Behavioral Health Guide

Behavioral Health and Applied Behavior Analysis
Group Agreements

Note: Includes but is not limited to: Commercial HMO, PPO, EPO plans, plans on and off the exchange (Pathway X, Pathway HMO, PPO, and EPO), and Medicare Advantage PPO Plans
Thank you for participating in the Anthem Blue Cross Behavioral Health Network! As a participating Group in our Behavioral Health Network you have 24/7 online access to tools and information.

We encourage you to visit our Anthem Blue Cross (Anthem) provider website at www.anthem.com/ca for up-to-date information that will help you effectively manage your relationship with 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 Blue Cross (Anthem) to our behavioral health 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 regarding this guide, please e-mail Behavioral Health Provider Relations at BHNetworkRelations@anthem.com.

Sincerely from all of us,

Behavioral Health Network Management
Anthem Blue Cross
## Table of Contents

Overview ........................................................................... 4
Understanding your Group Agreement ................................. 4
Group Representative Responsibilities ................................... 5
Adding Providers .................................................................. 6
Adding ABA Providers .......................................................... 7
Provider Leaves the Group ..................................................... 8
Group Terminates with Anthem ............................................. 8
Practice Changes .................................................................. 8
Credentialing/Re-credentialing .............................................. 9
Frequently Asked Questions (FAQ)
   General Group information ............................................... 10
   Applied Behavior Analysis (ABA) ....................................... 13
Resources
   Contact Anthem Behavioral Health ................................. 15
   Other Online Resources and Self-service Tools ............. 15
Group forms .......................................................................... 15
Glossary .............................................................................. 16
Overview

Group representatives and providers of a participating Behavioral Health (BH) and Applied Behavior Analysis (ABA) Group in the Anthem Behavioral Health Network are obligated to abide by the responsibilities outlined in the Participating Mental Health Practitioner Group Agreement, Participating Mental Health Practitioner Agreement, and Anthem Blue Cross Professional Manual (including any updates to the Manual).

All providers approved to be added to the Group Agreement are participating providers for any Anthem plans that access the Anthem Behavioral Health Network. This includes but is not limited to Commercial plans and plans on the exchange (Pathway HMO, PPO, and EPO) and Medicare Advantage PPO Plans. This does not include the Anthem Medi-Cal Managed Care Program, which is a different Agreement.

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

This Behavioral Health Guide can be shared with all participating group providers. Please refer to and print the Group Quick Reference Sheet for answers to everyday behavioral health topics and resources. To get the latest updates, benefits, eligibility, claims, manuals, each provider should be registered for:

- Availity Web Portal (Availity) at availity.com for benefits, eligibility and claims
- ProviderAccess® for manual, forms, claims reports and more. Register for ProviderAccess at provider2.anthem.com/wps/portal/ebpmybcc

The Behavioral Health Provider Resources Web Page is helpful too! It’s your “one-stop shop” behavioral health information center.

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 make practice changes. They cannot be made by the individual providers in the group.
Group Representative Responsibilities

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 will not be considered in-network or participating. **Anthem members should only be referred to in-network providers.**

**Group Representative Responsibilities to Anthem**

The Group Representative is responsible for sharing information with all participating providers in the group about Anthem, and various other Anthem Departments including Provider Relations, Contracting and Credentialing.

### Behavioral Health and ABA Groups

<table>
<thead>
<tr>
<th>Educate staff on Anthem processes</th>
<th>Disseminate to your staff:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>● Contractual requirements of the Group Agreement.</td>
</tr>
<tr>
<td></td>
<td>● Educational information (newsletters, Manuals, etc.).</td>
</tr>
<tr>
<td></td>
<td>● Billing Guidelines and process.</td>
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</tbody>
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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 providers.
- Login to CAQH. Review and attest every 120 days to avoid network participation interruptions due to outdated information.

<table>
<thead>
<tr>
<th>Notify Anthem of Group changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Adding a provider</td>
</tr>
<tr>
<td>● Removing a provider</td>
</tr>
<tr>
<td>● Practice Changes (TaxID, practice or mailing address)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference the Resource Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Behavioral Health Provider Resources Web page</td>
</tr>
<tr>
<td>● Who to contact for questions</td>
</tr>
<tr>
<td>● Online resources and self-service tools</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abide by Anthem Agreements</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Participating Mental Health Practitioner Group Agreement</td>
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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 to obtain a CAQH Provider ID.

