

## Behavioral Health Inpatient Authorization IVR Caller Guide


Hours of Availability: Monday – Friday 5:00 a.m. – 10:30 p.m. (MT); Saturday 5:00 a.m. – 5:00 p.m. (MT); Sunday – Closed

1 of 4

- Utilize your keypad when possible
- Avoid using cell phones
- Minimize background noise
- Mute your phone when you are not speaking

This caller guide does not apply to Blue Cross Medicare Advantage members.


### 1) Getting Started



Welcome to Blue Cross Blue Shield of Montana.  
Para asistencia en español, oprima siete.

▶

For information in English, please stay on the line for assistance.



If you're a Healthcare provider, please press 1. Otherwise, please stay on the line.


*Interruption Permitted*

▶

**Healthcare Provider**

No	Press 1 Press 2
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*Note: You can use your touch tone keypad to enter numeric information.*




To arrange for a peer call back, press 1. To initiate an expedited appeal, press 2. For benefits, eligibility or claim inquiry, press 3. For mental health or chemical dependency, press 4. For outpatient services, press 5. For Precertification of Inpatient services, press 6. For the special beginnings program for expectant mothers, press 7.

*Interruption Permitted*

▶

Peer Call Back	Press 1
Expedited Appeal	Press 2
Benefits, Eligibility, Claims	Press 3
<b>Mental Health or Chemical Dependency</b>	<b>Press 4</b>
Outpatient Precertification	Press 5
Inpatient Precertification	Press 6
Special Beginning Program	Press 7

### 2) Authorization and Referral Management




Is the patient a federal employee or dependent?

*Interruption Permitted*

▶

Federal Employee or Dependent	Press 1
<b>All Others</b>	<b>Press 2</b>



Authorization is required for certain services and determines medical necessity and appropriateness of treatment. Certification does not guarantee that services are eligible at time of admission or procedure, as it only assures the treatment meets the plan's medical necessity guidelines. Please call us back if you anticipate the length of stay will exceed the certificated days or the patient needs continued services. A recommended clinical review is optional and can be submitted online or by mail if services may not be covered based on medical necessity. Refer to our provider website for more information regarding utilization management and preservice reviews.

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In order to get eligibility or benefits, we'll need your rendering NPI. For claims or any other inquiries, we'll need your billing NPI. Now, what's your 10-digit NPI?

**Situational:**

If the system does not recognize the NPI, you will be prompted for a Tax ID.

**Interruption Permitted**

**Say or enter your NPI number.**

**Note:** Professional providers should use the rendering NPI of the individual rendering the services.



Which can I help you with? Eligibility and benefits, claims, authorization and referral management, or joining the network?

**Interruption Permitted**

Eligibility and Benefits

Press 1

Claims

Press 2

**Authorization and Referral Management**

**Press 3**

Joining the Network

Press 4

**Note:** Use [Availability® Essentials Authorizations](#) to submit your requests online.



Okay. Authorization and referral management. Excluding the three-character prefix, what's the subscriber ID?

**Situational:**

If multiple policies are found for your patient, you will be asked to provide their group number.

**Interruption Permitted**

**Say or enter only the subscriber ID, excluding the three-character prefix.**

**Note:** Alpha and numeric characters may be entered by touch tone keypad. The Alpha Touch Tone reference guide is available on [page 4](#) for assistance with keying alpha characters.



That's 123456789. Is that correct?

**Interruption Permitted**

Yes

Press 1

No

Press 2



Is this for medical, behavioral health or chemical dependency services?

**Interruption Permitted**

Medical

Press 1

**Behavioral Health**

**Press 2**

Chemical Dependency

Press 3

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Do you need to check procedure code requirements, request authorization and referral, or check the status?

*Interruption Permitted*

Check Procedure Code Requirements	Press 1
<b>Request Authorization and Referral</b>	<b>Press 2</b>
Check the Status	Press 3



Okay. Inpatient, outpatient or home?

*Interruption Permitted*

<b>Inpatient</b>	<b>Press 1</b>
Outpatient	Press 2
Home	Press 3



And do you want to create a new request or extend an existing request?

*Interruption Permitted*

<b>New Request</b>	<b>Press 1</b>
Extend Existing Request	Press 2



Please hold while I connect you. This call may be recorded.

*Interruption Permitted*

**Remain on the line while you are connected with a Behavioral Health Customer Advocate.**

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## Alpha Touch-Tone Reference

Alpha touch-tone is available as an alternative to voicing alpha-numeric mixed information.

To enter a **subscriber ID**, **group** or **claim number** containing alpha character(s):

- 1) Press the star key (\*) to begin a letter sequence
- 2) Press the number key containing the desired letter (e.g., press 2 for A, B or C)
- 3) Press 1, 2, 3 or 4 to indicate the position the letter is listed on the selected key (e.g., press \*21 to enter A)

A	=	*21
B	=	*22
C	=	*23

D	=	*31
E	=	*32
F	=	*33

G	=	*41
H	=	*42
I	=	*43

J	=	*51
K	=	*52
L	=	*53

M	=	*61
N	=	*62
O	=	*63

P	=	*71
Q	=	*72
R	=	*73
S	=	*74

T	=	*81
U	=	*82
V	=	*83

W	=	*91
X	=	*92
Y	=	*93
Z	=	*94

### Group Number

Ex. 1	Y	N	1	2	3	4
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Press	*93	*62	1	2	3	4
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Ex. 2	1	2	K	3	4	5
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Press	1	2	*52	3	4	5
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### Subscriber ID

Ex. 1	A	1	N	2	3	4	5	6	7
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Press	*21	1	*62	2	3	4	5	6	7
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Ex. 2	0	9	2	T	7	6	8
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Press	0	9	2	*81	7	6	8
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**Note:** Exclude three-character prefix when entering the subscriber ID.

### Claim Number

Ex. 1	2	1	3	4	F	5	6	7	0	X
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Press	2	1	3	4	*33	5	6	7	0	*92
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Ex. 2	2	0	1	T	8	7	6	5	0	C
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Press	2	0	1	*81	8	7	6	5	0	*23
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**Note:** The claim number should be 13 digits.

**Have questions or need additional education?** Email our [Provider Education Consultants](#).

*Be sure to include your name, direct contact information and Tax ID or Billing NPI.*

Checking eligibility and/or benefit information and/or obtaining prior authorization is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage, including, but not limited to, exclusions and limitations applicable on the date services were rendered. **Certain employer groups may require prior authorization or pre-notification through other vendors. If you have any questions, call the number on the member's ID card.** Regardless of any prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

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