# APPENDIX II: FORMS

## of the Professional Provider Office Manual



Forms are available online at www.bcbsla.com/providers >Resources >Forms

This is an appendix of the *Professional Provider Office Manual*, and is for informational purposes only. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12


**Blue Cross only accepts CMS-1500 "version 02/12." No black and white copies or faxed claims are accepted.**

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-1197 FORM 1500 (02-12)

# HEALTH INSURANCE CLAIM FORM (CMS-1500 VERSION 02-12) EXPLANATION

**Block 1** Type(s) of Health Insurance - Indicate coverage applicable to this claim by checking the appropriate block(s).

**Block 1A** Insured's I.D. Number - Enter the member's Blue Cross and Blue Shield identification number, including prefix, exactly as it appears on the identification card.

**Block 2** Patient's Name - Enter the full name of the individual treated.

**Block 3** Patient's Birth Date - Indicate the month, day and year. Sex - Place an X in the appropriate block.

**Block 4** Insured's Name - Enter the name from the identification card except when the insured and the patient are the same; then the word "same" may be entered.

**Block 5** Patient's Address - Enter the patient's complete, current mailing address and phone number.

**Block 6** Patient's Relationship to Insured - Place an X in the appropriate block. Self - Patient is the member. Spouse - Patient is the member's spouse. Child - Patient is either a child under age 19 or a full-time student who is unmarried and under age 25 (includes stepchildren). Other - Patient is the member's grandchild, adult-sponsored dependent or of relationship not covered previously.

**Block 7** Insured's Address - Enter the complete address; street, city, state and zip code of the policyholder. If the patient's address and the insured's address are the same, enter "same" in this field.

**Block 8** Reserved for NUCC USE - This section is reserved for NUCC use.

**Block 9** Other Insured's Name - If the patient has other health insurance, enter the name of the policyholder, name and address of the insurance company and policy number (if known).

**Block 10** Is patient's condition related to: a. Employment (current or previous)?; b. Auto Accident?; c. Other Accident?. Check appropriate block if applicable.

**Block 10D** When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes. When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the CMS-1500 claim form are available at www.nucc.org under Code Sets. When reporting more than one code, enter three blank spaces and then the next code.

**Block 11** Not required.

**Block 11D** When appropriate, enter an X in the correct box. If marked "YES," complete 9, 9A and 9D. Only mark one box.

**Block 12** Patient's or Authorized Person's Signature - Appropriate signature in this section authorizes the release of any medical or other information necessary to process the claim. Signature or "Signature on File" and date required. "Signature on File" indicates that the signature of the patient is contained in the provider's records.

**Block 13** Insured's or Authorized Person's Signature - Payment for covered services is made directly to participating providers. However, you have the option of collecting for office services from members who do not have a copayment benefit and having the payments sent to the patients. To receive payment for office services when the copayment benefit is not applicable, Block 13 must be completed. Acceptable language is:

a. Signature in block
b. Signature on file
c. On file
d. Benefits assigned
e. Assigned
f. Pay provider

Please Note: *Assignment language in other areas of the CMS-1500 claim form or on any attachment is not recognized. If this block is left blank, payment for office services will be sent to the patient. Completion of this block is not necessary for other places of treatment.*

**Block 14** Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the present illness, injury or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported.

**Block 15** Enter another date related to the patient's condition or treatment. Enter the date in the date in the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) format. Enter the applicable qualifier to identify which date is being reported.

**Block 16** Dates Patient Unable to Work in Current Occupation - Enter dates, if applicable.

**Block 17** Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider **– Required**
2. Ordering Provider **– Required**
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported to the left of the vertical, dotted line.

**Block 17A** Other ID #. The non-NPI ID number of the referring physician, when listed in Block 17.

**Block 17B** **NPI – Required**. Enter the national provider identifier (NPI) for the referring physician, when listed in Block 17.

**Block 18** For Services Related to Hospitalization - Enter dates of admission to and discharge from hospital.

**Block 21** **Diagnosis or Nature of Illness or Injury -** Enter the applicable ICD indicator to identify which version of ICD codes is being reported: "0" for ICD-10-CM codes- Note: All transactions, electronic or paper-based, for services on and after October 1, 2015, must contain ICD-10 codes or they will be rejected. Blue Cross will not accept ICD-9 codes for dates of services on or after October 1, 2015. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. Use the most specific diagnosis codes when reporting codes. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

**Block 23** Prior Authorization Number - Enter the authorization number obtained from Blue Cross/ HMO Louisiana, if applicable.

**Block 24A** Date(s) of Service - Enter the "from" and "to" date(s) for service(s) rendered.

**Block 24B** Place of Service - Enter the appropriate place of service code. Common place of service codes are:

Inpatient - 21 Outpatient - 22 Office - 11

**Block 24C** EMG - Enter the Type of Service code that represents the services rendered.

**Block 24D** Procedures, Services, or Supplies - Enter the appropriate CPT or HCPCS code. Please ensure your office is using the most current CPT and HCPCS codes and that you update your codes annually. Append modifiers to the CPT and HCPCS codes, when appropriate.

**Block 24E** Diagnosis Pointer - Enter the diagnosis code reference letter (pointer) as shown in Block 21 to relate the date of service and procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-9-CM or ICD-10-CM diagnosis codes must be entered in Block 21 only. Do not enter them in 24E.

**Block 24F** Charges - Enter the total charge for each service rendered. You should bill your usual charge to Blue Cross regardless of our allowable charges.

**Block 24G** Days or Units - Indicate the number of times the procedure was performed, unless the code description accounts for multiple units, or the number of visits the line item charge represents. Base units value should never be entered in the "units" field of the claim form.

**Block 24J** Rendering Provider ID # - Enter the NPI for the rendering physician for each procedure code listed when billing for multiple physicians' services on the same claim. Laboratory, Durable Medical Equipment, Emergency Room Physicians, Diagnostic Radiology Center, Laboratory and Diagnostic Services, Retail Health Clinic and Urgent Care Center providers do not have to enter a physician NPI in this block. Please enter the facility NPI in blocks 32A and 33A as instructed.

**Block 25** Federal Tax I.D. Number - Enter the provider's/clinic's federal Tax ID number to which payment should be reported to the Internal Revenue Service.

**Block 26** Patient's Account Number - Enter the patient account number in this field. As many as nine characters may be entered to identify records used by the provider. The patient account number will appear on the Provider Payment Register/Remittance Advice only if it is indicated on the claim form.

**Block 27** Accept Assignment - Not applicable - Used for government claims only.

**Block 28** Total Charge - Total of all charges in Item F.

**Block 29** Amount Paid - Not required.

**Block 30** Not required.

**Block 31** Signature of Provider - Provider's signature required, including degrees and credentials. Rubber stamp is acceptable.

**Block 32** Name and Address of Facility - Required, if services were provided at a facility other than the physician's office.

**Block 32A** NPI - Enter the NPI for the facility listed in Block 32.

**Block 32B** Other ID - The non-NPI number of the facility refers to the payer-assigned unique identifier of the facility.

