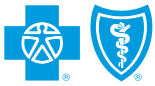 Louisiana

Frequently Asked Questions (FAQs)

Blue Advantage Overview

1. **What is Blue Advantage?**

   Blue Advantage is Blue Cross and Blue Shield of Louisiana's Medicare Advantage products and provider networks that are exclusively for Medicare Advantage-eligible customers. Blue Advantage follows the policies and procedures outlined by the Centers for Medicare and Medicaid Services (CMS).

2. **What Blue Advantage products are offered to Medicare Advantage-eligible customers?**

   We offer both Blue Advantage (HMO) and Blue Advantage (PPO) benefit plan options. With these benefit plans, our Blue Advantage members have coverage for a wide array of services including outpatient prescription drug coverage, hospitalization, home care, preventative care services and ambulance transportation.

3. **What are the Blue Advantage networks that are available to providers?**

   Blue Cross has two Blue Advantage provider networks to support the Blue Advantage benefit plans we offer. They are the Blue Advantage (HMO) and Blue Advantage (PPO) networks.

4. **Where in Louisiana are the Blue Advantage networks available?**

   Both the Blue Advantage (HMO) and Blue Advantage (PPO) networks are available statewide.

5. **How big are the Blue Advantage networks?**

   The Blue Advantage networks are robust and include hospitals, primary care providers (PCPs), specialists, mental health providers, routine vision and dental care providers as well as pharmacies. To access the Blue Advantage Provider Directory, visit the Blue Advantage Provider Portal, available through iLinkBlue (www.BCBSLA.com/ilinkblue), then click "Blue Advantage" under the "Other Sites" section. *(For more information on the Blue Advantage Provider Portal, see the Blue Advantage Provider Portal section of this FAQ.)*

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New Directions is an independent company that serves as the behavioral health manager for Blue Cross and Blue Shield of Louisiana and Blue Cross and Blue Shield of Louisiana HMO.

AIM is an independent company that serves as an authorization manager for Blue Cross and Blue Shield of Louisiana and Blue Cross and Blue Shield of Louisiana HMO.

Express Scripts, Inc. is an independent company that serves as the pharmacy benefit manager for Blue Cross and Blue Shield of Louisiana and Blue Cross and Blue Shield of Louisiana HMO.

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, incorporated as Louisiana Health Service & Indemnity Co., offers Blue Advantage (PPO). Both are independent licensees of the Blue Cross and Blue Shield Association.

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

Selecting a Primary Care Provider (PCP)

6. **Are Blue Advantage members required to select a PCP?**

   Blue Advantage members are required to select a PCP at the time of enrollment. The member's PCP will be responsible for providing, coordinating and arranging all medically necessary services for the member. In rare cases, if the member has not identified a PCP and we cannot verify his/her choice, a PCP may be assigned.

   A PCP serves as the member's total care coordinator for non-emergent care. It is important that members have a good relationship with their PCPs, as they provide most of their care. PCPs are available to members 24 hours a day, seven days a week through regular scheduling or on-call coverage.

7. **How often can Blue Advantage members change PCPs?**

   Members can change PCPs to another in-network PCP at any time, for any reason. The member may select a different PCP by contacting Blue Advantage Customer Service at 1-866-508-7145. The change will be effective the first day of the month following receipt of the member's request.

8. **Can Blue Advantage members see a specialist without a referral?**

   Yes. A Blue Advantage member can see a specialist without a PCP referral.

9. **When verifying member eligibility on the Blue Advantage Provider Portal, is PCP information available?**

   Yes. Each member's PCP's information is available on the Blue Advantage Provider Portal. To display eligibility for a Blue Advantage member, the Blue Advantage member ID, first name (or initial), last name and date of birth must be entered.

10. **Are all copayments the same for Blue Advantage members?**

    Copayments for Blue Advantage members may vary. Providers are encouraged to check member benefits and eligibility on the Blue Advantage Provider Portal, prior to rendering services.

11. **Will a provider be paid for treating patients if they are not the assigned PCP for the Blue Advantage member?**

    Yes. If the provider is in the same network as the member's plan and is not listed as the assigned PCP on the member ID card, the provider can still see the member and we will process the claim.

