### Major Characteristics
- **Blue Essentials** members must select an **Blue Essentials** Primary Care Physician (PCP).
- **Blue Essentials** physicians, professional providers, facility or ancillary providers may only bill for copayments, cost share and deductibles, where applicable.
- Some services may be self-referred to an **Blue Essentials** physician and professional provider (i.e., annual well woman exam, annual routine eye exam) as indicated by the member’s benefit plan.
- To receive benefits, all medical care must be directed by the selected **Blue Essentials** PCP. A PCP referral is required to all **Blue Essentials** Specialist Physicians, Professional Providers, Facility or Ancillary providers.
- To receive benefits, referrals to out-of-network physicians and professional providers must be authorized by the Medical Care Management Dept.
- Vision Care Services are provided by EyeMed Vision Care. Members can be directed to [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) to search for network providers or to call Member Services at (844) 684-2255.

### Benefits, Eligibility, Claims Status or Verification
- Eligibility and benefit information may be obtained through [avality.com](http://avality.com) or a web vendor of your choice or call **Blue Essentials** Provider Customer Service at 877-299-2377.
- Claim status may be obtained through the Avality Claim Research tool or a web vendor of your choice.
- To adjust a claim, call **Blue Essentials** Provider Customer Service at 877-299-2377.
- Verification of benefits does not apply to administrative services only (ASO) plans.
- All claims should be submitted electronically. **Blue Essentials** Electronic Payor ID: 84980.
- If the physician, professional provider, facility or ancillary provider must file a paper claim, mail claim to: **Blue Essentials**
  - P.O. Box 660044
  - Dallas, TX
  - 75266-0044
- **Blue Essentials** claims must be submitted within 180 days of the date of service. Claims that are not submitted within 180 days from the date of service are not eligible for reimbursement. Physicians, professional providers, facility and ancillary providers must submit a complete claim for any services provided to a member. **Blue Essentials** participating providers may not seek payment from the member for claims submitted after the 180 day filing deadline.

### Claim Reviews, All Correspondence
- Claim Reviews/Correspondence should be sent to:
  - **BCBSTX**
  - P.O. Box 660044
  - Dallas, TX
  - 75266-0044
- The Claim Review form with instructions is located on the **BCBSTX** website: [bcbstx.com/provider](http://bcbstx.com/provider).
- Click on the Education and Reference tab, then click on Forms.

### Preauthorization, Online Approval of Benefits for Select Outpatient Services and Inpatient Admissions
- Current listings of providers and their NPI numbers are available online through the [Exchange Web application or Provider Finder](http://www.bcbstx.com/provider/tools/exchange.html).
- For questions or problems, call the [Exchange Support Desk 800-746-4614](http://www.bcbstx.com/provider/tools/exchange.html).
- For case management or to contact the Medical Care Management Dept., call 855-896-2701.
- For referrals, approval of benefits for select outpatient preauthorizations and inpatient admissions, refer to the [Exchange webpage at](http://www.bcbstx.com/provider/tools/exchange.html).
- (Note: A link to the Preauthorization/Notification/Referral Requirements List is located in the left-side navigation under Related Resources) or refer to the [Blue Essentials](http://www.bcbstx.com/provider/tools/exchange.html) (formerly known as HMO Blue Texas), Blue Advantage HMO and [Blue Premier Provider Manual](http://www.bcbstx.com/provider/tools/exchange.html) (Sections D and E).

### Laboratory Services
- **Laboratory Services**
  - Quest Diagnostics, Inc. is the exclusive lab for **Blue Essentials** for all outpatient clinical reference laboratory services. For locations or questions, contact Quest at 888-277-8772, or visit Quest’s website at: [QuestDiagnostics.com](http://www.questdiagnostics.com). (IPAs/Medical Groups, see "IMPORTANT NOTE" at top of page.)
  - For physicians and professional providers located in the counties listed on the Additional Information page, the lab services/procedures that will be reimbursed on a fee-for-service basis if performed in the physician’s or professional provider’s office, are included on the Reimbursable Lab Services list located on the **BCBSTX** website at [bcbstx.com/provider](http://bcbstx.com/provider) or located in the **Blue Essentials** (formerly known as HMO Blue Texas), Blue Advantage HMO and [Blue Premier Provider Manual](http://www.bcbstx.com/provider/tools/exchange.html) (Sections B).

