BLUERIDE

AVAILITY ESSENTIALS PROFESSIONAL CLAIM SUBMISSION

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- Professional claim submission form
  - This document will cover professional claim submission details specific to BlueRide Non-Emergency Transportation providers.

**YOU WILL NEED TO COMPLETE REGISTRATION PRIOR TO ACCESSING THIS INFORMATION. IF YOU HAVE NOT FINISHED THE REGISTRATION PROCESS, COMPLETE THAT FIRST, THEN RETURN TO THIS DOCUMENT

SUBMITTING A CLAIM

Information you should have ready before beginning to enter a claim:

- Organization, if you have more than one to choose from
- Payer name – BlueRide Non-Emerg Transportation
- Patient information – If you do an Eligibility & Benefit Inquiry prior to starting the claim the member data will populate the claim submission screen
  - Name
  - Date of birth
  - Gender
  - Address
  - Subscriber/Member ID

SUBMITTING A CLAIM, CONTINUED

- Provider billing information – Enter this information in Manage My Organization to use the drop-down list to select a provider on the claim submission screen
  - Organization/Provider Name
  - Phone number
  - Address
  - Specialty/taxonomy code
  - NPI or UMPI, **if UMPI is used then it is required to be entered in Manage My Organization**
  - Tax ID

SUBMITTING A CLAIM, CONTINUED

- Diagnosis Code
  - ICD10 code R68.89 can be used
  - Do not enter the decimal point in the claim form (e.g., R6889)

- Claim level information
  - Authorization/Trip number is required
  - Patient Control Number (this is any number you use in your system to track services for the patient)
  - Place of Service, use 99 or 41 to allow for the pickup and drop-off addresses to be entered.
  - Pickup address
  - Drop-off address

SUBMITTING A CLAIM, CONTINUED

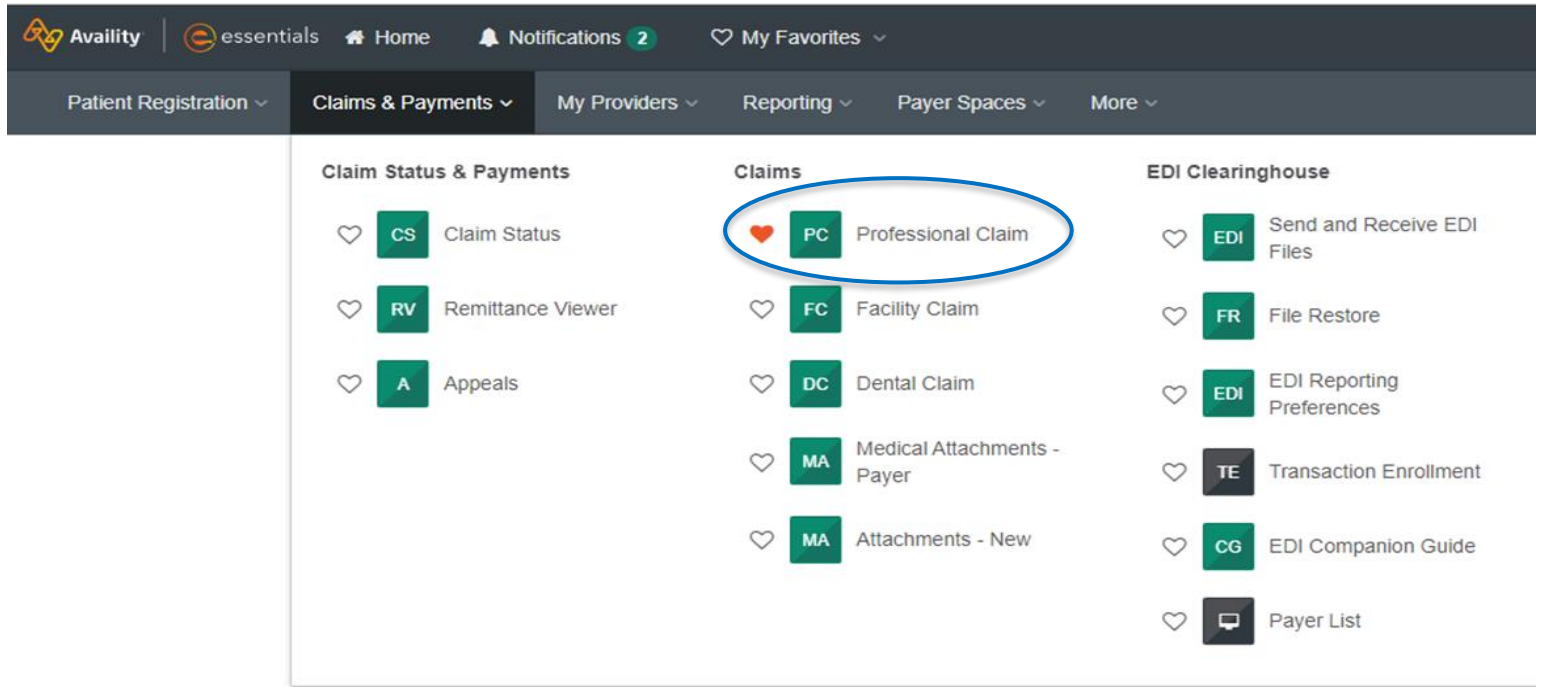
- Line Information
  - Date of service
    - Only bill dates of service in the same month on the same claim.
  - Procedure code
  - Description, for applicable procedure codes
  - Modifier, as applicable
  - Charge
  - Number of units

