Behavioral Health Guide

Commercial Behavioral Health and Applied Behavior Analysis (ABA) Group Agreements

**Note:** Includes but is not limited to Commercial HMO, PPO, EPO plans, plans on and off the exchange (Pathway EPO), and Medicare Advantage PPO Plans.
Thank you for participating in the Anthem Blue Cross commercial Behavioral Health Network!

As a participating commercial Behavioral Health or ABA group in our Network you have 24/7 online access to specific tools and information.

Visit our Behavioral Health Provider Resource web page for information that will help you effectively manage your relationship with Anthem Blue Cross (Anthem) while also saving you administrative time and resources.

This Behavioral Health Guide is an interactive document. You’ll find blue links throughout that take you to information quickly! It’s designed to answer day-to-day questions, introduce a number of resources, self-service tools and provide valuable information about Anthem to our provider practices on Anthem Participating Mental Health Practitioner Group Agreements.

We look forward to building a strong collaborative relationship with you. We are dedicated to working together to deliver quality care to our members, providing greater value to our customers and helping improve the health of our communities.

If you have questions about the guide, please contact our Behavioral Health Network Relations via email: CABHNetworkRelations@anthem.com.

Sincerely from all of us,

Behavioral Health Network Management
Anthem Blue Cross
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Overview

A group agreement includes all providers in the group who have successfully completed the Anthem Credentialing process (where applicable) and have been assigned a contract effective date. Providers who do not successfully complete credentialing or meet network selection criteria will not be considered in-network or participating.

Group representatives and providers of a participating Behavioral Health (BH) or Applied Behavior Analysis (ABA) group in the Anthem Behavioral Health Network are obligated to abide by the responsibilities outlined in the following:

- Participating Mental Health Practitioner Group Agreement
- Participating Mental Health Practitioner Agreement
- Anthem Blue Cross Professional Manual (including updates to the Manual)
- Behavioral Health Guide

Once added to a group agreement, participating providers serve any Anthem plans that access the Anthem Behavioral Health Network. This includes but is not limited to Commercial (HMO, PPO, EPO) plans and plans on the exchange (Pathway EPO) and Medicare Advantage PPO Plans.

This does not include the Anthem Medi-Cal Managed Care Program, which is a different agreement.

Members enrolled in the BlueCard® Program (out-of-area) also access the Anthem Behavioral Health Network when seeking services in California. As a participating Anthem provider, you may render services to members who are National Account members of other Blue Plans, and who travel or live in California.

This guide should be shared with all participating group providers for answers to everyday behavioral health topics and resources.

The Availity Web Portal (Availity) is Anthem’s secure website, available 24 hours a day, seven days a week, except during scheduled maintenance and national holidays. You can access real-time eligibility and benefits, claims status information, the Manual, fee schedules, online provider remittances, and more. Register for Availity at availity.com.

The Behavioral Health Provider Resources web page is helpful too! It’s your “one-stop shop” behavioral health information center.
The group representative is responsible for sharing information with all participating providers in the group about Anthem, and various other Anthem departments including Network Relations, Contracting and Credentialing.

### Behavioral Health and ABA Groups

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**Be sure to:**

- Verify benefits and eligibility for each member. Behavioral health services may be handled by another payer and other plans may require authorizations.
- Collect only the copay, coinsurance or deductible.
- Refer only to in-network or participating providers.
- Login to CAQH. Review and attest every 120 days to avoid network participation interruptions due to outdated information.

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Understanding your group agreement

A group agreement is between the “owner” of a group practice (TaxID owner) and Anthem. Owners designate “group representatives” to conduct business between the group and Anthem. The group’s representative is responsible for informing Anthem of providers who join or leave the group, and report practice changes such as address and phone numbers. Only designated group representatives can submit practice changes. Changes can’t be submitted by the individual providers in the group.

The group agreement includes all providers in the group who have successfully completed the Anthem Credentialing process (where applicable) and have been assigned a contract effective date. The providers who do not successfully complete credentialing or meet network selection criteria aren’t considered in-network or participating. Anthem members should only be referred to participating providers.

Associates (interns), psychological or physician assistants

Anthem doesn’t cover services rendered by associates (prior to January 1, 2018, marriage and family therapists and professional counselor associates were called, interns) psychological or physician assistants. Participating providers are required to personally render covered services to Anthem members. Services rendered by associates and assistants are not covered, even if supervised by the licensed provider.