### Behavioral Health Services (Mental Health and Chemical Dependency)
- **Magellan Behavioral Health Providers of Texas, Inc.** coordinates all behavioral health (mental health and chemical dependency) services for **Blue Essentials** members.
- To obtain preauthorization, check benefits, eligibility, claims status/problems or verification, call Magellan at 800-729-2422.
- The patient, Primary Care Physician (PCP) or behavioral health professional must contact Magellan to preauthorize all inpatient, partial hospitalization and outpatient behavioral health services.
- Preauthorization must be obtained prior to the delivery of care for behavioral health services.
- The physician or professional provider is responsible for filing claims.
- Mail claims to: [Magellan Behavioral Health Providers of Texas, Inc. Attn: Claims P.O. Box 1658 Maryland Heights, MO 63043](http://www.bcbstx.com/provider/tools/exchange.html).

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**This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the HMO Blue Texas Physician and Professional Provider – Provider Manual online at [bcbstx.com/provider](http://bcbstx.com/provider).**

Updated December 30, 2016
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
Claims Submission:
- All claims should be submitted electronically. The Electronic Payor ID for BCBSTX is 84980.
  - For support relating to claims that are being sent to the Availity platform, submitters should contact Availity Client Services at 800-AVAILITY (282-4546).
  - For support relating to claims and/or other transactions available on the Availity portal or other Availity platforms, submitters should contact Availity Client Services at 800-AVAILITY (282-4546).
  - For information on electronic filing, access the Availity website at availity.com.
- Paper claims must be submitted on the Standard CMS-1500 (02/12) or UB-04 claim form.
- All claims must be filed with the insured’s complete unique ID number including any letter or 3-digit alpha prefix.
- Duplicate claims may not be submitted prior to the applicable 30-day (electronic) or 45-day (paper) claims payment period.
- If services are rendered directly by the physician or professional provider, the services may be billed by the physician or professional provider. However, if the physician or professional provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services. **Note:** This does not apply to services provided by an employee of a physician or professional provider, e.g. Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered Nurse First Assistant, who is under the direct supervision of the billing physician or professional provider.

ParPlan is a Blue Cross and Blue Shield of Texas (BCBSTX) payment plan under which health care professionals agree to:
- File all claims electronically for BCBSTX patients;
- Accept the BCBSTX allowable amount;
- Bill members only for deductibles, cost-share (coinsurance) and medically necessary services which are limited or not covered; either at the time of service or after BCBSTX has reimbursed the provider; not bill BCBSTX for experimental, investigative or otherwise unproven or excluded services; and
- Not bill either BCBSTX or members for covered services which are not medically necessary.

For Blue Essentials members, BCBSTX encourages the provider’s office to:
- Ask for the member ID card at the time of a visit;
- Copy both sides of the member’s ID card and keep the copy with the patient’s file;
- Eligibility, benefits and/or verification requests, contact availity.com or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member’s ID card.
- Claim status may be obtained through the Availity Claim Research tool or a web vendor of your choice.
- For Claim Adjustments, call Provider Customer Service at 877-299-2377** to utilize the iExchange Web application at http://www.bcbstx.com/provider/tools/iexchange.html, to obtain approval of benefits to select outpatient services and inpatient admissions, maternity notifications, or for notification within 48 hours of an emergency hospital admission. For case management, call the Medical Care Management Department at 855-896-2701.

Provider Record and Network Effective Dates:
- A minimum of 30 days advance notice is required when making changes affecting the provider’s BCBSTX status, especially in the following areas:
  1. Physical address (primary, secondary, tertiary);
  2. Billing address;
  3. NPI and Provider Record ID changes;
  4. Moving from Group to Solo practice;
  5. Moving from Solo to Group practice;
  6. Moving from Group to Group practice; and
  7. Backup/covering providers.
- **New** Provider Record ID effective dates will be established as of the date the completed application is received in the BCBSTX corporate office. This applies to all additions, changes and cancellations.
- BCBSTX will not add, change or cancel information related to the Provider Record ID on a retroactive basis.
- Retroactive Provider Record ID effective dates will not be issued.
- Retroactive network participation will not be issued.
- Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new Provider Record ID.
- If the provider files claims electronically and their Provider Record ID changes, the provider must contact the Availity Health Information Network at 800-AVAILITY (282-4546) to obtain a new EDI Agreement.
- For Provider Record ID questions or to obtain a Provider Record ID application, please contact the Provider Services department at 972-996-9610, press 3.

