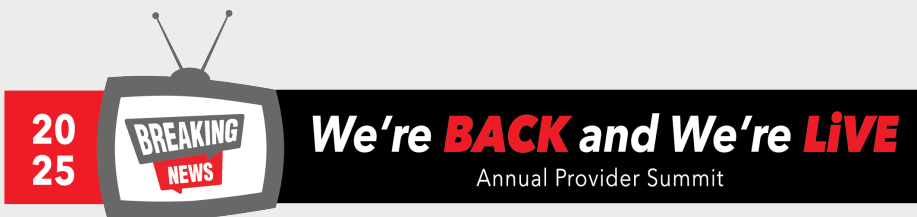


*Welcome to the*

# 2025 Annual Provider Summit



# Important Disclaimer

The information included in this presentation is general, and in no event, should be deemed as a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.

# Topics

- ❑ [Authorizations](#)
- ❑ [Benefits](#)
- ❑ [Claims](#)
- ❑ [Dental Networks](#)
- ❑ [Pharmacy](#)
- ❑ [Provider Enrollment](#)
- ❑ [Quality](#)
- ❑ [Self-serving Tools](#)

# Authorizations

# Topics to Discuss

- ❑ Overview of Authorizations
- ❑ Process for Authorizations
- ❑ Authorization Vendors
- ❑ Available Resources

# Authorizations Overview



# What You Need to Know About Authorizations

Authorizations are used to determine whether a service is medically necessary.

Authorization requirements can vary per plan and network.

Authorizations do not guarantee payment.

# Common Services That Require Authorization

Elective inpatient services (including maternity)

Skilled nursing facility admission

Home health and hospice

Durable medical equipment (DME)\*

Mental health and substance abuse

High tech imaging\*\*

Certain medications under the medical benefit

*\*DME dollar thresholds vary per plan but are typically \$500 or \$1,000. Please note threshold amounts can be lower than \$500.*

*\*\*These services are typically handled by Evolent.*



# General Guidelines for Authorizations

Submit elective requests prior to rendering services.

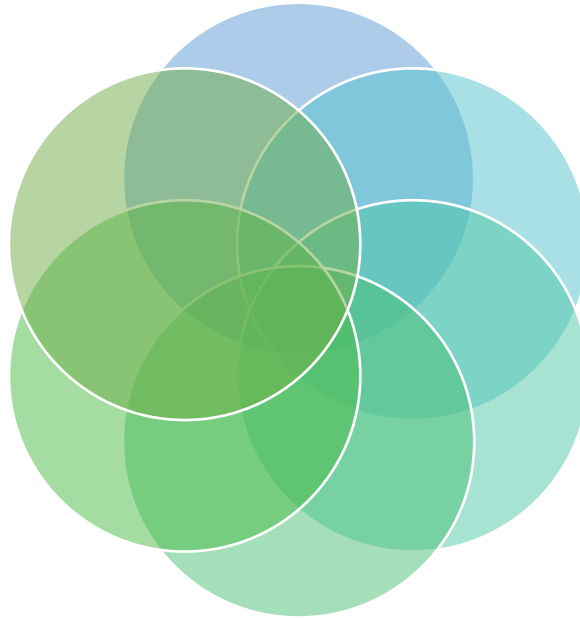
Mark requests as urgent **only** when they are urgent.

Submit requests once.

Submit a notification of emergency admission within 24-48 hours of admission.

Services must be covered under the member's plan.

Members must have active coverage at the time of request.



# Main Steps in the Authorization Process

Verify the member's benefits and provider network.

If authorization is required, initiate the request.

Receive a decision (Approval or denial).

# Required Information for Authorizations

## Patient Details

- Name
- ID number
- Date of birth

## Service Details

- CPT or HCPCS codes
- Diagnosis codes
- Date of service

## Location Details

- Facility
  - Name
  - Address
  - Tax ID or NPI
- Rendering
  - Name
  - Address
  - Tax ID or NPI

## Contact Information

- Phone number
- Fax number
- Email

## Clinicals

- Length of issue
- Attempted treatment
- Conservative medications
- Studies (i.e., labs, imaging)

# Process for Authorizations



# New Process to Get an Authorization

- ❑ Coming soon, we will implement a new process for requesting an authorization.
- ❑ My Insurance Manager will route you to a new web-based application, powered by Cohere Health, to enhance the efficiency of prior authorization decisions.
- ❑ Benefits of the new process include:
  - Accelerates and expands real-time approvals.
  - More seamless provider experience.
  - Decreases administrative efforts.
- ❑ The authorizations process for our third-party vendors will remain the same. This includes:
  - HealthHelp
  - Evolent
  - Avalon Healthcare Solutions
  - MBMNow
- ❑ **All clinical decisions are made by BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan.**

# How to Get an Authorization

- ❑ There is a single sign-on through My Insurance Manager<sup>SM</sup>.
- ❑ Under ***Patient Care***, select ***Pre-certification/Referral***.

The screenshot displays a web interface with two main sections: 'Health' and 'Dental'. Each section contains a list of menu items. In the 'Health' section, the 'Pre-Certification/Referral' option is highlighted with a red oval. The 'Dental' section also lists several options, including 'Pre-Treatment Estimate Entry' and 'Pre-Treatment Estimate Status'.

Health	
▶ Authorization Extension	▶ Patient Directory
▶ Authorization Status	▶ Pre-Certification/Referral
▶ Claims Status	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Service Review for Out-of-Area Members
▶ Institutional Claim Entry	▶ Professional Claim Entry
▶ Other Health Insurance	▶ Verify Primary Care Physician

Dental	
▶ Claims Status	▶ Patient Directory
▶ Dental Claim Entry	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Treatment Estimate Entry
▶ Other Dental Insurance	▶ Pre-Treatment Estimate Status

# How to Get an Authorization (Continued)

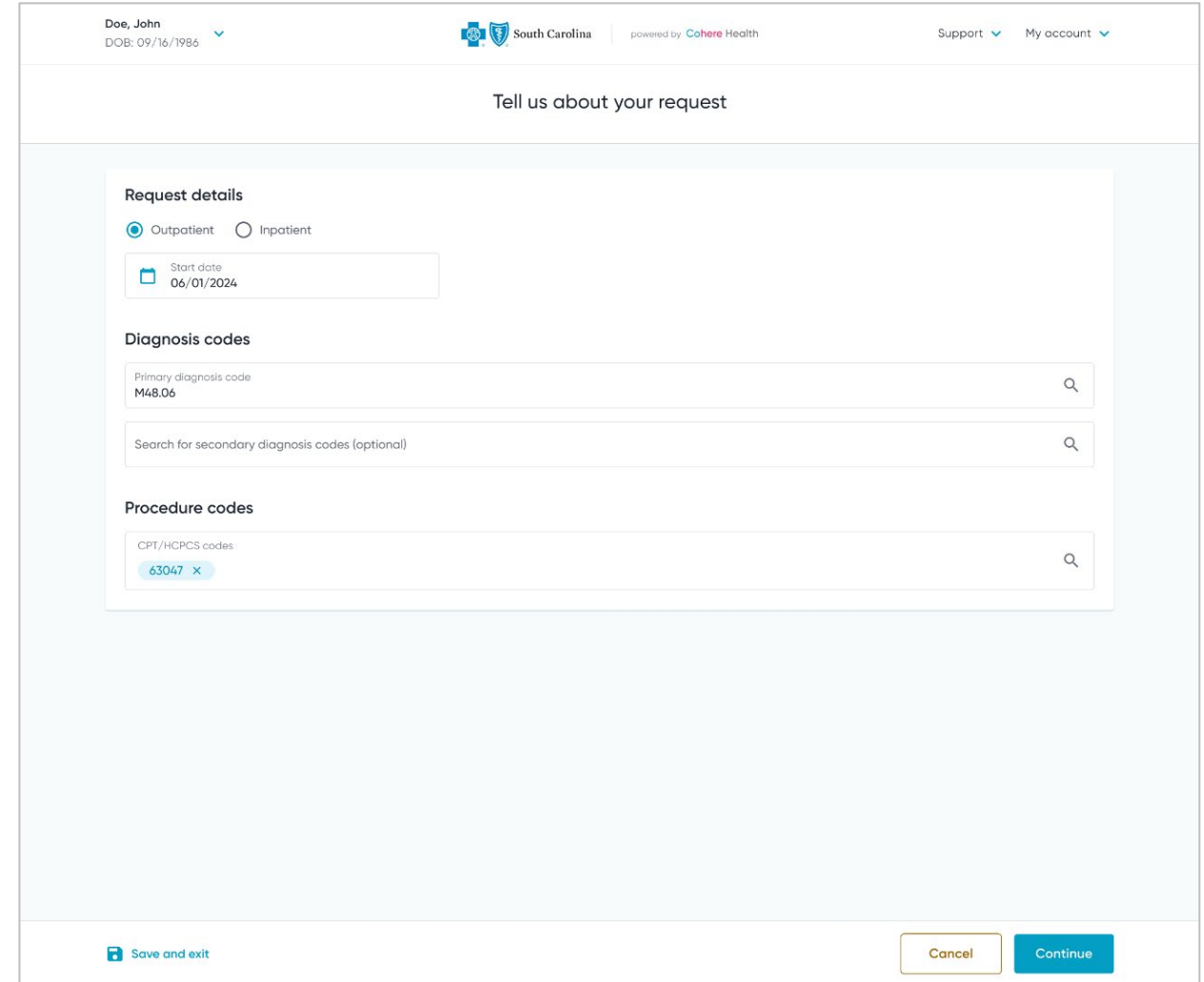
- ❑ When you reach the landing page of the new platform, you will see a full listing of authorizations under your tax identification number (TIN).
- ❑ The authorizations can be filtered by:
  - All
  - Upcoming
  - Pending review
  - Approved
  - Denied
  - Draft
  - Withdrawn
  - Completed
- ❑ You can also search for a specific patient or authorization.
- ❑ To start a new request, select ***Start auth request***.

The screenshot displays the South Carolina authorization management interface. At the top, there is a header with the South Carolina logo, 'powered by Cohere Health', and navigation links for 'Support' and 'My account'. Below the header, there is a search bar and a 'Filter by user' dropdown. A red circle highlights the 'Start auth request' button in the top right corner. The main content area shows a list of authorizations for a patient named John Doe. The list is sorted by 'Most recent'. Each authorization entry includes the patient's name, DOB, Member ID, Health plan, Services, Procedure codes, Submission date, and Dates of service. The first two entries are 'Approved' and the third is 'Draft'. Each entry has a 'Start continuation' button.

Patient Name	DOB	Member ID	Health plan	Services	Procedure codes	Submission date	Dates of service	Status	Action
Doe, John	01/26/1965	10119152022	BCBS South Carolina	Physical Therapy, Speech Therapy	97110, 97112, 92507	05/15/2024 3:45 PM	06/15/2024 – 09/30/2024	Approved	Start continuation
Doe, John	01/26/1965	10119152022	BCBS South Carolina	Myocardial Perfusion Imaging Single Photon Emission Computed Tomography (MPI-SPECT),...	78451, 78452, 93015	05/15/2024 3:45 PM	06/15/2024 – 09/30/2024	Approved	Start continuation
Doe, John	01/26/1965	10119152022	BCBS South Carolina	Physical Therapy	97110	--	12/01/2022 – 03/01/2023	Draft	Delete Continue
Doe, Jane	01/26/1965	10119152022	BCBS South Carolina	Physical Therapy	97110, 97112, 97114	12/01/2022	12/01/2022 – 04/01/2023		

# How to Get an Authorization (Continued)

- ❑ Select whether the service is outpatient or inpatient.
- ❑ Include the diagnosis and procedure code(s).
- ❑ Select ***Continue***.



The screenshot shows a web interface for a medical authorization request. At the top, it identifies the patient as "Doe, John" with a date of birth of "09/16/1986". The interface is for "South Carolina" and is "powered by Cohere Health". There are links for "Support" and "My account". The main heading is "Tell us about your request".

The form is titled "Request details" and includes the following sections:

- Request details:** Radio buttons for "Outpatient" (selected) and "Inpatient". A "Start date" field is set to "06/01/2024".
- Diagnosis codes:** A "Primary diagnosis code" field contains "M48.06". Below it is a field for "Search for secondary diagnosis codes (optional)".
- Procedure codes:** A "CPT/HCPCS codes" field contains "63047".

At the bottom of the form, there are three buttons: "Save and exit", "Cancel", and "Continue".

*Note: You have the option to save and exit the request at any time. You can also cancel the request if it's no longer needed.*



# How to Get an Authorization (Continued)

- ❑ Enter the provider details to include:
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
- ❑ There is a TIN search feature to make the process easier.
- ❑ Select ***Continue***.

The screenshot shows a web form titled "Providers" with the following sections:

- Care setting:** Radio buttons for "Outpatient" (selected) and "Inpatient".
- Place of service:** A dropdown menu.
- Ordering provider:** A search box with the text "Search for an ordering provider by NPI, TIN, or name" and a magnifying glass icon. To the right are buttons for "TIN" and "Address", each with a magnifying glass icon. Below the search box is a blue button with a plus sign and the text "+ Bailey, Christopher Eric MD".
- Performing or attending provider:** A checkbox labeled "Performing is the same as the ordering" which is unchecked. Below it is a search box with the text "Search for a performing or attending provider by NPI, TIN, or name" and a magnifying glass icon. To the right are buttons for "TIN" and "Address", each with a magnifying glass icon. Below the search box is a blue button with a plus sign and the text "+ Bailey, Christopher Eric MD".
- Performing facility or agency:** A search box with the text "Search for a performing facility or agency by NPI, TIN, or name" and a magnifying glass icon. To the right are buttons for "TIN" and "Address", each with a magnifying glass icon. Below the search box is a blue button with a plus sign and the text "+ 1ST START HEALTHCARE SERVICES".

At the bottom left of the form, there is a link that says "Save and exit".

# How to Get an Authorization (Continued)

- ❑ On this screen, the top portion will tell you which codes you requested require authorization.
- ❑ The bottom portion will tell you which codes do not require authorization.
- ❑ There's an option to expedite the request if it's an ***urgent matter***.
- ❑ Select ***Continue***.

The screenshot shows a web-based form for medical authorization. At the top, a green checkmark icon is followed by the text "Requires authorization". Below this, there are two date input fields: "Start date" with the value "04/30/2024" and "End date" with the placeholder "mm/dd/yyyy".

The form is divided into sections for different medical procedures:

- Physical Therapy (PT)**: Includes a "Number of visits" input field with the value "1". Below it is a procedure code "97110" with the description "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility". There is a "+ Add a procedure code" button.
- Total Knee Arthroplasty (TKA)**: Includes a procedure code "27447" with a "Units" input field set to "1" and the description "Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)". There is a "Remove" button and a "+ Add a procedure code" button.

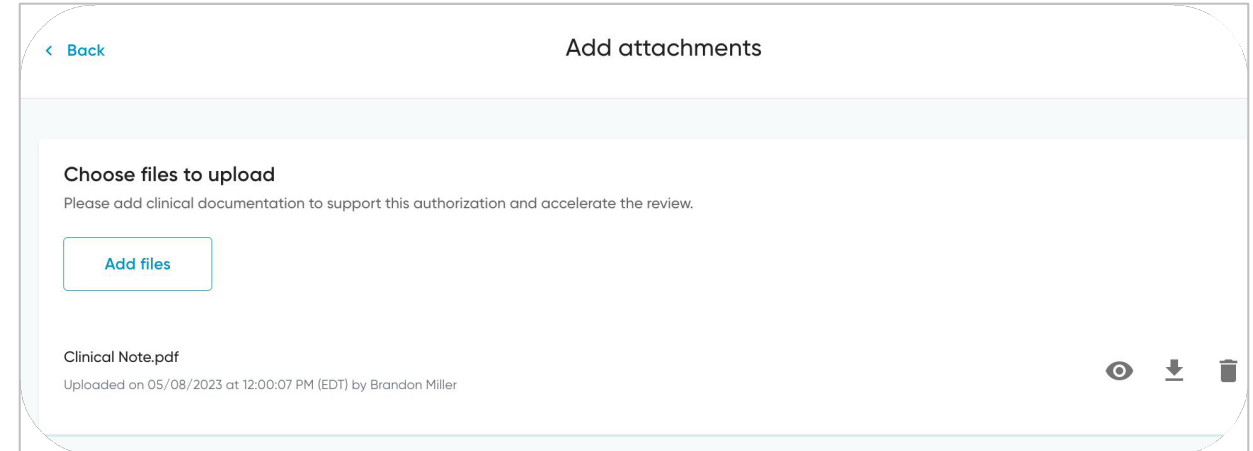
At the bottom of the form, there is an "Expedite" checkbox which is currently unchecked. Below this, a section with an information icon and the text "Doesn't require authorization in most cases" contains a procedure code "93798" and a "Download PDF" button with a dropdown arrow.

At the very bottom of the form, there are two buttons: "Save and exit" on the left and "Continue with 2 codes" on the right.

Note: The continue option will indicate the number of codes being requested for review.

# How to Get an Authorization (Continued)

- ❑ Upload all relevant clinical documentation for review.
- ❑ You will have the option to review the uploaded items or remove them.
- ❑ Select ***Continue***.



# How to Get an Authorization (Continued)

- ❑ Review all the relevant information.
- ❑ Select ***Submit services***.

Back Review services before submitting

🏠 Physical Therapy (PT), Total Knee Arthroplasty (TKA)

**This request duplicates an existing one**  
Duplicate submissions may be voided. The care setting (outpatient or inpatient), performing provider (if applicable), and facility match an existing request, including overlap in procedure codes and service dates.

ⓘ You can choose to withdraw the existing request, change details to avoid duplication, or call Cohere for assistance at (833) 283-0033.


📌 Draft 🗑 Delete  
Tracking #WKGB4665

---

**Details** ✎ Edit

Primary diagnosis	M25.561 - Pain in right knee
Secondary diagnosis	--
Care setting	Outpatient
Place of service	Ambulatory Surgical Center

[Save and exit](#) Submit services

  
**1 evidence-based suggestion to improve your request:**

**Expedited → Not expedited**  
The coverage and/or services on this request do not meet the requirements for an expedited request.

[Accept](#)

# How to Get an Authorization (Continued)

- ❑ After submitting the request, you will receive a faxed notification confirming the receipt of your service request.

 South Carolina powered by Cohere Health	From: <b>Cohere Health</b> Date requested: <b>05/01/2024</b>	<b>Response</b>
<b>We are confirming the receipt of your service request</b>		
To review the status of your request please go online to <a href="https://next.coherehealth.com/check_status">next.coherehealth.com/check_status</a>		
<hr/>		
<b>i</b> <b>Still faxing?</b> If so, you're missing out on timesaving benefits, including immediate auth decisions and transparent in-app clinical guidelines only available when using the CohereNext:® web portal to manage preauthorizations. Registration only takes a few minutes, and unlocks access for all users at your practice organization. Visit <a href="https://www.coherehealth.com/register">www.coherehealth.com/register</a> to begin.		
<hr/>		
Tracking #: <b>NPOA6057</b>		
<hr/>		
Patient: <b>John Doe</b>		Patient DOB: <b>01/26/1965</b>
<hr/>		
CPT/HCPCS code: <b>63047</b>		
Units (If applicable): <b>1</b>		
Dates of service: <b>06/01/2024 – 09/30/2024</b>		
<hr/>		
<b>Please note:</b> Physical therapy, occupational therapy, and speech therapy are not considered "urgent" services as defined in the Medicare Managed Care Manual. Therefore, Cohere Health will process all such requests according to standard timeframes.		
For answers to questions regarding the Cohere systems and available resources please go online to <a href="https://coherehealth.zendesk.com">https://coherehealth.zendesk.com</a> or <a href="https://coherehealth.com/resources">https://coherehealth.com/resources</a>		
<hr/>		

# How to Get an Authorization (Continued)

- ❑ You will be notified once the authorization is approved.
  - Portal notification
  - Faxed notification
- ❑ To view additional details, select ***View service summary*** inside the portal.



The screenshot shows an email notification from South Carolina, powered by Cohere Health. The main heading is "Your request has been approved". The email body includes the tracking number NPOA6057, service dates from 06/01/2024 to 09/30/2024, and a personalized greeting. A blue button labeled "View service summary" is visible. An inset window shows a detailed "Response" card with the following information:

- From: Cohere Health | Date requested: 05/01/2024
- Subject: We have finished processing your service request
- Message: To review the status of your request please go online to [next.coherehealth.com/check\\_status](https://next.coherehealth.com/check_status)
- Info: Still faxing? If so, you're missing out on timesaving benefits, including immediate auth decisions and transparent in-app clinical guidelines only available when using the CohereNext:® web portal to manage preauthorizations. Registration only takes a few minutes, and unlocks access for all users at your practice organization. Visit [www.coherehealth.com/register](https://www.coherehealth.com/register) to begin.
- Final Determination: **Approved** | Auth #: **NPOA6057** | Tracking #: **NPOA6057**
- Patient: **John Doe** | Patient DOB: **01/26/1965**
- CPT/HCPCS code: **63047**
- Units (If applicable): **1**
- Dates of service: **06/01/2024 – 09/30/2024**
- Please note: Physical therapy, occupational therapy, and speech therapy are not considered "urgent" services as defined in the Medicare Managed Care Manual. Therefore, Cohere Health will process all such requests according to standard timeframes.
- For answers to questions regarding the Cohere systems and available resources please go online to <https://coherehealth.zendesk.com> or <https://coherehealth.com/resources>

Note: You will also receive a notice if the request is denied.

# How to Get an Authorization (Continued)

- ❑ The **service summary** will outline the requested authorization to include:
  - Diagnosis and procedure code(s).
  - Place of service.
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
  - Dates of service.

 South Carolina | powered by  Cohere Health Questions about this service?  
Contact BCBS South Carolina  
(000) 000-0000

---

**Service summary**  
Created on 05/01/2024

---

**Diagnosis**  
M48.06 - Spinal stenosis, lumbar region without neurogenic claudication

**Service**  
Spinal Fusion and Decompression

Code	Status	Description
63047	1 unit approved	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

---

<b>Dates of service</b> 06/01/2024 – 09/30/2024	<b>Type</b> Outpatient
<b>Member ID</b> 10119152022	<b>Ordering provider</b> Bailey, Christopher Eric MD / NPI - 1861781510
<b>Patient name</b> Doe, John	<b>Performing or attending provider</b> Bailey, Christopher Eric MD / NPI - 1861781510
<b>Patient phone number</b> (617) 283-4909	<b>Performing facility or agency</b> Peachtree Orthopaedic Surgery Center / NPI - 1902861941
<b>Patient date of birth</b> 01/26/1965	<b>Facility state</b> Georgia
	<b>Authorization number</b> BCBS South Carolina - NPOA6057

# How to Get an Authorization (Continued)

- The ***patient summary*** will outline the same details as the service summary but will give you the option to view the clinical documentation that was provided.

The screenshot displays a patient summary page for a procedure titled "Spinal Fusion and Decompression". The page is part of the South Carolina healthcare system, powered by Cohere Health. It includes a "Start auth request" button in the top right corner. On the left, a patient profile for John Doe (Member ID 10119152022) is shown with personal and insurance details. The main content area shows the procedure is "Approved" with authorization #NPOA6057. A "Details" section lists primary and secondary diagnoses, care settings, and providers. Below this, a table lists the procedure code (63047) and its status (1 unit approved). An "Attachments" section shows a PDF clinical note uploaded by Connor Feick. At the bottom, it indicates the request was made by Connor Feick and provides a "Withdraw" option.

South Carolina | powered by Cohere Health | Support | My account

< Back | Patient summary | Start auth request

**Doe, John**  
Member ID 10119152022

Sex: Male  
DOB: 01/26/1965  
Age: 59  
Address: 420 Harvard St. #301 Brookline, MA  
Phone: (617) 283-4909  
Preferred written language: English  
PCP grouper ID: 918401720  
Plan: BCBS South Carolina  
Membership type: Commercial  
Plan type: HMO  
Plan year: 04/24/2024 - 04/24/2025

**Spinal Fusion and Decompression**

Approved  
Authorization #NPOA6057 • Tracking #NPOA6057

**Details**

Primary diagnosis: M48.06 - Spinal stenosis, lumbar region without neurogenic claudication  
Secondary diagnosis: --  
Care setting: Outpatient  
Place of service: Ambulatory Surgical Center  
Ordering provider: Bailey, Christopher Eric MD / NPI - 1861781510  
Performing or attending provider: Bailey, Christopher Eric MD / NPI - 1861781510  
Performing facility or agency: Peachtree Orthopaedic Surgery Center / NPI - 1902861941  
Dates of service: 06/01/2024 - 09/30/2024  
Expedited: No

**Spinal Fusion and Decompression**

Code	Status	Description
63047	1 unit approved	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

**Attachments (1)**

DoeJohn\_ClinicalNote.pdf  
Uploaded on 05/01/2024 02:39:51 PM (EST) by Connor Feick

Show clinical assessment

Requested by Connor Feick - Portal | Withdraw



# Authorization Vendors



# Third-Party Vendors That Manage Select Authorizations

- ❑ HealthHelp
- ❑ Evolent
- ❑ Avalon Healthcare Solutions
- ❑ Companion Benefit Alternatives (CBA)
- ❑ Specialty Pharmacy Manager (MBMNow)

*Note: These are independent organizations that offer utilization management on behalf of BlueCross and BlueChoice.*

# HealthHelp

- ❑ Manages authorizations for select procedures related to:
  - Musculoskeletal (MSK)
    - Procedures not currently reviewed by Evolent.
  - Cardiology
  - Surgical
  - Sleep studies
- ❑ Only applies to our Exchange plans with group numbers starting with 61, 62 and 65, except for our new Blue Direction plan (indicated by a 'B' in the fifth space of the group number).
- ❑ To request an authorization:
  - Use: My Insurance Manager<sup>SM</sup>
  - Call: 833-715-2255
  - Fax: 844-470-2666



# Evolut

- ❑ Manages the following types of authorization for most plans:
  - Radiation oncology
  - Advanced radiology
  - Musculoskeletal care (MSK)
- ❑ To request an authorization:
  - Use: My Insurance Manager or visit [www.RadMD.com](http://www.RadMD.com)
  - Call: 866-500-7664 for BlueCross members
  - Call: 888-642-9181 for BlueChoice® members



# Avalon Healthcare Solutions

- ❑ Manages authorizations for lab services in the following settings:
  - Office
  - Outpatient facility
  - Independent laboratory
- ❑ To request an authorization:
  - My Insurance Manager
    - Use the Prior Authorization System (PAS)
  - Call: 844-227-5769
  - Fax: 813-751-3760
    - Fax form located on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com):
      - Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits



*Note: Avalon does not review requests in an emergency room, ambulatory surgery center or inpatient hospital setting.*



# MBMNow (Specialty Pharmacy)

- ❑ Manages authorizations for certain specialty medications.
  - View the available lists on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).
    - Providers>Specialty and Pharmacy Drugs>Specialty Medical Medications
- ❑ To request an authorization:
  - Access MBMNow through My Insurance Manager
  - Call: 877-440-0089
  - Fax: 612-367-0742



BlueCross BlueShield of South Carolina

# Companion Benefit Alternatives

- ❑ Manages authorizations for behavioral health services.
  - Examples of services include:
    - Psychological testing
    - Behavioral health program admissions
    - Repetitive transcranial magnetic stimulation (rTMS)
- ❑ To request an authorization:
  - Visit [www.CompanionBenefitAlternatives.com](http://www.CompanionBenefitAlternatives.com).
  - Call: 800-868-1032



# Available Resources





# Standard Prior Authorization List

- ❑ BlueCross developed a standard prior authorization list.
  - [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)
    - Providers>Policies and Authorizations>Prior Authorization
- ❑ The list only applies to the following lines of business:
  - National Alliance
  - Major Group
  - Small Group and Individual
  - Planned Administrators Inc.
  - State Health Plan
- ❑ **The list is not all inclusive and is subject to change. It's a guide that includes the most requested services that require medical review for prior authorizations.**



## SERVICES THAT REQUIRE PRIOR AUTHORIZATION STANDARD LIST EFFECTIVE OCTOBER 2024

Many of our plans require prior authorization for certain procedures and services. This process allows us to check ahead of time whether services meet criteria for coverage by a member's health plan. Some services on this list may not be covered by the benefit plan. **Always verify benefits prior to services being rendered.**

Prior authorization is not a guarantee of payment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied.

**This list is not all inclusive and is subject to change. It is a guide that includes the most commonly requested services requiring a medical review.** Other services may require review based on our medical policies, guidelines or the employer group's plan of benefits. **Please review specific contract verbiage for exclusions, limitations and/or maximums.**

List does not apply to medical specialty drugs. To find out which medical specialty drugs require prior authorization under the medical plan or the Specialty Medical Benefit Management (SMBM) program, refer to [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) or My Insurance Manager™.

Some plans may require prior authorization for mental health services. Contact Companion Benefit Alternatives (CBA) to verify by calling 800-868-1032. CBA is a wholly owned subsidiary of Blue Cross Blue Shield.

### Online Resources and Tools

[www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)   [www.CompanionBenefitAlternatives.com](http://www.CompanionBenefitAlternatives.com)   <https://www.bcbs.com/blue-distinction-center/facility>

- Medical Policies
- Prior Authorization Forms and Information
- Clinical Form Resource Center
- Blue Distinction Center Facility Finder

### Prior Authorization List Applies to the Following BlueCross Lines of Business:

- National Alliance
- Major Group Fully Insured and ASO
- Small Group and Individual
- Planned Administrators Inc (PAI)
- State Health Plan

# Contact Information

Benefit Program	Authorization Service	Web-based Requests	Telephone Requests	Fax Requests
BlueCross	[various]	My Insurance Manager	800-334-7287	
BlueChoice	[various]	My Insurance Manager	800-950-5387	
FEP	[various]	My Insurance Manager	800-327-3238	
State Health Plan	[various]	My Insurance Manager	800-925-9724	
Avalon	Laboratory	Avalon PAS (inside My Insurance Manager)	844-227-5769	813-751-3760
CBA	Behavioral/Substance Abuse	<a href="http://www.CompanionBenefitAlternatives.com">www.CompanionBenefitAlternatives.com</a>	800-868-1032	
Evolut	<ul style="list-style-type: none"> <li>• Advanced Radiology</li> <li>• Musculoskeletal Care</li> <li>• Radiation Oncology</li> </ul>	<a href="http://www.RadMD.com">www.RadMD.com</a>	BlueCross: 866-500-7664  BlueChoice: 888-642-9181	888-656-1321
MBMNow	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742

# BlueCard Out-of-State Member Authorizations

Use the BlueCard Authorization/Medical Policy tool to verify authorization requirements for out-of-state members.

Providers Providers

[Home](#) / [Providers](#) / [Policies and Authorizations](#) / [Prior Authorization](#) / BlueCard Prior Authorization/Medical Policies

## BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate the process through [My Insurance Manager](#)<sup>SM</sup>. Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the menu.

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information you need, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

### Type of Information

Please select only one.

Medical Policy

General Precertification/Preauthorization Information

This field is required.

Alpha Prefix

This field is required.

If you experience difficulties or need additional information, please contact 800-676-BLUE.

**Routes you to the member's Home plan.**

# BlueCard Out-of-State Member Authorizations (Continued)

## Example

### BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, please contact the [Member Care Manager](#)<sup>SM</sup>. Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Member."

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

#### Type of Information

Please select only one.

- Medical Policy
- General Precertification/Preauthorization Information

Alpha Prefix

YPP ✓

Submit

If you experience difficulties or need additional information, please contact 800-676-BLUE.

The screenshot shows the Blue Cross NC website interface. The top navigation bar includes 'Shop Plans', 'Members', 'Providers', 'Employers', and 'Agents'. A search bar and a 'Log In' button are also present. The breadcrumb trail reads: Home > Providers > Prior authorization > Prior plan approval. The main heading is 'PROVIDERS' followed by 'Prior plan approval'. The text explains that prior review (prior plan approval, prior authorization, prospective review or certification) is the process Blue Cross NC uses to review the provision of certain behavioral health, medical services and medications against health care management guidelines prior to the services being provided. It lists examples of services that may require prior review: inpatient admissions, services and procedures received on an outpatient basis, such as in a doctor's office, and prescription medications. It also states that you can search for [services and durable medical equipment](#), or [medications](#) that require authorization for all places of service, including when performed during any inpatient admission, including both planned inpatient admissions and emergent inpatient admissions.<sup>1</sup> The page lists the following items that reviews may confirm:

- Member eligibility
- Benefit coverage
- Compliance with Blue Cross NC corporate and Blue Medicare medical policies regarding medical necessity
- Appropriateness of setting
- Requirements for use of in-network and out-of-network facilities and professionals
- Identification of comorbidities and other problems requiring specific discharge needs

# Peer-to-Peer Requests

- ❑ Process to review and discuss denied prior authorizations.
  - Must be requested before submitting claims.
- ❑ Required criteria:
  - Medical necessity adverse decision was received, along with health plan denial
  - Requested within two business days of the denial for inpatient or continued stay requests OR five business days for all other denials
  - Requested prior to an authorization
- ❑ Clinical discussion:
  - Facilitated within one business day of receipt of request
  - Our medical doctor makes two attempt to contact the rendering provider
  - A decision is rendered at the end of the call

# How to Request a Peer-to-Peer

## Initiating Requests and Checking Statuses

### South Carolina Website

- Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)

Providers>Forms>Other Forms>Peer-to-Peer Request

- Enter all pertinent details (and save the document)
- Email the form to [Peer.Medical@bcbssc.com](mailto:Peer.Medical@bcbssc.com) or fax to 803-264-9175

### Phone (for statuses and eligibility only)

- Call 803-264-8114

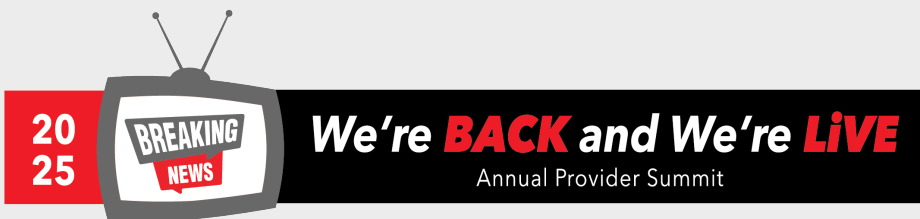
Available Monday - Friday

8:30 a.m. - 5:00 p.m. EST

# Utilization Management Courtesy Re-evaluations

- ❑ Utilization management courtesy re-evaluations are permitted for denials that are due to the following:
  - No clinical information submitted
  - Insufficient clinical information submitted
- ❑ To request a courtesy review, you must:
  - Specify the request is for a re-evaluation upon submission (via fax)
  - Submit clinical documentation within five business days of the denial notice

# Benefits





# Topics to Discuss

- ❑ 2025 Benefit Updates
- ❑ Benefit Reminders
- ❑ Available Resources

# 2025 Benefit Updates



# Preferred Blue



# Preferred Blue - New Groups

Group Name	Prefix	Vision	Dental	Rx
Resolute	SJX	Not covered	Metlife Dental	Express Scripts
Eau Claire Cooperative Health	EEA	Not covered	Not covered	Optum Rx

*Note: Be sure to verify eligibility and benefits for these new groups beginning Jan. 1, 2025.*

# State Health Plan



# State Health Plan - Standard Plan

Standard Plan	2024	2025
<b>Deductibles</b>		
Individual	\$515	No change
Family	\$1,030	No change
<b>Coinsurance Maximum</b>		
Individual (INN)	\$3,000	No change
Family (INN)	\$6,000	No change
Individual (OON)	\$6,000	No change
Family (OON)	\$12,000	No change
<b>Services</b>		
Office visits	\$15 copay	No change
Outpatient facility	\$115 copay	No change
Emergency room	\$193 copay	No change
Cardiac and pulmonary rehabilitation	\$15 copay	No change

# State Health Plan - Savings Plan

Savings Plan	2024	2025
<b>Deductibles</b>		
Individual	\$4,000	No change
Family	\$8,000	No change
<b>Coinsurance Maximum</b>		
Individual (INN)	\$3,000	No change
Family (INN)	\$6,000	No change
Individual (OON)	\$6,000	No change
Family (OON)	\$12,000	No change
<b>Services</b>		
Office visits	Full allowance until the deductible is met. Then, the coinsurance.	No change
Outpatient facility	Full allowance until the deductible is met. Then, the coinsurance.	No change
Emergency room	Full allowance until the deductible is met. Then, the coinsurance.	No change

# State Health Plan - MUSC Plan

MUSC Plan	2024	2025
<b>Deductibles</b>		
Individual	\$385	No change
Family	\$770	No change
<b>Coinsurance Maximum</b>		
Individual (INN)	\$2,200	No change
Family (INN)	\$4,400	No change
<b>Services</b>		
Office visits	PCP: \$25 copay Specialist: \$45 copay	No change
Outpatient facility surgery	\$290 copay	No change
Outpatient facility radiology (regular and advanced)	\$85 copay	No change
Inpatient facility	\$0	No change
Emergency room	\$193 copay	No change
Urgent care	\$85 copay	No change
Cardiac and pulmonary rehabilitation	\$15 copay	No change



# State Health Plan Authorizations

## ❑ **Medical Services**

– Medi-Call: 800-925-9724

## ❑ **Advanced Radiology**

– Evolent: 866-500-7664

## ❑ **Behavioral Health**

– Companion Benefit Alternatives: 800-868-1032

## ❑ **Pharmacy Specialty Drug**

– Express Scripts: 855-612-3128

## ❑ **Medical Specialty Drug**

– MBMNow: 877-440-0089

## ❑ **Laboratory Services**

– Avalon Healthcare Solutions: 844-227-5769

**Always verify benefits and eligibility prior to rendering services.  
Use My Insurance Manager<sup>SM</sup> or call 800-444-4311.**

# State Health Plan - Additional Information

## 2025 Changes

- ❑ State Health Plan is discontinuing the patient incentive for members receiving care at a BlueCross credentialed Patient Centered Medical Home (PCMH).
  - Normal plan provisions (copays and coinsurance) will apply to members who receive care at a PCMH.
- ❑ Members 18 years of age and under will have coverage for bone-anchored hearing aids (BAHA).

# Federal Employee Program



# Federal Employee Program - Blue Focus Plan

Blue Focus – No out-of-network benefits available.	2024	2025
<b>Deductibles</b>		
Individual	\$500	No change
Self - Plus One	\$1,000	No change
Family	\$1,000	No change
<b>Out-of-Pocket Maximum</b>		
Individual	\$9,000	No change
Self - Plus One	\$18,000	No change
Family	\$18,000	No change
<b>Services</b>		
Office visits (Includes primary and/or specialty care combined)	\$10 copay (first 10 visits)	No change
Telehealth	\$0 copay (first two visits) \$10 copay (all additional visits)	No change
Chiropractic care	\$25 copay up to 10 visits	No change

# Federal Employee Program - Blue Focus Plan (Continued)

Blue Focus – No out-of-network benefits available.	2024	2025
<b>Services (Continued)</b>		
Urgent care	\$25 copay	No change
Hospital care - Inpatient (prior authorization required)	30% COIN + BYD	No change
Hospital care - Outpatient	30% COIN + BYD	No change
ER - Accidental injury (within 72-hours)	\$0 copay	No change
ER - Medical emergency	30% COIN + BYD	No change

Note: For a full list of benefits and updates, please visit [www.fepblue.org](http://www.fepblue.org).

# Federal Employee Program - Standard Plan

Standard	2024	2025
<b>Deductibles</b>		
Individual	\$350	No change
Family	\$700	No change
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$6,000	No change
Family (INN)	\$12,000	No change
<b>Services</b>		
Physician care (INN)	\$30 copay (PCP) \$40 copay (Specialist)	No change
Telehealth (INN)	\$0 copay (first two visits) \$10 copay (additional visits)	No change
Urgent care - Accidental injury	\$0 copay	No change
Urgent care - Medical emergency	\$30 copay	No change

# Federal Employee Program - Standard Plan (Continued)

Standard	2024	2025
<b>Services (Continued)</b>		
Preventive care (INN)	\$0 copay	No change
Chiropractic care (INN)	\$30 copay up to 12 visits	No change
Hospital care - Inpatient (prior authorization required) (INN)	\$350 copay Per admission	No change
Hospital care - Outpatient (INN)	15% COINS + BYD	No change
ER - Accidental injury (within 72-hours) (INN)	\$0 copay	No change
ER - Medical emergency (INN)	15% COINS + BYD	No change

Note: For a full list of benefits and updates, please visit [www.fepblue.org](http://www.fepblue.org).

# Federal Employee Program - Basic Plan

Basic	2024	2025
<b>Deductibles</b>		
Individual	\$0	No change
Family	\$0	No change
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$6,500	<b>\$7,500</b>
Family (INN)	\$13,000	<b>\$15,000</b>
<b>Services</b>		
Physician care	\$35 copay (PCP) \$45 copay (Specialist)	\$35 copay (PCP) <b>\$50 copay (Specialist)</b>
Telehealth	\$0 copay (first two visits) \$15 copay (additional visits)	No change
Chiropractic care	\$35 copay up to 20 visits	No change
Urgent care	\$35 copay	No change



# Federal Employee Program - Basic Plan (Continued)

Basic	2024	2025
<b>Services (Continued)</b>		
Preventive care	\$0 copay	No change
Hospital care - Inpatient (prior authorization required)	\$250 copay, per day Up to \$1,500 per admission	<b>\$350 copay, per day</b> <b>Up to \$1,750 per admission</b>
Hospital care - Outpatient	\$150 copay Per day, per facility	<b>\$350 copay</b> <b>Per day, per facility</b>
ER - Accidental injury	\$250 copay Per day, per facility	<b>\$350 copay</b> <b>Per day, per facility</b>
ER - Medical emergency	\$250 copay Per day, per facility	<b>\$350 copay</b> <b>Per day, per facility</b>

Note: For a full list of benefits and updates, please visit [www.fepblue.org](http://www.fepblue.org).

# Federal Employee Program - Preventive Care

Blue Focus, Standard, and Basic	2024	2025
<b>Adult Preventive Care</b>		
<ul style="list-style-type: none"> <li>• Colorectal cancer tests, including:               <ul style="list-style-type: none"> <li>– Fecal occult blood test</li> <li>– Colonoscopy, with or without biopsy</li> <li>– Sigmoidoscopy</li> <li>– Double contrast barium enema</li> <li>– DNA analysis of stool samples</li> </ul> </li> <li>• Prostate cancer tests - Prostate Specific Antigen (PSA) test</li> <li>• Cervical cancer tests (including pap tests)</li> <li>• Screening mammograms (including mammography using digital technology)</li> </ul>	<p>Preventive care benefits for each of the following services listed are limited to one per calendar year.</p> <p>Pathology for Sigmoidoscopy and colonoscopy covered at 100% under preventive benefits.</p>	<p>No change</p>

# BlueChoice<sup>®</sup> HealthPlan



# BlueChoice® - Upcoming Changes

## New 2025 Implementations

- ❑ Vision vendor is changing to Pen Vision effective Jan. 1, 2025.
- ❑ Doctor's Care claims will no longer be processed as a primary care provider.
  - Will be considered urgent care.

# BlueChoice – Reminders

## ❑ **Verify eligibility and benefits before rendering services**

- Use My Insurance Manager
- Call Provider Services: 800-868-2528

## ❑ **Verify prior authorization requirements**

- Check the physician office manual.
- Call Health Care Services: 800-950-5387

## ❑ **Continuous glucose monitors**

- This benefit may fall under pharmacy or medical, depending on the member's plan.

## ❑ **Check drug lists to ensure medications are covered**

- Submit clinical information (including any similar medications tried and the member's reaction) along with the authorization request.

## ❑ **Obesity related services**

- These are not covered and are deemed a contract exclusion.

# BlueChoice – Reminders (Continued)

## ❑ Referral forms (located on [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com))

- Referrals must be completed for patients and can be submitted by:
  - Fax: 800-610-5685 or 803-714-6463
  - My Insurance Manager

## ❑ Submit claims within a timely manner

- Timely filing limit for original claims is 180 days from the date of service.
- Timely filing limit for corrected claims is one year from the date of service.

## ❑ Balance billing

- Network participating providers should not bill patients more than their liability.
- Remittances can be found on My Insurance Manager.

# Medicare Advantage



# Medicare Advantage - Plan Overview

## 2024 Plans

- ❑ Blue Basic PPO
- ❑ Total PPO (Lowcountry, Midlands, Upstate)
- ❑ Total Value PPO (Lowcountry, Midlands, Upstate)
- ❑ Secure HMO (Greenville, Richland)

## 2025 Plans

- ❑ Blue Basic PPO
- ❑ Total PPO (Lowcountry, Midlands, Upstate)
- ❑ Total Value PPO (Lowcountry, Midlands, Upstate)
- ❑ **No Secure HMO plans for 2025**



# Medicare Advantage - BlueCross Total Plan

BlueCross Total	2024	2025
<b>Deductibles</b>		
In-network & Out-of-network	\$0	No change
<b>Out-of-Pocket Maximum</b>		
From in-network providers:	\$6,900	<b>\$8,900</b>
From in-network & out-of-network providers combined	\$10,000	<b>\$13,500</b>
<b>Services</b>		
Outpatient office visits	INN - \$0 copay (PCP) INN - \$25 copay (Specialist) OON - \$30 copay (PCP) OON - \$55 copay (Specialist)	INN - \$0 copay (PCP) <b>INN - \$17 - \$47 copay (Specialist)</b> OON - \$30 copay (PCP) <b>OON - \$50 copay (Specialist)</b>
Inpatient hospital - Acute	INN - \$300 copay, per day (1-4) INN - \$0 copay, per day (5-90) OON - 40% COINS for total stay	<b>INN - \$450 copay, per day (1-2)</b> INN - \$0 copay, per day ( <b>3-90</b> ) OON - 40% COINS for total stay
Inpatient hospital - Psychiatric	INN - \$645 copay, per day (1-4) INN - \$0 copay, per day (5-90) OON - 40% COINS for total stay	<b>INN - \$675 copay, per day (1-3)</b> INN - \$0 copay, per day ( <b>4-90</b> ) OON - 40% COINS for total stay

# Medicare Advantage - BlueCross Total Plan (Continued)

BlueCross Total	2024	2025
<b>Services (Continued)</b>		
Skilled nursing facility (SNF)	INN - \$0 (days 1-20) INN - \$203 copay (days 21-100) OON - 40% COINS for total stay	INN - \$0 (days 1-20) <b>INN - \$214 copay (days 21-100)</b> OON - 40% COINS for total stay
Urgently needed services	INN & OON - \$55 copay, per visit	<b>INN &amp; OON - \$10 copay, per visit</b> <b>Outside of USA - \$45 copay, per visit</b>
Worldwide Emergency/Urgent Coverage	\$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Ambulance services (Ground or air)	INN & OON - \$295 copay, per trip	No change
Hearing aids	\$699-\$999 using TruHearing Two per year (one per ear)	No change
Preventive dental (Fluoride treatment not covered)	INN - \$0 copay (two, per year) OON - 50% COINS \$3,500 maximum (combined)	INN - \$0 copay (two, per year) OON - 50% COINS <b>\$4,500 maximum (combined)</b>
Comprehensive dental (Medicare covered services)	INN - \$50 copay OON - 40% COINS \$3,500 maximum (combined)	INN - \$50 copay <b>OON - \$50 copay</b> <b>\$4,500 maximum (combined)</b>
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS \$1,000 benefit maximum \$3,500 maximum (combined)	INN & OON - 50% COINS \$1,000 benefit maximum <b>\$4,500 maximum (combined)</b>

Note: The combined maximum is for preventive and comprehensive dental services.

# Medicare Advantage - BlueCross Total Value Plan

BlueCross Total Value	2024	2025
<b>Deductibles</b>		
In-network & Out-of-network	\$0	No change
<b>Out-of-Pocket Maximum</b>		
In-network	\$7,900	<b>\$9,350</b>
Out-of-network	\$11,300	<b>\$14,000</b>
<b>Services</b>		
Outpatient office visits	INN - \$0 copay (PCP) INN - \$30 copay (Specialist) OON - \$40 copay (PCP) OON - \$55 copay (Specialist)	INN - \$0 copay (PCP) <b>INN - \$17 - \$47 copay (Specialist)</b> OON - \$40 copay (PCP) OON - \$55 copay (Specialist)
Inpatient hospital - Acute	INN - \$350 copay per day (1-4) <b>Midlands/Coastal/Upstate</b> OON - 20% COINS of total cost <b>Lowcountry</b> OON - 50% COINS of total cost	<b>INN - \$465 copay per day (1-2)</b> <b>INN - \$0 copay, per day (3-90)</b> <b>OON - 40% COINS for total stay</b>
Inpatient hospital - Psychiatric	INN - \$645 copay per day (1-3) <b>Midlands/Coastal</b> OON - 20% COINS of total cost <b>Upstate/Lowcountry</b> OON - 50% COINS of total cost	<b>INN - \$675 copay, per day (1-3)</b> <b>INN - \$0 copay, per day (4-90)</b> <b>OON - 50% COINS for total stay</b>

# Medicare Advantage - BlueCross Total Value Plan (Continued)

BlueCross Total Value	2024	2025
<b>Services (Continued)</b>		
Skilled nursing facility (SNF) (100 benefit day max, per year)	INN - \$0 (days 1-20) INN - \$203 copay (days 21-100) OON - 50% COINS for total stay	INN - \$0 (days 1-20) <b>INN - \$214 copay (days 21-100)</b> OON - 50% COINS for total stay
Emergency care	INN & OON - \$100 copay, per visit	<b>INN &amp; OON - \$110 copay, per visit</b>
Worldwide emergency	\$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Urgent care	\$55 copay	<b>INN &amp; OON - \$10 copay, per visit</b> <b>Outside of USA - \$45 copay, per visit</b>
Ambulance services (Ground or air)	INN & OON - \$295 per one way trip	<b>INN - \$310 copay, per one-way trip</b> <b>OON - \$325 copay, per one-way trip</b>
Hearing aids	\$699-\$999 using TruHearing Two per year (one per ear)	No change
Preventive dental	INN - \$0 copay (two visits per year) OON - 50% COINS \$2,000 maximum (combined)	INN - \$0 copay (two, per year) OON - 50% COINS <b>\$3,000 maximum (combined)</b>
Comprehensive dental (Medicare covered services)	INN & OON - \$50 copay \$2,000 maximum (combined)	INN - \$50 copay OON - 50% COINS <b>\$3,000 maximum (combined)</b>
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS \$500 benefit maximum \$2,000 maximum (combined)	INN & OON - 50% COINS <b>\$3,000 maximum (combined)</b>

Note: The combined maximum is for preventive and comprehensive dental services.

# Medicare Advantage - BlueCross Blue Basic Plan

BlueCross Blue Basic	2024	2025
<b>Deductibles</b>		
In-network & Out-of-network	\$0	No change
<b>Out-of-Pocket Maximum</b>		
In-network	\$5,900	No change
Out-of-network	\$9,550	No change
<b>Services</b>		
Outpatient office visits	INN - \$0 copay (PCP) INN - \$35 copay (Specialist) OON - \$30 copay (PCP) OON - \$45 copay (Specialist)	INN - \$0 copay (PCP) <b>INN - \$30 copay (Specialist)</b> OON - \$30 copay (PCP) OON - \$45 copay (Specialist)
Inpatient hospital - Acute	INN - \$325 copay, per day (1-6) INN - \$0 copay, per day (7-90) OON - 20% COINS for total stay	No change
Inpatient hospital - Psychiatric	INN - \$645 copay, per day (1-3) OON - 20% COINS for total stay	No change

# Medicare Advantage - BlueCross Blue Basic Plan (Continued)

BlueCross Blue Basic	2024	2025
<b>Services (Continued)</b>		
Skilled nursing facility (SNF)	INN - \$0 copay (days 1-20) INN - \$196 copay (days 21-100) OON - 20% COINS for total stay	INN - \$0 copay (days 1-20) <b>INN - \$214 copay (days 21-100)</b> OON - 20% COINS for total stay
Urgently needed services	INN & OON - \$40 copay	<b>INN &amp; OON - \$10 copay</b> <b>Outside of USA - \$45 copay, per visit</b>
Emergency care	\$90 copay, per visit (Waived if admitted within 24 hours)	<b>\$110 copay, per visit</b> (Waived if admitted within 24 hours)
Worldwide Emergency/Urgent Coverage	\$250 service specific deductible, then 20% COINS for emergency care outside the United States.	No change
Ambulance services (Ground or air)	INN & OON - \$275 per trip	No change

# Medicare Advantage - BlueCross Blue Basic Plan (Continued)

BlueCross Blue Basic	2024	2025
<b>Services (Continued)</b>		
Hearing Aids	\$699-\$999 using TruHearing 2 per year (one per ear)	No change
Preventive Dental (Fluoride treatment not covered)	INN & OON - \$0 copay (Two per year) \$2,000 maximum (combined)	INN - \$0 copay (Two per year) <b>OON - 50% COINS</b> <b>\$3,500 maximum (combined)</b>
Comprehensive Dental (Medicare covered services)	INN - \$50 copay OON - 30% COINS \$2,000 maximum (combined)	INN - \$50 copay OON - 50% COINS <b>\$3,500 maximum (combined)</b>
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS \$2,000 benefit maximum	INN & OON - 50% COINS <b>\$3,500 benefit maximum</b>

Note: The combined maximum is for preventive and comprehensive dental services.

