

ProviderAccess Professional Claims Submission Help

ProviderAccess eClaims allows healthcare providers to submit claims electronically to Blue Cross and Blue Shield of Alabama. Claim submission is supported for primary, secondary and tertiary payment. Claim entry screens are divided into five categories: Patient, Claim Information, Line Information, Other Insurance and Adjustments. Required fields are marked with an asterisk (*).

Patient

Claim Type: Professional

- **Primary:** A primary claim is filed when Blue Cross is the payer to adjudicate first.
- **Secondary:** A secondary claim is filed when Blue Cross is the payer to adjudicate after the primary payer.
- **Tertiary:** A tertiary claim is filed when Blue Cross is the payer to adjudicate after both the primary and secondary payers.

Patient Information: Patient contract number and demographic information is prepopulated using membership data from Blue Cross and Blue Shield of Alabama. If changes are required to the prepopulated information, use the "Edit" function. If the patient and/or sub-contract is outside the state, the user is responsible for populating those fields.

Edit: Edit patient information.

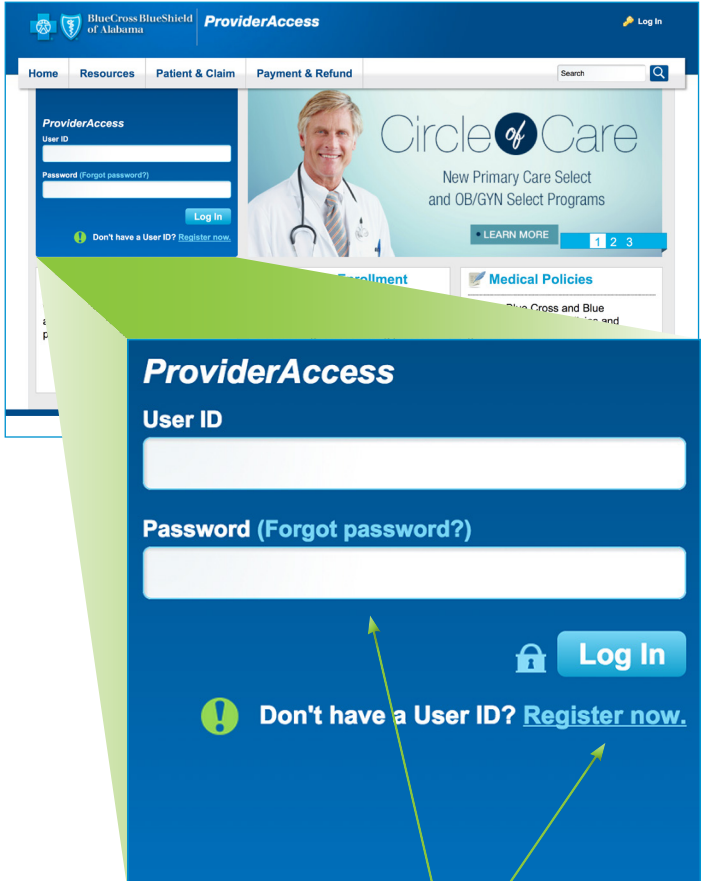
Subscriber Information: The subscriber's demographic information is prepopulated using membership data from Blue Cross and Blue Shield of Alabama. If changes are required to the prepopulated information, use the "Edit" function.
Edit: Edit subscriber information.

Patient Account Number: An identifying number unique to the patient that is assigned by the provider and used to post payments and easily retrieve the patient record. Letters and numbers are allowed. Special characters are not allowed.

Accept Assignment: Answering "Yes" indicates that the provider accepts Medicare assignment. Answering "No" indicates the provider does not accept Medicare assignment.

Release of Information: Answering "Yes" indicates that the provider has a signed statement by the patient authorizing the release of medical data to other organizations. Answering "I" indicates that the provider has informed consent to release medical information for conditions or diagnoses regulated by federal statutes.

