BlueCross BlueShield of Illinois

BLUE REVIEW℠

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS JUNE 2016

New CDC Guidelines for Prescribing Opioids for Chronic Pain

Part 1 of a 3-Part series describing the CDC guidelines for prescribing opioids

In March 2016, the Centers for Disease Control and Prevention (CDC) issued new recommendations for prescribing opioid medications for chronic pain, excluding reasons for cancer, palliative and end of life care.[1] These recommendations were in response to an increased need for provider education due to a nationwide epidemic of opioid overdose and opioid use disorder.

The CDC has developed 12 recommendations, grouped into three areas of consideration:

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow up and discontinuation
- Assessing risk and addressing harms of opioid use

The first three recommendations in the first area of consideration – Determining when to initiate or continue opioids for chronic pain – are described below. The remainder of the recommendations will appear in the future issues of the *Blue Review*.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. According to the new guidelines released in March 2016, the CDC recommends non-pharmacologic and non-opioid pharmacologic therapy as the preferred treatment for chronic pain. In terms of pain relief and function, health care providers should weigh the benefits versus the risk when using opioid therapy. If a provider decides to use opioid therapy, non-pharmacologic and non-opioid pharmacologic therapy should also be incorporated, when possible.
   - Non-pharmacologic therapies can include: physical therapy, weight loss for knee osteoarthritis, psychological therapies such as cognitive-behavioral therapy (CBT) and exercise therapy.
   - Non-opioid pharmacologic therapy can include: acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs) and certain antidepressant and anticonvulsant medications.
   - Comprehensive pain management may include a coordination of different specialties including primary care, mental health, physical therapy and social work.

(continued on page 2)

BlueCard® Program Manual Reminders

To assist you when you are providing care and services to out-of-area Blue Plan members, a BlueCard Program Manual is available in the Standards and Requirements section of our website at *bcbsil.com/provider*.

This manual includes information on how the BlueCard program works, how to identify BlueCard members, claim filing guidelines, key contacts, answers to frequently asked questions, a glossary of BlueCard terms and other important details.

Examples of specific sections included in the BlueCard Program Manual are:

- BlueCard Program Advantages for Providers
- Coverage and Eligibility Verification
- Electronic Provider Access
- Ancillary Claims
- Contiguous Counties/Overlapping Service Areas

We encourage you to become familiar with the procedures and guidelines in this helpful resource.

Blue Cross Community Options℠ Clinical Practice and Preventive Health Guidelines

The 2016 Blue Cross Community Options Clinical Practice and Preventive Health Guidelines are now available. If you provide services to Blue Cross Community MMAI (Medicare-Medicaid Plan)℠, Blue Cross Community ICP℠ or Integrated Care Plan, or Blue Cross Community Family Health Plan℠ (FHP) members, you may request a copy of the Blue Cross Community Options Clinical Practice and Preventive Health Guidelines by contacting Kevin Kirk at 312-653-2539 or *Kevin_Kirk@bcbsil.com*. Or, contact your Blue Cross Community Options Provider Network Consultant. For additional Blue Cross Community Options resources, visit the Network Participation section of our website at *bcbsil.com/provider*.

The clinical practice guidelines are for informational purposes only and are not a substitute for the independent medical judgment of health care providers. Providers are instructed to exercise their own independent medical judgment in providing health care to members.

Please note that the fact that a guideline is available for any given treatment, or that a service has been preauthorized, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member's ID card.

(New CDC Guidelines for Prescribing Opioids, continued from page 1)

2. The guidelines also state that providers should establish realistic goals for pain relief and function with the patient before starting opioid therapy. Prior to starting therapy, patients should be engaged in conversation about how their opioid therapy may be discontinued (i.e., an exit strategy) if the benefits do not outweigh the risks. Opioid therapy should only be continued if there are clinically meaningful improvements in pain and function that outweigh any risks to patient safety.
   - Patients should understand that while opioid therapy can reduce pain short term, there is no solid evidence that opioids will continue to improve pain and function with long-term use.
   - Providers may not want to prescribe opioids for longer than 30 days to ensure that the patient's pain is reassessed at intervals.
   - Measuring improvements in function can include emotional, social and physical dimensions.
3. Finally, the guidelines note that providers should ensure that patients are aware of all serious adverse side effects of opioid use, as well as the more common side effects of opioids and how to alleviate them. Additionally, the provider should review with patients the responsibilities of managing opioid therapy and include them in the final decision of whether or not to start, or continue, opioid therapy.
   - Serious adverse side effects of opioids can potentially include fatal respiratory depression and/or opioid use disorder that can be life-long and cause major distress.
   - Common side effects of opioids can include: constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence and withdrawal symptoms when stopping opioid therapy.
   - Given the risks, clinicians should review the risks and possible diminished benefits of continued opioid therapy with patients on a periodic basis, at least once every three months.

