



# eClaims Reference Guide

## Dental Secondary

Blue Cross and Blue Shield of Alabama requires healthcare providers to send claims electronically. Paper submission of claims are not accepted. Use this reference guide for filing electronic dental claims.

- 1 Log in to **ProviderAccess**, hover over **Patient & Claim** and click on “Claims Entry (eClaims).”

The screenshot shows the ProviderAccess dashboard. At the top left is the BlueCross BlueShield of Alabama logo. The main header area includes the text "ProviderAccess" and "Welcome, John Blue". On the right side of the header, there are links for "Feedback", "Profile", "Users", and "Log out", along with the text "Logged in as: JBlue". Below the header is a navigation menu with tabs for "Home", "Resources", "Patient & Claim", "Payment & Refund", and "Profiles & Reports". A search bar is located to the right of the "Profiles & Reports" tab. Under the "Patient & Claim" tab, there are three columns of links: "Patient", "Claim", and "Referrals". The "Claim" column has a yellow box around "Claim Entry (eClaims)" with a circled "1" next to it. Other links in the "Claim" column include "Advanced Explanation Of Benefits Request", "Audit Report - eClaims", "Audit Report - Vendor Submissions", "Claim Status", and "Medical Record Request".

- 2 Choose the correct **Business** and **Provider** from the drop-down boxes. Next, click the “New Claim” tab.

The screenshot shows the "Claim Entry (eClaims)" form. At the top, there are five input fields: "Business" (with a dropdown menu showing "ABC PROVIDER"), "Provider" (with a dropdown menu showing "JOHN BLUE"), "NPI" (with a dropdown menu showing "1234567890"), "Patient" (empty), and "Contract Number" (empty). Below these fields is the heading "Claim Entry (eClaims)". At the bottom of the form, there are three buttons: "Saved Claims", "Submitted Claims", and "New Claim" (with a plus sign icon). A "print" button with a printer icon is located in the bottom right corner.

- Choose your patient from the **Recent Patients** list and click “Continue” to populate the required fields. If your patient is not listed, enter the contract number, first and last name, and date of birth, then click “Continue.”

BlueCross BlueShield of Alabama **ProviderAccess** Welcome, John Blue Feedback  
Profile | Users | Log out

Logged in as: JBlue

Home Resources **Patient & Claim** Payment & Refund Profiles & Reports Search

Business: ABC PROVIDER Provider: JOHN BLUE NPI: 1234567890 Patient: [Select Patient] Contract Number: [Contract Number]

Recent Patients

Contract Number	Patient Name
XAD123456789	JOHN DOE
XAD123456789	JANE DOE
XAD123456789	JUNE DOE
XAD123456789	JACK DOE
XAD123456789	JILL DOE
XAD123456789	JAKE DOE
XAD123456789	JUDE DOE
XAD123456789	JADE DOE

Contract Number \*

Don't have the contract number?

First Name \*  Middle Initial

Last Name \*

Date of Birth \*    Gender

Clear Continue

**Note:** There may be a few exceptions where the patient cannot be located in the system (e.g., a new member or out-of-state member). There is an option to bypass this screen and manually enter the information. Hit the “Continue” button twice and then select “Bypass Verification” as shown in the image to the right. You will have to manually key the information, it will not be automatically populated.

Invalid/Missing Subscriber/Insured ID

Contract Number \* XAD123456789

Don't have the contract number?

First Name \* JOHN Middle Initial

Last Name \* DOE

Date of Birth \* 01/02/1960    Gender

Bypass Verification Clear Continue

4 Choose “Dental” and “Secondary” as your **Claim Type** and add your **Patient Account Number**. The Patient Account Number is a unique identifier assigned by you, for your patients (e.g., chart number). Click “Next.”

