Eligibility and Benefits User Guide

June 2023

An Eligibility and Benefits Inquiry should be completed for each Blue Cross and Blue Shield of Illinois (BCBSIL) patient prior to every scheduled appointment. The Availity® Essentials Eligibility and Benefits Inquiry includes important information regarding the patient's benefits, such as membership verification, coverage status, applicable co-payment, co-insurance, deductible amounts, etc. Additionally, the benefit quote may include information on applicable benefit prior authorization requirements.

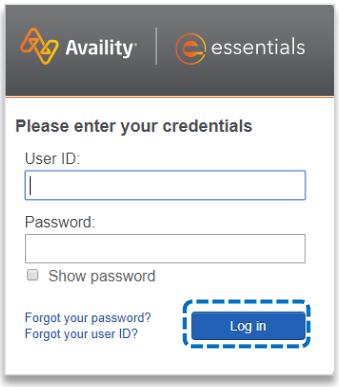
Not yet registered with Availity Essentials? Visit Availity and complete the online registration today, at no cost.

Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

1) Getting Started

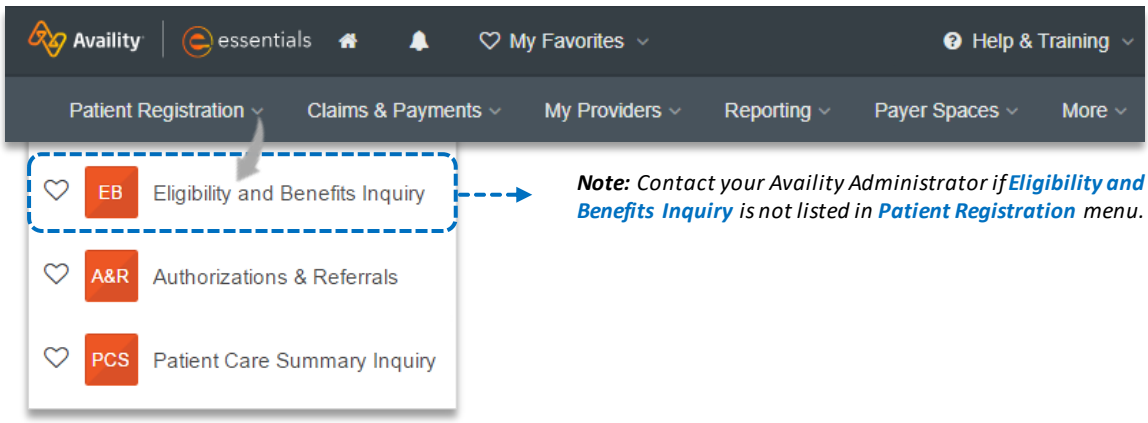
- Go to Availity
- Select **Availity Essentials Login**
- Enter **User ID** and **Password**
- Select **Log in**

Note: *Only registered Availity users can access **Eligibility and Benefits Inquiry**.*



2) Eligibility and Benefits Inquiry

- Select **Patient Registration** from the navigation menu
- Select **Eligibility and Benefits Inquiry**



Note: *Contact your Availity Administrator if **Eligibility and Benefits Inquiry** is not listed in **Patient Registration** menu.*

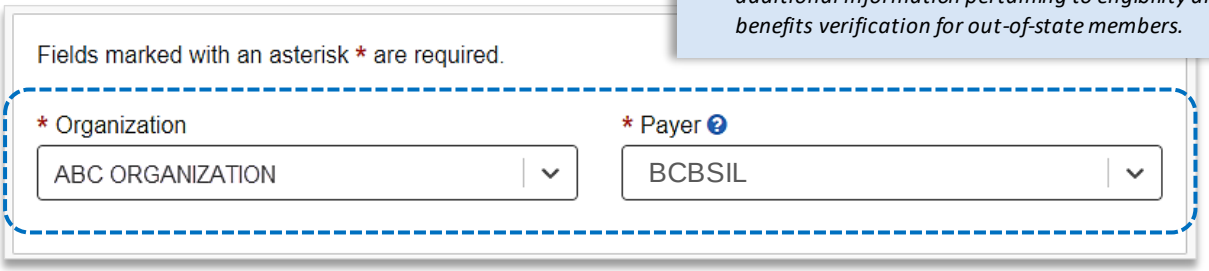
Important Note: *To ensure your provider information is available in the **Select a Provider** drop-down list, add your Billing and/or Rendering NPIs and Tax ID numbers to **Manage My Organization** under **My Account Dashboard** on the Availity Essentials homepage. For detailed instructions, refer to the **Manage My Organization User Guide**.*