For additional information use this link from MN DHS.

https://www.dhs.state.mn.us

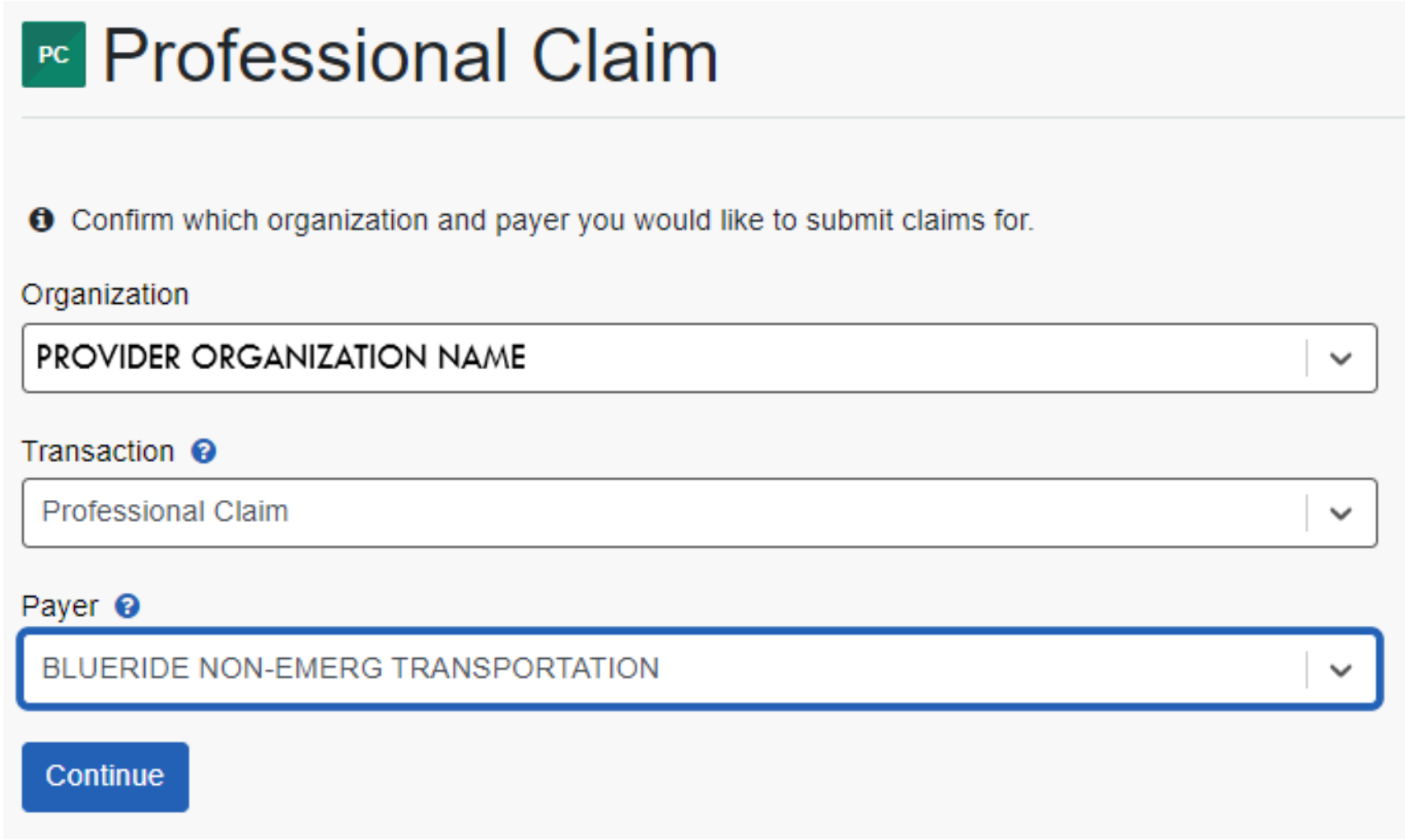
SUBMITTING A CLAIM, CONTINUED

To open Submit a Claim, go to the “Claims & Payments” drop down menu, choose “Professional Claim”

