Independence Blue Cross

www.ibx.com

Partners in Health UPDATE

March 2008

Working Together For Quality Health Care

Updating your CAQH online data

For participating providers that utilize the Council for Affordable Quality Healthcare's (CAQH) online application system (OAS) for credentialing purposes, please remember to update Section 6 — Professional Liability Insurance Carrier — when attesting or reattesting to the application. This will reduce the requests your office/practice receives for this information.

For more information on CAQH's OAS, please visit *www.caqh.org/ucd.php.*

For articles specific to your area of interest, look for the appropriate icon:

- Professional
- Facility
- Ancillary

INSIDE THIS ISSUE

IBC's NPI contingency plan to continue through May 23, 2008

After careful assessment of provider readiness, we have determined that a significant percentage of providers have either not yet registered their NPIs with IBC or have not begun submitting their NPIs on claims. Therefore, IBC's NPI contingency plan will continue through May 23, 2008 — the latest date allowed by the Centers for Medicare & Medicaid Services (CMS). Unless CMS announces an extension, you must use your NPI on all claims as of May 23, 2008, or your claims will reject.

IBC's contingency plan: Dual use

IBC's contingency plan includes a dual use strategy that allows providers to submit all electronic and paper claims with NPIs and 10-digit legacy provider identifiers (IBC-assigned IDs that providers use to identify themselves as an IBC-participating health care provider). If providers have registered their NPI with IBC or submitted an NPI with a CMS certification, they may continue to submit claims with their NPI and 10-digit legacy identifier during the contingency period, consistent with our dual use strategy.

Our dual use strategy is intended to ensure that IBC is NPI compliant, but in a manner that maintains operations, recognizes providers' varying states of readiness, and avoids unnecessary disruption in providers' cash flow.

More information about IBC's NPI dual use claims submission, including the entire IBC NPI contingency plan, electronic and paper claim submission instructions, and relevant FAQs, is available on *www.ibx.com/providers/npi.*

Register your NPI online with provider registration web form

Providers may now register their NPIs with IBC online by submitting an NPI provider registration web form.

Please visit *www.ibx.com/providers/npi/provider_registration.html* to register your NPI information with us.

NPIs must be registered with IBC

NPI-only claims will reject if NPI is not registered with IBC

As previously stated in our NPI contingency plan, NPI-only claims will reject if providers have not registered their NPIs with us. IBC can accept claims with an NPI as the primary identifier if providers have registered their NPI with us. However, providers must register their NPI with IBC prior to submitting NPI-only claims.*

Once you have registered your NPI with us, you may continue to submit claims with the NPI and 10-digit legacy identifier, consistent with our dual use strategy.

In addition to all providers currently participating with IBC, NPIs will be required for new practitioners who request participation with IBC. The NPI, if not already registered, will also be requested as part of the recredentialing process.

**IBC will receive contracted behavioral health providers' NPI information directly from Magellan Behavioral Health, Inc. For further information, please contact Magellan National Provider Services Center at 1-800-788-4005, or visit Magellan at www.magellanhealth.com.*

NPI resources

Registering your NPIs with IBC

When providers register their NPIs with IBC, we are able to link the NPIs to existing data in our internal processing systems. To mitigate any potential impact on a provider's cash flow, we have requested that providers register their NPIs with us before submitting an NPI claim.

Registering your NPI with IBC is easy. Once you have obtained your NPI, you may register using either of the following methods:

- **Online.** Register your NPI online by submitting the appropriate NPI provider registration web form on *www.ibx.com/providers/npi/provider_registration.html.*
- **Paper.** Register your NPIs with us by mailing your completed custom NPI Submission Form. This form has been included in mailings to participating provider offices.

Contact your Network Coordinator with questions regarding the new provider registration web form or your custom NPI Submission Form.

