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## Section 1

### Introduction to the BlueCard® Program

As a contracted provider of Blue Shield of California (Blue Shield), you may render services to patients who are insured by other states' Blue Plans, and who travel in or live within California.

This section describes the advantages of the BlueCard Program, and provides information to make filing claims easy. You will find helpful information about:

- Identifying out-of-state Blue plan members
- Verifying eligibility and benefits
- Other states' Blue plan medical policies and pre-certification requirements
- Requesting and obtaining authorizations
- Submitting BlueCard claims and requesting medical records
- Resources and contact information

### Definition of the BlueCard Program

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

### BlueCard Program Advantages to Providers

The program allows you to conveniently submit claims for patients from out-of-state Blue Plans, either domestic or international, directly to Blue Shield.

Blue Shield is your primary contact for BlueCard claim submission, claims processing, and provider inquiries.

Blue Shield continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations. In doing so, your patients will have a positive experience with each visit.

### Services Processed Through the BlueCard Program

Claims for all inpatient, outpatient and professional services generated for out-of-state Blue plan members are processed through the BlueCard Program.

# The BlueCard® Program

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## Products Included in the BlueCard Program

A variety of products and claim types are eligible to be delivered via BlueCard, however not all Blue Plans offer all the products listed below to their members.

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization)
- POS (Point of Service)
- HMO (Health Maintenance Organization)
  - HMO claims are eligible to be processed under the BlueCard Program or through the Away From Home Care Program.
- Blue Cross Blue Shield Global Core
- GeoBlue Expat claims
- Medigap – Medicare Complementary/Supplemental
- Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates
  - These cards will not have a suitcase logo.
- Stand-Alone SCHIP (State Children's Health Insurance Plan) if administered as part of Medicaid
  - Payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards do not have a suitcase logo. Stand-Alone SCHIP programs will have a suitcase logo
- Standalone vision
- Standalone prescription drugs

*Note: Standalone vision and standalone self-administered prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.*

*Note: Definitions of the above products are available in the Glossary of Terms section of this manual*

## Products Excluded from the BlueCard Program

The following claims are excluded from the BlueCard Program:

- Stand-alone dental claims
- Self-administered prescription drugs claims
- Vision claims delivered through an intermediary model (using a vendor)
- Federal Employee Program (FEP) member claims
- Medicare Advantage\*

\*Medicare Advantage is a separate program from BlueCard and delivered through its own centrally-administered platform. However, since you might see members of other Blue Plans who have Medicare Advantage coverage, there is a section on Medicare Advantage claims processing in this manual.

# The BlueCard® Program

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## Section 2

### How Does the BlueCard Program Work?

#### How to Identify Members

##### Member ID Cards

When members of out-of-state Blue plans arrive at your office or facility, be sure to ask them for their current Blue plan membership identification card.

The main identifier for out-of-area members is the three-character prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo, for eligible Traditional, HMO, POS or indemnity members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to Blue Shield's PPO provider contract. Please note that EPO products may have limited benefits out-of-area. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

For members having traditional or HMO coverage, you will be reimbursed according to Blue Shield's traditional provider contract. For members who have POS coverage, you will be reimbursed according to Blue Shield's POS provider contract, if you participate in the BlueCard POS voluntary program or you will be reimbursed according to Blue Shield's Traditional provider contract, if you don't participate in the BlueCard POS voluntary program.

Some Blue ID cards don't have any suitcase logo on them. The ID cards for Medicaid, State Children's Health Insurance Programs (SCHIP) if administered as part of State's Medicaid, and Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products. While Blue Shield routes these claims for out-of-area members to the member's Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's Blue Plan via the established electronic crossover process.

## How to Identify Members *(cont'd.)*

### Member ID Cards *(cont'd.)*

Important facts concerning member IDs:

- A correct member ID includes the three-character prefix (first three positions) and all subsequent characters, up to a total of 17 positions. This means that you may see cards with IDs between 6 and 14 numbers or letters following the prefix.
- Do not add or delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- The three-character prefix is critical for the electronic routing of specific HIPAA-compliant transactions to the appropriate Blue plan.
- Members who are part of the Federal Employee Program (FEP) will have the letter "R" in front of their member ID. FEP claims are not processed by the BlueCard Program. Providers are required to submit claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Mail hard-copy FEP professional claims that require medical records to the FEP claims unit at P. O. Box 272510, Chico, CA 95927-2510.
- Note that most out-of-state Blue plan member ID cards have plan names that begin with "Blue Cross Blue Shield" brand names and identifies the state where members receive coverage. However, some Blue plans have unique plan names that do not begin with "Blue Cross Blue Shield" branding and do not identify the state where the member receives coverage. Nevertheless, you can submit BlueCard claims to Blue Shield for members whose ID cards have unique Blue plan names. For a current list of the unique Blue plan names, email [BlueCardMarketing@blueshieldca.com](mailto:BlueCardMarketing@blueshieldca.com).

Examples of member IDs:

A2A1234567



Prefix

ABC1234H567



Prefix

2A212345678901234



Prefix

# The BlueCard® Program

## How to Identify Members (cont'd.)

### Three-Character Prefix

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

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

Do not assume that the member's ID is the Social Security number. All Blue plans have replaced Social Security numbers on member ID cards with a unique, alternative identifier.

A correct member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 characters following the prefix. Three-character prefix may contain a mix of alpha and numeric characters.

As a provider serving out-of-state Blue Plan members, you may find the following tips helpful:

- Ask the member for his or her most current Blue ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in your patient's file.
- Verify with the member that the ID on the card is not his or her Social Security number. If it is, call the BlueCard® Eligibility line at (800) 676-BLUE to verify the ID.
- Member IDs must be reported exactly as shown in the ID card and must not be changed or altered. Do not add or omit any characters from the member ID.
- Blue plan member ID cards are formatted to reflect brand guidelines established by the Blue Cross and Blue Shield Association. The ID cards are designed to make it easier for members and providers to find information they need. Design elements include:
  - Easier-to-read member information featured on the front of the card.
  - A single toll-free provider phone number for provider customer service, hospital pre-admission or pre-authorization information and prescription processing information for pharmacists, listed together on the back of the card.
  - The Blue plan's Web URL and mailing instructions for medical claims that require attachments are included on the back of the card.



The three-character prefix.

The "PPO in a suitcase" logo may appear in the lower right corner of the I.D. card.

Note: ID card samples are not the actual depiction of cards; they show the general look and feel for the brand guidelines from the Association.

## How to Identify Members *(cont'd.)*

### BlueCard PPO Basic ID Cards

Verifying Blue patients' benefits and eligibility is now more important than ever since new products and benefit types have entered the market, due to the Affordable Care Act. In addition to patients who have traditional Blue PPO, HMO, POS, or other coverage, you may now see patients who have a BlueCard PPO Basic product.

When you see the "PPOB in a suitcase" logo on the front of the member's ID card, it means the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

Currently, Blue Shield does not offer a BlueCard PPO Basic network to members. However, you may see patients with BlueCard PPO Basic coverage by an out-of-state Blue Plan. Providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California.

### Sample of BlueCard PPO Basic Member ID Card

	<b>BlueCross BlueShield of Geography</b>	<b>Blue Product</b>	<b>ALPHA</b> <small>Employer Group</small>
Member Name <b>Member Name</b>	Dependents <b>Dependent One</b>		
Member ID <b>XYZ123456789</b>	<b>Dependent Two</b>		
	<b>Dependent Three</b>		
Group No. <b>023457</b>	Plan <b>PPO</b>		
BIN <b>987654</b>	Office Visit <b>\$15</b>		
Benefit Plan <b>HIOPT</b>	Specialist Copay <b>\$15</b>		
Effective Date <b>00/00/00</b>	Emergency <b>\$75</b>		
Plan Code <b>123</b>	Deductible <b>\$50</b>		
 			

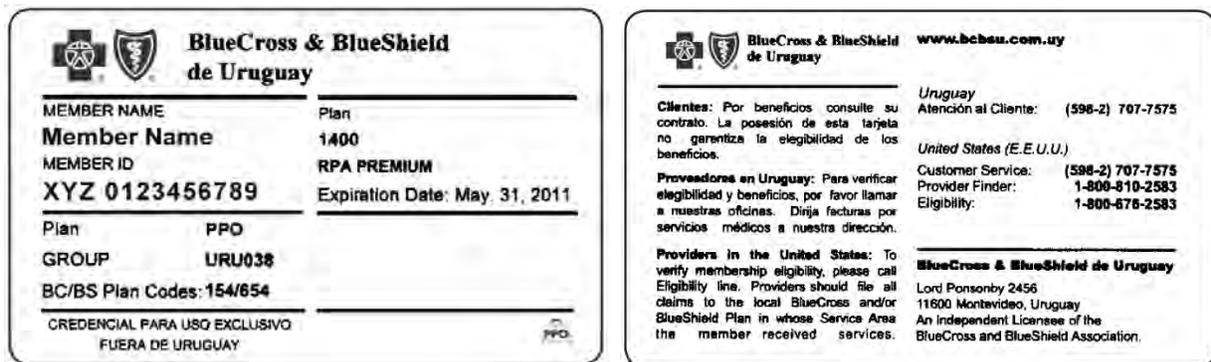
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## How to Identify Members (cont'd.)

### How to Identify International Blue Plan Members

Occasionally, you may see identification cards that are from members of International Licensees or that are for international-based products. Currently those Licensees include Blue Cross Blue Shield of the U.S. Virgin Islands, BlueCross & BlueShield of Uruguay, Blue Cross and Blue Shield of Panama, and Blue Cross Blue Shield of Costa Rica, and those products include those provided through Blue Shield Global Core and the Blue Cross Blue Shield Global™ portfolio. Always check with Blue Shield of California as the list of International Licensees and products may change. ID cards from these Licensees and for these products will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and electronically submit their claims to Blue Shield of California. See below for sample ID cards for international members and products.

#### Example of an ID card from an International Licensee:



#### Examples of ID cards for International Products

##### Illustration A – Blue Cross Blue Shield Global portfolio:



## How to Identify Members (cont'd.)

### Illustration B – Shield-only ID Card:

*Please Note:* In certain territories, including Hong Kong and the United Arab Emirates, Blue Cross branded products are not available. The ID cards of members in these territories will display the Blue Shield Global logo (see example below):

		<a href="http://www.bupaglobalaccess.com">www.bupaglobalaccess.com</a>	
Member Name:	Employer Group Name:	U.S. Customer Service	+1 786-257-4741
Member ID:	Employer Group No.:	U.S. Customer Service Toll Free	+1 844-369-3797
Rx Group No.		Providers Inquiries & Precertification	+1 844-369-3099
BIN		Evacuation/Repatriation (if included):	+44 1273 333911
PCN:		Prescription/Pharmacy Information and Pharmacy Help Desk	+1 855-767-1864
		Members: See benefit booklet for services covered by your plan. Possession of this card does not guarantee eligibility for benefits.	
		Underwritten by Bupa or its Designated Affiliate, independent licensees of the Blue Cross Blue Shield Association.	
		Blue Shield Global is a brand owned by BCBSA.	
		Process claims through Pharmacy Data Management (PDMI).	
		U.S. Service Center Palmetto Bay Village Center 17901 Old Cutler Road, Suite#400 Palmetto Bay, FL 33157 Email: <a href="mailto:info@bupaglobalaccess.com">info@bupaglobalaccess.com</a>	
		 Pharmacy benefits administrator.	

