



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

June 2017

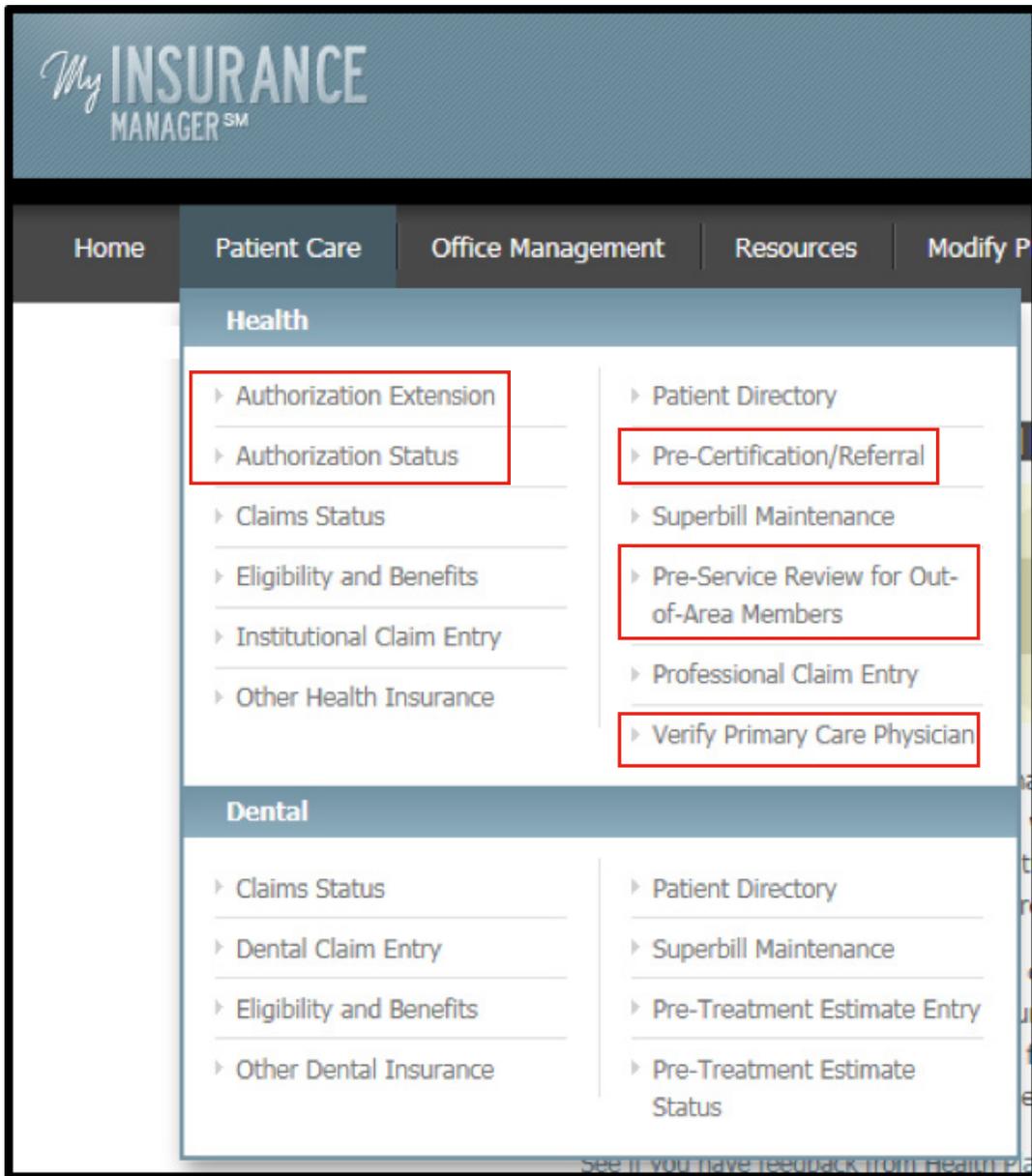
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# My Insurance Manager<sup>SM</sup> User Guide



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Pre-certification and/or referral requirements vary from group to group or by Plan.

## Pre-Certification/Referral – General Instruction

The screenshot shows the 'Pre-Certification/Referral' form. At the top, there is a navigation bar with 'Home', 'Patient Care', 'Office Management', 'Resources', 'Modify Profile', 'Profile Administration', and 'Staff Directory'. Below the navigation bar, there is a welcome message and a 'Log Out' link. The main heading is 'Pre-Certification/Referral' with a 'Printer-Friendly' icon. A note states: 'Please note: If you navigate away from a pre-certification or referral request without finishing and submitting it, your information will be lost and you will need to start over. We will not save partially completed requests on our system.' The form includes several fields: 'Health Plan' (BlueCross BlueShield Plans), 'Member ID' (ZCZ065922516805), 'Patient's Date of Birth' (10/01/1958), 'Patient Gender' (MALE), 'Date of Service or Admission Date' (02/10/2017), and 'Location' (YOUR PRACTICE/FACILITY NAME). A 'Continue' button is at the bottom.

From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient information. **Continue.**

The screenshot shows the 'Request' section of the 'Pre-Certification/Referrals' form. The left sidebar contains patient information: 'Date of Service' (02/10/2017), 'Insurance' (BlueCross BlueShield Plans, Member ID: ZCZ065922516805), and 'Patient' (MICHAEL TESTING, Date of Birth: 10/01/1958). The main area is titled 'Request' and contains a 'Request Type' section. A note says: 'In order to help us identify the required service, please answer these questions:'. There are two columns of radio button options: 'Which type of service are you requesting?' (Procedure, Non-Procedure, Laboratory Test, Behavioral Health Treatment, Maternity, Specialty Drug) and 'Where will this service take place?' (Inpatient Hospital, Outpatient Facility). A note at the bottom states: 'Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our pre-certification requirements.' Buttons for 'Continue', 'Ask Health Care Services', and 'Back' are at the bottom, along with a 'Start Over' link.

At the Request Type screen, choose the type of service and where the service will take place. Options for where the service will take place change with each type of service. Required fields for each request type option:

- Procedure – Inpatient Hospital; Outpatient Hospital
- Non-Procedure – Inpatient Hospital; Outpatient Facility; Skilled Nursing Facility; Home\*
- Laboratory Test – Independent Lab; Outpatient Facility; Office
- Behavioral Health Treatment – Inpatient Hospital; Outpatient Hospital; Office
- Maternity – Inpatient Facility; Outpatient Facility; Home\*
- Specialty Drug – Specialty Drug

Continue. Choose **Ask Health Care Services** for questions about the service request if you are unable to answer using My Insurance Manager or by reviewing the Plan's applicable medical policy and/or clinical guidelines.

\*Not applicable for BlueChoice plans.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

\* Required

**Date of Service**  
02/10/2017

---

**Insurance**  
Plan Name:  
BlueCross BlueShield Plans  
Member ID:  
ZCZ065922516805

---

**Patient**  
Patient's Name:  
MICHAEL TESTING  
Date of Birth:  
10/01/1958

[Change Patient](#)

### Request

**Request Type**

In order to help us identify the required service, please answer these questions:

Which type of service are you requesting?

Procedure

Non-Procedure

Laboratory Test

Behavioral Health Treatment

Maternity

Specialty Drug

Where will this service take place?

Inpatient Hospital

Outpatient Facility

Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our [pre-certification requirements](#).

[Continue](#) [Ask Health Care Services](#) or [Back](#) [Start Over](#)

---

**Fast-Track Requests**

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z All

20 Results

<a href="#">COLONOSCOPY</a>	<a href="#">Detail</a>
<a href="#">COLPOSCOPY</a>	<a href="#">Detail</a>
<a href="#">CONIZATION OF CERVIX</a>	<a href="#">Detail</a>
<a href="#">CT CHEST</a>	<a href="#">Detail</a>
<a href="#">CT OF ABDOMEN</a>	<a href="#">Detail</a>
<a href="#">CT OF EXTREMITY</a>	<a href="#">Detail</a>
<a href="#">CT OF HEAD/NECK</a>	<a href="#">Detail</a>
<a href="#">CT OF SPINE</a>	<a href="#">Detail</a>
<a href="#">CT PELVIS</a>	<a href="#">Detail</a>
<a href="#">CT SCAN</a>	<a href="#">Detail</a>
<a href="#">CUBITAL TUNNEL DECOMPRESSION</a>	<a href="#">Detail</a>

Fast-Track Selection:  
**COLONOSCOPY**

Diagnosis:  
**R109 UNSPECIFIED ABDOMINAL PAIN**

Procedure(s):  
**45378 - 45385 COLONOSCOPY, FLEXIBLE;  
DIAGNO**

Don't see the results you're looking for? [Submit a customized pre-certification request.](#)

If you don't see the Fast-Track Request you want, go back and choose a different service category or setting, or select Unlisted.

Fast Track Requests will become visible once the request type is determined. The requests are alphabetized. There are numerous results of procedures listed for each letter of the alphabet shown. Click on the appropriate Procedure link or its Detail link to reveal the fast-track selection, diagnosis code and procedure code(s). Place the cursor on the desired procedure to select.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) Go to Message Center

## Pre-Certification/Referrals Printer-Friendly

**Date of Service** \* Required  
02/10/2017

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ065922516805

**Patient**  
Patient's Name: MICHAEL TESTING  
Date of Birth: 10/01/1958  
[Change Patient](#)

### Request

**Request Type**  
In order to help us identify the required service, please answer these questions:

Which type of service are you requesting?  
 Procedure  
 Non-Procedure  
 Laboratory Test  
 Behavioral Health Treatment  
 Maternity  
 Specialty Drug

Where will this service take place?  
 Inpatient Hospital  
 Outpatient Facility

**Please note:** Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our [pre-certification requirements](#).

[Continue](#) [Ask Health Care Services](#) or [Back](#) [Start Over](#)

### Fast-Track Request

SEPTOPLASTY

### Diagnosis Information

**This transaction can only be associated with ICD-10 codes. If you are typing in a code, please verify it is a valid ICD-10 code.**

Principal Diagnosis:  
J342 DEVIATED NASAL SEPTUM

### Patient's Information

Please enter the clinical information for this request. In order to continue with this authorization, you should include the specific requested procedure code(s) and corresponding diagnosis code(s) in the Clinical Information box. If you have medical records or other files to support this request, click Attach Clinical Documentation.  
**Please note: We currently only accept PDF files at this time.**

\* Clinical Information:

[Attach Clinical Documentation](#)

### Procedure/Service Information

Please verify this information:

**Procedure 1:**

Date of Service Begins: 02/10/2017	Date of Service Ends: 02/10/2017
Service Requested: 30520 SEPTOPLASTY OR SUBMUCOUS RESE	Approved Service Range: 30520 SEPTOPLASTY OR SUBMUCOUS RESE 30520 SEPTOPLASTY OR SUBMUCOUS RESE
Quantity: 1 Unit	

[Continue](#) [Change Fast-Track Selection](#) or [Back](#) [Start Over](#)

Diagnosis Information will also appear on the screen. Verify information for the service beginning and end dates. Enter Clinical Information in the required field. You can also **Attach Clinical Documentation**. Refer to page 135 for Attach Clinical Documentation instructions. **Continue**; or click **Change Fast-Track Selection** to return to the previous screen.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service** \* Required

02/10/2017

---

**Insurance**

Plan Name:  
BlueCross BlueShield Plans

Member ID:  
ZCZ065922516805

---

**Patient**

Patient's Name:  
MICHAEL TESTING

Date of Birth:  
10/01/1958

[Change Patient](#)

**Fast-Track Request**

Request:  
INTESTINAL OBSTRUCTION

---

**Other Information**

Please complete this information:

Level of Service:  
E - ELECTIVE

Release of Information:  
Y - YES, PROVIDER HAS A SIGNED STATEMENT PERMITTING RELEASE OF MEDICAL BILLING DATA RELATE[ ]

---

**Facility**

Please make sure this is the location where the service will take place.

\* Facility Providing Service: [ ] Address: [ ]

---

**Provider**

Please make sure this provider will perform the service.

Individual Rendering Service: [ ] Address: [ ]

[Add Secondary Provider \(+\)](#)

---

**Practice**

Please make sure this practice will be responsible for this service.

\* Group Practice: 123456789 Address: YOUR PRACTICE NAME  
654 PHYSICIAN PKWY STE B  
YOUR CITY, SC 29292-0000

Please note: The provider you choose must be in the member's health plan provider network for us to pay maximum benefits.

[Continue](#) or [Back](#) [Start Over](#)

The next screen is Fast-Track Request. It is optional to provide other information in place of the default data for level of service [E-Elective; O3-Emergency; U-Urgent]; release of information (optional); facility providing service; provider(s); and the practice. If you need to choose a different practice location, click the magnifying glass icon to search for other locations affiliated with your account. At the Facility Providing Service field, search for the specific location upon clicking the magnifying glass icon.

