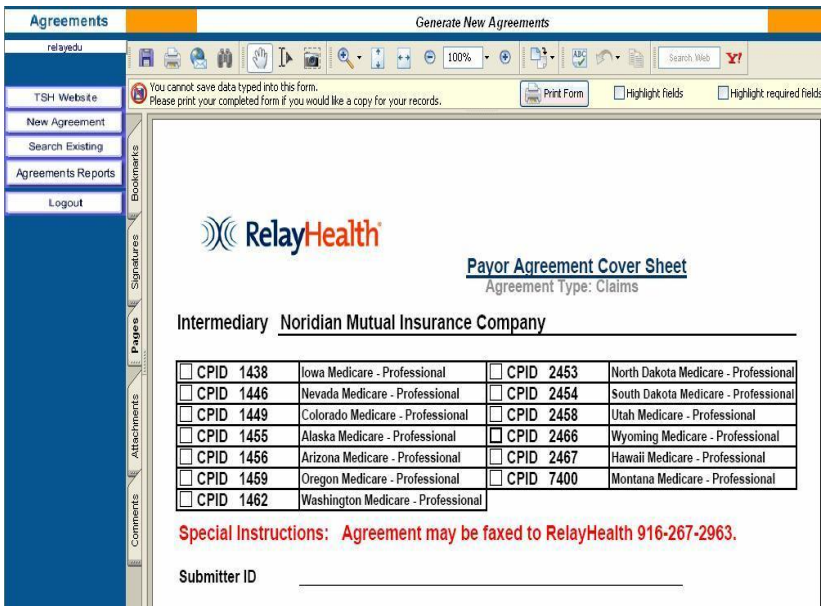


Opening the Agreement

The agreement will open within the web browser window.

If users do not have their Adobe Acrobat or Adobe Reader open, it will load before the agreement appears in the window.

The length of time required to load the agreement depends on the size of the agreement and on the speed of the user's network or internet connection.



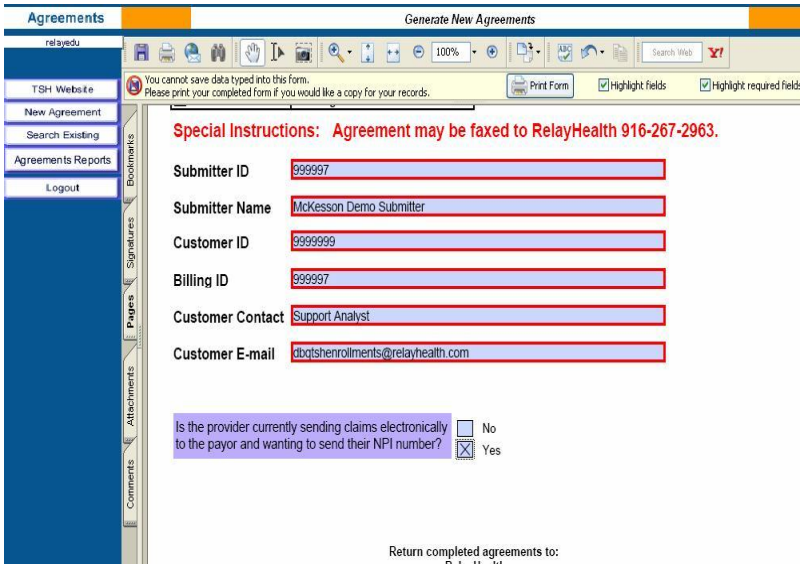
Completing the Agreement Coversheet

1. Complete the Submitter ID field.
    a. The Submitter ID must be six numerics; if the Submitter ID is shorter, prefill with zeros.
    b. Users may only submit agreements under their own Submitter number unless additional access is granted by an Administrator.
    c. Users will receive an error message if they attempt to use a Submitter ID to which they are not linked.

    After the user exits the Submitter field, the application will:

    d. Verify that users have permission to create an agreement under the Submitter ID entered.
    e. Automatically pull and prefill the Submitter ID's corresponding Name, Customer ID, and Billing ID.
    f. Move the user to the next required field, Customer Contact.
2. The Customer Contact and E-mail fields are required.
3. The E-mail field is scripted to verify a correctly formatted address.

After completing the Agreement coversheet, the user may tab or click to the next agreement field.



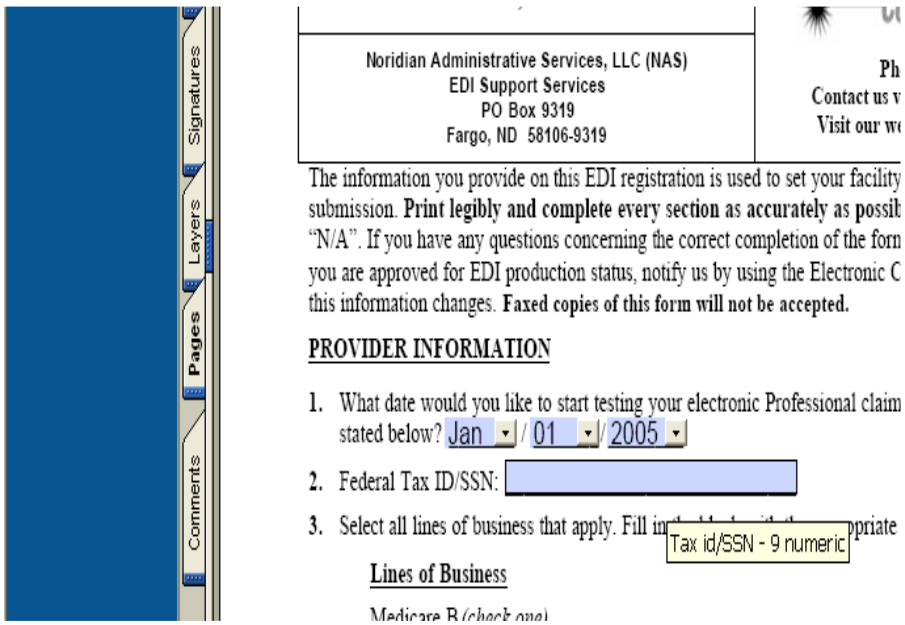
Completing the Agreement

The agreement will be populated with checkboxes, blank fields, drop down boxes, pre-filled RelayHealth information, and hints for completing the agreement.

Tool Tips

The RelayHealth Registration team has built in hints for each field to allow for easier completion. To show the hint, or tool tip, for each field, simply mouse over the field.

- If there is a specific format combination required for the field, it is noted in the tool tip.
- The tip will generally appear directly below the mouse.

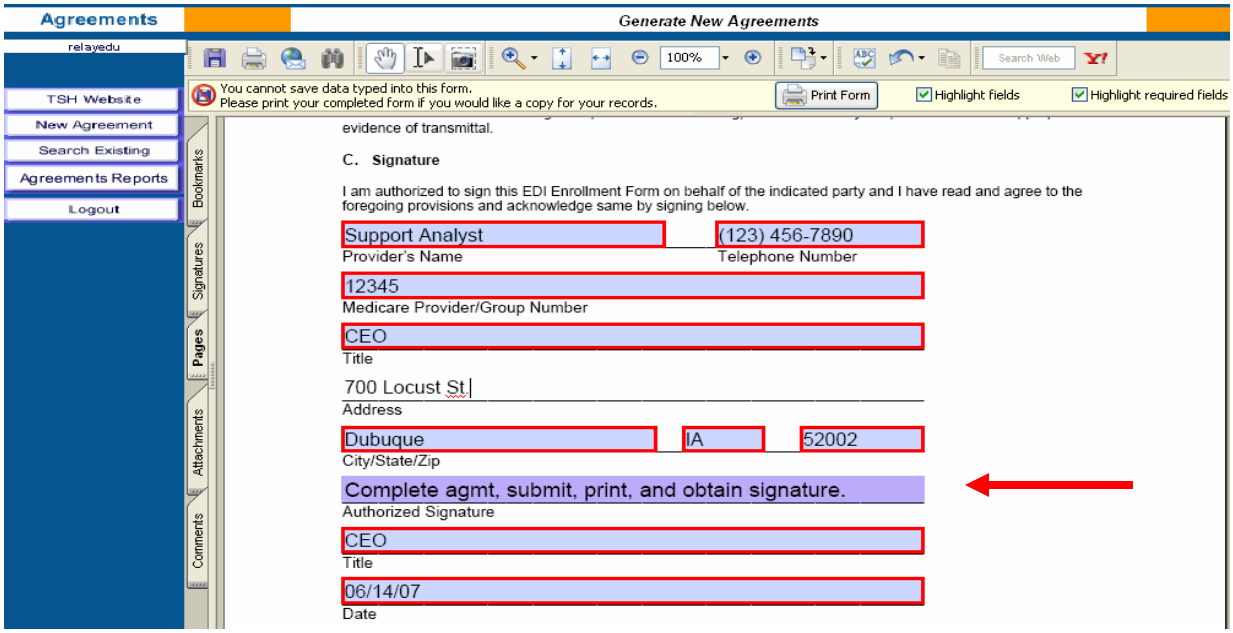


Visible but not printed fields

The RelayHealth Registration team has created specific fields with special notes.

These fields are designated by their special lavender background color.

The most common visible but not printed field notifies users when a signature is required on the agreement.

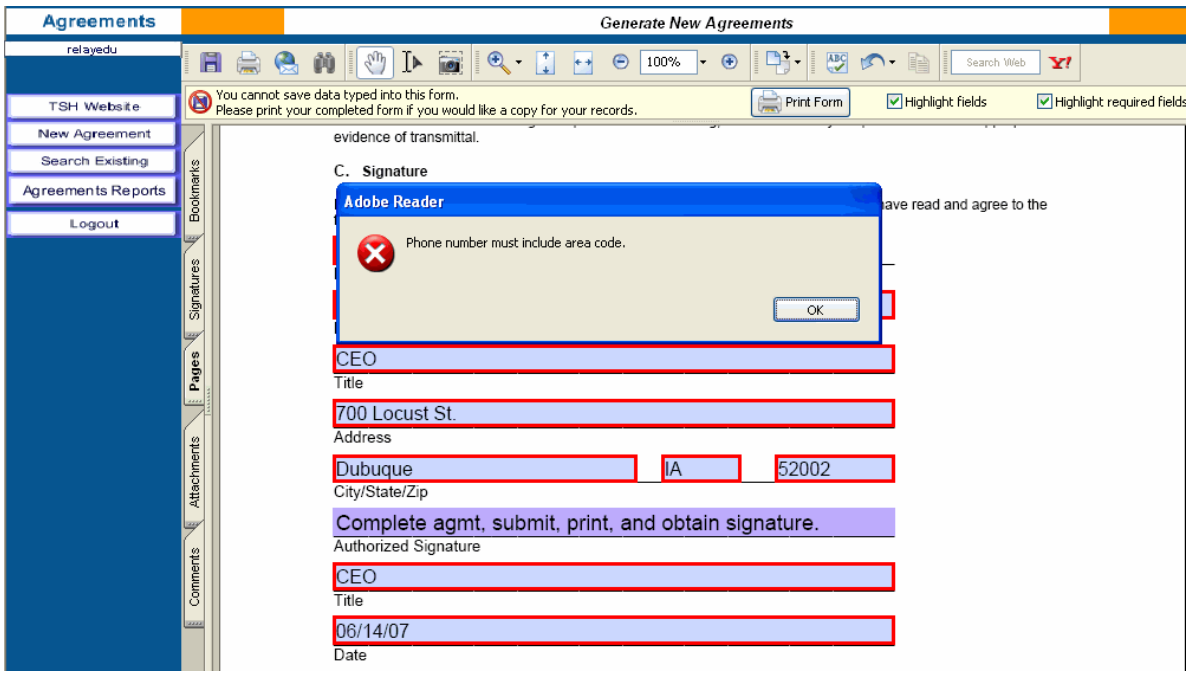


Edited Fields

All agreements have fields with built in edits. These edited fields will give the user immediate errors upon leaving the field if completed incorrectly. After pressing the OK button on the error, the application will return the user to the incorrect field for correction.

Commonly Edited Fields:

- Provider ID
- Telephone & Fax Numbers
- Email Address
- State in Provider Address
- Date
- Zip Code



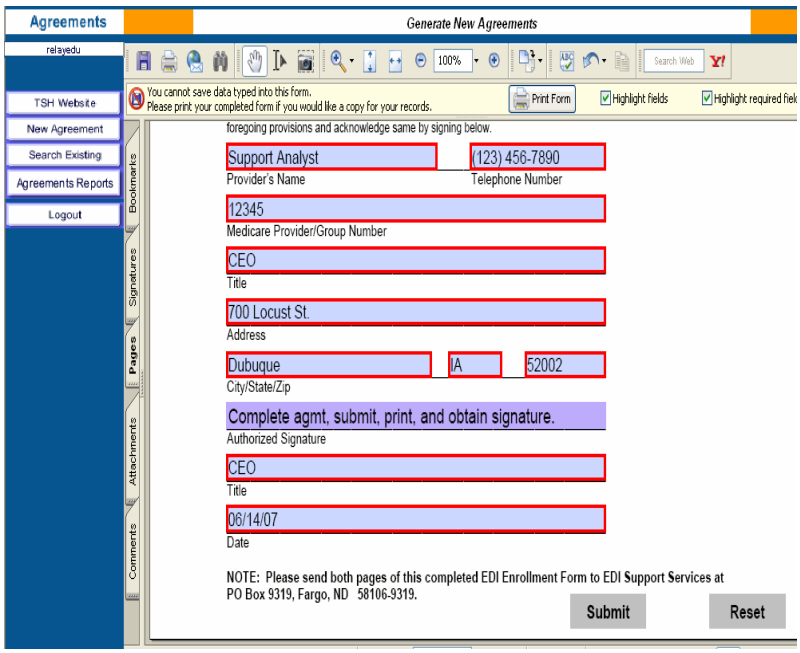
Whenever possible, the RelayHealth Registration team has pre-filled any RelayHealth information required by the payor.

Users will be unable to change any pre-filled RelayHealth information within the Agreement.

Reset/Submit Buttons

If users ever need to clear all the fields on the agreement, they may do so by going to the end of the agreement and click the Reset button. The Reset button will return all fields to their defaults, including the CPID choice on the coversheet, if applicable.

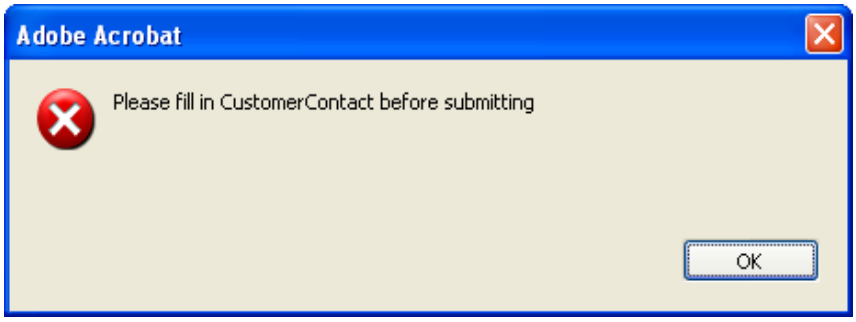
When the agreement is complete, submit the agreement to have all edits checked by clicking the Submit button at the end of the agreement.



Submitting the Agreement

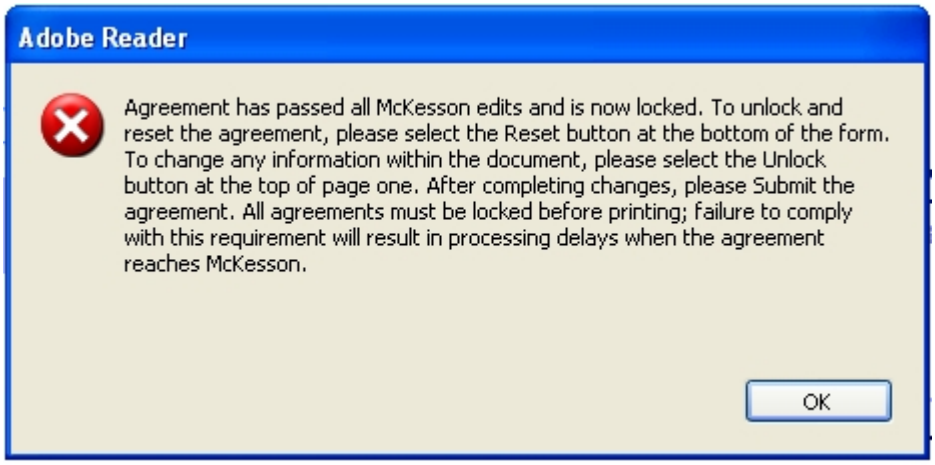
One of the key things verified when users submit the agreement is that all required fields have been completed. If a required field has not been completed, an error will appear stating that the required field must be filled in.

After users click the OK button on the error, the application will return the user to the field that needs completion.



After an agreement has passed all RelayHealth edits, all fields are locked and the following window will appear.

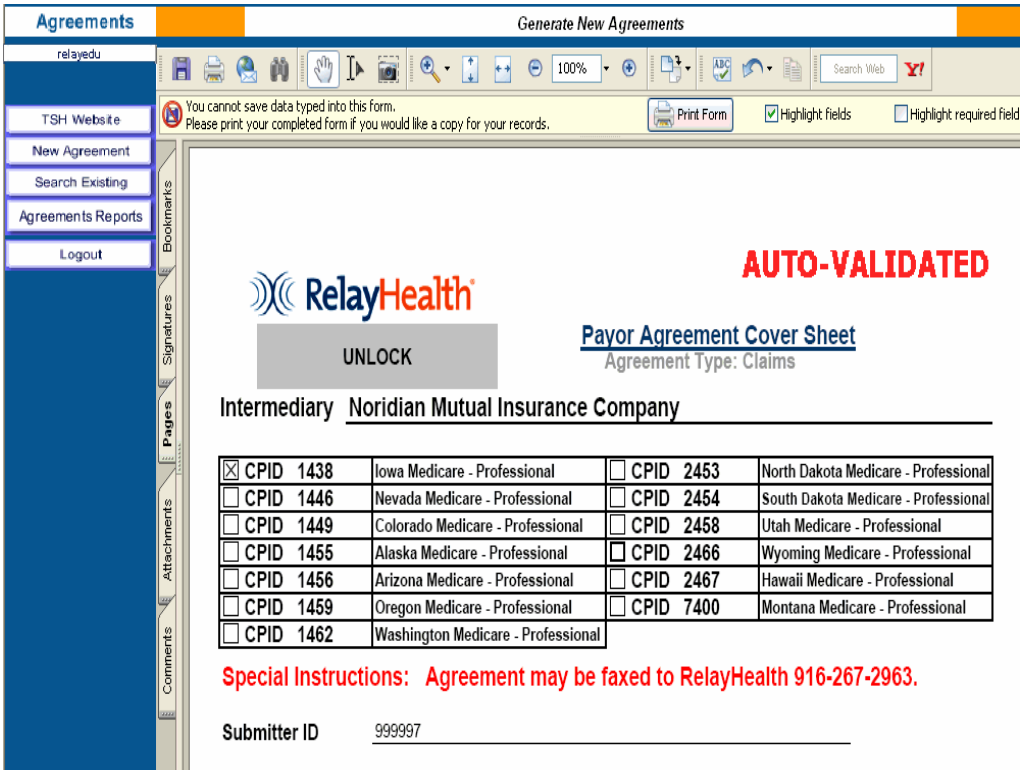
Agreements must be printed while locked to ensure they will be processed correctly.



