

Web Claims Submission Guide





Sign in to your account

New user? [Register Now.](#)

User Name:

Password:

Remember me

[Forgot User Name?](#)

[Forgot Password?](#)

Sign In

Sign into your BCBSRI.com Provider Portal by clicking [here](#). If you do not have a BCBSRI account, please create one by clicking [here](#).

(* Indicates required field.)

[View All](#) | [Create New](#) | [Activity Report](#)

Provider Home

Conference Call Info

Medicaid
Communications

Doula Information

Claims & Billing

Web Claim Submission

Preauthorization

Patient Eligibility

Account Access

Settlements/RAs

Cost Estimator

Welcome,

ADMINISTRATOR

LAST SIGN-IN: 05/25/23 10:54 AM ET

Alerts & Updates

No alerts or updates at this time.

Check Eligibility

If a member's ID has 12 or 13 digits, you do not need to enter the prefix

Member ID

Service Date 05/25/2023

[Search by Name or SSN](#) | [Search by Member ID](#) [Ac](#)

Remittance Advice

Enter Remittance Advice search criteria.

For Admins Only*

How to grant access to staff accounts

* Enable Features:

- Web Claims Submission
- Secure Messaging
- Update Practice Information
- View Claim Status
- Respond To Patient Reviews
- Authenticate Provider
- Preauthorization Requests (Medical Only)
- Settlements/RAs
- Check Eligibility

[Select All](#) | [Clear All](#)

Enable staff account management:

- Manage Staff Accounts

After logging into your account, you will see Web Claim Submission on the left-hand side. Click this link.

Please read before proceeding. If you do not have access to Web Claim Submission, you must ask your Admin of your account to grant you access. If you are an admin and do not have access, please contact ProviderRelations@bcbsri.org.

*Below are the claim draft history submitted through Web Claim Application

[SUBMIT NEW CLAIM](#)

Items per page: 5

1 - 5 of 445



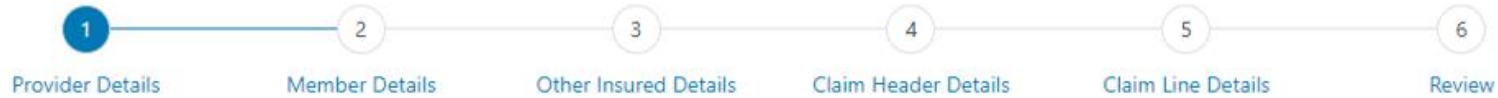
VIEW CLAIM DRAFTS

DRAFT HISTORY

MEMBER ID	PATIENT FIRST NAME	PATIENT LAST NAME	PATIENT DOB	PROVIDER NAME	CREATION DATE	ACTION
-----------	--------------------	-------------------	-------------	---------------	---------------	--------



Once you click on Web Claim Submission this will bring you to a separate browser that will show where you will submit your claims. To submit a claim, click on SUBMIT NEW CLAIM. This application is for CMS1500 forms only. We do not currently have the capability to submit a UB04 form on the web and FEP members are out of scope as well for this process.



Provider Details

Select Provider: *

Provider *

Please note only one NPI per web submitted claim

Accept Medicare Assignment: *

Yes No

Billing Entity NPI:

If you have a Type 2 group NPI please enter here

[Next](#)

Section 1 Provider Details

You will need to appropriately fill out all 5 sections of the claim, then section 6 to review. This screen is where you will select the rendering provider/facility that the claim is being submitted for. If the rendering provider/ facility is not found in the drop down, that means the NPI is not loaded in your username and will need to be added to your Portal. Click [here](#) for directions to add an NPI to your Portal. When completed, click Next.



