Provider Connection Reference Guide

The Provider Connection website gives you easy access to the tools and information you need to serve Blue Shield and Blue Shield Promise members as well as to support your practice.

Use this reference guide to learn more.

blue california ®

blue california ®
Promise Health Plan

Blue Shield/Blue Shield Promise Provider Connection reference guide directory

If you are viewing this guide online, the linked page numbers take you to instructions for key activities you can do on Provider Connection. Use the *Directory* button at the bottom of each page to return to this table of contents.

Background: If your organization is new to Provider Connection, you must establish an account.

Establishing an account:

The person executing the initial Provider Connection registration is considered an Account Manager. When the maximum allowed number of Account Managers register, Provider Connection will display a message. Most organizations can have at least two Account Managers. There are three types of provider accounts. The links below take you to step-by-step instructions with screenshots for how to register for the account type most appropriate to your business.

1. Provider
2. MSO
3. Billing Service

Account Managers:

Once registered, the Account Manager(s) will see an *Account management* link in their top-level navigation after log in. It provides direct access to all activities falling within the role.

Once established, the Account Manager(s) – not Blue Shield – sets up user profiles. Blue Shield will email each user a temporary password. Users have 30 days to visit the site and change their password or the account will be deleted.

Users:

All users (and Account Managers) have a *Manage my profile* page where they can do things like update their username/ password, change their email, set their email preferences, and locate their Account Manager. After log in, a "badge" with the user's initials appears at the end of the white navigation bar. Click this badge to access the *Manage my profile* page.

Additional support:

- This Provider Connection Account FAQ provides answers to the most frequently asked questions about establishing and maintaining a Provider Connection account as an Account Manager or user.

- A password must be updated every 365 days. See Update your Provider Connection password if you need help changing your password or if your account is locked or disabled.

- The Provider Connection training page includes links to the above resources and more. No log in is required.

Background: Below is a high-level snapshot of how to navigate the Provider Connection website. Authenticated tools require log in, but there are many resources on Provider Connection that do not.

Instructions:

1. **Top level navigation:** General site actions like *Contact us* and *Help.*

2. **White navigation bar:** Links to the home page, five site sections, Search, and Log in/Register. When you click a section link, the blue line indicates the section drop-down menu you have activated.

   - Blue Shield uses two-step authentication. To verify your identity each time you login, enter your username/password plus the code Blue Shield sends to your email.

   - After logging in, you will see a "badge" with your initials at the end of the white navigation bar. Click to access your *Manage my profile* page.

3. **Section drop-down menu:** Links to the most-used content and tools within the specific section.

4. **Overviews:** Each section has an overview that provides a high-level table of contents for information on the page.

Tip: Blue Shield Promise resources that do not require log in are integrated throughout Provider Connection. They are also available from the Blue Shield Promise Provider Portal. Links in the footer of each website allow you to move between the two websites.

Background: Blue Shield has designed our provider directory accuracy processes to be compliant with both the 2021 Consolidated Appropriations Act (CAA) and California Senate Bill (SB) 137 requirements.
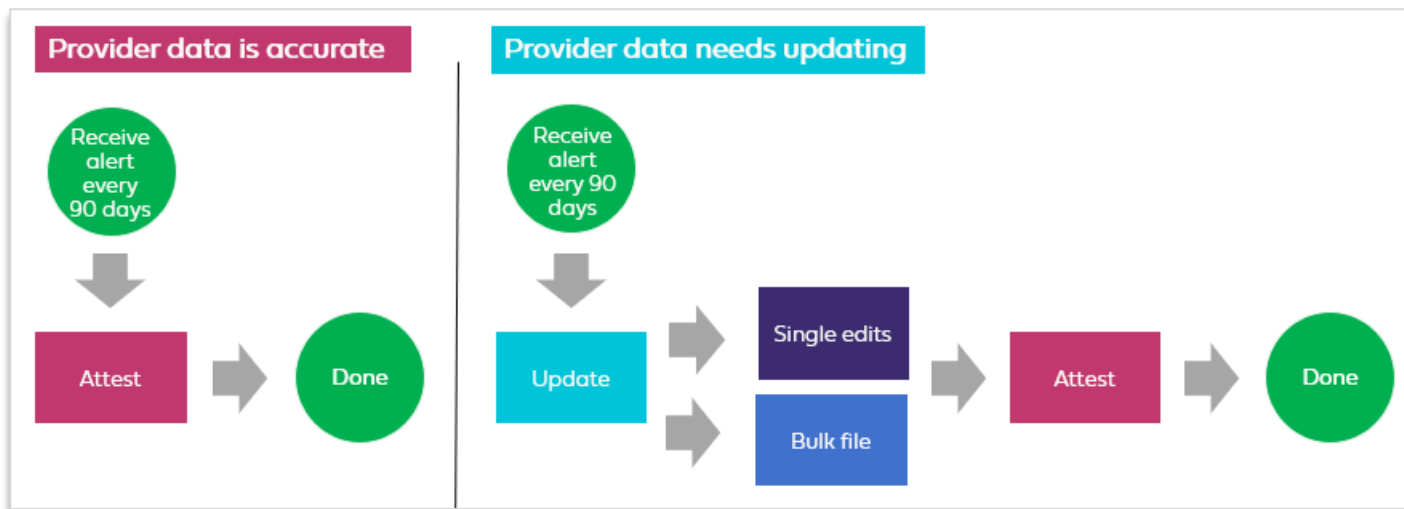
Process:
- Online attestation to data accuracy every 90 days, even if data has not changed. Blue Shield will alert a provider when it is time to attest.
- Directory updates at any time either by:
  - Single edits on the Provider Connection *Provider & Practioner Profiles* page.
  - Blue Shield's bulk data file – the *Provider Data Validation Spreadsheet* – downloaded from *Provider & Practioner Profiles,* then uploaded back to the page.

