Submitting 1500 Quick Claims in Availity

Including Zero-Dollar Claims

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

HIGHMARK | HIGHMARK

Quick Claims in Availity – Faster & Simpler

The Availity Quick Claims tool is for providers that utilize the **HCFA-1500 claim form.**

If you have regular patients or a repeatable set of claims, **Quick Claims** will save you time and reduce duplication.

NOTE: Quick Claims is **not** currently available for the following two products:

- Highmark Senior Health (PA)
- Highmark Senior Solutions (WV)

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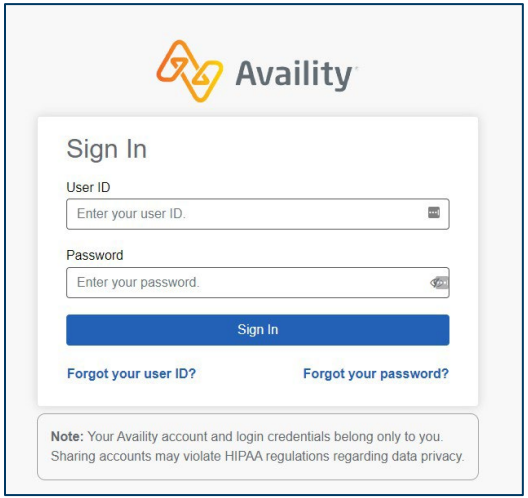
To use Quick Claims in Availity®, you will need to be assigned the **Eligibility and Benefits** and **Claims** roles. This can be done by your Availity administrator.

- **IMPORTANT:** Before using **Quick Claims**, you must conduct an **Eligibility and Benefits Inquiry**.

1) Sign on using your own login and password.



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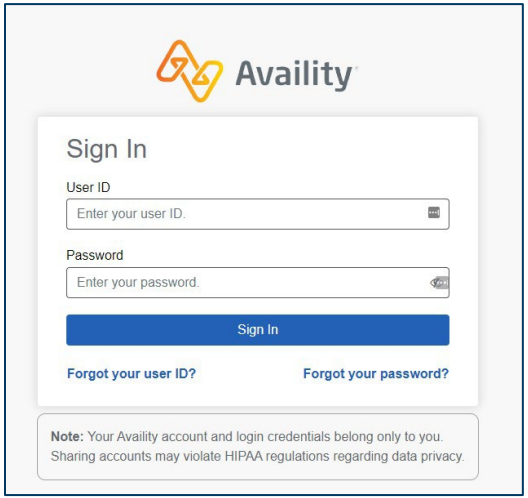

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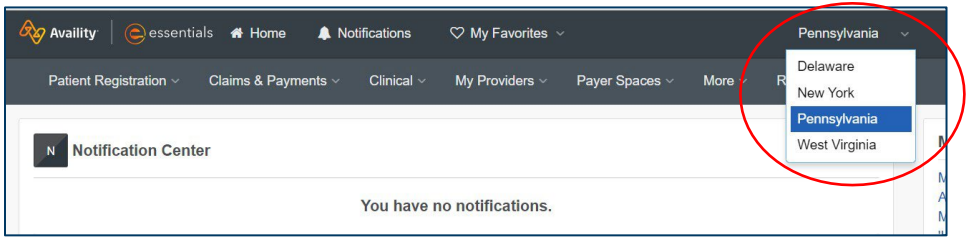
2) Once in Availity, select the **State** you're contracted in from the top tool bar.



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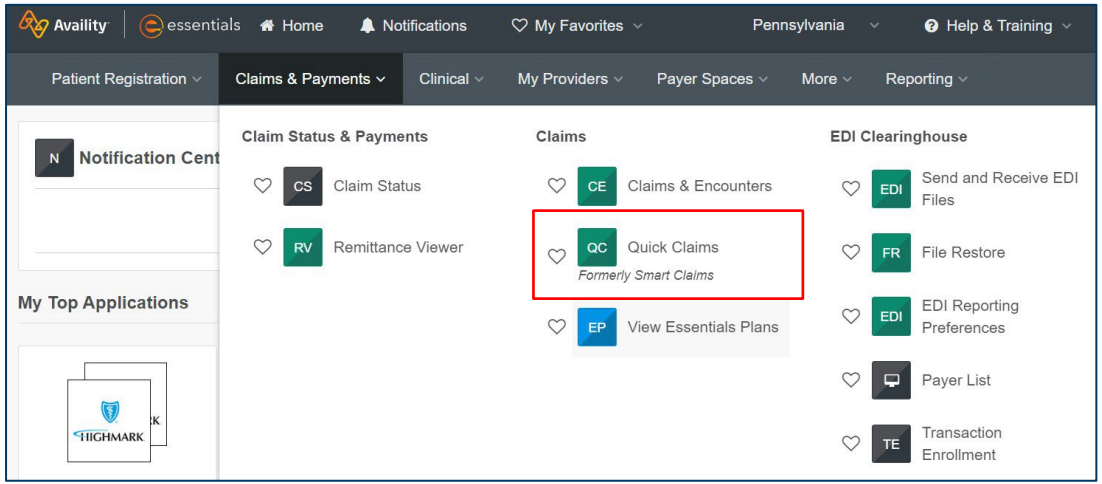
3) Choose **Claims and Payments** from the task bar and then **Quick Claims**.

