

THERE FOR YOUR HEALTH



fepblue.org



BlueCross
BlueShield

Federal Employee Program.



access
to care 2026
FEDERAL & POSTAL

TRIPLE-S SALUD 

Dear Triple-S Salud provider:

This booklet contains important information about the Blue Cross and Blue Shield Federal Employee Program (FEP), including coverage and service area management details. Its purpose is to provide general information about FEP coverage to help you better serve our FEP population.

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What is the BCBS Federal Employee Program (FEP)?

The federal government provides its employees and retirees with different medical coverage options under the Federal Employee Health Benefit Program (FEHBP) and the Postal Service Health Benefits Plan Program (PSHBP).

- The BCBS Federal Employee Program, better known by its acronym FEP, is one of the medical plan options available under the FEHB Program for federal employees and retirees. This plan provides its members nationwide coverage including the United States, its territories and overseas. The location where services are provided determines the BCBS plan that will support both members and providers. Therefore, when services are provided in Puerto Rico, the BCBS plan that will assist providers in processes such as eligibility and benefits, claims processing, payments, and clinical management will be Triple-S Salud.

How are FEP members identified?

The FEP ID card can be identified by the *Blue Cross Blue Shield Federal Employee Program* logo and the member ID begins with the letter R followed by eight digits. Ex. R99999999.

- FEHB- Federal Employee Health Benefits
- PSHB- Postal Service Health Benefits: US Postal workers. Policy began on 01/01/2025
- MPDP ID only applies for pharmacy benefits for members with Medicare part D
- *This only applies to members who have MPDP. Other members will have one card per household with the name of the primary insured person.
- Members may provide an ID card that differs from the images shown. It is important to contact our customer service line to determine eligibility

FEP Standard Option™

		Government-Wide Service Benefit Plan
Member Name JONATHAN Q DOE	fepblue.org	
Member ID XXXXXXXXXX	Standard Option Enrollment Code	106
RxIIN RxPCN RxGrp	610239 FEPRX 65006500	Scan this code to view your plan's deductibles and out-of-pocket maximums. Or visit fepblue.org/standard .

FEP Basic Option™

		Government-Wide Service Benefit Plan
Member Name JONATHAN Q DOE	fepblue.org	
Member ID XXXXXXXXXX	Basic Option Enrollment Code	111
RxIIN RxPCN RxGrp	610239 FEPRX 65006500	Scan this code to view your plan's deductibles and out-of-pocket maximums. Or visit fepblue.org/basic .

FEP Blue Focus™

		Government-Wide Service Benefit Plan
Member Name JONATHAN Q DOE	fepblue.org	
Member ID XXXXXXXXXX	Standard Option Enrollment Code	104
RxBIN RxPCN RxGrp	004336 MEDADV RX7117	Scan this code to view your plan's deductibles and out-of-pocket maximums. Or visit fepblue.org/standard .
FEP Medicare Prescription Drug Program (MPDP) CMS S2135 801		

- PSHB - Postal workers ID cards have a stamp logo. Also, their Enrollment code has 2 digits and a letter

		Government-Wide Service Benefit Plan
Member Name JONATHAN Q DOE	fepblue.org	
Member ID XXXXXXXXXX	FEP Blue Standard™ Enrollment Code	33F
RxIIN RxPCN RxGrp	610239 FEPRX 65006500	Scan this code to view your plan's deductibles and out-of-pocket maximums. Or visit fepblue.org/standardpostal .

		Government-Wide Service Benefit Plan
Member Name JONATHAN Q DOE	fepblue.org	
Member ID XXXXXXXXXX	FEP Blue Basic™ Enrollment Code	33B
RxIIN RxPCN RxGrp	610239 FEPRX 65006500	Scan this code to view your plan's deductibles and out-of-pocket maximums. Or visit fepblue.org/basicpostal .

		Government-Wide Service Benefit Plan
Member Name JONATHAN Q DOE	fepblue.org	
Member ID XXXXXXXXXX	FEP Blue Focus® Enrollment Code	35C
RxIIN RxPCN RxGrp	610239 FEPRX 65006500	Scan this code to view your plan's deductibles and out-of-pocket maximums. Or visit fepblue.org/focuspostal .