If you change the Group Practice, you must select an Individual Rendering Provider in a subsequent screen. The information will then populate in the corresponding fields shown.

**Continue.**

### Health Care Finder - Facility Search

For this type of authorization, you must identify the facility that will be responsible for the service.

Search Type:  
**FACILITY/RENDERING LOCATION**

\* Facility Type:  
 -- Please Choose One --

**Location**  
 Please enter the **State**, as well as the **City** and/or the **County**.

\* State:  City:  County:

Facility Name:  
  
 must have at least two letters

From the Health Care Finder – Facility Search screen, designate the facility type and the state where the procedure will be performed. Enter a city or county.

### Health Care Finder - Facility Search

Results: 2 found.

Select	Health Care Facility	Address	City, State & ZIP Code	Telephone
<input type="radio"/>	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
<input type="radio"/>	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

or [Back](#)

Select a facility from the results that appear from the Health Care Finder – Facility Search screen. **Continue**.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) Go to Message Center

## Pre-Certification/Referrals Printer-Friendly

**Date of Service**  
02/10/2017

**Insurance**  
Plan Name:  
BlueCross BlueShield Plans  
Member ID:  
ZCZ065922516805

**Patient**  
Patient's Name:  
MICHAEL TESTING  
Date of Birth:  
10/01/1958

[Change Patient](#)

### Verification

Please review the information you have given us for this authorization request.

Please note: All contracts reimburse differently depending upon the network status of the provider. Always verify benefits prior to the delivery of services.

### Contact Information

Please give us a phone number where we can reach you if we have questions.

**Primary Phone:** ( 987 ) 654 - 3210 **Ext.:**

[Patient](#) [Requestor](#) [Procedure/Service](#) [Providers](#)

### Procedure/Service Information

**Fast-Track Request:** INTESTINAL OBSTRUCTION  
**Date of Service:** 02/10/2017

### Procedure/Service Information

Please verify this information:

**Procedure 1**

**Date of Service Begins:** 02/10/2017 **Date of Service Ends:** 02/11/2017

**Diagnosis Information:**  
1. K5660 - UNSPECIFIED INTESTINAL OBSTRUCTION

### Service Request Information

**Level of Service:** E - ELECTIVE  
**Release of Information:** Y - YES, PROVIDER HAS A SIGNED STATEMENT PERMITTING RELEASE OF MEDICAL BILLING DATA RELATED TO A CLAIM

[Edit This Information](#)

### Additional Service Lines

Line	Procedure Code	Service Amount	Date of Service	Additional Information
1			02/10/2017-02/11/2017	<a href="#">Add</a>

[Add/Edit Additional Patient Level Information](#)

[Submit](#) or [Back](#) [Start Over](#)

At the Verification screen, you must include the best contact number to be reached in case we have questions about the pre-certification/referral request.

- Follow the [Edit This Information](#) link to update pre-certification/referral request data.
- From the Procedure/Service tab, you can include other general service level information that will support medical necessity of the services requested in the Additional Service Lines field. Select the corresponding box(es) to include specific additional service level line information for Dental Service Information; Tooth Information; Repetitive Therapy (non-chiropractic); Service Trace Number; and/or Paperwork related to this service. Click **Done** or **Back** to return to the previous screen.

**Submit.** If you need to review any of the information you entered for the pre-certification request, click on the applicable tabs shown: Patient; Requestor; Procedure/Service; or Providers.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals [Printer-Friendly](#)

**Date of Service** \* Required  
02/10/2017

**Insurance**  
Plan Name:  
BlueCross BlueShield Plans  
Member ID:  
ZCZ065922516805

**Patient**  
Patient's Name:  
MICHAEL TESTING  
Date of Birth:  
10/01/1958  
[Change Patient](#)

If you would like to share additional information that will support the medical necessity of the services you have requested, please check the appropriate boxes.

**Additional Patient Level Information**

<input type="checkbox"/> Home Health Care	<input type="checkbox"/> Patient Condition & Additional Information
<input type="checkbox"/> Home Oxygen Therapy	<input type="checkbox"/> Related Cause Information
<input type="checkbox"/> Additional Justification	<input type="checkbox"/> Repetitive Therapy (non-chiropractic)
<input type="checkbox"/> Ambulance Transport (Non-emergency)	<input type="checkbox"/> Spinal Manipulation Services
<input type="checkbox"/> Institutional Claim Code	

[Done](#) or [Back](#) [Start Over](#)

If you select the [Add/Edit Additional Patient Level Information](#) link, you can share additional information that will support medical necessity of the services requested. Required fields for each option:

- Home Health Care – Prognosis; Home Health Start Date
- Home Oxygen Therapy – Type of Delivery System; Oxygen Flow Rate; Prescribed Equipment 1
- Additional Justification – Activities Permitted; Ambulance Certification; Chiropractic Certification; Functional Limitations; Mental Status; Oxygen Therapy Certification; Durable Medical Equipment
- Ambulance Transport (Non-emergency) – Transport Code; Location Type; Address Line 1; City; State; ZIP
- Institutional Claim Code – Admission Type Code; Admission Source Code; Patient Status Code; Nursing Home Residential Code
- Patient Condition & Additional Information – Prognosis; Current Health Conditions; Onset Illness Date
- Related Cause Information – Related Cause 1
- Repetitive Therapy (non-chiropractic) – Total Number of Treatments Required; Treatments Will Be Administered Every; Treatments Will Occur Over A Total Period of; Delivery of Services Provided on a Calendar Basis Of; Delivery of Services Provided on a Time Basis of
- Spinal Manipulation Services – Complicated Condition

Click [Done](#) to return to the previous Verification screen. [Submit](#).

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service**  
02/10/2017

---

**Insurance**  
Plan Name:  
BlueCross BlueShield Plans  
Member ID:  
ZCZ065922516805

---

**Patient**  
Patient's Name:  
MICHAEL TESTING  
Date of Birth:  
10/01/1958

[Change Patient](#)

**Authorization Confirmation**

✔ Your Inpatient Hospital request is: **APPROVED**  
Your authorization number for this request is: 1704112199900

ⓘ Please note: Our response to your request is not a guarantee of payment or reimbursement or a guarantee of the Member's eligibility for coverage. We will review all claims to verify that:

- The pre-authorization request and the claim information you submit are consistent.
- The patient is eligible for benefits at the time of treatment.
- The patient's health plan covers the services he or she receives.
- All health plan requirements have been satisfied (e.g. limitations, waiting periods, copayments, deductibles, network eligibility, etc.)

We will pay claims in accordance with these findings.

[New Authorization](#) or [Print Confirmation](#)

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service**  
02/13/2017

---

**Insurance**  
Plan Name:  
BlueCross BlueShield Plans  
Member ID:  
ZCZ065922516805

---

**Patient**  
Patient's Name:  
MICHAEL TESTING  
Date of Birth:  
10/01/1958

[Change Patient](#)

**Authorization Confirmation**

✔ Your Outpatient Facility request is: **PENDED - Requires Medical Services Review.**

ⓘ Please note: Our response to your request is not a guarantee of payment or reimbursement or a guarantee of the Member's eligibility for coverage. We will review all claims to verify that:

- The pre-authorization request and the claim information you submit are consistent.
- The patient is eligible for benefits at the time of treatment.
- The patient's health plan covers the services he or she receives.
- All health plan requirements have been satisfied (e.g. limitations, waiting periods, copayments, deductibles, network eligibility, etc.)

We will pay claims in accordance with these findings.

ⓘ We have received your pre-certification request and have forwarded it to Medical Services for review.

If you have not already submitted clinical documentation to support this request, or need to submit additional documentation:

- For State Health Plan members (member ID prefix SCZ), fax information to 803-264-0183.
- For other BlueCross BlueShield of South Carolina members, fax information to 803-264-0258.
- For members of other Blue Plans, fax information to 803-264-0181.

If your request has been Pended and requires additional medical review, you may be able to receive an approval within 24 hours of submitting your request. If your request is for one of these services, please visit [here](#) to learn the additional clinical information you need to submit for approval.

- CPAP and BIPAP
- Continuous Pressure Maching (CPM)
- Insulin Pump
- Maternity
- Orthotics
- Oxygen
- Prosthesis
- Septoplasty
- Wheelchair
- Wound Care

Please check back in two business days for a response.

[New Authorization](#) [STATchat](#) or [Print Confirmation](#)

The Authorization Confirmation screen displays the authorization number. The authorization response will also show if the request is approved or has been placed in a pending status for further medical review. You can now create a new authorization, attach clinical document for pended authorizations and/or speak with Provider Services via STATchat.

The screenshot shows a web application interface for Pre-Certification/Referrals. At the top, there is a navigation bar with tabs: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, and Staff Directory. Below the navigation bar, a welcome message reads "Welcome, YOUR NAME of YOUR PRACTICE/FACILITY" with a "(Log Out)" link and a "Go to Message Center" link. The main heading is "Pre-Certification/Referrals" with a "Printer-Friendly" icon. On the left side, there are three sections: "Date of Service" with the value "02/13/2017", "Insurance" with "Plan Name: BlueCross BlueShield Plans" and "Member ID: ZCZ065922516805", and "Patient" with "Patient's Name: MICHAEL TESTING" and "Date of Birth: 10/01/1958". A "Change Patient" button is located below the patient information. The main content area is titled "Request" and contains a "Request Type" section. It asks "Which type of service are you requesting?" with radio buttons for Procedure (selected), Non-Procedure, Laboratory Test, Behavioral Health Treatment, Maternity, and Specialty Drug. It also asks "Where will this service take place?" with radio buttons for Inpatient Hospital and Outpatient Facility (selected). A note states: "Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our [pre-certification requirements](#)." Below this are "Continue", "Ask Health Care Services", and "Back" buttons, along with a "Start Over" link. The "Fast-Track Requests" section shows an alphabetical index (A-Z, All) and "199 Results". A list of medical procedures is displayed, each with a "Detail" link. A red box highlights the link "Submit a customized pre-certification request." below the list. A note at the bottom says: "If you don't see the Fast-Track Request you want, go back and choose a different service category or setting, or select Unlisted."

From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose the type of service and where the service will take place. **Continue**. The Fast-Track Requests field becomes visible after you select the location. Click **Submit a customized pre-certification request**.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service**  
02/13/2017 \* Required

**Insurance**  
Plan Name:  
BlueCross BlueShield Plans  
Member ID:  
ZCZ065922516805

**Patient**  
Patient's Name:  
MICHAEL TESTING  
Date of Birth:  
10/01/1958  
[Change Patient](#)

**Other Information**  
Please complete this information:  
Level of Service:  
E - ELECTIVE  
Release of Information:  
Y - YES, PROVIDER HAS A SIGNED STATEMENT PERMITTING RELEASE OF MEDICAL BILLING DATA RELATE[...]

**Facility**  
Please make sure this is the location where the service will take place.  
\* Facility Providing Service:  
1470258369  
Address:  
XYZ SURGERY CENTER  
852 OPERATION RD.  
CITY, SC 29292-9292

**Provider**  
Please make sure this provider will perform the service.  
Individual Rendering Service:  
Address:  
[Add Secondary Provider \(+\)](#)

**Practice**  
Please make sure this practice will be responsible for this service.  
\* Group Practice:  
Address:

Please note: The provider you choose must be in the member's health plan provider network for us to pay maximum benefits.

[Continue](#) or [Back](#) [Start Over](#)

At the Other Information screen, provide additional information for level of service [E-Elective; 03-Emergency; U-Urgent]; release of information; facility providing service; provider(s); and the practice.

**Health Care Finder - Practice Search** ✕

For this type of authorization, you must identify the practice that will be responsible for the service.

**Search Type:**  
GROUP/PROVIDER PRACTICE

\* **Specialty:**  
-- Please Choose One --

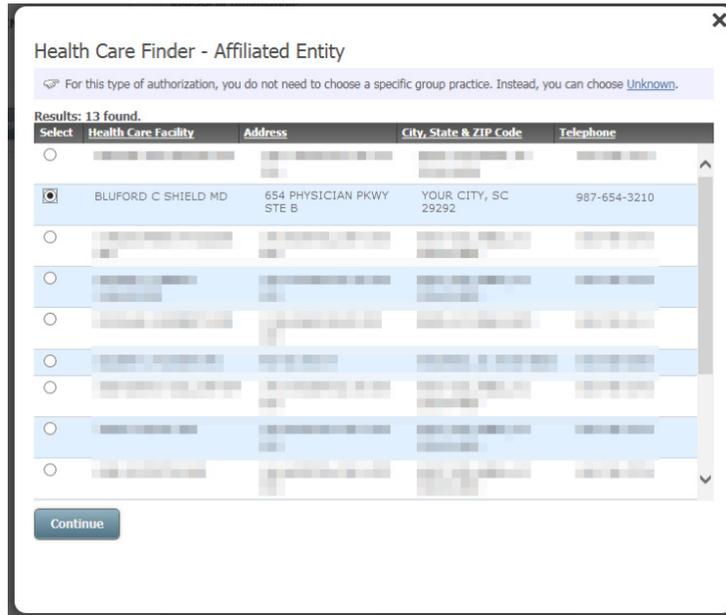
**Location**  
Please enter the State, as well as the City and/or the County.

