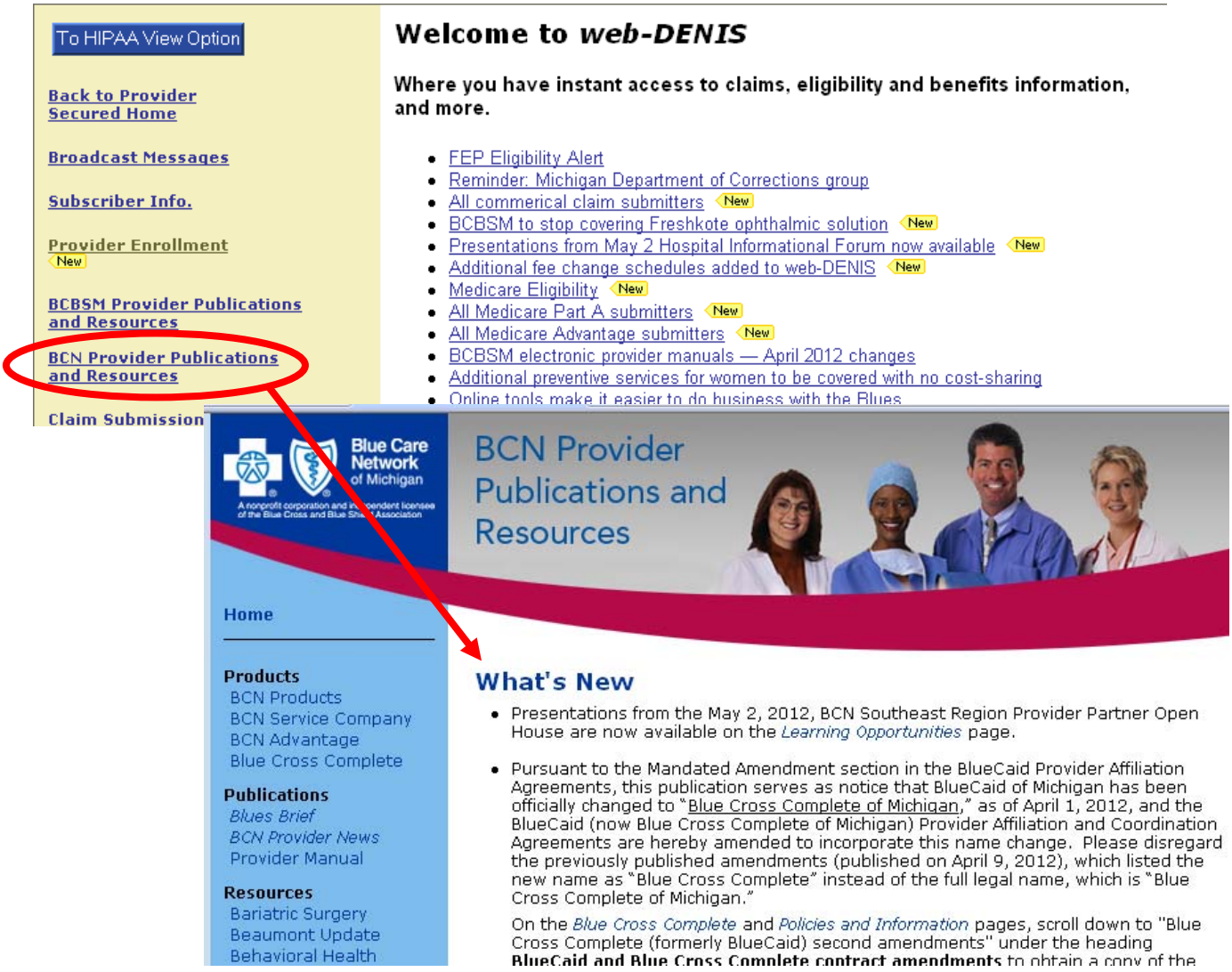
Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

