



Frequently Asked Questions (FAQs)

Cost & Utilization Reporting

version 7.0



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eServices Customer Reporting

What is eServices Customer Reporting?

Employer eServices Customer Reporting (eCR) is a web-based system for viewing and/or generating cost and utilization reports based on reliable and up-to-date paid claims data (including a rolling 36 months of historical claim data). The system is accessible 24 hours a day, seven days per week, with the exception of down time for data loads and maintenance.

Reports are classified into four main categories: Financial Reports, Pharmacy Reports, Medical Reports, and Membership Reports.

The reports available depend on the level of reporting:

- Standard & Select – customized report parameters deliver detailed data and membership/utilization information
- Expanded – variety of report templates and levels of information designed to facilitate utilization analysis and provide detailed performance information on the plans, network, medical management, and managed pharmacy programs

System Access, Policy Numbers, Reports

What are the minimum requirements to use eServices Customer Reporting?

- **Browsers:** Microsoft Edge Version 95.0.1020.40 (Official Build) (64-bit), Google Chrome Version 98.0.4758.82 (Official Build) (64-bit)
- **Browser Settings:** Cookies and 128-bit encryption enabled. DHTML recommended for optimal performance.
- **Internet Connection:** High-speed LAN/T1, cable, or DSL connection with support for SSL
- **Software:** Latest version of Adobe Acrobat Reader to view PDF files

What level of access do I have?

You can determine your access level by answering the following questions based upon content visible on the **Reports Home** screen:

1. Do you see a section labeled **Run Custom Reports**?
 - a. Click the **Medical** folder under **Run Custom Reports**
 - b. If “Bill Count by Month” is listed first, you have **Expanded** access.
 - c. If “Bill Count by Month” is not listed first, Click the **Financial** folder then Click **Premium vs Claims-Incurred – UNDERWRITING** folder under **Run Custom Reports** and go to Question 2.
2. Which report is listed first under the **Financial>Premium vs Claims-Incurred - UNDERWRITING** folder?
 - a. If “Premium vs Claims Incurred Including IBNR - Underwriting - Basic” is listed first, you have **Select** access.
 - b. If “Premium vs Claims Incurred Including IBNR - Underwriting - Non-Standard - Core” is listed first, you have **Standard** access.

Or you can determine your access level by opening the Financial folder and viewing the reports that are available.



- If you see both Claim Expenses by Size of Payment and Claim Expenses by Size of Payment – Core, you have **Select** access.
- If you see only Claim Expenses by Size of Payment – Core, you have **Standard** access.
- If you see Financial Managed Ad Hoc, you have **Expanded** access.

How do I change my access level?

Contact your representative for more information about buy-ups to higher levels of reporting or switching your security level (e.g., confidential vs. non-confidential).



What should I do if I have access to the wrong policy?

Please contact eServices Customer Reporting End User Support immediately if you have unauthorized access to a policy.

All individuals using the eServices Customer Reporting application are legally obligated to refrain from using the reporting application for abusive, fraudulent, or otherwise illegal purposes—including, but not limited to, viewing information obtained via unauthorized access to a customer policy.

Why do I have access to multiple policies?

There are a few legitimate reasons why you would have access to multiple policies. First, your role may require you to access information for different customers. Brokers are a common example.

Second, a parent company may identify its distinct business divisions by assigning each to a different policy. By doing so, the parent company can perform a company-wide analysis by selecting all the policy numbers or perform a targeted study by selecting the number of a specific division. UnitedHealth Group is a real-world example of a parent company. It is comprised of several divisions including UnitedHealthcare, Uniprise, and Ingenix, among others. To simplify reporting, UnitedHealth Group assigns a separate policy number to each of these divisions.

Finally, a company may identify the different products within its plan design by assigning each to a different policy. For example, you could have one policy number assigned to your Definity® health care plan and another to your PPO.

Can I pick and choose which reports I get?

No. The reports contained at each of the three main service levels (Standard, Select, and Expanded) were identified in conjunction with representatives from the business community. If the information found in your set of reports does not address a specific need, please contact your representative for other reporting options.



Why don't I have access to confidential reports?

