

APPENDIX II: FORMS

of the Professional Provider Office Manual

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Forms are available online at www.lablue.com/providers > Resources > Forms

This is an appendix of the Blue Cross and Blue Shield of Louisiana (Louisiana Blue) *Professional Provider Office Manual*, and is for informational purposes only. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail our policies. Louisiana Blue retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided are proprietary and confidential and may constitute trade secrets.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12



**Blue Cross only accepts CMS-1500
"version 02/12." No black and white
copies or faxed claims are accepted.**

CARRIER

☐ PICA										☐ PICA																			
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐ (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐										7. INSURED'S ADDRESS (No., Street)									
CITY STATE										CITY STATE																			
ZIP CODE TELEPHONE (Include Area Code) ()										ZIP CODE TELEPHONE (Include Area Code) ()																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐										a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES ☐ NO ☐										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, complete items 9, 9a, and 9d.									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.															13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.														
SIGNED DATE															SIGNED														
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL															15. OTHER DATE MM DD YY QUAL														
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE															17a. NPI														
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.															20. OUTSIDE LAB? YES ☐ NO ☐ \$ CHARGES														
A. B. C. D. E. F. G. H. I. J. K. L.															22. RESUBMISSION CODE ORIGINAL REF. NO.														
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT (Family Plan) I. ID. QUAL. J. RENDERING PROVIDER ID. #															23. PRIOR AUTHORIZATION NUMBER														
1 2 3 4 5 6															25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐ 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use														
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)															32. SERVICE FACILITY LOCATION INFORMATION														
SIGNED DATE															33. BILLING PROVIDER INFO & PH # ()														
a. NPI b.															a. NPI b.														

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM (CMS-1500 VERSION 02-12)

EXPLANATION

- Block 1** Type(s) of Health Insurance - Indicate coverage applicable to this claim by checking the appropriate block(s).
- Block 1A** Insured's I.D. Number - Enter the member's Louisiana Blue identification number, including prefix, exactly as it appears on the identification card.
- Block 2** Patient's Name - Enter the full name of the individual treated.
- Block 3** Patient's Birth Date - Indicate the month, day and year. Sex - Place an X in the appropriate block.
- Block 4** Insured's Name - Enter the name from the identification card except when the insured and the patient are the same; then the word "same" may be entered.
- Block 5** Patient's Address - Enter the patient's complete, current mailing address and phone number.
- Block 6** Patient's Relationship to Insured - Place an X in the appropriate block. Self - Patient is the member. Spouse - Patient is the member's spouse. Child - Patient is either a child under age 19 or a full-time student who is unmarried and under age 25 (includes stepchildren). Other - Patient is the member's grandchild, adult-sponsored dependent or of relationship not covered previously.
- Block 7** Insured's Address - Enter the complete address; street, city, state and zip code of the policyholder. If the patient's address and the insured's address are the same, enter "same" in this field.
- Block 8** Reserved for NUCC USE - This section is reserved for NUCC use.
- Block 9** Other Insured's Name - If the patient has other health insurance, enter the name of the policyholder, name and address of the insurance company and policy number (if known).
- Block 10** Is patient's condition related to: a. Employment (current or previous)?; b. Auto Accident?; c. Other Accident?. Check appropriate block if applicable.

Block 10D When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes. When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the CMS-1500 claim form are available at www.nucc.org under Code Sets. When reporting more than one code, enter three blank spaces and then the next code.

Block 11 Not required.

Block 11D When appropriate, enter an X in the correct box. If marked "YES," complete 9, 9A and 9D. Only mark one box.

Block 12 Patient's or Authorized Person's Signature - Appropriate signature in this section authorizes the release of any medical or other information necessary to process the claim. Signature or "Signature on File" and date required. "Signature on File" indicates that the signature of the patient is contained in the provider's records.

Block 13 Insured's or Authorized Person's Signature - Payment for covered services is made directly to participating providers. However, you have the option of collecting for office services from members who do not have a copayment benefit and having the payments sent to the patients. To receive payment for office services when the copayment benefit is not applicable, Block 13 must be completed. Acceptable language is:

- | | |
|-----------------------|----------------------|
| a. Signature in block | d. Benefits assigned |
| b. Signature on file | e. Assigned |
| c. On file | f. Pay provider |

Note: Assignment language in other areas of the CMS-1500 claim form or on any attachment is not recognized. If this block is left blank, payment for office services will be sent to the patient. Completion of this block is not necessary for other places of treatment.

Block 14 Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the present illness, injury or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported.

Block 15 Enter another date related to the patient's condition or treatment. Enter the date in the date in the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) format. Enter the applicable qualifier to identify which date is being reported.

Block 16 Dates Patient Unable to Work in Current Occupation - Enter dates, if applicable.

Block 17 Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider – **Required**
2. Ordering Provider – **Required**
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported to the left of the vertical, dotted line.

Block 17A Other ID #. The non-NPI ID number of the referring physician, when listed in Block 17.

Block 17B **NPI – Required.** Enter the national provider identifier (NPI) for the referring physician, when listed in Block 17.

Block 18 For Services Related to Hospitalization - Enter dates of admission to and discharge from hospital.

Block 21 **Diagnosis or Nature of Illness or Injury** - Enter the applicable ICD indicator to identify which version of ICD codes is being reported: "0" for ICD-10-CM codes. **Note:** All transactions, electronic or paper-based, for services on and after October 1, 2015, must contain ICD-10 codes or they will be rejected. Blue Cross will not accept ICD-9 codes for dates of services on or after October 1, 2015. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. Use the most specific diagnosis codes when reporting codes. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

Block 23 Prior Authorization Number - Enter the authorization number obtained from Louisiana Blue/HMO Louisiana, if applicable.

Block 24A Date(s) of Service - Enter the "from" and "to" date(s) for service(s) rendered.

Block 24B Place of Service - Enter the appropriate place of service code. Common place of service codes are:

Inpatient - 21 Outpatient - 22 Office - 11

Block 24C EMG - Enter the Type of Service code that represents the services rendered.

- Block 24D** Procedures, Services, or Supplies - Enter the appropriate CPT or HCPCS code. Please ensure your office is using the most current CPT and HCPCS codes and that you update your codes annually. Append modifiers to the CPT and HCPCS codes, when appropriate.
- Block 24E** Diagnosis Pointer - Enter the diagnosis code reference letter (pointer) as shown in Block 21 to relate the date of service and procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-9-CM or ICD-10-CM diagnosis codes must be entered in Block 21 only. Do not enter them in 24E.
- Block 24F** Charges - Enter the total charge for each service rendered. You should bill your usual charge to Louisiana Blue regardless of our allowable charges.
- Block 24G** Days or Units - Indicate the number of times the procedure was performed, unless the code description accounts for multiple units, or the number of visits the line item charge represents. Base units value should never be entered in the "units" field of the claim form.
- Block 24J** Rendering Provider ID #
- NPI - Enter the NPI for the rendering physician for each procedure code listed when billing for multiple physicians' services on the same claim. Laboratory, Durable Medical Equipment, Diagnostic Radiology Center, Laboratory and Diagnostic Services, and Retail Health Clinic providers do not have to enter a physician NPI in this block. Please enter the facility NPI in blocks 32A and 33A as instructed. Beginning Jan. 1, 2026, Emergency Room Physicians and Urgent Care Center providers are required to file the rendering provider NPI and taxonomy code.
- Taxonomy - Enter the 10-digit taxonomy code if required by the payer for adjudication.
- Block 25** Federal Tax I.D. Number - Enter the provider's/clinic's federal Tax ID number to which payment should be reported to the Internal Revenue Service.
- Block 26** Patient's Account Number - Enter the patient account number in this field. As many as nine characters may be entered to identify records used by the provider. The patient account number will appear on the Provider Payment Register/Remittance Advice only if it is indicated on the claim form.
- Block 27** Accept Assignment - Not applicable - Used for government claims only.
- Block 28** Total Charge - Total of all charges in Item F.

- Block 29** Amount Paid - Not required.
- Block 30** Not required.
- Block 31** Signature of Provider - Provider's signature required, including degrees and credentials. Rubber stamp is acceptable.
- Block 32** Name and Address of Facility - Required, if services were provided at a facility other than the physician's office.
- Block 32A** NPI - Enter the NPI for the facility listed in Block 32.
- Block 32B** Other ID - The non-NPI number of the facility refers to the payer-assigned unique identifier of the facility. Enter the 10-digit taxonomy code that corresponds with the provider's type. The taxonomy code is used to determine the specialty of the provider and is required when we are unable to locate a single match for the NPI entered.
- Block 33** Billing Provider Info & Ph # - Enter complete name, address, telephone number for the billing provider.
- Block 33A** NPI - Enter the NPI for the billing provider listed in Block 33.
- Block 33B** Other ID # - The non-NPI number of the billing provider refers to the payer-assigned unique identifier of the professional.

