BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross Blue Shield Association.

2021 Annual Provider Summit

Frequently Asked Questions

1. **How long will coverage for COVID-19 last?**
   Although a definitive answer cannot be provided, please be mindful that we will keep the provider community abreast of any changes that may occur via newsletters and bulletins.
2. **For high dollar claims reviews, how can the requested information be submitted?**
   Itemized bills for high dollar claims reviews can be submitted (when requested) via My Insurance Manager℠. If medical records are needed, a separate request will be sent with instructions on how to submit.
3. **For prior authorizations in My Insurance Manager℠, is there a limit for submitting documentation?**
   Yes, there is a limit of 10 attachments with a maximum of 30MB, which is equivalent to 10,000 pages.
4. **How can providers determine benefit coverage for a procedure?**
   Providers are encouraged to verify eligibility and benefits using My Insurance℠ Manager or by calling the Provider Services number on the back of the member's ID card prior to rendering services.
5. **Who would providers contact for questions on claims for out-of-state members?**
   As a South Carolina provider, you would contact BlueCross BlueShield of South Carolina for assistance.
6. **How would Healthy Blue℠ members get in contact with someone regarding free benefits (e.g., diapers, eye exams, etc.)?**
   A full list of the additional benefits for Healthy Blue℠ members (at no cost) can be located on www.HealthyBlueSC.com. The members can redeem some of these benefits online through their secure account. They can check their eligibility on the Benefit Reward Hub or call the Customer Care Center at 866-781-5094.
7. **Why do claims deny when billed with a covered diagnosis code, per the CAM policies?**
   The procedure and diagnosis codes listed in the medical policies are included only as general reference and may not be all inclusive. The services being rendered must meet the medical necessity criteria outlined in each policy.
8. **How often are updates made to the pharmacy formularies?**
   Usually, reviews and updates are done on a quarterly basis unless there is an immediate need.
9. **Can dental providers see members from any plan participating in the Dental GRID?**
   Yes, the Dental GRID allows dentists to see members from other participating BlueCross BlueShield plans at the local reimbursement level.
10. **How long does the provider reconsideration review process take?**
    Usually, we ask providers to allow up to 30-45 business days for the review to be completed.