Availity's Professional 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 does not require the use of a separate clearinghouse or practice management system.

Note: *This user guide provides instructions on completing and submitting the Professional 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.

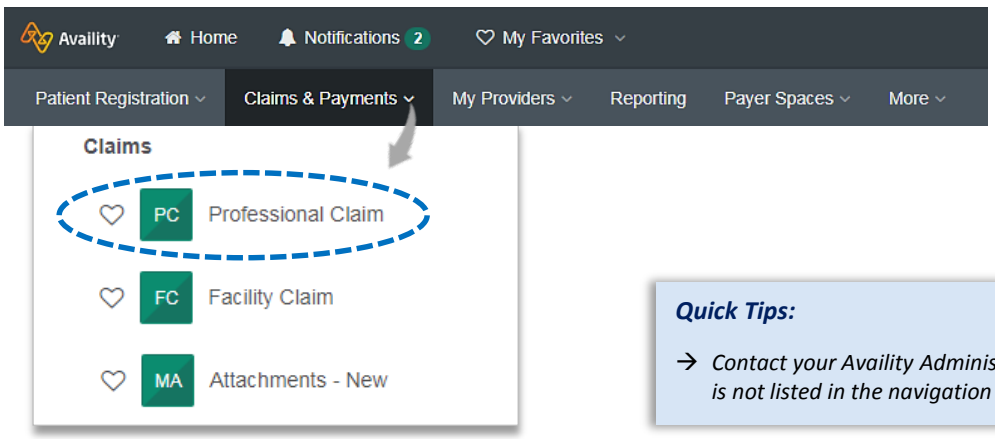
1) Getting Started

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

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

2) Accessing the Professional Claim Form

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

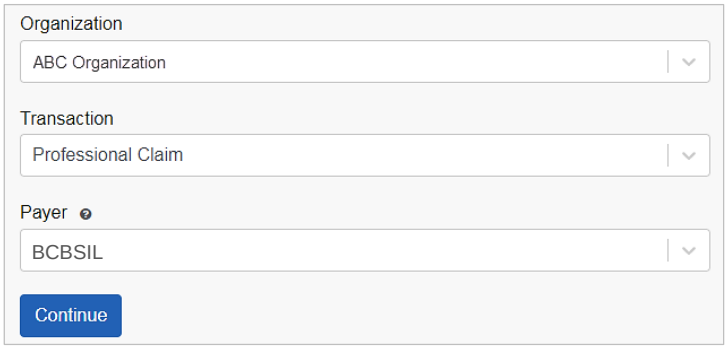


Quick Tips:

→ *Contact your Availity Administrator if **Professional 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**