Go to
AlabamaBlue.com/providers.



The image shows a screenshot of the ProviderAccess website. The top navigation bar includes 'Home', 'Resources', 'Patient & Claim', and 'Payment & Refund'. A search bar is located on the right. The main content area features a 'Circle of Care' banner for 'New Primary Care Select and OB/GYN Select Programs'. Below the banner is a login form with fields for 'User ID' and 'Password (Forgot password?)', a 'Log In' button, and a link for 'Don't have a User ID? Register now.' A green callout box is overlaid on the bottom right of the login form, pointing to the input fields and the 'Register now' link.

Enter your User ID and Password to login.
If you have not yet registered, then
click on "Register Now."

Line Information

Claim Line Items: Up to 50 line items may be keyed for a professional claim. As each line is keyed and saved, *eClaims* will present another line.

Diagnosis Code: Up to 12 diagnosis codes may be keyed. Diagnosis codes may be keyed with or without the decimal. Enter the diagnosis code in the field provided and press "Add" or the enter key. As additional diagnosis codes are entered, they will populate the fields available up to 12.

Date(s) of Service: Date may be keyed with or without the slash or chosen from the date selector (calendar) provided. Place of Service: The "Place of Service" code identifies the location where the service was rendered. You may key the two-digit place of service or choose from the drop-down list. Click on the Help (?) icon to view a list of Place of Service codes and their descriptions.

Procedure Code: Enter the CPT® or HCPCS code to report the medical service and/or procedure performed.

Modifier(s): Enter up to five modifiers to help identify a medical procedure.

Diagnosis Code Pointer(s): The diagnosis code pointer is used to "point" to the diagnosis code that relates to the service. Valid values are one through 12.

Charges: Enter the charges for each service. Charges may be keyed with or without the decimal.

Emergency Indicator: The "Emergency Indicator" is used to report whether or not the services rendered were related to an emergency. The field is defaulted to "No." If services are emergency related, select "Yes" from the drop-down box.

Days/Units: Used to report multiple visits, units of supplies, or mileage. Decimal values (.5, .75) are allowed.

Anesthesia Minutes: When the provider entering the claim is an anesthesiologist or CRNA, then the "Anesthesia Minutes" field will be presented. Enter the minutes or units. Decimal values (.5, .75) are allowed.

Procedure Code Description: A free-form description field used to provide additional information when a "Not Otherwise Classified" (NOC) procedure code is entered.

National Drug Code: All valid NDC numbers contain 11 digits. If the numbers on the packaging do not contain the required digits, add leading zeros (0) to fulfill the 11-digit requirement.

Example NDC on the package: 567 412 6

Actual number (5-4-2 format): 00567 0412 06

Submit electronically as: 00567041206

Unit(s): The unit field is to indicate the quantity of the drug. Decimal values are allowed.

Unit of Measure: Enter the unit of measure in which a measurement has been taken.

- Internal Unit
- Gram
- Milligram
- Milliliter
- Unit

Add/Cancel: Clicking "Add" will save the line item to the Claim Lines Table. Clicking "Cancel" does not save the line item and clears any data entered.

Next: Clicking "Next" will advance you to the next page.

Claim List: Clicking "Claim List" will navigate to the view that displays saved and submitted claims.

Submit Claim: Clicking "Submit Claim" will allow you to submit the claim to be processed without entering information on the claim information screen.

Claim Lines: Once the line item information is entered, it is populated in table form to allow viewing and/or editing of each line item. If editing is required, select the claim line.

X Icon: Clicking the "X" will delete the claim line.

Claim Information

The Claim Information screen is designed to gather relevant information regarding the specific claim being entered.

Billing Office Address/Service Location Address: If the provider has more than one location on file with Blue Cross and Blue Shield of Alabama, select the location where the service was rendered. Additionally, if the service was rendered somewhere other than the provider's office, provide the address where the service was rendered. Ambulance providers, see "Ambulance Transportation."