**Block 33** Billing Provider Info & Ph # - Enter complete name, address, telephone number for the billing provider.

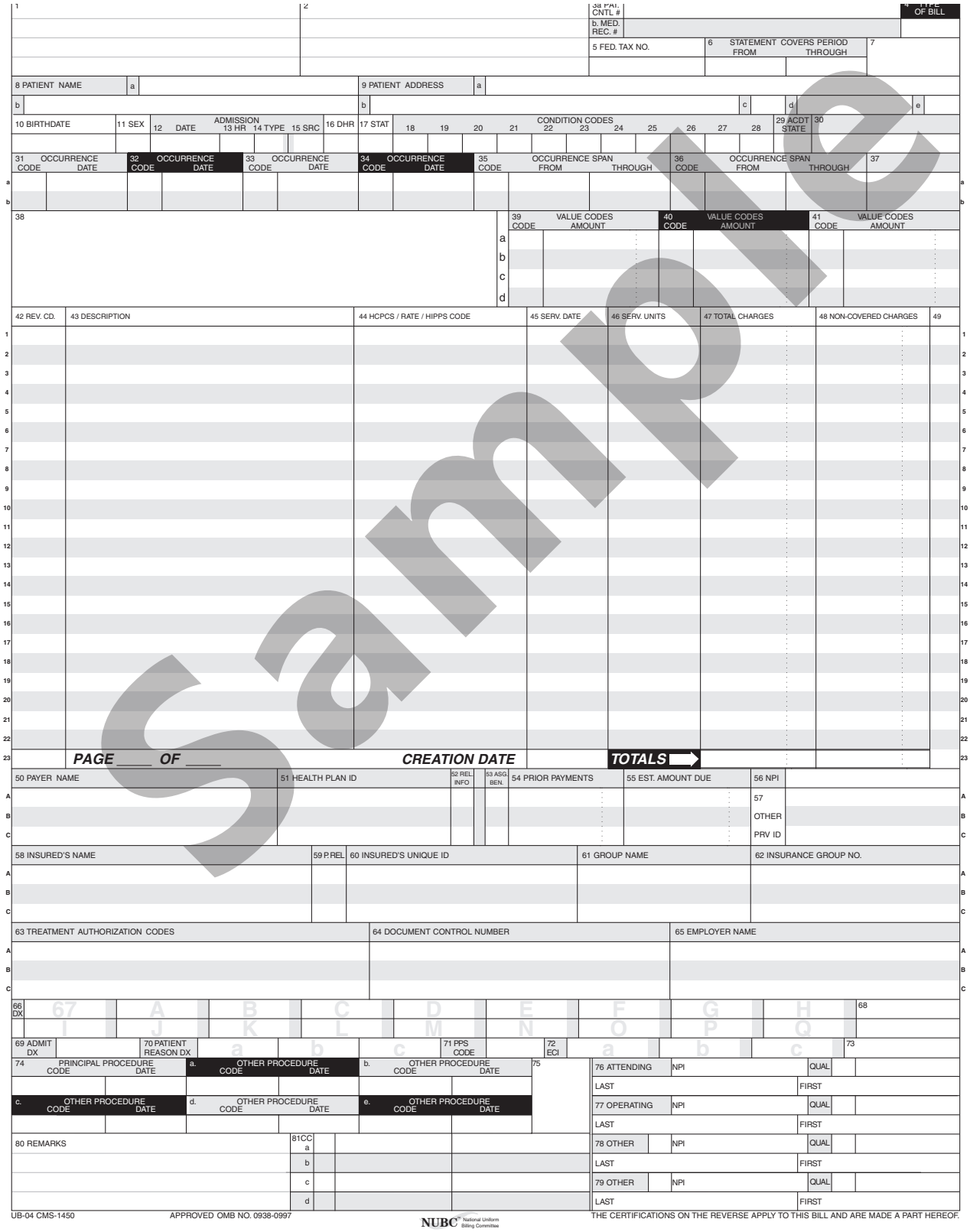
**Block 33A** NPI - Enter the NPI for the billing provider listed in Block 33.

**Block 33B** Other ID # - The non-NPI number of the billing provider refers to the payer-assigned unique identifier of the professional.

Example

# UB-04 CLAIM FORM

The following sample UB-04 claim form and instructions are given for those providers who should file claims using a UB-04 claim form, specifically acute care facilities, dialysis and home health providers.



## UB-04 CLAIM FORM EXPLANATION

**Block 1** Enter billing provider name and address.

**Block 2** Enter pay-to provider name and address, if different than Block 1.

**Block 3A** Patient Control Number: Enter the number or code that is used by your facility to retrieve or post financial records.

**Block 3B** Medical Record Number: Enter the number or code that is used by your facility to retrieve or post medical/health records

**Block 4** Type of Bill: This is a three-position code that indicates the type of facility, the bill classification and the frequency.

**Block 5** Fed. Tax ID: Enter Tax ID number of the facility.

**Block 6** Statement Covers Period: Enter the first date associated with this claim in the "From" box and enter the final date of the claim in the "Through" box.

**Block 8A-8B** Patient Name: Enter the patient's name with last name first, then first name and middle initial, if any. Do not use titles or nicknames.

**Block 9A-9E** Address: Patient address must be completed.

**Block 10** Birthdate: Enter the patient's actual date of birth in MM-DD-YYYY format.

**Block 11** Sex: An "M" for male or an "F" for female must be present.

**Block 12** Admission Date: This field is required for inpatient claims and not required for outpatient claims.

**Block 13** HR: This field is required for inpatient claims and not required for outpatient claims.

**Block 14** Type: This field is required for inpatient claims and not required for outpatient claims.

**Block 15** SRC: This field is required for inpatient claims and not required for outpatient claims.

**Block 16** DHR: Discharge hour field is required on all final inpatient claims except for 021x. This includes claims with a Frequency Code of 1 (Admit through Discharge), 4 (Interim-Last Claim) and 7 (Replacement of Prior Claim) when the replacement is for a prior final claim.

**Block 17** STAT: Enter the applicable discharge status code. This field is not required for outpatient claims, but can be present.

**Blocks 18-28** Condition Codes: The condition code(s) is a two-position code that identifies conditions, if any, relating to this bill that may affect payer processing.

**Block 29** Two-digit state abbreviation where the accident occurred.

**Block 30** Reserved for assignment by the National Uniform Billing Committee (NUBC).

**Blocks 31-34** Occurrence Codes and Occurrence Dates: The occurrence code is a two-position code used to determine liability, coordination of benefits and to administer subrogation clauses in the member contract/certificate. The occurrence date is the date that corresponds with the preceding occurrence code. The date must be in MM-DD-YYYY format and is required if occurrence codes are used.

**Block 35-36** Occurrence Span Codes and Dates: These fields are used when the patient was seen as an outpatient for follow-up treatment. In the "From" field, enter the first date the patient was treated for this condition. In the "Through" field, enter the last date the patient was treated for this condition. This field is not required for inpatient claims.

**Block 37** Reserved for assignment by the NUBC.

**Block 38** The name and address of the party responsible for the bill.

**Blocks 39-41** Value Code/Amount: Value code(s) identify data necessary for processing claims. The value amount is the dollar amount or number associated with the corresponding value code. A value amount must be present for each value code. If the amount does not represent a dollar amount, two zeros should be entered following the number. Example: If the patient received three units of blood, enter 300.

**Block 42** Rev CD: The revenue code is the code that best identifies a particular accommodation/ancillary service that was rendered to the patient. Revenue codes can be duplicated only if the rates differ.

**Block 43** Description: The provider reports the NDC code. The provider enters a narrative description or standard abbreviation for each revenue code shown. This field is not required but may be present.

**Block 44** HCPCS/Rates: The rate is the actual charge for the services rendered. If rates are different, duplicate the revenue code to show the different rates. Revenue codes can only be duplicated when the rates are different. Rate multiplied by units must equal charges.

**Block 45** Serv. Date: Date of service for HCPCS code listed. If there are multiple dates of service for the same HCPCS code, each date must be listed on a separate line.

**Block 46** Service Units: Service units are the number of times a service was rendered per date of service.

**Blocks 42-47** Line 23: The PAGE__ of __, CREATION DATE and total charges TOTALS should be reported on all pages of the UB-04.

**Block 47** Total Charge: Enter the amount charged for each of the revenue codes given. If rates and units are present, multiply these to get the total charges except when rates are zeros.

**Block 49** Reserved for assignment by the NUBC.

**Block 50** Payer Name: This field is required only on lines 50 B and 50 C when indicating other payer information.

**Block 52** REL INFO: The release information field must be "Y" if you are filing electronically. This indicates that you have signed written authority to release medical or billing information for purposes of claiming insurance benefits. If "N," you must file hardcopy.

**Block 53** ASG BEN: Enter one of the following codes to indicate who will receive payment for the claim:

Y Assignment/payment to provider
N Assignment/payment to member

Blue Cross pays all participating providers directly unless assignment indicates to pay the member.

**Block 56** NPI: Enter the appropriate national provider identifier (NPI) number in this field.

**Block 57** Other Prv ID: Enter your Blue Cross assigned five-digit or ten-digit provider number in this field.

**Block 58** Insured's Name: If the patient is not the insured, enter the member's name exactly as it appears on the Blue Cross identification card.

**Block 59** P REL: If the patient and insured are the same, this field is not required. If the patient is not the insured, enter one of the following codes that identifies the patient's relationship to the contract holder:

| | | | |
|---|---|---|---|
| 01 | Spouse | 18 | Self |
| 19 | Child | 20 | Employee |
| 21 | Unknown | 39 | Organ donor |
| 40 | Cadaver donor | 53 | Life Partner |
| G8 | Other relationship | | |

**Block 60** Insured's Unique ID: Enter the member's identification number exactly as it appears on the ID card.

**Block 61** Group Name: This field is required if known.

**Block 62** Insurance Group No.: Enter the group number as it appears on the member's ID card.

**Block 63** Treatment Authorization Codes: Enter the Blue Cross authorization number, when available.

**Block 65** Employer Name: Enter the patient's employer in this field. If patient is a housewife, retired, unemployed or a student in college, enter this. Do not enter the member's employer, unless the patient is the employer.

