

## Claims Submission and Billing Information

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## Overview

Pennsylvania Blue Shield processes over 245,000 private business claims per day. During 1999, it processed more than 61 million claims. The Company could not have accomplished this without the cooperation of providers, office and medical assistants who prepare and submit claims to Blue Shield.

This section of the *Blue Shield Reference Guide* contains information to help you prepare and submit claims to Blue Shield. It explains the flow of information, from verifying the eligibility of members to completing claim forms and billing options. Step-by-step instructions and guidelines are included here for each of these activities.

## Verifying eligibility

There are several ways to verify eligibility of Blue Shield members: CareConnect, OASIS, InfoFax and identification cards.

### CareConnect

If you have access to the Internet, you can use your computer to obtain eligibility and claim status information. CareConnect provides electronic and paper billers daily direct access to pertinent databases and valuable reference material needed by health care professionals.

You can access CareConnect at [www.careconnect.com](http://www.careconnect.com). Refer to Section 10, "Provider Services and Information Sources," for more information about CareConnect.

### OASIS

OASIS (Office Assistance Information System) is Blue Shield's fully-automated, telephone response service. Providers may call OASIS on a touch-tone telephone to determine benefits, service restrictions and to obtain enrollment and claim status information.

OASIS is easy to use and provides clear and concise information about Blue Shield's medical-surgical, Medigap (65 Special/Security 65) and vision programs. The service is available 7 a.m. to 11 p.m., Monday through Friday, and 7 a.m. to 5 p.m., Saturday and Sunday. It allows for unlimited inquiries on multiple patients per telephone call.

Four specific areas of information are available through OASIS:

1. Benefit inquiry — By inputting the patient's agreement number or health insurance claim (HIC) number and a benefit category number, OASIS will respond with the member's benefit information.
2. Service restriction inquiry — OASIS will provide the patient's last date of service, if any, for vision examinations, frames and lenses.
3. Enrollment inquiry — OASIS will verify the member's agreement and any spouse or dependents enrolled, including group numbers and effective dates, as well as the type of plan(s) under which the member is covered, that is, medical-surgical, vision or major medical.
4. Status of claim inquiry — For participating providers, OASIS will provide the status of a patient's claims for services performed by the provider including check number, check amount and payee.

To access OASIS, call (800) 462-7474, or in the Harrisburg area, (717) 975-6800 on your touch-tone telephone.

To obtain a copy of the *OASIS Quick Reference Guide*, please call Blue Shield's Shipping Control department at (717) 763-3256 and ask for form No. 2556.

If you have questions about OASIS, or need OASIS training for your staff, please contact your Provider Relations representative.

### **InfoFax**

InfoFax is a free service that allows you access to enrollment and benefits information and claims status through the use of your touch-tone telephone. The information is sent to your fax machine.

InfoFax is similar to OASIS in that you enter the patient's information into the system through your touch-tone telephone. Instead of the information being read back to you, the response is faxed to you in minutes.

Please refer to Section 10, "Provider Services and Information Sources," for more information about InfoFax.

### **Identification cards**

Blue Shield issues members a variety of identification cards, depending upon the type of program and the location of the Blue Cross Plan through which members are enrolled. Generally, the identification card includes the following information:

- Identification number — alpha-numeric\* characters used to identify the member (often the member's Social Security number);
- Group number — a series of alphabetical and numeric characters assigned to employment groups, professional associations and direct payment programs;
- Plan code — three digits that identify the Blue Cross and Blue Shield Plan through which the member is enrolled;
- Type of agreement — a brief description of the type of agreements and coverage of the member. Not all identification cards have this information;
- BlueCard — all BlueCard members can be identified by a three-digit alphabetical prefix preceding the member identification number on their identification card. You can identify an eligible PPO BlueCard member by the "PPO in a suitcase" logo on their identification card.

Examples of some identification cards are included in the Appendix. Since the Blue Cross Plans periodically update the format of the identification cards, the information provided on the sample identification cards may change without prior notice.

## **General guidelines for completing and mailing claim forms**

In today's business world, there is little reason to submit claims on paper. Electronic transactions and online communications are integral to health care. In fact, Blue Shield's claim system places a higher priority on processing and payment of claims filed electronically. If you are not already billing electronically, please refer to Section 6, "Electronic Data Interchange," for information on how to take advantage of the electronic solutions available to you.

**If you choose to submit paper claims, always print or type all information on the claim form.** Clear, concise reporting on the form helps us to interpret the information correctly. If we need to hold the claim for additional information, you'll experience payment delays.

**Please complete the claim form in its entirety.** Our claims examiners code each claim individually. If you submit several claim forms for the same member, but fill in only essential details on one form, Blue Shield will delay the claims with missing details until all information is secured.

*\*Alphabetical prefixes are used in conjunction with the identification number to identify the member's coverage.*

In cases where you must use several claim forms to report multiple services for the same patient, total the charges on each form separately. Treat each form as a separate and complete request for payment. Do not carry balances forward. It also is important that you report all other essential information on each claim form.

Complete private business claims for services provided to a Blue Shield member on the appropriate claim form and mail them to one of these appropriate addresses:

**Central Site Accounts claims**

Pennsylvania Blue Shield  
PO Box 898852  
Camp Hill, Pa. 17089-8852

**Federal Employee Program claims**

Pennsylvania Blue Shield  
PO Box 898854  
Camp Hill, Pa. 17089-8854

**Keystone Health Plan West claims**

Keystone Health Plan West, Inc.  
PO Box 898819  
Camp Hill, Pa. 17089-8819

**Medical-surgical claims**

Pennsylvania Blue Shield  
PO Box 890062  
Camp Hill, Pa. 17089-0062

**Medigap claims**

Pennsylvania Blue Shield  
Medigap Claims Department  
PO Box 898845  
Camp Hill, Pa. 17089-8845

**Vision claims**

Clarity Vision, Inc.  
PO Box 890500  
Camp Hill, Pa. 17089-0500

**Ordering forms**

When ordering forms, please specify the form number and quantity desired. A sample re-ordering request form (form No. MA558) is included on Pages 5 - 6. Send the form to:

Pennsylvania Blue Shield  
Shipping Control Department  
PO Box 890089  
Camp Hill, Pa. 17089-0089

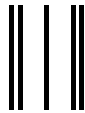
You may also call Blue Shield's automated ordering system at (717) 763-3256.





P.O. Box 890089  
Camp Hill, PA 17089-0089

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
PROVIDER NUMBER



PLACE  
1ST CLASS  
STAMP  
HERE

MA558 J 03/00

SHIPPING CONTROL  
PENNSYLVANIA BLUE SHIELD  
PO BOX 890089  
CAMP HILL PA 17089-0089



**REORDERING REQUEST--PENNSYLVANIA BLUE SHIELD\* FORMS**

Pre-Printed	Non-Printed	CLAIM FORMS	
_____ 12	_____	(15)	1-Part Vision Claim Form
	_____ 31	(122)	1-Part CRNA Claim Form
	_____ 55	(4F1)	FEP Health & Benefits Claim Form
_____ 09	_____ 75	(5574)	1-Part UCCI Dental Claim Form
	_____ 80	(980)	1-Part Computer Pin-Fed Vision Claim Form
	_____	(1300)	OptiChoice Vision Claim Form <b>(Members Only)</b>
_____ 20	_____ 83	(1500A)	1-Part Medical/Surgical Claim Form
	_____ 84	(1500A-2)	2-Part Medical/Surgical Claim Form
_____ 21	_____	(1500A-OL)	1-Part Anesthesia Claim Form
	_____ 53	(1517)	1-Part Children's Hearing Claim Form
	_____ 54	(1525)	1-Part Concurrent Claim Form

**MANUALS/GUIDES/DIRECTORIES**

_____ 1V	(PB26)	PremierBlue Physician Directory - East
_____ 66	(PB27)	PremierBlue Physician Directory - Central
_____ 89	(PB28)	PremierBlue Physician Directory - Western
_____ 33	(MC1-095)	Provider Network Directory Insert (POS)
_____ 44	(184)	Access Care Directory
_____ 63	(270)	Dental Procedure Terminology Manual
_____ 58	(319)	Procedure Terminology Manual
_____ 18	(HM319)	Procedure Terminology Manual - Western
_____ 67	(476)	Blue Shield Reference Guide
_____ 64	(2554)	OASIS Quick Reference Guide/Dental
_____ 73	(2555)	OASIS Quick Reference Guide/Vision
_____ 72	(2556)	OASIS Quick Reference Guide/Med-Surg
_____ 46	(4801)	Comp. Service Reference Guide - East
_____ 92	(8016)	Suppliers Manual
_____ 22	(HM8016)	Suppliers Manual- Western

**MISCELLANEOUS FORMS**

_____ 02	_____ 59	(CL318)	Mental Health - Gov't Service Plan
	_____ 76	(CL323)	Request for Review
	_____ 1E	(LSQ&A)	LifeStride Questions and Answers
	_____ 35	(221)	Service Bene Information Card
	_____ 26	(606)	Authorization for Referral Services
	_____ 65	(2907)	Precertification Request
_____ 17	_____ 94	(3861)	Therapy Treatment Plan
	_____ 1D	(3897)	Vision Claim Submission & Billing-PBS Vision
	_____ 1C	(4128)	OptiChoice Questions and Answers
	_____ 27	(4323)	Return of Monies
	_____ 41	(9755)	Blue Choice Network Referral Form
	_____ 81		Educational Package/Take Home Supplies
	_____		Other: _____
	_____		_____
	_____		_____

Provider's Name		Provider Number
Present/Old Address		
New Address		
Specialty Change (NOTE: Must have supporting document from Provider)		
From:	To:	
Individual Requesting Change	Phone Number	Effective Date

\* An Independent Licensee of the Blue Cross and Blue Shield Association

**Please tape and return. Do not staple.**



## OCR scanner improves claims processing time

Blue Shield uses an OCR (Optical Character Recognition) scanner for direct entry of claims and encounters into its claims processing system, OSCAR (Optimum System for Claims Adjudication and Reporting). OCR technology is an automated alternative to manually entering claims data. The OCR equipment scans the claim form, recognizes and “reads” the printed data then translates it into a format for direct entry into OSCAR. The scanner can “read” both computer-prepared and typewritten claim forms.

Direct entry of claims by the OCR scanner is an advantage to you because it requires less human intervention in preparing and entering your claims. The scanner reads, numbers and images your claims in one step. OCR scanning reduces claim entry time. However, OCR claims do not receive the same priority processing as do electronically submitted claims.

For the most efficient processing, we recommend you use a “rubine red” OCR claim form. The OCR scanner is programmed to read the 1500A, 1500A-2, 1500A-C, 1500A-C1, HCFA 1500 and HCFA 1500A 10/89. You can obtain the 1500A or the 1500A-2 claim form for manual billing by contacting Blue Shield’s Shipping Control department at (717) 763-3256. The HCFA 1500 is available from:

- The Government Printing Office, (202) 720-2791 or,
- The American Medical Association, (800) 621-8335, Option 3

### Guidelines for submitting claims for OCR scanning

To ensure your claims and encounters are scanned as quickly as possible, we ask that you follow these claim submission guidelines:

- Use computer-printed forms or type the data within the boundaries of the fields provided.
- Do not use a rubber stamp for any fields on the claim form. The scanner cannot properly read data from a rubber stamp. Any stamps, for example, “Encounter Form,” should be in black ink and placed in the upper left-hand corner of the form.
- Regularly change your print ribbon to ensure print readability. Light print cannot be read by the scanner.
- Always provide Blue Shield with the original claim form. Do not send copies of claims — they cannot be scanned. If you use a two-part form, send the original claim rather than the copy.
- Avoid using special characters such as dollar signs, hyphens, slashes or periods.
- Avoid extra labeling on fields.
- Use X’s for marking Yes or No blocks. Do not use other alphabetical indicators such as Y for Yes, N for No, F for Female or M for Male.
- Use black ink. Do not use red ink. The scanner cannot read red ink.
- Avoid use of excessive amounts of correction fluid on the claims.
- Use flat envelopes for mailing claims. Do not fold claim forms. Folded or wrinkled claim forms cannot be effectively read by the scanner.
- The OCR scanner is designed to read computer prepared or typewritten claim forms. Claims with superbill attachments cannot process through the OCR scanner. Type data from the superbill directly onto the claim form.
- For OCR claims, please report all information about a service on one line. If the service dates, diagnosis code, charge, etc., are reported on separate lines, the scanner “creates” an extra line. This causes the claim to suspend, increasing processing time.
- Use a range of print of 10 or 12 characters per inch (CPI).
- The OCR red (rubine) form is preferred over the blue form. Submit all claims on 20-pound paper.

- Do not fill in blank fields or space with unnecessary data. For example, if hospitalization dates are not required, leave the field blank rather than entering 00/00/0000 or XX/XX/XXXX. However, if the charge is zero, enter 0 00 in the charge field.
- Do not highlight the claim form or attachments. Highlighted information becomes blackened out when imaged and is not legible.

Here are some examples of how to submit claims correctly:

<b>Insured's ID number</b>	
<b>Correct</b>	<b>Incorrect</b>
QBC123456789	QBC-123-45-6789
	QBC 123/45/6789
<b>Charges</b>	
<b>Correct</b>	<b>Incorrect</b>
20 00	\$20.00
<b>Dates</b>	
<b>Correct</b>	<b>Incorrect</b>
12271949	12/27/49
	12-27-49
	12-27-1949
	12/27/1949
<b>Procedure codes with modifiers</b>	
<b>Correct</b>	<b>Incorrect</b>
9005052 7102026	90050-52 71020/26
QBC123456789	ID # QBC123456789
<b>Insured's policy group</b>	
<b>Correct</b>	<b>Incorrect</b>
123456	GRP # 123456
NAS123	GRP # NAS123

## Private business medical-surgical claim form

Blue Shield accepts many claim forms for submitting private business claims. These include the 1500A and the HCFA 1500 claim form. Please refer to Pages 15 - 18 in this section for examples of these claim forms. Here are the field requirements on most standard claim forms:

**Patient's Name** — Enter the full name (last, first, middle initial, if any) of the patient. Do not use nicknames, or “baby boy” or “baby girl” or “baby A” or “baby B.” Please use the patient’s legal name. Report only one patient per claim form. The 1500A and the HCFA 1500 require different formats for names.