Example UB-04 CLAIM FORM

The following sample UB-04 claim form and instructions are given for those providers who should file claims using a UB-04 claim form, specifically acute care facilities, dialysis and home health providers.

1		2		3a PAT. CNTL. #		4 TYPE OF BILL	
				b. MED. REC. #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME		9 PATIENT ADDRESS					
b		b		c		d	
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18	19
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
CODE		CODE		CODE		CODE	
a		a		a		a	
b		b		b		b	
35 OCCURRENCE SPAN FROM THROUGH		36 OCCURRENCE SPAN FROM THROUGH		37			
CODE		CODE		CODE		CODE	
a		a		a		a	
b		b		b		b	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
CODE		CODE		CODE		CODE	
a		a		a		a	
b		b		b		b	
c		c		c		c	
d		d		d		d	
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	PAGE OF	CREATION DATE	TOTALS				23
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							A
B						57 OTHER	B
C						PRV ID	C
58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.			
A							A
B							B
C							C
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME					
A							A
B							B
C							C
66 DX	67	A	B	C	D	E	F
		G	H	I	J	K	L
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 EC	73			
a	b	c	d	e	f	g	h
74 PRINCIPAL PROCEDURE DATE	75	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80	81
CODE	CODE	QUAL	QUAL	QUAL	QUAL	QUAL	QUAL
a	b	LAST	FIRST	LAST	FIRST	LAST	FIRST
c	d	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80	81
CODE	CODE	QUAL	QUAL	QUAL	QUAL	QUAL	QUAL
e	f	LAST	FIRST	LAST	FIRST	LAST	FIRST
80 REMARKS	81CC a	b	c	d			

UB-04 CMS-1450

APPROVED OMB NO. 0938-0997

NUBC[®] National Uniform Billing Committee

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

UB-04 CLAIM FORM EXPLANATION

Block 1	Enter billing provider name and address.
Block 2	Enter pay-to provider name and address, if different than Block 1.
Block 3A	Patient Control Number: Enter the number or code that is used by your facility to retrieve or post financial records.
Block 3B	Medical Record Number: Enter the number or code that is used by your facility to retrieve or post medical/health records
Block 4	Type of Bill: This is a three-position code that indicates the type of facility, the bill classification and the frequency.
Block 5	Fed. Tax ID: Enter Tax ID number of the facility.
Block 6	Statement Covers Period: Enter the first date associated with this claim in the "From" box and enter the final date of the claim in the "Through" box.
Block 8A-8B	Patient Name: Enter the patient's name with last name first, then first name and middle initial, if any. Do not use titles or nicknames.
Block 9A-9E	Address: Patient address must be completed.
Block 10	Birthdate: Enter the patient's actual date of birth in MM-DD-YYYY format.
Block 11	Sex: An "M" for male or an "F" for female must be present.
Block 12	Admission Date: This field is required for Louisiana Blue inpatient claims and not required for outpatient claims. Note: Inpatient and outpatient claims for BlueCard® (insured through an out-of-area Blue Plan) or FEP members may require the admission date when submitted to Louisiana Blue for processing.
Block 13	HR: This field is required for Louisiana Blue inpatient claims and not required for outpatient claims. Note: Inpatient and outpatient claims for BlueCard or FEP members may require the HR when submitted to Louisiana Blue for processing.

Block 14	Type: This field is required for Louisiana Blue inpatient claims and not required for outpatient claims. Note: Inpatient and outpatient claims for BlueCard or FEP members may require the type when submitted to Louisiana Blue for processing.
Block 15	SRC: This field is required for Louisiana Blue inpatient claims and not required for outpatient claims. Note: Inpatient and outpatient claims for BlueCard or FEP members may require the SRC when submitted to Louisiana Blue for processing.
Block 16	DHR: Discharge hour field is required on all final inpatient claims except for 021x. This includes claims with a Frequency Code of 1 (Admit through Discharge), 4 (Interim-Last Claim) and 7 (Replacement of Prior Claim) when the replacement is for a prior final claim.
Block 17	STAT: Enter the applicable discharge status code. This field is not required for Louisiana Blue outpatient claims, but can be present. Note: Inpatient and outpatient claims for BlueCard or FEP members may require a discharge status code when submitted to Louisiana Blue for processing.
Blocks 18-28	Condition Codes: The condition code(s) is a two-position code that identifies conditions, if any, relating to this bill that may affect payer processing.
Block 29	Two-digit state abbreviation where the accident occurred.
Block 30	Reserved for assignment by the National Uniform Billing Committee (NUBC).
Blocks 31-34	Occurrence Codes and Occurrence Dates: The occurrence code is a two-position code used to determine liability, coordination of benefits and to administer subrogation clauses in the member contract/certificate. The occurrence date is the date that corresponds with the preceding occurrence code. The date must be in MM-DD-YYYY format and is required if occurrence codes are used.
Block 35-36	Occurrence Span Codes and Dates: These fields are used when the patient was seen as an outpatient for follow-up treatment. In the "From" field, enter the first date the patient was treated for this condition. In the "Through" field, enter the last date the patient was treated for this condition. This field is not required for inpatient claims.
Block 37	Reserved for assignment by the NUBC.
Block 38	The name and address of the party responsible for the bill.

Blocks 39-41	Value Code/Amount: Value code(s) identify data necessary for processing claims. The value amount is the dollar amount or number associated with the corresponding value code. A value amount must be present for each value code. If the amount does not represent a dollar amount, two zeros should be entered following the number. Example: If the patient received three units of blood, enter 300.
Block 42	Rev CD: The revenue code is the code that best identifies a particular accommodation/ancillary service that was rendered to the patient. Revenue codes can be duplicated only if the rates differ.
Block 43	Description: The provider reports the NDC code. The provider enters a narrative description or standard abbreviation for each revenue code shown. This field is not required but may be present.
Block 44	HCPCS/Rates: The rate is the actual charge for the services rendered. If rates are different, duplicate the revenue code to show the different rates. Revenue codes can only be duplicated when the rates are different. Rate multiplied by units must equal charges.
Block 45	Serv. Date: Date of service for HCPCS code listed. If there are multiple dates of service for the same HCPCS code, each date must be listed on a separate line.
Block 46	Service Units: Service units are the number of times a service was rendered per date of service.
Blocks 42-47	Line 23: The PAGE__ of __, CREATION DATE and total charges TOTALS should be reported on all pages of the UB-04.
Block 47	Total Charge: Enter the amount charged for each of the revenue codes given. If rates and units are present, multiply these to get the total charges except when rates are zeros.
Block 49	Reserved for assignment by the NUBC.
Block 50	Payer Name: This field is required only on lines 50 B and 50 C when indicating other payer information.

- Block 52** REL INFO: The release information field must be "Y" if you are filing electronically. This indicates that you have signed written authority to release medical or billing information for purposes of claiming insurance benefits. If "N," you must file hardcopy.
- Block 53** ASG BEN: Enter one of the following codes to indicate who will receive payment for the claim:
- Y Assignment/payment to provider
N Assignment/payment to member
- Louisiana Blue pays all participating providers directly unless assignment indicates to pay the member.
- Block 56** NPI: Enter the appropriate national provider identifier (NPI) number in this field.
- Block 57** Other Prv ID: Enter your Louisiana Blue assigned five-digit or ten-digit provider number in this field.
- Block 58** Insured's Name: If the patient is not the insured, enter the member's name exactly as it appears on the Louisiana Blue identification card.
- Block 59** P REL: If the patient and insured are the same, this field is not required. If the patient is not the insured, enter one of the following codes that identifies the patient's relationship to the contract holder:
- | | |
|-----------------------|-----------------|
| 01 Spouse | 18 Self |
| 19 Child | 20 Employee |
| 21 Unknown | 39 Organ donor |
| 40 Cadaver donor | 53 Life Partner |
| G8 Other relationship | |
- Block 60** Insured's Unique ID: Enter the member's identification number exactly as it appears on the ID card.
- Block 61** Group Name: This field is required if known.
- Block 62** Insurance Group No.: Enter the group number as it appears on the member's ID card.
- Block 63** Treatment Authorization Codes: Enter the Louisiana Blue authorization number, when available.