3) Organization & Payer Selection

- Select your **Organization** and choose **BCBSIL** as the Payer from the drop-down list for local policies
- Other Payer Selections:
  - **Blue Cross Community Health Plans** *(Illinois Medicaid)*
  - **Blue Cross Medicare Advantage**
  - **Other Blue Plans** *(out-of-state policies)*

Quick Tip:

→ *Contact the patient's home plan via 800-676-2583 for additional information pertaining to eligibility and benefits verification for out-of-state members.*



4) Provider Information

- Select the applicable **Provider** name from **Select a Provider** drop-down list to auto populate the remaining field

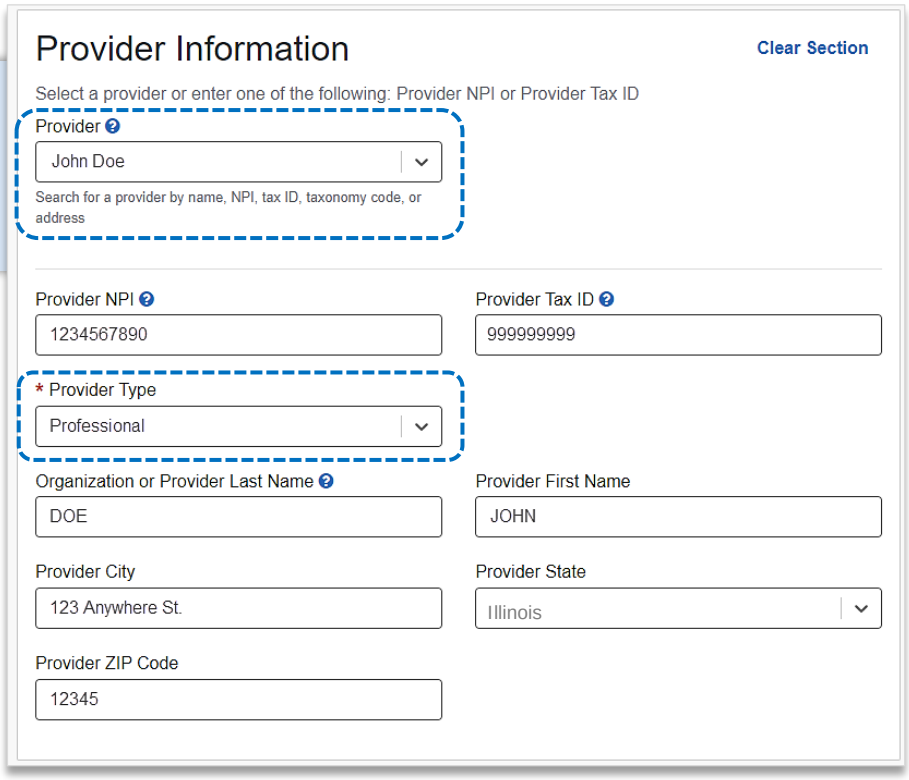
Note: *If the provider's name does not appear in the **Select a Provider** drop-down, enter the NPI and Tax ID numbers. Also, enter the street Address and Suite ONLY if multiple service locations are associated with the NPI number.*

Quick Tips:

→ *Professional providers should utilize the treating physician's Rendering NPI (Type 1).*

→ *Institutional providers should use the Billing NPI (Type 2).*

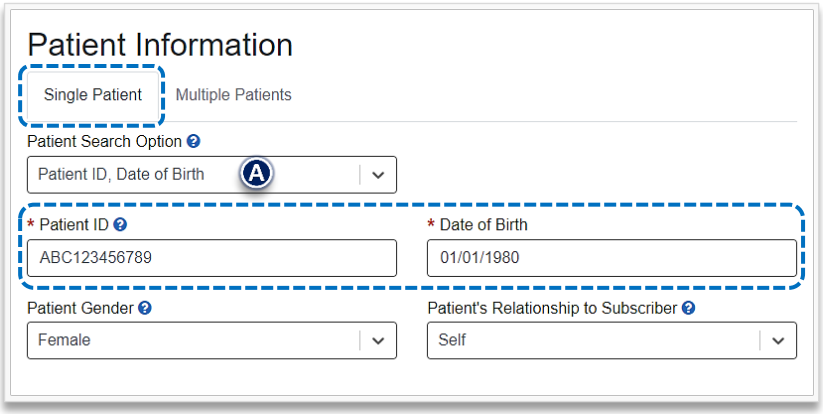
- Select a **Provider Type** from the drop-down:
  - **Professional**
  - **Institutional**



