

NaviNet

User Guide

Overview

Purpose of this User Guide

The purpose of this guide is to provide an abbreviated, user-friendly reference tool to help your practice get started using the most common functions offered by NaviNet quickly and efficiently.

Highmark has developed this guide as a tool for its providers. This user guide is not published by NaviNet, and NaviNet did not participate in its development or publication.

NaviNet provides additional user guides and video tutorials in the **Help** section on the NaviNet website, as outlined in Section 3 of this user guide.

Highmark is not responsible for maintaining or updating the NaviNet site; and this guide may not necessarily reflect the most current updates to the NaviNet site.

Note: Some of the functionalities represented in this user guide may be specific to Highmark.

NaviNet offers your office:

- Reliable member information right on your desktop.
- Cost-effective tools and services through a single, secure Web portal.
- Intuitive navigation to get your staff up and running quickly.
- Increased efficiency for streamlining business processes.
- Reliable access to the following transactions:
 - Eligibility and Benefits Inquiry
 - Claim Status Inquiry
 - Procedure/Diagnosis Codes
 - and more

Get started now to see the benefits NaviNet offers.

New to NaviNet?

Go to NaviNet at navinet.navimedix.com.

Click on the “**Register for a new account**” link to begin the enrollment process.

This information is issued on behalf of Highmark Blue Shield and its affiliated Blue companies, which are independent licensees of the Blue Cross Blue Shield Association. Highmark Inc. d/b/a Highmark Blue Shield and certain of its affiliated Blue companies serve Blue Shield members in 21 counties in central Pennsylvania and 13 counties in northeastern New York. As a partner in joint operating agreements, Highmark Blue Shield also provides services in conjunction with a separate health plan in southeastern Pennsylvania. Highmark Inc. or certain of its affiliated Blue companies also serve Blue Cross Blue Shield members in 29 counties in western Pennsylvania, 13 counties in northeastern Pennsylvania, the state of West Virginia plus Washington County, Ohio, the state of Delaware and 8 counties in western New York. All references to Highmark in this document are references to Highmark Inc. d/b/a Highmark Blue Shield and/or to one or more of its affiliated Blue companies.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides secure, web-based portal between providers and health insurance companies.

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NantHealth | NaviNet

Username

Password

SIGN IN

[Forgot username?](#) [Forgot password?](#)

[Register for a new account](#)

New Users – signing up

Enrollment is easy.

1. To enroll in NaviNet via online enrollment go to:
navinet.navimedix.com
2. Click “Register for a new account”

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Sign Up for NaviNet

Already have a NaviNet account?
[Sign In to NaviNet](#)
 If you already have a NaviNet account and need to make changes or add services, you must sign in to NaviNet first.

Looking to find out more about NaviNet?
[Learn More >>](#)

If your office is already using NaviNet, please contact your Security Officer, who will create a NaviNet account for you.

Registration Is Free!
All you need is a Federal Tax ID. [Tell me more >>](#)
 Or for Expedited Registration:
A Federal Tax ID and a recently submitted claim (within the last 90 days)
 NaviNet will use the details of the claim to authenticate your office. If you do not have a claim handy, you may still register, but the process will take longer.
 You will be designated as a NaviNet Security Officer for your office. [Tell me more >>](#)

[Continue](#)

Have you already submitted a registration request? [Check the status of your registration](#)

Registration is free.

Look here for the information you need to gather before you register for NaviNet.

If you already use NaviNet for another payer, there is no need to sign up again. Use your same username and password.

Sign Up for NaviNet

1 About You
2 About Your Office
3 Select Health Plans and Products
4 Security Verification

Already have a NaviNet account?

[Sign In to NaviNet](#)

If you already have a NaviNet account and need to make changes or add services, you must sign in to NaviNet first.

About You

How did you find out about NaviNet?

-- Select --

Prefix First name Last Name Suffix

Title

Email Address

Work Phone Number Extension

Next »

To register, follow the four-step process.

1. Complete the About You section.
2. Complete the About Your Office section.
3. Select desired Services and Products.
4. NaviNet will provide Security Verification and assign your user name.

You will be asked to create a password.

SIGN IN

Sign up for NaviNet > What is a NaviNet security officer?

What is a NaviNet security officer?

Oct 22, 2021 | 1 min read

A NaviNet security officer manages user access to NaviNet to ensure HIPAA compliance.

NaviNet-enabled offices must have at least one NaviNet security officer. Consider having two security officers, especially if you're in a larger office.

NaviNet security officers are typically office supervisors, lead administrators, experienced NaviNet users, or members from IT or the Privacy/Security department.

Only security officers can access the Administration menu.

[Find your NaviNet security officer](#)

Visit your NaviNet profile page to find your NaviNet security officer.

Parent topic: [Sign up for NaviNet](#)

Tags: NaviNet Office and Account Management

The role of your Security Officer

For HIPAA compliance, each provider office should designate a Security Officer to be aware of the electronic storage and transmission of member information within and from your office.

The person who registers your practice for NaviNet will be automatically assigned as your Security Officer.

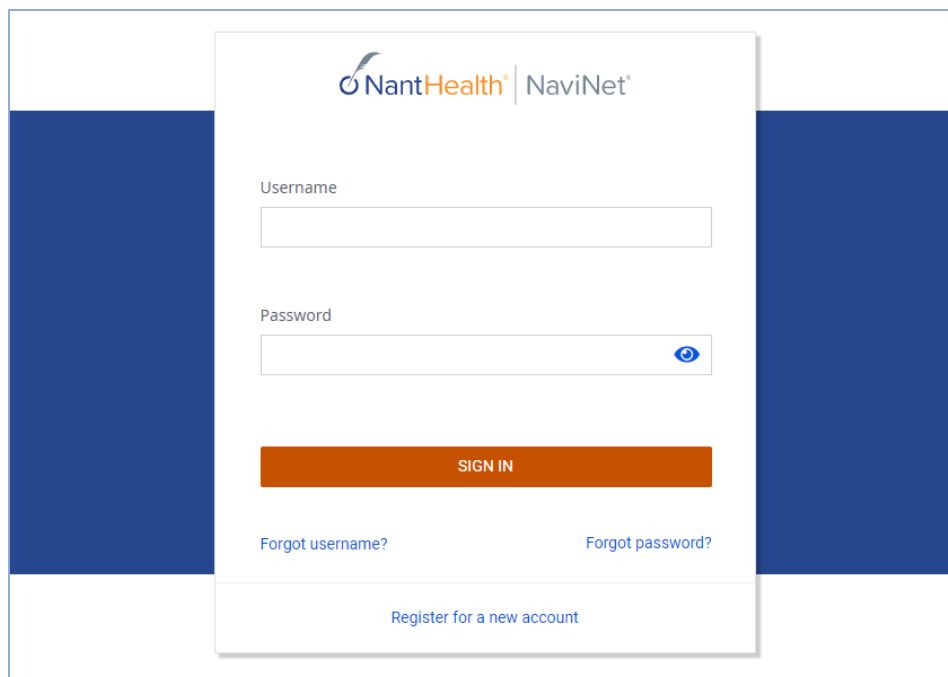
Click on the NaviNet Administrators tab under the Help section for more information about the roles and responsibilities of your Security Officer.



