



BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

MY INSURANCE MANAGER

Prior Authorization Guide





TABLE OF CONTENTS

Just for Health Provider.....	3
Pre-Service Review for Out-of-Area Members	7
Verify Primary Care Physician	9
Just for Dental Providers.....	10
Pre-Treatment Estimate Entry.....	10
Pre-Treatment Estimate Status	16
Troubleshooting Tips – Patient Care Functions.....	17

JUST FOR HEALTH PROVIDER

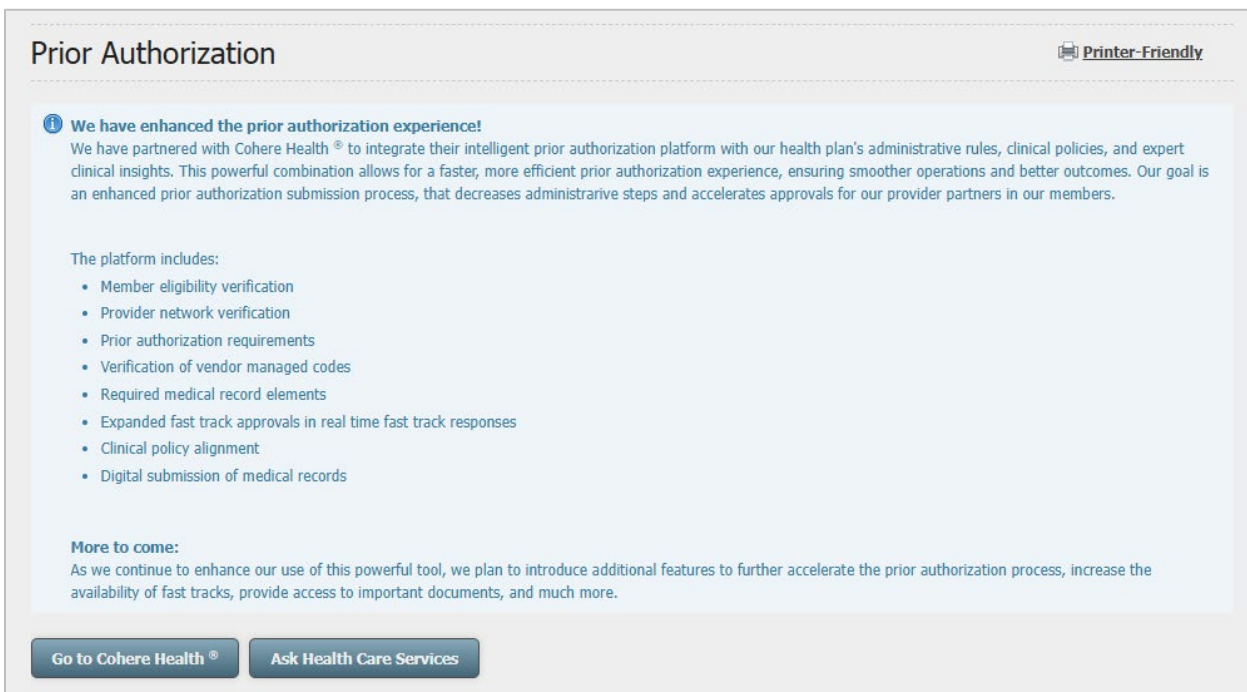
For prior authorizations, do the following:

1. Under **Patient Care**, select **Pre-Certification/Referral**.



A screenshot of a web application menu titled "Health". The menu is organized into two columns. The left column contains: Authorization Extension, Authorization Status, Claims Status, Eligibility and Benefits, Institutional Claim Entry, and Other Health Insurance. The right column contains: Patient Directory, Pre-Certification/Referral, Superbill Maintenance, Pre-Service Review for Out-of-Area Members, Professional Claim Entry, and Verify Primary Care Physician. Each item is preceded by a right-pointing chevron icon.

2. Select **Go to Cohere Health**.



A screenshot of a web page titled "Prior Authorization". In the top right corner, there is a "Printer-Friendly" icon and text. Below the title, there is a blue information banner with a circular icon containing an 'i'. The banner text reads: "We have enhanced the prior authorization experience! We have partnered with Cohere Health® to integrate their intelligent prior authorization platform with our health plan's administrative rules, clinical policies, and expert clinical insights. This powerful combination allows for a faster, more efficient prior authorization experience, ensuring smoother operations and better outcomes. Our goal is an enhanced prior authorization submission process, that decreases administrative steps and accelerates approvals for our provider partners in our members." Below the banner, the text "The platform includes:" is followed by a bulleted list: Member eligibility verification, Provider network verification, Prior authorization requirements, Verification of vendor managed codes, Required medical record elements, Expanded fast track approvals in real time fast track responses, Clinical policy alignment, and Digital submission of medical records. Below the list, the text "More to come:" is followed by a paragraph: "As we continue to enhance our use of this powerful tool, we plan to introduce additional features to further accelerate the prior authorization process, increase the availability of fast tracks, provide access to important documents, and much more." At the bottom of the page, there are two buttons: "Go to Cohere Health®" and "Ask Health Care Services".

