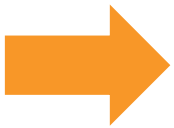
Welcome to the Blue Cross Network

For the listening benefit of webinar attendees, we have muted all lines and will be starting our presentation shortly.

- This helps prevent background noise (e.g., unmuted phones or phones put on hold) during the webinar.
- This also means we are unable to hear you during the webinar.
- Please submit your questions directly through the webinar platform.



How to submit questions:

- Open the Q&A feature at the bottom of your screen, type your question related to today's training webinar and hit "enter."
- Once your question is answered, it will appear in the "Answered" tab.
- All questions will be answered by the end of the webinar.

Louisiana

Welcome to the Blue Cross Network

Professional Webinar

Presented by Anna Granen
Senior Provider Relations Representative
Blue Cross and Blue Shield of Louisiana

October 2023

HMO Louisiana, Inc. is a subsidiary of Blue Cross and Blue Shield of Louisiana. Both companies are independent licensees of the Blue Cross Blue Shield Association.

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross Blue Shield Association, offers Blue Advantage (PPO).

Carelon Medical Benefits Management (Carelon) is an independent company that serves as an authorization manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

Lucet is an independent company that serves as the behavioral health manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

Avalon is an independent company that serves as a laboratory insights advisor for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

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Welcome to Blue Cross!

As a new to Blue Cross provider or new staff member for an existing provider, we want to make sure you have the tools and resources you need when doing business with Blue Cross. Today we will discuss:

- ✓ online resources
- ✓ network participation
- ✓ using iLinkBlue
- ✓ authorization information
- ✓ claims research
- ✓ claims editing
- ✓ network maintenance
- ✓ provider support

Online Resources

Online Provider Directories

Keeping your information updated is extremely important to help our members find you.

We publish demographic information in our online provider directory. The directory is available on our website at **www.bcbsla.com**.

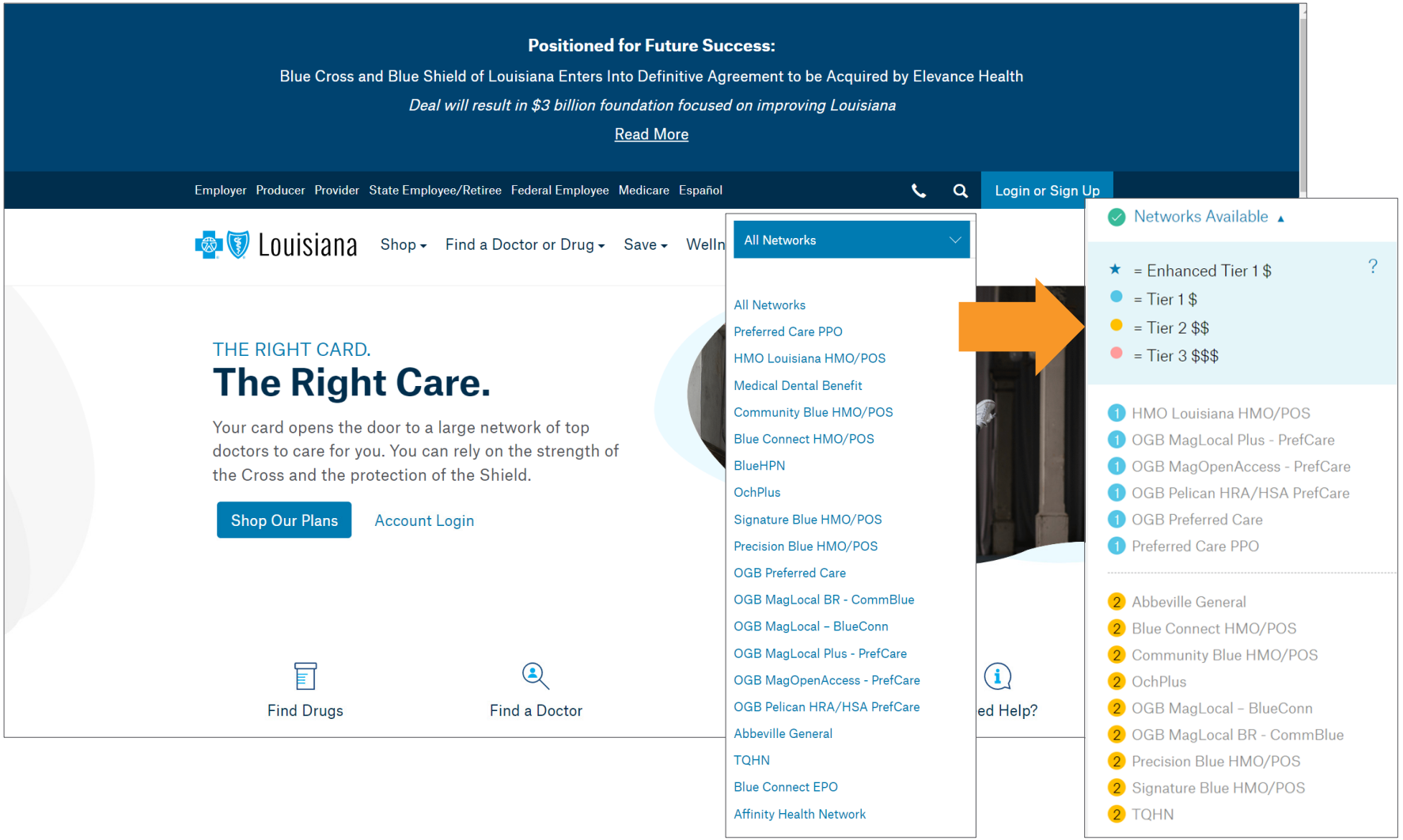
- Addresses (location information)
- Phone numbers
- Accepting new patients
- Providers working at certain locations
- Information about telehealth services

For professional providers to be listed in our directories, they must be available to schedule patients' appointments a **minimum of 8 hours per week** at the location listed.

It is the contractual responsibility of all participating providers keep their information current with Blue Cross. To report changes in your information, use the **Provider Update Request Form**. Our Provider Credentialing & Data Management Department will work with you to help ensure your information is current and accurate.

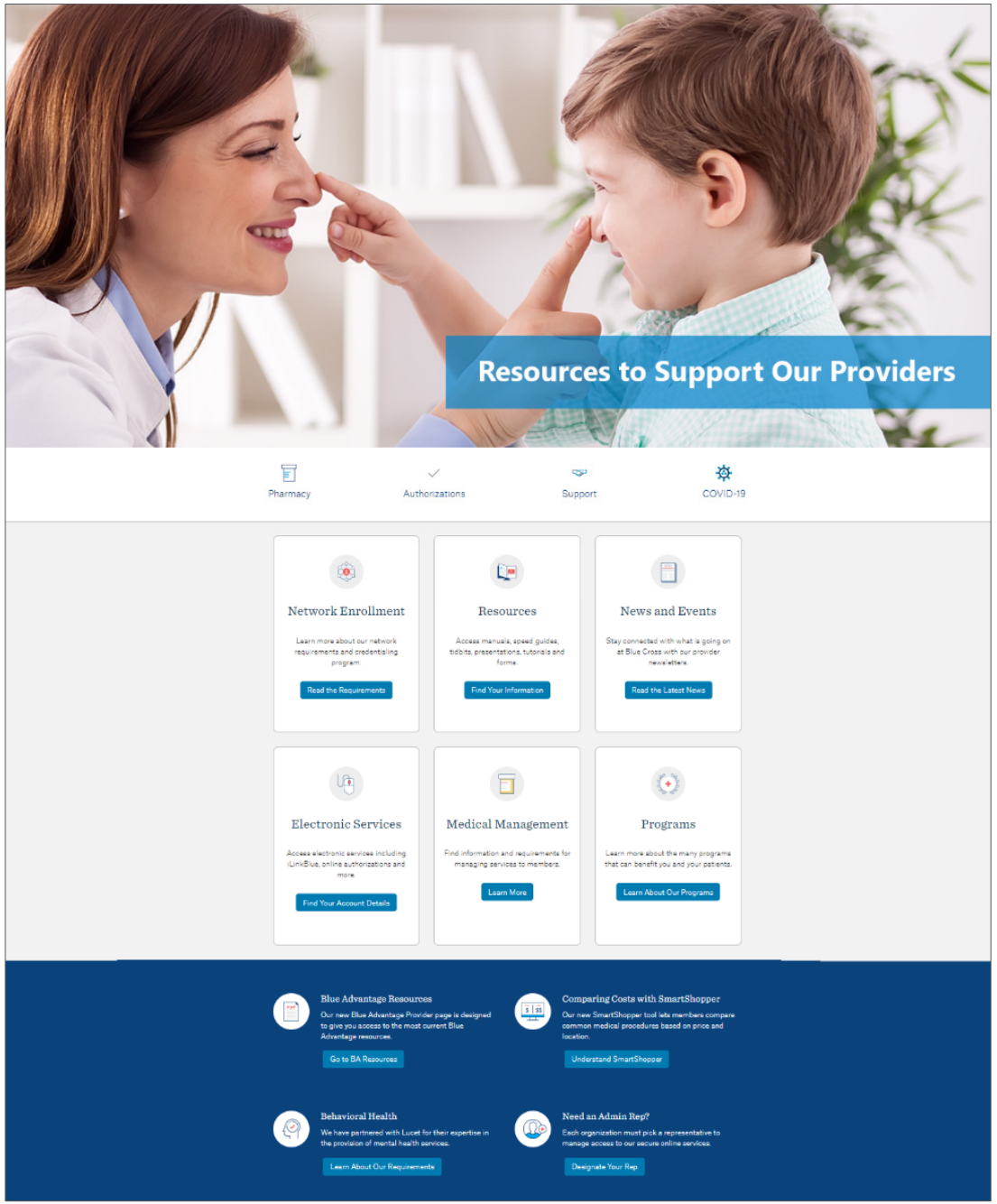
Online Provider Directories

www.bcbsla.com >Find a Doctor or Drug >Local Provider Directory



The Provider Page

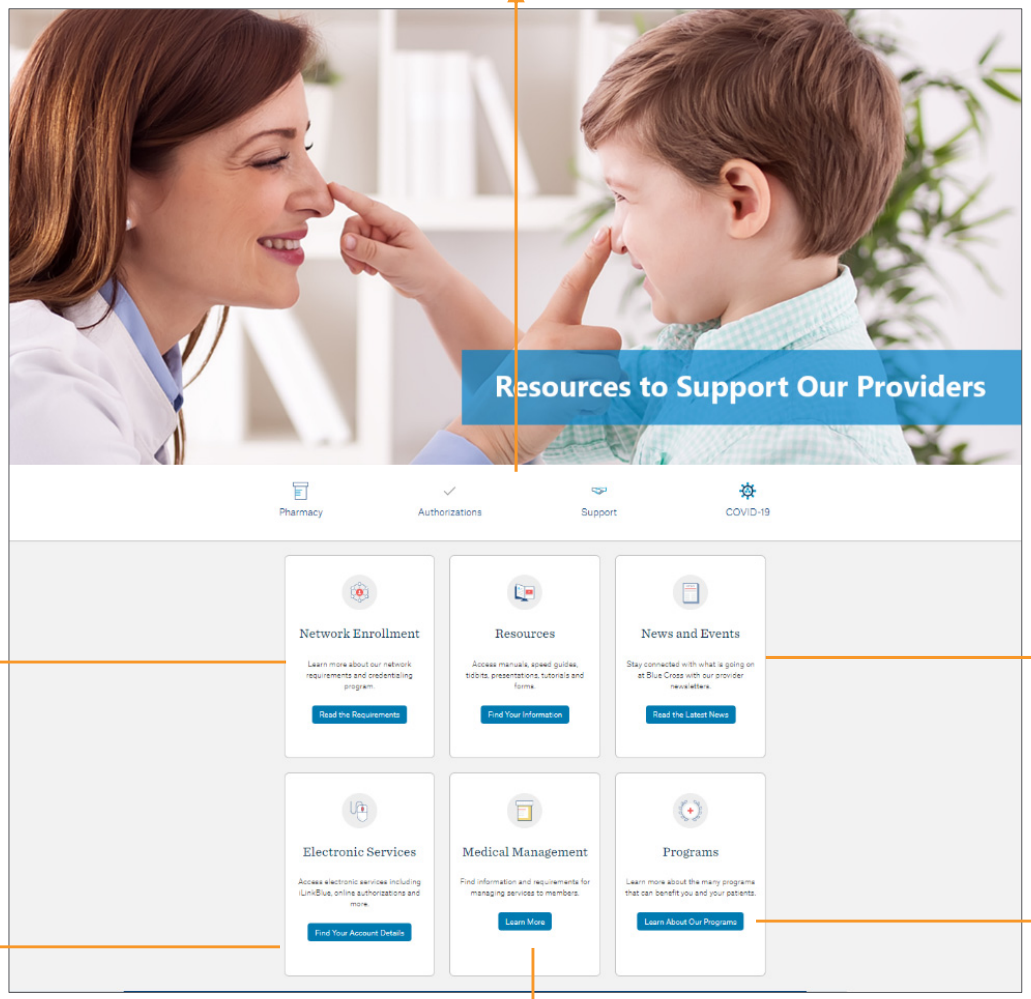
www.bcbsla.com/providers



The Provider Page

www.bcbsla.com/providers

Resources
Access manuals, speed guides, toolkits, presentations, tutorials and forms.



Network Enrollment
Learn more about our network requirements and credentialing program.

Electronic Services
Access electronic services including iLinkBlue, online authorizations and more.

News and Events
Stay connected with what is going on at Blue Cross with our provider newsletters.

Programs
Learn more about the many programs that can benefit you and your patients.

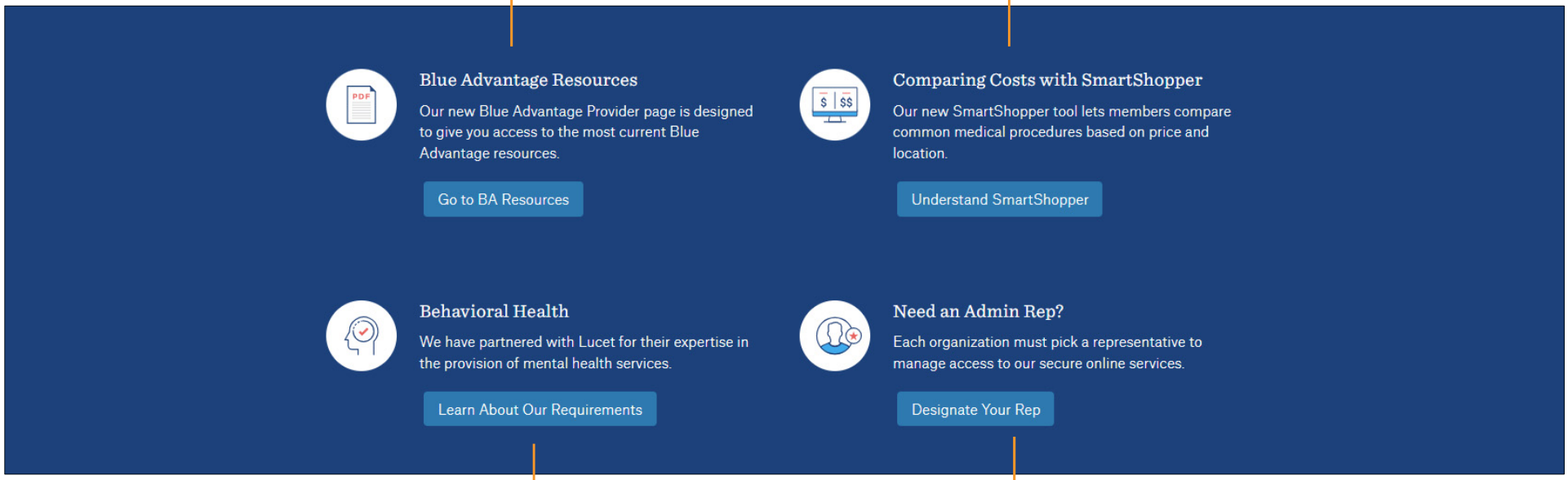
Medical Management
Find information on requirements for managing services to members.

The Provider Page

www.bcbsla.com/providers

Blue Advantage Resources
Our new Blue Advantage Provider page is designed to give you access to the most current Blue Advantage resources.

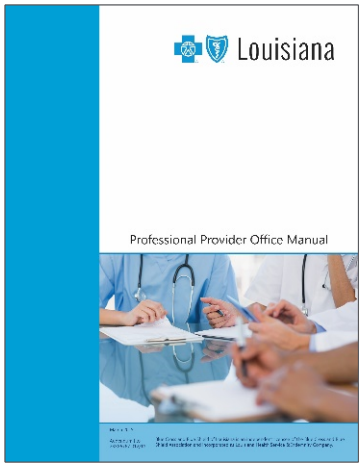
Comparing Costs with SmartShopper
Our new SmartShopper tool lets members compare common medical procedures based on price and location.

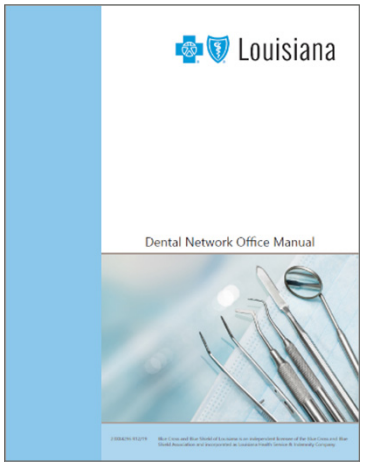


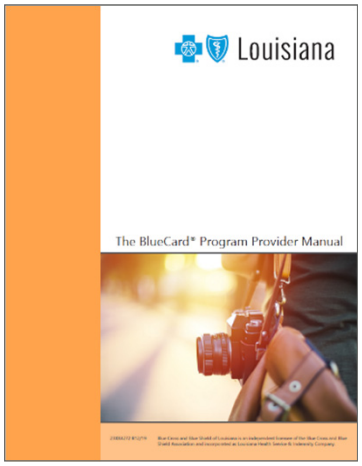
Behavioral Health
We have partnered with Lucet for their expertise in the provision of mental health services.

Need an Admin Rep?
Each organization must pick a representative to manage access to our secure online services.

Provider Manuals







www.bcbsla.com/providers >Resources >Manuals

Our manuals are an extension of your member provider agreement.

The manuals include the information you need as a participant in our networks:

- Reimbursement Information
- Claims Submission
- Billing Guidelines
- Medical Management
- Provider Disputes
- Network Overviews
- Authorization Requirements
- And much more

Newsletters

Stay connected with what is going on at Blue Cross with our **provider newsletters**.

www.bcbsla.com/providers >Newsletters

A publication to keep our network providers up to date on the latest news at Blue Cross and Blue Shield of Louisiana.

provider networknews 2023 2ND QUARTER

Providing health guidance and affordable access to quality care

Our Epic Payer Platform Helps Streamline Provider Partnerships

Blue Cross is excited to announce that it now has Epic Payer Platform. This enhancement supports increased partnership and transparency with our providers. The goal is to improve our provider experience and how care is delivered to our members—your patients.

Certain Epic functions are currently available to select provider organizations. We are coordinating with them as a beta effort to ensure enhanced clinical data exchange, ADT and scheduling notifications, and to support richer data sets for analytics. More functionalities will be implemented throughout this year.

In the coming months we will expand what Payer Platform will do, both internally and with our provider partners. This will help us connect with a larger number of providers to support reporting for value-based programs, identify and close gaps in care, increase the visibility and usability of claims data for providers, and streamline administrative processes.

The foundational capabilities of Payer Platform that exist today will also support the workflows for Blue Cross' internal clinical teams starting in November. The additional automation and integrated data streams that are part of this platform will support:

- Smoother prior authorization processes
- Increased collaboration with providers on case and disease management
- Overall administrative savings

More information about this system and educational materials, including provider webinars, are coming later this year as we launch more services on the Epic platform.

If you have any questions or would like to interface with our current Epic functionalities, please contact our Provider Relations Department at provider.relations@bcbsla.com.

www.bcbsla.com/providers
www.bcbsla.com/linkblue

Louisiana

A publication to keep our network providers informed on the latest Blue Advantage (HMO) | Blue Advantage (PPO) news.

Blue Advantage Insight Newsletter

June 2023

In this edition:

page article

2 Wellness Coupon Program
3 Wellness Visits Are a Good Time to Discuss Immunizations
3 Are You Using Our Online Blue Advantage Resources?
4 Update Your Blue Advantage Electronic Transactions
5 Help Members Beat the Heat as Summer Approaches
7 Blue Advantage PCP Incentives: Rewarding Quality Care
7 Discussing Medication Adherence Benefits Members

Louisiana Blue Advantage (HMO) | Blue Advantage (PPO)

18NW2756 R06/23
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Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, an Independent Licensee of the Blue Cross Blue Shield Association, offers Blue Advantage (PPO).

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Network News

Our quarterly newsletter for network providers.

Blue Advantage Insight

Our newsletter for our Blue Advantage (HMO) and Blue Advantage (PPO) network providers.

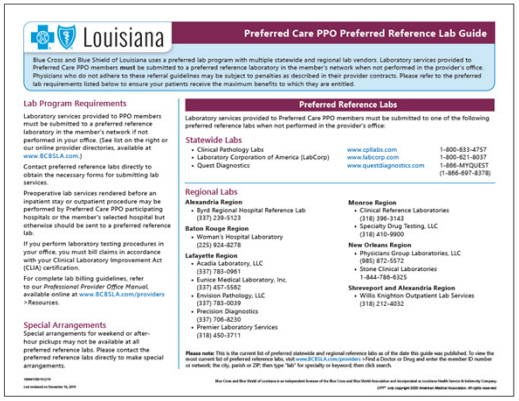
Not Getting Our Newsletters?

