BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

The BlueCard® Program Provider Guide

2021 Edition

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1. Introduction: The BCBS BlueCard® program makes filing claims easy

As a participating provider of the Blue Cross® Blue Shield® of Arizona (BCBSAZ) network, you may render services to patients who are National Account members of other BCBS Plans, and who travel or live in Arizona.

This guide describes the advantages of the BCBS system and provides information to make filing claims easy. You'll find helpful information about:

- Identifying BCBS members and products
- Verifying eligibility
- Obtaining pre-service reviews
- Filing claims
- Who to contact with questions

2. What is the BlueCard program?

2.1 Definition

BlueCard® is a national program coordinated by the Blue Cross Blue Shield Association (BCBSA) that enables members of a BCBS Plan to obtain healthcare service benefits while traveling or living outside of that Plan's service area. The program links participating healthcare providers in the independent BCBS Plans across the U.S. and in more than 170 countries and territories worldwide, through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other BCBS Plans, both domestic and international, to BCBSAZ.

BCBSAZ is your primary contact for claim payment, adjustments, and issue resolution. In certain instances (e.g., medical records requests for prior authorization, concurrent review, or disease management), the member's BCBS Plan may contact you directly.

2.2 BlueCard program—advantages for providers

More than 640,000 members from other BCBS Plans are currently residing in Arizona. BCBSAZ continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations. Working together, we can ensure that your patients will have a positive experience at each visit.

2.3 Products from other BCBS Plans

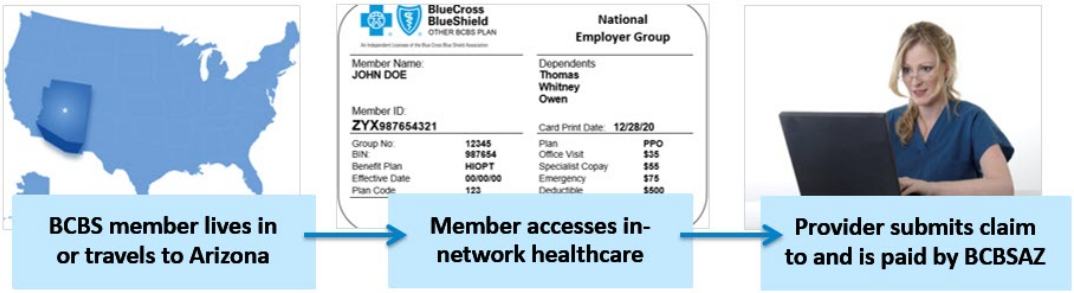
A variety of products from other BCBS Plans are eligible for out-of-area services. **Claims for these services should be submitted to BCBSAZ,** not to the member's BCBS Plan:

- PPO plans
- Traditional (indemnity insurance) plans
- EPO plans
- HMO plans
- Blue High Performance Network℠ (BlueHPN℠) EPO plans
- POS (point of service) plans
- International plans/benefits
- Medicare Complementary (Medigap) and Supplemental plans
- Medicare Advantage plans
- Medicaid plans
- State Children's Health Insurance Program (SCHIP) and Special Needs Plans (SNPs) if administered as part of a Medicaid program
- Stand-alone vision plans that are *not* delivered using a vendor
- Stand-alone prescription drug program plans that are *not* delivered using a vendor

The following types of products from other BCBS Plans might be eligible for out-of-area services, but you would ***not*** submit claims to BCBSAZ. For these products, **follow the instructions on the back of the member ID card:**

- All stand-alone dental plans
- Vision products delivered through an intermediary model (using a vendor)
- Self-administered prescription drug products delivered through an intermediary model (using a vendor)

3. How the out-of-area BlueCard program works



Let's say a member has PPO coverage through Blue Cross Blue Shield of Tennessee. There are two scenarios in which that member might need to see a provider in another BCBS Plan's service area, such as Arizona:

1. The member is traveling in Arizona.
2. The member resides in Arizona and has employer-provided coverage through Blue Cross Blue Shield of Tennessee.

The member can obtain in-network provider information by using the online **"Find a Doctor"** directory available at provider.bcbs.com/ or by calling the BlueCard Access® Line at 1-800-810-BLUE (2583). When the Tennessee member contacts a BCBSAZ provider, the provider can verify the member's eligibility and coverage information via a HIPAA electronic eligibility transaction, using the online Eligibility & Benefits Inquiry tool at azblue.com/providers or by calling the BlueCard Eligibility Line at 1-800-676-BLUE (2583).

After rendering services, the provider files a claim with BCBSAZ. BCBSAZ forwards the claim to Blue Cross Blue Shield of Tennessee for adjudication according to the member's benefits and the provider's contract with BCBSAZ. When the claim is finalized, the Tennessee Plan issues an explanation of benefits (EOB) to the member. BCBSAZ reimburses the provider and issues the remittance advice.

3.1 How to identify BCBS members

3.1.1 ID cards and prefixes

Be sure to check the member's current BCBS ID card. One of the main identifiers for out-of-area BCBS members is the BCBS Plan logo in the upper left corner of the card. Another important element is the member ID prefix. The ID cards may also display the:

- PPO "suitcase" logo, indicating broad access for eligible PPO members
- PPOB suitcase logo, for PPO members with access to the BlueCard PPO "Basic" network
- Blank suitcase logo, for members with no access outside of the plan's service area (e.g., HMO plans), except for urgent and emergency services, or when other care has been preauthorized
- BlueHPN suitcase logo, with Blue High Performance Network in the upper right or lower left corner, for BlueHPN EPO members

Other important information about member IDs:

- A correct member ID includes the *prefix* (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see a total of 17 characters including the prefix. Here are some examples:

  ABC1234567

  ABC1234H567

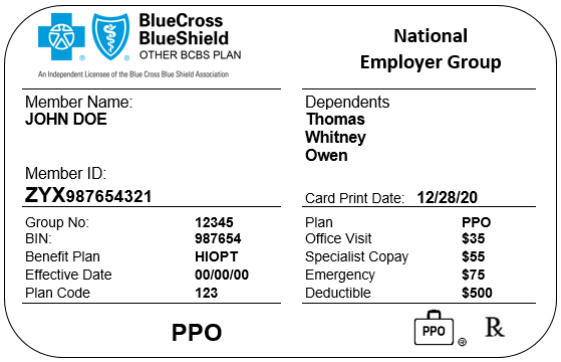
  ABC12345678901234

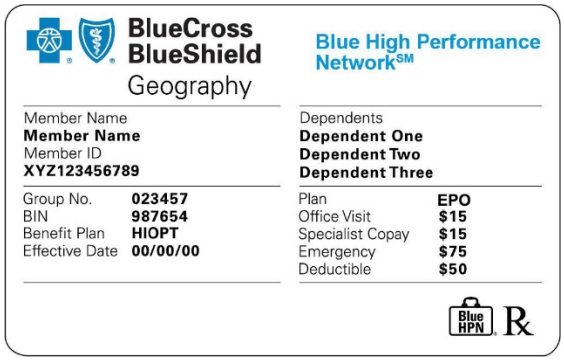
- Do not add or delete characters within the member ID.
- The prefix is critical for identifying and routing to the member's BCBS Plan.
- Prefix exceptions: Federal Employee Program® (FEP®) members will have the letter "R" followed by nine numbers. TPA-administered plans will not have a member ID prefix.

As a provider servicing out-of-area BCBS members, you may find the following tips helpful:

- Check the most current ID card at every visit. This will ensure that you have the most up-to-date information in the member's file.
- Include copies of the front and back of the member's ID card in the patient record and pass this key information on to your billing staff.
  - Reminder: the member ID number must be reported exactly as shown on the ID card and must not be changed or altered. Don't make up prefixes and don't add or omit any characters to/from the member ID.
  - The member's ID is *not* the member's Social Security number. All BCBS Plans replaced Social Security numbers on member ID cards with an alternative, unique identifier.

Sample BCBS Plan ID cards:





3.1.2 Suitcase logos

Many BlueCard ID cards display a suitcase logo. Here are examples of the various suitcase logos and what they mean:

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO or an EPO product. In either case, you will be reimbursed according to your BCBSAZ PPO provider contract. Please note that EPO products might have limited out-of-area benefits and this would be indicated on the back of the member's ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product and the member has access to a PPO network, referred to as **BlueCard PPO Basic.**

Each BCBS Plan determines which network is used for the BlueCard PPO Basic network. BCBSAZ has designated the statewide PPO to be part of this national network. Providers are reimbursed for covered services in accordance with their PPO contract with BCBSAZ.

The BlueHPN (Blue High Performance Network) in a suitcase logo indicates that the member is enrolled in a BlueHPN EPO product. Members must obtain services from BlueHPN providers to receive full benefits.

Each BCBS Plan participating in the national BlueHPN network determines which network is used for coverage in the included metropolitan service area(s). For the Phoenix metropolitan area, the Alliance Network is the designated BlueHPN network. If you are not part of the Alliance Network and offer emergency care within the Greater Phoenix metropolitan area or offer urgent or emergency services outside of the Phoenix metro area, you will be reimbursed according to your participation agreement for the statewide PPO network (just like you are for other EPO products). Members with BlueHPN plans have no other out-of-network coverage.

The empty suitcase logo indicates that the member is enrolled in one of the following types of products: traditional, HMO, or POS. For BlueCard members with traditional, HMO, and POS coverage, providers are reimbursed according to their specific BCBSAZ provider contract.

Please note: Some BCBS ID cards don't have any suitcase logo on them, including:

- ID cards for Medicaid and the State Children's Health Insurance Program (SCHIP) if administered as part of a state's Medicaid program
- ID cards for Medicare Complementary and Supplemental products, also known as Medigap.

Government-determined reimbursement levels apply to these products.

