BlueCross BlueShield of Illinois

Claim Status Tool User Guide

via Availity® Essentials

Dec. 2021

The Availity Claim Status Tool is the recommended electronic method for providers to acquire detailed claim status for claims processed by Blue Cross and Blue Shield of Illinois (BCBSIL) for the following members:

- BCBSIL Commercial – including Federal Employee Programs® (FEP®) and On and Off Exchange
- Government Programs – including Illinois Medicaid and Blue Cross Medicare Advantage

Providers can improve their accounts receivable and increase administrative efficiencies by utilizing the Claim Status tool to check status online for all your BCBSIL patients. Results are available in real-time and provide more detailed information than the HIPAA-standard claim status (276/277 transaction).

Quick Reference:

→ Refer to page 4, 5, and 6 to view claim status results for **commercial claims**

→ Refer to page 7 to view claim status results for **government programs claims**

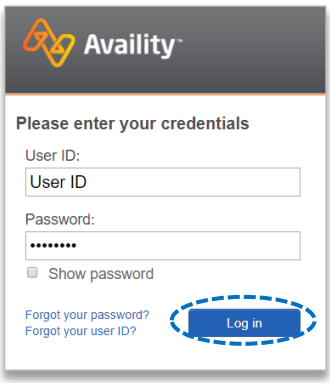
→ Refer to page 8 and 9 to view basic **HIPAA-standard claim status results** *(276/277 transaction)*

Note: *If you do not have Availity access, you may obtain basic claim status online by completing a 276/277 transaction through your preferred web vendor.*

1) Getting Started

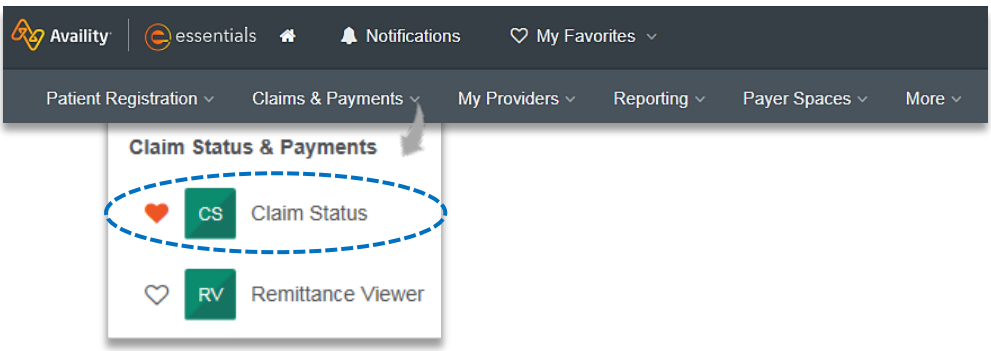
- Go to Availity
- Select **Availity Essentials Login**
- Enter User ID and Password
- Select **Log in**

Note: *Only registered Availity users can access the Claim Status Tool. If you are not a registered Availity user, you may complete the guided online registration process at Availity, at no cost.*



2) Accessing Claim Status

- Select **Claims & Payments** from the navigation menu
- Select **Claim Status**



Note: *Contact your Availity administrators if the **Claim Status** tool is not listed in the **Claims & Payments** menu.*

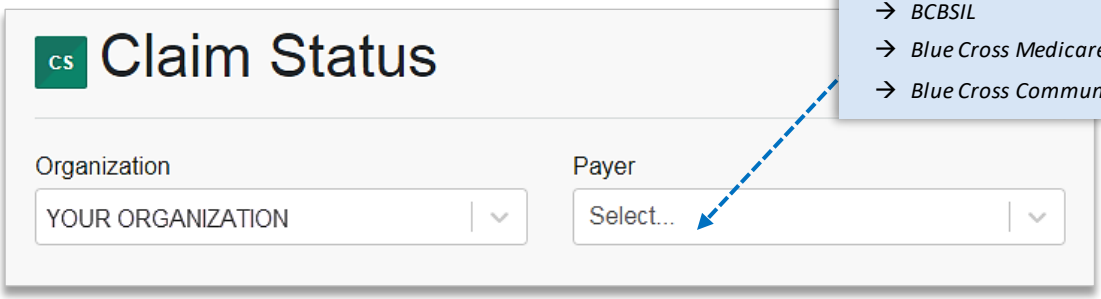
3) Submitting Transactions

Claim status may be obtained using a Member ID or Claim Number. Both options are illustrated in this step.

- Choose the **Organization**
- Select the appropriate **Payer** from the drop-down list

Payer Selection Options:

- → *BCBSIL*
- → *Blue Cross Medicare Advantage*
- → *Blue Cross Community Health Plans*

