

The Availity Claim Status Tool is the recommended electronic method for providers to acquire detailed claim status for claims processed by Blue Cross and Blue Shield of New Mexico (BCBSNM) for the following members:

- BCBSNM Commercial – including Federal Employee Programs® (FEP®) and On and Off Exchange
- Government Programs – including New Mexico Medicaid and Blue Cross Medicare Advantage

Providers can improve their accounts receivable and increase administrative efficiencies by utilizing the Claim Status tool to check status online for all your BCBSNM patients. Results are available in real-time and provide more detailed information than the HIPAA-standard claim status (276/277 transaction).

Quick Reference:

- Refer to page [4](#), [5](#), and [6](#) to view claim status results for **commercial claims**
- Refer to page [7](#) to view claim status results for **government programs claims**
- Refer to page [8](#) and [9](#) to view basic **HIPAA-standard claim status results** (276/277 transaction)

Note: If you do not have Availity access, you may obtain basic claim status online by completing a 276/277 transaction through your preferred web vendor.

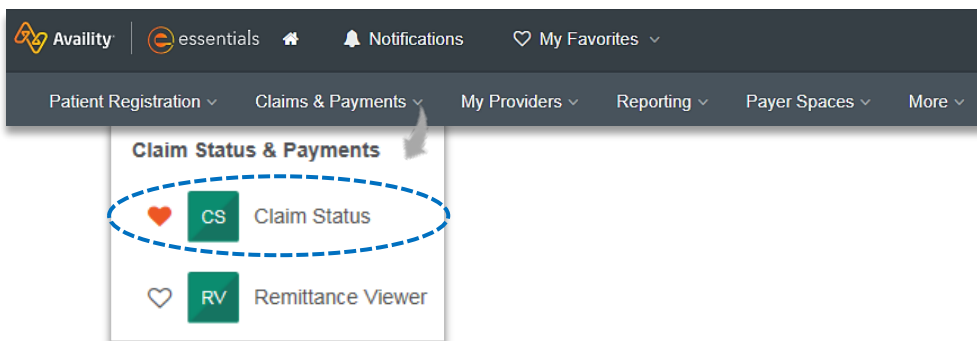
1) Getting Started

- ▶ Go to [Availity](#)
- ▶ Select [Availity Essentials Login](#)
- ▶ Enter User ID and Password
- ▶ Select [Login](#)

Note: Only registered Availity users can access the Claim Status Tool. If you are not a registered Availity user, you may complete the guided online registration process at [Availity](#), at no cost.

2) Accessing Claim Status

- ▶ Select [Claims & Payments](#) from the navigation menu
- ▶ Select [Claim Status](#)



Note: Contact your Availity administrators if the [Claim Status](#) tool is not listed in the [Claims & Payments](#) menu.

3) Submitting Transactions

Claim status may be obtained using a **Member ID** or **Claim Number**. Both options are illustrated in this step.

- ▶ Choose the **Organization**
- ▶ Select the appropriate **Payer** from the drop-down list

The screenshot shows the 'Claim Status' interface with two dropdown menus. The 'Organization' dropdown is set to 'YOUR ORGANIZATION'. The 'Payer' dropdown is set to 'Select...'. A blue dashed arrow points from a callout box to the Payer dropdown.

Payer Selection Options:

- BCBSNM
- Blue Cross Medicare Advantage
- Blue Cross Community Centennial
- Other Blues Plans

Search by Member:

- ▶ Select the **Search by Member** tab
- ▶ Choose the Billing Provider from the **Select a Provider** drop-down list or enter the **Provider NPI** (Type 2) – Professional providers should choose or enter the Rendering NPI (Type 1)
- ▶ Enter the **Member ID** including the preceding three-character prefix for commercial and New Mexico Medicaid patients
- ▶ Enter **Service Dates** in MM/DD/YYYY format
- ▶ Select **Submit**

The screenshot shows the 'Claim Status' interface with the 'Search by Member' tab selected and circled in blue. The 'Payer' dropdown is set to 'BCBSNM'. The 'Provider NPI' field contains '1234567890' and the 'Member ID' field contains 'ABC123456789'. The 'Service Dates' field shows '09/01/2020' to '10/01/2020'. A blue dashed circle highlights the 'Submit' button. A callout box titled 'Quick Tip:' contains the text: '→ The NPI must match the NPI submitted on the claim.'

