Blue Cross complete of Michigan

CONNECTIONS

March/April 2018

Table of Contents

State extends deadline for providers to enroll in the Michigan Medicaid program

Recently, the Michigan Department of Health and Human Services required that all providers who serve Michigan Medicaid beneficiaries, including providers participating in a managed care organization's provider network, to be screened and enrolled in the Michigan Medicaid program. The regulations prohibit payment to providers who are not appropriately screened and enrolled.

Due to the overwhelming response from providers, MDHHS will extend both the implementation dates of March 1 for denying claims for typical non-enrolled providers, and May 1 for denying pharmacy claims for non-enrolled prescribers.

MDHHS will give at least 60 days advance notice for implementing the following actions for providers who are not enrolled:

- MDHHS will prohibit MCOs from making payments to all typical rendering, referring, ordering, operating, billing, supervising, and attending providers not enrolled in CHAMPS.
- MDHHS will prohibit payment for prescription drug claims written by a prescriber who is not enrolled in CHAMPS.

In addition, MDHHS is awaiting guidance from federal partners regarding the enrollment requirements for atypical providers and will share those updates once available.

See the attached link for full details of the MDHHS Medicaid provider enrollment press release **MedicaidProviderEnrollment_UPDATE_PressRelease.pdf**.

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State updates Early and Periodic Screening, Diagnostic, and Treatment guidelines

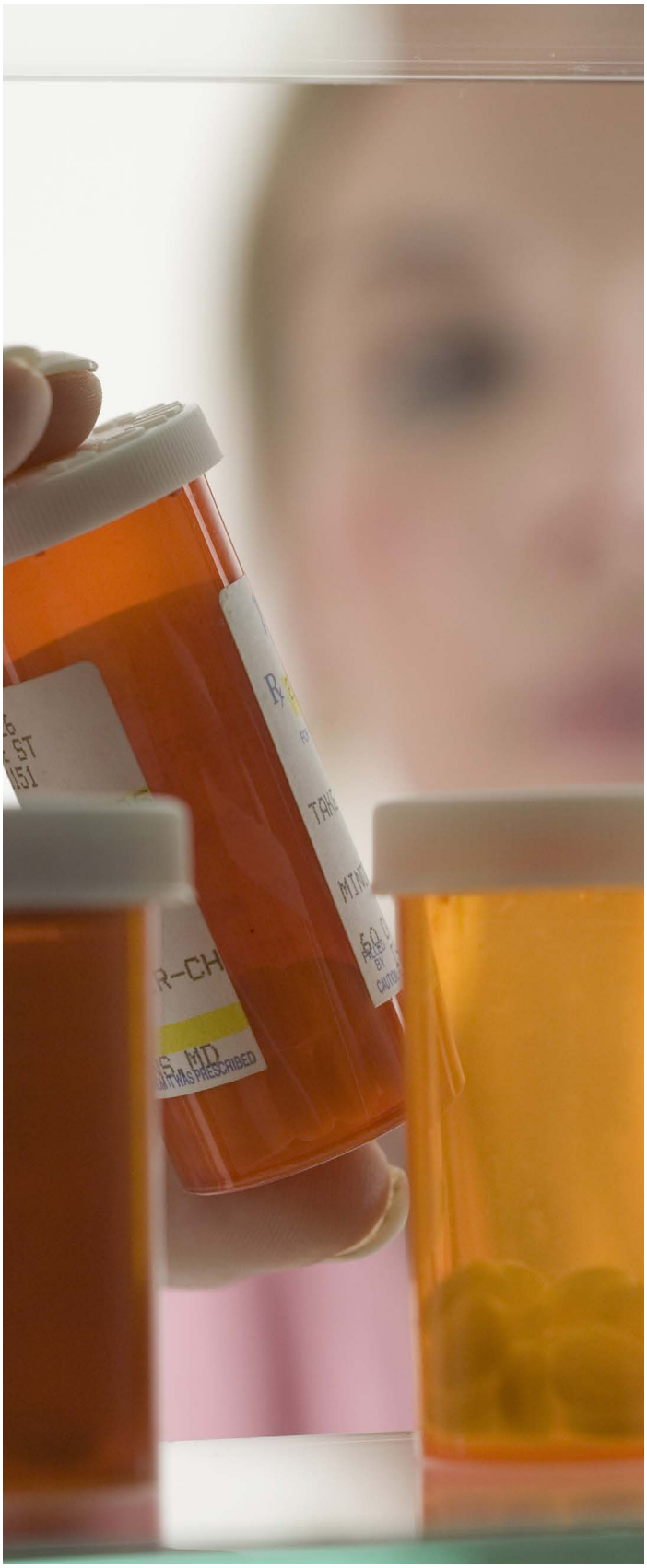
The Michigan Department of Health and Human Services updated its *Medicaid Provider Manual* to include updates to the Early and Periodic Screening, Diagnostic, and Treatment guidelines. The American Academy of Pediatrics' new periodicity schedule along with new preventive pediatric health care prompted the updates. AAP updated the periodicity schedule to reflect changes of previously endorsed ages and recommendations, and to include new screenings, procedures and guidelines.