\* **State:** South Carolina **City:**  **County:** -- Please Choose One --

**Practice Name:**  
  
must have at least two letters

[Select](#)

The Health Care Finder – Practice Search screen appears when you select the Practice magnifying glass icon. Identify the practice that will be responsible for the service. **Select.**



The Health Care Finder – Affiliated Entity screen appears after you designate the practice responsible for the service. Select the facility and **Continue**.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

### Pre-Certification/Referrals Printer-Friendly

**Date of Service** \* Required  
02/13/2017

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ065922516805

**Patient**  
Patient's Name: MICHAEL TESTING  
Date of Birth: 10/01/1958  
[Change Patient](#)

**Other Information**  
Please complete this information:  
Level of Service: E - ELECTIVE  
Release of Information: Y - YES, PROVIDER HAS A SIGNED STATEMENT PERMITTING RELEASE OF MEDICAL BILLING DATA RELATEI

**Facility**  
Please make sure this is the location where the service will take place.  
\* Facility Providing Service: 1470258369 Address: XYZ SURGERY CENTER 852 OPERATION RD CITY, SC 29292-9292

**Provider**  
Please make sure this provider will perform the service.  
Individual Rendering Service: \*\*\*\*\* Address: BLUFORD C SHIELD MD 654 PHYSICIAN PKWY STE B YOUR CITY, SC 29292 987-654-3210  
[Add Secondary Provider \(+\)](#)

**Practice**  
Please make sure this practice will be responsible for this service.  
\* Group Practice: \*\*\*\*\* Address: YOUR PRACTICE NAME 654 PHYSICIAN PKWY STE B YOUR CITY, SC 29292 987-654-3210

Please note: The provider you choose must be in the member's health plan provider network for us to pay maximum benefits.

[Continue](#) or [Back](#) [Start Over](#)

Note all required fields have been updated with selections from secondary screens. **Continue**.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service**  
02/13/2017

**Insurance**  
Plan Name:  
**BlueCross BlueShield Plans**  
Member ID:  
**ZCZ065922516805**

**Patient**  
Patient's Name:  
**MICHAEL TESTING**  
Date of Birth:  
**10/01/1958**

[Change Patient](#)

**\* Required**

**Diagnosis Information**

Please choose the most appropriate diagnosis code for this request.

**Diagnosis Information**

**i** This transaction can only be associated with ICD-10 codes. If you are typing in a code, please verify it is a valid ICD-10 code.

\* Principal Diagnosis:   Date of Diagnosis:

[Add Additional Diagnosis Codes](#)

**Clinical Information**

If you need to identify the department within your organization that made this request, please enter a department identifier:

264 character maximum

[Attach Clinical Documentation](#)

**Service Type Selection**

Service Type:

Institutional

Professional

None

**Additional Patient Level Information [+]**

From Event Date:  To Event Date:  Discharge Date:

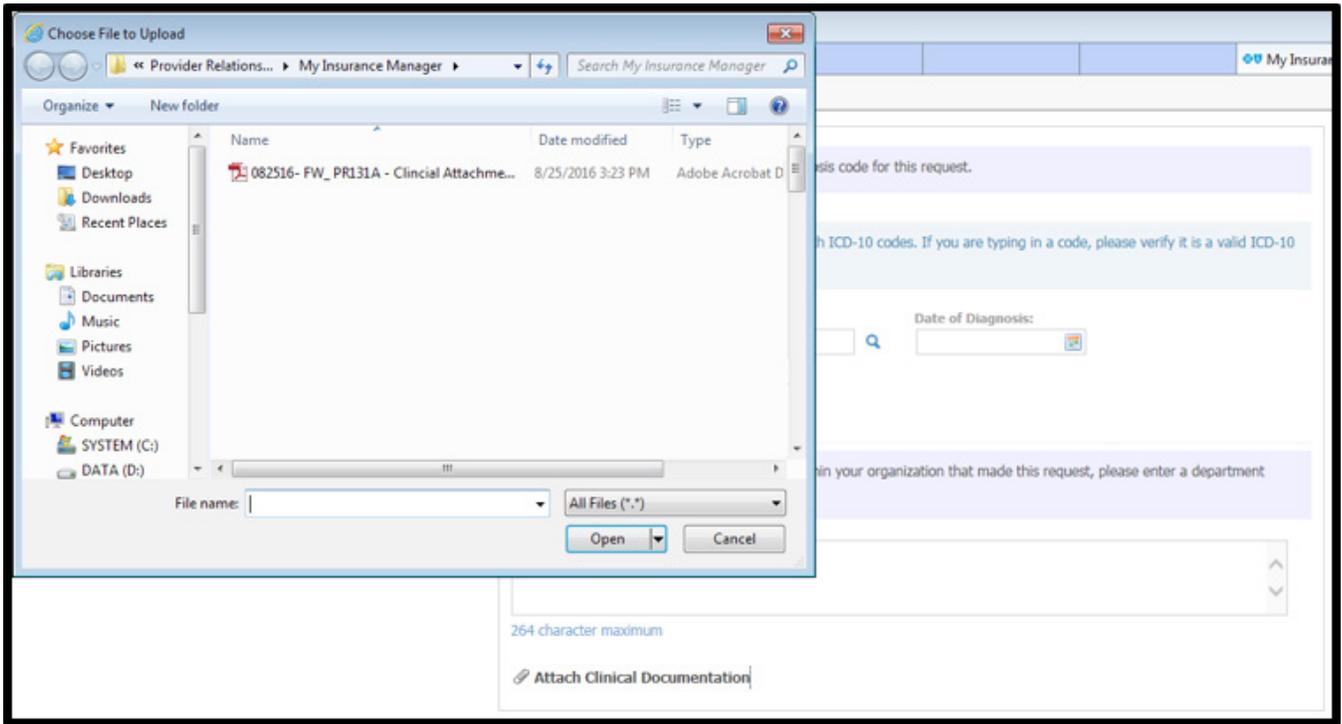
mm/dd/yyyy      mm/dd/yyyy      mm/dd/yyyy

[Continue](#) or [Back](#) [Start Over](#)

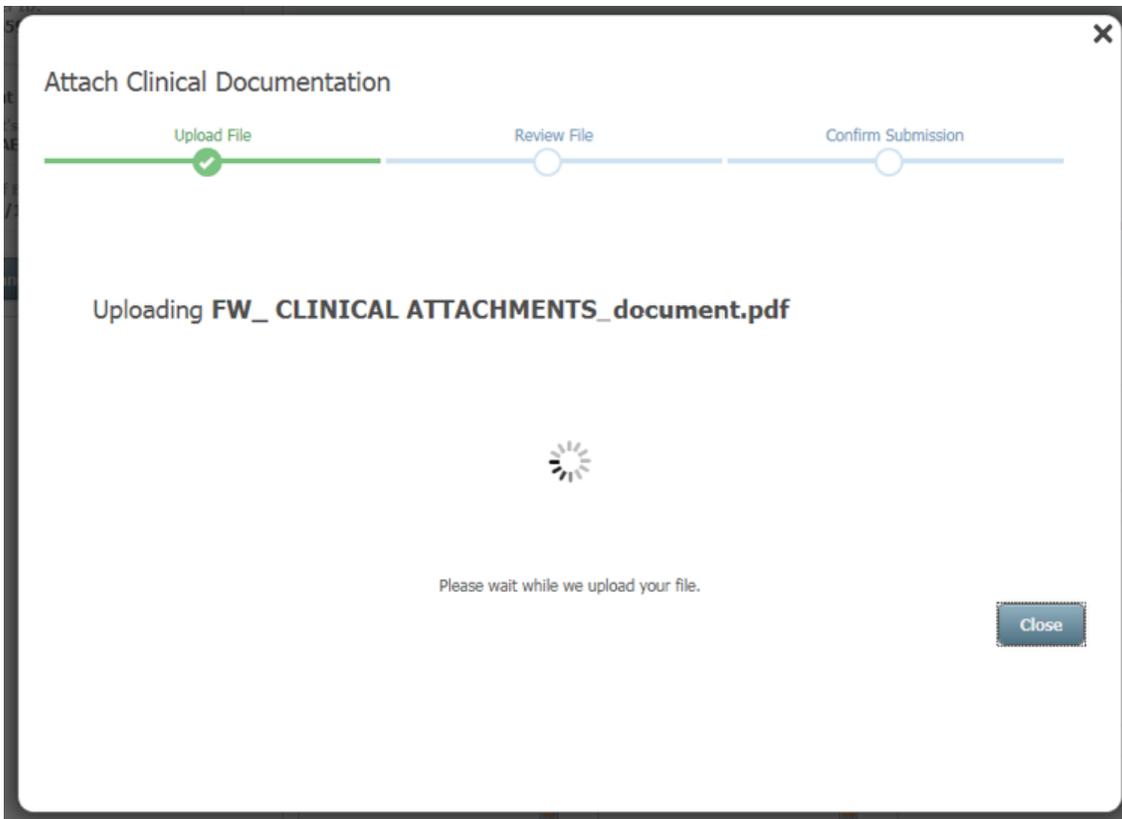
The Diagnosis Information screen is next in the customized pre-certification request process. At Principal Diagnosis field, enter the appropriate ICD-10 diagnosis code without including a decimal. You can also search for the specific diagnosis code by clicking the magnifying glass icon.

- When you choose Institutional for the Service Type Selection, the view expands to show required entries for Procedure Code Type and Code.
- When you choose Professional for the Service Type Selection, the view expands to show required entries for Procedure Code Type; Code and Primary Diagnosis.
- When appropriate, select **Attach Clinical Documentation** to add medical information or other files to support the pre-certification/referral request. This link will not appear unless the procedure requires clinical documentation.

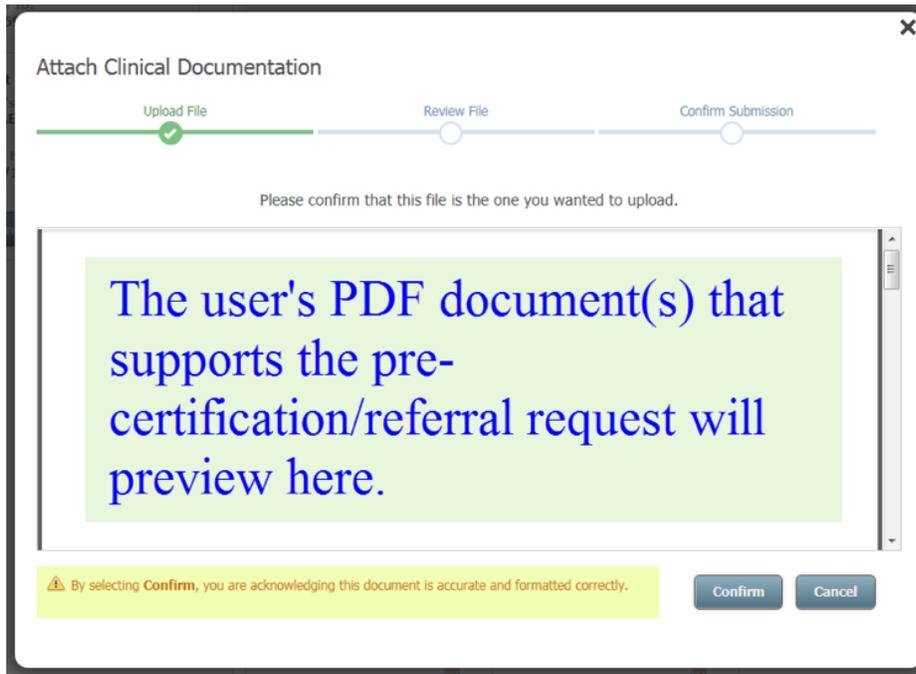
**Continue.** Follow the process through Verification and Authorization Confirmation screens.