Visit [Provider data management](#) for a step-by-step overview of the entire attestation/update process. See the *Provider Data Validation Companion Guide* for detailed instructions on how to make demographic updates in this spreadsheet.

Who can execute this process:
- Provider Connection Provider and MSO Account Managers and users to which they give provider demographic information access. [See instructions on the next page for how to assign user access.](#)
  - Billing Managers have view-only access.

Background: Account Managers can assign provider demographic data access to designated users so that the most appropriate staff members validate/update/attest to provider directory information.

Instructions:

1. From the *Account management* page, click **Manage your user accounts** located under the *Manage user accounts* section.

2. Click the **View** link for a specific user.

3. That user's *Account information* will display.

4. Move the *Provider & practitioner data* toggle to the right.

5. When the user logs in after access is granted, they will see a link to *Provider & practitioner profiles* in their top navigation bar.

Manage user accounts

The tables below show any pending user accounts followed by all other accounts. Select a user to update their tax IDs, claims access, and account status.

Create user account   Help ⓘ

Active and disabled accounts

||| Filter results   ⤢ Transfer selected accounts   🗑 Delete selected accounts   🖨 Print   ⬇ Download

☐ NAME ▲	USERNAME ▽	CLAIMS ▽	REAL-TIME CLAIMS ▽	PROVIDER & PRACTITIONER DATA ▽	CREATED ▽	STATUS ▽	
☐ Person, User	user123	Yes	No	No	10/07/2019	Active	View

🏠 > Account management > Manage user accounts > Account Information

Account information

Contact information

Name	Username	Phone
Person, User	Person, User	999-999-9999
Main St. City, State, 90000	personuser@comcast.net	

User permissions   Help

- 🔵 Claims
- ⚪ Real-time claims
- 🔵 Provider & practitioner data

Account administration

Account status
- ⚪ Active
- ⚪ Deactivated

Reset password

Logout | Messenger | Provider & practitioner profiles | Manage my profile | Contact us | Help | Feedback   🔍 Search Provider Connection

blue california   Provider Connection

Eligibility & benefits ⌄   Authorizations ⌄   Claims ⌄   Guidelines & resources ⌄   News & education ⌄

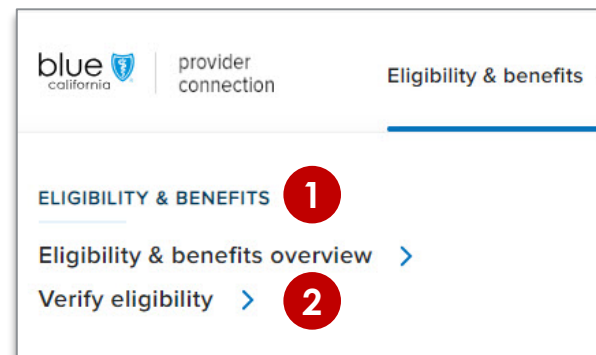**Background:** *Verify eligibility* lets you confirm that a patient is a Blue Shield, Blue Shield Promise or Other Blue Plan member. The tool contains up to two years of data at any one time. It is updated daily.

Instructions:

1. After log in, click **Verify eligibility** from the home page or click **Eligibility & benefits** from the white navigation bar.