# Medicare Advantage - Preventive Care

All Plans (Total, Total Value, & Blue Basic)	2024	2025
<b>Services</b>		
Annual wellness visit/Annual physical	\$0 Copay	No change
Lab work	\$0 Copay	No change
Preventive screenings: <ul style="list-style-type: none"><li>• Colorectal cancer screening</li><li>• Breast cancer screening</li><li>• Bone mineral density tests</li><li>• Diabetic eye exam</li><li>• Eyeglasses and frames</li><li>• Glaucoma screening</li></ul>	\$0 Copay	No change



# Medicare Advantage Plan Authorizations

## ❑ Medical Services

- My Insurance Manager
- 855-843-2325

## ❑ Behavioral Health

- [www.CompanionBenefitAlternatives.com](http://www.CompanionBenefitAlternatives.com)
- 833-971-4075

## ❑ Laboratory Services

- My Insurance Manager
  - Prior Authorization System (PAS)
- 844-227-5769

## ❑ DME (in the home setting), Home Health and Home Infusion Services

- Integrated Home Care Services
- 844-215-4264

Always verify benefits and eligibility prior to rendering services.  
Use My Insurance Manager or call 855-843-2325.

*Note: Throughout the year there may be changes to the services that require prior authorization. Periodically check, for any code changes, additions, or deletions.*

# Medicare Advantage Plan - Value Added Benefits

## ❑ **FitOn Health**

- A flexible health and fitness benefit with 22 monthly credits to use on a nationwide network of gyms, local fitness studios, or community centers.
- Credits can be used to cover a variety of options - monthly gym membership with unlimited visits, fitness studio classes, and at-home fitness accessories and equipment.

## ❑ **Transportation (Note: Benefit only applies to Total and Blue Basic plans)**

- 24 one-way non-emergency rides to health-related locations such as in-patient facilities, health plan sponsored health events and other approved medical centers
- Members must schedule rides at least 48 hours before pick-up time
- *Transportation benefit does not apply to the Total Value PPO plans*

## ❑ **Over the counter**

- \$55 - \$100 credit per quarter (credit dependent on plan - Total, Total Value or Blue Basic)
- Orders can be placed by phone, online, or catalog
- Members receive a Flex card for local pharmacies to purchase select items

# Medicare Advantage Plan - Value Added Benefits

## ❑ Post discharge meals

- 10 free frozen meals after each inpatient or rehab discharge
- Orders must be placed through the care management team

## ❑ Annual wellness incentive

- All members receive a \$40 annual incentive after completing a wellness exam or physical
  - o Received as additional money on the over-the-counter Flex card

## ❑ In-home health assessment award **(New for 2025)**

- All members receive a \$50 health assessment award after completing an in-home health assessment through Signify

## ❑ Routine eye exams and eyewear

- One routine eye exam every year and one pair of lenses or contact lenses every year
- Frames are covered every two years
- This benefit is only covered through a BlueCross authorized vendor, (EyeMed)

# Medicare Advantage Plan - Value Added Benefits

## ❑ Concierge pharmacy services

- For members that received a denial due to step therapy or prior authorization, or those who have difficulty obtaining medications

## ❑ Member health events

- Members can attend local health events sponsored by BlueCross BlueShield of South Carolina
  - Includes free services
  - Allows members to speak with a BlueCross representative for assistance
  - Has games for social interactions

# Medicare Advantage Plan - Inflation Reduction Act

For plans with Part D coverage:

- ❑ \$35 limit for monthly insulin copay.
  - Shown as Tier 3 in formulary but special pricing.
- ❑ Part D vaccines (such as shingles) covered at \$0 (pharmacy).
- ❑ \$35 copay INN and OON for a 1-month supply of Medicare Part B insulins for use in home infusion pumps.
- ❑ Members stay in the Initial Coverage stage until their total out-of-pocket costs reach \$2,000. They then move to the Catastrophic Coverage stage. **(New for 2025)**
- ❑ Members will pay 0% cost share in Catastrophic Coverage stage.

# Medicare Advantage Plan - CMS Stars Ratings

- ❑ **Schedule** patients for Medicare Annual Wellness Exams annually
- ❑ **Document** all care in the patient's medical records
- ❑ **Code and bill** appropriately for services rendered and conditions addressed
- ❑ **Promote** medication adherence
- ❑ **Recommend** formulary alternatives, when necessary
- ❑ **Recommend** participation in disease management programs
- ❑ **Respond** to medical record requests (within five business days)

# Medicare Advantage Plan - CMS Stars Ratings (Continued)

- ❑ BlueCross BlueShield of South Carolina is pleased to announce we have **successfully repeated** our 4 Star Rating with our PPO Plans. This includes our Total, Total Value and Blue Basic plans.
- ❑ In addition to this 4 Star Rating, we have multiple individual star measures that reached 5 Stars:
  - Excellent customer service - based on member survey
  - Reliable call center accuracy and availability - based on CMS secret shopper calls
  - Low rate of member complaints - based on CMS reporting
  - Low rate of member disenrollment - based on CMS reporting
  - Timeliness processing of member appeals - based on CMS reporting
  - Personalized medication review - based on membership participation
  - Quality improvement in clinical measures - based on clinical outcomes

# Medicare Advantage Plan - Network Sharing

- ❑ Allows Medicare Advantage (MA) PPO members from other Blue Plans to get in-network benefits.
- ❑ Available in 48 states, District of Columbia and Puerto Rico.
- ❑ Eligible members will have the following symbol on their ID cards:



## Tips for accuracy:

- ❑ Verify eligibility for out-of-area MA PPO members using the BlueCard Eligibility Line or through My Insurance Manager.
- ❑ Submit claims for all BlueCross BlueShield members, regardless of state, to BlueCross BlueShield of South Carolina.
- ❑ Review member care gap reports and pay attention to open quality care gaps and patient health concerns.
- ❑ Ensure documentation of completed services while patients are visiting from other states.



# Medicare Advantage Plan - General Reminders

- ❑ Check the member's ID card to determine their plan type
- ❑ Follow Medicare guidelines at [www.cms.gov](http://www.cms.gov) for covered services
- ❑ Verify eligibility and benefits at each visit prior to rendering services
- ❑ Prior authorization requirements may differ from other plans
  - View the requirements and methods for obtaining authorization at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)
    - Providers>Medicare Advantage>Prior Authorization
- ❑ When possible, always refer members to network participating providers
- ❑ Review the Medicare Advantage provider manuals for more information
  - Update: Section 3:8: Confidentiality and Data Use
    - Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)

# Group and Individual



# Individual and Family Plans - Chiropractic Coverage

- ❑ Beginning Jan. 1, 2025, all individual and family plans will have benefits for chiropractic services.
- ❑ High deductible plans will be subject to the applicable deductible and coinsurance.
- ❑ All other plans will have a \$25 copay.
- ❑ **All plans will have \$500 benefit period maximum, per member.**

*Note: Use My Insurance Manager or call Provider Services to verify member specific benefits.*

# Individual and Family Plans - Adult Vision Coverage

- ❑ Beginning Jan. 1, 2025, the following plans will include benefits for adult vision through VSP:
  - BlueEssentials EPO Silver 14 + Vision
  - Blue Direction POS Silver 1 + Vision
  - Regional HMO Silver 2 + Vision
- ❑ \$25 copay for exam
- ❑ \$50 copay for lenses and frames
  - Frames covered up to retail allowance of \$100.
    - 20% off any amount over the retail allowance.

*Note: Use My Insurance Manager or call Provider Services to verify member specific benefits.*

# New Regional HMO Plan - Blue Beaufort

- ❑ Blue Beaufort will be a new plan available to members in 2025.
  - Members must live in Beaufort county.
- ❑ The plan does not have out-of-network benefits except for urgent or emergent services.
- ❑ Plan includes Beaufort Memorial providers.

# Existing Regional HMO Plans

- ❑ Other existing regional HMO plans include:
  - **Blue Reedy**
    - Members must live in Greenville, Laurens, Oconee and Pickens counties.
    - Includes Prisma Health Upstate providers.
  - **Blue Pee Dee**
    - Members must live in Florence, Georgetown, Horry and Marion counties.
    - Includes MUSC, Tidelands and Conway Medical Center providers.
  - **Blue Congaree**
    - Members must live in Kershaw, Lexington and Richland counties.
    - Includes MUSC and Lexington Medical Center providers.
  - **Blue Cooper**
    - Members must live in Berkeley, Charleston, Dorchester, Orangeburg and Williamsburg counties.
    - Includes MUSC providers.
- ❑ These plans do not have out-of-network benefits except for urgent or emergent services.

# Regional HMO - Plans with Cost Share Reductions (CSR)

Plan	CSR 3	CSR 2	CSR 1	Silver 2*
<b>Deductibles</b>				
Individual	\$0	\$1,700	\$5,900	\$7,900
Family	\$0	\$3,400	\$11,800	\$15,800
<b>Coinsurances</b>				
	50%	50%	50%	50%
<b>Out-of-Pocket Maximum</b>				
Individual (INN)	\$850	\$2,250	\$7,050	\$8,800
Family (INN)	\$1,700	\$4,500	\$14,100	\$17,600
<b>Services</b>				
Physician care (PCP and Specialist)	PCP - \$10 copay Specialist - \$40 copay	PCP - \$20 copay Specialist - \$40 copay	PCP - \$20 copay Specialist - \$40 copay	PCP - \$20 copay Specialist - \$40 copay
Telehealth (Blue CareOnDemand)	\$0 copay (up to 4 visits) \$15 copay (after 4 <sup>th</sup> visit)	\$0 copay (up to 4 visits) \$15 copay (after 4 <sup>th</sup> visit)	\$0 copay (up to 4 visits) \$15 copay (after 4 <sup>th</sup> visit)	\$0 copay (up to 4 visits) \$15 copay (after 4 <sup>th</sup> visit)

\*Benefits are the same for Silver 2 + Vision.

Note: There are no out-of-network benefits except for urgent or emergent services.

# Regional HMO - Bronze Plans

Plan	Bronze 1	Bronze 2
<b>Deductibles</b>		
Individual	\$7,900	\$9,200
Family	\$15,800	\$18,400
<b>Coinsurances</b>		
	45%	0%
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$8,850	\$9,200
Family (INN)	\$17,700	\$18,400
<b>Services</b>		
Physician care (PCP and Specialist)	PCP - \$48 copay Specialist - \$65 copay	0% coinsurance
Telehealth (Blue CareOnDemand)	\$0 copay (up to 4 visits) \$20 copay (after 4 <sup>th</sup> visit)	0% coinsurance

Note: There are no out-of-network benefits except for urgent or emergent services.



# BlueExtend<sup>SM</sup> PPO

- ❑ BlueExtend PPO will be a new plan available to members in 2025.
- ❑ The plan will have in and out-of-network benefits.
  - Using an in-network provider is preferred as there will be lower cost shares for the member.
- ❑ Plan prefix is ***BXZ***.

# BlueExtend<sup>SM</sup> PPO - Gold Plans

Plan	HD Gold 1	HD Gold 2
<b>Deductibles</b>		
Individual	\$3,400	\$3,850
Family	\$6,800	\$7,700
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$3,400	\$3,850
Family (INN)	\$6,800	\$7,700
<b>Services</b>		
Physician care (PCP and Specialist)	0% Coinsurance	0% Coinsurance
Telehealth (Blue CareOnDemand)	0% Coinsurance	0% Coinsurance

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

# BlueExtend<sup>SM</sup> PPO - Silver Plans

Plan	CSR 3 Not HSA Qualified	CSR 2 Not HSA Qualified	CSR 1 HSA Qualified	HD Silver 1 HSA Qualified
<b>Deductibles</b>				
Individual	\$575	\$1,600	\$4,300	\$4,950
Family	\$1,150	\$3,200	\$8,600	\$9,900
<b>Out-of-Pocket Maximum</b>				
Individual (INN)	\$575	\$1,600	\$4,300	\$4,950
Family (INN)	\$1,150	\$3,200	\$8,600	\$9,900
<b>Services</b>				
Physician care (PCP and Specialist)	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance
Telehealth (Blue CareOnDemand)	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

# BlueExtend<sup>SM</sup> PPO - Silver Plans

Plan	CSR 3 Not HSA Qualified	CSR 2 Not HSA Qualified	CSR 1 HSA Qualified	HD Silver 2 HSA Qualified
<b>Deductibles</b>				
Individual	\$700	\$1,750	\$4,550	\$5,550
Family	\$1,400	\$3,500	\$9,100	\$11,100
<b>Out-of-Pocket Maximum</b>				
Individual (INN)	\$700	\$1,750	\$4,550	\$5,550
Family (INN)	\$1,400	\$3,500	\$9,100	\$11,100
<b>Services</b>				
Physician care (PCP and Specialist)	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance
Telehealth (Blue CareOnDemand)	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

# BlueExtend<sup>SM</sup> PPO - Bronze Plans

Plan	HD Bronze 1 HSA Qualified	HD Bronze 2 HSA Qualified
<b>Deductibles</b>		
Individual	\$6,600	\$8,000
Family	\$13,200	\$16,000
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$6,600	\$8,000
Family (INN)	\$13,200	\$16,000
<b>Services</b>		
Physician care (PCP and Specialist)	0% Coinsurance	0% Coinsurance
Telehealth (Blue CareOnDemand)	0% Coinsurance	0% Coinsurance

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

# BlueExtend<sup>SM</sup> PPO - Standard Plans

Plan	Standard Gold	Standard Silver	Standard Bronze
<b>Deductibles</b>			
Individual	\$1,500	\$5,000	\$7,500
Family	\$3,000	\$10,000	\$15,000
<b>Coinsurances</b>			
	25%	40%	50%
<b>Out-of-Pocket Maximum</b>			
Individual (INN)	\$7,800	\$8,000	\$9,200
Family (INN)	\$15,600	\$16,000	\$18,400
<b>Services</b>			
Physician care (PCP and Specialist)	PCP - \$30 copay Specialist - \$60 copay	PCP - \$40 copay Specialist - \$80 copay	PCP - \$50 copay Specialist - \$100 copay
Telehealth (Blue CareOnDemand)	\$30 copay	\$40 copay	\$50 copay

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

# BlueExtend<sup>SM</sup> PPO - Standard Plans with CSR

Plan	CSR 3	CSR 2	CSR 1	Standard
<b>Deductibles</b>				
Individual	\$0	\$500	\$3,000	\$5,000
Family	\$0	\$1,000	\$6,000	\$10,000
<b>Coinsurances</b>				
	25%	30%	40%	40%
<b>Out-of-Pocket Maximum</b>				
Individual (INN)	\$2,000	\$3,000	\$6,400	\$8,000
Family (INN)	\$4,000	\$6,000	\$12,800	\$16,000
<b>Services</b>				
Physician care (PCP and Specialist)	PCP - \$0 copay Specialist - \$10 copay	PCP - \$20 copay Specialist - \$40 copay	PCP - \$40 copay Specialist - \$80 copay	PCP - \$40 copay Specialist - \$80 copay
Telehealth (Blue CareOnDemand)	\$0 copay	\$20 copay	\$40 copay	\$40 copay

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

# BlueExtend<sup>SM</sup> (Private Marketplace)

- ❑ The current BlueExtend private marketplace plans will still be available to members in 2025.
- ❑ The plan will have in and out-of-network benefits.
  - Members must see providers in the BlueEssentials network while in South Carolina.
  - When traveling outside of South Carolina, they can see providers who participate in the BlueCard Program.
- ❑ Plan prefix is ***XBE***.



# BlueExtend<sup>SM</sup> (Private Marketplace) - Gold Plans

Plan	Gold 1	HD Gold 2
<b>Deductibles</b>		
Individual	\$1,800	\$3,500
Family	\$3,600	\$7,000
<b>Coinsurances</b>		
	25%	0%
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$4,500	\$3,500
Family (INN)	\$9,000	\$7,000
<b>Services</b>		
Physician care (PCP and Specialist)	PCP - \$10 copay Specialist - \$50 copay	0% coinsurance
Telehealth (Blue CareOnDemand)	\$10 copay	0% coinsurance

# BlueExtend<sup>SM</sup> (Private Marketplace) - Silver Plans

Plan	Silver 1	HD Silver 2
<b>Deductibles</b>		
Individual	\$4,400	\$5,400
Family	\$8,800	\$10,800
<b>Coinsurances</b>		
	35%	0%
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$8,800	\$5,400
Family (INN)	\$17,600	\$10,800
<b>Services</b>		
Physician care (PCP and Specialist)	PCP - \$30 copay Specialist - \$65 copay	0% coinsurance
Telehealth (Blue CareOnDemand)	\$20 copay	0% coinsurance

# BlueExtend<sup>SM</sup> (Private Marketplace) - Bronze Plans

Plan	Bronze 1	HD Bronze 2
<b>Deductibles</b>		
Individual	\$4,500	\$7,050
Family	\$9,000	\$14,100
<b>Coinsurances</b>		
	50%	0%
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$8,900	\$7,050
Family (INN)	\$17,800	\$14,100
<b>Services</b>		
Physician care (PCP and Specialist)	PCP - \$60 copay Specialist - \$90 copay	0% coinsurance
Telehealth (Blue CareOnDemand)	\$20 copay	0% coinsurance

# Blue Direction Point of Service (POS)

- ❑ Blue Direction will be a new plan available to members in 2025.
  - Members must live in Hampton, Jasper and Sumter counties.
- ❑ The plan does not have out-of-network benefits except for urgent or emergent services.
- ❑ Members are assigned a primary care provider.
  - Referrals are required for specialists and other providers.
    - Referrals are not required for emergent services.

# Blue Direction - Plans with CSR

Plan	CSR 3	CSR 2	CSR 1	Silver 1*
<b>Deductibles</b>				
Individual	\$0	\$400	\$4,900	\$6,500
Family	\$0	\$800	\$9,800	\$13,500
<b>Coinsurances</b>				
	20%	40%	50%	50%
<b>Out-of-Pocket Maximum</b>				
Individual (INN)	\$1,500	\$3,050	\$7,350	\$9,200
Family (INN)	\$3,000	\$6,100	\$14,700	\$18,400
<b>Services</b>				
Physician care (PCP and Specialist)	PCP - \$0 copay Specialist - \$8 copay	PCP - \$12 copay Specialist - \$35 copay	PCP - \$25 copay Specialist - \$60 copay	PCP - \$25 copay Specialist - \$60 copay
Telehealth (Blue CareOnDemand)	\$0 copay	\$12 copay	\$20 copay	\$20 copay

\*Benefits are the same for Silver 1 + Vision.

Note: There are no out-of-network benefits except for urgent or emergent services.

# Blue Direction - Plans with CSR (Continued)

Plan	CSR 3	CSR 2	CSR 1	Silver 2
<b>Deductibles</b>				
Individual	\$0	\$500	\$3,000	\$5,000
Family	\$0	\$1,000	\$6,000	\$10,000
<b>Coinsurances</b>				
	25%	30%	40%	40%
<b>Out-of-Pocket Maximum</b>				
Individual (INN)	\$2,000	\$3,000	\$8,000	\$8,000
Family (INN)	\$4,000	\$6,000	\$16,000	\$16,000
<b>Services</b>				
Physician care (PCP and Specialist)	PCP - \$0 copay Specialist - \$10 copay	PCP - \$20 copay Specialist - \$40 copay	PCP - \$40 copay Specialist - \$80 copay	PCP - \$40 copay Specialist - \$80 copay
Telehealth (Blue CareOnDemand)	\$0 copay	\$20 copay	\$40 copay	\$40 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

# Blue Direction - Standard Plans

Plan	Standard Gold	Standard Silver
<b>Deductibles</b>		
Individual	\$1,500	\$5,000
Family	\$3,000	\$10,000
<b>Coinsurances</b>		
	25%	40%
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$7,800	\$8,000
Family (INN)	\$15,600	\$16,000
<b>Services</b>		
Physician care (PCP and Specialist)	PCP - \$30 copay Specialist - \$60 copay	PCP - \$40 copay Specialist - \$80 copay
Telehealth (Blue CareOnDemand)	\$30 copay	\$40 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

# BlueEssentials<sup>SM</sup>

- ❑ BlueEssentials will continue to be available to members in 2025.
- ❑ These plans do not have out-of-network benefits except for urgent or emergent services.
- ❑ Plan prefixes are *ZCF* and *ZCU*.



# BlueEssentials<sup>SM</sup> - Gold Plans

Plan	Gold 1	Gold 5
<b>Deductibles</b>		
Individual	\$2,500	\$250
Family	\$5,000	\$500
<b>Coinsurances</b>		
	25%	50%
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$4,900	\$9,200
Family (INN)	\$9,800	\$18,400
<b>Services</b>		
Physician care (PCP and Specialist)	PCP - \$20 copay Specialist - \$60 copay	PCP - \$20 copay Specialist - \$40 copay
Telehealth (Blue CareOnDemand)	\$10 copay	\$20 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

# BlueEssentials<sup>SM</sup> - Plans with CSR

Plan	CSR 3	CSR 2	CSR 1	Silver 14*
<b>Deductibles</b>				
Individual	\$0	\$1,100	\$4,200	\$6,900
Family	\$0	\$2,200	\$8,400	\$13,800
<b>Coinsurances</b>				
	15%	15%	20%	50%
<b>Out-of-Pocket Maximum</b>				
Individual (INN)	\$1,500	\$2,800	\$7,350	\$8,700
Family (INN)	\$3,000	\$5,600	\$14,700	\$17,400
<b>Services</b>				
Physician care (PCP and Specialist)	PCP - \$10 copay Specialist - \$45 copay	PCP - \$10 copay Specialist - \$50 copay	PCP - \$15 copay Specialist - \$50 copay	PCP - \$25 copay Specialist - \$50 copay
Telehealth (Blue CareOnDemand)	\$5 copay	\$5 copay	\$15 copay	\$20 copay

\*Benefits are the same for Silver 14 + Vision.

Note: There are no out-of-network benefits except for urgent or emergent services.

# BlueEssentials<sup>SM</sup> - Plans with CSR

Plan	CSR 3	CSR 2	CSR 1	Silver 39
<b>Deductibles</b>				
Individual	\$0	\$0	\$0	\$0
Family	\$0	\$0	\$0	\$0
<b>Coinsurances</b>				
	20%	20%	20%	20%
<b>Out-of-Pocket Maximum</b>				
Individual (INN)	\$2,850	\$2,850	\$5,600	\$8,100
Family (INN)	\$5,700	\$5,700	\$11,200	\$16,200
<b>Services</b>				
Physician care (PCP and Specialist)	PCP - \$5 copay Specialist - \$10 copay	PCP - \$15 copay Specialist - \$45 copay	PCP - \$40 copay Specialist - \$80 copay	PCP - \$40 copay Specialist - \$80 copay
Telehealth (Blue CareOnDemand)	\$4 copay	\$15 copay	\$40 copay	\$40 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

# BlueEssentials<sup>SM</sup> - Silver Plans

Plan	Silver 15	Silver 16	HD Silver 20	Silver 21	Silver 28
<b>Deductibles</b>					
Individual	\$2,300	\$3,900	\$5,100	\$7,000	\$6,900
Family	\$4,600	\$7,800	\$10,200	\$14,000	\$13,800
<b>Coinsurances</b>					
	50%	50%	0%	25%	50%
<b>Out-of-Pocket Maximum</b>					
Individual (INN)	\$8,950	\$8,400	\$5,100	\$8,500	\$8,400
Family (INN)	\$17,900	\$16,800	\$10,200	\$17,000	\$16,800
<b>Services</b>					
Physician care (PCP and Specialist)	PCP - \$30 copay Specialist - \$60 copay	PCP - \$25 copay Specialist - \$50 copay	0% coinsurance	PCP - \$25 copay Specialist - \$60 copay	PCP - \$30 copay Specialist - \$60 copay
Telehealth (Blue CareOnDemand)	\$20 copay	\$15 copay	0% coinsurance	\$20 copay	\$20 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

# BlueEssentials<sup>SM</sup> - Bronze Plans

Plan	Bronze 4	Bronze 6
<b>Deductibles</b>		
Individual	\$7,200	\$0
Family	\$14,400	\$0
<b>Coinsurances</b>		
	50%	0%
<b>Out-of-Pocket Maximum</b>		
Individual (INN)	\$9,200	\$9,200
Family (INN)	\$18,400	\$18,400
<b>Services</b>		
Physician care (PCP and Specialist)	PCP - \$43 copay Specialist - \$65 copay	PCP - \$45 copay Specialist - \$100 copay
Telehealth (Blue CareOnDemand)	\$20 copay	\$25 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

# Blue VirtuConnect - Standard Plans

Plan	Gold 1	Silver 1	Bronze 1
<b>Deductibles</b>			
Individual	\$1,500	\$5,000	\$7,500
Family	\$3,000	\$10,000	\$15,000
<b>Coinsurances</b>			
	25%	40%	50%
<b>Out-of-Pocket Maximum</b>			
Individual (INN)	\$7,800	\$8,000	\$9,200
Family (INN)	\$15,600	\$16,000	\$18,400
<b>Services</b>			
Physician care (PCP and Specialist)	PCP - \$30 copay Specialist - \$60 copay	PCP - \$40 copay Specialist - \$80 copay	PCP - \$50 copay Specialist - \$100 copay
Telehealth (Blue CareOnDemand)	\$0 copay (up to 12 visits) \$10 copay (after 12 <sup>th</sup> visit)	\$0 copay (up to 8 visits) \$10 copay (after 8 <sup>th</sup> visit)	\$0 copay (up to 4 visits) \$10 copay (after 4 <sup>th</sup> visit)

Note: There are no out-of-network or out-of-state benefits except for urgent or emergent services.

# Blue VirtuConnect - Plans with CSR

Plan	CSR 3	CSR 2	CSR 1	Silver 1
<b>Deductibles</b>				
Individual	\$0	\$500	\$3,000	\$5,000
Family	\$0	\$1,000	\$6,000	\$10,000
<b>Coinsurances</b>				
	25%	30%	40%	40%
<b>Out-of-Pocket Maximum</b>				
Individual (INN)	\$2,000	\$3,000	\$6,400	\$8,000
Family (INN)	\$4,000	\$6,000	\$12,800	\$16,000
<b>Services</b>				
Physician care (PCP and Specialist)	PCP - \$0 copay Specialist - \$10 copay	PCP - \$20 copay Specialist - \$40 copay	PCP - \$40 copay Specialist - \$80 copay	PCP - \$40 copay Specialist - \$80 copay
Telehealth (Blue CareOnDemand)	\$0 copay	\$0 copay (up to 8 visits) \$10 copay (after 8 <sup>th</sup> visit)	\$0 copay (up to 8 visits) \$10 copay (after 8 <sup>th</sup> visit)	\$0 copay (up to 8 visits) \$10 copay (after 8 <sup>th</sup> visit)

Note: There are no out-of-network or out-of-state benefits except for urgent or emergent services.

# Benefit Reminders





# Network Participating Providers

- ❑ Network participating providers should always use or refer members to other network participating providers, when necessary.
  - This includes laboratories.
- ❑ By using other network participating providers:
  - Members will have lower cost-shares.
  - Members will not be subject to balance billing.

# Appointment Availability

## □ Primary Care Physicians

- New and established patient visits
  - Scheduled within 15 days
- Urgent appointments
  - Scheduled within 48 hours

## □ Specialists

- New and established patient visits
  - Scheduled within 30 days
- Urgent appointments
  - Scheduled within 48 hours

# Available Resources



# Getting Benefits Through the Voice Response Unit

## ❑ **Call one of the following numbers to use the voice response unit:**

- Columbia or Lexington: 803-788-8562
- Other locations in South Carolina: 800-868-2510
- Outside of South Carolina: 800-334-2583
- BlueChoice®: 800-868-2528
- State Health Plan: 800-444-4311
- Federal Employee Program: 888-930-2345
- BlueCard Eligibility: 800-676-BLUE (2583)

## ❑ **Be sure to have the following information ready:**

- Your Tax ID or NPI
- Patient identification number (including the prefix)
- Patient's date of birth

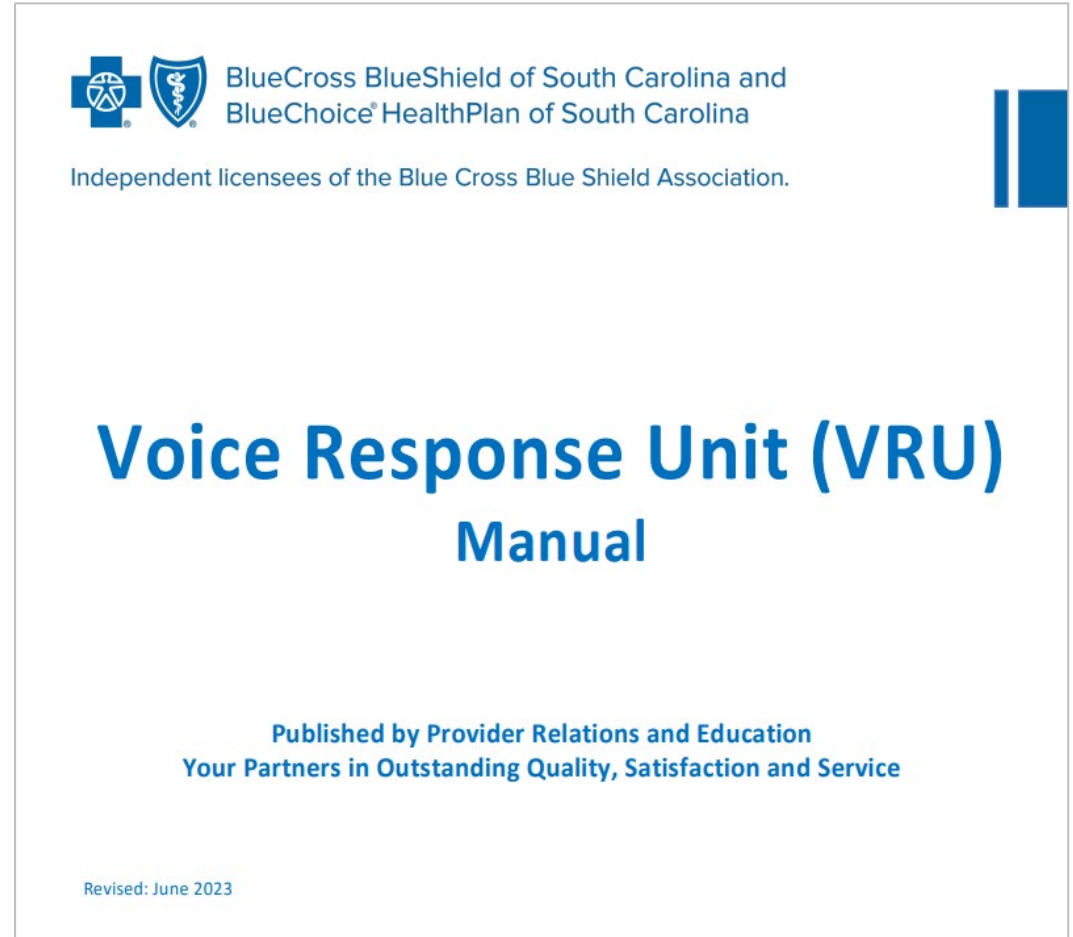
# Getting Benefits Through the Voice Response Unit (Continued)

## ❑ You will hear the following information:

- Type of coverage
- Effective date
- Benefit period
- Group number

## ❑ Available benefit options:

- Hospital
  - Inpatient and outpatient
- Behavioral health
- Rehabilitation
- Home health
- And much more!



# Getting Benefits in My Insurance Manager

Step 1

Health	
▶ Authorization Extension	▶ Patient Directory
▶ Authorization Status	▶ Pre-Certification/Referral
▶ Claims Status	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Service Review for Out-of-Area Members
▶ Institutional Claim Entry	▶ Professional Claim Entry
▶ Other Health Insurance	▶ Verify Primary Care Physician

Dental	
▶ Claims Status	▶ Patient Directory
▶ Dental Claim Entry	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Treatment Estimate Entry
▶ Other Dental Insurance	▶ Pre-Treatment Estimate Status

Step 2

Eligibility and Benefits Printer-Friendly

\* Required

**Patient Selection**

\* Health Plan:  
--Please Choose One--

\* Member ID:  
  
include alpha prefix, if applicable

\* Patient's Date of Birth:  
  
mm/dd/yyyy

**Additional Information** [+] show/hide

\* Date of Service:  
04/30/2024   
mm/dd/yyyy

\* Location:   Primary ID:

# Getting Benefits in My Insurance Manager - General Benefits

## Step 3 (When pulling general benefits.)

### Eligibility Request

\* Required

#### Choose Eligibility View

**i** Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

- General Eligibility and Benefits
- Eligibility and Benefits by Service Type
- Eligibility and Benefits by Procedure Code

Submit

# Getting Benefits in My Insurance Manager - General Benefits

## Date of Service

04/30/2024

## Insurance

Plan Name:  
BLUECROSS AND BLUESHIELD OF SC

Plan ID:  
38520

Member ID:  
ZCZ065922516805

Group Number:  
036011101

Member's Name:  
MICHAEL TESTING

## Patient

Patient's Name:  
MICHAEL TESTING

Relationship to Member:  
SUBSCRIBER

Gender:  
MALE

Date of Birth:  
10/01/1958

Address:  
P O BOX 24015  
COLUMBIA, SC 292244015

[Change Patient](#)

## Response Details

Eligibility Response [\[±\]](#)

Policy Effective Date:

06/01/2002

Benefit Period:

04/01/2024 - 04/01/2025

**IN AND OUT OF NETWORK**

### Global Benefits

This patient has active coverage.

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: **\$250.00** PER SERVICE YEAR - **\$250.00** REMAINING

INDIVIDUAL OUT OF POCKET: **\$750.00** PER SERVICE YEAR - **\$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

FAMILY DEDUCTIBLE: **\$500.00** PER SERVICE YEAR - **\$500.00** REMAINING

FAMILY OUT OF POCKET: **\$1,500.00** PER SERVICE YEAR - **\$1,500.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

[Printer-Friendly](#)

[View Benefit Booklet for this patient](#)

Service▲	Place of Service▲	Diagnosis Code (ICD-10)▲	Specialty▲
▼ <a href="#">1- MEDICAL CARE</a>			
This patient has active coverage.			
Insurance Type: INDEMNITY			
Plan Name: INDEMNITY			
For this service type, you will see only a covered/not covered message here and not full benefits details. For more detailed benefits, submit a request for Eligibility and Benefits by Service Type or by Procedure Code.			
▶ <a href="#">33- CHIROPRACTIC</a>	11- OFFICE		
▶ <a href="#">35- DENTAL CARE</a>			
▶ <a href="#">47- HOSPITAL</a>	22- ON-CAMPUS OUTPATIENT HOSPITAL		
▶ <a href="#">48- HOSPITAL - INPATIENT</a>	21- INPATIENT HOSPITAL		
▶ <a href="#">50- HOSPITAL - OUTPATIENT</a>	22- ON-CAMPUS OUTPATIENT HOSPITAL		
▶ <a href="#">51- HOSPITAL - EMERGENCY ACCIDENT</a>	23- EMERGENCY ROOM - HOSPITAL		
▶ <a href="#">52- HOSPITAL - EMERGENCY MEDICAL</a>	23- EMERGENCY ROOM - HOSPITAL		
▶ <a href="#">86- EMERGENCY SERVICES</a>	23- EMERGENCY ROOM - HOSPITAL		
▶ <a href="#">88- PHARMACY</a>			
▶ <a href="#">98- SPECIALIST</a>	11- OFFICE		
▶ <a href="#">98- PROFESSIONAL (PHYSICIAN) VISIT - OFFICE</a>	11- OFFICE		
▶ <a href="#">BZ- PHYSICIAN VISIT - OFFICE: WELL</a>	11- OFFICE		
▶ <a href="#">MH- MENTAL HEALTH</a>			
▶ <a href="#">UC- URGENT CARE</a>	20- URGENT CARE FACILITY		

[Ask Provider Services](#)

[New Search](#)

[Back](#)



# Getting Benefits in My Insurance Manager - Service Type

## Step 3 (When pulling benefits by service type.)

Eligibility Request \* Required

Choose Eligibility View

*Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.*

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

General Eligibility and Benefits

Eligibility and Benefits by Service Type

Eligibility and Benefits by Procedure Code

\* Service Type Code:  
--Please Choose One--

Primary Diagnosis Code (ICD-10):

[Add Diagnosis Code](#)

Place of Service: (recommended)  
Office - 11

Service Facility/Billing Location:

Rendering/Performing Provider:  
JOHN M JONES MD

## Other Service Types

ABORTION - 84  
ACUPUNCTURE - 64  
AIDS - 85  
AIR TRANSPORTATION - 57  
ALCOHOLISM - AJ  
ALLERGY - GY  
ALLERGY TESTING - 79  
ALTERNATE METHOD DIALYSIS - 15  
AMBULATORY SERVICE CENTER FACILITY - 13  
ANESTHESIA - 07  
ANESTHESIOLOGIST - 97  
AUDIOLOGY EXAM - 71  
BLOOD CHARGES - 10  
BRAND NAME PRESCRIPTION DRUG - 91  
BRAND NAME PRESCRIPTION DRUG - NON-FORMULARY - B3  
BURN CARE - B1  
Brand Name Prescription Drug - Formulary - B2  
CABULANCE - 58  
CANCER - 87

# Getting Benefits in My Insurance Manager - Service Type

[Printer-Friendly](#)

**Date of Service**  
04/30/2024

---

**Insurance**  
Plan Name:  
BLUECROSS AND BLUESHIELD OF SC

---

Plan ID:  
38520

---

Member ID:  
ZCZ065922516805

---

Group Number:  
036011101

---

Member's Name:  
MICHAEL TESTING

**Response Details**

Eligibility Response [\[+\]](#)

---

Policy Effective Date:  
06/01/2002

Benefit Period:  
04/01/2024 - 04/01/2025

[View Benefit Booklet for this patient](#)

**IN AND OUT OF NETWORK**

**Global Benefits**

✔ This patient has active coverage.

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: **\$250.00** PER SERVICE YEAR - **\$250.00** REMAINING

INDIVIDUAL OUT OF POCKET: **\$750.00** PER SERVICE YEAR - **\$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

FAMILY DEDUCTIBLE: **\$500.00** PER SERVICE YEAR - **\$500.00** REMAINING

FAMILY OUT OF POCKET: **\$1,500.00** PER SERVICE YEAR - **\$1,500.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

**Patient**

Patient's Name:  
MICHAEL TESTING

---

Relationship to Member:  
SUBSCRIBER

---

Gender:  
MALE

---

Date of Birth:  
10/01/1958

---

Address:  
P O BOX 24015  
COLUMBIA, SC 292244015

[Change Patient](#)

Service▲	Place of Service▲	Diagnosis Code (ICD-10)▲	Specialty▲
▼ <a href="#">50- HOSPITAL - OUTPATIENT</a>	22- ON-CAMPUS OUTPATIENT HOSPITAL		
<p>✔ This patient has active coverage.</p> <p>Insurance Type: INDEMNITY</p> <p>Plan Name: INDEMNITY</p> <p>THIS MEMBER CURRENTLY HAS AN HSA WITH A PAYMENT OPTION WHICH ALLOWS FOR AUTOMATIC PAYMENT DIRECTLY TO THE PROVIDER. QUALIFIED MEDICAL EXPENSES WITH THE EXCEPTION OF DENIED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT.</p> <p>RESPONSES TO ALL FUTURE DATED INQUIRIES ARE BASED ON THE PATIENT'S CURRENT BENEFITS AND ARE SUBJECT TO CHANGE.</p> <p>YOU HAVE REQUESTED BENEFITS FOR A MEMBER THAT HAS BENEFIT EXCEPTIONS AT THE PROCEDURE CODE LEVEL. TO OBTAIN MORE SPECIFIC INFORMATION, PLEASE REQUEST BENEFITS ON MY INSURANCE MANAGER USING A SPECIFIC PROCEDURE CODE AND DIAGNOSIS CODE.</p> <p><a href="#">View Additional Messages</a></p> <p>INDIVIDUAL COINSURANCE: <b>15%</b></p>			
▶ <a href="#">51- HOSPITAL - EMERGENCY ACCIDENT</a>	23- EMERGENCY ROOM - HOSPITAL		
▶ <a href="#">52- HOSPITAL - EMERGENCY MEDICAL</a>	23- EMERGENCY ROOM - HOSPITAL		
▶ <a href="#">A0- PROFESSIONAL (PHYSICIAN) VISIT - OUTPATIENT</a>	22- ON-CAMPUS OUTPATIENT HOSPITAL		

[Ask Provider Services](#)

[New Search](#)

[Back](#)

# Getting Benefits in My Insurance Manager - Procedure Code

## Step 3 (When pulling benefits by procedure code.)

Eligibility Request \* Required

**Choose Eligibility View**

*Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.*

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

General Eligibility and Benefits

Eligibility and Benefits by Service Type

Eligibility and Benefits by Procedure Code

**\* Procedure Code:**

**Modifiers:**

**Primary Diagnosis Code (ICD-10):**

[Add Diagnosis Code](#)

**Place of Service:** (recommended)  
Office - 11

**Service Facility/Billing Location:**

**Rendering/Performing Provider:**  
JOHN M JONES MD

**Choose Eligibility View**

*Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.*

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

General Eligibility and Benefits

Eligibility and Benefits by Service Type

Eligibility and Benefits by Procedure Code

**\* Procedure Code:**

**Modifiers:**

**Primary Diagnosis Code (ICD-10):**

[Add Diagnosis Code](#)

**Place of Service:** (recommended)  
Office - 11

**Service Facility/Billing Location:**

**Rendering/Performing Provider:**  
JOHN M JONES MD

# Getting Benefits in My Insurance Manager - Procedure Code

[Printer-Friendly](#)

**Date of Service**  
04/30/2024

---

**Insurance**  
Plan Name:  
BLUECROSS AND BLUESHIELD OF SC

---

Plan ID:  
38520

---

Member ID:  
ZCZ065922516805

---

Group Number:  
036011101

---

Member's Name:  
MICHAEL TESTING

---

**Patient**  
Patient's Name:  
MICHAEL TESTING

---

Relationship to Member:  
SUBSCRIBER

---

Gender:  
MALE

---

Date of Birth:  
10/01/1958

---

Address:  
P O BOX 24015  
COLUMBIA, SC 292244015

---

[Change Patient](#)

**Response Details**

Eligibility Response [\[±\]](#)

---

Policy Effective Date:  
06/01/2002

---

Benefit Period:  
04/01/2024 - 04/01/2025

---

[View Benefit Booklet for this patient](#)

**IN AND OUT OF NETWORK**

**Global Benefits**

This patient has active coverage.

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: **\$250.00** PER SERVICE YEAR - **\$250.00** REMAINING

---

INDIVIDUAL OUT OF POCKET: **\$750.00** PER SERVICE YEAR - **\$750.00** REMAINING

---

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

---

FAMILY DEDUCTIBLE: **\$500.00** PER SERVICE YEAR - **\$500.00** REMAINING

---

FAMILY OUT OF POCKET: **\$1,500.00** PER SERVICE YEAR - **\$1,500.00** REMAINING

---

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

Service▲	Place of Service▲	Diagnosis Code (ICD-10)▲	Specialty▲
▼ <a href="#">CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES- 99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANA</a>	11- OFFICE		
<p> This patient has active coverage.</p> <p><b>Insurance Type:</b> INDEMNITY</p> <p><b>Plan Name:</b> INDEMNITY</p> <p>THIS MEMBER CURRENTLY HAS AN HSA WITH A PAYMENT OPTION WHICH ALLOWS FOR AUTOMATIC PAYMENT DIRECTLY TO THE PROVIDER. QUALIFIED MEDICAL EXPENSES WITH THE EXCEPTION OF DENIED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT.</p> <p>RESPONSES TO ALL FUTURE DATED INQUIRIES ARE BASED ON THE PATIENT'S CURRENT BENEFITS AND ARE SUBJECT TO CHANGE.</p> <p>YOU HAVE REQUESTED BENEFITS FOR A MEMBER THAT HAS BENEFIT EXCEPTIONS AT THE PROCEDURE CODE LEVEL. TO OBTAIN MORE SPECIFIC INFORMATION, PLEASE REQUEST BENEFITS ON MY INSURANCE MANAGER USING A SPECIFIC PROCEDURE CODE AND DIAGNOSIS CODE.</p> <p><a href="#">View Additional Messages</a></p> <hr/> <p><b>INDIVIDUAL COINSURANCE: 15%</b></p>			
<a href="#">Ask Provider Services</a>		<a href="#">New Search</a>	
<a href="#">Back</a>			

# Member ID Card Guide

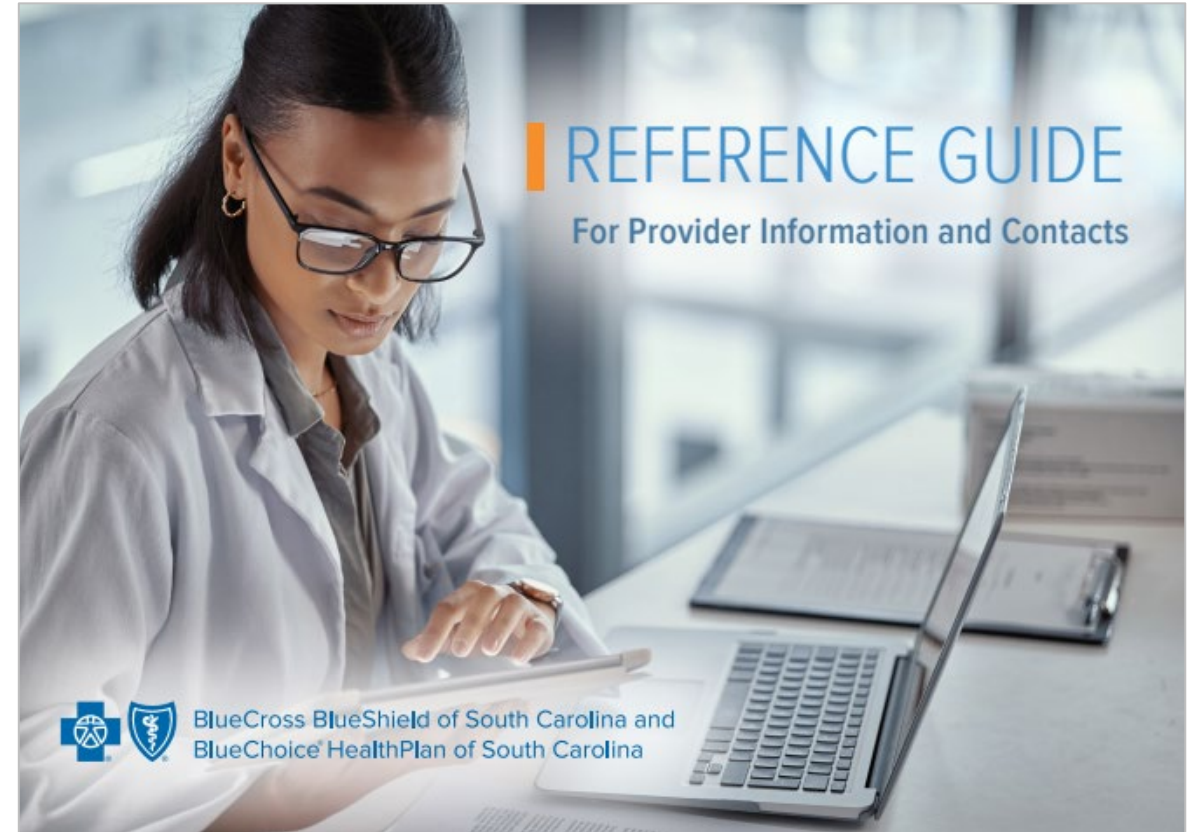
- ❑ Get an overview of various plans, associated networks and example of the ID card you may see.
  - Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com):
    - Providers>Tools and Resources>Guides

## MEMBER IDENTIFICATION CARD GUIDE



# Quick Reference Guide

- ❑ Identify the most efficient ways to get the benefit information, prior authorizations and much more.
  - Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com):
    - Providers>Tools and Resources>Guides



# Claims

# Topics to Discuss

- ❑ Submission of Claims
- ❑ Self-serving Claim Tools
- ❑ Claim Reminders
- ❑ Helpful Tips



# Submission of Claims



# Ways to Submit Claims

- Claims can be submitted:
  - **Electronically (through your clearinghouse)**
    - Use the appropriate payor ID.
  - **Using My Insurance Manager**
    - Select Original Claim on the Claim Information page.
  - **By mail**
    - Use the appropriate address on the back of the member's ID card.

*Note: Refer to the Claims section of our website for additional details.  
Providers>Claims and Payments*

# Submitting Claims Electronically

Submitting claims electronically through your clearinghouse is the preferred method.

Benefits of electronic submissions include:

- ❑ Quicker turnaround time.
- ❑ Shorter reimbursement cycles.
- ❑ Ability to catch errors that may delay processing.

Medical Plan Payor IDs	
State Health Plan	00400
BlueCross BlueShield of South Carolina	00401
Federal Employee Plan (FEP)	00402
Healthy Blue <sup>SM</sup>	00403
Planned Administrators, Inc. (PAI)	00886
BlueChoice <sup>®</sup> HealthPlan	00922
Medicare Advantage	00C63

Dental Plan Payor ID	
BlueCross BlueShield of South Carolina	38520

*Note: Refer to the Claims section of our website for additional details.  
Providers>Claims and Payments>Claims Submission*

# Submitting Claims through My Insurance Manager

- ❑ Submitting claims through My Insurance Manager is quick and easy.
- ❑ When you hover over Patient Care, you will see the option to enter institutional or professional claims for health services, as well as claim entry for dental services.



# Submitting Claims by Mail

While electronic submission is the preferred method for submitting claims, we do allow providers to submit their claims by mail. The addresses include:

## BlueCross BlueShield of South Carolina

(Columbia Service Center)

P.O. Box 100300  
Columbia, SC 29202

## BlueCross BlueShield of South Carolina

(Greenville Service Center)

P.O. Box 6000  
Greenville, SC 29606

## State Health Plan

P.O. Box 100605  
Columbia, SC 29260

## Federal Employee Program

P.O. Box 600601  
Columbia, SC 29260

## BlueChoice HealthPlan

P.O. Box 6170  
Columbia, SC 29260

## Healthy Blue<sup>SM</sup>

P.O. Box 100317  
Columbia, SC 29202

*Note: If you are unsure of which address to use, you can always refer to the back of the member's identification card.*

# Important Information on Submitting Corrected Claims

- ❑ Corrected claims can be submitted:
  - **Electronically (through your clearinghouse)**
    - Use the appropriate payor ID.
    - For institutional claims, use frequency code 7 (which indicates an adjustment).
    - For professional claims, enter the original claim number in Box 22 of the CMS-1500.
      - Include a description for the reason of the adjustment in Box 19.
  - **Using My Insurance Manager**
    - Select Replacement of Prior Claim on the Claim Information page.
  - **By mail**
    - Use the appropriate address on the back of the member's ID card.
    - Be sure to label the claim as a corrected claim.
- ❑ For all avenues, include all lines from the original claim, along with the correction(s) needed.

