

Summary

Creating a secondary or tertiary claim on ConnectCenter follows same process as creating a primary claim.

1. Log in to Connect Center and select Create a Claim – Professional from Claims Menu.

CHANGE ConnectCenter		Submitter: 210378 - ConnectCenter Testing		Training User
Home Worklist Verifica	n Claims Remits Reports Payer Tools Mo	lbox Help Admin		
	Claim Search		0	
	Claim File Search Claim Health Vita	i	Regulatory Information	
	Create a Claim	m: To: Filter Options		
	Claim Status Institutional	26/2022 🗰 6/24/2022 🗰 Last 30 Days 🗸 🔍	Questions about the	

2. Claim form opens.

Connect	tCenter			Submitter: 210378 - ConnectCenter Testing		Training User
Home	Worklist	Verification	Claims Remits Reports Payer Tools Mailbo	x Help Admin		
			¢laim		Live Chat	
			1500 FORM CLAIM DETAILS	SERVICE LINE DETAILS		
				Payer Information		
			Health Insurance Claim Form	Payer Name . Payer ID. Payer Responsibility.	ST BCBSMA 9496 P-Primary V	
				Address Line 1 / 2:	ATA CAPTURE PO BOX 986020	
				City, Stote, Zip:	OSTON MA 02298	
			1. Medicare Medicare Medicaid Trice Port A(#) Port B(#) (#) or D	ore (D#, ChampVA Group oD#) (D#) FECA Bl (D#) (D#) Lung (D	Ik Other (CDR) CC5010-MABCBS-MH1	
			2. Potient's Nome (Lost Nome, First Nome, Middle Initial, Suffix) DOE JOHN	3. Potient's Birth Date (HM/DD)/YYYY) Sex 01/01/1970 M ✓ F	4. Insured's Name (Last Name, First Name, Middle Initial, Suffix) DOE JOHN	
			5. Potient's Address (No., Street)	6. Potient Relationship To Insured	7. Insured's Address (No., Street)	
			123 SUNNYSIDE DR	Ser 🖌 spouse 📋 child 📋 other	123 SUNNYSIDE DR	
			BOSTON MA	8. Reserved For NUCC Use	BOSTON MA	
			Zip Code 02370		Zip Code 02370 Telephane (include Area Code)	
			Other Insured's Name (Lost Name, Rist Name, MI, Suffix)	10. Is Patient's Condition Related To: a. Employment? (Current Or Previous)	11. Insured's Policy Group Or FECA Number	
			a. Other Insured's Policy or Group Number	Ves No V b. Auto Accident? Place (State)	a. Insured's Date Of Birth (MM/DD/YYYY) Sex 01/01/11970 M ✔ F	
			b. Reserved For NUCC Use	Yes □ No ♥ c. Other Accident?	b. Other Claim ID (Designated By NUCC)	
			c. Reserved For NUCC Use	Yes 🗆 No 🗹	c. Insurance Plan Name Or Program Name	
			d. Insurance Plan Nome Or Program Name	10d. Claim Codes (Designated By NUCC)	d. Is There Another Health Benefit Plan? Yes No VI If yes, complete items 9, 9a and 9d.	
			Read Back of Form Before Completing & Signing Thi 12. Neterits CP Authorized Person's Signiture I autorize the mile com I also request payment of government benefits either to myo Signed: Y	Form be of any medical or other information necessary to process the dr to the porty who accepts assignment below. Date: (http://D0/1111)	Insured's Ciri Authorized Penson's Signature I outhorize popment of medical benefits to the undersigned prycloan of supplier for services described below Signed: Y	
			LL Date Of Connect Street, Internet Street, and Deserves, CARD, ORD, CONCOM	(12.000 000 000 000 000 000 000 000 000 00	Contract Destant Line (see Section 2010)	



3. In Payer Information section, change sequence indicator from Primary to Secondary or Tertiary.



4. Complete diagnosis and service line information, as normal. Charges entered on each line should be total charges for service without any reductions related to prior payments.

