Availity's Facility Claim submission feature offers providers a no-cost solution to quickly submit an electronic claim or encounter to Blue Cross and Blue Shield of New Mexico (BCBSNM). Electronic claim submission can accelerate the claim and reimbursement process. This Availity option doesn't require the use of a separate clearinghouse or practice management system.

Note: *This user guide provides instructions on completing and submitting the Facility Claim Submission form via the Availity portal. The guide is for educational purposes and should not be interpreted as advice on how to bill a claim.*

Not Registered with Availity? Complete the guided online registration process today at Availity, at no charge.

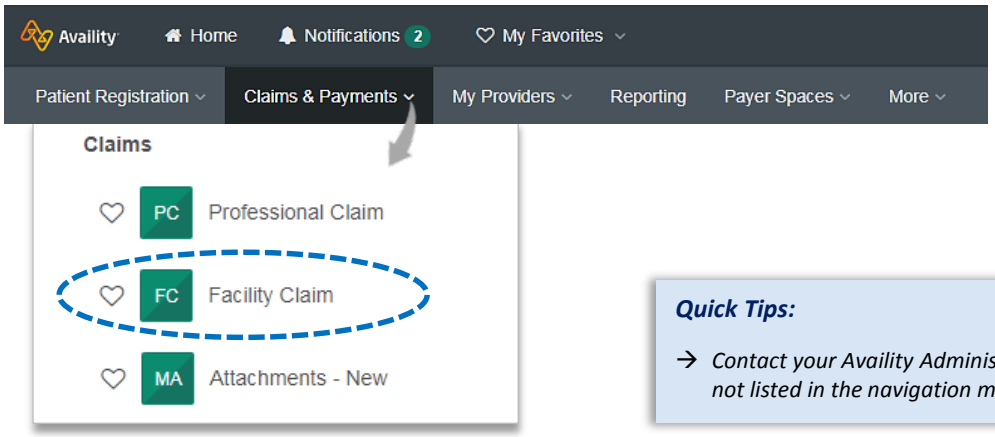
1) Getting Started

- Go to Availity
- Select **Availity Portal Login**
- Enter User ID and Password
- Select **Log in**

Note: *Only registered Availity users can access the Facility Claim option.*

2) Accessing the Facility Claim Form

- Select **Claims & Payments** from the navigation menu
- Select **Facility Claim**



Quick Tips:

→ *Contact your Availity Administrator if* ***Facility Claim*** *is not listed in the navigation menu.*

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

3) Payer Selection

- Select your **Organization**
- Choose **Transaction** from the drop-down list
- Select **Payer** from the drop-down list
- Select **Continue**

Organization
ABC Organization

Transaction
Facility Claim

Payer
BCBSNM

Continue

4) Patient Information

- Select **Facility Type**
- Select Primary or Secondary from the **Responsibility Sequence**
- Enter **Statement From & To Date** *(must be past or current date)*

Complete the following:

- **Last Name**
- **Date of Birth**
- **Gender**
- **Address**
- **City, State, Zip Code**
- **Relationship to Subscriber**

Quick Tips:

→ *All fields with red asterisks * are required fields.*

→ *If submitting a Secondary claim, make sure to include all primary claim information.*

* Payer: ? BCBSNM
* Organization: ABC ORGANIZATION
Transaction Type: ? Facility Claim
* Facility Type: ? 13 - Hospital Outpatient
Responsibility Sequence: ? Primary
* Statement: ? From MM / DD / YYYY To MM / DD / YYYY

Patient Information

* Last Name: DOE
First Name: JANE
Middle Name or Initial:
* Date of Birth: 01 / 01 / 1985 (MM DD YYYY)
Date of Death: MM / DD / YYYY
* Gender: FEMALE
Country: ? United States
* Address 1: 123 ANYWHERE ST.
Address 2:
* City, State, ZIP Code: CITY Select One 5555 - 0000
* Relationship to Subscriber: ? Self
release signature from provider on behalf of patient
Patient Amount Paid: ?