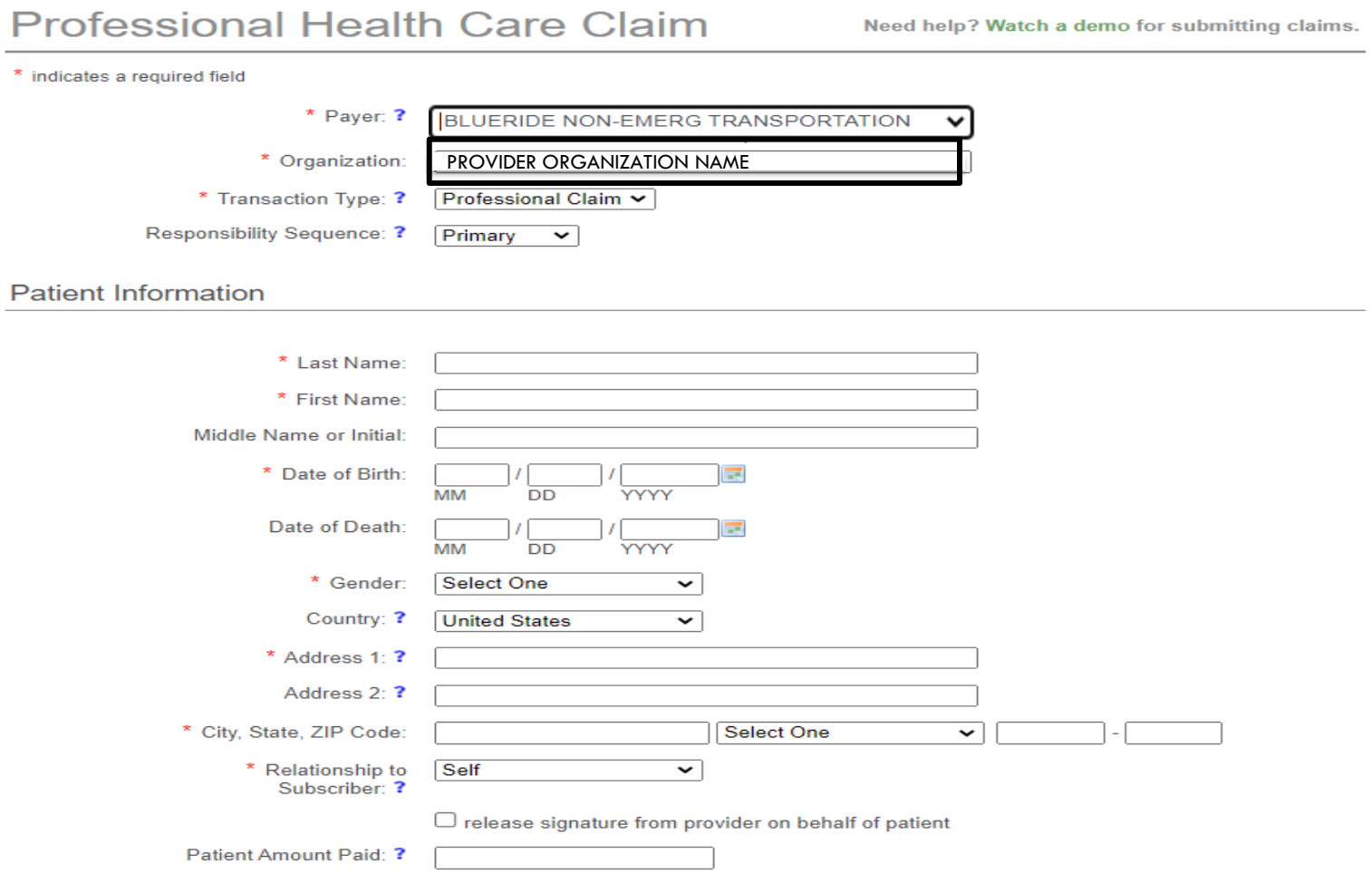


TIP: Click ♥ to add to favorites for quicker access in the future.