- If you receive an error message asking you to configure **Quick Claims** settings, please contact your administrator for setup.



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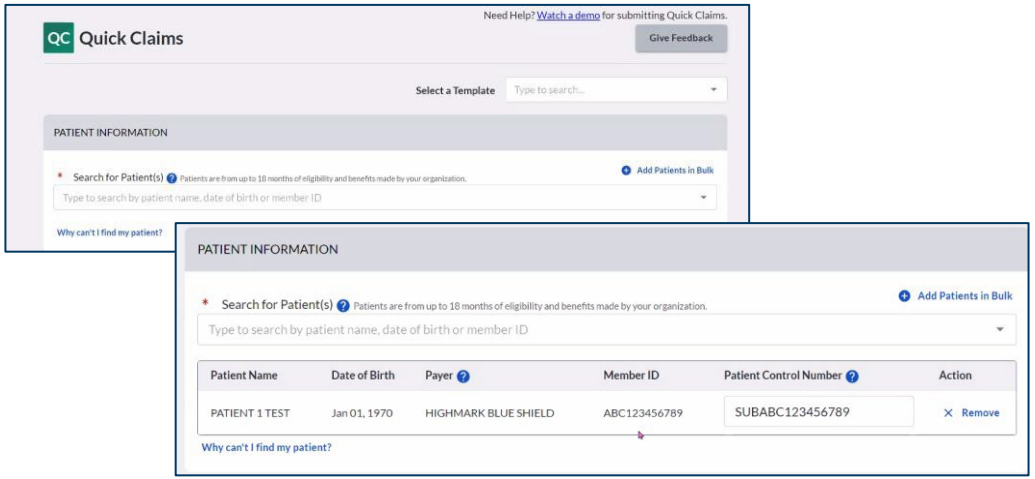
4) Complete the **Patient Information** section by using the dropdown to search for patients whose eligibility and benefits have been run. See note on Slide 2.

- You can complete a quick claim for one patient or **Add Patients in Bulk** for multiple patients (up to 50 patients). Your **Patient Control Number/Claim Number** will be individual to your organization and can be “0”.

a) Single-patient search view:



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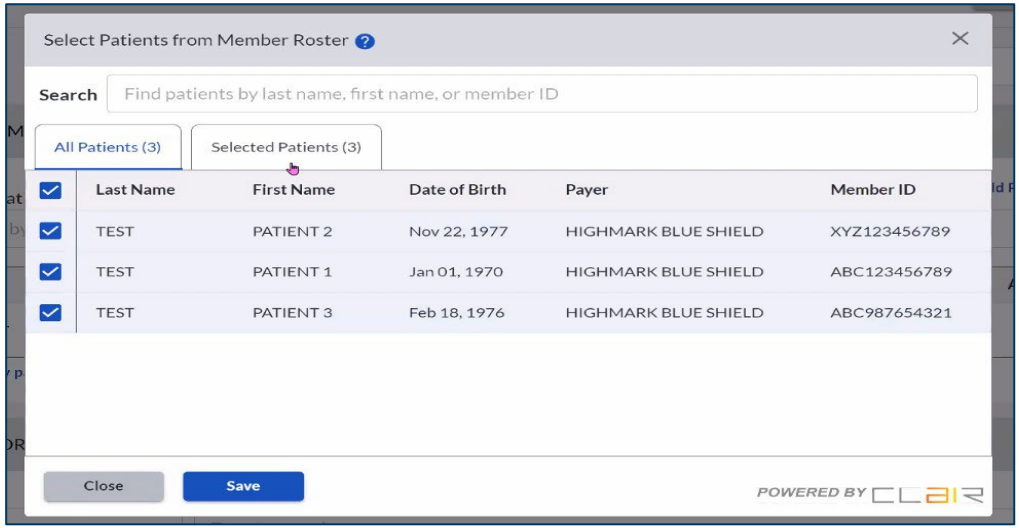
b) Multiple-patient search view:



