

Welcome to the

2026 Annual Provider Summit



2026 Annual Provider Summit

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 Included

- Authorizations
- Benefits
- Claims
- Dental Networks
- Pharmacy
- Provider Enrollment
- Quality
- Self-service Tools

Authorizations



2026 Annual Provider Summit

Topics to Discuss

- ❑ Overview of Authorizations
- ❑ Authorization Partners
- ❑ Reminders
- ❑ Cohere Health

Overview of Authorizations



2026 Annual Provider Summit



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.

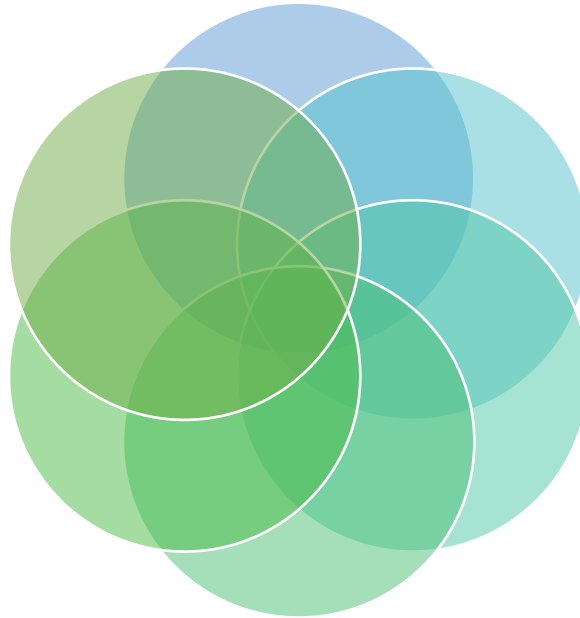
Mark requests as urgent **only** when they are urgent.

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

Submit requests once.

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)

Authorization Partners

Organizations That Manage Select Authorizations

- ❑ Avalon Healthcare Solutions
- ❑ Companion Benefit Alternatives (CBA)
- ❑ Evolent
- ❑ HealthHelp
- ❑ Integrated Home Care Services (IHCS)
- ❑ OptumRx (MBMNow)

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

Avalon Healthcare Solutions

- ❑ Manages authorizations for lab services in the following settings:
 - Office
 - Outpatient facility
 - Independent laboratory
- ❑ To request an authorization:
 - Use: My Insurance Manager
 - Call: 844-227-5769
 - Fax: 813-751-3760
 - Fax form located on 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.



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:
 - Use: My Insurance Manager or visit www.CompanionBenefitAlternatives.com
 - Call: 800-868-1032



*Note: This does not apply to commercial autism (ABA therapy) services.
For these services, submit your request to austimsupport@companiongroup.com.*



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
 - Call: 866-500-7664 for BlueCross members
 - Call: 888-642-9181 for BlueChoice® members



HealthHelp

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



Integrated Home Care Services

- ❑ Manages certain authorizations for Medicare Advantage
- ❑ Services include:
 - Durable medical equipment (DME) in the home setting
 - Home health
 - Home infusion services
- ❑ To request an authorization:
 - Call: 844-215-4264
 - Fax: 844-215-4265



OptumRx (MBMNow)

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



BlueCross BlueShield of South Carolina

Reminders



2026 Annual Provider Summit



Standard Prior Authorization List

- ❑ BlueCross developed a standard prior authorization list.
 - 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 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 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

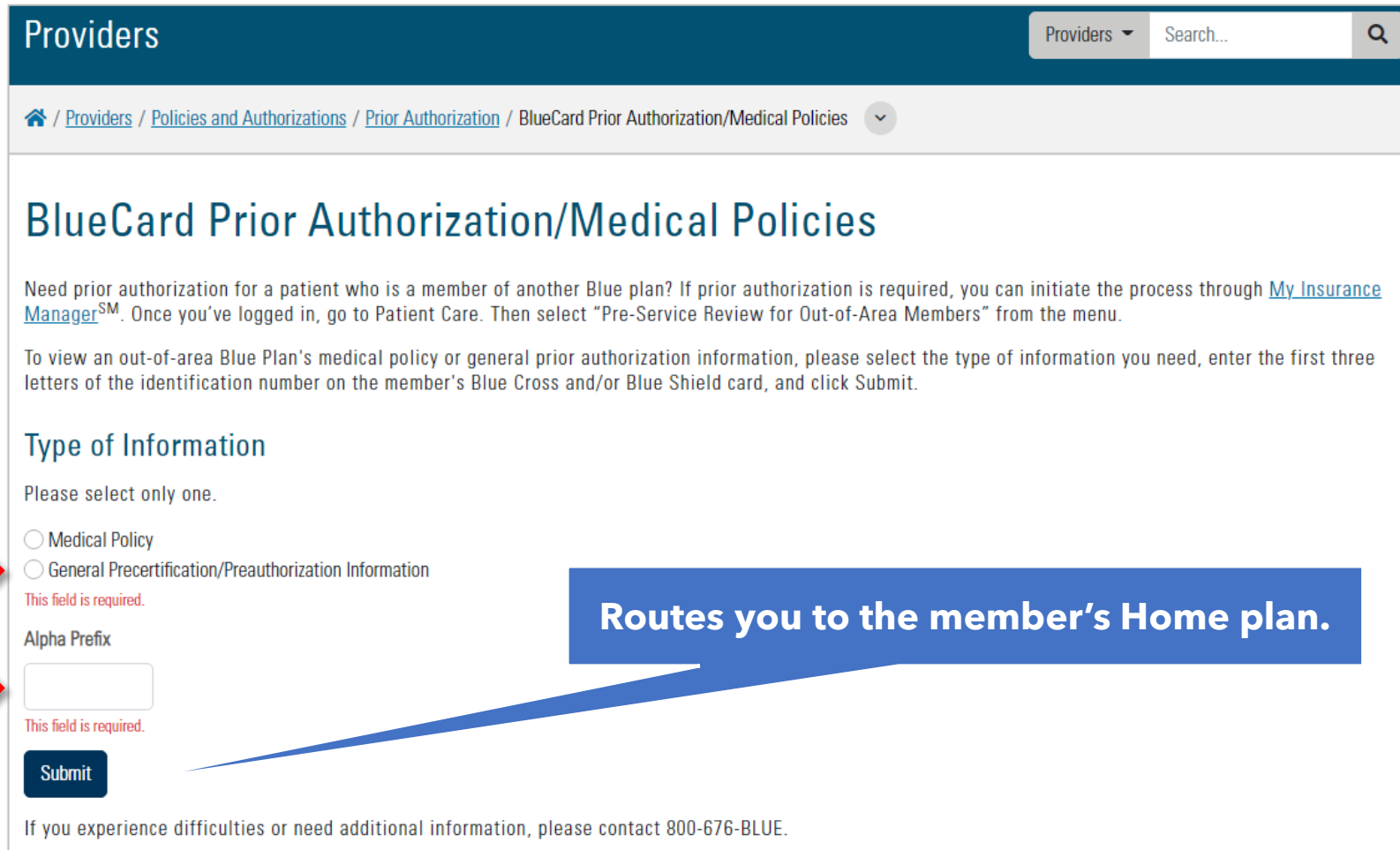


Contact Information

Plan or Vendor	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	My Insurance Manager	844-227-5769	813-751-3760
CBA	<ul style="list-style-type: none"> • Behavioral health • Substance abuse 	My Insurance Manager or www.CompanionBenefitAlternatives.com	800-868-1032	
Evolent	<ul style="list-style-type: none"> • Advanced Radiology • Musculoskeletal Care • Radiation Oncology 	My Insurance Manager or www.RadMD.com	BlueCross: 866-500-7664 BlueChoice: 888-642-9181	888-656-1321
MBMNow	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742
IHCS	<ul style="list-style-type: none"> • DME, home health and home infusion 		844-215-4264	844-215-4265
Cohere Health	*Platform for medical authorization requests.	My Insurance Manager	888-787-0309	

BlueCard Out-of-State Member Authorizations

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



Providers

Providers Search...

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](#)SM. 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.

Submit

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 Manager](#)SM. 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

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

Home > Providers > Prior authorization > Prior plan approval

PROVIDERS

Prior plan approval

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. Inpatient admissions, services and procedures received on an outpatient basis, such as in a doctor's office, and prescription medications may be subject to prior review.

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.¹

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

Note: If you run into any issues with the other Blue plan's website, you must contact that Blue plan for assistance.

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
- ❑ 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

- ❑ Visit SouthCarolinaBlues.com and complete the Peer-to-Peer Request form.
 - Providers>Forms>Other Forms
 - Email: Peer.Medical@bcbssc.com
 - Fax: 803-264-9175
- ❑ For status or questions, call 803-264-8114.
 - Available Monday - Friday, 8:30 a.m. to 5 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

Cohere Health

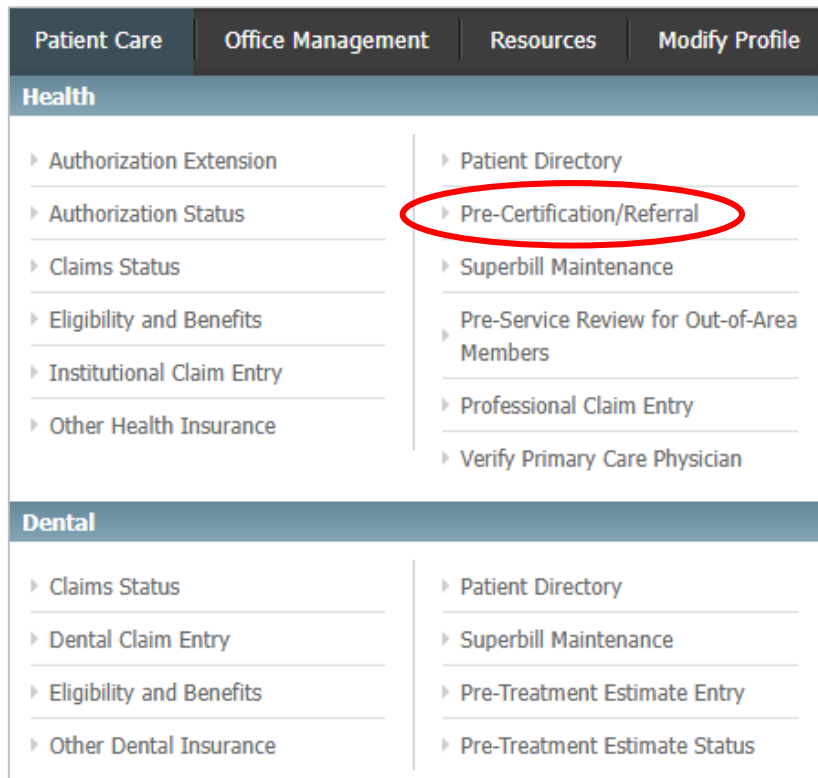


2026 Annual Provider Summit



How to Get an Authorization

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




Proceed to the Cohere Health


- ❑ You will be prompted to go to the Cohere Health platform to submit the prior authorization request.
- ❑ Medicare Advantage will begin going through the Cohere Health platform **Dec. 19, 2025**.
 - DME, home health and home infusion services will still be managed by IHCS.

Medicare Advantage: View the prior authorization requirements exclusively for our Medicare Advantage plans [here](#).

Specialty Medical Benefit Management (SMBM) medication prior authorizations click [here](#).

 [Printer-Friendly](#)

Prior Authorization

 **We have enhanced the prior authorization experience!**

We have partnered with Cohere Health[®] to integrate their intelligent prior authorization platform with our health plan's administrative rules, clinical policies, and expert clinical insights. This powerful combination allows for a faster, more efficient prior authorization experience, ensuring smoother operations and better outcomes. Our goal is an enhanced prior authorization submission process, that decreases administrative steps and accelerates approvals for our provider partners in our members.

The platform includes:

- Member eligibility verification
- Provider network verification
- Prior authorization requirements
- Verification of vendor managed codes
- Required medical record elements
- Expanded fast track approvals in real time fast track responses
- Clinical policy alignment
- Digital submission of medical records

More to come:

As we continue to enhance our use of this powerful tool, we plan to introduce additional features to further accelerate the prior authorization process, increase the availability of fast tracks, provide access to important documents, and much more.

[Go to Cohere Health[®]](#) [Ask Health Care Services](#)

Cohere Health Landing Page

- ❑ 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 Cohere Health landing page for South Carolina. The page header includes the South Carolina logo, the text "powered by Cohere Health", and links for "Support" and "My account". A search bar is located at the top, and a "Start auth request" button is highlighted with a red circle. The main content area shows a list of authorizations for a patient named John Doe, with details for services, procedure codes, submission dates, and dates of service. The list includes entries for Physical Therapy, Speech Therapy, Myocardial Perfusion Imaging, and Physical Therapy. Each entry has a status indicator (Approved or Draft) and a "Start continuation" or "Delete" button.

Cohere - Information About the Request

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

The screenshot shows a web form titled "Tell us about your request" for a user named "Doe, John" with a date of birth of "09/16/1986". The form is powered by "Cohere Health" and is associated with "South Carolina". It includes a "Support" link and a "My account" link. The form contains 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". A "Search for secondary diagnosis codes (optional)" field is empty.
- 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.

Cohere - Provider Details

- ❑ 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***.

Providers

Care setting

Outpatient Inpatient

Place of service ▼

Ordering provider

Search for an ordering provider by NPI, TIN, or name 🔍 TIN 🔍 Address

+ Bailey, Christopher Eric MD

Performing or attending provider

Performing is the same as the ordering

Search for a performing or attending provider by NPI, TIN, or name 🔍 TIN 🔍 Address

+ Bailey, Christopher Eric MD

Performing facility or agency

Search for a performing facility or agency by NPI, TIN, or name 🔍 TIN 🔍 Address

+ 1ST START HEALTHCARE SERVICES

[Save and exit](#)

Cohere - Determination of Authorization Requirements

- ❑ 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 displays a web interface for determining authorization requirements. At the top, a green checkmark indicates 'Requires authorization'. Below this, there are input fields for 'Start date' (04/30/2024) and 'End date' (mm/dd/yyyy). The interface is divided into sections for different medical procedures:

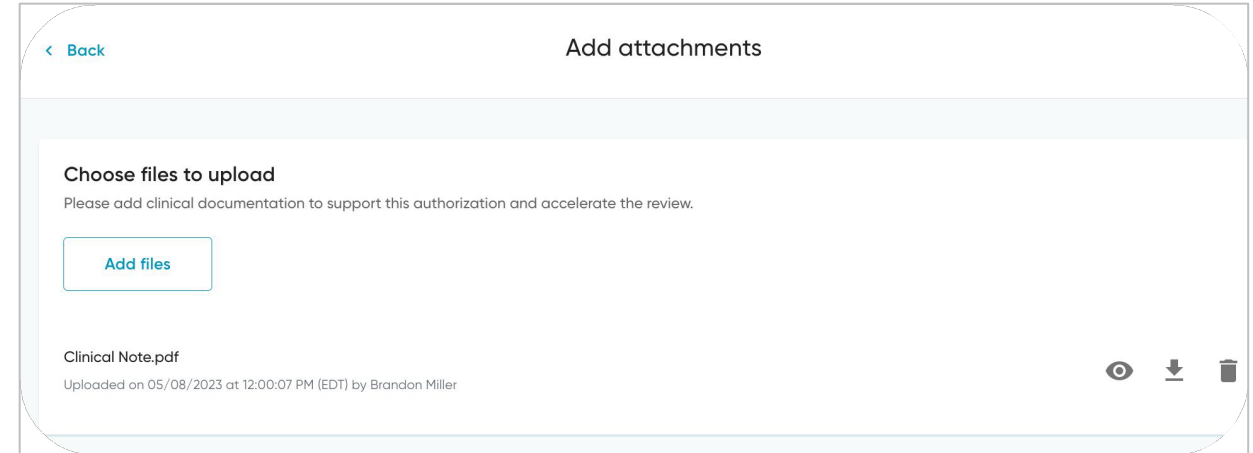
- Physical Therapy (PT):** Includes a 'Number of visits' input field set to '1' and a procedure code '97110' with the description 'Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility'. There is an 'Add a procedure code' button.
- Total Knee Arthroplasty (TKA):** Includes a procedure code '27447' with 'Units' 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 an 'Add a procedure code' button.

At the bottom of the main section, there is an 'Expedite' checkbox. Below this, a section with an exclamation mark icon indicates 'Doesn't require authorization in most cases' for code '93798', with a 'Download PDF' button. At the very bottom, there are two buttons: 'Save and exit' and 'Continue with 2 codes'.

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

Cohere - Clinical Documentation

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



Cohere - Submitting Request

- ❑ 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](#)

Cohere - Confirmation

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

 South Carolina powered by Cohere Health	From: Cohere Health Date requested: 05/01/2024	Response
We are confirming the receipt of your service request		
To review the status of your request please go online to next.coherehealth.com/check_status		
<hr/>		
i 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 to begin.		
<hr/>		
Tracking #: NPOA6057		
<hr/>		
Patient: John Doe		Patient DOB: 01/26/1965
<hr/>		
CPT/HCPCS code: 63047		
Units (If applicable): 1		
Dates of service: 06/01/2024 – 09/30/2024		
<hr/>		
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		
<hr/>		

Cohere - Notification

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

South Carolina | powered by Cohere Health

Your request has been approved

Tracking #: **NPOA6057**
Dates of service: **06/01/2024 - 09/30/2024**

Hello <user's name>,

Thank you for submitting a service request. We have reviewed your request and it has been approved. Please see the decision (including the authorization number) below.

[View service summary](#)

South Carolina | powered by Cohere Health

From: **Cohere Health** | Date requested: **05/01/2024** | [Response](#)

We have finished processing your service request

To review the status of your request please go online to next.coherehealth.com/check_status

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 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.

Cohere - Service Summary

- ❑ 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

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

Cohere - Patient Summary

- 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 the 'Patient summary' page for John Doe. The patient's personal information is listed on the left, including sex (Male), DOB (01/26/1965), address (420 Harvard St., #301 Brookline, MA), phone ((617) 283-4909), preferred language (English), PCP grouper ID (918401720), plan (BCBS South Carolina), membership type (Commercial), plan type (HMO), and plan year (04/24/2024 - 04/24/2025). The main content area shows a summary for 'Spinal Fusion and Decompression', which is marked as 'Approved' with authorization #NPOA6057. A 'Details' section lists the 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), and expedited status (No). Below this, a table titled 'Spinal Fusion and Decompression' shows a code 63047 with a status of '1 unit approved' and a description: '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'. An 'Attachments (1)' section shows a PDF file named 'DoeJohn_ClinicalNote.pdf' uploaded on 05/01/2024 at 02:39:51 PM (EST) by Connor Feick. At the bottom, it notes the request was made by Connor Feick - Portal and provides a 'Withdraw' option.

Benefits



2026 Annual Provider Summit

Topics to Discuss

- ❑ 2026 Benefit Updates
 - State Health Plan
 - Federal Employee Program
 - BlueChoice® HealthPlan
 - Medicare Advantage
 - Group and Individual
- ❑ Benefit Reminders
- ❑ Available Resources
- ❑ My Insurance ManagerSM
 - Benefits and Eligibility

2026 Benefit Updates



2026 Annual Provider Summit



State Health Plan

State Health Plan - Standard Plan

Standard Plan	2025	2026
Deductibles		
Individual	\$515	No change
Family	\$1,030	No change
Coinsurance Maximum		
Individual (INN)	\$3,000	No change
Family (INN)	\$6,000	No change
Individual (OON)	\$6,000	No change
Family (OON)	\$12,000	No change
Services		
Office visits	\$15 copay	No change
Outpatient facility	\$115 copay	No change
Inpatient hospitalization	Full allowance until the deductible is met. Then, the coinsurance.	No change
Emergency room	\$193 copay	No change

INN: In network; OON: Out-of-network

State Health Plan - Savings Plan

Savings Plan	2025	2026
Deductibles		
Individual	\$4,000	No change
Family	\$8,000	No change
Coinsurance Maximum		
Individual (INN)	\$3,000	No change
Family (INN)	\$6,000	No change
Individual (OON)	\$6,000	No change
Family (OON)	\$12,000	No change
Services		
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
Inpatient hospitalization	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 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

– Caremark: 833-291-3646

❑ 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 ManagerSM or call 800-444-4311.

State Health Plan - Additional Information

2026 Changes

- Effective Jan. 1, 2026, Caremark will be the pharmacy benefit manager for State Health plans.
 - Members will receive a new pharmacy card by Dec. 31, 2025.

Sample ID Card



Federal Employee Program



2026 Annual Provider Summit



Federal Employee Program - Blue Focus Plan

Blue Focus – No out-of-network benefits available.	2025	2026
Deductibles		
Individual	\$500	\$750
Self - Plus One	\$1,000	\$1,500
Family	\$1,000	\$1,500
Out-of-Pocket Maximum		
Individual	\$9,000	\$10,000
Self - Plus One	\$18,000	\$20,000
Family	\$18,000	\$20,000
Services		
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

Note: For 2026, FEP separated Federal employees and Postal Service employees for all plans.
Visit www.fepblue.org for a full list of benefits.

Federal Employee Program - Blue Focus Plan (Continued)

Blue Focus – No out-of-network benefits available.	2025	2026
Services (Continued)		
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

BYD: Benefit year deductible

Federal Employee Program - Standard Plan

Standard	2025	2026
Deductibles		
Individual	\$350	No change
Family	\$700	No change
Out-of-Pocket Maximum		
Individual (INN)	\$6,000	No change
Family (INN)	\$12,000	No change
Services		
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	2025	2026
Services (Continued)		
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

Federal Employee Program - Basic Plan

Basic	2025	2026
Deductibles		
Individual	\$0	No change
Family	\$0	No change
Out-of-Pocket Maximum		
Individual (INN)	\$7,500	No change
Family (INN)	\$15,000	No change
Services		
Physician care	\$35 copay (PCP) \$50 copay (Specialist)	No change
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	2025	2026
Services (Continued)		
Preventive care	\$0 copay	No change
Hospital care - Inpatient (prior authorization required)	\$350 copay, per day Up to \$1,750 per admission	\$425 copay, per day Up to \$2,975 per admission
Hospital care - Outpatient	\$350 copay Per day, per facility	\$425 copay, per day Up to \$2,975 per admission
ER - Accidental injury	\$350 copay Per day, per facility	\$425 copay Per day, per facility
ER - Medical emergency	\$350 copay Per day, per facility	\$425 copay Per day, per facility

Federal Employee Program - Preventive Care

Blue Focus, Standard, and Basic	2025	2026
Adult Preventive Care		
<ul style="list-style-type: none"> • Colorectal cancer tests, including: <ul style="list-style-type: none"> – Fecal occult blood test – Colonoscopy, with or without biopsy – Sigmoidoscopy – Double contrast barium enema – DNA analysis of stool samples • Prostate cancer tests - Prostate Specific Antigen (PSA) test • Cervical cancer tests (including pap tests) • Screening mammograms (including mammography using digital technology) 	<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 HealthPlan



2026 Annual Provider Summit







BlueChoice - New HMO Plan

□ Choice Select

- New small group for BlueChoice effective Jan. 1, 2026.
- Members must select a ProActive MD physician within the appropriate network.
- Referrals are required for specialist visits.
- The prefix for this plan will be ZCC.

Sample ID Card

				
SUBSCRIBER'S FIRST NAME				
SUBSCRIBER'S LAST NAME				
Member ID				
ZCC000000000				
PLAN	PPD	IN NETWORK	INDIVIDUAL	FAMILY
PLAN CODE	380.04	DEDUCTIBLE	\$XX,XXX	\$XX,XXX
RxBIN	021684	OUT OF POCKET	\$XX,XXX	\$XX,XXX
RxGRP	CHC	OUT OF NETWORK	\$XX,XXX	\$XX,XXX
		DEDUCTIBLE	\$XX,XXX	\$XX,XXX
		OUT OF POCKET	\$XX,XXX	\$XX,XXX
www.BlueChoiceSC.com				




		www.BlueChoiceSC.com	
MEMBERS Member Services: 800-868-2528 Out of Area: 800-810-2583			
PROVIDERS Mental Health: 800-868-1032 Authorization: 800-950-5387 Pharmacy: 855-811-2218 Vision: 833-918-0490 Dental: 800-222-7156			
BlueChoice HealthPlan is an independent licensee of the Blue Cross Blue Shield Association.			
P.O. Box 6170 Columbia, SC 29260-6170		Rx Powered by BlueChoice HealthPlan	
File Dental Claims to: Columbia Service Center P. O. BOX 100300 Columbia, SC 29202-3300 B46			


BlueChoice - New EPO Plan

❑ Palmetto Option

- New Affordable Care Act plan for BlueChoice effective Jan. 1, 2026.
- Members will not have OON benefits, except for emergent services.
- Referrals and prior authorization required for specialist visits.
- The prefix for this plan will be ZPC.

Sample ID Card

	
<hr/>	
SUBSCRIBER'S FIRST NAME	
SUBSCRIBER'S LAST NAME	
Member ID	
ZPC000000000	
<hr/>	
PLAN CODE	
380.04	
RxBIN	021684
RxGRP	CHC
<hr/>	
Focus on life. Focus on health. Stay focused.	
www.BlueChoiceSC.com	
	

	www.BlueChoiceSC.com
<hr/>	
Members: See your benefit booklet for covered services. Possession of this card does not guarantee eligibility for services. Services outside the Blue Option Network are only covered for urgent or emergency care performed in an urgent treatment center or emergency room.	MEMBERS
Providers: Preauthorization required for some hospital outpatient procedures and all hospital inpatient admissions. Authorization required for MRI, MRA, CT and PET procedures.	Member Services: 855-816-7636
Benefits available in network only.	Out of Area: 800-810-2583
BlueChoice HealthPlan	PROVIDERS
P.O. Box 6170	Mental Health: 800-868-1032
Columbia, SC 29260-6170	Pharmacy: 855-811-2218
	Authorization: 800-950-5387
	Vision: 833-918-0490
<hr/>	
B30	BlueChoice HealthPlan is an independent licensee of the Blue Cross Blue Shield Association.
	Rx Powered by BlueChoice HealthPlan

BlueChoice – Reminders

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

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

❑ **Verify prior authorization requirements**

- Use My Insurance Manager
- 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)

- 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



2026 Annual Provider Summit



Medicare Advantage - Plan Overview

2026 Plans

- ❑ Blue Basic PPO
- ❑ Total PPO (Lowcountry, Midlands, Upstate)
- ❑ Total Value PPO (Lowcountry, Midlands, Upstate)

Medicare Advantage - BlueCross Total Plan

BlueCross Total	2025	2026
Deductibles		
In-network & Out-of-network	\$0	No change
Out-of-Pocket Maximum		
From in-network providers:	\$8,900	No change
From in-network & out-of-network providers combined	\$13,500	No change
Services		
Physician office visits	INN - \$0 copay (PCP) INN - \$17 - \$47 copay (Specialist) OON - \$30 copay (PCP) OON - \$50 copay (Specialist)	INN - \$0 copay (PCP) INN - \$35 copay (Specialist) OON - \$30 copay (PCP) OON - \$55 copay (Specialist)
Inpatient hospital - Acute	INN - \$450 copay, per day (1-2) INN - \$0 copay, per day (3-90) OON - 40% COINS for total stay	INN - \$425 copay, per day (1-3) INN - \$0 copay, per day (4-90) OON - 40% COINS for total stay
Inpatient hospital - Psychiatric	INN - \$675 copay, per day (1-3) INN - \$0 copay, per day (4-90) OON - 40% COINS for total stay	INN - \$690 copay, per day (1-3) INN - \$0 copay, per day (4-90) OON - 40% COINS for total stay

Medicare Advantage - BlueCross Total Plan (Continued)

BlueCross Total	2025	2026
Services (Continued)		
Skilled nursing facility (SNF) (100 benefit day max, per year)	INN - \$0 (days 1-20) INN - \$214 copay (days 21-100) OON - 40% COINS for total stay	INN - \$0 (days 1-20) INN - \$218 copay (days 21-100) OON - 40% COINS for total stay
Urgently needed services	INN & OON - \$10 copay, per visit Outside of USA - \$45 copay, per visit	No change
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	INN & OON - \$350 copay, per trip
Hearing aids	\$699-\$999 using TruHearing Two per year (one per ear)	No change
Preventive dental (Fluoride treatment not covered)	INN - \$0 copay (two visits, per year) OON - 50% COINS \$4,500 maximum (combined)	INN - \$0 copay (two visits, per year) OON - 50% COINS \$2,500 maximum (combined)
Comprehensive dental (Medicare covered services)	INN - \$50 copay OON - \$50 copay \$4,500 maximum (combined)	INN - \$50 copay OON - \$50 copay \$2,500 maximum (combined)
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS \$4,500 maximum (combined)	INN & OON - 50% COINS \$2,500 maximum (combined)

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

Medicare Advantage - BlueCross Total Value Plan

BlueCross Total Value	2025	2026
Deductibles		
In-network & Out-of-network	\$0	No change
Out-of-Pocket Maximum		
In-network	\$9,350	\$9,250
Out-of-network	\$14,000	\$13,900
Services		
Physician office visits	INN - \$0 copay (PCP) INN - \$17 - \$47 copay (Specialist) OON - \$40 copay (PCP) OON - \$55 copay (Specialist)	INN - \$0 copay (PCP) INN - \$45 copay (Specialist) OON - \$40 copay (PCP) OON - \$55 copay (Specialist)
Inpatient hospital - Acute	INN - \$465 copay per day (1-2) INN - \$0 copay, per day (3-90) OON - 40% COINS for total stay	INN - \$425 copay per day (1-4) INN - \$0 copay, per day (5-90) OON - 40% COINS for total stay
Inpatient hospital - Psychiatric	INN - \$675 copay, per day (1-3) INN - \$0 copay, per day (4-90) OON - 50% COINS for total stay	INN - \$690 copay, per day (1-3) INN - \$0 copay, per day (4-90) OON - 50% COINS for total stay

Medicare Advantage - BlueCross Total Value Plan (Continued)

BlueCross Total Value	2025	2026
Services (Continued)		
Skilled nursing facility (SNF) (100 benefit day max, per year)	INN - \$0 (days 1-20) INN - \$214 copay (days 21-100) OON - 50% COINS for total stay	INN - \$0 (days 1-20) INN - \$218 copay (days 21-100) OON - 50% COINS for total stay
Emergency care	INN & OON - \$110 copay, per visit	INN & OON - \$115 copay, per visit
Worldwide emergency	\$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Urgent care	INN & OON - \$10 copay, per visit Outside of USA - \$45 copay, per visit	No change
Ambulance services (Ground or air)	INN - \$310 copay, per one-way trip OON - \$325 copay, per one-way trip	INN - \$350 copay, per one-way trip OON - \$365 copay, per one-way trip
Hearing aids	\$699-\$999 using TruHearing Two per year (one per ear)	\$699-\$999 using TruHearing Two per year (one per ear)
Preventive dental	INN - \$0 copay (two visits, per year) OON - 50% COINS \$3,000 maximum (combined)	INN - \$0 copay (two visits, per year) OON - 50% COINS \$1,500 maximum (combined)
Comprehensive dental (Medicare covered services)	INN - \$50 copay OON - 50% COINS \$3,000 maximum (combined)	INN - \$50 copay OON - 50% COINS \$1,500 maximum (combined)
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS \$3,000 maximum (combined)	INN & OON - 50% COINS \$1,500 maximum (combined)

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

Medicare Advantage - BlueCross Blue Basic Plan

BlueCross Blue Basic	2025	2026
Deductibles		
In-network & Out-of-network	\$0	No change
Out-of-Pocket Maximum		
In-network	\$5,900	No change
Out-of-network	\$9,550	No change
Services		
Physician office visits	INN - \$0 copay (PCP) INN - \$30 copay (Specialist) OON - \$30 copay (PCP) OON - \$45 copay (Specialist)	INN - \$0 copay (PCP) INN - \$35 copay (Specialist) 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	INN - \$325 copay, per day (1-5) INN - \$0 copay, per day (6-90) OON - 20% COINS for total stay
Inpatient hospital - Psychiatric	INN - \$645 copay, per day (1-3) OON - 20% COINS for total stay	INN - \$690 copay, per day (1-3) OON - 20% COINS for total stay

Medicare Advantage - BlueCross Blue Basic Plan (Continued)

BlueCross Blue Basic	2025	2026
Services (Continued)		
Skilled nursing facility (SNF)	INN - \$0 copay (days 1-20) INN - \$214 copay (days 21-100) OON - 20% COINS for total stay	INN - \$0 copay (days 1-20) INN - \$218 copay (days 21-100) OON - 20% COINS for total stay
Urgently needed services	INN & OON - \$10 copay Outside of USA - \$45 copay, per visit	No change
Emergency care	\$110 copay, per visit (Waived if admitted within 24 hours)	\$115 copay, per visit (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	2025	2026
Services (Continued)		
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 \$3,000 maximum (combined)
Comprehensive Dental (Medicare covered services)	INN - \$50 copay OON - 50% COINS \$3,500 maximum (combined)	INN - \$50 copay OON - 50% COINS \$3,000 maximum (combined)
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS \$3,500 benefit maximum (combined)	INN & OON - 50% COINS \$3,000 benefit maximum (combined)

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

Medicare Advantage - Preventive Care

All Plans (Total, Total Value, & Blue Basic)	2025	2026
Services		
Annual wellness visit/Annual physical	\$0 Copay	No change
Lab work	\$0 Copay	No change
Preventive screenings: <ul style="list-style-type: none">• Colorectal cancer screening• Breast cancer screening• Bone mineral density tests• Diabetic eye exam• Eyeglasses and frames• Glaucoma screening	\$0 Copay	No change

Medicare Advantage Plan Authorizations

❑ Medical Services

- Use: My Insurance Manager
- Call: 855-843-2325

❑ Behavioral Health

- Visit: www.CompanionBenefitAlternatives.com
- Call: 833-971-4075

❑ Laboratory Services

- Use: My Insurance Manager
- Call: 844-227-5769

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

- Integrated Home Care Services
 - Call: 844-215-4264
 - Fax: 844-215-4265
 - Use one of the appropriate coversheets on the website.

