NC Medicaid Managed Care
Provider Playbook

NC Medicaid

Fact Sheet

Children and Family Specialty Plan (CFSP) Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2

Question	Healthy Blue Care Together's Response
What are the options (electronic, facsimile, paper) for filing a claim for CFSP?	**Electronic Submission of Claims** Blue Cross NC uses Availity as its exclusive partner for managing all Electronic Data Interchange (EDI) transactions. EDI, including Electronic Remittance Advices (835) allows for a faster, more efficient and cost-effective way for providers and employers to do business. Use Availity for the following EDI transactions • Health Care Claim: Professional (837P) • Health Care Claim: Institutional (837I) • Health Care Eligibility Benefit Inquiry and Response (270/271) • Health Care Services Prior Authorization (278) • Health Care Services Inpatient Admission and Discharge Notification (278N) • Health Care Claim Payment/Advice (835) • Health Care Claim Status Request and Response (276/277) • Medical Attachments (275)

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	Availity's EDI submission options: EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – Availity.com > Provider Solutions > EDI Clearinghouse. Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway) **Paper Claims:** Providers must submit a properly completed UB-04 or CMS-1500 (08-05) claim form to: Blue Cross NC | Healthy Blue Care Together Claims Department P.O. Box 61010 Virginia Beach, VA 23466
Where should a provider submit behavioral health claims?	All behavioral health claims should be submitted directly to Healthy Blue Care Together electronically through Availity or by mailing a paper claim.
Where should a provider submit physical health claims?	All physical health claims should be submitted directly to Healthy Blue Care Together electronically through Availity or by mailing a paper claim.
Where should a provider submit pharmacy health claims?	All pharmacy health claims should be submitted directly to Healthy Blue Care Together electronically through Availity or by mailing a paper claim.
Where should a provider submit vision claims?	Providers should submit claims to EyeMed through one of the following methods: • Online: claims.eyemedvisioncare.com/claims/loginForm.emvc • 837 EDI Clearinghouse • On paper fax to: 866-293-7373 • On paper mail to: EyeMed Vision Care/FAA P.O. Box 8525 Mason, OH 45040
Where should a provider submit	All DME claims should be submitted directly to Healthy Blue Care Together electronically through Availity or by mailing a paper claim.

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claims for durable medical equipment (DME)?	
Where should a provider route NEMT claims to?	The Transportation Providers will utilize an electronic submission method through the Modivcare TP Portal. • Mailing address is 798 Park Ave NW, Norton, VA 24273. • Fax is 866-528-0462 • Email is support.claims@modivcare.com.
How does CFSP comply with the Department's "good faith" contracting requirements for purposes of determining rates?	The Healthy Blue Care Together provider network will meet availability, accessibility, and quality goals and requirements. In developing the Healthy Blue provider network, we will negotiate with any willing provider in good faith regardless of provider or our affiliation. The health plan or subcontractor to the extent that the subcontractor is delegated responsibility by the health plan for coverage of services and payment of claims under the Medicaid Managed Care Contract, will not include exclusivity or non-compete provisions in contracts with providers, including non-medical service providers (e.g. non-emergency medical transportation drivers), require a provider to participate in the governance of a Provider-led Entity (PLE), or otherwise prohibit a provider from providing services for or contracting with any other PHP. The health plan has a strong monitoring program that ensures providers meet members' needs and program requirements. The health plan's Chief Network Officer will conduct random audits of provider records in Salesforce to validate compliance with the Good Faith Provider Contracting Policy. The health plan will perform ongoing activities to recruit new Providers to retain currently participating providers of all specialties. The health plan will not enact any recruitment or retention activity that is or could potentially be discriminatory of Providers that serve high-risk populations or specialize in complex conditions that require costly treatment. The health plan will not discourage its Network providers from contracting with other Managed Care Organizations. The health plan will conduct a good faith effort to contract with North Carolina and contiguous county Providers, who are enrolled Medicaid Providers within the state of North Carolina, using contract mailing, ongoing negotiations and continuing communications with the Providers to receive a completed network agreement. All communications are documented in Salesforce, including if the Provider chooses not to contract or does not meet the qualifications to participate in the Network.

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	Providers contracted with the Healthy Blue Standard Plan are not automatically contracted with Healthy Blue CFSP, as each operates under a separate contract.
What information is needed from the provider to file a claim?	Claim submissions, whether electronic or paper, must include the following information: • Member's ID number including alpha prefix • Member's name • Member's date of birth • ICD-10-CM diagnosis code • Date of service • Place of service • Procedures, services or supplies rendered with Current Procedural Terminology (CPT)-4 codes/Healthcare Common Procedure Coding System (HCPCS) codes/disease-related groups, Itemized charges • Days or units • Provider tax ID number • Provider name according to contract • Billing provider information and rendering provider information when different than billing or when billing a group taxonomy • National Provider Identifier (NPI) of billing and rendering provider when applicable, or Administrative Provider Identification (API) when NPI is not appropriate • Taxonomy of billing provider, attending and rendering provider when submitted • Coordination of benefits/other insurance information • Precertification number or copy of precertification • NDC, unit of measure and quantity for medical injectables Provider and member data will be verified against state reference data for accuracy and active status. Be sure to validate this data in advance of claims submission. This validation will apply to all provider data submitted and applies to atypical and out-of-state providers.
How can a provider enroll to use Electronic Funds	Providers and facilities can register, enroll and manage account changes for EFT through EnrollSafe at enrollsafe.payeehub.org. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. Not

