



An Eligibility and Benefits Inquiry should be completed for each Blue Cross and Blue Shield of Illinois (BCBSIL) patient prior to every scheduled appointment. Eligibility and benefit quotes include important information regarding the patient’s benefits, such as membership verification, coverage status, applicable copayment, coinsurance and deductible amounts. Additionally, the benefit quote may include information on applicable benefit prior authorization requirements.

Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility, any claims received during the interim period and the terms of the member’s certificate of coverage applicable on the date services were rendered.

Not yet registered with Availity? Visit [Availity](#) and complete the online registration today, at no cost.

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 [Eligibility and Benefits Inquiry](#).

2) Eligibility and Benefits Inquiry

- ▶ Select [Patient Registration](#) from the navigation menu
- ▶ Select [Eligibility and Benefits Inquiry](#)

Note: Contact your Availity Administrator if [Eligibility and Benefits Inquiry](#) is not listed in [Patient Registration](#) menu.

3) Payer Selection

- ▶ Select **BCBSIL** from the Payer drop-down list for local policies
- ▶ **Blue Cross Community Health Plans** (Illinois Medicaid)
- ▶ **Blue Cross Medicare Advantage**
- ▶ Select **Other Blue Plans** for out-of-state policies

A screenshot of a web form showing a dropdown menu for 'Payer'. The selected option is 'BCBSIL'. There is a small blue question mark icon to the right of the 'Payer' label.

Note: Contact the patient's home plan via 800-676-2583 for additional information pertaining to eligibility and benefit verifications for out-of-state members.

4) Provider Information

- ▶ Select applicable provider name from **Select a Provider** drop-down to auto populate the **NPI** field*
- ▶ Select a **Provider Type** from the drop-down:
 - Professional
 - Institutional

* If the applicable provider's name does not appear in the **Select a Provider** drop-down, enter the NPI in the NPI field.

Notes: Professional providers should utilize the treating physician's rendering NPI (Type 1).
Institutional providers should use the billing NPI (Type 2).

A screenshot of a 'Provider Information' form. It includes a 'Select a Provider' dropdown with a search bar, a 'Provider Type' dropdown, an 'NPI' text field, and three text fields for 'Address', 'Suite', and another empty field.

Important Note:

→ Enter the street **Address** and **Suite** ONLY if multiple service locations are associated with the NPI.

5) Service Information

- ▶ Select **Place of Service** from the drop-down list
- ▶ Choose the applicable **Benefit/Service Type**

Notes: The **As of Date** can be changed to submit inquiries for a past or future date of service.

Past date inquiries can be received up to 12 months prior to the current date.

Future date inquiries can be requested within the current month.

A screenshot of a 'Service Information' form. It includes an 'As of Date' text field with '09/23/2021', a 'Place of Service' dropdown, and a 'Benefit / Service Type' dropdown. A circled 'A' icon is next to the 'Benefit / Service Type' dropdown.

A A list of your most frequently used **Benefit/Service Types** will appear at the top of the drop down.

6) Check Pre-Authorization Service Information

The procedure code inquiry option is for prior authorization determination only and is not a code-specific quote of benefits.

- ▶ Enter up to eight valid **CPT/HCPCS Code** to determine if prior authorization is required for specific procedure code(s)

CPT/HCPCS Code inquiry for prior authorization is not yet supported for the following BCBSIL lines of business:

- Federal Employee Program® (FEP®)
- Medicare Advantage
- Illinois Medicaid

Important Tips

- ▶ If a benefit/service Type is not selected, the place of service and at least one CPT/HCPCS code must be submitted.
- ▶ If a CPT/HCPCS code is not entered, the place of service and benefit/service type are required.

7) Single Patient Inquiry

- ▶ Enter the following information:
 - **Patient ID** (including three-character prefix)
 - **Date of Birth**
- ▶ Select **Submit**

B Select the **Patient Search Option** drop-down to incorporate additional search criteria (*i.e.*, patient name, group number, etc.).

8) Multiple Patient Inquiry

- ▶ Select the **Add Multiple Patients** check-box
- ▶ Enter the following information for 2 to 50 patients in the same request:
 - **Patient ID** (including three-character prefix)
 - **Date of Birth**
- ▶ Select **Submit**

C Enter each patient’s information on a separate line. Press enter to start a new line. Separate each piece of information with a comma.

9) Patient History List

► Once an eligibility and benefits request is completed, a new **Patient Card** will appear in the **Patient History List**, including all members entered in the request:

- Inactive Membership
- Active Membership
- Transaction Error

Notes: To see all patients within your organization, uncheck "My Patients Only". Users can **Edit** or **Delete** the patient's eligibility and benefits search from the Patient History List. The Patient History List holds up to 200 patients for 24 hours.

