

The BlueCard[®] Program Provider Manual

May 2020

This manual is designed to offer you, as a Blue Cross and Blue Shield of Illinois (BCBSIL) independently contracted provider, information about the BlueCard Program. BlueCard is a program that allows members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan's service area.

Please review and become familiar with the procedures and guidelines outlined in this manual, so that you can properly provide service to members that belong to other Blue Plans.

This information does not constitute, and is not intended as, legal or financial advice.

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1. Introduction: BlueCard Program Makes Filing Claims Easy

As a participating provider with Blue Cross and Blue Shield of Illinois (BCBSIL), you may render services to patients who are National Account members of other Blue Plans, and who travel or live in Illinois.

This manual describes the advantages of the program, and provides information to make filing claims easy. This manual offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining pre-certifications/preauthorizations
- Filing claims
- Whom to contact with questions

2. What is the BlueCard Program?

2.1 Definition

BlueCard is a national program that enables members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan's service area. The program links participating health care providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Your local Blue Plan is your sole contact for claims payment, adjustments and issue resolution.

2.2 BlueCard Program Advantages to Providers

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to BCBSIL. BCBSIL will be your one point-of-contact for all of your claims-related questions.

Nearly 1 million other Blue Plans' members are currently residing in Illinois.

BCBSIL continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations. In doing so, your patients will have a positive experience with each visit.

2.3 Products Included in BlueCard

A variety of products and claim types are eligible to be delivered via BlueCard, however not all Blue Plans offer all of these products to their members. **Currently, BCBSIL offers products indicated by the asterisk below, however you may see members from other Blue Plans who are enrolled in the other products:**

- Traditional* (indemnity insurance)
- PPO* (Preferred Provider Organization)
- EPO* (Exclusive Provider Organization)
- POS (Point-of-Service)
- HMO* (Health Maintenance Organization)
- Medigap
- Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards will not have a suitcase logo.
- SCHIP (State Children's Health Insurance Plan) if administered as part of Medicaid. Payment is limited to the member's Plan's state Medicaid reimbursement rates. These member ID cards also do not have a suitcase logo. Stand-alone SCHIP programs will have a suitcase logo.
- Stand-alone vision*
- Stand-alone prescription drugs*

NOTE: Stand-alone vision and stand-alone self-administered prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the member's ID card.

NOTE: Definitions of the above products are available in the Glossary of Terms section of this Manual

2.4 Products Excluded from the BlueCard Program

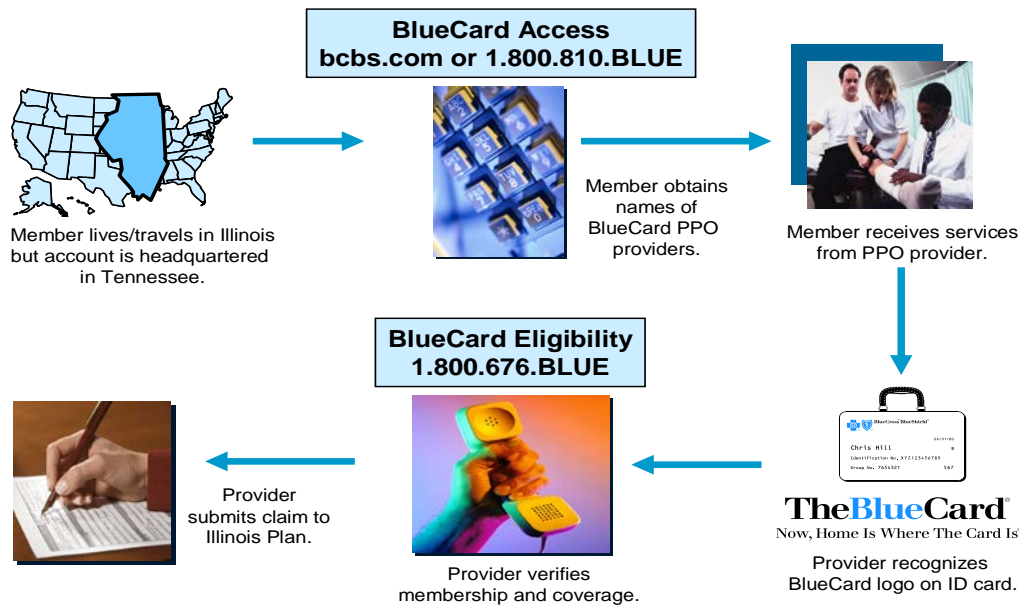
The following claims are excluded from the BlueCard Program:

- Stand-alone dental
- Vision delivered through an intermediary model (using a vendor)
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)
- Medicaid and SCHIP that is part of the Medicaid program
- Medicare Advantage*
- The Federal Employee Program® (FEP)

Please follow BCBSIL billing guidelines.

*Medicare Advantage is a separate program from BlueCard. However, since you might be seeing members of other Blue Plans who have Medicare Advantage coverage, we have included a section on Medicare Advantage claims processing in this manual.

3. How the BlueCard Program Works



In the example above, suppose a member has PPO coverage through BlueCross BlueShield of Tennessee. There are two scenarios where that member might need to see a provider in another Plan's service area, in this example, Illinois:

- 1) If the member was traveling in Illinois, or
- 2) If the member resided in Illinois and had employer-provided coverage through BlueCross BlueShield of Tennessee.

In either scenario, the member can obtain the names and contact information for BlueCard PPO providers in Illinois by calling the BlueCard Access® line at 800-810-BLUE (2583). The member also can obtain information on the Internet, using the BlueCard National Doctor and Hospital Finder available at bcbs.com.

NOTE: members are not obligated to identify participating providers through either of these methods but it is their responsibility to go to a PPO provider if they want to access PPO in-network benefits

When the member makes an appointment and/or sees an Illinois BlueCard PPO provider, the provider may verify the member's eligibility and coverage information via the BlueCard Eligibility® line at 800-676-BLUE (2583). The provider also may obtain this information via a HIPAA electronic eligibility transaction if the provider has established electronic connections for such transactions with the local Plan, Blue Cross and Blue Shield of Illinois.

After rendering services, the provider in Illinois files a claim locally with Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield of Illinois forwards the claim internally to BlueCross BlueShield of Tennessee, which adjudicates the claim according to the member's benefits and the provider's arrangement with the Illinois Plan. When the claim is finalized, the Tennessee Plan issues an explanation of benefit or EOB to the member, and the Illinois Plan issues the explanation of payment or remittance advice to its provider and pays the provider.

3.1 How to Identify Members

3.1.1 Member ID Cards

When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card.


The main identifier for out-of-area members is the prefix. The ID cards also may have:


- PPO in a suitcase logo, for eligible PPO members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
- Blank, or empty suitcase logo


Important facts concerning member IDs:

- A correct member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between six and 14 numbers/letters following the prefix.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- The prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Members who are part of the FEP will have the letter "R" in front of their member ID number.

Examples of ID numbers:

ABC1234567

Alpha
Prefix

ABC1234H567

Alpha
Prefix

ABC12345678901234

Alpha
Prefix

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in your patient's file.
- Verify with the member that the ID number on the card is not his/her Social Security Number. If it is, call the BlueCard Eligibility line 800-676-BLUE (2583) to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- Remember: Member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers.

Prefix

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card, and pass this key information to your billing staff. Do not make up prefixes or assume that the member's ID number is the Social Security Number. All Blue Plans replaced Social Security numbers on member ID cards with an alternate, unique identifier.

Sample ID Card:



BlueCard ID cards have a suitcase logo, either as an empty suitcase or as a PPO in a suitcase.

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to your BCBSIL PPO provider contract. Please note, however, that EPO products may have limited benefits out-of-area. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product from a Blue Plan and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

Providers will be reimbursed for covered services in accordance with your PPO or Traditional contract with BCBSIL.

The empty suitcase logo indicates that the member is enrolled in one of the following products: BCBS Traditional, Managed Care/POS or Managed Care/HMO delivered through the BlueCard Program.




Some Blue ID cards don't have any suitcase logo on them. Those are the ID cards for Medicaid, SCHIP if administered as part of State's Medicaid, and Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products. While BCBSIL routes all of these claims for out-of-area members to the member's Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's Plan via the established electronic crossover process.