2. Click **Verify eligibility** from the drop-down menu.

3. *Verify eligibility* opens and defaults to **SEARCH SINGLE MEMBER**. Click **SEARCH MULTPLE MEMBERS** to search for up to 10 subscriber IDs at one time.

4. For single member search, enter member data using one of the following:

   - Subscriber ID (9-16 alpha numeric characters)

   - Member name and date of birth

   - Last four (4) digits of SSN

   - MBI and date of birth (Medicare only)

   - First nine (9) characters of CIN

5. Click the active **Search** button. The eligibility results screen displays – see next page.

1. **Status:** Eligibility is green if active.

2. Upper right navigation provides links to eligibility details, a PDF of the member ID card, benefits, and *Check claims status.*

3. **Blue Shield only:** When Blue Shield is not primary, Coordination of Benefits (COB) information will display for Commercial members if the data is in our system.

Note: When verifying eligibility for Blue Shield TotalDual (HMO D-SNP) members with matching Medi-Cal through Blue Shield Promise ("full duals"), two of the above results panels will present, one for Medicare (primary) and one for Medi-Cal (secondary). When this is the case, the member ID card will be active on the Medicare results screen and inactive on the Medi-Cal.

Background: Clicking **Details** from the eligibility results screen provides access to additional information about the member. The first item you will see is *Network status*.

For the following six networks, the eligibility results screen tells you if you are in or out of the member's network:

1. PPO DMHC
2. PPO DOI Blue Shield Life
3. IFP EPPO
4. CalPers EPO
5. PPO GMAPD
6. PPO IMAPD

Note:

- For members not in one of the above networks, providers will be directed to *Find a Doctor* to determine network status.

- For capitated members, providers will be directed to contact the IPA.

If you have more than one Tax ID registered with Blue Shield, a *Check status* link will present. Clicking this link launches a three-step process.

1. Identify the appropriate Tax ID by selecting or searching in the pop-up that presents. Click **Continue**.
   - Select = (1-5 Tax IDs)
   - Search = (5+ Tax IDs)

2. Identify the appropriate provider by selecting or searching in the pop-up that presents. Click **Continue**.
   - Select = (2-5 providers/practitioners)
   - Search = (5+ providers/practitioners)

3. The network status displays.
   - Note: The system will save up to four recent searches as a default.

Network status ⓘ
Check status

1

① TIN ② Provider ③ Status

Check network status

Search for a TIN or organization name

TIN or organization name

Enter at least four characters from a TIN

Cancel

2

✔ TIN ② Provider ③ Status

Check network status

TIN / organization:
777673891 - PALOMAR POMERADO HEALTH

Search for a provider name

Provider name

Enter at least four characters from a provider name

‹ Back   Search

3

✔ TIN ✔ Provider ③ Status

Check network status

Network status:
⊘ In network

TIN / organization:
4343001 -- PALOMAR CITY MED CTR

Provider name:
PALOMAR CITY MED CTR
123 Main St, Homeland,

‹ Back   Close

Background: Clicking **Details** from the eligibility results screen provides access to additional information about the member. After *Network status*, the following information displays.
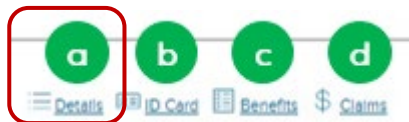
1. General member information

2. Special programs eligibility

Click the **+** sign to expand these sections as needed:

3. Member coverage information.

4. Total deductibles, copays, and out-of-pocket maximums.

5. PCP and IPA/medical group assignment if applicable.

1 Member information

Member phone	Language	Subscriber dues paid to
555-555-5555	Not Selected	N/A

2 Special Programs

Maven maternity status
Eligible

3 Member coverage details

⊕ Future coverage

⊕ Current coverage

⊕ Historical coverage

⊕ Historical coordination of benefits

4 Deductibles and out-of-pocket maximums

⊕ Future deductibles and out-of-pocket maximums

⊕ Current deductibles and out-of-pocket maximums

⊕ Historical deductibles and out-of-pocket maximums

5 ⊕ PCP and IPA / Physician group

Tip: The *Visits Accumulator* presents as part of Deductibles/OOP for **Commercial** members only. It tracks visits to specialty providers when their plan covers a set number of visits per plan year. Specialty visits covered by third parties such as American Specialty Health (ASH) are not tracked by the tool.

Background: Clicking **Benefits** from the eligibility results screen provides access to a detailed view of the member's benefits.

1. *Benefit summary* view is the default – lists benefits in alpha order on the left with details on the right.

2. *Benefit categories* view expands/collapses on the left with details on the right.