Send an email to **provider.communications@bcbsla.com**. Put "newsletter" in the subject line. Please include your name, organization name and contact information.

Speed Guides & Tidbits

Speed Guides offer quick reference to network authorization requirements, policies and billing guidelines.

www.bcbsla.com/providers
>Resources >Speed Guides


Louisiana
Preferred Care PPO Preferred Reference Lab Guide

Blue Cross and Blue Shield of Louisiana uses a preferred lab program with multiple statewide and regional lab vendors. Laboratory services provided to Preferred Care PPO members must be submitted to a preferred reference laboratory in the member's network when not performed in the provider's office. Physicians who do not adhere to these referral guidelines may be subject to penalties as described in their provider contracts. Please refer to the preferred lab requirements listed below to ensure your patients receive the maximum benefits to which they are entitled.

Lab Program Requirements

Laboratory services provided to PPO members must be submitted to a preferred reference laboratory in the member's network if not performed in your office. (See list on the right or our online provider directories, available at www.BCBSLA.com.)

Contact preferred reference labs directly to obtain the necessary forms for submitting lab services.

Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by Preferred Care PPO participating hospitals or the member's selected hospital but otherwise should be sent to a preferred reference lab.

If you perform laboratory testing procedures in your office, you must bill claims in accordance with your Clinical Laboratory Improvement Act (CLIA) certification.

For complete lab billing guidelines, refer to our *Professional Provider Office Manual*, available online at www.BCBSLA.com/providers >Resources.

Special Arrangements

Special arrangements for weekend or after-hour pickups may not be available at all preferred reference labs. Please contact the preferred reference labs directly to make special arrangements.

Preferred Reference Labs

Laboratory services provided to Preferred Care PPO members must be submitted to one of the following preferred reference labs when not performed in the provider's office:

Statewide Labs

- Clinical Pathology Labs — www.cplabs.com — 1-800-633-4757
- Laboratory Corporation of America (LabCorp) — www.labcorp.com — 1-800-621-8037
- Quest Diagnostics — www.questdiagnostics.com — 1-866-MYQUEST (1-866-697-8378)

Regional Labs

Alexandria Region
- Byrd Regional Hospital Reference Lab (337) 239-5123

Baton Rouge Region
- Woman's Hospital Laboratory (225) 924-8278

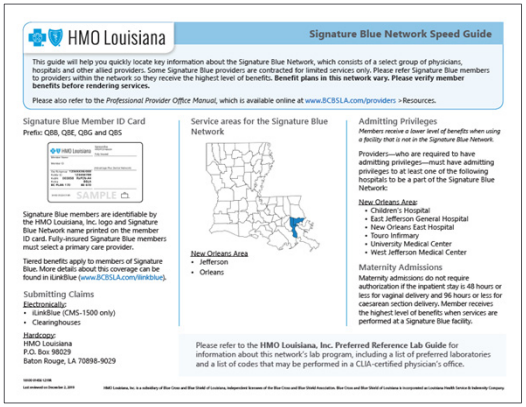
Lafayette Region
- Acadia Laboratory, LLC (337) 783-0961
- Eunice Medical Laboratory, Inc. (337) 457-5582
- Envision Pathology, LLC (337) 783-0039
- Precision Diagnostics (337) 706-8230
- Premier Laboratory Services (318) 450-3711

Monroe Region
- Clinical Reference Laboratories (318) 396-3143
- Specialty Drug Testing, LLC (318) 410-9900

New Orleans Region
- Physicians Group Laboratories, LLC (985) 872-5572
- Stone Clinical Laboratories 1-844-788-6325

Shreveport and Alexandria Region
- Willis Knighton Outpatient Lab Services (318) 212-4032

Please note: This is the current list of preferred statewide and regional reference labs as of the date this guide was published. To view the most current list of preferred reference labs, visit www.BCBSLA.com/providers >Find a Doctor or Drug and enter the member ID number or network; the city, parish or ZIP; then type "lab" for specialty or keyword; then click search.


HMO Louisiana
Signature Blue Network Speed Guide

This guide will help you quickly locate key information about the Signature Blue Network, which consists of a select group of physicians, hospitals and other allied providers. Some Signature Blue providers are contracted for limited services only. Please refer Signature Blue members to providers within the network so they receive the highest level of benefits. **Benefit plans in this network vary. Please verify member benefits before rendering services.**

Please also refer to the *Professional Provider Office Manual*, which is available online at www.BCBSLA.com/providers >Resources.

Signature Blue Member ID Card

Prefix: QBB, QBE, QBG and QBS

SAMPLE

Signature Blue members are identifiable by the HMO Louisiana, Inc. logo and Signature Blue Network name printed on the member ID card. Fully-insured Signature Blue members must select a primary care provider.

Tiered benefits apply to members of Signature Blue. More details about this coverage can be found in iLinkBlue (www.BCBSLA.com/linkblue).

Submitting Claims

Electronically:
- iLinkBlue (CMS-1500 only)
- Clearinghouses

Hardcopy:
HMO Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

Service areas for the Signature Blue Network

New Orleans Area
- Jefferson
- Orleans

Admitting Privileges

Members receive a lower level of benefits when using a facility that is not in the Signature Blue Network.

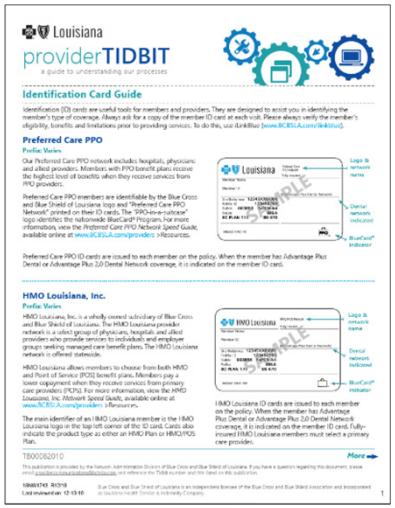
Providers—who are required to have admitting privileges—must have admitting privileges to at least one of the following hospitals to be a part of the Signature Blue Network:

New Orleans Area:
- Children's Hospital
- East Jefferson General Hospital
- New Orleans East Hospital
- Touro Infirmary
- University Medical Center
- West Jefferson Medical Center

Maternity Admissions

Maternity admissions do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for caesarean section delivery. Member receives the highest level of benefits when services are performed at a Signature Blue facility.

Please refer to the **HMO Louisiana, Inc. Preferred Reference Lab Guide** for information about this network's lab program, including a list of preferred laboratories and a list of codes that may be performed in a CLIA-certified physician's office.


Louisiana
providerTIDBIT
a guide to understanding our processes

Identification Card Guide

Identification (ID) cards are useful tools for members and providers. They are designed to assist you in identifying the member's type of coverage. Always ask for a copy of the member ID card at each visit. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue (www.BCBSLA.com/linkblue).

Preferred Care PPO

Prefix: Varies

Our Preferred Care PPO network includes hospitals, physicians and allied providers. Members with PPO benefit plans receive the highest level of benefits when they receive services from PPO providers.

Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and "Preferred Care PPO Network" printed on their ID cards. The "PPO-in-a-suitcase" logo identifies the nationwide BlueCard® Program. For more information, view the *Preferred Care PPO Network Speed Guide*, available online at www.BCBSLA.com/providers >Resources.

Preferred Care PPO ID cards are issued to each member on the policy. When the member has Advantage Plus Dental or Advantage Plus 2.0 Dental Network coverage, it is indicated on the member ID card.

HMO Louisiana, Inc.

Prefix: Varies

HMO Louisiana, Inc. is a wholly owned subsidiary of Blue Cross and Blue Shield of Louisiana. The HMO Louisiana provider network is a select group of physicians, hospitals and allied providers who provide services to individuals and employer groups seeking managed care benefit plans. The HMO Louisiana network is offered statewide.

HMO Louisiana allows members to choose from both HMO and Point of Service (POS) benefit plans. Members pay a lower copayment when they receive services from primary care providers (PCPs). For more information, view the *HMO Louisiana, Inc. Network Speed Guide*, available online at www.BCBSLA.com/providers >Resources.

The main identifier of an HMO Louisiana member is the HMO Louisiana logo in the top left corner of the ID card. Cards also indicate the product type as either an HMO Plan or HMO/POS Plan.

HMO Louisiana ID cards are issued to each member on the policy. When the member has Advantage Plus Dental or Advantage Plus 2.0 Dental Network coverage, it is indicated on the member ID card. Fully-insured HMO Louisiana members must select a primary care provider.

More

TB00082010

Louisiana
providerTIDBIT
a guide to understanding our processes

Automated Benefits & Claim Status

Provider Services is an automated KEYPAD or VOICE RESPONSE telephone system designed to help providers reach the area of service needed. Use this guide to easily navigate this provider phone tool.

Customer Care Center 1-800-922-8866

Benefits are subject to the terms of a member's contract/certificate and our medical policies. Claims are subject to allowable charges, which are established by Blue Cross as the maximum allowed amount for services covered under the member contract/certificate.

Please have the following information ready when calling:
- Provider's NPI
- Provider's Tax ID Number
- Provider's ZIP Code
- Member ID Number
- Member's 8-digit Date of Birth
- Date of Service

Welcome to Blue Cross and Blue Shield of Louisiana Provider Services. To expedite your call please have the member identification number available. Which type of policy are you calling about?

1. Medical 2.Vision* 3. Dental 4. Life

(Pause for you to say or key-in a policy type)

Please say or enter your 10-digit NPI. (Pause for you to say or key-in NPI)

Please say or enter your nine-digit Tax ID. (Pause for you to say or key-in Tax ID)

*Note: If calling about a vision policy, you will be asked if your call is for routine eye coverage, such as an eye exam/eye glasses, or contact. Answer "yes" to make your call to an appropriate representative. Answer "no" to continue to the Provider Menu to reach the service needed.

Provider Menu

Provider menu. Which are you calling about?

1. Benefits
2. Claims
3. Authorizations
4. An Out-of-state Policy
5. A Payment Register Fax, or
6. None of the Above

More

TB00092010

Provider Tidbits are quick guides designed to help you with our current business processes.

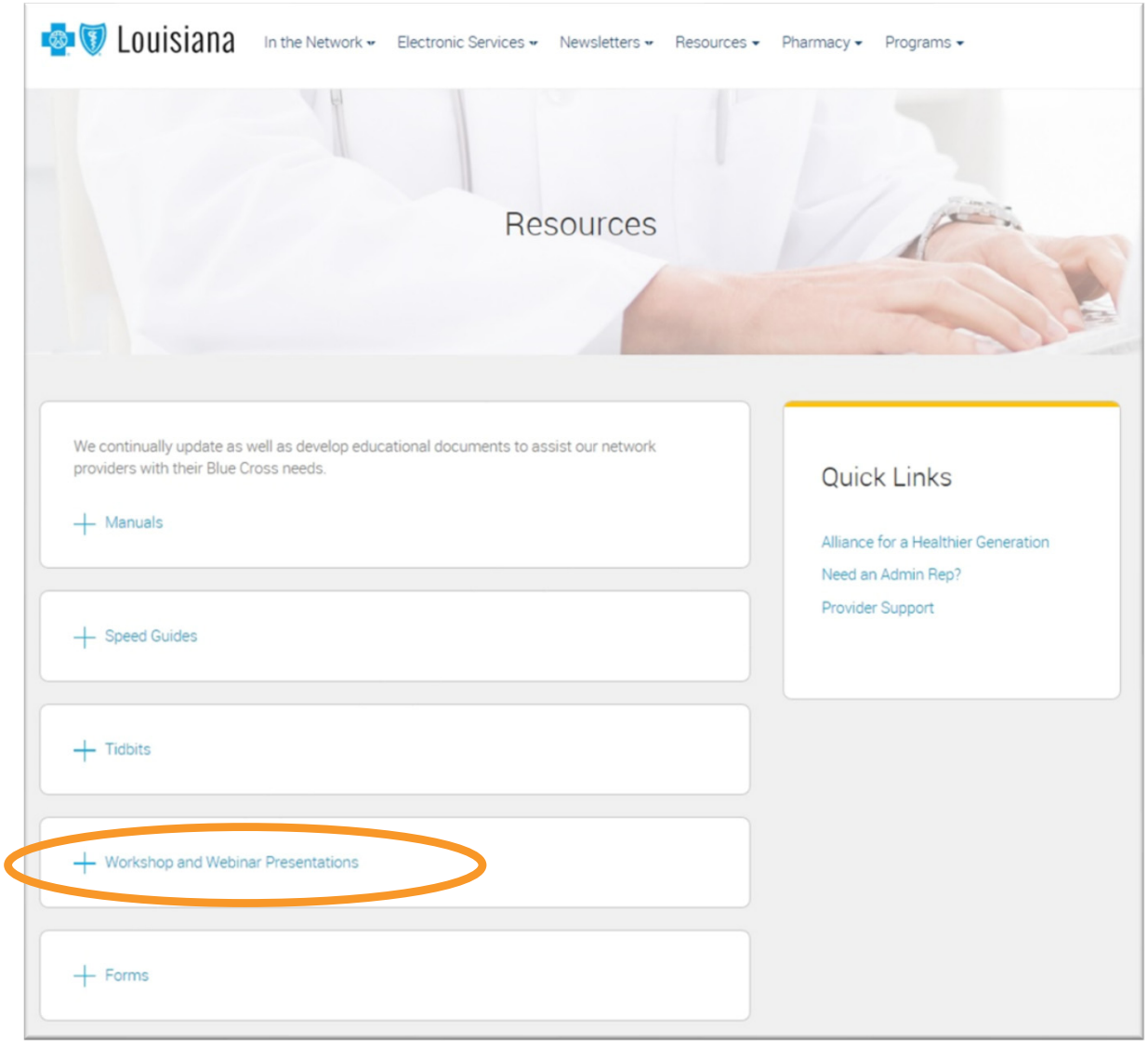
www.bcbsla.com/providers
>Resources >Tidbits

Workshops and Webinars

Provider Workshops and Webinars are held throughout the year to offer training and updates on Blue Cross policies and procedures.

Invites to attend these events are sent to the providers' correspondence email address.

PDF copies of our workshops and webinars are available online.



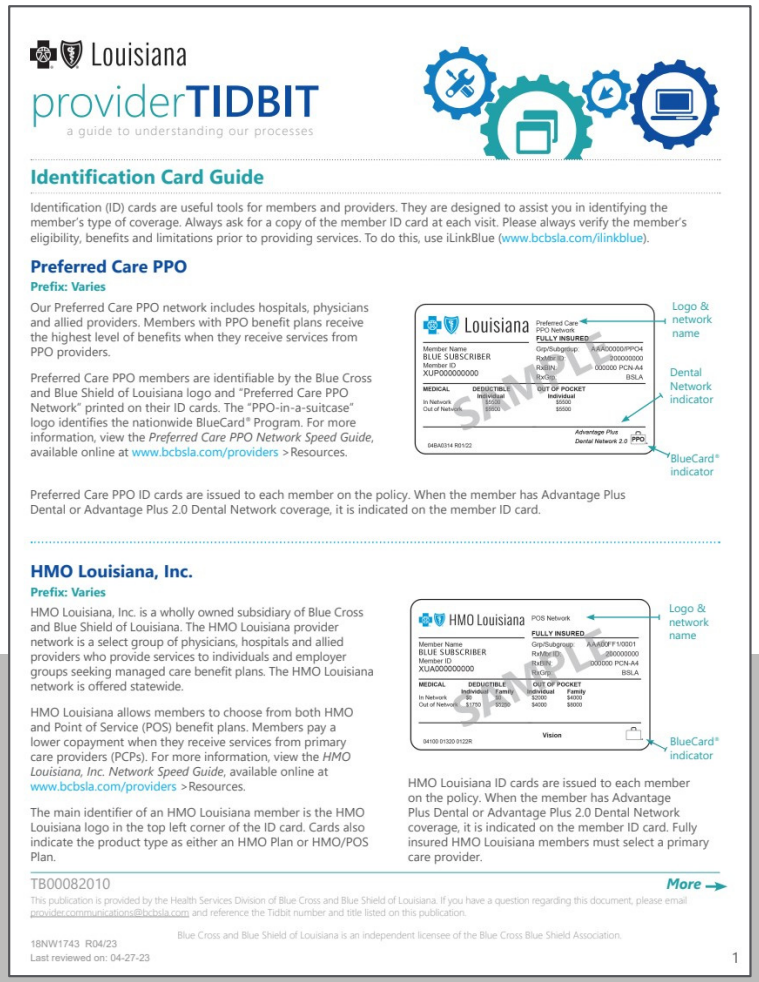
www.bcbsla.com/providers >Resources >Workshop and Webinar Presentations

Our Networks

Blue Cross' Provider Networks

Blue Cross offers several provider networks that are tied to our members' benefit plans. These networks include:

- Preferred Care PPO
- HMO Louisiana, Inc.
- Blue Connect
- BlueHPN
- Community Blue
- Precision Blue
- Signature Blue
- Blue Advantage (HMO) | Blue Advantage (PPO)
- Ochsner Health Network



Louisiana

providerTIDBIT

a guide to understanding our processes

Identification Card Guide

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Preferred Care PPO

Prefix: Varies

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Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and "Preferred Care PPO Network" printed on their ID cards. The "PPO-in-a-suitcase" logo identifies the nationwide BlueCard® Program. For more information, view the *Preferred Care PPO Network Speed Guide*, available online at www.bcbsla.com/providers >Resources.

Logo & network name

Dental Network indicator

BlueCard® indicator

Preferred Care PPO ID cards are issued to each member on the policy. When the member has Advantage Plus Dental or Advantage Plus 2.0 Dental Network coverage, it is indicated on the member ID card.

HMO Louisiana, Inc.

Prefix: Varies

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The main identifier of an HMO Louisiana member is the HMO Louisiana logo in the top left corner of the ID card. Cards also indicate the product type as either an HMO Plan or HMO/POS Plan.

Logo & network name

BlueCard® indicator

HMO Louisiana ID cards are issued to each member on the policy. When the member has Advantage Plus Dental or Advantage Plus 2.0 Dental Network coverage, it is indicated on the member ID card. Fully insured HMO Louisiana members must select a primary care provider.

TB00082010

More →

This publication is provided by the Health Services Division of Blue Cross and Blue Shield of Louisiana. If you have a question regarding this document, please email provider.communications@bcbsla.com and reference the Tidbit number and title listed on this publication.

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

18NW1743 R04/23

Last reviewed on: 04-27-23

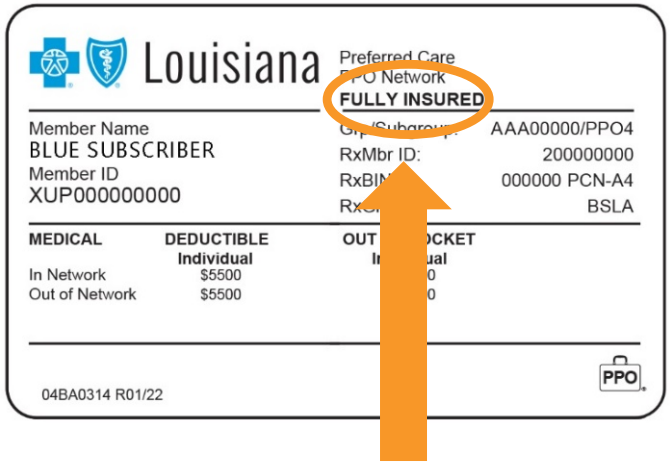
1

Our Identification Card Guide Provider Tidbit is a guide to identify members' applicable networks when looking at the ID card. Go to www.bcbsla.com/providers, click "Resources," then "Provider Tidbits."

Fully Insured & Self Funded

FULLY INSURED

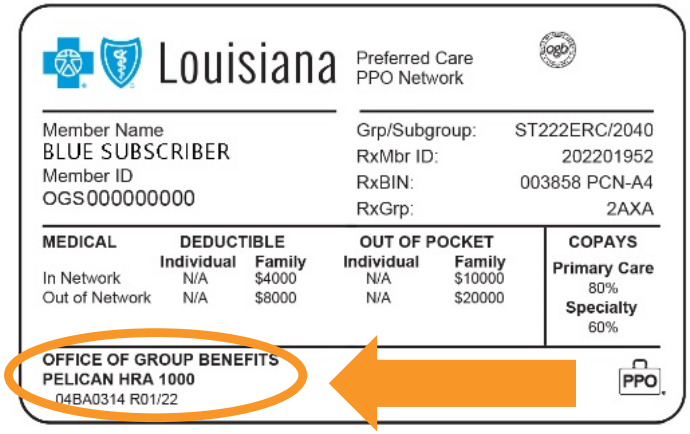
Group and individual policies issued by Blue Cross/HMOLA, and claims are funded by Blue Cross/HMOLA.



"Fully Insured" notation

SELF FUNDED

Group policies issued by Blue Cross/HMOLA but claims payments are funded by the employer group, not Blue Cross/HMOLA.



- **"Fully Insured" NOT noted**
- **Self-funded group name listed**

The benefit, limitation, exclusion and authorization **requirements often vary for self-funded groups**. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue (**www.bcbsla.com/ilinkblue**).

BlueCard® Program (out-of-area) Members

BlueCard® is a national program that enables members of any Blue Cross Blue Shield (BCBS) Plan to obtain healthcare services while traveling or living in another BCBS Plan service area. The main identifiers are the prefix and the "suitcase" logo on the member ID card.

The suitcase logo provides the following information about the member:

The PPOB suitcase indicates the member has access to the exchange PPO network, referred to as BlueCard PPO basic.