3.2 How to identify members with BlueHPN plans

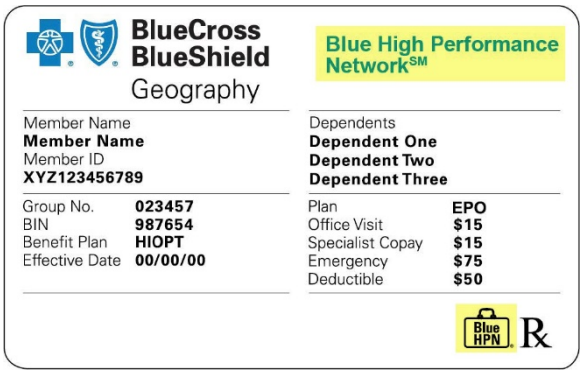
Blue High Performance Network (BlueHPN) plans are available to members living and working in key metropolitan areas. The plans use a national narrow network, and members must access in-network BlueHPN providers to receive full benefits. In Arizona, the BlueHPN for the Greater Phoenix metropolitan area consists of providers in the Alliance Network. If you are not contracted for the Alliance Network, it's important to note that benefits for services rendered by non-BlueHPN providers are limited to emergency care within the Greater Phoenix metro area, and to emergency and urgent care outside of the Phoenix metro service area. Outside of the BlueHPN service areas, urgent care must be provided by BCBS-contracted providers.

You can recognize BlueHPN members by the following:

- The Blue High Performance Network name on the front of the member ID card
- The BlueHPN suitcase logo in the bottom right corner of the member ID card

The back of ID card includes information about benefit limitations. For these limited benefits, if you are not a BlueHPN (Alliance Network) provider, you will be reimbursed according to your BCBSAZ PPO provider agreement, just like you are for other EPO products.

Sample BlueHPN member ID card:



3.3 How to identify members with BCBS international plans

Occasionally, you may see ID cards from members with GeoBlue or Blue Cross Blue Shield Global™ coverage or members with benefit plans from BCBS international licensees.

The ID cards from these licensees and product lines contain three-character prefixes and may or may not have one of the benefit product logos referenced on page 7. Please treat these members the same as you would domestic BCBS Plan members:

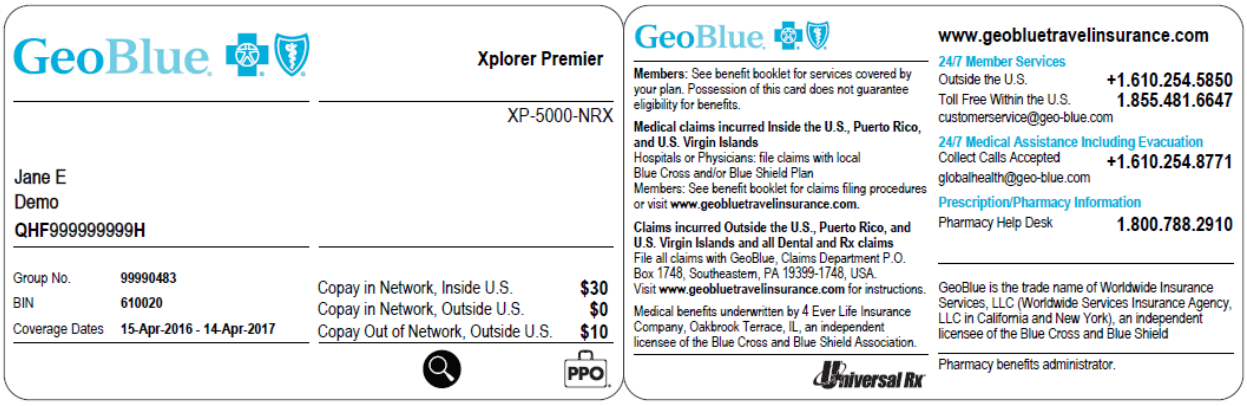
- Check eligibility and benefits using the online eligibility and benefits tool at azblue.com/providers or call the U.S. customer service number on the back of the ID card.
- Do not collect any upfront payment from the member beyond the applicable cost-share amounts, such as deductible, coinsurance and copay.
- File claims with BCBSAZ.

- Check claim status by using the online claim status tool in the secure provider portal at azblue.com/providers or use the automated IVR phone system at 602-864-4320 or 1-800-232-2345.

Sample ID card issued by an international licensee:

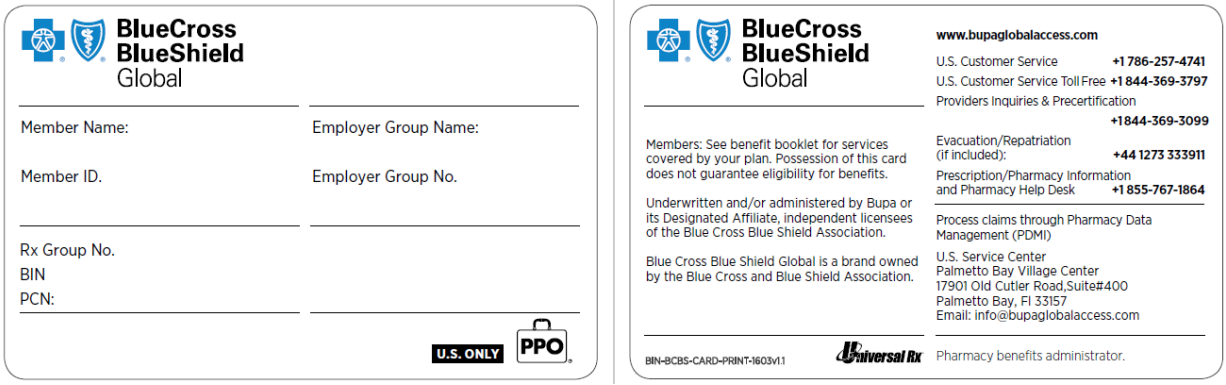
Sample ID cards for international products:

1. **GeoBlue ID card sample:**

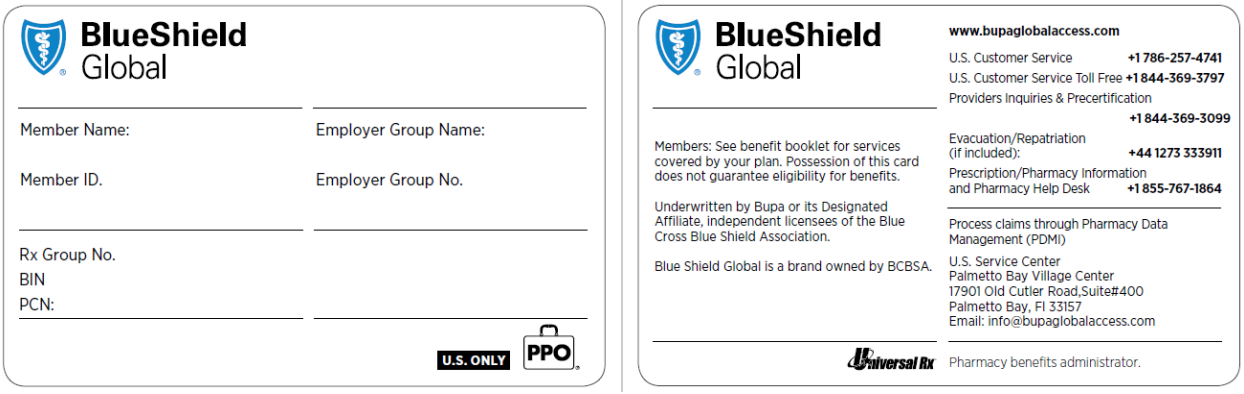


GeoBlue is the trade name of Worldwide Insurance Services, LLC (known as Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of Blue Cross Blue Shield Association, made available in cooperation with Blue Cross and Blue Shield companies in select service areas.

2. **Blue Cross Blue Shield Global ID card sample:** These international products, both supplemental and stand-alone, serve the needs of mobile individuals and employees when living, working, studying, or traveling globally.



3. **Shield-only ID card sample:** In certain territories, including Hong Kong and the United Arab Emirates, Blue Cross-branded products are not available. The ID cards of members in these territories will display the Blue Shield Global logo.



Bupa Global is a trade name of Bupa, the international healthcare company. Bupa is an independent licensee of Blue Cross and Blue Shield Association. Bupa Global is not licensed by the Blue Cross Blue Shield Association to sell products branded with the Blue Cross Blue Shield marks in Anguilla, Argentina, British Virgin Islands, Canada, Costa Rica, Panama, Uruguay and U.S. Virgin Islands. In Hong Kong, Bupa Global is only licensed to use the Blue Shield marks. Please consult policy terms and conditions for coverage availability.

Canadian ID cards

Important note: The Canadian Association of Blue Cross Plans and its member Plans are separate and distinct from the Blue Cross Blue Shield Association (BCBSA) and its member Plans in the United States.

You may occasionally see ID cards for people who are covered by a Canadian Blue Cross Plan. Claims for Canadian Blue Cross Plan members are not processed through the BlueCard Program.

Please follow the instructions of the Blue Cross Plans in Canada and those on the ID cards for servicing their members. The Blue Cross Plans in Canada are:

Alberta Blue Cross	Ontario Blue Cross Care	Quebec Blue Cross
Manitoba Blue Cross	Pacific Blue Cross	Saskatchewan Blue Cross
Medavie Blue Cross		

Source: bluecross.ca/en/contact.html

3.4 Limited benefits products

Verifying BCBS patients' benefits and eligibility is important, now more than ever, with multiple products and benefit types in the market. In addition to patients who have traditional BCBS PPO, HMO, POS, or other coverage, typically with high lifetime coverage limits (i.e., $1 million or more), you may now see patients whose annual benefits are limited to $50,000 or less.