3. Select **Start auth request**.

South Carolina | powered by Cohere Health | Support | My account

Filter by user Search (Patient name, Member ID, Auth ID) [Start auth request](#)

Health plan

- All
- BCBS South Carolina
- Humana

Status

- All (316)
- Upcoming (116)
- Pending review (2)
- Approved (22)
- Denied (7)
- Draft (2)
- Withdrawn (95)
- Completed (200)

Sort by: Most recent

Patient	DOB	Member ID	Health plan								
Doe, John	01/26/1965	10119152022	BCBS South Carolina								
<table border="1"> <thead> <tr> <th>Services</th> <th>Procedure codes</th> <th>Submission date</th> <th>Dates of service</th> </tr> </thead> <tbody> <tr> <td>Physical Therapy, Speech Therapy</td> <td>97110, 97112, 92507</td> <td>05/15/2024 3:45 PM</td> <td>06/15/2024 - 09/30/2024</td> </tr> </tbody> </table> <p>Approved Authorization #NPOA6057 • Tracking #NPOA6057 Start continuation</p>				Services	Procedure codes	Submission date	Dates of service	Physical Therapy, Speech Therapy	97110, 97112, 92507	05/15/2024 3:45 PM	06/15/2024 - 09/30/2024
Services	Procedure codes	Submission date	Dates of service								
Physical Therapy, Speech Therapy	97110, 97112, 92507	05/15/2024 3:45 PM	06/15/2024 - 09/30/2024								
Doe, John	01/26/1965	10119152022	BCBS South Carolina								
<table border="1"> <thead> <tr> <th>Services</th> <th>Procedure codes</th> <th>Submission date</th> <th>Dates of service</th> </tr> </thead> <tbody> <tr> <td>Myocardial Perfusion Imaging Single Photon Emission Computed Tomography (MPI-SPECT),...</td> <td>78451, 78452, 93015</td> <td>05/15/2024 3:45 PM</td> <td>06/15/2024 - 09/30/2024</td> </tr> </tbody> </table> <p>Approved Authorization #NPOA6057 • Tracking #NPOA6057 Start continuation</p>				Services	Procedure codes	Submission date	Dates of service	Myocardial Perfusion Imaging Single Photon Emission Computed Tomography (MPI-SPECT),...	78451, 78452, 93015	05/15/2024 3:45 PM	06/15/2024 - 09/30/2024
Services	Procedure codes	Submission date	Dates of service								
Myocardial Perfusion Imaging Single Photon Emission Computed Tomography (MPI-SPECT),...	78451, 78452, 93015	05/15/2024 3:45 PM	06/15/2024 - 09/30/2024								
Doe, John	01/26/1965	10119152022	BCBS South Carolina								
<table border="1"> <thead> <tr> <th>Service</th> <th>Procedure codes</th> <th>Submission date</th> <th>Dates of service</th> </tr> </thead> <tbody> <tr> <td>Physical Therapy</td> <td>97110</td> <td>--</td> <td>12/01/2022 - 03/01/2023</td> </tr> </tbody> </table> <p>Draft Tracking #AJSD3781 Delete Continue</p>				Service	Procedure codes	Submission date	Dates of service	Physical Therapy	97110	--	12/01/2022 - 03/01/2023
Service	Procedure codes	Submission date	Dates of service								
Physical Therapy	97110	--	12/01/2022 - 03/01/2023								
Doe, Jane	01/26/1965	10119152022	BCBS South Carolina								
<table border="1"> <thead> <tr> <th>Service</th> <th>Procedure codes</th> <th>Submission date</th> <th>Dates of service</th> </tr> </thead> <tbody> <tr> <td>Physical Therapy</td> <td>97110, 97112, 97114</td> <td>12/01/2022</td> <td>12/01/2022 - 04/01/2023</td> </tr> </tbody> </table>				Service	Procedure codes	Submission date	Dates of service	Physical Therapy	97110, 97112, 97114	12/01/2022	12/01/2022 - 04/01/2023
Service	Procedure codes	Submission date	Dates of service								
Physical Therapy	97110, 97112, 97114	12/01/2022	12/01/2022 - 04/01/2023								

4. Choose whether the service is outpatient or inpatient and include the diagnosis and procedure codes. Be sure to include all potential codes that could be billed. Select **Continue**.

