# Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠and MyBlue Health℠ Provider Manual – Filing Claims - Claim Review Process

**Please Note**

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health**. These specific requirements will be noted with the plan/network name. If a plan/network name is not specifically listed or the "**Plan**" is referenced, the information will apply to **all** HMO products.

**In this Section**

The following topics are covered in this section:

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual –Filing Claims - Claim Review Process

**Claim Review Process Overview**

Review this section for information on refunds and recoupments and submitting adjustment requests.

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**Capitated Medical Groups - Important Note**

Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and prior authorization processes, contracting, and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/affiliated with a capitated Medical Group are subject to that entity's procedures and requirements for the Plan's provider complaint resolution.

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**Claim Review Process**

**Claim Review Process** is available to physicians or professional providers as described below.

- **Claim Reconsideration Requests:**
  Claim reconsideration requests are submitted electronically for review and/or reevaluation of situational finalized claim denials online (including BlueCard® out-of-area claims). This method of inquiry submission is preferred over faxed/mailed claim disputes, as it allows you to upload supporting documentation and monitor the status via Availity® Essentials.

  For more details, refer to the Claim Reconsideration Requests page and instructional user guide in the **Provider Tools** section of our website.

- **Claim Review Form**
  To request a claim review by mail, complete the Claim Review Form which can be found on the BCBSTX website under **Education and Reference** then **Forms**. Include the following:
  - Reason for claim review request – use the Claim Review Form and Ineligible Reason Code List to determine if your claim meets eligibility requirements for review.
  - Be as specific as possible in detailing your request for review.
  - It is necessary to provide all required data elements and use the proper form or your review will be rejected.

- **Electronic Refund Management (eRM)**
  eRM is an on-line refund management tool for overpayment reconciliation and related processes. See more information on eRM further in this section F.

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# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

**Claim Review Process, cont.**

## Submission of Additional Information

At the time the claim review request is submitted, please attach any additional information you wish to be considered in the claim review process. This information may include supporting medical documentation specific to the claim denial and the reason for review, remember to submit only the medical records needed to support the review (HIPAA - minimum necessary).

The following are examples of what is **not** considered eligible under this review process (not an all-inclusive list):

- Membership denials, claim corrections, request for Medicare or Other Carrier paid amounts, these should be submitted electronically as a corrected claim.
- Denials related to non-covered benefits – these will not be reviewed for medical necessity – they are non-covered services under the member's benefit plan.
- Claim status questions regarding a pending claim or pending adjustment.

To submit **additional information** due to receiving a letter requesting the information from BCBSTX, it should be submitted using the letter received or the Additional Information Form**.** To submit electronically, use the **Claim Reconsideration Requests** function via **Availity Claim Status tool**, if applicable.

Examples of requested information (not all inclusive):

- Medical records, progress reports, Operative report, diagnostic test results, history and physical exam, discharge summary, itemized bills.

To submit a **corrected claim**, you should submit it electronically by following instructions under **Electronic Replacement/Corrected Claim Submissions** or if you must submit paper, it should include a Corrected Claim Form. These forms can be found under Forms under the Education and Reference section on our provider website.

Examples of when to file **Corrected Claim** (non all inclusive):

- Any change to the claim, Explanation of Medicare Benefit, Other insurance payment information, any claim previously denied for missing information

**Please file electronically when possible.**

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

**Proof of Timely Filing**

For those claims which are being reviewed for timely filing, the **Plans** will accept the following documentation as acceptable proof of timely filing:

- Texas Department of Insurance (TDI) Mail Log
- Certified Mail Receipt (only if accompanied by TDI mail log)
- Availity Electronic Batch (EBR) Response Reports
- Above documentation indicating that the claim was filed with the wrong division of Blue Cross and Blue Shield of Texas
- Documentation from the **Plan** indicating claim was incomplete
- Documentation from the **Plan** requesting additional information
- Primary carrier's EOB indicating claim was filed with primary carrier within the timely filing deadline.

