

Provider Connection Reference Guide

The Provider Connection website gives you easy access to the tools and information you need to serve Blue Shield and Blue Shield Promise members as well as to support your practice.

Use this reference guide to learn more.



If you are viewing this guide online, the linked page numbers take you to instructions for key activities you can do on Provider Connection. Use the *Directory* button at the bottom of each page to return to this table of contents.

Page	Action
3	Registration & account management for Account Managers and Users
4	Website navigation
5	Provider directory online validation and update process <ul style="list-style-type: none">• Assign user access to provider demographic information
7	Verify member eligibility plus view eligibility and coverage details, benefits, and member's ID card
13	Create member rosters
14	Locate authorization tools and resources
15	Options for submitting claims
16	Use the <i>Claims Routing Tool</i> to determine where to send paper claims
17	Account Managers: Enroll in ERA and EFT online plus check or edit enrollment status
18	Use <i>Check Claim Status</i> to search claims and find EOBs
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21	Submit a dispute online or by mail
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24	Quick links



Background: If your organization is new to [Provider Connection](#), you must establish an account.

Establishing an account:

The person executing the initial Provider Connection registration is considered an Account Manager. When the maximum allowed number of Account Managers register, Provider Connection will display a message. Most organizations can have at least two Account Managers. There are three types of provider accounts. The links below take you to step-by-step instructions with screenshots for how to register for the account type most appropriate to your business.

1. [Provider](#)
2. [MSO](#)
3. [Billing Service](#)

Account Managers:

Once registered, the Account Manager(s) will see an *Account management* link in their top-level navigation after log in. It provides direct access to all activities falling within the role.

Once established, the Account Manager(s) – not Blue Shield – sets up user profiles. Blue Shield will email each user a temporary password. Users have 30 days to visit the site and change their password or the account will be deleted.

Users:

All users (and Account Managers) have a *Manage my profile* page where they can do things like update their username/password, change their email, set their email preferences, and locate their Account Manager. After log in, a “badge” with the user’s initials appears in the white menu bar. Click this badge to access the *Manage my profile* page.

Additional support:

- This [Provider Connection Account FAQ](#) provides answers to the most frequently asked questions about establishing and maintaining a Provider Connection account as an Account Manager or user.
- A password must be updated every 365 days. See [Update your Provider Connection password](#) if you need help changing your password or if your account is locked or disabled.
- The [Provider Connection training page](#) includes links to the above resources and more. No log in is required.



Background: Below is a high-level snapshot of how to navigate the [Provider Connection](#)* website. Authenticated tools require log in, but there are many resources on Provider Connection that do not.

Instructions:

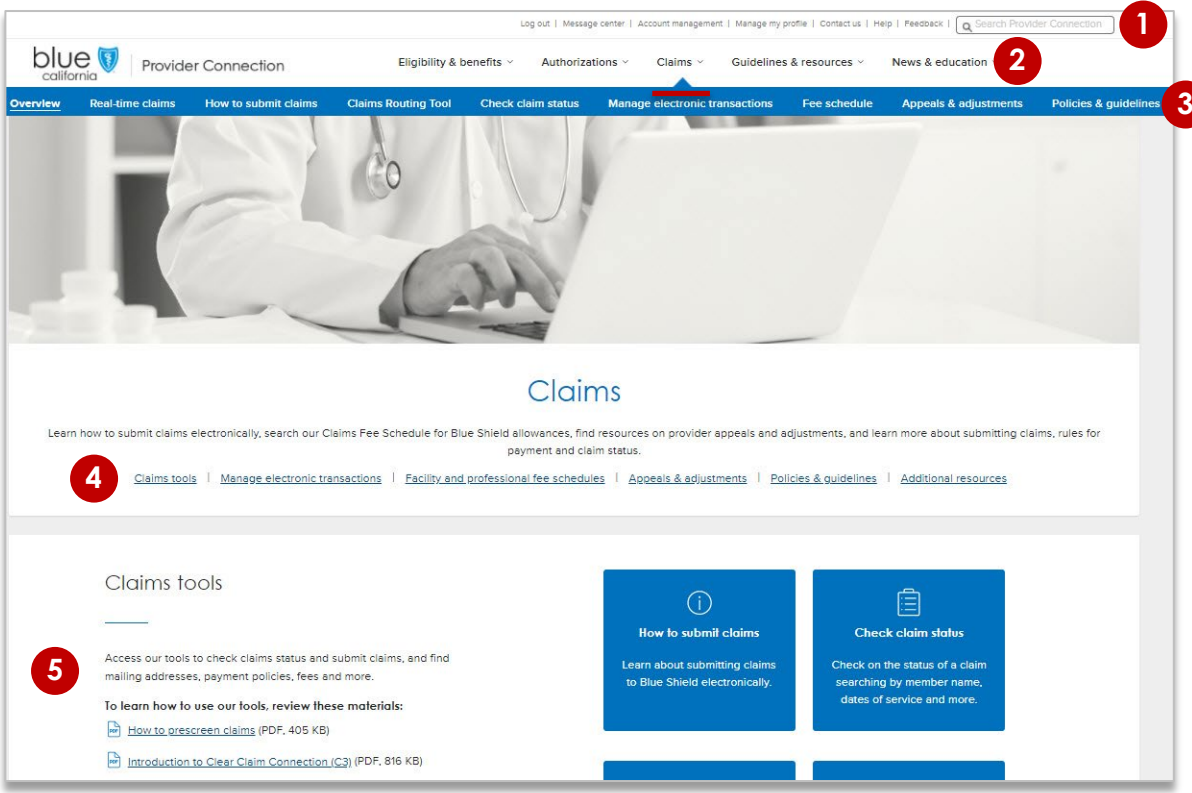
- 1. **Top level navigation:** General site actions like *Login/register* and *Help*.
 - Blue Shield uses two-step authentication. To verify your identity each time you login, enter your username/password plus the code Blue Shield sends to your email.