- Block 65** Employer Name: Enter the patient's employer in this field. If patient is a housewife, retired, unemployed or a student in college, enter this. Do not enter the member's employer, unless the patient is the employer.
- Block 66** ICD Version Indicator: Qualifier Code "9" required on claims representing services through September 30, 2015. Qualifier Code "0" required on claims representing services on October 1, 2015, and beyond.
- Block 67** Principle Diagnosis Code: The principal diagnosis code must be entered in this field. You must use ICD-10-CM codebook. The first position should contain "V" or a numeric character. The second and third positions must be numeric with no punctuation. Fourth and fifth positions must be numeric or blank.
- Blocks 67A-Q** Other Diagnosis Codes: These fields should be used when additional conditions exist at the time of admission or develop subsequently and affect the treatment received or the length of stay. Follow the coding guidelines for the principal diagnosis code.
- Block 68** Reserved for assignment by the NUBC.
- Block 69** Admit Dx: Enter the ICD-10-CM diagnosis code related to the patient's admission.
- Block 70** The ICD-CM diagnosis code describing the patient's reason for visit at the time of outpatient registration.
- Block 71** The Prospective Payment System (PPS) code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
- Block 72** The ICD diagnosis code pertaining to external cause of injuries, poisoning or adverse effect. See ICD-10-CM Guidelines for Coding and Reporting.
- Block 74** Principal Procedure Code/Date: The principal procedure should be entered in this field. This is the procedure that was performed for treatment rather than diagnostic or exploratory purposes, or the procedure that is most related to the principal diagnosis. The procedure coding method must be ICD-10-CM. Enter the date the primary/principal procedure was performed in MM-DD-YYYY format.
- Block 74A-E** Other Procedure Code/Date: For outpatient billing, if a CPT code is not required, enter the ICD-10-CM procedure code. Enter the date of the additional procedure(s) in MM-DD-YYYY format.

Block 75	Reserved for assignment by the NUBC.
Block 76	Attending: Enter the NPI, last name and first name of the attending physician who rendered the services. This field is required.
Block 77	Operating: Enter the NPI, last name and first name of the operating physician who had primary responsibility for surgical procedures. This is only required when a surgical procedure code is listed.
Block 78-79	Other: Required. Enter the NPI, last name and first name of referring physician, assistant surgeon, and/or rendering physician, as applicable.
Block 80	Remarks: The remarks field must be completed if the type bill is "XX5" or "XX6" or if the third digit of a revenue code is "9" or if revenue codes 920 or 940 are present.
Block 81	Enter B3-qualifier and then your respective taxonomy code. All claims need to be filed with a taxonomy code to ensure timely and accurate claims processing.
Remarks	If the claim is for a federal employee contract and therapy revenue codes 42X, 43X or 44X are present, the actual dates of service for each revenue code must be entered in the remarks field.

ILINKBLUE 1500 CLAIM ELECTRONIC ENTRY

iLinkBlue allows the electronic submission of professional 1500 claim forms giving providers the capability of submitting HCFA 1500 claims directly into the claims processing systems at Louisiana Blue, HMO Louisiana, Federal Employee Program (FEP) and BlueCard (out-of-area) members.

Please refer to the *iLinkBlue 1500 Claims Entry Manual*, which is available on iLinkBlue (www.lablue.com/ilinkblue) under the "Resources" section.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) ☐ Request for Predetermination/Preauthorization
☐ Statement of Actual Services ☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) 7. Gender ☐ M ☐ F ☐ U 8. Policyholder/Subscriber ID (Assigned by Plan)
9. Plan/Group Number 10. Patient's Relationship to Person named in #5
☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

11a. Other Payer ID

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34. Diagnosis Code List Qualifier ☐ (ICD-10 = AB)	31a. Other Fee(s)
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	34a. Diagnosis Code(s) (Primary diagnosis in "A")	32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Patient/Guardian Signature _____ Date _____

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Subscriber Signature _____ Date _____

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number () - 52a. Additional
Provider ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender ☐ M ☐ F ☐ U 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other 19. Reserved For Future
Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender ☐ M ☐ F ☐ U 23. Patient ID/Account # (Assigned by Dentist)

ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)
(Use "Place of Service Codes for Professional Claims") 39a. Date Last SRP

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment 43. Replacement of Prosthesis
☐ No ☐ Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Signed (Treating Dentist) _____ Date _____

53a. Locum Tenens Treating Dentist? ☐

54. NPI 55. License Number

56. Address, City, State, Zip Code 56a. Provider Specialty Code

57. Phone Number () - 58. Additional
Provider ID

Description of ADA Dental Claim Form Explanation

- Block 1** Mark this box if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons under 21.
- Block 2** Enter the number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
- Block 3** Enter the patient's primary insurance carrier's information.
- Block 4-11** Fill in other coverage information. Leave blank if no other coverage.
- Block 8** Policy Holder/Subscriber's identification number for additional coverage.
- Block 12-14** Enter Subscriber's personal insurance information here.
- Block 15** This is the member's identification number assigned by Louisiana Blue.
- Block 16-17** This is the member's or employer group's plan or policy number. May also be known as the certificate number and employer name.
- Block 18** Check indicating the relationship of the patient to the Policyholder/Subscriber.
- Block 19-23** Complete only if the patient is not the primary subscriber (i.e., "Self" not checked in Block 18).
- Block 19** Check "FTS" if the patient is a dependent and a full-time student; "PTS" is a part-time student. Otherwise, leave blank.
- Block 23** Enter if dentist's office assigns a unique number to identify the patient that is not the same as the subscriber identifier number assigned by the payer (e.g., chart number).
- Block 24** Enter date the procedure was performed.
- Block 25** Designate tooth number or letter when the procedure code directly involves a tooth. Use the area of the oral cavity code set from ANSI/ADA/ISO Specification number 3950m, "Designation System for Teeth and Areas of the Oral Cavity."
- Block 26** Enter applicable ANSI ASC X12 code list qualifier. Use "JP" when designating teeth using the ADA's Universal/National Tooth Designation System. Use "JO" when using the ANSI/ADA/ISO Specification No. 3950.
- Block 27** Designate tooth number when the procedure code reported directly involves a tooth. If a range of teeth is being reported, use a hyphen (-) to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.

- Block 28** Designate tooth surface(s) when the procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: B=Buccal; D=Distal; F=Facial; L=Lingual; M=Mesial and O=Occlusal.
- Block 29** Use the appropriate dental procedure code from the current version of the Code on Dental Procedures and Nomenclature.
- Block 30** Description of codes.
- Block 31** This is the dentist's full fee for the dental procedure reported.
- Block 32** This is used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.
- Block 33** This is the total of all fees listed on the claim form.
- Block 34** Report missing teeth on each claim submission.
- Block 35** Use "Remarks" space for additional information such as "reports" for "999" codes or multiple supernumerary teeth. Oral surgeons should place the diagnosis code in this field.
- Block 36** The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental healthcare. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian or other individual as appropriate under state law and the circumstances of the case.
- Block 37** Subscriber Signature: This is necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.
- Block 38** Indicate the place of treatment by choosing "Provider's Office," "Hospital," "Extended Care Facility (ECF)" (e.g., nursing home) or "Other."
- Block 39** Fill in the number of each type of enclosures in the appropriate boxes provided.
- Block 40** Indicate whether or not the treatment is for orthodontics purposes.
- Block 41** If "yes" is checked in Block 40, list date appliance was placed.
- Block 42** If "yes" is checked in Block 40, list how many months of treatment are remaining.
- Block 43** If "yes" is checked in Block 40, indicate whether or not a replacement of prosthesis was done.
- Block 44** If "yes" is checked in Block 43, list date of prior placement.
- Block 45** Indicate what the treatment is resulting from, if applicable.

- Block 46** List date of accident.
- Block 47** Report what state the accident occurred.
- Block 48** This is the individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
- Block 49** Billing dentist's national provider identifier (NPI).
- Block 50** This refers to the license number of the billing dentist. This may differ from that of the treating dentist that appears in the treating dentist's signature block.
- Block 51** The Internal Revenue Service requires that either the SSN or TIN of the billing dentist or dental entity be supplied only if the provider accepts payment directly from the third-party payer. When the payment is being accepted directly, report the: 1) SSN if the dentist is unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic.
- Block 52** Billing dentist or dental entity's phone number.
- Block 52a** Additional Provider ID #.
- Block 53** This is the treating, or rendering, dentist's signature and date the claim form was signed. Dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance, but not completed.
- Block 54** Treating dentist's NPI.
- Block 55** Treating dentist's license number.
- Block 56** This is the full address, including city, state and zip code, where treatment is performed by the treating (rendering) dentist.
- Block 57** Treating dentist or treatment location phone number.
- Block 58** Additional Provider ID #.



