Behavioral Health Guide

Behavioral Health Facility Agreement

Health plans that access the Anthem Blue Cross (Anthem) Behavioral Health network include but are not limited to commercial HMO, PPO, EPO, and Medicare Advantage Supplemental Plans unless otherwise designated by Anthem.

Note: Vivity HMO, Priority Select HMO, and Pathway plans are excluded from your Agreement unless designated by Anthem.

Thank you for participating in the Anthem commercial Behavioral Health network!

As a participating commercial behavioral health facility in our Network, you have 24/7 online access to specific tools and information.

Visit our **Behavioral Health Provider Resources** web page for information that will help you effectively manage your relationship with Anthem while also saving you administrative time and resources.

This Behavioral Health Guide is an interactive document. You will find blue links throughout that take you to information quickly! It is designed to answer day-to-day questions, introduce several resources, self- service tools, and provide valuable information about Anthem to our participating behavioral health providers.

We look forward to building a strong collaborative relationship with you. We are dedicated to working together to deliver quality care to our members, providing greater value to our customers and helping improve the health of our communities.

Sincerely from all of us,
Behavioral Health Network Management
Anthem Blue Cross

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Overview

Facilities participating in the Anthem Behavioral Health Network are obligated to abide by the responsibilities outlined in your Facility Agreement (Agreement) and our provider manuals.

Anthem health plans that access the Anthem Blue Cross Behavioral Health Network include but are not limited to commercial HMO, PPO, EPO, and Medicare Advantage Supplemental Plans unless otherwise designated by Anthem. Note: Vivity HMO, Priority Select HMO, Pathway plans are excluded from your Agreement unless designated by Anthem.

Members in the BlueCard Program (out-of-area) also access the Anthem Behavioral Health Network when seeking services in California. As a participating Anthem Facility, you may render services to those who are members of other Blue Plans, and who travel or live in California. For more, refer to BlueCard in the *FAQ* section.

This Behavioral Health Guide should be shared with all participating Facility representatives and staff.

To get updates, benefits, eligibility, claims status, provider manuals and request authorization, register for Availity Essentials, our exclusive provider secure website at **Availity.com**.

Note: Each Facility representative must have an individual login. Login information should not be shared.

The **Behavioral Health Provider Resources** website is helpful too! It is your one-stop shop behavioral health information center and can be found on **anthem.com/ca**.

Facility general responsibilities

Behavioral health facility	
Education on Anthem processes	**Disseminate to your staff:** • Contractual requirements of the Facility Agreement • Educational information (newsletters, provider manuals) • Billing guidelines and process **Be sure to:** • Verify benefits and eligibility for each Member. Behavioral health services may be handled by another payer and plans may require authorizations. • Collect only the copay, coinsurance or deductible. • Refer only to in-network providers.
Notify Anthem of group changes	• Tax identification number (Tax ID) • National Provider Identifier (NPI) • Location changes (Tax ID, practice or mailing address) • Adding/removing services
Reference the guide	• Behavioral health provider resources website • Who to contact for questions • Online resources and self-service tools
Abide by Anthem Agreements	• Your Facility Agreement • Provider manuals

Understanding your Facility Agreement

An officer of the Facility (CEO, CFO, COO, President, VP, etc.) enters into the Anthem Agreement on behalf of the Facility. The officer can appoint a representative to lead and conduct administrative changes. A request on company letterhead, signed and dated giving the representative authorization to make decisions on the officer's behalf is required. The representative is responsible for informing Anthem of Facility changes — adding locations or services, address, or phone number changes, etc.

The Facility Agreement is enacted after successful completion of the Anthem credentialing process (where applicable) and the assignment of a contract effective date. Any facility that does not successfully complete credentialing or meet screening criteria will not be considered in-network or participating. **Anthem members should only be referred to in-network providers.**

Participating Facilities are obligated to abide by responsibilities outlined in the Agreement, provider manuals as well as those discussed in the BH Facility Guide (Guide).

Facility general responsibilities (cont).

Participating facilities are required to do the following:

- Cooperate with Anthem's Quality Improvement Program and Utilization Management Program.
- Ensure the hours of operation are sufficient to prevent delays detrimental to the health and access to care.
- Render treatment and be reimbursed for those services, which are in accordance with the Agreement and behavioral health benefit plan.
- Except for copayments, coinsurance and/or deductible amounts, a participating Facility shall not invoice, or balance bill a member.

