PROVIDER RESOURCE CENTER REFERENCE GUIDE

Provider Relations

BlueCross BlueShield
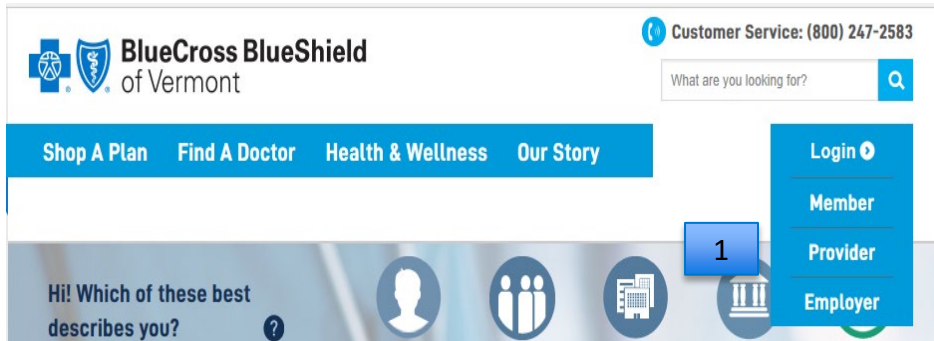of Vermont
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TABLE OF CONTENTS

SECTION 1:
USER REGISTRATION

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SECTION 1: USER REGISTRATION

To start the registration process, go to
bluecrossvt.org/provider-login

1. Select "Provider" option under "Login" to access the Provider Resource Center.

2. Select "Register Now" to start the provider registration process. The provider or office manager should be the first to register, as the local administrator role is automatically assigned to the first user. (The local administrator can add additional users.)

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SECTION 1: USER REGISTRATION (CONT.)

3. Confirm you are the appropriate person for the local administrator role.

Provider Resource Center Registration

If you are the first individual registering for your practice/office you will be assigned the role "Local Administrator." This means, you will have access to:

- All standard features of the Provider Resource Center (same access as a "user")
- Plus, the System Administrator feature for setting up and overseeing all other users of the registered practice/office (restricted access for Local Administrators only)

Typically, the "Local Administrator" is assigned to the office manager of the practice/office. However, local administrator rights can be assigned to more than one person at the practice/office.

ATTENTION BILLING SERVICES: Your registration request will deny, as access is granted through the practice Local Administrator.

I am the appropriate person for the "Local Administrator" role, continue to registration ➤

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SECTION 1: USER REGISTRATION (CONT.)

4. Enter required information. Be sure to make note of your username and password. Confirmation will be sent to the email address you provide.

SECTION 1: USER REGISTRATION (CONT.)

5. Enter your office information and select "Next." (Do **NOT** enter hyphens in the tax ID field.)

SECTION 1: USER REGISTRATION (CONT.)

6. Review your registration summary. Verify office contact and user information. Select "Edit" if necessary. Once completed, select "Finish."

SECTION 1: USER REGISTRATION (CONT.)

7. Make a note of your username and password. You will **<u>NOT</u>** be able to return to this page once you select "Next."i

SECTION 1: USER REGISTRATION (CONT.)

8. You have completed your registration. Once your application is processed, you will be notified via email whether it has been approved or denied.

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We'll see you through.

Registration Complete

Thank you. Your registration with Blue Cross and Blue Shield of Vermont is now complete.

Next

Congratulations! You have completed your registration.

Once your account is ready, you will be notified via the e-mail address you provided during registration.

Once your account has been confirmed you will be able to log in with your user-name and password.

Please allow up to three business days in order for your account to be confirmed.

SECTION 1: USER REGISTRATION (CONT.)