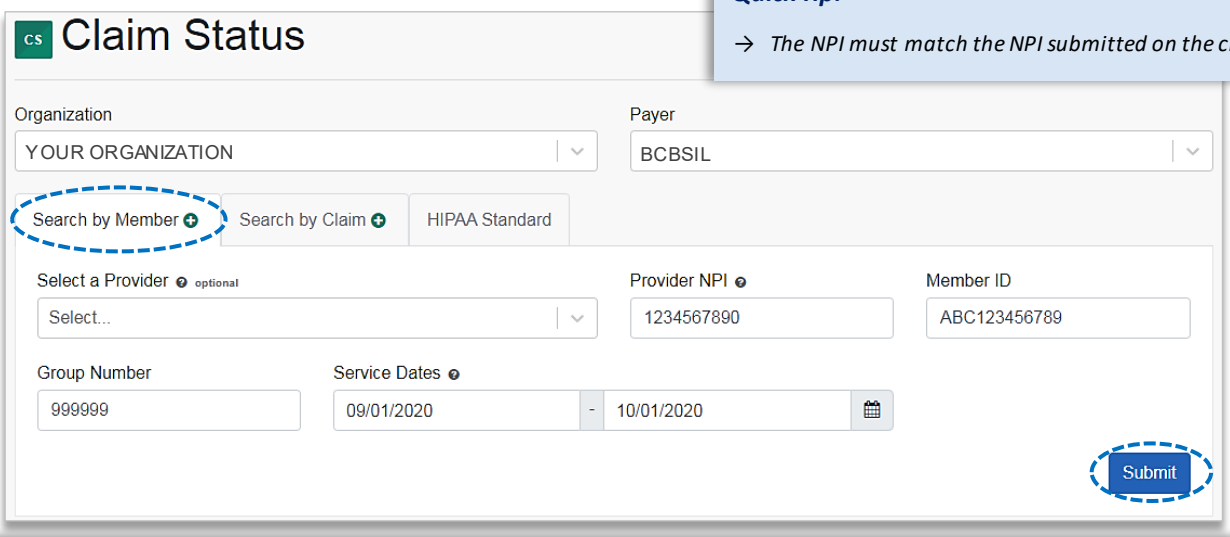


Search by Member:

- Select the **Search by Member** tab
- Choose the Billing Provider from the **Select a Provider** drop-down list or enter the **Provider NPI** (Type 2)
- Enter the **Member ID** including the preceding three-character prefix for commercial and Illinois Medicaid patients
- Enter **Service Dates** in MM/DD/YYYY format
- Select **Submit**

Quick Tip:

- → *The NPI must match the NPI submitted on the claim.*



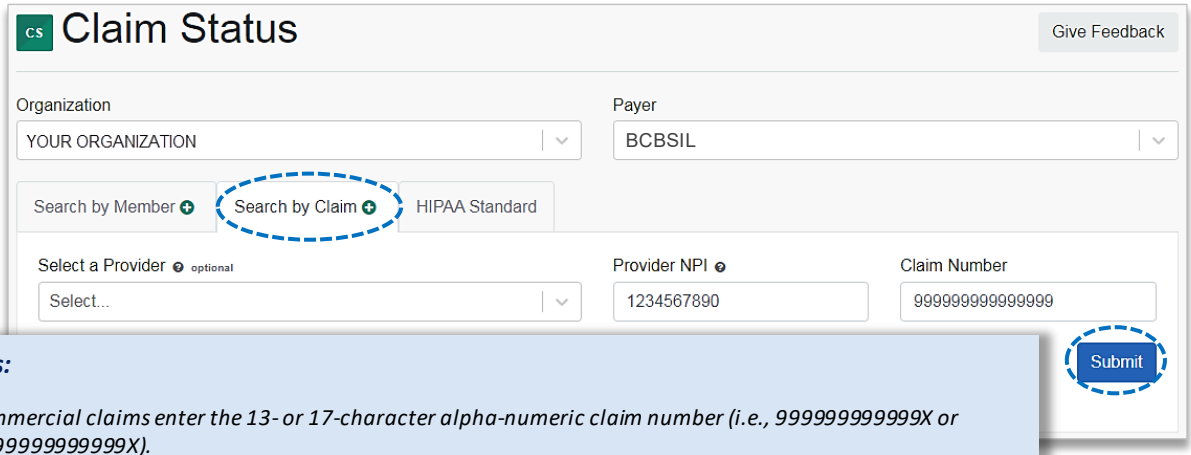
Quick Tips:

- → *Federal plans do not have a three-character prefix. The letter "R" should be typed as part of the Patient ID (i.e., R87654321). Enter the Group Number as 0FEP00.*
- → *Out-of-state plans may contain more than three-characters (e.g., WMWAN1234567). Enter the Group Number as 123456.*
- → *Claim status for Medicare Advantage and Illinois Medicaid members is available for **Service Dates** from 1/1/2016 to current.*

3) Submitting Transactions *(continued)*

Search by Claim:

- Select the **Search By Claim** tab
- Choose the Billing Provider from the **Select a Provider** drop-down list or enter the **Provider NPI** (Type 2)
- Enter the **Claim Number** and select **Submit**



Quick Tips:

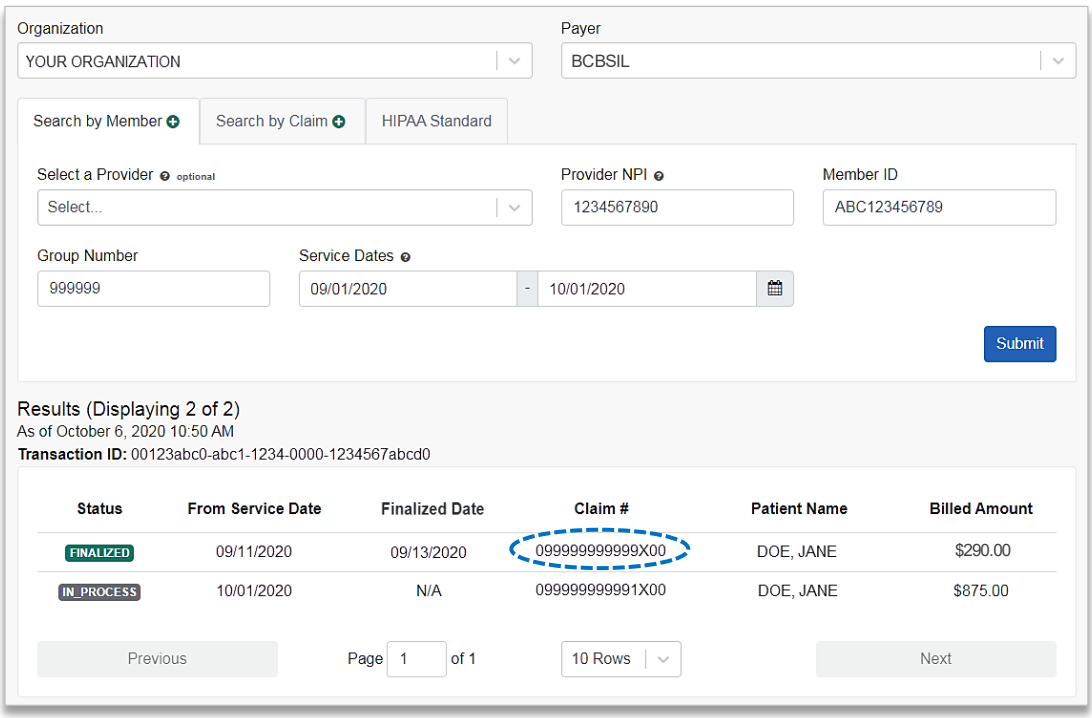
→ *For commercial claims enter the 13- or 17-character alpha-numeric claim number (i.e., 999999999999X or 02020999999999999X).*