# Self-serving Claim Tools



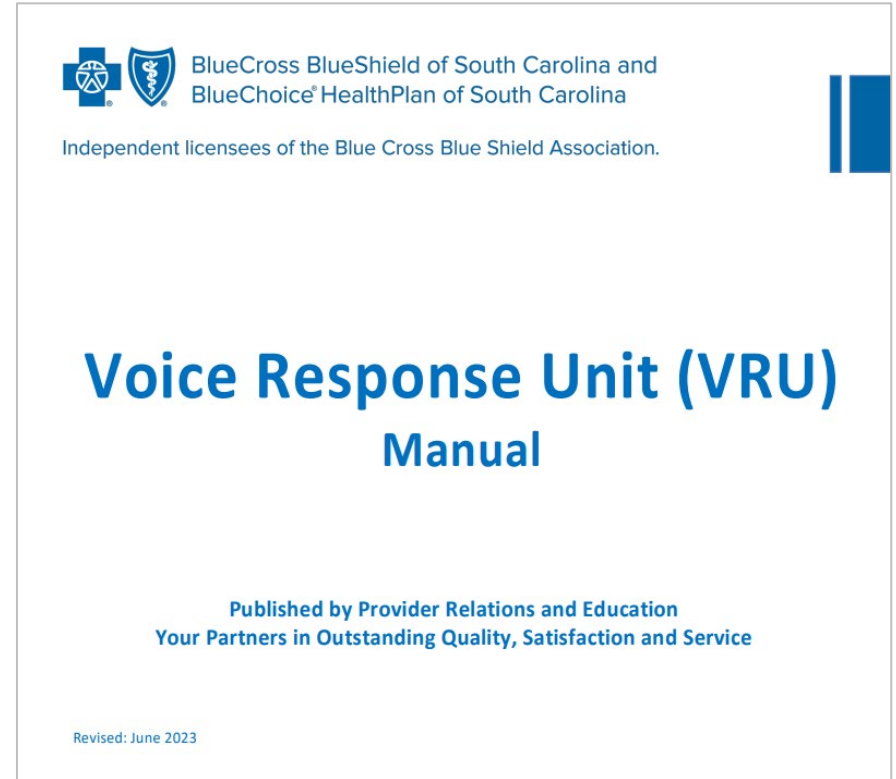
# Claims Information Through the Voice Response Unit

## ❑ Call one of the following numbers to use the voice response unit:

- Columbia or Lexington: 803-788-8562
- Other locations in South Carolina: 800-868-2510
- Outside of South Carolina: 800-334-2583
- BlueChoice®: 800-868-2528
- State Health Plan: 800-444-4311
- Federal Employee Program: 888-930-2345

## ❑ Be sure to have the following information ready:

- Your Tax ID or NPI
- Patient identification number (including the prefix)
- Patient's date of birth
- Date of service of the claim





# Claims Information Through the Voice Response Unit (Continued)

❑ **If a claim was paid or applied patient liability, you will receive the following:**

- Processed date
- Remittance date
- Check number
- Amount paid
- Amount applied to the patient liability

❑ **If a claim is denied, you will receive the following:**

- Denial reason
- Remittance date

*Note: If a claim is processed to the member, please contact them for the details. Submitting a HIPAA transaction (267/277) will let you know if the claim processed to the member.*

# My Insurance Manager

- My Insurance Manager is the quickest way to get claims information. You can use the portal to:
  - Submit claims.
  - Check the status of claims.
  - View refund letters.
  - Get help with claims using:
    - Ask Provider Services.
    - STATchat.

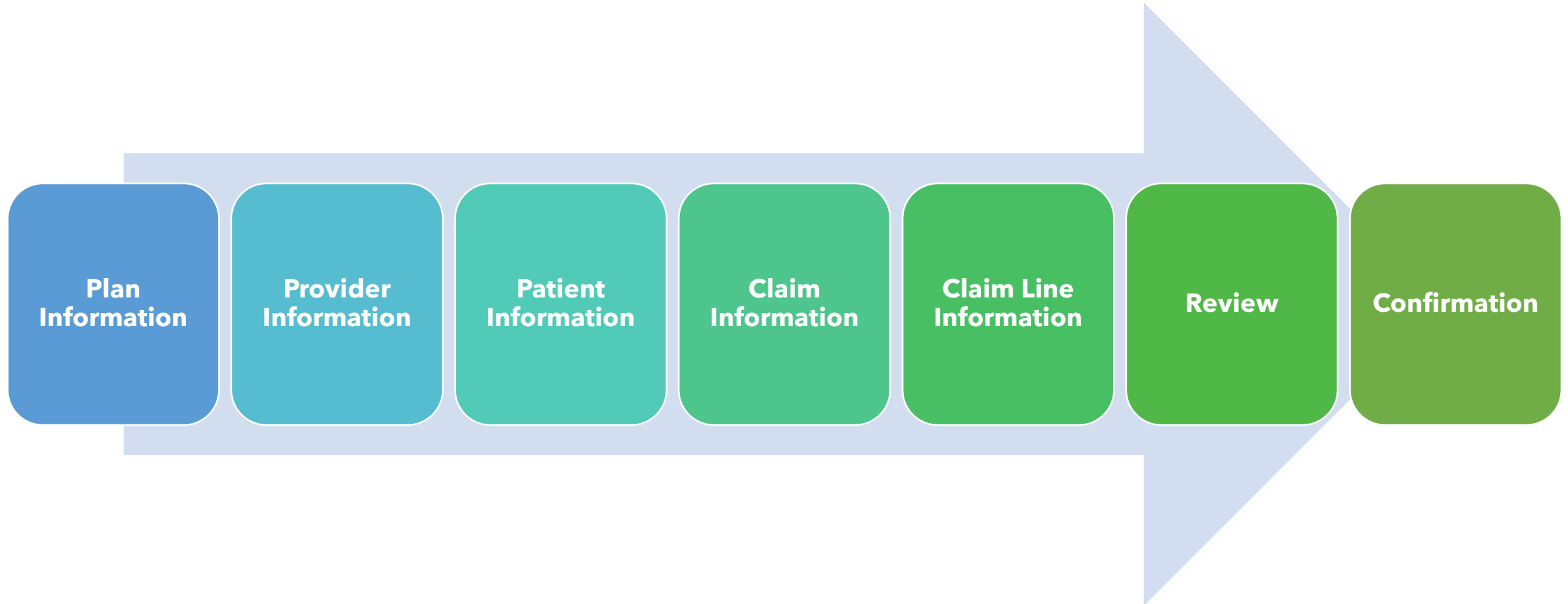
*Note: Review the available My Insurance Manager guides on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).*

# My Insurance Manager: Submitting Claims



# Submitting Claims Through My Insurance Manager

There are seven screens that you will progress through when using My Insurance Manager to submit claims.



# Steps to Submit Claims Through My Insurance Manager

Start Here

<b>Health</b>	
▶ Authorization Extension	▶ Patient Directory
▶ Authorization Status	▶ Pre-Certification/Referral
▶ Claims Status	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Service Review for Out-of-Area Members
▶ Institutional Claim Entry	▶ Professional Claim Entry
▶ Other Health Insurance	▶ Verify Primary Care Physician
<b>Dental</b>	
▶ Claims Status	▶ Patient Directory
▶ Dental Claim Entry	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Treatment Estimate Entry
▶ Other Dental Insurance	▶ Pre-Treatment Estimate Status

Step 1

Professional Claim Entry Printer-Friendly

Plan Information    Provider Information    Patient Information    Claim Information    Claim Line Information    Review    Confirmation

Please note: This feature is not available from 11:30 p.m. to 4 a.m. Eastern Time for maintenance purposes.

**Who Can File Online?**  
Health care professionals located in South Carolina or in counties contiguous to the state may submit claims online.

The following guidelines apply for ancillary services:

- File claims for Independent Clinical Laboratory services to the Blue Plan in whose service area the specimen was drawn.
- File claims for Durable or Home Medical Equipment to the Blue Plan in whose service area the equipment was shipped to or purchased in a retail store
- File Specialty Pharmacy claims to the Blue Plan in whose service area the ordering physician is located.

All other professionals must submit claims to the Blue Plan in their local service areas.

**Plan Information**

**Submitter Information**

If this information is not correct, please [modify your profile](#). Any information you entered will be lost if you navigate away from this page.

Name: Terrence Archie    ID: 123456789    Email Address: [redacted]

Phone: [redacted]    Extension: Not Available    Fax: Not Available

**Plan Information**

Choose the Plan under which the patient had insurance coverage on the date(s) of service. We require both a From Date of Service and a To Date of Service. If this claim is for a single date of service, enter the same date in both fields.

\* Plan: --Please Choose One--    \* Is the selected plan the primary payer? Yes

\* From Date of Service: [redacted]    To Date of Service: [redacted]

mm/dd/yyyy    mm/dd/yyyy

Continue    X Cancel this claim

Note: At any time, you can select "Cancel this claim" to abort the process.

# Steps to Submit Claims Through My Insurance Manager (Continued)

## Step 2

Professional Claim Entry Printer-Friendly

Plan Information **Provider Information** Patient Information Claim Information Claim Line Information Review Confirmation

Date of Service: 04/24/2024 \* Required

Insurance: Plan Name: BlueCross BlueShield Plans

**Choose a Billing Provider**

Click Choose a Billing Provider to select from a list of locations affiliated with your Tax ID. The billing location address must be the physical address (not P.O. Box) and must contain a 9-digit ZIP code.

Provider ID Type: Primary ID (NPI)

Provider ID: 444444440

Provider's Name: JOHN M JONES MD

\* Address Line 1: 4101 PERCIVAL RD # 0 Address Line 2:

\* City: COLUMBIA \* State: South Carolina \* ZIP Code: 29229 - 8320

\* Provider Accepts Assignment: Assigned \* Provider Signature on File: Yes

Specialty/Taxonomy Code:  Search

Rendering Provider Information

Please Note: You must identify a Rendering Provider on all claims when the services were not rendered by the Billing Provider.

## Step 3

Professional Claim Entry Printer-Friendly

Plan Information Provider Information **Patient Information** Claim Information Claim Line Information Review Confirmation

Date of Service: 04/24/2024 \* Required

Insurance: Plan Name: BlueCross BlueShield Plans

**Patient Information**

Patient Details

Please note: Changes made to this information will not be updated in your Patient Directory.

Enter the Member ID as shown on the member's ID card.

Choose a Patient or enter the information here.

\* Member ID: ZCZ769902477864 \* Relationship to Member: SELF \* Patient Account Number: ABC123  
include alpha prefix, if applicable

\* Last Name: Testing First Name: Michael M.I.: Suffix:

\* Date of Birth: 10/01/1958 \* Gender: MALE  
mm/dd/yyyy

\* Country: United States

\* Address Line 1: P.O. Box 24011 Address Line 2:

\* City: Columbia \* State: South Carolina \* ZIP Code: 29224 -

Patient Consent

\* Benefits Assigned to Provider: Yes

Note: You must select "Choose a Billing Provider" if more than one location is on file.

# Steps to Submit Claims Through My Insurance Manager (Continued)

## Step 4

Professional Claim Entry Printer-Friendly

Plan Information **Provider Information** Patient Information **Claim Information** Claim Line Information Review Confirmation

**Date of Service**  
04/24/2024

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ769902477864

**Patient**  
Patient's Name: Michael Testing  
Relationship to Member: SELF  
Gender: MALE  
Date of Birth: 10/01/1958

**Claim Information** \* Required

**Superbill Information**

**Please note:** Based on the date of service for this claim, the list of Superbill Templates may include ICD-9 and ICD-10 templates. You can convert ICD-9 to ICD-10 by selecting "Create a New or Edit an Existing Template".

Choose a Superbill Template:  
None

[Create a New or Edit an Existing Template](#)

**Service Information**

\* Place Of Service: Office - 11 Medical Record Number:

\* Claim Type: Original Claim

**Claim Entry Options**

Please choose the information that you want to add to this claim.

Ambulance Information  Medicare Information  
 Accident Information  Prior Authorization or Referral Number  
 Claim Note Information  Service Facility Information  
 Hospitalization Date(s)

**Continue** or **Back** Cancel this claim

## Step 5

Professional Claim Entry Printer-Friendly

Plan Information Provider Information Patient Information **Claim Information** **Claim Line Information** Review Confirmation

**Date of Service**  
04/24/2024

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ769902477864

**Patient**  
Patient's Name: Michael Testing  
Relationship to Member: SELF  
Gender: MALE  
Date of Birth: 10/01/1958

**Claim Line Information** \* Required

**Claim Amounts**

**Please note:** We will calculate the Total Claim Charges automatically based on the amounts you enter on the claim lines.

Total Claim Charges: \$ 0.00 Patient Paid: \$ Total Number of Lines: 1

**Diagnosis Codes**

**Please note:** At least one diagnosis code is required.

\* Diagnosis Codes:

**Claim Lines**

**Please note:** You must identify a Rendering Provider on all claim lines when these services were not rendered by the Billing Provider or by the Rendering Provider identified earlier.  
You must identify a Referring Provider on all claim lines when these services are related to a referral.

**Line 1**

\* Procedure:  Modifiers:  Charges: \$

\* Unit Type: --Please Choose One-- Unit(s):

\* From Date of Service: 04/24/2024 To Date of Service:  Primary and Secondary Diagnosis Codes:

mm/dd/yyyy mm/dd/yyyy

Place of Service: Procedure Description:

# Steps to Submit Claims Through My Insurance Manager (Continued)

## Step 6

Professional Claim Entry Printer-Friendly

Plan Information Provider Information Patient Information Claim Information **Claim Line Information** Review Confirmation

**Date of Service**  
04/24/2024

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ769902477864

**Patient**  
Patient's Name: Michael Testing  
Relationship to Member: SELF  
Gender: MALE  
Date of Birth: 10/01/1958

**Claim Review**  
This is a summary of the claim information you are about to submit. Please make any necessary changes and submit.

**Provider Information**  
Submitter's Name: Terrence Archie  
Billing Location: JOHN M JONES MD  
Plan: BlueCross BlueShield Plans

**Patient Information**  
Member ID: ZCZ769902477864  
Date of Birth: 10/01/1958  
Gender: MALE  
Patient's Name: Michael Testing  
Patient Account Number: ABC123

**Claim Information**  
This is a claim-level summary. Click Add Additional Claim Information to add information that applies to the entire claim. If another payer is primary on this claim and you wish to add or edit adjustments at the claim level, click Claim Level Adjustments. To add or edit adjustments at the line level, see the Claim Line Information section below.

Total Charges: \$ 250.00  
Dates of Service: 04/24/2024

[Add Additional Claim Information](#)

**Claim Line Information**

Line	Procedure	From Date of Service	Charges	Additional Line Information
1	99213	04/24/2024	\$ 250	<a href="#">Add</a>

Select Submit from this screen.

## End Here

Professional Claim Entry Printer-Friendly

Plan Information Provider Information Patient Information Claim Information Claim Line Information Other Payer Information Adjustments Review **Confirmation**

**Date of Service**  
04/24/2024  
4

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ769902477864

**Patient**  
Patient's Name: michael testing  
Relationship to Member: SELF  
Gender: MALE  
Date of Birth: 10/01/1958

**Claim Confirmation**  
Please note: We have received and are processing your claim. Here is your claim number.

Click on View Patient Receipt for a printable receipt detailing the patient's liability. Receipts are only available for claims that have finalized. The View Patient Receipt button will not appear for claims that require further processing.

**Confirmation**

Claim Number: 41XXX232000000  
Member ID: ZCZ769902477864  
Patient's Name: michael testing

Patient's Date of Birth: 10/01/1958  
Patient's Gender: Male

[Create New Claim](#) [View Claim Status](#)



# My Insurance Manager: General Claims Status



# Checking the Status of a Claim

Start Here



**Health**

- ▶ Authorization Extension
- ▶ Authorization Status
- ▶ **Claims Status**
- ▶ Eligibility and Benefits
- ▶ Institutional Claim Entry
- ▶ Other Health Insurance

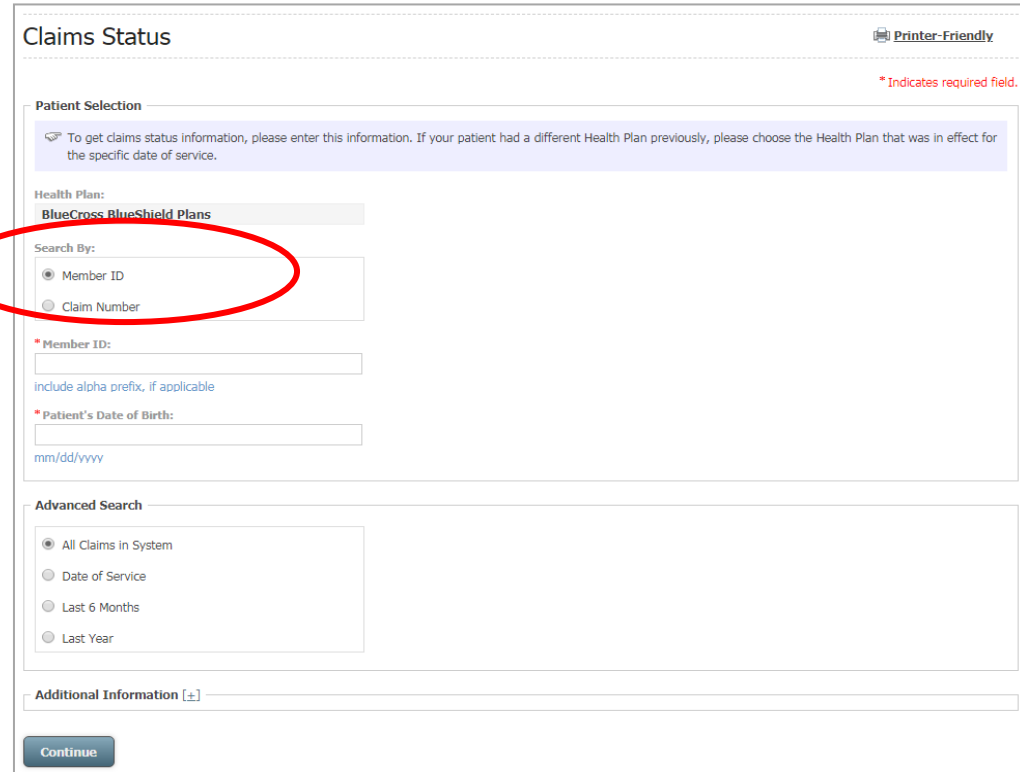
- ▶ Patient Directory
- ▶ Pre-Certification/Referral
- ▶ Superbill Maintenance
- ▶ Pre-Service Review for Out-of-Area Members
- ▶ Professional Claim Entry
- ▶ Verify Primary Care Physician

**Dental**

- ▶ Claims Status
- ▶ Dental Claim Entry
- ▶ Eligibility and Benefits
- ▶ Other Dental Insurance

- ▶ Patient Directory
- ▶ Superbill Maintenance
- ▶ Pre-Treatment Estimate Entry
- ▶ Pre-Treatment Estimate Status

Step 1



Claims Status Printer-Friendly

\* Indicates required field.

**Patient Selection**

To get claims status information, please enter this information. If your patient had a different Health Plan previously, please choose the Health Plan that was in effect for the specific date of service.

Health Plan:  
BlueCross BlueShield Plans

Search By:

- Member ID
- Claim Number

\* Member ID:

include alpha prefix, if applicable

\* Patient's Date of Birth:

mm/dd/yyyy

**Advanced Search**

- All Claims in System
- Date of Service
- Last 6 Months
- Last Year

Additional Information [±]

Continue




Note: Searching for claims using the member's identification number is the recommended option.

# Checking the Status of a Claim (Continued)

Step 3

Claims Summary List *(click a column title to sort)* Showing 3 Results

List of health claims

<u>Claim Number</u>	<u>Claim Status</u>	<u>Primary ID</u>	<u>Beginning Date of Service</u> ▼	<u>Process Date</u>	<u>Total Charges</u>
 <a href="#">207103LDG0000</a>	PROCESSED	15	03/07/2022	03/12/2022	\$81.00
 <a href="#">207404P250000</a>	PROCESSED	16	03/07/2022	03/15/2022	\$130.50
 <a href="#">2029023B80000</a>	PROCESSED	16	01/18/2022	01/31/2022	\$362.00

[Ask Provider Services](#)

# Checking the Status of a Claim (Continued)

Claim Number:  
207103LDG0000

Check your remittance voucher for any non-covered or non-allowed charges which may be the member's responsibility.

Primary Status:  
**FINALIZED-THE CLAIM/ENCOUNTER HAS COMPLETED THE ADJUDICATION CYCLE AND NO MORE ACTION WILL BE TAKEN.**

**Patient Liability** Detailed Status Information Additional Status Information

Detail

Status Effective Date: 03/12/2022 Date(s) of Service: 03/07/2022 - 03/07/2022 Processed Date: 03/12/2022

Primary ID: 1000000000 Organization or Provider's Name: UNI. HEALTH SYSTEM

Total Charges: \$81.00 Amount Paid: \$0.00 Bill Type: 141

Patient Account Number: 2402

Here is a list of the line items associated with this claim. Showing 1 Result

Line Summary List

Line Item	Line Status	Date(s) of Service	Line Charges	Amount Paid
01	PROCESSED	03/07/2022 - 03/07/2022	\$81.00	\$0.00

Revenue Code:  
0310 - LABORATORY PATHOLOGICAL,0,GENERAL CLASSIFICATION

Procedure Code:  
S1310 - LABORATORY PA

Previous Claim Next Claim Ask Provider Services or Back

Claim Number:  
207103LDG0000

Check your remittance voucher for any other non-covered or non-allowed charges which may be the member's responsibility.

Patient Liability

Please note: The amount in the Other field includes any non-covered charges that are not copayments, deductibles or coinsurance. This amount may also include reimbursements from the member's Health Reimbursement Account. For more specific details, please see your remittance advice for this claim.

Deductible:	Copayment:	Coinsurance:	Other:	Total:
\$72.42	\$0.00	\$0.00	\$0.00	\$72.42

Back

Status Details

FINALIZED-THE CLAIM/ENCOUNTER HAS COMPLETED THE ADJUDICATION CYCLE AND NO MORE ACTION WILL BE TAKEN.

107 - PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS

Additional Status Information

Description:  
CLAIM HAS PROCESSED

# My Insurance Manager: Refunds



# Getting Assistance with Refunds

- ❑ Refund letters are in My Insurance Manager.
  - Search by the refund control number (RCN) or posting date.
  - Includes the patient details and reason for the refund request.
- ❑ Call Provider Services at 800-868-2510 and select option 4 if you need additional information on a refund.
  - Certain lines of business have a separate phone number (i.e., State Health Plan).


Refund Letters

Plans included: BlueCross BlueShield of South Carolina, State Health Plan, BlueChoice HealthPlan, HealthyBlue and FEP. Refund Letters are stored by the dates we create them.

Refund Control Number  Or Posting Date

STATE REFUNDS (AX-B15)  
PO Box 100300  
COLUMBIA SC 29202-3300

0000128

 South Carolina  
BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association  
Visit MyInsuranceManager at www.SouthCarolinaBlues.com

NOVEMBER 11, 2021

000128  
0001 of 0001

Re: Patient: \_\_\_\_\_  
ID Num: \_\_\_\_\_  
Provider: \_\_\_\_\_  
Date(s) of Refund: \_\_\_\_\_

Dear Provider:

We sent a payment to you on March 01, 2021, in error for the patient listed above. We must request a refund of \$338.40 for the reason(s) stated below:

**THE MEDICARE COINSURANCE IS INCORRECT.**

If we have not heard from you within 30 days, we will deduct this amount from future payments to you. Please send this amount, along with a copy of this letter, to:

BlueCross BlueShield of South Carolina  
Attn: Lockbox AX-A31  
1-20 at Alpine Road  
Columbia, SC 29219

We thank you for your cooperation and apologize for any inconvenience. If you have any questions, please call our Provider Service department at 800-444-4311.

Sincerely,

State Group Refunds

PLB ADJUSTMENTS						
PreProv	Reason Code	Reference Id	Amount			
	WO: Overpayment Recovery	P2126417272	338.4			
	WO: Overpayment Recovery	P2126417320	90.9			
REMITTANCE SUMMARY						
Totals	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj
	.00	.00	.00	.00	.00	429.30
						Paid
						-429.30

# My Insurance Manager: Ask Provider Services



# Overview of Ask Provider Services

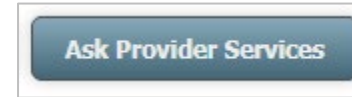
- ❑ Ask Provider Services is a feature in My Insurance Manager that lets you submit secured web inquiries for help with claims.
- ❑ This feature is intended to assist with **complex issues** and not general claim status.

Examples of <i>appropriate</i> questions to ask...	Examples of <i>inappropriate</i> questions to ask...
Why was line one of the claim denied as noncovered?	What is the status of the claim?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?



# Submitting Web Inquiries

- ❑ From the claim screen, select ***Ask Provider Services***.
- ❑ Enter all the necessary information in the available fields.
- ❑ Be sure to ask clear, probing questions.
- ❑ Select Submit Question.



**Inquiry**

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

**How would you like to contact Provider Services?**

Submit your question online

Talk to Provider Services online  
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

**Health Plan:**  
BlueCross BlueShield Plans

**Inquiry Reason:**  
Claim Status Inquiry

\* Patient's First Name:  \* Patient's Last Name:  \* Patient's Member id:  Patient's Date of Birth:  11/13/1955  
mm/dd/yyyy

\* Location:   Primary ID:

\* Please enter a question:

or [Back](#)

# Viewing Web Inquiry Responses

- ❑ To view responses to your inquiries:
  - Select Go to Message Center.
  - You can narrow the results by entering the ID number and selecting specific months.
- ❑ Enhancements made:
  - You now have the option to see up to **90 days** of inquiries.
  - Provider Administrators can view all the web inquiries submitted and responses received under the Tax ID.
    - Enter the member's ID number and select the staff member from the drop-down menu.

[Go to Message Center](#)

Search by Member ID:  Select a Plan...

Last 30 Days Results (0)

Message Tools < Last 30 Days Go >

Date	Subject
We did not find any messages for the time period you chose. Please try your request again with a different time period.	

Office Staff View

Message Center

Please note: The Message Center will only show mail you submitted through My Insurance Manager. This mailbox will not show other communications you may receive from us, such as faxes or regular mail, that may relate to your questions.

Search by Member ID:  Select a Plan...

Search by Staff Member:  [show/hide](#)

Staff Member:

Last 90 Days Results (4)

Message Tools < Last 90 Days Go >

Date	Subject
<input type="checkbox"/> 01/16/2024	HEALTH - Eligibility Question - KRISTA FUNDERBURK
<input type="checkbox"/> 01/16/2024	HEALTH - Claim Status Inquiry - KRISTA FUNDERBURK
<input type="checkbox"/> 01/16/2024	HEALTH - Claim Status Inquiry - KENNETH CATOE
<input type="checkbox"/> 01/16/2024	HEALTH - Claim Status Inquiry - LAWIS TAYLOR

Administrator View

# My Insurance Manager: STATchat



# Overview of STATchat

- ❑ STATchat is a feature that let's you speak with a Provider Services representative.
- ❑ The feature is available through My Insurance Manager.
- ❑ System requirements include:
  - A current version of Adobe Flash Player
  - A compatible web browser, such as Microsoft Edge or Google Chrome.
  - A headset or standalone microphone with speakers connected to your computer.

Ask Provider Services

STATchat \* Required

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

How would you like to contact Provider Services?

Submit your question online

Talk to Provider Services online  
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

Inquiry Name:  
BlueCross BlueShield Plans

Inquiry Reason:  
Claim Status Inquiry

\* Patient's First Name: f    \* Patient's Last Name: K    \* Patient's Member id: B: 9Q

\* Location:    Primary ID: 1

[Need help using STATchat?](#)

Launch STATchat or [Back](#)

STATchat - Internet Explorer

STATchat    Hang Up

Status: **Connected**  
Call Id: 8141917300

Wearing a headset?

1	2	3
4	5	6
7	8	9
*	0	#

MUTE    KEYPAD

Having trouble with the audio?

Note: The operation hours may vary for certain lines of business.

# Claim Reminders



# Laboratory Services

- ❑ Avalon Healthcare Solutions manages the laboratory benefits on behalf of BlueCross and BlueChoice®.
- ❑ Access the current list of participating laboratories at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).
- ❑ Review the medical policies before rendering services to ensure criteria is followed for coverage.
  - Benefits of reviewing the medical policies:

Prevents delays in claims processing

Ensures proper and timely payment

Reduces the need for reconsiderations

# Medical Policy Criteria for Laboratory Services

Policy Rule	Definition
Experimental and investigational	Procedure is not covered under the member's benefit due to exclusion
Demographic limitations	Limitations based on the member's age/sex
Excessive procedure units	Total units within and across claims for a single date of service more than necessary
Excessive units per period of time	Maximum allowable units within a defined period of time has been exceeded
Insufficient time between procedures	Minimum time required before a second procedure is warranted
Rendering provider limitations	Providers/procedures not permitted in combination
Diagnosis does not support test requested	Procedure was not appropriate for the clinical situation
Mutually exclusive codes	The procedure is not valid with other procedures on the same date of service

Examples of claims that rejected due to policy criteria not being met:

Laboratory Test	Issue With the Claim	Rejection Applied
Vitamin D	Testing rendered two weeks after initiation of Vitamin D therapy	Insufficient time between procedures
Thyroid Disease	Testing of reverse T3, T3 uptake	Experimental and investigational
Testosterone	Testing saliva for testosterone	Experimental and investigational

# Locating Medical Policies

- ❑ Medical policies can be found on:
  - [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)
    - Providers>Policies and Authorizations>Medical Policies
  - [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com)
    - Providers>Medical Policies
- ❑ CPT and diagnosis codes listed on each policy are not a guarantee of payment.
  - Included for general reference.
  - Lists may not be all-inclusive.

The screenshot shows the 'Medical Policies' page on a website. At the top, there is a dark blue navigation bar with links for 'HOME', 'CONTACT US', 'ACCESSIBILITY', and 'DISCLAIMER'. Below this is a search bar with the text 'Search...' and a magnifying glass icon. A horizontal menu of letters from 'All' to 'Z' is positioned below the search bar. On the left side, there are two sections: 'Category' and 'Date Posted'. The 'Category' section lists various medical categories with their respective counts: Medicine (123), Administrative (25), Other (32), Durable Medical Equipment (39), Prescription Drug (83), Laboratory (138), Surgery (126), Therapy (80), Radiology (95), Mental Health (6), Ob/Gyn/Reproduction (10), and All (757). The 'Date Posted' section lists dates from October 2022 (1) to All (757). The main content area on the right displays a list of medical policies, each with a title and a date. The policies listed are: Abatacept (Orencia®) (Prescription Drug | April 1, 2014), ABDOMEN MRA (Angiography) (Radiology | January 1, 2021), Abdominoplasty, Panniculectomy and Lipectomy (Surgery | June 1, 2015), Ablation of Peripheral Nerves to Treat Pain (Surgery | May 1, 2016), Absorbable Nasal Implant for Treatment of Nasal Valve Collapse (Surgery | October 1, 2019), Accelerated Breast Irradiation and Brachytherapy Boost After Breast-Conserving Surgery for Early-Stage Breast Cancer (Therapy | July 1, 1996), and Accident and Medical Emergency Services (Administrative | January 15, 1997).



# Example of Medical Policy

## Vitamin D Testing - CAM 126

Category: Laboratory  
 Department: Medical Affairs  
 Original Date: January 2016

Last Reviewed: January 2024

Next Review: Coding Section

### Description

Vitamin D is a precursor to steroid hormones and plays a key role in calcium absorption and intestinal absorption of calcium. Other effects include a lesser stimulation of intestinal osteoblast function, osteoclast activation, and bone resorption (Pazirandeh & Burns 2014).

Vitamin D is present in nature in two major forms. Ergocalciferol, or vitamin D2, is found in fortified foods and contains significant amounts of vitamin D. Cholecalciferol, or vitamin D3, is synthesized in the body and is found in fortified foods, most notably milk and cereals (Sahota, 2014).

Though "The risk of vitamin D deficiency differ[s] by age, sex, and race and ethnicity, inadequate dietary intake of vitamin D-containing foods, and malabsorption syndrome are common causes of deficiency (Sahota, 2014).

### Regulatory Status

#### Food and Drug Administration (FDA)

A search of the FDA Device database on May 26, 2022, for "vitamin D" yielded 42 results. Most of these tests are performed in house. These laboratory-developed tests (LDTs) are regulated by the Center for Devices and Radiological Health (CDRH) under the Laboratory Improvement Amendments of 1988 (CLIA '88). As an LDT, the U.S. Food and Drug Administration (FDA) approval is not currently required for clinical use.

### Policy

Application of coverage criteria is dependent upon an individual's benefit coverage.

- For individuals with an underlying disease or condition which is specifically a suspected of hypervitaminosis of Vitamin D, 25-hydroxyvitamin D serum testing is not considered **MEDICALLY NECESSARY**.
- As part of the total 25-hydroxyvitamin D analysis, testing for D2 and D3 fractions is not considered **MEDICALLY NECESSARY**.
- For individuals who have documented vitamin D deficiency, repeat testing for supplementation therapy is considered **MEDICALLY NECESSARY** with the following:
  - Repeat testing for the monitoring of supplementation therapy should not be considered **MEDICALLY NECESSARY**.
  - Once therapeutic range has been reached, annual testing meets coverage criteria.
- For the evaluation or treatment of conditions that are associated with defects in vitamin D metabolism, testing is considered **MEDICALLY NECESSARY**.
- The following testing is considered **NOT MEDICALLY NECESSARY**:
  - Measurement of serum 1,25-dihydroxyvitamin D to screen for vitamin D deficiency.
  - Routine screening for vitamin D deficiency with serum testing in asymptomatic individuals.

Code	Number	Description
CPT	82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed
	82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed
	0038U	Vitamin D, 25 hydroxy D2 and D3, by LC-MS/MS, serum microsample, quantitative Proprietary test: Sensieva™ Droplet 25OH Vitamin D2/D3 Microvolume LC/MS Assay Lab/Manufacturer: InSource Diagnostics
ICD-10-CM	A15.0 – A15.9	Tuberculosis
	A19.0 – A19.9	Military Tuberculosis
	A15.7, A19.0 – A19.9	Primary or military tuberculosis
	C81.00 – C84.99	Other Lymphoma
	C81.00 – C96.9	Lymphoma
	C85.10 – C85.99	Unspecified B-cell lymphoma
	C85.20 – C85.29	Unspecified B-cell lymphoma
	C85.80 – C85.89	Other specified types of B-cell lymphoma
	C85.90 – C85.99	Non-Hodgkin lymphoma
	D61.09	Fanconi's anemia
	E66.01 – E66.09	Obesity
	D86.0 – D86.85	Sarcoidosis
	D86.86	Sarcoid arthropathy
	D86.87	Sarcoid myositis
	D86.89	Sarcoidosis of other sites
D86.9	Sarcoidosis, unspecified	
E20.0	Idiopathic hypoparathyroidism	
E20.1	Pseudohypoparathyroidism	
E20.8	Other hypoparathyroidism	
E20.9	Hypoparathyroidism, unspecified	
E21.0	Primary hyperparathyroidism	
E21.1	Secondary hyperparathyroidism	
E21.2	Other hyperparathyroidism	
E21.3	Hyperparathyroidism, unspecified	

### History From 2016 Forward

01/25/2024	Annual review, no change to policy intent. Updating description, table of terminology, rationale and references.
01/26/2023	Annual review, updating policy for clarity and consistency. Adding verbiage to guidelines regarding bariatric procedures. Also updating description, rationale and reference.
08/08/2022	Interim review, updating policy for clarity. Also updating description, rationale, and references.
01/11/2022	Annual review, no change to policy intent. Updating rationale and references.
01/05/2021	Annual review, no change to policy intent. Updating description, rationale and references.
04/08/2020	Interim review to add Z79.2 to the policy. No change to policy intent.
01/06/2020	Annual review, updating guidelines and coding. No change to policy intent.
05/23/2019	Corrected typo to coding
01/08/2019	Annual review, no change to policy intent. Updating ICD coding.
01/22/2018	Annual review, no change to policy intent.
08/21/2017	Updated coding. No other changes.
08/09/2017	Updated coding. No other changes.
06/19/2017	Updated coding section. No other changes.
04/26/2017	Updated category to Laboratory. No other changes made.
01/04/2017	Annual review, no change to policy intent.
01/05/2016	NEW POLICY

# High Dollar Pre-payment Review (HDPR)

The process of reviewing high dollar *inpatient* hospital claims.

Used to validate the services billed align with what was rendered.

# Criteria Used for HDPR

The following criteria must be met for an HDPR to occur:

Inpatient institutional  
(acute care) claim

Claim has an allowed  
amount of \$100k or  
more

Any pricing  
methodologies except  
for per diem, flat-fee  
case rate and DRG

# General Process of an HDPR

Provider submits their claim to BlueCross.

BlueCross confirms it's an ***inpatient*** claim with an allowance of ***\$100k or more.***

A claim line with revenue code 0249 is added to the claim.

The claim line is denied with ***CARC*** 216 and ***RARC*** N183

An itemized bill is ***requested.***

Note: Review the Inpatient Non-Reimbursable Charge/Unbundling Policy guide on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) for more information.

# Examples of Itemized Bills

## ❑ *Acceptable* itemized bill:

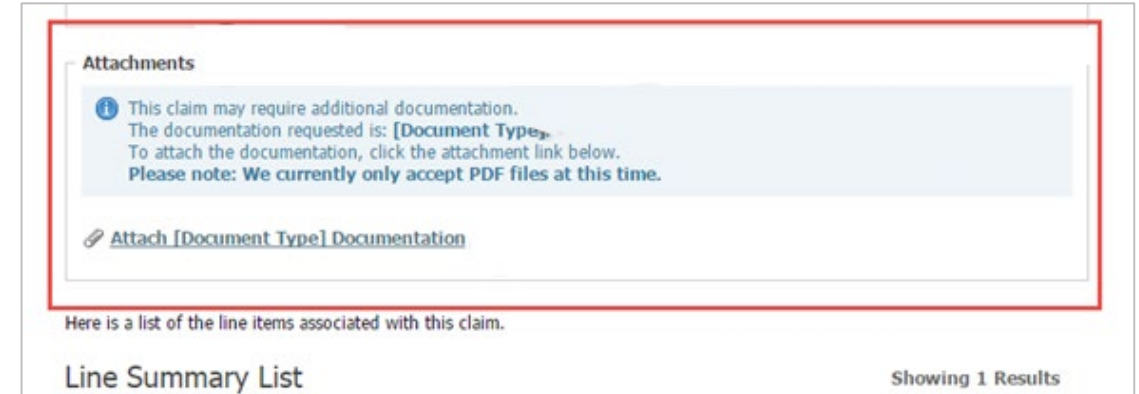
42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Dicyclomine 10 MG		010322	1	27.00
0250	Nitroglycerin 0.4 MG		010322	1	28.73
0250	Midazolam 10 MG	J2250	010322	2	29.09
0250	Atorvastatin 40 MG		010322	2	76.93
0272	Catheter Angiographic		010322	1	226.00

## ❑ *Unacceptable* itemized bill:

42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Pharmacy			336	7780.81
0272	Sterile supplies			8	7680.40
0278	Supply/implant		010322	2	6385.00

# Claim Attachments in My Insurance Manager

- ❑ Claim Attachments is a feature in My Insurance Manager that allows you to upload requested documentation directly into the portal for a claim.
  - 30 MB limit for each document.
- ❑ Documentation that can be uploaded includes:
  - Accident questionnaires
  - Certificate of medical necessity (for DME)
  - Medical records
  - Other health insurance
  - Primary explanation of benefits
  - Itemized bills



Note: Review the "What You Need to Know About Claim Attachments" guide on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) for more information.

# Provider Reconsiderations and Guidelines

- ❑ Provider reconsiderations are used to investigate the outcome of a finalized claim.
- ❑ General guidelines for provider reconsiderations:

## Reasons for a reconsideration

- ❑ Medical necessity determination
- ❑ Lack of authorization for emergent services when the member **cannot** present themselves as a BlueCross member

## \*Reasons that do not require a reconsideration

- ❑ Membership issues
- ❑ Eligibility or benefit denials
- ❑ Lack of authorization for non-emergent services when you know the member is a BlueCross member

*\*For reasons listed in this column, contact the appropriate Provider Services department using Ask Provider Services, STATchat<sup>SM</sup> or call the phone number on the back of the member's identification card.*

# Reconsideration, Corrected Claim, or Provider Services

- Knowing when to submit a provider reconsideration versus a corrected claim or contacting Provider Services is important.

## Examples of when to submit a provider reconsideration:

### Provider reconsideration

A claim is rejected because the medical necessity could not be determined.

A claim is rejected for lack of authorization, but the member was comatose when they arrived at the hospital.

## Examples of when to submit a corrected claim:

### Corrected claim

An anesthesia claim is submitted with the incorrect modifier and rejects as a duplicate.

A provider only performs the Cesarean delivery but submits their claim with the procedure 59515 (which includes postpartum care), causing the claim to process globally.

## Examples of when to contact Provider Services:

### Provider Services


A corrected claim was submitted but rejected as a duplicate.

A claim is rejected for no prior authorization, but you have the authorization number.



# Submitting a Provider Reconsideration

- ❑ Use the South Carolina Provider Reconsideration Form.
  - [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)
  - [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com)
- ❑ Include supporting documentation.
  - History and physical records
  - Operative notes
  - Office notes
  - Progressive notes
- ❑ Be mindful of the timely filing limits.

 BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina  
Independent licensees of the Blue Cross Blue Shield Association.

**South Carolina Provider Reconsideration Form**

This form is intended for use by physicians and other health care professionals in South Carolina. If you are located outside of South Carolina and have claims questions, reviews, or appeals, please direct them to your local Blue® plan. To request a claim review, please complete this form for BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan members. Use this form as the cover transmittal sheet for all supporting documentation. Forms submitted without supporting documentation will not be considered. Be sure to complete each section.

You may wish to seek reconsideration of a claim:

- If you have additional documentation that supports a reversal of the claim determination.
- If you want a reconsideration of the claim adjudication.

**Provider Information**

Provider's Name: \_\_\_\_\_ NPI or Tax ID: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Email: \_\_\_\_\_  
Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient and Claim Information**

Patient's Name: \_\_\_\_\_ Member ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Claim Number (Do **not** attach claim): \_\_\_\_\_ Date of Service: \_\_\_\_\_

**Reconsideration**

Check the appropriate boxes below to specify the type of service and request.

Medical Services  Initial Request  
 Laboratory Services  Subsequent Request\*

\*Note: Subsequent requests **must** include the initial decision along with new or additional information to be re-reviewed.

Brief description of request/desired action you want us to take as result of this claim review:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description of attachments included (office records, lab reports, physician orders, etc.):  
\_\_\_\_\_  
\_\_\_\_\_

**Please Fax or Mail to (send to only one):**

Plan	Reconsideration Time Limits	Fax Number	Mailing Address
BlueChoice® HealthPlan	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
BlueEssentials™ & Blue Option™	180 days from remit date	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Preferred Blue® & BlueCard®	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Group & Individual	180 days from remit date	803-264-4172	AX-F25, I-20 @ Alpine Road, Columbia, SC 29219
State Health Plan	6 months from remit date	803-264-4204	AX-810, P.O. Box 100605, Columbia, SC 29260
Federal Employee Program	90 days from remit date	803-264-8104	AX-805, P.O. Box 600601, Columbia, SC 29260
Medicare Advantage	60 days from remit date	803-264-9581	AG-780, P.O. Box 100191, Columbia, SC 29202

Revised: February 2023

# Pricing Inquiries

- ❑ A pricing inquiry is an investigation of the reimbursement applied to a claim.
- ❑ Before submitting pricing inquiries, verify the following:

Member's plan  
(i.e., Commercial or Exchange)

Non-covered charges  
or denied lines

Applied cutbacks

Date of service  
(Fee schedule year)

MUEs

*Note: If you use third-party vendors to submit inquiries on your behalf, be sure they are aware of this information.*

# Ancillary Claim Filing Guidelines

## Durable Medical Equipment

- File to the Plan whose state the equipment was purchased at a retail store; or
- File to the Plan whose state the equipment was shipped

## Independent Clinical Laboratory

- File to the Plan where the specimen was drawn.
- The location of where the specimen was drawn is determined by the physical location of the referring provider.

## Specialty Pharmacy

- File to the Plan whose state the ordering physician is located.

# Submission of Requested Medical Records

- ❑ If medical records are requested, be sure to submit them as soon as possible.
- ❑ Medical records could be requested to:
  - Adjudicate claims.
  - Support medical necessity for a denied claim.
  - Close gaps in care for quality measures (HEDIS®) based on claim history.
- ❑ The submission of medical records is a **non-billable** event.
  - Share this information with any third-party vendors that submit medical records on your behalf (i.e., Ciox, ScanSTAT).

# National Drug Codes

- ❑ National drug codes (NDCs) are used when submitting claims for drugs.
- ❑ NDCs must have 11 digits and follow the 5-4-2 format.
- ❑ If the drug package lists an NDC with 10 digits, it must be converted into an 11-digit NDC using the following table:

10-Digit Format		Add a zero in...		Report NDC as...
<b>4-4-2</b>	#### - #### - ##	<b>1<sup>st</sup> position</b>	0#### - #### - ##	0#####
<b>5-3-2</b>	##### - ### - ##	<b>6<sup>th</sup> position</b>	##### - 0### - ##	#####0#####
<b>5-4-1</b>	##### - ##### - #	<b>10<sup>th</sup> position</b>	##### - ##### - 0#	#####0#

# The BlueCard Program

## Overview

- ❑ The BlueCard program allows Blue plan members to get health care services while traveling or living in another Blue plan's service area.
- ❑ The program links participating health care providers across the country and internationally through a single, electronic network for claims processing and reimbursement.

## Benefits to Providers

- ❑ Let's you conveniently submit claims for members from other Blue plans directly to BlueCross BlueShield of South Carolina.
- ❑ Gives you one point of contact for all your claims-related questions.

*Note: For more information, review the BlueCard Program manual on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).*

# The BlueCard Program (Continued)

## Products Included

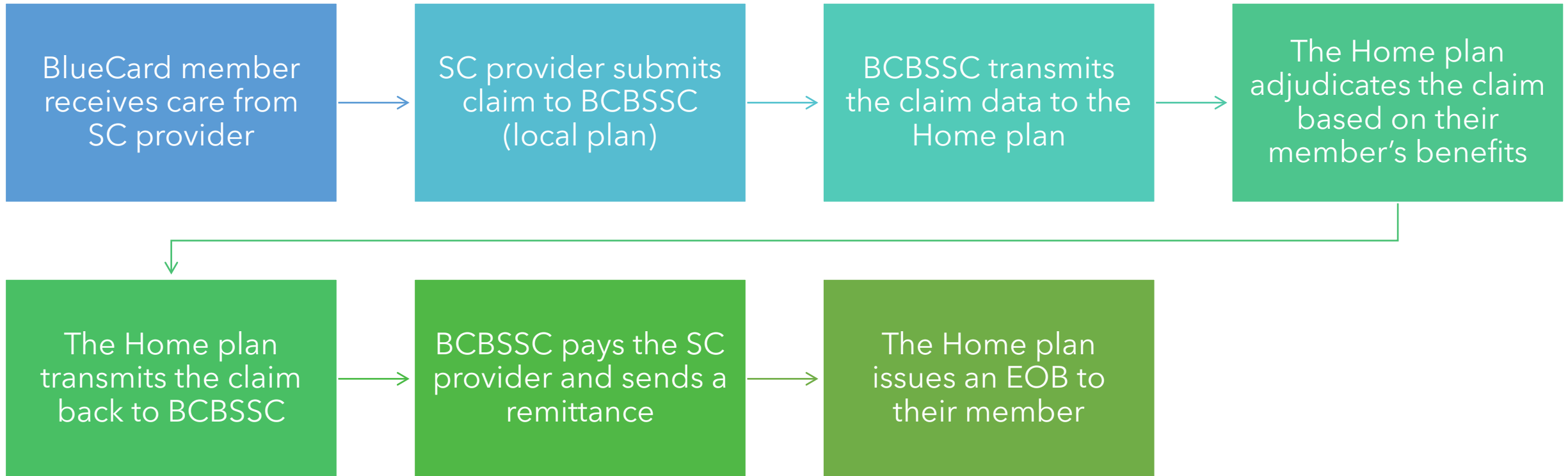
- ❑ Preferred Provider Organization (PPO)
- ❑ Exclusive Provider Organization (EPO)
- ❑ Health Maintenance Organization (HMO)
- ❑ Point of Service (POS)

## Products Excluded

- ❑ Stand-alone dental
- ❑ Vision products delivered through a vendor
- ❑ Self-administered prescription drugs products delivered through a vendor
- ❑ Medicaid and SCHIP plans
- ❑ Medicare Advantage
- ❑ Federal Employee Program (FEP)

# The BlueCard Program (Continued)

## Process Flow





# Helpful Tips



# Claims That Require a Questionnaire Response

- ❑ Accident or subrogation
  - Generated based on trauma related diagnoses on a claim
  - Allow members at least **60 days** to respond and for the review to be completed
- ❑ Other health insurance (OHI)
  - Generated based on the member's age, if they have more than only policy on file, etc.
  - Must be completed by the member.
    - Members can mail or fax the questionnaire, call Member Services or update their information using My Health Toolkit.