Are you a provider in our Vermont Blue Advantage (VBA) network? Please register separately at the link below for access to the VBA portal and these services:

- Check member eligibility and benefits
- Review claims status
- Find forms and other resources
- Search the provider and facility directory
- Access guidelines and other materials

https://www.vermontblueadvantage.com/pages/providers

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SECTION 2:

SYSTEM ADMINISTRATOR – VIEWING USERS

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SECTION 2: SYSTEM ADMINISTRATOR – VIEWING USERS

1. Only the local administrator can edit users. Select "System Administrator."
2. "User Maintenance" will appear, listing all users on your practice's access list.

User Maintenance

User Name	Office Security	Company Name	Company ID Number	User ID	Last Login	User Status	User Index
Sally Jones	user	Provider	98765312	Sjon1	05/11/2018	confirmed	13685
M. Smith	user	Provider	98765312	Msmi1	03/01/2018	confirmed	1358
John Smith	user	Provider	98765312	Jsmi5	04/28/2018	confirmed	1258

Administration
User Preferences
System Administrator

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SECTION 3:

SYSTEM ADMINISTRATOR – EDITING USER INFORMATION

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SECTION 3: SYSTEM ADMINISTRATOR – EDITING USER INFORMATION

1. Only the local administrator can edit users. Select "System Administrator."
2. "User Maintenance" will appear, listing all users on your practice's access list. Click on the user's name.
3. Make the appropriate changes, then click "Submit."

SECTION 4:

SYSTEM ADMINISTRATOR – ADDING A NEW USER

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SECTION 4: SYSTEM ADMINISTRATOR – ADDING A NEW USER

1. Only the local administrator can edit users. Select "System Administrator."
2. Select "Add User."
3. Enter all required information.
4. Select "Add."

SECTION 4: SYSTEM ADMINISTRATOR – ADDING A NEW USER (CONT.)

5. Select a user role from the drop-down menu. (The user will not be added unless a role is selected. See next page for a description of user roles.)
6. Select "Select Role."
7. Click "Submit."

SECTION 4: SYSTEM ADMINISTRATOR – ADDING A NEW USER (CONT.)

Provider Resource Center Functions

General Content:
- Resource Center Page
- Provider Search
- Tools and Resources
- Reports

Eligibility and Benefits:
- Eligibility and Benefit Inquiries
- Accumulators (Benefit Usage Information)

Claims Inquiries:
- Claim Status Inquiries, including realtime
- Clear Claims Connect (C3) Tool
- Prior Authorizations (Acuity Connect)
- Provider Vouchers (Remittance Advices), Capitation Vouchers

System/Local Administrator:
- Add/remove users; edit user information

User Roles – Access Levels

Office Manager (also called Local Administrator), Office Manager w/o Demographics
- General Content
- Eligibility/Benefits
- Claims Inquiry
- System Administrator
- Provider Vouchers (Remittance Advices), Capitation Vouchers
- Acuity Connect (on-line prior approval)

Provider, General Staff:
- General Content
- Eligibility/Benefits
- Claims Inquiry
- Provider Vouchers (Remittance Advices), Capitation Vouchers
- Acuity Connect

Admitting Staff:
- General Content
- Eligibility/Benefits

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SECTION 5:

SYSTEM ADMINISTRATOR – REMOVING USERS

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SECTION 5: SYSTEM ADMINISTRATOR – REMOVING USERS

1. Only the local administrator can remove users. Select "System Administrator."
2. "User Maintenance" will appear, listing all users on your practice's access list. Click on the name of the user you want to remove.
3. Check the box next to the user's role.
4. Click "Remove".

5.   Indicate reason for removing user, e.g., "No longer employed by practice."

6.   Select "Yes."

7.   A confirmation screen will appear.

Are you sure you wish to remove this user?

This action cannot be undone.
Removing the selected roles will remove the user's registration with Blue Cross and Blue Shield of Vermont.
A reason must be entered for this action.
Click the Yes button to continue.

◦ Reason:

5

◦ Indicates required field

6 | Yes | No

7.

