BlueCross BlueShield of Oklahoma

Electronic Professional Claim Submission User Guide

September 2023

Professional Claim submission via the Availity® Essentials portal offers providers a no-cost solution to quickly submit an electronic claim or encounter to Blue Cross and Blue Shield of Oklahoma (BCBSOK). Electronic claim submission can accelerate the claim and reimbursement process. This Availity option does not require the use of a separate clearinghouse or practice management system.

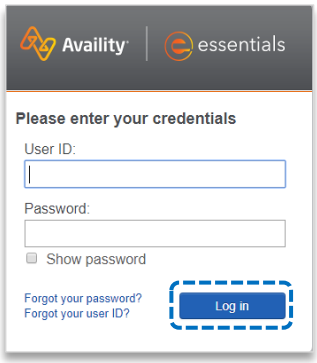
Not Registered with Availity? Complete the guided online registration process today at Availity, at no charge.

Note: *This user guide provides instructions on completing and submitting the Professional Claim Submission form via Availity Essentials. The guide is for educational purposes and should not be interpreted as advice on how to bill a claim.*

1) Getting Started

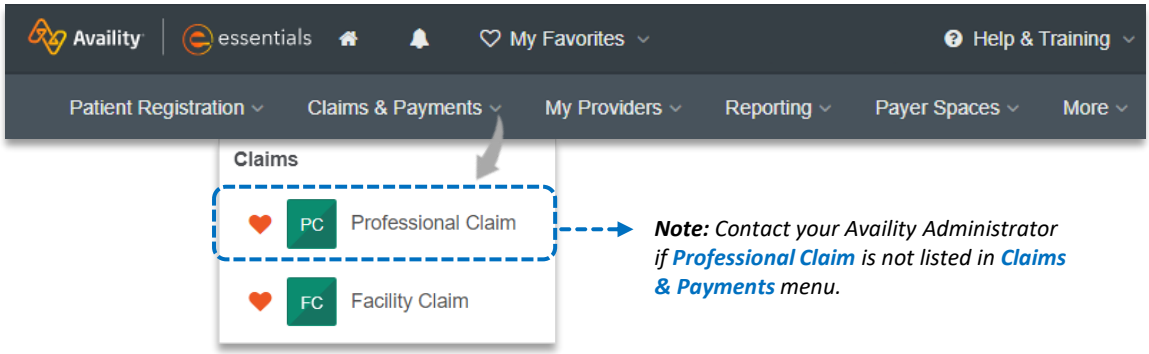
- Go to Availity
- Select **Availity Essentials Login**
- Enter User ID and Password
- Select **Log in**

Note: *Only registered Availity users can access this **Professional Claim** submission option.*



2) Accessing Professional Claim Form

- Select **Claims & Payments** from the navigation menu
- Select **Professional Claims**



Note: *Contact your Availity Administrator if **Professional Claim** is not listed in **Claims & Payments** menu.*

Important Note: *To ensure your provider information is available in the **Select a Provider** drop-down list, your Availity Administrator can add your Billing and Rendering NPIs and Tax ID numbers to **Manage My Organization** under **My Account Dashboard** on the Availity Essentials homepage. For detailed instructions, refer to the **Manage My Organization User Guide**.*

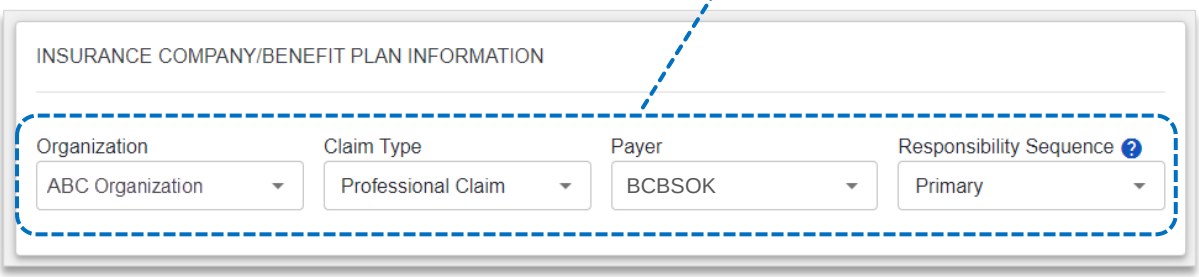
3) Claim Type & Payer Selection

- Choose Organization
- Choose *Claim Type* of **Professional Claim**
- Select the appropriate **Payer** from the drop-down list
- Select **Responsibility Sequence** *(e.g., Primary, Secondary, or Tertiary)*