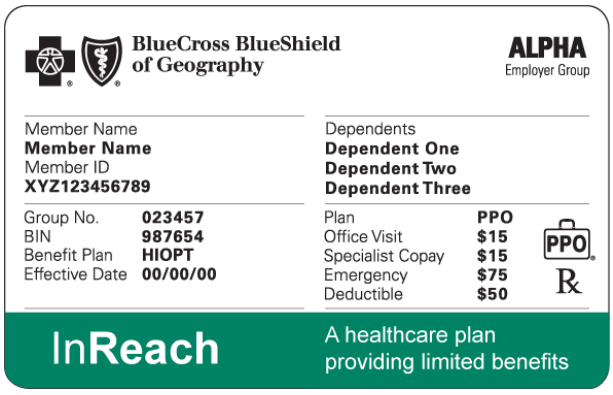
Currently, BCBSAZ doesn't offer such limited benefit plans. However, you might see patients with limited benefits who are covered by another BCBS Plan.

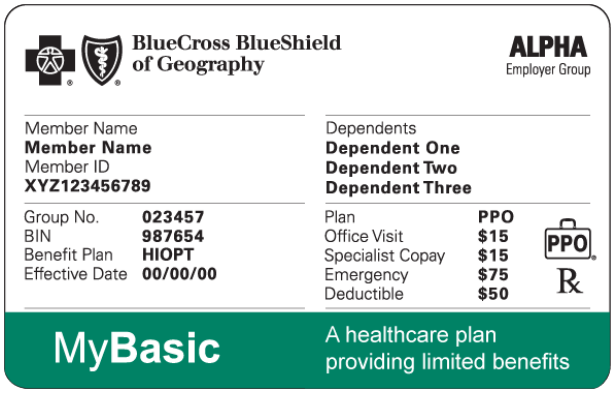
How to recognize members with limited benefits products

Members with limited benefits coverage (that is, annual benefits limited to $50,000 or less) carry ID cards that may have one or more of the following indicators:

- The product name, such as **InReach** or **MyBasic**
- A **green stripe** at the bottom of the card
- A statement either on the front or the back of the ID card stating this is a limited benefits product
- A **black cross and/or shield** to help differentiate it from other identification cards

Sample of limited benefit ID cards:





How to find out if the patient has limited benefit coverage

You can check for limited benefit coverage and current accumulated benefits by submitting a HIPAA 270 eligibility inquiry to BCBSAZ via the secure provider portal on azblue.com/providers or via an electronic data interchange (EDI) transaction. You can also call the BlueCard eligibility line at 1-800-676-BLUE (2583).

What to do if the patient's benefits are exhausted before the end of their treatment

Annual benefit limits should be handled in the same manner as any other limits on medical coverage. Any services beyond the covered amounts or the number of treatment are the member's liability.

We recommend that you inform patients of any potential cost share they may have as soon as possible.

3.4.1 Reference-based benefits

Reference-based benefits may be included in employer group plans to encourage employees to take a more active role in healthcare decisions and cost management. Reference-based benefits set a dollar amount that the plan will pay for certain healthcare services. This type of benefit is not applicable to any service that is urgent or emergent.

Reference-based benefit designs hold the member responsible for any expenses above the calculated “reference cost” ceiling for a single episode of service. Members with reference-based benefits use consumer transparency tools to determine if a provider will deliver the service at or under the reference cost. Members might also ask you to estimate how much a service will cost.

Providers receive their contracted reimbursement rate on all procedures related to applicable reference-based benefits.

Example 1: If a member has a reference cost ceiling of $500 for an MRI of the spine and the allowed amount is $700, the Plan will pay up to $500 for the procedure and the member is responsible for the remaining $200.

Example 2: If a member has a reference cost ceiling of $600 for a CT scan of the head/brain and the allowed amount is $400, the Plan will pay up to $400 for the procedure and the member has no responsibility for amounts over the allowed amount for covered services.

If the cost of the services rendered exceeds the reference cost ceiling, the Plan will pay benefits up to the reference cost ceiling. The member must pay standard cost-share amounts (coinsurance, copay, or deductible) and any amount above the reference cost ceiling, up to the contractual allowed amount.

How to identify if a member is covered under reference-based benefits

In the response from a benefits and eligibility inquiry, you will be notified if the member is covered under reference-based benefits for a particular service type:

MSG*REFERENCE-BASED BENEFITS APPLY. ADDITIONAL PATIENT LIABILITY MAY APPLY~

You can also call the Blue Eligibility number at 1-800-676-2583 to verify if a member is covered under reference-based benefits.

There is no need to do anything different if a member is covered under reference-based benefits

You do not need to take any additional steps for these members and you should submit claims to BCBSAZ as you normally do. If you want to verify the reference cost maximum prior to rendering a service covered under reference-based benefits, you can contact the member’s BCBS Plan by calling the Blue Eligibility number at 1-800-676-2583.

How reference-based benefits are shown on a payment remittance

When you receive a payment remittance, it will show that the claim was paid per the member’s benefits with any amount over the reference cost being applied to the benefit maximum.

3.5 Member eligibility and coverage verification

To verify a BCBS member's eligibility and coverage, submit an electronic inquiry to BCBSAZ at azblue.com/providers or call BlueCard Eligibility at 1-800-676-BLUE (2583).

- **Electronic inquiries** – Submit a HIPAA 270 transaction (eligibility) to BCBSAZ via azblue.com/providers.
  - You can receive real-time responses to your eligibility requests for out-of-area members between 6:00 a.m. and midnight, Central Time, Monday through Saturday.
- **Phone inquiries** – Call BlueCard Eligibility 1-800-676-BLUE (2583).
  - English- and Spanish-speaking phone operators are available to assist you.
  - BCBS Plans are located throughout the country and may operate on a different time schedule than BCBSAZ. You may be transferred to a voice response system linked to customer enrollment and benefits if you call outside of a Plan's regular business hours.
  - The BlueCard Eligibility line is for eligibility, benefit, and precertification/referral authorization inquiries only. It should not be used to check claim status. *For claim filing information, see the Claim Filing section of this guide.*
- **Inquiries for members with BlueHPN EPO plans**

  BlueHPN EPO members will be identified as such on the HIPAA 271 transaction from BCBSAZ. If you are a BlueHPN provider (participating in the BCBSAZ Alliance Network), you should look for the in-network cost-share information on the HIPAA 271 response. If you are not a BlueHPN provider, be aware that the only services covered for BlueHPN EOP members are emergent care within BlueHPN product areas, and urgent and emergency care outside of the BlueHPN product service areas (in Arizona, the BlueHPN service area is the Greater Phoenix metropolitan area). All other services are considered out-of-network and will be indicated with a 100% member cost share on the HIPAA 271 transaction.

  Most BlueHPN members will have the ***BlueHPN without Tiers*** version of the BlueHPN product, and this will be indicated on the HIPAA 271 transaction. Some members will have the ***BlueHPN with Tiers*** version of the BlueHPN product, and these members will have an in-network benefit and a Tier 2 benefit. For these members, Tier 2 benefits apply only to BlueHPN providers in the New Jersey and Philadelphia BlueHPN product service areas. If you are a BlueHPN provider not located in the New Jersey or Philadelphia BlueHPN service areas, you can disregard the Tier 2 benefit information on the HIPAA 271 transaction.
- **Electronic health ID cards**

  Some BCBS Plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process. Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider's system.

  An electronic health ID card has a magnetic stripe on the back of the ID card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the three-track magnetic stripe.

  Please note: Providers need a *Track 3 Card Reader* in order for the data on track 3 of the magnetic stripe to be read (tracks 1 & 2 are proprietary to the financial industry).

Sample of electronic health ID card:

3.6 Utilization review

Online router tool: To access precertification/prior authorization information for out-of-area BCBS members, you can use the online router tool. Log in to the secure portal at azblue.com/providers and go to "Practice Management > Precertification > BlueCard (Out-of-Area) Members." Enter the member ID prefix to be routed to the member's BCBS Plan. See section 3.9 for more information.

Phone: You may also contact the member's BCBS Plan on the member's behalf by calling BlueCard Eligibility at 1-800-676-BLUE (2583). Ask to be transferred to the utilization review area. When precertification/prior authorization for a specific member is handled separately from eligibility verifications at the member's BCBS Plan, your call will be routed directly to the area that handles precertification/prior authorization. You will select the option related to the type of service:

- Medical/surgical
- Behavioral health
- Diagnostic imaging/radiology
- Durable medical equipment (DME)

When requesting precertification/prior authorization, please provide as much information as possible to minimize potential claim issues. Providers are encouraged to follow up immediately with a member's BCBS Plan to communicate any changes in treatment or setting to ensure that an existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for changes may result in claim processing delays, payment denials, and penalties.

Requests for clinical information and medical records: The member's BCBS Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

- **Pre-service utilization management for out-of-area members:** When records are required for utilization review/management processes, other BCBS Plans may request them directly from BCBSAZ-contracted providers. For example, when requesting precertification for a scheduled inpatient surgery for an out-of-state BCBS Plan member, **send records directly to the member's BCBS Plan to expedite the review process.**
- **Post-service claims for out-of-area members:** For claims, the member's BCBS Plan will request any necessary medical records through us. We will send you a notice requesting the records. You must send us the requested records, along with a copy of the request notice (including the identifying barcode), within 10 business days from the date on the notice.

Always include a copy of the request notice when submitting medical records
Place a copy of the records request notice on top of the records and fax to **602-864-3137.** Records for BlueCard members submitted without a copy of the request notice will be returned, causing significant delays. We cannot forward unsolicited medical records to other BCBS Plans.

If you are unable to fax records, please use the following mailing address:

BlueCard Claims – T201
Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ 85002

Penalties: For most benefit plans, BCBSAZ will assess a $500 penalty to the servicing network provider for failure to obtain precertification for services requiring precertification as per the member's benefit plan. This applies to BCBSAZ members and out-of-area BlueCard members. For facility-related precertification requirements (such as inpatient admissions, SNF, EAR, and LTAC), the penalty applies to the facility and not the professional provider. Providers considered in-network for the member's benefit plan may not bill the member for this penalty amount.

Exception: For members with PPO plans, a penalty may be applied to the member when the rendering provider is out-of-network and a required precertification was not obtained.