User Registration Successfully Removed
The user registration has been successfully removed.
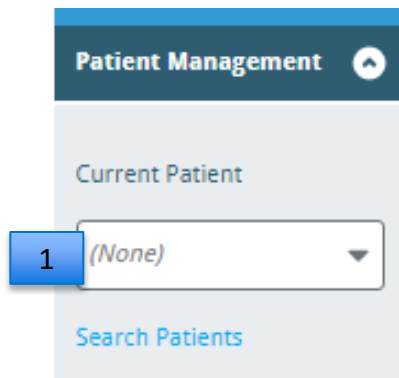
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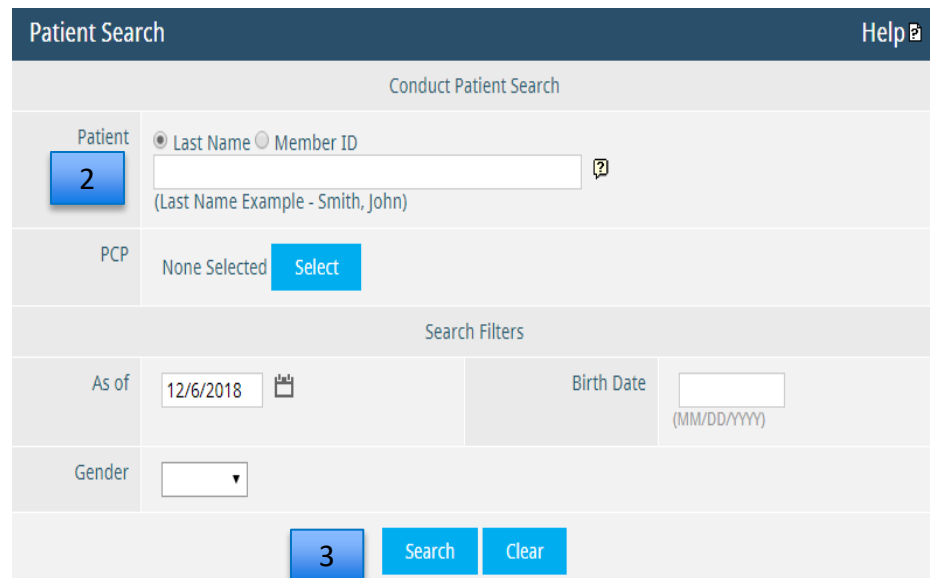
SECTION 6:

ELIGIBILITY, BENEFITS AND ACCUMULATORS – VERMONT MEMBERS

SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – VERMONT MEMBERS

1. Select "Search Patients" under "Patient Management."

2. Enter patient information by last, first name format or by member ID number.

3. Select "Search"

SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – VERMONT MEMBERS (CONT.)

4. To continue to benefits and accumulator information, click "Select." Member name will display in "Current Patient" box. See next page for additional instructions.

5. To view member's prefix and benefit summary, select patient's name. Be sure to choose the patient record with the ID number starting with "V" to view current records.

	Name	Sex	Birth Date	Address	Phone	ID	Primary Care Provider
Select	DOE, JOHN M	M	09/01/2013	Smith Street, VT	(802) 123-4567	1234567891	
Select	DOE, JOHN M	M	09/01/2013	Smith Street, VT	(802) 123-4567	V1234567891000	
Select	DOE, JOHN A	M	04/28/1954	Smith St, VT	(802) 234--5678	2345678912	

Patient Search Results — Help

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SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – VERMONT MEMBERS (CONT.)

7. Once you have clicked "Select," member's name appears in the box under "Current Patient."

8. Select "Eligibility" under "Patient Management."

SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – VERMONT MEMBERS (CONT.)

9.   This will bring up the patient record in "Realtime Eligibility inquiry."

Real-time Eligibility Inquiry

Job Aides

Our eligibility job aides give a general overview of how to conduct eligibility requests, as well as how to run specific requests based on provider/facility type.

BCBSVT Members - Prepopulated Fields

Conduct a patient search, then **click on the eligibility link under patient management.** The selected patient's information will prepopulate in the patient ID field and subscriber information fields - even if they are not the subscriber. Subscriber ID numbers end in 001, all other ending values (e.g., 002, 003, etc.) are dependents.