Differences between the “BlueCard Program” & FEP




 BlueCross BlueShield Geography		Blue Product ALPHA Employer Group
Member Name Member Name Member ID XYZ123456789	Dependents Dependent One Dependent Two Dependent Three	
Group No. 023457 BIN 987654 Benefit Plan HIOPT Effective Date 00/00/00 Plan Code 123	Plan PPO Office Visit \$15 Specialist Copay \$15 Emergency \$75 Deductible \$50	
 		

Regular BCBS (Blue Card)

- ID card with only a Blue Cross, Blue Shield, or both (BlueCross/BlueShield) logos that include the name of the state associated with the plan, also known as the home plan or the name of the BCBSA plan.
- Member ID numbers begin with a three-letter prefix followed by a sequence of numbers and/or letters. For example: XOF12233H3444
- The ID card includes a group number.
- For benefits and eligibility, call the member’s BCBS plan in the US.

How does this process work?

1. Call the home BCBS plan for eligibility and benefits. The number to call should be located on the back of the member’s ID card. You can also call (800) 676-2583, press option 2 for providers.
2. Confirm with the member’s plan representative to see how services are covered in Puerto Rico.
3. Submit claims electronically or by paper to Triple-S, in the same way you do for Triple-S Commercial (professional and institutional invoices only).

 BlueCross BlueShield Federal Employee Program.		Government-Wide Service Benefit Plan 
Member Name JONATHAN Q DOE	fepblue.org	
Member ID XXXXXXXXXX	Basic Option Enrollment Code 111	
RxIIN RxPCN RxGrp	610239 FEPRX 65006500	Scan this code to view your plan's deductibles and out-of-pocket maximums. Or visit fepblue.org/basic . 

Federal Employee Program

- The ID card will always have the logo of the BlueCross BlueShield Federal Employee Program.
- The member ID number will begin with the letter R followed by numeric digits or 8 digits. For Example: R12345678.
- It does not include a group number, only an “enrollment code.”

How does this process work?

1. Call the FEP Exclusive Customer Service line for eligibility and benefits, claims status, and payment information.
2. Verify with the customer service representative eligibility, benefits, and applicable member liability (deductible, copay, coinsurance).
3. Submit claims (paper or electronic) to your local BCBS (Triple-S Salud).

It is important to verify eligibility and benefits before providing services. To verify eligibility and benefits for FEP members, contact the FEP Exclusive Customer Service line Monday through Friday from 8:00 a.m. to 5:00 p.m. Atlantic Standard Time using the following numbers: FEHB (787)774-6082 or Free of charge (888)774-6082 PSHB (787)474-5220 or Free of charge (833)201-9257 and for PSHB 787-474-5220 or 833-201-9257.

FEP Summary of Benefits

Benefit	FEP Blue Focus	FEP Blue Basic	FEP Blue Standard
Virtual doctor visits through Teladoc Health®	You pay nothing	You pay nothing	You pay nothing
Primary care doctor	\$10 per visit for the first 10 primary and/or specialty care visits for each person on your plan†	\$35 copay ¹	\$30 copay
Specialists		\$50 copay ¹	\$40 copay
Mental health visits		\$35 copay	\$30 copay
Urgent care centers	\$25 copay	\$50 copay	\$30 copay
Chiropractic care	\$25 for up to 10 visits per year ²	\$35 for up to 20 visits per year	\$30 for up to 12 visits per year
Maternity	\$0 for doctor's visits \$3,500 for delivery	\$0 for doctor's visits \$0 for delivery at a Blue Distinction Center® (BDC) \$425 for delivery at all other facilities	\$0 copay
Inpatient hospital	30% coinsurance*	\$425 per day; up to \$2,975 per admission	\$350 copay
Outpatient hospital	30% coinsurance*	\$250 per day per facility ¹	15% coinsurance*
Surgery	30% coinsurance*	\$150 per surgeon in an office ¹ \$200 per surgeon in other settings ¹	15% coinsurance*
ER (Accidental injury)	\$0 within 72 hours	\$425 per day per facility	\$0 within 72 hours
ER (Medical emergency)	30% coinsurance*	\$425 per day per facility	15% coinsurance*
Lab work (Such as blood tests)	\$0 for first 10 specific lab tests**	15% coinsurance ¹	15% coinsurance*
Diagnostic services (Such as sleep studies, X-rays, CT scans)	30% coinsurance*	Up to \$100 in an office ¹ Up to \$250 in a hospital ¹	15% coinsurance*

Members with Medicare primary may have different cost share amounts that apply.

*Deductible applies.

¹ 50% of our allowance for agents, drugs and/or supplies you receive during your care.

† Deductible applies. In addition, you pay 50% of our allowance for agents, drugs and/or supplies you receive during your care.

