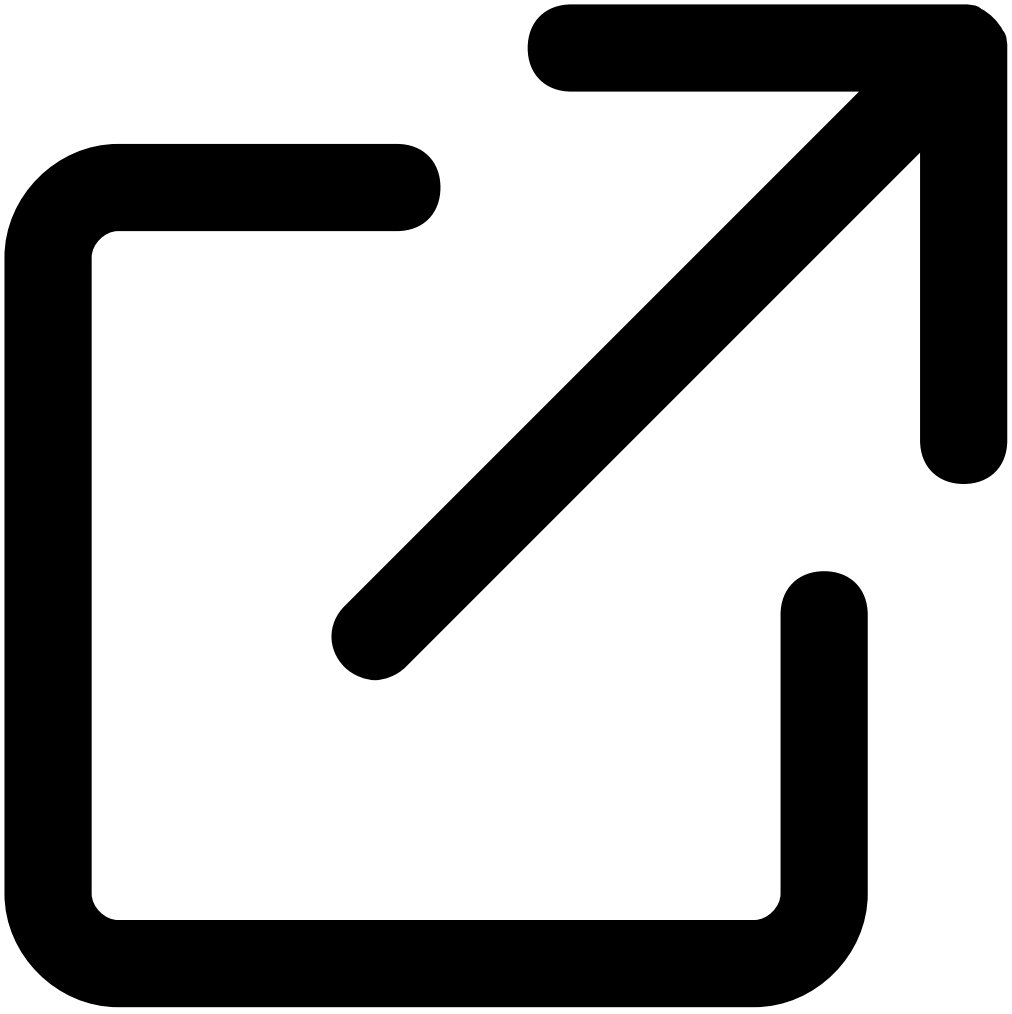

Network Participation

    - Network Participation
    - How to Join Our Networks
    - Update Your Information
    - Change of Ownership
- Claims and Eligibility

  Claims and Eligibility

    - Claims and Eligibility
    - BlueCard Program
    - Electronic Commerce
    - Eligibility and Benefits
    - Utilization Management
        - Prior Authorization Services For Fully Insured and ASO
        - Prior Authorizations Lists for Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO)
        - Prior Authorizations Lists for Designated Groups
        - Recommended Clinical Review Option
        - Prior Authorization Exemptions (Texas House Bill 3459)
    - Claims Filing Tips
    - Claim Status
    - Claim Review Process
    - Interactive Voice Response (IVR) System
    - Medicare Advantage Private Fee For Service
    - Eligibility and Benefits Inquiry (HIPAA 270/271)
- Education and Reference Center

  Education and Reference

    - Education and Reference Center
    - Blue Review
        - 2024 Blue Review
    - ERS Tools
    - TRS Tools
    - Forms
    - Identification Cards
    - Manuals
    - News and Updates
        - 2024 News and Updates
    - Provider Tools
    - Provider Training
    - Blue Review Archive
    - UTS -Tools
    - Fraud and Abuse
- Clinical Resources

  Clinical Resources

    - **Carelon**
    - Clinical Resources
    - Behavioral Health Care Management Program
    - Clinical Practice Guidelines
    - Quality Care – Partner With Your Patients
    - eviCore Prior Authorization Program
    - Special Beginnings - Maternity Program
    - Preventive Care Guidelines/Patient Wellness Guidelines
    - Quality Improvement Tip Sheet
    - Telemedicine and Telehealth Services
    - Health Equity and Social Determinants of Health (SDoH)
- Pharmacy Program