BlueCard or FEP Members

To check eligibility for BlueCard or FEP members, **click on the eligibility link under Office Management.**
Then complete the following **REQUIRED FIELDS:**

1) Subscriber Full Name

2) Subscriber Date of Birth (only **required if Subscriber is the patient.**)

3) Patient Full Name & Birth Date (only **required if Patient is NOT the Subscriber**)

   • Do not include suffix (Jr, Sr, III, etc) when entering the last name.

4) Patient ID - including ALPHA PREFIX (example: ZIA99999999900 | FEP example: R99999999900)

5) Requesting Provider

   • **By name** - use format: last name or last name, first name (example: smith or smith, john)
   • **By Provider NPI** - enter the individual billing provider's NPI not the group they are associated with.

For **Telemedicine Services** provided to a patient, **select 'Consultation (3)' from the Service Type drop-down.**

Please Note: Accumulated or remaining benefit amounts may not be returned for sensitive benefit inquiries.

Eligibility Search		
Conduct Eligibility Search		
Subscriber Information		

	Subscriber Name	First	Last		Birth Date	08/12/1955
9		JOHN	DOE			

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SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – VERMONT MEMBERS (CONT.)

10. The patient name searched for will appear in the "subscriber name" field even if the member is not the subscriber. If the member number on the "Eligibility Inquiry Prepopulated Form" (see page 25) ends in anything other than 01, this is NOT the subscriber.

SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – VERMONT MEMBERS (CONT.)

11. Search "Requesting Provider" by name (last name, first name format) or by NPI.

SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – VERMONT MEMBERS (CONT.)

12. Click on "Select" to choose the appropriate provider.

13. On the next screen, select "Service Type" from the drop-down.

14. Select "Search."

Provider Search

Select	Provider Name	Provider ID	Tax ID	Practice Name
12 Select	Jones D, DC	915A123456789	123456789	Health Care Practice

Requesting Provider	Jones D, DC (Provider NPI: 123456789) ⦿Name ○Provider NPI [ ] Search	
13 Service Type	Chiropractic (33) ▾	
	14 Search Clear	

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SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – VERMONT MEMBERS (CONT.)

15. Review eligibility details.
16. Review benefit.

15

Product	EXCLUSIVE PROVIDER ORGANIZATION	Eligibility/Benefit Start Date	Jan 1, 2016
Premium Paid Through Date		Eligibility/Benefit End Date	Dec 31, 9999
Grace Period Start Date		Contract Status	**Active - Pending Investigation**
Grace Period End Date		Relationship	Self
Group		Payer Contact Information	Name: Phone:
Coord. of Benefits Start Date			
		Coord. of Benefits End Date	
Additional Information			

In Network as of Jul 5, 2016

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Benefit Description	Coverage Level	Copay	Coinsurance	Active	Benefit Start/End Dates	Ref/Auth Required	Benefit limit	Additional Information
Physician Visit - Office: Well (Office)	Individual		0%	Y		N	N	
Chiropractic (Office)	Individual	$40		Y		N	Y	

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17. Select the appropriate accumulator. (Field will expand to show details.)

SECTION 7:

REALTIME BENEFIT, ELIGIBILITY & ACCUMULATORS

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SECTION 7: REALTIME BENEFIT, ELIGIBILITY & ACCUMULATORS

Use these instructions for eligibility and benefits of Federal Employee Program (FEP) members and Blue Card members (out-of-state Blue Cross Blue Shield members).

1. Select "Eligibility" under "Office Management."
2. This will bring you to the "realtime Eligibility Inquiry" page.

Office Management

1. Eligibility

Resource Center

Claim Status Inquiry

Fee Schedule Notices

Provider Vouchers

2. Real-time Eligibility Inquiry

Job Aides

Our eligibility job aides give a general overview of how to conduct eligibility requests, as well as how to run specific requests based on provider/facility type.

