

My **INSURANCE**
MANAGERSM

PRE-CERTIFICATION/REFERRAL

USER GUIDE



PRE-CERTIFICATION/REFERRAL USER GUIDE

To initiate a Pre-certification or Referral request, from the Patient Care menu choose Precertification/Referral.

Please note an important change: If you navigate away from a Pre-certification or Referral request without completing and submitting it, your information will be lost and you will need to start over. We do not save partially completed requests in My Insurance Manager.

PRE-CERTIFICATION/REFERRAL

Printer-Friendly

Pre-Certification/Referral

* Indicates required field.

Please note: If you navigate away from a pre-certification or referral request without finishing and submitting it, your information will be lost and you will need to start over. We will not save partially completed requests on our system.

Patient Selection

* Health Plan:
BlueCross BlueShield Plans

* Member ID:
999574317
include alpha prefix, if applicable

* Patient's Date of Birth:
10/01/1958
mm/dd/yyyy

Patient Gender:
[Dropdown]

Please note: You can submit:

- Non-behavioral Health Treatment Pre-certifications up to three days in the past and one year in the future.
- Behavioral Health Treatment requests up to five days in the past and one year in the future.
- Requests for Referrals with today's date or up to one year ahead.

* Date of Service or Admission Date:
01/17/2012
mm/dd/yyyy

* Location: The Best Hospital Medical Center Select Primary ID: 123456789

Continue

Select the appropriate Health Plan. Then, enter the Member ID, Patient's Date of Birth, the Date of Service and the Location for the procedure. Click Continue.

Pre-Certification/Referral

* Indicates required field.

Please note: If you navigate away from a pre-certification or referral request without finishing and submitting it, your information will be lost and you will need to start over. We will not save partially completed requests on our system.

⚠️ Our records show there is more than one patient with a date of birth similar to the one you entered. Please enter the patient's full name and select Continue.

Patient Selection

* Health Plan:
BlueCross BlueShield Plans

* Member ID:
495885097

* Patient's Date of Birth:
09/05/2011
mm/dd/yyyy

Patient Gender:
[Dropdown]

* Date of Service or Admission Date:
01/19/2012
mm/dd/yyyy

* Last Name: First Name: (recommended)

* Location: The Best Hospital Select Primary ID: 123456789

Continue or Cancel

If your patient has the same date of birth as other policy members (ex. Twins), you'll see additional fields where you need to enter the Patient's Last Name and First Name. This helps make sure the appropriate member receives the authorization.

PRE-CERTIFICATION/REFERRAL – PROVIDER INFORMATION

Printer-Friendly

Pre-Certification/Referrals

* Indicates required field.

Date of Service
01/19/2012

Insurance
Plan Name:
BlueCross BlueShield Plans

Member ID:
ZC2065922516805

Patient
Patient's Name:
MICHAEL TESTING

Date of Birth:
10/01/1958

Change Patient

Request Type

In order to help us identify the required service, please answer these questions:

Which type of service are you requesting?

Procedure

Non-Procedure

Behavioral Health Treatment

Where will this service take place?

Inpatient Hospital

Outpatient Facility

i Please note: Any drugs, services, treatment or supplies the BlueCross medical staff determines, with appropriate consultation, to be experimental, investigational or unproven are not covered services. For further information, please refer to our [pre-certification requirements](#).

Continue

Ask Health Care Services

or [Back](#)

Select the type of service you are requesting. Then, select the type of facility where the service will take place.

Fast-Track Requests

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z All

52 Results

A&P REPAIR/SLING	Detail
ABDOMINAL AORTIC ANEURYSM	Detail
ANTERIOR CERVICAL DECOMPRESSION	Detail
AORTIC VALVE REPLACEMENT	Detail
APPENDECTOMY/NOT PERFORATED	Detail
APPENDECTOMY/RUPTURED	Detail
ARTHRODESIS-CERVICAL/THORACIC/LUMBAR	Detail
BREAST RECONSTRC-GRAFT/FLAP	Detail
C-SECTION, BCBSSC	Detail
C-SECTION;STATE NOTIFICATION	Detail
CARG	Detail

Don't see the results you're looking for? [Submit a customized pre-certification request](#)

i Please note: If you don't see the Fast-Track Request you want, go back and choose a different service category or setting, or select Unlisted.

You will see this screen. You can select your procedure from the Fast Track option. If you don't see your procedure listed under Fast Track, you can choose to submit a customized pre-certification request.

PRE-CERTIFICATION/REFERRAL – FAST TRACK

Printer-Friendly

Pre-Certification/Referrals

* Indicates required field.