**Block 66** ICD Version Indicator: Qualifier Code "9" required on claims representing services through September 30, 2015. Qualifier Code "0" required on claims representing services on October 1, 2015, and beyond.

**Block 67** Principle Diagnosis Code: The principal diagnosis code must be entered in this field. You must use ICD-10-CM codebook. The first position should contain "V" or a numeric character. The second and third positions must be numeric with no punctuation. Fourth and fifth positions must be numeric or blank.

**Blocks 67A-Q** Other Diagnosis Codes: These fields should be used when additional conditions exist at the time of admission or develop subsequently and affect the treatment received or the length of stay. Follow the coding guidelines for the principal diagnosis code.

**Block 68** Reserved for assignment by the NUBC.

**Block 69** Admit Dx: Enter the ICD-10-CM diagnosis code related to the patient's admission.

**Block 70** The ICD-CM diagnosis code describing the patient's reason for visit at the time of outpatient registration.

**Block 71** The Prospective Payment System (PPS) code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.

**Block 72** The ICD diagnosis code pertaining to external cause of injuries, poisoning or adverse effect. See ICD-10-CM Guidelines for Coding and Reporting.

**Block 74** Principal Procedure Code/Date: The principal procedure should be entered in this field. This is the procedure that was performed for treatment rather than diagnostic or exploratory purposes, or the procedure that is most related to the principal diagnosis. The procedure coding method must be ICD-10-CM. Enter the date the primary/principal procedure was performed in MM-DD-YYYY format.

**Block 74A-E** Other Procedure Code/Date: For outpatient billing, if a CPT code is not required, enter the ICD-10-CM procedure code. Enter the date of the additional procedure(s) in MM-DD-YYYY format.

**Block 75** Reserved for assignment by the NUBC.

**Block 76** Attending: Enter the NPI, last name and first name of the attending physician who rendered the services. This field is required.

**Block 77** Operating: Enter the NPI, last name and first name of the operating physician who had primary responsibility for surgical procedures. This is only required when a surgical procedure code is listed.

**Block 78-79** Other: **Required**. Enter the NPI, last name and first name of referring physician, assistant surgeon, and/or rendering physician, as applicable.

**Block 80** Remarks: The remarks field must be completed if the type bill is "XX5" or "XX6" or if the third digit of a revenue code is "9" or if revenue codes 920 or 940 are present.

**Block 81** Enter B3-qualifier and then your respective taxonomy code. All claims need to be filed with a taxonomy code to ensure timely and accurate claims processing.

**Remarks** If the claim is for a federal employee contract and therapy revenue codes 42X, 43X or 44X are present, the actual dates of service for each revenue code must be entered in the remarks field.

## ILINKBLUE 1500 CLAIM ELECTRONIC ENTRY

iLinkBlue allows the electronic submission of professional 1500 claim forms giving providers the capability of submitting HCFA 1500 claims directly into the claims processing systems at Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Federal Employee Program (FEP) and BlueCard (out-of-area) members.

Please refer to the *iLinkBlue 1500 Claims Entry Manual*, which is available on iLinkBlue (www.bcbsla.com/ilinkblue) under the "Resources" section.

## ADA American Dental Association® Dental Claim Form

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**POLICYHOLDER/SUBSCRIBER INFORMATION** (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

**RECORD OF SERVICES PROVIDED**

| | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 29a. Diag. Pointer | 29b. Qty. | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ ( ICD-9 = B; ICD-10 = AB )
34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee $0.00

35. Remarks

**AUTHORIZATIONS**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment
43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number | 52a. Additional Provider ID

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number | 58. Additional Provider ID


J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746
or go online at adacatalog.org

## Description of ADA Dental Claim Form Explanation

**Block 1** Mark this box if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons under 21.

**Block 2** Enter the number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.

**Block 3** Enter the patient's primary insurance carrier's information.

**Block 4-11** Fill in other coverage information. Leave blank if no other coverage.

**Block 8** Policy Holder/Subscriber's identification number for additional coverage.

**Block 12-14** Enter Subscriber's personal insurance information here.

**Block 15** This is the member's identification number assigned by Blue Cross.

**Block 16-17** This is the member's or employer group's plan or policy number. May also be known as the certificate number and employer name.

**Block 18** Check indicating the relationship of the patient to the Policyholder/Subscriber.

**Block 19-23** Complete only if the patient is not the primary subscriber (i.e., "Self" not checked in Block 18).

**Block 19** Check "FTS" if the patient is a dependent and a full-time student; "PTS" is a part-time student. Otherwise, leave blank.

**Block 23** Enter if dentist's office assigns a unique number to identify the patient that is not the same as the subscriber identifier number assigned by the payer (e.g., chart number).

**Block 24** Enter date the procedure was performed.

**Block 25** Designate tooth number or letter when the procedure code directly involves a tooth. Use the area of the oral cavity code set from ANSI/ADA/ISO Specification number 3950m, "Designation System for Teeth and Areas of the Oral Cavity."

**Block 26** Enter applicable ANSI ASC X12 code list qualifier. Use "JP" when designating teeth using the ADA's Universal/National Tooth Designation System. Use "JO" when using the ANSI/ADA/ISO Specification No. 3950.

**Block 27** Designate tooth number when the procedure code reported directly involves a tooth. If a range of teeth is being reported, use a hyphen (-) to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.

**Block 28** Designate tooth surface(s) when the procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: B=Buccal; D=Distal; F=Facial; L=Lingual; M=Mesial and O=Occlusal.

**Block 29** Use the appropriate dental procedure code from the current version of the Code on Dental Procedures and Nomenclature.

**Block 30** Description of codes.

**Block 31** This is the dentist's full fee for the dental procedure reported.

**Block 32** This is used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.

**Block 33** This is the total of all fees listed on the claim form.

**Block 34** Report missing teeth on each claim submission.

**Block 35** Use "Remarks" space for additional information such as "reports" for "999" codes or multiple supernumerary teeth. Oral surgeons should place the diagnosis code in this field.

**Block 36** The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental healthcare. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian or other individual as appropriate under state law and the circumstances of the case.

**Block 37** Subscriber Signature: This is necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.

**Block 38** Indicate the place of treatment by choosing "Provider's Office," "Hospital," "Extended Care Facility (ECF)" (e.g., nursing home) or "Other."

**Block 39** Fill in the number of each type of enclosures in the appropriate boxes provided.

**Block 40** Indicate whether or not the treatment is for orthodontics purposes.

**Block 41** If "yes" is checked in Block 40, list date appliance was placed.

**Block 42** If "yes" is checked in Block 40, list how many months of treatment are remaining.

**Block 43** If "yes" is checked in Block 40, indicate whether or not a replacement of prosthesis was done.

**Block 44** If "yes" is checked in Block 43, list date of prior placement.

**Block 45** Indicate what the treatment is resulting from, if applicable.

**Block 46** List date of accident.

**Block 47** Report what state the accident occurred.

**Block 48** This is the individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.

**Block 49** Billing dentist's national provider identifier (NPI).

**Block 50** This refers to the license number of the billing dentist. This may differ from that of the treating dentist that appears in the treating dentist's signature block.

**Block 51** The Internal Revenue Service requires that either the SSN or TIN of the billing dentist or dental entity be supplied only if the provider accepts payment directly from the third-party payer. When the payment is being accepted directly, report the: 1) SSN if the dentist is unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic.

**Block 52** Billing dentist or dental entity's phone number.

**Block 52a** Additional Provider ID #.

**Block 53** This is the treating, or rendering, dentist's signature and date the claim form was signed. Dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance, but not completed.

**Block 54** Treating dentist's NPI.

**Block 55** Treating dentist's license number.

**Block 56** This is the full address, including city, state and zip code, where treatment is performed by the treating (rendering) dentist.

**Block 57** Treating dentist or treatment location phone number.

**Block 58** Additional Provider ID #.

Louisiana

# Alternative Dental Procedure Payment Responsibility Form

Complete and attach this form to the dental claim form when a member chooses an alternative, non-covered treatment.