4

## Dental Claim

Patient Line Information Claim Information

### Patient Information

#### Claim Type \*

- Dental  Predetermination  Professional  
 Primary  Secondary

### Patient Information

Click to Edit

Contract Number \* XAD123456789

First Name \* JOHN

Middle Initial

Last Name \* DOE

Date of Birth \* 05/28/1995

Gender \* Male

Address 1 \* 123 ANYSTREET

Address 2

City \* BIRMINGHAM

State \* Alabama

Zip Code \* 35244

Relationship to Insured \* 18 - Self

#### Patient Account Number \*

1234567

Accept Assignment? \*

- Yes  
 No

Do you have on file a signed statement by the patient authorizing the release of medical billing? \*

- Yes  
 Informed Consent

Next

Back to Claim List

Submit Claim

**Note:** Once you click the “Next” button, you will not be able to return to this page. If you realize you entered incorrect information on this page, delete the claim and start a **new claim**.

**\*Required fields**

5 Enter the **Claim Line** information and click “Add.” Repeat until all lines for the date of service have been added. The blue boxes with a question mark can be clicked to provide additional assistance.

Business 
Contract Number

Provider

NPI

Patient

### Dental Claim

Patient 
Line Information
Claim Information

### Dental Line Information

5

#### Enter Claim Line

DATE OF SERVICE *	PLACE OF SERVICE *	ORAL CAVITY DESIGNATION	TOOTH NUMBER	TOOTH SURFACE(S)	PROCEDURE CODE *	NUMBER OF PROCEDURES *	CHARGES *
<input type="text"/>	<input style="width: 100%;" type="button" value="?"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>			

#### Place of Service Codes

Code	Code Description
02	Telehealth
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
35	Adult Living Care Facility

**Note:** For orthodontic claim submissions, file the initial service banding fee with one of the appliance (braces) CDT codes: D8070, D8080 or D8090. Then, file CDT code D8670 for monthly adjustment services with at least 21 days between the visits.

**\*Required fields**

6 You may key up to 50 lines on this screen. After entering all lines, click "Next."

## Dental Claim

Patient

**Line Information**

Claim Information

### Dental Line Information

#### Enter Claim Line

DATE OF SERVICE *	PLACE OF SERVICE *	ORAL CAVITY DESIGNATION	TOOTH NUMBER	TOOTH SURFACE(S)	PROCEDURE CODE *	NUMBER OF PROCEDURES *	CHARGES *
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add Cancel

#### Claim Lines

Line #	Date(s) of Service	Place of Service	Oral Cavity Designation	Tooth Number	Tooth Surface(s)	Procedure Code	Number of Procedures	Charges	Actions
1	12/14/2023	11	10	04	B	D2383	1	213.00	
2	12/14/2023	11	20	12	D	D2383	1	213.00	

Next

Back to Claim List

Submit Claim

**Note:** Clicking "Back to Claim List" will place your claim in the Saved Claims section so you can return to it later.

7 If multiple addresses appear, select the address where the service was provided and choose any boxes that are applicable on the **Claim Information** screen then click “Next.” **Note:** If one of your locations is not present, contact Credentialing at 205-220-9545.

## Dental Claim

Patient 

Line Information 

**Claim Information**

Other Insurance

Adjustments

### Claim Information

Select	Billing / Service Address	Primary Specialty Description / Facility Type(s) of Service
<input checked="" type="radio"/>	123 ANYSTREET, BIRMINGHAM, AL 35244	General Dentistry
<input type="radio"/>	321 ANYSTREET, BIRMINGHAM, AL 35244	General Dentistry

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This is a corrected claim.

This claim has an attachment control number.

7

Next

Back to Claim List

Submit Claim

8 Enter the primary insurance information in the required fields indicated by an asterisk and click “Next.”

## Dental Claim

Patient ✓ Line Information ✓ Claim Information ✓ **Other Insurance** Adjustments

### Other Insurance

#### Primary Insurance

##### Payer

Name *	<input type="text" value="ABC Provider"/>
Address 1	<input type="text"/>
Address 2	<input type="text"/>
City	<input type="text"/>
State	<input type="text" value="Select"/>
Zip Code	<input type="text"/>

##### Subscriber

Same As	<input type="text" value="Patient"/>
First Name *	<input type="text" value="Jane"/>
Middle Initial	<input type="text"/>
Last Name *	<input type="text" value="Doe"/>
Address 1	<input type="text"/>
Address 2	<input type="text"/>
City	<input type="text"/>
State	<input type="text" value="Select"/>
Zip Code	<input type="text"/>
Primary Member ID *	<input type="text" value="XAD1234567890"/>

8 Next

Back to Claim List

Submit Claim

9 Enter the primary insurance payment, adjustment, contractual information, and date of payment. Amounts entered in the Line Level Adjustments and Primary Payer Information fields **MUST** equal the total amount of the claim. Payment, adjustment and contractual amounts must be submitted for each line of the claim. Then click **Next**. Once all lines are entered, click **Submit Claim**.