! 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. If you have questions about the process, e-mail the Behavioral Health Contracting team at: CABHContracting@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) - authorizes the group representative to sign the Anthem Blue Cross Group Agreement on a provider’s behalf.

3. E-mail documents to: CABHContracting@anthem.com.

4. “Subject Line” should read: GROUP ADD, Group Name
   Example:

   ![Example E-mail Image]

   Allow 15 business days before requesting status on a submitted 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.

*Required Forms

Only providers who successfully complete the Anthem credentialing process or meet network selection criteria are approved to participate in the Group Agreement.
Adding ABA Providers

Although eligible to render direct services when supervised by a QAS Provider, BCaBAs are not eligible to be added to a Group Agreement.

*Required Forms

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 BACB Certification to begin the approval process. Need a NPI? Request a NPI online at https://nppes.cms.hhs.gov.

The approval process can begin once the BCBA has an individual NPI and BACB Certification number.

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. If you have questions about the process, e-mail the Behavioral Health Contracting team at: CABHContracting@anthem.com.

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3. E-mail documents to: CABHContracting@anthem.com.

4. “Subject Line” should read: GROUP ADD, Group Name
   Example:

<table>
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<tr>
<th>To...</th>
<th><a href="mailto:CABHContracting@anthem.com">CABHContracting@anthem.com</a></th>
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<tr>
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<td>GROUP ADD, ZZZ Family Therapy</td>
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BCBAs must meet network requirements, receive an approval notification and an effective date to participate in the Group Agreement before being considered in-network.

Allow 15 business days before requesting status on a submitted 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 e-mail.
Provider Leaves the 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. E-mail “Subject Line” should read: BH TERM.

3. E-mail notice to: ProviderDatabaseAnthem@anthem.com. Example:

   To: ProviderDatabaseAnthem@anthem.com

   Subject: BH TERM

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.

Group Terminates with Anthem

Follow the process as above and indicate the entire group is terminating its Anthem Agreement.

Practice Changes

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

The Group Representative must promptly notify Anthem Provider Database 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 our Provider Database Management (PDM) team. Use the Group Practice Update Form to report your changes.
- E-mail the form to: ProviderDatabaseAnthem@anthem.com.
- E-mail “Subject Line” should read: BH CHANGE
- Tax ID changes require a completed and signed W-9 form.
Behavioral Health Guide for GROUPS

Credentialing
Applicable to licensed providers only.

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

Anthem's Credentialing Program accesses information through CAQH ProView™. Anthem requires licensed provider credentialing data to be current, attested and authorized for Anthem viewing rights. This is necessary for new providers requesting to join the Anthem network.

CAQH Proview™

All providers must be registered with CAQH Proview™. See CAQH Provider ID. Once a CAQH ID is received, register and complete the online application.

Need help? Contact the CAQH Help Desk by calling toll-free 1-888-599-1771 or e-mail at providerhelp@proview.caqh.org.

CAQH Provider ID

Register with CAQH ProView™ at the website proview.caqh.org to create an account online and receive a CAQH Provider ID. Once registered, use the CAQH Provider ID and password to access CAQH ProView™.

Follow the directions below.

1. Complete the online CAQH application.
2. Authorize Anthem for viewing rights to access to the information.
3. Verify the data and/or attest to it.
4. Upload and submit supporting documents.

Once all steps are completed, begin adding a provider(s) to the Group. See the section, Adding a Provider in this guide.

Anthem’s Re-credentialing Program requires review and verification of provider credentialing data every three years. Providers are notified about six months before the three year mark that they are due for re-credentialing.

It is very important that practice information for each group provider is current to receive notification and that CAQH applications are current and attested to by each provider to prevent termination for non-compliance.
What plans are included in the Anthem Group Agreement?

There are two types of Behavioral Health Agreements (contracts): Commercial and Medi-Cal. Your group may or may not be contracted with both. They are different agreements and fee schedules.

- **Commercial Agreement** includes but is not limited to Commercial and Pathway HMO, PPO, and EPO plans, and Medicare Advantage PPO.
- **Anthem Medi-Cal Managed Care Program** only applies to Anthem Medi-Cal members.