Since the person who enrolls your office will be automatically assigned as your Security Officer, it will be more efficient if you determine who is best suited to assume the Security Officer role and responsibilities prior to beginning enrollment.

1

Getting Started

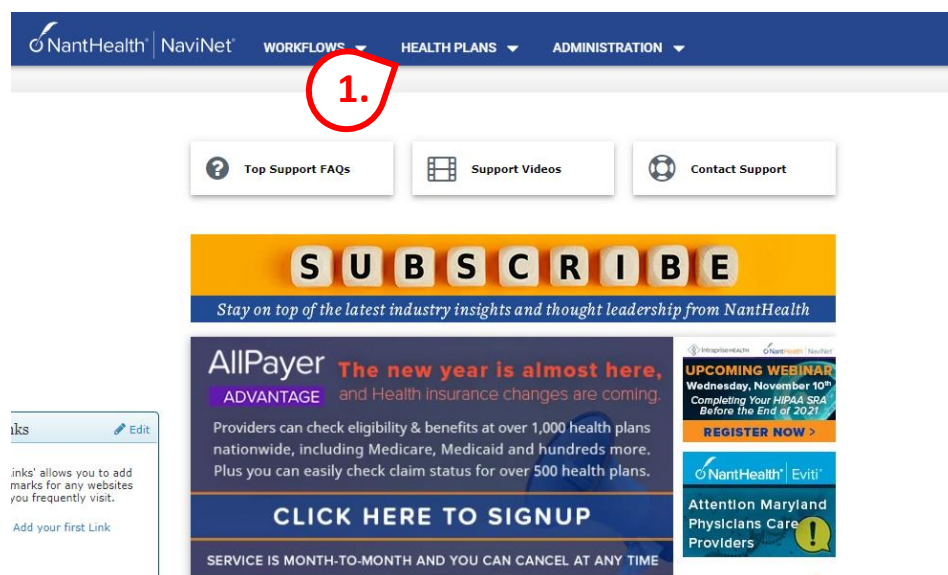


The login form for NantHealth NaviNet is centered on a white background. At the top is the NantHealth logo and the text 'NaviNet'. Below this are two input fields: 'Username' and 'Password'. The password field has a small eye icon to its right. Below the password field is an orange 'SIGN IN' button. At the bottom of the form are two links: 'Forgot username?' and 'Forgot password?'. Below the entire form is a link that says 'Register for a new account'.

Existing Users – signing on

Access the NaviNet website:

1. <https://navinet.navimedix.com>
2. Type in user name and password.
3. Click the Sign In button.



The home page features a dark blue header with the NantHealth logo and 'NaviNet' text. To the right of the logo are three navigation menus: 'WORKFLOWS', 'HEALTH PLANS', and 'ADMINISTRATION'. A red circle with the number '1.' is drawn around the 'HEALTH PLANS' menu. Below the header is a white section with three buttons: 'Top Support FAQs', 'Support Videos', and 'Contact Support'. Below this is a yellow banner with the word 'SUBSCRIBE' in large letters, followed by the text 'Stay on top of the latest industry insights and thought leadership from NantHealth'. Below the banner is a section for 'AllPayer ADVANTAGE' with the text 'The new year is almost here, and Health insurance changes are coming.' and 'Providers can check eligibility & benefits at over 1,000 health plans nationwide, including Medicare, Medicaid and hundreds more. Plus you can easily check claim status for over 500 health plans.' Below this is a blue button that says 'CLICK HERE TO SIGNUP'. At the bottom of this section is the text 'SERVICE IS MONTH-TO-MONTH AND YOU CAN CANCEL AT ANY TIME'. To the right of this section is a sidebar with a link to 'UPCOMING WEBINAR' and a link to 'Attention Maryland Physicians Care Providers'.

Home Page

This is the home page

1. From the top navigation bar, click on Health Plans.
2. Make your selection from the list of health plans provided in the drop down menu.

Quick User Tips

Adding Users to NaviNet

Only a NaviNet security officer can add a new user to NaviNet. If you're not a security officer, you won't see the Administration menu and can't perform these steps.

The new user can be a physician, a clinician, or any user in your office who benefits from using NaviNet except for a third-party user (see below).

If you create a new user and then realize that you entered a portion of the user's information incorrectly, you can fix it by terminating the user and then recreating the user.

Adding Third Parties to NaviNet

Do not add users from third parties that you contract with, such as billing or credentialing agencies. Third parties must create their own NaviNet account.

Terminating Users from NaviNet

If a member of your staff is no longer working with you, you must terminate their access to NaviNet.

Inactive Users

Users can click Forgot Password on the sign-in page to reset their own passwords unless their account is disabled or terminated. Security officers can reset and generate passwords to reactivate their accounts.

If a security officer's account goes inactive, the security officer cannot reset their own password. If a security officer needs their password reset, they must ask another security officer at your site or contact NantHealth Support.

The Eligibility and Benefits function within NaviNet allows you to access real-time eligibility and benefit information including deductible, co-pay, and coinsurance amounts for local members. You can review information up to 2 years in the past or up to 6 months in the future.

