# Provider Roles and Responsibilities: Overview

**Updated May 5, 2015**

In this section, we cover the Roles and Responsibilities of providers. The following topics are included:

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### Identification Card Samples

**Introduction**

The subscriber’s identification card (ID card) provides information concerning eligibility and contract benefits, and is essential for successful claims filing. The alpha prefix is a critical part of the ID number and identifies what group benefits apply or which Blue Cross and Blue Shield plan is responsible for payment. When submitting a claim the alpha prefix should always be entered as it appears on the ID card. If the correct alpha prefix is not provided, the claim may be unnecessarily delayed or denied.

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**Using the ID Cards**

Each subscriber receives an identification card (ID card) upon enrollment. Refer to the samples shown on the following page. This card is issued for identification purposes only and does not constitute proof of eligibility. Facility and Ancillary Providers should check to make sure the current group number is included in the subscriber’s records.

To assist in ensuring that your office always has the most current information for your Blue Cross and Blue Shield of Texas subscribers, it is recommended that you copy the subscriber’s ID card (front and back) for your files at each visit.

The ID card must be presented by the subscriber each time services are rendered. The ID card will indicate the following information:

- The subscriber’s identification number
- The employer group number (excluding the FEP group) through which coverage is obtained
- The current coverage effective date
- Plan number
- The name, NPI number, and telephone number of the Primary Care Physician (PCP) selected by the subscriber (if applicable)
- Some of the applicable copayments, i.e., PCP and/or Specialist visit, Emergency Room

The subscriber is required to report immediately to Blue Cross and Blue Shield of Texas (BCBSTX) Customer Service any loss or theft of his/her ID card. A new ID card will be issued. The subscriber is also required to notify BCBSTX within 30 days of any change in name or address. BCBSTX subscribers are also required to notify BCBSTX Customer Service regarding changes in marital status or eligible dependents.

The subscriber is not allowed to let any other person use his/her ID card for any purpose.

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**Other Information**

Much of the information you will need is printed on the face and reverse side of your patient’s ID card. Please note the copay amount is on the face of the card. Please call Provider Customer Service if you have questions.

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**Department of Insurance (DOI) Requirements**

The Texas Department of Insurance (TDI) requires carriers to identify members who are subject to the Texas Prompt Pay Legislation. The indicator of “TDI” will appear on the front (bottom center) of the ID cards when the group or member is subject to Texas Prompt Pay Legislation.

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Identification Card Samples

Traditional/Indemnity Subscriber ID Cards

The traditional ID cards will indicate the member’s prefix, subscriber ID number, their group number, and effective date of their coverage. They would never indicate PCP/SCP information, ER copays, etc. Prescription copays could be indicated. The prefix, including the subscriber ID #, and the group numbers are important information when filing your claims.

Example of a new Blue Choice PPO Fully Insured

BCA network value = PPO

Continued on next page
Complaint Procedure

Blue Choice PPO participating Facilities and Ancillary Providers are urged to contact Provider Customer Service when there is an administrative question, problem, or claims issue at 1-800-451-0287.

Provider Customer Service when there is an administrative question, problem, complaint or claims issue at 1-800-451-0287.

To appeal a Utilization Management medical necessity determination, contact the Utilization Management Department:

- Call 1-800-441-9188
- Hours: 6:00 am – 6:00 pm, CST, M-F and non-legal holidays and 9:00 am to 12:00 pm (noon) CST, Saturday, Sunday and legal holidays
- Messages may be left in a confidential voice mailbox after business hours

Utilization Management decisions may be formally appealed by phone, fax, or in writing. For review of denied claims, refer to Section F – Filing Claims in this Provider Manual.