PROFESSIONAL CLAIM FORM



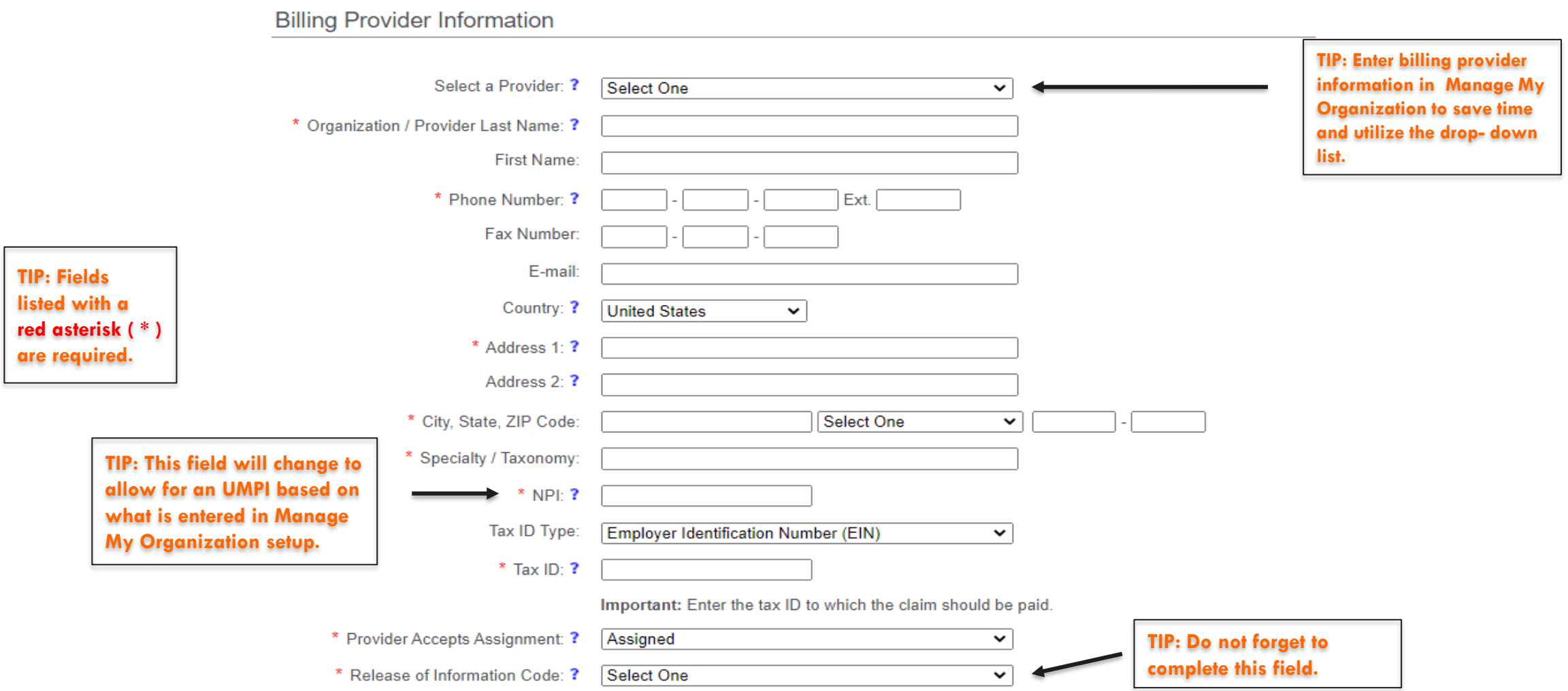
PROFESSIONAL CLAIM FORM, CONTINUED



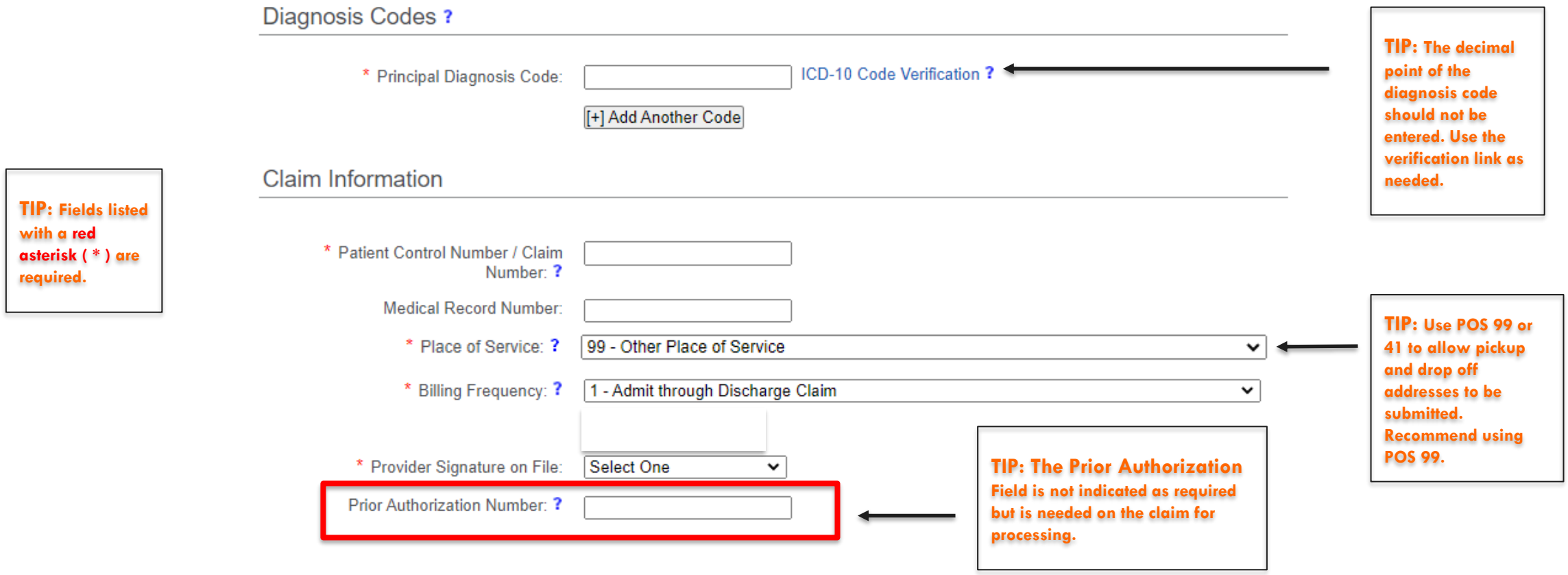
TIP: Submit an E&B Inquiry before opening the claim form. Patient information will populate from the E&B response.

