

The Claim Research Tool (CRT) is the recommended method for providers to acquire status on claims processed by Blue Cross and Blue Shield of Oklahoma (BCBSOK).\*

Organizations can improve their accounts receivable by utilizing this exclusive BCBSOK feature to check status for local, federal and out-of-state claims processed. Results are available in real-time and provide the equivalent of a Provider Claim Summary (PCS).

The CRT is currently unavailable for government programs (Medicare Advantage) claims. To verify status online for these claims, use the Claim Status (276 transaction) inquiry on the Availity portal, or your preferred web vendor.

*\*To obtain status on claims not processed by BCBSOK, users should contact the appropriate claim processing entity directly (i.e., third-party vendors, other carriers, etc.).*

## 1) Getting Started

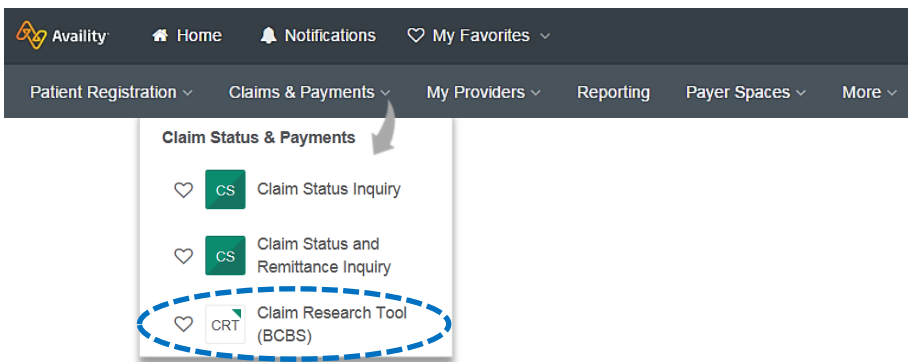
- ▶ Go to [availity.com](http://availity.com)
- ▶ Select **Availity Portal Login**
- ▶ Enter User ID and Password
- ▶ Select **Log in**

**Note:** Only registered Availity users can access the Claim Research Tool. If you are not a registered Availity user, you may complete the guided online registration process at [availity.com](http://availity.com) – at no charge.



## 2) Accessing CRT

- ▶ Select **Claims & Payments** from the navigation menu
- ▶ Select **Claim Research Tool (BCBS)**



**Note:** Contact your Availity administrators if **Claim Research Tool** is not listed in the **Claims & Payments** menu.

### 3) Submitting Transactions

Claim status may be obtained using a Patient ID or Claim Number (also referred to as Document Control Numbers – DCN). Both options are illustrated in this step.

#### Searching by Patient ID:

- ▶ Select **Patient ID** from the **Search Option** drop-down list
- ▶ Choose the Billing (Type 2) NPI from the **Express Entry** drop-down list or enter **NPI**
- ▶ Enter **Patient ID** (include the three-character prefix before the ID number)
- ▶ Enter **Group Number**
- ▶ Enter **Service Period** dates
- ▶ Select **Submit**

## Claim Research Tool [Learn More >>](#)

\* indicates a required field

\* Payer: ?

\* Search Option: ?

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#### Billing Provider Information

Express Entry - Provider: ?

\* NPI: ?

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#### Patient Information

\* Patient ID: ?

\* Group Number: ?

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#### Claim Information

\* Service Period: ? From  /  /  To  /  /

MM DD YYYY MM DD YYYY

**Quick Tip:**  
→ The **Payer** field will default to **BCBSOK** and cannot be changed.

#### Helpful Hints:

- Federal plans do not have a three-character prefixes. The letter R should be typed as part of the Patient ID (i.e., R87654321). Enter the Group Number as OFEPOK.
- Out-of-state plans may contain more than three-characters (e.g., WMWAN1234567). Enter the Group Number as 123456.

### 3) Submitting Transactions *(continued)*

#### Searching by Claim Number (DCN):

- ▶ Select **Claim Number** (DCN) from the **Search Option** drop-down list
- ▶ Choose the Billing (Type 2) NPI from the **Express Entry** drop-down list or enter **NPI**
- ▶ Enter the 13-digit alpha numeric claim number in the **Claim # (DCN)** field
- ▶ Select **Submit**

### Claim Research Tool

\* indicates a required field

\* Payer: ?

\* Search Option: ?

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**Billing Provider Information**

Express Entry - Provider: ?

\* NPI: ?

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**Claim Information**

\* Claim # (DCN): ?

#### Helpful Hints:


- To search for an adjusted or reprocessed claim, key the corresponding 2-digit suffix in addition to the 13-digit claim number (i.e., 999999999999X01).
- If copying and pasting the claim number from another document or program, be sure to delete any additional spaces.