Plans included in an Anthem individual Behavioral Health agreement

Participating providers serve any Anthem plan that accesses the Anthem Behavioral Health Network. This includes but is not limited to Commercial (HMO, PPO, EPO) plans and plan on and off the exchange (Pathway EPO) and Medicare Advantage PPO Plans.

You may render services to members who belong to other Blue Plans. The BlueCard® Program (BlueCard) is a national program that enables members who travel or live in California to obtain health care service benefits in another Blue Plan’s service area. Learn more about the BlueCard Program.

Plans not included in an Anthem individual Behavioral Health agreement

The Anthem commercial Behavioral Health Network Agreement does not include the Employee Assistance Program (EAP), Anthem Medi-Cal plans, Anthem Medicare Supplemental or Medicare HMO Plans.
Blue Shield of California

In other states, a company may carry the Blue Cross and Blue Shield name together, as a single entity. In California, there are two separate and independent Blue Cross Blue Shield companies. One is Anthem Blue Cross, and the other is Blue Shield of California.

Participation status after leaving a group

If a provider contracted under a group agreement leaves the group, is the provider still considered a participating (in-network) Anthem provider? No.

Providers under a group agreement are only considered participating with Anthem as long as they maintain a practice under the contracted group. The provider is considered out-of-network or non-participating after leaving a contracted group.

Go online to the Behavioral Health Provider Resources web page to find out how to request individual Network participation. Look at the top of the page under the tab, Join Our Networks for more instruction. Read and follow all instructions carefully.

Anthem does not reimburse for cancellations or “no shows”

We understand that some practices impose financial penalties on members who miss appointments. While not expressly prohibited by your contract with Anthem, we ask that you exercise compassion and sufficiently consider your patient’s medical condition before actually imposing a penalty. These policies must not be a barrier to access. Members can be accountable for “no-shows” if and only if the member has signed an agreement prior to rendering services, indicating informed willingness to personally accept financial liability prior to the “no-show” and if cancellation is not in accordance with the office’s cancellation policy. Charge cannot exceed the contract rate.

Advise the member of the office policy indicating responsibility for a cancellation or “no show” fee if the office policy is not followed (whatever it may be).
Credentialing

Applicable to licensed providers only.

Anthem’s Credentialing Program accesses information through CAQH ProView®. Credentialing data must be current, attested to and Anthem authorized viewing rights. Anthem requires this for all licensed providers being added to a group agreement.

License providers can register online with CAQH ProView® at the website proview.caqh.org to create an account and receive a CAQH Provider ID. Once registered, use the CAQH Provider ID and password to access CAQH ProView.

If a provider is denied in the credentialing process, the group is notified by Anthem Credentialing with the reason for the denial. The provider will not be added to the group agreement and is not considered participating.

Recredentialing

Anthem’s recredentialing policy requires review and verification of provider credentialing data every three (3) years. You’ll be notified about six (6) months before the three year mark that you’re due for recredentialing.

Keep your CAQH application current. Attest every 120 days to avoid network participation interruptions due to outdated information (addresses, or liability coverage, etc.)

To receive notification, your practice information on file must be current. It is equally important your that your CAQH application is current and attested, to prevent termination for non-compliance.

Follow steps 1-5 to attest to your CAQH application.

1. Login to CAQH ProView at proview.caqh.org.
2. Review your information for accuracy. Make sure all information is current and update if needed.
3. Attest to your application after data verification.
4. Authorize Anthem viewing rights to access your information.
5. Upload and submit supporting documents.

Login to CAQH, verify and attest to your application information regularly.

All providers must be registered with CAQH Proview. Call the CAQH Help Desk toll-free at 1-888-599-1771 or email: providerhelp@proview.caqh.org
Member ID cards

Members are required to have a copy of their card in one format or another, whether hard copy or electronic. Anthem member ID cards will display a three-character, alpha-only (letter) prefix or a combination of letters and numbers, known as an alpha-numeric prefix.

Anthem’s Mobile Application

We’ve developed a software application, “mobile app” for us with electronic devices such as a tablet or smartphone. The Anthem Blue Cross (Anthem) mobile app called, “Anthem BC Anywhere” allows members to manage their benefits on their smartphones, including electronic copies of their ID cards. They can easily access their ID card even when there is no internet connection. If the member chooses this option, a hard copy card will not be received.

