



BLUE CROSS AND BLUE SHIELD OF TEXAS

HMO BLUE[®] TEXAS AND BLUECHOICE[®]

Blue REVIEW

CONTAINS REQUIRED DISCLOSURES CONCERNING BLUE CROSS AND BLUE SHIELD OF TEXAS AND HMO BLUE TEXAS CLAIM PROCESSING PROCEDURES AND REQUIREMENTS.

TIME-SAVING STEPS

Sometimes, completing a claims form can be a daunting task. Therefore, *Blue Review* published this [Special Claims Issue](#). We hope it will answer most of your questions and help demystify the HCFA 1500 and UB92 claims forms. Information in this issue will help you submit cleaner claims, thus reducing the number of claims rejected and increase the timeliness of your reimbursements.

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1. Use Your Reports

Reports on transactions, rejections and explanations of payments are provided to your office from Blue Cross and Blue Shield of Texas (BCBSTX). The information in these reports can save your staff time and effort.

2. Take Note of Special Correspondence

Often providers receive requests for additional information before a claim can continue processing. These requests for information arrive as individual letters from Blue Cross and Blue Shield of Texas. Please read them carefully and submit the records requested.

3. Update Your Records Promptly

Once you review your reports/letters from BCBSTX, update your records to reflect current status. Many status questions can be answered without calls to Customer Service, which saves time for everyone involved. In fact, recent reports from our Customer Service Unit revealed that nearly 80 percent of the calls on claims status were unnecessary. This 80 percent involved claims that had been processed with reports or payments already sent to the provider office.

4. Use BCBSTX Automated Systems

The automated systems at BCBSTX are available for your convenience.

5. Call the BlueCard Toll-Free Number for Benefits

Dial **1-800-676-BLUE (2583)** to obtain membership and coverage information for members of Blues Plans outside of Texas (BlueCard out-of-state subscribers). The three alpha characters of the member ID number will direct your call to the appropriate home plan for benefit information.

6. Read the Member ID Card Carefully

Key information you will need to file claims is on the front and back of every member ID card. Use this information for efficient claims filing. (If you are a member of an Independent Physician Association (IPA), some claims will need to be filed with the IPA. More information on this will be sent out soon.)

7. Use Electronic Claims Submission

Electronic claims submission is by far the best way to send claims. To learn more about the latest information regarding electronic claims submission, visit www.thinedi.com (the Web site for Provider Automation).

8. Direct Necessary Questions to Customer Service

When the information is not available from your reports, BCBSTX publications, or through one of our automated systems, let our Customer Service Representatives work with you. When calling Customer Service, listen carefully to your options so your call will be routed to the appropriate unit. ■

SUBMITTING CLEAN CLAIMS FOR PROMPT PAYMENT

The Texas Administrative Code provides guidelines to help physicians, providers and insurance companies work more efficiently together with regard to claims. These guidelines, set forth in 28 Texas Administrative Code (TAC) 21.2801–21.2820, describe what constitutes a “clean claim,” from required information to required fields.

Pursuant to these rules, Blue Cross and Blue Shield of Texas and HMO Blue Texas requirements for a clean claim are set forth below. This issue is packed with information and user-friendly tools to further assist you in claims submission.

Required Claim Information

Blue Cross and Blue Shield of Texas and HMO Blue Texas consider a claim to be a clean claim if it contains:

1. All the required data elements set forth in 28 TAC Section 21.2803,
2. The additional data elements required by BCBSTX and HMO Blue Texas as set forth below,
3. The attachments required by BCBSTX and HMO Blue Texas, and
4. The amount paid by the primary plan or other valid coverage pursuant to 28 TAC Section 21.2803(e), if applicable.

HCFA 1500 Claim Form

These additional data elements are required by BCBSTX and HMO Blue Texas.

FIELD	DATA NEEDED
17	Referring physician name, if applicable
17a	Referring physician UPIN number, if applicable
18	Hospital dates of service, if applicable
20	Outside diagnostic services, if applicable
24K	Provider number
33	Physician name and address needs to include billing provider number

UB92 Claim Form

These additional data elements are required by BCBSTX and HMO Blue Texas.

