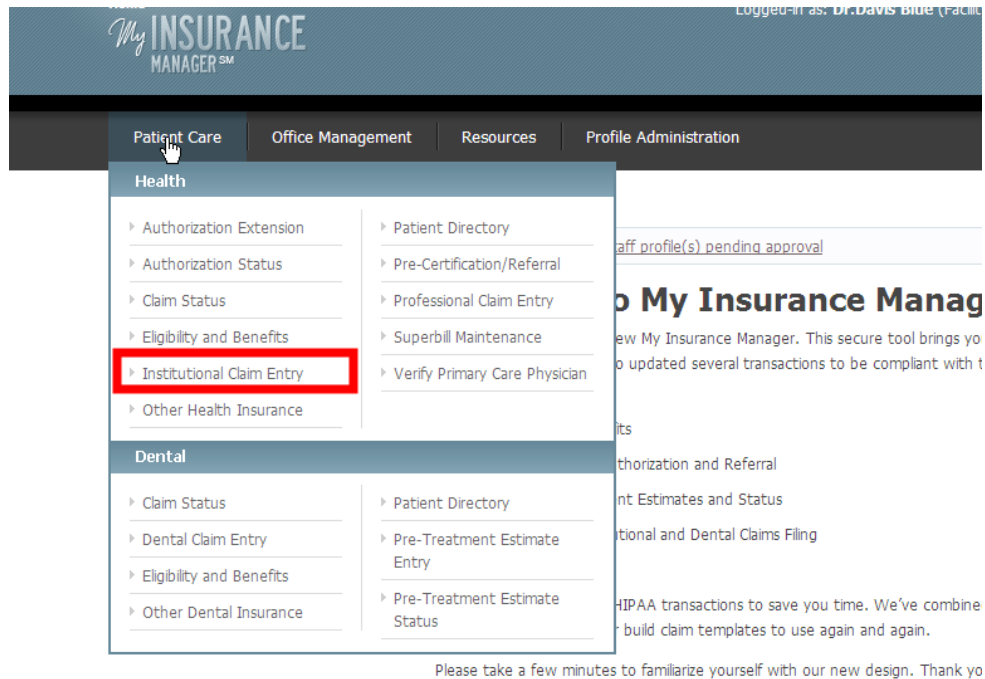


My **INSURANCE** **MANAGER**SM

INSTITUTIONAL CLAIMS ENTRY — UB04

USER GUIDE

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association



To file an institutional HCFA-1500 claim, from the Patient Care menu choose Institutional Claim Entry.

INSTITUTIONAL CLAIM ENTRY – PLAN INFORMATION

Printer-Friendly

Institutional Claim Entry

Plan Information
Provider Information
Patient Information
Claim Information
Claim Codes
Claim Line Information
Review
Confirmation

Plan Information

* Indicates required field.

Submitter Information

If the following information is not correct, please [modify your profile](#). Any information you entered will be lost if you navigate away from this page.

Name: <input type="text" value="Dr. Blue"/>	ID: <input type="text" value="570874077"/>	Email Address: <input type="text" value="rao.peddi@bcbscc.com"/>
Phone: <input type="text" value="(803) 264-1111"/>	Extension: <input type="text" value="1234"/>	Fax: <input type="text" value="(803) 123-7892"/>

Plan Information

* Plan:

- BlueCross BlueShield Plans
- Please Choose One--
- BlueCross BlueShield Plans**
- BlueChoice HealthPlan
- Employee Benefit Services dba Key Benefit Admin
- PEP
- Planned Administrators
- State Health Plan
- Thomas Cooper

mm/dd/yyyy mm/dd/yyyy

Plan Information

* Plan:

* Is the selected plan the primary payer?

* From Date of Service:

To Date of Service:

mm/dd/yyyy mm/dd/yyyy

The Plan Information page will list your profile information first. You will need to select a Plan, indicate if the plan is the primary payer. You will also need to enter the applicable dates of service.

Plan Information
Provider Information
Patient Information
Claim Information
Claim Line Information
Review
Confirmation

Note: Institutional claims entry features a progress bar near the top of the screen. You can go back to previous pages by clicking on the page you want.

INSTITUTIONAL CLAIM ENTRY – PROVIDER INFORMATION

* Indicates required field.