According to the MDHHS, federal regulations require state Medicaid programs to offer EPSDT services to eligible Medicaid beneficiaries younger than age 21. EPSDT visits cover medically necessary screening and preventive support services for children and should be performed in accordance with the AAP periodicity schedule, its components and medical guidelines. MDHHS issued a bulletin on December 1, 2017, detailing the changes to the EPSDT Medicaid policy based on the AAP's recommendations. Access the bulletin at **michigan.gov**.**

For additional information, contact MDHHS Provider Services at **1-800-292-2550**.

State proposes update on coverage of physician-administered drugs

On February 1, 2018, the Michigan Department of Health and Human Services issued a proposed policy that provided updates regarding the coverage of outpatient physician-administered drug and biological products. The policy describes the reimbursement process for specific Medicaid programs that cover physician-administered drugs that are Michigan Medicaid health care plans. The proposed provisions are effective for dates of services on or after July 1, 2017. Read the proposed policy on the MDHHS website: **michigan.gov/medicaidproviders.**** Click *Policy, Letters & Forms* from the list of selections.



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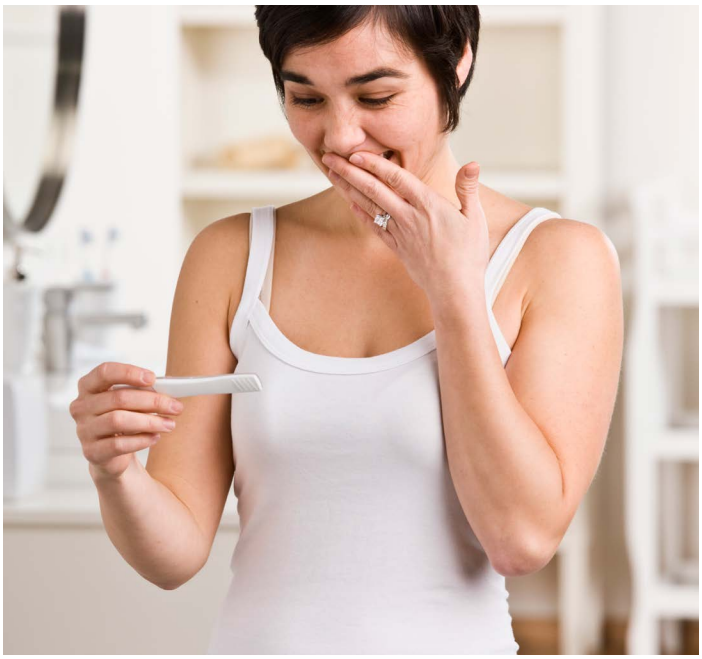
Timely prenatal care is important



Timely prenatal care plays a vital role in the health of mothers and their babies. Pregnant women who don't receive early and adequate prenatal care could be at risk of undetected complications. These problems could be treated too late in their pregnancy, which can increase adverse outcomes for both mom and baby.

Prenatal care within the first trimester also gives you an opportunity to educate and support your pregnant patients from pregnancy to motherhood.

Blue Cross Complete of Michigan evaluates how many pregnant mothers receive timely prenatal care visits. This is measured using the Healthcare Effectiveness Data and Information Set®. The HEDIS* quality of care specification measures the percentage of women who had a live birth and received a prenatal care visit during their first trimester or within 42 days of enrollment with the plan.

As a Blue Cross Complete provider, you can ensure timely prenatal care visits by following these recommendations:

- Encourage your patients to initiate prenatal care visits during the first 13 weeks of pregnancy.
- Code the first prenatal visit with a pregnancy diagnosis when you submit your claims.
- If a pregnant woman presents late in her first trimester, avoid coding the visit as a routine office visit or pregnancy confirmation. Instead, begin prenatal care to ensure you meet the timeliness to care measure.
- Educate your staff on the importance of confirming the estimated gestational age when scheduling the first prenatal visit.
- Institute a policy for handling no-shows for first prenatal visits that prioritizes the patient based on her estimated gestational age.

