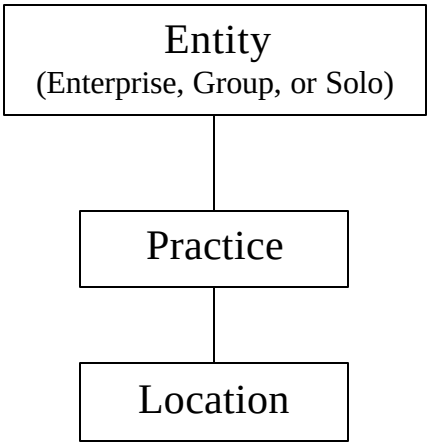
PROFILES

SequelMed is based on a hierarchical and relational setup, which therefore necessarily enforces a proper and efficient functional setup. In other words, you must define certain parameters before the next parameter could be defined and be effective. This hierarchical and relational setup is defined in the Profile menu of SequelMed and is the backbone of SequelMed.

The core of SequelMed's hierarchical and relational setup is the Entity-Practice-Location hierarchy, wherein an entity could be enterprise (a large conglomerate of practices and locations), group (a smaller conglomerate of practices and locations), or solo (a group of practices and locations comprising of 1-4 providers). This hierarchy can be illustrated as follows:



Entity is the parent body, which could be a multi-group company comprising of a group of doctors or a billing service, etc. Information is shared within an entity (for example, master patient index, employers, lawyers, schools, providers, patients, referring providers, procedures, diagnoses, place of service, type of service and other such parameters. All these and other shared profiles will be identified and explained later. The relationships that are built in the Profiles menu will then pertain to all practices under that entity. Entity (along with the assigning of respective practices, locations, resources and providers) is defined and created in the SequelMed Security application. For example, consider New York Medical Company (NYMC) as an entity. NYMC has Practice A, Practice B and so on. Each of these practices has isolated financials, which are unique only to that practice, but yet all these practices share the common resources, which we call profiles.

What all this means is that in order to define a location, it must be bound to a practice and therefore you must define a practice first. In order to define a practice, it must be bound to an entity and therefore you must define an entity first, which will be the parent body. Functionally speaking, as we will see later, this hierarchical and relational setup is enforced in SequelMed by the designation of mandatory blue fields, indicating that this field is required for proper setup. For example, in the location profile, practice is a mandatory field (indicated in blue). Hence, you must define the practice before you can assign any location to it. Similarly, before defining a plan, the insurance must be defined. In other words, at the Plan Profile level, you cannot create a new plan without first defining the insurance to which it is bound. In the

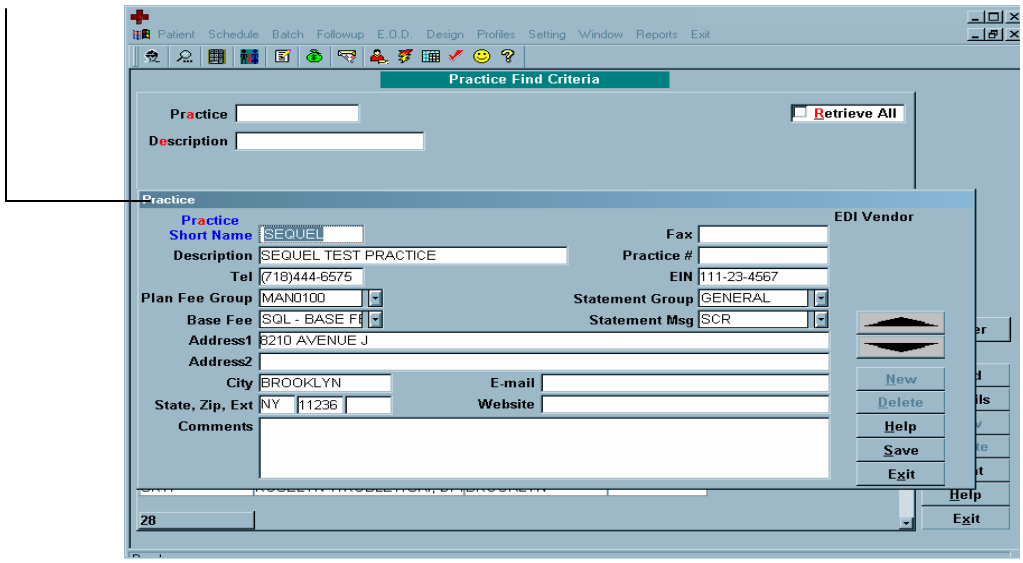
same way, you cannot define a plan address unless you have a plan to attach it to. (The Insurance-Plan-Plan Address hierarchy in SequelMed will be explained later). Why does SequelMed do this, what is the use of this hierarchy? Certainly, one simple answer is that it ensures proper setup of information. But more importantly, it avoids the duplication of information and allows you to capitalize on the reusing and centralization of information. In other words, a concept is defined once and used many times in the system. For example, a provider is defined once in an entity and used throughout all the practices, which are all part of one entity.

Another word on practice-location hierarchy: In the Profiles menu, fees also have a hierarchy in the system (which will be explained in greater detail in the 'Fee' section of the Profile menu). There is a system default fee, which is established at the procedure profile definition level. For example, a user may set this at zero at the entity level. When the billing coders enter claims, and they see a zero charge come in they know that practice does not have a base fee set for it. So we recommend that for every practice you establish a base fee structure and that way you can have a unique fee schedule at the commercial claim level for each practice. There is also what's called like an override priority, a prioritization. So some of these fields, like base fee or plan fee group may appear in both practice and location. Once its defined in practice, by definition every location created below that practice for which you leave those fields blank will default to the practice level. If it is blank at the practice, it will default to the system default. In order to illustrate this, consider the following example: For practice XYZ, we set up the plan fee group to be Manhattan, because three of the four locations are in Manhattan. So now if you go to the location profile and look for all the locations assigned to the practice XYZ, you could see that three of them are in Manhattan and one of them in Bronx. Now look in the location profile and see under plan fee group, you notice it is blank, which means that because practice has been defined as Manhattan, you could leave it blank. You could do the same with all three locations since they are located in Manhattan. But when we get to Bronx, we cannot leave it blank and instead have to put in a Bronx plan fee group. This will cause this particular location, which is in the Bronx, to bring in the correct fees for the Bronx taking priority over the plan fee group that was defined in the practice. This is basically an illustrated explanation of over-riding based on the hierarchy. Simply stated, whatever is lowest on the chain will override the one above it. And with regard to the fees, note that there are some providers that participate with one or more practices that say: "I want MY fees regardless of what is defined at the practice-location level". So in SequelMed hierarchy, if you look in the provider profile you will see the opportunity to put in a base fee for the provider. So you can put in base fee for the provider which will then override all the base fees and the system default fees which are defined at any location and practice with which he participates. This is also an example of an override scenario. Statement messages in SequelMed is another example: If a doctor wants his/her messages to read a certain way on statements, he/she can, irrespective of what transpires at the location and practice level, have his/her statement messages to override. Similarly, at the location level statement messages can override what is defined at the practice level.

In essence, there is a logical sequence in structuring, defining and setting up SequelMed. First, you set up the profiles that are required by other profiles and then other parts of the system in a certain structured order.

PRACTICE

At the top of the Profile menu is PRACTICE. Let's drill down and begin by defining a practice. The fields in the practice profile are described below:

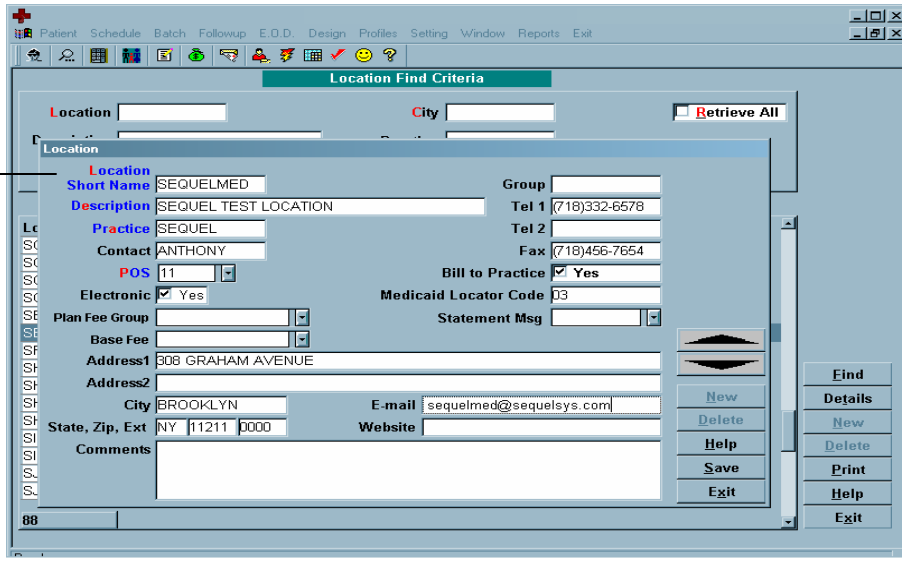


Field	Description
Practice Short Name	**User defined short name assigned to the practice. SequelMed recommends naming conventions to its users, because naming conventions will greatly facilitate quick bundle searches. For example, one way of doing this is using a three-letter acronym for practice, for isntance SCI (for Sequel Company, Inc.) Now if you go to the Location section in the Profile menu and find locations for practice SCI, every location name for this practice starts with SCI, so for example, SCI-5th Ave, SCI – Brown Street, SCI – New York Blvd, and so on. In this way, you can go in and put in location SCI, whether it be report or any browse screen and hit the Find button to find all of the locations for that practice.**
Description	**Full (descriptive) name of the practice**
Tel	**Telephone number of the practice**
Plan Fee Group	**Plan Fee Group is the contractual amount that is linked to the practice; Plan fee group is optional, which is why this field is not in blue. But if you are going to use the Plan Fee link feature of SequelMed, it is not optional at the practice level, you must define it at least there. Then it becomes optional at the location level. Note that if the Plan Fee Group is not defined at the location level, then the Plan Fee Group at the practice level takes effect.**
Base Fee	**Base fee that a provider charges. It is strongly recommended is to define a base fee for every practice and let the system default fee be zero. So if you put base fee and hit SET FEE button at the charge entry level, it will bang it in into the base fee that is established for that particular charge whether it be at the practice or location level.**

	The naming conventions are begun with a three-letter acronym for the practice, which is useful. This way you can list the base fees and know exactly which one belongs to which.
Fax	**Fax number of the practice, if any**
Practice #	**User-defined based on number of practices. Useful for grouping practices for reporting purposes.**
EIN	**Employer Identification Number of the Practice as assigned by the labor department. If this field is left blank, the provider's social security number will be billed.**
Statement Group	**User-defined group attached to practices for statement messages; allows you to send messages to a group of patients instead of sending the same message to different patients separately. The Groups are created in the Statements section of the Batch menu.**
Statement Message	**Type of practice-level message that would appear on patient statement, for example, "the practice(s) will be closed on July 4th". The messages are created in the Statement section of the Batch menu.**
Address 1	**Primary address of the practice, which will be printed on the claim form**
Address 2	**Secondary address of the practice, which does not get printed on the claim form**
City	**Name of the City where the practice exists**
State, Zip, Ext	**Two-letter abbreviated name of the State, Zip/Postal code and Zip Extension code where the practice exists**
E-mail	**E-mail address of the practice, if any.**
Website	**Web site address of the practice, if any.**
Comments	**Enter any comments related to the practice.**
EDI Vendor	**Electronic Data Interchange Vendor to whom the practice is billing electronically. It is based on the EIN or Tax ID number of the practice. If the practice is billing to the EDI Vendor through the Tax ID number of the practice, you attach it at the practice level. Note: EDI requires an external set up first before it can be functional in the SequelMed application.**

LOCATION

Location is the place(s) for the practice(s). It is the place(s) where the provider renders services. A location can be a hospital, clinic, physician's office, or a lab. Fee schedules can be attached with certain locations.



Field	Description
Location Short Name	**User defined short name assigned to the location**
Description	**Full (descriptive name) of the location**
Practice	**Short name of the practice to which this location is linked. This is a mandatory field, which means that the system will not allow you to set up the location properly. This also signifies the hierarchical and relational setup of SequelMed, as discussed in the Introductory section of Profiles menu. That is, without defining practice you cannot define a location.**
Contact	**Contact person's name at the location**
POS	**Place of Service code designated for the location. For example, if the location is an office, the POS Code is 11; if the location is an inpatient hospital, the POS code is 21, and so on. This field is a drop-down menu, which allows you to select the POS code using the drop-down menu. The drop down menu shows you both the POS and the POS code.**
Electronic	**Check this box if the location will be submitting claims electronically. It will be functional ONLY if the practice/location is setup for electronic billing.** **This electronic checkbox is part of a bigger structure, i.e. the methodology of electronic insurance in SequelMed. What must be in place for electronic insurance to be functional is that it has to be turned on at the vendor level visà-vis EDI Utility Setup, it has to be**

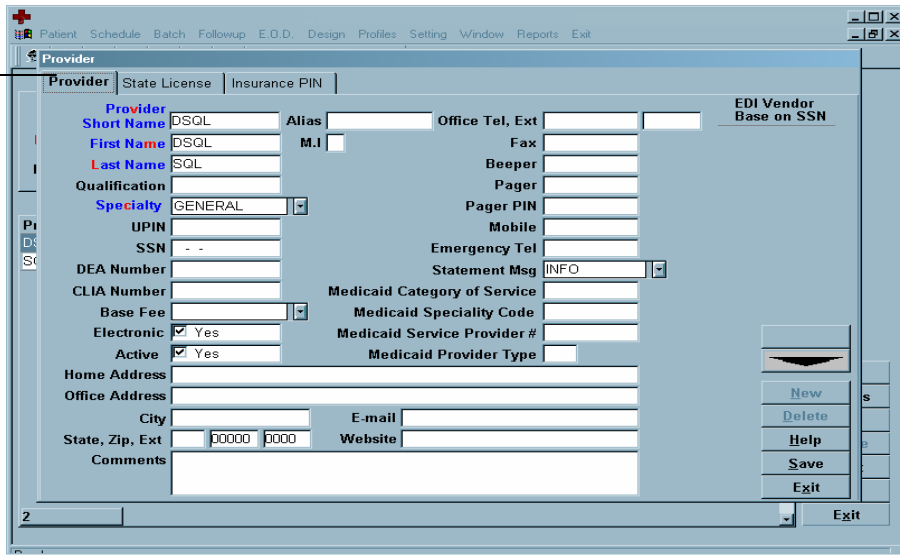
	enabled at the location level, it has to be enabled at the provider level, and the plan itself has to be attached to the electronic insurance. In the 'Electronic Insurances' section of the Profile menu, which defines the electronic vendor, the electronic insurance has to be first set up as a profile and then inserted into appropriate places at the plan definition level. The Plan also has an electronic checkbox, so even if you establish that connection, you can temporarily turn it on and off by clicking the checkbox on and off. And at Charge Entry time you can force onto paper and that overrides everything also.
	If the claims for a visit can only go electronically, it has to be set to electronic at all levels. In other words, the plan has to be attached to electronic insurance; the electronic checkbox has to be turned on at the plan level; the electronic checkbox has to be enabled at the practice and the location profiles level, and at charge entry time you have NOT forced on paper. If all this is done, that visit will then go electronically. So these are all the mechanisms that have to be understood and enforced to submit the claims electronically. But more importantly whether it is at the visit level, plan level, location level, practice level, or provider level you can temporarily disable with the use of this electronic checkbox. So if you are having problems with GHI electronic claims, turn it off at the plan level. If you are having problems with one patient that this particular patient requires all visits to be sent on paper or with reports, you can disable on a visit by doing it at the visit level for that patient. If some provider is flagged by Medicare for auditing purposes requiring the provider to send in all claims on paper, you can have the whole enterprise function electronically except for that particular provider. And if some particular location is having problem with electronic, you can disable at the location level.
Plan Fee Group	**Plan Fee Group is the contractual amount that is linked to the practice; Plan fee group is optional, which is why this field is not in blue. But if you are going to use the Plan Fee link feature of SequelMed, it is not optional at the practice level, you must define it at least there. Then it becomes optional at the location level. Note that if the Plan Fee Group is not defined at the location level, then the Plan Fee Group at the practice level takes effect.**
Base Fee	**Base fee that a provider charges. It is strongly recommended to define a base fee for every practice and let the system default fee be zero. So if you put base fee and hit SET FEE button at the charge entry level, it will bang it in into the base fee that is established for that particular charge whether it be at the practice or location level. The naming conventions are begun with a three-letter acronym for the practice, which is useful. This way you can list the base fees and know exactly which one belongs to which.**
Group	**This is a way to group multiple locations for reporting purposes**
Tel 1	**Primary telephone number of the location**
Tel 2	**Secondary telephone number of the location, if any**

Fax	**Fax number of the Location**
Bill to Practice	**If the practice wants to be billed to the practice address on the claims, then this box should be checked. If this box is not checked, the location address will be printed on the claims (which is the billing address). However, the Tax ID number on the claims is still the Tax ID of the practice.**
Medicaid Locator Code	**Applicable to Medicaid claims. For Medicaid, SequelMed allows you to put in specific payer information so that Medicaid billing is done correctly. Locator codes for Medicaid have to be attached to the location.**
Statement Message	**Type of message specific to the location that will appear on the statement of patients. For example, "the telephone of the location has been changed from 516-555-1212 to 516121-2555". The messages are created in the Statement section of the Batch menu.**
Address 1	**Primary address of the location, which will be printed on the claim form**
Address 2	**Secondary address of the location**
City	**Name of the City where the location exists**
State, Zip, Ext	**Two-letter abbreviated name of the State, Zip/Postal code and Zip Code Extension where the location exists**
E-mail	**E-mail address of the location, if any**
Web site	**Web site address of the location, if any**
Comments	**Enter any comments related to the location**

PROVIDER

In this profile, you enter the information related to providers in your practice. Provider Profile is a shared resource. In other words, providers don't necessarily belong to any particular enterprise, practice, or location. They are atomic units, their definitions are established once and then they could be used repeatedly throughout the system.