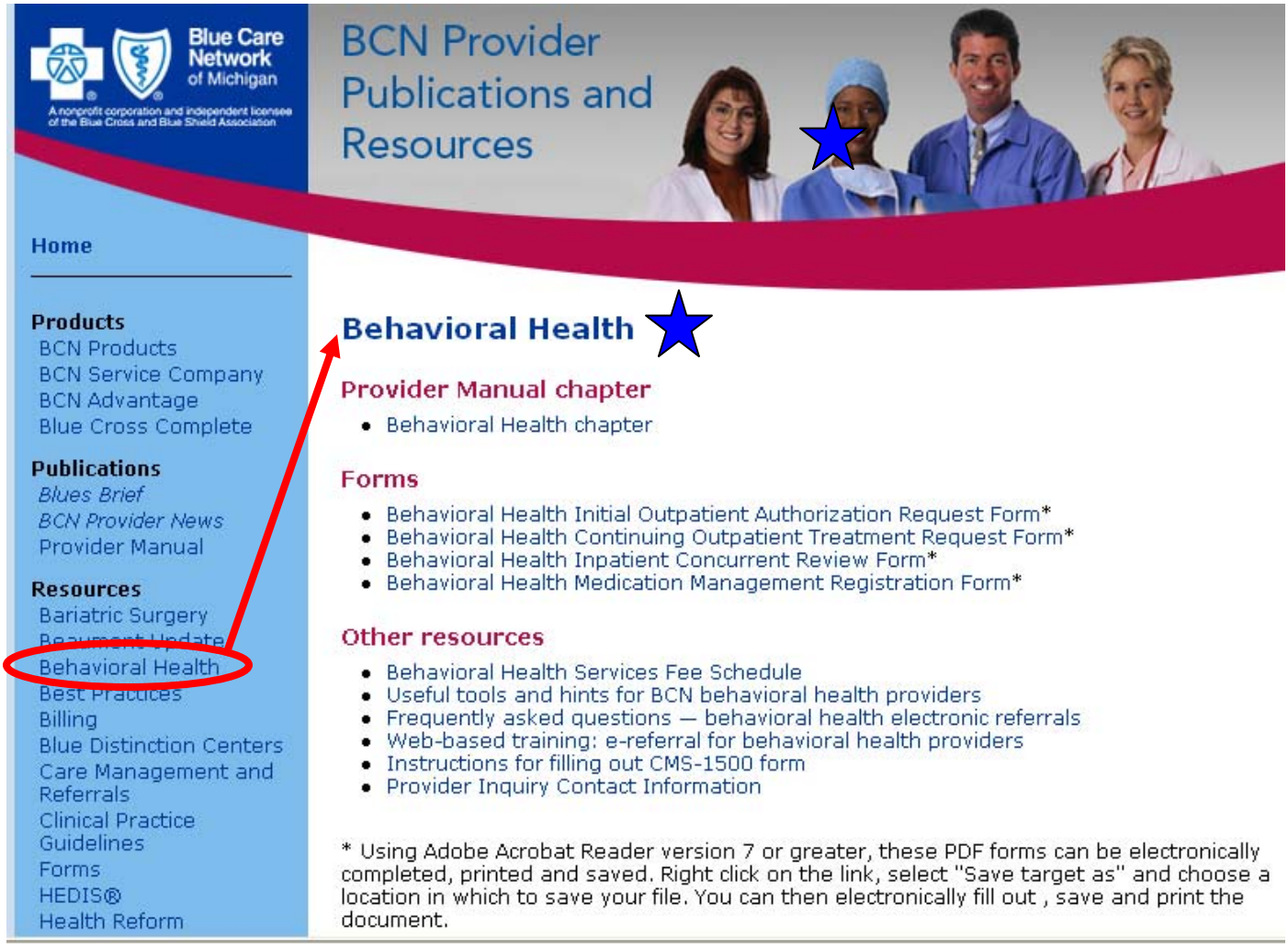
web-DENIS resources

Getting to web-DENIS resources

- Log in to web-DENIS. You'll need your password.
- Click *BCN Provider Publications and Resources*.