FIELD	DATA NEEDED
44	HPCPS/rates as required by contract
48	Non-covered charges, if applicable
51	Provider number
62	Group number

Additional TAC 21.2803 Requirements

- **Complete and accurate identification number exactly as it appears on the ID card.** An HMO identification number must include the hyphenated two-digit suffix. This is **HCFA field 1a** and **UB92 form locator 60**.
- **Complete and accurate group number.** This is **HCFA 1500 field 11** and **UB92 form locator 62**.
- **For paper claims**, each claim submitted for processing as the secondary insurance carrier **must have an EOP/EOB attached. For electronic claims**, each claim submitted for processing as the secondary insurance carrier **must have the required data elements included in the electronic record**.
- **Descriptions for unlisted codes**, such as Chart Notes and Medical Notes. An unlisted code is one that is not supported with description information in the CPT code listing. ■

COMMON ERROR FIELDS

To have the best possible success with claims submission, the following are important:

- Complete all fields required to process the claim.
- Ensure all fields are completed accurately.
- Send a clean, clear copy of the claim form that can be scanned into the system.
- Send original claim forms, not a copy.
- Make sure all entries are made above the line.

The fields listed below represent those where the most common claim submission errors occur for the HCFA 1500 and UB92 claim forms. These fields are frequently left blank or contain inaccurate information. Some of them are required for a clean claim and, if improperly completed, can result in a claim being rejected.

HCFA 1500 Common Claim Errors

FIELD	DATA NEEDED
1a	Enter the patient's identification number EXACTLY as it appears on the ID card. For example, the HMO identification number must have the hyphenated two-digit suffix to be accurate.
4	Enter the patient name as it appears on the ID card.
7	Enter the correct patient address.
9	Enter the name of the other insured.
9a	Enter the group number of the other insured.
9b	Enter the date of birth and gender of the other insured.
9c	Enter the employer or school name of the other insured.
9d	Enter insurance plan name or program name of the other insured.
11	Enter the group number.
11d	Indicate if there is another health benefit plan. If there is another health benefit plan and you check "yes," then fields 9–9d must also be completed.
14	Enter occurrence date. This is the date when the illness first appeared or the date an accident happened. For pregnancy, enter the LMP date.
15	Enter onset date, which indicates if the illness has occurred previously. If no previous onset, enter the occurrence date shown in Field 14.
24d	Enter valid procedure codes, including modifiers if applicable.
24k	Enter the six-digit performing provider number.
29	Enter the amount paid by the patient.
33	Enter the billing provider number.

UB92 Common Claim Errors

FIELD	DATA NEEDED
12	Enter the patient name as it appears on the ID card.
13	Enter the correct patient address.
32	Enter occurrence dates. Complete the dates as can best be determined based on patient information and medical records. In the absence of this information, use the date of service. This is the date the illness first appeared or the date an accident happened. For pregnancy, enter the LMP date. The onset date indicates if the illness has occurred previously. If no previous onset, enter the date of service.
51	Enter the billing provider number.
54	Enter the amount paid by the patient.
58	Enter the name of the other insured.
60	Enter the patient's identification number, or the ID number of the other insured, EXACTLY as it appears on the ID card. For example, the HMO identification number must have the hyphenated two-digit suffix to be accurate.
62a–c	Enter the group number.
62	Enter the group number of the other insured.
65	Enter the employer or school name.
80–81	Enter valid procedure codes, including modifiers if applicable.

HCFA 1500 CLEAN CLAIMS FIELDS

The fields listed here and highlighted on the next page are needed to process claims and are required by TDI, BCBSTX and HMO Blue Texas for the submission of clean claims.

