



Back To Basics

2024 ANNUAL PROVIDER SUMMIT



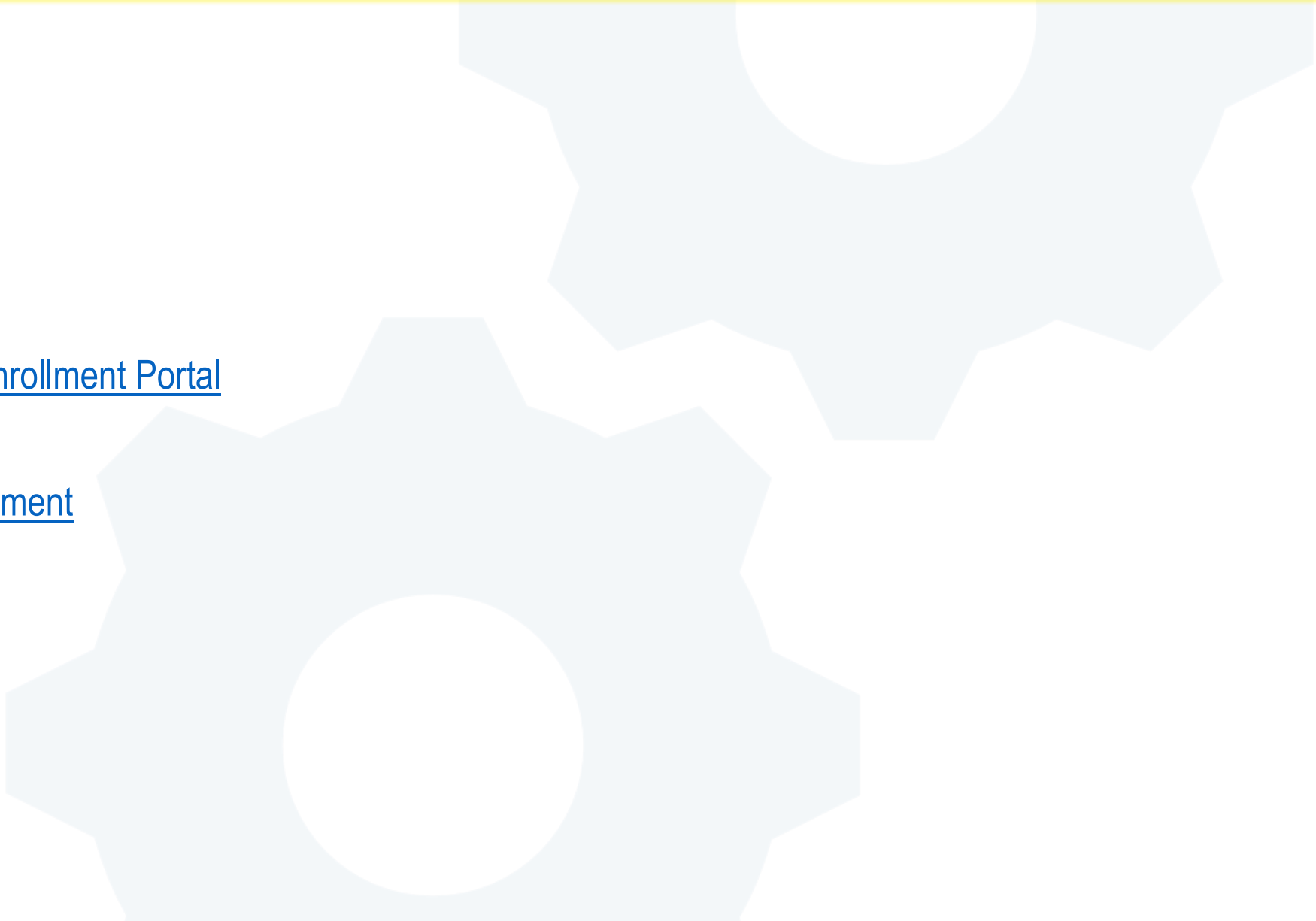
South Carolina

*BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross Blue Shield Association.*

Provider Relations and Education – Mission Statement

Provider Education and Relations' mission is to serve as liaisons between BlueCross BlueShield of South Carolina, BlueChoice HealthPlan, Healthy BlueSM and the health care community to promote positive relationships through continued education and problem resolution.


Topics

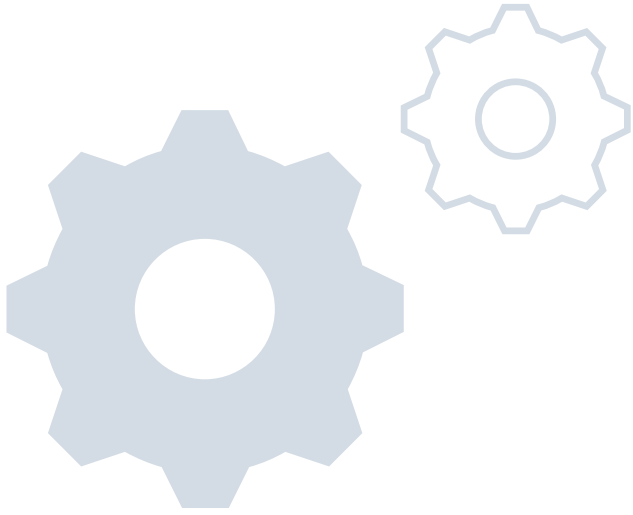
- [Authorizations](#)
 - [Benefits](#)
 - [Claims](#)
 - [Dental](#)
 - [Healthy BlueSM](#)
 - [My Provider Enrollment Portal](#)
 - [Pharmacy](#)
 - [Provider Enrollment](#)
 - [Quality](#)
 - [Web Tools](#)
- 

Authorizations



Agenda

- Authorizations 101
 - Authorization Tools
 - Special Programs
 - Upcoming Changes
 - Resources
- 
- The background of the slide features a decorative graphic of three interlocking gears. The gears are rendered in a light blue, semi-transparent style, giving them a subtle, watermark-like appearance. They are positioned in the lower half of the slide, with one gear in the foreground and two others behind it, creating a sense of depth and mechanical movement.



Authorizations 101



Authorizations 101

Overview

The health plan uses authorizations to determine whether a service is medically necessary, or if it is a covered benefit for the member.

Other terms for authorization

- Prior approval
- Precertification (or precert)

Note: Authorizations are not a guarantee of payment and requirements may vary per plan.

Authorizations 101

Services Requiring Authorization

The following services require authorization for most plans:

- Elective inpatient services (including maternity)
- Skilled nursing facility admission
- Home health and hospice
- DME when the purchase price or rental is \$XXX¹ or more
- Mental health and substance abuse
- High tech imaging² (MRIs, MRAs, CT Scans, PET Scans)
- Certain medications included under the medical benefit

¹ DME dollar thresholds vary per plan but are typically \$500 or \$1,000. Please note threshold amounts can be lower than \$500.

² These services are typically handled by NIA Magellan.

Always check benefits and eligibility for authorization requirements

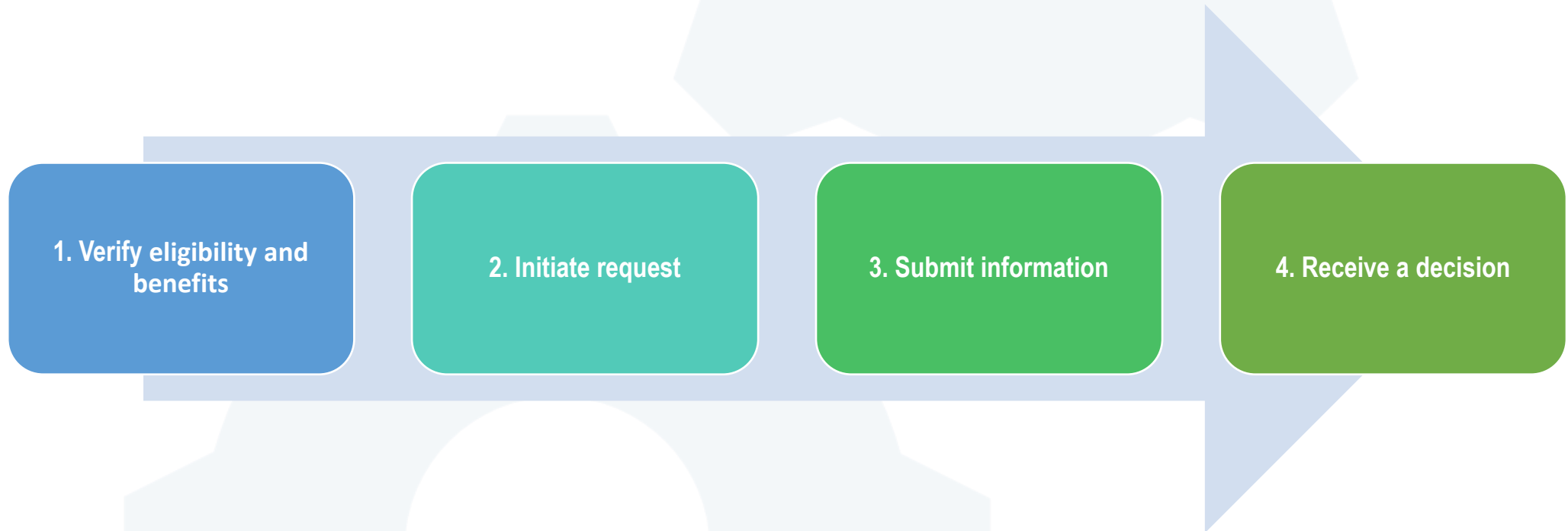
Authorizations 101

General Guidelines for Authorizations

- Submit elective requests prior to rendering services.
- Submit requests once and allow time for review.
- Services must be covered under the member's plan.
- Members must have active coverage at the time of request.
- Submit a notification of emergency admission within 24 – 48 hours of admission.
- Include the date of service on the appropriate forms.
- Mark requests as urgent **ONLY** when they are urgent.

Authorizations 101

Authorization Process



Authorizations 101

Authorization Methods

Authorizations can be requested using one of the following avenues:

- My Insurance ManagerSM - **Preferred**
 - Visit www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.
- Medical Forms Resource Center (MFRC) - **Preferred**
 - Visit www.SouthCarolinaBlues.com, www.BlueChoiceSC.com, or www.FormsResource.Center.
- Fax
 - Numbers located on fax form
- Phone
 - Check the member's ID card.
 - Phone requests should include:
 - MD and nurse's name.
 - Therapist's name (if the member is receiving therapy within 15 days of start of care and after evaluations).
 - BlueCross requires a signed Plan of Care (POC/485) within 30 days of start of care, per CAM 222.

Note: All methods listed are for South Carolina members.

Authorizations 101

Required Information for Authorizations

Patient Details

- Name, ID number and date of birth

Service Details

- CPT/HCPCS codes with correct units, diagnosis codes and MD orders

Location Details

- Name of facility, address and tax ID/NPI
- Name of rendering physician or office, address and tax ID/NPI

Contact Information

- Call back number and fax number

Date of Service

- Date when services are being rendered

Clinical Documentation

- How long the problem has been occurring, attempted treatments, conservative medications, studies (e.g., labs, imaging, assessments), etc.

Authorizations 101

Commonly Requested Authorizations

- Breast reductions
 - Clinicals should include height, weight, BMI and the number of grams to be removed.
- Hysterectomies
 - Clinicals should include recent imaging and conservative measures (or why they were not done).
- Surgeries
 - Clinicals should include attempted conservative therapies.
- Home Health
 - Clinicals should include:
 - MD/therapist name.
 - Treatment location.
 - Home health visit notes and homebound status.
 - Functional status for therapy.
 - Wound measurements, if applicable.



Authorization Tools



Authorization Tools

My Insurance Manager (MIM)

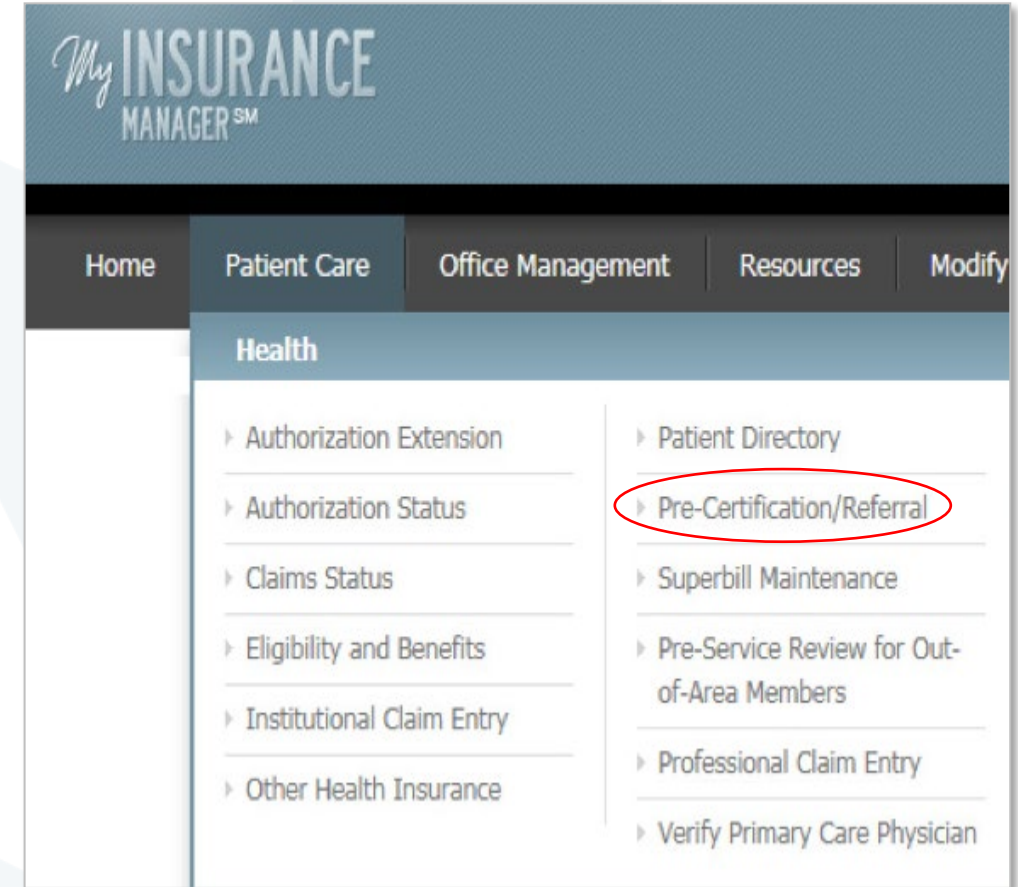
There are two options for obtaining authorizations through MIM:

Fast-Track

- Hundreds of available options
- Automated authorization number

Custom Request

- Allows specific details to be entered
- Authorization will pend for review; if approved, authorization number is provided



Note: MIM should be used for initial authorization requests. Please fax clinical documentation for updates or continued stay reviews.

Authorization Tools

My Insurance Manager (MIM) — Clinical Attachments

Clinicals are needed for authorization reviews. When prompted, be sure to:

- Select Attach Clinical Documentation.
- Upload file(s)
 - PDF format
 - 30 MB limit

The screenshot shows the 'Pre-Certification/Referrals' form in the My Insurance Manager (MIM) system. The form is divided into several sections:

- Header:** Navigation tabs (Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, Staff Directory) and user information (Welcome, YOUR NAME of YOUR PRACTICE/FACILITY, Log Out, Go to Message Center).
- Form Title:** Pre-Certification/Referrals (Printer-Friendly).
- Date of Service:** 02/13/2017.
- Insurance:** Plan Name: BlueCross BlueShield Plans, Member ID: ZCZ065922516805.
- Patient:** Patient's Name: MICHAEL TESTING, Date of Birth: 10/01/1958. A 'Change Patient' button is located below.
- Diagnosis Information:** A required section with a dropdown menu for selecting a diagnosis code. A note states: 'This transaction can only be associated with ICD-10 codes. If you are typing in a code, please verify it is a valid ICD-10 code.' Fields for 'Principal Diagnosis' and 'Date of Diagnosis' are present. A link 'Add Additional Diagnosis Codes' is available.
- Clinical Information:** A dropdown menu for entering a department identifier. A note states: 'If you need to identify the department within your organization that made this request, please enter a department identifier.' The dropdown is currently empty and has a character limit of 264.
- Attach Clinical Documentation:** A link with a document icon, circled in red, indicating where to click to upload clinical documentation.
- Service Type Selection:** Radio buttons for 'Institutional', 'Professional', and 'None'.
- Additional Patient Level Information:** Fields for 'From Event Date', 'To Event Date', and 'Discharge Date', each with a date picker and a format of mm/dd/yyyy.
- Footer:** 'Continue' or 'Back' buttons and a 'Start Over' link.

Authorization Tools

Medical Forms Resource Center (MFRC)

Complete requests in three easy steps:

1. Enter the facility and patient details.
2. Include all required clinicals.
3. Submit the request.

Benefits of using the MFRC:

- Offers various types of authorizations
- Guides you through the required documentation
- Receives priority processing

STEP 1
FACILITY & PATIENT INFORMATION

STEP 2
CLINICAL INFORMATION

STEP 3
COMPLETE FORM

Facility & Patient Information

Instructions:
Fields marked with an asterisk are required. The certification is not valid until you receive a certification number from us. All requests are subject to review. We may require additional documentation for some services. **Please print your request at the end of the submission process for your records.**

Facility Information

Facility's Name*

Attending MD First Name*

Attending MD Last Name*

Requesting MD First Name*

Requesting MD Last Name*

Phone*

Fax*

Facility's Tax I.D.* ?

Facility's NPI* ?

STEP 1
FACILITY & PATIENT INFORMATION

STEP 2
CLINICAL INFORMATION

STEP 3
COMPLETE FORM

Step 2 - Clinical Information

Instructions:
Fields marked with an asterisk are required. The certification is not valid until you receive a certification number from us. All requests are subject to review. We may require additional documentation for some services. **Please print your request at the end of the submission process for your records.**

Begin Date of Service*

End Date of Service*

CPT/HCPCS Codes

CPT/HCPCS Code*

[ADD ANOTHER](#)

Diagnosis Codes

Diagnosis Code*

[ADD ANOTHER](#)

Type of Service

Chemotherapy	+
Durable Medical Equipment	+
Home Health/Hospice	+
Admissions/Inpatient	+
LTAC/SNF/Rehab	+
Maternity	+
Medications	+
Office	+
Outpatient	+
Student Health Notification	+

Authorization Tools

Medical Forms Resource Center (Continued)

Examples of MFRC request

>*****HYSTERECTOMY*****<

DIAGNOSIS:
PELVIC PAIN

COMPREHESIVE EVALUATION?
FALSE

COMPREHENSIVE EVAL DETAILS:

LAPROSCOPIC, ENDOSCOPIC, OR IMAGING STUDIES?
TRUE

DETAILS OF STUDIES:
TV US PERFORMED 10/14/19

HOW LONG AS PAIN BEEN PRESENT?
YEARS BUT WORSENING LATELY PT FEELS DUE TO ESSURE COILS

DETAILS OF UTERINE SPARING TX:

SIGNATURE:

>*****BREAST REDUCTION*****<

GENDER: FEMALE

HEIGHT: 5'4

WEIGHT: 187

BMI: 36.3

BRA SIZE: 42 H

R BREAST VOLUME: 2400

L BREAST VOLUME: 2400

GRAMS TO REMOVE RIGHT: 600 GRAMS

GRAMS TO REMOVE LEFT: 600 GRAMS

NIPPLE POSITION R: 36 CM

NIPPLE POSITION L: 36 CM

ASSOCIATED SYMPTOMS: RASHES CONSTANTLY BETWEEN AND UNDER BREASTS,
NECK PAIN, SHOULDER PAIN, HEADACHES, BURNING SENSATIONS AND NUMBNESS
TO CERVICAL AND THORACIC ARE

DURATION OF SYMPTOMS: 2 YEARS

TREATMENTS TRIED: MEDICATIONS, PHYSICAL THERAPY, SPECIAL SUPPORT BRAS

SUPPORT BRA DURATION: 2 YEARS

MEDICATIONS TRIED: IBUPROFEN FOR 2 YEARS

PHYSICAL THERAPY DURATION: 12 WEEKS

IS THE PATIENT IN PAIN? YES|

PAIN SCALE: 8/10

SIGNATURE:

Authorization Tools

Fax Requests

When submitting requests via fax, include the Authorization Request Form or a coversheet with the following information:

Patient details (name, ID card number, and date of birth)

CPT/HCPCS and diagnosis codes

Provider location and date of service

Contact phone and fax number

To access this information:

Visit www.SouthCarolinaBlues.com and follow the path:
Providers>Prior Authorization>Precertification Request Form

For Mailing Images:

Focus Review/Health Care Services
I-20 @ Alpine Rd., AX-630
Columbia, SC 29219-0001

Authorization Tools

Fax Requests — Coversheet

Example of appropriate fax request coversheet

Required Information	Included?
Patient (Name, DOB and ID number)	Yes
Service (CPT and Diagnosis codes)	Yes
Location (Name, Address, Tax/NPI)	Yes
Contact (Phone and Fax number)	Yes
Date of Service	Yes

ABC Plastic Surgery
123 Alphabet St., Suite 150
Spartanburg, SC 29301
Phone 864-123-4567
Fax 864-987-6543

fax

TO: Authorizations FROM: Jimmy

FAX: 803-264-0183 PAGES: 3

PHONE: 800-334-7287 DATE: 1/24/2020

RE: Mighty Joe Young CC:

Urgent For Review Please Comment Please Reply Please Recycle

Comments:

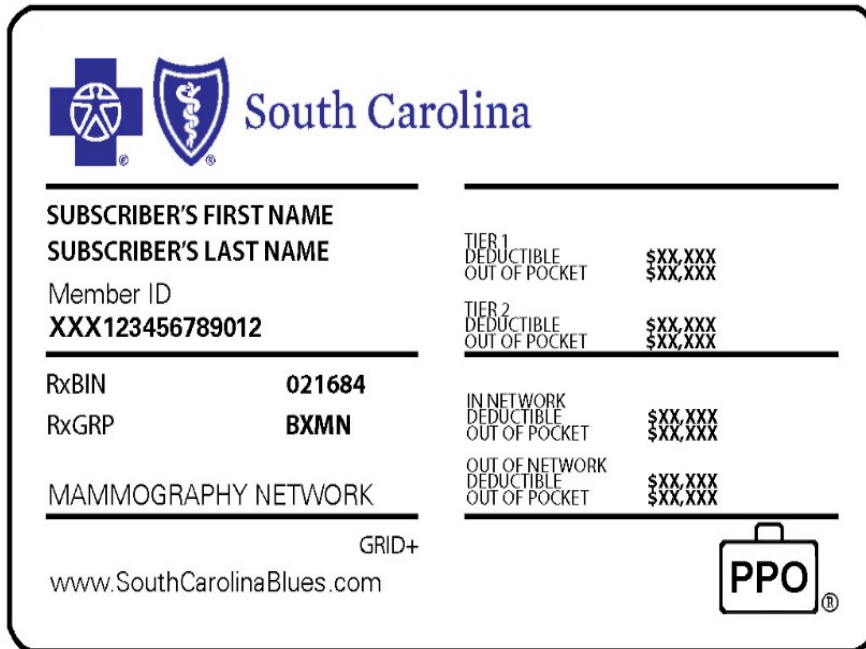
ID Number: ZYX0987654321
DOB: 11/14/2003
Outpatient Surgery, NPI 1472583690
Dr. Minnie Musketeer, NPI 3692581470
CPT Codes: 11446, 13152, 14060
DX Code: D23.22
DOS: 05/11/2020


Authorization Tools

Phone Requests

Contact the number on the back of the member's ID card.

Number will vary per plan.



 South Carolina

SUBSCRIBER'S FIRST NAME
SUBSCRIBER'S LAST NAME

Member ID
XXX123456789012


RxBIN **021684**
RxGRP **BXMN**

MAMMOGRAPHY NETWORK

GRID+

www.SouthCarolinaBlues.com

TIER 1 DEDUCTIBLE	\$XX,XXX
OUT OF POCKET	\$XX,XXX
TIER 2 DEDUCTIBLE	\$XX,XXX
OUT OF POCKET	\$XX,XXX
IN NETWORK DEDUCTIBLE	\$XX,XXX
OUT OF POCKET	\$XX,XXX
OUT OF NETWORK DEDUCTIBLE	\$XX,XXX
OUT OF POCKET	\$XX,XXX





 South Carolina

www.SouthCarolinaBlues.com

Providers: File claims with the local BlueCross and/or BlueShield Plan where member received services. Preauthorization required for some hospital outpatient procedures and all hospital inpatient admissions. MRI/MRA/PET/CT and radiation oncology therapy will require authorization to ensure benefit payment. "Buy and Bill" specialty drugs require precertification for benefit payment consideration.

Report all emergency admissions within 24 hours.

Medical & Dental - Please submit claims to:
P.O. Box 100300, Columbia, SC 29202

Customer Service: **800-760-5000**
Dental Customer Service: **800-222-7156**
PPO Network Providers: **800-810-2583**
Essential AdvocateSM: **855-638-5899**
Precertification: **800-334-7287**
Mental Health and Substance Abuse Precertification: **800-868-1032**
EyeMed: **866-939-3633**
Pharmacy Help Desk: **855-811-2218**
Buy and Bill Drugs-Precertification: **877-440-0089**

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MTR

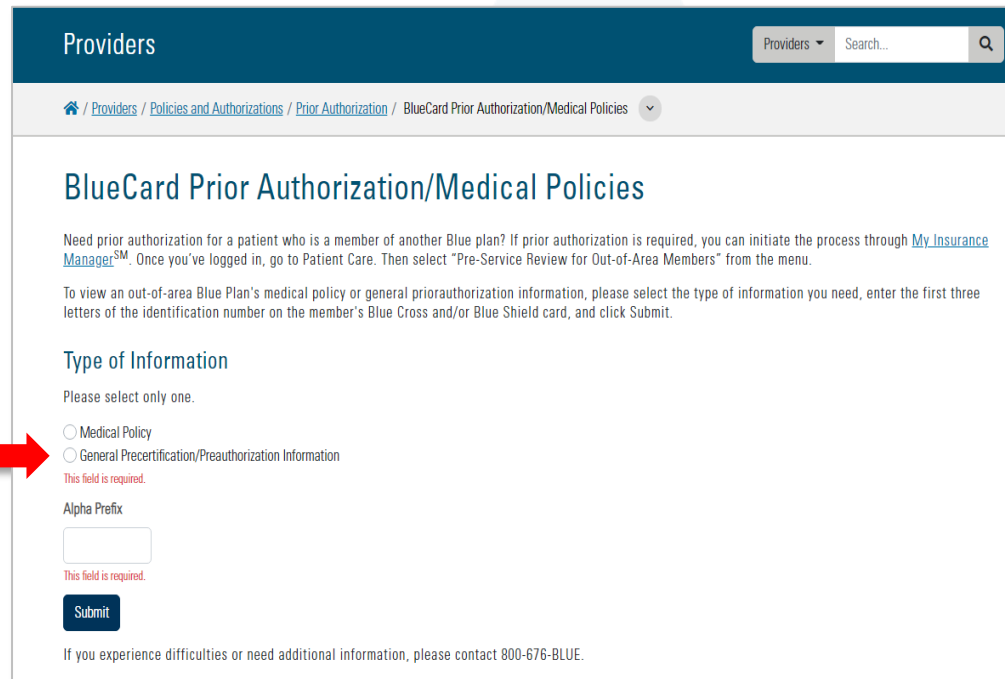
Note: Phone requests should include the MD and nurse's name. The therapist's name is needed if the member is receiving therapy within 15 days of start of care and after evaluations. BlueCross requires a signed Plan of Care (POC/485) within 30 days of start of care, per CAM 222.

Authorization Tools

BlueCard Prior Authorization Lookup

Authorizations for **out-of-state members** can be verified and obtained in two steps:

1. Use the BlueCard Prior Authorization Tool.
2. Initiate the authorization through My Insurance Manager.



Providers Providers

[Home](#) / [Providers](#) / [Policies and Authorizations](#) / [Prior Authorization](#) / [BlueCard Prior Authorization/Medical Policies](#)

BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate the process through [My Insurance Manager](#). Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the menu.

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information you need, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

Type of Information

Please select only one.

Medical Policy

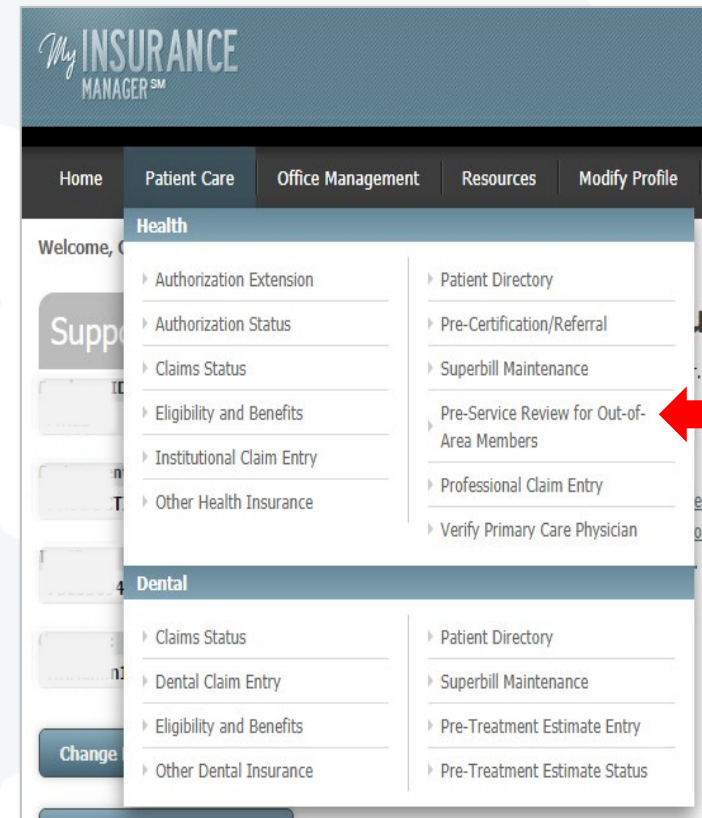
General Precertification/Preauthorization Information

This field is required.

Alpha Prefix

This field is required.

If you experience difficulties or need additional information, please contact 800-676-BLUE.



My INSURANCE MANAGER

Home Patient Care Office Management Resources Modify Profile

Welcome, Support

Health

- Authorization Extension
- Authorization Status
- Claims Status
- Eligibility and Benefits
- Institutional Claim Entry
- Other Health Insurance
- Patient Directory
- Pre-Certification/Referral
- Superbill Maintenance
- Pre-Service Review for Out-of-Area Members
- Professional Claim Entry
- Verify Primary Care Physician

Dental

- Claims Status
- Dental Claim Entry
- Eligibility and Benefits
- Other Dental Insurance
- Patient Directory
- Superbill Maintenance
- Pre-Treatment Estimate Entry
- Pre-Treatment Estimate Status



Special Programs



Special Programs

Third-party vendors that manage select authorizations for certain plans include:

- NIA Magellan
- Avalon Healthcare Solutions
- Specialty Pharmacy Manager (MBMNow)
- Companion Benefit Alternatives (CBA)

Note: These are independent organizations that offer utilization management on behalf of BlueCross and BlueChoice.

Special Programs

NIA Magellan

Types of authorization for most plans:

- Radiation Oncology
- Advanced Radiology
- Musculoskeletal Care (MSK)

To request an authorization:

- Visit www.RadMD.com.
- Call 866-500-7664 for BlueCross members.
- Call 888-642-9181 for BlueChoice members.

Magellan
HEALTHSM

Special Programs

Avalon Healthcare Solutions



Authorizations for lab services in the following settings:

- Office
- Outpatient facility
- Independent laboratory

To request an authorization:

- Prior Authorization System (PAS) through My Insurance Manager
- Phone: 844-227-5769
- Fax: 813-751-3760

Note: Avalon does not review requests for services provided in an emergency room, ambulatory surgery center or hospital inpatient place of service.

Special Programs



**LEVERAGING LAB VALUE INSIGHTS TO IMPACT CKD EARLY
DETECTION, CARE OUTCOMES, AND COSTS**



John Campbell, MD
AVP, Commercial
Clinical Operations &
Sr. Medical Director,
Blue Cross NC



Sherry Mullies
Strategic Planning &
Performance, Manager
Vendor Strategy, Blue
Cross NC



**Nate Henderson,
DO, FACP**
Chief Medical Officer &
VP, Clinical Quality,
BCBSSC



Bart Strickland
VP, Provider Services
& Health Care
Systems, BCBSSC

TIME  2 - 3 p.m. EDT **DATE**  Tuesday, September 19

REGISTER NOW



Recording and slides are available at:

[Webinars — Avalon Healthcare Solutions
\(avalonhcs.com\)](https://www.avalonhcs.com)

Avalon hosted a panel of experts from the health insurance industry to discuss the management of chronic kidney disease (CKD) through lab values, which can provide early identification and intervention:

- How Lab Value Insights can help health plans achieve improved value-based outcomes and reduce costs
- The significance of using actionable insights to inform and enhance CKD care management programs
- Lessons learned and next steps for leveraging Lab Values Insights for CKD & and beyond

Special Programs

Avalon and Healthy Blue join forces to deliver quality care beginning Jan. 1, 2024



The screenshot shows the Healthy Blue website homepage. At the top, there is a blue navigation bar with the Healthy Blue logo (a cross and a shield) and the text "Healthy Blue BlueChoice® HealthPlan of SC" on the left, and "Healthy Connections" with a colorful arrow icon on the right. Below the navigation bar, there are links for "Benefits", "Apply", "Care", and "Get Help" on the left, and "A A A", "Español", "Login", "Contact Us", "Providers", and a search icon on the right. The main content area features the heading "Welcome to Healthy Blue" above a large photograph of a smiling family (a man, a woman, and a child). Below the photo is a row of four service links: "FIND A DOCTOR" with a magnifying glass icon, "HOW TO ENROLL" with a plus sign icon, "HOW TO RENEW" with a circular refresh icon, and "GET YOUR ID CARD" with a card icon. At the bottom of the page, the text "Serving South Carolina Medicaid members" is displayed.

Special Programs

MBMNow

- Authorizations for specialty medications
- Medication lists are available online

To request an authorization:

- Access MBMNow through My Insurance ManagerSM
- Phone: 877-440-0089
- Fax: 612-367-0742



BlueCross BlueShield of South Carolina

Special Programs

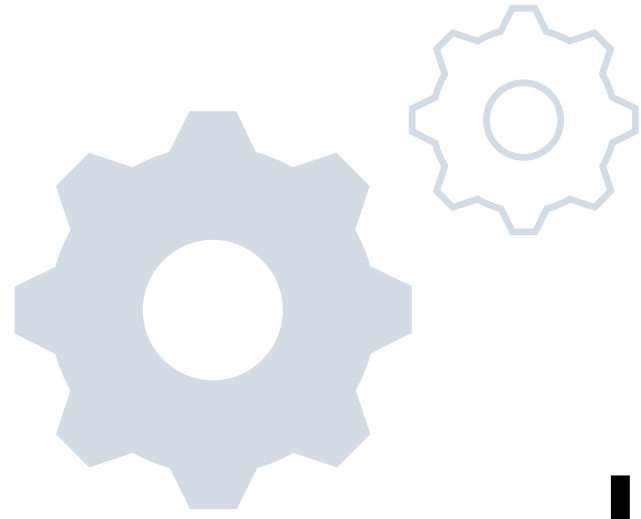
Companion Benefit Alternatives (CBA)

- Authorizations for behavioral health services.
- Examples of services that typically require authorization include:
 - Psychological testing.
 - Behavioral health program admissions.
 - Repetitive transcranial magnetic stimulation (rTMS).

To request an authorization:

- Visit www.CompanionBenefitsAlternatives.com and use the Forms Resource Center.
- Phone: 800-868-1032





Upcoming Changes



Upcoming Changes

Standardized Prior Authorization List

- In 2024, BlueCross will implement a standardized prior authorization list, which will include services that will require prior authorization regardless of the place of service.
- The list will include the highest volume and most common services or procedures requested by providers that could be deemed not medically necessary, investigational or cosmetic.

Plans that will be included are:

- Major Group (fully insured and administrative service only)
- Small Group and Individual
- National Alliance

Plans that will not be included are:

- BlueChoice® HealthPlan
- Exchange (Marketplace)
- Healthy BlueSM
- Medicare Advantage
- Federal Employee Program (FEP)

Upcoming Changes

Standardized Prior Authorization List (Continued)

Medical services that require prior authorization:

- Cardiac rehabilitation
- Cosmetic services
- DME (determined by dollar threshold of the plan)
- Enteral formula
- And more.

Behavioral health services that require prior authorization:

- Applied Behavioral Analysis (ABA therapy)
- Electroconvulsive Therapy (ECT)
- Intensive outpatient treatment
- Partial hospitalization
- Psychological testing

Note: These lists are not all inclusive.



Resources



Resources

Benefit Program	Authorization Service	Web-based Requests	Telephone Requests	Fax Requests
BlueCross	[various]	My Insurance Manager and MFRC	800-334-7287	803-264-0258 (Utilization Management) 803-264-0259 (Case Management)
BlueChoice	[various]	My Insurance Manager and MFRC	800-950-5387	800-610-5685
FEP	[various]	My Insurance Manager and MFRC	800-327-3238	N/A
Healthy Blue SM	[various]	My Insurance Manager and MFRC	866-757-8286	803-870-6500
State Health Plan (Medi-Call)	[various]	My Insurance Manager and MFRC	800-925-9724	803-264-0183
Avalon	Laboratory	Avalon PAS (inside My Insurance Manager)	844-227-5769	813-751-3760
CBA	Behavioral/Substance Abuse	www.CompanionBenefitAlternatives.com	800-868-1032	803-714-6456
NIA Magellan	<ul style="list-style-type: none"> • Advanced Radiology • Musculoskeletal Care • Radiation Oncology 	www.RadMD.com	BlueCross: 866-500-7664 BlueChoice: 888-642-9181	888-656-1321
MBMNow	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742

Resources

Peer-to-Peer Requests

Initiating Requests and Checking Statuses

Medical Forms Resource Center

- Visit www.FormsResource.Center.
- Select Request a Peer-to-Peer Discussion.
- Enter all pertinent details.
- Submit.

South Carolina Website

- Visit www.SouthCarolinaBlues.com.
Providers>Forms>Other Forms>Peer-to-Peer Request
- Enter all pertinent details (and save the document).
- Email the form to Peer.Medical@bcbsc.com or fax to 803-264-9175.

Phone (for statuses and eligibility only)

- Call 803-264-8114
Available Monday - Friday
8:30 a.m. – 5:00 p.m. EST

Required Criteria

- Medical necessity adverse decision was received, along with health plan denial
- Requested within two business days of the denial for inpatient or continued stay requests or five business days for all other denials
- Requested prior to an appeal

Resources

Peer-to-Peer Requests (Continued)

Clinical Discussion

- Facilitated within one business day of receipt of request
- Our medical doctor makes two attempts to contact the rendering provider
- A decision is rendered at the end of the call

Resources

Utilization Management (UM) Courtesy Re-evaluations

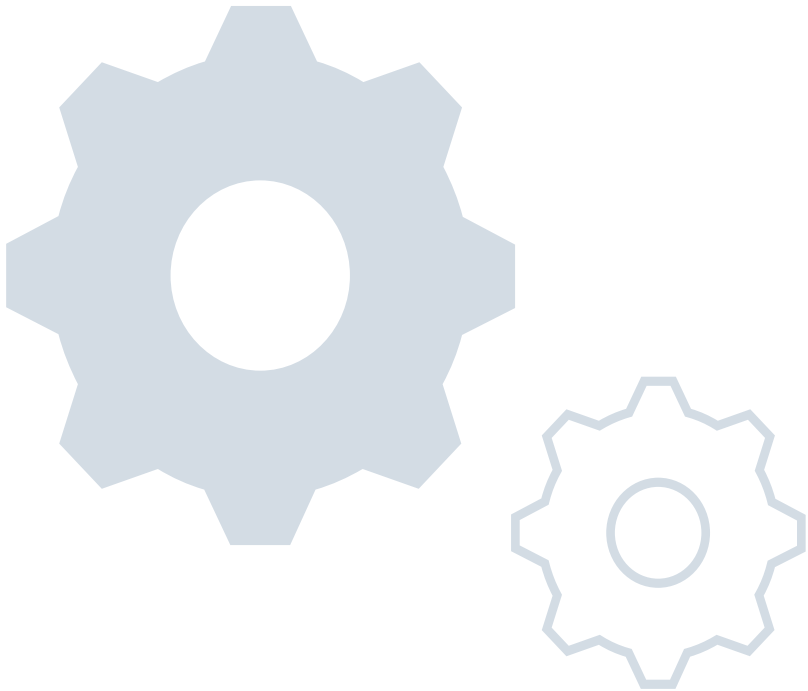
UM courtesy re-evaluations are permitted for denials that are due to the following:

- No clinical information submitted
- Insufficient clinical information submitted


To request a UM courtesy review, you must:

- Specify the request is for a re-evaluation upon submission (via fax).
- Submit clinical documentation within five business days of the denial notice.

Benefits



Agenda

- 2024 Benefits
 - What's New?
 - Benefit Reminders
 - Resources
- 
- The background features two large, light blue gears. One gear is positioned in the upper right quadrant, and the other is in the lower left quadrant. They are rendered in a semi-transparent style, allowing the white background to show through. The gears are interlocking, with the teeth of one gear fitting into the spaces between the teeth of the other.



2024 Benefits





Preferred Blue



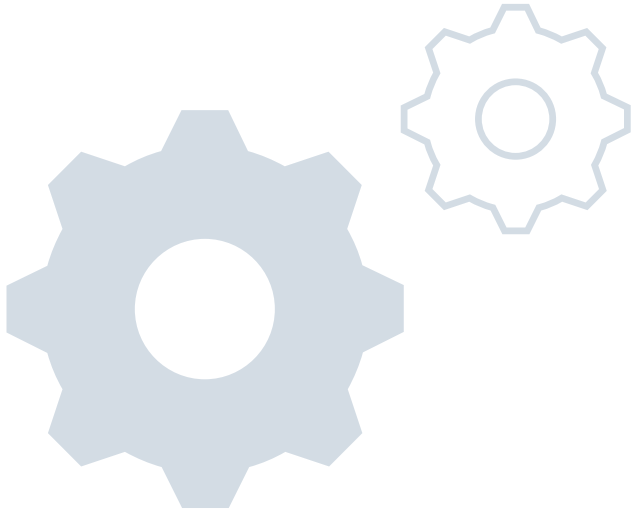
2024 Benefits

Preferred Blue

New Groups — Effective Jan. 1, 2024

Group Name	Prefixes
Spirax Sarco	• IIY
VELUX	• SJS
Vermeer	• SJS

Always verify benefits and eligibility prior to rendering services.
Use My Insurance ManagerSM (MIM) or call 800-868-2510.



State Health Plan



2024 Benefits

State Health Plan

Standard Plan	2023	2024
Deductibles		
Individual	\$515	No change
Family	\$1,030	No change
Coinsurance Maximum		
Individual (INN)	\$3,000	No change
Family (INN)	\$6,000	No change
Individual (OON)	\$6,000	No change
Family (OON)	\$12,000	No change
Services		
Office visits	\$15 copay	No change
Outpatient facility	\$115 copay	No change
Emergency room	\$193 copay	No change
Cardiac and pulmonary rehabilitation	\$15 copay	No change

2024 Benefits

State Health Plan

Savings Plan	2023	2024
Deductibles		
Individual	\$4,000	No change
Family	\$8,000	No change
Coinsurance Maximum		
Individual (INN)	\$3,000	No change
Family (INN)	\$6,000	No change
Individual (OON)	\$6,000	No change
Family (OON)	\$12,000	No change
Services		
Office visits	Full allowance until the deductible is met. Then, the coinsurance.	No change
Outpatient facility	Full allowance until the deductible is met. Then, the coinsurance.	No change
Emergency room	Full allowance until the deductible is met. Then, the coinsurance.	No change

2024 Benefits

State Health Plan

MUSC Plan	2023	2024
Deductibles		
Individual	\$385	No change
Family	\$770	No change
Coinsurance Maximum		
Individual (INN)	\$2,200	No change
Family (INN)	\$4,400	No change
Services		
Office visits	PCP: \$25 copay Specialist: \$45 copay	No change
Outpatient facility surgery	\$290 copay	No change
Outpatient facility radiology (regular and advanced)	\$85 copay	No change
Inpatient facility	\$0	No change
Emergency room	\$193 copay	No change
Urgent care	\$85 copay	No change
Cardiac and pulmonary rehabilitation	\$15 copay	No change

2024 Benefits

State Health Plan

Dependent Contraception

- Effective May 25, 2023: Standard, Savings and MUSC Plans
 - The State Health Plan began covering birth control at no member cost-share for primary members covered as child dependents.

Well Woman Visit

- Effective Jan. 1, 2024: Standard and Savings Plans
 - The State Health Plan will cover one well woman visit each year at no member cost-share for non-Medicare primary adults aged 19 and older who are covered under the Standard or Savings plan.
 - The well woman visit is in addition to the annual adult well visit.

2024 Benefits

State Health Plan

Reminders

- Routine and Diagnostic Colonoscopies
 - Covered at 100 percent for State Health Plan primary members, once every 10 years for aged 45 and older when rendered by an eligible in-network provider and follows the criteria listed in the United States Preventive Services Task Force (USPSTF)
- Cologuard
 - Covered at 100 percent, once every three years when rendered by an eligible in-network provider for aged 45 and older
 - Applies to the Savings, Standard, or MUSC plan (not Medicare as primary)
 - Must use in-network provider
 - Additional charges will apply for non-generic prep kit
- Patient Centered Medical Home (PCMH) for Standard and High Deductible Health Plan (HDHP)
 - Office visit copay is waived for PCMH in-person visits and subject to a 10 percent COINS after the deductible is met.
 - PCMH incentives do not apply to telehealth services

2024 Benefits

State Health Plan

Prior Authorizations

- Medical Services
 - Medi-Call: 800-925-9724
- Advanced Radiology
 - National Imaging Associates (NIA): 866-500-7664
- Behavioral Health Services
 - Companion Benefit Alternatives (CBA): 800-868-1032
- Pharmacy Specialty Drug
 - Express Scripts: 855-612-3128
- Medical Specialty Drug
 - MBMNow: 877-440-0089
- Laboratory Services
 - Avalon Healthcare Solutions: 844-227-5769

Always verify benefits and eligibility prior to rendering services.
Use My Insurance ManagerSM (MIM) or call 800-444-4311.



Federal Employee Program



2024 Benefits

Federal Employee Program

Blue Focus — No out of network benefits available	2023	2024
Deductibles		
Individual	\$500	No change
Self — Plus One	\$1,000	No change
Family	\$1,000	No change
Out-of-Pocket Maximum		
Individual	\$8,500	\$9,000
Self — Plus One	\$17,000	\$18,000
Family	\$17,000	\$18,000
Services		
Office visits (Includes primary and/or specialty care combined)	\$10 copay (first 10 visits)	No change
Telehealth	\$0 copay (first two visits) \$10 copay (all additional visits)	No change
Chiropractic care	\$25 copay up to 10 visits	No change

2024 Benefits

Federal Employee Program

Blue Focus — No out of network benefits available.	2023	2024
Services (Continued)		
Urgent care	\$25 copay	No change
Hospital care — Inpatient (prior authorization required)	30% COIN + BYD	No change
Hospital care — Outpatient	30% COIN + BYD	No change
ER — Accidental injury (within 72-hours)	\$0 copay	No change
ER — Medical emergency	30% COIN + BYD	No change

Note: For a full list of benefits and updates, please visit <https://www.fepblue.org/open-season/whats-new-2024>.

2024 Benefits

Federal Employee Program

Standard	2023	2024
Deductibles		
Individual	\$350	No change
Family	\$700	No change
Out-of-Pocket Maximum		
Individual (INN)	\$6,000	No change
Family (INN)	\$12,000	No change
Services		
Physician care (INN)	\$25 copay (PCP) \$35 copay (specialist)	\$30 copay (PCP) \$40 copay (specialist)
Telehealth (INN)	\$0 copay (first two visits) \$10 copay (additional visits)	No change
Urgent care — Accidental injury	\$0 copay	No change
Urgent care — Medical emergency	\$30 copay	No change

2024 Benefits

Federal Employee Program

Standard	2023	2024
Services (Continued)		
Preventive care (INN)	\$0 copay	No change
Chiropractic care (INN)	\$25 copay up to 12 visits	\$30 copay up to 12 visits
Hospital care — Inpatient (prior authorization required) (INN)	\$350 copay Per admission	No change
Hospital care — Outpatient (INN)	15% COINS + BYD	No change
ER — Accidental injury (within 72-hours) (INN)	\$0 copay	No change
ER — Medical emergency (INN)	15% COINS + BYD	No change

Note: For a full list of benefits and updates, please visit <https://www.fepblue.org/open-season/whats-new-2024>.

2024 Benefits

Federal Employee Program

Basic	2023	2024
Deductibles		
Individual	\$0	No change
Family	\$0	No change
Out-of-Pocket Maximum		
Individual (INN)	\$6,500	No change
Family (INN)	\$13,000	No change
Services		
Physician care	\$30 copay (PCP) \$40 copay (Specialist)	\$35 copay (PCP) \$45 copay (Specialist)
Telehealth	\$0 copay (first two visits) \$15 copay (additional visits)	No change
Chiropractic care	\$30 copay up to 20 visits	\$35 copay up to 20 visits
Urgent care	\$35 copay	No change

2024 Benefits

Federal Employee Program

Basic	2023	2024
Services (Continued)		
Preventive care	\$0 copay	No change
Hospital care — Inpatient (prior authorization required)	\$250 copay, per day Up to \$1,500 per admission	No change
Hospital care — Outpatient	\$150 copay Per day, per facility	No change
ER — Accidental injury	\$250 copay Per day, per facility	No change
ER — Medical emergency	\$250 copay Per day, per facility	No change

Note: For a full list of benefits and updates, please visit <https://www.fepblue.org/open-season/whats-new-2024>.