A Blue Choice PPO participating Facility or Ancillary Provider may contact the Texas Department of Insurance (TDI) to obtain information on companies, coverage, rights or complaints at 1-800-252-3439 or the Facility or Ancillary Provider may write the Texas Department of Insurance (TDI) at the following address:

Texas Department of Insurance
P.O. Box 149091
Austin, Texas 78714-9091
Fax to 1-512-475-1771
Web site: tdi5state.tx.us
Eligibility

Eligibility Questions
Should a question arise regarding eligibility of a subscriber for services covered under BCBSTX (e.g., does not have an ID card at time of service), the BCBSTX participating Physician/Provider may contact BCBSTX Customer Service to check benefits, eligibility, and request verification, if applicable, by calling the appropriate number listed below. When the subscriber does not present an ID card, a copy of the enrollment application may be accepted. BCBSTX also recommends that the subscriber’s identification be verified with a photo ID and that a copy be retained for his/her file. Your first point of contact is your electronic connectivity vendor, i.e. Availity, RealMed or other connectivity vendor or call:

BCBSTX Provider Customer Service
1-800-451-0287

Federal Employee Program — FEP (all areas)
1-800-442-4607

*Note: For out-of-state Blues plan subscribers; you may check eligibility by calling 1-800-676-BLUE (2583). You must have the alpha prefix from the subscriber’s ID card in order to utilize this service.

EFT/ERA
Provider should use his/her best effort to participate with BCBSTX’s Plan’s Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA) under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment form.

Eligibility Statement
BCBSTX complies with the Eligibility Statement Legislation, Senate Bill 1149. For additional information on Senate Bill 1149, please refer to the Texas Department of Insurance (TDI) Web site at www.tdi.state.tx.us.

Premium Payments for Individual Plan
Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with Federal guidance, Blue Cross and Blue Shield of Texas will accept third-party payment for premium directly from the following entities:

(1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (2) Indian tribes, tribal organizations or urban Indian organizations; and
(3) state and federal Government programs.

BCBSTX may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the Covered Persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSTX directly for any or all of an enrollee’s premium.

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Claim Verification Procedure

Introduction

Under the Texas Prompt Pay Legislation, providers of service have the right to request verification that a particular service will be paid by the insurance carrier.

Verification, as defined by TDI, is a guarantee of payment for health care or medical care services if the services are rendered within the required time frame to the patient for whom the services are proposed.

Verification Procedure

To initiate a request for verification, please contact BCBSTX Provider Customer Service at 1-800-451-0287 and select the prompt for verification, or Providers may submit the request in writing.

Note: Please be advised that verification is not applicable for all enrollees or providers. Routine eligibility check and benefit information may still be obtained when verification is not applicable.

The verification process includes researching eligibility, benefits, and authorizations. BCBSTX will respond to the provider’s request with one of the following letters within the required time frames:

- Request for Additional Information
- Verification Notice
- Declination Notice

Declination

Insurance carriers have the right to decline verification to a provider of service. Declination, as defined by the TDI, is a response to a request for verification in which a preferred provider carrier does not issue a verification for proposed medical care of health care services. A declination is not a determination that a claim resulting from the proposed services will not ultimately be paid.

Some examples of reasons for declination may include, but are not limited to:

1) Policy or contract limitations:
   (A) premium payment time frames that prevent verifying eligibility for a 30-day period;
   (B) policy deductible, specific benefit limitations, or annual benefit maximum;
   (C) benefit exclusions;
   (D) no coverage or change in subscriber eligibility, including individuals not eligible, not yet effective, or subscribership cancelled; and
   (E) pre-existing condition limitations.

A declination is simply a decision that a guarantee cannot be issued in advance, not a determination that a claim will not be paid. Therefore, if a declination is given, providers cannot bill the subscriber at the time of service except for the applicable copayments, deductibles, or coinsurance amounts.
Requests for verification of services will be issued by BCBSTX only if the claim processing will be performed by BCBSTX. If your request is for a service covered under a capitated independent physician association (IPA), medical group, or other delegated entity responsible for claim payment, please make your request for verification directly to the appropriate IPA or entity.