BCBSVT Members - Prepopulated Fields

Conduct a patient search, then **click on the eligibility link under patient management.** The selected patient's information will prepopulate in the patient ID field and subscriber information fields - even if they are not the subscriber. Subscriber ID numbers end in 001, all other ending values (e.g., 002, 003, etc.) are dependents.

BlueCard or FEP Members

To check eligibility for BlueCard or FEP members, **click on the eligibility link under Office Management.**
Then complete the following **REQUIRED FIELDS:**

1) Subscriber Full Name

2) Subscriber Date of Birth (only **required if Subscriber is the patient.**)

3) Patient Full Name & Birth Date (only **required if Patient is NOT the Subscriber**)

- Do not include suffix (Jr, Sr, III, etc) when entering the last name.

4) Patient ID - including ALPHA PREFIX (example: ZIA99999999900 | FEP example: R99999999900)

5) Requesting Provider

- **By name** - use format: last name or last name, first name (example: smith or smith, john)
- **By Provider NPI** - enter the individual billing provider's NPI not the group they are associated with.

For **Telemedicine Services** provided to a patient, **select 'Consultation (3)' from the Service Type drop-down.**

Please Note: Accumulated or remaining benefit amounts may not be returned for sensitive benefit inquiries.

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3. Complete these mandatory fields:
   - Subscriber full name
   - Subscriber date of birth

4. If patient is not the subscriber, also complete these mandatory fields:
   - Patient full name
   - Patient date of birth
   - Patient ID, including alpha prefix and member number (Ex: R9999999900)
   - Requesting provider
   - Service type. For all benefits, select "Health Benefit Plan Coverage (30)"

5. Select "Search."

6. Review eligibility details.

7. Review benefit.

6

Product	EXCLUSIVE PROVIDER ORGANIZATION	Eligibility/Benefit Start Date	Jan 1, 2016
Premium Paid Through Date		Eligibility/Benefit End Date	Dec 31, 9999
Grace Period Start Date		Contract Status	**Active - Pending Investigation**
Grace Period End Date		Relationship	Self
Group	H12452000	Payer Contact Information	Name: Bluecard Eligibility Phone: (800)676-2583
Coord. of Benefits Start Date			
		Coord. of Benefits End Date	
Additional Information			

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In Network as of Jul 5, 2016								
Benefit Description	Coverage Level	Copay	Coinsurance	Active	Benefit Start/End Dates	Ref/Auth Required	Benefit limit	Additional Information
Physician Visit - Office: Well (Office)	Individual		0%	Y		N	N	
Chiropractic (Office)	Individual	$40		Y		N	Y	

8. Select the appropriate accumulator. (Field will expand to show details.)

SECTION 8:

CLAIM INQUIRIES – VERMONT MEMBERS

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SECTION 8: CLAIM INQUIRIES – VERMONT MEMBERS

1. Select "Claim Status Inquiry" under "Office Management."

2. Enter claim number, member name, member number, or account number plus date of service. (Or enter a date span to see all claims within those dates.)

3. Choose the billing provider from the drop-down menu.

4. Select "Search."
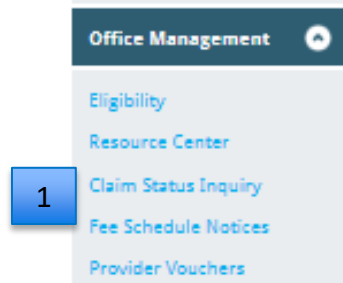
Office Management ⌃

Eligibility
Resource Center
1 Claim Status Inquiry
Fee Schedule Notices
Provider Vouchers

Claim Status Search

2 Claim Number		？
Date of Service	4/6/2016 📅 To 7/6/2016 📅	
Patient	○ Last Name ⦿ Member Id ○ Patient Account Number	
	？ (Patient List) ▼	
	(Last Name Example - Smith, John)	
	(ID Example - HP5555555,HP4444444)	
	(SSN Example - 555-55-5555, 444-44-444)	
	(Medicaid ID Example - AA55555,AA44444)	
	(Medicare ID Example - 5555555,4444444)	
3 Provider	▼	
► Status	☑ Paid ☑ Pended ☑ Denied	
	4 Search Clear	

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SECTION 8: CLAIM INQUIRIES – VERMONT MEMBERS

5. Review results. If there are multiple claims, click on the header to sort the column.

6. Select the hyperlinks (in blue) in each column for additional information. Click on "View" to review the provider voucher (remittance advice).