Unlock Button

1. To edit field content, please click the **Unlock** button.

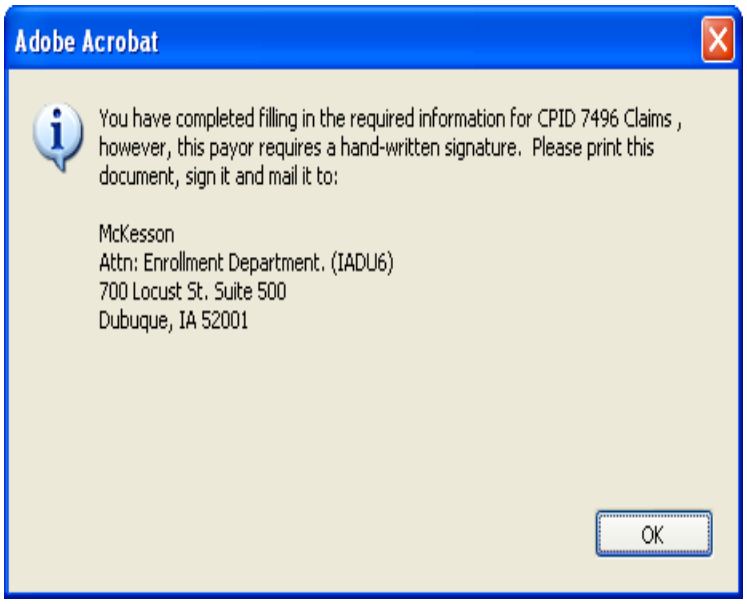
2. Click the **Submit** button after completing changes to the agreement to verify all fields have been completed correctly.



Printing Agreements

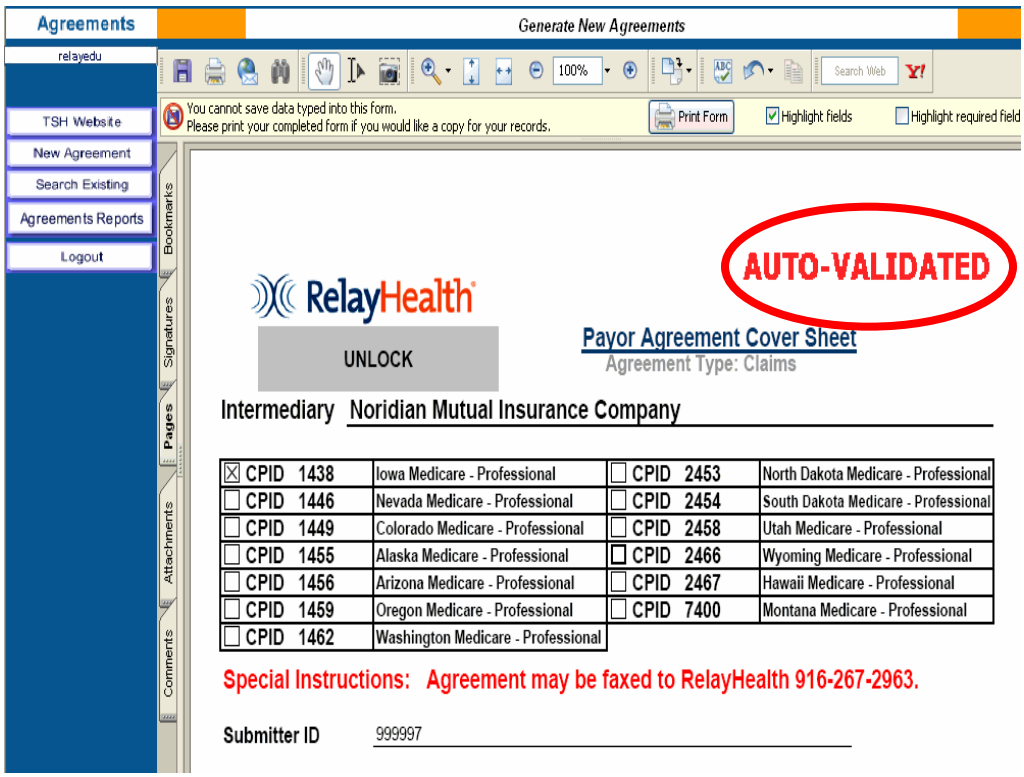
Many payors require signatures on their agreements. After completing and submitting an agreement that requires a provider signature, a notice will appear to the user instructing them to print the form.

RelayHealth's address is located on the coversheet of the form, after signing the agreement; the provider should forward it to RelayHealth.



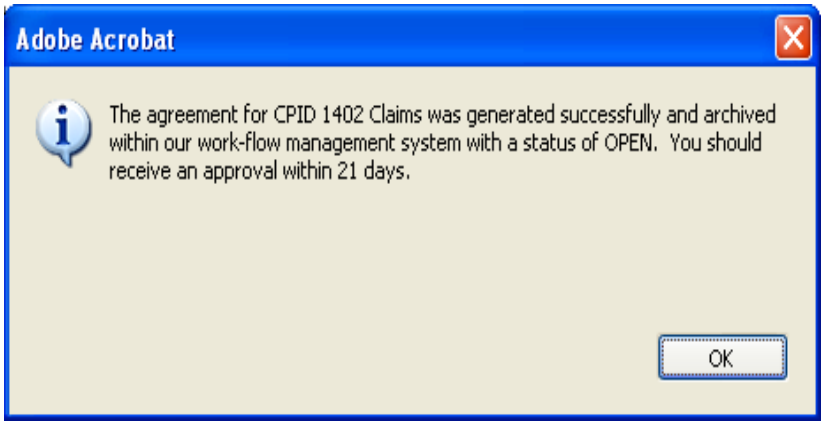
Auto-Validated Stamp

Agreements completed on line and submitted for validation by the system, will be stamped with an Auto-Validated stamp. The stamp indicates that all required information has been completed and all field values are valid. Auto-Validated stamped agreements receive first priority with regards to document review and processing to the payor. Ensure your documents receive the highest priority by clicking the Submit button at the end of the agreement.



Electronic Agreements

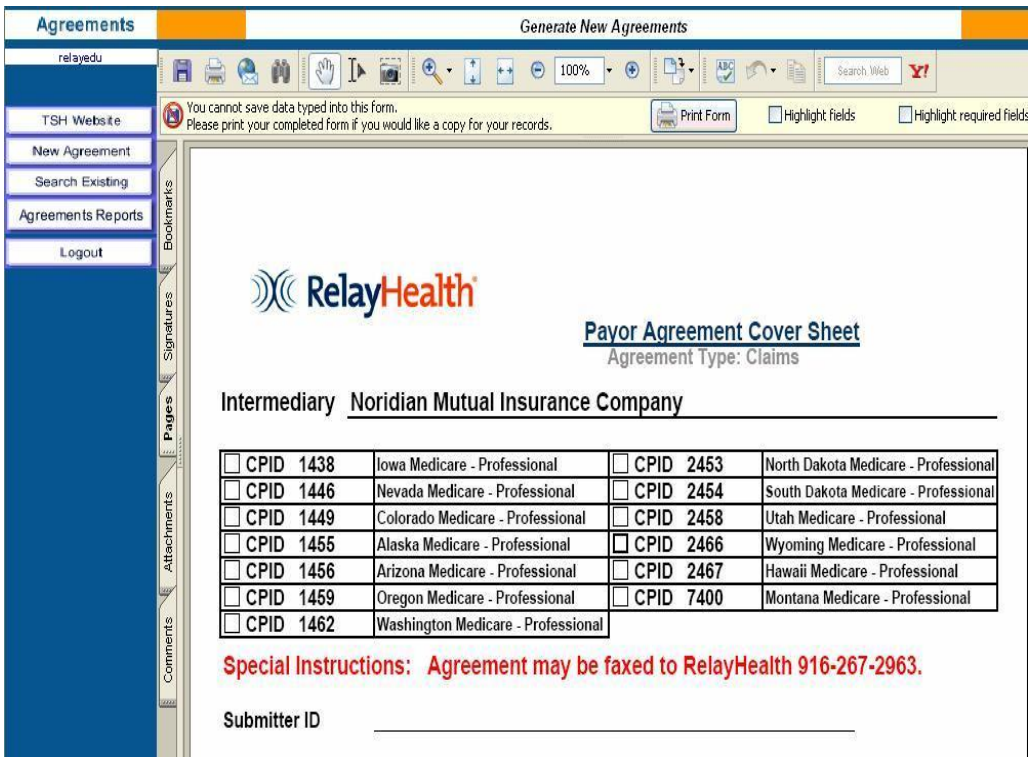
Agreements that do not require a provider signature will be submitted electronically to RelayHealth when users click the Submit button. The agreements submitted electronically to RelayHealth will immediately move into RelayHealth's document management system.



Multiple CPID's on Agreement

If the agreement covers multiple CPID's, the user must first select the appropriate CPID. The system will not allow providers to complete and submit one agreement with multiple CPID's checked. To submit an agreement for more than one CPID, select a CPID and submit the agreement, then unlock the agreement, select the additional CPID and submit again.

Repeat these steps as many times as necessary.



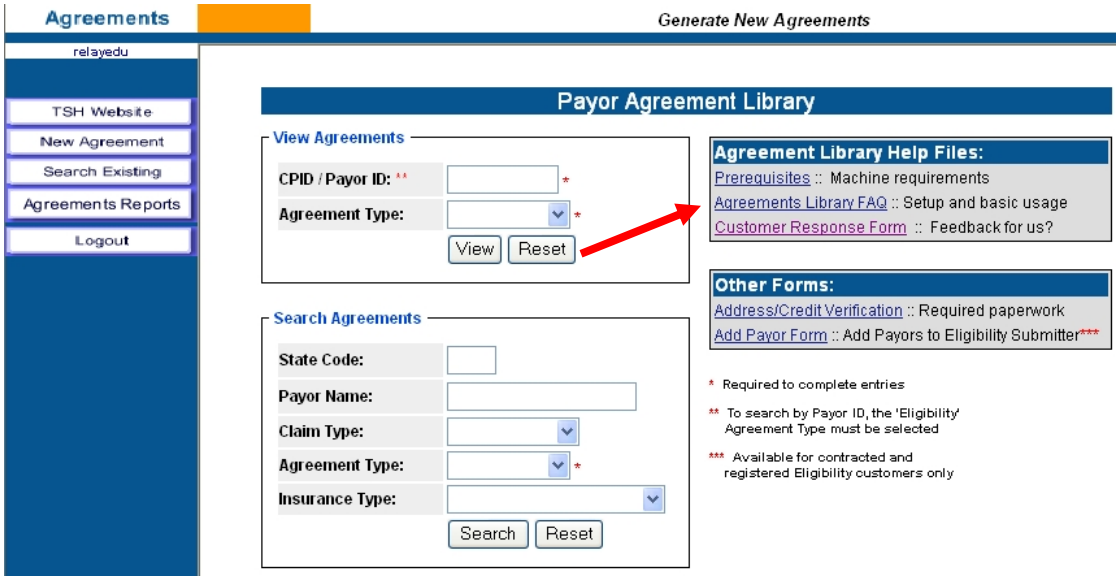
Payor Agreement Tips

- Do not save copies of agreements. The only way to guarantee all edits have been checked is to complete the agreement online.
- The most updated agreement is available online.
- Agreement cover sheets with multiple CPID's require a submission for each CPID.
- Mouse over fields to see tool tips about the requirements for the field.
- Before printing, always, complete the agreement and click the Submit button.

Assistance and Additional Forms

Assistance

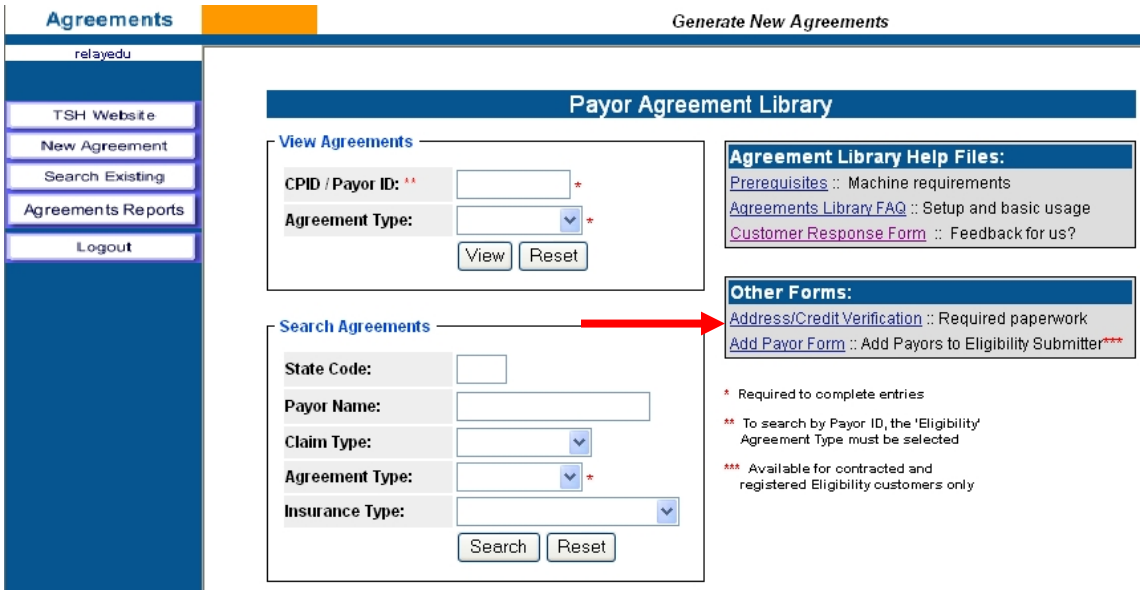
For assistance using the Payor Agreement Library, please see the Prerequisite and FAQ documents which may be accessed from the search page.



Additional Forms

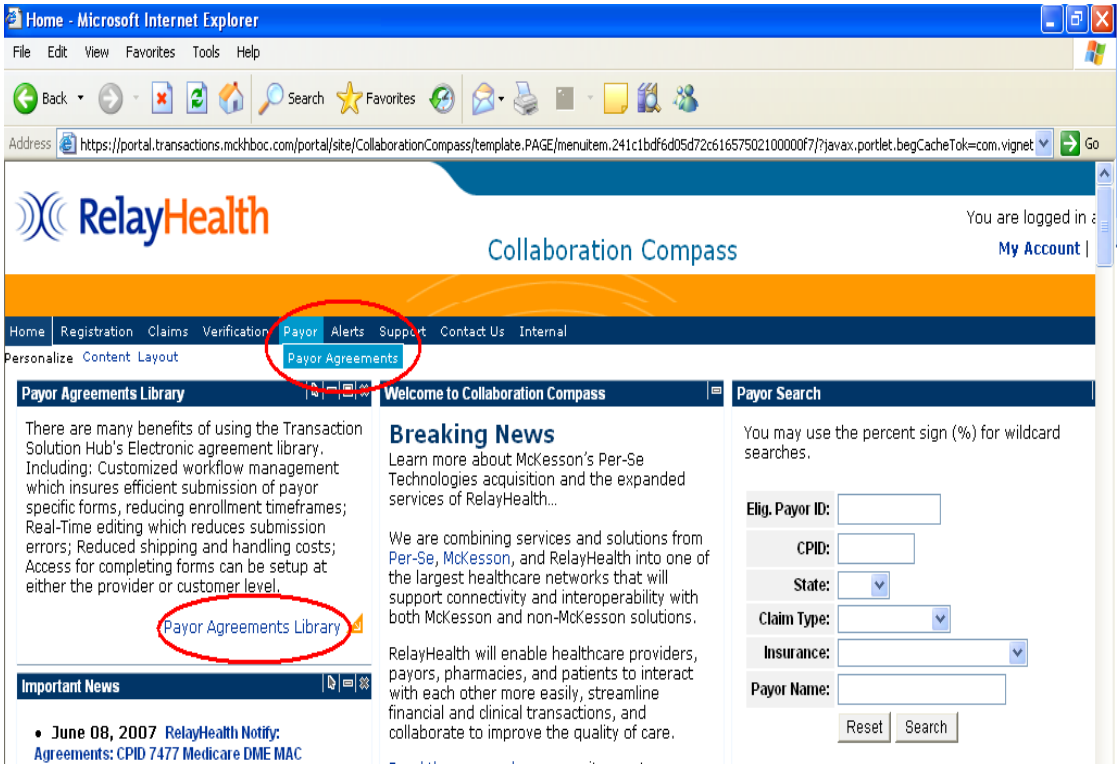
The following additional forms may also be accessed from the search page:

- Eligibility Add Payor form (for existing eligibility clients only)
- Address and Credit Verification

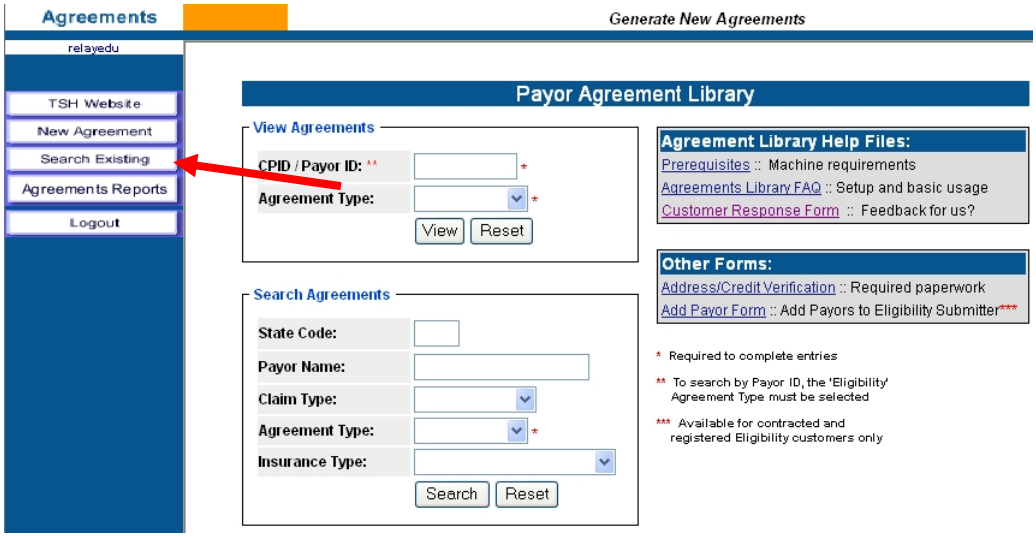


Accessing the Agreement Viewer

1. Login to the portal Website: www.collaborationcompass.com.
2. Select the link to the **Payor Agreement Library** under the **Payor** menu.
3. Another way is to add the **Payor Agreement Library** portlet to the homepage.