- 2. **White menu bar:** Navigational links to the five site sections and the home page. The arrow indicates the section you are in.

- 3. **Blue sub-menu bar:** Direct navigational links for the most-used content and tools within the specific section.

- 4. **Category headings:** High-level table of contents for information on the page. Clicking a category heading takes you to a category.

- 5. **Categories:** Contain quick links to tools and resources when appropriate, and clickable boxes that take you to your desired information.



* Blue Shield Promise resources that do not require log in are integrated throughout Provider Connection. They are also available from the [Blue Shield Promise Provider Portal](#). Links in the footer of each website allow you to move between the two websites.

High-level provider directory validation process

Background: Blue Shield has designed our provider directory accuracy processes to be compliant with both the 2021 Consolidated Appropriations Act (CAA) and California Senate Bill (SB) 137 requirements.

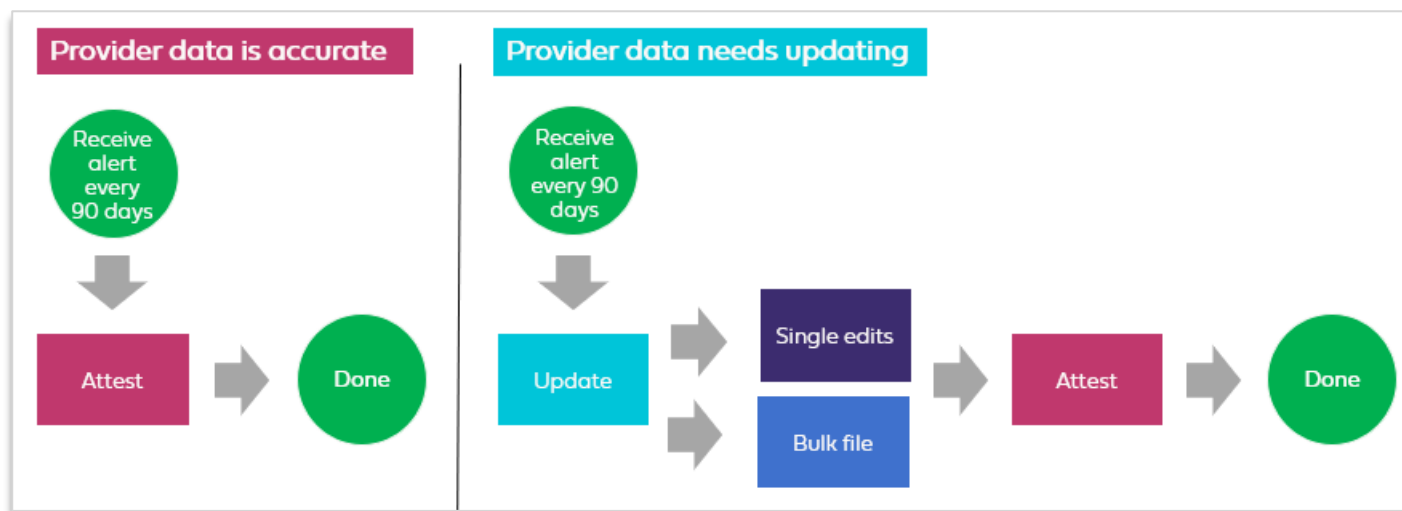
Process:

- Online attestation to data accuracy every 90 days, even if data has not changed. Blue Shield will alert a provider when it is time to attest.
- Directory updates at any time either by:
 - Single edits on the Provider Connection *Provider & Practitioner Profiles* page.
 - Blue Shield's bulk data file – the *Provider Data Validation Spreadsheet* – downloaded from *Provider & Practitioner Profiles*, then uploaded back to the page.

Visit [Provider data management](#) for step-by-step instructions on how to attest and update provider directory information in compliance with federal and state mandates. Tab 1 of the *Provider Data Validation Spreadsheet* has instructions for how to complete and save the spreadsheet.

Who can execute this process:

- Provider Connection Provider and MSO Account Managers and users to which they give provider demographic information access. [See instructions on the next page for how to assign user access.](#)
 - Billing Managers have view-only access.



Account Manager assign user access to provider & practitioner demographic information

Background: Account Managers can assign provider demographic data access to designated users so that the most appropriate staff members validate/update/attest to provider directory information.

Instructions:

1. From the *Account management* page, click **Manage your user accounts** located under the *Manage user accounts* section.
2. Click the **View** link for a specific user.
3. That user's *Account information* will display.
4. Move the *Provider & practitioner data* toggle to the right.
5. When the user logs in after access is granted, they will see a link to *Provider & practitioner profiles* in their top navigation bar.

Manage user accounts

The tables below show any pending user accounts followed by all other accounts. Select a user to update their tax IDs, claims access, and account status.