2024 Benefits

Federal Employee Program

Blue Focus, Standard, and Basic	2023	2024
Adult Preventive Care		
<ul style="list-style-type: none">• Colorectal cancer tests, including:<ul style="list-style-type: none">– Fecal occult blood test– Colonoscopy, with or without biopsy Sigmoidoscopy– Double contrast barium enema– DNA analysis of stool samples• Prostate cancer tests — Prostate Specific Antigen (PSA) test• Cervical cancer tests (including pap tests)• Screening mammograms (including mammography using digital technology)	<p>Preventive care benefits for each of the following services listed are limited to one per calendar year.</p> <p>Pathology for Sigmoidoscopy and colonoscopy covered at 100 percent under preventive benefits.</p>	<p>No change</p>



BlueChoice



2024 Benefits

BlueChoice

Reminders

- Verify eligibility and benefits
 - Verify eligibility and benefits via My Insurance ManagerSM (MIM) or by calling Provider Services.
 - Should be completed prior to rendering services
 - Providers should not ask members to call in to check the costs of procedure codes
- Verify prior authorization (PA) requirements
 - Verify PA by checking the physician office manual or calling Health Care Services.
 - Providers should not ask members to verify PA requirements.
- Benefits for continuous glucose monitors
 - May fall under pharmacy or medical (durable medical equipment), depending on the member's plan

2024 Benefits

BlueChoice

Reminders (Continued)

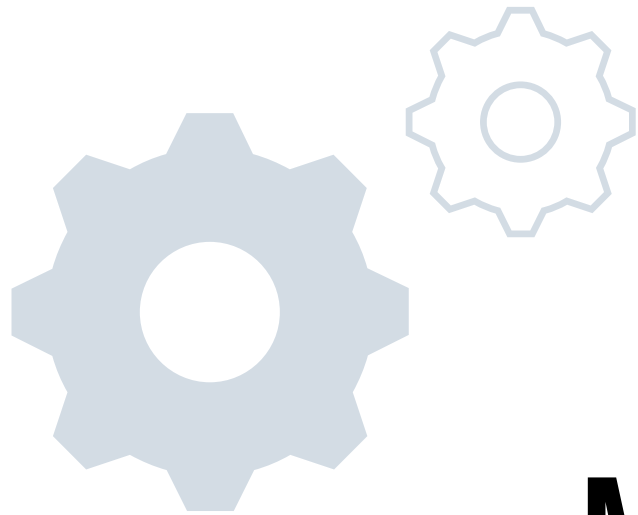
- Check drug lists to ensure medications are covered
 - Submit clinical information (including any similar medications tried and the member's reaction) along with the authorization request to avoid processing delays.
- Obesity related services are not covered
 - Considered a contract exclusion
- Referral forms
 - Referral forms must be completed for patients and can be submitted by:
 - Faxing the referral form to 800-610-5685 or 803-714-6463
 - Form can be located on www.BlueChoiceSC.com
 - Completing the referral through MIM

2024 Benefits

BlueChoice

Reminders (Continued)

- Submit claims within a timely manner
 - Timely filing limit for original claims is 180 days from the date of service.
 - Timely filing limit for corrected claims is one year from the date of service.
- Balance billing
 - Network participating providers should not bill patients more than their liability.
 - Remittances can be located on MIM.



Medicare Advantage



2024 Benefits

Medicare Advantage

BlueCross Total	2023	2024
Deductibles		
In-network & Out-of-network	\$0	No change
Out-of-Pocket Maximum		
From in-network providers:	\$6,500	\$6,900
From in-network and out-of-network providers combined	\$10,000	No change
Services		
Outpatient office visits	INN — \$0 copay (PCP) INN — \$30-40 copay (Specialist) OON — \$30 copay (PCP) OON — \$55 copay (Specialist)	INN — No change (PCP) INN — \$25 (Specialist) OON — No change (PCP) OON — No change (Specialist)
Inpatient hospital — acute	INN — \$350 copay, per day (1-4) INN — \$0 copay, per day (5-90) OON — 30% COINS for total stay	INN — \$300 copay, per day (1-4) INN — No change (5-90) OON — No change
Inpatient hospital — psychiatric	INN — \$624 copay, per day (1-4) INN — \$0 copay, per day (5-90) OON — 40% COINS for total stay	INN — \$645 copay, per day (1-4) INN — No change (5-90) OON — No change

2024 Benefits

Medicare Advantage

BlueCross Total	2023	2024
Services (Continued)		
Skilled nursing facility (SNF)	INN — \$0 (days 1-20) INN — \$196 copay (days 21-100) OON — 40% COINS for total stay	INN — No change (days 1-20) INN — \$203 copay (days 21-100) OON — No change
Urgently needed services	INN & OON - \$50 copay, per visit	INN & OON - \$55 copay, per visit
Worldwide Emergency/Urgent Coverage	\$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Ambulance services (Ground or air)	INN & OON — \$295 copay, per trip	No change
Hearing aids	\$699-\$999 using TruHearing Two per year (one per ear)	No change
Preventive dental (Fluoride treatment not covered)	INN — \$0 copay (two, per year) OON — 50% COINS \$3,000 maximum (combined)	No change \$3,500 maximum (combined)
Comprehensive dental (Medicare covered services)	INN — \$50 copay OON — 40% COINS \$3,000 maximum (combined)	INN — No change OON — No change \$3,500 maximum (combined)
Comprehensive dental (non-covered Medicare services)	INN & OON — 50% COINS \$1,000 benefit maximum \$3,000 maximum (combined)	No change \$3,500 maximum (combined)

2024 Benefits

Medicare Advantage

BlueCross Total Value	2023	2024
Deductibles		
In-network & Out-of-network	\$0	No change
Out-of-Pocket Maximum		
In-network	\$6,900	\$7,900
Out-of-network	\$11,000 (Midlands/Coastal) \$11,300 (Upstate/Lowcountry)	\$11,300
Services		
Outpatient office visits	INN — \$0 copay (PCP) INN — \$30 copay (Specialist) OON — \$40 copay (PCP) OON — \$55 copay (Specialist)	No change
Inpatient hospital — acute	Midlands/Coastal INN \$350 copay per days 1-5 Upstate/Lowcountry INN \$375 copay per days 1-5 OON — 50% of total cost	INN — \$350 copay per day (1-4) Midlands/Coastal/Upstate OON — 20% COINS of total cost Lowcountry OON — 50% COINS of total cost
Inpatient hospital — psychiatric	INN — \$624 copay, per day (1-3) OON — 50% COINS for total stay	INN — \$645 copay per day (1-3) Midlands/Coastal OON — 20% COINS of total cost Upstate/Lowcountry OON — 50% COINS of total cost

2024 Benefits

Medicare Advantage

BlueCross Total Value	2023	2024
Services (Continued)		
Skilled nursing facility (SNF) (100 benefit day max, per year)	INN — \$0 (days 1-20) INN — \$196 copay (days 21-100) OON — 50% COINS for total stay	INN — No change (days 1-20) INN — \$203 copay (days 21-100) OON — No change
Emergency care	INN and OON — \$95 copay, per visit	INN and OON — \$100 copay, per visit
Worldwide emergency	\$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Urgent care	\$50 copay	\$55 copay
Ambulance services (Ground or air)	INN — \$285 per one way trip OON — \$295 per one way trip	INN and OON — \$295 per one way trip
Hearing aids	\$699-\$999 using TruHearing Two per year (one per ear)	No change
Preventive dental	INN — \$0 copay (two visits per year) OON — 50% COINS \$2,000 maximum (combined)	No change
Comprehensive dental (Medicare covered services)	INN & OON — \$50 copay \$2,000 maximum (combined)	No change
Comprehensive dental (non-covered Medicare services)	INN & OON — 50% COINS \$500 benefit maximum \$2,000 maximum (combined)	No change

2024 Benefits

Medicare Advantage

BlueCross Secure — No out-of-network benefits.	2023	2024
Deductibles		
In-network	\$0	No change
Out-of-Pocket Maximum		
In-network	\$6,500	No change
Services		
Office visits	INN — \$0 copay (PCP) INN — \$30 copay (Specialist)	INN — No change (PCP) INN — \$35 copay (Specialist)
Inpatient hospital — acute	INN — \$325 copay, per day (1-6) INN - \$0 copay (7-90)	No change
Inpatient hospital — psychiatric	INN — \$624 copay, per day (1-3) INN — \$0 copay (4-90)	INN — \$645 copay, per day (1-3) INN — No change (4-90)
Skilled nursing facility (SNF)	INN — \$0 copay (days 1-20) INN — \$196 copay (days 21-100)	INN — No change (days 1-20) INN — \$203 copay (days 21-100)
Urgently needed services	INN — \$40 copay, per visit	INN — \$45 copay, per visit
Emergency care	\$95 copay, per visit (Waived if admitted within 24 hours)	No change

2024 Benefits

Medicare Advantage

BlueCross Secure — No out-of-network benefits.	2023	2024
Services (Continued)		
Worldwide Emergency/Urgent Coverage	\$250 service specific deductible, then 35% COINS for emergency care outside the United States	No change
Ambulance services (ground or air)	INN — \$285 per trip	No change
Hearing aids	\$699-\$999 using TruHearing Two per year (one per ear)	No change
Preventive dental	Not covered	No COINS or Copay for: 2 oral exams, per year 2 cleanings, per year 1 dental x-ray, per year
Comprehensive dental (Medicare covered services)	INN — \$50 copay	No change

2024 Benefits

Medicare Advantage

BlueCross Blue Basic	2023	2024
Deductibles		
In-network and Out-of-network	\$0	No change
Out-of-Pocket Maximum		
In-network	\$6,000	\$5,900
Out-of-network	\$10,000	\$9,550
Services		
Outpatient office visits	INN — \$0 copay (PCP) INN — \$35 copay (Specialist) OON — \$30 copay (PCP) OON — \$45 copay (Specialist)	No change
Inpatient hospital — acute	INN — \$325 copay, per day (1-6) INN — \$0 copay, per day (7-90) OON — 30% COINS for total stay	INN — No change (1-6) INN — No change (7-90) OON — 20% COINS for total stay
Inpatient hospital — psychiatric	INN — \$624 copay, per day (1-3) OON — 30% COINS for total stay	INN — \$645 copay, per day (1-3) OON — 20% COINS for total stay

2024 Benefits

Medicare Advantage

BlueCross Blue Basic	2023	2024
Services (Continued)		
Skilled nursing facility (SNF)	INN — \$0 copay (days 1-20) INN — \$196 copay (days 21-100) OON — 30% COINS for total stay	INN — No change (days 1-20) INN — No change (days 21-100) OON — 20% COINS for total stay
Urgently needed services	INN and OON — \$40 copay	No change
Emergency care	\$90 copay, per visit (Waived if admitted within 24 hours)	No change
Worldwide Emergency/Urgent Coverage	\$250 service specific deductible, then 20% COINS for emergency care outside the United States.	No change
Ambulance services (ground or air)	INN and OON — \$275 per trip	No change

2024 Benefits

Medicare Advantage

BlueCross Blue Basic	2023	2024
Services (Continued)		
Hearing Aids	\$699-\$999 using TruHearing 2 per year (one per ear)	No change
Preventive Dental (fluoride treatment not covered)	INN and OON — \$0 copay (Two per year) \$1,000 maximum (combined)	INN and OON — No change (Two per year) \$2,000 maximum (combined)
Comprehensive Dental (Medicare covered services)	INN — \$50 copay OON — 30% COINS \$1,000 maximum (combined)	INN — No change OON — 20% COINS \$2,000 maximum (combined)
Comprehensive dental (non-covered Medicare services)	INN and OON — 50% COINS \$1,000 benefit maximum	No change \$2,000 maximum (combined)

2024 Benefits

Medicare Advantage

All Plans (Total, Total Value, Secure, & Blue Basic)	2023	2024
Services		
Annual wellness visit/annual physical	\$0 Copay	No change
Lab work	\$0 copay	No change
Preventive screenings: <ul style="list-style-type: none">• Colorectal cancer screening• Breast cancer screening• Bone mineral density tests• Diabetic eye exam• Eyeglasses and frames• Glaucoma screening	\$0 Copay	No change

2024 Benefits

Medicare Advantage

Value-added benefits

- FitOn Health
 - A flexible health and fitness benefit with monthly credits to use on a nationwide network of gyms, local fitness studios or community centers.
 - Credits can be used to cover a variety of options — monthly gym membership with unlimited visits, fitness studio classes, and at-home fitness accessories and equipment.
- Transportation (Only for Secure, Total and Blue Basic plans)
 - 24 one-way non-emergency rides to health-related locations such as in-patient facilities, health plan sponsored health events and other approved medical centers
 - Members must schedule rides at least 48 hours before pick-up time.
- Over the counter
 - \$30-\$150 credit per quarter (credit dependent on plan — Secure, Total, Total Value or Blue Basic)
 - Orders can be placed by phone, online or catalog
 - Members receive a Flex card for local pharmacies to purchase select items
- Post discharge meals
 - 10 free frozen meals after each inpatient discharge
 - Orders must be placed through the care management team.

2024 Benefits

Medicare Advantage

Value-added benefits (Continued)

- Annual wellness incentive
 - All members receive a \$40 annual incentive after completing a wellness exam or physical
 - Received as additional money on the over-the-counter Flex card
- Concierge pharmacy services
 - For members that received a denial due to step therapy or prior authorization, or those who have difficulty obtaining medications
- Member health events
 - Members can attend local health events sponsored by BlueCross BlueShield of South Carolina.
 - Includes free services
 - Allows members to speak with a BlueCross representative for assistance
 - Has games for social interactions

2024 Benefits

Medicare Advantage

Prior Authorization — Important Notice: Integrated Home Care Services

- On July 5, 2023, our Medicare Advantage plans began requiring prior authorization through Integrated Home Care Services (IHCS) for all durable medical equipment (DME) used in the home setting, home health and home infusion services.
 - IHCS follows the Centers for Medicare and Medicaid Services guidelines to provide prior authorization for these services.
 - Services are covered when Medicare coverage criteria are met.
- The following places of service are included:
 - 4: Homeless shelter
 - 12: home
 - 13: Assisted living facility
 - 14: Group home
- Methods for requesting prior authorizations:
 - My Insurance Manager
 - Phone: 855-843-2325
 - Fax: 803-264-6552

Note: View the list of codes that will require prior authorization on www.SouthCarolinaBlues.com under Medicare Advantage.

2024 Benefits

Medicare Advantage

Integrated Home Care Services 2024

- Beginning Jan. 1, 2024, BlueCross will use IHCS for the coordination and provision of DME, home health and home infusion services.
- IHCS has contracted directly with providers to be in the IHCS network.
- These providers will work with IHCS on new claims submission criteria.

2024 Benefits

Medicare Advantage

Inflation Reduction Act (For plans with Part D coverage)

- \$35 limit for monthly insulin copay.
 - Shown as Tier 3 in formulary but special pricing.
- Part D vaccines (such as shingles) are covered at \$0.
- Effective July 1, 2023 — “You pay a \$35 copay in-network and out-of- network for a 1-month supply of Medicare Part B insulins for use in home infusion pumps.”
- Members will pay 0 percent cost share in Catastrophic drug stage.

2024 Benefits

Medicare Advantage

CMS Stars Ratings

- **Schedule** patients for Medicare Annual Wellness Exams annually.
- **Document** all care in the patient's medical records.
- **Code and bill** appropriately for services rendered and conditions addressed.
- **Promote** medication adherence.
- **Recommend** formulary alternatives, when necessary.
- **Recommend** participation in disease management programs.
- **Respond** to medical record requests (within five business days).

Note: We have successfully reached a 4 Star Rating with out PPO plans, which includes Total, Total Value and Blue Basic. We have also added Newberry county to our PPO plan coverage.

2024 Benefits

Medicare Advantage

Network Sharing

- Allows Medicare Advantage (MA) PPO members from other Blue Plans to get in-network benefits
- Available in 48 states, District of Columbia and Puerto Rico
- Eligible members will have the following symbol on their ID cards:



Tips for accuracy:

- Verify eligibility for out-of-area MA PPO members using the BlueCard Eligibility Line or through MIM.
- Submit claims for all BlueCross BlueShield members, regardless of state, to BlueCross BlueShield of South Carolina.
- Review member care gap reports and pay attention to open quality care gaps and patient health concerns.
- Ensure documentation of completed services while patients are visiting from other states.

2024 Benefits

Medicare Advantage

General Reminders

- Check the member's ID card to determine their plan type.
- Follow Medicare guidelines at www.cms.gov for covered services.
- Verify eligibility and benefits at each visit prior to rendering services.
- Prior authorization requirements may differ from other plans.
 - View the requirements and methods for obtaining authorization at www.SouthCarolinaBlues.com.
 - *Providers>Medicare Advantage>Prior Authorization*
- When possible, always refer members to network participating providers.
- Review the Medicare Advantage provider manuals for more information.
 - Update: Section 3.8: Confidentiality and Data Use.
 - Visit www.SouthCarolinaBlues.com .



Companion Benefit Alternatives



2024 Benefits

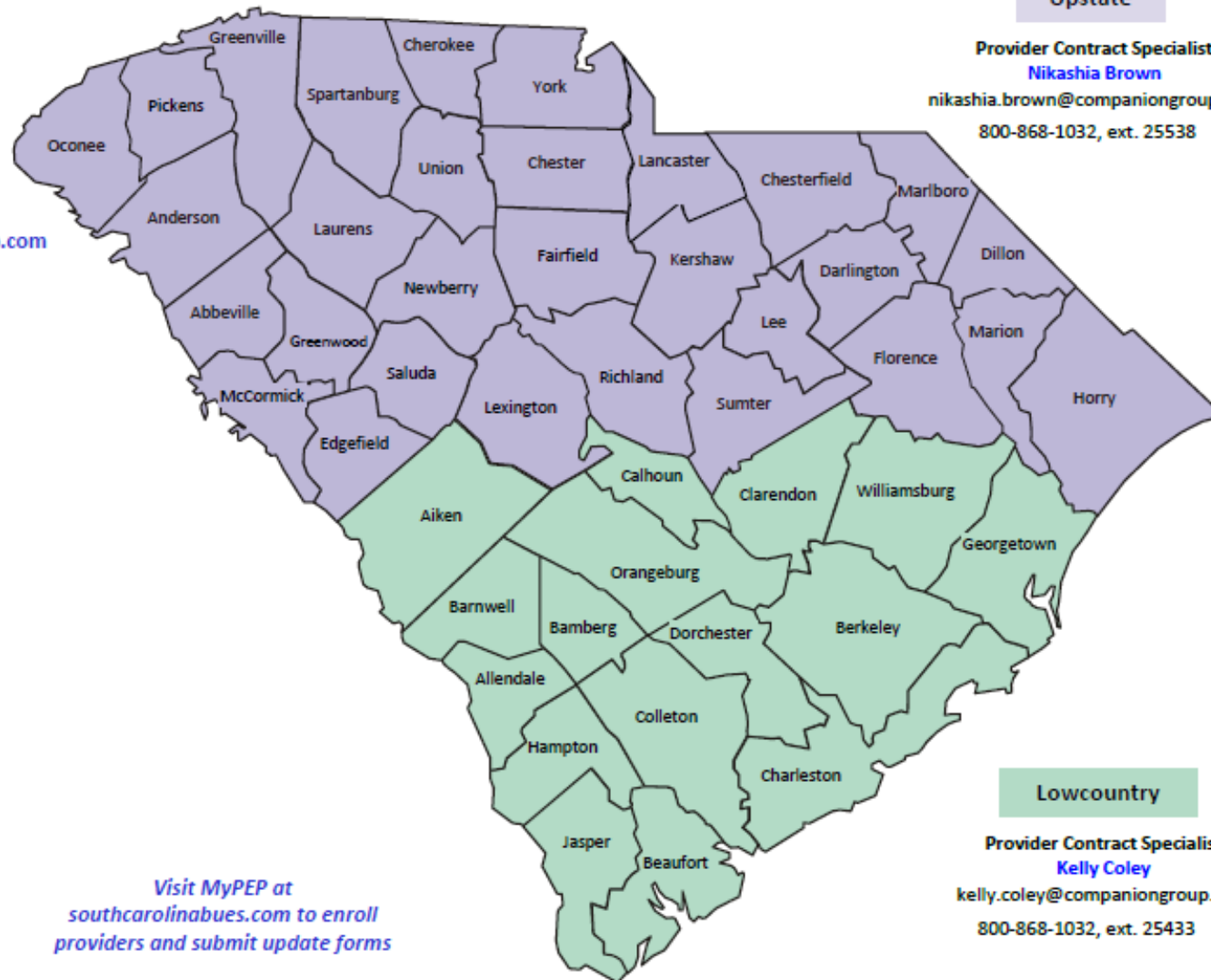
Companion Benefit Alternatives (CBA)

- CBA manages behavioral health enrollment.
- The CBA provider network services team offers support through
 - Email.
 - Phone.
 - In-person or virtual education.
 - Problem solving visits.
- Review the current CBA provider handbook located at www.CompanionBenefitAlternatives.com.

Providers>Provider Login

- Provider login password: cba123

Companion Benefit Alternatives Provider Representative Territory Map



Upstate

Provider Contract Specialist
Nikashia Brown
nikashia.brown@companiongroup.com
800-868-1032, ext. 25538

Lowcountry

Provider Contract Specialist
Kelly Coley
kelly.coley@companiongroup.com
800-868-1032, ext. 25433

General Inquiries
cba.provrep@companiongroup.com
Call 800-868-1032 or
Fax 803-714-6456

Provider Network Coordinator
Alicia McKnight
alicia.mcknight@companiongroup.com
800-868-1032, ext. 25744

Provider Claims Support
Sandra Hall
sandra.h.hall@companiongroup.com
800-868-1032, ext. 25154

Value-Based Program Coordinator
Brandi Poole
brandi.poole@companiongroup.com
800-868-1032, ext. 25229

Provider Network Services Director
Shonda Ball
shonda.ball@companiongroup.com
800-868-1032, ext. 25560



Visit MyPEP at
southcarolinabues.com to enroll
providers and submit update forms

2024 Benefits

Companion Benefit Alternatives (CBA)

Reminders

- Providers requesting to change their contracting status with the Behavioral Health (BH) network must contact CBA directly.
 - Termination of a provider's affiliation to a location will not terminate their agreement with CBA.
- CBA network providers who change their practices must notify CBA of the change and confirm their credentialing status can be transferred.
 - Recredentialing notices may be missed when providers change groups between the recredentialing cycles.
- A provider's directory specialty is based on their professional licensure as confirmed during the credentialing process and cannot be changed.
 - If the provider directory does not reflect your current practice location, contact CBA immediately.

2024 Benefits

Companion Benefit Alternatives (CBA)

Reminders (Continued)

- CBA does not credential or reimburse interns or anyone under the supervision of a licensed practitioner.
 - CBA credentials providers who are fully licensed and can independently work in a clinical setting.
 - Supervisors should not submit their information on claims to seek reimbursement for the supervisee.
- To assist CBA in enhancing the quality of care for our members, inform them of your availability for extended office hours or quick access appointment availability.
 - Information can be sent to CBA.Provrep@bcbssc.com.

2024 Benefits

Companion Benefit Alternatives (CBA)

Telehealth

- Providers must apply for telehealth approval.
 - Applications can be submitted through My Provider Enrollment Portal.
 - Approval applies to commercial health plans.
- Approved telehealth providers must notify the virtual care team (VirtualCare@bcbssc.com) of:
 - Any change in Tax ID or NPI, or additional locations.
 - Addition or removal of individual providers (each rendering BH provider requires approval).
 - A change of telehealth vendors.
 - No longer providing telehealth services.
- Telehealth services must comply with our medical policy, CAM 176.
 - www.SouthCarolinaBlues.com: *Providers>Medical Policies>Commercial and Contracted Plans*
- CBA telehealth participation is subject to continued CBA network status and active credentialing.
- The modifier 95 is required on all CPT codes when services are delivered via telehealth.
- Verify member eligibility and benefits for telehealth coverage.
 - Call the number of the back of the member's ID card.

2024 Benefits

Behavioral Health and Autism Applications

- CBA cannot accept the Individual Application in My Provider Enrollment Portal for enrollment.
 - The Behavioral Health Application and/or the Autism Panel Application must be submitted.
- Case comments can be submitted to verify the status of the application or submit a support case.
- Send an email to CBA.Provrep@bcbssc.com to verify if the provider is already enrolled in the network before completing an application.
- To be considered for the Healthy Blue network, providers must have their Medicaid ID number. Submit this using one of the following:
 - Entering the Medicaid ID number on the application.
 - Uploading the award letter from the South Carolina Department of Health and Human Services, which includes the Medicaid ID number.
 - Uploading a notice on letterhead with the providers name, NPI, case number and Medicaid ID number.

2024 Benefits

Behavioral Health and Autism Applications (Continued)

- Be sure to include the following:
 - Social security number
 - Tax ID number
 - NPI number
 - Medicaid ID number
 - Current copy of malpractice insurance policy
 - Practitioner's name must be included on the policy or listed on an attached roster.
 - Undergraduate and graduate information
 - Five years of continuous work history (provide explanation for any gaps)
 - Cultural Competency course completion date
 - This is required when applying for the Healthy Blue network.
 - Current copy of provider's license
 - A SC LLR* license verification is also acceptable.
 - Clearly name uploaded documents (i.e., license, malpractice, etc.)

*Labor, Licensing and Regulation

2024 Benefits

Nurse Practitioner Required Certification — APRNs and NPs

- As of Sept. 1, 2023, APRNs and NPs must have a behavioral health certification or accreditation at the time of initial credentialing to be considered for the CBA network.
- All established APRNs and NPs in the CBA network will be required to have a behavioral health certification or accreditation by Sept. 1, 2026, to maintain their network status.
- APRNs and NPs that do not have a behavioral health certification or accreditation should apply to one of the medical networks with BlueCross as they are not eligible for the CBA network.
 - Once credentialed, they can be affiliated to a predominately behavioral health practice.

2024 Benefits

Claims Support — Forms Resource Center

- All behavioral health providers have access to the Forms Resource Center (FRC) to submit clinical information for authorizations.
 - This has been expanded to allow network providers to submit a claim support inquiry for any claims that have been processed.
- As of Oct. 1, 2023, all claims request must be entered using the FRC form.
 - Visit www.CompanionBenefitAlternatives.com.
 - Select Provider (password: cba123).
 - Scroll down and select the Claims Support link.
- This form is used to request review of up to nine claims for possible adjustment.
 - For 10 or more claims, select the option to receive a template via secure email.
- All claims must be initialed through the FRC for proper handling and routing.

2024 Benefits

Upcoming Network Changes

- Upon completion of CMS certification, providers (including Licensed Professional Counselors and Licensed Marriage and Family Therapists) may be eligible to join the Medicare Advantage network.
 - Pre-registration begins Nov. 30, 2023, for Medicare Advantage.
 - Includes verification of demographics, credentialing status and contract status.
 - Pre-registration does not guarantee participation.
 - Providers must have an active Medicare number to participate in the Medicare Advantage network.
- Effective Jan. 1, 2024, Licensed Psycho-Educational Specialists will be eligible to join the Autism Panel in addition to the Healthy Blue network.
 - There is no change to the CBA network.
 - Reach out to CBA.Provrep@bcbssc.com for enrollment information.



What's New?



What's New?

ProgenyHealth

- **Oct. 9, 2023**, BlueCross began working with ProgenyHealth®.
- ProgenyHealth specializes in neonatal care management services, and their program enhances services for our members.
- With this program, ProgenyHealth's neonatologists, pediatricians and neonatal nurse care managers collaborate closely with our members, as well as attending physicians and nurses. This approach promotes healthy outcomes for BlueCross's premature and medically complex newborns.

Which plans are included:

- This program applies to:
 - BlueChoice HealthPlan.
 - Fully insured businesses (major group, small group and individual plans).
 - Some self-insured plans.

Note: Review the “New Assistance for Providers From ProgenyHealth” bulletin on www.SouthCarolinaBlues.com for more information.



Benefit Reminders



Benefit Reminders

BlueCard Program

- The BlueCard Program enables Blue Plan members to get health care service benefits and savings while traveling or living in another Blue Plan's service area.
- The program links participating health care providers across the country and internationally through a single electronic network for claims processing and reimbursement.



Benefit Reminders

BlueCard Program

Ancillary Filing Guidelines

Durable Medical Equipment (DME)

- File to the Plan whose state the equipment was purchased at a retail store; or
- File to the Plan whose state the equipment was shipped

Independent Clinical Laboratory

- File to the Plan where the specimen was drawn; or
- File to the Plan where the referring physician is located

Specialty Pharmacy

- File to the Plan whose state the ordering physician is located

Benefit Reminders

Medical Records

- Submit medical records upon request.
- Medical records could be requested to support medical necessity for claims adjudication or to close gaps in care for HEDIS®.
- The submission of medical records is a **non-billable event**.
 - Share this information with any outside vendors used to submit medical records on your behalf (e.g., Ciox, ScanSTAT, etc.).

Benefit Reminders

National Drug Code (NDC)

- NDCs must have 11 digits following the 5-4-2 format upon submission.
 - If the package lists an NDC with 10 digits, it must be converted to an 11-digit NDC.
 - First determine the format of your 10-digit NDC by closely examining the package information and counting the numbers separated by dashes.
- Once you have identified the format as either 4-4-2, 5-3-2 or 5-4-1, insert a zero according to the following table:

10-Digit Format		Add a zero in...		Report NDC as...
4-4-2	##### - ##### - ##	1 st position	0##### - ##### - ##	0#####
5-3-2	##### - ### - ##	6 th position	##### - 0### - ##	#####0#####
5-4-1	##### - ##### - #	10 th position	##### - ##### - 0#	#####0#

Benefit Reminders

Laboratory Services

- Use network participating laboratories to ensure low member cost shares.
- Access the current list of participating laboratories at www.SouthCarolinaBlues.com.
- All lab tests must be supported by the available medical policies located on our website.

Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits

Providers>Medical Policies>Commercial and Contracted Plan Policies

Benefits of reviewing medical policies:

- Prevents delays in claims processing
- Ensures proper and timely payment
- Reduces the need for reconsiderations



Reminders

Appointment Availability

Primary Care Physicians

- New and established patient visits
 - Scheduled within 15 days
- Urgent appointments
 - Scheduled within 48 hours

Specialists

- New and established patient visits
 - Scheduled within 30 days
- Urgent appointments
 - Scheduled within 48 hours



Resources



Resources

My Insurance Manager

Online portal giving access to check eligibility and benefits with the following options:

- General
- Service type
- Procedure code (recommended)

The image displays two screenshots of the My Insurance Manager website. The top screenshot shows the login page with a 'Welcome to My Insurance Manager!' banner, a login form with 'Username' and 'Password' fields, and a 'Register Now' button. Below the login form are 'Browser Requirements' for Internet Explorer 10 or higher, Mozilla Firefox (current version), Google Chrome (current version), and Safari (Mac OS Only). A 'Latest Features' section includes a 'Safeguard PHI!' alert. The bottom screenshot shows the website's navigation menu with 'Home', 'Patient Care', 'Office Management', 'Resources', and 'Modify'. The 'Patient Care' menu is expanded, showing 'Health' with sub-items: 'Authorization Extension', 'Authorization Status', 'Claims Status', 'Eligibility and Benefits' (circled in red), 'Institutional Claim Entry', and 'Other Health Insurance'. Other sub-items include 'Patient Directory', 'Pre-Certification/Referral', 'Superbill Maintenance', 'Pre-Service Review for Out-of-Area Members', 'Professional Claim Entry', and 'Verify Primary Care Physician'.

Resources

Voice Response Unit (VRU)

- The voice response unit (VRU) provides options to obtain eligibility, benefits and much more 24/7.
- The VRU is fully automated and offers quick and easy information over the phone without the need of speaking with a representative.

How to Access the VRU

- For BlueCross BlueShield of South Carolina members:
 - In South Carolina, call 800-868-2510.
 - In Columbia/Lexington, call 803-788-8562.
 - If out-of-state, call 800-334-2583.
- For BlueCard® members, call 800-676-BLUE (2583).
- For Federal Employee Program (FEP) members, call 888-930-2345.
- For State Health Plan members, call 800-444-4311.

Resources

BlueCard Out-of-State Member Authorizations and Medical Policies

You can verify authorization requirements and medical policies for out-of-state members using the BlueCard Authorization/Medical Policy tool.

Providers Providers

[Home](#) / [Providers](#) / [Policies and Authorizations](#) / [Prior Authorization](#) / BlueCard Prior Authorization/Medical Policies

BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate the process through [My Insurance Manager](#)SM. Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the menu.

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information you need, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

Type of Information

Please select only one.

Medical Policy

General Precertification/Preauthorization Information

This field is required.

Alpha Prefix

This field is required.

If you experience difficulties or need additional information, please contact 800-676-BLUE.

Resources

Member ID Card Guide

- You can get an overview of our various plans, associated networks and an example of the ID card you may see.
- Visit www.SouthCarolinaBlues.com and use the path:

Providers>Tools and Resources>Guides



BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

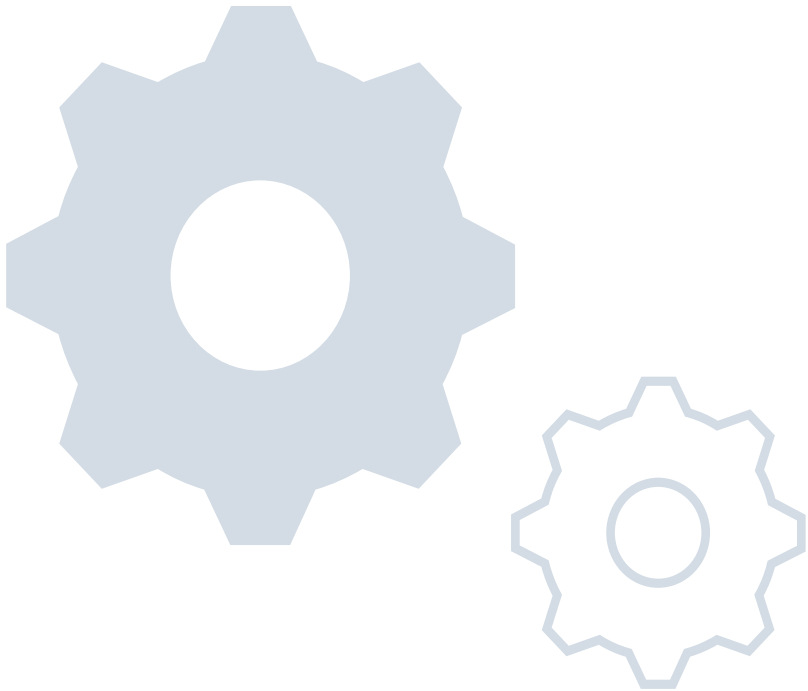
Independent licensees of the Blue Cross Blue Shield Association.

Member Identification Card Guide

Published by Provider Relations and Education
Your Partners in Outstanding Quality, Satisfaction and Service

Revised: May 2023

Claims

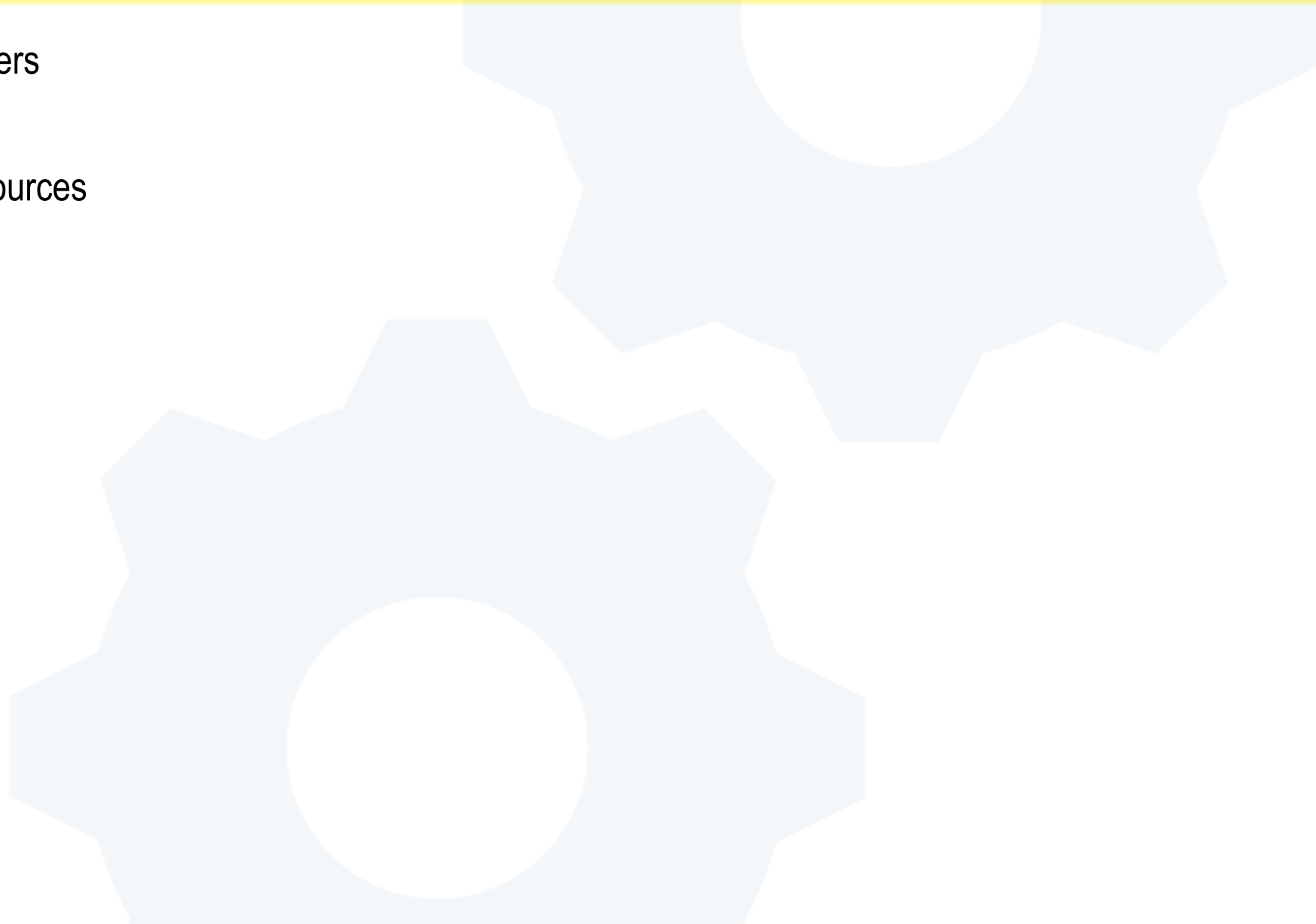


Claims Disclaimer

The information included is general and in no event should be deemed as a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.

Agenda

- Claim Reminders
- Claim Tips
- Available Resources





Claim Reminders



Claim Reminders

High Dollar Pre-payment Reviews

What is a high dollar pre-payment review (HDPR)?

- The process of reviewing high dollar inpatient hospital claims to ensure providers are billing in accordance with services rendered.

What happens during the HDPR process?

- Charges on the claim are reduced based on audit findings of the claim with the highest charges.
 - The audit threshold is determined by the admission date.
- A claim line with revenue code 0249 is added to the claim.
 - Line will deny with CARC 216, RARC N183
 - Determined by the *Inpatient Non-Reimbursable Charge/Unbundling* policy
 - www.SouthCarolinaBlues.com

Providers>Tools and Resources>Guides>Inpatient Non-Reimbursable Charge/Unbundling Policy

Claim Reminders

High Dollar Pre-payment Reviews (Continued)

Criteria for high dollar pre-payment reviews (HDPR).

- A HDPR takes place when the following criteria are met:
 - Inpatient institutional (acute care) claims; and
 - Claims with an allowed amount of **\$100,000 or more**; and
 - Any pricing methodologies except for the following pricing models that do not incorporate individual charges due to global pricing
 - Per-diem
 - Flat-fee case rate
 - DRG rate (except those in which a portion of the claim is charge-sensitive)

What is needed for the HDPR?

- Itemized bills
 - Submit, when requested, using the claims attachment feature in My Insurance ManagerSM.
 - **If medical records are needed, a separate request will be sent.**

Claim Reminders

Itemized Bills

Example of an acceptable itemized bill:

42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Dicyclomine 10 MG		010322	1	27.00
0250	Nitroglycerin 0.4 MG		010322	1	28.73
0250	Midazolam 10 MG	J2250	010322	2	29.09
0250	Atorvastatin 40 MG		010322	2	76.93
0272	Catheter Angiographic		010322	1	226.00

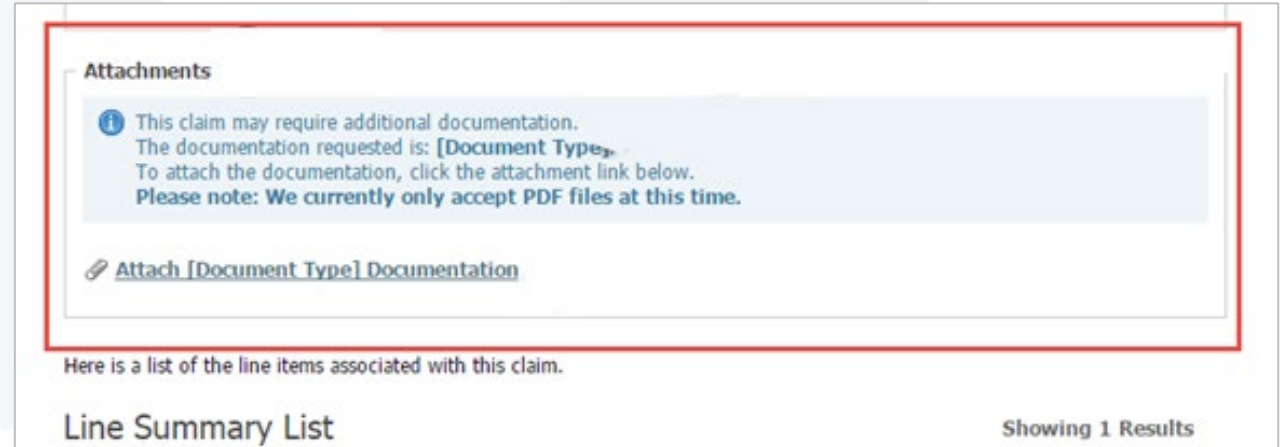
Example of an unacceptable itemized bill:

42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Pharmacy			336	7780.81
0272	Sterile supplies			8	7680.40
0278	Supply/implant		010322	2	6385.00

Claim Reminders

Claim Attachments

- Feature in My Insurance Manager that lets you upload requested information directly into the portal for a claim.
- The feature cannot be used for claims that have not been finalized.
- Types of documentation that can be uploaded include:
 - Accident questionnaires.
 - Certificate of medical necessity (for durable medical equipment).
 - Medical records.
 - Other health insurance.
 - Primary carrier explanation of benefits.
 - Provider reconsideration.
 - Itemized bills.



The screenshot shows a notification box titled "Attachments" with a red border. Inside the box, there is an information icon (i) followed by the text: "This claim may require additional documentation. The documentation requested is: [Document Type]. To attach the documentation, click the attachment link below. Please note: We currently only accept PDF files at this time." Below this text is a link that says "Attach [Document Type] Documentation" with a paperclip icon. Below the notification box, there is a line of text: "Here is a list of the line items associated with this claim." Below that is the heading "Line Summary List" and on the right side, it says "Showing 1 Results".

Note: Review the “What You Need to Know About Claim Attachment” guide on www.SouthCarolinaBlues.com for more information.

Providers>Tools and Resources>Guides

Claim Reminders

Laboratory Services

- Avalon Healthcare Solutions manages the laboratory benefits on behalf of BlueCross BlueShield of South Carolina and BlueChoice HealthPlan.
- Access the current list of participating laboratories at www.SouthCarolinaBlues.com.
Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits
- Before rendering lab services, review the Medical Policies pages to view the complete medical policy for specific labs to ensure the criteria is followed for coverage.

Benefits of reviewing medical policies:

- Prevents delays in claims processing
- Ensures proper and timely payment
- Reduces the need for reconsiderations



Claim Reminders

Laboratory Services — Medical Policies

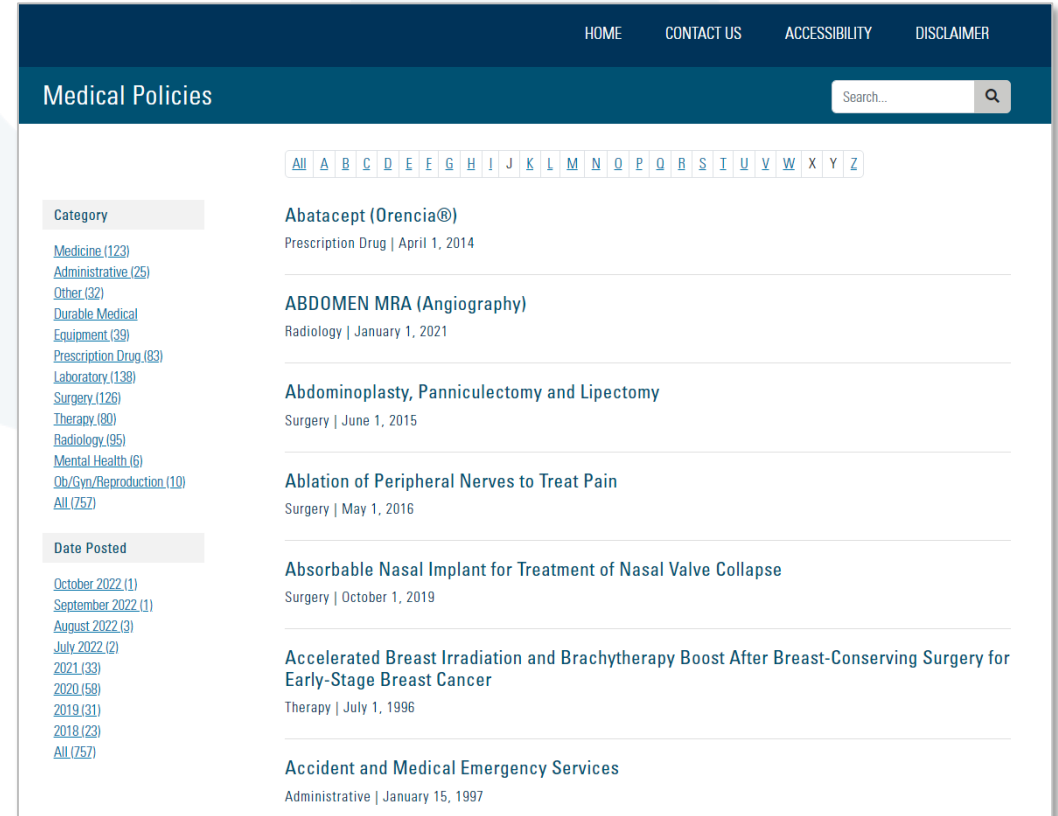
The Medical Policies pages can be found on one of the following:

- www.SouthCarolinaBlues.com

Providers>Medical Policies>Commercial and Contracted Plan Policies

- www.BlueChoiceSC.com

Providers>Medical Policies (under Resources)>Medical Policies



The screenshot shows a web page titled "Medical Policies" with a navigation bar at the top containing links for HOME, CONTACT US, ACCESSIBILITY, and DISCLAIMER. Below the navigation bar is a search bar and a list of policies. The policies are filtered by category and date posted. The categories listed are: Medicine (123), Administrative (25), Other (32), Durable Medical Equipment (39), Prescription Drug (83), Laboratory (138), Surgery (126), Therapy (80), Radiology (95), Mental Health (6), Ob/Gyn/Reproduction (10), and All (757). The date posted filters are: October 2022 (1), September 2022 (1), August 2022 (3), July 2022 (2), 2021 (33), 2020 (58), 2019 (31), 2018 (23), and All (757). The policies listed are:

- Abatacept (Orencia®)**
Prescription Drug | April 1, 2014
- ABDOMEN MRA (Angiography)**
Radiology | January 1, 2021
- Abdominoplasty, Panniculectomy and Lipectomy**
Surgery | June 1, 2015
- Ablation of Peripheral Nerves to Treat Pain**
Surgery | May 1, 2016
- Absorbable Nasal Implant for Treatment of Nasal Valve Collapse**
Surgery | October 1, 2019
- Accelerated Breast Irradiation and Brachytherapy Boost After Breast-Conserving Surgery for Early-Stage Breast Cancer**
Therapy | July 1, 1996
- Accident and Medical Emergency Services**
Administrative | January 15, 1997

Note: CPT and diagnosis codes listed on each medical policy are not a guarantee of payment but are included only as a general reference tool. They may not be all-inclusive.

Claim Reminders

Laboratory Services — Medical Policy Criteria

The following are the policy rule criteria used to determine coverage for laboratory services:

Policy Rule	Definition
Experimental and investigational	Procedure is not covered under the member's benefit due to exclusion
Demographic limitations	Limitations based on the member's age/sex
Excessive procedure units	Total units within and across claims for a single date of service more than necessary
Excessive units per period of time	Maximum allowable units within a defined period of time has been exceeded
Insufficient time between procedures	Minimum time required before a second procedure is warranted
Rendering provider limitations	Providers/procedures not permitted in combination
Diagnosis does not support test requested	Procedure was not appropriate for the clinical situation
Mutually exclusive codes	The procedure is not valid with other procedures on the same date of service

Examples

Laboratory Test	Example	Rejection Applied
Vitamin D	Testing rendered two weeks after initiation of Vitamin D therapy	Insufficient time between procedures
Thyroid Disease	Testing of reverse T3, T3 uptake	Experimental and investigational
Testosterone	Testing saliva for testosterone	Experimental and investigational

Claim Reminders

Provider Reconsiderations

What is a provider reconsideration?

- A request to investigate the outcome of a finalized claim.

What are the guidelines for a provider reconsideration?