Blue Advantage Member Identification (ID) Cards

12. **What information is shown on Blue Advantage member ID cards?**

    Blue Advantage member ID cards include demographic information about the covered member, as well as coverage information such as copayment or coinsurance responsibilities and important phone numbers. Blue Advantage (HMO) members will also have their PCP's name and phone number listed on their ID card.

13. What are the Blue Advantage member prefixes?

XUM is the prefix for Blue Advantage (HMO) members and XUN is the prefix for Blue Advantage (PPO) members.

14. What do I do if the Blue Advantage member does not have their member ID card?

Providers can get a copy of the member ID card through the Member ID Card feature on the Blue Advantage Provider Portal. Once providers login to the portal, they can access this feature under the Eligibility section. The member's ID prefix and number, first name (or initial), last name and date of birth will be required. You will be able to view and print copies of member ID cards for your patients only.

Blue Advantage Provider Portal

15. What is the Blue Advantage Provider Portal?

The Blue Advantage Provider Portal is your one-stop electronic resource for Blue Advantage information and is available through iLinkBlue (www.BCBSLA.com/ilinkblue), then click "Blue Advantage" under the "Other Sites" section.

By accessing the Blue Advantage Provider Portal, providers will have access to:

- Blue Advantage Provider Administrative Manual*
- Blue Advantage Provider Quick Reference Guide*
- Blue Advantage Provider/Pharmacy Directory
- Blue Advantage Drug Formulary Search
- Blue Advantage Forms*
- Blue Advantage Newsletters and Event Materials*
- Member Eligibility
- Claims Inquiry
- Authorization Inquiry
- Accountable Delivery System Platform (ADSP) for PCPs only
  (For more information on the ADSP, see the ADSP section of this FAQ.)

**These resources are also available on the Blue Advantage resource page, www.BCBSLA.com/providers >Blue Advantage Resources*

16. How is the Blue Advantage Provider Portal different from iLinkBlue?

While you log into iLinkBlue to access the Blue Advantage Provider Portal, you will not actually access Blue Advantage resources in iLinkBlue. The Blue Advantage Provider Portal includes secure information and tools that require a separate username and password from your current iLinkBlue username and password.

17. **How can Blue Advantage providers access the provider portal?**

    You must have a username and password to access key information that is only available for Blue Advantage providers on the portal. This access is granted by the designated security administrative representative at your organization.

18. **What is the role of the administrative representative?**

    The role of an administrative representative is to serve as the key person at your organization for delegating electronic access to appropriate users and ensuring that those appropriate users at your office/facility adhere to our guidelines. The administrative representative grants access to registered employees who legitimately must have access for the purpose of their job responsibilities.

19. **If I don't have an administrative representative, do I need to designate one?**

    Yes. The only way to gain secure access on the Blue Advantage Provider Portal is through your organization's administrative representative. To register an administrative representative for your organization, complete the registration packet found at www.BCBSLA.com/providers, choose "Provider Network" then click the "Designate Your Rep" button at the bottom of the page. Complete and email the packet to our Provider Identity Management (PIM) Team at PIMTeam@BCBSLA.com.

20. **How can a Blue Advantage provider register for access to the Blue Advantage Provider Portal?**

    Once you have an administrative representative and that person has granted you access to iLinkBlue, you must complete the following steps below to access the Blue Advantage Provider Portal:

    - Log into iLinkBlue (www.BCBSLA.com/ilinkblue).
    - Click on "Blue Advantage" under the "Other Sites" section to access the Blue Advantage Provider Portal.
    - Select "Create an account."
    - Complete the fields as requested (provider's Tax ID number and NPI will be required)
    - Once registration has been validated by your administrative representative, access will be granted.

    Each user MUST have their own portal account. Accounts may not be shared.

21. **Can a user's access be removed from the Blue Advantage Provider Portal?**

    Yes. If you have an employee who no longer requires access to the Blue Advantage Provider Portal, it is the role of the administrative representative to have that user's portal access removed. This should be done immediately upon understanding that the user no longer needs access to the portal.

22. **What are some reasons to remove Blue Advantage Portal access?**

    Reasons for removal of portal access could include the employee changing roles or terminating employment with your organization.

