Producer Bulletin

Capital BLUE

Producer Hotline Available for Individual and Medicare Products

Producer Communication #761
Issued May 31, 2016

Message

Capital BlueCross is pleased to announce that beginning June 1, 2016, Producers may call the Capital BlueCross Consumer Market Producer Hotline at 866-889-2516 with inquiries about enrolled Individual and Medicare members.

Details

Beginning on June 1, 2016, Producers who are listed as the agent of record on a policy will be able to contact the Capital BlueCross Consumer Market Producer Hotline at 866-889-2516 for inquiries pertaining to enrolled members in the following products: PersonalBlue PPO, Capital BlueCross Short Term Major Medical, Healthy Benefits HMO and PPO, SeniorBlue® HMO, SeniorBlue® PPO, SecureBlue Medicare Supplement, and BlueCross Dental℠ and Blue Cross Vision℠.

- Calls must pertain to enrolled members only. Calls regarding enrollment applications in process will either be transferred or the caller will be referred to their Preferred Agent.
- Producers can inquire about or verify the following:
  - Enrollment/Reinstatement
  - Premium Payment
  - Benefits
  - Limited Claims Information
- Callers will be requested to provide certain Member-identifiable information in order to identify the Member in question. (Attachment A)
- The Producer Hotline is available Monday – Friday from 8 AM until 6 PM.
- Please continue to refer enrolled Members with inquiries to the Customer Service Member line at 800-962-2242 (TTD/TTY: 800-242-4816).
- Please continue to use the appropriate group market segment line for inquiries regarding members enrolled through a group policy.

Attachments

- **Attachment A** – Consumer Unit Information Sheet
- **Attachment B** – Member Authorization Form

Questions

Contact your Preferred Agency with any questions. Thank you.

Capital BlueCross Market Producer Hotline for Individual & Medicare Products

Producers can contact CBC Consumer Market Producer Hotline to inquire on behalf of their enrolled PersonalBlue PPO, Capital BlueCross Short Term Major Medical, Healthy Benefits HMO and PPO, SeniorBlue® HMO, SeniorBlue® PPO, SecureBlue Medicare Supplement, BlueCross Dental℠ and Blue Cross Vision℠ clients. CBC Consumer Market Producer Hotline Service can be reached at **866-889-2516** between the hours of 8 AM and 6 PM EDT Monday through Friday. Producers must be listed as the Agent of Record for the contract in question and in addition to the Producer's National Producer Number (NPN) must have the following information available when calling in order to properly identify their clients:

- Member Name
- Member ID Number or SSN
- Member Date of Birth, or Date of Service or Claim Number (if calling about claim)

Producers are able to receive information about the following:

Enrollment	Premium Payment	Benefits	Claims*
Effective date	Premium rates	Covered and Non-covered Services	Filing and appeal procedures
Member ID Numbers	Premium due date	Deductibles and Coinsurance	Additional claim information: (Requires DOS or Claim Number)
Confirmation of Address, etc.	Last day to pay	Copay amounts	Receipt of Claim
Confirmation ID Cards were sent	Status of account	Limitations	Confirmation that a Claim was processed/paid
Request ID cards (ID cards will be sent to member's address on file)		In and Out of network Benefits	Confirmation Claim was processed correctly
Reinstatement Requests			Confirmation that the deductible/co-payment amounts were properly applied
			Confirmation of amount owed to the provider

*If you wish to receive more detailed claim information beyond what is listed above, a completed Member Authorization Form must be on file.

Please Note:
Call will be taken regarding enrolled members only. Calls regarding pending applications will be referred to the caller's Preferred Producer or transferred to the Individual Accounts or Medicare Producer Sales Support Team. The number above is for producer use only. Please refer enrolled Members to the Customer Service Member line on the back of their ID card.

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Member Authorization Form To Release Information

Dear Member,

The enclosed form is used to obtain authorization from the member whose information will be released, or the member's personal representative, to disclose the member's information to an individual or organization not otherwise authorized to receive this information.

This form is also used to receive member authorization to use or disclose a member's psychotherapy notes or to disclose member information related to HIV, mental health, or substance abuse.

CORRESPONDENCE UNIT • CAPITAL BLUE CROSS • P.O. BOX 779519 • HARRISBURG, PA 17177-9519

capbluecross.com

FAX: 717.651.8731

P0-9 (10/2013)

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Directions for Completing the Member Authorization Form To Release Information

This form is used to obtain authorization from the member or the member's personal representative to disclose the member's information to an individual or organization not otherwise authorized to receive this information. This form is also used to receive member authorization to use or disclose a member's psychotherapy notes or to disclose member information related to HIV, mental health, or substance abuse. This form may only be signed by the member or the member's "personal representative" (see description of personal representative below).

PLEASE PRINT

Member Information: Complete all information requested in this section for the member whose information will be released.

Important: Name, address, contract number, and date of birth are all required fields.

- **Contract Number:** Be sure to include any letters that appear in front of the member's Capital BlueCross medical identification number. If member has coverage with Capital BlueCross under more than one contract number, a separate Member Authorization Form must be completed for any applicable authorization related to coverage under each contract.

Authorization: There are two sections here.

Section I: The first section must always be completed. You must identify the individual(s) or organization(s) to receive the information. Describe the information as specifically as possible. If more space is needed to describe the information, describe on the back of the form. Next, describe why this information is being disclosed or check "This information is being disclosed at the request of the member (or the member's personal representative)." If no purpose of disclosure is given, Capital BlueCross will assume that this information is being disclosed at the request of the member (or member's personal representative).