### Canadian ID Cards

*Please Note:* The Canadian Association of Blue Cross Plans and its member plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member Plans in the United States.

You may occasionally see ID cards for people who are covered by a Canadian Blue Cross plan. Claims for Canadian Blue Cross plan members are not processed through the BlueCard® Program.

Please follow the instructions of the Blue Cross plans in Canada and those, if any, on the ID cards for servicing their members. The Blue Cross plans in Canada are:

Alberta Blue Cross	Ontario Blue Cross	Quebec Blue Cross
Manitoba Blue Cross	Pacific Blue Cross	Saskatchewan Blue Cross
Medavie Blue Cross		

Source: <http://www.bluecross.ca/en/contact.html>

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## How to Identify Members (cont'd.)

### Consumer Directed Health Care and Healthcare Debit Cards

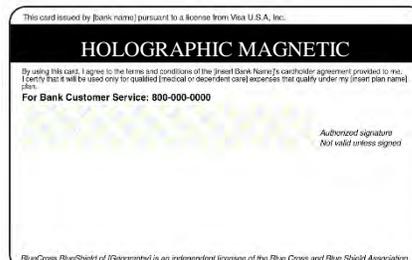
Consumer Directed Health Care (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. Health plans that offer CDHC plans provide the member with additional information to make an informed and appropriate healthcare decision using member support tools, provider and network information, and financial incentives. Members who have CDHC plans often carry healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangements (HRA), Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA). All three are types of tax favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some cards are “stand-alone” debit cards to cover out-of-pocket costs, while others also serve as a member ID card with the member ID number. These debit cards can help you simplify your administration process and can potentially help:

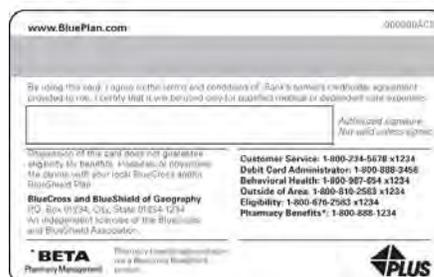
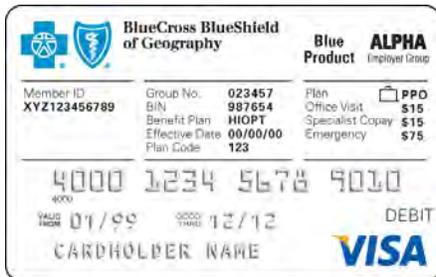
- Reduce bad debt
- Reduce paper work for billing statements
- Minimize bookkeeping and patient-account functions for handling cash and checks
- Avoid unnecessary claim payment delays

In some cases, the card will have the nationally recognized Blue logos, along with the logo from a major debit card organization such as MasterCard® or Visa®.

### Sample of Stand-Alone Healthcare Debit Card



### Sample of Combined Healthcare Debit Card and Member ID Card



## How to Identify Members *(cont'd.)*

### Consumer Directed Health Care and Healthcare Debit Cards *(cont'd.)*

The cards include a magnetic strip so providers can swipe the card at the point of service to collect the member copayment. With the healthcare debit cards members can pay for copayments and other out-of-pocket expenses by swiping the card through any provider's debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

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

### Limited Benefit Products

Verifying Blue plan patients' benefits and eligibility is now more important than ever, since new products and benefit types entered the market. In addition to patients who have traditional Blue PPO, HMO, POS or other coverage, typically with high lifetime coverage limits (i.e., \$1 million or more), you may now see Blue plan patients whose annual benefits are limited to \$50,000 or less.

Currently, Blue Shield does not offer such limited benefit plans to our members. However, you may see patients with limited benefits who are covered by an out-of-state Blue Plan.

#### How to recognize members with limited benefits products

Members with Blue limited benefits coverage (that is, annual benefits limited to \$50,000 or less) carry ID cards that may have one or more of the following indicators:

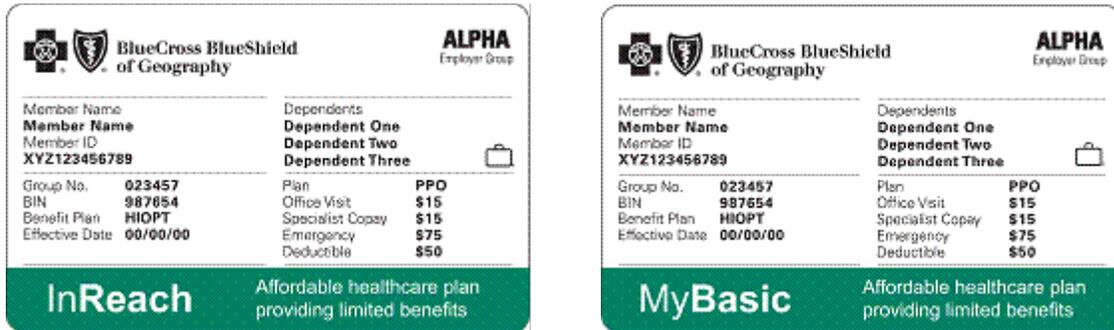
- Product name will be listed such as **InReach** or **MyBasic**
- A **green stripe** at the bottom of the card
- A statement either on the front or the back of the ID card stating this is a limited benefits product
- A **black cross and/or shield** to help differentiate it from other identification cards

# The BlueCard® Program

## How to Identify Members (cont'd.)

### Limited Benefit Products (cont'd.)

These ID cards may look like this:



### How to find out if the patient has limited benefit coverage

In addition to obtaining a copy of the patient's ID card and regardless of the benefit product type, we recommend that you verify patient's benefits and eligibility and collect any patient liability or copayment only. You may do so electronically by submitting an eligibility inquiry to Blue Shield at [blueshieldca.com/provider](http://blueshieldca.com/provider) or by calling BlueCard® Eligibility at (800) 676-BLUE (2583).

You will receive the patient's accumulated benefits to help you understand the remaining benefits left for the member. If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability he or she might have.

### What to do if the patient's benefits are exhausted before the end of their treatment

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatment might be member's liability. We recommend that you inform patients of any potential liability they might have as soon as possible.

## How to Identify Members *(cont'd.)*

### Helpful Tips

- Carefully determine the member's financial responsibility before processing payment. You can access the member's accumulated deductible by logging onto [blueshieldca.com/provider](https://blueshieldca.com/provider) or by calling the BlueCard® *Eligibility* line at (800) 676-BLUE (2583).
- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including three-character prefix) and avoid unnecessary claims payment delays.
- If the member presents a debit card (stand-alone or combined), be sure to verify the out-of-pocket amounts before processing payment:
  - Many plans offer well care services that are payable under the basic healthcare program. If you have any questions about the member's benefits or to request accumulated deductible information, please log onto [blueshieldca.com/provider](https://blueshieldca.com/provider) or call the BlueCard® *Eligibility* line at (800) 676-BLUE (2583).
  - You may use the debit card for member responsibility for medical services provided in your office.
  - You may choose to forego using the debit card and submit the claims to Blue Shield for processing. The Remittance Advice will inform you of member responsibilities.
  - All services, regardless of whether or not you've collected the member responsibility at the time of service, must be filed to Blue Shield for proper benefit determination and to update the members' claim history.
- Check eligibility and benefits electronically by logging onto Provider Connection at [blueshieldca.com/provider](https://blueshieldca.com/provider) or by calling (800) 676-BLUE (2583) and providing the three-character prefix. Additional features were added to all BlueCard eligibility and benefits search results. Online eligibility and benefits results for out-of-state Blue plan members also include the following elements:
  - Other payor information, if the member has other insurance
  - An authorization indicator, if authorization or referral is required
  - Pre-existing condition information, if applicable
  - Accumulated year-to-date deductible amounts
  - Accumulated year-to-date out-of-pocket costs
  - Accumulated year-to-date benefit maximum amounts
  - Accumulated year-to-date individual lifetime maximum amounts
- Please do not use the debit card to process full payment up front. If you have any questions about the member's benefits, log onto [blueshieldca.com/provider](https://blueshieldca.com/provider) to perform a BlueCard eligibility and benefits search, or call (800) 676-BLUE (2583). For questions about the debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

# The BlueCard® Program

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## Coverage and Eligibility Verification

Provider Connection, our provider website at [blueshieldca.com/provider](http://blueshieldca.com/provider), gives you direct access to current, reliable information for out-of-state Blue Plan members' eligibility, benefits, claims mailing address, and share of cost. You can receive more detailed benefit information when searching for out-of-state BlueCard members' benefits online. Submit an online inquiry about certain benefits you would like more information on, and the benefit information will be returned to you in the Provider Connection Message Center.

You can also verify out-of-state Blue Plan member eligibility, benefits coverage and share of cost information by calling BlueCard *Eligibility*® at (800) 676-BLUE (2583). This automated Voice Response Unit (VRU) will prompt you to provide the three-character prefix and will route your call to the member's Blue Plan.

Keep in mind that Blue plans are located throughout the country and may operate on a different time schedule than Blue Shield. You may be transferred to a voice response system linked to customer enrollment and benefits.

The BlueCard *Eligibility*® line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for determining where to submit your BlueCard claims or for claim status. See the Claim Filing section in this manual for claim filing information.

Blue Shield has created a BlueCard Eligibility and Benefits Verification Guide to help you acquire eligibility and benefits information for out-of-state Blue plan members quickly and efficiently the first time, so you're less likely to encounter issues with denials or delays. A PDF version of the guide is available on Provider Connection for downloading in the "Resources" tab of our BlueCard Program web page. Or if you'd like a printed copy of the guide, email [BlueCardMarketing@blueshieldca.com](mailto:BlueCardMarketing@blueshieldca.com).

## Coordination of Benefits (COB) Information on Blue Plan Members

Coordination of Benefits (COB) refers to how the Blue System ensures that Blue plan members receive full benefits and prevent double payment for services when a Blue plan member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Blue plan member benefit structures vary and state requirements around the collection of other insurance information differ across the country. To reduce the number of BlueCard claims being denied for lack of COB information, new processing standard requirements are in place to limit instances when Blue plans can reject claims for COB investigations.

When you see Blue plan patients who you are aware might have other health insurance coverage (i.e., Medicare, other Blue plan), please keep in mind the following:

- If Blue Shield of California or any other Blue plan is the primary payor, submit the other carrier's name and address with the claim to Blue Shield of California. If you do not include the COB information with the claim, the member's Blue plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.
- If another non-Blue health plan is primary and Blue Shield of California or any other Blue plan is secondary, submit the claim to Blue Shield of California only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

Carefully review the payment information from all payors involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the Blue Shield of California remittance advice as "patient liability" might be different from the actual amount the patient owes you, due to the combination of the primary insurer payment and your negotiated amount with Blue Shield of California.

