This manual is designed to offer you, as a Blue Cross and/or Blue Shield (BCBS) contracting provider, information about the BlueCard Program. BlueCard is a program that allows members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan’s service area.

Please review and become familiar with the procedures and guidelines outlined in this manual, so that you can properly provide service to members that belong to other BCBS Plans.

This information does not constitute, and is not intended as, legal or financial advice.
**Section 1—What is the BlueCard® Program?** ............................................................. 3  
Introduction ............................................................................................................................. 3  
Definition .................................................................................................................................. 3  
BlueCard® Program Advantages to Providers ........................................................................ 3  
Exclusions—Services Not Included In the BlueCard® Program.............................................. 3

**Section 2—How Does the BlueCard® Program Work?** .................................................. 4

How to Identify BlueCard Members ........................................................................................ 4  
Important Facts Concerning Member Identification Cards.................................................. 4  
Suitcase Logos ....................................................................................................................... 5  
Alpha Prefix ............................................................................................................................. 6  
How to Identify International Members .................................................................................. 8  
What products are impacted? ................................................................................................. 9  
How to Verify Eligibility and Benefits .................................................................................. 12  
Electronic Health ID Cards .................................................................................................... 13  
Helpful tips ............................................................................................................................ 14  
How to Obtain Utilization Review .......................................................................................... 15

**Section 3—Claim Filing** ...............................................................................................16

BlueCard Program Claim Filing ............................................................................................ 16  
International Claim Filing – BlueCard® Worldwide .............................................................. 17  
Medicare Advantage Program Overview ............................................................................. 18  
How to recognize Medicare Advantage Members ................................................................ 18  
Eligibility Verification ............................................................................................................. 18  
Medicare Advantage Claims Submission ............................................................................. 18  
Reimbursement for Medicare Advantage PPO, HMO, POS ................................................ 19  
Medical Records ................................................................................................................... 20  
Coordination of Benefits (COB) Claims ................................................................................ 21  
Medicare Primary—Blue Cross and Blue Shield Supplemental Claims............................... 22  
Reimbursement for BlueCard® Claims .................................................................................. 23  
Multiple Contracts ................................................................................................................. 24

**Section 4—Key Contacts** ............................................................................................27

**Section 5— Frequently Asked Questions** ................................................................. 28

**Section 6 - Glossary of BlueCard Program Terms** ..................................................34

**Section 7 – BlueCard Program Quick Tips** ............................................................... 36
BlueCard Program Provider Manual—1/09

Section 1—What is the BlueCard® Program?

Introduction

Blue Cross and Blue Shield (BCBS) Plans are proud of our 79-year history of service in the healthcare industry. Because of our partnership with providers like you, over 99 million members across the nation choose Blue Cross and Blue Shield as their health care insurer.

To build on our successful history, we are focusing on your needs by simplifying administrative processes. Service enhancements we are making include:

- Continuing to improve claim accuracy and claim resolution
- Improving timeliness of claims processing
- Promoting internal education to ensure an excellent provider service experience
- Conducting focus trainings to strengthen provider knowledge of the BlueCard program

BCBSIL understands the importance of ensuring easy administration for you and we want our members to have a positive experience with each visit. We pledge to meet your needs and expectations by providing you with a single point of contact for claims, customer service and provider education-related inquiries. Our commitment will allow you to provide the highest quality of care to your patients and our members.

This BlueCard Program Provider Manual will help you:

- Identify BlueCard members
- Verify eligibility and benefits
- File BlueCard claims and check claims status

Definition

BlueCard® is a national program that enables members of one BCBS Plan to obtain health care services while traveling or living in another BCBS Plan’s service area. The program links participating health care providers with the independent BCBS Plans across the country, and in more than 200 countries and territories worldwide, through a single electronic network for claims processing and reimbursement.

BlueCard® Program Advantages to Providers

The program allows you to submit claims for members from other BCBS Plans, domestic and international, directly to the Illinois Plan. BCBSIL is your sole contact for all of your claim-related questions.

BCBSIL continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations. In doing so, your patients will have a positive experience with each visit.

Exclusions—Services Not Included In the BlueCard® Program

- Prescription drugs
- Hearing/Vision
- Dental (non-surgical)
- Federal Employee Program (FEP) claims (Note: Examine the back of the member’s Identification card for FEP billing information)
Section 2—How Does the BlueCard® Program Work?

How to Identify BlueCard Members

When members from other BCBS Plans arrive at your office or facility, be sure to ask them for their current BCBS Plan membership identification card. The main identifiers are:

1. PPO in a suitcase logo, for eligible PPO members
2. Empty suitcase logo, for Traditional, POS or HMO members
3. An alpha prefix (the first three positions of the identification number)

Important Facts Concerning Member Identification Cards

1. The identification number can be a total of 17 characters (14 alpha numeric characters preceded by the 3 character alpha prefix)
2. Some identification numbers are less than 17 characters
3. Some identification numbers may include alpha characters in other positions following the alpha prefix, for example: YMOR412B000L005OB
4. The identification number no longer includes the Social Security Number (SSN)
5. The SSN has been replaced with a Unique Identification Number (UID)
6. The identification number includes the alpha prefix in the first three positions

Note: Please do not add/delete characters or numbers within the member ID, or change the sequence of the characters.
**Suitcase Logos**

The suitcase logo identifies BlueCard members. There are two types of suitcase logos: “PPO in a suitcase” logo and “Empty suitcase” logo. Only members with the suitcase logo on their Identification card may access the benefits of the BlueCard Program.