Workflows for this Plan

- Eligibility and Benefits Inquiry
- Auth Inquiry and Reports
- Authorization Submission
- Case Management Referral and Inquiry
- Claim Status Inquiry
- Claim Investigation Inquiry
- Claim Submission
- Estimate Submission
- Diagnosis Code Inquiry
- Allowance
- Procedure Code Inquiry
- Network Provider Inquiry
- Network Facility Inquiry
- Provider File Management
- AR Management
- BlueCrossBlueShield (Out of Area)

Welcome to Plan Central

HEADLINE	
HIGHMARK'S NOVEMBER CODING KNOWLEDGE COLLEGE WEBINAR	PR
UPCOMING UDC PROGRAM ENHANCEMENTS AND WEBINARS	PR
ANNUAL SCORECARDS NOW AVAILABLE FOR PHYSICAL MEDICINE PROVIDER PATHWAYS PARTICIPANTS	
NO SURPRISES ACT - UPCOMING CHANGES	
DELAY IN TRANSITION TO PNC HEALTHCARE FOR CLAIMS PAYMENTS AND REMITTANCES	PR

When news items are removed from this page, they will remain on the Plan Central Resource Center.

From the Plan Central Page

1. Select Eligibility and Benefits Inquiry from the left navigation bar.

A screenshot of the Eligibility and Benefits page is available on the next page with the following details.

- 1) **Patient Details:** Clicking on the View Patient Details link will provide you with more detailed patient information, demographics, and the patient's relationship to the subscriber
- 2) **View/Print**
- 3) **Other Insurance:** This tab will indicate whether other insurance information is on file for the patient
- 4) **View Current Member ID Card:** This link opens to the most current copy of the member's ID card
- 5) **Provisions link:** Provides information about the patient's medical and pharmacy benefits
- 6) **View Previous Coverage:** Allows you to see the previous coverage, if available
- 7) **Additional Benefits Provisions:** This is another way to access member benefits
- 8) **Benefits Accumulator:** Shows you the member's accumulated benefits including previous year totals
- 9) **Benefits:** You can choose a benefit type from the Benefits panel on the left side of the screen (for instance Chiropractic) to view the member's various benefits
- 10) **Health Benefit Plan Coverage:** This section outlines the amount remaining for the member's deductible and out of pocket amounts

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WORKFLOWS
HEALTH PLANS
ADMINISTRATION

Back to Patient Search Results
Eligibility & Benefits:

Page viewed: 10/04/2021

Eligibility and Benefits for
Female born on
View Patient Details

Highmark Blue Shield
No additional payer information on file
View/Print

Active from 05/20/2020 to 12/31/9999
Member ID:
Group:
Service Date: 10/04/2021

INSURANCE DETAILS
View Current Member ID Card

Group Information
Plan Area: 363
Alpha Prefix:
Advanced Imaging Ind: YES
Radiation Therapy Management: YES
Physical Medicine Management: YES
Genetic Testing: NO
Musculoskeletal Interventional Pain Management: No - Inpatient Auth Only Required

Site of Care Specialty Drugs: YES
Oncology Specialty Drugs: YES
Other Specialty Drugs: YES

Product:
CB Premier Flex HDHP EPO

Type:
Preferred Provider Organization (PPO)

PRIMARY CARE PROVIDER

CB Premier Flex HDHP EPO Provisions

Pharmacy Product Wide Provisions

View Previous Coverage

Additional Benefit Provisions

Benefit Accumulator

Benefits
Search ...
Health Benefit Plan Coverage
Abortion
Acupuncture
Air Transportation
Alcoholism
Allergy
Allergy Testing
Alternate Method Dialysis
Ambulatory Service Center Facility
Anesthesia
Anesthesiologist
Audiology Exam
Blood Charges
Brand Name Prescription Drug
Cabulance
Cardiac Rehabilitation
Case Management
Chemotherapy
Chiropractic

Health Benefit Plan Coverage
Set as default benefit view

In-Network:

Deductible:
\$3,000 per Contract
Family
• ENHANCED TIER NON-EMBEDDED
\$1,262.02 Remaining
Family
• ENHANCED TIER NON-EMBEDDED
\$6,000 per Contract
Family
• STANDARD TIER NON-EMBEDDED
\$4,262.02 Remaining
Family
• STANDARD TIER NON-EMBEDDED

Out-Of-Pocket Max:
\$1,250 per Contract
Individual
• ENHANCED TIER EMBEDDED
• ENHANCED TIER EXCLUDES COPAYMENTS

3

A/R Management

The Accounts Receivable (A/R) Management function allows you to access the Cash Management and EOB and Remittance Tools. download a copy of your weekly Explanation of Benefits (EOB) and Remittance reports in a PDF format (allowing you to be view and print your reports).

Workflows for this Plan

- Eligibility and Benefits Inquiry
- Auth Inquiry and Reports
- Authorization Submission
- Case Management Referral and Inquiry
- Claim Status Inquiry
- Claim Investigation Inquiry
- Claim Submission
- Estimate Submission
- Diagnosis Code Inquiry
- Allowance
- Procedure Code Inquiry
- Network Provider Inquiry
- Network Facility Inquiry
- Provider File Management
- AR Management
- BlueExchange® (Out-of-A
- Resource Center
- Claims Dashboard
- COB Questionnaire

Welcome to Plan Central

HEADLINE

- [HIGHMARK'S NOVEMBER CODING KNOWLEDGE COLLEGE WEBINAR](#)
- [UPCOMING UDC PROGRAM ENHANCEMENTS AND WEBINARS](#)
- [ANNUAL SCORECARDS NOW AVAILABLE FOR PHYSICAL MEDICINE PROVIDER PATHWAYS PARTICIPANTS](#)
- [NO SURPRISES ACT - UPCOMING CHANGES](#)
- [DELAY IN TRANSITION TO PNC HEALTHCARE FOR CLAIMS PAYMENTS AND REMITTANCES](#)

When news items are removed from this page, they will remain on the Plan Central page.

- Cash Management
- EOB And Remittance
- PCP CAP Rosters
- Specialist CAP Rosters

From the Plan Central Page

1. Click AR Management
2. Select Cash Management or EOB and Remittance.

Explanation of Benefits (EOB) and Remittance

This function allows you to download a copy of your weekly EOB and Remittance reports in a PDF format (allowing you to be view and print your reports).

