The BlueCard® Program

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

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

How to submit questions:

- Open the chat feature at the bottom of your screen to type your question related to today's training webinar.
- In the "Send to" field, select "All Panelists."
- Once your question is typed in, hit the "Send" button to send it to the presenter.
- We will address submitted questions at the end of the webinar.

The BlueCard® Program

Presented by:

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Provider Relations,

Blue Cross and Blue Shield of Louisiana

October 2021

What is the BlueCard Program?

- A national program that enables members of one Blue Cross and Blue Shield (BCBS) plan to obtain in-network healthcare services while traveling or living in another BCBS Plan service area.

- Linking participating healthcare providers with other Blue Plans across the country, and in more than 200 countries and territories worldwide, through a single electronic network for professional, outpatient and inpatient claims processing and reimbursement.

- Members have access to participating doctors and hospitals worldwide.

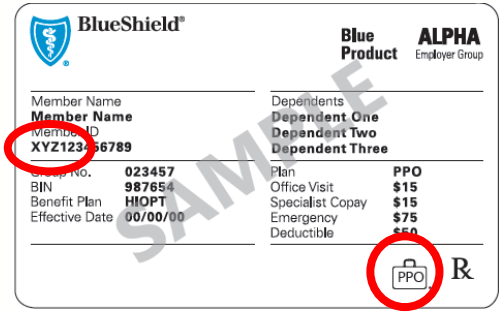
DID YOU KNOW?

More than 400,000 members from other Blue Plans reside in Louisiana.

How the BlueCard Program Works

Example

An Out-of-Area (OOA) Blue member with BlueCross BlueShield of Mississippi (BCBSMS) benefits lives in Louisiana and visits a Blue Cross and Blue Shield of Louisiana Preferred Care PPO network provider.



Louisiana provider recognizes the logo on the member ID card and verifies membership and coverage using iLinkBlue or by calling the BlueCard Eligibility Line.

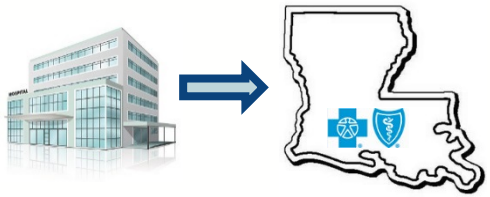
ilinkBlue

www.BCBSLA.com/ilinkblue

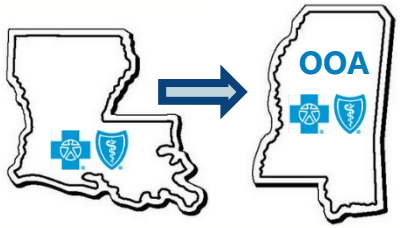
BlueCard Eligibility Line
1-800-676-BLUE
(1-800-676-2583)

How the BlueCard Program Works

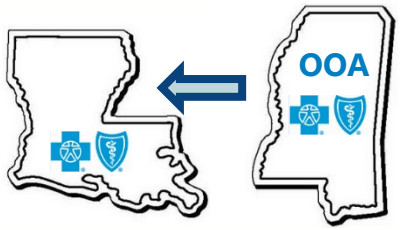
Example



Louisiana provider submits claim to BCBSLA.



BCBSLA submits electronic transaction to BCBSMS. BCBSMS applies the member's benefits.



BCBSMS routes the claim back to BCBSLA for provider reimbursement.

BCBSLA issues remittance and payment to our provider. BCBSMS issues an explanation of benefits (EOB) to the member.

Some ancillary services have different filing rules. Please reference the "Ancillary Claims" section of *The BlueCard Program Provider Manual* found online at **www.BCBSLA.com/providers** >Resources >Manuals.

BlueCard Products

BlueCard excludes:

- Stand-alone dental
- Vision delivered through an intermediary model
- Self-administered prescription drugs delivered through an intermediary model
- Medicaid and SCHIP that is part of the Medicaid program
- Federal Employee Program (FEP)*
- Medicare Advantage**

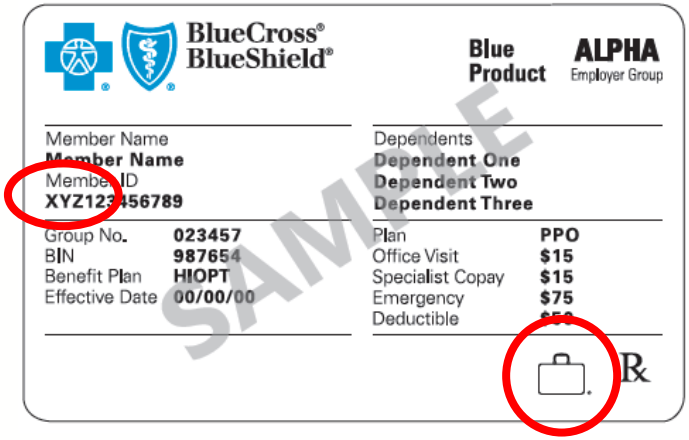
*FEP members have the letter "R" in front of their member number. Please follow your FEP billing guidelines for these contracts.

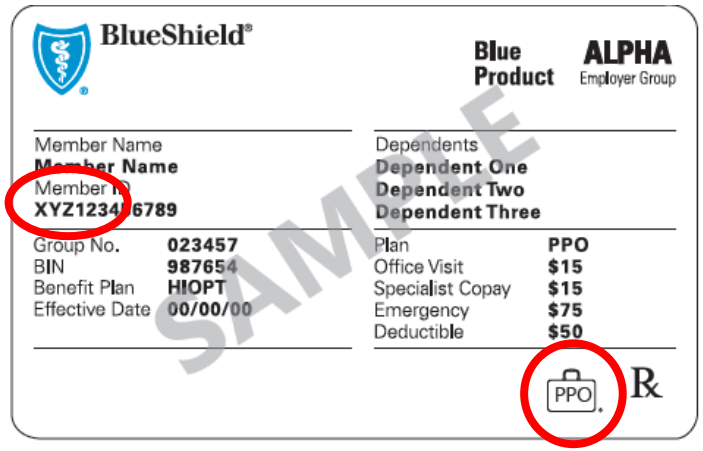
**Medicare Advantage is a separate program from BlueCard and delivered through its own centrally administered platform. However, since you might see members of other BCBS Plans who have Medicare Advantage coverage, there is a section on Medicare Advantage claims processing in *The BlueCard Program Provider Manual*.

Identifying BlueCard Members

The main identifiers for BlueCard members are the prefix and suitcase logo.

The three-character prefix at the beginning of the member ID number is the key element used to identify and correctly route out-of-area claims.





Helpful tips:

- Regularly obtain new copies of the member ID card (front and back).
- Verify the member's eligibility through iLinkBlue or by calling the BlueCard Eligibility Line at 1-800-676-2583.
- Carefully determine the member's financial responsibility before processing payment.
- If the member is using an HSA or HRA debit card, be sure to verify the member's cost share before processing payment.

Identifying BlueCard Member ID Cards

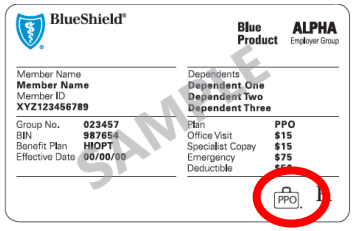
The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product.

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

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

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

Members must obtain services from BlueHPN providers to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for covered services in accordance with your BlueHPN contract with BCBSLA. If you are not a BlueHPN provider, it is important to note that benefits for services incurred with non-BlueHPN providers are limited to emergent care within BlueHPN product areas, and to urgent and emergent care taken from Page 9 of *The BlueCard Program Provider Manual*.



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

Medicare Advantage Members from Other Blue Plans

- Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare."
- All Medicare Advantage Blue Plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services.
- Medicare Advantage organizations may also offer a Special Needs Plan (SNP).
- MA Blue Plans may allow in- and out-of-network benefits, depending on the type of product selected.

How to verify eligibility and/or benefits for MA members from other Blue Plans:

- Call the BlueCard Eligibility Line, or submit an inquiry through **iLinkBlue**.

BCBSLA offers two MA products statewide

- Blue Advantage (HMO)
- Blue Advantage (PPO)

Benefit and eligibility for these products are handled through the Blue Advantage Provider Portal (**www.BCBSLA.com/ilinkblue** >Blue Advantage). This tool is not used for BlueCard MA members.

Medicare Advantage PPO Network Sharing

All Blue Plans that offer a MA PPO Plan participate in reciprocal network sharing. This allows Blue MA PPO members to obtain in-network benefits in the service area of any other Blue MA PPO Plan as long as the member sees a contracted MA PPO provider.