  Pharmacy Program

    - Pharmacy Program
    - Dispensing (Quantity vs. Time) Limits
    - Medicare Part D Pharmacy Updates

    - Prescription Drug List and Prescribing Guidelines
    - Specialty Pharmacy Programs
    - Prior Authorization and Step Therapy Programs
    - Split Fill Program
- Standards and Requirements

  Standards and Requirements

    - Standards and Requirements
    - Affordable Care Act (ACA)
    - Clinical Payment and Coding Policies
    - Consolidated Appropriations Act and Transparency in Coverage Final Rule
    - Disclosure Notices
        - 2024 Disclosure Notices
    - Federal Employee Program (FEP)
    - General Reimbursement Information
    - Manuals
    - Medical Policies
    - Medical Policy and Pre-certification/Pre-authorization Information for Out-of-Area Members
    - Physician Efficiency, Appropriateness, & Quality (PEAQ) Program
- Employers
- Producers
- Providers
- Company Information

Verification Processing

To support Texas prompt pay legislation, Blue Cross and Blue Shield of Texas has a verification of benefits process. Providers have the right to request a verification of benefits guaranteeing that a particular service will be paid by the insurance carrier for applicable BCBSTX members.

Verification Definition

The Texas Department of Insurance defines verification as *“a guarantee by an HMO or preferred provider carrier that the HMO or preferred provider carrier will pay for proposed medical care or health care services if the services are rendered within the required timeframe to the patient for whom the services are proposed.”*

Exclusions From Prompt Pay Legislation

Verification is not applicable for all enrollees or providers. A sample list of those health benefits plans excluded from prompt pay legislation include:

- Self-funded ERISA (Employee Retirement Income Security Act)
- Self-funded governmental, school and church health plans including:

    1. Federal Employee Program
    2. Employee Retirement System of Texas
    3. Texas Health Insurance Pool (THIP)
    4. Teacher Retirement System of Texas
    5. University of Texas System

- Out-of-state Blue Cross and Blue Shield plans
- Out-of-network (non-participating) providers

Identification Card Requirements

To assist in recognizing those subject to prompt pay legislation, the letters “TDI” will appear on the front of the BCBSTX member identification card when the member is subject to prompt pay legislation.

TDI Required Data Elements

Before submitting a request for verification, please be prepared to provide all of the following TDI required data elements at the time of your request.

- Patient name
- Patient identification number (exactly as shown on the current ID card)
- Patient date of birth
- Name of enrollee or subscriber
- Patient relationship to enrollee or subscriber
- Presumptive diagnosis, if known, otherwise presenting symptoms
- Description of proposed procedure(s) or procedure code(s)
- Place of service code where services will be provided and if place of service is other than provider's office or provider's location, name of hospital or facility where proposed service will be provided
- Proposed date of service
- Group number
- Name of the provider providing the proposed services(s)
- Provider's federal tax identification number
- If known to the provider, name and contact information of any other carrier including:
    - Other carrier's name
    - Address
    - Telephone number
    - Name of enrollee
    - Plan or Identification number
    - Group Number (if applicable)
    - Group Name (if applicable)

For **telephone requests**, please contact the appropriate Provider Customer Service Department number on the back of the member ID card or call **1-800-451-0287** .

Upon completion of processing, telephonic requests for verification will receive a fax notice followed by a written notice via U.S. Mail.

For those providers who prefer to submit a written request, please complete the Provider Request for Verification of Benefits Form and submit to the following address:

BCBSTX
Request for Verification of Benefits
P.O. Box 660044
Richardson, TX 75266-0044

Upon completion of processing, written requests for verification will receive a written notice via U.S. Mail.

Declination Notice

Verification is voluntary and may not be available to all members and/or providers. Some examples of reasons for declination may include, but are not limited to:

- No coverage or change in eligibility, including individuals not eligible, not yet effective or canceled
- Premium payment timeframes that prevent verifying eligibility for a 30-day period
- Policy deductible, specific benefit limitations or annual benefit maximum
- Benefit exclusions
- Pre-existing condition limitations
- BCBSTX is the secondary carrier

A declination notice simply means that a guarantee of benefit cannot be issued in advance, not a determination that a claim will not be paid. Please be advised that routine eligibility and benefit information may be obtained when verification is not applicable, or a declination has been issued.

Additional Information

Please refer to the on-line provider manuals for more information about verification.

Insurance Basics

- Health Care Costs
- Types of Health Insurance Coverage
- Glossary
- FAQs

Buying a Health Plan

- How to Enroll for Health Insurance
- Get a Quote/Browse and Buy Plans
- Premium Tax Credit Estimator
- Individual & Family Plans
- Medicare Plans

Member Resources

- Log in to Blue Access for Members
- Register for Blue Access for Members
- Pay My Bill
- Federal Employee Program (FEP)

- Legal and Privacy
- Non-Discrimination Notice
- Careers
- Contact Us
- Newsroom

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