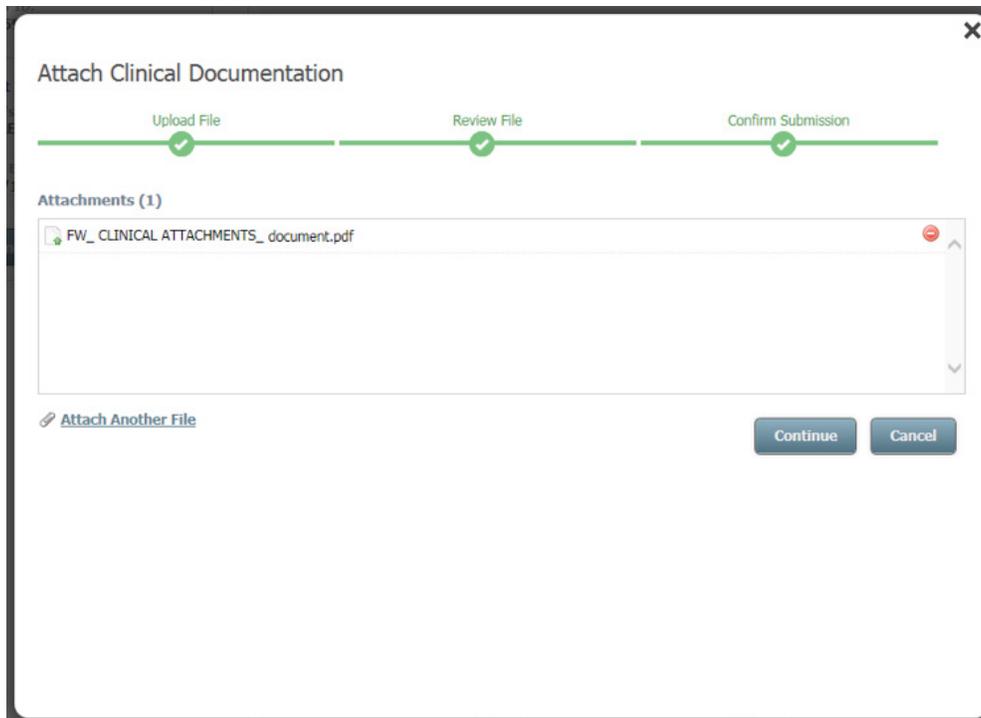
Choose a file [up to 10 documents] to attach. The file must be in PDF format with a maximum of 30 MB. Select **Open**.



This screen will appear when the file begins to upload to My Insurance Manager. If the file is invalid [i.e., a non-PDF file or one that exceeds 30 MB], you will receive this error message: the file type selected cannot be accepted; please try another type.



You can see a preview of the selected document during upload. Once you select **Confirm**, you will not be able to go back and view what was uploaded.



Review and confirm that this is the file you want to upload. You can choose to **Attach Another File**. You can abandon the clinical attachment process by clicking **Cancel**. To remove an attached document, select the red minus [-] button. **Continue**.

Home
Patient Care
Office Management
Resources
Modify Profile
Profile Administration
Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY [\(Log Out\)](#) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service**  
02/13/2017

**Insurance**  
Plan Name:  
**BlueCross BlueShield Plans**

Member ID:  
**ZCZ065922516805**

**Patient**  
Patient's Name:  
**MICHAEL TESTING**

Date of Birth:  
**10/01/1958**

Change Patient

### Request

\* Required

**Request Type**

In order to help us identify the required service, please answer these questions:

Which type of service are you requesting?

- Procedure
- Non-Procedure
- Laboratory Test
- Behavioral Health Treatment
- Maternity
- Specialty Drug

Where will this service take place?

- Independent Lab
- Outpatient Facility
- Office

**i** Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our [pre-certification requirements](#).

Continue
Ask Health Care Services
or [Back](#)
[Start Over](#)

### Fast-Track Requests

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z All

**20 Results**

<a href="#">BCR-ABL 1 CHRON MYELOID LEUK</a>	<a href="#">Detail</a>
<a href="#">BRCA1 AND BRCA2 TESTING</a>	<a href="#">Detail</a>
<a href="#">CARDIAC ION CHANNELOPATHY</a>	<a href="#">Detail</a>
<a href="#">CHROMOSOMAL MICROARRAY</a>	<a href="#">Detail</a>
<a href="#">CYSTIC FIBROSIS GENETIC TEST</a>	<a href="#">Detail</a>
<a href="#">CYTOCHROME P450 GENETIC TEST</a>	<a href="#">Detail</a>
<a href="#">EGFR MUTATION ANALYSIS NSCLC</a>	<a href="#">Detail</a>
<a href="#">FAMIL ADENOMAT POLYPOS/MUTYH</a>	<a href="#">Detail</a>
<a href="#">FLOW CYTOMETRY</a>	<a href="#">Detail</a>
<a href="#">FLT3/NPM1 IN ACUTE MYELOID</a>	<a href="#">Detail</a>
<a href="#">GENETIC TESTING GENERAL</a>	<a href="#">Detail</a>

**i** If you don't see the Fast-Track Request you want, go back and choose a different service category or setting, or select Unlisted.

From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose Laboratory Test as the service type and where the service will take place. **Continue**. You will see the Fast-Track Requests field after you select the location. Place the cursor on the desired procedure to select.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service**  
02/13/2017 \* Required

**Insurance**  
Plan Name:  
BlueCross BlueShield Plans  
Member ID:  
ZCZ065922516805

**Patient**  
Patient's Name:  
MICHAEL TESTING  
Date of Birth:  
10/01/1958  
[Change Patient](#)

### Request

**Request Type**  
In order to help us identify the required service, please answer these questions:

**Warning:** This health plan requires pre-certification for this lab procedure. Please call 1-844-227-5769, or visit [www.avalonhcs.com/provider](http://www.avalonhcs.com/provider) to continue this authorization request. This link leads to a third party website for a company that handles pre-authorizations on behalf of this Health Plan. That company is solely responsible for the content and privacy policy on its site.

**Which type of service are you requesting?**

- Procedure
- Non-Procedure
- Laboratory Test
- Behavioral Health Treatment
- Maternity
- Specialty Drug

**Where will this service take place?**

- Independent Lab
- Outpatient Facility
- Office

[Back](#)

**Note:** Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our [pre-certification requirements](#).

A message appears alerting you of special pre-certification/referral requirements for the selected service. Laboratory procedures that require pre-certification must be authorized via Avalon Healthcare Solutions (Avalon\*). Call 844-227-5769 to continue. Click the link [www.avalonhcs.com/provider](http://www.avalonhcs.com/provider) for additional information about laboratory pre-certification via Avalon.

\*Avalon is an independent company that provides laboratory benefit management services on behalf of BlueCross and BlueChoice.

My Insurance Manager

**AVALON**  
HEALTHCARE SOLUTIONS

[Provider Home](#) [Education Video Library](#) [Trial Claim Advice](#)

## Provider Home

Welcome to the Avalon Healthcare Solutions provider portal. Avalon partners with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan to administer a comprehensive suite of laboratory benefit management services. Currently, from this site you can access the Trial Claim Advice tool, training information and download any necessary documents and forms. Avalon continues to enhance the capabilities of the provider portal and we will keep you posted on new features as they become available.

If you have any questions, please call Avalon's Provider Services at 1-855-895-1676. Provider service representatives are available to help you Monday through Friday, 8:00 AM – 8:00 PM Eastern Time.

**Documents**

- [Avalon Claim Editor Demo.pdf](#)
- [Avalon FAQs - Claim Editor.pdf](#)
- [Avalon Pay and Educate Provider Notification 072016\\_ACB.pdf](#)
- [Trial Claim Advice User Guide SC providers - V1.pdf](#)

*Announcement!*

This screen appears when you follow the link to Avalon's website.

To fax a pre-certification/referral request to Avalon, use the Avalon Preauthorization Request Form. Find this form on the Lab Precertification page in the Providers section of our websites at [web.southcarolinablues.com/providers/educationcenter/precertification/labprecertification.aspx](http://web.southcarolinablues.com/providers/educationcenter/precertification/labprecertification.aspx) or [www.bluechoicesc.com/providers/educationcenter/providerresources/labprecertification.aspx](http://www.bluechoicesc.com/providers/educationcenter/providerresources/labprecertification.aspx).

From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose the type of service and where the service will take place. **Continue**.

You will see the Fast-Track Requests field after you have selected the location. Place the cursor on the desired procedure to select.

- There are only Radiology fast-track options for BlueCross and BlueChoice plans.
- There are no Radiation Oncology or Musculoskeletal Care fast-track options for BlueCross and BlueChoice plans.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service**  
02/14/2017 \* Required

**Insurance**  
Plan Name:  
BlueCross BlueShield Plans  
Member ID:  
ZCZ065922516805

**Patient**  
Patient's Name:  
MICHAEL TESTING  
Date of Birth:  
10/01/1958  
[Change Patient](#)

### Request

**Request Type**

In order to help us identify the required service, please answer these questions:

**⚠️** This health plan requires pre-certification for all scheduled outpatient Pet, CT scans, MRI(S), and MRA(S). Physicians requesting services on behalf of members should call 866-500-7664 or visit [www.radmd.com](http://www.radmd.com) to continue this authorization request. This link leads to a third party website for a company that handles preauthorizations on behalf of this Health Plan. That company is solely responsible for the content and privacy policy on its site.

**Service Request**  
**Fast Track:**  
Fast Track Request:  
Date of Service: 02/14/2017

**Procedure/Service Information:**  
**Procedure: 1**  
Date of Service Begins: 02/14/2017  
Date of Service Ends: 02/14/2017  
Service Requested: 62310  
Approved Service Range: 62310 - 62310  
Quantity: 1 Unit

**Service Request**  
**Fast Track:**  
Fast Track Request: MAGNETIC RESONANCE (EG, PROTO  
Date of Service: 02/14/2017

**Procedure/Service Information:**  
**Procedure: 2**  
Date of Service Begins: 02/14/2017  
Date of Service Ends: 02/14/2017  
Service Requested: 72141 MAGNETIC RESONANCE (EG, PROTO  
Approved Service Range: 72141 MAGNETIC RESONANCE (EG, PROTO - 72141 MAGNETIC RESONANCE (EG, PROTO  
Quantity: 1 Unit

**Diagnosis Information:**  
Principal Diagnosis: M549 DORSALGIA, UNSPECIFIED

Which type of service are you requesting?

Procedure  
 Non-Procedure  
 Laboratory Test  
 Behavioral Health Treatment  
 Maternity  
 Specialty Drug

Where will this service take place?

Inpatient Hospital  
 Outpatient Facility

[Back](#)

**i** Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our [pre-certification requirements](#).

A message appears alerting you of special pre-certification/referral requirements for the selected service. Advanced radiology procedures that require pre-certification must be authorized via National Imaging Associates (NIA\*) Magellan's website. Call 866-500-7664 or click the link [www.radmd.com](http://www.radmd.com) to continue radiology pre-certification via NIA Magellan.

\*NIA Magellan is an independent company that handles authorization for certain imaging services on behalf of BlueCross and BlueChoice.

This screen appears when you follow the link to NIA Magellan’s provider portal. Existing users may access the site via the green button. First-time users must complete required fields to create an account. Select the response that best describes your company [physician office that orders procedures; physician office that orders radiation cardiology procedures].

**Submit.**

A subsequent screen gives Menu Options and Account Information. Choose a Request link to be routed to the appropriate service type:

- Request an Exam – Advanced Radiology Services
- Request Physical Medicine – Physical Medicine Services
- Request a Radiation Treatment Plan – Radiation Oncology Services
- Request Pain Management or Minimally Invasive Procedure – Musculoskeletal Care Management
- Request Spine Surgery or Orthopedic Surgery – Musculoskeletal Care Management

Follow the NIA Magellan pre-certification process through subsequent screens to complete.

## Pre-Certification/Referral – Behavioral Health Instruction

The screenshot shows the 'Pre-Certification/Referrals' form. On the left, there are sections for 'Date of Service' (02/14/2017), 'Insurance' (BlueCross BlueShield Plans, Member ID: ZCZ065922516805), and 'Patient' (MICHAEL TESTING, Date of Birth: 10/01/1958). A 'Change Patient' button is below the patient information. The main 'Request' section asks for 'Request Type' and 'Where will this service take place?'. Under 'Request Type', 'Behavioral Health Treatment' is selected. Under 'Where will this service take place?', 'Outpatient Hospital' is selected. A note at the bottom states: 'Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our pre-certification requirements.' Buttons for 'Continue', 'Ask Health Care Services', 'Back', and 'Start Over' are at the bottom.

From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose Behavioral Health Treatment as the type of service, and where the service will take place. **Continue.**

This screenshot shows the 'Pre-Certification/Referrals' form with additional sections. The 'Fast-Track Request' section has 'PSYCH INTENSIVE OUTPATIENT' selected. The 'Diagnosis Information' section includes a note: 'This transaction can only be associated with ICD-10 codes. If you are typing in a code, please verify it is a valid ICD-10 code.' The 'Principal Diagnosis' is 'R69 - ILLNESS, UNSPECIFIED' and the 'Date of Diagnosis' is 02/14/2017. There is an 'Add Additional Diagnosis Codes' button. The 'Patient's Information' section has a note: 'Please enter the clinical information for this request. In order to continue with this authorization, you should include the specific requested procedure code(s) and corresponding diagnosis code(s) in the Clinical Information box. If you have medical records or other files to support this request, click Attach Clinical Documentation. Please note: We currently only accept PDF files at this time.' There are buttons for 'View Required Information' and 'Attach Clinical Documentation'. The 'Procedure/Service Information' section has a note: 'Please verify this information:'. Under 'Procedure 1', the 'Date of Service Begins' and 'Date of Service Ends' are both 02/14/2017. Buttons for 'Continue', 'Change Fast-Track Selection', 'Back', and 'Start Over' are at the bottom.