Facilities are responsible for sharing information with their staff about Anthem and the functions of Anthem's various departments including Utilization Management (UM), Provider Relations, Contracting, and Credentialing.

Credentialing

Anthem's Credentialing Program credentials Health care Delivery Organizations. A Health care Delivery Organization (HDO) is defined as a facility, institution or entity that is licensed, or certified (as applicable), in accordance with all applicable state and/or federal laws, which provides or delivers health care services.

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. Non-accredited HDOs are subject to individual review by the Credentials Committee (CC) and will be considered for Member access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review, which would adversely affect quality or care or patient safety.

This credentialing process includes Behavioral Health facilities that treat a variety of modalities including substance abuse, psychiatric and eating disorders, and multiple levels of care including, acute inpatient, detox, residential treatment, partial hospitalization programs, intensive outpatient programs and outpatient medication-assisted treatment (MAT) programs for opioid use disorders.

A facility must submit an application, a copy of specific licensure or certification (if applicable), and required documentation (refer to the **Behavioral Health Facility Application Checklist**) to Anthem for review. Failure to submit a complete application with applicable documents will result in a delay in processing; application will be returned. If Anthem screening criteria is met, the credentialing process will begin.

The process can take up to 180 days to complete.

During the credentialing process, Anthem will review the credentialing data as described in the following table unless otherwise required by regulatory or accrediting bodies. The table represents minimum requirements.

Verification element
Accreditation
License to practice
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

HDO type and Anthem approved accrediting agent(s)

Behavioral health

Facility type (behavioral health care)	Acceptable accrediting agencies
Acute carehospital — psychiatric disorders	CTEAM, DNV/NIAHO, TJC, HFAP
Acute inpatient hospital — chemical dependency/detoxification and rehabilitation	HFAP, NIAHO, TJC
Intensive family intervention services	CARF
Intensive outpatient — mental health and/or substance abuse	ACHC, DNV/NIAHO, TJC, COA, CARF
Outpatient mental health clinic	HFAP, TJC, CARF, COA
Partial hospitalization/day treatment — psychiatric disorders and/or substance abuse	CARF, DNV/NIAHO, HFAP, TJC, for programs associated with an acute care facility or residential treatment facilities
Residential treatment centers (RTC) — psychiatric disorders and/or substance abuse	DNV/NIAHO, TJC, HFAP, CARF, COA

Rehabilitation

Facility type (behavioral health care)	Acceptable accrediting agencies
Acute inpatient hospital — detoxification only facilities	DNV/NIAHO, HFAP, TJC
Behavioral health ambulatory detox	CARF, TJC
Methadone maintenance clinic	CARF, TJC
Outpatient substance abuse clinics	CARF, COA, TJC

Recredentialing

Anthem's Recredentialing Program requires review and verification of provider credentialing data every three years unless otherwise required by contract or state regulatory or accrediting bodies.

For continued Network participation, all required supporting documentation must be submitted. A Facility is notified about six months before the three year mark that recredentialing is due.

During the recredentialing process, Anthem incorporates reverification of initial credentialing information with review of any new credentialing information to assess whether HDOs continue to meet Anthem credentialing standards.

Utilization management

Anthem administers a Utilization Management (UM) Program to determine whether Hospital/Facility services provided to members are medically necessary. MCG Care Guidelines current edition, Behavioral Health guidelines (BHG) and ASAM guidelines are used by UM and care management staff for the review of behavioral health related services. Additional medical policies and clinical guidelines may also be used to supplement those guidelines.

For questions on these criteria, call UM toll-free at **800-274-7767** and review the **Behavioral Health Clinical Guidelines** available on our website, **anthem.com/ca** to understand the criteria used for decision making.

Interactive Care Reviewer

Save time when requesting authorization for services. Authorization can easily be requested through Availity using Interactive Care Reviewer (ICR), a web tool using IBM Watson™ innovation.

ICR offers a streamlined pre-certification and review process. It is available to Facilities requesting inpatient and outpatient medical and behavioral health services* for members covered by Anthem. You can also locate information on a previously submitted request that was not submitted via ICR (for example, via phone, fax, or electronic). You can access ICR through Availity at **Availity.com**.

* Note: ICR is not available for all Anthem lines of business or all types of cases. Check Availity for details.