This is a corrected claim: Select this option if this is a corrected claim. The claim number of the original claim is required and may be found on the remittance advice.

The patient has made a payment toward this claim: Enter any amount the patient has paid toward this claim.

This claim is related to an accident: Select this option if the service(s) entered on the claim are related to an accident. The following will be required if "Auto" is selected: the date the accident occurred, the accident type, and the state abbreviation. Date may be keyed with or without the slash or chosen from the date selector (calendar) provided.

The patient was hospitalized: Select this option to enter date(s) of hospitalization if the service(s) was rendered to the patient while hospitalized. Date may be keyed with or without the slash or chosen from the date selector (calendar) provided.

This claim has an Onset of Current Illness or Symptoms:

Select this option to enter the date. Date may be keyed with or without the slash or chosen from the date selector (calendar) provided.

The patient is unable to work in current occupation:

Select this option to enter date(s) the patient was unable to work in the current occupation. Date may be keyed with or without the slash or chosen from the date selector (calendar) provided.

This claim has a Care Plan Oversight NPI: Select this option to enter the care plan oversight NPI or use the "NPI Lookup" search provided. The care plan oversight NPI is required for Medicare Advantage contracts. This is the NPI of the home health agency or hospice providing services covered by Medicare.

This claim has condition codes: Select this option to enter up to 12 condition codes. These codes are used to report additional condition information that applies to the claim. Valid code values may be obtained through the National Uniform Billing Committee (NUBC). Enter the condition code in the field provided and press "Add." As additional condition codes are entered, they will populate the fields available, up to 12.

The patient used an ambulance or non-emergency transportation: Select this option if the patient was transported by ambulance or non-emergency transportation. Enter the address where the patient was picked up and the address where the patient was dropped off. If the ambulance pickup location is an area that does not have an assigned address, enter a description of the area where the patient was picked up, e.g., intersection of Cross and Shield Street or mile marker 127.

This claim has a referring physician: Select this option to enter the name and NPI (or use the NPI Lookup search provided) of the provider who referred the patient or ordered and/or supervised the service(s) or supplies on the claim.

This claim is ESA related: Select this option to enter ESA information.

This claim is for reporting purposes only (no payment is being requested): Select this option to submit an informational claim for reporting purposes only.

- Submit claims for services rendered prior to Blue Cross and Blue Shield of Alabama coverage.
- Submit claims whether you are the provider who rendered the service or if another provider rendered the service as long as it is documented in the patient's medical record.

- Use the date of service of the original procedure being submitted as documented in the patient's medical record.
- Use \$0.00 charges and use the number "1" as the unit of service.
- Since the claim will require at least one diagnosis code, use any diagnosis code currently applicable to the patient. It does not have to be a diagnosis directly related to the procedure being submitted.
- These claims will be acknowledged as accepted on the audit report.
- The claim number will begin with a number between 130 and 139.
- These claims will not be processed for payment; therefore, they will not be acknowledged on paper or electronic remittances.

Other Insurance

The "Other Insurance" screen is available to allow submission of claims when Blue Cross and Blue Shield of Alabama is the secondary or tertiary payer on the claim.

When filing claims that require other insurance, it is necessary to provide information about the primary and secondary (if applicable) payer(s) and the subscriber when the subscriber and the patient are different.

- **Primary:** The primary payer is the payer who adjudicates the claim first.
- **Secondary:** The secondary payer is the payer who adjudicates the claim after the primary payer.
- **Tertiary:** The tertiary payer is the payer who adjudicates the claim after both the primary and secondary payers.

Primary Insurance: Commercial is always defaulted as the insurance type. If Medicare is the payer that is primary on the claim, choose Medicare.

Payer: The name of the primary payer is required. If Medicare is the primary payer, then the name is defaulted.

