Behavioral Health Guide

Commercial Behavioral Health and Applied Behavior Analysis (ABA) Group Agreement

Note: Includes but is not limited to commercial HMO, PPO, on and off the exchange (Pathway), Medicare Advantage HMO and PPO Plans, and other plans designated by Anthem.

Thank you for participating in our commercial Behavioral Health network!

As a participating commercial behavioral health provider 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 us and save you administrative time and resources.

To ensure the guide functions properly, download and save this interactive Behavioral Health Guide to your computer. This guide is designed to answer questions, introduce resources, offer self-service tools, and provide valuable information about Anthem to our participating behavioral health providers.

We are dedicated to working together to deliver quality care to our members, providing greater value to our customers, and helping to improve the health of our communities.

Sincerely,
Behavioral Health Network Management
Anthem

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Overview

A group agreement includes all providers in the group who have successfully completed our credentialing process (where applicable) and have been assigned a contract effective date. Providers who do not successfully complete credentialing or meet network selection criteria will not be considered in-network or participating.

Group representatives and providers of a participating behavioral health (BH) or applied behavior analysis (ABA) group in our BH network are obligated to abide by the responsibilities outlined in their Agreement, the California Facility and Professional Provider Manual (Manual), including updates, and the Behavioral Health Guide.

Once added to a group agreement, participating providers serve any Anthem plans that access the Behavioral Health network. This includes but is not limited to commercial HMO, PPO, on and off the exchange (Pathway), Medicare Advantage HMO and PPO Plans, and other plans designated by Anthem. Please check your Agreement for any plan exclusions.

This does not include the Medi-Cal Managed Care (Medi-Cal) program or Medicare Supplemental plans, which are different agreements.

Members enrolled in the BlueCard Program (out-of-area) also access Behavioral Health network when seeking services in California. As a participating provider, you may render services to members who are National Account members of other Blue Plans, and who travel or live in California.

This guide should be shared with all participating group providers for answers to everyday behavioral health topics and resources.

Availity Essentials is available 24 hours a day, seven days a week, except during scheduled maintenance and national holidays. You can access real-time eligibility and benefits, claims status, the Manual, fee schedules, online provider remittances, and more. Register at **https://Availity.com**.

The **Behavioral Health Provider Resources** webpage is your one-stop shop BH information center. Bookmark this page for future reference.

Group representative general responsibilities

The group representative is responsible for sharing information with all participating providers in the group about Anthem, and our departments, including Contracting, Credentialing, and Provider Relationship Account Management.

BH and ABA groups	
Educate staff on Anthem's process	**Disseminate to your staff:** • Contractual requirements of the Group Agreement. • Payment/Fee Schedule: Understand the services you are contracted for and what you are allowed to bill for. • Educational information (newsletters, manuals, etc.) • Billing guidelines and process **Be sure to:** • Verify benefits and eligibility for each member. BH services may be handled by another payer, and plans may require authorizations. • Collect only the copay, coinsurance, or deductible. • Refer only to in-network or participating providers. • Log in to CAQH. Review and attest every 120 days to avoid network participation interruptions due to outdated information.
Notify Anthem of group changes	• Adding or removing a provider. • Open or closed practice • Practice Changes (tax ID, practice/ mailing address)
Reference the resource guide	• **BH Provider Resources** webpage • Who to contact for questions • Online resources and self-service tools
Abide by Anthem agreements, processes, and procedures	• Adhere to the terms in your Provider Agreement (contract) • Understand information in the Manuals • Follow operational procedures outlined in the BH and ABA Group Guide

Understanding your agreement

A group agreement is between the owner of a group practice (tax ID owner) and Anthem. Owners designate group representatives to conduct business with Anthem. The group's representative is responsible for informing when providers join or leave the group, and reporting practice changes such as address and phone numbers. **Only designated** group representatives can submit practice changes. Changes cannot be submitted by the individual **providers in the group**.

The group agreement includes all providers in the group who have successfully completed the Credentialing process (where applicable) and have an assigned contract effective date. The providers who do not successfully complete credentialing or meet network selection criteria are not considered in-network or participating. Members should only be **referred to participating providers**.