While ICR is used to request pre-certification or pre-service review for local Anthem members, we also offer the same ability for out-of-state members through the Availity functionality called electronic provider access (EPA). Enter specific Member information, and you are routed to the home plan of an out-of-state Member and from there, you can access the home plan's electronic pre-certification capabilities, if available.

Benefits and eligibility

Member plans and services change and vary. We cannot stress enough the importance of verifying benefits and eligibility, and authorization requirements before rendering services.

You have a few options available to you: call the toll-free number listed on the back of the member's identification (ID) card, use the fax back option of **Interactive Voice Response** (IVR), or online verification through Availity. Availity is the fastest, time-saving option.

Billing and claims

Electronic Data Interchange

Electronic claim submission is a safe, secure and *HIPAA* compliant way to transfer information. It is cost efficient — less paperwork, manual intervention, postage, and form stock. Electronic claims are faster and more accurate; transmit 24/7 avoiding postal delays and is Anthem's preferred method for submission.

Electronic funds transfer or EFT is the online process of transferring money from one account to another. Funds are received electronically instead of a traditional paper check.

Anthem has a strategic relationship with Availity to serve as our electronic data interchange (EDI) partner for all electronic data and transactions, including electronic remittance advice.

Benefits of EFT

Not only is receiving your payment more convenient, so is signing up for EFT. When you sign up for EFT through EnrollSafe, the new enrollment website, you will receive your payments up to seven days sooner than through the paper check method. What is more, it is easier to reconcile your direct deposits.

To register or manage EFT, go to **anthem.com/provider/edi** > State > EDI Resources > Electronic Funds.

Electronic remittance advice (ERA) makes reconciling your EFT payments easy and paper-free

Now that you are enrolled in EFT, using the digital ERA is the best way to reconcile your deposits — securely and safely. You will be issued a trace number with your EFT deposit that matches up with your ERA on Availity.

When using a clearinghouse or billing service, they will supply the 835 ERA for you.

Use Availity to register and manage ERA account changes with these easy steps:
Log in to Availity > My Providers > Enrollment Center > Transaction Enrollment

You also have the option to view or download a copy of the ERA under Payer Spaces > Anthem Blue Cross > Remittance Inquiry tool.

Refer to the **FAQ** section for enrollment information about EFT or ERA.

Ways to prevent delays

- Use the Anthem Payer ID code: 47198
- If you submit through a clearinghouse or use a software vendor, check with them for the correct value (code) for Anthem Blue Cross claims.
- Be sure the correct rendering provider and member information is included on the claim.
- Submit original claims within 90 days of performed services.

  Note: When behavioral health benefits are carved-out to another health plan, timely filing limits may be different than in your Agreement.

Billing requirements

- Diagnosis codes — ICD-10 diagnosis codes must be included for each care level. Refer to the current ICD-10 manual for the appropriate diagnosis codes.
- Revenue codes — Refer to your *Agreement Plan Compensation (PCS)*, formerly known as *Fee Schedule Exhibit C*, for applicable revenue codes.
- Utilization review must approve the level of care for all services where required. The authorization number is required for each claim and should be identified in field 63 on the *UB-04* claim.
- Each date of service must be billed on its own line.

Help with claim issue resolution

Send an online **secure message** through Availity or call Claims Customer Service or for questions about a claim. When calling Customer Service have the Member ID number, claim number (DCN) and prior call reference number available.

The reference number, also known as a tracking number, is a record of all calls made to Anthem. If the issue remains unresolved, ask for a supervisor. If the issue isn't resolved with a Customer Service representative or supervisor, **submit a provider dispute** including any reference number(s) supporting any previous calls about your issue.

The ***Provider Dispute Resolution Request*** **form** is used to initiate the formal dispute process for a claim that has already been adjudicated or when a provider disagrees with an Anthem billing determination.

Access the Supplemental Education Material (SEM) #11 online titled, ***Provider Dispute Resolution*** to learn more about the form.

Secure messaging

Availity provides the opportunity to ask a question about a claim online. Secure messages can be sent for local Anthem, Anthem Blue Cross Blue Shield, BlueCard out-of-area, and FEP (Federal Employee Program) member claims.

Detailed Information about secure messaging and your rights, responsibilities, and the related procedures for filing a dispute with Anthem are available under the section, *Dispute Resolution Process for Contracted Providers*, in the provider manuals.