21. Diagnosis C	Dr Nature Of Illne	ss Or Injury. REL	LATE A-L To Ser	vice Line Bel	ow (24E)					22. Res	ubmission G	ode	Original R	lef. No.	
A. Q219	В.		C.	D			ICD Ind.			New	Claim	~			
E.	E.		G.	н			<u> </u>			23. (QC	5	Prior Au	uthorizatio	n Number	
L.	J.		К.	L											
24. A. Date(s) o From: MM/DD/YYYY	of Service To: MM/DD/YYYY	B. Place of Service	C. EMG D. Pi (E	rocedures, Se xplain Unusu PT/HCPCS	ervices, or Sup xal Circumstar Modifier	oplies nces)	E.	Diagnosis Pointer	F. Charg	jes	G. Days or Units	H. EPSDT Family Plan	I. ID Qual	J. Rendering Provider ID#	
1															
01/01/202	2	11	930	24			A		\$	400.00	1		NPI		+

5. Add Patient Account No in Box 26 and click Total Charge refresh button in Box 28 to sum service line charges. If you don't have a default Billing Provider set, complete boxes 25 and 33.

25. Federal Tax I.D Number	26. Patient's Account No.	27. Accept Assignment? (For gov't claims, see back)	28. Total Charge	29. Amount Paid	30. Reserved For NUCC Use
22222223 SSN 🗌 EIN 🔽	TEST	Assigned 🗸	C \$400.00		
31. Signature Of Physician Or Supplier Including Degrees Or Credentials (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. Service Facility Location Info Name:	rmation	33. Billing Provider Ir First:	nfo. Middle: Last/O	rganization: Suffix:
Signed: Date: (MM/DD/YYYY) Y	Address Line One:	Address Line Two:	Address Line One: 2715 DAMON S	Address Li	ine Two:
	City: Stote: Zip	:	City: S EAU CLAIRE	Stote: Zip: WI 547012634	Telephone (indude Area Code) 7158348471
			1306838487 F	PXC 152W00000X	X +



6. Select Claim Details tab and click Collapse All. Open section labeled Other Insurance / COB. Open Payer sub section.

Claim							•	Live Chat	(
1500 FORM	CLAIM DETAILS	SERVICE LINE D	ETAILS						
Expand All > Col	llapse All								
Payer									
Insured/Subscriber									
Patient									
Billing Provider									
Rendering Provider									
Service Facility									
Pay to Provider Address									
Other Providers									
Claim Information									
Other Insurance/COB (2	2423 ALABAMA BLUE SH	IIELD Primary)							
Payer									
Payer Information					ID's				
ayer Responsibility Insurance	Type Claim Filing Ind	Benefits Assigned	_		ID Type	Paye	er Primary ID		
P 👻	CI	O Yes O No	O N/A		PI	24	23		
			CLEAR	FIND PAYER	ID Type	Paye	er Secondary ID		
Name									
ALABAMA BLUE SHIELD					ID Type	Oth	er ID		
Address 1		Address 2							
City	State	Zip Code		Country Code					
Group or Policy #	Group Name		Original Reference #						
rior Authorization #	Referral #								
Insured/Subscriber									
Payment/Adjudication									
Supplemental Provider Ir	nformation								
Other Insurance/COB									
DELETE CLAIM	Your claim I	nas been auto-save	ed. 04/10/2022 21	:29:26 CT	COPY	SAVE	VALIDATE	SUBMIT F	or

Quick Reference Guide



 Set Payer Responsibility to Primary or Secondary. Add Claim Filing Indicator. Use Find Payer to search for payer name on primary claim OR key in Payer Name and Payer Primary ID field. If you are manually entering payer information, include PI as ID Type. Close Payer subsection.

Payer			
Payer Information		ID's	
Payer Responsibility Insurance Type Claim P CI CI	Filing Ind Benefits Assigned O Yes O No O N/A	ID Туре РІ ID Туре ID Туре	Payer Primary ID 2423 Payer Secondary ID
Nome ALABAMA BLUE SHIELD		ID Type	Other ID
Address 1	Address 2		
City State	Zip Code	Country Code	
Group or Policy # Group N	Name Original Refer	ence #	
Prior Authorization # Referral	J #		



