

# CONNECTCENTER QUICK START

## INTRODUCTION

ConnectCenter™ is an eTool for real-time transactions and professional claim submission. It is a product of [Change Healthcare \(CHC\)](#).

You can use ConnectCenter to:

- [Verify benefits and eligibility](#)
- [Check claim status](#)
- [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)** and **home health care for Medicare HMO Blue members**.)

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

## ACCESSING CONNECTCENTER

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

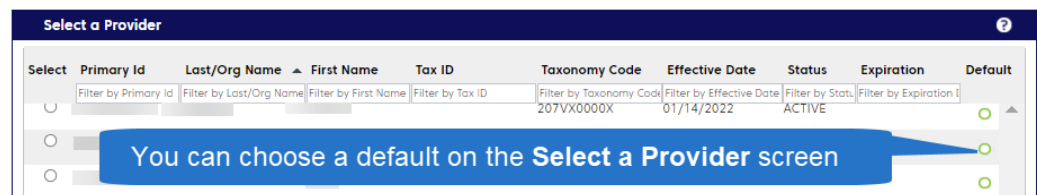
If you do not see the link, talk to the person in your practice or organization who is set up as administrator of your Provider Central account. They can grant you access to this tool.

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

## BEFORE YOU BEGIN

To save time later, it is strongly recommended that you:

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”). 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. Callouts include: 'Expand/collapse sections' pointing to the accordion menu; '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 the 'Select Claim Status' dropdown menu.

## HOME PAGE RESOURCES

Your home page includes a summary of the claims submitted through ConnectCenter in the last 30 days. Click a status in the pie chart to see claims with that status.

On the left side of your home page, you’ll see your **Worklists**. You can use these lists to manage claims that you may wish to correct and resubmit. Worklists are explained further on [page 11](#).

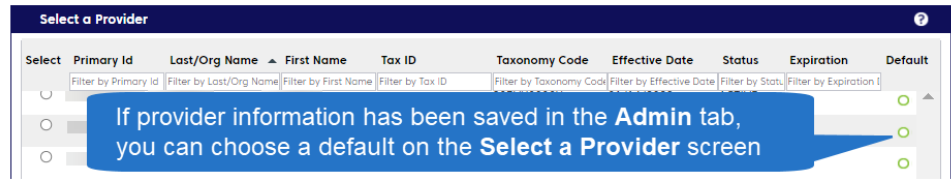
The screenshot shows the 'Home' page of ConnectCenter. Callouts include: 'Here are your Worklists. You can remove and edit items in these lists.' pointing to the 'Task Summary' section; 'Click a status to see claims.' pointing to the 'Claim Health Vitals' pie chart; and 'By default, the pie chart will reflect claims that were submitted within the last 30 days. You can change the date range using the filters above.' pointing to the date filters.

Current Status	%	Total Count	Claim Value
Good Standing	50%	26	\$351,787.70
Warnings	15.38%	8	\$126,395.25
Rejected	19.23%	10	\$36,257.92
Denied	15.38%	8	\$120,969.58

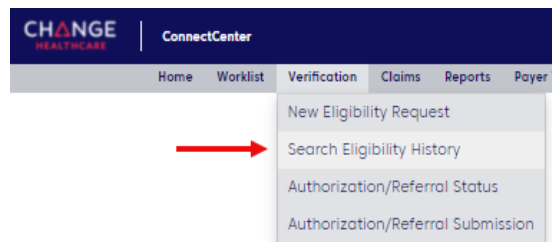
You can use ConnectCenter to verify eligibility for Massachusetts, out-of-state, Federal Employee Program, and international Blue Cross Blue Shield members. Responses are returned from the Blue plan that the member is contracted with, and the level of detail varies.

**Key steps**

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 members, you must enter 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:

**Eligibility Identifier** Live Chat

**Provider**

ID Type: \*  ID: \*

Taxonomy Code:  We don't require a Taxonomy Code

**Payer**

My Favorites:  Payer Name:

Payer Search Options:  Search options are here

**Request Information**

**Service Information**

Service Type: \*  Date of Service: From:  To:  Place of Service:

**General Information - Subscriber** Service types are here

Member ID:  Date of Birth:

First Name:  Gender:  Male  Female

Last Name:  Additional ID Type:  Additional ID:

**Dependent Information**

## UNDERSTANDING THE RESULTS

Your results will appear at the bottom of the page.