Required documentation for pregnancy-related diagnosis

For visits to a family practitioner or a primary care physician, a pregnancy-related diagnosis must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred and evidence of one of the following:

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, a pelvic exam with obstetric observations or measurements of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh[D] and ABO blood typing
  - Solitary TORCH antibody panel
  - A rubella antibody test or titer with a RH incompatibility (ABO/Rh) blood typing
  - Echography of a pregnant uterus
  - Documentation of LMP or EDD in conjunction with either of the following:
    - » Prenatal risk assessment and counseling or education
    - » Complete obstetrical history

It's important to know that for pregnant women eligible to receive Medicaid, coverage will be retroacted back to the first day of the month in which she applied. If your patient has already applied and is awaiting active coverage, do not delay prenatal care.

For additional information, contact Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance.

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Pregnant women can take advantage of coordinated care with Bright Start®

Blue Cross Complete of Michigan's Bright Start maternity program focuses on helping manage care for all pregnant members. Bright Start identifies pregnant members and helps them manage their pregnancy from conception through postpartum. A registered nurse will help coordinate the care and identify any high-risk behaviors to help eliminate barriers to having a healthy pregnancy.

If you think a member would benefit from these services, you can refer her to the Bright Start maternity program by calling **1-888-288-1722**.

Blue Cross Complete hosts community baby shower

Blue Cross Complete of Michigan is hosting a community baby shower on March 23, 2018, from 11 a.m. to 2 p.m. at the Northwest Activity Center, located at 18100 Meyers Road in Detroit.

Expectant parents will receive a variety of needed baby items while kids can receive lead screenings and dental cleanings. The baby shower will feature a Blue Cross Complete Community Health Navigator to schedule postpartum appointments. Our Bright Start maternity program representatives will also be there to talk to members.

Although this event is open to the public, registration is required. To register, call **1-844-280-9127**.

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Drug list resources available for Blue Cross Complete

Drug list details

A comprehensive drug list for Blue Cross Complete of Michigan is available on our website at **mibluecrosscomplete.com** under the *Pharmacy* tab.

The drug list can be accessed and reviewed in two ways:

- A printable PDF version is available by clicking on *Preferred Drug List*.
- You can also search by clicking *online drug list* in the second paragraph.

The searchable version provides additional details regarding quantity limits, prior authorization or other coverage details not available on the printable version. This includes guidance for obtaining specialty medications.

The Blue Cross Complete drug list is generic-friendly. Unless otherwise specified, in the event that a generic equivalent is available for a brand-name medication, claims processing will require that the generic equivalent be dispensed for the medication to be covered.

When a nonformulary drug or a drug that has an associated edit is inadvertently prescribed, prescribers and pharmacists are encouraged to work together to convert to a preferred drug, when appropriate.

Clinical edits

Various clinical edits, including prior authorization, step therapy, quantity limits and age limits are included on the drug list for specific medications. Prior authorization and step therapy criteria are available on the state of Michigan's website at **michigan.gov/mcopharmacy**.** It's important to remember that plans may be less stringent than the posted criteria for certain medications or classes.

Quantity limits and age limits are established for some medications on the drug list. Quantity limits, or dose optimization edits, are typically established in line with approved dosing schedules. If an elevated dose is required, above the approved quantity, the prior authorization process should be followed.

Age limits can be established for multiple reasons. Typically, age limits are implemented to reinforce safety protocol or to help refer a member to a more cost-effective dosage form such as the use of a tablet for an adult rather than a liquid. In the event that a preferred dosage form isn't medically appropriate, the prior authorization process should be used.

As part of the prior authorization process, providers must complete the *Blue Cross Complete Medication Prior Authorization Request form*.

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To download the form:

- Visit **bcbsm.com**.
- Click on the *Providers* tab.
- Select the *Help* tab and then *FAQ*.
- Scroll down until you find *Blue Cross Complete* and click it.
- Under *Pharmacy*, select *Prior Authorization Request form*.

The form must be 100 percent completed and submitted along with all appropriate documentation that may help us process the request. For example, you must include medical history, previous therapies tried and additional rationale. Incomplete forms or missing documentation may delay or prevent a request from being processed.

Completed prior authorization forms should be faxed to **1-855-811-9326**.