5) Single or Multiple Patient Inquiry

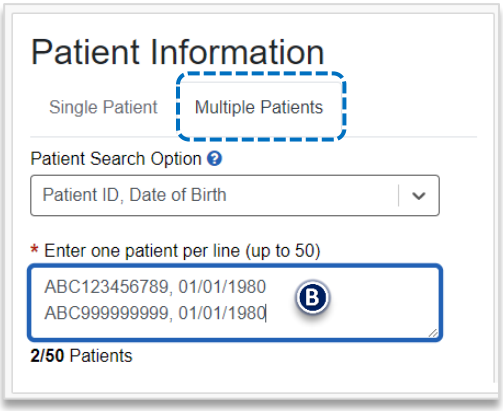
- Select the **Single Patient** tab and enter the following information:
  - **Patient ID** *(including three-character prefix)*
  - **Date of Birth**

Ⓐ Select the **Patient Search Option** drop-down to incorporate additional search criteria *(i.e., patient name, group number, etc.)*.



- Select the **Multiple Patients** tab and enter the following information for **2 to 50** patients in the same request:
  - **Patient ID** *(including three-character prefix)*
  - **Date of Birth**

Ⓑ Enter each patient's information on a separate line. Press enter to start a new line. Separate each piece of information with a comma.

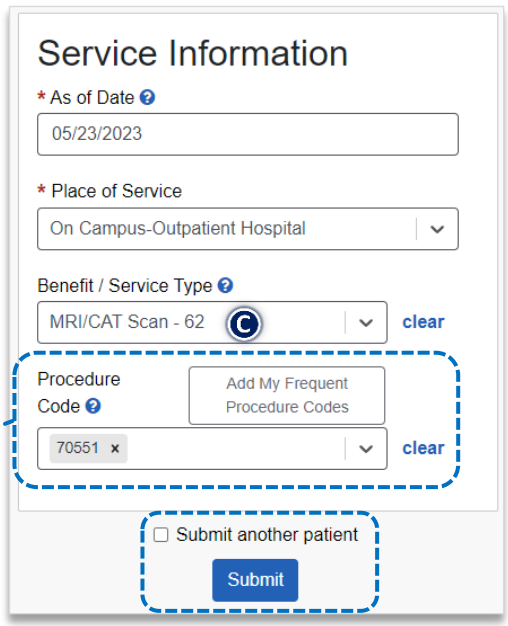


6) Service Information

- **As of Date** defaults to current date:
  - *The **As of Date** can be changed to submit inquiries for a <u>past</u> or <u>future</u> date of service.*
  - *<u>Past</u> date inquiries can be received up to 12 months prior to the current date.*
  - *<u>Future</u> date inquiries can be requested within the current month.*
- Select **Place of Service** from the drop-down list
- Choose the applicable **Benefit/Service Type**

Ⓒ A list of your most frequently used **Benefit/Service Types** will appear at the top of the drop down.

Enter up to *eight* **Procedure Codes** to confirm <u>prior authorization requirements **ONLY**</u>, as this is <u>**NOT** a code-specific quote of benefits</u> and select **Submit**



Important Notes:

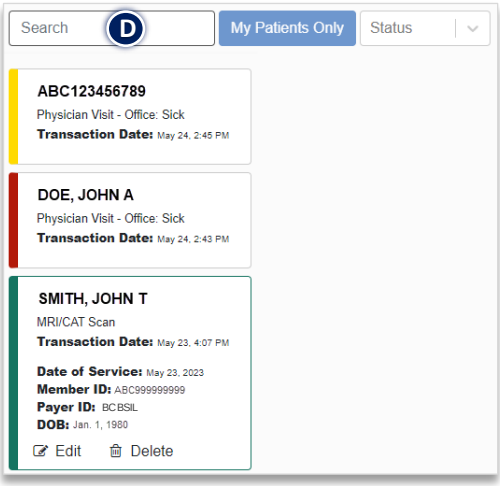
- *If a benefit/service Type is not selected, the place of service and at least one procedure must be submitted.*
- *If a procedure code is not entered, the place of service and benefit/service type are required.*
- *Procedure Code inquiry for prior authorization is <u>**NOT yet supported**</u> for BCBSIL Federal Employee Program® (FEP®), Medicare Advantage, or Illinois Medicaid members.*

