Anthem.

Health. Join In.

OHIO PROVIDER NETWORK ORIENTATION

Rev 10-2011

Table of Contents **Page**

Anthem.com 3
- Availity®
- MyAnthem℠ for Provider
- Imaging Services Precertification
    - Cardiology
    - Radiology
- Specialty Rx (Pharmacy) Precertification

Administrative Information 5
- Provider Maintenance Form
- Credentialing
- EDI (Electronic Data Transfer)
- Filing Paper Claims
- How to read a member card
- Provider Adjustment Form

Appeals 8
- Provider Complaint and Appeal Process
- Blue Card®
- Facets
- Federal
- Medicare

Behavioral Health 10

Contact List – Map, Network Territories and Frequently Called Numbers 11

Medical Policies 13

Milliman® Guidelines 13

Network Update (provider newsletter) 13

Precertfication Guidelines and Requirements 14

Pharmacy 14
- Formulary
- Specialty Drugs
- Reference Lab Network

Products 16
- Blue
- Lumenos®
- FEP
- Medicare
- Blue Card

Recovery 20
- Facets
- Federal

- National
- Blue Card

Anthem.com

Anthem.com offers important information and a range of electronic tools to facilitate doing business with Anthem Blue Cross and Blue Shield (Anthem). To view, go to www.anthem.com, select Provider (enter state), and click enter.

On the public portal, you will find business information, administrative tips, news updates and electronic tools that help you manage your day-to-day operations and utilize the secure provider portals, Availity® and MyAnthem℠ (User ID and password required). Availity, a multi-payer Web portal, allows providers to access real-time information from multiple payers via one secure sign-on. Due to Availity's ease of use, broad functionality and breadth of services, Anthem will transition many of our electronic tools to exclusive access via Availity.

Note: We are targeting the end of 2011 to shut down MyAnthem links to certain functionalities, including Eligibility & Benefits Inquiry and Claim Status Inquiry, and access to this information will then be available exclusively through Availity. Please watch for Anthem updates on additional functionality moving to exclusive access through Availity.

Availity

For Anthem members in local plans in Indiana, Kentucky, Missouri, Ohio and Wisconsin, as well as Blue Cross and Blue Shield members nationwide, you can find the following information on the Availity site:

- Eligibility and Benefits
- Claims Status Inquiry with the ability to ask questions through Secured Messaging* (requires MyAnthem Claims access)
- Imaging Services Precertification and Inquiry (requires Imaging & Specialty Rx Precert access)
- Specialty Rx Precertification and Inquiry (requires Imaging & Specialty Rx Precert access)
- Clinical Messaging – clinical alerts on patients' care gaps and medication compliance indicators
- Care Profile – real time, claims based electronic medical record which provides up to 24 months of a patient's most recent medical history form our system across multiple providers

For more information on Availity, to view a demo or to register, go to www.availity.com.

MyAnthem℠ for Provider

The following functionalities will continue to be available on MyAnthem:

- Fee schedule for participating providers
- Imaging and Specialty Rx precertification and inquiry
- Medical referral and pre-authorization inquiry
- Remit inquiry

Note:
If you need to register for MyAnthem, click "Register Now" under the MyAnthem box on the left-hand side of the Provider Home page. If your Tax Identification Number (TIN) is already registered, see your local Site Administrator to secure access or send an email to Central.eProvider.Rep@anthem.com with your name,

TIN and contact information. See below for additional information on Imaging Services and Specialty Rx precertification.

Imaging Services Precertification

Cardiology

- Submit and verify outpatient imaging precertification via Availity for the following modalities: CT/CTA, Nuclear Cardiology, MRI, PET, Cardiac CT/CTA, Cardiac PET, Cardiac MRI, MPI, Blood Pool Imaging/MUGA), Stress Echocardiography (SE), Resting Transthoracic Echocardiography (TTE), and Transesophagael Echocardiography (TEE).

- To assist you in preparing online and/or phone requests for MPI and SE, use the Clinical Information Work Sheet located at anthem.com>provider (enter state)>Imaging Services/Precertification>MPI or SE Work Sheet.

Radiology

- Submit and verify outpatient imaging precertification for the Radiology Utilization Program via Availity.
- Access the OptiNet online site assessment, an important tool that assists ordering providers in selecting the best location for high tech imaging services for their patients.

For more information, go to anthem.com>select provider (enter state)>Answers@Anthem.

Specialty Rx Precertification

- Submit online precertification for specialty drugs via Availity. You can find Specialty Pharmacy Clinical Data Submission Tools online, at anthem.com> select provider (enter state)>Answers at Anthem. The tools are designed to assist you in preparing online and/or phone requests.