**Dependent information**

**Response Information**

Active Coverage

**Demographic Information** USE MEMBER FOR

Patient Information	Subscriber Information	Plan Detail Information
Relationship: Self	First Name: <input type="text"/>	Plan Name: MANAGED - HMO BLUE NE \$3000 DEDUCTIBLE WITH HCCS
First Name: <input type="text"/>	Middle Name: <input type="text"/>	Plan Number: <input type="text"/>
Middle Name: <input type="text"/>	Last Name: <input type="text"/>	Plan Begin Date: 05/01/2017
Last Name: <input type="text"/>	Member ID: <input type="text"/>	Plan End Date: 12/31/9999
SSN: <input type="text"/>	SSN: <input type="text"/>	Group Name: <input type="text"/>
Date of Birth: <input type="text"/>	Date of Birth: <input type="text"/>	Group Number: <input type="text"/>
Gender: <input type="text"/>	Gender: <input type="text"/>	Policy Name: <input type="text"/>
Street: <input type="text"/>	Street: <input type="text"/>	Policy Number: <input type="text"/>
City State Zip: <input type="text"/>	City State Zip: <input type="text"/>	
Eligibility Begin Date: <input type="text"/>	Eligibility Begin Date: <input type="text"/>	
Eligibility End Date: <input type="text"/>	Eligibility End Date: <input type="text"/>	

**View Options**

Select View:  Service Types Returned:

**Eligibility**

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

**Response Information**

Inactive

**Demographic Information** USE MEMBER FOR

Patient Information	Subscriber Information	Plan Detail Information
Relationship: <input type="text"/>	First Name: <input type="text"/>	Plan Name: <input type="text"/>
First Name: <input type="text"/>	Middle Name: <input type="text"/>	Plan Number: <input type="text"/>
Middle Name: <input type="text"/>	Last Name: <input type="text"/>	Plan Begin Date: <input type="text"/>
Last Name: <input type="text"/>	Member ID: <input type="text"/>	Plan End Date: <input type="text"/>
SSN: <input type="text"/>	SSN: <input type="text"/>	Group Name: <input type="text"/>
Date of Birth: <input type="text"/>	Date of Birth: <input type="text"/>	Group Number: <input type="text"/>
Gender: <input type="text"/>	Gender: <input type="text"/>	Policy Name: <input type="text"/>
Street: <input type="text"/>	Street: <input type="text"/>	Policy Number: <input type="text"/>
City State Zip: <input type="text"/>	City State Zip: <input type="text"/>	
Eligibility Begin Date: <input type="text"/>	Eligibility Begin Date: <input type="text"/>	
Eligibility End Date: <input type="text"/>	Eligibility End Date: <input type="text"/>	

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.

General Information: Subscriber

**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					<ul style="list-style-type: none"> <li>Organization (PPO)           <ul style="list-style-type: none"> <li>PPO - ADVANTAGE BLUE DEDUCTIBLE WITH COINSURANCE</li> </ul> </li> </ul>
Medical Care	Active						
Mental Health	Active						
Urgent Care	Active						

USE MEMBER FOR Select Transaction ▼

▼ Demographic Information

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

▼ 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 -

The Human Readable view gives you more information.

The Copay view appears by default.

Select a different view to change what appears below the Eligibility heading.

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.
- For the benefit maximum and visits remaining, select “Limitations – Quantity.”
  - 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: Limitations Quantity Service Types Returned: [Empty]

**Eligibility**

In Network	Coverage Level	Quantity	Units	Time Period	Remaining	Message	Auth/Cert Required
						<ul style="list-style-type: none"> <li>REFER TO PRESCRIPTION DRUGS</li> <li>REFERRAL IS REQUIRED</li> <li>A REFERRAL IS REQUIRED FOR SPECIALIST VISITS, AN AUTHORIZATION IS REQUIRED FOR NEUROPSYCHOLOGICAL ASSESSMENT/TESTING</li> </ul>	
<b>Professional (Physician) Visit - Office [98] (2)</b>							
Individual		0	Quantity Used	Service Year		<ul style="list-style-type: none"> <li>DIABETES MANAGEMENT SERVICES (FIRST TWO VISITS PER CALENDAR YEAR)</li> <li>2 Visits Remaining</li> </ul>	

## 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** ▶ Live Chat ?

**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: [Redacted]  
 Health Care Financing Administration National Provider ID #: 1992887251

SUBSCRIBER INFORMATION  
 Insured or Subscriber: [Redacted]  
 Member ID: [Redacted]  
 Group #: [Redacted]

*Annotations:*  
 - "You can search by keyword here" points to the search field.  
 - "Select all" to copy and paste into a different application points to the SELECT ALL button.  
 - Blue Cross contact information appears at the top points to the Payer Information section.

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

- **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
- Primary care provider contact information

\* 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.