PROVIDER TAB



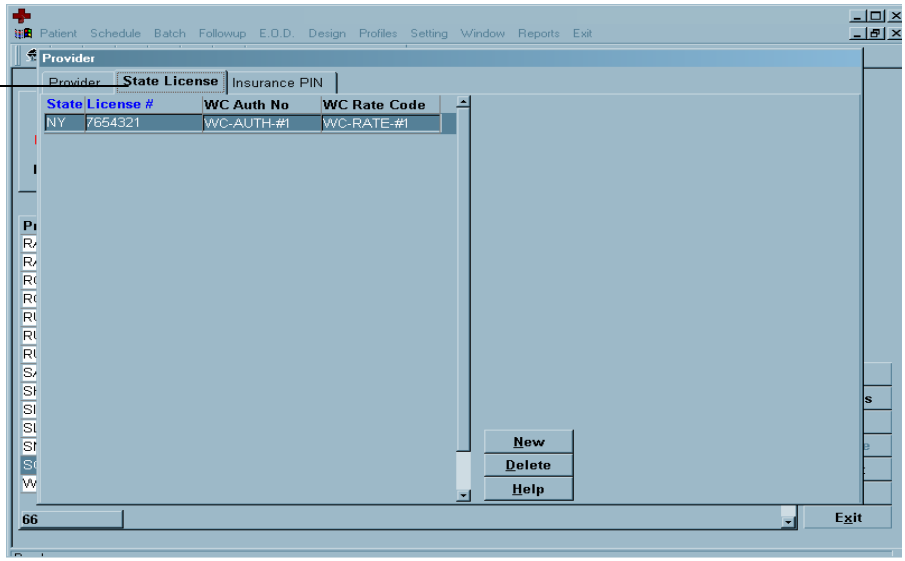
Field	Description
Provider Short Name	User defined short name assigned to the provider
First Name	First Name of the provider
Last Name	Last name of the provider
Alias	Alias, if any. This is used for scheduling purposes.
M.I.	Middle Initial of the provider
Specialty	User-defined short name of the provider's specialty; for example, OBGYN (for Obstetrics and Gynecology, CARDIO (Cardiologist), NEURO (for Neurology). Specialties are created only at the User level, accessible only to the administrator of the enterprise, practice or location.
UPIN	Provider's UPIN number
SSN	Provider's social security number
DEA Number	Provider's Drug Enforcement Agency number
CLIA Number	Provider's Clinical Laboratory Improvement Number. HCFA regulates all laboratory testing (except research) performed

	on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA)
Base Fee	**Base fee that a provider charges. You can override the base fee defined at the practice and location levels by selecting base fee defined for the particular provider.**
Electronic	**If the provider will be submitting electronically, this box should be checked**
Work Tel, Ext	**Provider's office telephone number and extension, if any**
Fax	**Fax number of the Provider**
Beeper	**Provider's beeper number, if any**
Pager	**Provider's pager number, if any**
Pager PIN	**Provider's pager Provider Identification Number, if any**
Mobile	**Provider's mobile/cell phone number, if any**
Emergency Tel	**Provider's emergency contact number**
Statement Msg	**Type of message that will appear on the statement of patients. For example, "the practice(s) will be closed on July 4th". The messages are created in the Statement section of the Batch menu.**
Medicaid Category of Service	**Applicable to Medicaid**
Medicaid Specialty Code	**Applicable to Medicaid**
Active	**You can make enter of new charges inactive for a particular provider un-clikcing this active check box**
Office Address	**Provider's office address**
Home Address	**Provider's home address**
E-mail	**E-mail address of the Provider**
Website	**Web site address of the Provider**
Comments	**Enter any comments related to the provider**
EDI Vendor Based on SSN	**This is when billing is being done under the provider's Social Security Number. This is useful, for example, in a situation where there may be some groups that don't have a Medicare group number for which the participating doctors in that group have Medicare numbers where they want to bill electronically to Medicare. The way you facilitate that is by setting up Empire as a vendor at a SSN level by provider and not putting it in the practice level. And all the electronic**

claims will then be billed to the provider's SSN and their Medicare provider number through the vendor.

STATE LICENSE TAB

Each provider is assigned a unique provider number. This is a mandatory number required by the law without which a provider cannot practice. Because a provider may practice in more than one state, it would be cumbersome to build all the state-specific information into the system. Instead, SequelMed allows you to create state-specific definitions. This is used mainly for Workers Compensation and No-Fault cases.

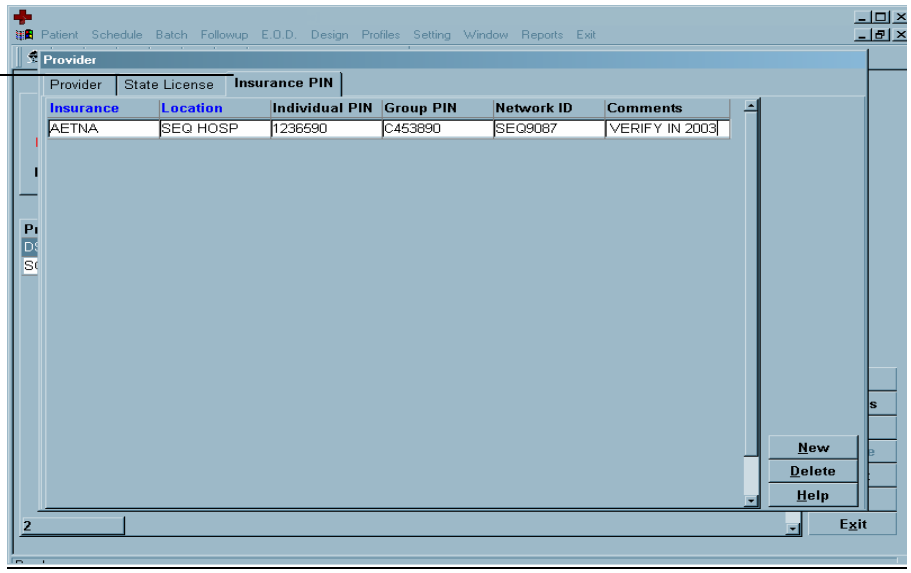


Field	Description
State	Two-letter abbreviation of the U.S. State (e.g. NY, NJ, PA, etc.), which issued the provider's license
License #	Provider's state license number
WC Auth No	Workers Compensation Authorization Code
WC Rate Code	Workers Compensation Rating Code

INSURANCE PIN TAB

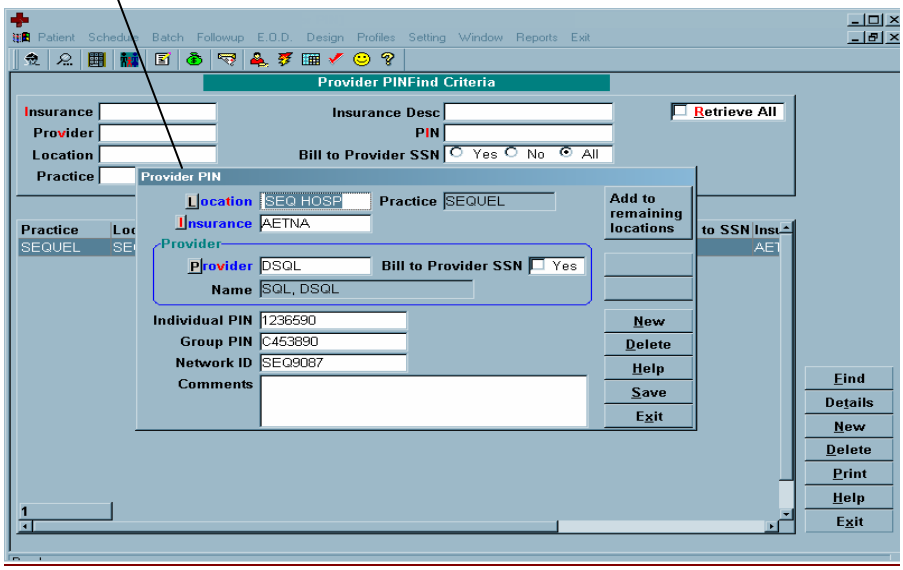
Field	Description
Insurance	User defined insurance company's short name
Location	User-defined short name of the location
Individual PIN	The unique individual Provider Identification Number assigned to the provider by the Insurance Company

Group PIN	**The unique Group Provider Identification Number assigned to the provider by the Insurance Company**
Network ID	**Used for Electronic Insurance, as required by insurance company**
Comments	**Comments, if any**



PROVIDER PIN

In the Provider PIN Profile, you set the relation between the plan, provider, location vis-à-vis the Provider Identification Number.

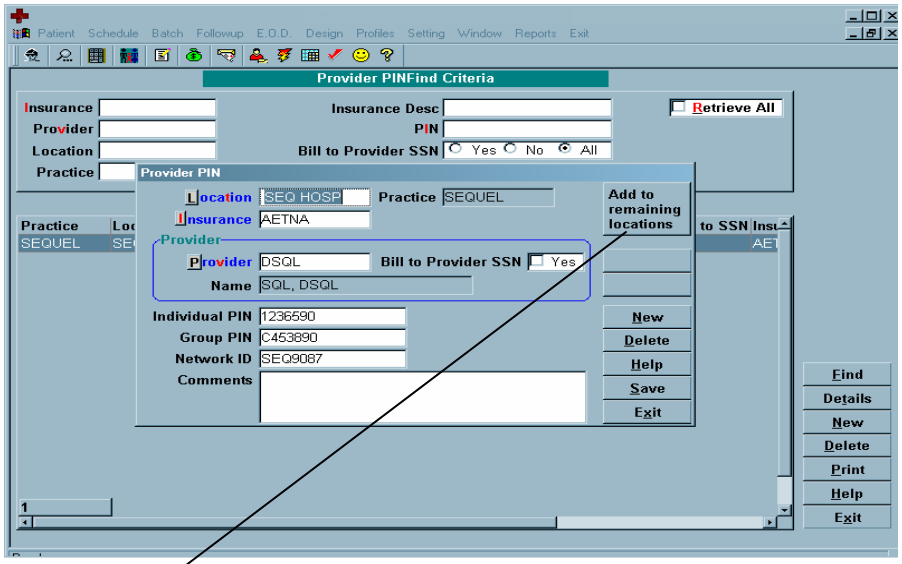


Field	Description
Location	**User-defined short name of the location**
Insurance	**User defined insurance company's short name**
Practice	**User-defined short name of the practice, which self-populates upon the entry of the location, which is why it appears grayed and cannot be edited here**

Provider

Provider	**Name of the provider**
Name	**Full Name of the provider, which self-populates based on the entry in the provider profile, which is why appears grayed and cannot be edited here**
Bill to Provider SSN	**If you want to bill to provider's social security number, check this box. This is useful for provider who has participation in a given plan for which he is a member of a group that he billing under but the group is not a member of the plan. For example, a practice has a Tax ID (or EIN) but does not have a Medicare group number, but the provider who practices there does have an individual PIN. In this scenario, for Medicare billing this checkbox is marked indicating that the provider's SSN is to be substituted for the EIN at the time of billing.**
Individual PIN	**The unique individual Provider Identification Number assigned to the provider by the Insurance Company**

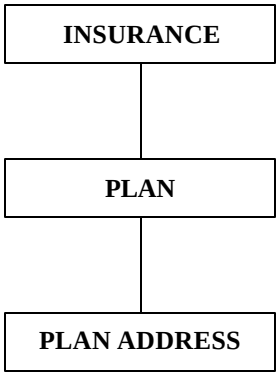
Group PIN	**The unique Group Provider Identification Number assigned to the provider by the Insurance Company**
Network ID	**Used for Electronic Insurance, as required by insurance company**
Comments	**Comments, if any**



Button	**Description**
Add to Remaining Locations	**If the PIN is same for the provider for all locations with which he participates with in a particular practice, then you can press this button and it will automatically create additional provider PIN relation for each location in that practice. That is, if you want to add this provider and its related information to the other locations also, you can do it here using this button.**

INSURANCE

"INSURANCE-PLAN-PLAN ADDRESS" HIERARCHY IN SEQUELMED

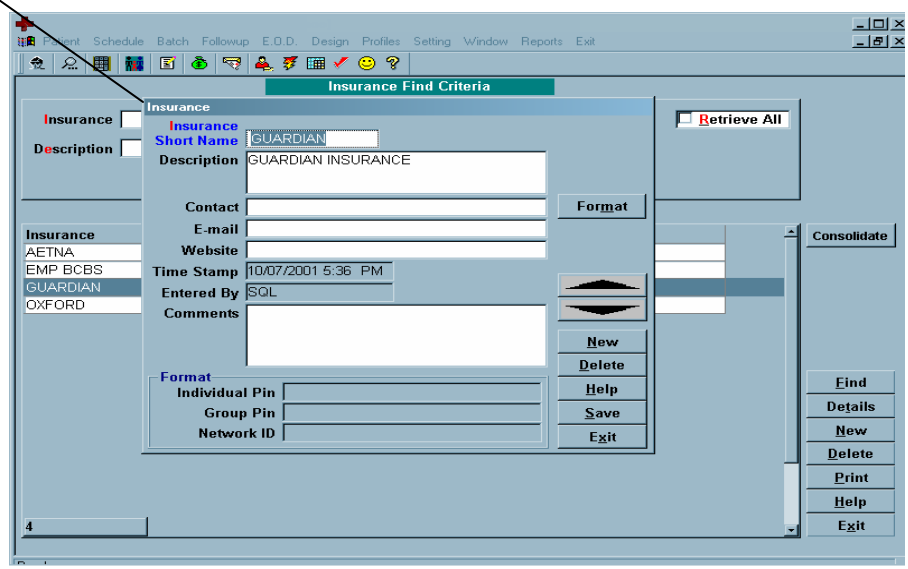


In most systems, the way insurance plans are defined can be very confusing. The reason it gets very confusing is because every time you have a new plan for an insurance company, or every time you have a new address for a plan, you have to literally redefine an entire new record, which encapsulates the insurance, the plan and the plan address. For example, for the insurance Oxford, the plan Oxford Freedom may have two or three different addresses, Oxford Liberty plan might have two or three different addresses, and so on. So there may be many different plans under Oxford, but actually there is only one insurance company. Most systems do not let you define it as such. So what SequelMed does is that, at the Insurance Profile level, it defines or establishes one insurance company (for ex: AETNA) in the entire system, or one Oxford in the entire system, or one Empire BCBS in the entire system, and so on. The Insurance definition quite simple: all that is mandatory is the name; description is optional. And optionally there is some other information there but the name and the description is key.

