

CHAPTER 6: BILLING AND PAYMENT

UNIT 2: ELECTRONIC CLAIM SUBMISSION

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What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

OBSOLETE

6.2 BENEFITS OF ELECTRONIC CLAIM SUBMISSION

Introduction

All it takes is a computer, the proper software, and an Internet connection for electronic claims submission. Instead of printing, bundling, and sending paper claims through the mail, simply enter and store claims data through your office computer.

Faster claim payment

Electronic claims are convenient, confidential, and operational around the clock. Highmark's claim processing system places a higher priority on claims filed electronically. Electronic claims will typically process in seven (7) to fourteen (14) calendar days, whereas paper claims will process in twenty-one (21) to twenty-seven (27) calendar days.

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Regulatory compliance

The payment progress targets defined above that are used in Pennsylvania are in compliance with timely claims payment regulations defined by Pennsylvania's Act 68, and reflect processing of clean claims that do not require manual intervention or investigation.

The payment progress targets defined above that are used in Delaware are in compliance with timely claims payment regulations defined by Delaware Insurance Regulation 1310, and reflect processing of clean claims that do not require investigation.

In West Virginia, the payment progress targets defined above are used and are in compliance with the timely claims payment regulations defined by the Ethics and Fairness In Insurer Business Practices Act, W.Va. Code §33-45-1 et seq., commonly referred to as the "Prompt Pay Act", and reflect processing of clean claims that do not require investigation.

For more information on these regulations, please see the manual's [Chapter 6.1: General Claim Submission Guidelines](#).

Cost effective

Electronic claim submission increases staff productivity by speeding claim preparation and delivery. Many of the paper claim processes are eliminated such as form printing, bundling, postage, and mailing.

Many errors experienced in the keying and processing of paper claim forms are reduced or eliminated. Electronic claim submission means greater claim acceptance rates and reduced staff time in claim research and resubmissions.

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6.2 BENEFITS OF ELECTRONIC CLAIM SUBMISSION, Continued

Convenient and confidential

Electronic submission provides the added benefit of both claim preparation and delivery at your convenience. Postal service hours of operation or delays do not limit your productivity. Electronic claims can be submitted 24 hours a day, seven days a week, 365 days a year. It is safe, immediate, and direct to Highmark. EDI security standards are in place to ensure your claim data remains confidential and secure.

NaviNet® claim submission

HIPAA-compliant 1500 (837P) and UB (837I) claim submission transactions are also available to participating professional providers and facilities in NaviNet.

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FOR MORE INFORMATION

For information on signing up for EDI and also NaviNet, please see the manual's [Chapter 1.3: Electronic Solutions – EDI & NaviNet](#).

To learn more about electronic claims submission, visit the **Electronic Data Interchange (EDI) Services** website. You can access the site by selecting **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu on the Provider Resource Center, or by clicking the applicable link below to access the site directly:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/bcbsde
- West Virginia: highmark.com/edi-wv

6.2 HIGHMARK EDI SERVICES SUPPORT

Overview The Highmark EDI Operations support staff is comprised of trained personnel dedicated to supporting electronic communications. They provide information and assistance with questions or problems you encounter with any aspect of your EDI transactions.

Support is free and staff is available Monday through Friday from 8 a.m. to 5 p.m. To save time when calling, be prepared to provide your Trading Partner number, NPI, and log-on identification to the support analyst.

EDI phone contact To contact a support analyst by phone, call **1-800-992-0246**.

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Accessible 24 hours a day, 7 days a week Electronic transactions can be sent and retrieved seven days a week, 24 hours a day. Electronic transactions can be submitted once or multiple times per day or week. Claim transmittal and report retrieval schedules are controlled by each office.

Information on EDI Claim Submission can be found on the EDI website by visiting the **Electronic Data Interchange (EDI) Services** website via the Provider Resource Center, or by clicking the applicable link below to access the site directly:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/bcbsde
- West Virginia: highmark.com/edi-wv

The EDI website has the most up-to-date information about doing business electronically with Highmark. Highmark recommends that you bookmark this site and consider it your first source when you have a problem or question.