Create user account Help

Active and disabled accounts Filter results Transfer selected accounts Delete selected accounts Print Download

NAME	USERNAME	CLAIMS	REAL-TIME CLAIMS	PROVIDER & PRACTITIONER DATA	CREATED	STATUS
Person, User	user123	Yes	No	No	10/07/2019	Active

Account information

Contact information

Name: Person, User Username: Person, User Phone: 999-999-9999

Main St.: City, State, 90000

personuser@comcast.net

User permissions

Claims (checked) Real-time claims (unchecked) Provider & practitioner data (checked)

Account administration

Account status: Active (selected), Deactivated

Reset password

Logout | Messages | Provider & practitioner profiles | Manage my profile | Contact us | Help | Feedback | Search Provider Connection

blue shield of california Provider Connection

Eligibility & benefits Authorizations Claims Guidelines & resources News & education

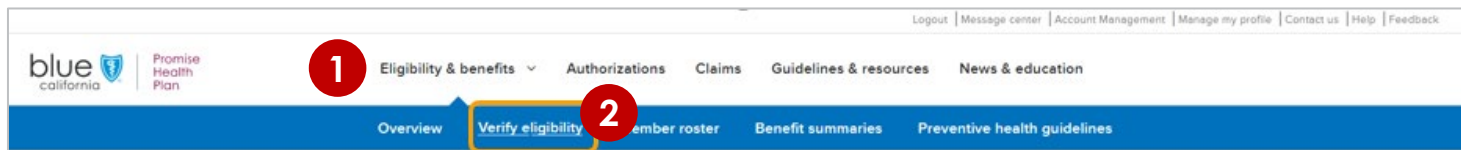


Verify member eligibility

Background: *Verify eligibility* lets you confirm that a patient is a Blue Shield, Blue Shield Promise or Other Blue Plan member. The tool contains up to two years of data at any one time. It is updated daily.

Instructions:

1. After log in, click **Eligibility & benefits** from the white navigation bar.
2. Click **Verify eligibility** from the blue navigation bar.



3. *Verify eligibility* opens and defaults to **SEARCH SINGLE MEMBER**. To search for up to 10 subscriber IDs at one time, click **SEARCH MULTIPLE MEMBERS**.

4. For single member search, enter member data using one of the following:

- Subscriber ID (9-16 alpha numeric characters)
- Member name and date of birth
- Last four (4) digits of SSN
- MBI and date of birth (Medicare only)
- First nine (9) characters of CIN

5. Click the active **Search** button. The eligibility results screen displays – [see next page](#).



Member name MEMBER, G		Status Eligible 1	2 Details ID Card Benefits Claims	
Subscriber ID 91911	Date of birth 02/02/1958	Gender Male	Member address 332WP, Los Angeles, CA, 90001	
Plan name Palo Alto Networks Inc Blue Shield Platinum PPO	Plan type Commercial PPO	Coverage effective / start date 02/01/2022	Coverage end / redetermination date Present	
Coordination of benefits EMPIRE BCBS 3	COB Order Primary	COB effective / start date [ⓘ] 01/01/2022		
PCP name N/A	Office visit copay In-network-\$20			

- 1. Status:** Eligibility is **green** if active.
- 2.** Upper right navigation provides links to eligibility details, a PDF of the member ID card, benefits, and *Check claims status*.
- 3. Blue Shield only:** When Blue Shield is not primary, Coordination of Benefits (COB) information will display for Commercial members if the data is in our system.

Note: When verifying eligibility for Blue Shield TotalDual (HMO D-SNP) members with matching Medi-Cal through Blue Shield Promise (“full duals”), two of the above results panels will present, one for Medicare (primary) and one for Medi-Cal (secondary). When this is the case, the member ID card will be active on the Medicare results screen and inactive on the Medi-Cal.



Background: Clicking **Details** from the eligibility results screen provides access to additional information about the member. The first item you will see is Network Status.



For the following six networks, the eligibility results screen tells you if you are in or out of the member's network:

1. PPO DMHC
2. PPO DOI Blue Shield Life
3. IFP EPPO
4. CalPers EPO
5. PPO GMAPD
6. PPO IMAPD

Note:

- For members not in one of the above networks, providers will be directed to [Find a Doctor](#) to determine network status.
- For capitated members, providers will be directed to contact the IPA.

Member name MEMBER, A		Status Eligible		Print Benefits Claims
Subscriber ID XEF91	Date of birth 01/01/1990	Gender Female	Member address STREET NO.1, Berkeley, CA, 94710	
Plan name Get Covered PPO	Plan type Commercial PPO (Fully insured)	Coverage effective / start date 01/01/2019	Coverage end / redetermination date Present	
Relationship to subscriber Subscriber	Subscriber name MEMBER, A	PCP name N/A	Office visit copay In-network-0%	

Network status ⓘ

Ⓜ In network

4343001 -- PALOMAR CITY MED CTR

Network status ⓘ

Ⓧ Out of network

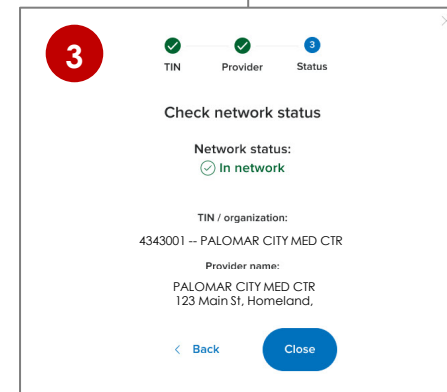
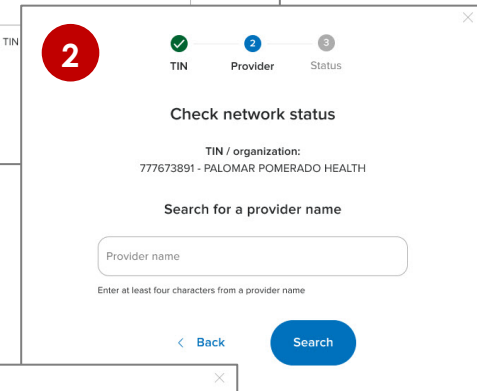
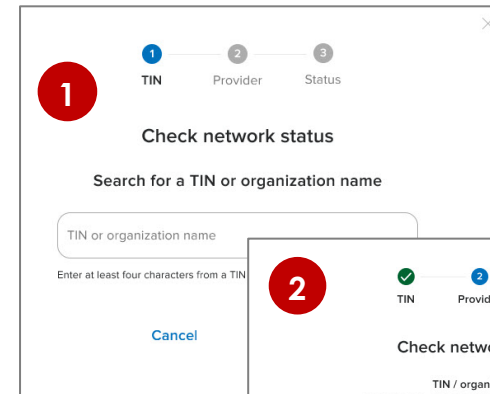
4343001 -- PALOMAR CITY MED CTR



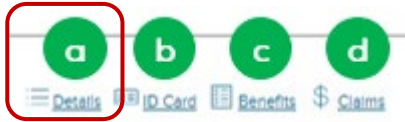
If you have more than one Tax ID registered with Blue Shield, a *Check status* link will present. Clicking this link launches a three-step process.



