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SECTION 1: USER REGISTRATION
SECTION 1: USER REGISTRATION

To start the registration process, go to http://www.bcbsvt.com.

1. Select “Provider” option under “Login” to access the Provider Resource Center.
2. Select “Register Now” to start the provider registration process. The provider or office manager should be the first to register, as the local administrator role is automatically assigned to the first user. (The local administrator can add additional users.)
SECTION 1: USER REGISTRATION (CONT.)

3. Confirm you are the appropriate person for the local administrator role.

Provider Resource Center Registration

If you are the first individual registering for your practice/office you will be assigned the role "Local Administrator." This means, you will have access to:

- All standard features of the Provider Resource Center (same access as a "user")
- Plus, the System Administrator feature for setting up and overseeing all other users of the registered practice/office (restricted access for Local Administrators only)

Typically, the "Local Administrator" is assigned to the office manager of the practice/office. However, local administrator rights can be assigned to more than one person at the practice/office.

**ATTENTION BILLING SERVICES:** Your registration request will deny, as access is granted through the practice Local Administrator.

I am the appropriate person for the "Local Administrator" role, continue to registration »
4. Enter required information. Be sure to make note of your username and password. Confirmation will be sent to the email address you provide.
5. Enter your office information and select “Next.” (Do **NOT** enter hyphens in the tax ID field.)
7. Make a note of your username and password. You will **NOT** be able to return to this page once you select “Next.”
8. You have completed your registration. Once your application is processed, you will be notified via email whether it has been approved or denied.
SECTION 1: USER REGISTRATION (CONT.)

Are you a provider in our Vermont Blue Advantage (VBA) network? Please register separately at the link below for access to the VBA portal and these services:

- Check member eligibility and benefits
- Review claims status
- Find forms and other resources
- Search the provider and facility directory
- Access guidelines and other materials

https://www.vermontblueadvantage.com/pages/providers
SECTION 2:
SYSTEM ADMINISTRATOR – VIEWING USERS
SECTION 2: SYSTEM ADMINISTRATOR – VIEWING USERS

1. Only the local administrator can edit users. Select “System Administrator.”
2. “User Maintenance” will appear, listing all users on your practice’s access list.

<table>
<thead>
<tr>
<th>User Name</th>
<th>Office Security</th>
<th>Company Name</th>
<th>Company ID Number</th>
<th>User ID</th>
<th>Last Login</th>
<th>User Status</th>
<th>User Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally Jones</td>
<td>user</td>
<td>Provider</td>
<td>98765312</td>
<td>Sjon1</td>
<td>05/11/2018</td>
<td>confirmed</td>
<td>13685</td>
</tr>
<tr>
<td>M. Smith</td>
<td>user</td>
<td>Provider</td>
<td>98765312</td>
<td>Msmit1</td>
<td>03/01/2018</td>
<td>confirmed</td>
<td>1358</td>
</tr>
<tr>
<td>John Smith</td>
<td>user</td>
<td>Provider</td>
<td>98765312</td>
<td>Jsmi5</td>
<td>04/28/2018</td>
<td>confirmed</td>
<td>1258</td>
</tr>
</tbody>
</table>
SECTION 3:
SYSTEM ADMINISTRATOR – EDITING USER INFORMATION
SECTION 2: SYSTEM ADMINISTRATOR – EDITING USER INFORMATION

1. Only the local administrator can edit users. Select “System Administrator.”
2. “User Maintenance” will appear, listing all users on your practice’s access list. Click on the user’s name.
3. Make the appropriate changes, then click “Submit.”
SECTION 4:
SYSTEM ADMINISTRATOR – ADDING A NEW USER
SECTION 2: SYSTEM ADMINISTRATOR – ADDING A NEW USER

1. Only the local administrator can edit users. Select “System Administrator.”
2. Select “Add User.”
3. Enter all required information.
4. Select “Add.”
SECTION 2: SYSTEM ADMINISTRATOR – ADDING A NEW USER (CONT.)

