Availity™ Claim Research Tool

The Claim Research Tool is the recommended method for providers to acquire status on claims processed by Blue Cross and Blue Shield of Oklahoma (BCBSOK). *

Organizations can improve their accounts receivable by utilizing this exclusive BCBSOK feature to check status for local, federal and out-of-state claims. Results are available in real-time and provide the equivalent of an Explanation of Benefits (EOB).

* To obtain status on claims not processed by BCBSOK, users should contact the appropriate claim processing entity directly (i.e., third party vendors, other carriers, etc.).

1. Getting Started

Go to availity.com

Select Availity Portal Login or Register

Enter User ID and Password

Select Log in button

Note: Only registered users can access the Claim Research Tool.

2. Accessing the Claim Research Tool

Select Claims from top mega menu

Select Claim Research Tool (BCBS)

Note: Contact your Availity account Administrator if Claim Research Tool (BCBS) is not listed in the Claims menu.
3. Running a Transaction

Claim status can be obtained using a Patient ID or 13-digit Claim Number. Claim Numbers are also referred to as a Document Control Numbers (DCN). Both options are illustrated below.

Note: The Claim Research Tool is an exclusive to BCBSOK offering. To check status on claims processed by other payers, use Claim Status Inquiry.

Search by Patient ID

Select Patient ID from the Search Option drop-down

Note: The Payer field will automatically default to BCBSOK.

For the Express Entry Provider, select the appropriate Billing (Type 2) NPI from the drop-down or enter the NPI manually

Complete these data fields:
- Patient ID (include the 3-letter alpha prefix before the identification number)
- 6-character Group Number
- Service Period dates

Select Submit

Helpful Hints:
- Federal plans do not have an alpha prefix. The letter R should be typed as part of the Patient ID (i.e., R87654321). Enter the Group Number as 0FEPOK.
- Out-of-state plans may contain more than three letters (e.g., WMWAN1234567). Enter the Group Number as 123456.

Instructions for running a transaction by claim number are included on page 3. Otherwise, proceed to step 4.
Search by Claim Number (DCN)

Select Claim Number (DCN) from the Search Option drop-down

For the Express Entry Provider, select the appropriate Billing (Type 2) NPI from the drop-down or enter the NPI manually

Key the 13-digit alpha numeric claim number in the Claim # (DCN) field

Select Submit

Helpful Hint:
- To search for an adjusted or reprocessed claim, key the corresponding 2-digit suffix in addition to the 13-digit claim number (i.e., 999999999999X01).
- If copying and pasting the claim number from another document or program, be sure to delete any additional spaces.

4. Search Results

To view detailed claim status for a specific date of service, select the corresponding Claim Number

Search Results

Payer: BCBSOK
Provider NPI: 1234567890
Member ID: ABC000000007
Group Number: 100999
Service Period: 10/01/2014 - 11/01/2014

Claims Found

<table>
<thead>
<tr>
<th>From Service Date</th>
<th>Processed Date</th>
<th>Claim Number</th>
<th>Billed Amount</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/09/14</td>
<td>10/10/14</td>
<td>999999999999X00</td>
<td>$155.00</td>
<td>Issued - No Payment</td>
</tr>
</tbody>
</table>

Note: The information returned will include original, adjusted, withdrawn and replacement claims.
5. Running a Transaction

Returned information includes:

- Claim Number
- Received Date
- Processed Date
- Claim Status
- Billed Amount
- Paid Amount
- Coinsurance
- Co-Pay / Deductible Amount
- Ineligible Amount(s)
- Check/EFT/Voucher
- Check Date
- Payee Name
- Health Care Account Amount
- Other Carrier / Medicare Paid Amount
- Patient Share Amount (total)
- Billing Provider ID / Name
- Rendering Provider ID / Name
- Line Item Breakdown
  - Service Dates
  - Revenue / Procedure Code
  - Diagnosis
  - Ineligible Reason Code / Amount
  - Copay / Coinsurance / Deductible breakdown
  - Modifier
  - Unit, Time, or Mile
- Ineligible Reason Code Descriptions

