

Submitting 1500 Quick Claims in Availity

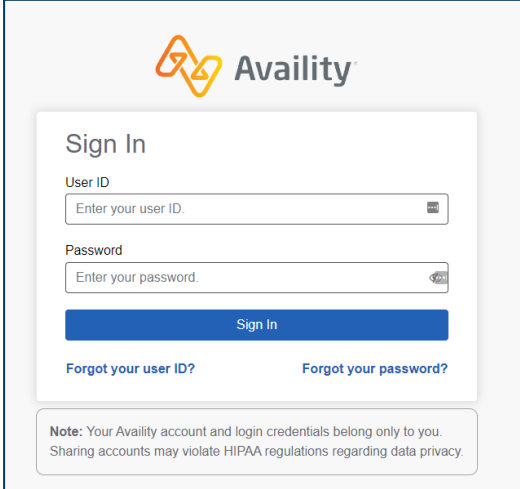
Note: The following presentation includes test data and not real member information.



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To access these applications within Availity, you will need to be assigned the Eligibility and Benefits role, as well as the Claims role. This can be done by your Availity administrator.

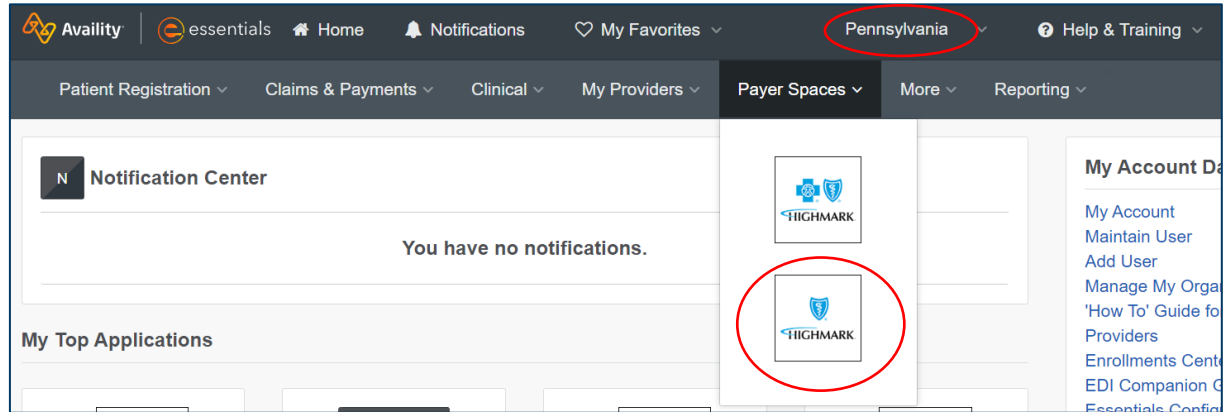
1) Sign on using your own login and password.



The screenshot shows the Availity Sign In page. At the top right is the Availity logo, which consists of two interlocking orange and yellow shapes followed by the word "Availity". Below the logo is a white box titled "Sign In". Inside this box, there are two input fields: "User ID" with the placeholder text "Enter your user ID." and "Password" with the placeholder text "Enter your password.". Below the password field is a blue "Sign In" button. At the bottom of the sign-in box are two links: "Forgot your user ID?" and "Forgot your password?". Below the sign-in box is a note: "Note: Your Availity account and login credentials belong only to you. Sharing accounts may violate HIPAA regulations regarding data privacy."

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2) Once in Availity, ensure you are in the correct State along the top tool bar, then go to “**Payer Spaces**” and choose the appropriate Highmark plan.