Member Details

Insured's ID Number: *

Insured's ID *

Insured ID is required

Patient's Date of Birth: *

Date of Birth *



Patient's Date Of Birth is required

Patient's Name:

Last Name

First Name

Middle Initial

Sex:

Sex

Patient's Relationship to Insured:

Relationship

Patient's Address:

Patient's Date of Birth must be entered with slashes & with a 4-digit year. Example 01/01/2023

Member Details

Insured's ID Number: *

Insured's ID *

Patient's Date of Birth: *

Date of Birth *



MM/DD/YYYY

Select Patient:

Patient

If the member is a twin, the system will automatically allow a drop down to select the correct patient.

Section 2 Member Details

When you are entering a claim for a local member, once you add in the member ID and DOB, the member information will automatically populate below. FEP claims are out of scope and will have to be submitted on paper or through your clearing house.

If the member information does not automatically populate, you will then need to enter in all sections. If the member is an out of area member, the information does not automatically populate, and you will need to manually enter all sections.

Telephone #:

Insured's Name:

Insured's Date of Birth:



MM/DD/YYYY

Sex:

Insured's Address:

Telephone #:

Patient's Account Number:

Signature on file to release medical/other information to process claims?*

Yes

No

Signature on file to authorize payment of medical benefits to provider?*

Yes

No

Back

Next

Section 2 Member Details continued

When scrolling down, you will see the insured's name. If the information does not automatically populate, you will need to manually enter all sections. Here you can also enter the Patients Account number if you have one. Click on the radio buttons on if the signature is on file for the member. When completed, click next.



Other Insured Details

Is Patient's Condition Related to:

a. Employment (current or previous):

Yes No

b. Auto Accident:

Yes No

c. Other Accident:

Yes No

Does The Patient Have Coverage With Another Carrier:

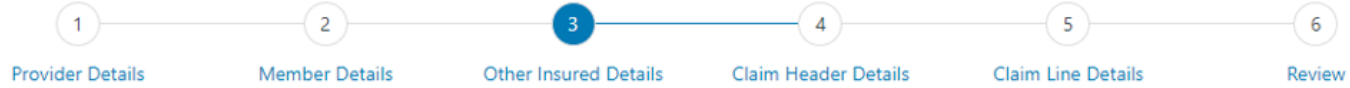
Yes No

Back

Next

Section 3 Other Insured Details

This section will be filled out if a member has other insurance for secondary, primary, or workers compensation. When completed, click next.



Other Insured Details

Is Patient's Condition Related to:

a. Employment (current or previous):

Yes No

b. Auto Accident:

Yes No State: *

c. Other Accident:

Yes No

Does The Patient Have Coverage With Another Carrier:

Yes No

[Back](#)[Next](#)

Section 3 Other Insured Details continued

If you need to use Auto Accident, please select the state.

Does The Patient Have Coverage With Another Carrier:

Yes No

Other Insurance Name:*

Insured Name *

Subscriber Name:*

Subscriber Name *

Other Insurance Policy / Group Number:*

Policy Number *

Does The Patient Have Coverage With Additional Carrier:

Yes No

Back

Next


Section 3 Other Insured Details continued

If member has Coordination of Benefits (COB), enter the other insurance information here. When completed, click next.




Claim Header Details

Date of Current Illness, Injury or Pregnancy (LMP):

MM/DD/YYYY


Other Provider (Referring, etc.):


NPI of Referring Physician:

Name of Referring Provider or Other Source:

Hospitalization Dates Related to Current Service:

MM/DD/YYYY

MM/DD/YYYY

Section 4 Claim Header Details

Fill this section out as appropriate to your claim.

Outside Lab:

Yes No

Diagnosis or Nature of Illness or Injury: *

A *	B	C	D
_____	_____	_____	_____
E	F	G	H
_____	_____	_____	_____
I	J	K	L
_____	_____	_____	_____

Prior Authorization Number:

Authorization Number

Total Charge: *

\$0.00 *

Amount Paid:

\$0.00



Add Attachments

File Name	Type

Back

Next

Add Attachments

Select Attachment Type:

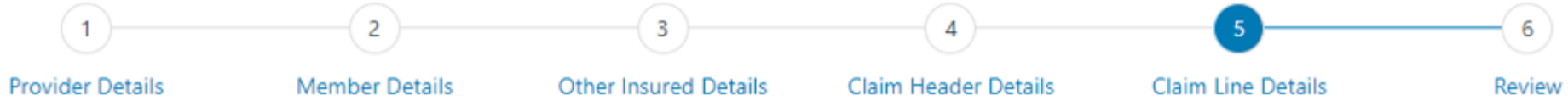
- Medical Record
- Other
- Other Carrier EOB

Browse

Type

Section 4 Claim Header Details Continued

Here you will enter the diagnosis code(s) and total charge amount. If you need to attach Medical Records, Other Carrier EOBs or any other documentation related to your claim click on Add Attachments and select the attachment type for the document that you are submitting. When completed, click next.



Claim Line Details

 [Add Line Item](#)

DATE(S) OF SERVICE		PROCEDURES, SERVICES OR SUPPLIES											
ITEM NO	FROM	TO	PLACE OF SERVICE	CPT/HPTCS	MODIFIER	NDC CODE	DIAGNOSIS POINTER	\$CHARGES	DAYS OR UNITS	ID. QUAL	TAXONOMY	RENDERING PROVIDER ID	ACTION

[Back](#)

[Review](#)



Section 5 Claim Line Details

Here you will be able to add your lines of the claim. Click on Add Line Item.

Note: You will need to select Add Line Item for each additional line of your claim

Claim Line Item Details

Date of Service: *

From *  To * 
MM/DD/YYYY MM/DD/YYYY

Place of Service: *

Place of Service *

11 - Office

Procedures, Services or Supplies: *

CPT/HCPCS : *

Modifiers:

NDC:

NDC

Please enter NDC in format (N4 + NDC Code + Space + Unit of Measurement + Quantity)

Diagnosis Pointer: *

Pointer 1 *

Pointer 2

Pointer 3

Pointer 4

Charges: *

\$0.00 *

Days Or Units: *

Days Or Units *

ID Qualifier:

ID Qualifier

Section 5 Claim Line Details Continued

A box will pop up with the following Claim Line Item Details to be filled out. You can type in the Date of Service with dashes or slashes or use the Calendar. You will need to appropriately fill out all mandatory fields which are identified by asterisks.

Rendering Provider ID #:
Provider ID

[Redacted]

Taxonomy:

Taxonomy

Enter other insurance information as applicable. You must upload other carrier's EOB.

Paid Date:

Paid Date



MM/DD/YYYY

Coinsurance:

\$0.00

Line Paid Amount:

\$0.00

MM/DD/YYYY

Coinsurance:

\$0.00

Line Paid Amount:

\$0.00

Deductible:

\$0.00

Copay:

\$0.00

Save

Close

Section 5 Claim Line Details Continued

Scrolling down you see the remainder of the mandatory fields that you will need to appropriately fill out. Click Save when finished.



Claim Line Details

Add Line Item

ITEM NO	DATE(S) OF SERVICE		PLACE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES		NDC CODE	DIAGNOSIS POINTER	SCHARGES	DAYS OR UNITS	ID. QUAL	TAXONOMY	RENDERING PROVIDER ID	ACTION
	FROM	TO		CPT/HPTCS	MODIFIER								
1	07/01/2022	07/01/2022	11	92507			F8082	100	1	0			Edit/View COB/Delete



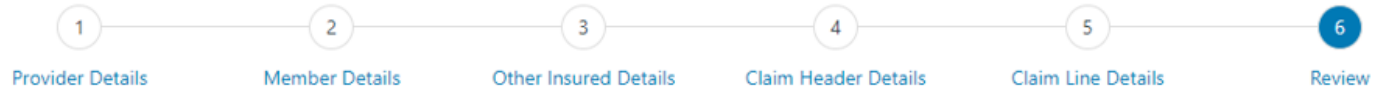
Back

Review

Section 5 Claim Line Details Continued

Here you will see your claim line details entered. You have the ability to edit, view, and delete this line if it is not correct. If you would like to add an additional line, click on Add Line Item. You can add up to 15 lines.