Payer Selection Options:

→ *BCBSOK*

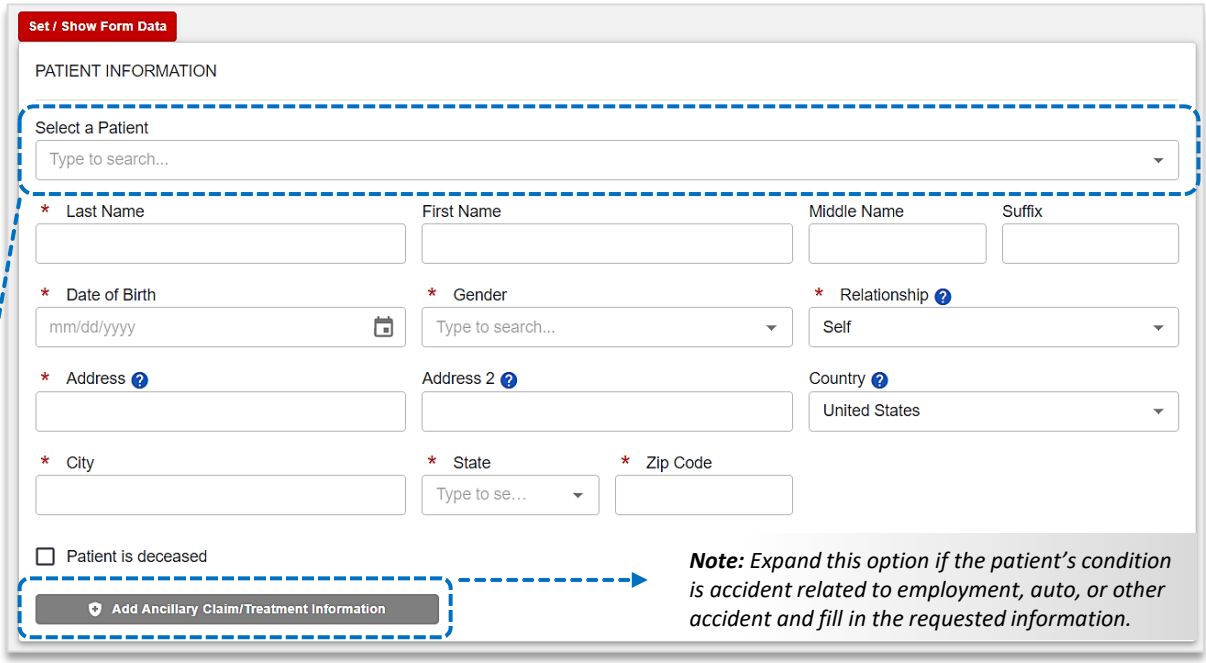
→ *Blue Cross Medicare Advantage*



4) Patient Information

Complete the required fields:

- **Last Name**
- **Date of Birth**
- **Gender**
- **Relationship to Subscriber**
- **Address**
- **City, State, Zip Code**



Note: *Expand this option if the patient's condition is accident related to employment, auto, or other accident and fill in the requested information.*