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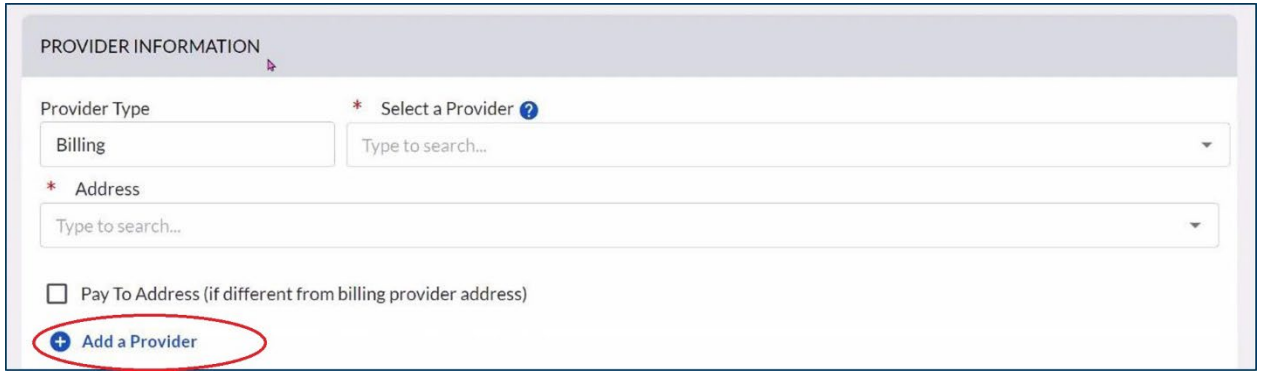
5) Complete the **Billing Provider Information** using the dropdown.

- Under **Manage My Organization**, use the **Select a Provider** dropdown and the remaining boxes will auto-populate.
  - Use **Group NPI**, not individual practitioner NPI.
  - Complete **Rendering Provider Information** by clicking the **Add a Provider** button at the bottom of the section and select **Rendering.**
  - Complete by selecting from the dropdown.



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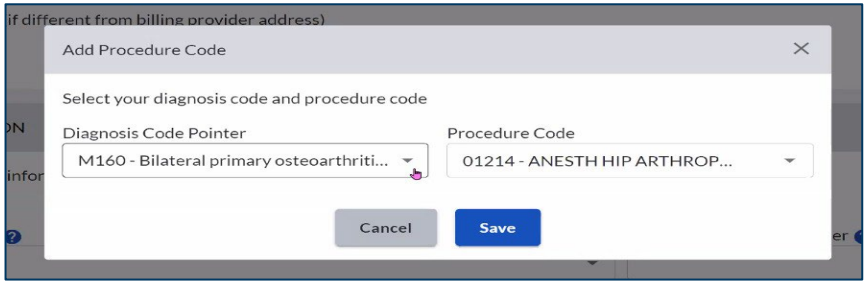
6) Enter **Claim Information.**

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 principal diagnosis. 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** – Use the search tool to enter the matching CPTII code. Be sure the Diagnosis Code Pointer is relating back to the correct diagnosis code.



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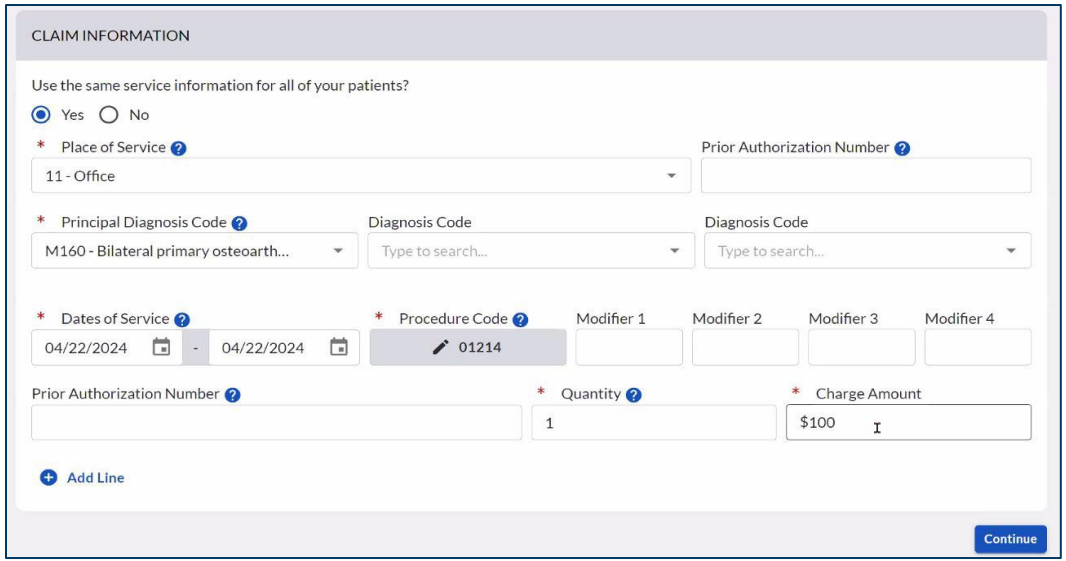
g. **Modifier** situational.
h. **Quantity** – 1.
i. **Charge Amount** – Enter correct amount. For **Zero-Dollar Claims**, enter “$0.00”.



