



# Welcome To Ambetter From Superior HealthPlan

Your Partner In Better Healthcare

2025 Provider Orientation

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# AGENDA

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## OVERVIEW

- Who We Are
- Affordable Care Act
- The Health Insurance Marketplace
- Our Networks

## WHAT YOU NEED TO KNOW

- Key Contact Information
- Provider Manual
- Provider Representatives
- Public Website and Secure Portal
- Verification of Eligibility, Benefits and Cost Shares
- Referrals
- Prior Authorization
- Claims, Billing and Payments
- Complaints, Grievances and Appeals
- Specialty Companies and Vendors

## QUESTIONS & ANSWERS





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# OVERVIEW

## #1 carrier

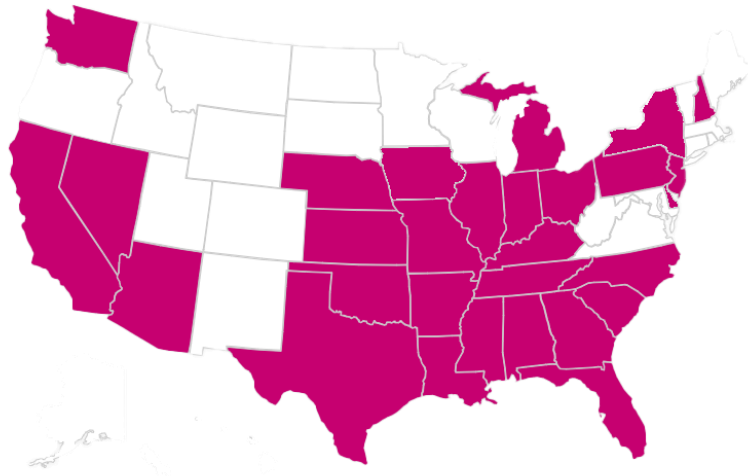
4.4M+

members insured

# 2014

Year that  
Ambetter  
began

28  
states



**Ambetter delivers high quality, locally-based healthcare services to its members, with our providers benefiting from enhanced collaboration and strategic care coordination programs.**

## We target a focused demographic

## We lower income, underinsured and uninsured

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## PARTNERSHIP

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- The **Ambetter plan design philosophy** is to provide affordable care to individuals or families that need to purchase healthcare coverage on their own.
- **Our products** focus on various cost shares — many with low or no copay amounts — to meet the budget and utilization needs of these consumers. This gives our members the peace of mind that they have full comprehensive medical coverage.
- Additionally, the **emphasis on reducing barriers and improving access to care** mitigates the risk of individuals showing up without insurance (uncompensated care). Ambetter's generous cost-sharing initiatives lower patient financial responsibility while also reducing the amount that providers need to collect at time of service.
- Most importantly, Ambetter plans encourage members to establish relationships with their primary care providers to **achieve favorable health outcomes**.

**WE ARE PROUD TO BE YOUR PARTNER**

# AFFORDABLE CARE ACT

## AFFORDABLE CARE ACT (ACA): Key Objectives

- Increase access to quality health insurance
- Improve affordability

## ADDITIONAL PARAMETERS:

- Dependent coverage to age 26\*
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80%\* for individual coverage)

*\*May be greater based on state requirements*



# AFFORDABLE CARE ACT

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## REFORM OF THE COMMERCIAL INSURANCE MARKET

- No more underwriting – guaranteed issue.
- There is no longer a federal tax penalty associated with not having minimum essential coverage\*.
- Minimum standards for coverage: essential health benefits and cost sharing limits.
- The ACA created premium tax credits (also known as subsidies) and cost-sharing reductions (CSR) to help reduce costs for eligible consumers who buy a plan through the Marketplace.
- Subsidies may be available to eligible individuals/families who have a household income between 100 and 400 percent of the Federal Poverty Level (FPL), based on the taxpayer's family size.
  - Currently, the subsidy cap has been eliminated through Plan Year 2025, but that may be extended.
- CSRs are available to eligible individuals/families who have a household income between 100 and 250 percent of the FPL, based on the taxpayer's family size.

*\*States may enact tax penalties for not purchasing insurance*

# HEALTH INSURANCE MARKETPLACE

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The Health Insurance Marketplace is a service available in every state that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace for most states, but some states run their own Marketplaces, also called Exchanges.

The Health Insurance Marketplace provides health plan shopping and enrollment services through websites, call centers, and in-person help. For more information visit, [HealthCare.gov](https://www.healthcare.gov).

## Potential members can:

- Register for the exchange
- Determine eligibility for all health insurance programs (including Medicaid)
- Shop for plans
- Enroll in a plan
- Exchanges may be state-based, federally facilitated, or a federal-state hybrid — **Texas is a federally-facilitated Marketplace**

*The Health Insurance Marketplace allows individuals to receive subsidies. Qualified Health Plans (QHPs) can be purchased through [Healthcare.gov](https://www.healthcare.gov), or a direct enrollment platform.*



# HEALTH INSURANCE MARKETPLACE

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## FINANCIAL COMES IN THE FORM OF:

- Advanced Premium Tax Credits (APTC)
- Cost-Sharing Reductions (CSR)

## ALL BENEFIT PLANS HAVE COST SHARES IN THE FORM OF COPAYS, COINSURANCE AND DEDUCTIBLES

- Some members qualify for assistance with their cost shares based on income level

*The Health Insurance Marketplace allows individuals to receive subsidies. Qualified Health Plans (QHPs) can be purchased through [Healthcare.gov](https://www.healthcare.gov), or a direct enrollment platform.*



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# 2025 AMBETTER PLANS

## OUR NETWORKS

- Ambetter offers a robust suite of innovative networks that give members more coverage options to fit their needs and budget.
- By offering increased product options, Ambetter also benefits providers by giving them exclusive access to new patient populations.
- Each Ambetter network is designed to offer members a unique type of coverage option specific to their state. This means that member plans and benefits can vary, and there may be referral or prior authorization requirements for certain types of care to be covered.
- As a provider, it is important you confirm which network and plan a member is in before extending care. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

## NETWORKS BUILD TO OFFER MORE

# AMBETTER HEALTH PREMIER

- The Ambetter core network consists of both Premier Silver and Premier Gold plans.
- Premier offers our broadest network of healthcare providers and hospitals offering affordable care to individuals or families that need to purchase healthcare coverage on their own.
- Referrals are not required.
- Premier silver plans provide the best value and most balance between monthly premiums and out-of-pocket costs.
- Premier Gold offers peace of mind for all healthcare needs. Members can expect higher monthly premiums to limit out-of-pocket expenses later.