3. The *Search* field activates when *Benefit categories* view is clicked.

   • Benefits are not listed by ICD-10 codes.

4. *Benefits download* (if logged in) or go to Benefit summaries if not logged in, to download/view a spreadsheet with detailed benefits for the all plans.

Benefit summary

Chiropractic and Acupuncture

Benefit	Network	Copay
Chiropractic/Acupuncture		
Chiropractic	Participating Providers	20% per Visit
Chiropractic	Non-Participating Providers	40% per Visit

General - General Subcategory - Benefit Maximums

Annual Medical Deductible	MILLS, JANET L	Applies to Annual Out of Pocket Maximum
Preferred & Non Preferred Provider	$1750	Yes
Maximum	$0	

Calculated over 12 months beginning January 1
For additional information about plan deductibles see Custom Benefits

| Annual Out of Pocket Maximum	MILLS, JANET L
Preferred & Non Preferred Provider	$4500
Maximum	$0

For additional information about out-of-pocket maximums see Custom Benefits

Tip: If a Promise Health Plan member, the link from the check eligibility results will take you to the Medi-Cal Member Handbook EOC.

Create member rosters

Background: Member rosters are lists of Blue Shield and Blue Shield Promise members who have selected a provider as their PCP or medical group. This list shows all providers associated with your account by Provider ID (PIN).

Instructions:

1. After log in, click **Eligibility & benefits** from the white navigation bar.

2. Click **Member rosters** from the drop-down menu.
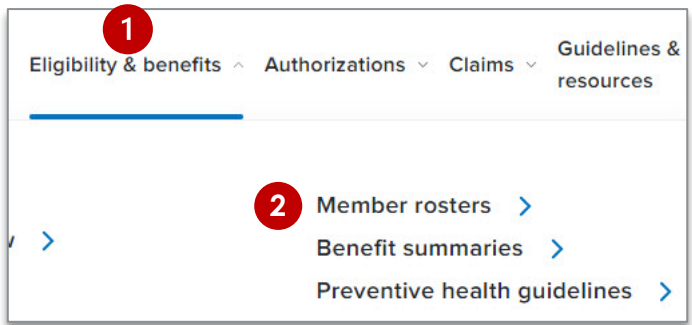

3. The member updates column displays either *New* or *Updates* (member disenrolled, moved to another PCP, or status changed to redetermined).

4. Click the linked number to view and/or export data.

5. Click **Export** to download an Excel spreadsheet with full member details.

   - Disenrolled Members Roster includes disenrollment dates.

   - Redetermined Members Roster displays members with upcoming redetermination dates within the next 90 days.

   - On Hold Members Roster displays members who missed their redetermination date and are within the 90-day grace period.

