CGM ECOLLECTIONS™ Client Setup Packet

February 2018

CGM ECOLLECTIONS™

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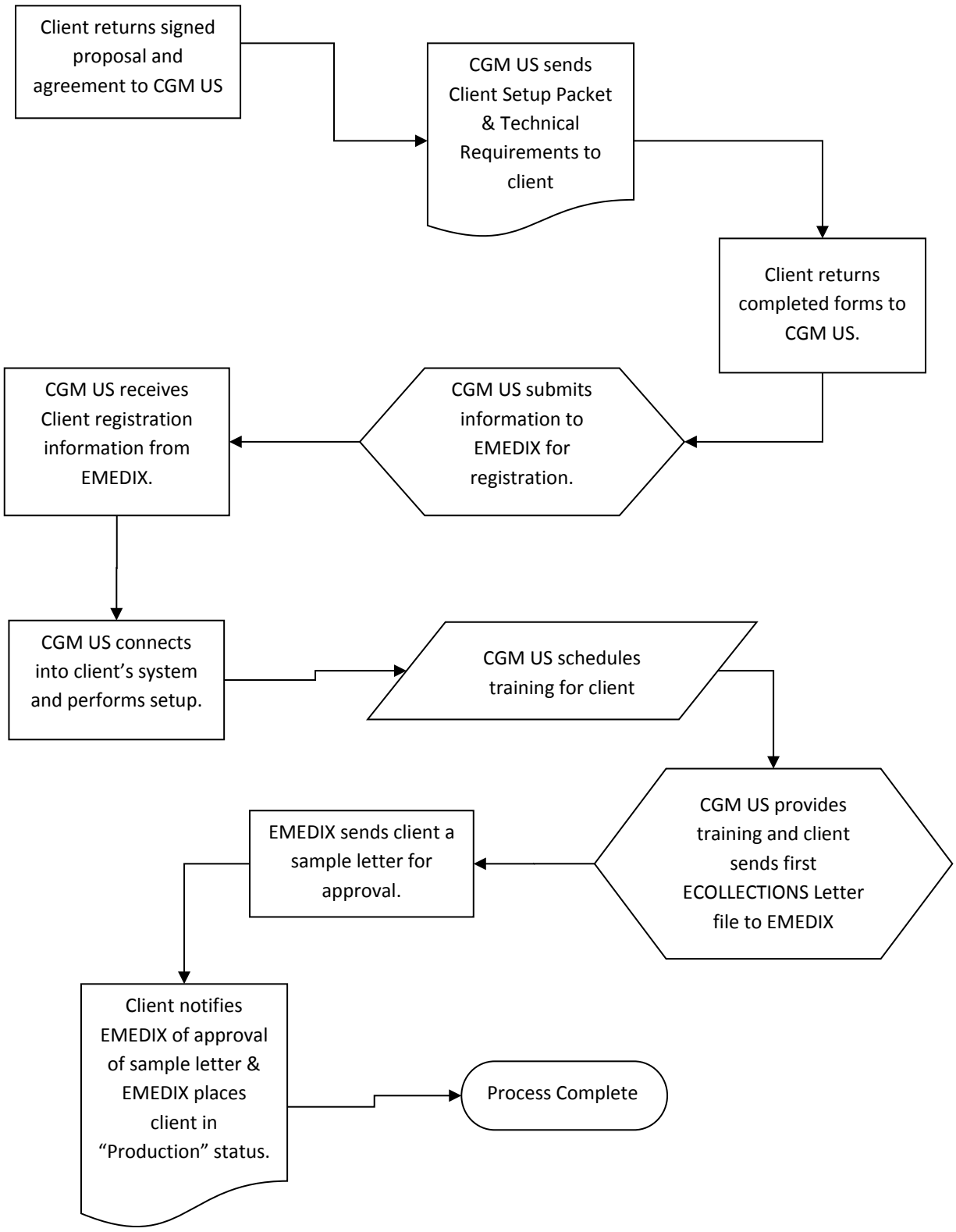
NOTICE

CompuGroup Medical US believes the information contained in this documentation to be accurate at the time of publication and reserves the right to make improvements in the product described herein at any time and without notice.

