Provider Inquiry Tip Sheet

Purpose of the Provider Inquiry and Provider Inquiry transaction

Provider Inquiry completely replaces a paper-based Provider Claim Inquiry Form that allows a user to submit claim adjustments and other inquiries on-line.

Note: This transaction is currently only accepted by Highmark BlueCross BlueShield of Western New York and Highmark BlueShield of Northeastern New York

**For more detailed information on this transaction, please link to the user guide here:*
http://wnyhealthenet.com/wp-content/uploads/2018/10/PROVIDER-INQUIRY-USER-GUIDE.pdf

Completing the Provider Inquiry Form:

Indicate Payer (Required)

Select payer from the drop-down list.

Provider Information

Required:

- Select Provider from provider from list

Patient Information

Required:

- Member ID Number
  - Prefix and Suffix must be present for BlueCard requests

Optional:

- Patient Account #
- First Name
- Last Name

Claim Information

Required:

- Claim #
  - Only ONE(1) claim can be submitted per inquiry
  - BlueCard inquiries must have a valid HealthNow claim number
- Inquiry Information
  - Please select appropriate 'Type' from dropdown
- Message
  - Do NOT include special characters (#!%^&*)

Optional:

- Attachment
  - Acceptable files types: png, bmp, gif, html, jpg, xls, xlsx, xsl, doc, docx, ppt, pptx, pdf, rtf, tiff, vsd, txt

- Most often, an attachment is not required. A listing of Inquiry Types below indicate whether or not an attachment is required (see Appendix A)

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

Once the submit button is hit and the inquiry has been successfully been received by the Payer, you will receive a pop-up message indicating the Inquiry #

Provider Inquiry Summary Form

Previously submitted inquiries can be viewed on the Provider Inquiry Summary page. You can search for inquiries by selecting search options and filters.

Indicate Payer (Required)
Select payer from the drop-down list.

Provider Information

Required:

- Select Provider from list

Inquiry Date Range

Required:

- From Date (defaulted to 30 days from current date)
  - Inquiry request must be within past 6 months
- To Date (defaulted to today's date)

Filter Options

Optional:

- Member ID#
- Patient Last Name
- Inquiry Type (select from dropdown)
- Inquiry Status (select from dropdown)
- Inquiry ID#
- Claim #

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

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

The information displayed will include all the information from the original inquiry submission, and if the inquiry is 'Closed', the determination message from the payer.

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.

Appendix A

Inquiry Type	Description	Attachment Required?
Claim Status	Used to inquire on the status of a claim when it is showing in a pended state or if there is a question regarding how the claim was processed. Co-pay/Co-Insurance/Deductible Inquiry. Paid incorrect Fee Schedule / Rate Inquiry	NO
Billed Amount	Used when requesting an adjustment to correct an amount billed on a claim.	NO
Change Units	Used when requesting an adjustment to the number of units billed for a specific procedure.	**YES**
Date of Service	Used when requesting an adjustment to correct the date of service billed on a claim.	NO
Diagnosis Code Change	Used when requesting an adjustment to correct a diagnosis code billed on a claim.	NO
Place of Service	Used when requesting an adjustment to correct the place of service on a claim.	NO
Procedure Code	Used when requesting an adjustment to correct the procedure code billed on a claim.	NO
Provider ID	Used when requesting an adjustment to correct the provider ID used on a claim.	NO
System Updates	Used when requesting an adjustment after updates have been made to a member's file (PCP change, Referrals, Authorizations, etc.)	**YES**
Valid Online Relationship	Used when requesting an adjustment on a claim for a covering provider that denied or processed out-of-network in error.	**YES**
Withdraw Payment	Used when requesting an adjustment to withdraw a claim that was billed/processed in error.	NO