Essential data elements required by TDI

FIELD	DATA NEEDED
1a	Subscriber's or patient's plan ID number
2	Patient's name
3	Patient's date of birth and gender
4	Subscriber's name
5	Patient's address (street or post office box, city, zip code)
6	Patient's relationship to subscriber
7	Subscriber's address
10	Whether patient's condition is related to employment, auto accident, or other accident
11	Subscriber's policy number
11a	Subscriber's birth date and gender
11c	HMO or preferred provider carrier name
11d	Disclosure of any other health benefit plans*
12	Patient's or authorized person's dated signature or notation that the dated signature is on file with the physician or provider
13	Subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider
14	Date of current illness, injury or pregnancy
15	First date of previous, same or similar illness
21	Diagnosis codes or nature of illness or injury
24A	Date(s) of service
24B	Place of service codes
24C	Type of service code
24D	Procedure/modifier code
24E	Diagnosis code by specific service
24F	Charge for each listed service
24G	Number of days or units
25	Physician's or provider's federal tax ID number
28	Total charge
31	Dated signature of physician or provider or notation that the dated signature is on file with the HMO or preferred provider carrier
32	Name and address of facility where services were rendered (if other than home or office)
33	Physician's or provider's billing name and address

*If answer in Field 11d is "yes," then data elements in Fields 9, 9a, 9b, 9c, and 9d must be completed. If answer is "no," then Fields 9, 9a, 9b, 9c, and 9d are not essential data elements if the physician or provider has on file a statement signed by the patient/insured within the last 12 months that there is no other coverage. Such statement may be in the form of initial or annual office visit questionnaires, patient sign-in sheets, a routine record update, etc.

Data elements required by TDI, if applicable. For example, fields 9, 9a, 9b, 9c and 9d must be completed if field 11d has data entered.

FIELD	DATA NEEDED
9	Other insured's or enrollee's name—applicable if Field 11d is answered "yes"***
9a	Other insured's or enrollee's policy/group number—applicable if Field 11d is answered "yes"***
9b	Other insured's or enrollee's date of birth—applicable if Field 11d is answered "yes"***
9c	Other insured's or enrollee's plan name (employer, school, etc)—applicable if Field 11d is answered "yes"***
9d	Other insured's or enrollee's HMO or insurer name—applicable if Field 11d is answered "yes"***
11b	Subscriber's plan name (employer, school, etc.)—applicable if health plan is a group plan
23	Prior authorization number—applicable when prior authorization is required
27	Whether assignment was accepted—applicable when assignment under Medicare has been accepted
29	Amount paid—applicable if an amount has been paid by or on behalf of the patient or subscriber or by a primary plan
30	Balance due—applicable if an amount has been paid by or on behalf of the patient or subscriber or by a primary plan

**Required unless the physician or provider submits proof of a good faith but unsuccessful effort to obtain this information from the enrollee/insured.

Data elements required by Blue Cross and Blue Shield of Texas and HMO Blue Texas

FIELD	DATA NEEDED
17	Referring physician name, if applicable†
17a	Referring physician UPIN number, if applicable†
18	Hospitalization dates related to current service, if applicable
20	Outside diagnostic services, if applicable
24K	Six-digit performing provider number
33	Billing provider number

†All specialist claims require these data elements.

