



BlueCard[®] Program

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The information in this section was developed in part by the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

I. What is the BlueCard® Program?

A. Definition

BlueCard® is a national program that enables members of one Blue [Plan](#) to obtain healthcare services while traveling or living in another Blue Plan's [service area](#). The program links participating healthcare providers with the independent Blue Cross and Blue Shield Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program allows you to submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Your local Blue Plan is your sole contact for claim payment, problem resolution, and adjustments.

B. BlueCard Program Advantages to Providers

The BlueCard Program allows you to conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to BCBSKS.

BCBSKS is your one point of contact for all of your claim-related questions.

C. Accounts Exempt from the BlueCard Program

The following claims are excluded from the BlueCard Program

- Stand-alone dental
- Prescription drugs and
- The Federal Employee Program (FEP).

Please follow your local billing guidelines.

II. How Does the BlueCard® Program Work?

A. How to Identify BlueCard® Members

Member ID Cards

When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card.

The main identifier for out of area members is the [alpha prefix](#). The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo

Important facts concerning member IDs:

- A correct member ID number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total.
- The alpha prefix on a member's ID must be three characters.
- Some member ID numbers may include alphabetic characters in other positions following the alpha prefix. Others may be fewer than 17 positions.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the alpha prefix.
- The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Members who are part of the Federal Employee Program (FEP) will have the letter "R" in front of their member ID number.

Alpha Prefix

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

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card, and pass this key information to your billing staff. Do not make up alpha prefixes.

Do not assume that the member's ID number is the social security number. **As of 2007, nearly all Blue Plans replaced Social Security numbers on the member ID card with an alternate unique identifier.**

Blank Suitcase Logo

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



The blank suitcase logo may appear anywhere on the front of the card

“PPO in a Suitcase” Logo

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



The "PPO in a suitcase" may appear anywhere on the front of the ID card.

To be considered a BlueCard PPO hospital, the provider must be a Blue Choice hospital.

Non-hospital facility providers (home health, hospice, end stage renal disease facility, medical care facility, birthing center) are considered a PPO provider just as long as they are a competitive allowance program (CAP) contracting provider.

How to Identify BlueCard **Point of Service** (POS) Members

The BlueCard POS program is for members who reside outside their Blue Plan's service area.

If a group is enrolled in BlueCard POS, then the employees are part of the POS program in the state in which they reside.

For non-hospital facility providers there is no special Blue Select provider network. Just as long as they're CAP they are considered a BlueCard POS provider.

Services must be authorized by the primary care physician.

How to Identify International Members

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

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

Sample foreign ID card:

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health debit cards members can pay for co-payments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HAS or FSA account.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities. If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit card.

Helpful tips

- Carefully determine the member's financial responsibility before processing payment. You can access the member's accumulated [deductible](#) by contacting the [BlueCard Eligibility](#) line at 1.800.676.BLUE (2583) or by using the online services at www.bcbsks.com
- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- If the member presents a debit card (stand-alone or combined), be sure to verify the out of pocket amounts before processing payment:
 - Many plans offer well care services that are payable under the basic healthcare program. If you have any questions about the member's benefits or to request accumulated deductible information, please contact 1.800.676.BLUE (2583).
 - You may use the debit card for member responsibility for medical services provided in your office.
 - You may choose to forego using the debit card and submit the claims to BCBSKS for processing. The Remittance Advice will inform you of member responsibilities.
 - All services, regardless of whether or not you've collected the member responsibility at the time of service, must be billed to the local Plan for proper benefit determination, and to update the member's claim history.
- Check eligibility and benefits electronically at www.bcbsks.com or by calling 1.800.676.BLUE (2583) and providing the alpha prefix.
- Please do not use the card to process full payment upfront. If you have any questions about the member's benefits, please contact 1.800.676.BLUE (2583), or for questions about the healthcare debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

C. Coverage and Eligibility Verification

Coverage and eligibility for out-of-area members can be verified through the BCBSKS Web site.

- Access for **both** local and out-of-area information is through the **same** “secured” services section of the BCBSKS Web site.
- For the most part, the same online screens will be used for BCBSKS members and out-of-area members.
- Inquiries about out-of-area members will require some additional information such as member name, date of birth, gender, relationship to insured, etc.
- The system will use the alpha prefix to determine if the inquiry is for a Kansas member or an out-of-area member.

After using the online inquiry process, if you need additional information for out-of-area members, contact:

BlueCard *Eligibility*® 1-800-676-BLUE (2583)

1. English and Spanish speaking phone operators are available to assist you.
2. Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule. You may be transferred to a voice response system linked to customer enrollment and benefits.
3. The BlueCard® *Eligibility* line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status. See the Claim Filing section for claim filing information.