Doe, John | South Carolina | powered by Cohere Health | Support | My account

Tell us about your request

Request details

Outpatient Inpatient

Start date: 06/01/2024

Diagnosis codes

Primary diagnosis code: M48.06

Search for secondary diagnosis codes (optional)

Procedure codes

CPT/HCPCS codes: 63047

[Save and exit](#) [Cancel](#) [Continue](#)

5. Enter the necessary provider details. Select **Continue**.

Providers

Care setting

Outpatient Inpatient

Place of service ▼

Ordering provider

Search for an ordering provider by NPI, TIN, or name 🔍 TIN 🔍 Address

+ Bailey, Christopher Eric MD

Performing or attending provider

Performing is the same as the ordering

Search for a performing or attending provider by NPI, TIN, or name 🔍 TIN 🔍 Address

+ Bailey, Christopher Eric MD

Performing facility or agency

Search for a performing facility or agency by NPI, TIN, or name 🔍 TIN 🔍 Address

+ 1ST START HEALTHCARE SERVICES

[Save and exit](#)

6. The codes listed at the top of the screen require prior authorization, while the codes listed at the bottom do not. Note: If the request is urgent, check the Expedite box. Select **Continue**.

Requires authorization

Start date - End date

Physical Therapy (PT)

Number of visits

97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

+ Add a procedure code

Total Knee Arthroplasty (TKA)

27447 Units Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) 🗑️ Remove

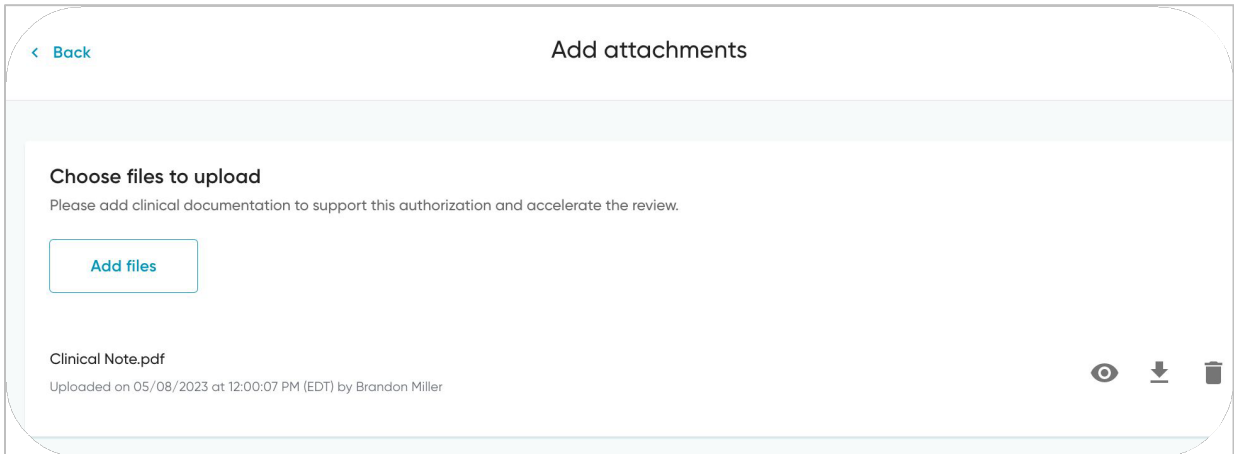
+ Add a procedure code

Expedite

Doesn't require authorization in most cases 93798 [Download PDF](#) ▼

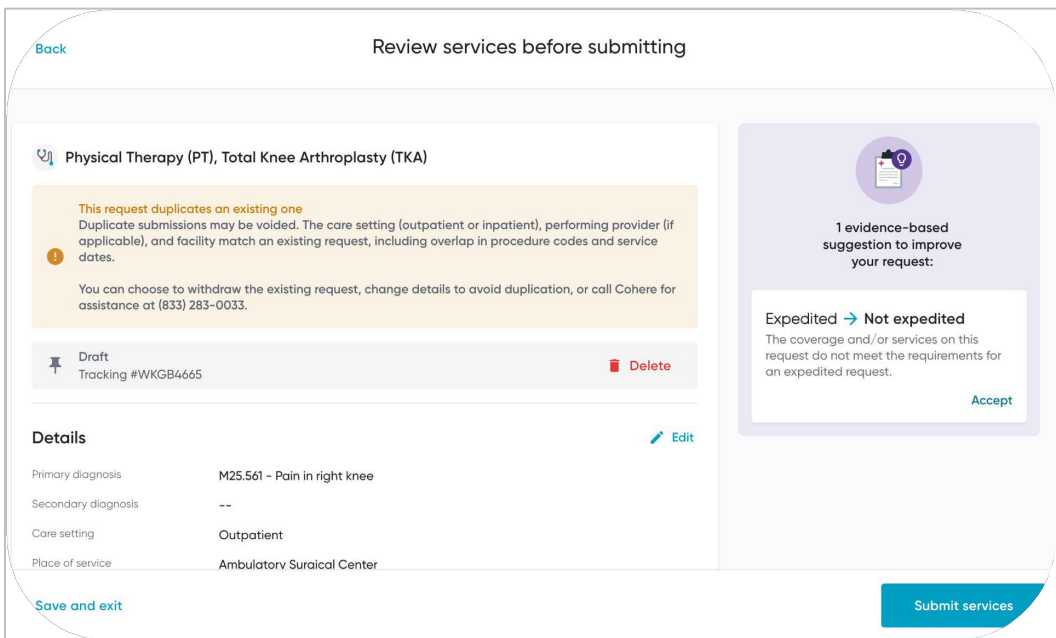
[Save and exit](#) [Continue with 2 codes](#)