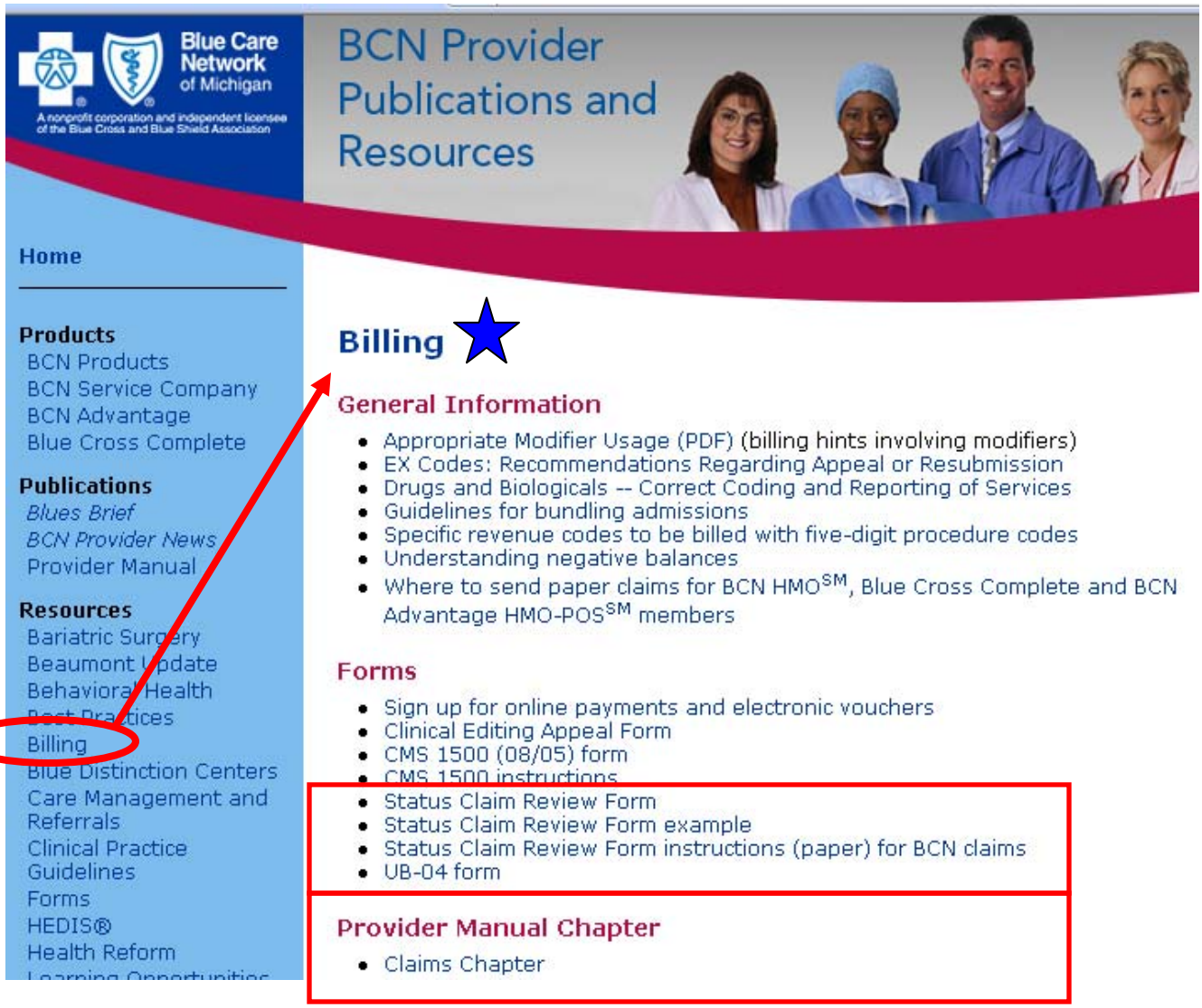
web-DENIS Behavioral Health page

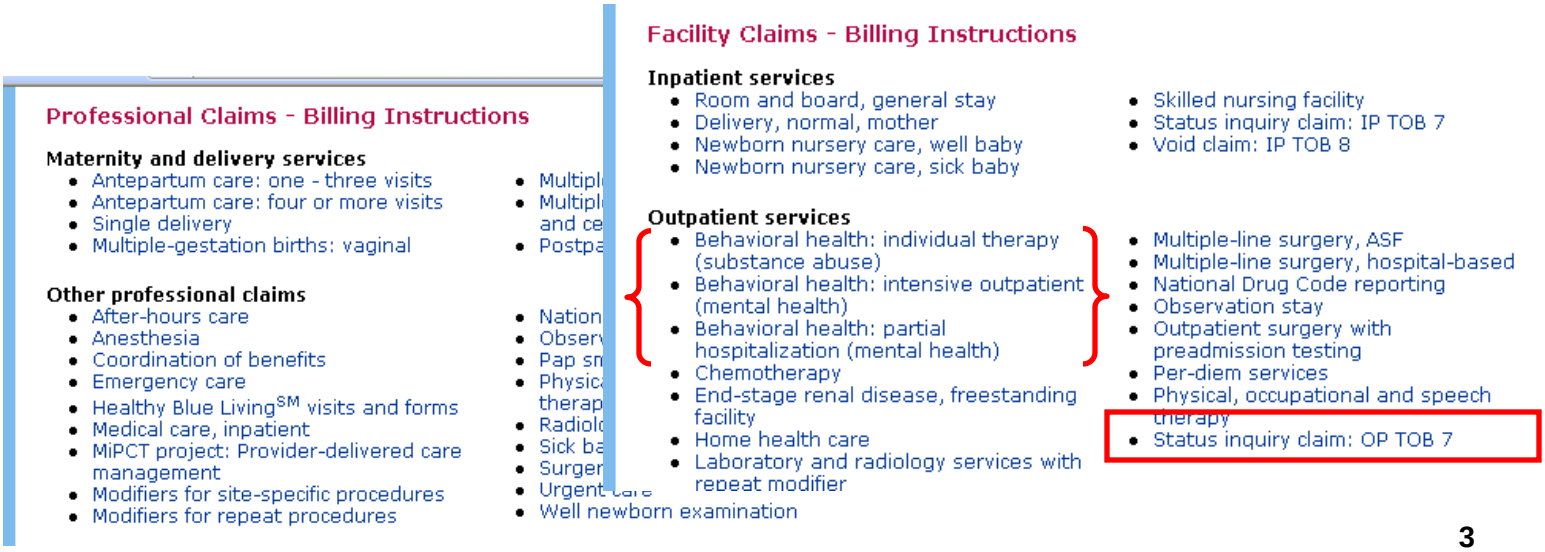


web-DENIS resources

Blue Care Network of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

web-DENIS Billing page





Blue Cross Blue Shield of Michigan

STATUS CLAIM REVIEW FORM

LAST NAME OF INSURED/SUBSCRIBER | FIRST NAME

GROUP NO. | SERVICE CODE

INSURED'S/SUBSCRIBER IDENTIFYING NO. *(INCLUDE ANY LETTERS)*

PHYSICIAN OR PROVIDER NAME, ADDRESS, ZIP CODE

PROVIDER CODE/NPI | TELEPHONE NUMBER

A. | B. NPI

BC/BS | F.E.P. | COMP. | O/S

P.O.T.A. | REJ. | CORR. | COMP NPR | ORIGINAL FORM WAS PAY PROVIDER YES | NO