CGM ECOLLECTIONS INSTALLATION PROCESS



CGM ECOLLECTIONS PRACTICE INFORMATION FORM

Complete the following and return to your project manager. This information is required a minimum of two weeks prior to the estimated *go-live* date to ensure a smooth installation. If you have multiple databases that will be sending CGM ECOLLECTIONS letters, complete a separate packet for each database. In addition, you will need to assign an individual to be responsible for all CGM ECOLLECTIONS activity.

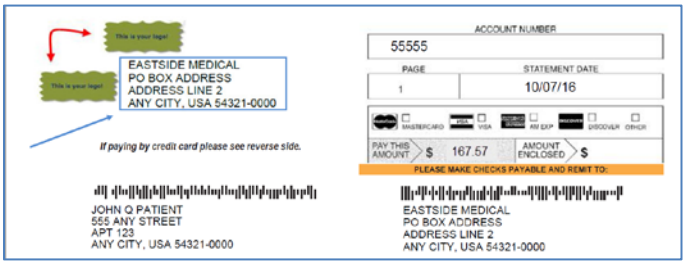
Client #		Database #	
Client Name		TPID/DSN #	
Address		Contact Person	
City, ST, Zip		Contact Phone #	
Phone #		Contact Email	
Fax #			

Complete the following to indicate which Users will need to access EMEDIX for CGM ECOLLECTIONS.

First Name	Last Name	EMEDIX Username	New User?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Setup Information

The following information will print in the **From** section at the top of the letter.



Practice Name	
Address Line One	
Address Line Two	
City, ST, Zip	

What phone # do you want to print at the bottom of the letter? _____

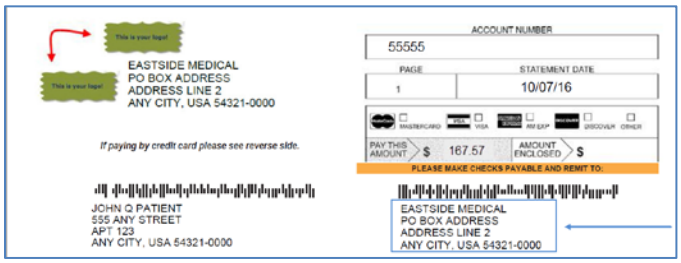
Credit Cards accepted: ☐ MasterCard and Visa ☐ Amex ☐ Discover ☐ None

Note: If you do ***not*** accept MasterCard and Visa, the **Amex** and **Discover Card** options are not available. If you select '**None'**, "SORRY, CREDIT CARDS NOT ACCEPTED AT THIS TIME" will print instead of the credit card logos.

Will you be providing a company logo image* to print in the **top portion** of the letter? (**Note**: the logo will print above your practice name or to the left of it, depending on the size of the image. See sample letters for placement)

☐ Yes ☐ No (**must be a bmp image less than 56kb in size.*)

The following information will print in the **Remit** section of the letter.



Make checks payable to: _____

Address Line One _____

Address Line Two _____

City, ST, Zip _____

Sign to acknowledge completion of this packet and receipt and understanding of the *CGM ECOLLECTIONS Technical Requirements*. You can contact CompuGroup Medical at 888-627-7633 to request a copy of the *CGM ECOLLECTIONS Technical Requirements* or you can access the Knowledge Tree folder in *CGM webPRACTICE™ Help* to download a copy.

If you elected to provide a company logo image file, you will need to send it to your project manager along with this completed form.

_____ _____

Client Name Date

_____ _____

Signature Title

This is your logo!

This is your logo!

EASTSIDE MEDICAL
PO BOX ADDRESS
ADDRESS LINE 2
ANY CITY, USA 54321-0000

ACCOUNT NUMBER
55555

PAGE	STATEMENT DATE
1	10/07/16

☐ MASTERCARD ☐ VISA ☐ AM EXP ☐ DISCOVER ☐ OTHER

PAY THIS AMOUNT $ 167.57 AMOUNT ENCLOSED $

If paying by credit card please see reverse side.

PLEASE MAKE CHECKS PAYABLE AND REMIT TO:

JOHN Q PATIENT
555 ANY STREET
APT 123
ANY CITY, USA 54321-0000

EASTSIDE MEDICAL
PO BOX ADDRESS
ADDRESS LINE 2
ANY CITY, USA 54321-0000

PLEASE DETACH HERE AND RETURN TOP PORTION WITH YOUR PAYMENT

PAST DUE

Patient Name: JOHN Q PATIENT
Account No: 55555
Notice Date: 10/07/16
Amount Due: $167.57

Dear Mr. Patient,

Just a reminder that your account is past due in the amount of $167.57. Please remit your payment today.