Administrative Information

Provider Maintenance Form
When a change occurs to your office address, phone number, or tax identification number (TIN); a physician or other credentialed health care practitioner (nurse-practitioner, physician assistant, nutritionist, occupational therapist, etc.) joins or leaves your practice; or any other significant modification to your office information takes place, you need to complete a Provider Maintenance Form. The form is online at anthem.com>provider (enter state)>Provider Maintenance Form. By completing this form, your office information will remain accurate in our Directories. Keeping your information up to date also ensures that disruptions will not occur in processing your claims.

Credentialing with CAQH (Council for Affordable Quality Healthcare)
Providers participating in Anthem networks apply for credentialing through the CAQH Universal Credentialing Data Source system. You submit one standard application, eliminating the need to complete multiple credentialing applications for health plans participating with the database. For more information, you can access the CAQH web site at **www.caqh.org**.

EDI (Electronic Data Interchange)
EDI allows you to submit claims, get remittance advices and retrieve claim file acknowledgements electronically. When you sign up for EDI transactions, you can see dramatic decreases in accounts receivables (A/R) days, rejection rates and paper claims. If you have questions about electronic submissions, or if you want to learn more about how EDI can work for you, please call 1-800-470-9630 or visit http://www.anthem.com/edi/ . The live chat is also located on the Home Page under Quick Links.

Filing Paper Claims
Please submit your claims electronically whenever possible. However, when you must submit a paper claim, use the standard Red CMS-1500 claim form for professional claims.

It is critical that paper claims be mailed to the address below. Mailing your claim to an incorrect address may result in it being handled improperly or otherwise being returned to you.

PO Box 105187
Atlanta, GA 30348

General tips for CMS-1500

- If your electronic claim is rejected by EDI, please do not resubmit it on paper. Correct the electronic claim and resubmit via EDI.
- Please do not handwrite your claims, as this may result in misinterpretation of data or claims returned as illegible.
- Do not use highlighter on your claim, as it may make the data unreadable.
- Use black ink; it is easier to read.
- Do not use a dot matrix printer which is difficult to read.
- Change the printer cartridge regularly to improve the quality of your claims.
- Check the printing of your claims from time to time so you are sure that lines are properly aligned and characters are easy to read.
- Make sure all characters are inside the fields; they should not “lie” on the lines or extend beyond the boxes or fields. Claims may be returned if we are unable to clearly identify or read the data within a box/field.

- Avoid sending photocopies. However, if you must send us a photocopy of an Explanation of Benefit (EOB) or other document, please be sure it is legible and no data is cut off the copy. Copies of faxes typically are very difficult to read, so please avoid these documents whenever possible.
- When submitting a claim with another carrier's EOB, make sure that the header information is included on the EOB so that we can properly apply other carrier payment information. Your claim will be returned if this information is not present.
- To avoid disclosing a member's Personal Health Information (PHI) when attaching another carrier EOB, please mark through other insured's claims data. Be careful NOT to mark through any information for the member whose claim is attached.
- It is critical that the name on the claim exactly match the name printed on the EOB.
- Unless submission rules do not allow, please file your secondary claim exactly as it was filed to the other carrier, i.e., same to and from dates, lines, charges, etc.
- It is typically not necessary for you to submit a claim for payment secondary to Medicare. Information on covered members is forwarded to the Medicare carriers so they can "cross-over" these secondary claims. You may check with Provider Inquiry to ensure your patient's Medicare information is on file with us.
- Medicare claims are sometimes not "crossed over" until several days after you are notified of the Medicare payment, so please allow at least 14 days before filing a secondary claim on paper. This reduces the receipt of duplicate claims and allows us to process all claims more timely.
- When submitting a claim with multiple pages, make sure all required information is on each page (patient information, insured information, provider information, etc.)
- If you receive a rejection letter on which we request correction of data, please resubmit the claim on a new claim form.
- Include the entire Member Identification number (including any prefix) in field 1a.
- All insured information is needed in fields 4 and 7 (Insured's name and address). Please do not use "Same" in field 7, even if the addresses are the same.
- Provider information is to be noted in the following fields:
    - 17 – Name of Referring Provider (if applicable)
    - 17b. – NPI of Referring Provider (if applicable)
    - 19 – Provider Taxonomy Code (if applicable) Refer to www.wpc-edi.com/taxonomy for a complete listing of provider taxonomy codes.
        - Field 19 currently is not a required field, but including this information may assist us in processing your claim. If a provider group/physician has one NPI number but multiple specialties, such as a therapy group with OT, PT and Speech, we strongly recommend that you report the taxonomy code to identify provider specialty.
        - If you are currently using field 19 for NOC or NDC codes, please move those to field 24.
    - 24i – When filing paper claims, please use the two digit qualifier 1B
    - 24j lower – Rendering Provider NPI
    - 25 – Federal Tax ID
    - 31 – Signature of physician or supplier
    - 32 – Service facility location Information: Complete name, address and zip code of the facility if the services were furnished in a hospital, clinic, lab, or facility other than the patient's home or physician's office.
    - 33 – Billing provider: Complete name and address is required (remit address)
    - 33a – Billing provider: Group NPI
    - 33b – Leave blank

How to read a member card

Anthem member identification (ID) cards provide you with needed information at a glance.

