BlueCross BlueShield of New Mexico

Helpful Tips for Preventing Claim Delays

Listed below are some of the most common issues that can cause delays in claims processing. Keep these tips in mind when filing claims.

Check eligibility and benefits before providing services

Checking member eligibility and benefits prior to services being rendered will save your office time and money. In addition, your office, as well as the BCBSNM member, will better understand the member's financial responsibility for the services. Visit the Eligibility and Benefits section for more information.

Alpha prefixes are vital when filing claims

The three-character alpha prefix at the beginning of the member's ID number is key to identifying and correctly routing out-of-state claims to the appropriate Blue Cross and Blue Shield (BCBS) Plan for processing. The alpha prefix identifies the BCBS Plan to which the member belongs and helps confirm the member's eligibility and coverage information.

An incorrect or missing alpha prefix can cause delays in the processing of your claims. To avoid these, please:

- Do not omit or randomly select an alpha prefix.
- Include the alpha prefix and all alpha-numeric characters on all correspondence and claims submitted to the BCBS Plan.
- Copy the member's ID card front and back for your records.

When there is only one insurance carrier

We receive thousands of claims each month that require unnecessary review for Coordination of Benefits (COB). That means possible delays or even denials of services pending receipt of the required information from members.

Following are some tips to help prevent claims processing delays on the CMS-1500 form when there is only one insurance carrier:

1. Box 11-d: If there is no secondary insurance carrier, mark the box "No."
2. Do not put anything in box 9, a through d. This area is reserved for member information for a secondary insurance payer.

When there are two insurance carriers

Be sure to include both the primary and secondary policy information on the claim.

Date of Current Illness and Occurrence Code

CMS-1500 claims – enter the Date of Current Illness (or onset date) in box 14 to indicate the date of the first symptom (for an illness), date of accident (for an injury), or date of the last menstrual period (for pregnancy).

UB-04 claims – enter the Occurrence Code and associated date in fields 31 through 36 to define a significant event related to the claim.

Remember that the first date of service is not always the onset/occurrence date. Claims may process differently depending on what date is entered. Be sure you are entering the actual date on all claims.

Provider information

Be sure to include all current and complete provider information on claims, including the current tax identification number and National Provider Identifier (NPI) number in the correct fields.

Preauthorization for initial stay and add-on days

Preauthorization is required for certain types of services. Preauthorization must be obtained for any initial stay in a facility and any additional days or services. If preauthorization is not obtained, benefits may be reduced. Refer to the Preauthorization section for more information.

Only submit additional medical records when requested

Physicians and professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a Radiology Quality Initiative (RQI) number from AIM Specialty Health℠, *do not* need to submit additional medical records to BCBSNM. If we need additional medical records to process a claim, we will request them.

Corrected claims

CMS-1500 corrected claims should be submitted electronically using the Claim Inquiry Resolution (CIR) tool. If you must file CMS-1500 corrections on paper, complete the Claim Review Form and attach the form to the top of the claim.

UB-04 corrected claims should be submitted electronically whenever possible. Refer to Section 8.13 of the Provider Reference Manual for more information about submitting corrected claims.

Claim status

If a response has not been received to a claim, please check the status online or via Provider Customer Service's automated phone system. If the claim is already on file but has not yet been processed, a resubmission will not expedite the processing of the original claim. Refer to the Claim Status section for more information.