7) Patient History List

- Once an eligibility and benefits request is completed, a new **Patient Card** will appear in the **Patient History List**, including all members entered in the request:
  - Transaction Error
  - Inactive Membership
  - Active Membership

Notes: *To see all patients within your organization, uncheck "My Patients Only". Users can **Edit** or **Delete** the patient's eligibility and benefits search from the Patient History List. The Patient History List holds up to 200 patients for 24 hours.*

D Locate the **Patient Card** by searching for Name, Date or Payer.

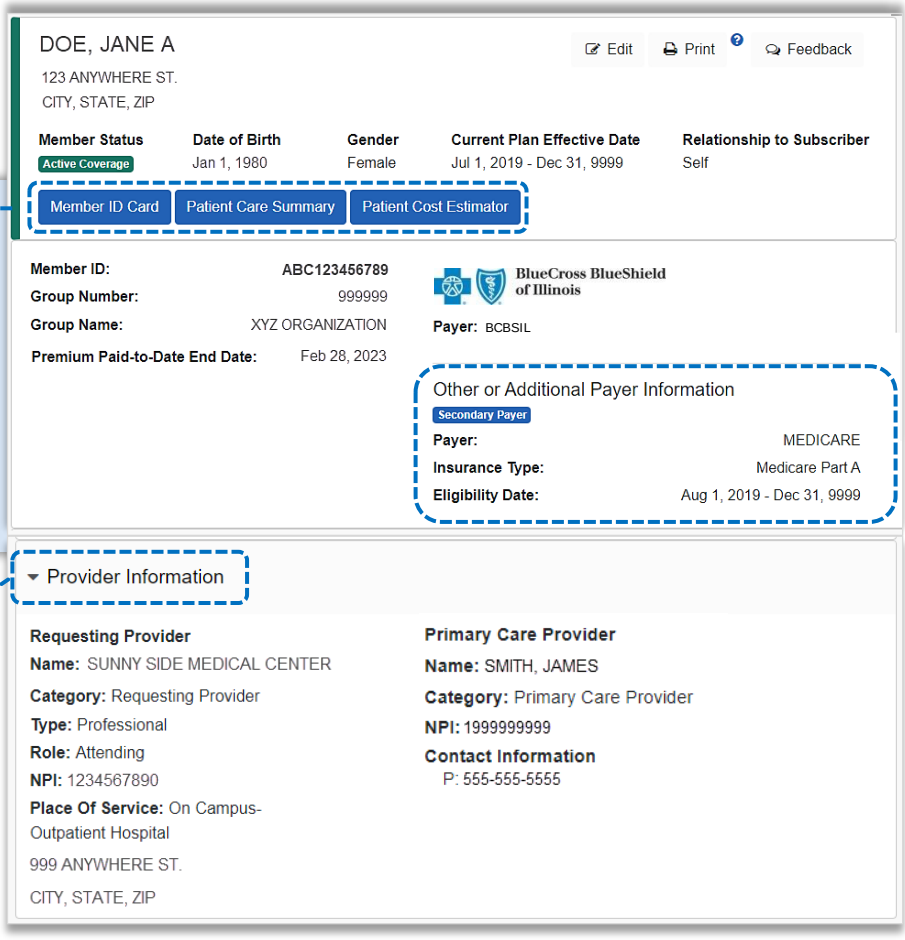


8) Eligibility Summary Results

- Real-time eligibility for the requested patient displays at the top portion of the page, including the following results:
  - Patient Information
  - Current Plan Effective Date
  - Subscriber Address
  - Group Number & Name *(employer)*
  - Premium Paid to End Date *(applies to Individual & Family Market plans only)*
  - Other or Additional Payer Information *(if applicable)*
  - Requesting Provider Information
  - Primary Care Provider *(if applicable)*

Quick Tips:

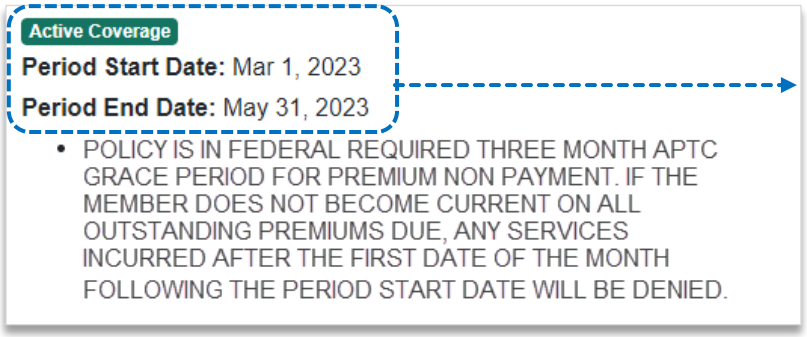
- → *Select **Member ID Card** if available to view and/or print the current patient's card. Refer to the next page for more information.*
- → *If applicable, access the **Patient Care Summary** to view the patient's health care history, based on claims data.*
- → *If applicable, use the **Patient Cost Estimator** to obtain real-time estimation of the requested services.*



Note: *Expand **Provider Information** to view the Requesting Provider and Primary Care Provider (if applicable) for the policy.*

9) Individual & Family Market Plans – Grace Period

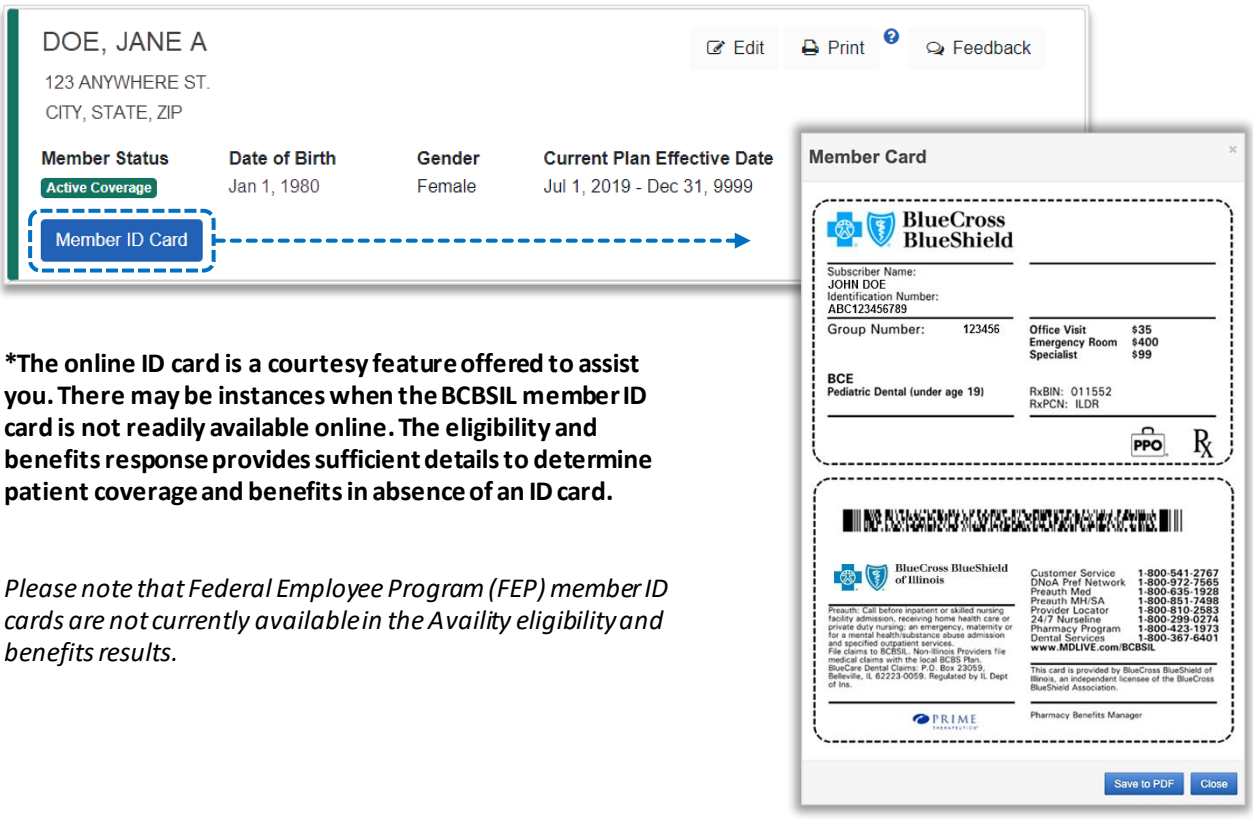
- Some individuals who purchase Individual & Family Market plans may receive an advance premium tax credit (APTC). These members qualify for a three-month grace period to pay their premium – provided they have already paid at least one month's premium in full.
- All allowable services provided during the first month of the grace period will be the responsibility of BCBSIL, subject to member cost sharing. BCBSIL will pend all claims incurred during the second and third months of the grace period. If the member pays all outstanding premium payment(s) in full, the claims will process according to the member's benefits.
- The **Plan Maximum and Deductibles** section will provide a grace period indicator for applicable members, including grace period start and end dates, as shown in the below example.