Drug list changes

Drug list changes approved by the Common Formulary Workgroup or the AmeriHealth Caritas Pharmacy and Therapeutics Committee are available by doing the following:

- Visit **mibluecrosscomplete.com**.
- Click on the *Pharmacy* tab.
- Select *Preferred Drug List* under the Preferred Drug List heading.

You can also reach the drug list by selecting *Resources for Providers* near the bottom of the homepage.

Depending on the type of drug list change, various forms of communications may be used.

Communication strategies may include letters, fax blasts, web documents and provider portal posts. Any necessary communication will be completed as early as possible prior to the implementation of a change. Most direct communications will be the result of a negative drug list change, such as the removal of a medication from the drug list or the addition of a clinical edit.

Medical exception process

In the event that a nonformulary drug is most appropriate for the member, the prior authorization process allows for a potential coverage consideration. As mandated, all formulary drugs listed on the Blue Cross Complete drug list are represented on the Michigan Pharmaceutical Product List for fee-for-service Medicaid. Although not all medications from the list are included on the plan's formulary, all medications on the MPPL must be considered for coverage under the pharmacy benefit. As with some nonpreferred formulary drugs, nonformulary drugs that are covered on the MPPL may be available through the prior authorization process.

Typically, if drug list criteria have been met and the preferred formulary drugs have failed or are not medically appropriate, then a nonformulary drug may be considered for coverage. Again, all supporting documentation must be submitted for us to consider covering a nonformulary drug.

Carve-out medications

A portion of the pharmacy benefit for Medicaid beneficiaries is carved out by the state of Michigan. The medications listed below are covered under the fee-for-service portion of the benefit.

- Anti-depressants
- Anti-anxiety
- Anti-epileptics
- Barbiturates
- Anti-hemophilic factors
- Cystic fibrosis transmembrane conductance regulator agents, antivirals for the treatment of hepatitis C
- Antiretrovirals for the treatment of HIV

Instead of billing Blue Cross Complete for the medications, the pharmacy must bill fee-for-service Medicaid, also known as the Magellan Medicaid Administration. Pharmacies will be alerted in a reject message if they submit a claim to Blue Cross Complete for a carve-out medication.

Reach the Magellan Medicaid Administration Clinical Call Center at **1-877-864-9014** for claims questions associated with these medications. You can also find additional information on the state of Michigan's fee-for-service drug coverage at **michigan.fhsc.com/providers/druginfo.asp**.**

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Remind your patients about the benefits of routine dental health

Research has shown there is a direct link between dental health and overall wellness. Regular dental exams can:

- Find problems with teeth and gums before they cause pain or are costly to treat.
- Prevent some problems from happening in the first place.
- Spot warning signs of diseases or other medical conditions in the mouth that are unrelated to the teeth.
- Establish a place to go for a dental emergency.

For these reasons, it's important that your patients see their dentist twice a year for routine maintenance. It applies to patients who don't have obvious problems or if they no longer have natural teeth. Just as your patients have made a habit of daily brushing and flossing, you can encourage them to stick to their routine of dental appointments twice a year.

Whom to call for dental services

Traditional Medicaid coverage	**Adults** — Contact a local dentist to see if he or she accepts FFS Medicaid coverage **Children up to age 21** — Healthy Kids Dental • To find a dentist, visit **HealthyKidsDental.org**,** or call **1-844-320-8465** for assistance. **(TTY 711)**
Healthy Michigan Plan dental services	Covered through Blue Cross Complete • To find a dentist, visit **mibluecrosscomplete.com**, or call **1-844-320-8465** for assistance. **(TTY 711)**
MIChild beneficiaries	To find a dentist, visit **HealthyKidsDental.org**,** or call **1-844-320-8465** for assistance. **(TTY 711)**

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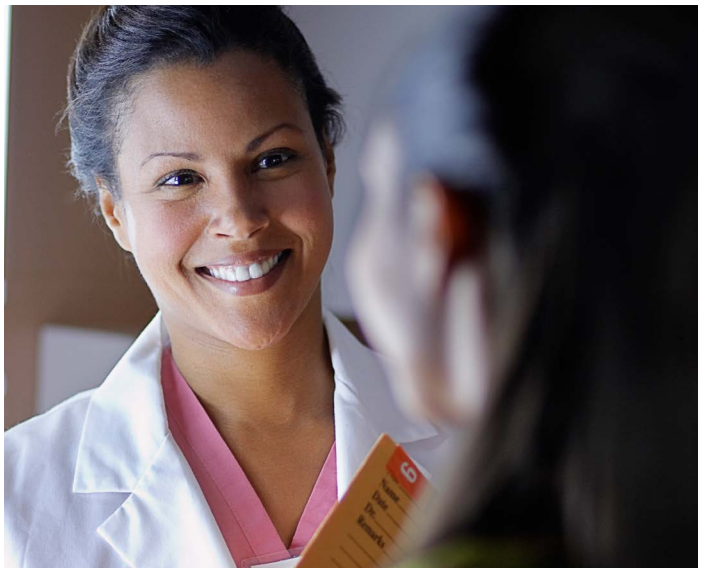
Study focuses on appointment availability and after-hours access for patients