**Types of Disputes & Timeframe for Requests**

There are two (2) levels of claim reviews available to you. For the following circumstances, the 1st claim review must be requested within the corresponding timeframes outlined below:

| DISPUTE TYPE | TIMEFRAME FOR REQUEST |
|---|---|
| **Audited Payment** | Within **45** days following the receipt of written notice of request for refund due to audited payment |
| **Overpayment** | Within **45** days following the receipt of written notice of request for refund due to overpayment |
| **Claim Dispute** | Within **180** days following the check date/date of the **Plan's** Explanation of Payment (EOP), or the date of the BCBSTX Provider Claims summary (PCS), for the claim in dispute |

The **Plans** will complete the 1st claim review within **45** days following the receipt of your request for a 1st claim review.

- If your claim has been maintained after review, you will receive a written notification of the claim review determination.
- If your claim has been overturned after reviewing your payment/PCS will serve as your notification.

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

**Types of Disputes & Timeframe for Requests, cont.**

If the claim review determination is not satisfactory to you, you may request a 2nd claim review.

- The **Plans** will complete the 2nd claim review within **45** days following the receipt of your request for a 2nd claim review.
- If your claim has been maintained after review, you will receive a written notification of the claim review determination
- If your clam has been overturned after reviewing, your payment/PCS will serve as your notification.
- The claim review process for a specific claim will be considered complete following your receipt of the 2nd claim review determination.

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

**Recoupment Process**

| Recoupment Process |
| --- |
| The Refund Policy for the **Plans** states that the **Plan** has 180 days following the payee's receipt of an overpayment to notify a health care provider that the overpayment has been identified and to request a refund.*<br><br>For additional information on the Plan's Refund Policy, including when a health care provider may submit a claim review and when an overpayment may be placed into recoupment status, please refer to the **"Refund Policy – Blue Essentials, Blue Advantage HMO, Blue Premier or MyBlue Health"** further on in Section F of this **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider – Provider Manual**.<br>In some unique circumstances a health care provider may request, in writing, that **the Plan** reviews all claims processed during a specified period; in this instance all underpayments and overpayments will be addressed on a claim-by-claim basis.<br><br>*** Notes:**<br><br>♦ The refund request letter may be sent at a later date when the claim relates to **Plan** accounts and transactions that are excluded from the requirements of the Texas Insurance Code and other provisions relating to the prompt payment of claims, including:<br>• Self-Funded ERISA (Employee Retirement Income Security Act<br>• Indemnity Plans<br>• Medicaid, Medicare and Medicare Supplement<br>• Federal Employees Health Benefit Plan<br>• Self–funded governmental, school and church health plans<br>• Out–of–State Blue Cross and Blue Shield plans (Blue Card)<br>• Out–of–Network (non–participating) providers<br>• Out–of–state provider claims including Away from Home Care<br>• Overpayments due to a settlement or a finding of medical malpractice or negligence that does not occur within the 180 days |

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

**Recoupment Process,** cont.

| Recoupment Process |
| --- |
| ♦ Refund requests resulting from settlement or finding of medical malpractice or negligence shall be due within 5 business days, and absent a mutual agreement, Blue Essentials will recover the full amount by offsetting current claims as described in this Refund Policy.<br><br>When a health care provider's overpayment is placed into a recoupment status, the claims system will automatically off-set future claims payment and generate a Provider Claims Summary (PCS) to the health care provider (Recoupment Process). The PCS will indicate a recouped line along with information concerning the overpayment of the applicable **Plan** claim(s).<br><br>To view an example of a recoupment, please refer to the sample PCS below in Section F in the **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health – Provider Manual.** |

