

INTRODUCTION

ConnectCenter™, owned and maintained by [Optum](#), is an eTool for real-time transactions and professional claim submission. ConnectCenter is available to all providers contracted with Blue Cross Blue Shield of Massachusetts.

Medical and dental providers can use ConnectCenter to:

- [Verify benefits and eligibility](#)
- [Check claim status](#)

Medical providers can:

- [Submit](#) and [verify referrals](#)
- Submit professional (1500) claims, including BlueCard® and Federal Employee Program claims

Authorizations

For authorization *submission* and *verification*, use our eTool, [Authorization Manager](#). (Reminder: Submit an authorization request—not a referral—for **outpatient rehab (PT/OT)**.)

However, you can use ConnectCenter to learn [authorization requirements](#).

ACCESSING CONNECTCENTER

Log in to our Provider Central website, bluecrossma.com/provider. On the left-hand side of the secure homepage, you'll see an eTools box. Click on ConnectCenter.

If you do not see the link, talk to the person in your practice or organization who is set up as administrator of your Provider Central account. They can grant you access to this tool.

You can also access ConnectCenter via the **eTools** tab in the main navigation bar. This page includes tips and resources for using the tool.

ENTERING YOUR PROVIDERS

It's a good idea to save default provider information in the Admin area of ConnectCenter. It needs to be done only once, and it will save you time in future inquiries.

1. Enter provider information by going to **Admin>Provider Management**. Read our [Provider Management Quick Tip](#) for help.
2. Save defaults for Requesting Provider, Billing Provider, and Rendering Provider. Defaults can be saved in Provider Management records and also in the **Select a Provider** screen.

Select	Primary Id	Last/Org Name	First Name	Tax ID	Taxonomy Code	Effective Date	Status	Expiration	Default
<input type="radio"/>	Filter by Primary Id	Filter by Last/Org Name	Filter by First Name	Filter by Tax ID	Filter by Taxonomy Code	Filter by Effective Date	Filter by Status	Filter by Expiration	
<input type="radio"/>					207VX0000X	01/14/2022	ACTIVE		<input type="radio"/>
<input type="radio"/>									<input type="radio"/>
<input type="radio"/>									<input type="radio"/>

You can choose a default on the **Select a Provider** screen

NAVIGATING AND ENTERING DATA

Required fields are marked with a red asterisk or a red outline. Be sure to complete them accurately. Include a prefix with the member ID number.

Dates must be entered in the MM/DD/YYYY format.

Do not use dashes when entering information like phone numbers, zip codes, and tax ID numbers.

Some ConnectCenter pages have expand/collapse sections (also called “accordions”). It is helpful to collapse sections you don’t need.

Inquiry responses appear at the bottom of the page (under the **Submit** button) and may include drop-down menus for changing the category of information displayed.

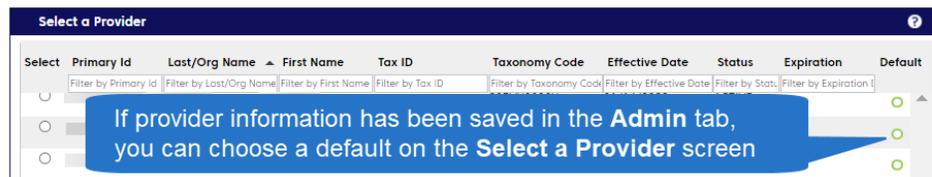
The screenshot shows the 'Claim Status' page with several sections: Billing Provider, Rendering Provider, Payer, Request Information, Claim Information, General Information - Subscriber, and Dependent Information. Below these are 'Response Information' and 'Payer Information' sections. A 'Submit' button is visible. Callouts include: 'Expand/collapse sections' pointing to the expand/collapse icons; 'Responses appear below the Submit button' pointing to the 'Response Information' section; and 'Drop-down menus allow you to change the information displayed' pointing to a dropdown menu in the 'Claim Status' section.

BENEFITS AND ELIGIBILITY

You can use ConnectCenter to verify eligibility for Massachusetts, out-of-state (BlueCard), Federal Employee Program, and international Blue Cross Blue Shield members. Responses are returned from the Blue plan that the member is contracted with, and the level of detail varies.

How to perform the inquiry

1. Go to **Verification>New Eligibility Request**.
2. Enter or find the requesting provider.
 - If you have entered providers using the **Admin** tab, you can choose a default Requesting Provider from the **Select a Provider** screen.