**Encourage members to return the questionnaire as soon as possible to avoid processing delays**

**Incorporate the forms in the onboarding paperwork**  
*Only submit the documentation if requested.*

# Importance of Using Correct Coding

- ❑ Accurate coding and reporting of services on medical claims is critical in assuring proper payment to providers.
- ❑ Common coding issues include:

**Invalid modifiers**

**Incorrect number of units**

**Diagnosis inconsistencies**

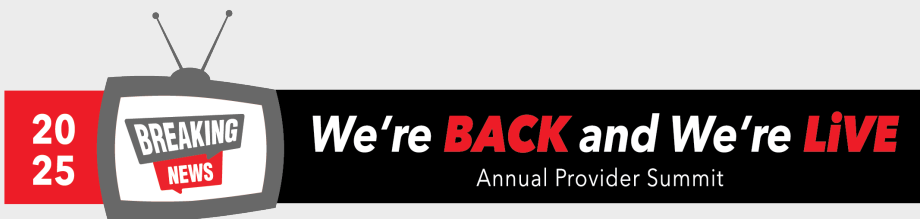
**Unbundled services**

**Age discrepancies**

**Unspecified codes**

*Note: This list may not be all-inclusive.*

# Dental Networks



# Topics to Discuss

- ❑ Dental Enrollment
- ❑ Dental Plans
- ❑ Dental GRID
- ❑ Dental Benefits and Claims
- ❑ 2025 Coding Updates

# Dental Enrollment



# Participating in the Dental Network

- ❑ Plans that use the Participating Dental Network include:
  - Commercial plans
  - Medicare Advantage plans
  - State Dental Plus
  - Companion Life Dental
  - FEP Basic, Standard, and BCBS FEP Dental
  - GRID members
- ❑ Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).
  - Providers>Provider Enrollment>**Join Our Networks**

# Individual Dental Enrollment

Checklist Items	Oral Surgery	Routine
Provider Enrollment Application		
Copy of SC Medical or Practice License		
Drug Enforcement Administration (DEA) Certification*		
Current Copy of Malpractice (Min. \$1M/\$3M)		
Authorization to Bill for Services		
Signed Contracts	Footnote 1	Footnote 2
Professional Training		
Hold Harmless**		
Appendix D**		
Medicaid ID Number***		

**\*Only if applicable.**

**\*\*Only if applying for BlueChoice® HealthPlan.**

**\*\*\*Only if applying for Healthy Blue.**

**1 Medical contract, dental contract or both.**

**2 Dental contract only.**



# Group Practice Dental Enrollment

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts*
Medicaid ID Number**
Add Practitioner Form***

**\*For oral surgeons applying for BlueChoice® and Healthy Blue. All other contracts are based on the individual practitioner's credentialing status.**

**\*\*Only for oral surgeons applying for Healthy Blue.**

**\*\*\*For each physician being added to the group. This is under the Maintain section of the portal.**

**Note: If the provider is not credentialed, you must complete the Provider Enrollment application.**

# In State, Out-of-Network Dental Enrollment

## Individual Physician

Checklist Items
Health Professional Application*
Authorization to Bill for Services*

**\*Needed for each individual being linked to the practice.**

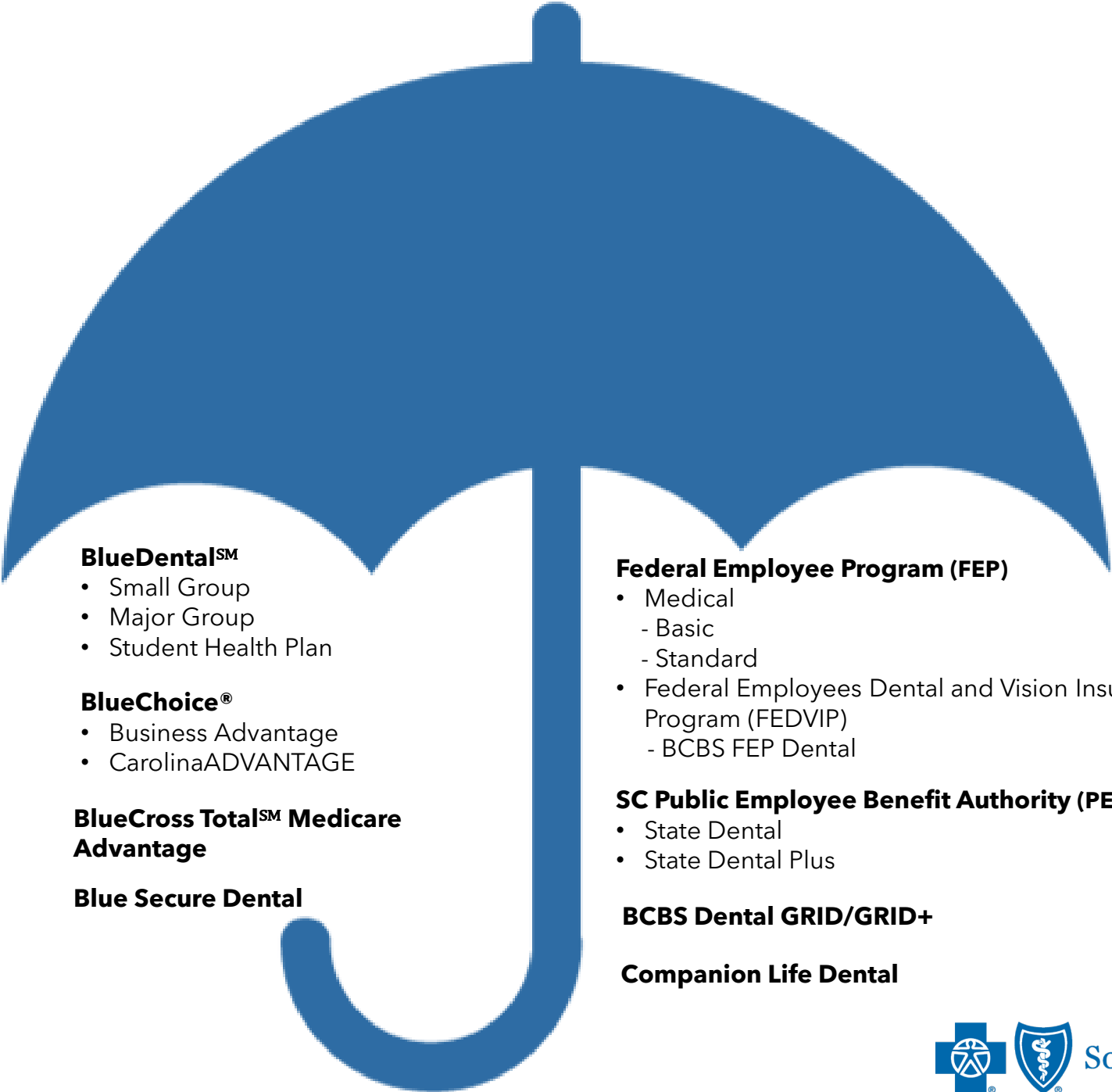
## Group Practice

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer Enrollment

# Dental Plans



# BlueCross BlueShield of South Carolina Dental Umbrella



**BlueDental<sup>SM</sup>**

- Small Group
- Major Group
- Student Health Plan

**BlueChoice<sup>®</sup>**

- Business Advantage
- CarolinaADVANTAGE

**BlueCross Total<sup>SM</sup> Medicare Advantage**

**Blue Secure Dental**

**Federal Employee Program (FEP)**

- Medical
  - Basic
  - Standard
- Federal Employees Dental and Vision Insurance Program (FEDVIP)
  - BCBS FEP Dental


**SC Public Employee Benefit Authority (PEBA)**

- State Dental
- State Dental Plus


**BCBS Dental GRID/GRID+**

**Companion Life Dental**


# Commercial Plans - Examples of ID Cards

 <b>South Carolina</b>	
SUBSCRIBER'S FIRST NAME _____ SUBSCRIBER'S LAST NAME _____	
Member ID <b>XXX123614046483</b>	
PLAN <b>DENTAL</b>	PLAN CODE <b>380</b>
_____ _____	
<a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a>	


  

 <b>South Carolina</b>	
<a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a> Customer Service: 1-800-922-1185	
BlueCross BlueShield of South Carolina P.O. Box 6000 Greenville, SC 29606-6000 An independent licensee of the Blue Cross and Blue Shield Association.	
DB	

**Dental only.**

 <b>South Carolina</b>	
SUBSCRIBER'S FIRST NAME _____ SUBSCRIBER'S LAST NAME _____	
Member ID <b>XXX123456789012</b>	
RxBIN <b>021684</b>	RxGRP <b>BXMN</b>
MAMMOGRAPHY NETWORK _____ _____	
_____ _____	
<a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a>	

 <b>South Carolina</b>	
<a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a> Customer Service: XXX-XXX-XXXX Dental Customer Service: XXX-XXX-XXXX PPO Network Providers: 800-810-2583 Essential Advocate™: 855-638-5839 Precertification: 800-334-7287 Mental Health and Substance Abuse Precertification: 800-869-1032 EyeMed: 866-939-3633 Pharmacy Help Desk: 855-811-2218 Buy and Bill Drugs - Precertification: 877-440-0089	
Providers: File claims with the local BlueCross and/or BlueShield Plan where member received services. Preauthorization required for some hospital outpatient procedures and all hospital inpatient admissions. MRI/MRA/PET/CT and radiation oncology therapy will require authorization to ensure benefit payment. "Buy and Bill" specialty drugs require precertification for benefit payment consideration.	
Report all emergency admissions within 24 hours.	
Medical & Dental - Please submit claims to: P.O. Box 100300, Columbia, SC 29202	
_____ _____	
An independent licensee of the Blue Cross and Blue Shield Association.	
MXX	

**Medical and dental.**

# Commercial Plans - Overview of Coverage

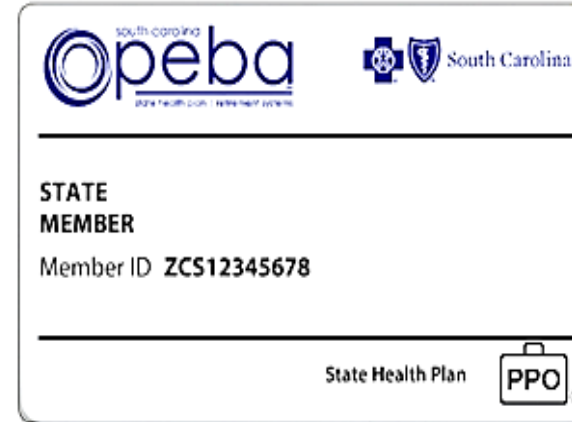
- ❑ There are some dental plans that use a network of participating providers, while other plans do not.
  - Members are always encouraged to select in-network providers.
    - Members that use out-of-network providers will be responsible for all charges exceeding the schedule of dental allowances
- ❑ Coverage levels include:
  - Preventive care
  - Restorative care
  - Major restorative care
  - Implant services (coverage varies per plan)
  - Orthodontic care (coverage varies per plan)

# State Basic Dental Plan

- ❑ SC Public Employee Benefit Association (PEBA) uses BlueCross BlueShield of South Carolina as an administrator for their dental plans.
- ❑ Benefits are divided into four classes:
  1. Diagnostic and preventive services
  2. Basic dental services
  3. Prosthodontics
  4. Orthodontics

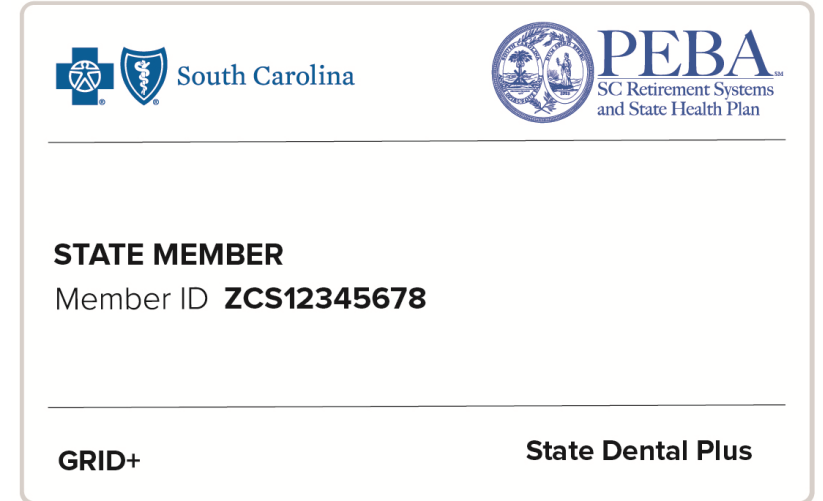
**Note: A \$1,000 benefit period maximum applies to classes 1-3.**

- ❑ Covered services are paid based on its schedule of dental procedures and allowable charges.
- ❑ As of Jan. 1, 2024, State Dental and Dental Plus no longer apply the alternate benefit for codes D2391 – D2394.



# State Dental Plus Plan



- ❑ Members with the Dental Plus plan will have ***State Dental Plus*** on their ID card.
- ❑ Dental Plus is a supplement to the Basic Dental plan and provides an additional \$1,000 benefit period maximum for classes 1-3.
- ❑ Dental Plus provides a higher level of reimbursement for services that the Basic Dental plan covers.
  - Reimbursement is based on the commercial negotiated rate with BlueCross BlueShield of South Carolina.
- ❑ Dental Plus members utilize the BlueCross BlueShield of South Carolina Network for in-network benefits.






# Federal Employee Program - Basic Option Plan

- ❑ Members have a \$35 copay for evaluations. If members have Medicare Part B or a FEDVIP plan, the FEDVIP plan pays the \$35 copay.
- ❑ FEP pays any balance up to the BlueCross Preferred Blue Participating Dental allowance.
- ❑ Basic members must use preferred dentists to receive benefits.
- ❑ If a service is not covered by FEP Basic, in-network providers can charge their usual and customary charge.

 <b>BlueCross BlueShield</b> Federal Employee Program.		Government-Wide Service Benefit Plan	
Member Name	<a href="http://www.fepblue.org">www.fepblue.org</a>		
Member ID	<b>R99999999</b>		
Enrollment Code	<b>112</b>	RxIIN	<b>610239</b>
Effective Date	<b>01/01/2008</b>	RxPCN	<b>FEPRX</b>
		RxGrp	<b>65006500</b>

 <b>BlueCross BlueShield</b> Federal Employee Program.		<a href="http://www.fepblue.org">www.fepblue.org</a>
<small>This card is used to obtain covered benefits under the Blue Cross and Blue Shield Service Benefit Plan (Basic Option). You MUST use Preferred providers to get benefits.</small>		
Customer Service:	<b>1-800-522-5566</b>	
Pre-certification:	<b>1-800-255-2042</b>	
Mental Health/ Substance Abuse:	<b>1-800-554-9504</b>	
Retail Pharmacy:	<b>1-800-626-5060</b>	
Blue Health Connection:	<b>1-888-258-3432</b>	
Assistance Overseas (Call collect):	<b>1-804-673-1678</b>	
<small>Pre-certification is required for all hospital admissions and is ultimately your responsibility. Benefits are reduced by \$500 if pre-certification is not obtained. For instructions, call the local Blue Cross and Blue Shield Plan serving the area where you are treated. In some areas, preferred hospitals will obtain pre-certification for you. Certain other services require prior approval. Please consult your benefit brochure for more information.</small>		
<small>Use of this card constitutes acceptance of the terms and conditions in the Service Benefit Plan Brochure (RI 71-006) for the applicable contract year, which is the only legal description of benefits.</small>		
<b>BlueCross and BlueShield of Geography</b> An independent licensee of the BlueCross and BlueShield Association.		

# Federal Employee Program - Basic Option Plan (Continued)

Covered Service	FEP Pays	Member Pays
<b>Clinical Oral Evaluations</b>		
Periodic oral evaluation*		
Limited oral evaluation		
Comprehensive oral evaluation*		
*Benefits are limited to a combined total of two evaluations per person per calendar year		
<b>Diagnostic Imaging</b>		
Intraoral - complete series including bitewings (limited to one complete series every three years)	Preferred: All charges in excess of member's \$35 copayment	Preferred: \$35 copayment per evaluation
<b>Preventive</b>		
Prophylaxis - adult (up to two per calendar year)	Participating/Non-participating: Nothing	Participating/Non-participating: Member pays all charges
Prophylaxis - child (up to two per calendar year)		
Topical application of fluoride or fluoride varnish - for children only (up to two per calendar year)		
Sealant - per tooth, first and second molars only (once per tooth for children up to age 16 only)		
<b>Not covered: Any service not specifically listed above</b>	Nothing	All charges

# Federal Employee Program - Standard Option Plan

- ❑ Members have no deductibles, copays or coinsurance.
- ❑ Members pay the difference between the fee schedule amount and the BlueCross Participating Dental allowance while using preferred dentists.
  - When using non-preferred dentists, members pay all charges in excess of the listed fee schedule.
- ❑ If a service is not covered by FEP Standard, both in and out-of-network providers can charge their usual and customary charge.

 <b>BlueCross BlueShield</b> Federal Employee Program.	Government-Wide Service Benefit Plan		<a href="http://www.fepblue.org">www.fepblue.org</a>
Member Name <b>Member Name</b>	<a href="http://www.fepblue.org">www.fepblue.org</a>		
Member ID <b>R99999999</b>			
Enrollment Code <b>104</b>	RxIIN <b>610239</b>		
Effective Date <b>01/01/2008</b>	RxPCN <b>FEPRX</b>		
	RxGrp <b>65006500</b>		

 <b>BlueCross BlueShield</b> Federal Employee Program.	<a href="http://www.fepblue.org">www.fepblue.org</a>
<small>This card is used to obtain covered benefits under the Blue Cross and Blue Shield Service Benefit Plan Basic Option. You MUST use Preferred providers to get benefits.</small>	Customer Service: <b>1-800-522-5566</b>
<small>Preauthorization is required for all hospital admissions and is ultimately your responsibility. Benefits are reduced by \$500 if preauthorization is not obtained. For instructions, call the local Blue Cross and Blue Shield Plan serving the area where you are treated. In some areas, Preferred hospitals will obtain preauthorization for you. Certain other services require prior approval. Please consult your benefit brochure for more information.</small>	Preauthorization: <b>1-800-255-2042</b>
<small>Use of this card constitutes acceptance of the terms and conditions in the Service Benefit Plan Brochure (R 71-005) for the applicable contract year, which is the only legal description of benefits.</small>	Mental Health/ Substance Abuse: <b>1-800-554-9504</b>
	Retail Pharmacy: <b>1-800-626-5060</b>
	Blue Health Connection: <b>1-888-258-3432</b>
	Assistance Overseas iCall collect: <b>1-804-673-1678</b>
	<b>BlueCross and BlueShield of Geography</b> An independent licensee of the BlueCross and BlueShield Association.

# Federal Employee Program - Standard Option Plan (Continued)

Covered Service	FEP Pays		Member Pays
	To Age 13	Age 13 and Over	
<b>Clinical Oral Evaluations</b>			<p>In Network The difference between the amounts listed to the left and the BlueCross Participating Dental Allowance</p> <p>Out of Network All charges in excess of the scheduled amounts listed to the left.</p>
Periodic oral evaluation (up to two per person per calendar year)	\$12	\$8	
Limited oral evaluation	\$14	\$9	
Comprehensive oral evaluation	\$14	\$9	
Detailed and extensive oral evaluation	\$14	\$9	
<b>Diagnostic Imaging</b>			
Intraoral complete series	\$36	\$22	
<b>Palliative Treatment</b>			
Palliative treatment of dental pain - minor procedure	\$24	\$15	
Protective restoration	\$24	\$15	
<b>Preventive</b>			
Prophylaxis - adult (up to 2 per person per calendar year)	---	\$16	
Prophylaxis - child (up to 2 per person per calendar year)	\$22	\$14	
Topical application of fluoride or fluoride varnish (up to two per person per calendar year)	\$13	\$8	
<b>Not covered: Any service not specifically listed above</b>	Nothing	Nothing	All charges

# Federal Employee Program - Blue Focus Plan

- ❑ Members with a Blue Focus plan do not have dental benefits directly with their plan.
- ❑ Members would need BCBS FEP Dental or another Federal Employees Dental and Vision Insurance Program (FEDVIP) for dental benefits.
- ❑ Claims would need to be filed directly to the FEDVIP plan.



BlueCross BlueShield Federal Employee Program. FEP Blue Focus. www.fepblue.org

Member Name: \*\* OC - DO NOT MAIL \*\* \*\* 0  
Member ID: R00010044

Enrollment Code: 131 Effective Date: 01/01/2012  
RxIDN: 619239 RxPCN: FEPROX RxGrp: 05000500



BlueCross BlueShield Federal Employee Program. www.fepblue.org

Customer Service: 1-800-000-0000  
1-800-000-0000  
Preauthorization: 1-800-000-0000  
Mental Health/Substance Abuse Preauthorization: 1-800-000-0000  
Retail Pharmacy: 1-800-624-5060  
Assistance Overseas (Call Collect): 1-804-673-1678  
Blue Health Connection: 1-888-258-3432

Preauthorization is required for all hospital admissions and is ultimately your responsibility. Benefits are reduced by \$500 if preauthorization is not obtained. For instructions, call the local Blue Cross and Blue Shield Plan serving the area where you are treated. In some areas, Preferred hospitals will obtain preauthorization for you. Certain other services require prior approval. Please consult your benefit brochure for more information.

Use of this card constitutes acceptance of the terms and conditions in the Service Benefits Plan Brochure (R 71-009) for the applicable contract year, which is the only legal description of benefits.

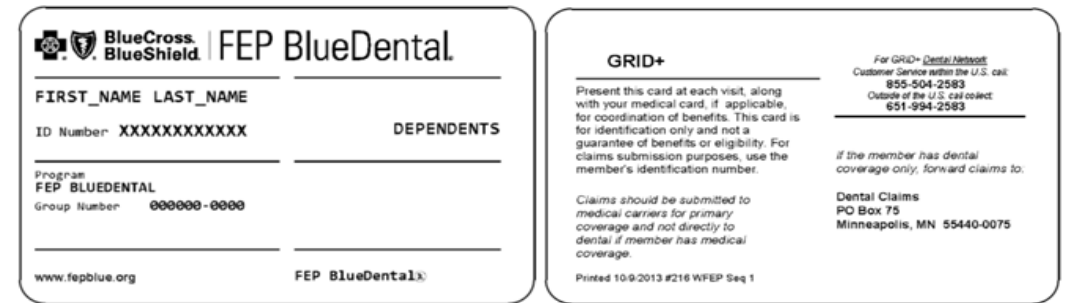
BlueCross and BlueShield of Georgia  
An Independent licensee of the BlueCross and BlueShield Association.

# Federal Employee Program - Blue Cross Blue Shield FEP Plan

- ❑ Members covered by FEP Basic Option medical plan and BCBS FEP Dental will not be responsible for the annual deductible when using an in-network provider.
- ❑ In accordance with Federal law, always file medical first if the member has dental benefits under their medical plan.
- ❑ As of Jan. 1, 2024, FEP Dental covers:
  - Two routine oral exams and one additional exam if a problem occurs between check ups.
  - Nitrous oxide for children aged 5 and under, and other individuals with medical conditions that may require it.



Sample of new BCBS FEP Dental ID Card



Sample of old FEP BlueDental ID Card

*Note: Existing members may have an ID card with the previous name, FEP BlueDental listed (as seen in the samples). New ID cards were not issued to existing members.*

# Federal Employee Program - Blue Cross Blue Shield FEP Plan (Continued)

	High Option		Standard Option	
	In-network	Out-of-network	In-network	Out-of-network
<b>Class A (Basic) services</b> (e.g., exams, cleanings, x-rays, sealants)	\$0	10% COINS	\$0	40% COINS
<b>Class B (Intermediate) services</b> (e.g., oral surgery, fillings, gum scaling)	30% COINS	40% COINS	45% COINS	60% COINS
<b>Class C (Major) services</b> (e.g., crowns, bridges, root canals, dentures)	50% COINS	60% COINS	65% COINS	80% COINS
<b>Class D (Orthodontics) services</b> (Adults and children)	50% COINS up to \$3,500 lifetime maximum per person	50% COINS up to \$3,500 lifetime maximum per person	50% COINS up to \$2,500 lifetime maximum per person	50% COINS up to \$1,250 lifetime maximum per person
<b>Annual Deductible</b> <b>Class A, B and C services</b> (Does not include Class D services)	\$0	\$50 per person	\$0	\$75 per person
<b>Annual Maximum</b> <b>Class A, B and C services</b> (Does not include Class D services)	Unlimited	\$3,000 per person	\$1,500 per person	\$750 per person

# Medicare Advantage: BlueCross Total, Blue Basic and Total Value

	BlueCross PPO Dental Benefit Highlights			
	Service	In-Network	Visits (per year)	Out-of-Network
Preventive Dental	Oral exams Cleanings	\$0	2	50% COINS
	Dental x-rays	\$0	1	50% COINS
Comprehensive Dental* (Non-Medicare covered services)	Restorative      Anesthesia Endodontics      Other oral/maxillofacial surgery Extractions      Other services (e.g., deep cleanings, fillings, Prosthodontics      Crowns, root canal, dentures, bridges) <b>Note: Implants are not covered.</b>			50% COINS (INN and OON)
Annual Maximum (Per member, per year)	BlueCross Total <sup>SM</sup> : <b>\$4,500</b> (Comprehensive and preventive combined) Total Value <sup>SM</sup> : <b>\$3,500</b> (Comprehensive and preventive combined) Blue Basic <sup>SM</sup> : <b>\$3,000</b> (Comprehensive and preventive combined)			

\*SC Blue Dental Network



# Blue Secure - Members 19 and Older

	Blue Secure Dental Gold 1		Blue Secure Dental Silver 1	
Member Age	19 or older			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$50 Individual and \$150 Family		\$50 Individual and \$150 Family	
Annual Maximum (Coverage limit)	\$1,500		\$1,000	
Class I - Preventive Procedures and Exams	0% COINS	20% COINS	0% COINS	30% COINS
Class II - Basic and Restorative*	30% COINS (after six months)	50% COINS (after six months)	50% COINS (after six months)	70% COINS (after six months)
Class III - Major Procedures**	50% COINS (after 12 months)	70% COINS (after 12 months)	70% COINS (after 12 months)	Not covered
Class IV - Orthodontia Services	Not covered			
Maximum Out-of-Pocket	N/A			

\* 6 month waiting period | \*\* 12 month waiting period

# Blue Secure - Members Under 19



	Blue Secure Dental Gold 1		Blue Secure Dental Silver 1	
Member Age	Under 19 years old			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$50 per child	\$100 per child	\$50 per child	\$100 per child
Annual Maximum (Coverage limit)	No limit			
Class I - Preventive Procedures and Exams	0% COINS	20% COINS	0% COINS	30% COINS
Class II - Basic and Restorative	30% COINS	50% COINS	40% COINS	60% COINS
Class III - Major Procedures	50% COINS	60% COINS	50% COINS	60% COINS
Class IV - Orthodontia Services (Prior authorization required)	50% COINS		50% COINS	
Maximum Out-of-Pocket per child	<b>\$425</b>	<b>\$850</b>	<b>\$425</b>	<b>\$850</b>
Maximum Out-of-Pocket total (All children)	<b>\$850</b>	<b>\$1,700</b>	<b>\$850</b>	<b>\$1,700</b>


# Dental GRID



# Overview of Dental GRID

- ❑ Dental GRID allows dentists to see members from other participating BlueCross BlueShield plans at the local plan's reimbursement levels.
- ❑ Our participating providers' reimbursement levels or provider agreements will not change when treating GRID members.
- ❑ Members in this program can be recognized by the work **GRID** or **GRID+** on their ID card.

	
SUBSCRIBER'S FIRST NAME _____	
SUBSCRIBER'S LAST NAME _____	
Member ID XXX123456789012	
RxBIN	021684
RxGRP	BXMN
MAMMOGRAPHY NETWORK _____	
GRID+	
www.SouthCarolinaBlues.com	
	

	
www.SouthCarolinaBlues.com	
Providers: File claims with the local BlueCross and/or BlueShield Plan where member received services. Preauthorization required for some hospital outpatient procedures and all hospital inpatient admissions. MRI/MRA/PET/CT and radiation oncology therapy will require authorization to ensure benefit payment. "Buy and Bill" specialty drugs require precertification for benefit payment consideration.	Customer Service: XXX-XXX-XXXX Dental Customer Service: XXX-XXX-XXXX PPO Network Providers: 800-810-2583 Essential Advocate™: 855-638-5839 Precertification: 800-334-7287 Mental Health and Substance Abuse Precertification: 800-868-1032 Eyelid: 866-939-3633 Pharmacy Help Desk: 855-811-2218 Buy and Bill Drugs - Precertification: 877-440-0089
Report all emergency admissions within 24 hours.	
Medical & Dental - Please submit claims to: P.O. Box 100300, Columbia, SC 29202	An independent licensee of the Blue Cross and Blue Shield Association.
MOX	

Sample Commercial - Medical and Dental ID Card

# GRID Participating Plans

<b>Anthem Insurance Companies, Inc.</b>		
Anthem Blue Cross of California	Anthem Blue Cross and Blue Shield of Colorado	Anthem Blue Cross and Blue Shield of Connecticut
Blue Cross and Blue Shield of Georgia	Anthem Blue Cross and Blue Shield of Indiana	Anthem Blue Cross and Blue Shield of Kentucky
Anthem Blue Cross and Blue Shield of Maine	Anthem Blue Cross and Blue Shield of Missouri	Anthem Blue Cross and Blue Shield of Nevada
Anthem Blue Cross and Blue Shield of New Hampshire	Empire Blue Cross and Blue Shield of New York	Anthem Blue Cross and Blue Shield of Ohio
Anthem Blue Cross and Blue Shield of Virginia	Anthem Blue Cross and Blue Shield of Wisconsin	
<b>Health Care Service Corporation (HCSC)</b>		
Blue Cross and Blue Shield Illinois	Blue Cross and Blue Shield Montana	Blue Cross and Blue Shield New Mexico
Blue Cross and Blue Shield Oklahoma	Blue Cross and Blue Shield Texas	
<b>Other</b>		
Blue Cross and Blue Shield of Arizona	Blue Cross and Blue Shield of Kansas	Blue Cross and Blue Shield of Kansas City
Blue Cross and Blue Shield of Massachusetts	Blue Cross and Blue Shield of Nebraska	Blue Cross and Blue Shield of Vermont (CBA Blue)
BlueCross BlueShield of North Carolina	BlueCross BlueShield of Tennessee	BlueCross of Idaho
BlueCross & BlueShield of Western/ BlueShield of Northeastern New York	Capital Blue Cross (Central PA)	CareFirst Blue Cross and Blue Shield (Maryland/District of Columbia)
Excellus BlueCross BlueShield (Rochester NY)	Horizon Blue Cross and Blue Shield of New Jersey	Wellmark Blue Cross and Blue Shield of Iowa

# Dental Benefits and Claims



# Verifying Eligibility and Benefits

Plan	My Insurance Manager <sup>SM</sup>	Provider Services
Commercial Dental Plans	Yes	800-222-7156 (Columbia center) 800-922-1185 (Greenville center)
State Basic Dental and Dental Plus	Yes	888-214-6230 803-264-3702 (Columbia area)
BCBS FEP Dental	Yes	855-504-2583
FEP Dental (Medical)	No	800-444-4325
BlueCross Total, Total Value and Blue Basic (Medicare Advantage Dental)	Yes	800-222-7156
Companion Life Dental	No	800-765-9603 or 800-753-0404, ext. 45921

# Filing Dental Claims Under the Medical Benefit

- ❑ For ***State dental plans***, the following codes should always be filed to State medical first:
  - Impacted teeth
    - D7220-D7251
  - Other surgical procedures
    - D7260, D7261, D7285, D7286
  - Excision or lesions
    - D7410-D7415
  - Remove of tumors, cysts, and neoplasms
    - D7440-D7465
  - Excision of bone tissue
    - D7471-D7490
- ❑ For ***BCBS FEP Dental***, always file claims to the medical plan first if the member has dental benefits under their medical plan.
- ❑ Use an 837P format with the accurate diagnosis code when rendering oral surgical services under State dental and other health plans.



# Filing Orthodontic Claims Electronically

- ❑ Submit one line with banding fee code (D8080-D8090) and the charge.
- ❑ Submit one line with the monthly adjustment code (D8670), the total months of treatment, and the total charge.
  - Do not file the claim each month
    - Payments are automatically sent until one or more of the following apply:
      - The patient exhausts his or her lifetime benefit maximum
      - The patient's dental coverage is terminated
      - The patient reaches the maximum age allowed for services under his or her policy
  - ***For a transfer care***, submit one line with the monthly adjustment code, total months of the remaining treatment, and the total remaining charge.

# General Guidelines for Filing Dental Claims

Dental Plan	Claims Filing Procedures
<b>Commercial and Medicare Advantage</b>	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. If applicable, mail paper claims to the mailing address on the back of the member's ID card. Timely filing varies. Verify when checking eligibility and benefits.
<b>Dental GRID</b>	Send claims to the mailing address on the member's ID card.
<b>BCBS FEP Dental</b>	Submit all claims to the member's primary medical plan first. See the member's medical ID card for submission. Timely filing is December 31 of the year following the year of service.
<b>State Basic Dental and State Dental Plus</b>	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. Timely filing is 24 months from date of service. Do not file a separate claim for Dental Plus members.

# National Electronic Attachment



Get Paid Faster! Use *FastAttach*™  
Electronic Claim Attachments.

## What is *FastAttach*?

*FastAttach* from NEA Powered by Vyne® is a compliant, HITRUST CSF Certified solution for submitting electronic claim attachments and supporting documentation required for claim adjudication. *FastAttach* eliminates manual, paper-based processes related to requests for supporting claim documentation and enhances denial tracking for dental providers. Say "goodbye" to claim processing delays and get reimbursements flowing with *FastAttach*.

Improve claim adjudication times by electronically transmitting:

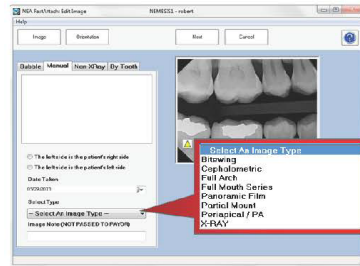
- X-rays
- Perio charts
- EOBs
- Narratives
- Pre-treatment estimates
- Secondary insurance information
- Any other documentation required to adjudicate a dental claim.

It automatically populates claim data eliminating the need for time consuming manual data entry. *FastAttach* is an encrypted, Internet based software and meets industry security requirements. Additionally, *FastAttach* interfaces with most major dental practice management systems and clearinghouses to further streamline your practice's workflow.

## How does *FastAttach* work?

*FastAttach* is easy to setup and use. Once a request is received for additional documentation, the user simply needs to import, upload, scan or capture the image and attach it to the electronic request. *FastAttach* supports the widest variety of image acquisition

methods in the industry including: screen capture, file import, scanner and secure mobile device capture through our patented *FastKapture* app for iOS® and Android®.



Easily attach X-rays or other required supporting documentation.

Once the image is captured in *FastAttach*, the user simply transmits the image to the NEA repository. NEA immediately sends a report back to the practice with an NEA Attachment Tracking Number for each file. The user places the NEA Tracking Number in the remarks or NTE section of the claim and sends the claim electronically through their claims clearinghouse.

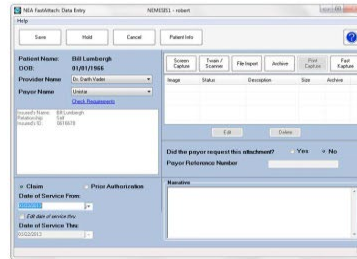
## Easy to Use & Access

- Simple, easy to read screens
- Minimal training required
- 24/7 secure, online access to your images
- Enables image sharing with other providers
- Works well for solo offices, multiple locations, multi-specialty clinics and more



Take advantage of the **BCBS South Carolina Promo**.  
Mention code: **BCBSSCRZ2M** & get **TWO months FREE**, plus \$0 Registration - a \$278 savings.  
*Expires 1/31/2020*

Call today to get started: 800.782.5150, option 2 | [nea-fast.com](http://nea-fast.com)



The Data Entry screen provides a simple interface for completing all of the attachment requirements.

## Unparalleled Customer Service

- UNLIMITED FREE customer service and support
- Online chat support tool
- Experienced, knowledgeable support staff
- Refresher training for staff at no additional cost

## Get Started Fast

- Minimal up-front costs - low monthly fee
- Rapid implementation (most take <1 hour)
- Compatible with most dental practice management systems and clearinghouses

## Easily view payer requirements

The *FastAttach* subscription also includes *FastLook*, an integrated solution that provides individual payer attachment requirements for claims adjudication. With *FastLook*, providers can search by payer name and procedure code to determine if an attachment needs to be sent and if so, the exact parameters of what needs to be sent. Knowing this up-front eliminates the hassle of sending unnecessary attachments and saves time.

## Communicate with Confidence Using Vyne Connect Encrypted Email

Did you know that sending emails that contain Protected Health Information (PHI) without using an encrypted email service to do so, could put you at risk for HIPAA violations and could even make your business a prime target for a cybersecurity breach?

NEA is attuned to your compliance needs. That's why every *FastAttach* subscription also includes access to our exclusive **Vyne Connect** encrypted email service. Improve the security of communications you send patients, payers and other providers by using Vyne Connect encrypted email exchange. It's simple to use and works with your existing email service, so no need to setup new email accounts. **Contact NEA to learn more - 800-782-5150, NEA option 2.**

Start sending **unlimited claim attachments electronically** to over 750 dental plans and payers with *FastAttach* and get the exclusive **Vyne Connect encrypted email service** - all for only **\$39 per month per office location\***!

Call or register online now and **save \$278** with promo code **BCBSSCRZ2M** at: (800) 782-5150, opt. 2 or [www.nea-fast.com](http://www.nea-fast.com).

\*Each dental practice office location submitting claim attachments is required to have its own *FastAttach* subscription and NEA Facility ID. Separate registration is required for each office location. Offices wishing to register more than one location, please contact NEA Sales for registration assistance. Vyne Connect email service includes up to 5 email accounts/addresses per NEA Facility ID. Monthly fees begin after any promotional period expires. Monthly service may be cancelled at any time.

100 Ashford Center North, Suite 300, Dunwoody, GA 30338 | 800.782.5150 | [nea-fast.com](http://nea-fast.com)

NEA-VYNE-FA-OVERVIEW-PROMOS-021919

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Note: All dental plans use the NEA except FEP.



# 2025 Coding Updates



# New Dental Codes

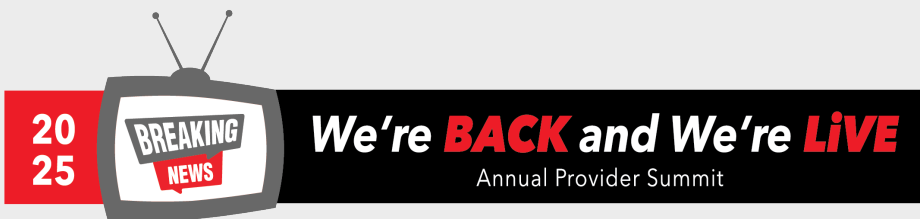
Code	Description
D2956	Removal of an indirect restoration on a natural tooth
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments
D6193	Replacement of an implant screw
D8091	Comprehensive orthodontic treatment with orthognathic surgery
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery
D9913	Administration of neuromodulators
D9914	Administration of dermal fillers
D9959	Unspecified sleep apnea services procedure, by report

**Note: Verify eligibility and benefits prior to rendering services.**

# Deleted Dental Codes

Code	Description
D2941	Interim therapeutic restoration
D6180	Repair implant abutment, by report

# Pharmacy



# Agenda

- Formulary Updates
  - Commercial (BlueCross and BlueChoice® HealthPlan)
    - Lowest Net Cost (LNC) Formulary
    - Premium Formulary
  - Exchange
  - Medicare
  - Healthy Blue<sup>SM</sup>



# Formulary Updates



# Commercial Plans



# Commercial

*Lowest Net Cost Formulary Updates*



# Lowest Net Cost Formulary Updates

## Additions

□ Beginning Jan. 1, 2025, the following drugs will be added.

Product	Formulary Status
EOHILLIA *#	Non-preferred Brand
REZDIFFRA *	Non-preferred Specialty
WINREVAIR *#	Non-preferred Specialty
ALYGLO *	Non-preferred Specialty
VOYDEYA *#	Non-preferred Specialty
MEIBO *	Preferred Brand
CEQUA *	Non-preferred Brand
TYRVAYA *	Non-preferred Brand

*\*Requires Prior Authorization*

*# Quantity limit applies*

# Lowest Net Cost Formulary Updates (Continued)

## Exclusions

- Beginning Jan. 1, 2025, the following drugs will be moved to non-formulary status.
- The products listed have alternatives on the formulary, many times, at a lower cost to the member.
  - Some covered alternatives may require prior authorization.

Product	Formulary Status
RIVFLOZA INJ	Non-formulary
ZYMFENTRA	Non-formulary
DUVYZAT	Non-formulary
OPSYNVI	Non-formulary

# Lowest Net Cost Formulary Updates (Continued)

## Prior Authorization

- Beginning Jan. 1, 2025, **XIIDRA OPTHALMIC DROPS** will require prior authorization.

## Quantity Limits

- Beginning Jan. 1, 2025, the following drugs will be moved to non-formulary status.

Product	Quantity Limit
ZYMFENTRA*	2 Syringe per 28
DUVYZAT *	420ml/30 days
FILSUVEZ *	19 tubes/30 days
OPSYNVI *	1 tab/day

\*Non-formulary

## Tier Changes

- Beginning Jan. 1, 2025, **WAKIX** will have an updated tier placement and will move from non-preferred brand to non-preferred specialty.
- Prior authorization will still be required.

# Lowest Net Cost Formulary Updates (Continued)

## Humira Biosimilar Update

- ❑ Beginning Jan. 1, 2025, Humira (brand) will be removed from the Lowest Net Cost Formulary. Adalimumab biosimilars will replace Humira as preferred products.
- ❑ This new biosimilar strategy provides continued quality of care for patients, guaranteed supply, availability of high-concentration doses, and affordability for patients, including manufacturer copay assistance programs and significant cost reduction.

High Concentration	Low Concentration
<b><u>Amjevita by Nuvaila (Low WAC)</u></b> 20mg/0.2mL 40mg/0.4mL 80mg/0.8mL	<b><u>Hadlima</u></b> 40mb/0.8mL

- ❑ Providers should send new prescriptions for one of the preferred biosimilar products to a network Specialty Pharmacy.
- ❑ Existing utilizers will have active prior authorizations pre-loaded for biosimilars.

# Commercial

*Premium Formulary Updates*





# Premium Formulary Updates

## Additions

- Beginning Jan. 1, 2025, the following drugs will be added.

Product	Formulary Status
CUTAQUIG	Non-preferred
PANZYGA	Non-preferred

## Exclusions

- Beginning Jan. 1, 2025, the following drugs will be moved to non-formulary status.
- The products listed have alternatives on the formulary, many times, at a lower cost to the member.
  - Some covered alternatives may require prior authorization.

Product	Formulary Status	Product	Formulary Status
VELPHORO	Non-formulary	HYRIMOZ	Non-formulary
VICTOZA	Non-formulary	ADALIM-ADBIM	Non-formulary
HUMIRA	Non-formulary	CYLTEZO	Non-formulary
ADALIM-ADAZ	Non-formulary	AMJEVITA (specific NDCs)	Non-formulary

# Premium Formulary Updates (Continued)

## Prior Authorization

- Beginning Jan. 1, 2025, the following drugs will require prior authorization and are excluded on the premium formulary.

Product	Formulary Status
WINREVAIR	Excluded
IQIRVO	Excluded
KISUNLA	Excluded

## Step Therapy

- Beginning Jan. 1, 2025, the following drugs will require a step therapy added or updated.

Therapeutic Class	Step 2 Drugs (Requires trial)	Step 1 Drugs
ANTI-INFECTIVES	MONDOXYNE NL AVIDOXY	Anyone one of the following generics: doxycycline and minocycline.
OPHTHALMOLOGY	BROMFENAC	Any of the following generic ophthalmic solutions: diclofenac, flurbiprofen and ketorolac.

# Premium Formulary Updates (Continued)

## Quantity Limits

- Beginning Jan. 1, 2025, the following drugs will require prior authorization and are excluded on the premium formulary.

Product	Quantity Limit
NUZYRA	1 course per fill, 2 fills per year
FASENRA	1 syringe per 56 days
XOLAIR 75 MG	2 syringes per 28 days
XOLAIR 300 MG	4 syringes per 28 days
AUBAGIO*	1 tablet per day
AUSTEDO XR	1 tablet per day
CABOMETYX	1 tablet per day
OJJAARA*	1 tablet per day
RUBRACA*	4 tablets per day
VIZIMPRO	1 tablet per day
POMALYST	1 capsule per day
KALYDECO	2 packets per day
EVERYSOI	8mL per day
NUZYRA	1 course per fill, 2 fills per year

\*Excluded from Premium Formulary.

# Premium Formulary Updates (Continued)

## Tier Changes

□ Beginning Jan. 1, 2025, the following drugs will have an updated tier placement.

<b>Downtiers</b>	<b>Uptiers</b>
OMVOH	MULPLETA
SOTYKTU	NUTROPIN AQ
TALZ	CIMERLI

# Premium Formulary Updates (Continued)

## Humira Biosimilar Update

- ❑ Beginning Jan. 1, 2025, Humira (brand) will be removed from the Premium Formulary. Adalimumab biosimilars will replace Humira as preferred products.
- ❑ This new biosimilar strategy provides continued quality of care for patients, guaranteed supply, availability of high-concentration doses, and affordability for patients, including manufacturer copay assistance programs and significant cost reduction.

High Concentration	Low Concentration
<b><u>Amjevita by Nuvaia (Low WAC)</u></b> 20mg/0.2mL 40mg/0.4mL 80mg/0.8mL	<b><u>Amjevita by Amgen</u></b> 10mg/0.2mL 20mg/0.4mL 40mg/0.8mL

- ❑ Providers should send new prescriptions for one of the preferred biosimilar products to a network Specialty Pharmacy.
- ❑ Existing utilizers will have active prior authorizations pre-loaded for biosimilars.

# Overview of Vaccines: LNC, Premium and ACA Updates

## Influenza and RSV Vaccines

- Members of non-grandfathered groups have flu vaccine coverage for a \$0 member copay.
- Grandfathered groups can elect seasonal vaccine coverage at either a \$0 or associated plan copay.

### Covered RSV Vaccines

Abrysvo*	Beyfortus^
Arexvy**	mRESVIA+

\* Approved for those  $\geq 60$  years old and in pregnancy at 32-36 weeks

\*\* Approved for those  $\geq 50$  years old

^ Approved for neonates and up to 24 months old

+ Approved for those  $\geq 60$  years old

### Covered Flu Vaccines

Afluria Trivalent	Fluad Trivalent*
Fluarix Trivalent	Flublok Trivalent
Flucelvax Trivalent	Flulaval Trivalent
Flumist Trivalent Intranasal**	Fluzone High-Dose PF*
Fluzone Trivalent	

\* Approved for those aged 65 years and older

\*\* Approved for those aged 2-49 years.

# Exchange Plans



# Exchange Formulary Updates

	Current Formulary	2025 Broad Formulary	2025 Narrow Formulary (Blue Direction Plan)
Tier Design	<p>Tier 1: Low-Cost Generic</p> <p>Tier 2: Generic</p> <p>Tier 3: Preferred Brand</p> <p>Tier 4: Non-Preferred Drug</p> <p>Tier 5: Generic/Preferred Brand Specialty</p> <p>Tier 6: Non-Preferred Brand Specialty</p>	<p>Tier 1: Generic</p> <p>Tier 2: Preferred Brand</p> <p>Tier 3: Non-Preferred Drug</p> <p>Tier 4: Specialty</p>	<p>Tier 1: Generic</p> <p>Tier 2: Preferred Brand</p> <p>Tier 3: Non-Preferred Drug</p> <p>Tier 4: Specialty</p>
Formulary Design	Average Coverage	Broad Coverage	Narrow Coverage
Amount of Formulary Drugs	3700+	6500+	2500+
HCR \$0 Copay List (Health Care Reform)	Yes	Yes	Yes

Note: Tiers 1, 2 are being combined to **Tier 1: Generic** and Tiers 5, 6 are being combined to **Tier 4: Specialty** for 2025.



# Exchange Formulary Updates (Continued)

## Top Disrupted Products

Product	Disease Category	Type of Disruption	Formulary Alternative
Vyvanse	ADHD/Narcolepsy	Up Tier	lisdexamphetamine
Symbicort	Asthma/COPD	Up Tier	Breyna, budesonide-formoterol fumarate
Humira	Inflammatory Conditions	Removal	Amjevita
Tresiba FlexTouch	Diabetes	Removal	Toujeo Solostar
Freestyle 3 Sensor GMS	Diabetic Supplies	Removal	Dexcom
Levemir FlexPen	Diabetes	Removal	Lantus Solostar
Tivicay	HIV	Up Tier	N/A
Pulmicort Flexhaler	Asthma/COPD	Removal	Qvar
One Touch Ultra 2 Device	Diabetic Supplies	Removal	N/A
fluticasone HFA	Asthma/COPD	Removal	Qvar
Victoza	Diabetes	Removal	Liraglutide, Trulicity

Note: Members Transitioning from Current ACA Formulary to the 2025 Broad ACA Formulary.

# Exchange Formulary Updates (Continued)

## Humira Biosimilar Update

- Beginning Jan. 1, 2025, Humira (brand) will be removed from the ACA formularies. Adalimumab biosimilars will replace Humira as preferred products.

### Humira Biosimilar Coverage

#### Humira EXCLUDED

No continuation of therapy

#### Amjevita by Nuvaila

20mg/0.2mL

40mg/0.4mL

80mg/0.8mL

#### Hadlima

40mg/0.8mL

- Providers should send new prescriptions for one of the preferred biosimilar products to a network Specialty Pharmacy.
- Existing utilizers will have active prior authorizations pre-loaded for biosimilars.

# Exchange Formulary Updates (Continued)

## Prior Authorizations

- ❑ Remain active through authorization term date.
  - Members who remain on an existing plan.
- ❑ Prior authorization terms Dec. 31, 2024
  - Members who move to a new plan.
    - Individual ACA > Small Group ACA
    - Individual ACA or Small Group ACA > Blue Direction
    - Individual ACA or Small Group ACA > BlueChoice HealthPlan
  - Drugs that are excluded on the new formulary.
  - Drugs that do not require a prior authorization under new formulary.

# Exchange Formulary Updates (Continued)

## Member and Provider Communications

- ❑ Member formulary change notification letters
  - Inform members of disruption in coverage assuming they will remain on their existing plan.
  - Letters mailed:
    - Nov. 1, 2024
    - Dec. 15, 2024
    - Feb. 1, 2025
  - Letters recommend consultation with provider and formulary alternatives when appropriate.
- ❑ Member prior authorization termination notification letters
  - Mailed to the member and provider.
  - Letters began mailing Nov. 1, 2024.

# Medicare



# 2025 IRA Changes



# 2025 IRA Changes

In August 2022, the Inflation Reduction Act (IRA) was signed into law.

2025 IRA directed changes for Medicare Part D:

1. Part D Benefit structure changes from a 4-phase to 3-phase
  - Elimination of Coverage Gap Phase (often called the “Donut Hole”)
  - 3-phases: (1) Deductible, (2) Initial Coverage Limit (ICL), and (3) Catastrophic
2. **Maximum \$2,000 out-of-pocket** for Part D covered drugs
3. Implementation of Medicare Prescription Payment Plan (M3P) (i.e. Copay Smoothing)
  - Allows members the option to spread their prescription costs over monthly installments paid directly to the plan versus at the pharmacy counter

# Medicare Prescription Payment Plan





# Medicare Prescription Payment Plan (M3P)

The **Medicare Prescription Payment Plan**, originally called “copay smoothing,” is part of the Inflation Reduction Act (IRA) that was signed into law in August of 2022. The IRA includes a wide range of provisions for clean energy, tax revenues, and healthcare costs.

Nicknamed the M3P, the Medicare Prescription Payment Plan requires Medicare Part D plans to provide their members the **option** to pay for Part D prescriptions through monthly payments to their plan instead of paying at the pharmacy starting January 1, 2025.



While the IRA contains other provisions aimed at lowering prescription drug costs, the M3P **does not change** the amount that members pay for their prescriptions.

# M3P - Likely to Benefit

## Members are likely to benefit from M3P if:

- ✓ **≥ \$2,000** in out-of-pocket drug costs from January – September prior to the plan year
- ✓ **\$600** out-of-pocket costs for a single prescription claim during the plan year
- ✓ Identified through additional plan-defined strategies during the plan year

# M3P - Likely to NOT Benefit

## Members are NOT likely to benefit from M3P if:

- ✘ Yearly drug costs are low.
- ✘ Drug costs are the same each month.
- ✘ Members who sign up late in the calendar year (after September).
- ✘ Don't want to change how you pay for your drugs.
- ✘ Get or are eligible for Extra Help from Medicare.
- ✘ Get or are eligible for a Medicare Savings Program.
- ✘ Get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP), a coupon program, or other health coverage.

# 2025 Medicare Advantage Plan and Formulary Changes



# 2025 Medicare Advantage Plan and Formulary Changes

## Important Reminders:

- ❑ All members should review their Annual Notice of Change (ANOC) that were mailed.
- ❑ Members experiencing disruption from the 2025 changes may receive additional communication via:
  - Letters
  - Call campaigns
  - Text messages
- ❑ Humira remains on formulary for 2025

Drug Name	Formulary Information
Humira	Tier 5, PA, QL
Adalimumab-ADBIM	Tier 5, PA, QL
Adalimumab-AATY	Tier 5, PA, QL

PA: Prior Authorization | QL: Quantity Limit

# Medicare Advantage Medication Adherence

- ❑ Prioritize 90-day supply prescriptions
- ❑ Some 90-day supply generic medications at **\$0 member cost** available for MAPD members
- ❑ Remember:
  - Insulin products have a **maximum \$35 copay**
  - GLP-1 products are not insulin
  - CMS still **excludes treatment for weight loss** from Part D coverage



Sample list 90-day supply products at **\$0 cost** for MAPD members:

- Alendronate
- Atorvastatin
- Glipizide
- Lisinopril
- Losartan
- Metformin / Metformin ER
- Pioglitazone
- Pravastatin
- Rosuvastatin
- Simvastatin
- Valsartan

# Medicare Pharmacy Resources

- ❑ MA (MAPD) Customer Service: **1-855-204-2744**
  - Now through March 31, we are available from 8 a.m. to 8 p.m. seven days a week.
- ❑ PDP Customer Service: **1-888-645-6025**
  - Now through March 31, we are available from 8 a.m. to 8 p.m. seven days a week.
- ❑ Online Resources: [www.scbluesmedadvantage.com](http://www.scbluesmedadvantage.com)

# Healthy Blue





# Healthy Blue Formulary Updates

□ Effective Jan. 1, 2025, the following products will be changing status:

	Previous Status	New Status	Effective Date
<b>Rho Kinase Inhibitors</b>			
<b>Rhopressa® (netarsudil)</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Rocklatan® (netarsudil/latanoprost)</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Rectal Anticonvulsants</b>			
<b>Diastat Acudial® (diazepam)</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Diastat Pedi System® (diazepam)</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Diazepam rectal gel system</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Multiple Sclerosis - Oral</b>			
<b>Dalfampridine (generic for Ampyra®)</b>	PDL non-preferred	PDL preferred	Effective 1/1/2025
<b>Fingolimod (generic for Gilenya®)</b>	PDL non-preferred	PDL preferred	Effective 1/1/2025
<b>Teriflunomide (generic for Aubagio®)</b>	PDL non-preferred	PDL preferred	Effective 1/1/2025
<b>Multiple Sclerosis - Injectable</b>			
<b>Kesimpta® (ofatumumab)</b>	PDL non-preferred	PDL preferred with criteria	Effective 1/1/2025

# Healthy Blue Formulary Updates (Continued)

	Previous Status	New Status	Effective Date
<b>Hypoglycemia Agents</b>			
<b>Baqsimi® (glucagon) nasal powder</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Glucagon 1mg injection</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Glucagon 1mg emergency kit</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Gvoke Hypopen® (glucagon)</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Proglycem® (diazoxide) oral suspension</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Zegalogue® (dasiglucagon) autoinjector/syringe</b>	Non-PDL	PDL preferred	Effective 1/1/2025
<b>Glucagon emergency kit (Fresenius Kabi)</b>	Non-PDL	PDL non-preferred	Effective 1/1/2025
<b>Diazoxide suspension</b>	Non-PDL	PDL non-preferred	Effective 1/1/2025
<b>Gvoke® (glucagon) vial/syringe</b>	Non-PDL	PDL non-preferred	Effective 1/1/2025
<b>Bladder Antispasmodic</b>			
<b>Fesoterodine ER (generic for Toviaz®)</b>	PDL non-preferred	PDL preferred	Effective 1/1/2025
<b>Myrbetriq® tablet</b>	PDL non-preferred	PDL preferred	Effective 1/1/2025
<b>Toviaz® tablet</b>	PDL preferred	PDL non-preferred	Effective 1/1/2025

# Healthy Blue Pharmacy Resources

## Pharmacy Benefit

- ❑ Medications at retail, specialty and mail order pharmacies.
- ❑ Drug is self-administered.
- ❑ Use the Comprehensive Drug Lookup Tool:  
<https://client.formularynavigator.com/Search.aspx?siteCode=1404420163>

### *Prior Authorization Information - CarelonRx*

- ❑ Phone: 844-410-6890
- ❑ Fax: 844-512-9005
- ❑ ePA Portal: [Covermy meds](#)
- ❑ Review time: 24 hours

## Medical Benefit

- ❑ Drug is provider-administered in the office, infusion center, etc.
- ❑ Use the Medical Specialty Drug List:  
<https://www.healthybluesc.com/providers/pharmacy>

### *Prior Authorization Information - CVS/Novologix*

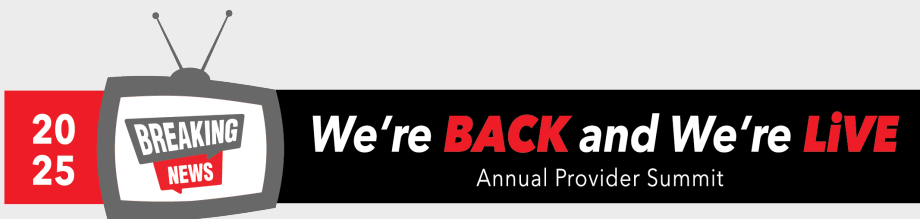
- ❑ Phone: 844-345-2803
- ❑ Fax: 866-494-9927
- ❑ Online Portal: My Insurance Manager<sup>SM</sup>
- ❑ Review time: Urgent, 72 hours; Standard, 14 days

# Healthy Blue Pharmacy Resources (Continued)

## Mail Order and Home Delivery

- ❑ Extra benefit available on most medications.
- ❑ Controlled substances are excluded.
- ❑ Up to 31-day supply or 90-day supply for certain medications.
- ❑ Phone: 833-396-0309
- ❑ Fax: 833-389-4172

# Provider Enrollment



# Topics to Discuss

- ❑ Provider Enrollment Requirements
- ❑ Overview of the Enrollment Process
- ❑ My Provider Enrollment Portal
- ❑ Completing Clean Applications
- ❑ Making Corrections to Applications
- ❑ Important Reminders
- ❑ Available Resources

# Provider Enrollment Requirements



# Provider Enrollment Applications

Application	Description
Enroll a Practitioner	New practitioners that want to enroll with BlueCross BlueShield of South Carolina.
Enroll a Group	New groups that want to enroll with BlueCross BlueShield of South Carolina.
Facility Information Request	Medical facilities that want to credential with BlueCross BlueShield of South Carolina.
Add Virtual Care	Practitioners or groups that want to render telemedicine and telehealth services.
Health Professional**	<b>In-state, out-of-network</b> practitioners that want to file claims to BlueCross BlueShield of South Carolina.
Behavioral Health**	New practitioners or groups that want to enroll in our behavioral health network.
Autism Provider Panel**	Applied behavior analysts that want to enroll in our autism provider panel.
Add a Satellite Location	<b>Enrolled groups</b> that have <b>new locations</b> that want to file claims to BlueCross BlueShield of South Carolina.
Submit a Name Change	Request to change the doing business as (DBA) name of a practice.
Change of Address	Request to update the physical, pay to, correspondence or billing agency address.
NPI Provider Notification**	<b>Out-of-state and out-of-network</b> practitioners or groups that want to register their NPI with BlueCross BlueShield of South Carolina.
Request to Add a Practitioner	Adding a practitioner's affiliation with a clinic, group or institution.
Remove a Practitioner	Terminating a practitioner's affiliation with a clinic, group or institution.