Notification timeframes: Participating providers must follow specified timeframes for pre-service review notifications:

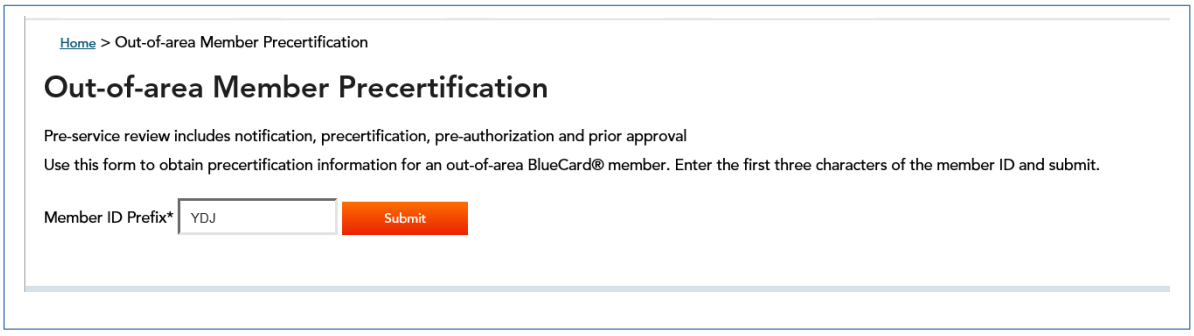
1. 48 hours to notify the member's Plan of change in pre-service review
2. 72 hours for emergency/urgent pre-service review notification

3.7 Online routing tools for pre-service reviews and clinical criteria

The BCBS online routing tools connect you to the member's Plan for clinical criteria (medical policy) and pre-service review (including prenotification, precertification, prior authorization, and prior approval). These tools use a secure routing mechanism initiated by entering the member's ID prefix.

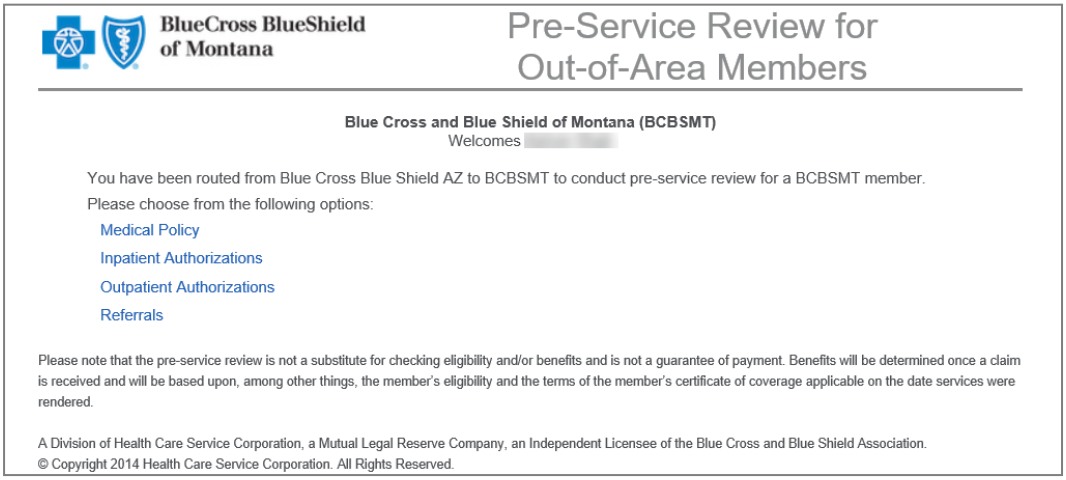
Out-of-area BlueCard pre-service review tool

1. Log in to the secure provider portal at azblue.com/providers and go to "Practice Management > Precertification > BlueCard (Out-of-Area) Members."
2. Enter the member ID prefix from the member's ID card.



3. On the next screen, click "Provider Lookup" to validate your NPI. After validation, the tool will securely connect you to the landing page for the member's BCBS Plan.

4. From the landing page, you can connect to the electronic pre-service review processes available for that particular BCBS Plan.

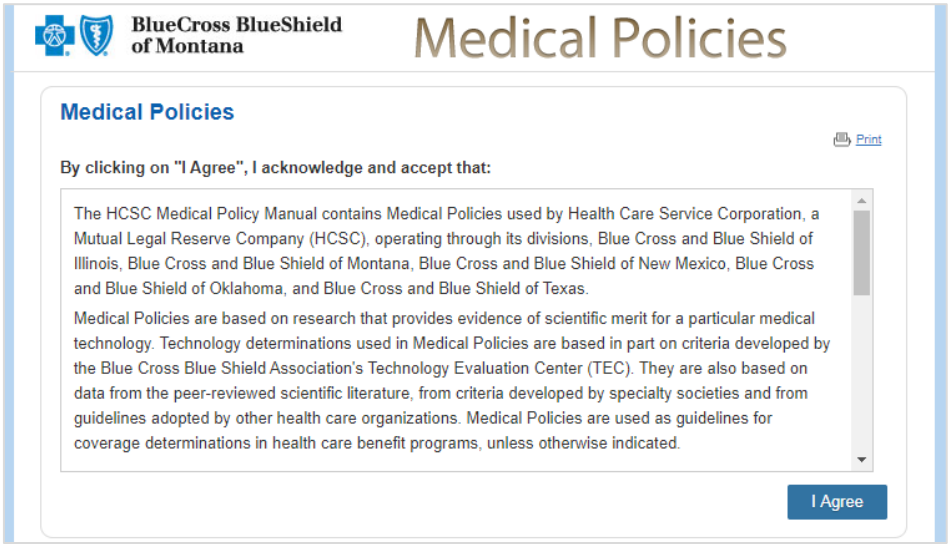


Because BCBS Plan pre-service review processes vary widely, landing pages may include instructions on how to conduct a pre-service review.

Out-of-area BlueCard clinical criteria tool

The out-of-area BlueCard clinical criteria routing tool is similar to the pre-service review routing tool. To access, log in to the secure portal at azblue.com/providers, go to "Practice Management > Clinical Criteria > BlueCard (Out-of-Area) Members," and enter the member ID prefix.

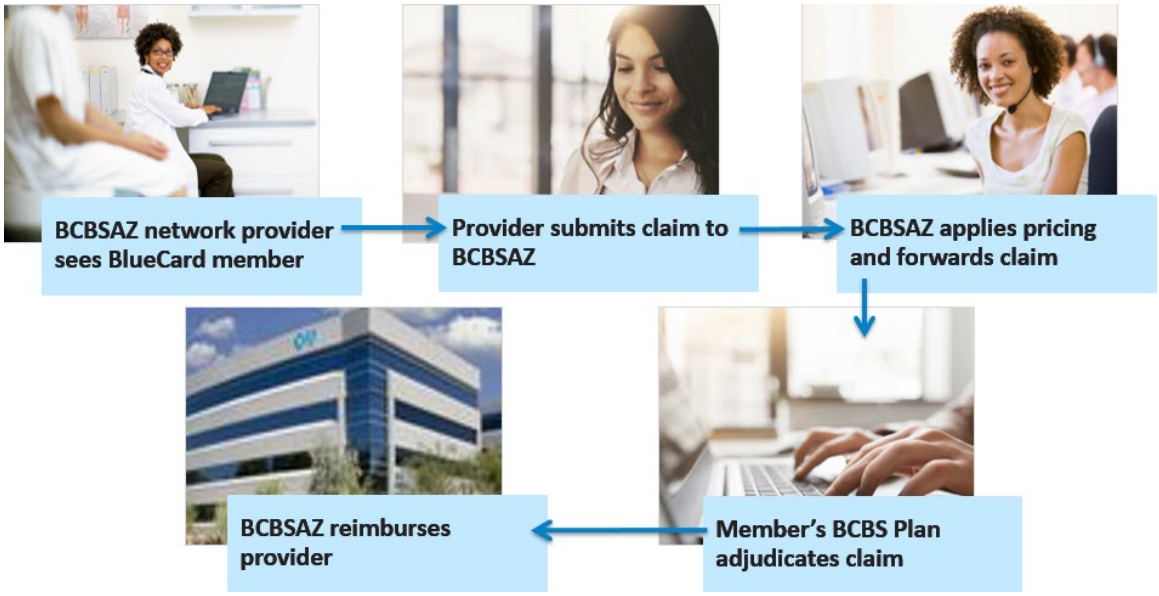
Sample landing page:



4. BCBS claim filing

4.1 How out-of-area BCBS claims flow through the system

Here is how claims flow through the BCBS BlueCard system:



In most cases, after servicing a member of another BCBS Plan, you should file the claim with BCBSAZ (see pages 25 through 28 for exceptions for ancillary and air ambulance claims). We will work with the member's Plan to process the claim, and then we'll issue payment to you under the terms of our contract with you and based on the member's benefits and coverage.

You should always submit claims to BCBSAZ electronically. Only if you are unable to submit claims electronically, mail them to: BCBSAZ, P.O. Box 2924, Phoenix, AZ 85062-2924.

Following these helpful tips will improve your claim experience:

- Check the current member ID card for the appropriate member information (including member ID prefix) to avoid unnecessary claim payment delays.
- Check eligibility and benefits electronically at azblue.com/providers or by calling 1-800-676-BLUE (2583). Be sure to provide the member's ID prefix.
- Verify the member's cost-share amount before processing payment (do not process full payment up front).
- Indicate any payment you collected from the patient on the claim. (On the 837 electronic claim submission form, check field AMT01=**F5** patient paid amount; on the CMS1500 locator, **29** amount paid; on the UB92 locator, **54** prior payment; on the UB04 locator, **53** prior payment.)
- Be sure to include the member's complete ID number when you submit the claim. This includes the three-character member ID prefix. Claims with incorrect or missing prefixes and member ID numbers cannot be processed.