You can search reports in two-week increments under your provider name to retrieve all EOBs and remittances created during that time period. The results will display by the statement date that represents the dates your funds are made available.

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WORKFLOWS
HEALTH PLANS
ADMINISTRATION

EOB and Remittance: Search Results

[Print](#)

[EOB and Remittance: Search Results](#)

Statement Date	Payment Type	Provider Number	Check Number	Check Amount	
09/29/2021	Explanation of Benefits				Download PDF
09/29/2021	Explanation of Benefits				Download PDF
09/29/2021	Explanation of Benefits				Download PDF
09/29/2021	Explanation of Benefits				Download PDF
09/29/2021	Spending Account Payment				Download PDF
10/06/2021	Explanation of Benefits				Download PDF
10/06/2021	Explanation of Benefits				Download PDF
10/06/2021	Explanation of Benefits				Download PDF

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The date range will default to the most recent two weeks; however, you can edit the date range and go back as far as 181 days in two-week increments.

Cash Management

Provides a weekly payment accumulation and a summary of payments received for the past six months.

You can retrieve individual payment details by selecting the Check or EFT#.

Weekly Provider Payment and History Inquiry

Cash Management System

Cash Management Systems provides payment history for previous weeks and detail about a particular check or EFT payment are also available. This application does not provide detailed claim information. Refer to your HIPAA 835, weekly EOB or Remittance, or use the Claim Status Inquiry available through NaviNet for claim detail.

Billing Provider Number:

Cycle Day	Daily Payment	Provider Number
Day1 - 10/4		
Day2 - 10/5	\$0.00	
Day3 - 10/6	\$0.00	
Day4 - 10/7	\$0.00	
Day5 - 10/8	\$0.00	
Sub Total		

Offset Amount

Est Check Amount

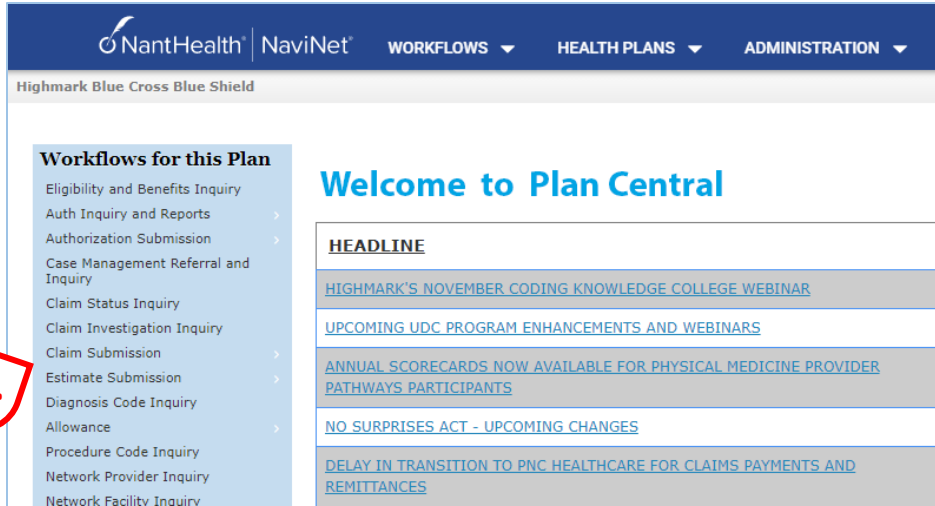
Avg Weekly Payment

\$0.00

Click on a column heading to change the sort order.
Click on the check number to see additional details.

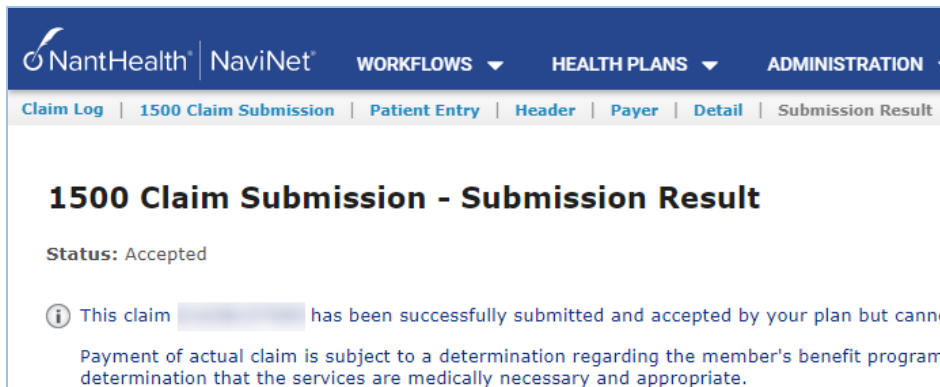
Issue Date	Amount	Check/EFT Ind	Check/EFT #	Paid Date	Check Status	Internal Status
10/06/2021		EFT Payments		10/06/2021	Paid	
10/06/2021		EFT Payments		10/06/2021	Paid	
10/06/2021		EFT Payments		10/06/2021	Paid	
10/06/2021		EFT Payments		10/06/2021	Paid	

Within the Claims functions, you will be able to submit, correct, or adjust claims, check your claims status, and investigate claims. (Providers in western and northeastern New York will not submit claims in NaviNet, but rather continue to submit claims electronically through Administrative Services of Kansas, Inc. (ASK) for patients on either legacy BCBSWNY or Highmark's system.)



Claim Submission

1. Choose Claim Submission from the left navigation.
2. Then select Claim 1500 Claim Submission for Professional Claims or UB Claim Submission for Facility Claims.
3. Once the claim is submitted you can:
 - Review the claim status in the upper-left corner.
 - If the claim is adjudicated and finalized, you can print a real-time member liability status or review claim details
 - If your claim was rejected, you can fix the errors and resubmit the claim directly from this function now or using the Claim Log later.



Tips and Tricks for Submitting Claims

Save: You can save without submitting the claim by using the save button

Patient Entry: To quickly find a local member, provide the claim service dates and the member/subscriber ID, and then click ID Search. To specify an out-of-area member, you must manually enter the patient information.