**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

Transportation

Over the counter

Post discharge
meals

Annual wellness
incentive

In-home health
assessment award

Routine eye exams
and eyewear

Concierge
pharmacy services

Member health
events

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.
- ❑ Members will pay 0% cost share in Catastrophic Coverage stage.

Medicare Advantage Plan - CMS Star Ratings

- ❑ Providers are eligible to earn financial incentives for Star rating performance by submitting CPT II codes or by joining a value-based program.
- ❑ To best impact Star ratings, providers should:
 - **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 - Chronic Conditions

- ❑ To ensure the full health status of the member is captured correctly, BlueCross will soon implement a new alert in the claim system to notify providers when chronic conditions are missing for a patient.
- ❑ **Key action:** Providers should review the patient record and resubmit the claim appropriate documentation.
- ❑ More information will be shared with providers when the alerts are live in the system.



Medicare Advantage Plan - Upcoming HCC Changes

- ❑ Once the alerts go live, the claims system will compare claims submissions to the patient's historical profile to determine whether a hierarchical category condition (HCC) code is missing.
- ❑ Error codes will start with a "UU".
- ❑ In the example, it shows heart failure, bladder, colorectal and other conditions are missing.

Welcome, Janet Landry of Multi specialty ([Log Out](#)) [Go to Message Center](#)

Professional Claim Entry

[Printer-Friendly](#)

[Plan Information](#) [Provider Information](#) [Patient Information](#) [Claim Information](#) [Claim Line Information](#) **Review** [Confirmation](#)

Dates of Service
06/12/2025 - 06/12/2025

Insurance
Plan Name: BlueCross BlueShield Plans
Member ID: zhp300425689341

Patient
Patient's Name: Donald Bindner JR
Relationship to Member: SELF
Gender: MALE
Date of Birth: 09/02/1952

Claim Review

The following errors were found:

- Line 1 UU0 ACUTE HEART FAILURE
- Line 1 UU1 ATHEROSCLEROSIS OF ARTERIES
- Line 1 UU2 ATRIAL ARRHYTHMIAS
- Line 1 UU4 BLADDER, COLORECTAL, AND OTHER CANCERS
- Line 1 UU5 CARDIOMYOPATHY/MYOCARDITIS

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: Janet Landry Billing Location: P.ST Plan: BlueCross BlueShield Plans

Patient Information
Member ID: zhp300425689341 Date of Birth: 09/02/1952 Gender: MALE
Patient's Name: Donald Bindner JR Patient Account Number: 123456789

Claim Information

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 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
 - Providers>Medicare Advantage>Prior Authorization
- ❑ When possible, always refer members to network participating providers.
- ❑ Review the Medicare Advantage provider manuals for more information.

Benefit Reminders



2026 Annual Provider Summit



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 Standards

□ **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



2026 Annual Provider Summit



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
- Patient's date of birth

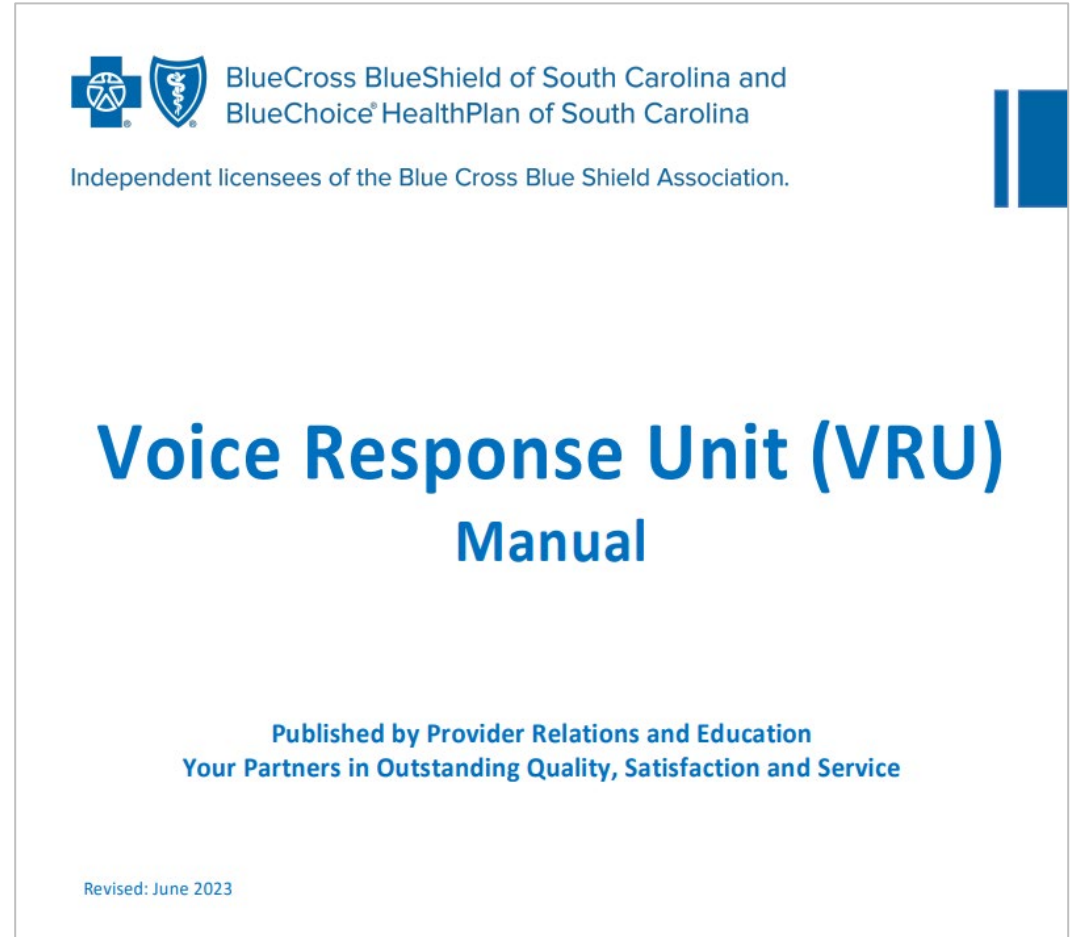
Getting Benefits Through the Voice Response Unit (Continued)

❑ You will hear the following information:

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

❑ Available benefit options:

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



Member ID Card Guide

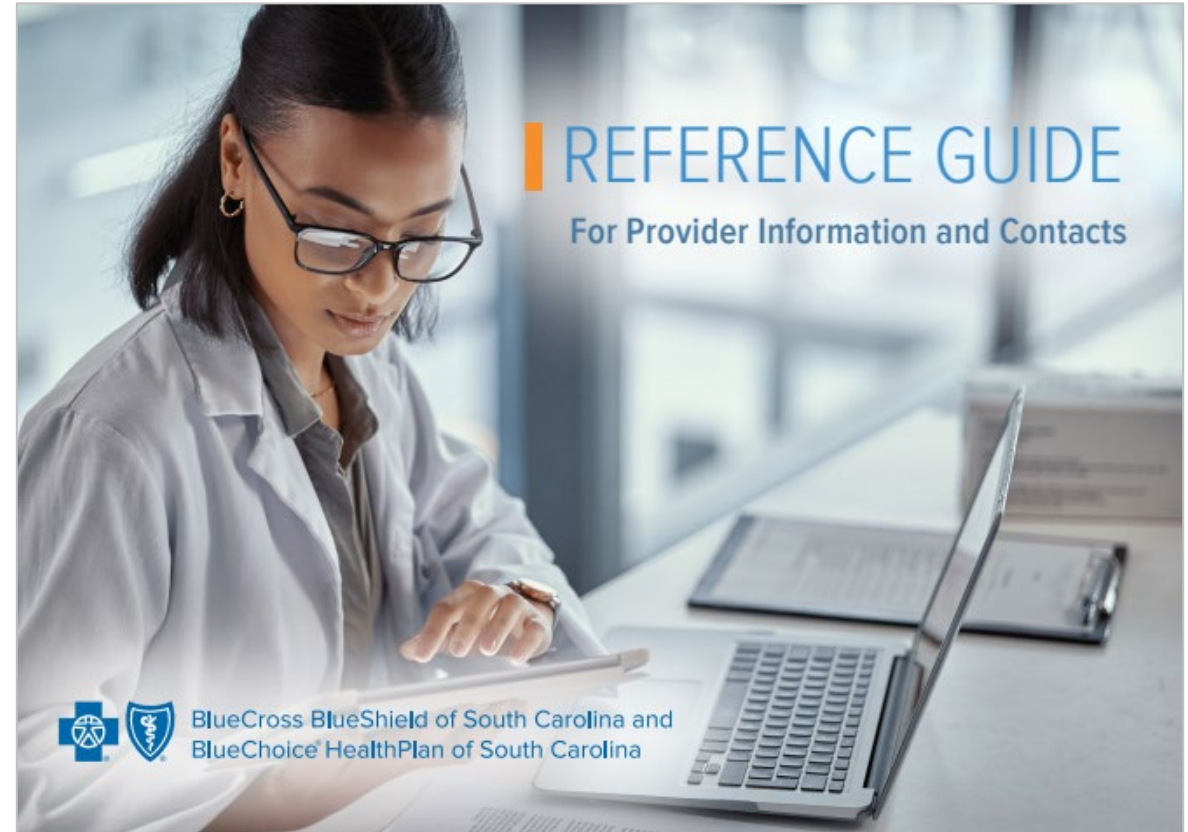
- ❑ Get an overview of various plans, associated networks and example of the ID card you may see.
 - Visit www.SouthCarolinaBlues.com:
 - Providers>Tools and Resources>Guides

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:
 - Providers>Tools and Resources>Guides



My Insurance Manager



2026 Annual Provider Summit



Benefits and Eligibility

Getting Benefits in My Insurance Manager

Step 1

Patient Care	Office Management	Resources	Modify Profile
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 **Select** **Primary ID:**

Continue **Clear All**

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>i 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](#)

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▲
▼ 50- HOSPITAL - OUTPATIENT	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>View Additional Messages</p> <hr/> <p>INDIVIDUAL COINSURANCE: 15%</p>			
▶ 51- HOSPITAL - EMERGENCY ACCIDENT	23- EMERGENCY ROOM - HOSPITAL		
▶ 52- HOSPITAL - EMERGENCY MEDICAL	23- EMERGENCY ROOM - HOSPITAL		
▶ A0- PROFESSIONAL (PHYSICIAN) VISIT - OUTPATIENT	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▲
▼ CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES- 99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANA	11- OFFICE		
<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>View Additional Messages</p> <hr/> <p>INDIVIDUAL COINSURANCE: 15%</p>			
Ask Provider Services		New Search	
Back			

Claims



2026 Annual Provider Summit

Topics to Discuss

- ❑ Submission of Claims
- ❑ Claim Reminders
- ❑ Helpful Tips
- ❑ My Insurance ManagerSM
 - Claims Submission
 - Claims Status
 - Ask Provider Services
 - STATchatSM
- ❑ My Remit Manager

Submission of Claims



2026 Annual Provider Summit



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.

*** Preferred method**

*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
- ❑ Improved cash flow
- ❑ Reduced administrative burden
- ❑ Payer compliance and data security
- ❑ 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
Planned Administrators, Inc. (PAI)	00886
BlueChoice® 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.



Note: This option should be used for claims that you may not get to go through your clearinghouse.

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

Medicare Advantage

P.O. Box 100191
Columbia, SC 29260

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.

Claim Reminders



2026 Annual Provider Summit



Laboratory Services

- ❑ Avalon Healthcare Solutions manages the laboratory benefits on behalf of BlueCross and BlueChoice®.
- ❑ Access the current list of participating laboratories on the BlueCross or BlueChoice website.
- ❑ 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
 - Providers>Policies and Authorizations>Medical Policies
 - www.BlueChoiceSC.com
 - Providers>Medical Policies
 - www.SCBluesMedAdvantage.com
 - Providers>Live 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 the navigation bar is a search bar with the text 'Search...' and a magnifying glass icon. The main content area is white and features a list of medical policies. On the left side, there are two filter menus: 'Category' and 'Date Posted'. The 'Category' menu 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' menu lists dates from October 2022 (1) to All (757). The main list of policies includes: '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). At the top of the main content area, there is a horizontal menu of letters from 'All' to 'Z' for alphabetical navigation.

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. The majority of these devices are laboratory-developed tests (LDTs) that do not perform 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, nodular
	C85.80 – C85.89	Other specified types of B-cell lymphoma
	C85.90 – C85.99	Non-Hodgkin lymphoma, unspecified
	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

Date	Change
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 for more information.

Examples of Itemized Bills

❑ *Acceptable* itemized bill:

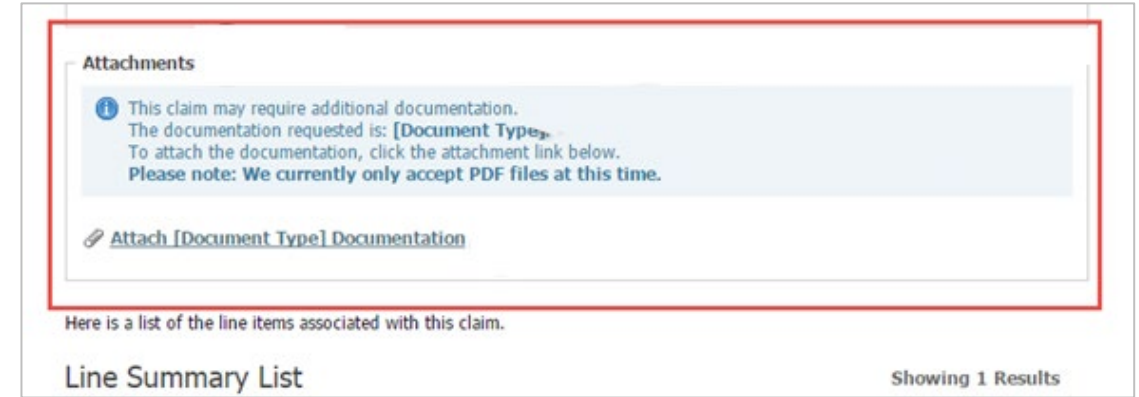
42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Dicyclomine 10 MG		010322	1	27.00
0250	Nitroglycerin 0.4 MG		010322	1	28.73
0250	Midazolam 10 MG	J2250	010322	2	29.09
0250	Atorvastatin 40 MG		010322	2	76.93
0272	Catheter Angiographic		010322	1	226.00

❑ *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 for more information.

Provider Reconsiderations

- ❑ A provider reconsideration is a ***one-time courtesy review*** offered to participating providers used to investigate the outcome of a processed claim.
 - Typically related to medical necessity, lack of authorization for emergent services, etc.
- ❑ Use the South Carolina Provider Reconsideration Form.
 - www.SouthCarolinaBlues.com
 - www.BlueChoiceSC.com
- ❑ Include supporting documentation.
 - History and physical records
 - Operative notes
 - Office notes
 - Progressive notes
- ❑ Be mindful of the timely filing limits.



Independent licensees of the Blue Cross Blue Shield Association.

South Carolina Provider Reconsideration Form

This form is intended for use by participating 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 one-time claim review for reconsideration, 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.

Refer to the Provider Reconsideration Guide online to determine if a provider reconsideration is warranted for the claim in question.

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 for the request.

Medical Services Laboratory Services

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®	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-B10, P.O. Box 100605, Columbia, SC 29260

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 approved authorization number.

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, Exchange or Medicare Advantage)

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.

Note: 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...
4-4-2	#### - #### - ##	1st position	0#### - #### - ##	0#####
5-3-2	##### - ### - ##	6th position	##### - 0### - ##	#####0#####
5-4-1	##### - ##### - #	10th position	##### - ##### - 0#	#####0#

The BlueCard Program

Overview

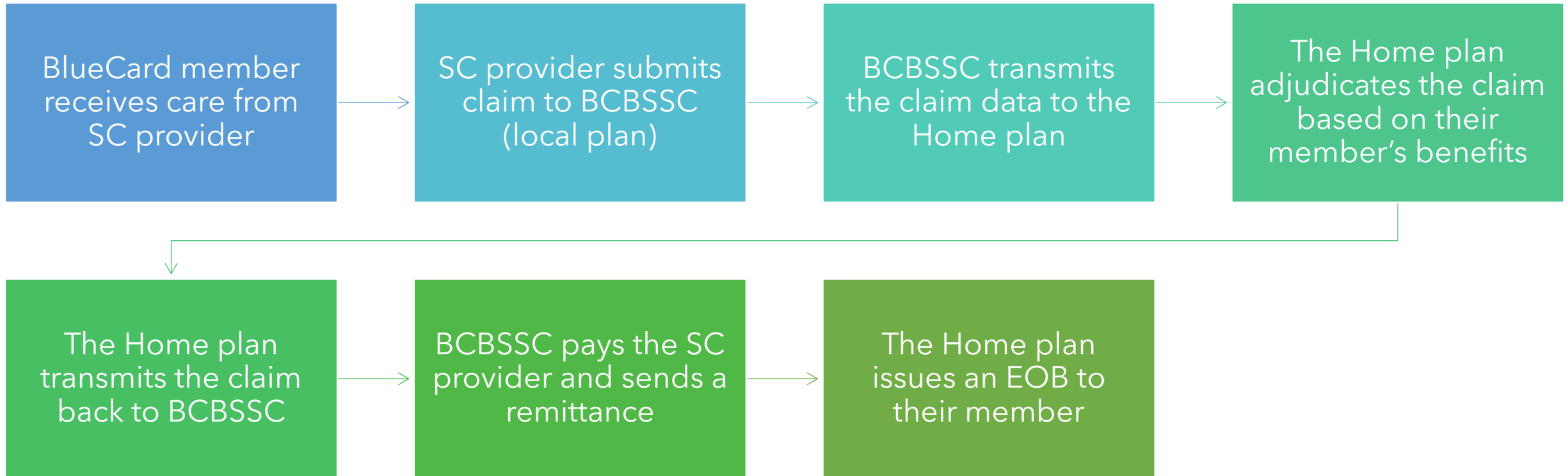
- ❑ The BlueCard program allows Blue plan members to get health care services while traveling or living in another Blue plan's service area.
- ❑ The program links participating health care providers across the country and internationally through a single, electronic network for claims processing and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

The BlueCard Program - Process Flow for Claims



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.

My Insurance Manager



2026 Annual Provider Summit



Claims Submission

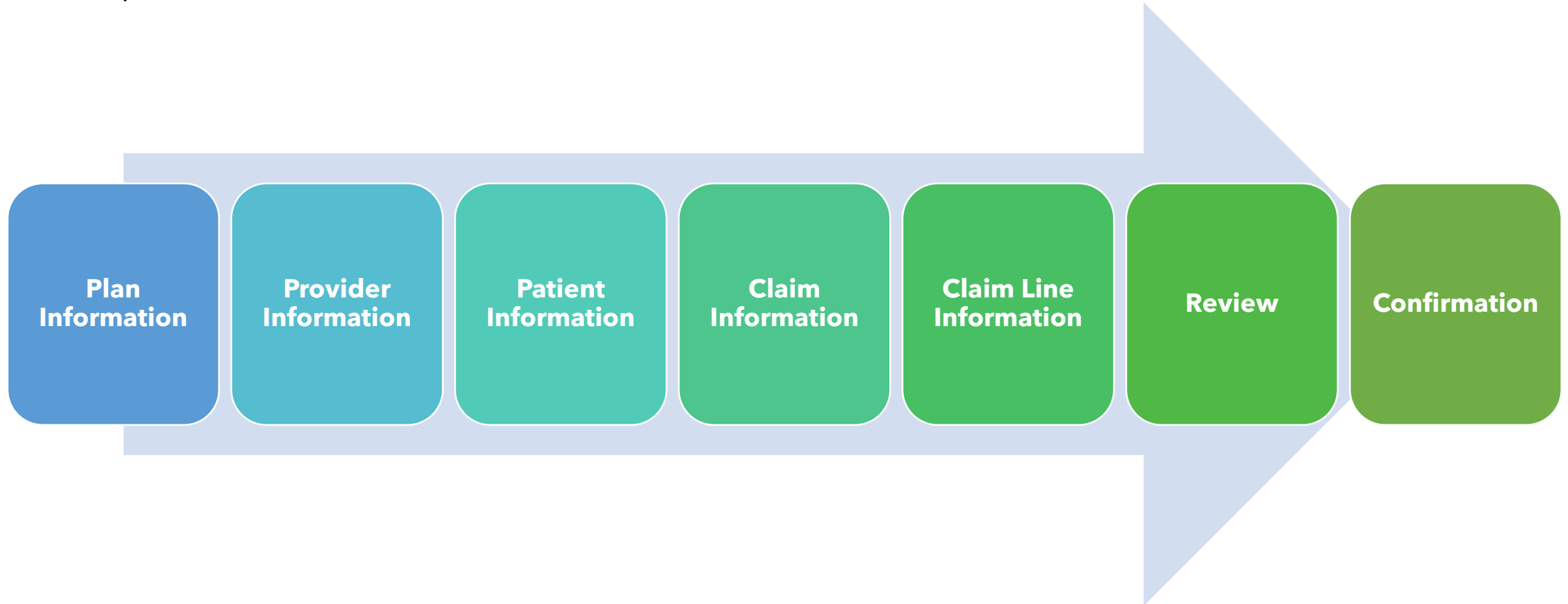


2026 Annual Provider Summit



Submitting Claims Through My Insurance Manager

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



Note: The screens for institutional and dental claim entry may include an additional screen.

Steps to Submit Claims Through My Insurance Manager

Start Here

Patient Care	Office Management	Resources	Modify Profile
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 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: t.archie@bluecross.com

Phone: (800) 361-6888 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: To Date of Service:

mm/dd/yyyy mm/dd/yyyy

Continue X Cancel this claim

Note: At any time, you can select "Cancel this claim" to end 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: 4444444440

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:

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: [] [] [] []

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	Add

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

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



2026 Annual Provider Summit



Checking the Status of a Claim

Start Here

Patient Care	Office Management	Resources	Modify Profile
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 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 2

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>
 207103LDG0000	PROCESSED	15	03/07/2022	03/12/2022	\$81.00
 207404P250000	PROCESSED	16	03/07/2022	03/15/2022	\$130.50
 2029023B80000	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: 24021

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 questions where the answers can be found in the portal or the VRU.

Examples of *appropriate* requests

Why was line one of the claim denied as noncovered?

Has the member returned the coordination of benefits questionnaire?

I need clarification regarding a recent recoupment made on the claim for date of service 01/30/2025.

Claim denied for no authorization, but the authorization number is on file under 123456789.

Examples of *inappropriate* requests

What is the status of the claim?

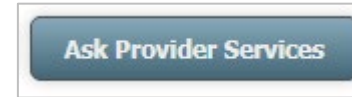
Has the claim been processed?

Did you receive the medical records for this claim?

Is there a claim on file for date of service 07/10/2025?

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 a Provider Services representative](#)
(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.
- ❑ 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 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.

The screenshot displays the 'Ask Provider Services' interface. At the top, there is a blue button labeled 'Ask Provider Services'. Below it, a text box explains that users can use the form to receive a response in the Message Center or talk to a representative. The 'How would you like to contact Provider Services?' section has two options: 'Submit your question online' and 'Talk to Provider Services online (Monday - Friday, 8:30 a.m. to 8 p.m. EST)'. The second option is selected and circled in red. The form includes fields for 'Inquiry Name' (BlueCross BlueShield Plans), 'Inquiry Reason' (Claim Status Inquiry), and patient information (First Name: J, Last Name: K, Member ID: B: i9Q). There are also fields for 'Location' and 'Primary ID' (1). A 'Launch STATchat' button is circled in red at the bottom. On the right, a 'STATchat - Google Chrome' window shows a 'Hang Up' panel with a keypad and a 'Wearing a headset?' checkbox. Below the keypad, there are 'Details' and 'Log' tabs, and a section for 'Automatic Number Identification' with the number 8789141651, 'Session ID', and 'Provider Tax ID' 571098556.

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

My Remit Manager

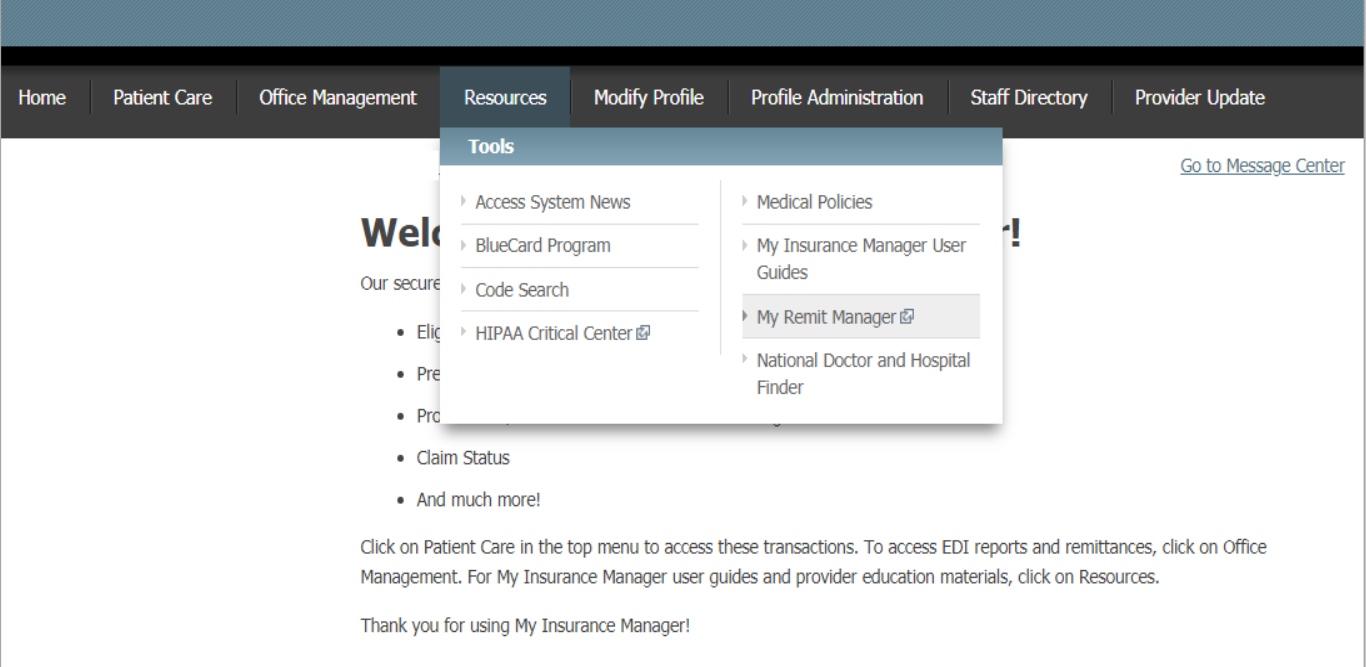


2026 Annual Provider Summit



Accessing My Remit Manager

- ❑ While in My Insurance Manager, hover over Resources and select My Remit Manager.