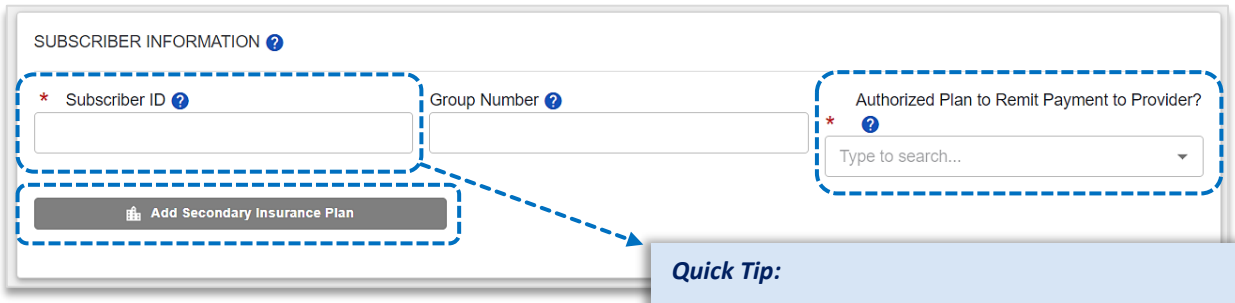
Quick Tips:

→ *If an **Availity Eligibility and Benefits Inquiry** is completed first, data will pre-populate into the Patient and Subscriber Information sections.*

→ *While "First Name" is not a required field, entering this information will ensure accurate processing of your claim.*

5) Subscriber Information

- Enter the **Subscriber ID**, including the three-character prefix *(i.e., ABC123456789)*
- Select **Authorized Plan to Remit Payment to Provider**
- If the member has a secondary insurance plan, select **Add Secondary Insurance Plan** and enter requested details



Quick Tip:

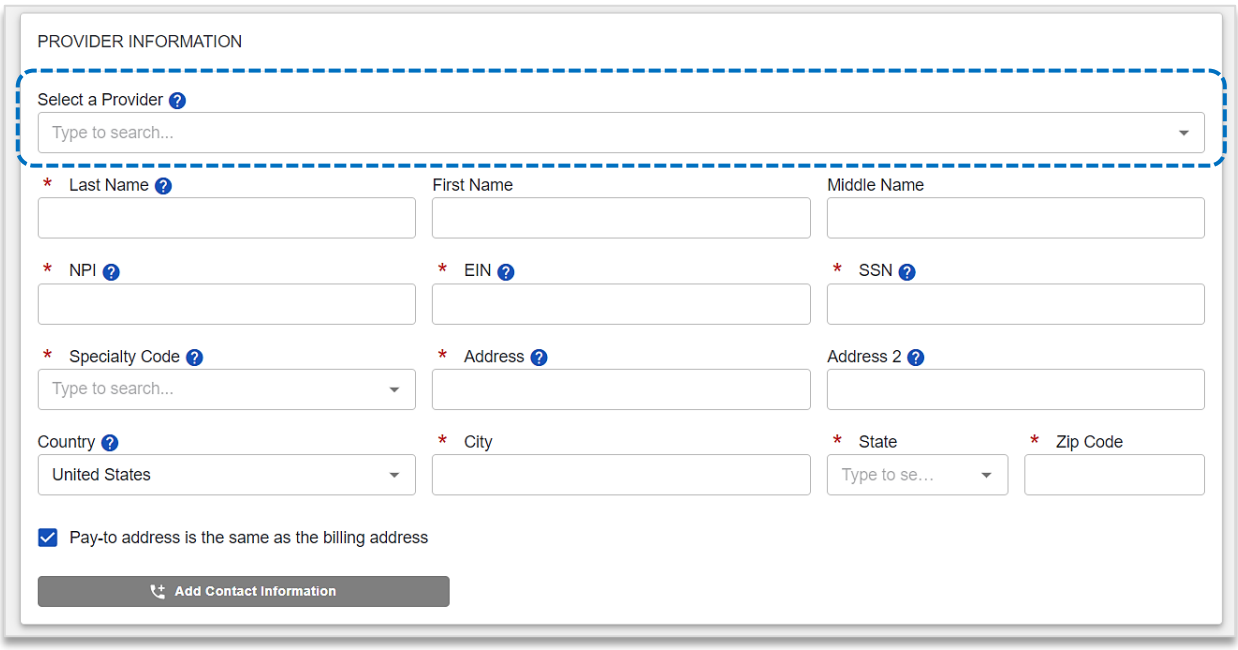
→ *Some out-of-state plans may have longer ID numbers; for these patients make sure you enter the three-character prefix and ID number as listed on the member's card. Include any alpha characters embedded within the ID.*

6) Billing Provider Information

The billing provider information can be automatically populated by choosing the appropriate provider from the **Select a Provider** drop-down listing. If the provider information is not available, simply add the provider information to **Manage My Organization.** For assistance, refer to the **Manage My Organization User Guide**.