- On the front of the card: Member’s name, product the member is under, co-pays, identification numbers (with prefix), group and plan codes.
- On the back of the card: Address and phone numbers for Provider Inquiry, Precertification, and the address to file claims.

The Anthem card and information may change when a group re-contracts with Anthem so check the card at each patient visit. Possession of the card does not guarantee eligibility so go on line or call to verify eligibility and benefits.

Provider Adjustment Form

The Provider Adjustment Form is used for Corrected Claims (office is adding, deleting or replacing information), Underpayments (office believes additional payment is due), Overpayments (Anthem has paid services twice, paid as primary, overpaid, etc.) The Provider Adjustment Form. is at anthem.com>provider(enter state)>Provider Adjustment Form.

Appeals

Provider Complaint and Appeal Process
For details on Anthem's Provider Complaint and Appeal Process, please see our Guide to Provider Complaints and Appeals, available online, at anthem.com>provider (enter state)>Guide to Provider Complaints and Appeals.

Anthem encourages Participating Providers to seek resolution of issues by using the procedures outlined in this Guide.

An appeal is a formal request submitted to Anthem to change a decision. Clinical appeals are requests to change decisions based on whether services or supplies are medically necessary or experimental/investigational; they can be expedited when they involve decisions on urgently needed care or standard when they involve non-urgent care.

To qualify for an expedited appeal, the request must involve an Anthem denial of one of the following:

- A pre-service issue or treatment that is urgently needed
- Concurrent treatment, i.e., member is in the hospital
- A life-threatening condition

Providers have one hundred eighty (180) calendar days to file an appeal from the date they receive notice of Anthem's initial decision.

*How to Begin: T*he provider can send us a letter of appeal. Be sure to note that you are "appealing" a decision we have made. Also, be sure to note the claim number, patient name, patient ID number.

Mail the appeal to:
Anthem Blue Cross and Blue Shield
Attn: Appeals Department
P.O. Box 105662
Atlanta, GA 30348

Or you may fax your appeal requests to 800-368-3238.

We will respond to clinical appeals within 30 calendar days and administrative appeals no later than 40 business days of receipt. Based upon the information we have, the information you send us and your appeal letter, we will make a decision to uphold or overturn the original decision.

Upholding the Original Decision

We will send you a letter stating we are upholding our original decision and what our reasoning is behind that decision. Please note: If we uphold our original decision the decision becomes final and all levels of our internal appeal process are exhausted.

Overturning Our Original Decision

We will send you a letter stating we are overturning our original decision and what our reasoning is behind that decision. If you are due additional payment, we will make that payment on your next remittance.

Important Contact Information
To find out if we've received your appeal and the status, please contact Provider Inquiry at.1-800-345-4344 or send a secured message from our Web site at www.anthem.com

Federal Employee Plan (FEP)

FEP Provider Appeal Process Guidelines:

- The provider must have previously submitted a verbal complaint to provider customer service (Provider Inquiry) prior to submitting an appeal. (The provider customer service number is on the back of the member's card.)
- The appeal request must be in writing and must be received within 180 days of the initial adverse action.
- The request must be submitted by the performing provider.
- The appeal request is for reconsideration of our payment/final denial of a claim.
- The claim determination must be final (no request for additional information, request for treatment plan, etc.).
- If the request relates to the denial of a prior approval, the patient must not have already received the services or been admitted. If services have been rendered or the patient has been admitted, an appeal cannot be accepted until the provider has submitted a claim and the Plan has made a final determination on the claim.
- The claim determination cannot hold the provider harmless.
- Only clinical denials (not medically necessary, experimental and investigational) when the amounts are provider liability are eligible for the provider appeal process. Administrative denials (timely filing) are not eligible for the provider appeal process and should be handled by customer service.
- The request must include member identification number, date(s) of service, claim number(s), reason for the appeal, and any written comments, documents, records, or other information relating to the case.

The Plan's decision is due within 30 calendar days from receipt of the appeal request.

