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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.
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.

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 sent 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.

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:

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

**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.
Using the Collaboration Compass Site

1. Click the "Move" icon.
2. Drag the portlet to the desired location.
The following describes each of the elements found on the Layout page:

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>RelayHealth Customer Webinar Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic</td>
</tr>
<tr>
<td>Logging SAGE Web Cases</td>
</tr>
<tr>
<td>Overview of Collaboration Compass</td>
</tr>
<tr>
<td>Patient Registration Overview</td>
</tr>
<tr>
<td>Overview of Real-Time ASP</td>
</tr>
<tr>
<td>Registration Overview</td>
</tr>
<tr>
<td>Reading Eligibility (CTI) Responses</td>
</tr>
<tr>
<td>Understanding Your Xa and XS Reports</td>
</tr>
<tr>
<td>Payor Agreement Library</td>
</tr>
<tr>
<td>Logging SAGE Web Cases</td>
</tr>
<tr>
<td>Registration Overview</td>
</tr>
</tbody>
</table>

Solutions to Secure Transmissions of PHI

The Transaction Solutions Hub 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 Checking, Communications Services connect you with the Transaction Solutions Hub.

Enhancing Your "Communications Skills"

- **InfExchange® HTTP2Client**
  A Java-based client that handles your batch submissions and downloads and sends your data securely over the Internet. Automate transmits to eliminate daily manual processes. No need for technical assistance to navigate firewalls. Patient Health Information (PHI) is encrypted from your system to the Transaction Solutions Hub, so you know your patients’ data is safe.

- **InfExchange® Web Link**
  Our web-based application makes it easy to upload and/or download data to the Transaction Solutions Hub using a standard web browser application like Microsoft Internet Explorer.

- **InfExchange® Dial-Up**
  InfExchange dial-up is a proven to modem communication option that can be scripted for automated processing and has a easy to use graphical interface. It is based on the stable Kermit protocol transfer method, uses fire compress for increased speed of transfers and is easy to install on your local computer.
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.
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.
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.
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.
• **FilePath** and **FileName** — 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
Third Party Processing Delay
Delay in Eligibility Determination
Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
Administration Delay in the Prior Approval Process
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 week 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 an 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](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.
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.

*Processing Electronic Claims in Medisoft* 74
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.
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 CLM STATUS REJECTIONS REPORT

SUBSCRIBER NAME: PAUL JOHNSON
PATIENT NAME: POLLY JOHNSON
PAYOR ID/NAME: 1500 MAGELLAN

SERVICE DATE: MM/DD/CCYY
CLAIM TOTAL: $0,000.00
TEACH NUMBER: 333333-619999
BILL TYPE: 111
CATEGORY CODE: AS - REJECTED

WARNING MESSAGE

SUCCESSFUL CLAIMS MUST CONTAIN BOTH ACCOM AND AMBILARY CHARGES (LODGE2400)

SUBSCRIBER NAME: PAUL JOHNSON
PATIENT NAME: POLLY JOHNSON
PAYOR ID/NAME: 1500 MAGELLAN

SERVICE DATE: MM/DD/CCYY
CLAIM TOTAL: $0,000.00
TEACH NUMBER: 333333-619999
BILL TYPE: 111
CATEGORY CODE: AS - REJECTED

SUCCESSFUL CLAIMS MUST CONTAIN BOTH ACCOM AND AMBILARY CHARGES (LODGE2400)
```

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:

Receiving Reports  81
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

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**Receiving Reports**  82
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
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<td>12,200.00</td>
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"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
- B = CARRIER-DIRECT
- C = PATIENT-DIRECT
- D = ELECTRONIC TO PAYER(2)
- E = PAPER CLAIM-MAILBOX
- 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.
Receiving Reports

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---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---RECREATE---RECREATE---RECREATE---</**

---

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:**

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**REPORT NO:** CP1115.01

**MONTHLY INSURANCE BILLING REPORT**

**SYSTEM ID - C980**

**PRINT DATE:** MM/DD/CCYY

**PRINT TIME:** 01:02:36

Please forward to the accounts payable department.

**REPORT LEGEND**

- **CPID:** CLEARINGHOUSE PAYOR ID
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.
### 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

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### 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.**

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### 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.**

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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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