For BCBSKS members, contact

Provider benefit line: 1-800-432-0272

D. Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/preauthorization for their services from their Blue Plan.

NOTE: There are many Plans that require precertification for diagnostic imaging, such as, MRI and CT scans even though the ID card does not indicate this information. We encourage all providers/facilities to verify benefits with the member's Plan prior to providing services.

When the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

You may also contact the member's Plan on the member's behalf. You can do so by calling BlueCard *Eligibility*® 1-800-676-BLUE (2583) – ask to be transferred to the utilization review area.

III. Claim Filing

A. National and International Claims

1. You should always submit claims to BCBSKS. Be sure to include the member's complete identification number when you submit the claim including the three-character alpha prefix-do not make up alpha prefixes.
2. In cases where there is more than one payer and Blue Cross and/or Blue Shield is a primary payer, submit [Other Party Liability \(OPL\)](#) information with the BCBS claim. Upon receipt, BCBSKS will electronically route the claim to the member's Blue Plan. The member's Plan then processes the claim and approves payment; BCBSKS will reimburse you for services.
3. Do not send duplicate claims. To check the status of the claim, visit our Web site at www.bcbsks.com (provider services section).

B. Medicare-Related Claims (Traditional Medicare)

For members with Medicare primary and Blue Plan secondary coverage,

- Submit claims to your Medicare intermediary or carrier
- On the Medicare claim, be sure to enter the correct Blue Plan name as the secondary payer. This may not be BCBSKS and you can verify the plan name by checking the member's ID card.
- Report the member's BCBS identification number including the alpha prefix. The alpha prefix appears in the first three positions of the ID number and is critical in confirming the member's coverage.

When you receive the Medicare remittance advice, look to see if the claim was automatically crossed over.

- If the Medicare RA indicates the claim was crossed over, the provider does not need to resubmit the claim.
- If the Medicare RA indicates the claim did not cross over, you need to wait 45 days after the Medicare RA date to submit the claim to BCBSKS with the Medicare remittance advice ([newsletter 09-04](#)). (All claims for any Blue Plan member should be sent to BCBSKS.)

NOTE: There may be times when the Medicare RA shows the claim crossed over but actually didn't. When this happens, Medicare will send a separate notice showing the internal/document control number, HIC number, medical record number, patient control number, beneficiary name, date of service, the date the claim was process and will state: "The above claims(s) was/were not crossed over to the patient's supplemental insurer due to a claim data errors". If this occurs, submit the claim to BCBSKS with the Medicare remittance advice.

How soon will the Blue Plan pay crossover claims?

The Medicare Coordination of Benefits Contractor (COBC) will cross over claim information to secondary payers AFTER Medicare pays the claim. (This includes satisfying the Medicare claim payment floor.) It may then take up to 14-30 business days for providers to receive payment from the Blue Plan.

What should I do in the meantime?

If you submitted a Medicare claim and haven't received a response,

- Don't automatically submit another claim.
- Check the online Medicare claim system to determine when Medicare paid.
- Use the BCBSKS Web site to check the status of the crossover claim.

C. Coding

Code claims as you would for BCBSKS claims.

D. Medical Records

There are times when the member's BCBS Plan will require medical records to review the claim. When this occurs, here's what will happen:

- The request for records will be sent to contracting providers by BCBSKS.
- Non-contracting providers could receive record requests from either BCBSKS or the plan where the member is enrolled.
- The request will include a cover sheet that will clearly indicate what records are needed.
- The cover sheet will also indicate where the records should be sent.
- The cover sheet that BCBSKS uses indicates both a fax number and a mailing address that can be used to return records. Our preference is that you fax the records to us if possible.
- **Providers are encouraged to respond to the record requests within 10 days.**
- Once the records are received by the local plan, they will be forwarded to the member's home plan for review and claim finalization.

This process for BlueCard record requests is intended to reduce the number of requests, provide clearer instructions, keep better track of requests and improve claim processing time.

E. Adjustments

Contact BCBSKS if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different.

F. Appeals

An appeal may be filed with the member's Plan by the member or if you choose to appeal on the member's behalf you will need to complete the "[Claim Appeal Representative Authorization Form](#)" located on our Web site and you can submit the appeal either to the member's Plan or to BCBSKS. Once BCBSKS receives the appeal, we will forward to the member's Plan. We will notify the provider where the appeal was sent and to whom.

G. Other Party Liability Claims

Other Party Liability (OPL) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment. You can also see the OPL section within this manual.