5. Select a user role from the drop-down menu. (The user will not be added unless a role is selected. See next page for a description of user roles.)
6. Select “Select Role.”
7. Click “Submit.”
SECTION 2: SYSTEM ADMINISTRATOR – ADDING A NEW USER (CONT.)

Provider Resource Center Functions
General Content:
• Resource Center Page
• Provider Search
• Tools and Resources
• Reports

Eligibility and Benefits:
• Eligibility and Benefit Inquiries
• Accumulators (Benefit Usage Information)

Claims Inquiries:
• Claim Status Inquiries, including realtime
• Clear Claims Connect (C3) Tool
• Prior Authorizations (Acuity Connect)
• Provider Vouchers (Remittance Advices), Capitation Vouchers

System/Local Administrator:
• Add/remove users; edit user information

User Roles – Access Levels
Office Manager (also called Local Administrator), Office Manager w/o Demographics
• General Content
• Eligibility/Benefits
• Claims Inquiry
• System Administrator
• Provider Vouchers (Remittance Advices), Capitation Vouchers
• Acuity Connect (on-line prior approval)

Provider, General Staff:
• General Content
• Eligibility/Benefits
• Claims Inquiry
• Provider Vouchers (Remittance Advices), Capitation Vouchers
• Acuity Connect

Admitting Staff:
• General Content
• Eligibility/Benefits
SECTION 5:
SYSTEM ADMINISTRATOR – REMOVING USERS
SECTION 5: SYSTEM ADMINISTRATOR – REMOVING USERS

1. Only the local administrator can remove users. Select “System Administrator.”
2. “User Maintenance” will appear, listing all users on your practice’s access list. Click on the name of the user you want to remove.
3. Check the box next to the user’s role.
4. Click “Remove”.

![User Maintenance screen with options to add or remove users.](image)
SECTION 5: SYSTEM ADMINISTRATOR – REMOVING A USER (CONT.)

5. Indicate reason for removing user, e.g., “No longer employed by practice.”
6. Select “Yes.”
7. A confirmation screen will appear.

![Confirmation Screen]

5
6
7.

User Registration Successfully Removed
The user registration has been successfully removed.
SECTION 6:
ELIGIBILITY, BENEFITS AND ACCUMULATORS – BCBSVT MEMBERS
SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – BCBSVT MEMBERS

1. Select “Search Patients” under “Patient Management.”
2. Enter patient information by last, first name format or by member ID number.
3. Select “Search”
SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – BCBSVT MEMBERS (CONT.)

4. To continue to benefits and accumulator information, click “Select.” Member name will display in “Current Patient” box. See next page for additional instructions.

5. To view member’s prefix and benefit summary, select patient’s name. Be sure to choose the patient record with the ID number starting with “V” to view current records.

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Birth Date</th>
<th>Address</th>
<th>Phone</th>
<th>ID</th>
<th>Primary Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOE, JOHN M</td>
<td>M</td>
<td>09/01/2013</td>
<td>Smith Street, VT</td>
<td>(802) 123-4567</td>
<td>1234567891</td>
<td></td>
</tr>
<tr>
<td>DOE, JOHN M</td>
<td>M</td>
<td>09/01/2013</td>
<td>Smith Street, VT</td>
<td>(802) 123-4567</td>
<td>V1234567891000</td>
<td></td>
</tr>
<tr>
<td>DOE, JOHN A</td>
<td>M</td>
<td>04/28/1954</td>
<td>Smith St, VT</td>
<td>(802) 234--5678</td>
<td>2345678912</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – BCBSVT MEMBERS (CONT.)

7. Once you have clicked “Select,” member’s name appears in the box under “Current Patient.”

8. Select “Eligibility” under “Patient Management.”
9. This will bring up the patient record in “Realtime Eligibility inquiry.”

**Real-time Eligibility Inquiry**

**Job Aides**

Our [eligibility job aides](#) give a general overview of how to conduct eligibility requests, as well as how to run specific requests based on provider/facility type.