Click Review when completed.



Review

Provider Details [Edit](#)

Select Provider: *

Provider

Remit Address:

Telephone #:


Tax ID / SSN:

Accept Medicare Assignment: *

Yes No

Billing Entity NPI:

Anything greyed out here will be auto populated with all the information you entered in sections 1 through 5.



Section 6 Review

The final review page will show all information entered. If anything needs to be changed or updated, click edit at the top right-hand side of each section.

Member Details

Edit



Insured's ID Number:
Insured's ID *

Patient's Date of Birth:
*

Anything greyed out here will be auto populated with all the information you entered in sections 1 through 5.

Patient's Name:
Last Name

First Name

Middle Initial

Sex:

Patient's Relationship to Insured:
Relationship

SELF

Patient's Address:

Telephone #:

Section 6 Review continued

The final review page will show all information entered. If anything needs to be changed or updated, click edit at the top right-hand side of each section.

Insured's Name:

Last Name

First Name

Middle Initial

Insured's Date of Birth:



Sex:

Anything greyed out here will be auto populated with all the information you entered in sections 1 through 5.

Insured's Address:

Telephone #:

Patient's Account Number:

Account Number

Section 6 Review continued

The final review page will show all information entered. If anything needs to be changed or updated, click edit at the top right-hand side of each section.

Other Insured Details



Edit

Is Patient's Condition Related to:

a. Employment (current or previous):

Yes No

b. Auto Accident:

Yes No

c. Other Accident:

Yes No

Does The Patient Have Coverage With Another Carrier:

Yes No

Anything greyed out here will be auto populated with all the information you entered in sections 1 through 5.

Section 6 Review continued

The final review page will show all information entered. If anything needs to be changed or updated, click edit at the top right-hand side of each section.

Claim Header Details

Edit



Date of Current Illness, Injury or Pregnancy (LMP):

Other Provider (Referring, etc.):

Other Provider

NPI of Referring Physician:

NPI

Name of Referring Provider or Other Source:

Last Name

First Name

Middle Name

Hospitalization Dates Related to Current Service:

From

To

Outside Lab:

Yes No

Anything greyed out here will be auto populated with all the information you entered in sections 1 through 5.

Section 6 Review continued

The final review page will show all information entered. If anything needs to be changed or updated, click edit at the top right-hand side of each section.

Diagnosis or Nature of Illness or Injury:*

A*	B	C	D
E	F	G	H
I	J	K	L

Prior Authorization Number:

Authorization Number

Total Charge:*

\$100.00

Amount Paid:

\$0.00

Anything greyed out here will be auto populated with all the information you entered in sections 1 through 5.

Attachments:

File Name	Type
-----------	------

Section 6 Review continued

The final review page will show all information entered. If anything needs to be changed or updated, click edit at the top right-hand side of each section.

Anything greyed out here will be auto populated with all the information you entered in sections 1 through 5.

[Edit](#)

Claim Line Details

ITEM NO	DATE(S) OF SERVICE		PLACE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES			DIAGNOSIS POINTER	SCHARGES	DAYS OR UNITS	ID. QUAL	TAXONOMY	RENDERING PROVIDER ID	ACTION
	FROM	TO		CPT/HPTCS	MODIFIER	NDC CODE							
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0	<input type="text"/>	<input type="text"/>	View COB

Save As Draft

Validate Claim

Submit Claim

Note: Claims submitted through this web claim application are processed based on the information provided and subject to the terms and conditions of the provider agreement and member benefit plan in effect as of the date of service. Payment is not guaranteed.

Section 6 Review Continued

Once you review your claim you can Click Validate Claim. If anything is missing or invalid a *red error message* will populate advising you what needs to be corrected.