6. Use **Search** or click **Filter** to view/download by provider name, address, PIN or IPA/medical group.
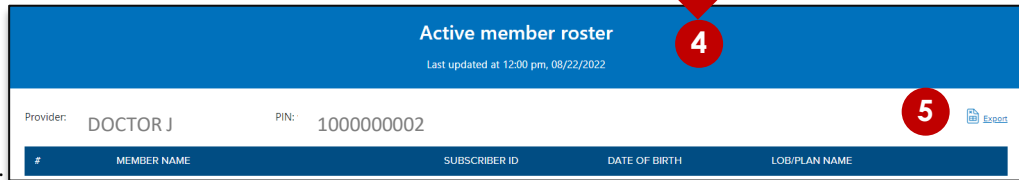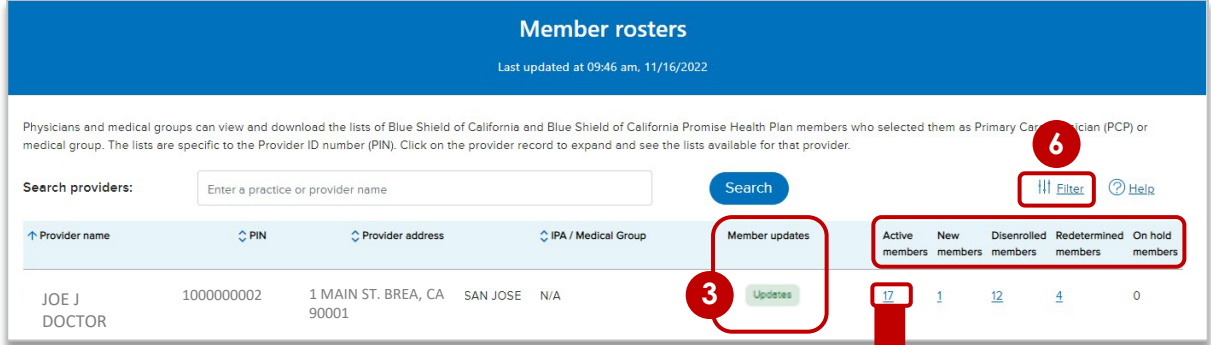
Background: Medical authorizations can be submitted online or fax. Rx requests can be submitted online, by fax, or via the Surescripts® or CoverMyMeds® EHR platforms. Authorization status for all requests can be viewed online via AuthAccel. See Authorization basics for providers for an overview of the authorization process at Blue Shield/Blue Shield Promise.
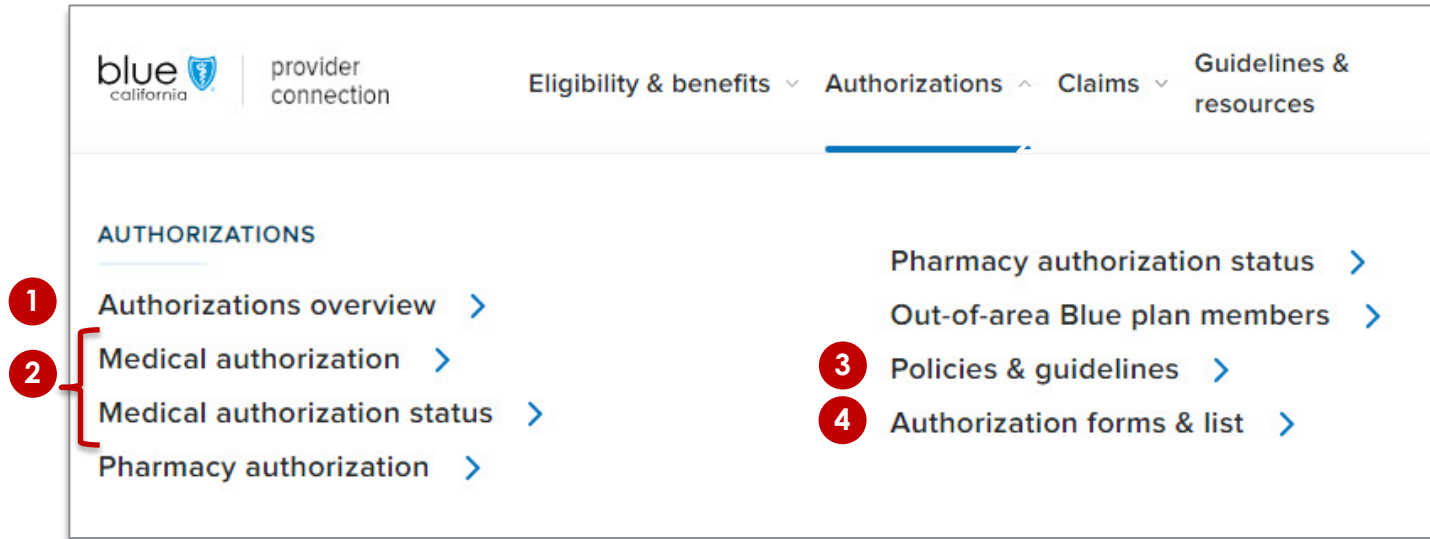
Orientation:

1. The overview section provides a high-level table of contents for information on the page plus an Authorization basics page that describes the process at Blue Shield.

2. The Authorizations section houses the AuthAccel online authorization tool, available after log in.
   - Click **Medical authorization** to submit medical requests via AuthAccel. Click **Medical authorization status** to view medical request status via AuthAccel, regardless of how they were submitted.
     - AuthAccel instructions are linked to each launch page as well as to AuthAccel Online Authorization System Training.

3. Click Clinical policies and guidelines to search medical and medication policies and requirements. No log in required.

4. Click Prior authorization lists and fax forms, and to learn about services requiring third-party authorization (e.g., National Imaging Associates [NIA]). No log in required.

Options for submitting claims

Background: There are three options for submitting claims to Blue Shield: by mail, electronically, or online from Provider Connection using SympliSend.

Mail	Electronically (EDI)	SympliSend
• The Claims Routing Tool tells you where to submit paper claims. No log in is required. • See next page for instructions.	• Step 1: Choose an approved EDI clearinghouse. • Step 2: Enroll in ERA and EFT. Provider Connection Account Mangers can enroll online: See page 17 for instructions. • Step 3: Contact the selected clearinghouse to enroll and begin exchanging electronic transactions. • See the EDI, ERA/EFT and Secondary 277CA FAQ .	• Via SympliSend after logging in to Provider Connection. • Submit digital paper claims, itemization requests, and digital correspondence related to previously processed or in process claims. • To launch, go to *Claims > Claim Tools >* and click the **Submit Via SympliSend** blue box • See user guide for instructions.