How to obtain an NPI

National Plan and Provider Enumeration System (NPPES) is currently accepting applications for NPIs. Providers who have not yet obtained an NPI may apply for it in either of the following ways:

- **Online.** Complete the Web-based application on *https://nppes.cms.hhs.gov.* It takes approximately 20 minutes to complete and is the most time-efficient way to obtain an NPI.
- **Paper.** Obtain a copy of the NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator. The form is available only upon request through the NPI Enumerator. Providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of the following ways:
  - Phone: 1-800-465-3203 or TTY/TDD 1-800-692-2326
  - Email: *customerservice@npienumerator.com*
  - Mail:
    NPI Enumerator
    P.O. Box 6059
    Fargo, ND 58108-6059

NPI web resources

IBC provider NPI website — *www.ibx.com/providers/npi*
Contains NPI background, FAQs, registration forms, web links, and other information

CMS main NPI website — *www.cms.hhs.gov/NationalProvIdentStand/*
Contains NPI Final Rule, FAQs, fact sheets, tip sheets, NPI Viewlet, Medicare MedLearn articles, and enumeration statistics

NPI Enumerator website — *https://nppes.cms.hhs.gov/NPPES/Welcome.do*
Main site to enter an NPI application

WEDI NPI outreach initiative — *www.wedi.org/npioi/index.shtml*
NPI Resource Center with information resources, industry readiness assessment survey, etc.

Payer codes for Select Advantage Private Fee-for-Service

As noted in the January 2008 *Partners in Health Update*, the IBC Companion Guides have been updated to reflect the payer codes for our new Medicare Advantage Private Fee-for-Service (PFFS) plan, Select Advantage. All providers submitting Select Advantage claims MUST use the SA704 payer code for electronic (837I and 837P) submissions, as stated in the Companion Guides. These specific codes will ensure that claims are processed and reported quickly and appropriately.

Also, when mailing Select Advantage paper claims, documents, or correspondence, please be sure to use the appropriate post office mailing address noted below:

Select Advantage Claims
P.O. Box 69350
Harrisburg, PA 17110

Paper claims submission guidelines

Effective March 1, 2008, we will no longer accept paper claim submissions on which information has been covered with correction fluid/correction tape or has been scratched out. Using correction fluid/correction tape or manually scratching out information causes concerns with auditing and processing procedures and is not compliant with HIPAA regulations. Beginning March 1, 2008, any such submissions will be returned to you, and a new clean claim submission will be required.

Although not preferred, if a correction is necessary, you may line out the incorrect data, neatly print the corrected data, and initial the correction. Please be sure the correction is legible.

Please contact your Network Coordinator if you have any questions about proper paper claim submissions.

Note: Although correction tape was not mentioned in the January edition of Partners in Health Update*, it is also not acceptable when submitting paper claims.*

IBC rejecting paper claims submitted on forms CMS-1500 (12/90) and UB-92

IBC no longer accepts paper claims submitted on forms CMS-1500 (12/90) and UB-92. All paper claims received after December 17, 2007, must be submitted on revised forms CMS-1500 (08/05) and UB-04. Paper claims submitted on forms CMS-1500 (12/90) and UB-92 will reject.

Provider Claim Payment Appeal process

As previously communicated in the August 2007 edition of *Partners in Health Update*, IBC supplements our Provider Claim Inquiry process with a two-level Claim Payment Appeal process for Professional Providers. This opportunity for additional claim payment review is available to providers who agreed to the court-approved Class Action settlement in the consolidated cases of Gregg, et al. vs. Independence Blue Cross, et al., Good vs. Independence Blue Cross, et al., and Pennsylvania Orthopaedic Society vs. Independence Blue Cross, et al.

Professional Providers who submit claims for services provided on or after August 1, 2006, to members enrolled in Pennsylvania and Delaware benefit plans will be eligible to pursue the Provider Claim Payment Appeal process described below. Services provided to eligible members must be considered medically necessary. Claims related to services provided to members enrolled in a New Jersey benefit plan will continue to use the appeal process mandated by New Jersey law. Plan information is located on the member's ID card.

Additionally, this two-level Provider Claim Payment Appeal process specifically applies to billing disputes related to general coding and the administration of claim payment policy.

Some examples of appealable events include:

- coding logic;
- application of claim payment policy;
- claim adjudication not consistent with law or contract.