The screenshot displays the top navigation bar of the My Insurance Manager website. The navigation menu includes: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, Staff Directory, and Provider Update. The Resources menu is open, showing a list of tools: Access System News, BlueCard Program, Code Search, HIPAA Critical Center, Medical Policies, My Insurance Manager User Guides, My Remit Manager (highlighted), and National Doctor and Hospital Finder. Below the navigation bar, the page content includes a welcome message, a list of services (Eligibility, Pre-authorization, Prior authorization, Claim Status, and And much more!), and instructions on how to access various transactions and reports. A "Go to Message Center" link is visible in the top right corner.

Available Remittances - Calendar View

- ❑ If remittances are available, there will be check links on the calendar.
- ❑ Providers can view previous months by selecting the appropriate arrows on the calendar.

The screenshot shows the 'My Remit Manager' interface. At the top, there are navigation tabs for 'Calendar', 'Month Details', and 'ERA Details'. Below this, the title is 'ERA by Check Date - September 2025'. There is a dropdown menu for 'View Checks By:' set to 'Check Date', and buttons for 'Check Summary Report' and 'Show Month'. The main area is a calendar for September 2025. The calendar grid shows days from 31st to 5th. The 1st of September is highlighted in yellow and contains a check icon and the text 'CHK: 4'. The 3rd of September contains a check icon and the text 'CHK: 59'. Other days are marked 'open'. Navigation arrows are visible at the top of the calendar grid.

September 2025						
S	M	T	W	T	F	S
31 open	1 open CHK: 4	2 open	3 open CHK: 59	4 open	5 open	6 open
7 open	8 open	9 open	10 open	11 open	12 open	13 open
14 open	15 open	16 open	17 open	18 open	19 open	20 open
21 open	22 open	23 open	24 open	25 open	26 open	27 open
28 open	29 open	30 open	1 open	2 open	3 open	4 open
5 open	6 open	7 open	8 open	9 open	10 open	11 open

Viewing Available Remittances

- ❑ Providers can view remittances based on the check number, payment amount, or payer.
- ❑ If they select a specific check number, the applicable remittances will populate.
- ❑ Select the Adobe icon next to the appropriate patient for the remittance to display.

The screenshot displays the 'My Remit Manager' interface. At the top, there are navigation tabs for 'Calendar', 'Month Details', and 'ERA Details'. Below this, the 'Calendar > Check Detail' section includes search filters for 'Start Date' (9/3/2025) and 'End Date' (9/3/2025), along with 'Show/Hide', 'Refresh', 'Export Excel', and 'Select All' options. A table of checks is shown with columns for 'Reco', 'Download', 'Check Number', 'Payment Method', 'Checkdate', 'Postdate', 'Billed', 'Paid', and 'Payer'. An Adobe icon is visible next to the first check number, 000002421.

An inset window titled 'Download Selected' shows a detailed view of remittances for the selected check. It includes a table with columns for 'Account', 'Patient', 'Payer Name', 'Payer ID', 'Status', 'Policy', 'DOS', 'Billed', and 'Paid'. The data shows 29 items in 3 pages, with the first few rows as follows:

Account	Patient	Payer Name	Payer ID	Status	Policy	DOS	Billed	Paid
IMA1: 71	ALK	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD9	93	7/25/2025	\$48.00 \$6.30
IMA1: 21	ALC	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD1	02	7/21/2025	\$238.03 \$102.82
IMA1: 90	BRC	SC HEALTHYBLUE MEDICAID	403	Denied	ZCD1	17	8/26/2025	\$21.00 \$0.00
IMA1: 30	DAV	SC HEALTHYBLUE MEDICAID	403	Denied	ZCD9	67	8/21/2025	\$166.00 \$0.00
IMA1: 60	FAH	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD5	18	8/22/2025	\$70.00 \$19.14
IMA1: 40	FAH	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD5	18	8/22/2025	\$168.03 \$72.77
IMA1: 01	FRA	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD6	07	7/23/2025	\$238.00 \$102.79
IMA1: 00	JAC	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD0	19	8/20/2025	\$238.03 \$102.81
IMA1: 11	JOH	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD8	01	7/22/2025	\$1,336.00 \$184.60
IMA1: 60	KAL	SC HEALTHYBLUE MEDICAID	403	Denied	ZCD9	43	8/21/2025	\$17.00 \$0.00

Example of Remittance

ERA Patient Listing

Electronic Reproduction ASC 005010X221A1

PH UNI AL GRP
A 14

ALI IFA
SC HEALTHYBLUE MEDICAID

CHECK/EFT: 001 100

CHECK DATE: 09/03/2025

Account: IMA1445923771 POS: 11 HIC: ZCD971 3 ICN: 5240097MD0000 Provider: 108 571004 8295641
Status: Processed as Primary

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary
571004971	07/25/2025	1		HC:36415	17.00				17.00	0.00	CO 45 17.00 HE N174
571004971	07/25/2025	1		HC:85025:QW	31.00	6.30			24.70	6.30	CO 45 24.70 HE N45
REMITTANCE SUMMARY					48.00	6.30	.00	.00	41.70	6.30	

TOTALS

Denied/Non-Covered: 0.00

CO 45 41.70 [Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).]
HE N45 [Payment based on authorized amount.]
HE N174 [This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group "PR".]

* Denotes Denied Or Non-covered Charges

REMITTANCE SUMMARY

Totals	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj	Paid
	48.00	6.30	.00	.00	41.70	.00	6.30

Dental Networks



2026 Annual Provider Summit

Topics to Discuss

- ❑ Dental Enrollment
- ❑ Dental Plans
- ❑ Dental GRID
- ❑ Dental Benefits and Claims
- ❑ 2026 Coding Updates

Dental Enrollment



2026 Annual Provider Summit



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.
 - 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****		
Board Certification*****		

*Must include past five years (active and inactive).

**Only if applicable.

***Only if applying for BlueChoice® HealthPlan.

****Only if applying for Healthy Blue.

*****If board certified.

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.

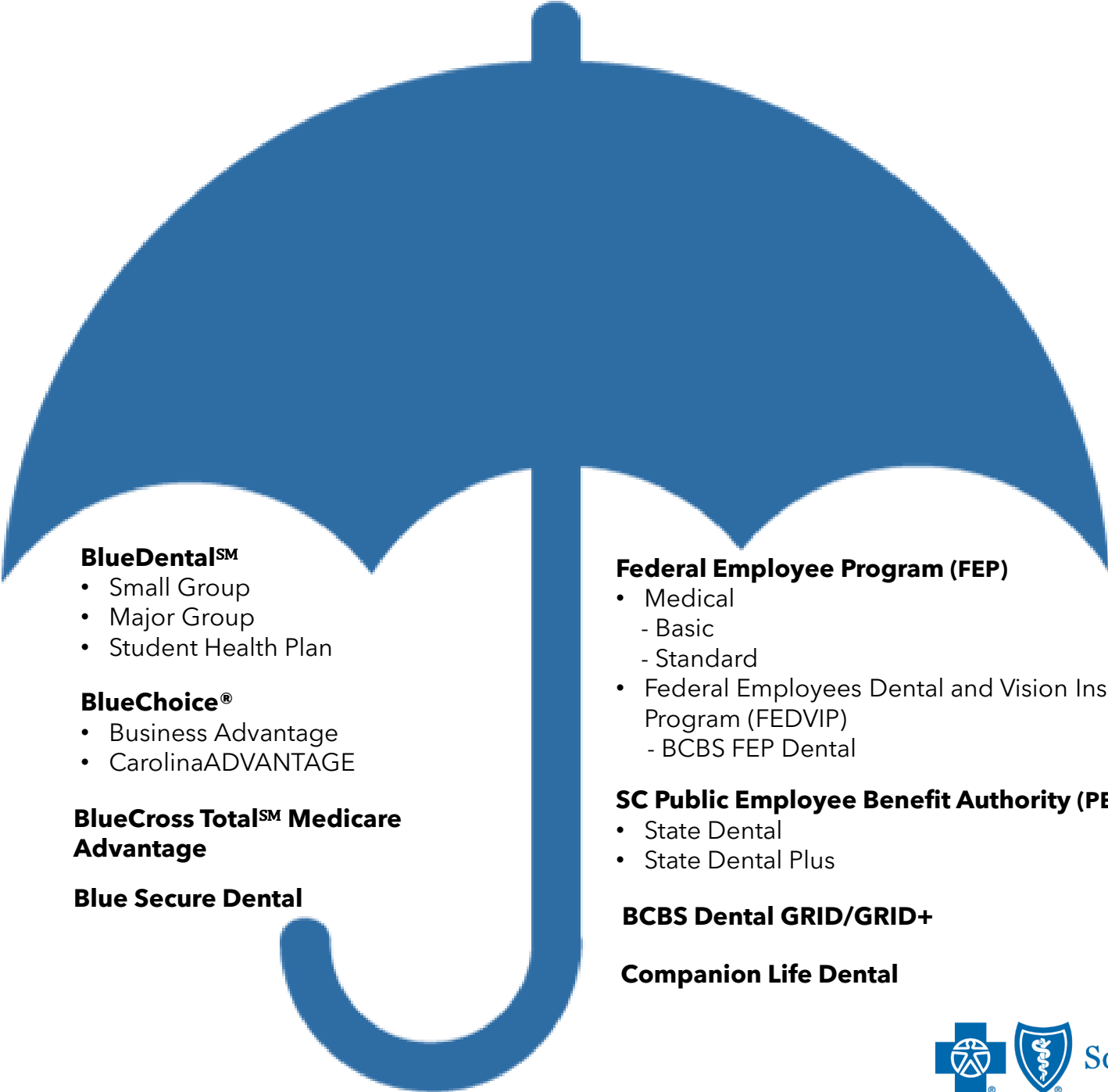
**Only for oral surgeons applying for Healthy Blue.

***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.

Dental Plans

BlueCross BlueShield of South Carolina Dental Umbrella



BlueDentalSM

- Small Group
- Major Group
- Student Health Plan

BlueChoice[®]

- Business Advantage
- CarolinaADVANTAGE

BlueCross TotalSM 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


Commercial Plans - Examples of ID Cards

 South Carolina	
SUBSCRIBER'S FIRST NAME _____ SUBSCRIBER'S LAST NAME _____	
Member ID XXX123614046483	
PLAN DENTAL	PLAN CODE 380
_____ _____	
www.SouthCarolinaBlues.com	

 South Carolina	
www.SouthCarolinaBlues.com 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.

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

 South Carolina	
www.SouthCarolinaBlues.com 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)

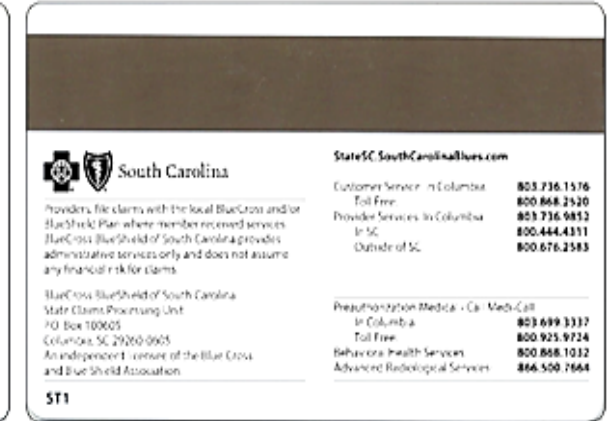
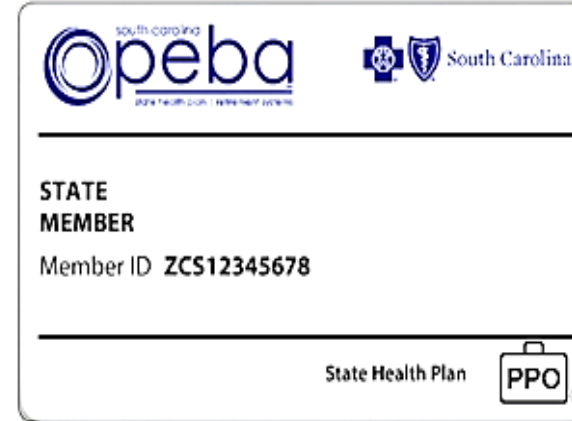
State Health Plan

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

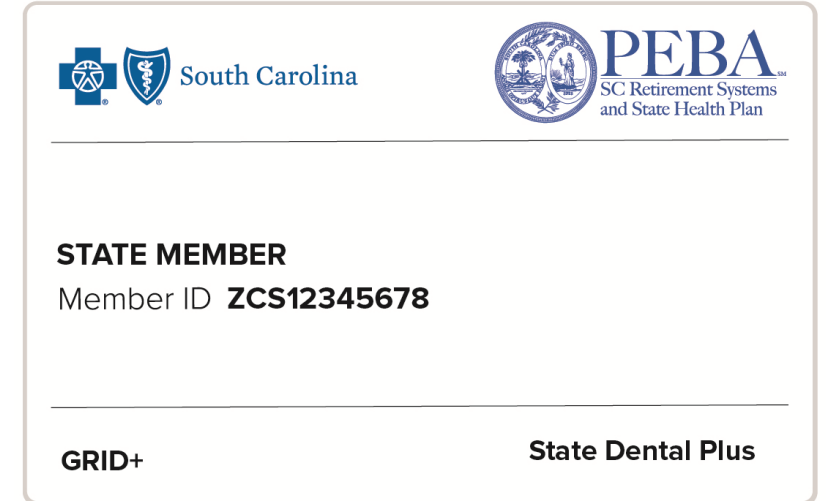
Note: A \$1,000 benefit period maximum applies to classes 1-3.

- ❑ 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



2026 Annual Provider Summit



Federal Employee Program - Basic Option Plan (Continued)

Covered Service	FEP Pays	Member Pays
Clinical Oral Evaluations		
Periodic oral evaluation*		
Limited oral evaluation		
Comprehensive oral evaluation*		
*Benefits are limited to a combined total of two evaluations per person per calendar year		
Diagnostic Imaging	Preferred: All charges in excess of member's \$35 copayment	Preferred: \$35 copayment per evaluation
Intraoral – complete series including bitewings (limited to one complete series every three years)		
Preventive	Participating/Non-participating: Nothing	Participating/Non-participating: Member pays all charges
Prophylaxis – adult (up to two per calendar year)		
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)		
Not covered: Any service not specifically listed above	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.

 BlueCross BlueShield Federal Employee Program.	Government-Wide Service Benefit Plan		www.fepblue.org
Member Name Member Name	www.fepblue.org		
Member ID R99999999			
Enrollment Code 104	RxIIN 610239		
Effective Date 01/01/2008	RxPCN FEPRX		
	RxGrp 65006500		

 BlueCross BlueShield Federal Employee Program.	www.fepblue.org
<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: 1-800-522-5566
<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: 1-800-255-2042
<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: 1-800-554-9504
	Retail Pharmacy: 1-800-626-5060
	Blue Health Connection: 1-888-258-3432
	Assistance Overseas iCall collect: 1-804-673-1678
	BlueCross and BlueShield of Geography 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	
Clinical Oral Evaluations			In Network The difference between the amounts listed to the left and the BlueCross Participating Dental Allowance Out-of-Network All charges in excess of the scheduled amounts listed to the left.
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	
Diagnostic Imaging			
Intraoral complete series	\$36	\$22	
Palliative Treatment			
Palliative treatment of dental pain – minor procedure	\$24	\$15	
Protective restoration	\$24	\$15	
Preventive			
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	
Not covered: Any service not specifically listed above	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 a FEDVIP plan for dental benefits.
- ❑ Claims would need to be filed directly to the FEDVIP plan.



BlueCross BlueShield Federal Employee Program FEP Blue Focus PPO

Member Name: _____ www.fepblue.org
** DC - DO NOT MAIL **

Member ID: **R00010044**

Enrollment Code: **131** RxIDN: **619239**
Effective Date: **01/01/2012** RxPCN: **FEPRX**
RxGrp: **65006500**



BlueCross BlueShield Federal Employee Program www.fepblue.org

Customer Service: **1-800-000-0000**
1-800-000-0000

Prescription: **1-800-000-0000**

Mental Health/Substance Abuse Prescription: **1-800-000-0000**

Retail Pharmacy: **1-800-624-5060**

Assistance Overseas (Call Collect): **1-864-673-1678**


Blue Health Connection: **1-888-258-3432**

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

This card is used to obtain covered benefits under the Blue Cross and Blue Shield Service Benefits Plan Basic Option. You MUST use Preferred providers to get benefits.
Prescription is required for all hospital admissions and is ultimately your responsibility. Benefits are reduced by \$500 if prescription 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 prescription 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 71400) for the applicable contract year, which is the only legal description of benefits.

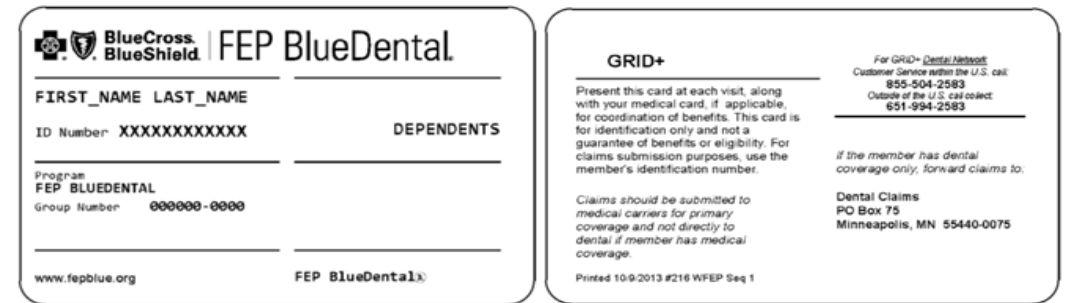
Federal Employee Program - Blue Cross Blue Shield FEP Plan

- ❑ Members covered by 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.



The image shows a sample of a new BCBS FEP Dental ID Card. It is divided into two main sections. The left section contains the following fields: ID Number, Program (High Option), Group Number, and a field for Dependents. The right section contains the GRID+ logo, contact information for dental network customer service (855-504-2583), and a note about dental coverage. It also includes the address for BCBS FEP Dental in Minneapolis, MN.

Sample of new BCBS FEP Dental ID Card



The image shows a sample of an old FEP BlueDental ID Card. It is divided into two main sections. The left section contains the following fields: FIRST_NAME LAST_NAME, ID Number (XXXXXXXXXX), Program (FEP BLUEDENTAL), Group Number (000000-0000), and a field for Dependents. The right section contains the GRID+ logo, contact information for dental network customer service (855-504-2583), and a note about dental coverage. It also includes the address for Dental Claims in Minneapolis, MN.

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
Class A (Basic) services (e.g., exams, cleanings, x-rays, sealants)	\$0	10% COINS	\$0	40% COINS
Class B (Intermediate) services (e.g., oral surgery, fillings, gum scaling)	30% COINS	40% COINS	45% COINS	60% COINS
Class C (Major) services (e.g., crowns, bridges, root canals, dentures)	50% COINS	60% COINS	65% COINS	80% COINS
Class D (Orthodontics) services (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
Annual Deductible Class A, B and C services (Does not include Class D services)	\$0	\$50 per person	\$0	\$75 per person
Annual Maximum Class A, B and C services (Does not include Class D services)	Unlimited	\$3,000 per person	\$1,500 per person	\$750 per person

Medicare Advantage



2026 Annual Provider Summit



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 Endodontics Extractions Prosthodontics Note: Implants are not covered.	Anesthesia Other oral/maxillofacial surgery Other services (e.g., deep cleanings, fillings, Crowns, root canal, dentures, bridges)		50% COINS (INN and OON)
Annual Maximum (Per member, per year)	BlueCross Total SM : \$2,500 (Comprehensive and preventive combined) Total Value SM : \$1,500 (Comprehensive and preventive combined) Blue Basic SM : \$3,000 (Comprehensive and preventive combined)			

*SC Blue Dental Network

Blue Secure

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	\$425	\$850	\$425	\$850
Maximum Out-of-Pocket total (All children)	\$850	\$1,700	\$850	\$1,700

Dental GRID






2026 Annual Provider Summit



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 Eyemed: 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

Anthem Insurance Companies, Inc.		
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	
Health Care Service Corporation (HCSC)		
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	
Other		
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



2026 Annual Provider Summit



Verifying Eligibility and Benefits

Plan	My Insurance Manager SM	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
Commercial and Medicare Advantage	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.
Dental GRID	Send claims to the mailing address on the member's ID card.
BCBS FEP Dental	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.
State Basic Dental and State Dental Plus	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.

2026 Coding Updates



2026 Annual Provider Summit



New Dental Codes

Code	Description
D0426	Point of care saliva sample collection, preparation, and analysis
D0461	Cracked tooth testing
D1720	Administration of influenza vaccine
D5877	Duplication of maxillary denture
D5878	Duplication of mandibular denture
D5909	Maxillary guidance device using a flange
D5930	Maxillary guidance device without using a flange
D5938	Complete maxillary removable resection prosthesis
D5939	Complete mandibular removable resection prosthesis
D5940	Partial maxillary removable resection prosthesis
D5941	Partial mandibular removable resection prosthesis
D5942	Maxillary implant removable prosthesis for edentulous arch
D5943	Mandibular implant removable prosthesis for edentulous arch
D5944	Maxillary implant removable prosthesis for edentulous arch partial
D5945	Mandibular implant removable prosthesis for edentulous arch partial
D5946	Maxillary implant fixed prosthesis for edentulous arch

Note: Verify eligibility and benefits prior to rendering services.

New Dental Codes

Code	Description
D5947	Mandibular implant fixed prosthesis for edentulous arch
D5948	Maxillary implant fixed prosthesis for edentulous arch partial
D5949	Mandibular implant fixed prosthesis for edentulous arch partial
D6280	Implant maintenance procedures
D6049	Scaling and debridement of a single implant with bleeding, inflammation and increased pocket depth
D6196	Restoration removal on an implant retained abutment
D9128	Photo biomodulation therapy; 15 minutes
D9129	Photobiomodulation therapy; subsequent 15 minutes
D9244	Enteral minimal sedation in office administration
D9245	Enteral moderate sedation administration
D9246	Non-IV parenteral moderate sedation administration 15 minutes
D9247	Non-IV parenteral moderate sedation administration subsequent 15 minutes
D9224	General anesthesia 15 minutes
D9225	General anesthesia subsequent 15 minutes
D9936	Occlusal guard cleaning

Note: Verify eligibility and benefits prior to rendering services.

Deleted Dental Codes

Code	Description
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth
D1705	AstraZeneca Covid-19 vaccine administration - first dose
D1706	AstraZeneca Covid-19 vaccine administration - second dose
D1707	Janssen Covid-19 vaccine administration
D1712	Janssen Covid-19 vaccine administration - booster dose
D9248	Non-intravenous conscious sedation

Pharmacy



2026 Annual Provider Summit

Agenda

- Formulary Updates
 - Commercial (BlueCross and BlueChoice® HealthPlan)
 - Lowest Net Cost (LNC) Formulary
 - Premium Formulary
 - Exchange
 - Medicare
 - Healthy BlueSM

Formulary Updates



2026 Annual Provider Summit



Commercial Plans

Commercial

Lowest Net Cost Formulary Updates



2026 Annual Provider Summit



Lowest Net Cost Formulary Updates

Additions

□ Beginning Jan. 1, 2026, the following drugs will be added.

Therapeutic Class	Product	Formulary Status
ONCOLOGY	ENSACOVE CAP *	NON-PREFERRED BRAND SPECIALTY
ONCOLOGY	GOMEKLI CAP/TAB*	NON-PREFERRED BRAND SPECIALTY
ONCOLOGY	GRAFAPEX INJ *	NON-PREFERRED BRAND SPECIALTY
ANTI-PARKINSONS	ONAPGO INJ **	NON-PREFERRED BRAND SPECIALTY
HEMOPHILIA	QFITLIA INJ #	NON-PREFERRED BRAND SPECIALTY
ONCOLOGY	ROMVIMZA CAP *	NON-PREFERRED BRAND SPECIALTY

**Requires Prior Authorization*

Quantity limit applies

Lowest Net Cost Formulary Updates (Continued)

Exclusions

- Beginning Jan. 1, 2026, 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.

Therapeutic Class	Product	Formulary Status
ANTIBIOTIC	BLUJEP A TAB	NON-FORMULARY
OPHTHALMIC GENE THERAPY	ENCELTO OPTHALMIC	NON-FORMULARY
ANALGESIC	JOURNAVX TAB	NON-FORMULARY
ANTIBIOTIC	ORLYNVAH TAB	NON-FORMULARY
NEPHROPATHY	VANRAFIA TAB	NON-FORMULARY
PRADER-WILLI SYNDROME	VYKAT XR TAB	NON-FORMULARY

Lowest Net Cost Formulary Updates (Continued)

Quantity Limits

- Beginning Jan. 1, 2026, the following drugs will be moved to non-formulary status.

Product	Quantity Limit
ORLYNVAH*	10 TABS/28 DAYS
VANRAFIA*	1 TAB/DAY

**Non-formulary*

Lowest Net Cost Formulary Updates (Continued)

Preferred Glucometer Test Strips Current and After Jan. 1, 2026

Product	Current Formulary Status (as of 09/15/25)	After 01/01/2026
ONETOUCH STRIPS	PREFERRED	NON-PREFERRED with prior authorization
CONTOUR STRIPS	PREFERRED	PREFERRED
ACCU-CHECK STRIPS	PREFERRED	PREFERRED

- ❑ Vouchers for Contour and Accu-Check Glucometers will be available as well as messaging at the pharmacy point of sale for \$0 coverage.

Stelara Biosimilar Update

- ❑ As of July 1, 2025, Stelara (brand) was removed from the Lowest Net Cost Formulary. The biosimilars below replaced Stelara as preferred products. Prior authorization still applies.

Product	Formulary Status
YESINTEK SC INJ	PREFERRED
SELARSDI SC INJ	PREFERRED

Commercial

Premium Formulary Updates



2026 Annual Provider Summit



Premium Formulary Updates

Downtiers/Additions

- Beginning Jan. 1, 2026, the following drugs will change tiering status.

Product	Formulary Status
EMGALITY	EXCLUDED to Tier 2
SUPPRELIN LA KIT	Tier 2 to Tier 3
OMECLAMOX-MIS Pak	Tier 2 to Tier 3
DEPEN Titratab	Tier 2 to Tier 3

Exclusions

- Beginning Jan. 1, 2026, 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
AJOY	Non-formulary	DAYVIGO	Non-formulary
APTOM	Non-formulary	DYMISTA	Non-formulary
BRILINTA	Non-formulary	ESTRO GEL	Non-formulary
COPAXONE	Non-formulary	NAMZARIC	Non-formulary

Premium Formulary Updates (Continued)

New Generic Availability

□ Beginning Jan. 1, 2026, the following drugs will have a generic alternative available at Tier 1.

Therapeutic Class	Brand Drug	Formulary status	Alternative
ANTICONVULSANT AGENT	APTION TAB	EXCLUDED	ESLICARBAZEPINE TAB
CARDIOVASCULAR AGENT	ENTRESTO	EXCLUDED	SACUBITRIL-VALSARTAN TAB
HEMATOLOGICAL AGENT	BRILINTA	EXCLUDED	TICAGRELOR TAB
HORMONAL AGENT	ESTROGEL GEL 0.06%	EXCLUDED	ESTRASIOL GEL PUMP 0.06%
MULTIPLE SCLEROSIS AGENT	COPAXONE 40mg SC INJ	EXCLUDED	GLATIRAMER SC INJ
NASAL AGENT	DYMISTA NASAL SPRAY	EXCLUDED	AZELASTINE-FLUTICASONE

ADHD Shortage Resolution

□ Beginning Jan. 1, 2026, Adderall XR will have a generic alternative available at Tier 1.

Brand	Formulary Status	Alternative
ADDERALL XR	EXCLUDED	AMPHETAMINE-DEXTROAMPHETAMINE ER CAP

Premium Formulary Updates (Continued)

Updates to Vigilant Drug List

□ Beginning Jan. 1, 2026, except for Stelara, which started July 1, 2025.

Clinical Duplicate Drugs	High-Cost Brands with Generics				High-Cost Generics	NEDL Non-FDA/Creams and Patches
Adderall XR	Activella	Cortef	Lipofen	Sinemet	But/APAP/CAF Codeine	Sodium Sulf Sus
Ajovy	Acular	Cosopt	Lomotil	Tamiflu	Candesartan tab	Diclofenac Gel
Auryxia	Adderall XR	Cosopt PF	Macrobid	Tenoretic	Bromfenac Drop 0.075%	
Dayvigo	Adipex-P	Daraprim	Maxitrol	Tiazac	Loteprednol Sus 0.2%	
Ferric Citra	Aldactone	Detrol LA	Mozobil	Venxxiva	Octreotide Kit	
Hercessi	Alrex	Dymista	Nardil	Vigamox	Clindamycin Gel 1%	
Herzuma	Analpram-HC	Edecrin	Neruontin	Zenzedi		
Inzirqo	Azopt	Emend Bipack	Ocuflox	Zyprexa Zydis		
Nypozi	Azulfidine	Emend Tripack	Pred Forte			
Ogivri	Bromsite	Estrace	Reglan			
Omeclamox	Carbaglu	Fasodex	Remeron			
Ontruzant	Carnitor	Hydrea	Teyataz			
Stelara	Cipro	Invega	Salafen			
Vyepti	Copaxone	Kaletra	Sandostatin			

Premium Formulary Updates (Continued)

Biosimilar Strategy Update

- As the **biosimilar market** continues to expand, we support strategies that align with our patient-first guiding principles of clinical quality, accessibility, and affordability.

Therapeutic Class	Originator	Current Tier	New Strategy
Osteoporosis	Prolia	Tier 2 PA/QL	Tier 2 PA/QL Stoboclo Tier 2 PA/QL Jubbonti TBD Conexence TBD
Cancer	Xgeva	Tier 2 PA	Tier 2 PA Osenvelt Tier 2 PA Wyost TBD Bomynta TBD
Autoimmune	Stelara	Non-Formulary	Tier 2 PA Wezlana Yesintek

Premium Formulary Updates (Continued)

Diabetes Test Strip Coverage Update

- ❑ Beginning Jan. 1, 2026, due to availability and accessibility concerns with OneTouch manufacturer LifeScan, BlueCross will be moving to Contour and Accu-check.
- ❑ New preferred brand **Contour** by Ascensia and **Accu-Check** by Roche will be preferred on Sep. 15, 2025.
- ❑ **OneTouch** by LifeScan will be moved to excluded on Jan. 1, 2026.