IMPORTANT PROMPT PAY INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input checked="" type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)						1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) ZGA 123456789															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane C.				3. PATIENT'S BIRTH DATE SEX MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> 07 24 44 M		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Jane C.															
5. PATIENT'S ADDRESS (No., Street) 1234 4th Street				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 1234 4th Street															
CITY Dallas		STATE TX		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		CITY Dallas		STATE TX													
ZIP CODE 75000		TELEPHONE (Include Area Code) (972) 555-0000				ZIP CODE 75000		TELEPHONE (INCLUDE AREA CODE) (972) 555-0000													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John A.						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
a. OTHER INSURED'S POLICY OR GROUP NUMBER Group 54321						11. INSURED'S POLICY GROUP OR FECA NUMBER Group 12345															
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> 08 18 42 M						a. INSURED'S DATE OF BIRTH: SEX MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> 07 24 44 M															
c. EMPLOYER'S NAME OR SCHOOL NAME XYZ Company						b. EMPLOYER'S NAME OR SCHOOL NAME ABC Company															
d. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross and Blue Shield of TX						c. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross and Blue Shield of TX															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED <u>Jane C. Doe</u> DATE <u>7/02/01</u>						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED <u>Jane C. Doe</u>															
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 06 02 01				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 06 02 01		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17a. I.D. NUMBER OF REFERRING PHYSICIAN															
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <u>216.3</u> 3. _____ 2. <u>401.9</u> 4. _____						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. _____															
23. PRIOR AUTHORIZATION NUMBER _____						24. PROCEDURE(S) OF SERVICE, PLACE OF SERVICE, TYPE OF SERVICE, PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EP/SDT Family Plan EMG COB RESERVED FOR LOCAL USE															
DATE(S) OF SERVICE From MM DD YY To MM DD YY		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EP/SDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
07 02 01		3		2		11100		1		25 00		1								CL889999	
07 02 01		3		6		99212		2		50 00		1								CL889999	
25. FEDERAL TAX I.D. NUMBER SSN EIN 721234567 <input type="checkbox"/> <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. 112234		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 75.00		29. AMOUNT PAID \$ 0.00		30. BALANCE DUE \$ 75.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <u>A.B. Clark, MD</u> DATE <u>7/18/01</u>				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) Family Medical-Surgical Clinic 8822 Main Street Dallas, TX 75200				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Family Medical-Surgical Clinic 8822 Main Street Dallas, TX 75200 (972) 555-1234 PIN# GRP# <u>7222</u>													

Indicates an essential data element required by TDI
 Indicates data elements required by TDI, if applicable.
 Indicates data elements required by Blue Cross and Blue Shield of Texas and HMO Blue Texas

UB92 CLEAN CLAIMS FIELDS

The fields listed here and highlighted on the next page are needed to process claims and are required by TDI, BCBSTX and HMO Blue Texas for the submission of clean claims by facilities and ancillaries.

Essential data elements required by TDI

FIELD	DATA NEEDED
1	Provider's name, address and phone number
3	Patient control number
4	Type of bill code
5	Provider's federal tax ID number
6	Statement period (beginning and ending date of claim period)
12	Patient's name
13	Patient's address
14	Patient's date of birth
15	Patient's gender
16	Patient's marital status
17	Date of admission
18	Admission hour
19	Type of admission (e.g.; emergency, urgent, elective, newborn)
20	Source of admission code
22	Patient status at discharge code
39-41	Value code and amounts
42	Revenue code
43	Revenue code description
46	Units of service
47	Total charge
50	HMO or preferred provider carrier name
58	Subscriber's name
59	Patient's relationship to subscriber
60	Patient's/subscriber's certificate number, health claim number, ID number
67	Principal diagnosis code
82	Attending physician ID
85	Signature of provider representative or notation that the signature is on file with the HMO or preferred provider carrier
86	Date bill submitted

Indicates conditional data elements required by TDI, if applicable to the claim

FIELD	DATA NEEDED
7	Covered days—applicable if Medicare is a primary or secondary payer
8	Non-covered days—applicable if Medicare is a primary or secondary payer
9	Coinsurance days—applicable if Medicare is a primary or secondary payer
10	Lifetime reserve days—applicable if Medicare is a primary or secondary payer and patient was an inpatient
21	Discharge hour—applicable if patient was an inpatient or was admitted for outpatient observation
24-30	Condition codes—applicable if the HCFA/UB92 manual contains a condition code appropriate to the patient's condition
31-35	Occurrence codes and dates—applicable if the HCFA UB92 manual contains an occurrence code appropriate to the patient's condition
36	Occurrence span code, from and through dates—applicable if the HCFA UB92 manual contains an occurrence span code appropriate to the patient's condition
44	HCPCS/Rates—applicable if Medicare is a primary or secondary payer
54	Prior payments, payer and patient—applicable if payments have been made to the provider by, or on behalf of, the patient or subscriber or by a primary plan
68-75	Diagnoses codes other than principal diagnoses code—applicable if there are diagnosis other than the principal diagnoses
79	Procedure coding methods used—applicable if the HCFA UB92 manual indicates a procedural coding method appropriate to the patient's condition
80	Principal procedure code—applicable if the patient has undergone an inpatient or outpatient surgical procedure
81	Other procedure code—applicable as an extension of field 80 if additional surgical procedures were performed