**Call FEP Customer Service for specific lab services covered at 100% and with applicable coinsurance.

² Up to 10 visits combined for chiropractic care and acupuncture.

This is a brief, informational summary and does not replace or modify the policy. For more details regarding the benefits, limitations, and exclusions, contact the exclusive FEP Customer Service line at for FEHB 787-774-6082 o 1-888-774-6082, for PSHB 787-474-5220 o 1-833-201-9257 lunes a viernes de 8:00am a 5:00pm AST (Tiempo Estándar del Atlántico)

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Preventive Benefits for Adults

All BCBS FEP coverage options have preventive services covered at 100% with participating providers from the Triple-S, Salud Network. The coverage allows one (1) service per calendar year at 100%. When billing these services, it is important to use the current preventive ICD-10 diagnostic code as the principal diagnosis. Preventive testing and labs require a valid medical order for coverage. Adult Preventive Services (older than 22 years) are covered once per calendar year and include screening tests classified with A & B according to the US Preventive Services Task Force (USPSTF). Preventive services for adults include:

Visits

Visits/exams for preventive care
Nutritional Counseling

Cancer Screenings

Colorectal

- Colonoscopy with or without biopsy
- Sigmoidoscopy
- Double Contrast Barium Enema
- Fecal Occult Blood Test

Others

- PSA
- Screening mammograms (including mammography using digital technology)
- Double Contrast Barium Enema
- Cervical Cancer Test
 - Pap Smear
 - HPV Screening

Lab Tests-Screenings

- CBC
- Basic or comprehensive metabolic panel test
- General Health Panel
- Fasting Lipoprotein Profile
- A1C
- CMP
- Cholesterol Screening
- Profile
- Urinalysis
- Sexually Transmitted Infectious Diseases (STID)
 - Syphilis
 - HIV
 - Chlamydia
 - Gonorrhea

Immunizations

<https://www.cdc.gov/vaccines/schedules/>

- COVID-19
- Human papillomavirus (HPV)
- Influenza (flue) - including Flu vaccine (live) nasal administration
- Measles, mumps, rubella
- Meningococcal
- Pneumococcal
- Tetanus/Tdap, diphtheria, pertussis booster
- Varicella
- Respiratory Syncytial Virus (RSV)
- Smallpox/Monkeypox)
- Herpes zoster (Shingles)
- (Members over 50 years)
- Hepatitis A & B
- RSV
- Mpox for high risk patients

*U.S. FDA licensure may restrict the use of the immunizations and vaccines to certain age ranges, frequencies, and/or other patient-specific indications, including gender.

Ultrasound screening

Abdominal Aortic Aneurysms (AAA)
(once per lifetime, for adults aged 65 to 75 years of age)

Immunizations

<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>

- Osteoporosis Screening (for females aged 65 and over, and for females age 50 to 64 with increased risk for osteoporosis)
- Latent Tuberculosis Screening
- Low-Dose CT screenings for lung cancer (for adults ages 50 to 80 who smoke or have a history of smoking)

Preventive Benefits for Children

All BCBS FEP coverage options provide preventive services covered at 100% with participating providers in the Triple-S, Salud Network. When billing these services, it is important to use the appropriate preventive ICD-10 diagnostic code as the primary diagnosis. Preventive tests and labs require a valid medical order for coverage.

Preventive services for children include:

Wellness Visits	Healthy Newborn Visits Well-Child W30 Visits (For children ages 15 to 30 months) Well-Child Annual Preventive Visits
Counseling Visits	Nutritional Counseling
Preventive Screenings	Developmental Screenings and Testing Hearing and Audiology Screenings and o, Vision Screenings
Preventive Laboratory Tests	Newborn Panel Basic Metabolic Panel General Health Panel CBC Fasting Lipoprotein Panel Cholesterol Screenings Urinalysis Hepatitis B & C1 Thyroid Assay o Thyroid Function Test
Age Limits Apply	Latent Tuberculosis Intradermal
Cervical Cancer Tests	Pap Smear HPV
STI's	Syphilis HIV Chlamydial Gonorrhea
Immunizations	Influenza Measles, Mumps, Rubella and Varicella Meningococcal and Pneumococcal Chicken pox Rotavirus Polio Tetanus, Diphteria and Pertussis COVID Hepatitis B Hepatitis A Influenza Type B (HIB)

*Subject to age limits, frequency and other specifications, according to FDA regulations

Member Cost-Sharing Information



ANNUAL DEDUCTIBLE:

An accumulative amount that is applied each policy year. The policy year for FEP is the same as the calendar year, starting January 1st through December 31st of every year. (Applies only to FEP Standard Option and FEP Blue Focus)



COPAY

Fixed payment amount for covered services.

