Using Availity Online for Eligibility and Benefits and Claim Status

Availity Online, formerly called “THIN Online,” is a service offered to providers in The Regence Group (TRG) network. You can use Availity Online to submit inquiries for eligibility and benefits and claims status for Blue plans outside of TRG. This document provides guidelines and tips for using Availity Online for these types of inquiries.

Table of Contents

About Availity Online ................................................................. 1
Best Practices in Availity Online ................................................ 2
Inquiring About Eligibility and Benefits .................................... 3
  Guidelines for Using this Feature ............................................. 3
  Guidelines for Viewing the Results ........................................ 4
Inquiring About Claim Status .................................................... 4
  Guidelines for Using this Feature ............................................. 4
  Guidelines for Viewing the Results ........................................ 5
REGENCE Errors and Other Problems .................................... 6

About Availity Online

When using Availity Online, keep these points in mind:

- Fields with an asterisk (*) are required.
- Errors related to the inquiry can be either HIPAA-specific or related to system problems.
- Inquiries you submit through Availity Online are routed to Blue Exchange, which forwards the inquiry to the other Blue plan. The other Blue plan processes the inquiry and sends a response back through Blue Exchange to Availity Online. You should receive a response from the other Blue plan under a minute after sending the inquiry.
Availity Online currently supports only Internet Explorer 6.0 or higher to run this web portal. To prevent errors related to your internet browser settings, you might try the following steps:

- Configure your browser’s privacy settings to medium or lower
- Set your browser to allow cookies from Availity Online
- Set any pop-up blockers to allow pop-ups from Availity Online
- Periodically clear the temporary internet files on your computer

**Best Practices in Availity Online**

Availity Online is a powerful tool, and this section lists a number of best practices to help you get the most out of it. Making these practices a habit can help you use Availity Online efficiently, reduce errors, and improve your productivity. Follow these guidelines when using Availity Online:

- Type member information into Availity Online EXACTLY as it appears on the insurance card, such as the member's or patient's ID number and last and first names. Always type the entire ID number as it displays on the ID card, including any alphabetical or numeric prefixes and suffixes. Do not include spaces.

- For all Blue plans, you must include the three-character alphabetical, or "alpha," prefix at the beginning of the subscriber or patient ID. The prefix helps Blue Exchange identify to which Blue plan to route the inquiry.

  **Note:** All BCBS plans are currently converting old member identifiers containing Social Security Numbers (SSNs) to new ones. BCBS expects to complete this process by January 1, 2006. Blue payers might not accept social security numbers in this field if the patient has received a new ID card.

- Type all dates in the format MM DD YYYY. You must type the month as a two-digit number. For example, if the month is February, you must type 02. When you type the fourth digit in the year, Availity Online automatically moves the cursor to the next field. You do not need to press the TAB key.
Inquiring About Eligibility and Benefits

The Eligibility and Benefits Inquiry feature in Availity Online allows you to verify eligibility for an individual member and confirm the benefits covered under the individual's contract.

You can verify eligibility and benefits each time a patient visits your office to ensure the patient data is current and accurate, increasing the likelihood that any claims you submit later will be free of errors. This step also enables you to collect the correct amount of co-payments, deductibles, and out-of-pocket expenses from the patient at the time of service.

Note: Availity Online does not store any patient or coverage information. It is simply a pipeline for information from the other Blue plan to you. For more information about the results, contact the other Blue plan using the phone number on the back of the patient's ID card.

Guidelines for Using this Feature

When using the Eligibility and Benefits Inquiry feature, keep these guidelines in mind:

- Use the recommended best practices described in the Best Practices in Availity Online section to save time, prevent errors, and improve the success of the inquiry.

- You can select either Professional or Facility in the Type of Benefits Requested field. The other Blue plan returns benefits as available.

- Complete the As of Date field as necessary to check eligibility and benefits for future appointments or to verify a patient's status during a previous visit. Availity Online allows this date to be up to 24 months in the past and up to 12 months in the future. The format for this field is MM DD YYYY.

- The inquiry form requires you to supply a variety of patient information, not just the patient ID. A reason for this requirement is the other Blue plan's computer system(s) might not be able to search for the patient using only the patient ID. Also, if the patient's first and last name, patient ID, and date of birth are all present in the request, HIPAA requires the payer to generate a response if the patient is in their database. All payers are required to support this search option using these required data elements. Requiring a variety of information ensures you get a response.