Indicates data elements required by Blue Cross and Blue Shield of Texas and HMO Blue Texas

FIELD	DATA NEEDED
44	HCPCS/Rates as required by contract
48	Non-covered charges, if applicable
51	Provider number
62	Group number

IMPORTANT PROMPT PAY INFORMATION

APPROVED OMB NO. 0938-0279

1 ABC Hospital 1234 Main Street Dallas, Texas 75234					3 PATIENT CONTROL NO. 112235			4 TYPE OF BILL 111																		
5 FED. TAX NO. 752345678		6 STATEMENT COVERS PERIOD FROM 01/01/02 01/03/02		7 COV D. 2	8 N-C D.	9 C-I D.	10 L-R D.	11																		
12 PATIENT NAME Jane M. Doe				13 PATIENT ADDRESS 1234 4th Street Dallas, Texas 75234																						
14 BIRTHDATE 08/10/1942	15 SEX F	16 MS M	17 DATE 01/01/02		18 HR	19 TYPE	20 SRC	21 O HR	22 STAT	23 MEDICAL RECORD NO. 000023456	24		25		26		27		28		29		30		31	
32 OCCURRENCE CODE 11	OCCURRENCE DATE 09/18/01	34 OCCURRENCE CODE	OCCURRENCE DATE	36 OCCURRENCE CODE	OCCURRENCE SPAN FROM	THROUGH	37	A	B	C	39 CODE	a	b	c	d	41 CODE	a	b	c	d						
Blue Cross Blue Shield PO Box 660044 Dallas, Texas 75266-0044										39 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT														
42 REV. CD.	43 DESCRIPTION			44 HCPCS / RATES		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49														
120	Room-Board/Semi			\$464.00			2	928 00																		
250	Pharmacy						38	335 70																		
270	Med-Surg Supplies						41	950 00																		
300	Laboratory						5	281 20																		
360	OR Services						5	1500 00																		
370	Anesthesia						5	1200 00																		
710	Recovery Room						2	300 00																		
001	Total Chgs							5494 90																		
50 PAYER Blue Cross Blue Shield PPO/POS				51 PROVIDER NO. HH0000		52 REL. INFO	53 ASG BEN	54 PRIOR PAYMENTS 00		55 EST. AMOUNT DUE		56														
57 DUE FROM PATIENT																										
58 INSURED'S NAME Jane M. Doe				59 P.REL.		60 CERT. - SSN - HIC. - ID NO. ZGP 1234567898			61 GROUP NAME ABC Group		62 INSURANCE GROUP NO. 12345															
63 TREATMENT AUTHORIZATION CODES ABC9D000			64 ESC			65 EMPLOYER NAME XYZ Company			66 EMPLOYER LOCATION 5678 Employers Lane Dallas, Texas																	
67 PRIN. DIAG. CD. 216.3	68 CODE 401.9	69	70 CODE	71	72 CODE	73	74 CODE	75	76 ADM DIAG. CD. 216.3	77 E-CODE	78															
79 P.C. CODE 9	80 PRINCIPAL PROCEDURE DATE 01/01/02	81 OTHER PROCEDURE CODE	82 ATTENDING PHYS. ID E12345 Dr. John Doe	83 OTHER PHYS. ID	84 REMARKS	85 PROVIDER REPRESENTATIVE X A.B. Clark, MD	86 DATE 01/10/02																			

B-92 HCFA-1450

OCR/Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

- Indicates an essential data element required by TDI
- Indicates data elements required by TDI, if applicable.
- Indicates data elements required by Blue Cross and Blue Shield of Texas and HMO Blue Texas