Associates (interns), psychological, or physician assistants

SB 855 amends existing California mental health parity legislation and broadens access to care for mental health or substance use disorders. The bill expands mental health services to include supervised providers (associates, interns, psychological or physician assistants). We do not directly contract with these provider types; however, they can render services to members if the supervising licensed provider is contracted with Anthem. The claim form should only include the licensed, contracted provider information. You should always verify member benefits and eligibility before rendering services.

Plans included in an Anthem behavioral health agreement

Participating providers serve any Anthem plan that accesses the Behavioral Health network. This includes but is not limited to commercial (HMO, PPO) plans and plans on and off the exchange (Pathway), and Medicare Advantage HMO and PPO Plans. **Check your Agreement for any plan exclusions**.

You may render services to members who belong to other Blue Plans. The BlueCard Program (BlueCard) is a national program that enables members who travel or live in California to obtain health care service benefits in another Blue Plan's service area. Learn more about the **BlueCard Program**.

Plans not included in an Anthem behavioral health agreement

The Anthem commercial BH network agreement does not include the Employee Assistance Program (EAP), Medi-Cal plans, and Medicare Supplemental plans offered by Anthem. Check your Agreement for any plan exclusions.

Blue Shield of California

In other states, a company may carry the Blue Cross and Blue Shield name together, as a single entity. In California, there are two separate and independent Blue Cross Blue

Shield companies. One is Anthem Blue Cross, and the other is Blue Shield of California.

Participation status after leaving a group

If a provider contracted under a group agreement leaves the group, is the provider still considered a participating (in-network) Anthem provider? No.

Providers under a group agreement are only considered participating with Anthem if they maintain a practice under the contracted group. The provider is considered out-of-network or non-participating after leaving a contracted group.

No shows and cancellations

We do not reimburse cancellations or no-shows; however, we understand that some practices impose financial penalties on members who miss appointments. While not expressly prohibited by your contract, we ask that you exercise compassion and consider your patient's medical condition before imposing a penalty. These policies must not be a barrier to access. Members can be accountable for no-shows if and only if the member has signed an agreement prior to rendering services, indicating willingness to personally accept financial liability prior to the no-show and if cancellation is not in accordance with the office's cancellation policy. Charges cannot exceed the contract rate.

Advise the member of the office policy indicating responsibility for a cancellation or no-show fee if the office policy is not followed (whatever it may be).

Credentialing

The Credentialing Program accesses information through CAQH ProView®. Credentialing data must be current, attested to, and Anthem was authorized viewing rights. We require this for all providers being added to a group agreement.

CAQH application must be completed for each provider to begin the enrollment process. Providers can register online at **proview.caqh.org** to create an account and receive a CAQH Provider ID. Once registered, use the CAQH Provider ID and password to access CAQH ProView.

If a provider is not accepted in the credentialing process, the Credentialing department will notify the group of the reason. The provider will not be added to the group agreement and is not considered participating.

Recredentialing

The recredentialing policy requires review and verification of provider credentialing data every three years. You will be notified about six months before the three-year mark that you are due for recredentialing.

Keep your CAQH application current. Attest every 120 days to avoid network participation interruptions due to outdated information (such as addresses or liability coverage).

Your practice information on file must be current to receive notification. It is equally important that your CAQH application is current and attested to prevent termination for non-compliance.

Follow steps 1-5 to attest to your CAQH application.

1. Log in to CAQH ProView at **proview.caqh.org**.
2. Review your information for accuracy. Make sure all information is current and update if needed.
3. Attest to your application after data verification.
4. Authorize Anthem viewing rights to access your information.
5. Upload and submit supporting documents

Login to CAQH. Verify and attest to your application information regularly.

All providers must be registered with **CAQHProview™**. Call the CAQH Help Desk toll-free at **888-599-1771** or email providerhelp@proview.caqh.org.

