eClaims Reference Guide
Dental Secondary

BlueCross BlueShield of Alabama

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)."

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

3 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."

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.

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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."

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

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

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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 🔒		Provider 🔒	NPI	Patient 🔒	Contract Number
ABC PROVIDER ▼		JOHN BLUE	1234567890 ▼	JANE DOE	XAD123456789 ▼

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 *
	▼	▼	▼	▼ ▼ ▼ ▼ ▼			$

Add   Cancel

Next

Place of Service Codes

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

Back to Claim List   Submit Claim

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 *
[📅]	[▲▼]	[▲▼]	[▲▼]	[▲▼] [▲▼] [▲▼] [▲▼] [▲▼]	[ ]	[ ]	$ [ ]

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
●	123 ANYSTREET, BIRMINGHAM, AL 35244	General Dentistry
○	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 *	ABC Provider
Address 1	
Address 2	
City	
State	Select ⬍
Zip Code	

Subscriber

Same As	Patient
First Name *	Jane
Middle Initial	
Last Name *	Doe
Address 1	
Address 2	
City	
State	Select ⬍
Zip Code	
Primary Member ID *	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.**

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

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			$	✖
2			$	✖
3			$	✖
4			$	✖
5			$	✖
6			$	✖

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Primary Payer Information

Primary Payer	ABC PROVIDER
Primary Member ID/HICN	XAD1234567890
Amount Paid *	$
Payment Date *	

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	✖

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Back to Claim List   Submit Claim

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 ➕ | | | | | print |

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.

(11)

| 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
● Date of Service

Start Date

End Date

Patient

First Name

Last Name

Account

Subscriber

First Name

Last Name

Submitted Amount

Contract Number

Clear Form   **Find Claim**

BlueCross BlueShield
of Alabama

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