Spotlight on Performance

Performance Recognition Awards Program Winners

Reducing Paper and Duplicate Paper Claims—1st Quarter 2004

During the month of May, Blue Cross and Blue Shield of Illinois honored providers who have successfully reduced paper and duplicate paper claim submissions at luncheons held throughout the state. We selected providers for awards from five geographic areas: Chicago Metropolitan Area, Eastern, Western, Northern and Southern Illinois. We then placed providers into similar size groupings based on the number of claims they submitted per month. From each size grouping we gave awards to winners who had the best overall quarter results in the following categories:

1. Consistent electronic claims submission
2. Highest reduction in paper claims
3. Highest reduction in paper duplicate claim submission

Congratulations to all of you on your efforts to become paper free and experience bottom-line benefits in productivity and profitability.

The University of Chicago Medical Center (U of C), submitting more than 10,000 claims per month, achieved outstanding results for the first quarter of 2004, winning awards in all three categories.

For the complete list of winners, please see “What’s New” on our Web site at: http://www.bcbsil.com/provider/index.htm. We will feature other winners in subsequent issues of the Blue Review.

More BCBSIL Members Receive New ID Numbers

Over the past few months we have kept you updated in the Blue Review on our initiative to provide members with unique identification numbers not based on their Social Security Number (SSN). In response to various state laws, BCBSIL is gradually converting subscribers’ identification numbers from their SSN to an alternative ID number, known as a Unique Identifier (UID). New ID cards are being issued with the new UID format for members to use when receiving health care services. The change will also affect the use of SSNs on the member’s Explanation of Benefits, Web site usage and internet transmissions.

Unique Identifiers are now appearing on the member identification cards of all new BCBSIL employer groups that enroll in 2004. Gradually between January 2004 and January 1, 2006, existing members will be converted to the Unique Identifiers and will receive new ID cards. You will also begin to see the UIDs on BlueCard (out-of-state BCBS) member identification cards now.

What should providers do?

It is important that you educate your office staff to recognize that the new identification numbers are no longer the same as your patients’ Social Security Numbers. Although we will continue to use a numeric ID number, BCBS plan UIDs could consist of a maximum of 17 characters, consisting of the 3-digit Blue Cross alpha prefix and up to 14 alpha/numeric characters.

When BCBS members visit your office to receive services, be sure to obtain a new copy of their ID card to ensure that you have the member’s correct ID number. At every patient visit, before rendering service, check each member’s eligibility and benefits through THIN Online or by calling our Provider Telecommunications Center at (800) 972-8088. Always keep track of when a new ID card has been issued for each patient, so you can then update the patient’s records. Please do not refuse acceptance of any BCBS member’s ID card until you confirm the validity of their new ID number.

To assist with timely claims processing, you should verify that your billing systems and that of the claims clearinghouses you use are now able to accommodate member ID numbers that are longer than 12 characters (3 digit alpha prefix and up to 14 letters or numbers). Electronic claims submitted with incomplete member ID numbers may result in a delay in payment, due to the need for manual claim intervention.

We will continue to provide you with updates on this project through the Blue Review, by mail and on our Web site in the “What’s New” section at: http://www.bcbsil.com/provider/index.htm.
IDPA Institutional Claims

In our June Blue Review we published information about Illinois Department of Public Aid’s (IDPA) “Start Slow” transition to HIPAA compliant formats, and listed the most common errors. The following is an addition to the June article as it relates to “Other Insurance” (OI) errors:

- Loop 2330B - Other Payer Secondary Identification and Reference
- REF01 - Must be “2U”
- REF02 - Must be the 3-digit TPL code followed by the 2-digit Status Code assigned by IDPA to other Payer

For example: REF*2U*90901
Code 909 = Medicare Part A
Code 910 = Medicare Part B

- For other TPL codes, please reference Appendix 9 in Chapter 100. For Status Codes, see Appendix 17 in Chapter 200, Handbook for Hospitals.
- QTY is required in Loop 2300 on Inpatient claims or encounters when covered, coinsurance, and lifetime reserved or non-covered days are being reported.

For a complete list of IDPA’s “Slow Start” transition strategy, please click on “What’s New” on our Web site at: http://www.bcbsil.com/provider/index.htm or call our EDI Hotline at (312) 653-7954.