The Provider Claim Payment Appeal process does not apply to:

- utilization management determination (e.g., claims for services considered non-medically necessary, experimental/investigational, cosmetic, dental rather than medical);
- medical necessity determination;
- eligibility determination (e.g., claims for services provided to a person who is not a member);
- audit and investigations performed by the Corporate and Financial Investigations department;
- fee schedule disputes.

To facilitate claim payment review, we encourage providers to submit a claim inquiry by calling Provider Services at 215-567-3590 or submitting a Physician Claim Inquiry Form found on *www.ibx.com/providers* to:

Physician Claim Inquiry
P.O. Box 7930
Philadelphia, PA 19101-7930

First Level Provider Claim Payment Appeal

Providers who disagree with an inquiry decision may initiate a First Level Provider Claim Payment Appeal by submitting the qualified claim(s), claim inquiry form, supporting documentation, and alternative claim payment justification to:

First Level Provider Claim Payment Appeals
P.O. Box 42500
Philadelphia, PA 19101-2500

Second Level Provider Claim Payment Appeal

If a provider disputes the First Level Provider Claim Payment Appeal determination, he or she may then submit a Second Level Provider Claim Payment Appeal by sending in a written request within 60 days of receipt of the decision of the First Level Provider Claim Payment Appeal. This request and information should be sent to:

Second Level Provider Claim Payment Appeals
P.O. Box 42500
Philadelphia, PA 19101-2500

The appeal will be reviewed by an internal Provider Appeals Review Board (PARB) consisting of three members: One medical director and two associates with no direct daily responsibility for claims issues. The decision will then be communicated to the provider and will include a detailed explanation of what action was taken and the reason for the action. The decision of the PARB will be the final decision of IBC and there will be no further appeal.

Note: This Provider Claim Payment Appeal process applies to both Medicare and Commercial members.

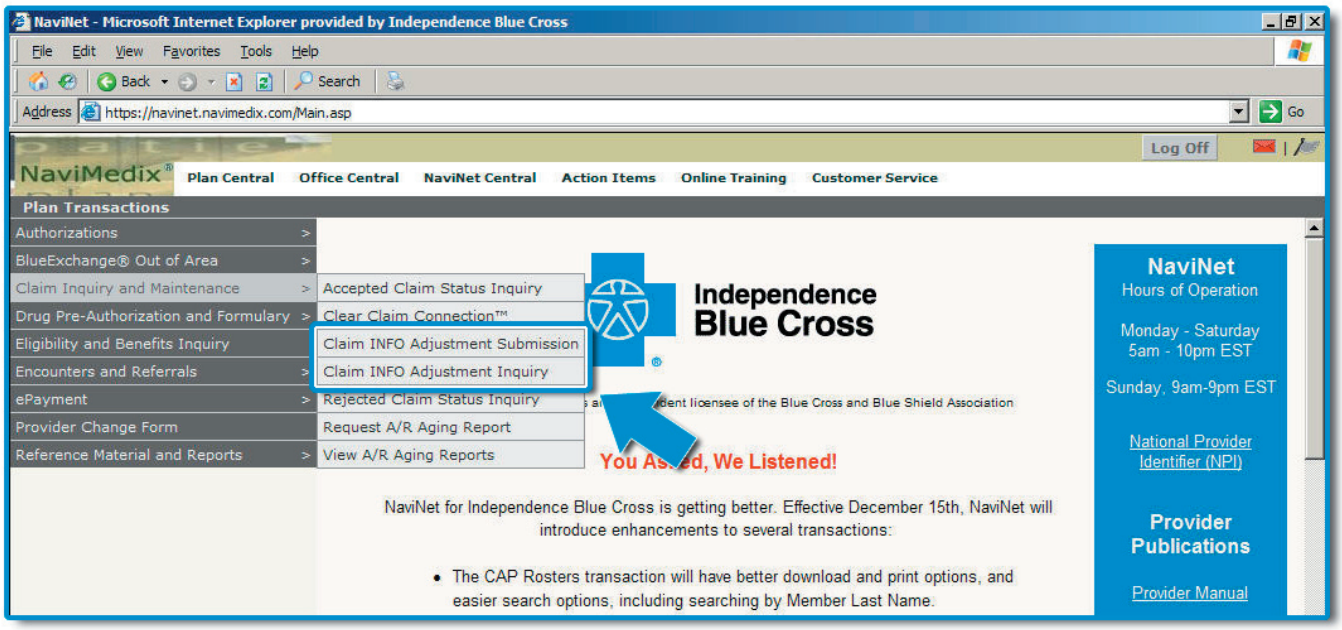
Claim INFO transactions now available on NaviNet®