## Select a network

☐ VALUE

This selective network of health care providers and hospitals supports Ambetter's lowest-premium product. All Value products require a referral from your PCP to see specialists.

☒ PREMIER

Our broadest network offering of health care providers and hospitals.

☐ TXSMP

Our network offering of health care providers and hospitals for the TXSMP product.

## OUR INNOVATIVE NETWORKS

## PCP SELECTION

- Ambetter Health emphasizes to members the importance of establishing a medical home (better care, greater appointment availability, consistent care, etc.). Part of that is the selection of a Primary Care Provider (PCP).
- While Silver and Gold members may see any provider they choose, Ambetter Health encourages providers to emphasize the importance of the medical home relationship to members.
- PCPs can still administer service if the member is not assigned to them and may wish to have member assigned to them for future care.
- PCPs should confirm that a member is assigned to their patient panel.
  - This can be done through the Secure Provider Portal.

# AMBETTER VALUE

- **VALUE:** This exclusive network of healthcare providers has referral requirements for certain types of care, along with prior authorization requirements for non-Value providers.
- Value has a more restrictive, yet inclusive and adequate network being offered within a limited set of counties:
  - Bexar, Collin, Dallas, Denton, Fort Bend, Harris, Montgomery, Rockwall, Tarrant, Travis, Williamson.
- The Ambetter Health Value plan design differs in the following:
  - Members will be assigned a PCP at the practitioner level.
  - Iny specialty care rendered by a specialist outside of the PCP's group will require a referral prior to services being rendered to our members.
- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, Behavioral Health/Substance Use Disorder, Urgent Care, Emergent Care, Labs, Radiology, Ambulance and Anesthesia.
  - The above provider or facility types will still be required to be in-network\* and prior authorization requirements will continue to apply, as applicable.

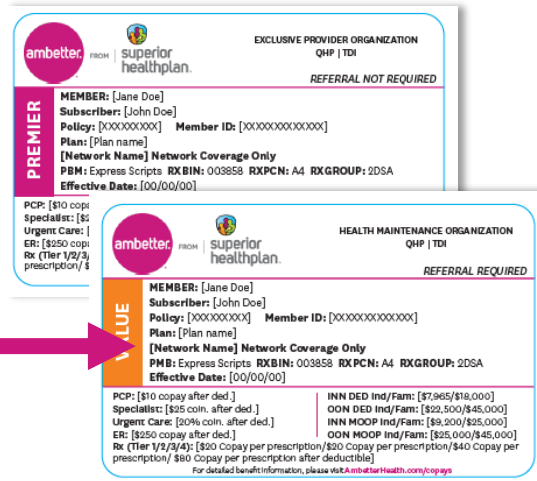


# HOW TO IDENTIFY A MEMBER'S NETWORK

All members receive an Ambetter member identification card. The ID card includes new information that includes:

- The **Ambetter Plan** the member has selected
- The **Provider Network** the member belongs to
- **Referral requirements** based on the member's plan selection.

**Note:** Presentation of a member ID card is not a guarantee of eligibility. Providers must verify eligibility on the same day services are rendered.



Back of Member ID Card





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# WHAT YOU NEED TO KNOW



## KEY CONTACT INFORMATION

**Ambetter from Superior HealthPlan**

**PHONE**

**[1-877-687-1196](tel:1-877-687-1196)**

**TTY/TDD**

**[1-800-735-2989](tel:1-800-735-2989)**

**WEB**

**[Ambetter.SuperiorHealthPlan.com](https://Ambetter.SuperiorHealthPlan.com)**

**PORTAL**

**[Provider.SuperiorHealthPlan.com](https://Provider.SuperiorHealthPlan.com)**



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# AMBETTER PROVIDER MANUAL

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## THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER.

The manual includes a wide-range of important information relevant to providers doing business with Ambetter. Key information includes:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives

The Provider Manual, along with Texas-specific QRGs and resources, can be found under the *Reference Materials* section on [!m better's Provider Resources webpage](#).



# PROVIDER SERVICES

The **Ambetter** Provider Services team includes trained staff available to respond quickly and efficiently to all provider inquiries, or requests, including:

- Credentialing/Network status
- Claims
- Request for adding/deleting physicians to an existing group

By calling Ambetter Provider Services at [1-877-687-1196](tel:1-877-687-1196) providers can access real time assistance for all their service needs.



# Provider Representatives

- As an **Ambetter** provider, you will have a dedicated Provider Representative available to assist you
- Our Provider Representatives serve as the primary liaisons between our health plan and the provider network
- Your Provider Representative is here to help you operate your practice and address needs, such as:

- ✓ Inquiries related to administrative policies, procedures, and operational issues
- ✓ Contract clarification
- ✓ Membership/provider roster questions
- ✓ Secure Portal registration and PaySpan/Zelis
- ✓ Provider education
- ✓ Demographic information updates
- ✓ Initiate credentialing of a new practitioner

# PROVIDER NETWORK OPERATIONS

- Forms to add new practitioners can be found on our website and should be submitted along with all credentialing documentation.
- Enrollments are effective 30 Calendar Days from the date all clean documents are received by Ambetter.