Alternative Dental Procedure Payment Responsibility Form

Complete and attach this form to the dental claim form when a member chooses an alternative, non-covered treatment.

Pursuant to Louisiana Senate Bill 73, which amended and/or reenacted La. R.S. 22:1513(C)(2)(b); 22:250.43(C) and 22:250.48, a Blue Cross and Blue Shield of Louisiana (BCBSLA) member may choose any type, form or quality of dental procedure, for which insurance coverage is not available, as long as the member approves in advance and in writing the charges for which he/she will be responsible. Additionally, if a member receives a dental diagnosis from a contracted provider that qualifies for a covered service pursuant to the member's contract/certificate or dental contract, the member may:

1. Choose the covered service provided for in the member contract/certificate or dental contract for the treatment of the condition diagnosed; or
2. Choose an alternate type, form or quality of dental procedure of equal or greater price to treat the diagnosed condition. If the member chooses this option, he/she must agree in advance and in writing to pay the difference between the allowed amount of the covered service and the amount of the chosen alternative service or procedure.

DENTIST INFORMATION	
Dentist Name	
Contact Name	National Provider Identifier (NPI)
Phone Number	Fax Number
COVERED SERVICE	
CDT Code	Description
Additional CDT Code	Description
ALTERNATIVE TREATMENT/SERVICE	
CDT Code	Description
Additional CDT Code	Description
MEMBER INFORMATION	
By receiving the above alternative treatment/service, I agree that I will be responsible for the difference between the allowed amount paid by BCBSLA and the amount charged by the dentist for the chosen alternative service or procedure.	
Member Signature	Date
Member Name (please print)	Member ID

18NW1061 R1/17

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

PROVIDER UPDATE FORMS

The following update forms should be used to notify Louisiana Blue of changes or additions to provider demographic information, including what is displayed in our provider directories. To find our update forms, visit www.lablue.com/providers, choose "Resources," then "Forms." Select a link based on the type of change you are making to access the applicable update form.

- Individual/Group Provider Update Request Form
- Facility Update Request Form
- Professional Tax Identification Number (TIN) Change Form
- Facility Tax Identification Number (TIN) Change Form
- Add Practice Location Form
- Add Facility Location Form
- National Provider Identifier (NPI) Change Form
- Request for Termination Form
- Link to a Group or Clinic Form
- Electronic Transactions Transfer (EFT) Change/Termination Form

Complete, sign and submit the update forms digitally with DocuSign®. It is not necessary to print and submit via hardcopy. These forms are accepted through DocuSign only and the sample forms on the next pages are for reference purposes.



Individual/Group Provider Update Request

Complete this form to report updated demographic or contact information for your individual or group provider record. For physical address changes, additional documentation is required (see list below). If you have non-demographic changes, please see our other forms available online at www.lablue.com/providers >Resources >Forms.

Please specify change(s):

- ☐ Name Change
☐ Specialty/Classification Change
☐ Physical Address Change
☐ Correspondence Address Change
☐ Billing Address Change
☐ Medical Records Address Change

Effective Date of Change: _____		Tax Identification Number: _____	
GENERAL INFORMATION			
Provider Name		Individual NPI	
Group/Clinic Name		Group/Clinic NPI	
Person Completing This Form			
Contact Email Address		Contact Phone Number	
Signature of Authorized Representative		Date	
NAME CHANGE			
Former Last Name		Former First Name	
New Last Name		New First Name	
Former Group/Clinic Name			
New Group/Clinic Name			
For individual name change please attach: • Copy of updated professional license showing the new name.		For group/clinic name change please attach: • Copy of EIN Letter showing new name for legal name change, or • W-9 showing new name for DBA change	
SPECIALTY/CLASSIFICATION CHANGE			
Former Individual Specialty		New Individual Specialty	
Please attach a copy of your completed education or board certification for new specialty.			
Changing clinic to Rural Health Center (RHC)? ☐ Yes ☐ No Please attach a copy of your DHH license.		Changing clinic to Federally Qualified Health Center (FQHC)? ☐ Yes ☐ No Please attach a copy of your CMS approval letter.	

Page 1 of 3

18NW3818 R01/25

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

PHYSICAL ADDRESS CHANGEThis request is for: ☐ Individual Provider ☐ Multiple Individual Providers (attach roster with provider names/NPIs)**Former Physical Address**

City, State and ZIP Code

Phone Number

New Physical Address

City, State and ZIP Code

Phone Number

Fax Number

Are you practicing as a primary care provider (PCP)?

☐ Yes☐ No

Specialty

Type of Practice:

☐ Solo☐ Group/Clinic☐ Hospital-based☐ Hospital-employed**Accepting New Patients**

Closing panel to new patients (No longer accepting new patients)

☐ Yes☐ No

Opening panel to accept new patients (My panel is currently closed and I would like to begin accepting new patients)

☐ Yes☐ No

Age Range of Patients (if applicable)

☐ 0-6 years☐ 7-11 years☐ 12-18 years☐ 19-65 years☐ Over 65☐ All Ages☐ Other: _____

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Office Hours	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____
Practice Hours (available appointment hours)	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____

For this practice location (please select one option only):

- ☐ I am available to see patients at least 8 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services, but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

CORRESPONDENCE ADDRESS CHANGE (for receiving provider communications)**Former Correspondence Address**

City, State and ZIP Code

Phone Number

New Correspondence Address

City, State and ZIP Code

Phone Number

Fax Number

Email Address

BILLING ADDRESS CHANGE (for payment registers, reimbursement checks, etc.)		
Former Billing Address		
City, State and ZIP Code		Phone Number
New Billing Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		
MEDICAL RECORDS ADDRESS CHANGE (for medical records request)		
Former Medical Records Address		
City, State and ZIP Code		Phone Number
New Medical Records Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

Return Form To: Email: network.administration@lblue.com

Page 3 of 3



Facility Update Request

Complete this form to report updated demographic or contact information for your facility. For physical address changes, additional documentation is required (see list below). If you have non-demographic changes, please see our other forms available online at www.lablue.com/providers >Resources >Forms.

Please specify change(s):

- ☐ Physical Address Change
☐ Correspondence Address Change
☐ Billing Address Change
☒ Medical Records Address Change

Effective Date of Change: _____		Tax Identification Number: _____	
GENERAL INFORMATION			
Facility Name			
Facility Type/Specialty		Facility NPI	
AUTHORIZED REPRESENTATIVE			
Name			
Contact Phone Number		Contact Email Address	
Signature of Authorized Representative			Date
PHYSICAL ADDRESS CHANGE			
Former Physical Address			
City, State and ZIP Code			Phone Number
New Physical Address			
City, State and ZIP Code		Phone Number	Fax Number
Business Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____
	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____
	Sun. ____ - ____		
Please include the following documentation showing the new physical address:			
• Copy of applicable license • Copy of updated liability insurance • Accreditation, if applicable			

CORRESPONDENCE ADDRESS CHANGE (for receiving provider communications)		
Former Correspondence Address		
City, State and ZIP Code	Phone Number	
New Correspondence Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		
BILLING ADDRESS CHANGE (for payment registers, reimbursement checks, etc.)		
Former Billing Address		
City, State and ZIP Code	Phone Number	
New Billing Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		
MEDICAL RECORDS ADDRESS CHANGE (for medical records request)		
Former Medical Records Address		
City, State and ZIP Code	Phone Number	
New Medical Records Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		



Professional Provider Tax Identification Number (TIN) Change

This form is for professional providers replacing a current TIN with a new TIN. Please include all practitioners affected by this change. Please complete this form in its entirety and include required supporting documentation as outlined in the "Required Attachments" section of this form. We will contact you with a new Provider Agreement to sign and return, if applicable.