Provider Information

Billing Location Information

*Click **Choose a Billing Provider** to select from a list of locations affiliated with your Tax ID. The billing location address must be the physical address (not P.O. Box) and must contain a 9-digit ZIP code.*

Choose a Billing Provider

Provider ID Type:

Provider ID:

Provider Name:

* Address Line 1:

Address Line 2:

* City: * State:

* ZIP Code + 4: -

* Provider Accepts Assignment:

Select **Choose a Billing Provider** to pick the location where the services are rendered. Once you choose a location, My Insurance Manager will automatically display the Provider ID Type, Provider ID, Provider’s Name and Address information. Please make sure the Provider Accepts Assignment and Provider Signature on File fields have the correct selections for your patient/situation.

Provider Locations Claims Entry Billing Provider

These locations are valid for the date(s): 09/04/2011

Select a location from this list.

Select	Provider ID ▲	Provider Name	Address	Specialty
<input type="radio"/>	123456789	Test Hospital	123 Hospital Lane, Columbia SC 29223-5555	SHORT TERM GENERAL HOSPITAL
<input type="radio"/>	234567891	Test Ambulatory Surgical Center	123 Surgery Place, Columbia, SC 29201-5555	AMBULATORY SURGICAL CENTER
<input type="radio"/>	345678912	Test Urgent Care Center	123 Urgent Road, Columbia, SC 29203-5555	URGENT CARE
<input type="radio"/>	456789123	Test Clinic	123 Clinic Ave, Columbia, SC 29223-5555	MULTI-SPECIALTY CLINIC
<input type="radio"/>	567891234	Test Internal Medicine	123 Medical Circle, West Columbia, SC 29160-5555	INTERNAL MEDICINE

Continue

INSTITUTIONAL CLAIM ENTRY – PROVIDER INFORMATION

Attending Provider Information

Provider ID Type:

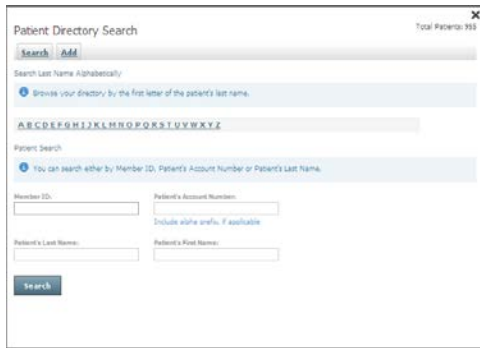
Provider ID:

or [Back](#) [X Cancel this claim](#)

Once you've selected a billing location, you have to enter the attending provider's identification number. First, select whether the Provider ID Type is a primary (NPI number) or a secondary number. Then, enter the Provider ID number.

INSTITUTIONAL CLAIM ENTRY – PATIENT INFORMATION

There are two options for entering your patient's information. You can select the Choose a Patient link if the patient is already loaded in your Patient Directory or you can manually enter the patient's information.



The screenshot shows a web interface titled "Patient Directory Search" with a close button (X) in the top right corner. Below the title, there is a search bar with "Search" and "Add" buttons. A "Total Patients: 753" indicator is visible. The interface is divided into two main sections: "Search Last Name Alphabetically" and "Patient Search".

Search Last Name Alphabetically: This section includes a blue instruction box: "Browse your directory by the first letter of the patient's last name." Below this is a horizontal list of letters from A to Z, with 'A' highlighted in blue.

Patient Search: This section includes a blue instruction box: "You can search either by Member ID, Patient's Account Number or Patient's Last Name." Below this are four input fields: "Member ID:", "Patient's Account Number:", "Patient's Last Name:", and "Patient's First Name:". There is also a checkbox labeled "Include alpha prefix, if available" located between the "Patient's Account Number" and "Patient's Last Name" fields. A "Search" button is located at the bottom left of this section.

This screen will display if you select Choose a Patient. For detailed instructions on using the Patient Directory please refer to the Patient Directory User Guide.

INSTITUTIONAL CLAIM ENTRY – PATIENT INFORMATION

Home
Logged-in as: Dr. Blue (generic practice) [Modify Profile](#) [Logout](#)

Patient Care
Office Management
Resources
Profile Administration

[Printer-Friendly](#)

Institutional Claim Entry

Step Information
Provider Information
Patient Information
Claim Information
Claim Codes
Claim Line Information
Review
Confirmation

* Indicates required field.

Dates of Service
01/03/2012 - 01/03/2012

Insurance
Plan Name:
BlueCross BlueShield Plans

Patient Information

Patient Details

Changes made to the information below will not be updated in your Patient Directory. Enter the Member ID as shown on the member's ID card.