A review on opioid selection, dosage, duration, follow-up and discontinuation will be included in next month's *Blue Review*.

[1]Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain- United States, 2016. MMWR Recomm Rep 2016; 65:1-49. DOI: *http://dx.doi.org/10.15585/mmwr.rr6501e1*.

The information mentioned here is for educational purposes only and is not a substitute for the independent medical judgment of a physician. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

Please note that the fact that a guideline is available for any given treatment, or that a service has been preauthorized, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member's ID card.

Help Your Patients Maximize Their Benefits

BCBSIL continues to educate members about their benefit coverage and how to use it, especially new members who may not know how to maximize their benefits by obtaining services from an in-network provider. You can help them by confirming your network status for the member's plan before services are provided. In addition, an in-network provider should refer the member to an in-network provider whenever possible.

You can utilize the Provider Finder® on our website at *bcbsil.com/provider* to locate in-network providers and facilities. As always, verifying eligibility and benefits is a critical first step before providing services to new **and** existing patients. Ask to see the member's ID card upon the first visit and every visit thereafter.

Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

Study Reveals Health Care Education Can Save Money

Newly published results of a recent study by the Blue Cross and Blue Shield Association (BCBSA) show that individuals who enrolled in Blue Cross and Blue Shield (BCBS) health plans after the Affordable Care Act (ACA) took effect had higher rates of disease and received significantly more medical care, on average, than those who enrolled in BCBS individual plans prior to 2014.[1]

"The findings underscore the need for all of us in the health care system, and newly insured consumers, to work together to make sure that people get the right health care service in the right care setting and at the right time," said Alissa Fox, senior vice president of the Office of Policy and Representation for BCBSA. "Better communication and coordination is needed so that everyone understands how to avoid unnecessary emergency room visits, make full use of primary care and preventive services and learn how to properly adhere to their medications."

The report, "Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience from 2014 and 2015," represents a comprehensive, in-depth study of actual medical claims among those BCBS members enrolled in individual coverage before and after the ACA took effect. The study also compares this group of individuals to those who receive insurance through their employers. The data was collected from independent BCBS companies across the country and focused on members ages 21 through 64. It excluded Medicare and Medicaid enrollment.

Comparing health status and use of medical services among these three groups, the study found that:

- Members who newly enrolled in BCBS individual health plans in 2014 and 2015 have higher rates of certain diseases such as hypertension, diabetes, depression, coronary artery disease, human immunodeficiency virus (HIV) and Hepatitis C than individuals who had BCBS individual coverage prior to implementation of the ACA.
- Consumers who newly enrolled in BCBS individual health plans in 2014 and 2015 received significantly more medical care, on average, than those with BCBS individual plans prior to 2014 who maintained BCBS individual health coverage into 2015, as well as those with BCBS employer-based group health insurance.
- The new enrollees used more medical services across all sites of care – including inpatient admissions, outpatient visits, medical professional services, prescriptions filled and emergency room visits.
- Medical costs of care for the new individual market members were, on average, 19 percent higher than employer-based group members in 2014 and 22 percent higher in 2015.

In addition to communication efforts, BCBS companies are expanding patient-focused care programs that emphasize prevention, wellness and coordinated care so new individual members get help with overcoming sickness and stay healthy longer.

BCBS companies across the country have participated in the new marketplaces more broadly than any other insurance carrier insuring more than 8.6 million individual members through Dec. 31, 2015. In addition to offering products on the federal and state-run marketplaces, all BCBS companies sell individual and group health insurance products throughout the country.

To see the full report, visit *bcbs.com/healthofamerica*.

[1] Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience from 2014 and 2015 [March 2016], *http://www.bcbs.com/healthofamerica/newly_enrolled_individuals_after_aca.pdf*

Dr. Stephen Ondra: 'How to Build on the Affordable Care Act'

Six years after it was signed into law, ACA has improved America's health care system in many important ways, Dr. Stephen Ondra writes in his latest post on the digital magazine Pulse. But there's still more that could be done to build on the foundation of health care reform. Dr. Ondra lists four key steps that could make the system more effective and sustainable for consumers, providers and payers.