**“PPO in a Suitcase” Logo**

You will immediately recognize BlueCard PPO members by the special “PPO in a suitcase” logo on their BCBS identification card. BlueCard PPO members are Blue Cross and Blue Shield members whose PPO benefits are delivered through the BlueCard Program. It is important to remember that not all PPO members participate in the BlueCard Program.

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**Empty suitcase logo**

An empty suitcase logo on a member’s identification card means that the member has Blue Cross and Blue Shield Traditional, Managed Care/POS, or Managed Care/HMO benefits delivered through the BlueCard Program.

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*The empty suitcase logo may appear anywhere on the front of the Identification card.*
Alpha Prefix

The three-character alpha prefix at the beginning of the member’s identification number is the key element used to identify and correctly route out-of-area claims. The alpha prefix identifies the BCBS Plan or national account to which the member belongs. It is critical for confirming a member’s eligibility and benefits.

There are two types of alpha prefixes: Plan-specific and Account-specific.

A correct member identification number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total. Do not assume that the member’s ID number is the Social Security number. All Blue Plans replaced Social Security numbers on member ID cards with an alternate, unique identifier.

Plan-specific
Plan-specific alpha prefixes are assigned to every BCBS Plan and start with X, Y, Z or Q.
- First character: X, Y, Z or Q
- Second character: A-Z
- Third character: A-Z

XO identifies the Illinois Plan.

The first two positions indicate the BCBS Plan to which the member belongs while the third position (for Illinois) identifies the product in which the member is enrolled. Each BCBS Plan has their own identifying third letter.

The third position of the alpha prefix identifies the following Illinois products:

<table>
<thead>
<tr>
<th>Code</th>
<th>Product Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XOP</td>
<td>PPO (Participating Hospitals only)</td>
</tr>
<tr>
<td>XOC</td>
<td>PPO Plus (Participating Hospitals and Physicians)</td>
</tr>
<tr>
<td>XOM</td>
<td>BlueChoice – Point of Service (POS)</td>
</tr>
<tr>
<td>XOF</td>
<td>PPO( Portable)</td>
</tr>
<tr>
<td>XOH</td>
<td>HMO (HMOI Illinois and BlueAdvantage HMO)</td>
</tr>
<tr>
<td>XOT</td>
<td>Traditional (Comprehensive Major Medical)</td>
</tr>
<tr>
<td>XOD</td>
<td>Dental</td>
</tr>
<tr>
<td>XOS</td>
<td>Medicare Supplemental – Individual</td>
</tr>
<tr>
<td>XON</td>
<td>Medicare Supplemental - Group</td>
</tr>
</tbody>
</table>
Account-specific
Account-specific alpha prefixes are assigned to centrally processed national accounts, which are employer groups that have offices or branches in more than one area. National accounts offer uniform benefit coverage to all of their employees. Account-specific alpha prefixes:
- Begin with letters other than X, Y, Z or Q
- Typically, will relate to the name of the group. All three positions are used to identify the national account

Doe, Jane
Identification Number
Group No.
Family

UAL11223333
081204

PRE-CERTIFY ALL INPATIENT CARE IN U.S.
How to Identify International Members

Occasionally you may see ID cards from Blue members residing abroad or members of foreign Blue Plans, which include: the U.S. Virgin islands, Uruguay and Panama. Please treat these members the same as domestic BCBS Plan members. The cards will include a three-letter alpha prefix at the beginning of the member’s identification number, identifying the member’s BCBS Plan. The third letter of the international alpha prefix will identify the foreign country.

For example: The alpha prefix for Uruguay is “URU”. The letter “U” identifies that the country is Uruguay. The identification cards of international BCBS plan members may look different than you are accustomed to seeing.

**Note:** The Canadian Association of BCBS Plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the U.S.

Claims for members of the Canadian Blue Cross Plans are not processed through the BlueCard Program. Please follow the instructions of these Plans and those, if any, on their ID cards for servicing their members. The Blue Cross Plans in Canada are:

- Alberta Blue Cross
- Manitoba Blue Cross
- Atlantic Blue Cross Care
- Quebec Blue Cross
- Saskatchewan Blue Cross
- Pacific Blue Cross
What products are impacted?

Currently four types of products are administered through the BlueCard Program:
- Traditional
- PPO (including Consumer Driven Health Care Products (CDHP)
- Managed Care/POS
- Managed Care/HMO

Traditional

The Traditional program offers an indemnity level of benefits to members traveling or living outside of their BCBS Plan’s area when seeking services from a BlueCard PPO provider.

PPO

The PPO program offers PPO benefits to members traveling or living outside of their BCBS Plan’s area when seeking services from a BlueCard PPO provider.
Consumer Driven Health Care Product (CDHP)

The Consumer Driven Health Care Product (CDHP) is a broad umbrella term that refers to a movement in the health care industry to empower members, reduce employer costs, and change consumer health care purchasing behavior. Members who have CDHP plans often carry health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Health Care Debit Cards

Some members carry health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Savings Account (HSA) or Flexible Spending Account (FSA). Health care debit cards are primarily used by members who have a Consumer Driven Health Care Plan.

The cards include a magnetic strip allowing providers to swipe the card at the point of service and collect the member cost-sharing amount. Use the member’s health care debit card to pay for copayments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the appropriate member’s HRA, HSA or FSA account.