6.2 REQUIRED ELECTRONIC CLAIM SUBMISSION FORMATS

Background

In 1979, the American National Standards Institute (ANSI) chartered the Accredited Standards Committee (ASC) X12 to develop and maintain uniform standards for Electronic Data Interchange (EDI). **ASC X12N** is the section of ASC X12 for the health insurance industry's administrative transactions.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Administrative Simplification provisions named ASC X12N as the mandated standard to be used for electronic transmission of health care transactions.

Required claim submission format

The current HIPAA electronic transaction standards for health care eligibility, claim status, referrals, claims, and remittances are the **ASC X12N Version 5010** transactions. The required formats for electronic claim submission are:

- **Professional:** ASC X12N 837 Health Care Claim: Professional Transaction Version 005010 ("837P")
 - **Institutional:** ASC X12N 837 Health Care Claim: Institutional Transaction Version 005010 ("837I")
-

Types of electronic submission

The following types of electronic claim submission are available to participating facilities:

- Batch submission and Real-Time Estimation/Adjudication (limited to a single claim) via any electronic data interchange vendor
- NaviNet® UB Claim Submission

Professional providers have the following options:

- Submission via any electronic data interchange vendor or billing service
- NaviNet® 1500 Claim Submission

Note: The NaviNet claim submission transactions are compliant with the HIPAA 837P and 837I formats.

6.2 REAL-TIME ESTIMATION AND ADJUDICATION

Introduction

Highmark's Real-Time tools are available to all NaviNet®-enabled contracted providers and to providers who submit electronic claims through a practice management system. These primary Real-Time capabilities include Real-Time Provider Estimation and Real-Time Claims Adjudication.

These real-time capabilities give providers the ability to discuss member financial liability with patients when services are scheduled or provided. Providers could also collect applicable payment or make payment arrangements at the time of services, if they wish to do so.

Real-Time Provider Estimation

The Real-Time Provider Estimation tool gives providers the ability to submit requests for specific health care services before or at the time services are rendered and receive a current estimate of the member's financial liability within seconds before the services are rendered.

The estimate takes into account the cost of the service provided and the amount of the deductible, coinsurance, and/or copayment and other coverage provisions included in the member's benefit program. This information, in turn, can be utilized to set the member's cost expectations prior to receiving services and collect or make arrangements for payment at the time of service. This function in NaviNet also allows the provider to print and give the member a *Highmark Real-Time Member Liability Statement-Estimate* for his/her records.

This tool should be used to give members an accurate estimate of their financial obligations prior to or at the time of service. To determine member liability after services are rendered, it is recommended that providers use the real-time claims adjudication tool (see below).

In NaviNet, we also make it is easy to turn a real-time estimation into a real-time 1500 Claim Submission with just a click of a button. For instructions on 1500 Claim and Estimate Submission, tutorials are available in the *NaviNet User Guides*. Select **Help** from the NaviNet toolbar to access them in **NaviNet Support**.

Note: Real-Time Estimation can be used for all Highmark products; however, estimate submission is not available for the Federal Employee Program (FEP).

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6.2 REAL-TIME ESTIMATION AND ADJUDICATION, Continued

Real-Time Claims Adjudication

The Real-Time Claims Adjudication tool gives providers the added ability to submit claims for specific health care services and receive a fully adjudicated response within seconds. This allows providers to determine, at the time of service, the correct amount the member owes. This, in turn, enables the provider to collect payment or make payment arrangements for the member's share of the cost at the time of service.

This function in NaviNet also allows the provider to print a *Highmark Real-Time Member Liability Statement* to give to the member for his/her records.

Accelerated Provider Payment

Accelerated Provider Payment allows providers who meet certain criteria to receive accelerated payment on real-time submitted claims. Providers will receive more frequent payments from Highmark -- within three (3) business days for claims that have been submitted in real-time.

Note: Accelerated payment does not apply to amounts paid from the member's consumer spending account.

Accelerated member EOB on member portal

Accelerated Explanation of Benefit (EOB) displays the member explanation of benefits (EOB) on the Highmark Member portal the next business day for all real-time submitted claims.