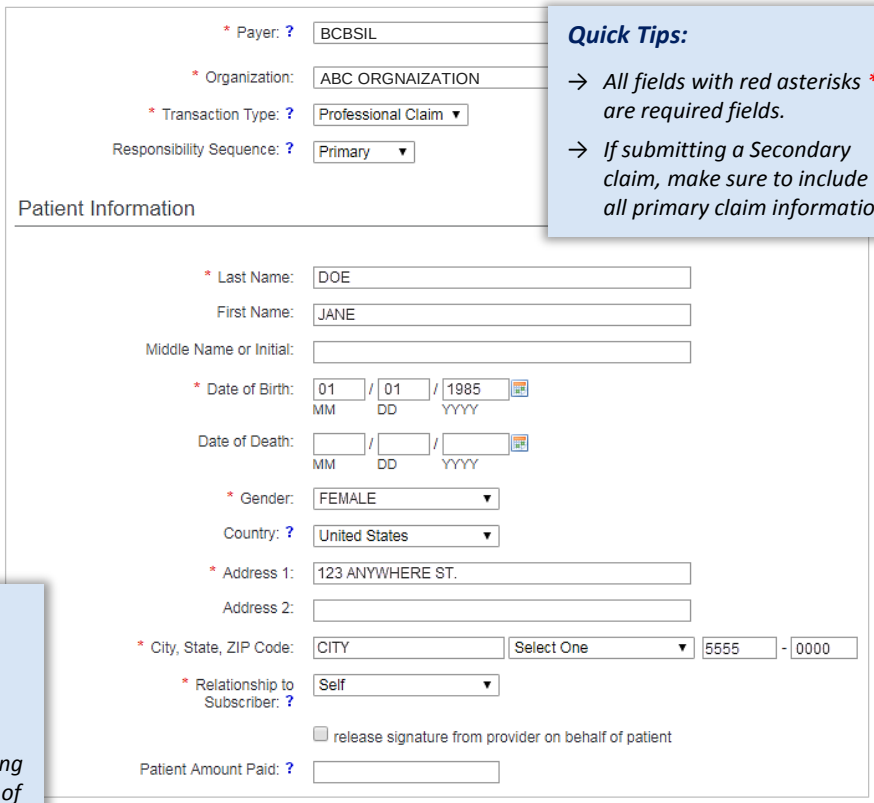


4) Patient Information

- Select Primary or Secondary from the **Responsibility Sequence**

Complete the following:

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



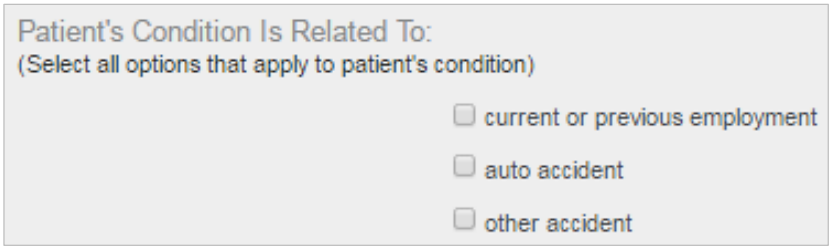
Quick Tips:

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

Quick Tips:

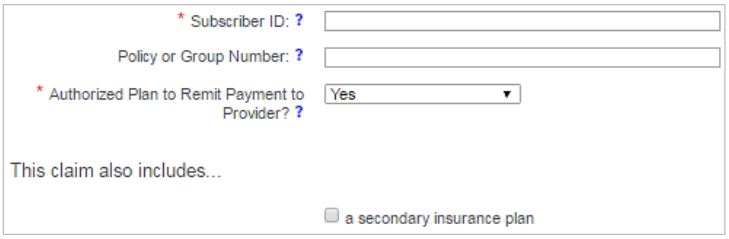
- → *If an Availity Eligibility and Benefits Inquiry is completed first, data will pre-populate into the Patient and Subscriber Information sections.*
- → *While "First Name" is not a required field, entering this information will ensure accurate processing of your claim.*

***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.*



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



Quick Tip:

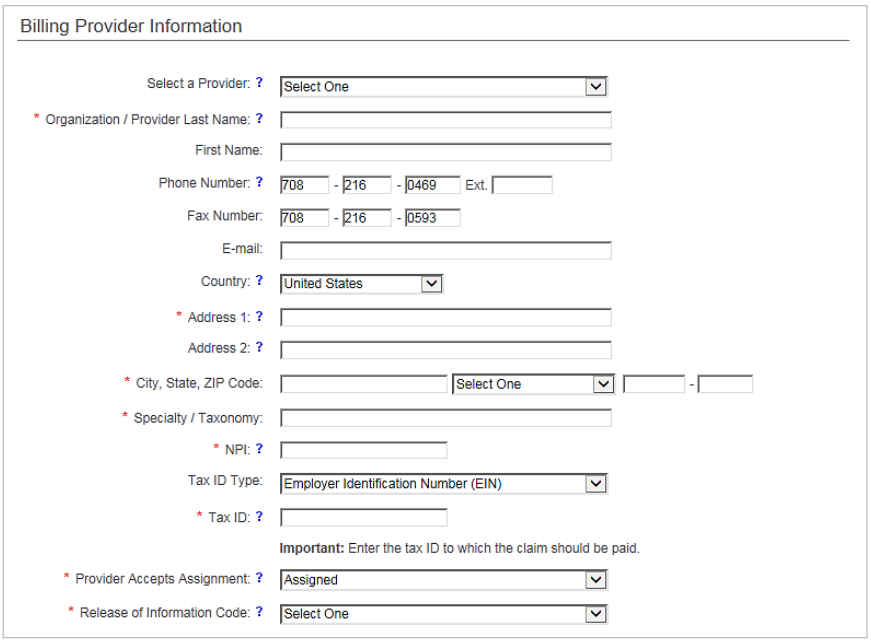
→ *Some out-of-state plans may have longer ID numbers; for these patients make sure you enter the three-character prefix and ID number as listed on the member's card. Include any alpha characters embedded within the ID.*

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.