- In cases where there is more than one payer and a BCBS Plan is a primary payer, submit other party liability (OPL) information with the BCBS claim. Upon receipt, BCBSAZ electronically routes the claim to the member's BCBS Plan. The member's Plan processes the claim and approves payment, and then BCBSAZ reimburses you for the services.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, slows down the claim payment process and creates confusion for the member.
- Check claim status by submitting an electronic HIPAA 276 transaction (claim status request), using the claim status inquiry tool on the secure provider portal at azblue.com/providers, or by contacting BCBSAZ at 602-864-4114.

4.2 Out-of-area BCBS Medicare Advantage claims

4.2.1 Medicare Advantage overview

Medicare Advantage (MA) is coordinated through a centrally administered platform. We include information about MA here to clarify how BCBS claims are handled. When you render services to a member with an MA plan from another BCBS Plan, send the claim to BCBSAZ.

In addition to the typical MA products (PPO, HMO, POS, PFFS), MA organizations may also offer a Special Needs Plan (SNP). Enrollment may be limited to subgroups of the Medicare population to ensure that members' special needs are met as effectively as possible.

As with all other types of plans, the level of benefits and coverage may vary depending on the specific plan. Always confirm eligibility and coverage by submitting an electronic inquiry or calling 1-800-676-BLUE (2583).

Types of MA plans include:

- **Medicare Advantage PPO**

  An MA PPO plan allows enrolled members access to covered services rendered by providers outside of the MA PPO network. Member cost-share amounts may be greater for out-of-network services. MA PPO plans may be offered on a local or regional (frequently multistate) basis. Special payment and other rules apply to regional PPO plans.

  BCBS MA PPO members have in-network access to BCBS MA PPO providers across the country through the reciprocal MA PPO network sharing program. For more information, see Section 4.2.2.

- **Medicare Advantage HMO**

  Generally (except in urgent or emergency care situations), medical services are only covered when rendered by in-network providers.

- **Medicare Advantage POS (point of service)**

  An MA POS program is an option that allows members to determine—at the point of service—whether they want to receive certain designated services within the HMO system, or seek such services outside of the HMO provider network (usually at greater cost to the

member). The MA POS plan may specify which services will be available outside of the HMO's provider network.

- **Medicare Advantage PFFS (private fee-for-service)**

  With an MA PFFS plan, the member may go to any Medicare-approved physician or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur when the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and when the provider has reasonable access to the terms and conditions of participation.

  The MA organization, rather than the Medicare program, pays for services rendered to such members. More about MA PFFS products:

  - You may see and treat any MA PFFS member without having a contract with BCBSAZ. If you provide services to a BCBS MA PFFS member, you will do so under the terms and conditions of that member's BCBS Plan.
  - You may choose to render services to an MA PFFS member on an episode-of-care (claim-by-claim) basis.
  - MA PFFS terms and conditions may vary for each BCBS Plan. Information about accessing the plan's terms and conditions will be on the back of the member's ID card.
  - Submit claims for out-of-area MA-PFFS members to BCBSAZ.

- **Medicare Advantage Medical Savings Account (MSA)**

  An MA MSA is a Medicare health plan option consisting of two parts. One part is a Medicare MSA health insurance policy with a high deductible. The other part is a special savings account in which Medicare deposits money to help members pay their medical bills.

BCBS MA ID card product logos:

BCBS Medicare Advantage ID cards display one of these product logos:		
	MEDICARE ADVANTAGE | HMO	Health Maintenance Organization
	MEDICARE ADVANTAGE | MSA	Medical Savings Account
	MEDICARE ADVANTAGE | PFFS	Private Fee-For-Service
	MEDICARE ADVANTAGE | POS	Point of Service
	MA | PPO MEDICARE ADVANTAGE	Preferred Provider Organization

4.2.2 MA PPO network sharing

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan, as long as the member sees a contracted MA PPO provider.

What BCBS MA PPO network sharing means for providers

If you are contracted with BCBSAZ for the MA BlueJourney PPO network and you see MA PPO members from other BCBS Plans, you should extend the same contractual access to care to them as you do to BCBSAZ MA PPO members. You will be reimbursed in accordance with your negotiated MA rate. These members will receive in-network benefits in accordance with their specific benefit plan.

If you are not a BCBSAZ-contracted MA BlueJourney PPO provider and you provide services for BCBS MA members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How to recognize an out-of-area member with a BCBS MA PPO plan

You can recognize an MA PPO member by the suitcase logo on the ID card. The "MA" in the suitcase indicates a BCBS member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, they should provide their BCBS member ID.

Contractual responsibility for providing services to out-of-area BCBS MA PPO members

If you are a BCBSAZ-contracted MA BlueJourney PPO provider, you must provide the same access to care as you do for BCBSAZ MA BlueJourney PPO members. You will receive the same contracted rates for those services.

If you are not contracted with BCBSAZ for the MA BlueJourney PPO network, you may see MA members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS MA members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

For practices closed to new BCBSAZ MA PPO members

If your practice is closed to new BCBSAZ MA BlueJourney PPO members, you do not have to provide care for out-of-area BCBS MA PPO members. The same contractual arrangements apply to these out-of-area network-sharing members as your BCBSAZ MA PPO members.

Note: Your BCBSAZ participation agreement states that you may not close your panel to BCBSAZ members unless you are also refusing all other patients. We require 60 days' prior written notice of your intent to close your practice.

Payment for providing services to out-of-area MA PPO members from BCBS Plans participating in the MA PPO network sharing program

If you are a BCBSAZ-contracted MA BlueJourney PPO provider, reimbursement for services rendered to out-of-area MA PPO members will be based on your contracted MA PPO rate. Once you submit the claim, BCBSAZ will work with the other BCBS Plan to determine benefits and send you the payment.

If you are not contracted for the BCBSAZ MA BlueJourney PPO network, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

Payment for providing services to other (non-PPO) out-of-area BCBS MA members

When you provide covered services to other out-of-area BCBS MA members, reimbursement will be based on the Medicare allowed amount. Once you submit the claim, BCBSAZ will send you the payment. However, these services will be covered under the member's out-of-network benefits unless they are for urgent or emergency care.

Requesting member payment up front or charging a member for non-covered services

Generally, you should not ask for full payment up front. You may ask for payment of the member's out-of-pocket expenses (deductible, copay, coinsurance, and non-covered services).

Please note: In compliance with CMS guidance, an advance beneficiary notice (ABN) or other similar waiver cannot be used as justification to charge an MA member for a non-covered service. When a service is not covered, you or the member must request a pre-service organization determination before the service is rendered.

When a pre-service organization determination is requested and coverage is denied, a Notice of Denial of Medical Coverage or Payment (CMS-10003) will be issued to the member and provider. Once the member receives the denial, the member can decide whether to move forward with the service at the member's expense. This should be well-documented in the member's records. If the member has not received this notice before the non-covered service is rendered, you may *not* charge the member for the service and may only charge for any applicable cost-share amounts.

The only exception to this requirement is when the service is one that has never been covered and is clearly excluded under the member's MA plan. To bill the member, you must be able to demonstrate compliance with this exception.

If you fail to follow the CMS-mandated procedures before rendering non-covered services, you will not be entitled to reimbursement for those services.

Balance billing for the difference between the provider's charge and the allowance

You may not balance bill the member for this difference. However, members may be billed for deductibles, coinsurance, and copays.

How to dispute a reimbursement amount

If you disagree with or have a question concerning the reimbursement amount you receive, contact BCBSAZ.

4.2.3 Eligibility and benefits for out-of-area BCBS MA members

You can check eligibility the same way you would for other out-of-area BCBS members. Log in to azblue.com/providers and use the online eligibility and benefits inquiry tool, or call 1-800-676-BLUE (2583).

Please note: If you experience difficulty obtaining eligibility information, please make a note of the member ID prefix and report it to BCBSAZ.

4.2.4 Utilization review for out-of-area BCBS MA members

You can check pre-service review requirements for out-of-area BCBS MA members by using the **out-of-area member precertification router tool.** To access the tool, log in to azblue.com/providers and go to "Practice Management > Precertification > BlueCard (Out-of-Area) Members."

You can also call the utilization management/precertification number on the back of the member's ID card. If the utilization management number is not listed on the back of the member's card, call BlueCard Eligibility at 1-800-676-BLUE (2583) and ask to be transferred to the utilization review area.

4.2.5 Claim submission for out-of-area BCBS MA members

Submit claims for out-of-area BCBS MA members as you would for any other out-of-area BCBS members:

- Submit claims for out-of-area MA members to BCBSAZ.
- Be sure to include the member's complete ID number when you submit the claim, including the three-character prefix.
- Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

4.2.6 Reimbursement for out-of-area BCBS MA members

- **If you are contracted with BCBSAZ for the BlueJourney PPO network,** and you see MA PPO members from other BCBS Plans, you must extend the same contractual access to care to them as you do to BCBSAZ MA PPO members. These members will receive in-network benefits in accordance with their member contract. You will be reimbursed as an in-network provider at your contracted MA PPO rate.

  In general, if you provide services for out-of-area MA members with HMO or POS plans, you will be considered out-of-network. Out-of-network services for HMO members must be preauthorized by the member's Plan. Applicable Medicare Advantage reimbursement rules apply. For urgent or emergency care for HMO members, you will be reimbursed at the in-network benefit level.

  Note: PFFS plans have their own terms and conditions.

- **If you are not contracted with BCBSAZ for the BlueJourney PPO network and you accept Medicare assignment,** you will be considered out-of-network for most MA members from other BCBS Plans.

For out-of-area MA HMO, POS, or PPO plans, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. Applicable Medicare Advantage reimbursement rules apply. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

Note: MA PFFS plans have their own terms and conditions.

Providers paid on a reasonable cost basis under Original Medicare should send a copy of their CMS Interim Payment Rate letter with their Medicare Advantage claim.

In general, providers may collect only the applicable cost-share amount (e.g., copay) from the member at the time of service and may not otherwise charge or balance bill the member.