4. To access the Agreement Viewer, select **Search Existing** from the menu on the left of the screen.



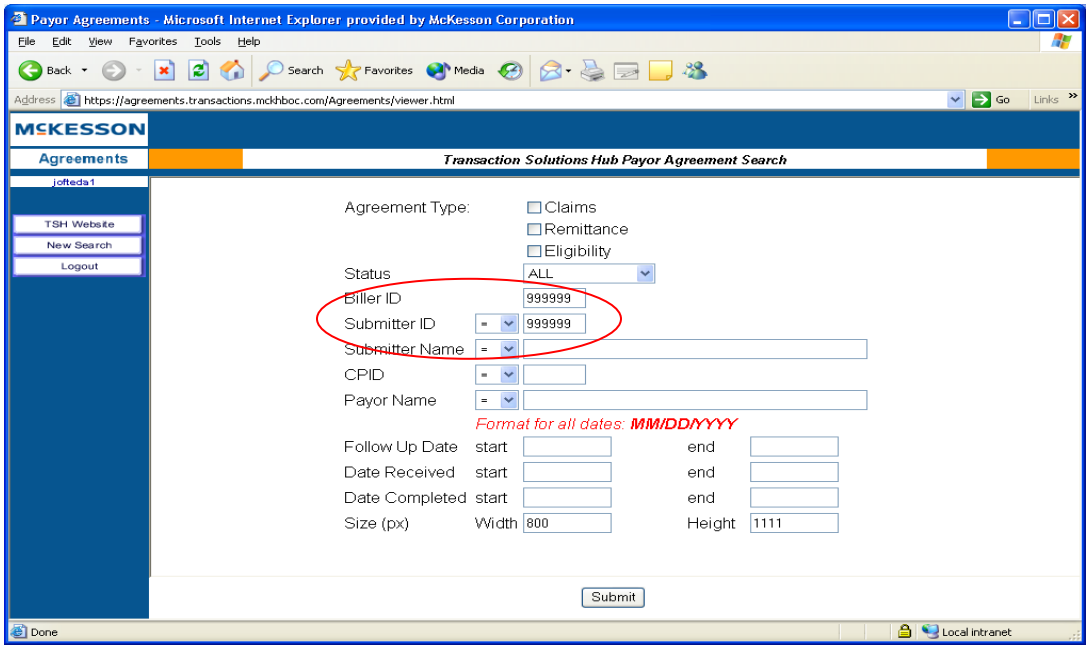
Agreement Viewer Features

Features that are available via the agreement viewer are the following:

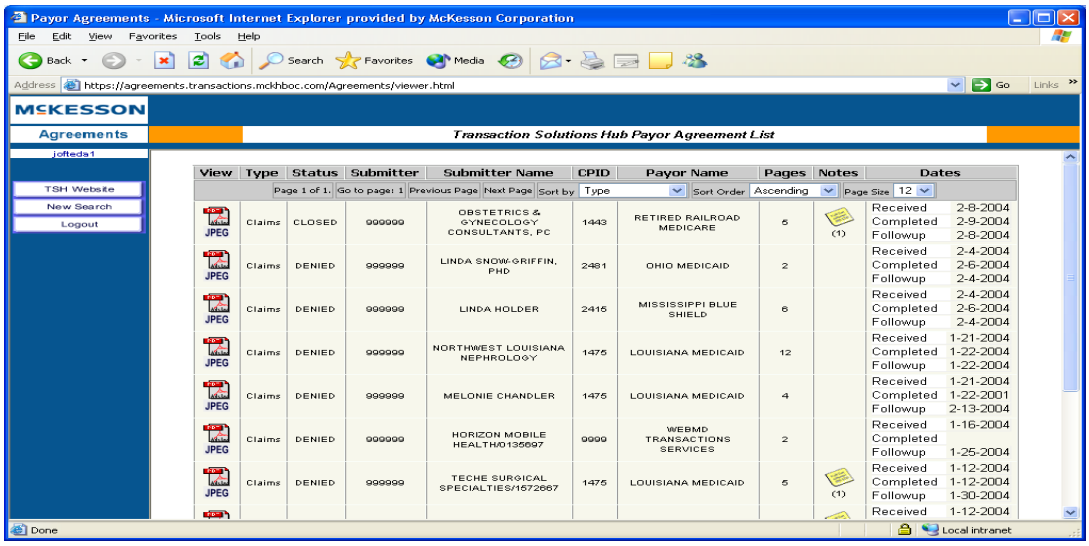
- Type of document (claims, remittance, eligibility)
- Status of the document
- Submitter number and name
- CPID and payor name
- Exporting of information to a csv file
- Able to read notations and how many on a document
- Ability to sort report by variety of fields
- Number of pages in a document
- Provider ID
- Important dates: received, completed, follow-up and mailed

Viewing Documents

1. Click the type of document to search on or leave blank to search all types:
    a. Claims
    b. Remittance
    c. Eligibility
2. Enter any valid search criteria from the choices listed and click on the **Submit** button.
3. The Biller ID and Submitter ID fields are only visible for users assigned the Master Agreement User role.

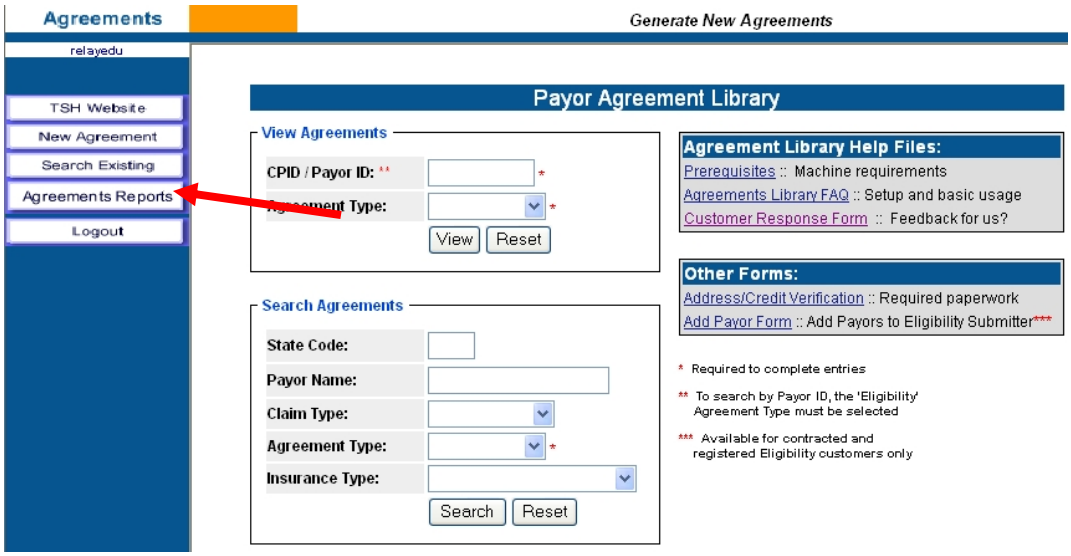


4. A display of documents matching the search criteria is listed.
5. Double-click the **PDF** icon to open the document.
6. Double-click the **Note** icon to view notes.



Agreement Reports

Daily Approval and Weekly Open Reports can be viewed online by clicking the Agreements Reports button.

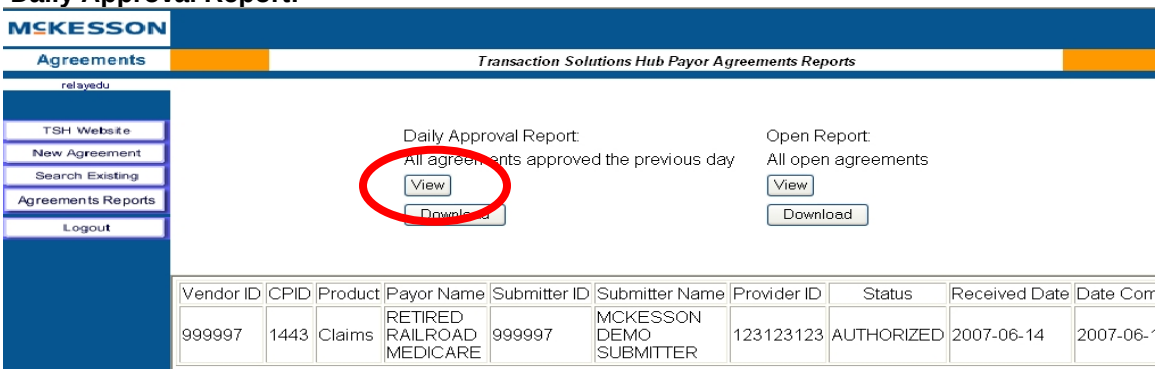


The following screen will be displayed with the options to view or download the Daily Approval Report and/or the Weekly Open Report.

Viewing Agreement Reports

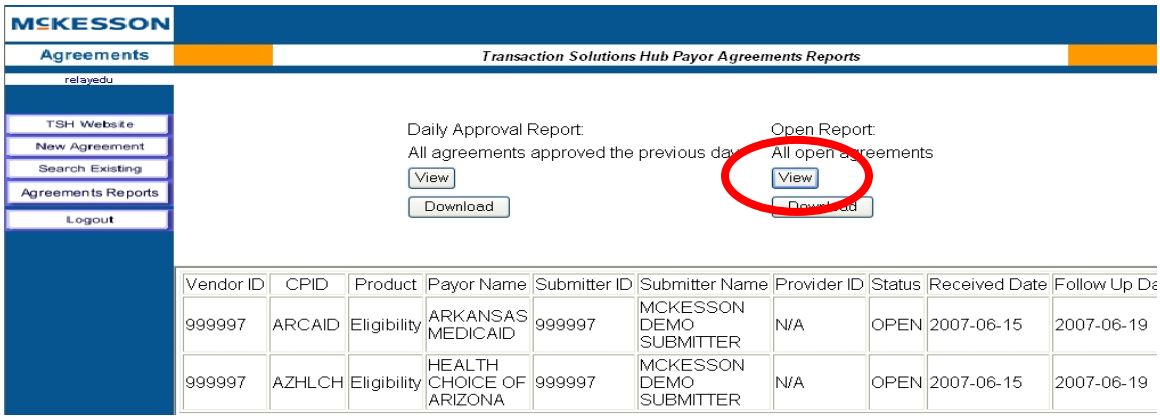
The View button will display (as shown below) the selected report on the screen. Prior business day authorized agreement information based upon the user's user id security access will be displayed; Submitter ID, CPID, provider number, status and date information. In addition, the Daily Approval Report is emailed each morning to a client designated email address. The email has an attachment in a .csv format, which again contains prior business day authorized agreements scoped at the Vendor ID level or Master Agreement User Level.

Daily Approval Report:



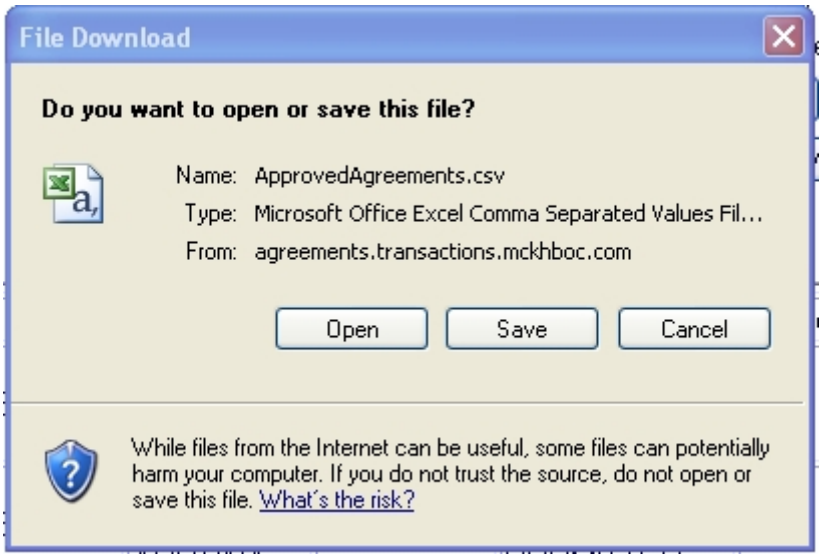
The Open Report viewed online (as shown below) will display all open agreements scoped to the user's user id security access. In addition, this report is emailed every Monday to a client designated email address. The email has an attachment in a .csv format, which contains open agreements scoped at the Vendor ID level or Master Agreement User Level.

Open Report

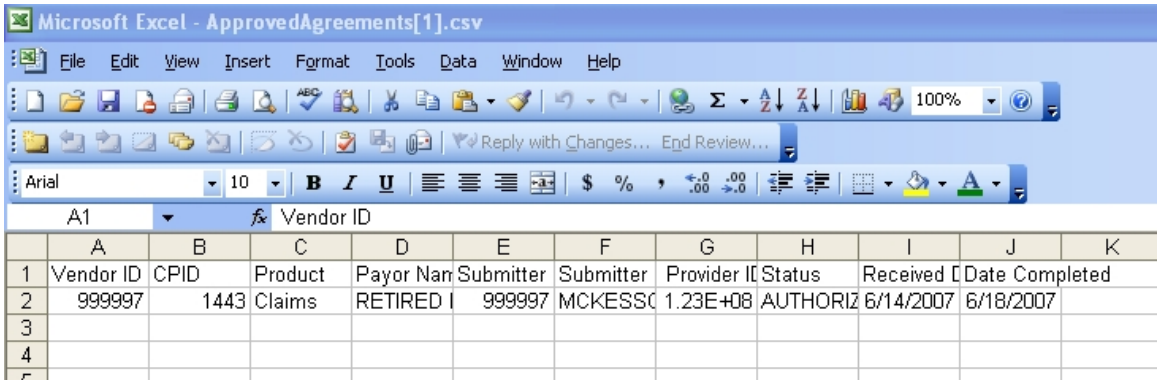


Downloading Agreement Reports

The Download button allows you to save the report to your local computer. The reports contain the same information as displayed by the View buttons but in a .csv format. When the Download button is depressed, the following message will be displayed.



The Open button will open the report in Excel and the Save button allows you to save the report to a specific location and format. The report will look like the following when opened in Excel.



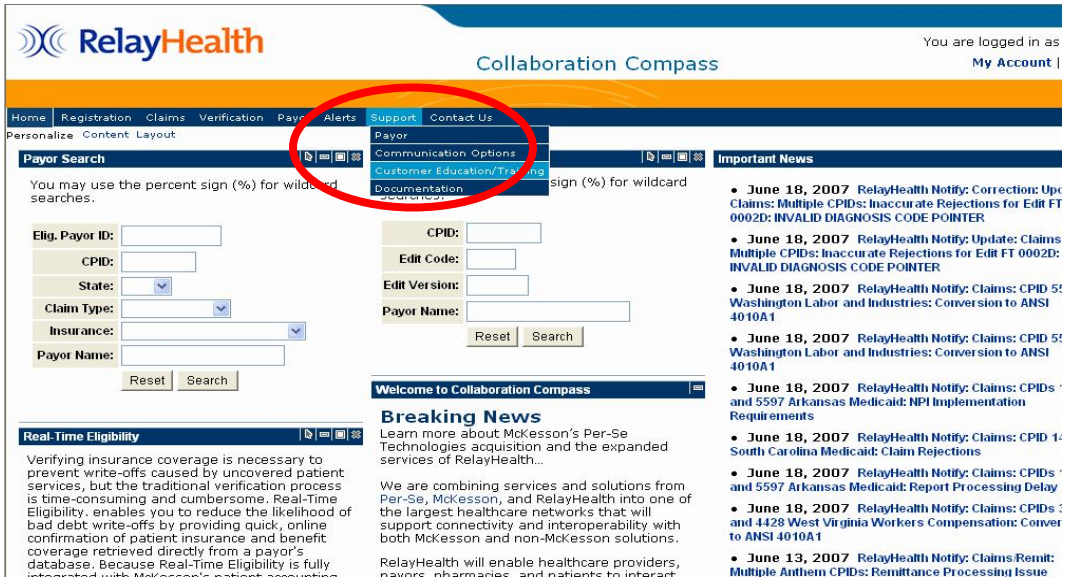
	A	B	C	D	E	F	G	H	I	J	K
1	Vendor ID	CPID	Product	Payor Nan	Submitter	Submitter	Provider ID	Status	Received D	Date Completed	
2	999997	1443	Claims	RETIRED I	999997	MCKESSC	1.23E+08	AUTHORIZ	6/14/2007	6/18/2007	
3											
4											

Training

Customer Training

Training is offered to RelayHealth clients and business partners via regularly scheduled webinars. Clients are notified of webinar dates via email. To view a complete list of webinars being offered:

1. Click Support.
2. Click Customer Education/Training.



Training documentation will be available to RelayHealth clients at any time if they contact RelayHealth Support.

End User Training

RelayHealth Business Partners are responsible for training their own clients on the Payor Agreement Library application.

Training materials are available to assist with client education.

Agreement Updates and Corrections

Immediately after RelayHealth is notified that a payor agreement is changing, the agreement will be pulled from the Payor Agreement Library and replaced with a notification stating that the form is under construction.

When the updated form has been published to the Payor Agreement Library, a customer notify will be sent to clients informing our clients the agreement is available for submission.

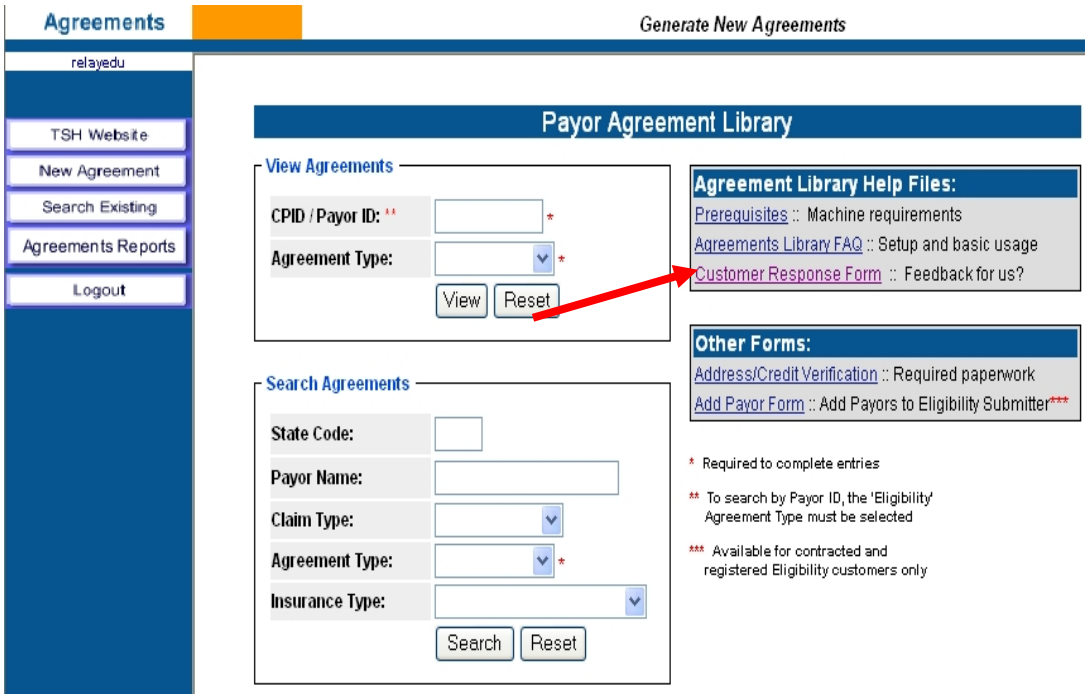
If the user finds an error that prevents form submission, please contact the RelayHealth Registration Team.