TIP: Fields listed with a red asterisk (*) are required.

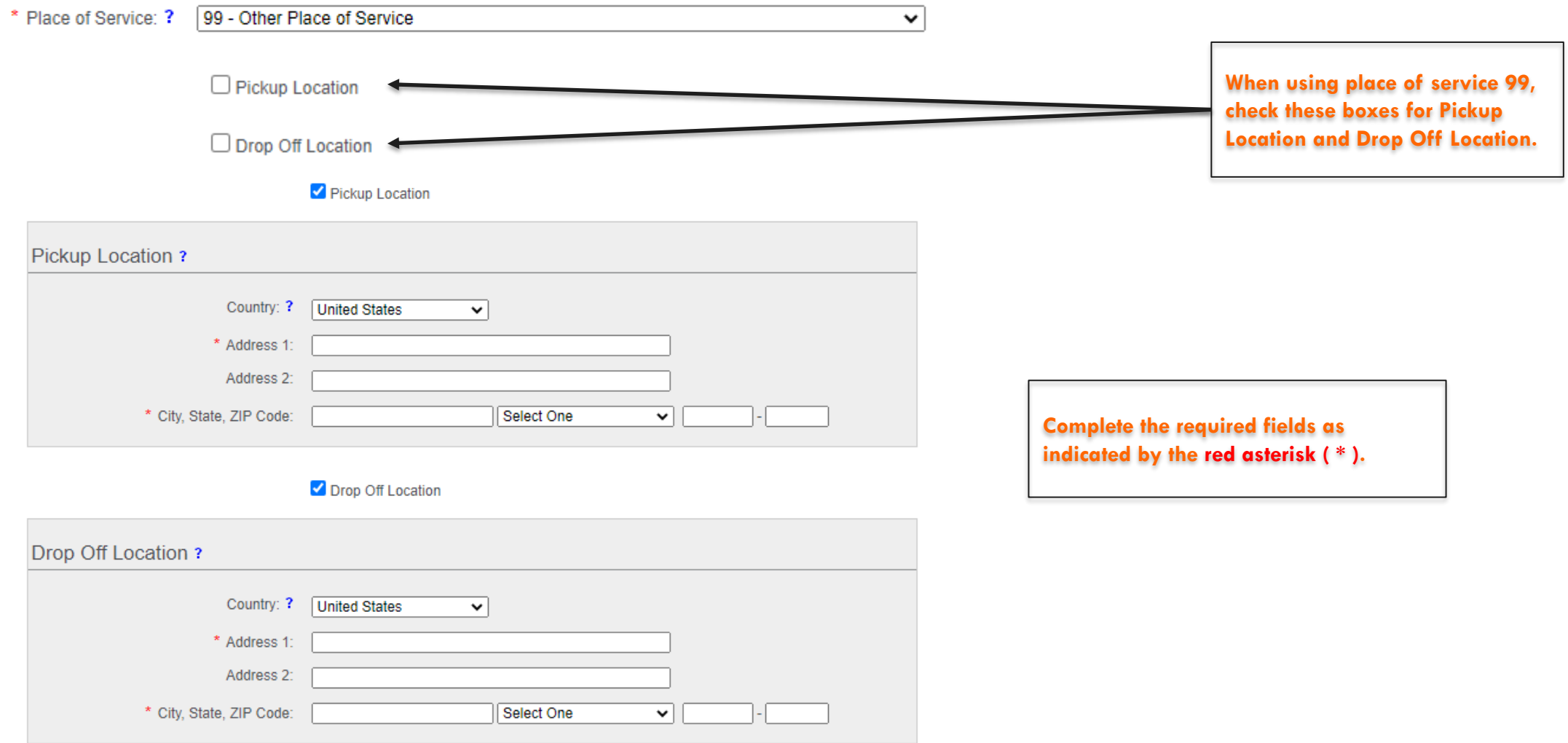
PROFESSIONAL CLAIM FORM, CONTINUED



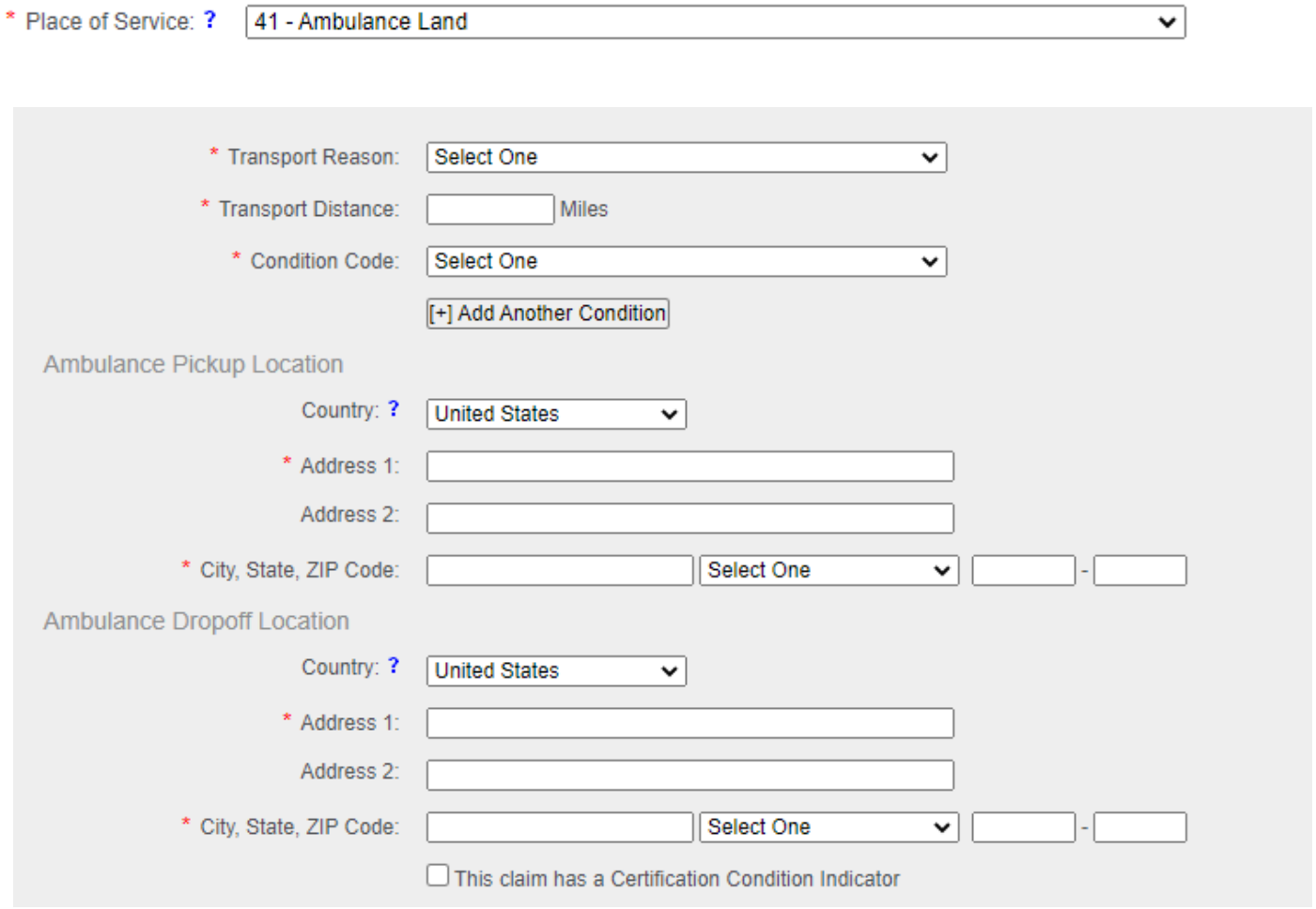
PROFESSIONAL CLAIM FORM, CONTINUED



PROFESSIONAL CLAIM FORM, CONTINUED POS 99



PROFESSIONAL CLAIM FORM, CONTINUED POS 41



When using place of service 41, the following fields will appear. Fields listed with a red asterisk (*) are required.

Transport Reason – any reason is allowed; recommendation would be Patient was transported for the benefit pf a preferred physician