3.2 How to Identify BlueCard Managed Care/POS Members

The Managed Care/POS program allows members traveling or living outside of their Blue Cross and Blue Shield (BCBS) Plan's service area to seek services from a BlueCard PPO provider. You can recognize Managed Care/POS members who are enrolled in out-of-area networks through the member ID card as you do for all other BlueCard members. The ID cards will include:

- The three-character prefix at the beginning of the member's ID number
- A local network identifier, such as Blue Product
- The empty suitcase logo

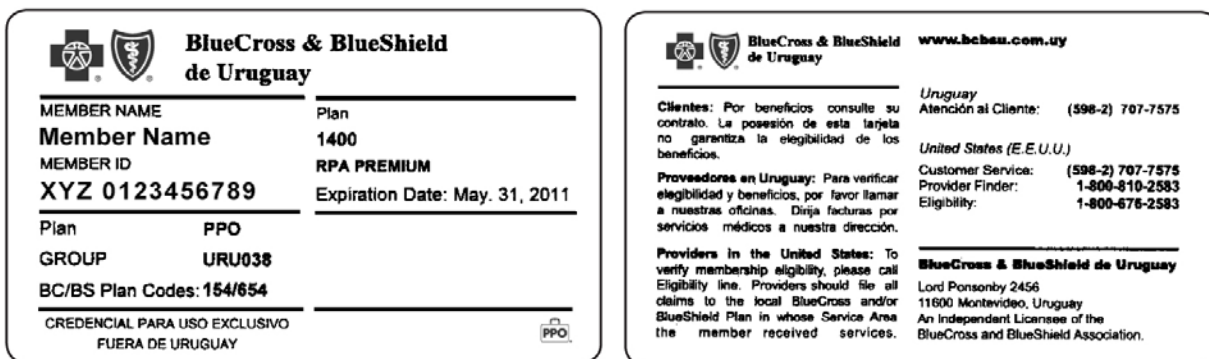
Sample ID Card:

	BlueCross® BlueShield®	Blue Product	ALPHA Employer Group
Member Name Member Name	Dependents Dependent One	Local POS Network Identifier	
Member ID XYZ123456789	Dependent Two		
Group No. 023457	Dependent Three		
BIN 987654	Plan POS	Office visit copay	
Benefit Plan HIOPT	Office Visit \$15		
Effective Date 00/00/00	Specialist Copay \$15		
	Emergency \$75		
	Deductible \$50		
		Empty suitcase identifier	
			

3.3 How to Identify International Members

Occasionally, you may see identification cards from members of International Licensees. Currently those Licensees include Blue Cross Blue Shield (BCBS) of U.S. Virgin Islands, BlueCross & BlueShield of Uruguay and Blue Cross and Blue Shield of Panama, but if in doubt, always check with BCBSIL as the list of International Licensees may change. ID cards from these Licensees will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and file their claims to BCBSIL.

Example of an ID card from an International Licensee:



You may also see patients who are enrolled in Worldwide Insurance Services (doing business as GeoBlueSM, the International Solutions Licensee), a product that provides medical coverage for employees of U.S.-based companies doing business abroad. The Blue System provides three separate offerings for international travelers and expatriates:

- Blue Cross Blue Shield Global[®] – Part of domestic coverage for local and National Account business
- FEP Overseas – Coverage extended to government employees overseas
- GeoBlue – A Blue-branded Licensee administering the International Solutions Licensee (ISL) products.

Members enrolled in the Worldwide Insurance Services product are covered in the United States for visits of up to 45 days. These members will access the networks of Blue Plans when in the United States. These ID cards will also contain a three-character prefix. Please treat these members the same as domestic Blue Plan members.

Submit all claims from international members or Worldwide Insurance Services members to BCBSIL.

If you are unsure about your participation status, call the BCBSIL Provider Telecommunications Center (PTC) at 800-972-8088.

Canadian ID Cards*

Please note: The Canadian Association of Blue Cross Plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the United States.

Claims for members of the Canadian Blue Cross Plans are not processed through the BlueCard Program. Please follow the instructions of these Plans and those, if any, on their ID cards for servicing their members. The Blue Cross Plans in Canada are:

Alberta Blue Cross	Ontario Blue Cross	Quebec Blue Cross
Manitoba Blue Cross	Pacific Blue Cross	Saskatchewan Blue Cross
Medavie Blue Cross		

*Source: <http://www.bluecross.ca/en/contact.html>

3.4 Consumer Directed Health Care and Health Care Debit Cards

Consumer Directed Health Care (CDHC) is a term that refers to a movement in the health care industry to empower members, reduce employer costs and change consumer health care purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate health care decision through the use of member support tools, provider and network information and financial incentives.

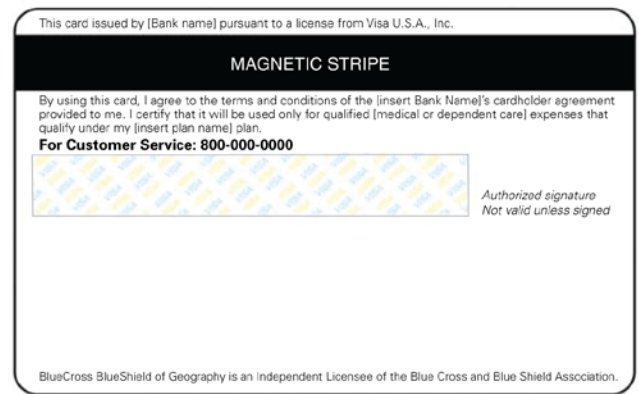
Members who have CDHC plans often carry health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). All three are types of tax-favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some cards are “stand-alone” debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

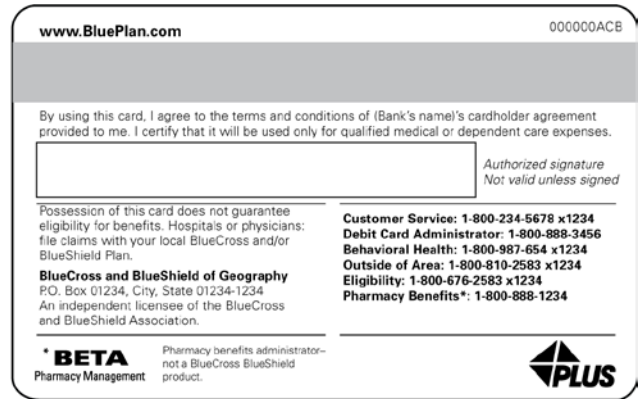
- Reduce bad debt
- Reduce paper work for billing statements
- Minimize bookkeeping and patient-account functions for handling cash and checks
- Avoid unnecessary claim payment delays

The card will have the nationally recognized Blue logos, along with the logo from a major debit card such as MasterCard® or Visa®.

Sample Stand-alone Health Care Debit Card:



Sample Combined Health Care Debit Card and Member ID Card:



The cards include a magnetic strip allowing providers to swipe the card to collect the member's cost-sharing amount (i.e., copayment). With health care debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as what you pay to swipe any other signature debit card.

Helpful Tips:

- *Using the member's current member ID number, including prefix, carefully determine the member's financial responsibility before processing payment. Check eligibility and benefits electronically via Availity® or your preferred web vendor, or by calling 800-676-BLUE (2583) and providing the member ID number including the prefix.*
- *All services, regardless of whether or not you've collected the member responsibility at the time of service, must be billed to BCBSIL for proper benefit determination, and to update the member's claim history.*
- *Please do not use the card to process full payment upfront. If you have any questions about the member's benefits, please contact 800-676-BLUE (2583). For questions about the health care debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.*

3.5 Limited Benefits Products

Verifying Blue patients' benefits and eligibility is important, now more than ever, as new products and benefit types continue to enter the market. In addition to patients who have traditional Blue PPO, HMO, POS or other coverage, typically with high lifetime coverage limits (i.e., \$1 million or more), you may now see patients whose annual benefits are limited to \$50,000 or less.

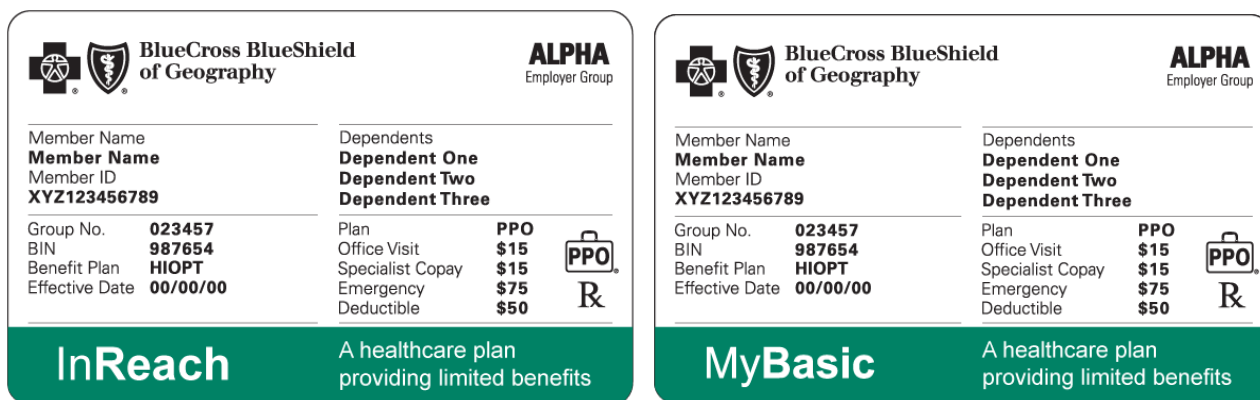
Currently BCBSIL doesn't offer such limited benefit plans to our members, however you may see patients with limited benefits who are covered by another Blue Plan.