7. Any claims with a "Pending" status are not final and may not reflect final processing results.

View EOP	Claim Number	Status	Patient	Patient Account No.	DOS	Provider	Billed	Paid	Payment Date	Coinsurance Amount	Copay Amount	Deductible Amount	Patient Disallow Amount	COB Amount
View	12346789	Finalized	Doe, John	0000BCBS	18 Apr 2016	D. Jones DC	$165.00	$92.82	25 May 2016	$0.00	$50.00	$0.00	$0.00	$0.00

Claim Status Search Results — Help

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SECTION 9:
REALTIME CLAIM INQUIRIES

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SECTION 9: REALTIME CLAIM INQUIRIES

Use the Realtime claim inquiry tool for:

- Federal Employees Program (FEP) members
- Blue Card members (out-of-state Blue Cross Blue Shield members)
- Blue Cross Blue Shield of Vermont members

1. Under "Office Management," select "Claim Status Inquiry."

2. Select "Click here to conduct a Realtime Claims search."

Office Management

Eligibility
Resource Center
1 Claim Status Inquiry
Fee Schedule Notices
Provider Vouchers
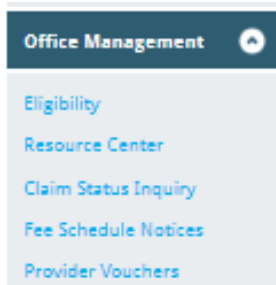
Blue Cross and Blue Shield of Vermont Members:

The patient search tool, found below, only provides claim status for currently active Blue Cross and Blue Shield of Vermont members (alpha prefixes ZIA, ZIB, ZID, ZIE, ZIG, ZIH, ZII, ZIK, ZIL, ZIU, ZIV, DVT, EVT, FVT, FAH, FAC, FAO, OMY and CWS).

- When searching by Member ID, you do not need to include the prefix (ex: "ZIA".)
- When searching by Last Name, you do not need to include the patient's suffix (Jr, Sr, III.)

BlueCard ® & Federal Employee Program (FEP) Members:

2 To check claim status for a BlueCard ® or Federal Employee Program (FEP) member, click here to conduct a Realtime Claim Search. Your request will process through the BlueCard ® search program, providing the most up-to-date informatio

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3. Complete all required fields. These are identified by a red asterisk (*).

4. Enter total claim charges (optional).

5. Select "Search."

Claim Status Inquiry - Real Time Search

Patient Information (Required)

Demographic Information
Member ID *   DOB *

Last Name *   First Name *   Sex *
                                              ○   ○
                                              Female   Male
                                              *

Provider Information (Required)

Provider Name   Provider Identifiers
Last Name *   First Name   Provider ID *   Provider Tax ID *

Claim Information (Optional) (Required)

Claim Data   Dates Of Service
                                               *Date Of Service Start *   *Date Of Service End *

Total Claim Charge

Search   Clear   * required field

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6. Review Results

Claim Status Search Results

Patient Information	Provider Information	Claim Total	
Patient: Doe, John	Provider: Dr. Jones	Amount Billed:	$100.00
	NPI: 123456789	Amount Paid:	$56.47
ID: V1234567890			

Claims

Claim Number	Account Number	Payment Date	Date of Service	Billed Amount	Payment Amount	Status
UNKNOWN		Jun 30 2016	Jun 23 2016	$100.00	$56.47	Finalized
Totals:				**$100.00**	**$56.47**	

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SECTION 10:

VOUCHERS AND CAPITATION VOUCHERS

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SECTION 10: VOUCHERS AND CAPITATION VOUCHERS

1. Select "Provider Vouchers" under "Office Management."

2. Select "Continue." Please note browser requirements.

3. Select practice NPI from the drop-down menu.

4. Enter start and end dates.

5. Select "Search."

SECTION 11:

NATIONAL DRUG CODE (NDC) TOOL

SECTION 11: NATIONAL DRUG CODE (NDC) TOOL

The NDC Tool is designed to assist practices in determining the unit of measure that must be reported on claims. The tool provides:

- Drug Name
- Dosage Form
- Manufacturer Name
- Billed Unit of Measure (indicates the appropriate unit of measure for billing.)

1. Under "Office Management," select "National Drug Code (NDC) Tool."
2. Click on hyperlink to access the current version of the tool.
3. Use "Ctrl-F" to navigate quickly navigate to the desired code. The 11-digit HNC code should be entered without dashes.

Clear Claims Connection (C3)

1 National Drug Code (NDC) Tool

Transaction History

NDC Tool

2 · 10/01/2020 NDC Tool

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SECTION 11: NATIONAL DRUG CODE (NDC) TOOL (CONT.)

4. Selected code will be highlighted.
5. The billed unit of measure field indicates the appropriate unit of measure (UN, GR, ML, ME, or F2) for billing.
6. If the code is not on file, it may be inactive or newly added. The tool is updated periodically, with at least 60 days' notice to providers.

00074634702	Humira	Prefilled Syringe Kit	ABBVIE	UN
00074647008	Pedialyte	Solution	ABBOTT NUTRITION	ML
00074647032	Pedialyte	Solution	ABBOTT NUTRITION	ML
00074647132	Pedialyte	Solution	ABBOTT NUTRITION	ML
00074659419	Synthroid	Tablet	ABBVIE	UN
00074659490	Synthroid	Tablet	ABBVIE	UN
00074662411	Synthroid	Tablet	ABBVIE	UN
00074662419	Synthroid	Tablet	ABBVIE	UN
00074662490	Synthroid	Tablet	ABBVIE	UN
00074679922	Kaletra	Tablet	ABBVIE	UN
00074706811	Synthroid	Tablet	ABBVIE	UN
00074706819	Synthroid	Tablet	ABBVIE	UN
00074706890	Synthroid	Tablet	ABBVIE	UN

SECTION 12:

CLEAR CLAIM CONNECT (C3)

SECTION 12: CLEAR CLAIM CONNECT (C3)

The C3 tool:

- Determines claims editing (claim check) prior to submission or after (to explain logic of processing).
- Provides claim editing logic only; results are not tied to benefits or medical policies.
- Looks back up to 99 lines regardless of rendering provider.

1. Under "Office Management," select "Clear Claims Connection (C3)."

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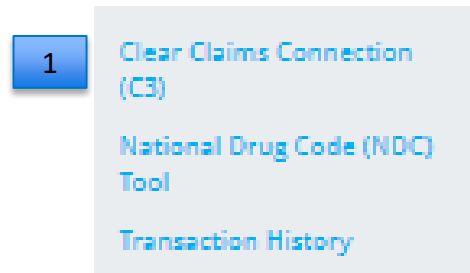
SECTION 12: CLEAR CLAIM CONNECT (C3) (CONT.)

2. Select claim type "professional" or "facility."

3. Enter the required information, including gender and date of birth.

4. Select "Review Claim Audit Results."

Section 13:

MEMBER EQUOTE GUIDE

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SECTION 13: MEMBER EQUOTE GUIDE

The Member eQuote Guide is a new tool to help you verify member benefits. It is the same tool used by our customer service team.

The eQuote Guide:

- Provides a simplified and more thorough benefit quote virtually.
- Links to important information such as a member contract documents, Medical Policies and Prior Approval lists.
- Allows you to determine whether state mandates apply to the member.
- Provides a reference number that can be used as proof you have verified a member's benefits.
- Saves you time by avoiding call center wait times.