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

MA | PPO
MEDICARE ADVANTAGE

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

MA PPO Network Sharing

- Blue MA PPO members are recognizable by the “MA” suitcase on the member ID card.
- Blue MA PPO members have been asked not to show their standard Medicare ID card when receiving services. Instead, Blue MA PPO members should provide their Blue Cross/Blue Shield member ID card.
- Claims for services rendered in Louisiana, should be filed directly to BCBSLA.

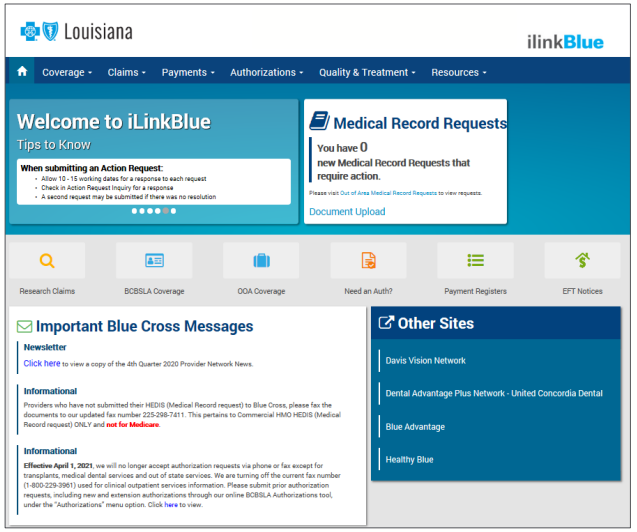
MA | PPO
MEDICARE ADVANTAGE

Provider Self-service Initiative

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

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

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

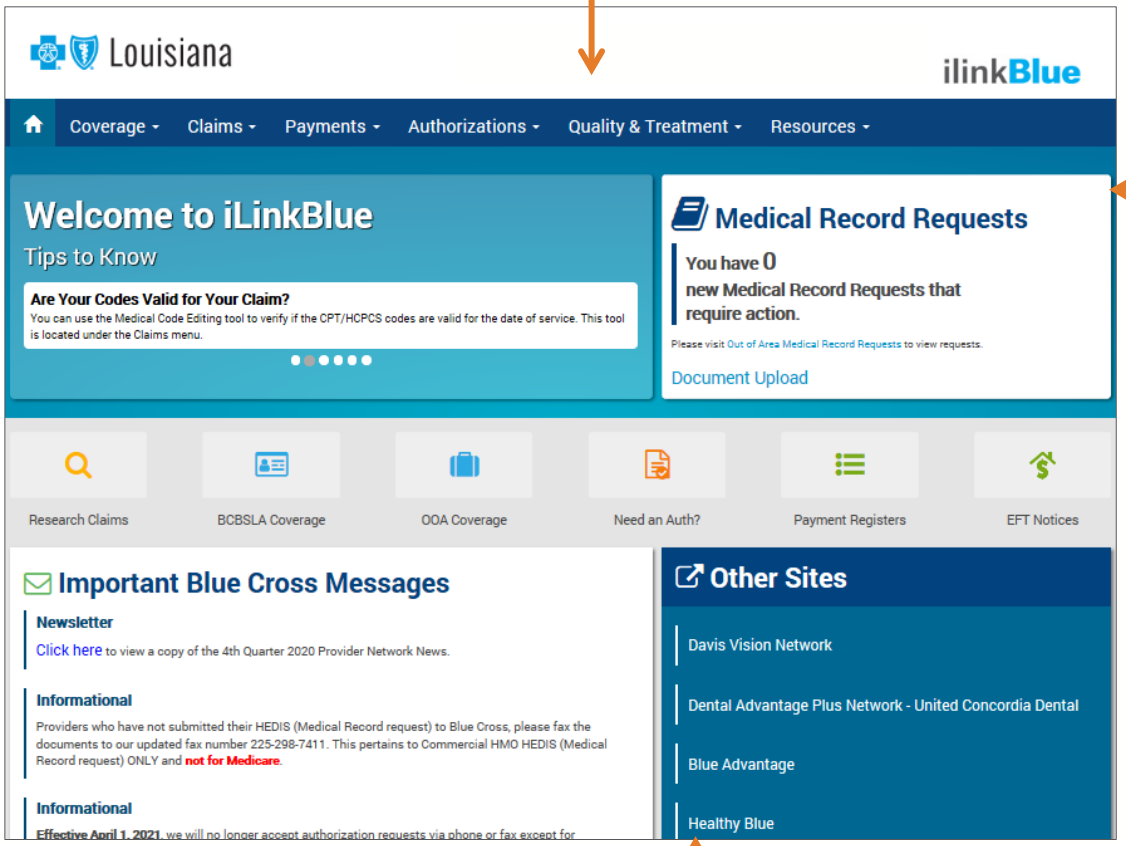


Self-service tools available to providers:

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

Navigating iLinkBlue

Top Navigation Bar
streamlines all of the iLinkBlue functions under six menus. When you click a menu option, a sub-menu appears that includes relevant features.



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

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

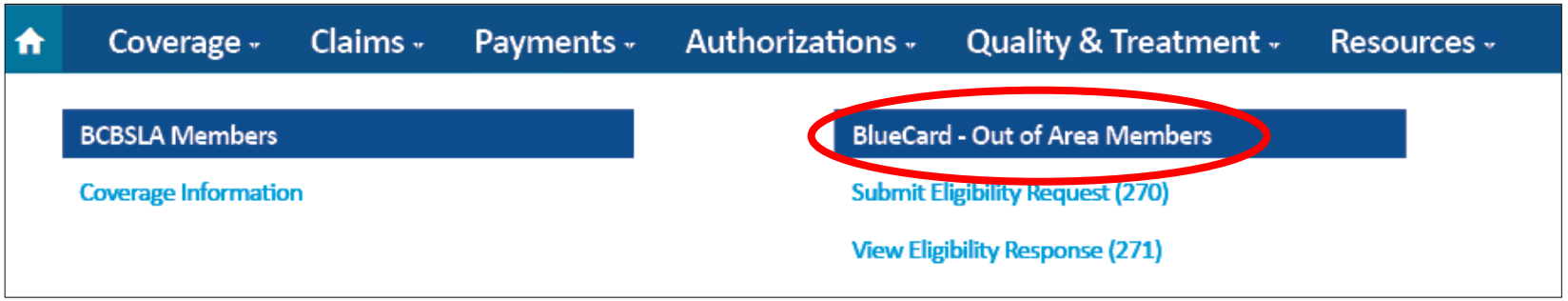
Other sites
We provide quick access to other commonly used sites a provider might need to access.

Medical Record Requests
You receive an alert when you have Out of Area Medical Record Requests for BlueCard members. To view these requests, click the "Out of Area Medical Record Requests" link on the alert. Does not include medical record requests for BCBSLA members.

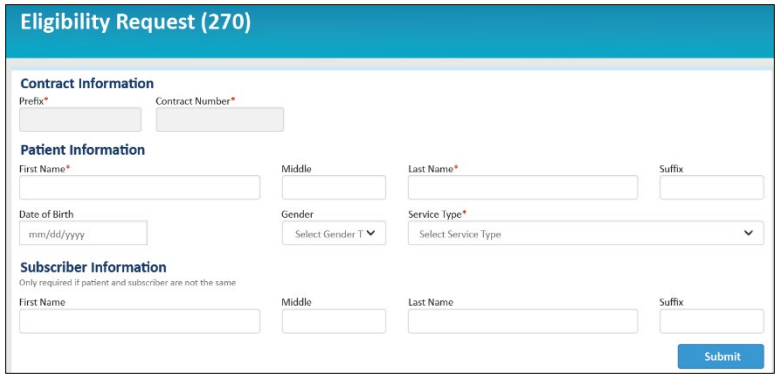
iLinkBlue: Coverage

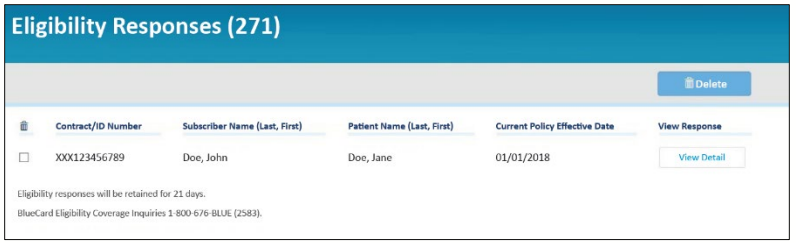
Submitting Eligibility Requests

Use this section to research coverage information for a BlueCard member (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana).



Submit Eligibility Request (270) – Click on this link to submit an electronic eligibility inquiry to the out-of-area member's Blue Plan. Enter the member's prefix (the first three characters of the member ID number), the contract number and then click "Submit."

