BlueCross BlueShield of Vermont
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Effective November 1, 2026, all claim filing limits will be fully enforced, regardless of date of service. We will no longer consider phone calls, emails, computerized printout of a patient account ledger, or any other correspondence to be proof of timely filing.

Providers can verify and review the receipt and status of a claim on the Provider Resource Center, or by contacting the appropriate customer services team. If contacting a customer service team, you must wait at least 30 days from the submission date before requesting a status.

If you would like assistance or instructions on using the Provider Resource Center, please contact the Provider Relations Team at (888) 449-0443 option 1.

Claim Filing Limits

New Claims:

- 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.

  *Electronically submitted 837 claim files that are denied back to a vendor/clearinghouse are not considered accepted into the Blue Cross VT system.

  *Paper claims that are returned to the provider through the US Postal Service are not considered accepted into the Blue Cross VT system.

- 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 of the date of discharge (inpatient) or from the date of service (outpatient and professional), 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 (outpatient and professional claims), unless stated otherwise in provider agreement.