Header: You can place any number in the patient account number if you don't know it. Click the Referring Provider and Servicing Facility headers to expand those sections

Detail: Provide the required diagnoses and service line details in this section of the form. To report NDC codes or ambulance data, or to report additional comments for Not Otherwise Classified (NOC) procedures click Add Details

Verification Screen: If you need to make edits to your claim, click the link in the upper-left corner.

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Highmark Blue Cross Blue Shield | 1500 Claim Submission | Patient Entry

1500 Claim Submission - Patient Entry

1. **1500 Claim Submission - Patient Entry**

Claim Dates of Service

From Date: 10/28/2021 To Date: 10/28/2021

Patient

*Member/Subscriber ID: ID Search Group Number:

*Last Name: *First Name: Middle:

*Address: Address 2:

*City: *State: *Zip:

Gender: UNKNOWN *Date of Birth: *Rela:

Subscriber

*Member/Subscriber ID:

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Secondary Coordination of Benefits Submission

If the member's primary insurer is not Highmark, you will need to adjust the Coordination of Benefits for the claim.

1. Choose **Claim Submission** from the left navigation on Plan Central and then complete **Patient Entry Screen**.

2. **Payer Screen:** Fill in the primary payer Explanation of Benefits (EOB) information by changing the primary payer from Highmark to the member's primary insurer. This can be done by selecting "Other" in the insurer options and typing the payer's name.

- To indicate that Highmark is the responsible payer for this secondary claim, select the Secondary Payer B option and change the secondary payer from None to Highmark.

3. **Claims Payments and Adjustments**

- Provide the detail from the primary payer's EOB.
- If the primary payer's payment exceeds the charge, adjust the contractual adjustment amount with the overage to balance the claim by choosing CO group code, typing 94 as the reason code, and then typing the amount paid in excess of the charge as a negative amount.

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1500 Claim Submission | Patient Entry | Header | Payer

1500 Claim Submission - Payer

Patient Information

Patient: Patient ID: Date of Birth:

Gender: Relationship: Group Number:

Subscriber: Subscriber ID:

Payer Information

☐ Primary Payer A: *Payer Name: *Release of Information: *Assignment of Benefits:

HIGHMARK HIGHMARK Y - YES, PROVIDER HAS SIGNED STATEMENT YES

Claim Payments and Adjustments

Payer A Payments: Payer A Adjudication Date: Claim Filing Indicator:

Payer A Remark Codes:

Group Code: Reason Code: Amount: Quantity: Group Code: Reason Code: Amount: Quantity:

1. 2.

Insured

*Member/Subscriber ID: Group Number: *Relationship To Subscriber:

*Last Name: *First Name: Middle:

☒ Secondary Payer B: *Payer Name: *Release of Information: *Assignment of Benefits:

OTHER Y - YES, PROVIDER HAS SIGNED STATEMENT YES

☐ Tertiary Payer C: NONE

Continue Save Exit Back to top

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Tips and Tricks

- Enter zero dollars as "0.00"
- Enter a negative amount with a negative sign in front of the amount (for example, "-10.00")

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Claim Log | 1500 Claim Submission | Patient Entry | Header | Payer | Detail

1500 Claim Submission - Detail

[Print](#)

Patient Information

Patient: Patient ID: Date of Birth:

Gender: Relationship: Group Number:

Subscriber: Subscriber ID:

Diagnosis Information

*Search Type: ☐ ICD-9 ☒ ICD-10

Enter DX codes without the decimal.

*Diagnosis Code 1: [Search](#) Diagnosis Code 2: [Search](#) Diagnosis Code 3: [Search](#) Diagnosis Code 4: [Search](#)

[Add More](#)

Anesthesia Related Procedure Information

Detail Information

Rendering/Service Provider: Taxonomy Code:

Service Facility ID: Description:

[Optional Search](#)

Secondary Coordination of Benefits Submission (cont.)

4. Detail Screen: At the reporting line level adjustment and payment information on this claim prompt, select **Yes** to report line-level adjustments and provide all required diagnosis codes and service line details

IMPORTANT: Total payments and adjustments that you enter on the Payer screen must match the value in the Total Service Charges box on the Detail screen, or Highmark will return the rejection edit 672.

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Claim Log | 1500 Claim Submission | Patient Entry | Header | Payer | Detail | Verification

1500 Claim Submission - Verification

5.

5. Verification Screen: Verify that the information is accurate and complete. Click a link in the upper-left corner to edit any page

1 This screen does NOT list every field on the claim, but rather lists key patient, code, and payer information. Please validate selecting "Submit" from this screen, the claim information will be processed with the provider and facility information you make a change, use the Breadcrumb Bar above.

Patient

Name: Member/Subscriber ID:

Gender: Date of Birth:

Group Number: Patient Account Number:

Billing Provider

Name: Provider NPI:

Rendering Provider

Name: Provider NPI:

Payer Information

Primary Payer: Secondary Payer: Tertiary Payer:

Diagnosis

Code: Description:

1.

4

Claims

The Claim Status Inquiry function allows you to 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.

Billing Entity
Type Name or ID to find provider...

Patient Details
Search by either ...

Member ID 1.

OR 2.

Last Name

First Name

Date of Birth mm/dd/yyyy

Claim Status Details

Service Start 07/30/2021 10/28/2021 Service End

Claim ID Optional 3.

Locate a Claim in the Claim Status Inquiry Function

You can search for the claim one of three ways:

- 1) **Search by member ID:**
 - **Local Members:** Perform the search with AND without the alpha prefix
 - **Blue Card (out-of-area) Members:** Claims must be searched by member ID and you must include the alpha prefix
- 2) **Search by Name/Date of Birth:**
 - Search results will only populate for local patients
- 3) **Search by Claim ID:**
 - Select your billing provider
 - Enter the claim ID without any patient information entered in the member ID or Name/Date of Birth fields



Ensure that the date range is set appropriately to capture the date range in question.

Claim Status: Search Results

Claim ID	Patient	Service Date(s)	Billed Amount	Payment Number	Payment Date	Paid Amount	Status
111111111111		09/23/2021 to 09/23/2021	\$141.00		09/30/2021	\$0.00	Claim Investigation
222222222222		06/23/2021 to 06/23/2021	\$175.00		07/07/2021	\$122.50	Claim Investigation
333333333333		05/17/2021 to 05/17/2021	\$110.00		05/25/2021	\$0.00	Finalized

Claim Found!

