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

Organizations can improve their accounts receivable by utilizing this exclusive BCBSIL 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 and Illinois Medicaid) 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 BCBSIL, users should contact the appropriate claim processing entity directly (i.e., third-party vendors, other carriers, etc.).

1) Getting Started

- Go to availability.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 availability.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 Tip Sheet

**Quick Tip:**

- The **Payer** field will default to **BCBSIL** 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 0FEP00.
- 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** dropdown list.
- Choose the Billing (Type 2) NPI from the **Express Entry** dropdown list or enter **NPI**.
- Enter the 13-digit alpha numeric claim number in the **Claim # (DCN)** field.
- Select **Submit**.

**Claim Research Tool**

<table>
<thead>
<tr>
<th>* Payer:</th>
<th>BCBSIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Search Option:</td>
<td>Claim Number (DCN)</td>
</tr>
</tbody>
</table>

**Billing Provider Information**

| * Express Entry - Provider: | Select One |
| * NPI: | 99999999999 |

**Claim Information**

| * Claim # (DCN): | 99999999999X01 |

**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**

<table>
<thead>
<tr>
<th>Payer:</th>
<th>BCBSIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider NPI:</td>
<td>99999999999</td>
</tr>
<tr>
<td>Member ID:</td>
<td>ABC998999999</td>
</tr>
<tr>
<td>Group Number:</td>
<td>123450</td>
</tr>
</tbody>
</table>

**Service Period:** 01/01/2019 – 09/13/2019

**Claims Found**

<table>
<thead>
<tr>
<th>From Service Date</th>
<th>Processed Date</th>
<th>Claim Number</th>
<th>Billed Amount</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/05/2019</td>
<td>05/07/2019</td>
<td>999999999999X01</td>
<td>$247.38</td>
<td>Paid</td>
</tr>
<tr>
<td>08/22/2019</td>
<td>08/28/2019</td>
<td>999999999999X01</td>
<td>$107.72</td>
<td>Paid</td>
</tr>
</tbody>
</table>
### 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

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**Quick Tip:**

Refer to page 5 to learn about Cotiviti, INC. code audit rationale.

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### Claim Details

**Patient Name:** DOE, JANE  
**Member ID:** 999999999  
**Alphanumeric Prefix:** ABC  
**Gender:** F  
**Group #:** 12345  
**Date of Birth:** 12/23/1988  
**Subscriber Name:** DOE, JOHN  
**Relationship To Subscriber:** Spouse  
**Patient Account #:** 1123456

**Claim Details**

- **Claim Number:** 99999999992500  
- **Claim Status:** PAID  
- **Check/EFT/Voucher:** E9999999999999  
- **Check Date:** 08/30/2019  
- **Payee Name:** ABC CLINIC  
- **Prior Paid AMT:** $0.00  
- **Prior Notification Deductible:** $0.00  
- **Health Care Account Amount:** $0.00  
- **Other Carrier Paid:** $0.00  
- **Patient Share Amount:** $0.00  
- **Medicare Paid Amount:** $0.00

---

### Service Lines

<table>
<thead>
<tr>
<th>Service Dates</th>
<th>Revenue / Procedure Code</th>
<th>Diagnosis Code</th>
<th>Billed AMT</th>
<th>Paid AMT</th>
<th>Ineligible Reason Code / Amount</th>
<th>Interim Discount</th>
<th>Copay</th>
<th>Coinsurance</th>
<th>Deductible</th>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>Unit Time / Mile</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/22/2019</td>
<td>96415</td>
<td>21483</td>
<td>$10.00</td>
<td>$0.00</td>
<td>V25</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>59</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>01/22/2019</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08/22/2019</td>
<td>88763</td>
<td>21483</td>
<td>$16.66</td>
<td>$10.56</td>
<td>T42 / $16.66</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>59</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>01/22/2019</td>
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<td></td>
</tr>
<tr>
<td>08/22/2019</td>
<td>55925</td>
<td>21483</td>
<td>$20.74</td>
<td>$15.00</td>
<td>T42 / $16.74</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>59</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>01/22/2019</td>
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</tr>
</tbody>
</table>

### Ineligible Reason Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V25</td>
<td>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.</td>
</tr>
<tr>
<td>T42</td>
<td>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.</td>
</tr>
</tbody>
</table>

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**Edit Inquiry**  
**Print**
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.

Additional Action(s) for Applicable Ineligible Reason Codes:

- View **Additional Actions(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.**

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**Ineligible Reason Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V15</td>
<td>Services have been unbundled. Please resubmit using appropriate code. This information submitted on the claim is inconsistent with current coding protocol. Patient cannot be billed for the disallowed code.</td>
</tr>
<tr>
<td>T12</td>
<td>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.</td>
</tr>
</tbody>
</table>

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**Ineligible Reason Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>269</td>
<td>This service is not covered for this diagnosis.</td>
</tr>
</tbody>
</table>
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@bcbsil.com

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