The 13 required elements a provider needs to supply in order to initiate a verification are as follows:

1) patient name
2) patient ID number
3) patient date of birth
4) name of enrollee or subscriber
5) patient relationship to enrollee or subscriber
6) presumptive diagnosis, if known, otherwise presenting symptoms
7) description of proposed procedure(s) or procedure code(s)
8) place of service code where services will be provided, and, if place of service is other than provider’s office or provider’s location, name of hospital or facility where proposed service will be provided
9) proposed date of service
10) group number
11) if known to the provider, name and contact information of any other carrier, including
   a) other carrier’s name
   b) address
   c) telephone number
   d) name of enrollee
   e) plan or ID number
   f) group number (if applicable)
   g) group name (if applicable)
12) name of the provider providing the proposed services
13) provider’s federal tax ID number

Note: In addition to the required elements, please be prepared to provide a referral or precertification number for those services that require an authorization. Please also provide your office fax number for your written confirmation. This will expedite BCBSTX response.
Facility and Ancillary Medical Group Credentialing: Overview

Blue Cross and Blue Shield of Texas (BCBSTX) Facility Credentialing Program consists of a fully accredited NCQA MCO standard based program that requires the credentialing of hospital and ancillary providers requesting participation or continued participation in the BCBSTX Blue Choice PPO and HMO Blue Texas networks.

The program is designed with four (4) process modules that include, but are not limited to:

- Initial application or recredentialing data collection and contracting process
- Initial credentialing/recredentialing verification process
- Review by the BCBSTX Facility Provider Credentialing Committee
- Completion of any request of the BCBSTX Facility Provider Credentialing Committee decisions.

Credentialing criteria used in the BCBSTX credentialing program:
- Should be met as a prerequisite to acceptance for contracting in a Blue Choice PPO and/or HMO network;
- Are applied to applicants; and
- Are reviewed/revised at least annually and modified as necessary to meet the requirements of the PPO and/or HMO.

BCBSTX credentials all facility providers that contract to provide health care to PPO and/or HMO subscribers.

Reminder: The credentialing process is an intense and timely process that may require up to six (6) months to complete. Please distribute this information to any new associates that your organization may retain as part of your business structure.
Facility and Ancillary Medical Group Credentialing Overview, Continued

Core Provider Services (Core PS) has established a statewide Facility Provider Credentialing Committee (FPCC) through which BCBSTX shall conduct activities to include but not be limited to reviews for all facility provider applicants. The FPCC was implemented to provide a mechanism for comprehensive review of health care issues affecting subscribers of Blue Cross and Blue Shield of Texas and to facilitate committee management processes to oversee the review process. In the review of the credentialing and recredentialing process, the FPCC shall oversee the following:

- Performance of the credentialing of initial applicants;
- Performance of triennial recredentialing of providers, which includes a review of data from subscriber complaints, quality and utilization management reviews, and patient satisfaction surveys as applicable;
- Review of credentialing and recredentialing decisions made by delegated entities where the plan retains the right to accept or deny providers;
- Review and proposal of recommendations for the policies and procedures for the credentialing and recredentialing of facility providers;
- Provision of oversight of the approval and review of existing and delegated credentialing entities;
- Review and proposal of recommendations based on the performance of deleted credentialing entities; and
- Assessment and evaluation of utilization, quality of care, and service issues.

The Medical Director of BCBSTX shall conduct the proceedings and oversight of the FPCC. The FPCC subscribership shall include but not be limited to the following subscribers: the FPCC Medical Director of BCBSTX, a minimum of six subscribers which represent the network contracting areas with BCBSTX, Quality Improvement Programs (QIP), Utilization Management/Provider Services, and subscribers of the Institutional Provider Work Group. A representative from the BCBSTX Legal department will attend on an as needed basis as deemed by the FPCC. The number of committee subscribers above the minimum of six shall be at the discretion of the BCBSTX Medical Director, who shall appoint subscribers who are broadly representative for the provider network.