Tip: EDI (Electronic data interchange) is the exchange of business transactions in a standardized format from one computer to another. For additional information on EDI, see How to submit claims on Provider Connection – no login required.

Background: The *Claims routing tool* tells you where to submit **paper** claims for Blue Shield/Blue Shield Promise. It can also be used to determine where to send BlueCard claims for out-of-state Blue plan members. No log in is required to use this tool.

Instructions:

1. No log in is required to use this tool. Go to Provider Connection and click Claims from the white navigation bar.

2. Click **Claims routing tool** from the drop-down menu.

3. Enter the first three characters of the member's ID.

4. Enter the date of service and click **Search**.

   a) If requested, enter the rest of the member ID and click **Search.**

5. The "send to" address will display. In most cases, so will a phone number for customer service should you need assistance.

6. Click **Start over** to conduct a new search.

Claims-routing tool

Enter the valid 3-character prefix which is the first 3 characters as displayed on the Member ID card to find where to submit your claim. All fields required.

3-character prefix
XYZ **3**

Member ID
Enter 9 - 20 characters **a**

BlueCross BlueShield
Member Name
Jane A. Sample
Member ID
XYZ234567890123

Date of service (up to 36 months before and 31 days after current date)
03/16/2021 **4**

Search   Reset

Claims-routing tool

Enter the valid 3-character prefix which is the first 3 characters as displayed on the Member ID card to find where to submit your claim. All fields required.

3-character prefix
ABC

BlueCross BlueShield
Member Name
Jane A. Sample
Member ID
XYZ234567890123

Date of service (up to 36 months before and 31 days after current date)
02/03/2021

Search   Reset

✉ Send claims to: **5**
Blue Shield of California
BlueCard Program
P.O. Box 1505
Red Bluff, CA 96080-1505

bluecard

📞 **Customer Service**
Claims phone: (800) 622-0632
Eligibility and benefits phone: (800) 676-BLUE (2583)

More information
BlueCard Program
Learn how to get claims processed for healthcare services provided to out-of-state Blue plan members.
Learn more about BlueCard Program

Background: Using EDI, you can receive claims payment information electronically (electronic remittance advice or ERA) and you can have claims payments deposited directly into your business account (electronic funds transfer or EFT).

Instructions:

After log in, Provider Connection Account Managers can determine if your organization is enrolled in ERA/EFT. If yes, you can edit your selections. If not, you can enroll right from this screen.

1. Click **Account Management** > **Provider & practitioner profiles**.

2. If you have more than one Tax ID (TIN), select the correct TIN from the drop-down menu and click **Search** to refresh the screen.

3. Click the **Remittance & Payments tab.** The screen will open on the EFT information for that TIN. Click **Edit** to enroll or to change your enrollment information.

4. To view/edit ERA , click **ERA** in the left navigation. Use the drop-down menu to choose a vendor (i.e., clearinghouse or trading partner). The vendor you choose applies to all providers under the selected Tax ID. Changes take up to three (3) business days.

Background: *Check claim status* is available from the home page and from the *Claims* section after log in. It contains a *Search* and *Other Blue* plans tabs. The *Appeal status* tab links to *Submitted disputes* on the *Claim issues & disputes* page.

Instructions: You must be linked to the Tax ID and Provider ID (TIN/PIN) of the claim for which you are searching.

1. Click **Check claim status.** The *Search* tab displays with claims from the last five years. The most recent will be at the top.
2. Enter data into one or more search fields and click **Search.**
3. Results will display below the blue header row. To sort results in alphabetical or ascending/descending order, click the desired column header and the up/down arrow once it presents.
4. Click the blue text links to see more detailed information about the member or claim or to view/download the EOB.
5. To clear the search and conduct a one, click **Start over.**

Tip: When using the *Other Blue plans* tab to conduct a search for member claims, all fields are required unless marked optional. Results will be sent to the user's Message Center.

Background: Clicking the claim number from the *Check claim status* search results opens the *Claim detail* page and provides access to the information below. Once a claim has been reviewed and finalized, the *EOB* will be available here. You will also see links to *Attach supporting documentation* (to a finalized claim) and *Resolve claim issue or dispute.*

1 — Claim status

2 — Download EOB

3 — File a dispute or attach documentation to finalized claim

4 — View all claims for this member

5 — Toggle between full and summary view

6 — View payment details

7 — This section presents when there is history such as claim adjustments and/or related claims

8 — This section includes line-item detail as well as claim messages and notes

Medical | Finalized | View EOB

Information is valid and up to date as of 11/17/2021 at 03:04 a.m.

