BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross Blue Shield Association.

2024 Annual Provider Summit

Frequently Asked Questions

Authorizations

1. **Where can we download all the information for authorizations to share with our office?**
   All authorization information will be located on the website www.SouthCarolinaBlues.com. We do ask that you do not print the information as updates are made. Please check the website for current versions.
2. **What ways can you request an authorization for quick approval?**
   Please use My Insurance Manager℠ (MIM) fast track option or Medical Forms Resource Center. Additional options to request authorization are available via phone or fax.
3. **What other options are there if you are unable to upload documentation for the authorization request on MIM?**
   Documentation can be faxed or mail if unable to upload through the portal.
4. **Where can we check to see if an authorization is required?**
   To verify if authorization is required you can call the provider services number on the back of the card or check for an authorization through MIM.
5. **Does the Medical Forms Resource Center (MFRC) have tracking numbers?**
   MFRC does not provide tracking numbers. You can check the status updates of any authorization submitted through MFRC in MIM.
6. **How can a provider request a retro-authorization?**
   BlueCross does not approve retro authorizations.

Benefits

7. **Where do you go to check eligibility and benefits for out of state members on the website?**
   Providers can call the BlueCard eligibility line at 800-676-2583 for out of state member benefits.
8. **How can a provider check benefits for a specific service?**
   To check coverage of a specific service Providers can us the Voice Response Unit (VRU), contact the Provider Services number listed on the back of the member's card or use MIM.
9. **What place of service should be used for telehealth?**
   Please request the most current card from the member to ensure the correct alpha prefix is used.
10. **Where can we find the benefit booklets for State Health Plan members?**
    The State member benefit booklets can be found on https://www.peba.sc.gov/health.

11. **How can a provider request to negotiate their contract rates?**
    Providers will need to contact their dedicated provider education consultant.

Claims

12. **How do we get a corrected claim processed as a corrected claim?**
    Please ensure that you are filing the correct bill type or corrected field to ensure that the claim shows it is a corrected claim.
13. **Are providers allowed to bill Healthy Blue members for claims that deny for OHI?**
    Providers can only bill Healthy Blue members for claims that deny as non-covered unless there is patient liability on the remit.
14. **Can a provider submit the Other Health Insurance (OHI) form on behalf of the member for claims processing?**
    OHI forms can be submitted on behalf of the member when completed and signed by the member. Exception: State Health Plan does not accept the OHI form from provider on behalf of member. Members also have the option to update OHI by calling or through My Health Toolkit. Please allow the member 60 days to update their OHI.

Dental

15. **What is the prefix associated with the Blue Cross Blue Shield FEP Dental plans?**
    Members that have the Blue Cross Blue Shield FEP Dental plan will have the prefix 'F'.

Healthy Blue℠

16. **Will the reconsideration form be updated to include Healthy Blue?**
    The reconsideration form on www.SouthCarolinaBlues.com is for commercial lines of business. Healthy Blue will use the claim dispute form located on their website, www.HealthyBlueSC.com.
17. **When can you start the authorization request with National Imaging Associates (NIA) for Healthy Blue?**
    NIA will begin accepting authorizations for Healthy Blue on January 1, 2024.
18. **Will providers automatically receive ERAs for Healthy Blue beginning 01/01/2024?**
    Providers will need to sign up to receive them for Healthy Blue.

Pharmacy

19. **Where is the prescription drug accumulator information found on a summary of benefits for member reference?**
    Accumulator information is listed on page 1 of the Summary of Benefits and Coverage for each BlueEssentials plan. The deductible and out-of-pocket information lists both the Individual and Family amounts. The other deductible for specific services area lists if there is a separate deductible for prescription drugs. More detail is found on page 2 of the Summary of Benefits and Coverage explaining individual Tier benefits (Copay or Coinsurance) and if a specific deductible applies.

Provider Enrollment

20. **Should the group enroll before submitting an application for an individual provider?**
    Both applications can be submitted simultaneously.
21. **How long should a provider wait for contracts when submitting an application?**
    Please allow 48 hours for contracts to be received. If no response received, please submit a support case requesting the contracts.
22. **How long does it take for an application to be reviewed?**
    Please allow 60-90 days for the review to be completed for a clean application.
23. **What are the steps for getting the missing items email if it is not received?**
    Please be sure to check your spam folder to ensure these emails are not being blocked when they are being sent. The email will be coming from Salesforce on the behalf of the Provider Enrollment area.
24. **Why is there not a system generated form for the CLIA requirement?**
    Providers are required to upload a copy of their CLIA certificate, a document BCBSSC cannot generate.
25. **How can a provider get their recredentialing date?**
    Providers are notified in advance when their recredentialing date is approaching. However, providers can contact their Provider Relations Consultant to get the recredentialing date.
26. **How can a provider upload renewed documents to an application that has been submitted or under review?**
    A provider can add a case comment requesting the case be reopened to uploaded updated documents. The case will need to be re-confirmed once completed.
27. **How can a provider update incorrect demographics listed in the directory?**
    Providers can update demographic information by using forms in My Provider Enrollment Portal such as DBA Name Change, Change of Address, etc. or they can make demographic updates within MIM.
28. **Should multiple applications be submitted for a group with different TINs?**
    An enrollment application will need to be submitted for each new TIN.

Quality

29. **Where can a provider locate past and present incentive payments for commercial LOBs?**
    Providers can reach out to the Quality team at NAVIGATOR@bcbssc.com.

Web Tools

30. **Who do we contact for technical assistance with MIM?**
    If you are experiencing any technical issues while using MIM, please contact technical support by calling 855-229-5720.
31. **Will there be a chat feature added in MIM in the future?**
    We have taken the suggestion to management and if a new feature becomes available, it will be on the website to use. We will send out an email blast to make all providers aware of any new changes.
32. **How long does it take to receive a response when submitting a request through Ask Provider Services?**
    Typically, a response should be within two business days. To ensure that your inquiry is being responded to in a timely manner, please send a detailed request and ask probing questions.

33. **Does the reply option for Ask Provider Service in MIM get routed to the representative who responded to the original inquiry?**

    At this time, no. The reply feature is available to prevent duplicate inquiries and are not routed back to the representative who addressed the original inquiry.

34. **Where is M.D. Checkup located?**

    M.D. checkup is a feature for provider validation and is in MIM under provider update tab.