If you have any questions regarding COB claims processing or payments in relation to Blue plan members, please contact the BlueCard Program Customer Service at (800) 622-0632.

Your involvement is needed to assist in collecting other insurance information from Blue plan members. To avoid claim rejections due to lack of COB information, use the COB Questionnaire to collect information from any Blue plan member who has insurance coverage in addition to his/her out-of-state Blue plan coverage.

When out-of-state Blue plan members state they have other insurance coverage in addition to their out-of-state Blue plan coverage, please perform one of the following:

1. During the patient's visit, request the patient complete and return the COB Questionnaire to you, then mail the completed form on behalf of the patient to Blue Shield to:  
Blue Shield of California, BlueCard Program, P.O. Box 1505, Red Bluff CA 96080
2. During the patient's visit, give the patient a COB Questionnaire with instructions to complete and submit the form to his or her out-of-state Blue plan as soon as possible.

Refer to the COB Questionnaire on the following pages or on [blueshieldca.com/provider](http://blueshieldca.com/provider) under *Guidelines and Resources*, then *Forms*, then *Patient Care Forms*.

# The BlueCard® Program



**BlueCross BlueShield Association**

An Association of Independent Blue Cross and Blue Shield Plans

## Coordination of Benefits Questionnaire

**Provider:** After the policy holder has completed and signed, please forward this form to your local Blue Cross and/or Blue Shield Plan immediately. Do not hold to submit with the claim.

Check here if you will be electronically submitting this to your local BC and/or BS Plan and you have the Policy Holders signature on file.

**Member:** Your Blue Cross and/or Blue Shield contract may contain a Coordination of Benefits (COB) provision. Your Plan depends upon your help in order to process your claims correctly and appreciates your prompt and accurate reply. If any of the information below changes, please contact your Blue Cross and/or Blue Shield Plan immediately.

Provider Name:	NPI (Give Tax ID if no NPI Number):
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Policyholder Name:	
Group Number:	Member ID Number with Three Letter Prefix:

### Section A Other Insurance

Are you or any other member of this Blue Cross and/or Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross and/or Blue Shield policy or Medicare?

- No If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."  
 Yes If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark those that apply:  Other Health Insurance  Other Dental Insurance

What type of policy is this?  Group  Individual Policy  Student Policy  Medicare Supplemental

Other Insurance Carrier's Name

Address

Address	State	Zip	Phone Number
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Dependent(s) listed on the other Insurance

Other Insurance Policyholder's Name	Policyholder's Date of Birth	ID Number
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Effective Date of Other Insurance  If Cancelled, Cancellation Date

- Is the policy holder:  Actively working for the group  Inactive  
 Retired, retirement date: \_\_\_\_\_  On COBRA, which began: \_\_\_\_\_

Policyholder's Employer

Address

City	State	Zip	Phone Number
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# The BlueCard® Program

<b>Section B</b>	<b>Medicare Information</b>
Do the policyholder and/or dependent(s) have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of person(s) with Medicare _____	
Medicare Number, including alpha character(s) _____	
Effective Date of Medicare Part A: _____ Effective date of Medicare Part B: _____	
Medicare Entitlement: <input type="checkbox"/> Yes <input type="checkbox"/> Disability* <input type="checkbox"/> Yes <input type="checkbox"/> End Stage Renal Disease (ESRD)*	
If the reason is for Disability or ESRD, please provide the following:	
1 <sup>st</sup> Date of Disability: _____	
1 <sup>st</sup> Date of Dialysis for ESRD: _____	
Was ESRD started in a facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was ESRD started as Self Dialysis of Home Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has a transplant been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide the date of the transplant: _____	

<b>Section C</b>	<b>Court Order Information</b>
Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
List the name(s) of the dependent(s) that this applies to. _____	
If yes, who is the person(s) listed to maintain health coverage? _____	
What is the relation to the child(ren)? _____	Who has custody of the child(ren) more than 50% of the time? _____
<i>Documentation of the court order may be requested from your Blue Cross and/or Blue Shield Plan</i>	

<b>Section D</b>	<b>Names of Dependent(s) on Blue Cross and/or Blue Shield Policy</b>			
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)

\_\_\_\_\_  
 Policy Holder Signature Date

925-07-371

# The BlueCard® Program

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## Out-of-State Blue Plan Members' Medical Policies and Pre-Certification/Prior Authorization Requirements

On Provider Connection, our provider website, you can now find information to help you treat out-of-state Blue plan members. You can view medical policies and general pre-certification/prior authorization requirements applicable to out-of-state Blue plan members, along with contact information to initiate the pre-certification/prior authorization process.

To access the medical policy and pre-certification/prior authorization requirements, follow the steps below:

1. Log onto [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).
2. Click on “Pre-Service Review for Out-of-area Members” within the *Authorizations* section of the opening landing page.
3. Enter the out-of-state Blue plan member’s three-character prefix, select either the medical policy or the prior authorization button, and then click on “Search.”

This online functionality gives providers easy access to information and provides a valuable supplement to the information you currently receive when verifying out-of-state Blue plan members’ benefits, eligibility and share of costs, directly from the member’s out-of-state Blue plan.

### Prior Authorization

Prior authorization of medical services for out-of-state Blue plan members is provided by the member’s Blue plan. Providers can request authorization for an out-of-state Blue plan member online by using the Electronic Provider Access (EPA) tool. The EPA tool will enable you to use Blue Shield’s provider website to gain secured access to an out-of-area Blue plan’s provider website to request authorization.

To access the EPA tool, log onto Provider Connection at [blueshieldca.com/provider](http://blueshieldca.com/provider) and click on the “Pre-Service Review for Out-of-area Members” within the *Authorizations* section. Choose from the available options to assist in obtaining the necessary information:

- Medical Policy Information – Select this option to obtain medical policy for a service.
- Prior Authorization Information – Select this option to determine if pre-service and pre-authorization is required for a service.
- Electronic Provider Access – Select this option to submit a pre-certification and prior authorization request.

Providers will need the member’s three-character prefix to complete each search. The prefix is the first three characters that precede the member identification number.

## Prior Authorization *(cont'd.)*

By entering a valid prefix, you will then be automatically routed to the member's Blue plan provider portal to begin an authorization request. Please note that each Blue plan's website is customized to their authorization services they offer.

Providers can also contact the member's Blue plan by calling the designated telephone number of the Health Care Services department located on the back of the member's ID card.

The member's Blue plan may contact you directly related to clinical information or to request medical records prior to treatment or for concurrent review or disease management for a specific member.

*Note: Failure to obtain required prior authorization or admission review may result in partial or total benefit denial and/or greater out-of-pocket expenses for Blue plan members. However, obtaining approval is not a guarantee of payment. Participating providers are responsible for obtaining pre-service review/preauthorization for inpatient facility services. In addition, members are held harmless when pre-service review/preauthorization is required and not obtained for inpatient facility services.*

## Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/authorization for outpatient services from their Blue Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (see section entitled Provider Financial Responsibility). In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

Providers must also follow specified timeframes for pre-service review notifications:

1. 48 hours to notify the member's Plan of change in pre-service review; and
2. 72 hours for emergency/urgent pre-service review notification.

General information on pre-certification/preauthorization information can be found on the Out-of-Area Member Medical Policy and Pre-Authorization/Pre-Certification Router at [blueshieldca.com/provider](http://blueshieldca.com/provider) utilizing the three-character prefix found on the member ID card.

When obtaining pre-certification/preauthorization, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to follow-up immediately with a member's Blue Plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

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

# The BlueCard® Program

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## Electronic Provider Access

Electronic Provider Access (EPA) gives providers the ability to access out-of-area member's Blue Plan provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes. EPA enables providers to use their local Blue Plan provider portal to gain access to an out-of-area member's Blue Plan provider portal, through a secure routing mechanism. Once in the Blue Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Blue Plan's local providers.

The availability of EPA varies depending on the capabilities of each Blue Plan. Some Blue Plans have electronic pre-service review for many services, while others do not. The following describes how to use EPA and what to expect when attempting to contact other Blue Plans.

### Using the EPA Tool

Log onto [blueshieldca.com/provider](https://blueshieldca.com/provider) and click on "Pre-Service Review for Out-of-area Members" within the *Authorizations* section. Choose the *Electronic Provider Access* option. You will be asked to enter the three-character prefix from the member's ID card. The prefix is the first three characters that precede the member subscriber identification number. The NPI and location of requesting provider are also required, as is whether or not you're a Blue Shield of California contracted provider. Once those fields have been filled out, click the "Submit" button.

After submitting, you are routed to the member's Blue Plan EPA landing page. This page welcomes you to the out-of-state Blue Plan's portal and indicates that you have left Blue Shield of California's provider portal. The landing page allows you to connect to the available electronic pre-service review processes. Because the screens and functionality of out-of-state Blue Plan pre-service review processes vary widely, other Blue Plans may include instructional documents or e-learning tools on their Blue Plan landing page to provide instruction on how to conduct an electronic pre-service review. The page may also include instructions for conducting pre-service review for services where the electronic function is not available.

The out-of-state Blue Plan landing page looks similar across the Blue Plan system, but will be customized to the particular Blue Plan based on the electronic pre-service review services they offer.

## Provider Financial Responsibility for Pre-Service Review for Blue Plan Members

Blue Shield's participating providers are responsible for obtaining pre-service review for inpatient facility services for BlueCard members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers must also:

- Notify the member's Blue Plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member's Blue Plan for pre-service review or for a change or modification of the pre-service review will result in claim processing delays and potential payment denials for inpatient facility services. The Blue plan member must be held harmless and cannot be balance-billed if pre-service review has not occurred\*.

Pre-service review contact information for a member's Blue Plan is provided on the member's identification card. Pre-service review requirements can also be determined by:

- Using the Electronic Provider Access (EPA) tool available at Blue Shield's provider portal at [blueshieldca.com/provider](http://blueshieldca.com/provider). *Note:* The availability of EPA will vary depending on the capabilities of each member's Blue Plan.
- Submitting an ANSI 278 electronic transaction to Blue Shield or calling (800) 676-BLUE.

Services that deny as not medically necessary remain the member's liability.

If you have any questions on Provider Financial Responsibility or general questions, please call Blue Shield at (800) 622-0632.

*\*Unless the member signed a written consent to be billed prior to rendering service.*

# The BlueCard® Program

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## Medical Records Requests and Processing

Blue Shield is dedicated to achieving a seamless delivery of medical records requests and processing for out-of-state Blue plan members and the providers who serve them.