The next level down in the Insurance-Plan-Plan Address hierarchy is the Plan. So if you want to look at all the plans attached to the Oxford Insurance Company you can search for them and find all the different plans. If you look into a specific plan, you must have a plan short name, a description, and you must put an Insurance name. It will not let you create a plan unless the Insurance is created. The other mandatory field in the plan is Plan Category, so by the same token you must define your category first. What is Plan Category in SequelMed? Many systems are loose about classification and categorization of plans; plan categories are for example, Medicaid, Medicare, BCBS and so on. You can identify a series of categories and you enforce when the plan is created to put the right category in it. In SequelMed, plan category mainly serves as a reporting tool.

In the Plan profile, you will notice that there is no reference to the plan address itself. It is because the address is the third hierarchy in the Insurance definition structure of SequelMed. Once plan addresses are created, you can put in a plan (Freedom), which is part of insurance (Oxford), and find the addresses that apply to the Oxford Freedom plan. It is very simple to add addresses in SequelMed. In most systems, you would have this set up as six separate insurances. Whereas here in SequelMed, you have the Insurance company as one and different plans attached to it can have separate addresses instead of linking the insurance company each time with each entry of address. As you can imagine, this rapidly eliminates many permutations.

INSURANCE



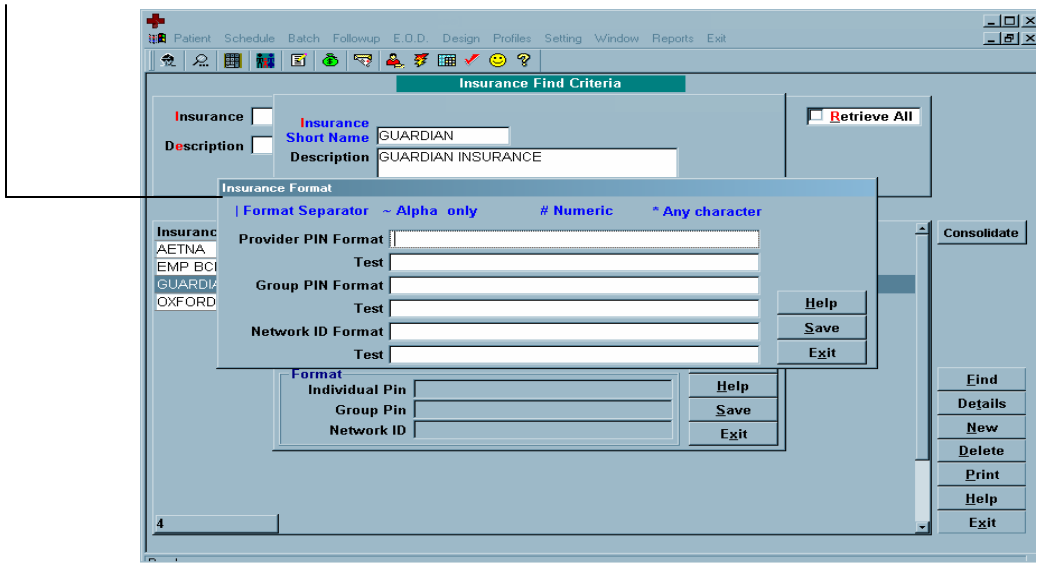
Field	Description
Insurance Short Name	User defined insurance company's short name
Description	Insurance company's full name
Contact	The insurance company's contact person
E-mail	E-mail address of the Insurance Company
Website	Web site address of the Insurance Company
Time Stamp	Time when the information is entered, generated automatically by SequelMed
Entered by	Name of the User who entered the information, generated automatically by SequelMed
Comments	Any comments related to the insurance company

Format

Individual PIN	The unique individual Provider Identification Number assigned to the provider by the Insurance Company
Group PIN	The unique Group Provider Identification Number assigned to the provider by the Insurance Company
Network ID	Used for Electronic Insurance, as required by insurance company

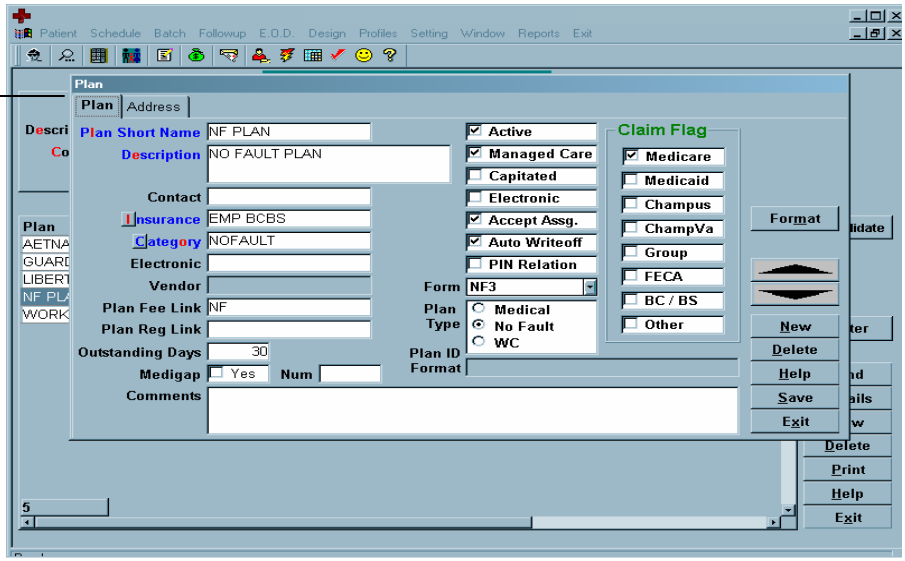
“Format” Button

This button, when clicked, opens up the ‘Insurance Format’ window, which is used to assign/correct a particular format of Provider PIN, Group PIN, and Network ID. If any format other than the format specified is typed, the system will not accept it and will prompt for the correct format. These formats appear in the Format field shown in the Insurance window.



PLAN

The Plan profile contains information about the plan carried by the patient. In plan profile, you enter all the plan information belonging to a particular insurance and category. All essential information such as the plan type or if the plan is electronic is entered in this profile. It is very important to fill this profile properly for accurate insurance billing.



Field	Description
Plan Short Name	**Enter a logical abbreviated name for the plan, using the following standard criteria as a guide:** **All no-fault plans must begin with "NF"';** **All workers' compensation plans must begin with "WC";** **All Medicare plans must begin with "MCR";** **All Medicaid plans must begin with "CAID";** **All gapped secondary plans begin with "GAP";** **For example, if a patient has plan XYZ secondary to Medicare, AND if that plan is gapped, the plan short name will be "GAPXYZ". If he or she has XYZ as primary, or secondary to any other plan, the plan short name will be XYZ.** **All plans should be given logical short names that will make them easy to search for. Plan short names cannot exceed ten characters**
Description	**Type the name of the plan as it should appear on the HCFA form;**
Contact	**If all claims for the plan should be sent to the attention of a person or a department, type this information in the "contact" field. This will print on the HCFA form with the word "Attn:" preceding it.** **Note: The contact information provided in the plan profile will print on every HCFA for every patient with this plan. If the contact information is specific to an individual patient or practice, do NOT enter it here.**
Insurance	**Choose the insurance company that administrates the plan you are creating. Press the "HOME" key to see a list of available insurance carriers. The insurance company name may be the same as the**

plan or different, depending on the situation. For example, if Blue Cross administers a plan called Alicare, the plan name will be Alicare, and the insurance attached to the plan will be Blue Cross;

Category — Press the "HOME" key in order to see a list of available categories. Choose the category from the list that best describes the nature of the plan. Select a category from the list by double-clicking on it or highlighting it and pressing enter. The following categories are to be used:

Short Name	Description
BCBS	Blue Cross Blue Shield
CAID_HMO	Medicad HMOs
CHAMPUS	Champus
COMMERCIAL	All private insurance plans
HMO	Health Maintenance Organizations
IPA/PO	Independent Physician Organizations
LIEN	Lien, Liability, and Slip & Fall
MCR_HMO	Medicare HMOs
MEDICAID	Medicaid plans, excluding HMOs
MEDICARE	Medicare Plans
MEDIGAP	Plans supplemental to Medicare whose claim information is forwarded automatically to them by Medicare
METROHLTH	Metropolitan Health Plan
NOFAULT	No-Fault plans
PHO	Physician Hospital Organizations
PPO	Preferred Provider Organizations
SUPPLEMENT	Medicare secondary plan that is not gapped
WOCLAW	Workers' Compensation Law Department
WORKCOMP	Workers' Compensation plans

Electronic — If claims for this plan can be submitted electronically, press "HOME" to choose the name of the "Electronic Insurance" through which the claims will be sent. If claims for this plan must be sent on paper, leave this field blank;

Vendor — Once an electronic insurance is selected, the "Vendor" field will be filled in automatically. The vendor is the clearinghouse and/or carrier to whom the electronic claims will be transmitted;

Plan Link — This field allows the user to link the plan to a fee schedule. The available plan links are as follows: Medicaid; Medicare; NF (no-fault);
WC (workers' compensation).
If the plan you are creating needs to be billed with any of the above standard fee schedules, choose the plan link corresponding to the plan by pressing "HOME" and selecting the appropriate item.
For example, all workers' compensation plans (as noted above, these plans will have short names beginning with "WC") must be created with the plank link "WC". As a result, any procedures billed

	under this plan will automatically use workers' compensation fees. Similarly, all Medicare plans will have "Medicare" in the Plan Link field, and all procedures billed will automatically have Medicare fees. **If the plan does not fall into any of the above categories, leave the "Plan Link" field blank.**
Outstanding Days	**This field tells the system how many days after submission to wait before sending a claim to follow-up. Unless there is a specific reason to put claims for this plan into follow-up sooner, set the plan to forty-five days, by typing "45" in this field. Less than 45 days may also be entered.**
Medigap	**If this claim is gapped, place a checkmark in the box next to "Yes" by clicking on it. This will keep claims secondary to Medicare from printing for this plan;**
Comments	**Type any comments or notes that you would like recorded for this plan. This information is strictly for the users' reference and will not print on claim forms;**
Active	**This flag will automatically be checked, indicating that the plan is valid and can be assigned to patients in the system. If the plan becomes inactive (i.e. goes bankrupt or ceases to exist), uncheck the active box to make the plan invalid system-wide. This will inactivate the plan for any existing patients and prevent future charges from being billed with this plan;**
Managed Care	**If this is a managed care plan, click on the checkbox, otherwise leave the box unchecked;**
Electronic:	**If claims for this carrier can be submitted electronically (an electronic insurance must be selected in the "Electronic" field), a checkmark should appear in this box. In order to suspend electronic submission for this plan, uncheck the box. This will force all claims for the carrier to print on paper. In order to re-instate electronic submission, place a checkmark in the box by clicking on it;**
Accept Assignment	**If this box is checked, all charges using this plan will default to having "accept assignment" checked on the HCFA form. This can be overridden on a claim by claim basis elsewhere in the system;**
Auto Writeoff	**If the plan uses electronic remittance posting, having auto-writeoff checked will cause the system to write-off all remaining balances after a carrier pays a portion of a line item. This can be overridden at payment posting time;**
Form	**Click on the down-arrow to choose the type of claim form on which claims should be sent. Choose from the following:** **HCFA: used for all carriers not requiring specialized forms;** **C4: used for Workers Compensation Claims;** **NF3: used for No Fault Insurance Claims;** **MEDICAIDNY: used for Medicaid carriers;**

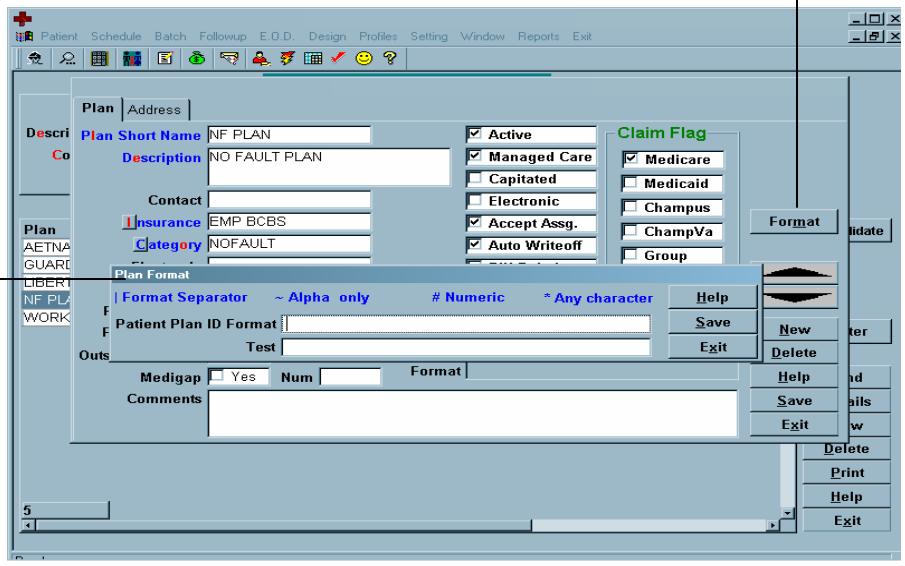
***Note*: The selection of the Form field will correspond with the Plan Type field below. For example, if in the Plan Type field, WC is selected then you will see C4 in the Form field as one of the choices and in fact must select C4 so that the claim may be printed appropriately on the C4 form. Similarly, if No Fault is selected in the Plan Type field then you will see NF3 in the Form field as one of the choices and in fact must select NF3 so that the claim may be printed appropriately on the NF3 form.**

Plan Type — **Choose the plan type (Medical, No-Fault, or WC) appropriate for the plan;**

Plan ID Format — **The Plan ID format will appear here, which can be designated and/or modified using the "Format" Button (see below)**

Claim Flag — **Choose the appropriate claim flag for the plan. The flag chosen on this screen will determine what claim flag will be checked in Box 1 on the HCFA form. The available claim flags are: Medicare; Medicaid; Champus; ChampVa; Group; FECA; BC/BS; Other.**

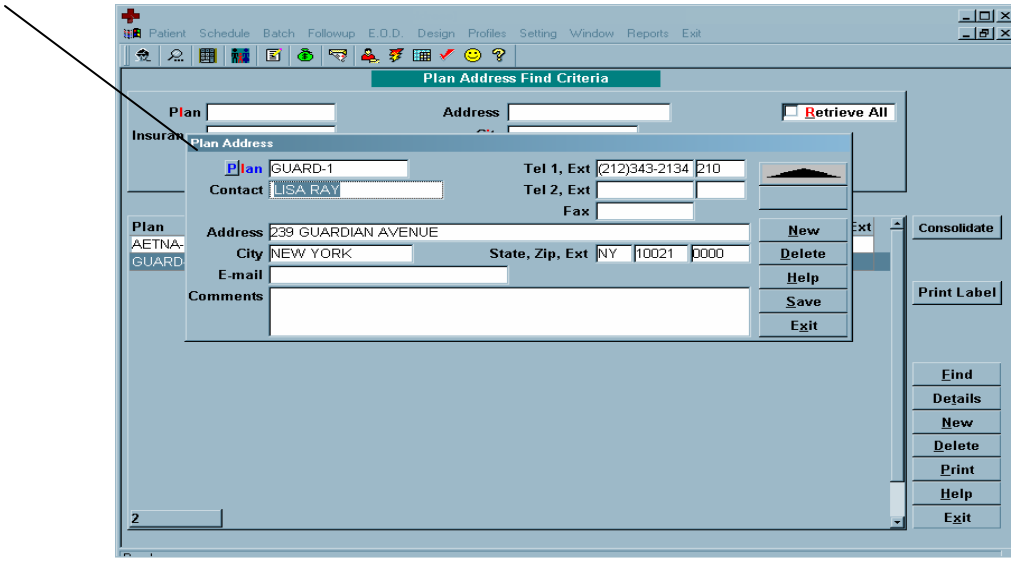
"Format" Button



The 'Plan Format' window, which is used to assign/correct Patient Plan ID format, opens up when the Format button is clicked. If any format other than the format specified is typed, the system wil not accept it and will prompt for the correct format. This format appears in the Plan ID Format field in the Plan window.

