

The Claim Inquiry Resolution (CIR) tool enables providers to submit claim reconsideration requests electronically for certain finalized claims.* This tool can be used as an alternative option to requesting claim adjustments over the phone or via the Blue Cross and Blue Shield of Oklahoma (BCBSOK) Claim Review Form. Also, this tool reduces administrative costs by decreasing the amount of correspondence that must be sent through the mail.

Note: The Claim Inquiry Resolution cannot be used to obtain eligibility and benefit information or claim status. Moreover, it is not a means to submit formal claim appeals or predeterminations. Users can employ this tool for finalized claims that require review relating to reasons outlined in this guide.

**The CIR tool is unavailable for Medicare Advantage claims.*

1) Getting Started

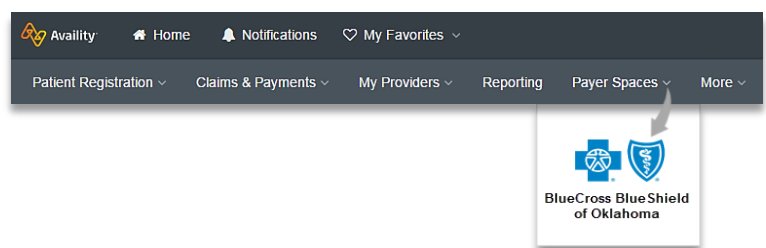
- ▶ Go to [Availity](#)
- ▶ Select [Availity Portal Login](#)
- ▶ Enter User ID and Password
- ▶ Select [Log in](#)



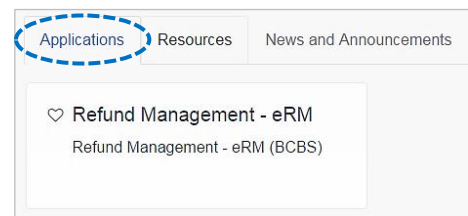
Note: Only registered Availity users can access Claim Inquiry Resolution.

2) Accessing Claim Inquiry Resolution

- ▶ Select [Payer Spaces](#) from the navigation menu
- ▶ Choose [Blue Cross and Blue Shield of Oklahoma](#)



- ▶ In BCBSOK Payer Spaces, select the [Applications](#) tab
- ▶ Next, select [Refund Management - eRM](#)



Notes:

- Contact your Availity Administrator if [Refund Management – eRM](#) is not listed in the Applications menu. Identify your Availity Administrator by referring to [My Administrators](#) under [My Account Dashboard](#) on the Availity home page.
- New users must complete the onboarding form and email verification in order to gain access to the eRM system.

3) Starting a New Inquiry

- ▶ Select the **Claim Inquiry Resolution** tab
- ▶ Select **Create New Claim Inquiry**

Refund Requests	InBox	Claim Inquiry Resolution	Check Alerts	Saved Sessions	Checks Not Received	Transaction Report	Maintenance Alerts
Appeal Id	DCN	User Name	Submission Date	Last Response Date	Last Response User	Patient Name	Patient Account
C123456789	123456789000X	JANE DOE	05/20/2020	05/21/2020	HCSC User	JANE DOE	999999999
C123456790	999999999999X	JANE DOE	05/20/2020	05/21/2020	HCSC User	JANE DOE	999999999
C123456791	222222222222X	JANE DOE	05/20/2020	05/21/2020	HCSC User	JANE DOE	999999999

Buttons: Refresh, Create New Claim Inquiry

4) Entering Claim Information

- ▶ For the NPI #, select the appropriate Type 2 Billing NPI from the drop-down list
- ▶ Enter the **13-digit claim number**
- ▶ Select the most applicable reason from the **Claim Inquiry Reason Codes** drop-down list*
- ▶ Select **Continue**

*Reference [page 5](#) for a detailed listing of each Claim Inquiry Reason Code.