### Dental Claim

Patient ✓
Line Information ✓
Claim Information ✓
Other Insurance ✓
Adjustments

#### Claim Adjustments

Line Level     Claim Level

#### Selected Claim Line

Line Number	Date(s) of Service	Place of Service	Oral Cavity Designation	Tooth Number	Tooth Surface(s)	Procedure Code	Number of Procedures	Charges
1	12/14/2023	11	10	04	B	D2383	1	213.00

#### Enter Adjustments

Enter the line level payment information from the primary payer.

#### Line Level Adjustments

	Group	Reason	Amount	Delete
1	▼	▼	\$ <input type="text"/>	✖
2	▼	▼	\$ <input type="text"/>	✖
3	▼	▼	\$ <input type="text"/>	✖
4	▼	▼	\$ <input type="text"/>	✖
5	▼	▼	\$ <input type="text"/>	✖
6	▼	▼	\$ <input type="text"/>	✖

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#### Primary Payer Information

Primary Payer	<input type="text" value="ABC PROVIDER"/>
Primary Member ID/HICN	<input type="text" value="XAD1234567890"/>
Amount Paid *	\$ <input type="text"/>
Payment Date *	<input type="text" value=""/>

Next Line

#### Claim Lines

Line Number	Date(s) of Service	Place of Service	Oral Cavity Designation	Tooth Number	Tooth Surface(s)	Procedure Code	Number of Procedures	Charges	Completed
1	12/14/2023	11	10	04	B	D2383	1	213.00	✖
2	12/14/2023	11	20	12	D	D2383	1	213.00	✖

1 to 2 of 2    < > Page 1 of 1

Back to Claim List
Submit Claim

**Note:** Visit the Reference for External Code Lists for a complete listing of Adjustment Reason Codes.

**10** Claims in the **Saved Claims** list have not been submitted to us for processing. Under the Actions heading, you can **Edit**, **Create a PDF** or **Delete** the claim. Clicking the Edit option will allow you to submit the claim.

## Claim Entry (eClaims)

Claim has been submitted successfully.

**Saved Claims**

Submitted Claims

New Claim 

10



Date Created	Date(s) of Service	Contract Number	Patient Name	Patient Account	Subscriber Name	Submitted Amount	Actions
01/17/2024	12/14/2023	XAD123456789	DOE JANE	1234567	DOE JANE	1125.00	  
01/17/2024	12/14/2023	XAD123456789	DOE JOHN	1234567	DOE JOHN	426.00	  
01/17/2024	12/14/2023	XAD123456789	DOE JANE	1234567	DOE JANE	426.00	  

**11** After the claim is submitted to Blue Cross, it will move into the **Submitted Claims** list. The last two weeks of submitted claims are shown by clicking the “Find Claim” button. You can also search for a specific claim using any of the search criteria.

You should also check your [Audit Reports](#), located in the Patient & Claim tab, after a claim is submitted. Review for any rejected claims, make the necessary changes and submit the claim.

Saved Claims**Submitted Claims**New Claim +

print

Searches with no search criteria entered will return claims submitted in the previous two weeks only. To expand the timeframe, enter specific search criteria.

### Claim Search

Date Created

Start Date

End Date

#### Patient

First Name

Last Name

Account

#### Subscriber

First Name

Last Name

Submitted Amount

Contract Number

Clear Form Find Claim

*For additional help, please contact:*

Provider eSolutions	1-205-220-6899
Provider Networks Consultant	1-866-904-4130

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The logo for BlueCross BlueShield of Alabama, featuring a blue cross with a white circle in the center, and a blue shield with a white caduceus symbol. To the right of the symbols, the text "BlueCross BlueShield of Alabama" is written in a bold, sans-serif font.

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