7. Upload the relevant clinical documents for review. Select **Continue**.



8. Review the services before submitting. Select **Submit services**.

- The orange box displays if there is a possible duplicate request on file. Review the current authorizations (whether approved or pending) to avoid submitting an unnecessary duplicate request that would eventually be voided.
- The purple box displays if there is an expedited request, but based on the services and clinicals, there's no evidence supporting the need for it to be expedited. The provider will be asked to consider changing the request to "not expedited" by selecting Accept. If not, they can continue with the expedited request.



After submitting the request, providers will receive a faxed notification confirming the receipt of the request. Once a determination is made, providers will be notified.

Note: Although BlueCross BlueShield of South Carolina, BlueChoice HealthPlan and Healthy Blue are using the Cohere Health platform, all clinical decisions are made by the appropriate health plan.

Pre-Service Review for Out-of-Area Members


From the Patient Care menu choose Pre-Service Review for Out-of-Area Members. Select View Medical Policy or Request Pre-Service Review; then Verify.

The screenshot shows a web application interface. At the top, there is a navigation bar with links: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, and Staff Directory. Below the navigation bar, a welcome message reads "Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out)" and a link "Go to Message Center". The main heading is "Pre-Service Review for Out-of-Area Members" with a "Printer-Friendly" icon. Below this, it states "Includes Notification, Pre-Certification, Pre-Authorization and Prior Approval" with a red asterisk and the word "Required". A light blue box contains instructions: "You can view the out-of-area Blue Plan's medical policy or request a pre-service review. Please select the type of information requested, enter the first three letters of the member's identification number on the BlueCross BlueShield ID card, and click Verify." Below this, a form asks "Please choose an Option:" with two radio buttons: "View Medical Policy" (selected) and "Request Pre-Service Review". A "Verify" button is at the bottom left.

When you select View Medical Policy, you will be redirected to this page of www.SouthCarolinaBlues.com. Choose Medical Policy, enter the Alpha Prefix and **Submit**.

The screenshot shows a web page titled "Providers" with a search bar and a breadcrumb trail: Home / Providers / Policies and Authorizations / Prior Authorization / BlueCard Prior Authorization/Medical Policies. The main heading is "BlueCard Prior Authorization/Medical Policies". Below this, there is explanatory text: "Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate the process through My Insurance ManagerSM. Once you've logged in, go to Patient Care. Then select 'Pre-Service Review for Out-of-Area Members' from the menu." and "To view an out-of-area Blue Plan's medical policy or general priorauthorization information, please select the type of information you need, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit." The "Type of Information" section has the instruction "Please select only one." and two radio buttons: "Medical Policy" (selected, indicated by a red arrow) and "General Precertification/Preauthorization Information". Below this is an "Alpha Prefix" text input field with a "This field is required." error message. A "Submit" button is at the bottom. At the very bottom, it says "If you experience difficulties or need additional information, please contact 800-676-BLUE."

You will be taken to the landing page of the other Blue Plan.



Pre-Service Review for Out-of-Area Members

Welcomes YOUR PRACTICE/FACILITY

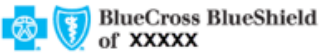
You have been routed from BlueCross BlueShield SC to [redacted] BCBS to conduct pre-service review for a(n) [redacted] BCBS member.

Please choose from the following options:

- [Request Preauthorization/Referral](#)
- [AIM Specialty Health](#)

©2005-2013 copyright of Anthem Insurance Companies, Inc.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. Use of the Anthem Web sites constitutes your agreement with our Terms of Use.



