

May 2006

## Fees at your fingertips

**B**lue Cross and Blue Shield of Louisiana is excited to announce that providers can now access their Blue Cross and HMO of Louisiana (HMOLA) fee schedules online. Professional fee schedules are now available through the newest feature on our secured site for providers, iLinkBLUE. Now, instead of contacting us and spending valuable time waiting on the phone for allowable charges or waiting for them to be mailed or faxed, you can access your fee schedule, anytime, online. Accessing fee schedules online will help reduce overpayments in refunds to members and ensure that you have the most up-to-date information to reconcile your accounts.

Accessing your fee schedules is easy on iLinkBLUE, just follow these steps:

1. Log on to iLinkBLUE, then click on "Fee Schedule" from the main menu
2. You will see the Professional Provider Fee Schedule page. Then enter the following information:
  - Provider Number
  - Participating Network
  - CPT® Code, Modifier and Site of Service
3. Click the submit button. The results of your query will be displayed instantly in a Microsoft Excel file format that you can view, print or save to your computer.

The fees available online are allowable charges for all Blue Cross networks (Key, Advantage Blue POS, Preferred Care PPO and HMOLA). Please note that this feature is not yet available to dentists, pain management providers or anesthesiologists.

iLinkBLUE continues to evolve to better serve our providers. Throughout the year look for more new features, such as Provider Self Registration for new passwords, Hospital Discharge/Utilization Reports to help hospitals manage their Blue Cross patients, Physician Profile Reports and comprehensive Medical Policies.

If you have any questions about how to access online fee schedules or how to get iLinkBLUE, contact us at (225) 293-5465 or e-mail us at [iLinkBLUE.providerinfo@bcbsla.com](mailto:iLinkBLUE.providerinfo@bcbsla.com). If you have questions about specific procedure codes on the online fee schedules, contact Network Administration at (800) 716-2299, option 3. ■

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# blues BEAT

## How to bill for surgical assistant services:

### • Blue Cross

Blue Cross reimburses the following provider types for procedures approved to have an assistant at surgery:

- Certified registered nurse first assistant (CRNFA)
- Nurse practitioner
- Physician assistant (PA)
- Registered nurse first assistant (RNFA)

The above provider types may file claims with individual provider numbers; however, we encourage these providers, when practical, to file claims using the supervising physician's Blue Cross 10-digit individual provider number, along with the -AS modifier. Claims filed with the supervising physician's provider number are paid at the in-network rate if the physician is in the Blue Cross network. Reimbursement will be 85 percent of the assistant surgeon allowable charge.

Please remember, modifiers -80, -81 or -82 are for assistant surgeon services performed by physicians only, not by nurses or physician assistants (PAs).

In the instance that these provider types have obtained their own Medicare number, they are allowed to file those claims under their individual number instead of the supervising physician's number.

### • FEP

Federal Employee Program (FEP) will pay for non-physician surgical assistance *only* when those services are billed under the supervising physician's number. These include PAs and any RN surgical assistant services for those procedures approved to have an assistant at surgery.

## Updates on [www.bcbsla.com](http://www.bcbsla.com)

The following items have been updated on the Provider page of [www.bcbsla.com](http://www.bcbsla.com):

- **Preventive Medicine Guidelines**  
⇒ Click on "Preventive Medicine Guidelines"
- **Participating Provider Office Manual & Dental Network Office Manual**  
⇒ Click on "Provider Manuals"
- **Online Provider Update Form**  
⇒ Click on "Forms for Providers"

## What's new in



- Professional fee schedules are now online (see page 1 for more details)
- Special education on Medicare Part D is now available
- Dental Network Office Manual has been updated

## Get the facts with Healthcare Facts®

Healthcare Facts® brings consumers the facts and figures about Louisiana hospitals in an easy-to-understand format that they already know: the food nutrition label. Healthcare Facts helps consumers shop for the best fit, best price and best value in hospital choices.

Information featured in Healthcare Facts comes from the hospitals themselves. Price comparisons are based on how much Blue Cross and our PPO customers paid the hospital for PPO inpatient (overnight) care from July 1, 2004, through June 30, 2005. Unlike some health care consumer information tools, Healthcare Facts is not designed to be a "report card" that rates hospitals or other health care providers. Instead, it provides factual and descriptive information that consumers can use to decide which hospital best fits their needs and preferences.