- Phone: 800-527-8133, option 1
- Fax: 916-267-2963
- Email: DBQTSHEnrollments@RelayHealth.com

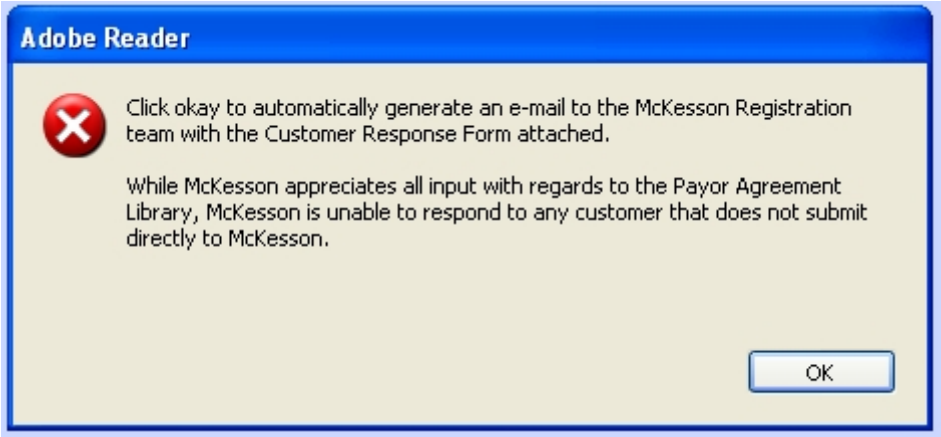
Please have the payor cpid, the page and location of the questionable field, the requested change and any other supporting documentation available when contacting RelayHealth Support.

Customer Feedback and Response Form

To give general feedback or request enhancements to the Payor Agreement Library, please complete the Customer Response Form which may be accessed from the search page.



After completing the form, please select the Submit button. An email will be generated, addressed to the RelayHealth Registration Team, with the form data attached. The user must select Send in their email application to send the email to RelayHealth.


Adobe Reader
Click okay to automatically generate an e-mail to the McKesson Registration team with the Customer Response Form attached.
While McKesson appreciates all input with regards to the Payor Agreement Library, McKesson is unable to respond to any customer that does not submit directly to McKesson.
OK

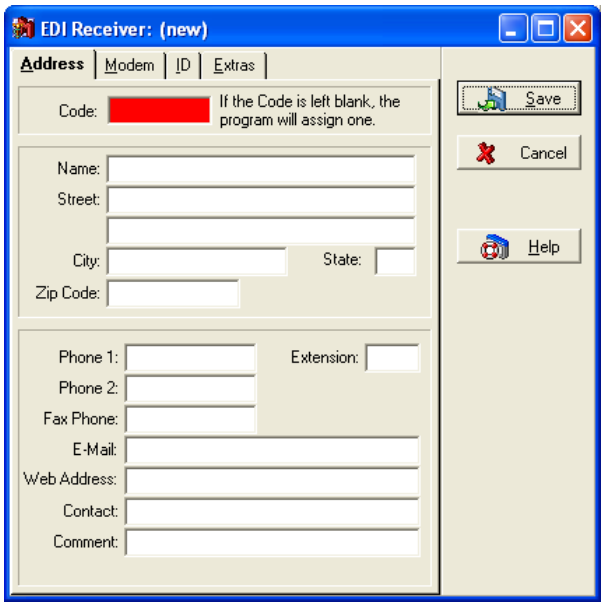
Setting Up Medisoft for RelayHealth

Broadband

If you are sending claims through the RelayHealth module, you must have an active high-speed internet connection.

EDI Receiver List Window

To set up the EDI receiver, go to the **Lists** menu and select **EDI Receivers**. In the **EDI Receiver List** window, click **New**. The **EDI Receiver** window opens.



Address Tab

If a field is not specified below, leave it blank or leave the default selection.

- **Code** — This field is automatically populated once you save the receiver.
- **Name** — Enter **RelayHealth**.
- **Extension** — If you use the ERA program and if multiple checks are sent in one remittance file, enter **ST:** in this field to separate the checks by ST/SE segment in the file.
- **Comment** — Leave blank or for former Exchange customers, enter **EXCHANGE**.

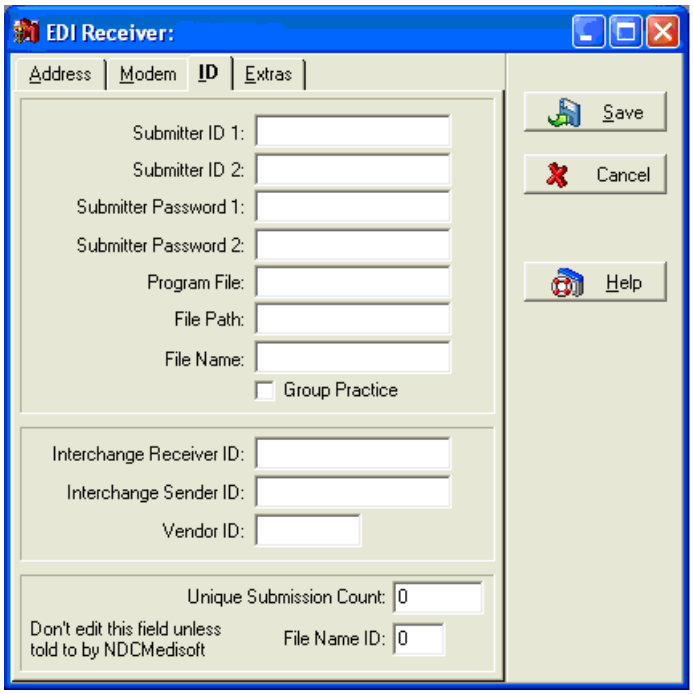
Modem Tab

If a field is not specified below, leave it blank or leave the default selection.

- **Transmission Mode** — Select **Active** unless sending test files.

ID Tab

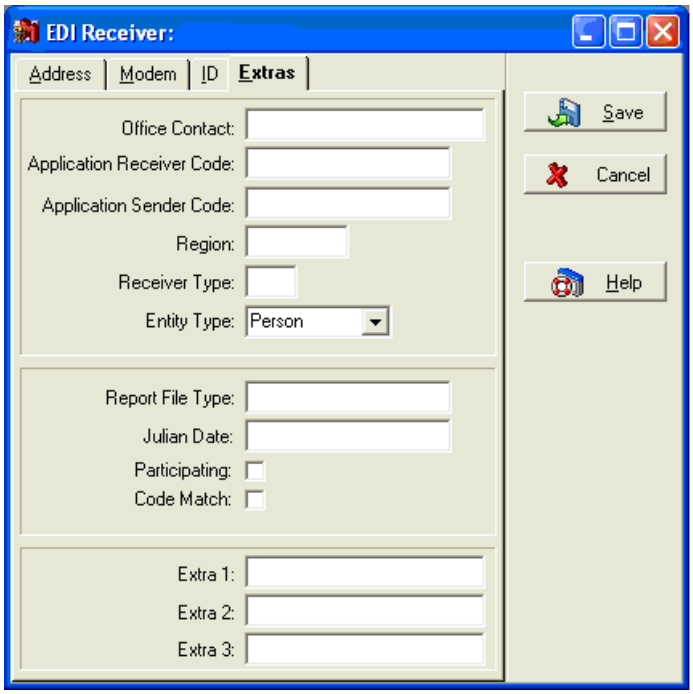
If a field is not specified below, leave it blank or leave the default selection. Enter the following information:



- **Submitter ID 1** — Enter your RelayHealth **Login**.
- **Submitter ID 2** — Enter your RelayHealth **Billing ID** plus the RelayHealth **Submitter ID.** Do not put any spaces between the two series of numbers. For instance, if your Billing ID equals 9999 and your Submitter ID equals 001234, then you would enter 9999001234.
- **Submitter Password 1** — Enter the password.
- **Submitter Password 2** — Leave blank or for former Exchange customers enter your Exchange ID.
- **Program File**—Enter **RELAYH**.
- **File Path** and **File Name** — Leave these fields blank.
- **Group Practice** — This check box determines whether group IDs are sent. If you are a group practice, click this box.
- **Interchange Receiver ID** — Leave this field blank.
- **Interchange Sender ID** — Leave this field blank.
- **Vendor ID** — Leave this field blank.
- **Unique Submission Count** — This field is used when filing claims for multiple practices. If you use multiple receivers to send claims, enter a number in this field to identify the receiver and prevent duplicate files. Enter a five-digit code for each receiver (10000-99999) but do not use alpha or special characters. If you are a billing service and you have the same ID and password for all data sets, enter a unique five-digit code for each receiver (10000-99999).

Extras Tab

If a field is not specified below, leave it blank or leave the default selection.



- **Office Contact** — Enter the name of the contact person in your office.
- **Application Receiver Code** — Leave this field blank.
- **Application Sender Code** — Leave this field blank.
- **Region** — Leave this field blank.
- **Receiver Type** — Leave this field blank.
- **Entity Type** — Enter **Person** if the practice bills insurance companies under the provider's name, i.e. Dr. John Smith. Enter **Non-Person** if the practice bills insurance companies under the practice name, i.e. Smith Chiropractic. If you have filled out the **Billing Service** tab in **Practice Information**, the billing service information will be sent no matter what you select in this field.
- **Report File Type**—Leave this field blank.
- **Julian Date** — Leave this field blank.
- **Participating** — Leave this field blank.
- **Code Match** — Leave this field blank.
- **Extra 1**, **2**, and **3** — Leave these fields blank.

Patients

If the patient has a suffix or prefix (i.e. Jr or Mrs) on his/her insurance card, you must enter the additional information in the patient's name field. Go to the **Lists** menu and select **Patients/Guarantors and Cases.** In the **Patient List** window, click an existing patient to edit or click **New Patient**.

Name, Address Tab

- **Last Name** — If you need to enter a suffix (i.e. Jr), enter it after a comma in this field. For example, enter **Last Name,Suffix**.
- **First Name** — If you need to enter a prefix (i.e. Mrs), enter it after a comma in this field. For example, enter **First Name,Prefix**.

Cases

Account Tab

- **Assigned Provider** — Click the down arrow to select the provider for this case.
- **Referring Provider** — If there is a referring provider, click the down arrow to select the provider. If there is no referring provider, you might want to enter the assigned provider as the referring

provider as well. This is required if CPT codes are used for ordering lab work or X-rays. No harm is done if the referring provider is listed. However, if the referring provider is listed, the UPIN is required.

Diagnosis Tab

- **EDI Notes** — If you need to send general notes concerning the entire claim, enter @NTE followed by a space and the Claim Note Text. If you need to send general information concerning a transaction, see the Transaction Documentation section below.
- **Report Type Code** — The report type code is a two-character code that indicates the title or contents of a document, report, or supporting item sent with electronic claims. Enter one of the following codes:

77	Support data for verification. REFERRAL – use this code to indicate a completed referral form
AS	Admission Summary
B2	Prescription
B3	Physician Order
B4	Referral Form
CT	Certification
DA	Dental Models
DG	Diagnostic Report
DS	Discharge Summary
EB	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)
MT	Models
NN	Nursing Notes
OB	Operative Note
OZ	Support Data for Claim
PN	Physician Therapy Notes
PO	Prosthetics or Orthotic Certification
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report

- **Report Transmission Code** — The report transmission code is a two-character code that defines the timing, transmission method, or format by which reports are sent with electronic claims. Enter one of the following codes:

AA	Available on request at provider site. This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.
BM	By mail
EL	Electronically only. Use to indicate that the attachment is being transmitted in a separate X12 functional group.
EM	E-mail
FX	By fax

- **Attachment Control Number** — The value you enter in the Attachment Control Number field is your own unique reference number, up to seven digits. This number is required if you select any report transmission code besides AA.

Policy Tabs

- **Insurance** — Click the down arrow to select the appropriate insurance company.
- **Policy Holder** — Click the down arrow to select the policy holder's chart number.
- **Policy Number** — Enter the policy number.
- **Relationship to Insured** — Click the down arrow to select the appropriate relationship between the patient and insured party.
- **Assignment of Benefits/Accept Assignment** — Check this box if the provider is accepting assignment of claims for this case. Also, the Relationship to Insured field must not be blank.

  Note: Generally, insurance companies will not accept both assigned and non-assigned claims in the same batch. This means if some of the claims are assigned and some are non-assigned, you must create separate batches.

- **Crossover Claim** — This field is on the Policy 2 tab. If you are submitting Medigap claims, check this box. Check the Medigap carrier list from your electronic claims carrier. For more on crossover claims, see the Filing Crossover Claims section on page 70.

  Note: If the carrier is a complimentary crossover carrier, leave this box unchecked. Go to the insurance carrier's record and check Complimentary Crossover on the EDI/Eligibility tab. When this is checked, the program does not send the secondary insurance information in the claims file but does mark the secondary claim as sent when the primary claim is sent.

Miscellaneous Tab

If you select **Chiropractic** as the practice type in the **Practice Information** window, fields that apply to chiropractic claims are added to the **Miscellaneous** tab.

- **Nature of Condition** — Enter a one-character code that indicates the condition: A for acute, C for chronic, or M for acute manifestation of a chronic condition.
- **No. Treatments-Month** — Enter up to two digits indicating the number of treatments the patient has received during the current month.
- **Treatment Months/Years** — Enter the letter M (for Month) or Y (for Year) followed by up to two digits indicating the number of months or years treatment has been rendered for this ailment. For example, if treatment has lasted six months, enter M6.
- **Date of Manifestation** — If M is entered in Nature of Condition and a date has been entered in the First Consultation Date field in the Condition tab, then Date of Manifestation must contain the corresponding date.

Medicaid and Tricare Tab

- Service Authorization Exception Code — This code is required on some Medicaid claims. Enter one of the following codes:

  1 Immediate/Urgent Care

  2 Services Rendered in a Retroactive Period

  3 Emergency Care

  4 Client as Temporary Medicaid

  5 Request from County for Second Opinion to Recipient can Work

  6 Request for Override Pending

  7 Special Handling

EDI Tab

These fields are required for certain types of claims. If applicable, enter a value in the field.

- **Care Plan Oversight #** — Enter the care plan oversight number.
- **Hospice Number** — Enter the hospice number. This is a second ID for a facility.
- **CLIA Number** — Enter the CLIA number. This number is assigned to labs and is required for lab claims.
- **Mammography Certification** — Enter the provider's or facility's mammography certification number. You can also enter this in the provider's or facility's record.
- **Medicaid Referral Access #** — Enter the patient's Medicaid referral access number. This number may also be called the Medipass number.
- **Demo Code** — When you file claims for this patient under demonstration projects, you need to enter a number so they can be tracked properly. If applicable, enter one of the following codes:

  39 Flu Demonstration

  45 Chiropractic Demonstration

- **IDE Number** — The IDE Number is required when there is an investigational device exemption on the claim. This is usually for vision claims but can also be assigned for other types of claims.
- **Assignment Indicator** — Enter the assignment indicator for this case. If you have cases where assignment is accepted only on clinical lab services, or if the patient refuses to assign benefits, enter one of the following codes:

  B Assignment accepted on clinical lab services only

  P Patient refuses to assign benefits

- **Insurance Type Code** — Enter the type of insurance the patient has. This is required when sending Medicare secondary claims. Enter one of the following codes:

  12 Medicare Secondary working aged beneficiary or spouse with employer group health plan

  13 Medicare Secondary end-stage renal disease beneficiary in the 12-month coordination period with an employer's group health plan

  14 Medicare Secondary, no-fault insurance including auto is primary

  15 Medicare Secondary Worker's Compensation

  16 Medicare Secondary Public Health Service (PHS) or other federal agency

  41 Medicare Secondary Black Lung

  42 Medicare Secondary Veteran's Administration

  43 Medicare Secondary disabled beneficiary under age 65 with Large Group Health Plan (LGHP)

  47 Medicare Secondary, other liability insurance is primary

- **Timely Filing Indicator** — Enter the code indicating why response to a request for information was delayed. This is usually required when a claim is submitted late. Enter one of the following codes:

  1 Proof of Eligibility Unknown or Unavailable

  2 Litigation

  3 Authorization Delays

  4 Delay in Certifying Provider

  5 Delay in Supplying Billing Forms

  6 Delay in Delivery of Custom-made Appliances

7 Third Party Processing Delay

8 Delay in Eligibility Determination

9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

10 Administration Delay in the Prior Approval Process

11 Other

- **EPSDT Referral Code** — Enter the patient's referral code for the EPSDT program.
- **Homebound** — Check this box if the patient is under homebound care.

Vision Claims

If you submit vision claims, enter values in these fields.

- **Condition Indicator** — Enter one of the following codes as the code indicator.

L1 General Standard of 20 degree or .5 Diopter Sphere or Cylinder Change Met

L2 Replacement due to loss or theft

L3 Replacement due to breakage or damage

L4 Replacement due to patient preference

L5 Replacement due to medical reason

- **Certification Code Applies** — Click this box if a certification code is applicable.
- **Code Category** — Enter the code category for the vision device. Enter one of the following codes:

E1 Spectacle lenses

E2 Contact lenses

E3 Spectacle frames

Home Health Claims

If you submit home health claims, enter values in these fields.