### Claim Details

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>999999999999999X00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received Date</td>
<td>10/09/2014</td>
</tr>
<tr>
<td>Processed Date</td>
<td>10/10/2014</td>
</tr>
<tr>
<td>From Service Date</td>
<td>10/08/2014</td>
</tr>
<tr>
<td>To Service Date</td>
<td>10/05/2014</td>
</tr>
</tbody>
</table>

### Claim Status: ISSUED - NO PAYMENT

- Billed Amount: $155.00
- Paid Amount: $0.00
- Coinsurance: $0.00
- Co-Pay/Deductible Amount: $45.77
- Ineligible Amount: $109.23
- DRG Code: 1234567890
- DRG Version: HOLMES CLINIC
- DRG Weight: 0.00

### Payee Name:

<table>
<thead>
<tr>
<th>Payee Name</th>
<th>HOLMES CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Paid AMT</td>
<td>$0.00</td>
</tr>
<tr>
<td>Prior Notification Deductible:</td>
<td>$0.00</td>
</tr>
<tr>
<td>Health Care Account Amount:</td>
<td>$0.00</td>
</tr>
<tr>
<td>Other Carrier Paid:</td>
<td>$0.00</td>
</tr>
<tr>
<td>Patient Share Amount:</td>
<td>$45.77</td>
</tr>
<tr>
<td>Medicare Paid Amount:</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Service Lines

<table>
<thead>
<tr>
<th>Service Line Date</th>
<th>Revenue Code</th>
<th>Diagnosis Code</th>
<th>Billed Amount</th>
<th>Paid Amount</th>
<th>Ineligible Reason Code / Amount</th>
<th>Ineligible Reason Code Description</th>
<th>Interim Discount</th>
<th>Copay</th>
<th>Coinsurance</th>
<th>Deductible</th>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>Unit or Time / Mile</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/08/2014</td>
<td>99999</td>
<td>R99.99</td>
<td>$155.00</td>
<td>$0.00</td>
<td>$109.23</td>
<td>Charges exceed PPO allowance.</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$45.77</td>
<td>99999</td>
<td>59</td>
<td>2</td>
</tr>
<tr>
<td>10/09/2014</td>
<td>99999</td>
<td>R99.99</td>
<td>$155.00</td>
<td>$0.00</td>
<td>$109.23</td>
<td>Charges exceed PPO allowance.</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$45.77</td>
<td>99999</td>
<td>59</td>
<td>2</td>
</tr>
</tbody>
</table>

### Ineligible Reason Codes

- Reason Code: 503
  - Description: Charges exceed PPO allowance.
Online Transaction Tips

How to avoid a *Claim Not Found* Response

- The Type 2 Billing NPI must matches the NPI submitted on claim.
- Enter the three letter alpha prefix prior to the member’s identification number in the Patient ID field.
- For local policies, the group number matches what was submitted on the claim.
- The date span entered as the Service Period includes the actual date(s) of service.

Institutional Claims

- Paid amounts reflected on the Detail Search Results screen indicates reimbursements applied per individual provider contracts (*e.g.*, Per Diem, DRG, etc.).
- Itemized payments listed in the line item breakdown will equal the total paid amounts indicated on Provider Claim Summaries (PCSs) and Electronic Remittance Advices (ERAs).

If...

- All line items are not displayed on the Detail Search Results screen, click the *More Results* link.
- The Detail Search Results screen prints are distorted, adjust the Page Orientation (*in Print Settings*) to landscape.
- The check number is not present on a finalized claim (see below), please allow additional time. The system reflects check information based on the payment schedule of the provider.

<table>
<thead>
<tr>
<th>Check / EFT / Voucher:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Check Date:</td>
<td>06/09/2016</td>
</tr>
<tr>
<td>Payee Name:</td>
<td>Holmes Clinic</td>
</tr>
</tbody>
</table>

Questions? Email the Provider Education Consultants at PECS@bcbsok.com

*Be sure to include your name, direct contact information, Tax ID or Billing NPI.*