\*\*These are included with either the Enroll a Practitioner or Enroll a Group application. The responses to the questions will trigger the path the application takes.



# Provider Enrollment Checklists

## Individual Provider Enrollment

- Ancillary Providers
- Dental Providers
- Advanced Practice Providers
- Pharmacists
- Physicians and Chiropractors

## Group Practice Enrollment

- Ambulance
- Dental
- Durable Medical Equipment
- Home Health, Hospice, etc.
- Pharmacy
- Physician Office

## Other

- Behavioral Health
- In State, Out-of-Network
- Out-of-State, Out-of-Network
- Satellite Locations

Note: Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) to review the available checklists.

# Example of an Individual Enrollment Checklist

## Physicians and Chiropractors

Checklist Items
Provider Enrollment Application
Copy of SC Medical or Practice License
Drug Enforcement Administration (DEA) Certification*
Current Copy of Malpractice (Min. \$1M/\$3M)
Authorization to Bill for Services
Signed Contracts
Professional Training**
Hold Harmless***
Appendix D***
Medicaid ID Number****

\*Only if applicable.

\*\*Required for MDs, DOs and DPMs.

\*\*\*Only if applying for BlueChoice HealthPlan.

\*\*\*\*Only if applying for Healthy Blue.

# Example of a Group Practice Enrollment Checklist

## Physician Office

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts**
Medicaid ID Number*
Add Practitioner Form***

\*Only if applying for Healthy Blue.

\*\*Only for BlueChoice and Healthy Blue. All other commercial contracts are based on the individual practitioner's credentialing status.

\*\*\*For each physician being added to the group. This is under the Maintain section of the portal.

*Note: If the provider is not credentialed, you must complete a full enrollment application.*

# Overview of the Enrollment Process



# What Happens When an Application is Received

- ❑ **The provider enrollment team reviews applications to determine if they are clean and completed.**
  - Only clean applications can be sent to the Credentialing Committee for review.
    - Applications that are incomplete or missing items are sent back to the provider, and they have **21 days** to return the necessary documentation.
    - If the missing items are not received, the application will be canceled on the 28<sup>th</sup> day.
- ❑ **Applications approved by the Credentialing Committee progress through the process and are sent to contracting for review.**
  - Applications that are not approved by the Credentialing Committee are sent to the Disciplinary Committee.
    - The outcome of the review is sent to the provider.
- ❑ **Once contracting reviews and executes the contracts, the application is sent to the enrollment team to load the provider into the system.**
  - If contracts are not executed, an explanation is sent to the provider.
- ❑ **After the provider is loaded into the system, a welcome email is sent to the provider and includes the network and affiliation dates.**

# Things to Keep in Mind

- ❑ **The Credentialing Committee reviews enrollment applications to ensure all required credentialing criteria is met.**
- ❑ **Network effective dates are determined by the Credentialing Committee's approval date per the following entity requirements:**
  - Utilization Review Accreditation Commission (URAC)
  - National Committee for Quality Assurance (NCQA)
  - South Carolina Department of Health and Human Services (SCHDDS), when applicable
- ❑ **Network effective dates cannot be backdated.**
- ❑ **Affiliation dates can be backdated.**
  - Affiliation dates are used to process commercial claims.
  - Can be backdated to the earliest start date for the practitioner, but no more than Jan. 1<sup>st</sup> of the previous year.

# My Provider Enrollment Portal




# New and Improved My Provider Enrollment Portal

- ❑ Coming soon, we will release our new and improved portal.
- ❑ The enhanced portal will make your interactions with enrollment smoother, more efficient and easier to manage.
- ❑ Key features and benefits:
  - Multiple user accounts linked to one Tax ID.
  - Simplified navigation.
  - Streamlined signing process with one event.
  - Clearer “action required” notifications.
  - Better application management.
  - Enhanced application tracking.
  - Personalized role selection for a customized experience.



# Getting Started with My Provider Enrollment Portal

- ❑ Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).
  - Providers>Provider Enrollment>**Join Our Networks**
- ❑ New users should select New User from the landing page of the portal.

 South Carolina

## Login to MyPEP

Our provider enrollment portal is your one-stop-shop for submitting provider enrollment requests.

[Log in](#)


[Forgot your password?](#) [Not a member?](#)

For assistance, please contact the provider education team, [Contact Support](#)

Select "Not a member?" if you've never signed up!

# Registering

- Options include: solo practitioner, provider group and credentialing company.

 South Carolina

## MyPEP Registration

Please take a moment to create a user ID for the MyPEP portal.

\* First Name

\* Last Name

\* Email

\* Password

\* Organization you are associated with

Select Organization ▼

- Provider Group
- Solo Practitioner
- Credentialing Company

customer support.

Already have an account?

The required details will vary based on the selection made.

# My Provider Enrollment Portal - Home Page

Search...

Archie

Home Applications Enroll Maintain Support

## My Provider Enrollment Portal

### Enroll with BlueCross BlueShield of South Carolina

Enroll to BlueCross BlueShield of South Carolina and BlueChoice Health Plan

[Enrollment Options](#)

Already enrolled, but want to make changes?

**#1** Join the largest health insurer in South Carolina

**11,000+** Physicians and nearly every hospital in South Carolina

What you'll see under Applications.

- My Started Applications
- My In-Progress Applications
- My Applications Action Required
- My Closed Applications

## Thank you for your interest in joining our network

My Provider Enrollment Portal (MyPEP) is our new provider enrollment tool. It offers a web-based solution for providers who are credentialed or interested in credentialing with BlueCross BlueShield of South Carolina to complete the enrollment process.

# My Provider Enrollment Portal - Applications Page



Applications

## My Started Applications ▾

1 item • Sorted by Application ID • Filtered by My applications - Application Status



	Application ID ↑ ▾	Created Date ▾	Application Status ▾	Practitioner ▾	Practice ▾	Resume Application ▾
1	IA-0000000035	10/29/2024, 8:24 AM	In Progress			▾



## My In-Progress Applications ▾

4 items • Sorted by Case Number • Filtered by All cases - Status, Closed, Case Record Type



	Case Number ↑ ▾	Contact Name ▾	Account Name ▾	Subject ▾	Status ▾	Type ▾	Date/Time Opened ▾
1	00001038	Terrence Archie	Brown Cardiology	<a href="#">Back to Mobility - Group</a>	Submitted	Group	10/29/2024, 9:07 AM ▾
2	00001039	Terrence Archie	Brown Cardiology	<a href="#">J. Doe - Individual</a>	Signed	Individual	10/29/2024, 9:07 AM ▾
3	00001041	Terrence Archie	Brown Cardiology	<a href="#">. - Satellite Location</a>	Submitted	Satellite Location	10/29/2024, 11:07 AM ▾
4	00001042	Terrence Archie	Brown Cardiology	<a href="#">. - Business Name Change</a>	Submitted	Business Name Change	10/29/2024, 11:10 AM ▾

# My Provider Enrollment Portal - Applications Page

## My Applications Requiring Action ▾

2 items • Sorted by Case Number • Filtered by All cases - Action required, Closed, Case Record Type



	Case ... ↑ ▾	Contact Name ▾	Account Name ▾	Subject ▾	Status ▾	Type ▾	Date/Time Opened ▾
1	00001084	Terrence Archie	Brown Cardiology	<a href="#">J. Doe - Individual</a>	Submitted	Individual	11/3/2024, 9:43 AM ▾

## My Closed Applications ▾

6 items • Sorted by Case Number • Filtered by All cases - Closed, Case Record Type • Updated a minute ago



	Case Number ↑	Subject ▾	Status ▾	Provider_Contact_Name ▾
1	00001091	<a href="#">D. Doe - Individual</a>	Approved	Daisy Doe ▾
2	00027892	<a href="#">Health Core Medical &amp; Aesthetics Inc - Satellite Location</a>	Approved	▾
3	00027909	<a href="#">Health Core Medical &amp; Aesthetics Inc - Virtual Care</a>	Approved	▾
4	00027936	<a href="#">Health Core Medical &amp; Aesthetics Inc - Business Name Change</a>	Approved	▾
5	00027937	<a href="#">Health Core Medical &amp; Aesthetics Inc - Business Name Change</a>	Approved	▾
6	00027939	<a href="#">Health Core Medical &amp; Aesthetics Inc - Business Name Change</a>	Approved	▾

# My Provider Enrollment Portal - Enroll Page

Search...

Home Applications Enroll Maintain Support

Archie

**My Provider Enrollment Portal**  
Your enrollment essentials, all in one place.

## Enroll

Enrolling with BCBS-SC is easy. First, tell us what you are trying to do. Are you enrolling a group practice? Are you enrolling a practitioner? Would you like to submit a facility information request? Make your selection and we will get some additional information to determine which of our networks apply (or to proceed and register out-of-network).

### Enroll a Group

A group practice consists of more than one healthcare practitioner working together under a single organization & has an NPI (type II organization). Start here to submit a group practice enrollment application.

### Enroll a Practitioner


A healthcare practitioner is any individual offering healthcare services & with an NPI (type I individual). Every practitioner offers their services through their individual practice or within a group practice. Start here to submit an enrollment application for a practitioner.

### Facility Information Request


An organization that offers healthcare services, is not classified as a practitioner or group of practitioners, & has an NPI (type II organization), can submit a facility information request.

# My Provider Enrollment Portal - Maintain Page

Home Applications Enroll **Maintain** Support




**My Provider Enrollment Portal**  
Your enrollment essentials, all in one place.




## Maintain


Here you can submit updates and requests to manage your practice and / or providers. Select from the menu below to get started.




**Add a satellite location**  
Add a new satellite location to your profile to expand your services.




**Request to add a practitioner to practice**  
Request to add a practitioner's association with your clinic, group, professional association, or institution.




**Remove a practitioner from practice**  
Remove a practitioner's association with your clinic, group, professional association or institution.



**Change of address**  
Update your location, billing, pay to or mailing/correspondence address to ensure you receive all correspondence and notifications.



**Add virtual care**  
Add telehealth / telemedicine services to your profile to offer remote consultations and care. You must already be enrolled in BCBS networks to add this option.



**Submit a name change**  
Submit a request to change your Doing Business As (DBA) name for accurate business representation.

# My Provider Enrollment Portal - Support Page

**My Support Cases** ▾

0 items • Sorted by Case Number • Filtered by My cases - Case Record Type

⚙️ ▾

Case Num... ↑ ▾ Contact Name ▾ Subject ▾ Status ▾ Priority ▾ Date/Time ... ▾ Case Owner ... ▾

**CONTACT SUPPORT**

Available types.

Search...

Home Applications ▾ Enroll Maintain Support

**CONTACT MYPEP SUPPORT**  
TELL US HOW WE CAN HELP.

TYPE  
--None-- ▾

SUBJECT

DESCRIPTION

[Upload File](#)

**SUBMIT**

Got a technical problem? A suggestion? You've come to the right place.

We want to hear from you.

- Question: We moved some things around - let us know if you have a question. We'll get it answered, and you'll help us improve others' experience in the process.
- Feature request: Got a provider enrollment wish list? (we do, too!) Tell us what would make things easier for you - we'd love to relay the message to our tech teams.
- Login issue: Tell us if you, or anyone on your account, is having an issue logging in and we'll get to the bottom of it.
- Problem: Any other issue related to myPEP's site and navigating, this is the spot for it.
- Feedback: The good, the great, the fantastic! And anything not-so-great - we want to hear that, too, because we are always looking to improve.

Got an application question? Need help or an update?

Leave us a comment!  
We see your comments - and leaving them where we know exactly which application, practitioner, or practice you are working on makes it so that we can get you answers even faster.

Leave us a comment on your open cases and we'll get back to you as soon as possible.

- ✓ --None--
- Login Issue
- Feature Request
- Question
- Problem
- Feedback
- Access request



# My Provider Enrollment Portal - Status Details

## Submitted

The application and ***all required documents*** have been sent to BlueCross BlueShield of South Carolina for review. Note: Submitted does not mean completed.

## Preliminary Review

The application is in the first review stage to ensure it's clean.

## Awaiting Signature

The application and applicable contracts have been sent to the provider (and other designated signers) for signatures.

## Signed

The application and applicable contracts have been signed.

## Secondary Review

The application has progressed to the next review stage.

# My Provider Enrollment Portal - Status Details (Continued)

## Final Review

The application has reached the final review stage.

## Approved

The application has been approved.

## Denied

The application has been denied.

## Cancelled

The application has been cancelled.

## Withdrawn

The application has been withdrawn per the provider's request.

# Completing Clean Applications



# Steps to Submitting a Clean Application

1. Complete the enrollment application inside the portal.
2. Sign the application and contracts ***electronically***.
  - These items will be available once the enrollment team sends the documents to you and the case is in the awaiting signature status.
3. If additional items are requested, submit those as soon as possible.

# Example of an Individual Enrollment Application

Clear navigation.

### Steps

- 1 **Let's Get Started**  
Provider Identifiers  
Network pre-qualifications  
Network selection
- 2 Practitioner Information
- 3 Upload Documents
- 4 Review
- 5 Submit

## Let's Get Started

### Practitioner - What to have ready

We'll walk you through setting up a new practitioner, and ensuring they are aligned with the correct group practice or established as an individual practice.

- Provider identifiers for the practitioner**  
You'll need the practitioner's NPI Number (type I individual). You will also need the Social Security Number (SSN).
- Contact Information**  
The full name, former surname(s), phone & preferred email are all important information we collect for each practitioner.
- Demographic Information**  
In addition to capturing gender, race and ethnicity, we'll also capture the practitioner's language(s).
- Professional qualifications**  
The practitioner's care specialty, state medical license, and board certification are all required.
- Education & professional training**  
The practitioner's relevant degrees and training (including the highest degree) are required. We also require residency for MDs, DOs, & DPMs.
- Employment**  
Aside from establishing current employment for the practitioner, we collect employment history up to 5 years (which can also span to include education and professional training).
- Authorization to Bill**  
For practitioners that are part of a group practice, they will sign off for the group on their authorization to bill.

Next

Pay close attention to what's needed.

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started  
[Provider Identifiers](#)  
Network selection
- 2 Practitioner Information
- 3 Upload Documents
- 4 Review & Sign
- 5 Submit

## Provider Identifiers

To get started, we need to run a search to see if you are already in our system. For practitioners, a Social Security Number and / or NPI Number (type I individual) will help us locate the correct practitioner.

Every practitioner is associated with a practice, be it a Group Practice or Individual Practice. The practice's Tax Id Number (TIN) and / or NPI Number (type II organization) will help us locate the correct practice.

### Practitioner information

Enter the practitioner's Social Security Number (SSN) and the unique NPI Number (type I individual) to jump start this enrollment application.

\* NPI Number (type I individual)

### Practice information

Enter the practice's Tax Id Number (TIN) and NPI Number (type II organization) to identify the practice to which this practitioner is associated. Individual practices do not provide an NPI Number (type II organization); the practitioner's NPI Number (type I individual) is sufficient. If the practitioner has acquired a unique Tax Id Number (TIN), such as an EIN, it can be entered here. If the practitioner uses their SSN as the TIN for the individual practice, do not enter it here.

### Practice Type

 Individual Practice Group Practice

\* Tax Id Number (TIN)

NPI Number (type II group)



### How we protect your information ?

We use state of the art 256-bit encryption to protect your data from prying eyes. Your personal information is safe with us.

[Save for later](#)

[Previous](#)

[Next](#)



South Carolina

# Example of an Individual Enrollment Application (Continued)

### Steps

- 1 **Let's Get Started**
  - Provider Identifiers
  - [Provider search results](#)
  - Network pre-qualifications
  - Network selection
- 2 Practitioner Information
- 3 Upload Documents
- 4 Review & Sign
- 5 Submit

## Provider search results

### No Group Found

We didn't find a group practice based on the lookup criteria you entered.

We didn't find a group practice based on the lookup criteria you entered. Here are some things you'll need to have ready:

1. Location information
2. Office contacts
3. Office hours
4. EFT information
5. Accreditations
6. and more

Click *Previous* to revisit your entry information; click *Next* to start fresh and we will walk you through our enrollment application.

### How we protect your information ?

We use state of the art 256-bit encryption to protect your data from prying eyes. Your personal information is safe with us.

[Previous](#) [Next](#)

# Example of an Individual Enrollment Application (Continued)

### Steps

- 1 Let's Get Started  
Provider Identifiers  
Provider search results  
[Network pre-qualifications](#)  
Network selection
- 2 Practitioner Information
- 3 Upload Documents
- 4 Review & Sign
- 5 Submit

## Network pre-qualifications

Before we dig in, let's be sure we get aligned to the right provider networks.

**Are all of your locations in South Carolina?**

Yes  No

**Does the practice offer telehealth visits or participate in telemedicine consults?**

Yes  No

**Are you a Behavioral Health or Autism Provider?**

\*Speciality Code

**How we protect your information?**

We use state of the art 256-bit encryption to protect your data from prying eyes. Your personal information is safe with us.



# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
  - Provider Identifiers
  - Provider search results
  - Network pre-qualifications
  - [Network selection](#)
- 2 Practitioner Information
- 3 Upload Documents
- 4 Review & Sign
- 5 Submit

## Network selection

Here are the available networks that align based on what we know. Select the networks for this enrollment application.

### \* Available Networks

CBA Behavioral Health	Preferred Blue	Blue Essentials
Healthy Blue	Medicare Advantage	CBA Autism Panel
Blue Options	Blue Participating Dental	State Health Plan
BlueChoice HealthPlan		

Out of Network



### How we protect your information ?

We use state of the art 256-bit encryption to protect your data from prying eyes. Your personal information is safe with us.

Note that selecting a network does not guarantee approval; your application will be reviewed to determine eligibility.

Previous

Next

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
  - Provider Identifiers
  - Provider search results
  - Network pre-qualifications
  - Network selection
  - [Practice Information](#)
  - Business Information
- 2 Practitioner Information
- 3 Upload Documents
- 4 Review & Sign
- 5 Submit

## Practice Information

Please provide information about your primary practice. Your primary practice is the main location where you provide healthcare services.

### Primary Practice

Your primary practice is the main location where you provide healthcare services.

\* Practice Name

ABC Family

\* Tax Id Number (TIN)

00-5555555

\* NPI (type II organization)

0099999999

\* Medicaid Id

01234567890

Medicare Number

Medicare Certificate Date

\* Website

https://www.abcfamily.com

\* Office Email

abcfamily@yahoo.com

Is this practice to be included in the directory?

Yes  No



### How we protect your information?

We use state of the art 256-bit encryption to protect your data from prying eyes. Your personal information is safe with us.

Save for later

Previous

Next

# Example of an Individual Enrollment Application (Continued)

### Steps

- Let's Get Started
  - Provider Identifiers
  - Provider search results
  - Network pre-qualifications
  - Network selection
  - Practice Information
  - Business Information**
- Practitioner Information
- Upload Documents
- Review & Sign
- Submit

## Business Information

Please provide your business name, owner details.

### Business Names

- \* Legal Business Name: ABC Family
- \* Doing Business As (DBA): ABC Family
- \* Date Established: 10-01-2024

I own the business / am a business owner.  
 I have additional business owners to add.

### Business Tax Identification


\* Type: CP 575 E Tax Id Number (TIN): 005555555

### Required Document

Please upload a copy of your CP575E

#### Upload Document


Please upload a copy of the required file(s) below.



Drag and drop here, [or choose a file](#)

**Note:** You may proceed with the form and upload this document at a later time.

#### Uploaded Files

-  Business Example.docx  
Successfully uploaded

**Note:** You may proceed with the form and upload this document at a later time.

### Business License

All hospitals, institutions and other facilities must complete this section.

Business License #

Certification Date


Indicate the number of beds, excluding exempt units

### Required Document

Please upload a copy of your Business License.

#### Upload Document

Please upload a copy of the required file(s) below.



Drag and drop here, [or choose a file](#)

**Note:** You may proceed with the form and upload this document at a later time.

**Note:** You may proceed with the form and upload this document at a later time.

Save for later

Previous **Next**



# Example of an Individual Enrollment Application (Continued)

## Steps





- 1 Group Information
- 2 **Location Details**
  - Location information
  - Hours of operation
  - Electronic funds transfer (EFT)
  - Accreditations
- 3 Practitioner Information
- 4 Upload Documents
- 5 Review
- 6 Submit

## Location Details

Will we require a list of all satellite locations (that are possibly already in PIMS) or just the new satellite locations? If we are asking for the NEW satellite locations, then the verbiage needs to be updated to state NEW.

### Location - What to Have Ready

Once we've established your primary location (either existing or new), you'll have an opportunity to add new satellite locations.

-  **Location addresses**  
The physical address, as well as the billing & correspondence addresses, are necessary to complete this section.
-  **Location contacts**  
Identify the office contacts for this location for credentialing, claims, billing, and others.
-  **EFT information**  
Enter your financial institution's information so that we can quickly, efficiently process your claims. Note that you'll need a designated fiduciary contact as a signer.
-  **Accreditations**  
You'll need your accreditations as applicable, including the accrediting body, accreditation number, and the most recent assessment date.

- > What is a primary location?
- > What is a satellite location?
- > Why do I need to provide information about my primary location?



#### What you'll see...

As you move through the next pages, you'll find a side navigation menu that will guide you smoothly through each step of the process.



#### Primary Practice Location

Your main hub of operations, where the majority of your business activities take place.



#### Satellite Locations

Additional locations that help in supporting and expanding your business operations.

Pay close attention to what's needed.

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Location Details  
[Location information](#)  
Hours of operation  
Electronic funds transfer (EFT)  
Accreditations
- 3 Practitioner Information
- 4 Upload Documents
- 5 Review & Sign
- 6 Submit

## Location information

### Primary location information

Your primary location is your main hub of operations, where the majority of your business activities take place.

#### Physical Address

This is the physical address for your primary location; it is not a P.O. box.

\* Street Address

123 Main St

\* City

Columbia

\* State

South Carolina

\* Zip Code

29202

\* Appointment Phone

(803) 555-1234

After Hours Phone

Fax

Is TDD available for accessibility for the hearing impaired?

Is location handicap accessible?

Does this location have 24/7 Phone Coverage?

Please select the language services offered at this location.

- Bilingual office staff
- Dedicated language services for specific language
- Language services vendor
- Health plan
- Remote video
- Telephone

#### Office Contact

Please enter this location's main office contact. You will have the opportunity to indicate below if they serve as a contact for additional roles.

\* First Name

John

\* Last Name

Doe

\* Phone

(803) 555-1234

\* Email

john.doe@abcfamily.com

#### Credentialing Contact

The Credentialing Contact is the same as the Office contact.

#### Claims Contact

The Claims Contact is the same as the Office contact.

#### Pay to/Billing Address

The Pay to/Billing Address is the same as the Physical Address.

#### Billing Contact

The Billing Contact is the same as the Office contact.

#### Correspondence Address

The Correspondence Address is the same as the Physical Address.

[Save for later](#)

[Previous](#)

[Next](#)

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Group Information
- 2 Location Details
  - Location information
  - Hours of operation**
  - Electronic funds transfer (EFT)
  - Accreditations
- 3 Practitioner Information
- 4 Upload Documents
- 5 Review
- 6 Submit

## Hours of operation

Please enter the hours of operation for the location, including the days and times your office is open to patients.

### Applying Times to Open Days

Note that you can enter a single day's start time and end time. When you click the button *Copy Times*, we'll apply the entered times to each day of the week that the office is open.

Copy times to all open days

Day of the Week	* Start Time	To	* End Time	Open
Monday	08:30 am		05:00 pm	<input checked="" type="checkbox"/>
Day of the Week	* Start Time	To	* End Time	Open
Tuesday	08:30 am		05:00 pm	<input checked="" type="checkbox"/>
Day of the Week	* Start Time	To	* End Time	Open
Wednesday	08:30 am		05:00 pm	<input checked="" type="checkbox"/>
Day of the Week	* Start Time	To	* End Time	Open
Thursday	08:30 am		05:00 pm	<input checked="" type="checkbox"/>
Day of the Week	* Start Time	To	* End Time	Open
Friday	08:30 am		05:00 pm	<input checked="" type="checkbox"/>
Day of the Week	Start Time	To	End Time	Closed
Saturday				<input type="checkbox"/>
Day of the Week	Start Time	To	End Time	Closed
Sunday				<input type="checkbox"/>

Save for later

Previous

Next

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Location Details  
Location information  
Hours of operation  
[Electronic funds transfer \(EFT\)](#)  
Accreditations
- 3 Practitioner Information
- 4 Upload Documents
- 5 Review & Sign
- 6 Submit

## Electronic funds transfer (EFT)

Please provide your banking details to set up Electronic Funds Transfer (EFT) for payments. EFT allows for secure and efficient direct deposit of payments into your bank account, ensuring timely and accurate reimbursement for services rendered.

### Financial Institution Information

Provide the details of your bank, including the bank name, account number, and routing number, to set up or update your EFT.

\* Financial Institution Name

Bank of America

\* Street Address

1000 Sumter St

\* City

Columbia

\* State

South Carolina

\* Zip Code

29201

\* Routing Number

999999999

\* Account Number

111222333444

### Requested EFT Start/Change Date

\* Start Date

10-01-2024

### Fiduciary Contact

Please enter a fiduciary contact who can confirm your banking information. This is typically a CFO, CEO, business owner or other individual with financial signing authority.

\* Are you authorized to sign?

Yes  No

Save for later

Previous

Next

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Location Details  
Location information  
Hours of operation  
Electronic funds transfer (EFT)  
[Accreditations](#)
- 3 Practitioner Information
- 4 Upload Documents
- 5 Review & Sign
- 6 Submit

## Accreditations

Please select *Yes* on the accreditations and certifications that pertain to your location and upload the corresponding document.

### CLIA Certification

Enter your Clinical Laboratory Improvement Amendments (CLIA) certification details. All hospitals, institutions and other facilities must complete this section.

**\* Does this location bill for lab services?**

Yes  No

**\* Do you have a CLIA certificate?**

Yes  No

**\* Certification Number**

AB987654

**\* Test Numbers**

15

**\* Effective Date**


09-01-2024

**\* Expiration Date**

12-31-2026

### Upload CLIA Certificate Document



Please upload a copy of the required file(s) below.



Drag and drop here, [or choose a file](#)

**Note:** You may proceed with the form and upload this document at a later time.

### Uploaded Files

 CLIA Example.docx Successfully uploaded	
--	---

### JCAHO Accreditation

Provide information on your Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation. All hospitals, institutions and other facilities must complete this section.

**\* Are you a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited?**

Yes  No

### Cardiac Rehabilitation Certification

Input your Cardiac Rehabilitation Certification details. All hospitals, institutions and other facilities must complete this section.

**\* Is your facility / entity cardiac rehabilitation certified?**

Yes  No

Additional Accreditation

Select the type of accreditation and provide info.

Select the Accrediting Body

[Save for later](#)

[Previous](#)

[Next](#)



# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 **Practitioner Information**
  - Practitioner information
  - Professional qualifications
  - Educational History & Training
  - Employment history
  - Hospital privileges
  - Patient Population
- 3 Upload Documents
- 4 Review
- 5 Submit

## Practitioner Information

### Practitioner - What to have ready

We'll walk you through setting up a new practitioner, and ensuring they are aligned with the correct group practice or established as an individual practice.



#### Contact Information

The full name, former surname(s), phone & preferred email are all important information we collect for each practitioner.



#### Demographic Information

In addition to capturing gender, race and ethnicity, we'll also capture the practitioner's language(s).



#### Professional qualifications

The practitioner's care specialty, state medical license, and board certification are all required.



#### Employment

Aside from establishing current employment for the practitioner, we collect employment history up to 5 years (which can also span to include education and professional training).



#### Education & professional training

The practitioner's relevant degrees and training (including the highest degree) are required. We also require residency for MDs, DOs, & DPMs.



#### Authorization to Bill

For practitioners that are part of a group practice, they will sign off for the group on their authorization to bill.

Previous

Next

Pay close attention to what's needed.

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 **Practitioner Information**
  - Practitioner information
  - Professional qualifications
  - Educational History & Training
  - Employment history
  - Hospital privileges
  - Patient Population
- 3 Upload Documents
- 4 Review
- 5 Submit

This script has been automatically saved, in order to resume in the future: Copy the link or Email me the link

## Practitioner information

### Contact information

Please enter the practitioner's name and identifying information as accurately as possible to ensure smooth processing.

* First Name	Middle Name	* Last Name
<input type="text" value="Jason"/>	<input type="text"/>	<input type="text" value="Doe"/>
Title	Suffix	Former surnames/Maiden Names
<input type="text"/>	<input type="text"/>	<input type="text"/>
* Social Security Number	* Date of Birth	Tax Id
<input type="text" value="444-11-4444"/>	<input type="text" value="07-13-1970"/>	<input type="text"/>
NPI Group	* NPI Number (type I individual)	Medicaid ID
<input type="text"/>	<input type="text" value="1444444444"/>	<input type="text"/>
Medicare Number	<input type="text"/>	

### Preferred Email

Please provide the practitioner's preferred email so that they will be able to sign their application package.

\* Practitioner's preferred email

## Demographic information

Providing language information is important and will be displayed in the directory

* Gender	* Race	* Ethnicity
<input type="text" value="Male"/>	<input type="text" value="Black or African American"/>	<input type="text" value="Not Hispanic or Latino"/>

## Languages

* Primary Spoken Language	* Secondary Language	* Do you provide a translation service?
<input type="text" value="English"/>	<input type="text" value="French"/>	<input type="text" value="No"/>

## \* Do you offer Sign Language?

Yes  No

## Authorization to bill

The practitioner will sign off an authorization to bill alongside the practice. Please verify the date this authorization to bill is to take effect. This is the date from which the practitioner is allowed to submit claims for services rendered. This date should align with the practitioner's start date with the group practice.

Auth to Bill Effective Date

I authorize to bill on my behalf

Save for later

Previous

Next

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Location Details
- 3 **Practitioner Information**
  - Practitioner information
  - Professional qualifications**
  - Educational history
  - Professional training
  - Employment history
  - Hospital privileges
  - Patient Population
- 4 Upload Documents
- 5 Review & Sign
- 6 Submit

## Professional qualifications

As we review your application, we will look to ensure that the care taxonomy specialty code(s) you enter align to the credentials you provide. Please take a moment to select the correct specialty and provide the pertinent license(s) and certification(s) so that the credentialing process is a smooth one.

### Care Taxonomy Lookup

The practitioner's care taxonomy & specialty help ensure we get the right credentials for verification. Please enter the 10-character code, or use a keyword search, to find your specialty. We can take up to two specialties.

\* Primary Specialty

207Q00000X - Family Medicine Physician

Secondary Specialty

### State Medical License

Enter all state medical license detail, including the issue date and expiration date.

\* Professional Designation

MD - Medical Doctor

\* Provider's License Type

State Medical License

\* License Number

ABC9999

\* State

South Carolina

\* Issue Date

01-13-2015

\* Expiration Date

12-31-2025

### Upload State Medical License Document

Please upload a copy of the required file(s) below.

Please upload a copy of the required file(s) below.



Drag and drop here, [or choose a file](#)

Note: You may proceed with the form and upload this document at a later time.

### Uploaded Files



State Example.docx

Successfully uploaded



[Save for later](#)

[Previous](#)

[Next](#)

# Example of an Individual Enrollment Application (Continued)

## Educational History & Training

### Educational History

Please provide detailed information about your educational history, including degrees earned, institutions attended, and date of completion, to help us verify your academic qualifications.



**What determines a full education**  
Please be sure to include the institution you have less than 5 years of employment picture of the practitioner's professional

* Educational Level	Medical School	* Program Name	MD
* Start Month	August	* Year	2005
* End Month	December	* Year	2014
* City	Greenville	State	South Carolina

### Degree Conferred

Individual asserts they have completed their education and holds the qualifications associated with the degree.

[Delete](#) [Add Degree](#)

* Educational Level	Masters Program	* Program Name	Biology
* Start Month	August	* Year	2001
* End Month	March		
* City	Rock Hill	State	South Carolina

### Degree Conferred

Individual asserts they have completed their education and holds the qualifications associated with the degree.

### Professional Training

If the practitioner has completed an internship, fellowship or residency, please provide details of the training. You may add additional entries / remove entries.

Add Trainings

### Training

* Training Type	Professional Training	* Institution Name	USC Greenville
* Program Name	Residency	City	Greenville
Country	United States	State	South Carolina

I am actively taking this training/program

* Start Date	02-03-2015	* End Date	12-31-2017
--------------	------------	------------	------------

### Cultural Competency Training

We verify that our practitioners have completed a cultural competency training as part of our enrollment process. Have you completed a cultural competency training?

Yes  No

Complete your training at [MyDiversePatients.com](#)

[Save for later](#)

[Previous](#)

[Next](#)

# Example of an Individual Enrollment Application (Continued)

**Steps**

- Let's Get Started
- Location Details
- Practitioner Information**
  - Practitioner information
  - Professional qualifications
  - Educational history
  - Professional training
  - Employment history**
  - Hospital privileges
  - Patient Population
- Upload Documents
- Review & Sign
- Submit

## Employment history

### Employment History

Please provide detailed information about the past five years of your employment history. Be sure to provide an explanation for work history gaps; any gap greater than 6 months requires an explanation.

[Delete](#) [Add Additional Employment](#)

### Employment Entry

Provide the timeframe and detail for the employment entry.

Employer Name  \* Start Month  \* Year

Are you currently employed at this organization?  
 Yes  No

### Employment Gap

For any employment gap greater than 6 months, please provide additional information for this timeframe.

Practitioner had gap of employment.

### Employment Entry

Provide the timeframe and detail for the employment entry.

Employer Name  \* Start Month  \* Year  \* End Month  \* End Year

Are you currently employed at this organization?  
 Yes  No

### Employment Gap

For any employment gap greater than 6 months, please provide additional information for this timeframe.

Practitioner had gap of employment.

[Save for later](#) [Previous](#) [Next](#)

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Location Details
- 3 **Practitioner Information**
  - Practitioner information
  - Professional qualifications
  - Educational history
  - Professional training
  - Employment history
  - [Hospital privileges](#)
  - Patient Population
- 4 Upload Documents
- 5 Review & Sign
- 6 Submit

## Hospital privileges

### Hospital Privilege Information

Do you have privileges at any hospital facility?

\* Do you have privileges at any hospital facility?

Yes  No

Describe arrangements for hospital care:

Send the patient to the emergency room.

[Save for later](#)

[Previous](#)

[Next](#)

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Location Details
- 3 **Practitioner Information**
  - Practitioner information
  - Professional qualifications
  - Educational history
  - Professional training
  - Employment history
  - Hospital privileges
  - [Patient Population](#)
- 4 Upload Documents
- 5 Review & Sign
- 6 Submit

## Patient Population

### Population Details

Please answer the following questions regarding the practitioner's patient population.

**\* Are there patient gender restrictions?**

Yes  No

**\* Are there patient age limitations?**

Yes  No

**\* Minimum Patient...**

0

**\* Maximum Patien...**

75

**\* Do you have any other patient limitations?**

Yes  No

[Save for later](#)

[Previous](#)

[Next](#)

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Location Details
- 3 Practitioner Information
- 4 **Upload Documents**  
Speciality Board Certification  
Malpractice Insurance  
Federal DEA license
- 5 Review & Sign
- 6 Submit

## Upload Documents

### Upload your licenses

[Save for later](#)

[Previous](#)

[Next](#)



# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Practitioner Information
- 3 Upload Documents  
[Speciality Board Certification](#)  
Malpractice Insurance  
Federal DEA license
- 4 Review
- 5 Submit

## Speciality Board Certification

Please take a moment to review your information for accuracy before we begin your application

**\* Are you board certified?**

Yes  No

Are you qualified to sit for the examination?

Yes  No

[Save for later](#)

[Previous](#)

[Next](#)

# Example of an Individual Enrollment Application (Continued)

**Steps**

- 1 Let's Get Started
- 2 Practitioner Information
- 3 Upload Documents
  - Speciality Board Certification
  - Malpractice Insurance**
  - Federal DEA license
- 4 Review
- 5 Submit

## Malpractice Insurance

* Carrier's Name	<input type="text" value="Cover Me"/>	* Policy Number	<input type="text" value="911"/>
* Street	<input type="text" value="1500 Hampton St."/>	* City	<input type="text" value="Columbia"/>
* State	<input type="text" value="South Carolina"/>	* Zip Code	<input type="text" value="29201"/>
* Effective Date	<input type="text" value="09-01-2024"/>	* Expiration Date	<input type="text" value="09-01-2025"/>
* Coverage Amount (Each Occurrence)	<input type="text" value="\$1 million"/>	* Coverage Amount (Aggregate)	<input type="text" value="\$3 million"/>

[Add Additional Insurance](#)


**Upload Malpractice Insurance Document**

Please upload a copy of the required file(s) below.

Drag and drop here, [or choose a file](#)

Note: You may proceed with the form and upload this document at a later time.

**Uploaded Files**

 **Malpractice Example.docx**  
Successfully uploaded

[Save for later](#) [Previous](#) [Next](#)

Select if more than one is needed due to malpractice crossover dates.

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Location Details
- 3 Practitioner Information
- 4 Upload Documents
  - Specialty Board Certification
  - Malpractice Insurance
  - [Federal DEA license](#)
- 5 Review & Sign
- 6 Submit

## Federal DEA license

Is the practitioner eligible to hold a DEA license?

**\* Are you eligible to hold a DEA license?**

Yes  No

**\* Is the practitioner DEA certified?**

Yes  No

**\* License #**

AB1234567

**\* Issue Date**

01-01-2015

### Upload DEA Registration Document

Please upload a copy of the required file(s) below.



Drag and drop here, [or choose a file](#)

Note: You may proceed with the form and upload this document at a later time.

### Uploaded Files



DEA Example.docx  
Successfully uploaded



[Save for later](#)

[Previous](#)

[Next](#)

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Practitioner Information
- 3 Upload Documents
- 4 Review
- 5 Submit

## Review

Save for later

Previous

Next

*Note: Review your application before selecting Next. Also, if any additional uploads are needed, they will be requested here.*

# Example of an Individual Enrollment Application (Continued)

## Steps

- 1 Let's Get Started
- 2 Location Details
- 3 Practitioner Information
- 4 Upload Documents
- 5 Review & Sign
- 6 Submit

## Submit

[Save for later](#)

[Previous](#)

[Submit Application](#)

# Example of an Individual Enrollment Application (Continued)

Search...

Home Applications ▾ Enroll Maintain Support

Archie ▾

Submitted Awaiting signatu... Signed Preliminary review Secondary review Final review Approved Denied Cancelled Withdrawn

Case #00001084 - Individual Application

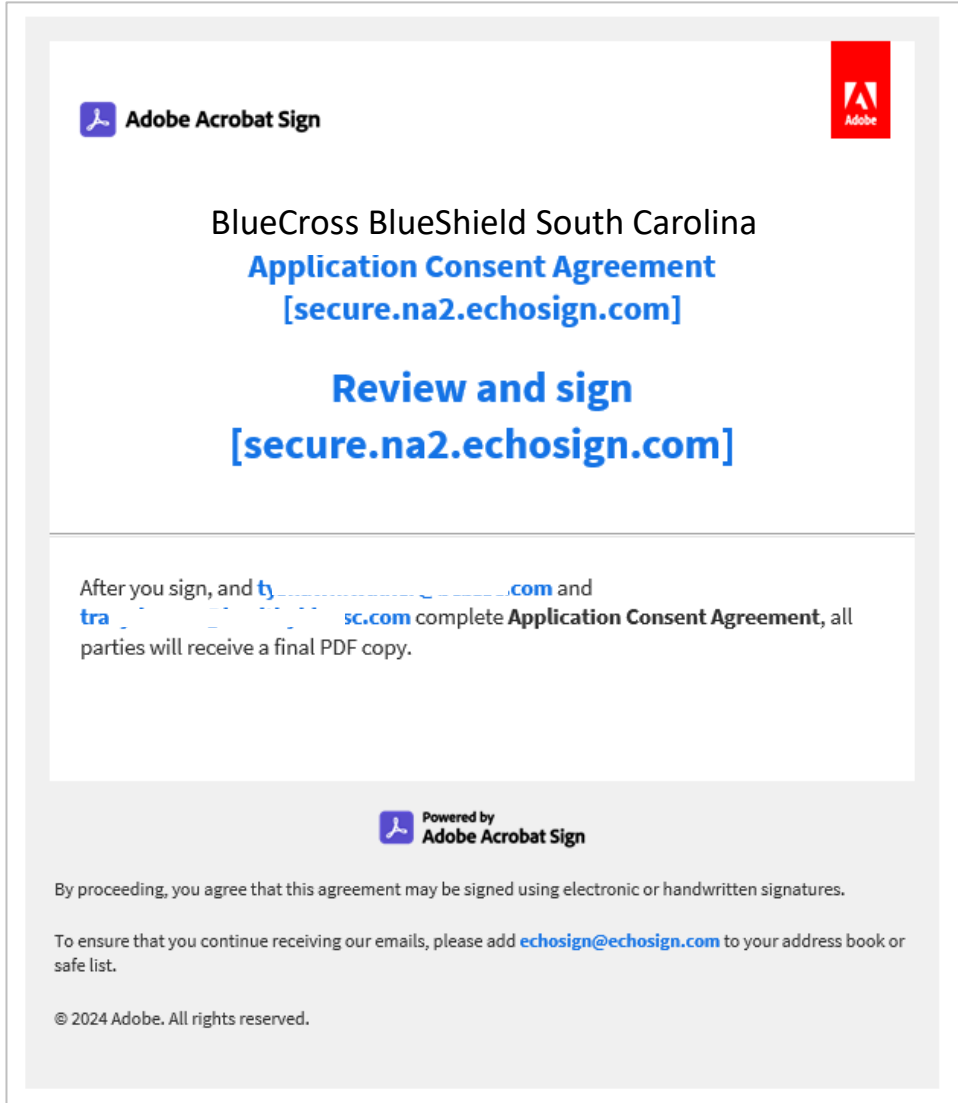
Provider Name James Doe	Status Submitted
Provider Practice ABC Family	Case Reference Number Case #00001084
Requested Networks <i>Blue Essentials;BlueChoice HealthPlan;Healthy Blue;Preferred Blue;State Health Plan</i>	Contact Name Terrence Archie
Application Type Individual	Contact Practice / Company Brown Cardiology

Case Comments (0) [New](#)

Open Agreements

No Action required at this time.

# Example of an Individual Enrollment Application (Continued)



Adobe Acrobat Sign

BlueCross BlueShield South Carolina  
**Application Consent Agreement**  
[secure.na2.echosign.com]

**Review and sign**  
[secure.na2.echosign.com]

After you sign, and [ty.....com](#) and [tra.....sc.com](#) complete **Application Consent Agreement**, all parties will receive a final PDF copy.

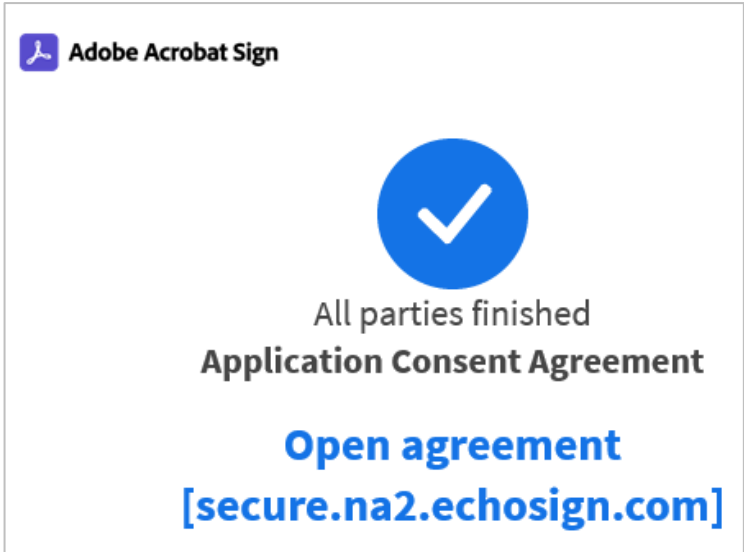
Powered by Adobe Acrobat Sign

By proceeding, you agree that this agreement may be signed using electronic or handwritten signatures.

To ensure that you continue receiving our emails, please add [echosign@echosign.com](mailto:echosign@echosign.com) to your address book or safe list.

© 2024 Adobe. All rights reserved.

All appropriate parties will receive the appropriate document to sign.



Adobe Acrobat Sign

**Application Consent Agreement**

**Open agreement**  
[secure.na2.echosign.com]

All appropriate parties will receive confirmation once completed.

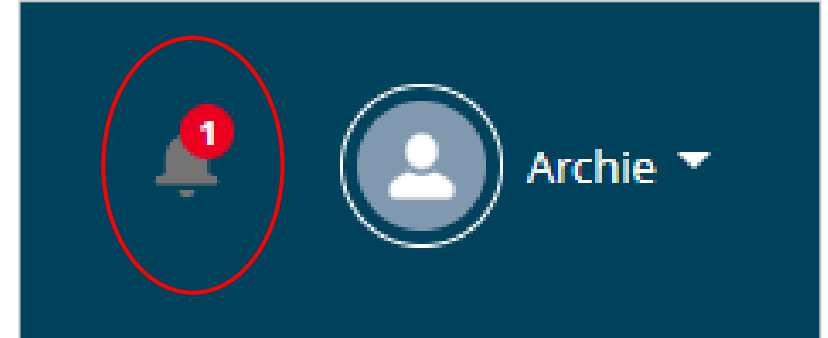
# Making Corrections to Applications





# Missing Items?

- ❑ If items are missing, you will see a notification once you log in.
- ❑ After selecting the notification bell, you will see details on the notice.



# Correcting Applications

- ❑ All corrections must be made in the portal.
  - Allows the system to track the corrections and applies them to the appropriate fields
  - The newly system generated document will include the corrections and should be resigned.
- ❑ Handwritten or other altered corrections are not accepted and will be returned.

# Steps for Making Corrections

- ❑ Review the action required.
- ❑ Select ***Launch Application*** to make the necessary corrections or to supply the requested items.

Action Required

Review the *Action Items* list and any case comments for additional detail.

[Launch Application](#)

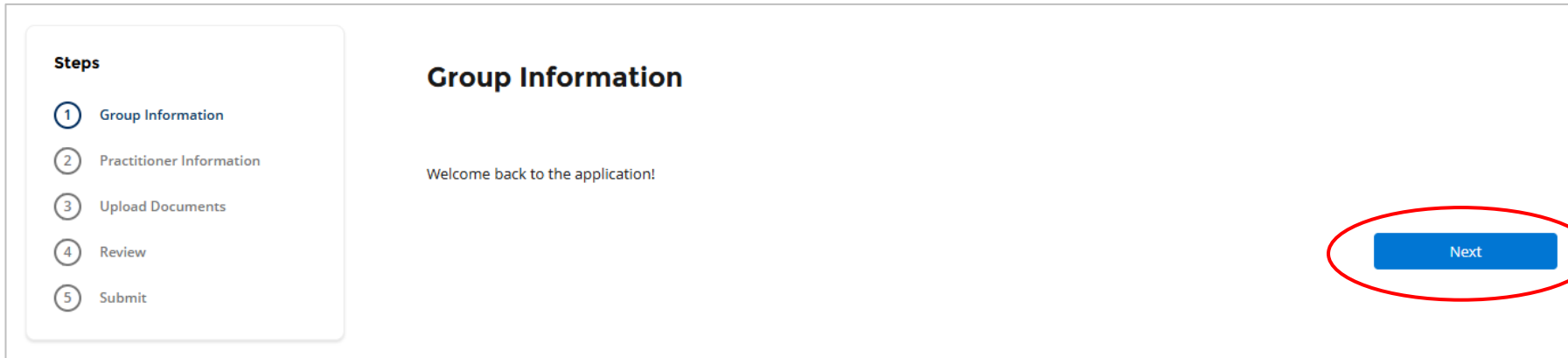
**Action Items**

1 of 1 item

Action Item Name	Issue	Next steps
Signer - Missing	Missing	Re-open application, correct & re-submit.

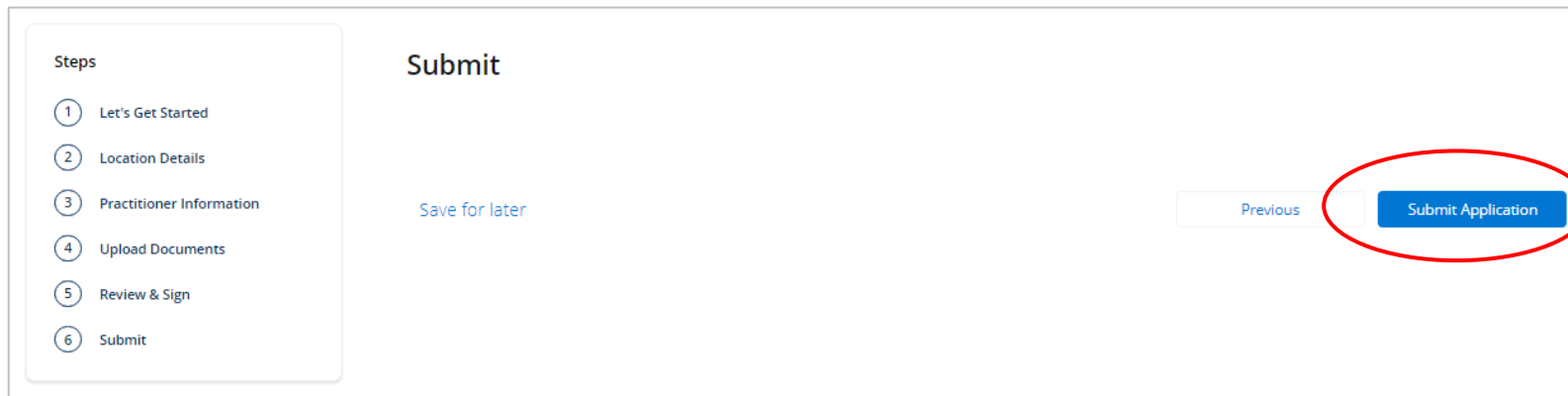
# Steps for Making Corrections (Continued)

- ❑ You'll see the "Welcome back" message.
- ❑ Select **Next** to begin the process.