If presented with an electronic card, you may still obtain a copy of the ID card for your records. Their Anthem BC Anywhere, mobile app has the option to email or fax their ID card from their phone, and you can view the ID card from Availity.

Things to know before rendering any services

- Is the member eligible for coverage?
- Is preauthorization of behavioral health services required (if applicable)?
- Always obtain authorization prior to rendering ABA services.
- Does the member access the Anthem Behavioral Health Network for services?
- What’s the copay, coinsurance or deductible?
- Collect the copayment, coinsurance and deductible from the member
- Where claims should be submitted?
- Bill Anthem directly for services. We recommend claims be submitted electronically

Benefits and eligibility

Member plans and services vary and may change. It’s important to verify benefits and eligibility, and authorizations requirements (if applicable). In this guide, read more about authorization under the subheading, Authorization requirements.

Before rendering services verify benefits and eligibility to determine coverage, copay copay information and whether authorization is needed because they may differ depending on each member and employer group. Behavioral health services may be handled by another payer and some plans require authorizations.
ABA specific benefits - If the member’s plan has not yet been updated with these benefits, be sure to ask or look for the member’s “professional nervous & mental benefits”, including deductible and copay.

Verify benefits and eligibility, and authorization requirements a few ways. Call the toll-free number listed on the back of the member’s ID card or online verification via Availity. Availity is the fastest, time-saving option.

Refer members (patients) in-network

In accordance with agreement terms, refer only to in-network or participating providers under their plan. Referring to an out-of-network provider is not allowed. To find a participating provider, use Anthem’s online provider directory. Our “Find a Doctor” tool (Provider Finder) is accessible via anthem.com/ca. Under the section, Anthem’s online provider directory, you’ll find guidance on how to search for a participating provider.

Authorization

It is important to verify authorization requirements when confirming benefits and eligibility, and whether mental health services are handled through Anthem. Authorization requirements vary depending on the service and each member’s plan. When services require pre-authorization use Interactive Care Reviewer (ICR) via Availity to streamline the process at no-cost.

Although most services don’t require pre-authorization, ABA services do.

ABA authorization requirements

- Most plans require pre-authorization. Verify before rendering services.
- Only ABA services for which authorization has been given will be covered.
- ABA services are authorized by CPT code, and claims will be processed by CPT code.
- Any codes billed without an authorization are not allowed.
- Pre-authorization request forms must be completed and submitted for all ABA requests. There are two types of ABA forms:
  - Adaptive Behavior Assessment Request Form. Use this form when requesting an assessment authorization.
  - Treatment Plan Request Form Autism Spectrum Disorders. Use this form when requesting additional services authorization.
  - Fax forms to 1-866-582-2287 toll free.
BlueCard® (out-of area)

You may render services to members who belong to other Blue Plans and who travel to or live in California. The BlueCard Program® lets you conveniently submit claims for other Blue Plans, including international Blue Plans, directly to Anthem Blue Cross. You can render services to a Blue Card member if their benefits allow it. Verify benefits and eligibility for BlueCard by calling toll-free 1-800-676-2583.

To learn more about BlueCard, visit the Behavioral Health Provider Resources web page, select Resources and Tools then Blue Card Program.

Carve-out services

Some Anthem plans may provide medical services but not provide coverage for mental health services. These services are carved-out or managed by another service or company. This is identified when verifying benefits or information is usually listed on the member ID card including the name and number to call for behavioral health services.

This is not included in your Anthem agreement and for the services to be covered, you must be a participating (in-network) with the other service or company.

Network Leasing Arrangements

Anthem Blue Cross has network leasing arrangements with a variety of organizations, which we call “other payors." Other payors and affiliates use the Anthem Blue Cross (Anthem) network.

Under the terms of your agreement, members of these other payors and affiliates may access the Anthem provider network. As such, they are entitled to the same Anthem billing considerations, including discounts and freedom from balance billing.

An online list of these other payors is available via Availity.

1. Login to availity.com.
2. From the top navigation bar find the Payer Spaces tab and select Anthem Blue Cross from the drop-down menu.
3. Choose the tile, Education and Reference Center.
5. The list of documents displays. Select Network Leasing Arrangements.
Availity

The Availity Web Portal, commonly known as Availity, is our secure website available at no charge to participating providers. Check member benefits and eligibility, deductible, claims status more easily online. You also have access to policies and educational resources, manuals, forms, the ability to research procedure code edits, remittance advice and much more.