Blue Cross Complete of Michigan conducted a study that measured provider compliance with health care access and availability standards set by Blue Cross Complete and the National Committee for Quality Assurance.

The study included primary care physicians, pediatricians, specialists, behavioral health prescribers and behavioral health nonprescribers. The study measured wait times for various types of appointments and access to providers outside of normal business hours.



Below is a summary of the overall compliance summary by appointment type:

Appointment Availability — Compliance Summary by Appointment Type				
	2016 Total PCP	2017		
		Total PCPs	PCPs	Pediatricians
Overall Compliance	73%	77%	77%	78%
Urgent Care	99%	100%	99%	100%
Routine Care	96%	98%	97%	99%
Preventive Care	94%	92%	91%	95%
Emergent Care	93%	96%	98%	91%
Wait Time	85%	89%	87%	91%

Appointment availability behavioral health summary:

Appointment Availability — Compliance Summary by Appointment Type				
	2016 Total Behavioral Health	2017		
		Total Behavioral Health	Prescribers	Non-Prescribers
Overall Compliance	49%	44%	31%	49%
Urgent Care	82%	76%	72%	77%
Routine Care	73%	77%	39%	87%
Preventive Care	99%	97%	89%	100%
Emergent Care	91%	89%	97%	86%
Non-Life Threatening Emergency Care	88%	82%	91%	80%
Wait Time	92%	98%	97%	98%

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Appointment availability specialist summary:

Appointment Availability — Compliance Summary by Appointment Type				
	2016	Total	High Volume Specialists	High Impact Specialists
Specialist Appointment	82%	90%	90%	92%

After-hours overall compliance

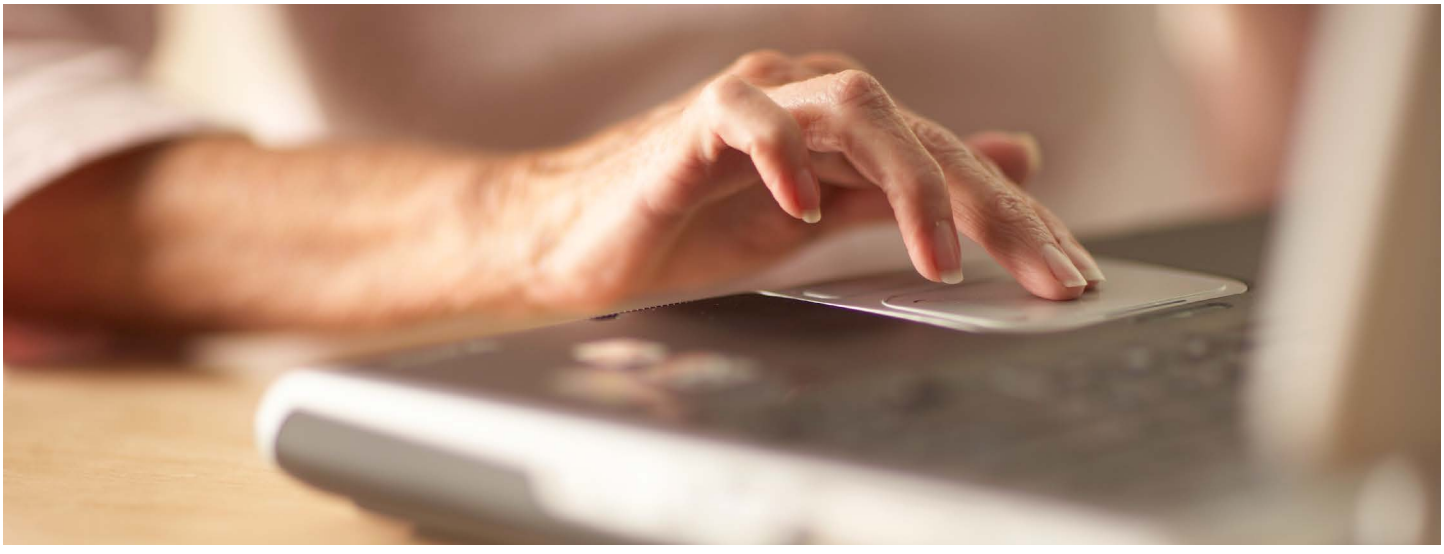
Appointment Availability — Compliance Summary by Appointment Type				
	Number Providers	Number Complaint	Number Non-complaint	% Compliant
Total Sample	250	184	66	74