1. PATIENT'S LAST NAME | 2. MID. | 3. FIRST NAME | 4. PAT'S BIRTH | 5. PAT'S SEX M | F | 6. PAT'S RELATIONSHIP TO INSURED SELF | SPOUSE | DEPENDENT

7. PATIENT'S MEDICARE HIB NO. | 8. PATIENT'S ACCT. NO. | 9. INSURED'S TELE. NO. | 10. WAS CONDITION REL TO EMP | AUTO | OTH | 11. CR IND | 12. ATTACH | 13. MULT.

14. INSURED'S STREET ADDRESS | 15. CITY | 16. ST. | 17. ZIP CODE | 18. PRIOR AUTHORIZATION NO.

19. DATE OF ILLNESS *(FIRST SYP.)* INJURY *(ACCIDENT)* PREGNANCY *(L.M.P.)* | 20. ADMISSION DATE | 21.DISCHARGE DATE | 22. SERVICE FACILITY CODE/NPI A. B. NPI | 23. REFERRING/ORDERING LICENSE # /NPI A. B. NPI

24. PPO REFERRING PHYSICIAN CODE/NPI A. B. NPI | 25. PAY'T. AMT. REC'D | 26. CHECK DATE | 27. CHECK NO. | 28. NON-PAYM'T CODE | 29. DOCUMENT NO.