Medical records related to your out-of-state Blue plan patients may be requested as part of the pre-claim experience, as part of a concurrent review or as part of the BlueCard claim appeal process. It is Blue Shield's responsibility to obtain medical records from our providers at the request of the member's Blue plan. However, in pre-claim situations, the member's Blue plan may directly contact you to request medical records if the member's Blue plan needs the records to make a determination as part of the prior authorization or pre-certification process or in situations that are deemed as an urgent medical need.

Blue Shield performs the following steps to ensure delivery of medical record requests and processing:

- When receiving a medical records request from the member's Blue plan, we verify whether or not the provider has already submitted the records.
- When a member's Blue plan requests medical records, we send the request to our providers within two business days of receipt of the out-of-state Blue plan's request.
- When requesting medical records from a provider, we strive to send concise and specific details to fulfill the request.
- We send medical record requests to the address and department indicated in your provider demographics profile.
- When providers respond to requests and submit medical records to us, we ensure that all records are sent electronically to the member's Blue plan within three business days on their receipt.
- We follow up with the member's Blue plan to ensure that records are reviewed and adjusted in a timely manner.
- We maintain copies or images of all medical records received from providers.

To make the medical records process more efficient, please respond to medical record requests within 10 days of the request.

## Section 3

### Claim Filing

#### Processing BlueCard Claims

Blue Shield processes BlueCard claims for inpatient, outpatient, professional, and ancillary\* services rendered to out-of-state Blue plan members. Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character prefix—do not make up prefixes. Claims with incorrect or missing prefixes and member identification numbers cannot be filed correctly.

*\*Ancillary providers who are Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies, and Specialty Pharmacy providers should file their claims according to the Ancillary Claims Filing Requirements listed further in this document.*

Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Please indicate the member's subscriber ID number, including the three-character prefix, on each electronically submitted claim. If you have any questions about the process or require additional information on electronic claim submission, contact our EDI Help Desk by calling (800) 480-1221 or emailing EDI\_BSC@blueshieldca.com.

You may now submit claims online through clearinghouse vendor Office Ally at <https://cms.officeally.com/Pages/ResourceCenter/Landing/BlueShieldCA.aspx>. Once at the EDI clearinghouse's website, you'll have the option to review the claim submission services offered. To visit Office Ally and for detailed information about electronic submissions, go to Provider Connection at [blueshieldca.com/provider](https://blueshieldca.com/provider) and click on *Claims*.

Mail hard-copy BlueCard claims that require medical records to:

Blue Shield of California  
BlueCard Program  
P. O. Box 1505  
Red Bluff, CA 96080-1505

# The BlueCard® Program

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## BlueCard Claim Tips

After the member of another Blue Plan receives services from you, you should submit the claim to Blue Shield of California. We will work with the member's Blue Plan to process the claim and the member's Blue Plan will send an explanation of benefit (EOB) to the member. We will send you an explanation of payment or remittance advice and applicable payment to you under the terms of our contract with you, and based on the member's benefits and coverage.

Following these helpful tips will improve your claim experience:

- Ask members for their current member ID cards and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including three-character prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider) or by calling (800) 676-BLUE (2583). Be sure to provide the member's three-character prefix.
- Verify the member's cost sharing amount before processing payment. Please do not process full payment upfront as Blue Plan members are responsible for their share of cost, deductible, co-insurance, and non-covered services.
- Indicate any payment you collected from the patient on the claim.
- Submit all BlueCard claims to Blue Shield of California. Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Be sure to include the member's complete subscriber identification number when you submit the claim. This includes the three-character prefix. Submit claims with only valid prefixes; claims with incorrect or missing prefixes and member identification numbers cannot be processed.
- Reduce claim adjustments by double-checking to ensure you've indicated the correct provider Tax ID Number (TIN), Provider Identification Number (PIN) and/or the National Provider Identifier (NPI) number.
- In cases where there is more than one payor and a Blue Plan is a primary payor, submit Other Party Liability (OPL) information with the BlueCard claim. Upon receipt, Blue Shield of California will electronically route the claim to the member's Blue Plan.
- **Do not send duplicate claims.** Sending another claim, or having your billing agency resubmit claims automatically, slows down the claims payment process and creates confusion for the member. Go to Provider Connection at [blueshieldca.com/provider](http://blueshieldca.com/provider) for direct access, 24 hours a day, seven days a week, for current, reliable information on BlueCard claims, payment status and claim reporting tools.
- To avoid denials as duplicates when submitting corrected BlueCard claims, file them after the original claim has finalized. After the original claim is finalized, you may submit the corrected claim electronically by identifying the claim as Type of Bill (XX7).
- If medical records are requested, send them to either the claims address listed on the request letter you received from Blue Shield or to the address that appears in the search results of the Claims Routing Tool or the eligibility and benefits inquiry.

## BlueCard Claim Tips *(cont'd.)*

- Check claims status by contacting Blue Shield of California at [blueshieldca.com/provider](http://blueshieldca.com/provider), contact Blue Shield's dedicated BlueCard Customer Service Unit at (800) 622-0632, or submit an electronic HIPAA 276 transaction to Blue Shield of California.
- You can reduce claim rejects by matching the admit date in Box 12 with the date in Box 6 on the UB 04 claim form. These dates must match for claims processing.
- If you're submitting implant reimbursements with bulk invoices, clearly indicate which implants were used in the service for which you are billing. Submit the manufacturer's invoice instead of the purchase order, unless your contract clearly states that a purchase order may be submitted.
- For implant claims, submit the implant invoice on the first submission with the claim. This will enable Blue Shield to process your claim in full on the first submission rather than processing surgery charges first and then adjusting the claim for the implant charges later.

Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. However, if you mail hard-copy BlueCard claims that require medical records, please consider these paper claim tips:

- Always use an original UB 04 claim form, not a photocopy. Duplicated claim forms often cannot be scanned and can create processing delays and accuracy risks.
- When typing or writing on the UB 04 claim form, avoid typing or writing over the titles of claim boxes.
- You may apply a stamp on the paper claims with clear messages; however, do not cover up key information with the stamp. Attaching a cover sheet to the claim is an acceptable alternative to applying a stamp to the claim form.
- Please type or write in a font size that is large enough so that your message can be clearly read.
- BlueCard hospital exception claims, provider correspondence, and all other BlueCard paper claims are sent to:

Blue Shield of California  
BlueCard Program  
P.O. Box 1505  
Red Bluff, CA 96080-1505

After you have submitted BlueCard claims to Blue Shield, you may obtain status and verify payment information on your BlueCard claims by accessing the *Claims* section on our website at [blueshieldca.com/provider](http://blueshieldca.com/provider). Use this tool as your primary resource for requesting and receiving details and status of BlueCard claim.

If you have remaining questions about your BlueCard claims after accessing the Claims section on our website, download the BlueCard Program claims brochure for facility providers (which is available in the resources tab of the BlueCard Program web page at [blueshieldca.com/bluecard](http://blueshieldca.com/bluecard)), or contact Blue Shield's dedicated BlueCard Customer Service Unit at (800) 622-0632.

# The BlueCard® Program

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## Submitting BlueCard Claims

Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. To determine where to send BlueCard claims, providers may:

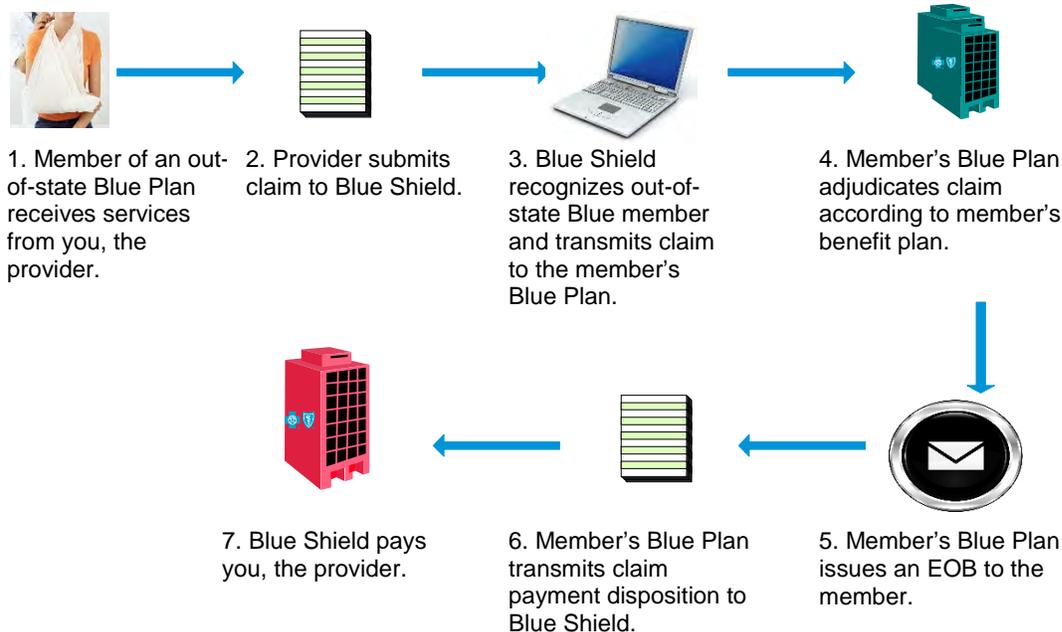
- 1) Access our Claims Routing Tool on Provider Connection at [blueshieldca.com/provider](https://blueshieldca.com/provider), click on “Access Claims Routing Tool” hyper-link within BlueCard Program section of the welcome landing page. Simply enter the member’s three-character prefix and date of service to instantly learn where to send the BlueCard claim.
- 2) Note the claim address and patient benefit information added to the online verification of Eligibility and Benefits search results returned by [blueshieldca.com/provider](https://blueshieldca.com/provider). You’ll find the information you need to correctly send BlueCard claims, as well as local Blue Shield commercial and FEP claims. On the right-hand side of your search results, refer to the appropriate payor information, claims mailing address for medical record attachments, claims unit’s toll-free telephone number and member eligibility toll-free telephone number.
- 3) If and for so long as the hospital or facility is not contracted with another licensee of the Blue Cross Blue Shield Association in the State of California, providers shall submit to Blue Shield for processing all claims for medical services furnished by the hospital or facility and process through the BlueCard Program, unless the member receiving such services is enrolled in a benefit plan having an exclusive arrangement with such other licensee of the Association.
- 4) If and for so long as the hospital or facility is contracted with both Blue Shield and another licensee of the Blue Cross Blue Shield Association in the State of California, and there is no exclusive arrangement with either Blue Shield nor the other license of the Association, the hospital or facility shall use best efforts to increase the number of claims for medical services process through the BlueCard Program (as defined in the Provider Manual) sent to Blue Shield for processing.
- 5) Request a BlueCard routing option from Blue Shield. The BlueCard routing option is a streamlined IT solution developed by Blue Shield that integrates with a provider’s clearinghouse and/or eligibility and benefits verification vendor’s system to simplify and automate selecting the correct California Blue plan for processing BlueCard claims. The BlueCard routing option is an alternative to using Blue Shield’s Claims Routing Tool on Provider Connection. To inquire about the BlueCard routing option, email [BlueCardMarketing@blueshieldca.com](mailto:BlueCardMarketing@blueshieldca.com).