Product	Current Formulary Status 9/15/2025	Formulary Status After 1/1/2026
Onetouch Strips	Preferred	Excluded
Countour	Preferred	Preferred
Accu-check	Preferred	Preferred

Note: Vouchers for Contour and Accu-Check Glucometers will be available as well as messaging at Pharmacy Point of Sale.

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 ≥ 60 years old and in pregnancy at 32-36 weeks
- ** Approved for those ≥ 50 years old
- ^ Approved for neonates and up to 24 months old
- + Approved for those ≥ 50 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.

Pharmacy Resources

Pharmacy Benefit

- ❑ Medications at retail, specialty and mail order pharmacies.
- ❑ Drug is self-administered.
- ❑ Use the Comprehensive Drug Lookup Tool:
<https://www.southcarolinablues.com/web/public/brands/sc/members/prescription-drugs/other-group-plans/pharmacy-benefits/>

Medical Benefit

- ❑ Drug is provider-administered in the office, infusion center, etc.
- ❑ Use the Medical Specialty Drug List:
 - *Specialty Medical Drug List, effective July 1, 2025*

Prior Authorization Information - Optum

- ❑ Phone: 855-811-2218
- ❑ Online Portal: CoverMyMeds
- ❑ Review time: Standard, 72 hours; Appeals, 14 days

Exchange Plans

General Pharmacy Updates for Exchange Plans

GLP-1 Provider Taxonomy Edit

Goal: Align use of GLP-1 medications with clinical expertise.

- ❑ As of Oct. 1, 2025, prescriptions for GLP-1 agents used to treat type 2 diabetes must be issued by an authorized provider whose scope of practice includes the diagnosis, monitoring, and management of diabetes.
- ❑ The edit reviews all diabetes GLP-1 medications at the point of sale or pharmacy counter.
- ❑ A reject occurs for diabetes GLP-1 medication claims if the provider does not have an eligible practice taxonomy code.
- ❑ The edit applies to all GLP-1 medications indicated for diabetes including:
 - dulaglutide (Trulicity)
 - exenatide (Byetta)
 - liraglutide (Victoza)
 - semaglutide (Ozempic, Rybelsus)
 - tirzepatide (Mounjaro)

Exchange Formulary Updates

	2026 Core (Broad) Formulary	2026 Select (Narrow) Formulary Narrow Network/HMO Plans
Tier Design	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Drug Tier 4: Specialty	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Drug Tier 4: Specialty
Formulary Design	Broad Coverage	Narrow Coverage
Amount of Formulary Drugs	4500+	2500+
HCR \$0 Copay List (Health Care Reform)	Yes	Yes

Exchange Formulary Updates (Continued)

Core Formulary (Broad)

- ❑ Reduced the amount of covered drug products
- ❑ Stratified generic tiering
 - Current formulary has most generic products on Tier 1
 - Placing higher cost generics on higher tiers
- ❑ HCR \$0 copay list still in place

Select Formulary (Narrow)

- ❑ Minimal removals
- ❑ Addition of general maintenance products to reduce member disruption
- ❑ Addition of quantity limit edits
- ❑ HCR \$0 copay list still in place

Note: Confirm formulary drug coverage status using the drug look-up tool on www.SouthCarolinaBlues.com.

Exchange Formulary Updates (Continued)

Diabetes Test Strip Coverage Update

- ❑ Due to availability and accessibility concerns with OneTouch manufacturer LifeScan BCBSSC will be moving Contour and Accu-check to formulary.
- ❑ **Contour** by Ascensia and **Accu-Check** by Roche will be preferred beginning 9/15/2025.
- ❑ **OneTouch** by LifeScan will be moved to excluded on 1/1/2026.

Product	Current Formulary Status (as of 9/15/2025)	After 1/1/2026
ONETOUCH STRIPS	PREFERRED	EXCLUDED
CONTOUR STRIPS	PREFERRED	PREFERRED
ACCU-CHECK STRIPS	PREFERRED	PREFERRED

- ❑ Vouchers for Contour and Accu-Check Glucometers will be available at the pharmacy for \$0.
- ❑ Members, providers and pharmacies are being notified of preferred product changes.

Exchange Formulary Updates (Continued)

Biosimilar Reminder

- Humira (brand) and Stelara (brand) products have been removed from Exchange formularies. The biosimilars below replaced Humira and Stelara as preferred products. Prior Authorization will still apply.

Formulary	Reference Product	Preferred Biosimilars
Core (Broad)	Stelara	Yesintek, Wezlana
	Humira	Amjevita, Hadlima
Select (Narrow)	Stelara	Yesintek, Selarsdi
	Humira	Amjevita, Hadlima

Exchange Formulary Updates (Continued)

Narrow Networks (Blue Cooper, Reedy, Pee Dee, Congaree and Beaufort)

- ❑ Narrow network plans are transitioning from the Core formulary to the Select formulary.
- ❑ Key areas of member impact:
 - Specialty anti-inflammatory products
 - GLP-1 products
 - Migraine products
 - Brand products with available generic alternatives

Note: Confirm formulary drug coverage status using the drug look-up tool on www.SouthCarolinaBlues.com.

Exchange Pharmacy Resources

Pharmacy Benefit

- ❑ Medications at retail, specialty and mail order pharmacies.
- ❑ Drug is self-administered.
- ❑ Use the Comprehensive Drug Lookup Tool:
<https://www.southcarolinablues.com/web/public/brands/sc/members/prescription-drugs/other-group-plans/pharmacy-benefits/>

Medical Benefit

- ❑ Drug is provider-administered in the office, infusion center, etc.
- ❑ Use the Medical Specialty Drug List:
 - *Specialty Medical Drug List, effective July 1, 2025*

Prior Authorization Information - Optum

- ❑ Phone: 855-811-2218
- ❑ Online Portal: CoverMyMeds
- ❑ Review time: Urgent, 24 hours; Standard, 72 hours.

Medicare

2026 IRA Changes



2026 Annual Provider Summit



Maximum Fair Price

2026 IRA Changes - Maximum Fair Price

- ❑ In August 2022, the Inflation Reduction Act (IRA) was signed into law.
- ❑ The law established the Medication Negotiation Program to negotiate maximum fair prices (MFPs) for certain high expenditure, single source and biological products.
- ❑ MFPs will be effective Jan. 1, 2026.
- ❑ The drug company with a selected drug is required to ensure the negotiated price is made available to eligible individuals and to the pharmacies, mail-order services, and other entities that dispense the selected drug to such individuals.
- ❑ All selected drugs must be included on Medicare formularies.

2026 IRA Changes - Maximum Fair Price (Continued)

2026 Selected Drugs

Drug Name	Commonly Treated Condition
Eliquis	Prevention & treatment of blood clots
Enbrel	Rheumatoid arthritis; Psoriasis; Psoriatic arthritis
Entresto	Heart failure
Farxiga	Diabetes; Heart failure; Chronic kidney disease
Fiasp, Novolog	Diabetes
Imbruvica	Blood cancers
Januvia	Diabetes
Jardiance	Diabetes; Heart failure
Stelara	Psoriasis; Psoriatic arthritis; Crohn's disease; Ulcerative colitis
Xarelto	Prevention & treatment of blood clots; Reduction of risk for patients with coronary or periphery artery disease



Looking ahead to 2027:

Austedo, Austedo XR
Breo Ellipta
Calquence
Ibrance
Janumet, Janumet XR
Linzess
Ofev
Otezla
Ozempic, Rybelsus, Wegovy
Pomalyst
Tradjenta
Trelegy Ellipta
Vraylar
Xifaxan
Xtandi

Medicare Prescription Payment Plan



2026 Annual Provider Summit



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 - 2026 Opt-in Requirements

- ❑ Effective in 2026, Part D plans will be required to automatically renew members who opted-in to the Medicare Prescription Payment Plan in 2025.
- ❑ If members change plans, they will need to opt-in to the payment option with their new plan.
- ❑ Members can sign up for this payment option anytime throughout the year.
 - Note: Opting-in prior to or at the beginning of the plan year will give the member more months to spread out their costs.

M3P - Likely to Benefit

Members are likely to benefit from M3P if:

- ❑ \geq **\$2,100** 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.

2026 Medicare Advantage Plan and Formulary Changes



2026 Annual Provider Summit



2026 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 2026 changes may receive additional communication via:
 - Letters
 - Call campaigns
 - Text messages
- ❑ **New Preferred Diabetic Testing Products**
 - ✓ **Accu-Chek** and **Contour** diabetic testing supplies are preferred
 - ✓ **New meters available to members at \$0**
 - × OneTouch diabetic testing supplies will become Non-formulary effective Jan. 1, 2026

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

Healthy Blue



Healthy Blue Formulary Updates

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

	Previous Status	New Status
Immunomodulators, Topical Atopic Dermatitis		
pimecrolimus cream (generic for Elidel®)	PDL Non-Preferred	PDL Preferred
tacrolimus ointment (generic for Protopic®)	PDL Non-Preferred	PDL Preferred
Steroids, Medium Potency		
fluocinolone cream / ointment / solution (generic for Synalar®)	PDL Non-Preferred	PDL Preferred
fluticasone cream / ointment (generic for Cutivate®) NOTE: Lotion will remain Non-Preferred	PDL Non-Preferred	PDL Preferred
Corticosteroids, Inhaler Devices		
Pulmicort® Flexhaler	PDL Non-Preferred	PDL Preferred
Anti-Migraine, CGRP Modulators, Preventive		
Ajovy® Injection	PDL Non-Preferred	PDL Preferred
Qulipta® Tablet	PDL Non-Preferred	PDL Preferred
ACE Inhibitors and Combinations		
ramipril (generic for Altace) capsule	PDL Non-Preferred	PDL Preferred
Beta Adrenergic Devices, Short Acting Inhalers		
albuterol HFA inhaler (generic for Proair® HFA)	PDL Non-Preferred	PDL Preferred
albuterol HFA inhaler (generic for Ventolin® HFA)	PDL Non-Preferred	PDL Preferred

Brand Over Generic

- ❑ Medicaid does not routinely cover brand-name products for which there are therapeutically equivalent generic products available.
- ❑ However, SCDHHS does mandate coverage of certain BRAND name products. See below and the list can be found here: <https://southcarolina.fhsc.com/>

Brand Name Preferred over Generic List Updated 10/1/2025						
Advair Diskus®	Carbatrol®	Epipen®*	Natroba®	Sabril® Powder Pack	Ventolin® HFA	
Advair HFA®	Celontin®	Epipen Jr®*	Oxycontin®	Spiriva® Handihaler®	Victoza®	
Alphagan P® 0.1%, 0.15%	Combigan®	Exelon® Patch	Pentasa®	Suboxone® Film	Vyvanse® Capsule	
Anoro® Ellipta®	Copaxone® 20mg/ml dose	Farxiga®	Pradaxa®	Symbicort®	Vyvanse® Chewable	
Aprise®	Daytrana®	Fycompa®	Proglycem®	Tegretol® XR	Xarelto® Tablet	
Arnuity® Ellipta®	Dexilant®	Lantus® Solostar®	Protonix® Suspension	Tektuma®	Xarelto® Suspension	
Azopt®	Dificid® Tablet	Lantus® Vial	Relpax®	Testim® Gel 1% Packet	Xigduo® XR	
Banzel® Tab	Durezol®	Lumigan®	Restasis®	Travatan-Z®		
Brilinta®	Elidel®	Myrbetriq® Tablet	Retin-A® Cream	Tresiba®		
Butrans®	Entresto® Tablet	Narcan® Nasal	Retin-A® Gel	Trileptal® Suspension		

- * = Brand and AUTHORIZED GENERIC (only) are BOTH Preferred
- Products listed in **RED** are new to the list since the last posted update

This list is current as of 10/01/2025, is subject to change at any time, should not be considered all-inclusive, and cannot be used for claims payment. **FOR INFORMATIONAL PURPOSES ONLY.**

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 ManagerSM
- ❑ 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



2026 Annual Provider Summit

Topics to Discuss

- ❑ Provider Enrollment Requirements
- ❑ Overview of the Enrollment Process
- ❑ Important Reminders
- ❑ My Provider Enrollment Portal
- ❑ Available Resources

Provider Enrollment Requirements



2026 Annual Provider Summit



Provider Enrollment Application Types

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**	In-state, out-of-network 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	Enrolled groups that have new locations 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**	Out-of-state and out-of-network 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
- Behavioral Health
- 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

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

Note: Visit 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*****
Board Certification*****

*Must include past five years (active and inactive).

**Only if applicable.

***Required for MDs, DOs and DPMs.

****Only if applying for BlueChoice HealthPlan.

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

*****If board certified.

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 Maintenance section of the portal.

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

Overview of the Enrollment Process



2026 Annual Provider Summit



Understanding the General Process of an Application



- ❑ After you complete and submit your application in My Provider Enrollment Portal, the application will be in the submitted status pending review.
- ❑ During the preliminary review, the application is assigned to an enrollment analyst for a high-level review to determine whether the application is clean (all the required information and items are included).*
- ❑ If the application is deemed clean, the analyst will send the application and agreements to the appropriate parties for electronic signatures.
- ❑ Once all appropriate parties have signed their applicable sections of the documents, the application will move to the next stage of the process.
- ❑ During the secondary review, the credentialing team takes a deeper look at the application, to include background checks for the practitioners, and sends the application to committee.*
- ❑ If everything is clear and approved by the committee, the application progresses to contracting.*
- ❑ During the final review, the enrollment team loads the provider into the system and sends a welcome notification to the credentialing contact that includes the network and affiliation dates.

**During these stages, any missing items or corrections needed will cause the application to be sent back to the provider.*

To prevent delays, be sure to review the checklists, include appropriate emails for signatures and answer disclosure questions correctly.

7-7-7 Rule for Missing Items

- ❑ Once an application is reviewed and an analyst determines something is needed, they will add a case comment explaining the issue.
- ❑ When you receive a notice for missing items or corrections that are needed to an application, we encourage you to return the requested information or make the necessary corrections as soon as possible.
- ❑ An automated notification is sent every seven days (**up to 21 days**).
 - Day seven: You will receive the first notification.
 - Day 14: You will receive the second notification.
 - Day 21: You will receive the final notification.
- ❑ If the requested items or corrections are not received by day 21, the application will be up for cancellation.

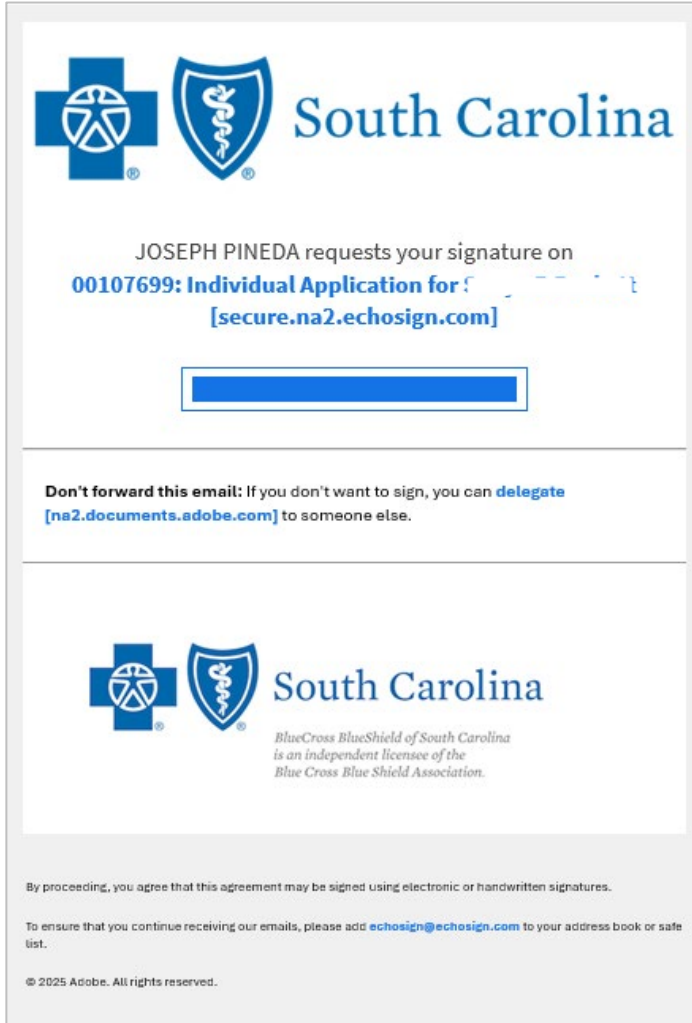
Note: The automated notifications will stop once the case is reviewed by the assigned analyst.

E-signing Process

- ❑ As of June 9, 2025, applications, contracts and other enrollment related documents can be signed electronically.
- ❑ For each application type—whether for initial enrollment or maintenance—you will be prompted to provide specific email addresses for various roles, such as:
 - Practitioner
 - Credentialing contact
 - Fiduciary contact
- ❑ When documents are ready for signature:
 - An email will be sent to the first required signer (for example, the practitioner for an individual application).
 - Once they sign, the next designated contact (such as the credentialing contact) will receive their e-sign email.
 - When all applicable parties have signed their portion of the documents, they will receive confirmation via email.

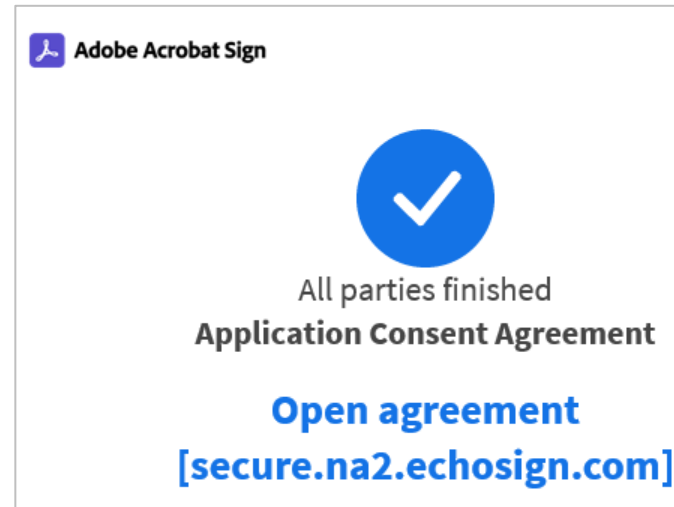
Note: When applicable, you must enter the practitioner's email address. It cannot be the email address for the practice.

Example of E-sign Emails



All appropriate parties will receive the appropriate document to sign.

All appropriate parties will receive confirmation once completed.



Note: Do not delete or ignore these emails—they are not spam or phishing attempts. Also, please do not respond to these emails.

Network and Affiliation Dates

- ❑ Network effective dates are based on the credentialing committee's approval date.
 - Network effective dates **cannot** be backdated.
- ❑ Affiliation dates are based on the practitioner's start date with the practice they are joining.
 - Affiliation dates can be backdated to the earliest start date for the practitioner, but no more than Jan. 1st of the previous year.
 - **This does not apply to the Healthy Blue network.**
 - This ensures we comply with South Carolina Department of Health and Human Services (SCDHHS) and National Committee for Quality Assurance (NCQA) standards and guidelines.

Important Reminders

Medicaid ID Requirements

- ❑ The Medicaid ID is needed for any practitioner or group that wishes to participate in the Healthy Blue network.
 - We encourage you to wait until you have the Medicaid ID number before beginning an application for the practitioner or group.
- ❑ The Medicaid ID must be registered with SCDHHS and **must be assigned to the practitioner or group NPI**, not the TIN.
- ❑ During the review process of an application, if the practitioner or group's Medicaid ID number is not validated or active with SCDHHS, they will not be considered for participation in the Healthy Blue network.

Important Information for the Healthy Blue Network

- ❑ When it comes to the credentialing process for the Healthy Blue network, providers have the right to:
 - Review information obtained from outside sources (i.e., state licensing boards) used to evaluate their credentialing application.
 - This does not include references, recommendations, or other peer-review protected information.
 - Correct any erroneous information submitted by outside sources.
 - If the credentialing staff identifies a discrepancy, they will notify the provider in writing (case comment).
 - Question the status of their credentialing application and receive a response by phone or email within seven calendar days to include:
 - The date their completed application was received.
 - Any outstanding items needed for completion.
 - The expected date of the credentialing decision.
- ❑ To exercise the above rights:
 - Submit a support case or a case comment if the application is still open and being worked.
 - Submit a faxed inquiry to 803-870-9997 if the application has been canceled.
 - Faxed inquiries can be submitted using a free formed letter.

Provider Medical Licenses and Work History

- ❑ For both the provider's medical licenses and work history, we need five years (60 consecutive months) of data.
- ❑ For medical licenses, you would include any applicable active and inactive licenses.
- ❑ For the work history, if there is a gap of six months or more, a detailed explanation is required for review.
 - When adding the work history in My Provider Enrollment Portal, we encourage you to list them in chronological order, starting with the current job.

Expiring Documents

- ❑ All documents being uploaded with the application must be current and should not expire within 30 days. This includes:
 - Medical licenses
 - Malpractice (COI)
 - Be sure the copy uploaded covers the requested start date for the practitioner.
 - DEA license
 - CLIA certificates
- ❑ If the document is going to expire within 30 days of submission, be sure to include a copy of the current document and the new or updated document.

Taxonomy and Languages

- ❑ The taxonomy selected during the application process must coincide with the practitioner's medical license.
 - For example, a nurse practitioner may specialize in family medicine; however, they should not select family medicine as their taxonomy. Instead, they should select nurse practitioner based on their license.
- ❑ When completing the enrollment application, be sure to select all the applicable languages the practitioner speaks.
 - This information is included in our directories and allows patients to select provider's that meet their language needs.

Misrouted Inquiries

- ❑ There are times when the provider enrollment team receives inappropriate requests related to:
 - Prior authorizations
 - Claims
 - Benefits
- ❑ For these types of inquiries, be sure to contact the appropriate Provider Services area based on the member's plan or use My Insurance ManagerSM.

Recredentialing Process

- ❑ **Recredentialing for network participating practitioners occurs every three years.**
 - If you need to know the upcoming recredentialing dates for a provider, email Recred.App@bcbssc.com.
 - Include the provider's name and NPI.
- ❑ **The credentialing team reaches out when the provider's recredentialing dates is approaching.**
 - The team reaches out to the practice on file that the provider is affiliated with to see if they are actively working at the location. It is important that we have the most accurate and up-to-date contact information on file.
 - 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 a provider is past due for their recredentialing or if the recredentialing is due within 60 days, a new enrollment application must be submitted.**

Note: Outreach begins two to three months in advance.

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

**Can join the Healthy Blue network.*

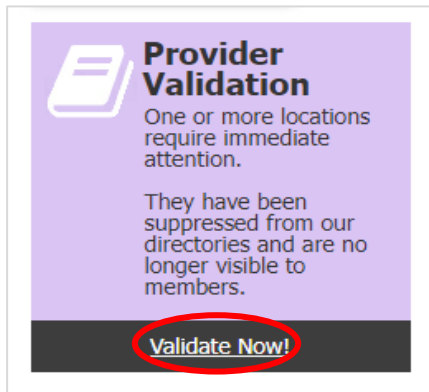
Note: This list may not be all inclusive.

Provider Directory Validation

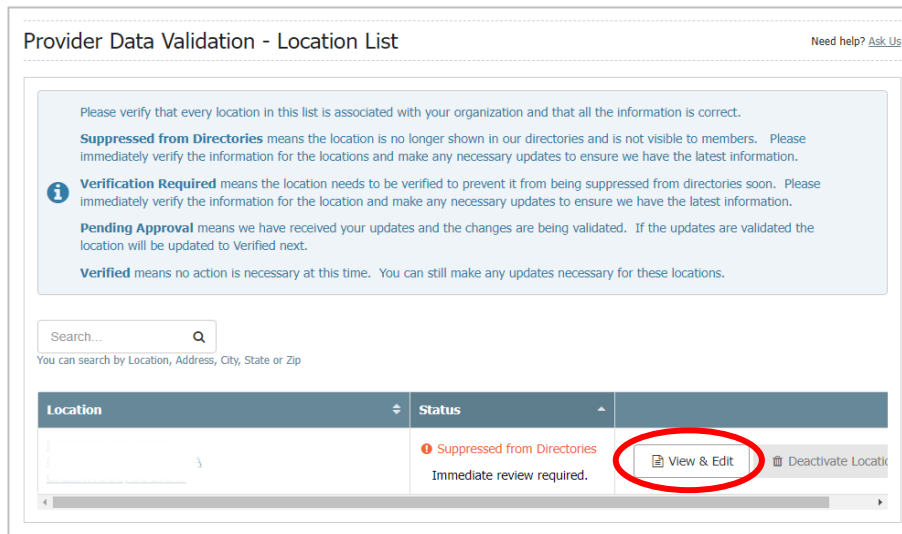
- ❑ Providers have been required to verify their demographic data at least **every 90 days** since Jan. 1, 2022.
 - This implementation was part of the No Surprises Act.
- ❑ Validation allows us to maintain accurate directories.
- ❑ Verification can be completed in M.D. Checkup (accessible through My Insurance Manager).
 - You can also respond to the email received from Provider.Directory@bcbssc.com.
- ❑ For outreach purposes, it is important to have the correct contact information on file.
 - If contact information needs to be updated for your practice, you can submit a support case in My Provider Enrollment Portal.
 - If contacts are different based on the location, be sure to include the specific details.

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.

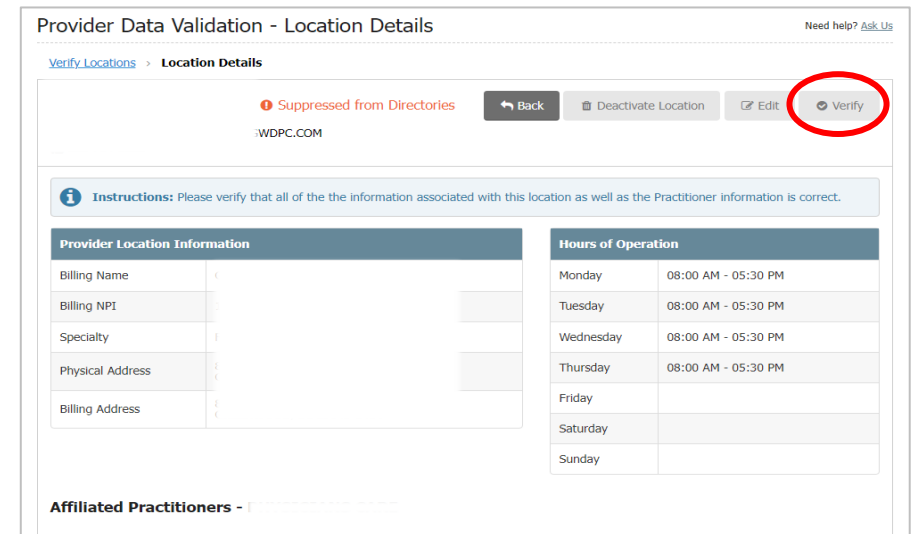
Pending Approval means we have received your updates and the changes are being validated. If the updates are validated the location will be updated to Verified next.

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	Actions
	Suppressed from Directories Immediate review required.	View & Edit Deactivate Location



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

- ❑ There are times in which you must make demographic updates to your practice or practitioner.
- ❑ Some updates can be made in My Provider Enrollment Portal, and some can be made using M.D. Checkup.

My Provider Enrollment Portal

- ❑ Submit a Name Change
- ❑ Change of Address
- ❑ Add a Satellite Location
- ❑ Request to Add a Practitioner
- ❑ Remove a Practitioner

M.D. Checkup

- ❑ Terminate (close) Location
- ❑ Change of Address
- ❑ Hours of Operations
- ❑ Add a Practitioner Affiliation
- ❑ Terminate Practitioner Affiliation

*Note: You can only add a practitioner in M.D. Checkup if they are **enrolled and associated** with the TIN.*

Terminating (Closing) Locations Using M.D. Checkup

- ❑ To close a location for your practice using M.D. Checkup:
 - Log into My Insurance Manager.
 - Select Provider Update.
 - Select Remove Location next to the location you wish to close.
 - Enter the effective date of change.
 - Select Remove.

My INSURANCE MANAGER

Home Patient Care Office Management Resources My Profile Profile Administration Staff Directory Provider Update

Provider Data Validation - Locations List

Need help? Ask Provider Services

Instructions: Please verify that every location in this list is associated with your practice and that all of the information is correct.

Search locations...

You can search by Location, Address, City, State or Zip

Location	Status	
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

Request to Remove Location

by, State or Zip

Are you sure you wish to remove Palmetto Northeast? Please enter the date on which you want this location to be removed.

Note: The removal date must be after the original effective date.

Requires Verification

mm/dd/yyyy

View & Edit

Requires Verification

View & Edit

Cancel Remove

Note: This function closes the location in our claims system.

Adding Practitioner Affiliations Using 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 **Request to Add Practitioner** application 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

My Provider Enrollment Portal

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.

M.D. Checkup

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.

