

Availity™ Eligibility and Benefits Inquiry

An eligibility and benefits inquiry should be completed for every patient at each visit to confirm membership and verify coverage, such as patient's copay, coinsurance and deductible amounts.

Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

1. Getting Started

Go to availability.com

Select [Web Portal Users Login](#).

Enter User ID and Password.

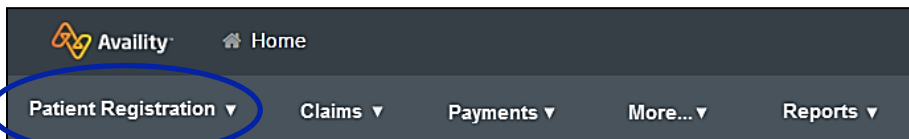
Select [Log in](#) button.

Note: Only registered users can access Eligibility and Benefits Inquiry.

2. Eligibility and Benefits Inquiry

Select [Patient Registration](#) from the top mega menu.

Select [Eligibility and Benefits Inquiry](#).




Note: Contact your Primary Access Administrator (PAA) if Eligibility and Benefits is not listed in the navigation menu.

3. Payer Selection

Select **BCBSOK** from the Payer drop-down for local policies.

Select **Other Blue Plans** for out-of-state policies.

Note: Contact the patient's home plan via 800-876-BLUE for additional information pertaining to eligibility and benefit verifications for out-of-state members.



4. Provider Information

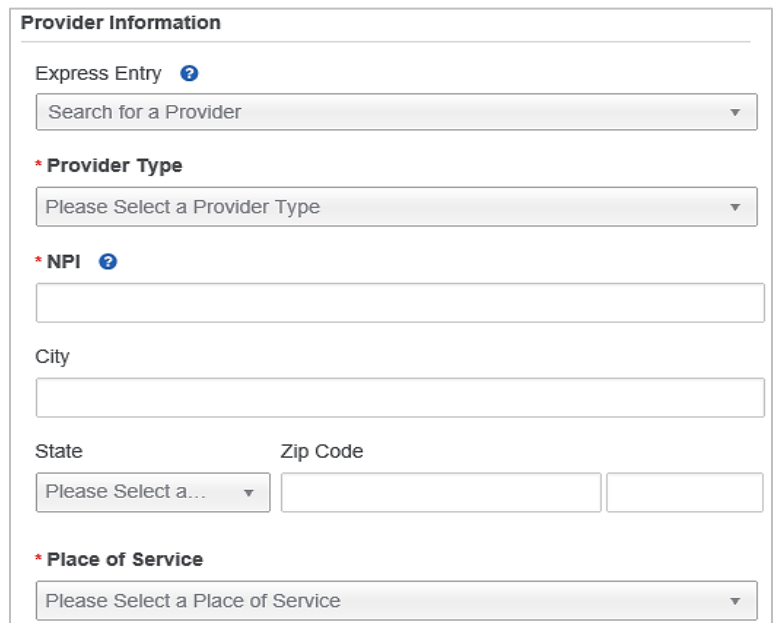
Select applicable provider name from Express Entry-Provider drop-down to auto-populate the *NPI* field.*

Complete the following:

- Provider Type
- Place of Service

Note: To receive accurate benefit quotes, professional providers should utilize the treating physician's rendering NPI (Type 1).

If providers have multiple organizations, the *City*, *State* and *Zip Code* fields should be utilized.



*If the applicable provider name does not appear in the Express Entry-Provider drop-down, enter the NPI into the NPI field.

5. Patient Information

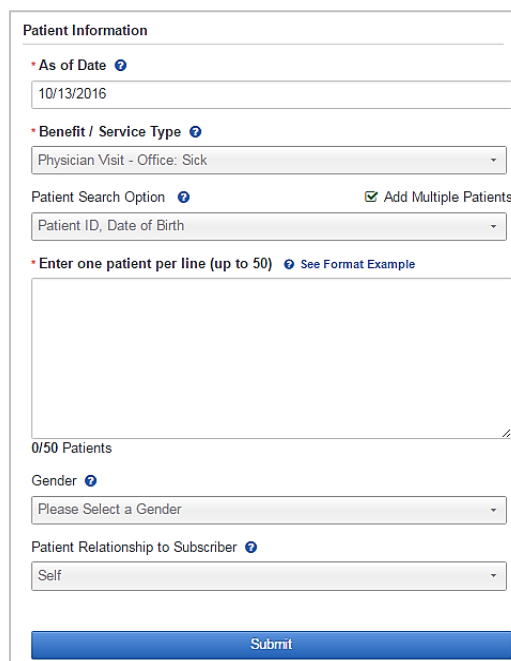
Select applicable Benefit/Service Type from the drop-down.