How can I recognize members with limited benefits products?

Patients who have Blue limited benefits coverage carry ID cards that have:

- Product name will be listed, such as **InReach** or **MyBasic**
- A **green stripe** at the bottom of the card
- A statement either on the front or the back of the ID card stating this is a limited benefits product
- A **black cross and/or shield** to help differentiate it from other identification cards.

These ID cards may look like this:



How do I find out if the patient has limited benefit coverage?

In addition to obtaining a copy of the patient's ID card and regardless of the benefit product type, we recommend that you verify patient benefits and eligibility and collect any patient liability or copayment only.

You may do so electronically by submitting HIPAA 270 eligibility inquiry to BCBSIL via Availity or your preferred web vendor. Or you may call the BCBSIL Provider Services at 800-972-8088 for local members, and the BlueCard eligibility line at 800-676-BLUE (2583) for out-of-area members.

Both electronically and via phone, you will receive the patient's accumulated benefits to help you understand the remaining benefits left for the member.

Tips:

- *In addition to obtaining a copy of the member's ID card, regardless of the benefit product type, always verify eligibility and benefits electronically via your preferred web vendor portal, or by calling 800-676-BLUE (2583). You will receive the member's accumulated benefits to help you understand his/her remaining benefits.*
- *If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability they might have.*
- *If you have questions regarding a Blue Plan's limited benefits ID card/product, please contact BCBSIL.*

What should I do if the patient's benefits are exhausted before the end of their treatment?

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatments may be the member's liability. In the event the member's benefits are exhausted, the provider may continue to provide treatment; however the member must agree in writing to pay for those services and the charge must not be more than the allowable amount. It is the provider's responsibility to inform the patient of any potential liability they might have as soon as possible.

Whom do I contact if I have additional questions about Limited Benefit Plans?

If you have any questions regarding BCBSIL or any other Blue Plans' Limited Benefits products, contact the BCBSIL PTC at 800-972-8088.

3.5.1 Reference Based Benefits

With health care costs increasing, employers are considering alternative approaches to control health care expenses by placing a greater emphasis on employee accountability by encouraging members to take a more active role while making health care decisions. Plans have begun to introduce Reference Based Benefits, which limit certain (or specific) benefits to a dollar amount that incents members to actively shop for health care for those services.

The goal of Reference Based Benefits is to have members engage in their health choices by giving them an incentive to shop for cost effective providers and facilities. Reference Based Benefit designs hold the member responsible for any expenses above a calculated "reference cost" ceiling for a single episode of service. Due to the possibility of increased member cost sharing, Reference Based Benefits will incent members to use Plan transparency tools, like the National Consumer Cost Tool (NCCT), to search for and identify services that can be performed at cost effective providers and/or facilities that charge at or below the reference cost ceiling.

How does Reference Based Benefits work?

Reference Based Benefits are a new benefit feature where the Plan will pay up to a pre-determined amount for specific procedures called a "Reference Cost." If the allowed amount exceeds the reference cost, that excess amount becomes the members' responsibility.

How are Reference Costs established?

The reference costs are established for an episode of care based on claims data received by BCBSIL from providers in your area.

How will I be reimbursed?

Reference Based Benefits will not modify the current contracting amount agreed on between you and BCBSIL. Providers can expect to receive their contract rate on all procedures where Reference Based Benefits apply.

Example 1: If a member has a reference cost of \$500 for an MRI of the spine and the allowable amount is \$700, then BCBSIL will pay up to the \$500 for the procedure and the member is responsible for the \$200.

Example 2: If a member has a reference cost ceiling of \$600 for a CT scan of the Head/Brain and allowable amount is \$400, then BCBSIL will pay up to the \$400 for the procedure.

How much will the member be responsible for out-of-pocket?

When Reference Based Benefits are applied and the cost of the services rendered is less than the reference cost ceiling, then BCBSIL will pay eligible benefits as it has in the past; while the member continues to pay their standard cost sharing amounts in the forms of: co-insurance, copay, or deductible as normal.

If the cost of the services rendered exceeds the reference cost ceiling, then BCBSIL will pay benefits up to that reference cost ceiling, while the member continues to pay their standard cost sharing amounts in the

forms of: co-insurance, copay, or deductible; as well as any amount above the reference cost ceiling up to the contractual amount.

How will I be able to identify if a member is covered under Reference Based Benefits?

When you receive a response from a benefits and eligibility inquiry, you will be notified if a member is covered under Reference Based Benefits. Additionally, you may call the Blue Eligibility number (800-676-2583) to verify if a member is covered under Reference Based Benefits.

Do I need to do anything different if a member is covered under Reference Based Benefits?

While there are no additional steps that you need to take, you may want to verify the reference cost maximum prior to performing a procedure covered under Reference Based Benefits. You can check if Reference Based Benefits apply to professional and facility charges for the member, by submitting an electronic benefits and eligibility inquiry to your local Blue Plan. Alternatively, you can contact the member's Plan by calling the Blue Eligibility number (800-676-2583).

Do Reference Based Benefits apply to emergency services?

No. Reference Based Benefits are not applicable to any service that is urgent or emergent.

How does the member identify services at or below the reference cost?

Members with Reference Based Benefits may use consumer transparency tools to determine if a provider will deliver the service for less than the reference cost.

How will the Reference Based Benefits cost apply to professional and facility charges?

For more information on how Reference Based Benefits will apply costs to the professional and facility charges, please submit an electronic benefits and eligibility inquiry to the member's local Blue Plan. If you have additional questions, you can contact the Blue Eligibility number (800-676-2583) for the member you are seeing. *For information on Electronic Provider Access, see Section 3.8.*

What if a member covered under Reference Based Benefits asks for additional information about their benefits?

Since members are subject to any charges above the reference cost up to the contractual amount for particular services, members may ask you to estimate how much a service will cost. Also, you may direct members to view their Blue Plans' transparency tools to learn more about the cost established for an episode of care.

What procedures are covered under Reference Based Benefits?

Applicable services may vary by employer group.

Where do I submit the claim?

You should submit the claim to BCBSIL under your current billing practices.

How will Reference Based Benefits be shown on a payment remittance?

When you receive payment for services the claim will pay per the member's benefits with any amount over the reference cost being applied to the Benefit Maximum.

Is there anything different that I need to submit with member claims?

No. You should continue to submit your claims as you previously have to BCBSIL.




3.6 Coverage and Eligibility Verification

For out-of-area Blue Plan members, submit an electronic inquiry to BCBSIL or call BlueCard Eligibility at 800-676-BLUE (2583) to verify the patient's eligibility and coverage.


- Electronic – Submit a HIPAA 270 transaction (eligibility) to BCBSIL via Availity or your preferred electronic web vendor portal.

Electronic eligibility and benefits (270/271) transactions may be conducted almost continuously, with the exception of Sunday, 8 p.m. to midnight, CT.