Please send the following items to  
[SHP.NetworkDevelopment@SuperiorHealthPlan.com](mailto:SHP.NetworkDevelopment@SuperiorHealthPlan.com):

- Contract clarification
- Initiate credentialing of a new practitioner
- Inquiries related to the status of a new practitioner or Join Our Network request

## PROVIDER DIRECTORY UPDATES

Providers can improve member access to care by ensuring that their data is current in our provider directory.

To update your provider data:

- Login to [Superior's Secure Provider Portal](#)
- From the main tool bar, select “! ccount Details”
- Select the provider whose data you want to update
- Choose the appropriate service location
- Make appropriate edits and click “Save”





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# PUBLIC WEBSITE AND SECURE PORTAL

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## AMBETTER PUBLIC WEBSITE

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### WHAT'S ON THE PUBLIC WEBSITE: [Ambetter.SuperiorHealthPlan.com](http://Ambetter.SuperiorHealthPlan.com)?

- Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- Provider Training
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing

# AMBETTER PUBLIC WEBSITE

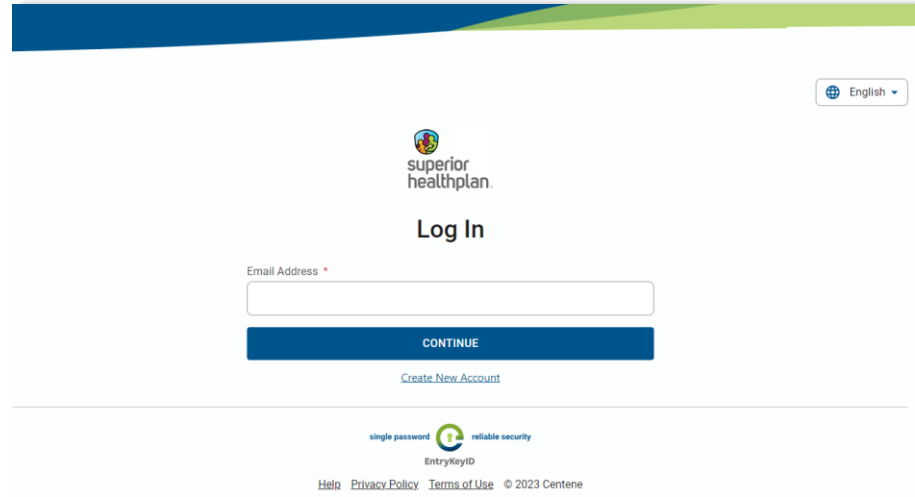


# SECURE PROVIDER PORTAL

REGISTRATION IS FREE AND EASY!



Visit the [Secure Provider Portal](#) to register or contact your local Provider Representative. To access their contact information visit, [Find My Provider Representative](#).



The screenshot shows the login page for the Superior Healthplan Secure Provider Portal. At the top right, there is a language selector set to "English". The Superior Healthplan logo is centered above the "Log In" heading. Below the heading is a text input field labeled "Email Address \*" with a red asterisk. A blue "CONTINUE" button is positioned below the input field. A link for "Create New Account" is located below the button. At the bottom, there is a section for "single password EntryKeyID" with the tagline "reliable security". The footer contains links for "Help", "Privacy Policy", and "Terms of Use", along with the copyright notice "© 2023 Centene".

# SECURE PROVIDER PORTAL

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# AVAILITY ESSENTIALS

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Centene (a parent company of Superior HealthPlan) has chosen Availity Essentials (Availity) as its new, secure provider portal. Providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources, via Availity Essentials. A phased rollout schedule by state goes through early 2025.

- Our current secure portal is still available for other functions that providers use today. For providers new to Availity Essentials, getting their Essentials account is the first step toward working on Availity.
- The provider organization's designated Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Administrators can register with Availity Essentials here:
  - [Availity Essentials website](#)
  - Providers needing additional assistance with registration can call Availity Client Services at **1-800-AVAILITY (1-800-282-4548)**, Monday through Friday, 8 a.m. – 8 p.m. EST.
- For general questions, providers can reach out to their Provider Representative.

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# SECURE PROVIDER PORTAL

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## WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility and patient listings
- Health records and care gap information
- Authorizations
- Claims submissions and status
- Corrected claims and adjustments
- Payment history
- Monthly PCP cost reports
- Provider analytics reports
- PCP Referrals for Value plans

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# SECURE PROVIDER PORTAL

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## INSIGHTFUL REPORTS

- PCP reports available on the Secure Provider Portal are generated monthly and can be exported into a PDF or Excel format.

## PCP REPORTS INCLUDE:

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High-Cost Claims



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# VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

# MEMBER ID CARD

Provider Services  
Contact Information

**ambetter**  
**HEALTH®**

REFERRAL NOT REQUIRED

**PREMIER**

**MEMBER:** [Jane Doe]  
**Subscriber:** [John Doe]  
**Policy:** [XXXXXXXXXX] **Member ID:** [XXXXXXXXXXXXXX]  
**Plan:** [Plan name]  
**[Network Name] Network Coverage Only**  
**RXBIN:** [003858] **RXPCN:** [A4] **RXGROUP:** [2CUA]  
**Effective Date:** [00/00/00]

**COPYAYS**  
PCP: [\$10 copay after ded.]  
Specialist: [\$25 coin. after ded.]  
Urgent Care: [20% coin. after ded.]  
ER: [\$250 copay after ded.]