3. The default **Payer Search Option** is for member ID number and subscriber date of birth. Select another option if desired.
 - For out-of-state (BlueCard) members, select the search option using the member's ID number (**including prefix**), name, and date of birth.
4. For detailed benefits information, go to the **Service Type** dropdown menu and select a specific service type. The default option, Health Benefit Plan Coverage, includes many common services.
5. Click **Submit**.
 - The **Submit – Review Later** button is useful if you would like to submit several inquiries before reviewing responses. Access your responses by going to **Verification>Search Eligibility History**.



This screenshot shows the **Eligibility Request** screen:

Benefits information appears below the demographic information. Depending on the member's plan and the type of service, your results may include details on authorization requirements, co-insurance, copayments, and deductibles.

Dependent Information

CLEAR SUBMIT - REVIEW LATER SUBMIT

Response Information HUMAN READABLE DATA VIEWER

▼ Active Coverage

Service Type	Status	Coverage Level	Amount	Time Period	Remaining	In Network	Message
Chiropractic	Active						
Chiropractic	Active						
Health Benefit Plan Coverage	Active	Individual					Organization (PPO) • PPO - ADVANTAGE BLUE DEDUCTIBLE WITH COINSURANCE
Medical Care	Active						
Mental Health	Active						
Urgent Care	Active						

Demographic Information USE MEMBER FOR Select Transaction

Patient Information	Subscriber Information	Plan Detail Information
Relationship: Spouse First Name: [Redacted] Middle Name: [Redacted] Last Name: [Redacted] SSN: [Redacted] Date of Birth: [Redacted] Gender: [Redacted] Street: [Redacted] City State Zip: [Redacted] Eligibility Begin Date: [Redacted] Eligibility End Date: [Redacted]	[Redacted]	Plan Name: PPO - ADVANTAGE BLUE DEDUCTIBLE WITH COINSURANCE Plan Number: [Redacted] Plan Begin Date: [Redacted] Plan End Date: [Redacted]

View Options

Select View: Copay Service Types Returned:

Eligibility

In Network	Coverage Level	Amount	Message	Auth/Cert Required	Facility Type
▲ Chiropractic [33] (1)					
Yes	Individual	\$35.00	• MEDICAL CARE	No	
▲ Emergency Services [86] (8)					
Yes	Individual	\$200.00	• EMERGENCY ROOM SERVICES	No	Emergency Room -

Callout 1: The Human Readable view gives you more information.

Callout 2: The Copay view appears by default. Select a different view to change what appears below the Eligibility heading.

Callout 3: When multiple service types are returned, you can scroll below or select an option here.

- Authorization requirements appear in the “Copay” view.
- Network information appears in the “Providers” view.

- If relevant to the service and the member’s plan, you may see page sections called “Limitation – Quantity” or “Limitation – Monetary.” Open these areas to see benefit maximums and visits remaining.
 - Reminder: Accumulated amounts are based on claims that were processed at the time of the inquiry and are not a guarantee of payment.

Here you see monetary limitations for a dental plan:

View Options

Select View: ALL VIEWS

Service Types Returned: ALL SERVICE TYPES, Health Benefit Plan Coverage [30], Dental Care [35], Dental Crowns [36], Diagnostic Dental [23], Endodontics [26]

Expand All | Collapse All

Copy, Coinsurance, Deductible, Benefit Description

Limitation - Monetary

In Network	Coverage Level	Limitation Type	Amount	Remaining	Time Period	Message	Auth/Cert Required
Dental Care [35] (1)							
Not Applicable	Individual	Limitation	\$1,500.00	\$1,500.00	Calendar Year		
Orthodontics [38] (1)							
Not Applicable	Individual	Limitation	\$1,250.00	\$1,250.00	LifeTime	<ul style="list-style-type: none"> LIMITED TO EACH MEMBER OF ANY AGE (NOT INCLUDED IN OVERALL BENEFIT MAXIMUM) 	

Here is an example for a medical plan with quantity limitations for diabetes management services. In this example, the user accessed the information using the “Select View” option for “Limitations – Quantity.”

View Options

Select View: Limitations Quantity

Service Types Returned:

Eligibility

In Network	Coverage Level	Quantity	Units	Time Period	Remaining	Message	Auth/Cert Required
Professional (Physician) Visit - Office [98] (2)							
	Individual	0	Quantity Used	Service Year		<ul style="list-style-type: none"> DIABETES MANAGEMENT SERVICES (FIRST TWO VISITS PER CALENDAR YEAR) 2 Visits Remaining 	

“Human Readable View”

If you find that **Select View** and **Service Types Returned** filters are more limiting than you would like, you can click the **Human Readable** button (below the **Submit** and **Clear** buttons) to access the complete response.