Possible next steps: Attach supporting documents · Resolve claim issue or dispute.

Member information

Member name	Mark, Twain
Date of birth	01/01/1985

View all claims for this member

Member ID	XEA910222675-00
Group number	W3000100

Claim details

Dates of service	11/01/2021–11/01/2021
Claim received	11/01/2021
Provider	JOE J DOCTOR

Amount billed	$1,235.00
Allowed amount	$121.21
Patient responsibility	$1,174.40
Amount paid	$60.60

Full view

Payment details

Check/EFT number	10026867
Check/EFT date	11/17/2021
Check/EFT status	Check Number Assigned

Check/EFT amount	$60.60
Payee name	Not Assigned
Payee address	N/A

Uploaded documents (15) Show ˅

Claim history Show ˅

Service and procedure details

Line #	Dates of service	Place of service	Units	Procedure code	Modifier	Amount billed	Allowed amount	Deductible	Copay	Co-Insurance	Amount paid
199	11/0...	Office	1	99219	N/A	$1,235.00	$121.21	$0.00	$0.00	$60.61	$60.60

Background: For all lines of business, documentation can be attached to a finalized claim.

To start the process for a finalized claim:

1. Click **Claims** then click **Check claim status** in the blue sub-menu bar.

2. Search for the finalized claim. (See Check claim status for instructions.)

3. Click the claim number to open the *Claim detail* page.

4. The *Claim detail* displays for that claim. Click **Attach supporting documents**.

Claim 000343305500
Finalized 07/30/2021

4

      Medical | Finalized – denied | View EOB

Possible next step: Attach supporting documents
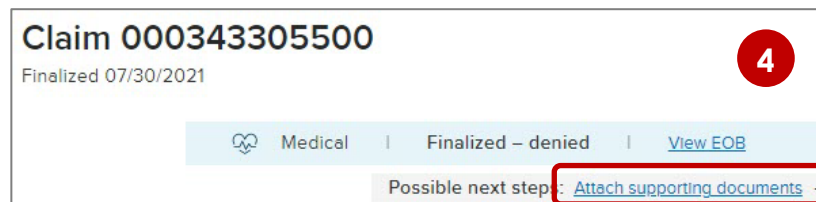
5. The *Attach Documents to a Claim* screen displays with prepopulated claims data.

6. See the Attach documentation to a finalized claim tutorial for the remaining steps, with screenshots, for how to complete this process.

Background: Disputes for most plan types can be initiated from the 1) *Claim detail screen* once the claim has been finalized or from the 2) *Claim issues & disputes* section, if you know the claim number. They can also be filed by mail.

Disputes can be filed for a single claim or multiple claims in a bulk dispute for the same type of issue. **To begin the online dispute process, log in and go to the Claims section:**

1. Click **Check claim status** in the white navigation bar.

2. Search for the finalized claim. (See Check claim status for instructions.)

3. Click the claim number to open the *Claim detail* page.

4. Click the **Resolve claim issue or dispute** link. This link will be active only if the claim has been finalized.

   • Note, if this is a claim type that cannot be disputed online, the link will say, "file a dispute by mail."

5. If you know the claim number, you can also file a dispute online directly from *Claim issues & disputes,* after log in.

6. See the Submit claim disputes online and view status tutorial for the remaining steps, with screenshots, for how to submit an online dispute.
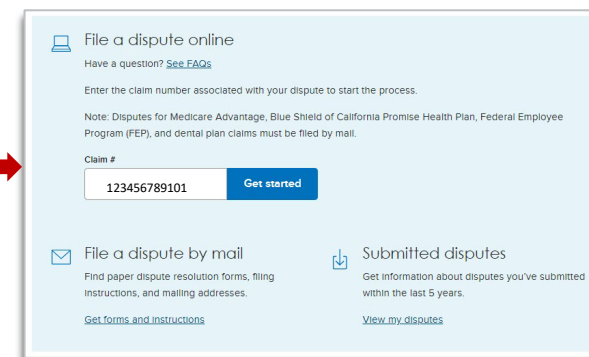

Tip: To insure you file a dispute correctly, see Learn more about the dispute process.

Background: The *Submitted disputes* link is available from the *Claim issues & disputes* section after log in. It contains all disputes submitted online or by mail.