If you have any questions about electronic claims submission, contact our EDI Help Desk at (800) 480-1221, email [EDI\\_BSC@blueshieldca.com](mailto:EDI_BSC@blueshieldca.com), or submit an EDI inquiry online on Provider Connection.

In cases where there is more than one payor and Blue Cross and/or Blue Shield is a primary payor, submit Other Party Liability (OPL) information with the Blue Cross and/or Blue Shield claim. Upon receipt, Blue Shield will electronically route the claim to the member’s Blue plan. The member’s Blue plan then processes the claim and applicable payment. Blue Shield will reimburse you for services.

## Submitting BlueCard Claims *(cont'd.)*

Below is an example of how claims flow through BlueCard



## Traditional Medicare-Related Claims

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is primary payor, submit claims to your local Medicare intermediary.
- All Blue claims are set up to automatically cross-over to the member's Blue Plan after being adjudicated by the Medicare intermediary.

### How do I submit Medicare primary/Blue plan secondary claims?

- For members with Medicare primary coverage and Blue plan secondary coverage, submit the claim first to your Medicare intermediary.
- Be certain that you include the exact name of the secondary plan and the complete subscriber number. The member's Blue plan subscriber number will include the three-character prefix followed by alpha-numeric values.
- When you receive the remittance advice from the Medicare intermediary, verify whether the claim has been automatically forwarded (crossed over) to the secondary payor (Blue plan). If the Medicare remittance advice indicates the claim has been crossed over, it means that Medicare has forwarded the claim, on your behalf, to the appropriate secondary plan for processing. There is no need for you to resubmit the claim to the Blue plan.

# The BlueCard® Program

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## Traditional Medicare-Related Claims *(cont'd.)*

### When should I expect to receive payment?

The Medicare intermediary will process and cross over the claim within about 14 business days. This means that the Medicare intermediary will be forwarding the claim to the secondary Blue plan on approximately the same date you receive the Medicare remittance advice. Please allow up to 30 additional calendar days before expecting payment or instructions regarding the secondary processing of the claim.

### What should I do if I have not received a Medicare remittance advice and/or payment for the claim?

If you submitted the claim to the Medicare intermediary and you have not received a response to your initial claim submission, do not automatically submit another claim to the secondary Blue plan. Instead, please take the following steps:

- Confirm that the Medicare intermediary received the claim and resend it to the Medicare intermediary only if it was not initially received.
- Wait until you receive the Medicare remittance advice for the claim.
- Wait an additional 30 calendar days after you receive the remittance advice to receive payment or instructions from the Blue plan regarding secondary coverage processing.
- If, after 30 calendar days, you have not received payment or instructions from the Blue plan regarding secondary claim processing, we recommend that you submit a secondary claim, including complete Medicare adjudication information, to the local Blue plan, as appropriate.

To avoid having your claim denied by the Blue plan as a duplicate, do not submit a secondary claim to the local Blue plan before taking each of the steps described above.

### Whom should I contact if I have questions?

If Blue Shield is the secondary healthcare coverage carrier for the patient, please contact us using the following information:

- Online at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider)
- Provider Customer Service, by telephone at (800) 541-6652
- By postal mail at Blue Shield of California, P.O. Box 272540, Chico, CA 95927-2540

If the patient's secondary plan is a Blue plan in a state other than California, please contact us using the following information:

- BlueCard Provider Customer Service, by telephone at (800) 622-0632
- By postal mail at BlueCard Claims, P.O. Box 1505, Red Bluff, CA 96080-1505

## Claims Filing for Air Ambulance Services for BlueCard Patients

Generally, as a healthcare provider you should file claims for your Blue Cross and Blue Shield patients to the local Blue Plan. However, there are unique circumstances when claims filing directions will differ based on the type of service rendered.

Claims for air ambulance services must be filed to the Blue Plan in whose service area the point of pickup ZIP code is located.

Note: If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

Service Rendered	How to File (Required Fields)	Where to File	Example
<b>Air Ambulance Services</b>	<p><b>Point of Pickup ZIP Code:</b></p> <ul style="list-style-type: none"> <li>▪ Populate item 23 on CMS 1500 Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup.</li> <li>▪ For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional.</li> <li>▪ Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual.</li> <li>▪ Form Locators (FL) 39-41.</li> <li>▪ Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee.</li> <li>▪ Value: Five digit ZIP code of the location from which the beneficiary is initially placed on board the ambulance.</li> <li>▪ For electronic claims, populate the origin information (ZIP code of the point of pick-up) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional.</li> </ul>	<p>File the claim to the Plan in whose service area the point of pickup ZIP code is located*.</p> <p>*BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.</p>	<ol style="list-style-type: none"> <li>1. The point of pick up ZIP code is in Plan A service area.</li> <li>2. The claim must be filed to Plan A, based on the point of pickup ZIP code.</li> </ol>

If you have questions about the claims filing for Air Ambulance Services for an out-of-state Blue plan member, please contact Blue Shield's BlueCard Customer Service Unit at (800) 622-0632.

# The BlueCard® Program

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## Medical Records

Blue Plans around the country have made improvements to the medical records process to make it more efficient. We now are able to send and receive medical records electronically among each other. This new method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

### Under what circumstances may the provider get requests for medical records for out-of-area members?

- **As part of the pre-authorization process** - If you receive requests for medical records from the member's Blue Plan prior to rendering services, as part of the pre-authorization process, you will be instructed to submit the records directly to the member's Blue Plan that requested them. This is the only circumstance where you would not submit them to Blue Shield.
- **As part of claim review and adjudication** - These requests will come from Blue Shield in a form of a letter requesting specific medical records and including instructions for submission.

### BlueCard Medical Record Process for Claim Review

- An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.
- A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact Blue Shield's dedicated BlueCard Customer Service team at (800) 622-0632 to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.
- If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact Blue Shield's dedicated BlueCard Customer Service team at (800) 622-0632 to determine if the records are needed from your office.
- Upon receipt of the information, the claim will be reviewed to determine the benefits.

### Helpful Ways You Can Assist in Timely Processing of Medical Records

- If the records are requested following submission of the claim, forward all requested medical records to Blue Shield's dedicated BlueCard Customer Service team at: Blue Shield of California, BlueCard Program, P. O. Box 1505, Red Bluff, CA 96080-1505.
- Follow the submission instructions given on the request, using the specified address, email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
- Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Blue Shield.
- Please submit the information to Blue Shield within 10 days of the request to avoid further delay.
- Only send the information specifically requested. Frequently, complete medical records are not necessary.
- Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

## Claims Coding

Code claims as you would for Blue Shield claims. Please refer to Section 4: Billing and Payment for further claim billing information and requirements.

## Claim Payment and Claim Status Inquiries

Blue Shield processes BlueCard claims in accordance to our contract agreement with you. Providers are required to receive claims payments electronically through direct deposit of funds into a provider's designated bank account. Providers are also required to receive Electronic Remittance Advice (ERA) files or view Explanation of Payment (EOP) using the Blue Shield provider portal unless the provider contract specifically states otherwise.

Go to Provider Connection at [blueshieldca.com/provider](https://blueshieldca.com/provider) 24 hours a day, seven days a week for current, reliable information on BlueCard claims, payment status, and claim reporting tools.

To obtain status and verify payment information on your BlueCard claims, access the *Claims* section on [blueshieldca.com/provider](https://blueshieldca.com/provider). Use this tool as your primary resource for requesting and receiving details on BlueCard claims.

If you have remaining questions about your BlueCard claims after accessing the *Claims* section on our website, contact Blue Shield's dedicated BlueCard Customer Service Unit at (800) 622-0632.

## Calls from Members and Others with Claim Questions

If Blue Plan members contact you, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

The member's Blue Plan should not contact you directly regarding claims issues, but if the member's Blue Plan contacts you and asks you to submit the claim to them, refer them to Blue Shield of California.

## Value Based Provider Arrangements

Plans have value-based care delivery arrangements in place with their providers. Each Plan has created their own arrangement with their provider(s), including reimbursement arrangements. Due to the unique nature of each Plan/provider arrangement, there is no common provider education template for value-based care delivery arrangements that can be created and distributed for use by all Plans.

## Claim Adjustments

Contact Blue Shield BlueCard Customer Service team at (800) 622-0632 if an adjustment is required.

## Provider Claim Appeals

Provider claim appeals for all BlueCard claims processed by Blue Shield are handled through Blue Shield. BlueCard claim appeals must be resolved within a 30-day timeframe. We will coordinate the appeal process with the member's Blue Plan, if needed. For more information on the BlueCard claim appeal process, contact our BlueCard dedicated Customer Service Unit at (800) 622-0632.

# The BlueCard® Program

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## Section 4 BlueCard Resources

### Claims Routing Tool

Determining where to submit BlueCard claims is the number one question providers ask about BlueCard claims. To find out which California Blue plan can process your BlueCard claim, access our Claims Routing Tool on Provider Connection at [blueshieldca.com/provider](http://blueshieldca.com/provider) and click on the *Access Claims Routing Tool* link within the *BlueCard Program* section. Simply enter the member's three-character prefix and date of service to instantly learn where to send your BlueCard claim.

### BlueCard Program Tutorials

Access our online BlueCard Program tutorials and quickly learn about our online tools. BlueCard tutorials are available anytime, 24 hours a day, 7 days a week. Select the topics you want to learn about, whenever it's convenient for you.

The tutorials will help you learn how to:

- Verify eligibility and benefits
- Access other Blue plans' medical policies, pre-certification guidelines and request medical authorizations
- Instantly determine where to submit claims with the Claims Routing Tool
- Check claims status, payment details and EOB's
- Get help on Medicare secondary claims involving out-of-state Blue plans

Log into Provider Connection at [blueshieldca.com/provider](http://blueshieldca.com/provider), click on the *BlueCard Program* link. Then choose from a variety of tutorial modules offered.

### BlueCard Program Webinars

We offer complimentary online BlueCard Program training sessions to give providers detailed information about serving other states' Blue plan members and processing out-of-state Blue plan claims.

We conduct monthly BlueCard Basics training as well as quarterly online training sessions on a wide variety of BlueCard topics. To attend one of our webinars, access our *Webinars* tab in the BlueCard Program web page on Provider Connection for the date, time, topic and type of provider whom the webinar is intended. You can also register for available BlueCard webinars by accessing *News & Education* on Provider Connection's opening landing page and clicking on the *Register for Webinars* link. To receive notification about BlueCard webinars, request more information by emailing [BlueCardMarketing@blueshieldca.com](mailto:BlueCardMarketing@blueshieldca.com).

### BlueCard Program Educational Resources

A wide variety of BlueCard educational flyers, brochures, and training videos are available on our BlueCard Program web page on Provider Connection. The BlueCard educational materials are also available in the *News & Education* link.