- Although Availity Online requires the Patient ID field, not all other Blue plans require the ID you enter in this field to match the patient ID in their system. Some plans require other criteria to match. Since plan requirements vary, complete all required fields to the best of your ability and complete as many optional fields on the page as possible.
• All Blue plans are in the process of replacing social security numbers as patient IDs and might not accept them in the **Patient ID** field if the patient has received a new ID card.

• The **Patient's Relationship to Subscriber** field describes the relationship between the patient described in the inquiry and the primary subscriber on the policy. The default option is **Self**.

**Guidelines for Viewing the Results**

When viewing the results of the eligibility and benefits inquiry, keep these guidelines in mind:

• Eligibility and benefits results vary from payer to payer because their computer systems differ from each other.

• If multiple results return for the patient or subscriber, click **View Summary** to view the appropriate results.

• When viewing the results on the summary page, click **View Details** to access the detailed results and benefits.

• When viewing the results on the detail page, you can click the summary results breadcrumb link at the top of the page to return to the summarized results.

**Inquiring About Claim Status**

You can view claim status using the Claim Status Inquiry feature in Availity Online.

**Note:** You can only view the results and statuses of claims your organization submitted. Availity Online does not store any patient or coverage information in its system. Availity Online is simply a pipeline for information from the other Blue plan to you. For more information about the results, contact the other Blue plan using the phone number listed on the back of the patient’s ID card.

**Guidelines for Using this Feature**

When inquiring about claims, keep these guidelines in mind:

• Use the recommended best practices described in the Best Practices in Availity Online section to save time, prevent errors, and improve the success of the inquiry.

• All required fields must match the data submitted on the claim.
• Type the provider’s nine-digit tax ID in the Provider Tax ID field.

   **Note:** Type only numbers and alphabetical characters in this field. Do not include spaces, dashes, commas, or other punctuation.

• If the billing provider is an organization instead of an individual, type the name of the organization in the Last Name field and leave the First Name field blank under Billing Provider Information.

• Select the correct response in the **Is the Subscriber the Patient?** field. If you select No, additional fields for the patient’s name and ID display under Patient Information. The name fields are always required, and the Patient ID field is required only if the ID differs from the subscriber’s ID.

• In the Subscriber ID and Patient ID fields, be sure you enter the ID EXACTLY as it appears on the ID card, including any prefixes. This information helps Blue Exchange route the inquiry to the correct Blue plan.

• The **Patient Account Number** field is required. If you do not know the patient’s account number, leave the field as unknown. The patient account number is the internal number or identifier the provider office uses to identify the patient in the office’s billing records and computer system. This number is not payer-assigned. It is used only to assist the office staff in cross-referencing the claim to the patient’s billing records.

• For the **Claim Service Period From** field, the date must be either today or in the past, but not prior to 01/01/2002.

• For the **Claim Service Period To** field, the date must be equal to or later than the date in the **Claim Service Period From** field. The format for both dates is MM DD YYYY.

• If you know the claim charge, type it in the **Total Claim Charge Amount** field. This information can help the other Blue plan search for the claim information.

**Guidelines for Viewing the Results**

When viewing the results of the claim status inquiry, keep these guidelines in mind:

• Claim status results vary from payer to payer.

• Results can include any multiple results matching all of the criteria you specified in the inquiry.

• The first results page to display is the summary. You can view detailed results by clicking View Details.

• For HMO encounters, some other Blue plans display zero in the **Total Claim Charge Amount** field.
• If the other Blue plan rejected the claim, information about the rejection displays in the Category and Status fields under Claim Information.

• If the payer accepted and paid the claim, the Check/EFT Number and Check Issue/EFT Effective Date fields display.

• The Claim Payment Amount field displays an amount if the payer paid the claim. This amount might not match the amount in the Total Claim Charge Amount field if special processing took place, such as splitting the claim. If the claim is still undergoing adjudication or is rejected, this field displays zero.

• If the payer rejected the claim and you need further information, contact the other Blue plan using the phone number listed on the back of the patient’s ID card.

**REGENCE Errors and Other Problems**

Occasionally, an error might occur if system problems or other issues arise. These errors display as REGENCE errors. If you receive any REGENCE errors, experience another problem, or have questions, call the Regence’s Web Support Team at 1-888-427-0470. They are available from 6AM to 6PM PT, weekdays. If an error is involved, write down the error code, which begins with “REGENCE,” and the error message before calling. Communicating this information to the Web Support Team can help them resolve the problem.