



Quick Tips, Guidelines and Reminders

Blue Cross and Blue Shield of Illinois (BCBSIL) maintains a network of independently contracted providers including physicians, hospitals, skilled nursing facilities, ancillary providers, Long-term Supports and Services (LTSS) and other health care providers through which Blue Cross Community MMAI (Medicare-Medicaid Plan)SM and Blue Cross Community Health PlansSM (BCCHPSM) members may obtain benefits for covered services.

While all providers are encouraged to refer to the Claims and Eligibility section of our website at bcbsil.com/provider for general information on how to conduct business with BCBSIL, there are some key differences you should be aware of when providing care and services to MMAI and BCCHP members. In-depth information is available in the Standards and Requirements/Provider Manual section of our Provider website. For quick reference purposes, a list of tips, guidelines and reminders is included below.

MMAI and BCCHP Billing Tips

- Contracted providers should submit claims electronically. If you use AvailityTM or Experian Health, the Payer ID is **MCDIL** for electronic BCCHP and MMAI claims. If you use a different vendor, contact them to confirm the correct Payer ID for electronic MMAI and BCCHP claims.
- To identify the payer on the CMS-1500, select "Other," rather than "Medicare" or "Medicaid" in field 1.
- For the Insured's ID Number, use the member ID exactly as it appears on the member's BCBSIL ID card, including the alpha prefix (**XOG**). The complete member ID number, including the alpha prefix, is required on all claims.
- When the Service Location is required, include the Name, Address and NPI for both the Billing Provider Information and Service Location.
- Atypical providers who do not have an NPI must use another primary identifier, such as Federal Tax ID.
- Taxonomy codes are required on all MMAI and BCCHP claims.
- If the member does not have an ID card, call Customer Services (see chart below).

Transition of Care and Preauthorization/Referral Guidelines

- Transition of care is available for new members, within 180 days (MMAI) and 90 Days (BCCHP with a review for continuation up to an additional 90 days).
 - Benefit preauthorization (for covered services) will be accepted from previous carriers.
 - Members can remain with their current provider, even if the provider is not contracted with BCBSIL.
 - All prior approvals for non-Part D drugs, therapies, or other services covered by Medicare or Medicaid will continue to be covered and will not be terminated at the end of the Transition of Care Period unless there is advance notice to the Member and transition to other services, if needed.
 - Prior benefit authorization is not required for emergency and urgent care services.
- PCPs do not need to obtain Specialist Referrals (benefit preauthorization) if the specialist is contracted with BCBSIL.
- Benefit preauthorization is required from BCBSIL for any new services (not in a current course of treatment) rendered by non-contracted providers. BCBSIL may request documentation in order to review the request for authorization.
- To request benefit preauthorization, contact Medical Management (see chart below).

Contacts, Reminders and Related Resources

- Please notify all of your affiliated offices of your participation in MMAI and BCCHP
- To request a contract or for general inquiries, contact Provider Network Services or send an email to govproviders@bcbsil.com or call 855-653-8126.
- For additional information, such as Provider Finder[®] links, forms and provider training modules, refer to the MMAI and BCCHP pages in the [Network Participation/Medicaid section](#) of our Provider website.
- The following phone and fax numbers may be used to reach MMAI and BCCHP areas as referenced above (Customer Services and Medical Management):

MMAI	BCCHP
Phone: 877-723-7702	Phone: 877-860-2837
Fax: 312-233-4060	Fax: 312-233-4060

Checking eligibility and/or benefit information and/or the fact 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.

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