INSTIL® HEALTH

My Insurance Manager℠
and
My Remit Manager

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Your Partners in Outstanding Quality, Satisfaction and Service

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Contents

Overview

My Insurance Manager is a unique, online tool for providers. Once you have registered, you can use it to access information about your claims and coverage for your patients. Secure encryption technology ensures any information you send or receive is completely confidential. Please note that you must access this tool through www.InStilHealth.com.

Registering

From the My Insurance Manager homepage, select **Register Now**.

Enter the billing tax identification number. Select **Continue**.

Your profile administrator and each authorized user must have a unique username and password registered in My Insurance Manager. If your practice is new to My Insurance Manager, the initial user account will be added as the profile administrator.

Complete all other required fields: first name; last name; business phone number; and business email. Create a username and password; and establish a security question and answer. Select **Continue.**

Create Profile

* Required

Profile Information

☞ Each person can register under your Tax ID. For example, both Stuart and Sally work for ABC Practice. Under Practice/Facility Name, both would enter "ABC Practice." Then, each would enter a different Username, Password and other registration information.

Tax ID:
123456789

Provider:
YOUR PRACTICE/FACILITY

Address:
4101 PERCIVAL RD
COLUMBIA, SC 29229-8320

Note: If this address is incorrect, please complete the change of address form.

*Primary Location:
YOUR PRACTICE/FACILITY   Select

Primary Work Location:
1111122222

Profile Type:
Office Staff

Contact Information

* First Name:

* Last Name:

* Phone Number:

* Email:

* Confirm Email:

Login Information:

* Desired Username:

5 to 11 characters.

* Password:

8 to 25 characters.

* Confirm Password:

Security Question

* Security Question
--Please Choose One--

* Security Answer:

Continue   or Cancel

Need help? Call us at 855-229-5720.

The profile administrator must validate the profile by entering claim information or requesting a security code. If you request a security code, you must choose a delivery method: email, fax or mail.

Validate Profile

Profile Validation

👉 Please choose a way to validate yourself as an administrator of this Tax ID.

- ○ Enter Claim Information
- ◉ Request Security Code

Request Security Code

Required

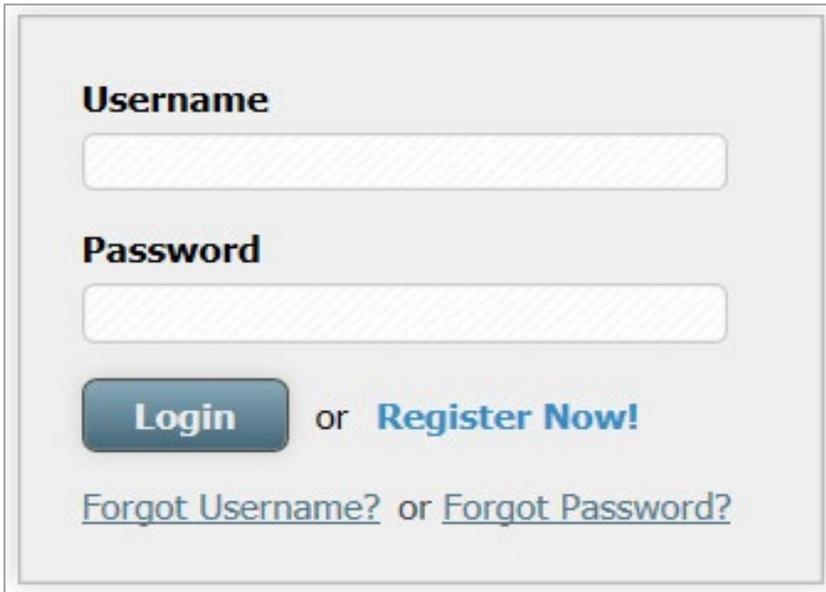ⓘ You can request that we send a Security Code via the delivery method we have on file associated with your Tax ID.

* Location:

[   ] [Select]

* Delivery Method:

- ○ **Email:**
- ○ **Fax:**
- ○ **Physical Address:**

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Logging In

After successful registration, you can log into My Insurance Manager and begin using the tool. From the My Insurance Manager home page, enter your credentials and select **Login**.

If you forget your credentials, you can select Forgot Username or Forgot Password. You will be prompted to enter your tax identification number and email address.
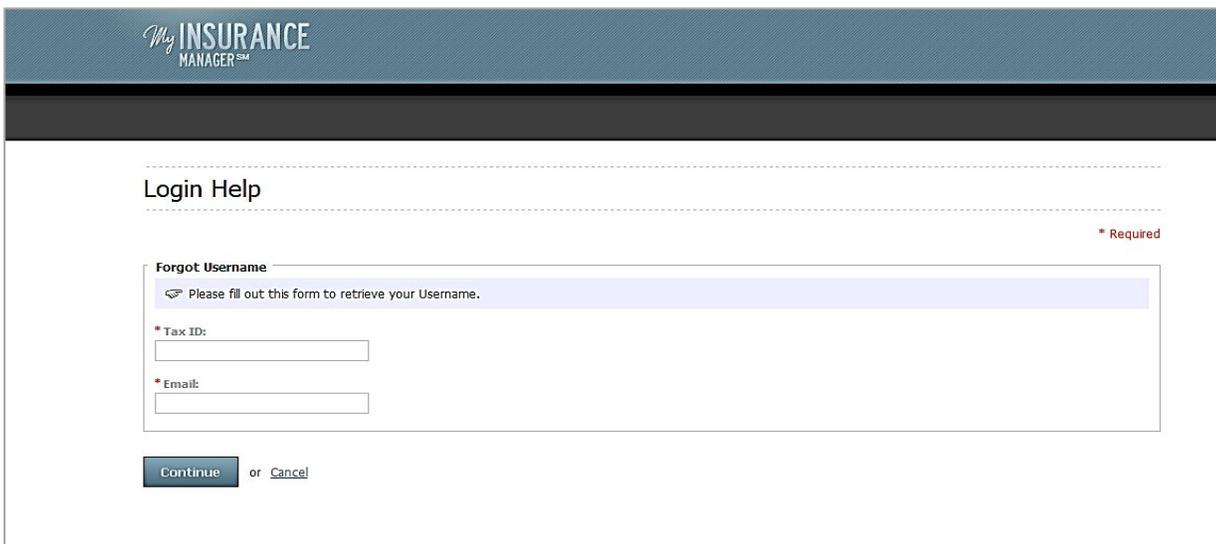
Additionally, you will receive a prompt to validate that you are trying to access the tool. You would select whether you want the security code emailed to you or if you want the system to call you. After choosing and option, select **Continue**.

We need to make sure it's you

It looks like you're using a different computer or device. For your security, we'll send you a code to help verify your information. This helps keep your account safe.

We will send you a security code to the preferred method of contact selected below. If you prefer a different contact method, please choose from below.

📞 Call me at ******4474

📧 Email me at z***********@bcbssc.com

Cancel   Continue

Need assistance? You can contact our customer support team by calling (855) 229-5720.

Enter the security code provided and select **Continue**.

Security Code

Please enter the 6-digit code that was sent to z***********@bcbssc.com.

Enter the code

Didn't receive a code?

Request a new code or you can choose a different way to recieve it.

Back   Continue

Need assistance? You can contact our customer support team by calling (855) 229-5720.

Profile Administration

The profile administrator for your practice manages the profiles associated with your TIN in My Insurance Manager. If your practice is new to My Insurance Manager, the initial user account will be added as the profile administrator. Any additional profile administrators must be approved by the initial administrator.

Note: If there is only one profile administrator, and they plan to leave the practice, they must make someone else the administrator to ensure there is a seamless transition.