Reasons that would require a reconsideration...	¹ Reasons that would not require a reconsideration...
Medical necessity determination	Membership, eligibility or benefit issues
Lack of authorization for non-emergent services when the member <u>does not</u> present themselves as a BlueCross BlueShield of South Carolina member	Lack of authorization for non-emergent services when the member presents themselves as a BlueCross BlueShield of South Carolina member

¹For reasons listed in this column, contact the appropriate Provider Services department using Ask Provider Services, STATchatSM or call the phone number on the back of the member's ID card.

Claim Reminders

Provider Reconsiderations — Requirements


Provider Reconsideration Form

- www.SouthCarolinaBlues.com
 - Providers>Claims & Payment>Appeals & Reconsiderations
- www.BlueChoiceSC.com
 - Providers>Find a Form>Provider Reconsideration Form

Supporting Documentation

- Supporting document must be included, such as:
 - History and physical records
 - Operative reports
 - Office notes
 - Progressive notes
- Reconsiderations cannot be reviewed without support.

Be mindful of the filing guidelines.


Independent licensees of the Blue Cross and Blue Shield Association

South Carolina Provider Reconsideration Form

This form is intended for use by physicians and other health care professionals in South Carolina. If you are located outside of South Carolina and have claims questions, reviews, or appeals, please direct them to your local Blue® plan. To request a claim review, please complete this form for BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan members. Use this form as the cover transmittal sheet for all supporting documentation. Forms submitted without supporting documentation will not be considered. Be sure to complete each section.

You may wish to seek reconsideration of a claim:

- If you have additional documentation that supports a reversal of the claim determination.
- If you want a reconsideration of the claim adjudication.

Provider Information

Provider's Name: _____ NPI or Tax ID: _____
Phone Number: _____ Ext: _____ Fax Number: _____
Contact Person: _____ Email: _____
Authorized Signature: _____ Date: _____

Patient and Claim Information

Patient's Name: _____ Member ID: _____ Date of Birth: _____
Claim Number (Do not attach claim): _____ Date of Service: _____

Reconsideration

Check the appropriate boxes below to specify the type of service and request.

<input type="checkbox"/> Medical Services	<input type="checkbox"/> Initial Request
<input type="checkbox"/> Laboratory Services	<input type="checkbox"/> Subsequent Request*

*Note: Subsequent requests must include the initial decision along with new or additional information to be re-reviewed.

Brief description of request/desired action you want us to take as result of this claim review:

Description of attachments included (office records, lab reports, physician orders, etc.):

Please Fax or Mail to (send to only one):

Plan	Reconsideration Time Limits	Fax Number	Mailing Address
BlueChoice® HealthPlan	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
BlueEssentials™ & Blue Option™	180 days from remit date	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Preferred Blue® & BlueCard®	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Group & Individual	180 days from remit date	803-264-4172	AX-F25, I-20 @ Alpine Road, Columbia, SC 29219
State Health Plan	6 months from remit date	803-264-4204	AX-B10, P.O. Box 100605, Columbia, SC 29260
Federal Employee Program	90 days from remit date	803-264-8104	AX-805, P.O. Box 600601, Columbia, SC 29260
Medicare Advantage	60 days from remit date	803-264-9581	AG-780, P.O. Box 100191, Columbia, SC 29202
Healthy Blue™	90 days from remit date	Click here for the Healthy Blue provider appeal request form.	

Revised Aug. 27, 2021

Claim Reminders

Provider Reconsiderations vs. Corrected Claims

Knowing when to submit a provider reconsideration versus a corrected claim is important.

Examples of when a provider reconsideration can be submitted.

Provider reconsideration

A claim is rejected because the medical necessity could not be determined

A claim is rejected for lack of authorization, but the member was comatose when they arrived at the hospital

Examples of when a corrected claim should be submitted.

Corrected claim

An anesthesia claim is submitted with the incorrect modifier and rejects as a duplicate

A provider only performs the Cesarean delivery, but submits their claim with the procedure 59515 (which includes postpartum care), causing the claim to process globally

Claim Reminders

Pricing Inquiries

What is a pricing inquiry?

- An investigation of the reimbursement applied to a claim.

Before submitting pricing inquiries, verify the following:

Member's plan
(i.e., Commercial or Exchange)

Non-covered charges
or denied lines

Applied cutbacks

Date of service

MUEs

Note: If using a third-party vendor, be sure to relay this information to them.

Claim Reminders

Refunds

For assistance with refunds:


- Access My Insurance Manager.
- Contact the number on the back of the member's ID card.

If you do not have the refund letter:

- Call Provider Services: 800-868-2510, opt. 4
 - Used for the following lines of business:
 - BlueCard
 - BlueEssentialsSM
 - Major Group
 - National Alliance
 - Small Group & Individual

0000128

STATE REFUNDS (AX-B15)
PO Box 100300
COLUMBIA SC 29202-3300

 South Carolina
BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association
Visit MyInsuranceManagerSM
at www.SouthCarolinaBlues.com

NOVEMBER 11, 2021

000128
0001 of 0001

Re: Patient: Jud
ID Number:
Provider Nu
Date(s) of S
Refund Num

Dear Provider:

We sent a payment to you on March 01, 2021, in error for the patient listed above. We must request a refund of \$41.80 for the reason(s) stated below:

THE MEDICARE COINSURANCE IS INCORRECT.

If we have not heard from you within 30 days, we will deduct this amount from future payments to you. Please send this amount, along with a copy of this letter, to:

BlueCross BlueShield of South Carolina
Attn: Lockbox AX-A31
I-20 at Alpine Road
Columbia, SC 29219

We thank you for your cooperation and apologize for any inconvenience. If you have any questions, please call our Provider Service department at 800-444-4311.

Sincerely,

State Group Refunds

Claim Reminders

Network Participating Providers

Network participating providers should always use or refer members to other network participating providers, when necessary, including laboratories.

By using or referring other network participating providers:

- Members will not have to bear the burden of higher out-of-pocket costs.
- Members will not be subject to balance billing.

Claim Reminders

Claim Submissions

Claims can be submitted using the following:

- Electronically (through your clearinghouse)
 - Preferred method
 - See the payer IDs
- My Insurance Manager (MIM)
- Mail (hard copy)
 - Use the address located on the back of the member's ID card

For more information, visit www.SouthCarolinaBlues.com:

Providers>Claims & Payments>Claims Submission

Medical Plans	
State Health Plan	00400
BlueCross BlueShield of South Carolina	00401
Federal Employee Plan (FEP)	00402
Healthy Blue SM	00403
Planned Administrators, Inc. (PAI)	00886
BlueChoice [®] HealthPlan	00922
Medicare Advantage	00C63

Dental Plans	
BlueCross BlueShield of South Carolina	38520

Claim Reminders

Claim Submissions — Corrected Claims

- Corrected claims can be submitted using one of the following avenues:
 - Electronically (the preferred method)
 - Enter frequency code 7 (which indicates an adjustment) in Box 22 of the CMS-1500.
 - Enter the original claim number in Box 22 of the CMS-1500.
 - Include a brief description for the reason of the adjustment in Box 19 of the CMS-1500.
 - My Insurance Manager (MIM)
 - Select Replacement of Prior Claim on the Claim Information page.
 - Mail (hard copy)
 - Ensure “Corrected Claim” is labeled on the claim.
- For all avenues, be sure to include **all lines** from the original claim along with the correction(s) that should be made.
- Guidance on submitting corrected claims can be located on www.SouthCarolinaBlues.com.

Providers>News and Events>News Archive>2021 News>Reminder: Corrected Claims



Claim Tips



Claim Tips

Claims Requiring Questionnaire Responses

- Accident or subrogation
 - Generated based on trauma related diagnoses on a claim
 - Allow members at least 60 days to respond and for the review to be completed
- Other health insurance (OHI)
 - Generated based on the member's age, if they have more than one policy on file, etc.
 - Must be completed by the member or the member can contact customer service to verify or update

Encourage members to return the questionnaire as soon as possible to avoid processing delays.

Incorporate the forms in the onboarding paperwork.
Only submit the documentation if requested.

Note: Both forms are on www.SouthCarolinaBlues.com.

Providers>Forms>Other Forms

Claim Tips

Correct Coding

- Accurate coding and reporting of services on medical claims is critical in assuring proper payment to providers.
- Common coding issues include:

Invalid modifiers

Incorrect number of units

Diagnosis inconsistencies

Unbundled services

Age or gender discrepancies

Unspecified codes



Available Resources



Available Resources

Voice Response Unit (VRU)

If we processed and paid a claim or applied patient liability, the VRU will provide:

- Processed date.
- Remittance date.
- Check number.
- Amount paid.
- Amount applied to the patient's liability (copay, deductible or coinsurance).

If we processed and denied a claim, the VRU will provide:

- Denial reason.
- Remittance date.

Note: If a claim is processed to the member, please contact them for the details. Submitting a HIPAA transaction (276/277) will advise if the claim was processed to the member.

Available Resources

My Insurance ManagerSM

My Insurance Manager (MIM) is the quickest way to obtain claims information. With MIM, you can:

- Submit claims.
- Check claims status.
- View refund letters.
- Get assistance with claims.
 - Ask Provider Services
 - STATchatSM

Additional information included in MIM:

- Eligibility and benefits
- Prior authorizations
- Provider updates

Note: Review the available MIM guides on www.SouthCarolinaBlues.com for more information.

Providers > Tools and Resources > My Insurance Manager

Available Resources

Ask Provider Services (Web inquiries)

- Ask Provider Services is a feature inside My Insurance Manager that allows you to submit secured web inquiries for help with claims.
- To get the most effective and accurate responses, ask specific, probing questions.
 - This feature should not be used for general claim status.

Examples of appropriate questions to ask...	Examples of inappropriate questions to ask...
Why was line one of the claim denied as noncovered?	What is the status of the claim?
Why were services applied to the member's deductible?	Have medical records been received?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?

Available Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Member ID (Recommended Option)

Be sure to:

- Select the appropriate Health Plan.
- Enter the **FULL** Member ID, including the prefix and any additional letters.
- Enter the date of birth.
- Select one of the advanced options.

Patient Selection

To get claims status information, please enter this information. If your patient had a different Health Plan previously, please choose the Health Plan that was in effect for the specific date of service.

*** Health Plan:**
--Please Choose One--

Search By:

Member ID
 Claim Number

*** Member ID:**
include alpha prefix, if applicable

*** Patient's Date of Birth:**
mm/dd/yyyy

*** Health Plan:**
--Please Choose One--
BlueCross BlueShield Plans
BlueChoice HealthPlan
State Health Plan
Federal Employee Program

*** Member ID:**
ypwj1 1
include alpha prefix, if applicable

Advanced Search

All Claims in System
 Date of Service
 Last 6 Months
 Last Year

Available Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Member ID (Continued)

Be sure to:

- Enter the patient's first and last name.
- Enter the **FULL** Member ID, including the prefix and any additional letters.
- The date of birth and location will auto-populate from the selected claim.
- Enter your question (be specific as possible).

Ask Provider Services

Inquiry

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

How would you like to contact Provider Services?

Submit your question online

Talk to Provider Services online
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

Health Plan:
BlueCross BlueShield Plans

Inquiry Reason:
Claim Status Inquiry

* Patient's First Name: * Patient's Last Name: * Patient's Member id: Patient's Date of Birth:
mm/dd/yyyy

* Location: Primary ID:

* Please enter a question:

or [Back](#)

Available Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Claim Number

Be sure to:

- Select the appropriate Health Plan.
- Enter the claim number.

Patient Selection

To get claims status information, please enter this information. If your patient had a different Health Plan previously, please choose the Health Plan that was in effect for the specific date of service.

*** Health Plan:**
--Please Choose One--

Search By:

Member ID

Claim Number

*** Claim Number:**

*** Health Plan:**
--Please Choose One--
BlueCross BlueShield Plans
BlueChoice HealthPlan
State Health Plan
Federal Employee Program

Continue

Available Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Claim Number (Continued)

Be sure to:

- Enter the patient's name, ID number, date of birth and location will auto-populate from the entered claim.
- Enter your question (be specific as possible).

Ask Provider Services

Inquiry

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

How would you like to contact Provider Services?

Submit your question online

Talk to Provider Services online
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

Health Plan:
BlueCross BlueShield Plans

Inquiry Reason:
Claim Status Inquiry

* Patient's First Name: * Patient's Last Name: * Patient's Member id: Patient's Date of Birth:
mm/dd/yyyy

* Location: Primary ID:

* Please enter a question:

or [Back](#)

Available Resources

Ask Provider Services — Viewing Web Inquiry Responses

Be sure to:

- Select Go to Message Center.
- To narrow the results, you can:
 - Enter the ID number and select the Health Plan.
 - Select specific months.

[Go to Message Center](#)

Search by Member ID: Select a Plan...

Last 30 Days Results (0)

Message Tools

Date ▲	Subject
We did not find any messages for the time period you chose. Please try your request again with a different time period.	

Note: If you submit an inquiry in one month and do not see a response, search by the member's ID number. The response may be listed under a different month.

Available Resources

STATchat

- STATchat is a fast and simple way to speak with a provider services representative.
- The feature is available through My Insurance Manager.

System Requirements

- A current version of Adobe Flash Player
- A compatible web browser, such as Microsoft Internet Explorer 10 or EDGE® or Google Chrome®
- A headset (recommended) or standalone microphone and speakers connected to your computer

Ask Provider Services

STATchat * Required

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

How would you like to contact Provider Services?

Submit your question online

Talk to Provider Services online
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

Inquiry Name:
BlueCross BlueShield Plans

Inquiry Reason:
Claim Status Inquiry

* Patient's First Name: / * Patient's Last Name: K * Patient's Member id: B: i9Q

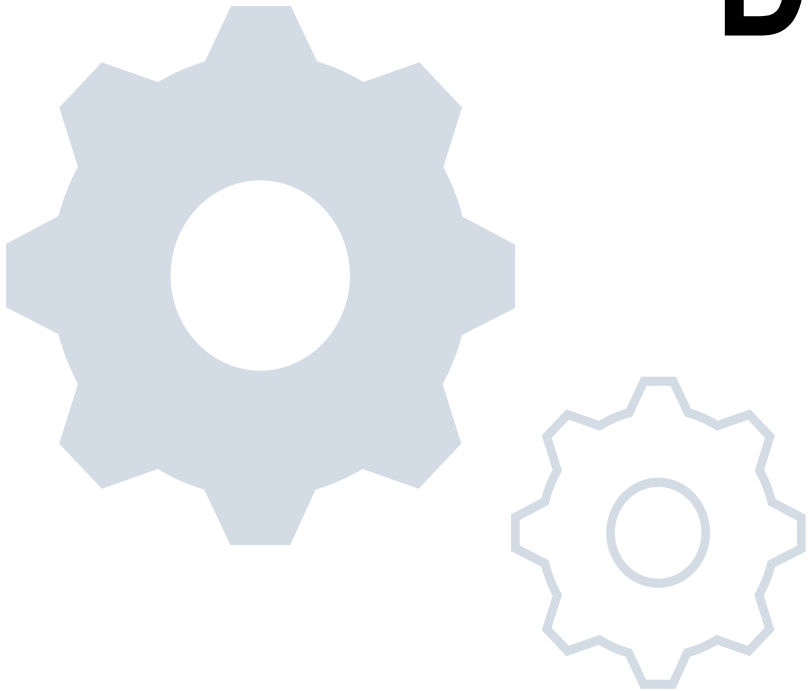
* Location: Primary ID: 1

[Need help using STATchat?](#)

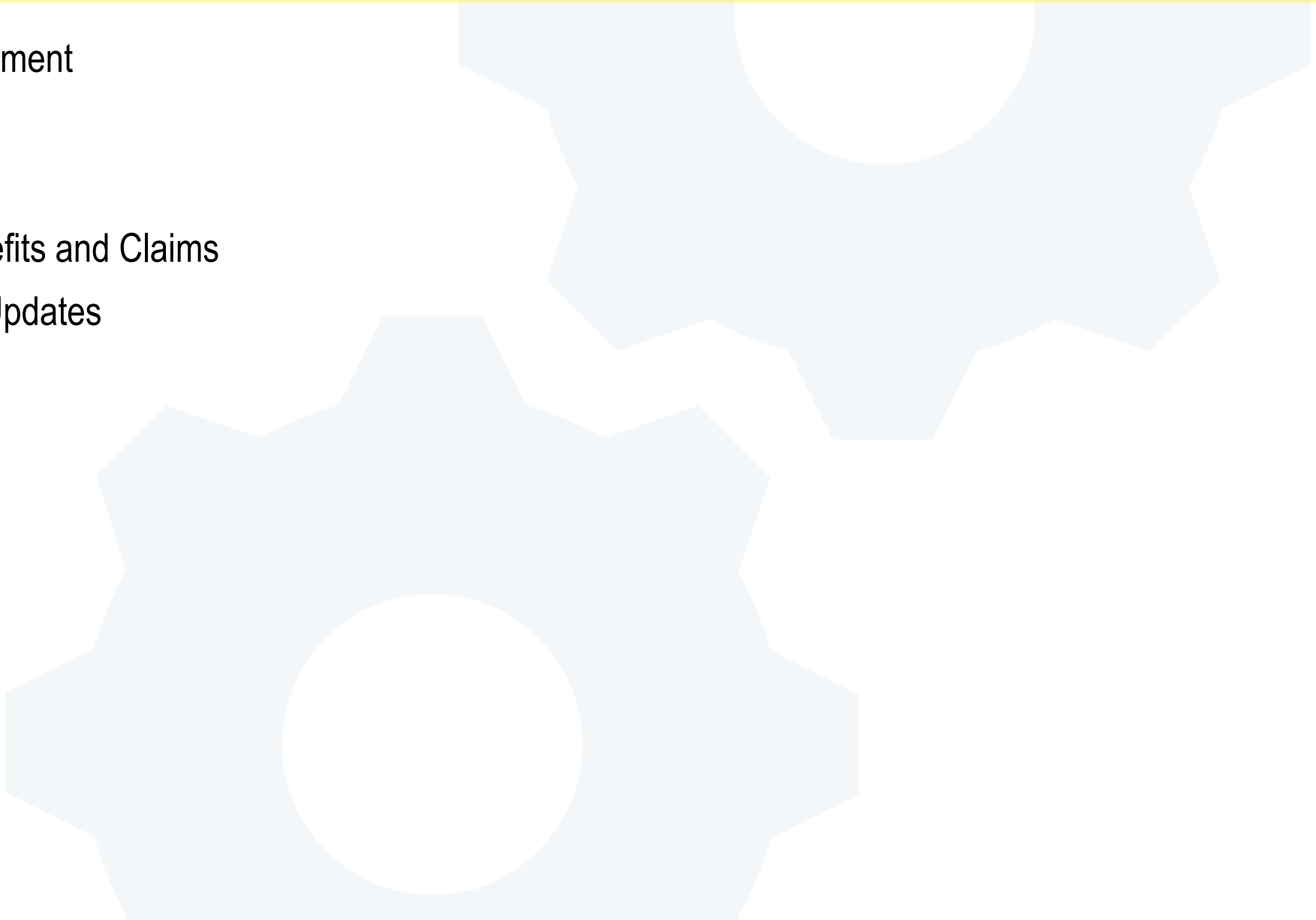
Launch STATchat or [Back](#)



Dental Network



Agenda

- Provider Enrollment
 - Dental Plans
 - Dental GRID
 - Eligibility, Benefits and Claims
 - 2024 Coding Updates
- 
- The background features two large, light blue gears. One gear is positioned in the lower-left quadrant, and the other is in the upper-right quadrant. They are partially overlapping and have a semi-transparent appearance, allowing the white background to show through.



Dental Provider Enrollment

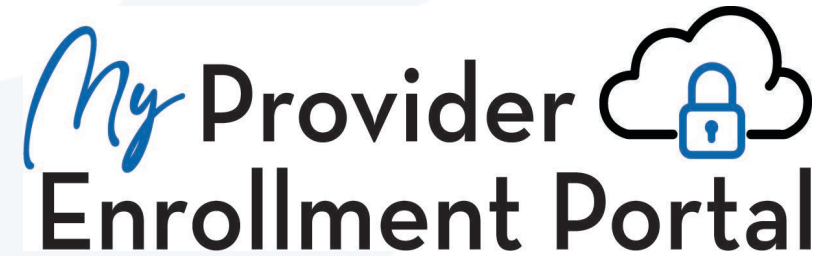


Dental Provider Enrollment

Participating Dental Network

- Plans that use the Participating Dental Network include:
 - Commercial plans.
 - Medicare Advantage plans.
 - State Dental Plus.
 - Companion Life Dental.
 - FEP Basic, Standard and BCBS FEP Dental.
 - GRID members.
- Visit www.SouthCarolinaBlues.com.

Providers>Provider Enrollment>My Provider Enrollment Portal



Individual Provider Enrollment

For Providers wanting to enroll with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan.

Note: This application applies to medical, dental, and mid-level providers.

ENROLL

Dental Provider Enrollment

Updates to Dental Enrollment Application

- Since implementing [My Provider Enrollment Portal](#), we have made updates to improve efficiency. The latest update is with the dental application.
- To streamline the process, all individual providers will use the same application.
- From the entry page, you will still select DDS or DMD as the provider type.

Note: The fields will be the same, but the application may look different.

Dental Provider Enrollment

What to Include with Initial Individual Enrollment

Checklist Items	Doctor of Dental Surgery (DDS)	Doctor of Dental Medicine (DMD)
Provider Enrollment Application		
Copy of SC Medical/Practice License		
DEA Certification	Note 1	
Current Copy of Malpractice (Min. \$1M/\$3M)		
Authorization to Bill for Services		
Clinical Lab Improvement Amendments		Note 2
Nurse Practitioner Preceptor Form		
Signed Contracts		
Hold Harmless – BlueChoice HealthPlan		
Appendix D – BlueChoice HealthPlan		
Additional Items for Medicaid		
Medicaid ID Number		Note 2
Nurse Protocols		
Physician Assistant Protocols		

1. Only needed if applicable.
2. Only needed if the DMD is applying for medical networks.

Note: Shaded fields are required.

Dental Provider Enrollment

What to Include with Initial Group Practice Enrollment

Checklist Items	Dental
Group Practice Application	
IRS Verification of Tax ID (No W-9s)	
Electronic Funds Transfer Enrollment	
Application for Satellite Location	
Clinical Lab Improvement Amendments	
Signed Contracts	
Copy of CMS Letter	
Copy of Medicare PTAN Letter	
Copy of Business License	
Copy of DHEC License	
Additional Items for Medicaid	
Medicaid ID Number	

Note: Shaded fields are required.

Dental Provider Enrollment

What to Include for In-State, Out-of-Network

Checklist Items
¹ Health Professional Application
¹ Authorization to Bill for Services
² Group Practice Application
² IRS Verification of Tax ID (No W-9s)
² Electronic Funds Transfer Enrollment

1. Needed for each individual being linked to the practice.
2. Needed if the group is not on file.

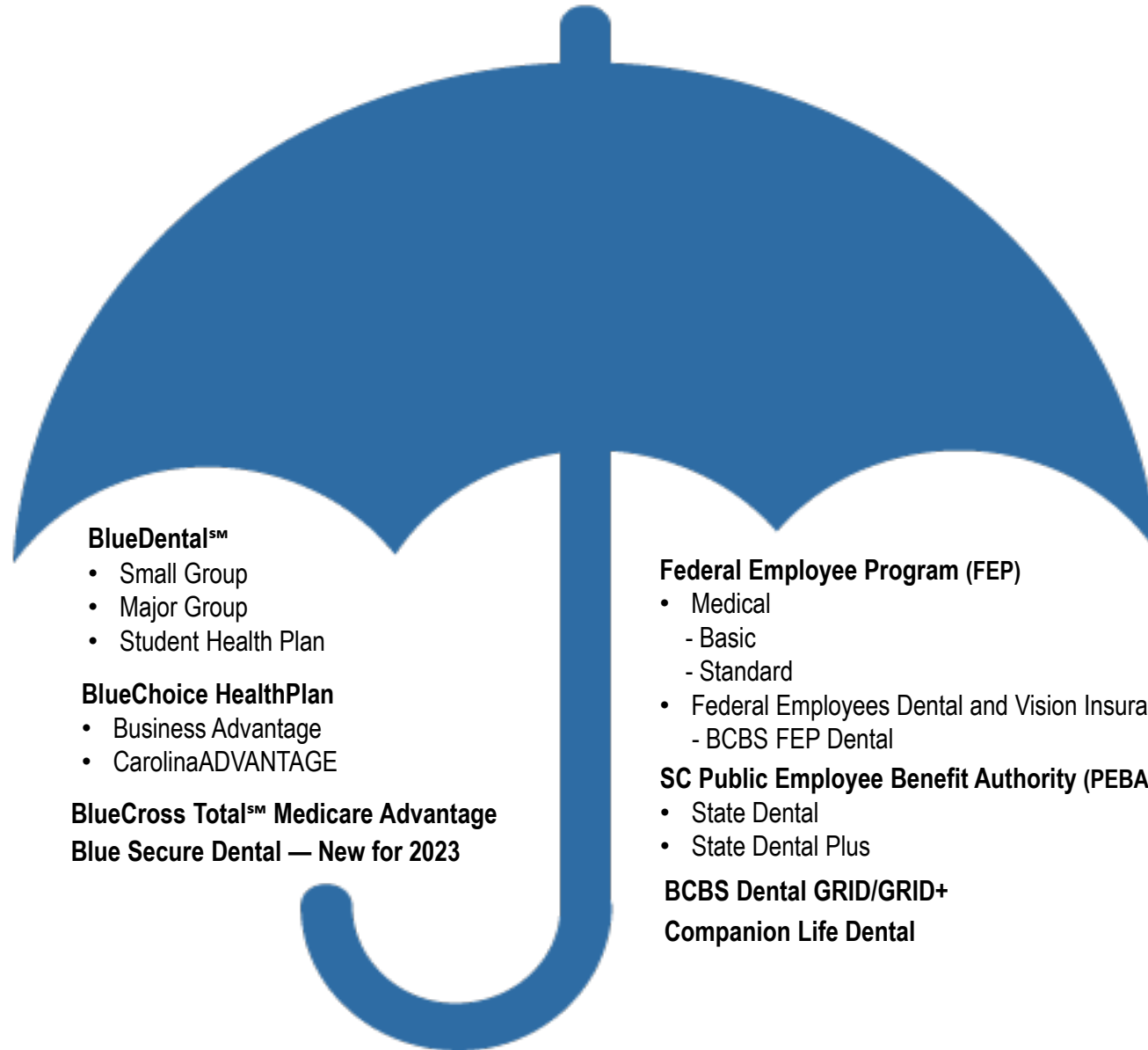
Note: This checklist applies to individual practitioners. Group practices that wish to remain out-of-network would complete the Group Enrollment application and select No for the network participation question.



Dental Plans



BlueCross BlueShield of South Carolina Dental Umbrella



BlueDentalSM

- Small Group
- Major Group
- Student Health Plan

BlueChoice HealthPlan

- Business Advantage
- CarolinaADVANTAGE

BlueCross TotalSM Medicare Advantage
Blue Secure Dental — New for 2023

Federal Employee Program (FEP)

- Medical
 - Basic
 - Standard
- Federal Employees Dental and Vision Insurance Program (FEDVIP)
 - BCBS FEP Dental

SC Public Employee Benefit Authority (PEBA)

- State Dental
- State Dental Plus

BCBS Dental GRID/GRID+

Companion Life Dental

Dental Plans



Commercial Plans


 South Carolina	
SUBSCRIBER'S FIRST NAME _____ SUBSCRIBER'S LAST NAME _____	
Member ID XXX123614046483	
PLAN DENTAL PLAN CODE 380	

www.SouthCarolinaBlues.com	

 South Carolina	www.SouthCarolinaBlues.com Customer Service: 1-800-922-1185
	BlueCross BlueShield of South Carolina P.O. Box 6000 Greenville, SC 29606-6000 An independent licensee of the Blue Cross and Blue Shield Association.
DB	

Sample Commercial — Dental Only ID Card

 South Carolina	
SUBSCRIBER'S FIRST NAME _____ SUBSCRIBER'S LAST NAME _____	
Member ID XXX123456789012	
RxBIN 021684 RxGRP BXMN	
MAMMOGRAPHY NETWORK _____ GRID+ _____	
www.SouthCarolinaBlues.com	

 South Carolina	www.SouthCarolinaBlues.com
Providers: File claims with the local BlueCross and/or BlueShield Plan where member received services. Preauthorization required for some hospital outpatient procedures and all hospital inpatient admissions. MRI/MRA/PET/CT and radiation oncology therapy will require authorization to ensure benefit payment. "Buy and Bill" specialty drugs require precertification for benefit payment consideration. Report all emergency admissions within 24 hours.	Customer Service: XXX-XXX-XXXX Dental Customer Service XXX-XXX-XXXX PPO Network Providers: 800-810-2583 Essential Advocate™: 855-638-5839 Precertification: 800-334-7287 Mental Health and Substance Abuse Precertification: 800-868-1032 EyeMed: 866-939-3633 Pharmacy Help Desk: 855-811-2218 Buy and Bill Drugs - Precertification: 877-440-0889
Medical & Dental - Please submit claims to: P.O. Box 100300, Columbia, SC 29202	An independent licensee of the Blue Cross and Blue Shield Association.
MOX	

Sample Commercial — Medical and Dental ID Card

Dental Plans

Commercial Plans (Continued)

- There are some dental plans that use a network of participating providers, while other plans do not.
 - Members are always encouraged to select in-network providers.
 - Members that use out-of-network providers will be responsible for all charges exceeding the schedule of dental allowances
- Coverage levels include:
 - Preventive care.
 - Restorative care.
 - Major restorative care.
 - Implant services (coverage varies per plan).
 - Orthodontic care (coverage varies per plan).

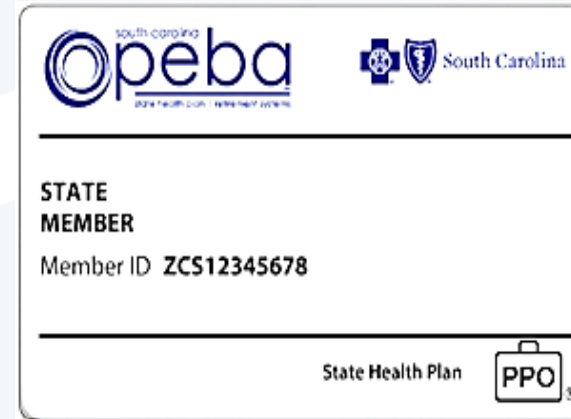
Dental Plans

State Plan: Basic Dental

- SC Public Employee Benefit Association (PEBA) uses BlueCross BlueShield of South Carolina as an administrator for their dental plans.
- Benefits are divided into four classes:
 1. Diagnostic and preventive services.
 2. Basic dental services.
 3. Prosthodontics.
 4. Orthodontics.

Note: A \$1,000 benefit period maximum applies to classes 1-3.

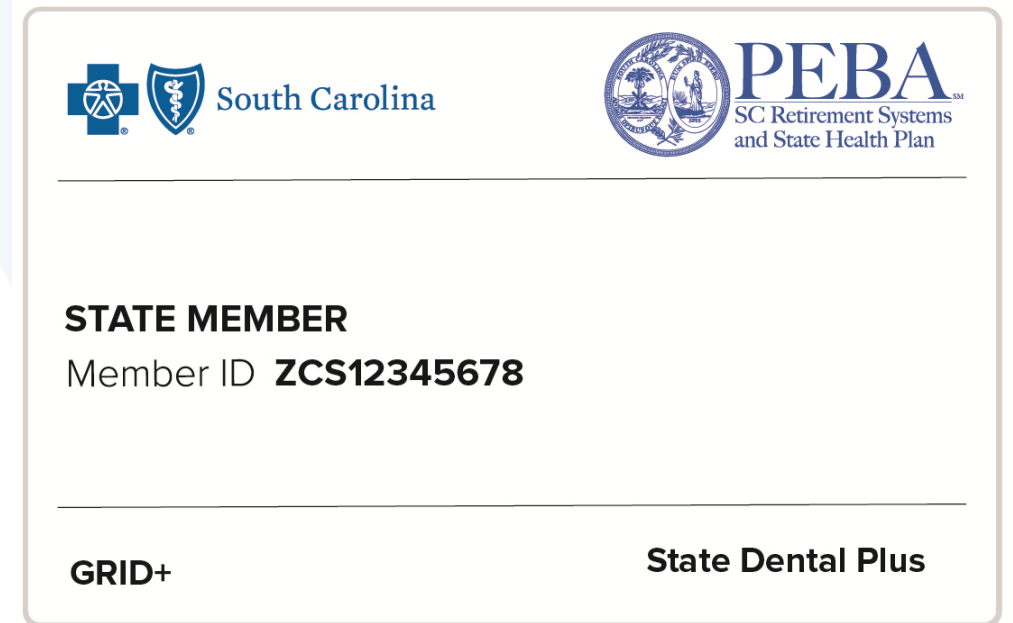
- Covered services are paid based on its schedule of dental procedures and allowable charges.
- Beginning Jan. 1, 2024, State Dental and Dental Plus will no longer apply the alternate benefit for codes D2391 – D2394.



Dental Plans

State Plan: Dental Plus



- Members with the Dental Plus plan will have **State Dental Plus** on their ID card.
- Dental Plus is a supplement to the Basic Dental plan and provides an additional \$1,000 benefit period maximum for classes 1-3.
- Dental Plus provides a higher level of reimbursement for services that the Basic Dental plan covers.
 - Reimbursement is based on the commercial negotiated rate with BlueCross BlueShield of South Carolina.
- Dental Plus members utilize the BlueCross BlueShield of South Carolina Network for in-network benefits.



Dental Plans

Federal Employee Program (FEP): Basic Option

- Members have a \$35 copay for evaluations. If members have Medicare Part B or a FEDVIP plan, the FEDVIP plan pays the \$35 copay.
- FEP pays any balance up to the BlueCross Preferred Blue Participating Dental allowance.
- Basic members must use preferred dentists to receive benefits.
- If a service is not covered by FEP Basic, in-network providers can charge their usual and customary charge.

 BlueCross BlueShield Federal Employee Program.	Government-Wide Service Benefit Plan		www.fepblue.org
Member Name Member Name	www.fepblue.org		
Member ID R99999999			
Enrollment Code Effective Date	112 01/01/2008	RxIIN RxPCN RxGrp	610239 FEPX 65006500
<small>This card is used to obtain covered benefits under the Blue Cross and Blue Shield Service Benefit Plan Basic Option. You MUST use Preferred providers to get benefits.</small>			
<small>Precertification is required for all hospital admissions and is ultimately your responsibility. Benefits are reduced by \$500 if precertification is not obtained. For instructions, call the local Blue Cross and Blue Shield Plan serving the area where you are treated. In some areas, Preferred hospitals will obtain precertification for you. Certain other services require prior approval. Please consult your benefit brochure for more information.</small>			
<small>Use of this card constitutes acceptance of the terms and conditions in the Service Benefit Plan Brochure (RI 71-005) for the applicable contract year, which is the only legal description of benefits.</small>			
<small>Customer Service:</small>			1-800-522-5566
<small>Precertification:</small>			1-800-255-2042
<small>Mental Health/ Substance Abuse:</small>			1-800-554-9504
<small>Retail Pharmacy:</small>			1-800-626-5060
<small>Blue Health Connection:</small>			1-888-258-3432
<small>Assistance Overseas (Call collect):</small>			1-804-673-1678
BlueCross and BlueShield of Geography An independent licensee of the BlueCross and BlueShield Association.			

Dental Plans

Federal Employee Program (FEP): Basic Option

Covered Service	FEP Pays	Member Pays
Clinical Oral Evaluations	Preferred: All charges in excess of member's \$35 copayment	Preferred: \$35 copayment per evaluation
Periodic oral evaluation*		
Limited oral evaluation		
Comprehensive oral evaluation*		
*Benefits are limited to a combined total of two evaluations per person per calendar year		
Diagnostic Imaging	Preferred: All charges in excess of member's \$35 copayment	Preferred: \$35 copayment per evaluation
Intraoral – complete series including bitewings (limited to one complete series every three years)		
Preventive	Participating/Non-participating: Nothing	Participating/Non-participating: Member pays all charges
Prophylaxis – adult (up to two per calendar year)		
Prophylaxis – child (up to two per calendar year)		
Topical application of fluoride or fluoride varnish – for children only (up to two per calendar year)		
Sealant – per tooth, first and second molars only (once per tooth for children up to age 16 only)		
Not covered: Any service not specifically listed above	Nothing	All charges

Dental Plans

Federal Employee Program (FEP): Standard Option

- Members have no deductibles, copays or coinsurance.
- Members pay the difference between the fee schedule amount and the BlueCross Participating Dental allowance while using preferred dentists.
 - When using non-preferred dentists, members pay all charges in excess of the listed fee schedule.
- If a service is not covered by FEP Standard, both in and out-of-network providers can charge their usual and customary charge.

 BlueCross BlueShield Federal Employee Program.	Government-Wide Service Benefit Plan		www.fepblue.org
Member Name Member Name	www.fepblue.org		
Member ID R99999999			
Enrollment Code 104	RxIIN 610239		
Effective Date 01/01/2008	RxPCN FEPRX		
	RxGrp 65006500		

 BlueCross BlueShield Federal Employee Program.	www.fepblue.org
<small>This card is used to obtain covered benefits under the Blue Cross and Blue Shield Service Benefit Plan Basic Option. You MUST use Preferred providers to get benefits.</small>	Customer Service: 1-800-522-5566
<small>Precertification is required for all hospital admissions and is ultimately your responsibility. Benefits are reduced by \$500 if precertification is not obtained. For instructions, call the local Blue Cross and Blue Shield Plan serving the area where you are treated. In some areas, Preferred hospitals will obtain precertification for you. Certain other services require prior approval. Please consult your benefit brochure for more information.</small>	Pre-certification: 1-800-255-2042
<small>Use of this card constitutes acceptance of the terms and conditions in the Service Benefit Plan Brochure (R 71-005) for the applicable contract year, which is the only legal description of benefits.</small>	Mental Health/ Substance Abuse: 1-800-554-9504
	Retail Pharmacy: 1-800-626-5060
	Blue Health Connection: 1-888-258-3432
	Assistance Overseas (Call collect): 1-804-673-1678
	BlueCross and BlueShield of Geography An independent licensee of the BlueCross and BlueShield Association.

Dental Plans

Federal Employee Program (FEP): Standard Option

Covered Service	FEP Pays		Member Pays
	To Age 13	Age 13 and Over	
Clinical Oral Evaluations			In Network The difference between the amounts listed to the left and the BlueCross Participating Dental Allowance
Periodic oral evaluation (up to two per person per calendar year)	\$12	\$8	
Limited oral evaluation	\$14	\$9	
Comprehensive oral evaluation	\$14	\$9	
Detailed and extensive oral evaluation	\$14	\$9	
Diagnostic Imaging			In Network The difference between the amounts listed to the left and the BlueCross Participating Dental Allowance
Intraoral complete series	\$36	\$22	
Palliative Treatment			Out of Network All charges in excess of the scheduled amounts listed to the left.
Palliative treatment of dental pain – minor procedure	\$24	\$15	
Protective restoration	\$24	\$15	
Preventive			Out of Network All charges in excess of the scheduled amounts listed to the left.
Prophylaxis – adult (up to 2 per person per calendar year)	---	\$16	
Prophylaxis – child (up to 2 per person per calendar year)	\$22	\$14	
Topical application of fluoride or fluoride varnish (up to two per person per calendar year)	\$13	\$8	
Not covered: Any service not specifically listed above	Nothing	Nothing	All charges


Dental Plans

Federal Employee Program (FEP): Blue Focus

- Members with a Blue Focus plan do not have dental benefits directly with their plan.
- Members would need BCBS FEP Dental or another Federal Employees Dental and Vision Insurance Program (FEDVIP) for dental benefits.
- Claims would need to be filed directly to the FEDVIP plan.



BlueCross BlueShield Federal Employee Program. FEP Blue Focus. Member Name: ** OC - DO NOT MAIL ** ** Q. Member ID: R00000044. Enrollment Code: 131. Effective Date: 01/01/2012. RxIDN: 610239. RxPCN: FEPRX. RxGrp: 65006500. www.fepblue.org

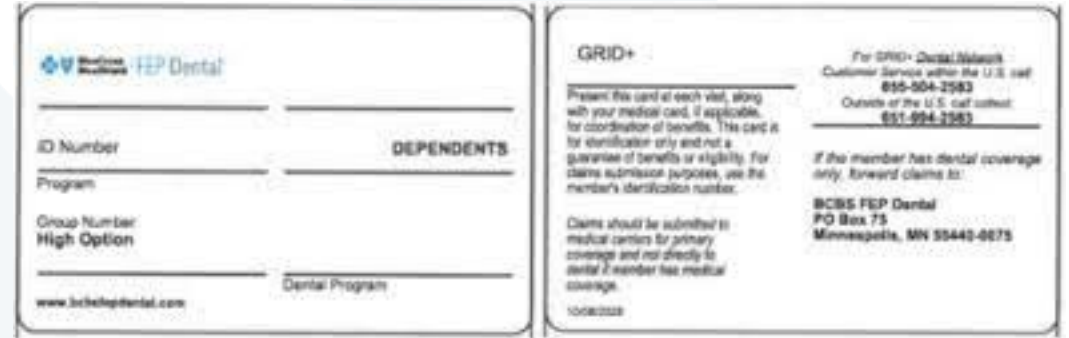


BlueCross BlueShield Federal Employee Program. www.fepblue.org. Customer Service: 1-800-000-0000. Precertification: 1-800-000-0000. Mental Health/Substance Abuse Precertification: 1-800-000-0000. Retail Pharmacy: 1-800-624-5060. Assistance Overseas (Call Collect): 1-804-673-1676. Blue Health Connector: 1-888-258-3432. BlueCross and BlueShield of Geography: An independent licensee of the BlueCross and BlueShield Association.

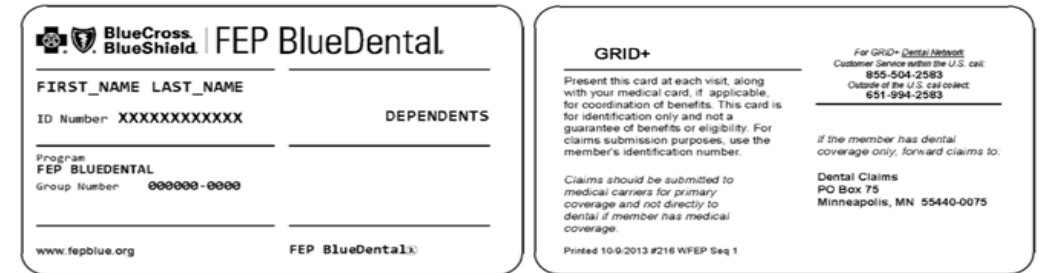
Dental Plans

Federal Employee Program (FEP): BCBS FEP Dental

- Members covered by FEP Basic Option medical plan and BCBS FEP Dental will not be responsible for the annual deductible when using an in-network provider.
- In accordance with Federal law, always file medical first if the member has dental benefits under their medical plan.
- Beginning Jan. 1, 2024, FEP Dental will cover:
 - Two routine oral exams and one additional exam if a problem occurs between check ups.
 - Nitrous oxide for children aged 5 and under, and other individuals with medical conditions that may require it.



Sample of new BCBS FEP Dental ID Card



Sample of old FEP BlueDental ID Card

Note: Existing members may have an ID card with the previous name, FEP BlueDental listed (as seen in the samples). New ID cards are not being issued to all existing members.

Dental Plans

Federal Employee Program (FEP): BCBS FEP Dental

	High Option		Standard Option	
	In-network	Out-of-network	In-network	Out-of-network
Class A (Basic) services (e.g., exams, cleanings, x-rays, sealants)	\$0	10% COINS	\$0	40% COINS
Class B (Intermediate) services (e.g., oral surgery, fillings, gum scaling)	30% COINS	40% COINS	45% COINS	60% COINS
Class C (Major) services (e.g., crowns, bridges, root canals, dentures)	50% COINS	60% COINS	65% COINS	80% COINS
Class D (Orthodontics) services (Adults and children)	50% COINS up to \$3,500 lifetime maximum per person	50% COINS up to \$3,500 lifetime maximum per person	50% COINS up to \$2,500 lifetime maximum per person	50% COINS up to \$2,500 lifetime maximum per person
Annual Deductible Class A, B and C services (Does not include Class D services)	\$0	\$50 per person	\$0	\$75 per person
Annual Maximum Class A, B and C services (Does not include Class D services)	No benefit limit	\$3,000 per person	\$1,500 per person	\$750 per person

Dental Plans

Medicare Advantage: BlueCross TotalSM, Blue BasicSM, Total ValueSM and Secure (HMO)


	BlueCross PPO Dental Benefit Highlights				HMO
	Service	In-Network	Visits (per year)	Out-of-Network	In-Network ONLY
Preventive Dental	Oral exams Cleanings	\$0	2	50% COINS	\$0
	Dental x-rays	\$0	1	50% COINS	\$0
Comprehensive Dental* (Non-Medicare covered services)	Restorative Anesthesia Endodontics Other oral/maxillofacial surgery Extractions Other services (e.g., deep cleanings, fillings, Prosthodontics crowns, root canal, dentures, bridges) <i>Note: Implants are not covered.</i>			50% COINS (INN and OON)	N/A
Annual Maximum (Per member, per year)	BlueCross Total: \$3,500 (Comprehensive and preventive combined) Total Value: \$2,000 (Comprehensive and preventive combined) Blue Basic: \$2,000 (Comprehensive and preventive combined)				N/A


*SC Blue Dental Network

Dental Plans

Blue Secure (Continued)

- Became effective on Jan. 1, 2023.
- Sample ID card:

	South Carolina
Member Name DTEST HTEST	DENTAL ONLY
Member ID 100010514534	
<hr/>	
<hr/>	
www.SouthCarolinaBlues.com	

	South Carolina	www.SouthCarolinaBlues.com
Dental – Please submit claims to: P.O. Box 100300, Columbia SC 29202		Claims: 800-222-7156 Enrollment and Billing: 855-404-6752
<hr/>		<hr/>
		BlueCross BlueShield of South Carolina P.O. Box 100300 Columbia, SC 29202 An independent licensee of the Blue Cross Blue Shield Association.
<hr/>		<hr/>
X21		

Dental Plans

Blue Secure (Continued)

	Blue Secure Dental Gold 1		Blue Secure Dental Silver 1	
Member Age	19 or older			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$50 Individual and \$150 Family		\$50 Individual and \$150 Family	
Annual Maximum (Coverage limit)	\$1,500		\$1,000	
Class I – Preventive Procedures and Exams	0% COINS	20% COINS	0% COINS	30% COINS
Class II – Basic and Restorative*	30% COINS (after six months)	50% COINS (after six months)	50% COINS (after six months)	70% COINS (after six months)
Class III – Major Procedures**	50% COINS (after 12 months)	70% COINS (after 12 months)	70% COINS (after 12 months)	Not covered
Class IV – Orthodontia Services	Not covered			
Maximum Out-of-Pocket	N/A			

* 6 month waiting period | ** 12 month waiting period

Dental Plans

Blue Secure (Continued)

	Blue Secure Dental Gold 1		Blue Secure Dental Silver 1	
Member Age	Under 19 years old			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$50 per child	\$100 per child	\$50 per child	\$100 per child
Annual Maximum (Coverage limit)	No limit			
Class I – Preventive Procedures and Exams	0% COINS	20% COINS	0% COINS	30% COINS
Class II – Basic and Restorative	30% COINS	50% COINS	40% COINS	60% COINS
Class III – Major Procedures	50% COINS	60% COINS	50% COINS	60% COINS
Class IV – Orthodontia Services (Prior authorization required)	50% COINS		50% COINS	
Maximum Out-of-Pocket Per Child	\$400	\$800	\$400	\$800
Maximum Out-of-Pocket Total (All children)	\$800	\$1,600	\$800	\$1,600







Dental GRID



Dental GRID

- Dental GRID allows dentists to see members from other participating BlueCross plans at the local plan's reimbursement levels.
- Our participating providers' reimbursement levels or provider agreements will not change when treating GRID members.
- Members in this program can be recognized by the work **GRID** or **GRID+** on their ID card.

 South Carolina	
SUBSCRIBER'S FIRST NAME _____ SUBSCRIBER'S LAST NAME _____	
Member ID XXX123456789012	
RxBIN	021684
RxGRP	BXMN
MAMMOGRAPHY NETWORK _____	
www.SouthCarolinaBlues.com	
	
	

 South Carolina	
www.SouthCarolinaBlues.com	
Providers: File claims with the local BlueCross and/or BlueShield Plan where member received services. Preauthorization required for some hospital outpatient procedures and all hospital inpatient admissions. MRI/MRA/PET/CT and radiation oncology therapy will require authorization to ensure benefit payment. "Buy and Bill" specialty drugs require precertification for benefit payment consideration.	
Report all emergency admissions within 24 hours.	
Medical & Dental - Please submit claims to: P.O. Box 100300, Columbia SC 29202	
Customer Service: XXX-XXX-XXXX Dental Customer Service: XXX-XXX-XXXX PPO Network Providers: 800-810-2583 Essential Advocate™: 855-630-5839 Precertification: 800-334-7287 Mental Health and Substance Abuse Precertification: 800-868-1032 EyeMed: 866-939-3633 Pharmacy Help Desk: 855-811-2218 Buy and Bill Drugs - Precertification: 877-440-0089	
An independent licensee of the Blue Cross and Blue Shield Association.	
MOX	

Sample Commercial - Medical and Dental ID Card

Dental GRID

Participating Plans

Anthem Insurance Companies, Inc.		
Anthem Blue Cross of California	Anthem Blue Cross and Blue Shield of Colorado	Anthem Blue Cross and Blue Shield of Connecticut
Blue Cross and Blue Shield of Georgia	Anthem Blue Cross and Blue Shield of Indiana	Anthem Blue Cross and Blue Shield of Kentucky
Anthem Blue Cross and Blue Shield of Maine	Anthem Blue Cross and Blue Shield of Missouri	Anthem Blue Cross and Blue Shield of Nevada
Anthem Blue Cross and Blue Shield of New Hampshire	Empire Blue Cross and Blue Shield of New York	Anthem Blue Cross and Blue Shield of Ohio
Anthem Blue Cross and Blue Shield of Virginia	Anthem Blue Cross and Blue Shield of Wisconsin	
Health Care Service Corporation (HCSC)		
Blue Cross and Blue Shield Illinois	Blue Cross and Blue Shield Montana	Blue Cross and Blue Shield New Mexico
Blue Cross and Blue Shield Oklahoma	Blue Cross and Blue Shield Texas	
Other		
Blue Cross and Blue Shield of Arizona	Blue Cross and Blue Shield of Kansas	Blue Cross and Blue Shield of Kansas City
Blue Cross and Blue Shield of Massachusetts	Blue Cross and Blue Shield of Nebraska	Blue Cross and Blue Shield of Vermont (CBA Blue)
BlueCross BlueShield of North Carolina	BlueCross BlueShield of Tennessee	BlueCross of Idaho
BlueCross & BlueShield of Western/ BlueShield of Northeastern New York	Capital Blue Cross (Central PA)	CareFirst Blue Cross and Blue Shield (Maryland/District of Columbia)
Excelsus BlueCross BlueShield (Rochester NY)	Horizon Blue Cross and Blue Shield of New Jersey	Wellmark Blue Cross and Blue Shield of Iowa



Eligibility, Benefits and Claims



Eligibility, Benefits and Claims

Verifying Eligibility and Benefits

Use My Insurance ManagerSM to verify eligibility and benefits or contact customer service.