Refunding the member

These Real-Time Capabilities allow providers to get fast, current, and accurate information to help in determining the patient's financial liability prior to or at the time of service. The provider tools will be especially useful as the member cost sharing increases and the use of spending accounts grow.

Please note, however, that if you collected payment from the member at the time of service for member liability, and then subsequently receive payment from Highmark and find an overpayment, be sure to issue the refund directly to the member **within thirty (30) calendar days**.

NaviNet User Guides

User Guides are available in NaviNet for real-time estimate submission and claim submission. To access NaviNet User Guides for both professional and facility providers, select **Help** from the toolbar, click on the **Health Plan** tab, and then select the applicable Highmark option for your service area.

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6.2 REAL-TIME ESTIMATION AND ADJUDICATION, Continued

Electronic Data Interchange (EDI) Services

Providers who are interested in integrating real-time capabilities within their practice management system should discuss this functionality with their software vendors. They should also review the Electronic Data Interchange (EDI) transaction and connectivity specifications in the Resources section on the EDI website.

To access the EDI website from the Provider Resource Center, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, or click on the applicable link below to access the applicable site directly:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/bcbsde
- West Virginia: highmark.com/edi-wv

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OBSOLETE

6.2 CLAIMS RECORD MANAGEMENT

Overview

Highmark provides electronic acknowledgments to enhance your ability to track and monitor your claim transactions.

Acknowledgment transactions

Electronic claims can be submitted via the 837 Professional (837P) and Institutional (837I) Health Care Claim Transactions. Upon receipt of the 837 transaction, there are several acknowledgment transactions available for tracking electronic claim submissions and payment depending on the capabilities of your software:

- 999 – Implementation Acknowledgment for Health Care Insurance
 - 277CA– Claim Acknowledgement
 - 835– Electronic Remittance Advice ERA
-

999 – Implementation Acknowledgment for Health Care Insurance

When transmitting claims in HIPAA Version 5010, you will receive the 005010X231 999 Transaction verifying that Highmark received your claim(s) file and indicating whether the file was “accepted” or “rejected” for further claim editing.

277CA – Health Care Claim Acknowledgment

This transaction is available approximately 24 hours after an accepted/accepted with errors 999 Implementation Acknowledgment for Health Care Insurance report is accepted. After the EDI claim editing process is complete, you are able to verify through the 277CA Claim Acknowledgment transaction that your claims were accepted and forwarded for claims processing. The 277CA also identifies claims that did not pass or were rejected by the editing process due to data errors.

The 277CA should be reviewed after every accepted/accepted with errors claim file transmission because it provides a valuable and detailed analysis of your claim file. Claims that were accepted should not be resubmitted. Highmark will no longer attempt to correct or retrieve missing information -- **this rejected claim data must be corrected and the claim resubmitted electronically.**

Trading partners submitting 837 claim transactions in Version 5010 must be able to accept the 005010X214 277 Health Care Claim Acknowledgment (277CA) Transaction.

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6.2 CLAIMS RECORD MANAGEMENT, Continued

835 – Health Care Claim Payment/Advice (Electronic Remittance Advice - ERA)

The 835 Health Care Claim Payment Advice, or Electronic Remittance Advice (ERA), is essentially an electronic version of a paper Explanation of Benefits (EOB) or remittance. When 835 ERA information is combined with an Accounts Receivable System (ARS), it provides an efficient method of reconciling your patients' accounts by providing financial information relating to your claim payments and denials. Your software vendor can advise you on your system's ERA and ARS capabilities.

Highmark's ERAs (835 transactions) are created on a weekly or daily basis to correspond with our weekly or daily payment cycles. Contact your software vendor to determine if your software is ERA capable. This transaction can help you reduce costs and improve office efficiency. Its benefits are:

- **Eliminates posting errors:** Little to no manual intervention, depending on the AR system, is necessary with electronic 835 posting. Errors associated with manual keying of payment data are eliminated.
- **Reduces posting time:** The 835 information allows you to electronically post payments to your AR system in a matter of minutes or hours instead of days. Actual posting time is dependent on the practice size and AR system. Electronic posting allows your staff more time to attend to patient needs instead of administrative tasks.
- **Accelerates payment process:** Electronic posting accelerates your ability to perform secondary billing of non-contractual financial liabilities. The Health Care Claim Payment/Advice (835) payment transaction files become available for retrieval after the payment cycle is complete, and remains available for seven (7) days. You can start your posting and subsequent secondary billing processes upon receipt of the electronic file.