The Claim INFO transactions are now available on NaviNet to professional providers. The *Claim INFO Adjustment Submission* transaction allows providers to submit claim adjustments through NaviNet for claims in a paid or denied status. Claims data is available for up to two years prior to the current date.

The *Claim INFO Adjustment Inquiry* transaction enables providers to review the status of submitted requests. Both transactions can be viewed through the *Claim Inquiry and Maintenance* menu under *Plan Transactions*. Please refer to the sample screen below.

For assistance with these or any other transactions offered through NaviNet, providers can view the User Guides under *Customer Service,* or they can contact NaviNet Customer Care at 1-888-482-8057.

NaviNet® is a registered trademark of NaviMedix, Inc.



PRODUCTS

Clarification to member benefits

Effective April 1, 2008, the following member benefit clarifications will be implemented:

- **Blood pressure monitor** (Flex and Non-Flex [HMO, POS]). Language is being added to clarify exclusions regarding coverage of home blood pressure monitors.
- **Diabetic education** (Flex and Non-Flex [HMO, POS, PPO], Personal Choice® HSA-qualified High Deductible Health Plans [HDHPs]). Language is being added to clarify that network professional providers, in addition to facility providers, are eligible to perform diabetic education.
- **Post-mastectomy care/home health care** (Non-Flex [HMO, POS]). Language is being added to clarify home health care coverage associated with post-mastectomy care.
- **Post-mastectomy care/lymphedema** (Flex and Non-Flex [HMO, POS, PPO], Personal Choice HSA-qualified HDHPs). Language is being added to clarify lymphedema coverage associated with post-mastectomy care.
- **Designated providers** (Flex and Non-Flex [HMO, POS]). Language is being clarified regarding the requirement that members must use designated capitated providers selected by their PCP for certain services.
- **Contraceptive exclusion** (Flex [HMO, POS, PPO], Non-Flex PPO, Personal Choice HSA-qualified HDHPs). Language is being added to clarify contract exclusion. Standard contracts exclude all contraceptives (e.g., devices, injectables, and implants).
- **Cognitive rehabilitation therapy** (Flex and Non-Flex [HMO, POS, PPO], Personal Choice HSA-qualified HDHPs). Language is being clarified to eliminate the mixed use of the definitions of cognitive rehabilitation therapy and cognitive therapy. Exclusion language is also being clarified to indicate under which circumstances cognitive rehabilitation therapy may be covered.

MEDICAL

Policy change notifications available online

To better communicate policy changes to providers, articles regarding changes to medical policies are now published on *www.ibx.com/medpolicy.* These policy change articles will be available at least 30 days in advance of the proposed changes to policy.

Please follow these instructions to read notifications:

1. Visit *www.ibx.com/medpolicy.*
2. Select *Accept and Go to Medical Policy Online.*
3. Select the *Commercial and Other Medicare Advantage policies* link.
4. Select *News & Announcements* from the *Medical Policy* column on the left sidebar.
5. Select links to notification articles.

Another new enhancement to the *News & Announcements* section is a listing of recently published policies to the website arranged by month. These listings are updated daily, so please check back frequently to see what's new.

Home uterine activity monitoring (HUAM) devices medical policy #05.00.65c

Effective April 1, 2008, we are changing our coverage position for home uterine activity monitoring (HUAM) devices to *not medically necessary*.

According to the American College of Obstetricians and Gynecologists, and based on a recent review of the available published literature on the use of HUAM to provide early detection of preterm labor (PTL) in women at high risk for PTL and preterm birth (PTB), the effectiveness of HUAM in improving health outcomes in these individuals has not been established. Therefore, there is inconclusive evidence on the use of HUAM in the treatment of early detection of PTL and PTB for women at high risk for these conditions.

