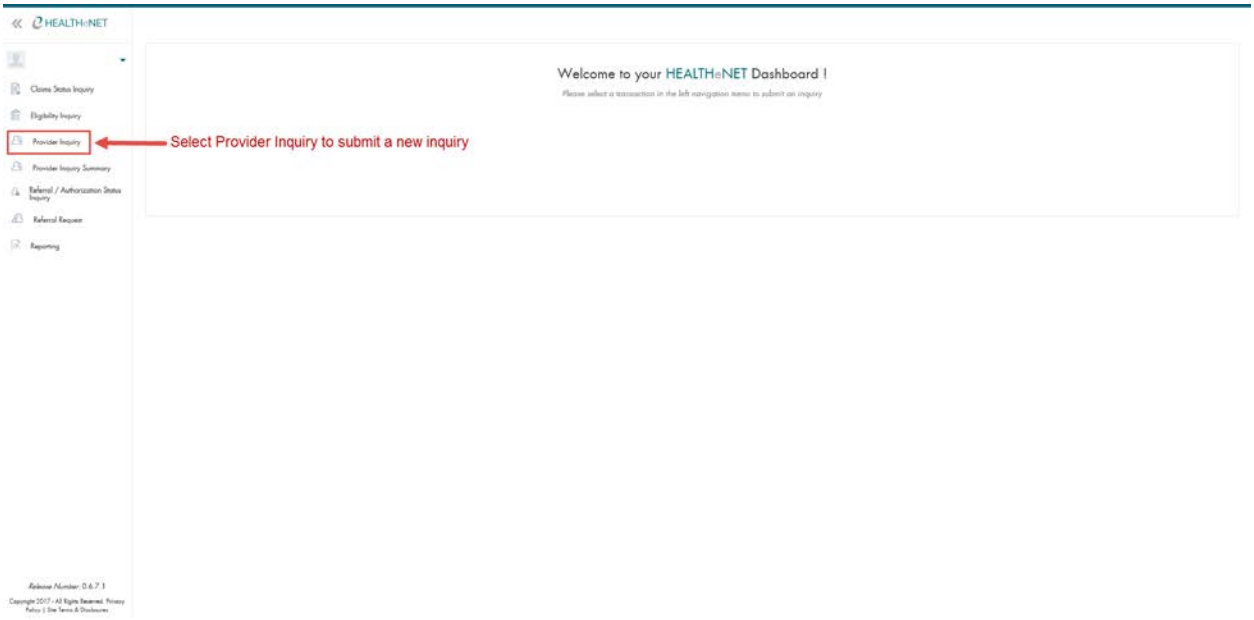
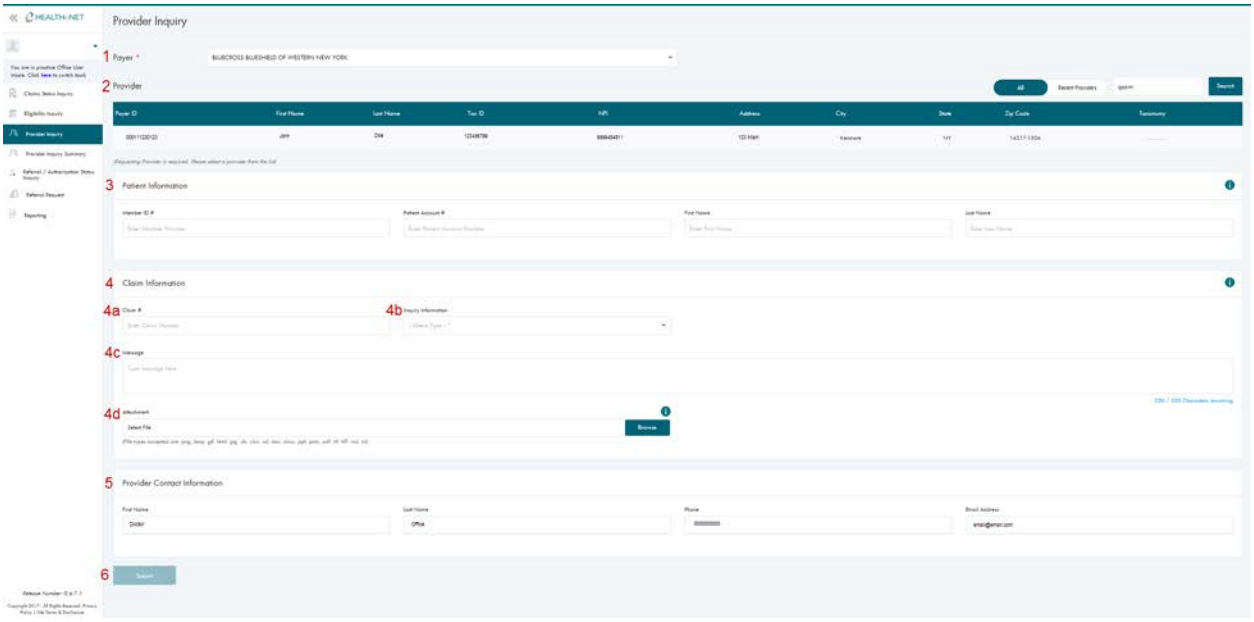
PROVIDER INQUIRY