**Patient's Date of Birth** — Enter date of birth in month, day, century, year format (MMDDCCYY). Eligibility for benefits is determined by date of birth. Age alone is not acceptable.

**Insured's Name** — Enter the full name of the person whose name appears on the identification card.

**Patient's Address** — The member’s home address, including street, city, state, ZIP code and telephone number (including area code), is important in establishing the identity of the individual.

**Patient's Sex** — Enter “X” in the appropriate block.

**Insured's ID number** — The identification number (also referred to as the agreement number) must be entered exactly as it appears on the identification card. Be sure to include all the numbers and any letters (alphabetical prefix). The alphabetical prefix code is needed to correctly route your claims through the claims processing system. Do not use hyphens.

**Patient's Relationship to Insured** — Enter “X” in the appropriate block.

**Insured's Group Number** — Enter the group number exactly as it appears on the identification card, including any prefixes or suffixes. Blue Shield determines benefits by the group number. Since there are many variations in benefits from one group to another, it is vital to report this number on the claim form.

**Other Health Insurance Coverage** — Indicate the name of the insured, the employer or group, name of the other insurance plan and identification or policy numbers, including Medicare. If there is no other insurance, enter “NONE.” If uncertain, enter “UNKNOWN.” If the patient has both basic Blue Shield coverage and Medicare coverage, please indicate which coverage is primary.

Do not enter miscellaneous information in this block such as: self pay, private pay, copay, etc.

**Was Condition Related to** — If no accident (automobile or other) has occurred, leave this field blank. If an automobile or other accident occurred, enter “X” in the appropriate block. This information is needed to avoid duplication of payment where Workers' Compensation, automobile insurance or liability insurance may be involved.

**Insured's Address** — This block is for the address of the member, the person with the insurance coverage, not his or her insurance company. Include complete street address, city, state and ZIP code.

**Date of Illness, Injury or Pregnancy** — If your services are performed as the result of an accidental injury or medical emergency, indicate the date of the injury or onset of illness. If the services performed are related to a pregnancy, report the date of the last menstrual period (LMP). Enter the date in month, day, century, year format (MMDDCCYY).

**Date First Consulted You for This Condition** — This information is needed to determine if a condition is pre-existing. On the HCFA 1500 claim form, report this information in Block 10d. Enter the date in month, day, century, year format (MMDDCCYY).

**Has Patient Ever Had Same or Similar Symptoms?** — Enter “X” in the appropriate block.

**If an Emergency** — Enter “X” in this block, if applicable. (See Section 9, “Medical Policy,” for more information about emergency care).

**Date Patient Able to Return to Work** — Enter the date in month, day, century, year format (MMDDCCYY).

**Dates of Total Disability and Dates of Partial Disability** — This information is important only when the services reported involve home and office visits. If home and office visits are a program benefit, the dates of disability should be circled. Enter the dates in month, day, century, year format (MMDDCCYY). Report only one set of disability dates per claim.

**Name of Referring Physician or Other Source** — Enter only the name of the referring party, if any.

**For Services Related to Hospitalization** — If you are reporting services performed in a hospital or skilled nursing facility, enter the date of admission and date of discharge. Do not enter a date if the services were provided in a hospital outpatient department. Admission and discharge dates should be reported on any claim containing the place of service code 1 or 8. Enter the dates in month, day, century, year format (MMDDCCYY). Be sure that the admission and discharge dates correspond to the dates of service. Submit separate claims for each hospital admission. Only one set of admission and discharge dates should be reported per claim. If the patient is still hospitalized when claims are submitted, report the last date of service as the discharge date.

**Name and Address of Facility Where Services Rendered** — If you are billing for services performed in a hospital (inpatient or outpatient), skilled nursing facility or nursing home, include the name, address and facility identification number. This information is important in case additional medical information is required to complete processing and evaluation of the claim, or to coordinate payments to other providers who participated in the patient's care. Refer to the Appendix for a list of facility identification numbers.

**Was Laboratory Work Performed Outside Your Office** — Enter "X" in the appropriate block. If the laboratory work was performed outside of your office, the laboratory that performed the work must bill directly for the services.

**Diagnosis, or Nature of Illness or Injury** — Enter the most appropriate three-, four- or five-digit ICD-9-CM diagnosis code (or in the case of diagnostic procedures, the symptoms) that made the reported treatment medically necessary. Be as specific as possible when reporting ICD-9-CM codes (that is, code 475 is a valid diagnosis code. If reported incorrectly as 475.0 or 475.00, it becomes invalid. This could delay processing of your claims.) List the primary diagnosis first. When reporting more than one ICD-9-CM diagnosis code, be sure to reference a diagnosis code to each service performed by reporting the reference number 1, 2, 3 or 4 from this block to the diagnosis code block on the line item. For additional information on diagnosis coding, refer to Pages 37 - 38.

**Date of Service** — Enter the date of service in month, day, century, year format (MMDDCCYY). The year is important because Blue Shield covers services billed within one year following the date of service. Refer to range dating on Pages 40 - 41 for additional information.

**Place of Service** — "Place of service" is based on the status of the patient rather than where the service was provided. For example, if a patient is an inpatient, but is taken to the office for a test, report this as "in-hospital" rather than "outpatient" or "office." This does not mean that you should report only one place of service per claim. If services were performed in the office as well as the hospital, you may report both on the same claim form. Be sure that the date of the office service does not fall within the dates reported for inpatient hospitalization. Do not report zeros in front of the place of service codes, for example, report 9 not 09.

Use the following place of service codes to report the place of service.

Place of service	Place of service code
Inpatient hospital	1
Outpatient hospital	2
Doctor's office	3
Patient's home	4
Day care facility	5
Night care facility	6
Nursing home	7
Skilled nursing facility	8
Ambulance	9
Other locations	0
Independent laboratory	A
Other medical-surgical facility	B
Residential treatment center	C
Specialized treatment facility	D

**Type of Service** — Leave blank.

**Procedure Code/Description of Service** — Report the service you performed, using the appropriate code and any applicable modifiers from the Pennsylvania Blue Shield *Procedure Terminology Manual (PTM)*.

Additional information on modifiers can be found on Pages 38 - 40. If you cannot find a code number that describes the procedure performed, use the appropriate “unlisted procedure” code and describe the service in the explanation block. If you report an “unlisted procedure” without providing a description of the service, claims processing will be delayed while we obtain the necessary information. Terminology is not required if the procedure code adequately describes the service. Always report a description of service if a procedure code is not available.

**Diagnosis Code** — Report the appropriate reference number (1, 2, 3 or 4) from the diagnosis block in this block. When reporting more than one ICD-9-CM diagnosis code, be sure to reference a diagnosis code to each service performed by reporting the reference number 1, 2, 3 or 4 from this block on the line item screen.

**Charges** — Report dollars and cents figures, even if the cents are “00.” This will ensure proper placement of the decimal when the figure is entered into our computer. This should be the doctor's total charge for the service(s) reported on that line. Avoid using dollar signs and decimal points. Blue Shield requires providers to submit itemized charges for reported services.

**Days or Units** — Report the total number of identical procedures or services, such as the number of lesions removed or the number of allergy tests performed. Any code that is inclusive of more than one service should be entered as “1” unit. Refer to the range dating information on Pages 40 - 41 for range-dated services.

**Performing Provider/Leave Blank/Reserved For Local Use** — When submitting claims to Blue Shield's private business medical-surgical programs, it is necessary to identify the specific provider that performed each service reported on the claim. If services are reported under a group practice's Blue Shield identification number (assignment account's) or one-person corporation's Blue Shield identification number, you must

identify the provider who actually performed the service by placing his or her individual Blue Shield identification number, including the alphabetical prefix, in this block. This block is labeled “leave blank” on most claim forms. The 1500A titles this block “performing provider.” On the HCFA 1500 claim form, this block is titled, “reserved for local use.” This information must be provided for each service listed on the claim.

**Signature of Physician/Supplier** — This block must be completed on all claims to affirm that the reported services were performed by the provider, or performed under the provider’s personal supervision. An individual’s name must be entered. Simply reporting the name of a group is insufficient.

**Has Fee Been Paid** — Enter “X” in the appropriate block. If partial payment has been made, leave blank.

**Total Charge** — Report total charges on the claim form in dollar and cents — even if the cents are “00.” This will ensure correct placement of the decimal point during claims processing. This should be the total charge for all services reported on the claim.

**Amount Paid** — This amount represents any partial or full payment of the total charge. If no payment was made, complete this block with zeros. Do not report payments by other insurance carriers in this block. If another insurance carrier has made payment, attach a copy of the Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB) to the claim.

**Balance Due** — Enter the difference between the total charge and the amount paid.

**Your Social Security Number** — Self-explanatory.

**Physician’s or Account’s Name, Address, ZIP Code and Provider Number** — The provider’s name, practicing address (not mailing address), ZIP code and complete provider number must be reported. Please report only one provider name and number in the block. The provider’s name must correspond accurately to the provider’s number. If you want a group or association to receive payment, enter their name, address and tax identification number. If you want the individual provider to receive payment, enter his or her name, address and Social Security number. Do not enter a group tax identification number with an individual provider name. A complete provider number consists of two alphabetical characters plus one to six numeric characters (for example, SM123456). If you are not sure what your complete provider number is, contact Blue Shield’s Provider Data Services department at (717) 763-3224. Do not report your Medicare UPIN number — it is not applicable for Blue Shield private business claims.

**Your Patient’s Account Number** — Optional for EMC billing providers only.

**Your Employer ID Number** — If you are a professional corporation or professional association, enter your IRS tax identification number.

**Your Telephone Number** — Self-explanatory. Always include the area code.

### **Private business medical-surgical claims tips**

To ensure that your claims are accurately processed and paid without delay, please follow these guidelines in completing the claim form:

- Type or print all the information on the claim form. This helps our claims examiners process your claims accurately.
- Fill in the information requested. We must have complete information before we can process the claim. If details are missing, we may need to contact you by telephone or letter, thereby delaying processing and payment of your claim.

- In cases where you must use several claim forms to report multiple services for the same patient, total the charges on each form separately. Treat each form as a separate and complete request for payment. Do not carry balances forward. It also is important that you report all other essential information on each claim form.
- Verify patient and member information, including alphabetical prefix and identification number, before completing the claim form. Make sure that the member's contract number is correctly reported on the claim form (including the alphabetical prefix) in the Insured's ID Number field. Do not submit a photocopy of the member's identification card.
- Include the date each service was provided.
- Submit a separate claim for each patient, even when they are members of the same family. When a patient has had multiple hospital admissions, submit separate claim forms for each hospital admission.
- Include the most definitive diagnosis code (up to five digits) provided in the *ICD-9-CM* manual. Report all diagnoses that are pertinent to the services provided.
- Identify the place of service. If services are provided in a hospital, specify whether the services are inpatient or outpatient.
- Include HCPCS codes (the codes found in Blue Shield's *PTM* to identify the service or services rendered. Other coding manuals may use the same code number to describe a different service.
- Avoid attaching superbills for the same services you have reported on the claim form.
- Avoid routinely submitting copies of your payment records or ledgers. They often omit vital information and it may be difficult to determine what services are to be considered for payment. Again, using the claim form will reduce the risk of error and expedite payment.
- Do not routinely send "Release of Information" forms signed by the patient. Our member agreements give us the right to receive the information without additional release forms.
- Avoid routinely attaching hospital notes (progress notes and order sheets) to claims. We will request this information if it is necessary to process the claim.
- Claims for emergency medical and emergency accident services should always include a date of onset and a date of service. The correct procedure codes for emergency treatment in the office are W9005 and W9006, and for treatment in the hospital outpatient area, W9025 and W9026.
- Be certain the total charge equals the service line charges.
- Be sure to include your provider number (that is, two alphabetical characters plus one to six numeric characters) in the Physician's or Account's Name, Address, ZIP code and Provider Number field.
- Submit coordination of benefits or Medicare information when the patient qualifies.
- When reporting circumcision for a baby boy, report the service on the baby's claim, not the mother's.
- Do not use highlighters to emphasize information on the claim. Highlighted information becomes blackened out when imaged and is not legible.
- Use black ink. Do not use red ink. The OCR image scanner cannot detect red ink.
- Anytime you have a question about how to complete a claim form, contact Blue Shield's Customer Service department or your Provider Relations representative.







**Pennsylvania Blue Shield**

An Independent Licensee of the Blue Cross and Blue Shield Association

PO BOX 890062  
CAMP HILL, PA 17089-0062

**CLAIM FORM**

**PATIENT & INSURED (SUBSCRIBER) INFORMATION** **READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM**

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. INSURED'S I.D. (include any letters)
TELEPHONE NUMBER	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. INSURED'S GROUP NO. (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE-Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	11. INSURED'S ADDRESS (Street, city, state, ZIP code)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**PHYSICIAN OR SUPPLIER INFORMATION**

14. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>	16A. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency)			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES	

23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE

1	
2	
3	
4	

24. FROM	A DATE OF SERVICE	TO	B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY: ) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES	G DAYS OR UNITS	H. PERFORMING PROVIDER

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof.)	26. HAS FEE BEEN PAID? YES <input type="checkbox"/> NO <input type="checkbox"/>	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNED _____ DATE _____	30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S OR ACCOUNT'S NAME, ADDRESS, ZIP CODE & PROVIDER NO.		
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.			
	34. YOUR TELEPHONE NO.			