**BCBSVT Members - Prepopulated Fields**

Conduct a patient search, then click on the eligibility link under patient management. The selected patient’s information will prepopulate in the patient ID field and subscriber information fields - even if they are not the subscriber. Subscriber ID numbers end in 001, all other ending values (e.g., 002, 003, etc.) are dependents.

**BlueCard or FEP Members**

To check eligibility for BlueCard or FEP members, click on the eligibility link under Office Management. Then complete the following **REQUIRED FIELDS:**

1. Subscriber Full Name
2. Subscriber Date of Birth (only required if Subscriber is the patient.)
3. Patient Full Name & Birth Date (only required if Patient is NOT the Subscriber)
   - Do not include suffix (Jr, Sr, III, etc.) when entering the last name.
4. Patient ID – including ALPHA PREFIX (example: ZIA9999999900 | FEP example: R9999999900)
5. Requesting Provider
   - By name - use format last name or last name, first name (example: Smith or Smith, John)
   - By Provider NPI - enter the individual billing provider’s NPI, the group they are associated with.

For Telemedicine Services provided to a patient, select ‘Consultation (3)’ from the Service Type drop-down.

*Please Note:* Accumulated or remaining benefit amounts may not be returned for directive benefit inquiries.

**Eligibility Search**

Conduct Eligibility Search

**Subscriber Information**

<table>
<thead>
<tr>
<th>First</th>
<th>Last</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOHN</td>
<td>DOE</td>
<td>08/12/1955</td>
</tr>
</tbody>
</table>
10. The patient name searched for will appear in the “subscriber name” field even if the member is not the subscriber. If the member number on the “Eligibility Inquiry Prepopulated Form” (see page 25) ends in anything other than 01, this is NOT the subscriber.
11. Search “Requesting Provider” by name (last name, first name format) or by NPI.

<table>
<thead>
<tr>
<th>Eligibility Search</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subscriber Information</strong></td>
<td></td>
</tr>
<tr>
<td>Subscriber Name</td>
<td>First: John, Last: Doe</td>
</tr>
<tr>
<td><strong>Patient Information (required if not the subscriber)</strong></td>
<td></td>
</tr>
<tr>
<td>Patient Name</td>
<td>First:</td>
</tr>
<tr>
<td>Member ID</td>
<td>V12345678910001</td>
</tr>
<tr>
<td>As of</td>
<td>12/18/2020</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
</tr>
<tr>
<td>Requesting Provider</td>
<td><strong>Name</strong>: Jones, D</td>
</tr>
<tr>
<td>Service Type</td>
<td><strong>Health Benefit Plan Coverage (30)</strong></td>
</tr>
</tbody>
</table>

---

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
12. Click on “Select” to choose the appropriate provider.
13. On the next screen, select “Service Type” from the drop-down.
14. Select “Search.”
SECTION 6: MEMBER ELIGIBILITY, BENEFITS & ACCUMULATORS – BCBSVT MEMBERS (CONT.)

15. Review eligibility details.
16. Review benefit.

<table>
<thead>
<tr>
<th>Product</th>
<th>Exclusive Provider Organization</th>
<th>Eligibility/Benefit Start Date</th>
<th>Eligibility/Benefit End Date</th>
<th>Contract Status</th>
<th>Relationship</th>
<th>Payer Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Jan 1, 2016</td>
<td>Dec 31, 9999</td>
<td>Active - Pending Investigation</td>
<td>Self</td>
<td>Name: Phone:</td>
</tr>
</tbody>
</table>

Coord of Benefits Start Date: [ ]
Coord of Benefits End Date: [ ]

Additional Information:

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Level</th>
<th>Copay</th>
<th>Coinsurance</th>
<th>Active</th>
<th>Benefit Start/End Dates</th>
<th>Ref/Auth Required</th>
<th>Benefit Limit</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Visit - Office: Well (Office)</td>
<td>Individual</td>
<td>0%</td>
<td>N/A</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Chiropractic (Office)</td>
<td>Individual</td>
<td>$40</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

In Network as of Jul 5, 2016
17. Select the appropriate accumulator. (Field will expand to show details.)