Pursuant to Louisiana Senate Bill 73, which amended and/or reenacted La. R.S. 22:1513(C)(2)(b); 22:250.43(C) and 22:250.48, a Blue Cross and Blue Shield of Louisiana (BCBSLA) member may choose any type, form or quality of dental procedure, for which insurance coverage is not available, as long as the member approves in advance and in writing the charges for which he/she will be responsible. Additionally, if a member receives a dental diagnosis from a contracted provider that qualifies for a covered service pursuant to the member's contract/certificate or dental contract, the member may:

1. Choose the covered service provided for in the member contract/certificate or dental contract for the treatment of the condition diagnosed; or

2. Choose an alternate type, form or quality of dental procedure of equal or greater price to treat the diagnosed condition. If the member chooses this option, he/she must agree in advance and in writing to pay the difference between the allowed amount of the covered service and the amount of the chosen alternative service or procedure.

| **DENTIST INFORMATION** | |
|---|---|
| Dentist Name | |
| Contact Name | National Provider Identifier (NPI) |
| Phone Number | Fax Number |
| **COVERED SERVICE** | |
| CDT Code | Description |
| Additional CDT Code | Description |
| **ALTERNATIVE TREATMENT/SERVICE** | |
| CDT Code | Description |
| Additional CDT Code | Description |
| **MEMBER INFORMATION** | |
| By receiving the above alternative treatment/service, I agree that I will be responsible for the difference between the allowed amount paid by BCBSLA and the amount charged by the dentist for the chosen alternative service or procedure. | |
| Member Signature | Date |
| Member Name (please print) | Member ID |



18NW1061 R1/17

## PROVIDER UPDATE REQUEST FORM

The Provider Update Request Form (available at www.bcbsla.com/providers >Resources >Forms) should be used to notify Blue Cross of changes or additions to provider demographic information, including what is displayed in our provider directories.

Use this form to submit any of the following change requests to our Provider Credentialing & Data Management Department.

| Provider Demographic Change |
| --- |
| Have a change in contact information, such as a new or updated email address |
| New providers join your practice |
| Obtain a new Tax ID number |
| Providers in your clinic retire or move |
| Close a practice |
| Merge a practice |
| Change or terminate your electronic funds transfer (EFT) payment information (commercial only) |

Complete, sign and submit the Provider Update Request Form digitally with DocuSign®. It is no longer necessary to print and submit this form hardcopy. The form is accepted through DocuSign only and the sample of the form on the next pages is for reference purposes.

Louisiana

# Provider Update Request Form

Complete this form to report updated information on your practice to Blue Cross and Blue Shield of Louisiana. Based on your Type of Change needed, DocuSign® highlights the relevant fields to your request, and those fields appear in red throughout the form.

This request applies to: ☐ Individual Provider ☐ Provider Group/Clinic

| CURRENT GENERAL INFORMATION | | |
|---|---|---|
| Provider Last Name | First Name | Middle Initial |
| Tax ID Number | Provider National Provider Identifier (NPI) | |
| Group/Clinic Name | Group/Clinic National Provider Identifier (NPI) | |
| Are you a primary care provider (PCP)? ☐ Yes ☐ No | Specialty | Date of Requested Change |

If you are an authorized representative completing this form on behalf of a provider, please indicate below.

| AUTHORIZED REPRESENTATIVE | |
|---|---|
| Name | |
| Contact Phone Number | Contact Email Address |
| **Submission Information** (form completed by) | |
| Signature of Authorized Representative | Date |
| **Provider Attestation** (where applicable) | |
| Signature of Provider | Date |

**TYPE OF CHANGE**

**Check all applicable boxes below to indicate the information you wish to change. This allows you to complete the required sections of the forms, as appropriate.**

| | | |
|---|---|---|
| ☐ Demographic Information | ☐ Electronic Funds Transfer (EFT) Termination or Change | ☐ Existing Providers Joining a New Provider Group (*includes solo providers creating a new provider group*) |
| ☐ Termination Request | ☐ Tax ID Number Change | ☐ Add New Practice Location (Existing Tax ID) |
| ☐ Remove Practice Location (Existing Tax ID) | | |

If you have any questions, please contact Provider Credentialing & Data Management at:

Phone: 1-800-716-2299, option 2 Email: PCDMstatus@bcbsla.com

23XX7231 R06/23

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

## Demographic Information

Please complete the following to change your demographic information (e.g., address, hours of operation, etc.).

| **NEW GENERAL INFORMATION** | | |
|---|---|---|
| **New** Last Name | **New** First Name | |
| **New** Group/Clinic Name | | |
| Languages Spoken | ☐ Adding Language Spoken *(please specify)* | |
| **Current** Specialty | | |
| Changing Specialty?<br>☐ Yes ☐ No | If yes, please specify **New** Specialty | Are you a primary care provider (PCP)?<br>☐ Yes ☐ No |
| Changing NPI?<br>☐ Yes ☐ No | If yes, please specify **New** NPI | |
| Changing clinic to Rural Health Center (RHC) or Federally Qualified Health Center (FQHC)?<br>☐ Yes ☐ No | If yes, please specify<br>☐ RHC ☐ FQHC | If yes, please attach a copy of your DHH license for RHC or CMS approval letter for FQHC. |

| **BILLING ADDRESS CHANGE (address for payment registers, reimbursement checks, etc.)** | | |
|---|---|---|
| **Former** Billing Address | | |
| City, State and ZIP Code | | Phone Number |
| **New** Billing Address | | |
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | Effective Date of Address Change |

| **MEDICAL RECORDS ADDRESS CHANGE (for medical records request)** | | |
|---|---|---|
| **Former** Medical Records Address | | |
| City, State and ZIP Code | | Phone Number |
| **New** Medical Records Address | | |
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | Effective Date of Address Change |

**PHYSICAL ADDRESS CHANGE (must include a copy of your liability insurance showing the new address)**

**Former** Physical Address

| City, State and ZIP Code | Phone Number |
|---|---|

**New** Physical Address

| City, State and ZIP Code | Phone Number | Fax Number |
|---|---|---|
| Email Address | Effective Date of Address Change | |

**Current** Type of Practice: ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Health plan/Payor-owned

**New** Type of Practice: ☐ No change ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Health plan/Payor-owned ☐ Hospital-based ☐ Hospital-employed

| Office Hours | Age Range *(if applicable, indicate age range)* |
|---|---|

**Accepting New Patients**

Closing panel to new patients (No longer accepting new patients)
☐ Yes ☐ No

Opening panel to accept new patients (My panel is currently closed and I would like to begin accepting new patients)
☐ Yes ☐ No

**Practice Hours** (available appointment hours)

| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

For this practice location (please select at least one option):

☐ I am available to see patients at least 16 hours per week on a regular basis.
☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
☐ I read tests or provide other services, but do not see patients at this location.
☐ I do not practice here, but this location is within the medical group with which I am employed.

**CORRESPONDENCE ADDRESS CHANGE (Please update the address you would like us to send our Provider Communications to, including manuals, newsletters, etc.)**

**Former** Correspondence Address

| City, State and ZIP Code | Phone Number |
|---|---|

**New** Correspondence Address

| City, State and ZIP Code | Phone Number | Fax Number |
|---|---|---|
| Email Address | Effective Date of Address Change | |

# Electronic Funds Transfer (EFT) Termination/Change

To update your current Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT) information, please complete the following information.

## TERMINATION/CHANGE REQUEST

☐ Please terminate me from the EFT program.

☐ Please change my EFT information as reflected below.

## CONSENT

If changing my EFT information, I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.

If changing my EFT information, I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in iLinkBlue.

## PROVIDER INFORMATION

| Provider Name | | |
|---|---|---|
| Provider Address: | | |
| City | State/Province | ZIP Code/Postal Code |

## PROVIDER IDENTIFIERS INFORMATION

| Provider Tax ID Number (TIN) or Employer Identification Number (EIN) | |
|---|---|
| National Provider Identifier (NPI) | Group NPI (if applicable) |

## PROVIDER CONTACT INFORMATION

| Provider Contact Name | Title | |
|---|---|---|
| Phone Number | Email Address | Fax Number |

## RETAIL PHARMACY INFORMATION

| Pharmacy Name |
|---|
| NCPDP Provider ID Number |

## FINANCIAL INSTITUTION INFORMATION

| | | |
|---|---|---|
| **Former** Financial Institution Name | | |
| **Former** Type of Account at Financial Institution | **Former** Financial Institution Account Number | **Former** Financial Institution Routing Number |
| **New** Financial Institution Name | | |
| **New** Type of Account at Financial Institution | **New** Financial Institution Account Number | **New** Financial Institution Routing Number |

**New** Account Number Linkage to Provider Identifier

☐ Provider Tax ID Number (TIN): _____

☐ National Provider Identifier (NPI): _____

## SUBMISSION INFORMATION

Include with Enrollment Submission

☐ Voided Check *(temporary checks are not accepted)*

or

☐ Bank Letter

Authorized Signature

☐ For change request:
This information is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act on it. An EFT Termination/Change Form must be completed if **any** of the above information changes.