Plan	Provider Services Voice Response Unit (VRU)	Fax
Commercial Dental Plans	800-222-7156 (Columbia center) 800-922-1185 (Greenville center)	803-264-7629
State Basic Dental and Dental Plus	888-214-6230 803-264-3702 (Columbia area)	803-264-7739
BCBS FEP Dental	855-504-2583	803-264-8104
FEP Dental (Medical)	800-444-4325	
BlueCross Total SM , Total Value SM and Blue Basic SM (MA Dental)	800-222-7156	803-264-7629
Companion Life Dental	800-765-9603 or 800-753-0404, ext. 45921	

Eligibility, Benefits and Claims

Filing Dental Claims Under Medical Benefits

- Use an 837P format with the accurate diagnosis code when rendering oral surgical services under State Dental and health plans.
- The following codes should always be filed to State Medical first:
 - Impacted teeth
 - D7220-D7251
 - Other surgical procedures
 - D7260, D7261, D7285, D7286
 - Excision or lesions
 - D7410-D7415
 - Remove of tumors, cysts, and neoplasms
 - D7440-D7465
 - Excision of bone tissue
 - D7471-D7490
- For BCBS FEP Dental, always file claims to the medical plan first if the member has dental benefits under their medical plan.

Eligibility, Benefits and Claims

Filing Orthodontic Claims Electronically

- Submit one line with banding fee code (D8080-D8090) and the charge.
- Submit one line with the monthly adjustment code (D8670), the total months of treatment, and the total charge.
 - Do not file the claim each month
 - Payments are automatically sent until one or more of the following apply:
 - The patient exhausts his or her lifetime benefit maximum.
 - The patient's dental coverage is terminated.
 - The patient reaches the maximum age allowed for services under his or her policy.
 - **For a transfer care**, submit one line with the monthly adjustment code, total months of the remaining treatment, and the total remaining charge.

Eligibility, Benefits and Claims

General Guidelines for Filing Dental Claims

Dental Plan	Claims Filing Procedures
Commercial and Medicare Advantage	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. If applicable, mail paper claims to the mailing address on the back of the member's ID card. Timely filing varies. Verify when checking eligibility and benefits.
Dental GRID	Send claims to the mailing address on the member's ID card.
BCBS FEP Dental	Submit all claims to the member's primary medical plan first. See the member's medical ID card for submission. Timely filing is December 31 of the year following the year of service.
State Basic Dental and State Dental Plus	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. Timely filing is 24 months from date of service. Do not file a separate claim for Dental Plus members.

Eligibility, Benefits and Claims

National Electronic Attachment (NEA)



Get Paid Faster! Use *FastAttach*™
Electronic Claim Attachments.

What is *FastAttach*?

FastAttach from NEA Powered by Vyne® is a compliant, HITRUST CSF Certified solution for submitting electronic claim attachments and supporting documentation required for claim adjudication. *FastAttach* eliminates manual, paper-based processes related to requests for supporting claim documentation and enhances denial tracking for dental providers. Say "goodbye" to claim processing delays and get reimbursements flowing with *FastAttach*.

Improve claim adjudication times by electronically transmitting:

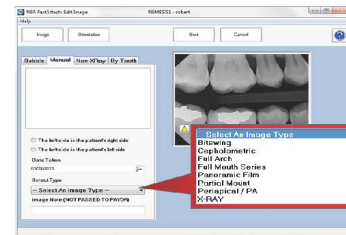
- X-rays
- Perio charts
- EOBs
- Narratives
- Pre-treatment estimates
- Secondary insurance information
- Any other documentation required to adjudicate a dental claim.

It automatically populates claim data eliminating the need for time consuming manual data entry. *FastAttach* is an encrypted, Internet based software and meets industry security requirements. Additionally, *FastAttach* interfaces with most major dental practice management systems and clearinghouses to further streamline your practice's workflow.

How does *FastAttach* work?

FastAttach is easy to setup and use. Once a request is received for additional documentation, the user simply needs to import, upload, scan or capture the image and attach it to the electronic request. *FastAttach* supports the widest variety of image acquisition

methods in the industry including: screen capture, file import, scanner and secure mobile device capture through our patented *FasKapture* app for iOS® and Android®.



Easily attach X-rays or other required supporting documentation.

Once the image is captured in *FastAttach*, the user simply transmits the image to the NEA repository. NEA immediately sends a report back to the practice with an NEA Attachment Tracking Number for each file. The user places the NEA Tracking Number in the remarks or NTE section of the claim and sends the claim electronically through their claims clearinghouse.

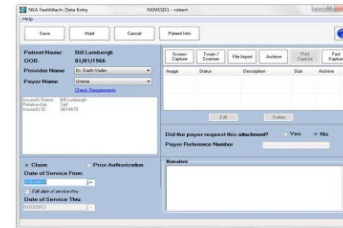
Easy to Use & Access

- Simple, easy to read screens
- Minimal training required
- 24/7 secure, online access to your images
- Enables image sharing with other providers
- Works well for solo offices, multiple locations, multi-specialty clinics and more



Take advantage of the **BCBS South Carolina Promo**.
Mention code: **BCBSSCRZ2M** & get **TWO** months
FREE, plus \$0 Registration - a \$278 savings.
Expires 1/31/2020

Call today to get started: 800-782-5150, option 2 | nea-fast.com



The Data Entry screen provides a simple interface for completing all of the attachment requirements.

Unparalleled Customer Service

- UNLIMITED FREE customer service and support
- Online chat support tool
- Experienced, knowledgeable support staff
- Refresher training for staff at no additional cost

Get Started Fast

- Minimal up-front costs - low monthly fee
- Rapid implementation (most take <1 hour)
- Compatible with most dental practice management systems and clearinghouses

Easily view payer requirements

The *FastAttach* subscription also includes *FastLook*, an integrated solution that provides individual payer attachment requirements for claims adjudication. With *FastLook*, providers can search by payer name and procedure code to determine if an attachment needs to be sent and if so, the exact parameters of what needs to be sent. Knowing this up-front eliminates the hassle of sending unnecessary attachments and saves time.

Communicate with Confidence Using Vyne Connect Encrypted Email

Did you know that sending emails that contain Protected Health Information (PHI) without using an encrypted email service to do so, could put you at risk for HIPAA violations and could even make your business a prime target for a cybersecurity breach?

NEA is attuned to your compliance needs. That's why every *FastAttach* subscription also includes access to our exclusive **Vyne Connect** encrypted email service. Improve the security of communications you send patients, payers and other providers by using Vyne Connect encrypted email exchange. It's simple to use and works with your existing email service, so no need to setup new email accounts. **Contact NEA to learn more - 800-782-5150, NEA option 2.**

Start sending **unlimited claim attachments electronically** to over 750 dental plans and payers with *FastAttach* and get the exclusive **Vyne Connect encrypted email service** - all for only **\$39 per month per office location***!

Call or register online now and **save \$278** with promo code **BCBSSCRZ2M** at: (800) 782-5150, opt. 2 or www.nea-fast.com.

*Each dental practice office location submitting claim attachments is required to have its own *FastAttach* subscription and NEA Facility ID. Separate registration is required for each office location. Offices wishing to register more than one location, please contact NEA Sales for registration assistance. Vyne Connect email service includes up to 5 email accounts/addresses per NEA Facility ID. Monthly fees begin after any promotional period expires. Monthly service may be cancelled at any time.

100 Ashford Center North, Suite 300, Dunwoody, GA 30338 | 800-782-5150 | nea-fast.com

NEA-VYNE-FA-OVERVIEW-FR00005-02/19

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Note: All dental insurance plans utilizes NEA, except for Federal Employee Program (FEP).



2024 Coding Updates



2024 Dental Coding Updates

New CDT Codes for 2024

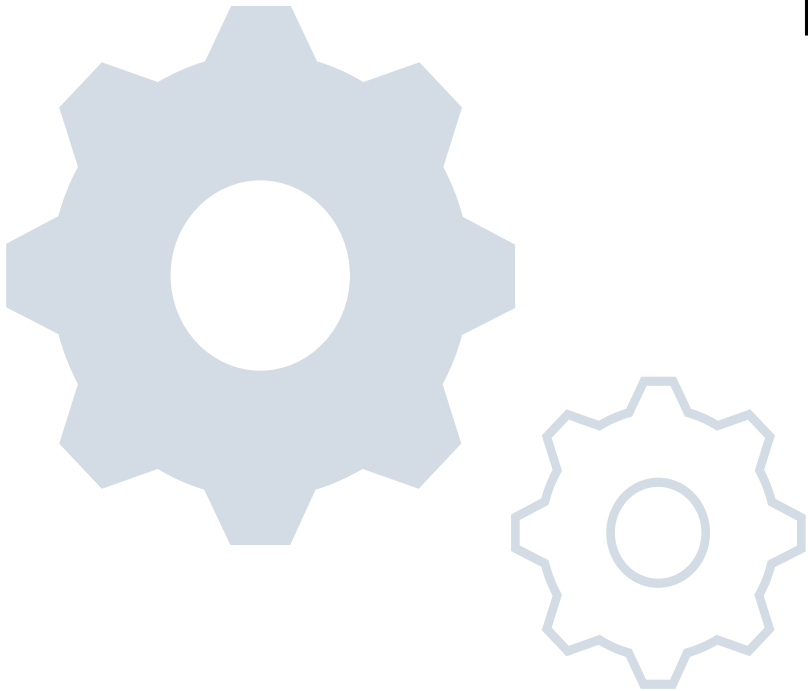
Code	Description
D0396	3D printing of a 3D dental surface scan
D1301	immunization counseling
D2976	band stabilization — per tooth
D2989	excavation of a tooth resulting in the determination of non-restorability
D2991	application of hydroxyapatite regeneration medicament — per tooth
D6089	accessing and retorquing loose implant screw — per screw
D7284	excisional biopsy of minor salivary glands
D7939	indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D9938	fabrication of a custom removable clear plastic temporary aesthetic appliance
D9939	placement of a custom removable clear plastic temporary aesthetic appliance
D9954	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device
D9955	oral appliance therapy (OAT) titration visit
D9956	administration of home sleep apnea test
D9957	screening for sleep related breathing disorders

Note the following:


- **Verify eligibility and benefits prior to rendering services.**
- **No deleted dental codes for 2024.**

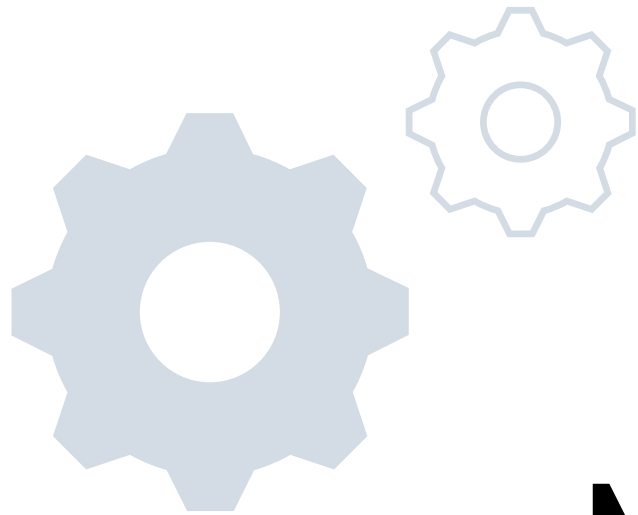


Healthy Blue



Agenda

- New Changes for 2024
 - Contacts and Resources
 - Benefits
 - Authorizations
 - Claims
 - Reminders
 - Community Services
- 
- The background features two large, light blue gears. One gear is positioned in the lower-left quadrant, and the other is in the upper-right quadrant. They are partially overlapping and have a semi-transparent appearance, allowing the white background to show through.





New Changes for 2024



New Changes for 2024

New ID Cards for Members

 Healthy Blue™ BlueChoice® HealthPlan of SC	
MEMBER SUBSCRIBER NAME MEMBER ID ZCD123456789	PRIMARY CARE PROVIDER(PCP) PROVIDER NAME XXX-XXX-XXXX
RxBIN 025771 RxPCN FMCAID RxGROUP RX42AS	

Member: Show this card and your Healthy Connections card when you get covered services. See your Member Handbook to learn more about covered benefits.

In an emergency, call 911 or go to the nearest emergency room. You don't need an OK ahead of time. We will pay for these services. Ask the hospital to call your PCP right away.

Providers: This card is for ID purposes and does not constitute proof of eligibility. This member has limited benefits outside of South Carolina. Providers should request eligibility information.

Out-of-state claims: Providers, file claims with the local BlueCross and/or BlueShield Plan where member received services.

www.HealthyBlueSC.com

Members

Customer Service:	866-781-5094
TTY Line:	866-773-9634
24-Hour Nurse line:	800-830-1525
Pharmacy Customer Service:	866-781-5094

Providers

Help for Pharmacists:	833-253-4711
Provider Service Call Center:	866-757-8286

Healthy Blue
P.O. Box 100317
Columbia, SC 29202-3317
Healthy Blue is offered by BlueChoice HealthPlan, an independent licensee of the Blue Cross Blue Shield Association.

B99

New Changes for 2024

New Mailing Address

Address	Used for...
P.O. Box 100317 Columbia, SC 29202-3317	<ul style="list-style-type: none">• Claims• Return mail• Member grievances• Provider disputes• Member and provider written correspondence (excluding appeals)

New Changes for 2024

New Provider Portals

My Insurance Manager

Start here if you've never signed up for the portal.

The screenshot displays the My Insurance Manager website interface. At the top left, the logo reads "My INSURANCE MANAGER SM". The main content area is divided into several sections:

- Login/Registration Form:** Features input fields for "Username" and "Password", a "Login" button, and a "Register Now!" button. The "Register Now!" button is circled in red, with a green callout box pointing to it from the left. Below the form are links for "Forgot Username?" and "Forgot Password?".
- Provider Resources:** A banner with a background image of a hand holding a tablet. It includes the heading "Provider Resources", a short paragraph, and a "Learn More" button.
- Browser Requirements:** A section titled "Browser Requirements" with a list of recommended browsers: Microsoft Edge*, Mozilla Firefox (current version), Google Chrome (current version), and Safari (Mac OS Only). It also includes contact information for assistance.
- Latest Features:** Two feature cards are shown. The first is titled "Safeguard PHI!" and discusses password security. The second is titled "See the Latest Bulletins!" and discusses updates. Both cards have "Learn how" or "Learn Now" buttons with right-pointing arrows.

New Changes for 2024

New Provider Portals

My Remit Manager

The screenshot shows the top navigation bar of a provider portal with the following items: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, Staff Directory, and Provider Update. A dropdown menu is open under 'Resources', listing various tools. The 'My Remit Manager' option is circled in red. Other items in the dropdown include: Access System News, BlueCard Program, Code Search, HIPAA Critical Center, Medical Policies, My Insurance Manager User Guides, and National Doctor and Hospital Finder. Below the dropdown, there is a 'Go to Message Center' link and a 'Welcome!' message. A list of services is visible, including 'Eligibility', 'Pre-authorization', 'Procedure', 'Claim Status', and 'And much more!'. A note at the bottom says: 'Click on Patient Care in the top menu to access these transaction Management. For My Insurance Manager user guides and provide Thank you for using My Insurance Manager!'

The screenshot shows the 'My Remit Manager' logo and the report title 'ERA by Check Date - May 2022'. There are two buttons: 'Check Summary Report' and 'Show Month'. A dropdown menu for 'View Checks By:' is open, showing 'Check Date' and 'Posting Date'. The main table is a calendar for May 2022 with columns for days of the week (S, M, T, W, T, F, S) and rows for dates. The table contains the following data:

	S	M	T	W	T	F	S
18	24 open	25 open CHK: 9	26 open CHK: 43	27 open	28 open	29 open CHK: 1	30 open
19	1 open	2 open CHK: 12	3 open CHK: 40	4 open CHK: 1	5 open	6 open CHK: 1	7 open
20	8 open	9 open CHK: 12	10 open CHK: 41	11 open	12 open	13 open CHK: 2	14 open
21	15 open	16 open CHK: 11	17 open CHK: 57	18 open	19 open	20 open CHK: 4	21 open

New Changes for 2024

New Vendors

Avalon Healthcare Solutions*

Manages utilization reviews for laboratory services.

PAS Portal (In My Insurance Manager)

Phone: 844-227-5769

Fax: 813-751-3760

National Imaging Associates* (NIA)

Manages utilization reviews for high tech imaging and radiology services.

www.RadMD.com

Phone: 888-642-9181

Novologix*

Manages utilization reviews for certain specialty drugs.

My Insurance Manager

New Changes for 2024

Updated Website

www.HealthyBlueSC.com



Same URL — just a different look!



Healthy Blue™
BlueChoice® HealthPlan of SC

Healthy Connections

AAA Español Members

Authorization and Eligibility ▾ Claims ▾ Patient Care ▾ Pharmacy Resources ▾

JOIN OUR NETWORK 🔍

Providers

Interested in joining our provider network? We look forward to working with you to provide quality services to our members.

JOIN OUR NETWORK

My Insurance Manager

File claims, get prior authorizations, check eligibility and benefits and more.

LOG IN REGISTER

[2023 Date of Service Login](#)
[Forgot Username or password?](#)



Contacts and Resources



Contacts and Resources

Website

www.HealthyBlueSC.com

Provider Service

Phone: 866-757-8286 or TTY: 866-773-9634

Fax: 803-870-6511

Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Disease Management (DM) Department

Phone: 866-757-8286 or TTY: 866-773-9634

Fax: 803-870-6502

Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Utilization Management (UM) Department

Phone: 866-757-8286 or TTY: 866-773-9634

Fax: 803-870-6500

Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Quick Reference Guide

Use this guide to identify the most efficient method to obtain benefit information and get preauthorization for certain services.

Vision Service Plan* (VSP)

Phone: 800-615-1883

Hours: Monday – Friday, 8 a.m. to 5 p.m. EST

Saturday, 10 a.m. to 3 p.m. EST

Sunday, 10 a.m. to 4 p.m. EST

24/7 Nurse line

Phone: 800-830-1525

Case Management (CM) Department

Phone: 866-757-8286 or TTY: 866-773-9634

Fax: 803-870-6501

Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Companion Benefit Alternatives (CBA)

Phone: 866-757-8286 or TTY: 866-773-9634

Fax: 803-870-6506

Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

National Imaging Associates* (NIA)

Phone: 888-642-9181

Hours: Monday – Friday, 8 a.m. to 5 p.m. EST

Website: www.RadMD.com

Contacts and Resources

CarelonRx – Prior Authorizations

Retail

Phone: 844-410-6890

Fax: 844-512-9005

Hours: Monday- Friday 8 a.m. to 8 p.m. EST
Saturday 10 a.m. to 2 p.m. EST

Home Delivery/Mail Order

Phone (24/7): 833-203-1737

Fax: 800-207-3118

Medical Injectables

Phone: 833-988-1264

Fax: 844-512-7027

Hours: 7 a.m. to 7 p.m. EST

Specialty Pharmacy

Phone (24/7): 833-255-0646

Fax: 833-263-2871

Contacts and Resources

BlueBlast

Monthly provider focused newsletter including:

- Important health plan updates
- Healthy Connections updates
- Announcements
- Billing and claims information
- And more

Visit www.HealthyBlueSC.com to sign up.



Provider communications

Stay current on **Healthy Blue** policies and processes, updates to clinical guidelines, state and federal regulatory changes, and other issues affecting your practice and patients.

[Subscribe to News Updates](#) 



Benefits



Benefits

Checking Covered Services

- Fee schedules
 - Visit www.scdhhs.gov/resource/fee-schedules*.
 - Information is listed by provider specialty
 - If the code appears on the fee schedule, it is covered
 - Medicaid Manage Care Organization (MCO) plans are required to offer at a minimum, the same benefits as Healthy Connections Fee for Service (FFS)
- Manuals
 - Visit www.scdhhs.gov/provider-manual-list*.
 - Information is listed by service type
 - Includes general information, billing details, claims guidelines and more

Benefits

Copays

Service	2023	2024
Primary care visits, RHCs*, and FQHCs*	\$3.30	\$0
Specialist visits (including optometrists)	\$3.30	\$0
Durable medical equipment (DME)	\$3.40	\$0
Chiropractic care	\$1.15	\$0
Home health (limited to 50 visits)	\$3.30	\$0
Outpatient hospital	\$3.40	\$0
Inpatient hospital	\$25.00	\$0

* Rural Health Clinics and Federally Qualified Health Clinics



Authorizations



Authorizations

Requesting Prior Authorizations

Prior authorizations can be requested through the below avenues:

- My Insurance Manager (preferred)
 - www.HealthyBlueSC.com
 - Providers>My Insurance Manager
- Medical Forms Resource Center (preferred)
 - www.HealthyBlueSC.com
 - Providers>Authorizations>Medical Forms Resource Center
- Phone (Utilization Management)
 - 866-757-8286
- Fax (Utilization Management)
 - 803-870-6500 (general requests)

Authorizations

Requesting Prior Authorizations — My Insurance Manager

There are two options for obtaining authorizations through MIM:

Fast-Track

- Hundreds of available options
- Automated authorization number

Custom Request

- Allows specific details to be entered
- Authorization will pend for review; if approved, authorization number is provided

The screenshot displays the My Insurance Manager (MIM) website. The top section features a login form with fields for Username and Password, a Login button, and a Register Now button. Below the login form is a 'Browser Requirements' section listing supported browsers: Internet Explorer 10 or Higher, Mozilla Firefox (current version), Google Chrome (current version), and Safari (Mac OS Only). The main navigation menu includes Home, Patient Care, Office Management, Resources, and Modify. The 'Health' dropdown menu is expanded, showing options such as Authorization Extension, Authorization Status, Claims Status, Eligibility and Benefits, Institutional Claim Entry, Other Health Insurance, Patient Directory, Pre-Certification/Referral, Superbill Maintenance, Pre-Service Review for Out-of-Area Members, Professional Claim Entry, and Verify Primary Care Physician. The 'Pre-Certification/Referral' option is circled in red.

Note: MIM should be used for initial authorization requests. Please fax clinical documentation for updates or continued stay reviews.

Authorizations

Requesting Prior Authorizations — Medical Forms Resource Center

Complete requests in three easy steps:

1. Enter the facility and patient details
2. Include all required clinicals
3. Submit the request

Benefits of using the MFRC

- Offers various types of authorizations
- Guides you through the required documentation
- Receives priority processing

STEP 1
FACILITY & PATIENT INFORMATION

STEP 2
CLINICAL INFORMATION

STEP 3
COMPLETE FORM

Facility & Patient Information

Instructions:
Fields marked with an asterisk are required. The certification is not valid until you receive a certification number from us. All requests are subject to review. We may require additional documentation for some services. Please print your request at the end of the submission process for your records.

Facility Information

Facility's Name*

Attending MD First Name*

Attending MD Last Name*

Requesting MD First Name*

Requesting MD Last Name*

Phone*

Fax*

Facility's Tax I.D.* ?

Facility's NPI* ?

STEP 1
FACILITY & PATIENT INFORMATION

STEP 2
CLINICAL INFORMATION

STEP 3
COMPLETE FORM

Step 2 - Clinical Information

Instructions:
Fields marked with an asterisk are required. The certification is not valid until you receive a certification number from us. All requests are subject to review. We may require additional documentation for some services. Please print your request at the end of the submission process for your records.

Begin Date of Service*

End Date of Service*

CPT/HCPCS Codes

CPT/HCPCS Code*

[ADD ANOTHER](#)

Diagnosis Codes

Diagnosis Code*

[ADD ANOTHER](#)

Type of Service

Chemotherapy	+
Durable Medical Equipment	+
Home Health/Hospice	+
Admissions/Inpatient	+
LTAC/SNF/Rehab	+
Maternity	+
Medications	+
Office	+
Outpatient	+
Student Health Notification	+

Authorizations

Requesting Prior Authorizations – Phone


- Contact the utilization management (UM) team at 866-757-8286.
- The following information is required:
 - Member’s name, date of birth, Medicaid number and address
 - ICD-10 codes
 - CPT/HCPCS codes and units or visit amounts where appropriate
 - Date(s) of service
 - Level of care as appropriate
 - Requesting or servicing provider’s Tax ID/NPI, address, phone and fax number
 - Servicing facility’s Tax ID/NPI, address, phone and fax number
 - For neonatal intensive care unit (NICU) admission, all the above plus the mother’s name, date of birth and Medicaid number

Authorizations


Requesting Prior Authorizations — Fax

Types of fax request forms include:

- Inpatient
- Psychological testing
- MCO — BabyNet
- MCO — Makena
- Universal Newborn — Pediatric offices
- Universal Synagis®



BlueChoice® HealthPlan of SC



Precertification Request Form

To prevent a delay in processing your request, fill out the form in its entirety with all appropriate information.

Request for pre-service review: Phone: 866-902-1689 Fax: 800-823-5520

Today's date:		Provider return fax:	
Member information:			
First name:	Last name:	Healthy Connections member ID:	
Address:		City, state, ZIP:	
Date of birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Contact phone:	
Additional member information:			
Referring provider: <input type="checkbox"/> Participating <input type="checkbox"/> Nonparticipating			
Full name:			
NPI:	Provider ID:	Tax ID number (TIN):	
Office contact name:	Office phone:	Office fax:	
Address:		City, state, ZIP:	
Specialty:			
Servicing provider: <input type="checkbox"/> Participating <input type="checkbox"/> Nonparticipating			
Full name:			
NPI:	Provider ID:	TIN:	
Office contact name:	Office phone:	Office fax:	
Address:		City, state, ZIP:	
Specialty:			

Healthy Blue
 Precertification Request Form
 Page 2 of 3

Servicing facility: <input type="checkbox"/> Participating <input type="checkbox"/> Nonparticipating	
Full name:	
NPI:	Provider ID: TIN:
Facility contact name:	Facility phone: Facility fax:
Address: City, state, ZIP:	
Requested service (for type of service, check all that apply):	
ICD-10 code(s):	Date/date range of service:
CPT® code(s) (include requested units):	
Type of service:	
<input type="checkbox"/> Outpatient	<input type="checkbox"/> Long-term services and supports/long-term care
<input type="checkbox"/> Planned inpatient	<input type="checkbox"/> Home health
<input type="checkbox"/> Emergent inpatient	<input type="checkbox"/> Durable medical equipment
<input type="checkbox"/> Skilled nursing facility	<input type="checkbox"/> Diagnostic study
<input type="checkbox"/> Hospice	<input type="checkbox"/> Office visit
<input type="checkbox"/> Personal care services	<input type="checkbox"/> Other:
Place of service:	
<input type="checkbox"/> Hospital	<input type="checkbox"/> Home
<input type="checkbox"/> Ambulatory surgery center	<input type="checkbox"/> Independent lab
<input type="checkbox"/> Office	<input type="checkbox"/> Nursing facility
History/treatment provided by referring physician:	

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Healthy Blue, provide the authorization number with your submission.

Emergent: Use for all nonelective inpatient admissions only when provider indicates that the admission was urgent, emergent or expedited (for admission on same day).

Urgent: Use for outpatient services only when provider indicates that the service is urgent, emergent or expedited.

Health plan use only		
Status:		
Approved:	Expires:	Authorization number:
Comments:		
Representative name:	Nurse reviewer:	

This authorization is based on medical necessity only and will be contingent upon eligibility and benefits. This is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Please call the number at the top of this form if this member has any additional medical or behavioral health needs.

www.HealthyBlueSC.com

BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association. BlueChoice HealthPlan has an Amerigroup Partnership Plan, LLC, an independent company, for services to support administration of Healthy Connections.

To report fraud, call our confidential Fraud Hotline at 877-725-2702. You may also call the South Carolina Department of Health & Human Services Fraud Hotline at 888-364-3224 or email fraudres@scdhhs.gov.

BSCPEC-2110-21 November 2021



Claims



Claims

Submitting Claims — Dates of Service on or before Dec. 31, 2023

The timely filing limit for original and corrected claims is 365 days and the following avenues can be used:

- **Electronically through your clearinghouse (preferred)**
 - Contact your clearinghouse for the appropriate payor ID.
- **Electronically directly to payer**
 - Use payor ID 00403.
 - For set up and information, contact E-Solutions at 800-470-9630.
- **Provider Portal**
 - Use Availity.
- **Mail (hard copy)**
 - Healthy Blue
 - P.O. Box 100124
 - Columbia, SC 29202-3124

Claims

Submitting Claims — Dates of Service on or after Jan. 1, 2024

The timely filing limit for original and corrected claims is 365 days and the following avenues can be used:

- **Electronically through your clearinghouse (preferred)**
 - Contact your clearinghouse for the appropriate payor ID.
- **Electronically directly to payer**
 - Use payor ID 00403.
 - For set up and information, contact Electronic Data Interchange Gateway at EDIG.Support@palmettogba.com.
- **Provider Portal**
 - My Insurance Manager
- **Mail (hard copy)**
 - Healthy Blue
 - P.O. Box 100317
 - Columbia, SC 29202-3317

Claims

Claim Payment Disputes — What is a claim payment dispute?

- Disagreement with the outcome of a claim
- Includes two steps:
 1. Claim payment reconsideration
 2. Claim payment appeal (only with member's consent)
- Common reasons for a claim payment dispute include issues related to, but not limited to:
 - Contractual payment
 - Disagreements over reduced or zero-paid claims
 - Post-service authorization
 - Other health insurance denial
 - Claim code editing
 - Duplicate claim
 - Retro-eligibility
 - Experimental/investigation procedures
 - Claim data
 - Timely filing

Claims

Claim Payment Disputes — Claim Payment Reconsiderations

- Initial request to investigate the outcome of a finalized claim
- Must be submitted within **90 calendar days** from the date of the explanation of payment
- Must include as much information as possible to explain why you feel the claim was processed incorrectly

How to submit:

- **Online**
 - My Insurance Manager
- **Verbally**
 - Provider Service: 866-757-8286
- **Mail (written)**
 - Healthy Blue
P.O. Box 100317
Columbia, SC 29202-3317

Claims

Claim Payment Disputes — Claim Payment Appeals (Only with member consent)

- Request submitted when there is a disagreement with the outcome of the claim payment reconsideration
- Must be submitted within **30 calendar days** from the explanation of payment or the claims payment reconsideration determination letter
- Must include as much information as possible to explain why you feel the claim was processed incorrectly

How to submit:

- **Mail (written)**

- Healthy Blue
P.O. Box 100317
Columbia, SC 29202-3317

Claims

Claims Assistance Workflow

Provider receives a denial or questions a payment.

Access My Insurance Manager for additional claims processing information.

If the issue is resolved,  no further action is required.

If the issue is unresolved,  to the next step.


Call Provider Service at 866-757-8286; obtain the name of the representative and a call reference number.

If the issue is resolved,  no further action is required.

If the issue is unresolved,  to the next step.

File a claim reconsideration (verbally or written).

If the issue is resolved,  no further action is required.

If the issue is unresolved,  to the next step.

If you're unsatisfied with the outcome of the reconsideration, file an appeal (with the member's consent).

If the issue is resolved,  no further action is required.

If the issue is unresolved,  to the next step.

Contact your Provider Relations Consultant. Provide the name, call reference number and prior steps taken.

Claims

Balance Billing

Balance billing is sending a member a bill for an amount that Healthy Blue did not reimburse on the submitted claim.

Per your Healthy Blue contract, **you are not permitted to balance bill for any portion of the services that the health plan does not pay.**

The member should be held harmless and not financially responsible for any amounts not paid for the contracted service(s) unless otherwise specified in the evidence of coverage (EOC).



Reminders



Reminders

Member Annual Eligibility

Ways for the member to apply or renew:

- Website: apply.scdhhs.gov
 - Select Apply for Medicaid or Submit Annual Review
- Fax: 888-820-1204
- Email: 8888201204@faxschdds.gov
- Mail:
SCDHHS Central Mail
P.O. Box 100101
Columbia, SC 29202
- In person: local eligibility office



SCAN ME

Reminders

Cultural Competency

- Cultural competency is a set of congruent behaviors, attitudes and policies that enable effective work in cross-cultural situations.
- Cultural awareness is the ability to recognize the cultural factors, values, communications and more that shape personal and professional behavior.

Skills include:

- Listening to others in an unbiased manner
- Using appropriate methods of interaction
- Recognizing the importance of cultural, social and behavioral factors in public health
- And more

Learn more about cultural competency:

- www.thinkculturalhealth.hhs.gov/education *

Reminders

Fraud, Waste and Abuse

- Providers are required to:
 - Comply with all applicable statutory, regulatory and other Medicaid managed care requirements in South Carolina.
 - Report any law violations and follow their organization's code of conduct that expresses their commitment to standards of conduct and ethical rules of behavior.

How to report:

- Call 800-763-0703.
- Complete the form at: <https://www.southcarolinablues.com/web/public/brands/sc/assistance/report-fraud/>
- Call the South Carolina Department of Health and Human Services (SCDHHS) at 888-364-3224 or email fraudres@scdhhs.gov.

Reminders

Access and Availability

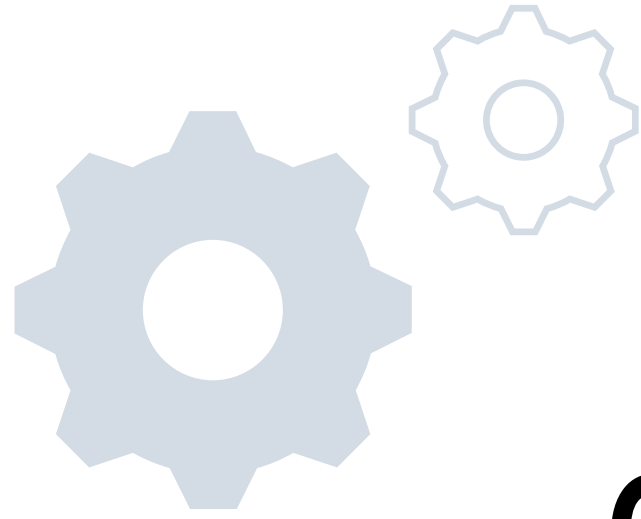
- Primary care

Type of visit	Availability standard
Routine	Within four to six weeks
Urgent, non-emergent	Within 48 hours
Emergent	Immediately upon presentation at a service delivery site

- Specialist care

Type of visit	Availability standard
Routine	Within four weeks; 12 week maximum for unique specialists
Urgent medical condition appointment	Within 48 hours of referral or notification from PCP
Emergent	Immediately upon referral

Note: Wait times should not exceed 45 minutes for a scheduled appointment of a routine nature.




Community Service





Community Service

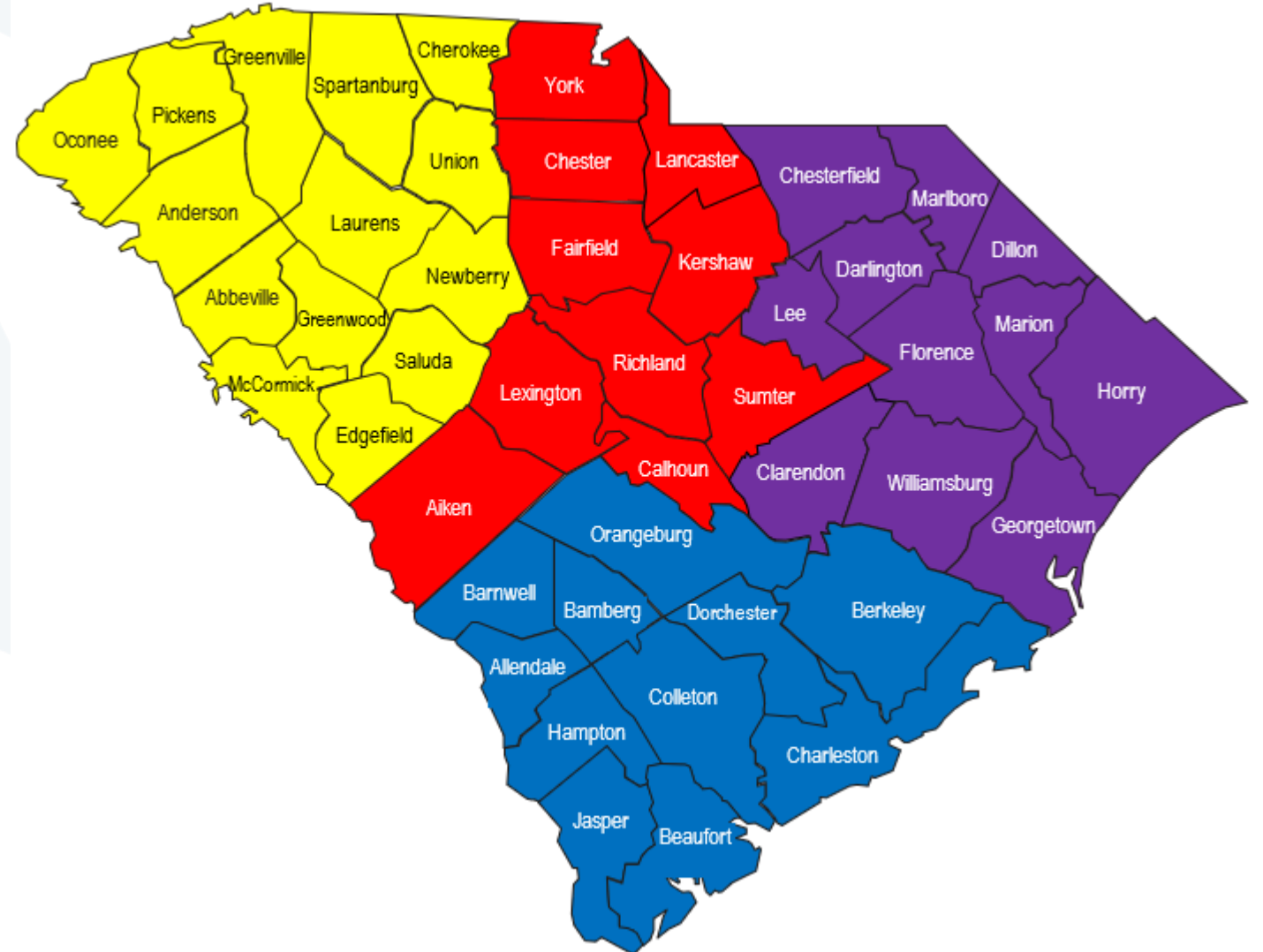
Community Outreach Specialists

 **Nathan Cox**
Nathan.Cox@bluechoicesc.com
(704) 941-7490

 **Marcell Barnes**
Marcell.BarnesJR@bluechoicesc.com
(803) 467-6011

 **Jessica Barnett**
Jessica.Barnett@bluechoicesc.com
(843) 693-0359

 **Leslie Bruton**
Leslie.Bruton@bluechoicesc.com
(864) 887-1127



Community Service

Social Media Platforms



@HealthyBlueSC



@HealthyBlueSC



@HealthyBlueSC

#HealthyBlueSC

Community Service

Value Added Benefits

Free cell phone with monthly minutes, data and texts

Free food delivery for qualifying members (up to \$40)

- Eligibility requirements apply

Free fruit and vegetables

- Eligibility requirements apply

Free adult vision

- Ages 21 & up
- Annual exam
- Glasses and frames every two years

\$35 Barnes & Noble Gift Card

- Babies 0 – 24 months

Free diapers and car seats

- Up to 15 months of age
- Case of diapers (200 count)
- Limited to no more than six, after well-child visits
- Car seat — eligibility requirements apply

\$100 Gift Card for GED Testing

- Ages 17 and up

Free tutoring services for grades K — 8th

Free Sports Physicals

- Ages 6 — 18

and MUCH, MUCH MORE!

Community Service


Member Incentives

Activity	2023 Current Reward Value	2024 Proposed Reward Value
Prenatal Care Visit	\$25	\$25
Postpartum Care Visit	\$50	\$50
Well Child Visits (ages 1 – 6) Later Well Child Visits (ages 7 – 8)	Max of \$80	Max of \$80
Annual Checkups (ages 3 – 21)	\$25	\$25
Pap Test	\$50	\$25
Breast Cancer Screen	\$50	\$25
Chlamydia Screening	\$25	\$25
Diabetes Eye Exam	\$25	\$25
Diabetes Blood Test	\$25	\$25
Flu Shot	\$10	\$20
HPV Shots	N/A	\$20
Colorectal Cancer Screening	N/A	\$10
Personal Health Assessment (Non-HEDIS)	N/A	\$20
My Health Toolkit (Non-HEDIS)	N/A	\$20

My Provider Enrollment Portal



Agenda

- My Provider Enrollment Portal Overview
 - Completing Clean Applications
 - Making Corrections to Applications
 - Resources and Helpful Tips
- 
- The background of the slide features two large, light blue gears. One gear is positioned in the lower-left quadrant, and the other is in the upper-right quadrant. They are rendered in a semi-transparent style, allowing the white background to show through. The gears are interlocking, symbolizing a process or system.



My Provider Enrollment Portal Overview



My Provider Enrollment Portal Overview

Use the portal to:

- Become a network provider.
- Receive automated status updates.
- Make certain updates for the physician or practice.
- Receive notifications when additional information is needed.

My Provider 
Enrollment Portal

My Provider Enrollment Portal Overview

Sign Up for Access to the Portal

Visit www.SouthCarolinaBlues.com.

Providers>Provider Enrollment>My Provider Enrollment Portal

South Carolina

Username

Password

Log in

[Forgot your password?](#) [New user?](#)

For assistance, please contact the provider education team using the request form.

[Request Form](#)

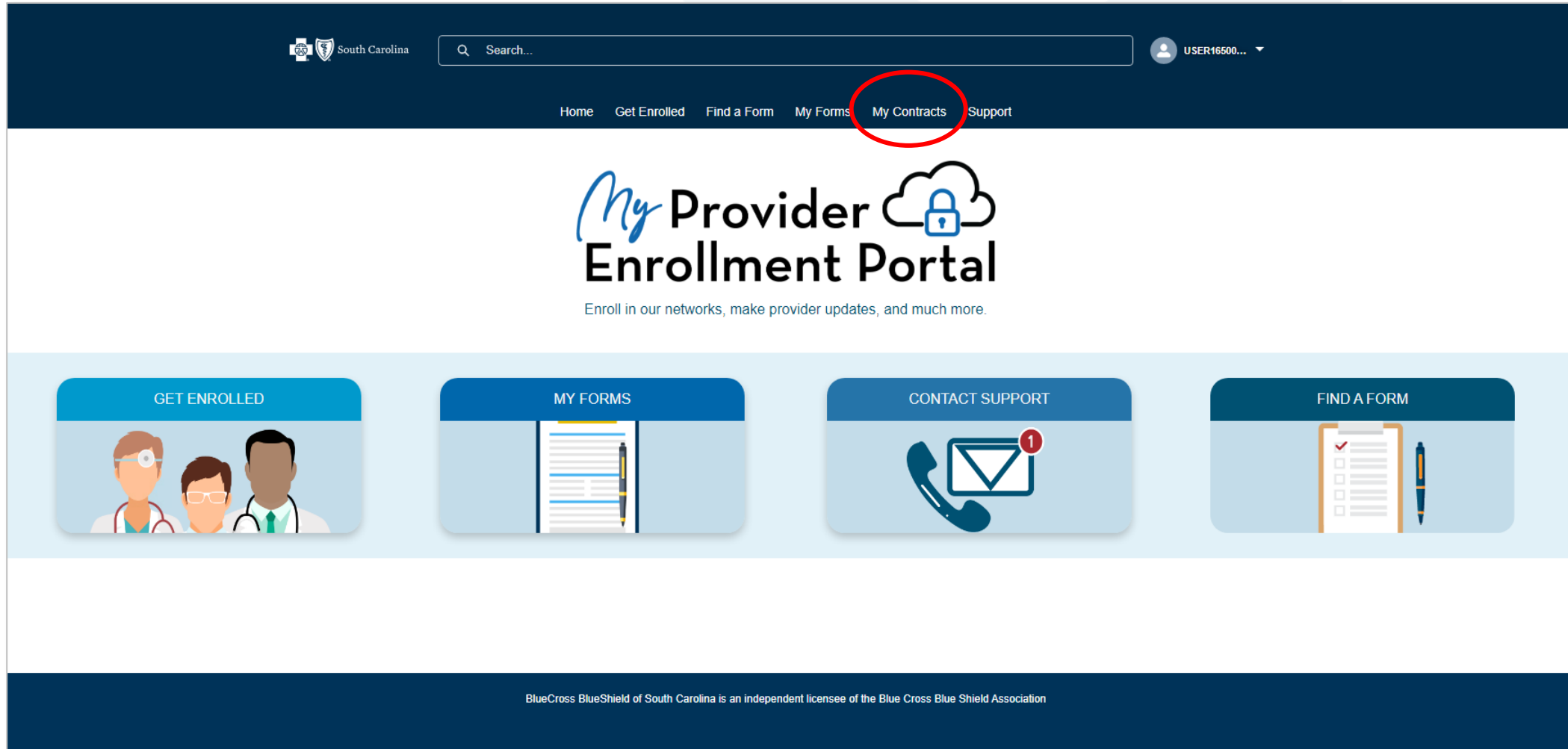
[View the user manual and frequently asked questions here.](#)

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross Blue Shield Association

Select New user if you've never signed up!

My Provider Enrollment Portal Overview

Home Page



The screenshot displays the home page of the My Provider Enrollment Portal. At the top left, the Blue Cross Blue Shield of South Carolina logo is visible. A search bar is located in the top center, and a user profile dropdown menu labeled 'USER16500...' is on the top right. The main navigation menu includes 'Home', 'Get Enrolled', 'Find a Form', 'My Forms', 'My Contracts', and 'Support'. The 'My Contracts' link is highlighted with a red circle. The central header features the 'My Provider Enrollment Portal' logo, which includes a cloud with a padlock icon, and the tagline 'Enroll in our networks, make provider updates, and much more.' Below this, there are four main action buttons: 'GET ENROLLED' with an icon of three doctors, 'MY FORMS' with a document and pen icon, 'CONTACT SUPPORT' with a phone and envelope icon and a red notification badge with the number '1', and 'FIND A FORM' with a checklist and pen icon. The footer contains the text: 'BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross Blue Shield Association'.

My Provider Enrollment Portal Overview

Get Enrolled

Review the available checklists before starting an application.

The screenshot displays the 'Get Enrolled' page of the My Provider Enrollment Portal. At the top, there is a navigation bar with the South Carolina logo, a search bar, and a user profile icon. Below the navigation bar, the main heading 'Get Enrolled' is followed by a sub-heading: 'Looking to join one of our networks? Select one of the appropriate forms below to get started.' A red oval highlights a note below this sub-heading: 'Please review the [available checklists](#) before starting an application to ensure all required documents and information is included.' The page is organized into several sections, each with an 'ENROLL' button:

- Individual Provider Enrollment:** For Providers wanting to enroll with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan. Note: This application applies to medical, dental, and mid-level providers. This application does NOT apply to Behavioral Health providers.
- Group Practice Enrollment:** For group practices wanting to enroll with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan. Note: Complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of the creation of a new location that wishes to file claims.
- Facility Information Request Form:** Complete this form to request the credentialing of a facility. Note: This form is for Medical, CBA and MAT facility credentialing.
- Virtual Care Services:** For providers or group practices wanting to participate with telemedicine and/or telehealth services. Note: You are not eligible for Virtual Care if you do not have a fully executed Business License Agreement with a vendor.
- Health Professional Application:** Complete this form to request the addition of a health professional to our database to enable that practitioner to file claims to BlueCross BlueShield of South Carolina and BlueChoice HealthPlan. Note: This is for in-state, out-of-network providers only.
- For Behavioral Health Providers:**
 - Behavioral Health:** For providers wanting to enroll in our behavioral health network. Note: Companion Benefit Alternatives, Inc. (CBA) manages our behavioral health network. CBA is a separate company that administers behavioral health benefits on behalf of BlueCross BlueShield of South Carolina.
 - Autism Provider Panel:** For Applied Behavior Analysts wanting to enroll in our Autism Provider Panel. Note: Companion Benefit Alternatives, Inc. (CBA) manages our Autism provider panel. CBA is a separate company that administers behavioral health benefits on behalf of BlueCross Blue Shield of South Carolina.

