

New Prior Authorization Requirements for Some Custom Account Members Will Take Effect Jan. 1, 2021

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Effective Jan. 1, 2021, some Blue Cross and Blue Shield of Illinois (BCBSIL) members with group coverage may need prior authorization for the following procedures:

- Carpal tunnel surgery
- Cholecystectomy
- Cardiac catheterization or angioplasty
- EGD-endoscopic procedure of the stomach or intestine
- Heart surgery
- Hip replacement
- Hysterectomy
- Knee arthroscopy
- Knee replacement
- Laminectomy
- Myringotomy
- Nasal endoscopy/ethmoidectomy
- Pelvic laparoscopy
- Removal of tonsils and/or adenoids
- Septoplasty
- Spinal fusion
- Tympanostomy

Which members may be affected by this change?

Here is a list of three-character member ID prefixes for some of the members that may be affected by the change referenced above: **ACX, PAS, V2T, VXJ, VXL, VXR, VXV, VYD**.

Reminders and Resources

Prior authorization requirements are specific to the patient's policy type and procedure(s) being rendered. Services performed without required prior authorization may be denied for payment and providers may not seek reimbursement from BCBSIL members. If you have any questions, call the number on the member's ID card.

It's critical to **check eligibility and benefits for each member prior to rendering services**, through the [Availity® Provider Portal](#) or your preferred web vendor. This step will confirm membership and other important details, such as prior authorization requirements and utilization management vendors, if applicable.

For more information, refer to the [Prior Authorization page](#) on our Provider website. Also continue to watch the [News and Updates](#) for important announcements. Articles also may be published in the [Blue Review](#).

Checking eligibility and benefits and/or obtaining prior authorization is not a guarantee of payment. Payment is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations and exclusions set forth in your patient's policy certificate and/or benefits booklet and/or summary plan description. Regardless of any benefit determination, the final decision regarding any treatment or service is between you and your patient. If you have any questions, call the number on the member's ID card.

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