Welcome Packet

Dear Valued MD On-Line Customer,

The employees of MD On-Line would like to take this opportunity to thank you for choosing to submit your claims utilizing one of our products. We are confident that you will immediately see the many benefits of submitting your health care transactions through our network. Our new submitter orientation packet is designed to assist you in learning how our claim processing system works.

Please keep in mind that our Customer and Technical Support personnel are available to assist you with any questions you may have. Customer Service and Tech Support can both be reached from **8:30AM-6:00PM EST** at the following toll-free number: **(888) 499-5465**. If you know which department you are trying to reach, please see below for the corresponding extension:

- **SALES** Account Executives – Option 1, Extension 201
- **TECHNICAL SUPPORT** – Option 2, Extension 202
- **CUSTOMER SUPPORT** – Option 3, Extension 203
- **ENROLLMENT** – Option 4, Extension 204
- **FINANCE** – Option 5, Extension 205
- **LINK 1500 HELP** – Option 6, Extension 206

Please be aware that MD On-Line provides additional valuable services that include Real-Time Eligibility, Patient Statements, Electronic Remittance Advice (ERA) and Credit Card Processing, Secondary Claims, and Practice Management Software. If you have not already enrolled to experience the ease and value of these services, we strongly urge you to give them a try. For more information regarding any of these useful services, please contact your MD On-Line Account Executive by calling (888) 499-5465.

Sincerely,
The MD On-Line Team

Please note: The invoicing of our standard Monthly Minimum fee, as outlined in our WebLink/LINK1500 Terms of Use Agreement, begins on the day your office registers. We encourage you to begin using the product immediately in order to take full advantage of the benefits our services have to offer.

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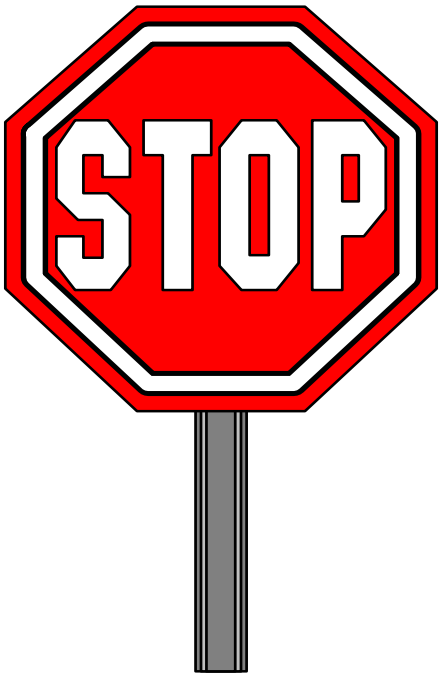


IT IS ESSENTIAL THAT YOU BOTH READ AND UNDERSTAND THE INFORMATION WITHIN THIS PACKAGE PRIOR TO TRANSMITTING YOUR CLAIMS TO MD ON-LINE.

Products

MD On-Line currently offers two methods for submitting electronic claims. Both are used through the website; the only requirement is Internet access.

Link1500™ is MD On-Line's claim submission solution for providers ***without*** practice management software. Use MD On-Line's easy-to-use secure internet based online CMS1500 form. Submit all your insurance claims without costly and confusing practice management software. Being able to quickly correct mistakes will allow you to eliminate a bottleneck in your revenue cycle.

Save payer and patient info: Only fill out payer and patient information once. After that, it's only one click away, saving you countless hours of data entry.

Save claims, submit later: Save completed claims and transmit them later. In the case of rejection, simply change the necessary fields and resubmit instead of re-entering all the data again.

WebLink™ is MD On-Line's claims management solution for providers ***with*** practice management software. Simply upload a file created by your practice management software to our secure online portal. Submit 24 hours a day, 7 days a week. MD On-Line is compatible with print image, 837, and NSF formats. Regardless of whether or not you have the newest version of popular software or an older version of an obscure product, MD On-Line can make WebLink work for your office.

Requirements: Pentium class PC, 32MB RA, Windows 95, 98, 2000, Me, XP, Vista or 7 with Internet Explorer 7.0 (or greater) with 128-bit encryption –**OR**- Mac OS X version 10.1 and higher with Safari version 3.1 or higher, 56k connection or better. For files, we accept print image, 837, and NSF formats.

PRACTICE EDGE – **Practice Management System**

In a world of Practice Management Systems, the dashboard solution from MD On-Line stands apart. Intuitive, complete, economical and technology-ready, we've taken the best of yesterday's systems and upgraded it to be the best for tomorrow's needs.

For practices that have yet to adopt a practice management system, our certified HIPAA compliant solution:

- Is easy to learn and use

- Is affordable, with monthly fees at a fraction of what's charged by other systems
- Is linked with MD On-Line's electronic claim and electronic health records solutions
- Is automatically populated with patient information from MD On-Line Link1500 accounts
- Links office visits to claims filing instantly
- Tracks billable charges, insurance payments and patient co-pay requirements

For practices that are seeking a <u>better</u> practice management solution, our certified HIPAA compliant solution:

- Supports multiple practitioners in a single office or in multiple offices
- Constructs and maintains a patient database, storing all demographic, insurance, appointment, and billing information
- Allows for scheduling of providers, specific treatment rooms, equipment and time blocks to accommodate patient needs
- Enables real-time eligibility and claim status checking with participating insurance companies

To find out more about ***PRACTICE EDGE***, please call our Sales Department at (888) 499-5465, ext. 1.

Secondary Health Insurance Claims

MD On-Line can accept secondary claims in either a Print Image or ANSI 837 format. Therefore, only WebLink customers can submit secondary claims.

ANSI 837 claims will process automatically to the secondary carrier, as these files have the secondary information built in. Print image claims will produce a form to key-in additional information from the EOB/ERA; the form will then be sent to the secondary insurance payer.

Real-Time Eligibility

ACCE$$™ is MD On-Line's patient eligibility verification solution, allowing you to make real-time inquiries into patients' eligibility status. Our solution allows for you to learn about the status of each patient's personal deductible and co-pay based on his or her coverage *before* the doctor even sees the patient. With ***ACCE$$™***, you are able to both manually enter and swipe card eligibility requests to hundreds of payers and receive payer specific data, as well as to store provider details to eliminate the need for data re-entry. A swipe card reader plugs right into the USB or keyboard port of your PC; eligibility responses are returned to the screen in a user friendly, printable format and are conveniently stored in a searchable transaction history system.

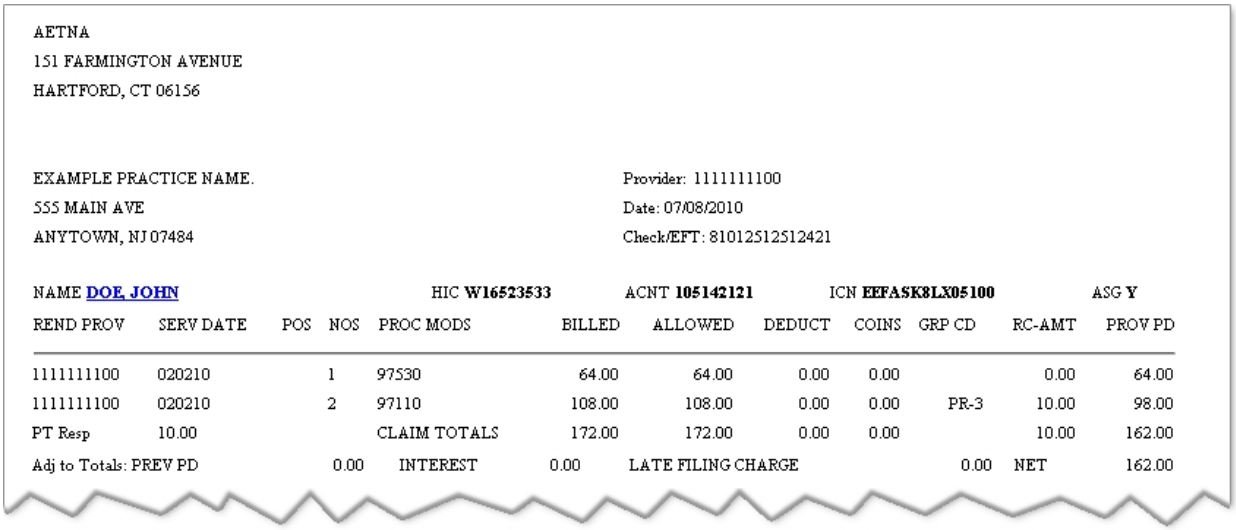
To learn more about ***ACCE$$™***, please contact an Account Executive by calling **888-499-5465**, ext. 201.

ERA / EOB

Electronic Remittance Advice (ERA) is the electronic equivalent of an Explanation of Benefits. An ERA provides detail on how your claims were adjudicated by the insurance carrier. As with all of our solutions, MD On-Line conforms to all HIPAA requirements by using the ASC X12 835 4010A1 format for ERA. Easy, secure online access lets you view, search, print, and download remittance information while reducing your paperwork.

The ERA will be in your MD On-Line account in the form of a message and will be in a machine and human readable format. If you are using a Practice Management Software you may be able to electronically post the ERA to your accounting system – no more manually entering payment information from a paper EOB! Not only will you receive payment information more quickly, but you will also reduce data entry errors.

Sample ERA:



AETNA
151 FARMINGTON AVENUE
HARTFORD, CT 06156

EXAMPLE PRACTICE NAME.
555 MAIN AVE
ANYTOWN, NJ 07484

Provider: 1111111100
Date: 07/08/2010
Check/EFT: 81012512512421

NAME **DOE, JOHN** HIC **W16523533** ACNT **105142121** ICN **EEFASK8LX05100** ASG **Y**

REND PROV	SERV DATE	POS	NOS	PROC MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP CD	RC-AMT	PROV PD
1111111100	020210		1	97530	64.00	64.00	0.00	0.00		0.00	64.00
1111111100	020210		2	97110	108.00	108.00	0.00	0.00	PR-3	10.00	98.00
PT Resp	10.00			CLAIM TOTALS	172.00	172.00	0.00	0.00		10.00	162.00

Adj to Totals: PREV PD 0.00 INTEREST 0.00 LATE FILING CHARGE 0.00 NET 162.00

Patient Statements

With MD On-Line as your partner, we can create the type of patient satisfaction that will enhance both your image and business operations. Our print, mail and data services will increase your patients' ability to understand their bills, thereby *decreasing both phone calls and payment delays for your healthcare organization*. MD On-Line offers your patients patient-friendly statement billing, as well as online bill presentation and payment. MD On-Line makes things simple for you as well, offering 24 hour a day, 7 day a week communication, East and West Coast processing facilities, and collection letter and return mail management programs, as well as the capability to change, store, and view actual letters and statements online.

For more information, contact an Account Executive today at **(888) 499-5465**, ext. 201.

Credit Card Processing

MD On-Line has partnered with Payment Processing Consultants, Inc. (PPC) to offer you a credit card transaction processing service superior to those of our competitors. Accredited by the Better Business Bureau, PPC is the recommended credit card processor for more than 1,500 medical practices. Whether you already have a credit card processing company or not, we invite you to compare Payment Processing Consultants' exclusive MD On-Line customer rates, lack of fees, and other services to those of other processors.