30. DIAGNOSIS OR ADDITIONAL INFORMATION AREA

	31. DATE OF SRV	32. DX CODE	33. PLACE	34. PROC. CODE	35. QTY.	36. DURATION	37. CHARGES	38. MISC. DATE	39. I.C.
1									
2									
3									
4									
5									
6									

	40. M-1	M-2	M-3	M-4	41. MED.REASONABLE	42. MED DEDUCT.	43. OTR CARRIER AMOUNT	44. QUAL.	RENDERING LICENSE #	45. RENDERING NPI
1								A. B.		NPI
2								A. B.		NPI
3								A. B.		NPI
4								A. B.		NPI
5								A. B.		NPI
6								A. B.		NPI

DO NOT WRITE IN THIS AREA - DOCUMENT NUMBER

PROVIDER SIGNATURE | DATE

Blue Care Network

Filling Out the Paper *Status Claim Review Form* for BCN Claims

For BCN claims, providers completing the *Status Claim Review Form* must re-bill the entire claim for any services performed on a particular date of service and include any corrections. The chart below provides step-by-step instructions for professional billers completing the paper *Status Claim Review Form* for BCN claims.

Note: For Blue Cross Blue Shield of Michigan claims, providers should follow the instructions on page 2 of the BCBSM *Status Review Claim Form*.

How to complete the paper *Status Review Claim Form*		
Field #	**Field Name**	**Information**
Upper left corner	**SUBSCRIBER INFORMATION**	
	Subscriber Name	Enter subscriber's last name and first name.
	Group Number	Not required
	Service Code	Not required
	Insured Subscriber Identifying No.	Enter the subscriber's alphanumeric ID number.
	Type of Coverage	• **BC/BS:** — Leave blank. • **F.E.P.** — Leave blank. • **COMP.** — Leave blank. • **O/S** — Leave blank.
Upper right corner	**PROVIDER INFORMATION**	
	Provider Name and Address	Enter the provider's name and address.
	Provider Code/NPI	Enter the NPI. Note: Effective Sept. 30, 2009, only the NPI is accepted as the provider identifier.
	Provider's Phone	Enter area code and phone number.

continued on next page

Filling Out the Paper *Status Claim Review Form* for BCN Claims

How to complete the paper *Status Review Claim Form*		
Field #	**Field Name**	**Information**
Located under provider code (upper right corner)	**Reason For Submission** **Enter an X in all boxes that apply.**	• **P.O.T.A.** — A payment was received other than what was anticipated. • **REJ.** — A rejection is being questioned. • **CORR.** — A correction to the original claim is being submitted. • **COMP NPR** — Leave blank. • **Original Form Was Pay Provider** — Enter an X in the appropriate box.
1	**Patient's Last Name**	Enter patient's last name.
2	**Mid**	If known, enter patient's middle initial.
3	**First Name**	Enter the patient's complete first name. Do not use a nickname unless the patient is listed that way on the contract.
4	**Patient's Birth**	Enter the patient's birth date in a six-digit format with no spaces (MMDDYY).
5	**Patient's Sex**	Enter an X in the appropriate box.
6	**Pat's. Relationship to Insured**	Enter an X in the appropriate box.
7	**Patient's Medicare HIB No.**	Leave blank.
8	**Patient's Account No.**	Not required. If an office has assigned a case number to the patient, enter it here. A maximum of 20 characters may be used. BCN will include this number on the payment voucher to assist providers in the patient's accounting.
9	**Insured's Tele No.**	Enter the subscriber's area code and phone number.
10	**Was condition Rel. to**	• EMP — Enter an X if the accident took place in the patient's place of employment. • AUTO — Enter X if the patient's condition is related to an auto accident. • OTH — Enter X if the accident is not related to employment or auto accident.
11	**CR Ind**	Leave blank.
12	**Attach**	Enter the number of pages attached to the claim form. This includes explanatory letters or copies of other carrier's payment vouchers. If the number of attachments is not indicated, the claim may not be processed correctly.
13	**Mult.**	Enter an X in this box if there are multiple diagnoses or to indicate that additional information is entered in field 30. This field applies only for claims with multiple diagnoses or additional information.
14	**Insured's Street Address**	Enter the subscriber's address.
15	**City**	Enter the subscriber's city.
16	**ST**	Enter the subscriber's two-letter state abbreviation as used by the U.S. Postal Service.
17	**Zip Code**	Enter the subscriber's ZIP code.
18	**Prior Authorization No.**	If billing a service that was authorized by BCN, enter the authorization number received. The number of digits may vary.