Effective Date of Change: _____		
GENERAL INFORMATION		
Former Provider Name	Former TIN	Former NPI
New Provider Name	New TIN	New NPI
Do you want to participate in your existing networks under the new TIN, if applicable? ☐ Yes ☐ No		
BILLING ADDRESS (for payment registers, reimbursement checks, etc.)		
Billing Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		
MEDICAL RECORDS ADDRESS (for medical records request)		
Medical Records Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		
CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)		
Correspondence Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		
PHYSICAL ADDRESS		
Physical Address		
City, State and ZIP Code	Phone Number	Fax Number

Accepting Patients (if applicable) ☐ New ☐ Existing ☐ Other: _____				Age Range of Patients (if applicable) ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____			
Office Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
Practice Hours (available appointment hours)	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
For this practice location (please select one option only): ☐ I am available to see patients at least 8 hours per week on a regular basis. ☐ I see patients here at least one day per month, but less than one day per week on a regular basis. ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only. ☐ I read tests or provide other services but do not see patients at this location. ☐ I do not practice here, but this location is within the medical group with which I am employed.							
REQUIRED DOCUMENTS							
☐ Roster of practitioners moving under new TIN (include name and NPI for each practitioner) ☐ Certificate(s) of Professional Liability Insurance for each practitioner ☐ Current Employer Identification Number (EIN) and W-9 Form or Federal Tax Deposit Coupon ☐ iLinkBlue and EFT agreements ☐ Administrative Representative Registration Form							
SUBMISSION INFORMATION (form completed by)							
Signature of Authorized Representative						Date	
Contact Email Address					Contact Phone Number		

Return Form To: Email: network.administration@lblue.com



Facility Tax Identification Number (TIN) Change Form

This form is for facilities replacing a current TIN with a new TIN. Please complete this form in its entirety and include required supporting documentation as outlined in the "Required Attachments" section of this form. We will contact you with a new Provider Agreement to sign and return, if applicable.

Effective Date of Change: _____

GENERAL INFORMATION

Former Provider Name	Former TIN	Former NPI
New Provider Name	New TIN	New NPI

Do you want to participate in your existing networks under the new TIN, if applicable? ☐ Yes ☐ No

REQUIRED DOCUMENTS

- ☐ Facility Initial Credentialing Form and supporting documentation.
- ☐ Change of Ownership (CHOW), if applicable.

SUBMISSION INFORMATION

Individual Completing the Form	Date
Contact Email Address	Contact Phone Number

Return Form To: Email: network.administration@lblue.com



Add Practice Location Form

Complete this form when one or more individual providers are adding an additional practice location(s) to an existing record. *If linking to a new provider group or clinic, please complete the Link to Group or Clinic Request Form instead.*

Effective Date of Change: _____				Tax Identification Number: _____			
GENERAL INFORMATION							
This request is for: ☐ Individual Provider ☐ Multiple Individual Providers (attach roster with provider names/NPIs)							
Provider Name						NPI	
Group/Clinic Name						Group/Clinic NPI	
Person Completing This Form							
Contact Email Address					Contact Phone Number		
Signature of Authorized Representative					Date		
LOCATION TO BE ADDED							
Physical Address							
City, State and ZIP Code				Phone Number		Fax Number	
Accepting New Patients ☐ New ☐ Existing Only ☐ Other: _____				Age Range of Patients (check all that apply) ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____			
Office Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
Practice Hours (available appointment hours)	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
For this practice location (please select one option only): ☐ I am available to see patients at least 8 hours per week on a regular basis. ☐ I see patients here at least one day per month, but less than one day per week on a regular basis. ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only. ☐ I read tests or provide other services but do not see patients at this location. ☐ I do not practice here, but this location is within the medical group with which I am employed.							

LOCATION TO BE ADDED							
Physical Address							
City, State and ZIP Code				Phone Number		Fax Number	
Accepting New Patients ☐ New ☐ Existing Only ☐ Other: _____				Age Range of Patients (check all that apply) ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____			
Office Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
Practice Hours (available appointment hours)	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
For this practice location (please select one option only): ☐ I am available to see patients at least 8 hours per week on a regular basis. ☐ I see patients here at least one day per month, but less than one day per week on a regular basis. ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only. ☐ I read tests or provide other services but do not see patients at this location. ☐ I do not practice here, but this location is within the medical group with which I am employed.							
LOCATION TO BE ADDED							
Physical Address							
City, State and ZIP Code				Phone Number		Fax Number	
Accepting New Patients ☐ New ☐ Existing Only ☐ Other: _____				Age Range of Patients (check all that apply) ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____			
Office Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
Practice Hours (available appointment hours)	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
For this practice location (please select one option only): ☐ I am available to see patients at least 8 hours per week on a regular basis. ☐ I see patients here at least one day per month, but less than one day per week on a regular basis. ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only. ☐ I read tests or provide other services but do not see patients at this location. ☐ I do not practice here, but this location is within the medical group with which I am employed.							

LOCATION TO BE ADDED

Physical Address

City, State and ZIP Code

Phone Number

Fax Number

Accepting New Patients

☐ New ☐ Existing Only☐ Other: _____

Age Range of Patients (check all that apply)

☐ 0-6 years ☐ 7-11 years ☐ 12-18 years☐ 19-65 years ☒ Over 65 ☐ All Ages☐ Other: _____

Office Hours

Mon.

Tues.

Wed.

Thurs.

Fri.

Sat.

Sun.

____ - ____

____ - ____

____ - ____

____ - ____

____ - ____

____ - ____

____ - ____

Practice Hours

(available
appointment hours)

Mon.

Tues.

Wed.

Thurs.

Fri.

Sat.

Sun.

____ - ____

____ - ____

____ - ____

____ - ____

____ - ____

____ - ____

____ - ____

For this practice location (please select one option only):

- ☐ I am available to see patients at least 8 hours per week on a regular basis.
- ☐ I see patients here at least one day per month, but less than one day per week on a regular basis.
- ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.
- ☐ I read tests or provide other services but do not see patients at this location.
- ☐ I do not practice here, but this location is within the medical group with which I am employed.

Return Form To:

Email: network.administration@lblue.com



Add Facility Location Form

Complete this form when adding additional practice location(s) to an existing facility record.

Effective Date of Change: _____				Tax Identification Number: _____			
GENERAL INFORMATION							
Facility Name						Facility NPI	
Person Completing This Form							
Contact Email Address					Contact Phone Number		
Signature of Authorized Representative					Date		
CHECKLIST							
Before returning this form to Louisiana Blue, please attach the following:							
• A copy of relevant licensure for the location(s) • A copy applicable accreditation of the location(s) • A copy of the certificate of insurance for the location(s)							
LOCATION TO BE ADDED							
Physical Address							
City, State and ZIP Code				Phone Number		Fax Number	
Office Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
LOCATION TO BE ADDED							
Physical Address							
City, State and ZIP Code				Phone Number		Fax Number	
Office Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____

Return Form To: Email: network.administration@lblue.com



National Provider Identifier (NPI) Change Form

Blue Cross and Blue Shield of Louisiana requires that this form be completed in its entirety. You must include required supporting documentation as outlined in the "Required Attachments" section of this form.

Effective Date of Change: _____		Tax Identification Number: _____	
GENERAL INFORMATION			
Former Provider Name		Former NPI	
New Provider Name (if the same, please type "no change")		New NPI	
BILLING ADDRESS (for payment registers, reimbursement checks, etc.)			
Billing Address			
City, State and ZIP Code		Phone Number	Fax Number
Email Address			
MEDICAL RECORDS ADDRESS (for medical records request)			
Medical Records Address			
City, State and ZIP Code		Phone Number	Fax Number
Email Address			
CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)			
Correspondence Address			
City, State and ZIP Code		Phone Number	Fax Number
Email Address			
PHYSICAL ADDRESS (if more than one physical location, please attach list of all locations)			
Physical Address			
City, State and ZIP Code		Phone Number	Fax Number

Page 1 of 2

18NW3815 01/25

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

Accepting Patients (if applicable) ☐ New ☐ Existing ☐ Other: _____				Age Range of Patients (if applicable) ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____			
Office Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
Practice Hours (available appointment hours)	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____

For this practice location (please select one option only):

☐ I am available to see patients at least 8 hours per week on a regular basis.

☐ I see patients here at least one day per month, but less than one day per week on a regular basis.

☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only.

☐ I read tests or provide other services but do not see patients at this location.

☐ I do not practice here, but this location is within the medical group with which I am employed.

REQUIRED DOCUMENTS

☐ iLinkBlue and EFT agreements

☐ Administrative Representative Registration Form

SUBMISSION INFORMATION (form completed by)

Signature of Authorized Representative	Date
Contact Email Address	Contact Phone Number

Return Form To: Email: network.administration@lblue.com



Request for Termination

Complete this form to request termination from one or more of our networks **OR** to remove a facility or provider practice location. All applicable information must be completed on this form.