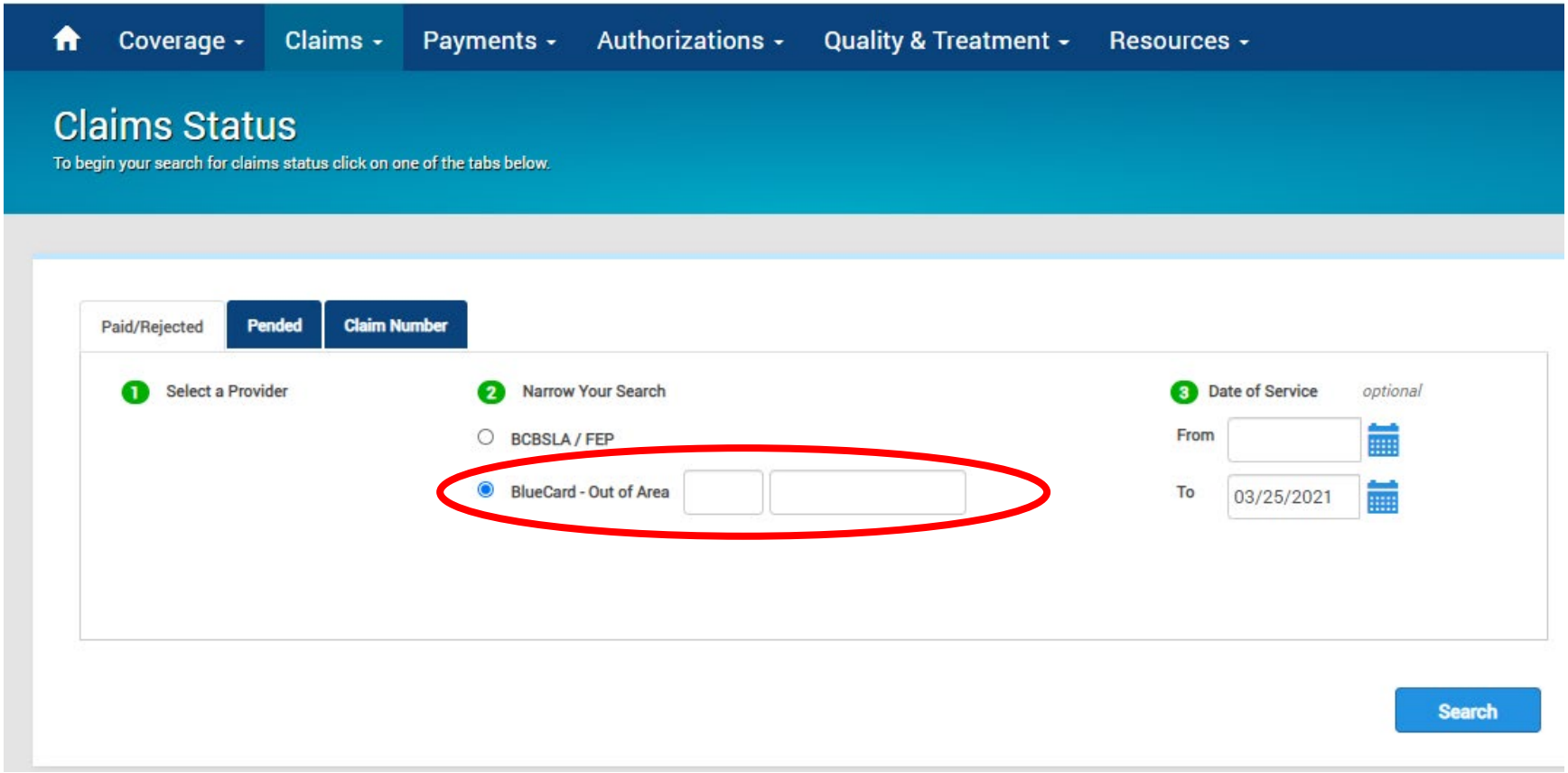




View Eligibility Response (271) – Click on this link to access the electronic response from the member's Blue Plan (shown above). Though not immediate, out-of-area responses are transmitted back usually within less than a minute. Eligibility responses are retained for 21 days.

iLinkBlue: Claims

BlueCard – Out of Area Claims Status



iLinkBlue: Claims

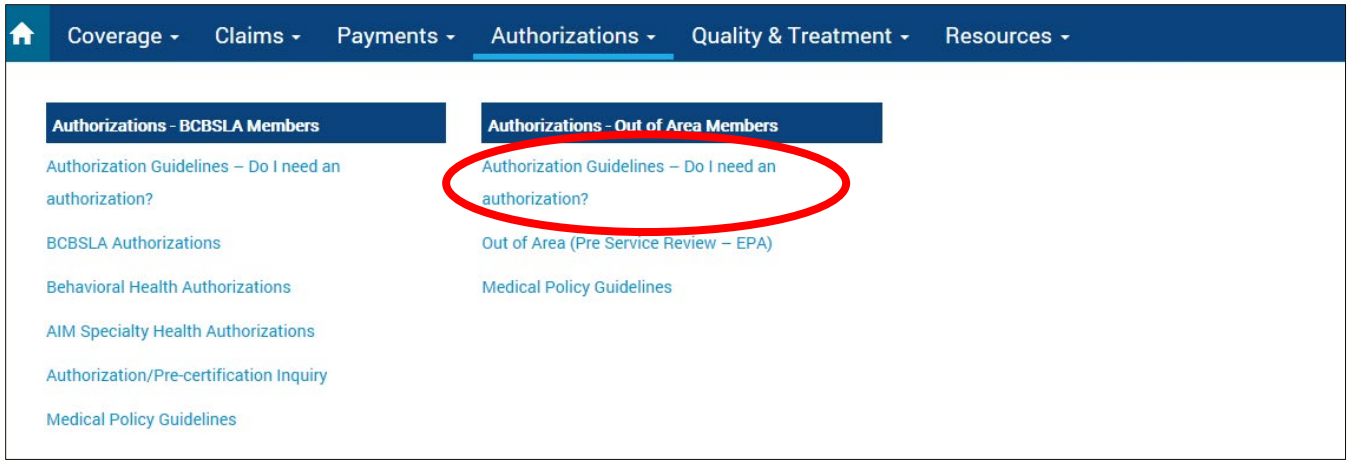
BlueCard – Out of Area Claims Status

Use this section to submit claims status inquiries for out-of-area (OOA) BlueCard members that cannot be found using the **Claims Status Search** tool.

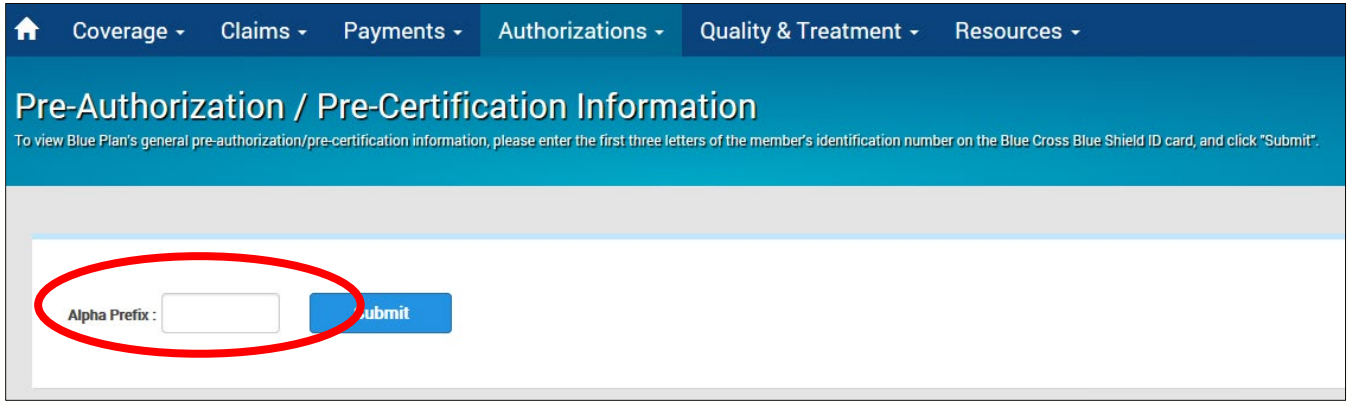
- **Submit OOA Claims Status Request (276)** – Click on this link to submit an electronic claim status inquiry to the out-of-area member's Blue Plan.
- **View OOA Claims Status Response (277)** – Click on this link to access the electronic response from the member's Blue Plan. Though not immediate, out-of-area responses are transmitted back usually within less than a minute.

iLinkBlue: Authorization and Billing Guidelines

Step 1: Log into iLinkBlue and click "Authorization Guidelines – Do I need an authorization" under Authorizations.