First, only self-funded (ASO) customers have access to confidential reports. Customers with a fully insured funding arrangement are legally barred from viewing the Protected Health Information (PHI) contained in confidential reports.

Second, ASO customers must request confidential access; so, if you are an ASO customer and do not have access to confidential reports, you, or someone else in your group has not requested confidential reports.

Contact your representative for more information about your security level.

Where can I get a census report?

Please contact your representative for assistance in obtaining the information you need.

Where can I find membership/eligibility information?

eServices Customer Reporting contains three reports that summarize your membership within a selected time frame. Membership reports are not the same as the eligibility reports available through Employer eServices. Membership reports do not provide information regarding a particular member's eligibility status.

Eligibility information is available via the **Enrollment** portion of the Employer eServices site. Enrollment services let you add new, term, or reinstate enrollees, as well as view and modify an individual's existing enrollment information.

Timing/Availability of Data and Reports

When is the latest data available?

Typically, all data from the prior month is added to the reporting system by the 10th workday of the current month. For example, May's data is added in June, June's is added in July, and so on. Once a new month of data is available, you can use it to run your custom reports.

Note: Weekends and holidays are not working days; therefore, the 10th workday can come as early as the 12th or as late as the 15th day of the month.

When are my automated reports delivered?

Due to low utilization, Automated Reports that have a duplicate Custom Report available, will be discontinued after April 2024.

Each report in your automated reporting package is delivered in a batch process that begins shortly after the latest data is added and ends on or before the 20th workday of the month. Since reports are systematically produced and delivered over several days, you are encouraged to routinely check the Automated Reports section of the Reports Home screen for delivery updates throughout this time period.

Note: Weekends and holidays are not working days; therefore, the 20th workday can come as early as the 26th or as late as the 31st day of the month.

How often are my automated reports delivered?

Two factors dictate how often you will receive automated reports:

- Your funding arrangement, and
- The number of subscribers in your plan

Funding Arrangement	Subscriber Count	Frequency
ASO	Any Number	Monthly
Mixed*		
Fully Insured	200 or more	Quarterly
	100-199	Annually*
* Frequency may increase for customers affiliated with broker incentive programs.		
Note: Frequency does not change with periodic fluctuations to your subscriber count.		

Report Results

Why are some results negative dollar amounts?

Typically, negative dollar amounts reflect adjustments made for claims paid during a prior period. If you have questions about the negative dollar amounts that appear on your report, contact your representative for more information.

Why is there a Subscriber Number of “9999999999”?

A Subscriber Number of “9999999999” is the default value for all “unknown” subscribers and is typically used when a transaction is processed for multiple subscribers. Examples of situations where this might occur are bulk adjustments and recoveries, capitated payments, and NYHCRA surcharges.

Why do I see claims with structure I don’t have?

There are occasions when a financial report may contain an unfamiliar structure value. These values may appear when manual adjustments are made to the claim. Manual adjustments occur outside the normal controls set in place for financial accounting.

If you are unfamiliar with the business structure applied to your organization, please contact your representative for more information.

Why do the results of financial reports differ from Medical and Managed Pharmacy reports?

The results of financial reports differ from Medical and Managed Pharmacy reports for two predominant reasons: dates and data.

1. **Dates** – there is an average delay of 2.5 days between the date a claim is processed for payment and the date the processed claim is booked to the financial accounting system.

Dates reference a point in time during which a particular set of activities took place. Medical and Managed Pharmacy reports are based on the dates information derived from claims were entered into the claim payment system—process dates. Financial reports, on the other hand, are based on the dates processed claims were logged into the financial accounting system—book dates.

Since there is a delay between the date a claim is processed and the date the claim is booked to the financial accounting system, there will inevitably



be some claims processed at the end of one month that are not booked until the start of the next one.

Therefore, any claims processed at months' end are not reported in that month's financial reports, while claims booked at the beginning of the month are not reported in that month's Medical and Managed Pharmacy reports.

2. **Data** – there are different sets of information used to produce a financial report versus a Medical or Managed Pharmacy report.