Edit

Claim Line Details														
		DATE(S) OF SERVICE		PROCEDURES, SERVICES OR SUPPLIES										
ITEM NO	FROM	TO	PLACE OF SERVICE	CPT/HPTCS	MODIFIER	NDC CODE	DIAGNOSIS POINTER	\$CHARGES	DAYS OR UNITS	ID. QUAL	TAXONOMY	RENDERING PROVIDER ID	ACTION	
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			<input type="text"/>	<input type="text"/>	1	0		<input type="text"/>	View COB	

Save As Draft

Validate Claim

Submit Claim

Note: Claims submitted through this web claim application are processed based on the information provided and subject to the terms and conditions of the provider agreement and member benefit plan in effect as of the date of service. Payment is not guaranteed.

Section 6 Review Continued

Once your claim is validated, Submit Claim will appear blue and you can now click for submission.

Claim submitted successfully under Claim ID: W000000

Close

Please note, when submitting your claim through BCBSRI.com, the claim number will be different than claims submitted on paper or electronically. Web claims submitted through the web will begin with a W or WI.

Congratulations! You successfully submitted your claim. A claim number will generate, please keep this number for your records.

Please note, we still allow for up to 30 days for a local claim and 45 days for an out of area claim processing.

Corrected Claims, Claim Adjustments, & Appeals





Corrected Claims

[Provider Home](#)[Conference Call Info](#)[Medicaid
Communications](#)[Doula Information](#)[Claims & Billing](#)[Web Claim Submission](#)[Preauthorization](#)[Patient Eligibility](#)[Account Access](#)

Welcome,

[Customer Service Information](#)[Log out](#)

Alerts & Updates

No alerts or updates at this time.

Check Eligibility

If a member's ID has 12 or 13 digits, you do not need to enter the prefix.

Member ID

Service Date

12/06/2023

Key Resources

[Download Provider Update](#)[Pharmacy Information](#)[ICD-10](#)[Forms](#)[Healthcare Reform](#)[LGBTQ Safe Zone Certification
Program](#)

Corrected Claims

After submitting a web claim online, if you need to correct something on the claim, you can use our corrected claim option. This will only work for claims submitted within the Web Claims Portal on BCBSRI.com provider portal.

The first step is to click on Claims & Billing on the left-hand side of your Provider Portal.

- Provider Home
- Conference Call Info
- Medicaid Communications
- Doula Information
- Claims & Billing
- Web Claim Submission
- Preauthorization
- Patient Eligibility
- Account Access
- Cost Estimator
- Update Practice Info
- Tools & Resources
- Referrals
- Quality
- HIPAA
- Update Web Account

Welcome,

STAFF
LAST SIGN-IN: 12/06/23 01:16 PM ET

Customer Service Information
[Log out](#)

View Claim Status

[Back to Patient Eligibility home page](#)

(* Required for Blue Cross & Blue Shield of Rhode Island Members)
(All criteria must be entered for non-Blue Cross & Blue Shield of Rhode Island Members)

Provider/Facility ID

(Under which the claim was filed)

* Member ID

(From Member ID card, All digits of the member's ID number must be entered, including the prefix.)

* Date of Birth (mmddyyyy)

Gender (F or M)

Last Name

First Name

* Start Date of Service (mmddyyyy)

End Date of Service (mmddyyyy)

Claim Charge (9 digit max, including cents)

Claim ID Number

View Claim Status

[Update Claim](#) ←

[Back to Patient Profile home page](#) | [Eligibility Lookup for this Member](#)

[Claim Search](#) > [Claim Details](#)

Claim Details

[Printer-Friendly Version](#)

Member Name	Member ID	Provider ID	Patient Control Number

Claim ID Number	Claim Status	Claim Status Code	Referring Physician
W	Completed	02	NOREF0

Diagnosis Code	Surgical Code	Payee Name	Other Carrier Paid Amount
M9059			\$0

Receive Date	Adjudication Date	Paid Date	Check #	Source
	07/31/2023			Web

	Amount Submitted	Amount Allowed	Amount Paid	Total Deductible	Total Copay	Total Co-Ins
Claim Total	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00