Note: *Not all members who purchase Individual & Family Market plans will receive the APTC.*

10) Member ID Card

- Select **Member ID Card** at the top of the Eligibility and Benefit results, if available*
- View, download and/or print the member's BCBSIL medical ID card

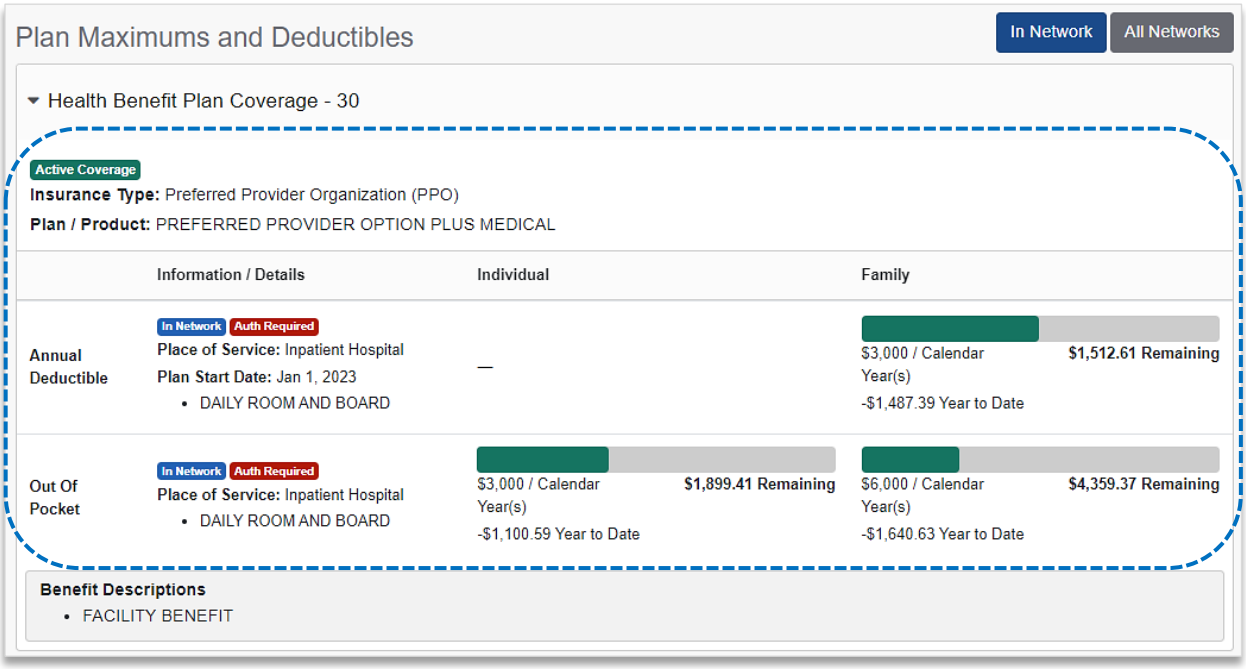


***The online ID card is a courtesy feature offered to assist you. There may be instances when the BCBSIL member ID card is not readily available online. The eligibility and benefits response provides sufficient details to determine patient coverage and benefits in absence of an ID card.**

Please note that Federal Employee Program (FEP) member ID cards are not currently available in the Availity eligibility and benefits results.