Healthcare Facts is a free, public service to all Louisiana health care consumers. You can access Healthcare Facts by visiting our website at [www.bcbsla.com](http://www.bcbsla.com) or you can go directly to [www.healthcarefacts.org](http://www.healthcarefacts.org). Invitations to participate in Healthcare Facts were extended to large hospitals initially. In July 2006, the community hospitals will be added to the Healthcare Facts website. ■

## Potential opportunities to reduce health care disparity in the management of patients with heart disease

The term “health care disparities” refers to persistent gaps in the quality of health and health care across ethnic, racial and gender groups. Areas where disparities in illnesses and services are most notable include: cardiovascular disease, cancer, stroke, HIV/AIDS, kidney dialysis, transplants, asthma, diabetes, maternal and child health and mental health.<sup>1</sup> Some reasons for these disparities are lack of access to quality care, inability to afford quality health insurance, lack of health education in the community and various socioeconomic factors.<sup>2</sup>

As the state’s largest health insurer and a member of the community, Blue Cross has a vested interest in the health of our citizens and the quality of care they receive. Our mission at Blue Cross is to “improve the lives of Louisianians by providing health guidance and affordable access to quality care.” Although we cannot directly eliminate all of the factors that cause disparities in health care, we can take action to address some of the problems. Initiatives that Blue Cross will be involved in to address this growing problem are:

1. Participate in efforts to educate at-risk communities and groups about health care.
2. Work with health care organizations to inform providers about health care disparities.
3. Promote more health professional education intended to reduce barriers to care.
4. Develop affordable, quality insurance products to reduce the number of uninsured.

The studies in the article below provide information about potential disparities in health care. We will select and highlight more studies in upcoming issues of *Network News*.

<sup>1</sup> National Academies of Sciences, April 2006, <http://www4.nationalacademies.org/onpi/webextra.nsf/web/minority?OpenDocument>

<sup>2</sup> Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, 2002

In a study supported by the Agency for Healthcare Research and Quality (11282), Dr. Spertus and colleagues at St. Luke’s Hospital studied 1,159 patients in a registry of patients with acute coronary syndrome (ACS) who were treated in two Kansas City hospitals. Researchers quantified the patients’ health status one year after ACS treatment using the Seattle Angina Questionnaire (SAQ) and the Short Form-12 Physical Component Score (SF-12 PCS).

The researchers concluded, “Blacks are 46 percent more likely than whites to suffer from angina (crushing chest pain), have worse quality of life, and experience poor physical function one year after being hospitalized for acute coronary syndrome (ACS, unstable angina or heart attack).” This was after controlling for differences in inpatient management, socioeconomic differences and clinical characteristic differences.

The researchers suggest, “Black patients with ACS may require closer monitoring to determine if they need additional treatment to improve their health,” particularly in the areas of, “differences in outpatient treatment, compliance with antianginal medications, and biologic mechanisms.” For more information, see “The Influence of Race on Health Status Outcomes One Year after an Acute Coronary Syndrome,” by Spertus, David Safley, M.D., Mukesh Garg, M.D., et al, in the November 15, 2005, *Journal of the American College of Cardiology*; Volume 46, Number 10; pp. 1838-1844.

In another study, primary care medication management of patients with hypertension diagnosed with “some type of chest pain syndrome (CPS)” differed based on ethnicity and sex. This study found that “women and blacks with CPS received fewer cardiovascular medications than men and whites, respectively, both overall and within diagnostic categories.” Of the 72,508 people listed in the Hypertension Initiative primary care database, 11percent had CPS and “most of these patients were prescribed statin drugs, aspirin, angiotensin converting enzyme inhibitors, and diuretics. About half were prescribed a beta-blocker.”