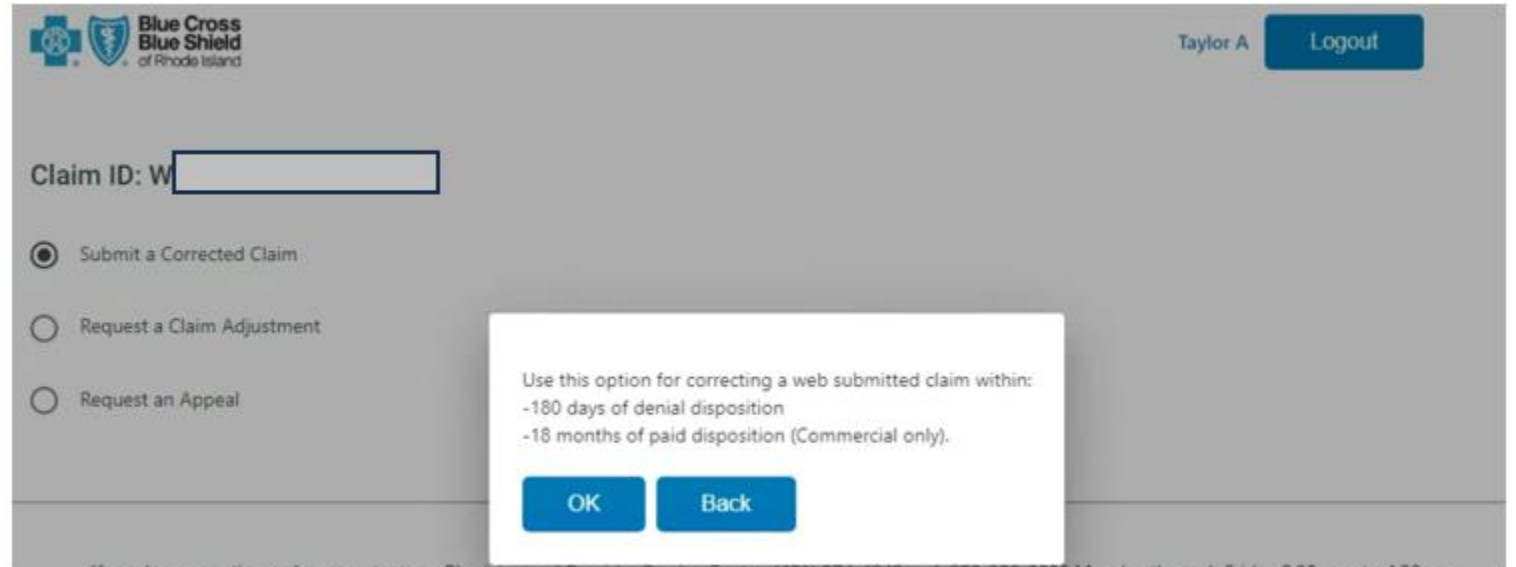
Corrected Claims

Once you click on Claims & Billing, you will need to use the down-arrow to click on the appropriate provider for your corrected claim. Then enter the member ID, DOB and DOS. Once this is all entered you can hit submit.

The View Claim Status page will appear with completed claim information. Check that this is the correct claim, then click on Update Claim. Please note – This correction is only available for Web Claims starting with a W or WI. You can also only submit for correction when the claim status is in 02.

Claim ID: W

- Submit a Corrected Claim
- Request a Claim Adjustment
- Request an Appeal



The screenshot shows the same portal interface as the first image, but with a pop-up dialog box overlaid. The dialog box contains the following text:

Use this option for correcting a web submitted claim within:
-180 days of denial disposition
-18 months of paid disposition (Commercial only).

At the bottom of the dialog box are two buttons: "OK" and "Back".

Corrected Claims

Once you click on Update Claim, this will open a new tab. Click on the Submit a Corrected Claim radio button. The pop up above will appear. Click OK.