- ☐ **There are six easy steps to submitting an inquiry.**
- ☐ **The red numbers on this screen shot have a matching instruction number beginning on the next page.**



PROVIDER INQUIRY INSTRUCTIONS

1. Select a **Payer** from the drop down list
   This Payer will receive your inquiry
   Once you have selected a Payer, the provider list for your organization will be made available to the user

2. Select a **Provider** from the drop-down list
   This indicates to our staff which provider you're inquiring about

3. If the inquiry is related to a specific member, enter the **Patient Information**:
   a. Member ID Number, including the Member ID suffix* *(required)*
      *Member Prefix and suffix are REQUIRED for any BlueCard inquiry
   b. Patient Account # *(optional)*
   c. First Name *(optional)*
   d. Last Name *(optional)*

4. If the inquiry is related to a specific claim, enter the **Claim Information**
   4a. **Claim #** - Enter corresponding claim #. Claim # is required for all BlueCard Inquiries
   - ☐ FEP claims CANNOT be submitted using this transaction

   4b. **Inquiry Information** - Select **Type** from the drop-down list
   - ☐ For assistance in choosing the Inquiry Type, please see page 7

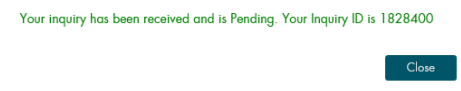
   4c. **Message -** Type your instructions to our staff
   - ☐ Remember, by providing the greatest detail possible to our staff, your inquiry has the best chance of being processed correctly and quickly

   4d. **Attachment -** You may include supporting documentation with your inquiry
   a. Select the "Browse**"** button to open your desktop folder
   b. Find your file and select it
   c. Your file name will now appear in the Attachment field
   d. This file will be sent to the payer with your inquiry

   Most often, an attachment **IS NOT REQUIRED** to process an inquiry. A listing of Inquiry Types that ***DO NOT REQUIRE*** attachments is on page 8.

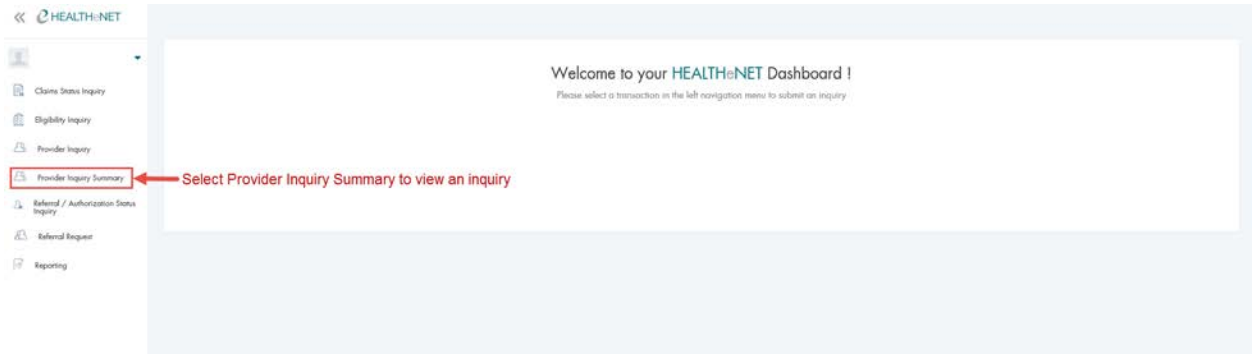
5. Check your **Provider Contact Information**, making sure it's correct.
   · In the event that our staff needs to contact you, this is critical information.
   · If your contact information is not correct, please speak with the Authorized Contact for your practice. Ask him/her to contact PCI Helpdesk and request an account update