Medicare A Response Reports—837

Effective June 14, 2004, the THIN clearinghouse began sending the 837I, 4010A1, format to AdminaStar Federal (ASF), the Medicare Part A intermediary. The response reports will contain the status of the ANSI inbound transaction to ASF.

- Medicare A EDI Inbound Acceptance Reports will communicate the “acceptance” status of the received ANSI Inbound transaction.
- Medicare A EDI Inbound Reject Reports will communicate the “rejected” status of a received ANSI inbound transaction. This report contains rejections of the transaction with errors on a particular beneficiary.

Below is a list of the most common errors found on Medicare Part A Reports:

<table>
<thead>
<tr>
<th>Loop</th>
<th>Segment/Element</th>
<th>ASF-ERROR</th>
<th>T60- Field</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>CLM-08</td>
<td>ASSGN BEN IND</td>
<td>30-17</td>
<td>Assignment of Indicator must be “N” or “Y”</td>
</tr>
<tr>
<td>2320</td>
<td>OI-03</td>
<td>ASSGN BEN IND</td>
<td>30-17</td>
<td>Values are “N” or “Y” on secondary insurance.</td>
</tr>
<tr>
<td>2310A</td>
<td>REF02</td>
<td>ATTN PHYS UPIN REQ</td>
<td></td>
<td>Attending Physician Identifier required for inpatient TOBs. REF01 (1G)</td>
</tr>
</tbody>
</table>

Direct Data Entry (DDE)

Claims received via DDE will be formatted to the required 837 4010 format and transmitted to the various payers effective June 28, 2004. For further DDE update information, please click on “What’s New” on our Web site at: http://www.bcbsil.com/provider/index.htm.
THIN EDI Topics

Below is a list of Electronic Data Interchange (EDI) topics as they relate to HIPAA compliance for all lines of business submitted through The Health Information Network (THIN):

Non-Compliant HIPAA Format Status

Effective July 1, 2004, ANSI 4010A1, T0301 and T60 versions should be the only electronic formats submitted to the THIN clearinghouse. The following “warning” messages are being generated for non-compliant electronic formats and will become rejections:

- W 161 UBF Ver 050 will Reject
- W 162 UBF Ver 060 will Reject
- W 163 NSF Ver 104 will Reject
- W 164 NSF Ver 2.0 will Reject
- W 165 NSF Ver 3.01 will Reject
- W 166 ANSI Ver 30322B will Reject
- W 167 ANSI 30513B will Reject

These messages apply to Blue Cross Blue Shield, Medicare, Illinois Department of Public Aid (IDPA) and commercial electronic “batch” submissions.

Medicare B News

Below is a list of common errors found in Medicare B claim submissions:

- Invalid modifiers: A valid modifier should have two characters, alpha or numeric. (Loop 2400 in the SV101 segments.)
- Supervising physician (attending physician) information is required for routine foot care, physical and occupational therapy. Loop 2310E, 2420D REF02 (1G). (Submitters sending T0301 format should show the Supervising in FB1-22)
- Referring physician is required for diagnostic procedures such as clinical lab, x-ray and also for consultations. Loop 2310A, 2420F REF02 (1G). (Submitters sending T0301 format should show the Referring Provider UPIN ID in EA0-21 and not EA0-20)

Medicare B claims submitted in the 837P 4010A1 or the Expanded T0301 formats must contain valid and complete information in the required segments and records.

iExchange Manual Now Available Online

iExchange is a free, internet care management product. iExchange is Blue Cross and Blue Shield of Illinois’ internet solution, enabling hospital providers to submit authorizations and extensions with instant approval, ultimately including functionality for case management and secure messaging.

To reference the iExchange Pre-Certification Training Manual, log on to http://www.bcbsil.com/provider/index.htm and select iExchange from the Electronic Commerce Section.

iExchange is a real-time tool that allows facilities to enter, extend, view and ultimately manage cases real-time. For more information, please contact your Blue Cross Provider Representative.

On the Line with our PTC

Requesting Physical Therapy Benefits

Routinely we receive feedback from our Provider Telecommunications Center (PTC) regarding provider issues they handle on a daily basis. One concern we would like to address in this article pertains to requests for outpatient physical therapy benefits.