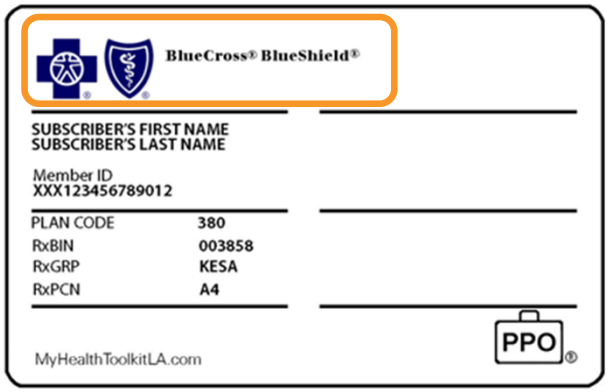
The PPO suitcase indicates the member is enrolled in a Blue Plan PPO or EPO product.

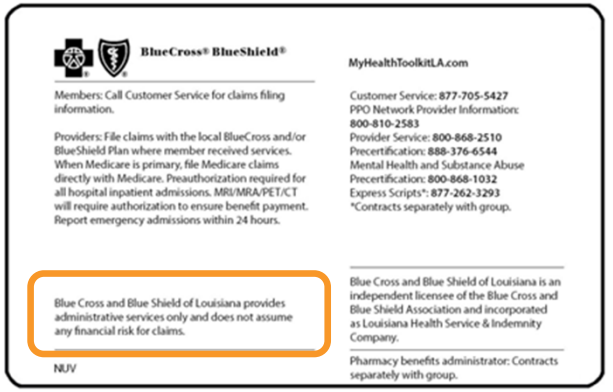
The empty suitcase indicates the member is enrolled in a Blue Plan traditional, HMO, POS or limited benefits product.

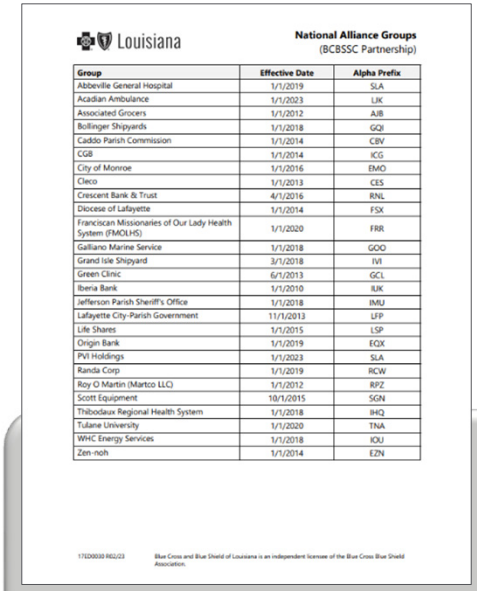
The HPN suitcase logo indicates the member is enrolled in a Blue High Performance Network℠ (BlueHPN) product.

National Alliance Members *(South Carolina Partnership)*

- National Alliance groups are administered through BCBSLA's partnership agreement with Blue Cross and Blue Shield of South Carolina (BCBSSC).
- BCBSLA taglines are present on the member ID cards; however, customer service, provider service and precertification are handled by BCBSSC.
- Claims are processed through the BlueCard program.







Louisiana

National Alliance Groups
(BCBSSC Partnership)

Group	Effective Date	Alpha Prefix
Abbeville General Hospital	1/1/2019	SLA
Acadian Ambulance	1/1/2023	LJK
Associated Grocers	1/1/2012	AJB
Bollinger Shipyards	1/1/2018	GQI
Caddo Parish Commission	1/1/2014	CBV
CGB	1/1/2014	ICG
City of Monroe	1/1/2016	EMO
Cleco	1/1/2013	CES
Crescent Bank & Trust	4/1/2016	RNL
Diocese of Lafayette	1/1/2014	FSX
Franciscan Missionaries of Our Lady Health System (FMOLHS)	1/1/2020	FRR
Gailliano Marine Service	1/1/2018	GOO
Grand Isle Shipyard	3/1/2018	IVI
Green Clinic	6/1/2013	GCL
Iberia Bank	1/1/2010	IUK
Jefferson Parish Sheriff's Office	1/1/2018	IMU
Lafayette City-Parish Government	11/1/2013	LFP
Life Shares	1/1/2015	LSP
Origin Bank	1/1/2019	EQX
PVI Holdings	1/1/2023	SLA
Randa Corp	1/1/2019	RCW
Roy O Martin (Martco LLC)	1/1/2012	RPZ
Scott Equipment	10/1/2015	SGN
Thibodaux Regional Health System	1/1/2018	IHQ
Tulane University	1/1/2020	TNA
WHC Energy Services	1/1/2018	IOU
Zen-noh	1/1/2014	EZN

17LD0030-REQ/23 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

We publish a list of these groups (with prefixes) in iLinkBlue (**www.bcbsla.com/ilinkblue**) under the "Resources" section.

Referring Members Out-of-network

You can find network providers to refer members to in our online provider directories at www.bcbsla.com >Find a Doctor.

The impact on your patients when you refer Blue Cross members to out-of-network providers include:

- higher cost shares (deductibles, coinsurances, copayments)
- no benefits for some members
- balance billing to member for all amounts not paid by Blue Cross if the provider is non-participating

If a provider continues to refer patients to out-of-network providers, their entire fee schedule could be reduced.

Member Referrals

Network providers should **always** refer members to other **network** providers.

- Referrals to out-of-network providers result in significantly higher cost shares (deductibles, coinsurance and copayments) for our members and is a breach of your Blue Cross provider agreement.

- Providers who consistently refer to out-of-network providers will be audited and may be subject to a **reduction** in their network reimbursement.

Laboratory Referrals

- All of our network providers should refer members to preferred reference lab vendors when lab services are needed and are not performed in the office.
- If you perform laboratory testing procedures in your office, we require a copy of your Clinical Laboratory Improvement Act (CLIA) certification.
- HMO Louisiana, Blue Connect, Community Blue, Precision Blue and Signature Blue physicians may perform a selection of lab tests from our In-office Lab List.

The ordering/referring provider NPI is required on all laboratory claims. Place the NPI in the indicated blocks:

- CMS-1500: Block 17B
- 837P: 2310A loop, using the NM1 segment and the qualifier of DN in the NM101 element

The In-office Lab List is available in our *HMO Preferred Reference Lab Guide* which is available online at **www.bcbsla.com/providers** >Resources >Speed Guides.

Using iLinkBlue

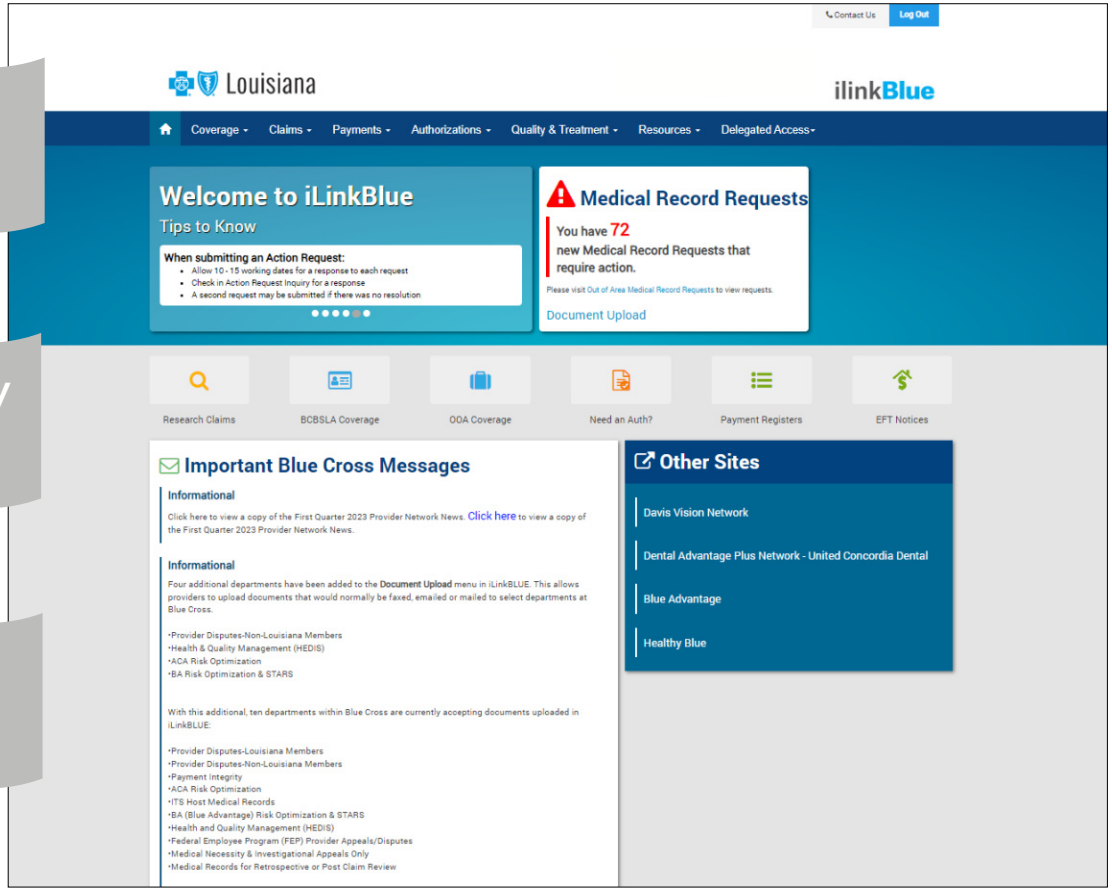
What is iLinkBlue?

iLinkBlue is Blue Cross and Blue Shield of Louisiana's secure online provider portal.

no cost to providers

user-friendly navigation

secure auth applications



www.bcbsla.com/ilinkblue

- Allowable Charges
- Authorizations
- Eligibility
- Benefits
- Coordination of Benefits (COB)
- Claims Research
- Electronic Funds Transfer
- Estimated Treatment Cost
- Grace Period Notices
- Manuals
- Medical Code Editing
- Medical Policies
- Payment Information
- Electronic Funds Transfer (EFT) Notifications
- BlueCard® Medical Record Requests
- Professional Claims Submission

The Administrative Representative Role

What is an Administrative Representative?

- An administrative representative is a person at your organization who has registered with Blue Cross to designate user access to our secure online services.
- They only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities.
- Your administrative representative must grant a user access to the following:
  - iLinkBlue
  - BCBSLA Authorizations
  - Behavioral Health Authorizations
  - Blue Advantage Provider Portal
  - Pre-Service Review
- One administrative representative is required to self-manage user access to our secure online services, but we recommend each organization assign more than one.

If you do not have an administrative representative registered with Blue Cross, please fill out and submit the Administrative Representative Registration Packet, which can be found on our Provider page (**www.bcbsla.com/providers**).

Accessing iLinkBlue

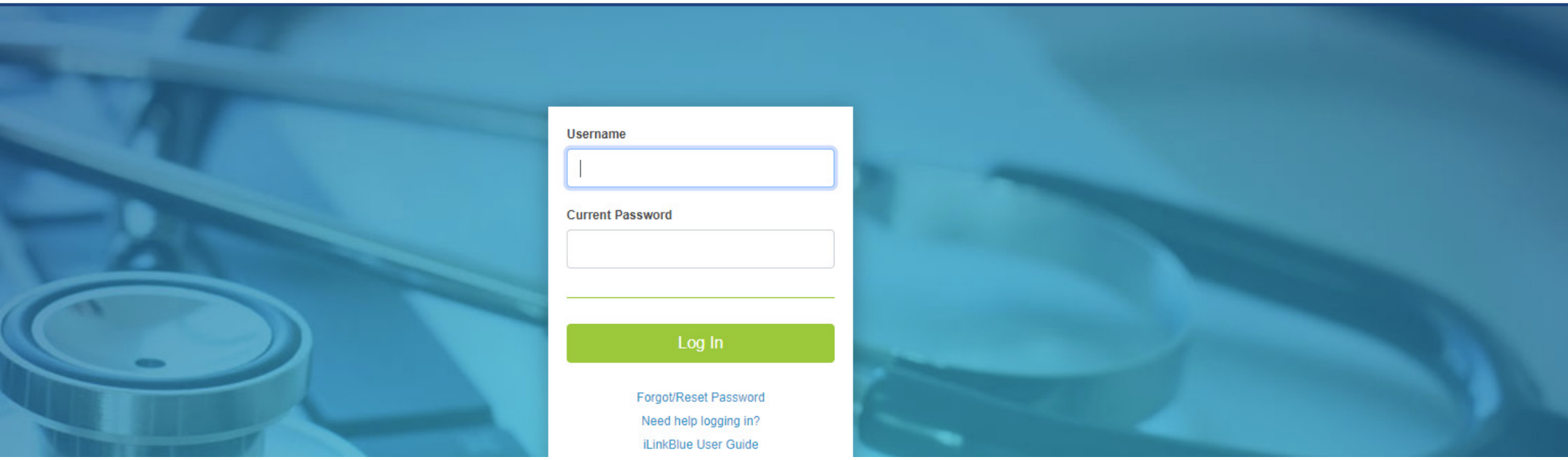
Need access to iLinkBlue?

Does your organization have an administrative representative?

- Reach out to your organization's administrative representative to request access.
- The administrative representative will use the Delegated Access application in iLinkBlue to set up your appropriate level of security access to iLinkBlue.
- Deeper levels of security may include member eligibility and coverage research, submitting claims, and/or access to secure authorization applications.

- Self designate at least one administrative representative at your organization.
- Complete the Administrative Representative Registration Packet. It is available online at **www.bcbsla.com/providers** >Electronic Services >Admin Reps.
- Contact our Provider Identity Management (PIM) Team at **PIMteam@bcbsla.com** or 1-800-716-2299, option 5 with questions.

Accessing iLinkBlue



Logging in for the first time:

- Password must be reset.
- Click on the "Forgot/Reset Password" button.
- Follow the prompts, enter your username and click the "Request Password" button.
- The system will send you an email to reset your password. Click on the link in the email. Follow the prompts.

Passwords

Passwords must be eight positions and contain a number, an uppercase letter, a lowercase letter and one special character (~! @#$%^&). Do not use your browser's password manager function to save or store your password. This can prevent you from changing your password when it expires.

iLinkBlue accounts that are not accessed for 180 days are locked due to inactivity. **Reach out to your administrative representative to have your account reset.**

If you are the administrative representative and need your password reset, reach out to the Provider Identity Management (PIM) Team.

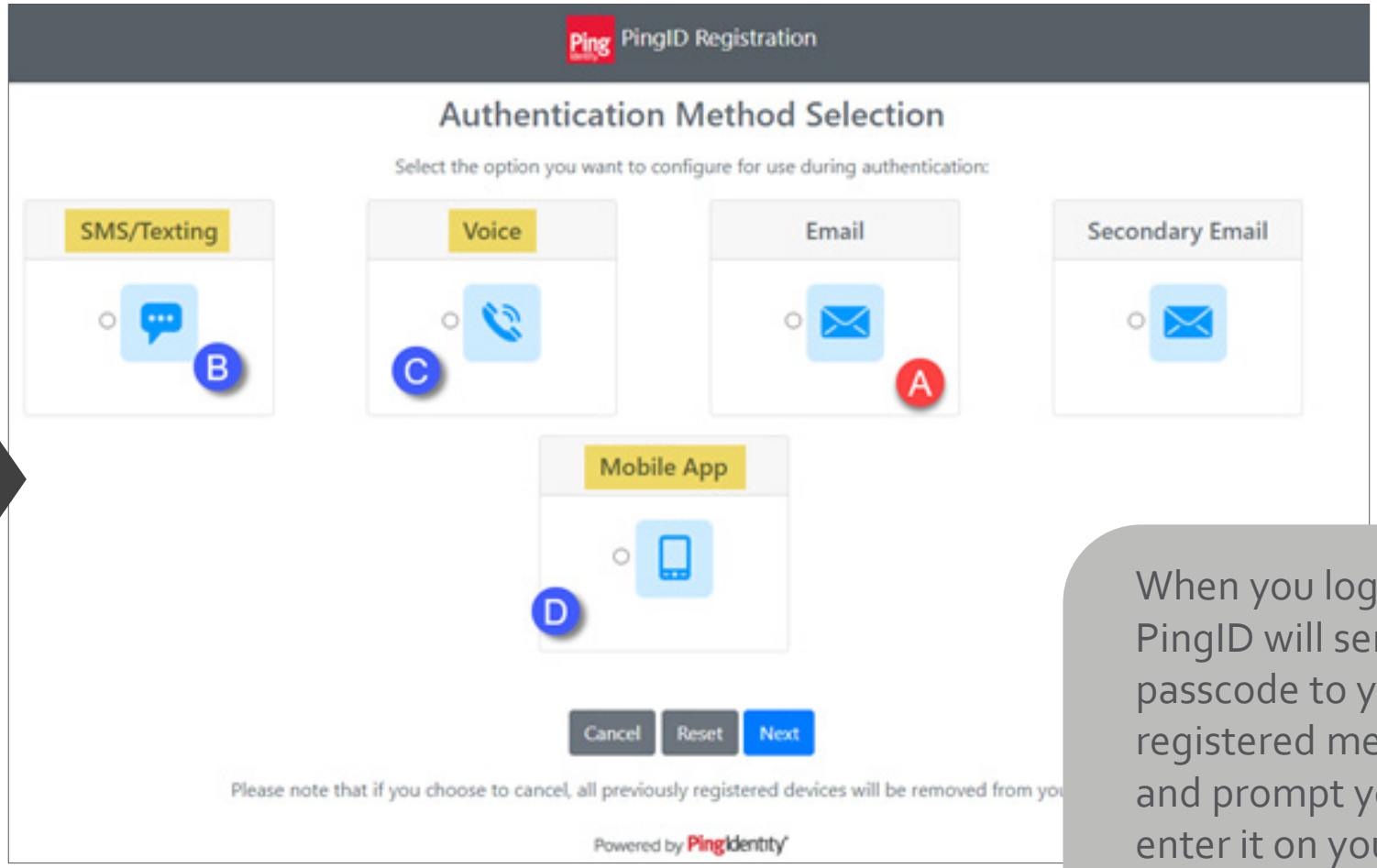
Phone: 1-800-716-2299, option 5
Monday – Friday 7:30 a.m. to 4 p.m.

Email: **PIMteam@bcbsla.com**

Multi-factor Authentication

Multi-factor authentication (MFA) is required to securely access iLinkBlue. MFA is a security feature that delivers a unique identifier passcode via email, text and other formats. To set up MFA, you must register an authentication method with PingID.

We recommend registering **two or more** options for account recovery.

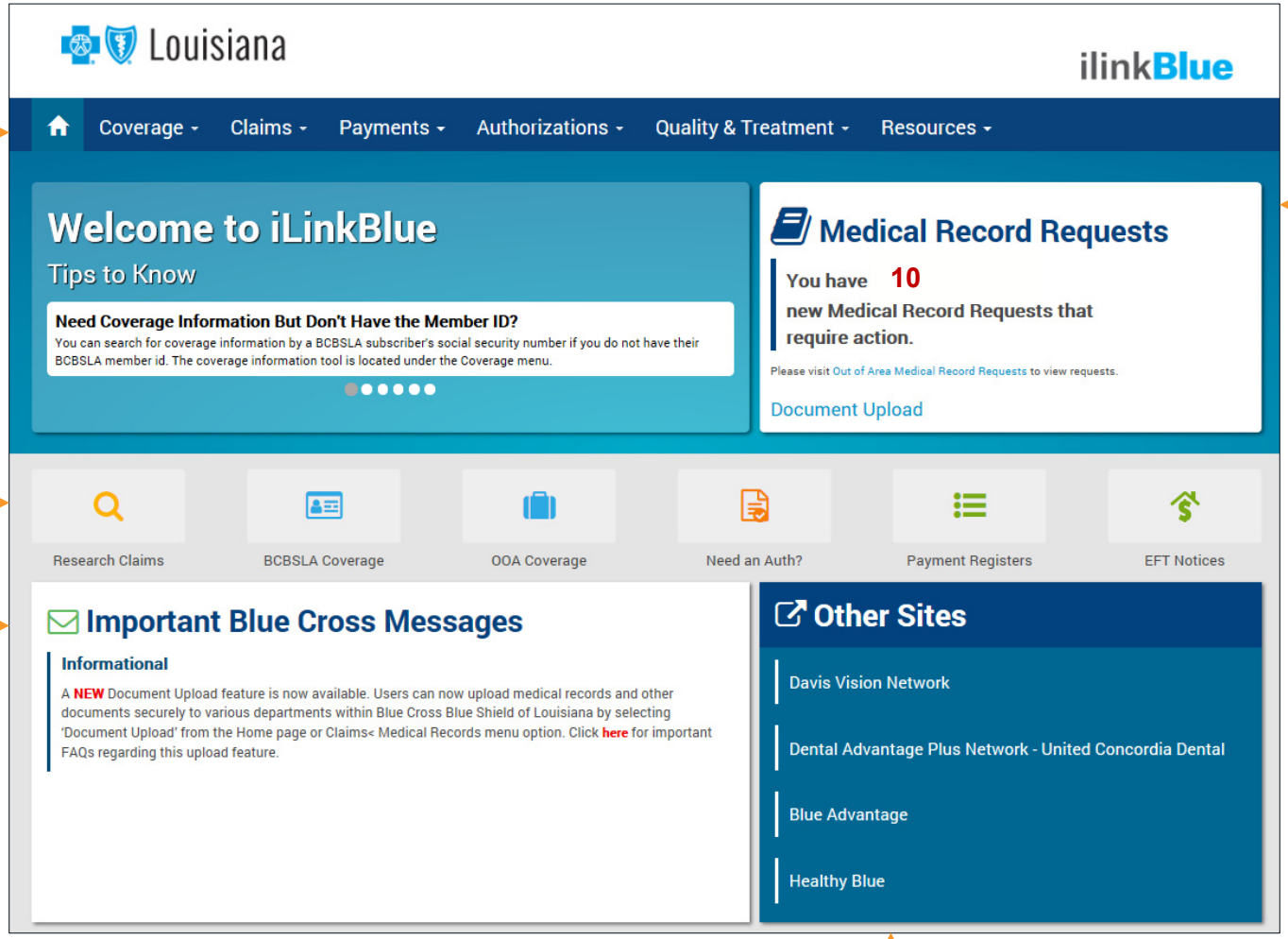


When you log in, PingID will send a passcode to your registered method and prompt you to enter it on your computer.