**SIGNATURE OF PHYSICIAN**

I certify that the services reported on this form were medically necessary for the patient and were performed by me personally or in my presence, or were performed under my supervision by my employee. If the services were performed under my supervision by

someone other than my employee, I have described the circumstances in item 24D. I understand that certain types of supervised services may not be covered. I will provide documentation as necessary to establish the validity of the claim.

**PLACE OF SERVICE CODES:**

1 – (IH)	–	Inpatient Hospital	8 – (SNF)	–	Skilled Nursing Facility
2 – (OH)	–	Outpatient Hospital	9 –	–	Ambulance
3 – (O)	–	Doctor's Office	0 – (OL)	–	Other Locations
4 – (H)	–	Patient's Home	A – (IL)	–	Independent Laboratory
5 –	–	Day Care Facility (PSY)	B –	–	Other Medical/Surgical Facility
6 –	–	Night Care Facility – (PSY)	C – (RTC)	–	Residential Treatment Center
7 – (NH)	–	Nursing Home	D – (STF)	–	Specialized Treatment Facility

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE  MEDICAID  CHAMPUS  CHAMPVA  GROUP HEALTH PLAN  FECA BLK LUNG  OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY M  F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED  
Self  Spouse  Child  Other

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS  
Single  Married  Other   
Employed  Full-Time Student  Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:  
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES  NO   
b. AUTO ACCIDENT? PLACE (State) YES  NO   
c. OTHER ACCIDENT? YES  NO   
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES  NO  \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A	B	C	D	E	F	G	H	I	J	K
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	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES  NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. BALANCE DUE \$

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.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

PIN# \_\_\_\_\_ GRP# \_\_\_\_\_

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

REORDER FROM STANDARD REGISTER FORM NO. HC0801-1

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

#### REFERS TO GOVERNMENT PROGRAMS ONLY

**MEDICARE AND CHAMPUS PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured": i.e., items 1a, 4, 6, 7, 9, and 11.

#### BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

#### SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

**NOTICE:** Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

#### NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101:41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

**DISCLOSURES:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

#### MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

## Federal Employee Program claim form

Blue Shield accepts various claim forms for Federal Employee Program (FEP) claims. These include the 1500A and the HCFA 1500 claim form. Please refer to Pages 15 - 18 in this section for examples of these claim forms. Here are the fields' requirements as they appear on most standard claim forms.

**Patient's Name** — Enter the full name (first name, middle initial, if any, and last name) of the patient. Do not use nicknames, or “baby boy” or “baby girl” or “baby A” or “baby B.” Please use the patient's legal name. Report only one patient per claim form. The 1500A and the HCFA 1500 require different formats for names.

**Patient's Date of Birth** — Enter date of birth in month, day, century, year format (MMDDCCYY). Eligibility for benefits is determined by date of birth. Age alone is not acceptable.

**Insured's Name** — Enter the full name of the person whose name appears on the identification card.

**Patient's Address** — The member's home address, including street, city, ZIP code and telephone number, is important in establishing the identity of the individual.

**Patient's Sex** — Enter “X” in the appropriate block.

**Insured's ID Number** — The identification number (also referred to as the agreement number) must be entered exactly as it appears on the identification card. Be sure to include all the numbers and any letters (alphabetical prefix). All FEP identification numbers begin with an “R.” Please be sure that the eight-digit numeric identification number follows the “R” prefix. Do not use hyphens.

**Patient's Relationship to Insured** — Enter “X” in the appropriate block.

**Insured's Group Number** — Enter the group number exactly as it appears on the identification card, including any prefixes or suffixes. Blue Shield determines benefits by the group number. Since there are many variations in benefits from one group to another, it is vital to report this number on the claim form.

**Other Health Insurance Coverage** — Indicate the name of the insured, the employer or group, name of the other insurance plan and identification or policy numbers, including Medicare. If there is no other insurance, enter “NONE.” If uncertain, enter “UNKNOWN.” If the patient has both basic Blue Shield coverage and Medicare coverage, please indicate which coverage is primary.

Do not enter miscellaneous information in this block, such as: self pay, private pay, copay, etc.

**Was Condition Related To** — If no accident (automobile or other) has occurred, leave this field blank. If an automobile or other accident occurred, enter “X” in the appropriate block. This information is needed to avoid duplication of payment where Workers' Compensation, automobile insurance or liability may be involved.

**Insured's Address** — This block is for the address of the member, the person with the insurance coverage, not his or her insurance company. Include complete street address, city, state, and ZIP code.

**Date of Illness, Injury or Pregnancy** — If your services are performed as the result of an accidental injury or medical emergency, indicate the date of the injury or onset of illness. If the services performed are related to a pregnancy, report the date of the last menstrual period (LMP). Enter the date in month, day, century, year format (MMDDCCYY).

**Date First Consulted You for this Condition** — This information is needed to determine if a condition is pre-existing. On the HCFA 1500 claim form, report this information in Block 10d. Enter the date in month, day, century, year format (MMDDCCYY).

**Has Patient Ever Had Same or Similar Symptoms?** — Enter “X” in the appropriate block.

**If an Emergency** — Enter “X” in this block, if applicable. (See Section 9, “Medical Policy,” for more information about emergency care.)

**Date Patient Able to Return to Work** — Enter the date in month, day, century, year format (MMDDCCYY).

**Dates of Total Disability and Dates of Partial Disability** — This information is important only when the services reported involve home and office visits. If home and office visits are a program benefit, the dates of disability should be circled. Enter the dates in month, day, century, year format (MMDDCCYY).

**Name of Referring Physician or Other Source** — Enter the name of the referring party, if any.

**For Services Related to Hospitalization** — If you are reporting services performed in a hospital, skilled nursing facility or nursing home, enter the date of admission and date of discharge. Do not enter a date if the services were provided in a hospital outpatient department. Admission and discharge dates should be reported on any claim containing the following place of service code: 1, 7 or 8. Enter the dates in month, day, century, year format (MMDDCCYY). Be sure that the admission and discharge dates correspond to the dates of service.

**Name and Address of Facility Where Services Rendered** — If you are billing for services performed in a hospital (inpatient or outpatient), skilled nursing facility or nursing home, include the name, address and facility identification number. This information is important in case additional medical information is required to complete processing and evaluation of the claim, or to coordinate payments to other providers who participated in the patient’s care. Refer to the Appendix for a list of facility identification numbers.

**Was Laboratory Work Performed Outside the Office?** — Enter “X” in the appropriate block. If the laboratory work was performed outside of your office, the laboratory that performed the work must bill directly for the services.

**Diagnosis, or Nature of Illness or Injury** — Enter the most appropriate three-, four- or five-digit ICD-9-CM diagnosis code (or in the case of diagnosis procedures, the symptoms) which made the reported treatment medically necessary. Be as specific as possible when reporting ICD-9-CM codes (that is, code 475 is a valid diagnosis code. If reported incorrectly as 475.0 or 475.00, it becomes invalid. This could delay processing of your claims.) List the primary diagnosis first. When reporting more than one ICD-9-CM diagnosis code, be sure to reference a diagnosis code to each service performed by reporting the reference number 1, 2, 3 or 4 from this block to the diagnosis code block on the line item. For additional information on diagnosis coding, refer to Pages 37 - 38.

**Date of Service** — Enter the date of service in month, day, century, year format (MMDDCCYY). The year is important because Blue Shield covers services billed within one year following the date of service. Refer to range dating on Pages 40 - 41 for additional information.

**Place of Service** — “Place of service” is based on the status of the patient rather than where the service was provided. For example, if a patient is an inpatient, but is taken to the office for a test, report this as “in-hospital” rather than “outpatient” or “office.” This does not mean, however, that you should report only one place of service per claim. If services were performed in the office as well as the hospital, you may report both on the same claim form. Be sure that the date of the office service does not fall within the dates reported for inpatient hospitalization. Do not report zeros in front of the place of service codes, for example, report 9 not 09.

Use the following place of service codes to report the place of service.

Place of service	Place of service code
Inpatient hospital	1
Outpatient hospital	2
Doctor's office	3
Patient's home	4
Day care facility	5
Night care facility	6
Nursing home	7
Skilled nursing facility	8
Ambulance	9
Other locations	0
Independent laboratory	A
Other medical-surgical facility	B
Residential treatment center	C
Specialized treatment facility	D

**Type of Service** — Leave blank

**Procedure Code/Description of Service** — Report the service you performed, using the appropriate code and any applicable modifiers from Blue Shield's *PTM*. Additional information on modifiers can be found on Pages 38 - 40. If you cannot find a code number that describes the procedure performed, use the appropriate "unlisted procedure" code and describe the service in the explanation block. If you report an "unlisted procedure" without providing a description of the service or without attaching a copy of the operative notes, the service cannot be processed for payment and will be denied for lack of information. Terminology is not required if the procedure code adequately describes the service. Always report a description of service if a procedure is not available.

**Diagnosis Code** — Report the appropriate reference number (1, 2, 3 or 4) from the diagnosis block in this block. When reporting more than one ICD-9-CM diagnosis code, be sure to reference a diagnosis code to each service performed by reporting the reference number 1, 2, 3 or 4 from this block on the line item screen.

**Charges** — Report dollars and cents figures — even if the cents are "00." This will ensure proper placement of the decimal when the figure is entered into our computer. This should be the doctor's total charge for the service(s) reported on that line. Avoid using dollar signs and decimal points. Blue Shield requires providers to submit itemized charges for reported services.

**Days or Units** — Report the total number of identical procedures or services, such as the number of lesions removed or the number of allergy tests performed. Any code that is inclusive of more than one service should be entered as "1" unit. Refer to the range dating information on Pages 40 - 41 for range dated services.

**Performing Provider/Leave Blank/Reserved For Local Use** — When submitting claims to Blue Shield's Federal Employee Program, it is necessary to identify the specific provider who performed each service reported on the claim.

If services are reported under a group practice's Blue Shield identification number (assignment account's) or one-person corporation's Blue Shield identification number, you must identify the provider who actually

performed the service by placing his or her individual Blue Shield identification number, including the alphabetical prefix, in this block. This block is labeled “leave blank” on most claim forms. The 1500A, titles this block “performing provider.” On the HCFA 1500 claim form, this block is titled, “reserved for local use.” This information must be provided for each service line listed on the claim.

**Signature of Physician/Supplier** — This block must be completed on all claims to affirm that the reported services were performed by the provider, or performed under the provider’s personal supervision. An individual’s name must be entered. Simply reporting the name of a group is insufficient.

**Has Fee Been Paid** — Enter “X” in the appropriate block. If partial payment has been made, leave blank.

**Total Charge** — Report total charges on the claim form in dollars and cents — even if the cents are “00.” This will ensure correct placement of the decimal during claims processing. This should be the total charge for all services reported on this claim.

**Amount Paid** — This amount represents any partial or full payment of the total charge. If no payment was made, complete this block with zeros. Do not report payments by other insurance carriers in this block. If another insurance carrier has made payment, attach a copy of the EOB or EOMB to the claim.

**Balance Due** — Enter the difference between the total charge and the amount paid.

**Your Social Security Number** — Self-explanatory.

**Physician’s or Account’s Name, Address, ZIP Code and Provider Number** — The provider’s name, practicing address (not mailing address), ZIP code and complete provider number must be reported. Please report only one provider name and number in the block. The provider’s name must correspond accurately to the provider’s number. If payment is to be made to an individual provider, his or her name, practicing address, ZIP code and complete provider number should be reported. If payment is to be made to a group (assignment account), the group’s name, practicing address, ZIP code and complete provider number should be reported. A complete provider number consists of two alphabetical characters plus one to six numeric characters (for example, SM1223456). If you are not sure of what your complete provider number is, contact our Provider Data Services department at (717) 763-3224. Do not report your Medicare UPIN number; it is not applicable for FEP claims.

**Your Patient’s Account Number** — Optional for electronic billing providers only.

**Your Employer ID number** — If you are a professional corporation or professional association, enter your IRS tax identification number.

**Your Telephone Number** — Self-explanatory. Always include the area code.

### **FEP claims tips**

To ensure that your claims are accurately processed and paid without delay, please follow these guidelines in completing the claim form:

- Type or print all the information on the claim form. This helps our claims examiners process your claims accurately.
- Fill in all the information requested. We must have complete information before we can process the claim. If details are missing, we may need to contact you by telephone or letter, thereby delaying processing and payment of your claim.
- In cases where you must use several claim forms to report multiple services for the same patient, total



the charges on each form separately. Treat each form as a separate and complete request for payment. Do not carry balances forward. It also is important that you report all other essential information on each claim form.

- Verify patient and member information before completing the claim form. All member identification numbers are prefixed with an “R” and must be reported along with an eight-digit numeric identification number. Make sure that the member’s contract number is correctly reported on the claim form in the Insured’s ID Number field. Do not submit a photocopy of the member’s identification card.
- Include the date each service was provided, beginning and ending.
- Submit a separate claim for each patient, even when they are members of the same family. When a patient has multiple hospital admissions, submit separate claim forms for each hospital admission.
- Include the most definitive diagnosis code (up to five digits) provided in the *ICD-9-CM* manual. Report all diagnoses that are pertinent to the services provided.
- When diagnosis codes fall between 800-999 please provide a condition date for the accident or illness.
- Diagnoses codes are required for FEP. Do not use “E” codes.
- Identify the place of service. If services are provided in a hospital, specify whether the services are inpatient or outpatient.
- Include HCPCS codes (the codes found in Blue Shield’s *PTM*) to identify the service or the services rendered. Other coding manuals may use the same code number to describe a different service.
- Avoid attaching superbills for the same services you have reported on the claim form.
- Avoid routinely submitting copies of your payment records or ledgers. They often omit vital information and it may be difficult to determine what services are to be considered for payment. Again, using the claim form will reduce the risk of error and expedite payment.
- Do not routinely send “Release of Information” forms signed by the patient. Our member agreements give us the right to receive the information without additional release forms.
- Avoid routinely attaching hospital notes (progress notes and order sheets) to claims.
- Surgical procedures do not require operative notes unless:
  - An “individual consideration” (IC) or “unlisted procedure” code is reported.
  - The service performed is a new procedure.
  - The service performed is potentially cosmetic.
  - Multiple primary surgeons participated in a surgical procedure.
  - The terminology for the reported code indicates, “by report” (BR).
  - A pre-authorization letter advised you to submit specific reports.
  - The service involves unusual circumstances. Remember also to report modifier 22. If this modifier is not reported, the special circumstances will not be considered.
- Claims for emergency medical and emergency accident services should always include a date of onset and a date of service. The correct procedure codes for emergency treatment in the office are W9005 and W9006, and for treatment in the hospital outpatient area, W9025 and W9026.
- When submitting claims for ambulance services, please include a completed trip report and detailed information concerning the medical necessity of the transport.
- Be certain the total charge equals the service line charges.
- Be sure to include your provider number (that is, two alphabetical characters plus one to six numeric characters) in the Physician’s or Account’s Name, Address, ZIP code and Provider Number field.
- Submit coordination of benefits of Medicare information when the patient qualifies. Also, include a Medicare effective date.
- Anytime you have a question about how to complete a claim form, contact Blue Shield’s Customer Service department or your Provider Relations representative.