6. If you do not enter the required information, the submit button will be 'greyed' out until all required fields are entered. · A pop-up message will verify that the inquiry was sent

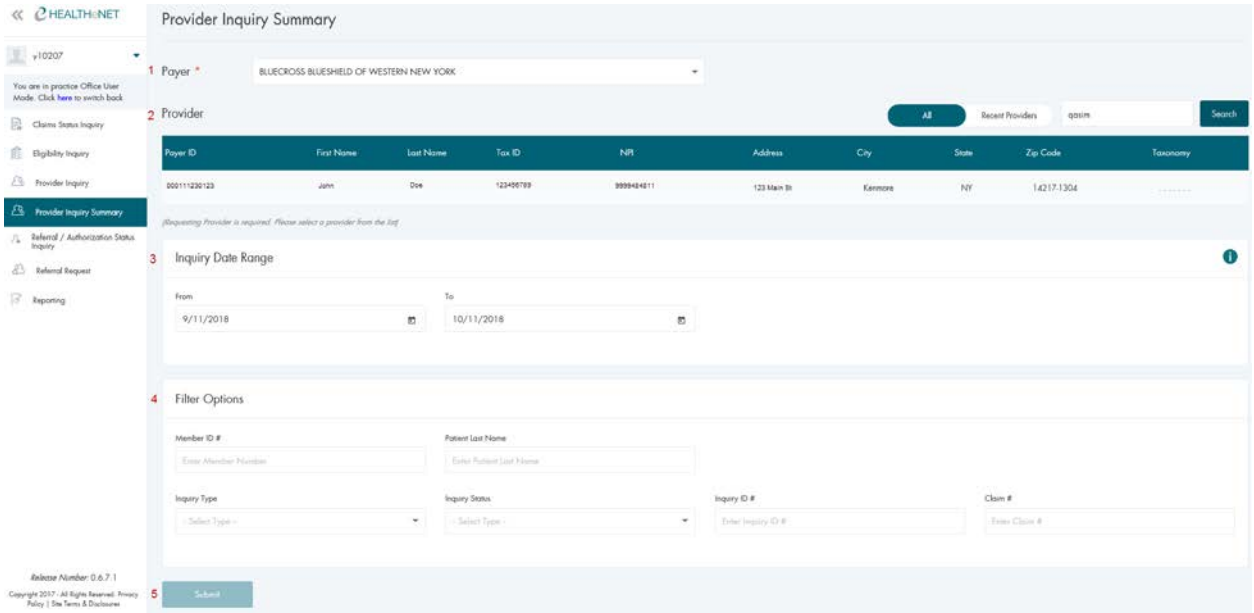


   · You may now check the status of your inquiry with **Provider Inquiry Summary**

PROVIDER INQUIRY SUMMARY



- ☐ **These are the steps to submitting an inquiry.**
- ☐ **The red numbers on this screen shot have a matching instruction number below.**



1. Select a **Payer** from the drop down list
   This is the Payer that the inquiry was submitted to
   Once you have selected a Payer, the provider list for your organization will be made available to the user

2. Select a **Provider** from the drop-down list (Required)
   This is the provider that the user wants to see all the inquiries for

3. Inquiry Date Range (Required)
   a. From Date (defaulted to 30 days from current date)
      - Inquiry request can only go back 30 days from original submission
   b. To Date (defaulted to today's date)

4. Filter Options (optional)
    a. Member ID#
    b. Patient Last Name
    c. Inquiry Type (select from dropdown)
    d. Inquiry Status (select from dropdown)
    e. Inquiry ID#
    f. Claim #

5. If you do not enter the required information, the submit button will be 'greyed' out until all required fields are entered.