Medicare

Information on the Medicare Advantage/Med Supplement appeals process is included in the following documents:

Medicare Advantage HMO & PPO Provider Manual Link:
www.anthem.com/shared/noapplication/f0/s0/t0/pw_ad094474.pdf?refer=ahpprovider&state=oh

Medicare Managed Care Manual Link (Section 60, Chapter 13) – outlines the rules for appeals & references provider roles:
http://www.cms.hhs.gov/manuals/downloads/mc86c13.pdf

The Medicare Advantage Appeals address is:

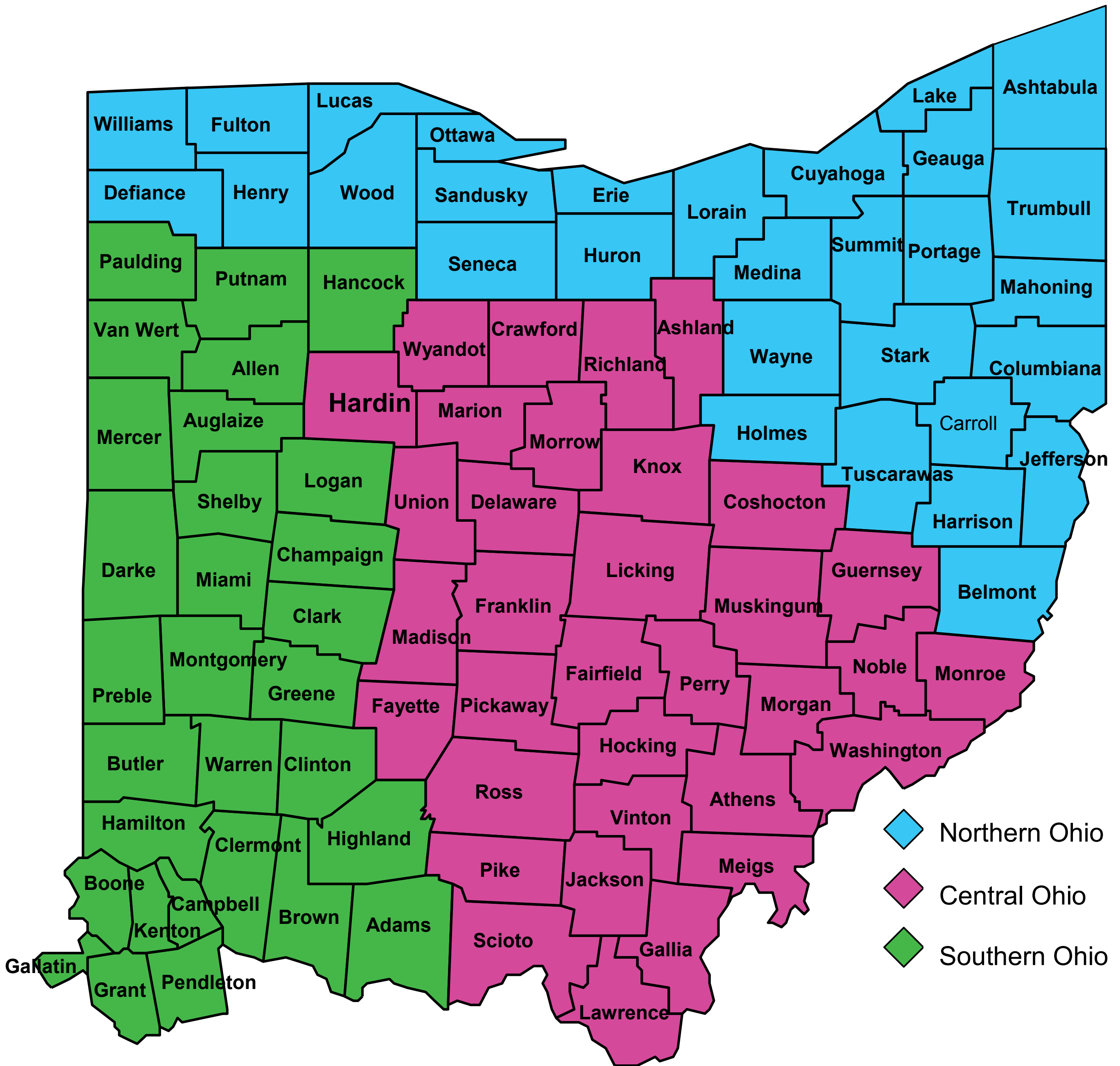
Anthem Blue Cross Blue Shield
Appeals Department
PO Box 1975
Fond du Lac, WI 54936-1975

Behavioral Health

The Office of Medical Policy and Technological Assessment (OMPTA) has developed policies that serve as one of the sets of guidelines for coverage decisions. Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the policies. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. Policy does not constitute plan authorization, nor is it an explanation of benefits.