Blue Cross and Blue Shield of Texas
 Attach a completed form to each claim submitted for reconsideration.
Provider Request for Claim Reconsideration Review
 Do not resubmit claims in question for payment unless instructed to do so by a reviewer. Attach supporting documentation to facilitate your review. For example the operative report, or medical records, etc.
 This review has been requested by (Name of Reviewer)

ParPlan/BlueChoice	ParPlan/BlueChoice, P.O. Box 655488, Dallas, Texas 75265-5488
FedSelect	FEP, P.O. 660129, Dallas, Texas 75265-0129
HealthSelect	HealthSelect, P.O. Box 833988, Richardson, Texas 75083-3988
HealthSelect Plus	HealthSelect Plus Customer Service, P.O. Box 833804, Richardson, Texas 75083-3804
HMO Blue Texas	HMO Blue Texas, Customer Service, P.O. Box 660044, Dallas, Texas 75266-0044

Claim Data:
 Identification Number (include six four-digit parts)
 Member's Name
 Group #
 Patient's Name
 Date(s) of Service
 Billed Amount

Provider Data:
 Today's Date
 Provider Number
 Provider Name
 Address
 Contact Person
 Reason for Review: (Please state your reason in the space provided)

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 HMO plan offered by BlueCross Texas HMO, Inc. © Blue Cross Blue Shield
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CLAIM RECONSIDERATION

When a provider questions a claim determination, a request for reconsideration can be submitted.

Examples of claim reconsideration requests are:

- A claim is denied for lack of precertification.
- A lower than expected level of benefits is allowed (*i.e.* out-of-network).
- A rebundling issue (claim check), allowed amount, etc.

To request a claim reconsideration, you must:

- Submit the request for reconsideration in writing.
- For the most efficient processing, use the form illustrated on this page. Ask your Provider representative for a copy.
- Requests must be submitted in a timely manner (within 12 months of the date of service for HMO).

Additional Information

At the time a reconsideration is submitted, it is important to include any additional information that the provider considers pertinent to coverage. This information could be:

- Reason for appeal request
- Provider progress notes
- Diagnostic testing results
- Pathology report
- History and physical exam
- Discharge summary
- Operative report
- Copy of contract showing correct allowable

Send Requests for Reconsideration to:

BlueChoice/ParPlan
 P.O. Box 655488
 Dallas, TX 75265-5488

HMO Blue Texas
 P.O. Box 660044
 Dallas, TX 75266-0044

HealthSelectSM
 P.O. Box 833988
 Richardson, TX 75083-3988

HealthSelect PlusSM—ERS
 P.O. Box 833804
 Richardson, TX 75083-3804

FedSelect—FEP
 P.O. Box 660129
 Dallas, TX 75266-0129

Reconsideration Period

If you request a retrospective reconsideration, which is made after a claim has been filed and denied, the decision will be made in the standard amount of time: 30 days after the request to review the claim denial determination has been received. ■

DUPLICATE CLAIMS ARE COSTLY

While legislative mandates and the Texas Department of Insurance allow for a 45-day claims process by carriers, many providers are still sending duplicate claims within 30 days of the original claim submission. Duplicate claims are extremely counter-productive for providers and insurance carriers.

Every time duplicate claims are filed:

1. Time is taken in the claims processing system that could be used to process claims already in process.
2. Valuable staff time is used to track duplicate claims and reconcile the system for BCBSTX.
3. Your staff loses office time completing and submitting the second claim.
4. You may be paying a billing service to resubmit a claim that was already in process to pay within a few days.

Why Are Duplicate Claims Filed?

Here are the top five reasons duplicate claims are filed, and ways to avoid these situations.

1. *An electronic claim has not been paid and a duplicate claim is submitted on paper.*

In the case of electronic claims, the reports received by your office can tell you if a claim is in process or if action is needed on your part. If the claim is in process, resubmitting on paper will not speed payment. In fact, it will delay payment as the duplicate claim is researched. Effectively using the reports generated will make filing additional claims unnecessary in most cases.

2. *A claim submitted on paper has not been paid.*

The goal is to process all claims in a timely manner allowing payments to be sent to providers within 45 days. Resubmitting prior to 45 days will not alter the process of the original claim and will cause additional claims volume in the system.