Improving member access to care and availability

We're aware that each provider office is unique and faces its own challenges. That's why we've provided a list of strategies that can be useful in improving overall access to care and availability:

- Implement same-day appointments for certain patient types
- Walk-in availability
- Leave appointment slots open daily
- Train office staff on how to identify emergency situations and triage the call with a provider so the patient can be seen immediately or directed to the emergency room
- Identify patterns in care in the office; if more urgent- or sick-care appointments are needed earlier in the week, schedule routine-care appointments for later in the week
- Extend office hours
- Educate members on appropriate use of after-hours services to manage utilization:
  - What symptoms require after-hours advice?
  - Use urgent care versus emergency room for low acuity illnesses or symptoms after hours
  - Emphasize importance of after-hours advice to prevent emergency room visits

We appreciate all of the quality care and access that you provide to our members. To discuss additional strategies for improving access to care and availability, contact your Blue Cross Complete provider account executive.



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Announcing new NaviNet® electronic claim inquiry enhancement

Blue Cross Complete of Michigan is pleased to announce a new function in NaviNet that can help reduce written correspondences. It can also minimize the time spent calling the Provider Services department with claim inquiries. The new claim inquiry feature lets you request an adjustment and track responses on claims that were previously finalized. For each submitted transaction, you'll receive an electronic response to the claim inquiry. The response will indicate if the claim was adjusted or it'll provide details explaining why the claim wasn't considered for an adjustment.

Blue Cross Complete encourages you to use the claim inquiry function. However, if you don't have NaviNet access, you can still contact Provider Services.

A few important points to note before you submit your claim inquiry:

- The claim inquiry submission feature is only for finalized claims.
- Claim inquiries are for individual claims.
- To receive notification of the status of your submitted inquiry, the notifications setting in NaviNet must be enabled. With notifications on, you can select how often and when you want to be notified.

After you complete and submit your claim inquiry, you'll receive a message in NaviNet that the transaction was received, indicating it was successfully submitted. Once the claim review has been completed, you'll be notified through NaviNet that a claim response is available. Responses can be expected within 10 business days. If, for any reason, you don't receive a response, please contact Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

For step-by-step instructions, see the *Claim Inquiry User Guide* that's available on our *Plan Central page* at **navinet.net**.** If your practice isn't registered with NaviNet, we highly recommend registering. To register, please visit **navinet.net**** and sign up, or contact your Blue Cross Complete provider account executive.

New functionality allows providers to resolve patient care gaps electronically through NaviNet

We're pleased to announce a new functionality in NaviNet for faster, simpler closing of care gaps for your patients, our members. This solution will reduce paperwork and enable more frequent status updates of care gaps. You no longer need to print and complete a worksheet and fax it back to us to resolve care gaps. Instead, the new *Care Gap Response* form allows you to close care gaps by entering information in NaviNet for services that you've provided. The *Care Gap Response form* requires supporting documentation.

After you submit the information, our quality team will review and confirm that it resolves the care gap. If additional information is needed to validate the service provided, you'll be notified in NaviNet.

NaviNet offers several ways to manage care gaps, once logged in.

- Click the *Activity* tab to see alerts for care gaps that need your response.
- Clicking on *Response Requested* in the *Activity* window takes you to the Care Consideration Detail page, where you can click on *Resolve Care Gaps* and enter information.
- Under the *Workflow* tab, *Patient Clinical Documents* shows the list of members with care gaps.

You can also see care gaps for your patients through *Eligibility and Benefits Inquiry*, and on the *Member Clinical Summary* and *Care Gap Query Report*.

For more information on viewing and closing care gaps, including how to navigate the Care Consideration Details page, see our attached *Care Gap Response Form Provider Guide*.

Effective January 29, 2018, use the new *Patient Clinical Documents* workflow to navigate to the Care Gap Response form. Here you'll be able to enter information on services you've provided.