23. **How should a provider request removal of a user's access from the Blue Advantage Provider Portal?**

    The administrative representative for your organization should submit a request for the removal of Blue Advantage Portal user access in writing by sending an email to customersupport@lumeris.com with the following information:

    - In subject line of your email, type "Removal of Portal Access."
    - Include the username and email of the person to be removed.
    - Provide the reason for removal.
    - Include your name, title, email address and telephone number.

    For technical questions relating to the Blue Advantage Provider Portal, you may contact Blue Advantage Customer Service at 1-866-508-7145.

24. **What should a provider do if they are locked out of the Blue Advantage Provider Portal?**

    If a provider is locked out of the Blue Advantage Provider Portal, they should contact the Blue Advantage Provider Portal Support department at customersupport@lumeris.com or call the Lumeris Technical Help Desk at 1-866-397-2812. Providers may be asked to verify their email and security questions before the account is reactivated and unlocked.

Medical Management and Authorizations

25. **What is the role of the Blue Advantage Medical Management department?**

    Certain services require prior authorization. The Blue Advantage Medical Management department is responsible for working directly with Blue Advantage network providers to administer authorizations and medical necessity determinations as well as monitor the appropriateness and efficiency of services rendered. Blue Advantage providers should not have members contact the Medical Management department for patient-specific information.

26. **Where can providers find the list of services that require prior authorization?**

    Blue Advantage publishes a comprehensive list of those services that require prior authorization. These lists are available on the Blue Advantage Provider Portal and the Blue Advantage resources page. Please refer to the following documents:

    - Provider Quick Reference Guide
    - DME and O&P Prior Auth List

27. **Should providers notify Blue Advantage for observation services?**

Providers should report observation cases and emergent hospital admissions to the Blue Advantage Medical Management department as follows:

- Outpatient observation: contact Medical Management within one business day of admission and discharge, and fax discharge summary/visit summary once the member is discharged.
- Emergency hospital admission: contact Medical Management within one business day. If an admission changes from observation to inpatient, the provider must notify Medical Management within one business day.

Observation services must also be reasonable and necessary to be covered. Claims for observation services will not be paid if timely notification is not made.

28. **Do I need a prior authorization for surgery?**

For outpatient surgical procedures that require prior authorization, Blue Advantage providers must contact the Blue Advantage Medical Management department at least 14 days prior to the procedure. For elective hospital admissions, Blue Advantage providers must contact Medical Management at least 14 days prior to an elective admission. If an elective admission is cancelled, please notify Medical Management of that cancellation and the reschedule date, if applicable. Refer to the Blue Advantage Quick Reference Guide for a list of procedures that require prior authorization.

29. **Can providers request prior authorizations online for Blue Advantage members?**

Online authorization options are available for the following services only through AIM Specialty Health (AIM):

- High-tech Radiology
- Radiation Oncology program
- Office and Outpatient Cardiology program
- Outpatient Musculoskeletal

To initiate prior authorizations for these services, access the AIM *ProviderPortal*SM that is available through iLinkBlue (www.BCBSLA.com/ilinkblue) under the "Authorizations" menu option or by calling AIM directly at 1-866-455-8416.

For services that require prior authorization directly from Blue Advantage, download the Prior Authorization Form from the Blue Advantage Provider Portal or contact the Blue Advantage Medical Management department at:

- phone: 1-866-508-7145, option 5, option 4
- fax: 1-877-528-5816
- 1-877-528-5818 (for inpatient)

The phones are forwarded to a secured voicemail system during non-business hours and the fax is available 24 hours a day, seven days a week. Notifications submitted via phone or fax will be confirmed by Blue Advantage Medical Management staff with a reference number. This reference number is not a guarantee of payment.

30. **Are inpatient admission and discharge notifications required?**

Yes. As a Blue Advantage network provider, you are required to provide notification for inpatient admissions and discharges. Blue Advantage network providers must submit clinical documentation to Blue Advantage within one business day of admission to complete the notification process and receive an authorization. Blue Advantage facilities are required to provide anticipated discharge dates to Blue Advantage Medical Management to issue final length-of-stay authorization for claims payment and ensure effective and appropriate coordination of after-care services.