Seeing an Anthem member

Member ID cards

Members are required to have a copy of their card in one format or another, whether hard copy or electronic. Member ID cards will display a three-character, alpha-only (letter) prefix or a combination of letters and numbers, known as an alpha- numeric prefix.

Mobile application

The Sydney℠ Health app is a no-cost mobile app for tablets and smartphones that allows members to conveniently manage their benefits on their smartphones, including electronic copies of their ID cards. If the member chooses to receive their ID card electronically, a physical copy will not be mailed.

The Sydney mobile app allows you to email or fax the ID card from the member's electronic device. You can also view the ID card at **https://Availity.com**. The Sydney app is available for iPhone and Android.

Seeing an Anthem member (cont.)

Things to know before rendering any services

- Is the member eligible for coverage?
- Is preauthorization of behavioral health services required (if applicable)?
- Always obtain authorization prior to rendering ABA services.
- Does the member access the Behavioral Health network for services?
- What is the copay, coinsurance, or deductible?
- Collect the copayment, coinsurance, and deductible from the member
- Where should claims be submitted?
- Electronically submit claims to Anthem directly (recommended).

Benefits and eligibility

Member plans and services vary and may change. It is important to verify benefits and eligibility and authorization requirements (if applicable). In this Guide, read more about authorization under the subheading *Authorization*.

Before rendering services, verify benefits and eligibility to determine coverage, copay information, and whether authorization is needed because they may differ depending on each member and employer group. BH services may be handled by another payer and some plans require authorization.

ABA specific benefits: If the member's plan has not yet been updated with these benefits, be sure to ask or look for the member's professional nervous and mental benefits, including deductible and copay.

Verify benefits and eligibility, and authorization requirements at **https://Availity.com** or call the toll-free number listed on the back of the member's ID card.

Refer members (patients) in-network

Per your Agreement, refer only to in-network or participating providers under their plan. Referring to an out-of-network provider is not allowed. To find a participating provider, use Anthem's online provider directory.

Our **Find Care** tool (Provider Finder) is accessible via **https://www.anthem.com/ca/provider**. This online resource provides help when searching for a participating provider.

Authorization

It is important to verify authorization requirements when confirming benefits and eligibility, and whether mental health services are handled through Anthem. Authorization requirements vary depending on the service and each member's plan.

When services require pre-authorization, use Interactive Care Reviewer (ICR) at **https://Availity.com** to streamline the process at no cost.

Although most services do not require pre-authorization, ABA services do.

ABA authorization requirements

- Most plans require pre-authorization. Verify before rendering services.
- Only ABA services for which authorization has been given will be covered.

- ABA services are authorized by CPT® code, and claims will be processed by CPT code.
- Any codes billed without authorization are not allowed.
- Use the current form when requesting pre-authorization for ABA services.
- When requesting pre-authorization for outpatient ABA services, submit an online request at **https://Availity.com** or fill out the **Adaptive Behavioral Treatment Request** and fax the completed form to **866-582-2287**.

BlueCard (out-of-area)

You may render services to members who belong to other Blue Plans and who travel to or live in California. The BlueCard Program lets you conveniently submit claims for other Blue Plans, including international Blue Plans, directly to Anthem. You can render services to a BlueCard member if their benefits allow it. Verify benefits and eligibility for BlueCard by calling toll-free **800-676-2583**. Access the **Blue Card Provider Program Manual** online to learn more about BlueCard.

Carve-out services

Some Anthem plans may provide medical services but not provide coverage for mental health services. These services are carved out or managed by another service or company. This is identified when verifying benefits or information is usually listed on the member ID card including the name and number to call for BH services.

This is not included in your Agreement, and for the services to be covered, you must be a participating (in-network) with the other service or company.

Network leasing arrangements

We have network leasing arrangements with organizations we call Other Payors. Other Payors and affiliates use the Anthem network.

Per your Agreement, members of these other payors and affiliates may access the provider network. As such, they are entitled to the same billing considerations, including discounts and freedom from balance billing.

