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A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
HMO Claims Address

The IPAs should submit all HMO risk and non-group approved claims to the following address:

PO Box 805107
Chicago, Illinois 60680-4112

Claim Processing Procedures

- All IPA responsibility claims should be submitted directly to the appropriate IPA for payment. All HMO responsibility claims should be submitted ELECTRONICALLY to BCBSIL.
- The member’s IPA will adjudicate claims received and offer the following dispositions:
  - **Group Approved (GA)** - IPA pre-authorized the services.
  - **Non-Group Approved (NGA)** - PCP/WPHCP IPA did not authorize the services.

The following chart lists the services that are the financial responsibility of the HMO and the financial responsibility of the IPA. Note: This list is not all inclusive.

<table>
<thead>
<tr>
<th>HMO Responsibility</th>
<th>IPA Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility charges for:</td>
<td></td>
</tr>
<tr>
<td>- Inpatient stays</td>
<td></td>
</tr>
<tr>
<td>- Outpatient surgery</td>
<td></td>
</tr>
<tr>
<td>- Out of area (NGA services)</td>
<td></td>
</tr>
<tr>
<td>- Emergency Room visit</td>
<td></td>
</tr>
<tr>
<td>Observation Units</td>
<td></td>
</tr>
<tr>
<td>Professional Emergency Admission - Charges prior to IPA notification</td>
<td></td>
</tr>
<tr>
<td>Professional charges for out of area emergency room visits</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td></td>
</tr>
<tr>
<td>All charges for:</td>
<td></td>
</tr>
<tr>
<td>- Extraction of fully bony impacted teeth</td>
<td></td>
</tr>
<tr>
<td>- Voluntary Sterilization</td>
<td></td>
</tr>
<tr>
<td>- Organ Transplants (approved by HMO)</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
</tr>
<tr>
<td>Vision Exam/Eyewear</td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency (if referred to HMO Network Provider)</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (if referred to HMO Network Provider)</td>
<td></td>
</tr>
<tr>
<td>Skilled Home Health (if referred to HMO Network Provider)</td>
<td></td>
</tr>
<tr>
<td>Outpatient dialysis (if referred to HMO network provider)</td>
<td></td>
</tr>
<tr>
<td>Orthotics/Prosthetics (O&amp;P) (if referred to HMO Network Provider. Note: Some O&amp;P items are always IPA risk. Contact IPA for more details.)</td>
<td></td>
</tr>
<tr>
<td>Medical Supplies (not from an MD office)</td>
<td></td>
</tr>
<tr>
<td>Ground Ambulance</td>
<td></td>
</tr>
<tr>
<td>ART/Infertility (if referred to HMO Network Provider)</td>
<td></td>
</tr>
<tr>
<td>Professional Fees for:</td>
<td></td>
</tr>
<tr>
<td>- Inpatient</td>
<td></td>
</tr>
<tr>
<td>- Outpatient</td>
<td></td>
</tr>
<tr>
<td>- In area Emergency Room visit</td>
<td></td>
</tr>
<tr>
<td>Outpatient Diagnostics</td>
<td></td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Medical Supplies from MD office</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td></td>
</tr>
<tr>
<td>Well Child Care</td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td></td>
</tr>
<tr>
<td>Periodic Health Exams</td>
<td></td>
</tr>
<tr>
<td>Dental - see Section II, C.2 of MSA</td>
<td></td>
</tr>
<tr>
<td>Orthotics/Prosthetics (O&amp;P) (if referred to Provider other than HMO Network Provider. Note: Some O&amp;P items are always IPA risk. Contact IPA for more details.)</td>
<td></td>
</tr>
<tr>
<td>Outpatient Radiation and Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>Outpatient Inhalation (Respiratory) Therapy</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hearing Screening</td>
<td></td>
</tr>
<tr>
<td>Outpatient Ancillary Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td></td>
</tr>
<tr>
<td>Outpatient dialysis (if referred to provider other than HMO network provider)</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (if referred to Provider other than HMO Network Provider)</td>
<td></td>
</tr>
<tr>
<td>Skilled Home Health (if referred to Provider other than HMO Network Provider or for an Ambulatory member)</td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency Professional Charges (if referred to Provider other than HMO Network Provider)</td>
<td></td>
</tr>
<tr>
<td>Day Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>ART/Infertility (If referred to Provider other than HMO Network Provider)</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (if referred to Provider other than HMO Network Provider)</td>
<td></td>
</tr>
<tr>
<td>Skilled Home Health (if referred to Provider other than HMO Network Provider or for an Ambulatory member)</td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency Professional Charges (if referred to Provider other than HMO Network Provider)</td>
<td></td>
</tr>
</tbody>
</table>
**HMO Responsibility Claims**

The HMO must determine Group Approval status on all HMO responsibility claims. There are three methods:

1. The HMO will send the claim to the IPA for approval status with a cover letter attached indicating the requested information. *(See sample letter on page 4).* The claims should be stamped with the approved HMO stamp using blue or black ink only, and returned back to the HMO within 5 working days of receipt. *(See below for sample IPA Approval Stamp).* The IPA number, name, approval status, date and initials should be filled in. Claims should be sent

   Approved claims will then be processed according to the benefits of the contract. Appropriate charge backs will be made to the IPA’s UM Fund. Non Group Approved claims will be denied and an Explanation of Benefits will be sent to the provider and member.

   **Sample IPA Approval Stamp**

   ![Sample IPA Approval Stamp](image)

   HMOI IPA #
   Date Received (By IPA)
   GA
   NGA
   Date Returned
   Name or Initial

2. Through the Automatic Group Approval Process (GAP), the IPA and a hospital must sign an Automatic Group Approval Agreement with the HMO. The IPA will provide group approval status to the hospital. The hospital will bill the HMO, with the group approval status noted on the claim form, and the claim will be processed accordingly.

3. The HMO will make available to the IPA the daily 578/095 report via the internet. This report can be accessed at [https://providers.hcsc.net/providers/il_login.html](https://providers.hcsc.net/providers/il_login.html). Each IPA user must have a secure sign on. The Network Consultant should be contacted to facilitate this. If technical assistance is needed after the sign on is received, contact our Help Desk at (312) 653-6675 and ask for the internet help desk through Blue Access.