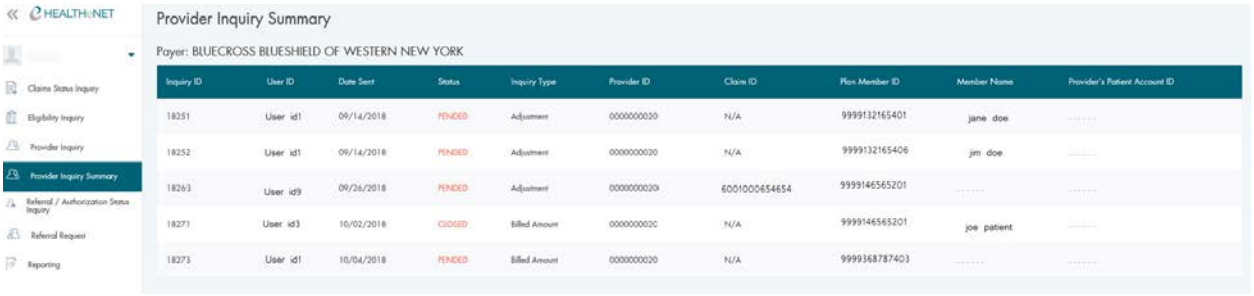
PROVIDER INQUIRY SUMMARY RESPONSE

Inquiries have two statuses, PENDED and CLOSED.

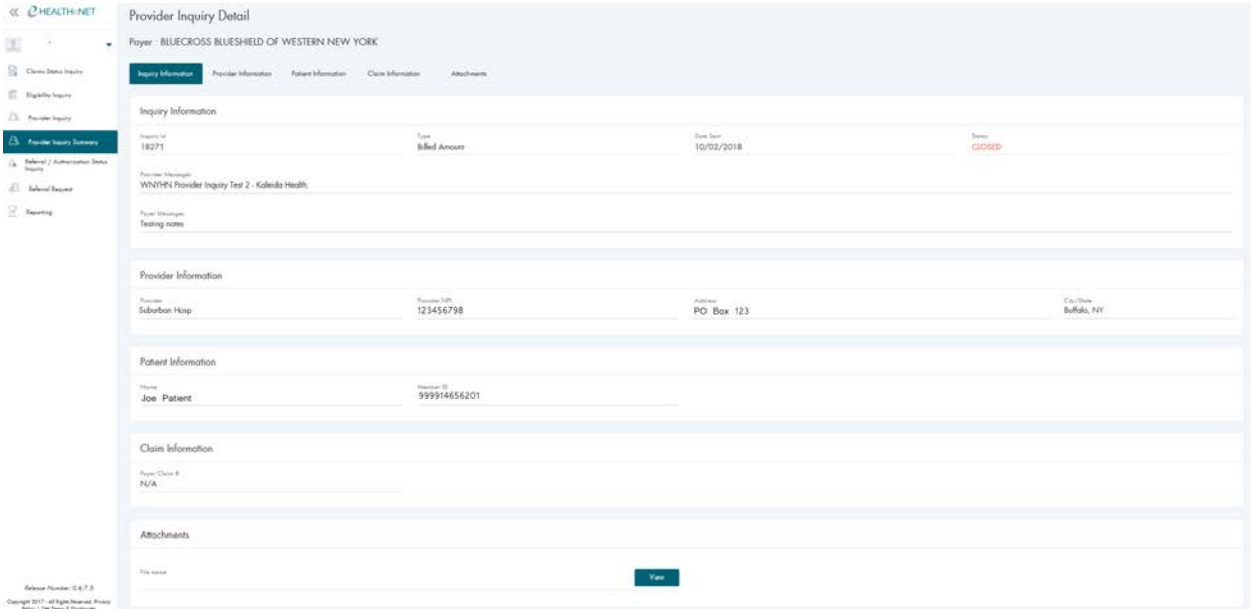
Pended inquiries are still open and do not have a final determination.
Closed inquiries have a final determination and will have that information in the "Payer Messages" section on the inquiry.

- All 'Closed' inquiries are final and cannot be reopened. A brand new Provider Inquiry must be sent if there is any question to the payer response. You may reference the original inquiry id in the new inquiry in the message section.