An online list of these other payors is available at https://Availity.com:

1. Log in to **Availity.com**.
2. From the top navigation bar find the *Payer Spaces* tab and select **Anthem** from the drop-down menu.
3. Choose the tile **Information Center**.
4. A new window will open. Select **Administrative Support**.
5. The list of documents will display. Select **Network Leasing Arrangements**.

Availity Essentials

Anthem administers a Utilization Management (UM) program to determine whether services provided to members are medically necessary. Medically necessary criteria are policies and clinical guidelines used by UM and care management staff. For questions on these criteria, call UM toll-free at **800-274-7767**.

In addition to the documents, we develop and maintain for coverage decisions, we may adopt clinical UM criteria (UM guidelines) developed and maintained by third-party organizations.

To determine which clinical UM guidelines have been adopted, customized, or to determine if there are applicable third-party criteria, visit **https://www.anthem.com/ca/provider** and select **Medical Policies and Guidelines**.

Utilization management

Anthem administers a Utilization Management (UM) program to determine whether services provided to members are medically necessary. Medical necessity criteria are policies and clinical guidelines used by UM and care management staff. For questions on these criteria, call UM toll-free at **800-274-7767**.

In addition to the documents, we develop and maintain for coverage decisions, we may adopt clinical utilization management criteria (UM guidelines) developed and maintained by third-party organizations.

To determine which clinical UM guidelines have been adopted, customized, or to determine if there are applicable third-party criteria, visit **anthem.com/ca** to read about Anthem's **medical policies and guidelines**.

ICR

Save time when submitting authorization requests and clinical information, and receive status on your request by using the innovative technology of ICR on **https://Availity.com**.

Billing and claims

This section provides an overview of general billing guidelines and claim submission requirements for the Behavioral Health network.

Claim submission process

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

Electronic data interchange

Claim submission via electronic data interchange (EDI) is a safe, secure, and HIPAA-compliant way to transfer information. It is cost-efficient, and EDI claims are faster and more accurate.

Availity Essentials is our EDI partner for all electronic data and transactions, including electronic remittance advice. Register for EDI to transmit claims 24/7 on **https://Availity.com**.

For additional information about electronic claims submission and other electronic transactions, including EFT and ERA, visit our **EDI webpage**. The Manual also contains helpful information.

General billing guidelines

- Use Anthem payer ID code: 47198 when submitting electronic claims.
- If you submit through a clearinghouse or use a software vendor, check with them for the correct value (code) for Anthem claims.
- ICD-10-CM diagnosis codes must be used for billing.
- Refer to the current ICD-10-CM manual for appropriate codes.
- Use the current CMS-1500 form.
- Include the individual NPI of the rendering provider.
- Provide all member information, including the complete member ID number with the three-character alpha-only or alpha-numeric prefix information on the claim.
- Rendering provider's name
- Rendering provider's NPI (the rendering provider should be the provider named in the authorization)
- Submit original claims within 90 days of performed services.
- Always bill referring to the fee schedule which includes the allowable behavioral health and ABA CPT codes. The CPT manual can be used for detailed information about each CPT code.

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

ABA-specific claim tips

- Use autism spectrum diagnosis
- Appropriate CPT code as defined on the fee schedule and the pre-authorization
- Codes billed should also be a part of the pre-authorization
- Applicable number of units for each CPT code, and total charges for each line
- Unit values in whole increments- billings with units that include fractions or decimals cannot be processed.

Where and how to submit BlueCard Program claims

- Always submit Anthem BlueCard claims to:
  Anthem
  P.O. Box 60007
  Los Angeles, CA 90060-0007
- Include the member's complete ID number when submitting the claim:
  - The complete ID number includes the three-character prefix.
  - Incorrect or missing information delays claims processing.
- Once received, the claim will electronically route to the member's Plan.
- We will work with the member's Plan to process the claim:
  - The Plan will send an explanation of benefits 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 member's benefits and coverage.

Claim issue resolution

Call Customer Service or send an online secure message on **https://Availity.com** for questions about a claim.

When calling Customer Service, have the member ID number, date of birth of the patient, and claim number (DCN). At the end of your call, you will receive a reference number.