Once you have located your claim, you can click on the claim ID number to view the details.

If you would like to send an investigation on the claim, you can click **Claim Investigation** to send your inquiry to Provider Service.

		Other Insurance Amount:	\$0.00	
		Penalty Amount:	\$0.00	
Date(s)	Revenue Code	Status	Billed Amount	Paid Amount
06/23/2021 to 06/23/2021	1.	<div><div>✔ Finalized</div><div>The claim/encounter has completed the adjudication cycle and no more action will be taken. (APPROVED).</div></div>		
			<div><div>View Additional Detail</div><div>2.</div></div>	

s is limited to those covered by the patient's benefit plan and dependent upon the patient's eligibility with their Health Plan. Time services are rendered, as with Plan's administrative and payment policies. There may be additional information pertaining to this claim, not included in this summary, which will be on the remittance Advice.

Reviewing Your Claim

Select a claim to see the **Claim Status Details** page.

1. Locate information about the claim and how it processed and paid.
2. Find **Additional Details** option for each line of the claim to see additional information about how the specific line was processed, including rejection reasons, as applicable.

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WORKFLOWS HEALTH PLANS ADMINISTRATION

Claim Investigation for: [Redacted] Print |

Investigation Request Date: 10/08/2021

<< Back

☒ Closed on 10/08/2021

Member's Insurance
 Patient Name: [Redacted]
 Member Name: [Redacted]
 Member ID: [Redacted]
 Group Number: [Redacted]

Provider(s)
 Billing Provider: [Redacted]
 NPI: [Redacted]

Total Charge: \$285.00
 Patient Account Number: [Redacted]
 Process Date: 09/08/2021

Claim Number: [Redacted]
Claim Date Range: 07/19/2021 to 07/19/2021

Actions
 Claim Investigation

Contact Details
 Name: [Redacted]
 Phone: [Redacted]

Investigation Comments:
 Investigation Reply: [Redacted]

Claim Investigation

Click **Claim Investigation** on the Claim Details page or from your claim search results (as explained on page X).

1. This will trigger the Investigation Claim # pop-up window. Select the investigation type that best suits your inquiry, complete all required fields, and submit your request.

Investigation Claim # [Redacted]

1.

Investigation Type

-- Select --

Claim Denied No Auth/Referral
 Claim Paid Low Level in Error
 Claim Pending over 45 Days
 COB Related
 Discrepancy on How Claim Processed
 Medicare Related
 Membership/Enrollment Denial
 NIA Retrospective Review
 Refund Request/Check Reissue

Contact First Name

Extension

Contact Phone Number

Cancel Submit

IMPORTANT: Claim investigations are per claim, not per line item. To reference a specific claim line, provide the line number in the Comments box.

Workflows for this Plan

- Eligibility and Benefits Inquiry
- Auth Inquiry and Reports
- Authorization Submission
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- Claim Status Inquiry
- Claim Investigation Inquiry**
- Claim Submission
- Estimate Submission
- Diagnosis Code Inquiry
- Allowance
- Procedure Code Inquiry
- Network Provider Inquiry
- Network Facility Inquiry

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Claim Investigation Inquiry

1. This function can be used to check the status of claim investigations you have previously submitted.

health | NaviNet[®] WORKFLOWS HEALTH PLANS ADMINISTRATION

Claims: **Investigation Inquiry Search**

Billing Provider

Investigation

Request Date From Request Date To

Investigation Status

Search

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2. Select the billing provider and search by the date the investigation was submitted. You can search one month at a time or by investigation status of Open, Closed, or Optional (all).

Claims: **Investigation Search Results** [Print](#)

<< Modify Search

Request Date	Patient	Member ID	Claim Number	Claim Service Date(s)	Claim Charge	Investigation Status	Investigation Close Date
09/07/2021				08/10/2021 to 08/10/2021	\$160.00	Closed	09/10/2021
09/08/2021				06/17/2021 to 06/17/2021	\$339.00	Closed	09/09/2021
09/08/2021				07/09/2021 to 07/09/2021	\$115.00	Closed	09/10/2021
09/08/2021				06/29/2021 to 06/29/2021	\$65.00	Closed	09/10/2021
09/08/2021				06/30/2021 to 06/30/2021	\$160.00	Closed	09/09/2021
09/08/2021				06/18/2021 to 06/18/2021	\$468.00	Closed	09/10/2021
09/08/2021				06/04/2021 to 06/04/2021	\$338.00	Closed	09/10/2021

3. A list of investigations completed in the time span requested will be displayed for review.

4. Click on the line to review the investigation and response.

If you do not agree with the response to your claim investigation, select **Claim Investigation** from within your inquiry to send an additional inquiry to Provider Service.

Workflows for this Plan

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Authorization Submission

1. This function allows you to submit services for authorization.

Tips and tricks for submitting authorizations:

- **Verify Your Information:** Ensure you verify your information during each step of the authorization submission process
- **Save Your Data:** NaviNet will save your data for you once you click Submit or you can click Save to save your authorization. Once saved, you can return to it later from the Referral/Authorization log
- **Selecting a Service Date:** In most cases, you are unable to select a date of service more than 10 days in the past
- **Finding the Member:** You will get your results faster if you give the patient's Member ID **and** the patient's date of birth or first name
- **Member ID and Date of Service Match Another Authorization:** If the member ID and date of service you submit match another service requested for that member ID in the last three days, you will get a warning message of a possible duplicate. If the request is not a duplicate, click **Continue** to proceed with the authorization. If it is a duplicate, click **Exit** and review the Authorization Inquiry and Reports function for more information
- **Searching for Specific Data:** If you need to find specific data, click **Optional Search**
- **Recording ICD-10 Codes:** Do not include a decimal point for ICD-10 Codes
- **Confirming/Editing Codes or Provider Numbers:** To edit these details, click **View Details**
- **Questionnaire/Response Form:** Depending on the type of service requested, you will either get a questionnaire or a response form to fill out once the authorization is submitted

Response Form

Please click "Add Attachment" to provide any additional clinical documents. [Add Attachment](#)

Tracking Number: Authorization Number: **2.**

Status: PENDING **1.**

Patient Info

Patient Last Name: Patient First Name:

Gender: Date of Birth:

Group #:

Member ID #:

Service Details:

Requested Service:

Proposed Date of Service:

Referred To Provider Information:

Billing Provider Name:

Address:

Service Provider:

Contact Name: Contact Phone:

Diagnosis Codes:

Diagnosis Code:

Procedure Codes:

Procedure Code:

[View Referral/Auth](#) [Review Notes](#)

Authorization Response Form

- 1. View the authorization status** in the upper-left corner. Some authorizations receive automatic approvals, while others will pend for review. If no authorization is required, the authorization appears with Cancelled-No Auth Required status
- 2. Adding Attachments:** Click Add Attachment in the upper-right corner to upload up to five attachments with a maximum file size of 32 MB.