Behavioral Health Medical Necessity Criteria

Contact List -- Ohio Provider Engagement & Contracting (PE&C) Map



Contact List – Network Territories, Addresses and Contact Numbers

Northern Ohio	Address	Contact Numbers
Akron/Canton	Anthem Blue Cross and Blue Shield 4150 Beldon Village NW, Suite 506 Canton, OH 44718	Phone – 800-331-8210 Fax – 330-493-2148
Cleveland/Toledo	Anthem Blue Cross and Blue Shield 8333 Rockside Road, Suite 200 Cleveland, OH 44125	Phone - 800-551-3119 Fax (Cleveland) – 216-573-4615 Fax (Toledo) – 419-897-4751
Youngstown	Anthem Blue Cross and Blue Shield 2405 Market Street Youngstown, OH 44567	Phone – 800-367-5891 Fax – 330-783-3545
Central Ohio	**Address**	**Contact Numbers**
Columbus	Anthem Blue Cross and Blue Shield 6740 N. High Street Worthington, OH 43085	Phone – 614-438-3400 Fax – 614-438-3900
Southern Ohio	**Address**	**Contact Numbers**
Cincinnati	Anthem Blue Cross and Blue Shield 4241 Irwin Simpson Rd. Mason, Oh 45040	Phone – 513-770-7607 Fax – 513-770-7510
Dayton	Anthem Blue Cross and Blue Shield 2 Prestige Place Suite 400 Miamisburg, OH 45342	Phone – 937-428-8808 Fax – 937-428-8890

Medical Policies
Medical policies, intended to reflect current scientific data and clinical thinking, set forth position statements for policy development and updates regarding the medical necessity of individual technologies, etc. However, Medical Policy does not take precedence over federal and state law, or contract language, including definitions and specific contract provisions/exclusions. In determining eligibility for coverage, these must be considered before Medical Policy.

To find Anthem's Medical Policies online, visit anthem.com>provider (enter state)>Medical Policies and Clinical UM Guidelines.

Milliman® Guidelines
Milliman Guidelines are a set of evidence-based clinical guidelines that span the continuum of care. They are used to guide authorization criteria.

Network Update
A newsletter for Anthem network providers is published every other month, or six times a year. It features business information, policy and process updates, and other information important to your day-to-day operations. When we post a new edition of *Network Update*, you are mailed a reminder postcard with instructions on how to download the newsletter. If your office doesn't have Internet access, and you would like a printed copy of Network Update, contact your local Network Relations consultant.

To download *Network Update*, visit anthem.com>provider (enter state)>Network Update.

Precertification
Anthem precertifies selected inpatient and outpatient medical services, including surgeries, major diagnostic procedures and referrals, to help ensure that the service meets criteria for medical necessity under the member's benefits contract.

For more detail, visit anthem.com>provider (enter state)> Precertification Guidelines.

For details on Specialty Pharmacy, Cardiology, and Radiology precertification requirements, visit anthem.com>provider (enter state)>Imaging Services/Precertification.

Pharmacy

Formulary

The Anthem Drug List/Formulary is a list of brand name and generic medications that have been reviewed and selected on the basis of quality and effectiveness by a committee of practicing doctors and clinical pharmacists. A member's co-pay is less for drugs on Anthem's formulary. To view Anthem's formulary, click the link below.

Search the Drug List/Formulary

In addition to the Formulary drug list, this site includes prior authorization criteria, tools and forms, physician fax form, and other useful information to help simplify the member benefits for pharmacy.

Specialty Drugs

Some specialty drugs must be precertified ***when billed under a member's medical benefits.*** Precertification requirements apply to specialty drugs billed with HCPC (J and Q codes) and CPT codes for the following places of service: Outpatient, ambulatory infusion, ambulatory surgery, home infusion, physician's office and dialysis centers (when drug billed separately).

Reference Lab Network

For physicians in Indiana, Kentucky and Ohio, if you order lab services for an Anthem member and you are not providing the service in your office, please refer the member to an Anthem Reference Lab network provider. This benefits the member – your patient – by reducing the member's financial responsibility.

To find participants in the Anthem Reference Lab Network, go to www.Anthem.com>Provider (enter state) and select Find a Doctor, located on the left side of the provider home page.

Then, to obtain a list of reference labs in your area, follow the prompts for:

- State
- Product
- Hospitals, Facilities, Services and Equipment
- Specialty—Laboratories

- Zip code or county

If you do not have access to the Internet, you can call the Anthem customer service number found on the member's identification card for the name of a reference lab near your office location.

Products

Blue

Blue Traditional®
A comprehensive major medical plan without networks, Blue Traditional members are free to see any provider. Blue Traditional includes deductibles, out-of-pocket costs and lifetime maximums, copayments and prescription benefits.

For further information on Blue Traditional product –
http://www.anthem.com/wps/portal/ahpprovider?content_path=agent/oh/f3/s1/t0/pw_005919.htm&state=oh&rootLevel=2&label=Blue%20Traditional%C2%AE

Blue Preferred® Primary
A health maintenance organization (HMO) product, Blue Preferred Primary requires members to select a primary care physician (PCP). Except for medical emergencies or urgent care, services must be obtained from a PCP or another network provider to be covered.