- **Total Visits Rendered** — Enter the total number of visits rendered.
- **Total Visits Projected** — Enter the total number of visits projected.
- **Number of Visits** — Enter the total number of visits.
- **Duration** — Enter the duration of the home health visits. Enter one of the following codes:

7 Day

35 Week

- **Number of Units** — Enter the number of units for the home visits.
- **Discipline Type Code** — Enter the discipline type code for the type of healthcare provider. Enter one of the following codes:

AI Home Health Aide

MS Medical Social Worker

OT Occupational Therapy

PT Physical Therapy

SN Skilled Nursing

ST Speech Therapy

- **Ship/Delivery Pattern Code** — Enter the pattern code for the home visits. Enter one of the following codes:

1	1st week of the month
2	2nd week of the month
3	3rd week of the month
4	4th seek of the month
5	5th week of the month
6	1st and 3rd weeks of the month
7	2nd and 4th weeks of the month
A	Monday through Friday
B	Monday through Saturday
C	Monday through Sunday
D	Monday
E	Tuesday
F	Wednesday
G	Thursday
H	Friday
J	Saturday
K	Sunday
L	Monday through Thursday
N	As directed
O	Daily Monday through Friday
S	Once anytime Monday through Friday
SA	Sunday, Monday, Thursday, Friday, Saturday
SB	Tuesday, through Saturday
SC	Sunday, Wednesday, Thursday, Friday, Saturday
SD	Monday, Wednesday, Thursday, Friday, Saturday
SG	Tuesday through Friday
SL	Monday, Tuesday, and Thursday
SP	Monday, Tuesday, and Friday
SX	Wednesday and Thursday
SY	Monday, Wednesday, and Thursday
SZ	Tuesday, Thursday, and Friday
W	Whenever necessary

- **Ship/Delivery Time Code** — Enter the time code for the home visits. Enter one of the following codes:

D	A.M.
E	P.M.
F	As directed

- **Frequency Period**—Enter the frequency period for the home visits. Enter one of the following codes:

  DA Days

  MO Months

  Q1 Quarter (time)

  WK Week

- **Frequency Count** — Enter the frequency count for the home visits.

Custom Tab

Note: This option is for sending ambulance information with claims and requires Medisoft Network Professional. If you do not have one of these programs or choose not to use the **Case Custom Window** setup provided, see Appendix C for instructions on entering required ambulance information.

If your insurance carrier requires you to send ambulance information for an electronic claim, Medisoft has a **Case Custom Window** setup that includes the necessary fields for this information. Contact Medisoft at (800) 333-4747 to request the files for the **Case Custom** window setup.

Note: If you have already created custom patient information in the **Case Custom Window**, this information will be overwritten when you copy the fields for this option. You can go back into that window and add again any preexisting fields and information to those created by this option.

See Appendix B for complete instructions on how to use the **Case Custom** window and what information is required.

Providers

Address Tab

- **Signature on File** — Check this box.
- **Signature Date** — Enter the date for the signature.
- **Entity Type** — Designate whether the provider is billing under the practice name or under the provider's name. Enter 1 for the provider or 2 for the practice.

Default Pins Tab

- **SSN/Federal Tax ID** — Enter the provider's Social Security Number or Federal Tax ID. Choose the option to the right to indicate whether the number entered is the Social Security Number or the Federal Tax ID.
- **PINs** — Enter the appropriate default PINs for this provider.
- **CLIA Number** — If you submit lab charges, enter the CLIA number.
- **Hospice Emp** — Click this box if the provider is a employee of a hospice.
- **CPO Number** — Enter the provider's care plan oversight number.
- **National Identifier** — Enter the provider's National Provider ID. This 10-digit number is a standardized identifier that provides each provider with a unique identifier to be used in transactions with all health plans. If the provider is part of a class or a group, you can enter the group National Provider ID in the Provider Class record.
- **Payee Number** — This field is for when you send GPNT (IL Medicaid) claims only. Enter the provider's payee number.
- **Taxonomy Code** — Enter the provider's taxonomy code in this field. The taxonomy code replaces the provider's specialty code.
- **Mammography Certification** — If the provider is certified to perform mammography procedures, enter the certification number in this field.

Default Group IDs Tab

- **Provider Class** — You can assign a provider to a class or group. First set up provider classes in the Provider Class window. If the group is assigned a national provider ID, that number is entered there. Then click the down arrow in this field to select a class for the provider.

- **Group Numbers** — Enter the appropriate group numbers for this provider.

PINs Tab

Depending on the type of claims you file, you could have separate PINs and/or Group IDs from each carrier. The PINs tab provides a PIN matrix where you can store these additional PINs and Group IDs. This matrix is also available in the **Insurance Carrier** window, PINs tab. You can enter information through either window.

You are also required to enter qualifiers to the PINs and Group IDs, if applicable. These qualifier codes indicate the PIN or Group ID type.

> **Note:** If you converted data from Medisoft 10 or previous, the qualifiers may have been converted as well. Verify that the qualifiers are correct for each PIN and/or Group ID.

Enter one of the following qualifiers for each insurance carrier to which you send electronic claims:

0B State License
1A Blue Cross Provider Number
1B Blue Shield Provider Number
1C Medicare Provider Number
1D Medicaid Provider Number
1G Provider UPIN Number
1H Champus Identification Number
1J Facility ID Number
B3 Preferred Provider Organization Number
BQ Health Maintenance Organization Code Number
EI Employer's Identification Number
FH Clinic Number
G2 Provider Commercial Number
G5 Provider Site Number
LU Location Number
N5 Provider Plan Network Identification Number
SY Social Security Number
U3 Unique Supplier Identification Number
X5 State Industrial Accident Provider Number

Refer to the implementation guide for your insurance carrier if you are not sure which qualifier to use. This is not provided by Medisoft but by your carrier.

Referring Providers

Address Tab

- **Last Name** and **First Name** — Enter the referring provider's first and last names.

Default PINs Tab

- **UPIN** — Enter the referring provider's UPIN.
- **CPO Number** — Enter the referring provider's care plan oversight number.

Insurance Carriers - Primary Carriers

Options Tab

- **Type** — Click the down arrow to select the correct insurance type. For commercial carriers, select **Other**.
- **Signature on File** fields — Select **Signature on File** in each of the Signature on File fields.
- **Default Billing Method** — Click the down arrow to select **Electronic**.

EDI/Eligibility Tab

- **EDI Receiver** — Click the down arrow to select the EDI receiver for this insurance carrier.
- **EDI Payor Number** — Enter the RelayHealth CPID. Obtain this number by going to https://portal.transactions.mckhboc.com/portal/site/TSHPortal/menuitem.0b56f96c2891389ab4bf8c10100000f7.
- **Complimentary Crossover** — If the carrier is a complimentary crossover carrier, check this box. When this option is checked, the program does not send the secondary insurance information in the claims file but does mark the secondary claim as sent when the primary claim is sent. For more on crossover claims, see the Filing Crossover Claims section on page 70.

Note: If you are submitting Medigap claims, go to the patient's case and check the **Crossover Claim** box on the **Policy 2** tab. Check the Medigap carrier list from your electronic claims carrier.

PINs Tab

Depending on the type of claims you file, you could have separate PINs and/or Group IDs from each carrier for different types of insurance. The PINs tab provides a PIN matrix where you can store these additional PINs and Group IDs. This matrix is also available in the **Provider** window, PINs tab. You can enter information through either window.

Insurance Carriers - Secondary Carriers

If your carrier accepts secondary claims electronically, create an additional insurance carrier record for secondary claims. Enter a name that will clearly distinguish this record as the one for secondary claims. All other field requirements are the same as for primary carriers. Be sure that this secondary carrier is the one selected in the patient's **Insurance 2** field of the **Case** window, **Policy 2** tab.

Insurance Carriers - Filing Crossover Claims

Medicare will forward claims to some secondary insurance carriers if you send the correct information about the secondary insurance to Medicare. Secondary insurance carriers that have signed a contract with Medicare to receive the claims from them are called Medigap carriers. Medicare assigns each of these Medigap carriers a Medigap number to identify it. This number is sometimes called an OCNA number. If you have not already obtained a list of these carriers from Medicare, call Medicare and request one. Do not call Medisoft for this document. To set up these carriers, check **Crossover Claim** in the **Case**, **Policy 2** tab.

Some insurance carriers that are secondary to Medicare are classified complimentary crossover carriers. For these carriers, Medicare does not need to receive any information about the secondary insurance carrier. The information is already stored at Medicare. These carriers do not have a Medigap number. To set up these carriers, check the **Complimentary Crossover** box on the **Insurance Carrier**, **EDI/Eligibility** tab. Do not check the **Crossover Claim** box in the **Case**, **Policy 2** tab.

Both Primary and Medigap Carriers

If the carrier you are setting up is used within the practice as both a primary EDI insurer and a Medigap insurer, you must enter the Medigap Number in the **EDI Extra 1/Medigap** field of the **Insurance Carrier** window, **EDI/Eligibility** tab. See also the Filing Crossover Claims section above.

Medigap Carriers

If the carrier you are setting up is only a Medigap carrier, fill in only the following fields in the specified windows:

- **Insurance Carrier, Options tab** —The Type field must show the correct insurance type. The Default Billing Method field need not say Electronic.
- **Insurance Carrier, EDI/Eligibility tab** —The EDI Extra 1/Medigap field must contain the Medigap Number.

No other fields are necessary in this window to set up a carrier that is only a Medigap carrier.

Addresses

- **Entity ID** — Enter a two-digit code that indicates the entity type. Enter one of the following values:

  FA = Facility

  LI = Independent lab

  TL = Testing lab

  77 = Service location

- **Purchased Services** — Click this check box if the practice purchases services from this facility or laboratory.
- **Mammography Certification** — If this facility is certified to perform mammography procedures, enter the certification number.

Procedure Codes

General Tab

- **Purchased Service** — Check this box to indicate the procedure is a service you purchase from a third-party, such as lab work.
- **National Drug Code** — Enter the code assigned to this procedure. This code is for reporting prescribed drugs and biologics and is applicable when sending electronic claims.
- **Code ID Qualifier** — Enter the qualifier for the code. This tells the insurance carrier what type of code you are sending and is applicable when sending electronic claims. **N4** is the National Drug Code modifier.

Transaction Entry

Transaction Grid

If filing anesthesia claims, add the **Quantity Qualifier** and the **Quantity** fields to the grid using the **Grid Columns** window. Click the button in the upper left-hand corner of the grid.

The **Grid Columns** window opens. Click **Add Fields** to open the **Add Fields** window. Search through the list of fields, select the appropriate field, and click **OK**. You are back on the **Grid Columns** window.

You have to add each field one at a time, so click **Add Fields** again to add another field. When you are finished adding fields, click **OK** in **Grid Columns** to return to **Transaction Entry**. The new fields are columns in the grid.

Once you have added the fields to the grid, enter the appropriate values in each field.

Transaction Documentation/Notes

If you need to send general notes concerning a transaction, enter **NTE:** followed by the Note Reference Code and Line Note Text in the **Transaction Documentation** window. Select the Note Reference Code from the following list. The Line Note Text is a free-form description to clarify the related data elements and their content.

ADD Additional information

DCP Goals, rehabilitation potential, or discharge plans

PMT Payment

TPO Third-party organization notes

If required by your carrier (and only if required by your carrier), enter **K3:** followed by fixed format information. This designation is rarely used.

Setup Complete

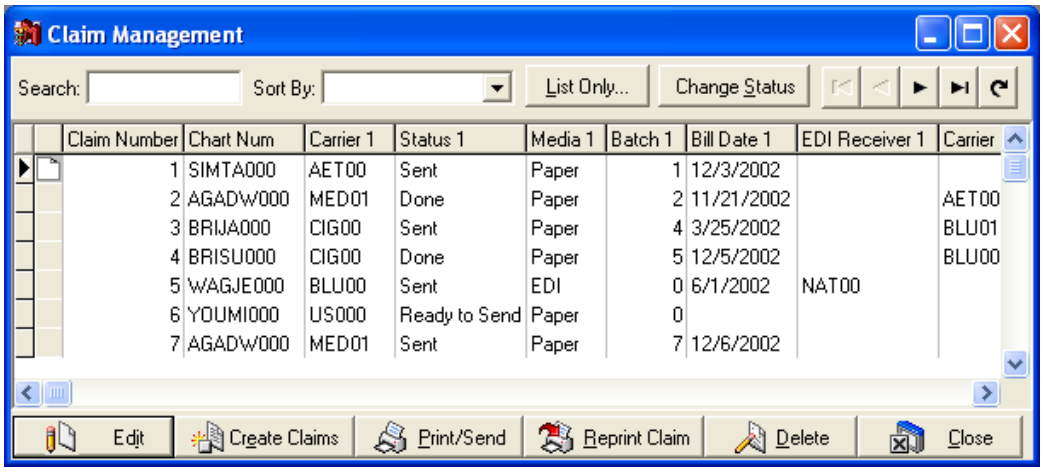
This completes the onetime setup preparation for sending electronic claims to RelayHealth. The next section describes the routine to follow each time you do insurance billing.

Processing Electronic Claims in Medisoft

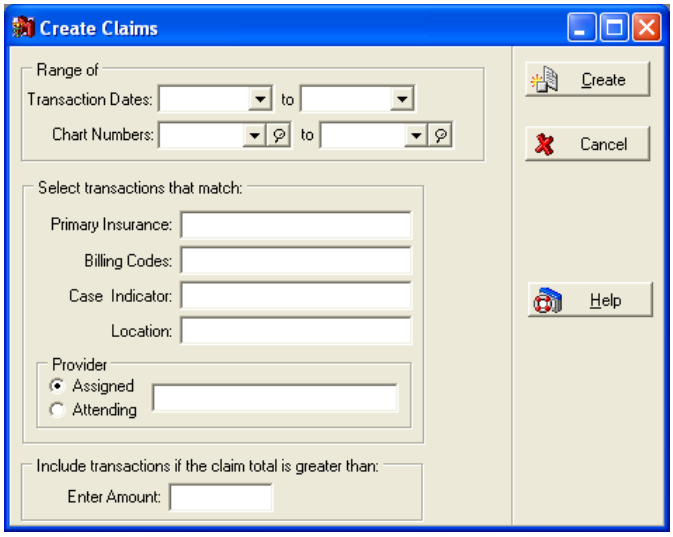
Creating Claims

Before you can send electronic claims, you must create them. To create claims, follow these steps:

1. Go to the **Activities** menu and select **Claim Management**. The **Claim Management** window opens.



2. Click the **Create Claims** button, and the **Create Claims** window opens.



3. Under most circumstances, leave the ranges in this window blank to create all unbilled electronic claims. However, if you want to restrict the batch here, fill in the desired ranges.

Note: To sort specifically by an attending provider instead of assigned provider, make sure to select **Attending** in the **Provider** section. You can enter multiple attending provider codes by separating them with commas.

4. Click the **Create** button when finished in this window.
5. The newly created claims appear in the window.

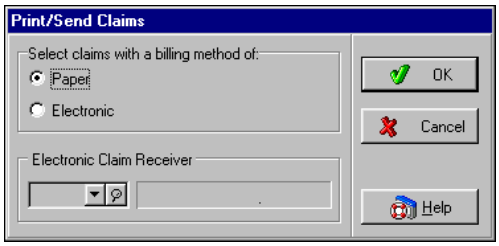
Sending Primary Claims

Before you send primary claims, verify the claims you want to process have the following settings:

- The Status 1 column is Ready to Send.
- The Media 1 column is EDI.
- The EDI Receiver 1 field shows the appropriate EDI receiver.

To send primary claims, follow these steps:

1. Click the **Print/Send** button in Claims Management. The **Print/Send Claims** window opens.

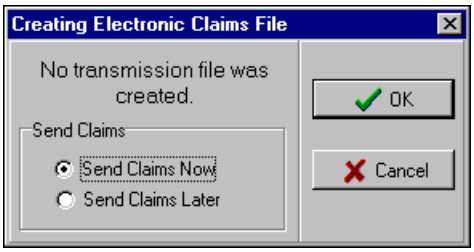


2. Choose **Electronic** and then select the **Electronic Claim Receiver**. Click **OK**. The **ANSI X12** window opens.

Note: If a button is grayed out, that option is not available from your electronic claims carrier.

3. You have 30 days to register the program, but we recommend that you register it before you go any further. See the Registering the Program section on page 78.
4. Click **Send Primary Claims**. The Data Selection Questions window opens.
5. Enter data filters to limit the claims that get sent. If you want to send all claims that are **Ready to Send**, have **Electronic** as the media, and are assigned to the EDI receiver, leave the fields blank.

6. Click **OK** and the program asks if you want to print a Verification Report. We recommend that you click **Yes** to view and print the report. It shows the claims that are included in the claim file. See the Verification Report section on page 75 for more information.
7. If you click **No** or have viewed and closed the Verification Report, the program asks if you want to continue with the transmission.
8. If you need to make changes from what you see on the Verification Report, click **No** and make the necessary changes. If you don't need to make any changes, click **Yes** to continue. The **Creating Electronic Claims File** window opens.



9. Choose to send claims now or later. If you choose to send claims later, you cannot use the Medisoft program until the time comes to send the claims. See the Sending Claims Later section on page 75 for more information. If you choose to send claims now, the program immediately begins transmitting the claims file.
10. If you get an error message that indicates a transmission error has occurred, you may not have entered or may have entered incorrectly a Submitter ID or password. This message could also indicate a data error, a problem with the modem connection, etc. Viewing the details of the process will help troubleshoot the error. Click the **Abort** button and correct the error. Then try to send claims again.
11. After the claims file has been transmitted, a dialog box is displayed stating that the transmission is complete.

Verification Report

When you click **OK** in the **Data Selection Questions** window, a message asks if you want to view a Verification Report.

If you click **Yes**, the Verification Report appears on the screen. It displays the claims you are about to send in the claim file. It also lets you check the batch for accuracy of claims and ensure the claims you intend to send are included.

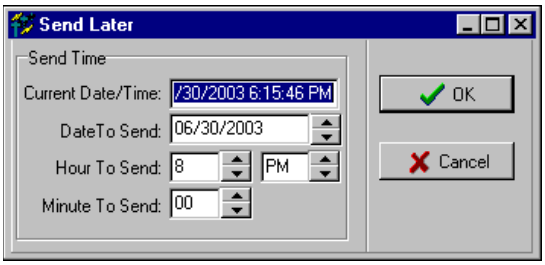
Some key fields to check include **POS** (Place of Service), **TOS** (Type of Service, if required), and **Diagnosis Code**. Medisoft does not attempt to perform any edits on the claims. If you see a message similar to **No facility is set up for this case**, it is merely to alert you to that fact. The claim may or may not require a facility. That is for you to determine.

Once you have reviewed the claims, you can print the report by clicking the Print speed button at the top of the window. Keep the printed report on file. Once this window is closed, you cannot call up the report again.

If you prefer to save this report to a file on your hard drive or other medium, you can do so by clicking the Save icon (diskette) at the top of the window. You can then select a folder and file name for the report. Always give the report a new file name because the previous file will be erased when you view the next verification report.
Click **Close** when done.

Send Claims Later

If you want to send the claims later, choose **Send Claims Later** and click **OK** in the **Creating Electronic Claims File** window. The **Send Later** window opens.



Select the time you want to send your claims using the date, hours, and minutes up/down arrow buttons. Click **OK** when done and the window will minimize until the set times are reached.

YOUR MEDISOFT PROGRAM WILL BE DISABLED until the file is transmitted or you cancel the transmission.