Some reasons why PPC is the ideal choice for your credit card processing needs:

- No application fee to sign up to accept credit cards
- No annual fee (which many credit card processors charge)
- No terms of service (you can cancel at any time)
- No cancellation fee
- No monthly minimum
- No charge to set-up Discover and American Express accounts

Our in-depth experience in medical practices across the country makes it easy for your office to profit from non-cash transactions using MD On-Line. For more information about credit card processing, please contact our Sales Department at (888) 499-5465, ext. 1.

Claim File Requirements

MD On-Line can accept professional healthcare claim data in several formats. This data is usually based on the CMS-1500 Health Insurance Claim Form, and must be in a Print Image, NSF or ANSI 837 4010A1 format, in order to interface with our claim processing system software. In addition, we will fully comply with the upcoming industry changes regarding HIPAA compliancy and accept and process transactions in the ANSI 837 5010 format according to published timelines.

Depending upon your particular Practice Management System, the procedures for preparing claim data for submission to our service can vary. Generally speaking, however, your system will need to create a file that is on an accessible hard drive. ANSI 837 4010A1 can also submit claims and retrieve reports using FTP.

This file can be an ASCII text (image) file of the CMS-1500 claim form or an NSF file (National Standard Format) 2.0 or higher, or an ANSI 837 4010A1 format file. We will soon be accepting ANSI 5010 as well.

The file should contain ALL data as required by the CMS, NSF or ANSI specification and the carriers to whom you wish to file your claim electronically (i.e. network or physician ID numbers, etc.).

The text (image) file should contain forms that maintain standard page length (60-66 lines per page), with consistency of this length of primary importance.

The file should **NOT** contain any information that isn't part of the CMS, NSF or ANSI 837 4010A1 specification.

The file should **NOT** contain any erroneous characters such as printer codes.

The file should **NOT** contain any compressed text.

If you are in doubt as to whether you can save this type of file or are unsure of the particular requirements listed above, please contact our Technical Services Department by calling (888) 499-5465, ext. 202. MD On-Line can also perform pre-installation file screening, whereby you provide us with a file containing the data that your PMS system prepares; we will then process the data through our testing facilities to confirm compatibility.

Thank you for choosing MD On-Line for your claim processing needs!

Field 19 Formats

Enter the information into Field 19 exactly as it is shown inside the quotation marks. Format requirements are also noted. Indicators are case and space sensitive. It is important that the information be placed in the order it appears below (X-ray, Initial TX date, Date last seen by referring MD, Nature of Condition). If you do not need to place any piece of information on any given claim, simply skip it. If you have any questions, please contact Customer Service at (888) 499-5465, ext. 203.

PLEASE NOTE: All new additions to field 19 should be reviewed by MD On-Line to determine if scanner adjustments are necessary. Make any additions, submit your claims, and then immediately contact MD On-Line Customer Support at (888) 499-5465, ext. 203 for assistance.

I. **X-RAY DATE**
EXAMPLE: "XRAY 01-30-2006" or "XRAY 01-30-06" FORMAT: (XRAY MM-DD-CCYY or XRAY MM-DD-YY)

II. **INITIAL TREATMENT DATE**
EXAMPLE: "INIT 01-30-2006" or "INIT 01-30-06" FORMAT: (INIT MM-DD-CCYY or INIT MM-DD-YY)

III. **DATE LAST SEEN BY REFERRING DOCTOR**
EXAMPLE: "DATE LAST 01-30-2006" or "DATE LAST 01-30-06"
FORMAT: (DATE LAST MM-DD-CCYY or DATE LAST MM-DD-YY)

IV. **NATURE OF CONDITION CODES**
A = Acute Condition C = Chronic Condition M = Acute Manifestation of Chronic Condition
EXAMPLE: "COND C"

When using Code A or M include the symptom date
EXAMPLE: "COND A 01-30-2006" or "COND A 01-30-06"
FORMAT: (COND A MM-DD-CCYY or COND A MM-DD-YY)

V. **SUPERVISING PROVIDER**
EXAMPLE: "SUPER: ID, FIRST NAME, LAST NAME" or
EXAMPLE: "SUPER: SAME" (Note: This will copy the data in CMS-1500 fields 17/17a to the Supervising fields)

VI. **REMARKS** (Maximum 80 Characters)
EXAMPLE: "REMARKS" OR "RMKS" then the text

VII. **RX DATE**
EXAMPLE: "RX 01-30-2006" or "RX 01-30-06" FORMAT: (RX MM-DD-CCYY or RX MM-DD-YY)

VIII. **HOME HEALTH CARE PLAN INFORMATION**
CR701 Discipline Code (AI, MS, OT, PT, SN or ST)
CR702 Total visits rendered, home health (Number up to 9 characters long)
CR703 Total visits projected, home health (Number up to 9 characters long)

EXAMPLE: (<> indicates one space): "CR7:PT<> 102<> 999999999"

Discipline Type Codes:

AI = Home Health Aide
MS = Medical Social Worker
OT = Occupational Therapy
PT = Physical Therapy
SN = Skilled Nursing
ST = Speech Therapy

IX. **SERVICE AUTHORIZATION EXCEPTION CODE**
EXAMPLE: "EXC 7"

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 Determine if Recipient Can Work
6 - Request for Override Pending
7 - Special Handling

X. **DELAY REASON CODE**
Example: "DRC 8"

1 - Proof of Eligibility Unknown or Unavailable
2 - Litigation
3 - Authorization Delays
4 - Delay in Certifying Provider
5 - Delay in Supplying Billing Forms
6 - Delay in Delivery of Custom-made Appliances
7 - Third Party Processing Delay
8 - Delay in Eligibility Determination
9 - Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10 - Administration Delay in the Prior Approval Process
11 – Other

XI. **DEMO 45**
Example: "RMKS DEMO 45" or "RMKS DEMO45"

XII. **EPSDT REFERRAL**
Example: "EPSDT Y AV" or "EPSDT N"

Yes/No Condition or Response Code (Condition Indicator – enter Y if there is a Condition Indicator, N if none)
Y Yes
N No

AV = Available – Patient Refused Referral
NU = Not Used *NU must be used if EPSDT N is used.
S2 = Under Treatment
ST = New Services Requested

XIII. **CLAIM SUPPLEMENTAL INFORMATION (Paperwork)**
Example: "PWK 77 AA 12345678911" or "PWK DG EL 78945612378"

Report Type Code

77 = Support Data for Verification	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	MT = Models	NN = Nursing Notes
OB = Operative Note	OZ = Support data for claim	PN = Physical Therapy Notes
PO = Prosthetics/Orthotic Certification	PZ = Physical Therapy Certification	RB = Radiology Films
RR = Radiology Reports	RT = Report of Tests and Analysis Report	

Report Transmission Code

AA = Available on Request at Provider site BM = By Mail EL = Electronically only
EM = Email FX = By fax

Identification Code
Use attachment control number

NDC: NDC Codes must be 11 digits (items XIV, XV, & XVI listed below):

A 10-digit NDC code is padded with a 'place-holder' (zero or *) by the drug supplier to make it a HIPAA compliant 11-digit NDC code. If your code is 10 digits, please contact your supplier for the valid 11-digit code. If your code contains an asterisk (*), please replace that with a zero (0). Visit the FDA website for more information and a link to search the National Drug Code Directory:

http://www.fda.gov/cder/ndc/database/docs/queryndclbl.htm

XIV. **NDC CODE & RX NUMBER (For Entire Claim)**
Example: "NDC 12345678910 RXN Q103J0885A4730"

NOTE: This data will be linked to all charge lines on the claim.

XV. **NDC CODE & RX NUMBER (Per Service Line)**
Example (Field 19): "RXN Q103J0885A4730"
Example (Field 24): "NDC 12345678910"

NOTE: This data will be linked to individual charge lines on the claim.

XVI. **NDC CODES & DRUG PRICING INFO**

NDC Code must list Unit Price, Quantity, & Unit of Measurement

Units of Measurement may be:
F2 International Unit
GR Gram
ML Milliliter
UN Unit

Example (Field 19): "NDP 15.00 25 F2"
Example (Field 24): "NDP 15.00 25 F2"

Data in Field 19: Links only to charge line with procedure code that starts with J.
Data in Field 24: Links to charge line the comment is linked to.

XVII. **DATE LAST WORKED**
Example: "DLW 01-30-2006" or "DLW 01-30-06" FORMAT: (DLW MM-DD-CCYY or DLW MM-DD-YY)

XVIII. **AMBULANCE CERTIFICATION**
Example: "AMB R C 12345 Y 05 brief reason for round trip (if needed)"

Example: AMB <Transport Code> <Transport Reason Code> <Transport Distance> <Condition or Response Code> <Condition Indicator(s)> <Round Trip Purpose Description>

Ambulance Transport Code (Indicates type of transport)
I Initial Trip
R Return Trip
T Transfer Trip
X Round Trip *Must include Round Trip Purpose Description if X*

Ambulance Transport Reason Code

A Patient was transported to nearest facility for care of symptoms, complaints or both. Can be used to indicate that patient was transported to a residential facility.
B Patient was transported for the benefit of a preferred physician
C Patient was transported for the nearness of family members
D Patient was transported for the care of a specialist or for availability of specialized equipment.
E Patient transferred to Rehabilitation Facility

Quantity (Transport Distance in Miles)

Yes/No Condition or Response Code (Condition Indicator – enter Y if the Condition Indicator applies, N if it does not apply)

Y Yes
N No

Condition Indicator(s) *REQUIRED – if more than one, enter all with no spaces (ex. 010509)

01 Patient was admitted to hospital
02 Patient was bed confined before the ambulance service
03 Patient was bed confined after the ambulance service
04 Patient was moved by stretcher
05 Patient was unconscious or in shock
06 Patient was transported in an emergency situation
07 Patient had to be physically restrained
08 Patient has visible hemorrhaging
09 Ambulance service was medically necessary
60 Transportation was to nearest facility

Round Trip Purpose Description (Free-form text – Required if Ambulance Transport Code = X)

XIX. NPI: BILLING, RENDERING, REFERRING, & FACILITY

Example: "NRF 1234567890 NFC 0987654321"

NBL ########## (Billing NPI)
NRD ########## (Rendering NPI)
NRF ########## (Referring NPI)
NFC ########## (Facility NPI)

XX. CORRECTED CLAIM SUBMITTAL **Do not use for Medicare – claims will be rejected**

Example: "CRTD 123456789"

In example above, 123456789 is the original claim number as assigned by the carrier (not the MD On-Line claim ID number).

XXI. CARE PLAN OVERSIGHT SERVICES

Example: "HHA 19-7260"

In field 23 on the CMS-1500 form, input "HHA" followed by the Care Plan Oversight Authorization Number. If also entering a CLIA number in field 23, place the CLIA information first, followed by the Care Plan Oversight information.