continued on next page

Filling Out the Paper *Status Claim Review Form* for BCN Claims

How to complete the paper ***Status Review Claim Form***		
Field #	**Field Name**	**Information**
19	**Date of**	• Enter the date the patient first experienced symptoms of the illness or condition for which services were performed, with the following exceptions: o If the service is related to end stage renal disease, enter the date of the first maintenance dialysis or the date of the kidney transplant. o If the service is related to an injury — whether it is the initial treatment or a follow-up service — enter the date of the injury. o If the service is related to pregnancy, enter the date of the last menstrual period. If unable to determine the LMP, use the estimated date of conception. • Enter the date in a six-digit format: for example, enter Jan. 1, 2007, as 010107.
20	**Admission Date**	If the service was performed on an inpatient basis, enter the admission date. Otherwise, leave the field blank. *For inpatient services only*
21	**Discharge Date**	If the service was performed on an inpatient basis, enter the discharge date. (Only the discharge doctor is responsible for this information.) Otherwise, leave the field blank. Use this field only for inpatient services performed by the physician who discharged the patient.
22	**Facility Code**	Not required
23	**Referring/ Ordering Physician Information**	Not required
24	**PPO Referring Physician Code/NPI**	Leave blank
25	**Payment Amt. Rec'd.**	Enter the total payment received for the services in question.
26	**Check Date**	Enter the date of the Remittance Advice for the service in question.
27	**Check No.**	Enter the check number from the Remittance Advice.
28	**Nonpayment Code**	Enter the nonpayment code from the Remittance Advice for the service in question.
29	**Document No.**	Enter the BCN claim number from the Remittance Advice for the service in question.
30	**Diagnosis or Additional Information Area**	• Diagnosis — Enter diagnosis codes. • Additional Information — Provide an explanation of why BCN should reconsider action on this claim. Enter additional information or any information that was omitted on the original claim. Describe any attachments. Attach a second sheet of paper if needed. If original claim was denied for no authorization on file and a copy of the authorization has been retained from the primary care physician, attach it to the *Status Claim Review Form*.

continued on next page

Filling Out the Paper *Status Claim Review Form* for BCN Claims

How to complete the paper *Status Review Claim Form*		
Field #	**Field Name**	**Information**
Service information In fields 31 through 45, enter service information. If entering information that was omitted or reported incorrectly on the original claim, enter an X in the small shaded box to the right of that item.		
31	**Date of Srvc.**	Enter the date each service was provided. Enter the date in a six-digit format (MMDDYY).
32	**Dx Code**	Enter the full five-digit, four-digit or three-digit ICD-9-CM code that represents the primary diagnosis.
33	**Place**	Enter the appropriate HIPAA-compliant location of service code to describe where care was provided. Refer to the CMS-1500 (08/05) claim information earlier in the *Professional Claim Examples* chapter of the *BCN Provider Manual*.
34	**Proc. Code**	Enter the five-character procedure code for the procedure performed.
35	**Qty.**	Enter the number of treatments, visits or anesthesia minutes.
36	**Duration**	Leave blank.
37	**Charges**	Enter the original charge billed for the service. If billing multiple services as one line item, enter the total amount for all services on the same service line. Do not include dollar signs, decimals, negative signs or any other nonnumeric characters. Also, do not indicate if the patient has already paid all or some portion of the charges; payments from the patient should not be shown anywhere on the form.
38	**Misc. Date**	• If reporting multiple services on one line, enter the last date of service in this field. • If the service date is related to pregnancy, enter the first date of prenatal care. • In all other cases, leave this field blank.
39	**I.C.**	Enter modifier 22 if reporting unusual circumstances and have used an unlisted procedure code*. **Use for unusual circumstances and unlisted procedure codes only.**
40	**Modifiers**	Enter up to four two-character modifiers to further define the procedure code entered in Field 34. Report up to four modifiers for each procedure code.
41	**Med. Reasonable**	Leave blank.
42	**Med. Deduct.**	If requesting additional BCN 65 payment, enter the total amount applied to the Medicare deductible as shown on the Medicare payment voucher. **Use only for BCN 65 inquiries when an amount was applied to the patient's deductible.**
43	**Other Carrier Amount**	Not required.
44	**Qual.** **Rendering** **License #**	A. Not required. B. Enter the rendering physician's BCBSM license number, for example, AS123456. This is crucial when billing with a Group Bill PIN.
45	**Rendering NPI**	Enter the rendering provider's NPI.
Lower right corner	**Provider Signature**	Enter the provider's authorized signature or stamped reproduction and date. If completing claims form on computer, "signature on file" is acceptable.