Advantages of Health Care Debit Cards

- Simplify administrative processes
- Reduce bad debt
- Reduce paper work for billing statements
- Minimize bookkeeping
- Avoid unnecessary claim payment delays

There are two types of Health Care Debit Cards:

Sample stand-alone Health Care Debit Card
(May or may not have a BCBS logo)

Sample combined Health Care Debit Card and Member Identification card
Managed Care/POS

The Managed Care/POS program allows members traveling or living outside of their BCBS Plan’s area to seek services from a BlueCard PPO provider. You can recognize Managed Care/POS members who are enrolled in out-of-area networks through the member identification card as you do for all other BlueCard members. The identification cards will include:

- The three-character alpha prefix at the beginning of the member’s ID number.
- A local network identifier, for example, BlueMark
- The empty suitcase logo

Managed Care/HMO

The Managed Care/HMO program provides HMO members and eligible dependents with health care benefits when traveling out-of-state. The program consists of two components:

- **Urgent Care**: Provides members with benefits for medical care that is not an emergency, but should not be postponed until the member returns home. The Managed Care/HMO for Urgent Care follows the exact same procedures and requirements as the standard BlueCard Program.
- **Follow-up Care**: Provides pre-arranged care for an illness or injury that originates before the member leaves home. BCBSIL HMO members must call the Illinois Plan to coordinate follow-up care.

The identification cards will include:

- The three-character alpha prefix at the beginning of the member’s ID number.
- A HMO network identifier, for example, HMO Illinois
- The empty suitcase logo
How to Verify Eligibility and Benefits

For out-of-area Blue Plan members

1. Electronic—Submit a HIPAA 270 transaction (eligibility) to BCBSIL through NDAS Online
   If you are not enrolled with NDAS Online, join the growing number of providers who take advantage of our online solutions. Sign up today. Go online to www.bcbsil.com/provider/index.htm and download the NDAS Online Enrollment Packet or contact our Electronic Commerce (E-Commerce) Center at (800) 746-4614.
   ▪ You can receive real-time responses to your eligibility requests for out-of-area members between 6:00 am and 12:00 Midnight, CST, Monday through Saturday.

2. Telephone – call BlueCard® Eligibility 1-800-676-BLUE (2583)
   ▪ English and Spanish speaking phone operators are available to assist you.
   ▪ Keep in mind that BCBS Plans are located throughout the country and may operate on a different time schedule than BCBSIL. You may be transferred to a voice response system linked to customer enrollment and benefits.
   ▪ The BlueCard® Eligibility line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status - see Claim Filing in Section 3.
Electronic Health ID Cards

- Some BCBS Plans, including ours, are in the process of implementing electronic health ID cards to facilitate a seamless coverage and eligibility verification process.
- Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to your system.
- A Blue electronic health ID card has a magnetic stripe on the back of the ID card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the 3-track magnetic stripe.
- Core subscriber/member data elements embedded on the third track of the magnetic stripe include: subscriber/member name, subscriber/member ID, subscriber/member date of birth and Plan ID.
- The Plan ID data element identifies the health plan that issued the ID card. Plan ID will help you facilitate health transactions among various payers in the marketplace.
- You/office will need a track 3 card reader in order for the data on track 3 of the magnetic stripe to be read (the majority of card readers in provider offices only read tracks 1 & 2 of the magnetic stripe; tracks 1 & 2 are proprietary to the financial industry).

Sample electronic health ID card:
Helpful tips

- Ask members for their current member identification card and regularly obtain new photocopies (front and back) of the member identification card. Having the current card will enable you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.

- Check eligibility and benefits electronically via NDAS Online or by calling (800) 676-BLUE (2583) and providing the member ID number including the alpha prefix.

- Carefully determine the member’s financial responsibility before processing payment. You can access the member’s accumulated deductible by contacting the BlueCard Eligibility line at (800) 676-BLUE (2583) or by using NDAS Online.

- If the member presents a debit card (stand-alone or combined):
  - Be sure to verify the member’s cost sharing amount before processing payment.
  - Do not use the card to process full payment upfront. If you have any questions about the member’s benefits, please contact (800) 676-BLUE (2583), or for questions about the health care debit card processing instructions or payment issues, please contact the toll-free debit card administrator’s number on the back of the card.

Helpful tips:

- You may use the debit card for member responsibility medical services provided in your office.
- You may choose to forego using the debit card and submit the claims to BCBSIL for processing. The Remittance Advice will inform you of the member’s responsibility.
- Many Plans offer well care services that are payable under the basic healthcare program. If you have any questions about the member’s benefits or to request accumulated deductible information, please contact (800) 676-BLUE (2583).
- All services, regardless of whether or not you’ve collected the member responsibility at the time of service, must be billed to BCBSIL for proper benefit determination, and to update the member’s claim history.

Some cards are “stand-alone” debit cards to cover out-of-pocket costs, while others also serve as a member ID card with the member ID number. These debit cards can help you simplify your administrative processes and can potentially help:
- Reduce bad debt.
- Reduce paper work for billing statements.
How to Obtain Utilization Review

You should remind members they are responsible for obtaining pre-certification/preauthorization for health care services from their BCBS Plan.

When the length of an inpatient hospital stay extends past the previously approved length of stay, additional days must be approved. Failure to obtain approval for additional days may result in claims processing delays and potential payment denials. You may also contact the member’s Plan on their behalf.