Section II: The second section is to be completed only if the information to be used or disclosed includes psychotherapy notes, or if the disclosure involves HIV, mental health, or substance abuse information.

If this authorization is being used for psychotherapy notes, it can only be used for that specific purpose and no other.

Psychotherapy notes are defined in the Health Insurance Portability and Accountability (HIPAA) Privacy Rule as:

*Notes made by a mental health professional that document or analyze the contents of conversations during counseling sessions, which are kept separate from the rest of the member's medical record, and **exclude** medication, prescription, monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary.*

Expiration and Revocation: Expiration information must be completed for an authorization to be valid. Check one of the three boxes provided to show when you want this authorization to expire. If you check the "specific date" box, you must write in a specific date. If no expiration box is checked, this form will expire six months after termination of enrollment with Capital BlueCross.

To revoke this authorization form, contact the Customer Service number on your ID card.

Personal Representative Information: A personal representative is the member's legal guardian, someone who has power of attorney over the member's health care decisions, or a parent, if the member is a dependent child under the age of 18 and not an emancipated minor. Also, a personal representative can be an executor, administrator, or person legally authorized to act on behalf of a deceased member or the member's estate. Other than a parent acting on behalf of a dependent child, under the age of 18 who is not an emancipated minor, we require a copy of the power of attorney or other court-initiated document as proof that the individual named should be recognized as the member's personal representative. For this form to be processed, it is important that a copy of any applicable power of attorney or other court-initiated document is included when you return this form to Capital BlueCross.

Signature/Date: The member whose information will be released or the member's personal representative must print their name, sign, and date this form for it to be processed.

Unless directed otherwise, please return this completed and signed form to:

Correspondence Unit
Capital BlueCross
P.O. Box 779519
Harrisburg, PA 17177-9519
Fax: 717.651.8731

PLEASE PRINT

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Member Authorization Form To Release Information

This form is used to obtain authorization from the member to disclose their information. This form may also be used to request the use of a member's psychotherapy notes. **This form may only be signed by the member whose information will be released or the member's "personal representative"** (see "Directions for Completing the Member Authorization Form" for a description of "personal representative").

Member Information: (Name of Member Whose Information Will Be Released)

Name: (First, Middle Initial, Last, Title {Sr., Jr., III.})	**Date of Birth:** (Month/Day/Year)
Address: (Including ZIP Code)	**Telephone Number:** (Including Area Code) (Optional)
Contract Number: (as shown on the member's Capital BlueCross medical identification card; include any letters that appear in front of identification number)	

Authorization: Section I must be completed for all authorizations. Section II must be completed only if member information related to HIV/AIDS, mental health, or substance abuse is to be disclosed, or if psychotherapy notes are used or disclosed.

Section I: (Please check all applicable boxes)

☐ **I authorize Capital BlueCross and its affiliates to disclose the above individual's protected health information to:**

Name _____ Phone Number _____

Address _____

(You must include the name, address, and phone number of the person(s) or organization(s) receiving the member information. If additional person(s) or organization(s) are being authorized, please list the name, address, and phone number on the back of this form.)

Description of the information to be disclosed: (If more space is needed to describe the information, please describe on back of this form.)

☐ All claims and appeals
☐ Specific claims: (specify date(s) of service, claim number(s), etc.)
_____
☐ Billing/enrollment
☐ Other: (please specify)

Purpose of Disclosure: (Please describe the reason why this information is needed or check (✓) the following:

☐ This information is being disclosed at the request of the member (or the member's personal representative.)

If no purpose of disclosure is given, then Capital BlueCross will assume that this information is being disclosed at the request of the member (or the member's personal representative).

Section II: I understand that my specific authorization is needed to release my information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case:

HIV/AIDS _____ (Initials)
Substance Abuse _____ (Initials)
Mental Health _____ (Initials)
Psychotherapy Notes _____ (Initials)
(See "Directions for Completing the Member Authorization Form" for a description of psychotherapy notes.)

Expiration and Revocation: One of the following expiration boxes must be checked (✓).

Expiration: This authorization will expire on: (Check one)

☐ This specific date

(Please note that even if a specific date is given, this authorization will expire no later than six months after termination of enrollment with Capital BlueCross.)

☐ Termination of enrollment with Capital BlueCross
☐ Six months after termination of enrollment with Capital BlueCross

If no expiration box is checked, then this form will expire six months after termination of enrollment with Capital BlueCross.

Right to Revoke: You may revoke this authorization form at any time. Contact Capital BlueCross Customer Service for further instructions. Your revocation of this authorization will not affect any action we take before we receive your notice of revocation.

Personal Representative Information: Complete this section if a personal representative is authorizing disclosure of the member's information. See "Directions for Completing the Member Authorization Form" for information and directions about personal representatives. A copy of a power of attorney or other court-initiated document will be required, if applicable.

Name: (First, Middle Initial, Last, Title {Sr., Jr., III.})	**Relationship to the Member:**
Address: (Including ZIP Code)	**Telephone Number:**

Signature/Date: The member whose information will be released or the member's personal representative must print their name, sign, and date this form for it to be processed.

I understand the nature of this release. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits, or payment of claims.

Print Name: _____

Signature: _____ **Date:** _____

☐ Please check (✓) this box if you would like to receive a copy of this form.

Unless directed otherwise, please return this completed and signed form to:

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Capital BlueCross
P.O. Box 779519
Harrisburg, PA 17177-9519
Fax: 717.651.8731