When you contact the PTC to inquire about a member’s outpatient physical therapy benefits, our Customer Service Representatives (CSRs) may ask you if the services are being performed in your office or in an outpatient therapy facility. We ask this information because sometimes benefits may differ based on the place of treatment, that can affect your reimbursement. So it is important that you always give the correct place of treatment when requesting benefits.

If you are a professional provider that files claims with a place of treatment code of “11” (office), this indicates the member is receiving treatment in your private office, in a location other than a hospital. The outpatient facility place of treatment code of “22” should only be used by hospitals and outpatient rehab/therapy treatment centers.

To understand that our CSRs participate in a quality program that tracks the types of responses they give when resolving inquiries. To ensure CSRs give out correct information and provide the best service, they must adhere to specific guidelines when completing a telephone call. We ask your cooperation in sharing any information they may need to better serve you.

Reminder: Please allow us 30 days to process your claims before contacting our office for status. Of course, if you utilize THIN Online, you can check the system as often as you like to track the disposition on your claims.
New Benefit for Assistant Surgeons

In accordance with the State of Illinois Public Act 93-280 Blue Cross and Blue Shield of Illinois (BCBSIL) has extended assistant surgeon benefits to include Registered Surgical Assistants and Registered Surgical Technologists. This law became effective for services rendered on or after January 1, 2004, and includes the following health care providers:

- Certified Surgical Assistants (CSAs)
- Certified Surgical Technicians (CSTs)
- Registered Nurse First Assistants (RNFAs)

Requirements for coverage are as follows:

- The Certified Surgical Assistant, Certified Surgical Technician or Registered Nurse First Assistant must be registered with the Illinois Department of Professional Regulation (IDPR)
- Surgical assistant services must be provided under the direct supervision of a BCBSIL contracting state licensed physician, dentist or podiatrist
- Surgical assistant services must be provided in a licensed hospital, ambulatory treatment center or office of a physician licensed to practice medicine in all its branches
- Surgical assist services must be defined by BCBSIL as eligible procedures for assist-at-surgery
- Surgical assist services must be included in the member benefit program

Surgical Assistants who have registered with the IDPR as of July 1, 2004, will be solicited for participation in the BCBSIL PPO Network. BCBSIL Provider Numbers will be assigned to those who meet the criteria and choose to participate. In the interim, surgical assistants may submit claims for services and reimbursement will be made directly to the surgical assistants.

Claim completion and submission:

- Claims are to be submitted in the CMS-1500 format, formerly HCFA-1500.
- Claims are to be submitted directly by the CSA, CST or RNFA
- Services must be reported with modifier “AS” (Assistant Surgeon) appended to the CPT procedure code in item 24D.
- Item #32 must list the name and address of the facility where the services were performed
- Item #33 on the CMS-1500 Form must list the name, address, telephone number and title (CSA, CST, RNFA) and provider number, when assigned, of the surgical assistant.

Reimbursement for surgical assist services:

- Reimbursement will be made directly to the CSA, CST or RNFA listed in item #33 on the CMS-1500 claim form
- CSA’s, CST’s and RNFA’s who are employed by a hospital or other facility are not eligible for direct reimbursement

We believe that this policy change reflects current medical practice and will support our ability to impact cost effective health care.

Email Addresses Needed

In our efforts to communicate with you as quickly, efficiently and economically as possible, we are asking that you provide us with your email address. You can provide us with your email address one of three ways:

1. Web site: Go online to http://www.bcbsil.com/provider/provider_file_update.htm, fill in the required information and email address. Complete the provider information form by populating all required fields and select “submit”. The form will then be routed to our Provider Services’ staff for updating.

2. Fax: If you choose to fax in your updates, please do so on your office letterhead for accuracy and fax it to the Provider Services Department at: (312) 856-1946.