The FPCC meets at least monthly and performs ad hoc meetings as deemed necessary based upon business need.
BCBSTX has established a fair and equitable review process by which a facility provider may appeal an adverse decision regarding a credentialing/recredentialing decision on their continued participation in a Blue Choice PPO and/or HMO network. Providers must:

- Submit a written appeal and any supporting documentation or pertinent facts that the provider feels would be beneficial in the review process within 60 days of the receipt of the registered letter from BCBSTX. This letter will indicate that an adverse decision has been made regarding credentialing/recredentialing or continuation within a Blue Choice PPO and/or HMO network, and;
- Submit the appeal to the appropriate Network Management Representative in your respective service area.

Once the review request has been received by BCBSTX, your Network Management Representative will present the review with any and all supporting documentation to the FPCC for a determination. In the event the FPCC requires additional information, the FPCC will render the request to the FPN to secure the documentation and submit to the FPCC. Note: The FPCC recommendation is intended to assist the Medical Director in the provider’s determination for participation in the BCBSTX network(s). The FPCC role is advisory in nature only, and, as such, the recommendation of the committee is not binding.

Upon completion of the review process, the Network Management Representative will forward the final determination in writing to the provider within 60 days of the initial notification to the provider or the date of the request for additional information to present to the FPCC for review.
What is the BlueCard® Program?

Definition
The BlueCard Program is a national program that enables members obtaining healthcare services while traveling or living in another Blue Cross Blue Shield (BCBS) Plan’s area to receive all the same benefits of their contracting BCBS Plan and access to providers and savings. The program links participating health care providers and the independent BCBS Plans across the country and around the world through a single electronic network for claims processing and reimbursement.

BlueCard® Program

Advantages
The BlueCard Program allows you to submit claims for members from other BCBS Plans including international BCBS Plans, directly to Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX will be your one point of contact for most of your claims-related questions.

Claims and Products Included in the BlueCard® Program
The BlueCard Program applies to all inpatient, outpatient, and professional claims. Traditional, PPO and HMO products are included in the BlueCard Program. The following products are optional under the BlueCard Program:
- Stand-alone dental and prescription drugs
- Stand-alone vision and hearing
- Medicare supplemental

Products Excluded from the BlueCard® Program
Medicare+Choice is excluded from the BlueCard Program. You must file Medicare+Choice claims with the member’s BCBS Plan.

Accounts Exempt from the BlueCard® Program
Claims for the Federal Employee Program (FEP) are exempt from the BlueCard Program. Please follow your FEP billing guidelines.

Continued on next page
How Does the BlueCard® Program Work?

How to Identify BlueCard Members

When members from other Blue Cross and Blue Shield Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifiers for BlueCard members are the alpha prefix, a blank suitcase logo, and, for eligible PPO members, the “PPO in a suitcase” logo.

Alpha Prefix

The three-character alpha prefix at the beginning of the member’s identification number is the key element used to identify and correctly route out-of-area claims. The alpha prefix identifies the Blue Cross Blue Shield Plan or national account to which the member belongs. It is critical for confirming a patient’s membership and coverage.

There are two types of alpha prefixes: Plan-specific and account-specific.

1. **Plan-specific alpha prefixes** are assigned to every Plan and start with X, Y, Z or Q. The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.
   - First character X, Y, Z or Q
   - Second character A-Z
   - Third character A-Z

2. **Account-specific prefixes** are assigned to centrally process national accounts. National accounts are employer groups that have offices or branches in more than one area, but offer uniform benefits coverage to all of their employees. Account-specific alpha prefixes start with letters other than X, Y, Z or Q. Typically, a national account alpha prefix will relate to the name of the group. All three positions are used to identify the national account.

Identification cards with no alpha prefix: Some identification cards may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the member’s ID card for how to file these claims. If that information is not available, call BCBSTX at 1-800-451-0287.

**It is very important to capture all ID card data at the time of service. This is critical for verifying membership and coverage.** We suggest that you make copies of the front and back of the ID card and pass this key information on to your billing staff. **Do not make up alpha prefixes.**

If you are not sure about your participation status (traditional, PPO or HMO), call *Blue Cross and Blue Shield of Texas.*
How Does the BlueCard® Program Work? Continued

A blank suitcase logo on a member’s ID card means that the patient has Blue Cross Blue Shield traditional or HMO benefits delivered through the BlueCard Program.