Tip: Before using the Human Readable view, review the options in the **Select View** dropdown menu:

View Options

Select View: Limitations Quantity

Service Types Returned: Vision (Optometry) [AL]

Eligibility

When you open the Human Readable view, you can scroll or use the search field to move quickly through the results.

Eligibility Data Viewer

Human Readable View

Search by Keyword(s) CLEAR

SELECT ALL

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS Eligibility
PAYER INFORMATION
Payer: BLUE CROSS BLUE SHIELD OF MASSACHUSETTS
Payer ID: MABCBS
Payer Contact Name: WHOLEHEALTH NETWORKS, INC., A TIVITY HEALTH COMPANY
Payer Contact Phone #: 8667261713
Payer Uniform Resource Locator (URL): WWW.BLUECROSSMA.COM/PROVIDER
Payer Contact Name: BCBSMA CLINICAL COORDINATION
Payer Contact Phone #: 8003276716
Payer Fax #: 8882821321

PROVIDER INFORMATION
Provider:
Health Care Financing Administration National Provider ID #: 1992887251

SUBSCRIBER INFORMATION
Insured or Subscriber:
Member ID:
Group #:

You can search by keyword here

"Select all" to copy and paste into a different application

Blue Cross contact information appears at the top

The Human Readable view begins with Blue Cross contact information. Other sections vary depending on the member's plan and product, but often include:

- Subscriber Information
- Primary care provider contact information
- **Coverage Level*** (such as "Family")
- **Insurance Type*** (such as HMO or PPO)
- **Plan Coverage Description***
 - Plan Coverage Description may appear multiple times in different places to indicate details such as the product name, whether the account is self-insured or fully insured, or whether the product has a certain benefit design feature. Here are some examples:
 - Plan Coverage Description - 1: PPO - ADVANTAGE BLUE DEDUCTIBLE WITH COINSURANCE
 - Plan Coverage Description - 2: SELF INSURED (or FULLY INSURED)
 - Plan Coverage Description - 3: HOSPITAL CHOICE COST SHARING

* These items are useful search terms in the Human Readable View.



Sections in the Human Readable view are numbered and appear in a format like this: ELIGIBILITY AND BENEFIT INFORMATION - 2

To understand the results, read all lines that are marked with the same number, and then read neighboring sections.

In the example below, section 6 indicates the individual deductible and section 7 indicates the individual deductible remaining. (Additional sections – not shown – might indicate the family deductible and the family deductible remaining.)

ELIGIBILITY AND BENEFIT INFORMATION - 6

Eligibility Benefit Information - 6: Deductible

Coverage Level - 6: Individual

Service Type - 6: Health Benefit Plan Coverage

Time Period Qualifier: Service Year

Monetary Amount - 6: \$3,000.00 ←

Message - 6 - 1: DEDUCTIBLE DOES NOT APPLY TO MOST PREVENTIVE HEALTH SERVICES, PRESCRIPTION DRUG BENEFITS AND CERTAIN OTHER SERVICES AS NOTED.

ELIGIBILITY AND BENEFIT INFORMATION - 7

Eligibility Benefit Information - 7: Deductible

Coverage Level - 7: Individual

Service Type - 7: Health Benefit Plan Coverage

Time Period Qualifier: Remaining

Monetary Amount - 7: \$2,625.00 ←

Message - 7 - 1: DEDUCTIBLE DOES NOT APPLY TO MOST PREVENTIVE HEALTH SERVICES, PRESCRIPTION DRUG BENEFITS AND CERTAIN OTHER SERVICES AS NOTED.

CLAIM STATUS

You can inquire on the status of any claim sent to Blue Cross Blue Shield of Massachusetts for processing.

How to perform the inquiry

1. Select a search method.
 - For any claim submitted to Blue Cross Blue Shield of Massachusetts, you can go to **Claims>Claim Status**. You will need to enter or select the billing provider, the date of service, and member information (ID, name, and date of birth).
 - For 1500 claims you submitted through ConnectCenter, you can perform a fast search by going to **Claims>Claim Search**.
2. Complete the minimum number of required or appropriate fields and click **Submit**.
 - Tip: You can begin a claim status inquiry from your eligibility search results. In the **Demographic Information** row, open the **Select Transaction** drop-down menu and select **Claim Status**. Then click the button, **Use Member For**. This will carry the member's policy information to the **Claim Status** screen.