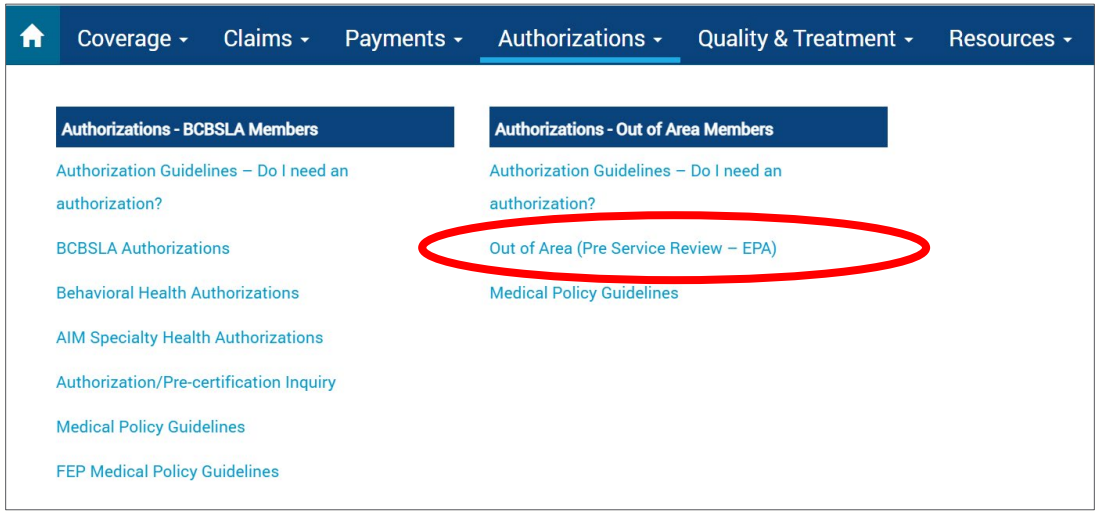
Step 2: Enter the member ID prefix.



iLinkBlue: Obtaining Authorizations

Out of Area (Pre-Service Review - EPA) – is designed to allow BCBSLA providers access to pre-service information offered by other Blue Plans.

- Enter the member ID three-character prefix.
- This will route you to the member's Blue Plan.
  - If the member's plan offers functionality, you will be able to enter the authorization request.
  - If the member's plan does not offer functionality, instructions on how to obtain the authorization request will be available.



Concurrent Review

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

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

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

Filing Claims

Submitting Claims for BlueCard Members

Submit BlueCard claims directly to BCBSLA.

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

Filing Claims with Your National Provider Identifier (NPI) – Your NPI is used for claims processing and internal reporting. Claim payments are reported to the Internal Revenue Service (IRS) using your Tax ID number (TIN).

Referring Physician NPIs – Referring physician NPIs are required on all applicable claims filed with BCBSLA and HMO Louisiana.

Medicare Primary Claims Processed Through the BlueCard Program – When services are rendered for a member from another Blue Plan and Medicare is primary, claims should be submitted directly to Medicare for primary payment. Medicare routes to member's Blue Plan.

Ambulance Claims

Ground Service

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

Air Service

- All air ambulance claims must include the 5-digit ZIP code of the point-of-pick-up. Claims that do not include the point-of-pick-up ZIP code on the claim will be denied for insufficient information.

Where to file air ambulance claims:

- If the pick-up location is in Louisiana, the claim should be filed directly to BCBSLA.
- If the pick-up location ZIP code is outside of Louisiana, the claim should be filed to the local Blue Plan that covers the area of pick-up.
- If the pick-up location is outside the US, the claim must be filed to the Blue Cross Blue Shield Global® Core (**www.bcbsglobalcore.com**).

Ancillary Claims

Filing Instructions

Ancillary providers are independent clinical laboratories, durable/home medical equipment (DME/HME) and supply providers and specialty pharmacies located within the BCBSLA service area.

Remote providers are those located outside of the service area and are contracted to act as a local provider.

Ancillary Claims

Filing Instructions

Ancillary Claims are filed to the local plan. The local plan is determined according to the below information:

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

Independent Clinical Laboratory:

The plan in the service area is determined by the state where the referring physician is located.

Durable/Home Medical Equipment (DME/HME):

The plan in the service area the equipment was shipped to or purchased.

Specialty Pharmacy:

The plan in the service area the ordering physician is located.

Dental and Oral Surgery Claims

ADA Claim Form

- When filing claims/calling for claim status for dental services, providers use the information on the Blue Plan named on the member ID card.
- ADA claim forms received by BCBSLA for dental services for BlueCard members will be sent back to the provider.

Dentists and oral surgeons should verify benefits for BlueCard program members prior to performing services by calling the number on the back of the member ID card.

Dental and Oral Surgery Claims

CMS-1500

- File dental services that fall under the medical care category on a CMS-1500 (professional) claim form.
- Dental services that fall under the medical care category and are filed on a CMS-1500 claim form will be processed by BCBSLA. Once BCBSLA receives the claim, we will electronically route the claim to the member's Blue Plan. The member's Blue Plan then applies benefits, approves payment and routes the claim back to BCBSLA. BCBSLA will then reimburse you.
- Dental claims submitted on a CMS-1500 claim form may be processed through BlueCard; therefore, providers should expect the remit or payment to come from BCBSLA if the claim is processed to pay the provider.
- Claims may also be submitted electronically on iLinkBlue.
- Additional information is available in the *Dental Network Office Manual*, available online at **www.BCBSLA.com/providers** >Resources.

Note: Our member benefit plans require oral surgery claims be processed first under the patient's dental coverage. Do not submit as a medical claim first.

Reimbursement

Claims Payment

Guidelines for BlueCard claims payment:

- If you have not received payment for a claim, do not resubmit the claim because it will deny as a duplicate.
- Check claim on iLinkBlue.
- Check the Not Accepted report on iLinkBlue under Claims, then Blue Cross Claims Confirmation Reports.
- If you have further questions with your claim you may then call the Customer Care Center at 1-800-922-8866.
    - For paid/rejected claims, you must provide the amount paid or ineligible amount, code and claim number.
    - For pended claims, you must provide the claim number and pended reason.

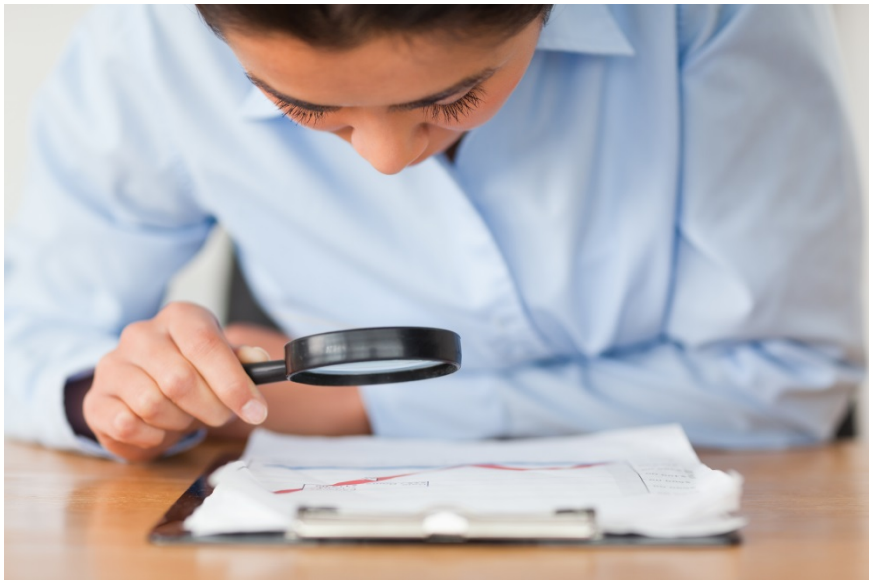
Note: In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. BCBSLA may either ask you for the information or give the member's Plan permission to contact you directly.

Reimbursement

Coordination of Benefits

Coordination of Benefits (COB) ensures members receive full benefits from their health benefit plans and prevents double payment for services when a member has coverage from two or more sources.

Please use the following guidelines when submitting COB claims:



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

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

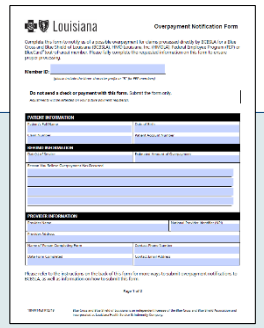
Coordination of Benefits Questionnaire form – This will help you and your patients avoid potential claim issues while streamlining claims processing and reducing the number of denials related to COB. This form is available online at **www.BCBSLA.com/providers** >Resources >Forms.

