

INTRODUCTION

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

Dental providers can use ConnectCenter to:

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

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.



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”).

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 a web interface titled "Claim Status" with a "Live Chat" icon in the top right. The page is organized into several expandable/collapsible sections, each with a right-pointing triangle icon: "Billing Provider", "Rendering Provider", "Payer", "Request Information", "Claim Information", "General Information - Subscriber", and "Dependent Information". Below these sections are "CLEAR" and "SUBMIT" buttons. Under the "SUBMIT" button, there is a "Response Information" section. Within this section, the "Claim Status" dropdown menu is expanded, showing a list of options: "1 - \$1,688.00, DCOS: 09/30/21, Claim: ". A callout points to this dropdown menu, stating "Drop-down menus allow you to change the information displayed". At the bottom of the page, there are fields for "Payer ID: MABCBS" and "Payer Claim Control Number: ". A second callout on the left side of the page points to the "SUBMIT" button area, stating "Responses appear below the Submit button". A third callout on the left side points to the expandable sections, stating "Expand/collapse sections".

BENEFITS AND ELIGIBILITY

You can use ConnectCenter to verify eligibility for Massachusetts and out-of-state 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

Go to **Verification>New Eligibility Request**. Your screen will look like this:

The screenshot shows the 'Eligibility Identifier' form in the Optum ConnectCenter interface. The form is divided into several sections: Provider, Payer, Request Information, General Information - Subscriber, and Dependent Information. Callouts highlight specific fields: 'Provider information' points to the ID, First Name, and Last/Org Name fields; 'Member information' points to the Member ID, First Name, Last Name, and Date of Birth fields; a note points to the 'Service Type' dropdown menu, stating 'You will need to change this dropdown from Medical to Dental Care'; and another callout points to the 'Submit' button.

Provider information

Member information
Always include the member ID prefix

Submit button

You will need to change this dropdown from Medical to Dental Care

The **Service Type** dropdown menu, located under the Request Information heading, defaults to “Medical.” You will need to change this option to “Dental Care.”

Enter the requesting provider and the member information (with ID prefix) and click **Submit**.

Options:

- If you have entered providers using the **Admin** tab, you can choose a default Requesting Provider from the **Select a Provider** screen.
- The default **Payer Search Option** is for member ID number and subscriber date of birth. Select another option if desired.
- For detailed benefits information, go to the **Service Type** dropdown menu and select a specific service type.
- 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**.

Understanding eligibility inquiry results

Your results will appear at the bottom of the page.

Response Information
HUMAN READABLE DATA VIEWER

▼ Active Coverage

Service Type	Status	Coverage Level	Amount	Remaining	Time Period	In Network	Message
Dental Care	Active						

▼ Demographic Information USE MEMBER FOR Select Transaction

Patient Information	Subscriber Information	Plan Detail Information
Relationship:	First Name:	Plan Name:
First Name:	Middle Name:	Plan Number:
Middle Name:	Last Name:	Plan Date:
Last Name:	Member ID:	Group Name:
SSN:	SSN:	Group Number:
Date of Birth:	Date of Birth:	Policy Name:
Gender:	Gender:	Policy Number:
Street:	Street:	Payer Contact:
City State Zip:	City State Zip:	Telephone:
Eligibility Date:	Eligibility Date:	Facsimile:

▼ View Options

Select View:

ALL VIEWS

Service Types Returned:

ALL SERVICE TYPES

Health Benefit Plan Coverage [30]

Dental Care [35]

Routine (Preventive) Dental [41]

Expand All Collapse All

▶ Copay

▶ Out Of Pocket

▶ Benefit Description

▶ Coordination of Benefits

▶ Limitation - Quantity

▶ Providers

The response information will include a red bar when a member's plan is no longer active.



Benefits information appears in accordions below the demographic information.

View Options

Select View:

Service Types Returned:

- ALL SERVICE TYPES
- Health Benefit Plan Coverage [30]
- Dental Care [35]
- Routine (Preventive) Dental [41]

[Expand All](#) [Collapse All](#)

- ▶ Copay
- ▶ Out Of Pocket
- ▶ Benefit Description
- ▶ Coordination of Benefits
- ▶ Limitation - Quantity
- ▶ Providers

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 or visits remaining.

Monetary limits will indicate the coverage amount per time period and the amount remaining in that time period.

- **Reminder:** Accumulated amounts are based on claims that were processed at the time of the inquiry and are not a guarantee of payment.

View Options

Select View:

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](#)

- ▶ Copay
- ▶ Coinsurance
- ▶ Deductible
- ▶ Benefit Description
- ▼ **Limitation - Monetary**

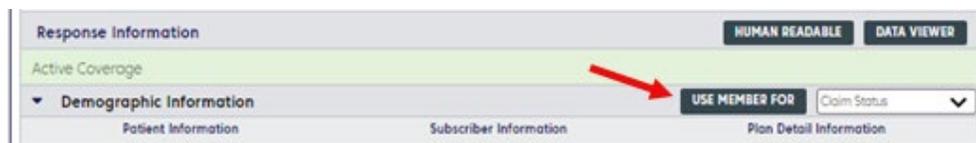
In Network	Coverage Level	Limitation Type	Amount	Remaining	Time Period	Message	Auth/Cert Required
▲ Dental Care [35] (1)							
Not Applicable	Individual	Limitation	\$1,500.00	\$1,500.00	Calendar Year		
▲ Orthodontics [38] (1)							
Not Applicable	Individual	Limitation	\$1,250.00	\$1,250.00	LifeTime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

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. 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).
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 **Submit**.

Response Information

Claim Status

Select Claim Status:
1 - \$1,688.00, DOS: 09/30/21, Claim: 2721

Payer Information

Payer ID: MABCBS Payer Claim Control Number: 2721

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

Payer Messages

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.

- 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.

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

03/26	New document.
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