XXII. MEASUREMENT/TEST RESULT

Example: "TR R2 33.8"
Example (multiple measurements): "TR R1 9.1 TR R2 27.4"

Format: <MeasurementIdentifier> <MeasurementQualifier> <Measurement Value>
NOTE: This data will attach to all 'J' codes on the claim. See below for valid Identifiers & Qualifiers.

Measurement Identifier

OG Original; Starting Dosage
TR Test Results

Measurement Qualifier
GRA Gas Test Rate
HT Height
R1 Hemoglobin
R2 Hemocrit
R3 Epoetin Starting Dosage
R4 Creatin
ZO Oxygen

Measurement Value (the value of the measurement)

XXIII. **P A R T – for Chiropractors billing Medicare – Incomplete Physical Exam Information**
Example: "RMKS PART"

Incomplete Physical Exam Information
For Chiropractic services ONLY:
Report the physical exam requirements in block 19

Use P, A, R, and T
(P) Pain/tenderness evaluated in terms of location, quality, and intensity;
(A) Asymmetry/misalignment identified on a sectional or segmental level;
(R) Range of motion abnormality (changers in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility); and
(T) Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament

*At least TWO are required
*One must be A or R
*You must enter RMKS (and one space) before the applicable letters (PAR and/or T)

XXIV. **REFERRAL NUMBER**
Example: "REFERRAL: 123456"

Note: Referral Number in field 19 requires that you also enter the name and NPI of the Referring Provider in fields 17 and 17b. If you wish to report a 'Prior Authorization Number', enter that number in field 23.

XXV. **MAMMOGRAPHY FDA CERTIFICATION NUMBER**
Example: "FDA 123456"

Required when mammography services are rendered by a certified mammography provider.

XXVI. **ANESTHESIA TIME**
Example: "TIME 40 BEG 1100 END 1140"

Data in Field 19: Links to first charge line
Data in Field 24: Links to charge line the comment is linked to

XXVII. **BILLING PROVIDER TAXONOMY (SPECIALTY) CODE**
Example: "BTX 261QM0801X"

Note: Rendering Provider Taxonomy Code (Loop 2310B PRV01 = PE) is based on specialty code on file:
WebLink – My Account >Manage Providers
Link1500 – Maintenance > Physician/Organization

837 Mapping: Loop 2000A PRV03 (PRV01 = BI, PRV02 = ZZ)

XXVII. **ASSUMED & RELINQUISHED CARE DATES (Medicare global surgery/shared post-op care)**
Example/Format: “D090 MMDDYY D091 MMDDYY”

D090 = Start/Assumed Care Date
D091 = End/Relinquished Care Date

837 Mapping: Loop 2300 DTP03 (DTP01 = 090 for Start, 091 for End, DTP02 = D8)

Helpful Hints

What follows are helpful hints about using our software. Remember, if you have a question that is not answered here, please contact us.

1. Secondary Insurance Carriers

Secondary claims may be transmitted to MD On-Line in either an image or an ANSI 837 format. To enable your account to send secondary claims in an image format, please contact Technical Support at (888) 499-5465, option 2. If you already submit your primary claims in an ANSI 837 format, you can send secondary claims in an ANSI 837 format without contacting technical support.

2. Training

We have attempted to design our products to be simple to use, and we provide several informational formats to assist you with understanding the process. First, we would like to direct you to our FAQ pages, included in this packet, for those questions most frequently asked when starting with us. In addition, LINK 1500 has a "Help" section, which is regularly updated to include instructions for the use of our on-line claim form. For the first few sessions, if your billing person has any questions, you may call (888) 499-5465. For LINK 1500 assistance, please ask for ext. 206; for WebLink assistance, please ask for ext. 202.

3. National Provider Identifier (NPI)

NPI numbers are issued to each provider, as well as to each group of providers. To apply for your NPI number, go to https://nppes.cms.hhs.gov/NPPES/Welcome.do

NOTE: Most carriers require you to register your NPI with them. Please contact the carrier directly to learn more about their requirements.

4. Variant Tables

You will occasionally receive dialogue boxes asking for clarification of information when you submit claims for a new doctor or to an insurance company for the first time. These messages will help us to update our system as you continue to add new insurance companies and doctors to your system. When you receive these messages, simply follow the on-screen instructions. If you are unsure of what to do when you see one of these messages, contact Customer Support at (888) 499-5465, ext. 203, while you still have the message on your screen.

NOTE: Choosing the wrong insurance carrier or signature could cause a delay in the claims being received by the insurance carrier, so be sure to call us with any questions.

5. Changes to your System

It is of the utmost importance that you contact Technical Support at (888) 499-5465, ext. 202, immediately if you plan to make ANY changes to your computer system (hardware or software) once your account has been approved for transmission. For example, any changes in the type of printer or practice management software you are using or a change in the TAX ID number your office is submitting under. You should also contact us if your office is planning to move. If you have any questions regarding whether or not a change might impact your transmissions, contact Technical Support.

NOTE: If you are planning to have multiple terminals at your site, you MUST contact Technical Support prior to initiating the additional installation and set-up.

6. General Edits

1. **Insurance company name, address, city, state and zip code** must all show on the top of your CMS -1500 form. The proper format is:

NAME	Example:	AETNA
ADDRESS		PO BOX 1234
CITY, STATE ZIP CODE		New York, NY 99999

NOTE: State code should be in a 2 character format as assigned by the Postal Service. Zip code should have either 5 or 9 digits.

It is your responsibility to ensure that the address is correct. Some insurance companies and some specific groups within insurance companies do not yet accept claims electronically. We will continue to update our system as new insurance companies start to accept claims electronically. You will be informed of these changes through the 'dialogue boxes' mentioned earlier.

2. **Patient's name** (Box 5 on the CMS–1500 form) and the **Insured's name** (Box 4 on the CMS–1500 form) should always be entered as LAST NAME, FIRST NAME. If you need to enter a middle initial, please enter LAST NAME, FIRST NAME, and MIDDLE INITIAL. Be sure to use the same format every time for last names. Individual names should also never have a space within them; for example, do not enter La Forgia, James (no space between the "a" and the "F").

3. **Group Number** (Box 11 on the CMS-1500 form) should always be entered if there is one. If the insurance company has not assigned one, leave the field blank.

4. If the insurance carrier requires a copy of the referral form, contact the carrier to obtain the **FAX number**. They will generally allow you to FAX them a copy of that form. Most carriers require you to do this before you transmit the claim.

5. **Days/Units of Service** (Box 24G on the HCFA-1500 form) should not be left blank. You must always have at least a "1" in this field.

6. You must be using current **CPT** and **ICD-9** manuals in order to obtain the proper codes for the current calendar year. Your claims will be rejected if you submit an invalid code.

7. When billing for **Multiple Units of Service** you must place the **TOTAL charge** in boxes 24F, 28 and 30.

   Example: Billing for procedure 97710 at $20.00 per with 3 units of service.
   Place the TOTAL Charge of $60.00 in boxes 24F, 28 and 30.

8. **Physician's Signature** (Box 31 on the HCFA-1500 form) should have the name of the doctor providing the service.

9. When using a **LAB ID** in box 32, please use one of the following formats:

General Hospital 123 Main St. Anytown, NJ 12345 ID:12345	or	ID:12345 General Hospital 123 Main St. Anytown, NJ 12345

7. Specific Edits

1. **BC/BS of New Jersey**: If a referral form is required, send the form in by mail to the Newark office. You have 30 days from the date of the electronic transmission to get the form to them.
2. **Cigna**: For the Insured's ID # (Box 1A on the HCFA-1500 form), unless designated by Cigna, use the Insured's Social Security #. The number on the card is almost always the group #.
3. **PHCS**: Do not submit claims directly to PHCS, unless required. Use the name and address of the payer indicated on the patient's insurance card. Some of the PHCS network payers do not accept claims electronically.
4. **Physician's Health Services (PHS)**: Any "Out-of-Network" Claims cannot be transmitted electronically at this time.
5. **NYLCARE**: HMO claims are not accepted electronically at this time.
6. **Medicare Claims (All States)**: The "Patient Relationship to Insured" field (Box 6) must always be SELF.

8. Claims Level Tracking and Patient Control Numbers (PCNs)

PCNs are typically assigned by your practice management software and are placed into box 26 on the CMS-1500 form – you probably know them as Patient Account Numbers.

MD On-Line affixes a 3 digit prefix to your patient account number to create a PCN. Some PCN examples are:

001-Smith789
002-JacksonE

Why do we do this? We need to be able to associate any messages coming back about your claim with the claim itself. This can occasionally cause an issue with auto posting ERAs, also known as 835s.

If you are experiencing difficulty because of the 3 digit prefix, you can opt out of Claims Level Tracking.

NOTE: To opt out, we'll need your written permission to disable this feature. Fax a written request on your practice letterhead to us at (973) 734-9910, or contact Customer Support at (888) 499-5465, ext. 203, for additional assistance.

Account Orientation

1. Managing Providers

To manage your providers, log on to your MD On-Line account and select "LINK 1500" under the "Claims/Transactions" heading in our Main Menu. Click on the blue "Maintenance" tab, and select "Physician/Organization" from the drop-down menu. After filling out the appropriate information, be sure to click "Save" – this will enable you to avoid having to fill out practice information every time you submit a new claim. You can repeat this same process with "Referring Physician", "Place of Service", "CPT", "NPI" and "Facility Information" by making the applicable selection from the "Maintenance" drop-down menu and filling out the appropriate information.

2. Payer Enrollment

To submit claims electronically, you will need to register the respective Doctors/Providers in your practice/billing service with the clearinghouse and the respective payer(s).

A full list of MD On-Line's payers and whether or not they require enrollment can be found on our website, under the tab named "Payer List". **Payers whose names appear in red require you to enroll with them before you can submit claims to them electronically. To register for a payer that requires enrollment, please complete the online forms or contact MD On-Line's Payer Enrollment Department at (888) 499-5465, ext. 204.**

When you receive written confirmation that your registration has been completed and approved by the payer(s), please contact MD On-line Payer Enrollment Department at (888) 499-5465, ext. 204, for further instructions before submitting electronically. Please be prepared to provide a hardcopy of your approval letter(s) to MD On-Line. These letters will serve as an authorization for MD On-Line to process your claims.

You can also add payers to your "Favorites" to further expedite your claim submission process. To do so, select "LINK 1500" under the "Claims/Transactions" heading in our Main Menu. Click on the blue "Maintenance" tab, and select "Favorite Insurance Companies". Then, simply click on a payer from the "Master Payer List" and click "Add to Favorites". This payer will then be added to your list of "Favorite Insurance Companies".

MD On-Line charges a Payer Registration Assistance Processing Fee to establish your non-commercial account. This fee covers administrative costs associated with establishing your account with the applicable carriers. This completed form MUST be returned to MD On-Line's Payer Enrollment Department prior to any approvals being granted.

If you have any other questions relating to electronic transmissions of Medicare, Medicaid or BC/BS claims, please contact MD On-line Customer Support.