PLAN ADDRESS

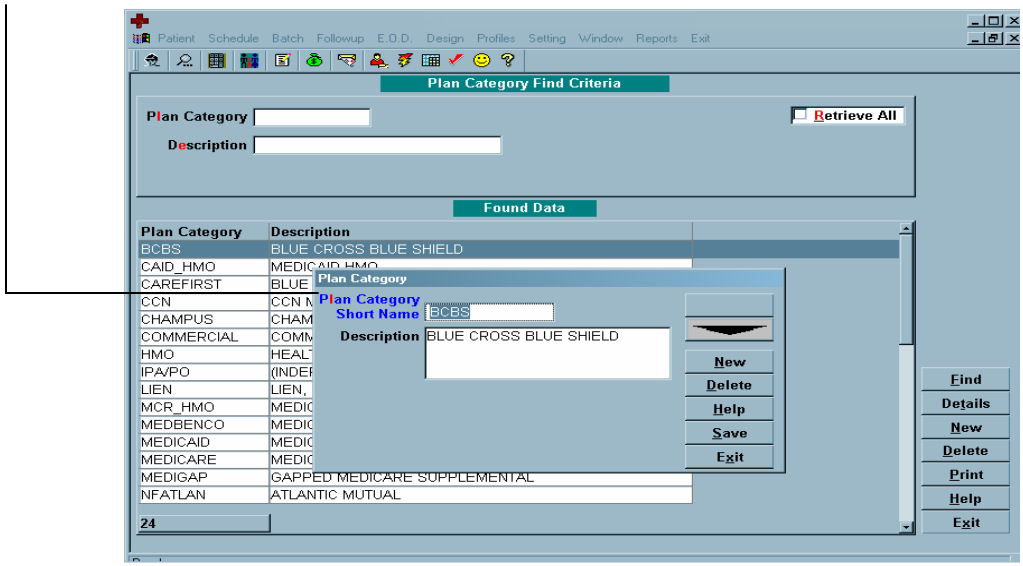
In this profile, we enter the address of a plan. Address entered in this profile is attached to a plan when printed on the HCFA form.



Field	Description
Plan	User-defined short name for the address of the plan
Contact Name	The contact person's name at this address
Tel 1, Ext	Primary telephone number/extension of the plan
Tel 2, Ext	Secondary telephone number/extension of the plan
Fax	Fax number of the plan
Address	Primary street/mailing/billing address of the plan
City	City of the plan address
State, Zip, Ext	State, Zip/postal code and extension of the plan address
E-mail	E-mail address of the plan, if any
Comments	Any comments related to the plan address

PLAN CATEGORY

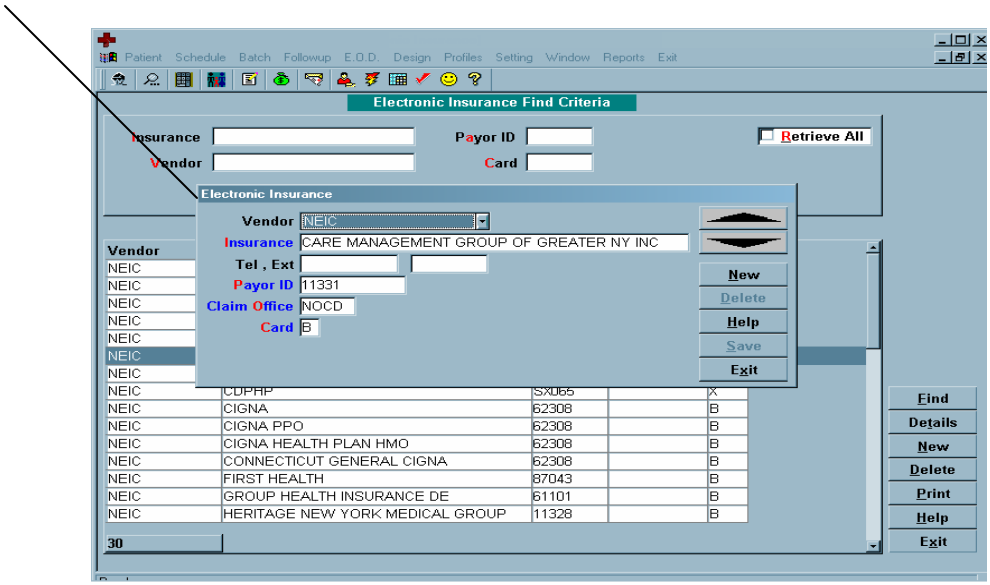
In Plan Category profile, you enter the categories of the plans. This is useful for reporting purposes, whereby plans can be categorized according to the type of plans they are (for ex: HMO, Commercial, etc.).



Field	Description
Plan Category Short Name	**Plan category short name used according to industry standards (for example: HMO for Health Maintenance Organization**
Description	**Plan category full (descriptive) name, for ex: Health Maintenance Organization for HMO**

ELECTRONIC INSURANCES

In Electronic Insurance Profile, all necessary information of the vendor who receives bills electronically for each insurance company is entered.

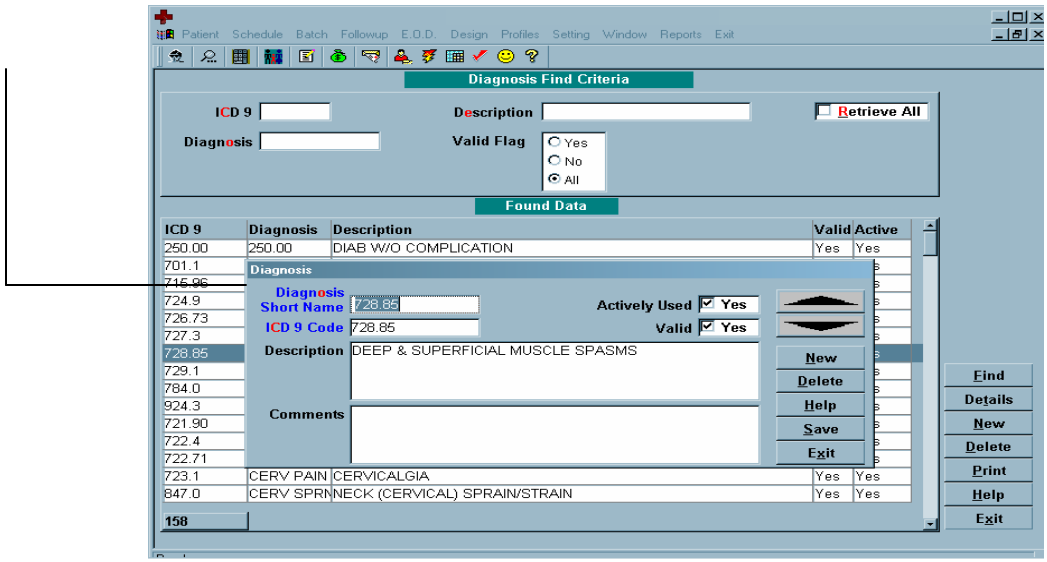


Field	Description
Vendor	**Name of the vendor handling electronic billing**
Insurance	**Name of the insurance company**
Tel, Ext	**Telephone Number and Extension, if any**
Payor ID	**Insurance Company ID provided by the Vendor**
Claim Office	**Claim Office # assign by the insurance company**
Card	**Card type from Envoy Payor list**

CODING

DIAGNOSIS

This is a three-digit number (with 1 or 2 digit extension) that indicates the diagnosis of the patient, i.e., the reason for which the patient comes to the doctor office, for example, headaches, measles and anxiety etc. In this profile, you basically define your diagnosis short name, ICD-9 codes, whether it is actively used or valid. “Actively Used” means that every time a given practice uses a particular diagnosis code it will automatically check “Actively Used”. This determines what appears when you are entering a charge when the pop up box of available choices appears. The “Valid” checkbox allows you to invalidate a code and make it no longer usable.

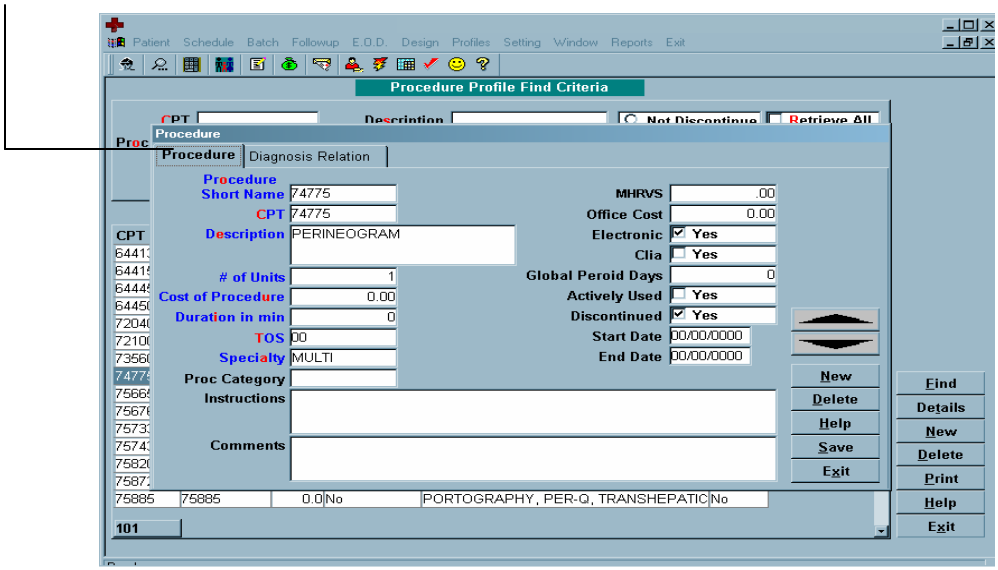


Field	Description
Diagnosis Short Name	**User-defined short name of the diagnosis**
ICD 9 Code	**International Classification of Diseases (9th Revision) Code**
Actively Used	**If diagnosis is used actively/frequently then this checkbox is checked. “Actively Used” means that every time a given practice uses a particular diagnosis code it will automatically check “Actively Used”. This determines what appears when you are entering a charge when the pop up box of available choices appears. In other words, the “Actively Used” checkbox determines what pops up.**
Valid	**The “Valid” checkbox allows you to invalidate a code and make it no longer usable. If the diagnosis is out-dated then the checkbox will be off/unmarked otherwise it should be on/marked.**
Description	**Detailed name of the diagnosis**
Comments	**Any comments related to the diagnosis**

PROCEDURE

The procedure (CPT) code is a five-digit number that describes what was done for the patient. For example, initial office visit has an E&M code of 99211. In this profile, we code all procedures AND establish corresponding diagnosis relationship. In the same way that we saw under Diagnosis a procedure relation, Procedure has Diagnosis Relation (as a tab), the fields of which are described below. Diagnosis Relation tab is to quickly cross reference which procedures have been linked to this diagnosis.

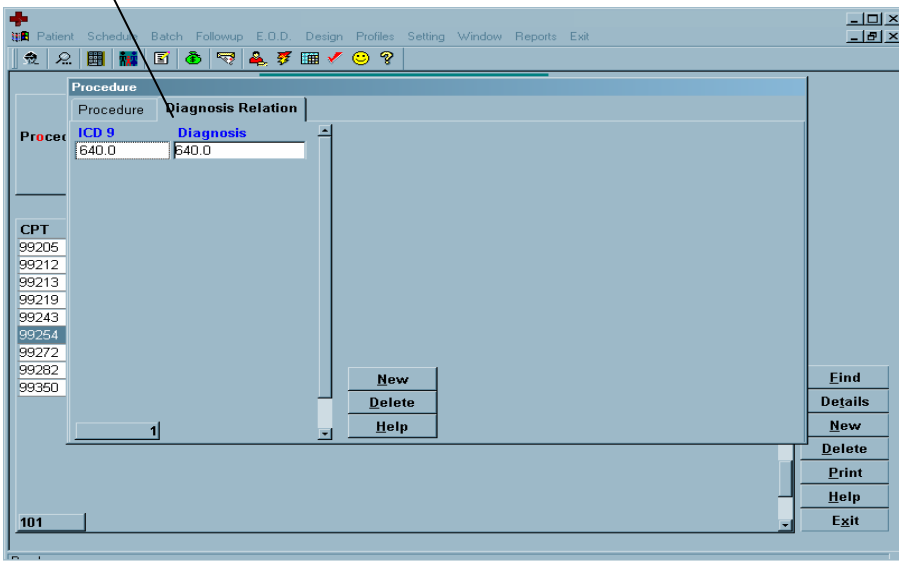
PROCEDURE TAB



Field	Description
Procedure Short Name	User-defined short name of procedure
CPT Code	Five-digit procedure code
Description	Detailed name of procedure
# of Units	Number of units for this procedure
Fee	Procedure fee
Cost of Procedure	Cost of procedure; used for reporting purposes
Duration in min	Time duration in minutes needed to complete the procedure; used for Anesthesia billing
TOS	Type of service code
Specialty	Specialty of the provider who performs the procedure
Proc Cat	Procedure category; used for reporting purposes
MHRVS	McGraw-Hill Relative Scale Unit; used for reporting purposes

Office Cost	**Office cost of procedure; used for reporting purposes**
Electronic	**Off if you don't want to send this procedure electronically, otherwise 'on'**
CLIA	**Provider's Clinical Laboratory Improvement Number. HCFA regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA)**
Global Period Days	**When a procedure is performed, the global period days indicates how many days after the procedure the follow up encounters with the provider are bundled or included into that. For example, if a doctor performs a surgical procedure and five days later the patient comes back, the doctor cannot do another procedure or count as a another visit because its included with that procedure that just happened five days ago**
Actively Used	**If procedure used frequently, the checkbox is on/marked otherwise off/unmarked (read detailed explanation above)**
Discontinued	**If this checkbox is on/marked then that specific procedure cannot be used (read detailed explanation above)**
Instructions	**Any instructions for the specific procedure**
Comments	**Any comments related to the procedure**

DIAGNOSIS RELATION TAB



In Procedure Diagnosis relation you can make relation between diagnosis and procedures to get maximum reimbursement. This relation is enforced only if the 'Diagnosis Relation' checkbox is checked at

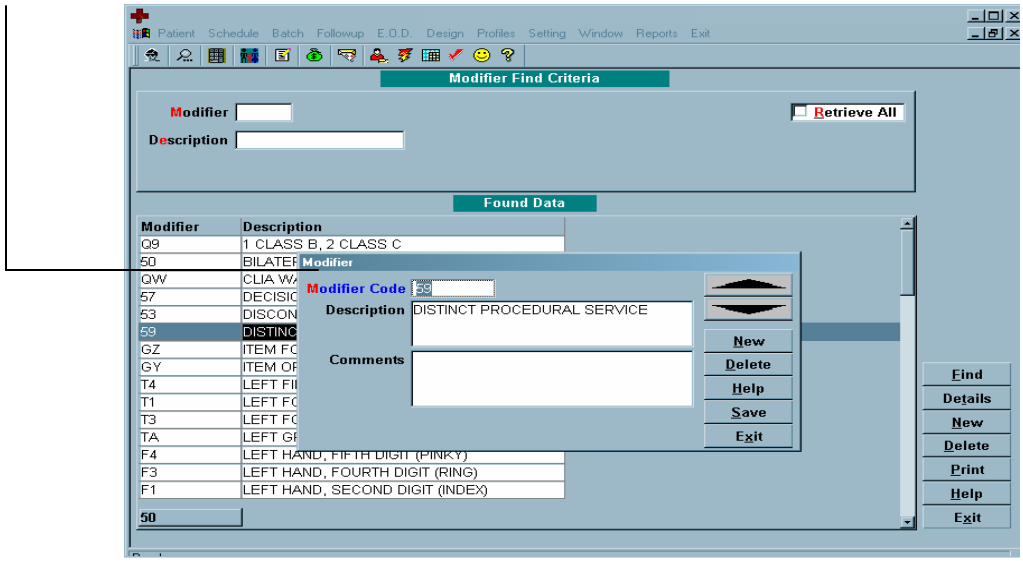
the User level. If activated, then the user can enter those Procedures in the charges for which the relation has been created with selected diagnosis.

You can enter new information by clicking on the ‘New’ button and selecting the ICD-9 code by pressing the ‘Home’ key in the respective field. To add more, just repeat the above method. Once selected, the information will appear in their respective fields.