If the contracted rate is lower than the copayment amount, the member will be responsible only for the contracted rate.



COINSURANCE

Percentage of the rate
Fixed payment amount
Triple-S commercial



MULTIPLE COPAY RULE APPLIES WHEN:

- More than one service on the same day
 - By the same provider
 - At the same facility
- In these instances, the member will pay only one copay per day. The highest copay will apply.

Calendar Year Deductible or CYD

Diagnostic Services

Medical visits or services related to an illness, follow-up care, medical condition or physician appointments. These services must be billed using ICD-10 diagnosis codes. For these types of services, the member will be responsible for copays, coinsurance, and deductibles established under the policy.

Annual Deductible for BCBS FEP Options:

The calendar year deductible, or CYD, applies only to FEP Blue Standard and FEP Blue Focus. This annual deductible is an amount of money that the member must accumulate and pay out-of-pocket each policy year. Once the calendar year deductible is met, regular benefits will apply as an established under the member's coverage.

- FEP Blue Standard
 - \$350 individual or \$700 family
- FEP Blue Focus
 - \$750 individual or \$1,500 family
 - The annual deductible accumulates through claims processing. You must submit claims as soon as possible so the yearly deductible can be applied. This applies even when the member is responsible for 100% of the cost of services. In this instance, providers should bill the contracted Triple-S, Salud fee.

For self-only coverage, the member will only be responsible for accumulating the individual deductible. In couple or family contracts, the first covered member to accumulate the individual deductible of \$350 (Standard) / \$750 (FBF), will satisfy the individual annual deductible.

To the complete family deductible, the remaining dependents must collectively contribute the remaining amounts to reach the \$700 (Standard) / \$1,500 (FBF) and meet the annual family deductible.

Example: Family of three (3) Enrolled in FEP Blue Standard

FEP Blue Standard	Accumulation of Deductibles	Accumulated
Member 1	First member to accumulate \$350 in the calendar year. Beginning on the date that the member satisfies the CYD amount, they will only be responsible for the regular benefits (15% coinsurance).	\$350.00 (Individual deductible met by one member only)
Member 2 Member 3	To complete the remaining \$350 of the family deductible, the amounts paid by the remaining dependents will be added. Once the remaining \$350 is accumulated, the \$700 family deductible is met. Once the family deductible has been met, the remaining dependents will only be responsible for the regular benefit (15% coinsurance).	\$350.00 (Family deductible accumulated collectively with the remaining dependents)
Total deductible per calendar year:		\$700

IMPORTANT: The annual deductible accumulates through claims processing. It is important to submit claims for payment as soon as possible to ensure that the accumulated amounts are rapidly applied and reflected towards the deductible.

The calendar year deductible does not apply to all services.

Examples:

- FEP Blue Standard
 - Does not apply to: physician visits, preventive services, hospitalizations, therapies, among others.
- FEP Blue Focus
 - Does not apply to preventive services, the first ten (10) physician visits, among others.



It is important to verify eligibility and benefits prior to providing services. To obtain eligibility and benefits of BCBS FEP members, you may contact to our FEP Exclusive Customer Service line Monday from 8:00 am a 5:00 pm AST using the following dedicated lines: FEHB 787-774-6082 or 888-774-6082 PSHB 787-474-5220 or 833-201-9257

How do I determine member liability for those who have a calendar year deductible (FEP Blue Standard and FEP Blue Focus)?

To better assist you with this, we are providing an example that explains the necessary steps to determine the member payment amounts.

The example below is for FEP Blue Standard:

A member will be receiving services for a medical procedure that has a negotiated rate with Triple-S, Salud of \$650. Under the FEP Blue Standard, the applicable benefit is 15% coinsurance, and it is subject to the annual deductible of \$350.

To determine the patient's out-of-pocket cost -sharing amount.

1. Call the FEP Exclusive Customer Service line at (787) 774-6082 or 1 (888) 774-6082 to verify if the member has met the individual and/or family annual deductible. If the member has not met the annual deductible, you will be subtracting the accumulated amount from the total annual deductible.