How do we know if a provider is contracted with our Group?

A provider is added to a Group Agreement after successfully completing the credentialing process and notification with an effective date is received from Anthem.

What if a provider is denied in the credentialing process?

If a provider is denied in the credentialing process, the provider will be notified by Anthem with the reason for the denial. The provider will not be added to the Group Agreement.

Can providers leave the group?

Yes. Contractually the group is required to give a 30 day notification when a provider leaves a group. After leaving, the provider is considered out of network unless effective under an Anthem individual Agreement or another Group Agreement.

Can Anthem members see a provider who left a contracted Group?

Yes. The provider is considered out-of-network (not all member plans have out of network benefits), unless the provider is contracted with Anthem under an Individual Agreement or another participating Group Agreement.

What if a member (patient) needs a referral?

All Anthem participating providers are required to refer members only to other participating providers. Verify benefits and eligibility and refer only to in-network (participating) providers under their plan. Use the Anthem Provider Finder at anthem.com/ca > Useful Tools > Find a Doctor.
What happens once a member schedules an appointment?

Before rendering services always verify benefits and eligibility to determine coverage and whether authorization is needed. Only collect the copay or coinsurance and send the claims directly the Anthem.

Does Anthem reimburse for “no shows”? 

Anthem does not reimburse for cancellations or “no shows.” However, 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).

Can interns or psychological assistants render services?

Contracted providers are required to personally render covered services to Anthem members. Services rendered by interns and assistants, even if supervised by the licensed provider, are not covered.

Is authorization needed to see a member?

It is important to verify authorization requirements when confirming benefits and eligibility. Authorization requirements vary depending on the service and each member’s plan. **Always verify benefits and eligibility** to determine authorization requirements because they may differ depending on each member and employer group.

Authorization

What is the authorization process?

When services require pre-authorization these options are available:

- **Interactive Care Reviewer (ICR)**, a web tool using IBM Watson™ innovation accessible through the Availity Web Portal (Availity). Initiate a request online and include attachments conveniently and at no-cost.
- **Outpatient Treatment Request (OTR)**, complete when authorization is needed for outpatient professional services.
Claims

What’s the claim submission process?

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

How are claim issues resolved?

Call claims customer service or send an online secure message through Availity. When calling customer service have the member ID number, claim number (DCN) and prior call reference number (if available). 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. The Provider Dispute Resolution Request is available on our Behavioral Health Provider Resources Web page. After submitting a provider dispute, you’ll receive written acknowledgment 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 Anthem Professional Manual.

What’s the enrollment process for Electronic Fund Transfer (EFT) or Electronic Remittance Advice (ERA)?

Use the CAQH Solution™, EnrollHub™ to register or manage account changes for EFT only, or EFT and ERA combined. Self-register for a new account at the website, solutions.caqh.org to enroll for EFT and ERA.

What is BlueCard® (out-of area)?

BlueCard is a national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan’s service area.

Conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to Anthem Blue Cross in CA through this Program. To learn more about BlueCard, refer to the BlueCard® Program Provider Manual.

Re-credentialing

How does re-credentialing work?

Refer to the Re-credentialing section of this guide, on page 9.
FAQ

Applied Behavior Analysis (ABA)

Does Anthem require ABA providers to be licensed?
No. Unlicensed Behavior Analysts (BCBA / BCBA-D) certified by the Behavior Analyst Certification Board (BACB) are also eligible to participate with Anthem for the provision of ABA services.

Are BCaBAs eligible for an Anthem Behavioral Health contract?
No. Only licensed providers and Board Certified Behavior Analysts are eligible for contracts with Anthem. BCaBAs, however, may render ABA care if supervised by a QAS Provider (licensed or BCBA).

Do BCBAs need an NPI number?
Yes. All contracted providers with Anthem are required to have an individual NPI. Go to the NPI website, https://nppes.cms.hhs.gov to request or look up an NPI.

May BCBAs request authorization and submit claims under their own names?
Yes. When contracted, BCBAs may request authorization and submit claims under their own names.

Is authorization needed to see a member for ABA?
Most plans require pre-authorization for all ABA services. Only those 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.