   The IPA will indicate approval status for each claim listed on the report. *(Refer to training materials which start on page 5 for process).* The IPA’s response must be made within 14 calendar days. If the response is not received, the HMO will assume the claim is group approved and pay accordingly. All units will be charged to the IPA and cannot be challenged. The related professional charges will also be considered approved and the IPA’s responsibility to pay.

   The IPA should download the data regularly for historical documentation purposes. The data definitions are located on the internet site.
Sample Letter Returning Claims to IPA

HMO ILLINOIS
A Blue Cross HMO
2787 McFarland Road  Rockford, Illinois 61107-6815  815/987-5100

To Whom It May Concern:

CLINIC # __________________________

We are returning the attached claim for one of the following reasons:

_____ After review of the attached claim, we found it is not our liability for payment.  We are, therefore, returning it to you for consideration and payment.

_____ We received the enclosed claim in our office and are sending it to you for your review and/or disposition.  Please return it to us if it is not your responsibility indicating either "GROUP APPROVED" or "NOT GROUP APPROVED."

_____ No indication of "GROUP APPROVED" or "NOT GROUP APPROVED" was made on the attached claim, so we are returning it for review a second time.

_____ We found a discrepancy in the approval status indicated on the attached claim versus information previously obtained on related claims.  Please review your file for clarification and disposition.

COORDINATION OF BENEFIT INFORMATION:

_____ Other  Insurance Name ________________________________________________

Insurance Company Address ________________________________________________

Coverage:  Single _____  Family _____  Effective Date:  ________________

Group Number:  _______  Member Number (Social Sec. Number)  ______________

Amount Paid:  $__________________________

Thank you for your continued promptness in service to the customer.

Sincerely,

Blue Cross Blue Shield of Illinois
Enc.
Internet 578/095 Report Training Materials

The following includes the steps to use the HMO Claims Report application. Follow the directions below to use the report and its functionality.

HMO Claims Report functionality includes the ability to view and respond to the group approval status of claims that are the financial risk of HMO Illinois and BlueAdvantage HMO. These reports can be downloaded, with the ability to view the data definitions of the report. Downloaded data includes claims that are waiting for a status as well as claims that you have provided a status.

Assumptions:
- User is currently logged on
- User has access to the IPA
- User has access to the claims reports

Instructions:
1. Select the HMO Claims Report link.
2. Click on 095-Request for Group Approval Status List
   - Choose the following reports to get more HMO Claim Information.
   - 095 - Request for Group Approval Status List
3. Select an IPA, if you have access to more than one, in the drop down box.
4. You should arrive at this search Window. You have multiple options to search for open or closed claims. To see the entire report you may click on display.
5. Alternatively, you may enter a search argument such as a ‘Report Date Range’ by clicking on the drop down box in ‘Report Date Range’ and then click “Display” to see the list.
6. You may also enter a search argument in the ‘Approval Status’ drop down, such as all open claims waiting for approval, OP. If no status is selected all claims will be displayed when you click on the “Display” button.
7. Scroll down and the list or index report will appear. If all claims were selected as in the example, the status column will display the disposition of the claim. To view or provide an approval status, click the DCN number on the left column.

<table>
<thead>
<tr>
<th>#</th>
<th>DCN Number</th>
<th>Report Date</th>
<th>Patient Name</th>
<th>Subscriber ID</th>
<th>FromDate</th>
<th>ToDate</th>
<th>Prc Ind</th>
<th>Provider Name</th>
<th>Status</th>
<th>Sub SSN</th>
<th>Acct Ref Num</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4009912320404</td>
<td>02/02/2004</td>
<td>VICTOR GAMACHE</td>
<td>000619909982</td>
<td>12/21/2003</td>
<td>12/31/2003</td>
<td>y</td>
<td>UNIVERSITY OF ILLINOIS HOSPITAL</td>
<td>GA</td>
<td>619-90-0982</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>4012946036088</td>
<td>02/02/2004</td>
<td>IRA ANDREWS</td>
<td>0006255826515</td>
<td>12/24/2003</td>
<td>12/24/2003</td>
<td>OS</td>
<td>ST JOHNS HOSPITAL</td>
<td>GA</td>
<td>635-02-5015</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>4012946030700</td>
<td>02/02/2004</td>
<td>GARY KAYMANN</td>
<td>0006267003920</td>
<td>11/14/2003</td>
<td>11/14/2003</td>
<td>OS</td>
<td>ST JOHNS HOSPITAL</td>
<td>GA</td>
<td>626-78-0309</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>4012946025006</td>
<td>02/02/2004</td>
<td>NICHOLAS JOHNSON</td>
<td>000612002970</td>
<td>11/14/2003</td>
<td>11/14/2003</td>
<td>OS</td>
<td>ST JOHNS HOSPITAL</td>
<td>GA</td>
<td>630-02-9720</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>4012946015000</td>
<td>02/02/2004</td>
<td>DONALD HENDERSON</td>
<td>000615888200</td>
<td>11/17/2003</td>
<td>11/17/2003</td>
<td>OS</td>
<td>ST JOHNS HOSPITAL</td>
<td>GA</td>
<td>615-08-8200</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>4012946016500</td>
<td>02/02/2004</td>
<td>EVAN WINGHER</td>
<td>000642104955</td>
<td>12/28/2003</td>
<td>12/28/2003</td>
<td>OS</td>
<td>ST JOHNS HOSPITAL</td>
<td>GA</td>
<td>642-16-4955</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>4012946016800</td>
<td>02/02/2004</td>
<td>SHELBY WINCHESTER</td>
<td>000683386137</td>
<td>12/17/2003</td>
<td>12/17/2003</td>
<td>OS</td>
<td>ST JOHNS HOSPITAL</td>
<td>GA</td>
<td>683-82-1375</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>4013912320400</td>
<td>02/02/2004</td>
<td>FORREST LANZA</td>
<td>000611824404</td>
<td>09/06/2004</td>
<td>09/06/2004</td>
<td>OS</td>
<td>ADVOCATE LUTHERAN GENERAL HOSP</td>
<td>GA</td>
<td>611-82-4400</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>4013906120700</td>
<td>02/02/2004</td>
<td>THOMAS RICHARDSON</td>
<td>000636723802</td>
<td>12/30/2004</td>
<td>01/01/2004</td>
<td>OS</td>
<td>RENNER HOSP</td>
<td>GA</td>
<td>636-72-3802</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>4022511285910</td>
<td>02/02/2004</td>
<td>BABY GIRL BERT</td>
<td>000633807462</td>
<td>09/04/2004</td>
<td>09/04/2004</td>
<td>IP</td>
<td>DRIVANCE ST JOHNS MEDICAL CTR</td>
<td>GA</td>
<td>633-04-7462</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>4022511285910</td>
<td>02/02/2004</td>
<td>BABY GIRL BERT</td>
<td>000633807462</td>
<td>09/04/2004</td>
<td>09/04/2004</td>
<td>IP</td>
<td>PROVENNA ST JOHNS MEDICAL CTR</td>
<td>GA</td>
<td>633-04-7462</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>4022511285910</td>
<td>02/02/2004</td>
<td>PATRICK DIGEST</td>
<td>000645932844</td>
<td>09/04/2004</td>
<td>09/04/2004</td>
<td>IP</td>
<td>CHILDREN MEMORIAL HOSPITAL</td>
<td>GA</td>
<td>646-94-2044</td>
<td></td>
</tr>
</tbody>
</table>
8. After clicking on the DCN on the index page, you will arrive at the update page. (example on next page)