Profile administrators can:

- Create profiles.
- Approve profiles.
- Deactivate profiles.
- Restore profiles.
- Modify profile types.
- Reset passwords.

Creating Profiles

To create a profile for an employee in the practice, the profile administrator would complete the Profile Information form. From here, they can set the employee's profile type as an office staff member or a profile administrator.

Approving Profiles

If an employee in your practice creates their own profile, it will pend until the profile administrator approves or denies the profile. The administrator can check the boxes next to the pending profiles and select the appropriate option.

If approved, the employee will be granted access and can use My Insurance Manager. If denied, the employee cannot use the portal.

Deactivating Profiles

If an employee in your practice leaves or no longer needs access to My Insurance Manager, the profile administrator should deactivate their profile. The administrator should check the box next to the individual's profile that needs to be deactivated and select Continue.

A confirmation box will appear. From there, select Submit, Back or Cancel.

Restoring Profiles

Deactivated profiles can be restored within 60 days. After 60 days, the system will purge the profiles.

To restore a profile, the administrator would check the box next to the profile that they want to restore, then select Continue.

A confirmation box will appear. From there, select Submit, Back or Cancel.

Modifying Profile Types

The profile administrator can modify profile types. This means they can convert an existing profile from office staff to profile administrator, and vice versa.

From the available profiles, the administrator must select the radio button next to the profile they want to modify. Next, select Continue.

A confirmation box will appear. From here, select Submit, Back or Cancel.

Modify Profile Types

Verification

⚠ You are about to convert this **Profile Administrator** profile to **Office Staff**.

ⓘ Please remember profile administrators can take the following profile actions:

- Create
- Approve
- Edit
- Deactivate
- Restore
- Modify

In addition, they can:

- Reset passwords.
- View and read all web inquiry (secure message) responses for their individual location.

Submit   **Back**   or *Cancel*

Resetting Passwords

If an employee forgets their password, or wants to change it, the profile administrator can reset their password.

From the available profiles, the administrator must select the radio button next to the profile that needs its password reset. Next, select Continue.

Reset Passwords

First Name:	Last Name:				Results (4)

Search

	Name▲	Username	Phone Number	Email	Location
○	▮▮▮▮▮	House133			JOHN M JONES MD
○	Scripting, Admin	scriptadmin			JOHN M JONES MD
○	Test, EQE	eqeadmin			JOHN M JONES MD
○	Testing, RSET	MEDADMSUPP			JOHN M JONES MD

Continue

Another box will appear for the administrator to enter a new, temporary password for the employee. After entering the new password, select Submit, Back or Cancel.

Reset Passwords

Reset Password

☞ Please enter a new Temporary Password.

Name:

▮▮▮▮▮

Username:

House133

*** Temporary Password**

8 to 25 characters.

Submit   **Back**   or *Cancel*
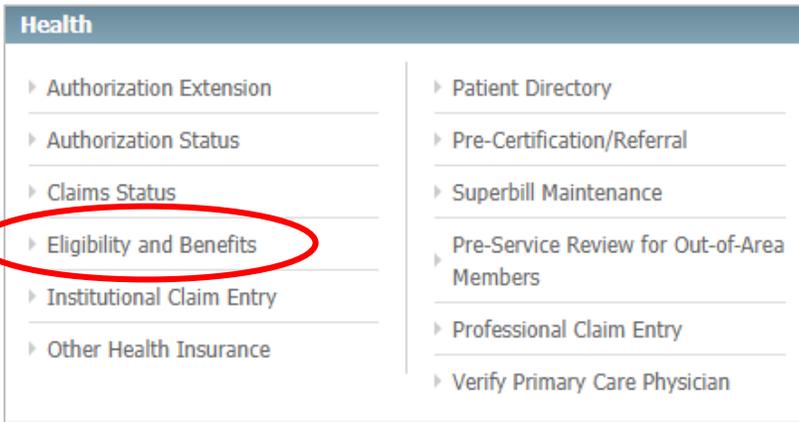
Eligibility and Benefits

Eligibility and benefits can be pulled in three different ways: general eligibility and benefits, eligibility and benefits by service type, or eligibility and benefits by procedure code.

We recommend providers use the procedure code option to ensure they get the most accurate details.
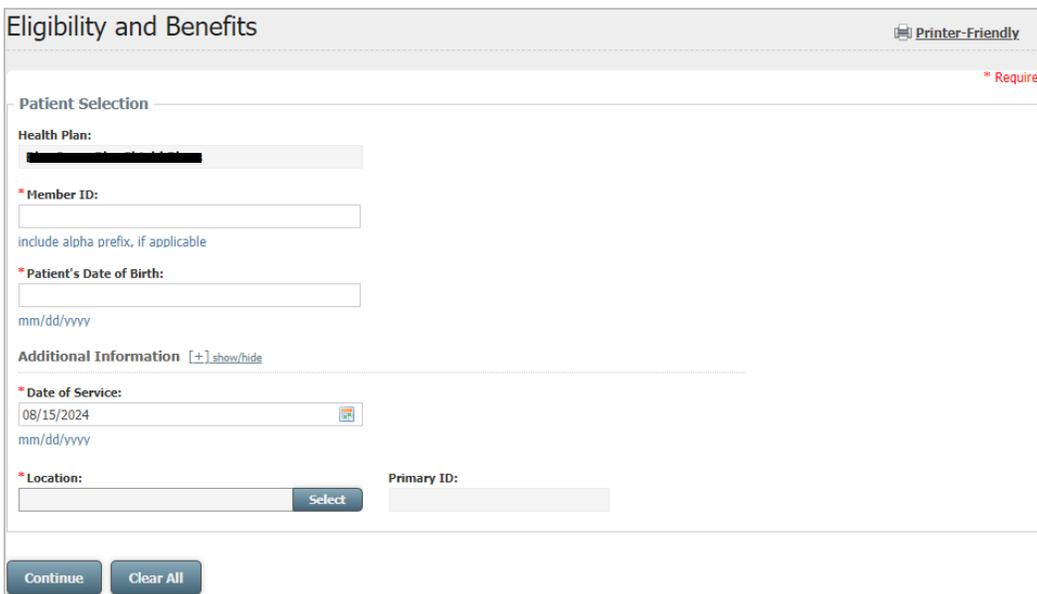
General Eligibility and Benefits

For general benefits do the following:

1. Under **Patient Care**, select **Eligibility and Benefits**.

2. Enter the details marked with an asterisk and select the appropriate location. Select **Continue**.

3. On the Eligibility Request screen, select **General Eligibility and Benefits**.

Eligibility Request

Choose Eligibility View

ℹ Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

- ◉ General Eligibility and Benefits
- ○ Eligibility and Benefits by Service Type
- ○ Eligibility and Benefits by Procedure Code

Submit

4. Select **Submit**.

You will be provided with the general details for the member. This includes things like their deductible, out-of-pocket maximums, and more. From the available list of services, you can select the different options to view the corresponding benefit that applies.

🖶 **Printer-Friendly**

Date of Service
04/30/2024

Response Details

Eligibility Response [+]

Insurance

Plan Name:
██████████

Plan ID:
38520

Member ID:
██████████

Group Number:
██████████

Member's Name:
MICHAEL TESTING

Policy Effective Date:
06/01/2002

Benefit Period:
04/01/2024 - 04/01/2025

🗎 View Benefit Booklet for this patient

IN AND OUT OF NETWORK

Global Benefits

✅ This patient has active coverage.