For further information on Blue Preferred Primary – HMO
http://www.anthem.com/wps/portal/ahpprovider?content_path=shared/noapplication/f3/s1/t0/pw_a034775.htm&state=oh&rootLevel=2&label=Blue%20Preferred%C2%AE/Blue%20Preferred%C2%AE%20Primary%20(HMO)

Blue Preferred Primary Plus
A point-of-service (POS) product, Blue Preferred Primary Plus combines the advantages of an HMO product with the freedom of a non-network option. With Blue Preferred Primary Plus, the highest level of benefits is given when a member obtains services from a network provider. If services are rendered by a non-network provider, the member's out of pocket expenses will be higher

Blue PrioritySM
Blue Priority is an Ohio local health insuring corporation (HIC) product with a smaller network encompassing the Greater Cincinnati and Dayton areas. Blue Priority requires members to select PCPs. Except for medical emergencies or urgent care, services must be obtained from a PCP or another network provider to be covered.

Blue Access®
A preferred provider organization (PPO) product, Blue Access does not require members to select a PCP. Members can see both network and non-network providers but Anthem offers a higher reimbursement level for covered services when members use network providers; less when they use non-network providers.

For more information on Blue products) – *link to manual*
http://www.anthem.com/provider/oh/f5/s1/t0/pw_035485.pdf?refer=ahpprovider&state=oh

Lumenos
A consumer-driven Health Plan, Lumenos plan options include Health Savings Account (HSAs), Health Reimbursement Accounts (HRAs) and Health Incentive Accounts (HIAs).

For more information on Lumenos –
http://www.anthem.com/provider/noapplication/f3/s10/t0/pw_ad084490.pdf?refer=ahpprovider&state=oh

Federal Employee Plan (FEP)
The Blue Cross and Blue Shield Association negotiates annually with the US Office of Personnel Management (OPM) to determine the benefits and premiums for the Blue Cross and Blue Shield Service Benefit Plan, also called the Federal Employee Plan (FEP). Anthem, the primary point of contact for FEP members in Indiana, Kentucky, Missouri, Ohio and Wisconsin, is responsible for processing claims and providing customer service to members participating in FEP.

A preferred provider organization (PPO) product, FEP does not require members to select a PCP. Members can see both network and non-network providers; however, a higher reimbursement level is offered for covered services when members use Anthem's network providers.

Medicare

Medicare Advantage HMO is a health maintenance organization (HMO) product replacing Traditional Medicare. It includes in-network benefits only and Primary Care Provider (PCP) is required.

Anthem Senior Advantage – Basic requires members to select a primary care physician (PCP). Except for medical emergencies or urgent care, services must be obtained from a PCP or another network provider to be covered.

Anthem Senior Advantage – Plus requires members to select a primary care physician (PCP). Except for medical emergencies or urgent care, services must be obtained from a PCP or another network provider to be covered.

For benefit differences on Anthem Senior Advantage Basic and Plus -
http://www.anthem.com/visitor/noapplication/f1/s0/t0/pw_b136103.pdf?refer=ahpmedicare

Anthem Senior Advantage – Value requires members to select a primary care physician (PCP). Except for medical emergencies or urgent care, services must be obtained from a PCP or another network provider to be covered.

For benefits on Value –
http://www.anthem.com/shared/noapplication/f3/s2/t6/pw_b135715.pdf?refer=ahpmedicare

Medicare Advantage PPO is a Preferred Provider Organization (PPO). Network and non-network benefits are available.

Anthem Medicare Preferred – Standard does not require members to select a PCP. Members can see both network and non-network providers. Anthem offers a higher reimbursement level for covered services when members use network providers; less when they use non-network providers.

Anthem Medicare Preferred – Select does not require members to select a PCP. Members can see both network and non-network providers. Anthem offers a higher reimbursement level for covered services when members use network providers; less when they use non-network providers.

For benefit differences on Anthem Medicare Standard and Select –
http://www.anthem.com/shared/noapplication/f3/s2/t6/pw_b135830.pdf?refer=ahpmedicare

Blue Medicare Access Standard (Regional PPO) does not require members to select a PCP. Members can see both network and non-network providers. Anthem offers a higher reimbursement level for covered services when members use network providers; less when they use non-network providers.

Blue Medicare Access Value (Regional PPO) does not require members to select a PCP. Members can see both network and non-network providers. Anthem offers a higher reimbursement level for covered services when members use network providers; less when they use non-network providers.