The following fields are ‘open’ to be completed by the IPA:

- **Internal Reference Number**: The IPA has the option to enter a number to identify the member, i.e., medical records #, patient account #, etc. Field is freeform, alpha/numeric, up to 13 characters.

- **GA - Group Approved**
  - a. Check the box by right clicking on your mouse.
  - b. This box should be checked and no date ranges entered if the entire stay has been managed by one of the IPA’s physicians or referred by an IPA physician.
  - c. Dates are entered if the claim is partially group approved. Enter the dates that the claim should be paid as group approved.

- **NGA - Not Group Approved**
  - a. Check the box by right clicking on your mouse.
  - b. This box should be checked and no date ranges entered if the entire stay has not been managed by one of the IPA’s physicians or referred by an IPA physician.
  - c. Dates are entered if the claim is partially group approved. Enter the dates that the claim was not managed by one of the IPA’s physicians or referred by an IPA physician.

- **MGR - Med Group Risk**
  - a. Check the box if you have determined that you would prefer to change the financial risk and the claim will be paid by the IPA in full.
  - b. The claim must be paid timely by the IPA.
  - c. No units will be charged on the UM Fund.
  - d. The claim cannot be submitted on a reinsurance claim.

- **Comments**
  - a. 200 characters, alpha/numeric
  - b. To be used when you want to send us information.

- **Approver**
  - a. 3 characters, alpha/numeric
  - b. For IPA internal use to document who submitted group approval status.

- **User**
  - Will be pre-filled with the name of the person who has signed on.
9. To return to the listing of claims click on the breadcrumb, 095-Request for Group Approval Status Report:

Home > 095-Request for Group Approval Status Report > 095-Request for Group Approval Claim Update
10. From the list window, if you click on a DCN for a claim that has already been updated by a member of your staff, you will arrive at a “read only” claim window.
**Trouble Shooting Tips:**

**What if I make a mistake?**
If you submit a claim on the Web with an incorrect response, follow the instructions below:
1. Open the claim in question on the Web
2. Make a screen print from the detail page that shows the status
3. On the screen print, write the corrected status
4. Make sure to explain the reason for the change in status
5. Sign and date
6. Print your name and the name of your IPA
7. Fax to (815) 639-7104

Note: If you are changing the status from group approved to not group approved, you must send your request to change the status within 5 days of the original submission.

**What if I can’t access the Web page?**
A security officer has been assigned to every IPA. Discuss your problem first with your internal security officer.
If you continue to have a problem, call the BCBSIL Help Desk at (312) 653-6675 for Blue Access help.

**What If I forgot my password or my sign on?**
Call the BCBSIL Help Desk at (312) 653-6675 for Blue Access help.

**What if BCBSIL is having technical problems and the Web page is not available for us to work our claims?**
If we are experiencing problems and the Web is unavailable for more than a few hours, we will not download and pay claims that will become 14 days old at the end of the day.

Note: It is not advised to wait until the 14th day to work your claims.

**What if I need a copy of the claim?**
The IPA should attempt to contact the provider for a copy of the claim, especially if the services were rendered by a contracted provider. In the event you are unable to obtain a copy, you may contact our claims office via email at the following address hmoclaimrequests@bcbsil.com. In the subject line of the email please indicate the IPA name and number. For PHI purposes, the body of the email will only need the DCN number of the claim. The claim will be faxed to the PDC contact person on our file.

**Where do I report other problems or if I have questions?**
Please contact your Network Consultant to be assisted in resolving any problems.
To Download Report

11. You can download (the full list) by clicking on the 'Download Data' button.

12. Depending on your browser, you will receive a message box.
   a) Netscape: You will probably receive a web browser message box indicating an unknown file type.

![Unknown File Type]

b) Internet Explorer: You will probably receive a File Download Dialog Box

![File Download]
13. Depending on your browser,
   a) Netscape: Click on the ‘Save File’ button.
   b) Internet Explorer: Click on the ‘Save this File to Disk’ radio button and click on ‘Ok’.
14. The Save As window will appear.

![Save As window](image)

Note: The File Name defaults to the Report Name, IPA Number, and Eligibility Period. However, you can change this if you want.

