

BlueCard[®] Program

Answers to Frequently Asked Questions

What is the BlueCard Program?

BlueCard is a national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare providers with the independent Blue Cross and Blue Shield Plans across the country, and in more than 200 countries and territories worldwide, through a single electronic network for claims processing and reimbursement. You may submit claims for patients from other Blue Plans, domestic and international, to your local Blue Cross and/or Blue Shield Plan. The local Blue Cross and/or Blue Shield Plan is your sole contact for education, contracting, claims payment/adjustments and problem resolution.

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Roles and Responsibilities

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What are the roles and responsibilities of the local Blue Cross and/or Blue Shield Plans to their providers?

Your local Blue Cross and/or Blue Shield Plan's responsibilities include all provider related functions, such as:

- Being the single contact for all claims payment, customer service issues, provider education, adjustments and appeals.
- Pricing claims and applying pricing and reimbursement rules consistent with provider contractual agreements.
- Forwarding all clean claims received to the member's Blue Cross and Blue Shield Plan to adjudicate based on eligibility and contractual benefits.
- Conducting appropriate provider reviews and/or audits.
- Confirming that providers are performing services and filing claims appropriately within their scope of practice and according to their local Blue Cross and/or Blue Shield Plan.

- Conducting HIPAA standard transactions.
- Training for providers on BlueCard (Plan optional)

What are the roles and responsibilities of the Member home plan to the provider?

- Adjudicate claims based on member eligibility and contractual benefits.
- Respond to prior authorization and pre-certification requests/inquiries.
- Request medical records through the local Plan when review for medical necessity, determination of a pre-existing condition, or high cost/utilization is required.

What are the roles and responsibilities for the Provider?

- Obtaining benefits and eligibility information, including covered services, copayments and deductible requirements.
- Filing claims with the correct local Plan and including, at minimum, the required elements to ensure timely and correct processing, such as:
 - Current member ID card number.
 - All Other Party Liability information.
 - All member payments such co-pay, co-insurance or deductibles
- Submitting medical records in a timely manner when requested by the local or member home Plan

Eligibility and Benefits

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How can Providers obtain member eligibility information?

Member eligibility information should be obtained by submitting a Blue Exchange Eligibility & Benefits Inquiry (HIPAA transaction 270) request through your local Blue Plan, but can also be obtained by calling 1-800-676-BLUE(2583). If prior authorization or pre-certification information is required in addition to eligibility, Providers should call 1-800-676-BLUE(2583).

- It is more beneficial when submitting a HIPAA transaction 270 request to use the appropriate Service Type codes for the specific service being provided. Use of the general Service Type “30” (Health Benefit Plan Coverage) or Service Type “1” (Medical Care) may not provide enough information to address all related Inpatient, Outpatient, Emergency and Professional benefits and does not include information on Benefit Limitations and Place of Service requirements.

Verify the member’s cost sharing amount before processing payment. Co-pay, co-insurance, deductibles and accumulated benefits can be obtained from the electronic Blue Exchange Eligibility & Benefits Response (HIPAA transaction 271) to the HIPAA transaction 270. Please do not process full payment upfront.

What specific information should the Provider Obtain?

It is recommended that Providers request the most current ID card at every visit since new ID cards maybe be issued to members throughout the year. Member ID cards may include one of several logos identifying the type of coverage the member has and/or indicating the provider’s reimbursement level.

- Blank (empty) suitcase

- Traditional, HMO (Health Maintenance Organization), POS (Point of Service) and Limited Benefit Product type benefits
- PPO in suitcase
 - PPO or EPO type benefits
- No suitcase
 - Medicaid, State Children’s Health Insurance Programs (SCHIP) administered as a part of a state’s Medicaid program, Medicare Complementary and Supplemental products, also known as Medigap type benefits.

The provider should request specific information including eligibility, benefits, cost sharing, prior authorization/pre-certification requirements, care/utilization management requirements, and concurrent review requirements when contacting the member home Plan for benefit and eligibility information.

Claim Submission

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How should providers bill claims for out-of-area members?

Providers should bill claims for out-of-area members the same way they bill claims for their local Blue Cross and/or Blue Shield Plan members. When submitting the claim:

- The member ID numbers should be reported exactly as shown on the ID card. Do not add, omit or alter any characters from the member ID number.
- Indicate on the claim any payment you collected from the patient.
- Only submit medical records if requested.

