Welcome To Ambetter of North Carolina Inc.

Your Partner In Better Healthcare

2025 Provider Orientation

PROVIDER ORIENTATION

2025

Confidential and Proprietary Information

AGENDA

OVERVIEW

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

WHAT YOU NEED TO KNOW

~ Key Contact Information
~ Provider Manual
~ Provider Engagement
~ 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

2025 Provider Orientation

OVERVIEW

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WE ARE
AMBETTER

We provide market-leading, affordable health insurance on the marketplace.

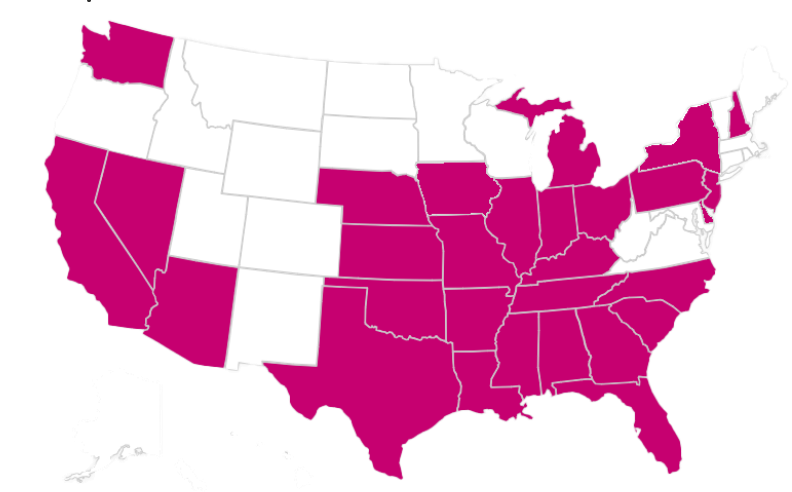
#1 carrier
on the health insurance marketplace*

4.4M+
members insured

**Statistical claims and the #1 Marketplace Insurance statement are in reference to national on-exchange marketplace membership and based on national Ambetter data in conjunction with findings from 2023 Rate Review data from CMS, 2023 State-Level Public Use File from CMS, state insurance regulatory filings, and public financial filings.*

2014
Year that Ambetter began

28
states



LOCAL APPROACH TO CARE

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

~ **Target a focused demographic**

~ **Lower income, underinsured and uninsured**

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Ambetter of North Carolina Inc.

2019

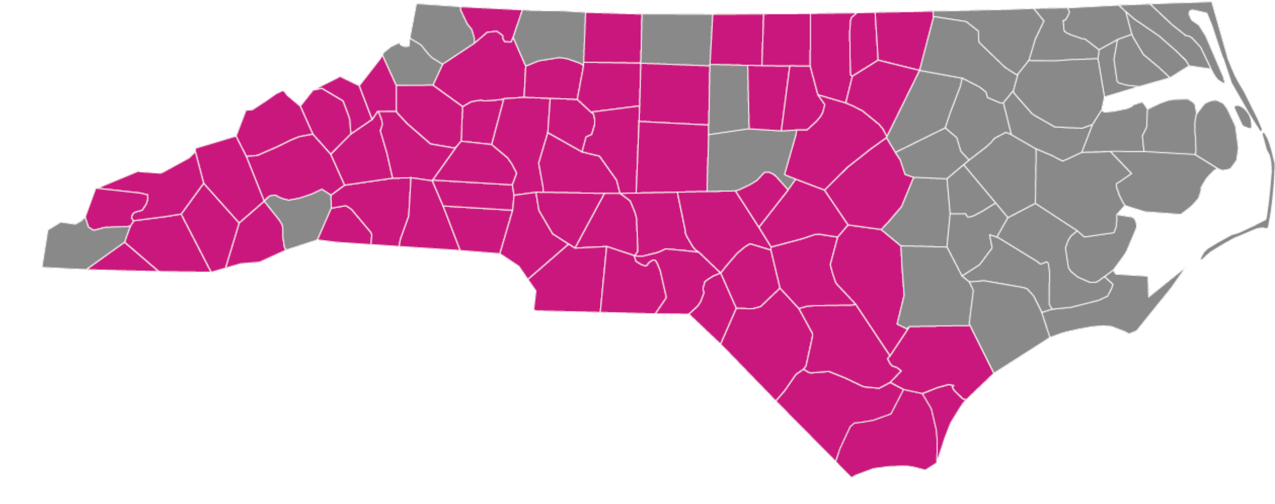
Year that Ambetter of North Carolina Inc. began in just 19 counties!