15. Verify the location where the file will be saved by reviewing the Save In field at the top of the window. You can change this location as desired.
16. Click on the ‘Save’ button.
17. The file will be saved in a .txt format to the location selected (step19).
Additional Functionality

Data Definition Table

18. To view a table with the data definitions of the report, click on the ‘Data Definition’ button.

19. The Data Definition table will be displayed in a pop up window.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Data Type</th>
<th>Length</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROV_ID</td>
<td>Number</td>
<td>3</td>
<td>Contracting Entity Number</td>
</tr>
<tr>
<td>PROV_SEQ_NBR</td>
<td>Number</td>
<td>3</td>
<td>Medical Group Number</td>
</tr>
<tr>
<td>GRP_NBR</td>
<td>Character</td>
<td>6</td>
<td>Group Number</td>
</tr>
<tr>
<td>SUB_LAST_NM</td>
<td>Character</td>
<td>20</td>
<td>Subscriber(Family).LastName</td>
</tr>
<tr>
<td>SUB_ID_NBR</td>
<td>Character</td>
<td>12</td>
<td>Subscriber Number (SSN)</td>
</tr>
<tr>
<td>LAST_NM</td>
<td>Character</td>
<td>20</td>
<td>Member Last Name—Could differ from subscriber Last Name</td>
</tr>
<tr>
<td>FIRST_NM</td>
<td>Character</td>
<td>20</td>
<td>Member First Name</td>
</tr>
<tr>
<td>BEN_PLAN_ABRR_CD</td>
<td>Character</td>
<td>6</td>
<td>HMO/BA Benefit Plan</td>
</tr>
</tbody>
</table>

20. You can close the data definition pop up window in one of two ways:

   a) Click on the ‘Close’ button at the bottom of the window.
   b) Click on the ‘x’ button at the top of the window.

Clearing Search Form

21. To clear your search criteria, at any time, click on the ‘Clear’ button.

22. The search form will be displayed. However, the results report that was displayed will not change.
Importing Downloaded File – Microsoft Access

The following includes the steps to import a downloaded file into Microsoft Access. At many steps, pages in parentheses will refer you to the specific section in this document that discusses the page's elements in full detail.

Assumptions:
- User has a database open in Microsoft Access.

Instructions:
1. Open the database, in which you wish to import the data.
2. From the top menu, select File – Get External Data – Import.
3. Find and select the downloaded file you wish to import (confirm you are looking in the right directory and that you have file type selected as text files.)
4. Click the **Import** button.
5. Select the Delimited file type radio button.

6. Click the **Next** button.
7. Select the Semicolon radio button for the delimiter.
8. Check the First Row Contains Field Names check box.
9. Click the Next button.
10. Select where you want to import the data. You can;
    a) import to a new table
    b) or select an existing table
11. Click the Next button.
12. Optional step - if desired or necessary, you can specify information about your fields (by selecting the options presented).
13. Click the Next button.
14. Select your primary key or allow Access to do it for you by selecting the appropriate radio button.
15. Click the Next button.
16. Confirm the table name is where you to import the file.
17. Click the Finish button.
18. You will receive an information success box that your data was imported successfully.
**Importing Downloaded File – Microsoft Excel**

The following includes the steps to import a downloaded file into Microsoft Excel. At many steps, pages in parentheses will refer you to the specific section in this document that discusses the page’s elements in full detail.

**Assumptions:**
- User has a database open in Microsoft Excel.

**Instructions:**
1. Open the file, in which you wish to import the data.
2. From the top menu, select **Open**.
3. Find the downloaded file you wish to import (confirm you are looking in the right directory and that you have file type selected at text files).

4. Click the **Open** button. Select the Delimited file type radio button.
5. Click the **Next** button.
6. Select the semi colon check box for the delimiter.
7. Click the **Next** button.
8. Select the column data format that you wish to use (general, text, date, or do not import) for each column.
   *Note: for the Eligibility List file and the Capitation by Benefit plan – you must select text data format for the BEN_PLAN_ABR_CD field.*

9. Click the **Finish** button.
10. Your data will be imported to your open Excel spreadsheet.
IPA Responsibility Claims

Payment should be made on valid referral bills within 30 days of receipt by the IPA, per the Medical Service Agreement.

If claim is Non-Group Approved (NGA) it should be stamped NGA and forwarded to the HMO.

The IPA should have written service agreements for all providers that are used regularly. These service agreements must describe:
- provider responsibilities
- agreed upon compensation, at least in general terms
- agreement to seek compensation solely from the IPA not from the member, or
- HMO; agreement to participate in quality of care review activities as requested by the IPA including allowing access to medical records for HEDIS reporting and other HMO quality improvement initiatives
- professional liability insurance coverage as specified in the Medical Service Agreement (MSA)
- agreement to preserve patient confidentiality; and
- agreement to accept the PPO fee schedule for referred or emergency services as specified in the Medical Service Agreement.

The HMO reserves the right, as outlined in the MSA, to pay a claim on behalf of the IPA. The HMO will deduct billed charges from the IPA’s monthly Capitation.

Out of Area Claims

Out of Area is defined as being more than 30 miles away from the IPA or IPA affiliated hospital. If an IPA refers and approves services for a member that is more than 30 miles away, the standard financial responsibility applies.

If an IPA did not approve or refer the member for an out of area service, the IPA should stamp the claim Non Group Approved and send it to the HMO.

The HMO pays all charges for outpatient, physician and ancillary services, and the physician and hospital charges for a resulting admission, provided services meet the Out of Area Emergency Criteria. All services should have been obtained in an emergency room or a hospital. Required follow-up visits that must occur before Members return in-area, due to vacation or business trips, are also covered.

No units are charged against the Utilization Management Fund for these hospital admissions. Whenever possible, the IPA should attempt to bring the Member back into the service area when the patient is stable and it is medically appropriate. Admission to a rehabilitation facility out-of-area from the acute hospital setting is not considered an emergency and is therefore not coverable.

Dependents who are away at an out-of-area school may seek services at an emergicenter or hospital emergency room for conditions that are Emergencies and for those that need immediate care (e.g., sprains, laceration, severe infections, etc.). All such services will be payable by the HMO. Such conditions as colds, sore throats, stomach flu, or basic physical examinations can be taken care of at the local student health center or private physician’s office, and are not covered by the HMO. The need for non-urgent diagnostic testing or elective surgical procedures is also not in benefit out-of-area. (Refer to Away from Home Care/Guest Membership in this section for more information regarding out of area students.)
Away from Home Care/Guest Membership

BCBSIL offers Away from Home Care (AFHC) benefits to HMO Illinois and BlueAdvantage HMO members through the Guest Membership program. Guest Membership is a courtesy membership for HMO members who are temporarily residing outside of their Home HMO service area. Members receive temporary enrollment in a participating Host HMO and access to a wide range of benefits, including routine and preventive services.