Please specify change:

- ☐ Full Termination
☐ Partial Termination (network specific)
☐ Remove Practice Location

Effective Date of Change: _____		Tax Identification Number: _____	
GENERAL INFORMATION			
Provider Type ☐ Facility ☐ Group/Clinic ☐ Individual Provider ☐ Other: _____			
Provider Name			NPI
If individual provider, are you part of a Group/Clinic? ☐ Yes ☐ No		If yes, what is the name of the affiliated Group/Clinic? Group/Clinic NPI	
Person Completing This Form			
Contact Email Address		Contact Phone Number	
Signature of Authorized Representative		Date	
NETWORKS BEING TERMINATED			
<u>Full Termination</u> ☐ Terminate Provider Record (claims can no longer be filed to Louisiana Blue for the Tax Identification Number listed above) <u>Reason for termination:</u> ☐ Left Group/Clinic ☐ Deceased ☐ Retired ☐ Closed Practice/Facility ☐ Moved Out of State ☐ Other: _____			
<u>Partial Termination</u> ☐ Terminate this provider from ALL networks (claims can still be filed to Louisiana Blue as a non-participating provider) ☐ Terminate this provider from the following network(s): ☐ HMO Louisiana, Inc. ☐ Blue Connect ☐ BlueHPN® ☐ Community Blue ☐ Precision Blue ☐ Signature Blue ☐ Dental ☐ FEP Preferred Dental ☐ Blue Advantage ☐ Medicare Select ☐ Other Please provide an explanation for terminating the network(s) checked above: _____ _____ _____			
<i>Note: Members who have seen the provider within the past 18 months are notified the provider no longer participates in the applicable networks being terminated.</i>			

-over-

LOCATION TO BE REMOVED

Physical Address

City

State

ZIP Code

LOCATION TO BE REMOVED

Physical Address

City

State

ZIP Code

LOCATION TO BE REMOVED

Physical Address

City

State

ZIP Code

Return Form To:Email: PCDMstatus@lblue.com



Link to Group or Clinic Request Form

Complete this form when an individual provider is linking to a provider group or clinic. You must include a copy of the Malpractice Liability Insurance Certificate for the physical location you are linking to. If you are linking to a new provider group or clinic that is not already set up with Louisiana Blue, please also fully complete and include the iLinkBlue agreement packet (includes an electronic funds transfer application); available online at www.lablue.com/providers >Electronic Services >iLinkBlue. *To link to more than two physical locations, make a copy of Page 2 of this form.*

GENERAL INFORMATION

Individual Provider Last Name	First Name	Middle Initial
Individual Provider NPI	Languages Spoken	
Group/Clinic Name	Group/Clinic NPI	
Group/Clinic Tax Identification Number	Effective Date	
What is your specialty?	Are you practicing as a primary care provider (PCP)? ☐ Yes ☐ No	

BILLING ADDRESS (for payment registers, reimbursement checks, etc.)

Billing Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

MEDICAL RECORDS ADDRESS (for medical records request)

Medical Records Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

CORRESPONDENCE ADDRESS (for general provider communications, letters, newsletters, etc.)

Correspondence Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

PHYSICAL ADDRESS

Physical Address		
City, State and ZIP Code	Phone Number	Fax Number
Email Address		

Type of Practice ☐ Solo ☐ Group/Clinic ☐ Hospital-based ☐ Hospital-employed							
Accepting New Patients ☐ New ☐ Existing Only ☐ Other: _____		Age Range of Patients (check all that apply) ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____					
Office Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
Practice Hours (available appointment hours)	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
For this practice location (please select one option only): ☐ I am available to see patients at least 8 hours per week on a regular basis. ☐ I see patients here at least one day per month, but less than one day per week on a regular basis. ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only. ☐ I read tests or provide other services but do not see patients at this location. ☐ I do not practice here, but this location is within the medical group with which I am employed.							
PHYSICAL ADDRESS							
Physical Address							
City, State and ZIP Code				Phone Number		Fax Number	
Email Address							
Type of Practice ☐ Solo ☐ Group/Clinic ☐ Hospital-based ☐ Hospital-employed							
Accepting New Patients ☐ New ☐ Existing Only ☐ Other: _____		Age Range of Patients (check all that apply) ☐ 0-6 years ☐ 7-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other: _____					
Office Hours	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
Practice Hours (available appointment hours)	Mon. ____ - ____	Tues. ____ - ____	Wed. ____ - ____	Thurs. ____ - ____	Fri. ____ - ____	Sat. ____ - ____	Sun. ____ - ____
For this practice location (please select one option only): ☐ I am available to see patients at least 8 hours per week on a regular basis. ☐ I see patients here at least one day per month, but less than one day per week on a regular basis. ☐ I cover or fill-in for colleagues within the same medical group on an as-needed basis only. ☐ I read tests or provide other services but do not see patients at this location. ☐ I do not practice here, but this location is within the medical group with which I am employed.							

CHECKLIST

Before returning this form to Louisiana Blue, please ensure the following:

- ☐ This form is fully completed, including the effective date of link
- ☐ A copy of the Malpractice Liability Insurance Certificate is attached
- ☐ This form is signed and dated
- ☐ Only if a new group or clinic not already on file with Louisiana Blue, a completed iLinkBlue agreement packet is included (available online at www.lablue.com/providers > Electronic Services > iLinkBlue)

SUBMISSION INFORMATION (form completed by)

Signature of Authorized Representative	Date
Contact Email Address	Contact Phone Number

Return Form To: Email: network.administration@lablue.com



Electronic Funds Transfer (EFT) Termination/Change Form

To **stop** receiving your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT) or to **change** your EFT information, please complete the following information:

TERMINATION/CHANGE REQUEST

- ☐ Please **terminate** me from the EFT program.
- ☐ Please **change** my EFT information as reflected below.

CONSENT

If changing my EFT information, I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.

If changing my EFT information, I hereby authorize the financial institution/bank named below, hereinafter called BANK, to credit and/or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the iLinkBlue.

PROVIDER INFORMATION

Provider Name

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI)

Group NPI (if applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name

Title

Phone Number

Email Address

Fax Number

FINANCIAL INSTITUTION INFORMATION

Former Financial Institution Name

Former Account Type at Financial Institution

Former Financial Institution Account Number

Former Financial Institution Routing Number

New Financial Institution Name

New Account Type at Financial Institution

New Financial Institution Account Number

New Financial Institution Routing Number

SUBMISSION INFORMATION

Indicate Type of Enrollment Submission included:

- ☐ Voided Check (*temporary checks are not accepted*) ☐ Bank Letter

Authorized Signature

- ☐ For change request:
This information is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act on it. An EFT Termination/Change Form must be completed if **any** of the above information changes.
- ☐ For termination request:
This information is to be removed from my account and remain in full force and effect until COMPANY has received written notification from me of new EFT information.

Written Signature of Person Submitting Enrollment

Printed Name of Person Submitting Enrollment

Submission Date

If you have any questions about this form or your EFT enrollment status, please contact Provider Credentialing & Data Management at:

Phone: 1-800-716-2299, option 2

Email: PCDMstatus@lblue.com

Page 2 of 2



Overpayment Notification Form

Complete this form to notify us of a possible overpayment for claims processed directly by BCBSLA for a Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana, Inc. (HMOLA), Federal Employee Program (FEP) or BlueCard® (out-of-area) member. Please fully complete the requested information on this form to ensure proper processing.

Member ID: _____
(please include the three-character prefix or "R" for FEP members)

Do not send a check or payment with this form. Submit the form only.

Adjustments will be reflected on your future payment register(s).

PATIENT INFORMATION

Patient's Full Name	Date of Birth
Claim Number	Patient Account Number

REFUND INFORMATION

Date(s) of Service	Estimated Amount of Overpayment
Reason You Believe Overpayment Has Occurred	

PROVIDER INFORMATION

Provider Name	National Provider Identifier (NPI)
Provider Address	
Name of Person Completing Form	Contact Phone Number
Date Form Completed	Contact Email Address

Please refer to the instructions on the back of this form for more ways to submit overpayment notifications to BCBSLA, as well as information on how to submit this form.

In Lieu of Submitting this Form

You may instead submit an Action Request through iLinkBlue (www.BCBSLA.com/ilinkblue). Go to the claim thought to be overpaid in iLinkBlue and submit an Action Request to have the claim reviewed for correct processing. To do this, click the "AR" button from the Claims Results screen or the "Action Request" button from the Claim Details screen to open a form that prepopulates with information on the specific claim. Please include your contact information. Please only submit one Action Request per claim; not one Action Request per line item of the claim. For more information on this process, please refer to our *iLinkBlue User Guide*, available online at www.BCBSLA.com/providers >Resources >Manuals.