Send a detailed question to clarify the status of a claim or to get additional information on a claim by secure message on Availity Essentials. Secure messages can be sent for local Anthem, BlueCard out-of-area, and Federal Employee Program® (FEP®) member claims.

Note: If you receive a bar-coded mail-back letter regarding a claim, do not use Secure Messaging to respond. Instead, place the mail-back letter on top of the requested information and follow the mailing instructions. If the issue remains unresolved, ask for a supervisor. If that does not resolve your issue, submit a provider dispute.

Submit a provider dispute

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 a billing determination.

Access the Supplemental Education Material (SEM) #11 titled, Which Form Do You Use to learn about our dispute process.

Submitting changes - adding providers

Digital provider enrollment is a way for providers to request participation with Anthem. The tool is accessible on **https://Availity.com** and uses CAQH ProView to extract data from the provider's CAQH profile.

Submit an enrollment application to:

- Add new providers to an existing participating group.
- Contract and enroll as a new group.

Use the web browser Google Chrome for an optimal experience.

Adding providers to the group agreement

The group representative is responsible for initiating the process to add a licensed provider or a board-certified behavior analyst (BCBA) to the group.

1. Register at **https://Availity.com**.
2. Providers must be registered with CAQH Proview. Follow the instructions in the *Credentialing* section of this Guide if your provider(s) is not registered.
3. Update the provider(s) CAQH profile and complete the following:
   - Review and attest the CAQH profile
   - Ensure Anthem is authorized to view your CAQH data
   - Select a primary specialty. This is the specialty that will be displayed in our directory.

Note: Each BCBA must have an individual NPI and a BCBA certification to begin the enrollment process. If you need an NPI easily request for one online at **nppes.cms.hhs.gov**.

Ready to access the application

Follow the steps below to access the enrollment application:

1. Log in to **https://Availity.com**.
2. Select **Payer Spaces**.
3. Select **Anthem**.
4. Select **Applications**, then **Provider Enrollment**.

The **Provider Enrollment Guide** will walk you through the process.

Only providers who successfully complete credentialing (when applicable) and meet network selection criteria will be allowed to participate in a group agreement.

We review all requests for completeness within 15 business days. The process can take up to 120 days to complete. We process applications in the order in which they are received.

The group representative can check status of a request on **https://Availity.com** under My Dashboard. A request updates in real time as it moves through the enrollment process.

The enrollment dashboard will display **Application Complete** along with the completion date. The completion date indicates when the provider was added to the group agreement and is ready to see Anthem members.

A Credentialing Completion date is not the same as the contracted date. It is just one of several steps that must be completed before a provider is approved and added to the group agreement.

Submitting changes — provider leaves the group, address changes and more

Providers contracted with Anthem should use **Availity Essentials' Provider Data Management (PDM) application** at **https://Availity.com** to request changes to existing practice information and more.

The group representative must notify Anthem in writing of any addition, deletion, or update of any kind of the group's practice within 30 days of such change. Changes can take up to 30 business days to complete.

Provider groups can do this by utilizing PDM capability available on **https://Availity.com** to update the groups provider data.

1. Log on to **https://Availity.com**.
2. Select **My Providers**, then **Provider Data Management (PDM)** to begin using PDM. IMPORTANT: Do not select Manage My Organization.
3. If you do not see Provider Data Management (PDM), contact Availity Client Services to get access.
4. If you have not registered to use Availity Essentials, you can sign up easily and securely at no cost.
5. If you have technical questions, call Availity Client Services toll-free **800-AVAILITY** (**800-282-4548**).

For larger organizations

Roster Automation is a new system upgrade that reads a standardized form, identifies necessary changes, updates the demographic system, and allows providers to submit changes in bulk.

Roster upload option

Allows providers to submit multiple updates within one spreadsheet via the Upload Rosters feature. Log in to Availity Essentials for more information.

FAQ

What plans are included in our Agreement?