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: **$250.00** PER SERVICE YEAR - **$250.00** REMAINING

INDIVIDUAL OUT OF POCKET: **$750.00** PER SERVICE YEAR - **$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

FAMILY DEDUCTIBLE: **$500.00** PER SERVICE YEAR - **$500.00** REMAINING

FAMILY OUT OF POCKET: **$1,500.00** PER SERVICE YEAR - **$1,500.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

Patient

Patient's Name:
MICHAEL TESTING

Relationship to Member:
SUBSCRIBER

Gender:
MALE

Date of Birth:
10/01/1958

Address:
P O BOX 24015
COLUMBIA, SC 292244015

Change Patient

Eligibility and Benefits by Service Type

For eligibility and benefits by service type do the following:

1. Under **Patient Care**, select **Eligibility and Benefits**.

2. Enter the details marked with an asterisk and select the appropriate location. Select **Continue**.

Eligibility and Benefits

Patient Selection

Health Plan:

▮▮▮▮▮▮▮▮▮▮▮▮

* **Member ID:**

include alpha prefix, if applicable

* **Patient's Date of Birth:**

mm/dd/yyyy

Additional Information [+] show/hide

* **Date of Service:**

08/15/2024

mm/dd/yyyy

* **Location:**   **Primary ID:**

[Select]

[Continue] [Clear All]

3. While the primary diagnosis is not required, it would be beneficial to include it if it's available. Also, be sure to select the appropriate place of service.

Eligibility Request

* Required

Choose Eligibility View

ℹ️ Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

○ General Eligibility and Benefits

🔵 Eligibility and Benefits by Service Type

○ Eligibility and Benefits by Procedure Code

* **Service Type Code:**

--Please Choose One-- ⌄

Primary Diagnosis Code (ICD-10):

🔍

⊕ **Add Diagnosis Code**

Place of Service: (recommended)

Office - 11 ⌄

Service Facility/Billing Location:

⌄

Rendering/Performing Provider:

JOHN M JONES MD ⌄

[Submit]

Other Service Types

ABORTION – 84
ACUPUNCTURE – 64
AIDS – 85
AIR TRANSPORTATION – 57
ALCOHOLISM – AJ
ALLERGY – GY
ALLERGY TESTING – 79
ALTERNATE METHOD DIALYSIS – 15
AMBULATORY SERVICE CENTER FACILITY – 13
ANESTHESIA – 07
ANESTHESIOLOGIST – 97
AUDIOLOGY EXAM – 71
BLOOD CHARGES – 10
BRAND NAME PRESCRIPTION DRUG – 91
BRAND NAME PRESCRIPTION DRUG – NON-FORMULARY – B3
BURN CARE – B1
Brand Name Prescription Drug – Formulary – B2
CABULANCE – 58
CANCER – 87

4. Select **Submit**.

You will be provided with the benefits for the specific service type selected for the member.

🖨 **Printer-Friendly**

Date of Service
04/30/2024

Response Details

Eligibility Response [±]

Insurance

Plan Name:
▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓

Plan ID:
38520

Member ID:
▓▓▓▓▓▓▓▓▓▓▓▓▓

Group Number:
▓▓▓▓▓▓▓▓

Member's Name:
MICHAEL TESTING

Patient

Patient's Name:
MICHAEL TESTING

Relationship to Member:
SUBSCRIBER

Gender:
MALE

Date of Birth:
10/01/1958

Address:
P O BOX 24015
COLUMBIA, SC 292244015

[Change Patient]

Policy Effective Date:
06/01/2002

Benefit Period:
04/01/2024 - 04/01/2025

📄 View Benefit Booklet for this patient

[IN AND OUT OF NETWORK]

Global Benefits

✅ This patient has active coverage.

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: **$250.00** PER SERVICE YEAR - **$250.00** REMAINING

INDIVIDUAL OUT OF POCKET: **$750.00** PER SERVICE YEAR - **$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

FAMILY DEDUCTIBLE: **$500.00** PER SERVICE YEAR - **$500.00** REMAINING

FAMILY OUT OF POCKET: **$1,500.00** PER SERVICE YEAR - **$1,500.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

Eligibility and Benefits by Procedure Code

For eligibility and benefits by procedure code do the following:

1. Under **Patient Care**, select **Eligibility and Benefits**.

2. Enter the details marked with an asterisk and select the appropriate location. Select **Continue**.

Eligibility and Benefits

🖶 Printer-Friendly

* Required

Patient Selection

Health Plan:

▓▓▓▓▓▓▓▓▓▓▓▓▓

* Member ID:

include alpha prefix, if applicable

* Patient's Date of Birth:

mm/dd/yyyy

Additional Information [+] show/hide

* Date of Service:

08/15/2024

mm/dd/yyyy

* Location:

Select

Primary ID:

Continue   Clear All

3. On the Eligibility Request screen, select **Eligibility and Benefits by Procedure Code**. While the primary diagnosis and modifiers are not required, it would be beneficial to include it if it's available. Also, be sure to select the appropriate place of service.

Eligibility Request

* Required

Choose Eligibility View

ⓘ Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

○ General Eligibility and Benefits

○ Eligibility and Benefits by Service Type

● Eligibility and Benefits by Procedure Code

* Procedure Code:

Modifiers:

Primary Diagnosis Code (ICD-10):

⊕ Add Diagnosis Code

Place of Service: (recommended)

Office - 11

Service Facility/Billing Location:

Rendering/Performing Provider:

JOHN M JONES MD

Submit

19

4. Select **Submit**.

You will be provided with the benefits for the procedure code entered.

Service▲		Place of Service▲	Diagnosis Code (ICD-10)▲	Specialty▲
▽ **CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES- 99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANA**		1- OFFICE		

✓ **This patient has active coverage.**

Insurance Type: INDEMNITY

Plan Name: INDEMNITY

THIS MEMBER CURRENTLY HAS AN HSA WITH A PAYMENT OPTION WHICH ALLOWS FOR AUTOMATIC PAYMENT DIRECTLY TO THE PROVIDER. QUALIFIED MEDICAL EXPENSES WITH THE EXCEPTION OF DENIED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT.

RESPONSES TO ALL FUTURE DATED INQUIRIES ARE BASED ON THE PATIENT'S CURRENT BENEFITS AND ARE SUBJECT TO CHANGE.

YOU HAVE REQUESTED BENEFITS FOR A MEMBER THAT HAS BENEFIT EXCEPTIONS AT THE PROCEDURE CODE LEVEL. TO OBTAIN MORE SPECIFIC INFORMATION, PLEASE REQUEST BENEFITS ON MY INSURANCE MANAGER USING A SPECIFIC PROCEDURE CODE AND DIAGNOSIS CODE.

View Additional Messages

INDIVIDUAL COINSURANCE: **15%**

Ask Provider Services   **New Search**   Back

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Authorizations

Currently, there are two options for getting prior authorization: fast-track and custom requests.

Fast-track offers several predetermined authorization requests based on the volume of requests received. They include specific codes based on the type of service, and the authorization number is typically provided after submitting the request.

Custom requests are available when a fast-track option is not. Please note that custom requests will pend for further review, and if approved, the authorization number will be provided.

Getting Prior Authorization – Current Process

For prior authorizations, do the following:

1. Under **Patient Care**, select **Pre-Certification/Referral**.

2. Enter the member's ID number and additional details marked with an asterisk. Select **Continue**.

3. Search for a fast-track option by procedure code, keyword or diagnosis code. You can also search for a fast-track option by request type. Select **Continue**.

Request

Search

☞ New - Enter a descriptive keyword, procedure code or diagnosis code to search for a Fast-Track service.

* Search:

◉ Procedure Code

○ Keyword

○ Diagnosis Code

ⓘ Please note: Any drugs, services, treatment or supplies our medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our pre-certification requirements.