4.2.7 BCBS National MA Coordination of Care Program

The BCBS National Coordination of Care Program was launched on January 1, 2020, to support BCBS MA PPO group members. The program aims to increase the quality of members' care by enabling BCBS MA PPO group members to receive appropriate care wherever they access care.

To better support all BCBS MA PPO group members residing in Arizona, BCBSAZ is working with providers to improve care by:

- Supporting providers with additional information about potential gaps in care
- Requesting medical records for a more complete understanding of members' health status

MA PPO group members participating in this program can be identified as having a member address in Arizona and this logo on their BCBS ID card:

MA | PPO
MEDICARE ADVANTAGE

How the program works

This program is designed to be beneficial to you, your practice, and your patients. It serves all MA PPO group members traveling or living in Arizona. Here are some of the benefits you might see:

- You will receive consolidated information on potential gaps in care and risk adjustment gaps, as well as medical record requests, for all BCBSAZ MA PPO members and other BCBS MA PPO members residing in Arizona.
- The MA PPO group members you see may come into your practice more frequently as a result of our requests for care gap closures. This allows for greater continuity of care.

Medical record requests
You will receive medical records requests related to your patients who are out-of-area BCBS MA PPO group members residing in Arizona. Per the program's structure, these members' BCBS Plans request medical records through BCBSAZ. You do not need to be in contact with any other BCBS Plan for the purposes of medical record retrieval.

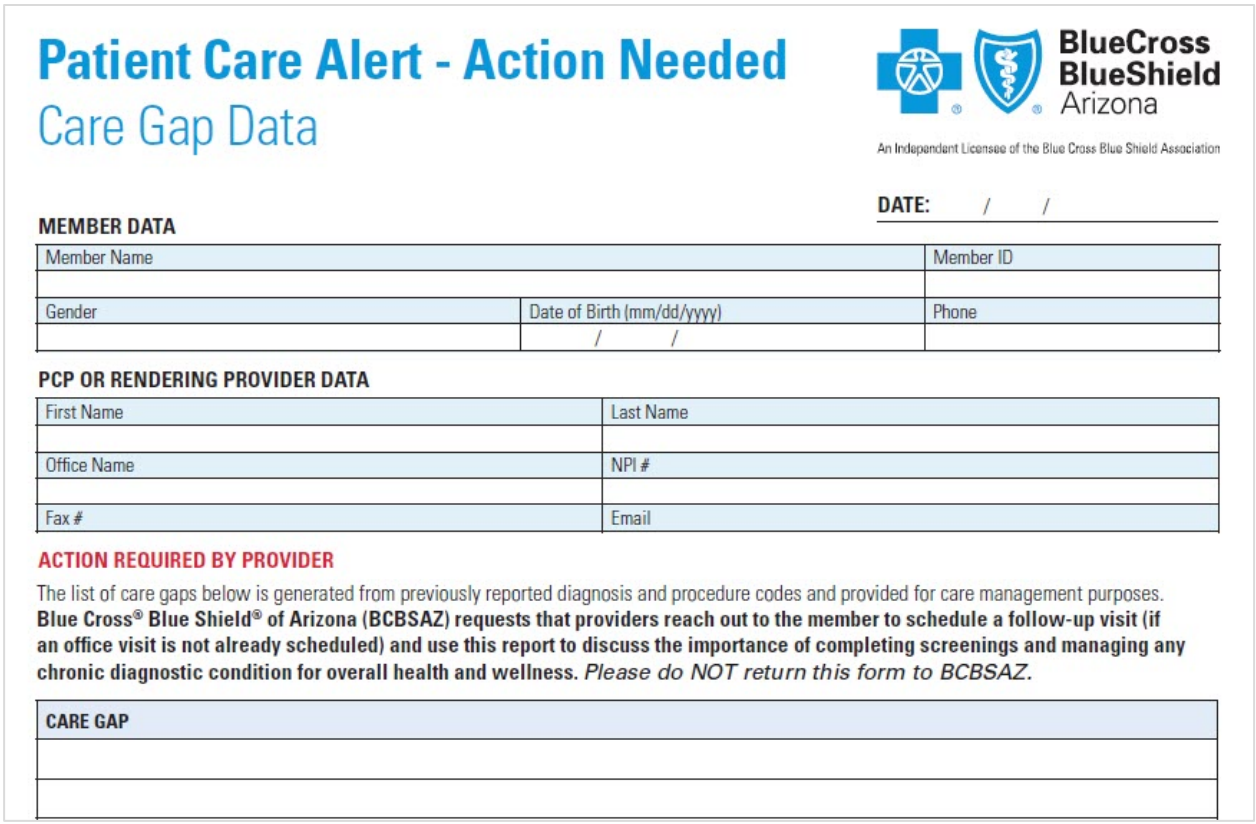
Reminder: You are contractually required to respond to records requests in support of risk adjustment, HEDIS, and other government-mandated activities within the requested time frame. This includes requests related to this program from vendors, such as Episource, that are acting on our behalf.

Gap closure requests

You might receive an increase in Stars and Risk Adjustment gap closure requests for your patients who are out-of-area BCBS MA PPO group members residing in Arizona. Per the program's structure, Stars or risk adjustment gaps for these members will be communicated through BCBSAZ. You do not need to be in contact with any other BCBS Plan for the purposes of gap closure.

You may receive "Patient Care Alerts" from BCBSAZ that indicate actions requested to close patient care gaps. Please follow up with members right away to take the necessary actions.

Sample BCBSAZ Care Alert:



Patient Care Alert - Action Needed

Care Gap Data

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

DATE: / /

MEMBER DATA

Member Name		Member ID
Gender	**Date of Birth (mm/dd/yyyy)**	**Phone**
	/ /	

PCP OR RENDERING PROVIDER DATA

First Name	Last Name
Office Name	NPI #
Fax #	Email

ACTION REQUIRED BY PROVIDER

The list of care gaps below is generated from previously reported diagnosis and procedure codes and provided for care management purposes. **Blue Cross® Blue Shield® of Arizona (BCBSAZ) requests that providers reach out to the member to schedule a follow-up visit (if an office visit is not already scheduled) and use this report to discuss the importance of completing screenings and managing any chronic diagnostic condition for overall health and wellness.** *Please do NOT return this form to BCBSAZ.*

CARE GAP

HIPAA/Privacy

Consistent with HIPAA and other applicable laws and regulations, BCBSAZ is contractually bound to preserve the confidentiality of health plan members' protected health information (PHI) obtained from medical records and provider engagement on Stars and/or risk adjustment gaps. You will only receive requests that are permissible under applicable law and consistent with your current practices. Patient-authorized information releases are not required for you to fulfill medical records requests and support closure of Stars and/or risk adjustment gaps received pursuant to this care coordination program.

If you have questions regarding the applicability of HIPAA or any other privacy law or regulation to this program, please contact your provider liaison.

4.3 Out-of-area BCBS Medicaid claims

Some BCBS Plans administer Medicaid programs in various states across the U.S. Because Medicaid is a state-run program, requirements vary for each state and thus for each BCBS Plan. Medicaid members have limited out-of-state benefits, typically covering only emergency situations. In some cases, such as continuity of care, covered children attending college out of state, or a lack of specialists in the member's home state, a Medicaid member may receive care in another state, and generally the care requires prior authorization.

If you choose to service out-of-state Medicaid members, you may be required to enroll in the member's home state Medicaid program to be reimbursed. Reimbursement is based on that state's Medicaid fee schedule. See below for more information.

4.3.1 Identifying out-of-area BCBS Medicaid members

BCBS ID cards do not always indicate that a member has a Medicaid product. ID cards for Medicaid members do not include the suitcase logo displayed on most ID cards, but they do include a disclaimer on the back providing information on benefit limitations. Always obtain eligibility and benefit information and prior authorization for services, using the same tools as you would for other BCBS members.

- Submit an eligibility inquiry by calling the BlueCard Eligibility Line at 1-800-676-BLUE (2583).
- Submit an online eligibility inquiry via the homepage of the secure provider portal at azblue.com/providers.
- Obtain pre-service review information using the out-of-area BCBS (BlueCard) router tool.

4.3.2 Medicaid reimbursement and billing

Submit claims for out-of-area BCBS Medicaid members to BCBSAZ. If you are contracted with BCBSAZ (Health Choice Arizona) for Medicaid, your contracted Medicaid rates apply only for Health Choice members; they do not apply to out-of-state Medicaid members. If you choose to see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member's home state.

If you provide services that are not covered by Medicaid to a Medicaid member, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member before the services are rendered.

In some circumstances, a state Medicaid program will have a copay, deductible, or coinsurance applied to the member's benefit plan. You may collect this amount from the member. Note that the coinsurance amount is based on the Medicaid fee schedule for that service.

Balance billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is prohibited by federal regulations (42 CFR 447.15).

4.3.3 Medicaid billing data requirements

When billing for a Medicaid member, check the Medicaid website of the state where the member resides for specific Medicaid billing requirements.

You must include the rendering and billing provider NPI on Medicaid claims, unless the provider is considered atypical (according to the NPI Final Rule 45CFR 160.103). Other required data includes rendering and billing provider taxonomy codes, billing provider's middle name or initial, and National Drug Codes (NDCs), as applicable. Ambulance claims must indicate transport distance, reason code, round-trip purpose description, stretcher purpose description, and patient weight.

4.3.5 Provider enrollment requirements

Some states require out-of-state providers to enroll in their state's Medicaid program to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement. To view provider enrollment requirements for BCBS Medicaid states, log in to the secure provider portal at azblue.com/providers and go to "Provider Resources > Guidelines > Medicaid Provider Enrollment Requirements."

If you are required to enroll in another state's Medicaid program, this information will be included in the response to an eligibility or benefit inquiry. You should enroll in that state's Medicaid program *before* submitting the claim. If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive the following message from BCBSAZ regarding the Medicaid provider enrollment requirements:

> *"The state where the member is enrolled in Medicaid requires that providers enroll in their Medicaid program before the Plan can pay the provider."*

You will be required to enroll before the Medicaid claim can be processed and before you receive reimbursement.