Through Availity detailed information can be queried on an unlimited number of members. The site allows users to spend less time on the telephone. The information on Availity is updated in real time – get the same information if you would call Customer Service.

Register for Availity today!

1. Go to availity.com. Select the orange Register button.

2. Scroll the page, select your organization type and follow the online registration wizard.

3. You’ll receive an email from Availity with a temporary password and next steps.

Login information should not be shared. Each staff member must have an individual login.

If you need further assistance, call Availity Client Services toll-free at 1-800-282-4548 Monday to Friday 5 a.m. to 4 p.m. PST.

For more information on navigating in Availity, select Help & Training (from the top navigation menu on the Availity home page).
Anthem administers a Utilization Management (UM) Program to determine whether services provided to members are medically necessary.

Medical necessity criteria are policies and clinical guidelines used by UM and care management staff. For questions on these criteria, call UM toll-free at 1-800-274-7767.

In addition to the documents we develop and maintain for coverage decisions, we may adopt clinical utilization management criteria (UM guidelines) developed and maintained by third party organizations.

To determine which clinical UM guidelines have been adopted, customized, or to determine if there are applicable third party criteria, visit anthem.com/ca to read about Anthem’s medical policies and guidelines. Select the UM Guidelines tab then choose By Category for information on the guidelines available for use.

The overview page also provides a link to the customizations to Milliman Care Guidelines (MCG) used by Anthem plans.

MCG care guidelines: Anthem licenses and utilizes MCG care guidelines to guide utilization management decisions for some health plans. This may include but is not limited to decisions involving pre-certification, inpatient review, level of care, discharge planning and retrospective review.

The MCG care guidelines licensed include: Inpatient & Surgical Care (ISC), General Recovery Care (GRG), Recovery Facility Care (RFC), Chronic Care (CC) and Behavioral Health Care Guidelines (BHG).

If you would like to request a hard copy of an individual clinical UM guideline or MCG guideline, please contact the member’s health plan at the number on the back of their ID card.

**Interactive Care Reviewer**

Save time when submitting requests that require authorization through the Availity, using Interactive Care Reviewer (ICR). This web tool, using IBM Watson™ innovation, makes the process easy and is available at availity.com.

**Note:** ICR is not available for all Anthem lines of business or all types of cases.
Billing and claims

This section provides general billing guidelines and claim submission requirements for Anthem Blue Cross Behavioral Health. We have included an overview of electronic billing and contact information for electronic data interchange, electronic remittance advice and electronic fund transfer products. In addition, some helpful tips on submitting a claim to reduce delay in payment or denial, as well as information on claim issue resolution, secure messaging and much more.

Claim submission process

Electronic submission is the preferred method. Paper claims (not recommended) should be submitted to the mailing address on the member’s ID card.

Electronic data interchange

Claim submission via Electronic Data Interchange (EDI) is a safe, secure and HIPAA compliant way to transfer information. It is cost efficient - less paperwork, manual intervention, postage, and form stock. EDI claims are faster and more accurate. Transmit claims 24/7 avoiding postal delays and it is Anthem’s preferred method for submission.

Contact our e-Solutions Team

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General billing guidelines

- Use the **Anthem Blue Cross Payer ID code: 47198** when submitting electronic claims.
- If you submit through a clearinghouse or use a software vendor, **check with them for the correct value (code) for Anthem Blue Cross** claims.
- ICD-10 diagnosis codes must be used for billing.
- Refer to the current ICD-10 Manual for appropriate codes.
- Use the current CMS-1500 form.
- Include the individual NPI of the rendering provider.
- Provide all member information including the complete member ID number with the three-character alpha only or alpha-numeric prefix information on the claim.
Behavioral Health and ABA Guide for GROUPS

- Rendering provider’s name
- Rendering provider’s NPI (the rendering provider should be the provider named in the authorization)
- Submit original claims within **12 months** of performed services.
  
  **Note:** When behavioral health benefits are carved-out to another health plan, timely filing limits may be different than in your Agreement.
- Always bill referring to the fee schedule which includes the allowable behavioral health and ABA CPT codes. The CPT manual can be used for detailed information about each CPT code.