Quick Tips:

→ *If an Availity Eligibility and Benefits Inquiry is completed first, data will pre-populate into the Patient and Subscriber Information sections.*

→ *While "First Name" is not a required field, entering this information will ensure accurate processing of your claim.*

Note: *If the patient's condition is related to employment, auto accident, or other accident check the appropriate box and fill in the requested information.*

Patient's Condition Is Related To:
(Select all options that apply to patient's condition)

- current or previous employment
- auto accident
- other accident

5) Subscriber Information

- Enter the **Subscriber ID**, including the three-character prefix *(i.e.. ABC123456789)*
- Select **Authorized Plan to Remit Payment to Provider**
- If the member has a secondary insurance plan select the field for **a secondary insurance plan** and enter requested information

* Subscriber ID: ?
Policy or Group Number: ?
* Authorized Plan to Remit Payment to Provider? ? Yes
This claim also includes...
a secondary insurance plan

Quick Tip:

→ *Some out-of-state plans may have longer ID numbers; for these patients make sure you enter the three-character prefix and ID number as listed on the member's card. Include any alpha characters embedded within the ID.*

6) Billing Provider Information

The billing provider information can be automatically populated by choosing the appropriate provider from the **Select a Provider** drop-down listing. Contact your Availity Administrator to have the provider information added if not available.

Complete the following:

- **Organization / Provider Last Name**
- **Address**
- **City, State, Zip Code**
- **Specialty / Taxonomy**
- **NPI**
- **Tax ID**
- **Provider Accepts Assignment**
- **Release of information code** *(related to HIPAA disclosures with your patient)*

Billing Provider Information

Select a Provider: ? Select One
* Organization / Provider Last Name: ?
Phone Number: ? - - Ext.
Fax Number: - -
E-mail:
Country: ? United States
* Address 1: ?
Address 2: ?
* City, State, ZIP Code: -
* Specialty / Taxonomy:
* NPI: ?
* Tax ID: ?
Important: Enter the tax ID to which the claim should be paid.
* Provider Accepts Assignment: ? Assigned
* Release of Information Code: ? Select One

Note: *If this claim has additional provider information, select the appropriate field and enter the requested information.*

This claim has additional provider information...
additional billing provider contact information
a billing provider pay-to address that is different from the billing provider address
a service facility location that is different from the billing provider

7) Attending Provider Information

- Enter the **Attending Provider** information

Attending Provider Information

Express Entry - Attending Provider: Select One
* Last Name:
* First Name:
* Specialty / Taxonomy:
* NPI: ?

This claim also includes...

☐ a rendering provider that is different from the attending provider

☐ an operating physician

8) Diagnosis Codes

- Enter the **Principal ICD-10 Diagnosis Code**
- Select **Add Another Code** to add up to 12 diagnosis codes

Diagnosis Codes ?

* Principal Diagnosis Code: J449 ICD-10 Code Verification ?
Present on Admission (POA): Select One
* Diagnosis Code 2: R05 ICD-10 Code Verification ? Remove
POA Indicator: Select One

[+] Add Another Code

9) Claim Information

- Enter the **Patient Control Number** *(the patient account number assigned by your office)*
- Select **Billing Frequency:**
  - **Frequency Code 1** *(new claim)*
  - **Frequency Code 7** *(replacement claim)*
  - **Frequency Code 8** *(void/cancel claim)*
- Enter any applicable **Prior Authorization Number**
- Select **Admission Type** *(if the options listed do not fit your scenario, choose Elective or Information Not Available)*
- Select **Admission Source**

* Patient Control Number / Claim Number: ?
Diagnosis Related Group (DRG) Code: ?
Medical Record Number:
* Billing Frequency: ? Select One
☐ this is an HMO claim
Prior Authorization Number: ?
Auto Accident Country: Select One
* Admission Type: Select One
* Admission Source: Select One

Quick Tip:

→ *If corrected claim or void/cancel of a prior claim is selected, a new required field will populate. The **Payer Claim/Control Number** is required (ICN/DCN). This tells the payer which claim needs to be corrected or voided.*

9) Claim Information *continued*

- Additional information may also be included on the standard claim form
- To include the additional information select the appropriate fields and include the requested details

This claim also includes...