- For Illinois members, contact the Provider Telecommunications Center (PTC) at (800) 972-8088
- For other Blue Plan members:
  - **Telephone**: Call BlueCard® Eligibility (800) 676-BLUE (2583) and ask to be transferred to the utilization review area.
  - **Electronic**: Submit a HIPAA 278 transaction (referral/authorization) to the Illinois Plan.

The member’s Blue Plan may contact you directly related to clinical information and medical records prior to treatment, or for concurrent review or disease management for a specific member.
Section 3—Claim Filing

BlueCard Program Claim Filing

The BlueCard Program allows you to submit claims electronically to the Illinois Plan for members from other BCBS Plans, including international BCBS Plans. The Illinois Plan is your one point of contact for claim inquiries.

You should always submit BlueCard claims electronically to the Illinois Plan.

Paper claims should be sent to:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

Claim Filing Exception:
If you contract with more than one BCBS Plan, refer to Multiple Contracts in this section to determine where your claims should be sent.

Note: Be sure to include the member’s complete identification number when you submit the claim. The complete identification number includes the three-character alpha prefix. Incorrect member identification numbers or missing alpha prefixes may delay claim processing.

How Claims Flow Through BlueCard

1. Member of another Blue Plan receives services from you, the provider
2. Provider submits claim to the local Blue Plan
3. Local Blue Plan recognizes BlueCard member and transmits standard claim format to the member’s Blue Plan
4. Member’s Blue Plan adjudicates claim according to member’s benefit plan
5. Member’s Blue Plan issues an EOB to the member
6. Member’s Blue Plan transmits claim payment disposition to your local Blue Plan
7. Your local Blue Plan pays you, the provider
Remember these helpful tips to improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically via NDAS Online, or by calling (800) 676-BLUE (2583). Be sure to provide the member’s alpha prefix.
- Indicate on the claim any payment you collected from the patient. (On the 837 electronic claim submission form, check field AMT01=F6 patient paid amount; on the CMS1500 locator 29 amount paid; and on UB-04 locator 53 prior payment.)
- Submit all Blue claims to BCBSIL. Be sure to include the member’s complete identification number when you submit the claim, including the three-character alpha prefix. Submit claims with only valid alpha prefixes. Claims with incorrect or missing alpha prefixes and member identification numbers cannot be processed.

**International Claim Filing – BlueCard® Worldwide**

The claim submission process for international BCBS Plan members is the same as for domestic Blue members. You should submit the claim electronically to the Illinois Plan.
Medicare Advantage Program Overview

“Medicare Advantage” (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as “traditional Medicare.”

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage [by calling (800) 676-BLUE (2583)] or submitting an electronic inquiry) for all Medicare Advantage members prior to providing service, since the level of benefits, and coverage rules, may vary depending on the Medicare Advantage plan.

How to recognize Medicare Advantage Members

Members will not have a standard Medicare card; instead, a Blue logo will be visible on their ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

Eligibility Verification

- Verify eligibility by contacting (800) 676-BLUE (2583) and providing an alpha prefix, or by submitting an electronic inquiry to BCBSIL, and providing the alpha prefix.
- Be sure to ask if Medicare Advantage benefits apply.
- If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to BCBSIL

Medicare Advantage Claims Submission

- Submit all Medicare Advantage claims to the Illinois Plan,
- Do not bill Medicare directly for any services rendered to a Medicare Advantage member.
- Payment will be made directly by a Blue Plan.
Reimbursement for Medicare Advantage PPO, HMO, POS

You will be reimbursed the equivalent of the current Medicare payment amount for all covered services (i.e. the amount you would collect if the member was enrolled in traditional Medicare). Refer to the member’s ID card for instructions on how to access their Blue Plan’s terms and conditions.

No Plan Contract: Services for out-of-area and local Medicare Advantage members

[Situation below is where the provider does not have a contract with the local Plan for MA and provides service to a local or out-of-area MA member.]

Based upon the Centers for Medicare and Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue Plan, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).
Medical Records

Blue Plans around the country have made improvements to the medical records process to make it more efficient. We now are able to send and receive medical records electronically among Plans. This new method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and eliminates lost or misrouted records.

Under what circumstances may the provider get requests for medical records for out-of-area members?

1. If you receive requests for medical records from other Blue Plans prior to rendering services, as part of the pre-authorization process, you will be instructed to submit the records directly to the member's Plan that requested them. This is the only circumstance where you would not submit them to BCBSIL.

2. Claim review and adjudication requests will come from BCBSIL in the form of a letter requesting specific medical records and including instructions for submission.

BlueCard Medical Record Process for Claim Review

1. An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.

2. A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact BCBSIL to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.

3. If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact BCBSIL to determine if the records are needed from your office.

4. Upon receipt of the information, the claim will be reviewed to determine the benefits.

Helpful Ways You Can Assist in Timely Processing of Medical Records

1. If the records are requested following submission of the claim, forward all requested medical records to
   Blue Cross and Blue Shield of Illinois
   PO BOX 805107
   Chicago, Illinois 60680-4112

2. Follow the submission instructions given on the request, using the specified address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.

3. Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by BCBSIL.