☐ For termination request:
This information is to be removed from my account and remain in full force and effect until COMPANY has received written notification from me of new EFT information.

**Page 2 of 2**

## Existing Providers Joining a New Provider Group

Complete the following information to link an individual provider to a provider group or clinic.

**BILLING ADDRESS (for payment registers, reimbursement checks, etc.)**

| | | |
|---|---|---|
| Billing Address | | |
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | |

**MEDICAL RECORDS ADDRESS (for medical records request)**

| | | |
|---|---|---|
| Medical Records Address | | |
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | |

**CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)**

| | | |
|---|---|---|
| Correspondence Address | | |
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | |

**FIRST PHYSICAL ADDRESS**

Do you want this location listed as "participating" or "non-participating" in Blue Cross networks?

☐ Participating ☐ Non-participating

| | | |
|---|---|---|
| Physical Address | | |
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | Group/Clinic NPI |
| Group Medicare PTAN Number | Individual Medicare PTAN Number | |

Type of Practice:
☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group
☐ Hospital-based ☐ Hospital-employed ☐ Health plan/Payor-owned

Accepting New Patients
☐ New ☐ Existing Only
☐ Other: _____

Age Range of Patients (check all that apply)
☐ 0-6 years ☐ 7-11 years ☐ 12-18 years
☐ 19-65 years ☐ Over 65 ☐ All Ages
☐ Other: _____

Office Hours

| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

| Practice Hours (available appointment hours) | | | | | | |
|---|---|---|---|---|---|---|
| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services, but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

## SECOND PHYSICAL ADDRESS (if necessary)

Do you want this location listed as "participating" or "non-participating" in Blue Cross networks?

☐ Participating ☐ Non-participating

| Physical Address | | |
|---|---|---|
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | Group/Clinic NPI |
| Group Medicare PTAN Number | Individual Medicare PTAN Number | |

Type of Practice: ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Health plan/Payor-owned

Accepting New Patients

☐ New ☐ Existing Only

☐ Other: _____

Age Range of Patients (check all that apply)

☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages

☐ Other: _____

| Office Hours | | | | | | |
|---|---|---|---|---|---|---|
| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

| Practice Hours (available appointment hours) | | | | | | |
|---|---|---|---|---|---|---|
| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services, but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

## CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

- ☐ A copy of the Malpractice Liability Insurance Certificate is attached.
- ☐ Check if this is a new group or clinic not already on file with Blue Cross and complete the iLinkBlue agreement packet. *(Note: providers joining existing groups that already have iLinkBlue access do not need to complete the iLinkBlue agreement packet.)*

## Termination Request

Please complete the following information to request termination from one or more of our networks. ALL applicable information must be completed before we will terminate network participation.

**NETWORKS BEING TERMINATED**

**Full Termination**

☐ Terminate Provider Record (claims can no longer be filed to Blue Cross)

Reason for termination:

☐ Left Group/Clinic ☐ Deceased ☐ Retired ☐ Closed Practice ☐ Moved Out of State

☐ Other: _____

**Partial Termination**

☐ Terminate this provider from ALL networks (claims can still be filed to Blue Cross as a non-participating provider)

☐ Terminate this provider from the following network(s):

☐ Preferred Care PPO
☐ HMO Louisiana, Inc.
☐ Blue Connect
☐ Community Blue
☐ Precision Blue
☐ Signature Blue
☐ Blue HPN
☐ Blue Advantage (HMO/PPO)
☐ Blue Cross Dental
☐ FEP Preferred Dental
☐ Healthy Blue Dual Advantage (HMO D-SNP)
☐ FMOL Health System
☐ Ochsner EPO

Please provide an explanation for terminating the network(s) checked above:

_____

_____

*Important Note: Members who have seen the provider within the past 18 months are notified that the provider no longer participates in the applicable networks being terminated.*

Office Use Only:

Provider Contracting Approval:

☐ Yes ☐ No Rep Initials: _____ Approved Term Date: _____

# Tax Identification Number (TIN) Change Request

Please complete this form to report a change in your Tax ID number.

| **GENERAL INFORMATION** | | |
|---|---|---|
| Are you an individual changing your Tax ID? ☐ Yes ☐ No | | |
| **Former** Provider Name | **Former** TIN | **Former** NPI |
| **New** Provider Name | **New** TIN | **New** NPI |
| Are you an entity changing your Tax ID? ☐ Yes ☐ No | | |
| **Former** Entity Name | **Former** TIN | **Former** NPI |
| **New** Entity Name | **New** TIN | **New** NPI |
| Effective Date of Change | Do you want to participate in your existing networks under the new TIN, if applicable? ☐ Yes ☐ No | |
| What is your specialty? | Are you a primary care provider (PCP)? ☐ Yes ☐ No | |

| **BILLING ADDRESS (for payment registers, reimbursement checks, etc.)** | | |
|---|---|---|
| Billing Address | | |
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | |

| **MEDICAL RECORDS ADDRESS (for medical records request)** | | |
|---|---|---|
| Medical Records Address | | |
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | |

| **CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)** | | |
|---|---|---|
| Correspondence Address | | |
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | |

## PHYSICAL ADDRESS

| Physical Address | | |
|---|---|---|
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | Group Medicare PTAN Number | Individual Medicare PTAN Number |

Type of Practice: ☐ Solo ☐ Multi-specialty Group ☐ Single Specialty Group ☐ Hospital-based ☐ Hospital-employed ☐ Health plan/Payor-owned

Accepting New Patients

☐ New ☐ Existing Only

☐ Other: _____

Age Range of Patients (check all that apply)

☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages

☐ Other: _____

Office Hours

| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

Practice Hours (available appointment hours)

| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services, but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

## REQUIRED ATTACHMENTS

Professional Provider:

- ☐ State Licenses including current licenses held in other states, State CDS License and Federal DEA Registration
- ☐ Certificate(s) of Professional Liability Insurance
- ☐ Current Employer Identification Number (EIN) **and** Form W-9 or Federal Tax Deposit Coupon
- ☐ iLinkBlue **and** EFT agreements
- ☐ Administrative Representative Registration Form

Facilities:

- ☐ Health Delivery Organization (HDO) Form and applicable attachment
- ☐ Accrediting entity certification (JCAHO, CHAP, etc.)
- ☐ License (State, Occupational, CLIA, etc.)
- ☐ Medicare Participation Letter (if applicable)
- ☐ Professional Liability Insurance Certificate or Products Liability Insurance Certificate (DME providers)
- ☐ Louisiana Patients' Compensation Fund Certificate (if applicable)
- ☐ EIN Letter **and** Form W-9
- ☐ iLinkBlue **and** EFT agreements
- ☐ Administrative Representative Registration Form

**Once all necessary documentation has been submitted, our Provider Contracting team will contact you with a new provider agreement to be signed and returned.**

## Add New Practice Location (Existing Tax ID)

Complete the information below when a provider is adding practice location(s) to an existing Tax ID.

**LOCATION TO BE ADDED**

Physical Address

| City, State and ZIP Code | Phone Number | Fax Number |
|---|---|---|
| | | |

| Email Address | Effective Date |
|---|---|
| | |

Accepting New Patients

☐ New ☐ Existing Only

☐ Other: _____

Age Range of Patients (check all that apply)

☐ 0-6 years ☐ 7-11 years ☐ 12-18 years

☐ 19-65 years ☐ Over 65 ☐ All Ages

☐ Other: _____

Office Hours

| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

Practice Hours (available appointment hours)

| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

For this practice location (please select at least one option):

☐ I am available to see patients at least 16 hours per week on a regular basis.

☐ I see patients here at least one day per month, but less than one day per week on a regular basis.

☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.

☐ I read tests or provide other services, but do not see patients at this location.

☐ I do not practice here, but this location is within the medical group with which I am employed.

