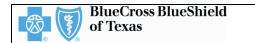
Blue Advantage HMOSM Quick Reference Guide

This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the HMO Blue TexasSM and Blue Advantage HMOSM Physician and Professional Provider — Provider Manual online at bcbstx.com/provider.



Blue Advantage HMO Quick Reference Guide Additional Information Page, cont'd

For Blue Advantage HMO, BCBSTX encourages the provider's office to:

- Ask for the member's ID card at the time of a visit:
- Copy both sides of the member's ID card and keep the copy with the patient's file;
- Eligibility, benefits and/or verification requests, contact availity.com, or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member's ID card.
- Utilize the iExchange Web application at http://www.bcbstx.com/provider/tools/iexchange.html to obtain approval of: referrals, select outpatient services and inpatient admissions, maternity notifications, or for notification within 48 hours of an emergency hospital admission. For case management, call the Medical Care Management Department at 855-896-2701.

Claims Submission:

- All claims should be submitted electronically. The Electronic Payor ID for BCBSTX is 84980.
 - For support relating to claims that are being sent to the Availity platform, submitters should contact Availity Client Services at 800-AVAILITY (282-4546).
 - For support relating to claims and/or other transactions available on the Availity portal or other Availity platforms, submitters should contact Availity Client Services at 800-AVAILITY (282-4546).
 - For information on electronic filing, access the Availity website at availity.com.
- Paper claims must be submitted on the Standard CMS-1500 (02/12) or UB-04 claim form.
- · All claims must be filed with the insured's complete unique ID number including any letter or 3-digit alpha prefix.
- Duplicate claims may not be submitted prior to the applicable 30-day (electronic) or 45-day (paper) claims payment period.
- If services are rendered directly by the physician or professional provider, the services may be billed by the physician or professional provider. However, if the physician or professional provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services. **Note**: This does not apply to services provided by an employee of a physician or professional provider, e.g. Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse First Assistant, who is under the direct supervision of the billing physician or professional provider.

Provider Record ID and Network Effective Dates:

- A minimum of 30 days advance notice is required when making changes affecting the provider's BCBSTX status, especially in the following areas:
- (1) Physical address (primary, secondary, tertiary); (2) Billing address; (3) NPI and Provider Record ID changes; (4) Moving from Group to Solo practice; (5) Moving from Solo to Group practice; (6) Moving from Group to Group practice; and (7) Backup/covering providers.
- New Provider Record ID effective dates will be established as of the date the completed application is received in the BCBSTX corporate office. This applies to all additions, changes and cancellations.
- BCBSTX will not add, change or cancel information related to the Provider Record ID on a retroactive basis.
- Retroactive Provider Record ID effective dates will not be issued.
- Retroactive network participation will not be issued.
- Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new Provider Record ID.
- If the provider files claims electronically and their Provider Record ID changes, the provider must contact the Availity Health Information Network at 800-AVAILITY (282-4546) to obtain a new EDI Agreement.
- For Provider Record ID questions or to obtain a Provider Record ID application, please contact the Provider Services department at 972-996-9610, press 3.

BlueCard (Out-of-State Claims):

- To check benefits or eligibility, call 800-676-BLUE (2583);
- File all that include a 3-digit alpha prefix on the member's ID card to BCBSTX (Note: The member's unique ID number may contain alpha characters which may or may not directly follow the 3-digit alpha prefix):
- File all other claims directly to the Home Plan's address as it appears on the back of the member's ID card;
- For status of claims filed to BCBSTX, contact availity.com or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member's ID card.

Blue Advantage HMO - Outpatient Clinical Reference Lab Services

All outpatient clinical reference lab services must be referred to Blue Advantage HMO's exclusive lab provider - Quest Diagnostics, Inc.

The Affordable Care Act (ACA) includes a provision that gives Health Insurance Marketplace members who receive advanced premium tax credits (APTC) also known as subsidies, a three-month grace period to pay their premium.

Grace Period Overview:

- The three-month grace period is only required for enrollees who have made one full premium payment during the benefit year and who are receiving the APTC.
- The health plan is responsible for adjudicating claims during the first month after a member enters the grace period. The claims adjudicated are for dates of service rendered within the first month of this grace period
- During the second and third months of the grace period, issuers have the choice of either pending the claims or adjudicating the claims and seeking a refund if the member doesn't pay all outstanding premium payments.
- If a member fails to pay all outstanding premiums by the end of the three-month grace period, the health plan must terminate the member's coverage.
- For additional details, go to www.Healthcare.gov.

. How will BCBSTX make providers aware?

- Eligibility and Benefits Determination will include a paid through date and be provided by:
 - Electronic and/or clearinghouse compliant with the HIPAA 270/271
 - Interactive Voice Response (IVR) / automated telephone system
 - Provider Customer Service
- Reminders to check for grace period status will be included on correspondence related to:
 - Pre-determinations
 - Preauthorizations
 - Referrals

Updated December 22, 2016 page 2 of 2

^{*} To access eligibility and benefits, you must have full subscriber's information, i.e. subscriber's ID, patient date of birth, etc.

^{**} To adjust a claim, you must have a document control number (claim number).