→ *If you are looking for an adjustment, key the corresponding 2-digit suffix in addition to the 13- or 17-character alpha-numeric claim number (i.e., 999999999999X01 or 02020999999999999X01).*

→ *For incremented claims (coordination of benefits), change the 0 to a 1 before the X or C at the at the end of the claim number to locate the secondary claim (i.e., 999999999991X).*

4) Search Results

- After completing the **Member ID** search, users can view detailed claim status for a specific date of service by selecting the corresponding **claim**



5) Detailed Search Results *Commercial Claims*

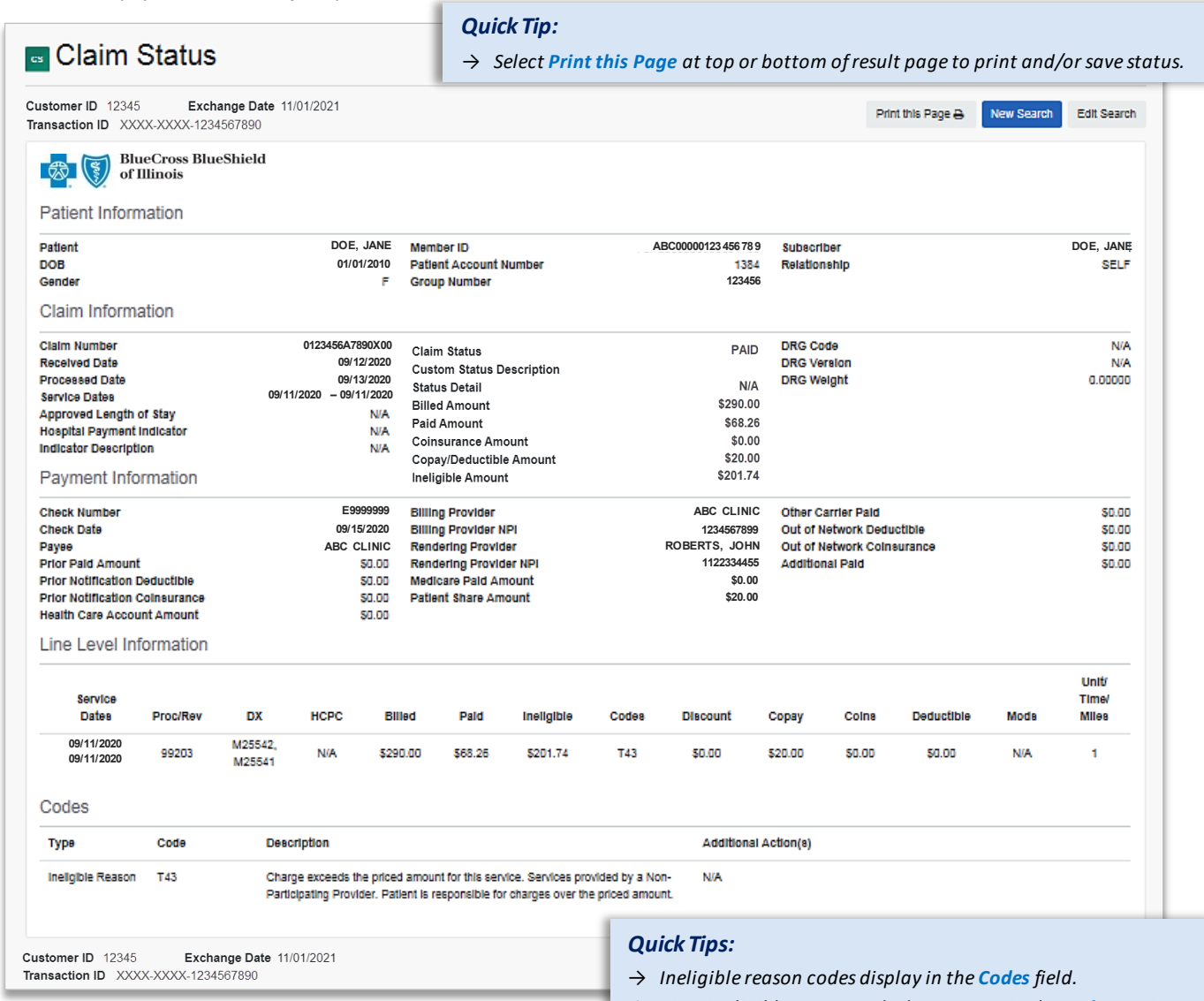
The following information is returned for BCBSIL commercial claims after the corresponding claim number is selected and/or the **Claim Number** search is completed:

- Claim Number
- Received Date
- Finalized Date
- Service Dates
- Approved Length of Stay
- Claim Status
- Custom Status Description
- Status Details
- Billed Amount
- Paid Amount
- Coinsurance Amount
- Copay / Deductible Amounts
- Ineligible Amount
- Check Number & Date
- Payee Information
- Prior Paid Amount
- Prior Notification Deductible & Coinsurance
- Health Care Account Amount
- Billing / Rendering Provider Information
- Other Carrier Paid / Medicare Paid Amount
- Patient Share Amount
- Out of Network Deductible / Coinsurance
- Additional Paid
- Line-Item Breakdown:
  - Service Dates
  - Procedure / Revenue Code
  - Diagnosis
  - HCPCS Code
  - Billed Amount
  - Paid Amount
  - Ineligible Amount & Code
  - Discount
  - Copay / Coinsurance / Deductible
  - Modifiers
  - Unit / Time / Miles

Note: *If the check number is not present on a finalized claim, please allow additional time. The system reflects check information based on the payment schedule of the provider.*

Quick Tip:

→ *Select **Print this Page** at top or bottom of result page to print and/or save status.*



Claim Status

Customer ID 12345 Exchange Date 11/01/2021
Transaction ID XXXX-XXXX-1234567890

Print this Page | New Search | Edit Search

BlueCross BlueShield of Illinois

Patient Information

Patient	DOE, JANE	Member ID	ABC000001234567 89	Subscriber	DOE, JANE
DOB	01/01/2010	Patient Account Number	1384	Relationship	SELF
Gender	F	Group Number	123456		

Claim Information

Claim Number	0123456A7890X00	Claim Status	PAID	DRG Code	N/A
Received Date	09/12/2020	Custom Status Description		DRG Version	N/A
Processed Date	09/13/2020	Status Detail	N/A	DRG Weight	0.00000
Service Dates	09/11/2020 – 09/11/2020	Billed Amount	$290.00		
Approved Length of Stay	N/A	Paid Amount	$68.26		
Hospital Payment Indicator	N/A	Coinsurance Amount	$0.00		
Indicator Description	N/A	Copay/Deductible Amount	$20.00		
		Ineligible Amount	$201.74		

Payment Information

Check Number	E9999999	Billing Provider	ABC CLINIC	Other Carrier Paid	$0.00
Check Date	09/15/2020	Billing Provider NPI	1234567899	Out of Network Deductible	$0.00
Payee	ABC CLINIC	Rendering Provider	ROBERTS, JOHN	Out of Network Coinsurance	$0.00
Prior Paid Amount	$0.00	Rendering Provider NPI	1122334455	Additional Paid	$0.00
Prior Notification Deductible	$0.00	Medicare Paid Amount	$0.00		
Prior Notification Coinsurance	$0.00	Patient Share Amount	$20.00		
Health Care Account Amount	$0.00				

Line Level Information

Service Dates	Proc/Rev	DX	HCPC	Billed	Paid	Ineligible	Codes	Discount	Copay	Coins	Deductible	Mods	Unit/ Time/ Miles
09/11/2020 09/11/2020	99203	M25542, M25541	N/A	$290.00	$68.26	$201.74	T43	$0.00	$20.00	$0.00	$0.00	N/A	1

Codes

Type	Code	Description	Additional Action(s)
Ineligible Reason	T43	Charge exceeds the priced amount for this service. Services provided by a Non-Participating Provider. Patient is responsible for charges over the priced amount.	N/A

Customer ID 12345 Exchange Date 11/01/2021
Transaction ID XXXX-XXXX-1234567890

Quick Tips:

→ *Ineligible reason codes display in the **Codes** field.*

→ *View ineligible reason code descriptions in the **Codes** section.*

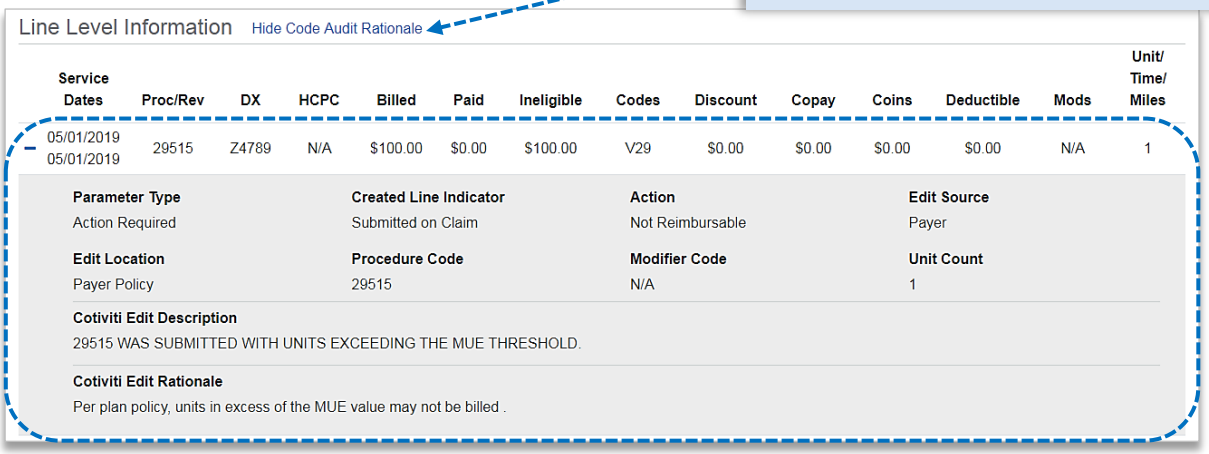
5) Detailed Search Results *Commercial Claims (continued)*

Cotiviti, Inc. Code Audit Rationale is available for finalized claims processed on or after Aug. 26, 2019:

- Select **View Code Audit Rationale** above the service line section or click on the **+** beside the applicable line(s)
- Once selected, service line(s) denied for Cotiviti logic will expand and display the following:
  - **Edit Description**
  - **Edit Rationale**

Quick Tip:

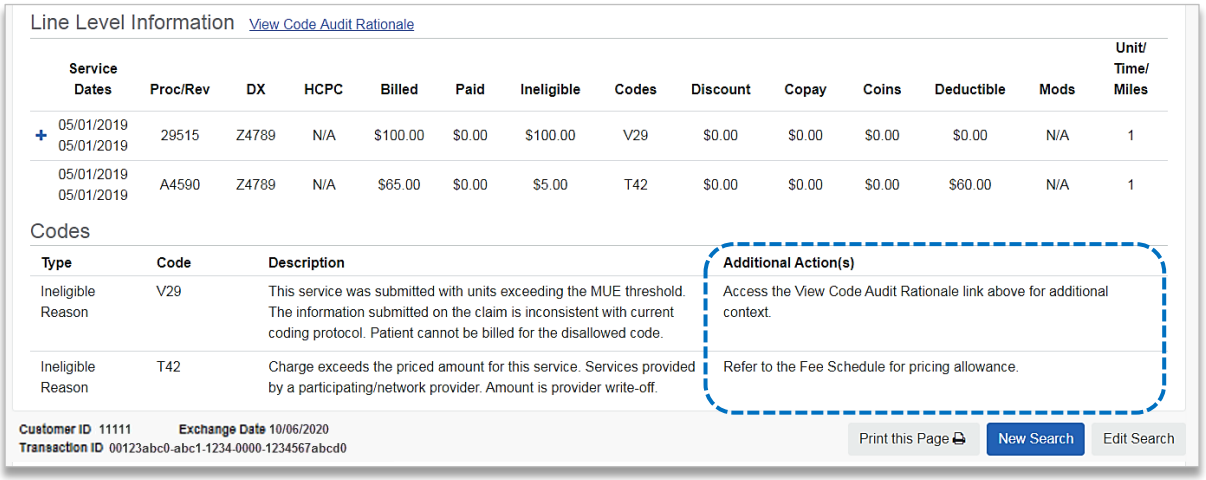
→ *Select **Hide Code Audit Rationale** or select minus sign (–) to collapse the expanded denial logic.*



Additional Action(s) for Applicable Ineligible Reason Codes:

- View **Additional Action(s)** to understand what further step(s) may be taken for certain claim denial scenarios

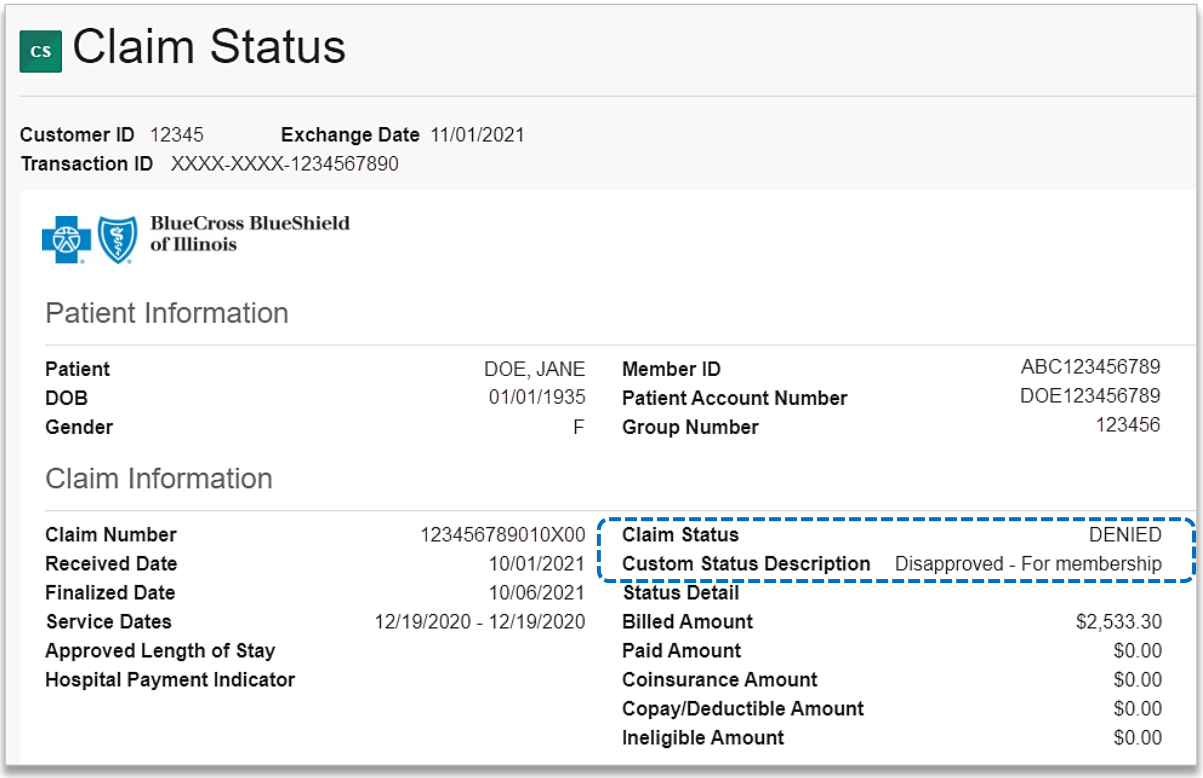
***Note:** **Additional Action(s)** only display for certain ineligible reason codes.*



5) Detailed Search Results *Commercial Claims (continued)*

There may be instances when providers receive a claim withdrawn notification after submission to BCBSIL. Providers can also determine why a claim was withdrawn via the Availity Claim Status tool response.