Your plan for better health.™

Pre-Service Review for Out-of-Area Members

BlueCross BlueShield of XXXXX

Welcomes YOUR NAME

You have been routed from BlueCross BlueShield SC to BCBS of XXXXX to conduct pre-service review for a BCBS of XXXXX member.

Please choose from the following electronic pre-service review options:

- **Inpatient or Outpatient Services** (Please note that the electronic pre-service review for In/Outpatient services is available 4a.m. to 1a.m., Monday through Friday.)
- **Radiological Services**

Other pre-service review options:

- **DME Services:** BCBS of XXXXX does not currently offer electronic pre-service review for DME services. Please call 1-800-888-8888 for DME pre-service review.
- **Mental Health Services:** BCBS of XXXXX does not currently offer electronic pre-service review for Mental Health services. Please call the number on the back of member's ID card for Mental Health pre-service review.

[View BCBS Pre-Certification Requirements.](#)

© 2017, Blue Cross and Blue Shield of North Carolina, an independent licensee of the Blue Cross and Blue Shield Association. All rights reserved. This site includes confidential and proprietary information. Use is protected by all applicable federal and state laws. Unauthorized access is not permitted.

Verify Primary Care Physician

From the Patient Care menu choose Verify Primary Care Physician. Complete the required information; make sure to enter the member ID exactly as it appears on the patient's insurance card, including the alpha prefix if applicable. Select **Continue**.

The screenshot shows the 'Verify Primary Care Physician' form. At the top, there is a navigation bar with links: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, and Staff Directory. Below the navigation bar, a welcome message reads 'Welcome, YOUR NAME of YOUR PRACTICE/FACILITY' with a '(Log Out)' link and a 'Go to Message Center' link. The main heading is 'Verify Primary Care Physician' with a 'Printer-Friendly' icon. A red asterisk note states '* Indicates required field.' The form contains three required fields: 'Health Plan' (a dropdown menu with 'BlueCross BlueShield Plans' selected), 'Member ID' (a text box containing 'zcz065922516805' with a note 'include alpha prefix, if applicable'), and 'Patient's Date of Birth' (a text box containing '10/01/1958' with a note 'mm/dd/yyyy'). A 'Continue' button is located at the bottom left of the form.

The Primary Care Physician Information will display on the next screen if applicable to the member's health plan.

The screenshot shows the results of the search. The navigation bar and welcome message are the same as in the previous screenshot. The main heading is 'Verify Primary Care Physician' with a 'Printer-Friendly' icon. A blue information box states: 'We list Primary Care Physician information according to Health Plans. If your patient had coverage under a different Health Plan and you would like to see that information, please search under the previous Health Plan.' Below this, the 'Inquiry Date' is '04/24/2017'. The 'Primary Care Physician Information' section contains a table with the following data:

Patient's Name	Effective Date	Provider's Information	Provider's Phone
MICHAEL TESTING		Our records show that this member's health plan coverage does not require the member to choose a primary care physician.	

On the left side of the form, there are two sections: 'Insurance' with 'Plan Name: BlueCross BlueShield Plans' and 'Member ID: ZCZ065922516805', and 'Patient' with 'Date of Birth: 10/01/1958'. At the bottom left, there is a 'Change Patient' button, and at the bottom center, there is a 'Back' button.

JUST FOR DENTAL PROVIDERS

Pre-Treatment Estimate Entry

From the Patient Care menu, choose Pre-Treatment Estimate Entry to get a real-time snapshot of the benefits that are payable at the time the pre-treatment processes. This is considered a prior authorization. Select the plan and then Continue.

The screenshot shows a web application interface for entering a Pre-Treatment Estimate. At the top, there is a navigation menu with links: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, and Staff Directory. Below the menu, a welcome message reads "Welcome, Your Name of Your Dental Practice" with a "(Log Out)" link and a "Go to Message Center" link. The main heading is "Pre-Treatment Estimate" with a "Printer-Friendly" icon. A progress bar below the heading shows steps: Plan Information (active), Provider Information, Patient Information, Claim Information, Claim Line Information, Review, and Confirmation. A note on the left states: "Please note: This feature is not available from 11:30 p.m. to 4 a.m. Eastern Time for maintenance purposes." The "Plan Information" section includes a "Submitter Information" form with fields for Name (Your Name), ID (987654321), Email Address (Your.Name@email.com), Phone ((987) 234-5678), Extension (Not Available), and Fax (Not Available). Below this is another "Plan Information" section with a note: "Please note: You are entering a Pre-Treatment Estimate request. Switch to create a Dental Claim Entry." and a dropdown menu for "Plan" with the text "--Please Choose One--". At the bottom, there are "Continue" and "Cancel this claim" buttons.

From the Provider Information screen select the hyperlinks for **Choose a Billing Provider** or **Choose a Rendering Provider** to have this information auto populated. **Choose a rendering provider** if it differs from the billing provider.

