



Using iExchange: Frequently Asked Questions

Aerial™ iExchange® (iExchange) is our web-based tool that supports the direct submission and online approval of benefits for preauthorizations and predeterminations requests related to inpatient admissions and select outpatient services. The system is available 24 hours a day, seven days a week – with the exception of every third Sunday of the month when the system will be unavailable from 11 a.m. to 3 p.m. CT. iExchange is accessible to physicians, professional providers and facilities contracted with Blue Cross and Blue Shield of Oklahoma (BCBSOK).

Out-of-area providers: Please refer to our [pre-service review tip sheet](#).

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1. How do I sign up for iExchange?

To set up a new iExchange account, you must be a contracted physician, professional provider or facility with BCBSOK. You can submit a request.

- **Availity™ Single Sign-On (SSO):**

- If you access the Availity™ Web Portal and are new to iExchange, your organization's Primary Access Administrator (PAA) can request access from their Availity account. By selecting the More option on the Availity tool bar in the top right-hand corner, the PAA should go to My Account – Pre Auth Registration (BCBS).
- Your PAA will receive an iExchange ID, user name and initial password once registration is complete. **Please refer to question #7 for additional details.**

- **Non-Availity Users:**

- If your office is new to iExchange, you will need to set up an initial administrator account.
- If you meet the criteria, complete and submit the [online enrollment form](#).
- Your office administrator will be sent an iExchange ID, user name and initial password.
- If you are a new employee in an office that already uses iExchange, contact your office administrator to establish a user name and initial password.

2. What are the technical system requirements for iExchange access (i.e., Web browser)?

To use iExchange you must be using a supported Web browser. iExchange currently supports these browsers and versions:

- Internet Explorer version 6 thru 11
- Mozilla Firefox all versions

For best results, it is recommended that you use a supported Web browser version to access iExchange.

3. Can I obtain eligibility, benefits and preauthorization requirements through iExchange?

No. iExchange only supports preauthorization/predetermination requests. Check eligibility and benefits to confirm any requirements. Submitting a request for preauthorization/predetermination is not a substitute for checking eligibility and benefits.

REQUESTS FOR OUT-OF-AREA MEMBERS

4. How can I conduct electronic preauthorization requests for out-of-area members?

BCBSOK contracted providers who would like to submit electronic preauthorization requests for out-of-area Blue Plan members must be registered Availity users. **Refer to the [Electronic Provider Access FAQs](#) for additional information.**

TYPES OF REQUESTS

5. What services can be submitted for preauthorization via iExchange?

Preauthorization requests can be submitted for the following **inpatient** services:

- Surgical
- Maternity
- Hospice
- Neo-natal
- Rehab
- Transplant
- Medical -- *Applies to anything that does not fall in the other inpatient categories*

Preauthorization requests can be submitted for the following **outpatient** services:

- Hospice
- Skilled nursing visit
- Home Infusion
- Therapy -- *Includes physical, occupational and speech therapies*
- Pharmacy – *Includes select physician-administered medications that may be covered under the members' medical benefits, if applicable, as required according to the BCBSOK Pharmacy Prior Authorization Program*
- Behavioral Health – *Includes requests for services that fall under the Intensive Outpatient Program (IOP)*

6. After submitting a request, when should I expect to receive a response?

Depending on the service and details of your request, iExchange may return an auto-approval upon submission. If your case moves to a pended status, the response time will vary based on the request type submitted. See chart below for details:

Request Type	Response / Completed
Inpatient	
Medical/Surgical	Within 2 to 3 business days
Outpatient	
Medical/Surgical	Within 2 to 3 business days
Behavioral/Mental Health (IOP)	Within 2 to 3 business days
Pharmacy	Within 3 business days

7. How do I determine if a predetermination request should be submitted via iExchange?

You would use your current process of verifying eligibility and benefits, as well as confirming if medically criteria must be met prior to submitting an electronic predetermination request.

8. Which Blue Cross policies are supported for predetermination submission via iExchange?

A predetermination request can be initiated for the following plan types; Commercial*, Retail** and FEP.

9. How would I submit a predetermination if I don't have access to iExchange?

You will still have the ability to fax the predetermination form along with the clinical documentation to the health plan.

10. How far out can I initiate a predetermination request?

iExchange will allow you to initiate a predetermination request for a duration of 365 days or in the case of a Retail request, until the end of the current year.

11. Can I send clinical attachments electronically through iExchange?

Yes. iExchange has been enhanced to allow electronic submission of clinical attachments for preauthorizations and predetermination requests

12. Are all file types allowed for clinical attachments?

No. All file types are not allowed. A list of allowable file types will display in the Request Attachment Section prior to uploading your clinical documentation.

13. Can multiple referral requests be submitted in iExchange for the same patient?

Yes. iExchange will allow multiple referral submissions to the health plan on an individual member. Please be aware that you will receive an informational message that any additional referral maybe a potential duplicate. However, the system will allow you to submit the referral for manual review.

[SINGLE SIGN-ON THROUGH AVAILITY](#)

14. What is single sign-on?

Single sign-on (SSO) allows a BCBSOK provider, who is registered with Availity, to use a single log in and password to gain direct access to iExchange for the submission of preauthorization requests from their Availity account. SSO eliminates the need for a BCBSOK provider to utilize separate URLs to complete this function. Availity can be used to check eligibility and benefit requests, as well as other electronic transactions. Additionally, SSO enables BCBSOK providers to submit requests for pre-service reviews for out-of-area Blue Plan members.

15. What is Availity?

Availity is a health information network that offers a multi-payer portal which gives physicians, hospitals and other providers access to multiple payers' information through a single website and a single log in and password (sign-on). Availity offers a variety of business and clinical solutions to help providers reduce administrative costs by eliminating paperwork and phone calls.

16. Do I have to register with Availity in order to access the SSO link for iExchange?

Yes. BCBSOK providers must be registered with Availity. There is no cost to register for BCBSOK providers. For registration information, visit availity.com. Once your registration with Availity is completed, your organization's PAA can request access to BCBSOK preauthorization from their Availity account.

17. How will I know that my registration has been completed and approved?

The Availity PAA will receive an email confirmation and notification in the Availity message center within 7 to 14 business days indicating the registration request is complete.

[RESOURCES AND SUPPORT](#)

18. What if I have additional questions?

- Visit the [iExchange page](#) of our website at bcbsok.com/provider for tip sheets to assist you with various types of requests.
- Attend a webinar – refer to the [iExchange page](#) for dates and times of upcoming sessions
- For technical support, contact our iExchange support staff at OK_iEXCHANGE_Help_Desk@hcsc.net

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Please note that verification of eligibility and benefits information, and/or the fact that any pre-service review has been conducted, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.