- Refer to the **Custom Status Description** field to view the reason why the claim was withdrawn
- After addressing the reason, resubmit the claim electronically to the local BCBSIL plan for processing



Claim Status

Customer ID 12345 **Exchange Date** 11/01/2021
Transaction ID XXXX-XXXX-1234567890

BlueCross BlueShield of Illinois

Patient Information

Patient	DOE, JANE	**Member ID**	ABC123456789
DOB	01/01/1935	**Patient Account Number**	DOE123456789
Gender	F	**Group Number**	123456

Claim Information

Claim Number	123456789010X00	**Claim Status**	DENIED
Received Date	10/01/2021	**Custom Status Description**	Disapproved - For membership
Finalized Date	10/06/2021	**Status Detail**	
Service Dates	12/19/2020 - 12/19/2020	**Billed Amount**	$2,533.30
Approved Length of Stay		**Paid Amount**	$0.00
Hospital Payment Indicator		**Coinsurance Amount**	$0.00
		Copay/Deductible Amount	$0.00
		Ineligible Amount	$0.00

6) Detailed Search Results *Government Program Claims*

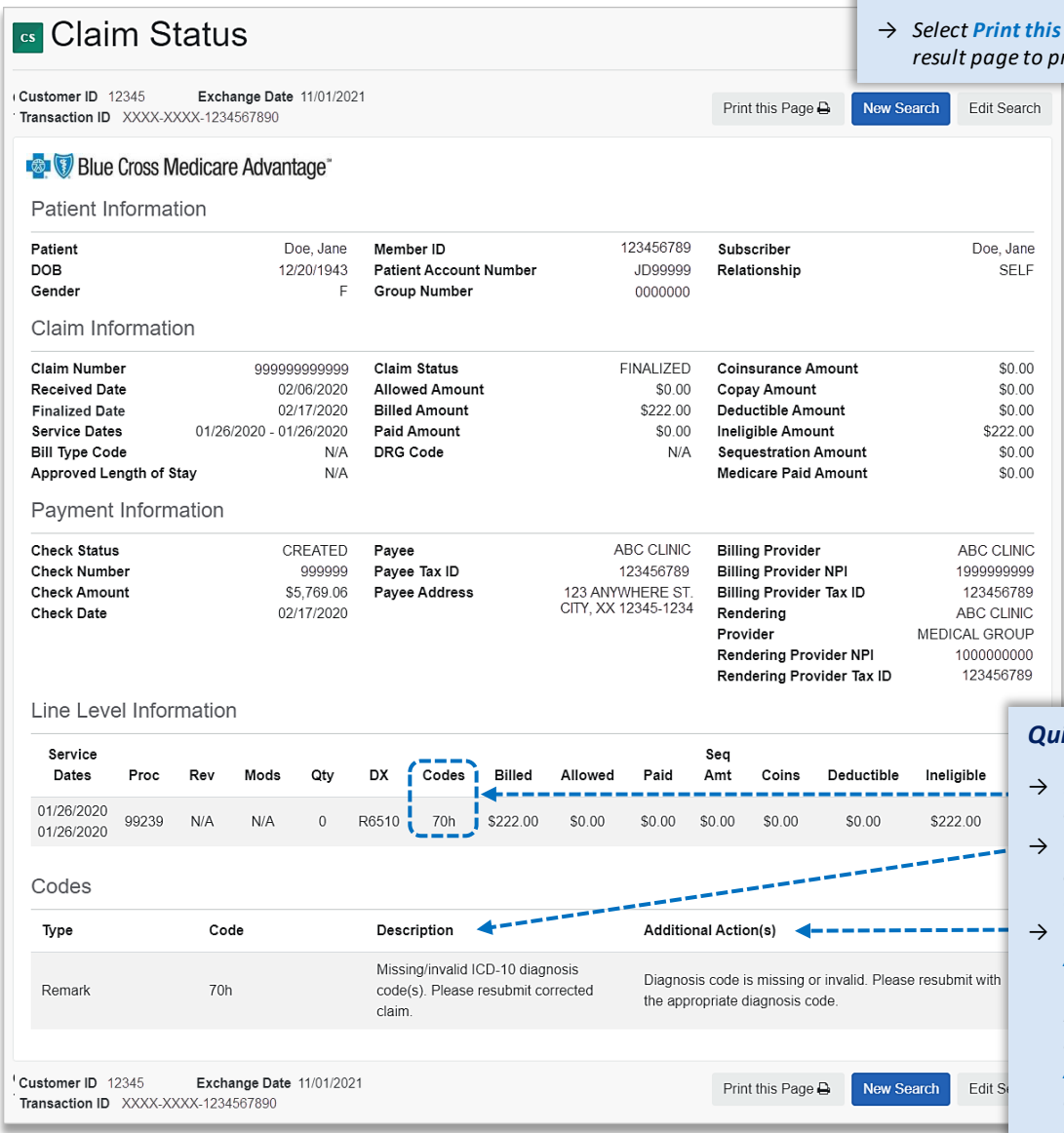
The following information is returned for government programs claims after the corresponding claim is selected and/or the **Claim Number** search is completed:

- Claim Number
- Received Date
- Finalized Date
- Service Dates
- Claim Status
- Allowed Amount
- Billed Amount
- Paid Amount
- Coinsurance Amount
- Copay & Deductible Amounts
- Ineligible Amount
- Sequestration Amount
- Medicare Paid Amount
- Check Status & Check Number
- Check Amount & Check Date
- Payee Information
- Billing Provider Information
- Rendering Provider Information
- Line-Item Breakdown:
  - Service Dates
  - Revenue / Procedure Code
  - Modifier
  - Quantity
  - Diagnosis
  - Ineligible Code & Amount
  - Allowed Amount
  - Paid Amount
  - Sequestration Amount
  - Copay / Coinsurance / Deductible