Navigating iLinkBlue

Top Navigation

The top navigation streamlines the iLinkBlue functions under six menus. When you click a menu option, a sub-menu appears that includes relevant features.



Quick Links

This area contains shortcuts to the six most-used iLinkBlue functions.

Message Board

Contains up-to-the minute posts for upcoming events, new features, system outages, holiday notices and other important bulletins.

Medical Record Requests

You receive an alert when you have Out of Area Medical Record Requests for BlueCard members. To view these requests, click the "Out of Area Medical Record Requests" link on the alert. This does not include medical record requests for BCBSLA members. To upload medical records and other documents, click the "Document Upload" link.

Other Sites

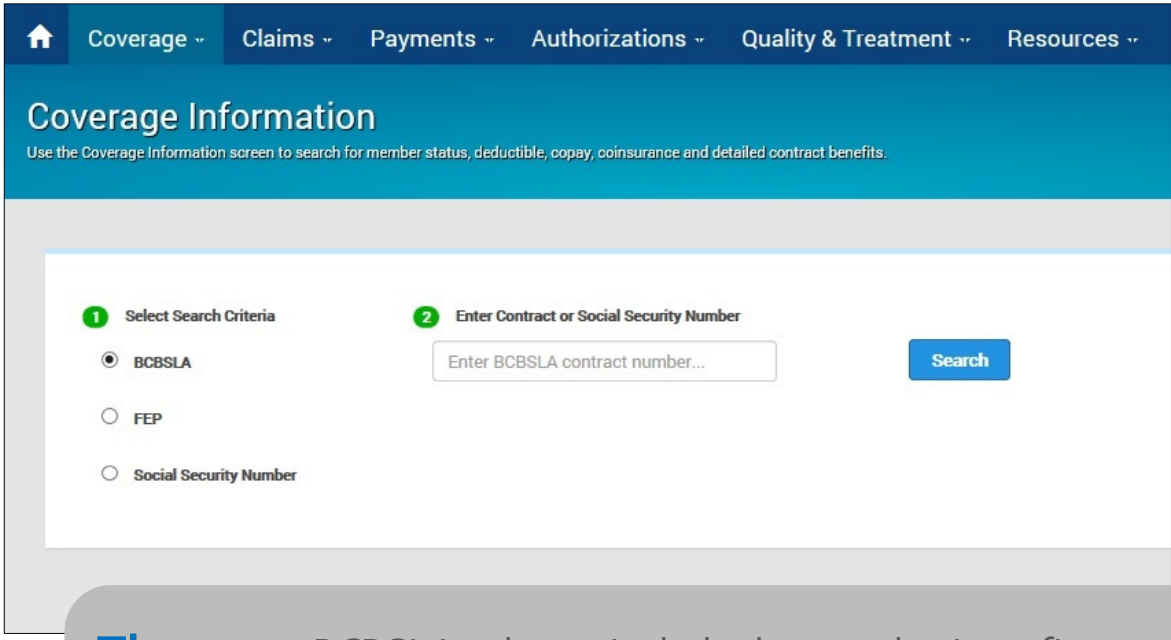
We provide quick access to other sites a provider might need to access.

Verifying Member Benefits in iLinkBlue

Use iLinkBlue (**www.bcbsla.com/ilinkblue**) to lookup a member's coverage information.

Choose the "Coverage" menu option. Enter them member ID number to view coverage information for:

- BCBSLA (including HMO Louisiana, Inc.) members
- FEP members. This section is not used for out-of-area members.



Tips

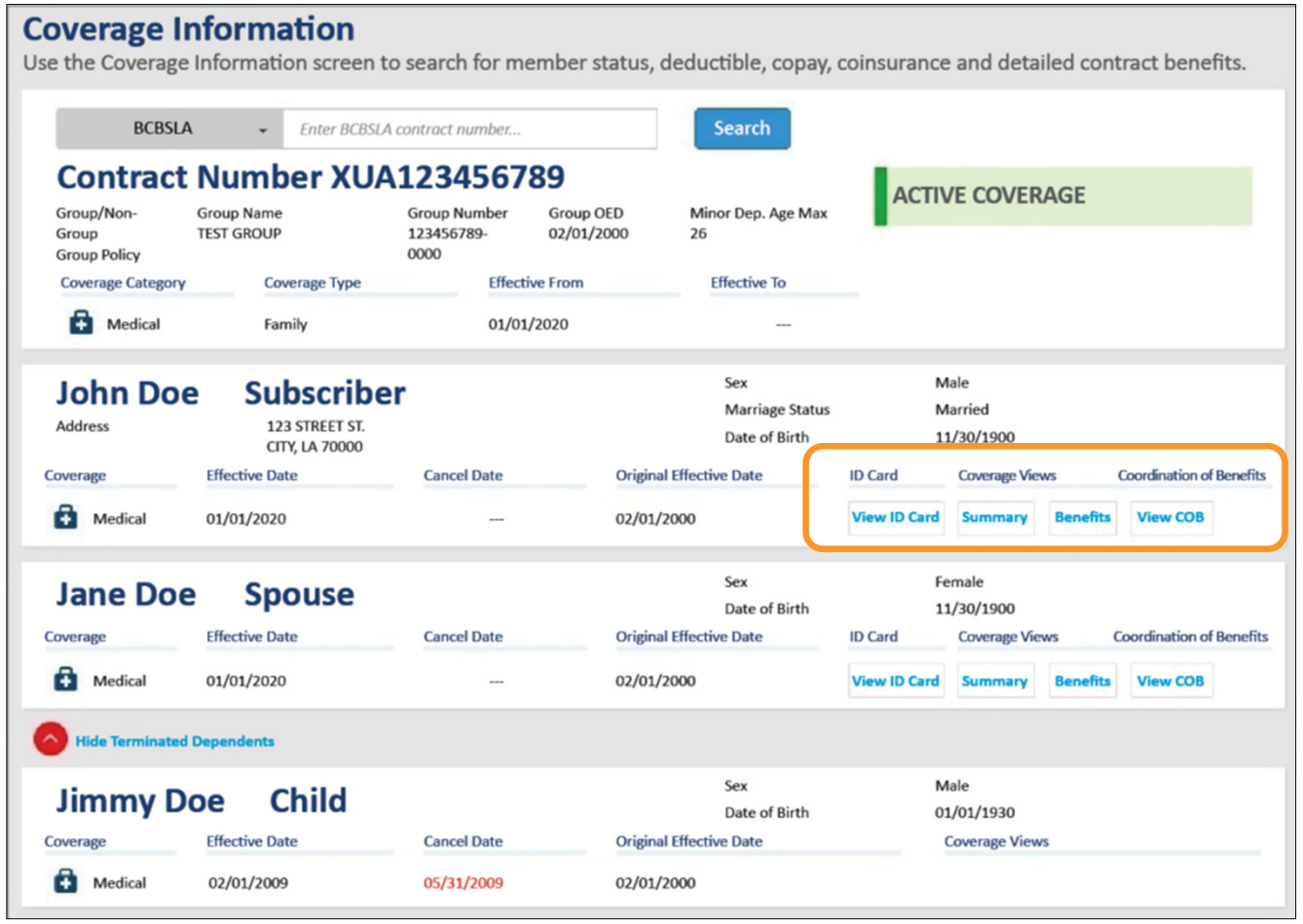
- BCBSLA – do not include the member's prefix.
- FEP – must include the letter "R"
- A different application is used for BlueCard (out-of-area) members

If you do not have the member ID number, you can search using the subscriber's Social Security Number (SSN), when available. iLinkBlue will return search results with the member ID number. An error message will display if searching by a dependent's SSN. It must be the SSN of the policy holder.

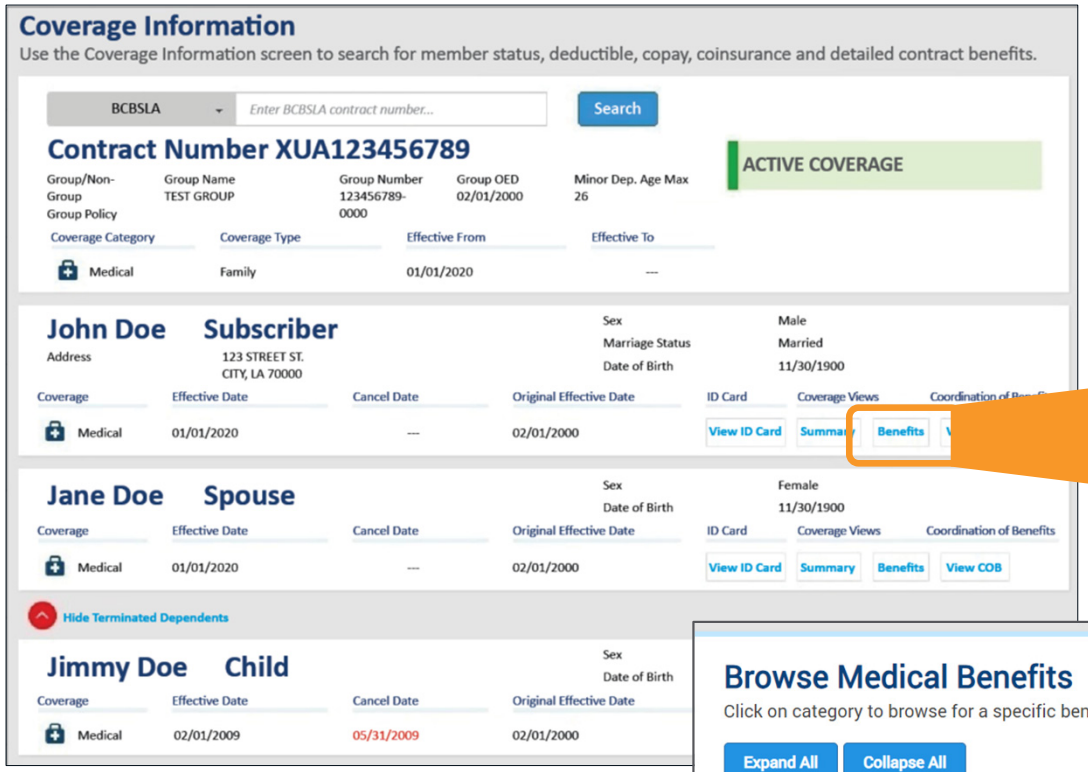
Coverage Information

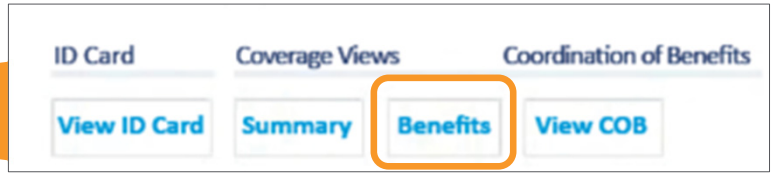
This screen identifies members covered on a policy, effective date and the status of the contract (active, pended, cancelled).

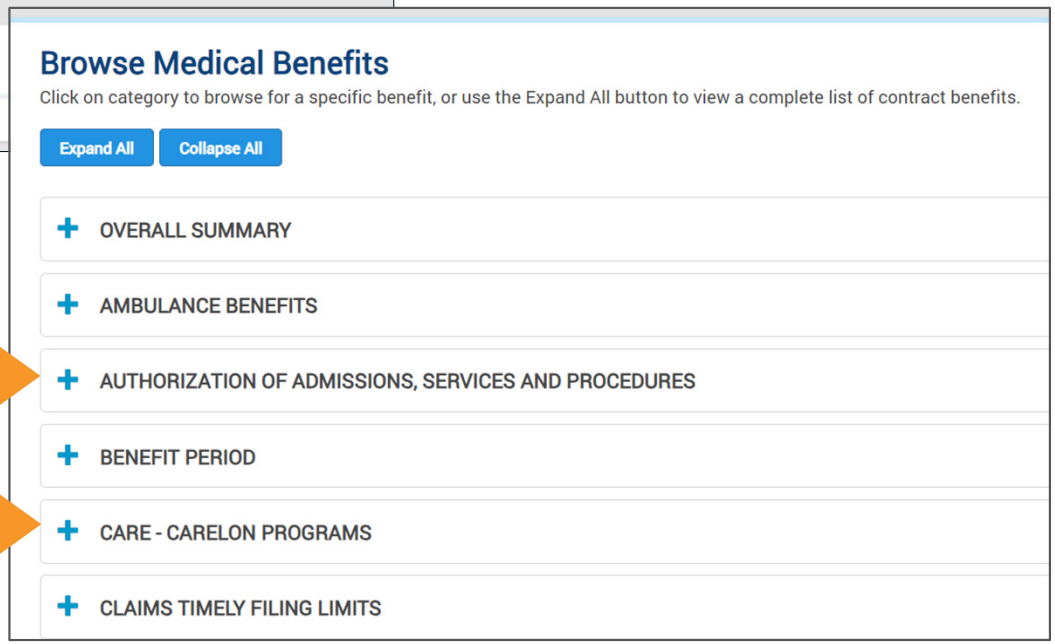
- The **View ID Card** button allows you to download a PDF of the member ID card.
- The **Summary** button allows you to view a benefit summary. It includes the member's cost share (deductible, copay and coinsurance) and remaining out-of-pocket amounts.
- The **Benefits** button allows you to view the coverage details of the member's benefits plan.
- The **View COB** button allows you to view coordination of benefits information.



Verifying Benefits for Members



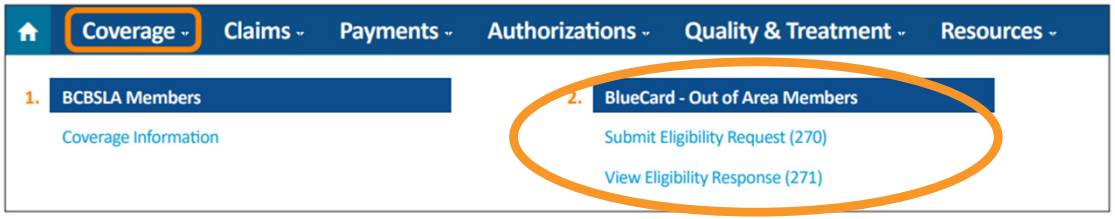


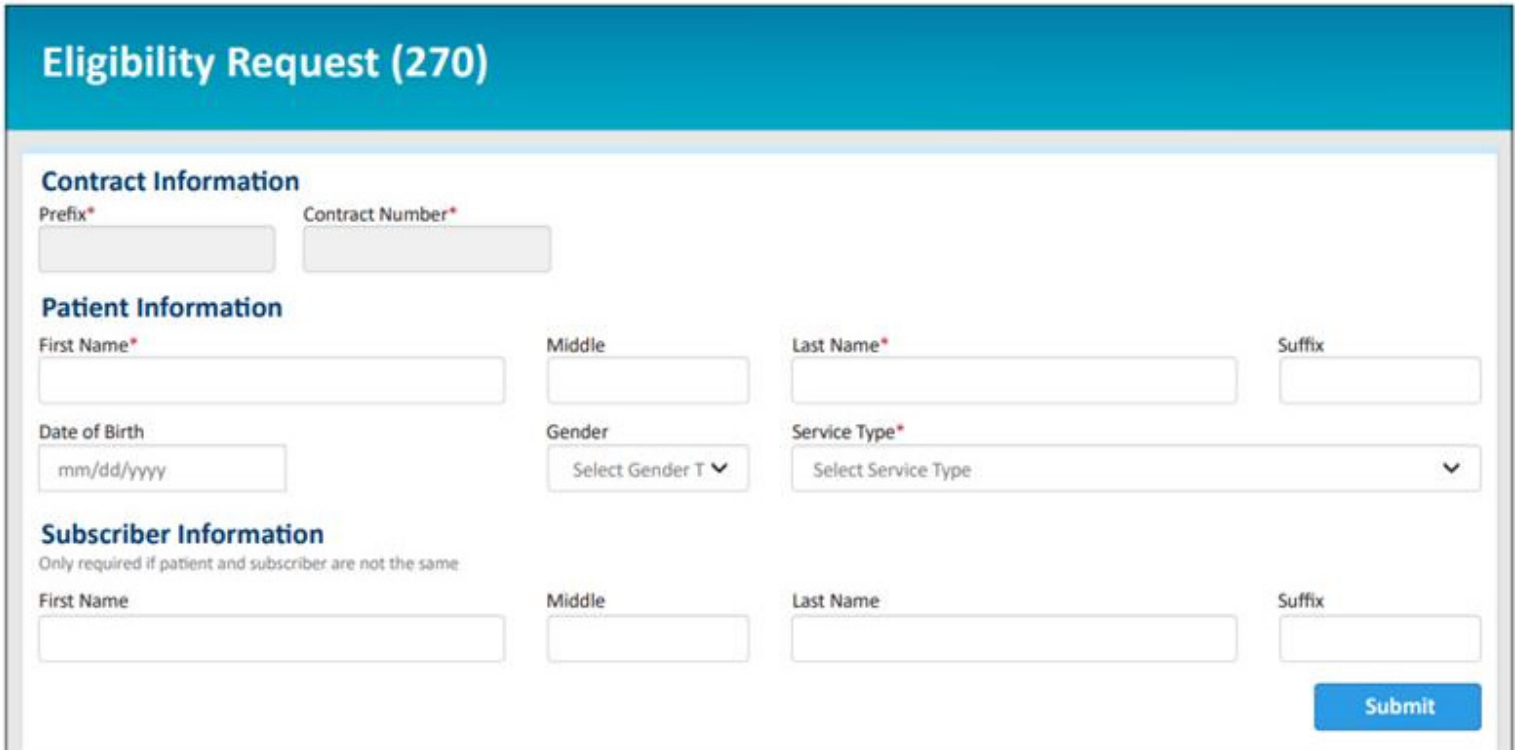


Click on **Benefits** to open the list of services covered under the member's policy. Also be sure to verify limitations and exclusions, as benefits vary by policy.

Verifying Benefits for BlueCard Members

Use the "Coverage" menu option to research BlueCard (out-of-area) member (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana).



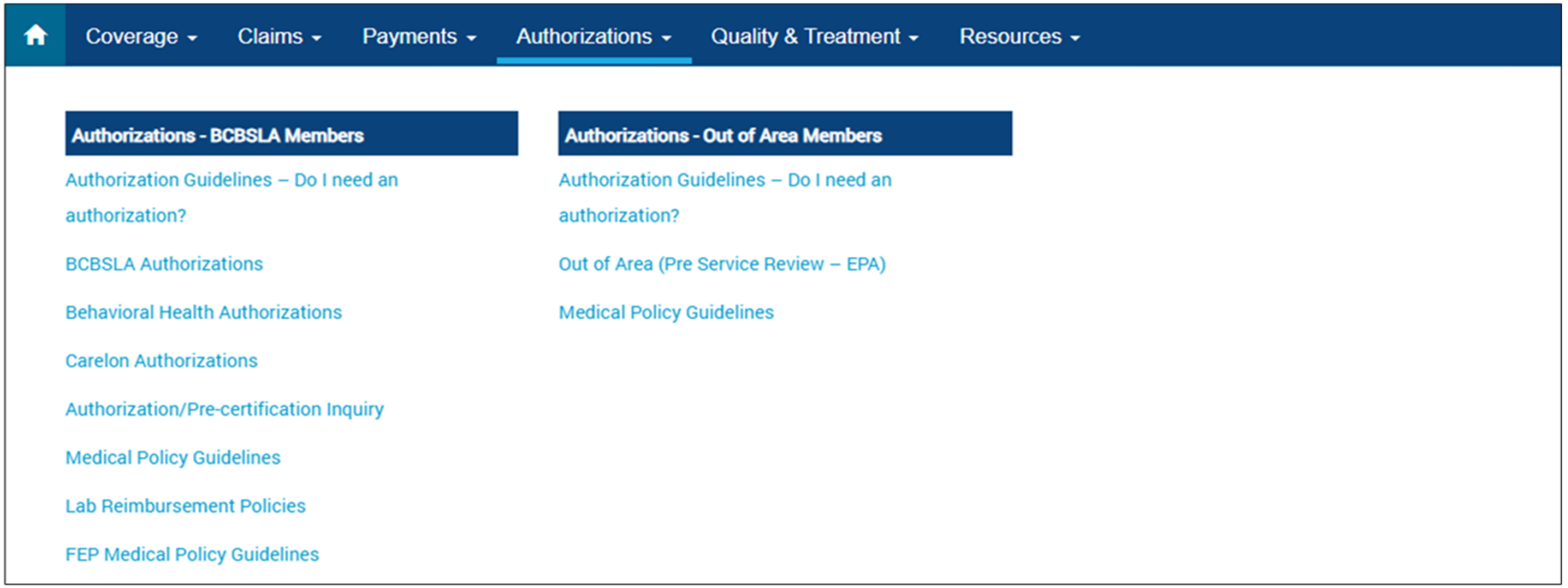


Learn More About iLinkBlue

For full information on the features of iLinkBlue, view our **iLinkBlue Webinar** presentation. It is available online at **www.bcbsla.com/providers** >Resources >Workshops & Webinars.