\$350 = FEP Blue Standard CYD
-\$250 = Member's accumulated deductible

\$100 Outstanding CYD amount (member responsibility)

2. Subtract the outstanding CYD amount that has not been met from the Triple-S, Salud contracted rate for the medical procedure.

\$650 = Triple-S, Salud contracted rate
-\$100 = Outstanding CYD amount (member responsibility)

\$550 Adjusted Rate after meeting the deductible

3. Apply regular benefit (15% coinsurance) to the remaining amount.

\$550 = Adjusted Rate
x15% = Applicable coinsurance

\$82.50 = Member liability (member responsibility)

4. Add the member liability amounts applied towards the annual deductible + applicable coinsurance. In the example above, the member liability will be \$182.50.

\$100 applied toward the CYD
+ \$82.50 towards the coinsurance

\$182.50 total member responsibility

Billing Frequently Asked Questions

1. Can providers contracted with Triple-S Salud accept BCBS FEP members?

Yes. The Triple-S Salud commercial contract states that Triple-S, Salud is a member of BCBSA, and participates in the BlueCard Program which facilitates access to healthcare services. Requirements include:

- Triple-S Salud participant physicians provide services to members of BCBSA plans.
- Triple-S Salud will process payment for claims that are covered in accordance with the member's policy

2. What fee will apply to the service provided?

Services will be based on Triple-S, Salud commercial contracted fees.

3. Can eligibility and benefits for FEP members be verified electronically?

No. To verify benefits and eligibility for FEP members, you must contact the FEP Exclusive Customer Service line:

FEHB 787-774-6082 or 888-774-6082
PSHB 787-474-5220 or 833-201-9257
Monday – Friday 8:00am - 5:00pm AST
(Atlantic Standard Time)

4. How are preventive service claims identified for payment at 100%?

To bill preventive services, you must send claims with a preventive primary diagnosis (ICD-10 code) for claims to pay at 100%. We will pay the first preventive service of the year at 100% for adults. If additional services are required, we will pay as a diagnostic service applying the regular copay/deductible/coinsurance.

5. Where can I send my claims for payment?

Claims may be submitted by paper or electronically. Make sure to have the correct patient's demographic information such as name and date of birth for correct adjudication.

Electronic claims can be sent using the same billing format used for Triple-S Salud commercial line of business using Payer ID 973.

Paper claims can be sent to the following address:

Triple-S Salud
PO Box 70299
San Juan, PR 00936-8299

To ensure correct processing and avoid unnecessary delays, make sure that the information submitted on your claims is clear and legible.

6. What is allowed timeframe for providers to submit claims?

Billing timeframe is in accordance with Triple-S Salud commercial contract.

7. What are the allowed claim adjustment timeframes for FEP members?

The process and timeframe for adjustments are in accordance with the Triple-S Salud commercial guidelines/policy.

8. Does BCBS FEP cover Medicare Part A&B deductibles and/or coinsurance?

Yes, FEP will cover the Medicare A and B annual deductibles. To process Medicare primary claims, the provider must send the Medicare Explanation of Payment along with the claim. The Medicare Explanation of Payment must reflect the Medicare approved amounts, deductibles and copayments applied, provider information, and the date of payment.

9. When Medicare A and B are is primary, does BCBS FEP waive the calendar year deductibles for FEP Blue Standard and FEP Blue Focus?

Yes, for FEP Standard Option and FEP Blue Focus, the applicable annual deductibles are waived.

10. How does coordination of benefits work when FEP is the secondary payer?

Traditional Medicare

For member with Medicare parts A and B as their primary plan, FEP coordinates according to the Medicare Coordination of Benefits rules. We will pay the remaining Medicare deductible and/or copays applying our benefit coverage and/or limitations.

Non-Medicare

As a secondary payer with other plans, FEP will pay only the difference between the payment of the primary plan and the provider’s contracted rate (VI Equicare contracted rate), applying deductibles, copays, and coinsurance.

11. What is the out-of-pocket maximum?

The out-of-pocket maximum, also referred to as the catastrophic protection, is the sum of all the applied deductibles, copays, and coinsurance for services covered by the plan, (medical and pharmacy) that the member paid at the time of service. These amounts accumulate and once they reach the established maximum amount, services will be covered 100% for the remainder of the calendar year. To know how much the member has accumulated towards the out-of-pocket maximum, you must contact the FEP Exclusive Customer Service line, since the amounts vary by coverage and family composition. The maximum out-of-pocket amounts are:

FEP Blue Standard \$6,000 Self \$12,000 Self & Family
--

FEP Blue Basic \$7,500 Self \$15,000 Self & Family

FEP Blue Focus \$10,000 Self \$20,000 Self & Family
--

HEDIS Billing

HEDIS – Healthcare Effectiveness Data and Information Set

What is HEDIS?