Even though more women and blacks received a chest pain diagnosis, 86 percent and 71 percent respectively compared to men and whites, 61 percent and 62 percent, they received fewer cardiovascular medications than men and whites. For more information, see “Prevalence, Treatment, and Control of Chest Pain Syndromes and Associated Risk Factors in Hypertensive Patients,” by Katharine H. Hendrix, M.S., Ph.D., Susan Mayhan, Daniel T. Lackland, Dr.P.H., and Brent M. Egan, M.D., in the August 2005 *American Journal of Hypertension*; Volume 18, Number 8; pp. 1026-1032. ■

### References

- Black patients fare worse than white patients after treatment for heart attack or unstable angina, downloaded on March 31, 2006, from <http://www.ahrq.gov/research/jan06/0106RA6.htm>
- Management of chest pain in patients with hypertension differs in men, women, and ethnic groups, downloaded on March 31, 2006, from <http://www.ahrq.gov/research/jan06/0106RA6.htm>

## 2006 BlueCard® program satisfaction survey... we appreciate your feedback

As a participating BlueCard® Program provider, your satisfaction is our top priority. Blue Cross values the care that you provide to our members. With your feedback, we can identify ways to serve you more effectively.

Last year's survey results identified that providers continue to experience significant improvements in their satisfaction with the BlueCard Program. Specifically, they noted service delivery enhancements in the following areas:

- Claims accuracy
- Claims timeliness
- Satisfaction with resolving problem claims
- Electronic eligibility verification
- Customer service
- Provider education

To continue evaluating our performance, we have asked The Response Center, an independent research company, to conduct telephone interviews on our behalf. They will contact a randomly selected sample of providers who cared for BlueCard members during 2005. This year's survey will be administered in two waves to give us a more up-to-date picture of your satisfaction. The first set of telephone interviews will be administered in May, and the second set will be scheduled during the fall.

The Response Center will ask to speak with the person in your office who is most knowledgeable about filing Blue Cross and Blue Shield claims and/or someone in the billing department. Please alert the appropriate staff in your office that they may be contacted. If you receive a call, please take a moment to participate, as your feedback is important to us.

If you have questions about the BlueCard Program or have suggestions for improvement, here are two ways to contact us:

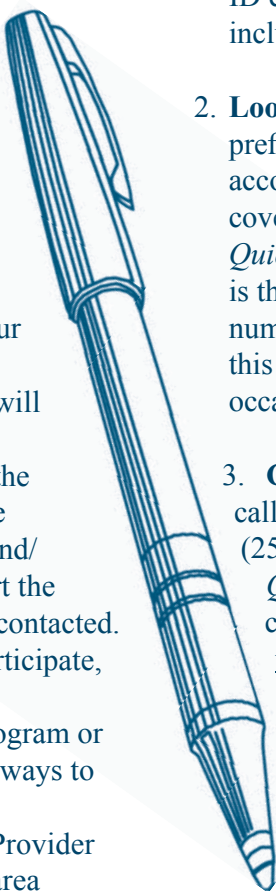
- Call (800) 922-8866 and ask to speak to the Provider Relations Representative who services your area
- Visit us online at [www.bcbsla.com](http://www.bcbsla.com)

Thank you in advance for taking the time to give us your feedback.

## How to avoid BlueCard® claim delays and rejections

We'll let you in on a secret: one of the biggest reasons for claim delays within BlueCard® is incorrect or missing alpha prefixes and identification numbers on claims. To avoid future delays, follow four simple steps:

- 1. Copy** - Make copies of the front and back of the member's ID card and pass this key information on to your billing staff. Be sure that the member has the most current ID card.  
*Quick Tip:* When you're referring a patient or a patient's information to another provider where there is not a face-to-face encounter, please include copies of the patient's ID card and the patient's complete identification number, including the alpha prefix.
- 2. Look** - Find the three-character alpha prefix. The alpha prefix identifies the member's Blue Plan or national account. It is also critical for confirming membership and coverage.  
*Quick Tip:* Do not assume that the member's ID number is the Social Security number. Use of the Social Security number on ID cards has been generally phased out as of this year. Alpha prefixes change, so recheck the ID card occasionally.
- 3. Contact** - Once you've identified the alpha prefix, call the BlueCard Eligibility® Line at (800) 676-BLUE (2583) to verify the member's eligibility and coverage.  
*Quick Tip:* For faster processing, use electronic capabilities. Visit our secure site, iLinkBLUE, at [www.bcbsla.com/ilinkblue](http://www.bcbsla.com/ilinkblue) or call (225) 291-4334 for assistance.
- 4. Submit** - After you include all the necessary information, submit the claim to BCBSLA, P.O. Box 98029, Baton Rouge, LA 70898-9029.  
*Quick Tip:* For faster processing please submit your claims electronically to your local Blue Plan. Visit [www.bcbsla.com/ilinkblue](http://www.bcbsla.com/ilinkblue) or call (225) 291-4334.  
If you have any further questions, please call the BlueLine at (800) 392-4076.