Quick Tips:

- Federal plans do not have a three-character prefix. The letter "R" should be typed as part of the Patient ID (i.e., R87654321). Enter the Group Number as OFEPNM.
- Out-of-state plans may contain more than three-characters (e.g., WMWAN1234567). Enter the Group Number as 123456.
- Claim status for Medicare Advantage members is available for **Service Dates** from 1/1/2016 to current.

3) Submitting Transactions *(continued)*

Search by Claim:

- ▶ Select the **Search By Claim** tab
- ▶ Choose the Billing Provider from the **Select a Provider** drop-down list or enter the **Provider NPI** (Type 2) – Professional providers should choose or enter the Rendering NPI (Type 1)
- ▶ Enter the **Claim Number** and select **Submit**

Quick Tips:

- For commercial claims enter the 13- or 17-character alpha-numeric claim number (i.e., 999999999999X or 0202099999999999X).
- If you are looking for an adjustment, key the corresponding 2-digit suffix in addition to the 13- or 17-character alpha-numeric claim number (i.e., 999999999999X01 or 0202099999999999X01).
- For incremented claims (coordination of benefits), change the 0 to a 1 before the X or C at the end of the claim number to locate the secondary claim (i.e., 999999999991X).

4) Search Results

- ▶ After completing the **Member ID** search, users can view detailed claim status for a specific date of service by selecting the corresponding **claim**

Status	From Service Date	Finalized Date	Claim #	Patient Name	Billed Amount
FINALIZED	09/11/2020	09/13/2020	099999999999X00	DOE, JANE	\$290.00
IN_PROCESS	10/01/2020	N/A	0999999999991X00	DOE, JANE	\$875.00

5) Detailed Search Results *Commercial Claims*

The following information is returned for BCBSNM commercial claims after the corresponding claim number is selected and/or the **Claim Number** search is completed:

- Claim Number
- Received Date
- Finalized Date
- Service Dates
- Approved Length of Stay
- Claim Status
- Custom Status Description
- Status Details
- Billed Amount
- Paid Amount
- Coinsurance Amount
- Copay / Deductible Amounts
- Ineligible Amount
- Check Number & Date
- Payee Information
- Prior Paid Amount
- Prior Notification Deductible & Coinsurance
- Health Care Account Amount
- Billing / Rendering Provider Information
- Other Carrier Paid / Medicare Paid Amount
- Patient Share Amount
- Out of Network Deductible / Coinsurance
- Additional Paid
- Line-Item Breakdown:
 - Service Dates
 - Procedure / Revenue Code
 - Diagnosis
 - HCPCS Code
 - Billed Amount
 - Paid Amount
 - Ineligible Amount & Code
 - Discount
 - Copay / Coinsurance / Deductible
 - Modifiers
 - Unit / Time / Miles

Note: If the check number is not present on a finalized claim, please allow additional time. The system reflects check information based on the payment schedule of the provider.

Quick Tip:

→ Select **Print this Page** at top or bottom of result page to print and/or save status.

Claim Status

Print this Page New Search Edit Search

Customer ID 12345 Exchange Date 11/01/2021
Transaction ID XXXX-XXXX-1234567890

Patient Information

Patient	DOE, JANE	Member ID	ABC00000123456789	Subscriber	DOE, JANE
DOB	01/01/2010	Patient Account Number	1334	Relationship	SELF
Gender	F	Group Number	123456		

Claim Information

Claim Number	0123456A7890X00	Claim Status	PAID	DRG Code	N/A
Received Date	09/12/2020	Custom Status Description		DRG Version	N/A
Processed Date	09/13/2020	Status Detail	N/A	DRG Weight	0.00000
Service Dates	09/11/2020 – 09/11/2020	Billed Amount	\$290.00		
Approved Length of Stay	N/A	Paid Amount	\$68.26		
Hospital Payment Indicator	N/A	Coinsurance Amount	\$0.00		
Indicator Description	N/A	Copay/Deductible Amount	\$20.00		
		Ineligible Amount	\$201.74		