For more information, please contact your Network Coordinator.

Bariatric surgery medical policy #11.03.02d

The medical policy on bariatric surgery #11.03.02d has been revised. The revisions to this policy are noted below and will be in effect on **April 1, 2008.**

A definition of the sleeve gastrectomy was added to the policy along with a policy statement that this procedure is experimental/investigational whether performed as a stand-alone procedure or the first step of a two-stage procedure.

The policy was revised to clarify coverage of obesity surgery for our Medicare Advantage members. Coverage as noted in this policy is consistent with the Centers for Medicare & Medicaid Services (CMS) national coverage determination, effective February 21, 2006.

The policy was revised to restrict coverage of bariatric surgery for adolescents as follows:

Surgical intervention for morbid obesity is considered medically necessary and, therefore, covered for an adolescent when all of the following criteria are met:

- The individual has either a Body Mass Index (BMI) greater than 50 or has a BMI greater than 40 and obesity-related comorbidities.
- The individual has attained or nearly attained physiologic maturity as defined by one of the following:
  - Tanner Stage IV (skeletal and sexual maturation is almost complete);
  - Ninety-five percent of adult height based on estimates from radiologic bone age.
- One of the following operations is planned for the individual:
  - Roux-en-Y gastric bypass with short limb (proximal) (150 cm or less) (laparoscopic [43644] or open [43846]);
  - Roux-en-Y gastric bypass with long limb (distal) (greater than 150 cm) (laparoscopic [43645] or open [43847]).

For surgical intervention of morbid obesity in adolescents, *all* bariatric procedures, other than those noted above as medically necessary, are considered experimental/investigational because the safety and/or efficacy of these procedures in adolescents cannot be established by review of the available published literature.

For all products, the following language was added to the policy to clarify the benefit contract language regarding complications and exclusions related to second surgical procedures for the treatment of obesity.

Complications

Complications of a bariatric surgical procedure may include those associated with any major surgery, such as bleeding or infection, but may also include those specific to the bariatric procedure itself or the method (laparoscopic vs. open) used. Complications associated with bariatric surgery (including those resulting from a technical failure) usually occur during the 30-day period following the operation. The most common include, but are not limited to, the following:

- band erosion
- band slippage
- internal hernia requiring further surgery
- leaks from or dehiscence of anastomoses or staple lines
- separation of stapled/sutured areas

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Bariatric surgery policy #11.03.02d (continued)

- wound separations
- ulcers
- nutritional deficiencies

Second surgical procedures

Repeat, revision, or reversal of any previous bariatric surgery is considered medically necessary and, therefore, covered when the procedure is required to treat complications (including those resulting from a technical failure) that, if left untreated, would result in endangering the health of the individual.

Second bariatric surgical procedures (including repeat, revision, or reversal procedures) that do not treat complications as described above are considered benefit exclusions and, therefore, not covered. The following are examples of conditions that are always denied a second bariatric surgical procedure because they do not qualify as a complication or technical failure:

- weight gain or weight plateau resulting from failure to follow the regimen of diet and exercise recommended after the first bariatric surgery;
- weight gain or weight plateau resulting from the dilation and other stabilization of the gastric pouch as a natural and ordinary occurrence in the aftermath of the first bariatric surgery.

PPO network rules for Provision of Specialty Services

Consistent with our ongoing efforts to clarify provider payment policies, Claim Payment Policy #00.01.25 — PPO Network Rules for Provision of Specialty Services for Durable Medical Equipment and Laboratory, Radiology, and Physical Medicine and Rehabilitative Services — is now available on *www.ibx.com/medpolicy.*

This policy documents a long-standing practice identifying the specific participating professional and ancillary provider specialties, and the applicable services that are eligible for payment to these providers under our PPO benefits programs. These services are billed as Current Procedural Terminology (CPT®*) or Healthcare Common Procedural Coding System (HCPCS) codes within the four procedure or equipment types, as identified below:

- durable medical equipment (which includes prosthetics or orthotics);
- laboratory services;
- radiology services;
- physical medicine and rehabilitative care services.