The screenshot shows a web interface for a multi-step application process. On the left, a 'Steps' sidebar lists five steps: 1. Group Information, 2. Practitioner Information, 3. Upload Documents, 4. Review, and 5. Submit. The main content area is titled 'Group Information' and displays the message 'Welcome back to the application!'. At the bottom right of the main area, there is a blue button labeled 'Next', which is circled in red to indicate it should be clicked.

- ❑ Once all the necessary corrections are made, resubmit the case.



The screenshot shows the final step of the application process, titled 'Submit'. The 'Steps' sidebar on the left now includes six steps: 1. Let's Get Started, 2. Location Details, 3. Practitioner Information, 4. Upload Documents, 5. Review & Sign, and 6. Submit. The main content area contains the text 'Save for later'. At the bottom right, there are two buttons: a light blue 'Previous' button and a dark blue 'Submit Application' button. The 'Submit Application' button is circled in red to indicate it should be clicked.

# Important Reminders



# Missing Items That Could Delay the Enrollment Process

## Incorrectly signed applications or contracts

- All applications and contracts must be signed by the appropriate parties (i.e., provider, fiduciary contact, etc.)

## Invalid dates

- Malpractice dates must be valid and active on or before the requested start date.
- State licenses must be active with current dates.

## Incomplete submissions or documentation

- Licenses, certificates (CLIA, when applicable) and malpractice verification must be included with the application.

### IMPORTANT NOTE:

An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:

- **Day 7 - First request**
- **Day 14 - Second request**
- **Day 21 - Third (final) request**

If the missing items are not received, the case will be placed in the "Cancelled" status.

# Recredentialing Process

- ❑ **Recredentialing for established providers occurs every three years.**
  - If you need to know the upcoming recredentialing dates for a provider, email [Recred.App@bcbssc.com](mailto:Recred.App@bcbssc.com).
    - Include the provider's name and NPI.
- ❑ **The credentialing team reaches out when the provider's recredentialing dates is approaching.**
  - First, the team calls to see if the provider is actively working at the location we have on file. If they are, the recredentialing application is sent by email or fax.
    - If a response is not received after the first outreach, a second attempt is made in 14 days.
    - If a response is not received after the second outreach, a third attempt is made in seven days.
    - If a response is not received after the third and final outreach, the process to terminate the provider is initiated.
- ❑ **If the recredentialing date is missed, the provider is termed, and new enrollment is required.**

# Non-credentialed Providers

Acupuncturists

Associate  
Counselors

Christian  
Science  
Practitioners

Diabetes  
Education

Dieticians\*

Education  
Specialists

Homeopaths

Lay Midwives

Massage  
Therapists

Naturopaths

Occupational  
Therapy  
Assistants

Physical  
Therapy  
Assistants

Psychology  
Assistants

Recreational  
Therapists

School  
Psychologists

Sports Trainers

Technicians

*Note: This list may not be all inclusive.  
\*Can join the Healthy Blue network.*

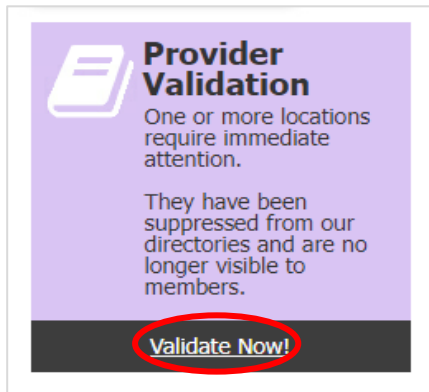


# Provider Directory Validation

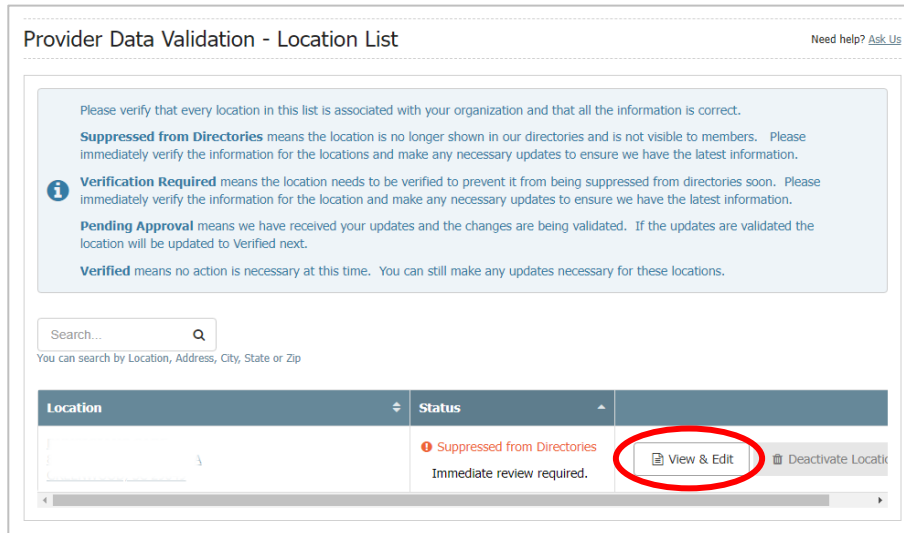
- ❑ Providers have been required to verify their demographic data at least **every 90 days** since Jan. 1, 2022.
  - This implementation was part of the No Surprises Act.
- ❑ Validation allows us to maintain accurate directories.
- ❑ Verification can be completed in M.D. Checkup (accessible through My Insurance Manager<sup>SM</sup>).
  - You can also respond to the email received from [Provider.Directory@bcbssc.com](mailto:Provider.Directory@bcbssc.com).

# LocationSuppressions Due to Missing Validation

- ❑ Locations are suppressed in the provider directory if more than 90 days has passed since the last validation was made.
- ❑ To have the suppressed status updated, the profile administrator should:
  - Log into My Insurance Manager.
  - Select Validate Now in the Provider Validation box.
  - Select View an Edit from the location list.
  - Review the information, make any necessary updates and select Verify.



**Provider Validation**  
One or more locations require immediate attention.  
They have been suppressed from our directories and are no longer visible to members.  
**Validate Now!**



Provider Data Validation - Location List

Please verify that every location in this list is associated with your organization and that all the information is correct.

**Suppressed from Directories** means the location is no longer shown in our directories and is not visible to members. Please immediately verify the information for the locations and make any necessary updates to ensure we have the latest information.

**Verification Required** means the location needs to be verified to prevent it from being suppressed from directories soon. Please immediately verify the information for the location and make any necessary updates to ensure we have the latest information.

**Pending Approval** means we have received your updates and the changes are being validated. If the updates are validated the location will be updated to Verified next.

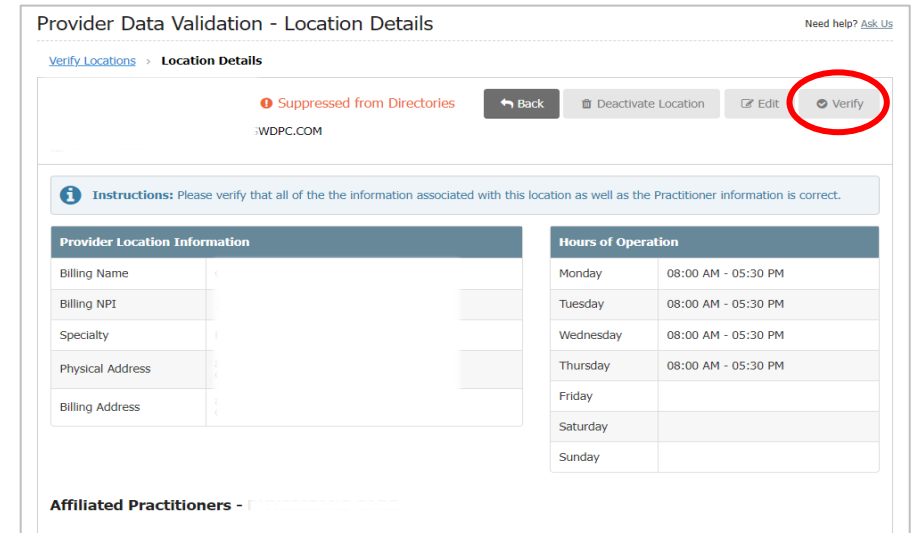
**Verified** means no action is necessary at this time. You can still make any updates necessary for these locations.

Search...

You can search by Location, Address, City, State or Zip

Location	Status
	Suppressed from Directories Immediate review required.

**View & Edit**



Provider Data Validation - Location Details

Verify Locations > Location Details

Suppressed from Directories

Back Deactivate Location Edit **Verify**

WDPC.COM

**Instructions:** Please verify that all of the the information associated with this location as well as the Practitioner information is correct.

Provider Location Information		Hours of Operation	
Billing Name		Monday	08:00 AM - 05:30 PM
Billing NPI		Tuesday	08:00 AM - 05:30 PM
Specialty		Wednesday	08:00 AM - 05:30 PM
Physical Address		Thursday	08:00 AM - 05:30 PM
Billing Address		Friday	
		Saturday	
		Sunday	

Affiliated Practitioners -

# Making Demographic Updates

## My Provider Enrollment Portal

- Doing Business As Name Change
- Change of Address
- Satellite Location
- Add or Terminate Practitioner Affiliation

## M.D. Checkup

- Terminate (close) Location
- Add or Terminate Practitioner Affiliation

*Note: You can only add a practitioner in M.D. Checkup if they are **enrolled and associated** with the tax identification number (TIN).*

# Terminating (Closing) Locations in M.D. Checkup

The screenshot shows the 'My Insurance Manager' interface. The top navigation bar includes 'Home', 'Patient Care', 'Office Management', 'Resources', 'Modify Profile', 'Profile Administration', 'Staff Directory', and 'Provider Update'. The main heading is 'Provider Data Validation - Locations List'. Below this is an instruction box: 'Instructions: Please verify that every location in this list is associated with your practice and that all of the information is correct.' A search bar is present with the text 'Search locations...'. Below the search bar, a table lists three locations:

Location	Status	View & Edit	Remove Location
Provider 1 Main Street	Requires Verification	View & Edit	Remove Location
Provider 2 Pine Road	Requires Verification	View & Edit	Remove Location
Provider 3 Davis Avenue	Requires Verification	View & Edit	Remove Location

The modal dialog is titled 'Request to Remove Location'. It asks: 'Are you sure you wish to remove Palmetto Northeast? Please enter the date on which you want this location to be removed.' A note states: 'Note: The removal date must be after the original effective date.' There is a date input field with a calendar icon and a 'mm/dd/yyyy' placeholder. Below the input field are 'Cancel' and 'Remove' buttons. To the right of the input field are 'View & Edit' buttons for the location.

**DO NOT use this function to remove a location from your VIEW!**

This block shows a close-up of the two buttons from the table in the previous screenshot: 'View & Edit' and 'Remove Location'.

# Adding Practitioner Affiliations in M.D. Checkup

- ❑ The practitioner must be ***enrolled and associated*** with the Tax ID.
  - If you are trying to add a practitioner to a different Tax ID, you must complete and submit the ***Add Practitioner Form*** in My Provider Enrollment Portal.
- ❑ Example:
  - TIN A - 123456789
    - Location 1: 123 Omega St., Columbia, SC 29203
    - Location 2: 456 Alpha Rd., Hopkins, SC 29061
  - TIN B - 987654321

Dr. Jane Doe is enrolled and associated with TIN A. She works at location 1 but is scheduled to see patients at location 2. She will be submitting claims for location 2 and needs to be added. Because Dr. Doe is already associated with TIN A, she can be added to location 2 through M.D. Checkup.

Dr. Jane Doe is enrolled but not associated with TIN B. She is scheduled to see patients at this new location. Because Dr. Doe is not associated with TIN B, the Add Practitioner Form must be completed and submitted through My Provider Enrollment Portal.

# Available Resources



# What Resources Are Available


- ❑ Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) and use the following path to access great resources for the portal and provider enrollment.
  - Providers>Provider Enrollment>***Join Our Networks***

**My Provider Enrollment Portal Manual**

**Provider Enrollment Presentation**

**Provider Enrollment FAQs**

# Quality



20  
25

We're **BACK** and We're **LIVE**  
Annual Provider Summit



# Topics to Discuss

- ❑ About Us
- ❑ National Committee for Quality Assurance (NCQA®)
- ❑ Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- ❑ Healthcare Effectiveness Data and Information Set (HEDIS®)
- ❑ Request for Information
- ❑ Lines of Business
- ❑ Quality Navigator Program
- ❑ Risk Adjustment Data Validation (RADV)
- ❑ Key Takeaways

# About Us



# About Us

## Healthcare Innovation and Improvement (HII) Quality Department



**Vision:** To ensure a Quality experience with every interaction.



**Mission:** Improve the health and experience of our members through innovative programs and collaborative partnerships that help make health care more affordable.



Committed to working with YOU to better serve our members.



# NCQA

## National Committee for Quality Assurance



# NCQA



NCQA is a private organization dedicated to improving healthcare quality by developing quality standards and performance measures.



Is a nonprofit organization that measures provider and health plan care quality and offers accreditation to high performing organizations.



Healthcare Effectiveness Data and Information Set (HEDIS) coordination



Provider involvement

# NCQA (Continued)

## What does NCQA mean to Providers?

### Contract

#### Bonuses Incentives

Provider performance in HEDIS measures often impacts the level of bonus and incentive payouts. Providers have the potential to earn through Value-Based Care, PCMH+ program, the PCMH+ Kids program, as well as through the Accountable Care Organizations offerings that have the upside and downside risk.

### Reporting

#### Data to the plan

When you report services rendered to our members back to us, it is a Win-Win for both of us. It helps us report HEDIS rates accurately & It helps you with your Quality Payment Program through CMS by impacting the Merit-Based Incentive Payment System (MIPS) and/or Alternative Payment Model (APM).

### Safety

#### Patient

Through NCQA, we are able to maintain a high-level of patient safety by providing you with accurate and up-to-date information via quality-based reporting which can help you in making decisions on your patients care. This can help to reduce unwarranted procedures and duplicative care, should a member transitions between providers.

# CAHPS

**Consumer Assessment of Healthcare Providers and Systems**



# CAHPS

- ❑ It's a survey used to report on and evaluate patient experiences with healthcare.
- ❑ A random sample of members are offered a survey from February to May.

## Consumer Satisfaction



Assesses patient's feedback ranking the health plan

## Prevention



Gauges patient's ranking of annual visits, vaccines, etc.

## Treatment



Measures the plan's consistency in providing recommended care

- ❑ The CAHPS survey represents the member or the patient experience portion of the HEDIS measure set. Once the survey is completed, plans submit CAHPS results to NCQA annually.



# CAHPS (Continued)

- ❑ The survey asks specific questions about member experience with the providers.
- ❑ Here's an example of the CAHPS questions and some possible solutions if they arise:

Opportunities	Possible Solutions
Q22 - Rating of Specialist seen most often	<ul style="list-style-type: none"><li>❑ Listen to patient concerns and spend adequate time with them</li><li>❑ Engage the patient in discussions about medications</li><li>❑ Avoid using medical jargon and technical language</li></ul>
Q18 - Rating of personal doctor	<ul style="list-style-type: none"><li>❑ Ensure that providers are informed about the patient's relevant medical and person background</li><li>❑ Remain up-to-date on medical advancements</li><li>❑ Connect with the patient on a personal level</li><li>❑ Reduce wait times in the office</li></ul>
Q9 - Ease of getting care, tests, or treatment	<ul style="list-style-type: none"><li>❑ Conduct a thorough assessment of the patient's needs</li><li>❑ Treat patients with urgent issues promptly</li><li>❑ Provider care and service quickly</li><li>❑ Minimize wait times and communicate reasons for delays</li></ul>

# HEDIS

## Healthcare Effectiveness Data and Information Set



# What is HEDIS?

- ❑ HEDIS is a tool that America's health plans use to measure performance on important dimensions of care and service.
- ❑ Its rates are designed to evaluate the effectiveness of a health plan's ability to demonstrate an improvement in its preventive care and quality measures to its members.



# Entities Using HEDIS



Exist to improve the quality of health care



Federal Employee Program (FEP)



\*Centers for Medicare and Medicaid Services



\*Quality Rating System for the ACA/Exchange

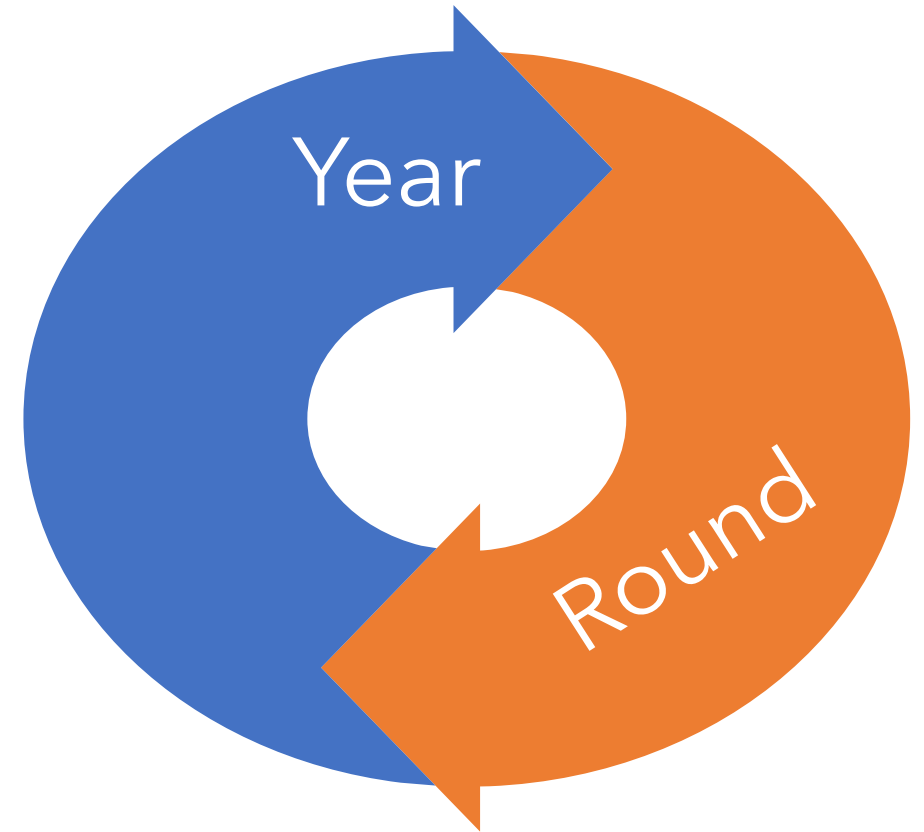
\*Medicare Advantage

\*Medicaid



# HEDIS: Prospective Season

- ❑ Continuously monitors rates in real-time.
- ❑ Runs from Jan. 1 to Dec. 31 of the current or measurement year.
- ❑ All quality data collected throughout the year will reduce the burden on your practice during HEDIS Production season, increase accuracy of the monthly quality reports we share and may impact those incentives and contractual bonuses.



# HEDIS: Prospective Season (Continued)

- ❑ Options for compliance include:
  - **Claims:** NCQA approved quality codes are going to be your fastest and easiest way to share this information. There is no manipulation of data or changes to normal business processes on your end or ours.
  - **Data transfer:** Electronic medical records (EMR) data transfer is how BlueCross BlueShield of South Carolina receives EMR data from providers. Please contact us at [Navigator@bcbssc.com](mailto:Navigator@bcbssc.com).
  - **Medical records:** Can also be accepted in Prospective season, but this a very labor-intensive option for both parties.
  - **Compliance forms:** The least preferred option, as these are just an attestation of care. If you submit a compliance form for a member, the form must be filled out in its entirety and submitted to BlueCross by Dec. 31 of the measurement year, and we may require a copy of the official medical record to prove the care for our auditor.
- ❑ **THE BIG TAKEAWAY:** By submitting appropriate quality codes via claims or submitting data transfers we will not need to request the actual medical record to verify services were completed during the measurement year.

# HEDIS: Retrospective Season

- ❑ Also referred to as Retro or Hybrid season or HEDIS Production.
- ❑ Looks at the care given or due in the prior measurement year.
- ❑ Runs from January to May of the year following the measurement year.
- ❑ HEDIS MY2024 refers to care given or due in 2024, which will be evaluated from January to May 2025.
- ❑ All requested member documentation is based on the selected HEDIS measure by NCQA.
- ❑ **BIG REMINDER:** As a contracted provider, you are contractually obligated to respond to the HEDIS medical record requests.



# On the Horizon

Method of collecting healthcare data through electronic systems, such as electronic health records (EHR), to improve the tracking, reporting, and analysis of clinical performance.

Providers use ECDS to ensure accurate and real-time data sharing across different healthcare settings, which is essential for maintaining quality care, patient safety, and meeting regulatory requirements.

For providers, both ECDS and HEDIS measures are crucial for:

1. Ensuring high-quality care delivery.
2. Meeting accreditation and regulatory requirements.

Hybrid measures are phasing out by MY 2030.

This represents a major impact on the way information is collected and reported, so we must all transition.



# Request for Information



# Request for Information

- ❑ Medical record requests are sent by email, fax or mail.
- ❑ Medical record requests are created based on the claims we receive from providers.
- ❑ Members are attributed to the primary care provider where the most claims have been received from over the last 18 months.
- ❑ Giving the Quality team remote access to your electronic health record (EHR) system allows them us to pull the medical records. This reduces the burden on the providers.
- ❑ Each medical record requests will be specific to the member and will include what information is needed to close the gap for a specific HEDIS measure.
- ❑ Providers must return the information listed in the box on the form.

# Request for Information (Continued)

- ❑ Providers must return the information listed in the box on the form.
- ❑ Medical record requests will include the list of items needed along with the time frame to close the gap.

Please send a copy of the following medical record(s) requested below:

Demographics page

-AND-

All office visit/encounter notes from 01/01/2024 to 12/31/2024

-AND-

Past Medical/Surgical history 2023 to 12/31/2024

-AND-


All lab tests from 01/01/2024 to 12/31/2024

-AND-

All consultation notes especially Urologist/Endocrinologists from to 12/31/2024

# Request for Information (Continued)

- ❑ Example of a Request for Information cover letter for our Exchange and FEP plans.
- ❑ Request will be sent via email, fax or mail.
- ❑ Email the Quality Navigator of your preferred method of contact at [Navigator@bcbssc.com](mailto:Navigator@bcbssc.com).

 South Carolina  
Department of Health and Human Services  
Division of Insurance

### Request for Medical Records - Cover Letter

To:	From: BlueCross BlueShield of South Carolina
NPI: -/TIN: -	Fax:
Phone:	Requested Date: 07/10/2024

**Greetings:**  
Please see the attached medical record requests for our HEDIS review of members for the **ACA/Exchange and FEP/ Federal Employee Program product lines**. Please return the requested medical records **within 7 business days**.

If the member has not had the service requested within the required time frame, please schedule the member for a visit to address these care opportunities.

For members who have received the service during the requested time frame, please return the records and include the Summary Member-Measure List, indicating which measure is being addressed.

You may send the information using your preferred method.

**PORTALS:**  
MRO: bchpbcshedis.requester.roilog.com  
Ciox: Customer Portal ID: 2213626, Address below is only for portal location validation:  
PO BOX 100300, AX310, Columbia, SC 29202

ShareCare: BCBS-29260-6170

**EMAIL:**  
HEDIS.Records@bcbssc.com

**FAX:**  
803-419-8191



**MAIL:**  
BlueCross BlueShield of South Carolina  
Attn: Quality Management Department  
P.O. Box 100300 AX-310  
Columbia, SC 29202

If you have questions or concerns, please email [Navigator@bcbssc.com](mailto:Navigator@bcbssc.com).  
In accordance with HIPAA, do not return any medical records that do not meet the measure time frame specified.

Thank you,  
Luna Lugo  
Manager, Quality Management  
BlueCross BlueShield of South Carolina

# Request for Information (Continued)

- ❑ Example of a Request for Information cover letter for our Healthy Blue (Medicaid) plan.
- ❑ Request will be sent via email, fax or mail.
- ❑ Email the Quality Navigator of your preferred method of contact at [Navigator@bcssc.com](mailto:Navigator@bcssc.com).

							
<b>Request for Medical Records - Cover Letter</b>							
<table border="0"><tr><td>To:</td><td>From: BlueCross BlueShield of South Carolina</td></tr><tr><td>NPI: -/TIN: .</td><td>Fax: 803-419-8191</td></tr><tr><td></td><td>Requested Date: .</td></tr></table>		To:	From: BlueCross BlueShield of South Carolina	NPI: -/TIN: .	Fax: 803-419-8191		Requested Date: .
To:	From: BlueCross BlueShield of South Carolina						
NPI: -/TIN: .	Fax: 803-419-8191						
	Requested Date: .						
Greetings:							
Please see the attached medical record requests for our HEDIS review of members for the <b>Medicaid Program</b> . Please return the requested medical records <u>within 7 business days</u> .							
If the member has not had the service requested within the required time frame, please schedule the member for a visit to address these care opportunities.							
For members who have received the service during the requested time frame, please return the records and include the Summary Member-Measure List, indicating which measure is being addressed.							
You may send the information using your preferred method.							
PORTALS:							
MRO: bchpbcshedis.requester.rolog.com							
Ciox: Customer Portal ID: 2213626, Address below is only for portal location validation: PO BOX 100300, AX310, Columbia, SC 29202							
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BlueCross BlueShield of South Carolina Attn: Quality Management Department P.O. Box 100300 AX-310 Columbia, SC 29202							
If you have questions or concerns, please email <a href="mailto:Navigator@bcssc.com">Navigator@bcssc.com</a> .							
In accordance with HIPAA, do not return any medical records that do not meet the measure time frame specified.							
Thank you, Luna Lugo Manager, Quality Management BlueCross BlueShield of South Carolina							

# Request for Information (Continued)

- ❑ Check the appropriate box and return the letter if you cannot find the patient, nor have medical records.
- ❑ Use My Insurance Manager (Office Management) to see Gaps in Care reports.
  - Gaps in Care reports are available monthly along with helpful documents for providers to access during the year.
  - Medicaid reports are sent separately by your Quality Navigator.

Please check the appropriate box:

- ❑ Medical record attached; please return via one of the following methods:

Portal Locations:

MRO: bchpbcshedis.requester.roilog.com

Ciox: Customer Portal ID: 2213626, Address below is only for portal location validation:  
PO BOX 100300, AX310, Columbia, SC 29202

ShareCare: BCBS-29260-6170

EMAIL: HEDIS.Records@bcssc.com

FAX: 803-419-8191

MAIL: BlueCross BlueShield of South Carolina, Attn: Quality Management Department, P.O.  
Box 100300 AX-310, Columbia, SC 29202

- ❑ No medical records found for the time frame requested
- ❑ Unable to locate patient in our system

# Lines of Business



# Lines of Business

## □ Healthy Blue (Medicaid)



## □ Health Insurance Exchange (HIX or ACA)



Independent licensees of the Blue Cross Blue Shield Association.

## □ Federal Employee Program (FEP)





# Health Insurance Exchange (Marketplace)

- ❑ The Exchange Line of Business (LOB) covers health plans on the insurance marketplace.
- ❑ Used by more than 90 percent of the nation's health plans, employers and regulators.
- ❑ The current population has over 276,000 members.
- ❑ Measures Clinical, customer satisfaction and patient quality.
- ❑ CMS provides guidance to health plans for the Exchange LOB via the Quality Ratings System (QRS) and Quality Health Plan (QHP) Technical Specifications and call letter.
  - The Annual Call letter communicates updates/changes during the Measurement Year, as well as discusses future planning for the LOB.
- ❑ For the Exchange line of business, QRS are produced in a star-based rating. The overall rating includes member experience, medical care and health plan administration.



# Federal Employee Program (FEP)

- ❑ Clinical quality, customer service and resource use (QCR).
- ❑ FEP program works based on priority measures that are weighted.
- ❑ This system is administered by the Federal Employee Plan Directors
- ❑ FEP is known to members as the Service Benefit Plan.
- ❑ Current State Population for FEP: Around 89,000.
- ❑ In January 2025, FEP will launch the Postal Service Health Benefit (PSHB) program. This program designation is for members within USPS. For 2025, we do not anticipate any impacts to our current quality structure.



# Healthy Blue<sup>SM</sup>

## □ Rating System

- Reporting of all health plan rating measures is required.
- Adult and child health care quality measures.
- Core set of children’s health care quality measures.
- Audit will be completed by an outside vendor, then submitted to NCQA.
- Additional information can be found on [www.HealthyBlueSC.com](http://www.HealthyBlueSC.com).



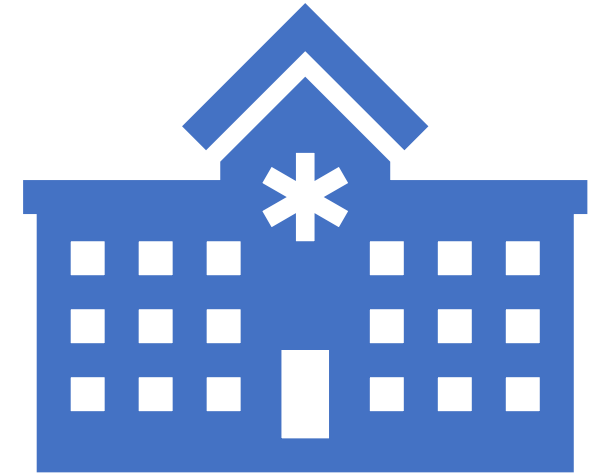
# Quality Navigator Program



# Quality Navigator Program

## Quality Navigator Model

- ❑ The quality navigator model is a population health and quality improvement program designed to assist primary care physicians (PCPs) in meeting quality metrics.
- ❑ The goal of the program is to assist PCPs by:
  - Streamlining care coordination.
  - Providing helpful tools and resources to support patient care efforts.
- ❑ Benefits of the Quality Program is that it:
  - Promotes accurate coding guidance.
  - Facilitates referrals to disease and case management programs to support treatment plans.
  - Assists with care coordination.
- ❑ Quality Navigator email: [Navigator@bcbssc.com](mailto:Navigator@bcbssc.com).



# Quality Navigator Program (Continued)

## What is the Quality Navigator Program?

- ❑ Participation is based on primary care specialties.
- ❑ Providers are automatically enrolled.
- ❑ There is no cost to providers.
- ❑ Multiple tools and offerings available to support providers.

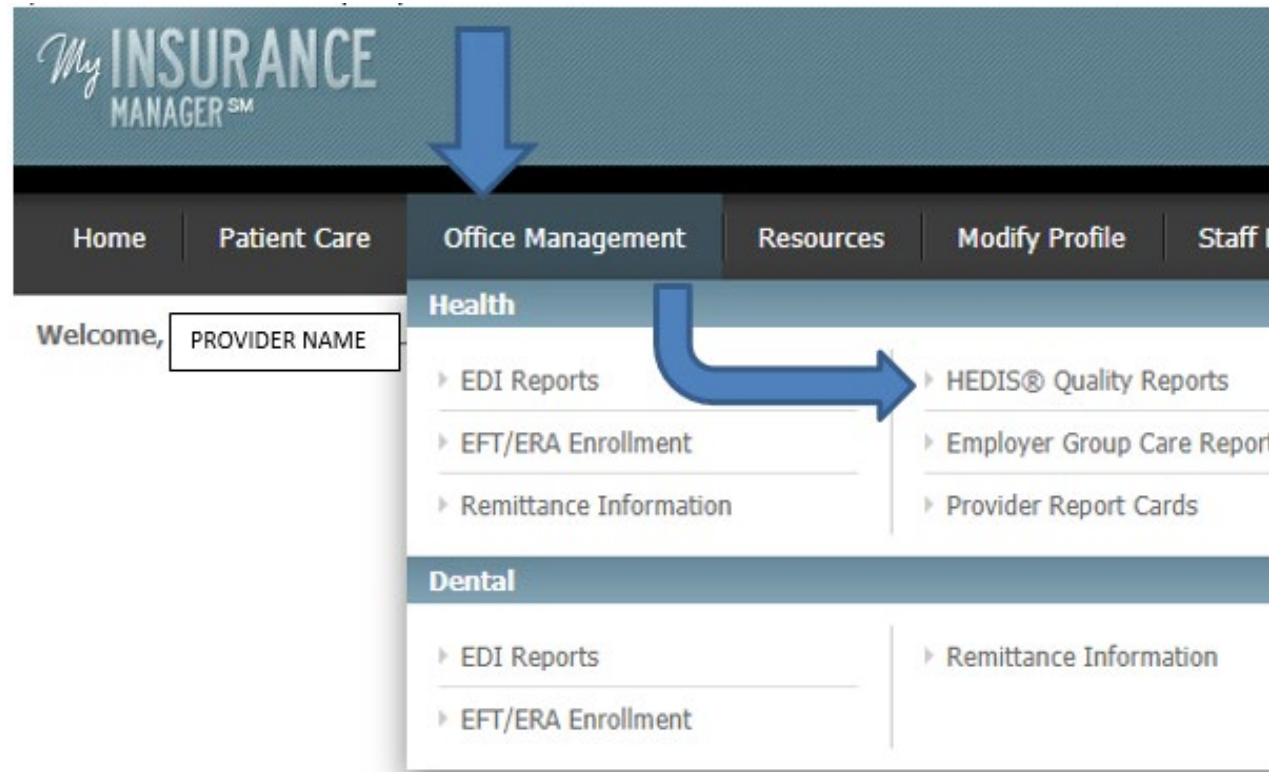
## What is a Quality Navigator?

- ❑ Dedicated team member with a registered nursing license or related healthcare bachelor's degree.
- ❑ Point of contact for care coordination and patient engagement.
- ❑ Education representative that can schedule sessions to assist with understanding NCQA measures, review open quality care opportunities, and collaborate with providers to improve quality scores.

# Quality Navigator Program (Continued)

## My Insurance Manager

Use My Insurance Manager to access Care Opportunity Reports or Gap in Care (GIC) Report for Prospective Season.



# Quality Navigator Program (Continued)

## Understanding Care Opportunity Reports or Gap in Care (GIC) Report

- ❑ Past medical history has been added for members (  )
- ❑ Non-compliance can be a true “gap” in care or a “gap” in data (  )
  - A true gap in care or non-compliance is when the member has not received the care.
  - A data gap is when the member has received the care, but this information was not shared with the plan.
  - Either way, the member will remain listed as “non-compliant” until the care is given AND that information is shared with us.
- ❑ Gap in Care report are available to access for providers **monthly** on My insurance manager portal.

First Name	Last Name	Date of Birth	Gender	Member ID_Card	LOB	Servicing Provider	Compliant Measures	Non-Compliant Measures	Past Medical History
John	Doe	1/1/1953	M	R12345566	Cross Exchange	My Provider	Acute Hospital Utilization, Acute Emergency Department Utilization	Colorectal Cancer Screening	Asthma COPD
Jane	Doe	1/1/1970	F	R12345566	Cross Exchange	My Provider	Controlling High Blood Pressure Breast Cancer Screening	Cervical Cancer Screening	Hypertension



# Incentives

**Bump up to qualify for incentives by end of year to get bonuses or incentives.**



## HEDIS® Measures Coding Reference Sheet for Practitioners and Coders

### Glycemic Status Assessment for Patients With Diabetes (GSD)

This measures the percentage of members 18-75 years of age with diabetes (types 1 and type 2) whose most recent glycaemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0%.
- Glycemic Status >9.0%.

#### To improve your score:

- CPT CAT II codes are available for coding HbA1c levels (see table below). Coding in a claim is equivalent to results from a lab for HEDIS.
- Order labs prior to patient appointments so they are available to code at the visit. Bill HbA1c testing if completed in office and ensure HbA1c result, and date are documented in the chart and the correct CPT II code is on the claim.
- Adjust therapy to improve HbA1c and BP levels and schedule follow-ups with patients to monitor changes.

#### Glycemic Status Billing Codes - Visit Date Must Be Specified

Code System	Codes	Definition	Charge \$ (24F)
CPT-CAT-II	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%	\$5.00
	3046F	Most recent hemoglobin A1c (HbA1c) level greater than 9.0%	\$5.00
	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%	\$5.00
	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	\$5.00

## FEP Provider CPT II Incentive



Provider Quality Incentive Program

## Healthy Blue Provider Incentive Program

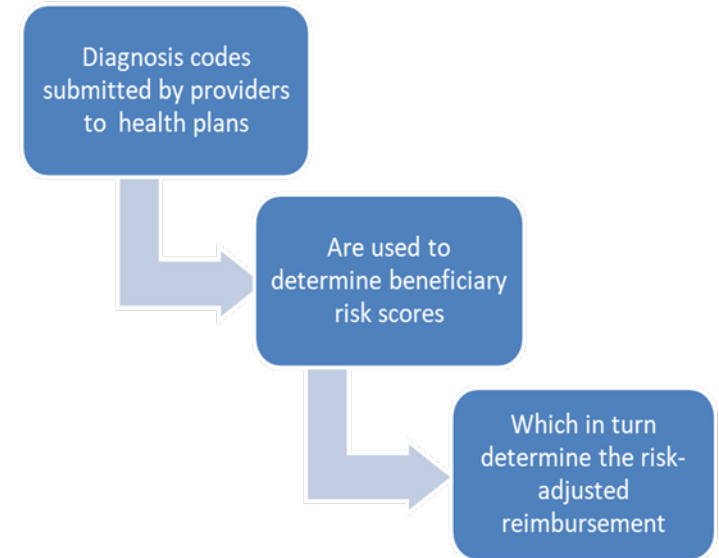


# RADV and RISK



# RISK Adjustment

- ❑ Risk Adjustment (RA) is a Payment methodology used by Medicare Advantage health plan and ACA (Affordable Care Act) plans to adjust health plan payments based on the enrollee health status and demographic characteristics.
- ❑ Risk adjustment methodology relies on enrollee diagnosis as specified by the ICD-10CM guidelines to prospectively adjust payments for a given enrollee based on the health status of the enrollee.
- ❑ This process allows for the estimated cost to treat a patient in a given year and make sure health providers are paid fairly for the patients they treat.
- ❑ Records are requested the 3<sup>rd</sup> quarter of the year. We request records and review charts for chronic conditions that were not submitted via claims but affect patient care and can be captured for patient status.



# RADV - RISK Adjustment Data Validation


- ❑ Center for Medicare & Medicaid Services (CMS) has a formal audit program to monitor health plan compliance with HCC (Hierarchical Condition Category) reporting regulations. HCCs are sets of medical codes (ICD-10CM) that are grouped into related categories.
- ❑ The goal of RADV audits is to ensure that the health status submitted by the plan is supported by health record documentation and meets reporting guidelines.
- ❑ RADV is CMS primary way to address improper overpayments. Accuracy is confirmed from reviewing charts from providers and sending them to CMS for secondary review after an initial review by our selected auditor.
- ❑ CMS requires all HCC diagnoses be submitted each year the condition is present. It is of critical importance that plans ensure that members with HCC diagnoses be seen by a qualified provider and all current HCC diagnoses be evaluated and reported each year.
- ❑ Audit reviews the prior benefit year for our selected Cross and Choice members.
- ❑ HHS - RADV is conducted every year for all issuers and the project runs from June- December.

# How RISK Adjustment Helps Providers

- Allows sicker members to receive fairly priced coverage since healthy members offset the difference.
- Identifies potentially new problems early.
- Reinforces self-care and prevention strategies.
- Coordinates care collaboratively.
- Avoids potential drug-drug/disease interactions.
- Improves the overall patient health care evaluations process.
- Improved office practice patterns and communication among the patient's health care team.

# RISK Cover Letter for Release of Information

Page 1 of 69

 Request for Medical Records (RISK) - Cover Letter

10/01/2024

Dear Provider,

We are contacting you because we are collecting medical records for our ACA Risk Adjustment process. We want to assure you that there are no financial consequences to you because of this request. Please note this is not related to previous medical record requests you may have received from us or any other vendor acting on our behalf.

To comply with this request, we have identified member medical records needed for 2024 dates of service. Enclosed, you will find the list of members seen by your practice in 2024. Please provide the entire 2024 medical chart for review, if unable to send whole year we have included the must have dates of services.

**\*Required medical record documentation:** progress notes and/or a standard template that includes a subjective, objective assessment plan (SOAP) for face-to-face office visit. Notes should include member name, date of visit and provider signature with credentials.

**Medical record documentation IF available:** history and physical, consult/specialist notes or letters. Demographics sheet, operative and pathology notes, procedure notes, physical, speech, and/or occupational therapist reports, emergency department records, discharge summary, signature logs.

We appreciate your cooperation and ask that you return the attached form and requested medical records via one of the following methods:

a) Please fax to 803-419-5715  
 b) Please email to [ACARISK.RECORDS@BCBSSC.COM](mailto:ACARISK.RECORDS@BCBSSC.COM)  
 c) Please mail using the address with P.O. Box number indicated below:  
 Blue Cross Blue Shield of South Carolina and Blue Choice Health Plan  
 Attn: ACARISK.RECORDS  
 Quality Improvement AX-310  
 P.O Box 6170, Columbia, SC 29260

Please understand it is very important that we receive the requested information in a timely manner and ask that you respond as quickly as possible. Please provide the requested member information specified on the attached documents within 10 business days of this request. Failure to respond to this request will result in an increase in medical record requests.

If you have any questions regarding this request, please contact **Nicole Hurd @ 803-264-3374 or Tara Dunn @ 803-382-5531** or send an email to [ACARISK.RECORDS@bebscc.com](mailto:ACARISK.RECORDS@bebscc.com).

Thank you in advance for your cooperation.

Sincerely,  
 Nive Raman, PMP, CPC, CRC  
 Manager, Program Change Quality Improvement

### Member Details for RISK

Provider: <<Name>> | <<TIN>> | <<Address>> : <<MemberCount>> Member(s)

Member Name   Registration No.   ID Card No.	Date of Birth   Gender	Chase ID	DOS From - DOS To	Measuremen Year
<<Name>>   <<RegNo>><<CellMerg e>>	<<Dob>>   <<Gender>><<C ellMerge>>	<<Chaseld>>	<<DOS>>	<<Measureme ntYear>>

Letter includes:

- Members information and dates of services we must have if they cannot provide the whole year.
- The types of records we are looking for (i.e., office notes, consults, etc.).
- How to return the records (i.e., fax, mail or email.).
- How you can reach use if you have any questions.

# RADV Cover Letter for Release of Information

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Center for Consumer Information & Insurance Oversight



Date: May 28, 2024

To: Hospitals, Physicians, and Practitioner Health Care Providers

From: Elizabeth Parish  
Director, Payment Policy & Financial Management Group  
Center for Consumer Information & Insurance Oversight  
Centers for Medicare & Medicaid Services (CMS)  
Department of Health and Human Services (HHS)

Re: Medical Record Requests for the HHS-operated Risk Adjustment Data  
Validation (HHS-RADV) Audit

**SPECIAL NOTE: In accordance with CMS policies, DO NOT FORWARD ANY MEDICAL RECORDS TO CMS OR ITS CONTRACTORS.** Medical records received by CMS will be destroyed. Please follow the instructions provided by the requestor.

The current HHS-RADV audit pertains to services provided during the 2023 calendar year.<sup>1</sup> The requesting entity has determined that one or more of your patients are included in the HHS-RADV audit sample for services rendered during 2023. Because 2023 HHS-RADV medical record review is time sensitive, **your immediate attention to this request is appreciated.**

Please find attached a medical record request from a health insurance company or its delegated entity. It is important to respond to this request by the date in the medical record request letter. These requests are applicable to all providers, whether or not the provider has a contractual agreement with the health insurance company.

Thank you in advance for your prompt cooperation.



Date: \_\_\_\_\_

2024 Dear Provider,

**IMPORTANT  
CMS AUDIT REQUEST**

**Why we are writing:**

We are contacting you because we have been notified by the Centers for Medicare & Medicaid Services (CMS) that we have been selected for Risk Adjustment Data Validation (RADV). This audit requires that we submit medical records validating diagnostic information that was previously submitted to CMS through claims.

We want to assure you that there are no financial consequences to you because of this audit. Please note this request is not related to previous medical record requests you may have received from us or any other vendor acting on our behalf.

**What you need to do:**

To comply with this audit request, CMS has identified member medical records needed for 2023 dates of service. Enclosed, you will find the list of members seen by your practice in 2023. Please provide the entire 2023 medical chart for review, if unable to send whole year we have included the must have dates of services.

Please bear in mind that medical records requested for audit purposes should be provided at no cost as a part of your contractual agreement with us.

**How to submit the requested records:**

To meet the CMS deadline, please submit the required medical records for 2023 to us by \_\_\_\_\_, You can submit the records via fax to 803-419-5715 or via email to [RADV.RECORDS@bcbssc.com](mailto:RADV.RECORDS@bcbssc.com). If you prefer, you can mail the medical records to:

BlueCross BlueShield of South Carolina  
Attn: ACA RADV Records  
Quality Improvement, AX-310  
P.O. Box 6170, Columbia, SC 29260

Please understand it is very important that we receive the requested information in a timely manner and ask that you respond as quickly as possible. Also, please send the requested medical records to us and don't send it to CMS or its contractors. Thank you in advance for your cooperation.

Sincerely,  
Nive Raman, F.M.P., C.P.C., C.R.C.  
Manager, Program Change  
Quality Improvement  
BlueCross BlueShield of South Carolina/BlueChoice  
HealthPlan

# RADV Cover Letter for Release of Information (Continued)



Please return by: **Process within 10 business days**

**Please return to:** Send the medical records to us along with a copy of the face sheet via fax to 803-419-5715; or via email to [RADV.RECORDS@bcssc.com](mailto:RADV.RECORDS@bcssc.com). If you prefer, you can mail the medical records to:

BlueCross BlueShield of South Carolina  
**Attn: ACA RADV Records**  
Quality Improvement, AX-310  
P.O. Box 6170, Columbia, SC 29260

*If any additional questions regarding this request, please contact **Nicole Hurd @ 803-264-3374** or **Savannah Miano @ 803-382-4519***

Provider Info-

TAX ID	NPI	GROUP NAME

Provider

TAX ID	NPI	GROUP NAME

Member Details-

MEMBER NAME	MEMBER ID Card	DOB	Chase ID	From DOS	To DOS

Letter includes:

- Members information and dates of services we must have if they cannot provide the whole year.
- The types of records we are looking for (i.e., office notes, consults, etc.).
- How to return the records (i.e., fax, mail or email.).
- How you can reach use if you have any questions.



# RADV Invoice Response Letter

Date: 09/09/2024

## FAX Coversheet

**To:** Medical Records Dept.  
**Fax No:** XXX-XXX-XXXX  
**Pages:** 1  
**From:** Provider Education  
**Contact No:** 803-264-4730

### Re:

Your medical records vendor is billing BCBSSC for medical records that were previously received or requested.

The submission of medical records is a non-billable event. Network providers should submit medical records requested at no cost to BCBSSC when requested.

**Please inform your medical records vendor and share this information with the appropriate staff.**

09/9/2024

Re: Record invoice response

Hello,

As a company BCBSSC does not make payments for any medical records. Providers have a contractual obligation to send us the charts free of charge-please refer to your contract with us or call providers office if this is a third party vendor. It is addressed under IV. A(10) last sentence, "BCBSSC or the Associate Plan will have the right to inspect, review and obtain copies of such records upon request at no charge." All providers signed an individual HIX Agreement with this language in it. If you have any questions about the contract you may contact provider education 800-288-2227

Kindly let us know if you need any other details regarding the requests.

Thanks for your prompt attention to this time sensitive request.

Thank you,

Nive Raman, PMP, CPC, CRC  
Risk Manager- Quality Improvement  
BlueCross BlueShield of South Carolina  
Phone: 803-264-4224  
[Nivedhitha.Raman@bcbsc.com](mailto:Nivedhitha.Raman@bcbsc.com)  
<http://www.bcbsc.com/confidentiality.htm>



The document being transmitted contains private, privileged and confidential information belonging to the sender and is intended for the use of the addressee only. If this transmission is received by anyone other than the addressee, please advise the sender immediately at 1-803-419-8191 (fax) so that we can arrange for the return of the documents. In such circumstances, you are advised that you may not review, disclose, copy, distribute or take any other action in connection with the documents transmitted.

P.O. Box 6170 Columbia, SC 29260-6170

[www.southcarolinablues.com](http://www.southcarolinablues.com), [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com)  
An Independent Licensee of Blue Cross and Blue Shield Association.

## IV. PREFERRED PROVIDER'S RESPONSIBILITIES.

### A. Preferred Provider shall:

- (1) Accept payment of the Fee Allowance amount as payment in full for Covered Services rendered to Members. All payments are subject to the terms of the Member's Benefits Contract. Member shall be solely responsible for any required Patient Pay Amounts and Preferred Provider shall not bill the Member any amount in excess of such Patient Pay Amounts for Covered Services. Payment will be adjusted for payments made to Preferred Provider pursuant to any coordination of benefits provisions in any health plan other than the Benefits Contract.
- (2) While performing services, maintain a physician-patient relationship with enrolled Members. Any and all medical service decisions, treatment decisions or exercises of medical judgment are Preferred Provider's responsibility.
- (3) Not discriminate against any Member on the basis of race, color, sex, age, religion, national origin, handicap or insurance plan in providing services under this Agreement. Preferred Provider may choose to be closed to new Members as a group but only if Preferred Provider is closed to new patients from all payor sources.
- (4) Cooperate and comply with the Provider Office Administrative Manual (located at [www.southcarolinablues.com](http://www.southcarolinablues.com) at the time of this writing).
- (5) Use only HIX Network Providers in the delivery of Covered Services unless Covered Services, supplies or equipment are not available from any HIX Network Provider, or in the case of an Emergency.
- (6) Provide Covered Services in an appropriate outpatient setting whenever safe, quality care can be provided in such a setting.
- (7) Cooperate fully with the Utilization Management Program.
- (8) Agree to provide a second opinion to Members who have already consulted with another HIX Network Provider.
- (9) Cooperate and participate with BCBSSC and any Associate Plan in any utilization control procedures, quality assurance activities, analysis of Member's risk status, external audit systems and grievance procedures, as may be established pursuant to the terms of the Benefits Contract, and comply with all final determinations rendered through the grievance process.
- (10) Maintain, with respect to each Member for whom Covered Services are provided under this Agreement, standard medical records in such form, containing such information, and meeting such record keeping requirements as might be required by applicable federal and state law. Preferred Provider will keep confidential, and take all reasonable precautions to prevent the unauthorized disclosure of any and all records prepared and/or maintained by this Agreement. BCBSSC or the Associate Plan will have the right to inspect, review and obtain copies of such records upon request at no charge.

# How Providers Can Help the Program

- The best thing you can do for your patients to keep this program going is have clear and thorough documentation in your notes.
- Another help is sending medical records as soon as request are received from insurer. Please call if you need help with pulling records. Help receive records from a third-party vendor in a timely manner.
- Only use the term "history of" if the patient no longer has this condition. Try using patient current medical conditions are... instead of patient with a history of.
- Address any chronic issue that may affect your decision making- coders are not doctors and can not make the connection if not clearly stated.
- Document all cause and effect relationships-document conditions which coexist at the time of the visit that require or affect patient care or treatment.
- More details on the condition are better for coding accuracy.

# Key Takeaways



# Positive Impacts on Quality Scores

## Customer service

With every member's interaction

## Schedule patients

Include periodic screenings and preventive services

Follow up on missed appointments

## Data Transfer

To reduce medical record requests or grant remote access to the quality navigator team.

## Codes

Submit NCQA-approved quality codes on claims when appropriate.



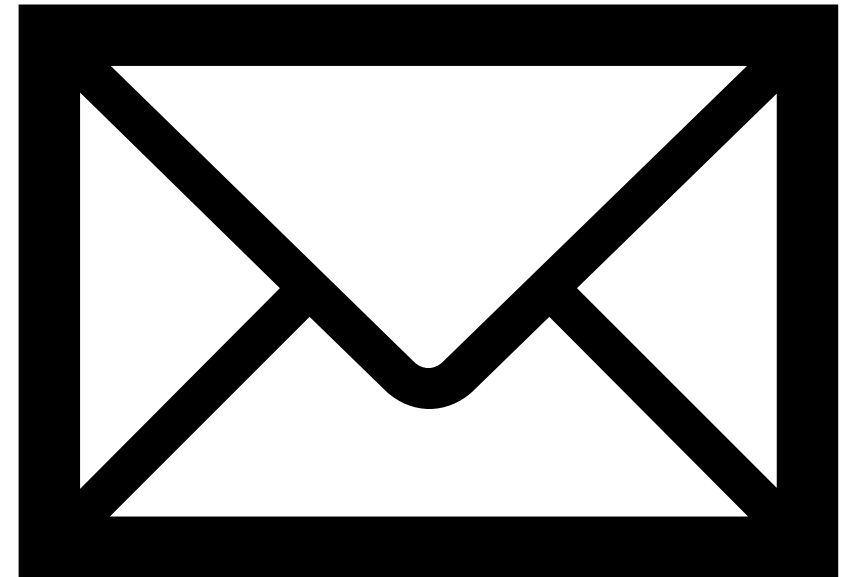
3051F



South Carolina

# Contact Information

- ❑ For general assistance or information about the Quality Navigator Program, email [Navigator@bcbssc.com](mailto:Navigator@bcbssc.com).