Which CPT codes should be used to bill for ABA services?
Refer to the fee schedule which includes each allowable ABA CPT code. and the CPT manual for detailed information about each ABA CPT code. The codes billed should also be part of the pre-authorization.

How are ABA service authorizations obtained?
Assessment and Treatment Plan request forms must be completed and submitted for all pre-certification requests.
What forms are needed to request an ABA authorization?

- **Pre-authorization for assessments** - complete the [Adaptive Behavior Assessment Request Form](#).
- **Pre-authorization of treatment plans** - complete the [Treatment Plan Request Form Autism Spectrum Disorders](#).
- Fax the forms to [1-866-582-2287](#) toll free.

#### ABA billing tips

1. Anthem recommends [electronic claims submission](#) for ABA services.
2. Always confirm benefits & eligibility and pre-authorization requirements before rendering care.
   
   Go online to [availity.com](#) or call the number on the back of the member’s health ID card. In the event a member’s plan has not yet been updated with ABA-specific benefits, be sure to ask or look for the member’s [professional nervous & mental benefits](#), including deductible and copay.
3. Obtain [authorization](#) prior to rendering ABA services.
4. If submitting paper claims, use the current CMS-1500 form (version 2/12). The CMS-1500 form has all the required elements for the processing of your claims. Missing elements could result in delays.
5. Include **all** of the following when submitting claims:
   
   - Names of the subscriber and patient, health care ID number
   - Autism spectrum diagnosis
   - Appropriate CPT code as defined on the fee schedule and 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
   - TaxID
   - Rendering provider’s name
   - Rendering provider’s NPI (the rendering provider should be the provider named in the authorization)
The Behavioral Health Provider Resources Page is a consolidated provider Web page with specific behavioral health information. Visit the Web page for announcements, tools and resources, forms, guidelines and more. Save it to Web “Favorites” to access easily!

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

Behavioral Health Contracting can be reached via e-mail for new contract requests at, CABHContracting@anthem.com. Refer to the section, Add a Provider for the process to add a provider to your Group Agreement.

- Anthem Blue Cross website
- Availity Web Portal (Availity) is a secure website for Anthem eligibility, benefits, and claim status inquiry. For services that require authorization, Interactive Care Reviewer (ICR) is the capability to request authorization online. Register for Availity to access these functions and more ‘value-add’ features and services.
- Behavioral Health Clinical UM Guidelines
- Behavioral Health Provider Resources is a consolidated provider Web page with specific behavioral health information.
- CAQH offers business efficiency solutions such as CAQH ProView™ for provider data collection and EnrollHub™ for enrollment for electronic payments (EFT) and electronic remittance advice (ERA). Register with CAQH to access these functions.
- Contact List of Anthem Departments is list of Anthem service departments and their contact information.
- Electronic Data Interchange (EDI) the computer-to-computer transfer of transactions and information using a variety of communications methods. Explore this e-solution to submit electronic claims directly to Anthem.
- ProviderAccess® is Anthem’s secure provider website for manuals, fee schedules, claim reports and more. Register for ProviderAccess to access this information.
- Provider Network Education offers a variety of 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
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 TPAs 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.”
Participating Groups under an Anthem Participating Mental Health Practitioner Group Agreement, are contracted for all Anthem Blue Cross Plans that access the Anthem Behavioral Health Network including, but not limited to: HMO, PPO, and EPO Commercial plans. HMO, PPO, and EPO plans on the exchange, and Medicare Advantage PPO Plans.

NOTE: The Behavioral Health Medi-Cal Network is covered by a different Agreement and fee schedule.

Behavioral Health Network Relations
Handles questions about fee schedules, Agreement (contract) language or requirements as specified in the Anthem Blue Cross Professional Manual, and adding providers to the Group Agreement. E-mail questions to: BHNetworkRelations@anthem.com.

Adding Providers to the Group Agreement
Refer to the Behavioral Health Guide for the process to “Add a provider”. If you have questions about the process, e-mail the Behavioral Health Contracting team at: CABHContracting@anthem.com.