Workflows for this Plan

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Auth Inquiry and Reports

1. **Searching for an Authorization:** You can search for authorizations submitted up to one year before and 60 days after the current date.

WORKFLOWS ▾ HEALTH PLANS ▾ ADMINISTRATION ▾

Ref/Auth Search

Referral/Authorization Inquiry

Name:

From: Date Of Service To:

Type: Type Of Service:

Status: Authorization Number:

Records 1-413 of 413, page: 1

Referral/Authorization Number	Date of Service	Patient Name	Patient Date of Birth	Referred from Billing Provider / Facility	Referred to Billing Provider / Facility	
	10/29/2021					Select
	10/29/2021					Survey Select
	10/29/2021					Survey Select
	10/29/2021					Survey Select

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2. The search results will populate at the bottom of the screen

3. To view more details about the authorization, or to add attachments, click **Select**.

4. **Adding Clinical Data:** To add clinical data, click **Survey**

6

Electronic Funds Transfer (EFT)

EFT is a secure process that directs Highmark claim payments to the provider's checking or savings account.

Providers that contracted with Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York before November 1, 2021 do not need to register for EFT again if their office was already set up with PaySpan.

EFT Attestation and Registration Provider Selection

Welcome, Diane Brain, you are accessing this functionality because you are the EFT Responsible party. Our records show that you are the current EFT Responsible Party (s) selected. The billing providers attached to this NaviNet office are listed below. Providers for whom you have already attested are selected.

Please select only those billing providers for whom you are the designated responsible party. Once you select the providers, you must attest that you are the legally responsible party and maintain the banking information for such providers.

If you do not need to select and Attest to any additional providers, please click Next.

Select	Provider Name	Street	City	State/Province	Zip code/postal code	Provider Federal Tax Identification Number (TIN)	National Provider Identifier (NPI)
<input checked="" type="checkbox"/>	PROVIDER NAME						

EFT Attestation and Registration

Your NaviNet Security Officer must enable the function for the EFT Responsible Party.

The EFT Attestation and Registration transaction allows the person who is designated as the provider's "EFT Responsible Party" to electronically attest, register, and/or maintain banking information on your behalf.

Once you are enrolled and start receiving EFT payments, you will no longer receive paper EOB statements or remittances.

You can view your electronic EOBs or remittances via the **AR Management** transaction as outlined on page [10](#) of this document.



Tips and Tricks

This [EFT Attestation and Registration Guide](#) can help you set up EFT for your office.

The Provider Resource Center (PRC) is where you go when you need information on reimbursement, medical policy, care management programs, credentialing, the Medical Policy Update Newsletter, Provider News, provider communications, forms, or other miscellaneous information that will help you with your administrative needs.

There are two versions of the PRC. One is public and the other is private and only accessible via NaviNet. The private version houses all the same information that is available on the public site *as well as* proprietary information like Highmark's fee schedules, Coding Education, Plan Central Library (discussed later in this guide), and some program-related documents.

Workflows for this Plan

- Eligibility and Benefits Inquiry
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- Authorization Submission >
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- Claim Status Inquiry
- Claim Investigation Inquiry
- Claim Submission >
- Estimate Submission >
- Diagnosis Code Inquiry
- Allowance >
- Procedure Code Inquiry
- Network Provider Inquiry
- Network Facility Inquiry
- Provider File Management
- AR Management >
- BlueExchange® (Out-of-Area) >
- Resource Center**
- Claims Dashboard
- COB Questionnaire
- Provider Facing Analytics

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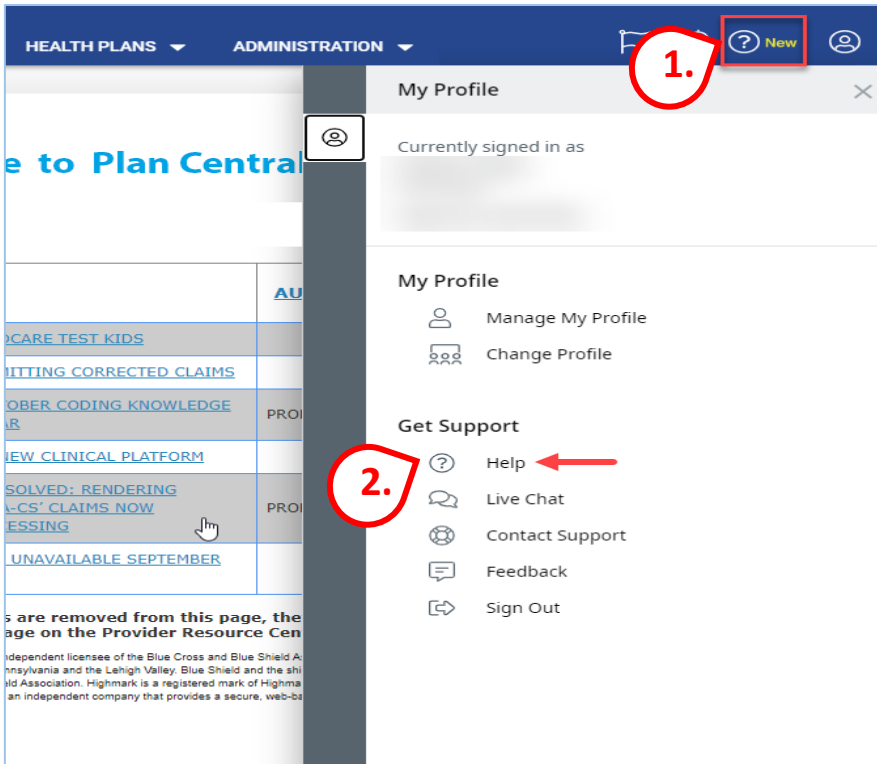
When news items are removed from this page, they will remain on the Resource Center.