# Self-serving Tools

# Topics to Discuss

- ❑ Website Overview
- ❑ Voice Response Unit
- ❑ My Insurance Manager<sup>SM</sup>
  - Getting Benefits
  - Submitting Claims
  - Claims Status
  - Ask Provider Services
  - STATchat<sup>SM</sup>
- ❑ My Remit Manager

# Website Overview





# SouthCarolinaBlues.com



SHOP PLANS

MEMBERS

PROVIDERS

EMPLOYERS

AGENTS

Providers

Providers ▾

Search...

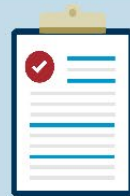


## My Insurance Manager

File claims, get prior authorizations, check eligibility and benefits, and more.

Log In

Feedback



Policies and



Claims and Payments >



Provider Enrollment >



South Carolina



Focus on life. Focus on health. Stay focused.



COVID-19



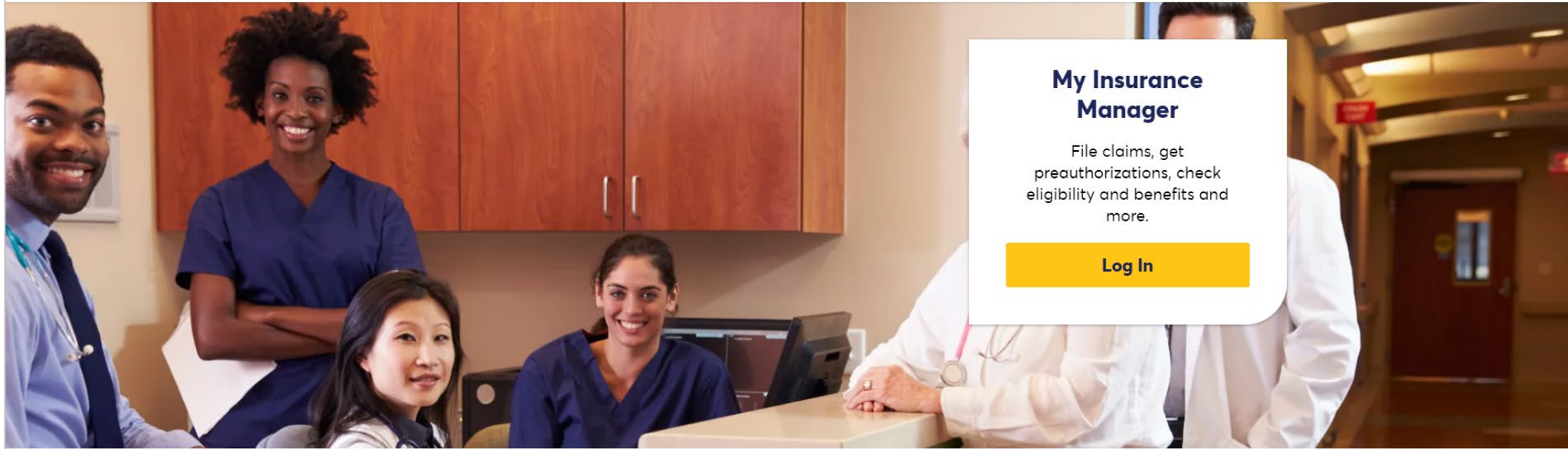
MEMBER CENTER



FIND CARE



FIND A FORM



## My Insurance Manager

File claims, get preauthorizations, check eligibility and benefits and more.

Log In

## Education Center

[Tools and Resources](#)



[Manuals & User Guides](#)



[Prior Authorization](#)



[Laboratory Benefits](#)



# HealthyBlueSC.com



AAA Español Members

Authorization and Eligibility ▾ Claims ▾ Patient Care ▾ Pharmacy Resources ▾

JOIN OUR NETWORK



## Providers

Interested in joining our provider network? We look forward to working with you to provide quality services to our members.

JOIN OUR NETWORK

### My Insurance Manager

File claims, get prior authorizations, check eligibility and benefits and more.

LOG IN

REGISTER

[2023 Date of Service Login](#)  
[Forgot Username or password?](#)

# News Bulletins

Providers

[Home](#) / [Providers](#) / [News and Events](#) / [Current News](#)

[www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)

### Current News

Topics

- [Medical Policies \(8\)](#)
- [Enrollment \(5\)](#)
- [Prior Authorization \(5\)](#)
- [Benefits \(4\)](#)
- [Medicare Advantage \(2\)](#)
- [COVID-19 \(1\)](#)
- [Pharmacy \(1\)](#)
- [Claims \(1\)](#)
- [Other \(1\)](#)
- [All \(23\)](#)

Date Posted

- [August 2023 \(3\)](#)
- [July 2023 \(2\)](#)
- [June 2023 \(1\)](#)
- [May 2023 \(5\)](#)
- [April 2023 \(1\)](#)
- [March 2023 \(3\)](#)
- [February 2023 \(2\)](#)
- [January 2023 \(6\)](#)
- [All \(23\)](#)

BlueChoice HealthPlan South Carolina

EMPLOYERS AGENTS PROVIDERS CONTACT MEDICAID

COVID-19 MEMBER CENTER FIND CARE FIND A FORM

[www.BlueChoiceSC.com](http://www.BlueChoiceSC.com)

### Continued Education on Biosimilars

### Glucagon-Like Peptide-1 Agents Utilization Management Update

### Medical Policy Updates (March 2023)

### Reminder: 90-Day Provider Validation Requirements

### Medical Policy Updates (June 2023)

## Bulletins

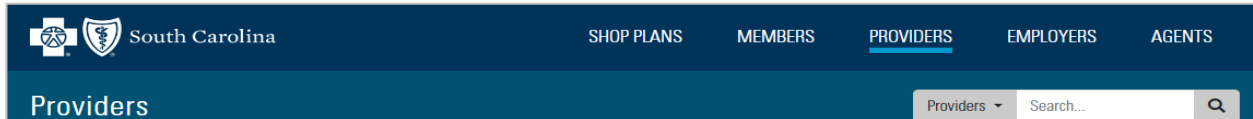
Our bulletins provide beneficial information to ensure you are always in the know. Always check the latest bulletins for any important updates or other details that could impact you.

- [Healthy Blue Waiving Copays in 2024](#)
- [My Remit Manager](#)
- [My Insurance Manager](#)
- [Reminder: Provider Enrollment 7-7-7 Rule](#)
- [Making Corrections to Provider Enrollment Applications](#)
- [Reminder: 90-Day Provider Validation Requirements](#)

[VIEW PAST BULLETINS](#)

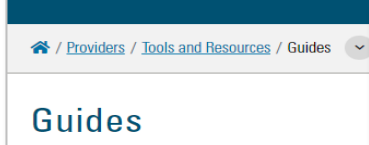
[www.HealthyBlueSC.com](http://www.HealthyBlueSC.com)

# Manuals and Guides

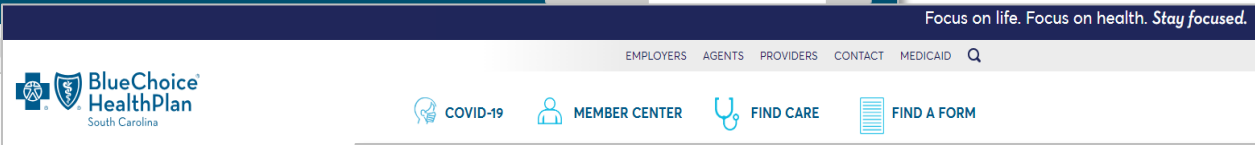


South Carolina navigation bar with links: SHOP PLANS, MEMBERS, PROVIDERS, EMPLOYERS, AGENTS. Search bar for Providers.

[www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)

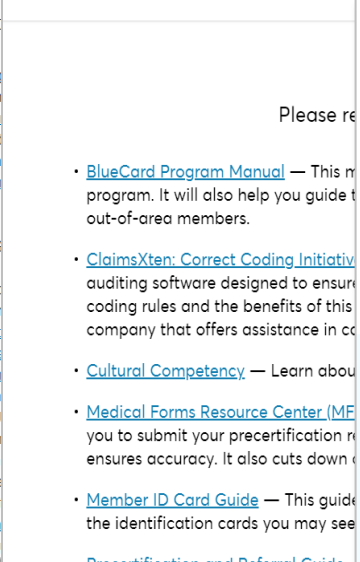


Guides section with a list of links for various topics like Ancillary Claims, Anesthesia Guidelines, etc.



BlueChoice HealthPlan navigation bar with links: EMPLOYERS, AGENTS, PROVIDERS, CONTACT, MEDICAID. Search bar.

[www.BlueChoiceSC.com](http://www.BlueChoiceSC.com)



- [BlueCard Program Manual](#) — This manual provides information for providers in the BlueCard program. It will also help you guide out-of-area members.
- [ClaimsXten: Correct Coding Initiative](#) — This software is designed to ensure coding rules and the benefits of this company that offers assistance in coding.
- [Cultural Competency](#) — Learn about the importance of cultural competency in providing quality care.
- [Medical Forms Resource Center \(MFC\)](#) — This resource center provides you to submit your precertification requests quickly.
- [Member ID Card Guide](#) — This guide provides information on the identification cards you may see.
- [Precertification and Referral Guide](#) — This guide provides information on the insurance manager and determining when a referral is needed.
- [Preventive Care Guide](#) — This guide provides information on preventive care for non-grandfathered plans.



Home / Providers / Resources / Forms, Policies & Guidelines

Healthy Blue is committed to supporting you in providing quality care and services to the members in our network. On this page you will find frequently used forms, provider manuals and guides, information for assessing coverage options, guidelines for clinical utilization management (UM), practice policies and support for delivering benefits to our members.

## Provider Manual

The Healthy Blue provider manual provides key administrative information, including the quality improvement program, the UM program, quality standards for participation, claims appeals, and reimbursement and administration policies.

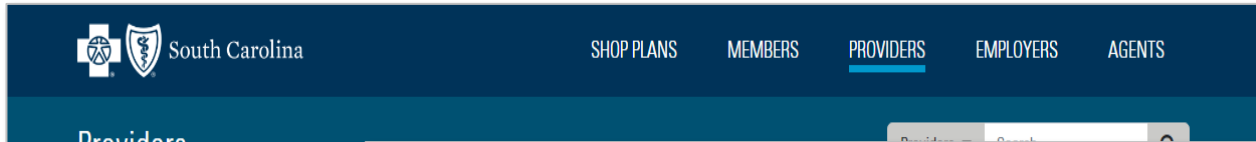
[View Provider Guides](#)

[Provider Manual](#)

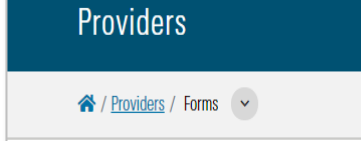
[Quick Reference Guide](#)

[www.HealthyBlueSC.com](http://www.HealthyBlueSC.com)

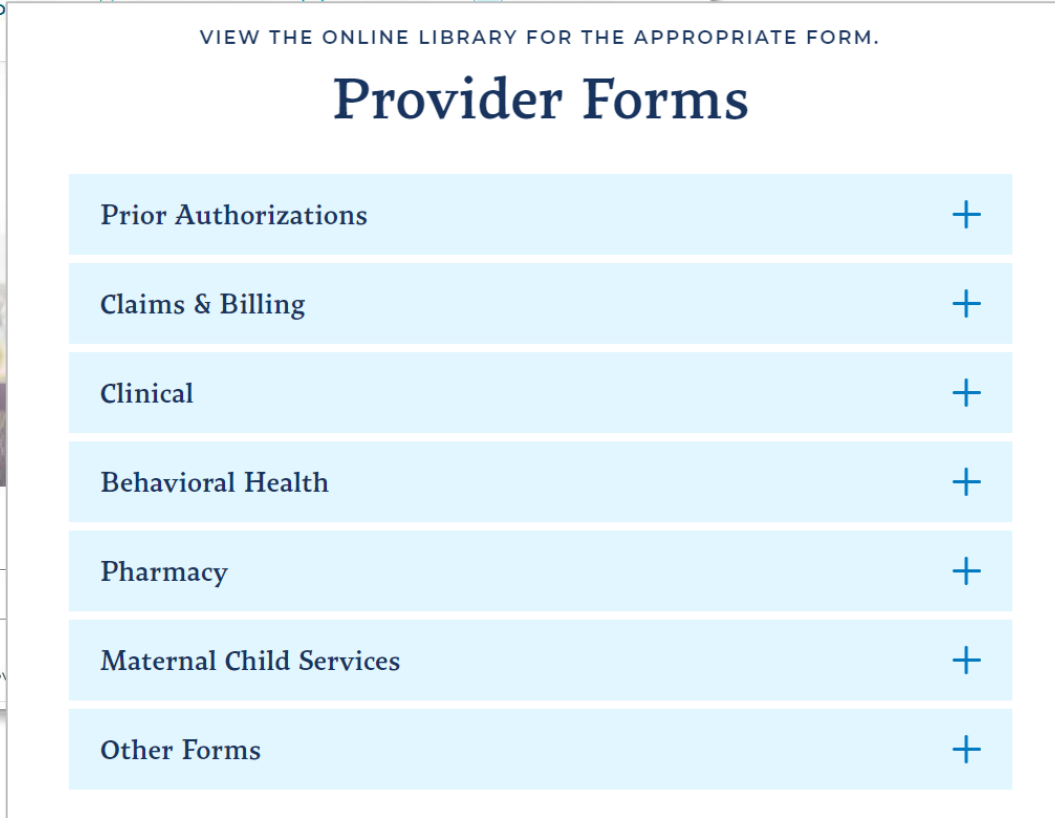
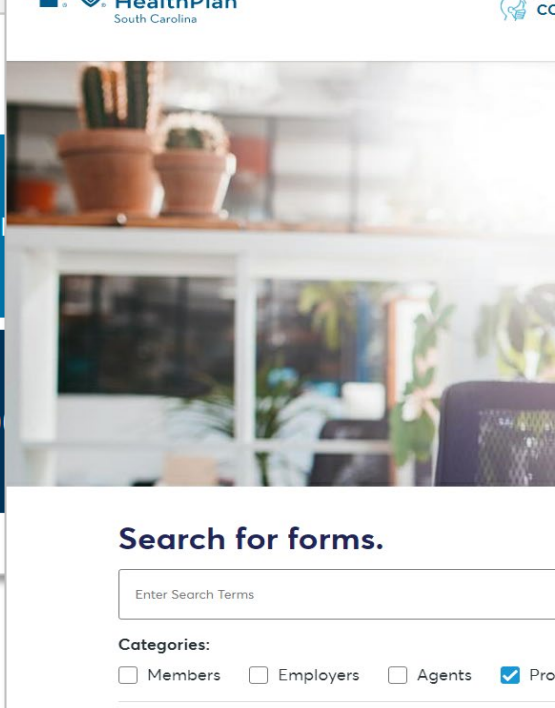
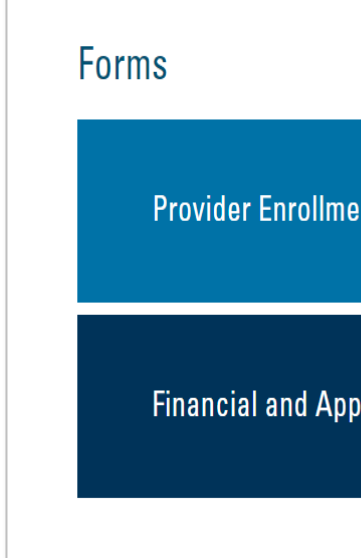
# Available Forms



[www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)



[www.BlueChoiceSC.com](http://www.BlueChoiceSC.com)



[www.HealthyBlueSC.com](http://www.HealthyBlueSC.com)

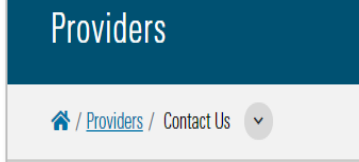
# How to Contact Provider Education



South Carolina

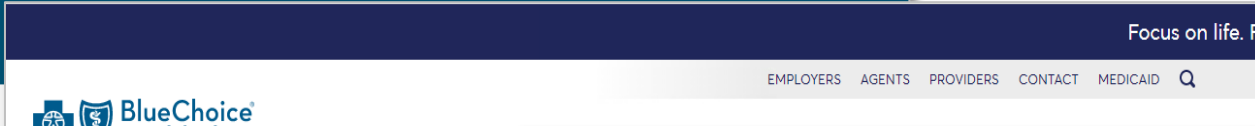
SHOP PLANS MEMBERS PROVIDERS EMPLOYERS AGENTS

[www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)



Providers

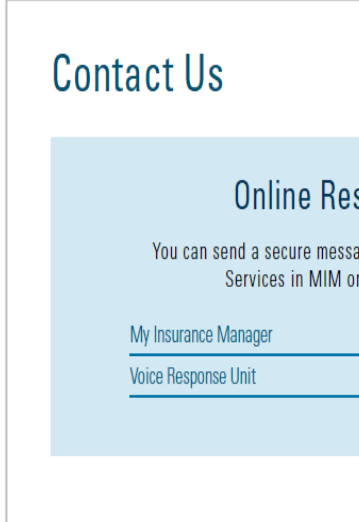
Home / Providers / Contact Us



BlueChoice HealthPlan South Carolina

EMPLOYERS AGENTS PROVIDERS CONTACT MEDICAID

[www.BlueChoiceSC.com](http://www.BlueChoiceSC.com)



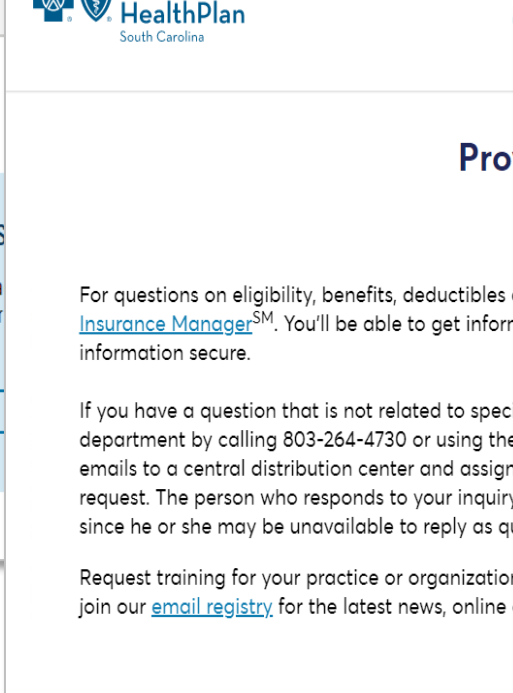
## Contact Us

### Online Res

You can send a secure message to our Provider Education Services in MIM or

[My Insurance Manager](#)

[Voice Response Unit](#)



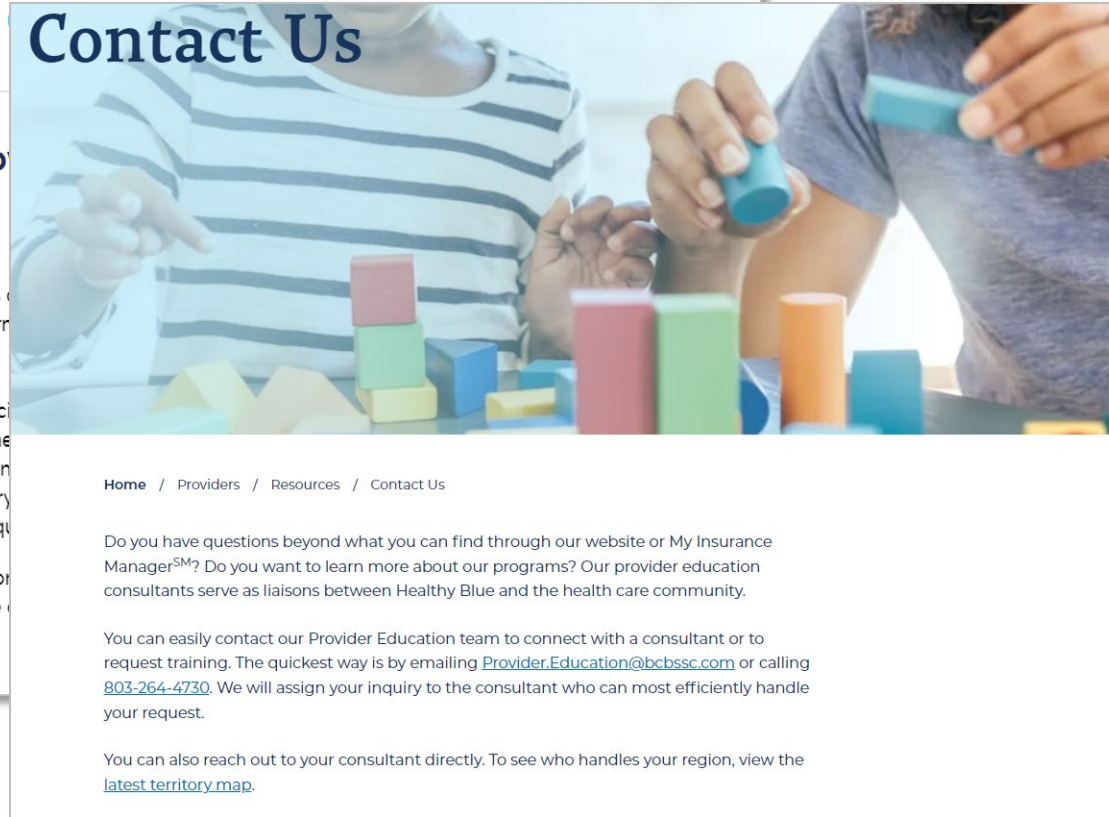
## Contact Us

Pro

For questions on eligibility, benefits, deductibles or [Insurance Manager](#)<sup>SM</sup>. You'll be able to get information secure.

If you have a question that is not related to special department by calling 803-264-4730 or using the emails to a central distribution center and assign request. The person who responds to your inquiry since he or she may be unavailable to reply as qu

Request training for your practice or organization join our [email registry](#) for the latest news, online



## Contact Us

Home / Providers / Resources / Contact Us

Do you have questions beyond what you can find through our website or My Insurance Manager<sup>SM</sup>? Do you want to learn more about our programs? Our provider education consultants serve as liaisons between Healthy Blue and the health care community.

You can easily contact our Provider Education team to connect with a consultant or to request training. The quickest way is by emailing [Provider.Education@bcbsc.com](mailto:Provider.Education@bcbsc.com) or calling [803-264-4730](tel:803-264-4730). We will assign your inquiry to the consultant who can most efficiently handle your request.

You can also reach out to your consultant directly. To see who handles your region, view the [latest territory map](#).

[www.HealthyBlueSC.com](http://www.HealthyBlueSC.com)

# Voice Response Unit





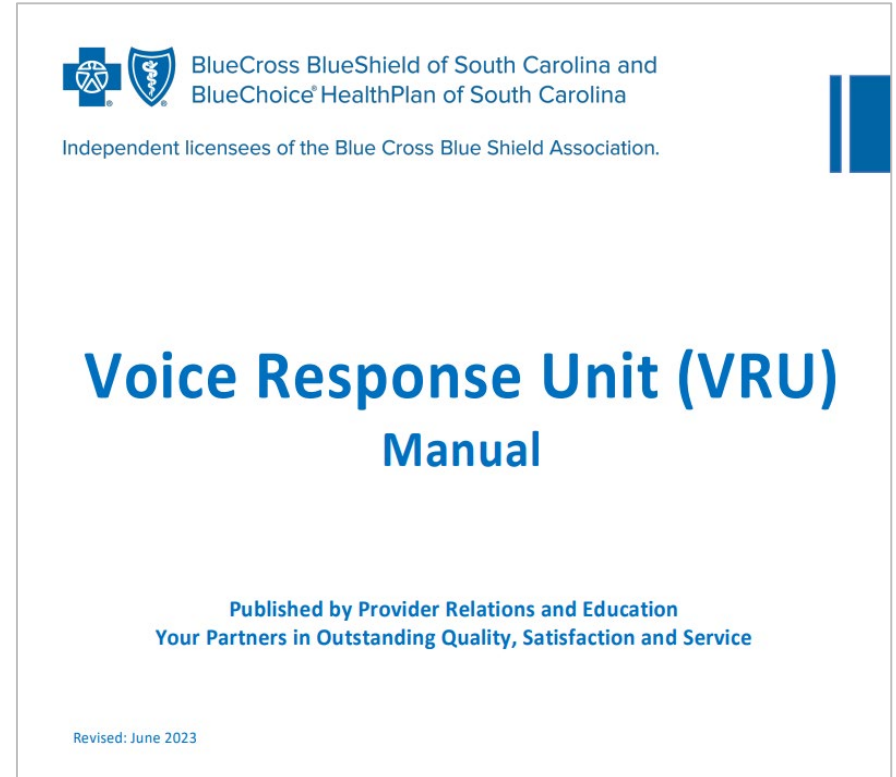
# Getting Benefits Through the Voice Response Unit

## ❑ Call one of the following numbers to use the voice response unit:

- Columbia or Lexington: 803-788-8562
- Other locations in South Carolina: 800-868-2510
- Outside of South Carolina: 800-334-2583
- BlueChoice® HealthPlan: 800-868-2528
- State Health Plan: 800-444-4311
- Federal Employee Program: 888-930-2345
- BlueCard Eligibility: 800-676-BLUE (2583)

## ❑ Be sure to have the following information ready:

- Your Tax ID or NPI
- Patient identification number (including the prefix)
- Patient's date of birth



# Getting Benefits Through the Voice Response Unit (Continued)

## ❑ You will hear the following information:

- Type of coverage
- Effective date
- Benefit period
- Group number

## ❑ Available benefit options:

- Hospital
  - o Inpatient and outpatient
- Behavioral health
- Rehabilitation
- Home health
- And much more!

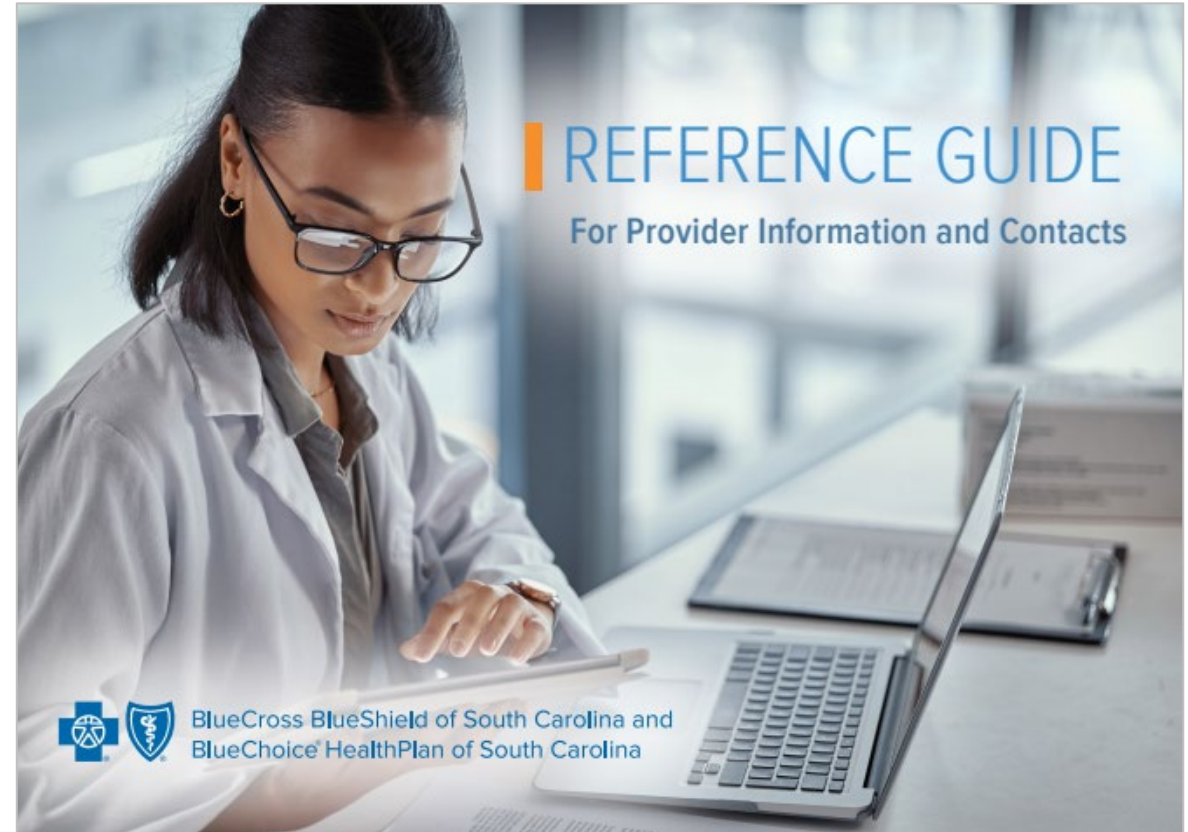
# Getting Claim Details Through the Voice Response Unit

- ❑ **Call one of the telephone numbers from the previous slide.**
- ❑ **Be sure to have the following information ready:**
  - Your Tax ID or NPI
  - Patient identification number (including the prefix)
  - Patient's date of birth
  - Date of service
- ❑ **If a claim was paid or applied patient liability, you will receive:**
  - Processed date
  - Remittance date
  - Check number
  - Amount paid or applied to patient liability
- ❑ **If a claim is denied, you will receive the following:**
  - Denial reason
  - Remittance date

*Note: If a claim is processed to the member, please contact them for the details. Submitting a HIPAA transaction (267/277) will let you know if the claim processed to the member.*

# Quick Reference Guide

- ❑ Identify the most efficient ways to the benefit information, prior authorizations and much more.
  - Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com):
    - Providers>Tools and Resources>Guides



# My Insurance Manager



# Overview of My Insurance Manager

- ❑ My Insurance Manager is a web-based tool used to check eligibility, benefits, claim status, get prior authorizations and much more.
- ❑ Available reference guides include:
  - Getting Started
  - Eligibility and Benefits
  - Claims Entry
  - Claims Status, Patient Directory, Superbill Maintenance and Coordination of Benefits
  - Precertification, Pre-Treatment Estimate for Authorization Status
  - Office Administration
  - Provider Validation: M.D. Checkup

Note: Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) to review the available guides.

# Getting Started with My Insurance Manager

- ❑ Visit one of the websites:
  - [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)
  - [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com)
  - [www.HealthyBlueSC.com](http://www.HealthyBlueSC.com)
- ❑ Select the available link to My Insurance Manager.
- ❑ From the home page, select **Register Now** if you're a first-time user.

The screenshot shows the My Insurance Manager website. At the top left is the logo "My INSURANCE MANAGER". Below it is a login form with fields for "Username" and "Password", and buttons for "Login" and "Register Now!". The "Register Now!" button is circled in red. Below the login form are links for "Forgot Username?" and "Forgot Password?". To the right of the login form is a banner image of a smiling female doctor with a stethoscope. The banner text says "Welcome to My Insurance Manager!" and "Log in to file a claim, check benefits and more! If you have never registered, you will need to create a profile." with a "Register Now" button. Below the banner is a "Browser Requirements" section with a list of supported browsers: Internet Explorer 10 or Higher, Mozilla Firefox (current version), Google Chrome (current version), and Safari (Mac OS Only). Below the browser requirements is a "Latest Features" section with two cards. The first card is titled "Is your password strong enough?" and "Safeguard PHI!" with a "Learn how" button. The second card is titled "Are you accepting new patients?" and "Let us know!" with a "Validate Now" button.

# Creating a Profile in My Insurance Manager

- ❑ When creating a profile, your **9-digit Tax ID number** must be entered.

**My INSURANCE MANAGER<sup>SM</sup>**

---

## Create Profile

[Printer-Friendly](#)

\* Required

Please enter your 9-digit Tax ID number.

\* Tax ID:

By clicking Continue, you agree to the [Terms and Conditions](#).

or [Cancel](#)

**Need help? Call us at 855-229-5720.**



# Creating a Profile in My Insurance Manager (Continued)

- ❑ The information associated with the Tax ID will pre-populate.
  - If there are multiple locations for the practice, you will be given the option to select the primary location.
- ❑ Enter the remaining contact and login information.
- ❑ Select a security question.

Create Profile Printer-Friendly Required

**Profile Information**

Each person can register under your Tax ID. For example, both Stuart and Sally work for ABC Practice. Under Practice/Facility Name, both would enter "ABC Practice." Then, each would enter a different Username, Password and other registration information.

Tax ID: 123456789 Provider: YOUR PRACTICE/FACILITY

Address: 4101 PERCIVAL RD COLUMBIA, SC 29229-8320 Note: If this address is incorrect, please complete the change of address form.

\* Primary Location: YOUR PRACTICE/FACILITY  Primary Work Location: 1111122222

Profile Type: Office Staff

**Contact Information**

\* First Name:

\* Last Name:

\* Phone Number:

\* Email:

\* Confirm Email:

**Login Information:**

\* Desired Username:

5 to 11 characters.

\* Password:

8 to 25 characters.

\* Confirm Password:

**Security Question**

\* Security Question:

\* Security Answer:

or

Need help? Call us at 855-229-5720.

# Creating a Profile in My Insurance Manager (Continued)

- ❑ If registering as the **profile administrator**, you must validate your profile by entering claim information or requesting a security code (recommended). Also, choose the delivery method for the code.

## Validate Profile Printer-Friendly

**Profile Validation**

Please choose a way to validate yourself as an administrator of this Tax ID.

Enter Claim Information

Request Security Code

**Request Security Code** \* Required

You can request that we send a Security Code via the delivery method we have on file associated with your Tax ID.

\* Location:  Select

\* Delivery Method:

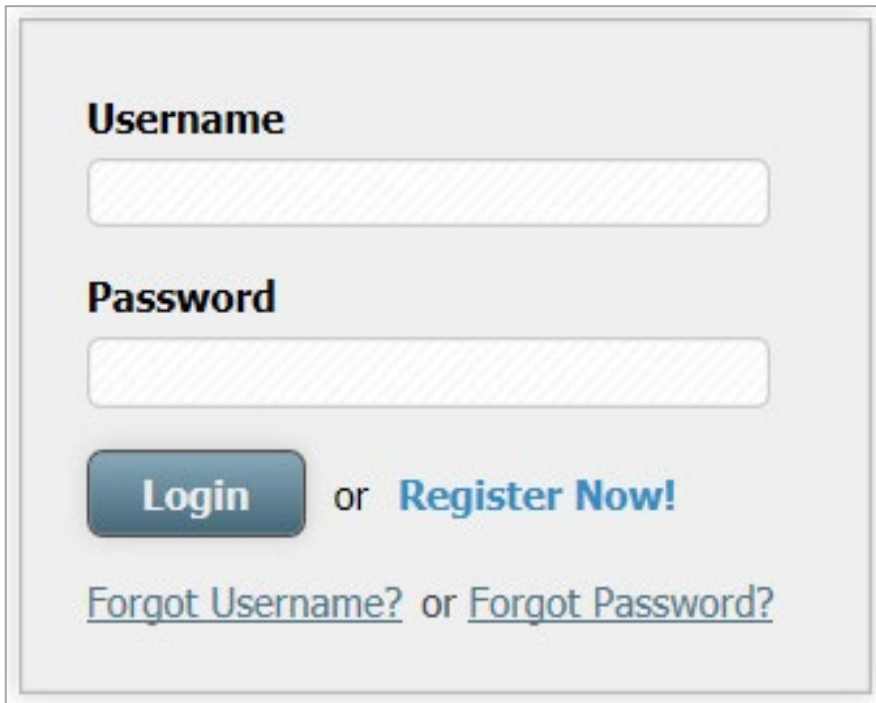
Email:

Fax:

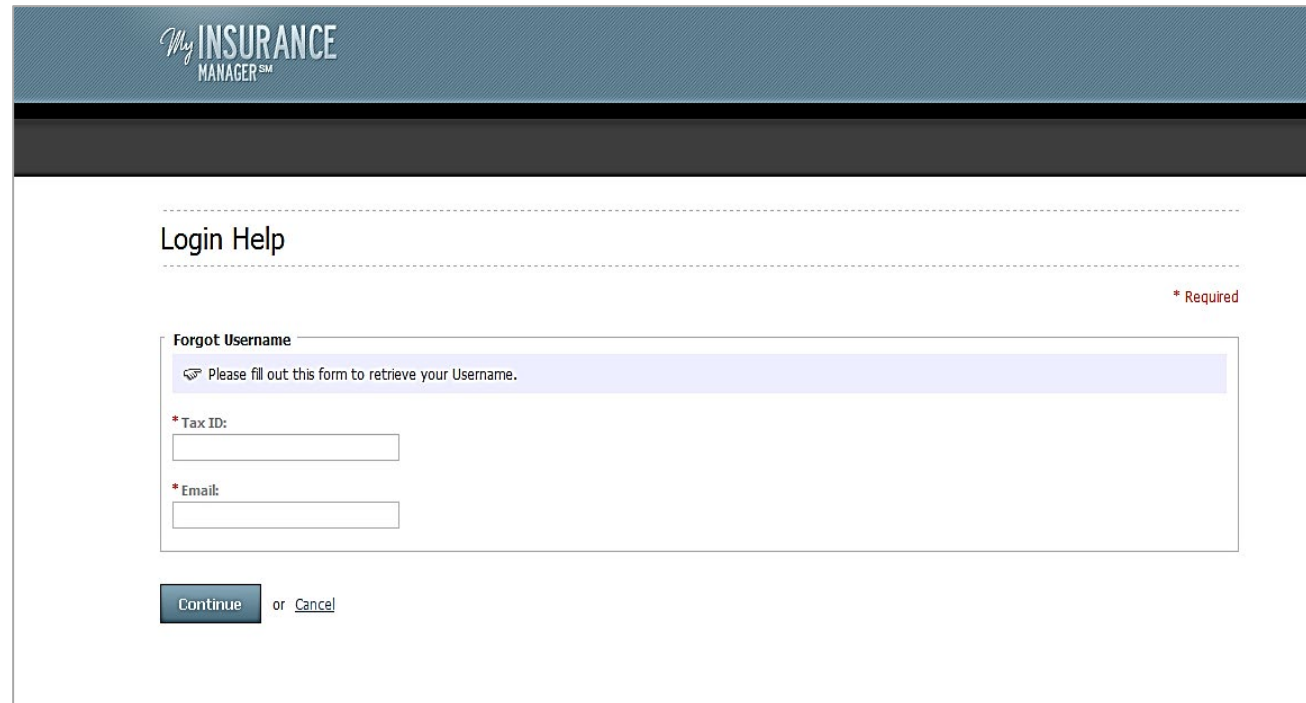
Physical Address:

# Log Into My Insurance Manager

- ❑ After completing registration, it can take up to two business days for the profile to be approved.
  - If the practice already has an established Profile Administrator, they can approve profiles immediately.
- ❑ When the profile is approved, use your username and password to log in.



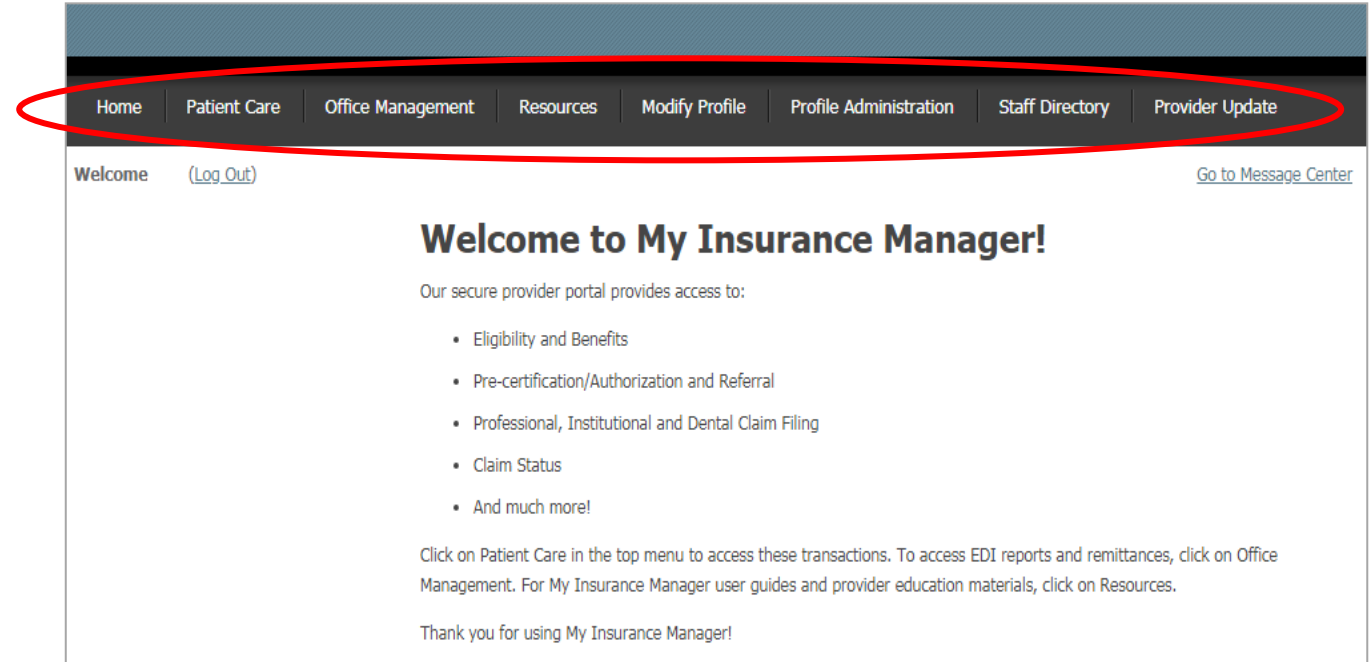
A screenshot of the My Insurance Manager login page. It features a light gray background with a white border. At the top, the text "Username" is displayed in bold. Below it is a white input field with a diagonal hatching pattern. Underneath, the text "Password" is displayed in bold, followed by another white input field with a diagonal hatching pattern. A blue button labeled "Login" is positioned to the left of the text "or Register Now!". At the bottom, there are two blue links: "Forgot Username?" and "Forgot Password?".



A screenshot of the My Insurance Manager "Forgot Username" page. The page has a dark blue header with the "My INSURANCE MANAGER SM" logo. Below the header is a "Login Help" section. A red asterisk and the word "Required" are visible. The "Forgot Username" section contains a light blue box with the text "Please fill out this form to retrieve your Username." Below this are two input fields: "\* Tax ID:" and "\* Email:". At the bottom, there are two buttons: "Continue" and "Cancel".

# Navigational Options

- ❑ The following administrative tabs are located at the top of the home page:
  - Patient Care
  - Office Management
  - Resources
  - Modify Profile
  - Profile Administration
    - Only available for administrators
  - Staff Directory
  - Provider Update (M.D. Checkup)



# Patient Care

Patient Care

Office Management

Resources

Modify Profile

## Health

- ▶ Authorization Extension
- ▶ Authorization Status
- ▶ Claims Status
- ▶ Eligibility and Benefits
- ▶ Institutional Claim Entry
- ▶ Other Health Insurance
- ▶ Patient Directory
- ▶ Pre-Certification/Referral
- ▶ Superbill Maintenance
- ▶ Pre-Service Review for Out-of-Area Members
- ▶ Professional Claim Entry
- ▶ Verify Primary Care Physician

## Dental

- ▶ Claims Status
- ▶ Dental Claim Entry
- ▶ Eligibility and Benefits
- ▶ Other Dental Insurance
- ▶ Patient Directory
- ▶ Superbill Maintenance
- ▶ Pre-Treatment Estimate Entry
- ▶ Pre-Treatment Estimate Status

# Office Management

<b>Office Management</b>	Resources	Modify Profile	Profile Adminis
<b>Health</b>			
▶ EDI Reports	▶ Refund Letters		
▶ EFT/ERA Enrollment	▶ HEDIS® Quality Reports		
▶ PCMH Reports	▶ Employer Group Care Reports		
▶ PCMH Patient Validation	▶ Provider Report Cards		
▶ Remittance Information			
<b>Dental</b>			
▶ EDI Reports	▶ Remittance Information		
▶ EFT/ERA Enrollment			

Note: PCMH reports are only available for PCMH providers.

# Office Management - Refund Letters

- ❑ Refund letters are in My Insurance Manager.
  - Search by the refund control number (RCN) or posting date.
  - Includes the patient details and reason for the refund request.
- ❑ Call Provider Services at 800-868-2510 and select option 4 if you need additional information on a refund.
  - Certain lines of business have a separate phone number (i.e., State Health Plan).

### Refund Letters

i Plans included: BlueCross BlueShield of South Carolina, State Health Plan, BlueChoice HealthPlan, HealthyBlue and FEP. Refund Letters are stored by the dates we create them.

Refund Control Number

Posting Date

--Please Choose--

Or

All Locations

**Search**

STATE REFUNDS (AX-B15)  
PO Box 100300  
COLUMBIA SC 29202-3300

0000128

South Carolina  
BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association  
Visit MyInsuranceManager at www.SouthCarolinaBlues.com

NOVEMBER 11, 2021

PF: \_\_\_\_\_  
PC: \_\_\_\_\_  
AT: \_\_\_\_\_

Re: Patient: \_\_\_\_\_  
ID Num: \_\_\_\_\_  
Provider: \_\_\_\_\_  
Date(s): \_\_\_\_\_  
Refund: \_\_\_\_\_

Dear Provider:

We sent a payment to you on March 01, 2021, in error for the patient listed above. We must request a refund of \$338.40 for the reason(s) stated below:

THE MEDICARE COINSURANCE IS INCORRECT.

If we have not heard from you within 30 days, we will deduct this amount from future payments to you. Please send this amount, along with a copy of this letter, to:

BlueCross BlueShield of South Carolina  
Attn: Lockbox AX-A31  
1-20 at Alpine Road  
Columbia, SC 29219

We thank you for your cooperation and apologize for any inconvenience. If you have any questions, please call our Provider Service department at 800-444-4311.

Sincerely,

State Group Refunds

PLB ADJUSTMENTS						
PreProv	Reason Code	Reference Id				Amount
	WO: Overpayment Recovery	P2126417272				338.4
	WO: Overpayment Recovery	P2126417320				90.9
REMITTANCE SUMMARY						
	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj
Totals	.00	.00	.00	.00	.00	429.30
						-429.30

# Office Management - Provider Report Card



BlueCross BlueShield of South Carolina and  
BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

## Provider Report Card

We continuously strive to make working with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan a pleasurable and efficient experience! Please review the results for your practice listed below.

Provider Name: ABC Hospital

Provider Number: 147258369

Last Roster Update: Not Current

Report Month: 8/1/2022

Measure	Previous Rate	Current Rate	Benchmark Rate	Rating
Electronic Media Claims Percentage (EMC)	99.06%	98.77%	93.68%	Above Average
Average Days to Process Claims	0.32	0.40	0.63	Above Average
First Pass Claim percentage (%)	91.59%	92.65%	95.83%	Above Average
First Call Resolution percentage (%)	33.33%	37.14%	90.54%	Below Average
Duplicate Filing Rates	0.47%	0.25%	0.00%	Above Average
Valid NDC Code Usage	100.00%	83.33%	77.78%	Below Average
Precertification Self-Service Usage (Web/VRU)				
Provider Claim Editor denial percentage (%)				

## Reference Documents

Provider Report Card Quick Reference Guide

For your convenience, we have provided a Quick Reference Guide that includes measure descriptions, terms, and comparison methodology for benchmarks on the Provider Report Card.

 [Quick Reference Guide](#)

Note: Empty fields indicate there was no data available for the measure during that period.



# Resources

Resources

Modify Profile

Profile Administration

Staff Director

## Tools

- ▶ Access System News
- ▶ Avalon Lab Benefit Manager
- ▶ Provider Portal 
- ▶ BlueChoice Find Care 
- ▶ Blue Cross Find Care 
- ▶ Code Search
- ▶ EDI Resources
- ▶ FEP Website
- ▶ Forms
- ▶ Lab/Biometric Data Upload
- ▶ Medical Policies
- ▶ My Remit Manager 
- ▶ Provider News and Events
- ▶ State Dental Plan Fee Schedule
- ▶ State Health Plan Fee Schedule
- ▶ Tools and Resources
- ▶ Washington Publishing Company  
Claim Adjustment Reason Codes

# Modify Profile

Modify Profile

Profile Administration

Staff Directory

Provider

## Profile Settings

▶ Change Contact Information

▶ Change Security Question

▶ Change Password

# Profile Administration

Profile Administration

Staff Directory

Provider Update

## Manage Profiles

▶ Create Profiles

▶ Approve Profiles

▶ Deactivate Profiles

▶ Restore Profiles

▶ Modify Profile Types

▶ Reset Passwords

*Note: If someone no longer works at your practice, deactivate their profile. Also, if you are the profile administrator and plan to leave, make someone else the profile administrator.*

# Staff Directory

Staff Directory

Provider Update

All Profiles for Tax ID: 123456789

Results (5)

Name ▲	Phone Number	Email	Location	Type
[REDACTED]	[REDACTED]	[REDACTED]	JOHN M JONES MD	Profile Administrator
[REDACTED]	[REDACTED]	[REDACTED]	JOHN M JONES MD	Profile Administrator
[REDACTED]	[REDACTED]	[REDACTED]	JOHN M JONES MD	Office Staff
[REDACTED]	[REDACTED]	[REDACTED]	JOHN M JONES MD	Profile Administrator
[REDACTED]	[REDACTED]	[REDACTED]	JOHN M JONES MD	Office Staff

# Provider Update (M.D. Checkup)

- ❑ Providers have been required to verify their demographic data at least **every 90 days** since Jan. 1, 2022.
  - This implementation was part of the No Surprises Act.
- ❑ Validation allows us to maintain accurate directories.
- ❑ Verification can be completed in M.D. Checkup (accessible through My Insurance Manager).
  - You can also respond to the email received from [Provider.Directory@bcbssc.com](mailto:Provider.Directory@bcbssc.com).

Provider Update

# Troubleshooting Tips for My Insurance Manager

- ❑ Complete the registration process to avoid limited access.
  - If credentialing is pending, be sure to wait until you receive confirmation that it is completed.
- ❑ Use one of the recommended browsers:
  - Internet Explorer 10 or higher
  - Mozilla Firefox
  - Google Chrome
  - Safari
- ❑ On Sundays, the portal is unavailable for maintenance from 5 p.m. to midnight.
- ❑ For any technical issues, call Technical Support at 855-229-5720.

# Getting Benefits



# Getting Benefits in My Insurance Manager

## Step 1

Health	
▶ Authorization Extension	▶ Patient Directory
▶ Authorization Status	▶ Pre-Certification/Referral
▶ Claims Status	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Service Review for Out-of-Area Members
▶ Institutional Claim Entry	▶ Professional Claim Entry
▶ Other Health Insurance	▶ Verify Primary Care Physician

Dental	
▶ Claims Status	▶ Patient Directory
▶ Dental Claim Entry	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Treatment Estimate Entry
▶ Other Dental Insurance	▶ Pre-Treatment Estimate Status

## Step 2

Eligibility and Benefits Printer-Friendly

**\* Required**

**Patient Selection**

**\* Health Plan:**  
--Please Choose One--

**\* Member ID:**  
  
include alpha prefix, if applicable

**\* Patient's Date of Birth:**  
  
mm/dd/yyyy

**Additional Information** [+] show/hide

**\* Date of Service:**  
04/30/2024   
mm/dd/yyyy

**\* Location:** JOHN M JONES MD  **Primary ID:**



# Getting Benefits in My Insurance Manager - General Benefits

## Step 3 (When pulling general benefits.)

### Eligibility Request

\* Required

#### Choose Eligibility View

**i** Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

- General Eligibility and Benefits
- Eligibility and Benefits by Service Type
- Eligibility and Benefits by Procedure Code

Submit

# Getting Benefits in My Insurance Manager - General Benefits

## Date of Service

04/30/2024

## Insurance

Plan Name:  
BLUECROSS AND BLUESHIELD OF SC

Plan ID:  
38520

Member ID:  
ZCZ065922516805

Group Number:  
036011101

Member's Name:  
MICHAEL TESTING

## Patient

Patient's Name:  
MICHAEL TESTING

Relationship to Member:  
SUBSCRIBER

Gender:  
MALE

Date of Birth:  
10/01/1958

Address:  
P O BOX 24015  
COLUMBIA, SC 292244015

Change Patient

## Response Details

Eligibility Response [±]

Policy Effective Date:

06/01/2002

Benefit Period:

04/01/2024 - 04/01/2025

IN AND OUT OF NETWORK

## Global Benefits

✔ This patient has active coverage.