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

1. BCBSKS or any other Blue Plan is the primary payer, submit other carrier's name and address with the claim to BCBSKS. If you do not include the OPL information with the claim, the member's Blue Plan 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.
2. Other non-Blue health plan is primary and BCBSKS or any other Blue Plan is secondary, submit the claim to BCBSKS only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the OPL information with the claim, the member's Blue Plan 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.

Note: Timely filing guidelines apply to all BlueCard claims even those that are secondary to another health plan.

H. Claim Payment

1. If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This also causes member confusion because of multiple Explanations of Benefits (EOBs). BCBSKS' standard time for claims processing is an annualized

average of 14 working days. However, claim processing times at various Blue Plans vary.

2. If you do not receive your payment or a response regarding your payment, please call BCBSKS at 1-800-432-3990 ext 4058 or visit our Web site at www.bcbsks.com, (provider services section) to check the status of your claim.
3. In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, BCBSKS will ask you for the information.

I. Claim Status Inquiry

BCBSKS is your single point of contact for all claim inquiries.

Claim Status Information for out-of-area members can be verified through the BCBSKS Web site.

- Access for **both** local and out-of-area information is through the **same** "secured" services section of the BCBSKS Web site.
- For the most part, the same online screens will be used for BCBSKS members and out-of-area members.
- Inquiries about out-of-area members will require some additional information such as member name, date of birth, gender, relationship to insured, etc.
- The system will use the alpha prefix to determine if the inquiry is for a Kansas member or an out-of-area member.

After using the online inquiry process, if you need additional information for out-of-area members, contact:

Toll free	1-800-432-3990 ext 4058
Topeka Local	(785) 291-4058

J. Calls from Members and Others with Claim Questions

1. If members contact you, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.
2. The member's Plan should not contact you directly regarding claims issues, but if the member's Plan contacts you and asks you to submit the claim to them, refer them to BCBSKS.

IV. What Products Are Included in the BlueCard[®] Program?

A. BlueCard[®] Traditional

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



B. BlueCard[®] PPO

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.



C. BlueCard[®] Managed Care/POS

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 Blue Select network and primary care physician (PCP) panels. Therefore, you should treat these members as you treat any other BCBSKS POS member, applying the same referral practices and network protocols.



D. HMO Patients Serviced Through the BlueCard[®] Program

Blue Cross Blue Shield (BCBS) HMO members affiliated with other BCBS Plans may seek care at your office or facility. You should handle claims for these members the same way as you do BCBSKS members and BCBS traditional, PPO and POS patients from other Blue Plans—by submitting them through the BlueCard Program.



E. Medicare Advantage

What is Medicare Advantage

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

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

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

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

Medicare Advantage plans may allow in-and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage (by calling 1.800.BLUE (2583) or submitting an electronic inquiry) for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules, may vary depending on the Medicare Advantage plan.

BCBSKS Policies and Procedures

The following information is located in the BCBSKS Policies and Procedures:

Medicare Advantage (MA) claims occurring under

a form of coverage offered by a Blue Cross and Blue Shield Plan other than BCBSKS should be submitted directly to BCBSKS, who will report the status of such claims on its remittance advices. However, MA claims cannot and will not be processed or appealed pursuant to BCBSKS Policies and Procedures. Such other Blue Plan is solely responsible for determining pricing and medical policy (as required by the Centers for Medicare & Medicaid Services). A provider's contracting status with the Centers for Medicare & Medicaid Services (CMS) determines MA payment allowances. The provider may appeal Medicare Advantage claims only to the Blue Plan providing the MA coverage regardless of whether BCBSKS or another Blue Cross and Blue Shield Plan issued payment. The provider agrees to abide by the final determination resulting from the MA appeals process, which is established by CMS. The appeals policies and procedures of such other Blue Plans should be obtained from those Blue Plans directly.

How to recognize Medicare Advantage Members

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

Types of Medicare Advantage Plans

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical

services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by Medicare Advantage plan.

MEDICARE ADVANTAGE | HMO

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine-at the point of service-whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO's provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO's provider network.

MEDICARE ADVANTAGE | POS

Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

MEDICARE ADVANTAGE | PPO

Medicare Advantage PFFS

A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage organization, rather than the Medicare program, pays physicians and providers on a fee-for-services basis for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instance where the provider is a network provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with BCBSKS.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan.
- Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.
- MA PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield Plan and we advise that you review them before servicing MA PFFS members.
- Submit your MA PFFS claims to BCBSKS.

MEDICARE | PFFS
ADVANTAGE

Medicare Advantage Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.