~132K

members insured

63

counties



View our coverage map!

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PARTNERSHIP

- 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

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

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 (HealthCare.gov) 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.

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 — North Carolina ***is a Federally Facilitated Marketplace***

The Health Insurance Marketplace allows individuals to receive subsidies. Qualified Health Plans (QHPs) can be purchased through Healthcare.gov, or a direct enrollment platform.

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HEALTH INSURANCE MARKETPLACE

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, or a direct enrollment platform.

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OUR NETWORKS

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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

OUR NETWORKS

Ambetter Health Premier Plans: The Ambetter core network– 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.

Ambetter Health Premier Plans in NC provide members managing diabetes with additional healthcare options and savings. Members will have lower out-of-pocket costs for certain medications, supplies, and clinical support. Members of these plans may have access to $0 copays for preferred insulin, as well as $0 copays for select mental health medications

Each Ambetter Health 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 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.

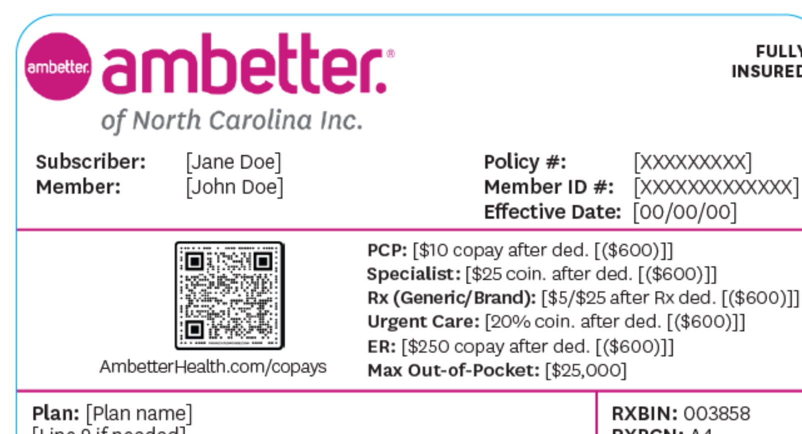
Our Innovative Networks

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.*



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WHAT YOU NEED TO KNOW

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KEY CONTACT INFORMATION

Ambetter of North Carolina Inc.

PHONE

Phone: 1-833-863-1310
(Relay 711)

WEB

https://www.ambetterofnorthcarolina.com/

PORTAL

Provider.AmbetterofNorthCarolina.com

AMBETTER PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER OF NORTH CAROLINA INC.

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 can be found in the Provider section of the Ambetter of North Carolina Inc. website at **https://www.ambetterofnorthcarolina.com/**

PROVIDER RELATIONS AND ENGAGEMENT

The **Ambetter of North Carolina Inc.** Provider Relations 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 of North Carolina Inc.** Provider Services at **1-833-863-1310,** providers are able to access real time assistance for all their service needs.

PROVIDER RELATIONS AND ENGAGEMENT

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

✓ Inquiries related to administrative policies, procedures, and operational issues
✓ Performance pattern monitoring
✓ Contract clarification
✓ Membership/provider roster questions
✓ Secure Portal registration and PaySpan
✓ Provider education
✓ HEDIS/care gap reviews
✓ Financial analysis
✓ EHR Utilization
✓ Demographic information updates
✓ Initiate credentialing of a new practitioner

PROVIDER NETWORK OPERATIONS

- Providers should submit updates to demographic data to AmbetterNCProviderDirectoryRequest@CENTENE.COM within 30 days of the data change becoming effective.
- Forms to add new practitioners can be found on our website and should be submitted along with all credentialing documentation to AmbetterNCProviderDirectoryRequest@CENTENE.COM
- Enrollments are effective 30 days from the date all clean documents are received by Ambetter.