My Provider Enrollment Portal



2026 Annual Provider Summit



Overview of Portal

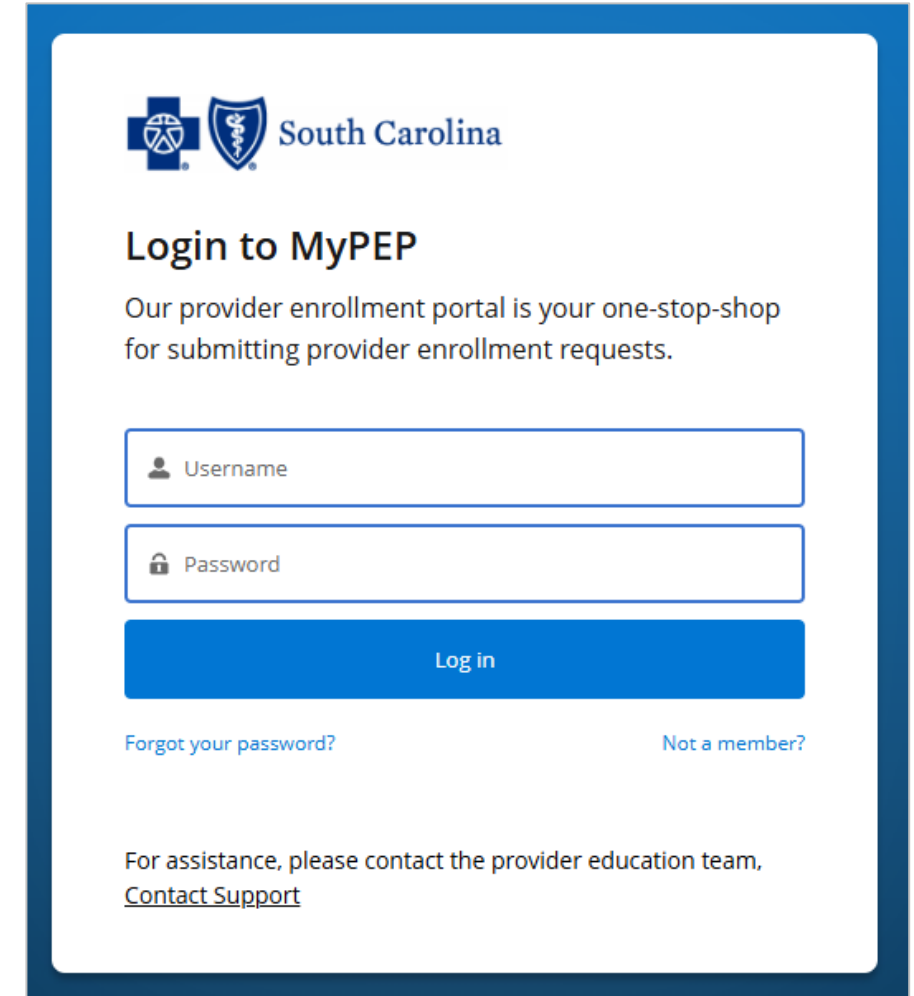


2026 Annual Provider Summit



Getting Started with My Provider Enrollment Portal


- ❑ Visit www.SouthCarolinaBlues.com.
 - Providers>Provider Enrollment>**Join Our Networks**
- ❑ Username format: **email.firstname.lastname**
- ❑ New users should select Not a member from the landing page of the portal.



The screenshot shows the login interface for the MyPEP portal. At the top left, there are two logos: a blue cross with a white circle inside, and a blue shield with a white caduceus. To the right of these logos is the text "South Carolina". Below the logos, the heading "Login to MyPEP" is displayed. Underneath the heading is a paragraph: "Our provider enrollment portal is your one-stop-shop for submitting provider enrollment requests." There are two input fields: the first is labeled "Username" with a person icon, and the second is labeled "Password" with a lock icon. Below these fields is a blue "Log in" button. At the bottom of the form area, there are two links: "Forgot your password?" on the left and "Not a member?" on the right. At the very bottom of the page, there is a line of text: "For assistance, please contact the provider education team, [Contact Support](#)".

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 - Started Applications

Applications
 **My Started Applications** ▾

13 items • Sorted by Application Type • Filtered by My applications - Application Status



Application Type ↑	Application Status	NPI Type I	NPI Type II	Resume Application	Created Date	
1	In Progress				3/31/2025, 7:28 AM	▾
2	In Progress				4/2/2025, 10:13 AM	▾
3	In Progress				4/29/2025, 8:45 AM	▾
4 Individual	In Progress				3/26/2025, 7:56 AM	▾
5 Individual	In Progress			Resume	4/2/2025, 10:30 AM	▾
6 Individual	In Progress			Resume	4/29/2025, 8:35 AM	▾
7 Individual	In Progress			Resume	5/9/2025, 9:19 AM	▾
8 Individual	In Progress	1555555555		Resume	6/23/2025, 7:42 AM	▾
9 Individual	In Progress	1777777777		Resume	7/1/2025, 7:06 AM	▾
10 Satellite Location	In Progress		1444444444	Resume	6/19/2025, 5:23 AM	▾

My Provider Enrollment Portal - In-Progress Applications

My In-Progress Applications ▾

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



	Case Number ↑ ▾	Type ▾	Provider ▾	Status ▾	Date/Time Opened ▾	
1	00031578	Group	Aesthetic Smiles of Myrtle Beach	Signed	3/31/2025, 7:37 AM	▾
2	00031581	Individual	Terrence Archie - MAGNOLIA ENDOCRINOLOGY LLC	Submitted	3/31/2025, 8:02 AM	▾
3	00031583	Virtual Care	MAGNOLIA ENDOCRINOLOGY LLC	Signed	3/31/2025, 8:29 AM	▾
4	00031584	Change of Address		Signed	3/31/2025, 8:36 AM	▾
5	00031585	Request to Add Practitioner	DAVID YOUNIE - FLOSSY PEDIATRIC DENTISTRY	Submitted	3/31/2025, 8:52 AM	▾
6	00031590	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	3/31/2025, 10:40 AM	▾
7	00031612	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	4/1/2025, 8:05 AM	▾
8	00031614	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	4/1/2025, 8:12 AM	▾
9	00031664	Request to Term Practitioner	TIMOTHY KAYLOR - ZONE PHYSICAL THERAPY	Submitted	4/2/2025, 5:18 AM	▾
10	00031668	Business Name Change	Provider Relations LLC	Submitted	4/2/2025, 5:53 AM	▾

My Provider Enrollment Portal - Applications Needing Action

My Applications Requiring Action ▾

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

Case Number ↑	Type	Provider	Status	Date/Time Opened
1	00031578	Group	Aest	
2	00031583	Virtual Care	MAC	

Case #00031578 - Group Application

Provider: Aesthetic Smiles of Myrtle Beach

Application Type: Group

Status: Signed

Case Reference Number: Case #00031578

Case Contact: Kristen Ward - Provider Relations LLC

Requested Networks

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
South Carolina - Missing	Missing	Re-open application, correct & re-submit.

Case Comments (2)

User	Public	Created Da...	Comment
User173...	<input checked="" type="checkbox"/>	3/31/2025, ...	Action Item - Name: South Carolina - Missing, Status: Open, Issue: Missing
User173...	<input checked="" type="checkbox"/>	3/31/2025, ...	Please add at least one provider to this location by using the Add Practitioner function when you relaunch the application.

Thank you

[View All](#)

Open Agreements

My Provider Enrollment Portal - Closed Applications

My Closed Applications ▾

1 item • Sorted by Case Number • Filtered by All cases - Closed, Case Record Type • Updated a few seconds ago



	Case Number ↑	Subject ▾	Status ▾	Provider ▾	
1	00032461	R. DASILVA - Request to Term Practitioner	Approved	ROBERT DASILVA - MIDLANDS ORTHOPAEDICS & NEUROSURGERY PA	▾

My Provider Enrollment Portal - Enroll Page

South Carolina

Search...

Home Applications ▾ Enroll Maintenance Support

Bravo ▾

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? 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 Application

COMING SOON

To request a Facility Application, please submit a support case.

My Provider Enrollment Portal - Maintenance Page

The screenshot shows the top navigation bar of the My Provider Enrollment Portal. On the left is the South Carolina logo. In the center is a search bar. On the right is a user profile icon labeled 'Bravo' with a dropdown arrow. Below the navigation bar is a main menu with links for Home, Applications, Enroll, Maintenance (which is highlighted), and Support. Below the menu is a banner image showing hands writing on a document. Overlaid on the banner is a white box with the 'My Provider Enrollment Portal' logo and the tagline 'Your enrollment essentials, all in one place.'

Maintenance

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

Maintain a Practice

Find all you need to maintain a group / healthcare entity's networks, locations, and business information.

A grid of six maintenance options for a practice, each with an icon and a brief description:

- Add a network**: Request to add a new network to your existing enrollment with BCBS-SC. Expand your services by joining additional networks within the BCBS-SC system.
- Add a satellite location**: Add a new satellite location to your profile to expand your services.
- Change of address**: Update your location, billing, mailing/correspondence address. You will receive all correspondence at this address.
- Request to add practitioner to practice/location**: Request to add a practitioner's association with your clinic, group, professional association, or institution.
- Request new network for practitioner**: For an enrolled practitioner, request to add a new network.
- Remove a practitioner from practice**: Remove a practitioner's association with your clinic, group, professional association or institution.

Maintain a Group's Practitioner

For enrolled practitioners and enrolled groups, update requests are easy. With the group's Tax Id Number (TIN) and the practitioner's NPI (type I individual) you will be able to add a practitioner to the group and the practice and/or location, add a network, and also remove a practitioner from the practice and/or location.

A grid of three maintenance options for a group's practitioner, each with an icon and a brief description:

- Request to add practitioner to practice/location**: Request to add a practitioner's association with your clinic, group, professional association, or institution.
- Request new network for practitioner**: For an enrolled practitioner, request to add a new network.
- Remove a practitioner from practice**: Remove a practitioner's association with your clinic, group, professional association or institution.

[Back Home](#)

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

Completing Clean Applications

Steps to Submitting a Clean Application

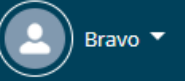
1. Complete the enrollment application inside the portal.
2. Sign the application and agreements ***electronically***.
 - The documents that must be signed will be sent to the appropriate parties included on the application.
 - **It is important to include the correct email addresses for each individual (i.e., provider, fiduciary contact, etc.)**
 - 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.



Search...



Home Applications ▾ Enroll Maintenance Support

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

Let's Get Started

View our application checklist below to enroll a Practitioner with their Individual Practice. When you are ready, click *Next* to begin.

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.

Next

Example of an Individual Enrollment Application (Continued)


Steps

- 1 Let's Get Started
- 2 **Group / Provider Look-Up**
Network pre-qualifications
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Group / Provider Look-Up

We need provider identifiers to search and identify if the practitioner and/or practice is already enrolled with BCBS-SC. For practitioners, we take the NPI number (type I individual); for practices, we take the Tax Id Number (TIN) and the NPI number (type II organization).

 You Need to enter either Taxid or NPI Type II to proceed

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.

IMPORTANT NOTE - CRITICAL DATA ELEMENTS: Ensure that you enter the correct Tax ID and NPI. These fields **CANNOT** be updated/corrected once submitted, if entered incorrectly this case will be cancelled and you will be required to start a new Individual Application.

Tax Id Number (TIN)

NPI Number (type II group)

This practitioner is a solo practitioner filing claims with only one NPI.

Practitioner information

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

* NPI Number (type I individual)



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
- 2 **Group / Provider Look-Up**
[Search results](#)
Network pre-qualifications
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit


This script has been automatically saved, in order to resume in the future: Copy the link or Email me the link

Search results

Practice found

Based on the TIN you entered, please select the corresponding Legal Business below and click 'Next' to continue.

March Madness Family Health, LLC
Tax ID: 579999999

 Select before proceeding

View when practice is found.

This script has been automatically saved, in order to resume in the future: Copy the link or Email me the link


Search results

Practice not found

We did not find a practice based on the Tax Id Number (TIN) and/or NPI (type II organization) you entered. Click 'Next' to continue with your Individual Application.

Please Note: Upon completion of this Individual Application, you must also complete a separate Group Application via the portal to complete the overall individual enrollment process.

If you need assistance with this process, please reach out to MyPep.Portal@BCBSSC.COM.


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](#)

View when practice is not found.

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
Search results
[Network pre-qualifications](#)
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Network pre-qualifications

Care Taxonomy

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.

Speciality Code

- 207Q00000X - Family Medicine Physician
- 106H00000X - Marriage & Family Therapist
- 364SP0810X - Child & Family Psychiatric/Mental Health Clinical Nurse Specialist
- 364SF0001X - Family Health Clinical Nurse Specialist
- 207VC0300X - Complex Family Planning Physician
- 207QA0000X - Adolescent Medicine (Family Medicine) Physician
- 207QA0401X - Addiction Medicine (Family Medicine) Physician
- 207QB0002X - Obesity Medicine (Family Medicine) Physician
- 207QG0300X - Geriatric Medicine (Family Medicine) Physician
- 207QH0002X - Hospice and Palliative Medicine (Family Medicine) Physician
- 207OS0010X - Sports Medicine (Family Medicine) Physician



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
- 2 Group / Provider Look-Up
- 3 **Network selection**
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Network selection

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

* Available Networks

BlueChoice
HealthPlan

Blue Options

Preferred Blue

Blue Essentials

State Health
Plan

Healthy Blue

Medicare
Advantage

Error: Available Networks is required.

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.

Example of an Individual Enrollment Application (Continued)

Steps








- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 **Practitioner Information**
Practitioner information
Professional qualifications
Educational History & Training
Employment history
Hospital privileges
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: Copy the link or Email me the link

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 for the provider is required.*
-  **Demographic Information**
Provider demographic information such as name, date of birth, NPI, social security number, gender, ethnicity, etc. will be asked and an answer required.
-  **Professional qualifications**
The practitioners care specialty, state medical license, board certifications, DEA** are all required. Provider's individual Medicaid Number.***
-  **Malpractice**
Certificate of Insurance for the effective date to current coverage period are required.
-  **Employment**
Current employer and previous employers' 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 MDs, DOs, and DPMs to provide their residency information.
-  **Signatures**
The provider will be required to sign all contracts, Authorization to bill, Hold Harmless*, Attestation of the accuracy of the application information. Office Representative will be required to sign the Representative portion of the Authorization to bill.

Example of an Individual Enrollment Application (Continued)

Steps

- Let's Get Started
- Group / Provider Look-Up
- Network selection
- Practitioner Information**
 - Practitioner information
 - Professional qualifications
 - Educational History & Training
 - Employment history
 - Hospital privileges
- Licenses and Professional Certifications
- Location Details
- Practice Locations
- Review Your Application
- Submit

This Omniscript is saved automatically. To resume the Omniscript later, Copy the link or Email me the link

Practitioner 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" value="MD"/>	<input type="text"/>	<input type="text"/>
*Social Security Number	*Date of Birth	Tax Id
<input type="text" value="000-11-0000"/>	<input type="text" value="07-13-1970"/>	<input type="text" value="579999999"/>
NPI Group	*NPI Number (type I individual)	Medicaid ID
<input type="text" value="122222222"/>	<input type="text" value="133333333"/>	<input type="text"/>
Medicare Number	*Provider Type	*Professional Designation
<input type="text"/>	<input type="text" value="Primary Care"/>	<input type="text" value="MD - Medical Doctor"/>

Preferred Email

Please provide the practitioner's preferred email so that they will be able to sign their application package. This is required as we cannot process your case without the practitioner's email.

* Practitioner's Email

Demographic information

Please provide all required demographic information, including full name, date of birth, NPI, Social Security number, and other relevant information, as requested. Gender, race, ethnicity, and languages spoken are optional. If you prefer not to answer optional questions, you may select "Declined to Answer" or "Unknown", where applicable. Additional spoken languages will be published in the provider directory to help members select providers who meet their language needs.

* Gender	* Race	* Ethnicity
<input type="text" value="Male"/>	<input type="text" value="Black or African American"/>	<input type="text" value="Declined to Answer"/>

Languages

Language(s) Spoken (other than English)- 1	Language(s) Spoken (other than English)- 2
<input type="text"/>	<input type="text"/>

Authorization to bill

Please confirm the effective date of this authorization. The Authorization to Bill date marks when the group will begin billing for services on behalf of the practitioner. It should coincide with the practitioner's start date at the group practice.

* Auth to Bill Effective Date

[Save for later](#) [Previous](#) [Next](#)

Note: You must enter the practitioner's email address. It cannot be the email address for the practice or anyone else.

Example of an Individual Enrollment Application (Continued)

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

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 Taxonomy
207Q00000X - Family Medicine Physician

Secondary Taxonomy

Do you wish to be listed in our provider directory with a specialty that is different from your primary taxonomy?
 Yes No

State Medical License

Enter all state medical license details, including the issue date and expiration date. Autism providers, please enter your c

* Professional Designation MD - Medical Doctor	* Provider's License Type State Medical License	* License Number ABC1234
* State South Carolina	* Issue Date 01-13-2020	* Expiration Date 12-31-2025
* License Status Active		

Upload Document

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)

Steps


- Let's Get Started
- Group / Provider Look-Up
- Network selection
- Practitioner Information**
 - Practitioner Information
 - Professional qualifications
 - Educational History & Training**
 - Employment history
 - Hospital privileges
- Licenses and Professional Certifications
- Location Details
- Practice Locations
- Review Your Application
- Submit

This script has been automatically saved, in order to resume in the future: Copy the link or Email me the link

Educational History & Training

Educational History

Please provide detailed information about your educational history, including degrees earned, institutions attended, and date of completion, to your academic qualifications.



What determines a full educational history?
Please be sure to include the institution where the practitioner received their most advanced medical education. If you have less than 5 years of employment history, include additional educational history to provide a complete picture of the practitioner's professional timeline.

* Educational Level	* Institution Name	* Please Specify Institution Name.
Medical School	OTHER	USC
* Degree Type	* Start Month	* Year
MD - DOCTOR OF MEDICINE	January	2010
* End Month	* Year	* Country
November	2016	United States
* City	State	
Columbia	South Carolina	

Degree Conferred

Individual asserts they have completed their education and holds the qualifications associated with that degree

Professional Training

If the practitioner has completed an internship, fellowship or residency, please update the selection from the dropdown provided and enter detail for this professional training. You may add additional entries / remove entries.

Add Trainings [Add Additional Training](#)

Training

* Training Type	* Institution Name
Professional Training	USC
* Program Name	City
Residency	Columbia
Country	State
United States	South Carolina

I am actively taking this training/program

* Start Date	* End Date
02-01-2016	12-31-2018

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 <https://thinkculturalhealth.hhs.gov/>

[Save for later](#) [Previous](#) [Next](#)

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 **Practitioner Information**
 - Practitioner information
 - Professional qualifications
 - Educational History & Training
 - Employment history**
 - Hospital privileges
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

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

Delete

[Add Additional 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.

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 **Practitioner Information**
Practitioner information
Professional qualifications
Educational History & Training
Employment history
[Hospital privileges](#)
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Hospital privileges

Hospital Privilege Information

Do you have privileges at any hospital facility?

Yes No

* Describe arrangements for hospital care:

Refer the patient to the nearest facility.

[Save for later](#)

[Previous](#)

[Next](#)

Note: Hospital privileges are based on admitting privileges.

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 **Licenses and Professional Certifications**
Speciality Board Certification
Malpractice Insurance
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Licenses and Professional Certifications

This next section will collect applicable requirements, including board certification, DEA license, and malpractice insurance.

[Save for later](#)

[Previous](#)

[Next](#)

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
 - [Speciality Board Certification](#)
 - Malpractice Insurance
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Speciality Board Certification

Providers who hold multiple board certifications should enter their primary certification details and upload copies of all certifications.

*** 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)

This Omniscrypt is saved automatically. To resume the Omniscrypt later, Copy the link or Email me the link

Malpractice Insurance

[Add Additional Insurance](#)

* Effective Date	01-01-2025	* Expiration Date	01-01-2026
* Coverage Amount (Each Occurrence)	\$1 million	* Coverage Amount (Aggregate)	\$3 million
* Carrier's Name	Cover Me	* Policy Number	911
* Country	United States	* Street	1500 Hampton St
* City	Columbia	* State	South Carolina
* Zip/Postal Code	29201		

Upload Document

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

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 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 **Licenses and Professional Certifications**
 - Speciality Board Certification
 - Malpractice Insurance
 - [Federal DEA license](#)
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Federal DEA license

Does this practitioner hold a DEA certification?

Yes No N/A

* License #

ABC987

* Issue Date

01-01-2020

* ExpirationDate

12-31-2025

* License Status

Active

Upload Document



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 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Location Details

A primary and additional locations can be added to this application. (Up to 5 per application).

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. Make sure to have your phone number available for these addresses as well.



Location contacts

Identify the office contacts for this location for credentialing, claims, billing, and others.



Clinical Laboratory Improvement Amendment

If you are CLIA certified, please submit a copy of the certification for each location listed on this application.

> [What is a primary location?](#)

[Save for later](#)

[Previous](#)

[Next](#)

Example of an Individual Enrollment Application (Continued)

This Omniscrypt is saved automatically. To resume the Omniscrypt later, Copy the link or Email me the link

Practice Locations

Primary location information
Your primary location is your main hub of operation

* Office practice name
March Madness

* Group Tax Id Number (TIN)
57-9999999

* Group NPI #
133333333

* Does this provider see patients at this location?
 Yes No

* If yes, do they accept new patients at this location?
 Yes No

* Do you accept Medicaid patients?
 Yes No

* Do you offer Sign Language?
 Yes No

* Do you provide a translation service?
No

Patient Population

* Are there patient gender restrictions?
 Yes No

* Are there patient age limitations?
 Yes No

* Do you have any other patient limitations?
 Yes No

Physical Address
This is the physical address for your primary location; it is not a P.O. box.
Should the Provider display in the Directory at this location?
 Yes No

* Street Address
123 Ohio St

* City
Columbia

* State
South Carolina

* County
Richland

* Zip Code
29202-

* Appointment Phone
(803) 555-1234

After Hours Phone

Fax

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 additional roles.

* First Name
Kyle

* Last Name
Barker

* Phone
(803)

* Email
mmadness@help.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

Billing Contact

The Billing Contact is the same as the Office contact.

Correspondence Address

The Correspondence Address is the same as the Physical Address.

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

Save for later

Previous Next

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Review Your Application

You are almost ready to submit this enrollment request!

If document upload sections appear below, please upload all required files before clicking **"Next"** to submit your application.
If no upload sections are shown, simply click **"Next"** to proceed to the final step and submit your application.

[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 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Submit

[Save for later](#)

[Previous](#)

[Submit Application](#)

Example of an Individual Enrollment Application (Continued)


Submitted Preliminary review Awaiting signature Signed Secondary review Final review Approved Denied Cancelled Withdrawn

Case #00032921 - Individual Application


Provider Jason Doe - March Madness Family Health	Status Submitted
Application Type Individual	Case Reference Number Case #00032921
	Case Contact Kristen Ward - Provider Relations LLC

Requested Networks
Blue Essentials;BlueChoice HealthPlan;Medicare Advantage;Preferred Blue

No action required at this time.

 Case Comments (0) [New](#)

Open Agreements

 Files (0) [Add Files](#)

[Upload Files](#)

Or drop files

Making Corrections to Applications

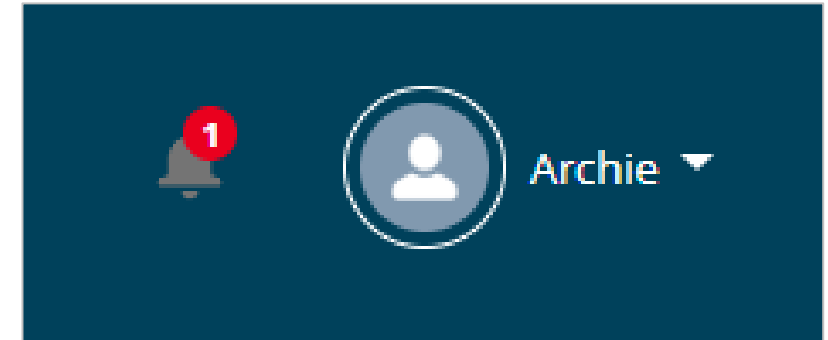


2026 Annual Provider Summit



Correcting Applications

- ❑ Currently, corrections can only be made to group or individual enrollment applications.
 - Corrections cannot be made to maintenance applications.
 - If an error or mistake is made after submission, a case comment must be made on the current case requesting to have it canceled, and a new maintenance application must be submitted.
- ❑ If items are missing or corrections are needed for an application, you will see a notification once you log into the portal.
- ❑ After selecting the notification bell, you will see that there is a new case comment for you to review.
- ❑ All corrections must be made in the portal.
 - 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](#)

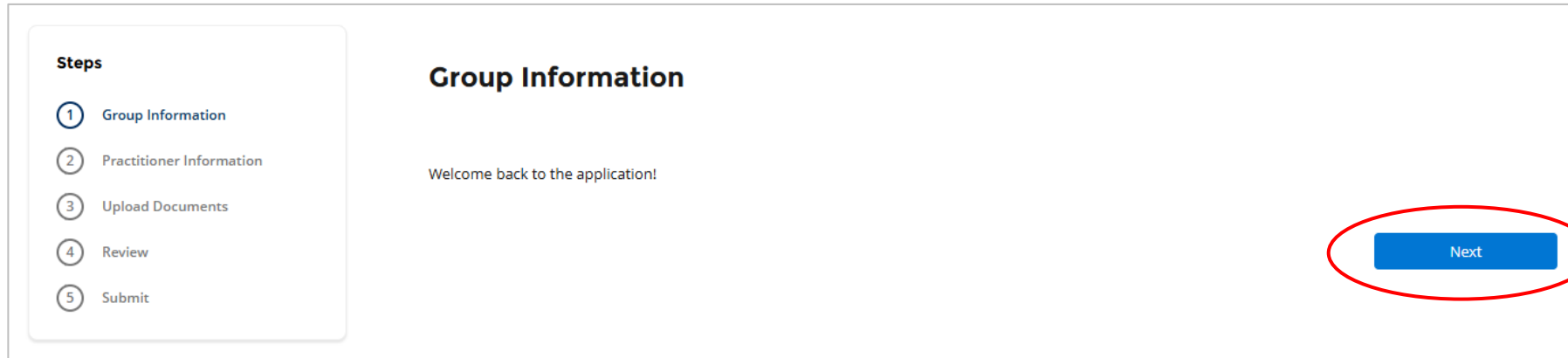
Action Items

1 of 1 item

Action Item Name	Issue	Next steps
Signer - Missing	Missing	Re-open application, correct & re-submit.

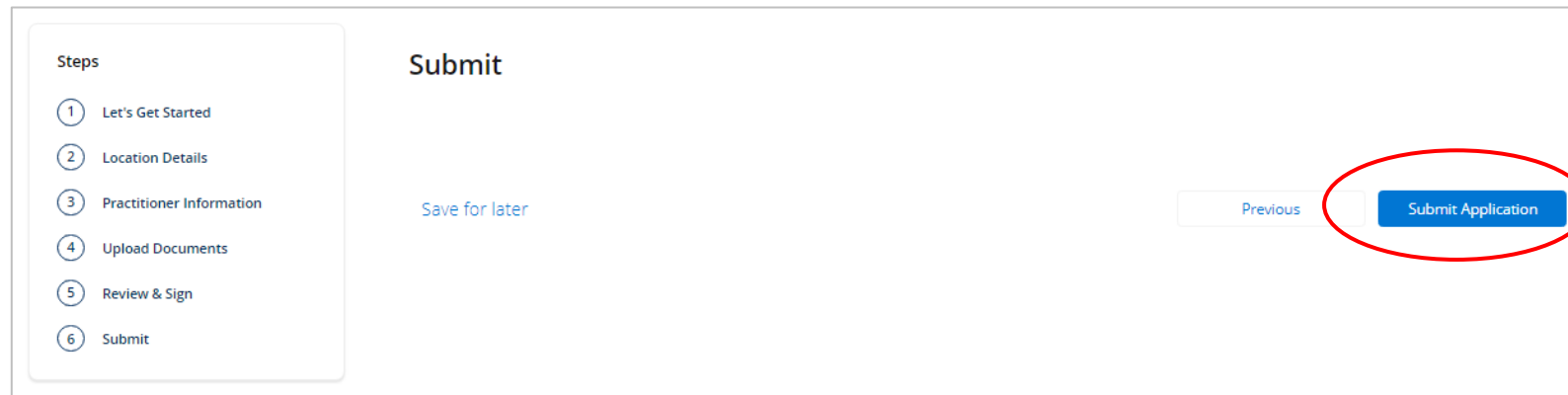
Steps for Making Corrections (Continued)

- ❑ 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 is the next action to take.

- ❑ Once all the necessary corrections are made, resubmit the case.



The screenshot shows a web interface for a multi-step application process. On the left, a 'Steps' sidebar lists 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 is titled 'Submit' and displays the message 'Save for later'. At the bottom right of the main area, 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 is the next action to take.

Available Resources

Useful Resources

- Visit 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

Checklists

"How to" Videos

Quality Improvement Strategy



2026 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



2026 Annual Provider Summit



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



2026 Annual Provider Summit



NCQA - Overview



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 - What It Means 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



2026 Annual Provider Summit



CAHPS - Overview

- 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



Standards & Guidelines

+



Quality Measures

+



Member Experience

**Consumer Assessment of Healthcare Providers and Systems (CAHPS)*

CAHPS – Sample of Survey Questions

Opportunities	Possible Solutions
Q22 – Rating of Specialist seen most often	<ul style="list-style-type: none"> <input type="checkbox"/> Listen to patient concerns and spend adequate time with them <input type="checkbox"/> Engage the patient in discussions about medications <input type="checkbox"/> Avoid using medical jargon and technical language
Q24 – Customer Service provided need information or help	<ul style="list-style-type: none"> <input type="checkbox"/> Ensure that representative are friendly and polite <input type="checkbox"/> Resolve issues completely and follow up with members <input type="checkbox"/> Ensure that representatives listen carefully and avoid interrupting
Q18 – Rating of personal doctor	<ul style="list-style-type: none"> <input type="checkbox"/> Ensure that providers are informed about the patient's relevant medical and person background <input type="checkbox"/> Remain up-to-date on medical advancements <input type="checkbox"/> Connect with the patient on a personal level <input type="checkbox"/> Reduce wait times in the office
Q9 – Ease of getting care, tests, or treatment	<ul style="list-style-type: none"> <input type="checkbox"/> Conduct a thorough assessment of the patient's needs <input type="checkbox"/> Treat patients with urgent issues promptly <input type="checkbox"/> Provider care and service quickly <input type="checkbox"/> Minimize wait times and communicate reasons for delays
Q5 – Made appointments for routine care at office or clinic	<ul style="list-style-type: none"> <input type="checkbox"/> Schedule appointments within sufficient time frame <input type="checkbox"/> Treat patients with great urgent issues promptly
Q4 – Got an appointment for urgent care as soon as needed	<ul style="list-style-type: none"> <input type="checkbox"/> Schedule appointments within sufficient time frame <input type="checkbox"/> Treat patients with great urgent issues promptly

HEDIS

Healthcare Effectiveness Data and Information Set



2026 Annual Provider Summit



What is HEDIS?