My Provider Enrollment Portal Overview

Find a Form

Find a Form
Use the following forms for other enrollment options or to provide additional information to BlueCross BlueShield of South Carolina

Update Location Information

- Doing Business As (DBA) Name Change Form**
Complete this form to change your doing business as (DBA) name.
[COMPLETE FORM](#)
- Change of Address Form**
Use this form to update your physical, pay to, correspondence and/or billing agency addresses for Preferred Blue®, BlueChoice HealthPlan, Healthy BlueSM, State Health Plan, and FEP networks.
Note: If you are changing a pay to address, the provider or the CEO, CFO, director of finance, or director of billing must sign this form for your protection.
[COMPLETE FORM](#)
- Application for Satellite Location**
Complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of the creation of a new location that wants to file claims.
Note: A W-9 cannot be accepted.
[COMPLETE FORM](#)

Update Provider Information

- NPI Provider Notification Form**
Register your National Provider Identifier (NPI) with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan using this form. If you registered for more than one NPI, complete this form for each NPI.
Attach your notification letter from the National Plan and Provider Enumeration System (NPPES) for each NPI you received. This verification is required.
Note: This form is for out-of-state and out-of-network providers only.
[COMPLETE FORM](#)
- Add or Terminate Practitioner Affiliation**
Please complete this form to request the addition or termination of a health professional's association with your clinic, group, professional association, or institution for BlueCross BlueShield of South Carolina for Preferred Blue®, BlueChoice HealthPlan, Healthy BlueSM, FEP and/or State Health Plan.
Note: This form should be completed no more than 30 days after the addition, termination or change.
[COMPLETE FORM](#)

My Provider Enrollment Portal Overview

My Forms

South Carolina

Search...

Home Get Enrolled Find a Form **My Forms** My Contracts Support

My Forms

Complete forms that have been started or check the status of applications already submitted.

- **In Progress/Not Submitted** – The application or form is being worked by the provider or their practice. It has not been completed for submission.
- **Submitted** – The application and all required documentation with applicable signatures, initials, and dates have been uploaded.
- **Awaiting Signature** – The application or form has been completed and submitted, but signatures are missing.
- **Awaiting Provider Response/Not Submitted** – Missing items are needed from the provider or their practice to continue the enrollment process. You will receive an email and case comment explaining what item(s) is needed.
- **Under Review** – The application or form has been assigned and has progressed through the enrollment process.
- **Congratulations! Complete** – The application or form has been approved and completed.
- **Denied** – The application or form was not approved. An explanation for the denial is sent through email or case comment.
- **Canceled** – The application or form is no longer being worked on and has been closed.

If your case is in the status of Awaiting Signature, click the case number to view next steps.

All Applications ▾ ↑

5 items • Sorted by Case Number • Filtered by All cases

	Case Number ↑	Practitioner Last N...	Status	Form Type	Date/Time Opened	
1	00011891	Bennett	Submitted	Individual Application	11/16/2022, 2:07 PM	▾
2	00012542		In Progress/Not Submitted	Individual Application	12/6/2022, 1:12 PM	▾
3	00021065		In Progress/Not Submitted	Individual Application	4/14/2023, 4:49 PM	▾
4	00024792		In Progress/Not Submitted	Group Application	6/4/2023, 1:09 PM	▾
5	00030455	Pickles	Under Review	Individual Application	8/4/2023, 3:09 PM	▾

All Applications ▾ ↑

LIST VIEWS

✓ All Applications (Pinned list)

Applications Awaiting Provider Response

Approved Applications

Denied Applications

Open Applications

Recently Viewed

Recently Viewed Cases

Recredentialing - Awaiting Response

Submitted Applications

My Provider Enrollment Portal Overview

My Contracts

South Carolina

Search...

Home Get Enrolled Find a Form My Forms **My Contracts** Support

My Contracts

Complete contracts that require your attention or check their status.

Contracts Awaiting Signature ▼ ↑

4 items • Sorted by Case • Filtered by All form contracts - Status

Case ↑	Status	Form Contract ...	Network List	Form Type	Last Modified Date
1 00030455	Awaiting Signature	FCR-12433	Blue Essentials	Individual Application	8/4/2023, 7:28 PM
		FCR-12434	Medicare Advantage	Individual Application	8/4/2023, 7:28 PM
		FCR-12436	State Health Plan	Individual Application	8/4/2023, 7:28 PM
		FCR-12435	Preferred Blue® (PPC and FEP)	Individual Application	8/4/2023, 7:28 PM


Recently Viewed ▼ ↑

LIST VIEWS

- All Contracts
- Contracts Awaiting Signature
- ✓ Recently Viewed (Pinned list)

My Provider Enrollment Portal Overview

Support

USER16500...

[Home](#) [Get Enrolled](#) [Find a Form](#) [My Forms](#) [My Contracts](#) [Support](#)

CONTACT PROVIDER SUPPORT

Complete the below support form for questions regarding correct applications and forms to use OR if after checking the directory you do not see a provider that should be loaded.
Note: For behavioral health providers, please include the provider's specialty in the description box.

*** FULL NAME**

*** EMAIL ADDRESS** ⓘ *** INDIVIDUAL NPI** ⓘ

GROUP NPI **TAX ID NUMBER** ⓘ

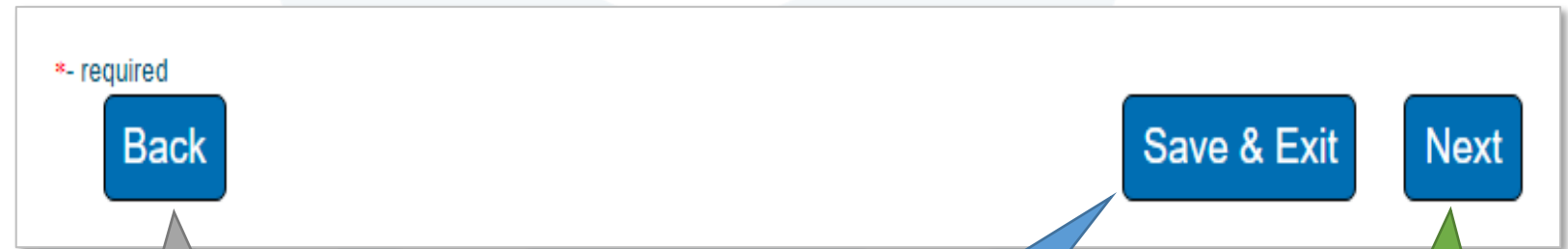
ROLE

*** SUBJECT** ⓘ

*** DESCRIPTION** ⓘ

My Provider Enrollment Portal Overview

Navigational Buttons

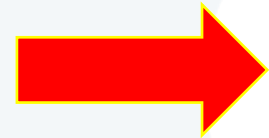


Use the Back button to move backwards in the application or form.

Use the Save & Exit button to save the entered data and exit the application or form.

Use the Next button to move forward in the application or form.

When you get here, you **MUST** select Next to submit the application.



My Provider Enrollment Portal Overview

Important Items in the Portal

Be mindful of the following items in the portal:

- Case numbers
- Statuses
- Contracts
- Case comments

My Provider Enrollment Portal Overview

Case Numbers — Generated with each application, form and support case.

My Forms
Complete forms that have been started or checked

All Applications ▼

1 item • Sorted by Case Number • Filtered by All cases

	Case Number ↑
1	00001796


Case numbers are used for:

- Checking statuses.
- Submitting case comments.
- Uploading provider contracts.

My Provider Enrollment Portal Overview

Statuses — Changes as the application or form progresses, or if additional information is needed.

My Forms
Complete forms that have been started or check the status of applications already submitted.

All Applications ▼ 

1 item • Sorted by Case Number • Filtered by All cases

Case Number ↑	Practitioner Last Name	Status
1	00001796	In Progress

Statuses include:

- In Progress/Not Submitted.
- Submitted.
- Awaiting Signature.
- Awaiting Provider Response/Not Submitted.
- Under Review.
- Congratulations! Complete.
- Denied.
- Canceled.

Note: Providers should not manually change their statuses.

My Provider Enrollment Portal Overview

In progress/Not submitted

The application or form is being worked by the provider or their practice. It has not been completed for submission.

Submitted

The application and **all required documentation with applicable signatures, initials and dates** have been uploaded.

Awaiting signature/Not Submitted

The application or form has been completed and submitted, **but signatures are missing.**

Awaiting provider response

Missing items are needed to continue the credentialing process.

My Provider Enrollment Portal Overview

Under review

The application or form has been assigned and has progressed through the credentialing process.

Congratulations! Complete

The application or form has been approved.

Denied

The application or form was not approved.

Note: Explanation for the denial is sent through email or case comment.

Canceled

The application or form is no longer being worked and has been closed.

My Provider Enrollment Portal Overview

Contracts — Provided during the application review process and must be included with the application.

My Contracts
Complete contracts that require your attention or check their status.

All Contracts ▾ ⚙

1 item • Sorted by Form Contract Name • Filtered by All form contracts - Status

	Form Contract Name ↑	Chosen Network ▾	Case ▾	Status
1	FCR-0521	BlueChoice HealthPlan	00001753	Awaiting Signature

Steps for contracts:

1. Download the contract(s).
2. Print the contract(s).
3. Have the practitioner sign the contract(s) in ink.
4. Upload the signed contract(s) to the appropriate case.

Note: Behavioral health contracts can be signed electronically.

My Provider Enrollment Portal Overview

Case Comments — Use for case-specific questions on applications and forms.

The screenshot shows the 'COMMUNICATION' section of the portal. A red circle highlights the 'Case Comments (0)' link. Below it, the 'APPLICATION INFO' section is visible, including fields for Case Number (00001706), Contact Name (Terrence Archie), Form Type (Provider Services), Status (Awaiting Signature), Date Received (2/28/2022), Description, and Subject.

New

The 'New Case Comment' form includes an 'Information' section with a text area for the comment body. Below the text area are two checkboxes: 'Public' and 'Send Customer Notification'. At the bottom right, there are 'Cancel' and 'Save' buttons.

Steps for case comments:

1. Select Case Comments
2. Select New
3. Enter your comment or question in the body
4. Select Save



Completing Clean Applications



Completing Clean Applications

Steps to Submitting Clean Applications

1. Complete the enrollment application inside My Provider Enrollment Portal.
2. Download, print and sign (include signatures, initials and dates) the application and other applicable documents.
 - Documents will be listed under Form Information.
3. Scan and upload the signed documents back to the case.
 - Select My Forms.
 - Select the case number.
 - Select Form Information.
 - Select Upload Files.
4. Download, print and sign (include signatures and dates) all applicable contracts.
5. Scan and upload the signed contracts to the case.

Completing Clean Applications

Checklist Items	Mid-Level	Physician	DDS*
Provider Enrollment Application			
Copy of SC Medical/Practice License			
DEA Certification			Note 1
Current Copy of Malpractice (Min. \$1M/\$3M)			
Authorization to Bill for Services			
Clinical Lab Improvement Amendments			
Nurse Practitioner Preceptor Form			
Signed Contracts			
Hold Harmless – BlueChoice HealthPlan			
Appendix D – BlueChoice HealthPlan			
Professional Training		Note 2	
Additional Items for Medicaid			
Medicaid ID Number			
Protocols (Written Agreement)	Note 3		

*Doctor of Dental Surgery

1. Only needed if applicable.
2. DOs, DPMs and MDs require at minimum residency.
3. Only needed for NPs and PAs.

Start Here!

Provider Enrollment Application

Provide the following information and then click Next to continue.

* Networks (Select all that apply)

Available

- Blue Essentials
- Blue OptionSM
- BlueChoice HealthPlan
- Healthy BlueSM
- Medicare Advantage
- Preferred Blue[®] (PPC and FEP)

Selected

* Your Role

--None--

* Provider's License Type ⓘ

--None--

* Credentialing Contact First Name

* Credentialing Contact Last Name

* Credentialing Contact Email

you@example.com

* Phone

Note: The email format must be a valid format. Ex.

johnsmith@healthcare.com

* Preferred Method of Contact

--None--

Completing Clean Applications

Provider Enrollment Application

Provide the following information and then click Next to continue.

* Networks (Select all that apply)

Available	Selected
Blue Option SM	Blue Essentials
BlueChoice HealthPlan	Medicare Advantage
Healthy Blue SM	Preferred Blue® (PPC and FEP)
Dental	State Health Plan

* Your Role: Office Manager

* Provider's License Type: Physician

* Credentialing Contact First Name: Tony

* Credentialing Contact Last Name: Bennett

* Credentialing Contact Email: tony.bennett@help.com

* Phone: 800-868-1122

* Preferred Method of Contact: Email

Note: The email format must be a valid format. Ex. johnsmith@healthcare.com

Next

Available license types.

* Provider's License Type ⓘ

- Physician
- None--
- Mid-Level Physician
- DDS
- DMD
- Ancillary (PT, OT, ST)
- Chiropractor
- Other

Note: Only select "other" if the provider's type is not listed. Also, you MUST have your Medicaid ID number to enroll in the Healthy BlueSM network.

Completing Clean Applications

Provider Enrollment Application

Applicant Information Medical/Professional Education Professional Training | >

Applicant Information

First Name*

Angelica

Last Name*

Pickles

Middle Initial

Suffix

Maiden Name

Gender(optional): M/F

--select an item--

Race*

White

Ethnicity*

Not Hispanic or Latino

Title (if applicable)

Professional Designation*

MD

Social Security #*

001122334

National Provider ID#*

9632587410

Birth Date (MM/DD/YYYY)*

02/01/1987

Provider Email Address*

angelica.pickles@abctestng.com

ECFMG # (if applicable)

What date will this provider start working for your practice (MM/DD/YYYY)*

11/13/2023

Language(s) Spoken (other than English)*

× English

What language services are offered through your practice?*

× Telephone

Area(s) of Specialty

Primary*

DERMATOLOGY

Include in Directory



Sub-Specialty

--select an item--

Include in Directory



Primary Taxonomy*

229N00000X

Provider Type*

Specialist

Must match
Authorization to Bill.

Save & Exit

Next

Completing Clean Applications

Provider Enrollment Application

Medical/Professional Education Professional Training License(s) Speciality E >

Medical/Professional Education

Name of School*

Clemson University

Start Date (MM/DD/YYYY)*

08/08/2005

Graduation Date (MM/DD/YYYY)*

12/16/2013

Country*

United States

City*

Clemson

State*

SC

Degree*

Doctorate

+ add item

*- required

Back

Save & Exit

Next

Completing Clean Applications

Provider Enrollment Application

[< Professional Training](#) [License\(s\)](#) [Speciality Board Certification](#) [Hospital Privile](#) [>](#)

Professional Training

Have you had Cultural Competency Training?*

No

Date Completed (Cultural Competency) (MM/DD/YYYY)

Do you have professional training to add?*

Yes

Training Institution*

Learn to Help

Program*

Residency

Country

United States

City*

Florence

State*

SC

Program Completed*

Yes

Start Date (MM/DD/YYYY)*

01/06/2014

Completion Date (MM/DD/YYYY)*

10/17/2016

[+ add item](#)

DOs, DPMs and MDs must have a minimum of residency training for credentialing.

Completing Clean Applications

Provider Enrollment Application

< **License(s)** Speciality Board Certification Hospital Privileges Work History Offi >

License(s)

Active?

State*
SC

License #*
911119

Issue Date (MM/DD/YYYY)*
01/14/2015

Expiration Date (MM/DD/YYYY)
01/14/2024

+ add item

***Upload a copy of your Active State License.**

State License Upload*

Add File...
✖ State License Example.docx

Federal DEA

Do you currently hold a federal DEA registration in each State you prescribe controlled substances?*

Yes

If DEA app has been submitted and is PENDING, DDS will not write prescriptions until DEA is finalized.

DEA License File*

Add File...
✖ DEA Example.docx

Licenses must be active on or before the requested start date for the practice.

Completing Clean Applications

Provider Enrollment Application

[< Speciality Board Certification](#) [Hospital Privileges](#) [Work History](#) [Office Practic](#) [>](#)

Speciality Board Certification

Are you board certified?*

No ▼

[+ add item](#)

If not certified, are you qualified to sit for the examination?

--select an item-- ▼

If you select Yes, additional details are required.

Completing Clean Applications

Provider Enrollment Application

< **Hospital Privileges** Work History Office Practice Information Electronic Claim >

Hospital Privileges

Do you have privileges at any hospital facility?*

Yes

If no please describe arrangements for hospital care:

Hospital*
Prisma Health

Department*
Outpatient

Street*
1300 Taylor Street

City*
Columbia

State*
SC

Zip Code*
29201

Status of Privileges*
Active

Affiliation From Date (MM/DD/YYYY)*
04/11/2018

Affiliation To Date (MM/DD/YYYY)

% Admissions*
100

+ add item

Admissions must total 100 percent. If there are multiple privileges, the TOTAL should be 100 combined, not separately.

Completing Clean Applications

Provider Enrollment Application

< **Work History** Office Practice Information Electronic Claim Filing Requirement | >

Work History

Please enter your current or most recent employer first.
To enter a future employer, ensure the Current checkbox is checked.

Current



Name of Previous/ Current Employer*

ABC Help

From Date (MM/DD/YYYY)*

01/16/2017

+ add item

Explanation of gaps in work history

Be sure to select the 'Current' box if the provider is currently working for the practice. Additionally, if their work history does not cover five years, please include an explanation.

Completing Clean Applications

Provider Enrollment Application

< Office Practice Information

Office Practice Information

Primary Site

Office practice name*
Healthy Hearts

Office e-mail*
healthyhearts@gmail.com

Practice Website

Physical Office Location

Physical Office Location (address) Should the Provider See Patients at this Location?
Yes

Street*
5516 Augusta Drive

City*
Columbia

State*
SC

Zip Code*
29219

Appointment Phone*
803-586-0001

County*
Richland

Contact Information

Office Contact First Name*
Tony

Office Contact Last Name*
Bennett

Phone #*
803-586-0002

Email*
tony.bennett@help.com

Credentialing contact same as office contact?

Credentialing Contact First Name*
Tony

Credentialing Contact Last Name*
Bennett

Phone #*
803-586-0002

Email*
tony.bennett@help.com

Group Information

Group EIN/TIN#*
01478521

Group NPI#*
9856324105

Group Medicare #

Has your group signed agreement to participate with Medicare in the past twelve months?
--select an item--

Bill for laboratory services at office?*
Yes

Current CLIA certification?*
Yes

CLIA Certification Number*
AB987654

Handicap access*
Yes

Is your office equipped with telecommunication devices for the deaf?
--select an item--

Does your office offer 24/7 coverage? (Y/N and Description)*
No

Please describe (If No, please explain)*
Triage system.

Is sign language assistance available?
--select an item--

Languages Spoken by staff*
 English

Billing Address

Billing Address Same as Office Location

Name claims payable to*
Healthy Hearts

Street/PO*
5516 Augusta Drive

City*
Columbia

State*
SC

Zip code*
29219

Billing Phone #*
803-586-0001

Billing Fax

Mailing Address

Mailing Address Same as Office Location?

Provider Patient Population

Does this provider see patients at this location?*

No

Do you accept Medicaid patients?*

No

If you have applied, your application will be pending until your Medicaid ID number has been received.

Individual Medicaid #

Are there patient age limitations?*

No

Are there patient gender restrictions?*

No Restrictions

Please describe any other patient limitations

Additional Location

Additional Location Needed

--select an item--

Completing Clean Applications

Provider Enrollment Application

< [Provider Disclosure Information](#) [Malpractice Insurance](#) [Auth to Bill](#) You are >

Provider Disclosure Information

If you are filling out this application on behalf of a provider, please skip this section. This section must be completed by the provider.

If you answer yes to any of the questions listed below, include a detailed explanation of each answer. The explanation must accompany the application for it to be considered a complete application.

1. Do you have any pending misdemeanor or felony charges?*

No

2. Have you ever been convicted of a felony?*

No

3. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?*

No

4. In the past five years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?*

No

5. Considering the essential functions of a practitioner in your area of practice in the past five years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?*

No

6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?*

No

7. Has your DEA certification or state-controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?*

No

8. Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited?*

No

9. Has your participation in Medicare, Medicaid, or any other government program ever been limited, curtailed or have you voluntarily excluded yourself from any of these programs?*

No

10. Has your participation in an Insurance Company network ever been limited or terminated?*

No

11. In the past five year and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?*

No

12. In the past five years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?*

No

13. Has any malpractice carrier ever made an out-of-court settlement or paid a judgement of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you?*

No

14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage?*

No

Completing Clean Applications

Provider Enrollment Application

< **Malpractice Insurance** Auth to Bill You are almost done. See instructions below >

Malpractice Insurance

Malpractice Insurance

Carrier's Name*

You're Covered, LLC

Policy Number*

911

Street*

1563 Ohio Street

City*

Columbia

State*

SC

Zip*

29203

Effective Date (MM/DD/YYYY)*

04/15/2019

Expiration Date (MM/DD/YYYY)*

04/15/2024

Additional coverage will be needed if the minimum coverage requirements are not met. Minimum coverage for mid-levels is \$1 mil / \$1 mil. Minimum coverage for all others is \$1 mil / \$3 mil.

Amount of Coverage (Each occurrence)*

\$1 million

Amount of Coverage (Aggregate)*

\$3 million

Malpractice must be current and active on or before the requested start date for the practice.

**Upload a copy of your malpractice insurance verification. This must include the practitioner's name on the certificate to be valid.*

Upload Malpractice Insurance*

Add File...

✖ Malpractice Example.docx

Completing Clean Applications

Provider Enrollment Application

< **Auth to Bill** You are almost done. See instructions below to complete your applica >

Auth to Bill

Date of Request (MM/DD/YYYY)
08/04/2023

Name of Clinic, Group, or Professional Association*
Healthy Hearts

Will bill for and receive charges or fees for my services effective (MM/DD/YYYY)*
11/13/2023

EIN Number*
01478521

Practitioner First Name
Angelica

Practitioner Last Name
Pickles

Practitioner SSN*
001122334

Practitioner's NPI*
9632587410

Practitioner's Email Address*
angelica.pickles@abctest.com

Representative Name*
Tony Bennett

Representative Title
Office Manager

Representative's Contact Telephone Number
803-586-0002

Representative's Email Address*
tony.bennett@help.com

Must match the requested start date with the practice on page one of the application.

Completing Clean Applications

Provider Enrollment Application

< You are almost done. See instructions below to complete your application. >

You are almost done. See instructions below to complete your application.

To complete your submission, go to the documents section under Form Information. Download your application, print, apply your signature, and re-upload them using the Upload Files button. Please note that your downloadable application will take a few minutes to appear.

Please note that:

1. You can always find your files under the "My Forms" section. Make note of your case number for easy access.
2. If contracts are required, they will be found in the "My Contracts" section with the reference to your case number.
3. If you need assistance, use the communication case comment section in this case. This way both you and your representative will have all the information and questions in one location.

*- required

Back

Save & Exit

Next

Select Next.

My Provider Enrollment Portal Overview

Next Steps for **Medical Documents** That Must Be Signed

Thank you

To complete your submission, go to the documents section under Form Information. Download your application, print, apply your signature, and re-upload them using the Upload Files button. Please note that your downloadable application will take a few minutes to appear.

Please note that:

1. You can always find your files under the "My Forms" section. Make note of your case number for easy access.
2. If contracts are required, they will be found in the "My Contracts" section with the reference to your case number.
3. If you need assistance, use the communication case comment section in this case. This way both you and your representative will have all the information and questions in one location.

For applications and forms (electronic or wet signature)

1. Select My Forms.
2. Select the appropriate case number.
3. Select Form Information.
4. Under Documents, select the document(s) that require signature.
5. Download the document(s) and have the signature(s) appended.
6. Scan the signed documents and follow steps 1 – 4 and select Upload Files.
7. Select the Confirm button to attest that **all required documentation with applicable signatures, initials and dates** have been uploaded.

For contracts (wet signature)

1. Select My Contracts.
2. Select the appropriate form contract name that corresponds with your case number.
3. Under Download Contract, select the link to download and sign the contract.
4. Follow steps 1 – 2 and select Upload Files.

My Provider Enrollment Portal Overview

Next Steps for **Behavioral Health Documents** That Must Be Signed

Thank you for your submission!

There are two options to sign and return applications/documents. They can be **wet signed** or they can be **e-signed**.

Signatures for Applications/Documents

An email will be sent to the individual practitioner for signature of their enrollment application allowing them to **e-sign** the application. However, as the credentialing contact, you also have the option to download the application, have the individual practitioner sign the application and upload the signed application to the case. See steps listed below. As the credentialing contact, you will receive a copy of the signed application.

For other documents and forms, if you wish to **e-sign**, an email will be sent from BCBS Admin at BCBS of SC (Formstack) requesting signatures. Once **e-signed** and submitted, we will receive your signed documents and begin processing your request. (Note: you will also receive an email containing the signed documents for your records.)

If you wish to **wet sign** the application/document, please see the instructions below.

1. Select "My Forms" from the MyPep options
2. Select the appropriate case number
3. Select Form Information
4. Under Documents at the bottom of the page, select the application/document requiring signature
5. Select Download at the top of the page
6. Print and sign the application/document
7. To upload the signed application/document, follow steps 1 and 2 above and click on Upload Files

Signatures for Contracts

Contractual agreements may be **e-signed** or **wet signed**. **Wet signed** documents are required to be downloaded, signed, and uploaded into the MyPep Tool. To submit signed contracts, please see these instructions.

1. Select "My Contracts" from the MyPep options
2. Sort on "All Contracts"
3. Locate your case number and click on corresponding "Form Contract Name"
4. This will take you to a page containing a link to the document.
5. Print and sign the document. Save the signed document to your computer.
6. To upload the signed document, follow steps 1 and 2 above and click on Upload Files.

For applications (if wet signing)

1. Select My Forms.
2. Select the appropriate case number.
3. Select Form Information.
4. Under Documents, select the document(s) that require signature.
5. Download the document(s) and have the signature(s) appended.
6. Scan the signed documents and follow steps 1 – 4 and select Upload Files.
7. Select the Confirm button to attest that **all required documentation with applicable signatures, initials and dates** have been uploaded.

For contracts (if wet signing)

1. Select My Contracts.
2. Select the appropriate form contract name that corresponds with your case number.
3. Under Download Contract, select the link to download and sign the contract.
4. Follow steps 1 – 2 and select Upload Files.

Completing Clean Applications

My Form

COMMUNICATION

 Case Comments (0) 


FORM FORM INFORMATION

Application Status: [Awaiting Signature](#) **Application Type:** [Individual Application](#) **Case Number:** [00030455](#) **Date Received:** [August 4, 2023](#)
Contact Name: [Terrence Archie](#) **Practitioner Name:** [Angelica Pickles](#) **Networks Chosen:** [Blue Essentials Medicare Advantage](#); [State Health Plan](#); [Preferred Blue® \(PPC and FEP\)](#)

Please wait for at least five minutes for the PDF files to generate.


You confirm that all required documents have been completed appropriately; all applications, associated forms, and contracting documents have been signed and/or initialed and dated (with current date) as indicated on these documents, and the required information/documentation and signed forms have been uploaded to the case.

Confirm


 Files (4)

Upload Files

 [Authorization to Bill -- 2023-08-04 12_58pm.pdf](#)
Aug 4, 2023 • 142KB • pdf

 [Provider Enrollment Application -- 2023-08-04 12_58pm.pdf](#)
Aug 4, 2023 • 350KB • pdf

 [State License Example.docx](#)
Aug 4, 2023 • 12KB • docx

 [Malpractice Example.docx](#)
Aug 4, 2023 • 12KB • docx

Only select this button AFTER the documents have generated and all required items have been uploaded.

If some of your files do not generate, Select Upload Files to add any missing documents.

Completing Clean Applications

FORM FORM INFORMATION

Application Status: [Submitted](#)

Application Type: [Individual Application](#)

Case Number: [00030455](#)

Date Received: [August 4, 2023](#)

Contact Name: [Terrence Archie](#)

Practitioner Name: [Angelica Pickles](#)

Networks Chosen: [Blue Essentials](#); [Medicare Advantage](#); [State Health Plan](#); [Preferred Blue® \(PPC and FEP\)](#)

Thank you for uploading your documents.

Completing Clean Applications

CONTRACTS AWAITING SIGNATURE

Form Contract Name	Network List	Form Type	Contract
FCR-12433	Blue Essentials	Individual Application	View
FCR-12434	Medicare Advantage	Individual Application	View
FCR-12435	Preferred Blue®		
FCR-12436	State Health Pla		

[View All](#)

Your Contracts Awaiting Signature

HELP:

This page contains the contracts that require your signature based on the Network that you have chosen to enroll in.

To download your contracts, click the link under **DOWNLOAD CONTRACT**.

Once you have signed the required contracts, upload them using the **UPLOAD FILES** button below.

If you are unsure what this contract is for, click the link under **CASE** to see which application this contract is associated with.

Contract Information

Form Contract Name

FCR-12433

Case

[00030455](#)

Form Type

Individual Application

Contact's Email

Status

Awaiting Signature

Chosen Network

Blue Essentials

Download Contract

https://bcssc12.my.salesforce.com/sfc/p/5f000000H7sW/a/5f000000XhGl/_rMjim6.xgkDcpY2QXiaMPvkKTZR5V_P.kKhayI8Jbc

Remember to download, sign and upload the contracts to your case.

Once you've Signed your Contract, Upload it Below

Files (0)

Upload Files

Upload Files

Or drop files



Making Corrections to Applications



Making Corrections to Applications

Correcting Applications

- All corrections must be made in the portal.
 - Allows the system to track the corrections and applies them to the appropriate fields
 - The newly generated documented will have the corrections and should be printed, signed, dated and initialed.
- Handwritten corrections will not be accepted and will be returned.

Making Corrections to Applications

Below is the information we are missing:

Here are your next steps:

1. If you are **ONLY** correcting information in the application:

- **CLICK** the Form tab to make your corrections in the application.
- **CLICK** the **NEXT** button at the bottom of each section.
- **AFTER** clicking the last **NEXT** button, **WAIT** until the new forms generate
- **DOWNLOAD** the updated PDFs to have them signed.

2. If you are **ONLY** uploading files and **DID NOT** correct any information in the application:

- **UPLOAD** your files **FIRST**.
- **CLICK** the **CONFIRM** button below the Documents section.

3. If you are correcting information in the application **AND** uploading files:

- **CORRECT** the information in the form like in Step 1 **FIRST**.
- **UPLOAD** the applicable files after the new PDFs are generated like in Step 2.
- **AFTER** your signed documents have been uploaded, click the **CONFIRM** button below the Documents section.

Making Corrections to Applications

COMMUNICATION

 Case Comments (1) 

 [ginelle c](#) 

Public:

Created Date:

8/4/2023, 6:36 PM

Comment:

The TIN for this test case is missing a digit.

[View All](#)

FORM

FORM INFORMATION

Application Status: [Awaiting Provider Response](#)

Application Type: [Individual Application](#)

Case Number: [00030455](#)

Date Received: [August 4, 2023](#)

Contact Name: [Terrence Archie](#)

Practitioner Name: [Angelica Pickles](#)

Networks Chosen: [Blue Essentials; Medicare Advantage; State Health Plan; Preferred Blue@ \(PPC and FEP\)](#)

Making Corrections to Applications

My Form

COMMUNICATION

Case Comments (1)

ginelle.c
Public:
Created Date: 8/4/2023, 6:36 PM
Comment: The TIN for this test case is missing a digit.

View All

FORM FORM INFORMATION

Provider Enrollment Application

< **Office Practice Information** Electronic Claim Filing Requirement Provider Discl >

INCORRECT

Group Information

Group EIN/TIN#*

01478521

CORRECTION

Group Information

Group EIN/TIN#*

014785210

You confirm that all corrected/missing documents/information, with the appropriate signatures/initials and dates if required, have been uploaded to the case.

Confirm



Resources and Helpful Tips



Resources and Helpful Tips

Available Resources

Visit www.SouthCarolinaBlues.com.

My Provider Enrollment Portal Manual

Providers>Tools and Resources>Guides>My Provider Enrollment Portal

My Provider Enrollment Portal FAQs

Providers>Tools and Resources>Frequent Questions>My Provider Enrollment Portal

Resources and Helpful Tips

Helpful Tips — File Uploads

- When you have a prompt to “Add file,” be sure to upload the corresponding item.
 - Applies to licenses and certificates.
- This helps ensure the document is included with the application and promotes a clean application.

**Upload a copy of your Active State License.*

State License Upload*

Add File...

Federal DEA

Do you currently hold a federal DEA registration in each State you prescribe controlled substances?*

Yes

If DEA app has been submitted and is PENDING, DDS will not write prescriptions until DEA is finalized.

DEA License File*

Add File...

*Note:- If you are CLIA certified, please submit copy of the certificate**

Add File...

**Upload a copy of your malpractice insurance verification. This must include the practitioner's name on the certificate to be valid.*

Upload Malpractice Insurance*

Add File...

Resources and Helpful Tips

Missing items — submit missing items as soon as possible.

- If items are missing, the application will be placed in the “Awaiting Signature” or “Awaiting Provider Response” status.
- An automated notification for missing items is sent every seven days until the missing information is received.
 - Outreach is made on:
 - Day 7 – First request
 - Day 14 – Second request
 - Day 21 – Third (final) request
- If the missing items are not received, the case will be placed in the “Canceled — Incomplete Submission” status.
 - Once in this status, it cannot be reopened, and a new application must be completed.

Pharmacy

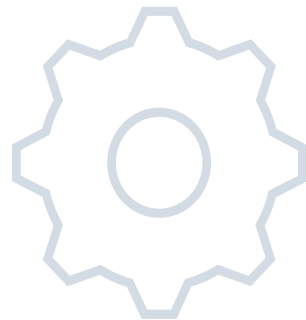


Agenda

- Formulary Updates
 - Commercial (BlueCross and BlueChoice)
 - Lowest Net Cost (LNC) Formulary
 - Premium Formulary
 - Exchange
 - Medicare
 - Healthy Blue Medicaid

Formulary Updates

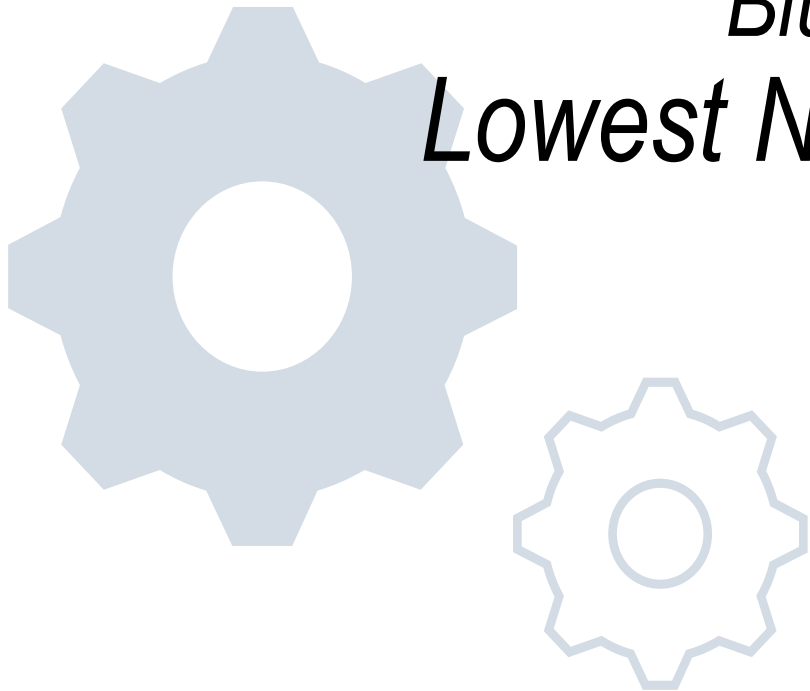
Commercial, Exchange, Medicare and Medicaid



Commercial

BlueCross and BlueChoice

Lowest Net Cost Formulary Updates



Lowest Net Cost Formulary Updates

- Additions
 - Effective Jan. 1, 2024, the following drugs will be added:

Product	Formulary Status
Uzedy [^]	Non-Preferred
Veozah ^{*#}	Non-Preferred
Vowst ^{*#}	Non-Preferred

* Requires Prior Authorization | # Quantity Limit | ^ Step Therapy

Lowest Net Cost Formulary Updates

Exclusions

- Effective Jan. 1, 2024, the following drugs will move to non-formulary status.
- The products listed have alternatives on the formulary, many times, at a lower cost to the member.

Non-Formulary Exclusion

- *Some covered alternatives may require prior authorization (PA).*
 - ✓ Advair Diskus
 - ✓ Airsupra
 - ✓ Flovent Diskus/HFA
 - ✓ Trokendi XR
 - ✓ Zavzpret

Excluded

- ✓ Qalsody

Lowest Net Cost Formulary Updates

Prior Authorization

Effective Jan. 1, 2024, the following drug will require prior authorization:

- ✓ Saxenda

Quantity Limits

Effective Jan. 1, 2024, the following drug will have quantity limits:

- ✓ Wegovy — 4 pens per 28 days

Lowest Net Cost Formulary Updates

Influenza and RSV Vaccines

- Members of non-grandfathered groups have flu vaccine coverage for a \$0 member copay.
- Grandfathered groups can elect seasonal vaccine coverage at either a \$0 or associated plan copay.

Covered RSV Vaccines	
Abrysvo*	Beyfortus ^
Arexvy**	

** Only approved for those ≥ 60 years old and in pregnancy at 32-36 weeks*

*** Only approved for those ≥ 60 years old*

^ Only approved for neonates and up to 24 months old

Covered Flu Vaccines	
Afluria Quadrivalent	Fluad Quadrivalent*
Fluarix Quadrivalent	Flublok Quadrivalent
Flucelvax Quadrivalent	Flulaval Quadrivalent
Flumist Quadrivalent Intranasal**	Fluzone High-Dose PF*
Fluzone Quadrivalent	

** Only approved for those aged 65 years and older*

*** Only approved for those aged 2-49 years.*

Lowest Net Cost Formulary Updates

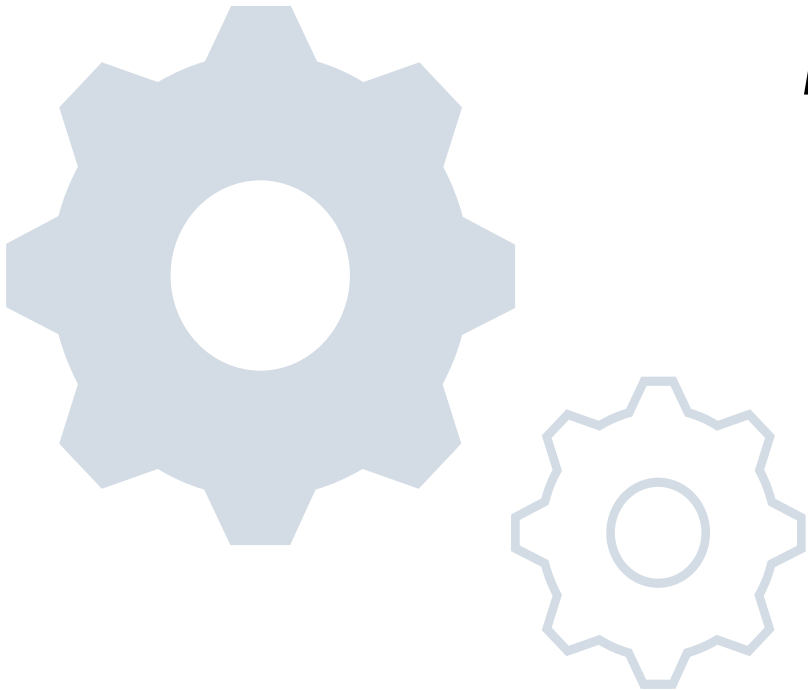
Continuous Glucose Monitors (CGM) Dexcom and Freestyle Libre Meters

Updated PA Criteria

- The prior authorization (PA) criteria for Dexcom and Freestyle CGMs will be updated to allow coverage for all members currently utilizing insulin. This is based on recommendations in the 2023 American Diabetes Association guidelines that CGMs be offered to individuals using intensive insulin therapy as well as basal insulin users that are capable of using the devices safely.
- “Smart PA” technology will be utilized to allow coverage for members with an insulin claim in the preceding 180 days without a formal PA request needing to be submitted.
- The PA criteria will also allow coverage for members using non-insulin anti-diabetic medication that have frequent recurring episodes of hypoglycemia (less than 70 mg/dL) despite appropriate modifications to medication, hypoglycemia unawareness, episodes of ketoacidosis, or hospitalization for uncontrolled glucose levels.
- The PA requirement will be moved to the **sensor** component of the CGM system. This change is being made as the sensor is the one component of every CGM system needed by all utilizers.

Commercial

Premium Formulary Updates



Premium Formulary Updates

- Additions
 - Effective Jan. 1, 2024, the following drugs will be added:

Product	Formulary Status
QVAR	PREFERRED
Udencya	NON-PREFERRED BRAND
Insulins by Lilly: Insulin lispro, Basaglar, and Rezvoglar	PREFERRED
Insulins by Novo: Novolog, Novolin, and Fiasp	PREFERRED
Insulins by Sanofi: Admelog and Apidra	PREFERRED
Humira Biosimilars: Adalimumab-adaz, Cyltezo, Hyrimoz	PREFERRED BRAND SPECIALTY

* Requires Prior Authorization | # Quantity Limit | ^ Step Therapy

Premium Formulary Updates

Exclusions

- Effective Jan. 1, 2024, the following drugs will move to non-formulary status.
- The products listed have alternatives on the formulary, many times, at a lower cost to the member.
 - *Some covered alternatives may require PA.*

- ✓ ADVAIR DISKUS
- ✓ AMPYRA
- ✓ AUBAGIO
- ✓ COPAXONE INJ
- ✓ ESBRIET
- ✓ FLOVENT HFA/DISKUS
- ✓ IMBRUVICA TABLETS
- ✓ LATUDA
- ✓ PULMICORT FLEXHALER
- ✓ REVATIO

- ✓ TROKENDI XR
- ✓ VYVANSE
- ✓ XALKORI
- ✓ XYOSTED
- ✓ XYREM
- ✓ HUMIRA BIOSIMILARS: ADALIMUMAB-FKIP, HADLIMA, HULIO, IDACIO, YUFLYMAN, YUSIMRY

Premium Formulary Updates

Prior Authorization

Effective Jan. 1, 2024, the following drug will require prior authorization:

- ✓ Nocdurna

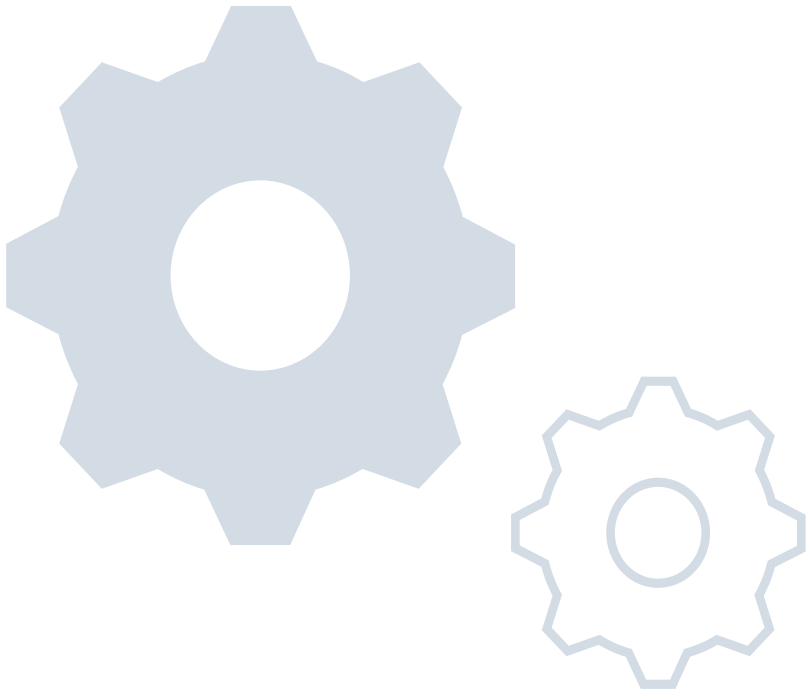
Premium Formulary Updates

Step Therapy

Effective Jan. 1, 2024, the following products will have a step therapy requirement added or updated:

Added	Step 1	Updated	Step 1
Pylera	Generic bismuth subcitrate-metronidazole-tetracycline	Azstarys	Any one of the following generics: amphetamine-dextroamphetamine IR/ER, dexamethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER
Symbicort	Any two of the following generic or preferred brands: budesonide/formoterol, Advair HFA, Breo Ellipta	Adderall XR	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexamethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER
Wixela and formoterol/salmeterol	Any one of the following generic or preferred brands: budesonide/formoterol, Advair HFA, Breo Ellipta	Aptensio XR, Concerta, Jornay PM, Methylin, Relexxi	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexamethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER
Evekeo	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexamethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER	Desoxyn	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexamethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER
Dexedrine, Procentra	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexamethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER		

Exchange



Exchange Formulary Updates

Key Formulary Additions

Product	Formulary Status
Dexcom and Freestyle Libre Continuous Glucose Monitors	Preferred Brand Tier with PA
Mounjaro	Preferred Brand Tier with PA
Vraylar	Non-Preferred Drug Tier with PA
Ubrelyv	Preferred Brand Tier with PA
Humira Biosimilars (Hadlima & adalumamab- adaz)	Preferred Brand Tier with PA
Viracept	Non-Preferred Specialty Tier
Xofluza	Non-Preferred Drug Tier with Quantity Limit

Exchange Formulary Updates

Quantity limits

Effective Jan. 1, 2024, the following products will have changes to quantity limits:

- Actemra
- Cibinqo
- Cimzia
- Dilaudid
- Enbrel
- Humira,
- hydromorphone
- Orencia
- Otezla
- Rinvoq
- Simponi
- Skyrizi
- Taltz
- tramadol
- tramadol/acetaminophen
- Tremfya
- venlafaxine
- Xeljanz/Xeljanz XR

Prior Authorization

Effective Jan. 1, 2024, the following products will require prior authorization:

- Byetta
- Mounjaro
- Ozempic
- Rybelsus
- Trulicity
- Victoza

Exchange Formulary Updates

Step Therapy

- Effective Jan. 1, 2024, the following product will have a step therapy requirement added:

Product	Step 1
Pradaxa	Generic dabigatran

Uptiers

- Effective Jan. 1, 2024, the following products will be covered at a higher tier:

Product	2023 Tier	2024 Tier
Pradaxa	Preferred Brand Tier	Non-Preferred Drug Tier
Dotti/Lyllana/Estradiol Biweekly Patch	Generic Tier	Non-Preferred Drug Tier
fluorouracil cream	Generic Tier	Non-Preferred Drug Tier
Fesoterodine ER	Generic Tier	Non-Preferred Drug Tier
hydrocortisone valerate cream	Generic Tier	Non-Preferred Drug Tier

Exchange Formulary Updates

Key Formulary Removals:

- Effective Jan. 1, 2024, the following products will be moving to Non-Formulary status:

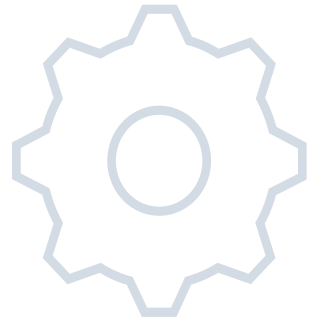
Products Removed	Formulary Alternative (s)
Mavyret	Epclusa, Harvoni, Zepatier, ribavirin
Viibryd	Generic vilazodone
Veltassa	Sodium polystyrene sulfonate, SPS
Zioptan and Rocklatan	Latanoprost, Lumigan, tafluprost, travoprost
Xiidra and Restasis	Generic cyclosporine ophthalmic
Latuda	Generic lurasidone
IVIG Products: Bivigam, Cuvitru, Flebogamma, Gammaplex, Hyqvia, Octagam, Privigen	Gammagard, Gammaked, Gamunex-C, Gamastan, Hizentra

Some covered alternatives may require prior authorization (PA).

Pharmacy Benefit to Medical Benefit

- Effective Jan. 1, 2024, the following products will be covered under the Medical benefit only:
 - All hemophilia factor products
 - Strensiq

Healthy Blue Medicaid



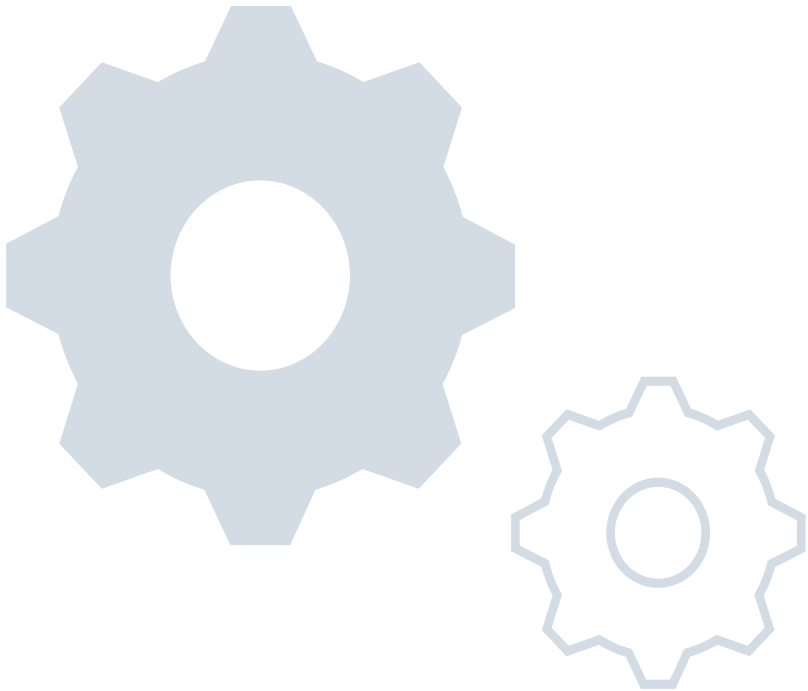
Healthy Blue Medicaid Formulary Updates

Key Formulary Updates:

- Effective Jan. 1, 2024, the following products will be moving to Preferred status:

Therapeutic class	Medication	Formulary status change	Potential alternatives (preferred products)
Colony-Stimulating Factors (G-CSF)	Fulphila	Non-Preferred to Preferred	N/A
Colony-Stimulating Factors (G-CSF)	Ziextenzo	Non-Preferred to Preferred	N/A
Colony-Stimulating Factors (G-CSF)	Nyvepria	Non-Preferred to Preferred	N/A
Nonsteroidal Anti-inflammatory Agents (NSAIDs)	celecoxib (all strengths)	Non-Preferred to Preferred; Remove PA	N/A
Antifungals - Topical	nystatin/triamcinolone ointment	Non-Preferred to Preferred; Remove PA	N/A
Human Insulin	Lantus	Non-Preferred to Preferred; Remove PA	N/A
Human Insulin	Basaglar Kwikpen	Preferred to Non-Preferred; Add PA	Lantus; insulin glargine-yfgn

Medicare



Medicare Formulary Updates

2024 Key Formulary Changes:

Products Added	Products Removed
Gemtesa	Flovent HFA
Nurtec	Invokana
Orencia	Suprep Bowel Kit
Otezla	Symbicort
Sutab	Victoza

2024 Part D Humira and Biosimilars Coverage:

Covered Products	Formulary Status
Humira	Tier 5 requiring PA with Quantity Limits
Cyltezo	Tier 5 requiring PA with Quantity Limits
Yuflyma	Tier 5 requiring PA with Quantity Limits

Medicare Formulary Updates

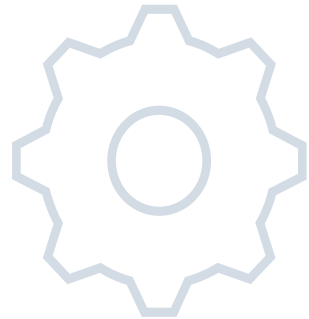
Covered Injectable Diabetes Treatment:

GLP-1 Receptor Agonists	Branded Insulins covered
Mounjaro	Humulin/Humalog
Ozempic	Novolin/Novolog
Trulicity	Lantus
	Levemir
	Toujeo
	Tresiba

Key UM Change

- GLP-1s will require Prior Authorization effective 1/1/2024

Pharmacy Resources



Pharmacy Resources

Specialty Drug Medical Benefit Management

Drug lists can be found on the Precertification and Pharmacy pages of the websites:

- www.SouthCarolinaBlues.com
- www.BlueChoiceSC.com

Access MBMNow via My Insurance Manager when you check the member's benefits.