Field	Description
ICD-9	**ICD-9 code for the diagnosis**
Diagnosis	**Description of the ICD-9 code**

MODIFIER

Procedure modifier codes indicate the amount added or subtracted from the usual fee of the procedure. Thus by selecting modifier in charge entry, you can increase or decrease the usual fee of the procedure.



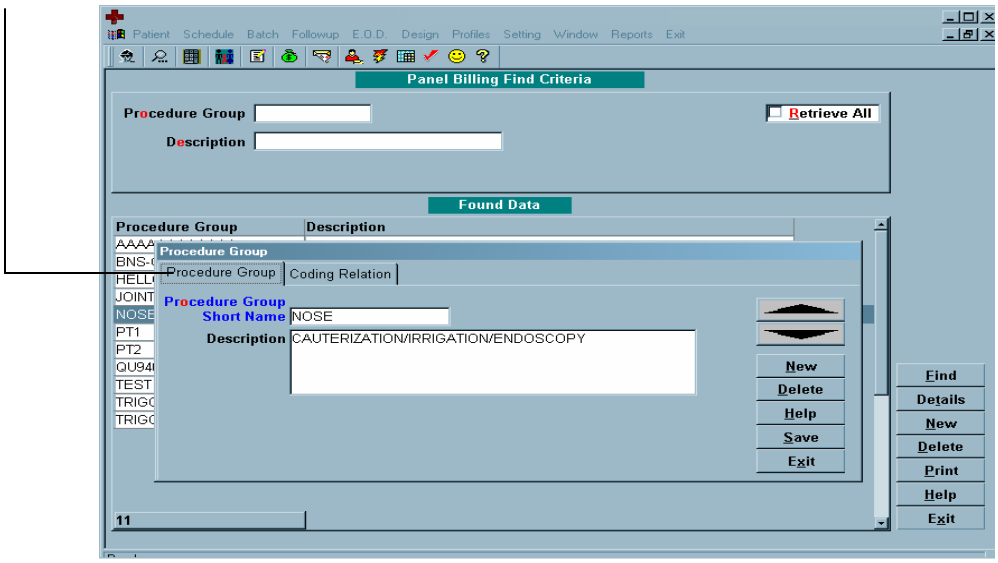
Field	Description
Modifier Code	Pre-defined two-digit modifier code
Description	Description of the modifier
Comments	Any comments related to the modifier

PANEL BILLING

The procedure group allows you to combine different procedures together in a group according to your requirement to enter charges. To activate this procedure in charges you must built the procedure group relation. This group will help you in charge entry window. This process of grouping procedures together for charges is referred to as panel billing. Panel Billing is very useful. At Charge Entry time you have an option of using the Procedure Group. The use of procedure groups saves time and eliminates mismatch between ICD-9 and CPT codes and modifiers since procedure groups are made after deliberation on correct matches of diagnoses, procedures and modifiers.

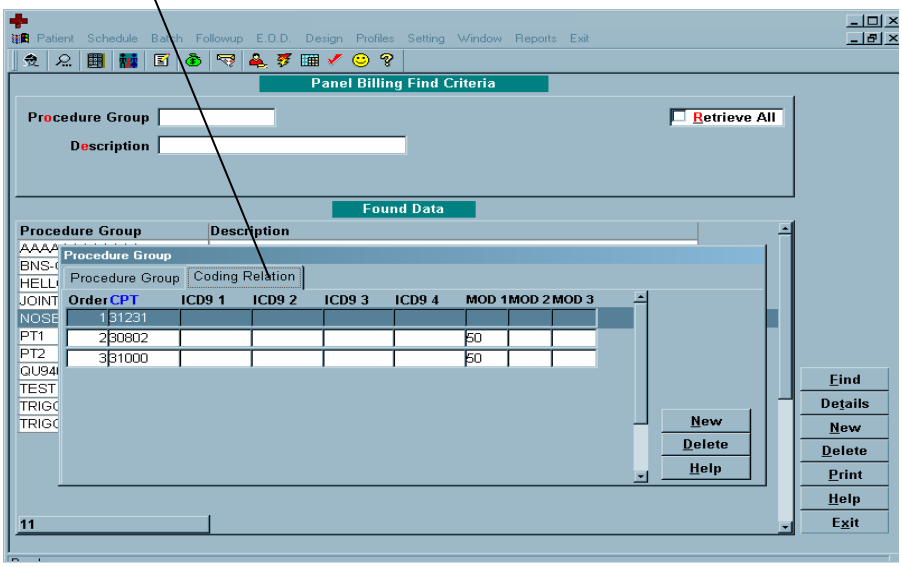
Let's illustrate this with an example: For Medicare under-served area, known as a QU area, you have to put a QU Modifier in the procedure to get paid a premium. Medicare under served areas will quarterly pay an extra 5% for most procedures billed in a medically under served area. And the way you seek that extra 5% benefit is by billing with a QU modifier. There are certain procedures that have a technical component and a professional component. When you bill a technical and professional component together, it is called billing globally. An example of that would be the 94060 code. So in normal billing if you bill a 94060 its billing globally. If you were only going to bill the technical component of that, you would put 94060.TC (TC for technical component). If you only wanted to bill professional component, you would put 94060.26 for the professional component. When Medicare established their QU program, they said that for those codes that have a professional/technical component, we will only pay that premium on the .26 modifier that is on the professional component. It is a hassle to bill because now you have to take that 94060 and instead of making one simple line item, you have to put in two line items: (1) a 94060.TC for the technical component and (2) a 94060.26.QU for the professional component for which you are asking for a premium for the medically under-served area. So rather than typing that in, if you know in advance, you could define a group called QU 94060 and actually in this way by naming it QU you could pull up list of all the QU's. How does it work? Under Coding, you define them under Procedure Group by simply defining them. And then attach functional meaning to them in the Procedure Group field in Charge Entry.

PROCEDURE GROUP TAB



Field	Description
Procedure Group Short Name	User-defined short name of the group
Description	Detailed (description) of the group

CODING RELATION TAB

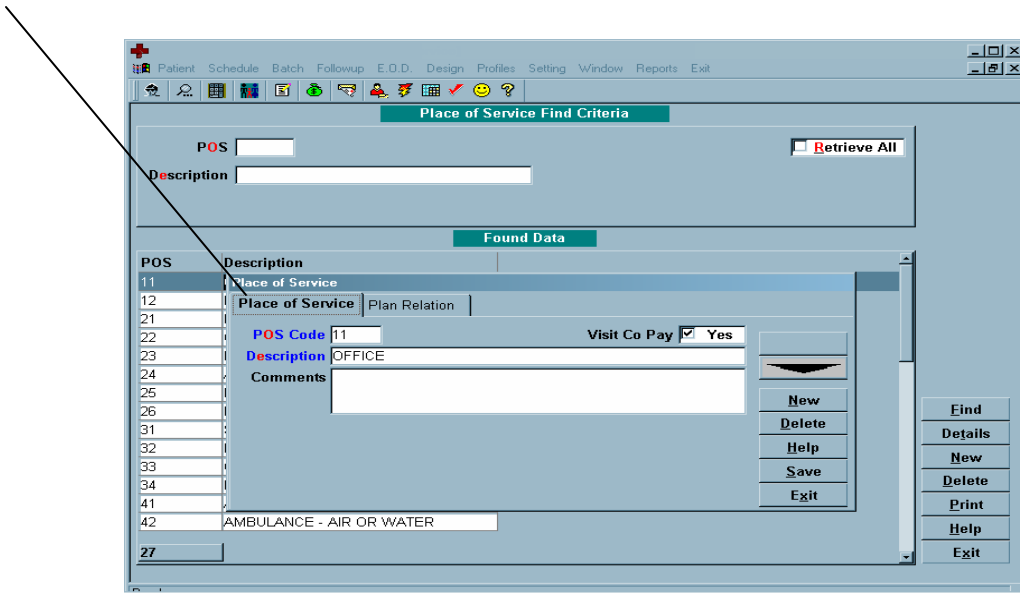


Field		Description
Order		Numerical order
CPT		CPT code
ICD9	1	First ICD-9 code
ICD9	2	Second ICD-9 code
ICD9	3	Third ICD-9 code
ICD9	4	Fourth ICD-9 code
MOD	1	First Modifier code
MOD	2	Second Modifier code
MOD	3	Third Modifier code

PLACE OF SERVICE

Place of Service is an insurance form designation as a numerical code indicating the facility where medical services were rendered. For example physician's office=11, ambulatory service center=24, inpatient hospital=21, emergency room hospital=25, nursing home=32, etc. In this profile, we code all the places where the services are rendered.

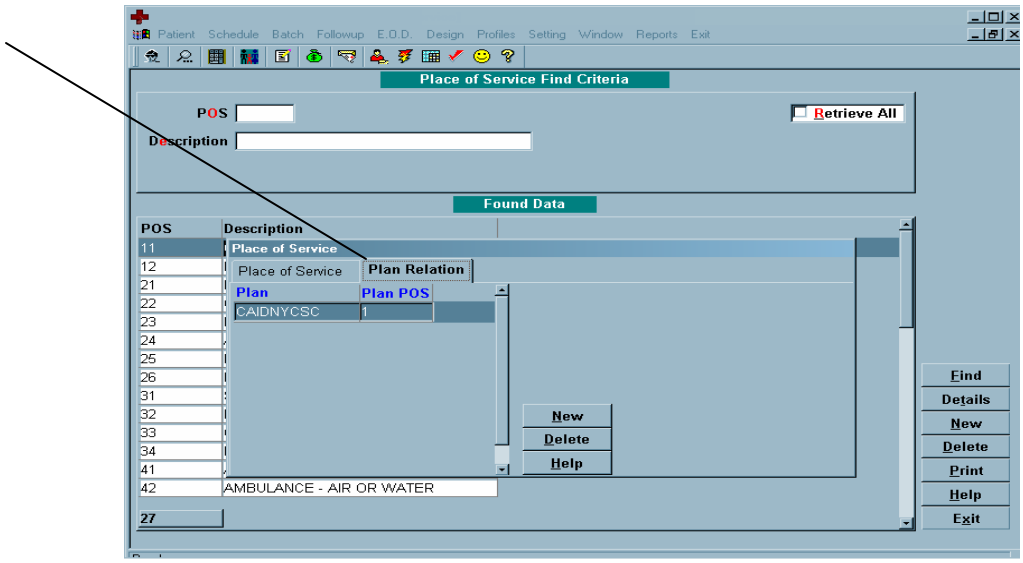
PLACE OF SERVICE TAB



Field	Description
POS	**Unique Numerical code for the place of service**
Description	**Name of place of service corresponding to the numerical code**
Visit Co Pay	**If the Visit Co Pay checkbox is checked, it will project the Visit Co Pay amount entered in the Insured Party section of the Patient Registration window into the Visit Co Pay field of the Charge Entry and Batch Charge Entry window**
Comments	**Any comments related to the place of service**

PLAN RELATION TAB

Place of Service is a coding parameter that, as described above, has a POS code with a description and a comment and an indication as to whether visit co-pay applies to that POS or not. This is essentially applicable to Medicare/HCFA-1500 standards. However, Medicaid has their own POS. For this reason, SequelMed provides a relationship between the POS code and Plan. A relation is basically a way of establishing unique definitions that are built on combinations of generic entities. Medicaid is a plan for which the POS codes are different than Medicare for the same place of service. For example, Medicaid uses POS code 1 instead of Medicare's 11. So, we can setup a plan relation by putting in the plan Medicaid and see that the POS 11 changes it to 1. If, for example, you are billing BCBS with POS 11 Office Visit, it will go through and bill that way. But when you bill a patient with Medicaid and put in POS 11, what happens is that because this relationship was established it will replace 11 with a 1 and therefore bill the claim properly to Medicaid. So the Plan POS code over-rides the POS Code.

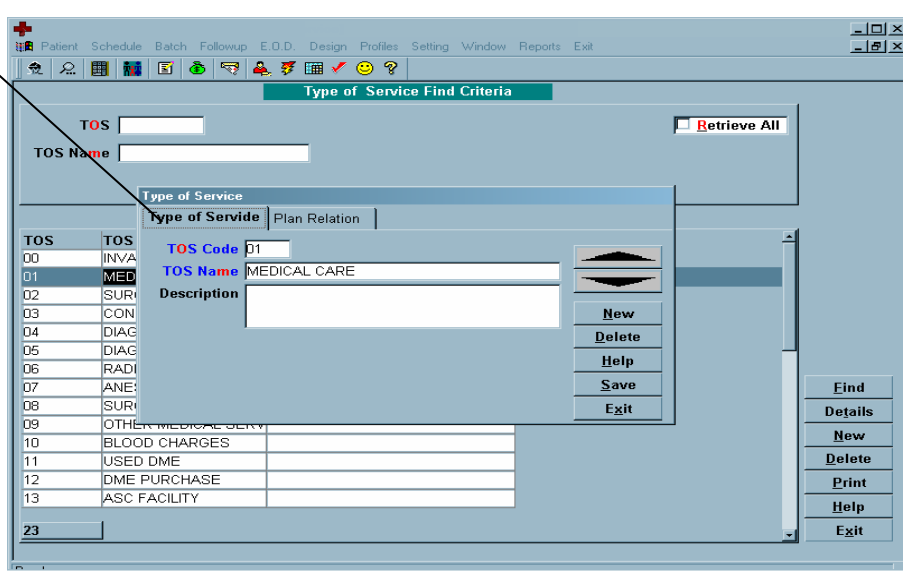


Field	Description
Plan	User-defined short name of the plan
Plan POS	Unique Numerical code for the place of service

TYPE OF SERVICE

Type of Service classifies each procedure. For example, medical care, surgery, x-ray, consultation, diagnostic lab, diagnostic, etc. In this profile, we code all the services.

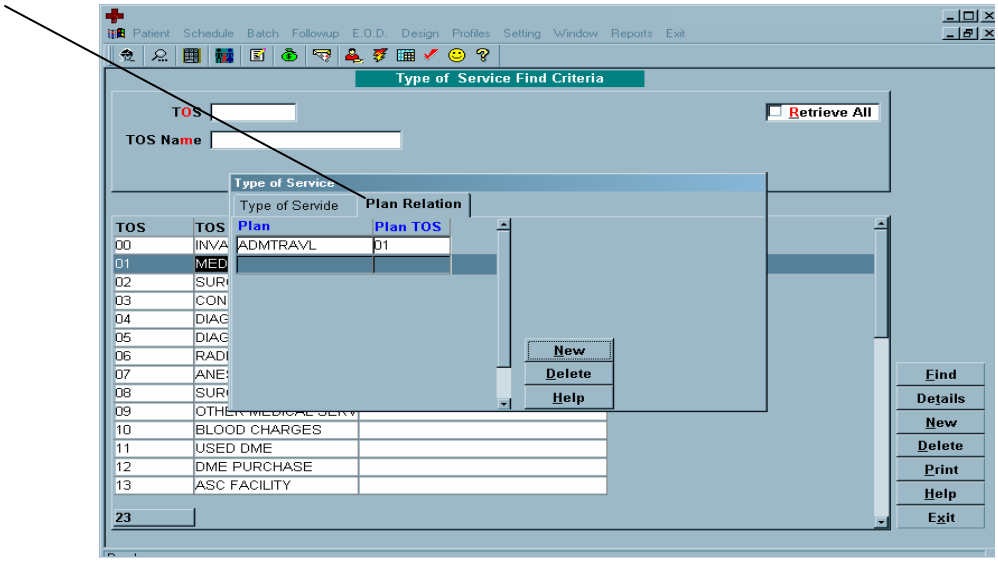
TYPE OF SERVICE TAB



Field	Description
TOS Code	Unique code for the type of service
TOS Name	Name of the type of service
Description	Description of the type of service

PLAN RELATION TAB

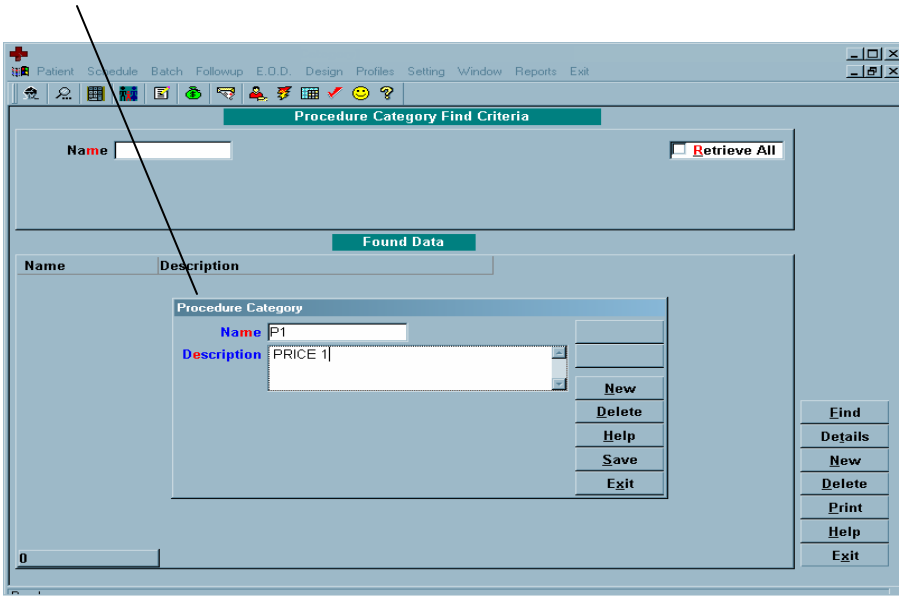
In the same manner as in Place of Service, the Type of Service also has a Plan Relation tab. When a certain plan requires a mapping of standard HCFA type of service or place of service to plan-specific type of service or plan service, most generally used by Medicaid or WC sometimes.



