Behavioral Health Professionals & Physicians

The Availity™ Eligibility and Benefits Inquiry allows providers to instantly confirm real-time patient eligibility and benefits, including covered services, copays, deductibles and more. Below you will find detailed instructions outlining how to obtain patient benefits on services rendered by your specialty.

Checking eligibility and/or benefit information is not a guarantee of payment. Please note that the fact that a guideline is available for any given treatment, or 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 back of the member's ID card.

1. Getting Started

Go to availity.com

Select Web Portal Users Login.

Enter User ID and Password.

Select Log in button.

Note: Only registered users can access Eligibility and Benefits Inquiry.

2. Eligibility and Benefits Inquiry

Select Patient Registration from the top mega menu.

Select Eligibility and Benefits Inquiry.

Note: Contact your Primary Access Administrator (PAA) if Eligibility and Benefits is not listed in the navigation menu.

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3. **Payer Selection**

Select **BCBSTX** from the Payer drop-down for local policies.

Select **Other Blue Plans** for out-of-state policies.

**Note:** Contact the patient’s home plan via 800-876-BLUE for additional information pertaining to eligibility and benefit verifications for out-of-state members.

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4. **Provider Information**

Select applicable provider name from Express Entry-Provider drop-down to auto-populate the NPI field.*

Complete the following:
- Provider Type
- Place of Service

**Note:** To receive accurate benefit quotes, professional providers should utilize the treating physician's rendering NPI (Type 1).

If providers have multiple organizations, the City, State and Zip Code fields should be utilized.

* If the applicable provider name does not appear in the Express Entry-Provider drop-down, enter the NPI into the NPI field.

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5. **Patient Information**

Select **Mental Health Provider – Outpatient** from the Benefit/Service Type drop-down.

Next, complete the following:
- Patient ID (including alpha prefix)
- Date of Birth
- For multiple patients (optional) - check the box that says Add Multiple Patients in the appropriate search option format.

Select **Submit**.

**Note:** The As of Date can be changed to submit inquiries for a past or future date of service. Past date inquiries can be received up to 12 months prior to the current date. Future date inquiries can be requested within the current month.
6. **Patient History List**

Once an eligibility and benefits request is completed, a new Patient Card will appear in the Patient History List, including all member’s entered in the request.

**Patient Card:**
- Green – Active Membership
- Red – Inactive Membership
- Orange – Transaction Error

**Search:** At the top left corner of the page, users can locate the Patient Card by searching for **Name, Date** or **Payer**.

**Notes:**
- To see all patients within your organization, uncheck “My Patients Only”.
- Users can Edit or Delete the patient’s Eligibility and Benefits search from the Patient History List
- Patient History List holds up to 200 patients for 24 hours

7. **Eligibility Summary Results**

Eligibility for the requested patient will be displayed in the Patient Information tab on the results screen.

Results include:
- **Patient Information**
- **Plan Date** *(current effective date)*
- **Subscriber Address**
- **Group Number**
- **Plan Sponsor Name** *(employer)*
- **Paid to Date**

*Individual members on and off the Health Insurance Marketplace*
Grace Periods

Some individuals who purchase insurance through the health insurance marketplace may receive an advance premium tax credit (APTC). These members qualify for a three-month grace period to pay their premium—provided they have already paid at least one month’s premium in full.

Allowable services provided during the first month of the grace period will be the responsibility of BCBSTX, subject to member cost sharing. BCBSTX will process all claims the member incurs during second and third months of the grace period. If the member does not pay the outstanding premium in full by the end of the third month, BCBSTX will send a request for refund to the provider for claims paid for services rendered in months two and three.

The Plan/Product Information section of the Eligibility Results screen will provide a grace period indicator for applicable members, including grace period start and end dates, as shown in the example below.

Note: Not all members who purchase coverage on the health insurance marketplace will receive the APTC.
8. Benefit Summary Results

Network status and the detailed benefit descriptions for the requested Benefit/Service Type are located under the Coverage and Benefits tab.

- Coverage Level *(individual or family)*
- Amount *(patient responsibility)*
- Quantity *(limitations or maximums)*
- Place of Service
- Time Period *(visit, calendar year, lifetime, etc.)*
- Description *(applicable services)*

**Note:** Only applicable benefits will be displayed. The below example does not show a maximum or limitation field; therefore, no limitations or maximums apply to these services.

![Benefit Summary Results](image-url)
9. Benefit Qualifiers

Below are examples of benefit qualifiers that may be returned depending on the patient’s benefit contract. This information will be located under the Patient Information and Coverage & Benefits tab.

**Note:** If these fields do not return, then no benefit qualifiers or preauthorization requirements apply.

### Focused Outpatient Management Program (FOMP)

FOMP uses data-driven and clinical intelligence rules to identify members whose treatment may benefit from further review and collaboration. Providers will receive a written request for additional clinical information when a FOMP member may potentially benefit from further treatment review.

Preauthorization is required for the following outpatient services when rendered to FOMP members:

- Electroconvulsive therapy (ECT)
- Psychological testing

The Benefit Description will advise if a member is included in this program.

**Note:** The Behavioral Health program is available only to those members whose health plans include behavioral health benefits through BCBSTX. Some members may not have outpatient behavioral health management. All behavioral health benefits are subject to the terms and conditions as listed in the member’s benefit plan.

10. Benefit Preauthorization Indicators

Benefit preauthorization indicators may be returned depending on the patient’s benefit contract. This information will be located on the Coverage and Benefits tab.

**Note:** If this field does not return, then no preauthorization requirements apply.

If BCBSTX is listed as the benefit preauthorization contact entity, specific Current Procedural Terminology (CPT®) codes that require benefit preauthorization will be listed in each for the service type.

**Questions?** Email the Provider Education Consultants at pecs@bcbstx.com.

*Be sure to include your name, direct contact information, Tax ID or Billing NPI.*

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