Another factor that may be driving the differences you are seeing is the actual content data itself. Financial data is streamlined to contain only information about transaction-related activity for claim payments. This includes special transactions such as manual adjustments, bulk refunds, and reversals—items not considered with Medical and Managed Pharmacy reports. Furthermore, whereas Medical reports are limited to medical coverage and Managed Pharmacy reports to Managed Pharmacy coverage, many financial reports include data for multiple lines of coverage (e.g., medical, Managed Pharmacy, dental, vision, etc.).

However, financial data does not include details for ineligible charges, discounts, cost sharing, coordination of benefits and other provisions of your plan design. Those details are found in the statistical claim data used to generate Medical and Managed Pharmacy reports—making these sets of reports ideal for tracking the utilization and performance of your plan.

Why do the results of financial reports differ from billing and banking reports?

Billing reports do not include information for self-funded (ASO) customers. Therefore, if your benefit program includes an ASO portion, those dollars appear in your financial reports, but do not appear in your billing reports.

The results of your banking reports are subject to the time lapses typical of the check clearing process. Therefore, funds that have yet to clear may not show up on your banking report, but those same dollars would appear in your financial reports regardless of whether the check cleared or not.

Billing reports are available via the “Billing” portion of Employer eServices. Financial reports are available via the “Reporting” portion of Employer eServices.



Why do the results of my report differ from the ones my representative gave me?

There are a number of valid reasons why your report results might not match the ones your representative gave you. Before you contact your representative about the discrepancy, please ask yourself the following questions:

1. Were identical parameters used to create the reports? If any of the parameters (e.g., population, dates, etc.) used to create one of the reports differ from the other, it is more than likely the results of those reports will also differ.
2. Was data added to the reporting system between the times the two reports were run? Each month, all 36 months inpatient and outpatient event data is refreshed, along with the past 12 months of membership, 11 months of COSMOS, and six months of UNet capitation data. Therefore, even if the parameters are identical, the results of one of your reports may reflect more current information than the other report.

If you are unable to determine the cause of the disparity, please contact the representative that supplied you with the report for assistance.

Data

How many months of data are available?

eServices Customer Reporting maintains a rolling 36 months of book, process, and membership data. As the most recent month of data becomes available, the oldest month of data is removed from the system. For example, when January's data was added during February 2022, the data for January 2019 was removed.

Since a claim can be booked or processed one or more months after a service was provided, the list of service dates will include months that precede the 36 months of book and process dates. For example, if the current 36 months of book dates extend back to February 2019, the data from that time frame will likely contain claims for services provided during January 2019 and prior.

Why are there more than 36 months of service dates?

Since a claim can be booked or processed months after a service was provided, the list of service dates will include months that precede the 36 months of book and process dates. For example, if the current 36 months of book dates extend back to February 2019, the data from that time frame will likely contain claims for services provided during January 2019 and prior.

What are the various date parameter definitions?

Membership Date

A point in time in which an individual participated in a given benefit.

Service Date

A point in time in which a benefit was used (i.e., a service was rendered/claim was incurred).

Process Date

A point in time in which information derived from a claim was entered into the claim payment system.

Book Date

A point in time in which a carrier's payment for a claim was registered to the financial accounting system.

Bill Date

A point in time in which an invoice was distributed to a customer for payment of an insurance premium.



How do I view information about a specific claimant?

UnitedHealth Group values customer/patient confidentiality; therefore, health care and benefit information for specific claimants is not readily available via eServices Customer Reporting.

While the “confidential” versions of the Detail Payment and Large Loss Claim Payment reports do contain Protected Health Information (PHI), the information conveyed in these reports is primarily tied to payment details—not diagnosis related information. And, because they do contain PHI, security requirements make these two reports available to self-funded (ASO) customers only.

If you have questions about PHI or the need for claimant-specific benefit information, please contact your representative.

How do I get a copy of business structure used in eServices Customer Reporting?

Contact your representative and ask for a copy of your plan design. This information is not readily available via the eServices Customer Reporting application.



Known Issues

What if I have trouble exporting my report?

If you are having trouble exporting, it is likely your report contains too many rows to export at one time. Try exporting your report in smaller segments by exporting one page of results at a time.