Choose a Patient or enter the information below.

* Member ID: <input type="text" value=""/>	* Relationship to Member: <input type="text" value="SELF"/>	* Patient Account Number: <input type="text" value=""/>
<small>(include alpha prefix, if applicable)</small>		
* Last Name: <input type="text" value=""/>	* First Name: <input type="text" value=""/>	* M.I.: <input type="text" value=""/>
Suffix: <input type="text" value=""/>		
* Date of Birth: <input type="text" value=""/>	* Gender: <input type="text" value="--Please Choose One--"/>	
<small>mm/dd/yyyy</small>		
* Country: <input type="text" value="United States"/>		
* Address Line 1: <input type="text" value=""/>		
Address Line 2: <input type="text" value=""/>		
* City: <input type="text" value=""/>	* State: <input type="text" value="--Please Choose One--"/>	
* ZIP Code: <input type="text" value=""/>		

Patient Consent

*** Benefits Assigned to Provider:**

*** Release of Information:**

Continue or [Back](#)
X Cancel this claim

Patient Consent

*** Benefits Assigned to Provider:**

*** Release of Information:**

On the Patient Information page there is a section for Patient Consent. Select the appropriate answer for Benefits Assigned to Provider and Release of Information before clicking Continue.

INSTITUTIONAL CLAIM ENTRY – CLAIM INFORMATION

[Printer-Friendly](#)

Institutional Claim Entry

Plan Information
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Confirmation

* Indicates required field.

Dates of Service
01/03/2012 - 01/03/2012

Insurance
Plan Name:
BlueCross BlueShield Plans
Member ID:
XYZ999574317

Patient
Patient's Name:
MICHAEL P TESTING
Relationship to Member:
SELF
Gender:
MALE
Date of Birth:
10/01/1958

Claim Information

Service Information

The Institutional "Bill Type" is defined by the information in the Facility Type and Claim Type/Frequency fields.
A Point of Origin for Admission or Visit is required on all claims unless the Facility Type is 14.

* Facility Type: * Claim Type/Frequency:

* Patient Status:

Admission Date: Admission Time: Discharge Time:

* Priority (Type) of Admission or Visit:

Point of Origin for Admission or Visit:

Continue or [Back](#) X Cancel this claim

Complete all required fields before clicking Continue.

INSTITUTIONAL CLAIM ENTRY – CLAIM CODES

* Indicates required field.

Claim Codes

Diagnosis and Condition Codes

Please use ICD-9-CM codes to report the following diagnosis information.

Principal Diagnosis Code: Principal Diagnosis Present on Admission (POA) Indicator:

Other Diagnosis Code: Other Diagnosis Present on Admission (POA) Indicator:

Other Diagnosis Code: Other Diagnosis Present on Admission (POA) Indicator:

Other Diagnosis Code: Other Diagnosis Present on Admission (POA) Indicator:

[Add Diagnosis Codes](#)

Please note: We require an **Admitting Diagnosis** on all inpatient claims and encounters, a **Reason for Visit** on all unscheduled outpatient visits, and an **E-Code** to describe an injury, poisoning or adverse effect.

Admitting Diagnosis Code:

Reason for Visit Code: Reason for Visit Code: Reason for Visit Code:

E-Code: E-Code Present on Admission (POA) Indicator:


[Add E-Codes](#)

Condition Codes:

Diagnosis Related Group (DRG) Code:

You must enter at least one Diagnosis Code on the Claim Codes screen. You can click Add Diagnosis Codes to add additional Diagnosis Codes to your claim. Note that an Admitting Diagnosis Code is required on all inpatient claims. Unscheduled outpatient claims require a Reason for Visit Code and an E-Code.

Procedure Codes

 We require the **Principal Procedure Code** and **Principal Procedure Code Date** on all inpatient claims when a procedure was performed and on Home IV therapy claims when surgery was performed during the inpatient stay from which the course of therapy was initiated.

Principal Procedure Code: Principal Procedure Code Date:

Other Procedure Code: Other Procedure Code Date:

[Add Other Procedure Codes](#)

Occurrence Codes and Dates

Occurrence Code: Occurrence Date:


[Add Occurrence Codes and Dates](#)

Occurrence Span Codes and Dates

Occurrence Span Code: Occurrence Span From Date: Occurrence Span To Date:

[Add Occurrence Span Codes and Dates](#)


Value Codes and Amounts

 Some information relating to another payer's adjudication of the claim may be reported as **Value Codes** here or as claim adjustments on the Other Payer Claim Adjustment page. If reported here, that adjudication information should not be repeated on that page.

Value Code: Amount:

[Add Value Codes and Amounts](#)

Treatment Codes

 We require **Treatment Codes** when home health agencies need to report plan of treatment information.

or [Back](#)

You can also enter the Principal Procedure Code and add Other Procedure Codes if needed. If applicable, complete the Occurrence Codes, Occurrence Dates, Occurrence Span Codes, Occurrence Span Dates, Value Codes, Amounts and Treatment Codes. Click Continue.

INSTITUTIONAL CLAIM ENTRY – CLAIM LINE INFORMATION

Institutional Claim Entry

Plan Information
Provider Information
Patient Information
Claim Information
Claim Codes
Claim Line Information
Review
Confirmation

* Indicates required field.

Dates of Service
01/03/2012 - 01/03/2012

Insurance
Plan Name:
BlueCross BlueShield Plans
Member ID:
XYZ999574317

Patient
Patient's Name:
MICHAEL P TESTING
Relationship to Member:
SELF
Gender:
MALE
Date of Birth:
10/01/1958

Claim Line Information

Claim Amounts

The Total Claim Charges will be calculated automatically based on the amounts entered on the claim lines.

Total Claim Charges: \$ 0.00 Total Number of Lines: 1

Claim Lines

We require the HCPCS Procedure Code and Date of Service on all outpatient claim lines when an appropriate HCPCS Level 1 (AMA CPT Code) exists for the services the patient received.

Line 1

* Revenue Code: Procedure Code Type: Procedure Code: Modifiers:

Procedure Description:

* From Date of Service: To Date of Service: * Unit Type: * Unit(s):

mm/dd/yyyy mm/dd/yyyy

* Line Charge Amount: \$ Non-Covered Charges: \$

Drug Identification: [\[-\] show/hide](#)

[Add a New Claim Line](#) X Cancel this claim

or [Back](#)

Enter the information from the line of your claim. The number of lines field automatically defaults to one. You can enter up to 99 lines for institutional claims. You will see claim line sections for each line of your claim. Complete the required fields. You can add additional lines at the bottom if you need to and you can also delete any lines you don't need. Click Continue.

Drug Identification: [\[-\] show/hide](#)

* National Drug Code: * Unit(s): * Measurement Code:

* Prescription Number Qualifier: * Prescription Number:

Click show/hide beside Drug Identification to add additional drug information. Note that if you show this section, you must complete all required fields before clicking Continue.

INSTITUTIONAL CLAIM ENTRY – CLAIM REVIEW

Institutional Claim Entry

Plan Information
Provider Information
Patient Information
Claim Information
Claim Codes
Claim Line Information
Review
Confirmation

Dates of Service
01/03/2012 - 01/03/2012

Insurance
Plan Name:
BlueCross BlueShield Plans
Member ID:
XYZ99574317

Patient
Patient's Name:
MICHAEL P TESTING
Relationship to Member:
SELF
Gender:
MALE
Date of Birth:
10/01/1958

Claim Review

☞ This is a summary of the claim information you are about to submit. Please make any necessary changes and submit.

Provider Information

Submitter Name: Billing Location: Plan:

Patient Information

Member ID: Date of Birth: Gender:

Patient's Name: Patient Account Number:

Claim Information

This is a claim-level summary. Click [Add Additional Claim Information](#) to add information that applies to the entire claim. If another payer is primary for this claim, click [Claim Level Adjustments](#) to add or edit adjustments at the claim level.

Total Charges: Dates of Service:

[Add Additional Claim Information](#)

Claim Line Information

Line	Revenue	From Date of Service	Charges	Additional Line Information
1	370	01/03/2012	\$ 250	Add

☞ If all the above information is accurate and you are ready to submit the claim for processing, click the **Submit** button. Please Note: We must validate all claim information before you can submit it for processing. If we find any errors, we will return the claim to you for correction. Once we validate the claim information and you have corrected any errors, you cannot make changes to that information.

or [Back](#)
[X Cancel this claim](#)

Confirm the claim information you entered. You can also enter additional claim information. After reviewing your claim, click Submit.