Eligibility Verification

- Verify eligibility by contacting 1.800.676.BLUE (2583) and providing an alpha prefix or online at www.bcbsks.com.
- Be sure to ask if Medicare Advantage benefits apply.
- If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to the BCBSKS BlueCard customer service center.

Medicare Advantage Claims Submission

- Submit all Medicare Advantage claims to BCBSKS.
- Do not bill Medicare directly for any services rendered to a Medicare Advantage member.
- Payment will be made directly by a Blue Plan.

Reimbursement for Medicare Advantage PPO, HMO, POS

Based upon the Centers for Medicare and Medicaid Services (CMS) regulations, if you are a

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

Special payment rules apply to hospitals and certain other entities (e.g., skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

NOTE: Enrollee payment responsibilities can include more than co-payments (e.g., deductibles).

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

Services for out-of-area Blue Medicare Advantage PFFS members

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, but are not obligated to provide services to such member under a contract with a Blue Plan, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount

you would collect if the beneficiary

were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

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

V. Glossary of BlueCard® Program Terms

Alpha Prefix

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

BlueCares.com

Blue Cross and Blue Shield Association's Web site, which contains useful information for providers.

BlueCard Access® 1-800-810-BLUE

<http://www.bcbs.com/healthtravel/finder.html>

A toll-free 800 number for you and members to use to locate healthcare providers in another Blue Plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

BlueCard Eligibility® 1-800-676-BLUE

A toll-free 800 number for you to verify membership and coverage information, and obtain pre-certification on patients from other Blue Plans.

BlueCard PPO

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

BlueCard PPO Member

Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.



BlueCard Doctor & Hospital Finder Web Site

<http://www.bcbs.com/healthtravel/finder.html>

A Web site you can use to locate healthcare providers in another Blue Cross and/or Blue Shield Plan's area –<http://www.bcbs.com/healthtravel/finder.html>. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you, as a provider, is incorrect on the Web site, please contact BCBSKS.

BlueCard Worldwide®

A program that allows Blue members traveling or living abroad to receive nearly cashless access to covered inpatient hospital care, as well as access to outpatient hospital care and professional services from healthcare providers worldwide. The program also allows members of foreign Blue Cross and/or Blue Plans to access domestic (U.S.) Blue provider networks.

Consumer Directed Healthcare/Health Plans (CDHC/CDHP)

Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs, and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information, and financial incentives.

Coinsurance

A provision in a member's coverage that limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional costs out-of-pocket.

Coordination of Benefits (COB)

Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Co-payment

A specified charge that a member incurs for a specified service at the time the service is rendered.

Deductible

A flat amount the member incurs before the insurer will make any benefit payments.

FEP

The Federal Employee Program.

Hold Harmless

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

Medicare Crossover

The Crossover Program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

Medicare Supplemental (Medigap)

Pays for expenses not covered by Medicare.

National Account

An employer group that has offices or branches in more than one location but offers uniform coverage benefits to all of its employees.

Other Party Liability (OPL)

A cost containment program that recovers money where primary responsibility does not exist because of another group health plan or contractual exclusions. Includes coordination of benefits, workers' compensation, subrogation, and no-fault auto insurance.

Plan

Refers to any Blue Cross and/or Blue Shield Plan.

Point of Service (POS)

Health benefit program in which the highest level of benefits is received when the enrollee obtains services from or at the direction of, his or her designated primary care physician gatekeeper. Substantial benefits still are provided when the enrollee obtains care from a provider of choice without gatekeeper approval.

Service Area

The geographic area in which a Licensee is authorized to use the Brands pursuant to the primary Blue Cross and/or Blue Shield License Agreement or to the Blue Cross and/or Blue Shield Controlled Affiliate License Agreement.

Suitcase Logo

The BCBSA branded trademark for the BlueCard Program.

VI. BlueCard® Program Quick Tips

The BlueCard Program provides a valuable service that lets you file all claims for members from other Blue Cross Blue Shield Plans to your local Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member’s ID card.
- Look for the three-character alpha prefix that precedes the member’s ID number on the ID card.
- There are many Plans that require precertification for diagnostic imaging, such as, MRI and CT scans even though the ID card does not indicate this information. We encourage all providers/facilities to verify benefits with the member's Plan prior to providing services.
- BlueCard® eligibility and claim status information is available on the BCBSKS Web site www.bcbsks.com (provider services section).

BlueCard Program - benefits and eligibility for out-of-area members	1-800-676-BLUE (2583)
BlueCard Program - claim inquiries for out-of-area members	1-800-432-3990 ext 4058
Provider Benefit Line - benefits and eligibility for Kansas members	1-800-432-0272
BCBSKS customer service center - claim inquiries for Kansas members	1-800-432-3990