In conjunction with this upgraded functionality release, Blue Cross Complete of Michigan will no longer accept fax submissions of the Care Gap Worksheet after January 29, 2018. Instead of faxing the worksheet over to us, you'll need to log in to NaviNet and complete the *Care Gap Response form*.

If you have any questions, contact your Blue Cross Complete provider account executive.

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Discover the benefits of electronic funds transfer

Electronic funds transfer is one of the most efficient and fastest cash management tools for providers. An EFT is the electronic exchange or transfer of funds from one account to another.

Here's why it's a good choice:

- It's safe, convenient, timely and less expensive than paper checks.
- There's no cost to participate.
- It eliminates problems associated with mailing multiple checks and paper payment vouchers.

EFT is Blue Cross Complete of Michigan's recommended choice of payment because of its overall efficiency. It improves the processing of all payments and simplifies payment reconciliation when used with a standard electronic remittance advice. An ERA is an electronic explanation of the payment. It includes:

- Information about the patient
- Services rendered
- Name of the provider that rendered services
- Any claims adjustments

EFT is a solid investment and a long-term, efficient tool for receiving payments. It's one of the best investments any provider office can make.

If you're interested in receiving electronic payments and remittance from Blue Cross Complete, enroll now at **changehealthcare.com**** and select Blue Cross Blue Shield of Michigan (payer ID: 32002) as your receiver.

If you have questions about EFT or need help enrolling, contact Change Healthcare at **1-866-506-2830 (option 1)** or your Blue Cross Complete provider account executive.

Here's information for providers about MI Marketplace Option

Starting on April 1, 2018, the Michigan Department of Health and Human Services will begin transitioning eligible beneficiaries from the Healthy Michigan plan to a MI Marketplace Option health care plan. The MI Marketplace health care plans are not Medicaid products. With their own provider networks and prescription drug formularies, they'll provide a more limited benefit package.

MDHHS will cover:

- Non-emergency medical transportation
- Family planning services provided by out-of-network providers
- Any MI Marketplace Option Medicaid covered services provided by out-of-network federally qualified health centers, rural health clinics and tribal health centers as wrap-around services

Not all Healthy Michigan plan beneficiaries will be required to transition to the MI Marketplace Option. Only individuals age 21 years and older who have incomes above 100 percent of the federal poverty level and have been enrolled in a Healthy Michigan plan may move to the MI Marketplace Option. And they must have been enrolled in the plan for at least one year without choosing a healthy behavior through a health assessment.

MDHHS will identify other individuals who are exempt from the MI Marketplace Option as it reviews beneficiary requests. The department will exempt beneficiaries with serious health conditions or complex needs from the MI Marketplace Option. Providers may work with beneficiaries to request exemption. Additional information on exemption will be made available by MDHHS at a later date.

MDHHS began notifying beneficiaries who may be eligible to transition to the MI Marketplace Option in November 2017. MDHHS also conducted a live provider informational webinar on November 7, 2017. To view the recorded version of the webinar, go to **michigan.gov/mimarketplaceoption**.**

MDHHS will issue a bulletin prior to April 1, 2018, with policies and guidance for the MI Marketplace Option.

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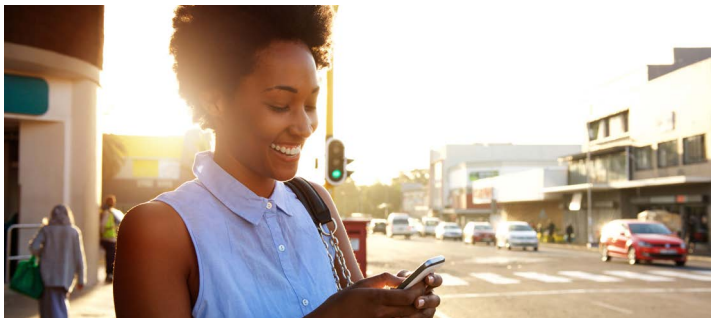
Learn more about Blue Cross Complete member rights and responsibilities

Members of Blue Cross Complete of Michigan have rights and responsibilities. Understanding these rights and responsibilities helps members get the most out of their health care benefits.