FOR MORE INFORMATION

To learn more about claims record management transactions, please visit the Electronic Data Interchange (EDI) Services website via the Provider Resource Center (select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu), or by clicking the applicable link below to access the site directly:

- Pennsylvania: highmark.com/edi
- Delaware: highmark.com/bcbsde
- West Virginia: highmark.com/edi-wv

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6.2 ATTACHMENTS FOR ELECTRONIC CLAIMS

Electronic claim attachments

It is not necessary or recommended that you submit claims requiring attachments via paper except in certain instances. These claims should be sent electronically utilizing the PWK, or paperwork attachment, specifications of the 837 electronic claim transaction. Two PWK option fields are built into the 837 transaction.

Supporting documentation can then be faxed or mailed to Highmark as indicated below for your service area:

PENNSYLVANIA	DELAWARE	WEST VIRGINIA
Attention: Document Preparation/Image	Attention: Document Preparation/Image	Attention: CDC Area
Fax to: 1-888-910-8797	Fax to: 1-888-910-9601	Fax to: 1-844-235-7266
Mail to: Highmark Blue Shield PWK (Paperwork) Additional Documentation P.O. Box 890176 Camp Hill, PA 17089-0176	Mail to: Highmark Blue Cross Blue Shield Delaware PWK (Paperwork) Additional Documentation P.O. Box 8832 Wilmington, DE 19899	Mail to: Highmark WV P.O. Box 7026 Wheeling, WV 26003

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PWK cover sheet

When submitting the additional documentation, please use the applicable cover sheet for your service area:

- Pennsylvania: [PWK \(Paperwork\) Supplemental Claim Information Cover Sheet](#)
- Delaware: [PWK \(Paperwork\) Supplemental Claim Information Cover Sheet](#)
- West Virginia: [Electronic Claim Attachment Cover Sheet](#)

These cover sheets are also available on the Provider Resource Center. Select **FORMS** from the main menu, and then select **Miscellaneous Forms**.

Visit EDI website for PWK specifications

To review the specifications and PWK process flow, please visit the Resource Center, and then select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu to access the **Electronic Data Interchange (EDI) Services** website.

If you currently work with a trading partner (software vendor and/or clearinghouse), or have an information technology (IT) department within your facility, they will be able to assist you with the technical aspects of the specifications. Simply tell your trading partner that you want to begin submitting attachment claims electronically.

6.2 NAIC CODES

Overview

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

NAIC codes are unique identifiers assigned to individual insurance carriers. Accurate reporting of NAIC codes along with associated prefixes and suffixes to identify the appropriate payer and to control routing is critical for electronic claims submitted to Highmark EDI (Electronic Data Interchange).

Claims billed with the incorrect NAIC code will reject on your 277CA report as A3>116, "Claim submitted to the incorrect payer." If this rejection is received, please file your claim electronically to the correct NAIC code. Please refer to the tables below for applicable NAIC codes for your service area.

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Highmark Delaware



DELAWARE		
NAIC CODE	PROVIDER TYPE	PRODUCTS
00070	Facility provider types	All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.
00570	All other provider types	All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.

Highmark West Virginia



WEST VIRGINIA		
NAIC CODE	PROVIDER TYPE	PRODUCTS
54828	All provider types	All Highmark West Virginia products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.
15459	All provider types	Highmark Senior Solutions Company Medicare Advantage Freedom Blue PPO (West Virginia plan only with alpha prefix HSR).