31. **Does Blue Advantage offer case management services?**

As a partner in managing the health needs of our members, Blue Advantage offers a variety of case management services that are available through coordination with the PCP or plan staff. Outreach is conducted to members identified as high risk. These services are available free of charge to all members not enrolled in a hospice program or residing in a long-term care facility and who agree to case management. Our programs focus on improving our members' health status and quality of life, access to community resources and reduction of unnecessary costs for CMS, our members and the plan. Our physician-led interdisciplinary team includes health outreach specialists, nurse case managers, social workers, behavioral health specialists and clinical pharmacists.

32. **What is the process for non-emergent or out-of-network services?**

A patient may have a medical need for a non-emergent service that cannot be met by a network provider. If unable to refer to other network providers:

- Members enrolled in the Blue Advantage (HMO) plan, require prior authorization from the Medical Management department before the patient can be referred to a non-participating provider
- Members enrolled in the Blue Advantage (PPO) plan, do not require prior authorization for out-of-network services

Advanced Beneficiary Notice (ABN)

33. **Are Advanced Beneficiary Notices (ABNs) applicable to Blue Advantage members?**

Advanced Beneficiary Notices (ABNs) are not applicable to members in Blue Advantage (or any Medicare Advantage plan). Blue Advantage providers must do the following to hold members financially liable for non-covered services not clearly excluded in the member's explanation of coverage (EOC):

- Request a pre-service organization determination from Blue Advantage if you know or have reason to believe that a service may not be covered by Medicare.
- If Blue Advantage denies the coverage request, we will issue an Integrated Notice of Denial (IDN) to the member and requesting provider.

- After the member is notified of denial via the IDN, prior to services being rendered, the provider may collect from the member fees for the specific services outlined in the IDN, should the member desire to receive them.

Pharmacy Management

34. What is the Blue Advantage Pharmacy network?

The Blue Advantage Pharmacy network provides coverage for prescription medications. Blue Advantage patients may have their prescriptions filled through a wide network of pharmacies, including mail-order. Please refer Blue Advantage patients to the Online Provider Directory for a comprehensive list of participating pharmacies in the Blue Advantage Pharmacy network (www.BCBSLA.com/myblueadvantage >Provider >Find a Provider, Hospital or Pharmacy).

Our pharmacy network includes pharmacies that offer preferred cost sharing. Members who fill their prescriptions at a preferred pharmacy (including mail-order) may pay less for their medications. Preferred pharmacies will be identified in the provider directory.

35. What drugs are covered under the Blue Advantage Part D formulary?

For a specific list of covered drugs, please refer to the Blue Advantage formulary, located on the Blue Advantage Provider Portal.

36. What pharmacy benefit manager does Blue Advantage use for Part D coverage determinations and appeals?

Blue Advantage uses Express Scripts, Inc. to perform certain Part D functions such as coverage determinations and appeals. For more information, refer to the Pharmacy Management section of the *Blue Advantage Provider Administrative Manual*.

37. Are there different levels of copayments or coinsurances for Blue Advantage Part D formulary?

Members pay a copayment for drugs in Tiers 1 through 4, and a coinsurance for drugs in Tier 5.

Blue Advantage Part D formulary is organized into five drug tiers:

- Tier 1 – Preferred Generics
- Tier 2 – Generic
- Tier 3 – Preferred Brand
- Tier 4 – Non-preferred Drug
- Tier 5 – Specialty

38. **Can Blue Advantage members receive an extended (90-day) supply of medications?**

Yes. We allow most medications, those in Tiers 1 through 4, to be filled as a 90-day supply at both retail pharmacies and via mail-order. For additional cost savings, patients can get a 90-day supply of Tier 1 and Tier 2 drugs for a $0 copay when filled at a preferred retail pharmacy or by mail. Please note: to take advantage of this benefit, it is best to write for a 90-day supply. Pharmacies may not be able to convert traditional 30-day prescriptions. Blue Advantage members can find more information about a 90-day supply and mail-order on the Pharmacy page of their Blue Advantage member portal. Specialty drugs on Tier 5 are limited to a 30-day supply.

