# BlueCard® Program
# Frequently Asked Questions

## 1. What Is the BlueCard® Program?

The BlueCard Program is a national program that enables members obtaining healthcare services while traveling or living in another Blue Plan's area to receive all the same benefits of their contracting Blue Plan and access to providers and savings. The program links participating health care providers and the independent Blue Plan across the country and around the world through a single electronic network for claims processing and reimbursement.

## 2. What products are included in the BlueCard® Program?

Currently four types of products are administered through the BlueCard Program: BlueCard Traditional, BlueCard PPO, BlueCard Managed Care/POS, and HMO.
The following products are *optional* under the BlueCard Program.

- Stand-alone dental and prescription drugs
- Stand-alone vision and hearing
- Medicare supplemental

## 3. What products and accounts are *excluded* from the BlueCard® Program?

Medicare+Choice is excluded from the BlueCard Program. You must file Medicare+Choice claims with the member's Blue Plan. In addition, claims for the Federal Employee Program (FEP) are exempt from the BlueCard Program. Please follow your FEP billing guidelines

## 4. What is the BlueCard® Traditional Program?

A national program that offers members traveling or living outside of their Blue Plan's area the traditional/indemnity level of benefits when they obtain services from a physician or hospital outside of their Blue Plan's service area.

## 5. What is the BlueCard® PPO Program?

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

## 6. What the BlueCard® Managed Care/POS Program?

Similar to BlueCard Traditional and BlueCard PPO, the BlueCard Managed Care/POS program is for members who reside outside their Blue Cross Blue Shield Plan's service area. However, unlike other BlueCard programs, BlueCard Managed Care/POS members are actually enrolled in the Highmark Blue Shield network and primary care physician (PCP) panels. *Therefore, you should treat these members as you treat any other Highmark Blue Shield POS member, applying the same referral practices and network protocols.*

## 7. Are HMO patients serviced through the BlueCard® Program?

Occasionally, BCBS HMO members affiliated with another Blue Plan will seek care at your office or facility. You should handle claims for these members the same way as you handle Highmark Blue Shield's members and BlueCard traditional, PPO and POS patients from other Blue Plans, by submitting them through the BlueCard Program.

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**8. How do I identify BlueCard® members?**

When members from other Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifiers for BlueCard members are the alpha prefix, a blank suitcase logo, and, for eligible PPO members, the "PPO in a suitcase" logo.

**9. What is an "alpha prefix"?**

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

**10. What are the various types of alpha prefixes?**

There are two types of alpha prefixes: plan-specific and account-specific.

**Plan-specific alpha prefixes** are assigned to every Plan and start with X, Y, Z, or Q. The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.

- First character X, Y, Z, or Q
- Second character A-Z
- Third character A-Z

**Account-specific prefixes** are assigned to centrally processed national accounts. National accounts are employer groups that have offices or branches in more than one area, but offer uniform benefits coverage to all of their employees. Account-specific alpha prefixes start with letters other than X, Y, Z, or Q. Typically, a national account alpha prefix will relate to the name of the group. All three positions are used to identify the national account.

**11. What do I do if a member has an identification card without an alpha prefix?**

Some identification cards may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the member's ID card for how to file these claims. If that information is not available, call Highmark Blue Shield 's Customer Service at 1-866-731-8080. ***It is very important to capture all ID card data at the time of service. This is critical for verifying membership and coverage.*** We suggest that you make copies of the front and back of the ID card and pass this key information on to your billing staff. **Do not make up alpha prefixes.**

**12. How do I determine a member's participation status (traditional, PPO, POS, or HMO)?**

To determine a member's participation status, check the ID card logo.

A blank suitcase logo on a member's ID card means that the patient has BlueCard traditional, POS, or HMO benefits delivered through the BlueCard Program.

You will immediately recognize BlueCard PPO members by the special "PPO in a suitcase" logo on their membership card. BlueCard PPO members are Blue members whose PPO benefits are delivered through the BlueCard Program. *It is important to remember that not all PPO members are BlueCard PPO members, only those whose membership cards carry this logo.* BlueCard PPO members traveling or living outside of their Blue Plan's area receive the PPO level of benefits when they obtain services from designated BlueCard PPO providers.