Sending Secondary Claims

If your carrier accepts secondary claims electronically, verify the claims you want to process have the following settings:

- A secondary receiver must be set up
- The claim Status 2 must be Ready to Send
- Media 2 must be Electronic
- The primary carrier must have paid on the account
- Transaction Insurance 2 Responsible must be true

To send secondary claims, follow these steps:

1. Click **Send Secondary Claims** in the main **ANSIX12** window. The **Remittance Tracking Information** window opens. Use this window to verify and/or edit the primary payment information that the carrier may require for secondary claims. See the Remittance Tracking section on page 77 for more information.
2. Once you are finished verifying or entering primary carriers' payment and adjustment information, click **Cancel**. The **Data Selection Questions** window opens.
3. If you want to filter the claims that send, enter values in the **Data Selection Questions** window and click **OK**. If you leave the ranges blank, all available claims assigned to the EDI receiver will be sent.
4. The program asks if you want to view a Verification Report. We strongly recommend that you view the report and print it now. It is your record of what you are sending. Click **Yes** to view the report.
5. After you view and print the Verification Report, close the preview window. The program asks if you want to continue with transmission. Click **Yes**. The **Creating Electronic Claims File** window opens.
6. Choose to send claims now or later. If you choose to send claims later, you cannot use the Medisoft program until the time comes to send the claims. If you choose to send claims now, the program immediately begins transmitting the claims file. See the Sending Claims Later section on page 75 for more information.
7. If you get an error message that indicates a transmission error has occurred, you may not have entered or may have entered incorrectly a Submitter ID or password. This message could also indicate a data error, a problem with the modem connection, etc. Viewing the details of the process will help troubleshoot the error. Click the **Abort** button and correct the error. Then try to send claims again.
8. After the claims file has been transmitted, a dialog box is displayed stating that the transmission is complete.

Remittance Tracking Information

The Remittance Tracking Information allows users to store and access information sent back by the primary insurance carrier. This information may be sent in Electronic Remittance Advice (ERA) files or on the Explanation of Benefits (EOB). When billing a secondary carrier, this information may be necessary in order to get paid the correct amount.

The new Remittance Tracking Information lets you manually add or edit information from EOBs. Information sent back in ERA files are automatically posted to the files when downloaded or viewed through one of Medisoft's Direct Claims programs. If the information sent in the ERA file is later found to be incorrect or have missing information, you can change the information and resend the secondary claim.

Claims appear in the Remittance Tracking Information window when they have a secondary insurance assigned. If no secondary insurance is assigned to the claim, no primary remittance information needs to be stored. You can add or edit primary remittance information on both the claim level and the transaction level. Only transactions assigned to a claim can have tracking information added or edited.
See the Remittance Tracking Information topic in the ANSI help file for information on the window.

Handling Rejected Claims

Entire Batch

If an entire batch is rejected, you can change the claim status of all the claims at one time. Highlight one of the claims and note the number listed in the **Batch 1** column. Click the **Change Status** button. The **Change Claim Status/Billing Method** window appears.

Choose the **Batch** radio button and enter the batch number from the **Batch 1** column in the **Claim Management** window. In the **Status From** area, choose **Sent**, and in the **Status To** area choose **Ready to Send**. All claims with that batch number will have the status changed to Ready to Send.
Click **OK** when done.

Single or Few Claims

When a claim has been rejected for errors, the error(s) must be corrected and the claim resent. You must also indicate the change of claim status in the **Claim Management** window to recreate the claim(s). This is done by highlighting the rejected claims, clicking the **Change Status** button, and changing the status from **Sent** to **Ready to Send**. See the Editing Claims section earlier in this manual.

If a single transaction of a claim has been rejected while the others were accepted, edit the claim and open the **Transaction** tab. Highlight the rejected transaction and click the **Split** button at the bottom of the window. This will remove this one transaction from the claim and create a new claim with a status of Ready to Send so it can be sent in the next batch. Clicking the **Remove** button removes the transaction from the claim, making it available to be added to another existing claim or become part of a new claim the next time you perform the create claims function.

Rebilling Claims

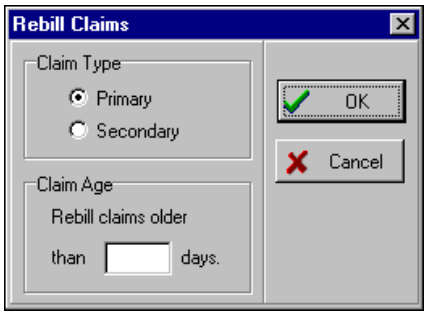
Primary Claims

You can rebill any unpaid claims that are older than the date you specify.

There are two requirements to rebill these claims:

1. The claim status must be Sent.
2. The claim must have a billing date.

Suppose you want to rebill all unpaid claims that are over 60 days old. Go to the **ANSI X12** window and click the **Rebill Claims** button.



Enter **60** in the **Rebill Claims** window and click **OK**. The **Data Selection Questions** window is displayed. Leave all of these fields blank and click **OK**.

All unpaid claims that are older than 60 days will be rebilled. The billing date is changed to today's date; however, the initial billing date remains the date the claim was first sent for payment.

Secondary Claims

Be sure that you have correctly met all the setup requirements for sending secondary claims electronically. In addition to the setup conditions set forth earlier in this manual, the following conditions must be met:

1. The claim status must be Sent.
2. The Secondary Billing Date on the claim must meet the **Rebill claims older than** specification.

Registering the Program

You have 30 days to register the program. We recommend that you register right away because the program will be locked at the end of the 30 days and you will not be able to access your data until the program is registered.

To register, go to the **Help** menu and select **Product Registration**. You can also click the **Register Product** button in the **ANSI X12** window.

All installed Medisoft-related products are listed in the opening **Medisoft Registration** window. If you have an Medisoft-related product that is not listed in this window, close registration and open and close each of the products that should be listed. Then reopen your Medisoft program.

To register your product, follow these steps.

1. In the product registration window, click the **Register** button.
2. In the **Purchase Information** window, enter all the practice information and click **Next**.
3. In the **Provider List** window, enter information for each provider in the practice. To enter a new provider, click **New**. Once you are finished entering the information, click **Next**.
4. In the **Serial Number List** window, enter your serial number. If you are upgrading from a previous version, enter your old serial number in the **Upgrade from Ser#** field. Click **Next**.
5. The **Registration Status** window opens, telling you whether registration was successful. If it was successful, the **Registered** column says **Yes**. If registration was not successful, the **Registered** column says **No** and the **Registration Errors** column shows the reason. Go to the help file and search for the Registration Errors topic for information on common registration errors.
6. Click the **Done** button to go back to the main product registration window. If registration was successful, click the **Close** button. If registration was not successful, click the **Register** button to go back through the process and fix the problem.

Receiving Reports

RelayHealth Reports Folder

When a customer is transmitting Electronic Claims, a directory is created inside the customer's data directory. This directory is typically called the name of the direct claims module (for example NHIC). Contained in this directory are folders named EMC, ERA, EOB, etc. These folders are used to store claim files, TCH files, ERAs, etc.

The RelayHealth module utilizes new folder called Reports. The Reports folder is used to store all of the Reports that a customer will receive from RelayHealth. The Reports folder has two sub-directories Payer and RelayHealth. The Payer folder contains all reports that come from the payer.

Report Naming Convention

The DBQ reports have a 2-letter prefix that indicates the report type, followed by the submitter id. The filename extension consists of 2 alphanumeric characters which indicate where the file relates back to a particular transmission within the series.

For example, the first time that you send a claim; you receive an AC (acknowledgment) and EC (exclusion reports) with a filename extension of "AA". Then the next day, the you send a new file, and the reports for that file come back with an "AB" extension. If Medicare then passes back information on some claims four days after that first file was transmitted—but those rejects relate back to that very first file— the extension on the report is "AA". AA through A9 is used as extensions for the first 35 transmissions. Then the extension change to BA and so on.

Clearinghouse Reports/Files

ACK Folder

Level I Edits

- High level to verify that an ANSI file is syntactically correct.
- If transaction does not pass the level I edits, the claims will reject at either the transaction set or file level.
- For more information on the Collaboration Compass site, see: www.collaborationcompass.com/Support/Documentation/RelayHealthReference Guide/LevelIExclusion Messages

XA Report- 997 File Acknowledgement Report

- Frequency: Same day as transmission
- Documents if the file transmission to RelayHealth was success or failed.

The 997 file documents which syntax edits are performed and which claims are rejected at the transaction set level.

Files in the format "XA<Submitter ID>.aa" (XA Files) are 997 acknowledgment reports, also known as first-level edits. These reports deal with whether the file as a whole was processed or unprocessed.

```
ISA*00*      *00*       *ZZ*CLAIMSCH     *ZZ*999999   *070728*1249*U*00401*128775486*0*P*
TA1*167892098*060728*1032*A*000~
GS*FA*ECGCLAIMS*P999999*20060728*1249*000000001*X*004010~
ST*997*000001~
AK1*HC*209~
AK2*837*0001~
AK3*SBR*022437*2000B*8~
AK4*10**3~
AK3*SBR*022484*2000B*8~
AK4*10**3~
AK5*R*5~
AK9*P*1*000001*000000~
SE*0000000010*000001~
GE*000001*000000001~
IEA*00001*128775486~
```

Level II Edits

All claims that make it through the 997 level will then be edited using the 277 transaction in which semantic edits are performed and claims are rejected at the claim level. The 277 data file lists both the accepted and rejected claims. This information is contained in files named with "XJ<Submitter ID>.aa".

XJ report- Front End Level II Edits (277 Claims Status Report)

- Frequency: Reported Received as it is generated by RelayHealth
- Contain only the rejected claim information

```
                    TSH 277 CLAIM STATUS REJECT REPORT              PAGE:     1
CPA425.02                                                              MM/DD/CCYY
                                                                       15:56:37

CONTROL #:      112049999
DATE/TIME:      03/02/05  15:56
PROD/TEST:      P
ORIGINATOR APPLICATION TRANS ID:      149999
TRANSACTION SET CREATION DATE:        MM/DD/CCYY
CLIENT ID/NAME:          009999 PHYSICAINS, INC
SUBMITTER ID/NAME:       929999 PHYSICIANS INC
--------------------------------------------------------------------------------
SUBSCR NAME:   PAUL JOHNSON
PATIENT NAME:  POLLY JOHNSON
PAYER ID/NAME : 1509   MAGELLAN
SERVICE DATE   : MM/DD/CCYY-MM/DD/CCYY          CLAIM TOTAL:          $8,400.00
TRACE NUMBER   : 3JRDYQ-619999                     CLAIM ID: 38939999
BILL TYPE      : 111                  MEDICAL RECORD NUMBER: 619999
CATEGORY CODE  : A3 =REJECTED
STS                          ERROR MESSAGE
---                          -------------
21 INPATIENT CLAIMS MUST CONTAIN BOTH ACCOM AND ANCILLARY CHARGES (LOOP2400)
--------------------------------------------------------------------------------
SUBSCR NAME:   PAUL JOHNSON
PATIENT NAME:  POLLY JOHNSON
PAYER ID/NAME : 1509   MAGELLAN
SERVICE DATE   : MM/DD/CCYY-MM/DD/CCYY          CLAIM TOTAL:          $9,600.00
TRACE NUMBER   : 3JRDYR-619999                     CLAIM ID: 38939999
BILL TYPE      : 111                  MEDICAL RECORD NUMBER: 619999
CATEGORY CODE  : A3 =REJECTED
STS                          ERROR MESSAGE
---                          -------------
21 INPATIENT CLAIMS MUST CONTAIN BOTH ACCOM AND ANCILLARY CHARGES (LOOP2400)
--------------------------------------------------------------------------------
CLAIMS ACCEPTED:        166                          AMOUNT:        258,485.76
CLAIMS REJECTED:          2                          AMOUNT:         18,000.00
```

Level III edits

Claims process through Level III edits, which means that the claims will process through both standard and payor specific edits.

Resources Available:

Payor Edits tool:

www.collaboration compass.com / Support / Payor / Payor Edits

Standard Edits:
www.collaboration compass.com / Support / Documentation / RelayHealth Reference Guide / Level II Exclusion Messages / ASC X12N V.4010 - Professional (or Institutional)

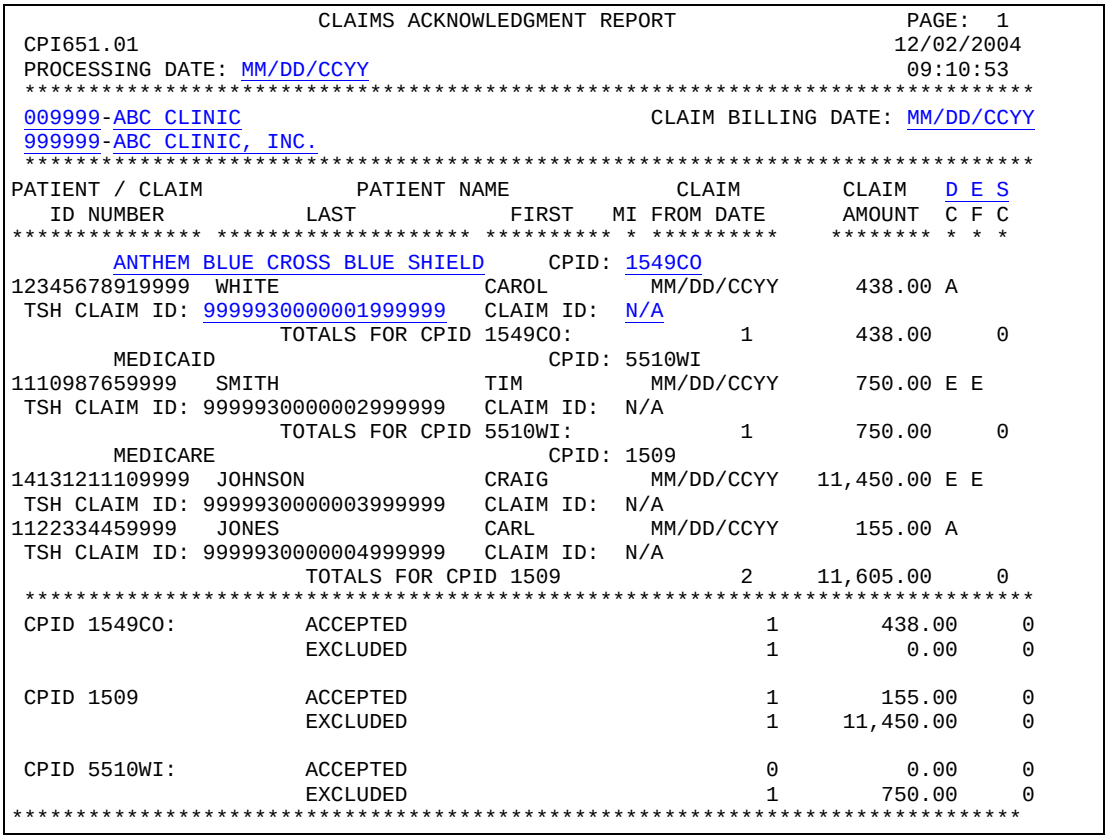
Both the Claims Acknowledgement and Exclusion Claims reports provide a summary of the claims processed. The claim totals are broken down by payor and documents the number of claims that were accepted and excluded, as well as the corresponding dollar amount.

Claims Acknowledgement Report (CA Report)

- Frequency: Reported Received as it is generated by RelayHealth
- This report documents all claims that went through the level 3 edit process.

The report documents the distribution of information to the payor using the D/C column, E/F column and S/C column.

- D/C column documents how the claim was distributed. Common situations are:
  - A, Claim accepted and transmitted to payor electronically
  - B, Claim sent to payor via paper
  - E, Claim returned to submitter via EMF (print image)
- E/F column documents that the claim receive errors. The code will equal an E, indicating that the claim was excluded at RelayHealth and will not be forwarded onto the payor.
- S/C column documents supplemental or additional claims.This applies to printed paper claims if the line item exceeds:
  - 6 lines for professional claims
  - 23 line items for Institutional claims



```
                        CLAIMS ACKNOWLEDGMENT REPORT                    PAGE:  1
 CPI651.01                                                             12/02/2004
 PROCESSING DATE: MM/DD/CCYY                                            09:10:53
 ************************************************************************************
 009999-ABC CLINIC                                  CLAIM BILLING DATE: MM/DD/CCYY
 999999-ABC CLINIC, INC.
 ************************************************************************************
PATIENT / CLAIM            PATIENT NAME              CLAIM        CLAIM    D E S
   ID NUMBER           LAST            FIRST    MI FROM DATE      AMOUNT   C F C
*************** ****************** ********** * **********    ********* * * *
        ANTHEM BLUE CROSS BLUE SHIELD      CPID: 1549CO
12345678919999  WHITE                 CAROL        MM/DD/CCYY      438.00 A
 TSH CLAIM ID: 9999930000001999999   CLAIM ID:  N/A
                     TOTALS FOR CPID 1549CO:            1        438.00     0
        MEDICAID                           CPID: 5510WI
1110987659999   SMITH                 TIM          MM/DD/CCYY      750.00 E E
 TSH CLAIM ID: 9999930000002999999   CLAIM ID:  N/A
                     TOTALS FOR CPID 5510WI:            1        750.00     0
        MEDICARE                           CPID: 1509
14131211109999  JOHNSON               CRAIG        MM/DD/CCYY   11,450.00 E E
 TSH CLAIM ID: 9999930000003999999   CLAIM ID:  N/A
1122334459999   JONES                 CARL         MM/DD/CCYY      155.00 A
 TSH CLAIM ID: 9999930000004999999   CLAIM ID:  N/A
                     TOTALS FOR CPID 1509               2     11,605.00     0
 ************************************************************************************
 CPID 1549CO:          ACCEPTED                          1        438.00     0
                       EXCLUDED                          1          0.00     0

 CPID 1509             ACCEPTED                          1        155.00     0
                       EXCLUDED                          1     11,450.00     0

 CPID 5510WI:          ACCEPTED                          0          0.00     0
                       EXCLUDED                          1        750.00     0
************************************************************************************
```

```
 999999 TOTALS:        ACCEPTED                              1        593.00     0
                       EXCLUDED                              3     12,200.00     0
                                                         ********  ************  ****
                       TOTAL-INPUT                           4     12,793.00     0
                       ************************************************************
                       (A)ELECTRONIC TO PAYER                2   +    0   =       2
                       (E) PAPER CLAIM-MAILBOX               2   +    0   =       2
                                                        **************************
                       TOTAL OUTPUT                          4   +    0   =       4
 ****************************************************************************
"D/C" (7TH COLUMN) IS THE DISTRIBUTION CODE COLUMN. THIS CODE WILL INDICATE HOW
THE CLAIM IS DISTRIBUTED. POSSIBLE VALUES ARE:
 A = ELECTRONIC TO PAYER  C = PATIENT-DIRECT          E = PAPER CLAIM-MAILBOX
 B = CARRIER-DIRECT       D = ELECTRONIC TO PAYER(2)  F = PAPER CLAIM-HARDCOPY
"E/F" (8TH COLUMN) IS THE ERROR FLAG COLUMN. POSSIBLE VALUES ARE:
  E = **ERROR** FAILED EDIT WOULD NOT ALLOW CLAIM TO BE FORWARDED TO CARRIER
  W = **WARNING** (NOT CURRENTLY USED)
"S/C" (9TH COLUMN) IS THE SUPPLEMENTAL CLAIMS COLUMN. AN ADDITIONAL CLAIM
CHARGE WILL BE APPLIED TO PRINTED PAPER CLAIMS WHEN THE SUBMITTED CLAIMS
EXCEEDS 6 LINE ITEMS ON PROFESSIONAL CLAIMS AND 23 LINE ITEMS ON INSTITUTIONAL
CLAIMS.  TSH CLAIM ID CONTAINS THE NUMBER ASSIGNED BY TSH; N/A INDICATES THAT
AN ID WAS NOT ASSIGNED.
CLAIM ID CONTAINS THE VALUE FROM THE REF D9 SEGMENT / EA6-08 FROM THE ORIGINAL
SUBMITTED CLAIM FILE; N/A INDICATES THAT A VALUE WAS NOT RECEIVED.
****************************************************************************
                          SUMMARY TOTALS BY CPID
              NUMBER OF     SUPPLEMENTAL       TOTAL             CLAIM    ADDL
   CPID        CLAIMS          CLAIMS          CLAIMS           AMOUNT    APP
  ******     **********     ************     **********     ************** ***
  1549CO             1                0              1            438.00
  1509               2                0              2         11,605.00
  5510WI             1                0              1            750.00   CC
             ----------     ------------     ----------     --------------
       TOTALS        4                0              4         12,793.00
```

Exclusion Claims Report (EC Report)

- Frequency: Reported received as it is generated.
- This report documents the claims that excluded during the level III edit process.