Blank Suitcase Logo

The easy-to-find alpha prefix identifies the member’s Blue Cross and Blue Shield Plan.

“PPO in a Suitcase” Logo

You will immediately recognize BlueCard PPO members by the special “PPO in a suitcase” logo on their membership card. BlueCard PPO members are Blue Cross and Blue Shield members whose PPO benefits are delivered through the BlueCard Program. It is important to remember that not all PPO members are BlueCard PPO members, only those whose membership cards carry this logo. BlueCard PPO members traveling or living outside of their Blue Plan’s area receive the PPO level of benefits when they obtain services from designated BlueCard PPO providers.
How Does the BlueCard® Program Work? Continued

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

Note: Front and back of ID card for BCBS member from Germany
How Does the BlueCard® Program Work? Continued

**How to Verify Membership and Coverage**

Once you’ve identified the alpha prefix, call BlueCard Eligibility to verify the patient’s eligibility and coverage.

1. Have the member’s ID card ready when calling.
2. Dial 1-800-676-BLUE (2583).

Operators are available to assist you weekdays during regular business hours (7am – 10pm EST). They will ask for the alpha prefix shown on the patient’s ID card and will connect you directly to the appropriate membership and coverage unit at the member’s Blue Cross Blue Shield Plan. If you call after hours, you will get a recorded message stating the business hours.

Keep in mind BCBS Plans are located throughout the country and may operate on a different time schedule than BCBSTX. It is possible you will be transferred to a voice response system linked to customer enrollment and benefits or you may need to call back at a later time.

**How to Obtain Utilization Review**

You should remind patients from other Blue Plans that they are responsible for obtaining precertification/preauthorization for their services from their Blue Cross and Blue Shield Plan. You may also choose to contact the member’s Plan on behalf of the member. If you choose to do so, you can ask to be transferred to the utilization review area when you call BlueCard Eligibility (1-800-676-BLUE (2583) for membership and coverage information.

**Where and How to Submit BlueCard® Program Claims**

You should always submit BlueCard claims to BCBSTX. You can submit these electronically but if you must submit a paper claim, please file them to P.O. Box 660044, Dallas, TX 75266-0044. Be sure to include the member’s complete identification number when you submit the claim. The complete identification number includes the three-character alpha prefix. Do not make up alpha prefixes. Incorrect or missing alpha prefixes and member identification numbers delay claims processing.

Once BCBSTX receives a claim, it will electronically route the claim to the member’s Blue Cross and Blue Shield Plan. The member’s Plan then processes the claim and approves payment, and BCBSTX will pay you.

If you are a non-PPO (traditional) provider and are presented with an identification card with the “PPO in a suitcase” logo on it, you should still accept the card and file with your local Blue Cross and Blue Shield Plan. You will still be given the appropriate traditional pricing.
How Does the BlueCard® Program Work? Continued

International Claims
The claim submission process for international Blue Cross and Blue Shield Plan members is the same as for domestic Blue Cross and Blue Shield Plan members. You should submit the claim directly to Blue Cross and Blue Shield of Texas.

Indirect, Support, or Remote Providers
If you are a health care provider that offers products, materials, informational reports, and remote analyses or services, and are not present in the same physical location as a patient, you are considered an indirect, support, or remote provider. Examples include, but are not limited to, prosthesis manufacturers, durable medical equipment suppliers, independent or chain laboratories, or telemedicine providers.

If you are an indirect provider for members from multiple Blue Plans, follow these claim filing rules:

• If you have a contract with the member’s Plan, file with that Plan.
• If you normally send claims to the direct provider of care, follow normal procedures.
• If you do not normally send claims to the direct provider of care and you do not have a contract with the member’s Plan, file with your local Blue Cross and Blue Shield Plan.