ABA specific claim tips

- Use autism spectrum diagnosis
- Appropriate CPT code as defined on the fee schedule and the pre-authorization
- Codes billed should also be a part of the pre-authorization
- Applicable number of units for each CPT code, and total charges for each line
- Unit values in whole increments- billings with units that include fractions or decimals cannot be processed

Where and how to submit BlueCard® Program claims

- Always submit Anthem BlueCard® claims to:
  Anthem Blue Cross
  P.O. Box 60007
  Los Angeles, CA 90060-0007
- Include the member’s complete ID number when submitting the claim.
  - The complete ID number includes the three-character alpha only or alpha-numeric prefix.
  - Incorrect or missing prefixes and Member ID information delay claims processing.
- Once Anthem Blue Cross receives the claim, it will electronically route the claim to the member’s Anthem Blue Cross and Blue Shield Plan.
- We will work with the member’s Plan to process the claim.
  - The member’s Plan will send an explanation of benefit or EOB to the member.
  - We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the Members benefits and coverage.
Electronic remittance advice and electronic fund transfer

CAQH offers a business efficiency solution via EnrollHub™ for electronic payments (EFT) and electronic remittance advice (ERA). Register with CAQH to access these functions and manage your EFT or ERA.

Enrollment process - Self-register for a new account at the website, solutions.caqh.org using the CAQH EFT/ERA EnrollHub tool – or you can sign up via the Availity Portal (Availity). Also on Availity, you can access a detailed explanation of payment for each transaction and register to receive email notification for electronic payments. If you wish, you can elect to receive an email notification each time a payment is made to you.

Viewing remittance advice

Access your remittance advice from Availity in a few steps.

1. Login to availity.com.
2. From the top navigation bar find the Payer Spaces tab and select Anthem Blue Cross from the drop-down menu.
3. Choose the tile, Remittance Inquiry.
   Note: Remittance advice is not accessible from “Remittance Viewer”, another application in Availity. Only select the Remittance Inquiry tile.

Claim issue resolution

Call claims Customer Service or send an online secure message through Availity for questions about a claim.

Customer service - When calling Customer Service have the member ID number, date of birth of the patient and claim number (DCN) and at the end of your call you will receive a reference number.

Secure messaging - Availity provides the opportunity to “ask a question” about a claim online. Send a detailed question to clarify the status of a claim or to get additional information on a claim. This functionality is only available via Availity. Secure messages can be sent for local Anthem, Anthem Blue Cross Blue Shield, BlueCard® out-of-area, and FEP® (Federal Employee Program®) member claims.

Note: If you received a bar-coded mail-back letter regarding a claim, please do not use Secure Messaging to respond. Instead, place the mail-back letter on top of the requested information and follow mailing instructions.

If the issue remains unresolved, ask for a supervisor. If the issue isn’t resolved with a Customer Service Representative or supervisor, submit a provider dispute.
Submit a provider dispute

The Provider Dispute Resolution Request form is used to initiate the formal dispute process for a claim that has already been adjudicated or when a provider disagrees with an Anthem billing determination.

We have supplemental education material (SEMs) on a variety topics available to you. Refer to Supplemental Education Material (SEM) #11 titled, “Provider Dispute Resolution” to learn more about our dispute process.

After submitting a provider dispute, you’ll receive written acknowledgement including a reference number. The reference number is needed when following up with Customer Service on the status of your provider dispute. For more information, refer to the Provider Dispute Resolution (PDR) Process in the Manual, available online via availability.com under the section, Administrative Support.
Anthem’s online provider directory

To access the Anthem Blue Cross online directory, our Provider Finder, follow the navigational instructions below.

1. Go online to anthem.com/ca.

2. Select the Providers option from the top navigation.

3. Another navigation pane opens. Select, Find a Doctor

4. A new window will open. Scroll down to Search as a Guest, then select the link, Search by All Plans and Networks
5. A new window will open. Enter information in the fields as shown below.

6. Results display. Email, download and save, or print.
Adding licensed providers to the group agreement

The group representative notifies in writing, Behavioral Health Contracting of the addition of any provider to the group.

Each newly licensed provider must attest to their CAQH application. It must also be complete and current to begin the credentialing and contracting process.

To register with CAQH ProView®, follow the instructions in the Credentialing section of this guide.