- Phone – Call BlueCard Eligibility at 800-676-BLUE (2583)
 - English and Spanish speaking phone operators are available to assist you.
 - Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule than BCBSIL. You may be transferred to a voice response system linked to customer enrollment and benefits.
 - The BlueCard Eligibility line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status. *See Section 4, Claim Filing for additional information.*
- Electronic Health ID Cards
 - Some BCBS Plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process.
 - Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider's system.
 - A BCBS electronic health ID card has a magnetic stripe on the back of the ID card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the three-track magnetic stripe.
 - Core subscriber/member data elements embedded on the third track of the magnetic stripe include: subscriber/member name, subscriber/member ID, subscriber/member date of birth and Plan ID.
 - The Plan ID data element identifies the health plan that issued the ID card. Plan ID will help providers facilitate health transactions among various payers.
 - Providers will need a *track 3 card reader* in order for the data on track 3 of the magnetic stripe to be read (the majority of card readers in provider offices only read tracks 1 & 2 of the magnetic stripe; tracks 1 & 2 are proprietary to the financial industry).
 - Sample of an electronic health ID card (*see next page*):

 BlueCross BlueShield of Geography		Blue Product ALPHA Employer Group	
Member Name Member Name Member ID XYZ123456789		Dependents Dependent One Dependent Two Dependent Three	
Plan Plan Code	PPO 123	Office Visit Specialist Copay Emergency Deductible	\$15 \$15 \$75 \$50
 			

www.BluePlan.com

 BlueCross BlueShield of Geography	Customer Service: 1-800-234-5678 x1234 Behavioral Health: 1-800-987-6543 x1234 Outside of Area: 1-800-810-2583 x1234 Eligibility: 1-800-676-2583 x1234 Pharmacy Benefits*: 1-800-888-1234
Members: See your benefit booklet for covered services. Possession of this card does not guarantee eligibility for benefits. Hospitals or physicians: file claims with your local BlueCross and/or BlueShield Plan. BlueCross and BlueShield of Geography provides administrative services and does not assume any financial risk for claims.	BlueCross and BlueShield of Geography P.O. Box 01234 City, State 01234-1234 An independent licensee of the BlueCross and BlueShield Association.
* BETA Pharmacy Management	Pharmacy benefits administrator – not a BlueCross BlueShield product.

3.7 Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/preauthorization for their services from their Blue Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (see Section 3.9, *Provider Financial Responsibility for Pre-service Review for BlueCard Members*). In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

Providers must also follow specified timeframes for pre-service review notifications:

1. 48 hours to notify the member's Plan of change in pre-service review; and
2. 72 hours for emergency/urgent pre-service review notification.

General pre-certification/preauthorization information can be found on the Out-of-Area Member Medical Policy and Pre-Authorization/Pre-Certification Router, available in the Claims and Eligibility/Prior Authorization section of the BCBSIL Provider website at bcbsil.com/provider, utilizing the three-letter prefix on the member ID card.

You may also contact the member's Plan on the member's behalf, as follows:

- For BCBSIL members, contact the BCBSIL PTC at 800-972-8088
- For other Blue Plan members:
 - Call BlueCard Eligibility 800-676-BLUE (2583) – ask to be transferred to the utilization review area.

When pre-certification/preauthorization for a specific member is handled separately from eligibility verifications at the member's Blue Plan, your call will be routed directly to the area that handles pre-certification/preauthorization. You will choose from four options depending on the type of service for which you are calling:

- Medical/Surgical
- Behavioral Health
- Diagnostic Imaging/Radiology
- Durable/Home Medical Equipment (D/HME)

If you are inquiring about both eligibility and pre-certification/preauthorization through 800-676-BLUE (2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the pre-certification/preauthorization area.

- o Submit an electronic HIPAA 278 transaction (referral/authorization) to BCBSIL.
- o The member's Blue Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

When obtaining pre-certification/preauthorization, please provide as much information as possible to help minimize potential claims issues. Providers are encouraged to follow up immediately with a member's Blue Plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

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.


3.8 Electronic Provider Access

On Jan. 1, 2014, the Blue Cross and Blue Shield Association launched Electronic Provider Access (EPA) – a new tool that gives providers the option to initiate online pre-service reviews for out-of-area Blue Plan members* as an alternative to calling the health plan. The term pre-service review as used with this tool refers to pre-notification, pre-certification, preauthorization and prior approval, among other pre-claim processes. As always, checking eligibility and benefits prior to conducting pre-service reviews is strongly encouraged.

Using the EPA Tool: Instructions for BCBSIL Providers

EPA was implemented for BCBSIL as of July 21, 2014. BCBSIL contracted providers must be registered with Availity to gain access to EPA. If you are not a registered Availity portal user, please visit availity.com to sign up quickly and easily. There is no registration fee.

The basic steps for initiating online pre-service reviews for out-of-area Blue Plan members* are included below. Also refer to the Related Resources at the end of this section for links to helpful tip sheets on the BCBSIL Provider website.

1. Log in to Availity 
2. Select Patient Registration menu option, choose Authorizations & Referrals, then Authorizations
3. Select Payer BCBSIL, then choose your organization
4. Select a Request Type and start request
5. Enter patient information (including the three-character prefix), requesting provider information and select Next
6. You will be securely routed to the EPA landing page on the member's Home Blue Plan portal. The EPA landing page will look similar across Blue Plans but will be customized to the particular Home Plan based on the electronic pre-service review services they offer.

Quick Tips:

If you need to access pre-certification/preauthorization information for the member's Home Plan, use this link to the [medical policy router tool](#) on the BCBSIL Provider website.

Related Resources

Refer to the Education and Reference Center/Provider Tools/Availity Authorizations section of our Provider website at bcbsil.com/provider where you will find a variety of helpful resources, including the following EPA tip sheets:

- [Pre-service Review for BCBSIL Members](#)
- [Pre-service Review for Out-of-area Members](#)

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.

3.9 Provider Financial Responsibility for Pre-Service Review for BlueCard Members

BCBSIL participating providers are responsible for obtaining pre-service review for inpatient facility services for BlueCard members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers also must:

- Notify the member's Blue Plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

The BlueCard member must be held harmless and cannot be balance-billed if pre-service review has not occurred.*

Pre-service review contact information for a member's Blue Plan is provided on the member's identification card. Pre-service review requirements can also be determined by:

- Using the Electronic Provider Access (EPA) tool (*see Section 3.8, Electronic Provider Access, for details*). NOTE: the availability of EPA will vary depending on the capabilities of each member's Blue Plan
- Submitting a HIPAA 278 electronic transaction to BCBSIL, or calling 800-676-BLUE (2583) and asking to be transferred to the utilization review area.

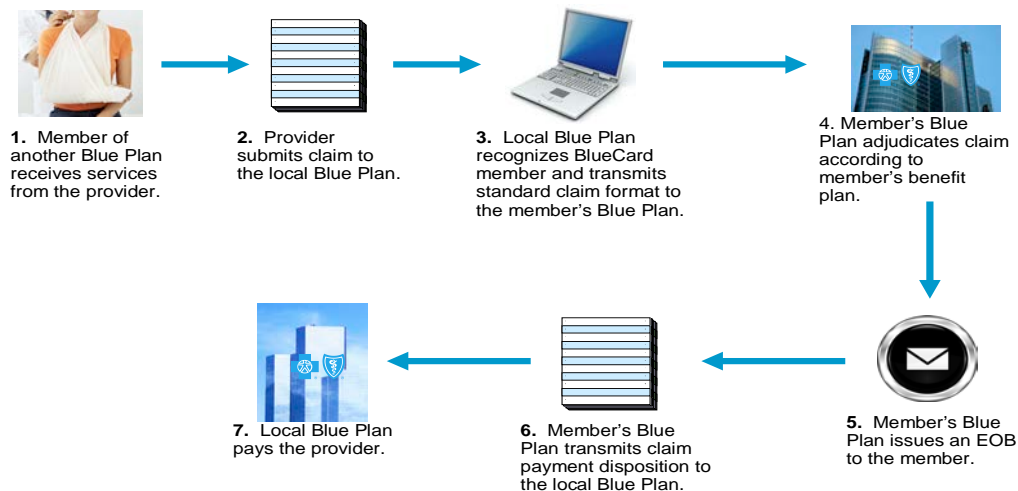
Services that deny as not medically necessary remain member liability.

**Unless the member signed a written consent to be billed prior to rendering the service.*

4. Claim Filing

4.1 How Claims Flow through BlueCard

Below is an example of how claims flow through BlueCard.



After the member of another Blue Plan receives services from you, you should file the claim with BCBSIL. We will work with the member's Plan to process the claim and the member's Plan will send the an explanation of benefits or EOB to the member, and we will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the member's benefits and coverage.

You should always submit claims to BCBSIL electronically to help expedite processing.

Paper claims should be mailed to:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

Following these helpful tips will help improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically via your preferred vendor portal, or by calling 800-676-BLUE (2583). Be sure to provide the member's prefix.
- Verify the member's cost sharing amount before processing payment. Please do not process full payment upfront.
- Indicate on the claim any payment you collected from the patient. (On the 837 electronic claim transaction, AMT01=**F5** patient paid amount; on the CMS-1500 paper claim, locator **29** amount paid; on the UB-04 paper claim, locator **53** prior payment.)
- Submit all Blue claims to BCBSIL. Be sure to include the member's complete identification number when you submit the claim. This includes the three-character prefix. Submit claims with only valid alpha prefixes; claims with incorrect or missing prefixes and member identification numbers cannot be processed.