Overpayments

- While BCBSLA does notify the provider of refund requests, we do not request or accept checks from providers for refunds on claims for out-of-area members. All overpayment reconciliations will be reflected on electronic remittance advices and/or payment registers.

- When an overpayment on a claim for an out-of-area member may have been made, providers are required to fill out and submit an **Overpayment Notification Form** for review to ensure that an overpayment did occur.

- If an unsolicited refund is received from a provider or the member's home plan, the check may be returned with a letter requesting that an Overpayment Notification Form be submitted.


Louisiana

Overpayment Notification Form

The Overpayment Notification form can be found online at **www.BCBSLA.com/providers** >Resources >Forms.

Resolving Claims Issues

Have an issue with a claim? We are here to help!

Depending on the type of claim issue, there are multiple ways to submit claims reviews:

- Submit Action Requests through iLinkBlue
- Provider Disputes
- Medical Appeals
- Administrative Appeals & Grievances

Submitting an Action Request is a great option for getting a quick and accurate resolution for your claim's issues. Action Requests:

- Reduce the time it takes for providers to receive a response from Blue Cross.
- Allow providers to see responses directly from the adjustments team after review.
- Allow providers to submit additional questions once they have reviewed the AR response.

Submitting Action Requests

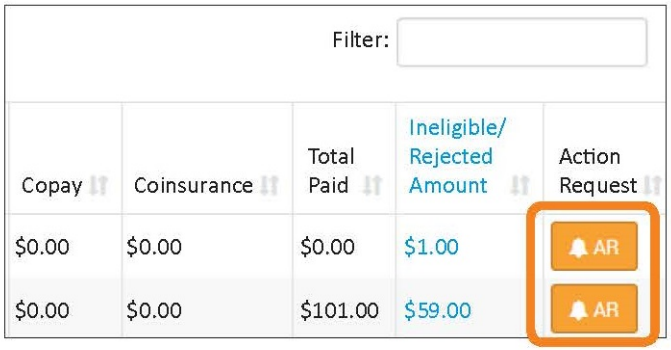
Action Requests allow you to electronically communicate with Blue Cross when you have questions or concerns about a claim.

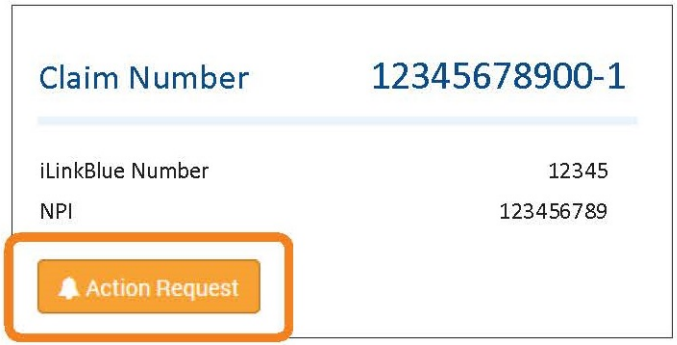
Common reasons to submit an Action Request

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

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

Submitting Action Requests



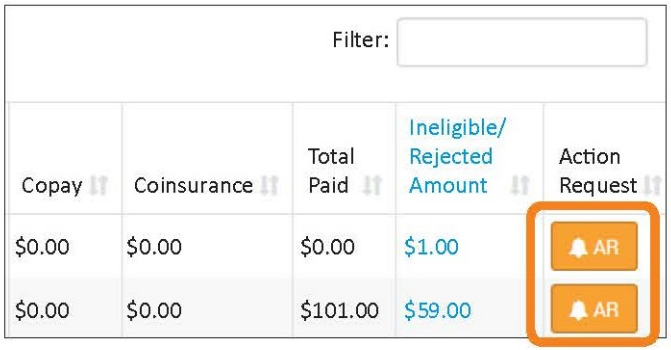


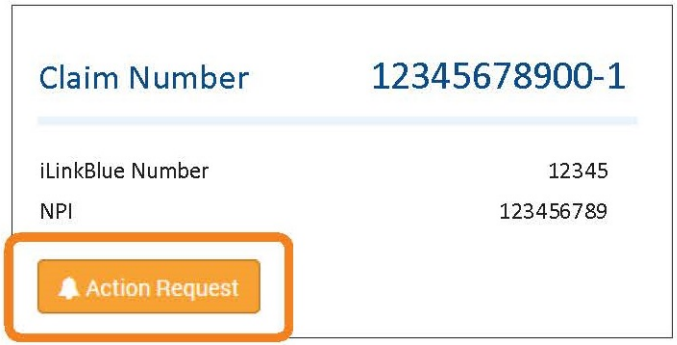
Submit an Action Request through iLinkBlue (**www.BCBSLA.com/ilinkblue**).

- On each claim, providers have the option to submit an Action Request review for correct processing.
- Click the **AR button** from the Claims Results screen or the **Action Request button** from the Claim Details screen to open a form that prepopulates with information on the specific claim.
- Please include your contact information.
- **Note**: You only have to do one Action Request per claim; not one Action Request per line item of the claim.

As an alternative to filing an Action Request, you may also contact the **Customer Care Center at 1-800-922-8866**.

Submitting Action Requests





- Request a review for correct processing.
- Be specific and detailed.
- Allow 10-15 business days for first request.
- Check iLinkBlue for a claims resolution.
- Submit a second action request for a review.
- Allow 10-15 business days for second request.

If you have followed the steps outlined here and still do not have a resolution, you may contact Provider Relations for assistance at **provider.relations@bcbsla.com**.

Email an overview of the issue along with two action request dates **OR** two customer service reference numbers if one of the following applies:

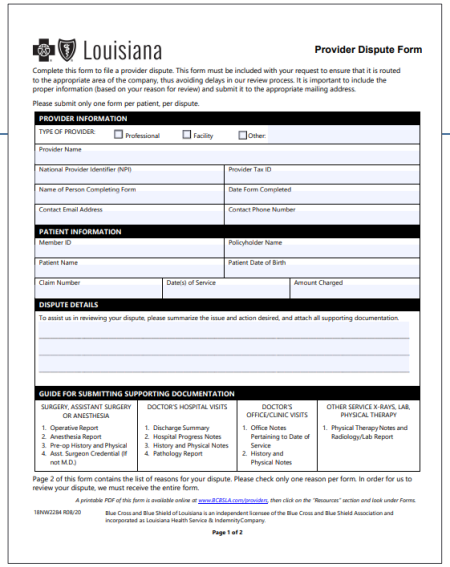
- You have made at least two attempts to have your claims reprocessed (via an action request or by calling the Customer Care Center) and have allowed 10-15 business days after second request; or
- It is a system issue affecting multiple claims.

Provider Disputes & Appeals

Sometimes it may be necessary for a provider to dispute or appeal a claim.

- Provider Disputes
  - Involves a denial that affects the provider's reimbursement.
- Medical Appeals
  - Involves a denial or partial denial based on:
    - Medical necessity, appropriateness, healthcare setting, level of care or effectiveness.
    - Determined to be experimental or investigational.
- Administrative Appeals & Grievances
  - Claims issue due to the member’s contract benefits, limitations, exclusions or cost share.
  - When there is a grievance.

Provider Disputes



Louisiana

Provider Dispute Form

Complete this form to file a provider dispute. This form must be included with your request to ensure that it is routed to the appropriate area of the company, thus avoiding delays in our review process. It is important to include the proper information (based on your reason for review) and submit it to the appropriate mailing address.

Please submit only one form per patient, per dispute.

PROVIDER INFORMATION

TYPE OF PROVIDER: ☐ Professional ☐ Facility ☐ Other:

Provider Name

National Provider Identifier (NPI) | Provider Tax ID

Name of Person Completing Form | Date Form Completed

Contact Email Address | Contact Phone Number

PATIENT INFORMATION

Member ID | Policyholder Name

Patient Name | Patient Date of Birth

Claim Number | Date(s) of Service | Amount Charged

DISPUTE DETAILS

To assist us in reviewing your dispute, please summarize the issue and action desired, and attach all supporting documentation.

GUIDE FOR SUBMITTING SUPPORTING DOCUMENTATION

SURGERY, ASSISTANT SURGERY OR ANESTHESIA	DOCTOR'S HOSPITAL VISITS	DOCTOR'S OFFICE/CLINIC VISITS	OTHER SERVICE X-RAYS, LAB, PHYSICAL THERAPY
1. Operative Report 2. Anesthesia Report 3. Pre-op History and Physical 4. Asst. Surgeon Credential (if not M.D.)	1. Discharge Summary 2. Hospital Progress Notes 3. History and Physical Notes 4. Pathology Report	1. Office Notes Pertaining to Date of Service 2. History and Physical Notes	1. Physical Therapy Notes and Radiology/Lab Report

Page 2 of this form contains the list of reasons for your dispute. Please check only one reason per form. In order for us to review your dispute, we must receive the entire form.