Review

Provider Details

View



Claim Line Details

Add Line Item

ITEM NO	DATE(S) OF SERVICE		PLACE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES		NDC CODE	DIAGNOSIS POINTER	CHARGES	DAYS OR UNITS	ID. QUAL	TAXONOMY	RENDERING PROVIDER ID	ACTION
	FROM	TO		CPT/HPTCS	MODIFIER								
1	06/01/2023	06/01/2023	11	92507									Edit/Delete/View COB



Back

Review

Corrected Claim submitted successfully under Claim ID: W

Close

Corrected Claims

The review page will automatically populate at this point. You will only be able to view the provider and member information. You will be able to edit other insurance, claim header details and claim line details. Once you have edited all information you can go through the normal workflow to validate and submit your claim.

Once submitted, you will receive the pop up showing the new corrected claim number to track. Please note, we still allow for up to 30 days for a local claim and 45 days for an out of area claim processing.

Claim Adjustments

Claim ID: E1

Submit a Corrected Claim

The Corrected Claims option is only available for a claim that was originally submitted using this Web Claim application. For any other claim, please submit electronically or on paper.

Request a Claim Adjustment

Referral/authorization obtained (Documentation attached with the auth#)

Review with additional documentation (Other insurance settlement, etc.)

Retraction request (filed in error, duplicate payment)

Corrected Coding Review

Medical Records Review

Request an Appeal

Request a Claim Adjustment

Referral/authorization obtained (Documentation attached with the auth#)

Review with additional documentation

Retraction request (filed in error, duplicate payment)

Corrected Coding Review

Medical Records Review

Request an Appeal

Use this option when submitting a claim adjustment.

If submitting another carrier EOB, it must be within 180 days of retraction.

OK

Back

Claim Adjustments

Follow the steps from slides 27-28. Once you get into the Web Claims Portal click on Request a Claim Adjustment radio button. Here you can choose what type of claim adjustments fits best for your claim. Click on the correct option and hit OK.

Claim Adjustment Request Form - Ref/Auth obtained (Auth# is attached)

Claim Number:


Member Name:


Member ID:

Provider Name:

NPI:

Date of Service:

From
7/26/2023 

To
7/26/2023 

Reason for Adjustment:

Medical Records/Supporting Documentation

Attachments:

Upload Attachment

Reason for Adjustment:

Medical Records/Supporting Documentation

BCBSRI/BlueCHIP Plans Settlement

Other Carrier Settlement

Other

File Name

File Name

Delete

Prov_Appeal_Test_11 MB.tif

Delete

Additional Comments:

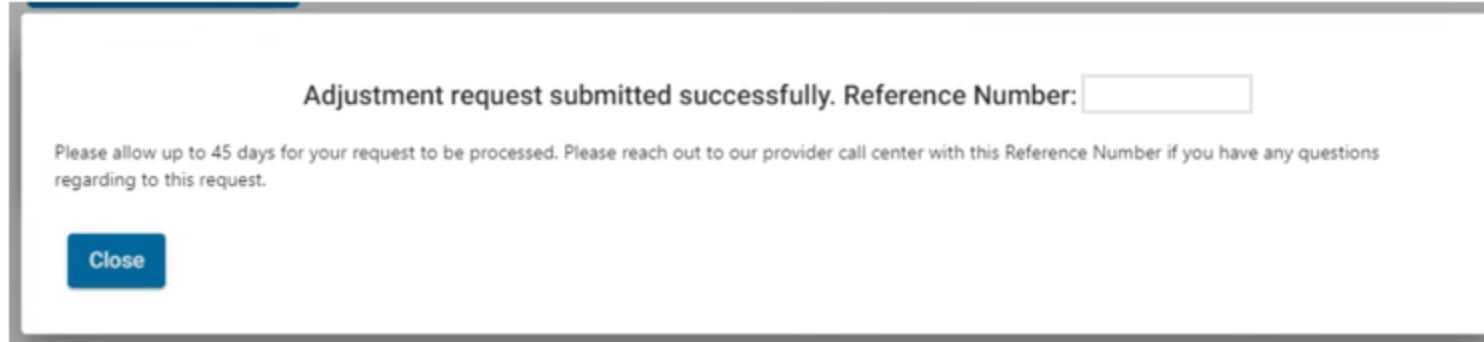
Characters Remaining: 0/282

Cancel

Submit

Claim Adjustments

Here you will view the member information and be able to attach supporting documentation (including a copy of your corrected claim, if that is what you are adjusting) as well as add any additional comments. When completed hit Submit.