Complete the required fields:

- **Provider Last Name**
- **NPI / Tax ID**
- **Specialty / Taxonomy**
- **Address / City, State, Zip Code**

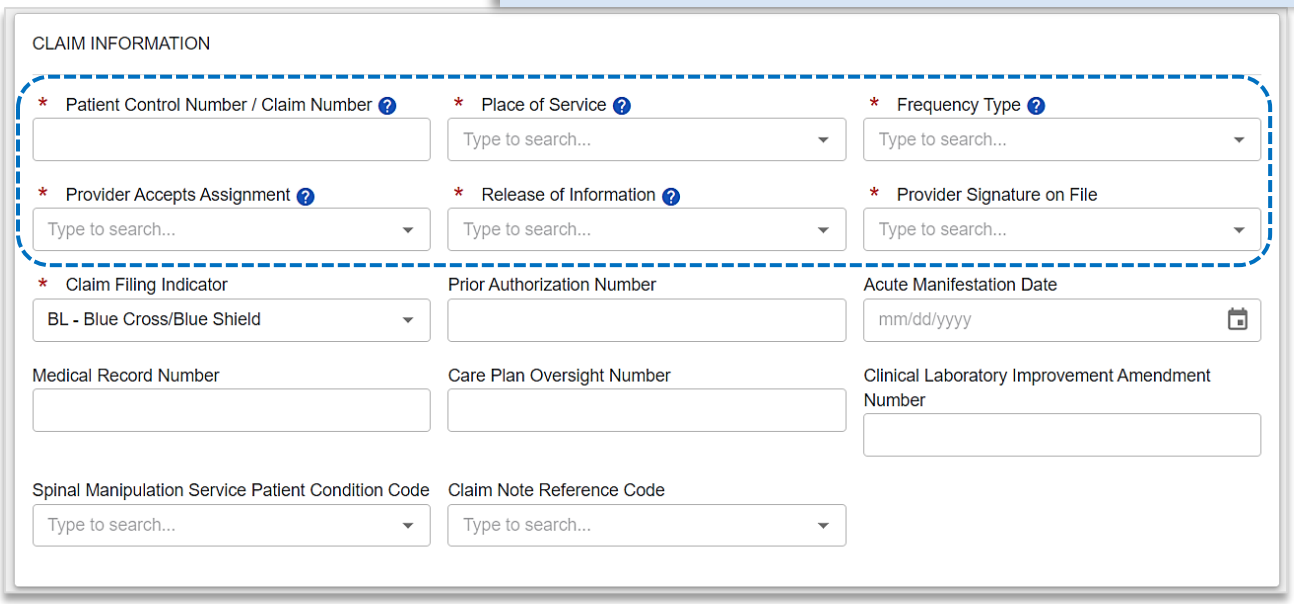


7) Additional Claim & Rendering Provider Information

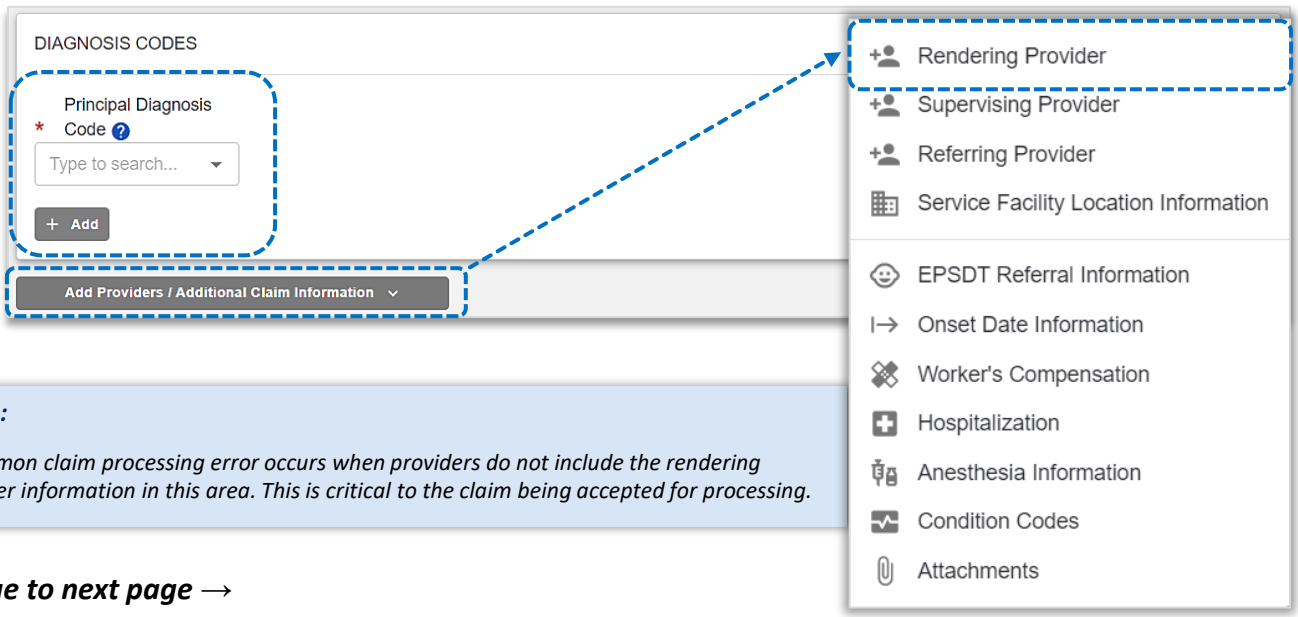
- Enter the **Patient Control Number** *(the patient account number assigned by your office)*
- **Place of Service**
- Select **Billing Frequency:**
  - **Frequency Code 1** *(new claim)*
  - **Frequency Code 7** *(replacement claim)*
  - **Frequency Code 8** *(void/cancel claim)*

Quick Tip:

→ *If corrected claim or void/cancel of a prior claim is selected, a new required field will populate. The **Payer Claim/Control Number** is required (ICN/DCN). This tells the payer which claim needs to be corrected or voided.*



- Enter the **Principal ICD-10 Diagnosis Code**
- Select **Add Another Code** to add up to 12 diagnosis codes
- Select **Add Provider** and click **Rendering Provider**



Quick Tip:

→ *A common claim processing error occurs when providers do not include the rendering provider information in this area. This is critical to the claim being accepted for processing.*

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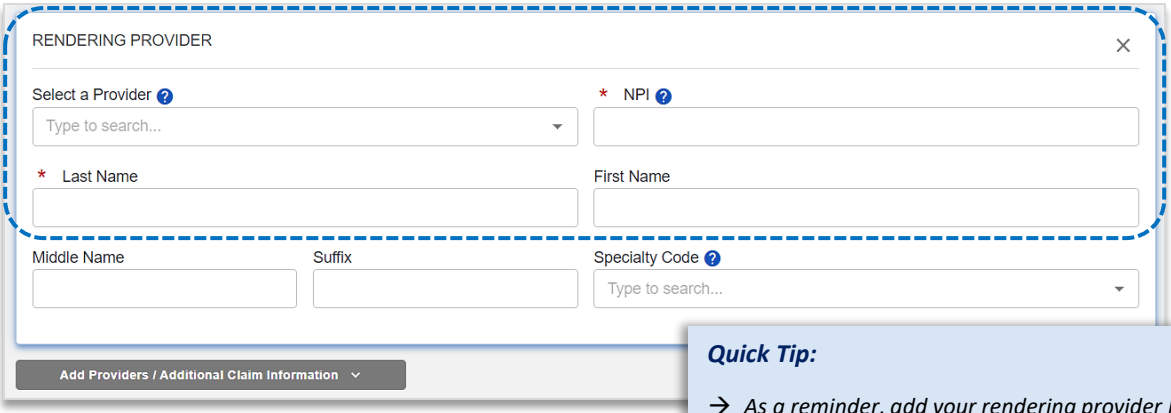
7) Rendering Provider Information *(continued)*