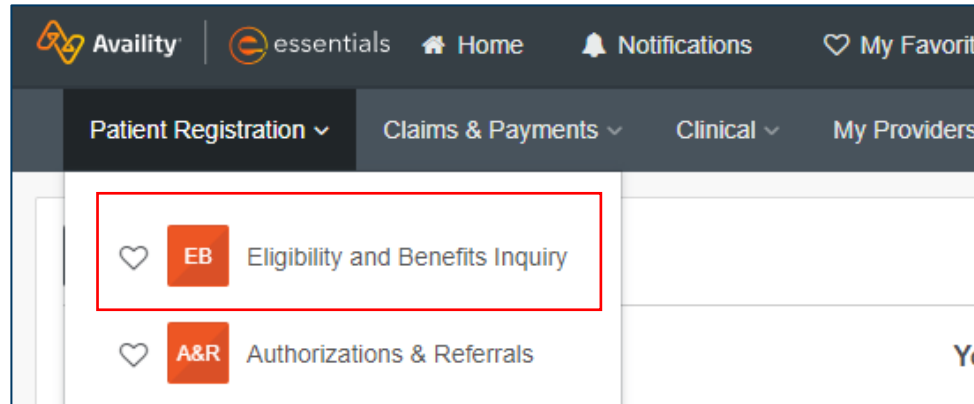


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3) Go to “**Patient Registration**” and “**Eligibility and Benefits Inquiry.**”

Once you check eligibility, this will help prepopulate members in your claim.

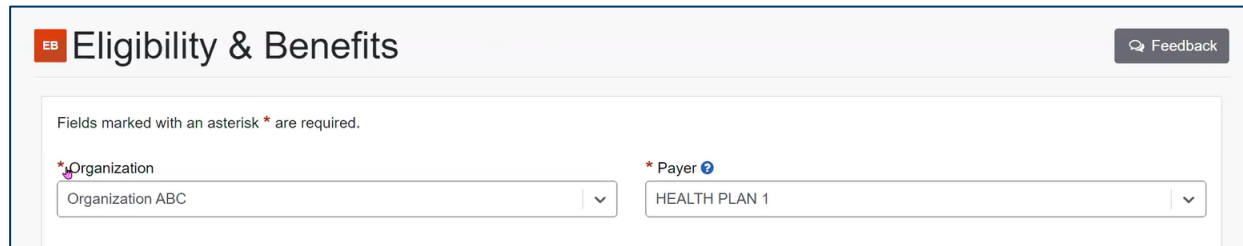
Note: To use Quick Claims, you **MUST** check Eligibility and Benefits first. If you are unable to check Eligibility and Benefits, you must use the standard 1500 claim submission.



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4) Choose your **Organization and Payer**.

Note: The Payer options that prepopulate are dependent on having the correct state chosen.



The screenshot shows a web interface for "Eligibility & Benefits". At the top left is a red square icon with "EB" and the text "Eligibility & Benefits". At the top right is a "Feedback" button with a speech bubble icon. Below the header, a message states "Fields marked with an asterisk * are required." There are two dropdown menus: the first is labeled "*Organization" and contains the text "Organization ABC"; the second is labeled "*Payer" and contains the text "HEALTH PLAN 1".

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5) Enter your **Provider Information**. As long as the appropriate provider is listed in your “Manage My Organization” list, you can use the dropdown which will populate the remainder of the section.

Note: Please use your Billing Group NPI or Practice NPI, as opposed to the individual practitioner.

Provider ⓘ

PROVIDER D NPI: 4040404040 • Tax ID: 44444444) ▼

Search for a provider by name, NPI, tax ID, taxonomy code, or address

Provider NPI ⓘ

4040404040

Provider Tax ID ⓘ

44444444

Organization or Provider Last Name ⓘ

PROVIDER D

Provider First Name

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6) Complete the **Patient Information** section.

a. **Member Search:** Use the dropdown to select which criteria you would like to use.

Note: You must use “Single Patient” search if you are searching for an out of area member. If searching by UMI/Member ID, no trailing zero is needed.

Patient Information

Member Search Single Patient Multiple Patients

Enter member information, then click on **Search**. If there are member search records, please click on one before clicking **Submit** at bottom of page.

Member Search Options ⓘ

Member Id, Date of Birth | ▾

Member ID/Policy Number Date of Birth

Enter Member ID mm/dd/yyyy

Clear Search

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7) Hit **Search** and select the correct patient listing that shows active coverage.

Member Id, Date of Birth ▼

Member ID/Policy Number: 116639642001 Date of Birth: 09/30/1964

Member	ID	Relationship	DOB	Payer	Coverage	Status
TEST, PATIENT 22	123456789	Subscriber	09/30/1964	HIGHMARK BLUE SHIELD	01/01/2020 - 12/31/9999	Active
PATIENT, TEST 3	123456789	Subscriber	09/30/1964	HIGHMARK BLUE SHIELD	01/01/2019 - 01/01/2020	Inactive

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8) Enter **Service Information**.

