Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.
The 1500 Claim Submission transaction allows providers who submit CMS-1500 claim forms to submit claims through the NaviNet® web portal for Independence Blue Cross (Independence) members. Providers are able to review the status of a submitted claim through the Claim Log (see the Claim Log Guide for additional details). The 1500 Claim Submission transaction is available to providers seven days a week.

Important notes
- This transaction does not represent a facsimile of the paper CMS-1500 claim form. Claims will be submitted following HIPAA 837P rules and format.
- Providers can submit Independence commercial and Medicare Advantage claims, as well as out-of-area Medicare Advantage PPO* (MAPPO) claims.
- Providers cannot submit any other BlueCard® out-of-area claims through this transaction. Providers will receive a claim rejection if attempted.
- Providers cannot submit Federal Employee Program (FEP) claims through this transaction. Providers will receive an on-screen red-line error message if attempted.
- Providers must reference their Claim Log to monitor the status of their claim submissions (see the Claim Log Guide for additional details).
- This transaction is only for submitting CMS-1500 claim forms. Providers cannot use this transaction to submit UB-04 claim forms.
- Claims submitted using this transaction must have a date of service on or after October 1, 2015. The transaction cannot process dates of service prior to October 1, 2015.
- At this time, providers cannot submit claims with secondary and tertiary payers using this transaction.

*The MAPPO program is a national initiative of the Blue Cross and Blue Shield Association, an association of independent Blue Cross® and Blue Shield® plans, that enables enrollees in one Blue Cross and/or Blue Shield MAPPO plan to obtain health care benefits and services from participating Blue Cross and/or Blue Shield Plan providers while traveling or living in another Blue plan's service area.

Submitting claims using 1500 Claim Submission
To begin submitting claims using this transaction, select Claim Inquiry and Maintenance from the Independence Workflows menu, and then select 1500 Claim Submission. This will take you to the Patient Entry screen.

Patient Entry screen
On the Patient Entry screen, you will need to enter the patient and subscriber information. Only fields with a red asterisk (*) are required. If the patient is not the subscriber, you will need to complete both the patient and subscriber sections. If the patient is the subscriber and you
select the “Self/Subscriber” option from the Relationship to Subscriber drop-down menu, the information only needs to be added once; the subscriber section will auto-populate.

Use the ID Search link on the Patient Entry screen to find the Independence member – this pre-populates the patient and subscriber information on the Patient Entry screen.

Note: The ID Search link can only be used for Independence members. If you are entering a claim for an out-of-area MAPPO member, you must manually enter the patient/subscriber information on the Patient Entry screen. If you attempt to use the ID Search link to locate out-of-area MAPPO members, you will get an “eligibility record not found” message.

There are two ways to use the ID Search link:

1. Enter the Member/Subscriber ID and then select ID Search. Enter the patient’s complete ID number (including alpha prefix) in the Member/Subscriber ID field and then select the ID Search link to open the Patient Search screen. If multiple member records are returned, as shown below, you will need to select the appropriate individual record, which will return you to the Patient Entry screen.
2. **Select the ID Search link without entering the Member/Subscriber ID.** If you select the ID Search link without entering the Member/Subscriber ID, you will need to enter the dates of service and Member/Subscriber ID and select the Search button, as shown below. If multiple member records are returned, you will need to select the appropriate individual record, which will return you to the Patient Entry screen, where the patient information will be pre-populated.

![ID Search Screen](image)

When manually entering information about the patient, as for out-of-area MAPPO members, please keep in mind the following:

- **Name:** First and last names are required; the middle name is optional.
- **Address:** Enter the patient’s physical address, including street, city, state, and ZIP code.
- **Date of Birth:** Dates must be entered using one of the following formats: MM/DD/YYYY, MM-DD-YYYY, or MMDDYYYY.
- **Relationship to Subscriber:** If the patient is the subscriber, then you must select the “Self/Subscriber” option from the drop-down menu and the subscriber section will auto-populate.

*Note:* As a reminder, providers cannot submit any other BlueCard® out-of-area claims or FEP claims through this transaction. Providers will receive an on-screen red-line error message if attempted.

Also note the following about the dates of service:

- The From Date and To Date will default to the current date. Modify these dates as needed.
- The From Date and To Date can be the same.
- Neither the From Date nor the To Date can be before October 1, 2015.
- For claims submitted using the 1500 Claim Submission transaction, timely filing rules continue to apply.

