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## AUTOMATIC FAX-BACK PROGRAM

Complete the form on page two to receive a faxed letter as each case is decisioned.

**Please note:** You must be participating with Blue Cross Blue Shield of Massachusetts to be eligible for this program.

### WHAT IS THE AUTOMATIC FAX-BACK PROGRAM?

The Blue Cross Blue Shield of Massachusetts Automatic Fax-Back Program is our automated fax process for **faxing individual decision letters** to the program's enrolled providers. It is designed to provide timely inpatient and outpatient information while meeting the legal notification requirements of the Massachusetts Managed Care Reform Law.

### HOW DOES THE PROGRAM WORK?

Once you are enrolled, the system automatically sends a fax notification whenever a member's case is decisioned. A new letter is triggered if any of the following element's change:

- Change in determination
- First date of service
- Number of approved units

*Note: A new letter **will not** be generated if you change the days or the service date range on your claim submission.*

### HOW DO I ENROLL?

Complete the form on page two and fax it to **1-617-246-4482**. We enter new fax numbers into our database once a week.

### HOW DOES BLUE CROSS ENSURE THE REPORT'S ACCURACY?

Blue Cross has systems in place to ensure the accuracy of the information contained in the report. **If our systems detect any errors, we do not fax case information until the information has been entered into our systems correctly.**

### WHAT IF I WANT TO CHANGE MY FAX NUMBER?

Please complete the form on page two and fax your request to **1-617-246-4482**.



# AUTOMATIC FAX-BACK PROGRAM: REQUEST FORM

Fax your completed form to Clinical Intake at **1-617-246-4482**.

To enroll in this program, please complete the information below. We can only send letters to one fax number per Provider ID number.

**Please print or type**

|                                                    |  |       |  |
|----------------------------------------------------|--|-------|--|
| Today's date                                       |  |       |  |
| Provider name                                      |  |       |  |
| Provider address                                   |  |       |  |
| NPI or provider ID                                 |  |       |  |
| Name of person completing form                     |  | Title |  |
| Contact phone #<br>(for questions about this form) |  |       |  |
| Fax #                                              |  |       |  |

## Multiple Provider IDs?

If your NPI is linked to multiple Provider IDs and you would like to update the fax number for all of them, please list each Provider ID along with its associated name.

| Provider ID | Provider/facility name |
|-------------|------------------------|
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