Instructions for BlueCard (out-of-area) Claims

For BlueCard members, do not send a check (payment) with this form. Submit the form only. All adjustments will be reflected on your future payment register(s). BCBSLA cannot accept payments for BlueCard members. If an unsolicited refund payment is received for a BlueCard member, it will be returned with a letter requesting an Overpayment Notification Form be submitted. You may instead submit an Action Request in lieu of the form.

General Refund Information

Upon submitting this form:

- If it is determined that an overpayment did occur, you will not receive further notification from us. The claim will be adjusted, and your payment register will reflect the change.
- If it is determined that an overpayment did not occur, you will receive notification explaining that no adjustment to the claim is necessary.

When BCBSLA discovers the overpayment:

- If it is determined that a provider has received an overpayment and has not yet informed us, Blue Cross will send notification requesting the provider respond either agreeing or appealing the overpayment within 30 days. For FEP members, the provider has 120 days to respond.
- After the applicable provider review period, the claim is adjusted and will be reflected on the provider's future payment register(s).

Return Form To:

BCBSLA Correspondence
P.O. Box 98029
Baton Rouge, LA 70898-9029

or Fax: (225) 297-2727
Attn: BCBSLA Correspondence

A printable version of this Overpayment Notification Form is available online at www.BCBSLA.com/providers >Resources >Forms.

If you have questions about this process, you may contact the Customer Care Center at 1-800-922-8866.



Authorization Form

Fax: 1-800-586-2299

Providers must submit authorization requests, including new and extension authorizations prior to the service being performed through our online Louisiana Blue Authorizations application. Louisiana Blue will not accept authorization requests via phone or fax, except in certain circumstances. Exceptions include transplants, dental services covered under medical, newborn sick babies, temporary members, most out-of-state services, and Carelon Medical Benefits Management (Carelon) inpatient authorization extensions and discharges. It is important to always verify member eligibility and benefits before rendering services. Providers can find the list of services that require authorization available online at www.lablue.com/providers > Resources.

Complete this form to submit authorizations for Louisiana Blue and HMO Louisiana, Inc. members for inpatient, outpatient and offices services that require an authorization directly from our authorization department. Our fax line is open Monday through Friday from 8:00 a.m. to 4:30 p.m. central time. Do not use this form for authorizations processed by Carelon, Express Scripts, Inc., etc.

Failure to fully complete this form could delay your authorization processing.

PATIENT DATA	Last Name	First Name	Middle Initial
Member/Subscriber ID Number			Date of Birth
CLINICAL DATA	☐ Inpatient Admit/Surgery ☐ Outpatient Procedure/Service ☐ DME ☐ Office		
Diagnosis Code(s) (ICD-10)		CPT/HCPCS Code(s) DME Requests (Include the purchase price for each code)	
Number of Visits Requested (If Applicable)		Date of Service/Admit Date	
REQUESTING PHYSICIAN	Last Name	First Name	Middle Initial
Address		Phone Number	Fax Number
NPI (National Provider Identifier) Number:			
FACILITY INFORMATION	Name		
Address		Phone Number	Fax Number
NPI (National Provider Identifier) Number:			

P.O. Box 98031, Baton Rouge, Louisiana 70898-9031 • Phone: 1-800-523-6435 • Fax: 1-800-586-2299

18NW2302 R01/26

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Carelon Medical Benefits Management (Carelon) is an independent company that serves as an authorization manager for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.



CONTACT PERSON	Name	Phone Number	Fax Number
Additional Information:			
Note: Inpatient Hospital Admissions in connection with childbirth do not require authorization. The authorization process is based on medical necessity only and is <u>not</u> a guarantee of payment. Services/procedures are subject to review by Louisiana Blue for contractual limitations or exclusions. Some policies apply penalties for failing to request prior authorization for specific services. Other policies will not cover a service without prior authorization. For urgent inpatient admissions, except those in connection with childbirth, you must notify Louisiana Blue of that admission within 48 hours or the next business day, to avoid penalties or non-coverage. If you are unsure if a policy allows for retrospective review, contact Customer Care at 1-800-922-8866. Always verify eligibility and benefits before providing services by contacting Customer Care or using iLinkBlue (www.lablue.com/ilinkblue).			



Retrospective Review Authorization Form

Fax completed form to 1-800-515-1150

Complete this form to submit retrospective authorizations for Blue Cross and Blue Shield of Louisiana (Louisiana Blue) and HMO Louisiana, Inc. members for inpatient, outpatient and office services that require an authorization. **Retrospective review requests have up to a 30-day response time.** Do not use this form for authorizations processed by Caredon Medical Benefits Management (Caredon), Express Scripts, Inc., etc.

Do not submit a request for retrospective review if you filed a claim. If we require additional medical records, Medical Management will request them using the Medical Records Request for Claim Review form.

Medical Records can be faxed or uploaded in iLinkBlue (www.lablue.com/ilinkblue). Click on the Document Upload link on the main page then select "Medical Records for Retrospective or Post Claim Review" from the department drop down. *Failure to fully complete this form could delay your authorization processing.*

PATIENT DATA	Last Name		First Name	MI
Member ID		Date of Birth		
CLINICAL DATA	☐ Inpatient Admit/Surgery	☐ Outpatient Procedure/Service	☐ Ambulatory Surgery	☐ Outpatient Hospital
Diagnosis Code(s) (ICD-10)		CPT® Code(s)		
Number of Visits Requested (If Applicable)		Date of Service/Admit Date (Start Date – End Date)		
REQUESTING PHYSICIAN	Last Name		First Name	MI
National Provider Identifier (NPI)		Phone Number	Fax Number	
Address				
FACILITY INFORMATION	Name			
National Provider Identifier (NPI)		Phone Number	Fax Number	
Address				
CONTACT PERSON	Name		Phone Number	Fax Number
Additional Information:				
Note: Inpatient Hospital Admissions in connection with childbirth do not require authorization. The authorization process is based on medical necessity only and is <u>not</u> a guarantee of payment. Services/procedures are subject to review by Louisiana Blue for contractual limitations or exclusions. Some policies apply penalties for failing to request prior authorization for specific services. Other policies will not cover a service without prior authorization. For urgent inpatient admissions, except those in connection with childbirth, you must notify Louisiana Blue of that admission within 48 hours or the next business day, to avoid penalties or non-coverage. If you are unsure if a policy allows for retrospective review, contact Customer Care at 1-800-922-8866. Always verify eligibility and benefits before providing services by contacting Customer Care or using iLinkBlue (www.lablue.com/ilinkblue).				

P.O. Box 98031, Baton Rouge, Louisiana 70898-9031 • Phone: 1-800-922-8866 • Fax: 1-800-515-1150

18NW3245 R01/26

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LOUISIANA UNIFORM PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

SECTION I — SUBMISSION

Submitted to: Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc./Express Scripts	Phone: 1-800-842-2015	Fax: 1-877-251-5896	Date:
--	--------------------------	------------------------	-------

SECTION II — PRESCRIBER INFORMATION

Last Name, First Name MI:		NPI# or Plan Provider #:		Specialty:	
Address:		City:		State:	ZIP Code:
Phone:	Fax:	Office Contact Name:		Contact Phone:	

SECTION III — PATIENT INFORMATION

Last Name, First Name MI:		DOB:	Phone:	☐ Male	☐ Female
				☐ Other	☐ Unknown
Address:		City:		State:	ZIP Code:
Plan Name (if different from Section I):	Member or Medicaid ID #:	Plan Provider ID:			
Patient is currently a hospital inpatient getting ready for discharge? ____ Yes ____ No Date of Discharge: _____					
Patient is being discharged from a psychiatric facility? ____ Yes ____ No Date of Discharge: _____					
Patient is being discharged from a residential substance use facility? ____ Yes ____ No Date of Discharge: _____					
Patient is a long-term care resident? ____ Yes ____ No If yes, name and phone number: _____					
EPSDT Support Coordinator contact information, if applicable: _____					

SECTION IV — PRESCRIPTION DRUG INFORMATION

Requested Drug Name:						
Strength:	Dosage Form:	Route of Admin:	Quantity:	Days' Supply:	Dosage Interval/Directions for Use:	Expected Therapy Duration/Start Date:
To the best of your knowledge this medication is: ____ New therapy/Initial request ____ Continuation of therapy/Reauthorization request						
For Provider Administered Drugs only:						
HCP/PCS/CPT-4 Code:		NDC#:		Dose Per Administration:		
Other Codes: _____						
Will patient receive the drug in the physician's office? ____ Yes ____ No						
– If no, list name and NPI of servicing provider/facility: _____						

SECTION V — PATIENT CLINICAL INFORMATION

Primary diagnosis relevant to this request:		ICD-10 Diagnosis Code:	Date Diagnosed:
Secondary diagnosis relevant to this request:		ICD-10 Diagnosis Code:	Date Diagnosed:
For pain-related diagnoses, pain is: ____ Acute ____ Chronic			
For postoperative pain-related diagnoses: Date of Surgery _____			
Pertinent laboratory values and dates (attach or list below):			
Date	Name of Test	Value	

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SECTION VI - This Section For Opioid Medications Only

Does the quantity requested exceed the max quantity limit allowed? ____Yes ____No (If yes, provide justification below.)