Field	Description
Plan	User-defined short name of the plan
Plan TOS	Unique Numerical code for the type of service

PROCEDURE CATEGORY

In the Procedure Category Profile, procedures belonging to the same category are grouped for internal use and reports. For example all lab procedures, or frequently used procedures, or any user-defined category can be grouped together in a particular category. This helps practices get reports for various groups of procedures for internal evaluation.



Field	Description
Name	User-defined name of the procedure category
Description	Description of the procedure category

FEE

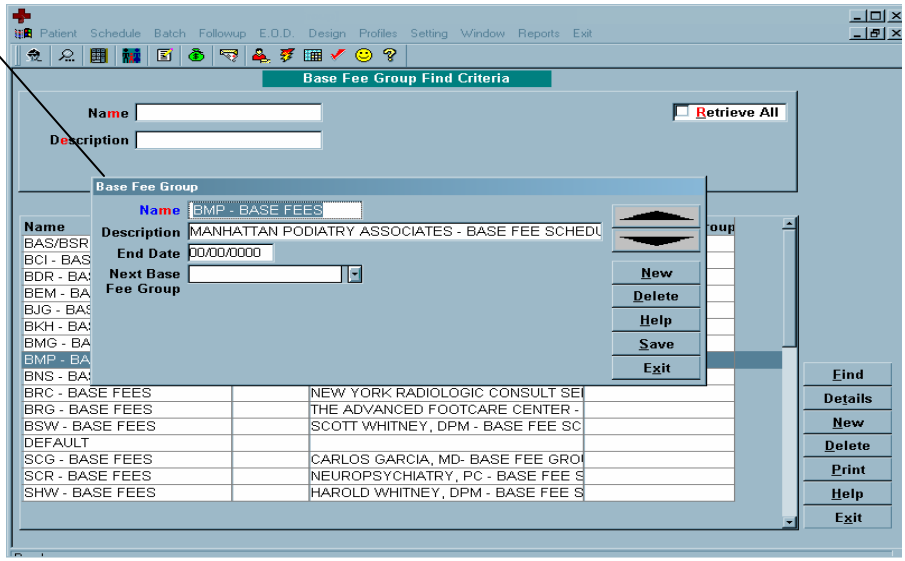
CONCEPT OF BASE FEE GROUP, PLAN FEE GROUP AND PLAN FEE LINK

Base Fee group is a provider usual and customary fee schedule. In the hierarchy of fee schedules, a base fee group is taken if Plan fee group is not defined. If neither is available then the system automatically takes standard fee for the procedure. A provider can choose to develop his/her particular base fee group (fee schedule) over time with respect to their charging methods for all plans. Or can simply create this base fee group (fee schedule) for commercial plans, which do not belong to any particular fee schedule. A base fee group can be assigned for the entire practice or for individual providers.

Plan fee group is the contractual amount that is linked to the practice. Fees for procedures can be modified and changed in many ways, one of them is pricing the procedures by arranging the different procedures under one plan fee group. When fee linking structure is defined in SequelMed, its determination is based on both spatial and temporal. In other words, it has to do with location and it has to do with year. So a Manhattan Medicare fee in 1999 is different from Manhattan fees for 2000. A Queens fee for 1999 is different from a Manhattan fee for 1999. The time component is in the name and in the expiration, the location component is in the name. The naming conventions help. So when you are defining the groups with the fee utility, there is some logic behind it. For example, you can make your Manhattan fee start with MAN, Brooklyn with BK, Queens with QUEENS, and so forth. The remainder of the plan fee group short name is then the date that that last is effective from so for example MAN 0100 and MAN 0101. This helps visually, when to change it and when it is obsolete. Every plan fee group has an expiration date, which tells it when to pick up the next one. So if you go to a third year, you have to change it in order to keep it accurate.

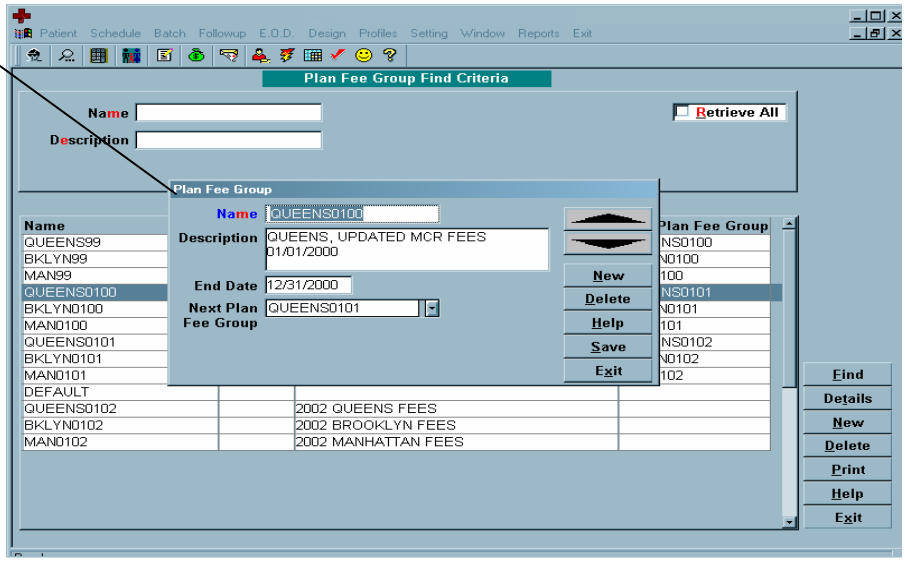
Plan Fee Link pertains to plan-specific fee schedules, which could be used and reused throughout the entity. The link itself is simple. It is just a name and description and the end date (expiration date) and when to pick up the next fee schedule. For example, WC might have a hundred different plans. Rather than establishing a very confusing set of relations at the plan profile level, or to have to define them a hundred times for each WC plan, we put in a concept of a plan fee link. Plan fee link gives a simple way of establishing, at the plan level, which fees they belong to. So you can define one plan fee link called WC for all the one hundred plans, and all you have to do at the plan level where the plan fee link field is put WC in for all one hundred WC plans and worry no more. This will bind it to the correct fee. In essence, plan fee links are put in the plan to bind it to the right fee and plan fee groups are put in the practice or location to bind it to the correct fee. So when you enter a charge based on the location and the plan you use, it will point to the right fee assuming that it is set up.

BASE FEE GROUP



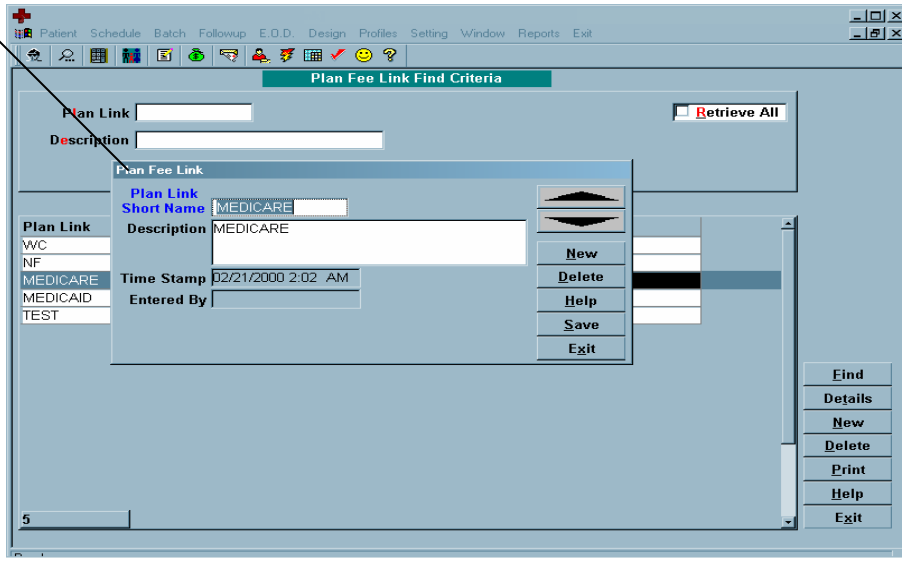
Field	Description
Name	User defined name assigned to the fee schedule used by the provider; A base fee group can be assigned for the entire practice(s) or for individual provider(s), or location(s).
Description	Description of the Base Fee group name
End Date	Date by which this fee schedule expires
Next Base Fee Group	After the end date, the system will pick up the next base fee group selected here and it will be effective

PLAN FEE GROUP



Field	Description
Name	Name you want to give to your group
Description	Details of the group
End Date	Date by which the fee schedule for the above-specified name ends/expires
Next Plan Fee Group	After the end date, the system will pick up the next plan fee group selected here and it will be effective

PLAN FEE LINK



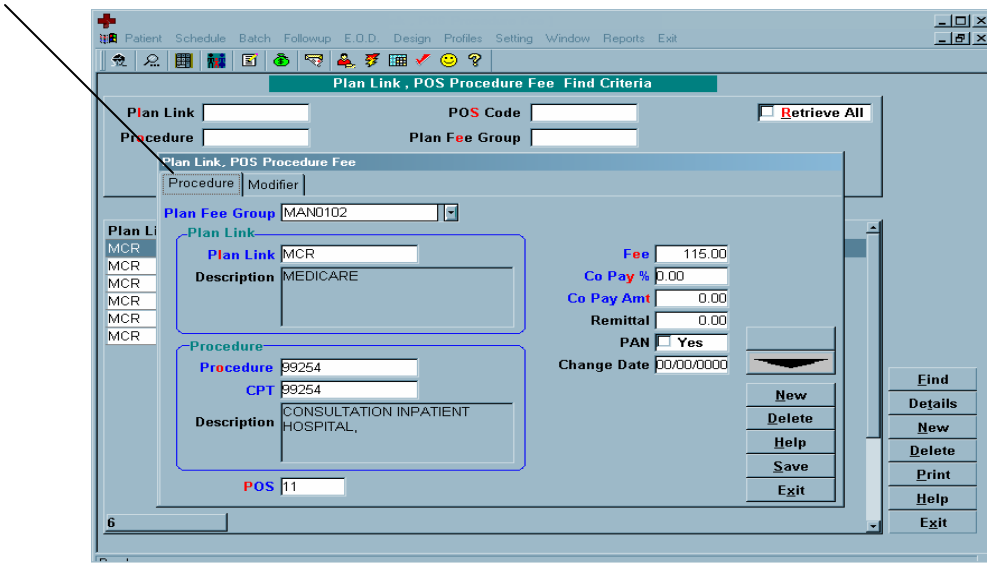
Field	Description
Plan Link Name	User-defined name of the plan link
Description	Description (any details) of the plan link
Time Stamp	Time when this information was entered, generated automatically by SequelMed
Entered by	User who entered the information, generated automatically by SequelMed

PLAN FEE LINK, POS AND PROCEDURE FEE

In SequelMed, there are two fundamental types of plan fee links. (1) plans for which place of service is required, i.e., plan for which the place of service has effect on the fee. For example, Medicare, which has a different fee structure for hospital versus office. (2) plans for which the place of service does not apply. For example, Workers Compensation and No-Fault, where the fee definitions are not POS-related.

This relation allows you to set plan procedure fee for each Place of Service. If this relation is set then it has the top most priority and this fee will be shown at the time of charge entry.

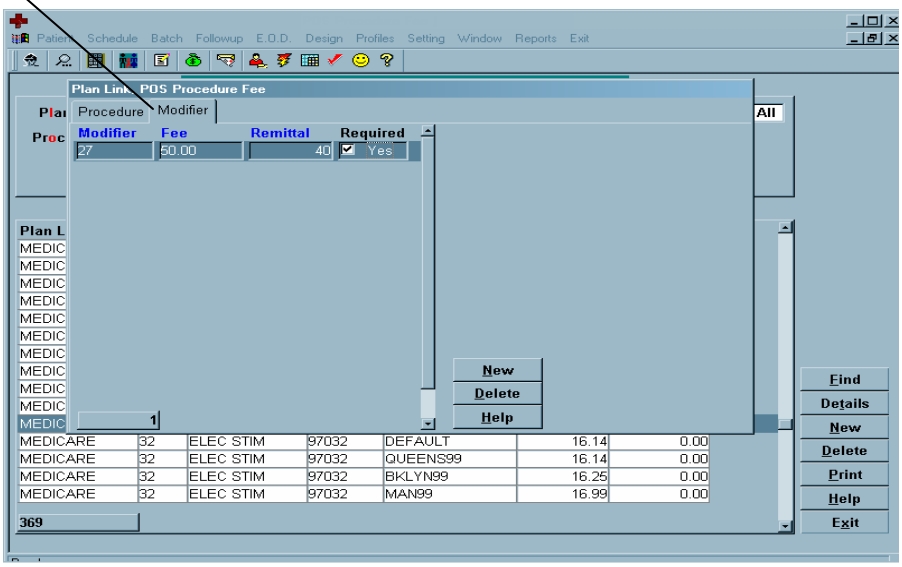
PROCEDURE TAB



Field	Description
Plan Fee Group	**User-defined name of the plan fee group**
Plan Link	
Plan	**Select the desired plan's short name**
Description	**Automatically gives description**
Procedure	
Procedure	**Select the desired procedure's short name**
CPT	**Automatically gives the CPT code**
Description	**Automatically gives the procedure's detailed name**
POS	**Code for Place of Service**
Plan Fee	**Allowed fee for the plan**

Co Pay %	**Co Pay percentage for this procedure from the plan**
Co Pay Amt	**Co Pay amount for this procedure from the plan**
Remittal	**Contractual Amount associated with the plan i.e. the amount that will be paid by the plan**
PAN	**If prior approval of insurance company is required for this procedure**
Change Date	**The date on which the fee was changed**

MODIFIER TAB

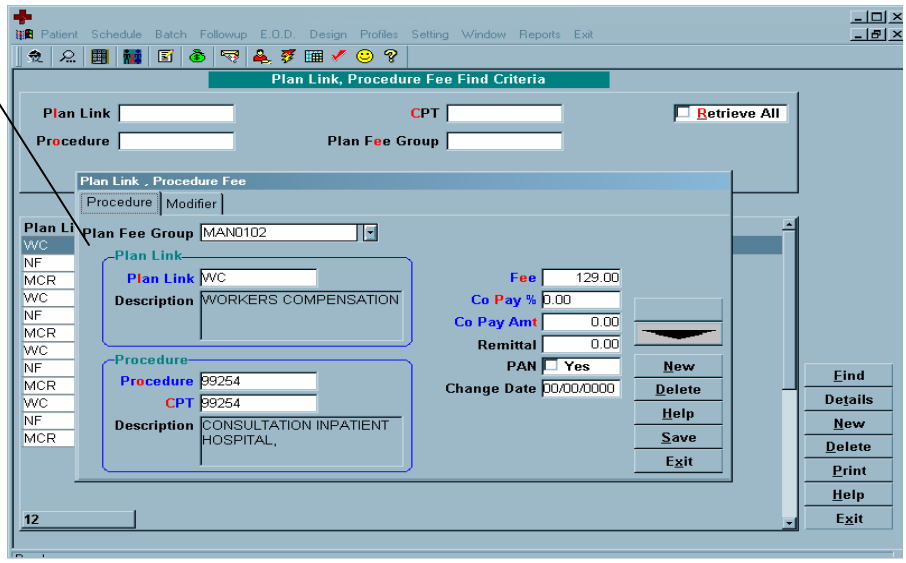


Field	**Description**
Modifier	**Pre-defined two-digit modifier code**
Fee	**Modifier fee**
Remittal	**Amount that was remitted**
Required	**If the modifier is required, this checkbox is to be checked**

PLAN FEE LINK, PROCEDURE FEE

As mentioned earlier, this fee link is for plans for which place of service does not effect the fee structure, for example, Workers Compensation and No-Fault plans. As a result, the fields of this section are identical to in all respects to the “Plan Fee Link, POS, Procedure Fee” section, except that this one does not contain a field for place of service because POS has no bearing on the fee.