Payment Information

Check Number	E9999999	Billing Provider	ABC CLINIC	Other Carrier Paid	\$0.00
Check Date	09/15/2020	Billing Provider NPI	1234567899	Out of Network Deductible	\$0.00
Payee	ABC CLINIC	Rendering Provider	ROBERTS, JOHN	Out of Network Coinsurance	\$0.00
Prior Paid Amount	\$0.00	Rendering Provider NPI	1122334455	Additional Paid	\$0.00
Prior Notification Deductible	\$0.00	Medicare Paid Amount	\$0.00		
Prior Notification Coinsurance	\$0.00	Patient Share Amount	\$20.00		
Health Care Account Amount	\$0.00				

Line Level Information

Service Dates	Proc/Rev	DX	HCPC	Billed	Paid	Ineligible	Codes	Discount	Copay	Coins	Deductible	Mode	Unit/ Time/ Miles
09/11/2020 09/11/2020	99203	M25542, M25541	N/A	\$290.00	\$68.26	\$201.74	T43	\$0.00	\$20.00	\$0.00	\$0.00	N/A	1

Codes

Type	Code	Description	Additional Action(s)
Ineligible Reason	T43	Charge exceeds the priced amount for this service. Services provided by a Non-Participating Provider. Patient is responsible for charges over the priced amount.	N/A

Quick Tips:

- Ineligible reason codes display in the **Codes** field.
- View ineligible reason code descriptions in the **Codes** section.

5) Detailed Search Results *Commercial Claims (continued)*

Cotiviti, Inc. Code Audit Rationale is available for finalized claims processed on or after Aug. 26, 2019:

- ▶ Select **View Code Audit Rationale** above the service line section or click on the **+** beside the applicable line(s)
- ▶ Once selected, service line(s) denied for Cotiviti logic will expand and display the following:
 - **Edit Description**
 - **Edit Rationale**

Quick Tip:
→ Select **Hide Code Audit Rationale** or select minus sign (-) to collapse the expanded denial logic.

Line Level Information [Hide Code Audit Rationale](#)

Service Dates	Proc/Rev	DX	HCPC	Billed	Paid	Ineligible	Codes	Discount	Copay	Coins	Deductible	Mods	Unit/ Time/ Miles
05/01/2019 05/01/2019	29515	Z4789	N/A	\$100.00	\$0.00	\$100.00	V29	\$0.00	\$0.00	\$0.00	\$0.00	N/A	1

Parameter Type	Created Line Indicator	Action	Edit Source
Action Required	Submitted on Claim	Not Reimbursable	Payer
Edit Location	Procedure Code	Modifier Code	Unit Count
Payer Policy	29515	N/A	1
Cotiviti Edit Description			
29515 WAS SUBMITTED WITH UNITS EXCEEDING THE MUE THRESHOLD.			
Cotiviti Edit Rationale			
Per plan policy, units in excess of the MUE value may not be billed .			

Additional Action(s) for Applicable Ineligible Reason Codes:

- ▶ View **Additional Action(s)** to understand what further step(s) may be taken for certain claim denial scenarios

Note: *Additional Action(s)* only display for certain ineligible reason codes.

Line Level Information [View Code Audit Rationale](#)

Service Dates	Proc/Rev	DX	HCPC	Billed	Paid	Ineligible	Codes	Discount	Copay	Coins	Deductible	Mods	Unit/ Time/ Miles
+ 05/01/2019 05/01/2019	29515	Z4789	N/A	\$100.00	\$0.00	\$100.00	V29	\$0.00	\$0.00	\$0.00	\$0.00	N/A	1
05/01/2019 05/01/2019	A4590	Z4789	N/A	\$65.00	\$0.00	\$5.00	T42	\$0.00	\$0.00	\$0.00	\$60.00	N/A	1

Type	Code	Description	Additional Action(s)
Ineligible Reason	V29	This service was submitted with units exceeding the MUE threshold. The information submitted on the claim is inconsistent with current coding protocol. Patient cannot be billed for the disallowed code.	Access the View Code Audit Rationale link above for additional context.
Ineligible Reason	T42	Charge exceeds the priced amount for this service. Services provided by a participating/network provider. Amount is provider write-off.	Refer to the Fee Schedule for pricing allowance.