Exceptions to BlueCard Claims Submissions
Occasionally, exceptions may arise in which *Blue Cross and Blue Shield of Texas* will *require* you to file the claim directly with the member’s Blue Plan. Here are some of those exceptions:

• You contract with the member’s Blue Plan (for example, in contiguous county or overlapping service area situations).
• The ID card does not include an alpha prefix.
• A claim is returned to you from Blue Cross and Blue Shield of Texas because no alpha prefix was included on the original claim that was submitted.

In some cases, *BCBSTX* will *request* that you file the claim directly with the member’s Blue Plan. For instance, there may be a temporary processing issue at *BCBSTX*, the member’s Blue Plan, or both that prevents completion of the claim through the BlueCard Program.

When in doubt, please file the claim electronically to Blue Cross and Blue Shield of Texas. *If you must file a paper claim, send to P.O. Box 660044 Dallas, TX 75266-0044* and we will handle the claim for you.
How Does the BlueCard® Program Work? Continued

When a member belongs to an account that is exempt from the BlueCard Program, Blue Cross and Blue Shield of Texas will electronically forward your claims to the member’s Blue Plan. That means you will no longer need to send paper claims directly to the member’s Blue Plan. Instead, you will submit these claims to BCBSTX. However, you will continue to submit Medicare supplemental (Medigap) and other Coordination of Benefits (COB) claims under your current process (see below).

How the Electronic Process Works

- You will submit these claims with alpha prefixes exempt from BlueCard directly to BCBSTX, which will forward the claims to the member’s Plan for you.
  ✓ It is important for you to correctly capture on the claim the member’s complete identification number, including the three-character alpha prefix at the beginning. If you don’t include this information, BCBSTX may return the claim to you and this will delay claims resolution and your payment.
  ✓ It is also important for you to call BlueCard Eligibility at 1-800-676-BLUE (2583) to verify the member’s eligibility and coverage.

- If the member’s claim is exempt from the BlueCard Program, BCBSTX will inform you that the claim is being forwarded to the member’s Plan.
  ✓ In most cases, the member’s Blue Plan will contact you for additional information. For example, if the member’s Plan cannot identify the member, the member’s Blue Plan may return the claim to you just as it would currently with a paper claim. If this happens, you will need to check and verify the billing information and resubmit the claim with additional/corrected information to Blue Cross and Blue Shield of Texas.

- The member’s Blue Plan will send you a detailed Explanation of Benefits (EOB)/payment advice with your payment or will send a notice of denial. If you have already been paid or you do not contract with Blue Cross and Blue Shield of Texas, the member’s Blue Plan may pay the member.
**How Does the BlueCard® Program Work?**

**Coordination of Benefits (COB) Claims**

Coordination of Benefits (COB) refers to how we make sure people receive full benefits and prevent 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.

If after calling 1.800-676-BLUE (2583) or through other means you discover the member has a COB provision in their benefit plan, and another insurance carrier is the primary payer, submit the claim along with information regarding COB to BCBSTX. If you do not include the COB information with the claim, the member’s Blue Plan or the insurance carrier 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.

**Medicare Supplemental (Medigap) Claims**

For Medicare supplemental claims, always file with the Medicare contractor first. Always include the complete Health Insurance Claim Number (HICN); the patient’s complete Blue Cross Blue Shield Plan identification number, including the three-character alpha prefix; and the Blue Cross Blue Shield Plan name as it appears on the patient’s ID card, for supplemental insurance. This will ensure crossover claims are forwarded appropriately.

Do not file with Blue Cross and Blue Shield of Texas and Medicare simultaneously. Wait until you receive the Explanation of Medical Benefits (EOMB) or payment advice from Medicare. After you receive the Medicare payment advice/EOMB, determine if the claim was automatically crossed over to the supplemental insurer.

**Crossover Claims:** If the claim was crossed over, the payment advice/EOMB should typically have Remark Code MA 18 (for CMS 1500 (08/05) claims) or MA 19 (for UB-04) printed on it, which states, “The claim information is also being forwarded to the patient’s supplemental insurer. Send any questions regarding supplemental benefits to them.” The code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.