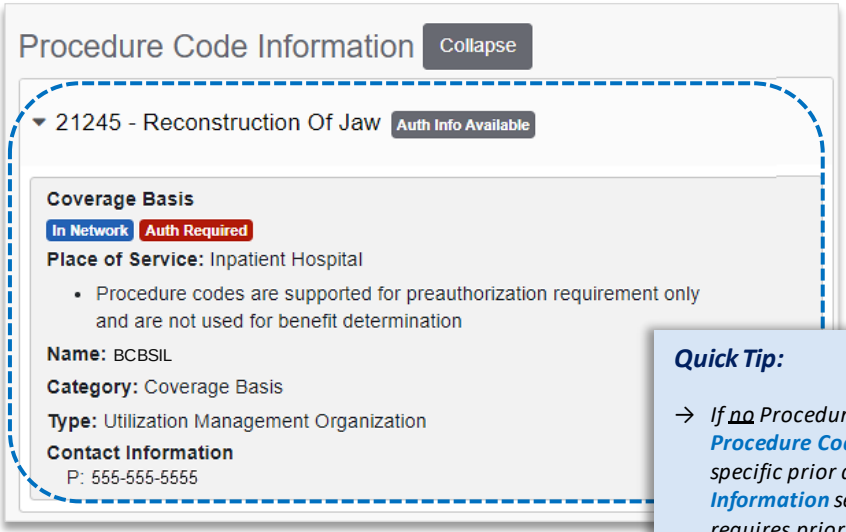
11) Plan Maximums & Deductibles

- **Plan Maximums and Deductibles** section includes the patient's policy coverage, as well as the applicable deductible and out of pocket benefit details for the selected Benefit/Service Type and will include the following results:
  - Policy Type
  - Coverage Level *(individual and/or family)*
  - Annual Deductible and/or Out-of-Pocket amounts *(patient responsibility including original and remaining balance)*
  - Time Period *(visit, calendar year, lifetime, etc.)*



12) Procedure Code Information *Prior Authorization Requirement*

- Expand **Procedure Code Information** to confirm prior authorization requirements for procedure code(s) entered in the request
- If **Auth Required**, the prior authorization vendor contact information is provided in the response



Quick Tip:

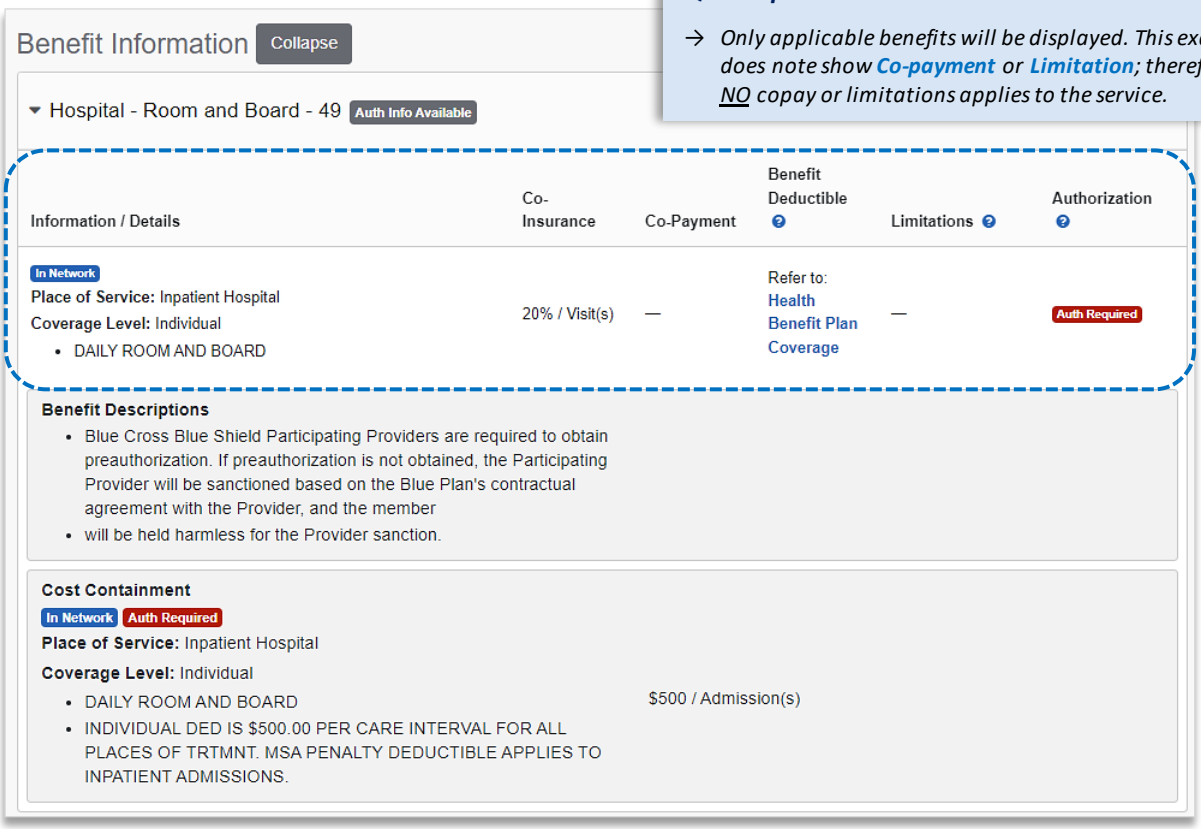
→ *If no Procedure Code(s) are entered in the request, the **Procedure Code Information** section will not display code-specific prior auth requirements. Refer to the **Benefit Information** section to determine if the service type requires prior authorization.*