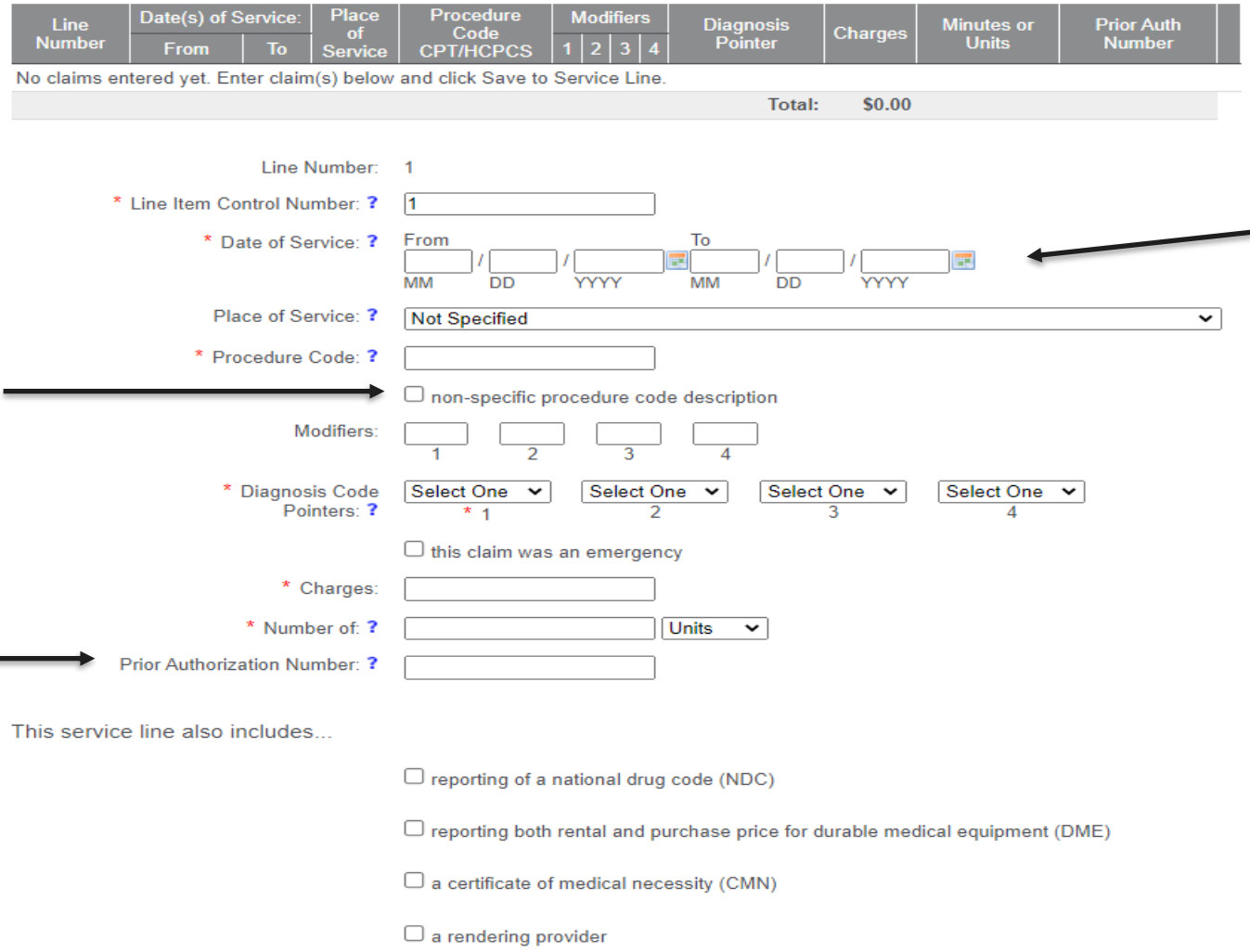
- Select One
- Patient was transported to nearest facility for care of symptoms, complaints, or both
- **Patient was transported for the benefit of a preferred physician**
- Patient was transported for the nearness of family members
- Patient was transported for the care of a specialist or for availability of specialized equipment
- Patient transferred to Rehab facility

Transport Distance - enter the number of miles being submitted on the claim.

Condition Code - any reason is allowed; recommendation would be Ambulance service is medically necessary.

- Select One
- Patient was admitted to the Hospital
- Patient was moved by stretcher
- Patient was unconscious or in shock
- Patient was transported in an emergency situation
- Patient had to be physically restrained
- Patient had visible hemorrhaging
- **Ambulance service was medically necessary**
- Patient is confined to a bed or chair

PROFESSIONAL CLAIM FORM, CONTINUED



Line Number	Date(s) of Service: From	To	Place of Service	Procedure Code CPT/HCPCS	Modifiers 1	2	3	4	Diagnosis Pointer	Charges	Minutes or Units	Prior Auth Number
No claims entered yet. Enter claim(s) below and click Save to Service Line.												
									Total:	$0.00		

Line Number: 1

* Line Item Control Number: ? 1

* Date of Service: ? From MM / DD / YYYY To MM / DD / YYYY

Place of Service: ? Not Specified

* Procedure Code: ?

☐ non-specific procedure code description

Modifiers: 1 2 3 4

* Diagnosis Code Pointers: ? Select One * 1 | Select One 2 | Select One 3 | Select One 4

☐ this claim was an emergency

* Charges:

* Number of: ? Units

Prior Authorization Number: ?

This service line also includes...

☐ reporting of a national drug code (NDC)

☐ reporting both rental and purchase price for durable medical equipment (DME)

☐ a certificate of medical necessity (CMN)

☐ a rendering provider

Save to Service Line

TIP: For procedure code A0999 with TP modifier, check this box to open a free-form text field to allow the description to be entered. (e.g., deadhead, no show).