Understanding claim status inquiry results

- Your results will appear at the bottom of the **Claim Status** page after you click the **Submit** button.
- If more than one claim matches your search criteria, a drop-down menu will appear under the **Claim Status** heading. Select a claim to see its status.
- Claim-level status messages—at the top of the **Payer Messages** section—will be followed by a service line table. Each line will include procedure code, service dates, charges, and adjudication status. If adjudication is complete, the payment amount appropriate to each service line will also be available.

CLEAR SUBMIT

Response Information

▼ **Claim Status**

Select Claim Status:
 1 - \$1,688.00, DOS: 09/30/21, Claim: 27212

Additional claims for the member on the same date of service may appear in a dropdown menu

▼ **Payer Information**

Payer ID: MABCBS Payer Claim Control Number: 27212

▼ **Claim Status Information**

Patient Last Name: Patient First Name: Patient Middle Name: Patient Account Number: Member Number: Type Of Bill: Billing Provider NPI: Billing Provider Number: Billing Provider Name: Rendering Provider NPI: Rendering Provider Tax ID: Rendering Provider Name:

Claim Service From Date: 09/30/2021
 Claim Service To Date:
 Claim Charge Amount: \$1,688.00
 Claim Payment Amount: \$0.00
 Check/EFT Date: Check/EFT Number: Additional Information

Claim-level status message

Service line messages

▼ **Payer Messages**

Category	Status
F2 : Finalized/Denial-The claim/line has been denied.	1 : For more detailed information, see remittance advice.

Line	Revenue Code	Procedure	Modifier	Units	Service Date	As of	Charge Amt	Payment Amt	Category/Status
		HC-45380	33	1	09/30/2021	10/15/2021	\$1,090.00	\$0.00	F2 : Finalized/Denial-The claim/line has been denied. 1 : For more detailed information, see remittance advice.
		HC-43235		1	09/30/2021	10/15/2021	\$598.00	\$0.00	F2 : Finalized/Denial-The claim/line has been denied. 252 : Authorization/certification number.

Fast searches for 1500 claims submitted through ConnectCenter

For 1500 claims you submitted through ConnectCenter, you can perform a fast search by going to **Claims>Claim Search**. Claims that match your search criteria will appear in a list. You can:

- sort your results by clicking a column heading
- filter your results by entering data in a field under a heading
- click a link for more information, as shown in the screenshot below.

CHANGE HEALTHCARE ConnectCenter Submitter: 155564 - ConnectCenter Demo User 1 MY SETTINGS

Home Worklist Verification Claims Remits Reports Payer Tools Analytics Mailbox Help Admin Log Out

Claim Search Results Live Chat

Bill: 155564 - ConnectCenter Demo Submitter: 155564 - ConnectCenter Demo

Claim ID	Patient Name	Service Date	Charges	Payer ID	Payer Name	Status	Submitter ID	Download CSV
3331234567896		06/08/2016	\$49,271.20	3507		Accepted	155564	Copy claim
3331234567897		06/08/2016	\$49,271.20	3507		Accepted	155564	Check real-time claim status
		10/20/2014	\$4,986.37	14		Payer Denied	155564	
		06/08/2016	\$49,271.20	3507		Accepted	155564	

View claim history, summary, and details

Open Claim Tracker pop-up

- The icon for real-time claim status (🔄) will be displayed for any claim that has been submitted to Blue Cross but has not yet reached a state of final adjudication. Click the icon to display claim status inquiry results like the example shown in the next section.
- If you copy a claim, it will appear in your **Incomplete Claims** worklist.
- Click the claim ID number to see a claim summary like the one below. The summary includes a claim tracker, history, and details.

Claim List Search Results ... Claim 3331234567891 ANDREW, DEMO [Live Chat](#) ?