Preferred Reference Laboratory

39. **What are the preferred reference laboratories for Blue Advantage?**

Lab	Phone	Email
Clinical Pathology Labs (CPL)	1-800-595-1275	www.cpllabs.com
Laboratory Corporation of America (LabCorp)	1-800-255-8279	www.labcorp.com
Quest Diagnostics	1-866-MY-QUEST (1-866-697-8378)	www.questdiagnostics.com

40. **What options are available for outpatient laboratory testing?**

Blue Advantage network providers have the following options for laboratory testing:

- Perform lab work in the office in accordance with the level of Clinical Laboratory Improvement Amendments (CLIA) certification.
- Draw labs in the office and send specimens to one of our participating reference lab facilities identified in our Provider/Pharmacy Directory.
- Send Blue Advantage members to a Blue Advantage network reference laboratory.

Behavioral Health Services

41. **Who administers behavioral health services for Blue Advantage members?**

Blue Advantage has partnered with New Directions for their expertise in the provision of behavioral health services. To arrange for care, the provider or member may call New Directions at 1-877-250-9167. No referral is needed.

- Blue Advantage (HMO) members must be directed to, and seen by, a provider within the Blue Advantage (HMO) network to receive covered services.
- Blue Advantage (PPO) members may be seen by a provider outside the Blue Advantage (PPO) network, however, members may incur additional costs.

Accountable Delivery System Platform (ADSP)

42. **What is the Accountable Delivery System Platform (ADSP)?**

    The ADSP is a web-based informatics application that contains a set of tools designed to put information in the hands of Blue Advantage PCPs. The information is provided in a series of reports and criteria-driven rules that allow a unique vantage point into the patient's health status across the entire continuum of care. The platform aggregates and analyzes data—including medical claims, EMR encounter data and lab and pharmacy data—to provide a comprehensive view of patient care. It then sends actionable clinical and financial data to physicians and other stakeholders at the point of medical decision-making to enable timely value-based healthcare decisions.

43. **How do PCPs access the ADSP?**

    Access to ADSP is located within the Blue Advantage Provider Portal, and available to PCPs only. PCPs must have a username and password to access the Lumeris ADSP. This is in accordance with CMS guidelines and the information provided is protected health information (PHI).

44. **Does the ADSP provide monthly reports on the health status of Blue Advantage members?**

    Between the second and fifteenth of each month, the administrative group level for each PCP office within the ADSP will be able to pull their member reports which will include eligibility information, medical and pharmacy claims data, capitation and premium information, Blue Advantage news and updates. The administrative group level is then responsible to forward this information to each individual PCP office. This information is also intended to help monitor the patient population's chronic diseases and co-morbidities to improve patient outcomes and successfully practice medicine within a risk-adjusted Medicare reimbursement model.

Claims

45. **Can Blue Advantage claims be submitted through the Blue Advantage Provider Portal or iLinkBlue?**

    No. Neither the Blue Advantage Provider Portal nor iLinkBlue can be used to submit Blue Advantage claims. Claims must be submitted using standard Medicare guidelines. Blue Advantage accepts the CMS-1500, UB-04 and electronically submitted claims from Change Healthcare.

    Blue Advantage providers are encouraged to work with their clearinghouse or electronic billing company to set up this information.

    - Blue Advantage providers must use the payor identification of **84555** on electronic claims and the claims must be routed to Change Healthcare.
    - All 835 electronic remittance advices (ERAs) must be retrieved from Change Healthcare and will be associated with payor identification **84555**. Providers must register with Change Healthcare to receive ERAs (835 feeds).
    - All 27X transactions must be submitted to Change Healthcare using the payor identification **BCLAM**.

46. **Are paper claims accepted on photocopied claim forms?**

No. Paper claims must be submitted on an original red/white claim form. If providers must bill on paper, they should follow standard CMS claims submission requirements including submission of the Blue Advantage member ID with leading zeros and NPI in the appropriate claim form fields.

47. **Where should paper claims be submitted?**

Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.
P.O. Box 7003
Troy, MI 48007

48. **Does Blue Advantage pay interest on clean claims over 30 days old?**

We will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day timeframe, we will pay interest on the claim according to Medicare guidelines.

49. **Can providers check the status of claims using the Blue Advantage Provider Portal?**

Yes. We encourage Blue Advantage network providers to use the Blue Advantage Provider Portal for standard claim-status checks. The Blue Advantage Provider Portal includes more information than is available from your clearinghouse. To access the claims inquiry feature on the Blue Advantage Provider Portal, you must have secure access.