Claim Inquiry Information

* = required

NPI #*:

Pfin Type:

Claim Number*:

Claim Inquiry Reason Codes*: [Look Up Claim](#)

Buttons: Continue, Cancel, [Show More Fields](#)

-Select a Reason-

- MEDICARE/OTHER INSURANCE EOB
- DUPLICATE DENIAL
- ADDITIONAL INFORMATION
- FEE SCHEDULE/PRICING INQUIRY
- ELIGIBILITY
- FEDERAL GROUP
- PRE-AUTHORIZATION DENIAL
- I-BILL - (HOST) PREPAY HIGH DOLLAR REVIEW

Quick Tips:

- If your claim was processed within the last 18 months, select **Look Up Claim** to populate the Subscriber ID, Group Number, Patient Account, Patient Name and Date of Service on the next screen.
- If your claim processed prior to 18 months, select **Show More Fields** to manually enter this information on the next screen.

5) Supporting Comments and Documentation

- ▶ In the **Comments** field, provide a thorough explanation as to why the claim should be reconsidered.
- ▶ Additional BCBSOK claim numbers for the same patient/issue that need reconsidered, can be listed in the **Additional Claims** section.
- ▶ Supporting documentation is only required if **Medicare / Other Insurance EOB** or **Additional Information** is chosen as the Claim Inquiry Reason Code. However, our staff may request additional information when necessary to continue reconsideration of a claim.
- ▶ There are two options for sending supporting documentation to BCBSOK:
 - ▶ Select the **Add File** and **Browse** buttons to upload applicable document(s)
 - ▶ Select **I will fax my supporting documentation** to fax applicable documentation*
- ▶ Select **Continue** to review your inquiry, then select **Submit**.

* A fax cover sheet (including the fax number) will be available for printing after the **Submit** button is selected. This fax cover sheets includes a bar code to help ensure the information you send is matched directly to the appropriate file and/or claim.

The screenshot displays the 'Claim Inquiry Information' form. Fields include NPI # (1234567890 - ABC HOSPITAL), Pfin Type (Facility), Claim Number (020209999999999999X), Claim Inquiry Reason Codes (MEDICARE/OTHER INSURANCE EOB), Group Number (123456), Subscriber ID (999999999), Patient Account (999999999), Patient First Name (JANE), Patient Last Name (DOE), and Date of Service (12/11/2020 to 12/11/2020). The 'Comments' field contains the text: 'Claim denied per Medicare EOB requested. Please see the attached EOB and review the claim for reprocessing.' The 'Supporting Documentation' section has an 'Add File' button and a checkbox for 'I will fax my supporting documentation'.

Quick Tip:

→ When uploading supporting documentation, users can add multiple attachments, with a total file size of 2GB. Individual file size should not exceed 25 MB. Acceptable file types are TIFF (.tif) and PDF (.pdf).

6) Claim Inquiry Tracking ID

- ▶ After the inquiry has been submitted, a **Claim Inquiry Tracking ID** will be provided for monitoring purposes.*

Your Claim Inquiry Tracking ID is C000000053

*The Tracking ID is only for reference within the Claim Inquiry Resolution. **BCBSOK Phone Customer Advocates do not utilize this tool.**

7) Tracking Inquiries

- ▶ Once a claim inquiry has been submitted, users can monitor BCBSOK’s receipt and response by returning to the [Claim Inquiry Resolution](#) tab.
- ▶ The **Last Response Date** and **Last Response User** fields display the date of the last action taken on an inquiry and by whom.
- ▶ Select the column headers to sort these fields in ascending and descending order.
- ▶ When HCSC is listed as the Last Response User, click the [details](#) link to view BCBSOK’s response to the inquiry.

Refund Requests	InBox	Claim Inquiry Resolution	Check Alerts	Saved Sessions	Checks Not Received	Transaction Report	Maintenance Alerts	
Appeal Id	DCN	User Name	Submission Date	Last Response Date	Last Response User	Patient Name	Patient Account	
C000000053	020209999999999999X	Jane Doe	01/02/2021	01/05/2021	HCSC User	J DOE	9999999999	details
C000000011	020209999999999911X	Linda Doe	01/05/2021	01/05/2021	LINDA DOE	J DOE	9999999999	details
C000000022	02020999999999922X	Rhonda Doe	01/02/2021	01/05/2021	HCSC User	J DOE	9999999999	details

8) Advanced Filtering

- ▶ Users may also utilize the filter option to search by a specific **Appeal ID Number** (i.e., C000000053).*
- ▶ Select **Advanced Options** to sort results by a specific username, patient name, account number, etc.