SUMMARY 1500 FORM CLAIM DETAILS SERVICE LINE DETAILS

Claim Tracker

Provider	Change Healthcare	Payer			Change Healthcare
Claim Submitted	Processed	Received	In Processing	Processed/Paid	Resubmitted
✓	✓	✓	-	✓	-

Claim History

Date	Activity	Status	Message
02/24/2015 01:22	Claim processed by Change Healthcare	A	Accepted
02/24/2015 16:10	Claim sent to Payor		Complete
02/24/2015 18:09	Payor Acknowledgement Received	A	Accepted

Claim Details [COPY CLAIM](#) [DATA VIEWER](#)

Claim Information	Patient Information
Submitter Name: ConnectCenter Demo Provider Claim ID: Change Healthcare Claim ID: 3331234567891 Resubmit Code: 1 Sequence Code: P Distribution Method: A Payer: DEMO PAYER ID: 1462 State Code: WA Type of Bill: 1	Account Number: 111123456 Name: DEMO L ANDREW Service Date(s): 02/12/2015 02/12/2015 Total Claim Charge: \$4,538.37 Insured ID: 222123456A Group ID:

Remittance Information

Remit Received: **03/07/2015 17:14** Paid By: **DEMO PAYER**
 Check/EFT: **963852741**
 Amount Paid: **\$897.85** Adjustments: **\$3,640.52** [VIEW EOB](#)

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REFERRAL SUBMISSION

Reminder: Submit an authorization request—*not* a referral—for **outpatient rehab (PT/OT)** and **home health care for Medicare HMO Blue members**. Use [Authorization Manager](#) for these services.

How to submit a referral

1. Go to **Verification>Authorization/Referral Submission**. (Reminder: do not use ConnectCenter for [authorization requests](#).) Complete required and appropriate optional fields. Do not enter procedure or service line level information.
 - For the **Type** field, you will usually select “Visits.”
 - Place of Service codes can be found [here](#).
2. Click **Submit**.

The following screenshot shows the **Authorization/Referral Submission** screen.

The screenshot displays the 'Authorization/Referral Submission' interface. At the top, there's a 'Payer' section with a 'My Favorites' dropdown and a 'Payer Name' field containing 'BLUE CROSS BLUE SHIELD OF MASSACHUSETTS', accompanied by a 'FIND PAYER' button. Below this is the 'General Information' section, which includes a 'Request Type' dropdown set to 'Specialty Care Review', a 'Service Type' dropdown menu (currently open, showing options like 'Consultation [3]', 'Infertility [83]', 'Maternity [69]', and 'Oral Surgery [40]'), and a 'Priority' dropdown. There are also checkboxes for 'Patient Condition is:' such as 'Accident Related', 'Employment Related', and 'Another Party is Responsible'. The 'ICD 10 Diagnosis Codes' section features 12 numbered input fields. At the bottom, there is a checkbox labeled 'Check if this request involves an ambulance'.

REFERRAL INQUIRIES

Referral inquiries will return results only if:

- The member's coverage is active at the time of the inquiry
- The referral is active (that is, the timeframe has not lapsed).

How to perform the inquiry

1. Go to **Verification>Authorization/Referral Status**.
2. Complete all required fields and only required fields. Note:
 - For **Provider Type**, select "Specialist" for any individual provider (non-facility).
 - Leave the **Previous Certification Number** field blank.
3. Click **Submit**.

The following screenshot shows the **Authorization/Referral Status** screen.

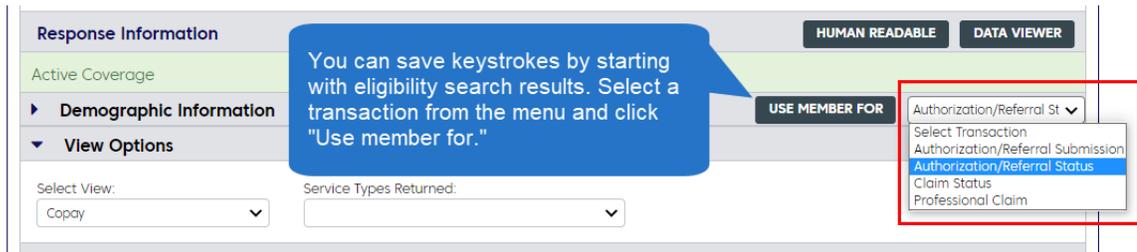
The screenshot displays the 'Authorization/Referral Status' form. At the top, there is a 'Live Chat' icon. The form is organized into several sections:

- Payer:** Includes a 'My Favorites' dropdown and a 'Payer Name' field containing 'BLUE CROSS BLUE SHIELD of MASSACHUSETTS'. A 'FIND PAYER' button is located to the right.
- Request Information:** Contains a 'General Information' section with a 'Request Type' dropdown set to 'Specialty Care Review' and a 'Previous Certification Number' field.
- Provider:** Features a 'Provider Type' dropdown set to 'Specialist', an 'NPI' dropdown, and fields for 'ID', 'First Name', and 'Last/Org Name'. A 'FIND PROVIDER' button is on the right.
- Subscriber:** Includes 'Member ID' and 'Date of Birth' (mm/dd/yyyy) fields.

