



Welcome to the Blue Cross Blue Shield Provider Line 1-800-496-5774

To direct your call, please say INTERRUPT Permitted!

- Medical
Pharmacy
Dental
Behavioral Health

In order to get eligibility and benefits, we need your rendering NPI. For claims and other inquiries, we need your billing NPI. Now, what is your 10-digit NPI?

National Provider ID (NPI) I'm not sure. If system does not recognize the NPI provided, you will be prompted for a Tax ID.

Which can I help you with? INTERRUPT Permitted!

- Eligibility and Benefits
Claims
Preauthorization
Other Services

MAIN MENU

At later points in the flow, you will have an option to easily return here by saying MAIN MENU.

LEGEND
Phone System Prompt
Caller Response Option(s)
Phone System Quotes
Touch-Tone Allowed
Touch-Tone Option
Tip



Eligibility



What's the subscriber's id?

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The alpha-numeric portion of the subscriber's ID excluding the 3 letter alpha prefix



A valid Oklahoma subscriber ID is required to receive patient-specific information.



What's the patient's date of birth?

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If multiple policies are found, you will be requested to provide the group number. Please respond with six-digit group number for best results.



The month, date and year with the century. (i.e., 07-23-1967 or July 23rd, nineteen sixty-seven)



The system will confirm the patient is covered with the following:

- Type of coverage (i.e., PPO, HMO, etc.)
- Current effective date
- Pre-existing waiting period information, *if applicable*
- Alpha prefix
- Group number
- PCP name or PCP not on file, *if applicable*
- PCP effective date, *if applicable*
- Termination or cancel date, *if applicable*
- Confirmation number



You will only hear applicable disclaimer(s) once per call.



Now you can say...

INTERRUPT Permitted!

- Repeat That** ①
- Benefit Details** ② ✓
- Next Patient** ③
- Main Menu** ④

If you need more information, say...Help

LEGEND

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Benefits



Tell me a service.

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Benefit quotes must be preceded by Eligibility.

You may be prompted for the service zip code, service address (at which the service will be rendered), provider type, and/or provider specialty.



Say, for example, *Office Visit, Chiropractic Services, or Physical Therapy*
Or say, *List Them* *Note: A list will be offered in groups of 5 with precedence based on provider type and/or specialty.*

**BENEFIT CATEGORY
KEY WORDS**
 (Alphabetically Listed)

- | | | | | | |
|-----------------------------|-----------------------------|-----------------------------------|--|------------------------|--------------------------|
| • Abortion | • Chemo Therapy | • Emergency Accident Care | • Lupron | • Organ Transplants | • Second Opinion |
| • Acupuncture | • Chiropractic Services | • Emergency Medical Care | • Mammogram | • Orthotics | • Sleep Study |
| • Allergy | • Circumcision | • Emergency Room | • Maternity | • Prosthetics | • Smoking |
| • Ambulance (Ground or Air) | • Colonoscopy | • Extended Care Facility | • Medical Supplies | • Pap Smear | • Speech Therapy |
| • Anesthesia | • Consultations | • Family Planning | • Medical Therapeutic | • Pathology | • Sterilization |
| • Assistant Surgeon | • Coordinated Home Care | • Hearing | • Mixed Therapy (includes physical therapy, occupational therapy & speech therapy) | • PET Scan | • Stress Test |
| • Behavioral Health | • Cosmetic | • Home Infusion Therapy | • MRI | • Physical Exam | • Surgery |
| • Biofeedback | • Dental | • Hospice | • Naprapathic Services | • Physical Therapy | • Therapies ² |
| • Birth Control | • Diabetic Management | • Hospital (Inpatient/Outpatient) | • Nutritional Counseling | • Podiatry | • TMJ |
| • Blood Transfusion | • Diagnostic ¹ | • 23 Hour Observation | • Occupational Therapy | • Preventive Care | • Ultrasound |
| • Cardiac Rehab | • Dialysis | • Infertility | • Office Services | • Private Duty Nursing | • Urgent Care |
| • CAT Scan | • Drugs | • Inhalation Therapy | • Office Visit | • PSA | • Routine Vision |
| • Catastrophic Protection | • Durable Medical Equipment | • Injections | • Office Services | • Respiratory Therapy | • Wigs |
| • Chemical Dependency | • EKG | • Laboratory | • Office Visit | • Self Injectables | • X-Ray |

¹ Further specify as: CAT Scan, MRI, X-Ray, Laboratory, Ultrasound, PET Scan, EKG, Mammogram, Pathology, Sleep Study, Stress Test, or Other

² Further specify as: Behavioral Health, Chemo Therapy, Mixed Therapy (includes physical therapy, occupational therapy and speech therapy), Physical Therapy, Occupational Therapy, Speech Therapy, Inhalation Therapy, Home Infusion, Respiratory



Some categories may be transferred to a customer advocate automatically at this point.



If member is a Federal Employee, there are only 16 benefit categories from which to choose as follows:

- | | | | |
|--|---|---|--|
| • Allergy ^① | • Diagnostic / Lab and X-ray ^① | • Behav. Health or Chem. Dep. ^① | • Catastrophic Protection ^① |
| • Chiropractic Svcs. ^② | • Physical, Occupational or Speech Therapy ^② | • Durable Medical Equipment ^② | |
| • Office Visit ^③ | • Preventive Care ^③ | • Hospice or Home Nursing Care ^③ | |
| • Inpatient Benefits ^④ | • Emergency Accident Care ^④ | • Drugs ^④ | |
| • Outpatient Benefits ^⑤ | • Maternity ^⑤ | • Dental ^⑤ | |
| <i>Toggles to next list</i> ^⑥ | <i>Toggles to next list</i> ^⑥ | <i>Toggles to next list</i> ^⑥ | |



Where is the service being rendered? (if applicable)

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Say, *Office* ^①
***Outpatient* ^②**
***Inpatient* ^③**

***Emergency Room* ^④**
***Home* ^⑤**
***Other Location* ^⑥**



The system will quote the following, if applicable:

- If the service is/is not covered
- Preauthorization requirements
- Copay amount
- Deductible amount per contract/calendar year and amount met YTD
- Co-insurance %
- Out-of-pocket limit per contract/calendar year and amount met YTD
- Benefit maximum and amount met YTD
- Lifetime max amount and amount met YTD
- Confirmation number



Say... *Repeat That* ^①

***Check Another Benefit* ^②**

You can also say...

***Next Patient* ^③**

***Claims Address* ^④**

***Main Menu* ^⑤**

***Customer Advocate* ^⑥**

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