Submitting changes

Adding services

Any changes to the services provided at any location of your Agreement require prior written notification to Anthem, and if applicable, a new *Hospital/Facility Services Form* and/or an amendment to the Agreement before such change(s) can go into effect.

To add new services to an existing Agreement, follow steps 1-5 below:

1. Request the addition of service(s) on company letterhead.
2. List the location(s) to which the service(s) should be added.
3. Sign by the Facility officer, and
4. Complete these documents for **each service location**:
   - **Behavioral Health Facility Application Checklist**
   - **Application** (when applicable)
   - **Hospital/Facility Services Form**
5. Email all completed documents and supporting documentation to the regional **Contract Manager**.

Note: Credentialing policy requires that each facility complete an application accompanied with supporting licensure, or accreditation/ certification documentation that matches the address of each facility location. Additionally, **each facility must have a unique NPI**.

Important: An amendment is required to add a service that is not already included under an existing Agreement.

Existing Agreement changes (tax ID, business name, location)

To change a Tax ID, business name and location for an existing Agreement, follow steps 1-5 below.

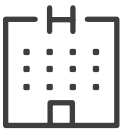
Important: When ready to submit, do not send the information to the Provider Database team. Send all completed documents and supporting documentation to the regional **Contract Manager**.

1. Submit existing Agreement changes on company letterhead.
2. List all requested changes to the Agreement.
3. Sign by the Facility officer, and
4. Complete these documents for each service location:
   - **Application** (when applicable)
   - ***Institutional Provider Change Request Form***
   - Tax ID changes require a completed and signed *W-9* form. The ***W-9*** can be downloaded from the IRS website.
5. Email all completed documents and supporting documentation to the regional **Contract Manager**.

Note: Credentialing policy requires that each facility complete an application accompanied with supporting licensure, or accreditation/ certification documentation that matches the address of each facility location. Additionally, each facility must have a unique NPI.

Important: An amendment is required to add a service that is not already included under an existing Agreement.

Adding locations



To add a new location to an existing Agreement, follow steps 1-5 below:

1. List the location(s) being added on company letterhead.
2. List the services(s) provided at each location, and
3. Sign by the Facility officer, and
4. Complete these documents for **each** facility:
   - **Behavioral Health Facility Application Checklist**
   - **Application** (when applicable)
   - **Hospital/Facility Services Form**
5. Email all completed documents and supporting documentation to the regional **Contract Manager**.

Note: Credentialing policy requires that each facility complete an application accompanied with supporting licensure, or accreditation/certification documentation that matches the address of each facility location. Additionally, each facility must have a unique NPI.

Updating information (mailing, billing, phone, or fax)

The facility representative must notify Anthem Provider Database in writing of any addition, deletion or update to a Facility mailing or billing address, phone, or fax number **within 30 days** of such change. Facility updates can take 30 business days to complete.

Follow steps 1-5 below to submit a change:

1. Complete the **Institutional Provider Change Request Form** to report changes.
2. Send mailing or billing address, and phone or fax number changes to our Provider Database Management team. Email the form to the mailbox ProviderDatabaseAnthem@anthem.com.
3. Add the phrase **BH FACILITY CHANGE** in the email subject line.
4. Tax ID changes require a completed and signed *W-9* form. The ***W-9*** can be downloaded from the IRS website.
5. Email all completed documents and supporting documentation to the regional **Contract Manager**.

Note: Changes to an address, business name or Tax ID for a location on an existing Agreement, should follow the steps outlined in the **Existing Agreement changes** section.

Credentialing policy requires that each location complete an application accompanied with supporting licensure, or accreditation/certification documentation that matches the address of each facility location. Additionally, each facility must have a unique NPI.

Updating services

To remove service(s) from an existing Agreement, follow steps 1-5 below:

1. List the service(s) no longer provided on company letterhead.

   Note: Only the service(s) identified will be removed.
2. List the location(s) impacted, and
3. Sign by the facility officer
4. Complete these documents for each facility:
   - **Hospital/Facility Services Form**
5. Email all completed documents and supporting documentation to the regional **Contract Manager**.

Terminating with Anthem

A facility may terminate an Agreement as of the expiration of the initial term by giving written prior notice as outlined in the *Term and Termination* section of your Agreement.

