



BlueCross BlueShield  
of Texas

## Federal Employee Program: Overview

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### Introduction

Blue Cross and Blue Shield Service Benefit Plan is the official name of coverage offered to federal employees and annuitants by participating Blue Cross and Blue Shield Plans. This plan is commonly referred to as the Federal Employee Program, or FEP. In the state of Texas, the Federal Employee Program is the network name of the Preferred Provider Organization (PPO) for federal employees.

FEP benefits may be redefined annually as determined by the Office of Personnel Management in Washington, D.C.

The Federal Employee Program network became effective on Jan. 1, 1993.

**BlueChoice network professionals are automatically included in the Federal Employee Program network.**

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### No PCP or Referrals

Subscribers of the Service Benefit Plan do not choose a primary care physician, and referrals are not required; however, a federal employee or dependent must seek care from a participating BlueChoice provider or facility in order to receive the highest level of benefits. Otherwise, if care is rendered by a nonparticipating BlueChoice provider or facility, out-of-network benefits will apply.

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### In this Section

This section covers the following Federal Employee Program topics.

Report Title	Page
Federal ID Card	H - 2
Federal Provider Customer Service	H - 3
Provider Claim Summary for the CMS 1500 (08/05)	H - 4
Provider Claim Summary for the UB-04	H - 6
Federal Precertification Requirements	H - 10
Federal Claims Filing Inquiries	H - 11
Federal Pharmacy Programs	H - 12
FEP Notes	H - 13

# Federal ID Card

## Enrollment Codes

Any federal subscriber carrying a current federal ID card is eligible to receive the Federal Preferred Provider Organization benefits.

The federal ID card is quite different from BlueChoice® ID cards. The following is a key to the Service Benefit Plan enrollment codes that appear on the federal ID card.

Enrollment Code	Benefits For	Benefit Option
104	Self Only	Standard
105	Self and Family	Standard
111	Self Only	Basic
112	Self and Family	Basic

## Option Defined

Standard Option and Basic Option indicate types of service covered and how much is payable.

## Example of the ID Card

Below is an example of the ID card for the Federal Employee Program.



- Federal Employee Program of Texas.
- No referral required.
- Physician outpatient surgery, including lab, X-ray, and machine diagnostic tests are subject to a \$300 Standard Option calendar year deductible; no deductible is required under Basic Option. Basic Option only applies if a Preferred (PPO) provider is used. (Basic Option only applies if a Preferred (PPO) provider is used.
- Eligible services payable at 85 percent with a 15 percent patient coinsurance responsibility for Standard Option.



# Federal Provider Customer Service

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## Capabilities

BCBSTX provides a dedicated Federal Provider Customer Service staff. The Customer Service representatives have access to federal subscriber information to give prompt inquiry response to:

- Benefits and subscriber eligibility
- Claims
- Current Federal Employee Program network information
- Formal and informal complaint procedures

The automated phone system also provides information for:

- Benefits
  - Eligibility
  - Claims Payment
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## Telephone Numbers and Hours

You may reach the BCBSTX Federal Provider Customer Service by calling:

**Toll-free 1-800-442-4607**

Hours: 9 a.m. to 5 p.m. (CT), Monday through Friday.

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## Mailing Address

Federal Provider Customer Service may also be contacted in writing at the following address:

**FEP Provider Customer Service  
P.O. Box 660044  
Dallas, TX 75266-0044**

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## Provider Claim Summary

FEP provides a Provider Claims Summary (PCS) form for physicians/providers (samples follow).

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**Sample of PCS Form for Physicians — Front**



**BlueCross BlueShield  
of Texas**

A Member of the Blue Cross and  
Blue Shield Association,  
An Association of Independent  
Blue Cross and Blue Shield Plans  
P.O. Box 660129  
Dallas, Texas 75266-0129

**DATE:** 05/27/97 **1**  
**PROVIDER NUMBER:** 0000123456 **2**  
**CHECK NUMBER:** 12345678 **3**  
**TAX IDENTIFICATION NUMBER:** 123456789 **4**

**PROVIDER CLAIM SUMMARY**

**5** JOHNATHAN H DOE MD  
ANESTHESIA GROUP  
1313 MOCKINGBIRD LANE  
SOMEWHERE TX 12345-6789



ANY MESSAGES WILL APPEAR ON PAGE 1

**6** PATIENT: JANE SMITH  
**7** PERF PRV: 000000000000000123456  
**8** CLAIM NO: 0000123456789999C  
**9** IDENTIFICATION NO: FEPTX-R12345678  
**10** PATIENT NO: 1234567890