This network rules policy addresses these services as provided in the office or outpatient setting, the home setting for DME, and independent laboratories for laboratory services. This policy applies to services billed on the CMS-1500 or 837P electronic claim form.

For more information, please contact your Network Coordinator.

Select Drug Program® formulary updates

The Select Drug Program formulary is a list of FDA-approved medications that were chosen for their medical effectiveness, safety, and value. The list changes periodically as the FutureScripts® Pharmacy and Therapeutics Committee reviews the formulary to ensure its continued effectiveness. The following are the most recent changes.

Generic additions

These generic drugs recently became available in the marketplace. When these generic drugs became available, we began covering them at the appropriate generic formulary copayment:

Generic drug	Brand drug	Formulary chapter	Effective date
alendronate	Fosamax®	10. Bones, Joints, & Muscles	February 6, 2008
balsalazide	Colazal®	8. Stomach, Ulcer, & Bowel Meds	December 28, 2007
granisetron	Kytril®	8. Stomach, Ulcer, & Bowel Meds	January 2, 2008
ibuprofen/oxycodone HCl	Combunox®	3. Pain, Nervous System, & Psych	November 27, 2007
norethindroneacetate/ethinyl estradiol/ferrous fumarate	Estrostep® Fe	11. Female, Hormone Replacement, Birth Control	October 23, 2007
ofloxocin otic drops	Floxin® Otic	6. Ear, Nose, & Throat Medications	September 28, 2007
oxcarbazepine	Trileptal®	3. Pain, Nervous System, & Psych	October 9, 2007
pantoprazole	Protonix®	8. Stomach, Ulcer, & Bowel Meds	December 24, 2007
ramipril	Altace®	4. Heart, Blood Pressure, & Cholesterol	December 21, 2007

Brand additions

These brand drugs will be covered at the appropriate brand formulary copayment:

Brand drug	Formulary chapter	Effective date
Isentress™	1. Antibiotics & Other Drugs Used For Infection	October 15, 2007
Lovenox®	9. Biotechnology	April 1, 2008

Once a brand drug becomes available in the marketplace and is approved by the FutureScripts Pharmacy and Therapeutics Committee as a formulary drug, it will be added to the formulary and will be available at the brand formulary copayment.

Brand deletions

These brand drugs will be covered at the appropriate non-formulary copayment:

Effective April 1, 2008

Brand drug	Generic drug	Formulary chapter
Altace®	ramipril	4. Heart, Blood Pressure, & Cholesterol
Floxin® Otic	ofloxocin otic drops	6. Ear, Nose, & Throat Medications
Fosamax®	alendronate	10. Bones, Joints, & Muscles
Kytril®	granisetron	8. Stomach, Ulcer, & Bowel Meds

The generic drugs for the above brand drugs are on our formulary and available at the generic formulary copayment.

Prescription drug updates

For members enrolled in an IBC prescription drug program, some drugs will be excluded from coverage because they are available over the counter. Over-the-counter medications are standard exclusions from all IBC prescription drug programs. Also, some drugs will require prior authorization. The purpose of prior authorization is to ensure that drugs are medically necessary and being used appropriately. These updates are below.

Over-the-counter exclusions

These brand drugs will no longer be covered under the prescription drug benefit because they are available over the counter:

Effective April 1, 2008

Brand drug	Generic drug	Drug category
Zyrtec®	Not available	Allergy
Zyrtec-D 12 Hour®	Not available	Allergy

Drugs requiring prior authorization

The prior authorization requirement for the following non-formulary drugs was effective at the time the drugs became available in the marketplace:

Brand drug	Generic drug	Drug category	Effective date
Azor™	Not available	Heart, Blood Pressure, & Cholesterol	October 5, 2007
Tasigna®	Not available	Cancer & Organ Transplant	November 9, 2007

The following non-formulary drug will be added to the list of drugs requiring prior authorization. Members taking this drug immediately prior to the effective date may continue to receive this drug without obtaining prior authorization until May 31, 2008.

Effective April 1, 2008

Brand drug	Generic drug	Drug category
Altabax™	Not available	Skin Medications

Connections℠ Kidney Program ends April 30, 2008

Since 2004, IBC, with RMS Disease Management Services, an independent company, has offered the Connections Kidney Program to provide disease management services to our members with end-stage renal disease (ESRD) on dialysis.