8. Open Insured / Subscriber sub-sections at top and bottom of claim form.

Claim								•	Live Chat	6
1500 FORM		LS	SERVICE LINE	DETAILS						
Payer										
 Insured/Subscriber 										
Insured/Subscriber Information	tion									
Last/Organization Name		First Nam	e	Middle Name	Suffix	Sex	Date of Birth			
TORRES		JOCEL	/N			F	01/01/20	00		
Address 1			Address 2							
516 MAIN STREET										
City	State		Zip Code		Country Code					
MEDFORD	MA		021550000							
Insured's ID #			Social Security #							
MTN981339082										
Patient										
Billing Provider										
Rendering Provider										
Service Facility										
Pay to Provider Address										
Other Providers										
Claim Information										
• Other Insurance/COB (24	123 ALABAMA	BLUE SHI	ELD Primary)							
Payer			,,							
Insured/Subscriber										
Insured/Subscriber Information	tion									
Last/Organization Name		Einst Nom		Middle Name	Suffix	Potient Pa	lationship to Ir	sured		
TORRES		JOCEL	/N	Middle Norrie	J	18	addonanip to ii	Isuleu		
Address I			Address 2							
01010410011221										
City	State		Zip Code		Country Code					
HEDFORD	MA		021550000							
ID Type	Insured's ID #		Social S	ecurity #						
MI	OTHERPAYERID									
Payment/Adjudication										
Supplemental Provider Inf	ormation									
Other Insurance/COB										
								_		
DELETE CLAIM	You	r claim ha	is been auto-sav	ved. 04/10/2022	21:31:26 CT	COPY	SAVE	VALIDATE	SUBMIT F	FOR

9. Copy / paste subscriber name and address information between sections.

Note: Insured ID# should NOT be copied. Other Insurance Insured ID# is required and must be Subscriber ID assigned by the prior payer. Enter MI in ID Type field. Patient Relationship to Insured is required. If subscriber is patient, enter 18 in field. If not, value can be copied from Patient section of claim form.



How to Create Secondary Claim in ConnectCenter

Claim												Live Chat	6
1500 FORM	CLAI	M DETAILS		SERVICE	LINE DE	TAILS							
Date(s) of Service From: To: MM/DD/YYYY MM/DD/YYYY	Place of Service	EMG P (i	Procedures, S (Explain Unus CPT/HCPCS	Services, or sual Circum Modifie	Supplies istances) r		Diagnosis Pointer	Charges	Days or Units	EPSDT Family Plan	ID Qual	Rendering Provider ID#	
1											NPI	×	
2											NDL	X	
3												¥	
4											NPI	+ X	
											NPI	(+	
5											NPI	+	
6											NPI	×	
Total Service Lines (0) ne 1 - To view details	s of a diffe	erent line	e, click o	on the a	pproprie	ate ser	vice line ab	oove				+Add Service Line	
* <u>Expand All</u> »	<u>Collapse</u> A	<u>All</u>											
Providers	11												
Other Insurance/CO	tion												
Other Insurance/CO	в												
				_						_			

10. Click Service Line Details tab. Line 1 will be selected by default.



Expand All	» <u>Colla</u>	<u>pse All</u>								
Providers										
Service Line	Information									
Service Line	Supplemental	I Informa	tion							
Authorizatio	ns/Referrals									
Attachments	5									
Ambulance										
Drug Identif	cation									
Test Results										
DME										
Other Insur	ance/COB (242	23 ALABA	MA BLUE SHIE	LD Primary)						
Payment/Adjuc	lication									
Payment/Adjuc	lication		Adjudication Pay	ment Date		Amount Paid			Patient Liability	
Payment/Adjuc Payer Primary ID 2423	lication		Adjudication Pay 04/01/2022	ment Date		Amount Paid		\$100.00	Potient Liability	\$300.00
Payment/Adjuct Payer Primary ID 2423 Product/Service ID	lication Procedure Code		Adjudication Pay 04/01/2022	ment Date	Modifier	Amount Paid	Modifier	\$100.00 Modifier	Patient Liability	\$300.00
Payment/Adjuct Payer Primary ID 2423 Product/Service ID HC	Procedure Code 93024		Adjudication Pay	ment Date	Modifier	Amount Paid Modifier	Modifier	\$100.00 Modifier	Patient Liability	\$300.00
Payment/Adjuct Payer Primary ID 2423 Product/Service ID HC Description	Procedure Code 93024	•	Adjudication Pay	ment Date	Modifier	Amount Paid Modifier	Modifier	\$100.00 Modifier	Potient Liability	\$300.00
Payment/Adjuct layer Primary ID 2423 roduct/Service ID HC lescription	Procedure Code 93024		Adjudication Pay 04/01/2022	ment Date	Modifier Paid Units	Amount Paid Modifier	Modifier	\$100.00 Modifier Bundled or Unbo	Potient Liability	\$300.00
ayment/Adjua ayer Primary ID 2423 roduct/Service ID HC escription	Procedure Code 93024	2	Adjudication Pay	ment Dote	Modifier Paid Units	Amount Paid Modifier	Modifier	\$100.00 Modifier Bundled or Unbo	Patient Liability	\$300.00

11. Open Other Insurance/COB section.

- 12. Prior Payer name and ID will appear on Other Insurance title bar. Copy Payer ID from there to Payer Primary ID field.
- 13. Copy Procedure Code from service line section to Procedure Code field in Other Insurance section. Enter HC in Product/Service ID field.