! IMPORTANT: Once a provider is registered with, and completed the CAQH online application, send one email and submit one roster identifying all providers to be added to the group agreement, along with the required documents for each provider. Send group add requests once every two weeks.

Follow steps 1-4 listed below to add a provider to the group agreement. Incomplete requests will not be processed. If you have questions about the process, email the group add request to: CABHGroups@anthem.com.

1. Submit in Excel format only, a completed Group Roster Information Sheet (only include providers being added).
2. Create a single PDF of these two (2) completed forms:
   - Practice Profile - indicates a provider’s areas of expertise
   - Resolution Granting Authority (RGA) - Signed by the provider(s), it names the person able to sign the Anthem Blue Cross Participating Mental Health Group Agreement on a provider’s behalf.
3. Email the documents to: CABHGroups@anthem.com.
4. Subject line should include three (3) things: the words, “Add to group”, your group name and the primary county served.

Example:

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<th><a href="mailto:CABHGroups@anthem.com">CABHGroups@anthem.com</a></th>
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<tr>
<td>Subject:</td>
<td>Add to group, ZZZ Family Therapy, San Diego</td>
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We review all requests for completeness within 15 business days and the group representative will receive an email regarding status of the request.

The credentialing process can take up to 120 days to complete. Once the credentialing and contracting process is completed for each provider the group representative will be notified by email.
Adding ABA providers

Although eligible to render direct services, BCaBAs are not eligible to be added to a group agreement.

Adding ABA providers to the group agreement

The group representative notifies in writing, Behavioral Health Contracting of the addition of any provider to the group.

Board Certified Behavior Analysts (BCBA)

BCBAs have different requirements than a licensed provider. Each BCBA must have an individual National Provider Identifier (NPI) and a BCBA certification to begin the approval process. Need a NPI? Easily request a NPI online at: https://nppes.cms.hhs.gov.

Send one email and submit one roster identifying all providers to be added to the group agreement, along with the required documents for each provider. Send group add requests once every two weeks.

Follow steps 1-4 listed below to add a provider to the group agreement. Incomplete requests will not be processed. If you have questions about the process, email the group add request to: CABHGroups@anthem.com.

1. Submit in Excel format only, a completed Group Roster Information Sheet (only include providers being added).

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3. Email the documents to: CABHGroups@anthem.com.

4. Subject line should include three (3) things: the words, “Add to group”, your group name and the primary county served. Example:

   To... CABHGroups@anthem.com
   Subject: Add to group, ABC Family Therapy, Los Angeles

All requests are reviewed for completeness within 15 business days and the group representative will receive an email regarding status of the request. The “add process” can take up to 120 days to complete. Once the process is completed for each BCBA, the group representative will be notified by email.

BCBAs must meet network requirements, receive an approval notification and a contract effective date before being considered in-network with a participating group.
When a provider leaves a group

The Group Representative notifies Anthem Provider Database in writing of the deletion of any provider from the group practice within 30 days of such deletion. Changes can take up to 30 business days to complete.

1. Term notices must be on company letterhead. Specify the termination applies only to the Group’s Taxpayer Identification Number (Tax ID) and include: Group name, Tax ID, provider’s name, NPI and date the provider left (is leaving) the group.

2. Include the words, BH TERM in the email subject line.

3. Email the notice to: ProviderDatabaseAnthem@anthem.com. Example:

   ![Image]

4. Advise the provider of the termination date (date no longer participating) with Anthem through the group. Note: Once the termination takes effect, the provider is out of network unless effective under an Anthem individual agreement or another group agreement.

Updating practice information such as addresses, phone numbers, Tax ID and more

The group representative must promptly notify Anthem’s Provider Database Management team (PDM) in writing of any addition, deletion or update of any of the group’s practice or billing addresses within 30 days of such change. Practice updates can take up to 30 business days to complete.

- Send address changes, additions or deletions to PDM.
- Tax ID changes require a completed and signed W-9 form.
- Open or closed practice
- Use the Group Practice Update Form to report changes.
- Email the form to: ProviderDatabaseAnthem@anthem.com.
- Include the words, BH CHANGE in the email subject line.

Example:

![Image]
Adding a provider to an existing group or checking status on a group add? The Commercial Behavioral Health Group Contracting team can be reached via email CABHgroups@anthem.com. Your subject line should include three (3) things: The words, “Add to group” or “Add to group status”, your group name and primary county served.