D Locate the **Patient Card** by searching for Name, Date or Payer.

10) Eligibility Summary Results

► Eligibility for the requested patient will display in the **Patient Information** tab and includes the following results:

- Patient Information
- Plan Date (*current effective date*)
- Subscriber Address
- Policy Type
- Payer
- Group Number
- Plan Sponsor Name (*employer*)
- Paid to Date (*on and off-exchange health plans*)
- Other or Additional Payer
- Provider Details

Quick Tip:

→ Access the **Patient Care Summary** to view the patient's health care history, based on claim information. For more information, refer to the [Patient Care Summary User Guide](#).

11) Grace Periods

- ▶ Some individuals who purchase on and off-exchange health plans may receive an advance premium tax credit (APTC). These members qualify for a three-month grace period to pay their premium – provided they have already paid at least one month’s premium in full.
- ▶ All allowable services provided during the first month of the grace period will be the responsibility of BCBSIL, subject to member cost sharing. BCBSIL will pend all claims incurred during the second and third months of the grace period. If the member pays all outstanding premium payment(s) in full, the claims will process according to the member’s benefits.
- ▶ The Plan/Product Information of the **Patient Information** tab will provide a grace period indicator for applicable members, including grace period start and end dates, as shown in the example.

Active Coverage

PERIOD START DATE Sep 01, 2021

PERIOD END DATE Nov 30, 2021

- POLICY IS IN FEDERALLY REQUIRED THREE MONTH APTC GRACE PERIOD FOR PREMIUM NON PAYMENT. IF MEMBER DOES NOT BECOME CURRENT ON ALL OUTSTANDING PREMIUMS DUE, ANY SERVICES INCURRED AFTER THE FIRST DAY OF THE MONTH FOLLOWING THE PERIOD START DATE WILL BE DENIED.

Note: Not all members who purchase on and-off exchange health plans will receive the APTC.

12) View Member ID Card

- ▶ Select **View Member ID Card**, if available*
- ▶ View, download and/or print the BCBSIL medical ID card

DOE, JANE Child of Subscriber

Member ID ABC123456789 **Plan / Coverage Date** Jan 01, 2018 - Dec 31, 9999

DOB Jan. 1, 1970

Gender Male

[Edit](#) [Print](#)

[Patient Care Summary](#) [View Member ID Card](#)

***The online ID card is a courtesy feature offered to assist you. There may be instances when the BCBSIL member ID card is not readily available online. The eligibility and benefits response provides sufficient details to determine patient coverage and benefits in absence of an ID card.**

Please note that Federal Employee Program (FEP) member ID cards are not currently available in the Availity eligibility and benefits results.

Member Card

Subscriber Name: JOHN DOE
Identification Number: ABC123456789
Group Number: 123456

Office Visit \$35	Emergency Room \$400
Specialist \$99	

BCE
 Pediatric Dental (under age 19)

RxBIN: 011552
RxPCN: ILDR

BlueCross BlueShield of Illinois

Prereath: Call before inpatient or skilled nursing facility admission, receiving home health care or private duty nursing; an emergency, maternity or for a mental health/substance abuse admission and specified outpatient services.
 File claims to BCBSIL. Non-Illinois Providers file medical claims with the local BCBS Plan.
 BlueCare Dental Claims: P.O. Box 23059, Belleville, IL 62223-0059. Regulated by IL Dept of Ins.

Customer Service 1-800-541-2767	DNAa Prof Network 1-800-972-7668
Prereath Med 1-800-635-1928	Prereath MHSA 1-800-851-7498
Provider Locator 1-800-810-2583	24/7 Nurseline 1-800-299-0274
Pharmacy Program 1-800-423-1573	Dental Services 1-800-367-6401

www.MDLIVE.com/BCBSIL

This card is provided by BlueCross BlueShield of Illinois, an independent licensee of the BlueCross BlueShield Association.

PRIME
Pharmacy Benefits Manager

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13) Benefit Summary Results

► Benefit details for the selected Benefit/Service Type will display in the **Coverage and Benefits** tab and will include the following results:

- Coverage Level (*individual or family*)
- Amount (*patient responsibility*)
- Quantity (*limitations or maximums*)
- Place of Service
- Time Period (*visit, calendar year, lifetime, etc.*)
- Description (*applicable services*)

DOE, JANE Child of Subscriber
 Member ID ABC123456789
 DOB Jan. 1, 1970
 Gender Female
 Plan / Coverage Date Nov 01, 2009 - Dec 31, 9999

Quick Tip:
 → Only applicable benefits will be displayed. The below example does not show a maximum or limitation field; therefore, no maximum or limitations apply to this example.