**SECOND LOCATION TO BE ADDED**

Physical Address

| City, State and ZIP Code | Phone Number | Fax Number |
|---|---|---|
| | | |

| Email Address | Effective Date |
|---|---|
| | |

Accepting New Patients

☐ New ☐ Existing Only

☐ Other: _____

Age Range of Patients (check all that apply)

☐ 0-6 years ☐ 7-11 years ☐ 12-18 years

☐ 19-65 years ☐ Over 65 ☐ All Ages

☐ Other: _____

Office Hours

| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

Practice Hours (available appointment hours)

| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services, but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

## THIRD LOCATION TO BE ADDED

| Physical Address | | |
|---|---|---|
| City, State and ZIP Code | Phone Number | Fax Number |
| Email Address | | Effective Date |

Accepting New Patients

☐ New ☐ Existing Only

☐ Other: _____

Age Range of Patients (check all that apply)

☐ 0-6 years ☐ 7-11 years ☐ 12-18 years

☐ 19-65 years ☐ Over 65 ☐ All Ages

☐ Other: _____

Office Hours

| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

Practice Hours (available appointment hours)

| Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|
| ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ | ____ - ____ |

For this practice location (please select at least one option):

- ☐ I am available to see patients at least 16 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services, but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

## CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

- ☐ A copy of the Malpractice Liability Insurance Certificate is attached.
- ☐ Check if this is a new group or clinic not already on file with Blue Cross and complete the iLinkBlue agreement packet. *(Note: providers joining existing groups that already have iLinkBlue access do not need to complete the iLinkBlue agreement packet.)*

## Remove Practice Location (Existing Tax ID)

Complete the information below when a provider is removing a practice location(s) from an existing Tax ID.

| GENERAL INFORMATION | | | |
|---|---|---|---|
| Individual Provider Last Name | First Name | | Middle Initial |
| Individual Provider NPI | | Languages Spoken | |
| Group/Clinic Name | | Group/Clinic NPI | |
| Group/Clinic Tax ID Number | | Effective Date | |
| What is your specialty? | | Are you a primary care provider (PCP)? ☐ Yes ☐ No | |

| LOCATION TO BE REMOVED | | | |
|---|---|---|---|
| Physical Address | | | |
| City | State | ZIP Code | Effective Date |

| SECOND LOCATION TO BE REMOVED | | | |
|---|---|---|---|
| Physical Address | | | |
| City | State | ZIP Code | Effective Date |

| THIRD LOCATION TO BE REMOVED | | | |
|---|---|---|---|
| Physical Address | | | |
| City | State | ZIP Code | Effective Date |

## TIPS FOR COMPLETING THE PROVIDER DISPUTE FORM

1. Be sure to check the box that most closely matches your provider type.
2. This form should be used when you believe a claim was:
   - Rejected as a duplicate
   - Denied for bundling
   - Denied for medical records
   - Payment/denial affects the provider's reimbursement (timely filing, authorization penalty, etc.)
   - Denied for a BlueCard member
3. Include the appropriate supporting documentation along with the Provider Dispute Form. For assistance in what to attach, see the "Suggested Supporting Documentation" section on the form for guidance.
4. The dispute will not be considered or claim review could be delayed if:
   - The entire Provider Dispute Form is not completely filled out
   - More than one reason is selected on the form for requesting a claim review
   - The form is submitted to the wrong departmental address or fax number instead of the correspondence information listed on the "Where to Send" section of the form
   - The form is submitted to multiple areas of the company

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 | Contact Fax Number |

## PATIENT INFORMATION

| | | |
|---|---|---|
| Member ID | Subscriber 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<br>2. Anesthesia Report<br>3. Pre-op History and Physical<br>4. Asst. Surgeon Credential (If not M.D.) | 1. Discharge Summary<br>2. Hospital Progress Notes<br>3. History and Physical Notes<br>4. Pathology Report | 1. Office Notes Pertaining to Date of Service<br>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.*

**PLEASE REVIEW MY DISPUTE FOR THE FOLLOWING REASON**

***Check only one reason per form.***

| | REASON FOR REVIEW | SUGGESTED SUPPORTING DOCUMENTATION | TIME TO ALLOW RESPONSE FROM BCBSLA FROM DATE SUBMITTED | WHERE TO SEND |
|---|---|---|---|---|
| ☐ | Claim payment/denial affects the provider's reimbursement (check the appropriate boxes below):<br>☐ Timely filing<br>☐ Reimbursement/ Contractual Allowable<br>☐ Authorization penalty<br>☐ Bundling/ Unbundling issue<br>☐ Refund | • Provider Dispute Form including reason for dispute; if bundling issue, reason why current bundling logic is incorrect, or if reimbursement issue, expected allowable amount<br>• Supporting medical documentation<br>• Proof of timely filing (only if denied for timely filing) | 60 days | MAIL OR FAX:<br>BCBSLA - Provider Disputes<br>P.O. Box 98021<br>Baton Rouge, LA 70898-9021<br>Or FAX: (225) 298-7035<br><br>ONLINE:<br>Through iLinkBlue (www.bcbsla.com/ilinkblue), click "Document Upload," then "Provider Disputes" in the drop-down menu. |
| ☐ | Claim denied for a BlueCard® member (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana) | • Provider Dispute Form including reason<br>• Supporting medical documentation | 60 days | MAIL OR FAX:<br>BCBSLA<br>P.O. Box 98029<br>Baton Rouge, LA 70898-9045<br>or FAX: (225) 297-2727 |

**FOR MEDICAL OR ADMINISTRATIVE APPEALS**

If you need to submit a medical appeal, administrative appeal or grievance on behalf of a member, then instead complete the Medical Appeals Request Form or Administrative Appeal Request Form. Both are available online at www.bcbsla.com/forms-and-tools under Appeals and Claims Forms.

If Blue Cross requires medical records, the Medical Management department will request them using the Medical Records Request for Claim Review form. Medical records can be uploaded in iLinkBlue (www.bcbsla.com/ilinkblue). Click on the Document Upload link on the main page then select "Medical Records for Retrospective or Post Claim Review" from the department drop down.

**FOR OTHER DISPUTES**

For more information on other types of disputes (not listed above) and how to submit them, review our Guide to Disputing Claims tidbit. It is available online at www.bcbsla.com/providers, click "Resources," then "Tidbits."

Louisiana

# Overpayment Notification Form

Complete this form to notify us of a possible overpayment for claims processed directly by BCBSLA for a Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana, Inc. (HMOLA), Federal Employee Program (FEP) or BlueCard® (out-of-area) member. Please fully complete the requested information on this form to ensure proper processing.

**Member ID:** _____

*(please include the three-character prefix or "R" for FEP members)*

**Do not send a check or payment with this form.** Submit the form only.

*Adjustments will be reflected on your future payment register(s).*

| **PATIENT INFORMATION** | |
|---|---|
| Patient's Full Name | Date of Birth |
| Claim Number | Patient Account Number |
| **REFUND INFORMATION** | |
| Date(s) of Service | Estimated Amount of Overpayment |
| Reason You Believe Overpayment Has Occurred | |
| **PROVIDER INFORMATION** | |
| Provider Name | National Provider Identifier (NPI) |
| Provider Address | |
| Name of Person Completing Form | Contact Phone Number |
| Date Form Completed | Contact Email Address |

Please refer to the instructions on the back of this form for more ways to submit overpayment notifications to BCBSLA, as well as information on how to submit this form.

**Page 1 of 2**

**In Lieu of Submitting this Form**

You may instead submit an Action Request through iLinkBlue (www.BCBSLA.com/ilinkblue). Go to the claim thought to be overpaid in iLinkBlue and submit an Action Request to have the claim reviewed for correct processing. To do this, 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. Please only submit one Action Request per claim; not one Action Request per line item of the claim. For more information on this process, please refer to our *iLinkBlue User Guide*, available online at www.BCBSLA.com/providers >Resources >Manuals.

**Instructions for BlueCard (out-of-area) Claims**

For BlueCard members, do not send a check (payment) with this form. Submit the form only. All adjustments will be reflected on your future payment register(s). BCBSLA cannot accept payments for BlueCard members. If an unsolicited refund payment is received for a BlueCard member, it will be returned with a letter requesting an Overpayment Notification Form be submitted. You may instead submit an Action Request in lieu of the form.

**General Refund Information**

Upon submitting this form:

- If it is determined that an overpayment did occur, you will not receive further notification from us. The claim will be adjusted, and your payment register will reflect the change.
- If it is determined that an overpayment did not occur, you will receive notification explaining that no adjustment to the claim is necessary.

When BCBSLA discovers the overpayment:

- If it is determined that a provider has received an overpayment and has not yet informed us, Blue Cross will send notification requesting the provider respond either agreeing or appealing the overpayment within 30 days. For FEP members, the provider has 120 days to respond.
- After the applicable provider review period, the claim is adjusted and will be reflected on the provider's future payment register(s).

**Return Form To:**

| | | |
|---|---|---|
| BCBSLA Correspondence | or | Fax: (225) 297-2727 |
| P.O. Box 98029 | | Attn: BCBSLA Correspondence |
| Baton Rouge, LA 70898-9029 | | |

A printable version of this Overpayment Notification Form is available online at www.BCBSLA.com/providers >Resources >Forms.

