Triple-S Salud, Blue Cross and Blue Shield Association, The BlueCard® Program and You

Triple-S' relation with the Blue Cross and Blue Shield Association (BCBSA) & The BlueCard® Program:

Triple-S Salud is an independent licensee of the Blue Cross and Blue Shield Association for Puerto Rico and the United States Virgin Islands.

The BCBSA established the national program known as BlueCard® Program, to which all the plans that are members of the Association must belong. Triple-S is a member of the BCBSA and therefore all participant providers in Triple-S should offer services to members of other Blue Cross and Blue Shield Plans in the United States.

The BlueCard® Program is a national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement. This Program facilitates access to health services in the areas they serve other member of BCBSA plans.

Triple-S participates in the BlueCard® Program through an agreement with the Blue Cross and Blue Shield Association (BCBSA).

If you are part of Triple-S Salud Participating Provider Network who serve our Commercial Segment population, you are a participant provider for all members of the Blue Card Program.

As a participating provider of **Triple-S Salud** you may render services to patients who are National Account members of other Blue Plans, and who travel or live in Puerto Rico.

BlueCard Program Advantages to Providers:

- The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to Triple-S Salud.
- Triple-S Salud will be your only point of contact for all of your claims-related questions.
- Working together, we can ensure your patients will have a positive experience at each visit.

How to identify the members / Member ID Cards:

When Members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifier for out-of-area members is the prefix. The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage. The ID cards also may have:

- PPO in a suitcase logo, for eligible PPO members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
- Blank suitcase logo

Important facts concerning member IDs & Tips:

- A correct member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numbers/letters following the prefix.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- The prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Members who are part of the FEP will have the letter "R" in front of their member ID number.
- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in the member's file.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- **Remember:** member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers.

Important contact information:

To verify the eligibility, benefits, deductibles, coinsurance and covered services of Blue Card Program members, you may use one of the following options:

- **Calling BlueCard Eligibility toll free number 1-800-676-BLUE (2583).**
- You can select Spanish language if you want.
- When calling, have available the member's contract number and prefix information.
- **If when requesting about the member's benefits you are asked if you are a PPO (Preferred Provider Organization) provider or if you are a Blue Cross/Blue Shield network provider, please answer Yes.**
- Or, submitting electronically HIPAA 270 eligibility inquiry to Triple-S Salud web portal or clearinghouse.
- **If you have any questions, please contact our Professional Relations Department at (787) 749-4700 or at 1 (877) 357-9777- (Tele Expreso).**
- The BlueCard Eligibility line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status.
- **Triple-S will pay contracted Triple-S fees for the services provided to this member** that are approved by the member's plan. You may bill your claims electronically or paper as you will for other TSS members.
- You can receive real-time responses to your eligibility requests for out-of-area members between 6:00 a.m. and Midnight, Central Time, Monday through Saturday.
- Blue Plans are located throughout the country and may operate on a different time schedule than Triple-S. You may be transferred to a voice response system linked to customer enrollment and benefits outside that Plan's regular business hours.

Claims Filing:

After the member of another Blue Plan receives services from you, you should file the claim with Triple-S Salud. We will work with the member's Plan to process the claim and the member's Plan will send an explanation of benefit or EOB to the member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the members benefits and coverage.

Remember:

- **You should always submit all Blue claims to Triple-S Salud.**
- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically and be sure to provide the member's prefix.
- Verify the member's cost sharing amount before processing payment. **Please do not process full payment upfront.**
- **Indicate any payment you collected from the patient on the claim**. (On the 837 electronic claim submission form, check field AMT01=F5 patient paid amount; on the CMS1500 locator 29 amount paid; on UB92 locator 54 prior payment; on UB04 locator 53 prior payment.)
- Be sure to include the member's complete identification number when you submit the claim. This includes the three-character prefix. Submit claims with only valid prefixes; claims with incorrect or missing prefixes and member identification numbers cannot be processed.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- Check claims status by contacting Triple-S Salud at **(787) 749-4700 or at 1 (877) 357-9777- (Tele Expreso)** or submitting an electronic HIPAA 276 transaction (claim status request) to Triple-S Salud.

Adjustments:

Contact Triple-S Salud if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different.

Provider's responsibilities with the BlueCard® Program:

- As a participating provider of Triple-S Salud you may render services to patients who are National Account members of other Blue Plans, and who travel or live in Puerto Rico.
- Updating Your Provider Information. Maintaining accurate provider information is critically important to ensure that consumers have timely access to care. Updated information helps us maintain accurate provider directories and also ensures that providers are more easily accessible to members.
- Since it is the responsibility of each provider to inform Plans when there are changes, providers are reminded to notify Triple-S Salud of any changes to their demographic information or other key pieces of information, such as a change in their ability to accept new patients, street address, phone number or any other change that affects patient access to care.