4. Please submit the information to BCBSIL as soon as possible to avoid further delay.

5. Only send the information specifically requested. Frequently, complete medical records are not necessary.

6. Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

7. Direct questions regarding medical records to the Illinois Plan at (800) 972-8088.

Remember: Do not send medical records with the claims. When requested, send only the minimum necessary medical records for the dates of service referenced.
Coordination of Benefits (COB) Claims

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

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

a. Another Blue Plan is the primary payer, and a non-Blue health plan is secondary, submit the other carrier's name and address with the claim to the Illinois Plan. If COB information is not included with the claim, the member's BCBS Plan will have to investigate the claim. Additional information may be requested, which can result in payment delay.  
   NOTE: If the member has two (2) BCBS Plans, be sure to determine which Blue Plan is the primary payer.

b. A non-Blue health plan is primary and BCBSIIL or another BCBS Plan is secondary, submit the claim to BCBSIIL only after receiving payment from the primary payer, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's BCBS Plan will have to investigate the claim. Additional information may be requested, which can result in payment delay.

Coordination of Benefits Questionnaire

To streamline our claims processing and reduce the number of denials related to COB, a Coordination of Benefits questionnaire is now available for you at [www.bcbsil.com/provider/forms.htm](http://www.bcbsil.com/provider/forms.htm) that will help you and your patients avoid potential claim issues.

When you provide services to any Blue Plan members and you are aware that they might have other health insurance coverage (i.e. Medicare, etc.), give a copy of the questionnaire to the member during their visit. Encourage all of your Blue Plan patients to complete the form and send it to the Blue Plan through which they are covered as soon as possible after leaving your office. Members will find the address on the back of their member identification card or by calling the customer service numbers listed on the back of the card. Collecting COB information from members before you file their claim eliminates the need to gather this information later, thereby reducing processing and payment delays.
Medicare Primary—Blue Cross and Blue Shield Supplemental Claims

Always submit your claims to Medicare first when Medicare is primary. The BCBS supplemental claims automatically crossover to the patient’s Plan. The electronic Crossover claims will contain all of the EOMB information (claim and remittance data) that is needed to process the BCBS supplemental claim.

Claims Crossover to BCBS from Medicare only after the Medicare 14-day payment holding period. The following information will let you know the claims that did crossover and those that did not:

1. The Medicare Remittance Advice (RA) will contain a message that the claim was forwarded to the appropriate Blue Plan.
2. Medicare will send notification to providers advising them of claims that did not crossover.

When claims do not crossover, follow these steps:

1. Wait the 14-day payment holding period for electronic claims and the 29-day payment holding period for paper claims submitted to Medicare.
2. Check the RA for the crossover indicator.
3. Review your Medicare notification of claims that did not crossover.

Claims that did not crossover may be submitted electronically to BCBSIL. Please abide by the following time frames:

1. If you submitted electronic claims to Medicare, it is best to wait approximately 30 days before submitting the supplemental claim. That includes the 14-day Medicare holding period, 7 days for the Coordination of Benefits Contractor (COBC) to crossover the claim to the patient’s BCBS Plan, and 7-10 days for the adjudication and payment of the supplemental claim by the BCBS Plan.
2. For claims submitted to Medicare via paper, you must wait the 29-day payment holding period, 7 days for the COBC crossover, and 7-10 days for the adjudication and payment of the BCBS supplemental claim.
Claims Status
BCBSIL is your single point of contact for all claim inquiries. You can make claim status inquiries in the following manner:

Electronic Submissions:
1. Access the electronic transaction report if you transmit claims through rEDI-link Blue to verify successful transmission.
3. Call the Provider Telecommunications Center (PTC) at (800) 972-8088.

Paper Submissions
1. Access our electronic database—NDAS Online—to verify eligibility and benefits.
2. Call the Provider Telecommunications Center (PTC) at (800) 972-8088.

Reimbursement for BlueCard® Claims

BCBSIL will reimburse you according to the contract guidelines when:
- The member is eligible for benefits
- The services are covered under the member’s plan*

The reimbursement for out-of-area members is the same as the fee schedule for local members.

*The member’s plan determines what services are considered eligible under all medical policy determinations (e.g., medical necessity, investigational, routine, etc.)

If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. If you do not receive your payment or a response regarding your payment within 30 days, please call BCBSIL at (1-800-92372-8088) or go to NDAS Online to check the status of your claim.

Claim Review for Illinois Contracting Providers
You may request a review by completing the Provider Request for Review form, which can be found on our Web site at www.bcbsil.com/provider/forms.htm. If you do not receive your payment or a response regarding payment, please contact our PTC at 1-800-972-8088.
Multiple Contracts

BlueCard Claim Filing for Bordering Counties (Contiguous Counties)

In some cases providers in bordering counties (contiguous areas) contract with two or more BCBS Plans. BCBSIL contracts with providers in Northwest Indiana. Outlined below are processes for filing claims under these circumstances.

Billing the Correct Plan for Your Service

Provider Located in Contiguous County in Indiana

- **Illinois and Indiana PPO Contracted Doctor**
  - **Illinois Plan Patient**
    - Submit Claim to **Illinois Plan**
    - Illinois Adjudicates Their Claim
    - Illinois Pays the Provider
  - **Indiana Plan Patient**
    - Submit Claim to **Indiana Plan**
    - Indiana Adjudicates Their Claim
    - Indiana Pays the Provider
  - **Other State Plan Patient**
    - Submit Claim to **Indiana Plan**
    - Other State Plan (Home) Adjudicates the Claim
    - Indiana Plan Where Claim is Filed Pays the Provider
Multiple Contracts