Surgical - 2

Co-Insurance - Surgical
 In Network Individual 20 % Visit
 Plan / Product Surgical
 Place of Service On Campus-Outpatient Hospital
 • SURGERY- PROFESSIONAL

Deductible - Surgical
 In Network Individual \$2,500.00 Service Year
 Plan / Product Surgical - \$74.66 Year to Date
 Benefit Date Nov 01, 2018
 Place of Service On Campus-Outpatient Hospital \$2,425.34 Remaining
 • SURGERY- PROFESSIONAL

Out of Pocket (Stop Loss) - Health Benefit Plan Coverage
 In Network Individual \$3,500.00 Service Year
 Plan / Product Health Benefit Plan Coverage - \$210.00 Year to Date
 Place of Service On Campus-Outpatient Hospital \$3,290.00 Remaining
 • SURGERY- PROFESSIONAL

14) Benefit Description

► Below are examples of **Benefit Descriptions** that may return depending on the patient’s benefit contract. This information will be located under **Coverage & Benefits** tab. Only applicable information will return.

Benefit Description

- THIS POLICY HAS AN EMPLOYER-FUNDED HEALTH CARE ACCOUNT THAT MAY BE USED TO PAY FOR QUALIFIED MEDICAL EXPENSES, INCLUDING, BUT NOT LIMITED TO, DEDUCTIBLE.

Benefit Description - Chiropractic

- THE FOLLOWING MUSCLE MANIPULATION MAXIMUM MAY BE COMBINED WITH OTHER THERAPY SERVICES.

Benefit Description - Surgical

- IN ACCORDANCE WITH THIS POLICY A BLUE DISTINCTION CENTER OF EXCELLENCE IS AVAILABLE FOR BARIATRIC SURGERY SERVICES. FOR MORE INFORMATION, REFER TO WWW.BCBS.COM/ABOUT-US/CAPABILITIES-INITIATIVES/BLUE-DISTINCTION/BLUE-DISTINCTION-SPECIALTY-CARE. :IN
- ACCORDANCE WITH THIS POLICY A BLUE DISTINCTION PLUS CENTER OF EXCELLENCE IS AVAILABLE FOR BARIATRIC SURGERY SERVICES. FOR MORE INFORMATION, REFER TO WWW.BCBS.COM/ABOUT-US/CAPABILITIES-INITIATIVES/BLUE-DISTINCTION/BLUE-DISTINCTION-SPECIALTY-CARE.

15) Prior Authorization Summary Results

- ▶ Prior authorization requirements are in the **Pre-Authorization Info** tab and are organized in two sections:
 - **Requested Procedure Code Authorization** – displays prior authorization requirements for the submitted procedure codes.
 - **Service Level Authorization** – displays additional prior authorization information for the benefit/service type selected. Prior authorization information for procedure codes related to the benefit may also be included.

The screenshot shows the 'Pre-Authorization Info' tab with two main sections:

Requested Procedure Code Authorization

Procedure Code	Auth Required?	Notes
22845 - Insert Spine Fixation Device In Network	Auth Required Inpatient Hospital	Contact Info: BCBSIL (888) 888-8888 • Procedure codes are supported for preauthorization requirement only and are not used for benefit determination

Service Level Authorization

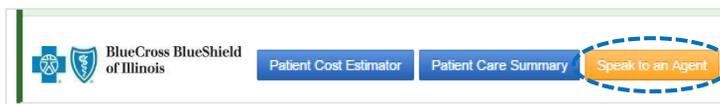
Service/Procedure Code	Auth Required?	Notes
Hospital - Inpatient In Network	Auth Required Inpatient Hospital	Contact Info: BCBSIL (888) 888-8888 • DAILY ROOM AND BOARD

If no procedure codes were entered this section will indicate "No pre-authorization information was requested."

If a benefit/service type is not selected in the request, this section will not display any prior authorization information and the Coverage and Benefits tab will not return any benefit details.

16) Speak to an Agent Feature

- ▶ In some instances, benefit information may not be readily available online. The **Speak to an Agent** feature gives priority access to the next available customer advocate during standard business hours.
 1. Select the **Speak to an Agent** button
 2. Dial the 800 number provided in the pop-up box
 3. Enter the 8-digit reference ID number via your touch tone keypad



Note: This feature will only be available for medical benefits that are managed by BCBSIL. The **Speak to an Agent** button will not be offered for benefit information managed by other entities (i.e., vendors, government programs and labor fund carve outs).

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

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