Institutional Claim Entry

Dates of Service
01/03/2012 - 01/03/2012

Insurance
Plan Name:
BlueCross BlueShield Plans
Member ID:
XYZ99574317

Patient
Patient's Name:
MICHAEL P TESTING
Relationship to Member:
SELF
Gender:
MALE
Date of Birth:
10/01/1958

Additional Claim Information

This information will apply to all claim lines included on this claim. If the information only applies to an individual claim line, then please submit it at the claim line level and not here. You can find more information on required information [here](#).

Additional Claims Information Selection

☞ This information will apply to all claim lines on this claim. To add information that applies to an individual claim line, return to the Claim Review page and click the [Add](#) link on the line to which the information applies. To proceed with adding claim-level information, please choose from the options below.

General Claim Information

Auto Accident State

Group Information

Billing Note Information

Investigational Device Billing Number

Claim Attachment Information

Medical Record Number

Claim Note Information

Patient Estimated Amount Due

Delay Reason Code

Peer Review Organization Approval Number

Demonstration Project ID

Prior Authorization or Referral Number

Reply & Escalate Screening, Diagnosis, and Treatment Information

Additional Provider Information

Operating Physician Information

Rendering Provider Information

Other Operating Physician Information

Service Facility Location Information

Referring Provider Information

Additional Other Payer Information

Treatment Adjustment Information

Outpatient Adjudication Information

Billing Note Information

*Billing Note:

Claim Note Information

(OPTIONAL) CLAIM INFORMATION (CLAIM_NOTE_INFORMATION) content here.

*Claim Note Type:

☐ Please Choose One:

*Claim Note:

(1) Characters remaining

[Add Claim Note](#)

or [Back](#)
[X Cancel this claim](#)

You will see the options you selected. You have to complete all required fields for the options you select.

NOTE: This guide is for training purposes only. This is not a guarantee of payment. Non-payment of premiums and other contractual limitations may result in denial of benefits or refunds.

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INSTITUTIONAL CLAIM ENTRY – CLAIM CONFIRMATION

Institutional Claim Entry

Plan Information
Provider Information
Patient Information
Claim Information
Claim Line Information
Review
Confirmation

Dates of Service
01/03/2012 - 01/03/2012

Insurance
Plan Name:
BlueCross BlueShield Plans

Member ID:
XYZ999574317

Patient
Patient's Name:
MICHAEL P TESTING

Relationship to Member:
SELF

Gender:
MALE

Date of Birth:
10/01/1958

Claim Confirmation

We have received and are processing your claim. Your claim number is below.

For details on the status of this claim, click [View Claim Status](#).

Click on [View Patient Receipt](#) for a printable receipt detailing the patient's liability. Receipts are only available for claims that have finalized. The view Patient Receipt button will not appear for claims that require further processing.

Confirmation

Claim Number: 20110043W	Member ID: XYZ999574317	Patient's Name: MICHAEL P TESTING
Patient's Date of Birth: 10/01/1958	Patient's Gender: Male	

Create New Claim
View Claim Status

After submitting your claim, you will receive the claim number. If your claim processed immediately, you may be able to view the patient receipt. Finally, from here you can create a new claim or view claim status on the claim you just submitted.

Claims Status - Detail

Insurance
Plan Name:
BlueCross BlueShield Plans

Member ID:
XYZ712600304843

Claim Number: 20110043W Primary Status: PENDING/IN REVIEW

Please note: Check your remittance voucher for any non-covered or non-allowed charges which may be the member's responsibility.

Patient
Patient's Name:
MICHAEL P TESTING

Date of Birth:
10/01/1958

Change Patient

Detail

Status Effective Date: 01/11/2012	Date(s) of Service: 01/03/2012 - 01/03/2012	Processed Date: PENDING
Primary ID: 570874077010	Organization or Provider's Name: INTERNAL MEDICINE AS	
Total Charges: \$150.00	Amount Paid: \$0.00	

Status Explanation
20 - ACCEPTED FOR PROCESSING

Previous Claim
Next Claim
Ask Provider Services
or
Back

Some claims process immediately. Others process overnight through batch processing. If the claim processes immediately, you will be able to see how much we paid on the claim. If you have a question about your claim, click Ask Provider Services and submit your inquiry. You will receive a response through your My Insurance Manager Mailbox.

NOTE: This guide is for training purposes only. This is not a guarantee of payment. Non-payment of premiums and other contractual limitations may result in denial of benefits or refunds.

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