**Claim Not Crossed Over:** If the payment advice/EOMB does not indicate the claim was crossed over and you accepted Medicare assignment, file the claim as you do today. BCBSTX or the member’s BCBS Plan will pay you the Medicare supplemental benefits. If you did not accept assignment, the member will be paid and you will need to bill the member.
### How Does the BlueCard® Program Work?

| Payment for BlueCard® Claims | If you have not received payment, do not resubmit the claim. If you do, **BCBSTX** will have to deny the claim as a duplicate. You will also confuse the member because he or she will receive another EOB and will need to call customer service. Please understand that timing for claims processing varies at each Blue Cross Blue Shield Plan. **Blue Cross and Blue Shield of Texas** standard time for claims processing is **30 days for electronically filed claims and 45 for paper claims.** The next time you do not receive your payment or a response regarding your payment, your first point of contact is your electronic connectivity vendor, i.e. Availity, RealMed or other connectivity vendor or you can call **BCBSTX** at **1-800-451-0287.** |
| Who to Contact for Claims Questions | If you have a question regarding Benefits and/or Eligibility, call the member’s home plan. If you have a question concerning anything else, i.e., allowed amount, first point of contact, contact your electronic connectivity vendor, i.e. Availity, RealMed or other connectivity vendor or call BCBSTX at **1-800-451-0287.** |
| How to Handle Calls from Members and Others With Claims Questions | If members contact you, tell them to contact their Blue Cross and Blue Shield Plan. Refer them to the front or back of their ID card for a customer service number. The member’s Plan should not be contacting you directly, unless you filed a paper claim directly with that Plan. If the member’s Plan contacts you to send them another copy of the member’s claim, refer them to **BCBSTX.** |
| Where to Find More Information About the BlueCard® Program | For more information about the BlueCard Program, call **Blue Cross and Blue Shield of Texas at 1-800-451-0287** or visit the Blue Cross and Blue Shield Association’s Web site at www.bcbs.com. |

*Continued on next page*
What Products Are Included in the BlueCard® Program?

**Background**
Currently four types of products are administered through the BlueCard Program: BlueCard Traditional, BlueCard PPO, BlueCard Managed Care, and HMO.

**BlueCard® Traditional**
A national program that offers members traveling or living outside of their Blue Plan’s area the traditional or indemnity level of benefits when they obtain services from a physician or hospital outside of their Blue Plan’s service area.

**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.

**HMO Patients Serviced Through the BlueCard® Program**
In the coming months, you may soon be seeing a growing number of Blue Cross Blue Shield (BCBS) HMO members affiliated with other BCBS Plans who will be seeking care at your office or facility. You should handle claims for these members the same way as you do BCBSTX members and BCBS traditional and PPO patients from other Blue Plans - by submitting them through the BlueCard Program.

*Continued on next page*
Room Rate Update Notification Form

**Background**
Numerous BCBSTX group and member benefits only provide for a semi-private room. The room rate BCBSTX has on file and loaded in the claims payment system is used to determine the patient’s liability on claims when the difference between the private room and the semi-private room is the patient’s responsibility. Therefore, the accurate information that you provide BCBSTX assists in adjudicating the claim with the correct patient liability.

**Room Rate Update Notification Form**
If your hospital(s) has not provided this information to BCBSTX in the last 12 months, we are requesting that you complete the form which will allow BCBSTX to either update our claims payment system, or confirm the current room rate loaded in the claims payment system is accurate.

**Future Updates**
For future updates, please notify BCBSTX at least 30 days prior to the planned effective date. You will find the Room Rate Update Notification form on the Blue Cross and Blue Shield of Texas Web site at [www.bcbstx.com/provider](http://www.bcbstx.com/provider) (refer to the downloadable forms area). Your completed form can be faxed to the fax numbers on the form or mailed to your Network Management Representative.

It is also important to notify us if your facility becomes private room only or a wing of the hospital is private room only.

Once the information is received, we will update our records with the effective date being the latter of:
- The actual effective date of the new rate or
- Date received by BCBSTX

If you have any questions or concerns, please contact your Network Management Representative.