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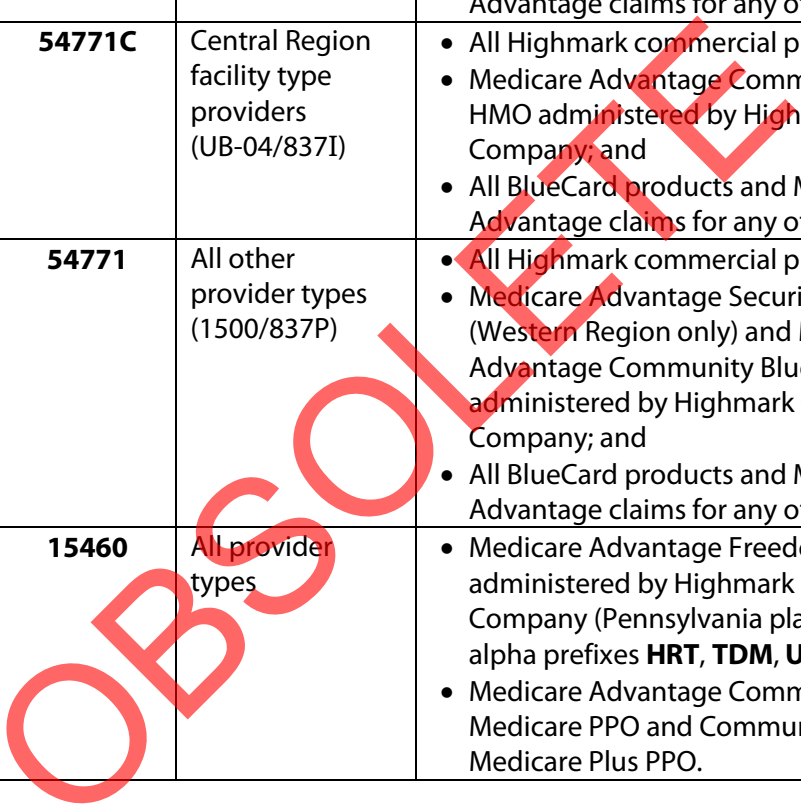
6.2 NAIC CODES, Continued

Pennsylvania



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PENNSYLVANIA		
NAIC CODE	PROVIDER TYPE	PRODUCTS
54771W	Western and Northeastern Regions -- facility type providers (UB-04/837I)	<ul style="list-style-type: none"> All Highmark commercial products; Medicare Advantage Security Blue HMO and Medicare Advantage Community Blue HMO administered by Highmark Choice Company; and All BlueCard products and Medicare Advantage claims for any other Blue Plan.
54771C	Central Region facility type providers (UB-04/837I)	<ul style="list-style-type: none"> All Highmark commercial products; Medicare Advantage Community Blue HMO administered by Highmark Choice Company; and All BlueCard products and Medicare Advantage claims for any other Blue Plan.
54771	All other provider types (1500/837P)	<ul style="list-style-type: none"> All Highmark commercial products; Medicare Advantage Security Blue HMO (Western Region only) and Medicare Advantage Community Blue HMO, both administered by Highmark Choice Company; and All BlueCard products and Medicare Advantage claims for any other Blue Plan.
15460	All provider types	<ul style="list-style-type: none"> Medicare Advantage Freedom Blue PPO administered by Highmark Senior Health Company (Pennsylvania plans only with alpha prefixes HRT, TDM, USK, HRF). Medicare Advantage Community Blue Medicare PPO and Community Blue Medicare Plus PPO.



6.2 CLAIM STATUS INQUIRIES

Introduction

Highmark offers providers electronic means of checking the status of a claim through NaviNet® Claim Status Inquiry or the HIPAA 276/277 Health Care Claim Status Request and Response transactions.

NaviNet® Claim Status Inquiry

NaviNet Claim Status Inquiry lets you view real-time, detailed claims information for any member, whether claims were submitted electronically or on paper. You can track the status of a claim from the start of the adjudication process until the time of payment, or you can look up claims dating back seven years.

If you have a question about how a claim was processed, you can launch a claims investigation and have the claim researched without going back to Plan Central or making a call to Highmark.

For more information, including instructions on how to access NaviNet's Claim Status Inquiry and claim investigation transactions, please see [Chapter 6.1: General Claim Submission Guidelines](#).