How to Create Secondary Claim in ConnectCenter

14. Add adjudication payment date, prior amount paid for line item, patient liability amount, and quantity of units previously paid.

ine 1 - To view	details of a	differen	t line, click (on the appi	ropriate se	rvice líne ab	ove			
* Expand All	» <u>Colic</u>	ipse All								
Providers										
 Service Line 	Information									
Service Line	Supplementa	I Informat	tion							
Authorization	ns/Referrals									
Attachments										
Ambulance										
Drug Identifie	cation									
Test Results										
- DHE										
 Other Insurd 	ince/COB (24	23 ALABA	MA BLUE SHIE	LD Primary)						
Payment/Adjud	ication									
Payer Primary ID			Adjudication Pay	ment Date		Amount Paid			Patient Liability	
2423			04/01/2022					\$100.00		\$300.00
Product/Service ID	Procedure Cod	e			Modifier	Modifier	Modifi	er Modifier		
HC	93024									
Description					Paid Units			Bundled or Unio	unalea Line#	
Adjustments										
Group Code		Reason		Amount	(Quantity				
	~									



15. In adjudication section, select an appropriate group code from drop down list of provided codes. Enter one or more reason codes for each group code selected. For help finding a reason code, enter a word that you would expect to find in code description. A pick list of matching codes will be displayed at the top of screen. Enter the amount and quantity of adjustment for each service line.

II	4						-
60 - CHARGES FOR OUT	PATIENT SERVICES ARE NOT COV	FRED WHEN PERFORME	D WITHIN A PERIOD OF T	IME PRIOR TO OR AFTER IN	PATIENT SERVICE	S. 🚔	•
258 - CLAIM/SERVICE N	OT COVERED WHEN PATIENT IS I	N CUSTODY/INCARCERA	(TED				×
274 - FEE/SERVICE NOT	PAYABLE PER PATIENT CARE CO	ORDINATION ARRANGEN	1ENT.				•
227 - INFORMATION REC	QUESTED FROM THE PATIENT/INS	URED/RESPONSIBLE PA	RTY WAS NOT PROVIDED	OR WAS INSUFFICIENT/INC	OMPLETE		×
142 - MONTHLY MEDICA	ID PATIENT LIABILITY AMOUNT.						•
B16 - NEW PATIENT QUA	ALIFICATIONS WERE NOT MET.						
32 - OUR RECORDS INDI	CATE THE PATIENT IS NOT AN EL	IGIBLE DEPENDENT.				Add St	n inn Linn
31 - PATIENT CANNOT B	E IDENTIFIED AS OUR INSURED.						The Life
177 - PATIENT HAS NOT	MET THE REQUIRED ELIGIBILITY	REQUIREMENTS.				*	
		apse All					
	Providers						
	Service Line Information						
	 Other Insurance/COB (24 	23 ALABAMA BLUE SHI	ELD Primary)				
	Payment/Adjudication		,,				
	Payer Primary ID	Adjudication Pa	yment Date	Amount Paid		Potient Liability	
	2423	04/01/2022			\$100.00		\$100.00
	Product/Service ID Procedure Cod	e	Modifi	er Modifier Modi	fer Modifier		
	HC 93024						
	Description		Deciel Health		D. stations are 1 lab	under Linest	
	beaupoort		1				
	Adjustments						
	Group Code	Reason	Amount	Guantity			
	Contractual Obligation	109	\$200.00	1			
	Group Code	Reason	Amount	Quantity			
	Patient Responsibility 🗸 🗸	patient	\$100.00	1			
	Group Code	Reason	Amount	Quantity			
	~						
			i				
	DELETE CLAIM	Your claim ho	as been auto-saved. 04/	10/2022 21:46:53 CT	COPY	SAVE VALIDATE	SUBMIT FORM

Note: The following fields will be validated to ensure all numbers and amounts are balanced:

- Within each line: total of all adjustment amounts under group patient responsibility should match patient liability amount entered at top of the payment/adjudication section
- Within each line: total of all adjustment amounts (including the patient responsibility amounts) plus amount entered in Amount Paid field at top of the section, should equal line item charge amount entered at top of page.
- Across service lines: total of Amount Paid values for each service line should be entered in Amount Paid field on Claim Details tab.
- 16. Click **VALIDATE** button to confirm all required fields are entered and all numbers and amounts balance.
- 17. Click **SUBMIT FORM** button to create claim.