NOTICE OF PROVIDER HANDBOOK CHANGES

Date: September 1, 2026

BlueCross BlueShield of Vermont
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The Provider Handbook has been updated with the following:

Summary:	Section 6.7 Claim Specific Guidelines
Explanation:	Drugs Dispensed or Administered by a Provider in an office, outpatient, ambulatory surgical center or home infusion setting (other than pharmacy) section, removed services where Medicare is the primary carrier under the "*The requirements does not apply to*" area.
Effective Date:	November 1, 2026
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.1 General Claim Information
Explanation:	Under the Claim Filing Limits, the following is **removed**: A provider/facility may request a review of timely filing denial within 90 days of the date on the provider voucher by: • Contacting the appropriate customer service team • The submission of a Provider Inquiry Form, available on the provider website under Provider Forms & Resources, Administrative Forms and Templates. Supporting documentation must be included with the request. This documentation may include: • The original claim number. • A copy of the computerized printout of the patient account ledger, with the submission date identified. Requests for review of untimely filing denials will be reviewed on a case-by-case basis. If the denial is upheld, a letter will be generated advising the provider of the outcome. If the denial is reversed, the claim will be processed for consideration on a future provider voucher.
Effective Date:	November 1, 2026
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.1 General Claim Information
Explanation:	Under the Claim Filing Limits, the following changes in red font are being made: • Must be submitted and **accepted** into the Blue Cross VT claim processing system* not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims) unless stated otherwise in the provider agreement. • If another payer is primary, claims must be submitted not more than 180 days from the date of the primary carrier's processing. • If Blue Cross VT is primary, but the provider has another carrier on file and submits to that carrier as primary, the other insurance explanation of benefits must have a processing date not more than 180 calendar days

	from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims), and in processing reflect the member was eligible during the date of service. If these requirements are met, claims can be considered for benefits. Claims submitted after the expiration of the 180-day calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims) will be denied for timely filing and cannot be appealed or billed/collected from the member. ***Adjustments and Corrected Claims:*** • Adjustments and corrected claims must be submitted not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (professional claims), unless stated otherwise in provider agreement.
Effective Date:	November 1, 2026
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.1 General Claim Information
Explanation:	Under the Adjustment/Corrected Claims, the following changes in red font are being made: Adjustments and corrected claims must be filed not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims) unless stated otherwise in the provider contract. DO NOT submit adjusted/corrected/late claims until you receive the original (or most recently submitted) claim processing on a provider voucher.
Effective Date:	November 1, 2026
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.1 General Claim Information
Explanation:	Under the Grace Period for Individuals through the Exchange, the following changes in red font are being made: ***Claims for dates of service during the first month of grace period:*** We process the claims, make applicable payments and report through to a provider voucher. These payments are never recovered, even if the membership terminates at the end of the grace period. If you find later (and not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims) that you need to request an adjustment on one of these claims, simply submit following our standard guidelines, and the adjustment will process as usual. If additional money is due, it will be paid.
Effective Date:	November 1, 2026
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.1 General Claim Information

Explanation:	Under the Provider Requested Claim Review, the following changes in red font are being made: A claim review request may be made directly by contacting our customer service department or filed in writing using the Payment Inquiry Form on our provider website under Provider Forms & Resources, Administrative Forms and Templates. Claim Review requests must be made not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims). All supporting documentation specific to the Claim Review must be supplied at the time of submission of the Payment Inquiry Form. The Claim Review request will be reviewed, and a letter of response provided pursuant to Blue Cross VT Policies.
Effective Date:	November 1, 2026
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 7 The BlueCard® Program
Explanation:	Under the Adjustment/Corrected Claims, the following changes in red font are being made: Adjustments and corrected claims are processed by Blue Cross VT for BlueCard® claims. * They must be filed not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims), unless stated otherwise in provider contract. DO NOT submit adjusted/corrected/late claims until you receive the original (or most recently submitted) claim processing on a provider voucher.
Effective Date:	November 1, 2026
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Notice of Right to Object in Writing

In accordance with 18 V.S.A. § 9418c contracted providers have the right to object to new or modified policies and manuals.

Providers who object must do so within 60 days of the date the notice related to a policy or manual change. The rationale for the objection to the change must be in writing including related area(s) of the policy or manual and rationale or reasoning for the objection.

These objections are to be directed to Provider Contracting. This can be done by email at: providercontracting@bcbsvt.com or US Postal Service BCBSVT Attn: Provider Contracting, PO Box 186, Montpelier, VT 05601.

Within 5 business days of receipt, the sender will receive confirmation of receipt of the objection.