If you have questions about this process, you may contact the Customer Care Center at 1-800-922-8866.

Louisiana

# Authorization Form

## Fax: 1-800-586-2299

Complete this form to submit authorizations for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. members for inpatient, outpatient and offices services that require an authorization directly from our authorization department. Do not use this form for authorizations processed by Carelon Medical Benefits Management (Carelon), Express Scripts, Inc. or Lucet, etc.

*Failure to fully complete this form could delay your authorization processing.*

| | | | |
|---|---|---|---|
| **PATIENT DATA** | Last Name | First Name | Middle Initial |
| Contract/Subscriber ID Number | | | Date of Birth |
| **CLINICAL DATA** | ☐ Inpatient Admit/Surgery | ☐ Outpatient Procedure/Service | ☐ Office |
| Diagnosis Code(s) (ICD-10) | | CPT® Code(s) | |
| Number of Visits Requested (If Applicable) | | Date of Service/Admit Date | |
| **REQUESTING PHYSICIAN** | Last Name | First Name | Middle Initial |
| Address | | Phone number | Fax Number |
| NPI (National Provider Identifier) Number: | | | |
| **FACILITY INFORMATION** | Name | | |
| Address | | Phone number | Fax Number |
| NPI (National Provider Identifier) Number: | | | |
| **CONTACT PERSON** | Name | Phone number | Fax Number |
| **Additional Information:** | | | |

***Note:*** *Maternity admissions to network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for Cesarean section delivery.*

The authorization process is based on medical necessity only and is *not* a guarantee of payment. Services/procedures are subject to review by Blue Cross and Blue Shield of Louisiana for contractual limitations or exclusions. Providers are required to check an individual's benefits, limitations and eligibility immediately prior to providing a benefit or service. You may log into iLinkBlue (www.bcbsla.com/ilinkblue) or call the customer service number printed on the member's ID card for specific member information.



P.O. Box 98031, Baton Rouge, Louisiana 70898-9031 ● Phone: 1-800-523-6435 ● Fax: 1-800-586-2299

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# Retrospective Review Authorization Form

**Fax completed form to 1-800-515-1150**

Complete this form to submit retrospective authorizations for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. members for inpatient, outpatient and office services that require an authorization. **Retrospective review requests have up to a 30-day response time.** Do not use this form for authorizations processed by Carelon Medical Benefits Management (Carelon), Express Scripts, Inc., Lucet, etc.

Do not submit a request for retrospective review if you filed a claim. If we require additional medical records, Medical Management will request them using the Medical Records Request for Claim Review form.

Medical Records can be faxed or uploaded in iLinkBlue (www.bcbsla.com/ilinkblue). Click on the Document Upload link on the main page then select "Medical Records for Retrospective or Post Claim Review" from the department drop down. *Failure to fully complete this form could delay your authorization processing*.

| | | | | | | |
|---|---|---|---|---|---|---|
| **PATIENT DATA** | Last Name | First Name | | | Middle Initial | |
| Member ID | | | Date of Birth | | | |
| **CLINICAL DATA** | ☐ Inpatient Admit/Surgery | ☐ Outpatient Procedure/ Service | ☐ Ambulatory Surgery | ☐ Outpatient Hospital | ☐ Office | ☐ Home |
| Diagnosis Code(s) (ICD-10) | | | CPT® Code(s) | | | |
| Number of Visits Requested (If Applicable) | | | Date of Service/Admit Date: Start Date – End Date | | | |
| **REQUESTING PHYSICIAN** | Last Name | First Name | | | Middle Initial | |
| Address | | | Phone Number | | Fax Number | |
| National Provider Identifier (NPI) | | | | | | |
| **FACILITY INFORMATION** | Name | | | | | |
| Address | | | Phone Number | | Fax Number | |
| National Provider Identifier (NPI) | | | | | | |
| **CONTACT PERSON** | Name | | Phone Number | | Fax Number | |
| Additional Information: | | | | | | |

***Note:*** *Maternity admissions to network facilities (or out-of-network facilities if the member has out-of-network benefits) do not require authorization if the inpatient stay is 48 hours or less for vaginal delivery and 96 hours or less for Cesarean section delivery.*

The authorization process is based on medical necessity only and is not a guarantee of payment. Services/procedures are subject to review by Blue Cross and Blue Shield of Louisiana for contractual limitations or exclusions. Some policies apply penalties for failing to request prior authorization for specific services. Other policies will not cover a service without prior authorization. For urgent inpatient admissions, you must notify Blue Cross of that admission within 48 hours or the next business day, to avoid penalties or non-coverage. If you are unsure if a policy allows for retrospective review, contact Customer Care at 1-800-922-8866. Always verify eligibility and benefits before providing services by contacting Customer Care or using iLinkBlue (www.bcbsla.com/ilinkblue).

P.O. Box 98031, Baton Rouge, Louisiana 70898-9031 ● Phone: 1-800-922-8866 ● Fax: 1-800-515-1150



18NW3245 R03/23

# LOUISIANA UNIFORM PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

## SECTION I — SUBMISSION

| Submitted to: | Phone: | Fax: | Date: |
|---|---|---|---|
| Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc./Express Scripts | 1-800-842-2015 | 1-877-251-5896 | |

## SECTION II — PRESCRIBER INFORMATION

| Last Name, First Name MI: | | NPI# or Plan Provider #: | Specialty: | |
|---|---|---|---|---|
| Address: | | City: | State: | ZIP Code: |
| Phone: | Fax: | Office Contact Name: | Contact Phone: | |

## SECTION III — PATIENT INFORMATION

| Last Name, First Name MI: | DOB: | Phone: | ☐ Male ☐ Female ☐ Other ☐ Unknown |
|---|---|---|---|
| Address: | City: | State: | ZIP Code: |
| Plan Name (if different from Section I): | Member or Medicaid ID #: | Plan Provider ID: | |

Patient is currently a hospital inpatient getting ready for discharge? ____ Yes ____ No Date of Discharge:_____
Patient is being discharged from a psychiatric facility? ____ Yes ____ No Date of Discharge:_____
Patient is being discharged from a residential substance use facility? ____ Yes ____ No Date of Discharge:_____
Patient is a long-term care resident? ____ Yes ____ No If yes, name and phone number:_____
EPSDT Support Coordinator contact information, if applicable:

## SECTION IV — PRESCRIPTION DRUG INFORMATION

Requested Drug Name:

| Strength: | Dosage Form: | Route of Admin: | Quantity: | Days' Supply: | Dosage Interval/Directions for Use: | Expected Therapy Duration/Start Date: |
|---|---|---|---|---|---|---|
| | | | | | | |

To the best of your knowledge this medication is: New therapy/Initial request
_____Continuation of therapy/Reauthorization request

**For Provider Administered Drugs only:**

HCPCS/CPT-4 Code:_____NDC#:_____Dose Per Administration:_____
Other Codes:_____
Will patient receive the drug in the physician's office? ____Yes ____No
– If no, list name and NPI of servicing provider/facility: _____

## SECTION V — PATIENT CLINICAL INFORMATION

| Primary diagnosis relevant to this request: | ICD-10 Diagnosis Code: | Date Diagnosed: |
|---|---|---|
| Secondary diagnosis relevant to this request: | ICD-10 Diagnosis Code: | Date Diagnosed: |

For pain-related diagnoses, pain is: _____Acute _____Chronic
For postoperative pain-related diagnoses: Date of Surgery_____

Pertinent laboratory values and dates (attach or list below):

| Date | Name of Test | Value |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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## SECTION VI - This Section For Opioid Medications Only

Does the quantity requested exceed the max quantity limit allowed? ___Yes ___No (If yes, provide justification below.)
Cumulative daily MME_____

Does cumulative daily MME exceed the daily max MME allowed? ___Yes ___No (If yes, provide justification below.)