You will see the Fast-Track Requests field after you select the location. Place the cursor on the desired procedure to select. Diagnosis Information, Patient's Information and Procedure/Service Information appear on the screen. Enter Clinical Information and **Attach Clinical Documentation** as appropriate. Verify the service beginning and end dates. **Continue.** Click **Change Fast-Track Selection** if you need to return to the previous screen.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service** \* Required

**Insurance**  
 Plan Name:  
 BlueCross BlueShield Plans  
 Member ID:  
 ZCZ065922516805

**Patient**  
 Patient's Name:  
 MICHAEL TESTING  
 Date of Birth:  
 10/01/1958

**Fast-Track Request**  
 Request:

**Other Information**  
 Please complete this information:  
 Level of Service:  
  
 Release of Information:

**Facility**  
 Please make sure this is the location where the service will take place.  
 \* Facility Providing Service:    
 Address:  
 BEHAVIORAL HEALTH CENTER  
 369 HOPE HWY  
 CITY, SC 29292-9292  
 753-951-4862

**Provider**  
 Please make sure this provider will perform the service.  
 \* Individual Rendering Service:    
 Address:  
 YOUR PRACTITIONER NAME  
 654 PHYSICIAN PKWY STE B  
 YOUR CITY, SC 29292  
 987-654-3210  
[Add Secondary Provider \(+\)](#)

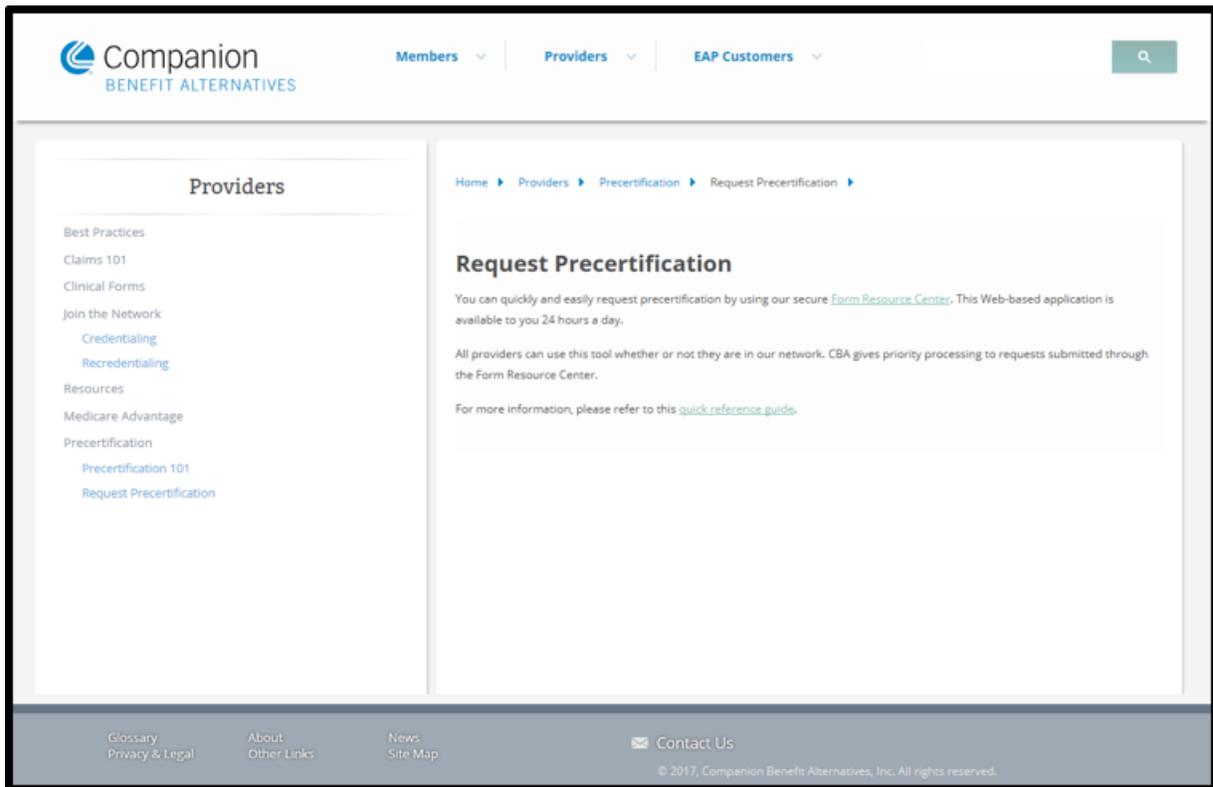
**Practice**  
 Please make sure this practice will be responsible for this service.  
 \* Group Practice:    
 Address:  
 YOUR PRACTICE NAME  
 654 PHYSICIAN PKWY STE B  
 YOUR CITY, SC 29292  
 987-654-3210

**Please note:** The provider you choose must be in the member's health plan provider network for us to pay maximum benefits.

or [Back](#) [Start Over](#)

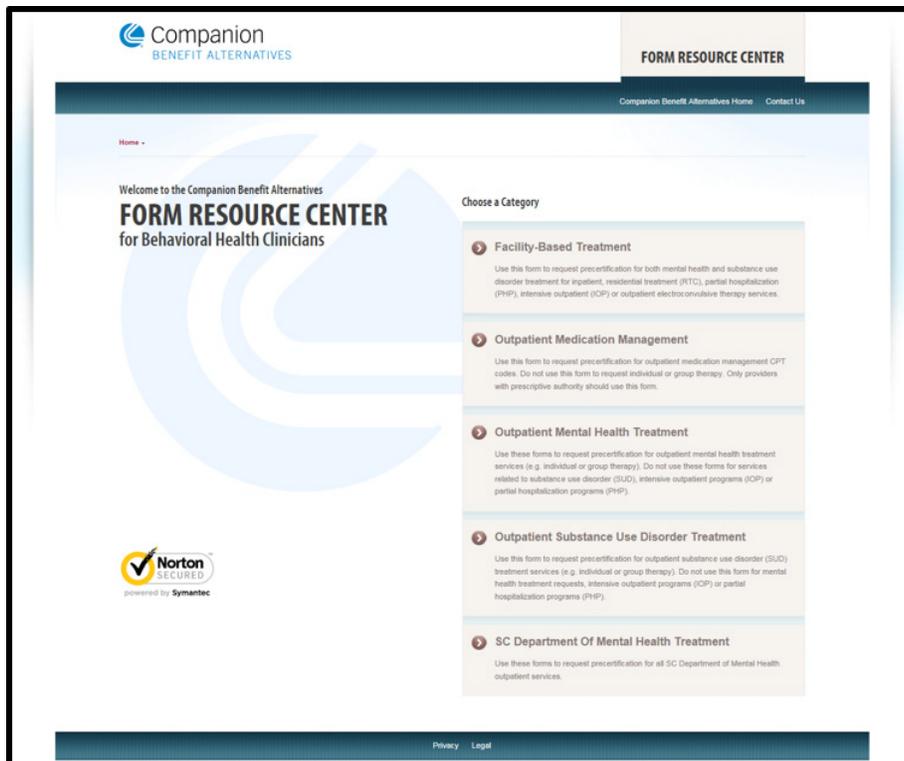
At the Other Information screen, provide additional information for level of service [E-Elective; O3-Emergency; U-Urgent]; release of information; facility providing service; provider(s); and the practice.

**Continue.** Follow the process through Verification and Authorization Confirmation screens.



Certain behavioral health services require online pre-certification via the Companion Benefit Alternatives (CBA\*) website. Call 800-868-1032 or visit the Provider page of [www.CompanionBenefitAlternatives.com](http://www.CompanionBenefitAlternatives.com) to continue.

\*CBA is a behavioral health managed care company that handles behavioral health care services on behalf of BlueCross and BlueChoice.



From the secure Form Resource Center page, you can easily complete web-based applications for Facility-Based Treatment; Outpatient Medication Management; Outpatient Mental Health Treatment; Outpatient Substance Use Disorder Treatment; and/or SC Department of Mental Health Treatment.

- To request pre-certification for psychological testing, contact CBA to request the appropriate form.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals [Printer-Friendly](#)

**Date of Service** \* Required  
02/14/2017

**Insurance**  
Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ065922516805

**Patient**  
Patient's Name: MARTHA TESTING  
Date of Birth: 09/01/1960  
[Change Patient](#)

### Request

**Request Type**  
In order to help us identify the required service, please answer these questions:

Which type of service are you requesting?

- Procedure
- Non-Procedure
- Laboratory Test
- Behavioral Health Treatment
- Maternity
- Specialty Drug

Where will this service take place?

- Inpatient Facility
- Outpatient Facility
- Home

**Continue** **Ask Health Care Services** or [Back](#) [Start Over](#)

**Fast-Track Requests**  
[A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#) [All](#)

**3 Results**

<a href="#">C-SECTION</a>	<a href="#">Detail</a>
<a href="#">SALPINGECTOMY/TUBAL PREG</a>	<a href="#">Detail</a>
<a href="#">VAGINAL DELIVERY</a>	<a href="#">Detail</a>

If you don't see the Fast-Track Request you want, go back and choose a different service category or setting, or select Unlisted.

From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose Maternity as the type of service, and where the service will take place. **Continue**.

You will see the Fast-Track Requests field after you select the location. Place the cursor on the desired procedure to select.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service** \* Required

02/14/2017

**Insurance**

Plan Name:  
BlueCross BlueShield Plans

Member ID:  
ZCZ065922516805

**Patient**

Patient's Name:  
MARTHA TESTING

Date of Birth:  
09/01/1960

[Change Patient](#)

### Request

**Request Type**

In order to help us identify the required service, please answer these questions:

**Which type of service are you requesting?**

Procedure

Non-Procedure

Laboratory Test

Behavioral Health Treatment

Maternity

Specialty Drug

**Where will this service take place?**

Inpatient Facility

Outpatient Facility

Home

**i** Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our [pre-certification requirements](#).

[Continue](#) [Ask Health Care Services](#) or [Back](#) [Start Over](#)

---

**Fast-Track Request**

VAGINAL DELIVERY

---

**Diagnosis Information**

**i** This transaction can only be associated with ICD-10 codes. If you are typing in a code, please verify it is a valid ICD-10 code.

Principal Diagnosis:  
080 ENCOUNTER FOR FULL-TERM UNCOMPLICATED DELIVERY

---

**Procedure/Service Information**

Please verify this information:

**Procedure 1:**

Date of Service Begins: 02/14/2017	Date of Service Ends: 02/16/2017
Service Requested: 59400 ROUTINE OBSTETRIC CARE INCLUD	Approved Service Range: 59400 ROUTINE OBSTETRIC CARE INCLUD 59400 ROUTINE OBSTETRIC CARE INCLUD
Quantity: 1 Unit	

[Continue](#) [Change Fast-Track Selection](#) or [Back](#) [Start Over](#)

Diagnosis Information and Procedure/Service Information appear on the screen. Verify the service beginning and end dates. **Continue**. Click **Change Fast-Track Selection** if you need to return to the previous screen.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Certification/Referrals Printer-Friendly

**Date of Service**  
02/14/2017

**Insurance**  
Plan Name:  
BlueCross BlueShield Plans  
Member ID:  
ZCZ065922516805

**Patient**  
Patient's Name:  
MARTHA TESTING  
Date of Birth:  
09/01/1960

[Change Patient](#)

\* Required

**Fast-Track Request**

Request:  
VAGINAL DELIVERY

**Other Information**

Please complete this information:

Level of Service:  
E - ELECTIVE

Release of Information:  
Y - YES, PROVIDER HAS A SIGNED STATEMENT PERMITTING RELEASE OF MEDICAL BILLING DATA RELATE(

**Facility**

Please make sure this is the location where the service will take place.

\* Facility Providing Service: \*\*\*\*\* Address: GENERAL HOSPITAL  
167 CARE DRIVE  
CITY, SC 29292-9292

**Provider**

Please make sure this provider will perform the service.

\* Individual Rendering Service: 123456789 Address: YOUR PRACTITIONER NAME  
654 PHYSICIAN PKWY STE B  
YOUR CITY, SC 29292  
987-654-3210

[Add Secondary Provider \(+\)](#)

**Practice**

Please make sure this practice will be responsible for this service.