Date of Service
03/19/2012

Insurance
Plan Name: BlueCross BlueShield Plans
Member ID: ZCZ065922516805

Patient
Patient's Name: MICHAEL TESTING
Date of Birth: 10/01/1958
[Change Patient](#)

Fast-Track Request
Request: AORTIC VALVE REPLACEMENT

Other Information
Please complete this information:
Level of Service: E - ELECTIVE
Release of Information: Y - YES, PROVIDER HAS A SIGNED STATEMENT PERMITTING RELEASE OF MEDICAL BILLING DATA REL

Facility
Please make sure this is the location where the service will take place.
Facility Providing Services: 123456789 [Select](#) Address: The Best Hospital Medical Center
123 Best Street
Best, USA 12345-1234

Provider
Please make sure this provider will perform the service.
Individual Rendering Service: [Select](#) Address:

Practice
Please make sure this practice will be responsible for this service.
Group Practice: [Select](#) Address:

Please note: The provider you choose must be in the member's health plan provider network for us to pay maximum benefits.

[Continue](#) or [Back](#)

If you selected your procedure through Fast Track, the information will display here. Note that most of your information will be pre-populated except for the Practice. You can enter the name of the Practice or click Search to find it.

Health Care Finder - Practice Search

For this type of authorization, you must identify the practice that will be responsible for the service.

Search Type:
GROUP/PROVIDER PRACTICE

* Specialty:
 --Please Choose One--

Location
 Please enter the State, as well as the City and/or the County.

* State: South Carolina City: County: --Please Choose One--

Provider's Name:

must have at least two letters

Search

Complete the required fields and click Search.

Health Care Finder - Practice Search

Results: 33 found.

Select	Health Care Facility	Address	City, State & ZIP Code	Telephone
<input type="radio"/>	Provider Office 1	1 Paper Street	Best Town, Best 12345	123-555-5555
<input type="radio"/>	Provider Office 1	1 Paper Street	Best Town, Best 12345	123-555-5555
<input type="radio"/>	Provider Office 1	1 Paper Street	Best Town, Best 12345	123-555-5555
<input type="radio"/>	Provider Office 1	1 Paper Street	Best Town, Best 12345	123-555-5555
<input type="radio"/>	Provider Office 1	5 Paper Street	Best Town, Best 12345	123-555-5551

Continue or [Back](#)

Health Care Finder - Affiliated Entity

Results: 23 found.

Select	Health Care Facility	Address	City, State & ZIP Code	Telephone
<input type="radio"/>	Bob Best	125 Best Street	Best Town, Good 12345-4125	555-555-5555
<input type="radio"/>	Bobby Best	1 Best Street	Best Town, Good 12345-4125	555-555-5551
<input type="radio"/>	Susie Better	25 Best Street	Best Town, Good 12345-4125	555-555-5558
<input type="radio"/>	Tony Bestie	25 Best Street	Best Town, Good 12345-4125	555-505-5555
<input type="radio"/>	Tom Best	25 Best Street	Best Town, Good 12345-4125	555-555-5550
<input type="radio"/>	Bob Nice	125 Best Street	Best Town, Good 12345-4125	555-552-5555

Continue or [Back](#)

The results will display office locations. Once you select a provider location, a list of affiliated providers will display. Make a selection and click Continue. The information will then become a part of your pre-certification request.

PRE-CERTIFICATION/REFERRAL – CUSTOMIZED REQUEST

Printer-Friendly

Pre-Certification/Referrals

* Indicates required field.

Date of Service
01/19/2012

Insurance
Plan Name:
BlueCross BlueShield Plans
Member ID:
ZCZ065922516805

Patient
Patient's Name:
MICHAEL TESTING
Date of Birth:
10/01/1958

Change Patient

Diagnosis Information
Please choose the most appropriate diagnosis code for this request.

Principal Diagnosis: Date of Diagnosis:

Search

[Add Additional Diagnosis Codes](#)

Clinical Information [\[+\] expand](#)
If you need to identify the department within your organization that made this request, please enter a department identifier.

264 character maximum

Service Type Selection
Service Type:
 Institutional
 Professional
 None

Additional Patient Level Information [\[+\] expand](#)
From Event Date: To Event Date: Discharge Date:

mm/dd/yyyy mm/dd/yyyy mm/dd/yyyy

Continue or Back

Printer-Friendly

Pre-Certification/Referrals

* Indicates required field.

Date of Service
01/19/2012

Insurance
Plan Name:
BlueCross BlueShield Plans
Member ID:
ZCZ065922516805

Patient
Patient's Name:
MICHAEL TESTING
Date of Birth:
10/01/1958

Change Patient

Diagnosis Information
Please choose the most appropriate diagnosis code for this request.

Principal Diagnosis: Date of Diagnosis:

Search

[Add Additional Diagnosis Codes](#)

Clinical Information [\[+\] expand](#)
If you need to identify the department within your organization that made this request, please enter a department identifier.

264 character maximum

Service Type Selection
Service Type:
 Institutional
 Professional
 None

Institutional Service Line Information 1
Place of Service:
13 - HOSPITAL - OUTPATIENT

Service Line Revenue Code:

* Procedure Date Type:
HC - HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURAL CODING SYSTEM (HCPCS)

* Code:
92967 - IMPLANTATION OF CATHETER

Lead Code, if any:

Procedure Description:

Unit Type:
--Please Choose One--

Quantity: From Date of Service: To Date of Service:

mm/dd/yyyy mm/dd/yyyy

Service Line Branch: Service Line Rate: Service Type: --Please Choose One--

Rating Home Provider/Status Code: Level of Care Code: --Please Choose One--

Facility [\[+\] expand](#)
Provider: [\[+\] expand](#)
Procedure: [\[+\] expand](#)
Additional Notes: [\[+\] expand](#)

Please enter any additional information regarding the request.