### Key steps

1. Select a search method.
  - For claims *you submitted through ConnectCenter*, you can perform a fast search by going to **Claims>Claim Search**.
  - 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).
2. Complete the minimum number of required or appropriate fields and click **Submit**.

### Tips

- 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.

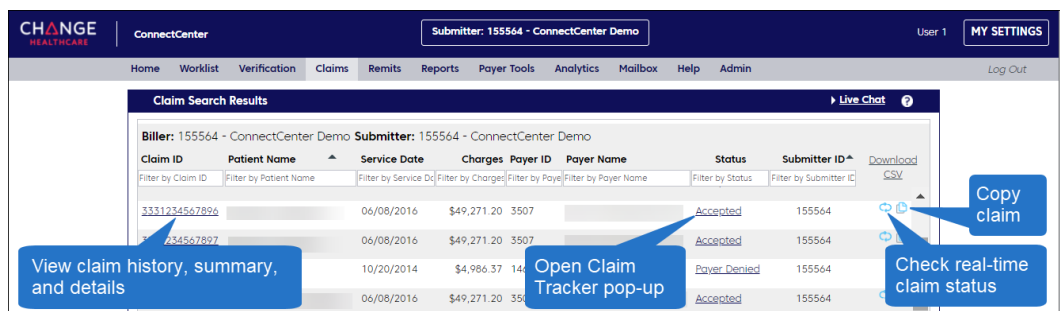


For more details about checking claim status, refer to our [Checking Claim Status Quick Tip](#).

## UNDERSTANDING THE RESULTS

### Claim search results

- If you perform a 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.



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

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**Response Information**

▼ **Claim Status**  
 Select Claim Status:  
 1 - \$1,688.00, DOS: 09/30/21, Claim: 2721: [dropdown]

▼ **Payer Information**  
 Payer ID: MABCBS      Payer Claim Control Number: 2721: [dropdown]

▼ **Claim Status Information**

Patient Last Name: [redacted]      Claim Service From Date: 09/30/2021  
 Patient First Name: [redacted]      Claim Service To Date: [redacted]  
 Patient Middle Name: [redacted]      Claim Charge Amount: \$1,688.00  
 Patient Account Number: [redacted]      Claim Payment Amount: \$0.00  
 Member Number: [redacted]      Check/EFT Date: [redacted]  
 Type Of Bill: [redacted]      Check/EFT Number: [redacted]

Billing Provider NPI: [redacted]      Additional Information  
 Billing Provider Number: [redacted]  
 Billing Provider Name: [redacted]

Rendering Provider NPI: [redacted]  
 Rendering Provider Tax ID: [redacted]  
 Rendering Provider Name: [redacted]

▼ **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.

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

Claim-level status message

Service line messages

**WORKLISTS**

Worklists are available through the **Home** page and **Worklist** tab. If you submit claims through ConnectCenter, you can use worklists to:

- Identify and correct problematic claims
- Create and use claim “templates” (by opening a claim in the Incomplete Claims worklist and copying it)



When creating a claim to use as a template, enter a keyword (like the diagnosis, or, if you’re working for a billing agency, the provider name) into the **Patient Last Name** field. The label will help you choose the correct template in your Incomplete Claims worklist.

The following screenshot was created using an ICD-10 diagnosis code for anxiety, so the Patient Last Name field includes the word “anxiety.”

The screenshot shows a 'Health Insurance Claim Form' with the following sections:

- Payer Information:** Payer Name: MASSACHUSETTS BLUE S, Payer ID: 2424, P-Primary. Address Line 1/2 and City, State, Zip are empty.
- Insurance Type:** Medicare Part A, Medicare Part B, Medicaid, Tricare, ChampVA, Group Health Plan, FECA Bk Lung, and Other (checked).
- Patient Information:** Patient's Name: ANXIETY (highlighted in red), Patient's Birth Date, Sex (M/F), Insured's Name, Insured's Address, and Patient Relationship (Self, Spouse, Child, Other).

Worklists for submitted claims reflect claims processed in the last six months. After six months, claims will drop off the worklists, but they are accessible from the Claim Search for two years.

Below is an example of a worklist for rejected claims. All claims with a “CHC Rejected” status need to be corrected before they can be sent to Blue Cross for adjudication. Choose **Work** to open a rejected claim and view error details. When you correct the claim for resubmission, be sure to use the **Validate** option to ensure that all errors have been resolved.