Customer ID 11111 Exchange Data 10/06/2020
Transaction ID 00123abc0-abc1-1234-0000-1234567abcd

Print this Page [New Search](#) [Edit Search](#)

5) Detailed Search Results *Commercial Claims (continued)*

There may be instances when providers receive a claim withdrawn notification after submission to BCBSNM. Providers can also determine why a claim was withdrawn via the Availity Claim Status tool response.

- ▶ Refer to the **Custom Status Description** field to view the reason why the claim was withdrawn
- ▶ After addressing the reason, resubmit the claim electronically to the local BCBSNM plan for processing

CS

Claim Status

Customer ID 12345 **Exchange Date** 11/01/2021
Transaction ID XXXX-XXXX-1234567890

**BlueCross BlueShield
of New Mexico**

Patient Information

Patient	DOE, JANE	Member ID	ABC123456789
DOB	01/01/1935	Patient Account Number	DOE123456789
Gender	F	Group Number	123456

Claim Information

Claim Number	123456789010X00	Claim Status	DENIED
Received Date	10/01/2021	Custom Status Description	Disapproved - For membership
Finalized Date	10/06/2021	Status Detail	
Service Dates	12/19/2020 - 12/19/2020	Billed Amount	\$2,533.30
Approved Length of Stay		Paid Amount	\$0.00
Hospital Payment Indicator		Coinsurance Amount	\$0.00
		Copay/Deductible Amount	\$0.00
		Ineligible Amount	\$0.00

6) Detailed Search Results *Government Program Claims*

The following information is returned for government programs claims after the corresponding claim is selected and/or the **Claim Number** search is completed:

- Claim Number
- Received Date
- Finalized Date
- Service Dates
- Claim Status
- Allowed Amount
- Billed Amount
- Paid Amount
- Coinsurance Amount
- Copay & Deductible Amounts
- Ineligible Amount
- Sequestration Amount
- Medicare Paid Amount
- Check Status & Check Number
- Check Amount & Check Date
- Payee Information
- Billing Provider Information
- Rendering Provider Information
- Line-Item Breakdown:
 - Service Dates
 - Revenue / Procedure Code
 - Modifier
 - Quantity
 - Diagnosis
 - Ineligible Code & Amount
 - Allowed Amount
 - Paid Amount
 - Sequestration Amount
 - Copay / Coinsurance / Deductible

Note: If the check number is not present on a finalized claim, please allow additional time. The system reflects check information based on the payment schedule of the provider.

Quick Tip:
→ Select **Print this Page** at top or bottom of result page to print and/or save status.

CS Claim Status

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New Search
Edit Search

Customer ID 12345 Exchange Date 11/01/2021
Transaction ID XXXX-XXXX-1234567890

Blue Cross Medicare Advantage™

Patient Information

Patient	Doe, Jane	Member ID	123456789	Subscriber	Doe, Jane
DOB	12/20/1943	Patient Account Number	JD99999	Relationship	SELF
Gender	F	Group Number	0000000		

Claim Information

Claim Number	99999999999	Claim Status	FINALIZED	Coinsurance Amount	\$0.00
Received Date	02/06/2020	Allowed Amount	\$0.00	Copay Amount	\$0.00
Finalized Date	02/17/2020	Billed Amount	\$222.00	Deductible Amount	\$0.00
Service Dates	01/26/2020 - 01/26/2020	Paid Amount	\$0.00	Ineligible Amount	\$222.00
Bill Type Code	N/A	DRG Code	N/A	Sequestration Amount	\$0.00
Approved Length of Stay	N/A	Medicare Paid Amount	\$0.00		

Payment Information

Check Status	CREATED	Payee	ABC CLINIC	Billing Provider	ABC CLINIC
Check Number	999999	Payee Tax ID	123456789	Billing Provider NPI	199999999
Check Amount	\$5,769.06	Payee Address	123 ANYWHERE ST. CITY, XX 12345-1234	Billing Provider Tax ID	123456789
Check Date	02/17/2020	Rendering Provider	ABC CLINIC	Rendering Provider NPI	100000000
		Rendering Provider Tax ID	MEDICAL GROUP	Rendering Provider Tax ID	123456789

Line Level Information

Service Dates	Proc	Rev	Mods	Qty	DX	Codes	Billed	Allowed	Paid	Seq Amt	Coins	Deductible	Ineligible
01/26/2020	99239	N/A	N/A	0	R6510	70h	\$222.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$222.00

Codes

Type	Code	Description	Additional Action(s)
Remark	70h	Missing/invalid ICD-10 diagnosis code(s). Please resubmit corrected claim.	Diagnosis code is missing or invalid. Please resubmit with the appropriate diagnosis code.