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Transfer (EFT) for payment?	being enrolled for EFT will result in paper checks being mailed to the mailing address Blue Cross NC has on file.
Does CFSP charge any clearinghouse or EFT fees?	There is no cost to providers for EFT enrollment through EnrollSafe.
Under what circumstances does CFSP offer an Out-of-Network agreement?	The health plan's Healthcare Networks Team will make reasonable attempts to contract in good faith with any out-of-network providers rendering ongoing care to an enrolled member. When the out-of-network provider is serving as a member's Primary Care Provider (PCP), the Healthcare Networks Team contacts the provider and encourages them to join the network. The health plan will reimburse out-of-network providers who provide services to a member in accordance with the Transition of Care requirements.
What is the first date CFSP intends to start issuing medical and pharmacy payments after Managed Care Launch? **What is the payment cycle for medical and pharmacy claims?**	Caremark PBM sends payments based on prompt pay laws for state and product type, typically Medicaid would be 14 days unless state specified otherwise. Commercial and marketplace would be different, but payment is determined the day claim is adjudicated as soon as they are live. Caremark or Blue Cross issue payments Monday - Friday excluding holidays - if check run lands on a holiday payment is sent out on the next business day.
What is the first date CFSP intends to start issuing vision and non-emergency medical transportation (NEMT) payments after Managed Care Launch? **What is the payment cycle for vision and NEMT claims?**	**EyeMed** Clean claims fully adjudicated to paid status by EOD on Monday, Dec. 1, 2025, will be paid on Tuesday, Dec. 2, 2025. For the next payment cycle, clean claims fully adjudicated to paid status by EOD on Monday, Dec. 8, 2025, will be paid on Tuesday, Dec. 9, 2025. EyeMed pays all Healthy Blue NC Medicaid claims weekly on Tuesdays. Clean claims submitted through online or 837 submission are commonly processed to paid status within 24-48 hours. Clean claims submitted through paper filing are processed and paid within 30 calendar days or less. **NEMT** The first payment date will be Dec. 12, 2025.

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	Claims are due by Wednesday for check run the following Friday. I.e. Checks will be issued on Dec. 12, 2025, for claims submitted on Dec. 3, 2025. *If claim due date falls on a holiday, claims must be submitted the day before for payment the following week. *If check run falls on a holiday, payment is sent out the business day before the holiday.
What message will providers see in the Provider Portal regarding individual claim status prior to first payments being released?	Providers can check the status of claims on the Availity Essentials portal or by calling Provider Services at 1-833-777-3698. Providers can also submit a Claim Status batch transaction through EDI.
How can providers determine which services require prior authorization for a health plan?	For the most up-to-date precertification/notification requirements and prior authorization form, providers should visit provider.healthybluenc.com and select Prior Authorization Lookup Tool under Resources.
How can providers submit a prior authorization for CFSP? **Does this process differ based on claim type?**	Providers can submit prior authorization requests online through Availity Essentials at Availity.com. (Select Patient Registration > Authorizations & Referrals). Other methods are through fax or by calling Provider Services at 1-833-777-3698. The fax forms are conveniently located on our website at provider.healthybluenc.com.
What member ID should be used when submitting claims?	Providers should use the member ID located on the ID card from Healthy Blue Care Together which includes an alpha prefix (HBL). A sample of the Healthy Blue Member ID card can be found in the Provider Manual in section 2.17.
How should an out of network provider submit physical health claims?	All providers, regardless of contract status, can submit claims through electronically or through paper submissions. Out of network providers may be subject to required prior authorization depending on the service.

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Which provider manuals should providers use for each claim type (behavioral health, physical health, vision, pharmacy, DME, NEMT, etc.)	All providers should use the Healthy Blue Care Together Provider Manual as their primary resource for important information regarding member benefits, prior authorizations, claims, health plan contact information and more. The Healthy Blue Care Together Provider Manual can be found on our website at provider.healthybluenc.com/north-carolina-provider For vision and NEMT, additional information may be available on our vendor websites.

How can providers appeal a claim for underpayment, denial, etc.?	Payment Dispute: There are several options for filing a provider dispute: Online: Use Availity Essentials, our secure provider portal, to select the Claims & Payments menu at Availity.com: Select Claim Status Select the organization and payer Complete the required fields for provider, patient and claim information. Select submit Locate the claim you want to dispute using Claim Status from the Claims & Payments menu If available, select Dispute Claim to initiate the dispute Go to Request to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit Written: Mail all required documentation (see below for more details), including the Claim Payment Appeal Form or the Reconsideration Form to: Blue Cross NC | Healthy Blue Care Together Provider Grievance and Appeals P.O. Box 61599 Virginia Beach, VA 23466-1599 Member Medical Appeals:

	Member medical necessity appeals must be filed within 60 calendar days of the date of action. Providers may appeal on behalf of the member with the member's written consent. Submit a member medical appeal to: Blue Cross NC | Healthy Blue Care Together Central Appeals and Grievance Processing P.O. Box 62429 Virginia Beach, VA 23466-62429 Providers can also file online with Availity Essentials: • Log into Availity.com • Locate claim using Claim Status • Select dispute button to initiate appeal • Navigate to Claims & Payments and select Appeals • Locate initiated appeal and upload documents Providers can also submit through fax at: 844-429-9635, by email at: ncmedicaidgrievances@nchealthyblue.com, or by phone at: 1-833-777-3611.
Where can a provider find a list of Known issues?	Healthy Blue Care Together posts weekly Known Issues Bulletins on our provider website to share information related to known claims issues. All bulletins will be stored on our provider's website within the Provider news archives (provider.healthybluenc.com/north-carolina-provider/archives).