3. *A claim was rejected for lack of additional information.*

If a claim is returned for more information or corrected data, the claim should be resubmitted WITH the information requested. Also, include a copy of the request for this additional data.

4. *The billing cycle automatically resubmits a claim after a specified period, which is less than 45 days.*

Refiling a claim prior to 45 days will not improve the payment time on a claim already submitted. Resubmitting claims prior to 45 days is costly to providers, especially if claims are processed through a billing service.

5. *Payment has been received, but not posted to show the claim is paid.*

It is very important to process all reports and checks promptly once they reach the provider's office. A significant number of Customer Service calls involve payments already made.

At Blue Cross and Blue Shield of Texas, we are committed to paying all claims as promptly and accurately as possible. We are asking your help in reducing duplicate claims and allowing our systems to work to their full capacity processing current claims on the first submission. ■

Customer Service Phone Numbers

BlueChoice PPO	.....	1-800-451-0287
HMO Blue Texas	.....	1-877-299-2377
HealthSelect™	.....	1-800-252-8039
HealthSelect Plus™	.....	1-888-585-9393
FEP	.....	1-800-442-4607
Medicaid	.....	1-800-399-5830

Claims Filing Addresses

BlueChoice/ParPlan
P.O. Box 660044
Dallas, TX 75266-0044

HMO Blue Texas
P.O. Box 660044
Dallas, TX 75266-0044

FedSelect — FEP
P.O. Box 660129
Dallas, TX 75266-0129

HealthSelect
P.O. Box 833988
Richardson, TX 75083-3988

HealthSelect Plus — ERS
P.O. Box 833804
Richardson, TX 75083-3804

Medicaid
P.O. Box 660015
Dallas, TX 75265-0015

MAKING CLAIMS FILING EASIER WITH THINSM

Blue Cross and Blue Shield of Texas offers The Health Information Network (THIN), an electronic claims clearing-house for institutional and professional health care providers. You may reduce your administrative cost, improve accuracy of payments and speed claims payment by filing all of your BCBSTX and HMO Blue Texas claims, encounter data and multiple commercial carriers through THIN.

Claims that can be Filed at No Cost through THIN

- All BCBSTX claims (including out-of-state claims)
- BlueChoice claims
- HMO Blue Texas claims
- HMO Blue Texas Medicaid claims
- State of Texas Employee claims (ERS)
- Federal Employee Program claims
- Blue Cross and Blue Shield Secondary claims
- Most Local and National Health Insurance Carriers and Payers (Commercial Claims)

THIN Services Benefit Submitters

THIN-APP

THIN-APP is a feature that allows providers to submit claims electronically for carriers who are not electronically connected to THIN. There is a fee for each claim processed and mailed using THIN-APP, equivalent to the current cost of first-class postage.

Online Inquiry

Free software for online inquiry gives you immediate, toll-free, access to the following Blue Cross and Blue Shield of Texas information:

- Verification of subscriber and dependent coverage

- Coverage effective dates
- Verification of subscriber's benefits
- Birth date verification
- Subscriber's group number
- Claims status inquiry
- Verification of electronic claims transmissions
- Unlimited number of inquiries

Electronic Remittance Notice

Electronic Remittance Notice (ERN) files for BCBSTX are available at no charge and may save providers both time and money by allowing Blue Cross (Institutional) and Blue Shield (Professional) payments to be posted automatically to patient accounts. ERNs are produced weekly and placed in an electronic mailbox.

Electronic Response Reports

Claims editing for accuracy and timely processing.

EDI Helpline

The EDI Helpline is available Monday through Friday, 8 a.m. to 4:30 p.m., CST at **(972) 766-5480**.

