BlueCard® Process
Frequently Asked Questions (FAQ)
April 2023

What is a BlueCard®?

BlueCard is a national program that enables members of one Blue Cross and Blue Shield (home plan) to obtain healthcare services while traveling or residing in another Blue Cross and Blue Shield plan's service area.

The local plan (host plan) or their delegate (i.e. CareCentrix) is responsible for receiving all claim and adjustment requests and will transmit them to the host plan who forwards to the appropriate BCBS home plan.

What is a home plan and host plan?

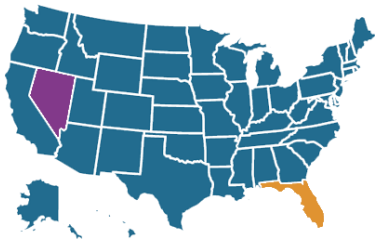
Home Plan is defined by the state or region where the health plan is issued or originated. Utilization management and prior authorization guidelines, as well as medical coverage guidelines of a home plan, apply regardless of where services are rendered. Some states have many BCBS plans.

- New York has Empire (NYC), BCBS Western NY, etc.
- Pennsylvania has PA Highmark, Capital PA and Independence PA (Philadelphia Area).

- Some home plans cover multiple states.
  - Anthem (14 states), WellPoint, Highmark covers PA, DE and Western NY, etc.

Host Plan is defined by the state/region where the services are being rendered.

Home and Host Plans – An Example:



Home Plan (NV) – The BCBS plan in the state or region where the health plan is issued or originated.

- Provider's source for eligibility and benefits.
- Utilization management, prior authorization guidelines and medical coverage guidelines apply regardless of where services are rendered.

Host Plan (FL) – The BCBS plan in the state where services are rendered.

- Florida Blue network is accessed for an in network provider.
- The Florida network provider then bills CareCentrix.

What is the BlueCard® authorization process? Will I still need authorization from CareCentrix for BlueCard members?

- **For Florida Home Health Services:** If services are registered with CareCentrix, CareCentrix will request authorization from the home plan on your behalf when required. Alternatively, providers can contact the home plan directly to obtain authorization. However, if you plan to request authorization from the home plan on a regular basis, please notify your contracting contact to prevent duplication of efforts and receive training.
- **For Durable Medical Equipment (DME), Orthotics and Prosthetics (O+P) and Home Infusion:** Provider must contact the home plan directly to obtain authorizations when required. Providers should maintain documentation of the authorization request, including all call reference numbers.

Will I receive any documentation if I accept a case from CareCentrix?

Yes, providers will receive a Service Registration Form (SRF) outlining the requested services. Please note, the SRF is not an authorization and is not a guarantee of payment. Please refer to the Provider Manual for more information.

How do I obtain prior authorization from the home plan?

There are three different ways a provider can obtain prior authorization from a home plan:

- **Contact BlueCard® by phone at 1-800-676-BLUE (2583)** to speak with a representative from the home plan and have ready the member's **3-character prefix ID number**.
    - **Important tip:** While confirming eligibility and benefits with the home plan, ask the representative if prior authorization is required for the specific HCPCS, and, if so, the representative can transfer you directly to the home plan's utilization review department.
- Electronically through their Health Plan's Self Service tools, if applicable.
- By fax request: Please **contact BlueCard at 1-800-676-BLUE (2583)** to determine if you are able to fax in your request, and, if so, obtain the appropriate fax number.

How should I verify member eligibility and benefits?

Providers may reference the BCBS Prefix Identification Tool to obtain information such as home plan contact information.

Providers may also call **1 (800) 676-BLUE (2583)**, provide the **3-character prefix of the member's ID number**, and the representative will transfer your call to the appropriate plan. Please be sure to notify the home plan that you are a contracted CareCentrix/Florida Blue provider.

Providers should verify eligibility and benefits for the exact services needed and continue to monitor eligibility and benefits while servicing the member.

Are there alternatives to contacting the home plan by phone to verify eligibility and benefits?

Yes. Providers can utilize the Health Plan's Self Service tools such as Availity (FloridaBlue) and Navinet (Horizon) to verify the member's eligibility and benefits. However, it is recommended that providers contact the home plan by phone to verify eligibility and benefits for the exact services requested.

What should I do if I am having difficulty obtaining prior authorization from the home plan?

Contact the member's home plan to obtain status on your authorization request. Encourage the member to contact the home plan as well if the delay in obtaining the authorization may impact the ability to receive care.

Advise the member's physician and/or the referral source if the delay in obtaining the authorization could push back the start of care.

If medical documentation is requested by the BlueCard® home plan for prior authorization, am I required to send it to CareCentrix or directly to the home plan?

Providers should work directly with the home plan. Please follow instructions provided by the home plan for submitting medical documentation needed to obtain prior authorization.

Please note that clinical documentation may also be required at the time of claims review. Documentation requested as part of claims processing should always be directed to CareCentrix and not to the BlueCard home plan.

What if the home plan does not require prior authorization for a requested service?

Providers should record the name of the representative, call reference number and any other pertinent information.

Services that do not require prior authorization may be reviewed after the services are rendered. The review could result in a denial, including, but not limited to, if the services are not deemed medically necessary.

Should I submit claims to CareCentrix or the member's home plan?

Providers should submit BlueCard® member claims to CareCentrix.

If your claim has been denied for failure to obtain prior authorization:
Please submit a claim reconsideration request to CareCentrix so we can review the claim and include documentation and any supporting clinical/visit notes.

For DME, O+P and Home Infusion: If you were told no prior authorization was required when you called the home plan and your claim was still denied for no prior authorization, please follow the above and include the name of the call representative and call reference number in your documentation.

Should I work with the member directly regarding questions about out-of-pocket responsibility?

No, the member should be directed back to the home plan if they have questions regarding their benefit plan.

For questions regarding member out-of-pocket responsibility, the member can contact the CareCentrix Patient Services Team directly at **1 (800) 808-1902** and **select option 2**. This team oversees member collections and can explain member's out-of-pocket responsibility as well as deductible amounts. Additionally, they can answer any questions about the member's cost share invoice.

Does this process impact all plan members including state, local and FEP members?

No, the BlueCard® process only impacts BlueCard members. It does not impact any other members, including state, local, and FEP. For all other members, providers should continue to work with CareCentrix in the same manner as they do today.