This will default to the current date. Benefit/Service Type chosen will determine the amount of detail provided. Please choose “Health Benefit Plan Coverage.”

Service Information

* As of Date ⓘ
07/03/2023

* Benefit / Service Type ⓘ
Health Benefit Plan Coverage - 30 x clear

Submit another patient

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9) Hit **Submit**. You will see the eligibility detail and a thumbnail on the left in green to indicate a successful run.

TEST, PATIENT 22

Health Benefit Plan Coverage

Transaction Date: Month Day, Time

Date of Service: Month Day, Year

Member ID: JOL101010101010

Payer ID: HIGHMARK BLUE CROSS BLUE SHIELD

DOB: Sep 30, 1964

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

ABC123456789

Allergy Testing

Transaction Date: Jul 3, 9:19 AM

Date of Service Month Day, Year

Transaction ID 99999999 Transaction Time Month Day, Time Customer ID 1111

TEST, PATIENT 22

123 MAIN STREET
ANYWHERE, FL 56555

[Edit](#) [Print](#) [Feedback](#)

Member Status	Date of Birth	Gender	Current Plan Effective Date	Relationship to Subscriber
Active Coverage	Sep 30, 1964	Male	Jan 1, 2020 - Dec 31, 9999	Self

[Patient Cost Estimator](#) [Member Card](#) [Additional Benefit Notes](#)


Member ID: JOL101010101010

Prior ID Number: 101010101010

Group Number: 987654321 XYZ

Group Name: GROUP ABCDEFGH

Plan Number: 123

Payer:  HIGHMARK BLUE SHIELD

Other or Additional Payer Information
No additional payer information provided.

▼ Provider Information

Requesting Provider

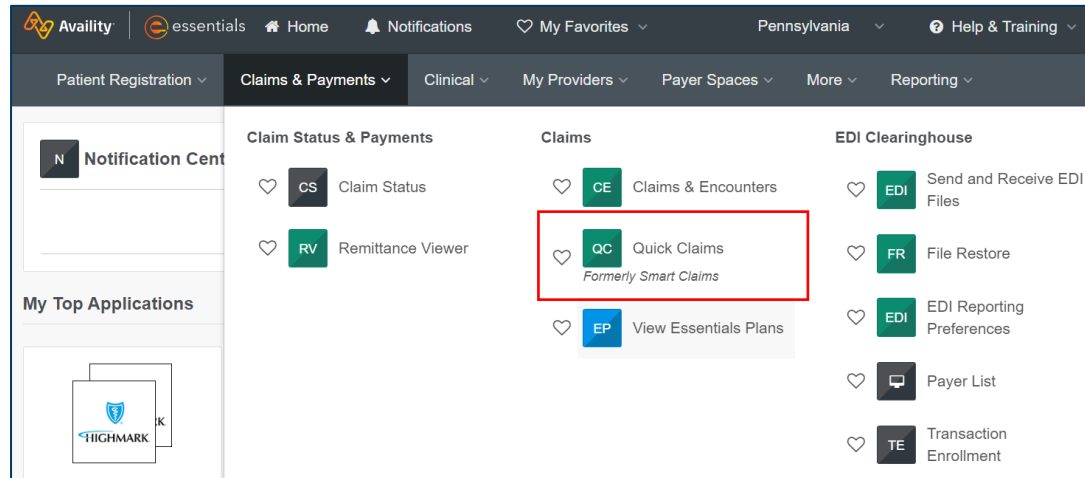
Name: Availity Test Org

Category: Requesting Provider

NPI: 22222222

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10) Once eligibility and benefits are run, you are ready to complete your Quick Claim. You will go to the **Claims and Payments** dropdown and choose “**Quick Claims.**” If you receive an error message asking you to configure Quick Claims settings, please contact your administrator for setup.