**For up-to-date provider information, visit us our Provider page at [www.bcbsla.com](http://www.bcbsla.com)!**

## Exit Medicare standard paper remittance mail-out – Enter Medicare Remit Easy Print software

Attention providers, physicians, suppliers and qualified non-physician practitioners billing Medicare carriers, including durable medical equipment regional carriers (DMERCs): Effective June 1, 2006, all current electronic remittance advice (ERA) providers will have their paper remit mailing discontinued. In the near future, you will receive a call from your Medicare Part B Electronic Data Interchange (EDI) representative to assist you in getting onboard with Medicare Remit Easy Print (MREP).

MREP is a free software program developed by the Centers for Medicare and Medicaid Services (CMS) that you will need in order to view and print the HIPAA-compliant ERA. The software gives providers and suppliers the following abilities:

- Easy navigation and viewing of the ERA using your personal computer
- Print the ERA in the Standard Paper Remittance format
- Search capability that allows providers and suppliers the ability to find claims information easily

- Print and export reports about ERAs, including denied, adjusted and deductible applied claims
- Easy-to-use method to archive, restore and delete imported ERAs

Providers and suppliers can view and print as many or as few claims as needed. This will be especially helpful when you need to print only one claim from the remittance advice when forwarding the claim to a secondary payer. MREP software can save you time resolving Medicare claim issues, and it provides features unavailable with the Standard Paper Remittance.

In order to use the MREP software, you will need to receive a HIPAA-compliant ERA (HIPAA 835). To find out how to receive a HIPAA-compliant ERA, learn more about the MREP software, and to download the software itself, contact the Medicare EDI Services helpline at (501) 378-2419 or toll-free at (866) 582-3247 or visit [www.cms.hhs.gov/AccessstoDataApplication/02\\_MedicareRemitEasyPrint.asp](http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp). ■

## Hospital Quality Measures Program

Blue Cross, along with the Blue Cross and Blue Shield Association (BCBSA) and 20 other Blues Plans, has elected to participate in a national Network Hospital Measurement Pilot program that allows us to provide quality and patient safety information on our network hospitals to select national accounts.

Beginning June 1, 2006, reports with information on key performance metrics will be available through a web application developed by WebMD Quality Services for participating Blues Plans, select national accounts and contracted hospitals to use. Access to this information is not available to individual Blue members at this time.

The reports in the pilot program are based on publicly available, evidence-based, clinical measures from CMS. The data concentrates on heart attacks, heart failure, pneumonia and patient safety indicators from the Agency for Healthcare

Research and Quality (AHRQ). Those indicators focus on failure to rescue, post-operative infection and decubitus ulcer. Data for all measures is collected and summarized by WebMD Quality Services on behalf of BCBSA and Blue Cross. A packet including an outline of each measure set with a list of definitions was mailed to Louisiana hospitals on May 1, 2006. The packet also included instructions on how the hospitals could view their information prior to its release on June 1, 2006.

The program will not only enable select national account employers to view this publicly available data, it will also expand efforts to measure and improve the quality of hospital care. The Network Hospital Measurement Pilot program is another step toward transparency in the health care industry.

As always, we appreciate the continued support of Louisiana hospitals regarding data sharing and our combined desire to provide meaningful information. ■

easy  
+ free  
- time  
EFT

### Electronic Funds Transfer and iLinkBLUE: The right equation for your office!

EFT means faster payment and no more waiting for mail delivery or time-consuming bank deposits. With EFT, Blue Cross deposits your payment directly into your checking or savings account. EFT, like iLinkBLUE, is a free service to providers. To sign up for EFT, complete the application found under "Electronic Services" on [www.bcbsla.com](http://www.bcbsla.com) and return it to us as instructed at the bottom of the form. For more information on EFT, please call (225)293-LINK (5465) or e-mail [ilinkblue.providerinfo@bcbsla.com](mailto:ilinkblue.providerinfo@bcbsla.com).