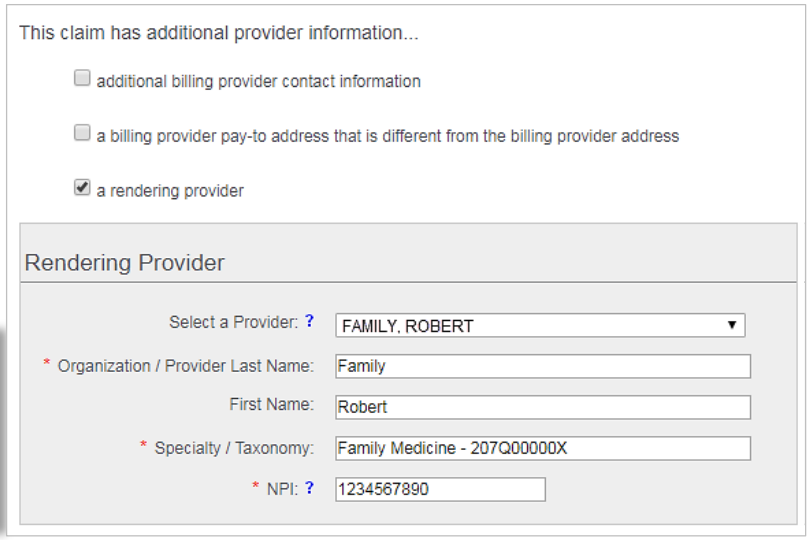
Complete the following:

- **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)*



7) Additional Provider Information

- Select **a rendering provider** and enter the associated **provider information** *(if applicable)*



Quick Tip:

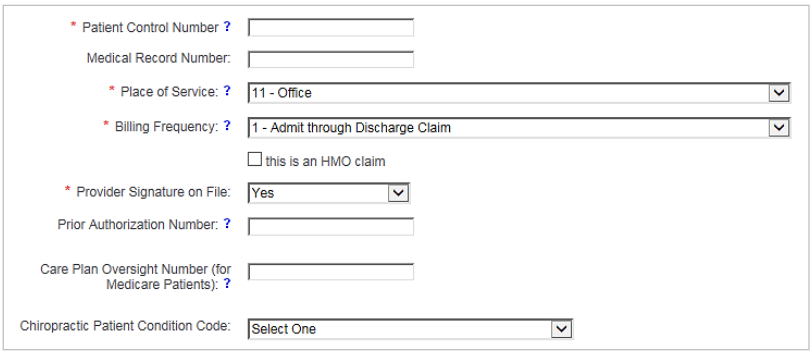
→ *A common claim processing error occurs when providers do not include the rendering provider information in this area. This is critical to the claim being accepted for processing.*

8) Diagnosis Codes

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

9) Claim 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)*
- Enter any applicable **Prior Authorization Number**

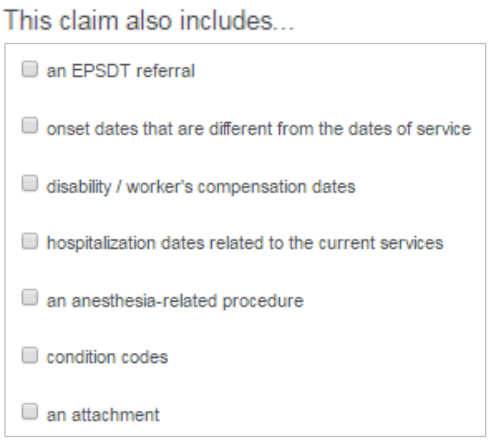


Quick Tip:

→ *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

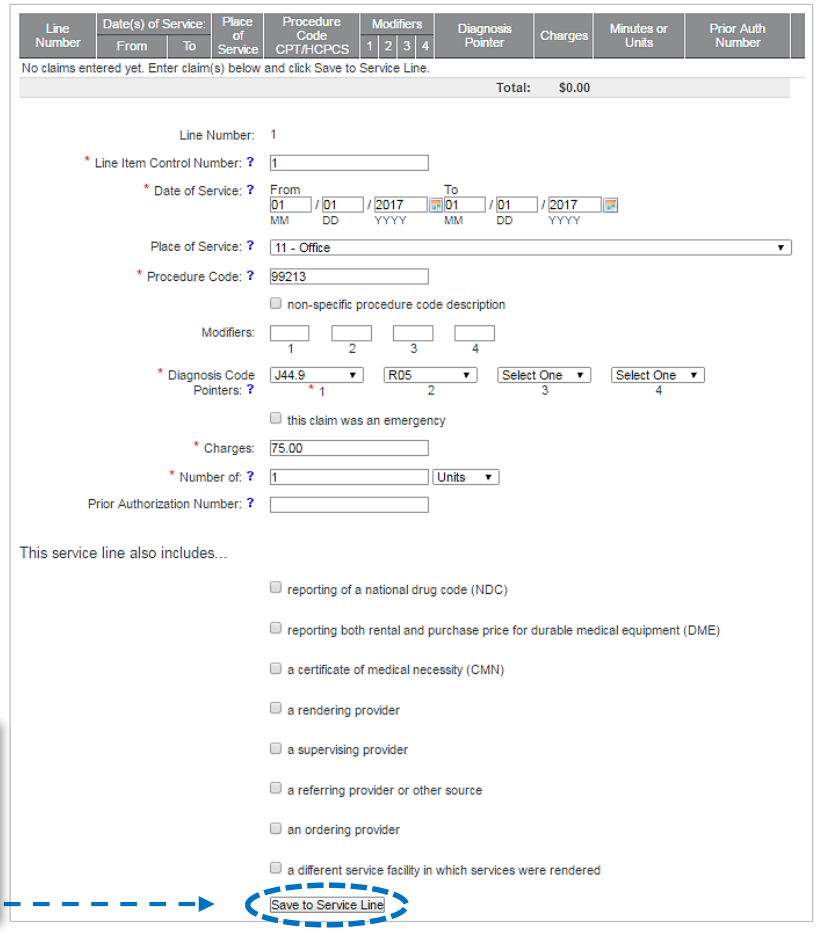


10) Service Line(s) & Submission

Enter the following:

- **Line Item Control Number** *(Service Line Number)*
- **Date of Service** *(i.e., 01/01/2020)*
- **Procedure Code**
- **Diagnosis Code Pointers** *(use drop-down to choose the appropriate order)*
- **Charges** *(excluding the "$" sign)*
- **Number Of** *(enter the number of units/minutes)*

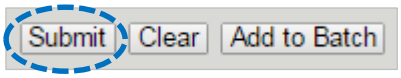
Note: *If the service line includes additional information, select the appropriate option and fill in the details as requested.*



Quick Tip:

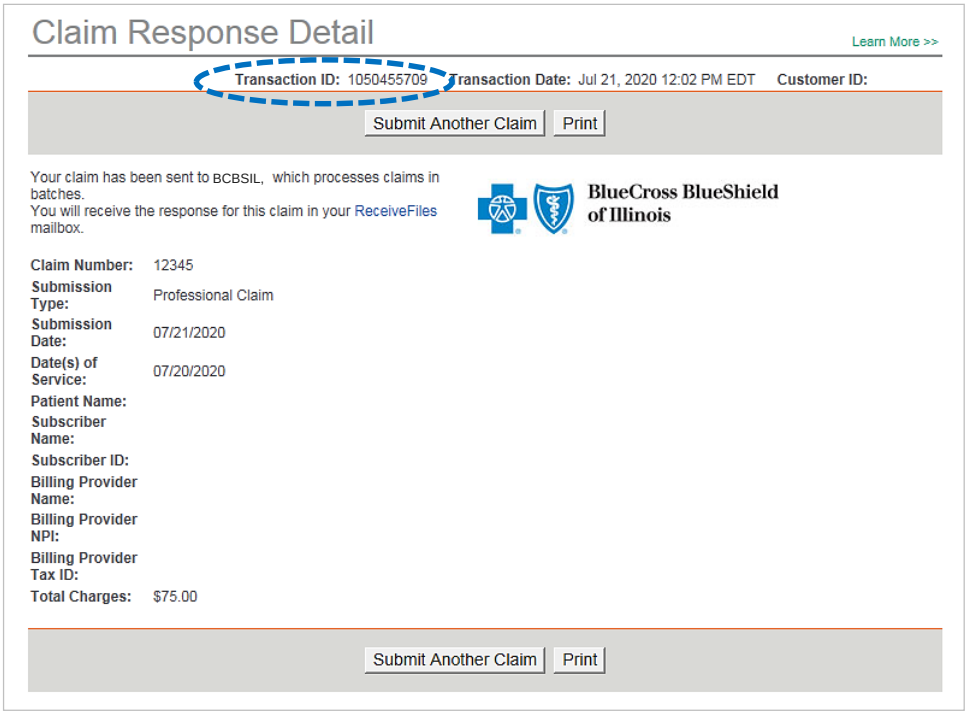
→ *Once all the service line information has been entered, select* ***Save to Service Line****. Without saving, the information will be removed. This also allows for additional service lines to be added.*

