Problem Resolution

It is our hope that the administration of your benefit plan will be problem-free. We recognize, however, that due to the sensitive nature of health care delivery, problems may arise. In the event a problem does occur, this section can be referenced to assist you in resolving issues as easily and expediently as possible.

If you or a member have attempted to resolve issues as indicated on the following pages, without satisfactory results, please gather as much information as possible and contact your Anthem Blue Cross Account Manager.

Anthem Blue Cross

HMO Issues

*Note: Before calling the Medical Group or Customer Service, the following information will typically be needed:

- Subscriber’s name
- Subscriber’s certificate (HCID) number (generally the number on the member’s ID card)
- Relationship to employee (if dependent)
- Specifics on the member’s issue (ideally including dates, names of people he or she spoke to, dates of service, name/address of provider, etc.)
- Group number

The member’s first contact for coordination of care, such as authorization for referrals and surgery, should always be the Primary Care Physician (PCP).

If the issue involves the Primary Care Physician, the Anthem Blue Cross HMO Coordinator at the Medical Group can help. For issues regarding a Medical Group (e.g., delays in scheduling appointments, problems with obtaining referrals to specialists, quality of care concerns, etc.), the member should contact the Anthem Blue Cross HMO Coordinator at the Medical Group. The member’s Medical Group phone number is listed on the ID card.

The Anthem Blue Cross HMO Customer Service toll-free number is listed on the member ID card.

Claims

If a Bill is received:

For situations where the member is being billed for services that were part of an Authorized Referral, the bill should not be ignored. The member should keep a copy of the bill for his or her records and send the original to the Anthem Blue Cross HMO Coordinator at his or her Medical Group with a brief explanation. The member should include his or her ID number (or copy of the ID card). If the member continues to receive bills, he or she should call Anthem Blue Cross HMO Customer Service at the 800 number listed on the member’s ID card.

If Emergency Services are Denied (In Area):

*Note: An emergency is an unexpected acute pain, or an illness, injury or condition that could permanently endanger health if not treated immediately. Some examples are severe chest pains, uncontrolled bleeding and unconsciousness. Sore throats and colds are generally not considered emergencies. Some conditions are serious, but do not require emergency care. Examples include flu symptoms or an ankle sprain. To receive care, the member should contact his or her Medical Group or PCP first. If a member goes to the Emergency Room for these conditions without being directed there by his or her PCP, Anthem Blue Cross HMO may not cover these charges.

If a member feels a payment for In-Area Emergency Services was denied in error, he or she should contact the Anthem Blue Cross HMO Coordinator at the Medical Group. The member may appeal the denial by writing to the Medical Group to explain why he or she feels the claim should be paid. The member should include a copy of the bill and his or her ID number along with the letter.

It is recommended that the member follow up a week later to verify that the copies were received. If the member is not satisfied with the response from the Medical Group, he or she should contact Anthem Blue Cross HMO. This appeal should be sent to:

Anthem Blue Cross HMO
P.O. Box 4089
Woodland Hills, CA 91365
If Emergency Services are Denied (Out of Area):
If a member receives emergency medical care while he or she is more than 20 miles away from his or her Medical Group, and is subsequently admitted to the hospital, the member should not contact his or her Medical Group, but should contact Anthem Blue Cross HMO within 48 hours – so we can monitor his or her progress and authorize further care. If Out-of-Area Emergency Services are denied, and the member does not feel that the denial was appropriate, the member should follow the steps outlined on the previous page for In-Area Emergency Services that are denied.

If Specialist Services Are Denied:
If a member feels his or her request to see a specialist was inappropriately denied, he or she may contact the Anthem Blue Cross HMO Coordinator at the Medical Group to appeal the denial. If the member is not satisfied with the response from the Medical Group, the member may appeal the denial by writing to the Medical Group to explain why he or she feels a referral to a specialist is needed. The member should include a copy of the bill and his or her ID number along with the letter. It is recommended that the member follow up a week later to verify that the copies were received. If the member is not satisfied with the response from the Medical Group, he or she should contact Anthem Blue Cross HMO. This appeal should be sent to:

Anthem Blue Cross HMO
P.O. Box 4089
Woodland Hills, CA 91365

Changing Primary Care Physicians:
A member may change his or her Primary Care Physician by contacting his or her assigned Medical Group, or by calling Anthem Blue Cross HMO Customer Service at the 800 number listed on his or her ID card. If a new ID card is not received within two weeks, the member should follow up with Customer Service.

Note: A subscriber may also make this change by completing a Change form for the Plan Administrator to submit with the Group Billing Statement.

Changing Medical Groups:
A member may change Medical Groups by calling Anthem Blue Cross HMO Customer Service at the 800 number listed on his or her ID card. A Service Representative will make the change and will send the member a new ID card. If the ID card is not received within two weeks, the member should follow up with Customer Service.

To select a new Medical Group, members should refer to the Anthem Blue Cross HMO Provider Directory to identify a Medical Group that is within a 30-mile radius of his or her home. This change may be made by a telephone call to Anthem Blue Cross HMO Customer Service, or by completing a Change form for the Plan Administrator to submit with the Group Billing Statement.

