Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual – Filing Claims - General Information

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health**. These specific requirements will be noted with the plan/network name. If a plan/network name is not specifically listed or the "**Plan**" is referenced, the information will apply to **all** HMO products.

THIS SECTION CONTAINS REQUIRED DISCLOSURES CONCERNING CLAIMS PROCESSING PROCEDURES

In this Section

The following topics are covered in this section:

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Claims Filing Overview	In this section, Blue Cross and Blue Shield of Texas (BCBSTX) will assist providers with basics regarding filing claims including timely filing and who to contact with questions.
Behavioral Health Note	**For information about behavioral health claims filing, refer to the "Behavioral Health" Section in the Provider Manual**
Capitated Medical Group - Important Note	Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and prior authorization processes, contracting, and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/affiliated with a capitated Medical Group are subject to that entity's procedures and requirements for the **Plan**'s provider complaint resolution.
Clinical Payment and Coding Policy	BCBSTX provides **Clinical Payment and Coding Policies** which are based on criteria developed using healthcare professionals and industry standard guidelines. Additional sources are used and can be provided upon request. The clinical payment and coding guidelines are not intended to provide billing or coding advice but to serve as a reference for facilities and providers. Refer to the Clinical Payment and Coding Policies under Standards and Requirements on the provider website to review the policies
Provider Tools	We have designed useful tools for health care providers whether doing research or streamlining billing. These tools can help evaluate costs, save time, improve service and more. Refer to the Provider Tools page on the provider website for more information.

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How to File Claims

Providers are encouraged to submit claims electronically using Availity® or their preferred vendor. Refer to Electronic Commerce on the provider website for information on submitting claims electronically. The BCBSTX electronic payor ID code is 84980.

Should you have a question about claims processing, as the first point of contact, call your electronic connectivity vendors, e.g., Availity® or contact the **Plan's** Provider Customer Service:

Blue Essentials: 1–877-299-2377
Blue Advantage HMO: 1–800-451-0287
Blue Premier: 1–800-876-2583
MyBlue Health: 1-800-451-0287

Timely Filing Procedures

The **Plan** claims must be submitted within **180** days of the date of service (DOS). For institutional claims, the timely filing period begins as of the DOS listed in the "Through" field of the "Statement Covers Period" of the UB-04. For professional claims, the filing period begins on the date service was rendered unless otherwise indicated by the provider contract and/or subscriber's health benefit plan. **Plan** health care providers must submit a complete claim for any services provided to a member. Claims that are not submitted within **180** days from the date of service are not eligible for reimbursement. Claims submitted after the designated cut-off date will be denied on a Provider Claim Summary (PCS).

The member cannot be billed for these denied services. The **Plan's** health care providers may not seek payment from the member.

Please ensure that statements are not sent to **Plan** members, in accordance with the provisions of your **Plan's** contract.

Corrected claims must be filed with the appropriate bill type and filed according to the claims filing deadline as listed in this manual or in the subscriber's contract. If a provider is unable to submit the corrected claim electronically, they must submit the paper claim with a Corrected Claim Form which can be found on the provider website under **Forms** in the **Education and Reference** menu.

If a health care provider feels that a claim has been denied in error for untimely submission, the health care provider may submit a request for claim review. Refer to the Claim Review Form and instructions.

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Timely Filing Procedures, cont.

If a claim is returned to the health care provider of service for additional information, it should be resubmitted to BCBSTX within 90 days. The 90 days begin with the date BCBSTX mails the request. The claim should be returned with the letter received or with an Additional Information Form which can be found on the provider website under **Forms** in the **Education and Reference** menu.

Provider Demographic Changes

Report changes immediately – to your name, telephone number, address, NPI number(s), specialty type or group practice, etc.

1) To submit changes directly to BCBSTX by email, go to bcbstx.com/provider and click on the **Network Participation** tab, then scroll down to – Update Your Information – and complete/submit the **Demographic Change Form**, or
2) Contacting your Network Management Office. For more detailed information, refer to Section A of this manual.