- Complete the required fields for the **Rendering Provider**
- Use the **Select a Provider** drop-down list to quickly auto-populate the associated provider information



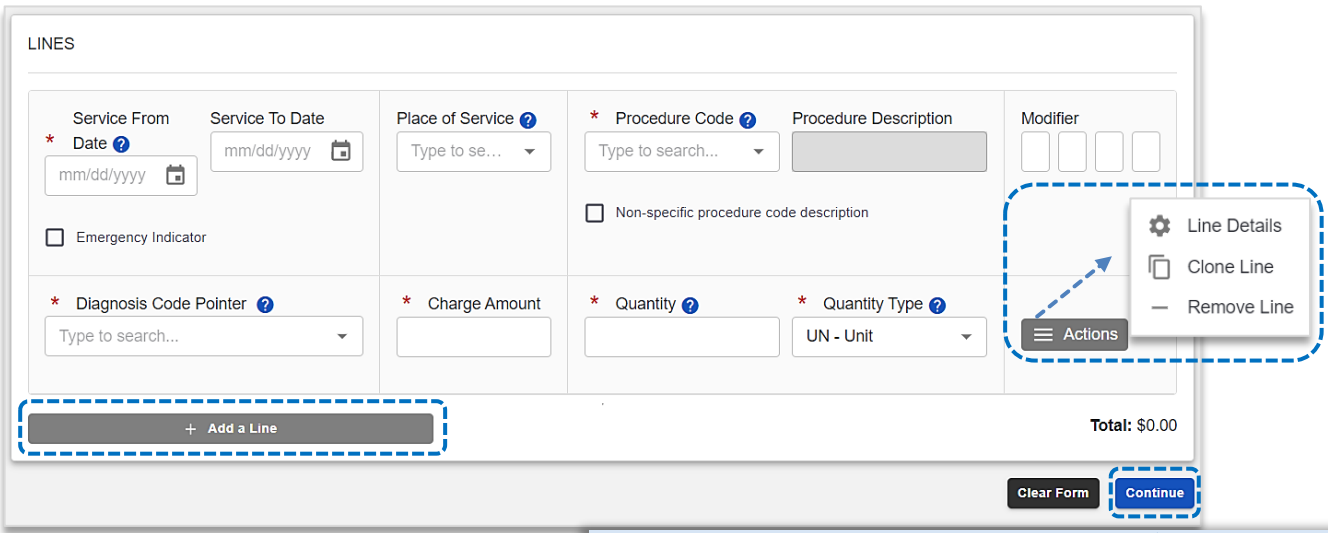
Quick Tip:

→ *As a reminder, add your rendering provider NPI and Tax ID to **Manage My Organization** for quick data-entry.*

8) Service Line(s) & Submission

Enter information in the required field:

- **Service From and To Date** *(i.e., 05/01/2023)*
- **Procedure Code**
- **Diagnosis Code Pointers** *(use drop-down to choose the appropriate order)*
- **Charges** *(excluding the "$" sign)*
- **Quantity & Quantity Type** *(enter the number of units/minutes)*
- Select **+ Add a Line** to include additional lines of service
- Use **Actions** to view **Line Details**, **Clone Line** or **Remove Line** of service