Next, complete the following:

- Patient ID (*including alpha prefix*)
- Date of Birth
- For multiple patients (optional) - check the box that says **Add Multiple Patients** in the appropriate search option format.

Select **Submit**.

Note: The *As of Date* can be changed to submit inquiries for a past or future date of service. Past date inquiries can be received up to 12 months prior to the current date. Future date inquiries can be requested within the current month.



A list of your most frequently used *Benefit / Service Types* will appear at the top of the drop down.

Select the Search Option drop-down to incorporate additional search criteria (*i.e.*, patient name, group number, etc.)

6. Patient History List

Once an eligibility and benefits request is completed, a new Patient Card will appear in the Patient History List, including all member's entered in the request.

Patient Card:

- Green – Active Membership
- Red – Inactive Membership
- Orange – Transaction Error

Search: At the top left corner of the page, users can locate the Patient Card by searching for **Name**, **Date** or **Payer**.

Note: To see all patients within your organization, uncheck “My Patients Only”. Users can Edit or Delete the patient’s Eligibility and Benefits search from the Patient History List. Patient History List holds up to 200 patients for 24 hours

7. Eligibility Summary Results

Eligibility for the requested patient will be displayed in the Patient Information tab on the results screen.

Results include:

- Patient Information
- Plan Date (*current effective date*)
- Subscriber Address
- Group Number
- Plan Sponsor Name (*employer*)
- Paid to Date *

* Individual members on and off the Health Insurance Marketplace

7. Eligibility Summary Results cont.

Additional eligibility information displayed on the Patient Information tab on the results screen.

Results include:

- Policy Type
- Payer
- Provider Details
- Other or Additional Payer

Plan / Product Information	
Active Coverage Insurance Type Health Maintenance Organization (HMO) Plan / Product Blue Advantage HMO	Service Types Health Benefit Plan Coverage
Payer Details	Other or Additional Payers
Payer BCBSOK	No Additional Payer Information
Provider Details	
Requesting Provider Name SMITH, JOHN Type Professional Role Attending NPI 123456789 Tax ID 987654321	
Benefit Disclaimer	
UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLE MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.	

Grace Periods

Some individuals who purchase insurance through the health insurance] may receive an advance premium tax credit (APTC). These members qualify for a three-month grace period to pay their premium—provided they have already paid at least one month's premium in full.

All allowable services provided during the first month of the grace period will be the responsibility of BCBSOK, subject to member cost sharing. BCBSOK will pend all claims incurred during the second and third months of the grace period. If the member pays all outstanding premium payment(s) in full, the claims will process according to the member's benefits.

The Plan/Product Information of the Patient Information tab will provide a grace period indicator for applicable members, including grace period start and end dates, as shown in the example below.

Note: Not all members who purchase coverage on the health insurance marketplace will receive the APTC.

Active Coverage
PERIOD START DATE May 01, 2015
PERIOD END DATE Jul 31, 2015
<ul style="list-style-type: none">• POLICY IS IN FEDERALLY REQUIRED THREE MONTH APTC GRACE PERIOD FOR PREMIUM NON PAYMENT. IF MEMBER DOES NOT BECOME CURRENT ON ALL OUTSTANDING PREMIUMS DUE, ANY SERVICES INCURRED AFTER THE FIRST DAY OF THE MONTH FOLLOWING THE PERIOD START DATE WILL BE DENIED.

8. Benefit Summary Results

Network status and the detailed benefit descriptions for the requested Benefit/Service Type are located under the Coverage and Benefits tab.