1. Identify the appropriate Tax ID by selecting or searching in the pop-up that presents. Click **Continue**.
 - Select = (1-5 Tax IDs)
 - Search = (5+ Tax IDs)
2. Identify the appropriate provider by selecting or searching in the pop-up that presents. Click **Continue**.
 - Select = (2-5 providers/practitioners)
 - Search = (5+ providers/practitioners)
3. The network status displays.
 - Note: The system will save up to four recent searches as a default.



Background: Clicking **Details** from the eligibility results screen provides access to additional information about the member. After Network Status, the following information displays.



1. General member information

2. Special programs eligibility

Click the + sign to expand these sections:

3. Current coverage information, plus future and historical if applicable.

4. Current total deductibles, copays, and out-of-pocket maximums.

5. Current PCP and IPA/medical group assignment if applicable.

1	<p>Member information</p> <table border="1"> <tr> <td>Member phone 555-555-5555</td> <td>Language Not Selected</td> <td>Subscriber dues paid to N/A</td> </tr> </table>	Member phone 555-555-5555	Language Not Selected	Subscriber dues paid to N/A
Member phone 555-555-5555	Language Not Selected	Subscriber dues paid to N/A		
2	<p>Special Programs</p> <p>Maven maternity status Eligible</p>			
3	<p>Member coverage details</p> <ul style="list-style-type: none"> + Future coverage + Current coverage + Historical coverage + Historical coordination of benefits 			
4	<p>Deductibles and out-of-pocket maximums</p> <ul style="list-style-type: none"> + Future deductibles and out-of-pocket maximums + Current deductibles and out-of-pocket maximums + Historical deductibles and out-of-pocket maximums 			
5	<p>+ PCP and IPA / Physician group</p>			

Tip: The *Visits Accumulator* presents as part of Deductibles/OOP for **Commercial** members only. It tracks visits to specialty providers when their plan covers a set number of visits per plan year. Specialty visits covered by third parties such as American Specialty Health (ASH) are not tracked by the tool.



Background: Clicking **Benefits** from the eligibility results screen provides access to a detailed view of the member's benefits.



1. The *Benefit summary* view is the default – lists in alpha order.
2. The *Benefit categories* view expands in left navigation pane.
3. The *Search* field activates when *Benefit categories* view is clicked.
 - Benefits are not listed by ICD-10 codes.
4. *Benefits download* (if logged in) or go to [Benefit summaries](#) if not logged in, to download/view a spreadsheet with detailed benefits for the all plans.

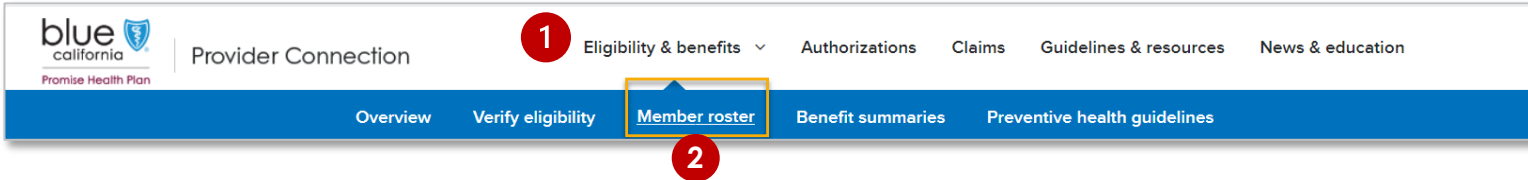
Benefit summary	1 Benefit summary		
Benefit download			
Pre-existing conditions			
Benefit categories			
Chiropractic and Acupuncture			
	Benefit	Network	Copay
	Chiropractic/Acupuncture		
	Chiropractic	Participating Providers	20% per Visit
	Chiropractic	Non-Participating Providers	40% per Visit

<input type="text" value="Search categories"/>	<input type="button" value="Search"/>	3 General - General Subcategory - Benefit Maximums																
Benefit summary																		
Benefit download	4																	
Pre-existing conditions																		
Benefit categories	2																	
<ul style="list-style-type: none"> General General Subcategory 	<table border="1"> <tr> <td>Annual Medical Deductible</td> <td>MILLS, JANET L</td> <td>Applies to Annual Out of Pocket Maximum</td> </tr> <tr> <td>Preferred & Non Preferred Provider</td> <td>\$1750</td> <td>Yes</td> </tr> <tr> <td>Maximum</td> <td>\$0</td> <td></td> </tr> </table> <p>Calculated over 12 months beginning January 1 For additional information about plan deductibles see Custom Benefits</p> <table border="1"> <tr> <td>Annual Out of Pocket Maximum</td> <td>MILLS, JANET L</td> </tr> <tr> <td>Preferred & Non Preferred Provider</td> <td>\$4500</td> </tr> <tr> <td>Maximum</td> <td>\$0</td> </tr> </table> <p>For additional information about out-of-pocket maximums see Custom Benefits</p>			Annual Medical Deductible	MILLS, JANET L	Applies to Annual Out of Pocket Maximum	Preferred & Non Preferred Provider	\$1750	Yes	Maximum	\$0		Annual Out of Pocket Maximum	MILLS, JANET L	Preferred & Non Preferred Provider	\$4500	Maximum	\$0
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Maximum	\$0																	
Benefit Maximums																		
Custom Benefits																		

Tip: If a Promise Health Plan member, the link from the check eligibility results will take you to the Medi-Cal Member Handbook EOC.