- Contact information for medical specialty drug authorizations:
 - Phone: 877-440-0089
 - Fax: 612-367-0742

Pharmacy Resources

PreCheck MyScript (PCMS)

PreCheck MyScript (PCMS) is a great tool that functions in real-time to provide:

- Benefit-specific, clinically appropriate, alternative medications.
- Displays savings opportunities at Optum Home Delivery and Optum Specialty Pharmacy.
- Provides members access to the same information via the OptumRx digital tools.

The benefits of using PCMS include:

- \$225 average member savings per prescription switch.
- More time with patients with fewer administrative tasks.
- Patient medication adherence and clinical outcomes due to lower costs.

Pharmacy Resources

Commercial and Affordable Care Act (ACA) Plans

- OptumRx Home Delivery Mail Service
 - E-scribe National Council for Prescription Drug Programs (NCPDP)
 - Mail NCPDP ID: 0556540
 - Specialty NCPDP ID: 5732676
- OptumRx Home Delivery
 - Call: 855-811-2218
 - Fax: 800-491-7997
- OptumRx Specialty Pharmacy
 - Call: 877-259-9428
 - Fax: 800-218-3221
- Specialty Medical Benefit Management
 - Call: 877-440-0089
 - Fax: 612-367-0742

Pharmacy Resources

Provider Plan Contact Information

Affordable Care Act (ACA) Plans

- BlueCross
 - ACA Individual Plan Members
 - Call: 855-823-0387
 - ACA Small Group Plan Members
 - Call: 855-819-0955

www.SouthCarolinaBlues.com

Commercial Plans

- View lists of covered drugs, excluded drugs and drug management programs at www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.
- The contact number is listed on the back of the member's ID card.
- For prior authorization, formulary exceptions and general inquiries, call 855-811-2218.

Pharmacy Resources

Medicare Advantage

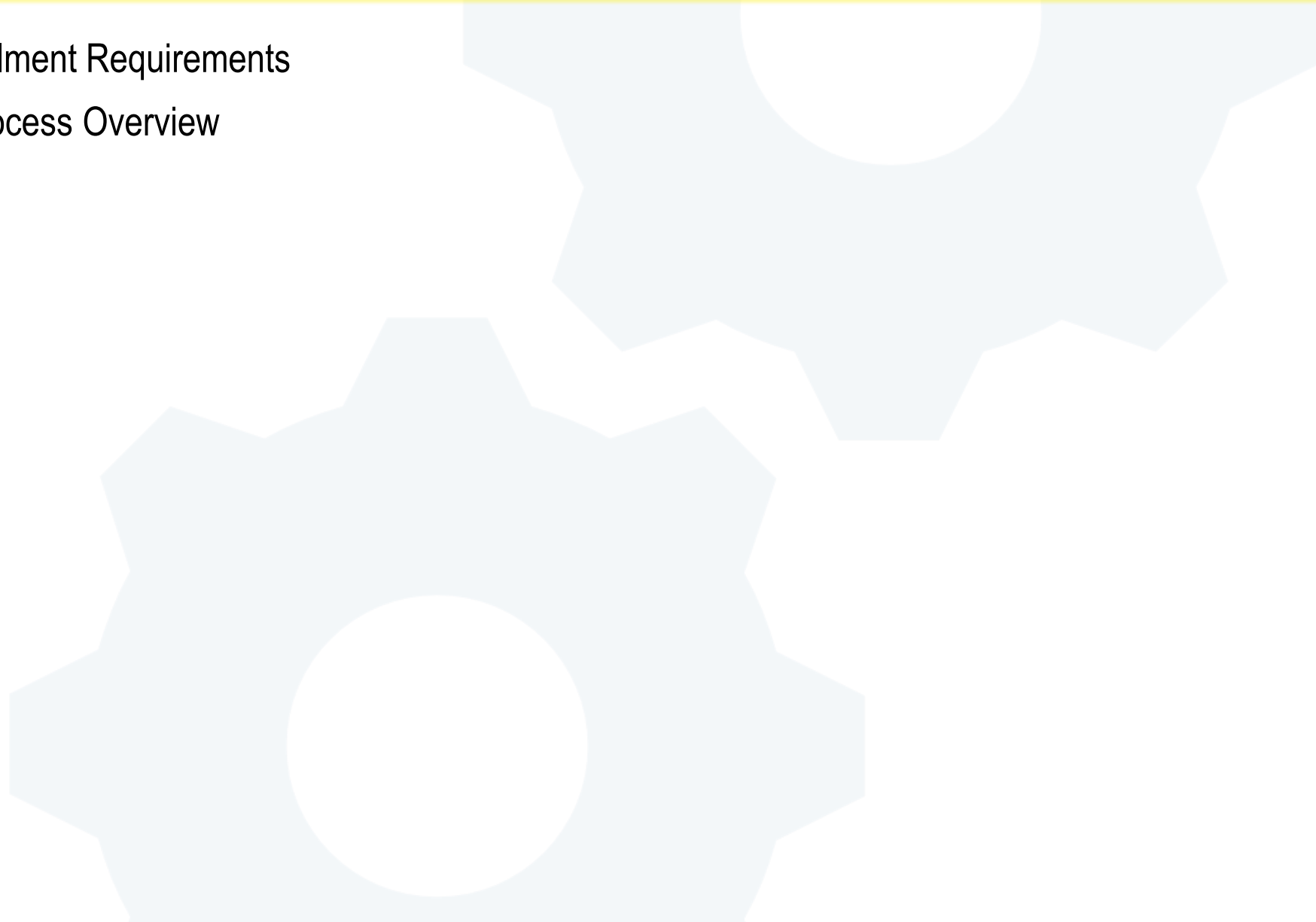
- OptumRx Home Delivery Mail Service
 - E-scribe National Council for Prescription Drug Programs (NCPDP)
 - Mail NCPDP ID: 0556540
 - Specialty NCPDP ID: 5732676
- OptumRx Home Delivery
 - Call: 855-540-5951
- OptumRx Mailing Address
 - P.O. Box 2975
Shawnee Mission, KS 66201-1375
- Coverage Determinations and General Inquiries
 - Call: 888-645-6025
 - Fax: 844-403-1028
- Websites
 - www.optumrx.com
 - www.SCBluesMedadvantage.com

Provider Enrollment



Agenda

- Provider Enrollment Requirements
- Enrollment Process Overview
- Reminders





Provider Enrollment Requirements



Provider Enrollment Requirements

Enrollment Applications and Forms

Application or form	Used for...
Individual Enrollment	New practitioners that want to enroll with BCBSSC (not Behavioral Health)
Group Practice Enrollment	New groups that want to enroll with BCBSSC
Facility Information Request	Medical facilities that want to credential with BCBSSC
Virtual Care Services	Practitioners or groups that want to render telemedicine and telehealth services
Health Professional	<u>In-state, out-of-network</u> practitioners that want to file claims to BCBSSC
Behavioral Health	New practitioners or groups that want to enroll in our behavioral health network
Autism Provider Panel	Applied behavior analysts that want to enroll in our autism provider panel
DBA Name Change	Changing the doing business as (DBA) name of a practice
Change of Address	Updating the physical, pay to, correspondence and billing agency address
Satellite Location	<u>Enrolled groups</u> that have <u>new locations</u> that want to file claims
NPI Provider Notification	Registering an NPI with BCBSSC
Add or Terminate Practitioner	Adding or terminating a practitioner's affiliation with a clinic, group or institution

Provider Enrollment Requirements

What to Include — Individual Enrollment

Checklist Items	Mid-Level	Physician	DDS*
Provider Enrollment Application			
Copy of SC Medical/Practice License			
DEA Certification			Note 1
Current Copy of Malpractice (Min. \$1M/\$3M)			
Authorization to Bill for Services			
Clinical Lab Improvement Amendments			
Nurse Practitioner Preceptor Form			
Signed Contracts			
Hold Harmless — BlueChoice			
Appendix D — BlueChoice			
Professional Training		Note 2	
Additional Items for Medicaid			
Medicaid ID Number			
Protocols (Written Agreement)	Note 3		

Locate the checklists by visiting www.SouthCarolinaBlues.com.
Providers>Provider Enrollment>Checklists and Signature Requirements

**Doctor of Dental Surgery*

1. Only needed if applicable.
2. DOs, DPMs and MDs require at minimum residency.
3. Only needed for NPs and PAs.

Note: Shaded fields are required.

Provider Enrollment Requirements

What to Include — Individual Enrollment (Continued)

Checklist Items	DMD*	Ancillary	Chiro
Provider Enrollment Application			
Copy of SC Medical/Practice License			
DEA Certification			
Current Copy of Malpractice (Min. \$1M/\$3M)			
Authorization to Bill for Services			
Clinical Lab Improvement Amendments	Note 1		
Nurse Practitioner Preceptor Form			
Signed Contracts			
Hold Harmless — BlueChoice			
Appendix D — BlueChoice			
Additional Items for Medicaid			
Medicaid ID Number	Note 1		
Protocols (Written Agreement)			

**Doctor of Dental Medicine*

1. Only needed if the DMD is applying for medical networks.

Note: Shaded fields are required.

Provider Enrollment Requirements

What to Include — Group Practice Enrollment

Checklist Items	Physician's Office	Ambulance	DME	Home Health, Hospice, Dialysis, Hospitals, Skilled Nursing, ASCs*	Pharmacy	Dental
Group Practice Application	Shaded	Shaded	Shaded	Shaded	Shaded	Shaded
IRS Verification of Tax ID (No W-9s)	Shaded	Shaded	Shaded	Shaded	Shaded	Shaded
Electronic Funds Transfer Enrollment	Shaded	Shaded	Shaded	Shaded	Shaded	Shaded
Application for Satellite Location	Shaded	Shaded	Shaded	Shaded	Shaded	Shaded
Clinical Lab Improvement Amendments	Shaded			Shaded	Shaded	
Signed Contracts	Shaded	Shaded	Shaded	Shaded	Shaded	Shaded
Copy of CMS Letter		Shaded	Shaded	Shaded	Shaded	
Copy of Medicare PTAN Letter			Shaded		Shaded	
Copy of Business License			Shaded	Shaded		
Copy of DHEC License				Shaded	Shaded	
Additional Items for Medicaid						
Medicaid ID Number	Shaded	Shaded	Shaded	Shaded	Shaded	

**Ambulatory Surgery Centers*

Note: Shaded fields are required.

Provider Enrollment Requirements

What to Include — In-State, Out-of-Network

Checklist Items
¹ Health Professional Application
¹ Authorization to Bill for Services
² Group Practice Application
² IRS Verification of Tax ID (No W-9s)
² Electronic Funds Transfer Enrollment

Note: This checklist applies to individual practitioners. Group practices that wish to remain out-of-network would complete the Group Enrollment application and select No for the network participation question.

1. Needed for each individual being linked to the practice.
2. Needed if the group is not on file.

Provider Enrollment Requirements

What to Include — Behavioral Health

Checklist items — all items are needed
Behavioral Health or Autism Panel Application
IRS Verification of Tax ID (or W-9)
CBA* Professional Agreements (Signed Contracts)
Hold Harmless Agreement
Appendix C
Copy of SC State License
Copy of DEA License, if applicable
Copy of Board Certification, if applicable
Nurse Protocols (NPs only)
Current Copy of Malpractice (Min. \$1M/\$3M)

**Companion Benefit Alternatives*

Provider Enrollment Requirements

E-signatures vs. Wet Signatures (Ink)

Medical	Allowed Signature
Provider Enrollment	Electronic or wet
Recredentialing	Electronic or wet
Facility Information Request	Electronic or wet
Health Professional	Electronic or wet
Doing Business As (DBA)	Electronic or wet
Change of Address (COA)	Electronic or wet
Add/Term Practitioner	Electronic or wet
Authorization to Bill	Electronic or wet
Electronic Funds Transfer (EFT)	Wet
Appendix D (BlueChoice only)	Wet
Hold Harmless (BlueChoice only)	Wet
All Contracts	Wet

Behavioral Health	Allowed Signature
Behavioral Health	Electronic or wet
Autism Panel	Electronic or wet
Facility Information Request	Electronic or wet
Authorization to Bill	Electronic or wet
All Contracts	Electronic or wet



Enrollment Process Overview



Enrollment Process Overview

Clean Application Process

1. Enrollment team receives complete enrollment application
2. Application is reviewed for completion and sent to the Credentialing Committee
 - Only complete and accurate applications are sent to the committee.
 - For applications with missing/incomplete documentation, providers are notified for **21 days** to submit the requested items.
 - If the missing items are not received within **28 days**, the application is canceled.
 - Non-approved applications go to the Disciplinary Committee for approval or denial
 - The verdict is sent to the provider.
3. Approved applications are sent to contracting for review
 - Approved contracts are executed
4. Welcome email and packet (with effective dates) is sent to the provider

Enrollment Process Overview

Clean Application Process — Things to Keep in Mind

- The credentialing committee reviews all enrollment applications to ensure all required credentialing criteria are met:
 - Utilization Review Accreditation Commission (URAC).
 - National Committee for Quality Assurance (NCQA).
 - South Carolina Department of Health & Human Services (SCDHHS), when applicable.
- Effective dates are based on the credentialing committee's approval date, per URAC requirements.
- Backdating **network dates** is not allowed.
 - Affiliation dates can be backdated.
 - Up to Jan. 1st of the previous year (e.g., affiliations for 2023 can go back to Jan. 1, 2022)
 - If the application is pending, email the claim showing the earliest date of service to Provider.Requested.Info@bcbsc.com.
 - If the application is completed, fax the claim to 803-264-4795.



Reminders



Reminders

Missing Items — Common Missing Items that Cause Delays in the Processing of Applications

Unsigned applications and contracts

For applications

1. Select My Forms.
2. Select the appropriate case number.
3. Select Form Information.
4. Under Documents, select the document(s) that require signature.
5. Download the document(s) and have the signature(s) appended.
6. Scan the documents and follow steps 1 – 4 and select Upload Files.
7. Select the Confirm button to attest that **all required documentation with applicable signatures, initials and dates** have been uploaded.

For contracts

1. Select My Contracts.
2. Select the appropriate form contract name that corresponds with your case number.
3. Under Download Contract, select the link to download and sign the contract.
4. Scan the documents and follow steps 1 – 2 and select Upload Files.

Invalid dates

- Malpractice dates must be current, valid and active on or before the requested start date.
- Signature dates on contracts and applications must be current.

IMPORTANT NOTE:

An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:

- ***Day 7 – First request***
- ***Day 14 – Second request***
- ***Day 21 – Third (final) request***

If the missing items are not received, the case will be placed in the “Canceled – Incomplete Submission” status. Once in this status, it cannot be reopened, and a new application must be completed.

Reminders

Missing Items — Common Missing Items that Cause Delays in the Processing of Applications (Continued)

Incomplete submissions

- Missing a copy of the following:
 - State or medical license
 - CLIA certificate
 - Malpractice verification

Note: - If you are CLIA certified, please submit copy of the certificate*

Add File...

***Upload a copy of your Active State License.**

State License Upload*

Add File...

***Upload a copy of your malpractice insurance verification. This must include the practitioner's name on the certificate to be valid.**

Upload Malpractice Insurance*

Add File...

IMPORTANT NOTE:

An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:

- **Day 7 – First request**
- **Day 14 – Second request**
- **Day 21 – Third (final) request**

If the missing items are not received, the case will be placed in the “Canceled – Incomplete Submission” status. Once in this status, it cannot be reopened, and a new application must be completed.

Reminders

Missing Items — Common Missing Items that Cause Delays in the Processing of Applications (Continued)

Incomplete submissions

- Missing DEA details

Federal DEA

Do you currently hold a federal DEA registration in each State you prescribe controlled substances?

Yes

If "Yes," upload your DEA registration below.

DEA License File*

Add File...

Federal DEA

Do you currently hold a federal DEA registration in each State you prescribe controlled substances?

N/A

N/A only applies to non-prescribing specialties.

Federal DEA

Do you currently hold a federal DEA registration in each State you prescribe controlled substances?

No

If "No," you must provide an explanation as to who will fulfill this requirement on your behalf.

If uploading explanation of prescribing plan, please input "See Attached" in the below field.

Written Explanation of Prescribing Plan*

OR

Upload Explanation of Prescribing Plan

Add File...

IMPORTANT NOTE:

An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:

- **Day 7 – First request**
- **Day 14 – Second request**
- **Day 21 – Third (final) request**


If the missing items are not received, the case will be placed in the "Canceled – Incomplete Submission" status. Once in this status, it cannot be reopened, and a new application must be completed.

Reminders

Missing Items — Common Missing Items that Cause Delays in the Processing of Applications (Continued)

Incomplete documentation

- Authorization to Bill missing effective dates and representative details

 BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

Authorization for Clinic/Group to Bill for Services

Please complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan that you have authorized a clinic/group/institution/location to bill for your services for:

- Preferred Blue (PPC and FEP)
- State Health Plan
- Medicare Advantage
- Blue Essentials
- Blue OptionSM
- Healthy BlueSM
- BlueChoice HealthPlan

BlueCross and BlueChoice HealthPlan reserve the right to accept or refuse authorization for a clinic/group/professional association/institution to bill for services.

*****This form does not qualify you to be a network provider.**

Date of Request: _____

I agree that _____ will bill for and receive charges or fees for my services effective _____

EIN Number: _____

Signature of Practitioner

Practitioner's Name Printed

Practitioner's SSN and NPI

Signature & Title of Clinic/Group/Professional Association/Institution Representative

Representative's Contact Telephone Number

Email Address (required for notification)

All highlighted fields
MUST be completed.

IMPORTANT NOTE:

An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:

- **Day 7 – First request**
- **Day 14 – Second request**
- **Day 21 – Third (final) request**

If the missing items are not received, the case will be placed in the "Canceled – Incomplete Submission" status. Once in this status, it cannot be reopened, and a new application must be completed.

Reminders

Recredentialing

- Recredentialing occurs every three years.
- Our credentialing team makes outreach when the provider's recredentialing date is approaching.
 - First, they call to see if the provider is actively working at the location on file.
 - If no response is received after the first attempt, a second attempt is made in **14 days**.
 - If no response is received after the second attempt, a third attempt is made in **seven days**.
 - If no response is received after the third and final attempt, the status change process begins.
- If the recredentialing date is missed, the provider is termed, and a new enrollment is required.

Note: Be sure the credentialing contact email address is current for outreach.

Reminders

Non-credentialed Providers



Note: This list may not be all inclusive.

Reminders

Provider Validation

As of **Jan. 1, 2022**, providers are required to verify their demographic data at least **every 90 days**. Our provider directory team also makes outreach every 90 days to ensure validation.

Note: Be sure the credentialing contact email address is current as this is what's used for outreach.

Importance of Validation

- Allows us to maintain accurate directories
- Ensures members know where to find you

How to Validate Information

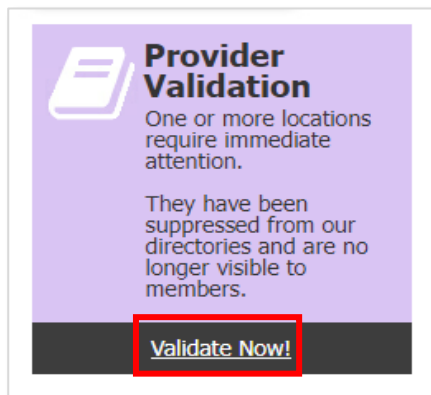
- M.D. Checkup

Reminders

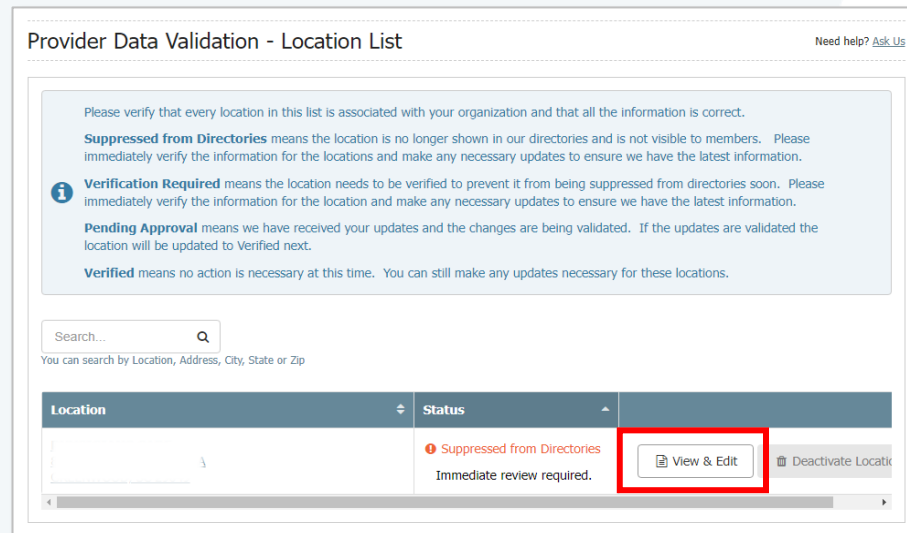
Provider Validation (Continued)

Has your location been suppressed?

- Locations are suppressed in the provider directory if more than 90 days has passed since the last validation was made, per the Consolidated Appropriations Act guidelines.
- To have the suppressed status updated, the group administrator should:
 - Log into My Insurance Manager.
 - Select Validate Now in the Provider Validation box.
 - Select View and Edit from the location(s) listed.
 - Review the information, make the necessary updates, if needed, and select Verify.



Provider Validation
One or more locations require immediate attention.
They have been suppressed from our directories and are no longer visible to members.
Validate Now!



Provider Data Validation - Location List

Please verify that every location in this list is associated with your organization and that all the information is correct.

Suppressed from Directories means the location is no longer shown in our directories and is not visible to members. Please immediately verify the information for the locations and make any necessary updates to ensure we have the latest information.

Verification Required means the location needs to be verified to prevent it from being suppressed from directories soon. Please immediately verify the information for the location and make any necessary updates to ensure we have the latest information.

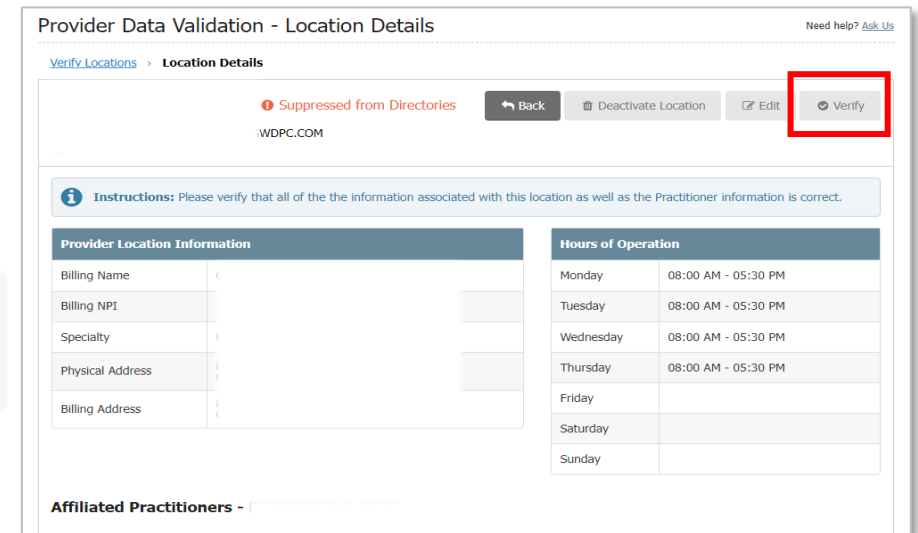
Pending Approval means we have received your updates and the changes are being validated. If the updates are validated the location will be updated to Verified next.

Verified means no action is necessary at this time. You can still make any updates necessary for these locations.

Search...
You can search by Location, Address, City, State or Zip

Location	Status
	Suppressed from Directories Immediate review required.

View & Edit



Provider Data Validation - Location Details

Verify Locations > Location Details

Suppressed from Directories

Back Deactivate Location Edit **Verify**

WDFC.COM

Instructions: Please verify that all of the the information associated with this location as well as the Practitioner information is correct.

Provider Location Information		Hours of Operation	
Billing Name		Monday	08:00 AM - 05:30 PM
Billing NPI		Tuesday	08:00 AM - 05:30 PM
Specialty		Wednesday	08:00 AM - 05:30 PM
Physical Address		Thursday	08:00 AM - 05:30 PM
Billing Address		Friday	
		Saturday	
		Sunday	

Affiliated Practitioners -

Reminders

Provider Updates — My Provider Enrollment Portal

The following updates can be made using My Provider Enrollment Portal:

- Business name change
 - Using the Doing Business As (DBA) Name Change form
- Address change
 - Using the Change of Address form
- NPI update
 - Using the NPI Provider Notification form
- Adding a location
 - Using the Application for Satellite Location form
- Adding or terminating practitioner affiliation
 - Using the Add or Terminate Practitioner Affiliation form



Reminders

Provider Updates — M.D. Checkup

What is M.D. Checkup?

- Web-based tool used for provider demographic updates
- M.D. Checkup is accessible through My Insurance Manager

The following updates can be made through M.D. Checkup:

- Business name change
- Address change
- Adding or terminating a location
- Adding or terminating a practitioner affiliation
 - You can only add a practitioner through M.D. Checkup if they are enrolled and associated with the tax identification number.



Reminders

M.D. Checkup — Removing Locations



My INSURANCE MANAGER™

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory Provider Update

Provider Data Validation - Locations List

Need help? Ask Provider Services

Instructions: Please verify that every location in this list is associated with your practice and that all of the information is correct.

Search locations...

You can search by Location, Address, City, State or Zip

Location	Status	
Provider 1 Main Street	Requires Verification	View & Edit Remove Location
Provider 2 Pine Road	Requires Verification	View & Edit Remove Location
Provider 3 Davis Avenue	Requires Verification	View & Edit Remove Location

Request to Remove Location

by, State or Zip

Are you sure you wish to remove **Palmetto Northeast**? Please enter the date on which you want this location to be removed.

Note: The removal date must be after the original effective date.

Requires Verification

mm/dd/yyyy

View & Edit

Requires Verification

View & Edit

Cancel Remove

View & Edit Remove Location

DO NOT use this function to remove a location from your VIEW!

Reminders

M.D. Checkup — Adding Practitioner Affiliations

To add a practitioner affiliation through M.D. Checkup:

- The practitioner must be enrolled and associated with the tax identification number (TIN).
 - Submit the Add/Terminate Practitioner Affiliation form to add a practitioner to a location under a different TIN.

Example:

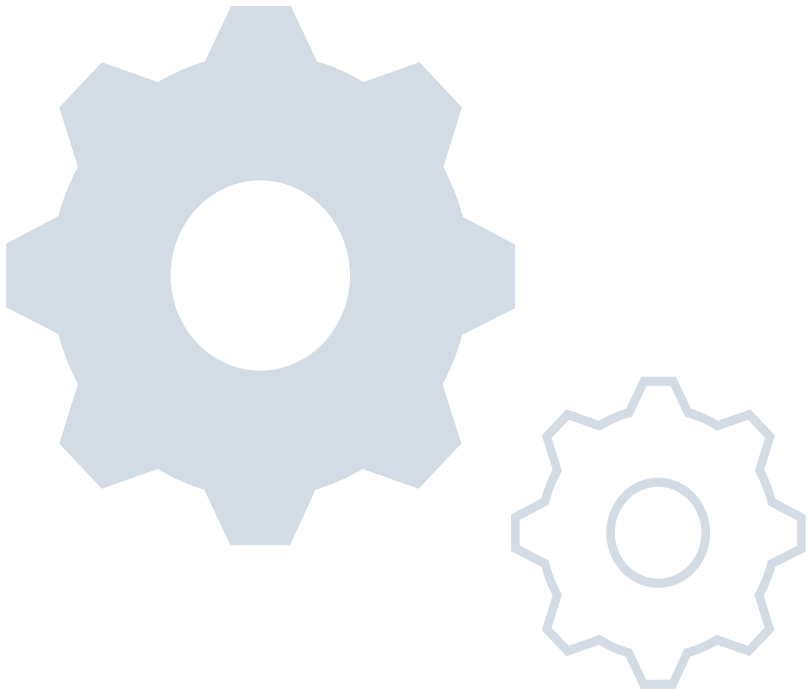
- *TIN A — 123456789*
 - Location 1
 - Location 2
- *TIN B — 987654321*

Dr. Tommy Pickles **is associated** with TIN A and works at Location 1. He can be added to Location 2 through M.D. Checkup.

Dr. Tommy Pickles **is not associated** with TIN B. To be added to this location, the Add/Terminate Practitioner Affiliation form must be submitted.



Quality Improvement Strategy



Introductions

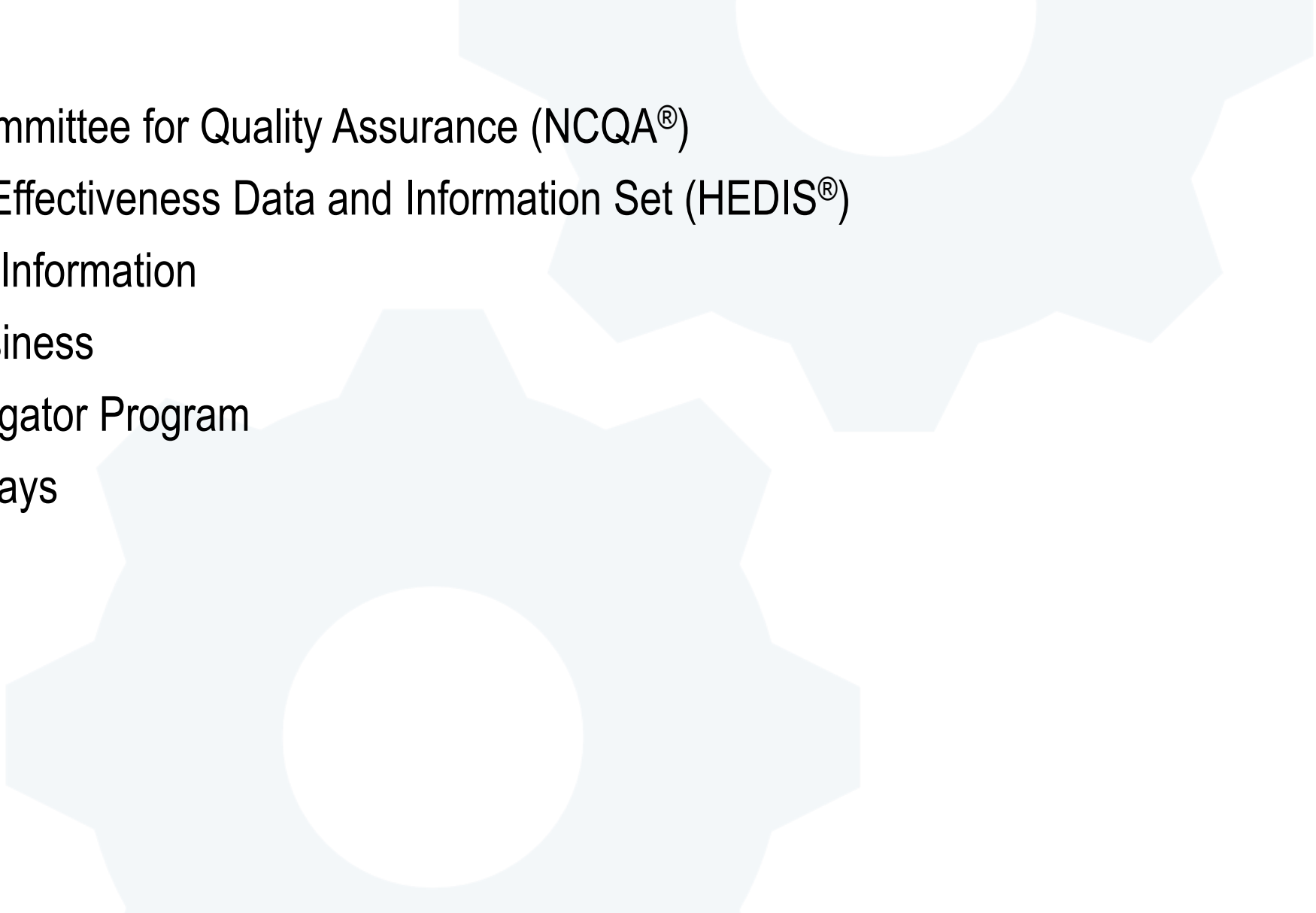


Hollie Strange
Director, Quality Improvement
Strategy



Luna Lugo Latorre
Manager, Quality
Management

Agenda

- About Us
 - National Committee for Quality Assurance (NCQA®)
 - Healthcare Effectiveness Data and Information Set (HEDIS®)
 - Request for Information
 - Lines of Business
 - Quality Navigator Program
 - Key Takeaways
- 




About Us





About Us



Health Care Innovation and Improvement




Vision: To ensure a quality health care experience with every interaction



Mission: Improve the health and experience of our members through innovative programs and collaborative partnerships that help make health care more affordable.



Committed to working with you to better serve our members






National Committee for Quality Assurance (NCQA[®])



National Committee for Quality Assurance (NCQA®)

- NCQA is a private organization dedicated to improving healthcare quality by developing quality standards and performance measures.
 - Healthcare Effectiveness Data and Information Set (HEDIS) coordination
 - Provider involvement
- 
- The background of the slide features several light blue gears of varying sizes, arranged in a way that suggests a mechanical or interconnected system. The gears are semi-transparent and overlap each other, creating a sense of depth and complexity. The largest gear is positioned in the lower-left quadrant, while smaller ones are scattered towards the top and right.

National Committee for Quality Assurance (NCQA®)

What does NCQA mean to you?

Contract

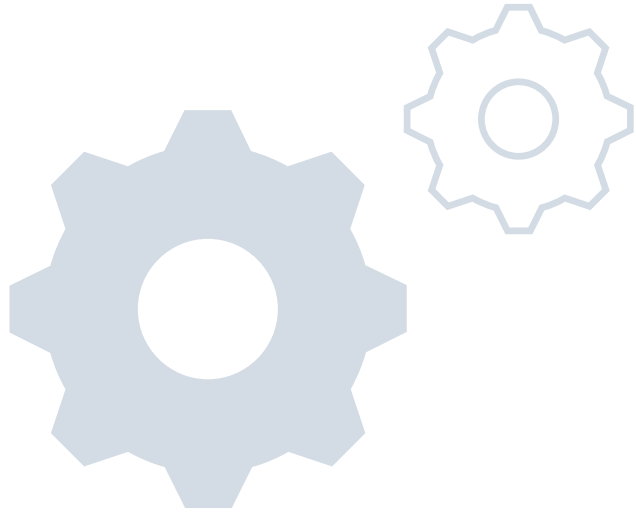
Bonuses
Incentives

Reporting

Data to
the plan

Safety

Patient



Health Care Effectiveness Data and Information Set (HEDIS[®])



Health Care Effectiveness Data and Information Set (HEDIS®)



HHealth Care
Effectiveness
Data and
Information
Set

It is a tool that America's health plans use to measure performance on important dimensions of care and service.

HEDIS rates are designed to evaluate the effectiveness of a health plan's ability to demonstrate an improvement in its preventive care and quality measures to its members.

Health Care Effectiveness Data and Information Set (HEDIS®)

Which entities use HEDIS data?



NCQA®
Exist to improve the quality of health care.



CMS

*Centers for Medicare and Medicaid Services (CMS)

*Quality Rating System for the ACA/Exchange products

*Medicare Advantage



FEP

Federal Employee Program (FEP)



Health Care Effectiveness Data and Information Set (HEDIS®)

HEDIS Prospective Season

- Also referred to as year-round.
- Continuously monitors rates in real-time.
- Runs from Jan. 1 to Dec. 31 of the current or measurement year.
- Additional options for compliance include:
 - Claims.
 - Data transfer.
 - Medical records.
 - Compliance forms.

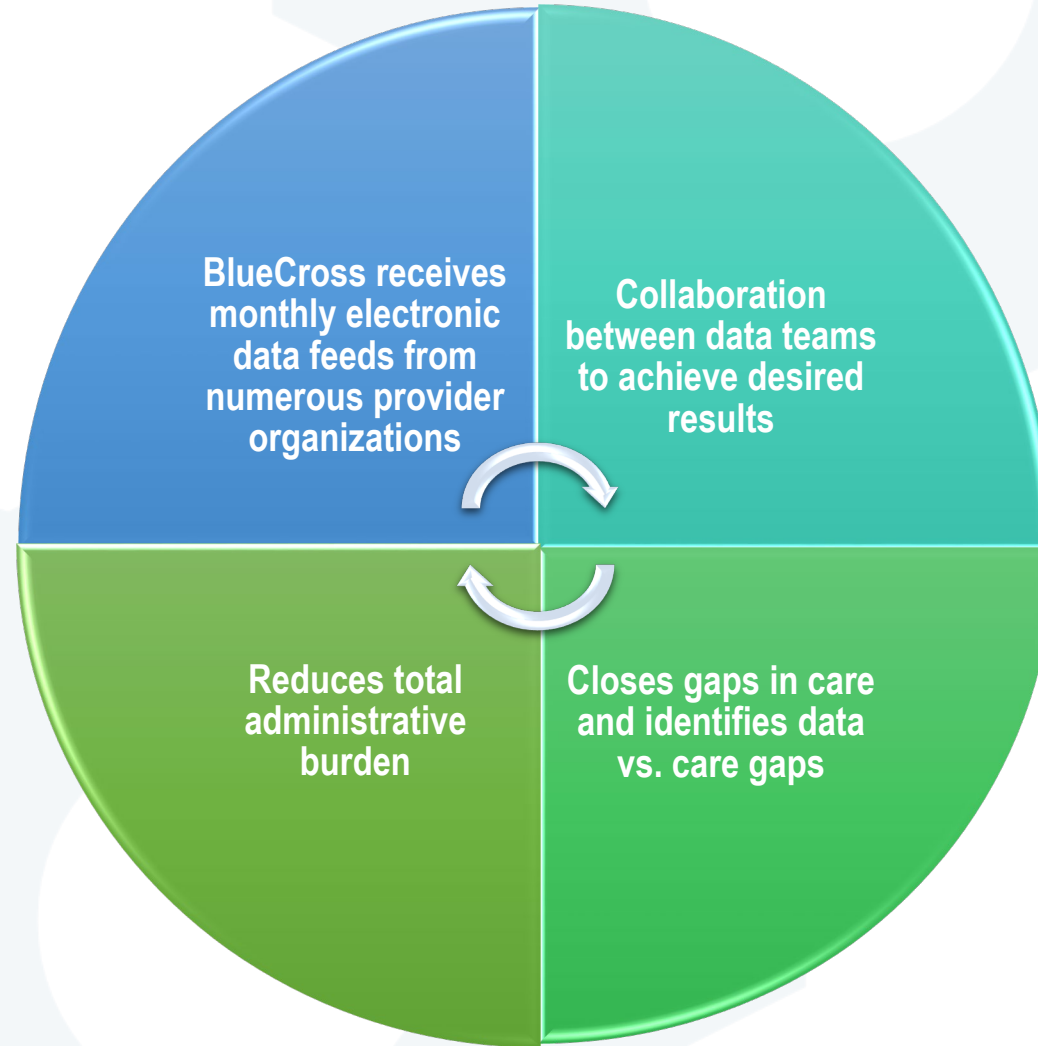
Health Care Effectiveness Data and Information Set (HEDIS®)

HEDIS Retrospective Season

- Also referred to as retro or hybrid season or HEDIS production
- Looks at the care given or due in the prior year (measurement year)
- Runs from January to May of the year following the measurement year
- HEDIS My2023 refers to care given or due in 2023, which will be evaluated from January to May 2024
- All requested member documentation is based on the selected HEDIS measure by NCQA

Health Care Effectiveness Data and Information Set (HEDIS®)

Electronic Data Transfer



Healthcare Effectiveness Data and Information Set (HEDIS®)

Electronic Data Transfer (Continued)



BlueCross currently has many providers that allow remote access to their EMR



Assigned navigator can locate and retrieve records from the EMR remotely



Helps to reduce provider burden



Request for Information



Request for Information

- How are requests sent?
 - Email
 - Fax
 - Mail

Note: Can be avoided by giving remote access to EMR. Email NAVIGATOR@bcbsc.com.

- How are requests created?
 - Claims
- How are members attributed?
 - Claims data

Note: You will only receive a request for medical records if the member has an open care gap.



Request for Medical Records - Cover Letter

To:	From: BlueCross BlueShield of South Carolina
NPI:	Fax: 803-419-8191
Phone:	Requested Date: 06/06/2023

Greetings:

Please see the attached medical record requests for our HEDIS review of members for the **ACA/Exchange and FEP/ Federal Employee Program product lines**. Please return the requested medical records within 7 business days. If this is not possible, reach out to Navigator@bcbsc.com to discuss alternate options.

In accordance with HIPAA, do not return any medical records that do not meet the measure time frame specified.

If the member has not had the service requested within the required time frame, please schedule the member for a visit to address these care opportunities.

Additional Comments: Prospective ROI Exchange

We appreciate your cooperation and ask that you return the attached form and requested medical records for each member by fax to **803-419-8191** or by secure email to **HEDIS.Records@bcbsc.com** or if a copy service is returning records on your behalf, please return these via the associated copy service portal.

If you are required to mail records, please send them to:
BlueCross BlueShield of South Carolina
Attn: Quality Management Department
P.O. Box 100300 AX-310
Columbia, SC 29202

If you have questions or concerns, please email Navigator@bcbsc.com.

Thank you,
Patty Carter
Manager, Corporate Quality Management
BlueCross BlueShield of South Carolina

Request for Information

- What information should be returned?
 - Providers must return the information listed in the requested box on the form.

Example of Request

Please send a copy of the following medical record(s) requested below:

Demographics page

-AND-

All office visit/encounter notes from 01/01/2023 to 12/31/2023

-AND-

Past Medical/Surgical history 2022 to 12/31/2023

-AND-

Vital sign flow sheets from 01/01/2023 to 12/31/2023

-AND-

All consultation notes from 01/01/2023 to 12/31/2023

Request for Information

- What should I do if I cannot locate the patient, nor have medical records for the timeframe requested?
 - Check the appropriate box and return the letter via fax, email or mail.

Please check the appropriate box:

- Medical record attached; please return via one of the following methods:

FAX: 803-419-8191

EMAIL: HEDIS.Records@bcbsc.com

MAIL: BlueCross BlueShield of South Carolina, Attn: Quality Management Department, P.O. Box 100300 AX-310, Columbia, SC 29202

Portal Locations:

MRO: bchpbcshedis.requester.roilog.com

Ciox: PO BOX 6170, AX310, Columbia, SC 29260, Customer ID: 1080191

ShareCare: BCBS-29260-6170

- No medical records found for the time frame requested
- Unable to locate patient in our system



Lines of Business



Lines of Business

Which lines of business are included?

- Health Insurance Exchange (HIX or ACA)
- Federal Employee Program (FEP)
- Healthy BlueSM (BlueChoice Medicaid)

Lines of Business

Health Insurance Exchange

- Quality Rating System (QRS)
- Technical specifications
 - Clinical, customer satisfaction, and patient quality measurement
 - Many plans collect HEDIS data, and the measures are specific
 - Outcome is a Star rating



Lines of Business

Federal Employee Program

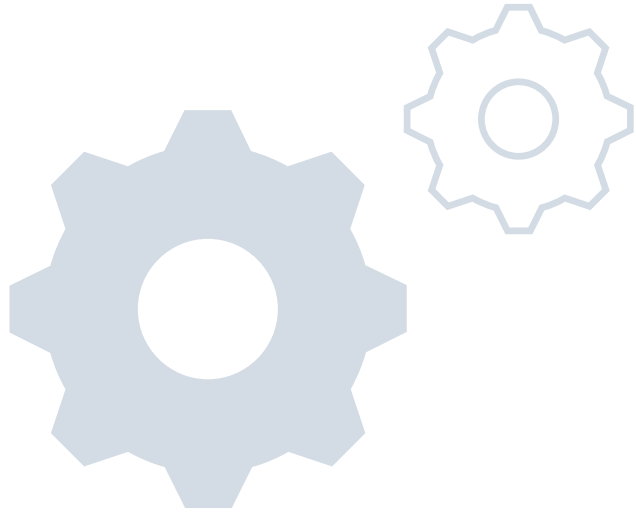
- Clinical quality, customer service and resource use (QCR)
- Technical specifications
 - NCQA technical specifications are the same as HIX
 - Audit is completed by an outside vendor, then submitted to NCQA
 - Clinical, customer satisfaction and patient experience
 - Outcome is Performance Improvement Plan (PIP) rating

Lines of Business

Healthy Blue

- Rating System
 - Voluntary reporting is changing to required
 - Adult and child health care quality measures
 - Core set of children's health care quality measures
 - Audit will be completed by an outside vendor, then submitted to NCQA





Quality Navigator Program



Quality Navigator Program

Quality Navigator Model

- The quality navigator model is a population health and quality improvement program designed to assist primary care physicians (PCPs) in meeting quality metrics.
- The goal of the program is to assist PCPs by:
 - Streamlining care coordination
 - Providing help tools and resources to support patient care efforts
- Benefits include:
 - Promotes accurate coding guidance
 - Facilitates referrals to disease and case management programs to support treatment plans
 - Assists with care coordination

Quality Navigator Program

What is the Quality Navigator Program?

- Participation is based on primary care specialties
- Providers are automatically enrolled
- There is no cost to providers
- Multiple tools and offerings available to support providers

What is a Quality Navigator?

- Dedicated team member with a registered nursing license or related health care bachelor's degree
- Point of contact for care coordination and patient engagement
- Education representative that can schedule sessions to assist with understanding NCQA measures, review open quality care opportunities, and collaborate with providers to improve quality scores

Quality Navigator Program

My Insurance Manager

Use My Insurance Manager to access care opportunity reports for prospective season.

My INSURANCE MANAGERSM

Home | Patient Care | **Office Management** | Resources | Modify Profile | Staff

Welcome, PROVIDER NAME

Health

- ▶ EDI Reports
- ▶ EFT/ERA Enrollment
- ▶ Remittance Information
- ▶ HEDIS® Quality Reports
- ▶ Employer Group Care Report
- ▶ Provider Report Cards

Dental

- ▶ EDI Reports
- ▶ EFT/ERA Enrollment
- ▶ Remittance Information

Quality Navigator Program

Understanding Care Opportunity Reports

- Past medical history has been added for members ()
- Non-compliance can be a true “gap” in care or a “gap” in data ()
 - A true gap in care or non-compliance is when the member has not received the care.
 - A data gap is when the member has received the care, but this information was not shared with the plan.
 - Either way, the member will remain listed as “non-compliant” until the care is given AND that information is shared with us.

