



Availity’s Facility Claim submission feature offers providers a no-cost solution to quickly submit an electronic claim or encounter to Blue Cross and Blue Shield of Illinois (BCBSIL). Electronic claim submission can accelerate the claim and reimbursement process. This Availity option doesn’t require the use of a separate clearinghouse or practice management system.

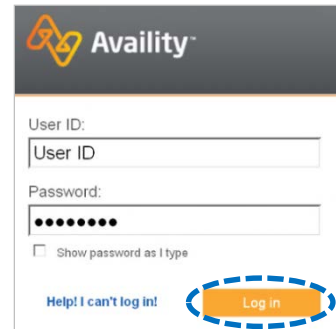
Note: This user guide provides instructions on completing and submitting the Facility Claim Submission form via the Availity portal. The guide is for educational purposes and should not be interpreted as advice on how to bill a claim.

Not Registered with Availity? Complete the guided online registration process today at [Availity](#),  at no charge.

1) Getting Started

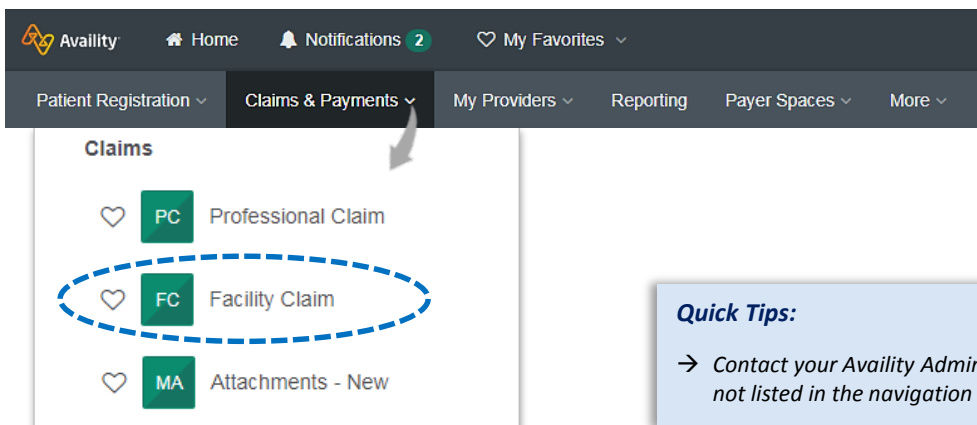
- ▶ Go to [Availity](#) 
- ▶ Select **Availity Portal Login**
- ▶ Enter User ID and Password
- ▶ Select **Log in**

Note: Only registered Availity users can access the Facility Claim option.



2) Accessing the Facility Claim Form

- ▶ Select **Claims & Payments** from the navigation menu
- ▶ Select **Facility Claim**



Quick Tips:

→ Contact your Availity Administrator if **Facility Claim** is not listed in the navigation menu.

3) Payer Selection

- ▶ Select your **Organization**
- ▶ Choose **Transaction** from the drop-down list
- ▶ Select **Payer** from the drop-down list
- ▶ Select **Continue**

Organization
 | ▾

Transaction
 | ▾

Payer
 | ▾

4) Patient Information

- ▶ Select **Facility Type**
- ▶ Select Primary or Secondary from the **Responsibility Sequence**
- ▶ Enter **Statement From & To Date**
(must be past or current date)

Complete the following:

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

Quick Tips:

- All fields with red asterisks * are required fields.
- If submitting a Secondary claim, make sure to include all primary claim information.

* Payer: ?

* Organization:

Transaction Type: ? ▾

* Facility Type: ?

Responsibility Sequence: ? ▾

* Statement: ? From / / To / /

Patient Information

* Last Name:

First Name:

Middle Name or Initial:

* Date of Birth: / /

Date of Death: / /

* Gender: ▾

Country: ? ▾

* Address 1:

Address 2:

* City, State, ZIP Code: ▾ -

* Relationship to Subscriber: ? ▾

release signature from provider on behalf of patient

Patient Amount Paid: ?

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.

Note: If the patient's condition is related to employment, auto accident, or other accident check the appropriate box and fill in the requested information.

Patient's Condition Is Related To:

(Select all options that apply to patient's condition)

- current or previous employment
- auto accident
- other accident

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 the field for a **secondary insurance plan** and enter requested information

* Subscriber ID: ?

Policy or Group Number: ?

* Authorized Plan to Remit Payment to Provider? ?

This claim also includes...

a secondary insurance plan

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. Contact your Availity Administrator to have the provider information added if not available.

Complete the following:

- ▶ **Organization / Provider Last Name**
- ▶ **Address**
- ▶ **City, State, Zip Code**
- ▶ **Specialty / Taxonomy**
- ▶ **NPI**
- ▶ **Tax ID**
- ▶ **Provider Accepts Assignment**
- ▶ **Release of information code** (related to HIPAA disclosures with your patient)

Billing Provider Information

Select a Provider: ?

* Organization / Provider Last Name: ?

Phone Number: ? - - Ext.

Fax Number: - -

E-mail:

Country: ?

* Address 1: ?

Address 2: ?

* City, State, ZIP Code: -

* Specialty / Taxonomy:

* NPI: ?

* Tax ID: ?

Important: Enter the tax ID to which the claim should be paid.

* Provider Accepts Assignment: ?

* Release of Information Code: ?

Note: If this claim has additional provider information, select the appropriate field and enter the requested information.

This claim has additional provider information...

- additional billing provider contact information
- a billing provider pay-to address that is different from the billing provider address
- a service facility location that is different from the billing provider

7) Attending Provider Information

- ▶ Enter the **Attending Provider** information

Attending Provider Information

Express Entry - Attending Provider:

* Last Name:

* First Name:

* Specialty / Taxonomy:

* NPI: ?