Blue Cross Blue Shield of Michigan

STATUS CLAIM REVIEW FORM

LAST NAME OF INSURED/SUBSCRIBER: SUBSCRIBER
FIRST NAME: SAMPLE
GROUP NO.: XXXXXX
SERVICE CODE:
INSURED'S/SUBSCRIBER IDENTIFYING NO. *(INCLUDE ANY LETTERS)*: XXX11111111101

PHYSICIAN OR PROVIDER NAME, ADDRESS, ZIP CODE:
SAMPLE PROVIDER
ADDRESS
CITY, STATE, ZIP CODE

PROVIDER CODE/NPI
A.
B. NPI: XXXXXXXXXX
TELEPHONE NUMBER: XXXXXXXXXX

BC/BS [ ] F.E.P. [ ] COMP. [ ] O/S [ ]
P.O.T.A. [ ] REJ. [ ] CORR. [X] COMP NPR [ ] ORIGINAL FORM WAS PAY PROVIDER [X] YES [ ] NO

1. PATIENT'S LAST NAME: PATIENT
2. MID.:
3. FIRST NAME: SAMPLE
4. PAT'S BIRTH: 050110
5. PAT'S SEX: [ ] M [X] F
6. PAT'S RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [X] DEPENDENT
7. PATIENT'S MEDICARE HIB NO.:
8. PATIENT'S ACCT. NO.: XXXXX
9. INSURED'S TELE. NO.: XXXXXXXXXX
10. WAS CONDITION REL TO: [ ] EMP [ ] AUTO [ ] OTH
11. CR IND: [ ]
12. ATTACH: [X]
13. MULT.: [ ]
14. INSURED'S STREET ADDRESS: ADDRESS
15. CITY: CITY
16. ST.: ST
17. ZIP CODE: XXXXX
18. PRIOR AUTHORIZATION NO.:
19. DATE OF ILLNESS *(FIRST SYP.)* INJURY *(ACCIDENT)* PREGNANCY *(L.M.P.)*:
20. ADMISSION DATE:
21. DISCHARGE DATE:
22. SERVICE FACILITY CODE/NPI
A.
B. NPI:
23. REFERRING/ORDERING LICENSE # /NPI
A.
B. NPI:
24. PPO REFERRING PHYSICIAN CODE/NPI
A.
B. NPI:
25. PAY'T. AMT. REC'D: 80 00
26. CHECK DATE: 072911
27. CHECK NO.: XXXXXX
28. NON-PAYM'T CODE:
29. DOCUMENT NO.: EXXXXXXXXXXX

30. DIAGNOSIS OR ADDITIONAL INFORMATION AREA

CORRECTING PROCEDURE CODE 90471 FROM ORIGINAL CLAIM. REPLACING IT WITH PROCEDURE CODE 90472.

	31. DATE OF SRV	32. DX CODE	33. PLACE	34. PROC. CODE	35. QTY.	36. DURATION	37. CHARGES	38. MISC. DATE	39. I.C.
1	072011	V068	11	90472	3		25 00		
	40. M-1 M-2 M-3 M-4	41. MED.REASONABLE	42. MED DEDUCT.	43. OTR CARRIER AMOUNT	44. QUAL.	RENDERING LICENSE #	45. RENDERING NPI		
	LT				A. B.		NPI XXXXXXXXXX		
2	072011	V0489	11	90473	1		25 00		
					A. B.		NPI XXXXXXXXXX		
3	072011	V068	11	90698	1		25 00		
					A. B.		NPI XXXXXXXXXX		
4	072011	3829	11	69210	1		45 00		
	LT				A. B.		NPI XXXXXXXXXX		
5									
					A. B.		NPI		
6									
					A. B.		NPI		

DO NOT WRITE IN THIS AREA - DOCUMENT NUMBER

PROVIDER SIGNATURE 080311

PROVIDER SIGNATURE DATE

Resubmitting a claim for inquiry

Facility providers can file a paper inquiry using a UB-04 with a TOB 7

Facility providers can submit a paper status inquiry claim using a UB-04 claim form with a TOB 7.

When completing the UB-04 with a TOB 7, the provider must rebill all services that were performed on a particular date of service and include any corrections. The claim should be submitted by completing the following steps:

1. Print and complete the UB-04 claim form available at web-DENIS > BCN Provider Publications and Resources > Billing > **UB-04 form**.