**COST SHARES**  
INN DED Ind/Fam: [\$7,965/\$18,000]  
OON DED Ind/Fam: [\$22,500/\$45,000]  
INN MOOP Ind/Fam: [\$9,200/\$25,000]  
OON MOOP Ind/Fam: [\$25,000/\$45,000]

For detailed benefit information, please visit [AmbetterHealth.com/copays](http://AmbetterHealth.com/copays)

Plans can include:

- PREMIER
- VALUE
- TXSMP

Certain plans may  
have a referral  
requirement.  
Please note:

1. Referral from PCP is required to see a specialist. Auth may be required.
2. Referral from PCP is not required to see a specialist. Auth may be required.

**Ambetter.SuperiorHealthPlan.com**

**Member/Provider Services:** 1-877-687-1196  
(Relay Texas/TTY 1-800-735-2989)  
**24/7 Nurse Line:** 1-877-687-1196

**Numbers below for providers:**  
Pharmacist Only: 1-833-750-4268  
EDI Payor ID: 68069  
[Centene Vision Services: 1-866-753-5779]  
[Centene Dental Services supported by  
United Concordia: 1-833-260-3625]

**Medical Claims Address:**  
Superior HealthPlan  
Attn: CLAIMS  
PO Box 5010  
Farmington, MO  
63640-5010

 **EXPRESS SCRIPTS®**

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2004-TX-C-00040

Pharmacy Benefit  
Information

## NAVIGATING THE MEMBER ID CARD

# ELIGIBILITY, BENEFITS AND COST SHARE

## PROVIDER MUST VERIFY MEMBER ELIGIBILITY

- Every time a member schedules an appointment.
- When the member arrives for the appointment.

## PANEL STATUS

- PCPs should confirm that a member is assigned to their patient panel.
  - This can be done via our Secure Provider Portal.
- PCPs can still administer service if the member is not on their panel, and they wish to have the member assigned to them for future care.

# VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

# ELIGIBILITY, BENEFITS AND COST SHARE

## ELIGIBILITY, BENEFITS AND COST SHARES CAN BE VERIFIED IN THREE WAYS

- ✓ **The Secure Provider Portal**
  - If you are already a registered user of Superior HealthPlan's secure provider portal, you do NOT need a separate registration
- ✓ **24/7 Interactive Voice Response System**
  - Enter the Member ID Number and the month of service to check eligibility
- ✓ **Contact Provider Services: 1-877-687-1196**

# VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES



# VERIFICATION OF ELIGIBILITY ON THE PORTAL

## Eligibility Check

Date of Service  
10/23/2024  
(mm/dd/yyyy)

Member ID or Last Name  
123456789 or Smith

Date Of Birth  
(mm/dd/yyyy)

Check Eligibility

Print

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	STATE	NETWORK	REFERRAL REQUIRED	RECENT ADT	CARE GAPS	LOG ER VISIT
	10/23/2024	 <a href="#">View details</a>	10/23/2024	TX	<u>VALUE</u> ⓘ	YES	NO		<div>ER Visit? Remove</div>

[Terms and Conditions](#) (new tab)   [Privacy Policy](#) (new tab)   Copyright © 2024, Centene Corporation

# VERIFICATION OF COST SHARES ON THE PORTAL

- To verify how much remains of a member's deductible, visit the **Cost Sharing** tab in their profile.

The screenshot shows the Ambetter Health portal interface. At the top, there's a navigation bar with icons for Manage Practice, Eligibility, Patients, PCP Referrals, Authorizations, Claims, and Messaging. Below this, a search bar shows 'Viewing Patients For: TIN' and 'Plan Type' set to 'Ambetter', with a 'GO' button and a 'Find Patient' button. The main content area is titled 'Smith' and has a 'Back to Patient List' button. A sidebar on the left lists various tabs: Overview, Cost Sharing (selected), Benefits Usage, Assessments, Health Record, ADT, Care Plan, Authorizations, Pharmacy PDL, Care Management Referrals, PCP Referrals, Coordination of Benefits, Claims, Benefit Documents, Document Resource Center, and Notes. The 'Cost Sharing' tab is active, displaying a green message box: 'This patient is eligible as of today, Aug 18, 2023. The premium paid through date is Aug 31, 2023 and the claims paid through date is Aug 31, 2023.' Below this, there's a section for 'Deductible' with a definition and a table showing the status for Family and Person. Another section for 'Out-Of-Pocket Limit' includes a definition and a table showing the status for Family and Person. A footnote at the bottom explains that values start at zero on January 1st and lists services that count towards the deductible.

**Overview**

**Cost Sharing**

**Benefits Usage**

**Assessments**

**Health Record**

**ADT**

**Care Plan**

**Authorizations**

**Pharmacy PDL**

**Care Management Referrals**

**PCP Referrals**

**Coordination of Benefits**

**Claims**

**Benefit Documents**

**Document Resource Center**

**Notes**

[Print Cost Sharing](#)

👍 This patient is eligible as of today, Aug 18, 2023. The premium paid through date is Aug 31, 2023 and the claims paid through date is Aug 31, 2023.

**Deductible**  
The fixed amount of money that you are responsible for paying before your insurance starts to pay. Whether or not you meet your deductible depends on how much healthcare you need throughout the year.

Type	Total Amount	Meet Year To Date*	Remaining
Family	\$15,000.00	\$0.00	\$15,000.00
Person	\$7,500.00	\$0.00	\$7,500.00

Co-insurance and Copayment information are contained in Schedule of Benefits.  
[Schedule of Benefits](#)

**Out-Of-Pocket Limit**  
The total amount you will spend for healthcare, after which the insurance company pays for all your medical care until the year ends.

Type	Total Amount	Meet Year To Date*	Remaining
Family	\$18,000.00	\$163.81	\$17,836.19
Person	\$9,000.00	\$163.81	\$8,836.19

\* These values will start at zero on January 1st. The following counts towards your deductible: medical costs, physician services, hospital services, EHB covered services, including pediatric, vision and mental health services, drug benefits.