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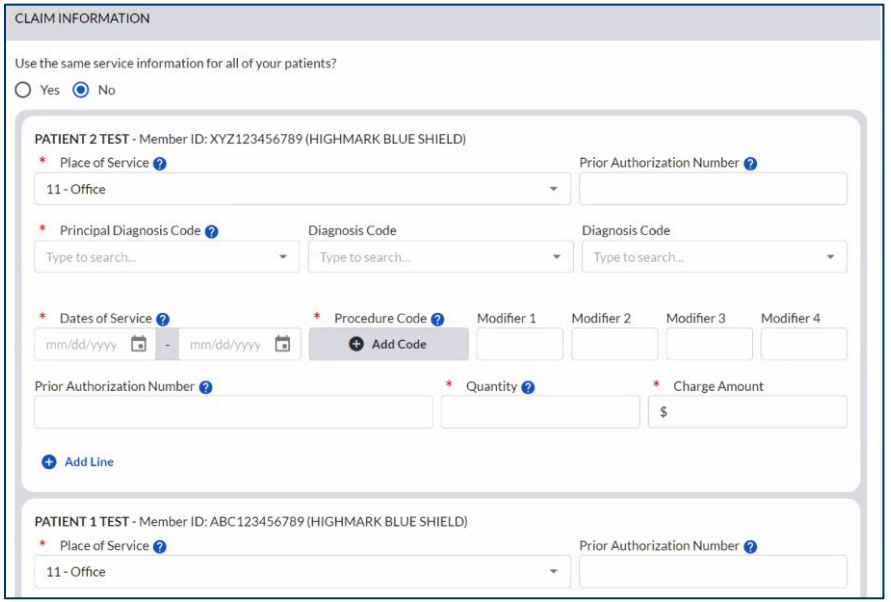
7) Use **Add a Line** to add multiple procedure codes.

- If you have chosen to add patients in bulk, the application will give you designated sections for each patient to be completed with the steps detailed previously.
- Once all patients have been entered, double-check the information.



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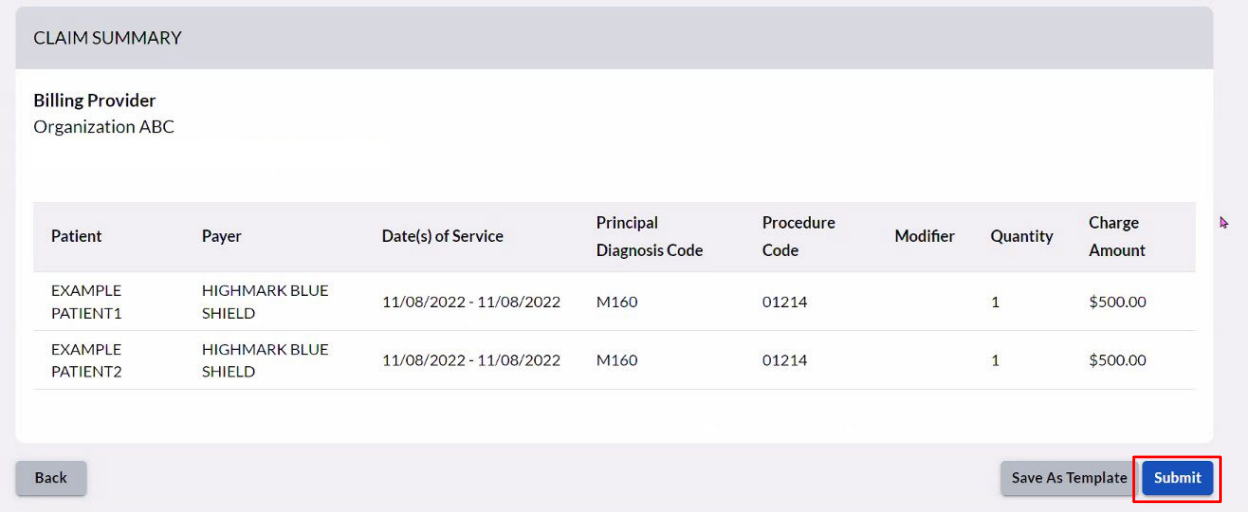
8) Click **Continue** and then **Submit.**



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