| | YES (True) | NO (False) | THE PRESCRIBER ATTESTS TO THE FOLLOWING: |
|---|---|---|---|
| SHORT AND LONG-ACTING OPIOIDS | | | A. A complete **assessment** for pain and function was performed for this patient. |
| | | | B. The patient has been **screened for substance abuse / opioid dependence**. *(Not required for recipients in long-term care facility.)* |
| | | | C. The **PMP** will be accessed **each** time a controlled prescription is written for this patient. |
| | | | D. A **treatment plan** which includes current and previous goals of therapy for both pain and function has been developed for this patient. |
| | | | E. **Criteria** for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient. |
| | | | F. **Benefits and potential harms** of opioid use have been discussed with this patient. |
| | | | G. An **Opioid Treatment Agreement** signed by both the patient and prescriber is on file. *(Not required for recipients in long-term care facility.)* |
| LONG-ACTING OPIOIDS | | | H. The patient requires continuous **around the clock** analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated. |
| | | | I. Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in pharmacologic/non-pharmacologic treatment section below. |
| | | | J. Medication has **not** been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time. |
| | | | K. Medication has **not** been prescribed for use as an as-needed (PRN) analgesic. |
| | | | L. Prescribing information for requested product has been **thoroughly reviewed** by prescriber. |

*IF NO FOR **ANY** OF THE ABOVE (A-L), PLEASE EXPLAIN:*

## SECTION VII - Pharmacologic & non-pharmacologic treatment(s) used for this diagnosis (both previous & current):

| Drug name | Strength | Frequency | Dates Started and Stopped or Approximate Duration | Describe Response, Reason |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| Drug Allergies: | Height (if applicable): | Weight (if applicable): |
|---|---|---|

Is there clinical evidence or patient history that suggests the use of the plan's pre-requisite medication(s), e.g. step medications, will be ineffective or cause an adverse reaction to the patient? ____Yes ____No (If yes, please explain in Section VIII below.)

## SECTION VIII — JUSTIFICATION (SEE INSTRUCTIONS)

**By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.**

Signature of Prescriber:_____ Date:_____

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Louisiana

# Guide to Completing the EFT Enrollment Form

Blue Cross and Blue Shield of Louisiana requires that participating providers enroll in our electronic funds transfer (EFT) service. EFT allows providers to receive payment electronically directly into their accounts. You can complete the EFT Enrollment Form at www.bcbsla.com/providers >Resources. The following information should help you complete the form.

## 1 CONSENT

The consent legally allows Blue Cross to electronically transfer funds to your financial account. The provision for Blue Cross to deduct funds applies when an erroneous credit occurs to a financial account resulting, for example, from a banking error.

## 2 PROVIDER INFORMATION

**Provider Name** – Complete legal name of institution, corporate entity, practice or individual provider

**Street Address** – The number and street name where a person or organization can be found

**City** – City associated with provider address field

**State/Province** – The two-character code associated with the State/Province/Region of the applicable country

**ZIP Code/Postal Code** – System of postal-zone codes (ZIP stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and utilize electronic reading and sorting capabilities

## 3 PROVIDER IDENTIFIERS INFORMATION

**Provider Federal Tax Identification Number (TIN) / Employer Identification Number (EIN)** – A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity

**National Provider Identifier (NPI)** – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted by HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

**Group NPI (if applicable)** – If part of a provider group, please also report the NPI for your group

## 4 PROVIDER CONTACT INFORMATION

**Provider Contact Name** – Name of a contact in provider office for handling ERA issues

**Title** – Title of the contact person

**Telephone Number** – Associated with the contact person

**Email Address** – An electronic mail address at which the health plan might contact the provider

**Fax Number** – A number at which the provider can be sent facsimiles

## 5 RETAIL PHARMACY INFORMATION *(this section should be completed by pharmacies only)*

**Pharmacy Name** – Complete name of pharmacy

**NCPDP Provider ID Number** – The NCPDP-assigned unique identification number

## 6 FINANCIAL INSTITUTION INFORMATION

**Financial Institution Name** – Official name of the provider's financial institution

**Financial Institution Routing Number** – The nine-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited

**Type of Account at Financial Institution** – The type of account the provider will use to receive EFT payments (e.g., checking, savings, etc.)

**Provider's Account Number with Financial Institution** – The provider's account number at the financial institution to which EFT payments are to be deposited

**Account Number Linkage to Provider Identifier** – Choose, then enter either the Provider TIN or NPI for the purpose of grouping (bulking) claim payments. Provider preference for grouping (bulking) claim payments must match preference for v5010 X12 835 remittance advice.

## 7 SUBMISSION INFORMATION

**Reason for Submission**

- **New Enrollment** – Check to indicate applying for new EFT enrollment

**Include with Enrollment Submission**

- **Voided Check** – A voided check is attached to provide confirmation of Identification/Account Numbers. Temporary checks are not accepted.

  or

- **Bank Letter** – A letter on bank letterhead that formally certifies the account owners routing and account numbers

**Authorized Signature** – The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment

**Written Signature of Person Submitting Enrollment** – The (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity

**Printed Name of Person Submitting Enrollment** – The printed name of the person signing the form

**Submission Date** – The date on which the enrollment is submitted

Providers should contact their financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. Shown below are the Data Elements that are necessary for re-association:

| CCD Record # | Field # | Field Name |
|---|---|---|
| 5 | 9 | Effective Entry Date |
| 6 | 6 | Amount |
| 7 | 3 | Payment Related Information |

**Late/Missing EFT and ERA Transactions Resolution Procedures:**

ERA (835) files are available weekly in trading partner mailboxes on Mondays, and no later than Wednesday, except during holidays or unexpected office closures. If you do not receive your ERA by close of business on Wednesday, you may contact EDI Services at 1-800-716-2299, option 3 or email EDIServices@bcbsla.com. Please include the Trading Partner ID, check number, check amount, check date and NPI.

EFT transactions are typically available at the provider's bank on Wednesday. If you have not received your deposit by close of business on Wednesday, you may contact EDI Services at 1-800-716-2299, option 3.

For questions about the ERA Form, please contact EDI Services at 1-800-716-2299, option 3. Also visit www.bcbsla.com/providers >Electronic Services >Clearinghouse.

To check the status of your ERA Form, you may submit your **request** via email to EDIServices@bcbsla.com. Please include the provider or group name, NPI, TIN or EIN and Trading Partner ID. Please allow three to five business days for setup.

To check the status of your EFT Form, you may submit your request via email to PCDMStatus@bcbsla.com. Please include the provider or group name, NPI and TIN or EIN. Please allow up to 15 business days for setup.

Provider's NPI must already be on file with Blue Cross. For more information on reporting your NPI to Blue Cross, visit www.bcbsla.com/providers >NPI or you may contact Provider Credentialing & Data Management at 1-800-716-2299, option 2.

Blue Cross does not set up ERAs for out-of-state providers.

Louisiana

# Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See included Guide to Completing the EFT Enrollment Form for detailed instructions.

## CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and to initiate adjustment for any credit entries made in error to the account indicated below.

I hereby authorize the financial institution/bank named below, hereinafter referred to as BANK, to credit and/ or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in iLinkBlue.

## PROVIDER INFORMATION

| | | |
|---|---|---|
| Provider Name | | |
| Provider Address: Street | | |
| City | State/Province | ZIP Code/Postal Code |

## PROVIDER IDENTIFIERS INFORMATION

| | |
|---|---|
| Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) | |
| National Provider Identifier (NPI) | Group NPI (if applicable) |

## PROVIDER CONTACT INFORMATION

| | | |
|---|---|---|
| Provider Contact Name | Title | |
| Telephone Number | Email Address | Fax Number |

## RETAIL PHARMACY INFORMATION

| |
|---|
| Pharmacy Name |
| NCPDP Provider ID Number |

## FINANCIAL INSTITUTION INFORMATION

| | | |
|---|---|---|
| Financial Institution Name | | |
| Financial Institution Routing Number | Type of Account at Financial Institution | Provider's Account Number with Financial Institution |

Account Number Linkage to Provider Identifier

- ❑ Provider Tax Identification Number (TIN): _____
- ❑ National Provider Identifier (NPI): _____

## SUBMISSION INFORMATION

Reason for Submission

- ❑ New Enrollment

Include with Enrollment Submission

- ❑ Voided Check *(temporary checks are not accepted)*

  or

- ❑ Bank Letter

Authorized Signature

I hereby acknowledge that the information provided on this form is true and correct. I further authorize COMPANY to utilize and rely on the information contained in this form until such time as I submit reasonable advance written notice to Company that this authorization has been terminated. I additionally acknowledge and agree that, in the event that any of the information I have provided on this form changes or becomes inaccurate, I must immediately submit an EFT Termination/Change Form containing such information necessary to correct such changed or inaccurate information.

_____
Written Signature of Person Submitting Enrollment

_____
Printed Name of Person Submitting Enrollment

_____
Submission Date

If you have any questions about this form or your EFT enrollment status, please contact Provider Credentialing & Data Management at:

Phone: 1-800-716-2299, option 2 Email: PCDMStatus@bcbsla.com

*For internal use only:* *iLB set up complete.*