Please send the following items to AmbetterNCProviderDirectoryRequest@CENTENE.COM

- **Contract Clarification**
- **Demographic information updates**
- **Initiate credentialing of a new practitioner**
- **Inquiries related to the status of a new practitioner or Join Our Network request**

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PUBLIC WEBSITE AND SECURE PORTAL

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AMBETTER PUBLIC WEBSITE

AMBETTEROFNORTHCAROLINA.COM

Ambetter Public Website

AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

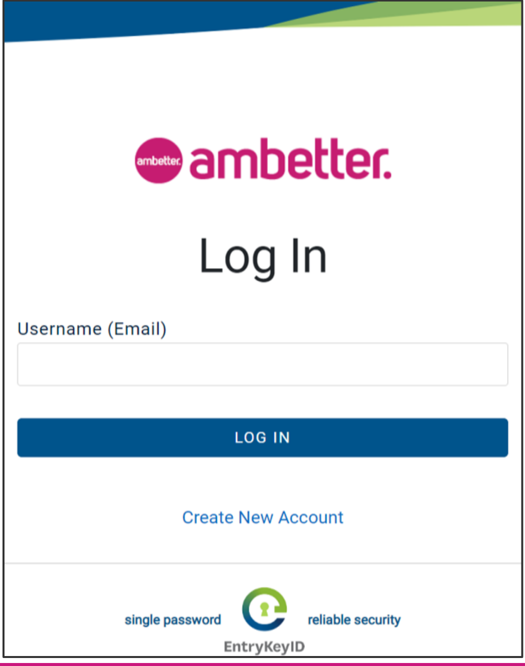
- Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing

SECURE PROVIDER PORTAL

REGISTRATION IS FREE AND EASY!

provider.ambetterofnorthcarolina.com

Contact your Provider Engagement Administrator to get started!

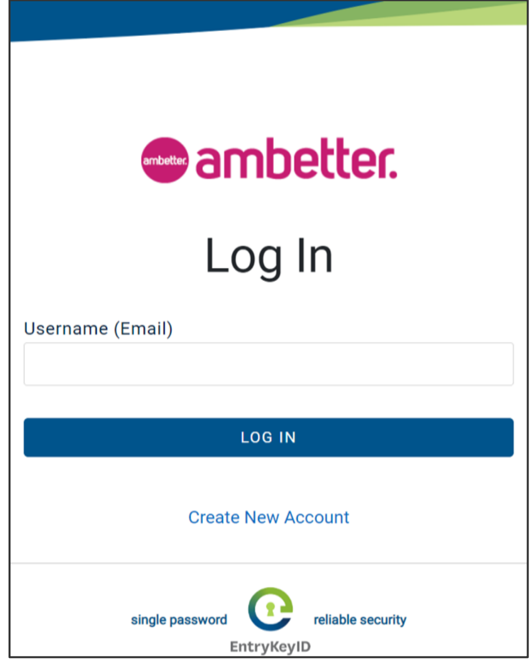


Secure Provider Portal

SECURE PROVIDER PORTAL

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



SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

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

PROVIDER.AMBETTEROFNORTHCAROLINA.COM

PCP REPORTS INCLUDE:

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

AVAILITY ESSENTIALS

Centene has chosen Availity Essentials 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:
    - **www.Availity.com/documents/learning/LP_AP_GetStarted**
    - Providers needing additional assistance with registration can call Availity Client Services at **1-800-AVAILITY (282-4548),** Monday through Friday, 8 a.m. – 8 p.m. ET.
- For general questions, providers can reach out to their health plan Provider Engagement representative.