Based on ongoing evaluations, we have decided to discontinue the Connections Kidney Program **effective April 30, 2008**. Members currently enrolled in the program will be transitioned to case managers in IBC's Care Management and Coordination department to ensure that they continue to receive the appropriate support.

Dialysis centers, primary care physicians, nephrologists with patients in the Connections Kidney Program, and members enrolled in the Connections Kidney Program will receive a letter detailing the program change.

To refer a member on dialysis to IBC Care Management, call 1-800-313-8628.

Encourage members to receive colorectal cancer screening

March is Colorectal Cancer Awareness month. IBC urges you to encourage your patients to be screened for colorectal cancer. Your personal recommendation has a tremendous influence on a patient's decision to seek recommended preventive health screenings.

Adherence to the colorectal cancer screening guidelines may lead to improved patient outcomes. To view our Plan-adopted guidelines, log on to *www.ibx.com/providers* and select the *Policies & Guidelines* link. Individual clinical decisions should be tailored to specific patient medical and psychosocial needs. Although this information is adapted from national sources, information in this area might evolve rapidly and lead to changes in recommendations. As changes occur, please update your practice accordingly.

Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services.

Connections℠ Health Management Programs: Supporting our members, your patients

Call the Provider Support Line at 1-866-866-4694 to refer a patient to the Connections℠ Health Management Program for Health Coaching.

Health Coaches provide disease management information for asthma, diabetes, COPD, HF, and CHD, as well as decision support information for numerous issues.

Call 1-866-398-8761 to refer patients with the following diseases to the Connections℠ AccordantCare™ Program:

- seizure disorders
- rheumatoid arthritis
- multiple sclerosis
- Crohn's disease
- Parkinson's disease
- systemic lupus erythematosus (SLE)
- myasthenia gravis
- sickle cell disease
- cystic fibrosis
- hemophilia
- scleroderma
- polymyositis
- dermatomyositis
- chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- amyotrophic lateral sclerosis (ALS)
- Gaucher disease

Partners in Health Update is a publication of the Provider Communications department for the exchange of information and ideas among the IBC provider community. Suggestions are welcome.

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Independence Blue Cross

IMPORTANT RESOURCES

View our online provider directories at www.ibx.com

CARE MANAGEMENT AND COORDINATION Case Management	215-567-3570 1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
CONNECTIONS℠ HEALTH MANAGEMENT PROGRAMS Connections℠ Health Management Program Provider Support Line	1-866-866-4694
Connections℠ Kidney Program	1-866-303-4CKP (4257)
Connections℠ AccordantCare™ Program	1-866-398-8761
CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/anti-fraud
CREDENTIALING Credentialing Hotline Credentialing Violation Hotline	www.ibx.com/credentials 215-988-6534 215-988-1413
eBUSINESS Help Desk	215-241-2305
FutureScripts® Prescription Drug Authorization Toll Free Fax	 1-888-678-7012 1-888-671-5285
Direct Ship Injectable Fax	1-888-678-7012 215-761-9165
Blood Glucose Meter Hotline	1-888-494-8213 (option 2)
FutureScripts® Secure Medicare Part D	1-888-678-7015
HEALTH RESOURCE CENTER Healthy Lifestyles℠	215-241-3367 1-800-275-2583*
Precertification	215-241-2100 1-800-227-3116*
PROVIDER MEDICAL POLICY WEB PAGE	www.ibx.com/medpolicy
PROVIDER NETWORK eSERVICES NaviNet® Portal Registration EDI Claim Registration	www.ibx.com/providers/navinet/index.html 215-640-7410
PROVIDER PHARMACY WEB PAGE	www.ibx.com/provider_rx
PROVIDER SERVICES (Policies/Procedures/Claims) HMO	215-567-3590 1-800-227-3119*
PPO	215-567-3694 1-800-332-2566*
PROVIDER SUPPLY LINE	1-800-858-4728

* Outside 215 area code

Visit our website at *www.ibx.com/providers/communications*