### **Special notes on diagnosis coding for FEP members**

Use special “V” ICD-9-CM diagnosis codes for FEP member claims. The “V” codes are related to circumstances other than the specific diseases or injuries that are classified under categories 001-999.

You can find these codes in the *ICD-9-CM* coding manual.

Specific “V” ICD-9-CM diagnosis codes are valid for FEP claims reporting only under these limited circumstances:

- 290-319, V40, V61 or V71.0 must be used for claims for mental illness and must also include the fourth character of the diagnosis code.
- When codes fall within 800-999, a condition must be reported for any accident or injury.
- “E” codes are not to be used for FEP.

### **Central site processing**

Blue Shield processes professional provider claims for some national accounts in the NASCO system. While this is a national account arrangement, Blue Shield providers should continue to send their claims for these groups to Blue Shield.

Blue Shield also processes facility claims for some national accounts in the NASCO system. This is a joint effort. While this is a national arrangement, hospitals, medical centers, etc., should continue to send their claims to Blue Shield.

Blue Shield also processes POS claims for the Central Point of Service and Hershey HealthStyle programs.

### **Central site claim form**

Blue Shield accepts many claim forms for submitting Private Business claims. These include the 1500A and the 1500 claim form. Please refer to Pages 15 - 18 in this section for examples of these claim forms. Here are the field requirements as they appear on most standard claim forms.

**Patient’s Name** — Enter the full name (last, first, middle initial, if any) of the patient. Do not use nicknames, or “baby boy” or “baby girl” or “baby A” or “baby B.” Please use the patient’s legal name. Report only one patient per claim form. The 1500A and the HCFA 1500 require different formats for names.

**Patient’s Date of Birth** — Enter date of birth in month, day, century, year format (MMDDCCYY). Eligibility for benefits is determined by date of birth. Age alone is not acceptable.

**Insured’s Name** — Enter the full name of the person whose name appears on the identification card.

**Patient’s Address** — The member’s home address, including street, city, state, ZIP code and telephone number (including area code), is important in establishing the identity of the individual.

**Patient’s Sex** — Enter “X” in the appropriate block.

**Insured’s ID number** — The identification number (also referred to as the agreement number) must be entered exactly as it appears on the identification card. Be sure to copy all the numbers and any letters (alphabetical prefix). The alphabetical prefix code is needed to correctly route your claims through the claims processing system. Do not use hyphens.

**Patient’s Relationship to Insured** — Enter “X” in the appropriate block.

**Insured's Group Number** — Enter the group number exactly as it appears on the identification card, including any prefixes or suffixes. Blue Shield determines benefits by the group number. Since there are many variations in benefits from one group to another, it is vital to report this number on the claim form.

**Other Health Insurance Coverage** — Indicate the name of the insured, the employer or group, name of the other insurance plan and identification or policy numbers, including Medicare. If there is no other insurance, enter "NONE." If uncertain, enter "UNKNOWN." If the patient has both basic Blue Shield coverage and Medicare coverage, please indicate which coverage is primary.

Do not enter miscellaneous information in this block such as: self pay, private pay, copay, etc.

**Was Condition Related to** — If no accident (automobile or other) has occurred, leave this field blank. If an automobile or other accident occurred, enter "X" in the appropriate block. This information is needed to avoid duplication of payment where Workers' Compensation, automobile insurance or liability insurance may be involved.

**Insured's Address** — This block is for the address of the member, the person with the insurance coverage, not his or her insurance company. Include complete street address, city, state and ZIP code.

**Date of Illness, Injury or Pregnancy** — If your services are performed as the result of an accidental injury or medical emergency, indicate the date of the injury or onset of illness. If the services performed are related to a pregnancy, report the date of the last menstrual period (LMP). Enter the date in month, day, century, year format (MMDDCCYY).

**Date First Consulted You for This Condition** — This information is needed to determine if a condition is pre-existing. On the HCFA 1500 claim form, this information should be reported in Block 10d. Enter the date in month, day, century, year format (MMDDCCYY).

**Has Patient Ever Had Same or Similar Symptoms?** — Enter "X" in the appropriate block.

**If an Emergency** — Enter "X" in this block, if applicable. (See Section 9, "Medical Policy," for more information about emergency care).

**Date Patient Able to Return to Work** — Enter the date in month, day, century, year format (MMDDCCYY).

**Dates of Total Disability and Dates of Partial Disability** — This information is important only when the services reported involve home and office visits. If home and office visits are a program benefit, circle the dates of disability. Enter the dates in month, day, century, year format (MMDDCCYY). Report only one set of disability dates per claim.

**Name of Referring Physician or Other Source** — Enter only the name of the referring party, if any.

**For Services Related to Hospitalization** — If you are reporting services performed in a hospital or skilled nursing facility or nursing home, enter the date of admission and date of discharge. Do not enter a date if the services were provided in a hospital outpatient department. Admission and discharge dates should be reported on any claim containing the place of service code 1, 7 or 8. Enter the dates in month, day, century, year format (MMDDCCYY). Be sure that the admission and discharge dates correspond to the dates of service. Submit separate claims for each hospital admission. Only one set of admission and discharge dates should be reported per claim. If the patient is still hospitalized when claims are submitted, report the latest date of service as the discharge date.

**Name and Address of Facility Where Services Rendered** — If you are billing for services performed in a hospital (inpatient or outpatient), skilled nursing facility or nursing home, include the name, address and facility identification number. This information is important in case additional medical information is required to complete processing and evaluation of the claim, or to coordinate payments to other providers who participated in the patient’s care. Refer to the Appendix for a list of facility identification numbers.

**Was Laboratory Work Performed Outside Your Office** — Enter “X” in the appropriate block. If the laboratory work was performed outside of your office, the laboratory that performed the work must bill directly for the services.

**Diagnosis, or Nature of Illness or Injury** — Enter the most appropriate three-, four- or five-digit ICD-9-CM diagnosis code (or in the case of diagnostic procedures, the symptoms) that made the reported treatment medically necessary. Be as specific as possible when reporting ICD-9-CM codes (that is, code 475 is a valid diagnosis code. If reported incorrectly as 475.0 or 475.00, it becomes invalid. This could delay processing of your claims.) List the primary diagnosis first. When reporting more than one ICD-9-CM diagnosis code, be sure to reference a diagnosis code to each service performed by reporting the reference number 1, 2, 3 or 4 from this block to the diagnosis code block on the line item. For additional information on diagnosis coding, refer to Pages 37 - 38.

**Date of Service** — Enter the date of service in month, day, century, year format (MMDDCCYY). The year is important because Blue Shield covers services billed within one year following the date of service. Refer to range dating on Pages 40 - 41 for additional information.

**Place of Service** — “Place of service” is based on the status of the patient rather than where the service was provided. For example, if a patient is an inpatient, but is taken to the office for a test, report this as “in-hospital” rather than “outpatient” or “office.” This does not mean that you should report only one place of service per claim. If services were performed in the office as well as the hospital, you may report both on the same claim form. Be sure that the date of the office service does not fall within the dates reported for inpatient hospitalization. Do not report zeros in front of the place of service codes, for example, report 9 not 09.

Use the following place of service codes to report the place of service.

Place of service	Place of service code
Inpatient hospital	1
Outpatient hospital	2
Doctor’s office	3
Patient’s home	4
Day care facility	5
Night care facility	6
Nursing home	7
Skilled nursing facility	8
Ambulance	9
Other locations	0
Independent laboratory	A
Other medical-surgical facility	B
Residential treatment center	C
Specialized treatment facility	D

**Type of Service** — Leave blank.

**Procedure Code/Description of Service** — Report the service you performed, using the appropriate code and any applicable modifiers from the Blue Shield *Procedure Terminology Manual (PTM)*. Additional information on modifiers can be found on Pages 38 - 40. If you cannot find a code number that describes the procedure performed, use the appropriate “unlisted procedure” code and describe the service in the explanation block. If you report an “unlisted procedure” without providing a description of the service, claims processing will be delayed while we obtain the necessary information. Terminology is not required if the procedure code adequately describes the service. Always report a description of service if a procedure code is not available.

**Diagnosis Code** — Report the appropriate reference number (1, 2, 3 or 4) from the diagnosis block in this block. When reporting more than one ICD-9-CM diagnosis code, be sure to reference a diagnosis code to each service performed by reporting the reference number 1, 2, 3 or 4 from this block on the line item screen.

**Charges** — Report dollars and cents figures, even if the cents are “00.” This will ensure proper placement of the decimal when the figure is entered into our computer. This should be the doctor’s total charge for the service(s) reported on that line. Avoid using dollar signs and decimal points. Blue Shield requires providers to submit itemized charges for reported services.

**Days or Units** — Report the total number of identical procedures or services, such as the number of lesions removed or the number of allergy tests performed. Any code that is inclusive of more than one service should be entered as “1” unit. Refer to the range dating information on Pages 40 - 41 for range-dated services.

**Performing Provider/Leave Blank/Reserved For Local Use** — When submitting claims to Blue Shield’s private business medical-surgical programs, it is necessary to identify the specific provider that performed each service reported on the claim. If services are reported under a group practice’s Blue Shield identification number (assignment account’s) or one-person corporation’s Blue Shield identification number, you must identify the provider who actually performed the service by placing his or her individual Blue Shield identification number including the alphabetical prefix in this block. This block is labeled “leave blank,” on most claim forms. The 1500A titles this block “performing provider.” On the HCFA 1500 claim form, this block is titled, “reserved for local use.” This information must be provided for each service listed on the claim.

**Signature of Physician/Supplier** — This block must be completed on all claims to affirm that the reported services were performed by the provider, or performed under the provider’s personal supervision. An individual’s name must be entered. Simply reporting the name of a group is insufficient.

**Has Fee Been Paid** — Enter “X” in the appropriate block. If partial payment has been made, leave blank.

**Total Charge** — Report total charges on the claim form in dollar and cents — even if the cents are “00.” This will ensure correct placement of the decimal point during claims processing. This should be the total charge for all services reported on the claim.

**Amount Paid** — This amount represents any partial or full payment of the total charge. If no payment was made, complete this block with zeros. Do not report payments by other insurance carriers in this block. If another insurance carrier has made payment, attach a copy of the Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB) to the claim.

**Balance Due** — Enter the difference between the total charge and the amount paid.

**Your Social Security Number** — Self-explanatory.

**Physician’s or Account’s Name, Address, ZIP Code and Provider Number** — The provider’s name,

practicing address (not mailing address), ZIP code and complete provider number must be reported. Please report only one provider name and number in the block. The provider's name must correspond accurately to the provider's number. If you want a group or association to receive payment, enter their name, address and tax identification number. If you want the individual provider to receive payment, enter his or her name, address and Social Security number. Do not enter a group tax identification number with an individual provider name. A complete provider number consists of two alphabetical characters plus one to six numeric characters (for example, SM123456). If you are not sure of what your complete provider number is, contact Blue Shield's Provider Data Services department at (717) 763-3224. Do not report your Medicare UPIN number — it is not applicable for Blue Shield private business claims.

**Your Patient's Account Number** — Optional for EMC billing providers only.

**Your Employer ID Number** — If you are a professional corporation or professional association, enter your IRS tax identification number.

**Your Telephone Number** — Self-explanatory. Always include the area code.

### **Central site processing claims tips**

Submitting incomplete claim forms can delay or cause incorrect processing of claims for central site accounts. You can help us shorten claims processing time by following these tips:

- Report service information on a 1500 claim form.
- Fill in all the information requested. We must have complete information before we can process the claim. If details are missing, we may need to contact you by telephone or letter, thereby delaying processing and payment of your claim.
- Report the member's contract number correctly in the Insured's ID Number field, preceded by the alphabetical prefix shown on the identification card. Do not submit a copy of the member's identification card.
- Report the member's group number, including alphabetical prefix, in the Insured's Group Number field.
- Avoid attaching superbills for the same services you have reported on the claim form.
- Do not range date services, except in the following instances:
  - DME (monthly rentals).
  - End stage renal disease (ESRD) related services, procedure codes 90918-90921.
  - Radiation therapy, procedure codes 77427.
- Medications — When providing information about medication, be sure to include the name, the dosage and the individual charge for each drug. Be sure that this information is legible.
- NOC codes — When reporting NOC procedure codes, provide a written description of the items or services. When more than one NOC is submitted, provide an individual description and charge for each item.
- Type or print all the information on the claim form. This helps our claims examiners process your claims quickly and accurately.
- Do not report services for which no charge was made on the claim form. In cases where you must use several claim forms to report multiple services for the same patient, total the charges on each form separately. Treat each form as a separate and complete request for payment. Do not carry balances forward. It also is important that you report all other essential information on each claim form.
- Verify patient and member information before completing the claim form.
- Include the date each service was provided, beginning and ending.