## Sample PCS Recoupment

DATE: MM/DD/YY
PROVIDER NUMBER: 0001112222
CHECK NUMBER: 123456789
TAX IDENTIFICATION NUMBER: 987654321

1 2 3 4

5 **ABC MEDICAL GROUP**
**123 MAIN STREET**
**ANYTOWN, TX 70000**

ANY MESSAGES WILL APPEAR ON PAGE 1

6 PATIENT: JOHN DOE
7 PERF PRV: 1234567890
8 CLAIM NO: 00001234567890C

9 IDENTIFICATION NO: P06666-XOC123456789
10 PATIENT NO: 12345KB

| 11 FROM/TO DATES | 12 PS* | 13 PAY | 14 PROC CODE | 15 AMOUNT BILLED | 16 ALLOWABLE AMOUNT | 17 SERVICES NOT COVERED | 18 DEDUCTIONS/ OTHER INELIGIBLE | 19 AMOUNT PAID |
|---|---|---|---|---|---|---|---|---|
| 02/09 – 02/09/12 | 03 | HMO | 99213 | 76.00 | 50.52 | (1) 25.48 | 0.00 | 50.52 |
| | | | | 76.00 | 50.52 | 25.48 | 0.00 | 50.52 |

20 AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $50.52

***DEDUCTIONS/OTHER INELIGIBLE***

TOTAL SERVICES NOT COVERED: 25.48
PATIENT'S SHARE: 0.00

PROVIDER CLAIMS AMOUNT SUMMARY

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| | | | |
|---|---|---|---|
| NUMBER OF CLAIMS: | 1 | AMOUNT PAID TO SUBSCRIBER: | $0.00 |
| AMOUNT BILLED: | $76.00 | AMOUNT PAID TO PROVIDER: | $50.52 |
| AMOUNT OVER MAXIMUM ALLOWANCE: | $25.48 | RECOUPMENT AMOUNT: | $31.52 |
| AMOUNT OF SERVICES NOT COVERED: | $25.48 | NET AMOUNT PAID TO PROVIDER: | $19.00 |
| AMOUNT PREVIOUSLY PAID: | $0.00 | | |

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* PLACE OF SERVICE (PS)
03 PHYSICIAN'S OFFICE.

25 MESSAGES:

(1).CHARGE EXCEEDS THE PRICED AMOUNT FOR THIS SERVICE. SERVICE PROVIDED BY A PARTICIPATING PROVIDER. PATIENT IS NOT RESPONSIBLE FOR CHARGES OVER THE PRICED AMOUNT.

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

## Professional Provider Claim Summary Field Explanations:

| | | |
|---|---|---|
| 1 | **Date** | Date the summary was finalized |
| 2 | **Provider Number** | Provider's NPI |
| 3 | **Check Number** | The number assigned to the check for this summary |
| 4 | **Tax Identification Number** | The number that identifies your taxable income |
| 5 | **Provider or Group Name and Address** | Address of the provider/group who rendered the services |
| 6 | **Patient** | The name of the individual who received the service |
| 7 | **Performing Provider** | The number that identifies the provider that performed the services |
| 8 | **Claim Number** | The Blue Shield number assigned to the claim |
| 9 | **Identification Number** | The number that identifies the group and member insured by BCBSTX |
| 10 | **Patient Number** | The patient's account number assigned by the provider |
| 11 | **From/To Dates** | The beginning and ending dates of services |
| 12 | **PS** | Place of service |
| 13 | **PAY** | Reimbursement payment rate that was applied in relationship to the member's policy type |
| 14 | **Procedure Code** | The code that identifies the procedure performed |
| 15 | **Amount Billed** | The amount billed for each procedure/service |
| 16 | **Allowable Amount** | The highest amount BCBSTX will pay for a specific type of medical procedure. |
| 17 | **Services Not Covered** | Non-covered services according to the member's contract |
| 18 | **Deductions/Other Ineligible** | Program deductions, copayments, and coinsurance amounts |
| 19 | **Amount Paid** | The amount paid for each procedure/service |
| 20 | **Amount Paid to Provider for This Claim** | The amount Blue Shield paid to provider for this claim |
| 21 | **Total Services Not Covered** | Total amount of non-covered services for the claim |
| 22 | **Patient's Share** | Amount patient pays. Providers may bill this amount to the patient. |
| 23 | **Provider Claims Amount Summary** | How all of the claims on the PCS were adjudicated |
| 24 | **Place of Service (PS)** | The description for the place of service code used in field 12 |
| 25 | **Messages** | The description for messages relating to: non-covered services, program deductions, and HMO reductions |