Dr. Ondra is senior vice president and enterprise chief medical officer of our health insurance plans in Illinois, Montana, New Mexico, Oklahoma and Texas. He said, "Of all the positive consequences of the ACA, probably the most fundamental is that it gave a much-needed urgency to the cause of health reform."

Read the four key steps to improving ACA in Dr. Ondra's latest article at *pulse.hcsc.com/category/delivery*. Watch for future articles from Dr. Ondra in this newsletter, and follow him on Twitter at @StephenOndra where he tweets about his work and the future of health care.

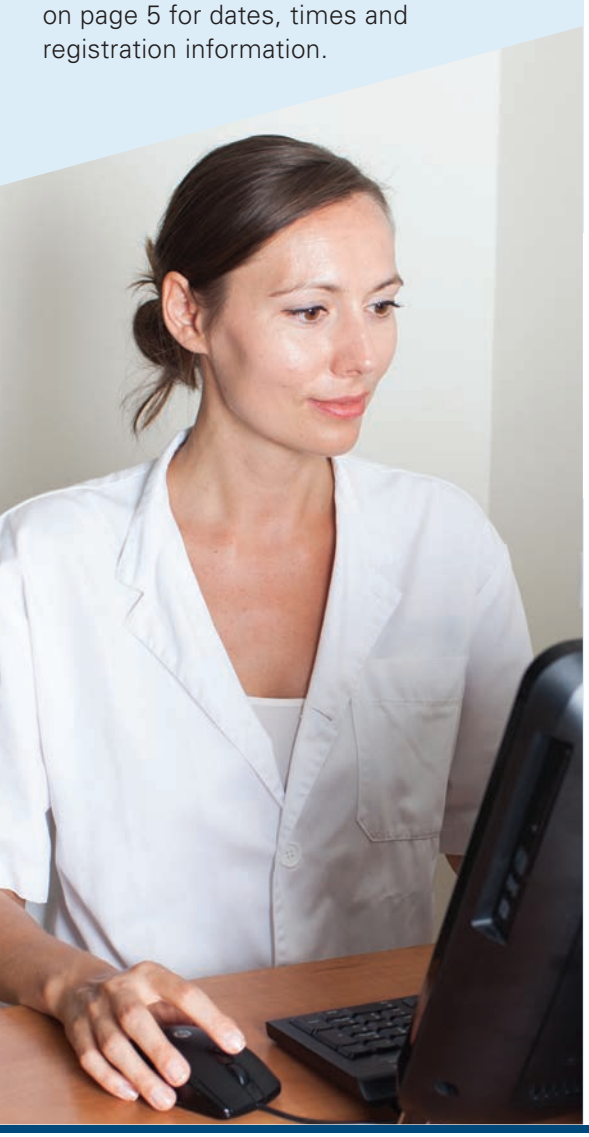
Reminder: Agent Assisted Corrected Claim Requests

As a reminder, effective July 11, 2016, corrected claim requests for previously submitted electronic or paper claims can no longer be initiated by calling Customer Service. Additionally, these requests will not be accepted via the Claim Inquiry Resolution option in our Electronic Refund Management (eRM) tool.

Electronic claim submitters are required to submit replacement/corrected claims utilizing claim frequency code 7. If corrections need to be submitted via paper, "corrected claim" must be indicated on the Claim Review Form, with the CMS-1500 or UB-04 claim form attached.

WEBINARS IN JUNE

Join us this month for a Provider Services Changes Coming webinar to learn more. See the Provider Learning Opportunities on page 5 for dates, times and registration information.



Electronic Options to Replace Duplicate Paper Provider Claim Summary Requests

Effective July 11, 2016, duplicate copies of paper Provider Claim Summaries (PCSs) will no longer be provided by BCBSIL. Providers who currently receive paper PCSs via U.S. Mail are strongly encouraged to enroll to receive an 835 Electronic Remittance Advice (ERA) from BCBSIL. The 835 ERA is a HIPAA-compliant method of receiving claim payment and remittance details, which can be automatically posted to your patient accounting system.