3. Mail: If you choose to mail in your updates, please do so on your office letterhead for accuracy and send it to: Blue Cross and Blue Shield of Illinois, 300 E. Randolph St., Chicago, IL 60601-5000, Attn: Provider Services, 27th Floor.
Results are in from the 2003 PPO Practitioner Satisfaction Survey. The PPO Practitioners were sampled to provide a representation of physicians in Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practice as well as consulting specialties. BCBSIL Quality Improvement received 1,599 completed questionnaires for a 21% response rate. The table shows the results of the 2003, 2002 and the 2001 surveys. Coordination of Care results regarding feedback received from various facilities and key specialists are included. The surveys used a Five-point scale, from Excellent to Poor to measure satisfaction. The results shown below are based on combined responses, Excellent, Very Good and Good or Yes.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Overall Satisfaction</td>
<td>94%</td>
<td>90%</td>
<td>91%</td>
</tr>
<tr>
<td>Specialist Network</td>
<td>94%</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>Utilization Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Precertifying Inpatient Admissions</td>
<td>87%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>-Authorizing Additional Days</td>
<td>84%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Claims Payment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Timeliness</td>
<td>90%</td>
<td>86%</td>
<td>84%</td>
</tr>
<tr>
<td>-Accuracy</td>
<td>84%</td>
<td>82%</td>
<td>81%</td>
</tr>
<tr>
<td>Member Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Understanding of physician role</td>
<td>77%</td>
<td>75%</td>
<td>70%</td>
</tr>
<tr>
<td>-Understanding of health plan benefits</td>
<td>59%</td>
<td>54%</td>
<td>52%</td>
</tr>
<tr>
<td>After-Hours Access</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Response Time &lt;30 minutes</td>
<td>88%*</td>
<td>87%*</td>
<td>88%*</td>
</tr>
<tr>
<td>BCBSIL Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Find needed information in communications on the BCBSIL Web site or THIN Online</td>
<td>76%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>-Provider Workshop</td>
<td>86%</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>-Provider Telecommunication Center (PTC)</td>
<td>70%</td>
<td>74%</td>
<td>70%</td>
</tr>
</tbody>
</table>

*Responses of PPO Practitioners in Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practice only.

Opportunities for Improvement

Questions with satisfaction rates of 70% or less, such as the ProviderTelecommunications Center (PTC), were seen as areas that need further intervention and represent potential opportunities for improvement.

Continuity and Coordination between Managed Care Physicians and Health Care Facilities

Since 2001, 80% or more of PPO practitioners in Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practice have reported that they always or usually receive reports from hospital inpatient facilities, outpatient surgery facilities and home health care agencies. PPO practitioners in all specialties generally rate reports from all facilities as useful and timely. When asked to rate feedback from specialists, 83% or more of PPO practitioners have reported they are satisfied with feedback from General Surgeons, Cardiologists, Orthopedic Surgeons, Ophthalmologists and Dermatologists.

In 2003, 90% or more of PPO practitioners reported they are satisfied with the timeliness of imaging and/or lab reports, inpatient discharge planning, the accuracy of pharmacy services and processing physician orders, the quality of discharge plans and the knowledge of the nursing staff.

The following areas continue to lag behind in Continuity and Coordination:

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Receive Reports from Skilled Nursing Facilities</td>
<td>72%*</td>
<td>69%*</td>
<td>71%*</td>
</tr>
<tr>
<td>Receive Reports from Emergency Rooms</td>
<td>79%*</td>
<td>80%*</td>
<td>78%*</td>
</tr>
<tr>
<td>Receive Feedback from Behavioral Health Specialists</td>
<td>76%</td>
<td>79%</td>
<td>75%</td>
</tr>
</tbody>
</table>

*Responses of PPO Practitioners in Internal Medicine, Pediatrics, Obstetrics-Gynecology, and General Practice Only.
Filing Instructions For Pipe Fitters’ Local 597

On June 1, 2004, BCBSIL welcomed members of the Pipe Fitters’ Local 597, to the Illinois PPO network. By now members should have received their new ID cards and can be identified as follows: group number P06944 and alpha prefix PPP. Now that Local 597 members have BCBSIL PPO (physician) coverage, it is important that you request that members present their new ID cards at each visit so you can verify their eligibility and benefits.

To avoid claim payment delays, contracting PPO providers servicing members belonging to labor groups must submit labor fund account claims directly to BCBSIL rather than to the labor fund office. You may need to update your internal records to reflect this procedure for claim filing purposes. Claims can be submitted electronically just as all other claims to expedite processing.

Important reminders for labor account groups when verifying eligibility and benefits:

- Call the account’s Health and Welfare local office. This contact telephone number is located on the back of the member’s BCBSIL ID card.
- When filing claims (Do not file directly to the fund office on this account):
  - File electronically with BCBSIL, or
  - Mail paper claims to: BCBSIL, P.O. Box 1364, Chicago, IL 60690.