A printable PDF of this form is available online at www.BCBSLA.com/providers, then click on the "Resources" section and look under Forms.

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

Page 1 of 2

A provider dispute is different than an appeal or grievance. Provider disputes are defined as written requests from our participating network providers (In Network Providers ONLY) questioning (or disputing) their allowable charge of a processed claim. Disputes could involve the following:

- Reimbursement concerns
  - Allowable disputes (**must include breakdown, fee schedule**)
  - Bundling issues (note: must always have medical records attached)
- Authorization issues
  - Penalties where the **provider** is liable for the amount
  - Failed to obtain authorization denials (**reason auth not obtained**)
- Refund Disputes
- Maximum daily benefit denials
- Timely Filing denials

Send through iLinkBlue: (**www.BCBSLA.com/iLinkBlue**), click "Document Upload," then "Provider Disputes" in the drop-down menu.

Hardcopy:
Blue Cross and Blue Shield of Louisiana
Attn: Provider Disputes
P.O. Box 98021
Baton Rouge, LA 70898-9021

Fax: (225) 298-7035

Form is available online at **www.BCBSLA.com/providers** >Resources >Forms.

Disputes Process for BCBSLA Claims

FIRST (ADMINISTRATIVE) LEVEL REVIEW

- Must be submitted in writing, using Claims Dispute Form and all supporting documentation.
- Provider will be sent an acknowledgement letter.
- BCBSLA has 60 days to review and respond.

Disputes Process for BCBSLA Claims

SECOND (STAFF) LEVEL REVIEW

- Once a resolution letter is sent, the provider has 30 days to respond and request a second level review (staff level review).
- For second level review, the provider must submit additional information. The review will be conducted by a different specialist.
- For the second level review, BCBSLA has 60 days to review and respond.

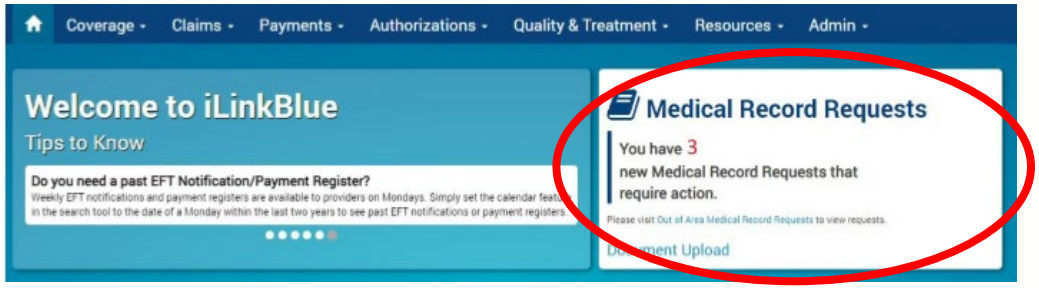
Disputes Process for BCBSLA Claims

THIRD (MANAGEMENT) LEVEL REVIEW

- Once a resolution letter is sent, provider has 30 days to respond in writing to request a third level review (management level review).
- Case is presented and decision is made by managers.
- Providers are notified of the decision and has the right to request arbitration.
- Arbitration is the final resolution.

Submitting BlueCard Medical Records

- Always direct medical records submissions to Blue Cross and Blue Shield of Louisiana when requested. You will be alerted of BlueCard medical record requests through our secure online tool iLinkBlue (**www.BCBSLA.com/ilinkblue**). These alerts will be visible on the iLinkBlue home page. Medical Record Requests will no longer be sent hardcopy.



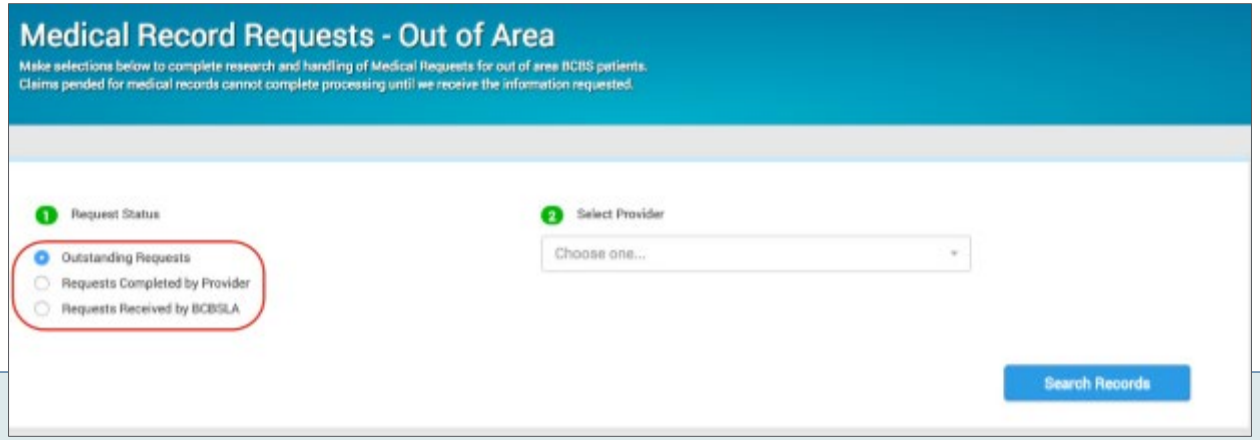
- If a claim denies for one of the following reasons: "lack of information received," "additional information needed" or "waiting on requested information," wait until you receive a medical records request in iLinkBlue before submitting records.
- For these types of denials, providers should wait 10 business days to allow us time to send a request for medical records. If you do not receive a request after 10 business days, contact customer service to verify the exact information needed.
- Send medical records to us within 10 business days after receiving an alert.
- Include a printed copy of the iLinkBlue medical record alert as the cover or first page of your submission.

More information Medical Records Guidelines for BlueCard can be found online at **www.BCBSLA.com/providers** >Resources >Tidbits

Submitting BlueCard Medical Records

BlueCard Medical Records Requests on iLinkBlue

- View medical records requests for your BlueCard patients in iLinkBlue by clicking the Out of Area Medical Record Requests link on the message board alert. You can also access requests by clicking on Claims >Medical Records >Out of Area Medical Record Requests.
- Use the Medical Record Requests section to research Outstanding Requests, Requests Completed By Provider and Requests Received by BCBSLA.

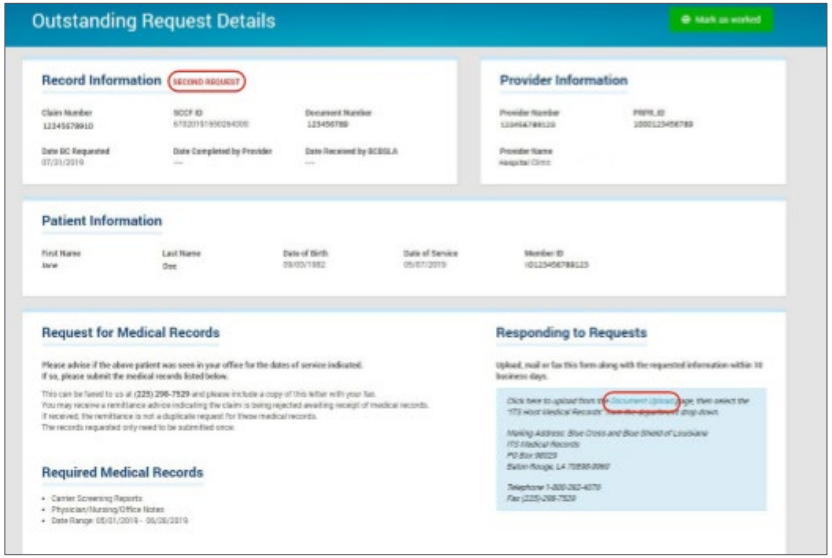


Once confirmed that we received your records, please allow 30 days for Blue Cross and Blue Shield of Louisiana and/or the member's Blue Plan to complete the review process. If you receive no response after 30 days, please follow up with us by calling the Customer Care Center at 1-800-922-8866.

Submitting BlueCard Medical Records

Second requests will display in red under **Outstanding Requests** search results. A second request displays when records have been requested more than once with no response.

After selecting a request from the search results, the **Outstanding Request Details** screen displays. This screen shows a summary of the medical record request including the claim, patient and provider information.