Background: Member rosters are lists of Blue Shield and Blue Shield Promise members who have selected a provider as their PCP or medical group. This list shows all providers associated with your account by Provider ID (PIN).

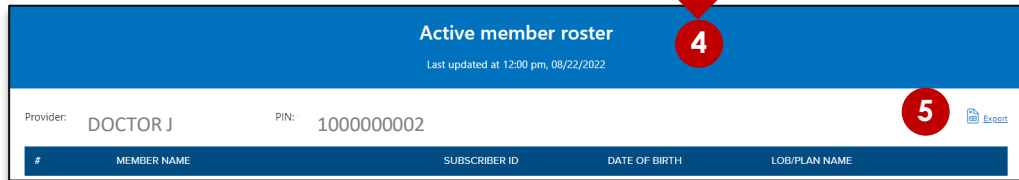
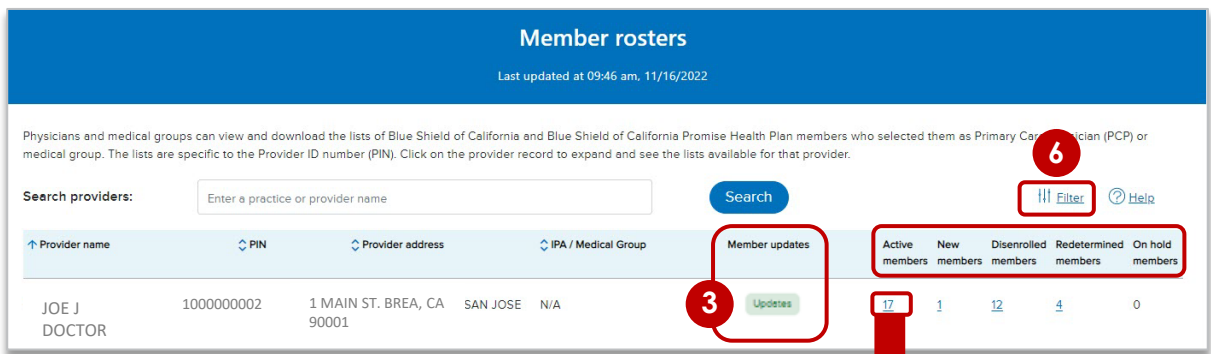


Instructions:

1. After log in, click **Eligibility & benefits** from the white navigation bar.
2. Click **Member roster** from the blue sub-menu bar.
3. The member updates column displays either *New* or *Updates* (member disenrolled or moved to another PCP).
4. Click the linked number to view and/or export data.
5. Click **Export** to download an Excel spreadsheet with full member details.

- Disenrolled Members Roster includes disenrollment dates.
- Redetermined Members Roster displays members with upcoming redetermination dates within the next 90 days.
- On Hold Members Roster displays members who missed their redetermination date and are within the 90-day grace period.

6. Click **Filter** to view/download by provider name, address, PIN or IPA/medical group.



Background: Medical authorizations can be submitted online or fax. Rx requests can be submitted online, by fax, or via the Surescripts® or CoverMyMeds® EHR platforms. Authorization status for all requests can be viewed online via AuthAccel. See [Authorization basics for providers](#) for an overview of the authorization process at Blue Shield/Blue Shield Promise.

Orientation:

1. The [Authorizations](#) section houses the AuthAccel online authorization tool, available after log in.
 - Click **medical authorization** to submit medical requests via AuthAccel. Click **Medical authorization status** to view medical request status via AuthAccel, regardless of how they were submitted.
 - AuthAccel can tell if auth is/is not required or is delegated for a Commercial or FEP medical service. Submit the request to determine.
 - AuthAccel instructions are linked to each launch page as well as to [AuthAccel Online Authorization System Training](#).
2. Click [Clinical policies and guidelines](#) to search medical and medication policies and requirements. No log in required.
3. Click Prior [authorization lists and fax forms](#), and to learn about services requiring third-party authorization (e.g., National Imaging Associates [NIA]). No log in required.

The screenshot displays the Blue Shield of California Provider Connection website. The navigation bar at the top includes 'Eligibility & benefits', 'Authorizations', 'Claims', 'Guidelines & resources', and 'News & education'. The 'Authorizations' section is highlighted with a red line and a red circle '1'. Below the navigation bar, there are three red circles: '1' points to the 'Medical authorization' link, '2' points to the 'Clinical policies & guidelines' link, and '3' points to the 'Authorization forms & list' link. The main content area features a section titled 'Authorizations' with a sub-section 'Authorization tools'. This section includes a paragraph about providers submitting requests and a list of PDF links: 'Submitting a medical prior authorization request (PDF, 383 KB)', 'Requesting an inpatient authorization (PDF, 407 KB)', 'Requesting a medication authorization administered by physician or care team (PDF, 449 KB)', 'Requesting a pharmacy authorization (PDF, 222 KB)', and 'View authorization status (PDF, 192 KB)'. To the right of the text is a grid of eight blue buttons with white icons and text, providing quick access to various authorization tasks.



Background: You have three options for submitting claims to Blue Shield: by mail, electronically, or online from Provider Connection using SympliSend.