A Specialty/Taxonomy Code is required when you enter the rendering provider information. Use the National Plan & Provider Enumeration System's (NPPES) website to locate your rendering provider's specialty/taxonomy code if you are unfamiliar with this number. NPPES is a separate program ran by the Centers for Medicare & Medicaid Services that handles these unique identifiers.

Users can also find the specialty/taxonomy code in My Insurance Manager by searching for a partial code or description. Select **Continue**.

The screenshot displays the 'Pre-Treatment Estimate' form in a web application. At the top, there is a navigation bar with links: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, and Staff Directory. Below the navigation bar, a welcome message reads 'Welcome, Your Name of Your Dental Practice' with a '(Log Out)' link and a 'Go to Message Center' link. The main heading is 'Pre-Treatment Estimate' with a 'Printer-Friendly' icon. A progress bar shows the current step as 'Provider Information', with other steps being 'Plan Information', 'Patient Information', 'Claim Information', 'Claim Line Information', 'Review', and 'Confirmation'. On the left, an 'Insurance' box shows 'Plan Name: BlueCross BlueShield Plans'. The 'Provider Information' section is marked as '* Required'. It contains two sub-sections: 'Billing Location Information' and 'Rendering Provider Information'. The 'Billing Location Information' section includes a note: '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.' Below this is a 'Choose a Billing Provider' button. The form fields are: 'Provider ID Type' (Primary ID (NPI)), 'Provider ID' (987654321), 'Provider's Name' (YOUR DENTAL PRACTICE), 'Address Line 1' (456 MAIN ST), 'Address Line 2' (empty), 'City' (FORT MILL), 'State' (South Carolina), 'ZIP Code' (29715 - 0000), 'Provider Accepts Assignment' (Assigned), and 'Provider Signature on File' (Yes). The 'Rendering Provider Information' section includes a note: 'Please Note: You must identify a Rendering Provider on all claims when the services were not rendered by the Billing Provider.' Below this is a 'Choose a Rendering Provider' button. The form fields are: 'Provider ID Type' (--Please Choose One--), 'Provider ID' (empty), 'Provider's Name' (empty), and 'Specialty/Taxonomy Code' (empty) with a 'Search' button. At the bottom, there are 'Continue' and 'Back' buttons, and a 'Cancel this claim' link.

On the Patient Information screen, add the required patient data elements as a one-time entry or use the Patient Directory. At the Patient Account Number field input the patient's unique number your practice or practice management software has assigned. You can create a patient account number if one does not exist. Select **Continue**.

Pre-Treatment Estimate

Printer-Friendly

- [Plan Information](#)
- [Provider Information](#)
- [Patient Information](#)**
- [Claim Information](#)
- [Claim Line Information](#)
- [Review](#)
- [Confirmation](#)

* Required

Insurance

Plan Name:
BlueCross BlueShield Plans

Patient Information

Patient Details

Please note: Changes made to this information 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 here.

* Member ID: * Relationship to Member: * Patient Account Number:

include alpha prefix, if applicable

* Last Name: First Name: M.I.: Suffix:

* Date of Birth: * Gender:

mm/dd/yyyy

* Country:

* Address Line 1: Address Line 2:

* City: * State: * ZIP Code: -

Patient Consent

* Benefits Assigned to Provider:

* Release of Information:

or [Back](#)

Cancel this claim

The next pre-treatment estimate entry screen is Claim Information. Bypass the option to choose or create/update a superbill from the drop-down menu. Choose the place of service. If appropriate, add Claim Entry Options by checking the box that corresponds with the claim information to be included. Select Continue.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, Your Name of Your Dental Practice (Log Out) Go to Message Center

Pre-Treatment Estimate Printer-Friendly

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

Insurance

Plan Name:
BlueCross BlueShield Plans

Member ID:
ZCZ065922516805

Member's Name:
MICHAEL TESTING

Patient

Patient's Name:
MARTHA TESTING

Relationship to Member:
SPOUSE

Gender:
FEMALE

Date of Birth:
09/01/1960

Claim Information * Required

Superbill Information

Choose a Superbill Template:
None

[Create a New or Edit an Existing Template](#)

Service Information

Claim Type:
Pretreatment Estimate

* Place Of Service:
Office - 11

Claim Entry Options

Accident Information

Claim Note Information

Orthodontics Information

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

Claim Line Information is the fifth screen in the pre-treatment estimate entry process. Enter the total number of lines (up to 50 lines) in the Claim Amounts section. There is also a second chance to include additional claim lines by selecting the **Add a New Claim Line** link at the bottom of the screen. Claim amounts will automatically calculate based on the amounts you enter on the claim lines.