[Continue]   [Ask Health Care Services]   or Back   Start Over

OR

Request

Request Type

☞ In order to help us identify the required service, please answer these questions:

Which type of service are you requesting?

◉ Procedure

○ Non-Procedure

○ Laboratory Test

○ Behavioral Health Treatment

○ Maternity

○ Specialty Drug

Where will this service take place?

○ Inpatient Hospital

◉ Outpatient Facility

ⓘ Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our pre-certification requirements.

[Continue]   [Ask Health Care Services]   or Back   Start Over

4. When searching by the request type, you will be provided with a full list of available fast-track options. Select the option that best fits the service being rendered.

If you do not see a fast-track option, select **Submit a Customized Pre-Certification Request**.

5. For fast-track, proceed with entering the requested data marked with an asterisk. Select **Continue**.

6. Include the principal diagnosis and attached the necessary clinical documentation. Select **Continue**.


7. Follow the remaining prompts to submit the request.

*Getting Prior Authorization – Cohere Process*

Soon, the current process for getting a prior authorization will change due to the implementation of using Cohere Health. While providers will still go through My Insurance Manager, the remaining steps for getting an authorization are different.

Do the following:

1. Under **Patient Care**, select **Pre-Certification/Referral**.
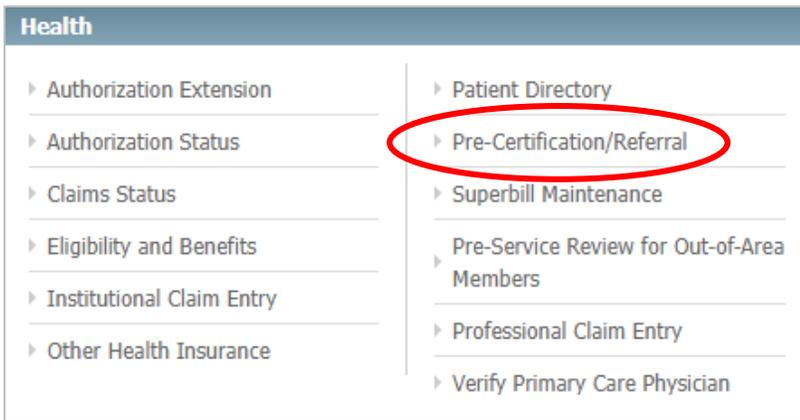
2. On the new Cohere Health landing page, select **Start auth request**.
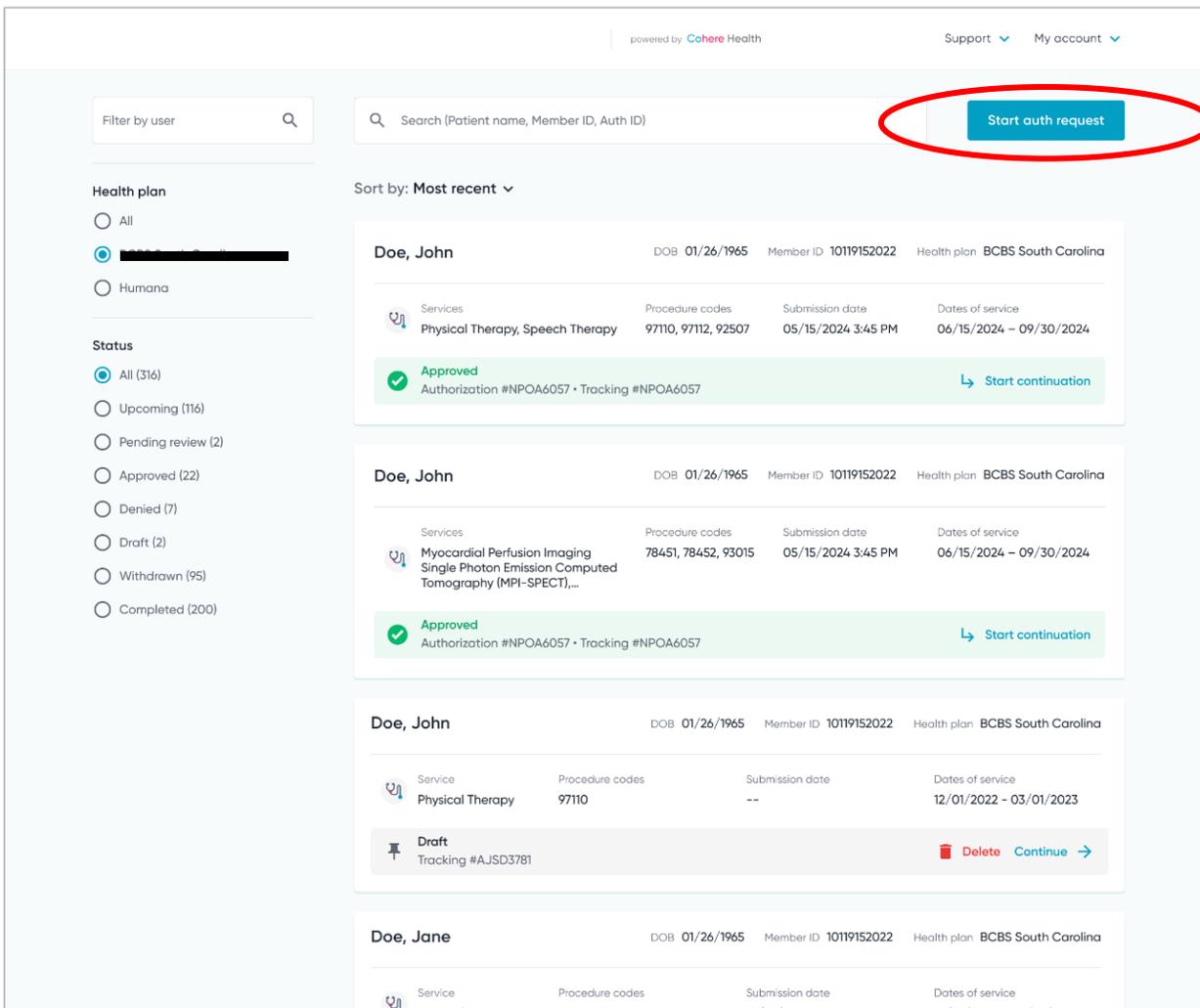
3. Choose whether the service is outpatient or inpatient and include the diagnosis and procedure codes. Select **Continue**.

4. Enter the necessary provider details. Select **Continue**.

5. The codes listed at the top of the screen require prior authorization, while the codes listed at the bottom do not. Note: If the request is urgent, check the Expedite box. Select **Continue**.

Requires authorization

Start date
04/30/2024

End date
mm/dd/yyyy

Physical Therapy (PT)

Number of visits
1

97110   Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

⊕ Add a procedure code

Total Knee Arthroplasty (TKA)

27447   Units   Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)   🗑 Remove
         1

⊕ Add a procedure code

☐ Expedite

❗ Doesn't require authorization in most cases   ⬇ Download PDF   ⌄
   93798

⟲ Save and exit   Continue with 2 codes

6.   Upload the relevant clinical documents for review. Select **Continue**.

‹ Back   Add attachments

Choose files to upload
Please add clinical documentation to support this authorization and accelerate the review.

Add files

Clinical Note.pdf
Uploaded on 05/08/2023 at 12:00:07 PM (EDT) by Brandon Miller   👁 ⬇ 🗑

7.   Review the services before submitting. Select **Submit services**.

Review services before submitting

Physical Therapy (PT), Total Knee Arthroplasty (TKA)

> **This request duplicates an existing one**
> Duplicate submissions may be voided. The care setting (outpatient or inpatient), performing provider (if applicable), and facility match an existing request, including overlap in procedure codes and service dates.
>
> You can choose to withdraw the existing request, change details to avoid duplication, or call Cohere for assistance at (833) 283-0033.