* The Appeal ID Number is the same as the Claim Inquiry Tracking ID.

Filter

Select Multiple NPIs (Ctrl+Click)

1234567890 - ABC HOSPITAL

1234567899 - HOLMES CLINIC

Appeal #

9) Verifying Responses

- ▶ The details screen will display the comments entered on the original inquiry submission as well as BCBSOK’s response.

Claim Inquiry Details for C000000053

Claim Inquiry Information

Claim Number 020209999999999999X	NPI Number / Provider Name 1234567890 - ABC HOSPITAL	Claim Inquiry Reason MEDICARE/OTHER INSURANCE EOB
Group Number 123456	Subscriber ID 9999999999	Service Dates 12/11/2020 - 12/11/2020
Patient Account 9999999999	Patient Name JANE DOE	

Correspondence

[Hide All](#)

ERM User On 12/31/2020 08:55

Claim denied per Medicare EOB requested. Please see the attached EOB and review the claim for reprocessing. [Print fax cover sheet](#)

HCSC User On 01/05/2021 09:14

Thank you for the inquiry. The requested documentation has been received and the claim has been adjusted. For claim status, please use the Claim Status Tool in Availity or your preferred web vendor.

[Return to Home](#)

Quick Tip:

→ Open a new CIR inquiry to request clarification or additional updates on the original inquiry.

Inquiry Reason Codes

Inquiry Reason Code	Purpose	Guidelines
Medicare or Other Insurance EOB	Send Medicare or another insurance’s Explanation of Benefits (EOBs) to BCBSOK.	<ul style="list-style-type: none"> Attach documents via Add File or I will fax my supporting documentation. Use the Comments field to indicate if EOBs will be uploaded or faxed. <p><i>Note: The EOB must be supplied in order for the inquiry to be processed.</i></p>
Duplicate Denial	Dispute claims that deny as duplicate in error.	<ul style="list-style-type: none"> Indicate any previous claim number(s) that may have triggered the duplicate denial. Include explanation specifying how the claims are different.
Additional Information	Submit specific information that was requested in the claim denial. <ul style="list-style-type: none"> Medical records Operation Reports Physician Notes, etc. 	<ul style="list-style-type: none"> Attach documents via Add File or I will fax my supporting documentation. Use the Comments field to indicate if documentation has been uploaded or faxed.
Fee Schedule / Pricing Inquiry (Professional providers)	Inquire on claims that process differently than contractual agreements.	<ul style="list-style-type: none"> Use the Comments field to indicate which specific line item did not process correctly.
Eligibility	Dispute claims that deny for non-eligible services or process differently than the eligibility quote that was previously received.	<ul style="list-style-type: none"> Include eligibility and benefit call reference numbers in the Comments field. Attach screen prints of online eligibility and benefit verification via the Add File or I will fax my supporting documentation. Use the Comments field to indicate if documentation has been uploaded or faxed.
Federal Group	Submit finalized claim inquiries pertaining to Federal Employee Program® (FEP®) members.	<ul style="list-style-type: none"> Attach documents via the Add File or I will fax my supporting documentation. Use the Comments field to indicate if documentation has been uploaded or faxed.
Pre-Authorization Denial	Request review of claims that deny for preauthorization when it was not advised as a requirement during the patient’s eligibility and benefit quote.	<ul style="list-style-type: none"> Supply preauthorization number for claims that deny per no record on file. Include eligibility and benefit call reference numbers or use the Add File or I will fax my supporting documentation functions to submit online eligibility and benefit screen prints. Use the Comments field to indicate if documentation has been uploaded or faxed.
I-Bill - (HOST) Prepay High Dollar Review	Submit inpatient itemized bill for any BlueCard® member billed at or more than \$100,000.	<ul style="list-style-type: none"> Attach documents via Add File or I will fax my supporting documentation. Use the Comments field to indicate if itemized bills have been uploaded or faxed.

Have questions or need additional education? Email the [Provider Education Consultants](#).

Have questions about the eRM Onboarding process? Email the [eRM Onboarding team](#).

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