  The only codes used are the “E” in the D/C column, and “E” in the E/F column advising that the claim was excluded at RelayHealth.

  For the claims populated on the Exclusion Claims report, an error code and brief description of the error received is also documented.

The first and second characters document the Edit Code.

If that is all that is documented, that indicates that a standard edit was received.

- Example: 80 INVALID RESPONSIBLE PARTY STATE

If the first and second characters are followed by an additional four characters, the four characters represent a version code.

If that is documented, it indicates that a payor specific edit was received.

- Example: 01 0001C:INVALID INSURED ID NUMBER

```
                          EXCLUSION CLAIMS REPORT                PAGE:    1
 CPI652.01                                                       MM/DD/CCYY
 PROCESSING DATE: MM/DD/CCYY                                       09:11:08
****************************************************************************
009999-ABC  CLINIC                              CLAIM BILLING DATE: MM/DD/CCYY
```

```
999999-ABC CLINIC, INC.
********************************************************************************
 PATIENT / CLAIM            PATIENT NAME              CLAIM        CLAIM    D E S
    ID NUMBER           LAST            FIRST   MI FROM DATE      AMOUNT   C F C
 *************** ****************** ********** * **********    ******** * * *
***               MEDICAID                          CPID: 5510WI
 1110987659999   SMITH               CARL          MM/DD/CCYY      750.00 E E
  TSH CLAIM ID: 9999930000002999999   CLAIM ID:  N/A
GJ  MISSING OCCURRENCE CODE DATE                                          UB
01  0050C:INVALID INSURED ID                  Z639999                    UB
                    TOTALS FOR CPID 5510WI:           1        750.00     0
***               BLUE CROSS BLUE SHIELD            CPID: 1509
14131211109999  JONES               WILLIAM       MM/DD/CCYY   11,450.00 E E
  TSH CLAIM ID: 9999930000003999999   CLAIM ID:  N/A
    ERROR 01    INVALID POLICY NUMBER
                    TOTALS FOR CPID 1509  :           1     11,450.00
********************************************************************************
CPID 1549CO:        EXCLUDED                          0          0.00     0
                    ACCEPTED                          1        438.00     0

CPID 1509           EXCLUDED                          1     11,450.00     0
                    ACCEPTED                          1        155.00     0

CPID 5510WI:        EXCLUDED                          1        750.00     0
                    ACCEPTED                          0          0.00     0

********************************************************************************
999999 TOTALS:      EXCLUDED                          2     12,200.00     0
                    ACCEPTED                          2        593.00     0
                                                  ********  ************  ****
                    TOTAL-INPUT                       4     12,793.00     0
                    ************************************************************
                    (A) ELECTRONIC TO PAYER           2   +     0   =       2
                    (E) PAPER CLAIM-MAILBOX           2   +     0   =       2
                                                  ****************************
                    TOTAL OUTPUT                      4   +     0   =       4
********************************************************************************
"D/C" (7TH COLUMN) IS THE DISTRIBUTION CODE COLUMN. THIS CODE WILL INDICATE HOW
THE CLAIM IS DISTRIBUTED. POSSIBLE VALUES ARE:
 A = ELECTRONIC TO PAYER  C = PATIENT-DIRECT          E = PAPER CLAIM-MAILBOX
 B = CARRIER-DIRECT       D = ELECTRONIC TO PAYER(2)  F = PAPER CLAIM-HARDCOPY
"E/F" (8TH COLUMN) IS THE ERROR FLAG COLUMN. POSSIBLE VALUES ARE:
  E = **ERROR** FAILED EDIT WOULD NOT ALLOW CLAIM TO BE FORWARDED TO CARRIER
  W = **WARNING** (NOT CURRENTLY USED)
"S/C" (9TH COLUMN) IS THE SUPPLEMENTAL CLAIMS COLUMN. AN ADDITIONAL CLAIM
CHARGE WILL BE APPLIED TO PRINTED PAPER CLAIMS WHEN THE SUBMITTED CLAIM EXCEEDS
6 LINE ITEMS ON PROFESSIONAL CLAIMS AND 23 LINE ITEMS ON INSTITUTIONAL CLAIMS.
```

```
                          EXCLUSION CLAIMS REPORT                 PAGE:  2
CPI652.01                                                         12/02/2004
PROCESSING DATE: 12/02/2004                                       01:29:27
********************************************************************************
339999-ABC CLINIC                              CLAIM BILLING DATE: 11/30/2004
339999-ABC CLINIC, INC.
********************************************************************************
                    EXCLUSION SUMMARY TOTALS BY CPID
               NUMBER OF     SUPPLEMENTAL       TOTAL            CLAIM    ADDL
    CPID        CLAIMS          CLAIMS          CLAIMS           AMOUNT    APP
   ******     **********     ************     **********     ************** ***
   5510WI            1                0             1            750.00   CC
   1509              1                0             1         11,450.00
              ----------     ------------     ----------     --------------
   TOTALS            2                0             2         12,200.00
```

Resubmit Folder

UA Report- Resubmitted Claims Acknowledgement Report (UA Report)

- These reports have a box indicating “Recreate” at the top of the report. Within the box, a message notes that the claims have been resubmitted.
- This report follows the same format as the original Claims Acknowledgement report.

```
     **********RECREATE***RECREATE***RECREATE***RECREATE***RECREATE**********
     ***                                                                   ***
     ***  THE FOLLOWING CLAIMS HAVE BEEN PROCESSED FOR RESUBMISSION TO     ***
     ***  THE PAYOR.  PLEASE REVIEW THIS REPORT TO DETERMINE WHICH         ***
     ***  CLAIMS HAVE NOT PASSED THE UPDATED MCKESSON EXCLUSIONS.          ***
     ***                                                                   ***
     **********RECREATE***RECREATE***RECREATE***RECREATE***RECREATE**********
-                       CLAIMS ACKNOWLEDGMENT REPORT                  PAGE:  1
  REC651.01                                                          MM/DD/CCYY
  PROCESSING DATE: MM/DD/CCYY                                        10:30:32
  ********************************************************************************
  009999-MILLBANKS CORPORATION                      CLAIM BILLING DATE: MM/DD/CCYY
  999999-SWAY
  ********************************************************************************
   PATIENT / CLAIM            PATIENT NAME             CLAIM        CLAIM   D E S
      ID NUMBER           LAST            FIRST    MI FROM DATE      AMOUNT  C F C
   *************** ******************** ********** * **********    ******** * * *
          MEDICARE - PART A                CPID: 1506IL
   309999          SKAMP                MARY ROSE   F 03/47/2003       47.00 F E
```

UE Report- Resubmitted Exclusion Claims Report (UE Report)

- Reports have a box indicating “Recreate” at the top of the report. Within the box, a message notes that the claims have been resubmitted.
- This report follows the same flow as the original Exclusion Claims report.

```
     **********RECREATE***RECREATE***RECREATE***RECREATE***RECREATE**********
     ***                                                                   ***
     ***  THE FOLLOWING CLAIMS HAVE BEEN PROCESSED FOR RESUBMISSION TO     ***
     ***  THE PAYOR.  PLEASE REVIEW THIS REPORT TO DETERMINE WHICH         ***
     ***  CLAIMS HAVE NOT PASSED THE UPDATED MCKESSON EXCLUSIONS.          ***
     ***                                                                   ***
     **********RECREATE***RECREATE***RECREATE***RECREATE***RECREATE**********
-                          EXCLUSION CLAIMS REPORT                    PAGE:  1
  REC652.01                                                          MM/DD/CCYY
  PROCESSING DATE: MM/DD/CCYY                                        10:30:35
  ********************************************************************************
  009999-MILLBANKS CORPORATION                      CLAIM BILLING DATE: MM/DD/CCYY
  999999-SWAY
  ********************************************************************************
   PATIENT / CLAIM            PATIENT NAME             CLAIM        CLAIM   D E S
      ID NUMBER           LAST            FIRST    MI FROM DATE      AMOUNT  C F C
   *************** ******************** ********** * **********    ******** * * *
          MEDICARE - PART A                CPID: 1506IL
   309999          SKAMP                MARY ROSE   F MM/DD/CCYY       47.00 F E
  41  INVALID TYPE OF BILL - MUST BE 71X        731                          UB
  70  INVALID STATEMENT FROM DATE               20030347                     UB
```

Summary Folder

F2 Report- Weekly and Monthly Insurance Billing Reports (F2)

- Frequency: Reports are received monthly and weekly

- The billing reports contain claim information and do not document electronic remittance (ERA).
- Both billing reports do not provide dollar amounts, only claim totals.
- Both billing reports break down the claims submitted by the CPID (payor ID), payor name, distribution method, the number of claims sent to the specific carrier, and the total claims that were transmitted.

Example of Weekly Billing report:

```
PAGE:     1                        COMMON PROCESSOR                                REPORT NO:   CPI105.01
                            WEEKLY INSURANCE BILLING REPORT                        REPORT DATE:
MM/DD/CCYY
                                    SYSTEM ID - C980                               PRINT DATE:
 MM/DD/CCYY
                                                                                   PRINT TIME:  14:35:36
                     ***************   BILLING ID - 000948   ***************
CLINIC                                                                                    LAST PROCESS
OFFICE #   PROVIDER NAME           FORM #    FORM DESCRIPTION     FORM TYPE     DATE        CLAIM COUNT
*************************************************************************************************************
*************************************************************************************************************
*************************************************************************************************************
***
***
                                                                                                      ***
***
                                                                                                     ***
***
                                                                                                      ***
***                                 PLEASE FORWARD TO THE ACCOUNTS PAYABLE DEPARTMENT
                 ***
***
                                                          ***
***
    ***
***
                                                                                                      ***
*************************************************************************************************************
*
*************************************************************************************************************
*************************************************************************************************************
**
PAGE:     2                     COMMON PROCESSOR                                  REPORT NO:   CPI105.01
                           WEEKLY INSURANCE BILLING REPORT                        REPORT DATE: MM/DD/CCYY
                                    SYSTEM ID - C980                               PRINT DATE:  MM/DD/CCYY
                                                                                   PRINT TIME:  14:35:36
                     ***************   BILLING ID - 000948   **************
CLINIC                                                                                    LAST PROCESS
OFFICE #   PROVIDER NAME          FORM #    FORM DESCRIPTION        FORM TYPE     DATE        CLAIM COUNT
099999  FAMILY PHYSICIANS         1420 - CONNECTICUT BLUE SHIELD        EMC      MM/DD/CCYY         37
                                  1420 - CONNECTICUT BLUE SHIELD        EMC      MM/DD/CCYY         60
                                                                     FORM ID TOTAL                    97
                                  2427 - CT BLUECARE FAM PLAN(MEDICAID) EMC      MM/DD/CCYY          1
                                  2427 - CT BLUECARE FAM PLAN(MEDICAID) EMC      MM/DD/CCYY         17
                                                                     FORM ID TOTAL                    18
                                  3429 - ENVOY-UNITEDHEALTHCARE         EMC      MM/DD/CCYY          3
                                  3429 - ENVOY-UNITEDHEALTHCARE         EMC      MM/DD/CCYY          3
                                                                     FORM ID TOTAL                     6
                                  4476 - CT WELFARE                     EMC      MM/DD/CCYY          2
                                                                     FORM ID TOTAL                     2
                                  4483 - ENVOY - HEALTHNET              EMC      MM/DD/CCYY          6
                                  4483 - ENVOY - HEALTHNET              EMC      MM/DD/CCYY          3
                                                                     FORM ID TOTAL                     9
                                  6400 - ENVOY-AETNA                    EMC      MM/DD/CCYY          9
                                  6400 - ENVOY-AETNA                    EMC      MM/DD/CCYY          9
                                                                     FORM ID TOTAL                    18
                                  6405 - ENVOY - CIGNA                  EMC      MM/DD/CCYY         11
                                  6405 - ENVOY - CIGNA                  EMC      MM/DD/CCYY          9
                                                                     FORM ID TOTAL                    20
                                  6440 - ENVOY- CONNECTICARE INC.       EMC      MM/DD/CCYY          6
                                  6440 - ENVOY- CONNECTICARE INC.       EMC      MM/DD/CCYY         13
                                                                     FORM ID TOTAL                    19
                                  6485 - OXFORD HEALTH PLAN         *PP* EMC      MM/DD/CCYY          7
PAGE:     3                       COMMON PROCESSOR                                  REPORT NO: CPI105.01
                           WEEKLY INSURANCE BILLING REPORT                        REPORT DATE:
MM/DD/CCYY
                                    SYSTEM ID - C980                               PRINT DATE:
 MM/DD/CCYY
                                                                                   PRINT TIME:  14:35:36
                     ***************   BILLING ID - 000948   **************
```

```
CLINIC                                                                                    LAST PROCESS
OFFICE #   PROVIDER NAME          FORM #    FORM DESCRIPTION        FORM TYPE          DATE       CLAIM COUNT
099999  FAMILY PHYSICIANS             6485 - OXFORD HEALTH PLAN          *PP* EMC  MM/DD/CCYY            5
```

Example of Monthly Billing report:

```
PAGE:     1                      CLEARINGHOUSE                                          REPORT NO:   CPI115.01
                      MONTHLY INSURANCE BILLING REPORT                                  REPORT DATE:
MM/DD/CCYY
                             SYSTEM ID - BILL (C350 )                                   PRINT DATE:
 MM/DD/CCYY
                                                                                        PRINT TIME:  01:02:36

BILLING ID       MICHAEL SMITH MD
000999           SUITE # 100
8120 SOUTH JOLLY STREET
NYTOWN          CO 99999
*************************************************************************************************************
*
*************************************************************************************************************
*
*************************************************************************************************************
****                                                                                                        ***
***                                                                                                         ***
***                                                                                                         ***
***                                                                                                         ***
***                                  PLEASE FORWARD TO THE ACCOUNTS PAYABLE
DEPARTMENT                      ***
***                                                                                                         ***
***                                                                                                         ***
***                                                                                                            **
*
*************************************************************************************************************
*
*************************************************************************************************************
*
*************************************************************************************************************
*PAGE:     2                      CLEARINGHOUSE                                          REPORT NO:
  CPI115.01
                         MONTHLY INSURANCE BILLING REPORT                               REPORT DATE:
MM/DD/CCYY
                                   SYSTEM ID - C980                                     PRINT DATE:
 MM/DD/CCYY
                                                                                        PRINT TIME:  01:02:36
   BILLING ID       MICHAEL SMITH MD
   000999           SUITE # 100
                    8120 SOUTH JOLLY STREET
                    ANYTOWN          CO 99999
SUBMITTER                               CPID                          DISTRIBUTION  LAST PROCESS
NUMBER    PROVIDER NAME                  #     CPID DESCRIPTION          METHOD        DATE     CLAIM COUNT
   070999 MICHAEL LOTT MD     1361 COMM HCFA 12/90 *CARR DIRECT*   PAYOR DIRECT   MM/DD/CCYY
55                            1415 COLORADO BC/BS                  EC          MM/DD/CCYY             5
                              2420 WESTERN                  *PP*   EC             MM/DD/CCYY             1
                              3429 METRO                    *PP*   EC             MM/DD/CCYY           184
                              4415 OVERCARE                 *PP*   EC             MM/DD/CCYY            86
                              4433 HEALTHCARE INC.          *PP*   EC             MM/DD/CCYY            43
                              5402 HAWKEYE HEALTHCARE       *PP*   EC             MM/DD/CCYY             2
                              6400 CENTRAL HEALTHCARE              EC             MM/DD/CCYY            79
                              6405 PPO/HMO                  *PP*   EC             MM/DD/CCYY           127
                              6408 GREAT EASTERN            *PP*   EC             MM/DD/CCYY            29
                              6409 LIFE AND HEALTH                 EC             MM/DD/CCYY            12
                              6417 ATLANTIC                        EC             MM/DD/CCYY             3
                              6422 AMERICAN                        EC             MM/DD/CCYY             2
                              6426 EAST COAST MUTUAL               EC             MM/DD/CCYY            14
                              6428 SOUTHERN ACCOCIATES             EC             MM/DD/CCYY             4
                              6435 NORHTERN MUTUAL                 EC             MM/DD/CCYY             3
                              6467 GLOBAL ASSOCIATES               EC             MM/DD/CCYY             2
                              6491 ATTITUDE HEALH                  EC             MM/DD/CCYY             2
                              7481 AMERICAN MEDICAL         *PP*   EC EXCLUSION   MM/DD/CCYY             2
                                                                     SUBMITTER TOTAL                     655 *
                                                                     BILLING ID TOTAL                    655
**

****************************************** REPORT LEGEND
**********************************************
*          CPID: CLEARINGHOUSE PAYOR ID
```

```
*          *PP*: PREFERRED PAYOR CREDIT
*          PAPER: PRINT IMAGE CLAIM RETURNED TO SUBMITTER
*          EC: ELECTRONIC CLAIM
*          PAYOR DIRECT: PAPER CLAIM SENT DIRECTLY TO PAYOR
*          PATIENT DIRECT: PAPER CLAIM MAILED DIRECTLY TO PATIENT
*          EC EXCLUSION: CLAIM COULD NOT BE SUBMITTED ELECTRONICALLY TO THE PAYOR; PRINT IMAGE CLAIM
           RETURNED TO SUBMITTER *
*          PAYOR DIR EXCL: CLAIM WAS EXCLUDED FROM PAYOR DIRECT PROCESSING; PRINT IMAGE CLAIM RETURNED
TO
           SUBMITTER          *
*          PAT DIR EXCL: CLAIM WAS EXCLUDED FROM PATIENT DIRECT PROCESSING; PRINT IMAGE CLAIM RETURNED
TO
           SUBMITTER        *
*************************************************************************************************
*
```