NOTE: All Non-Commercial claims for payers which require registration will be sent to paper if your registration is not complete or is not current. It is your responsibility to ensure that your registration is complete and current and that MD On-Line has been properly notified prior to submitting these Non-Commercial claims. Providers can check the status of payer enrollments from the Main Menu (Payer Enrollments).

3. Viewing Messages

To view messages in your LinkMail, log-in to your MD On-Line account and click "View Messages" under the "Claims/Transactions" heading in the Main Menu. MD On-Line frequently sends you messages regarding claim status, the acceptance or rejection of your claims, session results, company news and more, so be sure to check your messages regularly!

Once in your LinkMail mailbox, you can choose a range of dates for which to display messages. Claims related messages will always appear in **blue**. You can also choose to "Archive" selected messages; when selected, "Archive" means that your message will be stored separately so that it doesn't show with your main messages. This can be helpful when trying to reduce mailbox clutter.

NOTE: Archiving a message does NOT delete it! Archived messages may be viewed at any time by clicking the "View Archived Messages" link.

4. Session Report

Each time you submit a batch of claims through MD On-Line, you will receive an itemized report in your LinkMail detailing the following:

- Total claims submitted electronically and the total dollar amount of these claims. It will also list the insurance company, payer ID, patient control #, insured ID, eligibility, date of service, current status and dollar amount of each claim.
- Total claims that need to be printed out to paper and total dollar amount of these claims. Again, it will list the insurance company, payer ID, patient control #, insured ID, eligibility, date of service, current status and dollar amount of each claim.
- Session statistics
- Raw data file – a copy of the text file that was sent for that session

This report will also give you a "Session Tracking Number" for each session. **It is highly recommended that you print this report out and save it. This report is your proof that the claims were submitted.**

NOTE: If you choose to opt-out of our Print & Mail service, this report also informs you whether or not you need to print out any claims. For those customers that decide to opt-out of our Print & Mail service, MD On-Line will not be responsible if you fail to print and mail claims that require submission by paper. Be sure to fill out the Print & Mail Opt-Out Form at the end of this packet if you wish to opt-out of this service.

5. Clearinghouse Acceptance Reports

We will forward acceptance reports to you as we receive them via the **View Messages** button on the Main Menu. These reports will be automatically downloaded to your terminal.

NOTE: As your claims are processed through the clearinghouse, they are subject to several levels of checks and edits. The initial acceptance reports you receive will notify you that the claims have been received by the clearinghouse and have met the minimum quantitative standard to begin the process. However, the claims may still be rejected elsewhere in the process due to qualitative problems which will be reported to you in the standard rejection report.

6. Rejection Reports

We will forward rejection reports to your computer via our LinkMail electronic mail system. These reports can be viewed by logging on to MD On-Line and selecting **View Messages** from the Main Menu. There are three types of rejection reports: those issued by MD On-Line, those issued by the clearinghouse, and those issued by the insurance company. These reports will be automatically downloaded to your terminal after completion of a successful connection to the MD On-Line server. **Examples of each of these types of rejection reports can be located in the "Sample Report Pack", included in this Welcome Packet.**

It is imperative that you read these reports and address the reasons for rejection in a timely manner. Simply go back into your practice management system, fix any rejections and re-submit the claims. If you feel that a claim was rejected in error or do not understand the reason for rejection, please contact MD On-Line Customer Support at (888) 499-5465, ext. 203. **It is your responsibility to ensure that rejected claims are corrected and resubmitted.**

NOTE: MD On-Line is responsible for the transmission of your data only. We will not be able to answer questions on specific policy benefits and limitations.

We suggest you connect to MD On-Line at least twice a week even if you have no claims to transmit. You may have rejection reports waiting that pertain to previous claims submissions, monthly billing invoices or other informative mail.

7. Claim Status

You will automatically receive a message in your LinkMail inbox each time the status of your claim changes. To view these messages, you can login to your MD On-Line account and select the "View Messages" option from the Main Menu, and then search for any "Claim Status" messages.

If you know either the session tracking number or the range of dates in which the claim was submitted, you can search for the status of a particular claim by clicking "Session Results" under the "Claims/Transactions" heading in the Main Menu. Once the session in which the claim was submitted is located, click on the correct "Session Tracking Number", highlighted in blue. A summary of your claim submission session will then appear, showing you the insurance company, who the claim was routed to, payer ID, patient name, patient control #, insured ID, date of service, balance due and eligibility, in addition to the claim's current status.

NOTE: In the "Tools" box located within your session report, you will find helpful links to aid you with the following: creating claim notes, e-mailing our support team, submitting a timely filing letter, and submitting an appeals letter. Please see the sections below regarding timely filing letters and appeals letters for more information.

8. Claim Statistics

To view your claim statistics, log into your MD On-Line account, and select "Payer/Claim Statistics" under the "Claims/Transactions" heading in the Main Menu. Simply select the month which you wish to view and MD On-Line will provide you with relevant claim statistics, including claim volume by status, dollar amounts by status, claim volume by payer and an overview of each payer, including the number of claims submitted and the dollar amount.

9. Timely Filing Letter

If your resubmitted claim was rejected because the payer claimed it was beyond timely filing, pull up your session report (for instructions on how to access your session reports, please reference the "Claim Status" section above) and click on the "Clock" icon in the "Tools" box located within that session report. Clicking on this icon will allow you to print out a pre-filled letter to send to the carrier on your office letterhead.

10. Appeals Letter

If the insurance company maintains it never received your claim, for example, or if you identified a discrepancy between your contracted rate and actual reimbursement from the payer, pull up your session report (for instructions on how to access your session reports, please reference the "Claim Status" section above) and click on the "Scales of Justice" icon in the "Tools" box located within that session report. Clicking on this icon will allow you print out a pre-filled appeals letter to send to the carrier on your office letterhead.

11. Patient Search

To search for claims related to a particular patient, simply log into your MD On-Line account and select "Patient Search" from the Main Menu. A last name or patient control number, and a date range are required to perform a "Patient Search". You can choose to search by either the date of service or the date the claim was submitted to MD On-Line.

NOTE: This service is available to paying accounts ONLY. To change to a paying account, please contact our Finance Department at (888) 499-5465, ext. 205.

Sample Report Pack

Session Results (Post Transmission)
MD On-Line Rejection
Eligibility Rejection
Clearinghouse Acceptance
Clearinghouse Rejection
Insurance Company Acceptance
Insurance Company Rejection
Claim Status

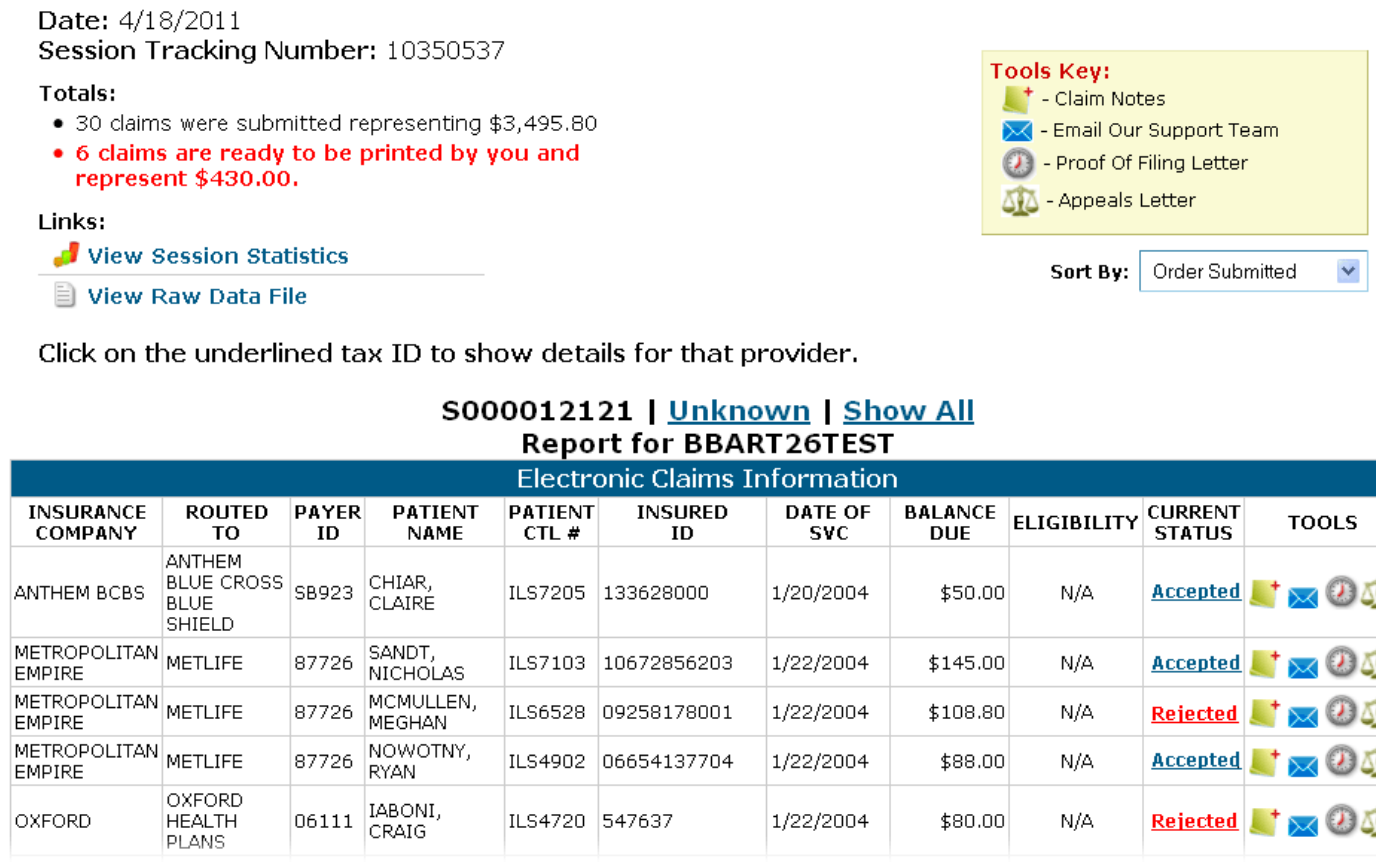
Sample: Session Results Report (*Post Transmission Report*)

This report details the claims that you have transmitted to MD On-Line. The section titled "Electronic Claims" will be processed by MD On-Line. If you have **not** opted-out of our Print & Mail service, MD On-Line will fully process the claims in the "Print & Mail" section. **If your office opts-out of our Print & Mail service, you will be responsible for printing and mailing these claims**. For claims listed in the "Unprocessed Claims" section, call our Customer Support department to determine the reason why they were unable to be processed.

The right hand column contains useful tools for you to manage your claims.

You may change the sort order by choosing from the "Sort by" drop down.

You may view the claims submitted under any provider's tax ID by clicking on the blue tax ID link for each one or you may choose 'show all'.



Date: 4/18/2011
Session Tracking Number: 10350537

Totals:

- 30 claims were submitted representing $3,495.80
- 6 claims are ready to be printed by you and represent $430.00.