13) Benefit Information

- Expand **Benefit Information** to view benefit details for the selected Benefit/Service Type, which includes the following results, if applicable:
  - Co-insurance
  - Co-Payment
  - Benefit Deductible *(select **Health Benefit Plan Coverage** to quickly toggle to the deductible and/or out-of-pocket details on the page)*
  - Limitations
  - Authorization requirements
  - Benefit Descriptions and/or other requirements for the selected Benefit/Service type

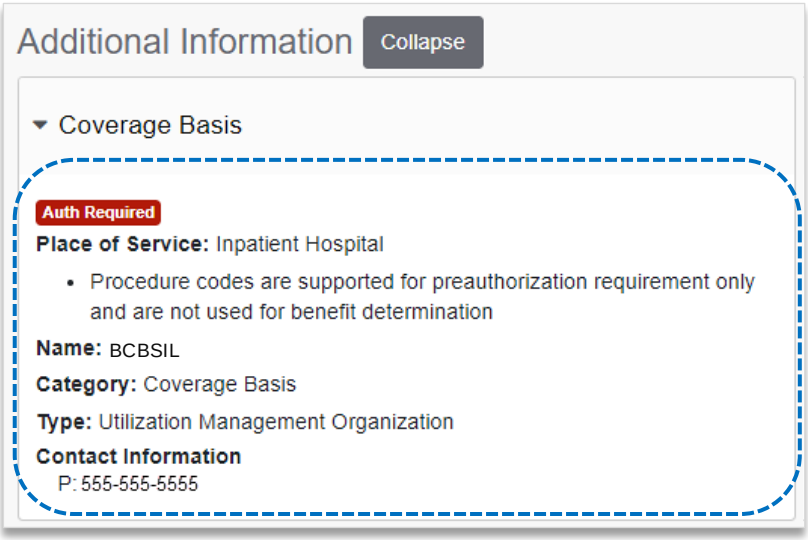
Quick Tip:

→ *Only applicable benefits will be displayed. This example does note show **Co-payment** or **Limitation**; therefore, NO copy or limitations applies to the service.*



14) Additional Information

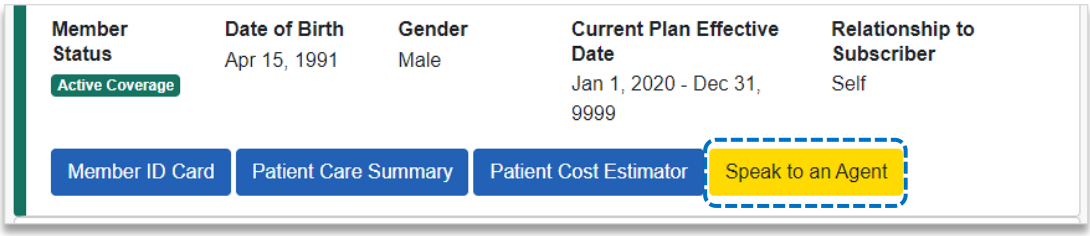
- Expand **Additional Information** to obtain any added information regarding the patient's coverage and benefits



15) Speak to an Agent Feature

- In some instances, benefit information may not be readily available online. The **Speak to an Agent** feature gives priority access to the next available customer advocate during standard business hours.

1. Select the **Speak to an Agent** button
2. Dial the 800 number provided in the pop-up box
3. Enter the 8-digit reference ID number via your touch tone keypad



Note: *This feature is only available for medical benefits that are managed by BCBSIL. The* ***Speak to an Agent*** *button will not be offered for benefit information managed by other entities (i.e., vendors, government programs and labor fund carve outs).*

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

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