## Section 5

### Medicare Advantage

#### Medicare Advantage Overview

“Medicare Advantage” (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as “traditional Medicare”). It offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans. All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

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

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

#### Types of Medicare Advantage Plans

##### Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by Medicare Advantage plan.

##### Medicare Advantage POS

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

##### Medicare Advantage PPO

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

# The BlueCard® Program

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## Types of Medicare Advantage Plans *(cont'd.)*

### Medicare Advantage PFFS

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

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

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

- You can see and treat any Medicare Advantage PFFS member without having a contract with Blue Shield.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan.
- Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.
- MA PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield Plan and we advise that you review them before servicing MA PFFS members.
- You can determine the Terms and Conditions related to a members' Medicare Advantage Plan by accessing the Medicare Advantage Plan Terms and Conditions Lookup Tool located under the "BlueCard Resources" link on the BlueCard Program page at [blueshieldca.com/provider](http://blueshieldca.com/provider). To use the tool, enter the first three characters of the member's identification number on the Blue Cross Blue Shield Medicare Advantage PFFS card and click "GO" to view the BCBS Medicare Advantage PFFS Plan's Terms & Conditions.
- Submit your MA PFFS claims to Blue Shield.

### Medicare Advantage Medical Savings Account (MSA)

A Medicare Advantage MSA plan is made up of two parts. One part is the Medicare Medical Savings Account (MSA) which is a type of savings account for members to pay for qualified medical expenses. The other part is the Medicare MSA Health Policy that is a special health insurance policy with a high deductible. Qualified medical expenses are services and products that otherwise could be deducted as medical expenses on the member's annual tax return, which includes but is not limited to doctor visits, hospital stays, dental exams and medical equipment. The Blue Plan calculates the amount and the Medicare program deposits the funds into the member's savings account. Savings balances accumulate interest or dividends tax free until spent and as long as the member spends the funds on qualified medical expenses, the money is tax free to the member.

## Types of Medicare Advantage Plans *(cont'd.)*

### Medicare Advantage SNP

A Medicare Advantage SNP allows a Medicare Advantage organization to offer benefit plans targeted to special needs populations and limit enrollment to only members with the special needs. Many MA organizations target Medicare populations with special needs defined by the presence of certain chronic diseases. For example, a SNP may only provide coverage for members with cardiovascular disease or members who have diabetes. Unlike other Medicare Advantage Plans, SNPs must provide Medicare prescription drug coverage. Medical Advantage SNPs also may target enrollment to dual-eligibles and to beneficiaries residing in institutions.

## How to Recognize Medicare Advantage Members

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

<p><i>Member ID cards for Medicare Advantage products will display one of the benefit product logos shown here:</i></p>		Health Maintenance Organization
		Medical Savings Account
		Private Fee-For-Service
		Point of Service
		Network Sharing Preferred Provider Organization

When these logos are displayed on the front of a member's ID card, it indicates the coverage type the member has in his/her Blue Plan service area or region. However, when the member receives services outside his/her Blue Plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

Blue Shield of California participates in Medicare Advantage PPO Network Sharing arrangements, and contracted provider reimbursement is based on the contracted rate with Blue Shield of California. Non-contracted provider reimbursement is the Medicare allowed amount based on where services are rendered.

*Tip: While all MA PPO members have suitcases on their ID cards, some have limited benefits outside of their primary carrier's service area. Providers should refer to the back the member's ID card for language indicating such restrictions apply.*

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## Eligibility Verification

Verify eligibility by contacting Medicare Member Services at **(800) 676-BLUE (2583)** and providing the member's prefix or by submitting an electronic inquiry to Blue Shield and providing the member's prefix. Be sure to ask if Medicare Advantage benefits apply. If you experience difficulty obtaining eligibility information, please record the prefix and report it to Blue Shield.

## Medicare Advantage Claims Submission

Submit all Medicare Advantage claims to Blue Shield. Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a Blue Plan.

## Reimbursement for Medicare Advantage PPO, HMO and POS

### **No Plan Contract: Services for out-of-area and local Medicare Advantage members**

Based upon the Centers for Medicare & Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue plan, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Special payment rules apply to hospitals and certain other entities (such as skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

*Note: Enrollee payment responsibilities can include more than copayments (e.g., deductibles). Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.*

### **Plan Contract: Services for local Blue Medicare Advantage members**

If you are a provider who accepts Medicare assignment and you render services to a local Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue Plan, you will be considered a contracted provider and be reimbursed per the contractual agreement.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

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

### **Plan Contract: Services for out-of-area Medicare Advantage Blue members**

If you are a provider who accepts Medicare assignment, has a Blue Plan contract to provide services for local Medicare Advantage enrollees only, and you render services to out-of-area Blue Medicare Advantage members, you will be reimbursed at the Medicare allowed amount (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

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

# The BlueCard® Program

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## Reimbursement for Medicare Advantage Private Fee-For-Service (PFFS)

### **Plan Contract: Services for local Medicare Advantage PFFS member**

If you are a provider who accepts Medicare assignment and you render services to a PFFS local Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue Plan, you will generally be considered a contracted provider and be reimbursed per the contractual agreement. This amount may be less than your charge amount.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, but may be able to balance bill the member in certain limited instances where the Blue plan with which you contract expressly allows for balancing billing of PFFS members.

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

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

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

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

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

## Medicare Advantage Network Sharing

### What is BCBS Medicare Advantage PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO Blue Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted Medicare Advantage PPO provider. Medicare Advantage PPO shared networks are available in 35 states and one territory:

Alabama	Arkansas	California	Colorado
Connecticut	Florida	Georgia	Hawaii
Idaho	Illinois*	Indiana	Kentucky
Maine	Massachusetts	Michigan	Missouri
Montana	North Carolina	Nevada	New Hampshire
New Jersey	New Mexico	New York	Ohio
Oklahoma	Oregon	Pennsylvania	Puerto Rico
South Carolina	Tennessee	Texas	Utah
Virginia	Washington	Wisconsin	West Virginia

### What does the BCBS Medicare Advantage PPO Network Sharing mean to me?

There is no change from your current practice. You should continue to verify eligibility and bill for services as you currently do for any out-of-area Blue Medicare Advantage member you agree to treat. Benefits will be based on the Medicare allowed amount for covered services and be paid under the member's out-of-network benefits unless for urgent or emergency care. Once you submit the MA claim, Blue Shield will send you payment.

When the logo is displayed on the front of a member's ID card, it indicates the coverage type the member has in his/her Blue Plan service area or region. However, when the member receives services outside his/her Blue Plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

### Do I have to provide services to these Medicare Advantage PPO network sharing members or other Blue MA members from out-of-area?

If you are a contracted Medicare Advantage PPO provider with Blue Shield of California, you must provide the same access to care as you do for local members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other Blue Plans but you are not required to do so. Should you decide to provide services to Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

If you choose to provide services to a Blue Private-Fee-for-Service (PFFS) member (as a "deemed" provider), you will be reimbursed for covered services at the Medicare allowed amount, as outlined in the Plan's PFFS Terms and Conditions.

# The BlueCard® Program

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## Medicare Advantage Network Sharing *(cont'd.)*

### What if my practice is closed to new local Blue Medicare Advantage PPO members?

If your practice is closed to new local Blue MA PPO members, you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

### If I chose to provide services, how do I verify benefits and eligibility?

Call BlueCard *Eligibility*® at (800) 676-BLUE (2583) and provide the member's three-character prefix located on the ID card. You may also submit electronic eligibility requests for Blue members, following these three easy steps:

1. Log in to Provider Connection at [blueshieldca.com/provider](https://blueshieldca.com/provider).
2. Click on the *Eligibility & Benefits* tab at the top of the web page and enter the required data fields to verify member eligibility.
3. Submit your request online.

### Where do I submit the claim?

You should submit the claim to Blue Shield under your current billing practices. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

### What can I expect for reimbursement?

Benefits will be based on the Medicare allowed amount when providing covered services to any Blue Medicare Advantage out-of-area members. Once you submit the MA claim, Blue Shield will send you the payment. These services will be paid under the members out-of-network benefits, unless services were for urgent or emergency care.

### What is the member cost sharing level and copayments?

Any MA PPO members from out-of-area will pay the out-of-network cost sharing amount. You may collect the copayment amounts from the member at the time of service.

### May I request payment upfront?

Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, copayment, coinsurance, and non-covered services).

Under certain circumstances, when the member has been notified in advance that a service will not be covered, you may request payment from the member before services are rendered or billed to the member. The member should sign an Advance Benefit Notification (ABN) form before services are rendered in these situations.

### May I balance bill the member the difference in my charge and the allowance?

No. You may not balance bill the member for this difference. Members may be balanced billed for any deductibles, co-insurance, and/or copays.

### What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact Blue Shield at (800) 622-0632.

## Section 6

### Health Insurance Marketplaces (Exchanges)

#### Health Insurance Marketplaces Overview

The Patient Protection and Affordable Care Act of 2010 provides for the establishment of Health Insurance Marketplaces (i.e. Exchanges), in each state, where individuals and small businesses can purchase qualified insurance coverage through internet websites. The intent of the Marketplace is to:

1. Create a more organized and competitive health insurance marketplace by offering consumers a choice of health insurance plans,
2. Establish common rules regarding insurance offerings and pricing,
3. Provide information to help consumers better understand the options available to them and,
4. Allow individual and small businesses to have the purchasing power comparable to that of large businesses.

The Marketplaces makes it easier for consumers to compare health insurance plans by providing transparent information about health insurance plan provisions such as product information, premium costs, and covered benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.

Each state is given the option to set-up its own "state-based" Marketplace approved by HHS for marketing products to individual consumers and small businesses. If states do not set up a state-based marketplace, the Department of Health and Human Services (HHS) establishes a federally-facilitated Marketplace, federally-supported Marketplace, or a state-partnership Marketplace in the state. Blue Plans that offer products on the Marketplaces collaborate with the state and federal governments for eligibility, enrollment, reconciliation, and other operations to ensure that consumers can seamlessly enroll in individual and small business health insurance products. Blue Shield of California has on-Exchange state-subsidized plans available for purchase through Covered California. Information on Covered California plans offered by Blue Shield can be accessed through Provider Connection at [blueshieldca.com/provider](http://blueshieldca.com/provider). Click on the *Health Care Reform for Providers* link in the *Guidelines & Resources* tab.

#### OPM Multi-State Plan Program

Under the Affordable Care Act of 2010, the Office of Personnel Management (OPM) was required to offer OPM sponsored products on the Marketplaces beginning in 2014. For a coverage effective date of Jan. 1, 2017, Blue Cross and Blue Shield Plans will participate in this program by offering these Multi-State Plans on Marketplaces in 21 states.

For 2017, the following Plans will offer Multi-State Plan products: ARBCBS, HCSC (IL, TX, OK, and MT), BCBSAL, BCBSM, BCBSM, and Anthem (CA, CO, CT, GA, IN, KY, ME, MO, NV, NH, NY, VA, and WI).