\* Group Practice: 123456789 Address: YOUR PRACTICE NAME  
654 PHYSICIAN PKWY STE B  
YOUR CITY, SC 29292  
987-654-3210

Please note: The provider you choose must be in the member's health plan provider network for us to pay maximum benefits.

[Continue](#) or [Back](#) [Start Over](#)

At the Other Information screen, provide additional information for level of service [E-Elective; O3-Emergency; U-Urgent]; Release of information; Facility providing service; Provider(s); and the Practice.

**Continue.** Follow the process through Verification and Authorization Confirmation screens.

The screenshot shows a web application interface for Pre-Certification/Referrals. At the top, there is a navigation bar with links: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, and Staff Directory. Below the navigation bar, a welcome message reads "Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out)" and a link "Go to Message Center" is visible. The main heading is "Pre-Certification/Referrals" with a "Printer-Friendly" icon. On the left side, there are three form sections: "Date of Service" with the value "02/13/2017", "Insurance" with "Plan Name: BlueCross BlueShield Plans" and "Member ID: ZCZ065922516805", and "Patient" with "Patient's Name: MICHAEL TESTING" and "Date of Birth: 10/01/1958". A "Change Patient" button is located below the patient information. The main "Request" section contains a "Request Type" form. It asks "Which type of service are you requesting?" with radio buttons for Procedure, Non-Procedure, Laboratory Test, Behavioral Health Treatment, Maternity, and Specialty Drug (selected). It also asks "Where will this service take place?" with a radio button for Specialty Drug (selected). A note states: "Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our pre-certification requirements." At the bottom of the request form are buttons for "Continue", "Ask Health Care Services", and "Back", along with a "Start Over" link. Below the request form is a "Fast-Track Requests" section with an alphabetical index (A-Z, All) and "278 Results". A list of drug names is shown, each with a "Detail" link: ABRAXANE, ACCRETROPIN, ACTEMRA IV/SC, ACTH-80, ACTIMMUNE NF, ADAGEN, ADCETRIS, ADCIRCA, ADEMPAS, ADVATE, and ADYNOVATE. A note at the bottom of this section says: "If you don't see the Fast-Track Request you want, go back and choose a different service category or setting, or select Unlisted."

From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose Specialty Drug as the service type and Specialty Drug as where the service will take place. **Continue.**

You will see the Fast-Track Requests field after you select the location. Place the cursor on the desired procedure to select.

A message appears alerting you of special pre-certification/referral requirements for the selected service. Certain specialty drugs require pre-certification via the CVS/caremark\* online authorization tool, Novologix. Call [866-284-9229](tel:866-284-9229) or follow the [click here link](#) to continue.

Other specialty drugs (for example, certain self-administered drugs) that do not require authorization via Novologix will continue through the My Insurance Manager pre-certification/referral process.

\*CVS/caremark – a division of CVS Health – is an independent company that provides pharmacy services on behalf of BlueCross and BlueChoice.

This screen appears when you follow the link to CVS/caremark’s Novologix provider portal. Follow the Novologix pre-certification process through subsequent screens to complete.

## Authorization Status

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

### Authorization Status [Printer-Friendly](#)

**\* Indicates required field.**

**Patient Selection**

Please note: The Health Plan you choose must have your National Provider Identifier (NPI) registered on file, as well as those of any providers you choose in the pre-certification or referral process.  
We will display behavioral health authorizations only to the rendering provider.

\* Health Plan:

\* Member ID:

include alpha prefix, if applicable

\* Patient's Date of Birth:

mm/dd/yyyy

\* Location:   Primary ID:

From the Patient Care menu choose Authorization Status. Complete the required information; make sure to enter the member ID exactly as it appears on the patient's insurance card, including the alpha prefix if applicable.

**Continue.**

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

### Authorization Status [Printer-Friendly](#)

**Insurance**

Plan Name: BlueCross BlueShield Plans  
Member ID: ZCZ065922516805  
Member's Name: MICHAEL TESTING

**Patient**

Patient's Name: MICHAEL TESTING  
Gender: MALE  
Date of Birth: 10/01/1958

Please note:  
We will display behavioral health authorizations only to the rendering provider.  
An approved authorization or referral is not a guarantee of payment or reimbursement or a guarantee of your eligibility for coverage. We will review all claims to verify that:

- The pre-authorization request and the claim information submitted are consistent.
- The patient is eligible for benefits at the time of treatment.
- The patient's health plan covers the services he or she receives.
- All health plan requirements have been satisfied (e.g. limitations, waiting periods, copayments, deductibles, network eligibility, etc.).

We will pay claims based on this information.

**Advanced Search**

All Authorizations

All Available Dates  
 Specific Beginning Date ...  
 Date Range ...

or [New Search](#)

Our records show these authorizations for the period you chose:

**Partial Authorization Status List** *(click a column title to sort)* Showing 8 Result(s)

Authorization Number	Status	Authorization Period	Healthcare Provider	Place of Service
<a href="#">1113708585249</a>	APPROVED	06/17/2011 - 06/17/2011	[REDACTED]	OUTPATIENT HOSPITAL
<a href="#">1113709022182</a>	APPROVED	05/30/2011 - 03/30/2011	[REDACTED]	OUTPATIENT HOSPITAL
<a href="#">1113309471513</a>	APPROVED	05/13/2011 - 09/15/2011	[REDACTED]	INPATIENT HOSPITAL
<a href="#">1113015470346</a>	APPROVED	05/10/2011 - 09/12/2011	[REDACTED]	INPATIENT HOSPITAL
<a href="#">1111909592043</a>	APPROVED	04/29/2011 - 05/04/2011	[REDACTED]	INPATIENT HOSPITAL
<a href="#">1109210583238</a>	APPROVED	04/02/2011 - 04/05/2011	[REDACTED]	INPATIENT HOSPITAL
<a href="#">View Authorization</a>	PENDING	02/21/2011 - 02/21/2011	[REDACTED]	INPATIENT HOSPITAL
<a href="#">View Authorization</a>	PENDING	01/22/2011 - 01/22/2011	[REDACTED]	OUTPATIENT HOSPITAL

We list authorization status records according to health plans. If your patient had a different health plan and you would like to see those records, please search under the previous health plan.

The Authorization Status screen displays next. You can narrow the Partial Authorization Status List according to search by All Available Dates, Specific Beginning Date or Date Range, then Update Results.

Follow the Authorization Number link to view an approved authorization; follow the View Authorization link to view a pending authorization.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) Go to Message Center

## Authorization Detail Printer-Friendly

**Insurance**  
 Plan Name: **BlueCross BlueShield Plans**  
 Member ID: **ZCZ065922516805**  
 Member's Name: **MICHAEL TESTING**

**Patient**  
 Patient's Name: **MICHAEL TESTING**  
 Gender: **MALE**  
 Date of Birth: **10/01/1958**  
[Change Patient](#)

If you need help, please [Ask Healthcare Services](#).

Please note: We will display behavioral health authorizations only to the rendering provider.

Authorization Number: **1704112199900**  
 Patient's Name: **MICHAEL TESTING**

Status	Authorization Period	Provider's Name	Place of Service	Days/Units
APPROVED	02/10/2017 - 02/11/2017	YOUR PRACTICE NAME	INPATIENT HOSPITAL	00001

Facility: FACILITY NAME

[Return to Authorization List](#)

This Authorization Detail screen appears when you follow the authorization number link from the Partial Authorization Status List. Click [Return to Authorization List](#), [Change Patient](#) or [Ask Healthcare Services](#) as appropriate.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) Go to Message Center

## Authorization Detail Printer-Friendly

**Insurance**  
 Plan Name: **BlueCross BlueShield Plans**  
 Member ID: **ZCZ065922516805**  
 Member's Name: **MICHAEL TESTING**

**Patient**  
 Patient's Name: **MICHAEL TESTING**  
 Gender: **MALE**  
 Date of Birth: **10/01/1958**  
[Change Patient](#)

If you need help, please [Ask Healthcare Services](#).

Please note: We will display behavioral health authorizations only to the rendering provider.

**Authorization is Pending**

**Authorization Number:**  
 Authorization is Pending

Patient's Name: **MICHAEL TESTING**

Status	Requested Period	Requesting Provider	Place of Service
PENDING	02/21/2011 - 02/21/2011	YOUR PRACTICE NAME	INPATIENT HOSPITAL

Facility: FACILITY NAME

If you have medical records or other files to support this request, click [Attach Clinical Documentation](#).  
 Please note: We currently only accept PDF files at this time.

[Attach Clinical Documentation](#)

[Return to Authorization List](#)

This Authorization Detail screen appears when you follow the View Authorization link from the Partial Authorization Status List. Click [Attach Clinical Documentation](#), [Return to Authorization List](#), [Change Patient](#) or [Ask Healthcare Services](#) as appropriate.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Authorization Status Printer-Friendly

**Insurance**  
Plan Name:  
**BlueCross BlueShield Plans**

Member ID:  
**ZCZ065922516805**

Member's Name:  
**MICHAEL TESTING**

---

**Patient**  
Patient's Name:  
**MICHAEL TESTING**

Gender:  
**MALE**

Date of Birth:  
**10/01/1958**

[Change Patient](#)

**Please note:**  
We will display behavioral health authorizations only to the rendering provider.  
An approved authorization or referral is not a guarantee of payment or reimbursement or a guarantee of your eligibility for coverage. We will review all claims to verify that:

- The pre-authorization request and the claim information submitted are consistent.
- The patient is eligible for benefits at the time of treatment.
- The patient's health plan covers the services he or she receives.
- All health plan requirements have been satisfied (e.g. limitations, waiting periods, copayments, deductibles, network eligibility, etc.).

We will pay claims based on this information.

All Authorizations  
Show me ONLY authorizations that I can ...  
Extend  
Update  
Appeal  
Provide Clinical Information for

All Available Dates  
 Specific Beginning Date ...  
 Date Range ...

[Update Results](#) [Show All Authorizations](#) or [New Search](#)

Our records show these authorizations for the period you chose:

**Partial Authorization Status List** *(click a column title to sort)* Showing 8 Result(s)

Authorization Number	Status	Authorization Period	Healthcare Provider	Place of Service
<a href="#">1113708585249</a>	APPROVED	06/17/2011 - 06/17/2011	[REDACTED]	OUTPATIENT HOSPITAL
<a href="#">1113709022182</a>	APPROVED	05/30/2011 - 05/30/2011	[REDACTED]	OUTPATIENT HOSPITAL
<a href="#">1113309471513</a>	APPROVED	05/13/2011 - 05/15/2011	[REDACTED]	INPATIENT HOSPITAL
<a href="#">1113015470346</a>	APPROVED	05/10/2011 - 05/12/2011	[REDACTED]	INPATIENT HOSPITAL
<a href="#">1111909592043</a>	APPROVED	04/29/2011 - 05/04/2011	[REDACTED]	INPATIENT HOSPITAL
<a href="#">1109210583238</a>	APPROVED	04/02/2011 - 04/05/2011	[REDACTED]	INPATIENT HOSPITAL
<a href="#">View Authorization</a>	PENDING	02/21/2011 - 02/21/2011	[REDACTED]	INPATIENT HOSPITAL
<a href="#">View Authorization</a>	PENDING	01/22/2011 - 01/22/2011	[REDACTED]	OUTPATIENT HOSPITAL

We list authorization status records according to health plans. If your patient had a different health plan and you would like to see those records, please search under the previous health plan.

From the Patient Care menu choose Authorization Extension. Complete the required fields and Continue. The Authorization Status displays next. The Advanced Search field defaults to Extend.

You can also select Extend [or Update; Appeal; Provide Clinical Information for] from the drop-down menu on the Authorization Status screen of a previous authorization status search.

The Partial Authorization Status List is shown. You can narrow the authorization status list according to search by All Available Dates, Specific Beginning Date or Date Range, then **Update Results**.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

## Pre-Service Review for Out-of-Area Members

Includes Notification, Pre-Certification, Pre-Authorization and Prior Approval \* Required

You can view the out-of-area Blue Plan's medical policy or request a pre-service review. Please select the type of information requested, enter the first three letters of the member's identification number on the BlueCross BlueShield ID card, and click Verify.

**\* Please choose an Option:**

View Medical Policy

Request Pre-Service Review

[Verify](#)

From the Patient Care menu choose Pre-Service Review for Out-of-Area Members. Select View Medical Policy or Request Pre-Service Review; then Verify.

Members Agents **Providers** Employers About BlueCross Newsroom Careers Search

## LIVE FEARLESS South Carolina

Home > Providers > Education Center > Precertification > BlueCard Precertification/Medical Policies

### BlueCard Precertification/Medical Policies

To view an out-of-area Blue Plan's medical policy or general precertification/preauthorization information, please select the type of information you need, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

#### Type of Information

Please select only one.