This claim also includes...

a rendering provider that is different from the attending provider

an operating physician

8) Diagnosis Codes

- ▶ Enter the **Principal ICD-10 Diagnosis Code**
- ▶ Select **Add Another Code** to add up to 12 diagnosis codes

Diagnosis Codes ?

* Principal Diagnosis Code: [ICD-10 Code Verification ?](#)

Present on Admission (POA):

* Diagnosis Code 2: [ICD-10 Code Verification ?](#) [Remove](#)

POA Indicator:

9) Claim Information

- ▶ Enter the **Patient Control Number** (the patient account number assigned by your office)
- ▶ Select **Billing Frequency**:
 - **Frequency Code 1** (new claim)
 - **Frequency Code 7** (replacement claim)
 - **Frequency Code 8** (void/cancel claim)
- ▶ Enter any applicable **Prior Authorization Number**
- ▶ Select **Admission Type** (if the options listed do not fit your scenario, choose *Elective or Information Not Available*)
- ▶ Select **Admission Source**

* Patient Control Number / Claim Number: ?

Diagnosis Related Group (DRG) Code: ?

Medical Record Number:

* Billing Frequency: ?

this is an HMO claim

Prior Authorization Number: ?

Auto Accident Country:

* Admission Type:

* Admission Source:

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.

9) Claim Information *continued*

- ▶ Additional information may also be included on the standard claim form
- ▶ To include the additional information select the appropriate fields and include the requested details

This claim also includes...

- an EPSDT referral
- external injury codes
- occurrence span codes
- occurrence information codes
- value codes
- condition codes
- treatment codes
- an attachment

10) Service Line(s) & Submission

Enter the following:

- ▶ **Line Item Control Number** (*Service Line Number*)
- ▶ **Revenue Code**
- ▶ **Date of Service** (*i.e., 01/01/2020*)
- ▶ **Charges** (*excluding the "\$" sign*)
- ▶ **Service Unit Count** (*enter the number of units/minutes*)

Note: If the service line includes additional information, select the appropriate option and fill in the details as requested.

Line Number	Date(s) of Service:		Procedure Code CPT/HCPCS	Modifiers				Revenue Code	Charges	Days or Units
	From	To		1	2	3	4			
No claims entered yet. Enter claim(s) below and click Save to Service Line.										
									Total:	\$0.00
Line Number:	1									
* Line Item Control Number: ?	<input type="text" value="1"/>									
* Revenue Code: ?	<input type="text"/>									
Date of Service: ?	From		To							
	MM	DD	YYYY	MM	DD	YYYY				
Procedure Code: ?	<input type="text"/>									
	<input type="checkbox"/> non-specific procedure code description									
Modifiers:	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>						
* Charges:	<input type="text"/>									
Non-Covered Charge Amount:	<input type="text"/>									
* Service Unit Count: ?	<input type="text"/>									Units <input type="text" value="1"/>
This service line also includes...										
<input type="checkbox"/> reporting of a national drug code (NDC)										
<input type="checkbox"/> a rendering provider that is different from the attending provider										
<input type="checkbox"/> an operating physician										
<input type="button" value="Save to Service Line"/>										

Quick Tip:

→ Once all the service line information has been entered, select **Save to Service Line**. Without saving, the information will be removed. This also allows for additional service lines to be added.

- ▶ After all appropriate information has been entered and reviewed, select **Submit** at the bottom of the claim form

11) Submission Confirmation

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

Claim Response Detail Learn More >>

Transaction ID: 1050455769
Transaction Date: Jul 21, 2020 09:11 AM EDT
Customer ID: 262573

Your claim has been sent to BCBSIL, which processes claims in batches. You will receive the response for this claim in your ReceiveFiles mailbox.

BlueCross BlueShield of Illinois

Claim Number: 12345
Submission Type: Facility Claim
Submission Date: 07/21/2020
Date(s) of Service: 07/20/2020
Patient Name:
Subscriber Name:
Subscriber ID:
Billing Provider Name:
Billing Provider NPI:
Billing Provider Tax ID:
Total Charges: \$1151.00

12) Confirming Claim Receipt

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

Claims & Payments ▾
My Providers ▾
Reporting
Payer Spaces ▾
More ▾

Claim Status & Payments

- ♥ CS Claim Status
- ♥ RV Remittance Viewer
- ♥ CRT Claim Research Tool (BCBS)

Claims

- ♥ PC Professional Claim
- ♥ FC Facility Claim
- ♥ MA Medical Attachments

EDI Clearinghouse

- ♥ EDI Send and Receive EDI Files
- ♥ FR File Restore
- ♥ EDI EDI Reporting Preferences

12) Confirming Claim Receipt *continued*

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

Send And Receive EDI Files [Learn More >>](#)

Select the Organization for the files to be uploaded and then submit.

* Organization:

Submit

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

Files				
Name	Size [B]	Date	File Options	Delete
Announcements		May 01 2015 00:00		
ReceiveFiles		Aug 12 2020 11:15		
SendFiles		Aug 12 2020 10:38		

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.

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

Files				
Sort By: Name Extension Date				
Name	Size [B]	Date	File Options	Delete
EBT-BCBSIL000-202000000000-001.ebt	1958	Sep 12 2020 10:00		
DPT-BCBSIL000-202000000000-001.dpt	1997	Sep 14 2020 10:15		
IBT-BCBSIL000-202000000000-001.ibt	1934	Sep 12 2020 10:00		

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.

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.

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