Draft
Tracking #WKGB4665   🗑 Delete

1 evidence-based suggestion to improve your request:

Expedited → **Not expedited**
The coverage and/or services on this request do not meet the requirements for an expedited request.

Accept

Details   ✏ Edit

Primary diagnosis	M25.561 – Pain in right knee
Secondary diagnosis	--
Care setting	Outpatient
Place of service	Ambulatory Surgical Center

Save and exit   **Submit services**

After submitting the request, providers will receive a faxed notification confirming the receipt of the request. Once a determination is made, providers will be notified. Note: Although InStil Health is using the Cohere Health platform, all clinical decisions are made by the health plan.

Claims

Submitting Claims

Submitting claims in My Insurance Manager can be done in a few simple steps. There are seven screens that you will progress through when using the portal to submit claims: Plan Information, Provider Information, Patient Information, Claim Information, Claim Line Information, Review and Confirmation.

To begin the process, do the following:

1. Under **Patient Care**, select **Institutional Claim Entry**, **Professional Claim Entry** or **Dental Claim Entry**. Note: The screens will be the same for each entry type. However, the Dental Claim Entry will ask additional questions related to the teeth.

2. Enter all the required details on the Plan Information page. Note: At any time, you can select **Cancel this claim** to abort the process.

3. Enter the required details on the Provider Information page. Note: You must select **Choose a Billing Provider** if more than one location is on file.

4. Enter the required details on the Patient Information page. Note: If you have a repeat patient, you can select **Choose a Patient** from your roster.

5. Enter the required details on the Claim Information page. Note: If you render certain services for multiple patients, you can create a **Superbill template** that will include the same details for each patient.

6. Enter the required details on the Claim Line Information page.

7. Review the details on the Claim Review page. If corrections are needed, you can select **Back**. If the information is accurate, select **Submit**.

8. The Claim Confirmation page will give you the claim number.

Checking Claims Status

There are two ways to get claims status: using the member identification number or using the claim number. We recommend using the identification number to ensure you pull all the available claims.

For claims status, do the following:

1. Under **Patient Care**, select **Claims Status**.

2. Select Member ID and enter the member's identification number along with their date of birth. Select **Continue**.

3. A list of the available claims will populate. Note, if the date of service in question does not pull, it could be purged from the system depending on the date of service.

Claims Summary List *(click a column title to sort)*

Showing 3 Results

List of health claims

Claim Number	Claim Status	Primary ID	Beginning Date of Service▾	Process Date	Total Charges
🔍 207103LDG0000	PROCESSED	15	03/07/2022	03/12/2022	$81.00
🔍 207404P250000	PROCESSED	16	03/07/2022	03/15/2022	$130.50
🔍 2029023B80000	PROCESSED	16	01/18/2022	01/31/2022	$362.00

Ask Provider Services

4. Select the claim you want to review. You can select the available buttons to view additional details on the claim.

Claim Number:
207103LDG0000

☞ Check your remittance voucher for any non-covered or non-allowed charges which may be the member's responsibility.

Primary Status:
FINALIZED-THE CLAIM/ENCOUNTER HAS COMPLETED THE ADJUDICATION CYCLE AND N O MORE ACTION WILL BE TAKEN.

Patient Liability   **Detailed Status Information**   **Additional Status Information**

Detail

Status Effective Date:	Date(s) of Service:	Processed Date:
03/12/2022	03/07/2022 - 03/07/2022	03/12/2022

Primary ID:	Organization or Provider's Name:
1_____	UNI_____

Total Charges:	Amount Paid:	Bill Type:
$81.00	$0.00	141

Patient Account Number:
2402_

Here is a list of the line items associated with this claim.

Line Summary List

Showing 1 Result

Line Item	Line Status	Date(s) of Service	Line Charges	Amount Paid
🔍 01	PROCESSED	03/07/2022 - 03/07/2022	$81.00	$0.00

Revenue Code:
0310 - LABORATORY PATHOLOGICAL,0,GENERAL CLASSIFICATION

Procedure Code:
S1310 - LABORATORY PA

Previous Claim   **Next Claim**   **Ask Provider Services**   or [Back]

Patient Liability –

Claim Number:

207103LDG0000

☞ Check your remittance voucher for any other non-covered or non-allowed charges which may be the member's responsibility.

Patient Liability

ⓘ Please note: The amount in the Other field includes any non-covered charges that are not copayments, deductibles or coinsurance. This amount may also include reimbursements from the member's Health Reimbursement Account.

For more specific details, please see your remittance advice for this claim.

Deductible:	**Copayment:**	**Coinsurance:**	**Other:**	**Total:**
$72.42	$0.00	$0.00	$0.00	$72.42

Back

Detailed Status Information –

Status Details

FINALIZED-THE CLAIM/ENCOUNTER HAS COMPLETED THE ADJUDICATION CYCLE AND NO MORE ACTION WILL BE TAKEN.

107 - PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS

Additional Status Information –

✖

Additional Status Information

Description:

CLAIM HAS PROCESSED

Claim Attachment Feature

Claim Attachments is a feature in My Insurance Manager that lets you upload **requested** documentation directly into the portal for a claim. Documents that can be uploaded include:

- Accident questionnaires
- Certificate of medical necessity (for durable medical equipment)
- Medical records
- Other health insurance
- Primary explanation of benefits
- Itemized bills