- In cases where there is more than one payer and a Blue Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue claim. Upon receipt, BCBSIL will electronically route the claim to the member's Blue Plan. The member's Plan then processes the claim and approves payment; BCBSIL will reimburse you for services.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- Check claim status by submitting an electronic HIPAA 276 transaction (claim status request) to BCBSIL.

4.2 Medicare Advantage Claims

4.2.1 Medicare Advantage Overview

"Medicare Advantage" (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare." (See Section 4.3, *Traditional Medicare-related Claims*.)

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage – by calling 800-676-BLUE (2583) or submitting an electronic inquiry – for all Medicare Advantage members prior to providing service, as the level of benefits and coverage rules may vary depending on the Medicare Advantage plan.

4.2.2 Types of Medicare Advantage Plans

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by Medicare Advantage plan.

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine – at the point of service – whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO's provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO's provider network.

Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-

network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Blue Medicare Advantage PPO members have in-network access to Blue MA PPO providers.

Medicare Advantage PFFS

A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage Organization, rather than the Medicare program, pays for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instance where the provider is a network provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with BCBSIL.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan.
- MA PFFS Terms and Conditions might vary for each Blue Plan and we advise that you review them before servicing MA PFFS members.
- Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.
- Submit your MA PFFS claims to BCBSIL.

Medicare Advantage Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

4.2.3 Medicare Advantage PPO Network Sharing

What is BCBS Medicare Advantage PPO Network Sharing?

All Blue Medicare Advantage PPO plans participate in reciprocal network sharing. This network sharing allows all Blue Plan MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO plan as long as the member sees a contracted MA PPO provider.

What does the Blue Plan Medicare Advantage (MA) PPO Network Sharing mean to me?

If you are a contracted MA PPO provider with BCBSIL and you see MA PPO members from other Blue Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your BCBSIL contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with BCBSIL and you provide services for any Blue Plan Medicare Advantage members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area member participating in the Blue Plans' MA PPO network sharing?

You can recognize a MA PPO member when their Blue Plan member ID card has the following logo.



The “MA” in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Plan member ID.

Do I have to provide services to Medicare Advantage PPO members from other Blue Plans?

If you are a contracted Medicare Advantage PPO provider with BCBSIL, you must provide the same access to care as you do for BCBSIL’s MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other Blue Plans but you are not required to do so. Should you decide to provide services to Blue Plan Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member’s out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local Blue Plan Medicare Advantage PPO members?

If your practice is closed to new local Blue Plan MA PPO members, you do not have to provide care for Blue Plan MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

How do I verify benefits and eligibility?

Call the BlueCard Eligibility Line at 800-676-BLUE (2583) and provide the member’s three-character alpha prefix located on the ID card.

You may also submit electronic eligibility requests for out-of-area Blue Plan members. If you experience difficulty obtaining eligibility information, please record the prefix and report it to BCBSIL. *See section 3.8, Electronic Provider Access.*

Where do I submit the claim?

You should submit the claim to BCBSIL under your current billing practices. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

What will I be paid for providing services to these out-of-area Medicare Advantage PPO network sharing members?

If you are a MA PPO contracted provider with BCBSIL, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, BCBSIL will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to Medicare Advantage out-of-area members not participating in the Medicare Advantage PPO Network Sharing?

When you provide covered services to other Blue Plan Medicare Advantage out-of-area members, benefits will be based on the Medicare allowed amount. Once you submit the MA claim, BCBSIL will send you the payment. However, these services will be paid under the member’s out-of-network benefits, with the exception of urgent or emergency care.

What is the member cost sharing level and co-payments?

A MA PPO member cost sharing level and copayment is based on the member's health benefit plan. You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 800-676-BLUE (2583).

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be billed for any deductibles, co-insurance and/or copays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact your BCBSIL Provider Network Consultant.

Whom do I contact if I have a question about MA PPO network sharing?

If you have any questions regarding the MA program or products, contact your BCBSIL Provider Network Consultant.

4.2.4 Eligibility Verification

- Verify eligibility by contacting 800-676-BLUE (2583) and providing a prefix or by submitting an electronic inquiry to your local Plan and providing the prefix.
- Be sure to ask if Medicare Advantage benefits apply.
- If you experience difficulty obtaining eligibility information, please record the prefix and report it to the BCBSIL PTC at 800-972-8088.

4.2.5 Medicare Advantage Claims Submission

- Submit all Medicare Advantage claims to BCBSIL.
- Do not bill Medicare directly for any services rendered to a Medicare Advantage member.
- Payment will be made directly by a Blue Plan.

4.2.6 Reimbursement for Medicare Advantage PPO, HMO, POS, PFFS

*Note to Provider: The reimbursement information below applies when a provider treats a Blue Medicare Advantage member to whom the provider's contract does **not** apply.*

Examples:

- A provider that is contracted for Medicare Advantage PPO business treats a Medicare Advantage HMO member.
- A provider that is contracted for commercial business only treats a MA PPO member.
- A provider that is contracted for Medicare Advantage HMO business treats any MA PPO member.
- A provider that is contracted for local Medicare Advantage HMO business treats an out-of-area MA HMO member.
- A provider that is not contracted with the local Plan treats a MA HMO member.

Based upon the Centers for Medicare & Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue Plan, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed

amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Special payment rules apply to hospitals and certain other entities (e.g., skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Providers that are paid on a reasonable cost basis under Original Medicare should send their CMS Interim Payment Rate letter with their Medicare Advantage claim. This letter will be needed by the Plan to calculate the Medicare Allowed amount.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

NOTE: Enrollee payment responsibilities can include more than copayments (e.g., deductibles).

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

4.2.7 Medicare Advantage Private Fee-For-Service (PFFS) Claim Reimbursement

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, but are not obligated to provide services to such member under a contract with a Blue Plan, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules by reviewing the Terms and Conditions under the member's Blue Plan. You can find the MA PFFS Terms and Conditions using the [Medicare Advantage Private Fee-for-Service \(PFFS\) tool](#) in the Standards and Requirements section of the BCBSIL website at bcbsil.com/provider. Simply enter the member's three-character prefix.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

Note to Provider: The reimbursement information below applies when a provider treats a Blue Medicare Advantage member to whom the provider's contract applies.

Examples:

- A provider that is contracted for Medicare Advantage PPO business treats an out-of-area Medicare Advantage PPO member.
- A provider that is contracted for Medicare Advantage HMO business treats an MA HMO member from the local Plan.

If you are a provider who accepts Medicare assignment and you render services to any Blue Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue Plan, you will be considered a contracted provider and be reimbursed per the contractual agreement.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

4.3 Traditional Medicare-related Claims

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is the primary payer, submit claims to your local Medicare intermediary.
- All Blue claims are set up to automatically crossover to the member's Blue Plan after being adjudicated by the Medicare intermediary.

How do I submit Medicare primary / Blue Plan secondary claims?

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification.
- Include the prefix as part of the member identification number. The member's ID will include the prefix in the first three positions. The prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. **DO NOT** resubmit that claim to BCBSIL.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to BCBSIL with the Medicare remittance advice.
- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.

When should I expect to receive payment?

Claims submitted to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed. This process may take up to 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14 to 30 business days for you to receive payment from the Blue Plan.

What should I do in the meantime?

If you submitted the claim to the Medicare intermediary/carrier, and haven't received a response to your initial claim submission, don't automatically submit another claim. Rather, you should:

1. Review the automated resubmission cycle on your claim system;
2. Wait 30 days; and
3. Check claim status before resubmitting.

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and may cause confusion for the member.

Whom do I contact if I have questions?

If you have questions, submit an online inquiry via your preferred electronic vendor portal or call the BCBSIL PTC at 800-972-8088.

4.4 International Claims

The claim submission process for international Blue Plan members is the same as for domestic Blue members. You should submit the claim directly to BCBSIL. See *Section 3.3 for additional information on servicing international members, along with a note regarding members of the Canadian Blue Cross Plans.*

4.5 Coding

Code claims as you would for BCBSIL claims.

4.6 Ancillary Claims

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies and Specialty Pharmacy providers. File claims for these providers as follows:

- **Independent Clinical Laboratory (Lab)** – File claims with the Plan in whose state the specimen was drawn
- **Durable/Home Medical Equipment and Supplies (D/HME)** – File claims with Plan in whose state the equipment was shipped to or purchased at a retail store
- **Specialty Pharmacy** – File claims with the Plan in whose state the Ordering Physician is located

Please note:

- If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.
- Contiguous county claims filing rules do not apply to ancillary claims.