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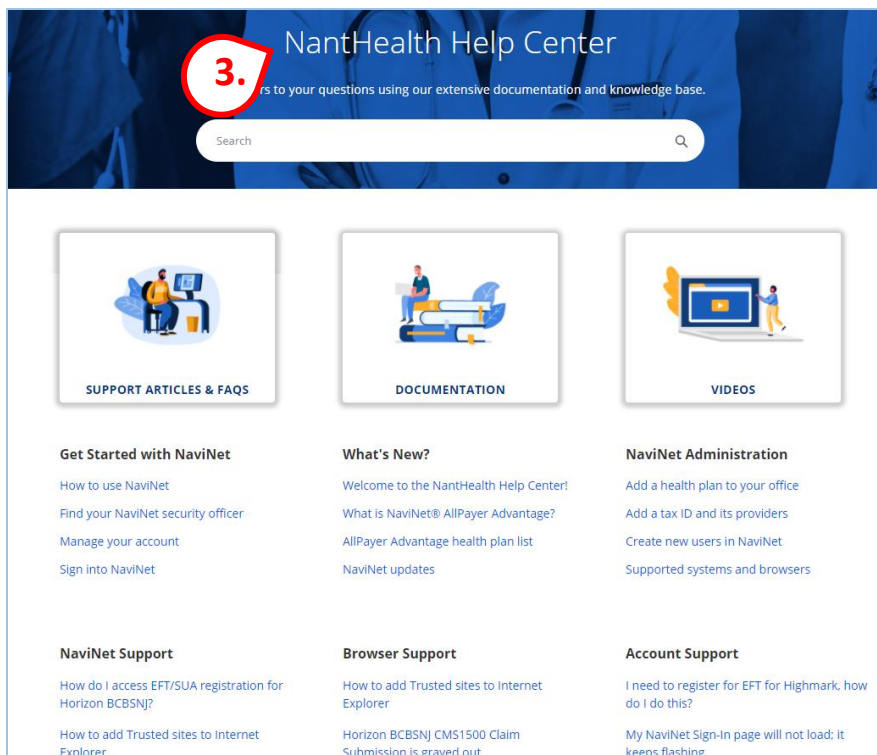
1. Use the Plan Central tab on the top navigation bar to navigate between health plans.
2. Use the side navigation bar to navigate between desired functions.
3. Pertinent messaging regarding workflow updates or plan information.
4. Information that may be of special interest to providers.

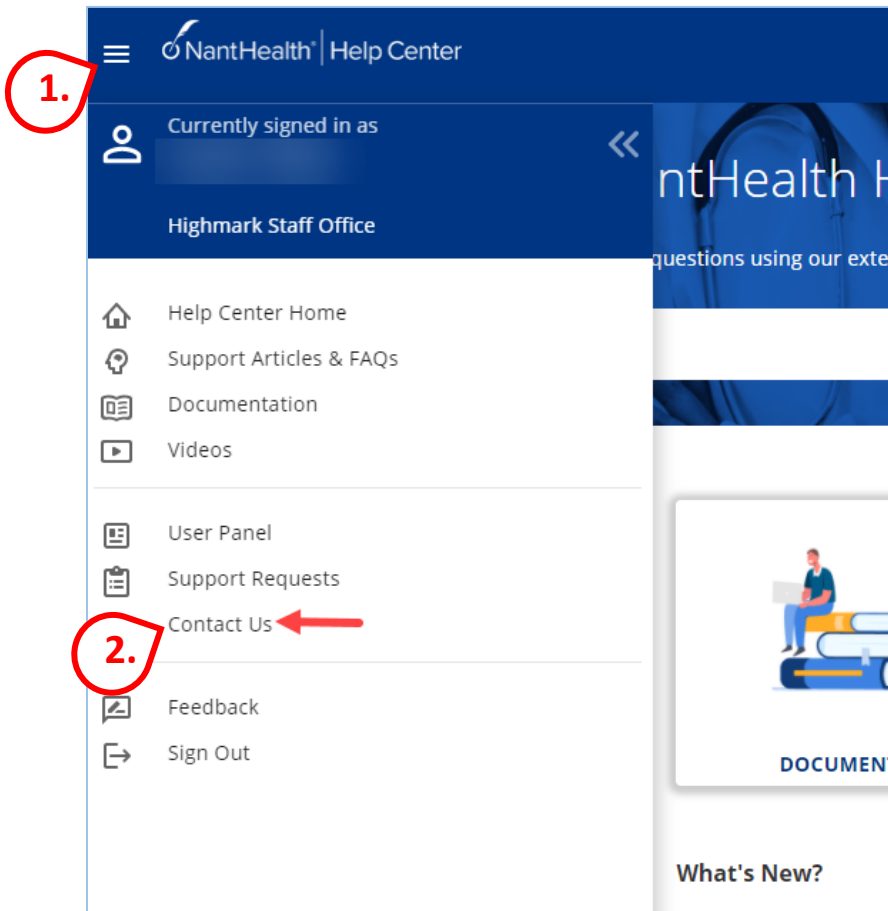
2.



Help Center

1. Access the built-in **Help Center** by clicking the question mark at the top right of the Plan Central screen.
2. Click **Help** under **Get Support**.
3. NaviNet's Help Center includes:
 - Support articles and FAQs
 - Access user guides and videos
 - Ability to contact NantHealth Support via phone, chat, or by opening a support request
 - Ability to send feedback and suggestions
 - Latest NaviNet updates
 - Helpful tips for the most common browser support and NaviNet administration questions like:
 - Checking cookie settings
 - Supported systems and browsers
 - Who is a Security Officer?





Contact NantHealth

1. Click on the three horizontal lines in the top left to open the side menu.
2. Here you will find the Contact Us link that will assist users in contacting NantHealth directly.