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11) Complete the **Patient Information** section by using the dropdown box to search for patients whose eligibility and benefits have been run. You can choose to complete a quick claim for one patient at a time, or “Add Patients in Bulk” to add multiple patients. You can add up to 50 patients at a time. Your “**Patient Control Number/Claim Number**” will be individual to your organization and can be “0.”

a) Single patient search view:

QC Quick Claims

Need Help? [Watch a demo](#) for submitting Quick Claims. [Give Feedback](#)

Select a Template

PATIENT INFORMATION

* Search for Patient(s) [?](#) Patients are from up to 18 months of eligibility and benefits made by your organization. [Add Patients in Bulk](#)

Why can't I find my patient?

PATIENT INFORMATION

* Search for Patient(s) [?](#) Patients are from up to 18 months of eligibility and benefits made by your organization. [Add Patients in Bulk](#)

Patient Name	Date of Birth	Payer ?	Member ID	Patient Control Number ?	Action
PATIENT 1 TEST	Jan 01, 1970	HIGHMARK BLUE SHIELD	ABC123456789	<input type="text" value="SUBABC123456789"/>	X Remove

Why can't I find my patient?

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b) Add patients in bulk view:

Select Patients from Member Roster ?

Search Find patients by last name, first name, or member ID

All Patients (3) Selected Patients (3)

<input checked="" type="checkbox"/>	Last Name	First Name	Date of Birth	Payer	Member ID
<input checked="" type="checkbox"/>	TEST	PATIENT 2	Nov 22, 1977	HIGHMARK BLUE SHIELD	XYZ123456789
<input checked="" type="checkbox"/>	TEST	PATIENT 1	Jan 01, 1970	HIGHMARK BLUE SHIELD	ABC123456789
<input checked="" type="checkbox"/>	TEST	PATIENT 3	Feb 18, 1976	HIGHMARK BLUE SHIELD	ABC987654321

Close Save

POWERED BY

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12) Enter **Provider Information** using the dropdown. This will prepopulate the remaining information.

PROVIDER INFORMATION

Provider Type * Select a Provider ?

Billing Type to search...

* Address Type to search...

Pay To Address (if different from billing provider address)

+ Add a Provider

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13) Enter Claim Information

- a. Determine whether you will be using the same service information for all your patients.
- b. **Place of Service** – 11-Office.
- c. **Prior Authorization Number** can be left blank
- d. **Principal Diagnosis Code** – You will enter the diagnosis codes from the EMR into the box. For example, for a diabetic patient, you might enter “E119.” You can add up to 3 diagnosis codes in Quick Claims.
- e. **Date of Service** – Enter the DOS; both fields are required.
- f. **Procedure Code** – Enter the matching CPTII code from the CPTII handout and be sure the Diagnosis Code Pointer is relating back to the correct diagnosis code.

if different from billing provider address)

Add Procedure Code

Select your diagnosis code and procedure code

Diagnosis Code Pointer

M160 - Bilateral primary osteoarthritis...

Procedure Code

01214 - ANESTH HIP ARTHROP...

Cancel Save

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- g. Modifier** not needed.
- h. Quantity** – 1.
- i. Charge Amount** – 0.

CLAIM INFORMATION

Use the same service information for all of your patients?
 Yes No

* Place of Service [?](#) Prior Authorization Number [?](#)

* Principal Diagnosis Code [?](#) Diagnosis Code Diagnosis Code

* Dates of Service [?](#) - * Procedure Code [?](#) Modifier 1 Modifier 2 Modifier 3 Modifier 4

Prior Authorization Number [?](#) * Quantity [?](#) * Charge Amount

[+ Add Line](#)

[Continue](#)

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14) Use the “**Add Line**” function to add multiple procedure codes (i.e., if you need to enter both a systolic and a diastolic blood pressure code).

15) If you have chosen to add patients in bulk, it will give you designated sections for each patient to be completed with the steps detailed previously.