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VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

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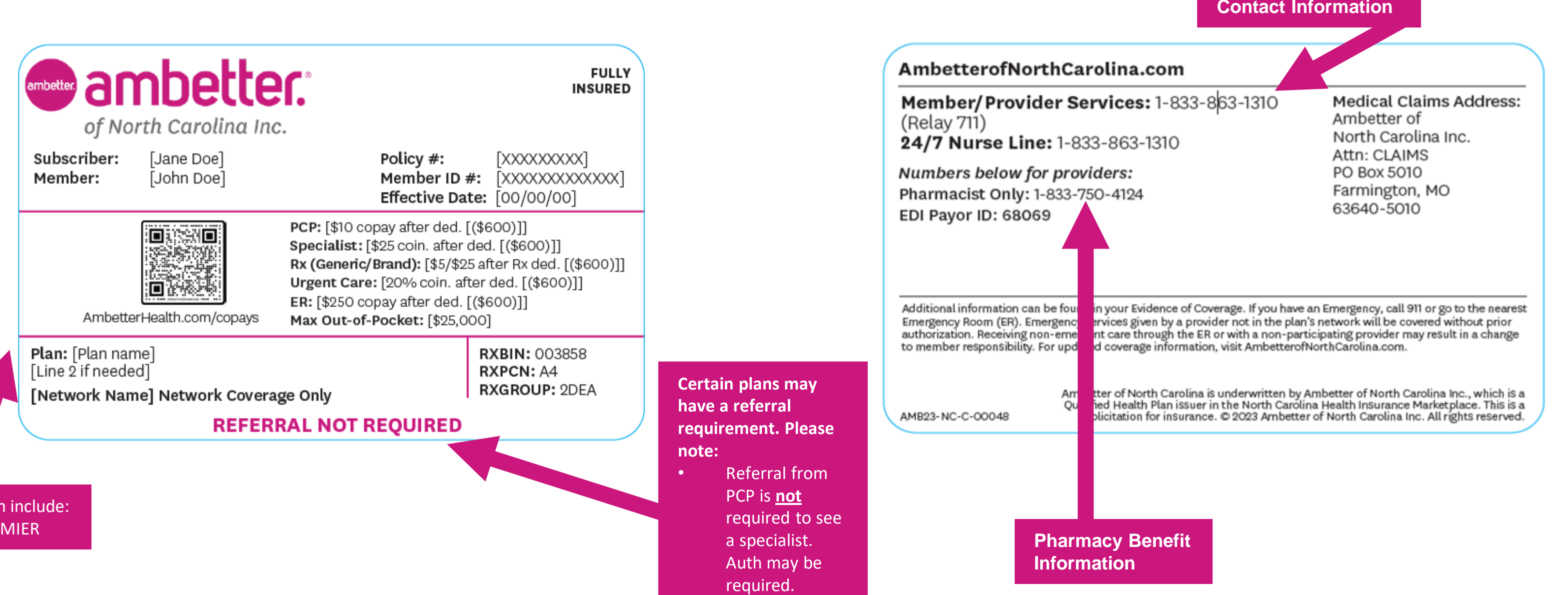
MEMBER ID CARD



Plans can include:
- PREMIER

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 Share

ELIGIBILITY, BENEFITS AND COST SHARE

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

✓ **The Ambetter Secure Portal: https://provider.ambetterofnorthcarolina.com**
If you are already a registered user of the Ambetter of **Ambetter of North Carolina Inc.** secure 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: 1-833-863-1310

Verification of Eligibility, Benefits and Cost Share

VERIFICATION OF ELIGIBILITY ON THE PORTAL

ambetter | Manage Practice | Eligibility | Patients | PCP Referrals | Authorizations | Claims | Messaging

Viewing Eligibility For : TIN | Plan Type: Ambetter | GO

We are currently experiencing issues displaying the 'PCP Referrals Made' list. Please search for the Member in order to see their referrals or call provider services for more information.

Required Action! Providers seeing members enrolled in Ambetter VALUE or VIRTUAL ACCESS products will need to ensure that PCP Referrals are created prior to providing care. Providers who are outside of the members Primary Provider Group will require a referral for services to be covered. Claims will deny if the referral is not in place.