At the bottom of the form, there are 'CLEAR' and 'SUBMIT' buttons. A blue callout box with a pointer to the 'Provider Type' dropdown contains the text: 'Choose "Specialist" for any non-facility referral'. The footer contains a 'Privacy Policy' link, copyright information for Change Healthcare, and the 'CHANGE HEALTHCARE' logo.

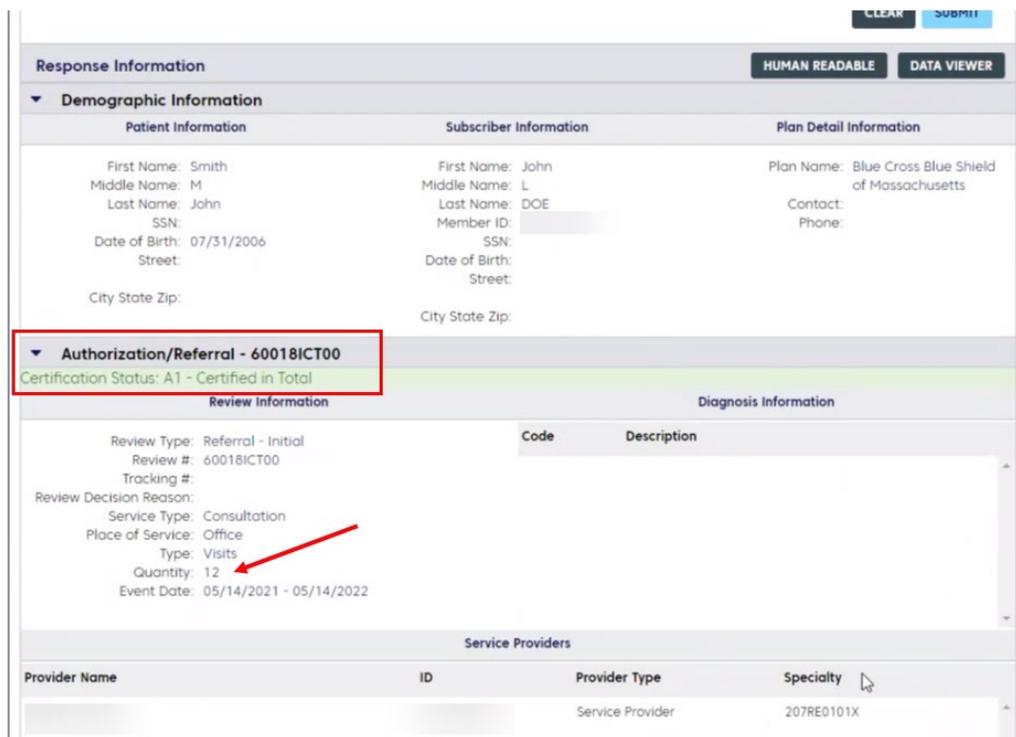
Tip:

- You can begin a referral inquiry from your eligibility search results. In the **Demographic Information** row, open the **Select Transaction** drop-down menu and select **Authorization/Referral Status**. Then click the button, **Use Member For**. This will carry the member's policy information to the **Authorization/Referral Status** screen.



Understanding referral inquiry results

- Results that match your search criteria will appear at the bottom of the page. An open referral will be indicated in a green bar.
- Under the **Review information** heading, you'll see the referral date range and visit quantity.



ADDITIONAL RESOURCES

More resources are available on our [ConnectCenter](#) page. For additional help, contact Optum's ConnectCenter support at **1-800-527-8133**.

- Select **option 2** for claims or claim status.
- Select **option 3**, then **option 1** for eligibility.

For help with Provider Central, please contact Blue Cross Blue Shield's EDI/Provider Self-Service Support Team at providercentral@bcbsma.com or **1-800-771-4097, option 2**.

DOCUMENT HISTORY

04/22	New document.
08/22	Updated screenshots for benefits and eligibility.
11/22	New screenshots and simplified instructions for referral submission. Added link for Place of Service codes.
01/24	Updated references to home health care. Authorization required now for Medicare HMO Blue only. Removed references to Online Services. Updated screenshot for eligibility search.
01/25	Updated reference to home health care since authorization is no longer required for Medicare HMO Blue.
03/25	Updated Related Resources.
03/26	Changed template. Updated document to reflect that ConnectCenter can now be used by dental providers. Updated Change Healthcare to Optum.

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