<table>
<thead>
<tr>
<th>Deductible Information</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Information Remaining As of Dec 13, 2018</td>
<td></td>
</tr>
<tr>
<td>Out of Pocket Maximum</td>
<td></td>
</tr>
<tr>
<td>Out of Pocket Information Remaining As of Dec 13, 2018</td>
<td></td>
</tr>
<tr>
<td>Benefit Limits</td>
<td></td>
</tr>
<tr>
<td>Benefit Limit Information Remaining As of Dec 13, 2018</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 7: REALTIME BENEFIT, ELIGIBILITY & ACCUMULATORS
SECTION 7: REALTIME BENEFIT, ELIGIBILITY & ACCUMULATORS

Use these instructions for eligibility and benefits of Federal Employee Program (FEP) members and Blue Card members (out-of-state Blue Cross Blue Shield members).

1. Select “Eligibility” under “Office Management.”
2. This will bring you to the “realtime Eligibility Inquiry” page.
3. Complete these mandatory fields:
   - Subscriber full name
   - Subscriber date of birth

4. If patient is not the subscriber, also complete these mandatory fields:
   - Patient full name
   - Patient date of birth
   - Patient ID, including alpha prefix and member number (Ex: R9999999900)
   - Requesting provider
   - Service type. For all benefits, select “Health Benefit Plan Coverage (30)”

5. Select “Search.”
SECTION 7: REALTIME BENEFIT, ELIGIBILITY & ACCUMULATORS (CONT.)

6. Review eligibility details.

7. Review benefit.

<table>
<thead>
<tr>
<th>Product</th>
<th>EXCLUSIVE PROVIDER ORGANIZATION</th>
<th>Eligibility/Benefit Start Date</th>
<th>Jan 1, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Premium Paid Through Date</td>
<td>Eligibility/Benefit End Date</td>
<td>Dec 31, 9999</td>
</tr>
<tr>
<td></td>
<td>Grace Period Start Date</td>
<td>Contract Status</td>
<td>Active - Pending Investigation</td>
</tr>
<tr>
<td></td>
<td>Grace Period End Date</td>
<td>Relationship</td>
<td>Self</td>
</tr>
<tr>
<td></td>
<td>Group</td>
<td>Payer Contact Information</td>
<td>Name: Bluecard Eligibility Phone: (800)676-2563</td>
</tr>
<tr>
<td></td>
<td>Coord. of Benefits Start Date</td>
<td>Coord. of Benefits End Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional Information</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Level</th>
<th>Copay</th>
<th>Coinsurance</th>
<th>Active</th>
<th>Benefit Start/End Dates</th>
<th>Ref/Auth Required</th>
<th>Benefit Limit</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Visit - Office: Well (Office)</td>
<td>Individual</td>
<td>0%</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic (Office)</td>
<td>Individual</td>
<td>$40</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. Select the appropriate accumulator. (Field will expand to show details.)

<table>
<thead>
<tr>
<th>Deductible Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Information Remaining As of Dec 13, 2018</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of Pocket Maximum</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Pocket Information Remaining As of Dec 13, 2018</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Limits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Limit Information Remaining As of Dec 13, 2018</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 8:  
CLAIM INQUIRIES – BCBSVT MEMBERS
SECTION 8: CLAIM INQUIRIES – BCBSVT MEMBERS

1. Select “Claim Status Inquiry” under “Office Management.”
2. Enter claim number, member name, member number, or account number plus date of service. (Or enter a date span to see all claims within those dates.)
3. Choose the billing provider from the drop-down menu.
4. Select “Search.”
SECTION 8: CLAIM INQUIRIES – BCBSVT MEMBERS

5. Review results. If there are multiple claims, click on the header to sort the column.

6. Select the hyperlinks (in blue) in each column for additional information. Click on “View” to review the provider voucher (remittance advice).