In the Claim Lines section, enter the procedure code and charges in those required fields. Search for the specific procedure code by selecting the magnifying glass icon.

Choose the tooth number or oral cavity from the drop-down menu. Selecting a tooth number or oral cavity is optional.

Enter additional information as appropriate for Treatment Start/Completion Dates; Prosthesis, Crown or Inlay Placement; Orthodontic Banding/Replacement Dates; and Rendering Provider Information. Select **Continue**.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, Your Name of Your Dental Practice (Log Out) [Go to Message Center](#)

Pre-Treatment Estimate Printer-Friendly

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

Insurance
 Plan Name: BlueCross BlueShield Plans
 Member ID: ZCZ065922516805
 Member's Name: MICHAEL TESTING

Patient
 Patient's Name: MARTHA TESTING
 Relationship to Member: SPOUSE
 Gender: FEMALE
 Date of Birth: 09/01/1960

Claim Line Information * Required

Claim Amounts

Please note: We will calculate the Total Claim Charges automatically based on the amounts you enter on the claim lines.

Total Claim Charges: \$ 500.00 Patient Paid: \$ Total Number of Lines: 1

Claim Lines

Please note:

- We require the Date of Service on all claims, except for Pre-Treatment Estimates.
- We require Date of Service, Place of Service, and Rendering Provider Information if they differ from the information previously entered at the claim level.
- We do not require Treatment Start Date and Treatment Completion Date if a Date of Service is entered.

Line 1

* Procedure: D7140 * Charges: \$ 500.00 Unit(s):

Procedure Description: Tooth # -OR- Oral Cavity: --Please Choose One--

Surfaces:
 Occlusal Mesial Distal Facial Incisal Lingual Buccal

Place of Service:

Treatment Start Date: mm/dd/yyyy Treatment Completion Date: mm/dd/yyyy

Prosthesis, Crown or Inlay Placement: --Please Choose One--

Orthodontic Banding Date: mm/dd/yyyy Replacement Date: mm/dd/yyyy

Rendering Provider Information: [+ show/hide]

[Add a New Claim Line](#)

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

This screen appears when searching for a procedure code. Search by description or code. Place your cursor on the desired procedure code to select it and be returned to the prior screen.

Procedure Code (HCPCS) Search Results

Showing 6 Result(s)

Filter results...

Code	Description
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT
D7111	EXTRACTION, CORONAL REMNANTS - DECIDUOUS TOOTH
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)

[New Search](#)

From the Review screen, examine your entries for the pre-treatment estimate. Submit the pre-treatment

estimate or return to any previous screen using the **back** hyperlink or selecting a screen title on the progress bar.

Select **Add Additional Claim Information** to add claim-level information.

The screenshot shows the 'Pre-Treatment Estimate' screen in the 'Claim Review' stage. The progress bar at the top indicates the current step. On the left, there are sections for 'Insurance' (BlueCross BlueShield Plans, Member ID: ZCZ065922516805, Member's Name: MICHAEL TESTING) and 'Patient' (Patient's Name: MARTHA TESTING, Relationship to Member: SPOUSE, Gender: FEMALE, Date of Birth: 09/01/1960). The main area contains 'Claim Review' information, including 'Provider Information' (Submitter's Name: YOUR NAME, Billing Location: YOUR DENTAL PRACTICE, Plan: BlueCross BlueShield Plans), 'Patient Information' (Member ID: ZCZ065922516805, Date of Birth: 09/01/1960, Gender: FEMALE), and 'Claim Information' (Total Charges: \$ 500.00, Dates of Service:). A table titled 'Claim Line Information' shows one line with Procedure D7140, Date of Service, Charges of \$ 500.00, and an 'Add' link. A note at the bottom states: '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.' Buttons for 'Submit', 'Back', and 'Cancel this claim' are visible.

To add information that applies to an individual claim line, select the **Add** link on the line to which the information applies. There is an option to **Cancel the claim** found at the bottom of each screen of the claim entry process. Select **Continue**.

A claim number is displayed on the Claim Confirmation screen. You can now begin a new pre-treatment estimate or view the status of a pre-treatment estimate.

The screenshot shows the 'Pre-Treatment Estimate' screen in the 'Confirmation' stage. The progress bar at the top indicates the current step. On the left, there are sections for 'Insurance' (BlueCross BlueShield Plans, Member ID: ZCZ065922516805, Member's Name: MICHAEL TESTING) and 'Patient' (Patient's Name: MARTHA TESTING, Relationship to Member: SPOUSE, Gender: FEMALE, Date of Birth: 09/01/1960). The main area contains 'Claim Confirmation' information, including a note: 'Please note: We have received and are processing your Pre-Treatment Estimate.' and a 'Confirmation' section with fields for 'Claim Number' (T7D10003W), 'Member ID' (ZCZ065922516805), 'Patient's Name' (MARTHA TESTING), 'Patient's Date of Birth' (09/01/1960), and 'Patient's Gender' (Female). Buttons for 'Create New Claim' and 'View Claim Status' are visible.