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

**Refund Policy**

| Refund Policy<br>Blue Essentials, Blue Advantage HMO,<br>Blue Premier and MyBlue Health |
|---|
| The **Plans** strive to pay claims accurately the first time; however, when payment errors occur, the **Plan** needs your cooperation in correcting the error and recovering any overpayment.<br><br>**When a health care provider identifies an overpayment:**<br><br>• If you identify a refund due to the **Plans**, please submit your refund to the following address:<br><br>Blue Cross and Blue Shield of Texas<br>Refund and Recovery<br>Dept. 0695<br>P.O. Box 120695<br>Dallas, TX 75312-0695<br><br>• View Provider Refund Form<br><br>**When the Plan Identifies an Overpayment:**<br><br>If the **Plan** identifies an overpayment, a refund request letter will be sent to the payee within 180 days following the payee's receipt of the overpayment that explains the reason for the refund and includes a remittance form and a postage-paid return envelope. In the event that the **Plan** does not receive a response to their initial request, a follow-up letter is sent requesting the refund.<br><br>• Within 45 days following its receipt of the initial refund request letter *(Overpayment Review Deadline)*, the health care provider may request a claim review of the overpayment determination by the **Plan** by submitting a request via eRM or the Claim Review Form in accordance with the Claim Review Process. In determining whether this deadline has been met, the **Plan** will presume that the refund request letter was received on the 5th business day following the date of the letter. |

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

**Refund Policy,** cont.

| Refund Policy |
| --- |
| • If the **Plan** does not receive payment in full within the Overpayment Review Deadline, they will recover the overpayment by offsetting current claims reimbursement by the amount due the **Plan** *(refer to Recoupment Process in this provider manual)* after the later of the expiration of the Overpayment Review Deadline or the completion of the Claim Review Process provided that the health care provider has submitted the Claim Review form within the Overpayment Review Deadline.<br>• For information concerning the Recoupment Process, please refer to the "Recoupment Process" above in this **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider – Provider Manual**.<br><br>***Note:*** *In some unique circumstances a health care provider may request, in writing, that the **Plan** review all claims processed during a specified period; in this instance all underpayments* and overpayments will be addressed on a claim-by- claim basis.<br><br>For additional information or if you have questions regarding the Refund Policy, please contact Provider Customer Service as follows:<br>1-877-299-2377 for Blue Essentials<br>1-800-451-0287 for Blue Advantage HMO or MyBlue Health<br>1-800-876-2583 for Blue Premier<br><br>If you want to request a review of the overpayment decision, please view the Claim Review Process and Electronic Refund Management within this Section F in the **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health – Provider Manual**. You can also locate the Claim Review Form and Instructions on the BCBSTX Provider website at bcbstx.com/provider. The information is located in **Forms** under the **Education & Reference** section. |

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

## Refund Letters – Identifying Reason for Refund

The **Plan's** refund request letters include information about the specific reason for the refund request, as follows:

- The services rendered require *Prior Authorization/Referral*; none was obtained.
- Your claim was processed with an *incorrect Copay/Coinsurance or Deductible.*
- Your claim was received after the timely filing period; *proof of timely filing needed.*
- Your claim was processed with the *incorrect fee schedule/allowed amount.*
- Your claim should be submitted to the *member's IPA or Medical Group.*
- Your claim was processed with the *incorrect anesthesia time/minutes.*
- Your claim was processed with in-network benefits; however, it should have been processed with *out-of-network benefits.*
- Total charges processed exceeded the amount billed.
- Per the Member/Provider this claim was submitted in error.
- *Medicare should be primary* due to ESRD. Please file with Medicare and forward the EOMB to BlueCross and BlueShield.
- The patient has *exceeded the age limit* and is not eligible for services rendered.
- The patient listed on this claim is *not covered under the referenced policy.*
- The dependent was *not a full-time student* when services were rendered; benefits are not available.
- The claim was processed with *incorrect membership information.*
- The services were performed by the anesthesiologist; however, they were *paid at the surgeon's benefit level.*
- The services were performed by the assistant surgeon; however, they were *paid at the surgeon's benefit level.*
- The services were performed by the co-surgeon; however, they were *paid at the surgeon's benefit level.*
- The service rendered was considered a *bilateral procedure*; separate procedure not allowed.
- Claims submitted for rental; *DME has exceeded purchase price.*
- Overpayment was identified, as another insurance carrier is the primary for this patient. HCSC is the secondary carrier, but paid primary in error.