First Name	Last Name	Date of Birth	Gender	Member ID_Card	LOB	Servicing Provider	Compliant Measures	Non-Compliant Measures	Past Medical History
John	Doe	1/1/1953	M	R12345566	Cross Exchange	My Provider	Acute Hospital Utilization, Acute Emergency Department Utilization	Colorectal Cancer Screening	Asthma COPD
Jane	Doe	1/1/1970	F	R12345566	Cross Exchange	My Provider	Controlling High Blood Pressure Breast Cancer Screening	Cervical Cancer Screening	Hypertension

Risk Adjustment Data Validation (RADV)

- **HHS-RADV** — CMS has a formal audit program to monitor health plan compliance with HCC (Hierarchical Condition Category) reporting regulations. Occurs each year auditing the previous benefit year. The goal of RADV audits is to ensure that the health status submitted by the plan is supported by health record documentation and meets reporting guidelines.
- **HHS-Risk Adjustment** — medical charts are retrieved and coded for missed opportunities each year to generate a more complete picture of member health status.
- **Documentation and Coding Practices**
 - Improve health record documentation
 - Code chronic conditions every year and document all cause-and-effect relationships
 - Clearly link complications or manifestations of a disease process
 - Include all diagnoses and only document diagnoses as “history of” or “past medical history (PMH)” when they no longer exist and are resolved.
 - ICD-10-CM codes for the encounter must be captured in the electronic health record (EHR), correctly passed to the practice management platform, and submitted on a claim

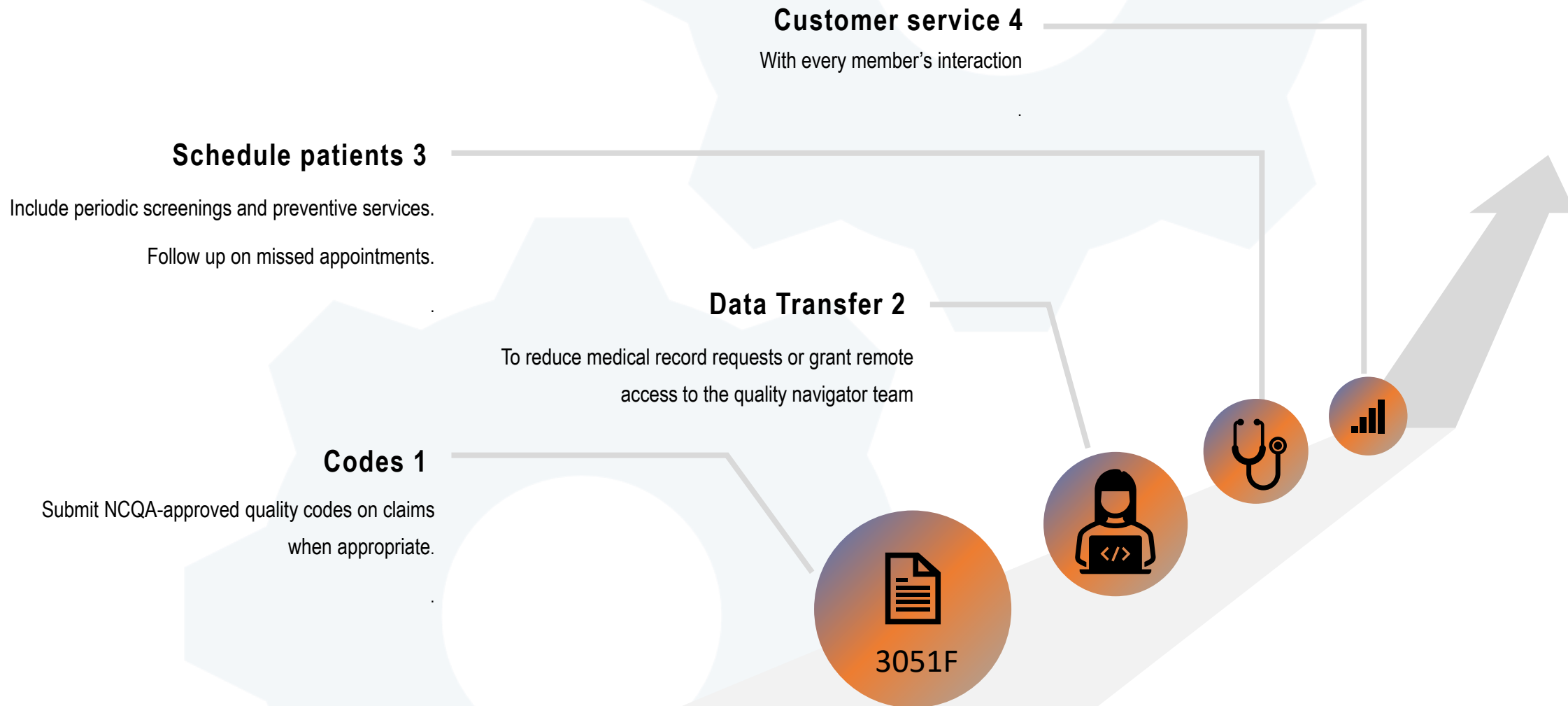


Key Takeaways



Key Takeaways

What will positively impact your quality score?

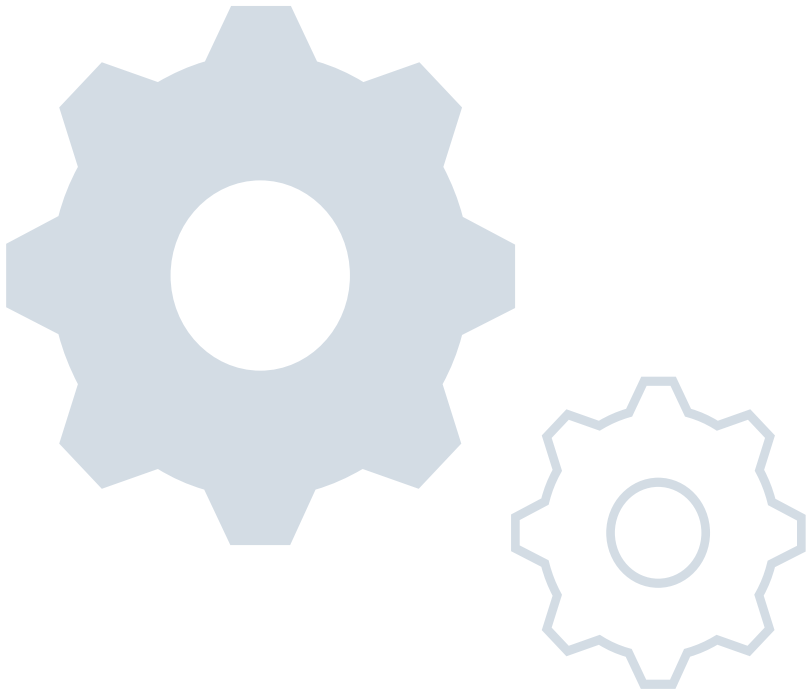


Key Takeaways

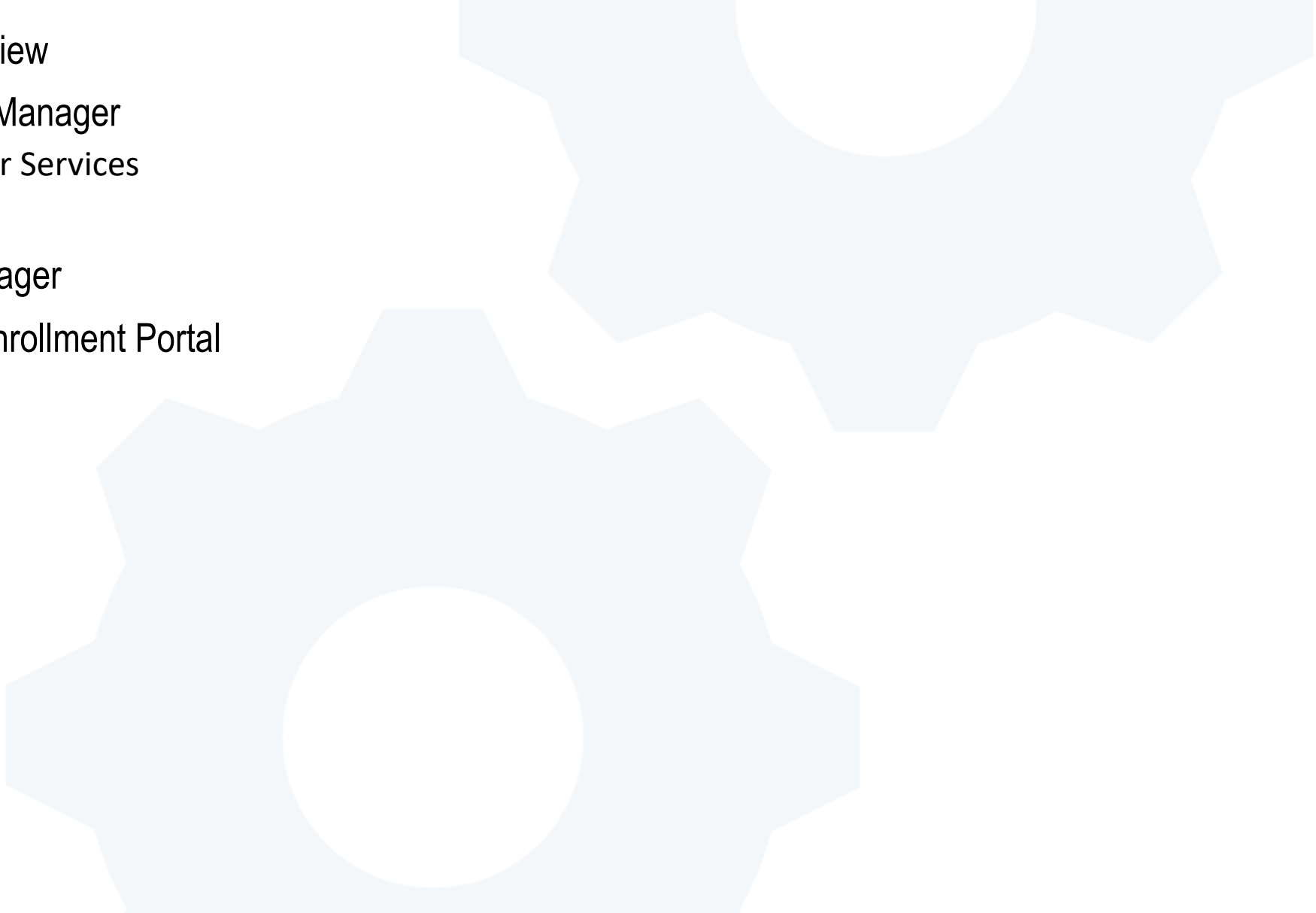
Contact Us

- Hollie Strange — Director, Quality Improvement Strategy
 - Hollie.Strange@bcbssc.com
- Luna S. Lugo RN, MSC — Manager, Quality Management
 - Luna.Lugo@bcbssc.com
- General assistance or information
 - NAVIGATOR@bcbssc.com

Web Tools



Agenda

- Website Overview
 - My Insurance Manager
 - Ask Provider Services
 - STATchatSM
 - My Remit Manager
 - My Provider Enrollment Portal
- 



Website Overview



Website Overview

We have three main websites:

- www.SouthCarolinaBlues.com
- www.BlueChoiceSC.com
- www.HealthyBlueSC.com

Provider pages of our websites include:

- Educational materials
- Access to various secure web tools
 - My Insurance Manager
 - My Remit Manager
 - My Provider Enrollment Portal

Website Overview

www.SouthCarolinaBlues.com

South Carolina

SHOP PLANS MEMBERS **PROVIDERS** EMPLOYERS AGENTS

Providers

My Insurance Manager
File claims, get prior authorizations, check eligibility and benefits, and more.
[Log In](#)

[Policies and](#) [Claims and Payments >](#) [Provider Enrollment >](#)

Feedback

Website Overview

www.BlueChoiceSC.com

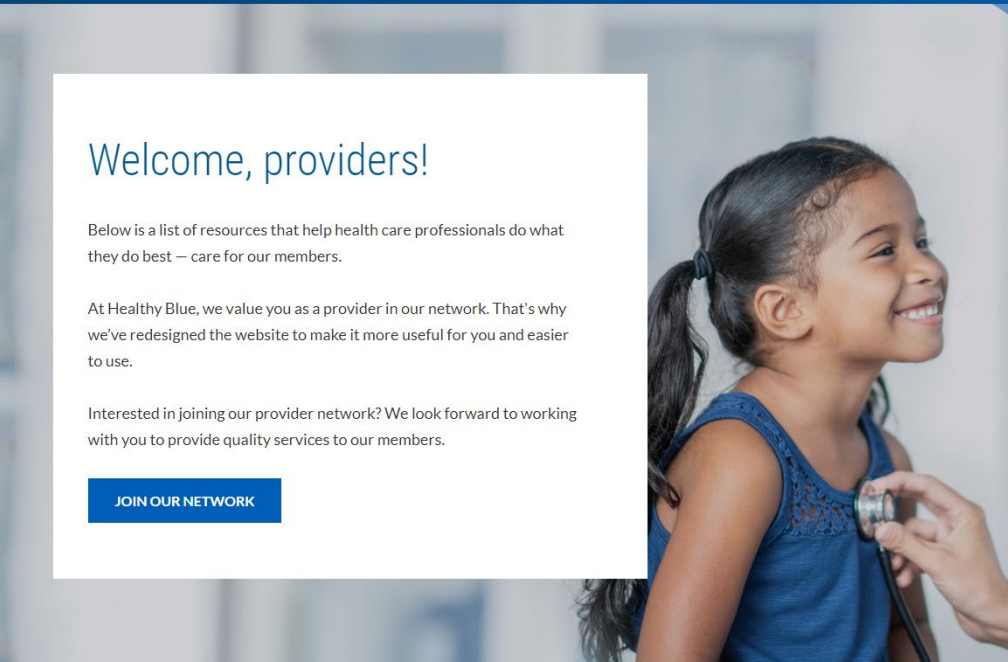
The screenshot displays the BlueChoice HealthPlan South Carolina website. At the top left is the logo with the tagline "Focus on life. Focus on health. Stay focused." The top right navigation bar includes links for EMPLOYERS, AGENTS, PROVIDERS, CONTACT, and MEDICAID, along with a search icon. Below this is a secondary navigation bar with icons and text for COVID-19, MEMBER CENTER, FIND CARE, and FIND A FORM. The main content area features a large photograph of diverse healthcare professionals. Overlaid on the right side of this image is a white box titled "My Insurance Manager" with the text "File claims, get preauthorizations, check eligibility and benefits and more." and a yellow "Log In" button. Below the image is the "Education Center" section, which lists four categories: "Tools and Resources", "Manuals & User Guides", "Prior Authorization", and "Laboratory Benefits", each accompanied by a blue arrow icon pointing to the right.

Website Overview

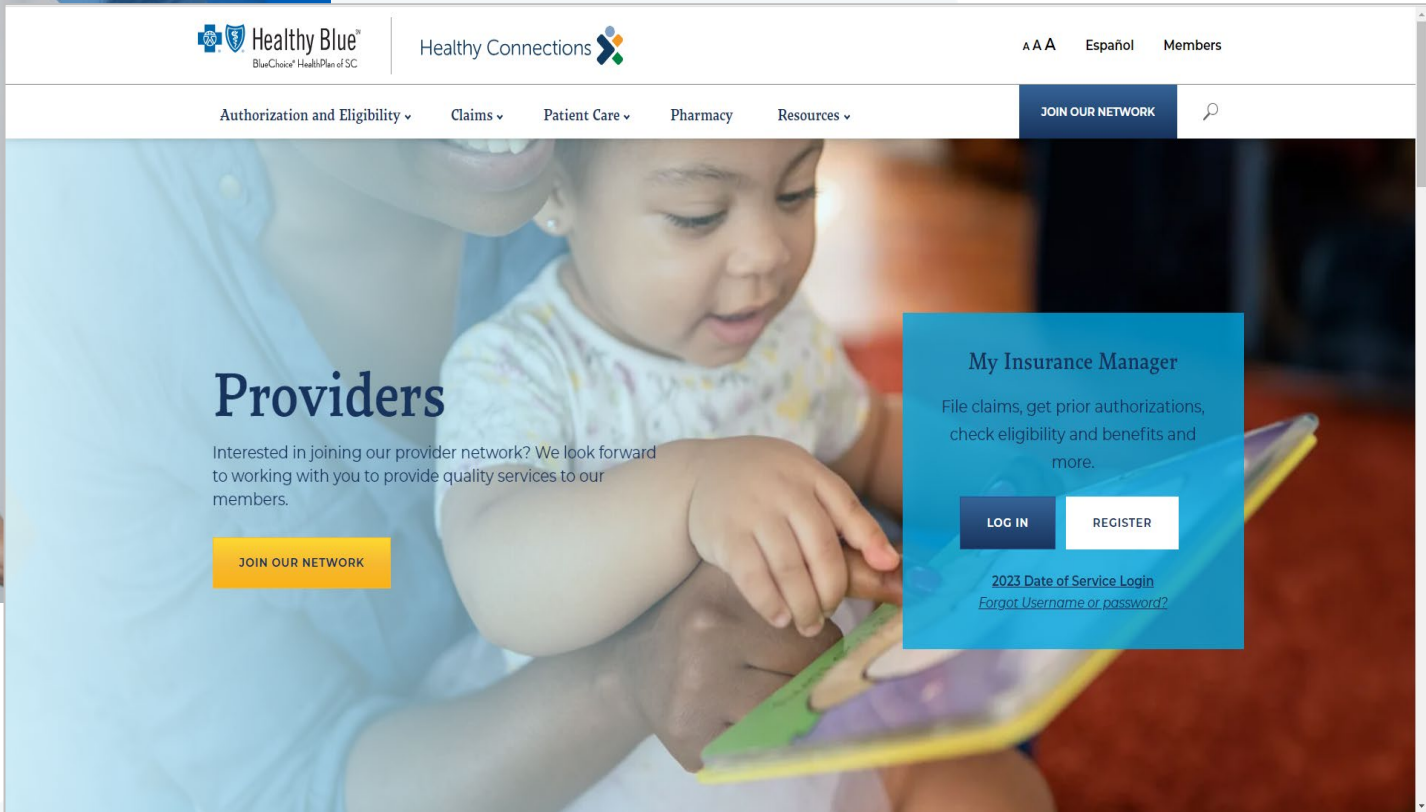
www.HealthyBlueSC.com



2023



2024



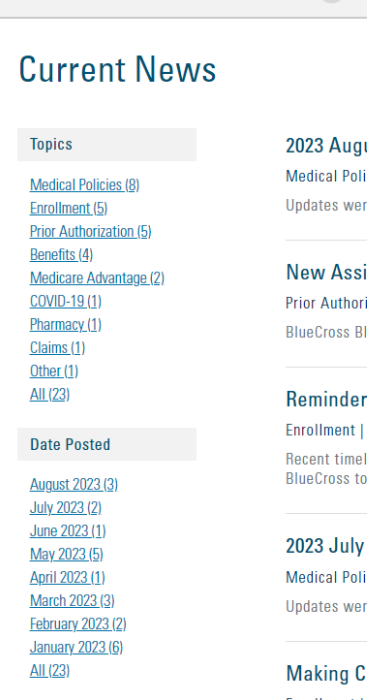
Website Overview

Provider Bulletins



Providers

www.SouthCarolinaBlues.com



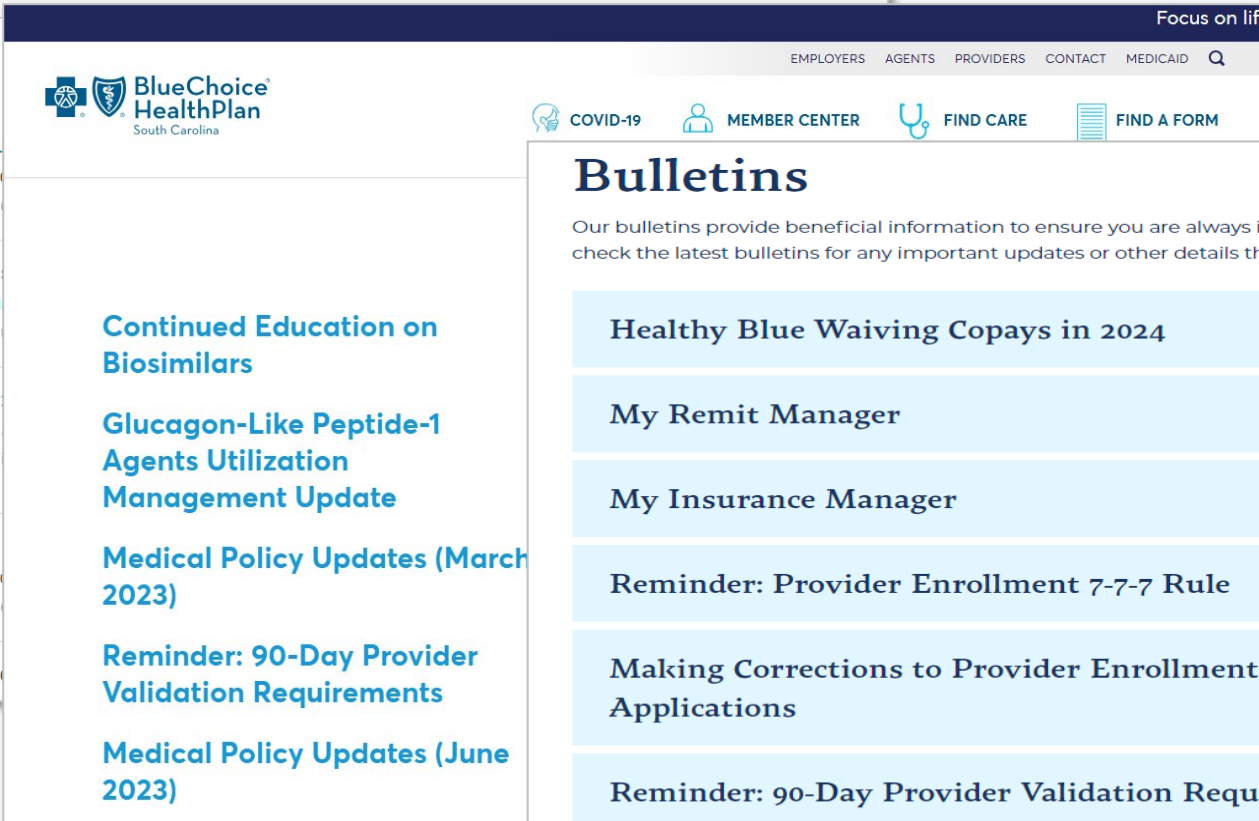
Current News

Topics

- Medical Policies (8)
- Enrollment (5)
- Prior Authorization (5)
- Benefits (4)
- Medicare Advantage (2)
- COVID-19 (1)
- Pharmacy (1)
- Claims (1)
- Other (1)
- All (23)

Date Posted

- August 2023 (3)
- July 2023 (2)
- June 2023 (1)
- May 2023 (5)
- April 2023 (1)
- March 2023 (3)
- February 2023 (2)
- January 2023 (6)
- All (23)



BlueChoice HealthPlan South Carolina

EMPLOYERS AGENTS PROVIDERS CONTACT MEDICAID

COVID-19 MEMBER CENTER FIND CARE FIND A FORM

Bulletins

Our bulletins provide beneficial information to ensure you are always in the know. Always check the latest bulletins for any important updates or other details that could impact you.

- Healthy Blue Waiving Copays in 2024
- My Remit Manager
- My Insurance Manager
- Reminder: Provider Enrollment 7-7-7 Rule
- Making Corrections to Provider Enrollment Applications
- Reminder: 90-Day Provider Validation Requirements

VIEW PAST BULLETINS

www.BlueChoiceSC.com

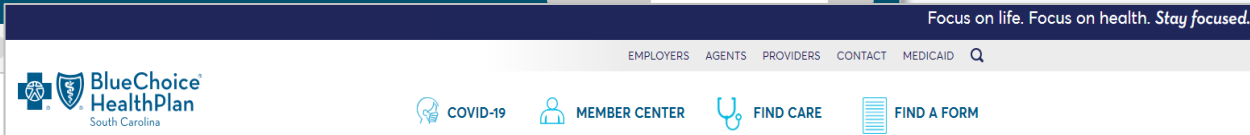
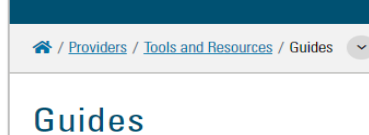
www.HealthyBlueSC.com

Website Overview

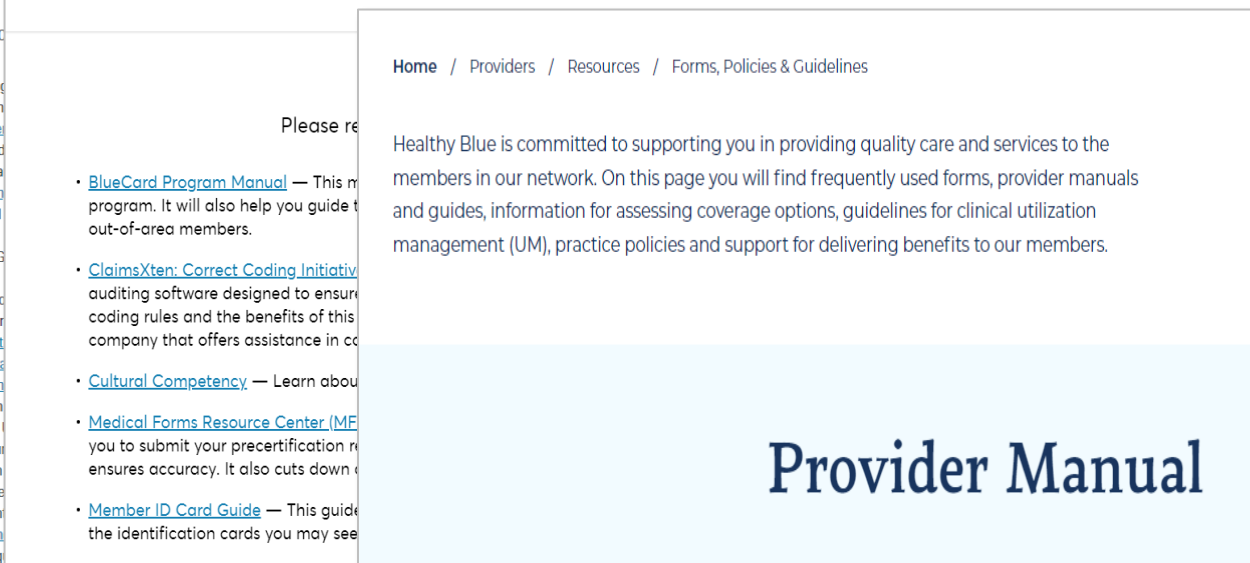
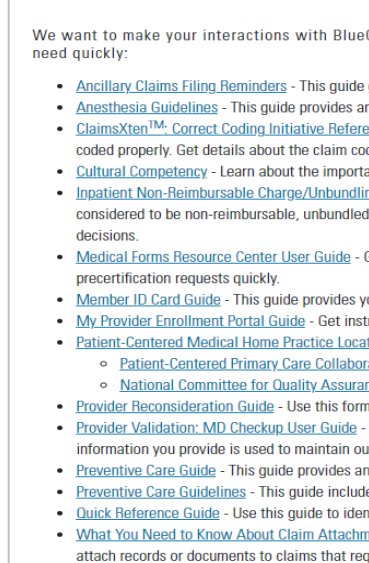
Manuals and Guides



www.SouthCarolinaBlues.com



www.BlueChoiceSC.com



www.HealthyBlueSC.com

Provider Manual

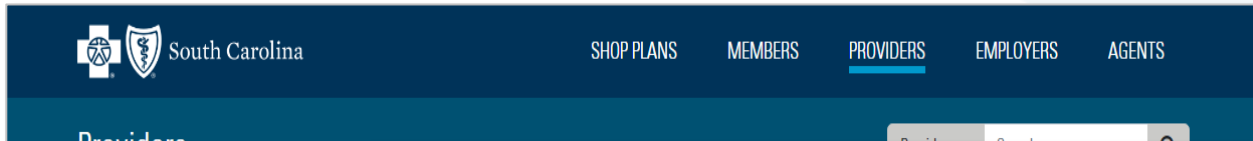
[View Provider Guides](#)

[Provider Manual](#)

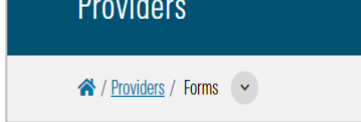
[Quick Reference Guide](#)

Website Overview

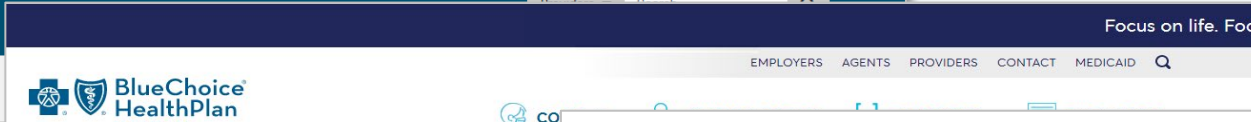
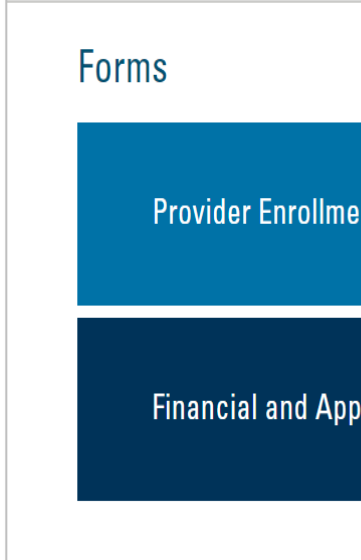
Forms



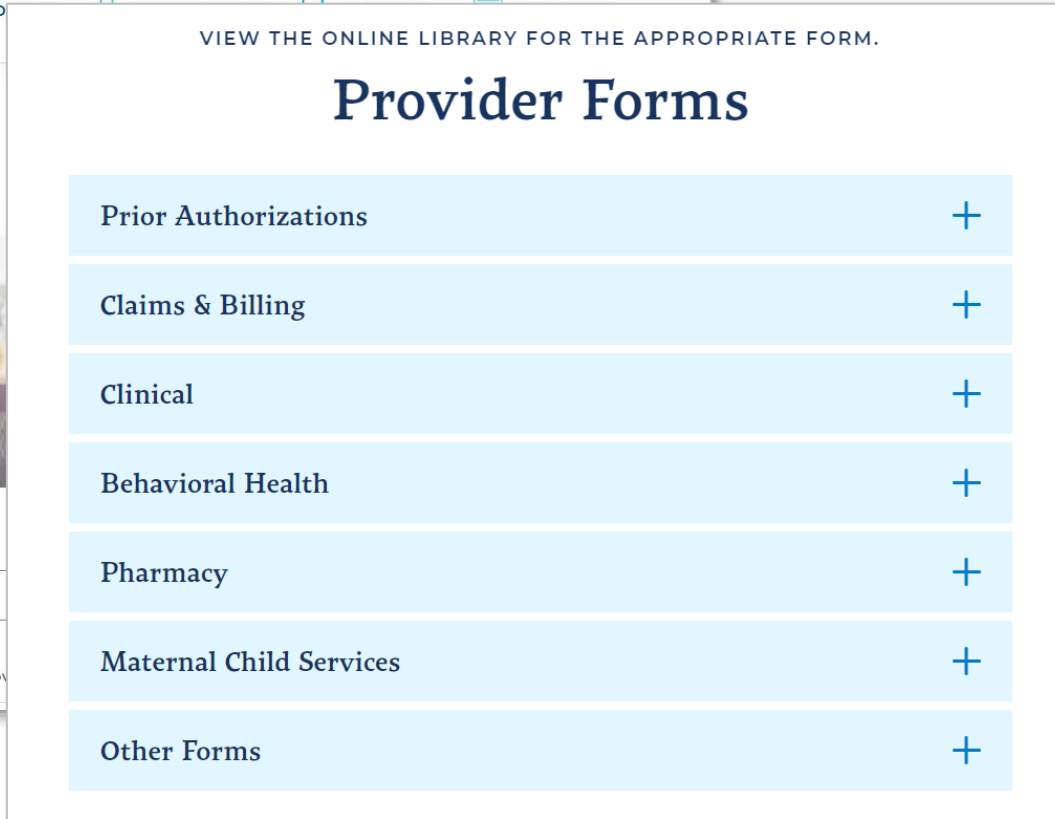
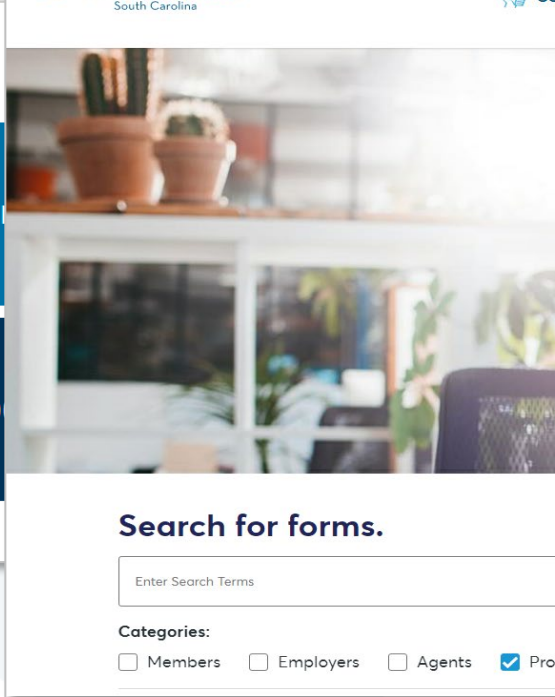
www.SouthCarolinaBlues.com



www.BlueChoiceSC.com



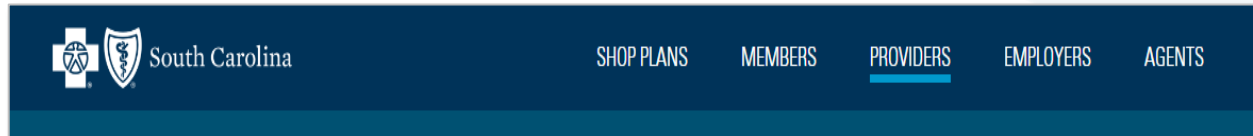
www.BlueChoiceSC.com



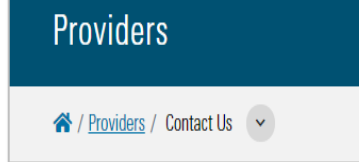
www.HealthyBlueSC.com

Website Overview

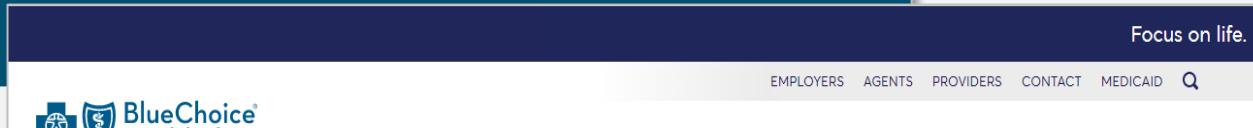
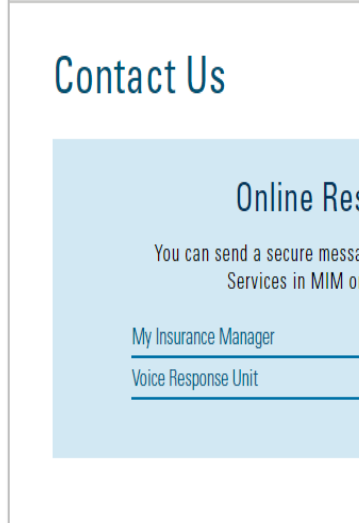
Contact us



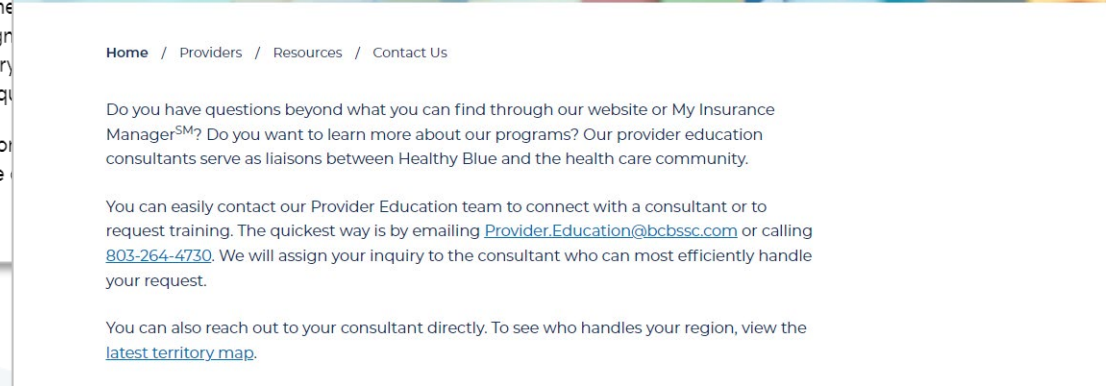
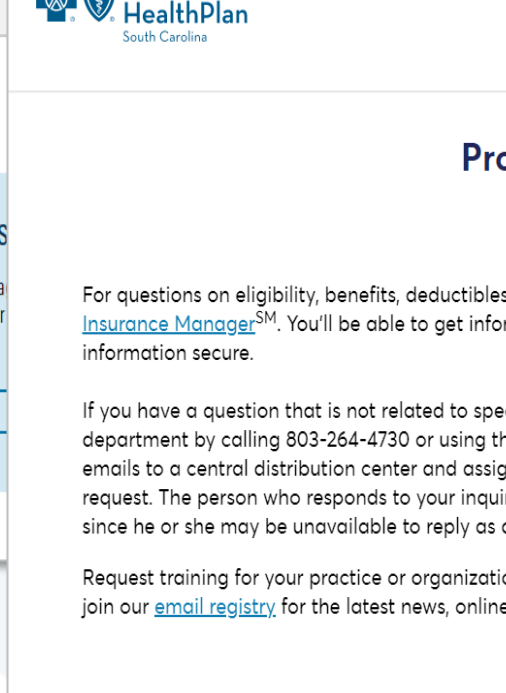
www.SouthCarolinaBlues.com



www.BlueChoiceSC.com



www.HealthyBlueSC.com





My Insurance Manager



My Insurance Manager

Overview

Tool used to check eligibility and benefits, claims status, request prior authorizations and much more

Available Guides:

- Getting Started
- Eligibility & Benefits
- Claims Entry
- Claims Status, Patient Directory, Superbill Maintenance & Coordination of Benefits
- Precertification, Pre-Treatment Estimate for Authorization Status
- Office Administration
- Provider Validation: M.D. Checkup

My Insurance Manager

Getting Started

- Select **Register Now** to get started.

Southcarolinablues.com>Providers>My Insurance Manager>Register Now

Start here.

The screenshot displays the My Insurance Manager website interface. At the top left, the logo reads "My INSURANCE MANAGER SM". Below the logo is a login and registration form with fields for "Username" and "Password", a "Login" button, and a "Register Now!" link. There are also links for "Forgot Username?" and "Forgot Password?". To the right of the form is a banner featuring a smiling female doctor and a computer monitor. The banner text says "Welcome to My Insurance Manager!" and "Log in to file a claim, check benefits and more! If you have never registered, you will need to create a profile." with a "Register Now" button. Below the banner is a "Browser Requirements" section with a list of supported browsers: Internet Explorer 10 or Higher*, Mozilla Firefox (current version), Google Chrome (current version), and Safari (Mac OS Only). Below the browser requirements is a "Latest Features" section with two cards. The first card asks "Is your password strong enough?" and "Safeguard PHI!" with a "Learn how" button. The second card asks "Are you accepting new patients?" and "Let us know!" with a "Validate Now" button.

My Insurance Manager

Getting Started (Continued)

When creating a profile, the 9-digit Tax ID must be entered. Select **Continue**.

My INSURANCE
MANAGERSM

Create Profile

[Printer-Friendly](#)

*** Required**

Please enter your 9-digit Tax ID number.

*** Tax ID:**

By clicking **Continue**, you agree to the [Terms and Conditions](#).

Continue or [Cancel](#)

Need help? Call us at 855-229-5720.

My Insurance Manager

Getting Started (Continued)

- The information associated with the Tax ID entered will auto-populate.
 - If there are multiple locations associated with the provider's practice, they will be given the option to select the primary location.
- Enter the remaining contact and login information, along with selecting a security question.
- Select **Continue**.

Create Profile Printer-Friendly

* Required

Profile Information

Each person can register under your Tax ID. For example, both Stuart and Sally work for ABC Practice. Under Practice/Facility Name, both would enter "ABC Practice." Then, each would enter a different Username, Password and other registration information.

Tax ID: Provider:

Address: Note: If this address is incorrect, please complete the [change of address form](#).

* Primary Location: Primary Work Location:

Profile Type:

Contact Information

* First Name:

* Last Name:

* Phone Number:

* Email:

* Confirm Email:

Login Information:

* Desired Username: 5 to 11 characters.

* Password: 8 to 25 characters.

* Confirm Password:

Security Question

* Security Question:

* Security Answer:

or

Need help? Call us at 855-229-5720.

My Insurance Manager

Getting Started (Continued)

If registering as the administrator, validation must be made by selecting: **Enter Claim Information** or **Request Security Code**. Also, select the delivery method to receive the code.

Recommended option

Validate Profile Printer-Friendly

Profile Validation

Please choose a way to validate yourself as an administrator of this Tax ID.

Enter Claim Information

Request Security Code

Request Security Code * Required

You can request that we send a Security Code via the delivery method we have on file associated with your Tax ID.

* Location: Select

* Delivery Method:

Email:

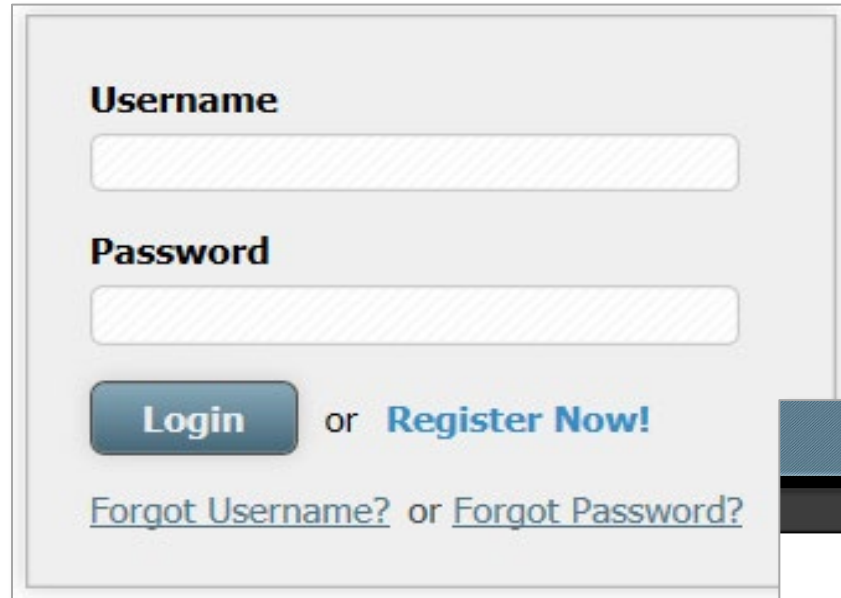
Fax:

Physical Address:

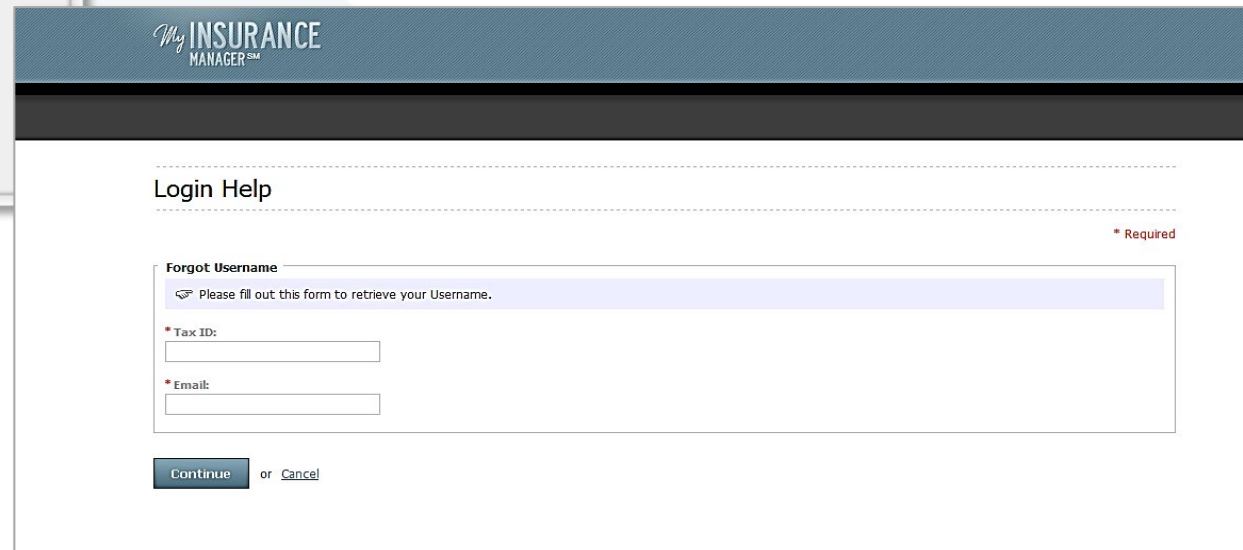
My Insurance Manager

Logging In

From the MIM homepage, enter the username and password. Select **Login**.



A screenshot of the login form on the My Insurance Manager homepage. It features two input fields: "Username" and "Password", both with a diagonal hatching pattern. Below the fields is a blue "Login" button, followed by the text "or Register Now!". At the bottom, there are two links: "Forgot Username?" and "Forgot Password?".



A screenshot of the "Forgot Username" help form on the My Insurance Manager website. The page has a dark blue header with the "My INSURANCE MANAGER" logo. Below the header is a "Login Help" section. A light blue box contains the text "Please fill out this form to retrieve your Username." and a "Forgot Username" label. Below this are two required input fields: "Tax ID:" and "Email:". At the bottom of the form is a "Continue" button and the text "or Cancel!".

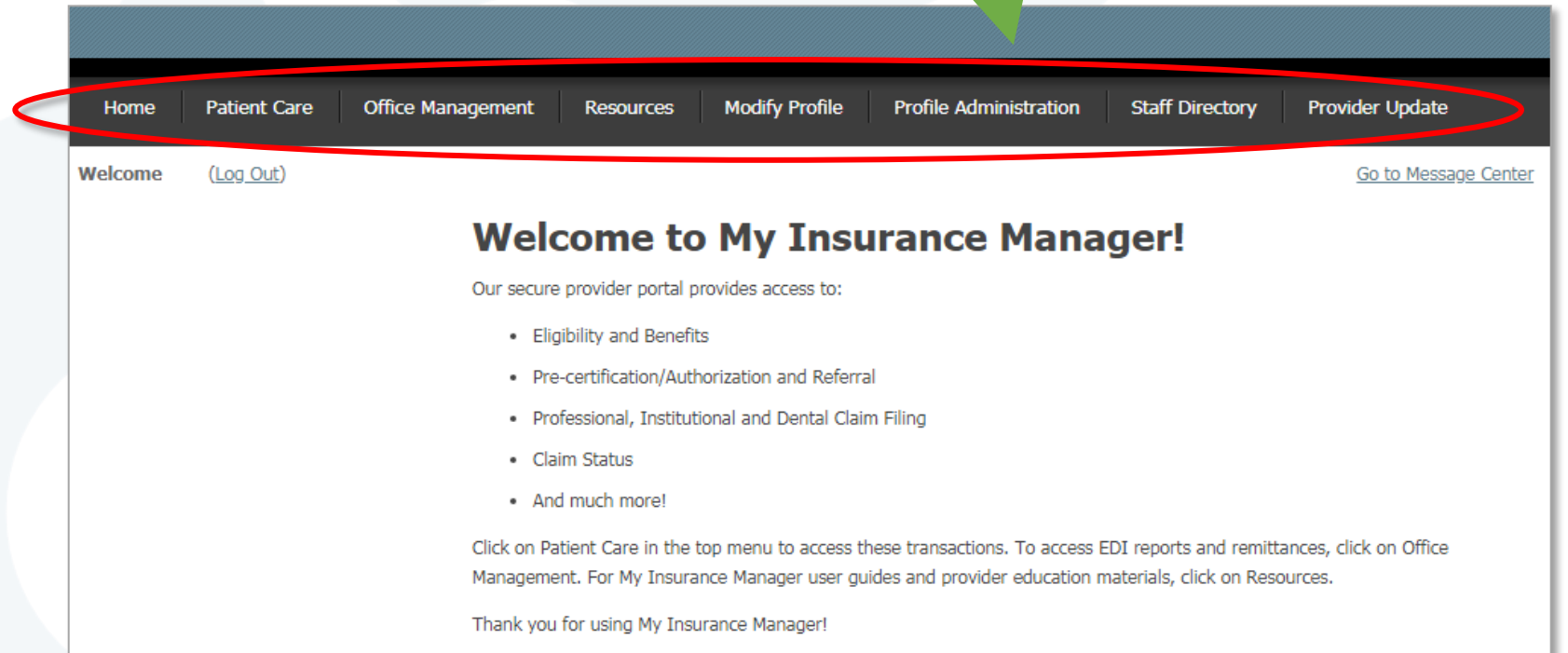
My Insurance Manager

Administrative Tabs

The following administrative tabs will be located at the top of the homepage:

- Patient Care
- Office Management
- Resources
- Modify Profile
- Profile Administration
- Staff Directory
- Provider Update (M.D. Checkup)

Only available for Profile Administrators



My Insurance Manager

Patient Care

- Patient Care is categorized by Health and Dental.
- For both Health and Dental services, the following options include:
 - View claims status.
 - Check eligibility and benefits.
 - Request prior authorizations.
 - and much more.



The screenshot displays the 'My Insurance Manager' interface. At the top, there is a navigation bar with four tabs: 'Patient Care', 'Office Management', 'Resources', and 'Modify Profile'. The 'Patient Care' tab is highlighted with a red circle. Below the navigation bar, the interface is divided into two main sections: 'Health' and 'Dental'. Each section contains a list of options, each with a right-pointing arrow icon.

Patient Care	
Health	
▶ Authorization Extension	▶ Patient Directory
▶ Authorization Status	▶ Pre-Certification/Referral
▶ Claims Status	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Service Review for Out-of-Area Members
▶ Institutional Claim Entry	▶ Professional Claim Entry
▶ Other Health Insurance	▶ Verify Primary Care Physician
Dental	
▶ Claims Status	▶ Patient Directory
▶ Dental Claim Entry	▶ Superbill Maintenance
▶ Eligibility and Benefits	▶ Pre-Treatment Estimate Entry
▶ Other Dental Insurance	▶ Pre-Treatment Estimate Status

My Insurance Manager

Office Management

- For both Health and Dental services, available options include EDI reports, enroll for EFT/ERA and view remittance information.
- Additional options for Health services include:
 - PCMH Reports and Patient Validation *
 - Refund Letters
 - HEDIS Reports
 - Employer Group Care Reports
 - Provider Report Cards



The screenshot displays the 'My Insurance Manager' interface. At the top, there is a navigation bar with four tabs: 'Office Management', 'Resources', 'Modify Profile', and 'Profile Adminis'. The 'Office Management' tab is highlighted with a red circle. Below the navigation bar, the interface is divided into two main sections: 'Health' and 'Dental'. Each section contains a list of options with a right-pointing arrow icon. The 'Health' section lists: EDI Reports, EFT/ERA Enrollment, PCMH Reports, PCMH Patient Validation, Remittance Information, Refund Letters, HEDIS® Quality Reports, Employer Group Care Reports, and Provider Report Cards. The 'Dental' section lists: EDI Reports, EFT/ERA Enrollment, and Remittance Information.