Mail	Electronically (EDI)	SympliSend
<ul style="list-style-type: none">• The Claims Routing Tool tells you where to submit paper claims. No log in is required.• See next page for instructions.	<ul style="list-style-type: none">• Step 1: Choose an approved EDI clearinghouse.• Step 2: Enroll in ERA and EFT. Provider Connection Account Mangers can enroll online: See page 17 for instructions.• Step 3: Contact the selected clearinghouse to enroll and begin exchanging electronic transactions.• See the EDI, ERA/EFT and Secondary 277CA FAQ .	<ul style="list-style-type: none">• Via SympliSend after logging in to Provider Connection.• Submit digital paper claims, itemization requests, and digital correspondence related to previously processed or in process claims.• To launch, go to <i>Claims > Claim Tools ></i> and click the Submit Via SympliSend blue box• See user guide for instructions.

Tip: EDI (Electronic data interchange) is the exchange of business transactions in a standardized format from one computer to another. For additional information on EDI, see [How to submit claims](#) on Provider Connection – no login required.

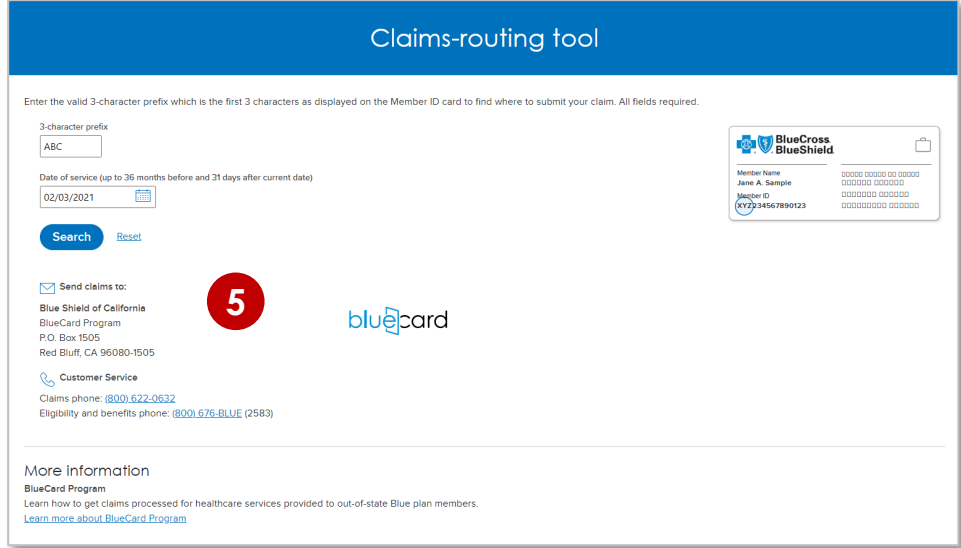
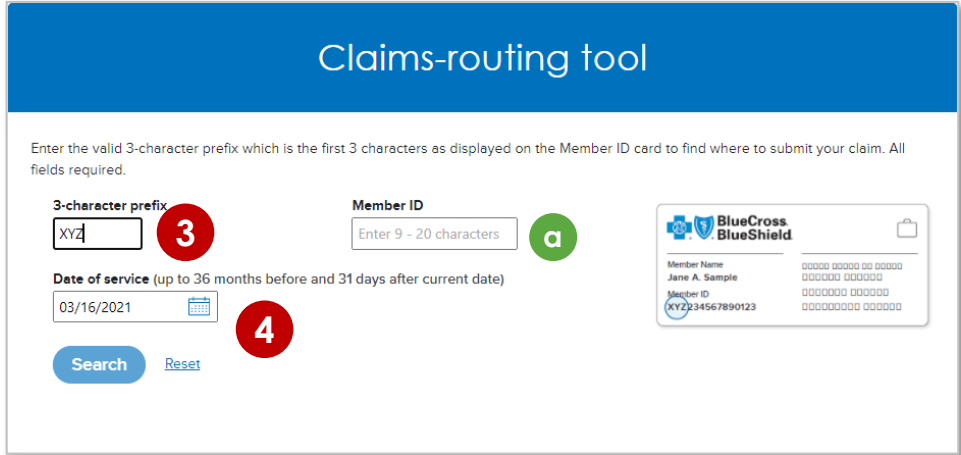


Use the Claims Routing Tool to determine where to send paper claims

Background: The *Claims Routing Tool* tells you where to submit paper claims for Blue Shield/Blue Shield Promise. It can also be used to determine where to send BlueCard claims for out-of-state Blue plan members. No log in is required to use this tool.

Instructions:

1. No log in is required to use this tool. Go to [Provider Connection](#) and click [Claims](#) from the white navigation bar.
2. Click **Claims Routing Tool** from the blue navigation bar.
3. Enter the first three characters of the member's ID.
4. Enter the date of service and click **Search**.
 - a) If requested, enter the rest of the member ID and click **Search**.
5. The "send to" address will display. In most cases, so will a phone number for customer service should you need assistance.
6. Click **Start over** to conduct a new search.



Background: Using EDI, you can receive claims payment information electronically (electronic remittance advice or ERA) and you can have claims payments deposited directly into your business account (electronic funds transfer or EFT).

Instructions:

After log in, Provider Connection Account Managers can determine if your organization is enrolled in ERA/EFT. If yes, you can edit your selections. If not, you can enroll right from this screen.

- 1. Click **Account Management > Provider & practitioner profiles.**
- 2. If you have more than one Tax ID (TIN), select the correct TIN from the drop-down menu and click **Search** to refresh the screen.
- 3. Click the **Remittance & Payments tab.** The screen will open on the EFT information for that TIN. Click **Edit** to enroll or to change your enrollment information.
- 4. To view/edit ERA, click **ERA** in the left navigation. Use the drop-down menu to choose a vendor (i.e., clearinghouse or trading partner). The vendor you choose applies to all providers under the selected Tax ID. Changes take up to three (3) business days.