Behavioral Health Network Relations can be reached via email, CABHNetworkRelations@anthem.com for questions about the fee schedule, Agreement (contract) language or requirements specified in the Anthem Blue Cross Professional Manual.

Include the following in your email to Behavioral Health Network Relations:

- Tax id number or NPI (type 1)
- Group Name and provider name and license type (PhD, MFT, MD etc.)
- Brief explanation on your issues or question

Online resources and self-service tools

- [Anthem Blue Cross website](#)
- [Anthem Blue Cross Professional Manual](#) accessible via Availity
- [Availity](#) a secure website for Anthem eligibility, benefits, claim status inquiry, manuals, authorization requests and more.
- [Behavioral Health Provider Resources](#) is a consolidated behavioral health specific website. Save it to your web “Favorites” to access easily!
- [Contact List of Anthem Departments](#) is list of Anthem service departments and contact information.
- [Provider Network Education](#) offers learning opportunities through seminars, webinars, a “Listening Library”, on-demand e-courses and Supplemental Education Materials (SEM).

Group forms

- [Resolution Granting Authority (RGA)](#)
- [Group Roster Information Sheet](#)
- [Group Practice Update Form](#)
- [Practice Profile](#)
- [ABA Assessment form](#)
- [ABA Treatment form](#)
Glossary

There are many terms and abbreviations used throughout this guide and in the process of conducting business with Anthem, that represent company and healthcare industry concepts and services. To help you understand the meaning of the terminology, the following is a glossary of terms. These terms and many more are available in the Glossary section in the Anthem Blue Cross Professional Manual.

Behavioral Health Carve-out. Some employers choose Anthem for medical services and “carve out” behavioral health services to other health plans. This means a member may present an Blue Cross/Blue Shield member ID card, but will have behavioral health benefits with another company.

Benefits. The types of care or services an insurance plan will pay for certain types of medical or behavioral health care.

CAQH. An online provider data-collection solution used by Anthem for the purposes of credentialing and other services. It streamlines provider data collection by using a standard electronic form that meets the needs of health plans, hospitals and other healthcare organizations.

CMS-1500. The most current health insurance claim form.

Coinsurance. An arrangement under which the insured person pays a fixed percentage of the allowable cost of medical care after the deductible has been paid.

Copayment or Copay. A type of member cost sharing that requires a flat amount per service.

Deductible. The amount of charges some members must pay for any covered expense before selected benefits are available under their plan. The member’s deductible is stated in his or her plan.

DCN (Document Control Number). A system assigned number once a claim is submitted for reimbursement. The number is used in claims follow up and may be referred as the “Claim Number”.

EDI (Electronic Data Interchange). Computer-to-computer transfer of transactions and information. Electronic billing is a component of EDI.

ERA (Electronic Remittance Advice). An electronic version of the EOB. Print or automatically post payments utilizing practice management software.

EFT (Electronic Funds Transfer). An option offered by which claim payments can be directly deposited into a provider’s financial institution account.

EOB (Explanation of Benefits). A written summary of the processing of a health care claim, sent to the provider of services and the member.

EOC (Evidence of Coverage). A complete listing of a member’s benefit plan as structured by the employer. The EOC is commonly known as the “Member Benefit Booklet.”

HCID: Health Care Identification Number. Otherwise known as the “member ID.”

NPI (National Provider Identifier). A unique 10-digit number issued by CMS to health care providers. Anthem requires an NPI for all provider types.

Participating Provider. A hospital, other health facility, physician or other health care professional that has an agreement with Anthem to provide health care services for prospectively determined rates.

Pathway and Pathway X Plans: Anthem’s names for the Affordable Care Act-compliant plans, offered on the Covered CA Exchange (Pathway X), and by Anthem directly (Pathway). Generally for individual members, but also to apply to some Small Group plans.

TPA (Third-party Administrator). Some employers use TPA’s to manage benefits & eligibility and/or process claims. The address and phone number for TPAs will be on the member’s ID card. See the definition for “Other Payors.” For a list of Other Payors (Network Leasing), refer to Appendix B in this Manual.

Tracking Number. A system assigned number to a call into Customer Service or Provider Care. This number refers to call documentation and is also the same as “Inquiry Tracking Number.”