50. **What is the difference between a resubmitted claim and a corrected claim?**

- A resubmitted claim is a claim processed by Blue Advantage and the provider resubmits the claim, due to a denial that occurs on either a claim line in question or the entire claim. If an amount was paid on the claim line in question, the provider should not use the claim resubmission process. However, if no payment was issued on the claim line in question, the claim can be resubmitted on paper or electronically.
- A corrected claim is a processed claim that a Blue Advantage provider needs to add, remove or change a previously paid claim line. This must be done within the time frame outlined in the Blue Advantage provider contract. An example of a corrected claim includes adding or removing a previously paid claim line or charges billed for a service not being rendered.

51. **How do I submit a corrected claim?**

Follow the traditional CMS process for resubmission versus corrected claims. All corrected claims must be clearly indicated as a correction as follows:

CMS-1500 Claim Form:

- EDI/1500/Professional claim forms submitted as "corrected claims" can be submitted electronically.
- In Loop 2300 ~ CLM05-03 must contain a "7," REF01 must contain an "F8" and REF02 must contain the Original Reference Claim Number.
- CMS-1500 paper claim forms submitted as "corrected claims" can also be submitted on paper. The paper CMS-1500 claim submitted must indicate a frequency of "7" in Field 22

(Resubmission Code Field) and the Original Reference Claim Number in Field 22 (Original Ref. No. Field).
- The claim form should reflect a clear indication as to what has been changed. All previous line items must be submitted on the corrected claim.

UB-04 Claim Form:

- EDI/UB/Facility claim forms submitted as "Corrected Claims" can be submitted electronically.
- The Type of Bill (TOB) must indicate a frequency of "7", the claim submitted must indicate in Loop 2300 REF01 an "F8" and REF02 must contain the Original Reference Claim Number.
- UB-04 paper claim forms submitted as "corrected claims" can also be submitted on paper.
- The paper UB-04 claim submitted must indicate a frequency of "7" in Field 4, the Original Reference Claim Number in Field 64 and a reason for the correction in field 80.

Timely Filing Requirements

52. What are the timely filing requirements for Blue Advantage?

- Blue Advantage participating and non-participating providers have 12 months from the date of service to file an initial claim unless the individual provider agreement states otherwise.
- Blue Advantage participating and non-participating providers have 12 months from the date the claim was processed (remit date) to resubmit or correct the claim unless the individual provider agreement states otherwise:
  - Providers can resubmit the claim if it was previously denied or the claim line in question was previously denied.
  - Following the corrected claims process, providers must submit a corrected claim if all lines of the claim were previously paid. For example, if the provider can add to, remove or make a change to the claim line (date of service, procedure code, etc.), a corrected claim should be submitted.
  - Non-participating providers have 60 days from the date the claim was processed (remit date) to appeal a claim determination.
  - Participating providers have 12 months from the date the claim was processed (remit date) to dispute a claim determination.

53. What supporting documentation is needed if I want to dispute a claim denied for timely filing?

- If your claim was filed electronically, the only proof Blue Advantage will accept as timely filing is the second level acceptance report from the clearinghouse that the claim was accepted by Blue Advantage.
- If your claim was filed hardcopy, you must submit supporting documentation from your practice management system including the applicable field descriptions since the documentation is specific to your system OR a CMS-1500/UB-04 with the original date billed AND documentation must support the claim being submitted within 12 months from the date of service, AND follow-up done at a minimum of every 60 days. If there is no

documentation supporting the follow-up activity, such as filed second submission MM/DD/YYYY or contacted plan and spoke with _________, on MM/DD/YYYY, the timely filing denial will stand. Blue Advantage must have the documentation for CMS audits.

Requests for Medical Records

54. Can Blue Advantage network providers charge for medical records?

No. Per your Blue Advantage provider network agreement, you are not to charge a fee for providing medical records to Blue Advantage or agencies acting on our behalf.

The Notice of Medicare Non-Coverage (NOMNC)

55. Should home health agencies use the CMS standard Notice of Medicare Non-Coverage (NOMNC)?

Yes. Home health agencies must use the CMS standard Notice of Medicare Non-Coverage (NOMNC). A sample of the NOMNC for home healthcare services can be found in the "Sample of Forms" section of the *Blue Advantage Provider Administrative Manual*.