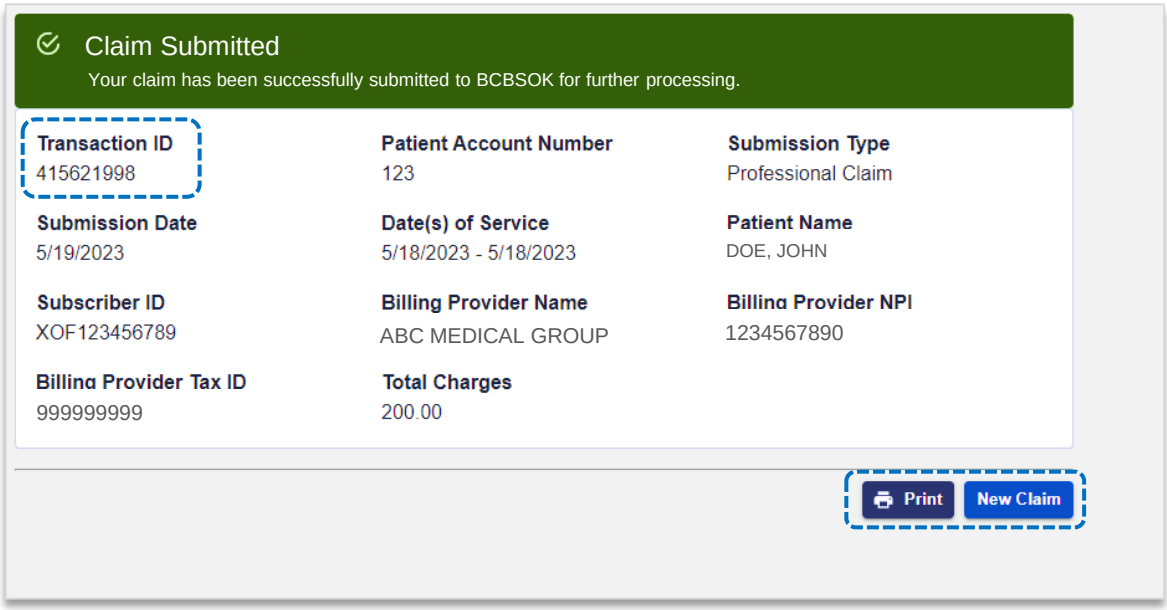


Quick Tip:

→ *Once all the required fields are completed, select **Continue** to review all data entered and **Submit** the 837 professional claim to BCBSOK.*