ERA ENROLLMENT

When enrolling for ERA, you are automatically enrolled to receive the Electronic Payment Summary (EPS), which is sent by BCBSIL as a companion file to the ERA. The EPS is an electronic copy of the paper PCS. The EPS may be used as an added tool when reconciling BCBSIL payments. To enroll to receive the ERA from BCBSIL, you must be a registered Availity™ user. Visit availity.com for registration and online ERA enrollment details. **When you enroll, you will also have the option to receive ERAs for out-of-area Medicare Supplemental claims.**

REMITTANCE VIEWER

Another option for viewing your claim payment information is through the Availity Remittance Viewer, a complimentary online tool that enables providers and/or their billing services to view and reconcile 835 ERA data. With this tool, providers/billing services can search for claim details by check number, date range or claim number.

The remittance viewer is accessible to providers who are enrolled for ERA and registered with Availity. Billing services that have been designated to receive ERA files on behalf of a provider may also review that provider's ERAs using the remittance viewer. If you have a billing service as your receiver, you may elect to view your ERAs by configuring the access options in the remittance viewer. A provider organization whose electronic claims are submitted through another clearinghouse also may access their ERA data using the remittance viewer, as long as the 835 file is received through Availity.

We invite you to join us for a webinar to learn more. See the Provider Learning Opportunities on page 5 for upcoming webinar dates, times and registration information.

Has your information changed? Let us know!

When seeking health care services, our members often rely upon the information in our online Provider Finder. In particular, potential patients may use this online tool to confirm if you or your practice is a contracted in-network provider for their health care benefit plan. Other providers may use the Provider Finder when referring their patients to your practice.

We encourage you to check your own information in the Provider Finder – look for the link on our Provider website Home page at *bcbsil.com/provider*. Is your online information accurate? If changes are needed, it's important that you inform BCBSIL as soon as possible.

USE OUR ONLINE CHANGE REQUEST FORMS

You can request most changes online by using one of our electronic change request forms. Visit the Network Participation/Update Your Information section of our Provider website to access instructions along with links to each type of form. There are three different change request forms to help you organize your information, as follows:

1. **Request Demographic Information Changes**
   Use this form to request changes to your practice information currently on file with BCBSIL (such as address, email or NPI). You may specify more than one change within your request as long as all changes relate to the same billing (Type 2) NPI. As a participating provider, your NPI(s) should already be on file with BCBSIL. You may use this online form to request changes, such as deactivation of an existing NPI.
2. **Request Addition of Provider to Group**
   Use this form to notify BCBSIL when a new individual provider joins your practice. Please remember that new providers are subject to credentialing review and will not be effective until the process is completed.
3. **Request Removal of Provider from Group**
   Use this form to notify BCBSIL when an individual provider is leaving any or all of your practice locations.

Please note that changes are not immediate upon submission of an online change request form. Processing can take a minimum of 30 business days. If you would prefer to mail or fax your changes to BCBSIL, there is a downloadable Provider Information Change Request Form in the Education and Reference/Forms section of our Provider website. If you have any questions or need assistance, contact Provider Network Operations at *netops_provider_update@bcbsil.com*.

EXCEPTIONS TO THE ONLINE REQUEST PROCESS

The following types of changes are more complex and require special handling:

- **Multiple changes, especially changes involving more than one billing (Type 2) NPI** – These should be submitted via email to netops_provider_update@bcbsil.com.
- **Tax ID changes that may, or may not, involve Legal Business Name changes** – This type of change often requires a new contract. To request a contract application, visit the Network Participation/Contracting section of our Provider website.
- **Ancillary provider changes** – Skilled nursing facilities, home health agencies, hospice, home infusion therapy, durable medical equipment (DME) suppliers, orthotics and prosthetics, dialysis centers, private duty nursing agencies and other ancillary providers may request changes by sending details to *ancillarynetworks@bcbsil.com*, or by calling 312-653-4820.

Provider Learning Opportunities

A snapshot of complimentary upcoming training sessions offered by BCBSIL is included below. To register, visit the Workshops and Webinars page in the Education and Reference Center on our website at *bcbsil.com/provider*.

BCBSIL WEBINARS

BCBSIL Back to Basics: 'Availity 101'
June 7, 2016
June 14, 2016
June 21, 2016
June 28, 2016
All sessions: 11 a.m. to noon

Introducing Remittance Viewer
June 15, 2016
July 6, 2016
July 13, 2016
All sessions: 11 a.m. to noon

iExchange Training: 2016 System Enhancements
June 8, 2016 – 11 a.m. to noon
June 23, 2016 – 2 to 3:15 p.m.