Complete steps 1-4 listed below to submit a termination:

1. Send the notice via email or postal mail. Termination notices must be on company letterhead, dated and signed by the Facility officer.
2. Include the Facility Tax ID, NPI, and reason for the termination, if any.
3. If sending the notice via email, email the notice to the appropriate regional **Contract Manager**.
4. Add the phrase **BH FACILITY TERMINATION** in the email subject line.

Anthem will send a confirmation of receipt via email or mail (to the address on file) with the effective date of the termination. **Terminations are effective pursuant to the *Term and Termination* section of your Agreement.**

Frequently asked questions

What plans are included in our Agreement?

Your Facility Agreement includes but is not limited to commercial HMO, PPO, and EPO plans, and Medicare supplemental plans. Note: Vivity HMO, Priority Select HMO, Pathway plans are excluded from your Agreement unless designated by Anthem.

How do we know if our facility is contracted?

A facility is contracted after successfully completing the credentialing process and notification with an effective date is received from Anthem.

What happens if a facility is denied in the credentialing process?

When a facility is denied in the credentialing process, Anthem will notify the facility with the reason for the denial. The facility will not be added to the network.

How does our facility add a location?

Refer to the subsection, **Adding locations** for steps to add a facility location and the subsection, **Existing Agreement changes** when changing information related to Tax ID, business name or location for an existing Agreement.

Can we add services to our current Agreement?

Refer to the subsection, **Adding services** for steps to add services to an existing Agreement.

What is the process for removing services no longer provided at our facility location(s)?

Refer to the subsection, **Updating services** for steps to remove services from an existing Agreement.

How to terminate our Agreement?

Under the subsection, **Terminating with Anthem** is where the termination process is outlined.

How do I close a service location?

On company letterhead, signed by the facility officer, identify the location that is no longer providing service. Only that specific location identified in the letter will be terminated. Refer to the subsection, **Updating services** for steps to delete a Facility location and the subsection, **Existing Agreement changes** when a location under an existing Agreement moves to another address location.

What is an amendment?

An amendment is a change to any part or section at any time during the term of the Agreement by mutual written consent from authorized representatives of Anthem and the facility.

When is an amendment required?

An amendment is required if changing a Tax ID, business name or when adding services and/or a new location not already included in the existing Agreement.

Is authorization needed to see a member?

Yes. Facility services require authorization. Verify authorization requirements when confirming benefits and eligibility. Authorization **requirements vary** depending on the service and each member's plan.

What is the authorization process?

Facility services require pre-authorization. These options are available to request authorization:

- **Interactive Care Reviewer (ICR)**, a web tool using IBM Watson™ innovation accessible through **Availity**. Initiate a request online and include attachments conveniently and at no-cost.
- Access the ICR webpage on anthem.com/ca to learn more.
- Call UM toll-free at **800-274-7767**.

What is the claim submission process?

Electronic submission is the preferred method. Direct deposit (EFT) is also available. Paper claims (not recommended) should be submitted to the mailing address on the member's ID card.

How are claim issues resolved?

Call claims customer service or send an online secure message through Availity. When calling customer service, have the member ID number, claim number (DCN) and prior call reference number (if available). If the issue remains unresolved, ask for a supervisor.

If the issue isn't resolved with a Customer Service Representative or supervisor, **submit a provider dispute**. After submitting a provider dispute, you will receive written acknowledgment including a reference number. For more information, refer to the Provider Dispute Resolution (PDR) Process in the provider manuals.

What is the enrollment process for electronic funds transfer (EFT) and electronic remittance advice (ERA)?

For additional information about electronic claims submission and other electronic transactions, including EFT and ERA, go online to our EDI website at **anthem.com/edi**. Scroll the page and choose Select Your State then pick California from the list. You will also find helpful information in the provider manuals.

What is BlueCard (out-of-area)?

BlueCard 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.

Conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to Anthem in CA through this Program.

To learn more about BlueCard, refer to the **BlueCard® Program Manual**.

How does re-credentialing work?

Refer to the **Recredentialing** section of this Guide.

Resources

Looking for specific behavioral health information?

Visit the Behavioral Health Provider Resources web page for access to announcements, tools and resources, forms, guidelines and more. Save the website: **anthem.com/ca/behavioralhealth** to your internet "Favorites" for easy and quick access to the page.

Contact Anthem Behavioral Health

If you have questions about this guide, visit the *Contact Us* page on **anthem.com/ca**.