HEDIS

- ❑ Evaluates performance in terms of clinical quality
- ❑ Administered by NCQA and used by Centers for Medicare & Medicaid Services for monitoring
- ❑ HEDIS Retrospective Review -
 - HEDIS MY2025 refers to care given or due in 2025, which will be evaluated from January to May 2026
- ❑ HEDIS Prospective Review -
 - Runs from Jan. 1 to Dec. 31 of the current measurement year



Healthcare Effectiveness Data and Information (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

- ❑ 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.
 - **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 MY2025 refers to care given or due in 2025, which will be evaluated from January to May 2026.
- ❑ 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 electronic clinical data systems (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 10/1/2023 to 12/31/2025

-AND-

Past Medical/Surgical history 2024 to 12/31/2025

-AND-

All radiology reports specifically mammograms from 10/1/2023 to 12/31/2025


-AND-

All consultation especially OB/GYN notes from 2023 to 12/31/2025

Quick Tip: Look for documentation of the most recent mammogram completed between Oct. 1, 2023-December 31, 2025.

Request for Information (Continued)

- ❑ Example of a Request for Information cover letter for our Exchange and FEP Plan.
- ❑ Request will be sent via email, fax or mail.
- ❑ Email the Quality Navigator of your preferred method of contact at Navigator@bcbssc.com.

 South Carolina
BlueCross BlueShield of South Carolina
An Equal Opportunity Member of the
Blue Cross and Blue Shield Association

Request for Medical Records - Cover Letter

To:	From: BlueCross BlueShield of South Carolina
NPI: -/TIN: -	Fax:
	Requested Date: 06/25/2025

Greetings:
Please see the attached medical record requests for our Prospective HEDIS review of members for the Exchange and FEP product line for Measurement Year (MY) 2025. The purpose of this request is to review medical records for services that were completed that we may not have received on a claim. We would appreciate it if you could send the requested medical records within 7 business days. Please be reminded that participating in provider's contract outlines access to medical records at no cost to the health plan.

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: bchpbcbshedis.requester.roilog.com
Datavant: Customer Portal ID: 2213626, Address below is only for portal location validation:
PO Box 100300, AX-310, 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.
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@bcbssc.com.

Request for Medical Records - Cover Letter

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 **Medicaid Program**. 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.
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



2026 Annual Provider Summit



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.
- ❑ This year FEP launched the Postal Service Health Benefit (PSHB) program. This program designation is for members within USPS.



Healthy BlueSM

□ 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.



Quality Navigator Program



2026 Annual Provider Summit



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.



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.

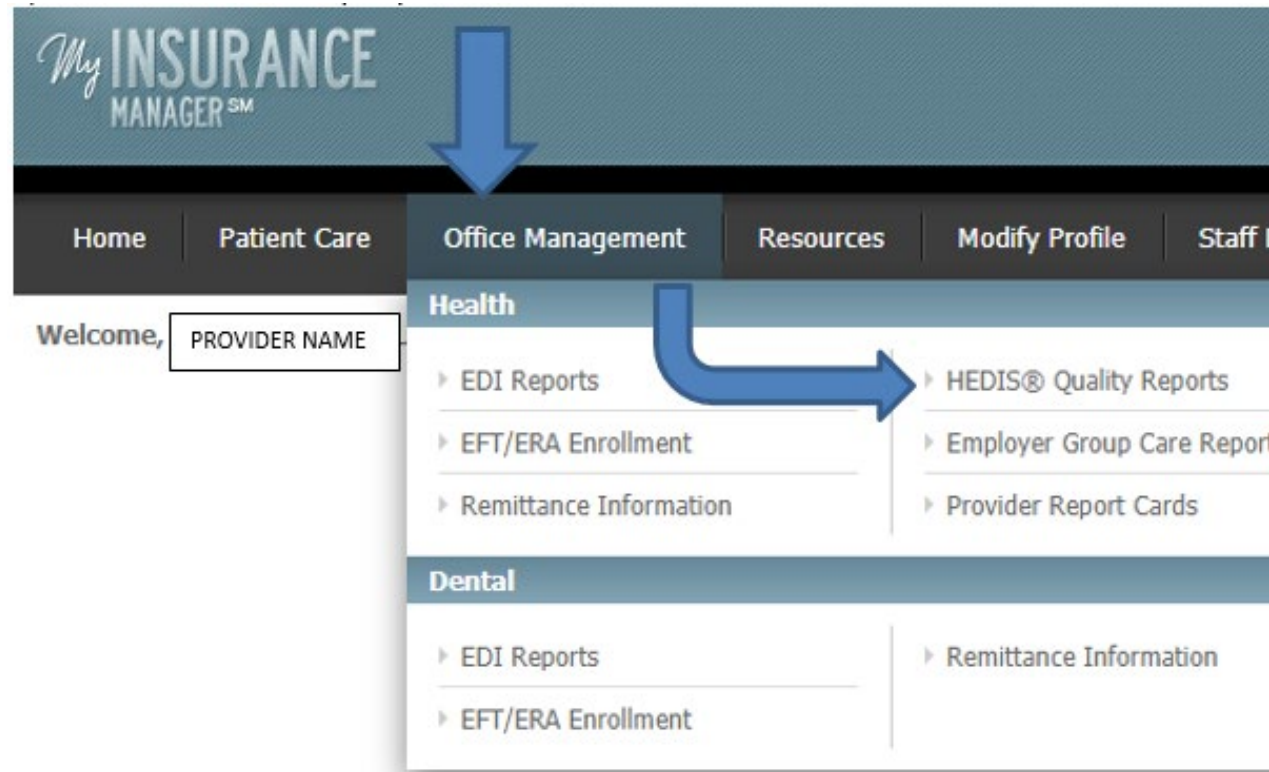
What is a Quality Navigator?

- ❑ Dedicated team member with a 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)

My Insurance Manager

- ❑ Convenient Solution for Providers
- ❑ Group and Location Level Reporting
- ❑ Additional Resources and Education Material

HEDIS® Quality Reports



For your convenience, we have provided reports of care opportunities for members across multiple lines of business at both the summary and detail level. Please feel free to view, download or print these files as needed.

Search

All Locations

Choose a Location

As of 12/14/2020 | Showing 41 Results

Report Name	Provider Name
All Locations Combined Summary Report	S IS
All Locations Combined Member Details Report	S IS
Location Level Summary Report	C .TH
Location Level Summary Report	U

Reference Documents

Incentive Plans

HEDIS® Quick Reference Guide with Coding

Quality Navigator Program

Compliance Forms

Webinar Information

NCQA End-User License Agreement

Note: Healthy Blue Gaps in Care reports are coming soon. Other lines of business are currently available.

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 glyceimic 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

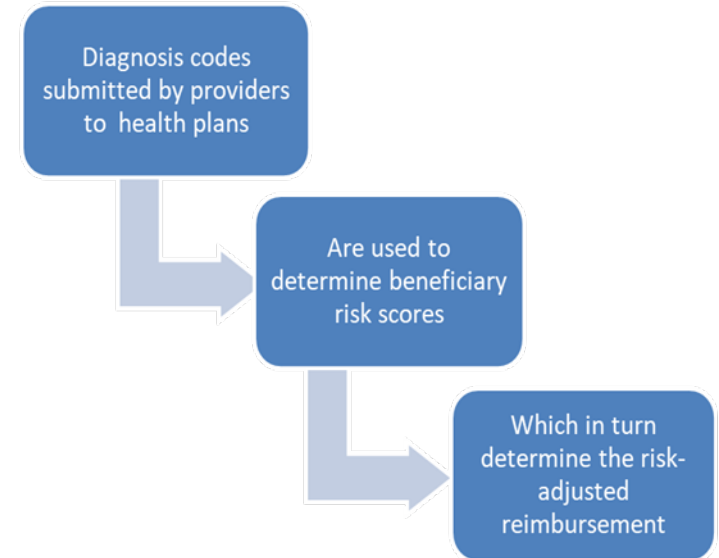


2026 Annual Provider Summit



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 throughout 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



Request for Medical Records (RISK) - Cover Letter

09/17/2025

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 2025 dates of service. Enclosed, you will find the list of members seen by your practice in 2025. Please provide the entire 2025 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 by one of the following methods:

- a) Please fax to 803-419-5715
- b) Please email to 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 **Savannah Miano @ 803-382-4519** or **Tara Dunn @ 803-382-5531** or send an email to ACARISK.RECORDS@bcbsc.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	Measurement Year
<<Name>> <<RegNo>><<CellMerge>>	<<Dob>> <<Gender>><<CellMerge>>	<<ChaseId>>	<<DOS>>	<<MeasurementYear>>

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.

According to HIPAA Privacy Rules (CFR 160.164), amended Aug. 14, 2002, health care providers can disclose protected health information (PHI) to health plans for the purpose of quality assurance, quality improvement and accreditation activities. Providers may disclose PHI to health plans for RISK® data collection without authorization from the patient when both the provider and health plan have a relationship with the patient and the information relates to that relationship (45 CFR 164.506 (c)(4)). This guidance is online at <https://www.govinfo.gov/content/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec164-506.pdf>

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 20, 2025
To: Hospitals, Physicians, and Practitioner Health Care Providers
From: Adrienne Patterson
Acting 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 2024 calendar year.¹ The requesting entity has determined that one or more of your patients are included in the HHS-RADV audit sample for services rendered during 2024. Because 2024 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: _____, 2025

**IMPORTANT
CMS AUDIT REQUEST**

Dear Provider,

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 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.

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. In addition, we do not have any affiliation nor contractual agreement with third-party record retrieval vendors and as such, are not permitted to contact them on your behalf.

How to submit the requested records:

To meet the CMS deadline, please submit the required medical records for 2024 to us by _____. You can submit the records via fax to 803-419-5715 or via email to 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

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,
Nice Raman, P.M.P., CPC, CRC
Manager, Program Change
Quality Improvement

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. 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: 09/11/2025

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.

09/9/2025

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
<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, www.BlueChoiceSC.com
An Independent Licensee of BlueCross and BlueShield Association

IV. PREFERRED PROVIDER'S RESPONSIBILITIES.

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 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

Key Takeaways - Providers

What will positively impact your quality score?

Customer service

Deliver care in a kind and courteous manner

Patient Care Coordination

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.

Take advantage of available coding incentives

HEDIS Electronic Clinical Data Systems Reporting

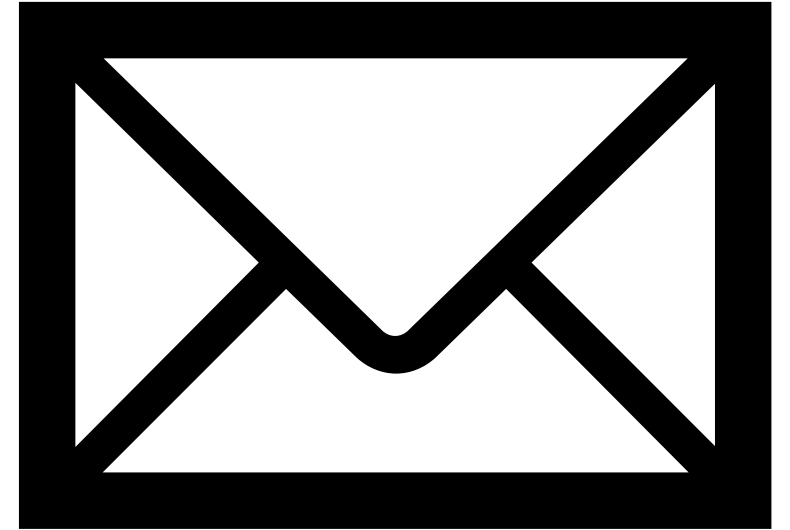
ECDS

ICD-10
CPT II



Contact Information

- ❑ For general assistance or information about the Quality Navigator Program, email Navigator@bcbssc.com.



Self-service Tools



Topics to Discuss

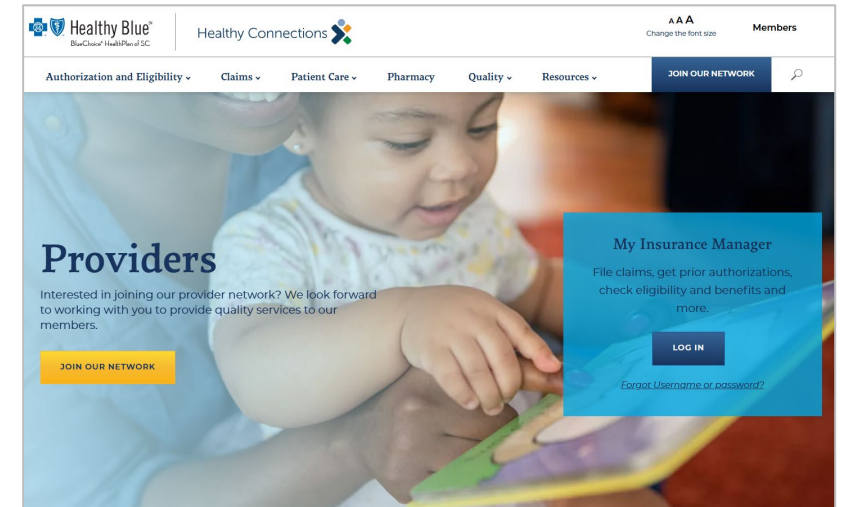
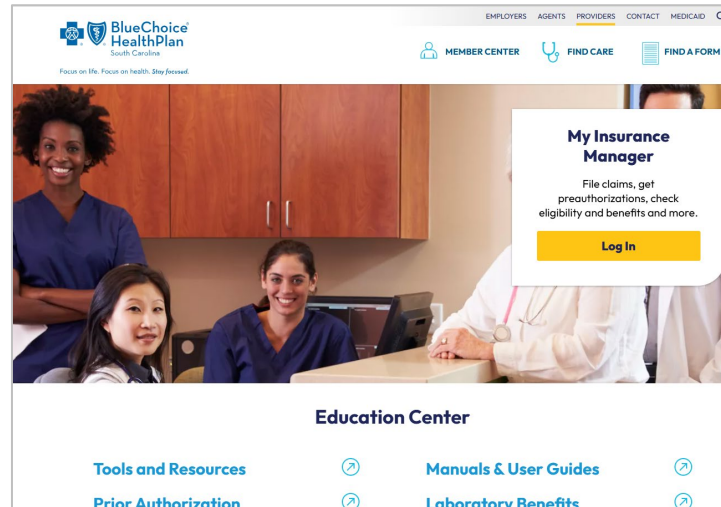
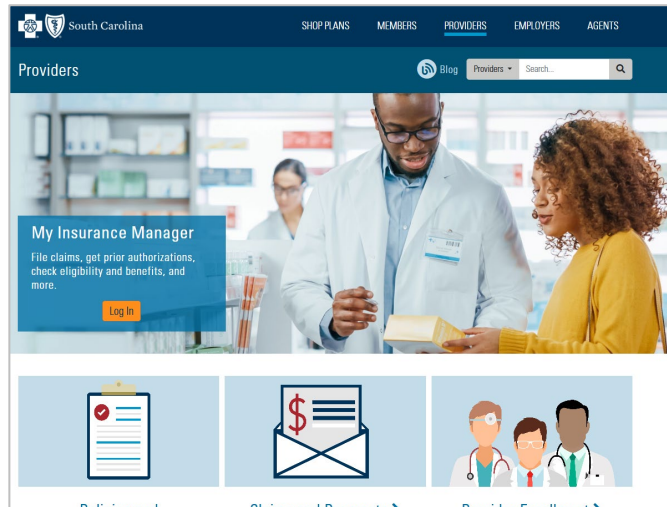
- ❑ Website Overview
- ❑ My Insurance ManagerSM
 - Registration and Overview
 - Benefits and Eligibility
 - Claims Submission
 - Claims Status
 - Ask Provider Services
 - STATchatSM
- ❑ My Remit Manager
- ❑ Cohere Health[®]
- ❑ My Provider Enrollment Portal
 - Overview of Portal
 - Completing Clean Applications
 - Making Corrections

Website Overview

Available Websites

□ Our websites include:

- www.SouthCarolinaBlues.com
- www.BlueChoiceSC.com
- www.HealthyBlueSC.com



My Insurance Manager



2026 Annual Provider Summit



Registration and Overview

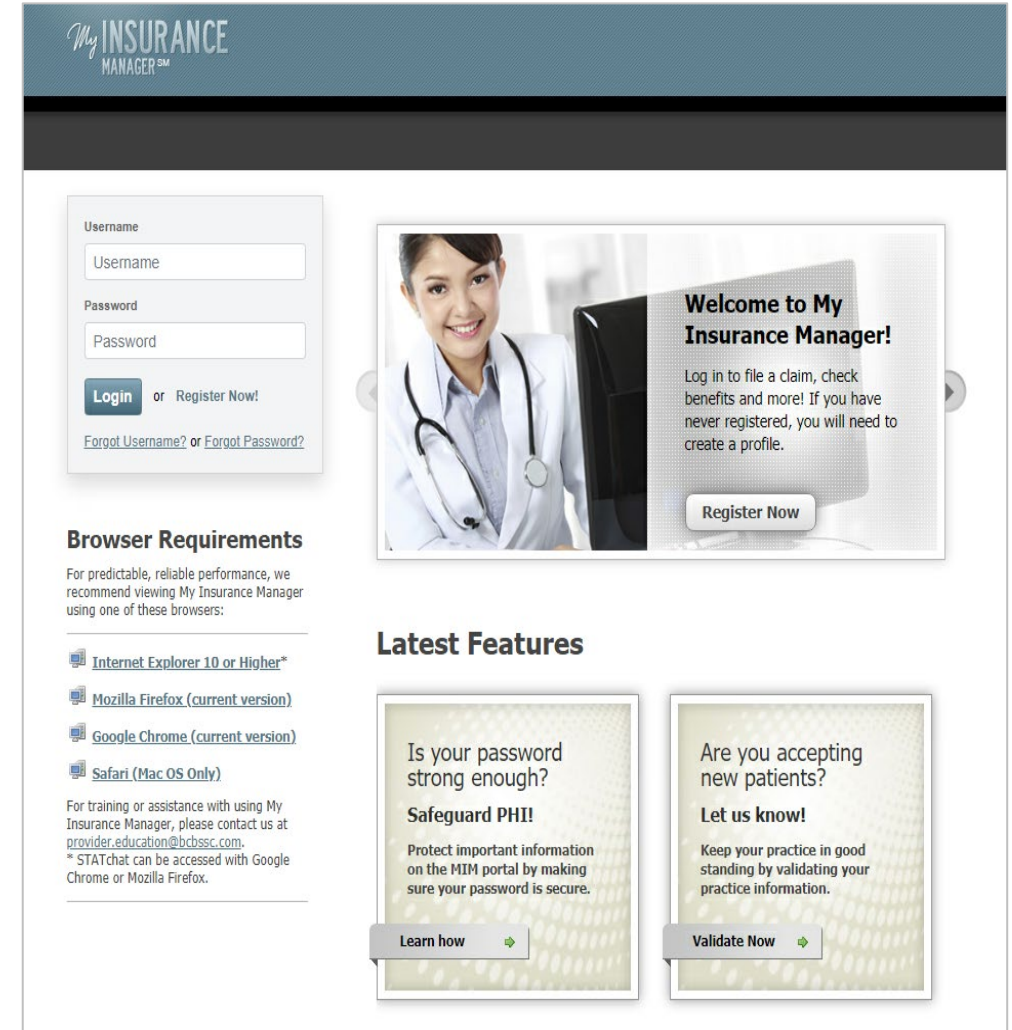


2026 Annual Provider Summit



Getting Started with My Insurance Manager

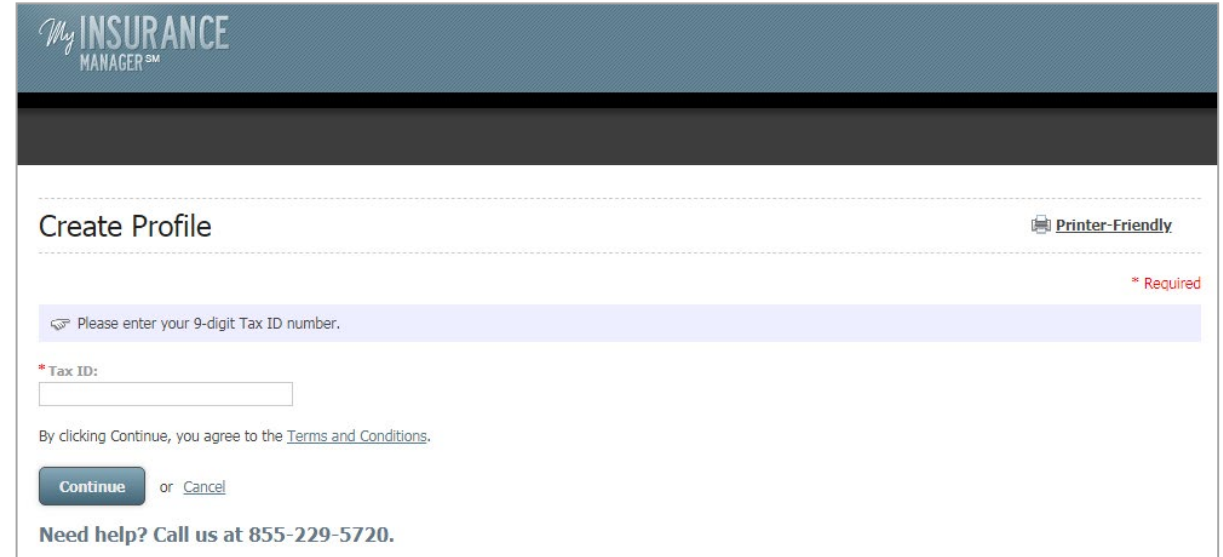
- ❑ Visit one of our websites and select Providers.
- ❑ You will have the option to access My Insurance Manager from several pages under the Provider section.
- ❑ If you do not already have an account for My Insurance Manager, from the home page of the portal, select Register Now.



The screenshot shows the My Insurance Manager website interface. At the top left is the logo "My INSURANCE MANAGER SM". Below it is a login form with fields for "Username" and "Password", a "Login" button, and a "Register Now!" link. There are also links for "Forgot Username?" and "Forgot Password?". To the right of the login form is a banner featuring a smiling female doctor and a computer monitor. The banner text reads "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 login form 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 this is a note about training and assistance, and a link to "provider.education@bcbscc.com". To the right of the browser requirements is a "Latest Features" section with two cards. The first card asks "Is your password strong enough?" and "Safeguard PHI!" with a "Learn how" button. The second card asks "Are you accepting new patients?" and "Let us know!" with a "Validate Now" button.

Creating a Profile in My Insurance Manager

- ❑ To create a profile in My Insurance Manager, you must have a 9-digit tax identification number (TIN).
- ❑ Enter the TIN in the appropriate field and select Continue.
- ❑ If you run into any technical issues, contact our technical support team at 855-229-5720.



The screenshot shows the 'My INSURANCE MANAGER' logo at the top left. Below it is a dark blue header bar. The main content area is white and titled 'Create Profile' on the left and 'Printer-Friendly' on the right. A light blue box contains the instruction 'Please enter your 9-digit Tax ID number.' with a red asterisk and the word 'Required' to its right. Below this is a text input field labeled '* Tax ID:'. Underneath the field is the text 'By clicking Continue, you agree to the [Terms and Conditions](#).' At the bottom of the form are two buttons: 'Continue' and 'Cancel'. Below the buttons is the text 'Need help? Call us at 855-229-5720.'

Profile Information

- ❑ 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 and include the answer.
- ❑ Select ***Continue***.

Create Profile Printer-Friendly

Profile Information Required

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: 111122222

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: --Please Choose One--

* Security Answer:

or

Need help? Call us at 855-229-5720.

Validating Profile

- ❑ 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.
- ❑ After completing registration, it can take up to two business days for the profile to be approved.
 - If the practice already has a profile administrator, they must review and approve profile requests.
- ❑ When the profile is approved, use your username and password to log in.

The screenshot shows a web form titled "Validate Profile" with a "Printer-Friendly" link in the top right corner. The form is divided into two main sections: "Profile Validation" and "Request Security Code".

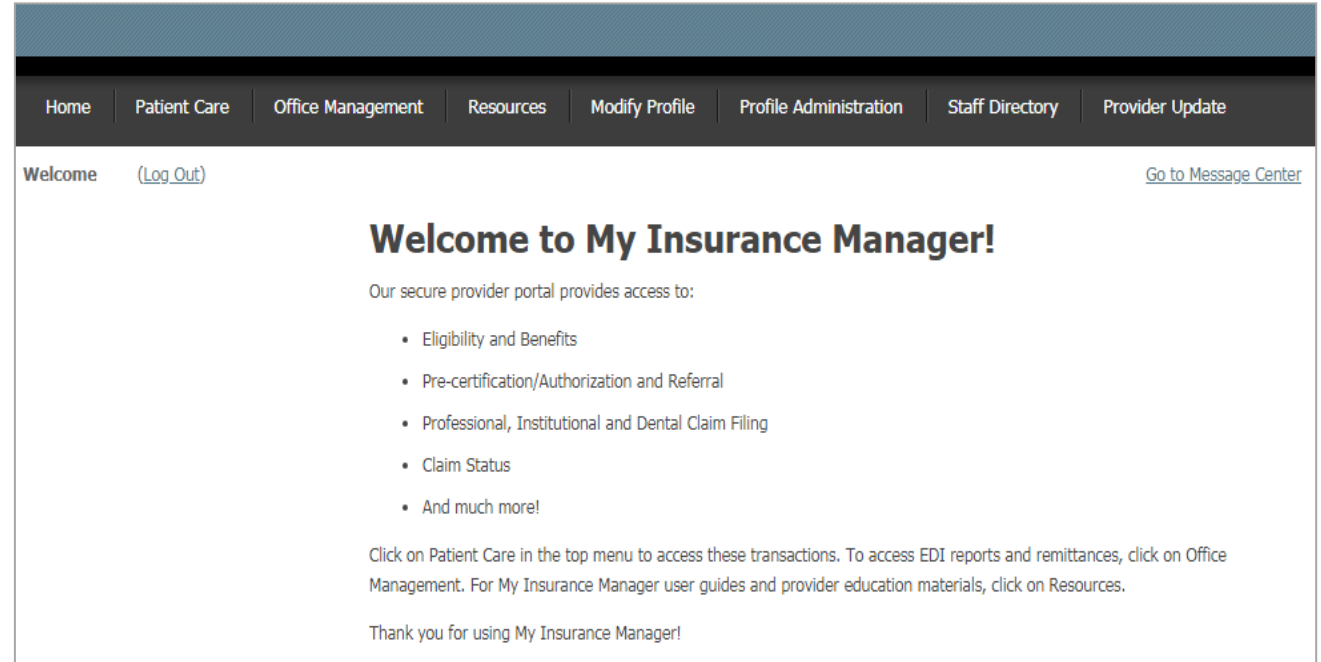
Profile Validation: This section contains a blue instruction bar: "Please choose a way to validate yourself as an administrator of this Tax ID." Below this are two radio button options: "Enter Claim Information" and "Request Security Code". The "Request Security Code" option is selected.

Request Security Code: This section features a blue information bar: "You can request that we send a Security Code via the delivery method we have on file associated with your Tax ID." To the right of this bar is a red asterisk and the word "Required". Below the bar are two required fields:

- Location:** A text input field with a "Select" button to its right.
- Delivery Method:** A section with three radio button options: "Email:", "Fax:", and "Physical Address:".

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

- ❑ There are several options available under Patient Care. Some of the most common requests include:
 - Claims Status
 - Eligibility and Benefits
 - Institutional or Professional Claim Entry
 - Pre-certification/Referral

Patient Care	Office Management	Resources	Modify Profile
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	






Office Management

- ❑ There are several options available under Office Management. Some of the most common requests include:
 - EDI Reports
 - Remittance Information
 - Refund Letters
 - HEDIS® Quality Reports

Office Management	Resources	Modify Profile	Staff Directory
Health			
<ul style="list-style-type: none">▶ EDI Reports▶ EFT/ERA Enrollment▶ PCMH Reports▶ PCMH Patient Validation▶ Remittance Information▶ Refund Letters		<ul style="list-style-type: none">▶ HEDIS® Quality Reports▶ PCP Assignment▶ Employer Group Care Reports▶ Provider Report Cards▶ Medicare Advantage Reports	
Dental			
<ul style="list-style-type: none">▶ EDI Reports▶ EFT/ERA Enrollment		<ul style="list-style-type: none">▶ Remittance Information	

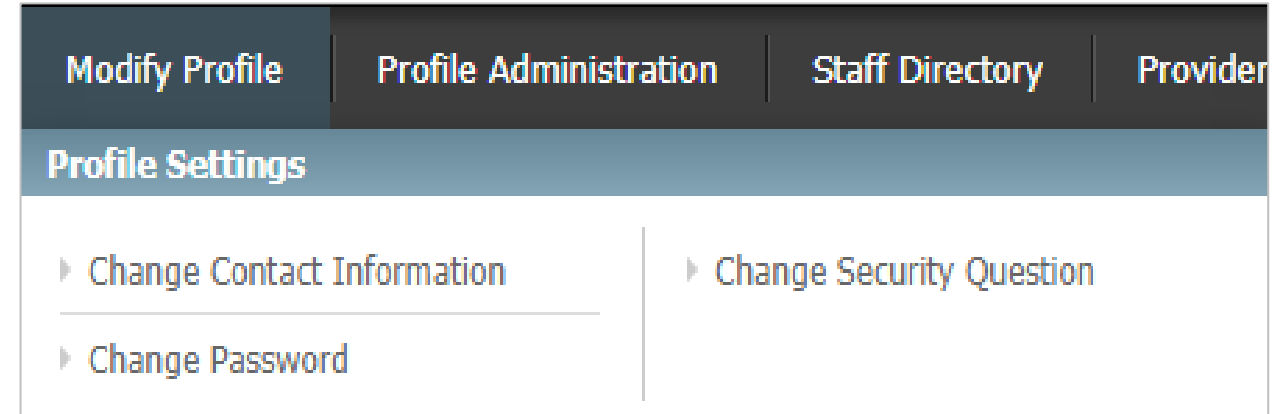
Resources

- ❑ There are several options available under Resources. Some of the most common requests include:
 - Find Care
 - Medical Policies
 - My Remit Manager

Resources	Modify Profile	Staff Directory	Provider Update
Tools			
▶ Access System News			
▶ Avalon Lab Benefit Manager			
▶ Provider Portal 			
▶ BlueChoice Find Care 			
▶ Blue Cross Find Care 			
▶ Code Search			
▶ EDI Resources			
▶ FEP Website			
▶ Forms			
▶ HealthyBlue Medicaid Find Care 			
▶ Lab/Biometric Data Upload			
▶ MCG Medical Care Guidelines			
			▶ HealthyBlue Population & Demographics
			▶ MIM Report Test
			▶ Medical Policies
			▶ HealthyBlue Medicaid Medical Policies
			▶ My Remit Manager 
			▶ Provider News and Events
			▶ State Dental Plan Fee Schedule
			▶ State Health Plan Fee Schedule
			▶ State Insurance Benefits
			▶ Tools and Resources
			▶ Washington Publishing Company Claim Adjustment Reason Codes

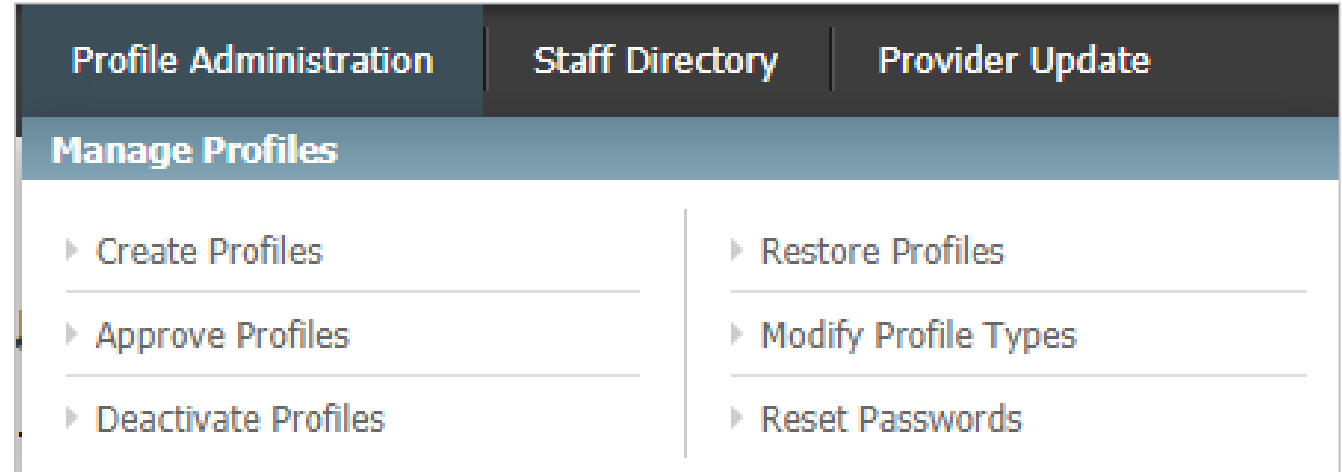
Modify Profile

- ❑ Modify Profile gives the user three options related to their profile settings:
 - Change Contact Information
 - Change Password
 - Change Security Question



Profile Administration

- ❑ Only the profile administrator for the practice will have this tab. The administrator can manage the following options for profiles:
 - Create Profiles
 - Create individual profiles for staff members.
 - Approve Profiles
 - Approve profiles that were created by staff members.
 - Deactivate Profiles
 - Close profiles for staff members that no longer work for the practice.
 - Restore Profiles
 - Restore profiles that were deactivated.
 - Modify Profile Types
 - Change a profile type from staff member to profile administrator and vice versa.
 - Reset Passwords
 - Reset password for staff members.