264 character maximum

All Service Line
Additional Patient Level Information [\[+\] expand](#)
From Event Date: To Event Date: Discharge Date:

mm/dd/yyyy mm/dd/yyyy mm/dd/yyyy

Continue or Back

If you want to submit a customized request, enter the appropriate information and click Continue.

PRE-CERTIFICATION/REFERRAL – PATIENT INFORMATION

[Printer Friendly](#)

Pre-Certification/Referrals

**In-Care required field.

Date of Service
01/19/2012

Insurance
Plan Name:
BlueCross BlueShield Plans
Member ID:
ZCZ065922516805

Patient
Patient's Name:
MICHAEL TESTING
Date of Birth:
10/01/1958

Change Patient

Authorization Verification

Please review the information you have given us for this authorization request.

Please note: All contracts reimburse differently depending upon the network status of the provider. Always verify benefits prior to the delivery of services.

Patients/Provider Information
Procedure/Service Information

Patient's Information

<small>Health Plan</small>	<small>Member's ID</small>	<small>Gender</small>	<small>Date of Service</small>
BlueCross BlueShield Plans	ZCZ065922516805	MALE	01/19/2012
<small>The Member Is:</small>	<small>Patient's Name:</small>	<small>Patient's Date of Birth:</small>	
SUBSCRIBER	MICHAEL TESTING	10/01/1958	

Requester's Information

<small>Identification Type:</small>	<small>Identification Code:</small>	
National Provider Identifier	123456789	
<small>Last Name / Organization:</small>		
THE BEST HOSPITAL MEDICAL CENTER		
<small>First Name:</small>	<small>MLT</small>	<small>Suffix:</small>
Address:		
123 Best Street Best Town, SC 12345		
Edit This Information		
<small>Contact</small>		
<small>Facility Identifier Code:</small>	<small>Facility Type/Qualifier:</small>	
FACILITY	NON PERSON	
<small>Contact Name:</small>		
Best Medical Center		
<small>Primary Contact Type:</small>	<small>Secondary Contact Type:</small>	
803-264-1111	Telephone Extension 1234	
Edit This Information		

Health Care Provider Information

Facility

<small>Referred To:</small>	<small>Provider Type:</small>	<small>Address:</small>
Tom Best	FACILITY / NON PERSON	123 Best Street, Suite 2 Best Town, SC 12345
<small>Entity Identifier Code:</small>	<small>Entity Type/Qualifier:</small>	
FA - Facility	NON PERSON	

Provider

<small>Referred To:</small>	<small>Provider Type:</small>	<small>Address:</small>
Susie Best	SERVICE PROVIDER / PERSON	1900 Good Street Best Town, SC 12345
<small>Facility Identifier Code:</small>	<small>Facility Type/Qualifier:</small>	
SJ - Service Provider	PERSON	

[Add/Edit Contact Information](#)

Practice

<small>Referred To:</small>	<small>Provider Type:</small>	<small>Address:</small>
Best Provider	GROUP PRACTICE / NON PERSON	1 23 Street Town Near You, SC 12345
<small>Entity Identifier Code:</small>	<small>Entity Type/Qualifier:</small>	
QV - Group Practice	NON PERSON	

Contact Information

Please give us a phone number where we can reach you in case we have questions.

Primary Contact:

[Add/Edit Additional Patient Level Information](#)

Confirm the information you entered and click Submit.

PRE-CERTIFICATION/REFERRAL – PATIENT INFORMATION

[Printer-Friendly](#)

Pre-Certification/Referrals

Date of Service
01/19/2012

Insurance
Plan Name:
BlueCross BlueShield Plans

Member ID:
ZCZ065922516805

Patient
Patient's Name:
MICHAEL TESTING

Date of Birth:
10/01/1958

[Change Patient](#)

Authorization Confirmation

✔ Your Inpatient Hospital request is: **APPROVED**
Your authorization number for this request is: 1201212470300

ⓘ Our response to your request is not a guarantee of payment or reimbursement or a guarantee of the Member's eligibility for coverage. We will review all claims to verify that:

- a. The pre-authorization request and the claim information you submit are consistent.
- b. The patient is eligible for benefits at the time of treatment.
- c. The patient's health plan covers the services he or she receives.
- d. All health plan requirements have been satisfied (e.g. limitations, waiting periods, copayments, deductibles, network eligibility, etc.)

We will pay claims in accordance with these findings.

ⓘ We have received your pre-certification request and forwarded it to Medical Services for review. Please check back in two days for a response. Thank you!

[New Authorization](#) or [Print Confirmation](#)

If the information doesn't have errors, you will receive a confirmation highlighted in green. From here you can submit another authorization request or print the confirmation of your current authorization.