Provider Type	How to file (required fields)	Where to file	Example
<p>Independent Clinical Laboratory (any type of non-hospital based laboratory)</p> <p>Types of Service include, but are not limited to: blood, urine, samples, analysis, etc.</p>	<p>Referring Provider:</p> <ul style="list-style-type: none"> – Field 17B on the CMS-1500 Health Insurance Claim Form or – Loop 2310A (claim level) on the 837 professional (837P) electronic claim transaction 	<p>File the claim to the Plan in whose state the specimen was drawn*</p> <p><i>*Where the specimen was drawn will be determined by which state the referring provider is located.</i></p>	<p>Blood is drawn* in a lab or office setting located in [enter Plan x service area]. Blood analysis is done in [enter Plan y service area].</p> <p><i>File to: [enter Plan x service area].</i></p> <p><i>*Claims for the analysis of a lab must be filed to the Plan in whose state the specimen was drawn.</i></p>
<p>Durable/Home Medical Equipment and Supplies (D/HME)</p> <p>Types of Service include, but are not limited to: Hospital beds, oxygen tanks, crutches, etc.</p>	<p>Patient's Address:</p> <ul style="list-style-type: none"> – Field 5 on the CMS-1500 paper claim form or – Loop 2010CA on the 837P electronic claim transaction <p>Ordering Provider:</p> <ul style="list-style-type: none"> – Field 17B on the CMS-1500 paper claim form or – Loop 2420E (line level) on the 837P electronic claim transaction <p>Place of Service:</p> <ul style="list-style-type: none"> – Field 24B on the CMS-1500 paper claim form or – Loop 2300, CLM05-1 on the 837P electronic claim transaction <p>Service Facility Location Information:</p> <ul style="list-style-type: none"> – Field 32 on the CMS-1500 paper claim form or – Loop 2310C (claim level) on the 837P electronic claim transaction 	<p>File the claim to the Plan in whose state the equipment was shipped to or purchased in a retail store.</p>	<p>A. Wheelchair is purchased at a retail store in [enter Plan y service area].</p> <p><i>File to: [enter Plan y service area]</i></p> <p>B. Wheelchair is purchased on the Internet from an online retail supplier in [enter Plan x service area] and shipped to [enter Plan y service area].</p> <p><i>File to: [enter Plan y service area]</i></p> <p>C. Wheelchair is purchased at a retail store in [enter Plan x service area] and shipped to [enter Plan y service area].</p> <p><i>File to: [enter Plan y service area]</i></p>

Provider Type	How to file (required fields)	Where to file	Example
<p>Specialty Pharmacy</p> <p>Types of Service: Non-routine, biological therapeutics ordered by a health care professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.</p>	<p>Referring Provider:</p> <ul style="list-style-type: none"> - Field 17B on the CMS-1500 paper claim form or - Loop 2310A (claim level) on the 837P electronic claim transaction 	<p>File the claim to the Plan whose state the <i>Ordering Physician is located.</i></p>	<p>Patient is seen by a physician in [enter Plan x service area] who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in [enter Plan y service area] where the member lives for 6 months of the year.</p> <p><i>File to: [enter Plan x service area]</i></p>

- The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.
- Providers are encouraged to verify Member Eligibility and Benefits by contacting the phone number on the back of the Member ID card or call 800-676-BLUE, prior to providing any ancillary service.
- Providers who utilize outside vendors to provide services (e.g., sending blood specimen for special analysis that cannot be done by the Lab where the specimen was drawn) should utilize in-network participating Ancillary Providers to reduce the possibility of additional member liability for covered benefits. To locate in-network participating providers, utilize the BCBSIL Provider Finder® on the BCBSIL website at bcbsil.com/provider.
- Members are financially liable for ancillary services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
- If you have any questions about where to file your claim, send an email to BCBSIL at ancillarynetworks@bcbsil.com or call 312-653-4820.

4.7 Air Ambulance Claims

Claims for air ambulance services must be filed to the Blue Plan in whose service area the point of pickup ZIP code is located.

NOTE: If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

Service Rendered	How to file (required fields)	Where to file	Example
<p>Air Ambulance Services</p>	<p>Point of Pickup ZIP Code</p> <p>Populate item 23 on CMS-1500 Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup.</p> <ul style="list-style-type: none"> - For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional. <p>Where Form CMS-1450 (UB-04) is used for air ambulance services not included with local hospital charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual.</p> <ul style="list-style-type: none"> - Form Locators (FL) 39-41 - Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee. - Value: 5-digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance. - For electronic claims, populate the origin information (ZIP code of the point of pickup) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional. 	<p>File the claim to the Plan in whose service area the point of pickup ZIP code is located.*</p> <p><i>*BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.</i></p>	<ul style="list-style-type: none"> - If the point of pickup ZIP code is in Plan A service area; - The claim must be filed to Plan A, based on the point of pickup ZIP code.

- The air ambulance claims filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.
- Where possible, providers are encouraged to verify Member Eligibility and Benefits by contacting the phone number on the back of the Member ID card or calling 1-800-676-BLUE.
- Providers are encouraged to utilize in-network participating air ambulance providers to reduce the possibility of additional member liability for covered benefits. To locate in-network participating providers, utilize the BCBSIL Provider Finder on the BCBSIL website at bcbsil.com/provider.
- Members are financially liable for air ambulance services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
- Providers who wish to establish Trading Partner Agreements with other Plans should contact the other Plans directly for information.
- If you have any questions about where to file your claim, contact your assigned BCBSIL Provider network Consultant (PNC).

4.8 Contiguous Counties/Overlapping Service Areas

4.8.1 Contiguous Counties

Claims filing rules for contiguous area providers are based on the permitted terms of the provider contract, which may include:

- Provider Location (i.e., *In which Plan service area is the provider's office located?*)
- Provider contract with the two contiguous counties (i.e., *Is the provider contracted with only one or both service areas?*)
- The member's Home plan and where the member works and resides (i.e., *Is the member's Home Plan with one of the contiguous county's Plans?*)
- The location of where the services were received (i.e., *Does the member work and reside in one contiguous county and see a provider in another contiguous county?*)

NOTE: Contiguous Counties guidelines do not apply to Ancillary Claim Filing. Ancillary claims must be filed to the local Plan based on the type of ancillary service provided. (See Section 4.6, *Ancillary Claims for more information*).

4.8.2 Overlapping Service Areas

Submission of claims in Overlapping Service Areas is dependent on what Plan(s) the Provider contracts with in that state, the type of contract the provider has (e.g., PPO, Traditional) and the type of contract the member has with their Home Plan.

- If you contract with all local Blue Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area Blue Plan member's claim with either Plan.
- If you have a PPO contract with one Blue Plan, but a Traditional contract with another Blue Plan, file the out-of-area Blue Plan member's claim by product type.
 - For example, if it's a PPO member, file the claim with the Plan that has your PPO contract.
- If you contract with one Plan but not the other, file all out-of-area claims with your contracted Plan.

4.9 Medical Records

Medical Records

Blue Plans around the country have made improvements to the medical records process to make it more efficient. We now are able to send and receive medical records electronically among each other. This method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

Under what circumstances may the provider get requests for medical records for out-of-area members?

- *As part of the preauthorization process – If you receive requests for medical records from other Blue Plans prior to rendering services, as part of the preauthorization process, you will be instructed to submit the records directly to the member's Plan that requested them. This is the only circumstance where you would not submit them to BCBSIL.*

- *As part of claim review and adjudication – These requests will come from BCBSIL in the form of a letter requesting specific medical records and including instructions for submission.*

BlueCard Medical Record Process for Claim Review

1. *An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.*
2. *A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact the BCBSIL PTC at 800-972-8088 to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.*
3. *If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact BCBSIL to determine if the records are needed from your office.*
4. *Upon receipt of the information, the claim will be reviewed to determine the benefits.*

Helpful Ways You Can Assist in Timely Processing of Medical Records

- *If the records are requested following submission of the claim, forward all requested medical records to BCBSIL.*
- *Follow the submission instructions given on the request, using the specified address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.*
- *Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by BCBSIL.*
- *Please submit the information to BCBSIL as soon as possible to avoid further delay.*
- *Only send the information specifically requested. Frequently, complete medical records are not necessary.*
- *Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.*

4.10 Adjustments

Contact BCBSIL if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different.

4.11 Appeals

Appeals for all claims are handled through BCBSIL. We will coordinate the appeal process with the member's Blue Plan, if needed.

4.12 Coordination of Benefits (COB) Claims

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If you discover the member is covered by more than one health plan, and:

- BCBSIL or any other Blue Plan is the primary payer, submit other carrier's name and address with the claim to BCBSIL. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.
- Other non-Blue health plan is primary and BCBSIL or any other Blue Plan is secondary, submit the claim to BCBSIL only after receiving payment from the primary payer, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the BCBSIL remittance advice as "patient liability" might be different from the actual amount the patient owes you, due to the combination of the primary insurer payment and your negotiated amount with BCBSIL.

