



## **Helpful Tips for Preventing Claim Delays**

Listed below are some of the most common issues that can cause delays in claims processing. Keep these tips in mind when filing claims:

### **Check benefits and eligibility before providing services**

Checking member benefits and eligibility prior to services being rendered will save your office time and money. In addition, your office, as well as the BCBSNM member, will better understand the member's financial responsibility for the services.

You may obtain benefits and eligibility – including covered services, copayments, and deductibles – for in-state or out-of-state members online through [Availity](#)<sup>®</sup> at no charge. You can also use our Interactive Voice Response automated system by calling the Provider Services Line at **888-349-3706**.

### **Alpha prefixes vital when filing claims**

The three-character alpha prefix at the beginning of the member's ID number is key to identifying and correctly routing out-of-state claims to the appropriate Blue Cross and Blue Shield (BCBS) Plan for processing. The alpha prefix identifies the BCBS Plan to which the member belongs and helps confirm the member's eligibility and coverage information.

An incorrect or missing alpha prefix can cause delays in the processing of your claims. To avoid these, please:

- Do not omit or randomly select an alpha prefix.
- Include the alpha prefix and all alpha-numeric characters on all correspondence and claims submitted to the BCBS Plan.
- Copy the member's ID card front and back for your records.

### **When there is only one insurance carrier**

We receive thousands of claims each month that require unnecessary review for Coordination of Benefits (COB). That means possible delays or even denials of services pending receipt of the required information from members.

Following are some tips to help prevent claims processing delays on the CMS-1500 form when there is only one insurance carrier:

1. Box 11-d: If there is no secondary insurance carrier, mark the box "No."
2. Do not put anything in box 9, a through d. This area is reserved for member information for a secondary insurance payer.

### **When there are two insurance carriers**

Be sure to include both the primary and secondary policy information on the claim.

## **Include “Date of Current Illness” and “Occurrence Code and Date” when submitting claims**

Including the “Date of Current Illness” or “Occurrence Code” and the associated date will help eliminate the need to contact Customer Service when a claim denies unexpectedly needing this information.

When submitting the CMS-1500, enter the “Date of Current Illness” (or onset date) in box 14 to indicate the date of the first symptom (for an illness), date of accident (for an injury), or date of the last menstrual period (LMP, for pregnancy). If the patient has had the same or similar illness, provide the first date of the illness in box 15.

When submitting the UB-04, enter the “Occurrence Code” and associated date in fields 31 through 36 to define a significant event related to the claim. The occurrence codes most commonly recognized by BCBSNM are as follows:

- 01: Auto accident
- 04: Employment-related accident
- 05: Other accident
- 10: Last menstrual period (LMP)
- 11: Onset of symptom/illness
- 33: First day of Medicare coordination period for End Stage Renal Disease (ESRD)

**Remember that the first date of service is not always the onset/occurrence date.** Claims may process differently depending on what date is entered. Be sure you are entering the actual date on all claims.

## **The CMS-1500 08/05 form: Boxes 14 and 15**

Do these boxes confuse you? If so, the following tips can help you complete these fields:

- **Box 14** is based on the patient’s current services and should always be filled out. BCBSNM uses this date to determine if the service is an emergency.
- **Box 15** needs to be filled out only if the policy indicates there is a pre-existing waiting period. You can verify this by calling the Provider Services Line at **888-349-3706**. If the quote indicates a pre-existing waiting period, you must fill in this box. We use this date to determine pre-existing conditions.

What date should I use?

- Use the date the patient was seen for the first time for this condition, even if seen by a physician other than you.
- Obtain this date from the patient during the history and physical

### **Provider information**

Be sure to include all current and complete provider information on claims, including the current tax identification number and National Provider Identifier (NPI) number in the correct fields.

### **Preauthorization for initial stay and add-on days**

Preauthorization is required for certain types of services. It is the responsibility of the member to confirm that preauthorizations are obtained by the provider for services requiring preauthorization. Preauthorization must be obtained for any initial stay in a facility and any additional days or services. If a member does not obtain preauthorization for initial facility care or services and any additional days or services, benefits may be reduced.

Preauthorization does not guarantee payment. All payments are subject to determination of the member's eligibility; payment of required deductibles, copayments, and coinsurance amounts; eligibility of charges as covered expenses; and application of the exclusions and limitations and other provisions of the policy at the time the services are rendered.

### **Only submit additional medical records when requested**

Physicians and professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a Radiology Quality Initiative (RQI) number from the American Imaging Management (AIM) *do not* need to submit additional medical records to BCBSNM. If we need additional medical records to process a claim, we will request them.

### **Corrected claims**

**CMS-1500 corrected claims** should be submitted electronically using the [Claim Inquiry Resolution \(CIR\) tool](#). If you must file CMS-1500 corrections on paper, complete the [Claim Review Form](#) and attach the form to the top of the claim.

**UB-04 corrected claims** should be submitted electronically whenever possible. Refer to [Section 8.6 of the Provider Reference Manual](#) for more information about submitting corrected claims.

### **Claim status**

If a response has not been received to a claim, please contact Customer Service at (888) 349-3706, or check the Availity Web site for claim status prior to resubmitting the claim. If the claim is already on file but has not yet been processed, a resubmission will not expedite the processing of the original claim.