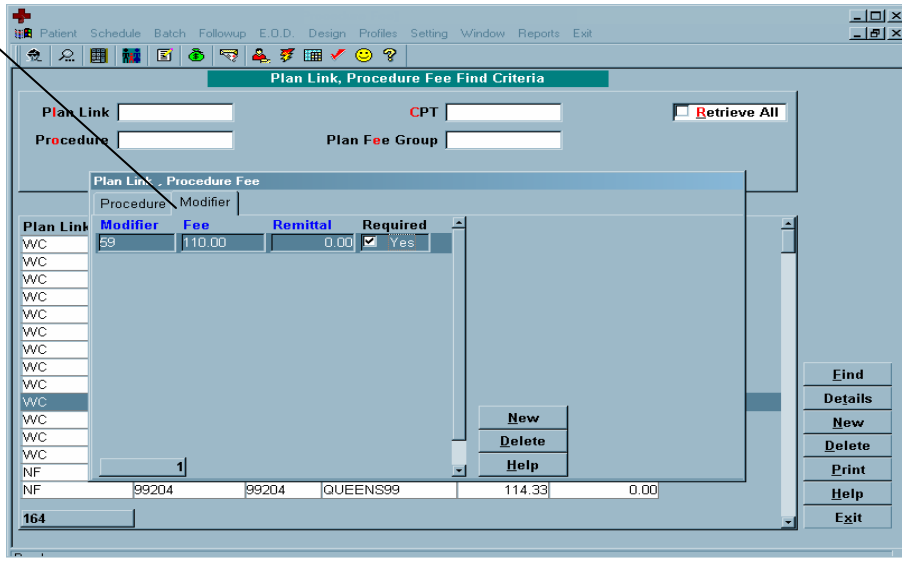
PROCEDURE TAB



Field	Description
Plan Fee Group	**User-defined name of the plan fee group**
Plan Link	
Plan	**Select the desired plan’s short name**
Description	**Automatically gives description**
Procedure	
Procedure	**Select the desired procedure’s short name**
CPT	**Automatically gives the CPT code**
Description	**Automatically gives the procedure’s detailed name**
Plan Fee	**Allowed fee for the plan**
Plan Co Pay %	**Co Pay percentage for this procedure from the plan**
Plan Co Pay Amt	**Co Pay amount for this procedure from the plan**
Plan Remittal	**Amount that will be remitted by the plan**

PAN	**If prior approval of insurance company is required for this procedure**
Change Date	**The date on which the fee was changed**

MODIFIER TAB

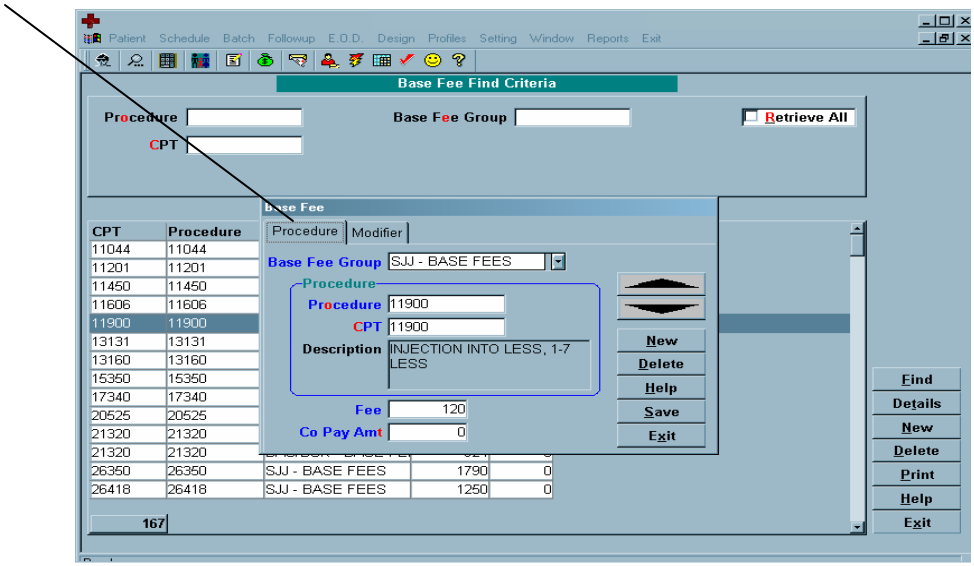


Field	Description
Modifier	**Pre-defined two-digit modifier code**
Fee	**Modifier fee**
Remittal	**Amount that was remitted**
Required	**If the modifier is required, this checkbox is to be checked**

BASE FEE

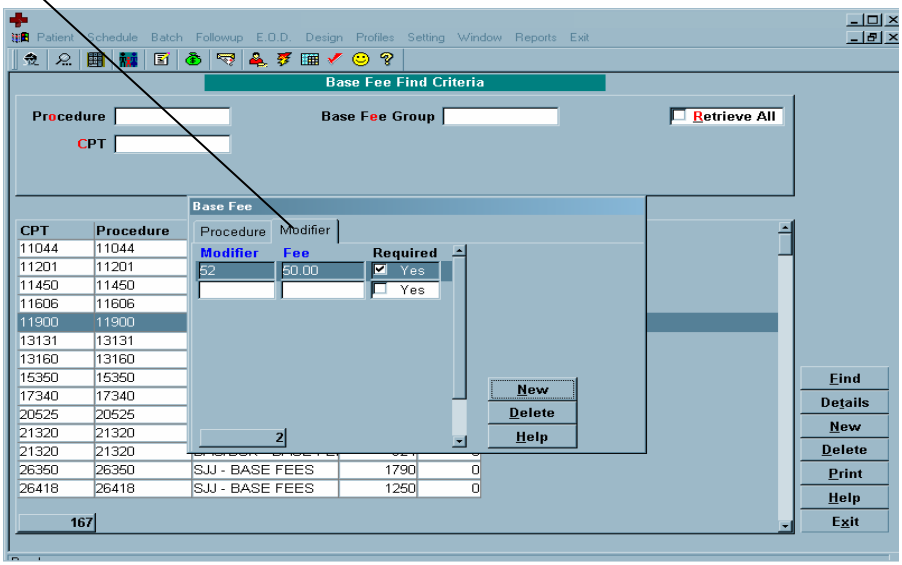
Base fee is similar in function to the above two links, but now instead of binding it back to the plan fee group, it will be bound to the base fee group, which could be defined by practice, location or provider.

PROCEDURE TAB



Field	Description
Base Fee Group	**User-defined name of the base fee group**
Procedure	
Procedure	**Select the desired procedure's short name**
CPT	**Automatically gives the CPT code**
Description	**Automatically gives the procedure's detailed name**
Fee	**Allowed fee for the procedure**
Co Pay Amt	**Co Pay amount for this procedure**

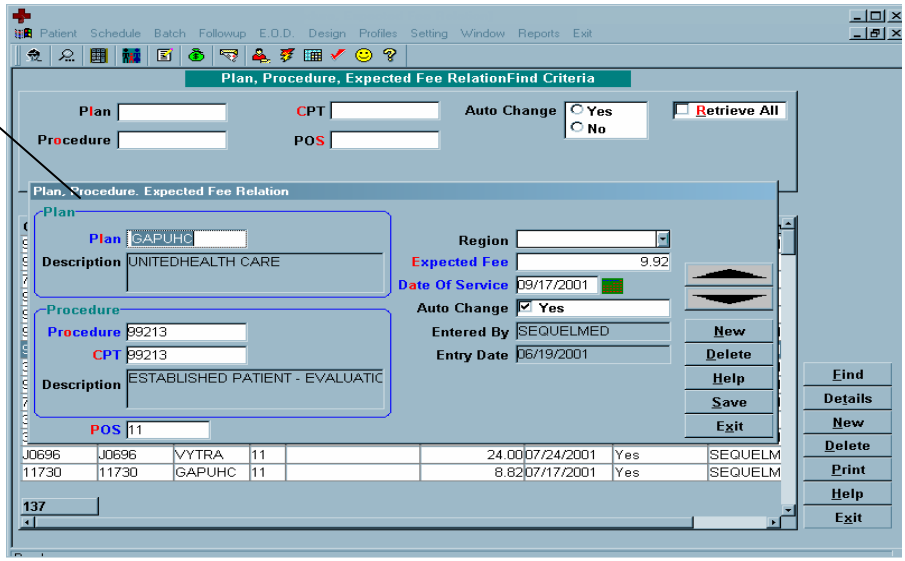
MODIFIER TAB



Field	Description
Modifier	Pre-defined two-digit modifier code
Fee	Modifier fee
Required	If the modifier is required, this checkbox is to be checked

EXPECTED PLAN PROCEDURE FEE

In Expected Plan Procedure relation or Plan Procedure & Expected Fee Relation, you enter the plan and procedure with expected fee. If the Plan, POS and Procedure relation has been created then the expected fee has to entered manually for the first time at the time the relation has been created later SequelMed will change the expected fee automatically if the Auto Change flag is been checked.

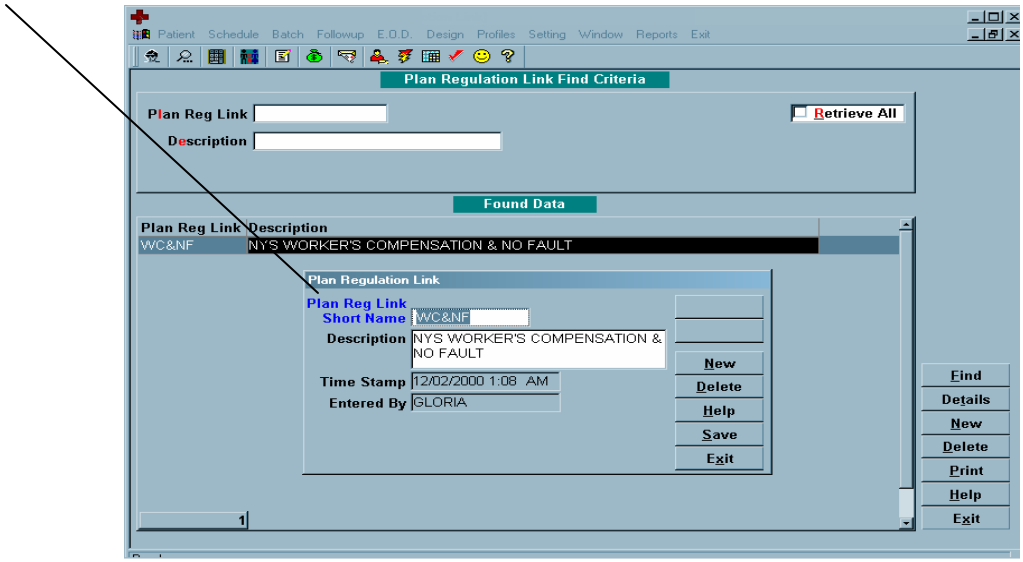


Field	Description
Plan	
Plan	**Select plan's short name**
Description	**Automatically gives plan's full name**
Procedure	
Procedure	**Select procedure short name**
CPT	**Select the CPT code**
Description	**Automatically gives procedure's detailed name**
POS	**Code for the Place of Service. (This field is only used when you have created the Plan, POS and Procedure Fee relation and now you want to create the expected fee relation for it)**
Region	**Geographical region for the place of service**
Expected Fee	**Expected fee from the plan**
Date Of Service	**The date the fee was changed**
Auto Change	**This checkbox will allow the system to automatically change the fee for you every time there is a change in the fee**
Entered By	**Name of the user who entered this information**
Entry Date	**Date when this information was entered into the system**

PLAN SPECIFIC EDITS

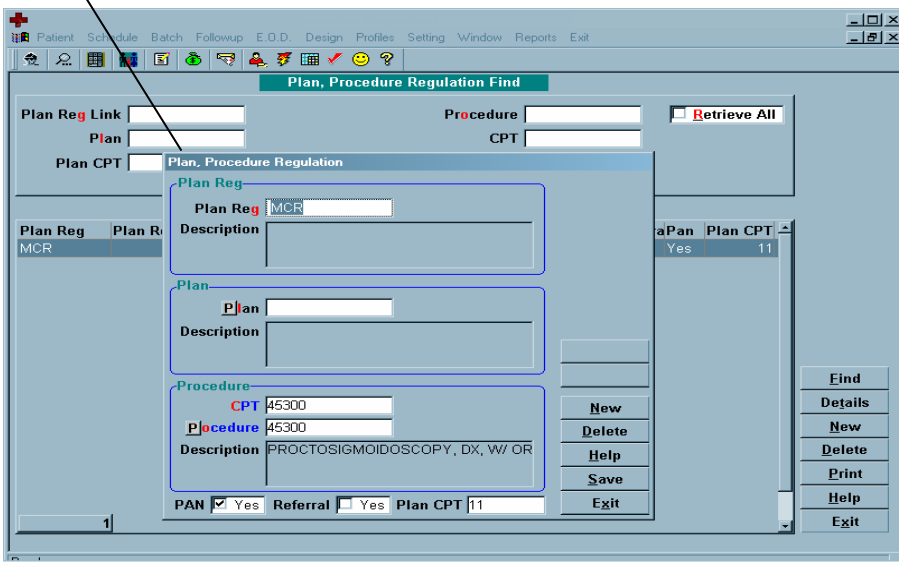
Plan Regulation Link and Plan Procedure Regulation in SequelMed facilitate the enforcement of plan specific regulations. The primary two functions these plan specific edits serves are: (1) to indicate PAN (Prior Authorization Number) requirement. (2) to map CPT codes; for example, Workers Compensation might have a plan regulation link that would bind all the regulations that apply to WC to that link. And these links defined in the location and practice sections of the Profile menu in order to be used and then correctly set up in the Plan, Procedure Regulation section, where it actually takes effect. The Plan Regulation Link itself is simple. Its just a name and description, time when it was entered and name of the user who entered it. The link actually takes effect in the Plan Procedure Regulation section where it ensures that prior authorization should be taken before entering procedures into charges. If PAN (Prior Authorization Number) is checked here, whenever procedure is entered in charges the system will ask for PAN.

