

ClaimsRevenue™ Connects Claim Validation With ERA Data to Help Practices Reduce Future Denials

New healthcare claims platform uses a practice's own remittance history to identify recurring denial patterns and improve future claim reviews

ST PETERSBURG, FL, UNITED STATES, August 27, 2026 /EINPresswire.com/ -- Every time a healthcare payer processes a medical claim, it sends valuable information back to the provider about what was paid, adjusted, or denied. ClaimsRevenue™ is building that information into the claims process so independent healthcare practices can use what happened to previous claims to help improve the ones they submit next.



The graphic is a dark blue announcement card for ClaimsRevenue. At the top left is the ClaimsRevenue logo with a bar chart icon. To the right of the logo is the text "ClaimsRevenue™". Below the logo is a photo of Sami Quazi, Founder & Chairman of ClaimsRevenue, with his name and title below it. To the right of the photo is the text "I'M PROUD TO ANNOUNCE I FOUNDED CLAIMSREVENUE™". Below this is a paragraph: "After spending three years developing and refining claims accuracy technology and processes at MoodRx—and achieving a denial rate under 0.5%—I founded ClaimsRevenue™ to bring that same expertise to other healthcare practices." Below the paragraph is a calendar icon and the text "PUBLIC LAUNCH SEPTEMBER 1, 2026". Below the calendar icon is a row of five icons with text: "CATCH CLAIM ISSUES BEFORE SUBMISSION", "UNCOVER DENIAL TRENDS & PAYER BEHAVIOR", "LEARN FROM YOUR OWN DATA TO IMPROVE FUTURE ACCURACY", "SPEND LESS TIME ON BILLING & MORE ON PATIENTS", and "BUILT FOR INDEPENDENT HEALTHCARE PRACTICES". At the bottom left is a bar chart icon and the text "THREE YEARS. REAL RESULTS. NOW WE'RE BRINGING WHAT WE LEARNED TO YOU." At the bottom right is a shield icon and the text "YOUR PRACTICE EARNED THE REVENUE. PROTECT IT."

ClaimsRevenue, which launches September 1, connects two core capabilities, Claims Validator™ and ERA Analyzer™, to create a continuous feedback loop between claim preparation and payer results.

The concept is straightforward. Claims Validator reviews professional medical claims before submission to identify potential errors, inconsistencies, and other issues that may contribute to denials or payment delays.

ERA Analyzer works on the other side of the process. It analyzes the Electronic Remittance Advice, or ERA, received after a payer processes a claim and helps the practice understand denials, adjustments, and recurring patterns.

ClaimsRevenue then brings those two sides together.

"Most practices already have an enormous amount of useful information sitting in their remittance history," said Sami Quazi, Founder of ClaimsRevenue. "Every denial tells you something. The real value comes when you can take what you learned from those claims and



Every denial tells you something. ClaimsRevenue helps practices use what they learned from yesterday's claims to help prevent tomorrow's denials."

Sami Quazi, Founder

use it before the next claim goes out the door."

Learning From the Practice's Own Claims

Medical billing rules can vary by payer, provider, procedure, diagnosis, and other characteristics of a claim.

That means general claim rules are only part of the picture.

A practice's own claims history can provide another source of information about the issues it encounters most often.

For example, if previous claims repeatedly encounter the same type of denial or adjustment, identifying that pattern can help the practice pay closer attention to similar issues when preparing future claims.

ClaimsRevenue is designed to make that history useful.

As additional ERAs are received and analyzed, ClaimsRevenue can identify recurring denial trends within the practice and incorporate that information into future claim reviews.

The result is a system that becomes more informed by the practice's own experience over time.

Moving Denial Intelligence Earlier in the Process

Traditionally, much of the work surrounding claim denials happens after the payer has already rejected or adjusted the claim.

By that point, the care has been provided and the claim has been submitted. Staff may then have to research the payer response, determine what happened, make corrections, resubmit the claim, and wait again for adjudication.

ClaimsRevenue is designed to move more of that knowledge to the point where it can be most useful: before the next claim is submitted.

"If we know a practice has encountered a particular problem before, we shouldn't ignore that information when reviewing its next claims," Quazi said. "The goal is to learn from what actually happened and put that knowledge back to work for the practice."

Built for Independent Healthcare Practices

ClaimsRevenue is designed for U.S. healthcare provider offices submitting professional medical claims using the CMS-1500/837P format, including:

- Primary care practices
- Physician specialty practices
- Medical and surgical practices
- Behavioral health and mental health practices
- Physical therapy practices
- Occupational therapy practices
- Other physician and allied health professional practices

The platform supports both individual and multi-provider practices, including organizations with multiple billing entities or tax identification numbers.

ClaimsRevenue is designed to complement the practice's existing revenue cycle by providing additional claim validation, remittance analysis, and practice-specific insight.

From Claim Submission to Payer Response and Back Again

ClaimsRevenue was built around the idea that claim preparation and claim results should not exist as separate processes.

Claims Validator looks forward by reviewing the claim that is about to be submitted.

ERA Analyzer looks backward by examining what happened to claims that have already been processed.

Connecting the two allows previous payer results to provide additional context for future claim reviews.

For independent practices with limited billing and administrative resources, that can turn information they already receive into something much more useful.

"Small practices don't need more data," Quazi said. "They need the data they already have to tell them something useful. If yesterday's denial can help prevent tomorrow's denial, that's information worth using."

ClaimsRevenue will officially launch to U.S. healthcare practices on September 1, 2026.

Learn more and watch a demonstration of ClaimsRevenue at ClaimsRevenue.com.

About ClaimsRevenue

ClaimsRevenue is a healthcare technology platform built for independent medical and allied health practices. The platform helps practices validate professional medical claims before submission, analyze Electronic Remittance Advice, and identify recurring patterns that may contribute to claim denials, payment delays, and lost revenue.

By connecting pre-submission claim validation with post-adjudication remittance analysis, ClaimsRevenue helps healthcare provider offices use their own claims experience to improve future revenue-cycle performance.

ClaimsRevenue is operated by MoodRx LLC, d/b/a ClaimsRevenue, a Florida limited liability company.

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