7. Any claims with a “Pending” status are not final and may not reflect final processing results.

<table>
<thead>
<tr>
<th>View EOP</th>
<th>Claim Number</th>
<th>Status</th>
<th>Patient</th>
<th>Patient Account No.</th>
<th>DOS</th>
<th>Provider</th>
<th>Billed</th>
<th>Paid</th>
<th>Payment Date</th>
<th>Coinsurance Amount</th>
<th>Copay Amount</th>
<th>Deductible Amount</th>
<th>Patient Disallow Amount</th>
<th>COB Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>View</td>
<td>12346789</td>
<td>Finalized</td>
<td>Doe, John</td>
<td>0000BCBS</td>
<td>18 Apr 2016</td>
<td>D. Jones DC</td>
<td>$165.00</td>
<td>$92.82</td>
<td>25 May 2016</td>
<td>$0.00</td>
<td>$50.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
SECTION 9:
REALTIME CLAIM INQUIRIES
SECTION 9: REALTIME CLAIM INQUIRIES

Use the Realtime claim inquiry tool for:

• Federal Employees Program (FEP) members
• Blue Card members (out-of-state Blue Cross Blue Shield members)
• Blue Cross Blue Shield of Vermont members

2. Select “Click here to conduct a Realtime Claims search.”
3. Complete all required fields. These are identified by a red asterisk (*).

4. Enter total claim charges (optional).

5. Select “Search.”
SECTION 9: REALTIME CLAIM INQUIRIES (CONT.)

6. Review Results

![Claim Status Search Results]

- **Patient Information**
  - Patient: Doe, John
  - ID: V1234567890

- **Provider Information**
  - Provider: Dr. Jones
  - NPI: 123456789

- **Claim Total**
  - Amount Billed: $100.00
  - Amount Paid: $56.47

- **Claims**
  - Claim Number: UNKNOWN
    - Payment Date: Jun 30 2016
    - Date of Service: Jun 23 2016
    - Billed Amount: $100.00
    - Payment Amount: $56.47
    - Status: Finalized

- **Totals:**
  - $100.00
  - $56.47
SECTION 10: VOUCHERS AND CAPITATION VOUCHERS
SECTION 10: VOUCHERS AND CAPITATION VOUCHERS

1. Select “Provider Vouchers” under “Office Management.”
2. Select “Continue.” Please note browser requirements.
3. Select practice NPI from the drop-down menu.
4. Enter start and end dates.
5. Select “Search.”
SECTION 11:
NATIONAL DRUG CODE (NDC) TOOL
SECTION 11: NATIONAL DRUG CODE (NDC) TOOL

The NDC Tool is designed to assist practices in determining the unit of measure that must be reported on claims. The tool provides:

- Drug Name
- Dosage Form
- Manufacturer Name
- Billed Unit of Measure (indicates the appropriate unit of measure for billing.)

2. Click on hyperlink to access the current version of the tool.
3. Use “Ctrl-F” to navigate quickly navigate to the desired code. The 11-digit HNC code should be entered without dashes.
SECTION 11: NATIONAL DRUG CODE (NDC) TOOL (CONT.)

4. Selected code will be highlighted.
5. The billed unit of measure field indicates the appropriate unit of measure (UN, GR, ML, ME, or F2) for billing.
6. If the code is not on file, it may be inactive or newly added. The tool is updated periodically, with at least 60 days’ notice to providers.
SECTION 12:
CLEAR CLAIM CONNECT (C3)
SECTION 12: CLEAR CLAIM CONNECT (C3)

The C3 tool:

- Determines claims editing (claim check) prior to submission or after (to explain logic of processing).
- Provides claim editing logic only; results are not tied to benefits or medical policies.
- Looks back up to 99 lines regardless of rendering provider.

1. Under “Office Management,” select “Clear Claims Connection (C3).”
2. Select claim type “professional” or “facility.”
3. Enter the required information, including gender and date of birth.
4. Select “Review Claim Audit Results.”
Section 13:

MEMBER EQUOTE GUIDE
SECTION 13: MEMBER EQUOTE GUIDE

The Member eQuote Guide is a new tool to help you verify member benefits. It is the same tool used by our customer service team.