- Submit a separate claim for each patient, even when they are members of the same family. When a patient has had multiple hospital admissions, submit separate claim forms for each hospital admission.
- Include the most definitive diagnosis code (up to five digits) provided in the *ICD-9-CM* manual. Report all diagnoses that are pertinent to the services provided.
- Identify the place of service. If services are provided in a hospital, specify whether the services are inpatient or outpatient.
- Include HCPCS codes (codes found in Blue Shield's *PTM*) to identify the service or services rendered. Other coding manuals may use the same code number to describe a different service.
- Avoid routinely submitting copies of your payment records or ledgers. They often omit vital information and it may be difficult to determine what services are to be considered for payment. Again, using the claim form will reduce the risk of error and expedite payment.
- Do not send "Release of Information" forms signed by the patient. Our member agreements give us the right to receive the information without additional release forms.
- Avoid routinely attaching hospital notes (progress notes and order sheets) to claims. If additional information is needed to process the claim, Blue Shield will request it.
- Claims for emergency medical and emergency accident services should always include a date of onset and a date of service. The correct procedure codes for emergency treatment in the office are W9005 and W9006, and for treatment in the hospital outpatient area, W9025 and W9026.
- Be certain the total charge equals the service line charges.
- Be sure to include your provider number (that is, two alphabetical characters plus one to six numeric characters) in the Physician's or Account's Name, Address, ZIP code and Provider Number Field.
- Submit coordination of benefits or Medicare information when the patient qualifies.
- Anytime you have a question about how to complete a claim form, contact customer service or your Provider Relations representative.

## BlueCard®

Blue Shield participates in the BlueCard program, which was mandated by the Blue Cross Blue Shield Association. This program was designed to replace the Inter-Plan Bank and Reciprocity programs.

The BlueCard program allows Plans to share their participating provider discounts with other Plans, as well as hold members harmless for the difference between the UCR allowance and the charge (when the contract is UCR). This also permits prompt payment to participating providers for services rendered to a member when performed outside their home state or plan area.

A BlueCard member has coverage through another Blue Cross and/or Blue Shield Plan. The member is entitled to receive benefits, provided the product is eligible for delivery through the BlueCard program.

Eligible lines of business that can be submitted through the BlueCard program are:

- basic medical-surgical, including oral surgery;
- basic institutional (hospital, etc.). The appropriate Blue Cross Plans will administer.

Ineligible lines of business:

- vision and hearing
- stand-alone dental and prescription drugs
- Medicare supplemental
- Federal Employee Program

## How to identify a BlueCard member

When members from other Blue Cross and Blue Shield Plans arrive at your office be sure to ask them for their current membership identification card. The two main identifiers for BlueCard members are the alphabetical prefix and, for eligible PPO members, the “PPO in a suitcase” logo.

### Alphabetical prefix

The three-character alphabetical prefix, for example, “ABC”, at the beginning of the member’s identification number is the key element used to identify and correctly route out-of-area claims. The alphabetical prefix identifies the Plan or national account to which the member belongs.

There are two types of alphabetical prefixes: Plan-specific and account-specific.

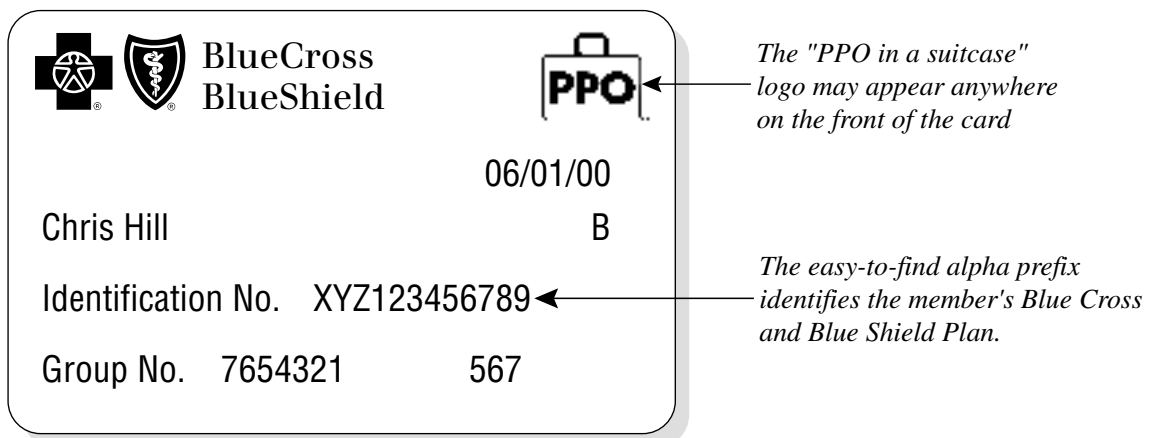
- Plan-specific alphabetical prefixes are assigned to every Plan and start with X, Y, Z or Q. The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.
- Account-specific alphabetical prefixes are assigned to centrally processed national accounts. National accounts are employer groups that have offices and branches in more than one area, but offer uniform coverage benefits to all of their employees. Account-specific alphabetical prefixes start with letters other than X, Y, Z or Q. Typically a national account alphabetical prefix will relate to the name of the group. All three positions are used to identify the national account.

Occasionally, you may see identification cards from foreign Blue Cross and Blue Shield members. These identification cards will also contain three-character alphabetical prefixes. The BlueCard claims process for international members is the same as that for domestic Blue Cross and Blue Shield members.

### “PPO in a suitcase” logo

You’ll immediately recognize BlueCard PPO members by the special “PPO in a suitcase” logo on their membership card.

- BlueCard PPO members are Blue Cross and Blue Shield members whose PPO benefits are delivered through the BlueCard Program.
- It is important to remember that not all PPO members are BlueCard PPO members, only those whose membership cards carry this logo.
- Members traveling or living outside of their Blue Plan’s area receive the PPO level of benefits when they obtain services from designated PPO providers.





### **Determining a member's eligibility**

With the member's most current identification card, you can verify membership and coverage by calling BlueCard eligibility at (800) 676-BLUE (2583). An operator will direct your call to the appropriate membership and coverage unit at the member's Blue Cross and Blue Shield Plan.

### **Guidelines for submitting claims for BlueCard members**

Blue Shield accepts many claim forms for private business claims. These include the 1500A and the HCFA 1500 claim form. Please refer to Pages 15 - 18 in this section for examples of these claim forms.

### **How BlueCard® program claims are processed**

Always submit your BlueCard claims to Pennsylvania Blue Shield. (The only exception is if you contract with the member's home plan, in which case you should file the claim directly to the member's Plan.)

- Pennsylvania Blue Shield will electronically route the claim to the member's Blue Cross and Blue Shield Plan.
- The member's Home Plan processes the claim and approves payment.
- Pennsylvania Blue Shield pays you for your services.

### **BlueCard claims tips**

- Ask to see the member's identification card at each visit. Alphabetical prefixes can change frequently. Reporting the wrong alphabetical prefix can cause payment delays.
- A three-character alphabetical prefix is required for accurate processing.
- Include the complete identification number, including the alphabetical prefix, when referring a BlueCard member for laboratory procedures, X-rays, etc.
- Authorization and precertification is done by the Home Plan.
- Submit all BlueCard claims to Pennsylvania Blue Shield for processing — remember, BlueCard claims can be submitted electronically.

### **Private business anesthesia claim form (1500A-OL)**

Blue Shield accepts many claim forms for Private Business claims.

Please refer to Pages 8 - 12 for item-by-item guidelines on how to complete these claim forms.

There are certain blocks on the anesthesia claim form (See Pages 33 - 34 for a sample anesthesia claim form) that require special attention. Here are the instructions for completing them:

**Date of Illness, Injury or Pregnancy** — Not applicable for anesthesia services.

**Date First Consulted You for This Condition** — Not applicable for anesthesia services.

**If an Emergency** — Not applicable for anesthesia service.

**Date Patient Able to Return to Work** — Not applicable for anesthesia services.

**Dates of Total Disability and Dates of Partial Disability** — Not applicable for anesthesia services.

**Name of Referring Physician or other Source** — Enter the name of the referring party, if any.

**Days or Units** — Report the total minutes in this block.





**Pennsylvania  
BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

**P.O. Box 890062  
Camp Hill, PA 17089-0062**

PATIENT & INSURED (SUBSCRIBER) INFORMATION			Please read instructions before completing or signing this form.				
1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH		3. INSURED'S NAME (First name, middle initial, last name)			
4. PATIENT'S ADDRESS (Street, city, state, zip code)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. INSURED'S ID or MEDICARE NO. (include any letters)			
TELEPHONE NUMBER ( )		7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER		8. INSURED'S GROUP NO. (or Group Name)			
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder, Plan Name and Address and Policy or Medical Assistance Number		10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>		11. INSURED'S ADDRESS (Street, city, state, zip code)			
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.							
PHYSICIAN OR SUPPLIER INFORMATION							
14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15. DATE FIRST CONSULTED YOU FOR THIS CONDITION		16.A. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>		16.B. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>	
17. DATE PATIENT ABLE TO RETURN TO WORK		18.A. DATES OF TOTAL DISABILITY FROM THROUGH		18.B. DATES OF PARTIAL DISABILITY FROM THROUGH			
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency)				20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED			
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)				22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES			
22. 1. 2. 3. 4.							
24. D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN							
A. DATE OF SERVICE FROM TO	* B. PLACE OF SERVICE	C. TOS	PROCEDURE CODE (IDENTIFY)	E. DIAGNOSIS CODE	F. CHARGES	G. DAYS OR UNITS	H. PERFORMING PROVIDER
UNITS <input type="checkbox"/> Basic <input type="checkbox"/> Time <input type="checkbox"/> Age Phys. Status No. (Choose One) I _____ II _____ III _____ IV _____ V _____ Other (Specify on Claim) Total Units @ \$ _____ = \$ _____							
<input type="checkbox"/> I certify that I was directing no more than four anesthetists concurrently.							
25. SIGNATURE OF PHYSICIAN OR SUPPLIER <i>(I certify that the statements on the reverse apply to this bill and are made a part hereof.)</i>		26. HAS FEE BEEN PAID? YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE		28. AMOUNT PAID	29. BALANCE DUE
SIGNED _____ DATE _____		30. YOUR SOCIAL SECURITY NO.		31. PHYSICIAN'S OR ACCOUNT'S NAME, ADDRESS, ZIP CODE & PROVIDER NO.			
32. YOUR PATIENT'S ACCOUNT NO.		33. YOUR EMPLOYER ID NO.					
		34. YOUR TELEPHONE NO.					

**SIGNATURE OF PHYSICIAN:**

I certify that the services reported on this form were medically necessary for the patient and were performed by under my supervision by my employee. If the services were performed under my supervision by someone other than my employee, I have described the circumstances in item 24D. I understand that certain types of supervised services may not be covered. I will provide documentation as necessary to establish the validity of the claim.

**PLACE OF SERVICE CODES:**

- |          |                             |           |                                   |
|----------|-----------------------------|-----------|-----------------------------------|
| 1 - (IH) | - Inpatient Hospital        | 8 - (SNF) | - Skilled Nursing Facility        |
| 2 - (OH) | - Outpatient Hospital       | 9 -       | - Ambulance                       |
| 3 - (O)  | - Doctor's Office           | 0 - (OL)  | - Other Locations                 |
| 4 - (H)  | - Patient's Home            | A - (IL)  | - Independent Locations           |
| 5 -      | - Day Care Facility (PSY)   | B -       | - Other Medical Surgical Facility |
| 6 -      | - Night Care Facility (PSY) | C - (RTC) | - Residential Treatment Center    |
| 7 - (NH) | - Nursing Home              | D - (STF) | - Specialized Treatment Facility  |

## **Anesthesia reporting tips**

### **Procedure code**

Report the surgical code when reporting anesthesia services. If a procedure code cannot be located for the exact service performed, report a description of service and select an unlisted procedure code (not otherwise classified) found at the end of each section of the *PTM*.

### **Modifier identifying anesthesia**

“WJ” modifier must be applied to the surgical procedure code to indicate anesthesia was administered.

### **Modifiers identifying anesthesia certification**

“AA” modifier must be used to indicate anesthesia service “personally performed” by anesthesiologist.

“AB” modifier must be used to indicate medical direction of “own employee” by anesthesiologist.

“AC” modifier must be used to indicate medical direction of “other than own employee” by anesthesiologist.

“AE” modifier must be used to indicate direction of “residents” in furnishing not more than two concurrent anesthesia services.

Note: Other modifiers that can be used to indicate anesthesia information can be found in the *PTM*.

### **Units (basic)**

Basic unit values have been assigned to most procedures and reflect the difficulty of the anesthesia service including the “pre” and “post” operative care evaluations.

### **Units (time)**

Report time in total number of minutes. Time must be indicated on all anesthesia claims. Anesthesia time begins when the doctor starts to “prepare” the patient for induction, and ends when the patient may safely be placed under postoperative supervision and the doctor is no longer in personal attendance.

### **Units (age)**

Indicate age units only for extremes in age.

For example:

- Less than one (1) year of age, or;
- Seventy-one (71) years of age or older.

### **Physical status**

Blue Shield does not allow additional units for physical status (PS) if it is not reported on the claim. Classification of PS must be reported (select only one) as:

PSI.) A normally healthy patient for an “elective” operation.

PSII.) A patient with a “mild” systemic disease.

PSIII.) A patient with a “severe” systemic disease that limits activity but is not incapacitating.

PSIV.) A patient with an “incapacitating systemic disease” that is a constant threat to life.

PSV.) A moribund patient who is not expected to survive for 24 hours with or without the operation.

**Other units**

Report other modifying units for situations such as emergency, utilization of total body hypothermia, hyperbaric pressurization, extracorporeal circulation or any other situation that is not a usual part of the surgical procedure. No allowance will be made for age, physical status or other conditions if not reported.