If you have questions, please contact the BCBSIL Provider Telecommunications Center at (800) 972-8088, or use THIN Online.

New Account Groups

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Group Number</th>
<th>Alpha Prefix</th>
<th>Product Type</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaziers Union Local No. 27</td>
<td>P15768</td>
<td>GLZ</td>
<td>PPO(Portable)</td>
<td>June 1, 2004</td>
</tr>
<tr>
<td>Riddell Sports Group, Inc.</td>
<td>015939-015944</td>
<td>RLD</td>
<td>PPO(Portable)</td>
<td>July 1, 2004</td>
</tr>
</tbody>
</table>

Key:

BlueAdvantage HMO = BlueAdvantage HMO
BlueEdge™ Participating Provider Option (PPO) = Consumer Driven Healthcare Product (CDHP)
CMM = Comprehensive Major Medical
POS = Point of Service (BlueChoice)
PPO = Participating Provider Option (Hospital and Physician Network)
PPO Hospital Network = Participating Provider Option (Hospital Network Only)
PPO(Portable) = BlueCard PPO
HMOI = Health Maintenance Organization of Illinois
HMOI AFHC = HMOI Away From Home Care

Blue Shield of California Prompt Payment Interest Checks

If you recently provided services to a Blue Shield of California member, you may be receiving an interest payment check. As a result of the passing of California Heath and Safety Legislation, Code 1371, Blue Shield of California will be issuing checks for interest owed to providers for claims for which the original payment was not made within the prompt payment time frames mandated by California law. These claims were adjudicated through our BlueCard out-of-state claims processing and reimbursement program. The California prompt payment legislation covers claims for all California residents, regardless of where the service was rendered.

Accompanying the interest payment check will be a letter, an Explanation of Benefits which identifies the member and service dates involved and a summary of how the interest payment was calculated. The letter will also include contact information and a direct number to the California Plan for your questions or concerns about the interest payment you receive.

Multiple Interest Payments

In some instances you may receive an interest payment from us (BCBSIL as Host) in accordance with our Illinois prompt pay statute, and from Blue Shield of California (as Home) in accordance with California law for the same services.

Contact Information

If you have any questions regarding this interest payment, please feel free to contact Blue Shield of California at (530) 351-6232, or at the following address: Blue Shield of California, P.O. Box 1505, Red Bluff, CA 96080
Third Quarter Workshop Schedule

Want to improve your knowledge of BCBSIL’s procedures, products and services and increase your efficiency as a network provider? The Provider Affairs Education Team can help you. Attend one of our free workshops to get important, up-to-date information on claims submission, the reimbursement process, advantages of verifying member eligibility and benefits, out-of-state processing, key resources, BCBSIL news — and much more. Workshops were designed for both the new and experienced provider and will give you the tools to assist in achieving administrative success as a network participant.

Online reservations may be made by logging on to www.bcbsil.com/provider/training.htm. A confirmation or “Request to Reschedule” form will be e-mailed to you.

<table>
<thead>
<tr>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional</strong></td>
<td><strong>Professional</strong></td>
<td><strong>Professional</strong></td>
</tr>
<tr>
<td>*Experienced Contracting Provider</td>
<td>*New Contracting Provider</td>
<td></td>
</tr>
<tr>
<td>In-House Workshop—Half Day</td>
<td>In-House Workshop—Full Day</td>
<td></td>
</tr>
<tr>
<td>July 21, 2004</td>
<td>August 4, 2004</td>
<td>September 8, 2004</td>
</tr>
<tr>
<td>Blue Cross and Blue Shield of Illinois</td>
<td>Blue Cross and Blue Shield of Illinois</td>
<td></td>
</tr>
<tr>
<td>300 East Randolph St.</td>
<td>300 East Randolph St.</td>
<td></td>
</tr>
<tr>
<td>Chicago, Illinois 60601</td>
<td>Chicago, Illinois 60601</td>
<td></td>
</tr>
<tr>
<td>(312) 653-4019</td>
<td>(312) 653-4019</td>
<td></td>
</tr>
<tr>
<td>*Experienced Contracting Provider</td>
<td><strong>Professional</strong></td>
<td></td>
</tr>
<tr>
<td>Off-Site Workshop—Half Day</td>
<td><strong>BlueChoice In-house Workshop—Half Day</strong></td>
<td></td>
</tr>
<tr>
<td>July 28, 2004</td>
<td>August 11, 2004</td>
<td>September 14, 2004</td>
</tr>
<tr>
<td>Memorial Medical Hospital</td>
<td>Blue Cross and Blue Shield of Illinois</td>
<td>Ingalls Memorial Hospital</td>
</tr>
<tr>
<td>701 N. 1st Street</td>
<td>300 East Randolph St.</td>
<td>Professional Office Building</td>
</tr>
<tr>
<td>Springfield, Illinois 62702</td>
<td>Chicago, Illinois 60601</td>
<td>Harvey, Illinois 60426</td>
</tr>
<tr>
<td>(217) 788-4448</td>
<td>(312) 653-4019</td>
<td>(708) 915-5700</td>
</tr>
</tbody>
</table>