Using the Claim Attachment Feature

1. Under **Patient Care**, select **Claims Status**.

2. Select Member ID and enter the member's identification number along with their date of birth. Select **Continue**.

Once you locate the claim in question, the **Claim Status Detail** page will reflect whether additional documentation may be needed as well as what type of documentation may be required. Note: You will not see the Attachments option unless the claim (or service within the claim) requires documentation.
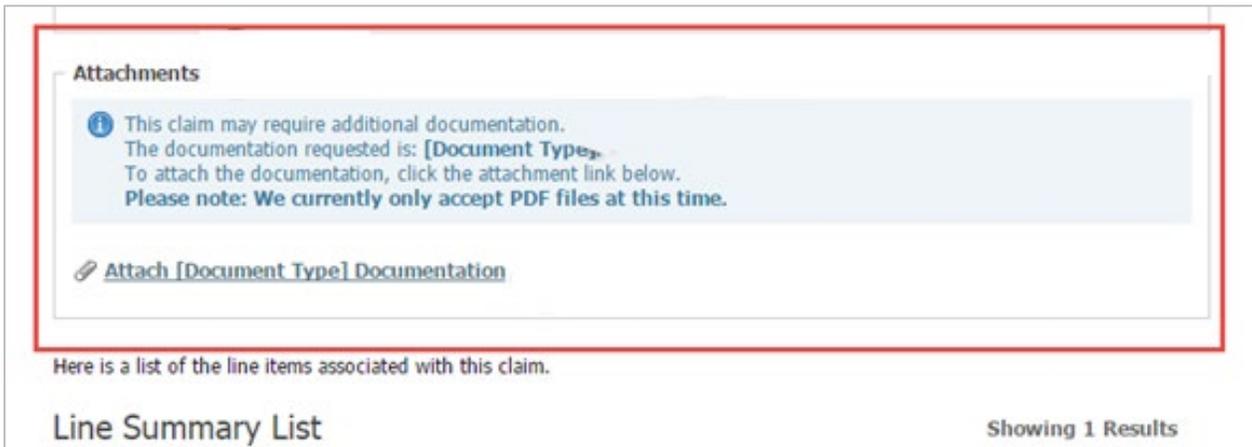
3. Select the **Attach Documentation** option to continue.
4. Next, look for and then select the document you want to attach. Once the appropriate document is chosen, select **Open**.
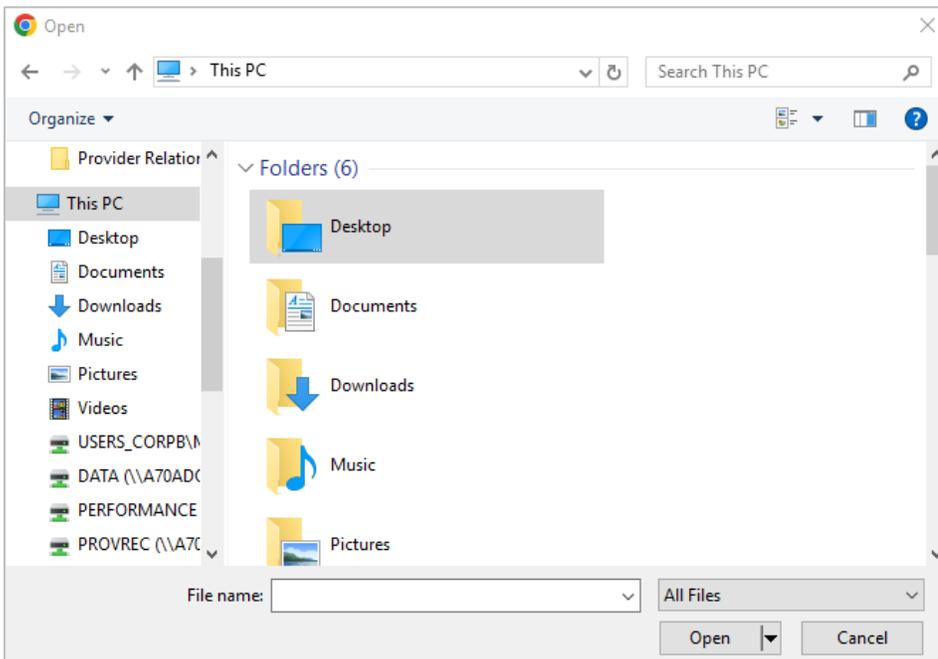
If the file is invalid (perhaps it is not a PDF file or it exceeds 30MB), then you will receive this message:

Attach [Document Type] Documentation

Upload File — Review File — Confirm Submission

⊘ We cannot accept the file type you selected. Please try another type.

📎 Attach Another [Document Type] File   Cancel
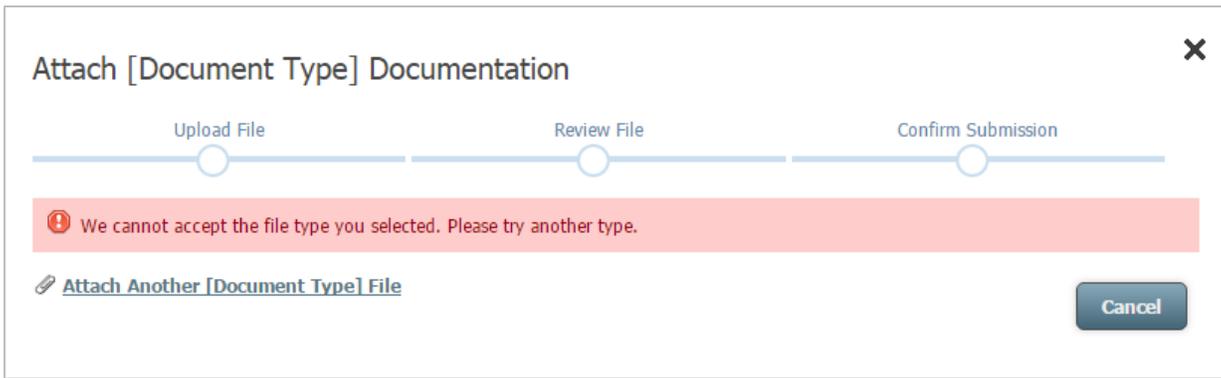
Once you have selected the correct document, it will display in the Attach Documentation screen.

Attach [Document Type] Documentation

Upload File ✓ — Review File — Confirm Submission

Please confirm that this file is the one you wanted to upload.

TEST PDF

⚠ By selecting **Confirm**, you are acknowledging this document is accurate and formatted correctly.   Confirm   Cancel

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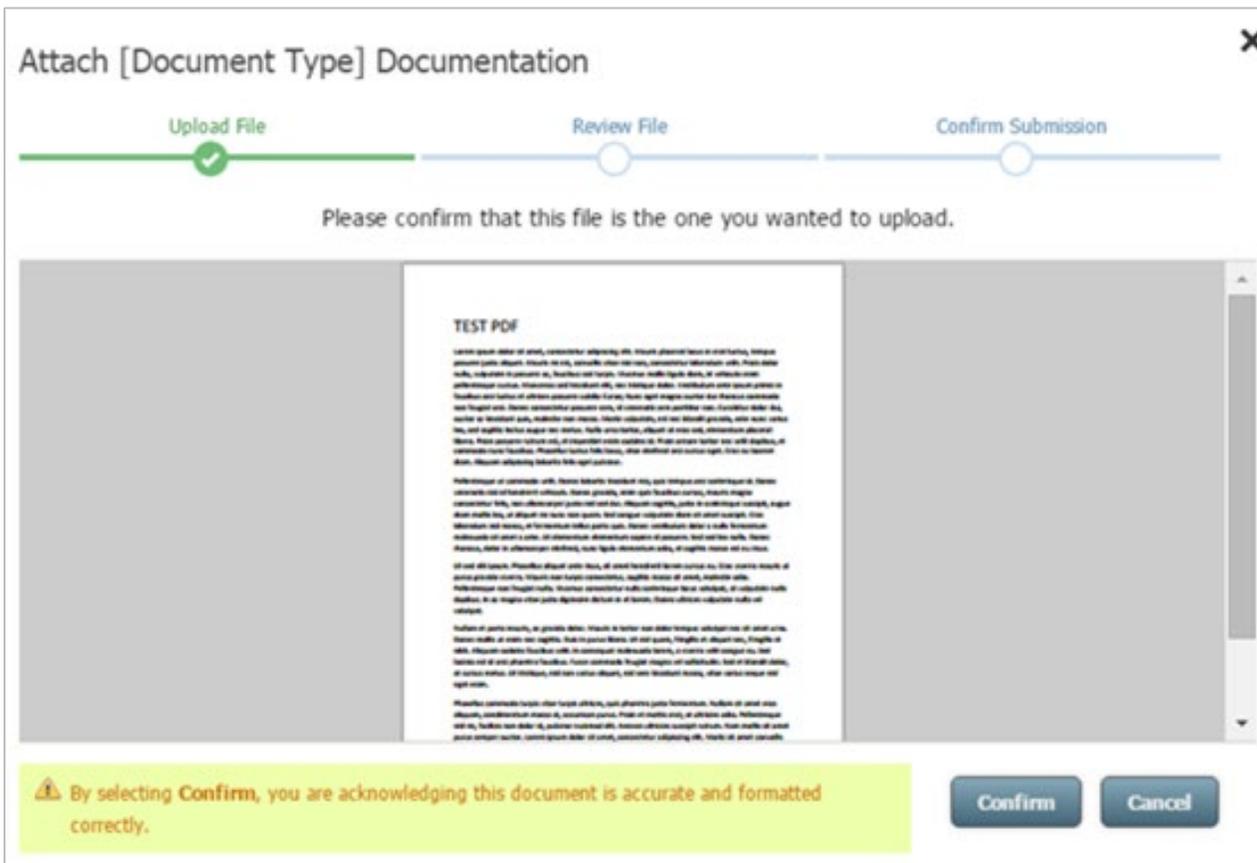
5. Review the document you have uploaded in the Attach Documentation screen and verify the document you want to attach is the one associated with the claim for the member. If the document you have attached contains more than one page, you can use the scroll option to view additional pages.