Links:

View Session Statistics
View Raw Data File

Tools Key:
- Claim Notes
- Email Our Support Team
- Proof Of Filing Letter
- Appeals Letter

Sort By: Order Submitted

Click on the underlined tax ID to show details for that provider.

S000012121 | Unknown | Show All
Report for BBART26TEST

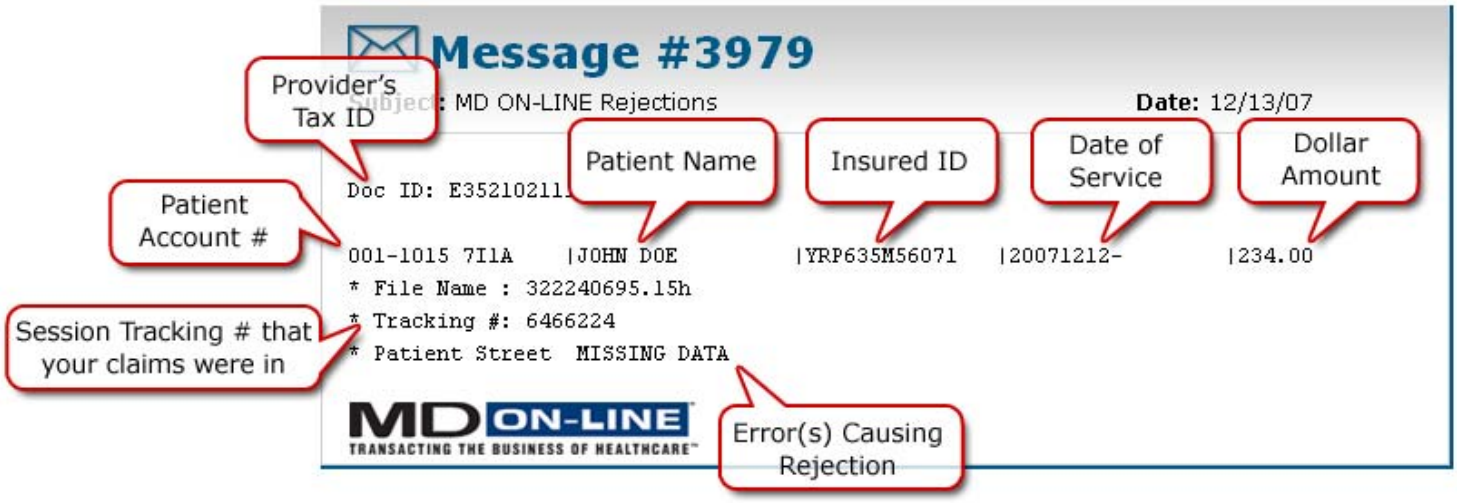
Electronic Claims Information

INSURANCE COMPANY	ROUTED TO	PAYER ID	PATIENT NAME	PATIENT CTL #	INSURED ID	DATE OF SVC	BALANCE DUE	ELIGIBILITY	CURRENT STATUS	TOOLS
ANTHEM BCBS	ANTHEM BLUE CROSS BLUE SHIELD	SB923	CHIAR, CLAIRE	ILS7205	133628000	1/20/2004	$50.00	N/A	Accepted	
METROPOLITAN EMPIRE	METLIFE	87726	SANDT, NICHOLAS	ILS7103	10672856203	1/22/2004	$145.00	N/A	Accepted	
METROPOLITAN EMPIRE	METLIFE	87726	MCMULLEN, MEGHAN	ILS6528	09258178001	1/22/2004	$108.80	N/A	Rejected	
METROPOLITAN EMPIRE	METLIFE	87726	NOWOTNY, RYAN	ILS4902	06654137704	1/22/2004	$88.00	N/A	Accepted	
OXFORD	OXFORD HEALTH PLANS	06111	IABONI, CRAIG	ILS4720	547637	1/22/2004	$80.00	N/A	Rejected	

Clicking on the "View Session Statistics" link will display information about the claims as they move through the adjudication process. The statistics will update daily.

Sample: MD On-Line Rejection Report

This report details the claims that you have transmitted to MD On-Line that have been rejected by first line edits in place at MD On-Line. This message will be found after submission of your claim packet in your "Messages" folder. The remainder of your claims, not rejected in this first line of edits, may still be rejected at several stages of processing either at subsequent clearinghouses or at the Payer levels, as explained in the reports following this page in your sample report package.



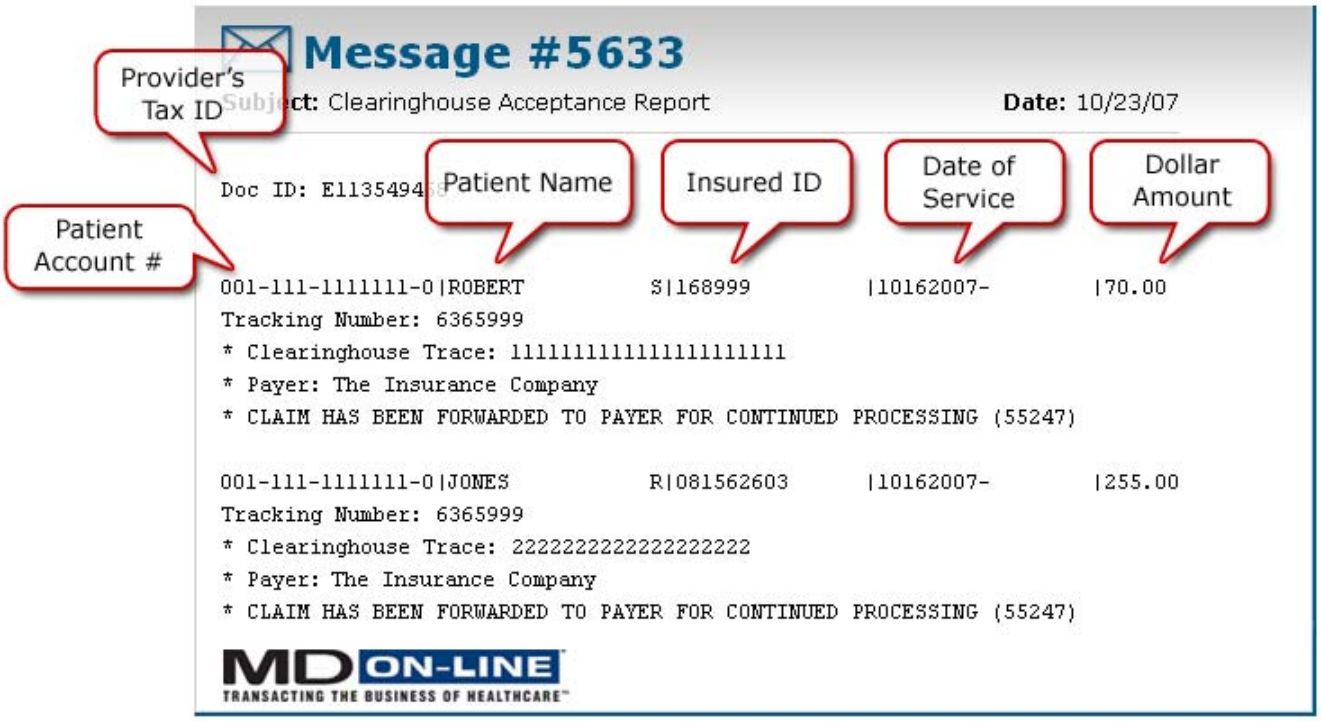
Sample: Eligibility Rejection Report

This report informs you of claims that do not pass eligibility checks. MD On-Line uses the data submitted on your claims to verify patient eligibility with the insurance carrier. If your claims are rejected by the insurance carrier for eligibility reasons, we will inform you on this report. If you have questions about why a claim is rejected on the report, you should contact the carrier directly. Claims that pass eligibility checks are then forwarded to the clearinghouse and insurance carriers for processing. It is your responsibility to review this report and to correct and re-submit claims which appear on it.

Please be advised that not all insurance carriers presently participate in eligibility checking, although more carriers are added to the list regularly.

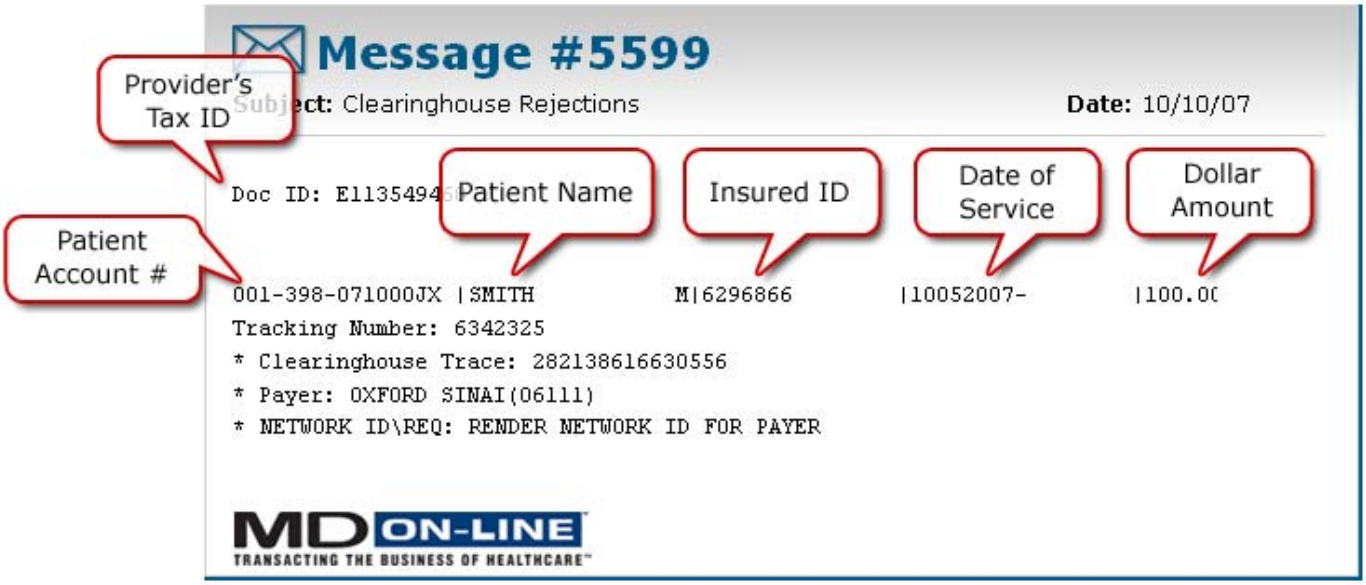
Sample: Clearinghouse Acceptance Report

This report informs you of claims that have been initially accepted at the clearinghouse level. This level of editing checks for basic data such as a valid CPT or ICD-9 code, valid dates of service, etc.. Because this is an initial edit only, it is possible that claims can be accepted at this level and then rejected at subsequent levels – check your Clearinghouse Rejection report for rejected claims.