For professional claims, if the member does not have other insurance, it is imperative to check either "YES" or "NO" on the electronic HIPAA 837 claim transaction or CMS-1500 paper claim form, in box 11D. Leaving the box unmarked can cause the member's Plan to stop the claim to investigate for COB.

Coordination of Benefits Questionnaire

To streamline our claims processing and reduce the number of denials related to Coordination of Benefits, Coordination of Benefits (COB) questionnaire is available to you in the Education and Reference/Forms section of our Provider website at bcbsil.com/provider under Member Information/Release Forms. This form will help you and your patients avoid potential claim issues.

When you provide service to any Blue Plan members and you are aware that they might have other health insurance coverage (e.g., Medicare, etc.), give a copy of the questionnaire to the member during their visit. Encourage all of your Blue Plan patients to complete the form and send it to the Blue Plan through which they are covered as soon as possible after leaving your office. Members will find the mailing address on the back of their member ID card, or by calling the customer service number listed on the back of the card. Collecting COB information from members before you file their claim eliminates the need to gather this information later, thereby reducing processing and payment delays.

4.13 Reimbursement for BlueCard Claims

BCBSIL will reimburse you according to the contract guidelines when:

- The member is eligible for benefits
- The services are covered under the member's plan*

The reimbursement for out-of-area members is the same as the fee schedule for local members. If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. If you do not receive your payment or a response regarding your payment within 30 days, please access your preferred online vendor portal to check the status of your claim.

**The member's plan determines what services are considered eligible under all medical policy determinations (e.g., medical necessity, investigational, routine, etc.).*

Claim Review for Illinois Contracting Providers

You may request a review by completing the Provider Review Form, which can be found in the Claims and Eligibility/Claim Review and Appeal section of our Provider website at bcbsil.com/provider. If you do not receive your payment or a response regarding payment, please contact our PTC at 800-972-8088.

Refunds and Overpayments

The Payment Recovery Program (PRP) allows BCBSIL to recoup overpayments made to BCBSIL contracting facilities and providers when payment errors have occurred. Overpayments may be identified by BCBSIL and/or the provider.

Electronic Refund Management (eRM) is an online refund management tool that features many practice enhancing components, which will help simplify overpayment reconciliation and related processes, and is available at no additional charge. For more information on eRM, visit the Claims and Eligibility/Refund Management section of our Provider website at bcbsil.com/provider.

4.14 Claim Status Inquiry

BCBSIL is your single point of contact for all claim inquiries. You can make claim status inquiries in the following manner:

- Electronically – send a HIPAA 276 transaction (claim status inquiry) to BCBSIL through your preferred online vendor portal.
- Electronic claim status transactions may be conducted almost continuously, with the exception of Sunday, 8 p.m. to midnight, CT.

4.15 Calls from Members and Others with Claim Questions

If members contact you, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

The member's Plan should not contact you directly regarding claims issues, but if the member's Plan contacts you and asks you to submit the claim to them, refer them to BCBSIL.

4.16 Value Based Provider Arrangements

Plans have value based care delivery arrangements in place with their providers. Each Plan has created their own arrangement with their provider(s), including reimbursement arrangements. Due to the unique nature of each Plan/provider arrangement, there is no common provider education template for value based care delivery arrangements that can be created and distributed for use by all Plans.

4.17 Key Contacts

Resources for Illinois Contracting Providers:

- BCBSIL Provider Services: 800-972-8088
- BCBSIL Provider Website: bcbsil.com/provider
- Electronic Commerce Vendor
 - Availity: availity.com, 800-AVAILITY (282-4548)
- BCBSIL Provider Network Consultants (**NOTE:** For Provider Network Consultant Assignments, visit the [Education and Reference Center](http://bcbsil.com/provider) on our website at bcbsil.com/provider)

Resources for All Providers:

- BlueCard Eligibility: 800-676-BLUE (2583)
- BlueCard Access: 800-810-BLUE (2583)*
- BlueCard Doctor & Hospital Finder Website: bcbs.com

**For BlueCard members to find a provider*

5. Frequently Asked Questions

5.1 BlueCard Basics

1. What is the BlueCard Program?

BlueCard is a national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you conveniently submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Your local Blue Plan is your sole contact for claims payment, adjustments and issue resolution.

2. What products are included in the BlueCard Program?

The following products/claims are included in the BlueCard Program:

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization)
- POS (Point of Service)
- HMO (Health Maintenance Organization)
- Medigap
- Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards also do not have a suitcase logo.
- SCHIP (State Children's Health Insurance Plan) if administered as part of Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards also do not have a suitcase logo. Stand-alone SCHIP programs will have a suitcase logo.
- Stand-alone vision
- Stand-alone prescription drugs

NOTE: Stand-alone vision and stand-alone self-administered prescription drugs programs are eligible to be processed thru BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.

3. What products are excluded from the BlueCard Program?

The following products/claims are excluded from the BlueCard Program:

- Stand-alone dental
- Medicare Advantage*
- The Federal Employee Program (FEP)

Please follow BCBSIL billing guidelines.

**Medicare Advantage is a separate program from BlueCard, however since you might be seeing members of other Blue Plans who have Medicare Advantage coverage, we have included a section on Medicare Advantage claims processing in this manual.*

4. What is the BlueCard Traditional Program?

It is a national program that offers members traveling or living outside of their Blue Plan's area traditional or indemnity level of benefits when they obtain services from a physician or hospital outside of their Blue Plan's service area.

5. What is the BlueCard PPO Program?

It is a national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

6. What is the BlueCard Managed Care/POS Program?

The Managed Care/POS program allows members traveling or living outside of their BCBS Plan's area to seek services from a BlueCard PPO provider. You can recognize Managed Care/POS members who are enrolled in out-of-area networks through the member identification card as you do for all other BlueCard members. The Identification cards will include:

- The three-character prefix at the beginning of the member's ID number
- A local network identifier, for example, BlueMark
- The empty suitcase logo

7. Can Managed Care/HMO members receive services through the BlueCard Program?

Yes, occasionally, Blue HMO members affiliated with other Blue Plans will seek care at your office or facility. You should handle claims for these members the same way as you do for BCBSIL members and Blue traditional, PPO, and POS patients from other Blue Plans by submitting them to BCBSIL.

5.2 Identifying Members and ID Cards

1. How do I identify members?

When members from Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifier for out-of-area members is the prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
- Empty suitcase logo, for eligible Manage Care/POS, Traditional and Managed Care/HMO members

2. What is a "prefix?"

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

3. What do I do if a member has an identification card without a prefix?

Some members may carry outdated identification cards that may not have a prefix. Please request a current ID card from the member.

4. How do I identify BlueCard Managed Care/POS members?

You can recognize Managed Care/POS members who are enrolled in out-of-area networks through the member identification card as you do for all other BlueCard members. The Identification cards will include:

- The three-character prefix at the beginning of the member's ID number
- A local network identifier, (for example, BlueMark)
- The empty suitcase logo

5. How do I identify Medicare Advantage members?

Members will not have a standard Medicare card; instead, a Blue logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

<p>Member ID cards for Medicare Advantage products will display one of the benefit product logos shown here:</p>		Health Maintenance Organization
		Medical Savings Account
		Private Fee-For-Service
		Point of Service
		Network Sharing Preferred Provider Organization

When these logos are displayed on the front of a member's ID card, it indicates the coverage type the member has in his/her Blue Plan service area or region. However, when the member receives services outside his/her Blue Plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

BCBSIL participates in Medicare Advantage PPO Network Sharing arrangements, and contracted provider reimbursement is based on the contracted rate with BCBSIL. Non-contracted provider reimbursement is the Medicare allowed amount based on where services are rendered.

Tip: While all MA PPO members have suitcases on their ID cards, some have limited benefits outside of their primary carrier's service area. Providers should refer to the back the member's ID card for language indicating such restrictions apply.

6. How do I identify international members?

Occasionally, you may see identification cards from members residing abroad or foreign Blue Plan members. These ID cards also will contain three-character prefixes. Please treat these members the same as domestic Blue Plan members.

7. What do I do if a member does not have an ID card?

- Obtain as much information as possible from the Blue Plan member, i.e., subscriber name and address, DOB and name of BCBS Plan
- Call (800) 676-BLUE (2583) and wait to be prompted to speak with a service representative
- If your office is not able to confirm member eligibility, follow your standard office procedures for servicing
- You can bill members without proof of insurance or verification.