6. To confirm the document is correct, select **Confirm**. By selecting **Confirm**, you are acknowledging that the document you have attached is accurate and formatted correctly. To cancel the document you attached, select **Cancel**. You will have several opportunities to cancel before completing the attachment process.

If you select **Cancel**, you'll see the option to either **Cancel Upload** or to **Return to Review**.

Once you confirm, you will see a list that displays the document along with its title. You will then have the option to attach additional documents, submit the attachment, cancel the attachment or delete any attachments you have already added.
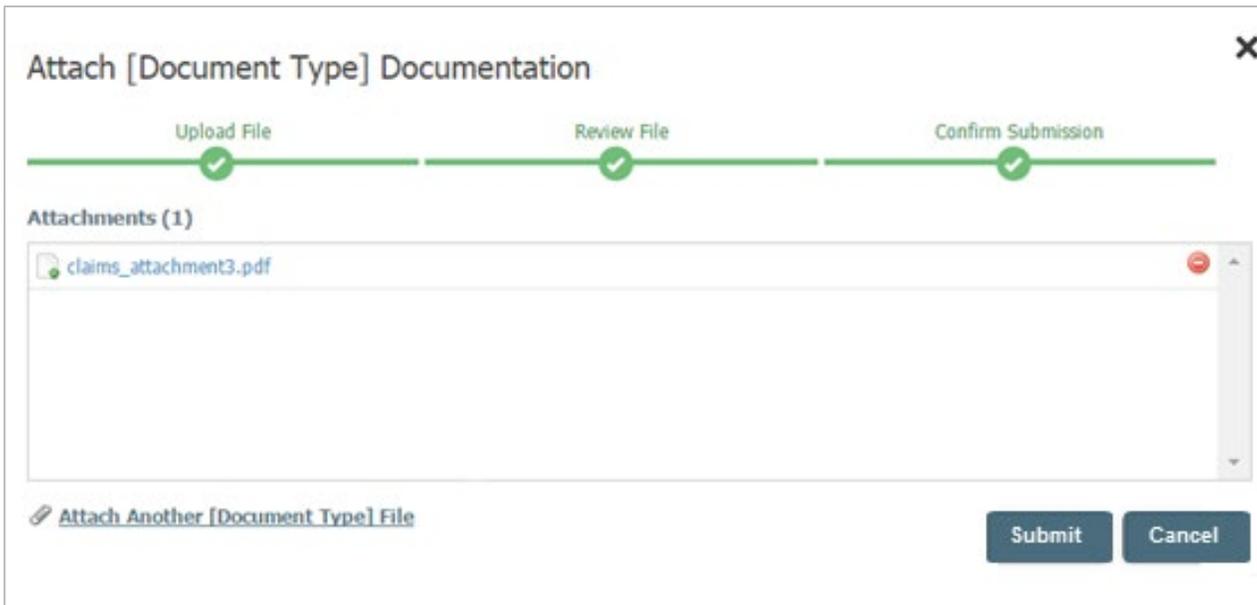
Select **Attach Another File** at the bottom of the screen to attach another document. Each new document you attach will appear in the list of attachments here on the Attach Documentation screen.

If you select **Attach Another File** by mistake, select **Cancel**. Next, Select **Ok** to proceed with your request to cancel the attachment or **Cancel** to return to the Attach Documentation screen.
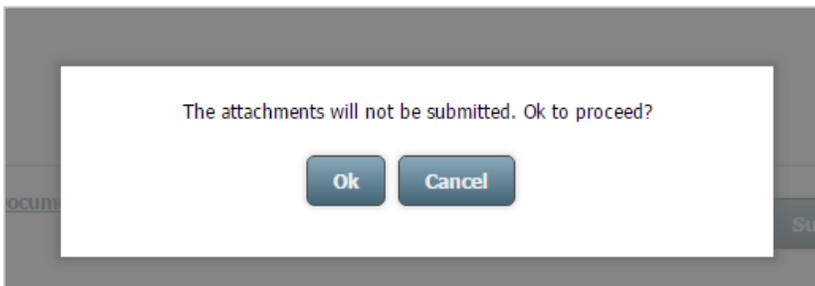
To remove a document you attach, select the red button.
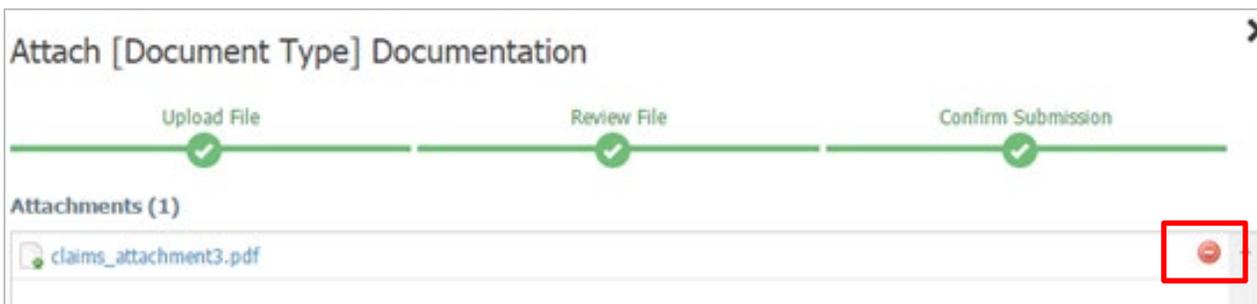
If you need to remove any document, a box will display asking if you wish to delete the selected document. If you select **Yes**, then the document you selected will be removed. Once the document is removed, the new number of attachments will reflect on the Attach Documentation screen. If you select **No**, the document you selected will remain.

Are you sure you want to delete
claims_attachment3.pdf?

Yes   No

7. Once you are satisfied with the documents attached, select **Submit**. When you select **Submit**, you will be routed back to the Claim Status Detail page and see the message, **"You have successfully submitted the requested documentation."**

Attachments

ℹ This claim may require additional documentation.
The documentation requested is: **[Document Type]**
To attach the documentation, click the attachment link below.
Please note: We currently only accept PDF files at this time.

✓ You have successfully submitted the requested documentation.

Attached Documents (1)

📄 report.pdf

🔗 **Attach [Document Type] Documentation**

Here is a list of the line items associated with this claim.

Line Summary List   **Showing 1 Results**

Once the documentation has been received, it will be routed to the appropriate department for review and adjudication. You will not receive a confirmation of receipt or a status after you've successfully submitted the documentation. You can print the Claim Status Detail page for your records.

Go to Message Center

Detailed Status Information   🖨 **Printer-Friendly**

Claim Number:

is

👉 Please see line items for more details about the payment of this claim.

Status Details

Ask Provider Services and STATchat℠

Ask Provider Services is a feature in My Insurance Manager that let's you submit secure web inquiries for help with claims. This feature is intended to assist with complex issues and note general claims status.