Claim Adjustments

Once you hit submit, you will get the following popup. Please document the reference number given for your own reference. Adjustments can take up to 45 days for processing.



Taylor A

Logout

Request an Appeal

Claim ID: W

- Submit a Corrected Claim
- Request a Claim Adjustment
- Request an Appeal

This appeal can only be submitted for one member. If there are multiple claims denied for the same member and the same reason they can be submitted with this appeal.

DO NOT use this option when submitting a corrected claim or a claim adjustment, such as:

- Other carrier EOB within 180 days of retraction
- Corrected claim within 180 days of denial disposition
- Corrected claim within 18 months of paid disposition (Commercial only)
- Claim not on file

For instances above, please select the Claim Adjustment or Corrected Claim option.

OK

Back

Request an Appeal

Follow the steps from slides 27-28. Once you get into the Web Claims Portal click on Request an Appeal radio button. Please note appeals online can only be submitted for one member at a time. Pre Service Appeals and complaints must be submitted BAU.

Appeal Request Form

Member Name:

Member ID:

Date of Service:

From

7/26/2023



To

7/26/2023



Claim Number:

Provider Name:

Group Name:

Phone:



Office Contact:

Reason for Appeal:

Timely Filing

Service not in Provider's Contract

Pre-Auth was denied during Initial Review

Administrative Claim Denial

Investigational/Experimental/Not Medically Necessary Denial

Provider not authorized for the service

Reason for Appeal:

Service not in Provider's Contract

Pre-Auth was denied during Initial Review

Administrative Claim Denial

Investigational/Experimental/Not Medically Necessary Denial

Provider not authorized for the service

Other

Request an Appeal

The screen above will appear prepopulated with member details from the claim you wish to appeal. You must put a telephone number and an office contact. Then you will choose your reason for appeal from the options provided.

Phone:

Office Contact:

Reason for Appeal:

Timely Filing

Claim not filed within TF guidelines. To comply with HIPAA, all other non-pertinent PHI on attached settlements must be blacked out

Attachments:

Upload Attachment

File Name

Delete

Prov_Appeal_Test_11 MB.tif

Delete

File Name

Delete

Prov_Appeal_Test_11 MB.tif

Delete

To include multiple claims for the same member and same denial reason, enter the claim numbers below:

Characters Remaining: 0/489

Additional Comments:

TEST

Characters Remaining: 4/188

Cancel

Submit

Note: Requests submitted through this web claim application are processed based on the information provided and subject to the terms and conditions of the provider agreement and member benefit plan in effect as of the date of service. Payment is not guaranteed.

Request an Appeal

Once you have chosen your reason for appeal, you can upload any attachment needed. You can then update multiple claims for the same member. You can also add any additional comments. Once you are done with your appeal you can hit submit.

Appeal request submitted successfully. Appeal Case Number:

Please allow up to 60 days for your request to be processed. Please contact our Grievances & Appeals Unit at (401) 459-5784 with this case number if you have any questions regarding this appeal.

Close

Request an Appeal

Congratulations! You successfully submitted your Appeal. You will receive an appeal case number. Please allow up to 60 days for our Grievance & Appeals team to review your appeal. If you have any question on your appeal, you can reach out to them directly at 401-459-5784 with your case number.

If you have any questions or concerns when submitting your claim, corrected claim, claim adjustment or appeal through BCBSRI.com, please contact ProviderRelations@BCBSRI.com.