The screenshot displays the 'CLAIM INFORMATION' section of a software interface. At the top, it asks 'Use the same service information for all of your patients?' with radio buttons for 'Yes' and 'No' (selected). Below this, there are two patient sections. The first section is for 'PATIENT 2 TEST - Member ID: XYZ123456789 (HIGHMARK BLUE SHIELD)'. It contains several fields: 'Place of Service' (dropdown menu showing '11 - Office'), 'Prior Authorization Number', 'Principal Diagnosis Code' (dropdown menu with 'Type to search...' text), 'Diagnosis Code' (dropdown menu with 'Type to search...' text), 'Dates of Service' (two date pickers), 'Procedure Code' (dropdown menu with 'Add Code' button), 'Modifier 1', 'Modifier 2', 'Modifier 3', and 'Modifier 4' (all dropdown menus). Below these are 'Prior Authorization Number', 'Quantity', and 'Charge Amount' (with a '\$' symbol) fields. An 'Add Line' button is located at the bottom of this section. The second section is for 'PATIENT 1 TEST - Member ID: ABC123456789 (HIGHMARK BLUE SHIELD)'. It contains 'Place of Service' (dropdown menu showing '11 - Office') and 'Prior Authorization Number' fields.

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16) Once all patients are completed, hit **Continue** and you can review all information entered (as seen below).

Need Help? [Watch a demo](#) for submitting Quick Claims. Give Feedback

QC Quick Claims

Please review the information we received while checking the patient's benefits. Fill in any missing information.

SOPHIA AVAILITY (SUBSCRIBER) ACTIVE Retry

* DOB * Gender * Payer * Subscriber ID

Policy/Group Number * Relationship * Country * Address

Suite * City * State * ZIP Code

[X Remove](#)

EXAMPLE PATIENT2 (SUBSCRIBER) ACTIVE Retry

* DOB * Gender * Payer * Subscriber ID

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17) Hit **Submit**.

CLAIM SUMMARY

Billing Provider
Organization ABC

Patient	Payer	Date(s) of Service	Principal Diagnosis Code	Procedure Code	Modifier	Quantity	Charge Amount
EXAMPLE PATIENT1	HIGHMARK BLUE SHIELD	11/08/2022 - 11/08/2022	M160	01214		1	\$500.00
EXAMPLE PATIENT2	HIGHMARK BLUE SHIELD	11/08/2022 - 11/08/2022	M160	01214		1	\$500.00

Back Save As Template **Submit**

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18) A box will pop up asking whether you wish to “Keep” or “Use” the information obtained from Eligibility and Benefits. You will choose “Keep.”

The screenshot shows a comparison dialog box with two columns: 'CURRENT' and 'FROM RETRY'. Each column contains a list of personal and identification details. The 'Policy/Group Number' field in both columns is highlighted with a red box. At the bottom of each column is a blue button labeled 'Keep' and 'Use' respectively. A double arrow symbol (») is positioned between the two columns. At the bottom of the dialog, there are small icons and labels for 'Relationship', 'Country', and 'Address'.

CURRENT	FROM RETRY
DOB: [REDACTED]	DOB: [REDACTED]
Gender: [REDACTED]	Gender: [REDACTED]
Subscriber ID: [REDACTED]	Subscriber ID: [REDACTED]
Policy/Group Number: [REDACTED]	Policy/Group Number: [REDACTED]
Relationship: Self	Relationship: Self
Country: United States	Country: United States
Address: [REDACTED]	Address: [REDACTED]
Suite: [REDACTED]	Suite: [REDACTED]
City: [REDACTED]	City: [REDACTED]
State: [REDACTED]	State: [REDACTED]
ZIP Code: [REDACTED]	ZIP Code: [REDACTED]

Keep Use

Relationship Country Address

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19) You will receive a confirmation about whether your claim was submitted, or if an error occurred.

✔ Success! Your claim has been submitted. Please access your organization's ReceiveFiles mail box to view claim responses. This can take up to 24 days.

Customer ID: 394657 Transaction Date: 05/08/24

CLAIM SUMMARY

Billing Provider
Organization ABC
123 Healthy Ave, Jacksonville, FL 123456789

Patient	Payer	Date(s) of Service	Principal Diagnosis Code	Procedure Code	Modifier	Quantity	Charge Amount
✔ SOPHIA AVAILITY	ABC HEALTHCARE	11/08/2022 - 11/08/2022	M160	01214		1	\$500.00

Transaction ID: 447729648

[Start New Claim](#) [Save As Template](#) [Print](#)

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