For benefit differences on Standard and Value Regional PPO –
http://www.anthem.com/shared/noapplication/f3/s2/t6/pw_b135832.pdf?refer=ahpmedicare

Blue Medicare Access℠ Classic (Regional PPO) does not require members to select a PCP. Members can see both network and non-network providers. Anthem offers a higher reimbursement level for covered services when members use network providers, less when they use non-network providers.

For benefits on Classic –
http://www.anthem.com/shared/noapplication/f3/s2/t6/pw_b135831.pdf?refer=ahpmedicare

Private Fee for Service Plan (PFFS) members are free to choose any doctor, specialist or hospital anywhere in the United States as long as the office accepts Medicare and agrees to accept the terms and conditions of payment. This Plan is sold in Colorado, Connecticut, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Virginia, and Wisconsin, but services can be provided anywhere in the U.S.

For further information on PFFS -
http://www.anthem.com/wps/portal/ahpmedicare?content_path=shared/noapplication/f4/s2/t0/pw_b135669.htm&label=2010%20Anthem%20PFFS%20Plans%20and%20Benefits

Medicare Supplement (Medigap) is designed to fill the “gaps” left by Original Medicare. The member must be enrolled in Original Medicare Parts A and B to qualify for Medicare supplement. The member is free to choose any doctor, specialist or hospital anywhere in

the U.S. as long as the office accepts Medicare and agrees to accept the terms and conditions of payment.

Medicare Select plans are designed to fill the “gaps” left by Original Medicare. The member must be enrolled in Original Medicare Parts A and B to qualify for these plans. The members are required to use a network hospital for inpatient services except in emergency situations or if the covered services are not available through a network facility.

For further information on Medicare Supplement plans –
http://www.anthem.com/wps/portal/ahpmedicare?content_path=shared/noapplication/f2/s2/t6/pw_ad094020.htm&label=Anthem%20Medicare%20Supplement%20Plan

Blue Card®
BlueCard is a program giving Anthem members access to Anthem benefits all across the nation by uniting the Anthem network with those of other Blue Cross and Blue Shield licensed companies. More than 80 percent of hospitals and nearly 90 percent of physicians in the U.S. contract with Blue Cross and Blue Shield Plans. The BlueCard Program links them all.

Anthem members pay less out of their pockets when they receive care from Blue Plan physicians and hospitals because Anthem covers more at the in-network benefit level. Currently four types of products are administered through the BlueCard Program:

- **BlueCard Traditional**
- **BlueCard PPO**
- **BlueCard Managed Care/POS**
- **BlueCard HMO**

BlueCard Traditional offers traditional, or indemnity level benefits to members who are traveling or living outside of their Blue Plan’s area.

BlueCard PPO offers PPO level benefits to members traveling or living outside of their Blue Plan’s area. For highest level of coverage, members must obtain services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard Managed Care/POS (Point of Service) is similar to BlueCard Traditional and BlueCard PPO except that members are actually enrolled in the Anthem Blue Cross and Blue Shield network and primary care physician (PCP) panels. Therefore, you should treat these members as you treat any other Anthem POS member, applying the same referral practices and network protocols.

BlueCard HMO patients serviced through the BlueCard Program receive coverage the same way as members in other Blue plans. You should submit claims for these members through the BlueCard Program.

Recovery
Anthem's Recovery program handles situations where claims were paid in error. If you discover that you filed an inaccurate claim that resulted in your receiving a larger payment than was actually due, you can file an adjustment, using the Provider Adjustment Form. To find it online, visit anthem.com, or click on the following link or copy and paste this address into your browser:
http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/in/f4/s0/t0/pw_ad080342.htm&rootLevel=3&state=in&label=Provider%20Adjustment%20Forms

For all products, when you initiate a refund to Anthem, please include the following information with your check:

- Anthem Provider Inquiry/Refund/Adjustment Form
- Subscriber identification number
- Patient's name
- Claim number
- Date of service
- Reason for the refund

If you mail in a copy of the payment voucher (PPL), please be sure the voucher is legible and circle the patient information that relates to the refund. By providing this critical information, Anthem will be able to expedite the process.

Anthem's Cost Containment Overpayment Avoidance Division also reviews claims for accuracy and requests refunds if claims are overpaid or paid inaccurately. Some common reasons for overpayments are:

- Paid wrong provider
- Allowance overpayments
- Billed in error
- Non-covered services
- Paid wrong number
- Terminated members
- Coordination of Benefits
- Late credits
- Duplicate
- Claims editing
- Total charge overpaid

If Anthem seeks a refund, its Recovery department notifies the provider via letter that a refund is owed. The letter includes the member and claim number, date of service, check number, reason and amount due, the Recovery phone number and fax number.

The following details the refund process by claims processing system/product.