Provider Services Changes Coming
June 8, 2016 – 2 to 3:30 p.m.
June 21 & 28, 2016 – 10 to 11:30 a.m.

BCBSIL Professional Provider Workshops

Learn about products, benefit preauthorization updates and new PPO credentialing guidelines.

June 22, 2016
Silver Cross Hospital
1900 Silver Cross Blvd.
New Lenox, IL 60451
The registration deadline is June 17, 2016.
Questions? Contact Michelle Brownfield-Nance at *michelle_brownfield-nance@bcbsil.com* or 312-653-4727.

June 23, 2016
BCBSIL
300 E. Randolph St., Chicago, IL 60601
The registration deadline is June 17, 2016.
Questions? Contact Ana Hernandez at *hernandeza2@bcbsil.com* or 312-653-6488.

A Valid State License is Required for Network Participation

As an independently contracted provider with BCBSIL, your agreement stipulates that you must hold a valid state professional license in the State of Illinois (SOI) or the state in which services are rendered to covered persons.

SOI physician licenses (M.D. and D.O.) typically expire on July 31. License renewal is required every three years. If you fail to renew your license before the expiration date, the SOI will place you in an inactive status.

Periodically, the status of medical licenses for participating providers is checked against the Illinois Department of Financial and Professional Regulation (IDFPR) databank. Providers with licenses identified as being inactive, suspended, revoked or in non-renewed status are ineligible for continued participation in any BCBSIL provider network.

It is important to complete the state license renewal process as early as possible to avoid being automatically deactivated from the BCBSIL networks in which you participate. Providers who are deactivated must submit a new contract application request in order to be reinstated.

For more information, such as license lookup and online renewal, visit idfpr.com.

This article is provided for informational purposes only and is not intended, nor should it be construed, as legal advice. If you have any questions regarding laws or regulations, you should consult with your legal advisor.

Legislative Review

Recently Enacted Laws Passed by Illinois State Legislature

The 2015 Illinois legislature passed several new laws that impact insurance coverage in 2016. Brief overviews of some of these new laws and amendments are listed below for your convenience.

PUBLIC ACT 99-0480 (HOUSE BILL 1) HEALTH-TECH

Effective Sept. 9, 2015, this Bill required state employee groups, Administrative Services Only (ASO) municipalities, and ASO counties to apply mental health parity. It allows licensed pharmacists to dispense opioid antagonists, drugs that block or inhibit the effect of opioids and can reverse the deadly effects of overdose. It also requires insurers to use policies and procedures for including substance abuse treatment drugs on their formulary that are no less favorable to members than the policies and procedures used to determine other drugs. It also requires insurers to follow the expedited coverage determination requirements for substance abuse treatment drugs in the Managed Care Reform and Patient Rights Act, and requires that interpretation of this section be in parity with applicable federal regulations. And, it requires group health plans to provide coverage for at least one opioid antagonist.

PUBLIC ACT 99-0167 (STATE BILL 1680) AMENDS THE INSURANCE CODE– ELECTRONIC DOCUMENT DELIVERY

This Bill requires certain disclosures and written member consent in order to deliver insurance notices and documents electronically. It was effective Jan. 1, 2016, and applies to fully insured PPO members.

PUBLIC ACT 99-0433 (HOUSE BILL 3673) AMENDS THE ILLINOIS INSURANCE CODE AND THE ILLINOIS PUBLIC AID CODE - MRI COVERAGE

This Bill requires insurers to cover a screening magnetic resonance imaging (MRI) with no cost-sharing (in-network only) when determined to be medically necessary by a licensed physician for all Illinois residents. It was effective Aug. 21, 2015, and applies to all insured members, with options added to the Enterprise Product Menu (previously known as the Standards Table) for ASO groups that want to follow IL legislation.

PUBLIC ACT 99-0421 (STATE BILL1764) INSURANCE CODE – INFERTILITY COVERAGE

This bill amends the Illinois Insurance Code and provides that insurers offering accident and health insurance to groups of more than 25 employees provide coverage for infertility treatments to covered individuals unable to attain a viable pregnancy or maintain a viable pregnancy (previously covered just those unable to sustain a successful pregnancy). It expands the definition of infertility to include individuals unable to conceive after one year of attempting to produce conception and those unable to conceive after diagnosis with a condition affecting fertility. This amendment was effective Jan. 1, 2016, and applies to fully insured (HMO and PPO) plans.