- The **Outstanding Request Details** screen displays second requests in red to the right of the Record Information.
- After submitting requested medical records to Blue Cross and Blue Shield of Louisiana, click the **Mark as worked** button.
- This moves the request to the **Completed by Provider** section. The request will no longer appear on the Outstanding Requests Details screen.

You have the option to submit medical records through iLinkBlue by clicking on "**Document Upload**." This accesses a tool that allows you to upload documents directly into iLinkBlue.

Medicare Crossover Claims

- Medicare crossovers are electronically filed claims that Medicare automatically forwards or "crosses over" to the member's Blue Plan when information is available in the Medicare eligibility file.
- When a Medicare claim is crossed over to an out-of-state Blue Plan, the Medicare remittance advice will have a message beneath the patient's claim information similar to….
  - *"Claim information forwarded to : BCBS of Texas"*
- If the remittance advice does not contain a message similar to this example, then the claim was not forwarded electronically to the member's Blue Plan for processing. The provider must then file the claim, along with a copy of the Medicare Remittance Advice, with the member's Blue Plan (as listed on the member ID card).
- If Medicare has forwarded the claim to the member's Blue Plan, please allow 25-30 days from the Medicare remittance advice date before contacting the member's Blue Plan.


Louisiana
providerTIDBIT
a guide to understanding our processes

Medicare Crossover Claims

Medicare crossovers are electronically filed claims that Medicare automatically forwards or "crosses over" to Blue Cross and Blue Shield of Louisiana when member information is available in the Medicare eligibility file. This process includes claims where Medicare is primary and Blue Cross and Blue Shield of Louisiana is secondary.

All Blue Cross and Blue Shield Plans (Blue Plans) have established a standardized Medicare Crossover Agreement with the Centers for Medicare & Medicaid Services (CMS). This standard agreement requires that crossover claims be sent directly from the Medicare Crossover Carrier, Group Health Inc (GHI), to the member's Blue Plan (information on BlueCard® members can be found on the backside of this guide).

This means all claims, regardless of the state where the service was rendered, will be sent directly to the member's Blue Plan. For example, Blue Cross and Blue Shield Louisiana receives crossover claims for our members even when the service was rendered in a state other than Louisiana.

How to Tell if a Medicare Claim Was Crossed Over

When a claim is crossed over to Blue Cross and Blue Shield of Louisiana from Medicare, there will be a message beneath the patient's claim information on the Medicare remittance advice.

"Claim information forwarded to: BCBS of Louisiana-Supplemental"
This message indicates the claim was forwarded electronically from Medicare to Blue Cross and Blue Shield of Louisiana for processing.

"Claim information forwarded to: BCBS of Louisiana-Other"
This message indicates the claim was forwarded electronically from Medicare to Blue Cross and Blue Shield of Louisiana National Employee Program area for processing.

If the remittance advice does not contain a message similar to these examples, then the claim was not forwarded to Blue Cross and Blue Shield of Louisiana for processing. Refer to the instructions on "Resubmitting a Claim That Did Not Crossover" on the reverse side of this guide.

Checking Claim Status on Crossover Claims

Please wait 21 days from the Medicare remittance advice date before checking on the status of the crossover claim in iLinkBlue (www.BCBSLA.com/linkblue) or by calling Provider Services at 1-800-922-8866.

If after 21 days, the claim cannot be located in iLinkBlue or by Provider Services, please contact BCH Services at 1-800-216-7583 or email BCHServices@bcbsla.com.

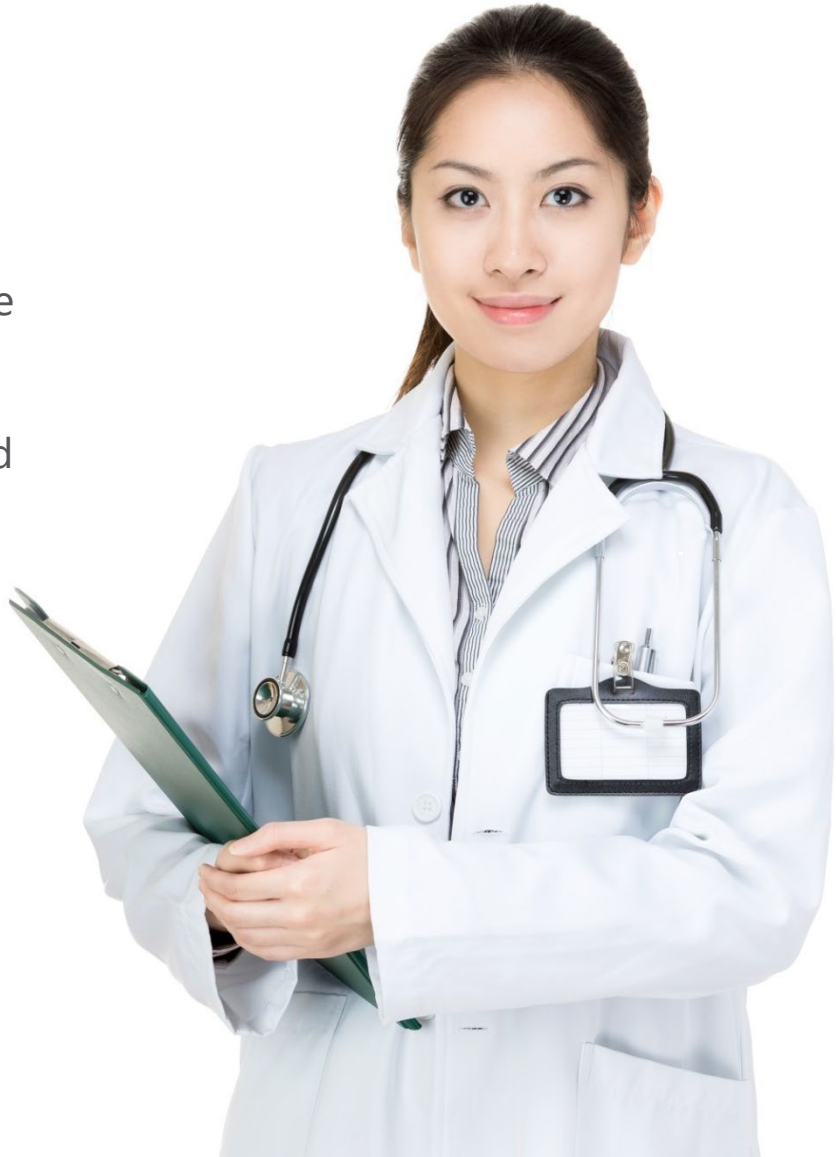
Please provide the following information:
- Provider NPI
- Member ID number
- Patient name
- Patient date of birth
- Date of service
- Amount charged

More

For more information, refer to the "Medicare Crossover Claims" Tidbit online at **www.BCBSLA.com/providers** >Resources >Tidbits.