What should you do if you haven’t received a response to your initial claim submission?

If you have a question regarding the status of an outstanding claim, you can submit an electronic Blue Exchange Claim Status Request (HIPAA transaction 276) or contact your local Plan.

Do not send in a duplicate claim. Sending another claim or having your billing agency resubmit claims automatically slows down the claims payment process and creates confusion for the member.

Coordination of Benefits

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How should Coordination of Benefits (COB) be handled when a member has Blue on Blue coverage? Another carrier?

In cases where Blue on Blue coverage has been identified, and the member has dual coverage with the same and/or differing Blue Plans you should consider the following:

- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member’s ID card for additional verification or ask them to complete the Universal Blue COB Questionnaire available on your local Plan’s website.
- On the electronic HIPAA transaction 837 or paper claim, it is important in box 11D “YES” or “NO” be checked for Professional claims or form fields 50, 58-62 be completed for Institutional claims

to ensure the claim will be reviewed properly by the local Blue Plan. For Professional claims if the member does not have other insurance, it is imperative that you indicate this. Leaving the box unmarked can cause the Member's Home Plan to stop the claim to investigate for COB. By completing the information, you are helping ensure your claim will be processed more timely.

- Review the EOP/EOB from the primary Blue Plan prior to submitting a claim to the secondary Blue Plan to avoid duplicate claims submission. The primary Blue Plan may have forwarded the claim to the secondary Blue Plan through BlueCard. If the secondary claim was not handled by the local Blue Plan then forward a copy of the claim to your local Blue Plan with any Other Party Liability (OPL) information included.
- Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability.

In cases where there is more than one payer and another Blue Plan or commercial insurance carrier is the primary payer, submit the other carrier's name and address or Explanation of Benefits with the claim to your local Plan. You may also go to your local Plan's website and download a copy of the Universal Blue COB Questionnaire that the member can complete and sign at the time of service and send it to your local Plan with the claim. Please ensure that the form is completely filled out and at a minimum, include your name and tax identification or NPI number, the policy holder's name, group number and identification number including the three character alpha-prefix and the member's signature. Not including the COB information with the claim may delay payment if the members home Plan investigates the claim needlessly.

If another non-Blue health plan is primary and any other Blue Plan is secondary, submit the claim to the local Plan only after receiving payment from the primary payer. Include the explanation of payment from the primary carrier with your claim submittal.

[Prior Authorization/Pre-Certification](#)

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Are providers required to cooperate with the member's Blue Plan prior authorization/pre-certification programs?

While out-of-area BlueCard members are currently responsible for obtaining prior authorization or pre-certification from their BCBS Plans, most providers choose to handle this obligation on the member's behalf. Members may be held financially responsible if necessary approvals are not obtained and the claim is denied. The provider may have to manage debt collection in this situation.

When verifying member eligibility and benefits, providers should request information on prior authorization and pre-certification, care management/utilization management and concurrent review, as required for inpatient or outpatient services.

How can Providers obtain prior authorization/pre-certification information for out-of-area members?

Member prior authorization or pre-certification information can be obtained both electronically and telephonically.

- General information on prior authorization and pre-certification information can be found on the local Blue Plan webpage under Out-of-Area Member Medical Policy and Pre-Authorization/Pre-Certification Router utilizing the three letter prefix found on the member ID card.
- Providers can also contact 1-800-676-BLUE(2583) to obtain prior authorization or pre-certification information. When prior authorization or pre-certification for a specific member is handled separately from eligibility verifications at the member's Blue Plan, your call will be routed directly

to the area that handles prior authorization or pre-certification. You will choose from four options depending on the type of service for which you are calling:

- Medical/Surgical
- Behavioral Health
- Diagnostic Imaging/Radiology
- Durable/Home Medical Equipment (D/HME)

If you are inquiring about both, eligibility and prior authorization or pre-certification, through 1-800-676-BLUE(2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the prior authorization or pre-certification area.

Please note that if a prior authorization and pre-certification determination is not provided at the time of the call, the determination may be communicated to a different area (i.e. facility's Utilization Management area) than the area that initiated the pre-certification request. Providers are encouraged to ask the member's Blue Plan about this situation when they call in order to prevent duplicate requests.