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**13. How do I identify BlueCard® Managed Care/POS members?**

The BlueCard Managed Care/POS program is for members who reside outside their Blue Plan's service area. However, unlike other BlueCard programs, BlueCard Managed Care/POS members are enrolled in Highmark Blue Shield's network and primary care physician (PCP) panels. You can recognize BlueCard Managed Care/POS members who are enrolled in Highmark Blue Shield's network through the member ID card as you do for all other BlueCard members.

**14. How do I identify international members?**

Occasionally, you may see identification cards from foreign Blue Plan members. These ID cards will also contain three-character alpha prefixes. *Please treat these members the same as domestic Blue Plan members.*

**15. How do I verify membership and coverage?**

Once you have identified the alpha prefix, call BlueCard ***Eligibility*** to verify the patient's eligibility and coverage.

- Have the member's ID card ready when calling.
- Dial 1-800-676-BLUE.

**16. How do I obtain utilization review?**

You should remind patients from other Blue Plans that they are responsible for obtaining precertification/preauthorization for their services from their Blue Plan. You may also choose to contact the member's Plan on behalf of the member. If you choose to do so, you can ask to be transferred to the utilization review area when you call BlueCard *Eligibility* (**1-800-676-BLUE**) for membership and coverage information.

**17. Where and how do I submit BlueCard® Program claims?**

You should always submit BlueCard claims to:

Claims Processing
PO Box 890062
Camp Hill, PA 17089-0062

Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character alpha prefix. **Do not make up alpha prefixes**. Incorrect or missing alpha prefixes and member identification numbers delay claims processing.

Once Highmark Blue Shield receives a claim, it will electronically route the claim to the member's Blue Plan. The member's Plan then processes the claim and approves payment, and Highmark Blue Shield will pay you.

**18. How do I submit international claims?**

The claim submission process for international Blue Plan members is the same as for domestic Blue Plan members. You should submit the claim directly to Highmark Blue Shield. (See the address listed in question 17.)

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**19. How do I submit claims if I am an indirect, support, or remote provider?**

If you are a health care provider that offers products, materials, informational reports, and remote analyses or services, and are not present in the same physical location as a patient, you are considered an indirect, support or remote provider. Examples include, but are not limited to, prosthesis manufacturers, durable medical equipment suppliers, independent or chain laboratories, or telemedicine providers.

If you are an indirect provider for members from multiple Blue Plans, follow these claim filing rules:
- If you have a contract with the member's Plan, file with that Plan.
- If you normally send claims to the direct provider of care, follow normal procedures.
- If you do not normally send claims to the direct provider of care and you do not have a contract with the member's Plan, file with your local Blue Plan.

**20. What are the exceptions to BlueCard claims submissions?**

Occasionally, exceptions may arise in which Highmark Blue Shield will ***require*** you to file the claim directly with the member's Blue Plan. Here are some of those exceptions:

- You contract with the member's Blue Plan (for example, in contiguous county or overlapping service area situations).
- The ID card does not include an alpha prefix.
- A claim is returned to you from Highmark Blue Shield because no alpha prefix was included on the original claim that was submitted.

In some cases, Highmark Blue Shield will ***request*** that you file the claim directly with the member's Blue Plan. For instance, there may be a temporary processing issue at Highmark Blue Shield, the member's Blue Plan, or both that prevents completion of the claim through the BlueCard Program.

When in doubt, please send the claim to Highmark Blue Shield and we will handle the claim for you.

**21. How do I handle claims for accounts exempt from the BlueCard Program?**

When a member belongs to an account that is exempt from the BlueCard Program, Highmark Blue Shield will electronically forward your claims to the member's Blue Plan. That means you will no longer need to send paper claims directly to the member's Blue Plan. Instead, you will submit these claims to Highmark Blue Shield. However, you will continue to submit Medicare supplemental (Medigap) and other COB claims under your current process.