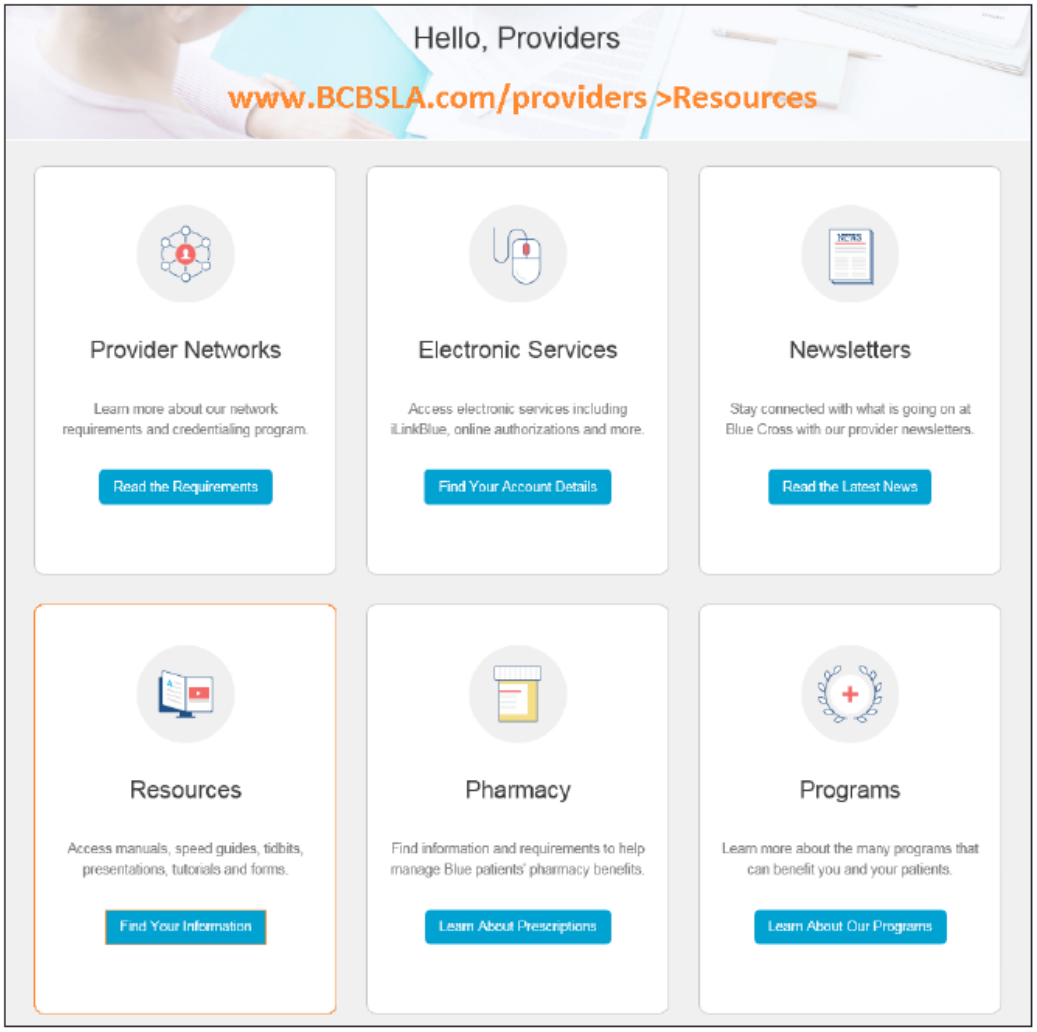
Medicaid Programs Claims

- Some Blue Plans administer Medicaid programs. Because Medicaid is a state-run program, requirements vary for each state/Blue Plan.
- You must accept the Medicaid fee schedule that applies in the member's home state.
- If you provide services that are not covered by Medicaid, you will not be reimbursed.
- Applicable Medicaid claims submitted without complete data elements may be pended or denied until the required information is received.
- Some states require that out-of-area providers enroll in their Medicaid program in order to be reimbursed.



Online Resources: Provider Page

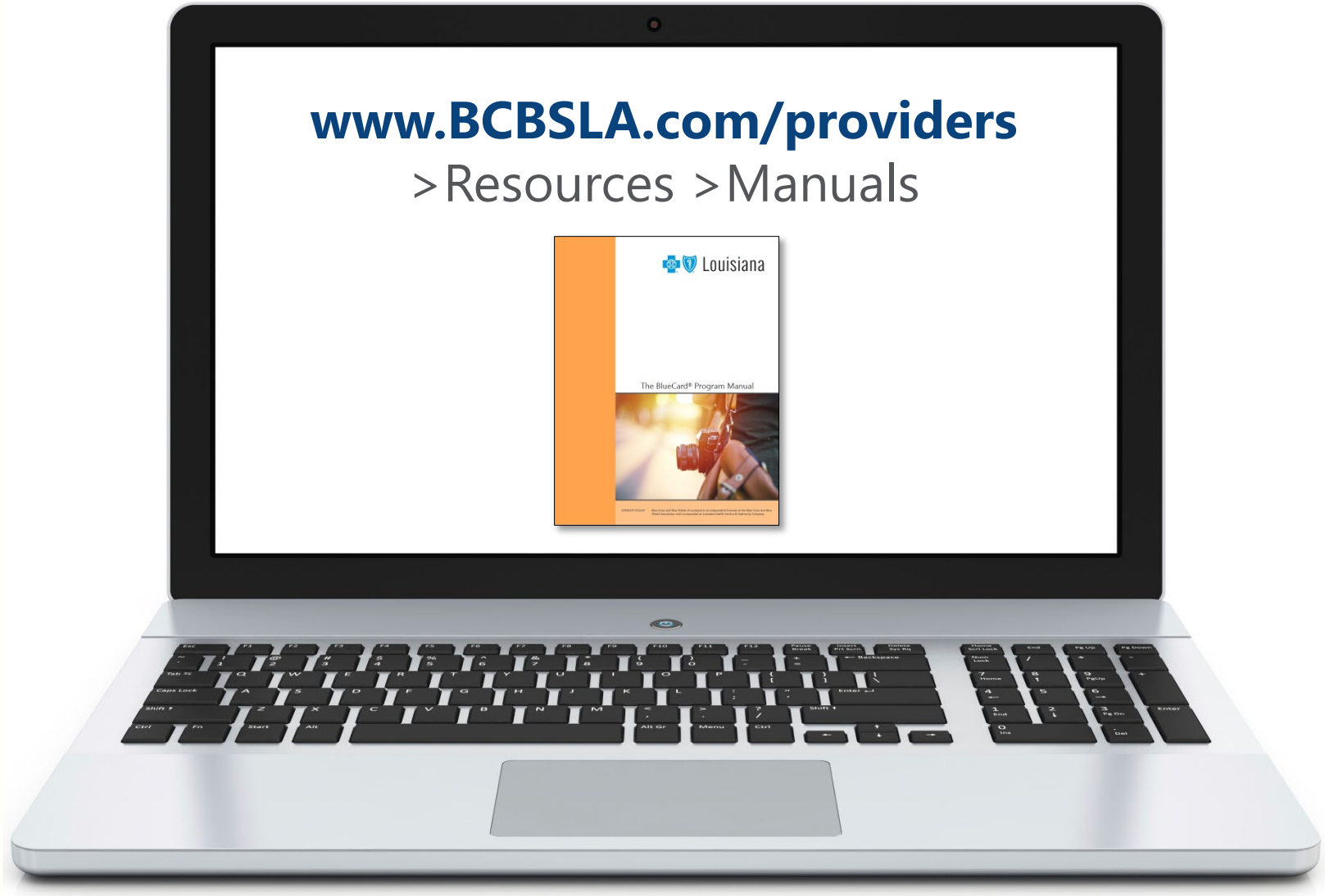
www.BCBSLA.com/providers



You will find information on:

- Provider Networks
  - Credentialing
  - Provider Support
- Electronic Services
  - Learn about iLinkBlue
  - Clearinghouse Services
  - Electronic Funds Transfer (EFT)
- Newsletters
- Resources
  - Manuals
  - Speed Guides & Tidbits
  - Forms for Providers
  - Workshop & Webinar Presentations
  - Provider Forms
- Pharmacy
- Programs
  - Quality Blue
  - Care Management
  - Specialty Care Insight
- And more!

More information about The BlueCard Program can be found in our online manual here:



Provider Relations

Provider Education & Outreach

Kim Gassie director

Jami Zachary manager

Anna Granen
Jefferson, Orleans, Plaquemines, St. Bernard, Iberville, Lafourche

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

Marie Davis
Assumption, Iberia, Lafayette, St. Charles, St. James, St. John the Baptist, St. Mary, Calcasieu, Cameron

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

Melonie Martin
East Baton Rouge, Ascension, West Baton Rouge

Patricia O'Gwynn
Allen, Avoyelles, Beauregard, Caldwell, Catahoula, Concordia, East Carroll, Evangeline, Franklin, LaSalle, Madison, Morehouse, Ouachita, Rapides, Richland, Tensas, Vernon, West Carroll. Acadia

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

Jennifer Aucoin **Angela Jackson** **Paden Mouton** **Brittany Thompson**

Provider Contracting

Shelton Evans director – shelton.evans@bcbsla.com

Jode Burkett manager – jode.burkett@bcbsla.com
Danielle Jackson manager – danielle.jackson@bcbsla.com

Ashley Wilson – ashley.wilson@bcbsla.com
Northshore

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Jason Heck – jason.heck@bcbsla.com
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Lafayette

Sue Condon – sue.condon@bcbsla.com
Baton Rouge

Shannon Taylor – shannon.taylor@bcbsla.com
Monroe

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

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

Provider Credentialing & Data Management (PCDM)

Provider Network Setup, Credentialing & Demographic Changes

Justin Bright director

Mary Reising Manager – mary.reising@bcbsla.com

Anne Monroe Provider Information Supervisor – anne.monroe@bcbsla.com

Rhonda Dyer Provider Information Supervisor – rhonda.dyer@bcbsla.com

If you would like to check the status on your Credentialing Application or Provider Data change or update, please contact the Provider Credentialing & Data Management Department by emailing **PCDMstatus@bcbsla.com**.

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

Call Centers

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

For information NOT available on iLinkBlue

Other Provider Phone Lines

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

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

Network Administration – **1-800-716-2299**

- **option 1** – for questions regarding provider contracts
- **option 2** – for questions regarding provider credentialing and data management
- **option 3** – for questions regarding EDI or clearinghouse issues
- **option 4** – for questions regarding provider relations
- **option 5** – for questions regarding administrative representative setup

Questions?

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