- With the submission of an Eligibility HIPAA transaction 270 request through your local Blue Plan, the Eligibility HIPAA transaction 271 response may indicate that a prior authorization or pre-certification is required for an eligible service.

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Are providers required to hold the patient harmless for penalties assessed for not following the member's Blue Plan authorization protocols?

The out-of-area BlueCard member is responsible for obtaining pre-certification or prior authorization from his/her Blue Cross and/or Blue Shield Plan. As a result, the member is responsible for any penalty assessed for non-compliance.

Medical Records

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Should a provider include medical records with the original claim?

Providers are not encouraged to submit unsolicited medical records or other clinical information unless requested. If medical records or other relevant information is needed to finalize the claim payment, the local Blue Cross and/or Blue Shield Plan will notify you.

- If you receive requests for medical records from other Blue Plans *prior to rendering services*, as part of the prior authorization process, please submit them directly to the member's Plan that requested them.
- Follow the submission instructions given on the request, using the specified physical or email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
- There is a difference between reviewing a claim for medical necessity after the service has already been rendered and reviewing a prior authorization for medical appropriateness; these reviews are not the same:
 - Medical Necessity - validates the service is medically necessary according to their members Blue Plan medical policy.

- Medically Appropriate - validates that service rendered matches the prior authorization and the dollar amounts are in-line.
- When a claim has been denied for medical records and the records have been submitted to your local Plan, it is recommended that providers wait at a minimum 20 business days before submitting a follow up request for status of claim adjudication.
- If you are the rendering or performing provider for a service, include the name and address of the referring or ordering provider on your original claim submission. Including this information will help ensure that if medical records are needed that they will be requested from the correct provider.

[Medical, Benefit, Payment Policy](#)

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Which Plan's Medical Policy applies for out-of-area members?

Only a member's Blue Plan Medical Policy applies to BlueCard claims. The member's Blue Plan Medical Policy applies to the interpretation and determination of medical necessity, medical appropriateness, investigational/experimental care, and clinical reviews as related to administration of the member's benefits and coverage.

[Claims Payment](#)

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How is a Provider payment determined?

- The local Plan applies pricing and reimbursement rules consistent with provider contractual agreements.
- The member's home Plan adjudicates the claim based on eligibility and contractual benefits.

Who pays the Provider?

Provider payable claims will be paid by the local Plan based on the provider's contract and subject to the member's benefit plan.

[Medicare Crossover](#)

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All Blue Plans crossover Medicare claims for services covered under Medigap and Medicare Supplemental products. This will result in automatic claims submission of Medicare claims to the Blue secondary payer, and reduce or eliminate the need for the provider's office or billing service to submit an additional claim to the secondary carrier.

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 the local Blue Plan. 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 card 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.

How do I handle Medicare Advantage (MA) claims?

For Medicare Advantage, submit claims to the local Blue Plan. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

- Ask for the member ID card. Members will not have a standard Medicare card; instead, Medicare Advantage members have distinctive product logos on their medical ID card to help you recognize them. All logos have the term “Medicare Advantage” in the design.
- Verify eligibility by contacting 1-800-676-BLUE(2583) and providing the alpha prefix. Be sure to ask if Medicare Advantage benefits apply.

Please review the remittance notice concerning Medicare Advantage plan payment, member’s payment responsibility and balance billing limitations.

What does Medicare Advantage PPO Network Sharing mean?

If you are a contracted MA PPO provider with the local plan and you see MA PPO members from other Blue Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your local Blue Plan contract. These members will receive in-network benefits in accordance with their member contract.

NOTE: If you are not a contracted MA PPO provider with your local Plan and you provide services for any Blue MA members, you will receive the Medicare allowed amount for covered services. For Urgent or Emergency care, you will be reimbursed at the member’s in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

Contiguous Counties/Overlapping Service Areas

What are the rules for filing claims in Overlapping Service Areas?

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Submission of claims in Overlapping Service Areas is dependent on what Plan(s) the Provider contracts with in that state, the type of contract the Provider has (ex. PPO, Traditional) and the type of contract the member has with their Home Plan.

- If you contract with all local Blue Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area Blue Plan member’s claim with either Plan.
- If you contract with one Plan but not the other, file all out-of-area claims with your contracted Plan.