The Multi-State Plan products are similar to other Qualified Health Plan products offered on the Marketplaces. Generally, all of the same requirements that apply to other state Marketplace products also apply to these Multi-State Plan products.

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## Health Insurance Marketplaces Overview *(cont'd.)*

### Exchange-Purchased Plans - Individual Grace Period

The Patient Protection and Affordable Care Act (PPACA) mandates a three month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue Plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally mandated individual grace period, providers may receive a notification from Blue Shield of California indicating that the member is in the grace period.

#### Exchange Individual Grace Period – Post Service Notification Letter to Provider

Communication to providers will include the following information:

*1. Notice-unique identification number (claim includes member information):*

Claim #: \_\_\_\_\_

*2. Name of the QHP and affiliated issuer (Home Plan name):*

*3. Explanation of the three month grace period:*

Under the Patient Protection and Affordable Care Act (PPACA), there is a three month grace period under Exchange-purchased individual insurance policies, when a premium due is not received for members eligible for premium subsidies. During this grace period, carriers may not disenroll members and, during the second and third months of the grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid.

*4. Purpose of the notice, applicable dates of whether the enrollee is in the second or third month of the grace period & individuals affected under the policy and possibly under care of the provider:*

Please be advised that a premium due has not been received for this subsidy eligible member and that the member and any eligible dependents are and at the time that your care was provided, were in the second or third month of the Exchange individual health insurance grace period. The above-referenced claim thus was pended due to non-payment of premium, and will be denied if the premium is not paid by the end of the grace period.

*5. Consequences:*

If the premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.

*6. QHP customer service telephone number:*

Please feel free to contact Blue Shield of California, Monday through Friday, at our Provider Customer Service Unit at (800) 541-6652 if you have any questions regarding this claim.

## Health Insurance Marketplaces Overview *(cont'd.)*

### Health Insurance Marketplaces Claims

The products offered on the Marketplaces will follow local business practices for processing and servicing claims. Providers should continue to follow current practices with Blue Shield of California for claims processing and handling such as outlined below.

1. Eligibility and Benefits
2. Care Management
  1. Pre-Service Review
  2. Medical Policy
3. Claim Pricing and Processing
  1. Contracting
  2. Claim Filing
  3. Pricing
  4. Claim Processing
  5. Medical Records
  6. Payment
  7. Customer Service

### How can I get more information about Health Insurance Marketplaces (Exchanges)?

If you would like more information about Health Insurance Marketplaces (Exchanges), log onto Provider Connection at [blueshieldca.com/provider](http://blueshieldca.com/provider). Once you are logged onto our provider portal, follow these steps for more information:

1. Click on the *Guideline & Resources* tab at the top of the landing page.
2. Find the *Features Topics* subhead on the right-hand side of the *Guidelines & Resources* page and click on the link entitled *Health Care Reform for Providers*.
3. On the next page, click on the link *Products and Network Available through Covered California*.

Here, you will find a wide variety of provider and member resources to enhance your understanding of Health Insurance Marketplaces.

### Who do I contact if I have a question about Health Insurance Marketplaces (Exchanges)?

If you have any questions regarding the Health Insurance Marketplaces, please contact Blue Shield's Provider Customer Service Unit at (800) 541-6652.

## Section 7

### Glossary of BlueCard Program Terms

<b>Administrative Services Only (ASO)</b>	<p>ASO accounts are self-funded, where the local plan administers claims on behalf of the account, but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits or timely filing limitations.</p> <p>Blue Shield of California receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.</p>
<b>Affordable Care Act</b>	<p>The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.</p>
<b>bcbs.com</b>	<p>Blue Cross and Blue Shield Association’s website, which contains useful information for providers.</p>
<b>BlueCard Access</b>	<p>Providers or members can use this toll-free number (800) 810-BLUE (2583) to locate healthcare providers in another Blue plan’s area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.</p>
<b>BlueCard Doctor and Hospital Finder</b>	<p>A website providers and members can use to locate providers in another Blue Cross and Blue Shield plan’s service area. This is useful when you need to refer the patient to a physician or healthcare facility in another location. You can access provider information for all 50 states as well as the BlueCard Worldwide network through blueshieldca.com. Click on <i>Find a Doctor</i> and then click on the <i>Providers outside of CA</i> link on the bottom of the page.</p>
<b>BlueCard Eligibility®</b>	<p>Providers can use this toll-free eligibility line at (800) 676-BLUE (2583) to verify membership and coverage information, and obtain pre-certification on patients from other Blue Plans.</p> <p>Providers can also access eligibility and benefits information for other Blue plan members by accessing blueshieldca.com/provider.</p>
<b>BlueCard PPO</b>	<p>A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield plan’s service area the PPO level of benefits when they obtain services from a physician or hospital designated as a PPO provider.</p>

# The BlueCard® Program

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**BlueCard PPO Basic**

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

When you see the "PPOB" in a suitcase logo on the front of the member's Blue Plan ID card, it means the member has selected a PPO plan product from a Blue Cross Blue Shield plan. Since Blue Shield of California does not have a BlueCard PPO Basic network, providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California

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**BlueCard PPO Member**

A Blue plan patient who carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.

**BlueCard PPO Network**

The network comprising those physicians, hospitals and other healthcare providers PPO members may elect to use to obtain the highest level of PPO benefits.

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**BlueCard PPO Provider**

A doctor, hospital or other healthcare entity enrolled in a network of designated PPO providers.

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**BlueCard Traditional**

A national program that offers members traveling or living outside of their Blue plan's service area the traditional, or indemnity, level of benefits when they obtain services from a physician or hospital outside of their Blue plan's service area. These members will carry an ID card featuring an "empty" suitcase logo.

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**Blue Shield Global Core®**

A program that allows Blue plan members traveling or living outside of the United States to receive healthcare services from participating international Blue plan healthcare providers. The program also allows members of international Blue plans to access U.S. Blue plan provider networks. The Global Network of participating providers can be accessed through [blueshieldca.com](http://blueshieldca.com). Click on *Find a Doctor* and then click on the *Providers outside of CA* link on the bottom of the page.

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**Consumer Directed Health Care/Health Plans (CDHC/CDHP)**

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

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**Coinsurance**

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

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# The BlueCard® Program

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<b>Coordination of Benefits (COB)</b>	Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.
<b>Copayment</b>	A specified charge that a member incurs for a specified service at the time the service is rendered.
<b>Deductible</b>	A flat amount the member incurs before the insurer will make any benefit payments.
<b>Electronic Provider Access</b>	Electronic Provider Access (EPA) is an online tool giving providers the ability to access out-of-area members' Blue plan provider websites to request medical authorization and pre-service review. To access the EPA tool, log into Provider Connection at <a href="http://blueshieldca.com/provider">blueshieldca.com/provider</a> and click on the <i>Authorizations</i> tab at the top, then <i>Managing Out-of-Area Blue Plan Members</i> . On the next screen, select <i>Pre-Service Review for Out-of-area Members</i> . Choose the <i>Electronic Provider Access</i> option and you will be connected directly to the Blue plan within a secured routing mechanism to begin your request.
<b>Essential Community Providers</b>	Healthcare providers that serve predominately low-income, high-risk, special needs and medically-underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.
<b>Exclusive Provider Organization (EPO)</b>	An Exclusive Provider Organization is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.
<b>FEP</b>	The Federal Employee Program.
<b>Hold Harmless</b>	An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed with a Blue plan as full payment for these services.

# The BlueCard® Program

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**Marketplace Exchange**

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards.

The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a federally-facilitated Marketplace in any state that does not do so.

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**Medicaid**

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women, Medicaid is governed by overall federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

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**Medicare Advantage**

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

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

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**Medicare Crossover**

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

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# The BlueCard® Program

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**Medicare Supplemental (Medigap)**

Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the “gaps” in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn’t cover.

Medigap policies are regulated under federal and state laws and are “standardized.” There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member’s Home Plan via Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.

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**National Account**

An employer group with employees and/or retirees located in more than one Blue Plan service area.

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**Other Party Liability (OPL)**

A cost containment program that ensure Blue plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers’ Compensation, subrogation and no-fault auto insurance.

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**Plan**

Refers to any Blue Cross and/or Blue Shield plan member’s health care service coverage, e.g., HMO, PPO, EPO, and POS.

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**Point of Service (POS)**

Point of Service is a health benefit program in which the highest level of benefits is received when the member obtains services from his/her primary care provider/group and/or complies with referral authorization requirements for care. Benefits are still provided when the member obtains care from any eligible provider without referral authorization, according to the terms of the contract.

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**PPOB**

A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.

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# The BlueCard® Program

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<b>Preferred Provider Organization (PPO)</b>	Preferred Provider Organization is a health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.
<b>Prefix</b>	The three characters preceding the subscriber identification number on the Blue plan ID cards. The prefix identifies the Blue plan or national account to which the member belongs and is required for routing claims.
<b>Provider Connection</b>	Blue Shield's provider website at <a href="http://blueshieldca.com/provider">blueshieldca.com/provider</a> contains useful information for our providers including: basic BlueCard patient administration and claims processing steps, eligibility and benefits information on other Blue plan members, and instructions on where to send BlueCard claims by accessing our Claims Routing Tool.
<b>Qualified Health Plan (QHP)</b>	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.
<b>Small Business Health Options Program (SHOP)</b>	Allows employers to choose the level of coverage and offer choices among health insurance plans. State-run Marketplaces were scheduled to become available by January 2014, with the federal government stepping in to run Marketplaces for states that were not ready. In 2016, all businesses with 100 or fewer employees must be able to purchase insurance through these Exchanges. The Marketplaces have the option of including employees with more than 100 employees beginning in 2017.
<b>State Children's Health Insurance Program (SCHIP)</b>	SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.
<b>Traditional Coverage</b>	Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.