Each facility is assigned, based on region. A Behavioral Health Facility Contract Manager (CM) is point of contact for questions about the Agreement (contract) language or requirements as specified in the provider manuals, or when changes are needed to an existing Agreement.

Contact the regional CM at the email below:

- **BHFacilityNoCal@anthem.com for counties:** Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glen, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Mateo, Santa Cruz, Santa Clara, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba
- **BHFacilitySoCal@anthem.com for counties:** Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura
- **CABHFacility@anthem.com for counties:** Los Angeles

Online resources and self-service tools:

- **Anthem website**
- **Provider Manuals** accessible via the Anthem website or Availity.
- **Availity** a secure website for Anthem eligibility, benefits, claim status inquiry, manuals, authorization requests and more.
- **Behavioral Health Provider Resources** is a consolidated behavioral health specific website. Save it to your web Favorites to access easily!
- **Contact List of Anthem Departments** is list of Anthem service departments and contact information.

Additional website resources can be found under the Links section of the manual.

Provider forms:

- ***Hospital/Facility Services Form***
- ***Institutional Provider Change Request Form***
- ***Eating Disorder Facility Profile***

Glossary

There are terms and abbreviations used throughout this guide and in the process of conducting business with Anthem which represent company and healthcare industry concepts and services. To help you understand the meaning of the terminology, the following is a glossary of terms. Other terms are available in the provider manuals.

Behavioral Health Carve-out: Some employers choose Anthem for medical services and carve out behavioral health services to other health plans. This means a member may present a Blue Cross Blue Shield member ID card but will have behavioral health benefits with another company.

Benefits: The types of care or services an insurance plan will pay for certain types of medical or behavioral healthcare.

CAQH: An online provider data-collection solution used by Anthem for the purposes of credentialing and other services. It streamlines provider data collection by using a standard electronic form that meets the needs of health plans, hospitals, and other healthcare organizations.

Coinsurance: An arrangement under which the insured person pays a fixed percentage of the allowable cost of medical care after the deductible has been paid.

Copayment or Copay: A type of member cost sharing that requires a flat amount per service.

Deductible: The amount of the charges some members must pay for any covered expense before selected benefits are available under their plan. The member's deductible is stated in his or her plan.

Document Control Number (DCN): A system assigned number once a claim is submitted for reimbursement. The number is used in claims follow up and may be referred as the "Claim Number."

Electronic Data Interchange (EDI): Computer-to-computer transfer of transactions and information. Electronic billing is a component of EDI.

Electronic Funds Transfer (EFT): An option offered by which claim payments can be directly deposited into a provider's financial institution account.

Electronic Remittance Advice (ERA): An electronic version of the *EOB*. Print or automatically post payments utilizing practice management software.

Explanation of Benefits (EOB): A written summary of the processing of a health care claim, sent to the provider of services and the member.

Evidence of Coverage (EOC): A complete listing of a member's benefit plan as structured by the employer. The *EOC* is commonly known as the Member Benefit Booklet.

HCID: Health Care Identification Number. Otherwise known as the member ID.

Health Care Delivery Organization(HDO): A facility, institution or entity that is licensed, or certified (as applicable), in accordance with all applicable state and/or federal laws, that provides or delivers health care services.

National Provider Identifier (NPI): A unique 10-digit number issued by CMS to health care providers. Anthem requires an NPI for all provider types.

Participating Provider: A hospital, other health facility, physician or other health care professional that has an Agreement with Anthem to provide health care services for prospectively determined rates.

Pathway and Pathway X Plans: Anthem's names for the *Affordable Care Act*-compliant plans, offered on the Covered CA Exchange (Pathway X), and by Anthem directly (Pathway). Generally, for individual members, but also to apply to some Small Group plans.

Third-party Administrator (TPA): Some employers use TPAs to manage benefits and eligibility and/or process claims. The address and phone number for TPAs will be on the member's ID card. See the definition for Other Payors in the Manual. For a list of *Other Payors (Network Leasing Arrangements)*, go online to Availity.

Tracking Number: A system assigned number to a call into Customer Service or Provider Care. This number refers to call documentation and is also the same as Inquiry Tracking Number.

Universal Billing Form (UB04): The *UB-04*, also known as the Form *CMS-1450*, is the uniform institutional (hospital) provider hardcopy claim form suitable for use in billing multiple third party payers.

Learn more about Anthem programs

https://www.anthem.com/ca

CABC-CM-031867-23-SRS31606