**Anesthesia certification**

The anesthesia certification must be reported on anesthesia claims. Anesthesia certification can be indicated by the use of a modifier or by selecting one of the following:

**A. Physician is doing the billing:**

1. I certify that the full anesthesia service was provided by **ME PERSONALLY**.
2. Anesthesia services were provided by **MY EMPLOYEE** under my medical direction.
3. Anesthesia services were provided by a **NON-EMPLOYEE** under my medical direction.
4. Anesthesia services were provided by a **NON-EMPLOYEE PHYSICIAN-IN-TRAINING** under my medical direction.

**B. CRNA is doing the billing:**

The facility must be reported.

1. Services were performed **IN COOPERATION WITH** the operating surgeon, assistant surgeon or attending physician.
2. Services were **DIRECTED/SUPERVISED** by a doctor other than the operating surgeon, assistant surgeon or attending physician (that is, anesthesiologist).

**Anesthesia claims tips**

To ensure that your claims are processed accurately and paid without delay, please follow these guidelines when completing the claim form:

- When epidural analgesia of a nerve block is administered for anesthetic purposes during a surgical procedure, report the appropriate procedure code for the surgical procedure with a “WJ” modifier. Do not report codes 62273-62282, 62310-62319, 64400-64450, 64470-64484, 64505-64530 with a “WJ” modifier when a nerve block is administered for anesthetic purposes.
- When epidural analgesia or a nerve block is administered as a therapeutic agent for the treatment of a non-surgical condition, report the appropriate injection/nerve block procedure code (62273-62282, 62310-62319, 64400-64450, 64470-64484, 64505-64530). Do not report a “WJ” modifier, time units, modifying units or anesthesia certification.
- The pre-, intra- or postoperative insertion of an epidural catheter for postoperative pain control (code 62318 or 62319) is not considered part of the global anesthesia allowance, and, therefore, is eligible for separate payment. Report procedure code 62318 or 62319 in addition to the anesthesia for the surgical procedure.
- Do not report procedure code 62318 or 62319 for subsequent adjustments or injections of epidural analgesia for postoperative pain control, as they are considered to be included in the global allowance for the epidural catheter insertion.
- Provide the name and performance verification status (personally, employee, non-employee or CRNA) of the individual performing the service. Only report one anesthesia service (and related services) per claim form. Provide the time units for each procedure.

## Security 65, 65 Special and other Medicare Part B supplemental claims

For patients with Pennsylvania Blue Shield Security 65, 65 Special or other Medicare Part B supplemental coverage, it is not necessary to submit a claim for payment after you submit one to Medicare Part B. The supplemental payment by Blue Shield should automatically follow the Medicare Part B payment.

If you do not receive the Explanation of Benefits payment within 14 days following receipt of the Medicare Part B payment, please mail the Explanation of Medicare Benefits (EOMB) with a completed 1500A claim form to:

Pennsylvania Blue Shield  
Medigap Claims Department  
PO Box 898845  
Camp Hill, Pa. 17089-8845

Do not highlight the Medicare payments in question. Either circle or place an asterisk (\*) next to the information you want to bring to our attention. Provide the patient's Blue Shield identification number and their complete name and address.

## Areas of special interest

### Diagnosis coding

Blue Shield requires you to report diagnoses codes from the *ICD-9-CM* (International Classification of Diseases, 9th Revision Clinical Modification) manual on its medical-surgical claim forms. The *ICD-9-CM* codes are used to assign numeric codes to disease, injuries, impairments, symptoms and causes of death. Since Blue Shield's claims processing system applies medical payment guidelines based on diagnoses codes, you must report the most appropriate three-, four- or five-digit diagnosis code on every claim.

Be as accurate as possible. For example, code 475 is a valid diagnosis code. If reported incorrectly as 475.0 or 475.00, it becomes invalid. Blue Shield may reject your claims for payment if you submit them without complete or accurate diagnoses codes.

We recommend that you purchase the *ICD-9-CM* coding manual to use for coding your claims.

### ICD-9-CM reporting tips

Report ICD-9-CM diagnoses codes in the "Diagnosis or Nature of Illness" block of the claim form. If a patient has several diagnoses, list only the diagnosis you are treating. Listing conditions you are not treating may result in rejection of services. Report the diagnosis code that made the reported treatment medically necessary. Use the 3-, 4- or 5- digit diagnosis code that is most appropriate and complete for the patient's conditions. When reporting more than one diagnosis, be sure to reference each diagnosis to the corresponding service performed by reporting the reference number 1, 2, 3 or 4 from the "Diagnosis Code or Nature of Illness or Injury" block in the "Diagnosis Code" block. (See examples 1 and 2 on Page 38.) You may report the diagnosis code alone, but you can include the terminology associated with the diagnosis code if you prefer. When you cannot or have not determined the exact disease, report the symptoms, signs or conditions affecting the patient (that is, dizziness, fatigue, fever or possible heart attack, suspected Alzheimer's disease). In those cases, use a diagnosis code matching the condition being considered as a possible diagnosis.

**Example 1**

23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE											
1	250.9		Diabetes								
2	786.5		Chest pain								
3											
4											
24.	A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H PERFORMING PROVIDER
	FROM	TO			PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)					
	10112000		0		82951	Glucose tolerance test	1	20	00		
	10112000		0		71020	Chest X-ray	2	35	00		

**Example 2**

23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE											
1	250.9										
2	786.5										
3											
4											
24.	A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H PERFORMING PROVIDER
	FROM	TO			PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)					
	10112000		0		82951	Glucose tolerance test	1	20	00		
	10112000		0		71020	Chest X-ray	2	35	00		

**Modifiers**

A modifier is a two-character code — either numeric, alphabetical or alpha-numeric — that is placed after the usual procedure code. A modifier permits a provider to indicate whether a service or procedure has been altered by specific circumstances, but not changed its definition or code. Up to three modifiers can be reported for each service. Some modifiers that are essential to accurate claims processing, and that also must be reported on the claim form (when applicable) are:

<b>Modifier</b>	<b>Definition</b>
LT	Identifies procedures performed on the left side of the body.
RT	Identifies procedures performed on the right side of the body.
50	Identifies bilateral procedures. Unless otherwise identified by a specific code, bilateral procedures should be identified by adding a 50 modifier to the appropriate procedure code.

Our claims processing system is programmed to look for RT or LT modifiers on codes for services that may be performed bilaterally. When reporting a procedure that can be performed on either side of the body, report the appropriate RT or LT modifier. If neither the 50, RT or LT modifiers are reported, one of the services will be rejected as a duplicate.

<b>Modifier</b>	<b>Definition</b>
76	Repeat procedure by same physician. Use this modifier to report all procedures or portions of procedures that are repeated on the same date.

The 76 modifier should be applied to the subsequent or repeat procedure only. Failure to use this modifier when appropriate will result in a rejection, as the service will be read as a duplicate.

When reporting injections of antineoplastic agents, report modifier XI or XJ:



<b>Modifier</b>	<b>Definition</b>
XI	Administration of an FDA-approved drug
XJ	Administration of an FDA-non-approved drug

Use these modifiers only with chemotherapy administration procedure codes (96400-96450, W9400) to determine the administration's eligibility. Additional modifiers are:

<b>Modifier</b>	<b>Definition</b>
YC	Emergency service, initial (for example, reporting an emergency interpretation of an EKG).
WH	Trauma case. Trauma cases are defined as those requiring necessary surgery due to a trauma diagnosis. When multiple surgical procedures are required due to trauma, add the modifier WH to the applicable procedure codes.
22	Identifies unusual services. When the service provided is of greater complexity than that usually required for the listed procedure, identify the service by adding the modifier 22 to the usual procedure code.

A complete listing of all modifiers can be found in the *PTM*.

### **Bilateral procedures**

When reporting procedures that were performed bilaterally, you must report the correct number of services to correspond with the modifier(s) you report. There are several ways to report bilateral procedures.

#### **“Right” and “left” modifiers**

If you report bilateral services on two lines of service, report an RT modifier on one line and an LT modifier on the other. The number of services on each line should be “1.”

<b>Example:</b>	20610	RT	\$35.00	(01)
	20610	LT	\$35.00	(01)

If you report bilateral services on one line of service, report RT and LT modifiers. The number of services should be “2.”

<b>Example:</b>	20610	RT LT	\$70.00	(02)
-----------------	-------	-------	---------	------

#### **“50” modifier**

If you report a “50” modifier to indicate bilateral procedures, report only one line of service. The number of services should be “2.”

<b>Example:</b>	20610	50	\$70.00	(02)
-----------------	-------	----	---------	------

If you are reporting multiple services performed on the same side of the body (for example, right arm, right leg), you may follow either of these examples:

<b>Example:</b>	20610	RT	\$70.00	(02)
		or		
	20610	RT	\$35.00	(01)
	20610	RT 76	\$35.00	(01)

In this case, the 76 modifier must be reported on the second line that reports the same procedure code for correct payment to be made.

Here are some common examples of incorrect reporting and the correct way to report services:

Incorrect reporting			Correct reporting		
20610 RT	\$35.00	(01)	20610 RT	\$35.00	(01)
20610 50 LT	\$35.00	(01)	20610 LT	\$35.00	(01)

The “50” modifier on the second line should not be reported since itemized charges are being reported for “right” and “left.”

Incorrect reporting			Correct reporting		
20610 50	\$70.00	(01)	20610 50	\$70.00	(02)

When reporting a “50” modifier, the number of services should always be “2.”

Incorrect reporting			Correct reporting		
20610 LT knee	\$35.00	(01)	20610 LT knee	\$35.00	(01)
20610 LT shoulder	\$35.00	(01)	20610 LT 76 shoulder	\$35.00	(01)

For the claim to process correctly, a “76” modifier must be reported on the second line to indicate “repeat services.”

**Range dating**

Do not range date services, except in the following situations:

1. DME monthly rentals

24.	A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY: ) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H. PERFORMING PROVIDER
	FROM	TO								
	07012000	07312000	4		E0720WS	1	75	00	1	

2. End stage renal disease (ESRD) related services procedure codes 90918-90921

24.	A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY: ) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H. PERFORMING PROVIDER
	FROM	TO								
	06012000	06302000	20		90921	1	200	00	1	

3. In-hospital medical visits may be range-dated if the services are identical and the visits were provided on consecutive dates of service within the same calendar month.

24.	A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY: ) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H. PERFORMING PROVIDER
	FROM	TO								
	04212000	04292000	10		99233	1	675	00	9	

4. Weekly radiation therapy procedure codes 77427. Five fractions of radiation therapy constitute a week of therapy, whether or not the fractions occur on consecutive days. Since the code represents a week (or five fractions) of therapy management the number of services reported for each multiple of five fractions should be one unit. Radiation therapy services may be reported weekly or monthly. The number of services reported for a week of five fractions would be “one” as is illustrated in the following example:

24.	A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H. PERFORMING PROVIDER
	FROM	TO			PROCEDURE CODE (IDENTIFY: )	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)					
	05012000	05052000	3		7742726	Weekly Radiation Therapy	1	365	00	1	
						(5 Fractions)					

A month of 20 fractions would be reported as four services as shown below:

24.	A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H. PERFORMING PROVIDER
	FROM	TO			PROCEDURE CODE (IDENTIFY: )	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)					
	05012000	05282000	3		7742726	Weekly Radiation Therapy	1	1460	00	4	
						(20 Fractions)					

Dates of treatment weeks should not overlap as shown here:

24.	A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H. PERFORMING PROVIDER
	FROM	TO			PROCEDURE CODE (IDENTIFY: )	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)					
	05012000	05072000	3		7742726	Weekly Radiation Therapy	1	365	00	1	
						(5 Fractions)					

Rather, reported dates of services should span the range of dates involved, as in this example:

24.	A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H. PERFORMING PROVIDER
	FROM	TO			PROCEDURE CODE (IDENTIFY: )	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)					
	05012000	05102000	3		7742726	Weekly Radiation Therapy	1	730	00	2	
						(A Total of 10 Fractions)					

Hyperfractions of radiation therapy occur when two smaller doses are given in one day of treatment. One week of hyperfractions would include 10 hyperfractions or five days. The number of services billed for that week should be “1”, as this example shows:

24.	A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H. PERFORMING PROVIDER
	FROM	TO			PROCEDURE CODE (IDENTIFY: )	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)					
	05012000	05052000	3		7742726	Weekly Radiation Therapy	1	365	00	1	
						(10 Hyperfractions)					

When providing radiation therapy services, the notation, “course of treatment ended” should only be used when the final treatment has been administered.

## **Documentation requirements**

Blue Shield requires that patient records document every service submitted for payment. This includes diagnostic tests, medical care, surgery and any other services eligible for payment by Blue Shield. Regulations issued by the Pennsylvania Board of Medical Education and Licensure support this policy.

If documentation is needed, Blue Shield will request it. Please retain your office records for audit purposes.

Hospital and office records must verify that a service: 1) was actually performed; 2) was performed at the level reported; and 3) was medically necessary. The services billed by the provider must be documented by personal notes and orders in the patient's records.

Blue Shield will use this criteria to determine if the provider has met the appropriate documentation requirements:

- Hospital medical visits — The admission and discharge records, doctor's orders and progress notes should clearly reflect the type, level of care and medical necessity of treatment billed by the doctor. The records not only should reflect the doctor's personal involvement in treating the patient, but also should reflect and be co-signed by the interns and residents who write the progress notes and order sheets;
- Surgical services — The operative report should indicate the name of the surgeon who performed the service. Minor surgical procedures not requiring an operative note must be documented in the progress notes. Also, the records should indicate the condition or diagnosis that documents the medical necessity for the surgery;
- Consultation — A consultation includes a history and an examination of the patient by a consultant whose services were requested by the attending physician. There should be a written report signed by the consultant. Additionally, the medical necessity for the consultation must be documented;
- Anesthesia — The anesthesia and/or operative report should indicate the name of the person who actually performed the anesthesia service. Anesthesia time units begin when the doctor begins to prepare the patient for induction and ends when the patient may be safely placed under postoperative supervision and the doctor is no longer in personal attendance. The records should reflect the actual time units reported;
- Medical reports — Office records should contain the patient's symptoms and/or complaints, diagnoses, tests performed, test results and treatment given or planned. In addition, the copies of hospital records should be clear and readable. In cases involving concurrent medical care, the consulting physician should submit these records with the request for review;
- Emergency medical/accident — Claims for emergency medical and emergency accident services always should include a date of onset and a date of service. The correct procedure codes for emergency treatment in the office are W9006 and W9005, and for treatment in the hospital outpatient area, W9026 and W9025.