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

- ❑ The staff directory simply shows a list of profiles associated with the TIN.

Staff Directory

All Profiles for Tax ID: 123456789

Results (5)

Name ▲	Phone Number	Email	Location	Type
Alamy, Jennifer	(603) 234-5678	amy@scstate.com	JOHN M JONES MD	Profile Administrator
Baker, Thomas	(603) 234-5678	tom@scstate.com	JOHN M JONES MD	Profile Administrator
Smith, John	(603) 234-5678	john@scstate.com	JOHN M JONES MD	Office Staff
Teague, Robert	(603) 234-5678	robert@scstate.com	JOHN M JONES MD	Profile Administrator
Teague, Robert	(603) 234-5678	robert@scstate.com	JOHN M JONES MD	Office Staff

Provider Update

- ❑ Providers are required to verify their demographic data at least every 90 days as part of the No Surprises Act implemented on Jan. 1, 2022.
- ❑ Validation allows us to maintain accurate provider directories.
- ❑ Verification can be completed using Provider Update (M.D. Checkup).
 - You can also respond to the email received from Provider.Directory@bcbssc.com.

Provider Update

Troubleshooting Tips

- ❑ 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.

Benefits and Eligibility

Getting Benefits in My Insurance Manager

Step 1

Patient Care	Office Management	Resources	Modify Profile
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 Select Primary ID:

Continue Clear All

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

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:

Primary Diagnosis Code (ICD-10):

[Add Diagnosis Code](#)

Place of Service: (recommended)

Service Facility/Billing Location:

Rendering/Performing Provider:

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▲
▼ 50- HOSPITAL - OUTPATIENT	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>View Additional Messages</p> <p>INDIVIDUAL COINSURANCE: 15%</p>			
▶ 51- HOSPITAL - EMERGENCY ACCIDENT	23- EMERGENCY ROOM - HOSPITAL		
▶ 52- HOSPITAL - EMERGENCY MEDICAL	23- EMERGENCY ROOM - HOSPITAL		
▶ A0- PROFESSIONAL (PHYSICIAN) VISIT - OUTPATIENT	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▲
▼ CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES- 99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANA	11- OFFICE		
<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>View Additional Messages</p> <hr/> <p>INDIVIDUAL COINSURANCE: 15%</p>			
Ask Provider Services		New Search	
Back			

Claims Submission

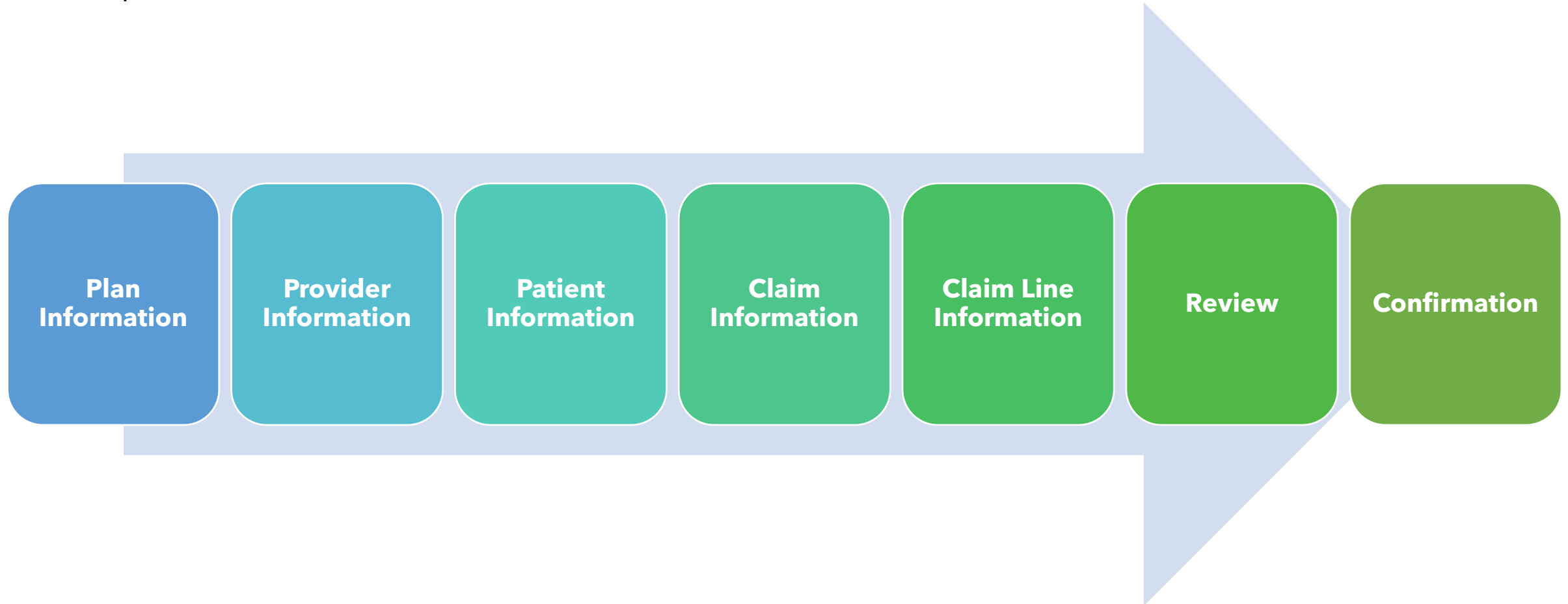


2026 Annual Provider Summit



Submitting Claims Through My Insurance Manager

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



Note: The screens for institutional and dental claim entry may include an additional screen.

Steps to Submit Claims Through My Insurance Manager

Start Here

Patient Care	Office Management	Resources	Modify Profile
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 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: t.archie@bluecross.com

Phone: (803) 333-3333 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: To Date of Service:

mm/dd/yyyy mm/dd/yyyy

Continue X Cancel this claim

Note: At any time, you can select "Cancel this claim" to end 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: 4444444440

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:

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: [] [] [] []

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	Add

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

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



2026 Annual Provider Summit



Checking the Status of a Claim

Start Here

Patient Care	Office Management	Resources	Modify Profile
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 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 2

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>
 207103LDG0000	PROCESSED	15	03/07/2022	03/12/2022	\$81.00
 207404P250000	PROCESSED	16	03/07/2022	03/15/2022	\$130.50
 2029023B80000	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: 24021

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 questions where the answers can be found in the portal or the VRU.

Examples of *appropriate* requests

Why was line one of the claim denied as noncovered?

Has the member returned the coordination of benefits questionnaire?

I need clarification regarding a recent recoupment made on the claim for date of service 01/30/2025.

Claim denied for no authorization, but the authorization number is on file under 123456789.

Examples of *inappropriate* requests

What is the status of the claim?

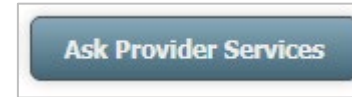
Has the claim been processed?

Did you receive the medical records for this claim?

Is there a claim on file for date of service 07/10/2025?

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 a Provider Services representative](#)
(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.
- ❑ 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 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.

The screenshot displays the 'Ask Provider Services' interface. At the top, there is a blue button labeled 'Ask Provider Services'. Below it, a text box explains that users can use the form to receive a response in the Message Center or talk to a representative. The 'How would you like to contact Provider Services?' section has two options: 'Submit your question online' and 'Talk to Provider Services online (Monday - Friday, 8:30 a.m. to 8 p.m. EST)'. The second option is selected and circled in red. The form includes fields for 'Inquiry Name' (BlueCross BlueShield Plans), 'Inquiry Reason' (Claim Status Inquiry), and patient information (First Name: J, Last Name: K, Member ID: B: i9Q). There are also fields for 'Location' and 'Primary ID' (1). A 'Launch STATchat' button is circled in red at the bottom. On the right, a 'STATchat - Google Chrome' window shows a 'Hang Up' panel with a keypad and a 'Wearing a headset?' checkbox. Below the keypad, there are 'Details' and 'Log' tabs, and a section for 'Automatic Number Identification' with the number 8789141651, 'Session ID', and 'Provider Tax ID' 571098556.

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

My Remit Manager

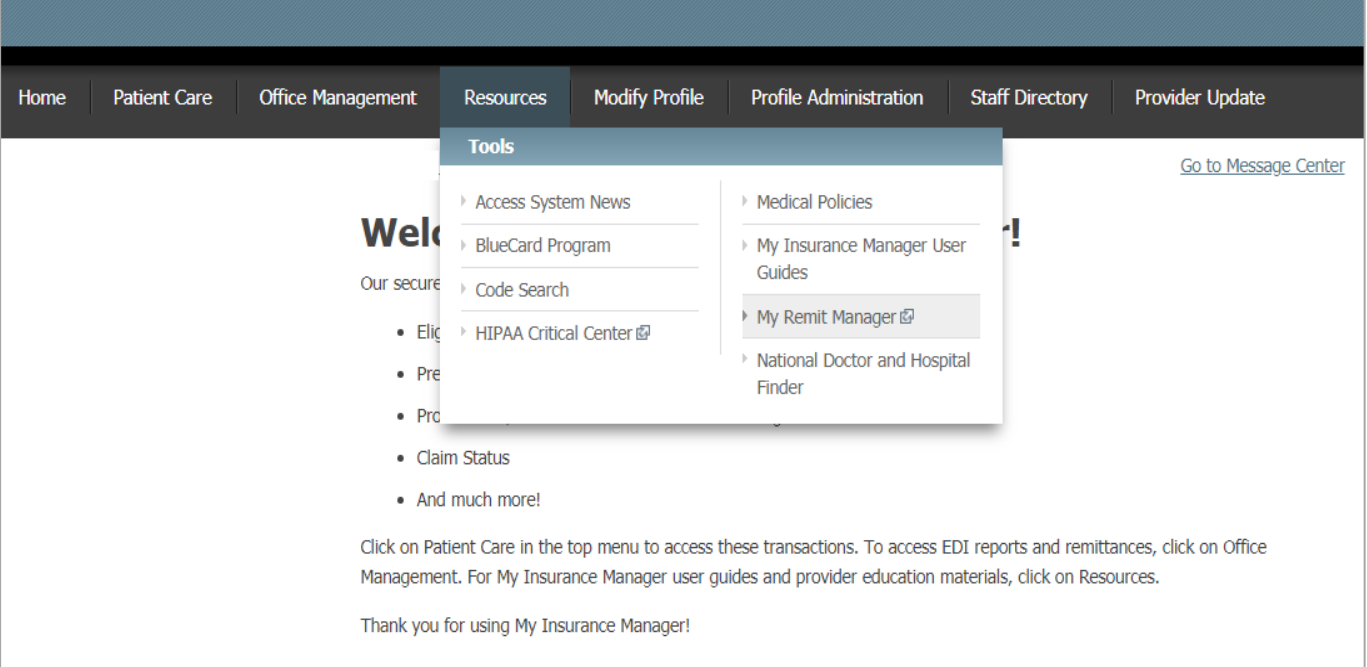


2026 Annual Provider Summit



Accessing My Remit 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 the following 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 and guides. The 'My Remit Manager' option is highlighted with a grey background. Other items in the Resources menu include Access System News, BlueCard Program, Code Search, HIPAA Critical Center, Medical Policies, My Insurance Manager User Guides, and National Doctor and Hospital Finder. Below the navigation bar, the main content area features a 'Welcome' message and a list of services. A 'Go to Message Center' link is visible in the top right corner. At the bottom of the page, there is a footer with the South Carolina logo and the text 'South Carolina'.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory Provider Update

Go to Message Center

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

Welcome

Our secure

- Elig
- Pre
- Pro
- 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!

Available Remittances - Calendar View

- ❑ If remittances are available, there will be check links on the calendar.
- ❑ Providers can view previous months by selecting the appropriate arrows on the calendar.

The screenshot shows the 'My Remit Manager' interface. At the top, there are navigation tabs for 'Calendar', 'Month Details', and 'ERA Details'. Below this, the title is 'ERA by Check Date - September 2025'. There is a dropdown menu for 'View Checks By:' set to 'Check Date', and buttons for 'Check Summary Report' and 'Show Month'. The main area is a calendar for September 2025. The calendar grid shows dates from 31st to 5th. The 1st and 3rd are highlighted in yellow. The 1st has a check link 'CHK-4' and the 3rd has a check link 'CHK-59'. Other dates are marked 'open'. Navigation arrows are present at the top of the calendar grid.

	S	M	T	W	T	F	S
31		1	2	3	4	5	6
open		open	open	open	open	open	open
36		CHK-4		CHK-59			
7		8	9	10	11	12	13
open		open	open	open	open	open	open
37							
14		15	16	17	18	19	20
open		open	open	open	open	open	open
38							
21		22	23	24	25	26	27
open		open	open	open	open	open	open
39							
28		29	30	1	2	3	4
open		open	open	open	open	open	open
40							
5		6	7	8	9	10	11
open		open	open	open	open	open	open
41							

Viewing Available Remittances

- ❑ Providers can view remittances based on the check number, payment amount, or payer.
- ❑ If they select a specific check number, the applicable remittances will populate.
- ❑ Select the Adobe icon next to the appropriate patient for the remittance to display.

The screenshot displays the 'My Remit Manager' web application. The main interface shows a 'Calendar > Check Detail' view with search filters for 'Start Date' (9/3/2025) and 'End Date' (9/3/2025). A table lists remittances with columns for 'Reco', 'Download', 'Check Number', 'Payment Method', 'Checkdate', 'Postdate', 'Billed', 'Paid', and 'Payer'. An Adobe icon is visible next to the 'Download' column for each row.

An inset window shows a detailed view of a selected remittance. It includes a 'Download Selected' button and a table with columns: 'Account', 'Patient', 'Payer Name', 'Payer ID', 'Status', 'Policy', 'DOS', 'Billed', and 'Paid'. The data in this table is as follows:

Account	Patient	Payer Name	Payer ID	Status	Policy	DOS	Billed	Paid
IMA1: 71	ALK	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD9	93	7/25/2025	\$48.00 \$6.30
IMA1: 21	ALC	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD1	02	7/21/2025	\$238.03 \$102.82
IMA1: 90	BRC	SC HEALTHYBLUE MEDICAID	403	Denied	ZCD1	17	8/26/2025	\$21.00 \$0.00
IMA1: 30	DAV	SC HEALTHYBLUE MEDICAID	403	Denied	ZCD9	67	8/21/2025	\$166.00 \$0.00
IMA1: 60	FAH	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD5	18	8/22/2025	\$70.00 \$19.14
IMA1: 40	FAH	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD5	18	8/22/2025	\$168.03 \$72.77
IMA1: 01	FRA	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD6	07	7/23/2025	\$238.00 \$102.79
IMA1: 00	JAC	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD0	19	8/20/2025	\$238.03 \$102.81
IMA1: 11	JOH	SC HEALTHYBLUE MEDICAID	403	Processed as Primary	ZCD8	01	7/22/2025	\$1,336.00 \$184.60
IMA1: 60	KAL	SC HEALTHYBLUE MEDICAID	403	Denied	ZCD9	43	8/21/2025	\$17.00 \$0.00

Example of Remittance

ERA Patient Listing

Electronic Reproduction ASC 005010X221A1

PH UNI AL GRP
A 14

ALI IFA
SC HEALTHYBLUE MEDICAID

CHECK/EFT: 001 100

CHECK DATE: 09/03/2025

Account: IMA1445923771 POS: 11 HIC: ZCD971 3 ICN: 5240097MD0000 Provider: 108 571004 8295641
Status: Processed as Primary

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary
571004971	07/25/2025	1		HC:36415	17.00				17.00	0.00	CO 45 17.00 HE N174
571004971	07/25/2025	1		HC:85025:QW	31.00	6.30			24.70	6.30	CO 45 24.70 HE N45
REMITTANCE SUMMARY					48.00	6.30	.00	.00	41.70	6.30	

TOTALS

Denied/Non-Covered: 0.00

CO 45 41.70 [Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).]
HE N45 [Payment based on authorized amount.]
HE N174 [This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group "PR".]

* Denotes Denied Or Non-covered Charges

REMITTANCE SUMMARY

Totals	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj	Paid
	48.00	6.30	.00	.00	41.70	.00	6.30

Cohere Health

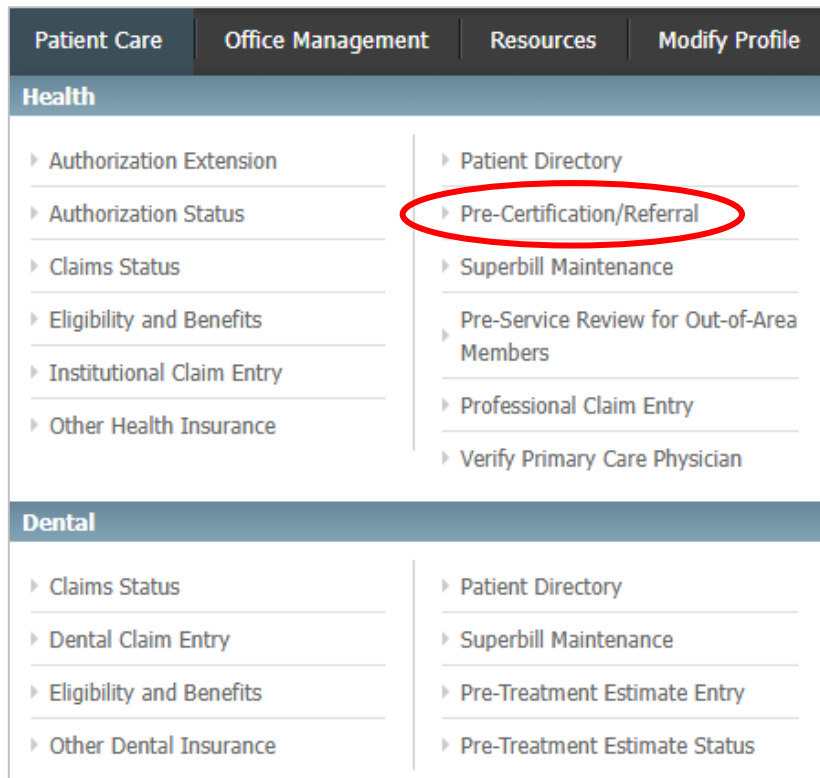


2026 Annual Provider Summit



How to Get an Authorization

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



Proceed to the Cohere Health

- ❑ You will be prompted to go to the Cohere Health platform to submit the prior authorization request.
- ❑ Medicare Advantage will begin going through the Cohere Health platform **Dec. 19, 2025.**

Medicare Advantage: View the prior authorization requirements exclusively for our Medicare Advantage plans [here](#).

Specialty Medical Benefit Management (SMBM) medication prior authorizations click [here](#).

 [Printer-Friendly](#)

Prior Authorization

We have enhanced the prior authorization experience!

We have partnered with Cohere Health[®] to integrate their intelligent prior authorization platform with our health plan's administrative rules, clinical policies, and expert clinical insights. This powerful combination allows for a faster, more efficient prior authorization experience, ensuring smoother operations and better outcomes. Our goal is an enhanced prior authorization submission process, that decreases administrative steps and accelerates approvals for our provider partners in our members.

The platform includes:

- Member eligibility verification
- Provider network verification
- Prior authorization requirements
- Verification of vendor managed codes
- Required medical record elements
- Expanded fast track approvals in real time fast track responses
- Clinical policy alignment
- Digital submission of medical records

More to come:

As we continue to enhance our use of this powerful tool, we plan to introduce additional features to further accelerate the prior authorization process, increase the availability of fast tracks, provide access to important documents, and much more.

[Go to Cohere Health[®]](#)

[Ask Health Care Services](#)

Cohere Health Landing Page

- ❑ 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 Cohere Health landing page for South Carolina. The page header includes the South Carolina logo, the text "powered by Cohere Health", and links for "Support" and "My account". A search bar is located at the top, and a "Start auth request" button is highlighted with a red circle. The main content area shows a list of authorizations for a patient named John Doe, with details for services, procedure codes, submission dates, and dates of service. The list includes entries for Physical Therapy, Speech Therapy, Myocardial Perfusion Imaging, and Physical Therapy.

Services	Procedure codes	Submission date	Dates of service
Physical Therapy, Speech Therapy	97110, 97112, 92507	05/15/2024 3:45 PM	06/15/2024 – 09/30/2024
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
Physical Therapy	97110	--	12/01/2022 – 03/01/2023

Cohere - Information About the Request

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

The screenshot shows a web form titled "Tell us about your request" for a user named "Doe, John" with a date of birth of "09/16/1986". The form is powered by "Cohere Health" and is associated with "South Carolina". It includes a "Support" link and a "My account" link. The form contains 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". A "Search for secondary diagnosis codes (optional)" field is empty.
- 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.

Cohere - Provider Details

- ❑ 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***.

Providers

Care setting

Outpatient Inpatient

Place of service ▼

Ordering provider

Search for an ordering provider by NPI, TIN, or name 🔍 TIN 🔍 Address

+ Bailey, Christopher Eric MD

Performing or attending provider

Performing is the same as the ordering

Search for a performing or attending provider by NPI, TIN, or name 🔍 TIN 🔍 Address

+ Bailey, Christopher Eric MD

Performing facility or agency

Search for a performing facility or agency by NPI, TIN, or name 🔍 TIN 🔍 Address

+ 1ST START HEALTHCARE SERVICES

[Save and exit](#)

Cohere - Determination of Authorization Requirements

- ❑ 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 displays a web interface for determining authorization requirements. 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 interface is divided into two main sections. The first section is titled "Physical Therapy (PT)" and contains a "Number of visits" input field with the value "1". Below this 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 blue plus icon and the text "Add a procedure code" below the code.

The second section is titled "Total Knee Arthroplasty (TKA)" and contains a procedure code "27447" with the description "Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)". There is a "Units" input field with the value "1" and a "Remove" button with a trash icon to the right of the code. Below the code is a blue plus icon and the text "Add a procedure code".

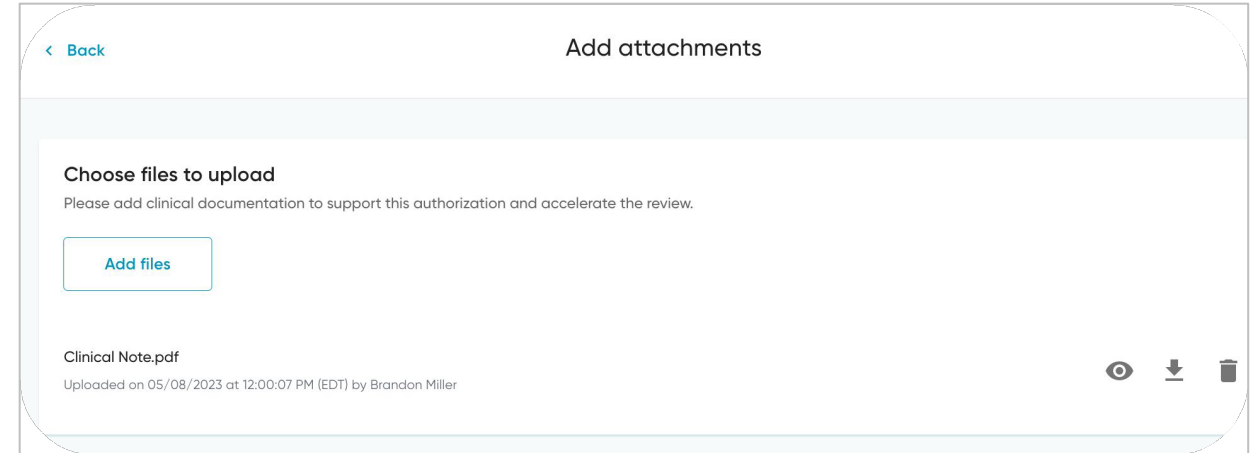
At the bottom of the form, there is a checkbox labeled "Expedite". Below the form, there is a section with a warning icon and the text "Doesn't require authorization in most cases" next to the code "93798". To the right of this section is a "Download PDF" button with a dropdown arrow.

At the bottom of the interface, 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.

Cohere - Clinical Documentation

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



Cohere - Submitting Request

- ❑ 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](#)

Cohere - Notification

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

South Carolina | powered by Cohere Health

Your request has been approved

Tracking #: **NPOA6057**
Dates of service: **06/01/2024 - 09/30/2024**

Hello <user's name>,

Thank you for submitting a service request. We have reviewed your request and it has been approved. Please see the decision (including the authorization number) below.

[View service summary](#)

South Carolina | powered by Cohere Health

From: **Cohere Health** | Date requested: **05/01/2024** | [Response](#)

We have finished processing your service request

To review the status of your request please go online to next.coherehealth.com/check_status

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 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.

Cohere - Service Summary

- ❑ 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

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

Cohere - Patient Summary

- 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 the 'Patient summary' page for John Doe. The patient's personal information is listed on the left, including sex (Male), DOB (01/26/1965), address (420 Harvard St., #301 Brookline, MA), phone ((617) 283-4909), preferred language (English), PCP grouper ID (918401720), plan (BCBS South Carolina), membership type (Commercial), plan type (HMO), and plan year (04/24/2024 - 04/24/2025). The main content area shows a summary for 'Spinal Fusion and Decompression', which is marked as 'Approved' with authorization #NPOA6057. A 'Details' section lists primary and secondary diagnoses, care setting (Outpatient), place of service (Ambulatory Surgical Center), ordering provider (Bailey, Christopher Eric MD), performing facility (Peachtree Orthopaedic Surgery Center), and dates of service (06/01/2024 - 09/30/2024). A table under 'Spinal Fusion and Decompression' shows one approved unit with code 63047. An 'Attachments' section includes a PDF file named 'DoeJohn_ClinicalNote.pdf' uploaded on 05/01/2024. The page also shows the requester (Connor Feick) and 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 [View info](#)

Performing or attending provider Bailey, Christopher Eric MD / NPI - 1861781510 [View info](#)

Performing facility or agency Peachtree Orthopaedic Surgery Center / NPI - 1902861941 [View info](#)

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 [View info](#) Withdraw

My Provider Enrollment Portal



2026 Annual Provider Summit



Overview of Portal

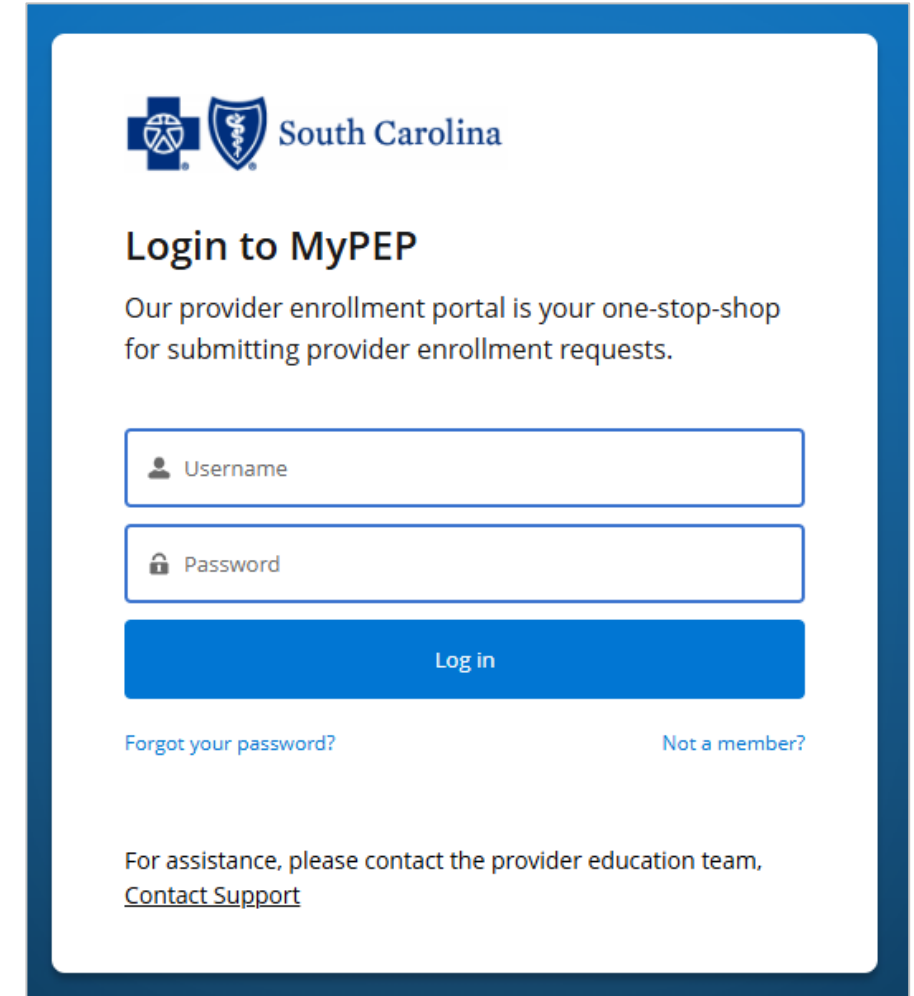


2026 Annual Provider Summit



Getting Started with My Provider Enrollment Portal


- ❑ Visit www.SouthCarolinaBlues.com.
 - Providers>Provider Enrollment>**Join Our Networks**
- ❑ Username format: **email.firstname.lastname**
- ❑ New users should select Not a member from the landing page of the portal.