PLAN REGULATION LINK



Field	Description
Plan Reg Link Short Name	User defined short name of the plan regulation link
Description	Description of the plan regulation link
Time Stamp	Time when the information was entered, generated automatically by the System
Entered By	Name of the User who entered the information, generated automatically by the System

PLAN, PROCEDURE REGULATION

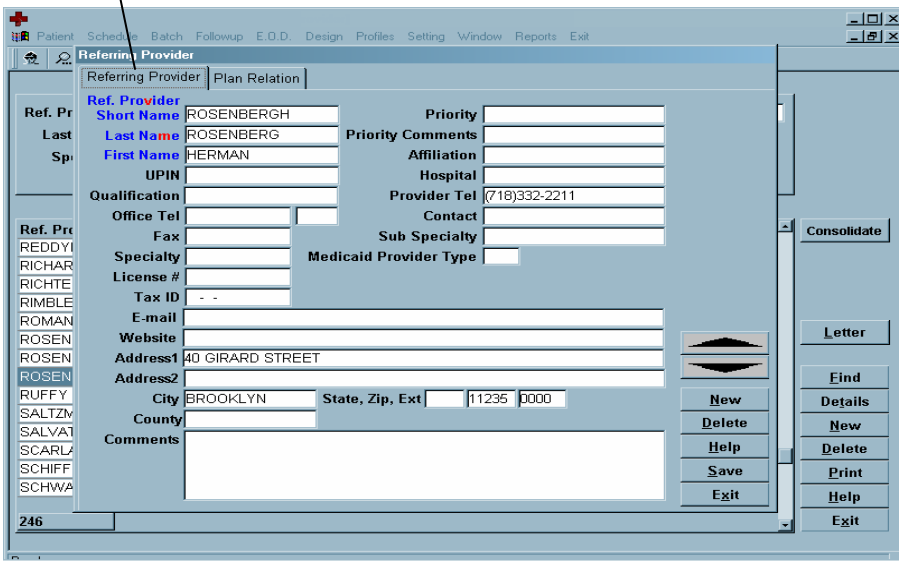


Field	Description
Plan Reg	
Plan Reg	**User defined short name of the plan regulation link**
Description	**Automatically gives the description of the plan regulation link**
Plan	
Plan	**User defined short name of the plan**
Description	**Automatically gives the description of the plan**
Procedure	
CPT Code	**Numerical CPT code for the procedure**
Procedure	**This field is automatically populated with the numerical CPT code for the procedure entered above**
Description	**Automatically gives the description of the procedure**
PAN	**Prior Authorization Number; If PAN is checked here, whenever procedure is entered in charge entry, the system will ask for PAN**
Referral	**Check this box if referral**
Plan CPT Code	**CPT code corresponding to the specific plan, i.e. the procedure which is cross-referenced for this plan for which the plan regulation link was created**

REFERRING PROVIDER

Referring Provider profile stores information about the providers who refer patients to your practice or a different provider.

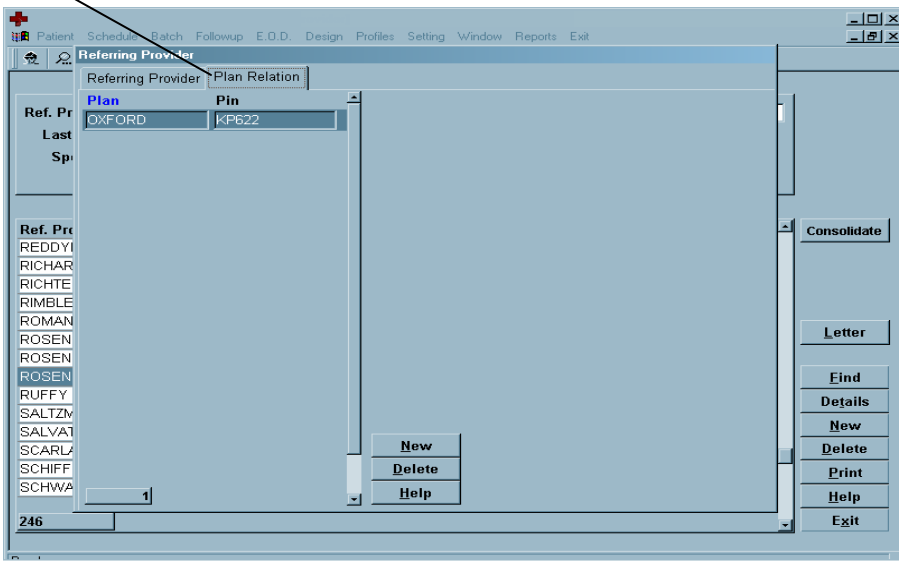
REFERRING PROVIDER TAB



Field	Description
Ref Provider Short Name	User defined referring provider's short name
Last Name	Referring provider's last name
First Name	Referring provider's first name
UPIN	Referring provider's UPIN number
Qualification	Qualifications of the referring provider
Office Tel	Referring provider's office telephone number
Fax	Referring provider's office fax number
Specialty	Referring provider's specialty
License #	Referring provider's license number
Tax ID	Referring provider's Tax Identification Number
Priority	Referring provider's priority; the practice can set the priority based on the referring provider's performance

Priority Comments	**User defined comments about the referring provider's priority**
Affiliation	**Affiliations of the referring provider with professional organizations**
Hospital	**Hospital where the referring provider practices**
Provider Tel	**Referring provider's personal telephone number**
Contact	**Referring provider's office manager's or main contact's name**
Sub Specialty	**Referrring provider's sub specialty**
E-mail	**Referring provider's e-mail address**
Website	**Referring provider's web site address**
Address 1	**Primary street address of the referring provider's offices**
Address 2	**Secondary street address, if any**
City	**Name of the city/town**
State, Zip, Ext	**State and the Zip**
County	**Name of the County**
Comments	**Any comments related to the referring provider**

PLAN RELATION TAB

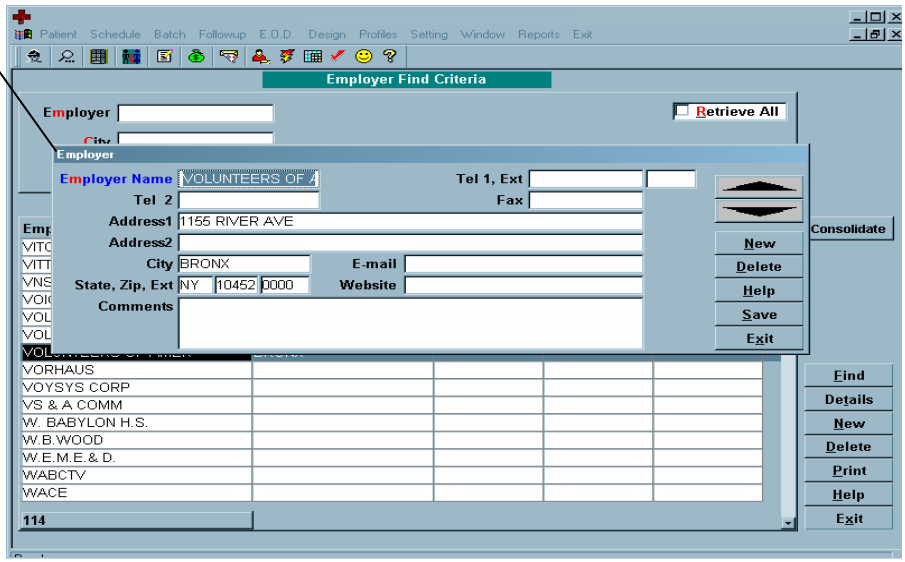


Field	Description
Plan	Short Name of the Plan
PIN	Provider Identification Number associated with the plan

PATIENT PROFILES

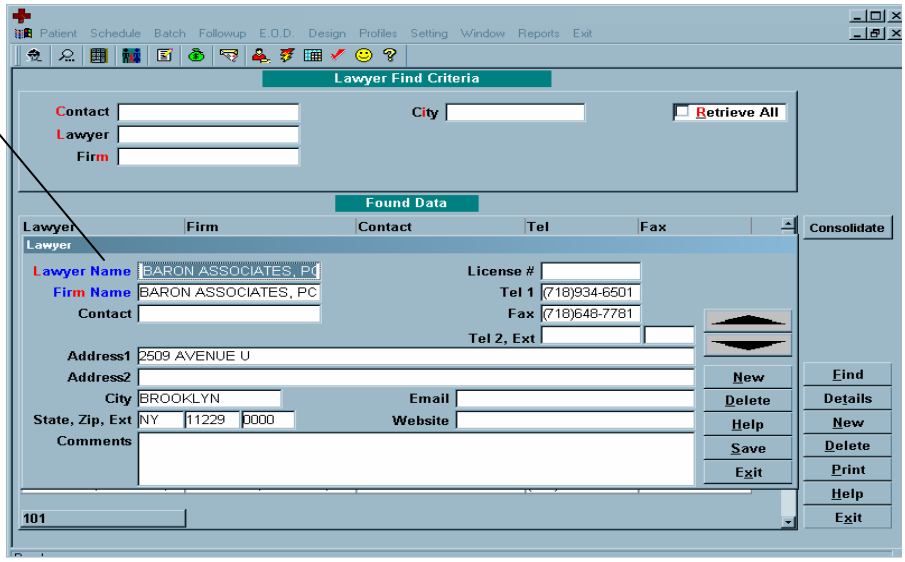
EMPLOYER

In this profile we code the patient's employer. This employer data is used in patient demographics or insured party entry.



Field	Description
Employer Name	Employer company's name
Tel 1, Ext	Primary telephone number and extension, if any
Tel 2	Secondary telephone number, if any
Fax	Fax number, if any
Address 1	Primary address of the employer
Address 2	Secondary address of the employer, if any
City	City where the employer is located
State, Zip, Ext	State, Zip, Ext where the employer is located
E-mail	E-mail address, if any
Website	Web site address, if any
Comments	Any comments related to the employer

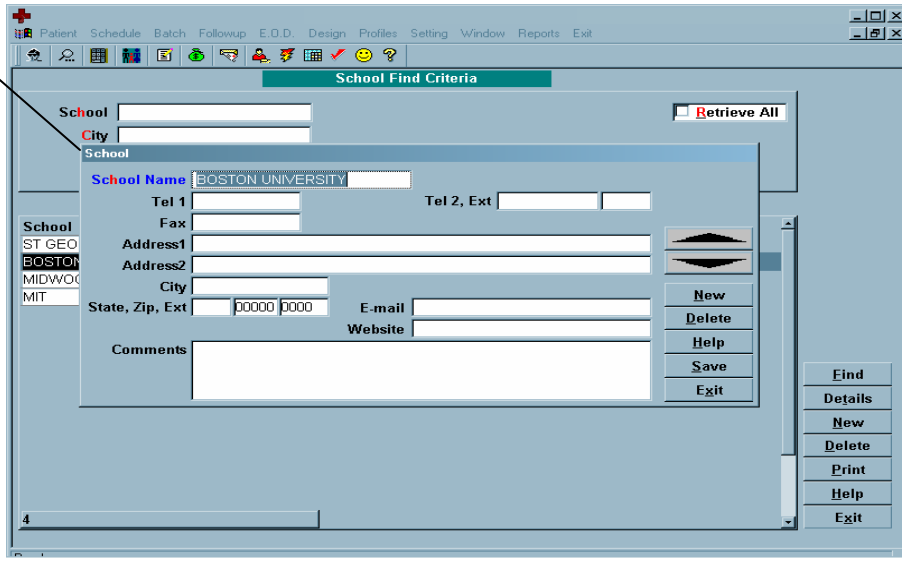
LAWYER



Field	Description
Lawyer Name	Lawyer name
Firm Name	Lawyer firm name
Contact	Contact person's name at the lawyer's office
License #	Lawyer's license number
Tel 1	Primary telephone number for the lawyer's office
Tel 2, Ext	Secondary telephone number and extension, if any
Fax	Fax number for the lawyer's office
Address 1	Primary address of the lawyer's office
Address 2	Secondary address, if any of the lawyer's office
City	City where the law office is located
State, Zip, Ext	State, Zip, Ext where the law office is located
Email	E-mail address of the lawyer, if any
Website	Web site address of the lawyer, if any
Comments	Any comments related to the lawyer and/or his office

SCHOOL

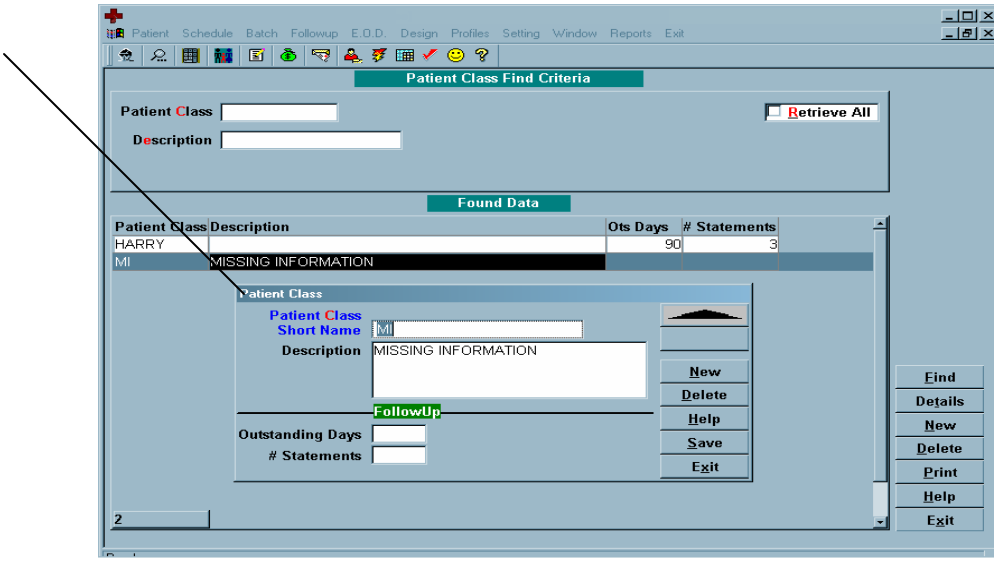
In School profile, you enter the information of all the schools your patients come from.



Field	Description
School Name	Name of the school
Tel 1	Primary telephone number of the school
Tel 2, Ext	Secondary telephone number of the school, if any
Fax	School's fax number
Address 1	Primary address of the school
Address 2	Secondary address of the school
City	City where the school is located
State, Zip, Ext.	State, Zip, Ext where the school is located
E-mail	School's e-mail address, if any
Website	School's web site address, if any
Comments	Any comments related to the school

PATIENT CLASS

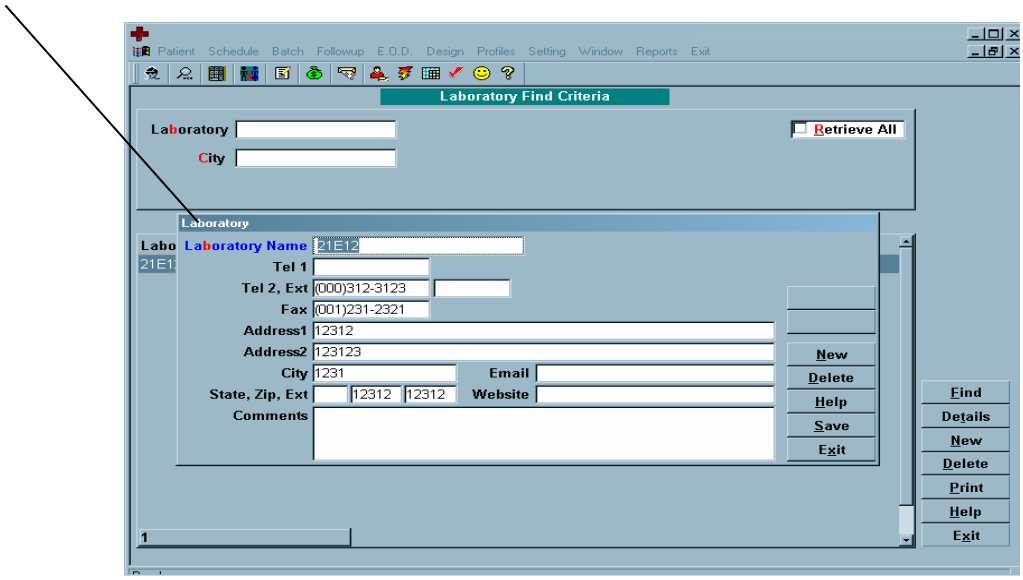
In the Patient Class profile, you can create different classes of patients. As an example, if you want to track all the patients who are coming from a certain institution such as a nursing home you can create a class code and link it to all the patients coming from nursing home. This will help you create multiple reports based on the class code.



Field	Description
Patient Class Short Name	User defined short name of the patient class
Description	Class name description or any relevant details

LABORATORY

In Laboratory profile, you enter the information about all the relevant labs: mailing address, telephone numbers, etc. Any comments for a specific lab can be entered here.



Field	Description
Laboratory Name	Laboratory name
Tel 1, Ext	Primary telephone number and extension
Tel 2	Additional telephone number, if any
Fax	Fax number, if any
Email	Email address, if any
Address 1	Primary address of the laboratory
Address 2	Secondary address of the laboratory
City	City where the laboratory is located
Email	Email address of the laboratory
Web Site	Web site of the laboratory
State, Zip, Ext	State, Zip, Ext where the laboratory is located
Comments	Any comments related to the laboratory