# medical policies update

Blue Cross continuously develops and revises medical policies in response to rapidly changing medical technology. Our commitment is to update the provider community as medical policies are adopted and/or revised. Please see the following updated medical policies:

## New medical policy guidelines

Effective Date	Medical Policy Coverage Guideline	Coverage Eligibility
January 1, 2006	Percutaneous Transluminal Angioplasty of Intracranial Atherosclerotic Stenosis with or without stenting	Investigational
July 24, 2006	Percutaneous Discectomy (with automated devices that involve placement of a probe within the intervertebral disc and aspiration of disc material using a suction cutting device).  Additional medical policies addressing disc procedures: • Percutaneous Intradiscal Electrothermal Annuloplasty (IDET) and Percutaneous Intradiscal Radiofrequency Thermocoagulation – Investigational • Decompression of the Intervertebral Disc Using Laser (Laser Discectomy) or Radiofrequency Energy (DISC Nucleoplasty) – Investigational	Investigational

❖ Requests for pre-authorization can be done prior to the effective dates.

## Changes to Coverage Eligibility of Recently Reviewed Guidelines

Effective Date	Medical Policy Coverage Guideline	Coverage Eligibility
March 15, 2006	Intrastromal Corneal Ring Segments	Coverage eligibility changed from investigational to eligible with criteria. Coverage eligibility will be considered when all of the following criteria are met for patients who: • have experienced a progressive deterioration in their vision, such that they can no longer achieve adequate functional vision on a daily basis with their contact lenses or spectacles; and • are 21 years of age or older; and • have clear central corneas; and • have a corneal thickness of 450 microns or greater at the proposed incision site; and • have corneal transplantation as the only other remaining option to improve their functional vision.

Provider inquiries related to medical policy coverage, eligibility guidelines or investigational status determinations will be considered upon written request. Requests for reconsideration must be accompanied by peer-reviewed, scientific evidence-based literature that substantiates why a technology referenced in a medical policy should be considered. Supporting data will be reviewed in accordance with medical policy assessment criteria.

**If you have questions about our medical policies or if you would like to receive a copy of a specific policy, please call the BlueLine at (800) 392-4076.**

## Blue Cross adopts CMS guidelines for billing allergen immunotherapy

After reviewing a random sampling of claims, it appears that some providers are billing incorrectly for allergen immunotherapy. Effective July 15, 2006, our policy for billing allergen immunotherapy will follow guidelines set by CMS. Therefore, when billing Blue Cross for allergen immunotherapy, providers should use the same guidelines used for billing Medicare beneficiary claims.

Please note there will be periodic audits done to ensure proper compliance with these guidelines. Additionally, documentation should include vaccine contents and dosage schedule and must be clearly and legibly written. Illegible documentation could result in denial of claim upon review. Providers should also be aware it has been reported that most patients generally do not exceed 20 units in an

average treatment period of 12 weeks. When reviewing documentation, Blue Cross will follow the Joint Task Force on Practice Parameters for medical necessity criteria, contraindications, proper duration of allergen immunotherapy, procedures for administering allergy tests and follow-up care. A complete list of Practice Parameters for Allergen Immunotherapy can be found on the Joint Council for Allergy, Asthma and Immunology website at [www.jcaai.org](http://www.jcaai.org).

The Office of Inspector General (OIG) recently released the results of their investigation of allergy immunotherapy provided to Medicare beneficiaries. If interested, this report can be found on the OIG website at [www.oig.hhs.gov](http://www.oig.hhs.gov).

For more information and examples regarding the CMS guidelines mentioned above, visit [www.cms.hhs.gov](http://www.cms.hhs.gov).

## Epoetin alfa first policy and prior authorization required on darbepoetin alfa

Epoetin alfa and darbepoetin alfa are bioequivalent drugs used to treat anemia for a variety of conditions, including, but not limited to, renal failure and cancer patients receiving chemotherapy. Effective August 1, 2006, epoetin alfa will be required as first-line therapy under the medical and pharmacy benefits. For the medical benefit, the epoetin alfa first policy will be effective for dates of claim processing starting on August 1, 2006. For the pharmacy benefit, epoetin alfa first policy will be effective August 1, 2006, as the prescription is requested.

Darbepoetin alfa usage will require pre-authorization when delivered in the physician's office or through a pharmacy. To obtain authorization, please call the prior authorization number on the back of the member's identification card. Darbepoetin alfa may be authorized when there is a documented failure of epoetin alfa after there is not a rise in hemoglobin of two grams or a target hemoglobin of 12 mg/dl has not been obtained after eight weeks of therapy or has significant side effects.