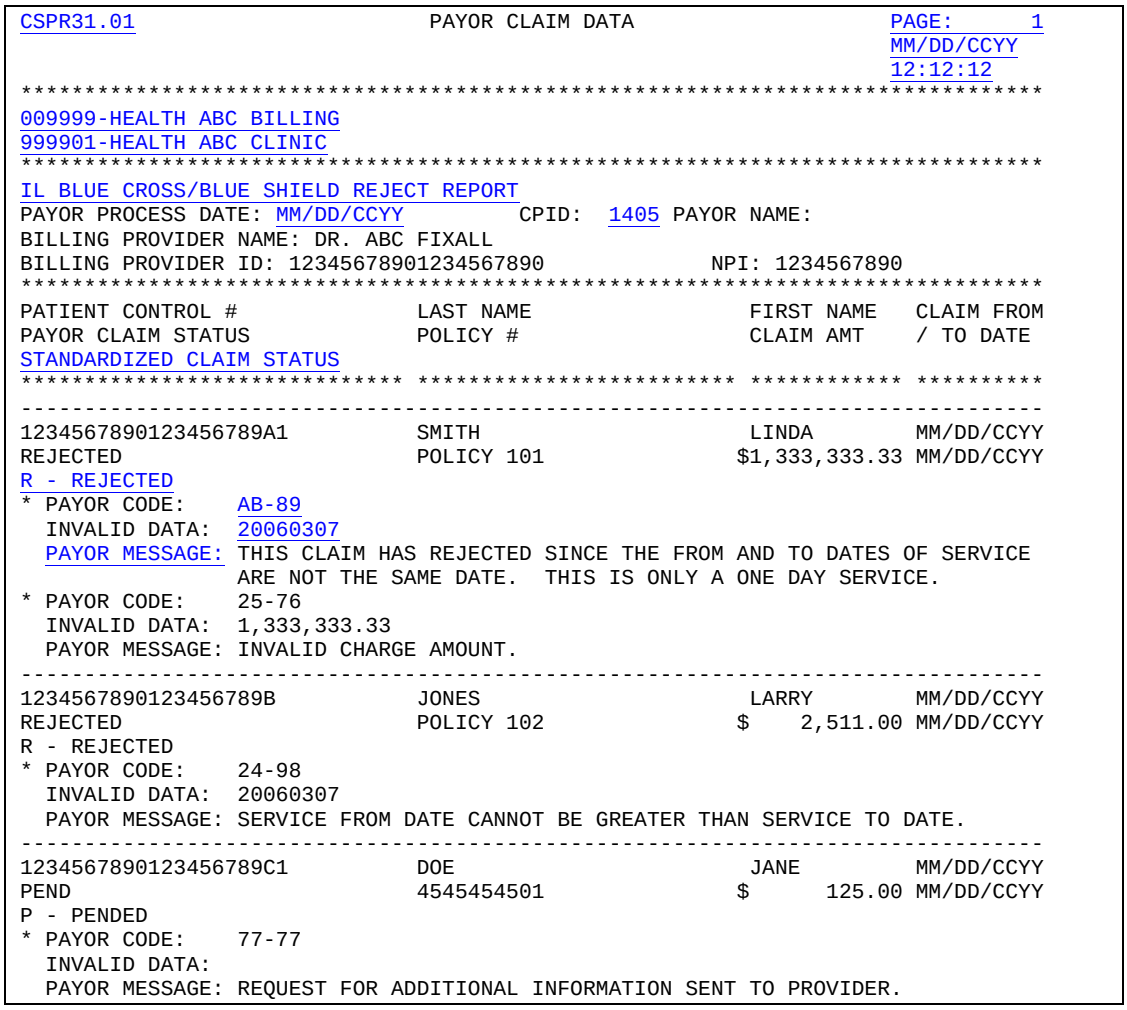
Payor Reports/Files

The reports include an SR report, SE report, and SB report.

SR Report- Payor Claim Data Report (SR Report)

- Frequency: Upon Receipt from the payer
- These reports show individual claim level activity from the payers. This data, however, is only available for certain carriers and trading partners. Many carriers only report this information at the EOB-level rather than passing back a rejection electronically.
- The standardized payor report documents all claim level report information--separate reports based on that status of the claim are not available.
- A claim status code is documented on the report to provide the status of the claim.

  The code equals one of the following:
  - A: Accepted
  - I: Request for additional information
  - M: Information message
  - P: Pending
  - R: Rejected
  - U: Unknown – report default
  - Z: Zero payment claim
- In addition to the claim status code, this report also documents any payor report messages provided by the payor.



```
CSPR31.01                          PAYOR CLAIM DATA                          PAGE:      1
                                                                             MM/DD/CCYY
                                                                             12:12:12
********************************************************************************
009999-HEALTH ABC BILLING
999901-HEALTH ABC CLINIC
********************************************************************************
IL BLUE CROSS/BLUE SHIELD REJECT REPORT
PAYOR PROCESS DATE: MM/DD/CCYY          CPID:  1405 PAYOR NAME:
BILLING PROVIDER NAME: DR. ABC FIXALL
BILLING PROVIDER ID: 12345678901234567890             NPI: 1234567890
********************************************************************************
PATIENT CONTROL #              LAST NAME                  FIRST NAME   CLAIM FROM
PAYOR CLAIM STATUS             POLICY #                   CLAIM AMT    / TO DATE
STANDARDIZED CLAIM STATUS
****************************** ********************** ************ **********
--------------------------------------------------------------------------------
123456789012345678 9A1         SMITH                      LINDA        MM/DD/CCYY
REJECTED                       POLICY 101              $1,333,333.33 MM/DD/CCYY
R - REJECTED
* PAYOR CODE:    AB-89
  INVALID DATA:  20060307
  PAYOR MESSAGE: THIS CLAIM HAS REJECTED SINCE THE FROM AND TO DATES OF SERVICE
                 ARE NOT THE SAME DATE.  THIS IS ONLY A ONE DAY SERVICE.
* PAYOR CODE:    25-76
  INVALID DATA:  1,333,333.33
  PAYOR MESSAGE: INVALID CHARGE AMOUNT.
--------------------------------------------------------------------------------
123456789012345678 9B          JONES                      LARRY        MM/DD/CCYY
REJECTED                       POLICY 102              $    2,511.00 MM/DD/CCYY
R - REJECTED
* PAYOR CODE:    24-98
  INVALID DATA:  20060307
  PAYOR MESSAGE: SERVICE FROM DATE CANNOT BE GREATER THAN SERVICE TO DATE.
--------------------------------------------------------------------------------
123456789012345678 9C1         DOE                        JANE         MM/DD/CCYY
PEND                           4545454501              $      125.00 MM/DD/CCYY
P - PENDED
* PAYOR CODE:    77-77
  INVALID DATA:
  PAYOR MESSAGE: REQUEST FOR ADDITIONAL INFORMATION SENT TO PROVIDER.
```

SE Report- Normalized Payor Claim Rejection Report

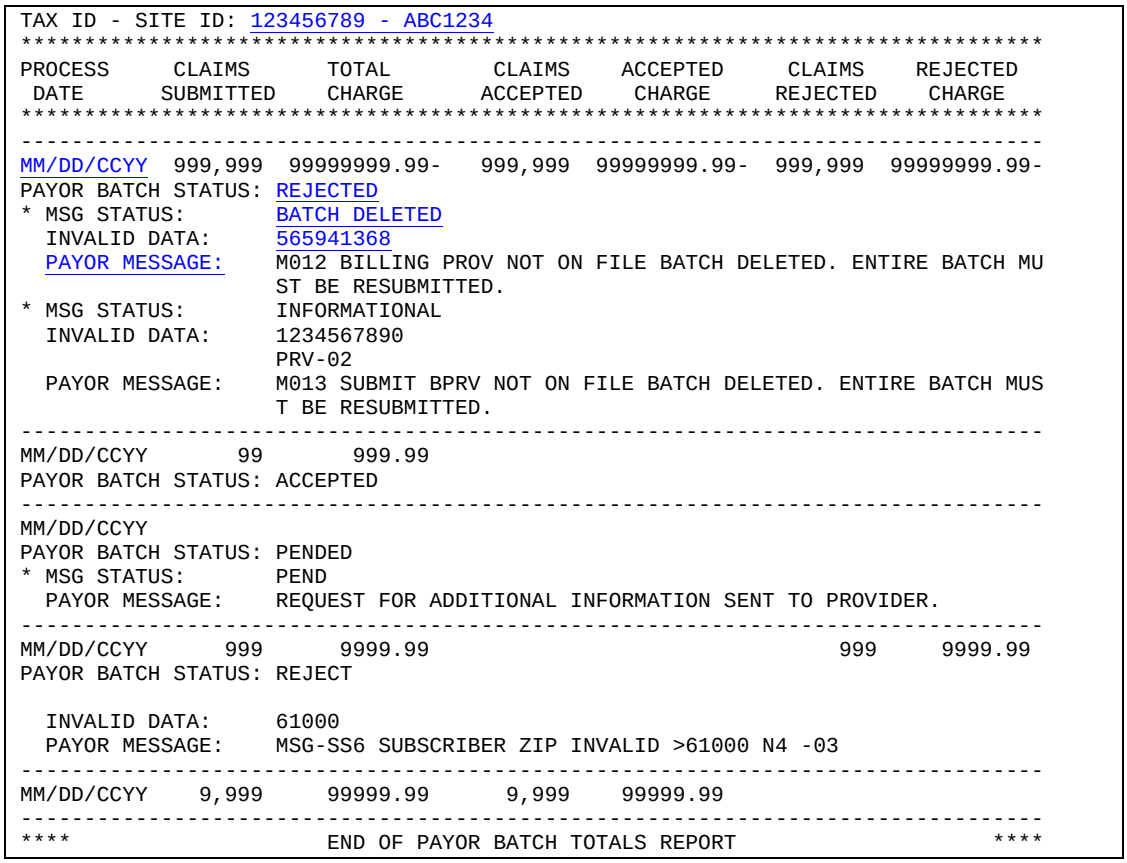
- Frequency: Upon Receipt from the payer.
- This standardized payor report documents only the claims that rejected at the payor.

```
CSPR31.02                    PAYOR CLAIM REJECTIONS                  PAGE:      1
                                                                     MM/DD/CCYY
                                                                     12:12:12
********************************************************************************
009999-HEALTH ABC BILLING
999901-HEALTH ABC CLINIC
********************************************************************************
IL BLUE CROSS/BLUE SHIELD REJECT REPORT
PAYOR PROCESS DATE: MM/DD/CCYY          CPID: 1405 ILLINOIS BC/BS
BILLING PROVIDER NAME: DR. ABC FIXALL
BILLING PROVIDER ID: 12345678901234567890             NPI: 1234567890
********************************************************************************
PATIENT CONTROL #              LAST NAME                  FIRST NAME   CLAIM FROM
PAYOR CLAIM STATUS             POLICY #                   CLAIM AMT    / TO DATE
STANDARDIZED CLAIM STATUS
****************************** ************************ ************ **********
--------------------------------------------------------------------------------
12345678901234567890A1         SMITH                      LINDA        MM/DD/CCYY
REJECTED                       POLICY 101               $1,333,333.33 MM/DD/CCYY
R - REJECTED
* PAYOR CODE:     AB-89
  INVALID DATA:   20060307
  PAYOR MESSAGE: THIS CLAIM HAS REJECTED SINCE THE FROM AND TO DATES OF SERVICE
                 ARE NOT THE SAME DATE.  THIS IS ONLY A ONE DAY SERVICE.
* PAYOR CODE:     25-76
  INVALID DATA:   1,333,333.33
  PAYOR MESSAGE: INVALID CHARGE AMOUNT.
--------------------------------------------------------------------------------
12345678901234567890B          JONES                      LARRY        MM/DD/CCYY
REJECTED                       POLICY 102               $     2,511.00 MM/DD/CCYY
R - REJECTED
* PAYOR CODE:     24-98
  INVALID DATA:   20060307
  PAYOR MESSAGE: SERVICE FROM DATE CANNOT BE GREATER THAN SERCICE TO DATE.
--------------------------------------------------------------------------------
```

SB Report- Normalized Payor Report

- Frequency: Upon Receipt from the payer.
- These reports show all batch level activity from the payers. They are only available for certain carriers—many carriers do not pass these back.
- This standardized payor report documents the payor batch level (provider level) information.

```
CSPR37.01                    PAYOR BATCH TOTALS                    PAGE:      1
                                                                   MM/DD/CCYY
                                                                   12:12:12
********************************************************************************
999901-HEALTH ABC CLINIC
009999-HEALTH ABC BILLING
********************************************************************************
IL BLUE CROSS/BLUE SHIELD REJECT REPORT
PAYOR NAME:       ILLINOIS BC/BS                                  CPID: 1405
PROVIDER NAME:    BILLING PROVIDER NAME
PROVIDER ID:      12345678901234567890123456789O              NPI: 1234567890
```



```
TAX ID - SITE ID: 123456789 - ABC1234
*******************************************************************************
PROCESS     CLAIMS      TOTAL        CLAIMS    ACCEPTED     CLAIMS    REJECTED
 DATE      SUBMITTED    CHARGE      ACCEPTED    CHARGE     REJECTED    CHARGE
*******************************************************************************
-------------------------------------------------------------------------------
MM/DD/CCYY  999,999  99999999.99-   999,999  99999999.99-  999,999  99999999.99-
PAYOR BATCH STATUS: REJECTED
* MSG STATUS:       BATCH DELETED
  INVALID DATA:     565941368
  PAYOR MESSAGE:    M012 BILLING PROV NOT ON FILE BATCH DELETED. ENTIRE BATCH MU
                    ST BE RESUBMITTED.
* MSG STATUS:       INFORMATIONAL
  INVALID DATA:     1234567890
                    PRV-02
  PAYOR MESSAGE:    M013 SUBMIT BPRV NOT ON FILE BATCH DELETED. ENTIRE BATCH MUS
                    T BE RESUBMITTED.
-------------------------------------------------------------------------------
MM/DD/CCYY       99       999.99
PAYOR BATCH STATUS: ACCEPTED
-------------------------------------------------------------------------------
MM/DD/CCYY
PAYOR BATCH STATUS: PENDED
* MSG STATUS:       PEND
  PAYOR MESSAGE:    REQUEST FOR ADDITIONAL INFORMATION SENT TO PROVIDER.
-------------------------------------------------------------------------------
MM/DD/CCYY      999      9999.99                                  999     9999.99
PAYOR BATCH STATUS: REJECT

  INVALID DATA:     61000
  PAYOR MESSAGE:    MSG-SS6 SUBSCRIBER ZIP INVALID >61000 N4 -03
-------------------------------------------------------------------------------
MM/DD/CCYY    9,999     99999.99      9,999    99999.99
-------------------------------------------------------------------------------
****                    END OF PAYOR BATCH TOTALS REPORT                    ****
```

Appendix A

Electronic Claims Batching Help

Batching claims electronically is much like batching paper claims. The software looks for billable claims to collect into a batch to send to your electronic carrier. The key here is billable. The software must see the claim as ready to be billed before it will be included in the batch. With this in mind, we can look for reasons a batch will not be created or certain claims are not being included in the batch.

Creating Electronic Claims in Claim Management

In the **Claim Management** window, you'll find a set of ranges to select the claims. Keep in mind that the more restrictive the ranges, the more likely you are to exclude a patient or transaction from the batch.

EDI Receiver Settings

Go to the Lists menu and select **EDI Receivers**. Bring to the window your electronic carrier. In the **Program File** field (ID and Extra tab), the field entry must be **RELAYH**.

> **Note:** The insurance **Default Billing Method** in the **Insurance Carrier** window must be set to **Electronic**. This can also be done in **Claim Management** prior to transmission.

If these settings are correct and the claim will still not batch, check the Patient Information.

Patient Information

The insurance carrier is assigned in the Policy 1 tab of the patient's **Case** window. Check to see that an insurance company has been assigned to the insured and the insurance company for which you are attempting to batch is set up as an EDI receiver.

If you still haven't found the problem, check the Procedure Code information for errors.

Procedure Code Information

Go to the **Lists** menu and select **Procedure/Payment/Adjustment Codes**. Locate the subject Procedure Code. Highlight the code and click **Edit**. Bring to the window the Procedure Code that you wish to batch. The **Procedure Type** field must have a value of Charge, Inside Lab Charge, or Outside Lab Charge. Any other value will not be billed to insurance.

If, after checking all these fields, you still cannot get a claim to batch, call support at (800) 689-4550. A friendly technician will be happy to assist you.

Appendix B

Sending Ambulance Information Electronically
(Medisoft Network Professional)

If your insurance carrier requires you to send ambulance information for an EDI claim, Medisoft has a **Case Custom Window** setup that includes the necessary fields for this information. Contact Medisoft at (800) 689-4550 to request the files for this setup.

> **Note:** If you have already created custom patient information in the **Case Custom Window**, this information will be overwritten when you copy the files for this option.

Once the files are copied into the correct folder or directory, open the **Patient List** window. Select any patient and edit the case. Open the Converted tab.

Click all check boxes that are applicable. Note that **Transportation Claim** must be checked before Medisoft can pull information from this window. In addition, if **Moved by Stretcher** is used, be sure to fill in the reason in the **Purpose of Stretcher** field lower in the window.

In the data entry windows, enter the following information as applicable:

Patient Weight: Must be presented in three digits. Use a lead zero if necessary (e.g., a weight of 90 would be entered 090).

Transport Type: Use one letter – select from the following:

I	Initial Trip
R	Return Trip
T	Transfer Trip
X	Round Trip

Trans(portation) To/For: Use one letter – select from the following:

A	Nearest Facility
B	Benefit of a Preferred Physician
C	Nearness of Family Members
D	Care of Specialist/Availability of Specialized Equipment

Miles Traveled: Must always be four digits. Use lead zeros as necessary (e.g., 23 miles would be entered 0023).
Origin Information: Enter the address where the ambulance trip began.
Destination Information: Enter the address of the destination, such as the hospital address.
Purpose of Round Trip: When applicable, enter the reason for any round trip.
Purpose of Stretcher: If a stretcher is required, enter reason.
Vehicle License: Enter the license plate number of the ambulance.

Appendix C

Glossary of RelayHealth Terms

Access Role: A role which grants a user access to a RelayHealth application.

Administrator: An administrator of a role may assign the role to other users.

Auto- Validated: An agreement that has passed all agreement field edits prior to submission.

CPID: A unique 4 numeric designation assigned by RelayHealth to a payor.

Customer ID: A RelayHealth-assigned number, previously known as a Billing ID.

Description: Another word for an Organization name.

Submit: A function within the application, Submit will commit a change to the user setup.

Submitter ID: A six digit, RelayHealth-assigned number, usually assigned to a single entity or provider.

Appendix D

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