## **Claim attachments eliminated**

You can send Blue Shield almost all of your claims electronically — and not have to worry about submitting additional paper documentation.

*The only exception: DME claims*

For Federal Employee Program (FEP) or major medical durable medical equipment (DME) claims, please send us a paper claim accompanied by a CMN the first time you submit a claim for the rental or purchase of a particular DME item. You can submit subsequent claims electronically for the same DME item, while the CMN is in effect — without submitting another copy of the CMN.

*Electronic claims receive higher priority*

If you don't submit DME claims, send us all your claims electronically and forget about attachments. If we need additional documentation to process the claim, we'll contact you after we've started reviewing it.

Blue Shield changed its medical-surgical claims processing system to place a higher priority on claims filed electronically.

*For select services, add the documentation to the electronic claim*

The following chart outlines a select number of services that might be considered cosmetic where Blue Shield still requires documentation. But now, instead of sending it on a paper attachment, report this information in the narrative field of the electronic claim format.

The chart identifies the services — and tells you what information we need.

When completing the narrative field, please enter the question number, and the appropriate response to that question. Remember to report all dates in the CCYYMMDD format.

The narrative field is located in this specification layout for the National Standard Format (NSF 2.0) and the X12 3051.

NSF 2.0: Narrative Field	X12 3051: Narrative Field
RECORD - HA0	LOOP - 2400
SEQUENCE - 05	SEQUENCE - NTE
POSITIONS - 40 to 320	REF - 02
	ELEMENT# - 3

If you've obtained preauthorization for the surgical procedures you're reporting, please include the preauthorization number in the narrative field in this format: P#:123456789.

**Procedure code**

15775, 15776 (Hair transplant)

**Required narrative****Please answer these two questions:**

1. Is this due to an accident or injury?
2. If yes, what is the date of the accident or injury?

**Sample response:**

1)Yes 2)19990118 P#:123456789

*If the procedure being performed is not due to an accident or injury, documentation may be requested post receipt of the claim.*

15780 - 15787

(Skin surgery/treatment)

**Please answer these three questions:**

1. Is this due to an accident or injury?
2. If yes, what is the date of the accident or injury?
3. Is this surgery being performed because of post-acne scarring?

**Sample response:**

1)Yes 2)19990118 3)No P#:123456789

*If the patient has a functional impairment that is not the result of an accident, documentation may be requested post receipt of the claim.*

**Procedure code**

15775, 15776 (Hair transplant)

**Required narrative****Please answer these two questions:**

1. Is this due to an accident or injury?
2. If yes, what is the date of the accident or injury?

**Sample response:**

1)Yes 2)19990118 P#:123456789

*If the procedure being performed is not due to an accident or injury, documentation may be requested post receipt of the claim.*

---

15780 - 15787

(Skin surgery/treatment)

**Please answer these three questions:**

1. Is this due to an accident or injury?
2. If yes, what is the date of the accident or injury?
3. Is this surgery being performed because of post-acne scarring?

**Sample response:**

1)Yes 2)19990118 3)No P#:123456789

*If the patient has a functional impairment that is not the result of an accident, documentation may be requested post receipt of the claim.*

---

15820, 15821, 15822, 15823

(Eyelid surgery)

67900 – 67908

(Facial and eyelid surgery)

**Please answer these two questions:**

1. Is visual impairment documented on the automated visual field study?
2. Do photographs indicate that part of the pupil is covered or the eyelid touches the eyelashes?

**Sample response:**

1)Yes 2)Yes P#:123456789

15824, 15825, 15826, 15828,

15829 (Rhytidectomy)

**Please answer this question:**

1. Is there functional impairment as a result of a disease state?

**Sample response:**

1)Yes P#:123456789

*If the answer to this question is no, documentation may be requested post receipt of the claim.*

---

15831 (Abdominal lipectomy)

**Please answer this question:**

1. Has abdominal skin fold created a symptomatic disease condition such as chronic pain, dermatitis or ulceration?

**Sample response:**

1)Yes P#:123456789

*If the answer to this question is no, documentation may be requested post receipt of the claim.*

---

Procedure code	Required narrative
19140 (Breast surgery)	<p><b>Please provide this information:</b></p> <ol style="list-style-type: none"> <li>1. Specify the type of tissue described in the pathology report.</li> <li>2. Specify the final diagnosis described in the pathology report.</li> </ol> <p><b>Sample response:</b> 1)Fibrous 2)Fibrous breast tissue</p>
19318 (Breast surgery/repair)	<p><b>Please provide this information:</b></p> <ol style="list-style-type: none"> <li>1. Report the number of grams removed from the patient. If this information does not meet our criteria, additional information may be requested.</li> <li>2. Report the height of the patient.</li> </ol> <p><b>Sample response:</b> 1)Grams 254 2)Height 5’7”</p>
19324, 19325 (Augmentation mammoplasty)	<p><b>Please answer these five questions:</b></p> <ol style="list-style-type: none"> <li>1. Is unilateral breast aplasia present?</li> <li>2. Has extirpative surgery, for example, mastectomy, with either immediate or delayed prosthesis, for benign disease been performed on the affected breast?</li> <li>3. Has the reconstructive procedure been performed following previous radical surgery for malignant disease on the affected breast?</li> <li>4. Is breast hypoplasia associated with Poland’s syndrome on the affected breast?</li> <li>5. Has surgery been performed for symmetry on the unaffected breast?</li> </ol> <p><b>Sample response:</b> 1)Yes 2)No 3)Yes 4)Yes 5)No P#:123456789 <i>If one of the above situations does not apply, documentation may be requested post receipt of the claim.</i></p>
19328, 19330 (Removal of implants)	<p><b>Please answer these three questions:</b></p> <ol style="list-style-type: none"> <li>1. Has infection, allergic reaction or complication (leakage, rupture) occurred?</li> <li>2. Has breast surgery, for example, mastectomy, capsulectomy, capsulotomy, been performed for benign or malignant disease?</li> <li>3. Has breast surgery been performed to replace implant with a larger or smaller size?</li> </ol> <p><b>Sample response:</b> 1)Yes 2)Yes 3)No P#:123456789 <i>If one of the above situations does not apply, documentation may be requested post receipt of the claim.</i></p>

**Procedure code**

19340, 19342  
(Insertion of breast prosthesis)

**Required narrative****Please answer these two questions:**

1. Was the original surgery (augmentation) performed for cosmetic reasons?
2. Was the original surgery for mastectomy of benign or malignant disease?

**Sample response:**

1)No 2)Yes P#:123456789

*If one of the above situations does not apply, documentation may be requested post receipt of the claim.*

21137, 21138, 21139, 21172,  
21175, 21179, 21180  
(Reduction, forehead)

**Please answer these two questions:**

1. Is this due to an accident or injury?
2. If yes, what is the date of the accident or injury?

**Sample response:**

1)Yes 2)19990118 P#:123456789

*If the patient has functional impairment that is not the result of an accident, documentation that reflects the functional impairment may be requested post receipt of the claim.*

30400, 30410, 30420  
(Nasal surgery)  
30430, 30435, 30450  
(Rhinoplasty)

**Please answer these three questions:**

1. Is this due to an accident or injury?
2. If yes, what is the date of the accident or injury?
3. Was functional breathing impaired?

**Sample response:**

1)Yes 2)19990118 3)Yes P#:123456789

*If the patient has functional impairment that is not the result of an accident, documentation that reflects the functional impairment may be requested post receipt of the claim.*

40650, 40652, 40654  
(Lip repair/surgery)

**Please answer these two questions:**

1. Is this due to an accident or injury?
2. If yes, what is the date of the accident or injury?

**Sample response:**

1)Yes 2)19990118 P#:123456789

*If the answer to the first question is no, documentation may be requested post receipt of the claim.*

69300 (Ear surgery)

**Please answer this question:**

1. Do photographs indicate that the ears are perpendicular to the head

**Sample response:**

1)Yes P#:123456789

Not otherwise  
classified (NOC) codes

**Report in the narrative field:**

- 1) A complete description of the service(s) rendered.



*Manipulation, physical therapy plans necessary*

Blue Shield continues to require written treatment plans for manipulation and physical therapy encounters in excess of 15 per calendar year. You can submit manipulation and physical therapy claims electronically. However, you must also complete a treatment plan on form No. 3861 and send it to:

Pennsylvania Blue Shield  
 PO Box 890140  
 Camp Hill, Pa. 17089-0140

For more information about filing your claims electronically, visit **www.careconnect.com** or call Highmark EDI Services at (800) 992-0246.

**Changing and combining reported codes**

In administering program policies, there are occasions when the reported procedure code is altered or charges reported separately are combined into a single line item. Here are some of the conditions under which our policy requires altering of services reported on a claim:

- The reported procedure code is obsolete or nonexistent.
- Separate procedure codes and charges are reported when we have a single code covering all services. In cases where Blue Shield changes the information submitted on a claim, the service and charge will not be used to calculate the provider’s profile.

**Facility identification numbers**

To help decrease processing time when reporting inpatient and outpatient services performed at facilities such as hospitals, skilled nursing facilities, nursing homes, etc., Blue Shield has implemented a facility coding system. You must report an eight-digit alphanumeric facility identification number in addition to the facility name and address in Block 21 of the claim form. Here is an example that shows how to report the facility identification number:

PHYSICIAN OR SUPPLIER INFORMATION										
14. DATE OF		ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)			15. DATE FIRST CONSULTED YOU FOR THIS CONDITION		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>		16A. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>	
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____			DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____					
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency)					20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____					
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office) City Hospital 20 North Street CI390000 Southside, PA 17000					22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES					
23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE										
1										
2										
3										
4										
24.										
A DATE OF SERVICE		B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY: _____) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)			E DIAGNOSIS CODE	F CHARGES	G DAYS OR UNITS	H. PERFORMING PROVIDER
FROM _____ TO _____										

Claims submitted without the necessary information, as shown in the example, may result in payment delays.

For the electronic biller, it is important to report the facility identification number without alphabetical characters. The facility identification number is required when you are reporting services that were rendered in an inpatient, outpatient or skilled nursing facility.

Please refer to the Appendix for a listing of all licensed facilities (hospitals and skilled nursing facilities) in Pennsylvania. It contains information received from the Pennsylvania Department of Health and the Blue

Cross Area Plans of Pennsylvania. The list will help you report the appropriate facility identification number.

The listing is sorted alphabetically by facility name, address and the eight-digit facility identification number.

## **Explanation of Benefits for medical-surgical contracts**

### **Participating providers**

An Explanation of Benefits (EOB) statement is sent to participating providers and to members. Along with the claim payments, participating providers receive an EOB listing all claims processed each week. This EOB lists each patient's claim separately. Each individual member on the provider's EOB also receives an EOB listing the services processed. (See Example 1, Provider EOB; Example 2, Member EOB.)

### **Non-participating**

Non-participating providers do not receive an EOB. Instead, the member receives the EOB and a check, if applicable. The member is responsible for reimbursing the non-participating provider for services performed. (See Example 2, Member EOB).

### **Information on EOB**

Both the participating provider and member EOB contain the following key information:

- Patient's name
- Agreement number
- Member's name
- Claim number
- Date of service
- Procedure code
- Doctor's charge
- Blue Shield's allowance
- Amount applied to deductible
- Amount applied to co-insurance
- Amount deducted for coordination of benefits

## **Explanation of Benefits for Medicare Part B supplemental contracts**

### **Assigned providers**

An EOB statement is sent to assigned providers and to members. Assigned providers will receive an EOB showing all claims processed each week. This EOB lists each patient's claim separately. Each individual member on the provider's EOB also receives an EOB listing the services processed. (See Example 3, Provider EOB; Example 4, Member EOB)

### **Non-assigned providers**

Non-assigned providers do not receive an EOB. Instead, the member receives the EOB and a check, if applicable. The member is responsible for reimbursing the non-assigned provider for services performed. (See Example 4, Member EOB)

### **Information on EOB**

Both the assigned and member EOB contain the following:

- Patient's name

- Medicare health insurance claim (HIC) number
- Claim number
- Date of service
- Procedure code
- Provider's charge
- Medicare approved amount
- Blue Shield's allowance
- Amount applied to Medicare Part B deductible

### **Inquiries about EOBs**

Members should direct their questions or comments to the phone number listed on their EOB. Participating providers should contact Blue Shield's Customer Service department if they have questions about coverage or disagree with the determination of a claim. For more information about inquiries please see Section 10, "Provider Services and Information Sources."