276/277 -- Health Care Claim Status Request and Response Transaction

The HIPAA-mandated 276/277 electronic claim status request and response are a paired transaction set -- the 276 transaction is used by the provider to request the status of a claim(s) and the 277 transaction is used by the payer to respond with information regarding the specified claim(s). The response returned by the payer indicates where the claim is in the adjudication process (e.g., pending or finalized). If finalized, detailed information is provided on whether the claim is paid or denied, and if denied or rejected, the reason is included.

Highmark will accept and return 276/277 transactions in Version 5010 format only. These transactions will only be accepted and returned via real-time; trading partners are not able to submit electronic inquiry transactions in a batch mode.

Information about the 276/277 transactions can be found in the *EDI Guide*, available on the Electronic Data Interchange (EDI) website. To access the website from the Provider Resource Center, select **Electronic Data Interchange (EDI) Services** from the main menu; or click on the applicable link below to access the applicable site directly:

- Pennsylvania: www.highmark.com/edi
- Delaware: highmark.com/bcbsde
- West Virginia: www.highmark.com/edi-wv

Providers in all regions can contact Highmark EDI Operations by phone at **1-800-992-0246**.

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6.2 NAVINET 1500 AND UB CLAIM SUBMISSION

Introduction

NaviNet® claim submission transactions let you submit HIPAA-compliant 837P Professional claims and 837I Institutional claims fast and easy in real-time.

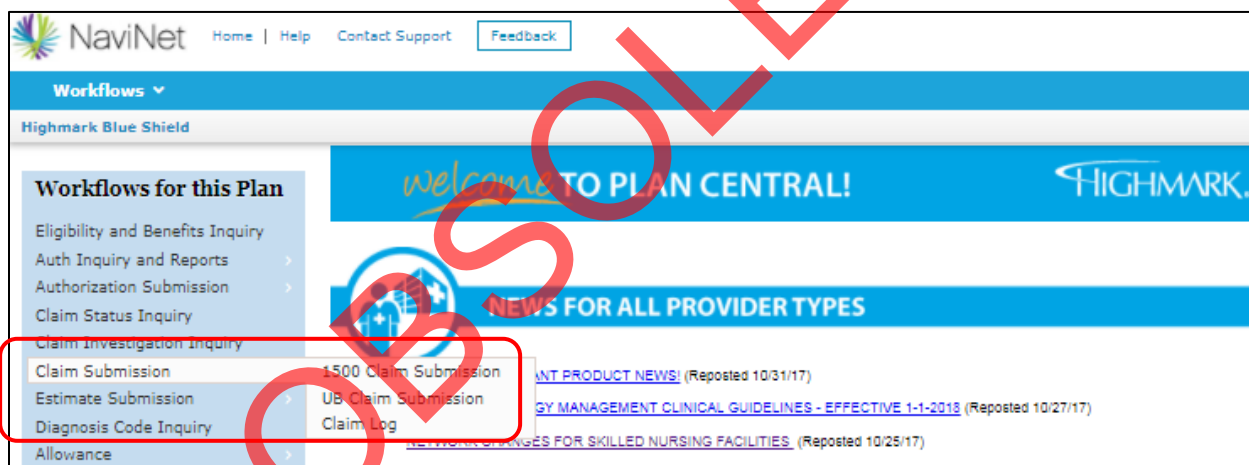
NaviNet’s real-time single claim submission lets you know the status of a claim at the time of entry and claim errors are corrected online. When submitted on the date the services were rendered, these capabilities allow providers to accurately identify and collect member responsibility before the patient leaves the office.

Accessing claim submission transactions

To access the claim submission transaction in NaviNet, first select Claim Submission under **Workflows For This Plan**. And then on the fly-out menu, select as follows:

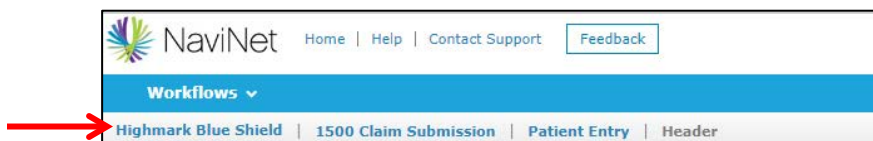
- Professional Services: Select **1500 Claim Submission**
- Facilities: Select **UB Claim Submission**

After selecting the transaction type, the **Patient Entry** screen appears for both **1500 and UB submissions**.