4.4 International BCBS claims

The claim submission process for international BCBS Plan members is the same as for domestic BCBS Plan members. You should submit the claim directly to BCBSAZ. *See section 3.2 for servicing international members and the note regarding members of Canadian Blue Cross Plans.*

4.5 Claim coding

Code claims as you would for BCBSAZ claims.

4.6 Ancillary claims

Ancillary providers (independent clinical laboratories, durable/home medical equipment suppliers, and specialty pharmacies) must follow unique claim filing rules as follows:*

Independent clinical laboratories (labs): File the claim to the BCBS Plan where the referring or ordering physician is located per their NPI/NPPES Registry.

Durable/home medical equipment (D/HME) suppliers: File the claim to the BCBS Plan where the equipment was shipped to or purchased at a retail store.

Specialty pharmacies: File the claim to the BCBS Plan where the ordering physician is located per their NPI/NPPES Registry.

**If you contract with more than one BCBS Plan in a state for the same product type (e.g., PPO or traditional), you may file the claim with either Plan.*

- The ancillary claim filing rules apply regardless of the provider's contracting status with the BCBS Plan where the claim is filed.
- Before providing ancillary services, you can verify member eligibility and benefits through an electronic inquiry by calling the phone number on the back of the member ID card, or calling BlueCard Eligibility at 1-800-676-2583.
- Providers using outside vendors to provide services (e.g., sending a blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) must use in-network participating ancillary providers to avoid additional member liability for covered benefits. Find in-network providers in the provider directory at azblue.com/directory.
- Members are financially liable for ancillary services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
- If you have questions about where to file your claim, contact the BCBSAZ BlueCard Customer Service Unit at 602-864-4114.

Ancillary claim filing examples:

Provider type	How to file (required fields)	Where to file	Example
Independent Clinical Laboratory (any type of non-hospital-based laboratory) Types of service include, but are not limited to, blood and urine sample analysis.	Referring or Ordering Provider: On the 837P Professional Electronic Submission: Loop 22420E for Ordering Physician; 2310A for Referring Physician (both at the claim level) On the CMS 1500: Field 17 (left of the dotted line); enter DK for Ordering Physician or DN for Referring Physician	Submit the claim to: The BCBS Plan where the *referring or ordering physician is located, per their NPI/NPPES Registry.* Note: • Claim must be processed based on information submitted on the claim. • The referring provider NPI, as submitted on the claim, must be used to determine where service was rendered. • Claims for lab analysis must be submitted to the Plan in whose service area the referring provider is located. • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.	Blood is drawn in a lab or office setting located in Arizona. The ordering physician is located in Arizona. Blood analysis is done in New Mexico. *Submit claim to* BCBSAZ.

Provider type	How to file (required fields)	Where to file	Example
Durable/Home Medical Equipment (D/HME) Supplier Types of service include, but are not limited to, hospital beds, oxygen tanks, and crutches.	Patient's Address: On the 837P Professional Electronic Submission: Loop 2010CA On the CMS 1500: Field 5 Referring or Ordering Provider: On the 837P Professional Electronic Submission: Loop 22420E for Ordering Physician; 2310A for Referring Physician (both at the claim level) On the CMS 1500: Field 17 (left of the dotted line); enter DK for Ordering Physician or DN for Referring Physician Place of Service: On the 837P Professional Electronic Submission: Loop 2300, CLM05-1 On the CMS 1500: Field 24B Service Facility Location Information: On the 837P Professional Electronic Submission: Loop 2310C (claim level) On the CMS 1500: Field 32	Submit the claim to: The BCBS Plan where the equipment was *shipped to or purchased in a retail store*	A. Wheelchair is purchased at a retail store in Arizona. *Submit claim to* BCBSAZ. _____ B. Wheelchair is purchased on the internet from an online retail supplier in Florida and shipped to Arizona. *Submit claim to* BCBSAZ. _____ C. Wheelchair is purchased at a retail store in Arizona and shipped to Florida. *Submit claim to* Blue Cross Blue Shield of Florida.
Specialty Pharmacy Types of service: Non-routine biological therapeutics ordered by a healthcare professional as a covered medical benefit, as defined by the member's Plan's Specialty Pharmacy formulary. Includes, but is not limited to, injectables and infusion therapies.	Ordering Provider: On the 837P Professional Electronic Submission: Loop 22420E for Ordering Physician (at the claim level) On the CMS 1500: Field 17 (left of the dotted line); enter DK for Ordering Physician	Submit the claim to: The Plan where the *ordering physician is located, per their NPI/NPPES Registry*	Patient is seen by a physician in Arizona who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in Montana, where the member lives for 6 months of the year. *Submit claim to* BCBSAZ.

4.7 Air ambulance claims

Claims for air ambulance services must be submitted to the BCBS Plan in whose service area the point-of-pickup ZIP code is located. If you contract with more than one BCBS Plan in a state for the same product type (e.g., PPO or traditional), you may file the claim with either Plan.

Service rendered	How to file (required fields)	Where to file	Example
Air Ambulance Services	Point-of-pickup ZIP code: ASC X12N Health Care Claim (837P) Professional: Populate the origin information (ZIP code of the point of pick up) in the Ambulance Pick Up Location Loop ASC X12N Health Care Claim (837I) Institutional: For air ambulance service not included with local hospital charges, populate the origin information (ZIP code of the point of pickup) in the Value Information Segment CMS 1500 Health Insurance Claim Form: Populate field 23 with the 5-digit ZIP code of the point of pickup CMS-1450 (UB-04) Insurance Claim Form: For air ambulance service not included with local hospital charges, populate Form Locators 39-41 with the 5-digit ZIP code of the point of pickup The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual • Form Locators: (FL) 39-41 • Code: A0 (Special ZIP code reporting) or its successor code specified by the National Uniform Billing Committee • Value: Five-digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance	Submit the claim to: Submit the claim to the Plan in whose service area the point-of-pickup ZIP code is located (except when the pickup location is outside of the U.S.). If you contract with multiple BCBS Plans that overlap service areas in the point-of-pickup ZIP code, you may file the claim with any of those Plans. When a member's pickup location is outside of the U.S., file the claim with Blue Cross Blue Shield Global Core at bcbsglobalcore.com or claims@bcbsaglobalcore.com, or mail to: Service Center, P.O. Box 2048, Southeastern, PA 19399.	A. The BCBSAZ member is picked up in ZIP code 85021 (Phoenix, AZ). Submit the claim to BCBSAZ. B. The BCBSAZ member is picked up in ZIP code 68107 (Omaha, NE). Submit the claim to Blue Cross Blue Shield of Nebraska. C. The BCBSAZ member is picked up in Mexico. Submit the claim to Blue Cross Blue Shield Global Core.

- The air ambulance claim filing rules apply regardless of the provider's contracting status with the BCBS Plan where the claim is filed.
- Where possible, providers are encouraged to verify member eligibility and benefits by calling the phone number on the back of the member's ID card or 1-800-676-BLUE (2583).
- Providers must use in-network participating air ambulance providers to reduce the possibility of additional member liability for covered benefits. Find in-network participating providers by using **BCBSAZ's "Find a Doctor" provider directory** at azblue.com/directory**.**
- Members are financially liable for air ambulance services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
- If you have questions about where to file your air ambulance claim, contact the BCBSAZ BlueCard Customer Service Unit at 602-864-4114.

4.8 Contiguous counties and overlapping service areas

4.8.1 Contiguous counties

Claims may be submitted directly to the member's BCBS Plan by contiguous-area providers, based on the permitted terms of the provider contract, which may include:

- Provider's location (In which BCBS Plan's service area is the provider's office located?)

- Provider's contract status with the two contiguous counties (Is the provider contracted with only one of the service areas, or both?)
- The member's BCBS Plan (Is the member's BCBS Plan in a county contiguous to the provider's location?)
- The member's location (Does the member live or work in the service area covered by his/her BCBS Plan?)
- The location where the services were received (Did the member receive service from a provider in a county contiguous to the member's BCBS Plan?)

4.8.2 Overlapping service areas

Submission of claims in an overlapping service area depends on what BCBS Plan(s) the provider contracts with in that service area, the type of contract the provider has (e.g., PPO or traditional), and the type of contract the member has with his or her BCBS Plan.

- If you contract with all BCBS Plans in your state for the same product type (e.g., PPO or traditional), you may file an out-of-area member's claim with either Plan.
- If you have a PPO contract with one BCBS Plan and a traditional contract with another BCBS Plan, file the out-of-area member's claim based on the product type. For example, if the member has a PPO plan, file the claim with the Plan that has your PPO contract.
- If you contract with one Plan but not the other, file all out-of-area member claims with your contracted BCBS Plan.

4.9 Medical records requests

You may get requests for medical records for out-of-area BCBS members for various reasons, including:

1. As part of the prior authorization process – If you receive requests for medical records from other BCBS Plans prior to rendering services, as part of the prior authorization process, you will be instructed to submit the records directly to that member's Plan.
   This is the only circumstance in which you would *not* submit records to BCBSAZ.
2. As part of a claim review and adjudication – These requests will come from BCBSAZ in the form of a letter, fax, email, or electronic communication requesting specific medical records and including instructions for submission.

If the requested records are not received, a remittance advice statement may be sent to your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records.

A remittance advice is not a duplicate request for medical records. If you submit medical records and subsequently receive a remittance advice indicating that records are needed, contact BCBSAZ at 602-864-411 to ensure that your original records submission has been received and processed. This will prevent you from having to send duplicate records unnecessarily.

If you receive a remittance advice indicating that records are needed and you did not receive a medical records request letter, contact BCBSAZ to determine if the records are needed from

your office. Upon receipt of the requested information, the claim will be reviewed to determine the benefits.