Medical Policy

General Precertification/Preauthorization Information

Alpha Prefix

[Submit](#)

If you experience difficulties or need additional information, please contact 800-676-BLUE.

- My Insurance Manager
- Forms
- Prescription Drug Information
- Education Center**
- Precertification**
- Medicare Advantage
- HIPAA Critical Center
- Quality Initiatives
- Benefit Update Meetings
- Providers Home
- Provider News
- Contact Us
- Site map

When you select View Medical Policy, you will be redirected to this page of [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). Choose Medical Policy, enter the Alpha Prefix and **Submit**.



## Pre-Service Review for Out-of-Area Members

Welcomes YOUR PRACTICE/FACILITY

You have been routed from BlueCross BlueShield SC to [redacted] BCBS to conduct pre-service review for a(n) [redacted] BCBS member.

Please choose from the following options:

- [Request Preauthorization/Referral](#)
- [AIM Specialty Health](#)

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You will be taken to the landing page of the other Blue Plan.

When you select Request Pre-Service Review, the screen expands to show additional required fields.

Home
Patient Care
Office Management
Resources
Modify Profile
Profile Administration
Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY ([Log Out](#)) [Go to Message Center](#)

## Pre-Service Review for Out-of-Area Members

[Printer-Friendly](#)

**Includes Notification, Pre-Certification, Pre-Authorization and Prior Approval** \* Required

You can view the out-of-area Blue Plan's medical policy or request a pre-service review. Please select the type of information requested, enter the first three letters of the member's identification number on the BlueCross BlueShield ID card, and click Verify.

\* Please choose an Option:

View Medical Policy

Request Pre-Service Review

\* Alpha Prefix:

TCN

**Contact Information**

\* First Name:

\* Last Name:

\* Phone:

\* Email:

\* Date Of Service:

\* Location:  Select

Verify

Complete all entries and **Verify**.

### BlueCross BlueShield of XXXXX Welcomes YOUR NAME

You have been routed from BlueCross BlueShield SC to BCBS of XXXXX to conduct pre-service review for a BCBS of XXXXX member.

Please choose from the following electronic pre-service review options:

- **Inpatient or Outpatient Services** (Please note that the electronic pre-service review for In/Outpatient services is available 4a.m. to 1a.m., Monday through Friday.)
- [Radiological Services](#)

Other pre-service review options:

- **DME Services:** BCBS of XXXXX does not currently offer electronic pre-service review for DME services. Please call 1-800-888-8888 for DME pre-service review.
- **Mental Health Services:** BCBS of XXXXX does not currently offer electronic pre-service review for Mental Health services. Please call the number on the back of member's ID card for Mental Health pre-service review.

[View BCSPre-Certification Requirements.](#)

You will then be taken to the pre-certification page of the other Blue Plan.

## Verify Primary Care Physician

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

### Verify Primary Care Physician

[Printer-Friendly](#)

\* Indicates required field.

**Patient Selection**

Enter this information to find the current Primary Care Physician information.

\* Health Plan:  
BlueCross BlueShield Plans

\* Member ID:  
zcz065922516805  
include alpha prefix, if applicable

\* Patient's Date of Birth:  
10/01/1958  
mm/dd/yyyy

[Continue](#)

From the Patient Care menu choose Verify Primary Care Physician. Complete the required information; make sure to enter the member ID exactly as it appears on the patient's insurance card, including the alpha prefix if applicable.

### Continue.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, YOUR NAME of YOUR PRACTICE/FACILITY (Log Out) [Go to Message Center](#)

### Verify Primary Care Physician

[Printer-Friendly](#)

**Insurance**

Plan Name:  
BlueCross BlueShield Plans

Member ID:  
ZCZ065922516805

Member's Name:  
MICHAEL TESTING

**Patient**

Date of Birth:  
10/01/1958

[Change Patient](#)

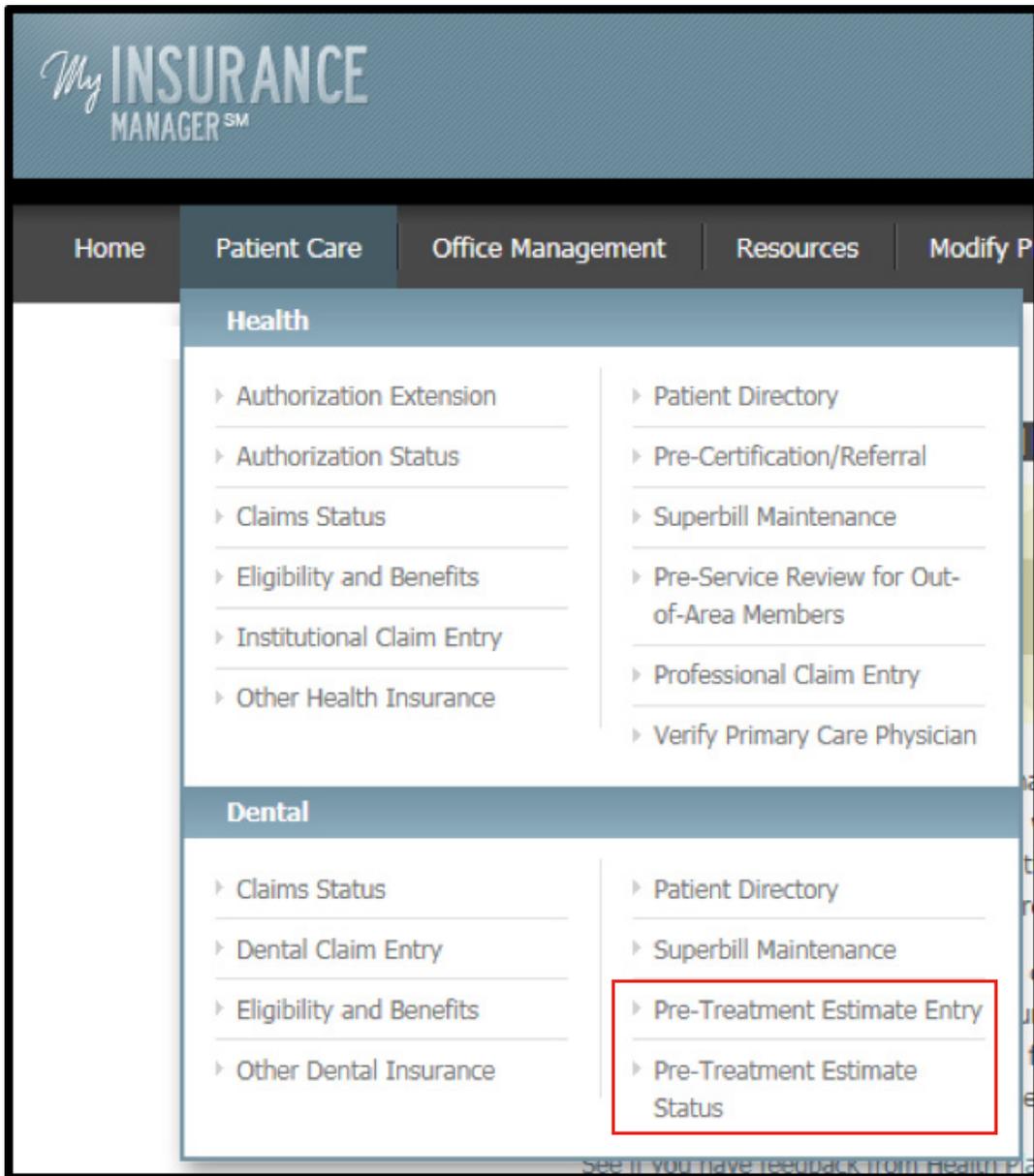
**Primary Care Physician Information**

**Primary Care Physician Information**

Patient's Name	Effective Date	Provider's Information	Provider's Phone
MICHAEL TESTING		Our records show that this member's health plan coverage does not require the member to choose a primary care physician.	

[Back](#)

The Primary Care Physician Information will display on the next screen if applicable to the member's health plan.



From the Patient Care menu, choose Pre-Treatment Estimate Entry to get a real-time snapshot of the benefits that are payable at the time the pre-treatment processes. This is considered a prior authorization. Select Pre-Treatment Estimate Status to see if we have approved the prior authorization request or if it is pending for additional information.

The screenshot shows a web application interface for entering a Pre-Treatment Estimate. At the top, there is a navigation bar with links: Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, and Staff Directory. Below the navigation bar, a welcome message reads "Welcome, Your Name of Your Dental Practice" with a "(Log Out)" link and a "Go to Message Center" link. The main heading is "Pre-Treatment Estimate" with a "Printer-Friendly" icon. A progress bar below the heading shows the current step: "Plan Information", followed by "Provider Information", "Patient Information", "Claim Information", "Claim Line Information", "Review", and "Confirmation".

On the left side, there is a blue information box: "Please note: This feature is not available from 11:30 p.m. to 4 a.m. Eastern Time for maintenance purposes." On the right side, there is a red asterisk indicating a required field: "\* Required".

The main content area is titled "Plan Information" and is divided into two sections:

- Submitter Information:** This section contains a warning: "If this information is not correct, please [modify your profile](#). Any information you entered will be lost if you navigate away from this page." Below this are input fields for Name (Your Name), ID (987654321), Email Address (Your.Name@email.com), Phone ((987) 234-5678), Extension (Not Available), and Fax (Not Available).
- Plan Information:** This section contains a note: "Please note: You are entering a Pre-Treatment Estimate request. [Switch to create a Dental Claim Entry](#)." Below this is a required field for Plan, labeled "\* Plan:", with a dropdown menu currently showing "--Please Choose One--".

At the bottom of the form, there is a "Continue" button on the left and a "Cancel this claim" link on the right.

From the Patient Care menu choose Pre-Treatment Estimate Entry. The Plan Information screen gives information about the submitter (i.e., the user account information). Select a plan and **Continue**.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, Your Name of Your Dental Practice (Log Out) [Go to Message Center](#)

## Pre-Treatment Estimate [Printer-Friendly](#)

Plan Information **Provider Information** Patient Information Claim Information Claim Line Information Review Confirmation

**Insurance** \* Required  
Plan Name: BlueCross BlueShield Plans

### Provider Information

**Billing Location Information**

Click Choose a Billing Provider to select from a list of locations affiliated with your Tax ID. The billing location address must be the physical address (not P.O. Box) and must contain a 9-digit ZIP code.

[Choose a Billing Provider](#)

Provider ID Type:  
Primary ID (NPI)

Provider ID:  
987654321

Provider's Name:  
YOUR DENTAL PRACTICE

\* Address Line 1: 456 MAIN ST Address Line 2:

\* City: FORT MILL \* State: South Carolina \* ZIP Code: 29715 - 0000

\* Provider Accepts Assignment: Assigned \* Provider Signature on File: Yes

**Rendering Provider Information**

Please Note: You must identify a Rendering Provider on all claims when the services were not rendered by the Billing Provider.

[Choose a Rendering Provider](#)

Provider ID Type:  
--Please Choose One--

Provider ID:

Provider's Name:

Specialty/Taxonomy Code:

or

From the Provider Information screen click the hyperlinks for **Choose a Billing Provider** and/or **Choose a Rendering Provider** to have this information auto-populated.

**Choose a rendering provider** if it differs from the billing provider.

A Specialty/Taxonomy Code is required when you enter the rendering provider information. Use the National Plan & Provider Enumeration System's (NPPES) website to locate your rendering provider's specialty/taxonomy code if you are unfamiliar with this number. NPPES is a separate program ran by the Centers for Medicare & Medicaid Services that handles these unique identifiers. Users can also find the specialty/taxonomy code in My Insurance Manager by searching for a partial code or description. **Continue**.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, Your Name of Your Dental Practice (Log Out) [Go to Message Center](#)

## Pre-Treatment Estimate Printer-Friendly

Plan Information Provider Information **Patient Information** Claim Information Claim Line Information Review Confirmation

\* Required

**Insurance**  
 Plan Name:  
**BlueCross BlueShield Plans**

### Patient Information

**Patient Details**

*Please note: Changes made to this information will not be updated in your Patient Directory.*

Enter the Member ID as shown on the member's ID card.

[Choose a Patient](#) or enter the information here.

\* Member ID:  \* Relationship to Member:  \* Patient Account Number:   
include alpha prefix, if applicable

\* Last Name:  First Name:  M.I.:  Suffix:

\* Date of Birth:  \* Gender:   
mm/dd/yyyy

\* Country:

\* Address Line 1:  Address Line 2:

\* City:  \* State:  \* ZIP Code:  -

**Patient Consent**

\* Benefits Assigned to Provider:

\* Release of Information:

or [Back](#)

On the Patient Information screen, add the required patient data elements as a one-time entry or use the Patient Directory. At the Patient Account Number field input the patient's unique number your practice or practice management software has assigned. You can create a patient account number if one does not exist. **Continue**.