If there are more than one (1) Provider Inquiries that fall within the designated time-frame and selected filters, the user will be presented with a list of inquiries to select from.



To view the detail of an inquiry, simply click on that inquiry and the inquiry summary will display. As you can see, all of the original data that was submitted to the payer has been saved, and you can, if needed, retrieve any attachments. If the inquiry is closed, you will also see the Payer's response



If there is only one (1) inquiry that meets the submitted criteria, the inquiry summary will immediately be displayed on the users screen.

Preferred Work Flow:
Claim Status Link

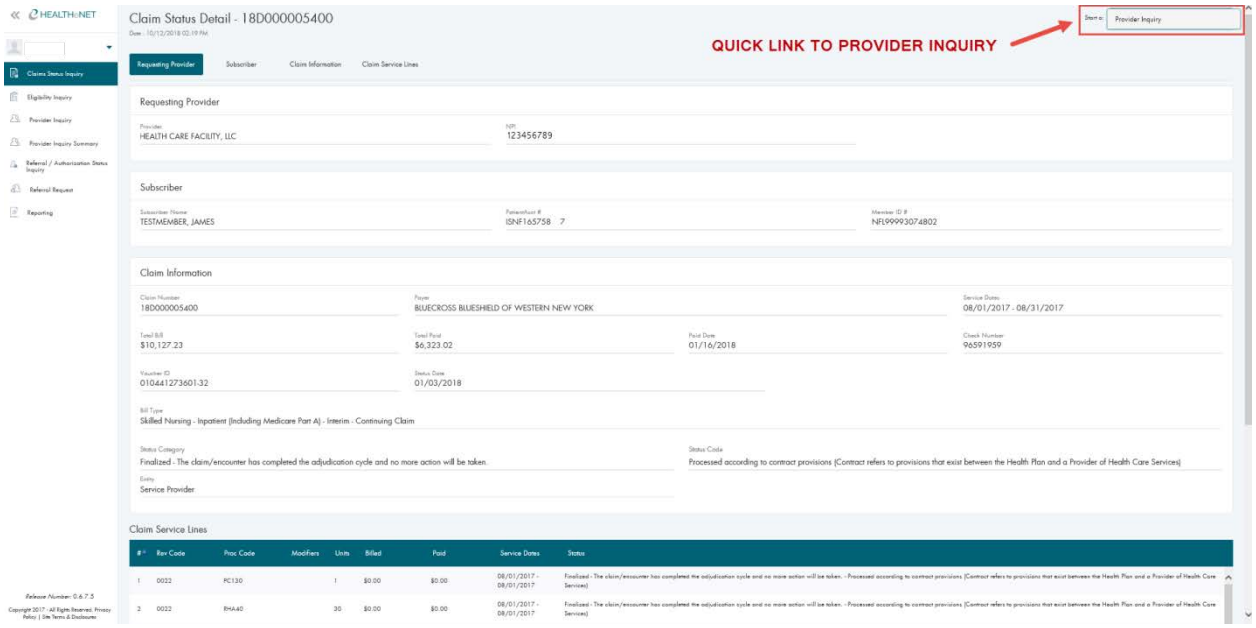
Now that you're familiar with the application, we will teach you a great shortcut for submitting inquiries. As users of HEALTHeNET you also have access to the **Claim Status** look-up tool.

We have built a link from the **Claim Status Detail** page directly to the Provider Inquiry tool!