HEDIS is the tool approved by the National Committee for Quality Assurance (NCQA). This tool is used by more than 90% of the healthcare plans in the United States to measure the performance in their services and care offered. HEDIS measures are designed to evaluate the effectiveness and quality improvement of the health plan. The use of CPT Category II codes makes it easier to track health quality of care. This provides accurate medical data and decreases requests for member’s records to review, identify and close gaps in care accurately and quickly.

Measure	Abbreviation	Priority	Codes
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	AAB	1	Episodes involving members 3 months of age and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. To qualify for a negative medication history, the following criteria must be met: - A period of 30 days prior to the episode date when the person had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. - No prescriptions dispensed? more than 30 days prior to the episode date that are active on the episode date.
Controlling High Blood Pressure	CBP	1	CPT CAT II: 3074F, 3075F / 3078F, 3079F
Glycemic Status Assessment for Patients with Diabetes	GSD	1	CPT CAT II: 3044F, 3051F
Use of Imaging Studies for Low Back Pain	LBP	1	Offer as an alternative treatment: <ul style="list-style-type: none"> • Muscle relaxant • Exercises to strengthen lower back • Massage or physiotherapy • Physical activity to limit muscle rigidity • Place a pillow between the legs when sleeping sideways or under the knees
Adult Immunization Status (Influenza 19 -65)	AIS-E	2	Members 19 years of age and older who are up to date on recommended routine vaccines for influenza. CVX: 88, 135, 140-141, 144, 150, 153,155, 158, 166, 168, 171, 185, 186, 197, 205, 302



OPM is encouraging providers to collect race and ethnicity data to ensure that health care is provided equitably to everyone.

Breast Cancer Screening	BCS-E	2	Codes to close the gap must be billed by the specialist performing the study. CPT: 77061-77063, 77065-77067
Cervical Cancer Screening	CCS-E	2	CPT 88141-88143, 88147, 88148, 88150, 88152, 88153, 88164, 88167, 88174, 88175 HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148 HrHPV Test: 87624-87625
Childhood Immunization Status	CIS-E	2	Two year old children that have received the following vaccines: four (DTap), three (IPV), one (MMR), three (HIB), three (Hep B), one (VZV), four (PCV), one (HepA), two or three (RV), two flu shots before the second birthday.
Colorectal Cancer Screening	COL-E	2	Codes to close the gap must be billed by the specialist performing the study. FOBT CPT: 82270, 82274 sDNA CPT: 81528 Sigmoidoscopy CPT: 45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45350 CT Colonography CPT: 74261-74263 Colonoscopy CPT: 44388-44392, 44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393
Follow - Up After Emergency Department Visit for Substance Use	FUA	2	Follow-up visit or pharmacotherapy dispensing event on the ED (emergency department) visit date or within 30 days after the ED (emergency department) visit (31 days total).
Follow - Up After Emergency Department Visit for Mental Illness	FUM	2	Follow-up visit for any diagnosis of a mental health disorder within 30 days after the ED (emergency department) visit (31 total days). Include visits that occur on the date of the ED(emergency department) visit.
Prenatal and Postpartum Care (Timeliness Prenatal Care)	PP C	2	Prenatal Bundled Services: CPT: 59400, 59425, 59426, 59510, 59610, 59618 HCPCS: H1005 Stand Alone Prenatal Visits: CPT: 99500 CPT-CAT-II: 0500F-0502F HCPCS: H1000-H1004
Statin Therapy for Patients With Cardiovascular Disease	SP C	2	Beneficiaries that continue receiving a statin medication of moderate to high intensity at least 80% of the treatment period
Use of Opioids from Multiple Providers	UOP	2	Avoid prescribing opioids from 4 or more different providers during measurement year (2026).
Acute Hospital Utilization	AHU	2	There is no CPT code for gap closure that can be billed by the physician.
Emergency Department Utilization	EDU	2	There is no CPT code for gap closure that can be billed by the physician.
Plan All - Cause Readmissions	PCR	2	There is no CPT code for gap closure that can be billed by the physician.