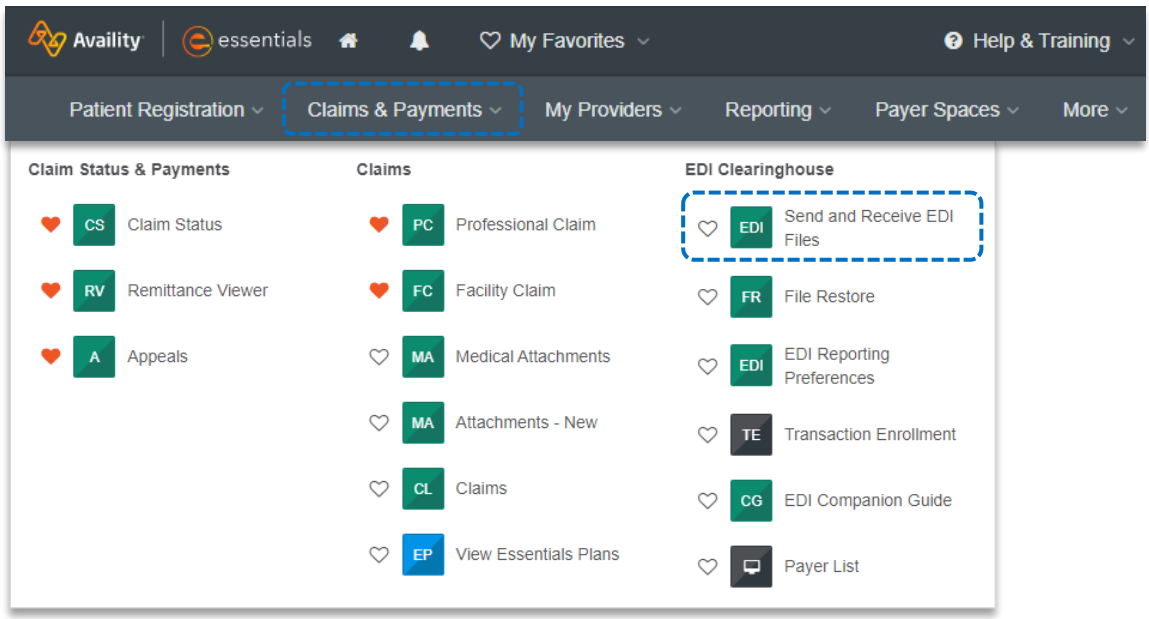
9) Submission Confirmation

- Once submitted a confirmation screen will return with a **Transaction ID** number *(this is not the claim number)*



10) Confirming Claim Receipt

- Select **Claims & Payments** from the navigation menu
- Select **Send and Receive EDI Files**



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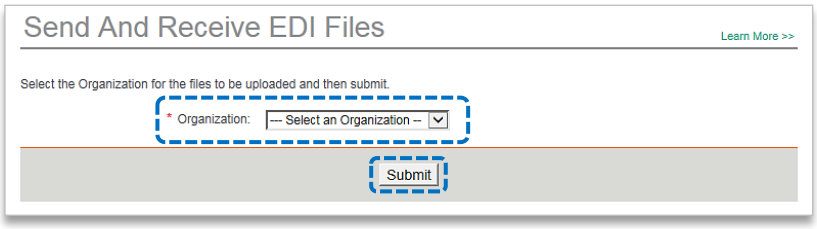
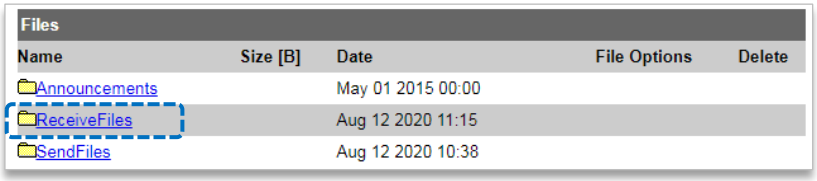
10) Confirming Claim Receipt *(continued)*

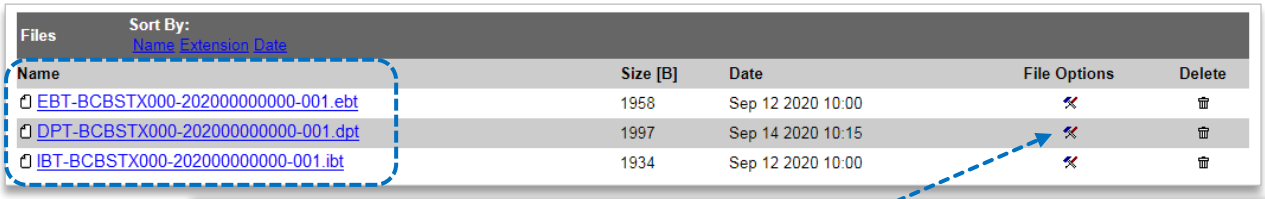
- Select **Organization**
- Select **Submit**



- Select **Receive Files** *(the below EDI Files will be available in **Receive Files** within 24 to 48 hours after submission)*



- Select the **EBT** file to confirm if the claim submission was accepted or rejected by BCBSOK



Quick Tips:

→ *If you are unable to view the file, select the **File Options** icon, then choose Text/Plain.*

→ *Once the claim has processed, use the **Availity Claim Status tool** to verify how the claim finalized.*

EDI File Types and Definitions:

→ ***IBT (Immediate Batch Text Response):** Immediately acknowledges accepted claims and identifies rejected claims due to HIPAA compliance edits and payers-specific edits. The IBT file are typically available in Receive Files within 30 mins. of submission.*

→ ***EBT (Electronic Batch Text Report):** Indicates if the claim was accepted or rejected by the payer. If applicable, reasoning for the claim rejection will be indicated.*

→ ***DPT (Delayed Payer Text Report):** Payer confirmation of receipt response showing assigned claim number.*

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

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