5.3 Verifying Eligibility and Coverage

1. How do I verify membership and coverage?

For BCBSIL members, check eligibility and benefits electronically via Availity or your preferred web vendor. Or call the BCBSIL Provider Services at 800-972-8088 to use our automated self-service phone system.

For other Blue Plan members, contact BCBSIL electronically or BlueCard Eligibility by phone to verify the patient's eligibility and coverage:

- Electronic – Submit a HIPAA 270 transaction (eligibility) to BCBSIL via Availity or your preferred electronic web vendor.
- Phone – Call BlueCard Eligibility at 800-676-BLUE (2583)

5.4 Utilization Review

1. How do I obtain utilization review?

You should remind patients that they are responsible for obtaining pre-certification/preauthorization from their Blue Plan for health care services. Effective July 1, 2014, participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility). *See Section 3.7, Utilization Review.*

You may also contact the member's Plan on the member's behalf. You can do so by:

For BCBSIL members, contact the BCBSIL PTC at 800-972-8088.

For out-of-area Blue Plans members,

- Electronic – Submit a HIPAA 278 transaction (referral/authorization) to BCBSIL.
- Phone – Call the utilization management/pre-certification number on the back of the member's card. If the utilization management number is not listed on the back of the member's card, call BlueCard Eligibility at 800-676-BLUE (2583) and ask to be transferred to the utilization review area.

See Section 3.8, Electronic Provider Access, for additional information.

5.5 Claims

1. Where and how do I submit claims?

You should always submit claims to BCBSIL electronically to help expedite processing.

Paper claims may be mailed to:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

NOTE: Be sure to include the member's complete identification number when you submit the claim, including the three-character prefix. Incorrect or missing prefixes and member identification numbers delay claim processing.

Claim Filing Exceptions:

Refer to Section 4, Claim Filing for information on Ancillary Claims, Air Ambulance Claims and Contiguous Counties/Overlapping Service Areas.

2. How do I submit international claims?

The claim submission process for international Blue Plan members is the same for domestic Blue Plan members. You should submit the claim directly to BCBSIL.

3. How do I handle COB claims?

When a member has coverage from two or more sources, the member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

BCBS Plans will coordinate benefits when a member has coverage from two or more carriers.

If you discover that the member is covered by more than one health plan, and:

- a. Another BCBS Plan is the primary payer:
 - o Submit the other carrier's name and address with the claim to the Illinois Plan
 - o If COB information is not included, the member's BCBS Plan will have to investigate the claim. Additional information may be requested, which can result in payment delay.
- b. A non-Blue health plan is primary and another BCBS Plan is secondary:
 - o Submit the claim to the Illinois Plan only after receiving payment from the primary payer, including the explanation of payment from the primary carrier
 - o If you do not include the COB information with the claim, the member's BCBS Plan will have to investigate the claim. Additional information may be requested, which can result in payment delay.

4. How do I handle traditional Medicare-related claims?

- When Medicare is primary payer, submit claims to your local Medicare intermediary.
- All Blue claims are set up to automatically cross over to the member's Blue Plan after being adjudicated by the Medicare intermediary.

5. How do I submit Medicare primary/Blue Plan secondary claims?

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from BCBSIL. Check the member's ID card for additional verification.
- Be certain to include the prefix as part of the member identification number. The member's ID will include the prefix in the first three positions. The prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to BCBSIL.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to BCBSIL with the Medicare remittance advice.
- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.

5.6 Contacts

1. Whom do I contact with claims questions?

Submit an electronic inquiry via your preferred online vendor portal or call the BCBSIL PTC at 800-972-8088.

For more information on electronic options, including online vendor portals, visit the Claims and Eligibility/Electronic Commerce section of the BCBSIL Provider website at bcbsil.com/provider.

2. How do I handle calls from members and others with claims questions?

If members contact you, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number. A member's Plan should not contact you directly, unless you filed a paper claim directly with that Plan. If the member's Plan contacts you to send it another copy of the member's claim, refer the Plan to BCBSIL.

3. Where can I find more information?

To learn more about BCBSIL programs, initiatives, learning opportunities and related resources such as the *Blue Review* provider newsletter, visit the BCBSIL Provider website at bcbsil.com/provider. Your assigned Provider Network Consultant can also offer personalized assistance. For more information, refer to the Provider Network Consultant page in our online [Education and Reference Center](#).

6. Glossary of BlueCard Program Terms

Administrative Services Only (ASO)

ASO accounts are self-funded, where the local plan administers claims on behalf of the account, but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits or timely filing limitations.

BCBSIL receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.

bcbs.com

Blue Cross and Blue Shield Association's website, which contains useful information for providers.

BlueCard Access 800-810-BLUE (2583)

A toll-free 800 number for you and members to use to locate healthcare providers in another Blue Plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

BlueCard Eligibility 800-676-BLUE (2583)

A toll-free 800 number for you to verify membership and coverage information, and obtain pre-certification on patients from other Blue Plans.

BlueCard PPO

A national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard PPO Member

Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.



[BlueCard Doctor & Hospital Finder Website](http://www.bcbs.com/healthtravel/finder.html)

This is a website you can use to locate health care providers in another Blue Plan's area: <http://www.bcbs.com/healthtravel/finder.html>. This is useful when you need to refer the patient to a physician or health care facility in another location. If you find that any information about you, as a provider, is incorrect on the website, please contact BCBSIL.

BlueCard Worldwide

A medical assistance program that provides Blue members traveling or living outside the United States, Puerto Rico and U. S. Virgin Islands with access to doctors and hospitals around the world.

Consumer Directed Health Care/Health Plan (CDHC/CDHP)

Consumer Directed Health Care (CDHC) is a broad umbrella term that refers to a movement in the health care industry to empower members, reduce employer costs, and change consumer health care purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate health care decision through the use of member support tools, provider and network information, and financial incentives.

Coinsurance

A provision in a member's coverage that limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional costs out-of-pocket.

Coordination of Benefits (COB)

Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Copayment

A specified charge that a member incurs for a specified service at the time the service is rendered.

Deductible

A flat amount the member incurs before the insurer will make any benefit payments.

EPO

An Exclusive Provider Organization or EPO is a health benefits program in which the Member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

FEP

The Federal Employee Program.

Hold Harmless

An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed on with a Blue Plan as full payment for these services.

Medicaid

A program designed to assist low-income families in providing health care for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women. Medicaid is governed by overall federal guidelines in terms of eligibility, procedures, payment level etc.; however states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

Medicare Advantage

Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as traditional Medicare.

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

Medicare Crossover

The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payer with Medicare's supplemental insurance company.

Medicare Supplemental (Medigap)

Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the "gaps" in original Medicare Plan coverage. Medigap policies help pay some of the health care costs that the original Medicare Plan doesn't cover.

Medigap policies are regulated under federal and state laws and are "standardized." There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member's Home Plan via Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under CMS. Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.

National Account

An employer group with employee and/or retiree locations in more than one Blue Plan's Service Area.

Other Party Liability (OPL)

Cost containment programs that ensure that Blue Plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers' Compensation, subrogation, and no-fault auto insurance.

Plan

Refers to any Blue Plan.

POS

Point of Service or POS is a health benefit program in which the highest level of benefits is received when the member obtains services from his/her primary care provider/group and/or complies with referral authorization requirements for care. Benefits are still provided when the member obtains care from any eligible provider without referral authorization, according to the terms of the contract.

PPO

Preferred Provider Organization or PPO is a health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.

PPOB

A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers, where they are available.

Prefix

Three characters preceding the subscriber identification number on the Blue Plan ID cards. The prefix identifies the member's Blue Plan or National Account and is required for routing claims.

State Children's Health Insurance Program (SCHIP)

SCHIP is a public program administered by the [United States Department of Health and Human Services](#) that provides [matching funds](#) to states for [health insurance](#) to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for [Medicaid](#). States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, [pregnant](#) women, and other adults.

Traditional Coverage

Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost-sharing features, such as deductibles, coinsurance or copayments.

7. BlueCard Program Quick Tips

The BlueCard Program provides a valuable service that lets you file all claims for members from other Blue Plans with your local Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character prefix that precedes the member's ID number on the ID card.
- Submit an electronic HIPAA 270 transaction (eligibility) to BCBSIL or call BlueCard Eligibility at 800-676-BLUE (2583) to verify the patient's membership and coverage.
- Submit the claim electronically to BCBSIL to help expedite the claims process. Always include the patient's complete identification number, which includes the three-character prefix.
- For claims inquiries, submit an electronic inquiry via your preferred online vendor portal or call the BCBSIL PTC at 800-972-8088.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized 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. If you have any questions, please call the number on the member's ID card.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

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