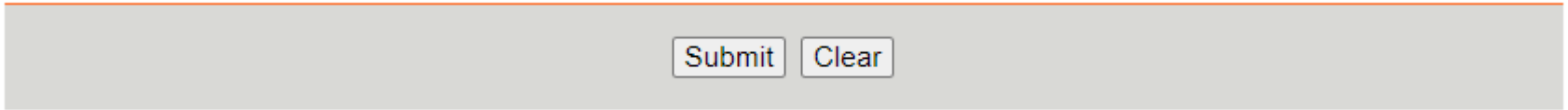
TIP: Only bill dates of service in the same month on the same claim.

TIP: If the line number Prior Authorization number is different then the Claim Level enter the Prior Authorization Number in this field.

TIP: Do not forget to click the "Save to Service Line" button after each line needing to be submitted

PROFESSIONAL CLAIM FORM, CONTINUED

After all claim lines have been added, click the “Submit” button



YOU WILL RECEIVE A CLAIM RESPONSE DETAIL.

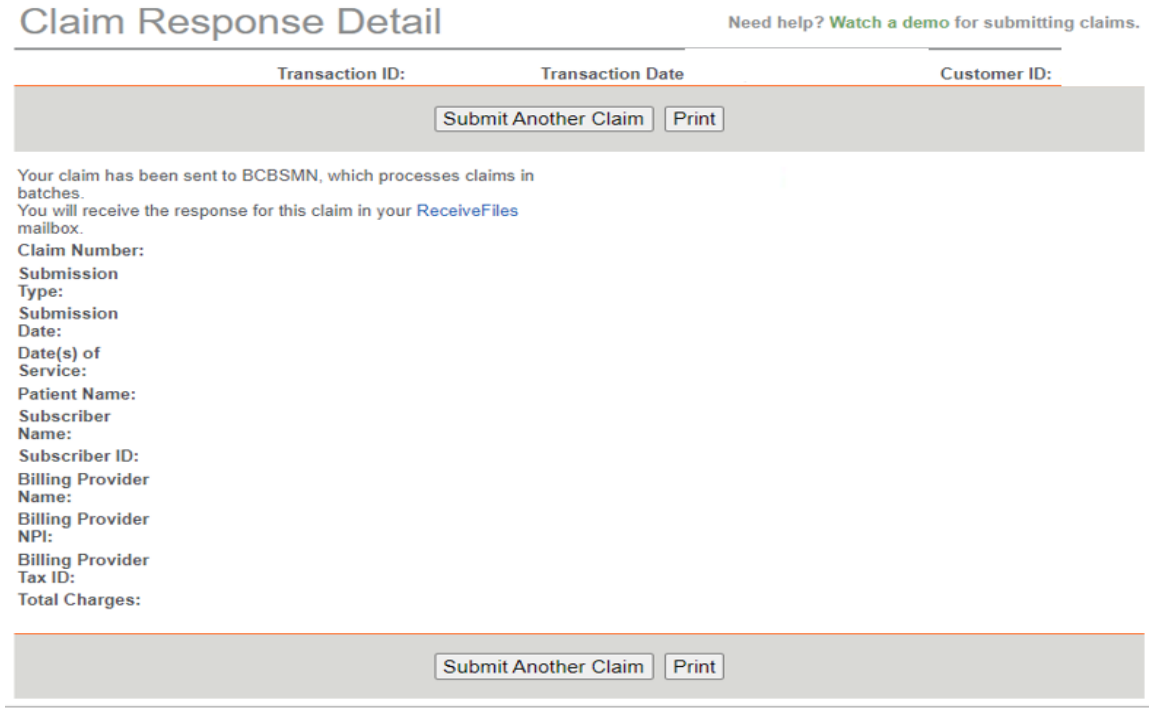
THIS ONLY MEANS THE CLAIM PASSED ALL PORTAL EDITS

AND WILL BE SENT TO THE PAYER FOR THE NEXT STEP

IN PROCESSING THE CLAIM.

YOU CAN EITHER PRINT/SAVE THIS CLAIM RESPONSE

DETAIL OR FIND IT IN YOUR SEND/RECEIVE EDI FILES.



PROFESSIONAL CLAIM FORM, CONTINUED

After a claim response detail is received, the payer will send a 277CA (Claim Acknowledgement) with an accepted or rejected message.

- If the claim is “Accepted”, it means that the claim will process through the adjudication system.
  - After the claim is finalized in the adjudication system, you will receive an Electronic Remittance Advice (ERA) with details on how the claim was adjudicated. The ERA is also known as an 835 EDI Transaction. The human readable version of the remittance can be found within the Remittance Viewer application on the Availity Essentials portal.
- If the claim is “Rejected”, it means that there will be an error message sent back to you. For claims submitted through the Availity Essentials Portal, the 277CA will be found in your mailbox in Send and Receive EDI files. This message will inform you what is needing to be corrected on the claim. After correcting the error, submit a new claim.

THANK YOU

For technical support contact Availity 1-800-282-4548 or 1-800-AVAILITY. Or select **Help & Training | Availity Support** for additional Availity assistance.