The screenshot shows the 'Rejected Claims' worklist with the following data:

Status	Payer	Provider	Patient Name	Svc Date	Amount	Last	Follow-Up	Download
<input checked="" type="checkbox"/> CHC Rejected	DEMO PAYER	DEMO PROVIDER BRION, METALI...		04/24/2014	\$2,921.00	02/26/2015	11/14/2016	WORK, CLOSE
<input type="checkbox"/> CHC Rejected	DEMO PAYER	DEMO PROVIDER DWANE, SILVER		02/04/2015	\$4,986.37	02/17/2015	mm/dd/yyyy	WORK, CLOSE
<input type="checkbox"/> CHC Rejected	DEMO PAYER	DEMO PROVIDER WILL, JOHNSON		02/24/2015	\$4,986.37	03/03/2015	mm/dd/yyyy	WORK, CLOSE
<input type="checkbox"/> CHC Rejected	DEMO PAYER	DEMO PROVIDER BROD, WHEAT, L		06/14/2014	\$489.00	03/10/2015	mm/dd/yyyy	WORK, CLOSE

Worklists can be filtered using fields under each column heading. You can close an item, delete it from your Worklist, or enter a follow-up date. (Items with a follow-up date appear in the My Follow-up Worklist.)

## 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.

### Key steps

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' form. At the top, there is a 'Live Chat' icon. The form is divided into several sections: 'Payer', 'General Information', and 'ICD 10 Diagnosis Codes'. In the 'Payer' section, there is a 'My Favorites' dropdown and a 'Payer Name' field containing 'BLUE CROSS BLUE SHIELD of MASSACHUSETTS' with a 'FIND PAYER' button. The 'General Information' section includes a 'Request Type' dropdown set to 'Specialty Care Review', a 'Service Type' dropdown menu with a red border and a list of options: 'Select', 'Consultation [5]', 'Infertility [83]', 'Maternity [99]', and 'Oral Surgery [40]', and a 'Priority' dropdown. Below these are checkboxes for 'Patient Condition is' with options: 'Accident Related', 'Employment Related', and 'Another Party is Responsible'. At the bottom of this section is a checkbox for 'Check if this request involves an ambulance'. The 'ICD 10 Diagnosis Codes' section consists of 12 numbered input fields arranged in two rows of six.

## 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).

### Key steps

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.

**Authorization/Referral Status** ▶ Live Chat ?

**Payer**

My Favorites:  Payer Name:  FIND PAYER

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**Request Information**

**General Information**

Request Type: \*  Previous Certification Number:

**Provider**

Provider Type: \*  Provider ID Type: \*  ID: \*  First Name:  Last/Org Name: \*  FIND PROVIDER

**Subscriber**

Member ID: \*  Date of Birth: \*

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Choose "Specialist" for any non-facility referral

**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.

**Response Information** HUMAN READABLE DATA VIEWER

Active Coverage

**Demographic Information**

**View Options**

Select View:  Service Types Returned:

**USE MEMBER FOR**

Authorization/Referral St. ▼

- Select Transaction
- Authorization/Referral Submission
- Authorization/Referral Status**
- Claim Status
- Professional Claim

You can save keystrokes by starting with eligibility search results. Select a transaction from the menu and click "Use member for."

**UNDERSTANDING THE 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.

CLEAR SUBMIT

**Response Information** HUMAN READABLE DATA VIEWER

**Demographic Information**

Patient Information	Subscriber Information	Plan Detail Information
First Name: Smith Middle Name: M Last Name: John SSN: Date of Birth: 07/31/2006 Street: City State Zip:	First Name: John Middle Name: L Last Name: DOE Member ID: SSN: Date of Birth: Street: City State Zip:	Plan Name: Blue Cross Blue Shield of Massachusetts Contact: Phone:

**Authorization/Referral - 60018ICT00**  
 Certification Status: A1 - Certified in Total

Review Information	Diagnosis Information				
Review Type: Referral - Initial Review #: 60018ICT00 Tracking #: Review Decision Reason: Service Type: Consultation Place of Service: Office Type: Visits Quantity: 12 Event Date: 05/14/2021 - 05/14/2022	<table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Code	Description		
Code	Description				

**Service Providers**

Provider Name	ID	Provider Type	Specialty
		Service Provider	207RE0101X

**RELATED RESOURCES**

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

- Select **option 2** for claims or claim status.
- Select **option 4** for eligibility.

Within the ConnectCenter application, you can request help by going to **Help>Create a Support Ticket**.

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

**DOCUMENT HISTORY**

4/15/22	New document.
8/3/22	Updated screenshots for benefits and eligibility.
11/4/22	New screenshots and simplified instructions for referral submission. Added link for Place of Service codes.
1/1/24	Updated references to home health care. Authorization required now for Medicare HMO Blue only. Removed references to Online Services. Updated screenshot for eligibility search.

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