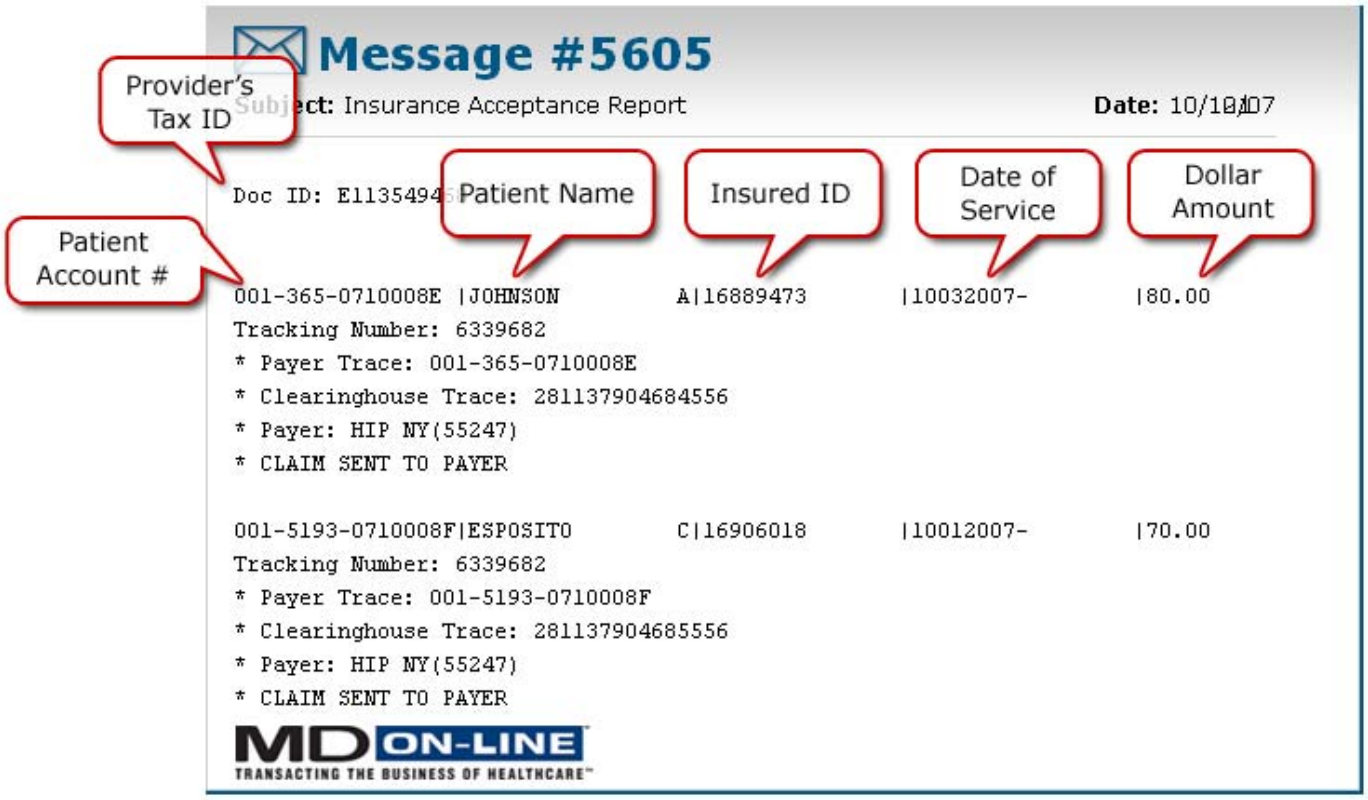
Sample: Clearinghouse Rejection Report

This report informs of claims that have been rejected at any level in the clearinghouse. Claims that appear on this report must be corrected by you and then re-submitted. Claims rejected at this level will NOT be forwarded on to the insurance carriers until corrected and re-submitted.



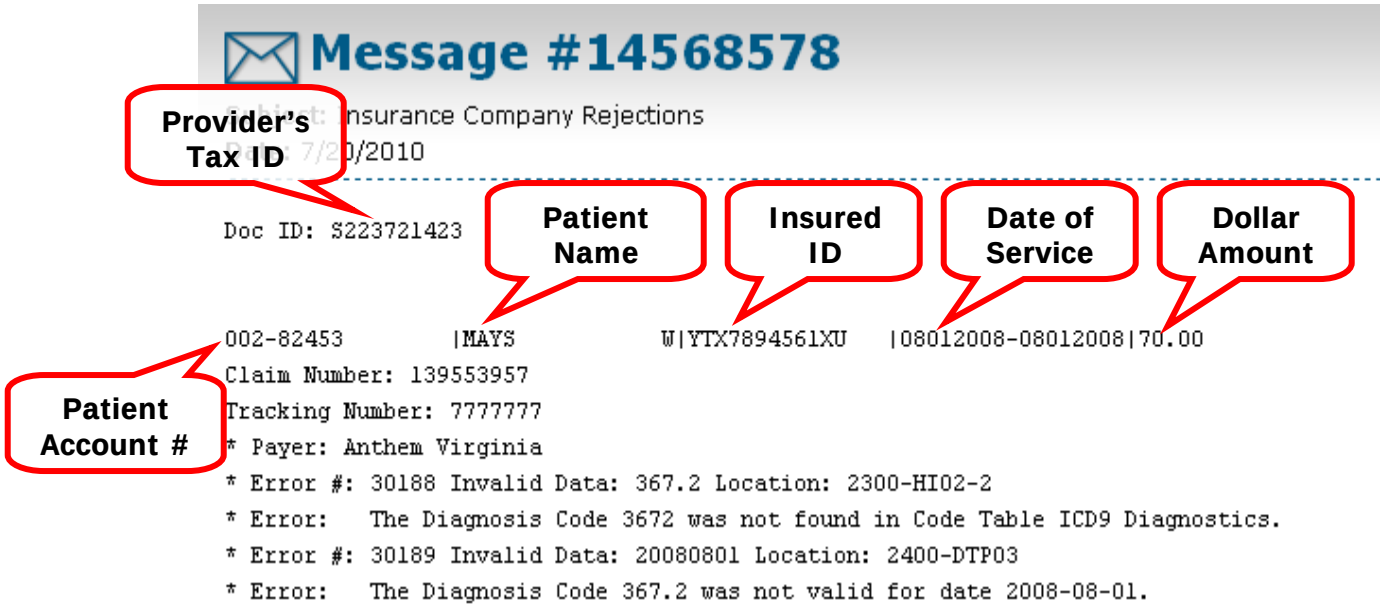
Sample: Insurance Company Acceptance Report

This report informs of claims that passed clearinghouse edits and were then sent to the insurance carrier, where they were accepted. You should contact the insurance carrier directly with questions about claims accepted at this level.



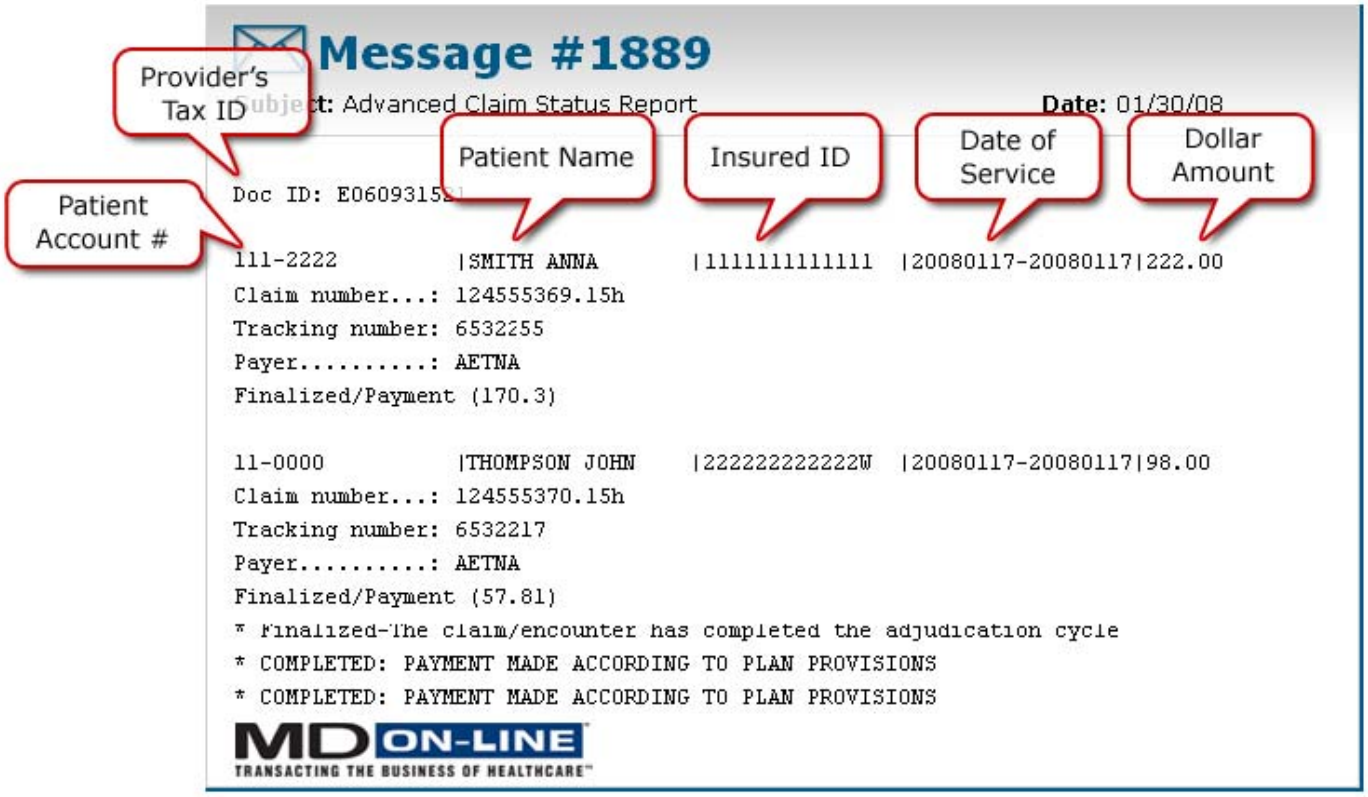
Sample: Insurance Company Rejection Report

This report informs of claims that pass clearinghouse edits and are then sent to the insurance carrier, where they were rejected. Rejections at this carrier level are policy level rejections directly from the insurance company. You should contact the insurance carrier directly with questions about rejections at this level.