- **FACETS (LOCAL Group): Member ID includes "M" in the middle of the number**

If mailing a refund, please make out the check to **Anthem Blue Cross and Blue Shield** and *mail with a copy of Anthem's letter* to:

Anthem Blue Cross and Blue Shield
Cost Containment Overpayment Avoidance
P.O. Box 73651
Cleveland, OH 44193-1177

If you are returning a check issued by Anthem Blue Cross and Blue Shield, please mail to:

Anthem Finance Dept.
1351 William Howard Taft
Mail-Point: CW1-262
Cincinnati, Ohio 45206

If the check is not received within 45 days of the letter date, recoupment will occur.

If you are returning a check by FED-EX, UPS, etc. please send to:

National City Account Receivable Center
Attn: Lockbox 73651
4100 West 150th St.
Cleveland, OH 44135

- **FEDERAL (FEP): Member ID begins with "R" and has eight digits after the R**

You will be notified of overpayment through provider remittance. The takeback will occur immediately after discovery of the overpayment.

If mailing a refund check, please make out the check to **Anthem Blue Cross and Blue Shield** and send to:

Anthem Blue Cross and Blue Shield
Cost Containment Overpayment Avoidance
P.O. Box 73651
Cleveland, OH 44193-1177

If you are returning a check issued by Anthem Blue Cross and Blue Shield, please mail to:

Anthem Finance Dept.
1351 William Howard Taft
Mail-Point: CW1-262
Cincinnati, Ohio 45206

If you are returning a check by FED-EX, UPS, etc., please send it to:

National City Account Receivable Center
Attn: Lockbox 73651
4100 West 150th St.
Cleveland, OH 44135

- **NATIONAL: Member ID includes AN in 4th and 5th sequence:**

When an overpayment is identified, you receive notice through the payment listing. Details of the overpayment are included in a section entitled, “Accounts Receivable Created.”

Recovery occurs on day 60 for professional providers. Facilities will be applied on the next payment listing. The takeback will be listed in the section titled “Accounts Receivable Applied”.

For a solicited refund, where you would like to send a check instead of having a recoupment on your payment listing, send in the check within 45 days, along with the AR number, patient name, patient ID number, claim number, date of service and reason for refund. Contact customer service and request the AR not to recoup. If the check has not been received after 60 days from freezing the AR, the AR will be reset to recoup status.

If mailing a refund check, please make out the check to **Anthem Blue Cross and Blue Shield** and send to:

Anthem Blue Cross and Blue Shield
Cost Containment Overpayment Avoidance
P.O. Box 73651
Cleveland, OH 44193-1177

If you are returning a check issued by Anthem Blue Cross and Blue Shield, please mail to:

Anthem Finance Dept.
1351 William Howard Taft
Mail-Point: CW1-262
Cincinnati, Ohio 45206

If you are returning a check by FED-EX, UPS, etc., send it to:

National City Account Receivable Center
Attn: Lockbox 73651
4100 West 150th St.
Cleveland, OH 44135

If the provider returns a check and the AR is still recouped, contact customer service (number on the back of member’s card). Give the AR number, check number and the dollar amount of the check.

- **Blue Card**

The Blue Card payment voucher has a vertical gray/white bar. If Anthem has identified an overpayment, you will receive notice on this voucher, via payment listing under the “Accounts Receivable Created” section. Below the title you will see the details for the overpayment.

Recoveries will occur on day 60 for professional providers. Facilities will be applied on the next payment listing. The takeback will be listed in the section titled “Accounts Receivable Applied”.

If you would like to send a check for a solicited refund, instead of having a recoupment on your payment listing, send in the check within 45 days along with the AR number, patient name, patient ID number, claim number, date of service and reason for refund. Contact BlueCard customer service (number on the back of member’s card) and request the AR not to recoup. If after 60 days from freezing the AR the check has not been received, the AR will be reset to recoup status.

If mailing a refund check, please make out the check to **Anthem Blue Cross and Blue Shield** and send to:

Anthem Blue Cross and Blue Shield
Cost Containment Overpayment Avoidance
P.O. Box 73651
Cleveland, OH 44193-1177

If you are returning a check issued by Anthem Blue Cross and Blue Shield, please mail to:

Anthem Finance Dept.
1351 William Howard Taft
Mail-Point: CW1-262
Cincinnati, Ohio 45206

If you are returning a check by FED-EX, UPS, etc., send it to:

National City Account Receivable Center
Attn: Lockbox 73651
4100 West 150th St.
Cleveland, OH 44135

If the check is not received within 45 days of the letter, recoupment will occur. If you send in a check and the AR is still recouped, contact Blue Card customer service. Give the AR number, check number and the dollar amount of the check.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In most of Missouri (excluding 30 counties in the Kansas City area) : RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross and Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance
Companies, Inc The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.