   Note: Providers should complete the form according to instructions available in the *National UB-04 Manual*.

   This includes the following:

   - Enter the appropriate type of bill code ending in 7.
   - Enter the claim number from the original or previous Remittance Advice for the service in question.

2. Attach any relevant documentation.
3. Mail the request to the appropriate address:

   Blue Care Network
   P.O. Box 68710
   Grand Rapids MI 49516-8710

   BCN Advantage
   - OR -
   Blue Cross Complete
   P.O. Box 68753
   Grand Rapids MI 49516-8753

For additional information on how to file a status inquiry claim, facility providers should review the claim example *Status inquiry claim: outpatient, TOB 7*, which is available at web-DENIS > BCN Provider Publications and Resources > Billing > **Status inquiry claim: outpatient, TOB 7**.

Resubmitting a claim for inquiry

Professional providers can file a paper inquiry using the *Status Claim Review Form*

Professional providers can submit a paper status inquiry using the *Status Claim Review Form*.

When completing the *Status Claim Review Form*, providers must rebill all services that were performed on a particular date of service and include any corrections. The claim should be submitted by completing the following steps:

1. Print and complete the front page of the *Status Claim Review Form*, which is available at web-DENIS > BCN Provider Publications and Resources > Billing > **Status Claim Review Form**.

   Note: Providers should complete the form according to the instructions available at web-DENIS > BCN Provider Publications and Resources > Billing > **Status Claim Review Form instructions (paper) for BCN claims**.

   This includes entering the claim number from the original or previous Remittance Advice for the service in question.

2. Attach any relevant documentation.
3. Mail the request to the appropriate address:

   Blue Care Network
   P.O. Box 68710
   Grand Rapids MI 49516-8710

   BCN Advantage
   - OR -
   Blue Cross Complete
   P.O. Box 68753
   Grand Rapids MI 49516-8753

For additional information on how to complete the form, professional providers should review the *Status Claim Review Form example* available at web-DENIS > BCN Provider Publications and Resources > Billing > **Status Claim Review Form example**.

Professional providers only: obtaining the paper form

A copy of the front page of the *Status Claim Review Form* (without the BCBSM back-page instructions) is available at web-DENIS BCN Provider Publications and Resources > Billing > **Status Claim Review Form**.

Note: To order large quantities of the *Status Claim Review Form*, providers should complete and fax or mail the *BCBSM Professional and Facility Supply Requisition Form*. This can be found at **MiBCN.com** > I am a provider > Provider Supply Forms > BCN Providers > **Use the Facility and Professional Provider Supply Requisition Form**.

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

UB-04 claim examples – outpatient

Status inquiry claim: outpatient, TOB 7

This claim example illustrates a status inquiry claim sent by a facility provider to request that BCN reconsider a denial on the original claim.

When completing the UB-04 with a TOB 7, providers must rebill all services that were performed on a specific date of service and communicate any corrections.

For additional information, providers should refer to the "Resubmitting a claim for inquiry" section of the *Claims* chapter of the *Blue Care Network Provider Manual*.

Form locator	Description	What to enter
4	TYPE OF BILL	Enter the appropriate outpatient type of bill code ending in 7, to indicate replacement of a prior claim.
54	PRIOR PAYMENTS	Enter the payment amount the provider has received toward payment of this bill prior to this billing date by the payer indicated.
64	DOCUMENT CONTROL NUMBER	Enter the 12-digit BCN claim number located on the original or previous Remittance Advice for the service in question.
80	REMARKS	Indicate the reason for resubmission.

Note: If any of the information presented here conflicts with the BCN provider contract, the contract language should be followed.

Guidelines for reviewing the claim examples: The entire claim must be completed before it is sent to BCN for processing. It is not possible to show examples of all types of claims, so providers may need to reference multiple examples to obtain the information needed to properly complete a claim.

Where appropriate, providers should substitute their own billing information. For example, a claim submitted for a different type of facility or classification will have a different type of bill (form locator 4) than that shown in the example. In all cases, providers should refer to the *National UB-04 Manual* for a detailed description of each form locator.

continued on next page

In Box 4 (Type of Bill), enter "7."

In Box 64, enter original claim number.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															a
b															b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE _____ OF _____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC a		
		b		
		c		
		d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	