* **Note:** The refund request letter may be sent at a later date when the claim relates to **Blue Essentials and Blue Advantage HMO** accounts and transactions that are excluded from the requirements of the Texas Insurance Code and other provisions relating to the prompt payment of claims, including:

- Self-funded ERISA (Employee Retirement Income Security Act)
- Indemnity Plans
- Medicaid, Medicare and Medicare Supplement
- Federal Employees Health Benefit Plan
- Self-funded governmental, school and church health plans
- Out-of-state Blue Cross and Blue Shield plans (BlueCard)
- Out-of-network (non-participating) providers

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

## Provider Refund Form (Sample)

**Please submit refunds to:**

**Blue Cross and Blue Shield of Texas Refund and Recovery Dept. 065**
**P.O. Box 120695**
**Dallas, TX 75312-0695**

| Provider Information: | | | |
|---|---|---|---|
| Name: | | | |
| Address: | | | |
| Contact Name: | | | |
| Phone Number: | | | |
| NPI Number: | | | |

| | Refund Information | | | |
|---|---|---|---|---|
| 1 | GROUP # FROM PCS | MEMBER I.D. FROM PCS | ADM DATE | CLAIM/DCM # |
| | PATIENT'S NAME | PROVIDER PATIENT # | LETTER REFERENCE # | REFUND AMOUNT |
| | REASON/REMARKS | | | |

| | Refund Information | | | |
|---|---|---|---|---|
| 2 | GROUP # FROM PCS | MEMBER I.D. FROM PCS | ADM DATE | CLAIM/DCM # |
| | PATIENT'S NAME | PROVIDER PATIENT # | LETTER REFERENCE # | REFUND AMOUNT |
| | REASON/REMARKS | | | |

| | Refund Information | | | |
|---|---|---|---|---|
| 3 | GROUP # FROM PCS | MEMBER I.D. FROM PCS | ADM DATE | CLAIM/DCM # |
| | PATIENT'S NAME | PROVIDER PATIENT # | LETTER REFERENCE # | REFUND AMOUNT |
| | REASON/REMARKS | | | |

| | Refund Information | | | |
|---|---|---|---|---|
| 4 | GROUP # FROM PCS | MEMBER I.D. FROM PCS | ADM DATE | CLAIM/DCM # |
| | PATIENT'S NAME | PROVIDER PATIENT # | LETTER REFERENCE # | REFUND AMOUNT |
| | REASON/REMARKS | | | |

| | Refund Information | | | |
|---|---|---|---|---|
| 5 | GROUP # FROM PCS | MEMBER I.D. FROM PCS | ADM DATE | CLAIM/DCM # |
| | PATIENT'S NAME | PROVIDER PATIENT # | LETTER REFERENCE # | REFUND AMOUNT |
| | REASON/REMARKS | | | |

| SIGNATURE | DATE | CHECK NUMBER | CHECK DATE |
|---|---|---|---|
| | | | |

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health - Provider Manual
# Filing Claims - Claim Review

## Provider Refund Form Instructions
## Refunds Due to Blue Cross and Blue Shield of Texas

### 1. Key Points to check when completing this form:

a) Group/Member Number: Indicate the number exactly as they appear on the PCS (Provider Claim Summary) – including group and member's identification number