Note: *If the check number is not present on a finalized claim, please allow additional time. The system reflects check information based on the payment schedule of the provider.*

Quick Tip:

→ *Select **Print this Page** at top or bottom of result page to print and/or save status.*



Claim Status

Customer ID 12345 Exchange Date 11/01/2021
Transaction ID XXXX-XXXX-1234567890

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Blue Cross Medicare Advantage

Patient Information

Patient	Doe, Jane	Member ID	123456789	Subscriber	Doe, Jane
DOB	12/20/1943	Patient Account Number	JD99999	Relationship	SELF
Gender	F	Group Number	0000000		

Claim Information

Claim Number	999999999999	Claim Status	FINALIZED	Coinsurance Amount	$0.00
Received Date	02/06/2020	Allowed Amount	$0.00	Copay Amount	$0.00
Finalized Date	02/17/2020	Billed Amount	$222.00	Deductible Amount	$0.00
Service Dates	01/26/2020 - 01/26/2020	Paid Amount	$0.00	Ineligible Amount	$222.00
Bill Type Code	N/A	DRG Code	N/A	Sequestration Amount	$0.00
Approved Length of Stay	N/A			Medicare Paid Amount	$0.00

Payment Information

Check Status	CREATED	Payee	ABC CLINIC	Billing Provider	ABC CLINIC
Check Number	999999	Payee Tax ID	123456789	Billing Provider NPI	1999999999
Check Amount	$5,769.06	Payee Address	123 ANYWHERE ST. CITY, XX 12345-1234	Billing Provider Tax ID	123456789
Check Date	02/17/2020			Rendering Provider	ABC CLINIC MEDICAL GROUP
				Rendering Provider NPI	1000000000
				Rendering Provider Tax ID	123456789

Line Level Information

Service Dates	Proc	Rev	Mods	Qty	DX	Codes	Billed	Allowed	Paid	Seq Amt	Coins	Deductible	Ineligible
01/26/2020 01/26/2020	99239	N/A	N/A	0	R6510	70h	$222.00	$0.00	$0.00	$0.00	$0.00	$0.00	$222.00

Codes

Type	Code	Description	Additional Action(s)
Remark	70h	Missing/invalid ICD-10 diagnosis code(s). Please resubmit corrected claim.	Diagnosis code is missing or invalid. Please resubmit with the appropriate diagnosis code.

Customer ID 12345 Exchange Date 11/01/2021
Transaction ID XXXX-XXXX-1234567890

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Quick Tips:

→ *Ineligible reason codes display in the **Codes** field.*

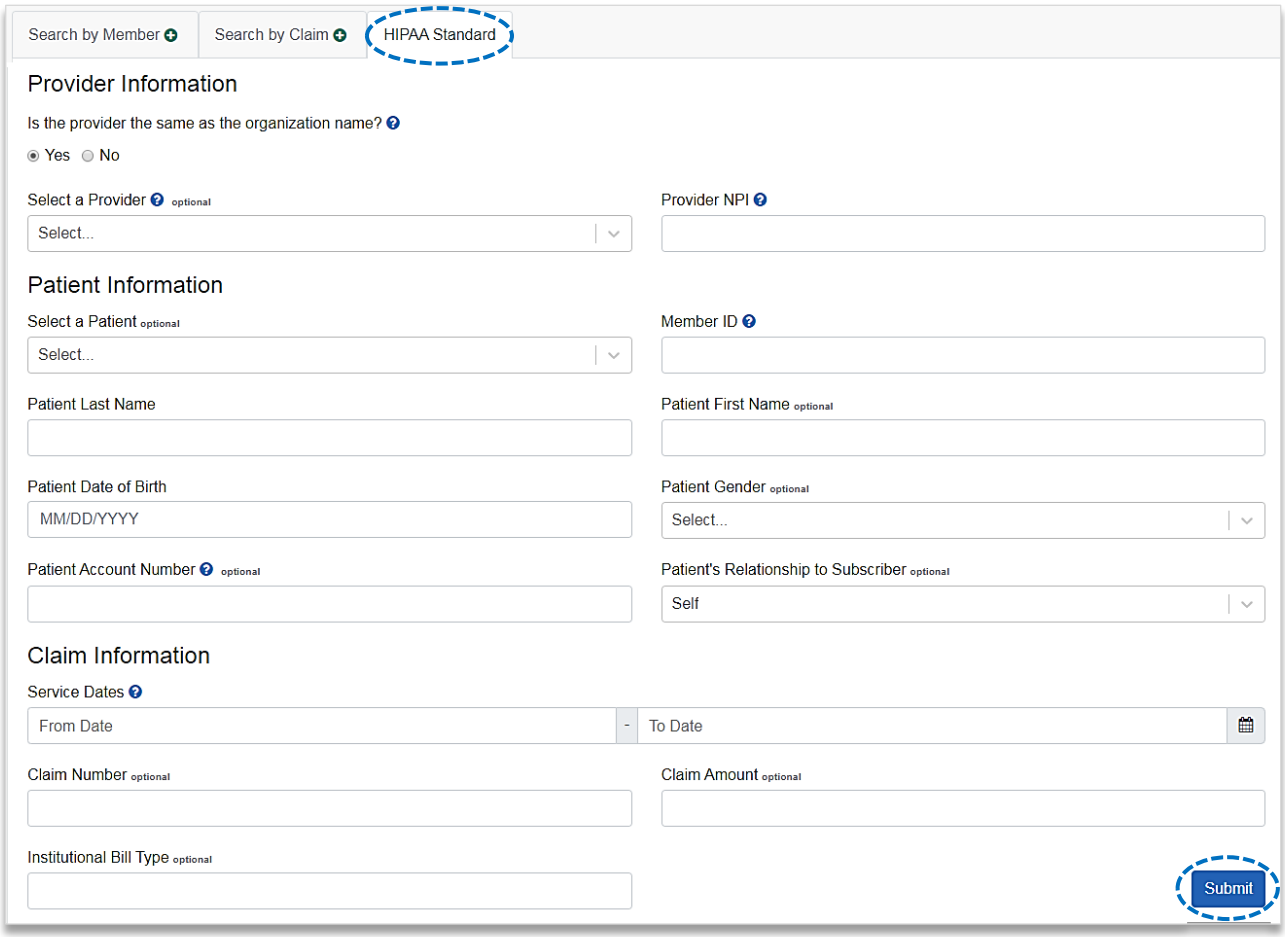
→ *View ineligible reason code descriptions in the **Codes** section.*