*Agenda: Experienced Contracting Provider
In-House & Off-site Workshop—Half Day
8:30 to 9 A.M. Registration
9 A.M. to 1 P.M. Overview: E-Commerce/Paper Reduction, Inquiry Options, BlueCard, Products

SCIs Being Returned to Hospital Providers

In the March 2004 Blue Review we notified you that we have eliminated the Single Case Inquiry (SCI) Form, a document used by hospitals to inquire about claim status. In May, we began mailing back all SCIs that we receive, accompanied by a letter advising you that BCBSIL no longer accepts these forms. The letter explains the correct way to handle the inquiry that was sent with the returned SCI.

The SCIs are being sent to you directly from our mail center, without being reviewed or scanned into our system. It is important that you now utilize the following available methods to obtain claim status:

1. Review your electronic reports
2. Access our electronic inquiry data base - THIN Online - which has new enhancements that upgrade the functionality.
   The ineligible reason codes and descriptions are displayed when a user views the status of a claim. This information allows for a clearer explanation of the claim status.
3. Call the Provider Telecommunications Center’s (PTC) Automated Information System (AIS) at 800-972-8088. If claim status is not available on the AIS, the system will provide the prompt for you to speak with a customer service representative.
BCBSIL Introduces RealMed Print Exchange

Print Exchange Offers the Following Features:

- **All-Payer Electronic Filing**
  RealMed’s Print Exchange does what its name implies – it changes your workstation’s print instructions into electronic claim filings. Using a single, simple process you can greatly speed up payment by instantly transmitting claims to all payers and eliminate postage and handling costs in less time than it takes to stuff envelopes.

- **Simple Installation and Operation**
  Print Exchange downloads to your workstation in less than 10 seconds and instantly appears as a new printer icon. Once Print Exchange is installed, you place claims from your practice management system into a designated “folder” on your workstation. When you are ready to send your claims, just, click the Print Exchange icon and they will be instantly sent electronically from your folder. Or, you can create a schedule for Print Exchange to automatically pick up your claims once a week, once a day or once a minute, depending on your workflow. If you wish, you can see an image of each claim and print it for your records.

- **Confirmation of Each Step**
  As soon as Print Exchange receives your claims, it sends a receipt confirmation that is accessible through RealMed’s Web site. You can track the progress of the claim to the payer or clearinghouse through RealMed’s online claims status screen. This up-to-the-minute status information minimizes the time spent calling the payer for more information.

- **HIPAA Compliance and Payer Requirements**
  If you are not able to generate HIPAA-compliant claims, RealMed makes them compliant prior to sending them to the payer. If you are worried about keeping up with payer specific rules that make claim filing difficult, RealMed will handle this for you as well. Just enter your claim information and RealMed takes care of the rest.

Print Exchange Includes Five Key Services:

1. Rapid Adjudication
2. Easy Check of Eligibility and Coverage Information
3. Automatic Error Checking
4. Automated Remittance Receipt
5. Automated Drop-to-Paper

Find Out More . . . Call 1-877-REALMED

A RealMed representative will answer any questions you have concerning RealMed’s Print Exchange service, give you access to RealMed’s VIP Web site and walk you through the enrollment process when you’re ready. No additional equipment is needed other than your current PC, a Windows-based printer and an Internet connection. A high-speed Internet connection is recommended. . Call 1-877-REALMED today to get started!