Pre-Treatment Estimate Status

From the Patient Care menu choose Pre-Treatment Estimate Status. Select a dental plan and enter the member ID and patient's date of birth. Select **Continue**.

The screenshot shows the 'Pre-Treatment Estimates' search form. At the top, there is a navigation bar with 'Home', 'Patient Care', 'Office Management', 'Resources', 'Modify Profile', 'Profile Administration', and 'Staff Directory'. Below the navigation bar, a welcome message reads 'Welcome, Your Name of Your Dental Practice' with a '(Log Out)' link and a 'Go to Message Center' link. There are also links for 'Get Adobe Reader' and 'Printer-Friendly'. The main heading is 'Pre-Treatment Estimates' with a red asterisk indicating required fields. A search instruction says 'To search for a Pre-Treatment Estimate, please enter this information.' The form includes three required fields: 'Dental Plan' (a dropdown menu with '--Please Choose One--'), 'Member ID' (a text input field with a note 'include alpha prefix, if applicable'), and 'Patient's Date of Birth' (a date input field with a note 'mm/dd/yyyy'). A 'Continue' button is at the bottom left.

The Estimate Detail screen displays next. Look to the Status field to determine if the estimate is in a pending or approved status.

You can now choose to send a secure email to Provider Services by selecting **Ask Provider Services**; or view **Previous Estimate** or view **Next Estimate**.

The screenshot shows the 'Estimate Detail' screen. It features the same navigation bar as the search form. The main heading is 'Pre-Treatment Estimates' with links for 'Get Adobe Reader', 'Printer-Friendly', and 'View Pre-Treatment Estimate Letter'. On the left, there are two summary boxes: 'Insurance' showing 'Plan Name: BlueCross BlueShield Plans' and 'Member ID: ZCZ065922516805', and 'Patient' showing 'Patient's Name: MARTHA TESTING' and 'Date of Birth: 09/01/1960'. A 'Change Patient' button is below the patient information. The main content area is titled 'Estimate Detail' and contains the following information: 'Here is the information about the pre-treatment estimate you chose.' and a disclaimer: 'Please note: This is not a guarantee of benefits or payment. All services are subject to any limitations or exclusions in the contract that are in effect at the time the patient receives services.' Below this, there are two rows of fields: 'Claim Number: T7D10003W' and 'Status: PENDING'. A section titled 'Pre-Treatment Estimate Information' contains: 'Provider's Name: YOUR DENTAL PRACTICE' and 'Primary ID: 987654321'; 'Date Received: 04/20/2017' and 'Date Processed: 04/20/2017'; 'Total Charges: \$500.00' and 'Non-Covered Amount: \$370.00'; 'Allowed Amount: \$64.00', 'Patient Liability: \$66.00', and 'Orthodontics?: No'. At the bottom, there are three buttons: 'Previous Estimate', 'Next Estimate', and 'Ask Provider Services'.

TROUBLESHOOTING TIPS

- If you get a “not covered” response with an eligibility end date of 12/31/999, this means a member’s dependent has been termed on an active policy. If you get a “covered” response with an eligibility end date of 12/31/9999, this means the patient (subscriber or dependent) is active.
- You cannot view dental eligibility and benefits for FEP BlueDental or out-of-state members.
- The dental code entered on the Eligibility and Benefits by Procedure Code inquiry may not be the procedure code returned on the eligibility response. The procedure code on the eligibility response is the code we will use to process the claim for this service. For example, when D2740 is entered the eligibility response will display details for D2751. An explanation for the code substitution is given.
- If you’ve reviewed your claim entry and continue to get an error message that states missing information is required, be sure an additional claim line field has not been expanded. For example, if you clicked the show/hide link for Drug Identification when you entered Claim Line Information but did not have prescription drug information to add, the claim will not submit without this information or without collapsing this option.
- B06 Invalid Point of Origin I84
- E07 Invalid Admission Date B04
- B9A Patient Reason for Visit/Admitting Diagnosis I
- B20 Revenue Code - Invalid I12
- H98 Room Days and/or Charges Required on Inpatient
- L25 Enter a valid tooth number or oral cavity



In the event of any inconsistency between the information in this handbook and agreement(s) between you and BlueCross BlueShield of South Carolina or BlueChoice HealthPlan, the terms of such agreement(s) shall govern. The information included is general and in no event should be deemed to be a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.