Blue Cross Policies
&
Finding Authorization Information

Finding Authorization Information



The Authorizations section of iLinkBlue includes resources and applications for both **BCBSLA Members** and **Out of Area Members**.

Many of the applications in this section require a higher level of security access.

- If the requested services are to treat a condition due to a complication of a non-covered service, claims will deny as non-covered regardless of medical necessity.
- Providers are responsible for checking member eligibility and benefits.

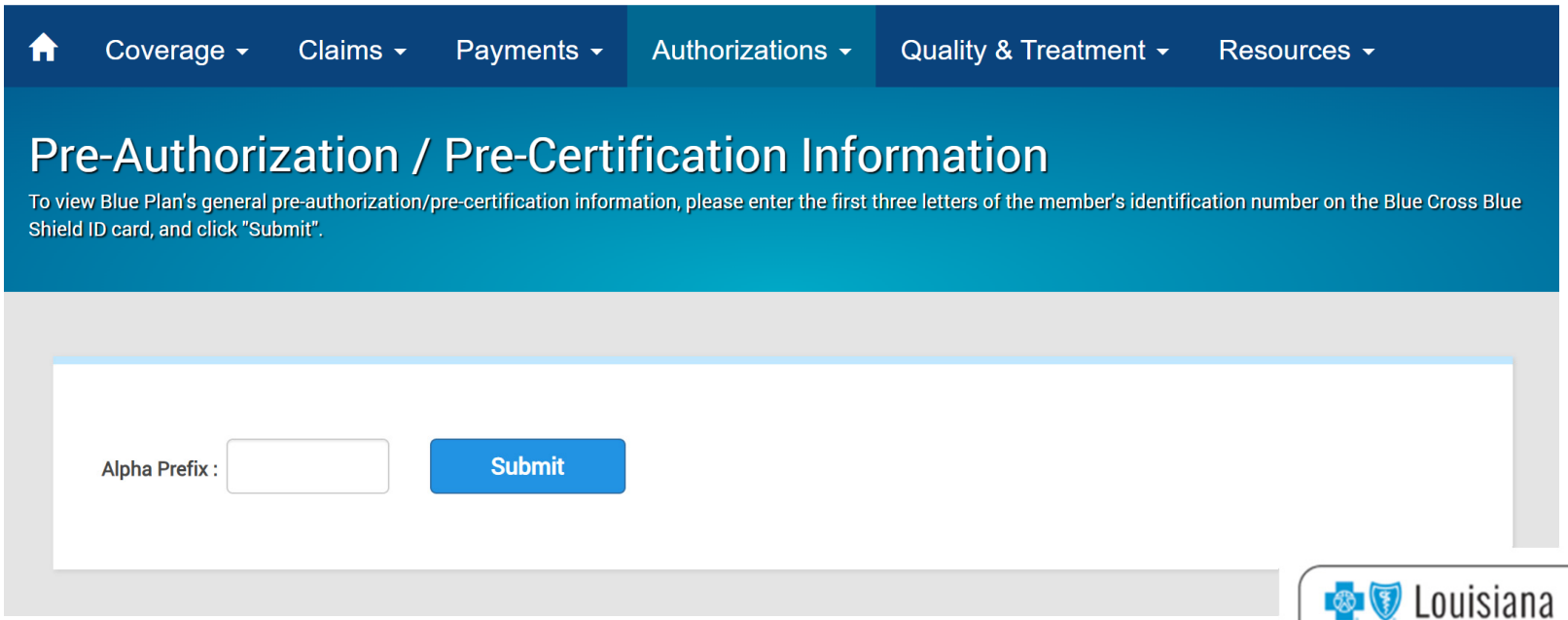
Finding Authorization Information

Authorizations - BCBSLA Members

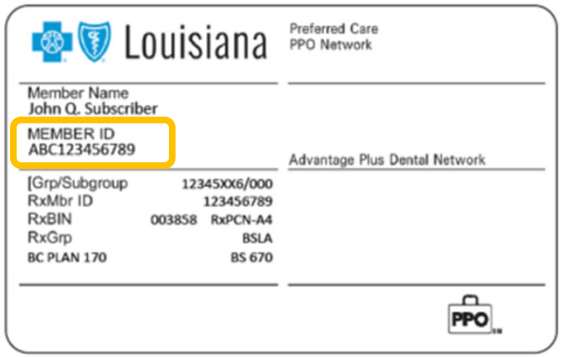
- Authorization Guidelines – Do I need an authorization?
- BCBSLA Authorizations
- Behavioral Health Authorizations
- Carelon Authorizations
- Authorization/Pre-certification Inquiry
- Medical Policy Guidelines
- Lab Reimbursement Policies
- FEP Medical Policy Guidelines

BCBSLA Members
Out of Area Members

Authorizations Guidelines - Do I need an authorization? – This application lets you research and view authorization requirements based on the member ID prefix.



Enter the member's prefix to access general pre-authorization/ pre-certification information.



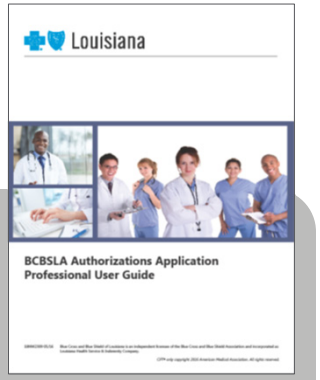
Authorizations

BCBSLA Members

BCBSLA Authorizations – submit and research authorizations for BCBSLA members. Upload clinical information.

Prior Authorization Mandate

- **Blue Cross does not accept authorization requests via phone or fax**, with a few exceptions including transplants, dental services covered under medical and out-of-state services.
- Prior authorization requests, including new and extension authorizations, must be submitted through our online BCBSLA Authorizations application available in iLinkBlue.
- The application allows providers to request authorizations 24 hours a day, seven days a week, in real time.
- In some cases, the application allows for immediate approval without Blue Cross personnel intervention.



For more information on how to use our BCBSLA Authorizations application, the *BCBSLA Authorizations Applications Professional User Guide* is available on iLinkBlue under the "Resources" tab, then click "Manuals."

Communicating with Blue Cross Regarding Authorizations

Creating an "Activity" is the **only** way to communicate with BCBSLA regarding authorizations. Do **not** use the "Notes" tab, as our Authorizations Department will not be notified.

An "Activity" **must** be added to an authorization when attempting to complete any of the following:

- Corresponding with our Authorizations Department
- Additional information is being forwarded
- Extending an authorization or adding additional services
- Changing an authorization
- Requesting peer-to-peer review (flag as critical)

The "Activity" must be assigned to: Provider Request Worklist.

It is very important to follow this process to ensure authorizations are handled accurately and timely.

Blue Cross requires providers to request prior authorizations through our BCBSLA Authorizations application. It is available online in iLinkBlue (**www.bcbsla.com/ilinkblue**).

Authorizations

BCBSLA Members

Behavioral Health Authorizations – behavioral health providers can request authorizations for behavioral health services and submit clinical information electronically. This web-based application is facilitated by Lucet.

Carelon Authorizations – submit and research authorizations for outpatient high-tech radiology, diagnostic, cardiology services, musculoskeletal (MSK) joint surgery, spine surgery, spine pain management and radiation oncology authorizations. This web-based application is facilitated by Carelon.

Authorization/Pre-certification Inquiry – view a provider's inpatient or outpatient authorizations on file with Blue Cross.

Medical Policy Guidelines – access the BCBSLA medical policy index to research Blue Cross' medical policies. Search for policies alphabetically by title or use the search bar to look by keywords or codes.

Lab Reimbursement Policies – access the policies used as part of Blue Cross' Lab Benefit Management Program. These policies are managed by Avalon.

FEP Medical Policy Guidelines – access medical policies that govern claims for Federal Employee Program members.

Laboratory Benefit Management Program

Blue Cross has partnered with Avalon Healthcare Solutions to manage our laboratory benefit management program.

Avalon provides:

- routine testing management services to ensure enforcement of laboratory policies
- automated review of high-volume, low-cost laboratory claims.

Blue Cross applies Avalon's automated policy enforcement to claims reporting laboratory services performed in office, hospital outpatient and independent laboratory locations.

Note: Laboratory services, tests and procedures provided in emergency room, hospital observation, and hospital inpatient settings are excluded from this program.

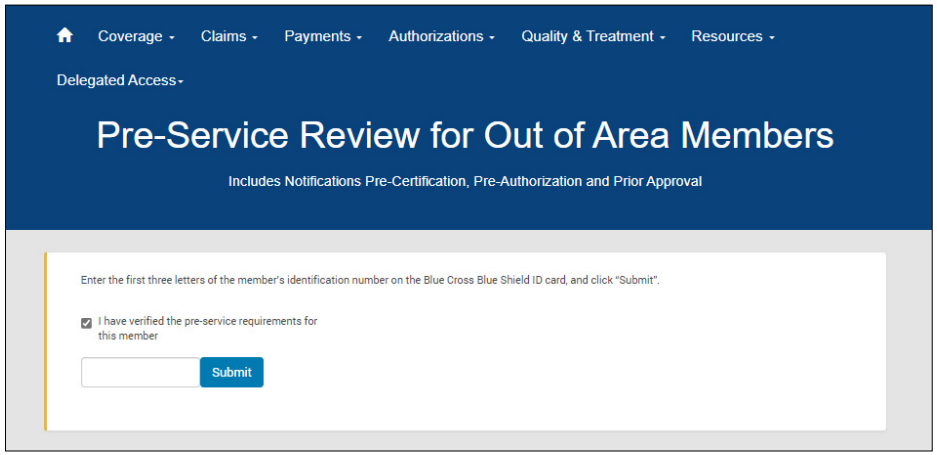
Providers can review and research laboratory policies and guidelines online at **www.bcbsla.com/providers**, click on "Medical Management," then "Lab Management."

Out of Area Members

Out of Area (Pre-Service Review – EPA)

This application routes you to the BlueCard member's Blue Plan.

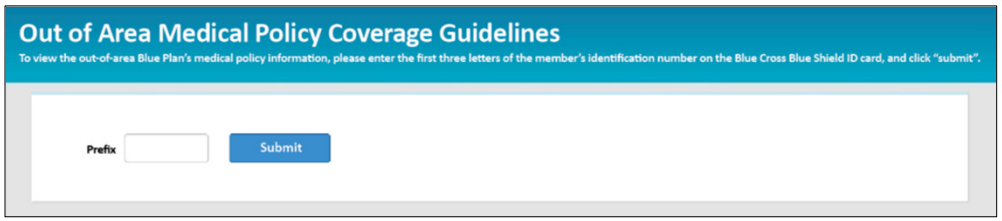
Enter the member ID prefix into the application to access pre-service capabilities, processes and requirements for your BlueCard patient.



Medical Policy Guidelines

Just as BCBSLA publishes medical policies for services provided to our members, it is the same for other Blue Plans. Use this application to access medical policies for BlueCard (out-of-area) members.

Enter the member ID prefix to be routed to the member's Blue Plan to research applicable medical policy information.



Claims Research

Electronic Claims

Electronic Data Interchange (EDI)

- The fastest, most efficient way to exchange eligibility information, payment information and claims.
- Blue Cross' experienced EDI staff is ready to assist in determining the best electronic solution for your needs.

Electronic Transaction Exchange

- Various healthcare transactions can be submitted electronically to the Blue Cross clearinghouse in a system-to-system arrangement.
- Blue Cross does not charge a fee for electronic transactions.
- You can send your transactions to Blue Cross via indirect submission through a clearinghouse or through direct submission to the Blue Cross EDI Clearinghouse.

For more information about system-to-system electronic transactions, please contact EDI Services at **EDIservices@bcbsla.com** or at 1-800-716-2299, option 3.

Submitting Claims

Electronic Transmission

Blue Cross accepts electronic claims transmitted via HIPAA 837P and 837I submitted electronically through your clearinghouse.

We do not charge a fee for electronic transactions.

Providers can submit transactions directly to us or indirectly through a third-party clearinghouse.

For more information on how to submit electronic claims to Blue Cross, visit **www.bcbsla.com/providers** >Electronic Services >Clearinghouse Services.

or

Hardcopy

For Blue Cross, HMO Louisiana, Blue Connect, Community Blue, Precision Blue, BlueHPN, Signature Blue, OGB and BlueCard Claims:

BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898

For FEP Claims:

BCBSLA
P.O. Box 98028
Baton Rouge, LA 70898

For Blue Advantage Claims:

Blue Advantage
130 DeSiard St, Ste 322
Monroe, LA 71201

CMS-1500 (professional)

Timely Filing

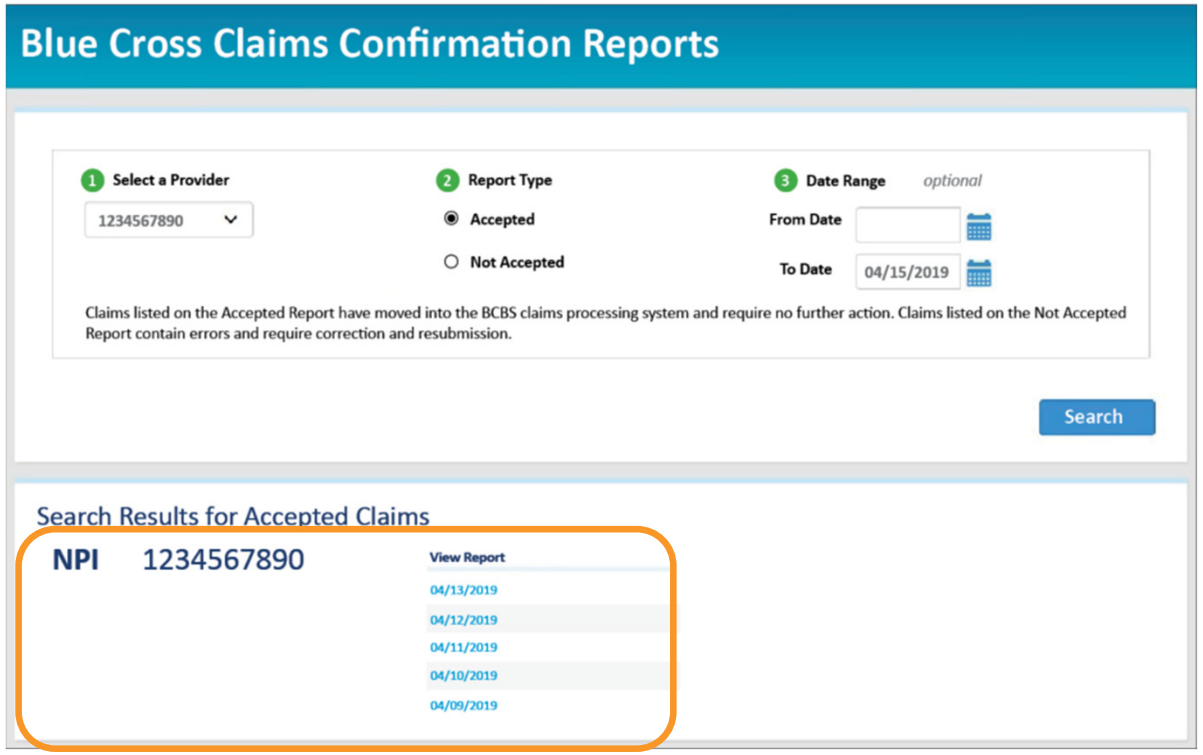
The member and Blue Cross are held harmless when claims are denied or received after the timely filing deadline.

Policy Type	Filing Requirements
• Preferred Care PPO • HMOLA (including Blue Connect, Community Blue, Precision Blue, Signature Blue) • BlueHPN	Claims must be filed within 15 months *(or length of time stated in the member's contract)* of date of service.
• Federal Employee Program (FEP)	Blue Cross FEP Preferred Provider claims must be filed within 15 months from date of service. Members/ Non-preferred providers have no later than December 31 of the year following the year in which the services were provided.
• Blue Advantage	Claim must be filed within 12 months of date of service. Claims must be resubmitted or corrected within 12 months of the date the claim was processed (remit date).
• Office of Group Benefits (OGB)	Claim must be filed within 12 months of the date of service. Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim.
• Self-funded Groups • BlueCard (out-of-area)	Timely filing standards may vary. Always verify the member's benefits (including timely filing standards).

Verifying Receipt of Claims

Confirmation Reports are generated in iLinkBlue and allow providers to electronically research submitted claims. Daily reports confirm acceptance of claims submitted directly through iLinkBlue, billing agency or clearinghouse.

- ✓ Reports are available within 24 hours of submitting claims (prior to 3 p.m.).
- ✓ Reports are available up to 120 days.
- ✓ Reports are displayed by date.



Sample Confirmation Reports

Confirmation Reports indicate detailed claim information on transactions that were accepted or not accepted for processing. Providers are responsible for reviewing these reports and correcting claims on the Not Accepted report.

Accepted Report Example

Blue Cross and Blue Shield of Louisiana
837 Accepted / Not Accepted / Warning Report
Professional Claims Report

SUBMITTER NUMBER: P0123456789
BC Red # 1234T5678Z
BC ID # T5678
NPI# 1234567891
SUBMITTER: ABCTESTCO
PROVIDER: TEST REGIONAL HOSPITAL
PROCESSING DATE: 04-12-19
PAGE 1

837P ACCEPTED REPORT

4-14-23

PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	AMOUNT	CH TRACKING NUMBER
L12345678	DOE	JOHN	XUA123458789	040819	040819	125.00	123459876123

PROVIDER BC ID # T5678 837P SUMMARY:
837P TOTAL CLAIMS ACCEPTED: 1 CLAIMS FOR $125.00
837P TOTAL CLAIMS NOT ACCEPTED: 0 CLAIMS FOR $0.00
837P TOTAL CLAIMS: 1 CLAIMS FOR $125.00

SUBMITTER: P0123456789 BHT03: 123456 TOTAL TRANSACTION SUMMARY:
TOTAL CLAIMS ACCEPTED: 1 CLAIMS FOR $125.00
TOTAL CLAIMS NOT ACCEPTED: 0 CLAIMS FOR $0.00
GRAND TOTAL CLAIMS: 1 CLAIMS FOR $125.00

Not Accepted Report Example

Blue Cross and Blue Shield of Louisiana
837 Accepted / Not Accepted / Warning Report
Professional Claims Report

SUBMITTER NUMBER: P0123456789
BC Red # 1234T5678Z
BC ID # T5678
NPI# 1234567891
SUBMITTER: ABCTESTCO
PROVIDER: TEST REGIONAL HOSPITAL
PROCESSING DATE: 04-12-19
PAGE 1

837P NOT ACCEPTED REPORT

4-14-23

PATIENT ACCOUNT NUM	PATIENT LAST NM	PATIENT FIRST NM	BC CONTRACT NUMBER	FROM DATE	THRU DATE	AMOUNT	ERROR DESCRIPTION	ERROR DATA
L12345678	DOE	JOHN	XUA123458789	040419	040419	206.00	PROVIDER LOCATION IRS CONFLICT	987654321
L78945612	PUBLIC	PEGGY	XUH321456987	032019	032019	206.00	PROVIDER LOCATION IRS CONFLICT	987654321

PROVIDER BC ID # T5678 837P SUMMARY:
837P TOTAL CLAIMS ACCEPTED: 0 CLAIMS FOR $0.00
837P TOTAL CLAIMS NOT ACCEPTED: 2 CLAIMS FOR $412.00
837P TOTAL CLAIMS: 2 CLAIMS FOR $412.00

SUBMITTER: P0123456789 BHT03: 123456 TOTAL TRANSACTION SUMMARY:
TOTAL CLAIMS ACCEPTED: 0 CLAIMS FOR $0.00
TOTAL CLAIMS NOT ACCEPTED: 2 CLAIMS FOR $412.00
GRAND TOTAL CLAIMS: 2 CLAIMS FOR $412.00

Payment Information

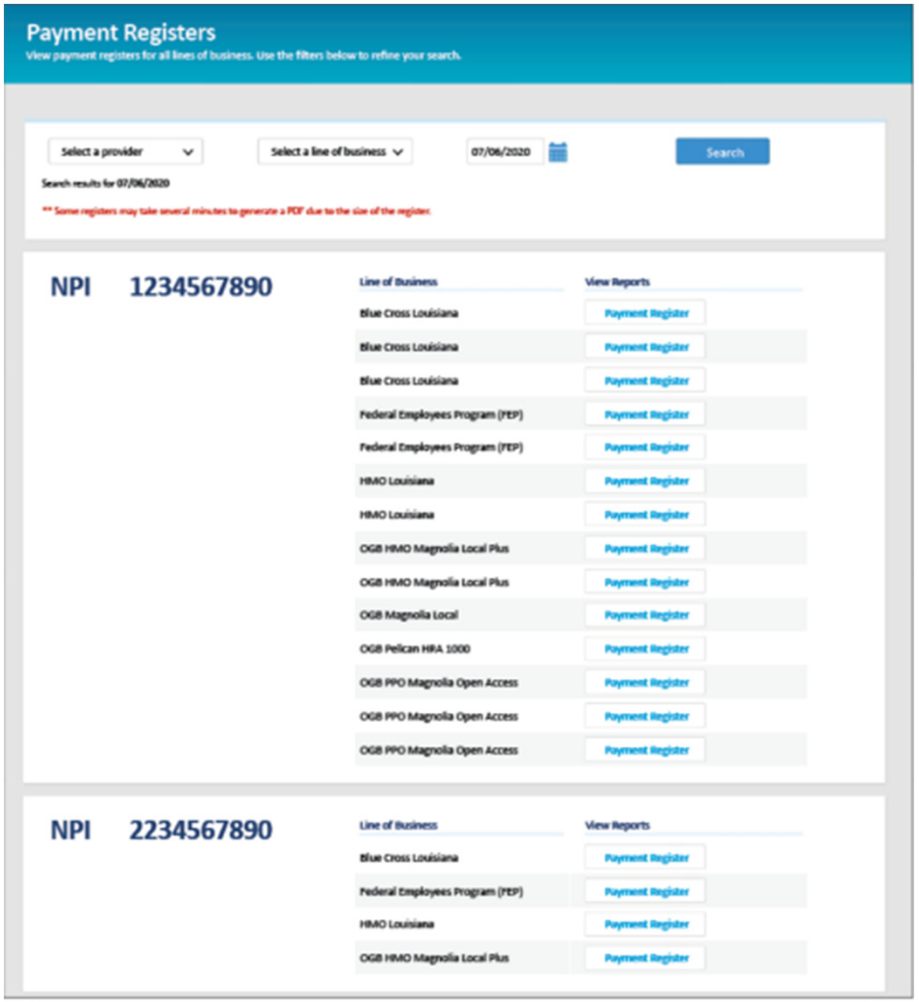
Use this section to access your Blue Cross payment information. Two years of payment registers and EFT notifications are available in iLinkBlue. EFT notifications for the week appear in the search results.