The member must be planning to reside outside of their Home HMO service area for at least 90 days to qualify. The member can then become a guest member of the BCBS HMO plan serving the area where he/she will be staying. This coverage applies to members who are:

- Long-term travelers
- Families living apart from the subscriber
- Students away at school
- Employees on extended work assignments

Membership

Most Guest Memberships are valid for a maximum of 1 year and can be renewed. The three group numbers used for hosted guest members of BCBSIL HMO are: **G64555, G64556 and G64559**. If you are a PCP that participates in our HMO product, you may provide services to a guest member from another BCBS HMO plan who selected you as their Primary Care Physician. Please note that guest members do not appear on any HMO eligibility listing.

Benefits

Guest members are entitled to coverage with BCBSIL HMO plan benefits. Hospital, physician, emergency room, x-ray and lab charges are covered by using their Guest Member ID card from our plan. Referrals to a specialist are still required, but can be written on your regular order pad. Just make sure guest members are directed within the HMO network for all of their care. Prescriptions are covered by using their Home HMO member ID card.

**Note:** BCBSIL should be contacted if the member needs Mental Health benefits, as some Home plans use their own network, even out of area.

Claims

Claims for services rendered to guest members should be submitted directly to BCBSIL HMO. They can be submitted electronically using the Guest Member information appearing on their Illinois ID card. Payment is made on a PPO fee schedule.

Questions

HMO providers should contact their IPA or call (800) 892-2803 if more information is needed about guest membership. We value your participation in the Guest Membership program. Please provide the same quality service to our guest members as you do for your assigned HMO members.
Out of Plan Claims

Out of Plan is defined as being within 30 miles of the service area of the IPA but not group approved.

The IPA is expected to become involved immediately upon notification of any Out of Plan admission. The IPA will be responsible to authorize care according to medical necessity. If the member is not stable, they will remain at the Out of Plan facility until medically appropriate to transfer or be discharged. The claim should be stamped Non Group Approved for the period prior to the IPA being notified; and Group approved for the period after the Group was notified. These days (units) are charged to the Utilization Management Fund according to the Medical Services Agreement.

If the member is stable [as determined by the Primary Care and Attending physicians], he/she can be transferred to an In Plan facility or discharged. The days (units) are charged against the UM fund accordingly.

If the member declines to be transferred or discharged, the IPA should follow the Termination of Benefits policy (TOB) as outlined in the Utilization Management Section of this manual.

If the IPA is not notified during the admission, the claim should be stamped Non Group Approved and sent to the HMO.

Emergency Room or Emergency Admission Claims

The IPA is financially responsible to pay physician and other professional charges for all in area emergency room services, subject to the HMO's determination that the services meet the definition of an Emergency Medical Condition.

An admission can occur as a result of an emergency room visit. The IPA is expected to become involved immediately upon notification of any In Area emergency admission. The IPA is responsible for all physician charges from the point of notification through discharge. The units will be charged to the UM Fund according to the Medical Service Agreement.

Please note: More information can be found in the Utilization Management Section of this manual regarding how to perform Utilization Management for these types of admissions.
Chemical Dependency Claims

All Chemical Dependency claims are the HMO’s responsibility with one exception. If the IPA personnel refers a member to a non-contracting Chemical Dependency provider without prior approval from the HMO, the professional charges become the IPA’s financial responsibility. When applicable, all days (units) will be charged against the IPA’s UM fund if a non-contracting provider is used. Normally, no days (units) are charged against the fund.

Infertility Claims

All infertility claims are the HMO’s responsibility with one exception. If the IPA personnel refers a member to a non-contracting Infertility provider, the professional charges become the IPA’s financial responsibility. When applicable, all days (units) will be charged against the IPA’s UM fund if a non-contracting provider is used. Normally, no days (units) are charged against the fund.

All Infertility claims and claim inquiries for services provided by HMO contracted providers should be forwarded to:

800 Westchester Avenue
5th floor, S-540
Rye Brook, NY 10528

Covered Services Expense Limitation

A member may have a Covered Services Expense Limitation otherwise known as an "out of pocket maximum". This amount may vary per Employer Group. The IPA or any other provider can continue to charge the member the appropriate co-payment or deductible through the year.

If a member has paid co-payments and/or deductibles that exceed this amount, the member must submit properly authenticated documentation to the HMO to be reimbursed for any expenses charged above the limit. If the IPA receives any member inquiries regarding this, the member should be referred to the Customer Service Number on the back of their ID card.
Reinsurance Claims – For Dates of Service after 1/1/2006

The HMO reinsures an increasing portion of the medical benefit costs incurred by the IPA, as defined in the Medical Service Agreement. Effective January 1, 2006, Reinsurance claims are calculated based on the IPA risk claims and encounter data that has been submitted monthly to the HMO, in a format acceptable to the HMO, no later than November 30th of the subsequent year. Please refer to your Medical Service Agreement (MSA) for specific details.

All IPA risk encounter data is to be submitted electronically on a monthly basis. IPAs will receive a monthly report showing which claims exceed the predetermined stop loss amount, and are therefore eligible for reimbursement. **Catastrophic claims will not be considered for reinsurance.**

- IPA risk claims and encounter data should only include newly paid/adjudicated claims. IPAs will be notified of apparent duplicate claims which must be corrected in subsequent monthly submissions.
- Claims which are the HMO’s financial responsibility to pay will not be considered for reinsurance – even if the IPA has paid the charges.
- IPA responsible charges shall be calculated at the lesser of the PPO Schedule of Maximum Allowance or the actual fee paid by the IPA for the services provided.
- Coordination of Benefits with a Primary Payer and/or Medicare must be concluded prior to submitting risk claims and encounter data, and the paid amounts should be net of COB; the HMO will not consider capitated services when the HMO is not primary.