- Coverage Level (*individual or family*)
- Amount (*patient responsibility*)
- Quantity (*limitations or maximums*)
- Place of Service
- Time Period (*visit, calendar year, lifetime, etc.*)
- Description (*applicable services*)

Note: Only applicable benefits will be displayed. The below example does not show a maximum or limitation field; therefore, no limitations or maximums apply to these services.

Transaction ID: 2643962484 Transaction Date: May 08 11:06 am Customer ID: 20506

DOE, JANE Subscriber

MEMBER ID: ABC123456789 DOB: Mar 30, 1984 GENDER: Female

PLAN / COVERAGE DATE: Jan 01, 2015 - Dec 31, 9999

DATE OF SERVICE: May 08, 2015

[Edit](#) [Delete](#) [Print](#)

Patient Care Summary

Patient Information
Coverage and Benefits

In Network ▾

Surgical

- [Payer Notes](#)
- [Co-Insurance](#)
- [Deductible](#)
- [Out of Pocket \(Stop Loss\)](#)

Health Benefit Plan Coverage

- [Payer Notes](#)
- [Deductible](#)
- [Out of Pocket \(Stop Loss\)](#)

Hospital - Ambulatory Surgical

- [Payer Notes](#)
- [Co-Insurance](#)
- [Deductible](#)
- [Out of Pocket \(Stop Loss\)](#)

[Feedback](#)

Surgical - 2

Payer Notes - Surgical

- This policy has an employer-funded health care account that may be used to pay for qualified medical expenses, including, but not limited to, deductible.

Co-Insurance - Surgical

In Network Individual **20 %** Visit

PLACE OF SERVICE: Outpatient Hospital

- MEDICAL COLONOSCOPY INSTITUTIONAL

Deductible - Surgical

In Network Individual **\$1,100.00** Calendar Year

- \$1,100.00 Year to Date

PLACE OF SERVICE: Outpatient Hospital

- MEDICAL COLONOSCOPY INSTITUTIONAL; SURGERY - INSTITUTIONAL

\$0.00 Remaining

9. Benefit Qualifiers and Preauthorization Indicators

Below are examples of benefit qualifiers that may be returned depending on the patient's benefit contract. This information will be located under the Patient Information and Coverage & Benefits tab.

Note: If these fields do not return, then no benefit qualifiers or preauthorization requirements apply.

• THIS POLICY HAS AN EMPLOYER-FUNDED HEALTH CARE ACCOUNT THAT MAY BE USED TO PAY FOR QUALIFIED MEDICAL EXPENSES, INCLUDING, BUT NOT LIMITED TO, DEDUCTIBLE.

• ALL CT/CTA, PET SCANS, MRI/MRA/MRS AND NUCLEAR CARDIOLOGY STUDIES WILL REQUIRE A RADIOLOGY QUALITY INITIATIVE NUMBER

Services Restricted to Following Provider

NAME PHYSICIANS HEALTH ASSOC OF
TYPE Independent Physicians Association (IPA)
123 ANYWHERE ST.
BEACH VIEW, FL 123456
P: 800-000-0000

NAME Customer Service

TYPE Payer

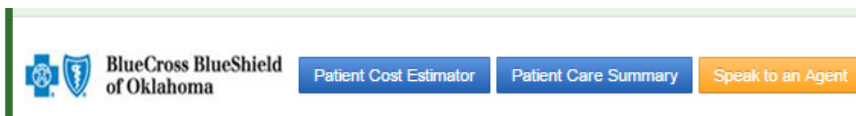
P: 800-000-0000

Auth Required

10. Speak to an Agent Feature

In some instances, benefit information may not be readily available online. The Speak to an Agent feature gives priority access to the next available customer advocate during standard business hours.

- 1) Select the [Speak to an Agent](#) button.
- 2) Dial the 800 number provided in the pop-up box.
- 3) Enter the 8-digit reference ID number via your touch tone key pad.



Note: This feature will only be available for medical benefits that are managed by BCBSOK. The Speak to an Agent button will not be offered for benefit information managed by other entities (e.g., vendors, government programs and labor fund carve outs).

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

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

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