THIN Electronic Response Reports

THIN has several different Response Reports that will assist you in managing the claims that you file electronically. *THIN Response Reports acknowledge all accepted claims, as well as the rejected claims.*

The Real-Time and Daily Confirmation reports are also available as a flat file, so you and your software vendor can reformat to your specific needs for automatic response posting. The new response reports available are:

- Real-Time Acceptance Reports
- Submitter Daily File Confirmation Report
- Provider Daily Claim Confirmation Report
- Sender and Payer Confirmation Report
- Submitter Payer Summary—Monthly Report ■

FILING UB92 CLAIMS NOW EASIER

Compared to paper claims, electronic claims offer more accurate processing and faster reimbursement. Now those who file UB92 claim forms can submit even more of them electronically.

The 20-detail line restriction has been eliminated from electronically submitted UB92 claim forms. You can now electronically submit up to 46 detail lines, including the 0001 total revenue code!

However, before you attempt to electronically submit claims with more than 20 detail lines, be sure to review your system edits with your vendor. Your software may need to be changed to accommodate the additional detail lines.

If you have questions regarding this change, please feel free to contact your Provider Automation Representative or the EDI Helpline at **(972) 766-5480**. ■

Attention Office Manager : We want to know how you rate Blue Review and its value to your office. Please work with your physician/health provider to complete the following survey.

PLEASE COMPLETE AND RETURN

Topics read the most are: (Check all that apply)

- Medical Practice Guidelines
- Claims Articles
- New Technology Information
- Disease Management
- Behavioral Health
- Physician Focus
- Benefits Articles
- Legislative Updates
- Medical Policy Articles
- Reimbursement Tips

After reviewing this newsletter, your opinion of the format is:

- Very Favorable
- Favorable
- Less Favorable

Did you find it easy to read?

- Very Reader-friendly
- Reader-friendly
- Not Reader-friendly

I have access to the World Wide Web:

- Yes
- No

Have you visited the BCBSTX Web site at www.bcbstx.com?

- Yes
- No

Who in your office reads the newsletter? (Check all that apply)

- Office Manager
- Claims Staff
- Physician/Provider

Are you aware of the following features of our Web site?

Provider FinderSM Yes No

Pharmacy FinderSM Yes No

Healthy Living Section Yes No

Provider Section Yes No

In the day-to-day management of your office, *Blue Review* is:

- Very Valuable
- Valuable
- Not Valuable

How would you like to receive company information?

(Check all that apply)

Mail Web Page Fax (____) _____

E-mail My E-mail address is _____

Blue Review makes a valuable contribution to your office by:

- Increasing efficiency
- Reducing claims rejections
- Offering new product information
- Bringing awareness of medical issues
- Providing practice guideline updates
- Other: _____

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 2956 DALLAS TX

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ATTN: CORPORATE COMMUNICATIONS LL-K-SOUTH
BLUE CROSS AND BLUE SHIELD OF TEXAS
PO BOX 660112
DALLAS TX 75266-9973

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Special Claims Issue

Look inside for helpful information on completing HCFA 1500 and UB92 claim forms for fewer rejected claims and more timely reimbursements.

Also Inside : Information on submitting electronic claims

bcbs and Claims Billing Services

Physicians and providers who contract with claims billing services reap many benefits. For one, it allows providers' staff more time for non-billing activities.

Often, provider billing services are the primary contact with Blue Cross and Blue Shield of Texas. This contact is generally to determine the status of a claim previously submitted for payment. To ensure that the relationship and communication between your billing service and BCBSTX is efficient, please consider the following:

- Share BCBSTX correspondence with your billing service, especially information that is related to claims or customer service.
- Verify that they consistently submit clean and accurate claims.
- Select a billing office that submits electronically, and reviews accept/reject reports regularly.
- Require that your billing service allow sufficient time for claims processing before resubmitting for payment. (Resubmission of claims prior to 45 days from initial filing slows the payment process for all involved, and could cost additional claims submission fees.) ■



**BlueCross BlueShield
of Texas**

Blue Review

Published quarterly for BlueChoice, ParPlan and HMO Blue Texas contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome.

Please mail to: Corporate Communications, *Blue Review* Editor, Blue Cross and Blue Shield of Texas, P.O. Box 655730, Dallas, Texas 75265-5730.

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