Select the *Continue* button once all information is entered to continue to the Header screen. At this point the record will be saved in the Claim Log.

**Header screen**

The Header screen, as shown on the next page, is where the patient information must be validated and the claim header data must be entered.
The following claim header data are required:

- **Billing Provider:** Select the correct Billing Provider from the drop-down menu. This menu only displays groups that (1) the user has access to and (2) currently submit 1500 claims today. Providers who do NOT currently submit 1500 claims will not appear.

- **Patient Account Number:** This is your patient claim/identifier number (e.g., Practice Management Account Number or internal record system).

- **Taxonomy Code:** This drop-down menu will auto-populate based on the Billing Provider.

- **Signature on File:** Select Yes or No from the drop-down menu (Yes is the default).

- **Accept Assignment:** Select Yes or No from the drop-down menu (Yes is the default).

- **Place of Service:** Select a place of service from the drop-down menu.

- **Claim Frequency:**
  - 1 – Original: Use when entering an original claim (this is the default).
  - 7 – Replacement of Prior Claim: Use when a specific claim has been issued for a specific provider, patient, payer, insured, and “Statement Covers Period.” Claim needs to be replaced/restated in its entirety. The payer must void the original, and the new claim should be processed as a complete replacement.
  - 8 – Void: Use when voiding/canceling a prior claim (i.e., a previously submitted claim for a specific provider, patient, payer, insured, and “Statement Covers Period”). Prior claim is to be eliminated in its entirety.

  *Note:* When using Claim Frequency code 7 (replacement) or 8 (void), the provider must complete the Original Claim Number field.

- **Authorization Number:** If entering an authorization number, you will be required to enter the Referring Provider further down the screen.
• **Referral Number:** The referral number is not required; however, if entered, you will be required to enter the Referring Provider further down the screen.

• **NAIC Code:** You are required to select the correct NAIC code from the drop-down menu:
  – 95056 (Keystone Health Plan East claims)
  – 54704 (Personal Choice® and MAPPO claims)

The following fields may also be required, depending on the claim data entered:

• Rendering/Servicing Provider
• Referring Provider
• Servicing Facility
• Ambulance Pick-Up
• Ambulance Drop-Off

**Referring Provider and Servicing Facility**

The Referring Provider and Servicing Facility fields on the Header screen can be expanded by clicking on the green down arrow to the left of the field name. (↩)

If a Referring Provider is required, the last name and National Provider Identifier (NPI) must be entered. A Referring Provider is required when:

• Your Place of Service is 81 – Independent Lab.
• You are a home infusion provider.

A Servicing Facility is required if the Place of Service is any of the following:

• 21 – Inpatient Hospital
• 22 – Outpatient Hospital
• 23 – Hospital Emergency Room
• 31 – Skilled Nursing Facility
• 32 – Nursing Facility
• 51 – Psych Facility- Partial Hospital
• 61 – Inpatient Rehab Facility

*Note:* You will only be permitted to enter a participating Servicing Facility. If the Servicing Facility is non-participating with Independence, you cannot use this tool to submit your claim.

Select the Optional Search link under Servicing Facility to get to the Facility Search Screen.
Use the Facility Search screen to execute the Optional Search action from the Header screen. The Facility Search screen will also display if you enter an invalid Servicing Facility Provider ID on the Header screen.

Through Optional Search, you will need to search by facility name or NPI:

- **Facility Name**: Execute a full or partial (using the wildcard*) name search.
- **Facility Number**: Enter the facility’s NPI.

Once the facility information is entered, select the Search button and results will appear for that facility search criteria.

![Facility Search Screen](image)

After selecting a facility from the results listed, you will be returned to the Header screen. Complete the Header screen and select *Continue* to reach the Payer screen.

**Other claim information**

Enter other dates and claim information on the Header screen as applicable. Dates for the following are based on the claim data entered on the Header screen:

- **Onset of Current Illness/Symptom**: Date must be equal or prior to the claim date.
- **Last Menstrual Period**: Date must be equal or prior to the claim date.
- **Initial Treatment**: Date must be equal or prior to the claim date.
- **Hearing and Vision Prescription Date**: Date must be equal or prior to the claim date.
- **Hospitalization Related to Current Services From and Hospitalization Related to Current Services To**: These fields are required if the Place of Service is one of the following:
  - 21 – Inpatient Hospital
  - 31 – Skilled Nursing Facility
  - 51 – Psych Facility- Partial Hospital
  - 55 – Residential Substance Abuse Treatment Facility
  - 56 – Psych Residential Treatment Center
  - 61 – Inpatient Rehab Facility
- **Disability From**: Date must be equal or prior to the claim date.
- **Disability To**: Date must be equal or prior to the claim date.
- **Condition Codes**: Codes must be completed in sequence.
- **Related Causes**: Field is not required/optional.
- **Employment**: Field is not required/optional.
• **Accidents**: If Auto Accident is selected, then State is required. If Other Accident is selected, then the Accident Date is required.