**Please note: The EOB you receive may vary slightly in format from the examples.**



Example 1: Provider EOB



Page 1 of 2

EXPLANATION OF BENEFITS  
CHECK IS ENCLOSED

SEPTEMBER 02, 1999

PROVIDER SUMMARY


Provider: ANESTHESIA ASSOCIATES  
Provider Number: 000777777

PAYMENT SUMMARY

PROVIDER CHECK NUMBER .....	016254423
TOTAL PROVIDER PAYMENTS .....	\$128.00
TOTAL MEMBER PAYMENTS .....	\$0.00



Camp Hill, PA 17089

  
 ANESTHESIA ASSOCIATES  
 PO BOX 1511  
 CAMP HILL PA 99999

PF000023

Provider Number: 000777777  
 Provider Name: ANESTHESIA ASSOCIATES

Page 2 of 2  
 SEPTEMBER 02, 1999

DATE(S) OF SVC	NUM OF SVCS	PROCEDURE CODE	PAY-MENT CODE	PROVIDER CHARGE	OUR ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	MEMBER LIABILITY AMOUNT	MEM LIAB CODE	OTHER INSURANCE AMOUNT	AMOUNT(S) PAID (* = MEMBER)	MESSAGE CODES
----------------	-------------	----------------	---------------	-----------------	---------------	-----------------------	--------------	-------------------------	---------------	------------------------	-----------------------------	---------------

PATIENT ACCT #: CONTRACT ID: 222334444  
 PATIENT: KATHY BEAR MEMBER: KATHY BEAR  
 CLAIM NUMBER: 99222011111

06/03/99	3	45380-WJ-AC	023	456.00	128.00	128.00	04				128.00	J2030,J9048
CLAIM TOTALS						328.00	16				128.00	

**MESSAGE(S):**  
 J2030 These services were performed by a CRNA who is not your employee. The allowance represents 50% of the amount that would be allowed if the anesthesiologist personally administered the anesthesia. We only pay the charge which represents direct services of an anesthesiologist.  
 J9048 This claim was processed using a Central Site Benefit Plan. If you have questions, please call the Central Site Dedicated Unit at (717) 975-8288.

**PAYMENT CODES:**  
 023 = PREMIERBLUE

**NON-CHARGEABLE AMOUNT CODES:**  
 04 = Nurse Anesthetist  
 16 = PremierBlue Differential

**MEMBER LIABILITY CODES:**



PF000023

||

Example 2: Member EOB



**EXPLANATION OF BENEFITS**  
KEEP FOR YOUR TAX RECORDS

HIGHMARK BLUE CROSS BLUE SHIELD  
CUSTOMER SERVICE  
PO BOX 898847  
CAMP HILL PA 17089-8847

Blue Cross and Blue Shield Plans of Pennsylvania are Independent Licensees of the Blue Cross and Blue Shield Association

Member: CHUCK JONES  
Patient: CHUCK JONES  
Provider: JOE SMITH MD  
(000555555)

ID Number: 000112222  
Claim Number: 99111011188

Page: 1 of 2  
Date: 09/02/99

PROCEDURE DESCRIPTION PROCEDURE CODE (NUMBER OF SERVICES)	SERVICE DATE(S)	PROVIDER'S CHARGE	ALLOWANCE	COVERED BENEFIT AMOUNT	AMOUNT NOT PAID	REMARKS
HOSPITAL VISIT 99221	(0001) 01/10/98	100.00	100.00	100.00	.00	
HOSPITAL VISIT 99232	(0020) 01/11/98- 01/30/98	2000.00	2000.00	2000.00	.00	
HOSPITAL VISIT 99232	(0028) 02/01/98- 02/28/98	2800.00	2800.00	2800.00	.00	
HOSPITAL VISIT 99232	(0001) 03/01/98	100.00	100.00	100.00	.00	
HOSPITAL VISIT 99232	(0001) 03/02/98	100.00	.00	.00	100.00	X5129 J9010



Camp Hill, PA 17089



#BWNBQH  
#OCS7195952866365#  
CHUCK JONES  
45 FRONT ST  
CAMP HILL PA 99999

**THIS IS NOT A BILL**

FOR CUSTOMER SERVICE CALL 1-800-367-9378.  
(Service by teletypewriter is available at 1-800-992-0137.)

S0000014

Example 2: Member EOB



**EXPLANATION OF BENEFITS**  
KEEP FOR YOUR TAX RECORDS

Blue Cross and Blue Shield Plans of Pennsylvania are Independent Licensees of the Blue Cross and Blue Shield Association

Member: CHUCK JONES ID Number: 000112222 Page: 2 of 2  
 Patient: CHUCK JONES Claim Number: 99111011188 Date: 09/02/99  
 Provider: JOE SMITH MD (000555555)

PROCEDURE DESCRIPTION PROCEDURE CODE (NUMBER OF SERVICES)	SERVICE DATE(S)	PROVIDER'S CHARGE	ALLOWANCE	COVERED BENEFIT AMOUNT	AMOUNT NOT PAID	REMARKS
HOSPITAL VISIT (0001) 99232	03/05/98	100.00	.00	.00	100.00	X5129 J9010
<b>TOTALS</b>		<b>5200.00</b>	<b>5000.00</b>	<b>5000.00</b>		

X5129 The lifetime maximum benefit available under the patient's coverage for the reported service has been paid. Therefore, no payment can be made.  
 J9010 For your convenience this claim has been forwarded to Major Medical for consideration. It is not necessary for you to submit a claim to Major Medical for this service. Major Medical will notify you when processing is completed.

These services were not performed by a participating provider.

We are paying you the amount in the covered benefit amount column. This payment is included in the enclosed check.

**EXPLANATION OF BENEFITS PAYMENT SUMMARY:**

Payment(s) on this Explanation of Benefits:

Paid To: CHUCK JONES

For Claim Number(s): 99111011188

\$5,000.00

**CHECK NUMBER 67786021 ENCLOSED: \$5,000.00**

These health benefits are entirely funded by the employer. We provide administrative and claims payment services only.

**THIS IS NOT A BILL**

S0000014





**Pennsylvania BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association

**EXPLANATION OF BLUE SHIELD BENEFITS**  
(COMPLEMENTS MEDICARE PART B)

X	PATIENT'S NAME/NUMBER	HEALTH INSURANCE CLAIM NUMBER/CONTROL NO.	PROCEDURE CODE	WHEN		SERVICE CODES	AMOUNT CHARGED	MEDICARE ALLOWED	BLUE SHIELD ALLOWED	MEDICARE DEDUCT.	BLUE SHIELD ELIGIBLE EXPENSE		TOTAL PAYMENT	MEDICARE PAYMENT	AGREEMENT NUMBER/ GROUP NUMBER	BLUE SHIELD USE ONLY	
				FROM	TO						CONSURANCE	DEDUCTIBLE					
				MO DAY Y	MO DAY Y												
	0083162	9960085707100	90921 *	12	17	12	17	77500	20764	000	1	000	000	000	000	054145-051	SX
				CLAIM	TOTALS	*	77500	20764	000	F	000	000	000	16611A			

TOTALS	NO. OF CLAIMS	AMOUNT CHARGED	MEDICARE ALLOWED	BLUE SHIELD ALLOWED	MEDICARE DEDUCTIBLE	BLUE SHIELD ELIGIBLE EXPENSE		TOTAL PAYMENT	MEDICARE PAYMENT
						CONSURANCE	DEDUCTIBLE		
PAGE -	1	775.00	207.64	0.00	0.00	0.00	0.00	0.00	166.11
CHECK -	1	775.00	207.64	0.00	0.00	0.00	0.00	0.00	166.11

SUMMARY	CHECK NO	0	PAID DATE	10/03/98	PAGE	1	OF	1
---------	----------	---	-----------	----------	------	---	----	---

PROVIDER NAME: SMITH ASSOCIATES PROVIDER NO. 000123456

SMITH ASSOCIATES  
BRIDGEPORT CT 06606-5534

**THIS IS  
NOT A BILL**

THE ADDRESS FOR FILING MEDIGAP CLAIMS IS:

PENNSYLVANIA BLUE SHIELD  
P. O. BOX 898845  
CAMP HILL, PA 17089-8845  
(717) 763-6695

PLEASE READ THE BACK OF THIS NOTICE FOR INFORMATION REGARDING CLAIM REVIEW PROCEDURES. WHEN QUESTIONING CLAIM STATUS, BENEFITS, OR ENROLLMENT INFORMATION, PLEASE USE INFOFAX AT 1-800-891-1856 OR OASIS AT 1-800-462-7474.

**EXPLANATION OF TERMS**

**EXPLANATION OF MESSAGE CODES**

- 01 - Charges for this service are not eligible under the subscriber's Blue Shield Program, therefore no payment can be made for these expenses.
- 02 - Payment of the first three (3) home or office medical care visits is the subscriber's responsibility.
- 03 - Charges for this service are not covered under the Medicare Program, therefore no Blue Shield payment can be made for these expenses.
- 04 - Duplicate charges are charges which have previously been filed with the subscriber's Blue Shield Program by the subscriber, Doctor, or Supplier. Since the charges have been reported once, we are unable to consider them again.
- 05 - These services were received prior to the effective date of the subscriber's Blue Shield Coverage, therefore, no payment is being made. **Please send any inquiries concerning this notice to the Blue Cross Plan where the subscriber pays his/her premium..**
- 06 - These services were received following the termination date of the subscriber's Blue Shield Coverage, therefore, no payment is being made. **Please send any inquiries concerning this notice to the Blue Cross Plan where the subscriber pays his/her premium.**
- 07 - Payment for this service will be made by the subscriber's Hospitalization Plan. **Please send any inquiries concerning this notice to the Blue Cross Plan where the subscriber pays his/her premium.**
- 08 - We have no record of the subscriber's membership, therefore, no payment is being made. **If the subscriber has Blue Shield Coverage, please write the subscriber's Agreement Number on this form and send it to the Blue Cross Plan where the subscriber pays his/her premium.**
- A The subscriber's Blue Shield Benefit maximum has been met, therefore no payment can be made for the service.
- B The deductible amount specified for the subscriber's Blue Shield agreement has not been satisfied. Payment for this service is the responsibility of the subscriber.
- C Blue Shield's liability for payment of medical care has been met.
- D The subscriber's Blue Shield benefit maximum has been met, therefore only a partial payment can be made for this service.
- F Pennsylvania Blue Shield provides administrative services only.
- O Medicare paid this service at a reduced rate. The subscriber's Blue Shield coverage made an additional payment for this service.

CODES FOR PLACE OF SERVICE			CODES FOR TYPE OF SERVICE		
1. Office	4. Skilled Nursing Facility	1. Medical care	4. Diagnostic X-ray	8. Assistance at surgery	
2. Home	5. Outpatient hospital	2. Surgery (Includes Treatment of Fractures)	5. Diagnostic laboratory	9. Other medical service	
3. Inpatient hospital	6. Independent laboratory	3. Consultation	6. Radiation therapy	0. Whole blood and packed red blood cells	
	7. Other		7. Anesthesia	A. Purchase of Durable Medical Equipment	

**MEDICARE ALLOWED** - The approved charge for each service or group of services as determined by the Medicare Part B carrier. Medicare pays 80% of the Medicare Allowed amount, after the annual Medicare Part B deductible has been satisfied.

**BLUE SHIELD ALLOWED** - The amount Pennsylvania Blue Shield can allow for the service based on the type of benefit covering the subscriber on the date of service. Pennsylvania Blue Shield pays 20% of the Blue Shield Allowed amount, after the annual Medicare Part B deductible has been satisfied.

**MEDICARE DEDUCTIBLE** - The amount applied to the annual Medicare Part B deductible.

**BLUE SHIELD ELIGIBLE EXPENSE: COINSURANCE** - Twenty percent (20%) of the total Blue Shield Allowed amount, over and above the Medicare Deductible, as specified by the Pennsylvania Blue Shield contract.

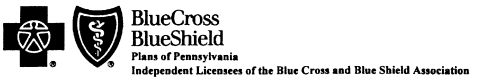
**BLUE SHIELD ELIGIBLE EXPENSE: DEDUCTIBLE** - The amount paid by Pennsylvania Blue Shield under certain contracts for approved charges applied to the annual Medicare Part B deductible.

**AMOUNT CHARGED** - The amount the Provider submitted for the service performed.

**MEDICARE PAYMENT** - The total amount Medicare paid for the services performed.

WHEN WRITING ABOUT A CLAIM PLEASE INCLUDE THE PATIENT'S NAME, THEIR HEALTH INSURANCE CLAIM NUMBER, THE CONTROL NUMBER, THE AGREEMENT NUMBER, AND THE SPECIFIC QUESTION.

Blue Shield will review your questions and notify you of its decision within 60 days unless special circumstances require additional time.



Example 4: Member EOB



**Pennsylvania BlueShield**  
 An Independent Licensee of the Blue Cross and Blue Shield Association  
 Camp Hill, PA 17089

Keep For Your Records

**EXPLANATION OF BLUE SHIELD BENEFITS**  
 (These Benefits Are In Addition To Your Medicare Part B Benefits)

**PATIENT INFORMATION**

Page: 1 OF 1  
 Date of this Explanation: MAY 20, 1996

Name of Patient:  
 Medicare Number:  
 Agreement Number:  
 Claim Number:

SERVICES WERE PROVIDED BY: SMITH INT ME

TYPE OF SERVICE (SERVICE CODE)	DATE (S) OF SERVICE	CHARGE	MEDICARE APPROVED	BLUE SHIELD APPROVED
OFFICE/OUTPATIENT VISIT (99213)	05/09/96	40.00	34.08	34.08
				34.08
				<del>X 20%</del> See Note 1
			Blue Shield Paid Your Provider	\$6.82 See Note 2

Note 1 Your coverage pays the 20 percent copayment not covered by Medicare.

Note 2 Our payment was sent to the provider who will accept Medicare's approved charge for covered services.

\*\*\*\*\* To appeal Medicare's payment decision, you must notify your Medicare Part B Carrier within six (6) months of this notice. SEE REVERSE SIDE FOR INFORMATION CONCERNING YOUR MEDICARE CARRIER.

123 FRONT ST  
 CAMP HILL PA 99999

If you have a question, please call 1-800-367-6565  
 Monday through Friday 8:00 a.m. to 4:30 p.m.  
 Please have a pen or pencil available to take notes.  
 Service for the Deaf via TDD equipment is available  
 at 1-800-345-3816. If you prefer to write, please send  
 your question to Pennsylvania Blue Shield,  
 P. O. Box 890052, Camp Hill, PA 17089-0052.

2116

THIS IS NOT A BILL

EXPLANATION OF TERMS

EXPLANATION OF MESSAGE CODES

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	7. Other		7. Anesthesia	A. Purchase of Durable Medical Equipment	

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