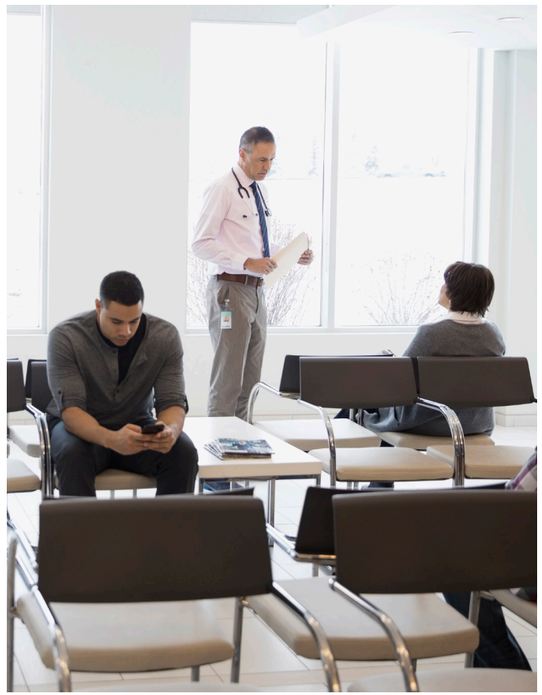
Once approved and added to a group agreement, participating providers serve any Anthem plans that access the Behavioral Health network. This includes but is not limited to Commercial HMO, PPO, on and off the exchange (Pathway), Medicare Advantage HMO and PPO Plans, and other plans designated by Anthem.

How do we know if our Group is contracted?

A BH or ABA group is contracted after successfully completing the credentialing process and receiving notification with an effective date from Anthem. Each provider added to the group must be submitted via Availity Essentials through the online Provider Enrollment to be reviewed and approved by Anthem.

How does our group add a location?

Refer to the subsection *Submitting Changes* for steps to update demographic information. By using the Provider Data Management (PDM) application at **https://Availity.com**.



How do I update a tax ID or business name?

An amendment or contract change is required. Email the California Network Development team at CANetworkDevelopment@anthem.com. For tax ID changes, be sure to include a signed W-9 form.

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 do I sign up for EFT?

EFT services for Anthem are handled by **EnrollSafe**. Email the EnrollSafe help desk at Support@payeehub.org or view the Support Guide **here** for assistance.

How are claim issues resolved?

Call customer service or send an online secure message through Availity Essentials. 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 is not 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.

How does re-credentialing work?

The credentialing policy requires review and verification of provider credentialing data every three years. You'll be notified about six months before the three-year mark that you are due for recredentialing. Keep your CAQH application current. Attest every 120 days to avoid network participation interruptions due to outdated information (such as addresses or liability coverage).

Resources

Contact Anthem's Behavioral Health at:

- Application or request status — Log in to Availity Essentials to view My Dashboard.
- Questions about adding a provider to your existing commercial BH or ABA group access the **Contact Us** page on **https://www.anthem.com/ca/provider**.
- Questions about new commercial BH or ABA individual (solo) or group email CANetworkDevelopment@anthem.com
- For general questions access the **Contact Us** page on **https://www.anthem.com/ca/provider**

Online resources and self-service tools:

- **https://www.anthem.com/ca/provider**
- **California Facility and Professional Provider Manual** accessible via our website or **https://Availity.com**.
- Availity Essentials is a secure website for eligibility, benefits, claim status inquiry, manuals, authorization requests and more.
- **Behavioral Health Provider Resources** is a consolidated BH specific website.
- **Contact List of Anthem Departments** is list of service departments and contact information.

Additional website resources can be found under the Links section of the provider manual accessible at **https://www.anthem.com/ca/provider**.

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 Glossary section of the Manual.

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 member ID card but will have BH 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.

CMS-1500: The most current health insurance claim form.

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 number of charges some members must pay for any covered expenses 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 to as the Claim Number.

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

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

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

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.

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, this is for individual members but also applies to some Small Group plans.

Third-party Administrator (TPA): Some employers use TPA's to manage benefits and eligibility and/or process claims. The address and phone number for TPA's 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.

Learn more about Anthem programs

https://www.anthem.com/ca/provider

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