<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>
DATE	TS*	PS**	AMOUNT BILLED	PROVIDER ADJUSTMENT	OVER MAX ALLOW	DEDUCTIONS/OTHER INELIGIBLE	SERVICES NOT COVERED	AMOUNT PAID
03/01/97	006	03	10.00	0.00	0.00	10.00 ( 1)	0.00	0.00
			10.00	0.00	0.00	10.00	0.00	0.00

**20** AMOUNT PAID TO PROVIDER FOR THIS CLAIM: \$0.00

\*\*\*DEDUCTIONS/OTHER INELIGIBLE\*\*\*

**21** CONTRACT DEDUCTIBLE: 10.00  
**22** DEDUCTIONS/OTHER INELIGIBLE: \$10.00  
**23** TOTAL SERVICES NOT COVERED: + 0.00  
**24** PATIENT'S SHARE: \$10.00

<b>25</b> AMOUNT BILLED:	\$10.00	PROVIDER ADJUSTMENT:	\$0.00
AMOUNT PAID TO PROVIDER:	\$0.00	AMOUNT OF SERVICES NOT COVERED:	\$10.00
AMOUNT PAID TO SUBSCRIBER:	\$0.00	AMOUNT PREVIOUSLY PAID:	\$0.00
NUMBER OF CLAIMS:	1	AMOUNT OVER MAXIMUM ALLOWANCE:	\$0.00

**26** \*TYPE OF SERVICE (TS) | **27** \*\*PLACE OF SERVICE (PS)  
006. MEDICAL | 03. PHYSICIAN'S OFFICE

**28**

MESSAGES:

( 1). A CONTRACT DEDUCTIBLE HAS BEEN TAKEN

SAMPLE

We  
the  
claim

## Sample of PCS Form for Physicians — Back

form with a sample copy on the reverse side of this explanation.

### ***PPO Provider Claim Summary Field Explanations***

<b>1</b>	Date	Date of summary.
<b>2</b>	Provider or Group Number	The BCBSTX assigned provider number.
<b>3</b>	Check Number	The number assigned to the check for this summary.
<b>4</b>	Tax Identification Number	The number that identifies your taxable income.
<b>5</b>	Provider or Group Name & Address	The provider/group who rendered the services and billing address.
<b>6</b>	Patient	The name of the individual who received the service.
<b>7</b>	Performing Provider Number	In a clinic/group practice, the actual performing provider number.
<b>8</b>	Claim Number	The BCBSTX number assigned to the claim.
<b>9</b>	Identification Number	The number that identifies the group and member insured by BCBSTX.
<b>10</b>	Patient Number	The patient's account number assigned by the provider.
<b>11</b>	Service Date(s)	The date(s) of service(s) rendered.
<b>12</b>	TS	Type of service.
<b>13</b>	PS	Place of service.
<b>14</b>	Amount Billed	The amount billed for each procedure/service.
<b>15</b>	Provider Adjustment	Not applicable on professional claims.
<b>16</b>	Over Max Allow	The amount exceeding the schedule of maximum allowances for the Plan. The patient is not responsible for this amount. This is the provider's write-off.
<b>17</b>	Deductions/Other Ineligible	Policy deductions, copayment and coinsurance amounts.
<b>18</b>	Services Not Covered	Noncovered services according to the member's contract.
<b>19</b>	Amount Paid	The amount paid for each procedure/service.
<b>20</b>	Amount Paid to Provider for this Claim	The amount BCBSTX paid to the provider for this claim.
<b>21</b>	Contract Deductible	The deductible amount applied to this claim (patient's responsibility).
<b>22</b>	Deductions/Other Ineligible	Same as field 17.
<b>23</b>	Total Services Not Covered	Same as field 18.
<b>24</b>	Patient's Share	Amount patient pays. Providers may bill this amount to the patient.
<b>25</b>	Claim Summary Section	Totals for claim(s) processed on this summary.
<b>26</b>	Type of Service (TS)	The description for the type of service code used in field 12.
<b>27</b>	Place of Service (PS)	The description for the place of service code used in field 13.
<b>28</b>	Messages	The description for messages relating to: Noncovered services / Policy deductions / Contract reductions

# Provider Claim Summary for the UB-04



**BlueCross BlueShield  
of Texas**

A Member of the Blue Cross and  
Blue Shield Association,  
An Association of Independent  
Blue Cross and Blue Shield Plans

P.O. Box 660044  
Dallas, Texas 75266-0044  
Toll Free (800) 451-0287

**PROVIDER CLAIM SUMMARY**

	DATE:	02/10/05	<b>1</b>
	PROVIDER NUMBER:	0000HH1234	<b>2</b>
	CHECK NUMBER:	12345678	<b>3</b>
TAX IDENTIFICATION NUMBER:		123156769	<b>4</b>