The image displays two screenshots of a web application interface. The top screenshot shows the 'Remittance & Payments' tab selected, with 'Electronic Funds Transfer' as the active section. A red circle with the number '3' is positioned above the 'Edit' link. The bottom screenshot shows the 'Electronic Remittance Advice' section, where a dropdown menu for 'Select vendor' is open, showing 'OFFCE ALLY'. A red circle with the number '4' is positioned above the dropdown menu. Both screenshots show a sidebar with 'EFT' and 'ERA' options, and a main content area with instructions and status information.

Check Claim Status – Search claims and find EOBs

Background: *Check claim status* is available from the home page and from the *Claims* section after log in. It contains a *Search* and *Other Blue plans* tabs. The *Appeal status* tab links to *Submitted disputes* on the *Claim issues & disputes* page.

Instructions: You must be linked to the **Tax ID and Provider ID (TIN/PIN)** of the claim for which you are searching.

1. Click **Check claim status**. The *Search* tab displays with claims from the last five years. The most recent will be at the top.
2. Enter data into one or more search fields and click **Search**.
3. Results will display below the blue header row. To sort results in alphabetical or ascending/descending order, click the desired column header and the up/down arrow once it presents.
4. Click the blue text links to see more detailed information about the member or claim or to view/download the EOB.
5. To clear the search and conduct a one, click **Start over**.

Showing 1–50 of 47734 claims: Dates of service 10/06/2018–10/06/2021

Claim status	Claim number	Claim type	Dates of service	EOB	Member name	Member ID/Subscriber ID	Provider name	Amount billed	Amount paid	Patient responsibility	Check/EFT number
IN PROCESS	000342	Medical	07/07/2020–07/07/2020	N/A	ROBERTS,	9102	QUEST DIAGNOSTICS	\$3,500.00	N/A	\$10.41	N/A

Tip: When using the *Other Blue plans* tab to conduct a search for member claims, all fields are required unless marked optional. Results will be sent to the user's Message Center.



Check Claim Status – Claim details screen

Background: Clicking the claim number from the *Check claim status* search results opens the *Claim detail* page and provides access to the information below. Once a claim has been reviewed and finalized, the *EOB* will be available here. You will also see links to *Attach supporting documentation* (to a finalized claim) and *Resolve claim issue or dispute*.

The screenshot shows a web interface for checking claim status. At the top, there are tabs for 'Medical', 'Finalized', and 'View EOB'. Below this, there are links for 'Attach supporting documents' and 'Resolve claim issue or dispute'. The main content is divided into sections: Member information, Claim details, Payment details, Uploaded documents, Claim history, and Service and procedure details. A table at the bottom shows line-item details for a service.

Line #	Dates of service	Place of service	Units	Procedure code	Modifier	Amount billed	Allowed amount	Deductible	Copay	Co-insurance	Amount paid
199	11/01/2021-11/01/2021	Office	1	99219	N/A	\$1,235.00	\$121.21	\$0.00	\$0.00	\$60.61	\$60.60

1 **Claim status**

2 **Download EOB**

3 **File a dispute or attach documentation to finalized claim**

4 **View all claims for this member**

7 **This section presents when there is history such as claim adjustments and/or related claims**

6 **View payment details**

5 **Toggle between full and summary view**

8 **This section includes line-item detail as well as claim messages and notes**

Claims – Attach documentation to a finalized claim

Background: For all lines of business, documentation can be attached to a finalized claim.

To start the process for a finalized claim:

1. Click **Claims** then click **Check claim status** in the blue sub-menu bar.
2. Search for the finalized claim. (See [Check Claim Status](#) for instructions.)
3. Click the claim number to open the *Claim detail* page.
4. The *Claim detail* displays for that claim. Click **Attach supporting documents**.



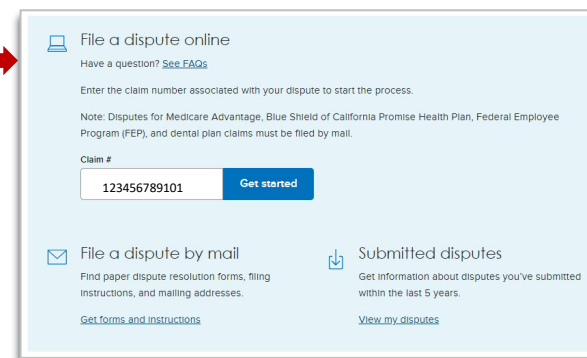
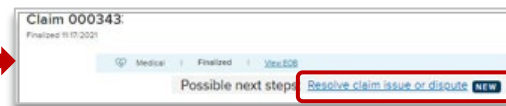
5. The *Attach Documents to a Claim* screen displays with prepopulated claims data.
6. See the [Attach documentation to a finalized claim tutorial](#) for the remaining steps, with screenshots, for how to complete this process.



Background: Disputes for all plan types can be initiated from the 1) [Claim detail screen](#) once the claim has been finalized or from the 2) *Claim issues & disputes* section, if you know the claim number. They can also be filed by [mail](#).

To begin the online dispute process, log in and go to the Claims section:

1. Click **Check claim status** in the blue sub-menu bar.
2. Search for the finalized claim. (See [Check Claim Status](#) for instructions.)
3. Click the claim number to open the *Claim detail* page.
4. Click the **Resolve claim issue or dispute** link. This link will be active only if the claim has been finalized.
5. If you know the claim number, you can also file a dispute online directly from *Claim issues & disputes*, after log in.
6. See the [Submit claim disputes online and view status tutorial](#) for the remaining steps, with screenshots, for how to submit an online dispute.