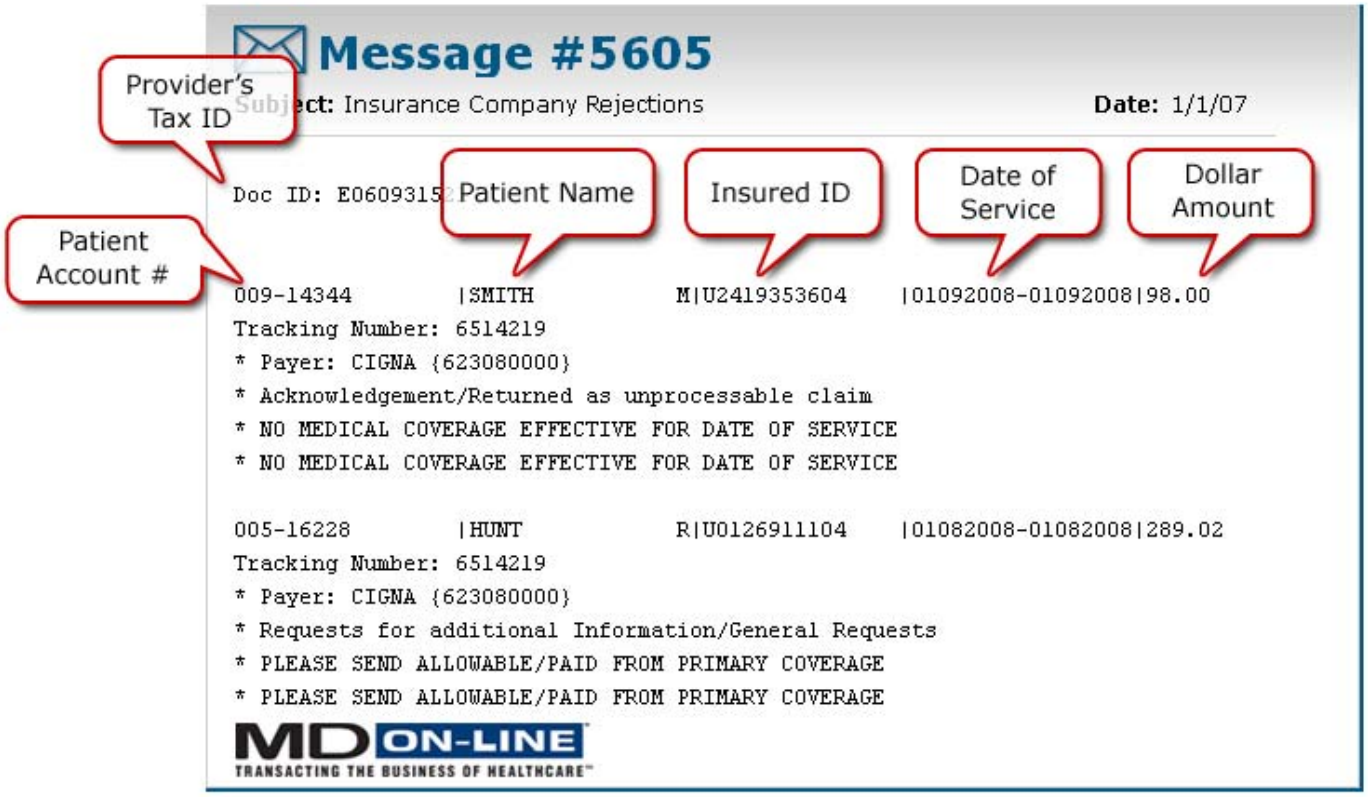
Sample: Advanced Claim Status Report

This report provides a more detailed level of reporting on the status of any claim you have submitted to an insurance carrier who participates in Claim Status (note: not all payers do). As your claims move through the adjudication process, a message will be sent back each time the status of the claim changes. This report includes detailed payment information that will not be found on the Basic Claim Status Report.



Sample: Basic Claim Status Report

This Basic Claim Status report informs you of status changes on any claim you have submitted to an insurance carrier who participates in claim status (note: not all do). As your claims move through the adjudication process, a message will be sent back each time the status of the claim changes. Rejections may occasionally be found on the report, so be sure to read it carefully.



Frequently Asked Questions

Q: What insurance companies can I submit claims to using your service?
A: Presently, we can submit your claims to over 2000 insurance companies electronically, and to most others via our Print & Mail service. See our Payer Lists for our electronic payer connection specifics.

Q: What Is LINK1500?
A: LINK1500 is the name of our online claim form product that allows you to simply submit your claims electronically via the Internet by filling out our online version of the CMS-1500 form right from the MD On-Line website. This process is fast and easy and our system tracks all of your submissions.

Q: What is meant by a *Live* terminal?
A: When you first register to use our 'batch-mode' product, WebLink, you will start by operating in test mode. While in test mode, you will be asked to transmit a small packet of claims to verify that we can read your transmissions successfully. When confirmed, your account will be switched to *Live* status and you will be ready to send all your commercial (a.k.a. participating) claims. Note: The submission of most non-commercial (a.k.a. non-participating) claims requires additional registration steps to be completed before live processing may commence. While in test mode, claims will not be sent to the insurance carriers.

Q: I understand that certain insurance carriers presently do not accept claims electronically. What do I do with these claims?
A: Our system has been designed to automatically separate claims that can go electronically from those that can not. The claims that cannot go electronically will be separated out of the session packet and automatically directed to our Print & Mail service.

Q: What is meant by Print & Mail?
A: When a batch of claims is transmitted to the MD-On Line network, there may be claims within that batch that cannot go electronically. This is because the payer that the claim is intended to reach is not currently set up to receive claims electronically. Most often, MD On-Line can print those claims and mail them (hard copy) directly to that specific payer. A per claim fee applies to this service.

Q: I want to print and mail my non-electronic claims myself. How is that accomplished?
A: MD On-Line offers an option to opt-out of the Print & Mail service for those customers who would rather handle the process for paper claim submissions themselves. This opt-out is available to Print Image submitters only. Once sorted and separated from the electronic claims in their claim batch, their non-electronic claims can be redirected back to you. To opt-out of our Print & Mail service, contact our billing department at (888) 499-5465, ext. 205.

Q: Do I need to list the Payer ID number on my claim form?
A: Print Image and NSF submitters do not need to include a payer ID. Based upon the Insurance company name and address listed on your HCFA form, we match up the correct Payer ID numbers for you. This saves you a lot of time and hassle as Insurance companies change their names and Payer ID numbers from time to time. **If you are submitting ANSI 837 files to MD On-Line, however, Payer IDs are required!**

Q: Will I have to enter my claim information twice using your system?
A: No. Our product is a "claim capture" program which interacts with your practice management system to acquire and send the claim information you have already entered.

Q: I am not computer savvy. Is your software difficult?
A: Our program is extremely easy to use. WebLink and Link1500 were specifically designed with the casual computer user in mind. We also have friendly Customer Support representatives who can assist you with any questions you may have.

Q: How soon can I expect payment on my claims?
A: The average turnaround time on claims submitted electronically is from 7 to 14 business days; however, we can not guarantee specific turnaround times due to factors within downstream clearinghouse and payer pipelines that are beyond our control.

Q: Will your software interfere with my office's practice management software?
A: No. Our program is totally separate from your existing practice management system. It simply transmits the claim information that your software "hands" it.

Q: What payment options are available?
A: We accept payment by credit card (MasterCard, Visa, American Express) or automatic debit from your checking or savings account. We wish to limit the volume of paper that enters and leaves our offices as well as yours; therefore, checks are accepted only under pre-approved circumstances. We also offer several pre-payment options that can save you more money.

Q: What if I don't submit any claims during a particular month?
A: You will only be responsible for the Monthly Minimum charge.

Q: When will I be billed?
A: You will receive your billing statement on a monthly basis beginning the month following your first live claims transmission. We send these via our proprietary mail service, called LinkMail, another feature of your MD On-Line product.

Q: Will I receive an invoice each month if I use credit card or automatic debit?
A: Yes. We provide monthly statements of your account activity indicating your method of payment. If you pay by credit card or automatic debit, no action is necessary on your part. Your monthly billing report will also include a service report outlining the claims you submit categorized by the insurance company the claims were sent to.

Q: Can I pay in advance?
A: Yes. We offer customers the option of prepaying for commercial claim charges. However, customers using this option will continue to be billed monthly for any non-commercial and/or paper claim charges incurred. Call us to discuss customized billing options.

Q: When is MD On-Line support available and how much does it cost?
A: Technical and Customer Support are available Mon.- Fri., 8:30am to 6:00pm (Eastern Standard Time), by calling (888) 499-5465. All support services to MD On-Line customers are free of charge!

Q: I need information about a specific transmission or claim. What should I do?
A: You should contact our Customer Support Department (888) 499-5465, ext. 203, with a tracking number found on your session results report (a.k.a. post-transmission report) and they will assist you. Please note that we are not a billing service and can only assist you in tracking your claims between your terminal and the carrier. We cannot provide information on the claim once it has entered the carriers system unless you are a subscriber to our Claim Status service and the payer is a participant of that program.

Q: What is Claim Status?
A: Claim Status is an enhancement to our LINK products that provides an extra level of information about your claim. Many insurance carriers respond with a transaction format which allows additional information which we can make available to you once your claim has entered the carrier's processing system.

Q: I have purchased a new computer/software package. Do I need to notify you?
A: Yes. We must be aware of any major changes to your system including new hardware (computer or modem), new software (PMS system or revision), new phone numbers, etc. Any changes within your system that could potentially affect your ability to communicate with us should be brought to our attention as soon as possible. If in doubt, call our Technical Support team at (888)499-5465, ext. 202.

Q: Our practice is planning to move to another location. Should we notify you?
A: Yes. If you will be receiving a new phone number, we must be made aware of the change. There are several system security issues that need to be addressed should you wish to reinstall your software or if you plan to relocate your existing computer terminal. If the proper procedure for reinstallation is not followed it could delay or prevent your claims

from being forwarded properly. Many of these security features are in place to protect you from fraudulent use of your system.

Q: How do I send claims to Medicare, Medicaid, and/or Blue Cross/Blue Shield?
A: Sending claims to these carriers requires a more complicated registration process, which can sometime take up to 4-6 weeks. We will supply the necessary forms for you and can assist you in this process. Contact our Enrollment Department at (888) 499-5465, ext. 204, for assistance.

Q: Can I send claims with secondary Payers?
A: Medical claims naming a secondary payer can be sent electronically as long as the primary named carrier accepts claims electronically. If you submit in the 837 format, you may send those claims directly. If you submit in a print image format, you will need to use our secondary claim product. For assistance, please call Tech Support at (888) 499-5465, ext. 2.

Q: I'm concerned about the security of my claim information and I've heard some electronic claims companies use the Internet (World Wide Web) to transmit their data. How safe are my claims with your service?
A: Our WebLink product is our most popular option available to you for submitting your claims via the World Wide Web. When using WebLink, the integrated encryption features of your web browser in conjunction with our Network Solutions Site Seal provides the highest level of confidence in the protection for your data transmissions. Either way, you can be assured that your claims are always handled in the strictest confidence, using the latest security features.

Q: How often can I submit claims and during what hours?
A: You may submit as often as you would like. Our network is available to receive claims 7 days a week, 24 hours a day.

Q: Can I save partial claims and return to them later?
A: No. Claims must be fully completed before saving. Once a claim is saved, however, you can wait to transmit it at a time of your choosing.

Q: Does resubmitting a claim delete my original claim?
A: No. Resubmitting a claim creates a new copy while still preserving the original. To access the original copy, log-in to your MD On-Line account and click on "Session Results" – this will allow you to input the tracking number or date submitted of the original claim so you can then locate it.

Q: What types of claims can I submit using your LINK services?
A: We presently accept the CMS-1500 Professional Health Care claim form in a print image/text file, NSF or ANSI 837 4010A1 format. We also accept Institutional claims in the 837i 4010A1 format.