Billing the Correct Plan for Your Service

Provider Located in Contiguous County in Indiana

- **Illinois PPO and Indiana Non-PPO Contracted Provider**
  - **Illinois Plan Patient**
    - Submit Claim to **Illinois Plan**
      - Illinois Adjudicates Their Claim
        - Illinois Pays the Provider
  - **Indiana Plan Patient**
    - Submit Claim to **Indiana Plan**
      - Indiana Adjudicates Their Claim
        - Indiana Pays the Provider
  - **Other State Plan Patient**
    - Submit Claim to **Illinois or Indiana Plan***
      - Other State Plan (Home) Adjudicates the Claim
        - IL or IN Plan Where Claim is Filed Pays the Provider

***When the visiting member has PPO benefits, the claim must be filed to the plan with whom the physician is PPO contracted.
Multiple Contracts

Billing the Correct Plan for Your Service

Provider Located in Contiguous County in Indiana

- **Indiana PPO**
  - Contracted Provider

- **Illinois Plan Patient**
- **Indiana Plan Patient**
- **Other State Plan Patient**

- Submit Claim to **Indiana Plan**

- **Illinois Plan Adjudicates the Claim**
- **Indiana Plan Adjudicates Their claim**
- **Other State Plan (Home) Adjudicates the Claim**

- **Indiana Plan Pays the Provider**
Section 4—Key Contacts

Resources for Illinois Contracting Providers:

1. Provider Telecommunications Center (PTC): (800) 972-8088.
2. BCBSIL Provider Web site: www.bcbsil.com/provider
3. NDAS Online Web site: www.ecare.com
   If you are not enrolled with NDAS Online, join the growing number of providers who take advantage of our online solutions. Sign up today. Go online to www.bcbsil.com/provider/index.htm and download the NDAS Online Enrollment Packet or contact our E-Commerce Center at (800) 746-4614.
4. BCBSIL Provider Network Consultant
   Note: To locate the name of your assigned Provider Network Consultant, visit our Web site at www.bcbsil.com/provider, and click on “Provider Network Consultant List” in the Provider Library section.

Resources for All Providers:

- BlueCard® Access: (800) 810-BLUE (2583)
- BlueCard® Eligibility: (800) 676-BLUE (2583)
- BlueCard Doctor & Hospital Finder Web Site: www.bcbs.com
Section 5— Frequently Asked Questions

BlueCard Basics

1. **What Is the BlueCard® Program?**
   BlueCard® is a national program that enables members of one BCBS Plan to obtain health care services while traveling or living in another BCBS Plan’s service area. The program links participating health care providers with the independent BCBS Plans across the United States and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

   The program allows you to submit claims for members from other BCBS Plans, domestic and international, to the Illinois Plan.

   The Illinois Plan is your sole contact for claims payment, problem resolution and adjustments.

2. **What products and accounts are excluded from the BlueCard Program?**
   - Prescription drugs
   - Hearing/Vision
   - Stand alone Dental (non-surgical)
   - Federal Employee Program (FEP) claims

3. **What is the Traditional Program?**
   A national program that offers an indemnity level of benefits to members traveling or living outside of their BCBS Plan’s area when seeking services from a BlueCard PPO provider.

4. **What is the PPO Program?**
   A national program that offers PPO benefits to members traveling or living outside of their BCBS Plan’s area when seeking services from a BlueCard PPO provider.

5. **What is a Consumer Driven Health Care Product (CDHP)**
   CDHP is a broad umbrella term that refers to a movement in the health care industry to empower members, reduce employer costs, and change consumer health care purchasing behavior. Members, who have CDHP plans often carry health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

6. **What is the Managed Care/POS Program?**
   The Managed Care/POS program allows members traveling or living outside of their BCBS Plan’s area to seek services from a BlueCard PPO provider. You can recognize Managed Care/POS members who are enrolled in out-of-area networks through the member identification card as you do for all other BlueCard members. The Identification cards will include:
   - The three-character alpha prefix at the beginning of the member’s ID number
   - A local network identifier, for example, BlueMark
   - The empty suitcase logo

7. **Can Managed Care/HMO members receive services through the BlueCard Program?**
   Yes, occasionally, BCBS HMO members affiliated with other BCBS Plans will seek care at your office or facility. You should handle claims for these members the same way as you do for members who are enrolled in BCBS traditional, PPO, and POS BCBS Plans—by submitting them to BCBSIL.
Identifying Members and Identification Cards

1. How do I identify members?
   When members from other BCBS Plans arrive at your office or facility, be sure to ask them for their current
   BCBS Plan membership identification card.

   The two identifiers for BlueCard members are the alpha prefix and suitcase logos. There are two (2) types of
   suitcase logos:
   - PPO in a suitcase logo, for eligible PPO members
   - Empty suitcase logo, for eligible Managed Care/POS, Traditional and Managed Care/HMO members.

2. What is an “alpha prefix?”
   The three-character alpha prefix at the beginning of the member’s identification number is the key element
   used to identify and correctly route claims. The alpha prefix identifies the BCBS Plan or national account to
   which the member belongs. It is critical for confirming a member’s eligibility and benefits.

3. What if a member has an identification card without an alpha prefix?
   If you cannot locate the alpha prefix on a member’s identification card, call the telephone number on the back
   of the identification card.

   NOTE: Some members may carry outdated identification cards that may not have an alpha prefix. Please request
   a current ID card from the member.

4. How do I identify Managed Care/POS members?
   You can recognize Managed Care/POS members who are enrolled in out-of-area networks through the
   member identification card as you do for all other BlueCard members. The Identification cards will include:
   - The three-character alpha prefix at the beginning of the member’s ID number
   - A local network identifier, (for example, BlueMark)
   - The empty suitcase logo

5. How do I identify international members?
   You may see identification cards from BCBS Plan members living in a foreign country. The cards will include
   a three-letter alpha prefix at the beginning of the member’s identification number, identifying the member’s
   BCBS Plan. The third letter of the international alpha prefix will identify the foreign country. Please treat these
   members the same as domestic BCBS Plan members.