→ *View **Additional Action(s)** to understand what further step(s) may be taken for certain claim denial scenarios. **Additional Action(s)** only displays for certain ineligible reason codes.*

7) HIPAA Standard Claim Status *276 request*

Use the **HIPAA Standard** tab to acquire basic claim status (276/277 transaction).

- Enter the **Provider** and **Patient Information** in the 276 request
- Select **Submit**



Quick Tips:

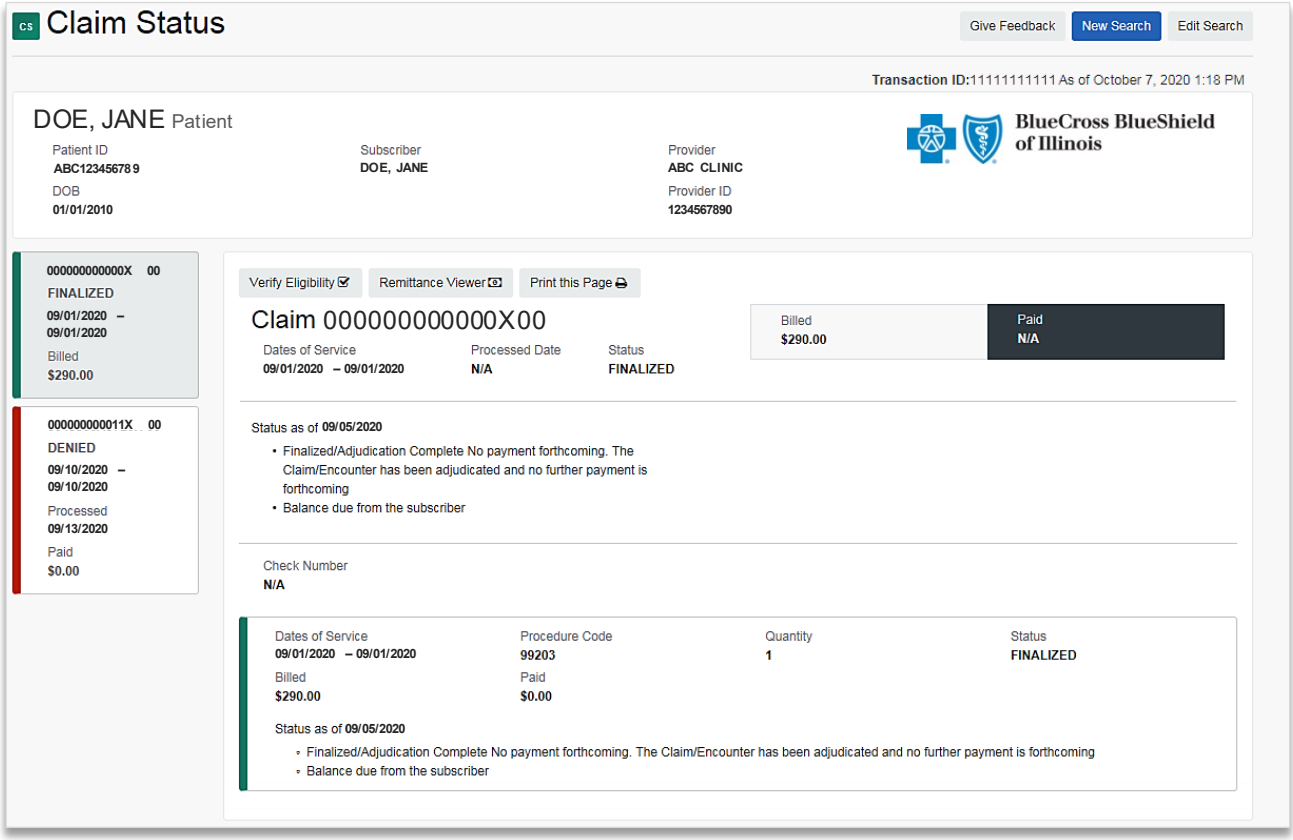
→ *Fields labeled as **optional** may be completed but are not required to receive a 277 response.*

→ *If you do not know the patient account number, you may enter "unknown" in the optional **Patient Account Number** field, and the account number will be returned in the 277 response.*

7) HIPAA Standard Claim Status *277 response (continued)*

The following information is returned in the **HIPAA Standard** 277 response, if applicable:

- Claim Number
- Service Dates
- Processed Date
- Claim Status
- Billed Amount
- Paid Amount
- Check Number
- Denial Reason



Quick Tip:

→ *If the information returned does not provide enough detail, complete the transaction using either the **Search by Member** or **Search by Claim** tab with the PLUS (⊕) sign.*

Have questions or need additional education? Email the Provider Education Consultants.

Be sure to include your name, direct contact information & Tax ID or billing NPI.