If you are unable to work around this issue, please contact your account representative.

Why did I receive an error message “exceeds row limitation” when I ran my report?

This error message appears if your report contains more than 60,000 rows. Your report will not run unless you break it into smaller segments that will bring back less data, such as limiting it on structure. For example, instead of running one report for Suffixes A, B, C, D; run one report for Suffixes A & B and another for C & D.

If you are unable to work around this issue, please contact your account representative.



Training, Help, and “How To” Steps

What types of training are available?

Employer eServices Cost & Utilization Reporting online help lets you view how to steps along with access to various reference materials.

Do not forget to consult Online Help at any time for a full and detailed explanation of the terminology, procedures, and reports when using the eServices Customer Reporting application.

How do I run a custom report?

Custom reports are run interactively via the eServices Customer Reporting application. This interactive process lets you set the conditions you want to investigate. These conditions are established via the answers you supply to a series of questions called “options.”

Options vary from one report to the next, but there are at least two conditions that must be set for all reports—the population and time period you want to investigate. The remaining options let you limit the results of your report and add details to it. To minimize confusion, the processes of limiting results and adding details are independently explored and explained.

Select a Report

Before you can set your reporting conditions, you have to pick the report that will help you achieve the goal of your study. If you are wondering which report will help you achieve your goal, Online Help contains a full description of each one.

Once you know which report you want to run, the Reports Home screen provides an easy way to begin.

1. Locate the Run Custom Reports section of the “Reports Home” screen.
2. Click the “Report Category” folder containing the report you want to run.
 - Opens a list of reports by category.
3. Click the link to the report you want to run.
 - After you select a report, the “Option” screen appears.



Select a Population

The first option of any report sets the population you want to investigate. Your population is the pool of individuals associated with your Policy Number. You can investigate the population in full or a predefined segment of it.

Investigate the Full Population

You can put your entire population under the microscope by selecting your Policy Number from the option screens. To do this, you must first clarify that you do not want to run the report with a predefined filter and then select your Policy Number.

From the option screen:

1. Select 1. Policy Number
2. Follow the onscreen instructions for the remaining steps.
3. Click Next.

From the next option screen:

1. Select your Policy Number from the “Available” field.
2. Follow the onscreen instructions for any remaining options.
3. Click Next.

Investigate a Predefined Segment of the Population

Suppose you want to target salaried employees in your study or exclude non-union members from another. In cases where you need to run reports on targeted segments of your organization, you can leverage the business units you defined during case installation to create a Group Segment Filter that identifies one or more of these units. You can then use the filters to create the focused reports you need.

From the option screen:

1. Select a Group Segment Filter from the “Available” box.
2. Follow the onscreen instructions for the remaining steps.
3. Click Next.

Select a Time Period

When investigating benefits, time is truly relative. The dates you choose always reference a point in time during which a particular set of activities took place. These activities occur within the population you identify and in relation to one or more benefits.



To select a time period, from the option screen:

1. Click the radio button for the type of activity you want to investigate.
2. Follow the onscreen instructions for the remaining steps.
3. Click Next.

From the next option screen:

1. Select the dates you want to investigate.
2. Follow the onscreen instructions for any remaining options.
3. Click Next.

There are several sets of activities you can track via eServices Customer Reporting. The most common activities are:

- **Membership** – participation in a given benefit
- **Service** – use of a benefit for which a claim is incurred
- **Process** – entry into a payment system of information derived from a claim
- **Book** – entry into a financial accounting system of payment by a carrier for a claim
- **Bill** – distribution of an invoice to a customer for payment of an insurance premium

The activities you can track differ by report. In fact, this is one of the primary differences between the four report categories.

- **Financial reports** – track “service” and/or “book” activity (unless premiums are referenced in the report; then track “service” and/or “bill/book”).
- **Managed Pharmacy reports** – track “service” and/or “process” activity of Managed Pharmacy claims.
- **Medical reports** – track “service” and/or “process” activity of medical benefit claims.
- **Membership reports** – track “membership” activity. (Since membership is the only activity tracked for these reports, you only need to select the time frame you want to investigate.)



What is a compound report and how does it differ from other reports?