- ☐ an EPSDT referral
- ☐ external injury codes
- ☐ occurrence span codes
- ☐ occurrence information codes
- ☐ value codes
- ☐ condition codes
- ☐ treatment codes
- ☐ an attachment

10) Service Line(s) & Submission

Enter the following:

- **Line Item Control Number** *(Service Line Number)*
- **Revenue Code**
- **Date of Service** *(i.e., 01/01/2020)*
- **Charges** *(excluding the "$" sign)*
- **Service Unit Count** *(enter the number of units/minutes)*

Note: *If the service line includes additional information, select the appropriate option and fill in the details as requested.*

Line Number	Date(s) of Service: From	Date(s) of Service: To	Procedure Code CPT/HCPCS	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Revenue Code	Charges	Days or Units

No claims entered yet. Enter claim(s) below and click Save to Service Line.

Total: $0.00

Line Number: 1

* Line Item Control Number: ? 1

* Revenue Code: ?

Date of Service: ? From MM / DD / YYYY To MM / DD / YYYY

Procedure Code: ?

☐ non-specific procedure code description

Modifiers: 1 2 3 4

* Charges:

Non-Covered Charge Amount:

* Service Unit Count: ? Units

This service line also includes...

☐ reporting of a national drug code (NDC)

☐ a rendering provider that is different from the attending provider

☐ an operating physician

Save to Service Line

Quick Tip:

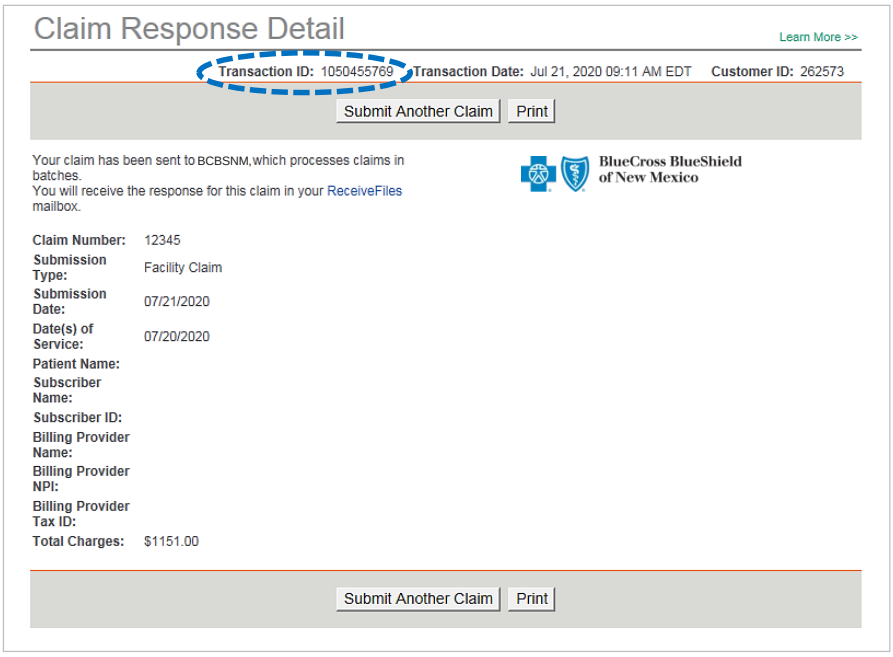
→ *Once all the service line information has been entered, select* ***Save to Service Line****. Without saving, the information will be removed. This also allows for additional service lines to be added.*

- After all appropriate information has been entered and reviewed, select **Submit** at the bottom of the claim form