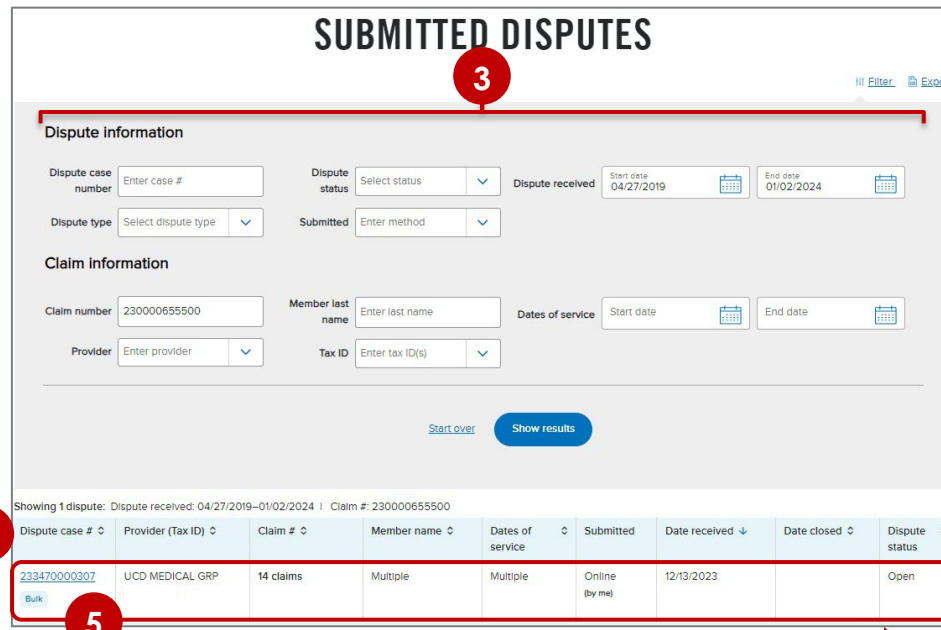
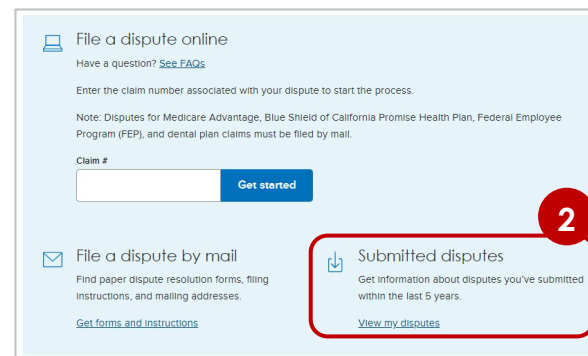
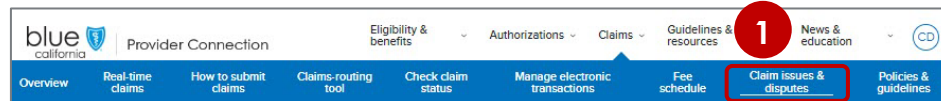
Tip: To insure you file a dispute correctly, see [Learn more about the dispute process](#).



View My Disputes: Search disputes and access determination letters

Background: The *Submitted disputes* link is available from the *Claim issues & disputes* section after log in. It contains all disputes submitted online or by mail.

1. Click **Claim issues & disputes** from the *Claims* section's blue sub-menu bar after log in.
2. Scroll to the blue box and click **View my disputes**.
3. Enter data related to the dispute(s) in one or more fields and click **Show results**.
4. Results display under the light blue header.
5. Click the dispute case number to access dispute case details including letters.



6. The *Dispute case details* screen displays all information and documentation connected to the dispute case number you selected.

- a. Dispute form and claim list (if bulk submission).
- b. Claim numbers included in the dispute submission.
- c. Supporting document uploaded by you with option to add additional documents to an open dispute.
- d. Correspondence and determination.

6

Dispute case 233470000307

OPEN
Bulk

Last updated 12/13/2023

Dispute details

Documents

📄
Dispute form (PDF)
a

📄
Claim list (CSV)

Total number of claims: 14

Claim numbers:

[230000667600](#), [230000655500](#), [230000603700](#), [230000655700](#), [230000554200](#), [230000504700](#), [230000438000](#), [230000440800](#), [230000443000](#), [230000455000](#), [230000445200](#), [230000443100](#), [230000462900](#), [230000438300](#)

[Show less](#) ^

Provider name: UCD MEDICAL GRP

Provider ID: PG00

Tax ID: 0503

Date received: 12/13/2023

Status: Open

d

Letter	Date issued
📄 Acknowledgement (PDF)	12/13/2023

Uploaded documents (1)

Supporting documents submitted on Provider Connection appear here. [Add documents](#)

Added on 12/13/2023

📄 03-03-PDF-test-doc-2.pdf (9.6 MB)

c

Medical record



Background: Blue Shield Promise resources that do not require log in are integrated throughout Provider Connection. They are also available from the [Blue Shield Promise Provider Portal](#). The links below will take you to content on Provider Connection, and in some cases, to content on the [Blue Shield Promise Provider Portal](#).

For Blue Shield providers
Ancillary provider listings
Behavioral health resources
Benefit summaries
BlueCard Program*
Claims policies & guidelines
Clinical policies and guidelines
Professional fee schedule search *
Drug formularies
Forms
Member ID card samples
Patient care resources
Provider manuals
Richman injectables policy
Spine surgery/pain management prior auth and Radiology and imaging prior auth <ul style="list-style-type: none"> National Imaging Associates (NIA) RadMD Sign in

For Blue Shield Promise providers
Benefit summaries
Behavioral Health Services
Clinical policies and procedures
Complex Case Management
Drug formularies
Forms
Health education resources
Medi-Cal Provider Incentive Program
Member ID card samples
Patient care resources
Provider manuals
Quality improvement

* Log in required.





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