Subscriber: The subscriber section is available to allow for entry of the name, address and identification number of the person who is the enrollee in the primary or secondary (if applicable) health plan. It is required if this person is different than the patient.

Same As: If the subscriber on the health plan that paid first or second (if applicable) has the same address as the patient on the claim, selecting the "Patient" button will populate the name and address from the "Patient" screen. If Medicare is the health plan that paid first, selecting the "Subscriber" button will populate the name and address from the "Patient" screen.

Primary Member ID/HICN: Enter the identification number assigned by the health plan that paid first or second.

Adjustments

The Adjustments screen is available to allow entry of the monetary adjustments and/or payments that the primary payer made on the claim. If Medicare is the primary payer on the claim, the adjustment information must be reported for each line item on the claim.

Claim Adjustments: Up to 36 adjustments can be keyed. "Line-level adjustments" is the default.

- **Line Level:** If the primary payer paid the claim at line level, choose "Line Level." If Medicare is the primary payer on the claim, the adjustment information must be reported for each line item on the claim.
- **Claim Level:** If the primary payer paid the claim at the claim level, choose "Claim Level."

Group: Enter the Group code or use the drop-down arrow to select the Group code. The Group code identifies the general category of the payment adjustment. Click on the Help (?) icon to view a list of Group codes and their descriptions.

Reason: Enter the Reason code or use the drop-down arrow to select the Reason code. The Reason code identified the detailed reason the adjustment was made. Click on the Help (?) icon to view a list of Reason codes and their descriptions.

Amount: Enter the amount of the adjustment. The amount can be entered with or without the decimal.

X Icon: Clicking the "X" will delete the claim line. **Add More:** Clicking "Add More" will add up to 36 adjustments.

Amount Paid: Enter the amount paid by the primary payer. The amount can be entered with or without the decimal.

Payment Date: Enter the date of the payment. The date may be keyed with or without the slash or chosen from the date selector (calendar) provided.

Save: Clicking "Save" will save the line adjustments if the "Claim List," "Next Line" or "Next" button is clicked.

Next Line: Clicking "Next Line" will advance you to the next line for adjustments to be entered.

Next: Clicking "Next" will advance you to the next page.

Secondary Adjustments

Claim Adjustments: Up to 36 adjustments can be keyed. "Line-level adjustments" is the default.

- **Line Level:** If the primary/secondary payer paid the claim at line level, choose "Line Level." If Medicare is the primary payer on the claim, the adjustment information must be reported for each line item on the claim.
- **Claim Level:** If the primary/secondary payer paid the claim at the claim level, choose "Claim Level."

Group: Enter the Group code or use the drop-down arrow to select the Group code. The Group code identifies the general category of the payment adjustment. Click on the Help (?) icon to view a list of Group codes and their descriptions.

Reason: Enter the Reason code or use the drop-down arrow to select the Reason code. The Reason code identifies the detailed reason the adjustment was made. Click on the Help (?) icon to view a list of Reason codes and their descriptions.

Amount: Enter the amount of the adjustment. The amount can be entered with or without the decimal.

X Icon: Clicking the "X" will delete the claim line.

Add More: Click "Add More" will add up to 36 adjustments.

Amount Paid: Enter the amount paid by the primary/secondary payer. The amount can be entered with or without the decimal.

Payment Date: Enter the date of the payment. Date may be keyed with or without the slash or chosen from the date selector (calendar) provided.

Next Line: Clicking "Next Line" will advance to the next line for adjustments to be entered.

Next: Clicking "Next" will advance to the next page. The Secondary Adjustments screen is available to allow entry of the monetary adjustments and/or payments that the secondary payer made on the claim.

Claim List: Clicking "Claim List" will navigate to the view that displays saved and submitted claims that have been saved and submitted.

Submit Claim: Clicking "Submit Claim" will allow you to submit the claim to be processed without entering information on the "Claim Information" screen.



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the
Blue Cross and Blue Shield Association