- **Payment Registers** – view, print or save your payment registers. If you have access to multiple NPIs, registers will be available for each.
- **EFT Notifications** – view Electronic Funds Transfer (EFT) Notifications. If you have access to multiple NPIs, EFT notifications will be available for each.

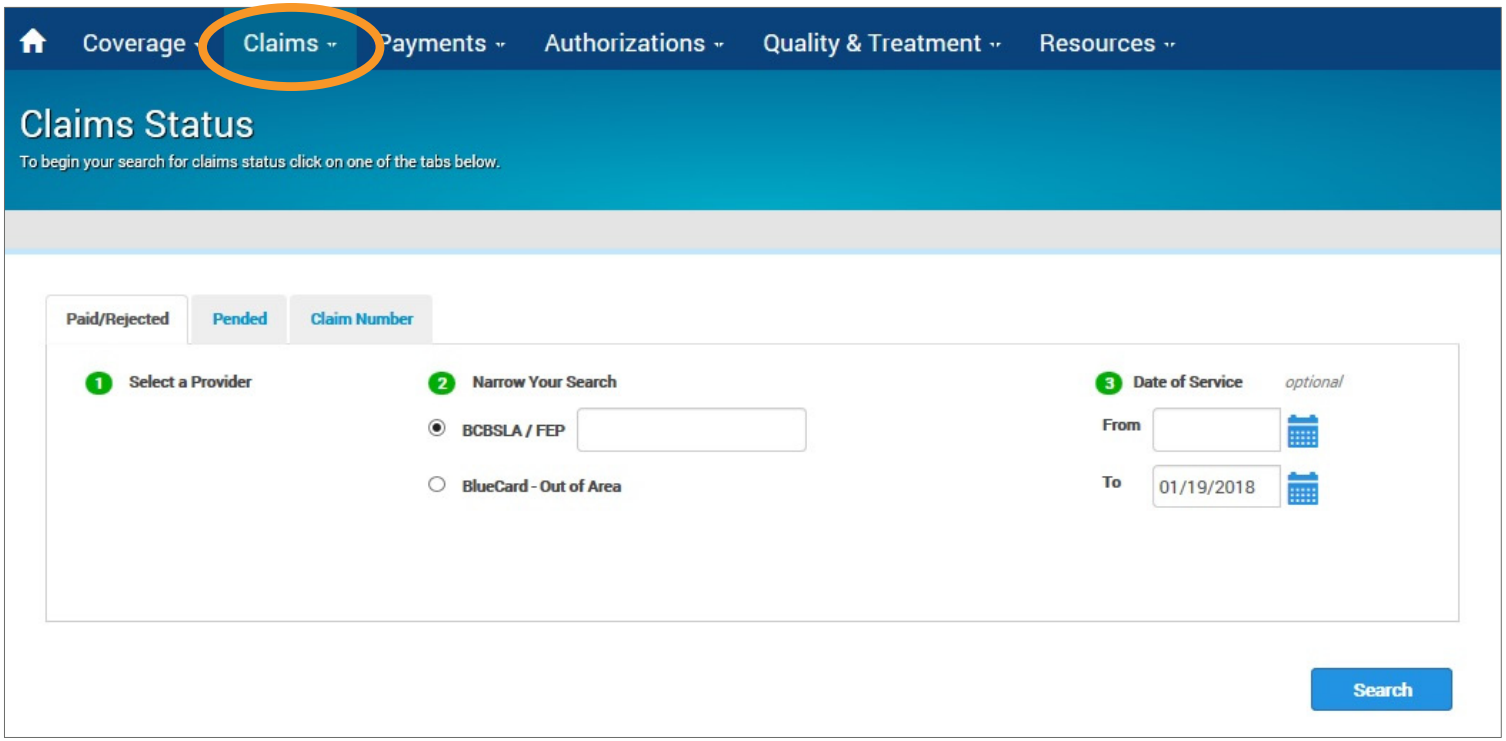
Need a past EFT Notification/Payment Register?

Weekly EFT notifications and payment registers are available to providers on Mondays, based on claims payments from the previous week.

Set the calendar feature in the search feature to the date of a Monday within the last two years. This allows you to see past EFT notifications or payment registers.



Claims Research



- Use the "Claims" menu option to research paid, rejected and pended claims.
- You can research BCBSLA, FEP and BlueCard-Out of Area claims submitted to Blue Cross for processing.

Submitting Action Requests

Action Requests allow you to electronically communicate with Blue Cross when you have questions or concerns about a claim.

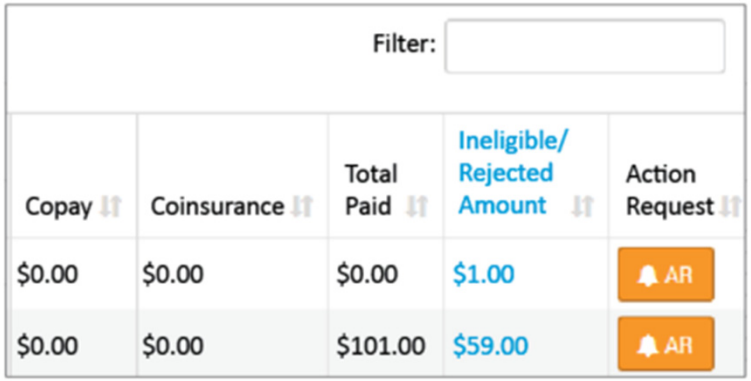
Common reasons to submit an Action Request

- Claim status (detailed denials)
- Claim denied for coordination of benefits
- Claim denied as duplicate
- Claim denied for no authorization (but there is a matching authorization on file)
- Information needed from member (coordination of benefits, subrogation)
- Medical records receipt
- No record of membership (effective and term date)
- Questioning non-covered charges
- Recoupment request
- Status of an appeal
- Status of a grievance

Action Requests do not allow you to submit documentation regarding your claims review.

Submitting Action Requests

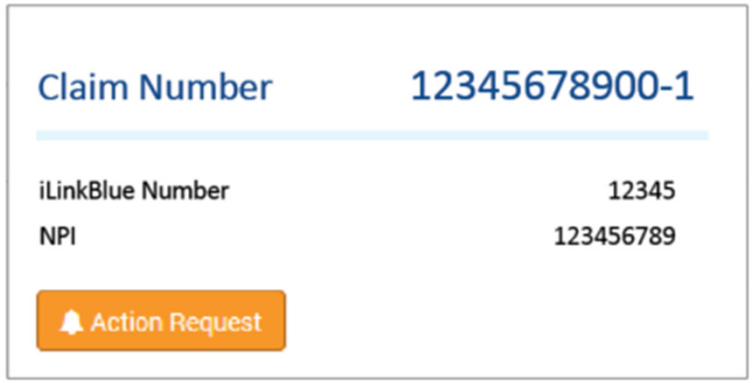
In iLinkBlue, on each claim, there is an **Action Request** button. It opens an electronic form that prepopulates with information on the specific claim. There are multiple places within iLinkBlue that include the action request buttons.



on the **Paid/Rejected Claims Results** screen

and

on the **Pended Claims Results** screen

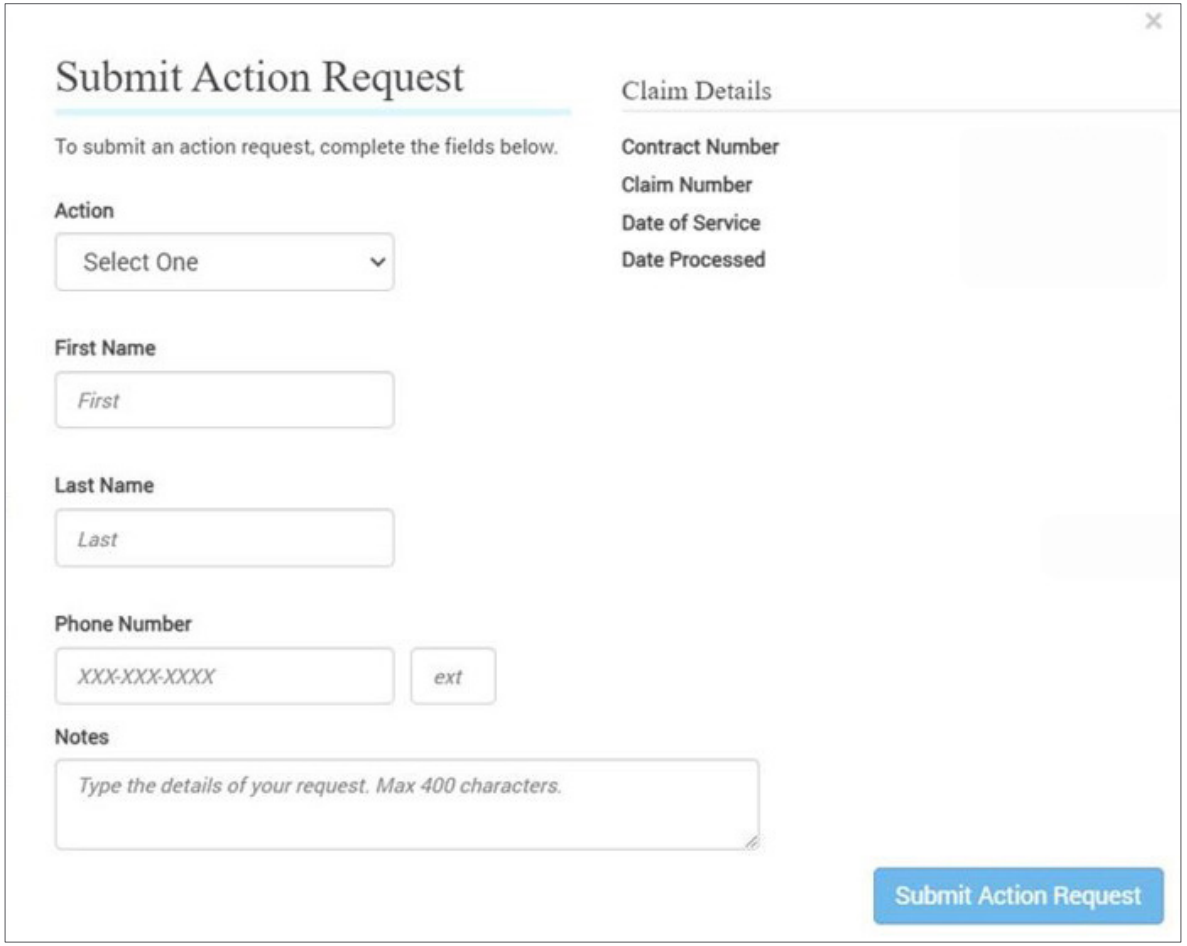


on the **Claims Detail** screen

Submitting Action Requests

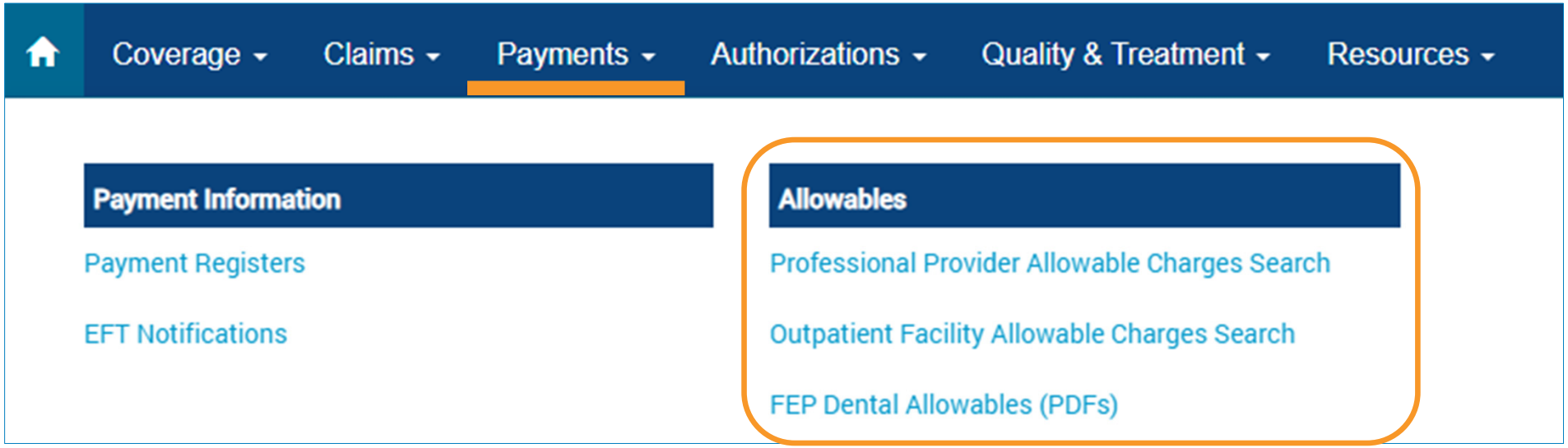
When submitting an Action Request:

- Include your contact information
- Be specific and detailed
- Allow 10-15 working days for a response to each request
- Check in Action Request Inquiry for a response
- Submit a second request if there was no resolution



As a second step to **submitting an Action Request**, if you did not get a resolution, you may also contact the **Customer Care Center** using the number on the back of the patient's member ID card.

Allowables Research

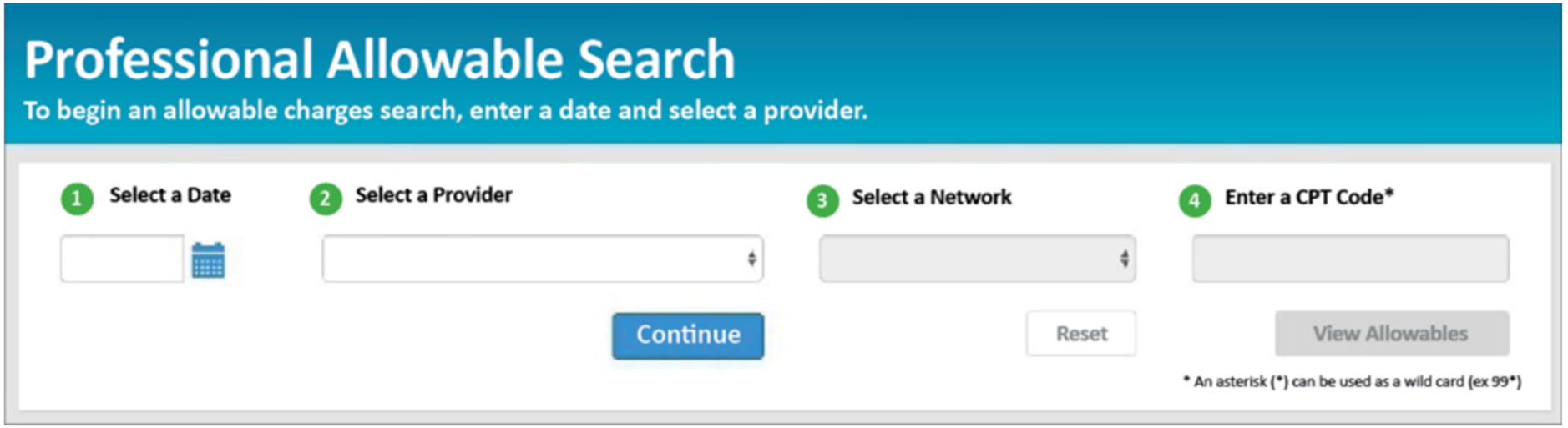


iLinkBlue includes two applications you can use to research Blue Cross allowables:

- **Professional Provider Allowable Charges Search**
- **Outpatient Facility Allowable Charges Search**

FEP Dental Allowables (PDFs) – this section includes printable PDFs for FEP Preferred Network dentists.

Allowables Research



Professional Allowable Search

- When searching for an allowable charge enter the date of service, appropriate network and the code.
- The date of service is important because you can search current, past or future (when available) allowable charges.

Providers must use iLinkBlue for professional allowable charges. Our Customer Care Center cannot assist with this service.

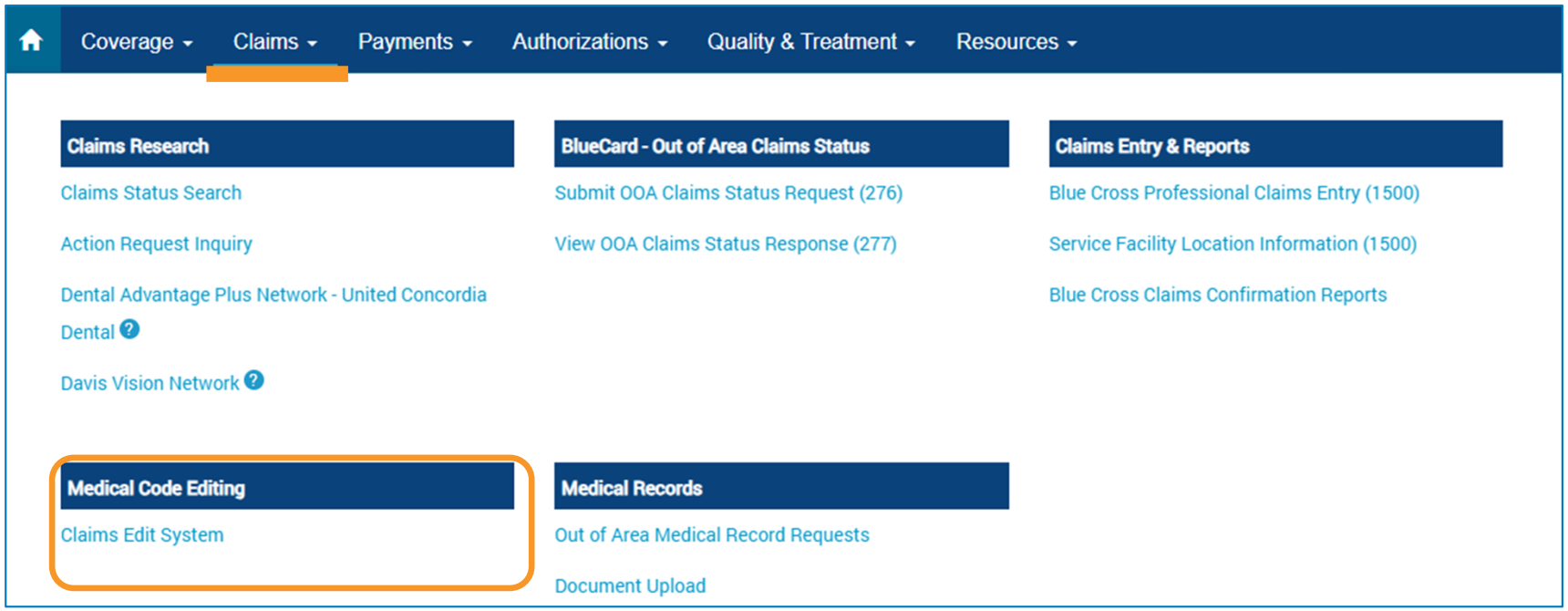
Claims Editing

Medical Code Editing

Use this section to evaluate code combinations to help reduce time-consuming disputes.