1. Click **Claim issues & disputes** from the *Claims* section's drop-down menu after log in.

2. Scroll to the blue box and click **View my disputes**.

3. Enter data related to the dispute(s) in one or more fields and click **Show results**.

4. Results display under the light blue header.

5. Click the dispute case number to access dispute case details including letters.
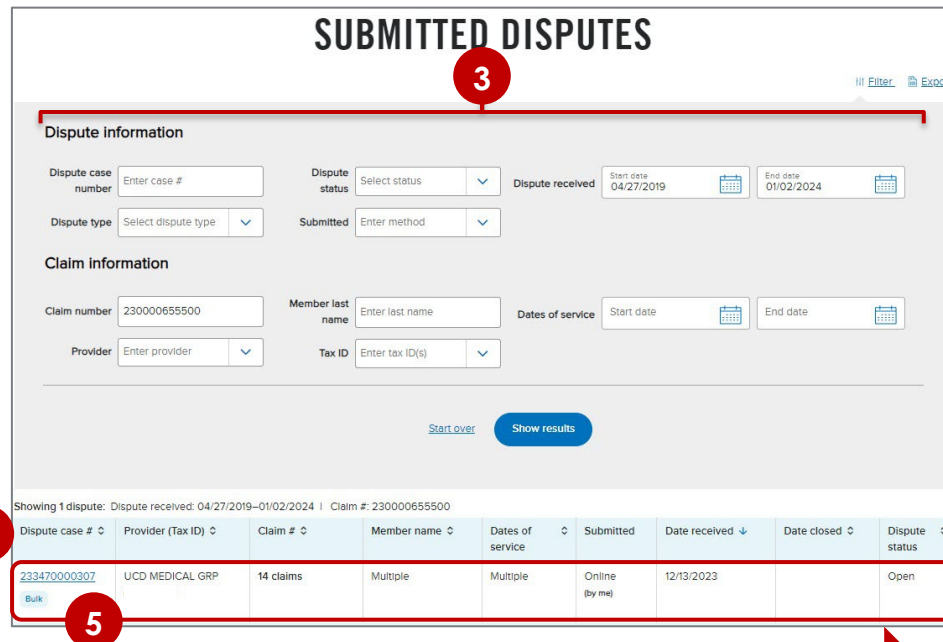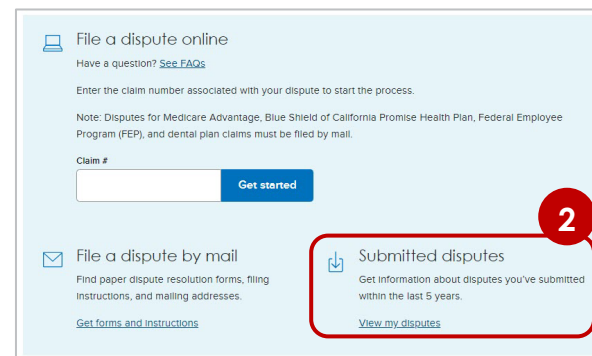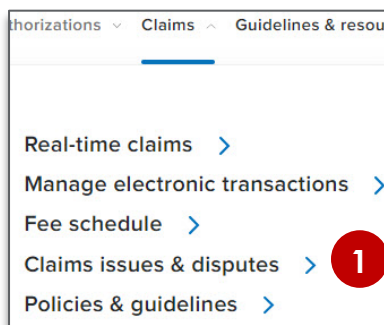
6. The *Dispute case details* screen displays all information and documentation connected to the dispute case number you selected.

   a. Dispute form and claim list (if bulk submission).

   b. Claim numbers included in the dispute submission.

   c. Supporting document uploaded by you with option to add additional documents to an open dispute.

   d. Correspondence and determination.

Background: Blue Shield Promise resources that do not require log in are integrated throughout Provider Connection. They are also available from the Blue Shield Promise Provider Portal. The links below will take you to content on Provider Connection, and in some cases, to content on the Blue Shield Promise Provider Portal.

For Blue Shield providers
Ancillary provider listings
Behavioral health resources
Benefit summaries
BlueCard Program*
Claims policies & guidelines
Clinical policies and guidelines
Professional fee schedule search *
Drug formularies
Forms
Member ID card samples
Patient care resources
Provider manuals
Richman injectables policy
Spine surgery/pain management prior auth and Radiology and imaging prior auth • National Imaging Associates (NIA) RadMD Sign in

For Blue Shield Promise providers
Benefit summaries
Behavioral Health Services
Clinical policies and procedures
Complex Case Management
Drug formularies
Forms
Health education resources
Medi-Cal Provider Incentive Program
Member ID card samples
Patient care resources
Provider manuals
Quality improvement

* Log in required.

blue
california ®

blue
california ®
Promise Health Plan