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: \$250.00 PER SERVICE YEAR - \$250.00 REMAINING

INDIVIDUAL OUT OF POCKET: \$750.00 PER SERVICE YEAR - \$750.00 REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

FAMILY DEDUCTIBLE: \$500.00 PER SERVICE YEAR - \$500.00 REMAINING

FAMILY OUT OF POCKET: \$1,500.00 PER SERVICE YEAR - \$1,500.00 REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

Printer-Friendly

View Benefit Booklet for this patient

Service▲	Place of Service▲	Diagnosis Code (ICD-10)▲	Specialty▲
1- MEDICAL CARE			
✔ This patient has active coverage.			
Insurance Type: INDEMNITY			
Plan Name: INDEMNITY			
<p>For this service type, you will see only a covered/not covered message here and not full benefits details. For more detailed benefits, submit a request for Eligibility and Benefits by Service Type or by Procedure Code.</p>			
33- CHIROPRACTIC	11- OFFICE		
35- DENTAL CARE			
47- HOSPITAL	22- ON-CAMPUS OUTPATIENT HOSPITAL		
48- HOSPITAL - INPATIENT	21- INPATIENT HOSPITAL		
50- HOSPITAL - OUTPATIENT	22- ON-CAMPUS OUTPATIENT HOSPITAL		
51- HOSPITAL - EMERGENCY ACCIDENT	23- EMERGENCY ROOM - HOSPITAL		
52- HOSPITAL - EMERGENCY MEDICAL	23- EMERGENCY ROOM - HOSPITAL		
86- EMERGENCY SERVICES	23- EMERGENCY ROOM - HOSPITAL		
88- PHARMACY			
98- SPECIALIST	11- OFFICE		
98- PROFESSIONAL (PHYSICIAN) VISIT - OFFICE	11- OFFICE		
BZ- PHYSICIAN VISIT - OFFICE: WELL	11- OFFICE		
MH- MENTAL HEALTH			
UC- URGENT CARE	20- URGENT CARE FACILITY		

Ask Provider Services

New Search

Back



South Carolina

# Getting Benefits in My Insurance Manager - Service Type

## Step 3 (When pulling benefits by service type.)

Eligibility Request \* Required

Choose Eligibility View

*Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.*

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

General Eligibility and Benefits

Eligibility and Benefits by Service Type

Eligibility and Benefits by Procedure Code

\* Service Type Code:  
--Please Choose One--

Primary Diagnosis Code (ICD-10):

[Add Diagnosis Code](#)

Place of Service: (recommended)  
Office - 11

Service Facility/Billing Location:

Rendering/Performing Provider:  
JOHN M JONES MD

Submit

## Other Service Types

ABORTION - 84  
ACUPUNCTURE - 64  
AIDS - 85  
AIR TRANSPORTATION - 57  
ALCOHOLISM - AJ  
ALLERGY - GY  
ALLERGY TESTING - 79  
ALTERNATE METHOD DIALYSIS - 15  
AMBULATORY SERVICE CENTER FACILITY - 13  
ANESTHESIA - 07  
ANESTHESIOLOGIST - 97  
AUDIOLOGY EXAM - 71  
BLOOD CHARGES - 10  
BRAND NAME PRESCRIPTION DRUG - 91  
BRAND NAME PRESCRIPTION DRUG - NON-FORMULARY - B3  
BURN CARE - B1  
Brand Name Prescription Drug - Formulary - B2  
CABULANCE - 58  
CANCER - 87

# Getting Benefits in My Insurance Manager - Service Type

[Printer-Friendly](#)

**Date of Service**  
04/30/2024

---

**Insurance**  
Plan Name:  
BLUECROSS AND BLUESHIELD OF SC

---

Plan ID:  
38520

---

Member ID:  
ZCZ065922516805

---

Group Number:  
036011101

---

Member's Name:  
MICHAEL TESTING

**Response Details**

Eligibility Response [\[+\]](#)

---

Policy Effective Date:  
06/01/2002

Benefit Period:  
04/01/2024 - 04/01/2025

[View Benefit Booklet for this patient](#)

IN AND OUT OF NETWORK

**Global Benefits**

✔ This patient has active coverage.

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: **\$250.00** PER SERVICE YEAR - **\$250.00** REMAINING

INDIVIDUAL OUT OF POCKET: **\$750.00** PER SERVICE YEAR - **\$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

FAMILY DEDUCTIBLE: **\$500.00** PER SERVICE YEAR - **\$500.00** REMAINING

FAMILY OUT OF POCKET: **\$1,500.00** PER SERVICE YEAR - **\$1,500.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

**Patient**

Patient's Name:  
MICHAEL TESTING

---

Relationship to Member:  
SUBSCRIBER

---

Gender:  
MALE

---

Date of Birth:  
10/01/1958

---

Address:  
P O BOX 24015  
COLUMBIA, SC 292244015

Change Patient

Service▲	Place of Service▲	Diagnosis Code (ICD-10)▲	Specialty▲
▼ <a href="#">50- HOSPITAL - OUTPATIENT</a>	22- ON-CAMPUS OUTPATIENT HOSPITAL		
<p>✔ This patient has active coverage.</p> <p>Insurance Type: INDEMNITY</p> <p>Plan Name: INDEMNITY</p> <p>THIS MEMBER CURRENTLY HAS AN HSA WITH A PAYMENT OPTION WHICH ALLOWS FOR AUTOMATIC PAYMENT DIRECTLY TO THE PROVIDER. QUALIFIED MEDICAL EXPENSES WITH THE EXCEPTION OF DENIED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT.</p> <p>RESPONSES TO ALL FUTURE DATED INQUIRIES ARE BASED ON THE PATIENT'S CURRENT BENEFITS AND ARE SUBJECT TO CHANGE.</p> <p>YOU HAVE REQUESTED BENEFITS FOR A MEMBER THAT HAS BENEFIT EXCEPTIONS AT THE PROCEDURE CODE LEVEL. TO OBTAIN MORE SPECIFIC INFORMATION, PLEASE REQUEST BENEFITS ON MY INSURANCE MANAGER USING A SPECIFIC PROCEDURE CODE AND DIAGNOSIS CODE.</p> <p><a href="#">View Additional Messages</a></p> <p>INDIVIDUAL COINSURANCE: <b>15%</b></p>			
▶ <a href="#">51- HOSPITAL - EMERGENCY ACCIDENT</a>	23- EMERGENCY ROOM - HOSPITAL		
▶ <a href="#">52- HOSPITAL - EMERGENCY MEDICAL</a>	23- EMERGENCY ROOM - HOSPITAL		
▶ <a href="#">A0- PROFESSIONAL (PHYSICIAN) VISIT - OUTPATIENT</a>	22- ON-CAMPUS OUTPATIENT HOSPITAL		

Ask Provider Services

New Search

[Back](#)

# Getting Benefits in My Insurance Manager - Procedure Code

## Step 3 (When pulling benefits by procedure code.)

Eligibility Request \* Required

**Choose Eligibility View**

*Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.*

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

General Eligibility and Benefits

Eligibility and Benefits by Service Type

Eligibility and Benefits by Procedure Code

**\* Procedure Code:**

**Modifiers:**

**Primary Diagnosis Code (ICD-10):**

[Add Diagnosis Code](#)

**Place of Service:** (recommended)  
Office - 11

**Service Facility/Billing Location:**

**Rendering/Performing Provider:**  
JOHN M JONES MD

**Choose Eligibility View**

*Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.*

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

General Eligibility and Benefits

Eligibility and Benefits by Service Type

Eligibility and Benefits by Procedure Code

**\* Procedure Code:**

**Modifiers:**

**Primary Diagnosis Code (ICD-10):**

[Add Diagnosis Code](#)

**Place of Service:** (recommended)  
Office - 11

**Service Facility/Billing Location:**

**Rendering/Performing Provider:**  
JOHN M JONES MD

# Getting Benefits in My Insurance Manager - Procedure Code

**Date of Service**  
04/30/2024

---

**Insurance**  
Plan Name:  
BLUECROSS AND BLUESHIELD OF SC

---

Plan ID:  
38520

---

Member ID:  
ZCZ065922516805

---

Group Number:  
036011101

---

Member's Name:  
MICHAEL TESTING

---

**Patient**  
Patient's Name:  
MICHAEL TESTING

---

Relationship to Member:  
SUBSCRIBER

---

Gender:  
MALE

---

Date of Birth:  
10/01/1958

---

Address:  
P O BOX 24015  
COLUMBIA, SC 292244015

---

[Change Patient](#)

**Response Details**

Eligibility Response [\[±\]](#)

---

Policy Effective Date:  
06/01/2002

---

Benefit Period:  
04/01/2024 - 04/01/2025

---

[View Benefit Booklet for this patient](#)

**IN AND OUT OF NETWORK**

**Global Benefits**

✔ This patient has active coverage.

---

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: **\$250.00** PER SERVICE YEAR - **\$250.00** REMAINING

---

INDIVIDUAL OUT OF POCKET: **\$750.00** PER SERVICE YEAR - **\$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

---

FAMILY DEDUCTIBLE: **\$500.00** PER SERVICE YEAR - **\$500.00** REMAINING

---

FAMILY OUT OF POCKET: **\$1,500.00** PER SERVICE YEAR - **\$1,500.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

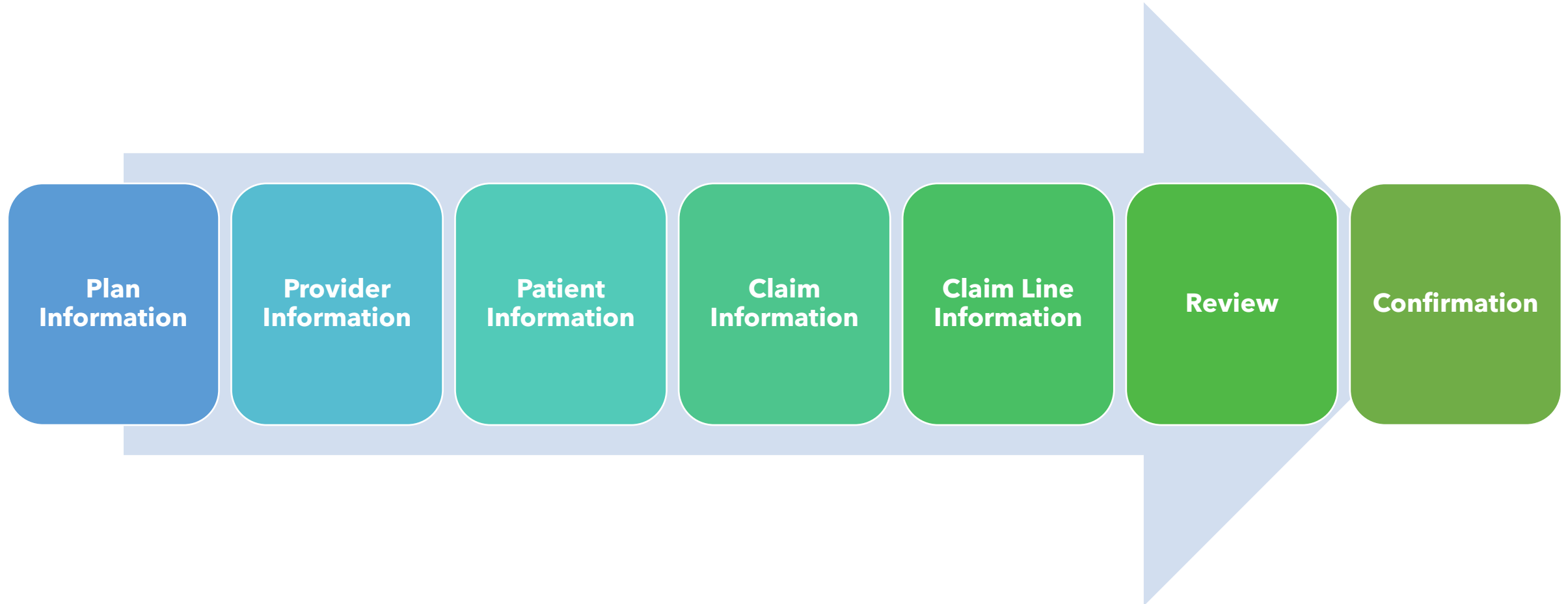
Service▲	Place of Service▲	Diagnosis Code (ICD-10)▲	Specialty▲
<a href="#">▼ CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES- 99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANA</a>	11- OFFICE		
<p><span style="color: green;">✔</span> This patient has active coverage.</p> <p><b>Insurance Type:</b> INDEMNITY</p> <p><b>Plan Name:</b> INDEMNITY</p> <p>THIS MEMBER CURRENTLY HAS AN HSA WITH A PAYMENT OPTION WHICH ALLOWS FOR AUTOMATIC PAYMENT DIRECTLY TO THE PROVIDER. QUALIFIED MEDICAL EXPENSES WITH THE EXCEPTION OF DENIED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT.</p> <p>RESPONSES TO ALL FUTURE DATED INQUIRIES ARE BASED ON THE PATIENT'S CURRENT BENEFITS AND ARE SUBJECT TO CHANGE.</p> <p>YOU HAVE REQUESTED BENEFITS FOR A MEMBER THAT HAS BENEFIT EXCEPTIONS AT THE PROCEDURE CODE LEVEL. TO OBTAIN MORE SPECIFIC INFORMATION, PLEASE REQUEST BENEFITS ON MY INSURANCE MANAGER USING A SPECIFIC PROCEDURE CODE AND DIAGNOSIS CODE.</p> <p><a href="#">View Additional Messages</a></p> <hr/> <p><b>INDIVIDUAL COINSURANCE: 15%</b></p>			
<p><a href="#">Ask Provider Services</a></p>		<p><a href="#">New Search</a>   <a href="#">Back</a></p>	

# Submitting Claims



# Submitting Claims Through My Insurance Manager

There are seven screens that you will progress through when using My Insurance Manager to submit claims.





# Steps to Submit Claims Through My Insurance Manager

Start Here

<b>Health</b>	
▶ Authorization Extension	▶ Patient Directory
▶ Authorization Status	▶ Pre-Certification/Referral
▶ Claims Status	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Service Review for Out-of-Area Members
▶ Institutional Claim Entry	▶ Professional Claim Entry
▶ Other Health Insurance	▶ Verify Primary Care Physician
<b>Dental</b>	
▶ Claims Status	▶ Patient Directory
▶ Dental Claim Entry	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Treatment Estimate Entry
▶ Other Dental Insurance	▶ Pre-Treatment Estimate Status

Step 1

Professional Claim Entry Printer-Friendly

Plan Information    Provider Information    Patient Information    Claim Information    Claim Line Information    Review    Confirmation

Please note: This feature is not available from 11:30 p.m. to 4 a.m. Eastern Time for maintenance purposes.

**Who Can File Online?**  
Health care professionals located in South Carolina or in counties contiguous to the state may submit claims online.

The following guidelines apply for ancillary services:

- File claims for Independent Clinical Laboratory services to the Blue Plan in whose service area the specimen was drawn.
- File claims for Durable or Home Medical Equipment to the Blue Plan in whose service area the equipment was shipped to or purchased in a retail store
- File Specialty Pharmacy claims to the Blue Plan in whose service area the ordering physician is located.

All other professionals must submit claims to the Blue Plan in their local service areas.

**Plan Information**

**Submitter Information**

If this information is not correct, please [modify your profile](#). Any information you entered will be lost if you navigate away from this page.

Name: Terrence Archie    ID: 123456789    Email Address: [redacted]

Phone: [redacted]    Extension: Not Available    Fax: Not Available

**Plan Information**

Choose the Plan under which the patient had insurance coverage on the date(s) of service. We require both a From Date of Service and a To Date of Service. If this claim is for a single date of service, enter the same date in both fields.

\* Plan: --Please Choose One--    \* Is the selected plan the primary payer? Yes

\* From Date of Service: [redacted]    To Date of Service: [redacted]

mm/dd/yyyy    mm/dd/yyyy

Continue    X Cancel this claim

Note: At any time, you can select "Cancel this claim" to abort the process.

# Steps to Submit Claims Through My Insurance Manager (Continued)

## Step 2

Professional Claim Entry Printer-Friendly

Plan Information **Provider Information** Patient Information Claim Information Claim Line Information Review Confirmation

Date of Service  \* Required

Insurance  
Plan Name:  
BlueCross BlueShield Plans

**Provider Information**

Billing Location Information

Click Choose a Billing Provider to select from a list of locations affiliated with your Tax ID. The billing location address must be the physical address (not P.O. Box) and must contain a 9-digit ZIP code.

**Choose a Billing Provider**

Provider ID Type:  
Primary ID (NPI)

Provider ID:  
4444444440

Provider's Name:  
JOHN M JONES MD

\* Address Line 1:  Address Line 2:

\* City:  \* State:  \* ZIP Code:  -

\* Provider Accepts Assignment:  \* Provider Signature on File:

Specialty/Taxonomy Code:

Rendering Provider Information

Please Note: You must identify a Rendering Provider on all claims when the services were not rendered by the Billing Provider.

## Step 3

Professional Claim Entry Printer-Friendly

Plan Information Provider Information **Patient Information** Claim Information Claim Line Information Review Confirmation

Date of Service  \* Required

Insurance  
Plan Name:  
BlueCross BlueShield Plans

**Patient Information**

Patient Details

Please note: Changes made to this information will not be updated in your Patient Directory.

Enter the Member ID as shown on the member's ID card.

Choose a Patient or enter the information here.

\* Member ID:  \* Relationship to Member:  \* Patient Account Number:   
include alpha prefix, if applicable

\* Last Name:  First Name:  M.I.:  Suffix:

\* Date of Birth:  \* Gender:   
mm/dd/yyyy

\* Country:

\* Address Line 1:  Address Line 2:

\* City:  \* State:  \* ZIP Code:  -

Patient Consent

\* Benefits Assigned to Provider:

Note: You must select "Choose a Billing Provider" if more than one location is on file.

# Steps to Submit Claims Through My Insurance Manager (Continued)

## Step 4

Professional Claim Entry Printer-Friendly

Plan Information **Provider Information** Patient Information **Claim Information** Claim Line Information Review Confirmation

**Date of Service**  
04/24/2024

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ769902477864

**Patient**  
Patient's Name: Michael Testing  
Relationship to Member: SELF  
Gender: MALE  
Date of Birth: 10/01/1958

**Claim Information** \* Required

**Superbill Information**

**Please note:** Based on the date of service for this claim, the list of Superbill Templates may include ICD-9 and ICD-10 templates. You can convert ICD-9 to ICD-10 by selecting "Create a New or Edit an Existing Template".

Choose a Superbill Template:  
None

[Create a New or Edit an Existing Template](#)

**Service Information**

\* Place Of Service: Office - 11 Medical Record Number:

\* Claim Type: Original Claim

**Claim Entry Options**

Please choose the information that you want to add to this claim.

Ambulance Information  Medicare Information  
 Accident Information  Prior Authorization or Referral Number  
 Claim Note Information  Service Facility Information  
 Hospitalization Date(s)

**Continue** or **Back** Cancel this claim

## Step 5

Professional Claim Entry Printer-Friendly

Plan Information Provider Information Patient Information **Claim Information** **Claim Line Information** Review Confirmation

**Date of Service**  
04/24/2024

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ769902477864

**Patient**  
Patient's Name: Michael Testing  
Relationship to Member: SELF  
Gender: MALE  
Date of Birth: 10/01/1958

**Claim Line Information** \* Required

**Claim Amounts**

**Please note:** We will calculate the Total Claim Charges automatically based on the amounts you enter on the claim lines.

Total Claim Charges: \$ 0.00 Patient Paid: \$ Total Number of Lines: 1

**Diagnosis Codes**

**Please note:** At least one diagnosis code is required.

\* Diagnosis Codes:

**Claim Lines**

**Please note:** You must identify a Rendering Provider on all claim lines when these services were not rendered by the Billing Provider or by the Rendering Provider identified earlier.  
You must identify a Referring Provider on all claim lines when these services are related to a referral.

**Line 1**

\* Procedure:  Modifiers:  Charges: \$

\* Unit Type: --Please Choose One-- Unit(s):

\* From Date of Service: 04/24/2024 To Date of Service:  Primary and Secondary Diagnosis Codes:

mm/dd/yyyy mm/dd/yyyy

Place of Service: Procedure Description:

# Steps to Submit Claims Through My Insurance Manager (Continued)

## Step 6

Professional Claim Entry Printer-Friendly

Plan Information Provider Information Patient Information Claim Information **Claim Line Information** Review Confirmation

**Date of Service**  
04/24/2024

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ769902477864

**Patient**  
Patient's Name: Michael Testing  
Relationship to Member: SELF  
Gender: MALE  
Date of Birth: 10/01/1958

**Claim Review**  
This is a summary of the claim information you are about to submit. Please make any necessary changes and submit.

**Provider Information**  
Submitter's Name: Terrence Archie  
Billing Location: JOHN M JONES MD  
Plan: BlueCross BlueShield Plans

**Patient Information**  
Member ID: ZCZ769902477864  
Date of Birth: 10/01/1958  
Gender: MALE  
Patient's Name: Michael Testing  
Patient Account Number: ABC123

**Claim Information**  
This is a claim-level summary. Click Add Additional Claim Information to add information that applies to the entire claim. If another payer is primary on this claim and you wish to add or edit adjustments at the claim level, click Claim Level Adjustments. To add or edit adjustments at the line level, see the Claim Line Information section below.

Total Charges: \$ 250.00  
Dates of Service: 04/24/2024

[Add Additional Claim Information](#)

**Claim Line Information**

Line	Procedure	From Date of Service	Charges	Additional Line Information
1	99213	04/24/2024	\$ 250	<a href="#">Add</a>

Select Submit from this screen.

## Step 7

Professional Claim Entry Printer-Friendly

Plan Information Provider Information Patient Information Claim Information Claim Line Information Other Payer Information Adjustments Review **Confirmation**

**Date of Service**  
04/24/2024  
4

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ769902477864

**Patient**  
Patient's Name: michael testing  
Relationship to Member: SELF  
Gender: MALE  
Date of Birth: 10/01/1958

**Claim Confirmation**  
Please note: We have received and are processing your claim. Here is your claim number.

Click on View Patient Receipt for a printable receipt detailing the patient's liability. Receipts are only available for claims that have finalized. The View Patient Receipt button will not appear for claims that require further processing.

**Confirmation**

Claim Number: 41XXX232000000  
Member ID: ZCZ769902477864  
Patient's Name: michael testing

Patient's Date of Birth: 10/01/1958  
Patient's Gender: Male

[Create New Claim](#) [View Claim Status](#)

# Claims Status



# Checking the Status of a Claim

Start Here



**Health**

- ▶ Authorization Extension
- ▶ Authorization Status
- ▶ **Claims Status**
- ▶ Eligibility and Benefits
- ▶ Institutional Claim Entry
- ▶ Other Health Insurance

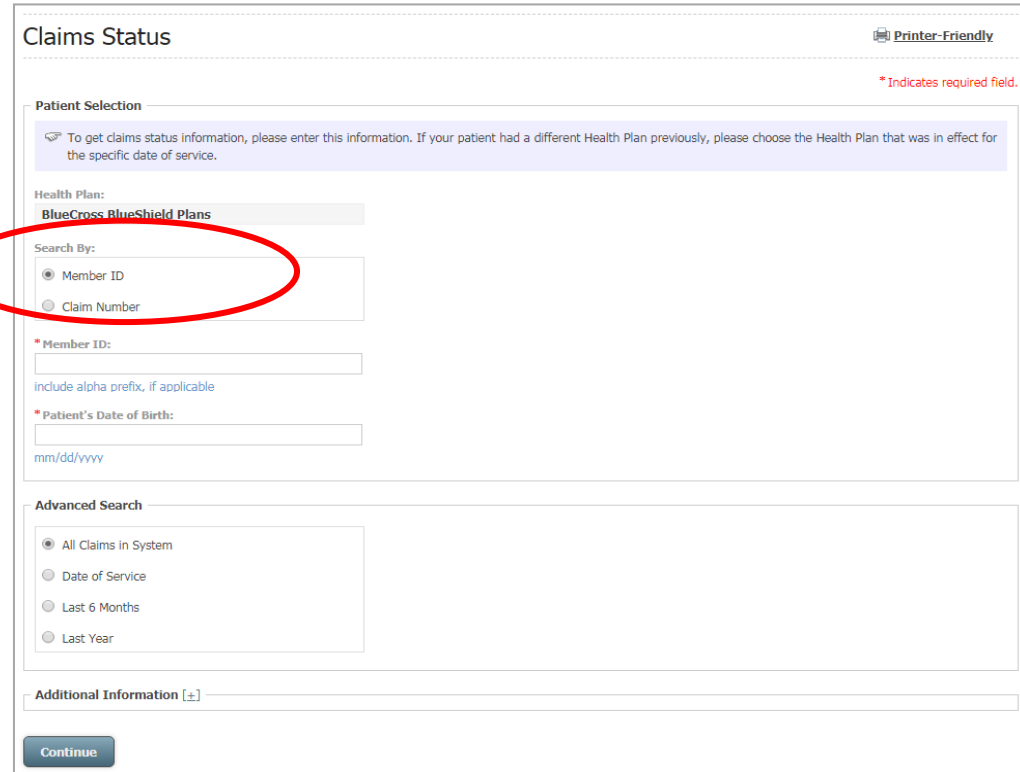
- ▶ Patient Directory
- ▶ Pre-Certification/Referral
- ▶ Superbill Maintenance
- ▶ Pre-Service Review for Out-of-Area Members
- ▶ Professional Claim Entry
- ▶ Verify Primary Care Physician

**Dental**

- ▶ Claims Status
- ▶ Dental Claim Entry
- ▶ Eligibility and Benefits
- ▶ Other Dental Insurance

- ▶ Patient Directory
- ▶ Superbill Maintenance
- ▶ Pre-Treatment Estimate Entry
- ▶ Pre-Treatment Estimate Status

Step 1



Claims Status Printer-Friendly

\* Indicates required field.

**Patient Selection**

To get claims status information, please enter this information. If your patient had a different Health Plan previously, please choose the Health Plan that was in effect for the specific date of service.

Health Plan:  
BlueCross BlueShield Plans

Search By:

- Member ID
- Claim Number

\*Member ID:  
  
include alpha prefix, if applicable

\*Patient's Date of Birth:  
  
mm/dd/yyyy

**Advanced Search**

- All Claims in System
- Date of Service
- Last 6 Months
- Last Year

Additional Information [±]

Continue




Note: Searching for claims using the member's identification number is the recommended option.

# Checking the Status of a Claim (Continued)

Step 3

Claims Summary List *(click a column title to sort)* Showing 3 Results

List of health claims

<u>Claim Number</u>	<u>Claim Status</u>	<u>Primary ID</u>	<u>Beginning Date of Service</u> ▼	<u>Process Date</u>	<u>Total Charges</u>
 <a href="#">207103LDG0000</a>	PROCESSED	15	03/07/2022	03/12/2022	\$81.00
 <a href="#">207404P250000</a>	PROCESSED	16	03/07/2022	03/15/2022	\$130.50
 <a href="#">2029023B80000</a>	PROCESSED	16	01/18/2022	01/31/2022	\$362.00

[Ask Provider Services](#)

# Checking the Status of a Claim (Continued)

Claim Number:  
207103LDG0000

Check your remittance voucher for any non-covered or non-allowed charges which may be the member's responsibility.

Primary Status:  
**FINALIZED-THE CLAIM/ENCOUNTER HAS COMPLETED THE ADJUDICATION CYCLE AND NO MORE ACTION WILL BE TAKEN.**

[Patient Liability](#) [Detailed Status Information](#) [Additional Status Information](#)

Detail

Status Effective Date: 03/12/2022 Date(s) of Service: 03/07/2022 - 03/07/2022 Processed Date: 03/12/2022

Primary ID: 100000000 Organization or Provider's Name: UNIVERSITY OF SOUTH CAROLINA

Total Charges: \$81.00 Amount Paid: \$0.00 Bill Type: 141

Patient Account Number: 2402

Here is a list of the line items associated with this claim. Showing 1 Result

### Line Summary List

Line Item	Line Status	Date(s) of Service	Line Charges	Amount Paid
01	PROCESSED	03/07/2022 - 03/07/2022	\$81.00	\$0.00

Revenue Code:  
0310 - LABORATORY PATHOLOGICAL,0,GENERAL CLASSIFICATION

Procedure Code:  
S1310 - LABORATORY PA

[Previous Claim](#) [Next Claim](#) [Ask Provider Services](#) or [Back](#)

Claim Number:  
207103LDG0000

Check your remittance voucher for any other non-covered or non-allowed charges which may be the member's responsibility.

Patient Liability

Please note: The amount in the Other field includes any non-covered charges that are not copayments, deductibles or coinsurance. This amount may also include reimbursements from the member's Health Reimbursement Account. For more specific details, please see your remittance advice for this claim.

Deductible:	Copayment:	Coinsurance:	Other:	Total:
\$72.42	\$0.00	\$0.00	\$0.00	\$72.42

[Back](#)

Status Details

FINALIZED-THE CLAIM/ENCOUNTER HAS COMPLETED THE ADJUDICATION CYCLE AND NO MORE ACTION WILL BE TAKEN.

107 - PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS

[Additional Status Information](#)

Description:  
CLAIM HAS PROCESSED



# Ask Provider Services



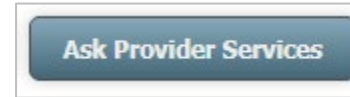
# Overview of Ask Provider Services

- ❑ Ask Provider Services is a feature in My Insurance Manager that lets you submit secured web inquiries for help with claims.
- ❑ This feature is intended to assist with **complex issues** and not general claim status.

Examples of <i>appropriate</i> questions to ask...	Examples of <i>inappropriate</i> questions to ask...
Why was line one of the claim denied as noncovered?	What is the status of the claim?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?

# Submitting Web Inquiries

- ❑ Enter all the necessary information in the available fields.
- ❑ Be sure to ask clear, probing questions.
- ❑ Select Submit Question.



**Inquiry**

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

**How would you like to contact Provider Services?**

Submit your question online

Talk to Provider Services online  
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

**Health Plan:**  
BlueCross BlueShield Plans

**Inquiry Reason:**  
Claim Status Inquiry

\* Patient's First Name:  \* Patient's Last Name:  \* Patient's Member id:  Patient's Date of Birth:   
mm/dd/yyyy

\* Location:   Primary ID:

\* Please enter a question:

or [Back](#)

# Viewing Web Inquiry Responses

- ❑ To view responses to your inquiries:
  - Select Go to Message Center.
  - You can narrow the results by entering the ID number and selecting specific months.
- ❑ Enhancements made:
  - You now have the option to see up to **90 days** of inquiries.
  - Provider Administrators can view all the web inquiries submitted and responses received under the Tax ID.
    - Enter the member's ID number and select the staff member from the drop-down menu.

[Go to Message Center](#)

Search by Member ID:  Select a Plan...

Last 30 Days Results (0)

Message Tools < Last 30 Days Go >

Date	Subject
We did not find any messages for the time period you chose. Please try your request again with a different time period.	

Office Staff View

Message Center

Please note: The Message Center will only show mail you submitted through My Insurance Manager. This mailbox will not show other communications you may receive from us, such as faxes or regular mail, that may relate to your questions.

Search by Member ID:  Select a Plan...

Search by Staff Member:  [show/hide](#)

Staff Member:

Last 90 Days Results (4)

Message Tools < Last 90 Days Go >

Date	Subject
<input type="checkbox"/> 01/16/2024	HEALTH - Eligibility Question - KRISTA FUNDERBURK
<input type="checkbox"/> 01/16/2024	HEALTH - Claim Status Inquiry - KRISTA FUNDERBURK
<input type="checkbox"/> 01/16/2024	HEALTH - Claim Status Inquiry - KENNETH CATOE
<input type="checkbox"/> 01/16/2024	HEALTH - Claim Status Inquiry - LAWIS TAYLOR

Administrator View

# STATchat



# Overview of STATchat

- ❑ STATchat is a fast and simple way to speak with a Provider Services representative.
- ❑ The feature is available through My Insurance Manager.
- ❑ System requirements include:
  - A current version of Adobe Flash Player
  - A compatible web browser, such as Microsoft Edge or Google Chrome.
  - A headset or standalone microphone with speakers connected to your computer.

Ask Provider Services

STATchat \* Required

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

How would you like to contact Provider Services?

Submit your question online

Talk to Provider Services online  
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

Inquiry Name:  
BlueCross BlueShield Plans

Inquiry Reason:  
Claim Status Inquiry

\* Patient's First Name: f    \* Patient's Last Name: K    \* Patient's Member id: B: 9Q

\* Location:    Primary ID: 1

[Need help using STATchat?](#)

Launch STATchat or Back

STATchat - Internet Explorer

STATchat

Hang Up

Wearing a headset?

Status: Connected  
Call Id: 8141917300

1	2	3
4	5	6
7	8	9
*	0	#

MUTE    KEYPAD

Having trouble with the audio?

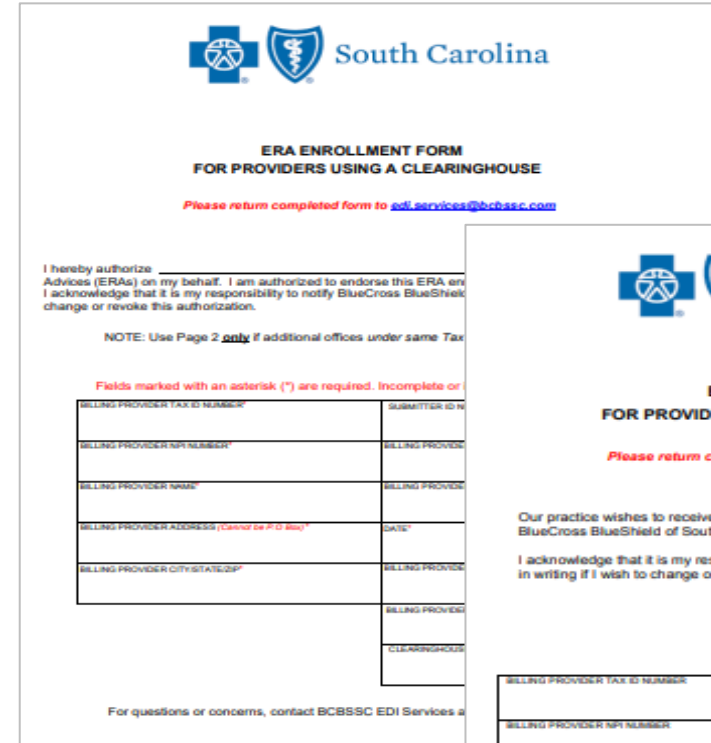
Note: The operation hours may vary for certain lines of business.


# My Remit Manager



# How to Receive Electronic Remittance Advices

- ❑ To pull remittances in My Remit Manager, you must ensure the necessary documents have been completed and submitted.
- ❑ Complete the ERA Enrollment Clearinghouse or ERA Enrollment Direct Submitter form located on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).
- ❑ Email the completed form to [EDI.Services@bcbssc.com](mailto:EDI.Services@bcbssc.com).




**South Carolina**

**ERA ENROLLMENT FORM  
FOR PROVIDERS USING A CLEARINGHOUSE**

Please return completed form to [edi\\_services@bcbssc.com](mailto:edi_services@bcbssc.com)

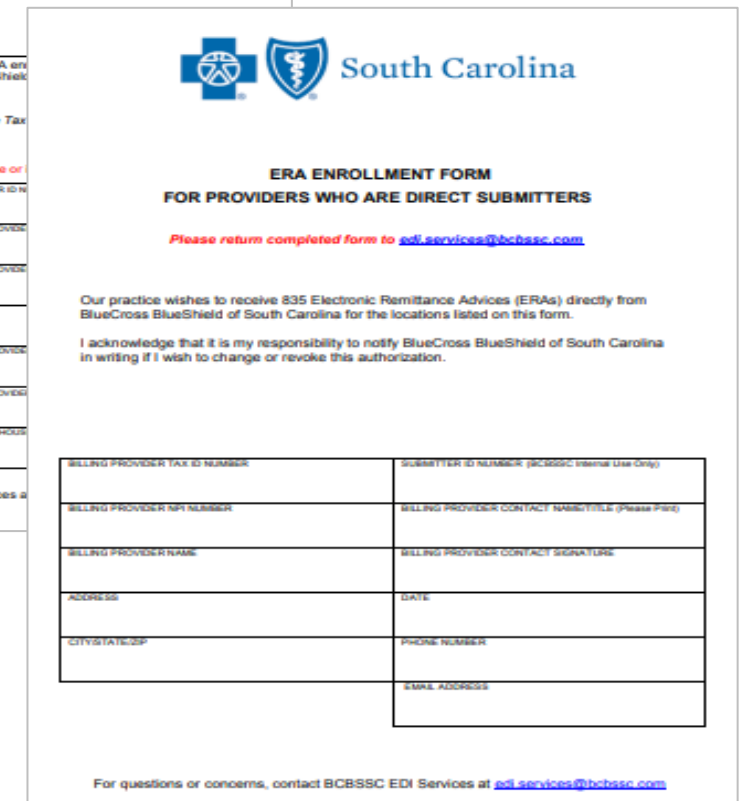
I hereby authorize \_\_\_\_\_  
 Advices (ERAs) on my behalf. I am authorized to endorse this ERA and I acknowledge that it is my responsibility to notify BlueCross BlueShield of South Carolina in writing if I wish to change or revoke this authorization.


NOTE: Use Page 2 **only** if additional offices under same Tax ID Number.

Fields marked with an asterisk (\*) are required. Incomplete or missing information may result in a delayed ERA.

BILLING PROVIDER TAX ID NUMBER*	SUBMITTER ID NUMBER
BILLING PROVIDER NPI NUMBER*	BILLING PROVIDER CONTACT NAME/TITLE (Please Print)
BILLING PROVIDER NAME*	BILLING PROVIDER CONTACT SIGNATURE
BILLING PROVIDER ADDRESS (Please Print) *	DATE
BILLING PROVIDER CITY/STATE/ZIP*	BILLING PROVIDER PHONE NUMBER
	BILLING PROVIDER EMAIL ADDRESS
	CLEARINGHOUSE

For questions or concerns, contact BCSSC EDI Services at [edi\\_services@bcbssc.com](mailto:edi_services@bcbssc.com)




**South Carolina**

**ERA ENROLLMENT FORM  
FOR PROVIDERS WHO ARE DIRECT SUBMITTERS**

Please return completed form to [edi\\_services@bcbssc.com](mailto:edi_services@bcbssc.com)

Our practice wishes to receive 835 Electronic Remittance Advices (ERAs) directly from BlueCross BlueShield of South Carolina for the locations listed on this form.

I acknowledge that it is my responsibility to notify BlueCross BlueShield of South Carolina in writing if I wish to change or revoke this authorization.

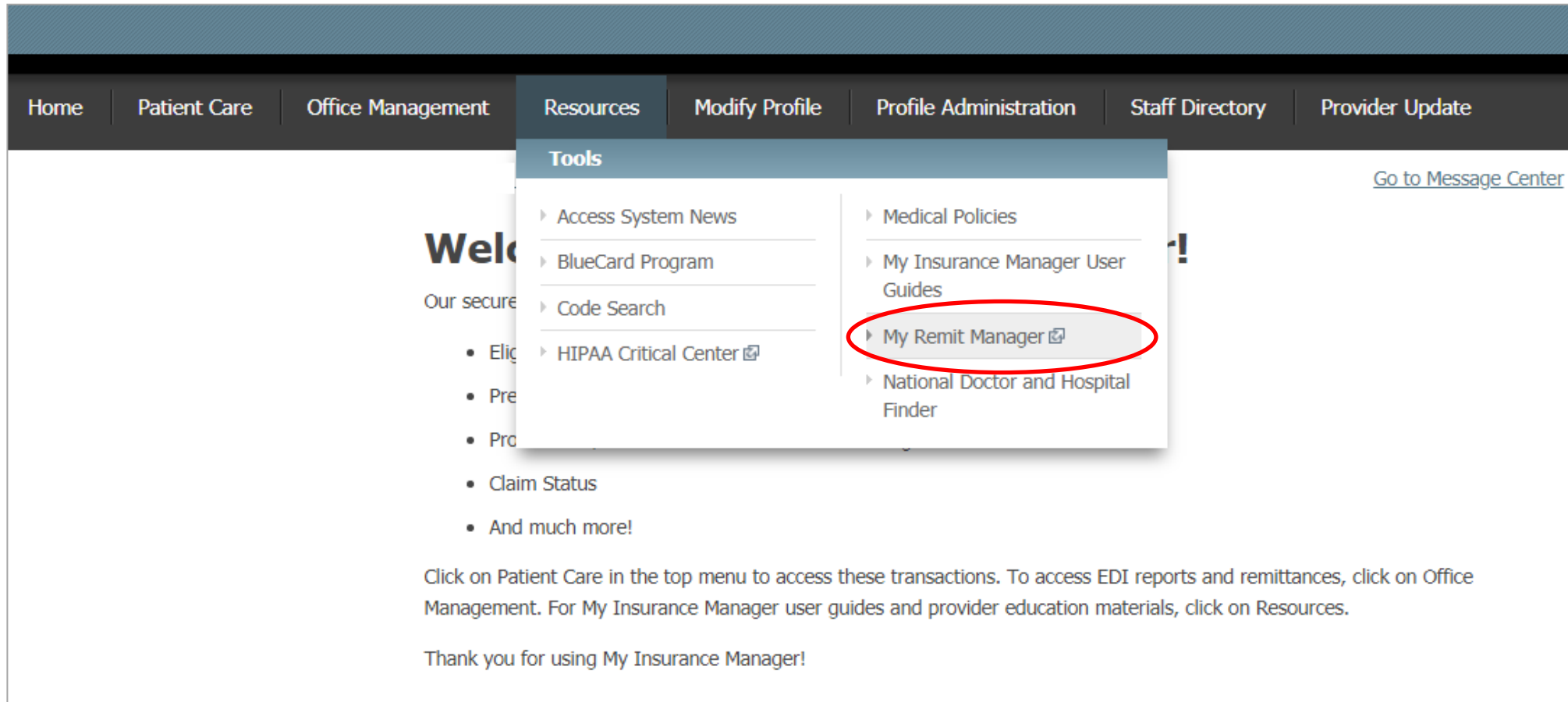
BILLING PROVIDER TAX ID NUMBER*	SUBMITTER ID NUMBER (BCSSC Internal Use Only)
BILLING PROVIDER NPI NUMBER*	BILLING PROVIDER CONTACT NAME/TITLE (Please Print)
BILLING PROVIDER NAME*	BILLING PROVIDER CONTACT SIGNATURE
ADDRESS	DATE
CITY/STATE/ZIP	PHONE NUMBER
	EMAIL ADDRESS

For questions or concerns, contact BCSSC EDI Services at [edi\\_services@bcbssc.com](mailto:edi_services@bcbssc.com)



# Accessing My Remit Manager in My Insurance Manager

- While in My Insurance Manager, hover over Resources and select My Remit Manager.



The screenshot displays the My Insurance Manager website interface. At the top, a dark navigation bar contains several menu items: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, Staff Directory, and Provider Update. The 'Resources' menu is currently open, showing a list of tools. The 'My Remit Manager' option is highlighted with a red circle. Below the navigation bar, the main content area features a 'Welcome' message and a list of services including Eligibility, Pre-authorization, and Claim Status. A 'Go to Message Center' link is visible in the top right corner. At the bottom of the page, there is a thank you message and instructions on how to access various transactions.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory Provider Update

Tools

- ▶ Access System News
- ▶ BlueCard Program
- ▶ Code Search
- ▶ HIPAA Critical Center
- ▶ Medical Policies
- ▶ My Insurance Manager User Guides
- ▶ My Remit Manager
- ▶ National Doctor and Hospital Finder

Go to Message Center

Welcome

Our secure

- Eligibility
- Pre-authorization
- Provider
- Claim Status
- And much more!

Click on Patient Care in the top menu to access these transactions. To access EDI reports and remittances, click on Office Management. For My Insurance Manager user guides and provider education materials, click on Resources.

Thank you for using My Insurance Manager!

# Viewing the Available Remittances

- ❑ Sort and view checks by the check or posting date.
- ❑ Select the Adobe icon to view the remittance.
- ❑ Select the check number to view:
  - Patients associated with the check.
  - Date of service.
  - Processed status (paid or denied).
  - Amount billed and paid.

The screenshot displays the 'My Remit Manager' interface for 'ERA by Check Date - May 2022'. The top section shows a calendar view for May 2022 with check numbers highlighted in red circles. The bottom section shows a detailed table of remittance items with columns for Reco, Download, Check Number, Payment Method, Checkdate, Postdate, Billed, Paid, Payer, and Provider. A red circle highlights the first few rows of the table.

Reco	Download	Check Number	Payment Method	Checkdate	Postdate	Billed	Paid	Payer	Provider
			ACH	11/1/2022	10/30/2022	\$9,485.00	\$1,572.00	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	\$7,807.00	\$1,749.13	STATE HEALTH PLAN	
			ACH	11/1/2022	10/30/2022	\$530.00	\$132.00	FEDERAL EMPLOYEE PLAN	
			ACH	11/1/2022	10/30/2022	\$2,105.00	\$213.04	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	\$1,157.00	\$96.18	STATE HEALTH PLAN	
			ACH	11/1/2022	10/30/2022	\$769.00	\$141.47	FEDERAL EMPLOYEE PLAN	
			ACH	11/1/2022	10/30/2022	\$178.00	\$117.00	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	\$196.80	\$24.14	STATE HEALTH PLAN	
			ACH	11/1/2022	10/30/2022	\$1,410.00	\$78.99	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	\$1,710.00	\$380.05	STATE HEALTH PLAN	

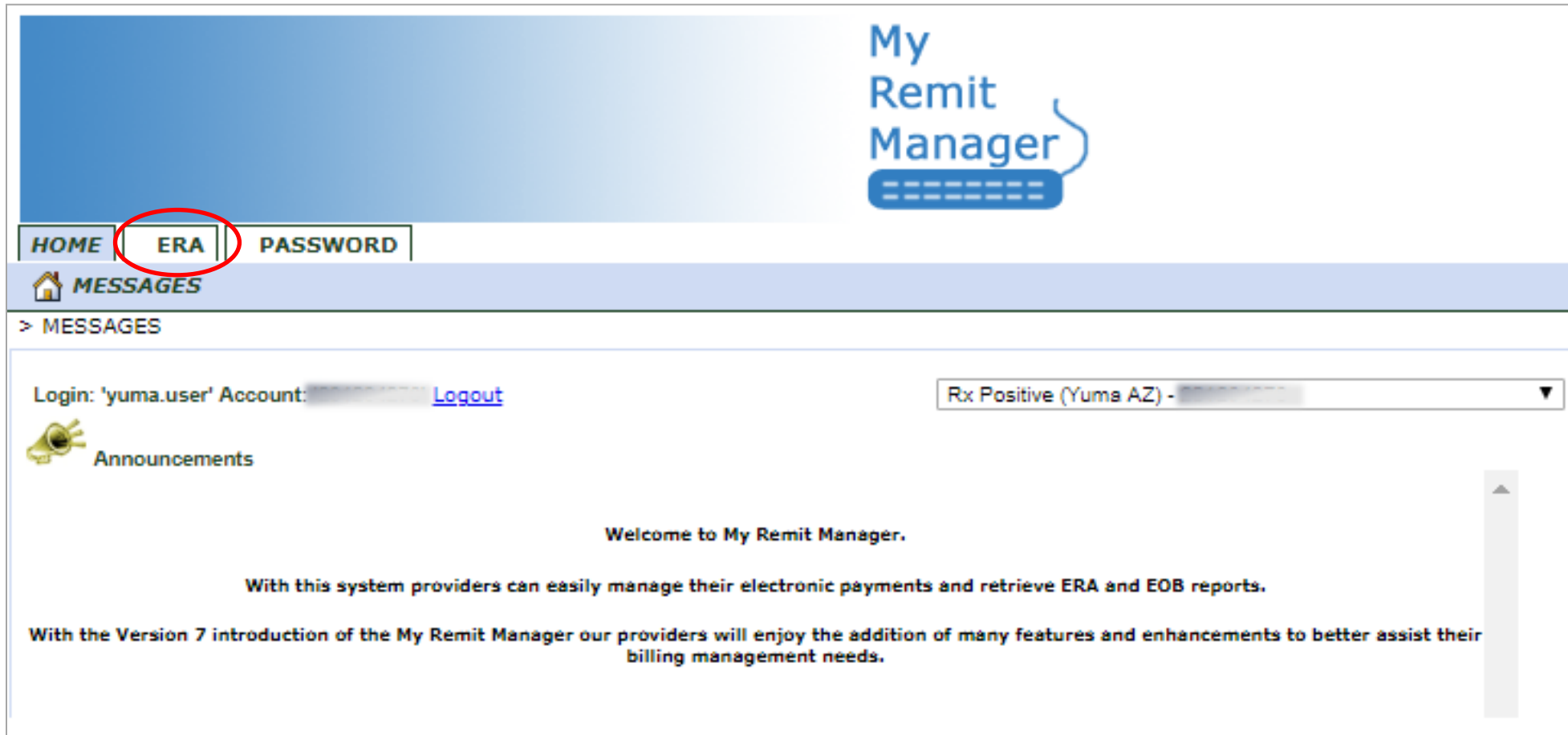
# External Access to My Remit Manager

- ❑ Link:  
[https://client.webclaims.com/v07\\_03/](https://client.webclaims.com/v07_03/)
- ❑ To sign up, email  
[EDI.Services@bcbssc.com](mailto:EDI.Services@bcbssc.com).
- ❑ You can also complete the My Remit Manager Access Request Form located on  
[www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

The image shows two parts of the South Carolina BlueCross BlueShield website interface. On the left is a 'Log In' box with fields for 'User Name' and 'Password', a 'Remember me next time' checkbox, and a 'Log In' button. Below it are links for 'Need to Register?', 'Forgot User Name or Password?', and 'Contact BCBSSC EDI Services at [edi.services@bcbssc.com](mailto:edi.services@bcbssc.com)'. On the right is the 'My Remit Manager Access Request Form' with the following fields: 'Billing Provider Name \*', 'Billing Provider Tax ID \*', 'Billing Provider NPI(s) \*' (with a note 'If more than one, please separate using commas.'), 'User Name \*' (split into 'First Name' and 'Last Name' fields), 'User Phone Number \*', and 'User Email \*'. A 'Submit Form' button is at the bottom right.

# Start With the ERA Tab

- ❑ Select the ERA tab to view the check and remittance information.



The screenshot shows the My Remit Manager web application interface. At the top right, the logo "My Remit Manager" is displayed. Below the logo is a navigation menu with three tabs: "HOME", "ERA", and "PASSWORD". The "ERA" tab is highlighted with a red circle. Below the navigation menu is a blue bar with a home icon and the text "MESSAGES". Below this bar is a section titled "> MESSAGES". In this section, there is a login status "Login: 'yuma.user' Account: [redacted] Logout" and a dropdown menu showing "Rx Positive (Yuma AZ) - [redacted]". Below the login status is a bell icon and the text "Announcements". The main content area contains a welcome message: "Welcome to My Remit Manager." followed by a paragraph: "With this system providers can easily manage their electronic payments and retrieve ERA and EOB reports." and another paragraph: "With the Version 7 introduction of the My Remit Manager our providers will enjoy the addition of many features and enhancements to better assist their billing management needs."

# Pulling the Remittance

- ❑ Select the date of the remittance needed.
- ❑ Select the associated check number.

HOME | REALTIME | CLAIMS | ERA | PASSWORD | ADMIN

CHECK DATE | POST DATE | PATIENTS | REPORTS | DOWNLOAD ERA

> CHECKS BY CHECK DATE

Login: terrence.schial Account: 1464822882 Logout [Switch Accounts](#)

Select Date

June 2021

IV	Sun	Mon	Tue	Wed	Thu	Fri	Sat
IV	30	31	1	2	3	4	5
IV	6	7	8	9	10	11	12
IV	13	14	15	16	17	18	19
IV	20	21	22	23	24	25	26
IV	27	28	29	30	1	2	3
IV	4	5	6	7	8	9	10

Billed vs. Paid by Week

Order By: Name Download ERA Download X12

Search for: Search Select All Unselect All

Hide Reconciled Payer: \*All Items Provider: \*All Items

RECC	CHECK NUMBER	CHECK TYPE	CHECK DATE	POST DATE	BILLED	PAID	PROVIDER	PAYER	TYPE
Select <input type="checkbox"/>	00025	CH	6/15/2021	6/13/2021	1879.00	354.33	LO SU		5010
Select <input type="checkbox"/>	00004	CH	6/15/2021	6/13/2021	2169.00	680.09	LO SU		5010
Select <input type="checkbox"/>	00011	CH	6/15/2021	6/13/2021	4981.00	880.26	LO SU		5010



# Thank you!