Eligibility Check

Date of Service (mm/dd/yyyy) 08/18/2023 | Member ID or Last Name 123456789 or Smith | DOB 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	
	08/18/2023	Smith ›View details	08/18/2023	FL	CMS Exp Bronze Std Core	NO	NO	Non-compliant for annual well visit.	ER Visit?	Remove

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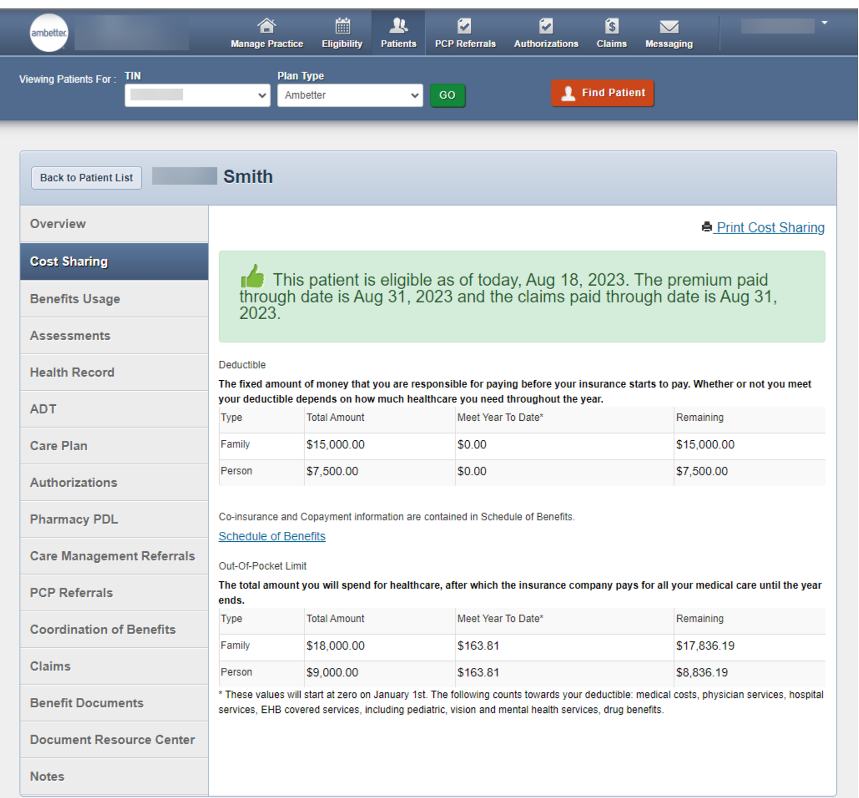
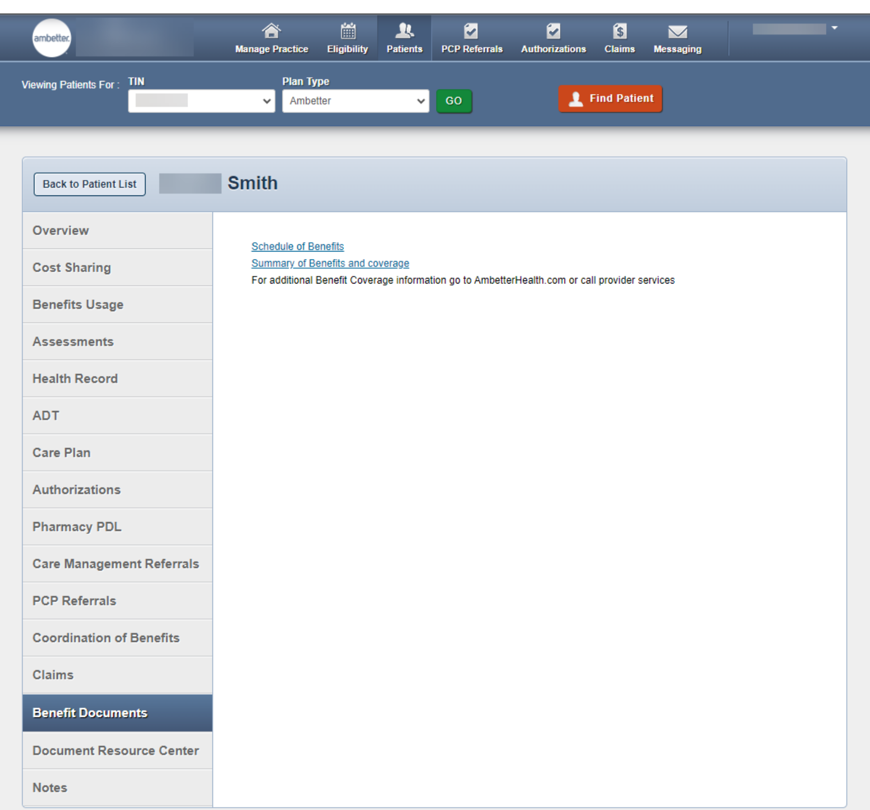
VERIFICATION OF COST SHARES ON THE PORTAL