Provider Practice Change Request

- **Complete** a Group Practice Update Form to ensure proper processing of all changes to practice or mailing addresses and Tax IDs. The form is available online on the Behavioral Health Provider Resources Web page.
- **Submit** changes directly to Anthem Provider Database at e-mail: ProviderDatabaseAnthem@anthem.com.
- **Add** the e-mail subject line: “BH Change” for easier processing and identification.
- **All changes must** be signed by the Group Administrator.
- **All changes** require a 30 day notification prior to the change.

Benefits & Eligibility
Login to availity.com or call the toll-free phone number on the back of the member’s ID card.

Resources you need everyday
- **Behavioral Health Provider Resources** is a behavioral health information Web page. Go to anthem.com/ca > Providers > Under “Learn More” select, Behavioral Health Provider Resources.
- **Availity** for benefits, eligibility, claims status inquiry or request online authorization through Interactive Care Reviewer (ICR). Register at availity.com for our exclusive Web based tool.
- **ProviderAccess®** for manuals, fee schedules, claims reports and more. Register for this secure website at provider2.anthem.com/wps/portal/ebpmybcc.

What to do when seeing an Anthem member
Determine coverage by verifying benefits and eligibility through Availity or call the toll-free phone number on the back of the member’s ID card. Ask the following questions:

- Is the member eligible for coverage?
- Is preauthorization of services required?
- Does the member access the Anthem Behavioral Health Network for services?
- What is the copay, coinsurance or deductible?
- Where should claims be submitted?

Collect the copayment, coinsurance and deductible from the member, and bill Anthem directly for services. We recommend claims be submitted electronically.

When using Availity for benefit verification, print or save the benefit verification Web page for your records.

Behavioral Health Network Update
Our online newsletter specifically designed for you, a participating behavioral health group.

Go to anthem.com/ca > Providers > Under “Learn More”, select Behavioral Health Provider Resources > Behavioral Health Network Update (Newsletter) to view current and archived newsletters.

Rev. 060117
Network eUPDATE
A Web tool for sharing vital information via e-mail. It features short timely critical business information as:

- Important website updates
- System changes
-Fee Schedules
-Claims and billing updates

Registration is fast and easy. There’s no limit to the number of subscribers who can register for Network eUPDATEs. Submit all e-mail addresses for your group.

Electronic Claims Filing Assistance
Billing electronically through Anthem, Electronic Data Interchange (EDI) is faster and more accurate. Transmit claims 24/7.

Call e-solutions toll-free at 1-800-470-9630 Monday - Friday 8 a.m. to 4:30 p.m. PT. or by e-mail: e-solutions.support@anthem.com to get started.

User Payer ID 47198 for electronic claims submission (transactions) directly to Anthem Blue Cross.

For submission through a clearinghouse or use of a software vendor, ask and confirm the correct value that should be used. Many clearing agencies use proprietary values, therefore we do not assign or maintain payer ID codes for other entities, vendors or clearinghouses.

Enroll with CAQH for Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA).
Health care providers can enroll easily in electronic payment and electronic remittance advice programs with multiple payers via a single, secure online process.

The CAQH Solution™, EnrollHub™, eliminates different forms required by each payer and centralizes EFT and ERA enrollment.

Logon to solutions.caqh.org and enroll into Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) today!

Claims Submission made easy
- Original claims must be submitted to Anthem within 12 months from the date services were rendered
- Correct rendering provider information - always include individual National Provider Identifier (NPI) and Tax ID
- Correct member and patient information - Anthem member ID, name and date of birth
- Electronically through Electronic Data Interchange (EDI) is easy. Call toll-free 1-800-470-9630 or e-mail e-solutions.support@anthem.com to get started today!
- Always refer to the member ID card for the correct claim mailing address.

Send some claims to a TPA. Send most behavioral health claims to Anthem Blue Cross at the following address:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

“Avoid” Network Participation Interruption
Our Credentialing Program verifies credentialing data every three years. Keep your CAQH applications current by attesting every four months to avoid network participation interruptions due to outdated information (office and mailing addresses, liability coverage etc). Complete re-attestation at the website, caqh.org

Find answers to BlueCard® (out-of-area) questions
You may render services to patients 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 in California.

Get help navigating the program and information about claim filing, eligibility, pre-authorization and contact information in the Blue Card Program Provider Manual. Go to anthem.com/ca > Providers > Enter > Under “Learn More” select Behavioral Health Provider Resources > Resources and Tools to access the Manual.