BlueCross BlueShield of Mississippi

Committed to a Healthier Mississippi.

Professional Claim Filing Guidelines

To ensure prompt and accurate processing of your claim, it is important that you follow the correct claim filing guidelines. Below are the claim filing guidelines for secondary, corrected and void only claims. These claims should be submitted electronically on the 837P Claim Submission format according to the referenced guidelines.

Claim Filing Guidelines for Secondary Claims

Secondary claims should be submitted electronically on the 837P Claim Submission format as indicated below:

- Accurate and complete information must be filed on all 837P secondary claims. This includes contractual obligation amounts as well as amounts applied to deductible, coinsurance, copay, allowed and paid.
- The primary payer's allowed amount must balance to the amount applied to the deductible, coinsurance, copay and payment or the claim may be denied.
- Primary payment information must be sent on 837P secondary claims in the following format:

Loop 2400 Service Line of the 837P Claim Submission

- Prior Payer Allowed Amount – AMT01 must contain the value 'AAE' and AMT02 must contain the monetary amount.
  Example:
  AMT*AAE*125.00~

Loop 2430 Line Adjudication Information of the 837P Claim Submission

- Prior Payer Paid Amount – SVD02 must contain the monetary amount.
  Example:
  SVD*00512*110.75*HC:84550**3~
- Prior Payer Deductible Amount – CAS02 must contain the value '1' and CAS03 must contain the monetary amount.
  Example:
  CAS*PR*1*14.25~
- If the Prior Payer denied the services, the following information should be supplied:
  - When denied for non-covered service – CAS02 must contain the value '96' and CAS03 must contain the monetary amount of the total charges.
    Example:
    CAS*OA*96*125.00~

- When denied for benefits terminated – CAS02 must contain the value '31' and CAS03 must contain the monetary amount of the total charges.
  Example:
  CAS*OA*31*125.00~

Claim Filing Guidelines for Corrected Claims

A corrected claim should only be filed if there is a change in the clinical or member information. Corrected claims should be submitted electronically on the 837P Claim Submission format as indicated below:

Loop 2300 Claim Information of the 837P Claim Submission

- CLM05-3 (Claim Type Code) must contain the value '7' (Replacement; replacement of prior claim.
  Example:
  CLM*A37YH566*500***11::7*Y*A*Y*Y*C~
- REF01 must contain the value 'F8' and REF02 must contain the original claim number.
  Example:
  REF*F8*123456789~
- Corrected claims must be submitted within 12 months from the payment date of the original claim.
- Only 1 corrected claim will be accepted per original claim.

Claim Filing Guidelines for Void Only Claims

Void Only claims should be submitted electronically on the 837P Claim Submission format as indicated below:

Loop 2300 Claim Information of the 837P Claim Submission

- CLM05-3 (Claim Type Code) must contain the value '8' (Void; void of prior claim.
  Example:
  CLM*A37YH566*500***11::8*Y*A*Y*Y*C~
- REF01 must contain the value 'F8' and REF02 must contain the original claim number.
  Example:
  REF*F8*123456789~