Office Management	Resources	Modify Profile	Profile Adminis
Health			
▶ EDI Reports		▶ Refund Letters	
▶ EFT/ERA Enrollment		▶ HEDIS® Quality Reports	
▶ PCMH Reports		▶ Employer Group Care Reports	
▶ PCMH Patient Validation		▶ Provider Report Cards	
▶ Remittance Information			
Dental			
▶ EDI Reports		▶ Remittance Information	
▶ EFT/ERA Enrollment			

*This report only applies and shows up for PCMH providers.

My Insurance Manager

Office Management — Refund Letters

Refund letters include:

- Reason for the refund
- Refund control number (RCN)
- Claim details
- Patient details


If you do not have the refund letter:

- Call Provider Services: 800-868-2510, opt. 4.
 - Used for the following lines of business:
 - BlueCard
 - BlueEssentialsSM
 - Major Group
 - National Alliance
 - Small Group & Individual

*PLB	*Provider Adjustment	Provider Adjustment	10/26/2021	0.00	-429.30		
PLB ADJUSTMENTS							
PreProv	Reason Code	Reference Id	Amount				
	WO: Overpayment Recovery	P2126417272	338.4				
	WO: Overpayment Recovery	P2126417320	90.9				
REMITTANCE SUMMARY							
	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj	Paid
Totals	.00	.00	.00	.00	.00	429.30	-429.30

0000192

I-20 @ Alpine Road
Columbia, SC 29219

 **South Carolina**
BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association
Log in to MyInsuranceManagerSM
at SouthCarolinaBlues.com.

SEPTEMBER 21, 2021

1000 30 1000
26 1000

LOS ANGELES CA 90074-9055

Re: Patient:
ID Num:
Date(s) of Service: March 17, 2021
Refund Number: P2126417272

Dear Provider:

Payment was forwarded to you on April 12, 2021, in error for the patient listed above. We must request that you refund \$338.40 for the reason listed below.

THE PATIENT'S OTHER INSURANCE COVERAGE IS THE PRIMARY POLICY AND MUST CONSIDER THESE CHARGES BEFORE US.

If we have not heard from you within 21 days, the refund amount will be deducted from future benefits payable to you and/or sent to our collections agency. Please send this amount to:

BlueCross BlueShield of SC
PO Box 6000
Columbia, SC 29260-0000

We thank you for your cooperation and apologize for any inconvenience. If you have any questions about this refund, please call our Customer Service department at 800-868-2500.

Sincerely,

My Insurance Manager

Office Management — Provider Report Cards

Provider Report Cards provide:

- Electronic Media Claims Percentages.
- Average Days to Process Claims.
- First Pass Claim Percentages.
- First Call Resolution Percentages.
- Duplicate Filing Rates.
- Valid NDC Code Usage.
- Precertification Self-Service Usage.
- Provider Claim Editor Denial Percentage.



BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Provider Report Card

We continuously strive to make working with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan a pleasurable and efficient experience! Please review the results for your practice listed below.

Provider Name: ABC Hospital

Provider Number: 147258369

Last Roster Update: Not Current

Report Month: 8/1/2022

Measure	Previous Rate	Current Rate	Benchmark Rate	Rating
Electronic Media Claims Percentage (EMC)	99.06%	98.77%	93.68%	Above Average
Average Days to Process Claims	0.32	0.40	0.63	Above Average
First Pass Claim percentage (%)	91.59%	92.65%	95.83%	Above Average
First Call Resolution percentage (%)	33.33%	57.14%	90.54%	Below Average
Duplicate Filing Rates	0.47%	0.25%	0.00%	Above Average
Valid NDC Code Usage	100.00%	83.33%	77.78%	Below Average
Precertification Self-Service Usage (Web/VRU)				
Provider Claim Editor denial percentage (%)				

Note: Empty fields indicate there was no data available for the measure during that period.

My Insurance Manager

Resources

Resources provide beneficial information, some of which may route to a separate website.

Most used resources are:

- Avalon Lab Benefit Manager Provider Portal
- Medical Policies
- My Remit Manager



The screenshot displays the navigation menu of the My Insurance Manager system. The 'Resources' tab is highlighted with a red circle. Below the navigation bar, a 'Tools' dropdown menu is visible, listing various resources and services. The resources listed include:

- Access System News
- Avalon Lab Benefit Manager Provider Portal
- BlueChoice Find Care
- Blue Cross Find Care
- Code Search
- EDI Resources
- FEP Website
- Forms
- Lab/Biometric Data Upload
- Medical Policies
- My Remit Manager
- Provider News and Events
- State Dental Plan Fee Schedule
- State Health Plan Fee Schedule
- Tools and Resources
- Washington Publishing Company Claim Adjustment Reason Codes

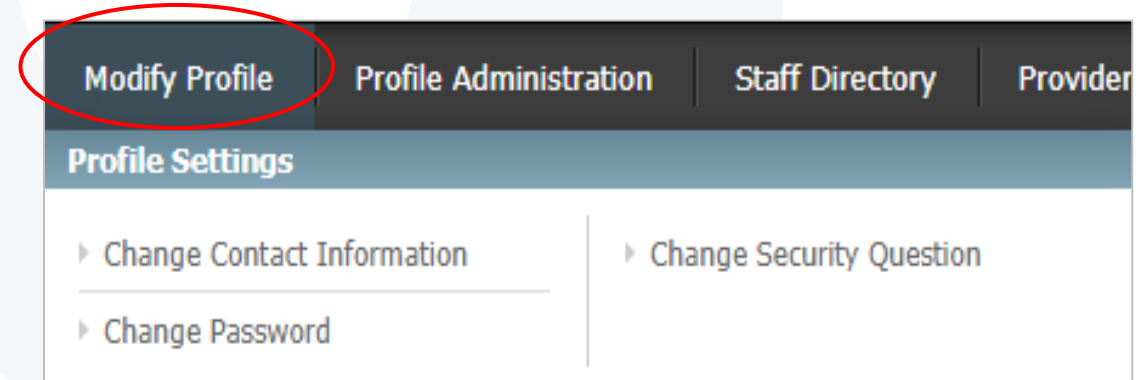
My Insurance Manager

Modify Profile

If changes are needed to your profile, look under Modify Profile.

Options include:

- Change Contact Information.
- Change Password.
- Change Security Question.



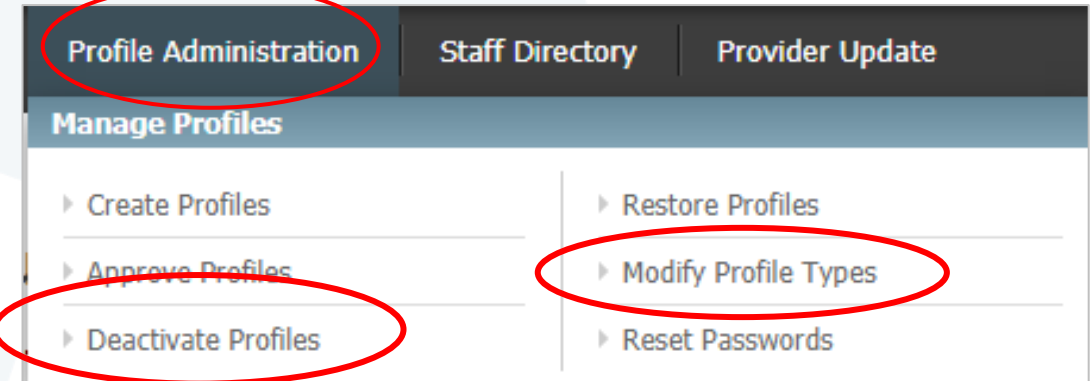
My Insurance Manager

Profile Administration

Profile Administration is available for the administrator(s) for the practice to:

- Create profiles.
- Approve profiles.
- Deactivate profiles.
- Restore profiles.
- Modify profile types.
- Reset passwords.

Only available for Profile Administrators.



The screenshot shows a navigation menu with three main items: Profile Administration, Staff Directory, and Provider Update. The Profile Administration item is circled in red. Below it is a sub-menu titled 'Manage Profiles' with six items: Create Profiles, Approve Profiles, Deactivate Profiles, Restore Profiles, Modify Profile Types, and Reset Passwords. The 'Approve Profiles' and 'Modify Profile Types' items are also circled in red.

Profile Administration	Staff Directory	Provider Update
Manage Profiles		
▶ Create Profiles		▶ Restore Profiles
▶ Approve Profiles		▶ Modify Profile Types
▶ Deactivate Profiles		▶ Reset Passwords

Note: If someone no longer works at your practice, deactivate their profile. Also, if you are the profile administrator and plan to leave, please make someone else the profile administrator.

My Insurance Manager

Staff Directory and Provider Update

- Staff Directory provides a list of profiles associated with the Tax ID in MIM.
- Provider Update (M.D. Checkup) allows updates and validations to be made to the demographic information we have in the Provider Directory.
 - As of Jan. 1, 2022, a provider update is required at least **every 90 days**, as part of the Consolidated Appropriations Act (CAA).
 - Locations are suppressed if validations are not made.

Staff Directory

Provider Update

My Insurance Manager

Troubleshooting Tips

- Complete the MIM registration process to avoid limited access features.
- Be sure to use one of the recommended browsers:
 - Internet Explorer (IE) 10 or higher.
 - Mozilla Firefox.
 - Google Chrome.
 - Safari.
- On Sundays from 5 p.m. to midnight EST, MIM is unavailable for maintenance.
- For technical issues, call Technical Support at 855-229-5720.



Ask Provider Services



Ask Provider Services

Ask Provider Services (Web inquiries)

- Ask Provider Services is a feature inside My Insurance Manager that allows you to submit secured web inquiries for help with claims.
- To get the most effective and accurate responses, ask specific, probing questions.
 - This feature should not be used for general claim status.

These answers are in MIM.

Examples of appropriate questions to ask...	Examples of inappropriate questions to ask...
Why was line one of the claim denied as noncovered?	What is the status of the claim?
Why were services applied to the member's deductible?	Have medical records been received?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?

Ask Provider Services

Ask Provider Services — Submitting Web Inquiries

Searching by Member ID (recommended option)

Be sure to:

- Select the appropriate Health Plan.
- Enter the **FULL** Member ID, including the prefix and any additional letters.
- Enter the date of birth.
- Select one of the advanced options.

Patient Selection

To get claims status information, please enter this information. If your patient had a different Health Plan previously, please choose the Health Plan that was in effect for the specific date of service.

* **Health Plan:**
--Please Choose One--

Search By:

Member ID
 Claim Number

* **Member ID:**
include alpha prefix, if applicable

* **Patient's Date of Birth:**
mm/dd/yyyy

* **Health Plan:**
--Please Choose One--
BlueCross BlueShield Plans
BlueChoice HealthPlan
State Health Plan
Federal Employee Program

* **Member ID:**
ypwj1 1
include alpha prefix, if applicable

Advanced Search

All Claims in System
 Date of Service
 Last 6 Months
 Last Year

Ask Provider Services

Ask Provider Services — Submitting Web Inquiries

Searching by Member ID (Continued)

Be sure to:

- Enter the patient's first and last name.
- Enter the **FULL** Member ID, including the prefix and any additional letters.
- The date of birth and location will auto-populate from the selected claim.
- Enter your question (be specific as possible).

Ask Provider Services

Inquiry

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

How would you like to contact Provider Services?

Submit your question online

Talk to Provider Services online
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

Health Plan:
BlueCross BlueShield Plans

Inquiry Reason:
Claim Status Inquiry

* Patient's First Name: * Patient's Last Name: * Patient's Member id: Patient's Date of Birth:
mm/dd/yyyy

* Location: Primary ID:

* Please enter a question:

or [Back](#)

Ask Provider Services

Ask Provider Services — Submitting Web Inquiries

Searching by Claim Number

Be sure to:

- Select the appropriate Health Plan.
- Enter the claim number.

Patient Selection

To get claims status information, please enter this information. If your patient had a different Health Plan previously, please choose the Health Plan that was in effect for the specific date of service.

*** Health Plan:**
--Please Choose One--

Search By:

Member ID

Claim Number

*** Claim Number:**

*** Health Plan:**
--Please Choose One--
BlueCross BlueShield Plans
BlueChoice HealthPlan
State Health Plan
Federal Employee Program

Continue

Ask Provider Services

Ask Provider Services — Submitting Web Inquiries

Searching by Claim Number (Continued)

Be sure to:

- Enter the patient's name, ID number, date of birth and location will auto-populate from the entered claim.
- Enter your question (be specific as possible).

Ask Provider Services

Inquiry

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

How would you like to contact Provider Services?

Submit your question online

Talk to Provider Services online
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

Health Plan:
BlueCross BlueShield Plans

Inquiry Reason:
Claim Status Inquiry

* Patient's First Name: * Patient's Last Name: * Patient's Member id: Patient's Date of Birth:
mm/dd/yyyy

* Location: Primary ID:

* Please enter a question:

or [Back](#)

Ask Provider Services

Ask Provider Services — Viewing Web Inquiry Responses

Be sure to:

- Select Go to Message Center.
- To narrow the results, you can:
 - Enter the ID number and select the health plan.
 - Select specific months.

[Go to Message Center](#)

Search by Member ID: Select a Plan...

Last 30 Days Results (0)

Message Tools

Date ▲	Subject
⚠ We did not find any messages for the time period you chose. Please try your request again with a different time period.	

Note: If you submit an inquiry in one month and do not see a response, search by the member's ID number. The response may be listed under a different month.



STATchat



STATchat

STATchat

- STATchat is a fast and simple way to speak with a provider services representative.
- The feature is available through My Insurance Manager.

System Requirements

- A current version of Adobe Flash Player
- A compatible web browser, such as Microsoft Internet Explorer 10 or EDGE® or Google Chrome®
- A headset (recommended) or standalone microphone and speakers connected to your computer

Ask Provider Services

STATchat * Required

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

How would you like to contact Provider Services?

Submit your question online

Talk to Provider Services online
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

Inquiry Name:
BlueCross BlueShield Plans

Inquiry Reason:
Claim Status Inquiry

* Patient's First Name: / * Patient's Last Name: K * Patient's Member id: B: i9Q

* Location: Primary ID: 1

[Need help using STATchat?](#)

Launch STATchat or [Back](#)





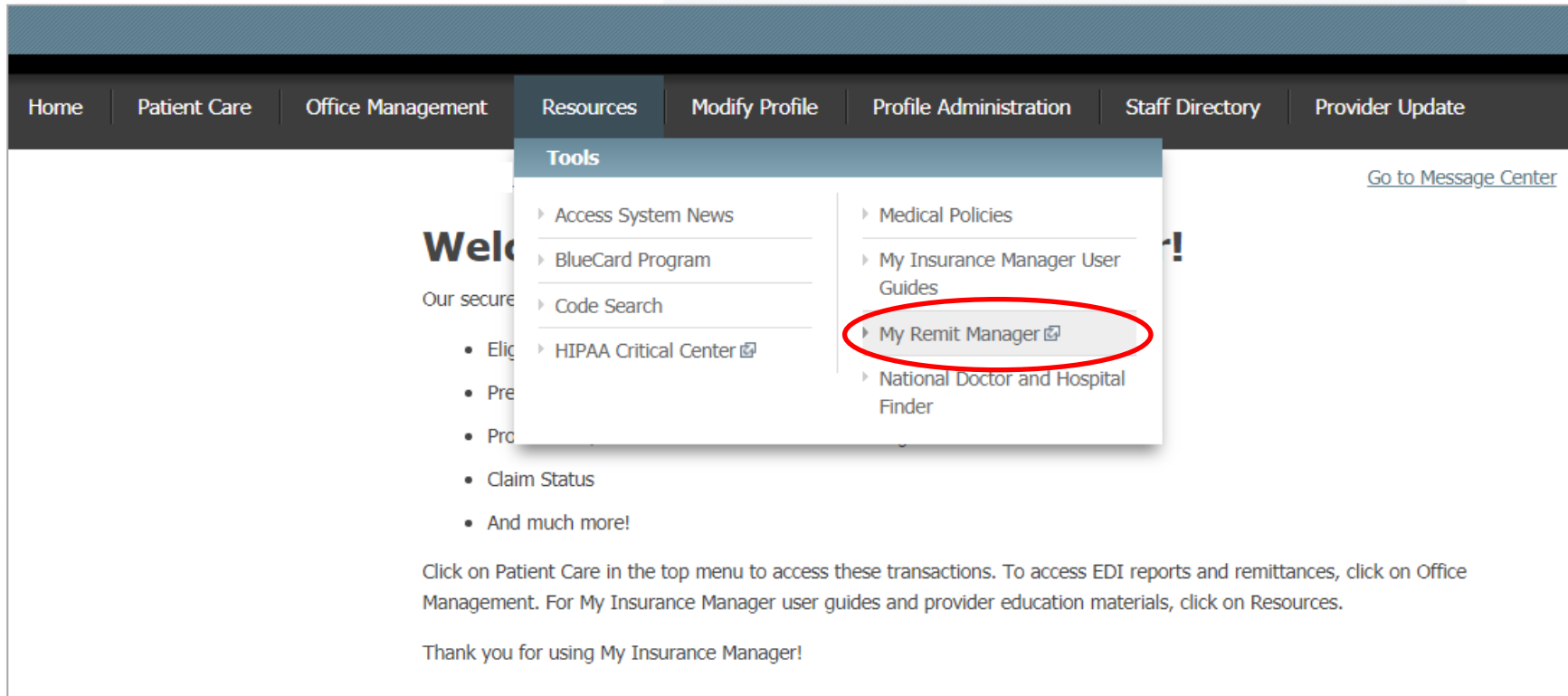
My Remit Manager



My Remit Manager

Access Through My Insurance Manager

- Tool used to track payments and pull electronic remittance advices
- From My Insurance Manager, hover over Resources, then select My Remit Manager



The screenshot displays the My Insurance Manager website interface. At the top, a dark navigation bar contains the following menu items: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, Staff Directory, and Provider Update. The 'Resources' menu is currently open, showing a list of tools. The 'My Remit Manager' option is highlighted with a red circle. Other visible options in the Resources menu include Access System News, BlueCard Program, Code Search, HIPAA Critical Center, Medical Policies, My Insurance Manager User Guides, and National Doctor and Hospital Finder. The main content area features a 'Welcome' message and a list of services, including Claim Status and And much more!. A 'Go to Message Center' link is visible in the top right corner. At the bottom, there is a note about accessing transactions and a thank you message.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory Provider Update

Tools

- › Access System News
- › BlueCard Program
- › Code Search
- › HIPAA Critical Center
- › Medical Policies
- › My Insurance Manager User Guides
- › My Remit Manager
- › National Doctor and Hospital Finder

Go to Message Center

Welcome!

Our secure...

- Elig...
- Pre...
- Pro...
- Claim Status
- And much more!

Click on Patient Care in the top menu to access these transactions. To access EDI reports and remittances, click on Office Management. For My Insurance Manager user guides and provider education materials, click on Resources.

Thank you for using My Insurance Manager!

My Remit Manager

My Remit Manager Through My Insurance Manager

- Sort and view checks by the check date or posting date
- Select the Adobe icon to view the Remit
- Select the check number to view:
 - Members associated with the check
 - DOS
 - Processed status (paid or denied)
 - Amount billed and paid

The screenshot shows the 'My Remit Manager' interface. At the top, there's a header with the logo and the title 'ERA by Check Date - May 2022'. Below the header, there's a 'View Checks By:' dropdown menu with options 'Check Date' (selected), 'Check Date', and 'Posting Date'. To the right, there are buttons for 'Check Summary Report' and 'Show Month'. The main area is a calendar for May 2022. The calendar shows days of the week (S, M, T, W, T, F, S) and dates. Check numbers are displayed for various dates: 'open' for 24, 25, 26, 27, 28, 29, 30; 'CHK: 9' and 'CHK: 43' for 26; 'CHK: 1' for 29; 'CHK: 1' for 6; 'CHK: 2' for 13; and 'CHK: 4' for 20. A red circle highlights the 'CHK: 9' and 'CHK: 43' entries on May 26th.

The screenshot shows a list of checks in the 'My Remit Manager' interface. The table has columns for 'Reco', 'Download', 'Check Number', 'Payment Method', 'Checkdate', 'Postdate', 'Billed', 'Paid', 'Payer', and 'Provider'. The 'Download' column contains Adobe icons for each row. A red circle highlights the 'Download' column. The table shows 10 rows of check data, all with 'ACH' as the payment method and '11/1/2022' as the check date. The 'Billed' and 'Paid' columns show various amounts. The 'Payer' column lists 'BLUECROSS BLUESHIELD OF SOUTH CAROLINA' and 'STATE HEALTH PLAN'. The 'Provider' column is mostly empty.

Reco	Download	Check Number	Payment Method	Checkdate	Postdate	Billed	Paid	Payer	Provider
			ACH	11/1/2022	10/30/2022	\$9,485.00	\$1,572.00	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	\$7,807.00	\$1,749.13	STATE HEALTH PLAN	
			ACH	11/1/2022	10/30/2022	\$530.00	\$132.00	FEDERAL EMPLOYEE PLAN	
			ACH	11/1/2022	10/30/2022	\$2,105.00	\$213.04	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	\$1,157.00	\$96.18	STATE HEALTH PLAN	
			ACH	11/1/2022	10/30/2022	\$769.00	\$141.47	FEDERAL EMPLOYEE PLAN	
			ACH	11/1/2022	10/30/2022	\$178.00	\$117.00	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	\$196.80	\$24.14	STATE HEALTH PLAN	
			ACH	11/1/2022	10/30/2022	\$1,410.00	\$78.99	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	\$1,710.00	\$380.05	STATE HEALTH PLAN	


My Remit Manager

External Access to My Remit Manager

- Link: https://client.webclaims.com/v07_03/
- To sign up or for password resets, email EDI.Services@bcbssc.com.
 - The MRM Access Request Form can also be completed, which is located on www.SouthCarolinaBlues.com.

Providers>Tools and Resources>My Remit Manager

- New registrants will receive their username and password, along with instructions via email.



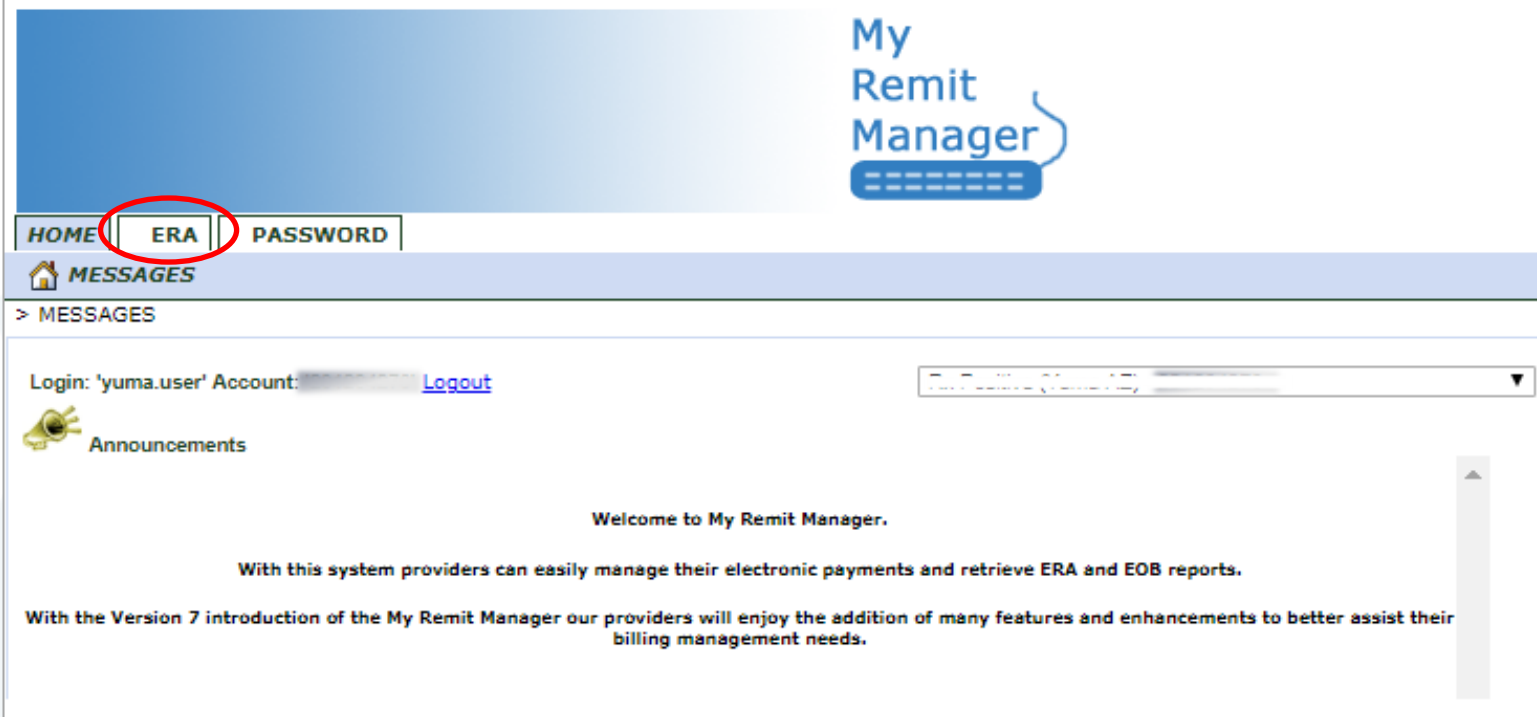
The screenshot displays two overlapping web forms. The top form is the login page for the South Carolina BlueCross BlueShield. It features the organization's logo and name, followed by a 'Log In' section with input fields for 'User Name' and 'Password', a 'Remember me next time' checkbox, and a 'Log In' button. Below the login fields, there is a section for users who need to register or have forgotten their credentials, directing them to contact BCBSSC EDI Services.

The bottom form is the 'My Remit Manager Access Request Form'. It contains several required fields for registration: 'Billing Provider Name *', 'Billing Provider Tax ID *', 'Billing Provider NPI(s) *' (with a note to separate multiple NPIs with commas), 'User Name *' (split into 'First Name' and 'Last Name' fields), 'User Phone Number *', and 'User Email *'. A 'Submit Form' button is located at the bottom right of this form.

My Remit Manager

External Access to My Remit Manager (Continued)

Select the ERA tab to view check and remittance information.



The screenshot displays the My Remit Manager web application interface. At the top right, the logo "My Remit Manager" is visible. Below the logo, there is a navigation bar with three tabs: "HOME", "ERA", and "PASSWORD". The "ERA" tab is highlighted with a red circle. Below the navigation bar, there is a "MESSAGES" section with a home icon and the text "MESSAGES". Below this, there is a "MESSAGES" section with a right-pointing arrow and the text "MESSAGES". Below this, there is a "Login: 'yuma.user' Account: [redacted] Logout" section. Below this, there is an "Announcements" section with a megaphone icon. Below this, there is a "Welcome to My Remit Manager." section. Below this, there is a "With this system providers can easily manage their electronic payments and retrieve ERA and EOB reports." section. Below this, there is a "With the Version 7 introduction of the My Remit Manager our providers will enjoy the addition of many features and enhancements to better assist their billing management needs." section.

My Remit Manager

ERA Tab — Pulling the Remittance

- Select the date of the remittance needed.
- Select the associated check number.

HOME REALTIME CLAIMS ERA PASSWORD ADMIN

CHECK DATE POST DATE PATIENTS REPORTS DOWNLOAD ERA

> CHECKS BY CHECK DATE

Login: 'terrence.scribal' Account: 1464832889 Logout [Switch Accounts](#)

Select Date ▼

June 2021

IV	Sun	Mon	Tue	Wed	Thu	Fri	Sat
IV	30	31	1	2	3	4	5
IV	6	7	8	9	10	11	12
IV	13	14	15	16	17	18	19
IV	20	21	22	23	24	25	26
IV	27	28	29	30	1	2	3
IV	4	5	6	7	8	9	10

Billed vs. Paid by Week

Week	Billed	Paid
Week 1	7K	2K
Week 2	17K	4K
Week 3	9K	2K
Week 4	8K	0K

Order By: Name ▼ [Download ERA](#) [Download X12](#)

Search for: Search [Select All](#) [Unselect All](#)

Hide Reconciled Payer: *All Items Provider: *All Items

RECC	CHECK NUMBER	CHECK TYPE	CHECK DATE	POST DATE	BILLED	PAID	PROVIDER	PAYER	TYPE
Select <input type="checkbox"/>	0002	CH	6/15/2021	6/13/2021	1879.00	354.33	LO SU		5010
Select <input type="checkbox"/>	0004	CH	6/15/2021	6/13/2021	2169.00	680.09	LO SU		5010
Select <input type="checkbox"/>	00011	CH	6/15/2021	6/13/2021	4981.00	880.26	LO SU		5010

My Remit Manager

ERA Tab — Pulling the Remittance (Continued)

Select the account of the patient.

HOME REALTIME CLAIMS **ERA** PASSWORD ADMIN

CHECK DATE POST DATE PATIENTS REPORTS DOWNLOAD ERA

> CHECKS BY CHECK DATE > PATIENTS

Check Number/Date
Payer
Provider
Status

[ERA Patient Per Page](#) [ERA Patient Listing](#) [ERA Patient Summary](#) [ERA Text](#) [Export](#)
[Selected ERA Per Page](#) [Unselect All](#)

1 Records 1-5 of 5

ACCOUNT	PATIENT	STATUS	POLICY
46184		<input type="checkbox"/> Processed as Primary	
46208		<input type="checkbox"/> Processed as Primary	
46039		<input type="checkbox"/> Processed as Secondary	
46157		<input type="checkbox"/> Processed as Primary	
46008		<input type="checkbox"/> Processed as Secondary	

ERA Patient Listing

Electronic Reproduction ASC 005010X221A1

CHECK/EFT: 0000420012 CHECK DATE: 06/15/2021

Account: 46030 POS: 11 HIC: 16002110 ICN: 110102210000 Provider: 1021277010 10100000 111000003

Status: Processed as Secondary

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary
161633693	05/20/2021	1		HC:99202	145.00	70.12			131.14	13.86	*OA 23 131.14
REMITTANCE SUMMARY					145.00	70.12	.00	.00	131.14	13.86	

TOTALS

Denied/Non-Covered: 131.14

*OA 23 131.14 [Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments]

* Denotes Denied Or Non-covered Charges

REMITTANCE SUMMARY

Totals	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj	Paid
	145.00	70.12	.00	.00	131.14	.00	13.86

My Remit Manager

ERA Tab — Patient Search

Enter the patient's name in last name, first name format.

The screenshot shows the 'ERA' tab selected in the navigation menu. Below the menu is a toolbar with icons for 'CHECK DATE', 'POST DATE', 'PATIENTS', 'REPORTS', and 'DOWNLOAD ERA'. The main content area is titled '> PATIENTS' and contains a search form with the following fields:

- Search for:** A text input field with a 'Search' button.
- Filter on:** A dropdown menu set to 'None' and a 'Select Date' dropdown.
- Payer:** A dropdown menu set to 'All Items'.
- From Date:** A text input field.
- To Date:** A text input field.
- Status:** A dropdown menu set to 'All Items'.
- Provider:** A dropdown menu set to 'All Items'.

At the bottom of the form, there are several links: [ERA Patient Per Page](#), [ERA Patient Listing](#), [ERA Patient Summary](#), [ERA Text](#), [Export Selected ERA Per Page](#), and [Unselect All](#). A 'RECORD' label is visible to the right of the links.

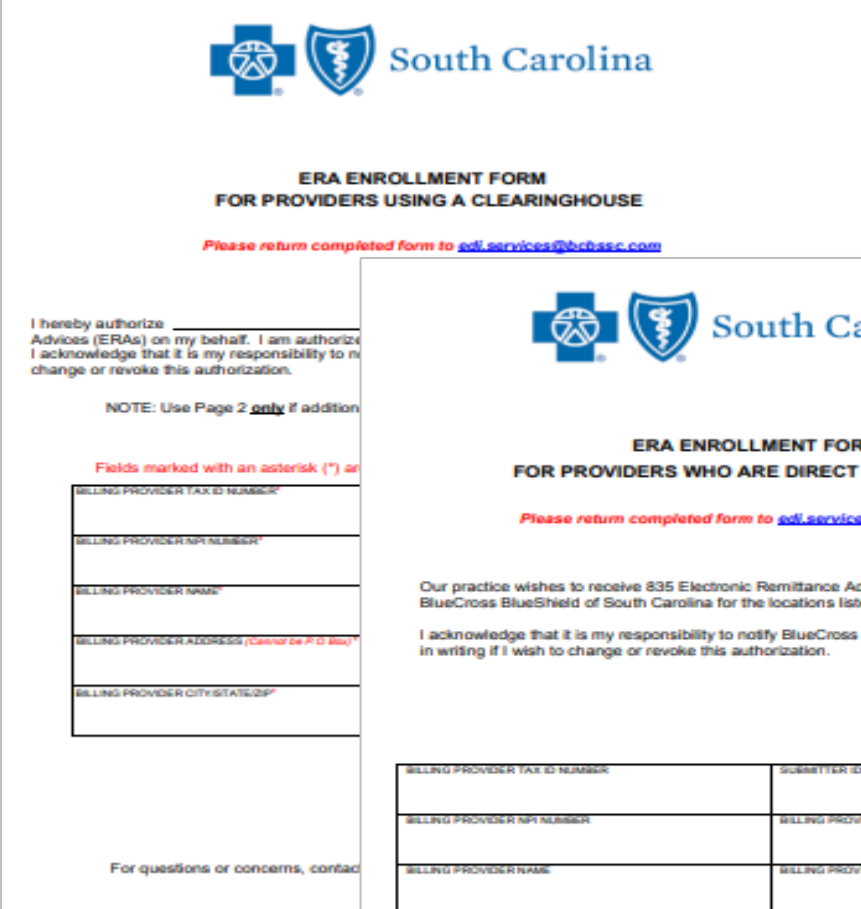
- ERA Patient Per Page
- ERA Patient Listing
- ERA Patient Summary
- ERA Text
- Export Selected ERA Per Page
- Unselect All


My Remit Manager

Electronic Remittance Advice (ERA)

How to Receive ERAs

- Complete the ERA Enrollment/Clearinghouse or ERA Enrollment/Direct Submitter Form located on www.SouthCarolinaBlues.com.
Providers>Claims and Payment>Payment and Remittance Advices
- Submit the completed form to EDI.Services@bcbssc.com.



 South Carolina

**ERA ENROLLMENT FORM
FOR PROVIDERS USING A CLEARINGHOUSE**

Please return completed form to edi.services@bcbssc.com

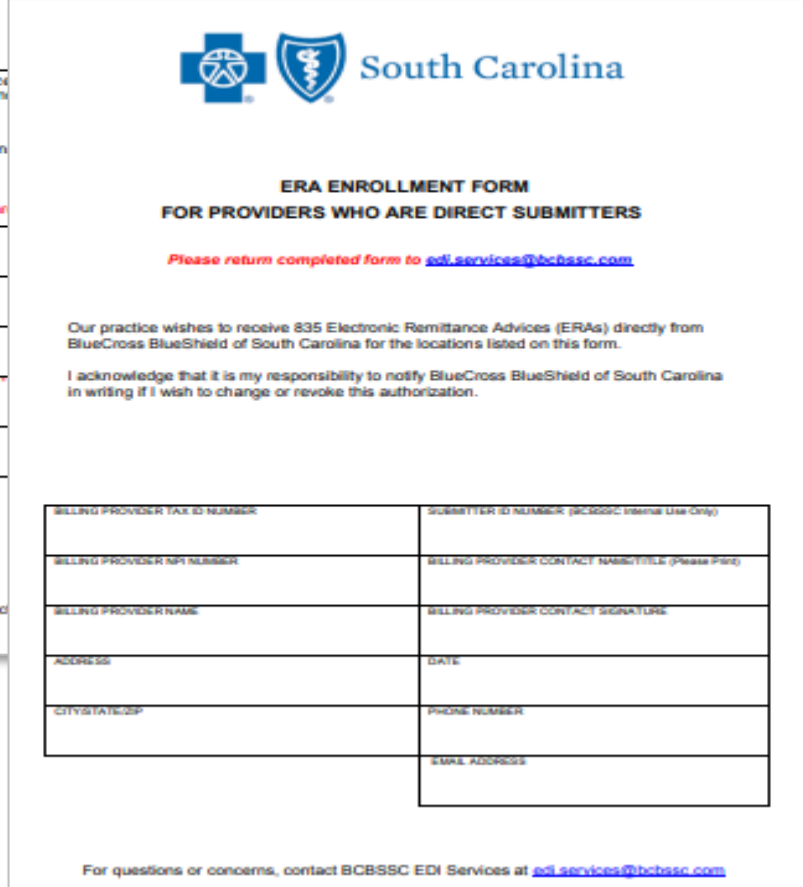
I hereby authorize _____
Advices (ERAs) on my behalf. I am authorized
I acknowledge that it is my responsibility to notify
change or revoke this authorization.


NOTE: Use Page 2 **only** if additional

Fields marked with an asterisk (*) are

BILLING PROVIDER TAX ID NUMBER*
BILLING PROVIDER NPI NUMBER*
BILLING PROVIDER NAME*
BILLING PROVIDER ADDRESS (Cannot be P.O. Box)*
BILLING PROVIDER CITY/STATE/ZIP*

For questions or concerns, contact



 South Carolina

**ERA ENROLLMENT FORM
FOR PROVIDERS WHO ARE DIRECT SUBMITTERS**

Please return completed form to edi.services@bcbssc.com

Our practice wishes to receive 835 Electronic Remittance Advices (ERAs) directly from BlueCross BlueShield of South Carolina for the locations listed on this form.

I acknowledge that it is my responsibility to notify BlueCross BlueShield of South Carolina in writing if I wish to change or revoke this authorization.

BILLING PROVIDER TAX ID NUMBER	SUBMITTER ID NUMBER (BCBSSC Internal Use Only)
BILLING PROVIDER NPI NUMBER	BILLING PROVIDER CONTACT NAME/TITLE (Please Print)
BILLING PROVIDER NAME	BILLING PROVIDER CONTACT SIGNATURE
ADDRESS	DATE
CITY/STATE/ZIP	PHONE NUMBER
	EMAIL ADDRESS

For questions or concerns, contact BCBSSC EDI Services at edi.services@bcbssc.com



My Provider Enrollment Portal

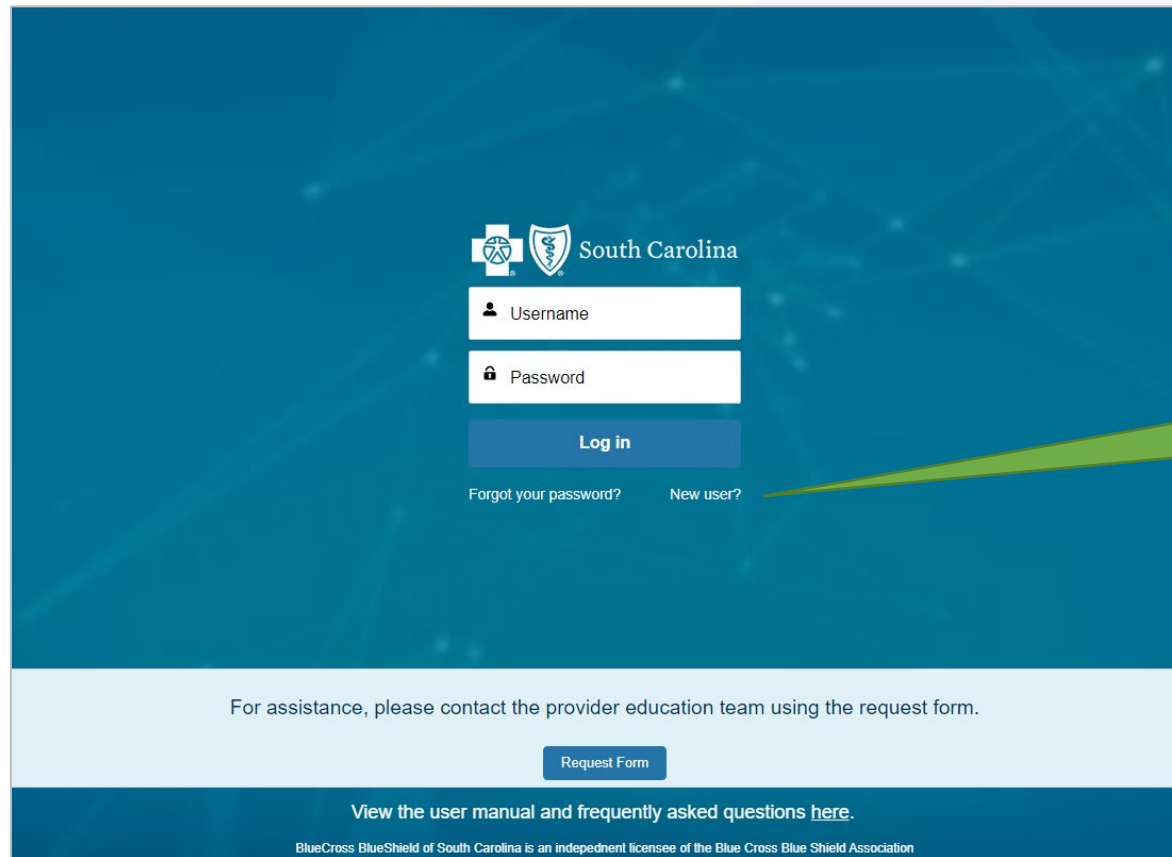


My Provider Enrollment Portal

Sign Up for Access to the Portal

Visit www.SouthCarolinaBlues.com.

Providers>Provider Enrollment>My Provider Enrollment Portal



The screenshot shows the login page for the My Provider Enrollment Portal. At the top, there is a logo for South Carolina with a cross and shield icon. Below the logo are two input fields: 'Username' and 'Password'. A blue 'Log in' button is positioned below the password field. Underneath the button are two links: 'Forgot your password?' and 'New user?'. A green callout bubble points to the 'New user?' link. At the bottom of the page, there is a light blue banner with the text 'For assistance, please contact the provider education team using the request form.' and a 'Request Form' button. Below that is a dark blue footer with the text 'View the user manual and frequently asked questions [here](#).' and a small disclaimer: 'BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross Blue Shield Association'.

Select New user if you've never signed up!

My Provider Enrollment Portal

Home Page

The screenshot displays the home page of the My Provider Enrollment Portal. At the top left, there is a logo for South Carolina. A search bar is located in the top center. On the top right, a user profile is shown with the text 'USER16500...'. The navigation menu includes 'Home', 'Get Enrolled', 'Find a Form', 'My Forms', 'My Contracts' (highlighted with a red circle), and 'Support'. The main heading reads 'My Provider Enrollment Portal' with a cloud and lock icon. Below the heading is the text 'Enroll in our networks, make provider updates, and much more.' A row of four action buttons is present: 'GET ENROLLED' with a doctor icon, 'MY FORMS' with a document icon, 'CONTACT SUPPORT' with a phone and envelope icon and a red notification bubble with the number '1', and 'FIND A FORM' with a checklist icon. The footer contains the text: 'BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross Blue Shield Association'.

My Provider Enrollment Portal

Get Enrolled

Review the available checklists before starting an application.

The screenshot displays the 'My Provider Enrollment Portal' website. At the top, there is a dark blue header with the BlueCross BlueShield of South Carolina logo, a search bar, and a user profile icon. Below the header is a navigation menu with links for Home, Get Enrolled, Find a Form, My Forms, My Contracts, and Support. The main content area is titled 'Get Enrolled' and includes a sub-header: 'Looking to join one of our networks? Select one of the appropriate forms below to get started.' A red oval highlights a note: 'Please review the [available checklists](#) before starting an application to ensure all required documents and information is included.' Below this are several enrollment options, each with an 'ENROLL' button:

- Individual Provider Enrollment**: For Providers wanting to enroll with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan. Note: This application applies to medical, dental, and mid-level providers. This application does NOT apply to Behavioral Health providers.
- Group Practice Enrollment**: For group practices wanting to enroll with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan. Note: Complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of the creation of a new location that wishes to file claims.
- Facility Information Request Form**: Complete this form to request the credentialing of a facility. Note: This form is for Medical, CBA and MAT facility credentialing.
- Virtual Care Services**: For providers or group practices wanting to participate with telemedicine and/or telehealth services. Note: You are not eligible for Virtual Care if you do not have a fully executed Business License Agreement with a vendor.
- Health Professional Application**: Complete this form to request the addition of a health professional to our database to enable that practitioner to file claims to BlueCross BlueShield of South Carolina and BlueChoice HealthPlan. Note: This is for in-state, out-of-network providers only.
- For Behavioral Health Providers**:
 - Behavioral Health**: For providers wanting to enroll in our behavioral health network. Note: Companion Benefit Alternatives, Inc. (CBA) manages our behavioral health network. CBA is a separate company that administers behavioral health benefits on behalf of BlueCross BlueShield of South Carolina.
 - Autism Provider Panel**: For Applied Behavior Analysts wanting to enroll in our Autism Provider Panel. Note: Companion Benefit Alternatives, Inc. (CBA) manages our Autism provider panel. CBA is a separate company that administers behavioral health benefits on behalf of BlueCross Blue Shield of South Carolina.

My Provider Enrollment Portal

Find a Form

South Carolina

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Find a Form

Use the following forms for other enrollment options or to provide additional information to BlueCross BlueShield of South Carolina

Update Location Information

Doing Business As (DBA) Name Change Form

Complete this form to change your doing business as (DBA) name.

COMPLETE FORM

Change of Address Form

Use this form to update your physical, pay to, correspondence and/or billing agency addresses for Preferred Blue®, BlueChoice HealthPlan, Healthy BlueSM, State Health Plan, and FEP networks.

Note: If you are changing a pay to address, the provider or the CEO, CFO, director of finance, or director of billing must sign this form for your protection.

COMPLETE FORM

Application for Satellite Location

Complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of the creation of a new location that wants to file claims.

Note: A W-9 cannot be accepted.

COMPLETE FORM

Update Provider Information

NPI Provider Notification Form

Register your National Provider Identifier (NPI) with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan using this form. If you registered for more than one NPI, complete this form for each NPI.

Attach your notification letter from the National Plan and Provider Enumeration System (NPPES) for each NPI you received. This verification is required.

Note: This form is for out-of-state and out-of-network providers only.

COMPLETE FORM

Add or Terminate Practitioner Affiliation

Please complete this form to request the addition or termination of a health professional's association with your clinic, group, professional association, or institution for BlueCross BlueShield of South Carolina for Preferred Blue®, BlueChoice HealthPlan, Healthy BlueSM, FEP and/or State Health Plan.

Note: This form should be completed no more than 30 days after the addition, termination or change.

COMPLETE FORM

My Provider Enrollment Portal

My Forms

South Carolina

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My Forms

Complete forms that have been started or check the status of applications already submitted.

- **In Progress/Not Submitted** – The application or form is being worked by the provider or their practice. It has not been completed for submission.
- **Submitted** – The application and all required documentation with applicable signatures, initials, and dates have been uploaded.
- **Awaiting Signature** – The application or form has been completed and submitted, but signatures are missing.
- **Awaiting Provider Response/Not Submitted** – Missing items are needed from the provider or their practice to continue the enrollment process. You will receive an email and case comment explaining what item(s) is needed.
- **Under Review** – The application or form has been assigned and has progressed through the enrollment process.
- **Congratulations! Complete** – The application or form has been approved and completed.
- **Denied** – The application or form was not approved. An explanation for the denial is sent through email or case comment.
- **Canceled** – The application or form is no longer being worked on and has been closed.

If your case is in the status of Awaiting Signature, click the case number to view next steps.

All Applications ▼ ↑

5 items • Sorted by Case Number • Filtered by All cases

	Case Number ↑	Practitioner Last N...	Status	Form Type	Date/Time Opened	
1	00011891	Bennett	Submitted	Individual Application	11/16/2022, 2:07 PM	▼
2	00012542		In Progress/Not Submitted	Individual Application	12/6/2022, 1:12 PM	▼
3	00021065		In Progress/Not Submitted	Individual Application	4/14/2023, 4:49 PM	▼
4	00024792		In Progress/Not Submitted	Group Application	6/4/2023, 1:09 PM	▼
5	00030455	Pickles	Under Review	Individual Application	8/4/2023, 3:09 PM	▼

All Applications ▼ ↑

LIST VIEWS

- ✓ All Applications (Pinned list)
- Applications Awaiting Provider Response
- Approved Applications
- Denied Applications
- Open Applications
- Recently Viewed
- Recently Viewed Cases
- Recredentialing - Awaiting Response
- Submitted Applications

My Provider Enrollment Portal

My Contracts

South Carolina

Search...

USER146200...

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My Contracts

Complete contracts that require your attention or check their status.

Contracts Awaiting Signature ▼ ↑

4 items • Sorted by Case • Filtered by All form contracts - Status

Case ↑	Status	Form Contract ...	Network List	Form Type	Last Modified Date
1 00030455	Awaiting Signature	FCR-12433	Blue Essentials	Individual Application	8/4/2023, 7:28 PM
		FCR-12434	Medicare Advantage	Individual Application	8/4/2023, 7:28 PM
		FCR-12436	State Health Plan	Individual Application	8/4/2023, 7:28 PM
		FCR-12435	Preferred Blue® (PPC and FEP)	Individual Application	8/4/2023, 7:28 PM


Recently Viewed ▼ ↑

LIST VIEWS

- All Contracts
- Contracts Awaiting Signature
- ✓ Recently Viewed (Pinned list)

My Provider Enrollment Portal

Support

USER16500...

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CONTACT PROVIDER SUPPORT

Complete the below support form for questions regarding correct applications and forms to use OR if after checking the directory you do not see a provider that should be loaded.
Note: For behavioral health providers, please include the provider's specialty in the description box.

*** FULL NAME**

*** EMAIL ADDRESS** ⓘ

*** INDIVIDUAL NPI** ⓘ

GROUP NPI

TAX ID NUMBER ⓘ

ROLE

*** SUBJECT** ⓘ

*** DESCRIPTION** ⓘ

Thank you!