This communication is intended for informational purposes only. It is not intended to provide, does not constitute, and cannot be relied upon as legal, tax or compliance advice. The information contained in this communication is subject to change based on future regulation and guidance.

ClaimsXten™ Outpatient Facility Rules: Implementation Update for FEP and BlueCard Host

On March 18, 2016, BCBSIL posted an updated reminder regarding the upcoming implementation of three new Outpatient Facility Rules for dates of service beginning on or after May 23, 2016, for Federal Employee Program (FEP) groups and BlueCard Host claims.

This notification is to announce the implementation of these new rules for BlueCard Host has been postponed. The implementation for BlueCard Host claims will be on or after July 18, 2016. The implementation for Federal Employee Program was completed with date of service effective May, 23, 2016. As provided in our previous disclosure notice, the new rules are summarized below.

MEDICALLY UNLIKELY EDITS (MUES) MULTIPLE LINES RULE

This new facility rule identifies claim lines where the MUE has been exceeded for a Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) code, reported by the same provider, for the same member, on the same date of service.

An MUE is an edit that reviews claims for units of service for a HCPCS or CPT code for services rendered by a single provider/supplier to a single beneficiary on the same date of service. The ideal MUE is the maximum units of service that would be reported for a HCPCS or CPT code on the vast majority of appropriately reported claims. The maximum allowed is the total number of times per date of service that a given procedure code may be appropriately submitted by the same provider.

OUTPATIENT CODE EDITOR BUNDLING RULE

This new facility rule identifies claims containing code pairs found to be unbundled according to the Centers for Medicare & Medicaid Services (CMS) Integrated Outpatient Code Editor (I/OCE). One of the functions of the I/OCE is to edit claims data to help identify inappropriate coding due to the following reasons: The procedure is a mutually exclusive procedure that is not allowed by the Correct Coding Initiative (CCI) and/or the procedure is a component of a comprehensive procedure that is not allowed by the CCI.

UNBUNDLED PAIRS OUTPATIENT RULE

This new facility rule identifies the unbundling of multiple surgical codes when submitted on facility claims. This rule detects surgical code pairs that may be inappropriate for one of the following reasons: One code is a component of the other code, or these codes would not reasonably be performed together on the same date of service.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSIL's code-auditing software. For more information on C3 and ClaimsXten, including answers to frequently asked questions, refer to the Clear Claim Connection page in the Education and Reference Center/Provider Tools section of our website at *bcbsil.com/provider*. Additional information also may be included in upcoming issues of the *Blue Review*.

Reminder: Professional Behavioral Health Areas of Expertise Information Still Needed

We are updating our provider file to include professional behavioral health areas of expertise. This information will appear in our Provider Finder as an added level of detail for our members, and your potential patients, when they are searching for behavioral health services.

If you haven't done so already, please take a moment to complete our brief online Professional Behavioral Health Areas of Expertise Survey, which is available now in the Clinical Resources/Behavioral Health Care Management Program/Related Resources section of our website at *bcbsil.com/provider*.

TIPS FOR SURVEY COMPLETION

- Demographic information is required.
- The survey must be completed in one sitting; you cannot save or pause, once you begin entering data.
- Select no more than five areas of expertise, along with the applicable age ranges.*
- Verify that all information is correct then click "Submit."

The survey is intended to take no more than 10 minutes of your time. Your responses will help us update our provider file to more accurately represent the services you provide to our members. Thank you for your participation!

*If you provide services at multiple locations, the areas of expertise you select will be applicable to all locations.

BlueCross BlueShield of Illinois

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WHAT'S INSIDE?

Blue Review is a monthly newsletter published for institutional and professional providers contracting with Blue Cross and Blue Shield of Illinois. We encourage you to share the content of this newsletter with your staff. *Blue Review* is located on our website at *bcbsil.com/provider.*

The editors and staff of *Blue Review* welcome letters to the editor. Address letters to:

BLUE REVIEW
Blue Cross and Blue Shield of Illinois
300 E. Randolph Street – 24th Floor
Chicago, Illinois 60601-5099
Email: *bluereview@bcbsil.com*
Website: *bcbsil.com/provider*