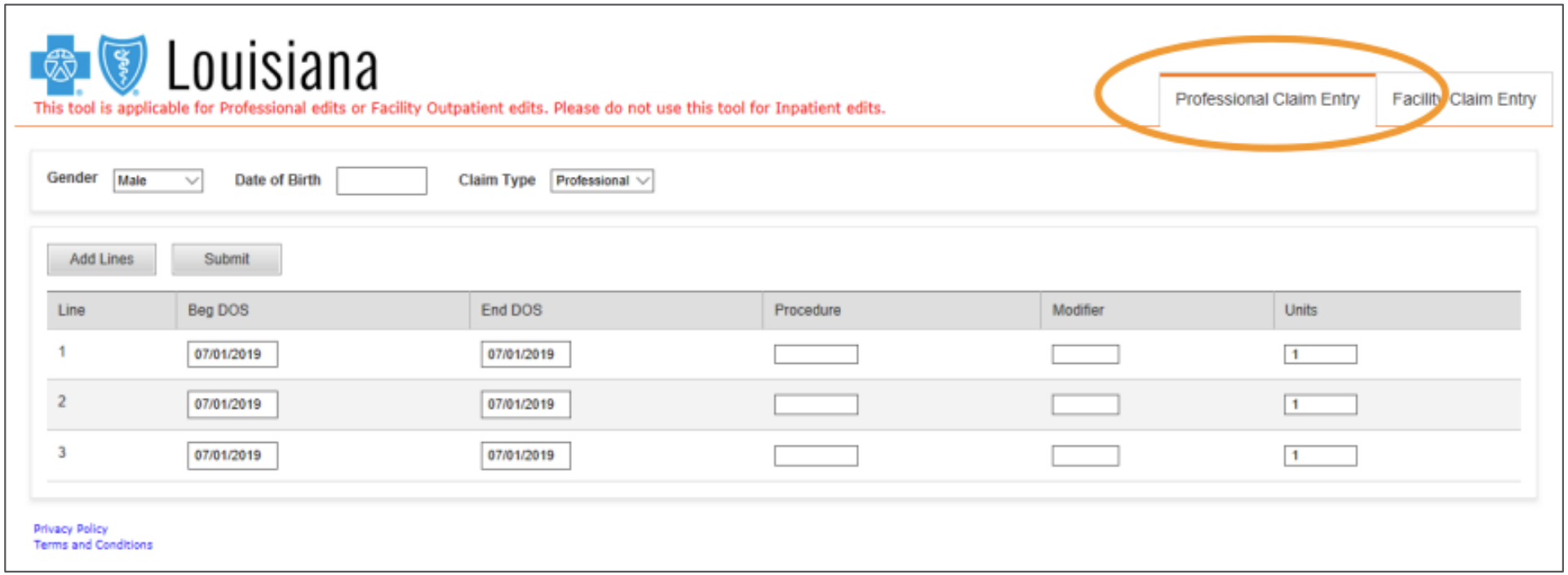
Claims Edit System – This is an easy-to-use code-auditing reference application designed to help providers determine claim edit outcomes.

The CES application in iLinkBlue is not a pricing or a claims processing application. It is a research application designed to evaluate code combinations in the Blue Cross claims-editing system.

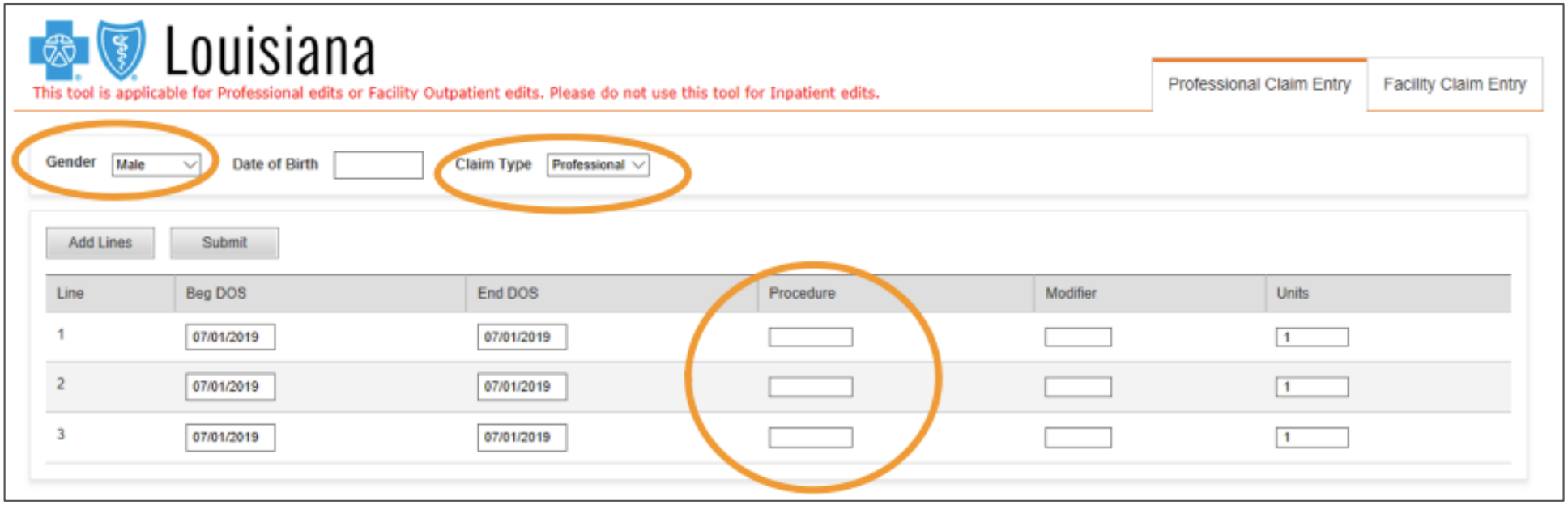


Claims Editing System Application

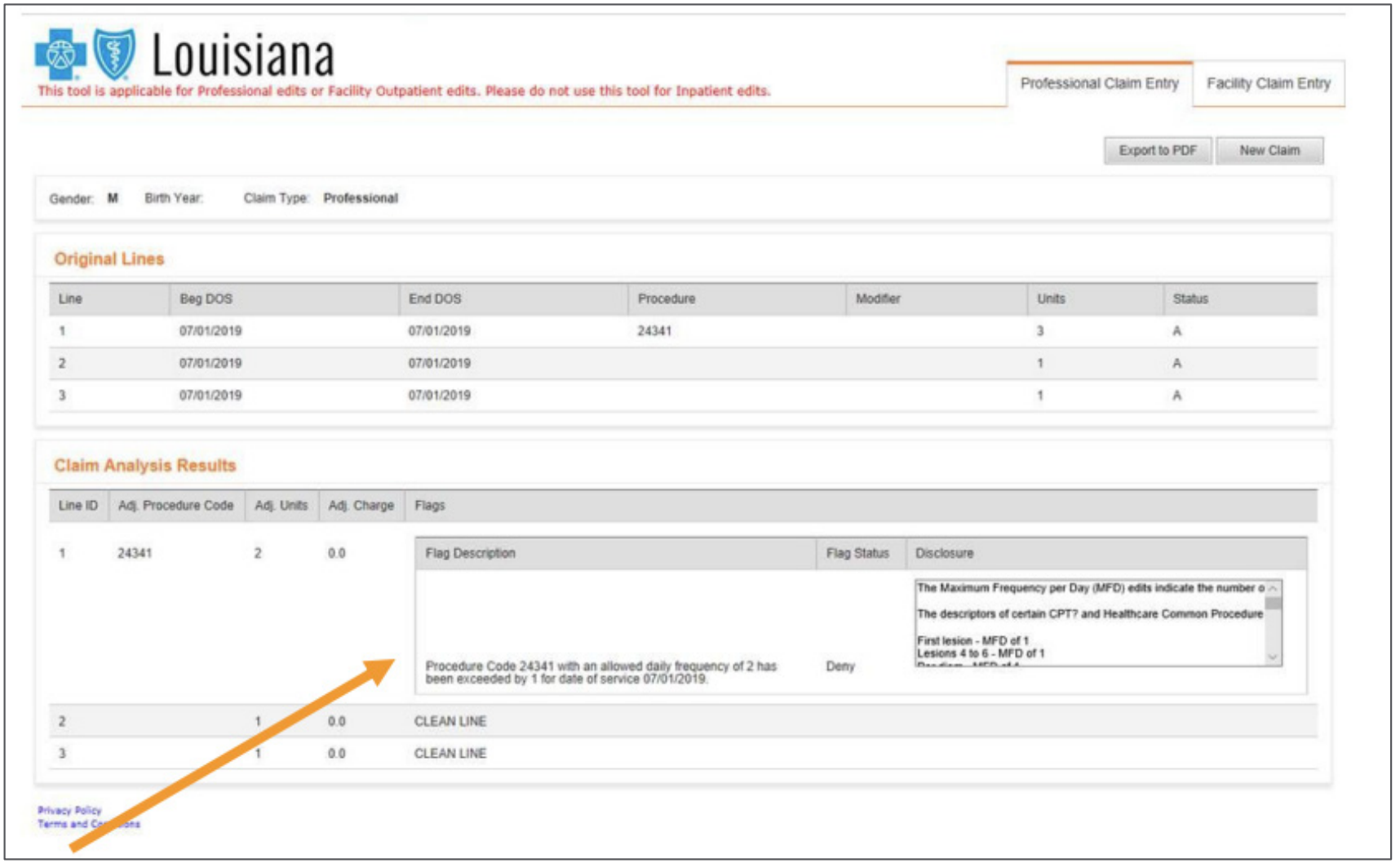
The CES tool is available for both **outpatient facility** and **professional** claims. Please make sure you select the correct tab as the edits and modifiers will not be the same.



CES Application Mandatory Fields

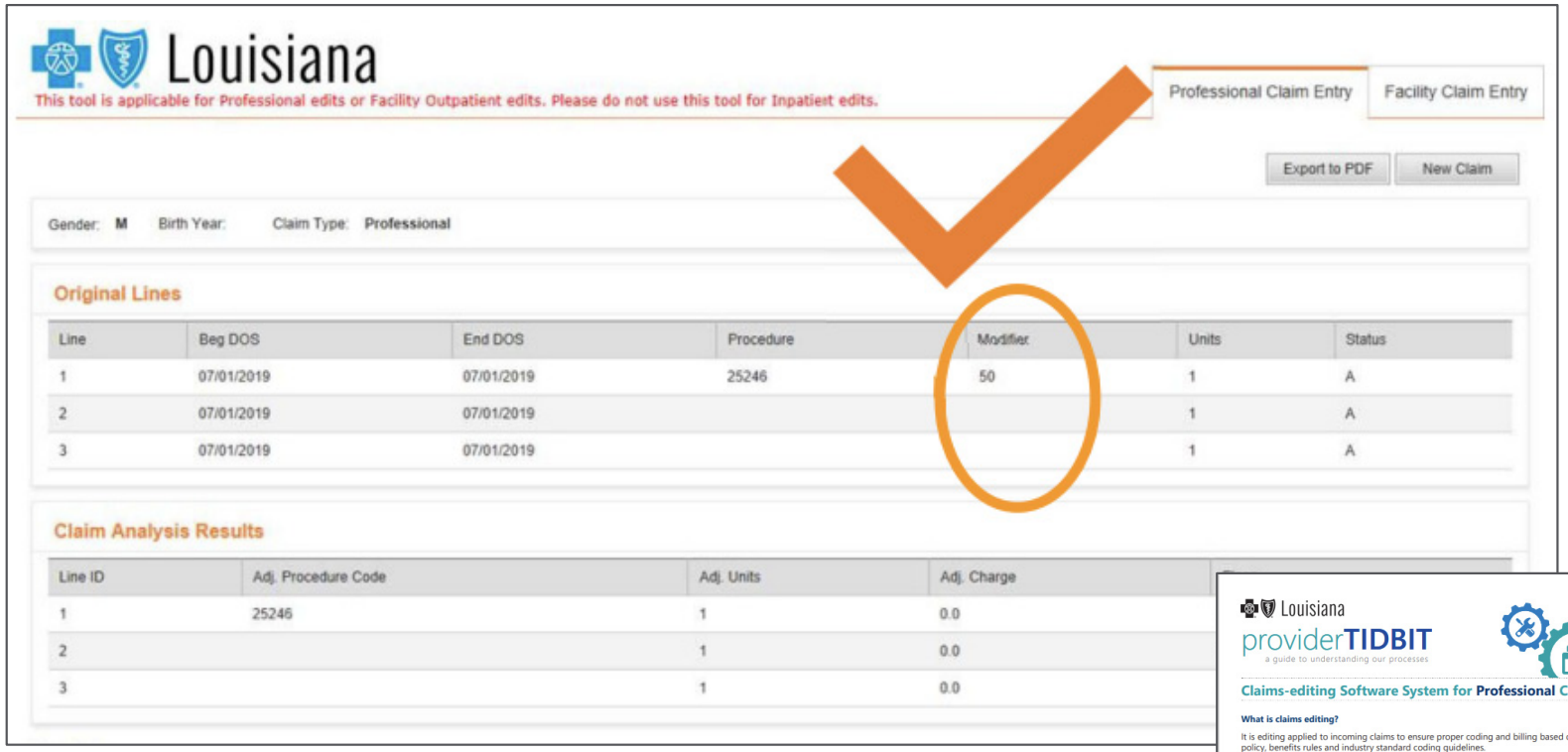


CES Application Outputs

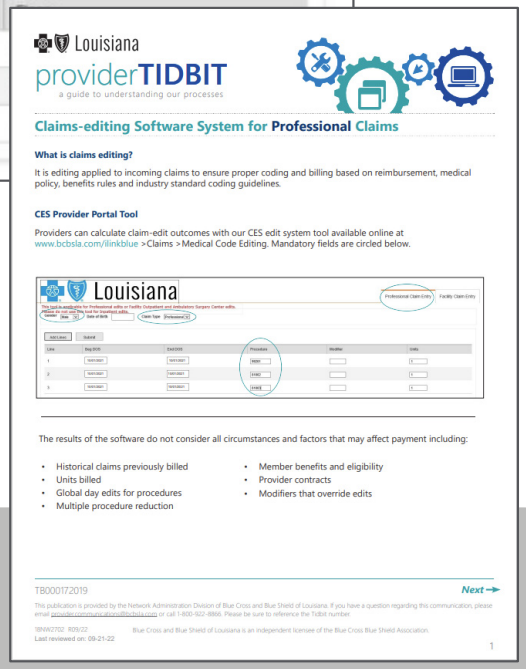


CPT Code 24341 – Repair, tendon or muscle, upper arm or elbow daily max frequency limit of 2 units. Code on one line with 3 units – 2 units will pay, 1 unit will deny.

CES Application Outputs



CPT 25246 (injection procedure) – billed correctly with Modifier 50



The CES Provider Tidbit can be found online at **www.bcbsla.com/providers**, click on "Resources," then "Tidbits."

Helpful Reminders

Benefits of Proper Clinical Documentation

- Allows identification of high-risk patients.
- Allows opportunities to engage patients in care management programs and care prevention initiatives.
- Reduces the administrative burden of medical record requests and adjusting claims for both the provider and Blue Cross.
- Reduces costs associated with submitting corrected claims.
- Use of Category II Codes can reduce the need for medical records.

Coding to the Highest Level of Specificity

- Include chronic conditions in documentation.
- Code to the highest specificity.
- Monitored, Evaluated, Assessed or Treated (MEAT) should be noted.
- Clarify whether a condition is **chronic** or **acute**.
- Clarify whether a condition is **controlled** or **uncontrolled** to document the current status of condition/how it is being managed.
- Clarify the **type of diabetes** (if applicable).

Example: Notes may say "Diabetes Type II and CKD Stage III,"
but if stated as "CKD III Due to Diabetes," it would result in a different ICD-10 Code.

Improper documentation could result in audits and/or the request of medical records.

Medical Record Requests

From time to time, you may receive a medical record request from us or one of our vendors to perform medical record chart audits on our behalf.

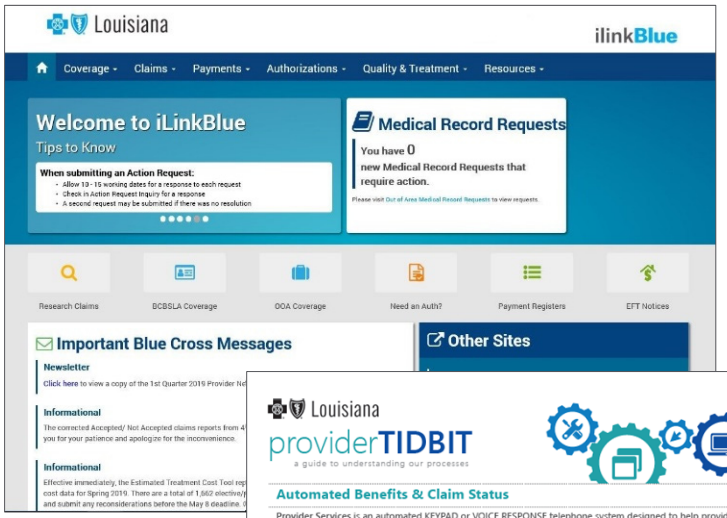
- Per your Blue Cross network agreement, **providers are not to charge a fee** for providing medical records to Blue Cross or agencies acting on our behalf.
- If you use a copy center or a vendor to provide us with requested medical records, providers are to ensure we receive those records without a charge.
- You do not need to obtain a distinct and specific authorization from the member for these medical record releases or reviews.
- The patient's Blue Cross subscriber contract allows for the release of the information to Blue Cross or its designee.
- iLinkBlue has a Document Upload feature allowing documents, including medical records for retrospective or post claim review, to be uploaded that would otherwise be faxed, emailed or mailed.

Provider Self-service

Providers are required to use our self-service tools for:

- Member eligibility
- Claim status inquiries
- Professional allowable searches
- Medical policy searches

These services will no longer be handled directly by our Customer Care Center.



Self-service tools available to providers:

- iLinkBlue (**www.bcbsla.com/ilinkblue**)
- Interactive Voice Recognition (IVR) (1-800-922-8866)
  - The Automated Benefits & Claim Status (IVR Navigation Guide) Tidbit will help you navigate the IVR system and is available at **www.bcbsla.com/providers** >Resources >Tidbits.
- HIPAA 27x transactions

Credentialing, Recredentialing & Updating Your Information

Credentialing is Required for Network Participation

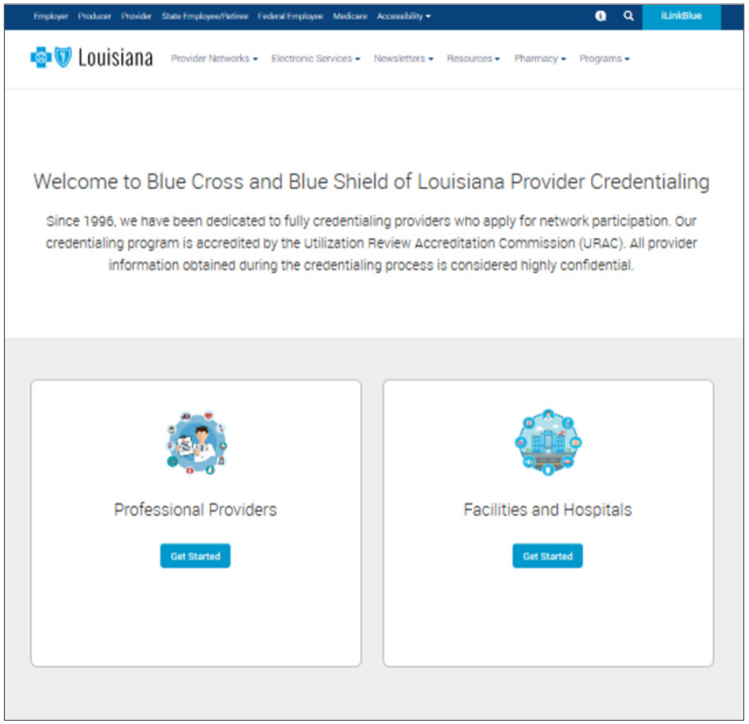
Blue Cross and Blue Shield of Louisiana credentials all practitioners and facilities that participate in our networks.

We partner with **symplrCVO** to conduct credentialing verification processes for our commercial networks.

Network Participation

To join our networks, you must complete and submit documentation to start the credentialing process or to obtain a provider record.

- Go to the **Join Our Networks** page then, select **Professional Providers** or **Facilities and Hospitals** to find:
  - Credentialing packets
  - Quick links to the Provider Update Request Form
  - Credentialing criteria for professional, facility and hospital-based providers
  - Frequently asked questions (FAQs)

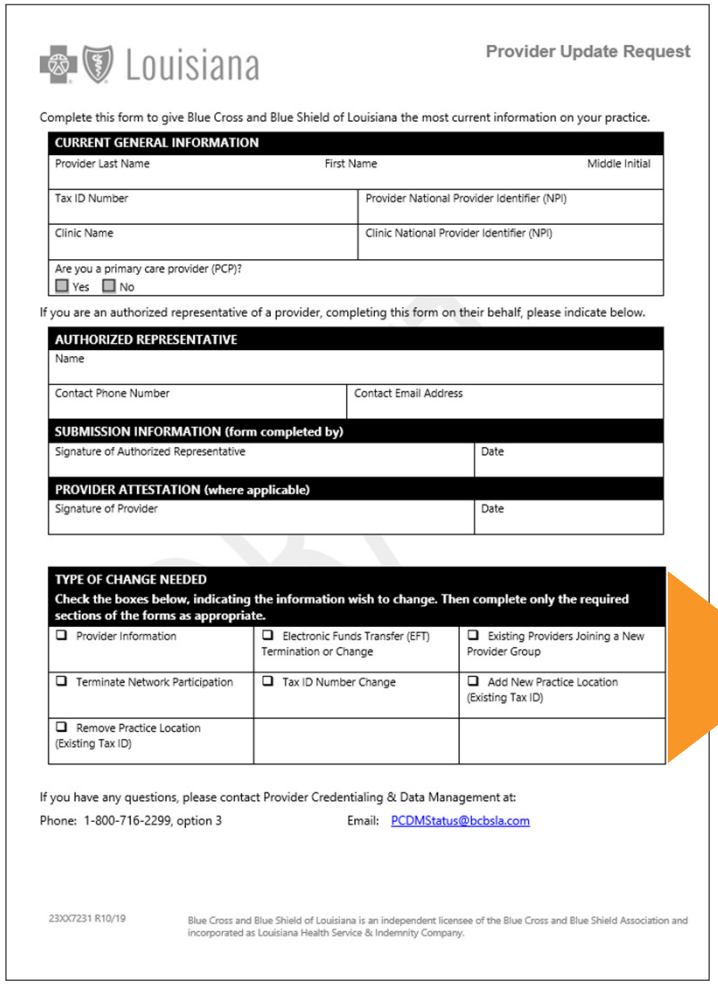


www.bcbsla.com/providers >Network Enrollment >Join Our Networks

Updating Your Information

It is important that we always have your most current information!

Our **Provider Update Request Form** accommodates all your change requests, which are handled directly by our Provider Data Management team.



Louisiana

Provider Update Request

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice.

CURRENT GENERAL INFORMATION

Provider Last Name	First Name	Middle Initial
Tax ID Number	Provider National Provider Identifier (NPI)	
Clinic Name	Clinic National Provider Identifier (NPI)	
Are you a primary care provider (PCP)? ☐ Yes ☐ No		

If you are an authorized representative of a provider, completing this form on their behalf, please indicate below.

AUTHORIZED REPRESENTATIVE

Name	
Contact Phone Number	Contact Email Address

SUBMISSION INFORMATION (form completed by)

Signature of Authorized Representative	Date

PROVIDER ATTESTATION (where applicable)

Signature of Provider	Date

TYPE OF CHANGE NEEDED

Check the boxes below, indicating the information wish to change. Then complete only the required sections of the forms as appropriate.

☐ Provider Information	☐ Electronic Funds Transfer (EFT) Termination or Change	☐ Existing Providers Joining a New Provider Group
☐ Terminate Network Participation	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

If you have any questions, please contact Provider Credentialing & Data Management at:

Phone: 1-800-716-2299, option 3 Email: PCDMStatus@bcbsla.com

23XX7231 R10/19

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

This form allows you to make any of the following changes. Simply check the appropriate box(es) to indicate the type of change needed. You may select more than one option.

TYPE OF CHANGE

Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.

☐ Demographic Information	☐ Electronic Funds Transfer (EFT) Termination or Change	☐ Existing Providers Joining a New Provider Group (*includes solo providers creating a new provider group*)
☐ Termination Request	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

The form is available online at **www.bcbsla.com/providers** >Resources >Forms.

Updating Your Information

It is important that we always have your most current information!

- Indicate on the Provider Request Form they type of change you are requesting.
- You will **only** need to fill out the section of this form that needs updating. Completing the entire form is not required.

TYPE OF CHANGE **Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.**		
☐ Demographic Information	☐ Electronic Funds Transfer (EFT) Termination or Change	☐ Existing Providers Joining a New Provider Group (*includes solo providers creating a new provider group*)
☐ Termination Request	☐ Tax ID Number Change	☐ Add New Practice Location (Existing Tax ID)
☐ Remove Practice Location (Existing Tax ID)		

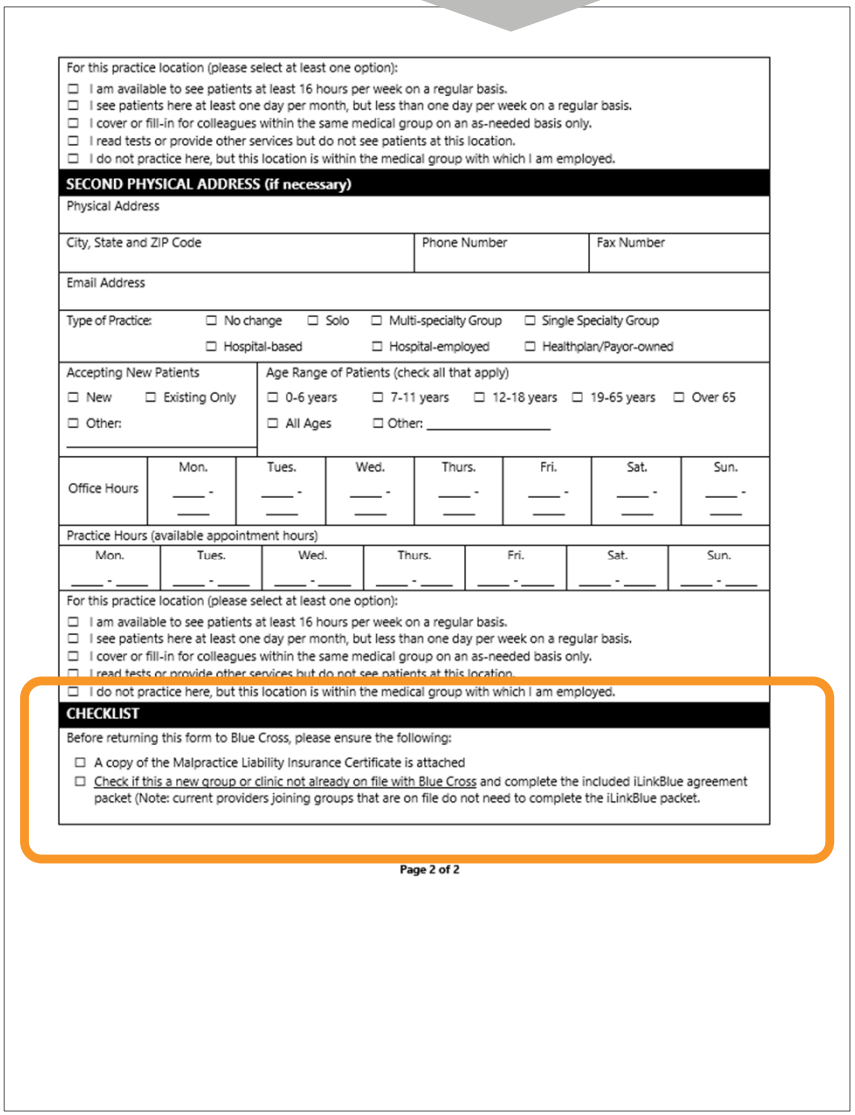
Updating Your Information

It is important that we always have your most current information!

Some change selections on the **Provider Update Request Form** include a checklist of required supporting documentation needed to complete your request.

- Complete the checklist:
- Ensure all requested items on the checklist are included or completed before submitting.

Submissions that are missing checklist items will be returned.



For this practice location (please select at least one option):
☐ I am available to see patients at least 16 hours per week on a regular basis.
☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
☐ I read tests or provide other services but do not see patients at this location.
☐ I do not practice here, but this location is within the medical group with which I am employed.

SECOND PHYSICAL ADDRESS (if necessary)

Physical Address

City, State and ZIP Code | Phone Number | Fax Number

Email Address

Type of Practice: ☐ No change ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Healthplan/Payor-owned

Accepting New Patients
☐ New ☐ Existing Only
☐ Other:

Age Range of Patients (check all that apply)
☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65
☐ All Ages ☐ Other: _____

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

Practice Hours (available appointment hours)

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___	___ - ___

For this practice location (please select at least one option):
☐ I am available to see patients at least 16 hours per week on a regular basis.
☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
☐ I read tests or provide other services but do not see patients at this location.
☐ I do not practice here, but this location is within the medical group with which I am employed.

CHECKLIST

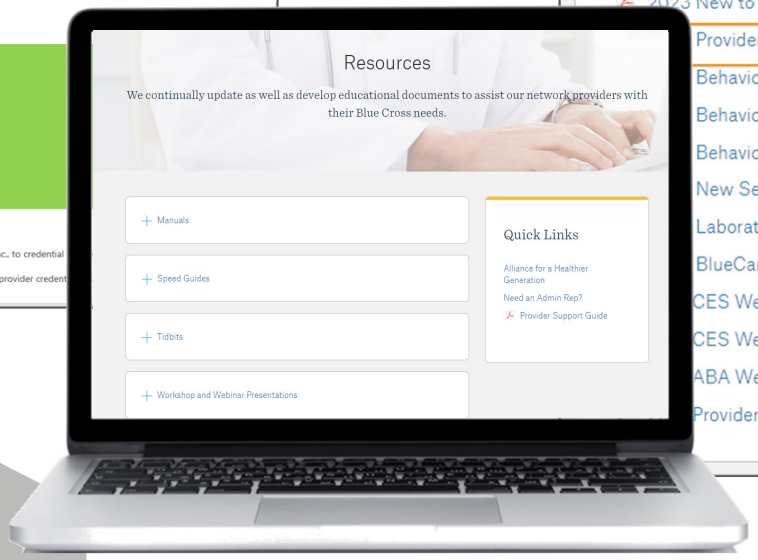
Before returning this form to Blue Cross, please ensure the following:

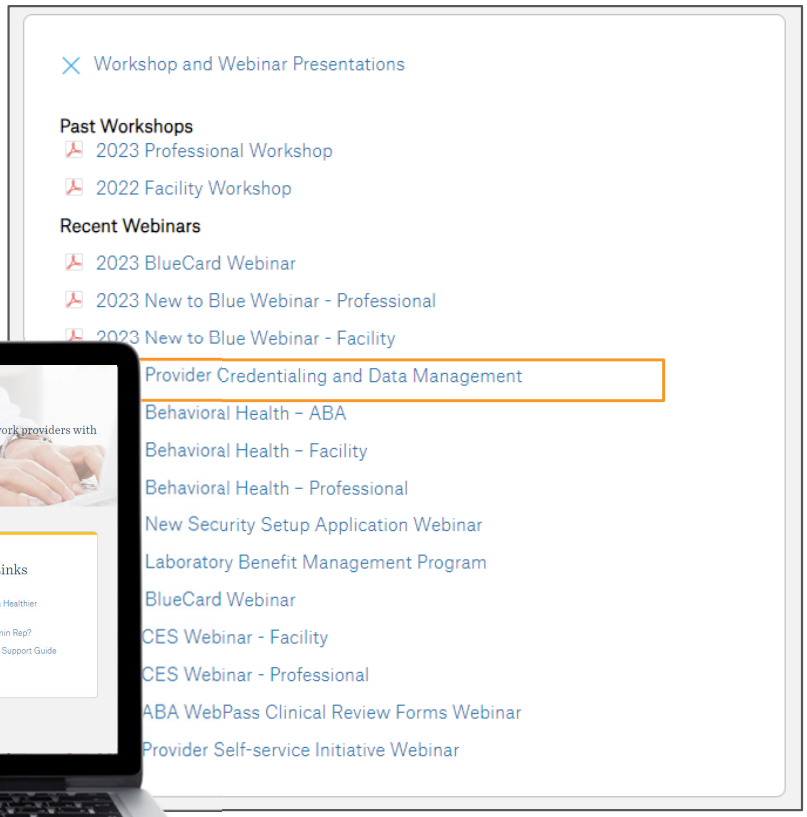
☐ A copy of the Malpractice Liability Insurance Certificate is attached
☐ Check if this a new group or clinic not already on file with Blue Cross and complete the included iLinkBlue agreement packet (Note: current providers joining groups that are on file do not need to complete the iLinkBlue packet.

Page 2 of 2

Learn More About Credentialing and Recredentialing

For full information on how to complete the credentialing/recredentialing processes, view our **Provider Credentialing & Data Management Webinar** presentation. It is available online at **www.bcbsla.com/providers** >Resources >Workshops & Webinars.





To attend this webinar on November 1, register using the link in our upcoming Provider Weekly Digests.

Support

Customer Care Center

Customer Care Center	1-800-922-8866
FEP Dedicated Unit	1-800-272-3029
OGB Dedicated Unit	1-800-392-4089
Blue Advantage	1-866-508-7145

For information NOT available on iLinkBlue

Other Provider Phone Lines

BlueCard Eligibility Line – 1-800-676-BLUE (1-800-676-2583)
for out-of-state member eligibility and benefits information

Fraud & Abuse Hotline – 1-800-392-9249
Call 24/7 and you can remain anonymous as all reports are confidential

Health Services Division – 1-800-716-2299

- **option 1** – for questions regarding provider contracts
- **option 2** – for questions regarding credentialing and provider record information
- **option 3** – for questions regarding iLinkBlue and clearinghouse information
- **option 4** – for questions regarding provider relations
- **option 5** – for questions regarding security access to online services

Provider Relations

Kim Gassie Director

Jami Zachary Manager

Marie Davis – Sr. Provider Relations Rep.
Allen, Avoyelles, Beauregard, Caldwell, Catahoula, Concordia, East Carroll, Evangeline, Franklin, LaSalle, Madison, Morehouse, Ouachita, Rapides, Richland, Tensas, Vernon, West Carroll, Acadia

Anna Granen – Sr. Provider Relations Rep.
Jefferson, Orleans, Plaquemines, St. Bernard, Iberville

Mary Guy
East Feliciana, St. Helena, St. Tammany, Tangipahoa, Washington, West Feliciana, Livingston, Pointe Coupee, St. Martin, Terrebonne

Melonie Martin
East Baton Rouge, Ascension, West Baton Rouge

Lisa Roth
Bienville, Bossier, Caddo, Claiborne, Desoto, Grant, Jackson, Lincoln, Natchitoches, Red River, Sabine, Union, Webster, Winn, Jefferson Davis, St. Landry, Vermilion

Yolanda Trahan
Assumption, Iberia, Lafayette, St. Charles, St. James, St. John the Baptist, St. Mary, Calcasieu, Cameron, Lafourche

provider.relations@bcbsla.com | 1-800-716-2299, option 4

Paden Mouton, Supervisor

Provider Contracting

Jason Heck, Director – jason.heck@bcbsla.com

Diana Bercaw, Lead Provider Network Development Representative – diana.bercaw@bcbsla.com
Jefferson, Orleans, Plaquemines, St. Bernard, St. Tammany, Tangi and Washington parishes

Jordan Black, Sr. Provider Network Development Representative – jordan.black@bcbsla.com
Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes

Sue Condon, Lead Network Development & Contracting Representative – sue.condon@bcbsla.com
West Feliciana, East Feliciana, St. Helena, Pointe Coupee, West Baton Rouge, East Baton Rouge, Livingston, Ascension, Assumption and Iberville parishes

Cora LeBlanc, Sr. Provider Network Development Representative – cora.leblanc@bcbsla.com
St. John The Baptist, Terrebonne, Lafourche, St. Charles, St. James, Tensas, Madison, East Carroll, West Carroll, Franklin, Richland, Morehouse, Ouachita, Caldwell, Union, Concordia, Catahoula and Lasalle parishes

Dayna Roy, Sr. Provider Network Development Representative – dayna.roy@bcbsla.com
Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Grant, Jefferson Davis, Rapides and Vernon parishes

Lauren Viola, Provider Network Development Representative – lauren.viola@bcbsla.com
Caddo, Bossier, Webster, Claiborne, Desoto, Red River, Bienville, Sabine, Natchitoches, Winn, Jackson and Lincoln parishes

provider.contracting@bcbsla.com | 1-800-716-2299, option 1

Doreen Prejean **Mary Landry** **Karen Armstrong**

Provider Credentialing & Data Management

Provider Network Setup, Credentialing, Contracting & Demographic Change

Vielka Valdez, Director, Provider Network Operations
vielka.valdez@bcbsla.com

Kaci Guidry, Manager, Provider Credentialing and Data Management
kaci.guidry@bcbsla.com

Kristin Ross, Manager, Provider Contract Administration
kristin.ross@bcbsla.com

Chrisy Cavalier, Supervisor, Provider Information (PCDM Status)
chrisy.cavalier@bcbsla.com

If you would like to check the status on your credentialing application or provider data change or update, please contact the Provider Credentialing & Data Management Department.

PCDMstatus@bcbsla.com | 1-800-716-2299, option 2

At this time, we will address the questions you submitted electronically through the webinar platform.

Appendix

Expedited Processing

In addition to reimbursement during credentialing, Act 897 allows providers a 30-day expedited application for reimbursement during credentialing.

To qualify for the expedited time frame, providers must meet the following requirements:

- Provider must have admitting privileges to a network hospital or an approved exception. Provider must list this information in the hospital affiliations section on the appropriate credentialing application.
- Must have the same provider type agreement on file with Blue Cross (e.g., physician, allied health, facility, dental agreements).
- Agrees to hold our members harmless for payments above the allowable amount.

Requesting expedited processing:

Include with the initial credentialing application via DocuSign:

- Letter asking Blue Cross to invoke the expedited process.
  - The letter must include your agreement to hold our members harmless for payments above the allowable amount.
  - The letter must be on company letterhead and signed by the provider.
- Signed admitting privileges agreement to a network hospital.

Example Letter to Blue Cross

The Letter, included in the initial credentialing application via DocuSign, must:

- Ask Blue Cross to invoke the Louisiana law that extends existing requirements for credentialing of physicians to all healthcare providers;
- Include your agreement to hold our members harmless for payments above the allowable amount;
- Be on letterhead and signed by the provider.

Sample Letter

{Date}

Dear Blue Cross and Blue Shield of Louisiana:

In accordance with the Louisiana law extending certain requirements for credentialing of physicians to all healthcare providers, please accept this written request to reimburse ***{provider's name}*** *for services provided as a new provider at* ***{provider's group name}*** *at our group contract rate and with in-network benefits.* ***{Provider's group name}*** *agrees that all contract provisions, including holding covered members harmless for charges beyond the Blue Cross allowable amount and the member's cost share amount (deductible, coinsurance and/or copayment, as applicable) will apply to the new provider.*

{Signature of the provider}

Electronic Payment Registers

HIPAA 835 Transaction

- Providers who submit claims electronically can receive an electronic file containing their weekly Provider Remittance Advice/Payment Register (ERA).
- The ERA is available Monday mornings, allowing providers to begin posting payments as soon as possible.
- ERA specifications are available from Blue Cross at no cost to vendors and providers, but they do require programming changes by your practice management billing system vendor. Traditionally, there is an upfront fee from your billing system vendor for programming.
- From that point, you may receive the Blue Cross weekly Remittance Advice/Payment Register at no charge.

For more information, please contact Blue Cross EDI Services at **EDIservices@bcbsla.com** or at 1-800-716-2299, option 3.

National Drug Code (NDC) Required on Drug Claims

Use the following billing guidelines to report required NDCs on professional CMS-1500 claims:

- NDC code editing will apply to any clinician-administered drugs billed on the claim, including immunizations. The claim must include any associated HCPCS or CPT code (except HCPCS codes beginning with the letter "A").
- Each clinician-administered drug must be billed on a separate line item.
- Claims that do not meet the requirements will be rejected and returned on your "Not Accepted" report. Units indicated would be "1" or in accordance with the dosage amount specified in the descriptor of the HCPCS/CPT code appended for the individual drug.
- Providers may bill multiple lines with the same CPT or HCPCS code to report different NDCs.
- The following NDC edits will apply to electronic and paper claims that require an NDC, but no valid NDC was included on the claim:
  - NDCREQD – NDC CODE REQUIRED
  - INVNDC – INVALID NDC

Failure to report NDCs on claims will result in automatic rejections.

Reporting NDCs on Professional Claims

For Hardcopy Claims

On the CMS-1500 claim form, report the NDC in the shaded area of Box 24A. We follow the CMS guidelines when reporting the NDC. The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g., N49999999999. The drug quantity and measurement/qualifier should be included.

For Electronic Claims 837P

Report the 11-digit NDC in loop 2410, Segment LIN03 of the 837. The NDC will be validated during processing. The corresponding quantity and unit(s) of measure should be reported in loop 2410 CTP04 and CTP05-1. Available measures of units include the international unit, gram, milligram, milliliter and unit.

For iLinkBlue Claims (Professional Only)

Select 24K to expand the claim line to report the NDC, Quantity and Measurement:

- NDC Code Field: Enter the 11-digit NDC code. No alpha characters, spaces or hyphens can be present.
- Quantity: Numeric value of quantity.
- Measurement: Select the appropriate measurement from the drop-down menu.
  - F2 – International Unit
  - GR – Gram
  - ME – Milligram
  - ML – Milliliter
  - UN – Unit

Reporting NDCs on Professional Claims

You must enter the NDC on your claim in the 11-digit billing format (no spaces, hyphens or other characters). If the NDC on the package label is less than 11 digits, you must add a leading zero to the appropriate segment to create a 5-4-2 format.

How should the NDC be entered on the claim? See the examples below:

10-Digit Format on Package	10-Digit label format Example	11-Digit Format	11-Digit Format Example
4-4-2	9999-9999-99	5-4-2	09999-9999-99
5-3-2	99999-999-99	5-4-2	99999-0999-99
5-4-1	99999-9999-9	5-4-2	99999-9999-09

If the NDC is not submitted in the correct format, the claim will be denied.

Closed Formulary

- Most of our members follow a Covered Drug List. Covered Drug Lists include thousands of generic and brand drugs, but not all drugs.
- **Please consider prescribing drugs that are covered** or have lower out-of-pocket costs when you believe it is appropriate. If members fill a prescription drug that is not on the covered drug list, they could have to pay the full cost of the drug out of pocket.
- **You may ask for a clinical review** (similar to prior authorization) if your patient has a medically necessary need for a *non-formulary* drug. Find information about submitting a prior authorization at **www.bcbsla.com** >Provider >Pharmacy. This is not available for drugs excluded from coverage.

You and your patients can check the Covered Drug List and find up-to-date information about drug coverage at **www.bcbsla.com/covereddrugs**.

Provider's Role in Documenting

Accuracy and specificity in medical record documentation and coding is critical in creating a complete clinical profile of each individual patient.

- Each page of the patient's medical records should include the following for a face-to-face visit:
  - Patient name
  - Date of birth or other unique identifier
  - Date of service including the year
- Provider signature (must be legible and include credentials).
- Report ALL applicable diagnoses on claims and report at the highest level of specificity (CMS-1500 claim forms can accommodate up to 12 diagnosis codes).
- Include all related diagnoses, including chronic conditions you are treating.
- Medical records **must support ALL** diagnosis codes on claims.