Customer ID 12345 Exchange Date 11/01/2021
Transaction ID XXXX-XXXX-1234567890

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New Search
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Quick Tips:

- Ineligible reason codes display in the **Codes** field.
- View ineligible reason code descriptions in the **Codes** section.
- View **Additional Action(s)** to understand what further step(s) may be taken for certain claim denial scenarios. **Additional Action(s)** only displays for certain ineligible reason codes.

7) HIPAA Standard Claim Status 276 request

Use the **HIPAA Standard** tab to acquire basic claim status (276/277 transaction).

- ▶ Enter the **Provider** and **Patient Information** in the 276 request
- ▶ Select **Submit**

The screenshot shows a web form for submitting a HIPAA Standard claim status request. At the top, there are three tabs: 'Search by Member', 'Search by Claim', and 'HIPAA Standard' (which is selected and circled in blue). Below the tabs are three main sections:

- Provider Information:** Includes a question 'Is the provider the same as the organization name?' with radio buttons for 'Yes' (selected) and 'No'. Below this is a dropdown menu for 'Select a Provider' (optional) and a text field for 'Provider NPI'.
- Patient Information:** Includes a dropdown menu for 'Select a Patient' (optional), a text field for 'Member ID', a text field for 'Patient Last Name', a text field for 'Patient First Name' (optional), a text field for 'Patient Date of Birth' with a 'MM/DD/YYYY' placeholder, a dropdown menu for 'Patient Gender' (optional), a text field for 'Patient Account Number' (optional), and a dropdown menu for 'Patient's Relationship to Subscriber' (optional) with 'Self' selected.
- Claim Information:** Includes a date range selector for 'Service Dates' with 'From Date' and 'To Date' fields, a text field for 'Claim Number' (optional), a text field for 'Claim Amount' (optional), and a text field for 'Institutional Bill Type' (optional).

A blue 'Submit' button is located in the bottom right corner of the form, also circled in blue.

Quick Tips:

- Fields labeled as **optional** may be completed but are not required to receive a 277 response.
- If you do not know the patient account number, you may enter "unknown" in the optional **Patient Account Number** field, and the account number will be returned in the 277 response.

7) HIPAA Standard Claim Status 277 response (continued)

The following information is returned in the **HIPAA Standard 277** response, if applicable:

- Claim Number
- Service Dates
- Processed Date
- Claim Status
- Billed Amount
- Paid Amount
- Check Number
- Denial Reason

CS Claim Status

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Transaction ID:111111111111 As of October 7, 2020 1:18 PM

DOE, JANE Patient

Patient ID ABC123456789 DOB 01/01/2010	Subscriber DOE, JANE	Provider ABC CLINIC Provider ID 1234567890
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000000000000X 00
FINALIZED
09/01/2020 – 09/01/2020
Billed
\$290.00

Verify Eligibility
Remittance Viewer
Print this Page

Claim 000000000000X00

Dates of Service 09/01/2020 – 09/01/2020	Processed Date N/A	Status FINALIZED
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Billed
\$290.00

Paid
N/A

000000000011X 00
DENIED
09/10/2020 – 09/10/2020
Processed
09/13/2020
Paid
\$0.00

Status as of 09/05/2020

- Finalized/Adjudication Complete No payment forthcoming. The Claim/Encounter has been adjudicated and no further payment is forthcoming
- Balance due from the subscriber

Check Number
N/A

Dates of Service 09/01/2020 – 09/01/2020	Procedure Code 99203	Quantity 1	Status FINALIZED
Billed \$290.00	Paid \$0.00		

Status as of 09/05/2020

- Finalized/Adjudication Complete No payment forthcoming. The Claim/Encounter has been adjudicated and no further payment is forthcoming
- Balance due from the subscriber

Quick Tip:

→ If the information returned does not provide enough detail, complete the transaction using either the [Search by Member](#) or [Search by Claim](#) tab with the PLUS (+) sign.

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.