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, Your Name of Your Dental Practice (Log Out) [Go to Message Center](#)

## Pre-Treatment Estimate Printer-Friendly

Plan Information Provider Information Patient Information **Claim Information** Claim Line Information Review Confirmation

\* Required

**Insurance**

Plan Name:  
**BlueCross BlueShield Plans**

Member ID:  
**ZCZ065922516805**

Member's Name:  
**MICHAEL TESTING**

**Claim Information**

**Superbill Information**

Choose a Superbill Template:  
None

[Create a New or Edit an Existing Template](#)

**Service Information**

Claim Type:  
Pretreatment Estimate

\* Place Of Service:  
Office - 11

**Claim Entry Options**

Accident Information

Claim Note Information

Orthodontics Information

or [Back](#)

The next pre-treatment estimate entry screen is Claim Information. Bypass the option to choose or create/update a superbill from the drop-down menu. Choose the place of service. If appropriate, add Claim Entry Options by checking the box that corresponds with the claim information to be included.

**Continue.**

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, Your Name of Your Dental Practice (Log Out) Go to Message Center

## Pre-Treatment Estimate Printer-Friendly

Plan Information Provider Information Patient Information Claim Information **Claim Line Information** Review Confirmation

\* Required

**Insurance**

Plan Name:  
**BlueCross BlueShield Plans**

Member ID:  
**ZCZ065922516805**

Member's Name:  
**MICHAEL TESTING**

### Claim Line Information

**Claim Amounts**

Please note: We will calculate the Total Claim Charges automatically based on the amounts you enter on the claim lines.

Total Claim Charges: \$ **500.00** Patient Paid: \$  Total Number of Lines:

**Claim Lines**

Please note:

- We require the Date of Service on all claims, except for Pre-Treatment Estimates.
- We require Date of Service, Place of Service, and Rendering Provider Information if they differ from the information previously entered at the claim level.
- We do not require Treatment Start Date and Treatment Completion Date if a Date of Service is entered.

**Line 1**

\* Procedure:   \* Charges: \$  Unit(s):

Procedure Description:  Tooth # -OR- Oral Cavity:

Surfaces:

Occlusal  Mesial  Distal  Facial  Incisal  Lingual  Buccal

Place of Service:

Treatment Start Date:  Treatment Completion Date:

Prosthesis, Crown or Inlay Placement:

Orthodontic Banding Date:  Replacement Date:

Rendering Provider Information: [\[+\] show/hide](#)

[Add a New Claim Line](#)

or [Back](#)

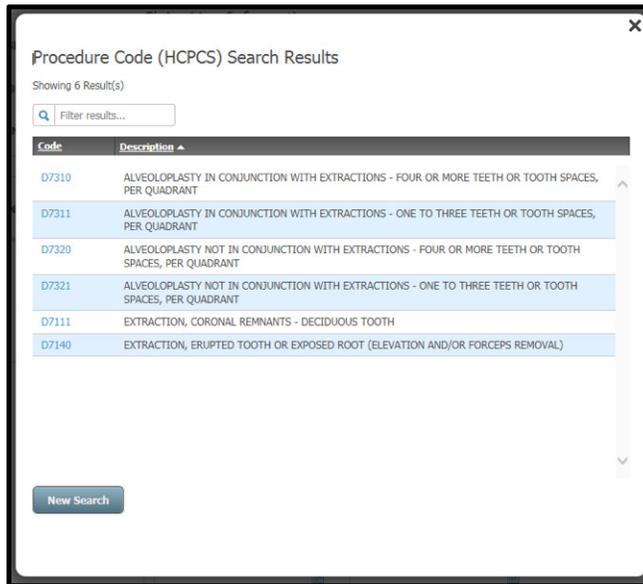
Claim Line Information is the fifth screen in the pre-treatment estimate entry process. Enter the total number of lines (up to 50 lines) in the Claim Amounts section. There is also a second chance to include additional claim lines by clicking the **Add a New Claim Line** link at the bottom of the screen. Claim amounts will automatically calculate based on the amounts you enter on the claim lines.

In the Claim Lines section, enter the procedure code and charges in those required fields. Search for the specific procedure code by clicking the magnifying glass icon.

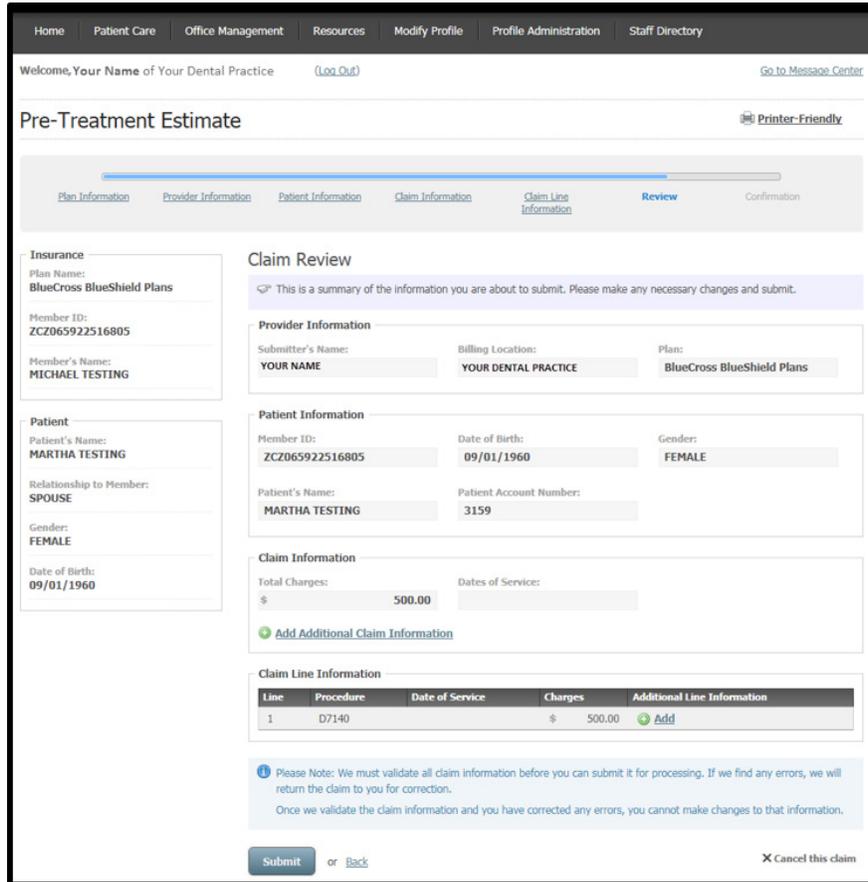
Choose the tooth number or oral cavity from the drop-down menu. Selecting a tooth number or oral cavity is optional.

Enter additional information as appropriate for Treatment Start/Completion Dates; Prosthesis, Crown or Inlay Placement; Orthodontic Banding/Replacement Dates; and Rendering Provider Information.

**Continue.**



This screen appears when searching for a procedure code. Search by description or code. Place your cursor on the desired procedure code to select it and be returned to the prior screen.



From the Review screen, examine your entries for the pre-treatment estimate. Submit the pre-treatment estimate or return to any previous screen using the **back** hyperlink or clicking on a screen title on the progress bar.

Select **Add Additional Claim Information** to add claim-level information.

To add information that applies to an individual claim line, click the **Add** link on the line to which the information applies.

There is an option to **Cancel the claim** found at the bottom of each screen of the claim entry process.

**Submit.**

Home Patient Care Office Management Resources Modify Profile Profile Administration Staff Directory

Welcome, Your Name of Your Dental Practice (Log Out) [Go to Message Center](#)

# Pre-Treatment Estimate Printer-Friendly

Plan Information Provider Information Patient Information Claim Information Claim Line Information Review **Confirmation**

**Insurance**

Plan Name:  
**BlueCross BlueShield Plans**

Member ID:  
**ZCZ065922516805**

Member's Name:  
**MICHAEL TESTING**

**Patient**

Patient's Name:  
**MARTHA TESTING**

Relationship to Member:  
**SPOUSE**

Gender:  
**FEMALE**

Date of Birth:  
**09/01/1960**

## Claim Confirmation

*Please note: We have received and are processing your Pre-Treatment Estimate.*

**Confirmation**

Claim Number: **T7D10003W** Member ID: **ZCZ065922516805** Patient's Name: **MARTHA TESTING**

Patient's Date of Birth: **09/01/1960** Patient's Gender: **Female**

[Create New Claim](#) [View Claim Status](#)

A claim number displays on the Claim Confirmation screen. You can now begin a new pre-treatment estimate or view the status of a pre-treatment estimate.

## Pre-Treatment Estimate Status

The screenshot shows the 'Pre-Treatment Estimates' selection screen. At the top, there is a navigation bar with links for Home, Patient Care, Office Management, Resources, Modify Profile, Profile Administration, and Staff Directory. Below the navigation bar, a welcome message reads 'Welcome, Your Name of Your Dental Practice' with a '(Log Out)' link. On the right, there is a 'Go to Message Center' link and icons for 'Get Adobe Reader' and 'Printer-Friendly'. The main heading is 'Pre-Treatment Estimates'. A red asterisk note states '\* Indicates required field.' The 'Patient Selection' section contains a search instruction: 'To search for a Pre-Treatment Estimate, please enter this information.' Below this are three required fields: 'Dental Plan' (a dropdown menu with '--Please Choose One--'), 'Member ID' (a text input field with a note 'include alpha prefix, if applicable'), and 'Patient's Date of Birth' (a date input field with a note 'mm/dd/yyyy'). A 'Continue' button is located at the bottom left.

From the Patient Care menu choose Pre-Treatment Estimate Status. Select a dental plan, and enter the member ID and patient's date of birth. **Continue**.

The screenshot shows the 'Pre-Treatment Estimate Detail' screen. The navigation bar and welcome message are identical to the previous screen. The main heading is 'Pre-Treatment Estimates'. On the right, there are links for 'Get Adobe Reader', 'Printer-Friendly', and 'View Pre-Treatment Estimate Letter'. The 'Insurance' section shows 'Plan Name: BlueCross BlueShield Plans' and 'Member ID: ZCZ065922516805'. The 'Patient' section shows 'Patient's Name: MARTHA TESTING' and 'Date of Birth: 09/01/1960', with a 'Change Patient' button. The 'Estimate Detail' section contains the text: 'Here is the information about the pre-treatment estimate you chose. Please note: This is not a guarantee of benefits or payment. All services are subject to any limitations or exclusions in the contract that are in effect at the time the patient receives services.' Below this is a table of estimate information:

Claim Number:	Status:	
T7D10003W	PENDING	
<b>Pre-Treatment Estimate Information</b>		
Provider's Name:	Primary ID:	
YOUR DENTAL PRACTICE	987654321	
Date Received:	Date Processed:	
04/20/2017	04/20/2017	
Total Charges:	Non-Covered Amount:	
\$500.00	\$370.00	
Allowed Amount:	Patient Liability:	Orthodontics?:
\$64.00	\$66.00	No

At the bottom, there are three buttons: 'Previous Estimate', 'Next Estimate', and 'Ask Provider Services'.

The Estimate Detail screen displays next. Look to the Status field to determine if the estimate is in a pending or approved status.

You can now choose to send a secure email to Provider Services by clicking **Ask Provider Services**; or view **Previous Estimate** or view **Next Estimate**.

## Troubleshooting Tips – Patient Care Functions

- If you get a “not covered” response with an eligibility end date of 12/31/999, this means a member’s dependent has been termed on an active policy. If you get a “covered” response with an eligibility end date of 12/31/9999, this means the patient (subscriber or dependent) is active.
- You cannot view dental eligibility and benefits for FEP BlueDental or out-of-state members.
- The dental code entered on the Eligibility and Benefits by Procedure Code inquiry may not be the procedure code returned on the eligibility response. The procedure code on the eligibility response is the code we will use to process the claim for this service. For example, when D2740 is entered the eligibility response will display details for D2751. An explanation for the code substitution is given.
- If you’ve reviewed your claim entry and continue to get an error message that states missing information is required, be sure an additional claim line field has not been expanded. For example, if you clicked the show/hide link for Drug Identification when you entered Claim Line Information but did not have prescription drug information to add, the claim will not submit without this information or without collapsing this option.
- B06 Invalid Point of Origin I84
- E07 Invalid Admission Date B04
- B9A Patient Reason for Visit/Admitting Diagnosis I
- B20 Revenue Code -----Invalid I12
- H98 Room Days and/or Charges Required on Inpt
- L25 Enter a valid tooth number or oral cavity

**This guide is for training purposes only. This is not a guarantee of payment. Non-payment of premiums and other contractual limitations may result in denial of benefits or refunds.**



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