To avoid further collection action, please respond immediately.

If you have any questions regarding these charges, please contact our billing office at 602-555-0111.

Sincerely,

EASTSIDE MEDICAL Billing Department

YOUR PAYMENT OPTIONS

888.555.5555 Option 2 CC By credit card By check

EASTSIDE MEDICAL
PO BOX ADDRESS
ADDRESS LINE 2
ANY CITY, USA 54321-0000

ACCOUNT NUMBER
55555

PAGE	STATEMENT DATE
1	10/07/16

☐ MASTERCARD ☐ VISA ☐ AM EXP ☐ DISCOVER ☐ OTHER

PAY THIS AMOUNT $ 167.57 AMOUNT ENCLOSED $

If paying by credit card please see reverse side.

PLEASE MAKE CHECKS PAYABLE AND REMIT TO:

JOHN Q PATIENT
555 ANY STREET
APT 123
ANY CITY, USA 54321-0000

EASTSIDE MEDICAL
PO BOX ADDRESS
ADDRESS LINE 2
ANY CITY, USA 54321-0000

PLEASE DETACH HERE AND RETURN TOP PORTION WITH YOUR PAYMENT

2ND NOTICE

Patient Name:	JOHN Q PATIENT	Notice Date:	10/07/16
Account No:	55555	Amount Due:	$167.57

Dear Mr. Patient,

Although we sent you a reminder that your account is past due in the amount of $167.57, the charges remain unpaid and are seriously past due.

Please remit payment in full or contact our office within the next ten business days to set payment arrangements.

If you have any question regarding this balance, please contact our billing office at 602-555-1212.

Sincerely,

EASTSIDE MEDICAL Billing Department

YOUR PAYMENT OPTIONS

888.555.5555 Option 2 CC By credit card By check

This is your logo!

This is your logo!

EASTSIDE MEDICAL
PO BOX ADDRESS
ADDRESS LINE 2
ANY CITY, USA 54321-0000

ACCOUNT NUMBER
55555

PAGE	STATEMENT DATE
1	10/07/16

☐ MASTERCARD ☐ VISA ☐ AM EXP ☐ DISCOVER ☐ OTHER

PAY THIS AMOUNT $ 167.57 | AMOUNT ENCLOSED $

PLEASE MAKE CHECKS PAYABLE AND REMIT TO:

If paying by credit card please see reverse side.

JOHN Q PATIENT
555 ANY STREET
APT 123
ANY CITY, USA 54321-0000

EASTSIDE MEDICAL
PO BOX ADDRESS
ADDRESS LINE 2
ANY CITY, USA 54321-0000

PLEASE DETACH HERE AND RETURN TOP PORTION WITH YOUR PAYMENT

FINAL NOTICE

Patient Name: JOHN Q PATIENT
Account No: 55555
Notice Date: 10/07/16
Amount Due: $167.57

Dear. Mr. Patient,

This letter is your final notice. Your account is seriously past due in the amount of $167.57.

You have ten (10) business days from the date of this letter to remit payment on this balance. If you fail to do so, your account will be turned over to a collection agency.

Sincerely,

EASTSIDE MEDICAL Billing Department

YOUR PAYMENT OPTIONS

888.555.5555 Option 2 CC By credit card By check

CREDIT CARD PAYMENT

You may pay this bill by credit card. Complete the form below and return in the enclosed envelope.

AMOUNT: $_____

CARD NUMBER:_____SECURITY CODE:_____

CREDIT CARD:_____CARD EXPIRES: _____/_____
MO. YR.

PRINT CARD HOLDER'S NAME:_____

SIGNATURE:_____

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT PLEASE INDICATE...

Your Name_____ Marital Status _____

Street_____ Home Phone _____

City_____State_____ Zip _____

Employer_____ Business Phone_____

Employer Address_____

Insurance Company_____Contract No._____

Insurance Company Address_____

Insurance Policy Number_____

Other Information_____

_____

Sample of the back side of each collection letter.