Keep in mind

Prior Authorization - For services that require prior approval, we must receive the request prior to performing the service. When providers render services, send the information to Triple-S Salud, the local BCBS Plan for evaluation and approval. Send your prior approval request to:

FEP Case Management
Email: fep.cmreview@ssspr.com
Fax to (787)774-4824

Once received, the plan has 14 days to provide a response to your request, and 72 hours for expedited cases. To ensure that the necessary information is provided, we suggest that you fill out the prior approval form and include any necessary medical documents to justify the medical necessity.

To know what services require preauthorization, call the FEP Exclusive Customer Service line at FEHB 787-774-6082 o 888-774-6082 PSHB 787-474-5220 o 833-201-9257

IMPORTANT: If you do not receive a response in the indicated timeframe, include proof of submission to the email or fax provided above to avoid denials in payment.

Medical Reviews - In cases that do not require prior approval but may be subject to medical necessity, you may send the Medical Review form along with any necessary medical documents to justify the medical necessity. Make sure to include the Medical Order as part of your documentation.

For pre-service cases, the plan has 14 days to provide a response to your request, and 72 hours in expedited cases. In these cases, send the medical review form to our FEP Case Management to the email or fax provided above. For post-service cases, you have 30 days to request medical review.

Medical Orders - The medical orders are needed for requests for imaging, laboratory services, durable medical equipment, medications, and others. The medical order will be valid for 6 months from the date of issue. Be sure to include the necessary information in the medical order to avoid delays in service and the need for new medical orders. Request our BCBS FEP Claims Guide by calling our exclusive FEP line.

FEHB 787-774-6082 or 888-774-6082
PSHB 787-474-5220 or 833-201-9257



**BlueCross
BlueShield**

Federal Employee Program.

Preauthorization #: _____

Date: _____

Medical Review Form

Member Name:		Member Tel:	
Member Email:		Alternative Tel:	
Member ID Number:		DOB:	

Provider NPI:		Provider Tel:	
Provider Contact:		Contact Tel:	
Provider Email:		Fax:	

This form does not substitute the Medical Order. Make sure to include the Medical Order as part of your documentation. Also include additional medical documentation, such as laboratory services, diagnostic testing, medications, among others, to justify the medical necessity.

For pre-service cases, the plan has 14 days to provide a response to your request, and 72 hours in expedited cases. For post-service cases, you have 30 days to request medical review. If you do not receive a response in the indicated timeframe, you must include evidence of your submission.

Expedited Request:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Progress Notes Included:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of pages included:		Primary Diagnosis (ICD 10):	

Services to be evaluated:

CPT Code(s)	Date Range (From-To), if applicable	Additional Diagnosis (ICD 10)
Additional Comments:		
For Internal Use:		
Determination: Approved <input type="checkbox"/> Not Approved <input type="checkbox"/>		Rationale:
Evaluated By:		Date:

To submit by email, send to fep.cmreview@ssspr.com and by fax to (787)774-4824 Attn: FEP Case Management

Rev 05/2022



**BlueCross
BlueShield**

Federal Employee Program.

Preauthorization #: _____

Date: _____

Prior Approval Form

Member Name:		Member Tel:	
Member Email:		Alternative Tel:	
Member ID Number:		DOB:	

Provider NPI:		Provider Tel:	
Provider Contact:		Contact Tel:	
Provider Email:		Fax:	

The following services are considered pre-service claims; therefore, prior approval must be obtained prior to receiving the service. Once received, the plan has 14 days to provide a response to your request, and 72 hours in expedited cases.

This form does not substitute the Medical Order. Make sure to include the Medical Order as part of your documentation. Also include additional medical documentation, such as laboratory services, diagnostic testing, medications, among others, to justify the medical necessity.

If you do not receive a response in the indicated timeframe, you must include evidence of your submission.

Expedited Request:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Progress Notes Included:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of pages included:		Primary Diagnosis (ICD 10):	

Services to be evaluated:

CPT Code(s)	Date Range (From-To), if applicable	Additional Diagnosis (ICD 10)

Additional Comments:

For Internal Use:

Determination:
Approved Not Approved

Rationale:

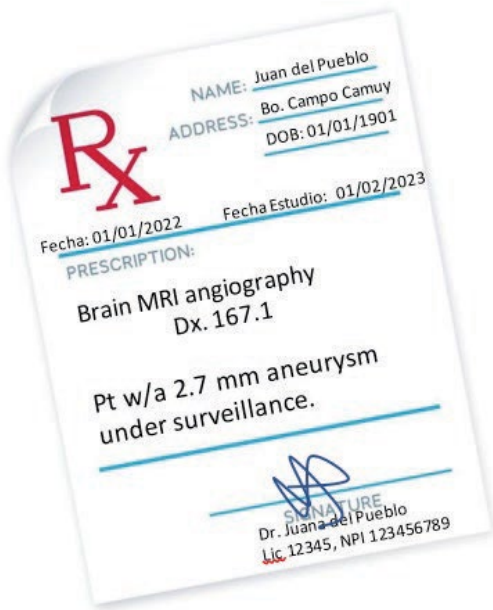
Evaluated By:

Date:

To submit by email, send to fep.cmreview@ssspr.com and by fax to (787)774-4824 Attn: FEP Case Management

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Anatomy of a Medical Order



- 1 Patient identifier: Include full name in the medical order and add at least 2 additional identifiers (ex. Date of birth and address)
- 2 Date: It is necessary for requests with time limits. You may estimate the date when the study will be conducted. *You cannot leave this blank.
- 3 Service/Diagnostic in ICD10 must be specific.
- 4 Medical justification/ or Relevant Medical History. Include Clinical History to be used as a guide and/or important clinical decisions.
- 5 Physician's information: Be sure to include Name, License Number, NPI and signature.

Pharmacy Services

The pharmacy network is managed individually by the following:

 Retail Pharmacy Program 1-800-624-5060	 Mail Service Pharmacy For refills, call: 1-800-262-7890	 Specialty Drug Program 1-888-346-3731	 FEP Medicare Prescription Drug Program 1-888-338-7737
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For more pharmacy information you can access:
<http://www.fepblue.org/pharmacy/prescriptions>



Notice: Informing individuals of nondiscrimination and access requirements and the nondiscrimination statement: Discrimination is against the law.

Triple-S Salud, Inc. complies with the applicable federal civil rights laws and does not discriminate, exclude, or treats persons differently for reasons due to race, color, national origin, age, sex or disability.



Provides auxiliary aids and free services to people with disabilities to communicate effectively with us, such as:

- Certified Sign Language Interpreters
- Information written in other formats (large print, audio, accessible electronic formats, among others).

Provides free translation services to people whose first language is not Spanish, such as:

- Certified Interpreters
- Information written in other languages.

If you need to receive these services, contact a Customer Service Representative.

If you believe that Triple-S Salud, Inc. has not provided these services to you or has discriminated in any way based on race, national origin, color, age, sex, or disability, please contact:

Customer Service Representative

P.O. Box 11320, San Juan, PR 00922-9905

Telephone: (787) 774-6081 or

1-800-716-6081

TTY: (787) 792-1370 or 1-866-215-1999

TSACompliance@sssadvantage.com

You can file your complaint in person, by mail, fax, or email. If you need help to file your complaint, a Customer Service Representative is available to help you.

You can file your complaint for violation of civil rights with the U.S. Department of Health and Human Services, Civil Rights Office electronically through its portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> by mail, or by phone at: 200 Independence Ave, SW Room 509F, HHH Bldg Washington, D.C. 20201 Phone:

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 787-774-6081, libre de costo 1-800-716-6081; (TTY/TDD) 787-792-1370; libre de costo 1-866-215-1999.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 787-774-6081, Toll Free 1-800-716-6081; (TTY/TDD) 787-792-1370; Toll-Free 1-866-215-1999.

For more information on FEP members (contract ID number beginning with the letter "R"), call our FEP Exclusive Customer Service line 787-774-6082 or 1-888-774-6082 (toll free) Monday through Friday from 8:00 am to 5:00 pm AST for eligibility, benefits, claims status, among others. For more information, access our website: www.ssspr.com.

 **Provider Service Line: FEHB** (787) 774-6082 o 888-774-6082 • **PSHB** (787) 474-5220 o 833-201-9257



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Federal Employee Program.



Harold Collazo

Providers Service Executive
Cellular: (787) 690-4925
(787) 749-4949 Ext. 832-1038
haroldco@ssspr.com

Irmgard Rossy Mayo

FEP Quality Analyst
Cellular: (787) 600-3067
irossym@ssspr.com

Anaysha Rivera

FEP Quality Analyst
(787) 749-4949
ext. 832-2124

Yamaris Oquendo

Care Management Clerk
(787) 749-4949
ext. 832-2110

Mairim Santiago

Disease Management Nurse
(787) 749-4949
ext. 832-2899

Manejo de Casos FEP

Email: fep.cmreview@ssspr.com
Fax: (787) 774-4824