Submitting Web Inquiries

Once you are on the claim screen in My Insurance Manager, you will see a button labeled **Ask Provider Services**. Select the button.
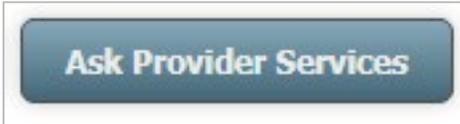
On the Inquiry screen, be sure **Submit your question online** is selected. Enter the required details. Be sure to ask clear, probing questions, as this will ensure you receive the best response. After all the information has been included, select **Submit Question**.

Viewing Web Inquiry Responses

To view responses to your inquiries, do the following:

1. Log into My Insurance Manager.
2. Select **Go to Message Center** on the right-hand side.

Go to Message Center

3. You can narrow the results by entering the member's identification (ID) number and selecting specific months. If a response is available, it will appear in your list.

Note: Provider Administrators can view all web inquiry submissions and responses associated with the Tax ID. After entering the member's ID number, they can select a staff member from the available drop-down menu.

My Remit Manager

Accessing My Remit Manager

You can access My Remit Manager directly inside My Insurance Manager. Hover over **Resources** and select **My Remit Manager**.
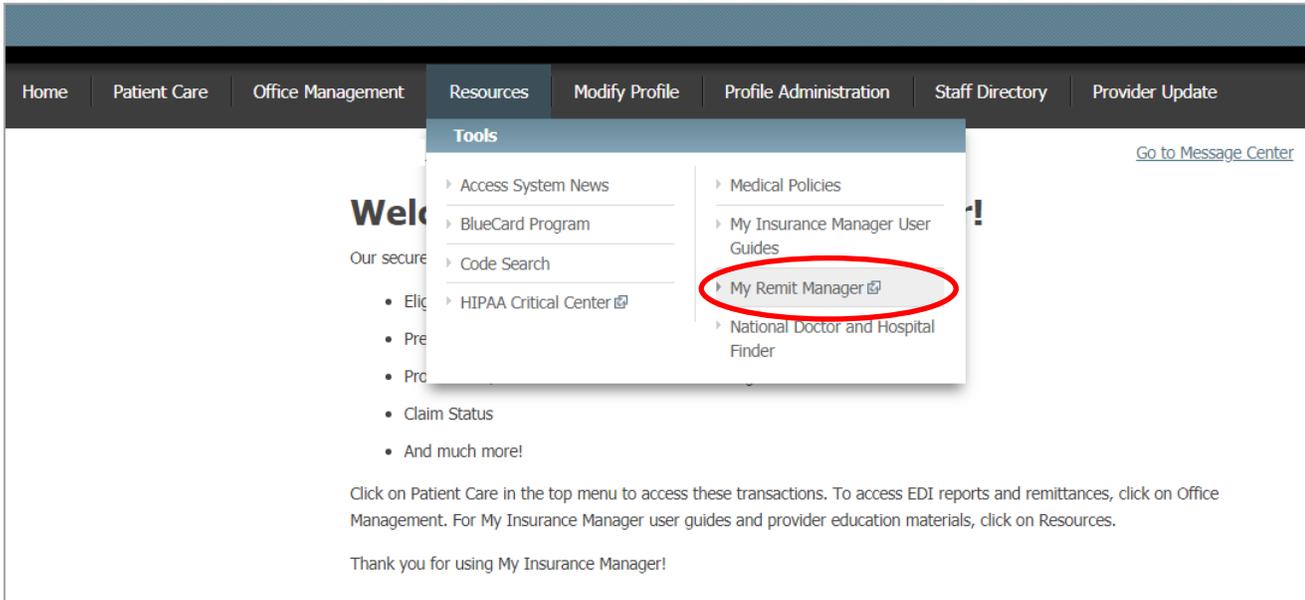
1. From the My Remit Manager landing page, select the Check link on the date in question.

2. Select the Adobe icon to view the full remittance or select the available check numbers to view specific patient details.

Reco	Download	Check Number	Payment Method	Checkdate	Postdate	Billed	Paid	Payer	Provider
☐		_____	ACH	11/1/2022	10/30/2022	$9,485.00	$1,572.00	Bl	
☐		_____	ACH	11/1/2022	10/30/2022	$7,807.00	$1,749.13	ST	
☐		_____	ACH	11/1/2022	10/30/2022	$530.00	$132.00	FE	
☐		_____	ACH	11/1/2022	10/30/2022	$2,105.00	$213.04	Bl	
☐		_____	ACH	11/1/2022	10/30/2022	$1,157.00	$96.18	ST	
☐		_____	ACH	11/1/2022	10/30/2022	$769.00	$141.47	FE	
☐		_____	ACH	11/1/2022	10/30/2022	$178.00	$117.00	Bl	
☐		_____	ACH	11/1/2022	10/30/2022	$196.80	$24.14	ST	
☐		_____	ACH	11/1/2022	10/30/2022	$1,410.00	$78.99	Bl	
☐		_____	ACH	11/1/2022	10/30/2022	$1,710.00	$380.05	ST	

⏮ ◀ 1 2 3 4 5 ▶ ⏭ Page size: 10 ▼   44 items in 5 pages

Check Selected:

ERA Patient Listing

Electronic Reproduction ASC 005010X221A1

UNIVE

	CHECK/EFT: 0001375495		CHECK DATE: 03/01/2022

BLUECROSS BLUESHIELD OF SOUTH CAROLINA -EXCHANGE

Account: POS: 13   HIC: L   ICN: 205402TVL0000   Provider: 1568419976 030219309 1417949694

Status: Processed as Primary
MOA: N45

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary		
030219309	02/17/2022	1	0300	HC:80061	84.50	28.11			56.39	28.11	CO	45	56.39
											HE	N45	
030219309	02/17/2022	1	0300	HC:36415	31.50	6.30			25.20	6.30	CO	45	25.20
											HE	N45	
REMITTANCE SUMMARY					116.00	34.41	.00	.00	81.59	34.41			

TOTALS

Denied/Non-Covered: 0.00
CO   45   81.59   [Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO
                     depending upon liability).]
HE   N45   [Payment based on authorized amount.]

* Denotes Denied Or Non-covered Charges

N45:Payment based on authorized amount.

	CHECK/EFT: 0001375495		CHECK DATE: 03/01/2022

BLUECROSS BLUESHIELD OF SOUTH CAROLINA -EXCHANGE

Account: POS: 13   HIC: L   ICN: 202705KQM0000   Provider: 1568419976 030219309 1649664913

Status: Processed as Primary
MOA: N2

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary		
030219309	01/19/2022	1	0450	HC:99283	1,040.94	490.41			600.53	440.41	PR	3	50.00
											CO	94	550.53
											HE	N2	
REMITTANCE SUMMARY					1,040.94	490.41	.00	.00	600.53	440.41			

TOTALS

Denied/Non-Covered: 0.00
PR   3   50.00   [Co-payment Amount]
CO   94   550.53   [Processed in Excess of charges.]
HE   N2   [This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.]

* Denotes Denied Or Non-covered Charges

N2:This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.

	CHECK/EFT: 0001375495		CHECK DATE: 03/01/2022

BLUECROSS BLUESHIELD OF SOUTH CAROLINA -EXCHANGE

Account: POS: 13   HIC: L   ICN: 205402R9Y0000   Provider: 1568419976 030219309 1356374755

Status: Processed as Primary
MOA: N2,N363

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary		
030219309	02/15/2022	1	0300	HC:U0005	25.00	52.50			-27.50	52.50	CO	94	-27.50
											HE	N2	
030219309	02/15/2022	1	0300	HC:U0003	102.30	157.50			-55.20	157.50	CO	94	-55.20
											HE	N363	
											HE	N2	
REMITTANCE SUMMARY					127.30	210.00	.00	.00	82.70	210.00			