**Calculation**

In order to be eligible for reinsurance, the IPA must pay IPA-responsible charges incurred by any one member in any one Agreement Year up to the threshold indicated in the MSA; the threshold changes annually. The HMO will then pay the IPA for 80%, 90% or 100% of additional eligible charges that exceed the threshold incurred for that Member in that Agreement Year, according to the terms outlined in the MSA.

**For example, based on the threshold and attachment points outlined in the 2007 MSA:**

<table>
<thead>
<tr>
<th>Paid Charges -</th>
<th>IPA Responsible Charges</th>
<th>HMO Responsible Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>$11,000.00 in claims</td>
<td>$11,000.00</td>
<td>(None)</td>
</tr>
<tr>
<td>The IPA has now met the stop-loss, and is at the 80% reimbursement level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$82,500.00 more in claims</td>
<td>$16,500.00</td>
<td>20%</td>
</tr>
<tr>
<td>$27,500.00</td>
<td>total</td>
<td></td>
</tr>
<tr>
<td>$66,000.00</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>The IPA has now spent a total of $27,500.00, and is therefore is now at the 90% reimbursement level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$275,000.00 more in claims</td>
<td>$27,500.00</td>
<td>10%</td>
</tr>
<tr>
<td>$55,000.00</td>
<td>total</td>
<td></td>
</tr>
<tr>
<td>$247,500.00</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>The IPA has now spent a total of $55,000.00, and is therefore is now at the 100% reimbursement level.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Reporting**

On a monthly basis, the HMO will calculate and report charges eligible for reinsurance.

- Eligible charges will be calculated at the lesser of the PPO Schedule of Maximum Allowance or the actual fee paid by the IPA for the services provided. Services that do not have a PPO Schedule of Maximum Allowance value will be calculated at the lesser of paid or a 30% discount from charges.
- The IPA will be provided with a denial reason if the claim is ineligible for reinsurance (HMO risk, Not a Covered Service, Invalid Code etc.)

Periodically, the IPAs will receive a report detailing reinsurance eligible charges that appear to be duplicates, or for which the HMO was not primary. IPAs will be given an opportunity to review and respond to these reports before an adjustment is made to a subsequent report of repriced eligible charges.

**Payment**

Every month, IPAs will be provided with a report in paper form and/or online showing all claims that are eligible for reimbursement through the most current time period for which data was submitted, and information on how those claims/encounters have been repriced. The total amount due, less any previously paid amount, will be added to the capitation payment cycle for the following month along with member information that can be tied back to the monthly report.

**Questions/Problems**

If there are questions or problems concerning reinsurance, please contact your Provider Network Consultant.
Reinsurance Claims – For Dates of Service prior to 1/1/2006

The HMO reinsures an increasing portion of the medical benefit costs incurred by the IPA, as defined in the Medical Service Agreement. Effective January 1, 2003, Reinsurance claims are calculated based on the Agreement year (calendar year) as stated in the Medical Service Agreement. In order to be eligible for payment, the IPA must submit reinsurance claim(s) no later than November 30th of the subsequent year. Please refer to your Medical Service Agreement (MSA) for specific details.

- A reinsurance claim can be submitted when the individual member’s expenses reach the predetermined amount (stop-loss). The claims can be submitted monthly after this point or as the IPA determines necessary. **Catastrophic claims cannot be submitted for reinsurance.** Refer to note in How to Fill Out the Reinsurance Forms Section.
- The reinsurance claim report should only list newly submitted claims. If the report has previously submitted claims listed they should be clearly crossed out to differentiate between the old and new claims.
- Claims that are the HMO's financial responsibility to pay cannot be submitted for reinsurance – even if the IPA has paid the charges.
- IPA responsible charges shall be calculated at the lesser of the PPO Schedule of Maximum Allowance or the actual fee paid by the IPA for the services provided.
- Coordination of Benefits with a Primary Payer and/or Medicare must be concluded prior to filing Reinsurance. When documenting the paid amount, COB must be deducted from billed charges (if applicable). A copy of the EOB or EOMB must be submitted with the reinsurance claim.
Calculation

In order to be eligible for reinsurance, an IPA must pay the first $8,000 of IPA-responsible charges incurred by any one member in any one Agreement Year. (For members receiving Synagis, the threshold is $6,000.) The HMO will then pay the IPA for additional charges incurred for that Member in that Agreement Year, as follows:

1. Eighty percent (80%) of those IPA-responsible charges, which exceed $8,000 of total expenses, incurred for the Member in that Agreement Year.

   The IPA will continue to be reimbursed at the level of 80% of eligible charges until the total amount of all IPA-responsible charges paid by the IPA for the Member reaches $20,000 (net) during that Agreement Year.

2. Ninety percent (90%) of those IPA-responsible charges, which exceed $20,000 of total expenses, incurred for the Member in that Agreement Year.

   The IPA will continue to be reimbursed at the level of 90% of eligible charges until the total amount of all IPA-responsible charges paid by the IPA for the Member reaches $40,000 (net) during that Agreement Year.

3. One hundred percent (100%) of those IPA-responsible charges, which exceed $40,000 of total expenses, incurred for the Member in that Agreement Year.

For example:

<table>
<thead>
<tr>
<th>Paid Charges</th>
<th>IPA Responsible Charges</th>
<th>HMO Responsible Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>$8,000.00 in claims</td>
<td>$8,000.00</td>
<td>(None)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$60,000 more in claims</td>
<td>$12,000.00 20%</td>
<td>$48,000.00 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$20,000 total</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$200,000 more in claims</td>
<td>$20,000.00 10%</td>
<td>$180,000.00 90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$40,000.00 total</td>
</tr>
</tbody>
</table>

The IPA has now met the stop-loss, and is at the 80% reimbursement level.

The IPA has now spent a total of $20,000; therefore is now at the 90% reimbursement level.