Note: If the member is in a course of treatment when making a request to change his or her Medical Group or PCP, the request can be denied until the course of treatment is completed.

Prescription Drug Plan Issues

Note: Before calling Customer Service, the following information will typically be needed:

• Subscriber’s name
• Subscriber’s certificate (HCID) number (generally the number on the member’s ID card)
• Relationship to employee (if dependent)
• Specifics on the member’s issue (ideally including dates, names of people he or she spoke to, dates of service, name/address of provider, etc.)
• Group number

Members can call the Prescription Drug Plan Customer Service number for issues regarding Drug Plan eligibility, finding a participating pharmacy (in state or out of state), requests for claim forms, or the status of reimbursement check processing.

Prescription Drug Plan Customer Service
800-700-2541
Hours: 8:30 a.m. to 5:00 p.m.
**Rx Claim Filing**

In the event a claim form is required because the member needs reimbursement for medicine he or she purchased, a claim form can be obtained by calling the Prescription Drug Plan Customer Service number on his or her ID card, or by contacting his or her Plan Administrator.

**To File an Rx Claim**

The member should:

1. At the time of dispensing for the prescription, take the claim form to the Pharmacy for the Pharmacist to complete.
2. Sign the form along with the Pharmacist.
3. Send the completed form to the address indicated on the claim form with copy of the Rx receipt.

- If the member’s eligibility information is not available in the Anthem Blue Cross system, please contact your Anthem Blue Cross Account Manager. **Note: The member may need to purchase the prescription and submit a claim form.**

- If the prescription was filled at a Nonparticipating Pharmacy, the completed form and receipt should be mailed to the address listed on the claim form.

**Note:** Prescription Drug claim processing time can take up to three weeks. To avoid delays in claim processing, the member should carefully review the completed claim form to ensure that all areas are completed, including those areas that need to be completed by the Pharmacist.

**Dental Issues**

**Note:** Before calling Customer Service, the following information will typically be needed:

- Subscriber’s name
- Subscriber’s certificate (HCID) number (generally the number on the member’s ID card)
- Relationship to employee (if dependent)
- Specifics on the member’s issue (ideally including dates, names of people he or she spoke to, dates of service, name/address of provider, etc.)
- Group number

**Anthem Blue Cross Dental** PPO members should call with questions regarding the *Explanation of Benefits*, benefit questions, pre-authorization of major work (recommended, but not required for services provided by an Anthem Blue Cross Dental Blue or Prudent Buyer PPO Dentist), eligibility questions, claims issues, help finding an Anthem Blue Cross Network Dentist, etc. The Dental Customer Service 800 number is on the ID card.

Members can also call Dental Customer Service if they have a problem with an Anthem Blue Cross Network Dentist requiring payment in full at the time of service, or billing the patient for the amount over the Anthem Blue Cross negotiated rate.

**Dental Net** members should call with questions regarding benefits and coverage, eligibility, copays, optional treatment, help locating a participating Dental Net office, transferring from one Dental office to another (one transfer per month is permitted), referrals to Dental Net specialists, and any problems with participating Dental Net Offices (e.g., access, quality of service, etc.).

Members can also call Dental Customer Service if they have a problem with a Dental Net Provider billing the patient for an amount other than the required copay amount listed in the subscriber’s *Evidence of Coverage* booklet.
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PPO Issues

Note: Before calling Customer Service, the following information will typically be needed:

- Subscriber’s name
- Subscriber’s certificate (HCID) number (generally the number on the member’s ID card)
- Relationship to employee (if dependent)
- Specifics on the member’s issue (ideally including dates, names of people he or she spoke to, dates of service, name/address of provider, etc.)

- Group number

Members can contact the Anthem Blue Cross PPO Customer Service unit for questions regarding the Explanation of Benefits, benefit questions, eligibility questions, claims issues, help finding an Anthem Blue Cross PPO Physician, etc. The Anthem Blue Cross PPO Customer Service number is on the subscriber’s ID card.

Members can also call the Customer Service unit if they have a problem with an Anthem Blue Cross PPO Provider requiring payment in full at the time of service, or billing the patient for the amount of the Anthem Blue Cross PPO write-off.

Membership Eligibility Issues

Note: Before calling Customer Service, the following information will typically be needed:

- Subscriber’s name
- Subscriber’s certificate (HCID) number (generally the number on the member’s ID card)
- Relationship to employee (if dependent)
- Specifics on the member’s issue (ideally including dates, names of people he or she spoke to, dates of service, name/address of provider, etc.)

- Group number

Members can call the Customer Service number to correct the spelling of a name, update an address or generate an ID card.

Only the Plan Administrator can add or delete members.

You should contact your Premium Specialist, whose name and phone number are printed at the top of your monthly premium billing, and submit the appropriate paperwork:

- To request the addition or deletion of members
- To move members to a different plan suffix (e.g., members who move to a new billing location, change from Anthem Blue Cross HMO to Anthem Blue Cross PPO, etc.), which requires a new enrollment form indicating the plan change
- To discuss billing issues, etc.
- A recap form, which must accompany all maintenance changes, adds, terminations, COBRA, etc.

Note: When adding a new member, be certain the application form has been filled out completely, and has been signed and dated.