6. How do I identify Medicare Advantage members?
   Members will not have a standard Medicare card; instead, a Blue logo will be visible on the ID card. The
   following examples illustrate how the different products associated with the Medicare Advantage program will
   be designated on the front of the member ID cards:
7. What do I do if a member does not have an ID card?
   - Obtain as much information as possible from the Blue Plan member, i.e., subscriber name and address, DOB and name of BCBS Plan
   - Call (800) 676-BLUE (2583) and wait to be prompted to speak with a service representative
   - If your office is not able to confirm member eligibility, follow your standard office procedures for servicing members without proof of insurance or verification.

Verifying Eligibility and Benefits

How do I verify eligibility and benefits?

1. Online – access NDAS Online
   *If you are not enrolled with NDAS Online, join the growing number of providers who take advantage of our online solutions. Sign up today. Go online to www.bcbsil.com/provider/index.htm and download the NDAS Online Enrollment Packet or contact our E-Commerce Center at (800) 746-4614.*

2. Telephone – call BlueCard® Eligibility (800) 676-BLUE (2583)
   - English and Spanish speaking phone operators are available to assist you.
   - BCBS Plans are located throughout the country and may operate on a different time schedule than BCBSIL. You may be transferred to a voice response system linked to customer enrollment and benefits.
   - The BlueCard® Eligibility line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status - see Claim Filing in Section 2.

Utilization Review

1. Who is responsible for utilization review?
   You should remind members they are responsible for obtaining pre-certification/preauthorization for health care services from their BCBS Plan.

   When the length of an inpatient hospital stay extends past the previously approved length of stay, additional days must be approved. Failure to obtain approval for additional days may result in claims processing delays and potential payment denials. You may also contact the member’s Plan on their behalf.

   - For Illinois members, contact the Provider Telecommunications Center (PTC) at (800) 972-8088
   - For other Blues Plan members:
     - **Telephone:** Call the utilization management/pre-certification number on the back of the member’s card. If the utilization management number is not listed on the back of the member’s card, Call BlueCard® Eligibility at (800) 676-BLUE (2583), and ask to be transferred to the utilization review area.
     - **Electronic:** Submit a HIPAA 278 transaction (referral/authorization) to BCBSIL.
Claims

1. Where and how do I submit claims?
   You should always submit BlueCard claims electronically to the Illinois Plan.

   **Paper claims should be sent to:**
   Blue Cross and Blue Shield of Illinois
   P.O. Box 805107
   Chicago, Illinois 60680-4112

   **Claim Filing Exception:**
   If you contract with more than one BCBS Plan, refer to Multiple Contracts in Section 3.

   **Note:** Be sure to include the member’s complete identification number when you submit the claim, including the three-character alpha prefix. Incorrect or missing alpha prefixes and member identification number’s delay claim processing.

2. How do I submit international claims?
   The claim submission process for international BCBS Plan members is the same as for domestic Blue members. You should submit the claim electronically to BCBSIL.

3. How do I handle COB claims?
   When a member has coverage from two or more sources, the member’s contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

   BCBS Plans will coordinate benefits when a member has coverage from two or more carriers.

   If you discover that the member is covered by more than one health plan, and:
   a. Another BCBS Plan is the primary payer:
      ▪ Submit the other carrier’s name and address with the claim to the Illinois Plan
      ▪ If COB information is not included, the member’s BCBS Plan will have to investigate the claim. Additional information may be requested, which can result in payment delay.

   b. A non-Blue health plan is primary and another BCBS Plan is secondary:
      ▪ Submit the claim to the Illinois Plan only after receiving payment from the primary payer, including the explanation of payment from the primary carrier
      ▪ If you do not include the COB information with the claim, the member’s BCBS Plan will have to investigate the claim. Additional information may be requested, which can result in payment delay.
4. How do I handle Medicare-related claims?

- When Medicare is the primary payor, submit claims to your local Medicare intermediary.
- As of Jan. 1, 2008, all Blue claims are set up to automatically cross over to the member’s Blue Plan after being adjudicated by the Medicare intermediary.

**How do I submit Medicare primary / Blue Plan secondary claims?**

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from BCBSIL. Check the member’s ID card for additional verification.
- Be certain to include the alpha prefix as part of the member identification number. The member’s ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

*When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:*

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to BCBSIL.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to BCBSIL with the Medicare remittance advice.
- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
- For claim status inquiries, contact our Provider Telecommunications Center at (800) 972-8088.

Always submit your claims to Medicare first when Medicare is primary. The BCBS supplemental claims automatically crossover to the patient’s Plan. The electronic Crossover claims will contain all of the EOMB information (claim and remittance data) that is needed to process the BCBS supplemental claim.

Claims Crossover to BCBS from Medicare only after the Medicare 14 day payment holding period. The following information will let you know the claims that did crossover and those that did not:

1. The Medicare Remittance Advice (RA) will contain a message that the claim was forwarded to the appropriate Blue Plan.
2. Medicare will send notification to providers advising them of claims that did not crossover.

When claims do not crossover, follow these steps:

1. Wait the 14-day payment holding period for electronic claims and the 29-day payment holding period for paper claims submitted to Medicare.
2. Check the RA for the crossover indicator.
3. Review your Medicare notification of claims that did not crossover.