The IPA has now spent a total of $40,000; therefore is now at the 100% reimbursement level.
How to Fill Out the Reinsurance Forms

All reinsurance claims must be submitted on the Reinsurance claim forms or on a comparable computer generated report. (see next page for a sample). If the required documents are not completed appropriately, the Reinsurance claim will be returned to the IPA. A cover letter will be included explaining the exact information needed or missing.

When submitting a reinsurance claim that has been sent back for more information, please return the original reinsurance claim cover sheet with the requested information and write “Re-submission” in the upper left hand corner of the cover sheet.

If submitting reinsurance for a member who has catastrophic claims for that same period, make a notation on the reinsurance cover sheet that “all catastrophic claims have been removed.”
### Sample Reinsurance Claim Cover Sheet

**HMO ILLINOIS**

A Blue Cross HMO

**REINSURANCE CLAIM COVER SHEET**

Date Submitted: ____________________________
Preparer’s Name: ____________________________  Preparer’s Phone Number: ____________________________

**IPA INFORMATION:**

IPA Name & #: ____________________________
Address: ____________________________________________________________________________

BCBSI Provider Number: ____________  Agreement Year: ____________________________

**MEMBER INFORMATION**

Member’s Name: ____________________________  Benefit Plan: ____________________________
Member’s Group and Identification #: ____________________________

Total Amount Paid by the IPA: $ ____________________________

---

**FOR HMO OFFICE USE ONLY**

Total Claim Submitted: $ ____________________________

Ineligible Amount: $ ____________________________

Reason:

- [ ] Over PPO Schedule of Maximum Allowance
- [ ] Prior to or after Agreement Year
- [ ] Previously Submitted
- [ ] Other ____________________________

IPA Financial Responsibility: $ ____________________________

Total Amount Allowed $ ____________________________
Amount Reimbursed at 80% $ ____________________________
Amount Reimbursed at 90% $ ____________________________
Amount Reimbursed at 100% $ ____________________________

Year to Date Expense:

- IPA $ ____________________________
- HMO $ ____________________________

Revised 8/97

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BlueCross BlueShield of Illinois
A Member of the BlueCross and BlueShield Association, An Association of Independent BlueCross and BlueShield Plans
HMO Forms

*Note:* Complete according to the information below.

- **Section A: Clinic/Patient Information**
  This section contains information used to determine if and when you should file a claim. It is mandatory that this section is completed. If your IPA’s Provider Number is not known - please verify this information by calling your Provider Network Consultant or the Consumer Affairs Department at (312) 653-6600. All fields must be completed in order for the claim to be adjudicated, including a signature and phone number of the individual completing the form.

- **Section B: For office use only**
  Please do not complete any information contained in this section. The HMO will complete this area and a copy will be returned for your records.

- **Section C: Itemized Charges**
  **Category I - Primary Care Physicians (PCPs):**
  Charges for these physicians *do not require proof of payment.* Simply list all dates of service, CPT codes and paid amount if PCP is paid fee for service (FFS). The equivalent FFS amount can be used if the service was provided by a capitated/salaried PCP. The Blue Cross and Blue Shield PPO Schedule of Maximum Allowance schedule can be used to determine the equivalent fee for service amount. If individual dates of service are listed – itemized bills do not need to be submitted. If all dates of services are lumped together – itemized bills will need to be submitted with the Reinsurance claim. See the sample Category I - Primary Care Physician (PCP) form on the next page.
Sample Category I - Primary Care Physician (PCP) Form

Itemized Charges
For
Primary Care Physicians
(Proof of Payment Not Required)

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Provider</th>
<th>Type of Service</th>
<th>Place of Treatment</th>
<th># of Anesthesia Minutes</th>
<th># of Units (for J &amp; Q Codes)</th>
<th>Amount Billed</th>
<th>Amount Paid</th>
<th>Ineligible Amount</th>
<th>Amount Allowed</th>
</tr>
</thead>
</table>
**Category II - Capitated and Salaried Providers:**
(Fill out form in the Same method as described in Category I)

**Itemized Charges**
For
*Capped and Salaried Providers*
(Proof of Payment Not Required)

<table>
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<tr>
<th>Date of Service</th>
<th>Provider</th>
<th>Type of Service</th>
<th>Place of Treatment</th>
<th># of Anesthesia Minutes</th>
<th># of Units (for J &amp; Q Codes)</th>
<th>Amount Billed</th>
<th>Amount Paid</th>
<th>Ineligible Amount</th>
<th>Amount Allowed</th>
</tr>
</thead>
</table>
## Category III - Fee for Service Providers:

**Itemized Charges**

*For*

**Fee for Service Providers**

(Proof of Payment Not Required)

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Provider</th>
<th>Type of Service</th>
<th>Place of Treatment</th>
<th># of Anesthesia Minutes</th>
<th># of Units (for J &amp; Q Codes)</th>
<th>Amount Billed</th>
<th>Amount Paid</th>
<th>Ineligible Amount</th>
<th>Amount Allowed</th>
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</table>
Computer Generated Report

Note: Complete according to the information below.

The HMO will also accept a computer generated report from the IPA (in lieu of the itemized pages of the forms) if it includes the same data elements and meets the following conditions:

- The cover page (containing Sections A & B) must always be submitted.
- The report must contain the following elements:
  - Date of service – do not lump dates of service (if dates are lumped – a copy of each itemized bill will need to be submitted with the form)
  - Diagnosis Code
  - Procedure code – either a revenue, CPT-4, HCPCS or an ICD-9 code
  - When submitting facility component charges, if revenue codes are not identified then copies of the UB-92 will be required.
  - Place of Treatment
  - If including claims for anesthesia, document the number of minutes. If information is not included on report, a copy of the claim should be submitted.
  - If including claims for services with multiple units (ie., J or Q codes) indicate number of units.
  - Provider name
  - Type of provider (PCP, capitated/salaried or fee for service)
  - Amount billed by provider
  - Amount of discount – dollar amount that was deducted from billed amount (If no discount has been given – mark not applicable (N/A) in this column).
  - Amount paid – (after discount, copay and COB has been deducted)
  - Date paid
  - Check number

If all above listed information is on the computer report – itemized bills and copies of the checks do not need to be submitted. The HMO will reserve the right to request these items if needed to assist in the processing of the Reinsurance claim.