Member rights

Member rights will be honored by all Blue Cross Complete staff and affiliated providers. Members have the right to:

- Understand information about their health care
- Get required care as described in this book
- Be treated with dignity and respect
- Privacy of their health care information, as outlined in this handbook
- Treatment choices, in spite of cost or benefit coverage
- Full participation in making decisions about their health care
- Refuse to accept treatment
- Voice complaints, grievances or appeals about Blue Cross Complete and its services, benefits, providers and care
- Get clear and easy-to-understand written information about Blue Cross Complete's services, practitioners, providers, rights and responsibilities
- Review their medical records and ask that they be corrected or amended
- Make suggestions regarding Blue Cross Complete's rights and responsibilities policies
- Be free from any form of abuse, being restrained or secluded, as a means of coercion, discipline, convenience or retaliation when receiving services
- Request and receive:
  - The Blue Cross Complete Provider Directory
  - The professional education of their providers, including those who are board- certified in the specialty of pain medicine for evaluation and treatment
  - The names of hospitals where their physicians are able to treat them
  - The contact information for the state agency that oversees complaints or corrective actions against a provider
  - Any authorization, requirements, restrictions or exclusions by service, benefit or a specific drug
  - The information about the financial agreements between Blue Cross Complete and a participating provider

Member responsibilities

Members have the responsibility to:

- Know their Blue Cross Complete certificate
- Know their Member Handbook and all other provided materials
- Call Customer Service with any questions
- Seek services for all non-emergency care through their primary care physician
- Use the Blue Cross Complete provider network
- Be referred and approved by Blue Cross Complete and their primary care physician for out-of-network services
- Make and keep appointments with their primary care physician
- Contact their doctor's office if they need to cancel an appointment
- Be involved in decisions regarding their health
- Behave in a proper and considerate manner to providers, their staff, other patients and Blue Cross Complete staff
- Tell Blue Cross Complete of address changes, any changes for their dependent coverage and any other health coverage
- Protect their ID card against misuse
- Call Customer Service right away if their card is lost or stolen
- Follow their doctor's instructions regarding their care
- Make treatment goals with their physician
- Contact the Blue Cross Complete Anti-Fraud unit if they suspect fraud

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Additional rights and responsibilities

In addition to these rights and responsibilities, members also have these rights:

- To ask for and get information about how our company is structured and operated
- To have their health information stay confidential
- To use their rights without changing the way they're treated by us, health care providers or the state of Michigan
- To ask for the professional credentials of their provider
- To ask for any prior authorization requirements, limits, restrictions or exclusions
- To ask about the financial responsibility between Blue Cross Complete and any network provider
- To know if there are any provider incentives, such as pay-for-performance
- To ask about stop loss coverage

Members also have the responsibility to tell their doctor and Blue Cross Complete about their health and health history.

If you have any questions, contact your Blue Cross Complete provider account executive or Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

Help us keep the Blue Cross Complete provider directory updated

Please confirm your information for our member provider directory. Some of the key items we include in the directory are:

- Provider name
- Address
- Phone number
- Fax number
- Office hours
- Open status
- Hospital affiliations
- Multiple locations

To view your provider information:

- Visit **mibluecrosscomplete.com**
- Click on *Find a Doctor*
- Submit a written notice of any changes to Blue Cross Complete, using the *Blue Cross Complete Provider Change form* at **mibluecrosscomplete.com/provider**.

Send completed forms by:

- Email: **bccproviderdata@mibluecrosscomplete.com**
- Fax: **1-855-306-9762**
- Mail: Blue Cross Complete of Michigan
  Attention: Provider Network Management
  100 Galleria Officentre, Suite 210
  Southfield, MI 48034

If you have questions, contact your Blue Cross Complete provider account executive. In addition, you must make these changes with NaviNet at **navinet.net**.** Contact NaviNet at **1-888-482-8057** or **support@navinet.net**.

Report suspected fraud to Blue Cross Complete

Providers who suspect that another Blue Cross Complete of Michigan provider, employee or member is committing fraud should notify the Blue Cross Complete Anti-Fraud unit as follows:

- Phone: **1-855-232-7640**. TTY users call **711**.
- Fax: **1-215-937-5303**
- Email: **fraudtip@mibluecrosscomplete.com**
- U.S. mail:
  Blue Cross Complete Anti-Fraud unit
  P.O. Box 018
  Essington, PA 19029

The Blue Cross Complete Anti-Fraud unit supports the efforts of local and state authorities in prosecuting fraud. Reports of suspected fraud related to Blue Cross Complete may also be sent directly to the Michigan Department of Health and Human Services in one of the following ways:

- Call **1-855-MI-FRAUD (1-855-643-7283)**
- Online at **michigan.gov/fraud****
- By writing to:
  Office of Inspector General
  P.O. Box 30062
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