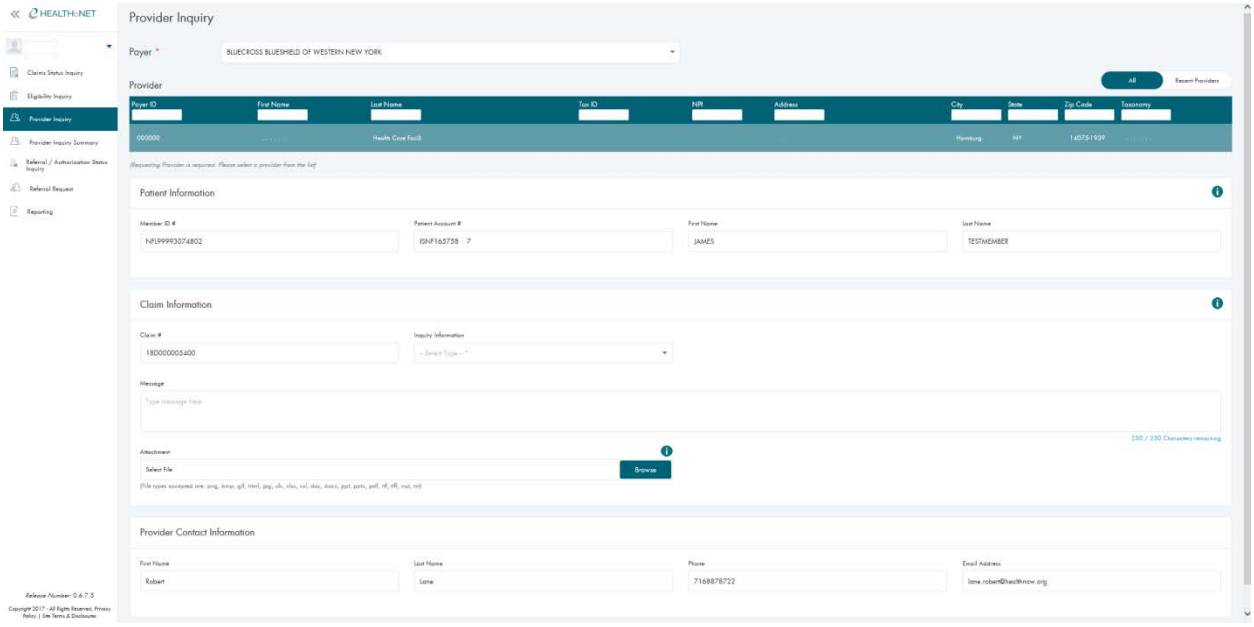
By clicking the **Provider Inquiry** link on this screen, an inquiry is automatically created for that claim and the fields are pre-filled with all of the available information. You may then complete the Inquiry Information Type and Message field, attach a document if needed, and submit!

This is a great time-saving option.

PLEASE NOTE:
This method is preferred when submitting an inquiry regarding a claim.
All Claim Information will be pre-populated on the Inquiry screen, reducing errors and saving you valuable time.



Clicking that link brings up the Inquiry Page



Choosing an Inquiry Type Tipsheet

Billed Amount – Used when requesting an adjustment to correct an amount billed on a claim.

Change Units – Used when requesting an adjustment to the number of units billed for a specific procedure.

Date of Service – Used when requesting an adjustment to correct the date of service billed on a claim.

Diagnosis Code Change – Used when requesting an adjustment to correct a diagnosis code billed on a claim.

Place of Service – Used when requesting an adjustment to correct the place of service on a claim.

Procedure Code – Used when requesting an adjustment to correct the procedure code billed on a claim.

Provider ID – Used when requesting an adjustment to correct the provider ID used on a claim.

SHD – Definite Dupe – Used when requesting an adjustment regarding a claim that was denied as a Duplicate Claim incorrectly.

System Updates – Used when requesting an adjustment after updates have been made to a member's file (PCP change, Referrals, Authorizations, etc.)

Valid Online Relationship – Used when requesting an adjustment on a claim for a covering provider that denied or processed out-of-network in error.

Withdraw Payment – Used when requesting an adjustment to withdraw a claim that was billed/processed in error.

Other Party Liability (OPL) – Used when requesting an adjustment for OPL claims. Must be selected if this is the type of claim the inquiry is for.

Adjustment – Used when requesting an adjustment that does not fall within one of the Types listed.

HEDIS or Quality – Used when submitting HEDIS or Quality information requested from a Payer.

Risk Revenue – Used when submitting information regarding Risk Revenue. This would be based on a request from a Payer to provide additional information.

Special Investigations Unit – Used when submitting information requested from a Payer's Special Investigations Unit.

Adjustment Requests that
Do Not Require Attachments:

· Billed Amount
· Date of Service
· Diagnosis Code
· Place of Service
· Procedure Code
· Provider ID Number
· Co-pay/Co-Insurance/Deductible Inquiry
· Paid incorrect Fee Schedule / Rate Inquiry
· Withdraw Payment