# VERIFICATION OF BENEFITS ON THE PORTAL

The screenshot displays the Ambetter Health portal interface. At the top, a navigation bar includes icons and labels for Manage Practice, Eligibility, Patients, PCP Referrals, Authorizations, Claims, and Messaging. Below this, a search bar allows users to view patients by TIN and Plan Type (currently set to Ambetter), with a green 'GO' button and an orange 'Find Patient' button. The main content area shows the patient profile for 'Smith'. On the left is a sidebar menu with options: Overview, Cost Sharing, Benefits Usage, Assessments, Health Record, ADT, Care Plan, Authorizations, Pharmacy PDL, Care Management Referrals, PCP Referrals, Coordination of Benefits, Claims, Benefit Documents (highlighted in blue), Document Resource Center, and Notes. The main content area for 'Smith' includes a red circle highlighting the 'Schedule of Benefits' link, followed by the 'Summary of Benefits and coverage' link and a note: 'For additional Benefit Coverage information go to AmbetterHealth.com or call provider services'.

ambetter

Manage Practice Eligibility Patients PCP Referrals Authorizations Claims Messaging

Viewing Patients For: TIN [ ] Plan Type: Ambetter [ ] GO Find Patient

Back to Patient List Smith

Overview

Cost Sharing

Benefits Usage

Assessments

Health Record

ADT

Care Plan

Authorizations

Pharmacy PDL

Care Management Referrals

PCP Referrals

Coordination of Benefits

Claims

Benefit Documents

Document Resource Center

Notes

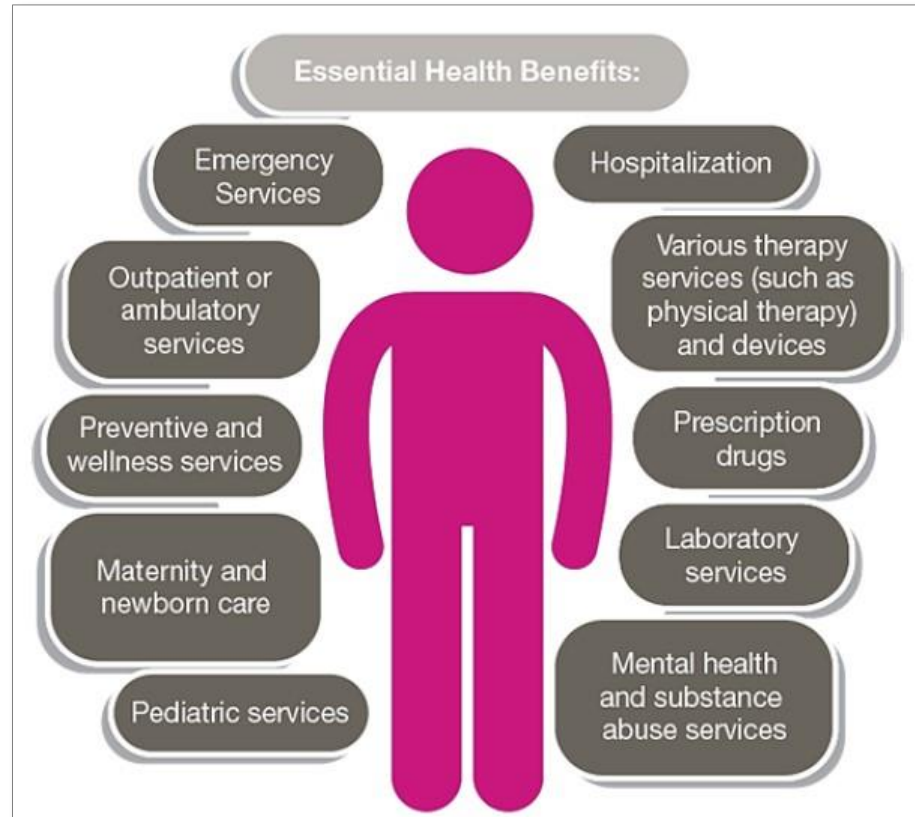
[Schedule of Benefits](#)

[Summary of Benefits and coverage](#)

For additional Benefit Coverage information go to AmbetterHealth.com or call provider services

# ESSENTIAL HEALTH BENEFITS

- Essential Health Benefits are offered within each Ambetter Health plan.



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## OTHER BENEFITS

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- My Health Pays Rewards
- Health Management programs
- Optional Dental and Vision
- Start Smart for Your Baby
- Your Better Health Center
- Abenity – Ambetter Perks
- Farmbox
- Virtual 24/7 Care
  - This is one-time, episodic care, available 24/7, and delivered virtually



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# REFERRALS

# AMBETTER PCP REFERRAL REQUIREMENTS

- The Ambetter Value plan has referral requirements.
- For services to be covered under these plans, they must be provided by or referred by a PCP.
- If a referral is not initiated, services performed outside of the member's assigned provider or primary care group will be denied.
- Prior authorization requirements will also apply, as necessary.
- Referral requirements are reiterated throughout the Ambetter Guide and member plan materials to ensure members understand the rules associated with their plan. Referring providers can use the Ambetter Secure Provider Portal to initiate referrals on behalf of members.

Ambetter Plan	Referral Requirement?
PREMIER	No
VALUE	Yes, for care outside of PCP

# MAKING AN AMBETTER VALUE REFERRAL FOR A SPECIALIST

### Find a Provider

Search for a doctor, facility, pharmacy and much more using the form below.

#### Where are you searching?

Enter an address or zip code to search for a provider nearby.

[Use my current location](#)

☐ Search by street address

Required \*

City, County or ZIP Code \*

☐ Are you searching outside the state where you enrolled in your plan?