Submit | Clear | Add to Batch

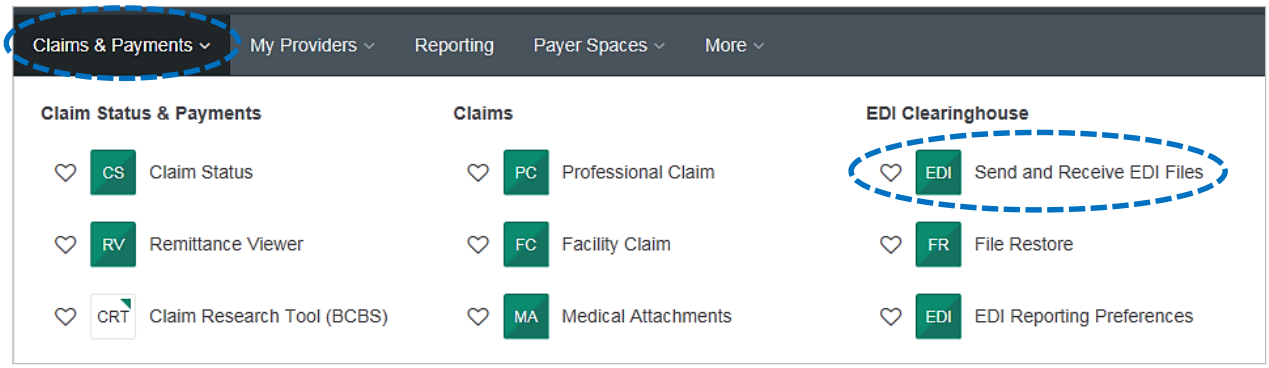
11) Submission Confirmation

- Once submitted a confirmation screen will return with a **Transaction ID** number *(this is not the claim number)*



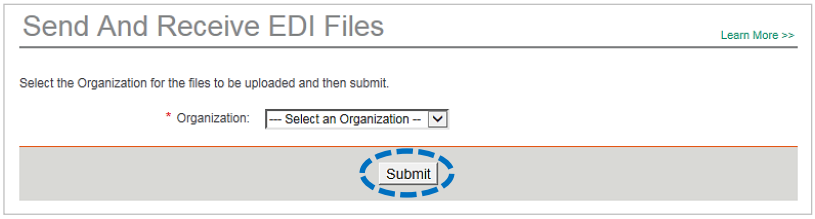
12) Confirming Claim Receipt

- Select **Claims & Payments** from the navigation menu
- Select **Send & Receive EDI Files**

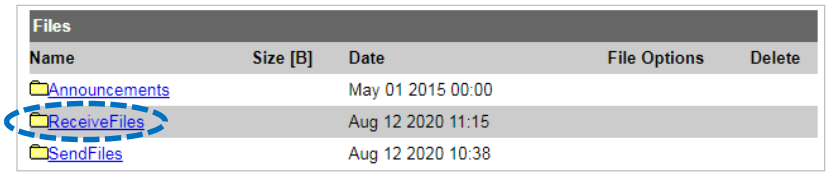


12) Confirming Claim Receipt *continued*

- Select **Organization**
- Select **Submit**



- Select **Receive Files** *(the below EDI Files will be available in **Receive Files** within 24 to 48 hours after submission)*



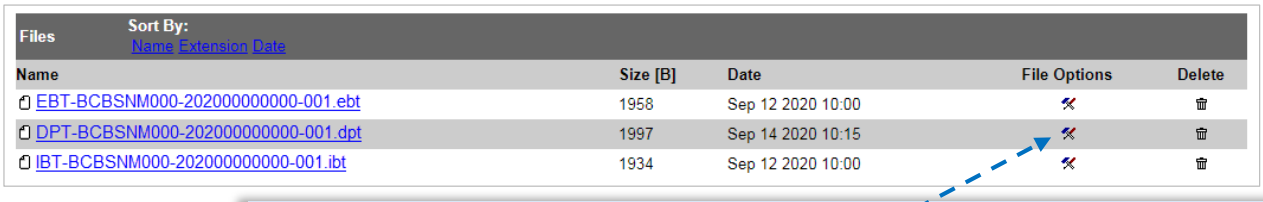
EDI File Types and Definitions:

→ ***IBT (Immediate Batch Text Response):*** *Immediately acknowledges accepted claims and identifies rejected claims due to HIPAA compliance edits and payers-specific edits. The IBT file are typically available in Receive Files within 30 mins. of submission.*

→ ***EBT (Electronic Batch Text Report):*** *Indicates if the claim was accepted or rejected by the payer. If applicable, reasoning for the claim rejection will be indicated.*

→ ***DPT (Delayed Payer Text Report):*** *Payer confirmation of receipt response showing assigned claim number.*

- Select the **EBT** file to confirm if the claim submission was accepted or rejected by BCBSNM



Quick Tips:

→ *If you are unable to view the file, select the **File Options** icon, then choose Text/Plain.*

→ *Once the claim has processed, use the Availity Claim Status tool to verify how the claim finalized.*

Have questions or need additional education? Email the Provider Education Consultants.

Be sure to include your name, direct contact information & Tax ID or billing NPI.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSNM. BCBSNM makes no endorsement, representations or warranties regarding any products or services provided by independent third party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in screen reader. Other Adobe accessibility tools and information can be downloaded at http://access.adobe.com.