The eQuote Guide:

• Provides a simplified and more thorough benefit quote virtually.
• Links to important information such as a member contract documents, Medical Policies and Prior Approval lists.
• Allows you to determine whether state mandates apply to the member.
• Provides a reference number that can be used as proof you have verified a member’s benefits.
• Saves you time by avoiding call center wait times.

Note:

➢ A real-time eligibility check needs to be done prior to using the eQuote Guide to confirm the member is active and the status of their out-of-pocket and benefit limits.

➢ eQuote Guides are not available for BlueCard Plans, Federal Employee Program, New England Health Plan, Access Blue New England, or Medicare Supplemental Plans.
1. Select “Search Patients” under “Patient Management.”
2. Enter patient information by last name, first name format or by member ID number.
3. Select “Search.”
4. Click “Select” next to the member’s name.

Select the correct patient record

Click the ‘Select’ button next to the desired patient, whose ID starts with ‘V’

<table>
<thead>
<tr>
<th>Patient Search Results</th>
<th>Help</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
<td>Sex</td>
</tr>
<tr>
<td>FLOWER, WALL</td>
<td>F</td>
</tr>
</tbody>
</table>

4
SECTION 13: MEMBER EQUOTE GUIDE (CONT.)

5. Select “Click here to view the eQuote Guide.”
6. Your benefit verification reference number is located in the Record Locator field. Please save this reference number for your records as it will not be available once you have closed the guide.

7. Select “Open eQuote Guide” to review the member’s quote guide.
8. The quote guide will open with information specific to the member. To search a specific benefit, you can either click on the benefit under the table of contents or conduct a search by using control “F” and then entering your search criteria (for example, “chiropractic services”).

### QHO- Benefit Quote Guide

<table>
<thead>
<tr>
<th>Alpha Prefix:</th>
<th>VE1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier Level:</td>
<td>Individual</td>
</tr>
<tr>
<td>Network:</td>
<td>Vermont: BCBSVT Network, Out of State: BlueCard EPO/PPO Network</td>
</tr>
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<td>Contract Documents for:</td>
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<td>VEHI Platinum and Gold Exclusive Provider Organization (EPO) PCP Benefits Description</td>
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<td>Additional Information:</td>
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Publish Date: 02/10/2021

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9. This is an example of the information the eQuote Guide provides. (In this case, it is specific to chiropractic services.)

**Chiropractic Services:**

Chiropractic care is eligible based on medical necessity. A Network Chiropractor must perform the services or there are no benefits. Treatment must be for a neuromusculoskeletal condition (that is a condition of the bones, joints, or muscles). Prior approval is not required for the first 12 visits per member per plan year. If additional visits are necessary, prior approval is required. The prior approval form must be submitted before the 13th treatment and should be accompanied by progress notes to support the need for additional visits. There is a $30 co-payment per visit up to the $6,600 individual out-of-pocket limit. Services are then eligible at 100% of the allowed amount for the rest of the plan year.

Some diagnostics, for example x-rays rendered by a Chiropractor, are eligible under the plan. Services are eligible at 100% of the allowed amount.

**ADDITIONAL INFORMATION:**

- Physical therapy services billed by a chiropractor will apply a visit to the combined PT/OT/ST limit and will also apply a chiropractic visit (regardless of whether an additional chiropractic service is rendered). The “Chiropractic Services” and “Physical Therapy/Medicine” medical policies outline the specific procedure codes that apply.

- The Plan may allow an out of network provider at the network level of benefits when there is not a network provider with appropriate training and experience to provide the medically necessary services needed to meet the particular health care needs of a member; or
SECTION 13: MEMBER EQUOTE GUIDE (CONT.)

10. To print the document, click on the printer icon at the top right-hand corner of the page.

11. Once the review is complete, close the tab by clicking on the “x” at the top of the page.
SECTION 14:
NEED HELP?
SECTION 13: NEED HELP?

For assistance, contact Provider Relations at Blue Cross Blue Shield of Vermont at:

- By email: ProviderRelations@BCBSVT.com
- By phone: (888) 449-0443, option 1