A compound report is comprised of two or more sections. Each section is actually an individual report that can be opened separately via a link located below it. When you open a section, the system automatically reproduces the report that was used to create it—a copy of which is accessible via your list of “Recent Reports.”

The full compound report only offers a limited set of reporting features. However, once a section is opened, it can be formatted and manipulated like any other report.

Feature	Reports	Compound Reports
Sections of Output	One	Two or more
Menus	File, View, Data, and Format	File
Toolbar	Numerous items appear in the toolbar	
Attribute Forms	Yes	No
Banding	Yes	No
Drill*	Yes	No
Export	Yes, with exporting options	Yes, without exporting options
Filter on Selections*	Yes	No
Graph	Yes	No
Grid and Graph	Yes	No
Lock Headers	Yes	No
Merge Headers	Yes	No
Move	Yes	No
Outline	Yes	No
Page-by	Yes	No
PDF	Yes	No
Pivot	Yes	No
Print	Yes, with printing options	Yes, without printing options
Report Filter	Yes	No
Save as Template	Yes	No
Sort	Yes	No
Style	Yes	No
Toggle Thresholds	Yes	No
Totals	Yes	No

* Only available to customers with Expanded services



Differences between Reports and Compound Reports

The following are compound reports:

- Claim Experience
- Cost and Utilization by Procedure
- Cost and Utilization Summary
- Health Care Cost Management Summary
- Inpatient Utilization and Costs by Admission Type
- Managed Pharmacy Plan Performance
- Managed Pharmacy Critical Indicators
- Managed Pharmacy Utilization by Age Group
- Membership with Demographic and Geographic Factors
- Outpatient Utilization by Diagnosis
- Premium vs. Claims – Paid
- Top Drug Utilization Ranked by Total Net Paid
- Top Drug Utilization Ranked by Volume
- Top Hospitals Ranked by Total Net Paid
- Top Physicians Ranked by Total Net Paid
- Top Therapeutic Class Utilization Ranked by Total Net Paid
- Top Therapeutic Class Utilization Ranked by Volume
- Utilization and Costs by Provider Type
- Utilization by Age Group

Where are my automated reports?

Automated reports are sorted into folders and housed on a separate page within eServices Customer Reporting. This page is accessible via a link near the upper left of the Summary screen.

For most customers, automated reports are placed in a folder that corresponds to the month in which the reports were produced. However, if you have access to multiple groups, a separate folder exists for each group. Within each group's folder are the monthly folders, and within the monthly folders—your automated reports.



How do I define a specific segment of my population?

When you need to run reports on targeted segments of your organization, you can leverage the business units you defined during case installation to create a Group Segment Filter that identifies one or more of those business units. You can then use the filters to create the focused reports you need.

For example, suppose you want to run two sets of reports—one for salaried and another for hourly employees. The only way to identify these two distinct business segments is to assign a code to individuals in one group, and another code to those in the other. This coding takes place during your case installation in consult with your representative. (Contact your representative for more details about your business structure.)

Task	Step	Action
Create a Group Segment Filter	1	Go to the Reports Home screen or click Tools .
	2	Under Reporting Tools , click Create and Modify Group Segment Filters .
When the Group Segment Filter screen opens:	1	In the Name field, type a name for your filter.
	2	[Optional] In the Description field, type a description for your filter.
	3	Click the Create button.
When the next screen opens, select a Policy Number:	1	If Attribute box is blank, click Add Tribute .
	2	Type the Policy number in the Search box.
	3	Click the Search icon.
	4	Select Operator .
	5	In the Elements field, select a Policy Number .
	6	Click Move to Selected .
	7	Click the Append button.
To narrow the filter to a specific group of members [optional]:	1	In Expression group 1 of 1 , under Policy Numbers, click Add Attribute .
Add Attribute – In the Attributes list:	1	<ul style="list-style-type: none"> To narrow by Suffix values, select Suffix. To narrow by Account values, select Account. To narrow by Plan Variation values, select Plan Variation. To narrow by Report Code values, select Report Code. To narrow by Franchise Code 1 values, select Franchise Code 1. To narrow by Franchise Code 2 values, select Franchise Code 2. Select the codes from the Elements field.