A grace period will be allowed for patients in a current cycle of chemotherapy with the use of darbepoetin alfa occurring prior to the effective date of this policy. We will authorize the darbepoetin alfa through a cycle of chemotherapy in progress; however, we will not continue to authorize it for a new cycle of chemotherapy.

If the above criteria are not met, then darbepoetin alfa will be denied as not medically necessary. If you currently have patients on darbepoetin alfa who meet the criteria for failure to respond to epoetin alfa, it is not required that you wait until August 1, 2006, to get an authorization for continued use after August 1, 2006. ■

## New prior authorization requirements for Rituximab

Rituximab has recently been approved by the FDA for rheumatoid arthritis. Effective with the publication of this newsletter, Rituximab will require pre-authorization for the indication of rheumatoid arthritis. To obtain authorization, please call the pre-authorization number on the back of the member's card.

Rituximab will be eligible for coverage when used in combination with methotrexate for the treatment of adult patients with moderate to severe rheumatoid arthritis who have not adequately responded to one or more tumor necrosis factor antagonists. Rituximab is administered as a treatment course of two, 1000 mg intravenous infusions separated by two weeks. This therapy can be repeated in six month's time if rheumatoid arthritis has significantly improved or stabilized.

Rituximab will continue to be eligible for coverage for non-Hodgkin's lymphoma, relapsed/refractory chronic lymphocytic leukemia, relapsed/refractory Waldenstrom's Macroglobulinemia or immune or idiopathic thrombocytopenic purpura. These indications do not require pre-authorization.

For indications not listed above, which would be "off-label," pre-authorization is required. If Rituximab is accepted for off-label usage in the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information, it will be eligible for coverage. In addition, if Rituximab is proven safe and effective and is accepted for the treatment of a specific medical condition by results of controlled clinical studies published in at least two peer-reviewed, national medical journals, it will be eligible for coverage. If the criteria above are not met, then Rituximab will be deemed as not a covered benefit. ■

For a list of drugs that require prior authorization, please refer to our website at [www.bcbsla.com](http://www.bcbsla.com), click on "Provider," then "Prescription Drug Program," and lastly, "Prescription Drugs Requiring Prior Authorization."

## Coming soon: HEDIS chart reviews

As many of you may already know, the current HEDIS chart review season is upon us. For those unfamiliar with the term, HEDIS is a set of standardized performance measures that include health issues, such as cancer, and customer experience areas, such as claims processing. Blue Cross reviews HEDIS measures annually, identifying opportunities for improvement as well as noting those areas in which Blue Cross is at or above the South Central Benchmark.

To obtain the best values for HEDIS measures, a combination of claims data and chart review data is needed. In the most recent years, we have relied solely upon our administrative (claims) data for HEDIS. At this time, Blue Cross is resuming data collection in the form of chart reviews. This means that your office may be contacted by representatives from Blue Cross or a contracted vendor acting on our behalf for record reviews. There are several factors involved in this process, and while it is designed to be minimally disruptive to your offices, we appreciate your cooperation in the timely scheduling and disclosure of the chart reviews as it is our intent to have this year's HEDIS season completed as quickly and efficiently as possible. Please be advised that special considerations will be given to offices that have been significantly affected by the recent hurricanes. ■

## NPI Reminder!

Recently we sent you a reminder regarding the **National Provider Identification (NPI)** number. The NPI will be required for filing claims as of May 23, 2007. You can find all the information you need to apply for and obtain your NPI at [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov). You can apply online or download and print a paper application that can be mailed or faxed to the enumerator who will be assigning your NPI.

As soon as you have received your NPI, please notify us by including it on one of the following forms:

- Louisiana Standard Credentialing Application (LSCA)\*
- Blue Cross Provider Update form\*

\*These forms can be accessed through our website, [www.bcbsla.com](http://www.bcbsla.com).

- Blue Cross Recredentialing Application

Please note that Blue Cross cannot apply for or assign you an NPI. You must follow the instructions at [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov).

**May 23, 2007: NPI will be required for all Blue Cross claims, both electronic and paper.**

*Our home, Louisiana.*

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