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



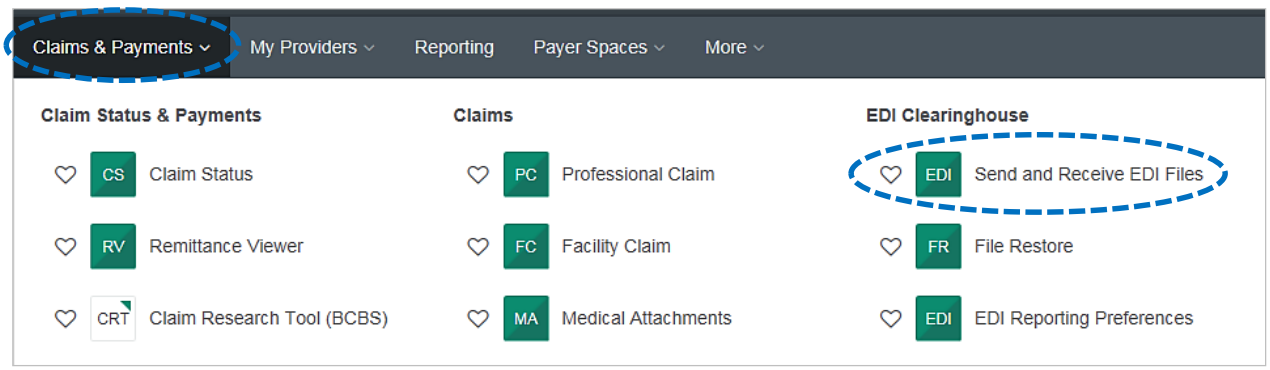
11) Submission Confirmation

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



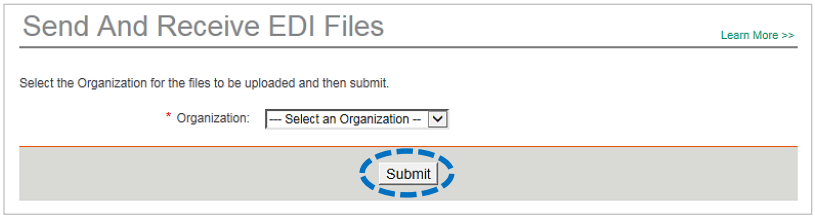
12) Confirming Claim Receipt

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

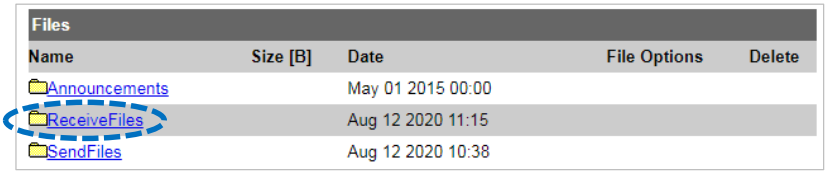


12) Confirming Claim Receipt *continued*

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



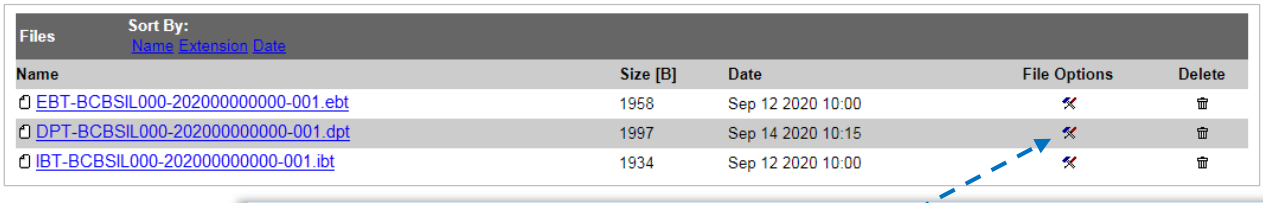
- Select **Receive Files** *(the below EDI Files will be available in **Receive Files** within 24 to 48 hours after submission)*



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



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.