Q: How much do upgrades cost and how do I get them?
A: As a MD On-Line customer, version upgrades are automatically downloaded to your computer without any action on your part and at no charge. Information about new products and enhancements that work in conjunction with our claim software will be sent to you via LinkMail for your consideration.

Q: I know I need to change or add information to my CMS- 1500. I cannot manipulate my software to make the changes myself. What should I do?
A: The software vendor that supplied your practice management software is often the best source of information and support in making these types of changes.

Q: What if support is no longer available from my PMS vendor?
A: Contact our Technical Support Department at (888) 499-5465, ext. 202, and we will make every attempt to assist you.

Q: What is LinkMail?
A: LinkMail is MD On-Line's internal system of communication to our customers. When you connect with our system, your messages are automatically downloaded right to your terminal. You will be able to read, print and/or save these messages, which can address anything from claim submission feedback to your monthly bill.

Q: Will I receive a report every time I submit claims?
A: Yes. This report is known as the Session Results (a.k.a. p*ost transmission* report). It lists the claims that were submitted in each claim file transmission. The report provides summary information on each claim and whether the claim

was submitted electronically or if it will be printed to paper and mailed. This report should be treated as a receipt of what was transmitted and should be kept as a permanent record for reconciliation purposes.

Q: How much does your software cost?
A: We charge a one-time startup fee. In addition, we also charge a monthly minimum fee for unlimited claims to the carriers listed on our participating payers list. Since some practices can qualify for discount and sponsorship programs, please call us for up-to-date pricing based upon your situation.

Q: How can I get more information?
A: Call one of our Account Executives at (888) 499-5465, ext. 201. They will be happy to answer any additional questions you may have.

Payment Options Info Sheet

Each month your office will receive an invoice from us, regardless of the payment method you choose. Your invoice will appear in your MD On-Line LinkMail by the 15th of each month. Please remember that the invoice you receive from MD On-Line each month includes unlimited transactions for the submission of participating, non-participating and/or Print & Mail claims processed during the previous month. In addition, any additional charges that you may have incurred will also be included. If you wish to pay for our services on a monthly basis, please choose Option 1 or Option 2 below. We also offer Option 3 for those who desire a discount option. **Be sure to fill out the attached Bank Account/Debit Form if you wish to utilize either Option 1 or Option 2.**

1. Automatic Bank Account Debits:
Automatic debiting can occur from any financial institution's saving or checking account. Charges are deducted from your account on a monthly basis for the amount noted as due on your monthly invoice.

2. Credit Cards:
We accept Visa, MasterCard, or American Express. You can choose to have your monthly balance due charged to your credit card.

(To our Credit Card and Bank Debit Customers…our discounted prepayment programs are also available for those who wish to prepay their account. The amount of your discount is based upon the prepayment term selected.)

3. Prepayment Option & Payment by Check:
Our standard policy does **not** allow us to accept checks for payment on a monthly basis. However, if your accounting department can only process payments for services by check, we can accept checks as outlined in our 'Reserve Account' policies.

Prepayment Option:
For those submitting participating claims, we offer two discounted prepayment programs. If you intend to pay by Credit Card or Bank Debit, we offer discounts for 6-month or 12-month prepayment. Please call our billing office for details at **(888) 499-5465, ext. 205**.

Note: If you intend to submit non-participating and/or Print & Mail paper claims, please see Reserve Account.

Reserve Account:
For those who prefer to pay by check for the submission of non-participating and/or Print & Mail paper claims, we require participation in our Reserve Account program. This program creates a reserve account from which your monthly fees and charges are deducted each month. Since most accounts that submit non-participating and/or Print & Mail paper claims have a fluctuating balance each month, no specific time period is associated with this account. To establish this type of account, mail your check to the MD On-Line Finance Department in the amount noted. This payment creates your reserve balance. When your Reserve Account balance falls below a pre-set level, you will be sent a reminder note on your invoice to mail an additional payment to replenish your account.

Customer's Responsibility:

As your financial information changes (i.e., credit card expires, account number changes, etc.), please contact our office to keep your records updated. If we are unable to obtain funds from the account information you have provided, we will first contact your office with a reminder call. After two attempts to obtain the correct information without a response, your terminal will be deactivated and your access to our system will be suspended until your payment and/or valid billing information is received. Upon our receipt of payments due and/or valid account information, your account will be reactivated. Reactivation charges may apply.

Bank Account Debit/ Credit Card Form
4 Campus Drive, Parsippany, NJ 07054

MD On-Line offers two automated payment options for charges associated with our services. Please choose one by completing the appropriate section below and faxing to us at **973-734-9910**, or mail to our address above. You may also pay by credit card or bank debit card using the 'Pay Now' feature found on your MD On-Line home page under 'Maintenance'.

Our credit card option allows your monthly charges to be conveniently billed directly to your credit card account. When this payment option is in effect, your billing statements will indicate "*Credit Card*" as your Usual Payment Method. Alternately, your monthly charges can be debited directly from your bank savings or checking account. If you want debits via your savings account, please obtain your bank's ABA (Routing) and your account number from your financial institution, otherwise please forward us a voided check for the account from which you wish to have our charges debited. When this payment option is chosen, your bills will indicate "*Bank Debit*" as your Usual Payment Method. In an effort to minimize paperwork in our office as well as yours, MD On-Line does not accept checks as payment for monthly charges, however we do offer a discounted pre-payment option, which is payable by check. Please contact our billing department for further details regarding our pre-pay option by calling **888-499-5465**.

Using either of our automated methods, the total amount due for your bill will automatically be deducted from your checking, savings, or charged to your credit card account each month. There is no additional charge to you for paying your bills using either of these methods. You will continue to receive a billing statement each month for your records. Payments will be charged the business day after your billing statement date as indicated on your monthly MD On-Line billing statement.

If a transaction is refused by your financial institution for any reason, your MD On-Line account may be subject to additional charges. If you intend to dispute charges on your bill, please contact the MD On-Line billing office at the number indicated on your bill as soon as possible. Any adjustments made to your current bill will be included in your next month's billing statement. Please call **888-499-5465**, Monday through Friday 8:30am - 5:00pm, to discuss updating any of your billing information, especially if any account information has changed or if you wish to make changes to any of your payment option choices.

CREDIT CARD FORM: Circle one: Discover Visa Master Card American Express

The undersigned hereby agrees and authorizes MD On-Line, Inc. to keep my signature on file and to charge the bankcard account identified below for all amounts due on our MD On-Line, Inc. account.

Account #: _____ Exp: _____

Name on Card: _____ Security code _____

(3 Digits on back, 4 Digits on front for AMEX)

Credit Card's Billing Address: _____

City:_____ State: _____ Zip: _____

Telephone:_____ Fax: _____

Customer/Practice Name: _____

Signature:_____ Date: _____

Name:_____ Tax ID / SSN: _____

(Please Print)

BANK DEBIT FORM*:*

I hereby authorize MD On-Line, Inc. to automatically debit my checking or savings account (as noted) each month. I understand that MD On-Line reserves the right, upon written notification, to terminate my participation in this payment option. My participation in this payment option is subject to MD On-Line's approval.

CUSTOMER NAME: _____ TAX ID# / SSN: _____

_____ _____

Please Print – Authorized Name *Account Signature* *Date*

Type of Account (please check one)
☐ Personal
☐ Commercial/Business

Please debit my (please check one)
☐ Checking Account (Enclose voided check)
☐ Savings Account (Complete the information below)

BANK ACCOUNT #: _____ **ABA (Routing) #:** _____

BANK NAME: _____ **PHONE NUMBER:** _____

Print & Mail Service Info and Opt-Out Form

- MD On-Line's software allows the seamless ability to print and mail your claims to most payers unable to accept them electronically, at the rate of $0.47 per claim.
- This service provides for the automatic capture, processing, printing, and mailing of your claims to those carriers unable to accept them electronically, with a few exceptions.
- This service cannot process any claims for secondary payers. Claims involving secondary insurance carriers cannot be printed at a remote location due to EOB attachment requirements. If you have claims which have secondary carriers included in your transmission packets, please contact Customer Support at (888) 499-5465, ext. 203. Adjustments may be required for your account.
- Certain claims, such as some Medicaid and Medicare types, cannot be sent via Print & Mail due to special paper claim requirements by the carriers. Contact Customer Support for specific payers to which this applies.
- If you do not wish to take advantage of this service, please fax this form to (973) 734-9910 to opt-out of this feature.
- Your regular monthly bill will include the per claim charges for this Print & Mail service.
- **NOTE: LINK1500 and 837 submitters may NOT opt-out of Print & Mail and MUST utilize the Print & Mail service.**

IMPORTANT NOTE:

You are solely responsible for the paper claim requirements of the payers to whom you submit claims. MD On-Line is not responsible for rejections due to a specific payer's paper claim requirements.

Upon verification of your billing information, your terminal will be fully activated for our Print & Mail feature. If you have any questions or need any additional assistance regarding this feature, please call (888) 499-5465, ext. 205.

Opt-Out Confirmation:

I intend to print and mail my healthcare claims from my office. I do not want MD On-Line to perform this service for our account. By signing below, I am **opting-out** of MD On-Line's Print & Mail service and I understand that it is my responsibility to ensure that claims identified as non-electronic are submitted to the insurance company.

Practice Name Date

Signature Print Name Phone

Please FAX this form to: (973) 734-9910

Only fax this form to MD On-Line if you want to Print & Mail your own non-electronic claims

Referral Program

Provide a referral and BOTH practices will receive a FREE month of service! *

Now that MD On-Line has assisted your office in streamlining operations and decreasing account receivable lead times, we would like to ask you to share your positive experience with other health care providers.

If you refer a practice to us and that practice signs up to utilize one of our LINK products, we will reward the referring office *and* the referred office with one free month of service. Plus, an additional free month of service will be credited to your account for each new customer referral you provide!

There is NO limit to the number of free months you can receive for the referrals you provide!

We would like to thank you in advance for your consideration of referring practices to MD On-Line.

Remember:
Save Time. Save Money. Eliminate Paper.

MD On-Line
...making health care transactions easy!

***** Note: To qualify for our referral reward, the referred office must actively use the services of MD On-Line for at least 30 days. MD On-Line will waive your regular monthly minimum fee for one (1) month as a reward for your referral, upon completion of referred office's 30-day use of any MD On-Line claim processing product.

Practice Referral: *(Their practice info)*

The practice listed below is interested in receiving more information on MD On-Line Products and Services:

Practice Name: _____

Contact Name: _____

Phone: _____

Best Time to Call: _____

Referring Practice: (*Your practice info*)

Practice Name: _____

Contact Name: _____

Phone: _____

Date of Referral: _____

If you wish to discuss our referral incentives in more detail, please contact our Sales Department at (888) 499-5465, ext. 201.

MD On-Line, Inc.
4 Campus Drive - Parsippany, NJ 07054
Toll Free : (888) 499-5465 / Fax : (973) 734-9910
Visit us on the web at: www.mdol.com