Reinsurance claims should be submitted to:

HMO Claims Department
Attn.: Reinsurance Unit
2787 McFarland Rd.
Rockford, Illinois 61107-6815

The IPA will be reimbursed directly. The HMO will pay the IPA any amount due for the reinsurance claims within 60 days of receiving satisfactory documentation.
Preadmission Testing Claims (PAT)

Outpatient diagnostic testing services are usually the IPA’s responsibility. However, tests performed prior to an inpatient or outpatient surgical procedure can be the HMO’s responsibility in the following circumstance:

- Claims must only be submitted on the appropriate PAT claim form. See the next page for a sample Preadmission Testing Claim Form. The PAT claim form must be submitted with the claim stamped GA. The form must be filled out completely. If the form is not filled out completely or correctly – it will be returned to the IPA.

- For Blue Shield claims – the BCBS Usual & Customary fee schedule is used for reimbursement. Blue Cross claims will be reimbursed at the IPA’s paid amount or at the billed amount if the service was capitated.

- All PAT claims should be submitted within one year of the date of service.

- Office visit charges are reimbursable in conjunction with diagnostic testing codes only. Office visit services without related diagnostic tests are not reimbursable under PAT.

- PAT claim forms need to match the bills that are submitted with it. The Claims office has requested that only one provider and one patient be listed per PAT claim form. Please do not put multiple providers and/or multiple patients on the same PAT claim form.

- If the provider is capitated, the word “capitated” should be written in the “Amount Paid” field on the PAT claim form. You do not have to write the dollar amount paid to the provider for capitated services. The Rockford Claims Office will calculate the payment.

Effective Jan. 1, 2010, reimbursement for Pre-admission testing has been removed from the Medical Service Agreement. All outpatient diagnostic testing is the financial responsibility of the IPA.

- The deadline to submit PAT claims with dates of service prior to Jan, 1, 2009 is Jan. 31, 2010.

- If IPAs submit PAT claims prior to Jan. 31, 2010, that are more than one year old from the date of service, HMO will process these claims for payment if they were previously adjudicated incorrectly and/or submitted and not received. However, new PAT claim submissions submitted prior to Jan. 31, 2010, that are not within one year of the date of service will be denied for payment and returned to the IPAs.

- The deadline to submit PAT claims with dates of service from Jan. 1, 2009 to Dec. 31, 2009 is Dec. 31, 2010.
# Pre-Admission Testing Claim Form

IPA Name: 
IPA Number: 
Patient Name: 
Group/Identification Number: 
Date of Admission to Hospital: 

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Provider</th>
<th>Diagnosis</th>
<th>Type of Service</th>
<th>Billed Amount</th>
<th>Paid Amount</th>
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Itemized bills are attached
Other Non-Capitated Services (Catastrophic Claims)

There are several conditions that the HMO considers catastrophic. Group Approved services related to these conditions that are usually the IPA’s responsibility become the HMO’s responsibility. These situations are:

- Voluntary sterilization
- Extraction of completely bony impacted teeth
- Organ transplants, related pre-surgical laboratory and diagnostic tests performed by the designated Transplant Facility, and follow-up within 365 days of the Transplant, provided IPA obtained prior approval for Organ Transplant from the HMO

The IPA has two options:
1. The HMO will reimburse the IPA at the lesser of billed charges or at the PPO Schedule of Maximum Allowances. The claims must be stamped “Group Approved” and submitted on the Catastrophic Claims Form to the HMO Claims Department. See the next page for the sample Catastrophic Claims Form.

2. The IPA also has the option to have the HMO pay the contracting or non-contracting provider directly. Each claim must be stamped “Group Approved”. In addition, a note indicating the type of claim (voluntary sterilization, extraction of completely bony impacted teeth, organ transplant related) must be written by the stamp. Use black or blue ink only, but do not use a highlighter pen.
# CATASTROPHIC CLAIM FORM

Medical Group/IPA Name: ________________________________________________

Medical Group/IPA Number: _____________________________________________

Patient Name: _________________________________________________________

Group/ID #: __________________________________________________________

Payee: __________________________________________________________________

<table>
<thead>
<tr>
<th>DATE OF SERVICE</th>
<th>PROVIDER</th>
<th>DIAGNOSIS</th>
<th>TYPE OF SERVICE</th>
<th>BILLED AMOUNT</th>
<th>PAID AMOUNT</th>
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</tbody>
</table>

Itemized bills are attached
Past Due Claims (PDC) Process

Please refer to the HMO Policy and Procedure Section of this manual for more details on the Past Due Claims (PDC) process.

The PDC Challenge Form as described in the policy can be found on the next page.
Past Due Claims (PDC) Challenge Form

HMO ILLINOIS
A Blue Cross HMO
2787 McFarland RD    Rockford, IL 61107-6815       815-639-7100

HMO Past Due Claims Appeal Form
(Form must be filled out completely to be considered for appeal)

Date: ________________    IPA #: _______________
Group #: ______________    SSN: _______________
Date of Service: __________   Amount Billed:______________
Provider Name: ____________________________    HMO Claim #:   _____________________________
Did you receive the PDC notice?    YES     NO
(Must circle Yes or No)
Did you respond to the PDC notice?    YES      NO
(If yes, must provide fax confirmation and copy of response)

(Section below must be completed to receive cap reimbursement if appeal is approved)

_____ Provider capitated on __________.   Provider was called on ________ and was instructed not to
    bill member again. (Provide dates in spaces above)

_____ Stale dated claim. Provider called on ________ and was instructed not to bill member again.

_____ Claim paid on ___________ with check (voucher) #  ________________.

_____ Claim is Not Group Approved

Other
____________________________________________________________________________________

************************************************************************************

Reply Section
To Be Completed by the HMO

Appeal Approved: _________    Appeal Denied: ________

Explanation:_________________________________________________________________________________________________________________
____________________________________________________________________________________________

Completed By:______________    Date Completed: ___________

Blue Cross/Blue Shield of Illinois
A Member of the Blue Cross and Blue Shield Association, An Association of Independent Blue Cross and Blue Shield Plans