Select your plan

1. Go to the [Ambetter Guide webpage](#).
2. Input the City, County or ZIP Code you are searching for and click *Select your plan*.
3. Under “What is your health plan?,” select the Ambetter Value option. Click the *Continue* button to advance.
  1. If you do not see an Ambetter Value option, click on *Change Location* to ensure the information is correct.
4. Search for a specific specialty, facility/group name, provider name or NPI. There is also the option to search by category.
5. Submit the search.
6. On the results page, use the filter options to narrow the results to the specific needs of the member.
7. Click through on any result to see full details about the provider, including their NPI.



# MAKING A REFERRAL: SECURE PROVIDER PORTAL

ONCE YOU IDENTIFY THE SPECIALIST'S NAME  
AND NPI, SUBMIT THE INFORMATION ON THIS  
SCREEN.

1. Click on **PCP Referrals** tab at the top of the screen.
2. Click the **Create Referral** button.
3. Complete the fields on the PCP Referral form.

**Tip:** Please utilize the Helpful Information section for assistance / guidance.

The screenshot shows the 'Create Referral' form in the Ambetter Health Secure Provider Portal. The form is titled 'Create Referral' and includes the following sections:

- Referral Information:** Fields for Patient Name (Smith), Birth Date, Plan (Ambetter Value), Member ID, and Primary Provider Group.
- Referral Date:** Fields for Start Date (08/18/2023) and End Date (11/16/2023). A note states: 'Select a Start Date to determine the type of referral required. \*All fields required except Notes and Attachments.' A link to the 'Ambetter Guide' is provided.
- Helpful Information:** A section stating 'No referral necessary for the following Specialties:' followed by a list: Anesthesiology, Behavioral Health/Substance Use Disorder, Labs, Diagnostic and Gynecology, Radiology (X-ray, Imaging), and Urgent or Emergent Services.
- Referring Provider:** A search field for 'ENTER NAME OR NPI' with a 'SEARCH' button. Fields for Name, Title, and Phone are shown.
- Referral Type & Visits:** A dropdown for 'Select Referral Type' (Consult & Treatment) and a field for 'Visits' (1).
- Referred To Provider:** A search field for 'ENTER NAME OR NPI' with a 'SEARCH' button. Fields for Name, Title, and Phone are shown.
- Referred To Provider's Specialty:** A dropdown for 'Select Specialty'.
- Notes (optional):** A text area for 'Enter some notes here...' with a character count of 0/400.
- ATTACHMENTS:** A section for 'Drag & Drop Files' or 'Select Files From Your Computer'. It specifies 'Upload PDF or Word Doc' and '5 MB maximum and 25 MB maximum per file'.

At the bottom of the form, there is a disclaimer: 'Note: Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual.' Below the disclaimer are 'CANCEL' and 'NEXT' buttons.

# RECEIVING A REFERRAL

1. Once you receive a referral for care from the member's PCP, the member will schedule an appointment with you.
2. Log in to the Ambetter Secure Provider Portal.
3. Navigate to **Referrals** tab at the top.
4. Click on **Referrals Received** to see the referral tracking table.
5. When you are ready to submit a claim for the referred service, reference this table for the referral ID/REF#.
6. Submit claims form with the REF#.
7. Claim form **MUST** include a REF# if a referral is required for the service. **If no REF# is submitted, the claim will be denied.**

The screenshot shows the Ambetter Secure Provider Portal interface. At the top, there's a navigation bar with tabs: Manage This Site, Eligibility, Patients, PCP Referrals, Authorizations, Claims, and Messaging. Below this, there's a section for 'PCP Referrals' with a 'What's New: Filter Referrals' notification. The main content area is divided into two tabs: 'PCP Referrals Received' (selected) and 'PCP Referrals Made'. The 'PCP Referrals Received' tab displays a table with columns: Submitted, IT, Referral ID, Member Name, Plan, Specialty, Visits Left, Start-End Dates, and Status. The table lists several referrals, including REF05, REF35, REF06, REF64, REF02, REF18, REF61, REF9800E0966, and REF80AC4788. A 'Filter' button and a 'Filter By Keywords' search bar are located above the table. At the bottom of the table, there's a 'DOWNLOAD' link and a 'Rows per page' dropdown set to 10, showing 1-9 of 9 rows.

Submitted	IT	Referral ID	Member Name	Plan	Specialty	Visits Left	Start-End Dates	Status
07/20/2023		REF05		Ambetter Value	Obstetrics & Gynecology 6 Allowed Visits	6	07/20/2023 - 10/18/2023	Active
06/30/2023		REF35		Ambetter Value	Obstetrics & Gynecology 12 Allowed Visits	12	06/30/2023 - 09/28/2023	Active
06/02/2023		REF06		Ambetter Value	Obstetrics & Gynecology Gynecology 6 Allowed Visits	6	06/02/2023 - 07/31/2023	Expired
03/30/2023		REF64		Ambetter Value	Obstetrics & Gynecology 6 Allowed Visits	6	03/30/2023 - 06/28/2023	Expired
03/27/2023		REF02		Ambetter Value	General Acute Care Hospital 6 Allowed Visits	6	03/27/2023 - 06/26/2023	Expired
03/04/2023		REF18		Ambetter Value	Obstetrics & Gynecology 6 Allowed Visits	6	03/04/2023 - 06/22/2023	Expired
03/22/2023		REF61		Ambetter Value	Obstetrics & Gynecology 6 Allowed Visits	6	03/22/2023 - 06/20/2023	Expired
03/07/2023		REF9800E0966		Ambetter Value	Obstetrics & Gynecology Gynecology 6 Allowed Visits	6	03/07/2023 - 06/05/2023	Expired
02/23/2023		REF80AC4788		Ambetter Value	Obstetrics & Gynecology 6 Allowed Visits	6	02/23/2023 - 05/24/2023	Expired

Rows per page: 10 1-9 of 9

**Visits Left** is based on claims processing starting on 1/1/2023. If Ambetter has not received a claim for a date of service, it will not be included in the counts above.