How to ensure timely processing of medical records

1. If the records are requested after the submission of a claim, promptly forward all requested medical records to BCBSAZ.
2. Follow the submission instructions given on the request, using the specified physical or email address or fax number. The address or fax number for medical records may be different from the address you use to submit claims.
3. Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly when BCBSAZ receives them.
4. Submit all requested information to BCBSAZ as soon as possible to avoid further delay.
5. Only send the information specifically requested. Complete medical records are often not necessary.
6. Please do *not* proactively send medical records with a claim or claim adjustment. Wait until you receive a request. Unsolicited claim attachments typically delay claim payments.

4.10 Claim adjustments

Submit electronic claim adjustments to BCBSAZ when you need to make corrections or changes. Claim adjustments can only be made after the claim has been processed and the remit is available. BCBSAZ will work with the member's BCBS Plan for adjustments. Medical records may be requested later to support some corrections, but do *not* send them with the initial submission.

4.11 Appeals

BCBSAZ handles appeals for all out-of-area BCBS claims. We will coordinate the appeal process with the member's BCBS Plan, if necessary.

4.12 Coordination of benefits

Coordination of benefits (COB) refers to how we ensure that members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order in which the entities share responsibility for payment (i.e., which one has primary responsibility and which one(s) has/have secondary responsibility).

If you discover the member is covered by more than one health plan, and:

- **BCBSAZ or any other BCBS Plan is the primary payer:** Submit the other carrier's name and address with the claim to BCBSAZ. If you do not include the COB information with the claim, the member's BCBS Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.

- **Another non-BCBS health plan is primary and BCBSAZ or any other BCBS Plan is secondary:** Submit the claim to BCBSAZ only after receiving payment from the primary payer, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's BCBS Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.

Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the BCBSAZ remittance advice as "patient liability" might be different from the actual amount the patient owes you because of the combination of the primary insurer payment and your negotiated amount with BCBSAZ.

For Professional claims if the member does not have other insurance, it is imperative on the electronic HIPAA 837 claims submission transaction or CMS 1500 claim form, in box 11D, that either "YES" or "NO" be checked. Leaving the box unmarked can cause the member's Plan to stop the claim to investigate for COB.

Coordination of benefits questionnaire

To streamline our claim processing and reduce the number of denials related to coordination of benefits, a COB questionnaire form is available to you at azblue.com/Forms. Using this form can help avoid potential claim issues and delays.

When you service BCBS members and you are aware that they might have other health insurance coverage (e.g., through Medicare, another BCBS Plan, or any other insurance plan), give them a copy of the COB questionnaire during their visit. Ensure that the form is completely filled out and, at a minimum, includes your name and tax identification or NPI number, the policy holder's name, group number, and identification number (including the three-character prefix), and the member's signature. Send the completed form to BCBSAZ as soon as possible. BCBSAZ will work with the member's Plan to get the COB information updated. Collecting COB information from members before you file their claim eliminates the need to gather this information later, thereby reducing claim processing and payment delays.

4.13 Claim payment

You can check the status of your claim for payment information. Use the claim status tool on the homepage of the secure provider portal at azblue.com/providers or call BCBSAZ at 602-864-4114. Do *not* resubmit the claim because it will be denied as a duplicate and generate a second EOB for the member.

In some cases, a member's BCBS Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, BCBSAZ may ask you for the information or give the member's Plan permission to contact you directly.

4.14 Claim status inquiry

BCBSAZ is your single point of contact for all claim inquiries. You can check claim status in the following ways:

- Use the claim status inquiry tool on the homepage of the secure provider portal at azblue.com/providers
- HIPAA transactions 276/277 (inquiry/response) – real-time or batch
- IVR phone system at 602-864-4114 or 1-800-441-0483

4.15 Claim questions from BCBS members

If BCBS members ask you questions about a claim, advise them to contact their BCBS Plan and refer them to their ID card for a customer service number.

The member's BCBS Plan should not contact you directly regarding claim issues. Any claim inquiry calls from the member's Plan should be referred to BCBSAZ.

4.16 Key contacts

For more information:

- Visit the BCBSAZ website and secure provider portal at azblue.com/providers.
- Call BCBSAZ at 602-864-4114 or 1-800-441-0483.
- Contact your BCBSAZ provider liaison.

5. Glossary

Administrative Services Only (ASO)

ASO accounts are self-funded, and the group's BCBS plan administers claims on behalf of the account but does not fully underwrite the claims. ASO accounts may have customized benefits or claim processing requirements. There may be specific requirements that affect medical benefits, submission of medical records, coordination of benefits, timely filing limitations, or appeals and grievances procedures.

bcbs.com

The Blue Cross Blue Shield Association website.

BlueCard Provider Access® 1-800-810-BLUE (2583)

A toll-free access line that helps you in referring a patient to a physician or healthcare facility in another location.

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

A toll-free eligibility line that helps you verify membership and coverage information, and obtain precertification for members from other BCBS Plans.

Blue High Performance Network (BlueHPN)

A national network of providers in key metropolitan areas to offer national accounts enhanced quality and cost savings through EPO plans.

BlueCard PPO

A national program that offers members traveling or living outside of their BCBS Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider. The member ID card will display a PPO "suitcase" logo in the lower right corner:

Blue Cross Blue Shield Global Core

Blue Cross Blue Shield Global Core refers to the international coverage included in some member benefit plans issued by Blue Cross Blue Shield licensees.

Blue Cross Blue Shield Global®

Blue Cross Blue Shield Global is the brand used to identify the comprehensive portfolio of Blue Cross Blue Shield's international products and services, serving the needs of mobile individuals and employees when living, working, studying, or traveling globally.

Bupa Global

Bupa Global is the international health insurance division of Bupa. Bupa is an independent licensee of the Blue Cross Blue Shield Association. Bupa Global offers expatriate and globalist benefit plans to those residing outside of the U.S.

Coordination of Benefits (COB)

Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order in which entities share responsibility for payment (i.e., which one has primary responsibility and which one(s) has/have secondary responsibility).

Exclusive Provider Organization (EPO)

A health benefits program in which the member receives no benefits for care obtained outside the network except emergency care. There is no requirement for a designated primary care physician.

GeoBlue®

GeoBlue is the trade name of Worldwide Insurance Services, LLC, an independent licensee of the Blue Cross Blue Shield Association, made available in cooperation with Blue Cross and Blue Shield companies in select service areas. GeoBlue offers expatriate, travel, and student/faculty benefit plans and services to those residing within the U.S.

Hold Harmless

An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed on with a BCBS Plan as full payment for these services.

Medicaid

A program designed to assist low-income families in accessing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include children younger than 6 in low-income families and low-income pregnant women. Medicaid is governed by overall federal guidelines in terms of eligibility, procedures, payment level, etc., but states have a broad range of options within those guidelines to customize the program to their needs, and they can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the state department of health (or similar state agency).

Medicare Advantage (MA)

The program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as “traditional Medicare”). MA offers Medicare beneficiaries several product options similar to those available in the commercial market.

Medicare Supplement (Medigap)

Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the gaps in Original Medicare coverage. Medigap policies are regulated under federal and state laws and are standardized (Medigap Plans A through L). Each plan has a different set of basic and extra benefits.

Medigap plans are separate from Medicare Advantage (MA) products. Medigap plans *supplement* Original Medicare and Medicare Advantage plans *replace* Original Medicare.

Member ID Prefix

Three characters at the beginning of the subscriber identification number on BCBS Plan ID cards. The prefix identifies the member’s BCBS Plan and is essential for routing and applying member benefits and coverage information.

National Account

An employer group with employee and/or retiree locations in more than one BCBS Plan’s service area.

National Doctor and Hospital Finder

A national provider directory that can be used to locate healthcare providers in another BCBS Plan's area. This is useful if you need to refer a patient to a physician or healthcare facility in another location. If you find that any information in the directory about you, as a provider, is incorrect, please contact BCBSAZ at 602-864-4114.

Other Party Liability (OPL)

This refers collectively to cost containment programs that ensure that BCBS Plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, workers' compensation, subrogation, and no-fault auto insurance.

Point of Service (POS)

A health benefit program in which the highest level of benefits is received when members obtain services from their primary care provider/group and comply with referral authorization requirements for care. Benefits are still provided when members obtain care from any eligible provider without referral authorization, according to the terms of the contract.

Preferred Provider Organization (PPO)

A health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.

BlueCard PPO "Basic" network (PPOB)

Similar to BlueCard PPO/EPO, this broad national network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.

State Children's Health Insurance Program (SCHIP)

A public program administered by the U.S. Department of Health and Human Services that provides matching funds to states for providing health insurance to families with children. The program was designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

Traditional Coverage

A health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost-share features, such as deductibles, coinsurance, or copays.

6. BlueCard Program quick reference guide

The BlueCard Program connects members from other BCBS Plans with BCBSAZ providers.

Here are some key points to remember:

- File a copy of the front and back of the member's ID card in the patient record.
- To verify a patient's membership and coverage, submit an electronic HIPAA 270 transaction (eligibility) to BCBSAZ via azblue.com/providers, use the online Eligibility & Benefits Inquiry tool in the secure provider portal, or call BlueCard Eligibility at 1-800-676-BLUE (2583).
- For precertification and clinical criteria information, use the out-of-area BlueCard router tools on the BCBSAZ secure provider portal at azblue.com/providers in "Practice Management" under the "Precertification" and "Clinical Criteria" headers. These tools connect you with the member's BCBS Plan.
- Submit claims electronically to BCBSAZ. Always include the patient's complete ID number, which includes the three-character prefix. Only if you can't submit claims electronically, mail them to P.O. Box 2924, Phoenix, AZ 85062-2924.
- For claim inquiries:
    - Use the online claim status tool at azblue.com/providers in "Practice Management."
    - Use the IVR automated phone system at 602-864-4320 or 1-800-232-2345.
    - Call BCBSAZ at 602-864-4114.