BlueCard (Out-of-State Claims):
- To check benefits or eligibility, call 800-676-BLUE (2583)**;
- File all claims that include a 3-digit alpha prefix on the subscriber/member ID card to BCBSTX (**Note:** The member’s unique ID number may contain alpha characters which may or may not directly follow the 3-digit alpha prefix);
- File all other claims directly to the Home Plan’s address as it appears on the back of the subscriber/member ID card;
- For status of claims filed to BCBSTX, contact availity.com or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member’s ID card or as listed on the previous pages for the appropriate plan type.

*Interactive Voice Response (IVR) system. To access, you must have full member/subscriber information, i.e. member/subscriber’s ID, patient date of birth, etc.*
**To adjust a claim, you must have a document control number (claim number).*

Continued on next page
Blue Essentials – Outpatient Clinical Reference Lab Services (Exception: Capitated IPAs/Medical Groups – see note below):

- For physicians and professional providers located in the following counties, the lab services/procedures that will be reimbursed on a fee-for-service basis if performed in the physician’s and professional provider’s office for Blue Essential's members are included on the Reimbursable Lab Services list located on the BCBSTX website @ bcbstx.com/provider or located in Section B of the Blue Essentials (formerly known as HMO Blue Texas), Blue Advantage HMO and Blue Premier Provider Manual. (Austin, Bell, Bexar, Brazoria, Calhoun, Chambers, Collin, Comal, Cooke, Dallas, Denton, Ellis, Fannin, Fort Bend, Galveston, Gonzales, Grayson, Grimes, Guadalupe, Hardin, Harris, Hood, Houston, Hunt, Jackson, Jefferson, Johnson, Kaufman, Lavaca, Leon, Liberty, Madison, Matagorda, McLennan, Montague, Montgomery, Orange, Parker, Polk, Robertson, Rockwall, San Jacinto, Somervell, Tarrant, Trinity, Victoria, Walker, Waller, Washington, Wharton & Wise).

- **All other outpatient clinical reference lab services must be referred to Blue Essential’s exclusive provider - Quest Diagnostics, Inc.**

*Note: Physicians and professional providers who are contracted/affiliated with a capitated IPA/Medical Group, and physicians and professional providers who are not part of a capitated IPA/Medical Group but who provide services to a member whose PCP is a member of a capitated IPA/Medical Group, must contact the applicable IPA/Medical Group for instructions regarding outpatient laboratory services.*

The Affordable Care Act (ACA) includes a provision that gives Health Insurance Marketplace members who receive **advanced premium tax credits (APTC)** also known as subsidies, a three-month grace period to pay their premium.

- **Grace Period Overview:**
  - The three-month grace period is only required for enrollees who have made one full premium payment during the benefit year and who are receiving the APTC.
  - The health plan is responsible for adjudicating claims during the first month after a member enters the grace period. The claims adjudicated are for dates of service rendered within the first month of this grace period.
  - During the second and third months of the grace period, issuers have the choice of either pending the claims or adjudicating the claims and seeking a refund if the member doesn’t pay all outstanding premium payments.
  - If a member fails to pay all outstanding premiums by the end of the three-month grace period, the health plan must terminate the member’s coverage.

- **How will BCBSTX make providers aware?**
  - Eligibility and Benefits Determination will include a paid through date and be provided by:
    - Electronic and/or clearinghouse compliant with the HIPAA 270/271
    - Interactive Voice Response (IVR) / automated telephone system
    - Provider Customer Service
  - Reminders to check for grace period status will be included on correspondence related to:
    - Pre-determinations
    - Preauthorizations
    - Referrals

*Interactive Voice Response (IVR) system. To access, you must have full member information, i.e. member’s ID, patient date of birth, etc.*

This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the applicable online provider manual at [bcbstx.com/provider](http://bcbstx.com/provider).