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### 2024 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus

#### Section 3. How You Get Care

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**Service Type:** Severe obesity surgery in an outpatient hospital or ambulatory surgical center (ASC)

**Primary Payor:** Other healthcare insurance

**Precertification:** Not applicable

**Prior Approval:** Yes

**Service Type:** Residential treatment center admission – inpatient

**Primary Payor:** Other healthcare insurance

**Precertification:** Yes

**Prior Approval:** Not applicable

**Service Type:** Residential treatment center – outpatient care

**Primary Payor:** Other healthcare insurance

**Precertification:** Not applicable

**Prior Approval:** Yes

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- **Prior notification – Maternity care**

We encourage you to notify us of your pregnancy during the first trimester. Please contact us at the phone number on the back of your ID card and provide the following information:

- Enrollee’s name and Plan identification number
- Expected delivery date
- Date of your first prenatal appointment
- Name and phone number of the provider (i.e., physician, nurse practitioner, nurse midwife) providing your prenatal, delivery, and postnatal care
- Name and location of the place you intend to deliver (i.e., hospital, birthing center, your home)

- If you plan to deliver in a hospital, the type of delivery and the estimated number of days you will be in the hospital.

We will advise you if any additional information is needed.

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### **How to request precertification for an admission or get prior approval for *Other services***

You, your representative, your physician, or your hospital, residential treatment center or other covered inpatient facility must call us at the phone number listed on the back of your ID card any time prior to admission or before receiving services that require prior approval with the following information:

- Enrollee's name and Plan identification number;
- Patient's name, birth date, and phone number;
- Reason for inpatient admission, proposed treatment, or surgery;
- Name and phone number of admitting physician;
- Name of hospital or facility;
- Number of days requested for hospital stay;
- Any other information we may request related to the services to be provided

Note: If we approve the request for prior approval or precertification, you will be provided with a notice that identifies the approved services and the authorization period. You must contact us with a request for a new approval five (5) business days prior to a change to the approved original request, and for requests for an extension beyond the approved authorization period in the notice you received. We will advise you of the information needed to review the request for change and/or extension.

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- **Non-urgent care claims**

For non-urgent care claims (including non-urgent concurrent care claims), we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for *Other services* that must have prior approval. We will notify you of our decision within 15 days after the receipt of the pre-service claim.

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