Please report all changes **30** to **45** days in advance of the effective date of the change, otherwise, these changes will not become effective until **30** to **60** days in from the date BCBSTX receives written notification.

Keeping BCBSTX informed of any changes allows for appropriate claims processing, as well as maintaining each **Plan's** Provider Directory with current and accurate information.

Addresses for Claims Filing & Customer Service Phone Numbers

The member's Identification (ID) card provides claims filing and customer service information. If in doubt, please call the **Plan's** Provider Customer Service at the numbers listed below. Although the submission of claims electronically is the preferred method, when a paper claim is submitted, use the appropriate address indicated below:

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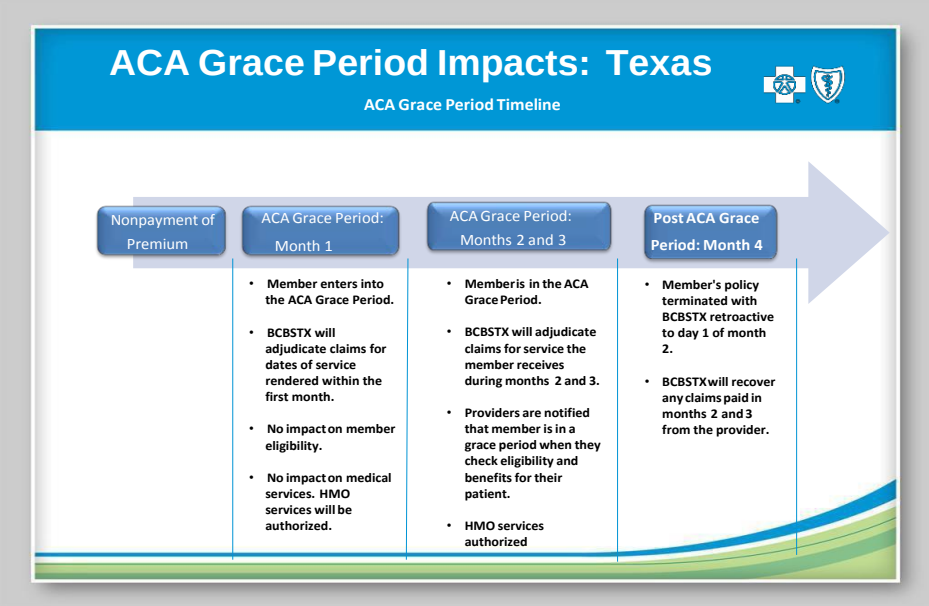
Addresses for Claims Filing & Customer Service Phone Numbers, cont.

Plan / Group	Claims Filing Address
Blue Essentials: 1-877-299-2377 **Blue Advantage HMO: 1-800-451-0287** **Blue Premier: 1-800-876-2583** **MyBlue Health - 1-800-451-0287**	P.O. Box 660044 Dallas, TX 75266-0044
BCBSTX Employees and Dependents: 1-888-662-2395	P.O. Box 660044 Dallas, TX 75266-0044

Blue Advantage HMO Only Grace Period

The **Affordable Care Act (ACA)** includes a provision that gives Health Insurance Marketplace members who receive **advanced premium tax credits (APTC**) also known as subsidies, a three-month grace period to pay their premium



Blue Essentials Only Grace Period

The standard **30**-day grace period will apply for enrollees.

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Filing Claims Reminders

- BCBSTX will not accept any screen prints sent by physicians or professional providers that have been generated on the health care provider's system.
- All **Plan** health care providers are required to use their applicable NPI number when filing **Plan** claims.
- If the **Plan** member gives a **Plan** health care provider the wrong insurance information, the **Plan** health care provider must submit the EOB *(Explanation of Benefits)* from the other insurance carrier. This information must reflect timely filing and the **Plan** health care provider must submit the claim to BCBSTX within **180** days from the date a response is received from the other insurance carrier.