Note:

➤ A real-time eligibility check needs to be done prior to using the eQuote Guide to confirm the member is active and the status of their out-of-pocket and benefit limits.

➤ eQuote Guides are not available for BlueCard Plans, Federal Employee Program, New England Health Plan, Access Blue New England, or Medicare Supplemental Plans.

SECTION 13: MEMBER EQUOTE GUIDE (CONT.)

1. Select "Search Patients" under "Patient Management."
2. Enter patient information by last name, first name format or by member ID number.
3. Select "Search."

SECTION 13: MEMBER EQUOTE GUIDE (CONT.)

4. Click "Select" next to the member's name.

Select the correct patient record

Click the **'Select' button** next to the desired patient, whose **ID starts with 'V'**

Return to Previous Page

Pages: (1)   Results: 1

Patient Search Results								Help
	Name	Sex	Birth Date	Address	Phone	ID	Primary Care Provider	Sponsor
4 Select	FLOWER, WALL	F			(802) 555-5552	V8	PITCHER, MARK	BCBSVT

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SECTION 13: MEMBER EQUOTE GUIDE (CONT.)

5. Select "Click here to view the eQuote Guide."

6. Your benefit verification reference number is located in the Record Locator field. Please save this reference number for your records as it will not be available once you have closed the guide.

7. Select "Open eQuote Guide" to review the member's quote guide.

8. The quote guide will open with information specific to the member. To search a specific benefit, you can either click on the benefit under the table of contents or conduct a search by using shift "F" and then entering your search criteria (for example, "chiropractic services").

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QHO- Benefit Quote Guide

Alpha Prefix: VEI	
Tier Level: Individual	
Network: Vermont: BCBSVT Network Out of State: BlueCard EPO/PPO Network	
Contract Documents for: 000C4	
o VEHI Platinum and Gold Exclusive Provider Organization (EPO) PCP Benefits Description	
Additional Information:	
o This is not a Blue Edge Plan	
o ---	

Publish Date: 02/10/2021

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9. This is an example of the information the eQuote Guide provides. (In this case, it is specific to chiropractic services.)

9

additional guidelines.

Chiropractic Services:

Chiropractic care is eligible based on medical necessity. A Network Chiropractor must perform the services or there are no benefits. Treatment must be for a neuromusculoskeletal condition (that is a condition of the bones, joints, or muscles). Prior approval is not required for the first 12 visits per member per plan year. If additional visits are necessary, prior approval is required. The prior approval form must be submitted before the 13th treatment and should be accompanied by progress notes to support the need for additional visits. There is a $30 co-payment per visit up to the $6,600 individual out-of-pocket limit. Services are then eligible at 100% of the allowed amount for the rest of the plan year.

Some diagnostics, for example x-rays rendered by a Chiropractor, are eligible under the plan.Services are eligible at 100% of the allowed amount.

ADDITIONAL INFORMATION:

o   Physical therapy services billed by a chiropractor will apply a visit to the combined PT/OT/ST limit and will also apply a chiropractic visit (regardless of whether an additional chiropractic service is rendered). The "Chiropractic Services" and "Physical Therapy/Medicine" medical policies outline the specific procedure codes that apply.

o   The Plan may allow an out of network provider at the network level of benefits when there is not a network provider with appropriate training and experience to provide the medically necessary services needed to meet the particular health care needs of a member; or

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SECTION 13: MEMBER EQUOTE GUIDE (CONT.)

10. To print the document, click on the printer icon at the top right-hand corner of the page.

11. Once the review is complete, close the tab by clicking on the "x" at the top of the page.

SECTION 14:

NEED HELP?

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SECTION 14: NEED HELP?

For assistance, contact Provider Relations at Blue Cross Blue Shield of Vermont at:

- By email: ProviderRelations@BCBSVT.com
- By phone: (888) 449-0443, option 1

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