Add Attribute – In the Operators list:	1	<ul style="list-style-type: none"> To include all values less than a specific value, click <, then in the Elements list, click that value. To include all values greater than a specific value, click >, then in the Elements list, click that value. To exclude one value only, click <>, then in the Elements list, click that value. To include one value only, click =, then in the Elements list, click that value. To include all values greater than or equal to a specific value, click >=, then in the Elements list, click that value. To include all values less than or equal to a value, click <=, then in the Elements list, click that value. To include all values between two values, click between, then in the Elements list, click those values. To include a range of values, click in, then in the Elements list, click those values. To exclude a range of values, click not in, then in the Elements list, click those values.
	2	Click Move to Selected .
	3	When the values appear in the Selected Elements list, click Append .
	4	[Optional] To further the filter, click Add Attribute , [Optional] Repeat Steps 2-6.
	5	When you are finished, click Save .



How do I add more details to my custom report (Report On)?

Adding details to your report lets you distribute results into new and meaningful areas of study. Attributes are added to reports via the Report On option. The Report On option is optional, and each report contains a different set of attributes to pick from.

NOTE: This option is not available for the following reports: Claim Expenses by Size of Payment – Core, and Premium vs. Claims Including IBNR- Underwriting – Non-Standard – Core.

From the option screen:

1. Click the attribute you want to add to your investigation.
2. Click Move to Selected arrow.
3. Follow the onscreen instructions for the remaining steps.
4. Click the Next button.

How do I limit the information in my custom report (Filter On)?

In addition to setting limits on the population and the time period you want to investigate, each report contains a set of attributes from which you can further refine your results. These attributes are listed within the Filter On option. The Filter On option is optional, and each report contains a different set of attributes to pick from.

NOTE: This option is not available for the following reports: Claim Expenses by Size of Payment – Core, and Premium vs. Claims Including IBNR- Underwriting – Non-Standard – Core.

In essence, an attribute is a word or phrase used to categorize a set of related values. A simple example is “gender.” Gender categorizes both males and females; hence, males and females are values of gender. If you opt to “filter on” gender, you must decide which gender you want to investigate—males or females.

To filter a value of a simple attribute, go to a report’s option screen:

1. Click the **attribute** containing the values you want to investigate.
2. Click **Move to Selected** arrow.
3. Click the **Next** button.



From the next set of options:

1. Click the **values** you want to investigate.
2. Click **Move to Selected** arrow.

Some attributes categorize values at multiple levels of detail (from general to specific) called a “hierarchy.” For example, “relationship” is divided into 4 distinct levels—category, summary, group, and detail. Your investigation may warrant a study of all subscribers (category level) or just those identified as a surviving spouse (detail level).

Some reports have additional options that require you to set limits on the data. For example, you must limit membership reports to one type of coverage (e.g., Medical, Managed Pharmacy, etc.). Therefore, if you select “Managed Pharmacy” coverage when running a membership report, the results will not contain any information for medical, vision, or any other type of coverage.

Can I save a report and rerun it for a different time frame (or some other parameter)?

Yes. From the report results screen, click **Save** in the toolbar to open the “Save As” dialogue box.

Type a name for the report into the Save As field and click the **Save** button. By default, the report is saved to do the following when accessed:

- The option screen will appear.
- Your original selections are retained for all options.

To access your saved report, click **Tools** from the navigation bar and then click **Manage Your Report Templates**.

Can I save or change the system’s default export and print settings?

The system’s default export and print settings can be adjusted from the Preferences screen. To view the Preferences screen, click **Tools** from the main navigation bar, then click the **Preferences** link.

The left side of the Preferences screen contains links to the various topics you can edit, including Export and Print. Each topic contains several settings that you can adjust to your liking.

Remember to click **Apply** to finalize your settings for each topic you modify.



Where can I get more information about a specific report?

Online Help contains details of each report including a sample report. To get help with a specific report while working within the reporting application:

1. Click the **Help** link in the Navigation menu.
2. Click the **Reports** tab.
3. Select the link for the report you want to learn more about.