Once all data is entered on the Header screen, select the *Continue* button.

**Payer screen**

On the Payer screen, the primary payer will default to Independence. You must complete the following required fields:

- Primary Payer A
- Release of Information
- Assignment of Benefits

Then select the *Continue* button to proceed to the Detail screen.

**Detail screen**

Enter all the required fields on the Detail screen and select *Continue*. 
You can enter the following items on the Detail screen:

- **Diagnosis codes:** Type a code in the Diagnosis Code field or select the Search link. If searching for a diagnosis code, either enter the diagnosis code (without decimal points) or a description of the diagnosis and select Search.
  
  Click on the appropriate diagnosis code row to have the code appear in the Detail screen. Please note the following:
  
  - Only ICD-10 codes are accepted as valid.
  - Codes must be entered without decimal points.
  - You can enter up to 12 diagnosis codes by selecting the Add More link, which is displayed below the most recently added line.

- **Rendering/Servicing Provider:** If this field is not pre-populated, you will have the ability to select a provider from the Rendering/Servicing Provider drop-down menu.

- **Service Facility ID:** See page 6 to determine when a Referring Provider/Servicing Facility is needed.

- **Dates of service:** Dates of service must be on or after October 1, 2015.

- **Diagnosis pointer:** At least one diagnosis pointer is required to make a valid service line.

- **CPT®/HCPCS:** You can enter a CPT/HCPCS (Current Procedure Terminology/Healthcare Common Procedure Coding System) code directly or select the Search link. If you select the Search link, you can either enter a full code or description or a partial code or description (using the wildcard*). Entering a partial code will produce all possible codes, as shown below. Click on the appropriate row to have the code appear in the Detail screen.
- **Charges**: Providers cannot use more than two decimal places. To report zero charges, enter $0.00.
- **Quantity**: Providers must specify a quantity for any CPT/HCPCS code entered.
- **Add details**: Select the *Add Details* link if you need to report ambulance, drug, or National Occupational Classification (NOC) code data. If you select the link, the Additional Details page will display for that service line.

Use the Additional Line Notes field to add comments for Not Otherwise Classified (NOC) procedures. To return to the Detail screen, either use the breadcrumbs at the top of the screen or select the *Continue* button. You can add up to 50 service lines for a single claim.

- **Service lines**: Select *Add More* if you need to add additional service lines to the Detail screen. If selected, one additional row of four diagnosis codes will be painted to the screen directly below the previous row. The *Add More* link will become inactive after 12 diagnosis codes have been added.
- **Add provider/facility**: If your claim includes more than one place of service or rendering provider, select the *Add Provider/Facility* link. In the new section that appears, enter information about the additional place of service or rendering provider.
- **Rendering provider**: If a rendering provider was previously selected, this field will auto-populate.

*Note*: The Anesthesia-Related Procedure Information section is only required for specific CPT/HCPCS codes.

Providers must complete all required claim detail data for the claim, and then select the *Continue* button.

**Verification screen**

The Verification screen displays a read-only summary of key data entered by the user from the Patient Entry, Header, Payer, and Detail screens. Confirm that the data on the Verification screen, as shown on the next page, is correct and select the *Submit* button.

You can also select the *Save* button to save the claim data and submit it later. Partially completed/saved claims can be accessed at a later time for completion through the Claim Log.
Use the breadcrumbs bar to navigate back to the entry screen to make edits.

The Submission Result screen will display once you have selected the Submit button on the Verification screen.

**Submission Result screen**

The Submission Result screen confirms that the claim was successfully submitted. Select the Continue button to return to Independence NaviNet Plan Central. You can review the Claim Log to check the status of your claim submission (see the Claim Log Guide for additional details).

If you have questions about submitting CMS-1500 claim forms through NaviNet, call the eBusiness Hotline at 215-640-7410.

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