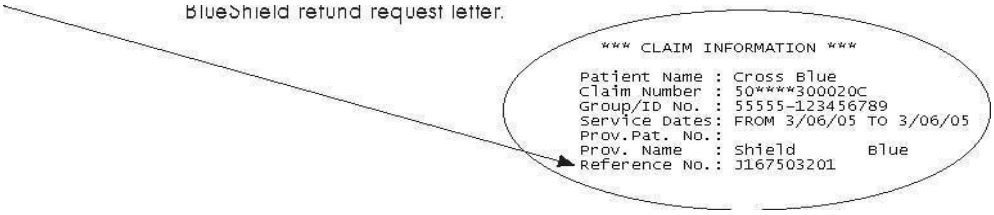
b) Admission Date: Indicate the admission or outpatient service date as MMDDYY entry.

c) BCBS Claim/DCN #: Indicate the BlueCross BlueShield Claim/DCN number as it appears on the PCS/EOB.

Please do not use your provider patient number in this field.

d) Provider Patient #: Indicate the Patient account number assigned by your office.

e) Letter Reference #: **If applicable**, indicate the RFCR letter reference number located in the BlueCross BlueShield refund request letter.




f) Check Number and Date: Indicate the check number and date you are remitting for this refund.

g) Amount: Enter the total amount refunded to BlueCross Blue Shield.

h) Remarks/Reason: Indicate the reason as follows:

- "C.O.B. Credit" — Payment has been received under two different Blue Cross memberships or from Blue Cross and another carrier. Indicate name, address, and amount paid by other carrier.
- "Overpayment" — Blue Cross payment in excess of amount billed; provider has posted a credit for supplies or services not rendered; provider cancelled charge for any reason; or claim incorrectly paid per contract.
- "Duplicate Payment" — A duplicate payment has been received from BlueCross for one instance of service (e.g. same group and member number).
- "Not our Patient" — Payment has been received for a patient that did not receive services at this facility/treatment center.
- "Medicare Eligible Duplicate Payment" — Payment for the same service has been received from Blue Cross and the Medicare intermediary.
- "Workers Compensation" — Payment for the same service has been received from Blue Cross and a Workers' Compensation carrier.

### 2. Mail the refund form along with your check to:

Blue Cross and Blue Shield of Texas
Refund and Recovery - Dept. 0695
P.O. Box 120695
Dallas, TX 75312-0695

# Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

**Electronic Refund Management (eRM)**

eRM is on-line refund management tool which will help simplify overpayment reconciliation and related processes. The eRM application is available at **no additional charge**.

Enjoy **single sign-on** through Availity Essentials. *(Note: You must be a registered user with Availity to take advantage of eRM.)*

**To register:**

- **Visit** the Availity Essentials website.
- **Receive electronic notifications of overpayments** to help reduce record maintenance costs.
- **View overpayment requests** – search/filter by type of request, get more details and obtain real-time transaction history for each request.
- **Settle your overpayment requests** – Have BCBSTX deduct the dollars from a future claim payment. Details will appear on your PCS or EPS; information in your eRM transaction history can also assist with recoupment reconciliations.
- **Pay by check** – You will use eRM to generate a remittance form showing your refund details. One or multiple requests may be refunded to BCBSTX check number(s) will show on- line.
- **Submit unsolicited refunds** – If you identify a credit balance, you can elect to submit it on-line and refund your payment to BCBS by check, or have the refund deducted from a future claim payment.
- Stay aware with system **Alerts** – You will receive notification in certain situations, such as if BCBSTX has responded to your inquiry or if a claim check has been stopped.

**How to Access eRM via Availity**

Once you are registered with Availity:

- Log into Availity Essentials
- Select **Payer Spaces** from the navigation menu and choose **BCBSTX**
- Select the **Applications** tab, then choose **Refund Management** eRM*

*New users will be prompted to complete the one-time eRM onboarding form and email verification to gain access to the eRM system.

If you are unable to access eRM from the BCBTX-branded Payer Spaces,contact your Primary Access Administrator (PAA). To identify your Availity Administrator(s), select My Account under My Account Dashboard on the Availity homepage. Contact Availity Client Services at **1-800-282-4548** or visit the Availity website for more information or assistance.