**5** COUNTY MEDICAL CENTER  
P. O. BOX 123456  
YOUR CITY, TX. 12345-1234

**ANY MESSAGES WILL BEGIN ON PAGE 1**

**\*\*\*\*\* INPATIENT**

PATIENT: HORMAN DOE	PATIENT NO: 123456789	ADMIT DATE	FROM DATE	END DATE
CLAIM NO: 0000123456789000X	CLAIM TYPE:	01/30/05	01/30/05	01/31/05
GROUP-SUB NO: FEPTX-12345678	HPI: D	DRG		

DAYS /TRT	DRG CODE	PROVIDER CHARGE	OTHER / WITHHOLD	PAYABLE ALLOWABLE	FACILITY	ADJUSTED PROV. CHARGE	MANAGED CARE DEDUCTION(S)	TOTAL AMOUNT PAID
001	294	\$10,816.00	\$8,022.01-	\$2,795.99		\$2,795.99	\$500.00	\$2,195.99

MESSAGES/REASONS: OE , OH , DRG

\*\*\* DEDUCTIONS/OTHER INELIGIBLE \*\*\*

CONTRACT DEDUCTIBLE/COPAY:	\$100.00
MANAGED CARE DEDUCTION(S):	\$500.00
TOTAL DEDUCTIONS/OTHER INELIGIBLE:	\$600.00
PATIENT'S SHARE:	\$600.00

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PROVIDER CLAIMS AMOUNT SUMMARY

NUMBER OF CLAIMS: 1	AMOUNT PAID: \$2,195.99
PROVIDER CHARGES: \$10,618.00	RECOUPMENT AMOUNT: \$0.00
ADJUSTED PROVIDER CHARGES: \$2,795.99	NET AMOUNT AMOUNT: \$2,195.99
PATIENT'S SHARE: \$600.00	

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CLAIM TYPE

MESSAGES/REASONS:

- (OE ). A CONTRACT DEDUCT I BLE/COPAY HAS BEEN TAKEN.
- (OH ). PROGRAM REQUIREMENTS AS IDENTIFIED BY THE MEMBER'S CONTRACT HAVE NOT BEEN FULFILLED. THIS IS THE PATIENT'S LIABILITY.
- (DRG). THE PAYMENT ON THIS CLAIM HAS BEEN PROCESSED ACCORDING TO THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990. THE PAYMENT PROVIDED IS THE SAME AS THE PAYMENT YOU WOULD HAVE RECEIVED HAD THE PATIENT BEEN ENROLLED IN MEDICARE PART A. THE PAYMENT IS BASED ON THE MEDICARE DRG PRICE. THE SUBSCRIBER IS NOT RESPONSIBLE FOR THE DIFFERENCE.

## Provider Claim Summary for the UB-04, Continued

**Fields  
1-9**

The Provider Claim Summary (PCS) is a notification statement sent to contracting providers with Blue Cross and Blue Shield of Texas (BCBSTX) after a claim has been processed. The following table explains fields 1 through 9 on this report:

Field Number	Field Name	Information Provided
1	Date	Date the summary was finalized.
2	NPI Number	The NPI Number.
3	Check Number	Number assigned to the check for this summary.
4	Tax Identification Number	Number which identifies provider's taxable income.
5	Provider or Group Name & Address	The provider/group address where the services were rendered.
6	Patient	Name of the individual who received the service.
7	Claim Number	The Blue Cross number assigned to the claim.
8	Group-Sub Number	Number that identifies the employer group and member.
9	Patient Number	The patient's account number assigned by the provider.

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## Provider Claim Summary for the UB-04, Continued

### Fields 10-19

The following table explains fields 10 through 19 on this report:

Field Number	Field Name	Information Provided
10	Claim Type	Code for type of claim (benefit plan) – see field 27.
11	HPI Indicator	Blue Cross payment method for this claim. <b><u>IND</u></b> <b><u>DESCRIPTION</u></b> D        DRG B        Outpatient DRG Cap W        Withhold/Discount R        Case Rate E        % of charge w/cap F        Fee Schedule P        Per Diem N        Negotiated C        Inpatient Case Rate
12	Admit Date	Date of admission.
13	From Date	Beginning and ending dates of services rendered.
14	End Date	
15	Days/Treatment	Number of days/treatment.
16	DRG Code	DRG code for this type of service.
17	Provider Charge	Total amount of billed charges.
18	Other Payable/Withhold	Other payable amounts, such as discounts or withholds, that affect the adjusted provider charges.
19	Facility Allowable	The provider's allowed amount according to the negotiated contract.