Claims that did not crossover may be submitted electronically to the Illinois Plan, but utilize these time frames:

1. If you submitted electronic claims to Medicare, it is best to wait approximately 30 days before submitting the supplemental claim (14 day Medicare holding period, 7 days for the Coordination of Benefits Contractor (COBC) to crossover the claim to the patient’s BCBS Plan, and 7-10 days for the adjudication and payment of the supplemental claim by the BCBS Plan.
2. For claims submitted to Medicare via paper, you must wait the 29-day payment holding period, 7 days for the COBC crossover, and 7-10 days for the adjudication and payment of the BCBS supplemental claim.
Contacts

1. **Who do I contact with claims questions?**
   Access NDAS Online or call our PTC at (800) 972-8088.

   *If you are not enrolled with NDAS Online, join the growing number of providers who take advantage of our online solutions. Sign up today. Go online to [www.bcbsil.com/provider/index.htm](http://www.bcbsil.com/provider/index.htm) and download the NDAS Online Enrollment Packet or contact our E-Commerce Center at (800) 746-4614.*

2. **How do I handle calls from members with claims questions?**
   If members contact you, tell them to contact their local Blue Plan. Refer them to the front or back of their Identification card for a customer service number. A member’s Plan should not contact you directly, unless you filed a paper claim directly with that Plan. If the member’s Plan requests you to send them another copy of the member’s claim, refer the Plan to the Illinois Plan.

3. **Where can I find more information?**
   For more information:
   - Call our PTC at (800) 972-8088
   - Visit the BCBSIIIL Provider Web site at [www.bcbsil.com/provider](http://www.bcbsil.com/provider)
   - Contact your Provider Network Consultant.
Section 6 - Glossary of BlueCard Program Terms

**Alpha Prefix**
Three characters preceding the subscriber identification number on Blue Plan ID cards. The alpha prefix identifies the member’s Blue Plan or national account and is required for routing claims.

**bcbs.com**
Blue Cross and Blue Shield Association’s Web site, which contains useful information for providers.

**BlueCard Access® (800) 810-BLUE (2583)**
A toll-free 800 number for you and members to use to locate healthcare providers in another BCBS Plan’s area. This number is useful when you need to refer the member to a physician or healthcare facility in another location.

**BlueCard Eligibility® (800) 676-BLUE (2583)**
A toll-free 800 number for you to verify eligibility and benefit information, and obtain pre-certification on members from other BCBS Plans.

**BlueCard PPO**
A national program that offers members traveling or living outside of their BCBS Plan’s area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

**BlueCard Member**
BCBS Plan members with BlueCard coverage are identified by the suitcase logo on their identification card. The ‘PPO’ in a suitcase logo identifies eligible PPO members and the empty suitcase logo is carried by traditional and managed care members. Only members with the suitcase logo may access the benefits of the BlueCard program.

**BlueCard Doctor & Hospital Finder Web Site** [http://www.bcbs.com/healthtravel finder.html](http://www.bcbs.com/healthtravel finder.html)
A Web site used to locate all BCBS Plan healthcare providers when the member needs a referral to a physician or healthcare facility. If you find that any information about you, as a provider, is incorrect on the Web site, please go to our IL Web site at [http://www.bcbsil.com/provider/provider_file_update.htm](http://www.bcbsil.com/provider/provider_file_update.htm) to update your information.

**BlueCard Worldwide®**
A program that allows BCBS Plan members traveling or living abroad to receive access to covered inpatient and outpatient hospital care and professional services from healthcare providers worldwide. The program also allows members of international BCBS Plans to access domestic (U.S.) BCBS provider networks.

**Coinsurance**
A percentage of an eligible expense that a member is required to pay out-of-pocket towards a covered health care service. The amount is determined by the member’s benefit plan.

**Consumer Driven Health Care Product (CDHP)**
CDHP is a broad umbrella term that refers to a movement in the health care industry to empower members, reduce employer costs, and change consumer health care purchasing behavior. Members, who have CDHP plans often carry health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

**Coordination of Benefits (COB)**
Coordination of Benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member’s contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

**Co-payment**
A charge that a member incurs at the time of service for specific health care services.

**Deductible**
A required payment due by a member during a given time period before payment by their health plan begins.
FEP
The Federal Employee Program.

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

Medicare Advantage
"Medicare Advantage" (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as “traditional Medicare.” MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

Medicare Crossover
A program established to transfer Medicare claim information directly to the member’s Medicare Supplemental insurance carrier.

National Account
An employer group that has offices or branches in more than one BCBS Plan’s service area but offers uniform benefit coverage to all of its employees.

Plan
Refers to any BCBS Plan.
Section 7 – BlueCard Program Quick Tips

The BlueCard Program provides a valuable service that lets you file all claims for members from other BC and/or BS Plans with BCBSIL.

Here are some key points to remember:

- Make a copy of the front and back of the member’s ID card.
- Look for the three-character alpha prefix that precedes the member’s ID number on the ID card.
- Call BlueCard Eligibility at (800) 676-BLUE to verify the patient’s membership and coverage or submit an electronic HIPAA 270 transaction (eligibility) to the Illinois Plan.
- Submit the claim to BCBSIL electronically, or via paper. Always include the patient’s complete identification number, which includes the three-character alpha prefix.
- For claims inquiries, call our PTC at (800) 972-8088.