### 4) Search Results

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

**Note:** The information returned will include original, duplicate, adjusted, withdrawn and replacement claims.

## Search Results [Learn More >>](#)

Payer:	BCBSOK	 <p><b>BlueCross BlueShield of Oklahoma</b></p>	
Provider NPI:	9999999999		
Member ID:	ABC999999999		
Group Number:	123456		Service Period: 01/01/2019 – 09/13/2019

**Claims Found**

From Service Date	Processed Date	Claim Number	Billed Amount	Status
05/05/2019	05/07/2019	999999999991X00	\$247.38	Paid
08/22/2019	08/28/2019	999999999992X00	\$107.72	Paid

## 5) Detailed Search Results

The following information is returned after the corresponding claim number is selected and/or the Claim Number search is completed:

- Claim Number
- Received Date
- Processed Date
- Claim Status
- Billed Amount
- Paid Amount
- Coinsurance
- Co-Pay / Deductible Amount
- Ineligible Amount(s)
- Check/EFT/Voucher
- Check Date
- Payee Name
- Health Care Account Amount
- Other Carrier / Medicare Paid Amount
- Patient Share Amount (total)
- Billing Provider ID / Name
- Rendering Provider ID / Name
- Line Item Breakdown:
  - Service Dates
  - Revenue / Procedure Code
  - Diagnosis
  - Ineligible Reason Code / Amount
  - Copay / Coinsurance / Deductible
  - Modifier
  - Unit, Time, or Mile
  - Ineligible Reason Code Descriptions

### Detail Search Results [Learn More >>](#)

Edit Inquiry Print

**Patient Name:** DOE, JANE  
**Member ID:** 999999999  
**Alphanumeric Prefix:** ABC  
**Gender:** F  
**Group #:** 123456  
**Date of Birth:** 12/20/1956

**BlueCross BlueShield  
of Oklahoma**

**Subscriber Name:** DOE, JOHN  
**Relationship To Subscriber:** Spouse  
**Patient Account #:** 1123456

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**Claim Details** [View Less](#)

<b>Claim Number:</b> 99999999992X00	<b>Claim Status:</b> Paid
<b>Received Date:</b> 08/23/2019	<b>Billed Amount:</b> \$107.72
<b>Processed Date:</b> 08/28/2018	<b>Paid Amount:</b> \$25.36
<b>From Service Date:</b> 08/22/2019	<b>Coinsurance:</b> \$0.00
<b>To Service Date:</b> 08/22/2019	<b>Co-Pay/Deductible Amount:</b> \$0.00
<b>Status Details:</b>	<b>Ineligible Amount:</b> \$82.36
<b>Hospital Payment Indicator:</b>	<b>DRG Code:</b>
<b>Approved Length of Stay:</b>	<b>DRG Version:</b>
	<b>DRG Weight:</b>

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<b>Check/EFT/Voucher:</b> E9999999	<b>Billing Provider ID:</b> 9999999999
<b>Check Date:</b> 08/30/2019	<b>Billing Provider Name:</b> ABC CLINIC
<b>Payee Name:</b> ABC CLINIC	<b>Rendering Provider ID:</b> 1999999999
<b>Prior Paid AMT:</b> \$0.00	<b>Rendering Provider Name:</b> JAMES JOE
<b>Prior Notification Deductible: ?</b> \$0.00	<b>Additional Pay:</b> \$0.00
<b>Health Care Account Amount:</b> \$0.00	<b>Prior Notification Coinsurance: ?</b> \$0.00
<b>Other Carrier Paid:</b> \$0.00	<b>Out of Network Deductible:</b> \$0.00
<b>Patient Share Amount:</b> \$0.00	<b>Out of Network Coinsurance:</b> \$0.00
<b>Medicare Paid Amount:</b> \$0.00	

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**Service Lines** [View Code Audit Rationale](#)

Service Dates	Revenue/Proc Code	Diagnosis Code	Billed Amt	Paid Amt	Ineligible Reason Code /Amt	Interim Discount	Copay	Coinsurance	Deductible	HCPCS Code	Modifier	Unit/ Time/ Mile
08/22/2019 -08/22/2019	36415	Z3483	\$20.00	\$0.00	V25/ \$20.00	\$0.00	\$0.00	\$0.00	\$0.00		59	1
08/22/2019 -08/22/2019	86703	Z3483	\$55.96	\$10.36	T42/ \$45.62	\$0.00	\$0.00	\$0.00	\$0.00			1
08/22/2019 -08/22/2019	85025	Z3483	\$31.74	\$15.00	T42/ \$16.74	\$0.00	\$0.00	\$0.00	\$0.00			1

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**Ineligible Reason Codes**

Code	Description
V25	Services have been unbundled. Please resubmit using appropriate code. The information submitted on the claim is inconsistent with current coding protocol. Patient cannot be billed for the disallowed code.
T42	Charge exceeds the priced amount for this service. Services provided by a Participating/Network Provider. Patient is not responsible for charges over the priced amount.