The screenshot shows the login interface for the MyPEP portal. At the top left, there are two logos: a blue cross with a white circle inside, and a blue shield with a white caduceus. To the right of these logos is the text "South Carolina". Below the logos, the heading "Login to MyPEP" is displayed. Underneath the heading is a paragraph: "Our provider enrollment portal is your one-stop-shop for submitting provider enrollment requests." There are two input fields: the first is labeled "Username" with a person icon, and the second is labeled "Password" with a lock icon. Below these fields is a blue "Log in" button. At the bottom of the form area, there are two links: "Forgot your password?" on the left and "Not a member?" on the right. At the very bottom of the page, there is a line of text: "For assistance, please contact the provider education team, [Contact Support](#)".

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...

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 - Started Applications

Applications
 **My Started Applications** ▾

13 items • Sorted by Application Type • Filtered by My applications - Application Status



Application Type ↑	Application Status ▾	NPI Type I ▾	NPI Type II ▾	Resume Application ▾	Created Date ▾	▾
1	In Progress				3/31/2025, 7:28 AM	▾
2	In Progress				4/2/2025, 10:13 AM	▾
3	In Progress				4/29/2025, 8:45 AM	▾
4	Individual	In Progress			3/26/2025, 7:56 AM	▾
5	Individual	In Progress		Resume	4/2/2025, 10:30 AM	▾
6	Individual	In Progress		Resume	4/29/2025, 8:35 AM	▾
7	Individual	In Progress		Resume	5/9/2025, 9:19 AM	▾
8	Individual	In Progress	1555555555	Resume	6/23/2025, 7:42 AM	▾
9	Individual	In Progress	1777777777	Resume	7/1/2025, 7:06 AM	▾
10	Satellite Location	In Progress		Resume	6/19/2025, 5:23 AM	▾

My Provider Enrollment Portal - In-Progress Applications

My In-Progress Applications ▾

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



	Case Number ↑ ▾	Type ▾	Provider ▾	Status ▾	Date/Time Opened ▾	
1	00031578	Group	Aesthetic Smiles of Myrtle Beach	Signed	3/31/2025, 7:37 AM	▾
2	00031581	Individual	Terrence Archie - MAGNOLIA ENDOCRINOLOGY LLC	Submitted	3/31/2025, 8:02 AM	▾
3	00031583	Virtual Care	MAGNOLIA ENDOCRINOLOGY LLC	Signed	3/31/2025, 8:29 AM	▾
4	00031584	Change of Address		Signed	3/31/2025, 8:36 AM	▾
5	00031585	Request to Add Practitioner	DAVID YOUNIE - FLOSSY PEDIATRIC DENTISTRY	Submitted	3/31/2025, 8:52 AM	▾
6	00031590	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	3/31/2025, 10:40 AM	▾
7	00031612	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	4/1/2025, 8:05 AM	▾
8	00031614	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	4/1/2025, 8:12 AM	▾
9	00031664	Request to Term Practitioner	TIMOTHY KAYLOR - ZONE PHYSICAL THERAPY	Submitted	4/2/2025, 5:18 AM	▾
10	00031668	Business Name Change	Provider Relations LLC	Submitted	4/2/2025, 5:53 AM	▾

My Provider Enrollment Portal - Applications Needing Action

My Applications Requiring Action ▾

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

Case Number ↑	Type	Provider	Status	Date/Time Opened
1 00031578	Group	Aest	✓ ✓ ✓ Signed Secondary review Final review Approved Denied Cancelled Withdrawn	
2 00031583	Virtual Care	MAC		

Case #00031578 - Group Application

Provider: Aesthetic Smiles of Myrtle Beach | Status: Signed

Application Type: Group | Case Reference Number: Case #00031578

Case Contact: Kristen Ward - Provider Relations LLC

Requested Networks

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
South Carolina - Missing	Missing	Re-open application, correct & re-submit.

Case Comments (2) New

User	Public	Created Da...	Comment
User173...	<input checked="" type="checkbox"/>	3/31/2025, ...	Action Item - Name: South Carolina - Missing, Status: Open, Issue: Missing
User173...	<input checked="" type="checkbox"/>	3/31/2025, ...	Please add at least one provider to this location by using the Add Practitioner function when you relaunch the application. Thank you

[View All](#)

Open Agreements

My Provider Enrollment Portal - Closed Applications

My Closed Applications ▾

1 item • Sorted by Case Number • Filtered by All cases - Closed, Case Record Type • Updated a few seconds ago



	Case Number ↑	Subject ▾	Status ▾	Provider ▾	
1	00032461	R. DASILVA - Request to Term Practitioner	Approved	ROBERT DASILVA - MIDLANDS ORTHOPAEDICS & NEUROSURGERY PA	▾

My Provider Enrollment Portal - Enroll Page

South Carolina

Search...

Home Applications ▾ Enroll Maintenance Support

Bravo ▾

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? 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 Application

COMING SOON

To request a Facility Application, please submit a support case.

South Carolina

My Provider Enrollment Portal - Maintenance Page

The screenshot shows the top navigation bar of the My Provider Enrollment Portal. On the left is the South Carolina logo. In the center is a search bar. On the right is a user profile icon labeled 'Bravo'. Below the navigation bar is a main banner with the 'My Provider Enrollment Portal' logo and the tagline 'Your enrollment essentials, all in one place.' Below the banner is a navigation menu with links for Home, Applications, Enroll, Maintenance (which is highlighted), and Support.

Maintenance

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

Maintain a Practice

Find all you need to maintain a group / healthcare entity's networks, locations, and business information.

A grid of six maintenance options for a practice, each with an icon and a brief description:

- Add a network**: Request to add a new network to your existing enrollment with BCBS-SC. Expand your services by joining additional networks within the BCBS-SC system.
- Add a satellite location**: Add a new satellite location to your profile to expand your services.
- Change of address**: Update your location, billing, mailing/correspondence address. You will receive all correspondence at this address.
- Request to add practitioner to practice/location**: Request to add a practitioner's association with your clinic, group, professional association, or institution.
- Request new network for practitioner**: For an enrolled practitioner, request to add a new network.
- Remove a practitioner from practice**: Remove a practitioner's association with your clinic, group, professional association or institution.

Maintain a Group's Practitioner

For enrolled practitioners and enrolled groups, update requests are easy. With the group's Tax Id Number (TIN) and the practitioner's NPI (type I individual) you will be able to add a practitioner to the group and the practice and/or location, add a network, and also remove a practitioner from the practice and/or location.

A grid of three maintenance options for a group's practitioner, each with an icon and a brief description:

- Request to add practitioner to practice/location**: Request to add a practitioner's association with your clinic, group, professional association, or institution.
- Request new network for practitioner**: For an enrolled practitioner, request to add a new network.
- Remove a practitioner from practice**: Remove a practitioner's association with your clinic, group, professional association or institution.

[Back Home](#)

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

Completing Clean Applications

Steps to Submitting a Clean Application

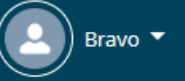
1. Complete the enrollment application inside the portal.
2. Sign the application and agreements ***electronically***.
 - The documents that must be signed will be sent to the appropriate parties included on the application.
 - **It is important to include the correct email addresses for each individual (i.e., provider, fiduciary contact, etc.)**
 - 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.



Search...



Home Applications ▾ Enroll Maintenance Support

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

Let's Get Started

View our application checklist below to enroll a Practitioner with their Individual Practice. When you are ready, click *Next* to begin.

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.

Next

Example of an Individual Enrollment Application (Continued)


Steps

- 1 Let's Get Started
- 2 **Group / Provider Look-Up**
Network pre-qualifications
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Group / Provider Look-Up

We need provider identifiers to search and identify if the practitioner and/or practice is already enrolled with BCBS-SC. For practitioners, we take the NPI number (type I individual); for practices, we take the Tax Id Number (TIN) and the NPI number (type II organization).

 You Need to enter either Taxid or NPI Type II to proceed

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.

IMPORTANT NOTE - CRITICAL DATA ELEMENTS: Ensure that you enter the correct Tax ID and NPI. These fields **CANNOT** be updated/corrected once submitted, if entered incorrectly this case will be cancelled and you will be required to start a new Individual Application.

Tax Id Number (TIN)

NPI Number (type II group)

This practitioner is a solo practitioner filing claims with only one NPI.

Practitioner information

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

* NPI Number (type I individual)



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)

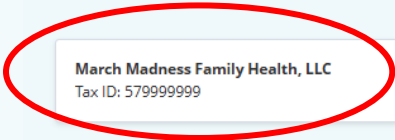
This script has been automatically saved, in order to resume in the future: Copy the link or Email me the link


Search results

Practice found

Based on the TIN you entered, please select the corresponding Legal Business below and click 'Next' to continue.

March Madness Family Health, LLC Tax ID: 579999999
--



 Select before proceeding

Steps

- Let's Get Started
- Group / Provider Look-Up**
[Search results](#)
Network pre-qualifications
- Network selection
- Practitioner Information
- Licenses and Professional Certifications
- Location Details
- Practice Locations
- Review Your Application
- Submit

This script has been automatically saved, in order to resume in the future: Copy the link or Email me the link

Search results

Practice not found

We did not find a practice based on the Tax Id Number (TIN) and/or NPI (type II organization) you entered. Click 'Next' to continue with your Individual Application.

Please Note: Upon completion of this Individual Application, you must also complete a separate Group Application via the portal to complete the overall individual enrollment process.

If you need assistance with this process, please reach out to MyPep.Portal@BCBSSC.COM.

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](#)

View when practice is found.

View when practice is not found.

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
Search results
[Network pre-qualifications](#)
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Network pre-qualifications

Care Taxonomy

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.

Speciality Code

- 207Q00000X - Family Medicine Physician
- 106H00000X - Marriage & Family Therapist
- 364SP0810X - Child & Family Psychiatric/Mental Health Clinical Nurse Specialist
- 364SF0001X - Family Health Clinical Nurse Specialist
- 207VC0300X - Complex Family Planning Physician
- 207QA0000X - Adolescent Medicine (Family Medicine) Physician
- 207QA0401X - Addiction Medicine (Family Medicine) Physician
- 207QB0002X - Obesity Medicine (Family Medicine) Physician
- 207QG0300X - Geriatric Medicine (Family Medicine) Physician
- 207QH0002X - Hospice and Palliative Medicine (Family Medicine) Physician
- 207OS0010X - Sports Medicine (Family Medicine) Physician



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
- 2 Group / Provider Look-Up
- 3 **Network selection**
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Network selection

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

* Available Networks

BlueChoice
HealthPlan

Blue Options

Preferred Blue

Blue Essentials

State Health
Plan

Healthy Blue

Medicare
Advantage

Error: Available Networks is required.

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.

Example of an Individual Enrollment Application (Continued)

Steps








- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 **Practitioner Information**
Practitioner information
Professional qualifications
Educational History & Training
Employment history
Hospital privileges
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

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 for the provider is required.*
-  **Demographic Information**
Provider demographic information such as name, date of birth, NPI, social security number, gender, ethnicity, etc. will be asked and an answer required.
-  **Professional qualifications**
The practitioners care specialty, state medical license, board certifications, DEA** are all required. Provider's individual Medicaid Number.***
-  **Malpractice**
Certificate of Insurance for the effective date to current coverage period are required.
-  **Employment**
Current employer and previous employers' 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 MDs, DOs, and DPMs to provide their residency information.
-  **Signatures**
The provider will be required to sign all contracts, Authorization to bill, Hold Harmless*, Attestation of the accuracy of the application information. Office Representative will be required to sign the Representative portion of the Authorization to bill.

Example of an Individual Enrollment Application (Continued)

Steps

- Let's Get Started
- Group / Provider Look-Up
- Network selection
- Practitioner Information**
 - Practitioner information
 - Professional qualifications
 - Educational History & Training
 - Employment history
 - Hospital privileges
- Licenses and Professional Certifications
- Location Details
- Practice Locations
- Review Your Application
- Submit

This Omniscript is saved automatically. To resume the Omniscript later, Copy the link or Email me the link

Practitioner 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" value="MD"/>	<input type="text"/>	<input type="text"/>
*Social Security Number	*Date of Birth	Tax Id
<input type="text" value="000-11-0000"/>	<input type="text" value="07-13-1970"/>	<input type="text" value="579999999"/>
NPI Group	*NPI Number (type I individual)	Medicaid ID
<input type="text" value="122222222"/>	<input type="text" value="133333333"/>	<input type="text"/>
Medicare Number	*Provider Type	*Professional Designation
<input type="text"/>	<input type="text" value="Primary Care"/>	<input type="text" value="MD - Medical Doctor"/>

Preferred Email

Please provide the practitioner's preferred email so that they will be able to sign their application package. This is required as we cannot process your case without the practitioner's email.

* Practitioner's Email

Demographic information

Please provide all required demographic information, including full name, date of birth, NPI, Social Security number, and other relevant information, as requested. Gender, race, ethnicity, and languages spoken are optional. If you prefer not to answer optional questions, you may select "Declined to Answer" or "Unknown", where applicable. Additional spoken languages will be published in the provider directory to help members select providers who meet their language needs.

* Gender	* Race	* Ethnicity
<input type="text" value="Male"/>	<input type="text" value="Black or African American"/>	<input type="text" value="Declined to Answer"/>

Languages

Language(s) Spoken (other than English)- 1	Language(s) Spoken (other than English)- 2
<input type="text"/>	<input type="text"/>

Authorization to bill

Please confirm the effective date of this authorization. The Authorization to Bill date marks when the group will begin billing for services on behalf of the practitioner. It should coincide with the practitioner's start date at the group practice.

* Auth to Bill Effective Date

[Save for later](#) [Previous](#) [Next](#)

Note: You must enter the practitioner's email address. It cannot be the email address for the practice or anyone else.

Example of an Individual Enrollment Application (Continued)

Steps

- Let's Get Started
- Group / Provider Look-Up
- Network selection
- Practitioner Information**
 - Practitioner information
 - Professional qualifications**
 - Educational History & Training
 - Employment history
 - Hospital privileges
- Licenses and Professional Certifications
- Location Details
- Practice Locations
- Review Your Application
- Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

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 Taxonomy
207Q00000X - Family Medicine Physician

Secondary Taxonomy

Do you wish to be listed in our provider directory with a specialty that is different from your primary taxonomy?
 Yes No

State Medical License

Enter all state medical license details, including the issue date and expiration date. Autism providers, please enter your c

* Professional Designation MD - Medical Doctor	* Provider's License Type State Medical License	* License Number ABC1234
* State South Carolina	* Issue Date 01-13-2020	* Expiration Date 12-31-2025
* License Status Active		

Upload Document

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)

Steps


- Let's Get Started
- Group / Provider Look-Up
- Network selection
- Practitioner Information**
 - Practitioner Information
 - Professional qualifications
 - Educational History & Training**
 - Employment history
 - Hospital privileges
- Licenses and Professional Certifications
- Location Details
- Practice Locations
- Review Your Application
- Submit

This script has been automatically saved, in order to resume in the future: Copy the link or Email me the link

Educational History & Training

Educational History

Please provide detailed information about your educational history, including degrees earned, institutions attended, and date of completion, to your academic qualifications.



What determines a full educational history?
Please be sure to include the institution where the practitioner received their most advanced medical education. If you have less than 5 years of employment history, include additional educational history to provide a complete picture of the practitioner's professional timeline.

* Educational Level	* Institution Name	* Please Specify Institution Name.
Medical School	OTHER	USC
* Degree Type	* Start Month	* Year
MD - DOCTOR OF MEDICINE	January	2010
* End Month	* Year	* Country
November	2016	United States
* City	State	
Columbia	South Carolina	

Degree Conferred

Individual asserts they have completed their education and holds the qualifications associated with that degree

Professional Training

If the practitioner has completed an internship, fellowship or residency, please update the selection from the dropdown provided and enter detail for this professional training. You may add additional entries / remove entries.

Add Trainings [Add Additional Training](#)

Training

* Training Type	* Institution Name
Professional Training	USC
* Program Name	City
Residency	Columbia
Country	State
United States	South Carolina

I am actively taking this training/program

* Start Date	* End Date
02-01-2016	12-31-2018

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 <https://thinkculturalhealth.hhs.gov/>

[Save for later](#) [Previous](#) [Next](#)

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 **Practitioner Information**
 - Practitioner information
 - Professional qualifications
 - Educational History & Training
 - Employment history**
 - Hospital privileges
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

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

Delete

[Add Additional 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.

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 **Practitioner Information**
Practitioner information
Professional qualifications
Educational History & Training
Employment history
[Hospital privileges](#)
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Hospital privileges

Hospital Privilege Information

Do you have privileges at any hospital facility?

Yes No

* Describe arrangements for hospital care:

Refer the patient to the nearest facility.

[Save for later](#)

[Previous](#)

[Next](#)

Note: Hospital privileges are based on admitting privileges.

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 **Licenses and Professional Certifications**
Speciality Board Certification
Malpractice Insurance
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Licenses and Professional Certifications

This next section will collect applicable requirements, including board certification, DEA license, and malpractice insurance.

[Save for later](#)

[Previous](#)

[Next](#)

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
 - [Speciality Board Certification](#)
 - Malpractice Insurance
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Speciality Board Certification

Providers who hold multiple board certifications should enter their primary certification details and upload copies of all certifications.

*** 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)

This Omniscrypt is saved automatically. To resume the Omniscrypt later, Copy the link or Email me the link

Malpractice Insurance

[Add Additional Insurance](#)

* Effective Date	01-01-2025	* Expiration Date	01-01-2026
* Coverage Amount (Each Occurrence)	\$1 million	* Coverage Amount (Aggregate)	\$3 million
* Carrier's Name	Cover Me	* Policy Number	911
* Country	United States	* Street	1500 Hampton St
* City	Columbia	* State	South Carolina
* Zip/Postal Code	29201		

Upload Document

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

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 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 **Licenses and Professional Certifications**
 - Speciality Board Certification
 - Malpractice Insurance
 - [Federal DEA license](#)
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Federal DEA license

Does this practitioner hold a DEA certification?

Yes No N/A

* License #

ABC987

* Issue Date

01-01-2020

* ExpirationDate

12-31-2025

* License Status

Active

Upload Document



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 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Location Details

A primary and additional locations can be added to this application. (Up to 5 per application).

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. Make sure to have your phone number available for these addresses as well.



Location contacts

Identify the office contacts for this location for credentialing, claims, billing, and others.



Clinical Laboratory Improvement Amendment

If you are CLIA certified, please submit a copy of the certification for each location listed on this application.

> [What is a primary location?](#)

[Save for later](#)

[Previous](#)

[Next](#)

Example of an Individual Enrollment Application (Continued)

This Omniscrypt is saved automatically. To resume the Omniscrypt later, Copy the link or Email me the link

Practice Locations

Primary location information
Your primary location is your main hub of operation

* Office practice name
March Madness

* Group Tax Id Number (TIN)
57-9999999

* Group NPI #
133333333

* Does this provider see patients at this location?
 Yes No

* If yes, do they accept new patients at this location?
 Yes No

* Do you accept Medicaid patients?
 Yes No

* Do you offer Sign Language?
 Yes No

* Do you provide a translation service?
No

Patient Population

* Are there patient gender restrictions?
 Yes No

* Are there patient age limitations?
 Yes No

* Do you have any other patient limitations?
 Yes No

Physical Address
This is the physical address for your primary location; it is not a P.O. box.
Should the Provider display in the Directory at this location?
 Yes No

* Street Address
123 Ohio St

* City
Columbia

* State
South Carolina

* County
Richland

* Zip Code
29202-

* Appointment Phone
(803) 555-1234

After Hours Phone

Fax

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 additional roles.

* First Name
Kyle

* Last Name
Barker

* Phone
(803)

* Email
mmadness@help.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

Billing Contact
 The Billing Contact is the same as the Office contact.

Correspondence Address
 The Correspondence Address is the same as the Physical Address.

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

Save for later

Previous Next

Example of an Individual Enrollment Application (Continued)

Steps

- 1 Let's Get Started
- 2 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Review Your Application

You are almost ready to submit this enrollment request!

If document upload sections appear below, please upload all required files before clicking "**Next**" to submit your application.
If no upload sections are shown, simply click "**Next**" to proceed to the final step and submit your application.

[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 Group / Provider Look-Up
- 3 Network selection
- 4 Practitioner Information
- 5 Licenses and Professional Certifications
- 6 Location Details
- 7 Practice Locations
- 8 Review Your Application
- 9 Submit

This script has been automatically saved, in order to resume in the future: [Copy the link](#) or [Email me the link](#)

Submit

[Save for later](#)

[Previous](#)

[Submit Application](#)

Example of an Individual Enrollment Application (Continued)

Submitted Preliminary review Awaiting signature Signed Secondary review Final review Approved Denied Cancelled Withdrawn

Case #00032921 - Individual Application

Provider Jason Doe - March Madness Family Health	Status Submitted
Application Type Individual	Case Reference Number Case #00032921
	Case Contact Kristen Ward - Provider Relations LLC

Requested Networks
Blue Essentials;BlueChoice HealthPlan;Medicare Advantage;Preferred Blue

No action required at this time.

Case Comments (0) [New](#)

Open Agreements

Files (0) [Add Files](#)

[Upload Files](#)

Or drop files

Making Corrections to Applications

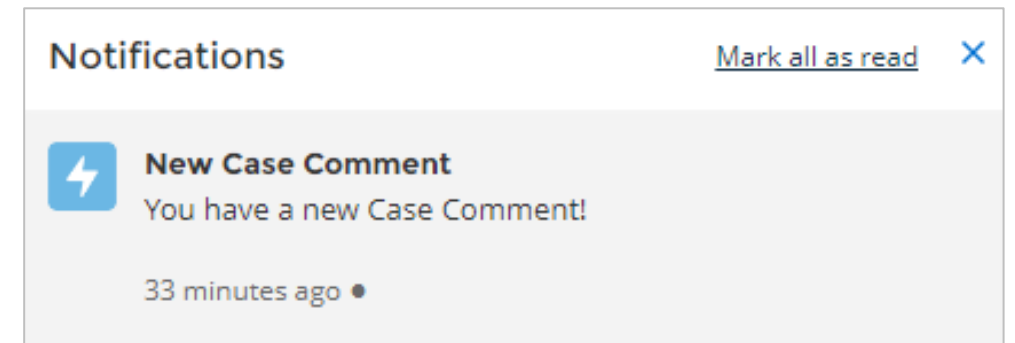
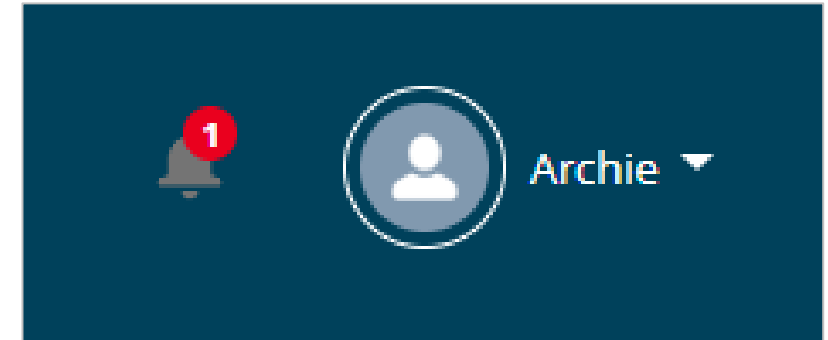


2026 Annual Provider Summit



Correcting Applications

- ❑ Currently, corrections can only be made to group or individual enrollment applications.
 - Corrections cannot be made to maintenance applications.
 - If an error or mistake is made after submission, a case comment must be made on the current case requesting to have it canceled, and a new maintenance application must be submitted.
- ❑ If items are missing or corrections are needed for an application, you will see a notification once you log into the portal.
- ❑ After selecting the notification bell, you will see that there is a new case comment for you to review.
- ❑ All corrections must be made in the portal.
 - 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](#)

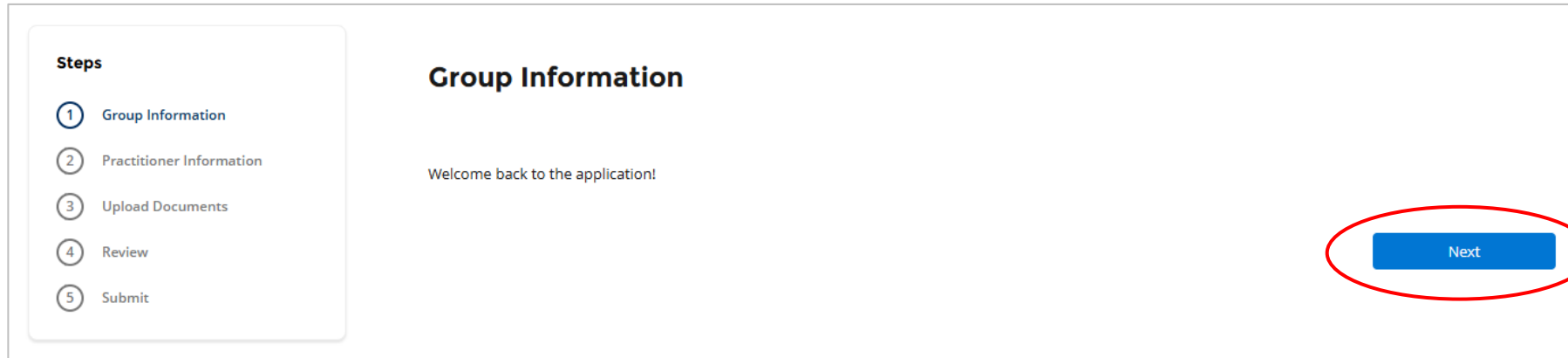
Action Items

1 of 1 item

Action Item Name	Issue	Next steps
Signer - Missing	Missing	Re-open application, correct & re-submit.

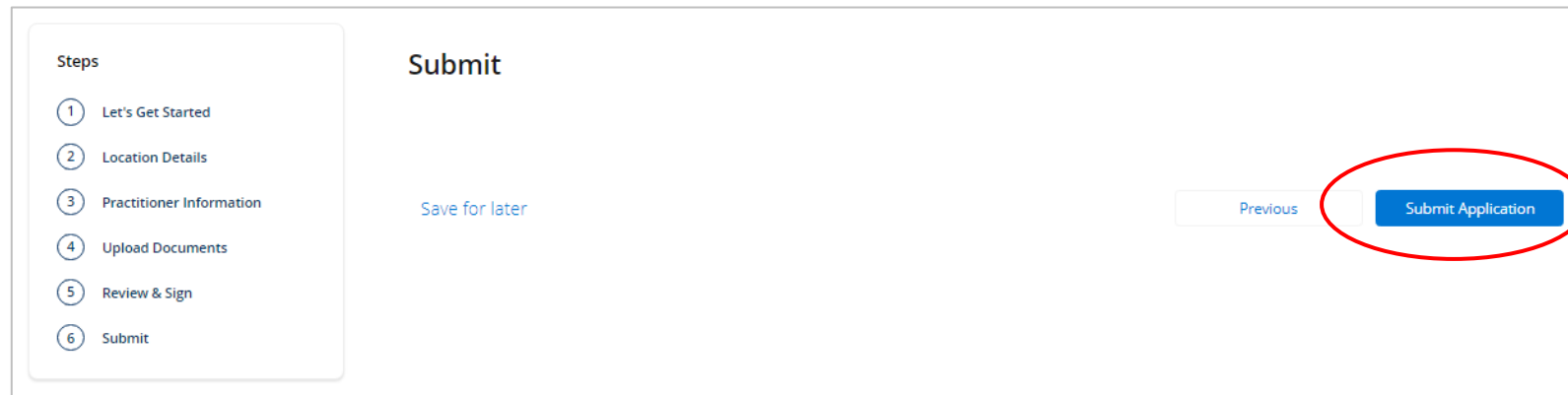
Steps for Making Corrections (Continued)

- ❑ You'll see the "Welcome back" message.
- ❑ Select **Next** to begin the process.



The screenshot shows a web interface for the 'Group Information' step. On the left, a 'Steps' sidebar lists five steps: 1. Group Information (highlighted with a blue circle), 2. Practitioner Information, 3. Upload Documents, 4. Review, and 5. Submit. The main content area is titled 'Group Information' and contains the text 'Welcome back to the application!'. At the bottom right, there is a blue button labeled 'Next', which is circled in red.

- ❑ Once all the necessary corrections are made, resubmit the case.



The screenshot shows a web interface for the 'Submit' step. On the left, a 'Steps' sidebar lists six steps: 1. Let's Get Started, 2. Location Details, 3. Practitioner Information, 4. Upload Documents, 5. Review & Sign, and 6. Submit (highlighted with a blue circle). The main content area is titled 'Submit' and 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, both of which are circled in red.

Thank you!