**Status Type Explanation**

- ACTIVE: The referral is still within the start date and end date
- EXPIRED: The end date for the referral has passed
- CANCELLED: The referral has been cancelled by the referring provider
- CLOSED: The referral number was submitted with a claim



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# PRIOR AUTHORIZATION

# HOW TO SECURE A PRIOR AUTHORIZATION

## NEED PRIOR AUTHORIZATION?

It can be requested in the following ways:

- ✓ **The Secure Provider Portal** (This is the preferred and fastest method)
- ✓ **Phone**
  - **1-877-687-1196**
- ✓ **Fax**
  - Outpatient: 1-855-537-3447 (Medical) or 1-844-307-4442 (Behavioral)
  - Inpatient: 1-866-838-7615 (Medical) or 1-866-900-6918 (Behavioral)
    - The fax authorization forms are located on [Ambetter's Provider Resources webpage](#).

*After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line.  
Notification of authorization will be returned via phone, fax, or web.*



# IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- The *Prior Authorization Prescreen Tool* can be found on the **Ambetter's Prior Auth Requirements webpage**.

Are Services being performed in the Emergency Department?

☐ Yes ☒ No

Types of Services	YES	NO
Are the services being performed or ordered by a non-participating provider (professionals/facilities)?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for dental surgeries?	<input type="radio"/>	<input checked="" type="radio"/>
Are oral surgery services being provided in the office?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving Gender Reassignment services?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

90791

[CHECK FOR PRE-AUTH](#)

**N**  
No

**90791 - PSYCH DIAGNOSTIC EVALUATION**  
No authorization required.

To submit a prior authorization [Login Here](#).

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# REQUIREMENTS

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## PROCEDURES / SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE\*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g. CT, MRI, PET)
- Infertility
- Pain Management

*\*This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

# PRIOR AUTHORIZATION REQUIREMENTS

# REQUIREMENTS

## INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING\*:

- All elective/scheduled admission notifications requested at least 5 Business Days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral Health Services:
    - Partial Hospitalization Program (PHP) and/or Intensive Outpatient Program (IOP)
    - Residential Treatment (Mental Health/Substance Use)
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
  - Observation stays more than 23 hours require Inpatient Authorization
  - Urgent/Emergent Admissions
    - Within 1 Business Day following the date of admission
    - Newborn deliveries must include birth outcomes

*\*This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

# PRIOR AUTHORIZATION REQUIREMENTS

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# REQUIREMENTS

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## ANCILLARY SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE\*:

- Air ambulance transport (non-emergent fixed-wing airplane)
- Durable medical equipment (DME)
- Home health care services, including:
  - Home infusion
  - Skilled nursing
  - Therapy
  - Private duty nursing
  - Adult medical day care
  - Hospice
  - Furnished medical supplies and DME

*\*This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

# PRIOR AUTHORIZATION REQUIREMENTS



## TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required 5 Business Days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required 5 Business Days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within 1 Business Day
Observation – 48 hours or less	Notification within 1 Business Day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within 1 Business Day
Emergency room and post stabilization, urgent care and crisis intervention	No prior authorization required
Maternity admissions	Notification within 1 Business Day
Newborn admissions	Notification within 1 Business Day
Neonatal Intensive Care Unit (NICU) admissions	Notification within 1 Business Day
Outpatient Dialysis	Notification within 3 Calendar Day

## PRIOR AUTHORIZATION REQUEST TIMEFRAMES

# TIMEFRAMES

Type	Timeframe
Prospective/Urgent	3 Calendar Days
Prospective/Non-Urgent	3 Calendar Days
Concurrent/Urgent	24 Hours
Retrospective	30 Calendar Days

## UTILIZATION AUTHORIZATION TIMEFRAMES

## CORRECT CODING

### PRIOR AUTHORIZATION WILL BE GRANTED AT THE CPT CODE LEVEL

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.
- It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission, or the claim will deny.
- Ambetter will update authorizations but will **not** retro-authorize services.
  - The claim will deny for lack of authorization.
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

## CORRECT CODING FOR PRIOR AUTHORIZATION

# PREAUTHORIZATION EXEMPTIONS

- Providers will be exempt for six months from obtaining prior authorizations for specific services in which, during the review period, if they received 90% medical necessity approval, with a minimum of 5 requests per service/procedure code/prescription.
  - Concurrent Inpatient review services are excluded from preauthorization exemption.
  - Prescription, outpatient and elective inpatient procedures are subject to review for prior authorization exemption.
- January and June of each year we are able to review between 5 and 20 medical records for claims received and may rescind prior authorization exclusion if:
  - 90% of medical necessity criteria are not met for the sample size.
  - Providers may request an independent review from an IRO if they disagree with Ambetter Health's decision.
- Out-of-network providers will still require prior authorization unless the provider is exempt for the service/procedure code/prescription.



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# CLAIMS, BILLING AND PAYMENTS

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# CLAIMS

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## WHAT IS A CLEAN CLAIM?

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation, or particular circumstance requiring special treatment that prevents timely payment.

## ARE THERE ANY EXCEPTIONS?

- A claim for which fraud is suspected.
- A claim for which a third-party resource should be responsible.

# HOW TO SUBMIT A CLAIM

The timely filing deadline for initial claims is 95 Calendar Days from the date of service, or date of primary payment, when Ambetter is secondary.

## CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. The [Secure Provider Portal](#)
2. **Electronic Clearinghouse**
  1. Payor ID 68069
  2. Clearinghouses currently utilized by Ambetter will continue to be utilized
  3. For a listing of our clearinghouses, visit the *Claims and Claims Payments* section of the [Ambetter Provider Resources webpage](#).
3. **Mail**

Ambetter  
P.O. Box 5010  
Farmington, MO 64640-5010



# CLAIM RECONSIDERATIONS AND DISPUTES

## CLAIM RECONSIDERATIONS

- For reconsideration requests, providers can use the **Reconsider Claim** button on the Claim Details screen within the Secure Provider Portal.
- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 120 Calendar Days of the Explanation of Payment.
- Mail claim reconsiderations to:  
Ambetter from Superior HealthPlan  
Attn: Level I – Request for Reconsideration  
PO Box 5010  
Farmington, MO 63640-5010

## CLAIM DISPUTES

- Must be submitted within 120 Calendar Days of the Explanation of Payment
- A Claim Dispute form can be found on the visit the *Claims and Claims Payments* section of the [Ambetter Provider Resources webpage](#).
- Mail completed Claim Dispute form to:  
Ambetter from Superior HealthPlan:  
Attn: Level II Claim Dispute  
PO Box 5010  
Farmington, MO 63640 5010





# CLAIM SUBMISSION SUSPENDED STATUS

## WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- After the first 30 Calendar Days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- A provision of the Affordable Care Act (ACA) allows members who are receiving Advanced Premium Tax Credits (APTCs) a three-month grace period for paying claims.
- While the member is in a suspended status, claims will be pended.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium, the claims will be released, and the provider may bill the member directly for services.

# CLAIM SUBMISSION SUSPENDED STATUS

## EXAMPLE TIMELINE OF A MEMBER IN SUSPENDED STATUS

- **January 1<sup>st</sup>**  
Member pays premium.
- **February 1<sup>st</sup>**  
Premium due – member does not pay.
- **March 1<sup>st</sup>**  
Member placed in suspended status.
- **April 1<sup>st</sup>**  
Member remains in suspended status.
- **May 1<sup>st</sup>**  
If premium remains unpaid, member is terminated.  
Provider may bill member directly for services rendered.

Claims for  
members in a  
suspended  
status are not  
considered  
“clean claims.”

# HELPFUL INFORMATION ABOUT CLAIMS

## MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE

- Claims **must** be submitted with the rendering provider's taxonomy code.
- The claim will deny if the taxonomy code is not present.
- This is necessary in order to accurately adjudicate the claim.

## REMINDER: DO NOT FORGET THE CLIA NUMBER

- If the claim contains CLIA-certified or CLIA-waived services, the CLIA number **must** be entered in **Box 23** of a paper claim form or in the appropriate loop for Electronic Data Interchange (EDI) claims.
- Claims will be rejected if the CLIA number is not on the claim.

# BILLING THE MEMBER

## COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, co-insurance and any unpaid portion of the deductible may be collected at the time of service.
- Deductible information, including the amount that has been paid toward the deductible so far, can be accessed via the **Secure Provider Portal**.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 Calendar Days.



# CLAIMS PAYMENTS

## PAYSPAN®/ZELIS: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan® Health, recently acquired by Zelis, a free solution that helps providers transition into electronic payments and automatic reconciliation
- If you currently utilize PaySpan®, you will need to register specifically for Ambetter
- **Set up your PaySpan® account:**
  - Visit [PaySpan Sign In webpage](#) and click **Register**
  - You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

# ELECTRONIC FUNDS TRANSFER



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# COMPLAINTS, GRIEVANCES AND APPEALS

# COMPLAINTS, GRIEVANCES AND APPEALS

## CLAIMS

- A provider must exhaust the claims reconsideration and claims dispute process before filing a complaint/grievance or appeal.

## COMPLAINT/GRIEVANCE

- A complaint is a verbal or written expression by a provider, which indicates dissatisfaction or dispute with Ambetter Health's policies, procedures, or any aspect of Ambetter Health's functions.
- A letter will be sent to the provider acknowledging receipt of the complaint within 5 Business Days.
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 Calendar Days.
  - The letter includes the decision/resolution of the complaint, the facts utilized to resolve it and the provider's right to pursue arbitration or file a complaint with TDI if they are not satisfied with the outcome.



# COMPLAINTS, GRIEVANCES AND APPEALS

## APPEALS

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal.

## MEDICAL NECESSITY

- Must be filed within 180 Calendar Days from the Notice of Adverse Determination.
- Ambetter shall acknowledge receipt within 5 Business Days of receiving the appeal.
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 Calendar Days.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 1 working day from the date all information necessary to complete the appeal is received.



# COMPLAINTS, GRIEVANCES AND APPEALS

## MEMBER REPRESENTATIVES

- Members may designate a provider to act as their representative for filing appeals related to medical necessity.
- Ambetter requires that this designation by the member be made in writing and provided to Ambetter.
- No punitive action will be taken against a provider by Ambetter for acting as a member's representative.

## NEED MORE INFORMATION?

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual as well as in our Texas-specific QRGs under the *Reference Materials* section of the [Ambetter's Provider Resources webpage](#).





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# SPECIALTY SERVICES & VENDORS

# SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services Cardiovascular Procedures	Evolent	<a href="#">Evolent website</a> Phone: <a href="tel:1-877-687-1196">1-877-687-1196</a>
Vision Services	Envolve Vision	<a href="#">Envolve Vision website</a> Phone: <a href="tel:1-866-753-5779">1-866-753-5779</a>
Dental Services	Envolve Dental	<a href="#">Envolve Dental website</a> Phone: <a href="tel:1-833-260-3625">1-833-260-3625</a>
Pharmacy Services	Express Scripts	Phone: <a href="tel:1-866-399-0928">1-866-399-0928</a> Fax: 1-866-399-0929

## OUR SPECIALTY COMPANIES AND VENDORS



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# Questions & Answers