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## Provider Claim Summary for the UB-04, Continued

**Fields  
20-29**

The following table explains fields 20 through 29 on this report:

Field Number	Field Name	Information Provided
20	Adjusted Provider Charges	The allowed amount including other payable or withhold.
21	Managed Care Deduction(s)	Managed care deductions including penalties, copayments and coinsurance amounts.
22	Total Amount Paid	The amount paid to the provider for this service.
23	Contract Coinsurance	The coinsurance/deductible amount applied to this claim.
24	Total Deductions/Other Ineligible	Total deductions and other ineligible amounts.
25	Patient's Share	Amount patient pays. Providers may bill this amount to the patient.
26	Provider Claims Amount Summary	Total for claim(s) processed on this summary.
27	Claim Type	The description for the type of claim in field 10. <b>Code      Definition</b> Blank    Traditional/Indemnity M        Managed Care S        Coordination of Benefits T        Managed Care w/Coordination of Benefits
28	Messages/Reasons (appears on last page of PCS)	The description for messages relating to: •Non-covered services •Program deductions •PPO reductions
29	Messages/Reasons Description	

# Federal Precertification Requirements

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## **Inpatient Precertification**

All inpatient hospital admissions with the exception of maternity admissions for routine deliveries must be precertified. This includes Behavioral Health (Mental Health/Substance Abuse) admissions. If the patient's medical condition requires a stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean delivery, the maternity admission must be certified for the additional days.

**Note:** Your FEP patient will have a \$500 reduction in benefits if inpatient admissions are not precertified.

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## **Outpatient Precertification**

Precertification for FEP subscribers is required for the following outpatient care and services:

- Outpatient Surgical Services (Call 1-800-442-4607)
  - Home Hospice Care (Call 1-800-442-4607)
  - Outpatient Mental Health and Substance Abuse Treatment (Call 1-800-528-7264)
  - Organ/Tissue Transplants (Call 1-800-442-4607)
  - Clinical Trials for Certain Organ/Tissue Transplants (Call 1-800-225-2268 for more information)
  - Prescription Drugs – Certain prescriptions require prior approval (Call 1-800-624-5060 to request prior approval)
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## **Telephone Numbers**

To obtain inpatient precertification (**excluding behavioral health**) or outpatient precertification, call:

**1-800-443-2744**

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### **Standard Option**

## **Mental Health/ Substance Abuse Precertification**

If your patient enrolled in Standard Option, the highest level of coverage for inpatient mental health care may be obtained when treatment is received in Preferred mental health facilities. Your patients must contact the local Plan for certification before receiving inpatient treatment. To receive certification, call:

**Call Magellan Behavioral Health at 1-800-528-7264.**

### **Basic Option**

If your patient enrolled in Basic Option, benefits are provided only when treatment is received from a Preferred mental health provider. Your patients must receive certification before receiving any services. To receive certification, call:

**Call Magellan Behavioral Health at 1-800-528-7264.**

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## **Outpatient Mental Health/ Substance Abuse Information**

### **Standard and Basic Options**

Outpatient mental health and substance abuse services require prior approval by calling 1-800-528-7264 before receiving any services.

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## Federal Claims Filing Inquiries

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**Telephone  
Numbers  
and Address**

For federal claims inquiries, contact BCBSTX Federal Provider Customer Service by calling:

**Toll-free 1-800-442-4607**

Address written claims inquiries to:

**BCBSTX  
FEP Customer Service  
P.O. Box 66044  
Dallas, TX 75266-0044**

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# Federal Pharmacy Programs

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## **Telephone Numbers for Information**

Some prescription drugs require prior approval through the Retail Pharmacy Program for federal subscribers. To assist the subscriber with the prior approval process or if you need information about the federal pharmacy programs, please call the following toll-free numbers:

### **Retail Pharmacy Program Customer Service**

1-800-624-5060

### **Mail Order Prescription Program**

1-800-262-7890

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# FEP Notes

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## Blue Health Connection

Physicians and subscribers benefit from Blue Health Connection.

Blue Health Connection is a toll-free service that provides 24-hour health care information available to Blue Cross and Blue Shield of Texas Federal Employee Program (FEP) subscribers. The service enables subscribers to make informed, appropriate health care decisions. Subscribers can call the Blue Health Connection Audio Health Library®1 at **1-888-BLUE-432** and get prerecorded information and literature on more than 450 health topics.

Additionally, FEP subscribers can speak to experienced, specially trained nurses who can help answer their health care questions. Using nondiagnostic, symptom-based assessment guidelines, the nurses help subscribers identify appropriate sources and time frames for care.

With Blue Health Connection, network physicians may benefit through a reduction of after-hour and inappropriate phone calls. We also expect Blue Health Connection to help reduce unnecessary hospital emergency visits. Subscribers will receive supportive information, in addition to that given by their physician.

**Please Note:** Blue Health Connection should only be used by FEP subscribers. However, preferred physicians are offered one courtesy call to be used as a demonstration. Preferred physicians should identify themselves, so they will not be included in the utilization data for the program.

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1 Blue Health Connection is the name used by Blue Cross and Blue Shield Federal Employee Program for Personal Health Advisor.

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