Wayfinder

NaviNet’s “Wayfinder” allows you to navigate between screens through the claim submission process by clicking on the screen name in the bar.



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6.2 NAVINET 1500 AND UB CLAIM SUBMISSION, Continued

Claim submission screens

The claim submission process navigates through the following screens for both 1500 and UB submissions – required fields are notated with a red asterisk:

- **Patient Entry:** For an easier and faster way to confirm your patient information, enter the patient’s Member/Subscriber ID and the Statement Period From and Thru fields, and then click on **ID Search**. The patient information will automatically populate and you can click on **Continue** to advance to the next screen.
- **Header:** General information is entered on the Header screen, such as Billing Provider, Rendering/Servicing Provider, Patient Account Number
- **Payer:** Highmark can be entered as primary, secondary, or tertiary payer. If Highmark is secondary or tertiary, you will be required to enter all applicable information from the previous payer(s).
- **Detail:** Enter the information identifying the services – such as date of service, HCPCS/HIPPS codes, modifiers, and revenue codes -- and the charges for the services.
- **Verification:** Key patient, code, and payer information will be displayed here. Confirm that the data on screen is correct and click **Submit**. If you need to make a change, you can use the Wayfinder (or “breadcrumb bar”) to go back to the screen that needs revision.

Claim Log

To review your claims submitted via NaviNet, select **Claim Submission** under Workflows For This Plan, and then click **Claim Log**.

1500 Claim Submission tips

- Professional claims are limited to 50 lines.
- Clicking **Exit** on any screen takes you out of the claims submission process.
- If you want to leave a screen without submitting information, use the Wayfinder.
- Only claims originally submitted through NaviNet can be corrected and resubmitted through the Claim Log.
- Do not enter a decimal point when entering ICD-10 diagnosis codes.
- If you receive the error "Entity not approved as an electronic submitter. (code=496, source=Claim)," please contact NantHealth Support for assistance.
- On the Patient Entry screen, if you select anything in the Relationship to Subscriber field other than "18-Self/Subscriber", you must manually enter the subscriber information in the fields provided.
- To submit a Claim Attachment (PWK), on the header page, choose the Attachment Method (Fax, Mail, or Available on Request), type the Attachment Control Number, which is assigned by the provider, select the Attachment Type from the dropdown list, and continue to submit the claim. A cover sheet must accompany your attachment; you can obtain one from the Resource Center under the EDI link.

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6.2 NAVINET 1500 AND UB CLAIM SUBMISSION, Continued

UB Claim Submission tips

- Clicking **Exit** on any screen takes you out of the claims submission process.
- Do not enter a decimal point when entering ICD-10 diagnosis codes.
- To add more service lines to the Claim Submission Detail screen, select the number of lines from the dropdown menu and click **Add Lines**. A maximum of 999 service lines are available for each claim.
- Only claims originally submitted through NaviNet can be corrected and resubmitted through the Claim Log.
- When reporting an adjustment bill type on the Claim Submission Header screen, the original claim number is required.
- The first name and last name are required when reporting Attending, Operating, or Other providers.

FOR MORE INFORMATION

For detailed instructions and additional tips, **User Guides** are available in NaviNet for 1500 and UB claim submission.

To access NaviNet User Guides for both professional and facility providers, select **Help** from the toolbar, and then select the applicable Highmark option for your service area.

NaviNet support

If you have a critical issue, NaviNet Support is available by calling **1-888-482-8057**. Phone support is available Monday through Friday from 8 a.m. to 11 p.m. and on Saturday from 8 a.m. to 3 p.m.

You can also open a case online any time to get assistance from the NaviNet Customer Support team, or “chat” with a NaviNet Customer Service representative in real time. Live chat is also available Monday through Friday from 8 a.m. to 11 p.m. and on Saturday from 8 a.m. to 3 p.m.

Click on **Contact Support** on the top left of the NaviNet screen to open a case or to access live chat:

