Louisiana

2023

The BlueCard® Program Provider Manual

23XX4272 R02/23

Blue Cross and Blue Shield of Louisiana BlueCard® Program Provider Manual

This manual is designed to provide information to aid you in servicing members of a Blue Plan other than Blue Cross and Blue Shield of Louisiana (BCBSLA). These members are referred to as BlueCard members.

To use this manual, first familiarize yourself with the Quick Reference Guide, Table of Contents, Definitions section and Summary of Changes page.

Periodically, we send newsletters and informational notices to providers. Please keep such information and a copy of your respective provider agreement(s) along with this manual for your reference. Updated office manuals and provider newsletters may be found on the Provider page of our website (www.bcbsla.com/providers >Resources).

If you have questions about the information in this manual or your participation as a network provider, please email provider.contracting@bcbsla.com.

Blue Cross and Blue Shield of Louisiana

Quick Reference Guide

This reference guide contains the contact information for the services listed within this manual. Please refer to this guide as needed when reading this manual.

Appeals	Please mail appeals to the appropriate address: **Standard Administrative Appeal** Medical Benefits: BCBSLA Appeals and Grievance P.O. Box 98045 Baton Rouge, LA 70898-9045 Pediatric Dental Care Benefits: (applicable to non-grandfathered individual and small group only) BCBSLA Dental Customer Service P.O. Box 69420 Harrisburg, PA 17106-9420 Pediatric Vision Care Benefits: (applicable to non-grandfathered individual and small group only) BCBSLA c/o Davis Vision P.O. Box 791 Latham, NY 12110 **Standard Medical Appeal** (if it is an expedited medical appeal, please put Attn: Expedited Medical Appeal) BCBSLA Medical Appeals P.O. Box 98022 Baton Rouge, LA 70898-9022 Fax: (225) 298-1837

BlueCard Eligibility®	Call BlueCard Eligibility to verify patient eligibility and benefits. You can receive real-time responses to your eligibility requests for out-of-area members between 6 a.m. and midnight, Central Time, Monday through Saturday. **phone:** 1-800-676-BLUE (1-800-676-2583)
Claims	**Electronic:** Please submit electronic claims through Blue Cross-approved clearinghouse locations. For more information about filing claims through Blue Cross approved clearinghouse locations, visit the Clearinghouse section of our Provider page (www.bcbsla.com/providers >Electronic Services >Clearinghouse Services). CMS-1500 Electronic claims also may be submitted through iLinkBlue (www.bcbsla.com/ilinkblue). **Hardcopy:** BCBSLA Claims Department P.O. Box 98029 Baton Rouge, LA 70898-9029
Customer Care Center	Providers are required to use our self-service tools for member eligibility, claim status inquiries, professional allowable searches and medical policy searches. Our self-service options are: • iLinkBlue (www.bcbsla.com/ilinkblue) • Interactive Voice Recognition (IVR) - (1-800-922-8866) • HIPAA 27x Transactions - (1-800-216-2583) For all other inquiries, please have your NPI, the member ID number, patient date of birth and the date of service when calling. **phone:** 1-800-922-8866

Disputes	Please include the Provider Dispute Form and/or a detailed reason for the claims dispute. Find the Provider Dispute Form on our Provider page (www.bcbsla.com/providers >Resources >Forms). Participating provider claims disputes for Blue Cross and Blue Shield of Louisiana members can be submitted in the following ways: **Hardcopy:** BCBSLA Provider Disputes P.O. Box 98021 Baton Rouge, LA 70898-9021 **Fax:** (225) 298-7035 **iLinkBlue** (www.bcbsla.com/ilinkblue)**:** Select "Document Upload" from the Home page or "Claims" and then "Medical Records" menu options. In the Document Upload tool, choose "Provider Disputes" in the drop-down menu. Participating provider claims disputes for BlueCard® members (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana) can be submitted in the following ways: **Hardcopy:** BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9045 **Fax:** (225) 297-2727
EDI Services	Claims may be submitted electronically to Blue Cross directly from your office or through a Blue Cross-approved clearinghouse. For more information about filing claims electronically and/or approved clearinghouse locations, please contact our EDI Services: **email:** EDIservices@bcbsla.com **phone:** 1-800-716-2299, option 3

Electronic Funds Transfer (EFT)	All providers must be part of our EFT program. With EFT, Blue Cross deposits your payment directly into your checking or savings account. For more information on EFT, visit the EFT section of the Provider page at www.bcbsla.com/providers >Electronic Services >Electronic Funds or contact us: **email:** PCDMstatus@bcbsla.com **phone:** 1-800-716-2299, option 2
iLinkBlue	iLinkBlue is a free online provider tool that includes services such as: • Eligibility verification • Benefits (copayments, deductible and coinsurance) • Claims status (paid, rejected and pended) • Allowable charges • Action requests • Payment registers • Medical policies • Authorization requests • and more! **iLinkBlue:** www.bcbsla.com/ilinkblue For questions regarding iLinkBlue please contact our EDI Services: **email:** EDIservices@bcbsla.com **phone:** 1-800-716-2299, option 3
Overpayments	If you believe an overpayment has occurred for an out-of-state member, please complete and submit an Overpayment Notification Form. BCBSLA will then review the claim to ensure that an overpayment did occur. The Overpayment Notification Form is located on our Provider page (www.bcbsla.com/providers >Resources >Forms).

Provider Credentialing & Data Management	Blue Cross partners with Vantage Health Plan for the processing of provider credentialing and recredentialing activities. Credentialing packets and criteria are available on our Provider page at www.bcbsla.com/providers >Provider Networks >Join Our Network >Professional Providers >Join Our Network. The Blue Cross Provider Credentialing & Data Management team handles demographic changes. To change your address, phone number, Tax ID number, etc., please use the Provider Update Request Form, located on our Provider page (www.bcbsla.com/providers >Resources >Forms). For more information on our credentialing and data management process, including frequently asked questions, visit www.bcbsla.com/providers >Provider Networks >Join Our Networks >Professional Providers >Join Our Network. For all other inquiries: **email:** PCDMstatus@bcbsla.com **phone:** 1-800-716-2299, option 2
Provider Contracting	Provider Contracting supports inquiries related to your provider agreement(s). **email:** provider.contracting@bcbsla.com **phone:** 1-800-716-2299, option 1
Provider Identity Management Team (PIM)	PIM is a dedicated team that helps establish and manage system access to our secure electronic services, including the setup process for administrative representatives. **email:** PIMteam@bcbsla.com **phone:** 1-800-716-2299, option 5

Provider Page	Our Provider page is designed to serve provider needs. Use this page to help locate important information such as: • Authorizations • Credentialing • Resources • Newsletters • OGB • Pharmacy Management • Provider Tools • Quality Blue **website:** www.bcbsla.com/providers
Provider Relations	Provider Relations representatives assist providers and office staff with information about Blue Cross and its programs and procedures. Provider Relations representatives do not handle routine claim inquiries and benefit questions. **email:** provider.relations@bcbsla.com **phone:** 1-800-716-2299, option 4

Table of Contents

Section 1: BlueCard® Program Overview

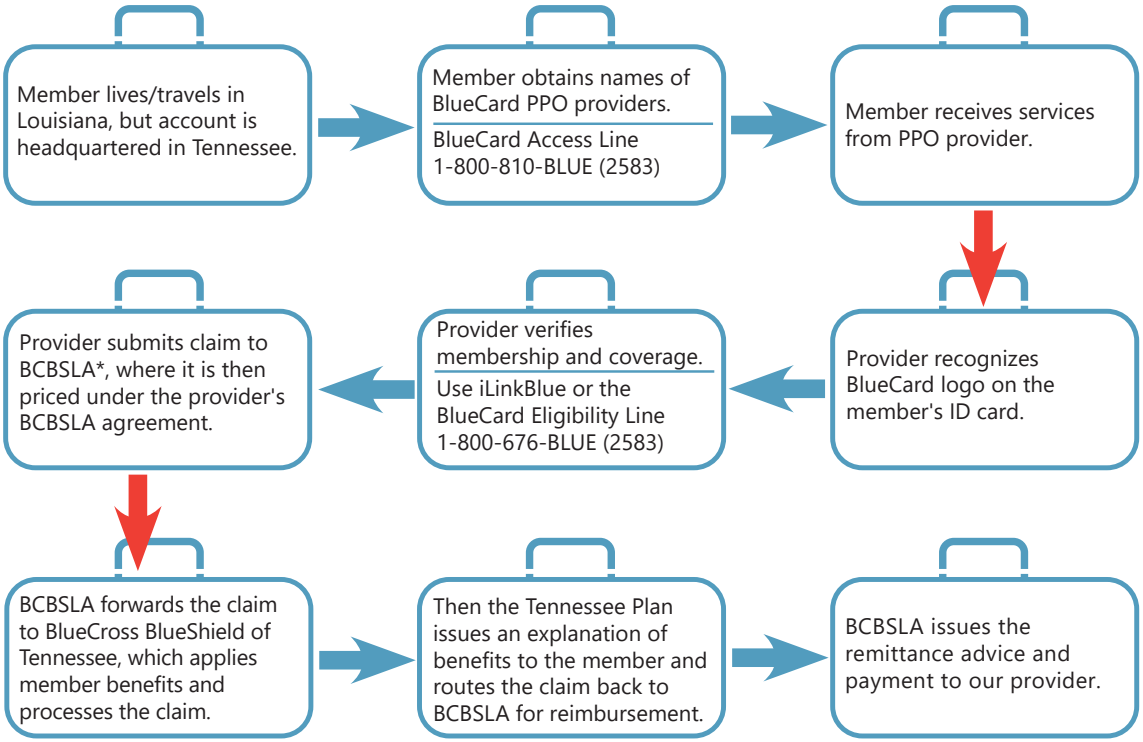
WHAT IS THE BLUECARD PROGRAM?

BlueCard is a national program that enables members of one Blue Cross and Blue Shield (BCBS) Plan to obtain in-network health care services while traveling or living in another BCBS Plan service area. BlueCard links participating health care providers with other Blue Plans across the country, and in more than 200 countries and territories worldwide, through a single electronic network for professional, outpatient and inpatient claims processing and reimbursement.

Through BlueCard, you can submit claims for Blue members visiting you from other areas directly to Blue Cross and Blue Shield of Louisiana (BCBSLA). We are your sole contact for all BCBS claims submissions, payments, adjustments, services and inquiries.

A majority of all doctors and hospitals throughout the United States contract with Blue Cross and/or Blue Shield Plans. Outside of the United States, members have access to participating doctors and hospitals worldwide. Not only can members take advantage of savings that BCBSLA has negotiated with providers, members do not have to complete a claim form or pay up front for health care services, except for out-of-pocket expenses, such as deductible, copayments and coinsurance. All Blue Plans participating in the BlueCard Program must deliver to BlueCard members from other Blue Plans' the same provider discounts that they have negotiated for their own members.

HOW DOES THE BLUECARD PROGRAM WORK?



* Some ancillary services have different filing rules. Please reference the "Ancillary Claims" section of this manual.

ADVANTAGES OF PARTICIPATING IN THE BLUECARD PROGRAM

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to BCBSLA. We are your focal point for claim submissions, payments, adjustments, services and inquiries for any BlueCard members to whom you provide services.

More than 400,000 Blue Plan members from other Blue Plans reside in Louisiana. You have easy access to coverage information on these members through the BlueCard Eligibility line.

The BlueCard Program's billing process provides quicker payments for your services to out-of-area patients.

SERVICES AND PRODUCTS COVERED UNDER THE BLUECARD PROGRAM

The BlueCard Program applies to all inpatient, outpatient and professional claims. PPO, POS and HMO products are included in the BlueCard Worldwide Program.

The following products are optional under the BlueCard Program:

- Stand-alone vision and hearing
- Medicare supplement

The following products are excluded under the BlueCard Program:

- Stand-alone dental
- Vision delivered through an intermediary model (using a vendor).
- Self-administered prescription drugs delivered through an intermediary model.
- Medicaid and SCHIP that is part of the Medicaid program.
- Federal Employee Program (FEP). FEP members have the letter "R" in front of their member number. Please follow your FEP billing guidelines for these contracts.
- Medicare Advantage (PPO and PFFS Plans). Medicare Advantage is a separate program from BlueCard; however, you may see members of other Blue Plans who have Medicare Advantage coverage. We have included a section on Medicare Advantage claims processing in this manual.

IDENTIFYING BLUECARD MEMBER ID CARDS

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

A correct member identification number includes the three-character prefix in the first three positions and all subsequent characters up to a total of 17 positions. Some member identification numbers may include alphabetic characters within the body of the number. These alphabetic characters are part of the member's identification number and are not considered to be part of the three-character prefix.

Prefix

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

It is very important to capture all identification card data at the time of service. If the information is not captured correctly, you may experience a delay in claims processing. We suggest that you always make copies of the front and back of the member ID cards and pass this key information on to your billing staff and any other providers you refer the member to, for example, lab, X-ray, etc. Do not make up prefixes.

Do not assume that the member ID number is a Social Security number. All Blue Plans replaced Social Security numbers on member ID cards with alternate, unique identifiers.

No Prefix

Some member ID cards may not have a prefix or suitcase logo, which may indicate that claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the card for how to file claims. If that information is not available, call the customer service number indicated on the member ID card.

Suitcases on Member ID Cards

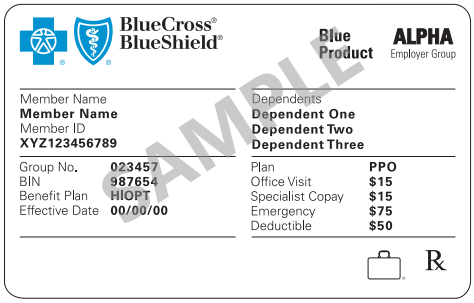
A blank "suitcase" logo on a member ID card indicates that the member has Blue Cross and Blue Shield Traditional, POS or HMO benefits delivered through the BlueCard Program.

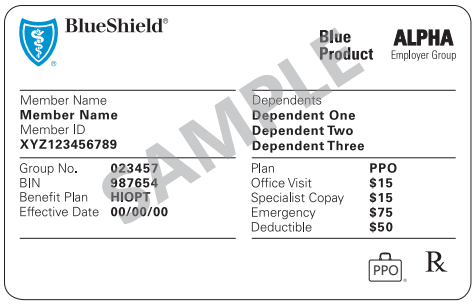
The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product.

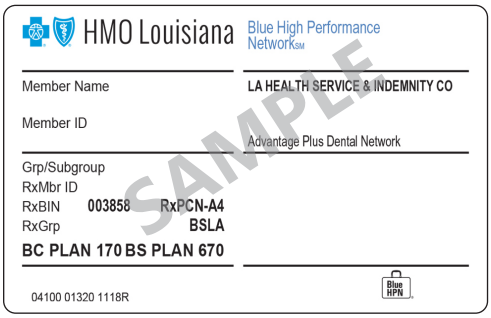
The PPOB suitcase indicates the member has access to the exchange PPO network, referred to as BlueCard PPO basic.

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

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

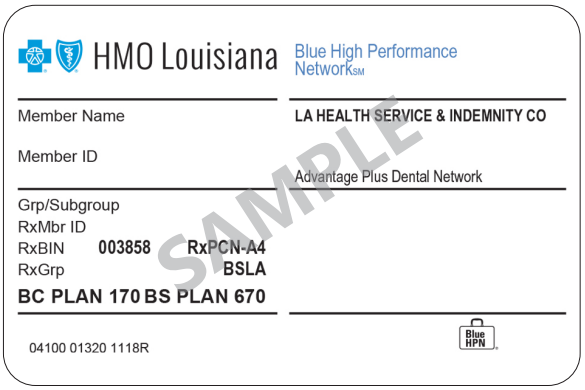






IDENTIFYING BLUECARD BLUEHPN MEMBERS

Blue High Performance Network$_{SM}$ (BlueHPN) is a national network focused on enhancing the quality of care and delivery of cost savings to large self-funded employer groups. This network allows eligible employer groups with employees located throughout the country seamless access to a quality and affordable health care network nationwide.



BlueHPN members have access to providers participating in the BlueHPN network across the nation. HMO Louisiana, Inc. offers a BlueHPN network.

BlueHPN is an Exclusive Provider Organization (EPO). This means benefits are only covered for care by in-network providers. It is important to note that for non-BlueHPN providers, benefits for services incurred are limited to emergent care within BlueHPN product areas, and to urgent and emergent care outside of BlueHPN product areas. Benefit limitations are included on the back of the BlueHPN member ID card. If you are a non-BlueHPN provider but participate in the Preferred Care PPO network, you will be reimbursed for services provided to BlueHPN members according to your PPO allowable charges.

BlueHPN members are recognizable by:

- The Blue High Performance Network name on the front of the member ID card
- The BlueHPN in a suitcase logo in the bottom right hand corner of the member ID card

CONSUMER-DIRECTED BENEFITS

Terms Used in this Section

Consumer-directed health care	CDHC
Consumer-directed health plans	CDHP
Health reimbursement account	HRA
Health savings account	HSA
Flexible spending-account	FSA

CDHC is a movement in the health care industry designed to empower members, reduce employer costs and change consumer health care purchasing behavior. CDHC provides the member with additional information to make informed and appropriate health care decisions through the use of member support tools, provider and network information and financial incentives. CDHC includes many different benefit plans and services including CDHP, high-deductible health plans and the option to use debit cards for payment. In conjunction with these plans, members may have a HRA, HSA or FSA.

When the consumer is paying more of the bill, you may need to devote resources to conducting pre-service work with patients. Consumers on a high-deductible health plan may require more specialized service work due to the questions on cost and options.

When the Consumer Is Paying More of the Bill

	Sales/Marketing Fulfillment	Pre-Service ★	At Point of Service ★	Post-Service
CONSUMER	• Seeks education about choices • Selects health plan • Selects network/ providers	• Seeks information • Estimates costs to compare providers and treatment options • Seeks quality information about providers	• Knows what they owe • Can apply payment from a variety of sources, including access to credit	• Seeks help with next steps of treatment plan - Health information/ coaching - Efficient sources
PROVIDER	• Promotion to consumers • Performance information for consumers	• Determines member eligibility and benefits • May estimate member responsibility for upcoming service • May inform member of estimate in advance	• Determines eligibility, benefits and specific member responsibility • Collects correct amount from the source selected by the member	• Provides feedback on performance • Seeks improvements - Administrative - Clinical

Consumer-directed Health Plan (CDHP)

High-deductible health plans (HDHPs) partnered with member personal savings accounts (PSAs), such as a HSA, HRA or FSA, form a CDHP. The type of account used in these arrangements has strong implications to the administration of the CDHP, as the IRS regulations governing these tax-favored PSAs vary significantly.

Once members have met their deductible, covered expenses are paid based on the member's benefit plan. As a participating provider, you should treat these members just as you would any other BCBS member:

- You should accept the BCBS reimbursement amount/allowable charge (up to the member's deductible amount) and any coinsurance amount, if applicable, as payment in full.
- If you collect billed charges up front, you must refund the member the difference between your charge and the BCBS reimbursement amount/allowable charge within 30 days.

Examples of what to collect from CDHP members:

1.	Member's Total Deductible	$2000	Member has met deductible
	Member's Deductible Paid	$2000	
	Allowable Charge	$ 100	
	Amount to be collected from member	$ 0	
	BCBS Pays	$ 100	
2.	Member's Total Deductible	$2000	Member has NOT met deductible
	Member's Deductible Paid	$1000	
	Allowable Charge	$ 100	
	Amount to be collected from member	$ 100	
3.	Member's Total Deductible	$2000	Member with coinsurance
	Member's Deductible Paid	$2000	
	Allowable Charge	$ 100	
	Member's Coinsurance (20%)	$ 20	
	Amount to be collected from member	$ 20	
	BCBS Pays	$ 80	

BlueCard members whose plan includes a debit card can pay for out-of-pocket expenses by swiping the card through any debit card swipe terminal. These cards are used just like any other debit card. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account. If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to accept any other signature debit card.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their debit cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities.

Below are some helpful tips that will guide you when processing claims for and payments from Blue members with a CDHP plan like *Blue*Saver:

- Commit to pre-service work with patients. Contact to confirm appointment and ask them to bring a copy of their current member ID card. Offer to discuss out of pocket expenses prior to their visit.

- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
- Verify the member's eligibility or benefits through iLinkBlue or by calling BlueCard Eligibility® and providing the prefix.
- Carefully determine the member's financial responsibility before processing payment.
- If the member presents an HSA or HRA debit card or debit/ID card, be sure to verify the member's cost sharing or out-of-pocket amount before processing payment.
- Please do not use the card to process full payment up front.
- File claims for all members with CDHPs (including those with BlueCard) to BCBSLA.

If you have any questions about the health care debit card processing instructions or payment issues, please contact the debit card administrator's toll-free number on the card.

Identifying CDHP Members

Many CDHP members carry health care debit cards that allow them to pay for out-of-pocket costs using funds from their HRA, HSA or FSA.

Some cards are "stand-alone" debit cards which cover out-of-pocket costs, while others also serve as a member identification card as they include the member's identification number. The combined card will have a nationally recognized Blue logo, along with the logo from a major debit card company such as MasterCard® or Visa®.

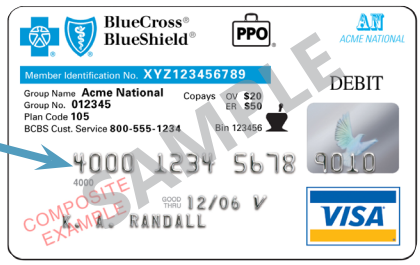
Members can use their cards to pay outstanding balances on billing statements. If your office currently accepts credit card payments, there is no additional equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit cards.

If the member presents a debit card (stand-alone or combined), be sure to verify the member's cost sharing amount before processing payment. Do not use the card to process full payment up front.

You may check CDHP members' benefits and eligibility online by accessing iLinkBlue or by calling Customer Care Center.

Sample: stand-alone health care debit card

Sample: combined health care debit card and member ID card



LIMITED BENEFIT PRODUCTS

InReach or MyBasic

Verifying Blue member benefits and eligibility is more important than ever. There are a variety of new health insurance products on the market including limited benefit plans.

Currently BCBSLA does not offer limited benefit plans; however, you may see patients with limited benefits who are covered by another Blue Plan.

Identifying Members: Out-of-state Blue members, who have limited benefits coverage, carry ID cards that have:

- either of two product names - InReach or MyBasic,
- a tagline in a green stripe at the bottom of the ID card; and,
- a black cross and/or shield to help differentiate it from other identification cards.

Verifying Eligibility: In addition to obtaining a copy of the member ID card (regardless of the benefit product type), we recommend that you verify benefits and eligibility. You may do so electronically through iLinkBlue for out-of-area members. By verifying eligibility, you will receive the patient's accumulated benefits to help you understand the remaining benefits left for the member.

When benefits are exhausted: Any services beyond the covered amounts or the number of treatments may be the member's liability. We recommend that you inform the member of any potential liability they may have as soon as possible.

BLUE ADVANTAGE (HMO) AND BLUE ADVANTAGE (PPO)

Blue Advantage is our Medicare Advantage product. For information to aid you in servicing members with Blue Advantage health care benefits, please refer to the *Blue Advantage Provider Administrative Manual*. It is located on the Blue Advantage Provider Portal, available through iLinkBlue.

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).

Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

MEDICARE ADVANTAGE MEMBERS FROM OTHER BLUE PLANS

Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare."

All Medicare Advantage Blue Plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well, such as enhanced vision and dental benefits.

Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including the following benefit options:

- HMO - health maintenance organization

  A MA HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by MA plan.

- POS - point-of-service

  A MA POS program is an option available through some Medicare HMO programs. It allows members to determine—at the point of service—whether they want to receive certain designated services within the HMO system or seek such services outside the HMO's provider network (usually at greater cost to the member). The MA POS plan may specify which services will be available outside of the HMO's provider network.

- PPO - preferred provider organization

  A MA PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. MA PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs. Blue MA PPO members have in-network access to Blue MA PPO providers.

- PFFS - private fee-for-service

  A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

MA Blue Plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers can and should confirm the Blue MA member's level of coverage prior to providing services as benefits and coverage rules may vary depending on the MA Blue Plan.

- Blue Cross and Blue Shield of Louisiana and HMO Louisiana MA members: go to iLinkBlue (www.bcbsla.com/ilinkblue) to access our Blue Advantage Provider Portal (link is located under the "Other Sites" section).
- MA members from other Blue Plans – call the BlueCard Eligibility Line at 1-800-676-BLUE (2583) or submitting an electronic inquiry through iLinkBlue.

MA PPO Network Sharing

Blue Cross and Blue Shield of Louisiana offers a Medicare Advantage (MA) PPO product statewide.

All Blue Plans that offer a MA PPO Plan participate in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO Plan as long as the member sees a contracted MA PPO provider. In Louisiana, we share our MA PPO network with MA PPO members from other states.

- If you are a participating provider in our MA PPO network, you should provide the same access to care for Blue MA PPO members as you do for our members. Services for Blue MA PPO members will be reimbursed in accordance with your BCBSLA MA PPO allowable charges. The Blue MA PPO member's in-network benefits will apply.
- If your practice is closed to new members, you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members.
- If you are not a participating provider in our MA PPO network, but do accept Medicare (participating or non-participating) and you see Blue MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergent care, you will be reimbursed at the member's in-network benefit level.

Blue MA PPO members are recognizable by the "MA" suitcase on the member ID card.

Blue MA PPO members have been asked not to show their standard Medicare ID card when receiving services. Instead, Blue MA PPO members should provide their Blue Cross and Blue Shield member ID card.

Claims for services rendered in Louisiana, should be filed directly to Blue Cross and Blue Shield of Louisiana. Do not bill Medicare directly for any services rendered to a Blue MA PPO member.

Section 2: BlueCard Authorizations and Billing Guidelines

MEDICAL POLICY, AUTHORIZATION, CERTIFICATION ROUTER

Louisiana and out-of-area providers have access to general medical policy, prior authorization and prior certification information for other Louisiana and out-of-area members through iLinkBlue.

Please Note: Information is not available for Medicare Advantage or Federal Employee Program (FEP) members.

Louisiana Providers

Louisiana providers will login to iLinkBlue and enter the member's prefix into the Medical Policy Coverage Guidelines or Prior Authorization/Prior Certification Information hyperlinks on the iLinkBlue navigational menu bar. If the patient is a BCBSLA member, the provider will retrieve general Louisiana medical policy, prior authorization and prior certification information.

If the patient is an out-of-area member, the provider can connect to the member's home plan through iLinkBlue to retrieve general medical policy, prior authorization and prior certification information.

- Use the tools under "Authorizations - BCBSLA Members" to search for information on Blue Cross and Blue Shield of Louisiana members.
- Use the tools under "Authorizations - Out of Area Members" to search for information for members of another Blue Plan.

Once in the tool, enter the member's prefix. The tool reads the prefix and then electronically routes the user to the member's Blue Plan to retrieve the general medical policy, prior authorization or prior certification information.

Out-of-Area Providers

Providers will connect to their local Blue Plan's online portal and will be routed to iLinkBlue through a BCBS Association router. This router provides access to Louisiana medical policy, prior authorization and prior certification information.

AMBULANCE CLAIMS

Ground Service

All ground ambulance claims must include the point-of-pick-up ZIP code.

Air Service

All air ambulance claims must include ZIP codes.

Ambulance providers must include the five-digit ZIP code of the point-of-pick-up. This is required for both emergent and non-emergent air ambulance services. This claims filing requirement also applies for Medicare crossover claims when Medicare's benefits do not cover the claim.

- For claims filed electronically through a clearinghouse, include the pick-up location ZIP code in the 2310E Ambulance Pick-up Location loop of the ASC X12N Health Care Claim (837).
- For hardcopy and iLinkBlue-filed claims, include the pick-up location ZIP code on Block 23 of the CMS-1500 claim form.

Claims that do not include the point-of-pick-up ZIP code on the claim will be denied for insufficient information.

Where to file air ambulance claims:

- If the pick-up location ZIP code is in Louisiana, the claim should be filed directly to Blue Cross and Blue Shield of Louisiana.
- If the pick-up location ZIP code is outside of Louisiana, the claim should be filed to the local Blue Plan that covers the area of pick-up.
- If the pick-up location is outside of the United States, Puerto Rico or U.S. Virgin Islands, the claim must be filed to the Blue Cross Blue Shield Global® Core (www.bcbsglobal.com).

ANCILLARY CLAIMS

Ancillary providers are independent clinical laboratories, durable/home medical equipment (DME/HME) and supply providers and specialty pharmacies located within BCBSLA's service area. An ancillary provider located outside of the BCBSLA service area is considered a remote provider.

A remote provider is an independent clinical laboratory, DME/HME supply or specialty pharmacy provider located outside of the BCBSLA service area that is contracted with BCBSLA under a license agreement to act as a local provider solely for services rendered in our service area.

Ancillary Claims Filing Instructions

Ancillary claims for independent clinical laboratory, DME/HME and supply and specialty pharmacy are filed to the local plan. The local plan is determined according to the below information:

- If a remote provider contract is in place with the local plan, the claim must be filed to the local plan, and it would be considered a participating provider claim.
- If a remote provider contract is not in place with the local plan, the claim must be filed to the local plan, and it would be considered a nonparticipating provider claim.

Independent Clinical Laboratory (Lab)	The plan in whose service area the specimen is drawn. This is determined by the state where the referring physician is located.
Durable/Home Medical Equipment (DME/HME)	The plan in whose service area the equipment was shipped to or purchased at a retail store.
Specialty Pharmacy	The plan in whose service area the ordering physician is located. • Specialty Pharmacy is characterized as non-routine, biological therapeutics ordered by a health care professional as a covered medical benefit as defined by the plan's Specialty Pharmacy formulary. • Specialty Pharmacy generally includes injectables and infusion therapies that require complex care. Examples of major conditions these drugs treat include, but are not limited to cancer, HIV/AIDS and hemophilia.

Definition of Local Plan for Ancillary Services

Ancillary Claims Filing: Independent Clinical Laboratory (Lab) Claims

Lab claims must be filed to the Blue Plan where the specimen was drawn. Where the specimen was drawn will be determined by which state the referring provider is located. The referring physician NPI number must be filed on all ancillary claims. If the referring physician NPI is not listed, the claim will be returned.

- CMS-1500 Health Insurance Claim Form:
  - The NPI of the referring provider is identified in Block 17B - NPI of referring provider or other source.
- 837 Professional Electronic Submission:
  - The NPI of the referring provider is populated in loop 2310A.

Ancillary Claims Filing: Durable/Home Medical Equipment (DME/HME) Claims

DME/HME claims must be filed to the Blue Plan where the equipment was shipped to or purchased at a retail store.

- CMS-1500 Health Insurance Claim Form:
  - The patient address where the DME/HME was shipped to in Block 5.
  - The NPI of the ordering provider is identified in Block 17B - NPI of referring provider or other source.
  - The place of service (POS) in Block 24B.
  - The service facility location in Block 32 (for retail store information or location other than the patient address).
- 837 Professional Electronic Submission:
  - The patient address is populated in loop 2010CA.
  - The NPI of the ordering provider is populated in loop 2420E.
  - The POS of the member is populated in loop 2300, CLM05-01.
  - The service facility location is populated in loop 2310C.

Ancillary Claims Filing: Specialty Pharmacy Claims

Specialty pharmacy claims must be filed to the Blue Plan where the ordering physician is located.

- CMS-1500 Health Insurance Claim Form:
  - The NPI of the ordering provider is identified in Block 17B - NPI of referring provider or other source.
- 837 Professional Electronic Submission:
  - The NPI of the ordering provider is populated in loop 2310A.

Scenarios

- An independent laboratory receives and processes member's blood specimen. Member's blood was drawn in Louisiana but processed in Texas by a contracted remote provider. The claim should be filed in Louisiana - the service area where the specimen was drawn. Please note: "Where the specimen was drawn" will be determined by the state the referring provider is located. The referring physician's NPI number must be filed on all ancillary claims. If the referring physician's NPI is not listed, the claim will be returned.
- A durable/home medical equipment provider in Mississippi receives and processes a request for DME for a member in Louisiana. The equipment is then shipped to Louisiana for the member for pick up and/or purchase. The claim should be filed in Louisiana; the service area where the equipment is received/purchased.
- A specialty pharmacy in Louisiana receives a prescription order for a non-routine, biological therapeutic drug for a BCBSLA member who lives in Tennessee. The drug is ordered by a Tennessee provider. The drug is then shipped to the BCBSLA member living in Tennessee. The claim should be filed in Tennessee—the service area where the drug was ordered.

Please Note: BCBSLA only accepts Electronic Remit Advices (ERAs) printed using Medicare Remit Easy Print.

Split Claims

When a claim is billed that meets the following criteria, the provider should split the charges into two claims:

- When the claim is outpatient and the professional claim spans a calendar year.
- When participating and nonparticipating providers are billed on the claim.
- When the claim is from a single provider whose status changes from participating to nonparticipating or from non-participating to participating during the span of services billed on the claim.
- When there is membership coverage changes, the claim must be split at the date of coverage change.
- When a claim is received that includes both surprise bill services (as specified under the No Surprises Act and its accompanying regulations) and those that are not considered surprise bill services. For more information about the No Surprises Act, visit www.cms.gov/nosurprises.
- When a mother and newborn claim includes a discharge date for the baby that is after the mother's discharge date.
- When a mother and newborn claim includes NICU admission, the claim must be split on the date the baby is admitted to the NICU.

Depending on plan processes, the Blue Plan may also require the claim to be split if multiple professional providers are billed on the same claim.

SUBMITTING BLUECARD® MEDICAL RECORDS

All participating providers are required to return medical record request(s) within 30 calendar days of the original requests. Failure to respond timely to these requests may result in limitation of payment or no payment.

1. Always submit medical records directly to BCBSLA when you receive a Medical Record Request Form from BCBSLA.
2. Wait until you receive a request for medical records from BCBSLA before submitting medical records for any denial or notification for: lack of information received, additional information needed or waiting on requested information.
3. Promptly send medical records to BCBSLA after receiving a request for medical records.
4. Always include the Request for Medical Records Form that you received as the cover or first page of the records.

Upon receipt of medical records, please allow 30 days for BCBSLA or the member's Blue Plan to complete the review process. If no response is received after 30 days, please follow-up with BCBSLA by calling Customer Care Center.

BlueCard Medical Records should NOT be submitted

- With a copy of the originally-filed claim as an attachment.
- Unless you received a request for medical records from BCBSLA.
- Without the Request for Medical Records Form.
- Via certified mail.

Medical Record Requests Available in iLinkBlue

After logging into iLinkBlue, a message will show on the iLinkBlue message board when there are open BlueCard medical record requests for your patients.

You can access current and worked requests by clicking on the message link or from the "Out of Area Medical Record Requests" option under the "Claims" iLinkBlue menu tab. Currently, these BlueCard medical record requests are still being sent to providers hardcopy in addition to being available on iLinkBlue, and medical records must still be submitted hardcopy to Blue Cross.

UTILIZATION REVIEW

When the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claim processing delays and potential payment denials.

You may also contact the member's Blue Plan on their behalf. Here's how:

For BCBSLA members, contact Customer Care Center at 1-800-922-8866 for benefits.

For other Blue Plans members:

- Call BlueCard Eligibility at 1-800-676-2583 – ask to be transferred to the utilization review area.
- Submit an electronic HIPAA 278 transaction (referral/authorization) to BCBSLA.
- The member's Blue Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

Section 3: Filing Claims

SUBMITTING CLAIMS FOR BLUECARD MEMBERS

You should always submit BlueCard claims directly to BCBSLA. The only exceptions are:

- If you are contracted with the member's Blue Plan (e.g., in contiguous county/parish or over-lapping service area situations), in which case you should file the claim directly to the member's Plan.
- If you are a dentist, please follow the instructions listed later in this section.
- Ancillary claims. See the Ancillary Claims section of this manual.

Once BCBSLA receives the claim, we will electronically route the claim to the member's Blue Plan. The member's Blue Plan then applies member benefits and processes the claim and approves payment, routes the claim back to BCBSLA. BCBSLA will then reimburse you.

Please refer to the Quick Reference Guide in the front of the manual for information about where to submit claims.

Filing Claims with Your National Provider Identifier (NPI)

Your NPI is used for claims processing and internal reporting. Claim payments are reported to the Internal Revenue Service (IRS) using your Tax ID number (TIN). To appropriately indicate your NPI and TIN on UB-04 and CMS-1500 claim forms, follow the corresponding instructions for each form included in this manual. Remember, claims processing cannot be guaranteed if you have not notified BCBS of your NPI, by using one of the methods above, prior to filing claims.

For more information, including whom should apply for an NPI and how to obtain your NPI, visit the CMS web site at www.cms.hhs.gov/NationalProvIdentStand. If you have any questions about the NPI relating to your BCBSLA participation, please contact Provider Credentialing and Data Management.

Referring Physician NPIs

Referring physician NPIs are required on all applicable claims filed with BCBSLA and HMO Louisiana. Place the NPI in the indicated blocks of the referenced claim forms:

- CMS-1500: Block 17B
- UB-04: Block 78
- 837P: 2310A loop, using the NM1 segment and the qualifier of DN in the NM101 element
- 837I: 2310D loop, segment NM1 with the qualifier of DN in the NM101 element

Hardcopy Claims

Please submit hardcopy claims to BCBSLA at the address found in the Quick Reference Guide at the front of this manual.

Electronic Claims

Please submit electronic claims through BCBS approved clearinghouse locations. For more information about filing claims through approved BCBS clearinghouse locations, please contact our EDI Services.

Electronic claims also may be submitted through iLinkBlue (www.bcbsla.com/ilinkblue).

Medicare Primary Claims Processed Through the BlueCard Program

When services are rendered for a member from another Blue Plan and Medicare is primary, claims should be submitted directly to Medicare for primary payment. Medicare providers receive Electronic Remittance Advices (ERAs) in place of hardcopy Remittance Advices (RAs). Upon receiving your ERA, please verify if Medicare crossed your claim(s) over to the appropriate Blue Plan. Claims that are not crossed over by Medicare should be filed directly to BCBSLA with a copy of the Medicare ERA. Do not submit Medicare-related claims to BCBSLA before receiving an ERA from Medicare.

DENTAL AND ORAL SURGERY CLAIMS

Dentists and oral surgeons should verify benefits for BlueCard program members prior to performing services by calling the number on the back of the member ID card. The following guidelines apply to BlueCard dental claims filing only.

ADA Claim Form

- Dental providers and oral surgeons filing claims for dental services on an American Dental Association (ADA) claim form (hardcopy) should submit the claim to the Blue Plan named on the member ID card; do not file with BCBSLA.
- Dental providers and oral surgeons calling for claim status regarding dental services filed on an ADA claim form should call the number provided on the BlueCard member ID card; do not call BCBSLA as we cannot access this information to assist you.
- ADA claim forms received by BCBSLA for dental services for BlueCard members will be sent back to the provider advising the provider to file the claim to the Blue Plan named on the BlueCard member ID card.
- Dental claims submitted on an ADA claim form must be processed through the Blue Plan on the member's ID card. Providers should not expect payment from BCBSLA. The member or provider will get paid directly from the BlueCard member's Blue Plan or intermediary adjudicating the claim.
- Providers should call the number on the BlueCard member ID card for inquiries regarding claim status for dental services filed on an ADA claim form to the Blue Plan on the member's ID card.

CMS-1500 and Electronic Claim Forms for Dental Services

- Electronic claims received by BCBSLA for dental services provided to BlueCard members will be returned to the provider to re-file the claim to the Blue Plan named on the member ID card.
- It is recommended by BlueCard that dental providers and oral surgeons filing dental services that fall under the medical care category, do so on a CMS-1500 (professional) claim form or professional electronic claim form.
- Dental services that fall under the medical care category and are filed on a CMS-1500 claim form or professional electronic claim form will be processed by BCBSLA and sent to the Blue Plan named on the BlueCard member ID card for adjudication under medical policy guidelines. This does not guarantee payment.
- Dental services filed incorrectly or with missing information on a CMS-1500 claim form or professional electronic claim form will be returned to the provider for a corrected claim.
- Dental claims submitted on a CMS-1500 claim form or professional electronic claim form may be processed through BlueCard; therefore, providers should expect the remit or payment to come from BCBSLA, if the claim is processed to pay the provider. If the claim is processed by the member's home plan to pay the BlueCard member, the member will receive payment from the member's Blue Plan and not from BCBSLA.
- Providers should call BCBSLA for inquiries regarding claim status for dental services filed on a CMS-1500 claim form or professional electronic claim form.

MEDICARE CROSSOVER DUPLICATE CLAIMS

When a Medicare claim crosses over, providers are to wait 30 calendar days from the Medicare remittance date before submitting a claim to Blue Cross and Blue Shield of Louisiana. Claims you submit to Medicare are immediately crossed over to Blue Cross only after they have been processed by Medicare. This process may take approximately 14 business days to occur. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days from the crossover for you to receive payment or instructions from Blue Cross.

Providers should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare benefits may exhaust or have exhausted, please continue to submit claims to Medicare to allow the crossover process to occur and for the member's benefit policy to be applied.

Medicare primary plans, including those with Medicare exhaust services that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date, will be rejected.

In addition, the following Medicare-crossover servicing updates are in place for all Blue Plans to more accurately price and process Medicare claims:

- Providers should directly submit excluded services to BCBSLA with Modifier GY on each line of the claim for the service that is excluded or not covered by Medicare. Blue Cross will apply the contracted rate with the provider to accurately process the claim according to the member's benefit.
- Modifier GY should be used with the specific, appropriate Healthcare Common Procedure Coding System (HCPCS) code, if available. If there is not a specific HCPCS code to describe the services, a "not otherwise classified code" (NOC) must be used with Modifier GY.
- When a member has benefits for services excluded or not covered by Medicare, the provider will receive a notification from Medicare with instructions to submit claims for those services directly to Blue Cross. Instructions will be included in either a paper or electronic remittance advice or in a letter from the Blue Plan.

HEALTHY BLUE MEDICAID PROGRAM CLAIMS

Medical claims for the Healthy Blue Medicaid Program must be filed according to the instructions on the back of the member ID card.

BLUE MEDICAID PROGRAMS CLAIMS

Some Blue Plans administer Medicaid programs. Because Medicaid is a state-run program, requirements vary for each state, and thus each BCBS Plan.

When you see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member's home state. Please remember that billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is specifically prohibited by federal regulations.

If you provide services that are not covered by Medicaid to a Medicaid member, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.

When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements.

Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received:

- National Drug Code
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)
- Billing Provider (Second) Address Line
- Billing Provider Middle Name or Initial
- (Billing) Provider Taxonomy Code
- (Rendering) Provider Taxonomy Code
- (Service) Laboratory or Facility Postal Zone or ZIP Code
- (Ambulance) Transport Distance
- (Service) Laboratory Facility Name
- (Service) Laboratory or Facility State or Province Code
- Value Code Amount
- Value Code
- Condition Code
- Occurrence Codes and Date
- Occurrence Span Codes and Dates
- Referring Provider Identifier and Identification Code Qualifier
- Ordering Provider Identifier and Identification Code Qualifier
- Attending Provider NPI
- Operating Physician NPI
- Claim or Line Note Text
- Certification Condition Applies Indicator and Condition Indicator [Early and Periodic screening diagnosis and treatment (EPSDT)]
- Service Facility Name and Location Information
- Ambulance Transport Information
- Patient Weight
- Ambulance Transport Reason Code
- Round Trip Purpose Description
- Stretcher Purpose Description

Some states require that out-of-state providers enroll in their Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement.

Section 4: Reimbursement

CLAIMS PAYMENT

BCBSLA's Guidelines for BlueCard Claims Payment

- If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This also causes member confusion because of multiple explanations of benefits (EOBs).
- Check claim status by:
  - Researching the claim through iLinkBlue or
  - Calling Customer Care Center

Please Note: In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, BCBSLA may either ask you for the information or give the member's Plan permission to contact you directly.

COORDINATION OF BENEFITS

Coordination of benefits (COB) refers to how the Blue System ensures that members receive full benefits from their health benefit plans and prevents double payment for services when a member has coverage from two or more sources. Please follow these guidelines when submitting claims to BCBSLA when COB is required:

- If BCBSLA or any other Blue Plan is the primary payer, submit the other carrier's name and address with the claim to BCBSLA.
- If a non-Blue health plan is primary and BCBSLA or any other Blue Plan is secondary, submit the claim to BCBSLA only after receiving payment from the primary payor, including the explanation of payment from the primary carrier.

Carefully review the payment information from all payors involved on the remittance advice(s) before balance billing the patient for any potential liability.

Coordination of Benefits Questionnaire

To streamline claims processing and reduce the number of denials related to COB, a questionnaire is now available to you on the BCBSLA Provider page. This will help you and your patients avoid potential claim issues. When you see any Blue members and you are aware that they might have other health insurance coverage such as Medicare, give a copy of the questionnaire to them during their visit. Ask them to complete the form and send it to the Blue Plan through which they are covered as soon as possible after leaving your office. Members will find the appropriate contact information on the member ID card. Providers may submit the form to BCBSLA on behalf of the out-of-state member and it will be communicated to the member's plan for updating.

If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping. For more information on BCBSLA's COB process, see your *Professional Provider Office Manual*, available on our Provider page.

OVERPAYMENTS

BCBSLA does not process refund requests and does not request or accept checks from providers for refunds on claims for out-of-state members. All overpayment reconciliation will be reflected on electronic remittance advices and/or payment registers.

When an overpayment on a claim for an out-of-state member may have been made, providers are required to fill out and submit an Overpayment Notification Form for review to ensure that an overpayment did occur. A printable version of the Overpayment Notification Form is located in the Forms section of our Provider page. Complete the form and fax or mail to BCBSLA.

If it is found that an overpayment did occur, you will not receive further notification from us, and your payment register will reflect the change. If an overpayment did not occur, you will receive notification explaining that no change is necessary.

If an unsolicited refund is received from a provider or the member's Home Plan, the check may be returned with a letter requesting that an Overpayment Notification Form be submitted. If it is found that a provider has received an overpayment, with or without the provider soliciting the refund, BCBS will send notification requesting the provider respond either agreeing or appealing the overpayment within 30 days. If no response is received, the provider is notified that the claim may be adjusted if necessary. Again, all transactions will be reflected on the provider's payment registers or electronic remittance advices. If you have questions on this process, please contact Customer Care Center.

Section 5: Appeals

APPEALS

Appeals for all claims are handled through BCBSLA. We will coordinate the appeal process with the member's Blue Plan, if needed.

For more information on the BCBSLA appeals process, please see the appeals section of your *Professional Provider Office Manual* found on the Provider page.

Section 6: BlueCard Frequently Asked Questions

How do I verify a member's benefits?

Member benefits and eligibility can be verified electronically through iLinkBlue or you can call BlueCard Eligibility®. You will need the member ID card prefix. Complete instructions are available on iLinkBlue.

What about utilization review (authorization for services)?

Hospitals and other participating providers have agreed to obtain authorization for Blue members. You should still remind patients from other Blue Plans of their responsibility for obtaining authorization for their services from their Blue Plan.

When the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

You may contact the member's Plan on behalf of the member by:

- Calling BlueCard Eligibility and ask to be transferred to the utilization review department
- Submitting a HIPAA 278 transaction (referral/authorization) to BCBSLA

Where do I send medical records?

When other Blue Plan members have a claim that requires medical records, you will receive a request for medical records from BCBSLA. We will take the appropriate measures to forward medical records to the member's Blue Plan.

Who do I call about claims status, adjusting BlueCard claims and resolving other issues?

BCBSLA is your sole contact for claims status, adjustments and problem resolution. Providers with access to iLinkBlue can check the status of claims online as well as submit electronic requests for claims review. Providers may also call the Customer Care Center for all their service needs.

When and how will I be paid for BlueCard claims?

BlueCard claims payments are included in your weekly BCBSLA Provider Payment Register. Providers with EFT receive their payments directly into their checking or savings account and view their Weekly Provider Payment Registers in iLinkBlue.

BCBSLA requires all providers to be a part of our electronic funds transfer (EFT) program. You must have iLinkBlue to be eligible for EFT. For more information on EFT, please call BlueCard Eligibility.

What should I do when I haven't received a payment for my BlueCard claim?

If you do not receive claims payment or a response regarding your claim, please do not resubmit claims. Resubmitted claims are often denied as duplicates. First, check the claim's status on iLinkBlue. If claim information cannot be found online, call the Customer Care Center for status.

Participating providers agree not to bill members for any difference between billed charges and the amount the provider has contractually agreed to accept as payment in full for those services.

In some cases, a member's Blue Plan may require additional information to complete the processing of a claim. If additional information is needed, BCBSLA may either ask you for the information or give the member's Plan permission to contact you directly.

How do I handle calls from members and others regarding claims status or payment?

If a member contacts you, tell the member to contact their Blue Plan. Refer them to the front or back of their member ID card for a customer service number. The member's Plan should not be contacting you directly. However, if the member's Plan does contact you to send them another copy of the member's claim, refer them to BCBSLA.

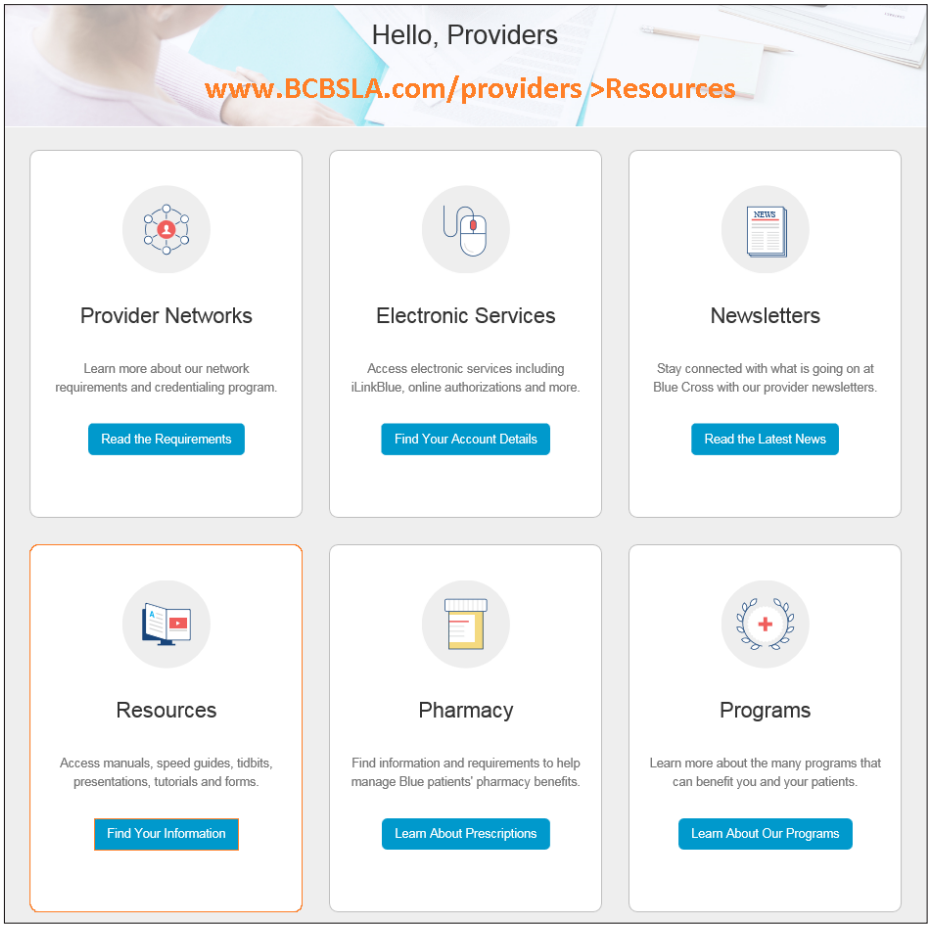
How can I find out more information about the BlueCard Program?

For more information about the BlueCard Program, call BlueCard Eligibility or visit the BlueCard website www.bcbs.com.

Appendix I - Online Resources

Provider Page

Blue Cross and Blue Shield of Louisiana's provider website serves our provider needs. Use this page to help locate important information.



You will find information on:

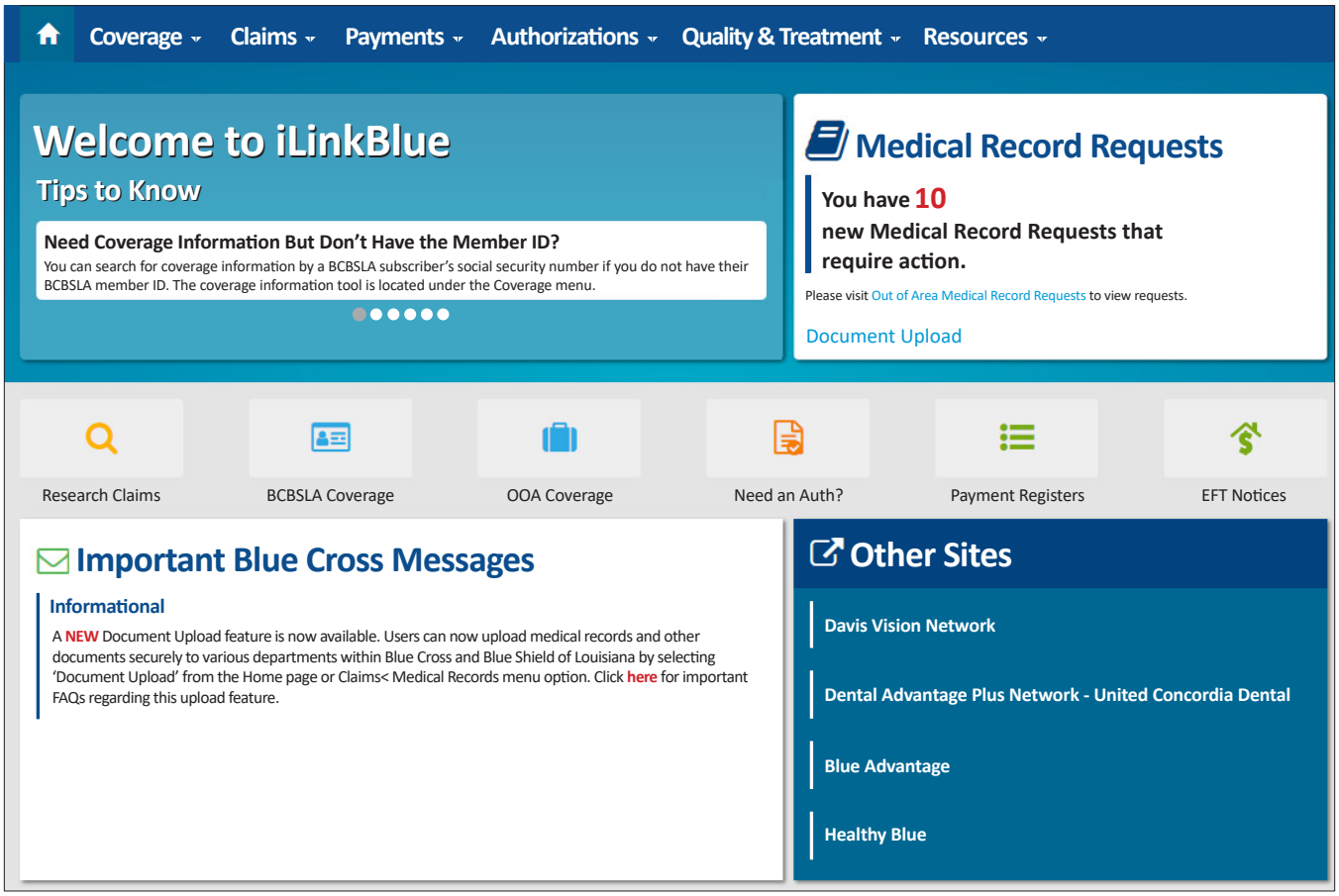
- Provider Networks
  - Credentialing
  - Provider Support
- Electronic Services
  - Learn about iLinkBlue
  - Clearinghouse Services
  - Admin Reps
  - Electronic Funds
- Newsletters
  - Network News
  - Blue Advantage Insight
  - Past Newsletters
- Resources
  - Manuals
  - Speed Guides
  - Tidbits
  - Workshops and Webinars
  - Forms for Providers
- Pharmacy
- Programs
  - Quality Blue
  - Care Management
  - Specialty Care Insight

www.bcbsla.com/providers

iLinkBlue

Blue Cross and Blue Shield of Louisiana's iLinkBlue is our secure online tool for facility and professional health care providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, and payment queries and transactions.

To gain access to iLinkBlue, you must complete the iLinkBlue agreement packet. The iLinkBlue provider agreement packet is available on our Provider page.



iLinkBlue is your one-stop for:

- Benefits
- Eligibility
- Claims Research
- Payment Information
- Authorizations
- Electronic Funds Transfer
- BlueCard Medical Record Requests
- Medical Policies
- Manuals
- Allowable Charges
- Estimated Treatment Cost
- Grace Period Notices
- Medical Code Editing
- And so much more!

www.bcbsla.com/ilinkblue

Summary of Changes

Below is a summary of changes to the *BlueCard Program Provider Manual*. Minor revisions not detailed in the summary include modifications to the text for clarity and uniformity, grammatical edits and updates to web links referenced in the document.

January 2023

Quick Reference Guide

- Provider Credentialing & Data Management – updated description of Vantage Health Plan partnership, updated instructions for accessing credentialing packets and finding more information on the Blue Cross credentialing and data management process

Section 1: BlueCard Program Overview

- Blue Advantage (HMO) and Blue Advantage (PPO) – updated tagline

February 2023

Section 2: BlueCard Authorizations and Billing Guidelines

- Medical Policy, Authorization, Certification Router – updated iLinkBlue screenshot image to add Carelon Authorizations
- Split Claims – added billing guidelines for splitting a claim

www.bcbsla.com/providers

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