Cumulative daily MME _____

Does cumulative daily MME exceed the daily max MME allowed? ____Yes ____No (If yes, provide justification below.)

	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
SHORT AND LONG-ACTING OPIOIDS			A. A complete assessment for pain and function was performed for this patient.
			B. The patient has been screened for substance abuse / opioid dependence . <i>(Not required for recipients in long-term care facility.)</i>
			C. The PMP will be accessed each time a controlled prescription is written for this patient.
			D. A treatment plan which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			E. Criteria for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			F. Benefits and potential harms of opioid use have been discussed with this patient.
			G. An Opioid Treatment Agreement signed by both the patient and prescriber is on file. <i>(Not required for recipients in long-term care facility.)</i>
LONG-ACTING OPIOIDS			H. The patient requires continuous around the clock analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			I. Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in pharmacologic/non-pharmacologic treatment section below.
			J. Medication has not been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			K. Medication has not been prescribed for use as an as-needed (PRN) analgesic.
			L. Prescribing information for requested product has been thoroughly reviewed by prescriber.
IF NO FOR ANY OF THE ABOVE (A-L), PLEASE EXPLAIN:			

SECTION VII - Pharmacologic & non-pharmacologic treatment(s) used for this diagnosis (both previous & current):

Drug name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason
Drug Allergies:			Height (if applicable):	Weight (if applicable):
Is there clinical evidence or patient history that suggests the use of the plan's pre-requisite medication(s), e.g. step medications, will be ineffective or cause an adverse reaction to the patient? ____Yes ____No (If yes, please explain in Section VIII below.)				

SECTION VIII — JUSTIFICATION (SEE INSTRUCTIONS)

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Signature of Prescriber: _____

Date: _____



Guide to Completing the EFT Enrollment Form

Blue Cross and Blue Shield of Louisiana requires that participating providers enroll in our electronic funds transfer (EFT) service. EFT allows providers to receive payment electronically directly into their accounts. You can complete the EFT Enrollment Form at www.lablue.com/providers >Resources. The following information should help you complete the form.

1 CONSENT

The consent legally allows Louisiana Blue to electronically transfer funds to your financial account. The provision for Louisiana Blue to deduct funds applies when an erroneous credit occurs to a financial account resulting, for example, from a banking error.

2 PROVIDER INFORMATION

Provider Name – Complete legal name of institution, corporate entity, practice or individual provider

Street Address – The number and street name where a person or organization can be found

City – City associated with provider address field

State/Province – The two-character code associated with the State/Province/Region of the applicable country

ZIP Code/Postal Code – System of postal-zone codes (ZIP stands for “zone improvement plan”) introduced in the U.S. in 1963 to improve mail delivery and utilize electronic reading and sorting capabilities

3 PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN)/Employer Identification Number (EIN) – A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity

National Provider Identifier (NPI) – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted by HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Group NPI (if applicable) – If part of a provider group, please also report the NPI for your group

4 PROVIDER CONTACT INFORMATION

Provider Contact Name – Name of a contact in provider office for handling ERA issues

Title – Title of the contact person

Telephone Number – Associated with the contact person

Email Address – An electronic mail address at which the health plan might contact the provider

Fax Number – A number at which the provider can be sent facsimiles

5 RETAIL PHARMACY INFORMATION *(this section should be completed by pharmacies only)*

Pharmacy Name – Complete name of pharmacy

NCPDP Provider ID Number – The NCPDP-assigned unique identification number

6 FINANCIAL INSTITUTION INFORMATION

Financial Institution Name – Official name of the provider's financial institution

Financial Institution Routing Number – The nine-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited

Type of Account at Financial Institution – The type of account the provider will use to receive EFT payments (e.g., checking, savings, etc.)

Provider's Account Number with Financial Institution – The provider's account number at the financial institution to which EFT payments are to be deposited

Account Number Linkage to Provider Identifier – Choose, then enter either the Provider TIN or NPI for the purpose of grouping (bulking) claim payments. Provider preference for grouping (bulking) claim payments must match preference for v5010 X12 835 remittance advice.

7 SUBMISSION INFORMATION

Reason for Submission

- **New Enrollment** – Check to indicate applying for new EFT enrollment

Include with Enrollment Submission

- **Voided Check** – A voided check is attached to provide confirmation of Identification/Account Numbers. Temporary checks are not accepted.

or

- **Bank Letter** – A letter on bank letterhead that formally certifies the account owners routing and account numbers

Authorized Signature – The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment

Written Signature of Person Submitting Enrollment – The (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity

Printed Name of Person Submitting Enrollment – The printed name of the person signing the form

Submission Date – The date on which the enrollment is submitted

Providers should contact their financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. Shown below are the Data Elements that are necessary for re-association:

CCD Record #	Field #	Field Name
5	9	Effective Entry Date
6	6	Amount
7	3	Payment Related Information

Late/Missing EFT and ERA Transactions Resolution Procedures:

ERA (835) files are available weekly in trading partner mailboxes on Mondays, and no later than Wednesday, except during holidays or unexpected office closures. If you do not receive your ERA by close of business on Wednesday, you may contact EDI Services at 1-800-716-2299, option 3 or email EDIservices@lblue.com. Please include the Trading Partner ID, check number, check amount, check date and NPI.

EFT Transactions are typically available at the provider's bank on Wednesday. If you have not received your deposit by close of business on Wednesday, you may contact the Customer Care Center at 1-800-922-8866.

For questions about the ERA Form, please contact EDI Services at 1-800-716-2299, option 3. Also visit www.lblue.com/providers >Electronic Services >Clearinghouse.

To check the status of your ERA Form, you may submit your **request** via email to EDIservices@lblue.com. Please include the provider or group name, NPI, TIN or EIN and Trading Partner ID. Please allow three to five business days for setup.

To check the status of your EFT Enrollment or EFT Change Form, you may submit your request via email to PCDMstatus@lblue.com. Please include the provider or group name, NPI and TIN or EIN. Please allow up to five business days for new setups.

Provider's NPI must already be on file with Louisiana Blue. For more information on reporting your NPI to Louisiana Blue, visit www.lblue.com/providers >NPI or you may contact Provider Credentialing & Data Management at 1-800-716-2299, option 2.

Louisiana Blue does not set up ERAs for out-of-state providers.



Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See included Guide to Completing the EFT Enrollment Form for detailed instructions.

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and to initiate adjustment for any credit entries made in error to the account indicated below.

I hereby authorize the financial institution/bank named below, hereinafter referred to as BANK, to credit and/ or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in iLinkBlue.

PROVIDER INFORMATION

Provider Name

Provider Address: Street

City

State/Province

ZIP Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI)

Group NPI (if applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name

Title

Telephone Number

Email Address

Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name

NCPDP Provider ID Number

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution Routing Number

Type of Account at Financial Institution

Provider's Account Number with Financial Institution

Account Number Linkage to Provider Identifier

☐ Provider Tax Identification Number (TIN): _____

☐ National Provider Identifier (NPI): _____

SUBMISSION INFORMATION

Reason for Submission

☐ New Enrollment

Include with Enrollment Submission

☐ Voided Check (*temporary checks are not accepted*)

or

☐ Bank Letter

Authorized Signature

I hereby acknowledge that the information provided on this form is true and correct. I further authorize COMPANY to utilize and rely on the information contained in this form until such time as I submit reasonable advance written notice to Company that this authorization has been terminated. I additionally acknowledge and agree that, in the event that any of the information I have provided on this form changes or becomes inaccurate, I must immediately submit an EFT Termination/Change Form containing such information necessary to correct such changed or inaccurate information.

Written Signature of Person Submitting Enrollment

Printed Name of Person Submitting Enrollment

Submission Date

If you have any questions about this form or your EFT enrollment status, please contact Provider Credentialing & Data Management at:

Phone: 1-800-716-2299, option 2

Email: PCDMstatus@lblue.com

For internal use only:

iLB set up complete.