**22. How do I handle COB claims?**

If after calling **1-800-676-BLUE** or through other means you discover the member has a COB provision in their benefit plan, and Highmark Blue Shield is the primary payer, submit the claim along with information regarding COB to Highmark Blue Shield. If you do not include the COB information with the claim, the member's Blue Plan or the insurance carrier will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

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**23. How do I handle Medicare Supplemental (Medigap) claims?**

For Medicare supplemental claims, always file with the Medicare contractor first. Always include the complete Health Insurance Claim Number (HICN); the patient's complete Plan identification number, including the three-character alpha prefix; and the Blue Plan name as it appears on the patient's ID card, for supplemental insurance. This will ensure crossover claims are forwarded appropriately.

Do not file with Highmark Blue Shield and Medicare simultaneously. Wait until you receive the Explanation of Medical Benefits (EOMB) or payment advice from Medicare. After you receive the Medicare payment advice/EOMB, determine if the claim was automatically crossed over to the supplemental insurer.

Crossover Claims: If the claim was crossed over, the payment advice/EOMB should typically have Remark Code MA 18 printed on it, which states, "The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them." The code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.

Claim Not Crossed Over: If the payment advice/EOMB does not indicate the claim was crossed over and you accepted Medicare assignment, file the claim as you do today. Highmark Blue Shield or the member's Blue Plan will pay you the Medicare supplemental benefits. If you did not accept assignment, the member will be paid and you will need to bill the member.

**24. Who do I contact for claims questions?**

Highmark Blue Shield Customer Service at 1-866-731-8080.

**25. How do I handle calls from members and others with claims questions?**

If a member contacts you, tell the member to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number. The member's Plan should not be contacting you directly, unless you filed a paper claim directly with that Plan. If the member's Plan contacts you to send them another copy of the member's claim, refer them to Highmark Blue Shield.

**26. How will HIPAA Administrative Simplification regulations impact the claims process?**

One of the aspects of the Heath Insurance Portability and Accountability Act of 1996 (HIPAA) calls for the standardization of electronic transactions and code sets. This mandate requires the elimination of all local (proprietary) file formats and code sets.

The ability to electronically bill for BlueCard claims will not be eliminated by HIPAA. The format of the electronic claims submission for both BlueCard and non-BlueCard billing must change to adhere to the Federally mandated format for Claims Submission. This format is the ASC X12N 4010A1 837 Transaction.

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This format must be used for all claims submitted on or after October 16, 2003. Electronic Claim submission is not the only format affected by HIPAA. The law also mandates the use of standard formats for the following transactions:

- Health Care Claims or Equivalent Encounter Information;
- Eligibility for a Health Plan;
- Referral Certification and Authorization;
- Health Care Claim Status;
- Enrollment and Disenrollment in a Health Plan;
- Health Care Payment and Remittance Advice;
- Health Plan Premium Payments; and
- Coordination of Benefits.

The law also requires the use of national medical and administrative code sets. The national medical code sets named in the August 2000 Final Rule are:
- Health Care Financing Administration Common Procedure Coding System (HCPCS)
- International Classification of Diseases Volumes 1, 2, and 3 (ICD-9)
- Current Procedural Terminology, 4th Edition. (CPT-4)
- Code on Dental Procedures and Nomenclature (CDT)
- National Drug Codes (NDC)

The Administrative or non-Medical National Codes sets are too voluminous to list here. Some examples of these are:
- Gender
- Patient Relationship to Insured
- Country Code
- State Abbreviations etc.

All the code sets needed for each of the individual HIPAA standard transactions are contained within the Implementation Guides. These guides are available for free when downloaded from Washington Publishing Company's Web Site.www.wpc-edi.com

If you are not currently an EDI submitter to Highmark Blue Shield, and want take advantage of this technology, you can sign-up on Highmark Blue Shield's website using the following URL: https://www.highmarkblueshield.com/health/pbs-professionals/edi-services/signup.html

This is a free service offered by Highmark Blue Shield. The online sign-up applications are encrypted upon submission for your protection.

**27. Where can I find more information about the BlueCard® Program**

For more information about the BlueCard Program, call your Highmark Blue Shield Provider Relations Representative or visit the Blue Cross and Blue Shield Association's Web Site at www.bcbs.com.