# The BlueCard® Program

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## Other Payor Summary List

Other Payor Summary List	
Other Payor Summary List	Type of Plan
Blue Cross Blue Shield Plans	Individual and Group Health Plans
Other Arrangements	Arrangements pursuant to which Blue Shield subsidiaries, e.g., Blue Shield of California Life & Health Insurance Company, may utilize the Blue Shield Life Network.
Blue Shield of California Life & Health Insurance	Individual Health Plans (Blue Shield Life Network)
Risk Management Accounts (RMCs)	<p><u>Group health plans</u> - Blue Shield of California provides one or more of the following services for a fixed administrative fee: administrative services (such as eligibility and claims processing), benefit determinations, generation of identification (ID) cards, check issuance, and reconciliation.</p> <p>The group is at risk for the cost of health care.</p> <p>Only large groups are eligible.</p> <p>This list is updated periodically. Please contact Blue Shield of California directly if an updated list is needed.</p>
Name A-Pe	Name Pi-Z
24 Hour Fitness USA, Inc.	PIH Health (Presbyterian Intercommunity Hospital)
ACCO Management Company	Pinterest Inc
Activision Publishing, Inc.	Pioneers Memorial Healthcare District
Adventist Health Systems/West	Playworks Education Energized
AGI Publishing DBA Valley Yellow Pages	Pomona Valley Hospital Medical Center
AirConditioning and Refrigeration Industry Joint Trust	Premium Packing, Inc
Alhambra Unified School District	Prime HealthCare Services
All FAB Precision Sheetmetal	Printing Specialties & Paper Products Joint Benefits H&W
Allen Lund Company, Inc.	Public Storage
Alliance HealthCare Services	Radnet, Inc.
Amarillo College of Hairdressing dba Milan Institute	Raley's
Amerit Fleet Solutions	REC Solar Commerical Corp
Ampla Health	Rescue Public Agency
Andreini agAdvantageCaptive	Risk Management Strategies
Aricent US Inc	Riverside Community College District
ARM, INC. (ARM, Physical IP, Inc.)	Rolling Hills Casino
Armanino, LLP	Roman Catholic Bishop of Sacramento
bebe stores inc	Ruiz Food Products, Inc.
Big Creek Lumber	Sabor Farms LLC
Blackhawk Network Holdings, Inc.	Saddleback Valley USD
Bolthouse Farms Inc	Sakura Finetech USA Inc
Braun Electric Company Inc	San Benito Health Care District
Brighton Collectibles,LLC.	San Francisco Electrical Workers Health & Welfare
Burrtec Waste Industries Inc	San Francisco Symphony, Inc.
Buttonwillow Warehouse Co Inc.	San Joaquin Valley College
California Olive Ranch, Inc.	Saticoy Lemon
California Valued Trust	Save Mart Supermarkets
Cambro Manufacturing Company	Saxco International LLC
Carl Warren and Company	Self-Insured Schools of California
Carlsbad Unified School District	Sensient Technologies Corporation
Citrus Valley Health Partners, Inc.	Service Systems. Inc.

## Other Payor Summary List

Name A-Pe	Name Pi-Z
City of San Jose	Sheet Metal Workers Intl Assoc Local Union 104
City of Tulare	Sheppard, Mullin Richter & Hampton LLP
City of Tulare - SJVIA	Shoretel, Inc.
Clovis Unified School District	Sign Pictorial and Display Industry
Cornerstone On Demand Inc	SISC/Alexander Valley
Cotton On USA, Inc.	SISC/Alpaugh USD
County of Imperial	SISC/Alvord USD
County of Kings	SISC/Antelope Valley CCD
County of Orange	SISC/Arcadia USD
County of San Mateo	SISC/ASCIP La Canada USD
CrossFit, Inc	SISC/Azusa Unified School District
CSAC Excess Insurance Authority	SISC/Bennett Valley Union Elementary
CSEBA/Alta Loma School District	SISC/Cabrillo College
CSEBA/Bear Valley Unified School District	SISC/Calistoga Joint Unified School District
CSEBA/Beaumont Unified School District	SISC/Ceiba Public Schools
CSEBA/Central School District	SISC/Central Region School
CSEBA/Centralia School District	SISC/Ceres Unified School District
CSEBA/Chaffey Community College District	SISC/Chawanakee USD
CSEBA/Chartersafe - Clear Passage Education Center	SISC/Chowchilla Elementary
CSEBA/Chartersafe - New Opportunities Organization	SISC/Cinnabar Elementary
CSEBA/Chartersafe - Paramount Collegiate Academy	SISC/Cloverdale Unified
CSEBA/Chartersafe - Pathways	SISC/College of the Desert
CSEBA/Chartersafe - River Springs Charter School	SISC/Denair Unified
CSEBA/Chartersafe - Ross Valley Charter School	SISC/Dunham School District
CSEBA/Chartersafe - Sierra	SISC/EI Centro Elementary School District
CSEBA/Chino Valley	SISC/Empire Union Elementary
CSEBA/Colton Jt. Unified School District	SISC/Firebaugh-Las Deltas Joint Unified School District
CSEBA/Covina Valley Unified School District	SISC/Fort Ross Elementary
CSEBA/Cucamonga School District	SISC/Fullerton Elementary School District
CSEBA/East San Gabriel Valley ROP	SISC/Geyserville Unified
CSEBA/East Whittier City School District	SISC/Gratton Elementary
CSEBA/Encinitas Union School District	SISC/Gravenstein Union Elem
CSEBA/Etiwanda School District	SISC/Guerneville SD
CSEBA/Hemet Unified School District	SISC/Harmony Union Elementary
CSEBA/Hesperia Unified School District - Classified	SISC/Hart Ransom Union Elementary
CSEBA/Mountain View School District	SISC/Hickman Community Charter School District
CSEBA/North Orange County ROP	SISC/Holtville Unified
CSEBA/Ontario-Montclair School District	SISC/Kashia Elementary
CSEBA/Ramona Unified School District	SISC/Kentfield School District
CSEBA/Rim of the World Unified School District	SISC/Kenwood Elementary
CSEBA/San Bernardino Community College District	SISC/Keyes Union School District
CSEBA/San Bernardino CSS	SISC/Kings Canyon Unified
CSEBA/San Marino Unified School District	SISC/Liberty Elementary
CSEBA/Santee School District	SISC/Los Banos USD
CSEBA/Savanna School District	SISC/Madera County Office of Education
CSEBA/Summit Leadership Academy High Desert	SISC/Marin Community College District
CSEBA/Victor Valley College	SISC/Mark West Union
CSEBA/Yucaipa Calimesa Joint USD (Classified)	SISC/Mendocino USD
DataSafe, Inc	SISC/Monte Rio Union Elem
Delano Union School District	SISC/Montgomery Elem
Delta Dental of California	SISC/Oak Grove Union Elem

## Other Payor Summary List

Name A-Pe	Name Pi-Z
Dexcom Inc.	SISC/Old Adobe Union Elem
Downey Unified School District	SISC/Pajaro Valley Unified School District
eBay, Inc	SISC/Palmdale Aerospace Academy
EDCO Disposal Corp Inc	SISC/Palmdale School District
Educational Media Foundation	SISC/Pasadena Unified School District
EIA/Amador County	SISC/Petaluma School District
EIA/City of Huntington Beach	SISC/Piner-Olivet Union Elem
EIA/City of Irvine	SISC/Plumas Unified School District
EIA/City of Redding	SISC/Redwood Empire School Ins Grp
EIA/City of Walnut Creek	SISC/Rincon Valley Union Elem
EIA/City of Yuba City	SISC/Rio School District
EIA/Community Development Commission of Los	SISC/Roberts Ferry Union Elementary
EIA/County of Imperial	SISC/Roseland Elem
EIA/County of Santa Barbara	SISC/Salida Union Elementary
EIA/EI Dorado County	SISC/Santa Cruz City Schools
EIA/Mendocino Coast District Hospital	SISC/Santa Maria Joint Union High School District
EIA/Santa Barbara Superior Courts	SISC/Santa Rosa Junior College
EIA/Small Group Program	SISC/Sebastopol Ind Charter
EIA/South Coast Air Quality Management District	SISC/Shiloh Elementary
Emser Tile, LLC	SISC/Shoreline Unified
Enphase Energy Inc	SISC/Sierra Joint Community College District
Ensign Services, Inc.	SISC/Sierra Unified
Excess Insurance Authority (EIA)	SISC/Sonoma County Office of Ed
Faith Farming LLC & Innovative Produce Inc.	SISC/South Orange County CCD
Fire Districts Association of California	SISC/Stanislaus Union Elementary
Foster Farms	SISC/Tamalpais Union HSD
Fox Factory Inc.	SISC/Tree of Life Charter
Freedom Communications	SISC/Twin Hills Union SD
Fresno City Employees Health & Welfare Trust	SISC/Two Rock Union Elementary
Fresno Truck Center	SISC/Waugh Elem
Fry's Electronics	SISC/West Hills CCD
Gallo Cattle Co a Ltd Partnership	SISC/West Side Union School District
Golden Gate Bridge Highway & Transport Dist.	SISC/West Sonoma County HSD
Golden State Medical Supply, Inc.	SISC/Westminster School District
Hanford Joint Union High School District	SISC/Westside Union Elem
Hankey Investment Co.	SISC/Wilmar Union Elem
HCL America Inc.	SISC/Yosemite Community College District
Healdsburg District Hospital	SISC/Yosemite USD
HealthCare Conglomerate Associates LLC	SoCal Pipe Trades
Hunt & Sons, Inc.	Southern California Edison Company
Hutchison & Bloodgood	SpaceX
ILWU-PMA Welfare Plan	SSL (Space Systems/Loral LLC)
Indian Health Council, Inc.	Stanford University
Integro USA	Stanford University Postdoctoral Scholars
Interface Rehab, Inc.	Stellartech Research Corporation
Irvine Unified School District	Sukut Construction Inc
JBR Inc. DBA San Francisco Bay Gourmet Coffee	Tanimura & Antle Fresh Foods, Inc.
John Muir Health	The Gymboree Corp
John Muir Health	The Heffernan Group
KS Industries LP	The Lagunitas Brewing Company
La Tapatia Tortilleria, Inc.	The Sun Valley Group

## Other Payor Summary List

Name A-Pe	Name Pi-Z
Linear Technology Corporation	The Sun Valley Group, Inc.
Long Beach Unified School District	Threshold Enterprises LTD
Lush Handmade Cosmetics, Ltd.	Tom's Truck Center
Madsen, Kneppers and Associates	Topcon Positioning Systems Inc. dba Topcon America Corp
Manco Abbott, Inc.	Tri Cal
Marin Healthcare District	Truilite WSG, LLC
Mendocino County Schools (Staywell JPA)	Tule River Indian Tribal Council
Methodist Hospital	Tutor Perini Corporation
Mi Pueblo	UA 447 Local Pipe Trades & Welfare Trust Fund
Mi Pueblo Newco LLC	Uber Technologies Inc.
Monterey Peninsula Surgery Center LLC	UFCW & Employers Benefit Trust
Mutual Trading Company	UFCW Northern California and Drug Employers Health and Welfare Trust
National University	United Agricultural Benefit Trust
Newport Group, Inc	University of California
Nichols Farm	Valley Children's Hospital
Nikon Precision, Inc.	Valley Pacific Petroleum Services
North Coast Schools Medical Insurance Group	Verity Health System
Northern CA Sheet Metal Workers Local 162	Victor Community Support Services Inc
Northern California General Teamsters Security Fund & Teamsters Retiree Trust	Washington Hospital
Northern California Tile Industry Health Trust	Wesco Aircraft Hardware Corp
Onni Group./Onni Properties	Whittier Union High School District
Orchard Machinery Corporation	Yocha Dehe Wintun Nation (Cache Creek Casino)
Pacific Southwest Container, LLC	Yusen Logistics
Palantir Technologies	ZenDesk Inc.
Pandora Media Inc	Zenith Talent Corporation
PayPal Holdings, Inc.	Zynga Inc.
Pechanga Band Of Luiseno Mission Indians	