Edit Inquiry Print

**Quick Tip:**  
→ Refer to [page 5](#) to learn about Cotiviti, INC. code audit rationale.

## 5) Detailed Search Results (continued)

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

- ▶ Select **View Code Audit Rationale** above the service line section (displayed on previous page)
- ▶ 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** to collapse the expanded denial logic.

Service Lines  Hide Code Audit Rationale

Service Dates	Revenue/Proc Code	Diagnosis Code	Billed Amt	Paid Amt	Ineligible Reason Code/Amt	Interim Discount	Copay	Coinsurance	Deductible	HCPCS Code	Modifier	Unit/ Time/ Mile
08/22/2019 -08/22/2019	36415	Z3483	\$20.00	\$0.00	V25/ \$20.00	\$0.00	\$0.00	\$0.00	\$0.00		59	1
Parameter Type		Created Line Indicator		Action		Procedure Code		Modifier Code		Unit Count		
Action Required		Submitted on Claim		Not Reimbursable		36415				1		
Edit Source: Payer						Edit Location: Payer Policy						
Cotiviti Edit Description: THE LAB CODE 85025 INCLUDES THE SERVICE DESCRIBED BY 36415, THEREFORE 36415 IS NOT REIMBURSABLE.												
Cotiviti Edit Rationale: Per payer policy, laboratory services, when billed by the doctor, includes the blood drawing/collection associated with the service.												
08/22/2019 -08/22/2019	86703	Z3483	\$55.98	\$10.36	T42/ \$45.62	\$0.00	\$0.00	\$0.00	\$0.00			1
08/22/2019 -08/22/2019	85025	Z3483	\$31.74	\$15.00	T42/ \$16.74	\$0.00	\$0.00	\$0.00	\$0.00			1

**Ineligible Reason Codes**

Code	Description
V25	Services have been unbundled. Please resubmit using appropriate code. The information submitted on the claim is inconsistent with current coding protocol. Patient cannot be billed for the disallowed code.
T42	Charge exceeds the priced amount for this service. Services provided by a Participating/Network Provider. Patient is not responsible for charges over the priced amount.

### Additional Action(s) for Applicable Ineligible Reason Codes:

- ▶ View **Additional Action(s)** in the Ineligible Reason Code section 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.

Service Lines

Service Dates	Revenue/Proc Code	Diagnosis Code	Billed Amt	Paid Amt	Ineligible Reason Code/Amt	Interim Discount	Copay	Coinsurance	Deductible	HCPCS Code	Modifier	Unit/ Time/ Mile
09/04/2019 -09/04/2019	99213	L84, R2681	\$168.76	\$0.00	269/ \$168.76	\$0.00	\$0.00	\$0.00	\$0.00			1

**Ineligible Reason Codes**

Code	Description	Additional Action(s)
269	This service is not covered for this diagnosis.	Verify the correct diagnosis was billed. If the claim was coded/billed incorrectly, submit an electronic replacement claim with billing frequency code 7. View tip sheet for more information on submitting replacement claims electronically. <a href="https://www.bcbsok.com/pdf/submitting-replacement-corrected-claims-ok.pdf">https://www.bcbsok.com/pdf/submitting-replacement-corrected-claims-ok.pdf</a>

## Transaction Tips

### How to avoid a “Claim Not Found” response:

- The Type 2 Billing NPI must match the NPI submitted on claim.
- Enter the three character prefix prior to the member’s identification number in the Patient ID field.
- For local policies, the group number matches what was submitted on the claim.
- The date span entered as the Service Period includes the actual date(s) of service.

### Institutional Claims:

- Paid amounts reflected on the Detail Search Results screen indicates reimbursements applied per individual provider contracts (e.g., Per Diem, DRG, etc.).
- Itemized payments listed in the line item breakdown will equal the total paid amounts indicated on Provider Claim Summaries (PCS) and Electronic Remittance Advices (ERA).

### If...

- All line items are not displayed on the Detail Search Results screen, click the More Results link.
- The Detail Search Results screen prints are distorted, adjust the Page Orientation (in Print Settings) to landscape.
- The check number is not present on a finalized claim (see below), please allow additional time. The system reflects check information based on the payment schedule of the provider.

Check / EFT / Voucher:

Check Date: 06/09/2019

Payee Name: ABC Clinic

**Have questions or need additional education?** Email the Provider Education Consultants at [PECS@bcbsok.com](mailto:PECS@bcbsok.com)

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

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