VERIFICATION OF BENEFITS ON THE PORTAL



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PRIOR AUTHORIZATION

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HOW TO SECURE A PRIOR AUTHORIZATION

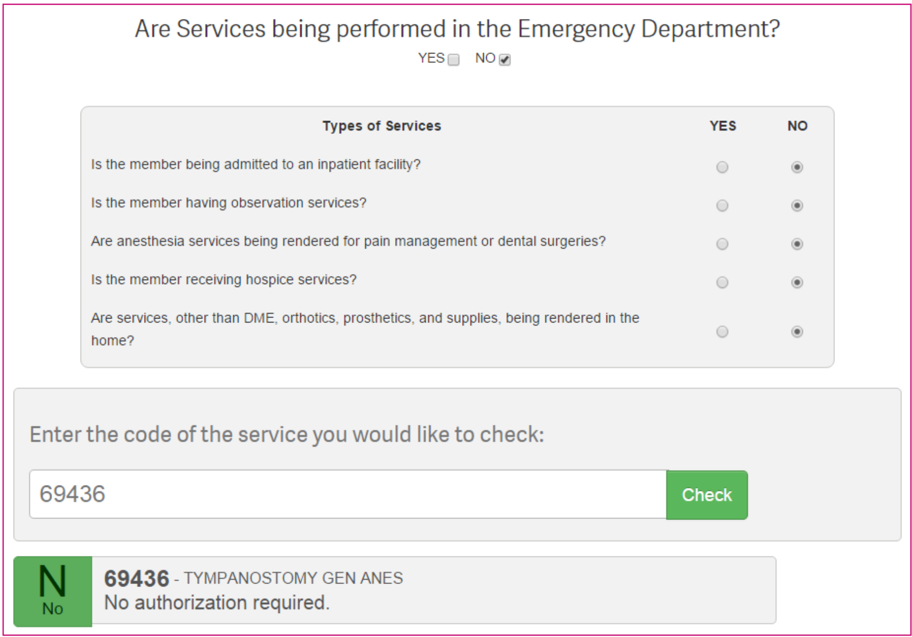
NEED PRIOR AUTHORIZATION?
It can be requested in the following ways:

- ✓ Secure Web Portal (This is the preferred and fastest method.)
  https://provider.ambetterofnorthcarolina.com
- ✓ Availity Essentials
- ✓ Phone
  1-833-863-1310
- ✓ Fax
  1-844-536-2412

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.
- Available on the provider section of the Ambetter of North Carolina Inc. website at ambetterofnorthcarolina.com



REQUIREMENTS

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.*

REQUIREMENTS

INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING*:

- All elective/scheduled admission notifications requested at least 5 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)

  ~ Newborn deliveries must include birth outcomes

  ~ Hospice care

  ~ Rehabilitation facilities

  ~Transplants, including evaluation

- Observation stays more than 48 hours require Inpatient Authorization
- Urgent/Emergent Admissions within 1 day following the date of admission

**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

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 five (5) days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five (5) days prior to the elective outpatient service date
Emergent inpatient admissions	Notification within 24 hours
Observation –48 hours or less	Notification within one (1) business day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within one (1) business day
Maternity admissions	Notification within (1) day
Newborn admissions	Notification within (1) day
Neonatal Intensive Care Unit (NICU) admissions	Notification within (1) day
Outpatient Dialysis	Notification within (1) day
Organ Transplant -Initial Evaluation	Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services.
Clinical trials services	Prior Authorization required at least 30 days prior to receiving clinical trial services.

Prior Authorization Timeframes

TIMEFRAMES

Type	Timeframe
Prospective/Urgent	Within 3 business days of receipt of the request.
Prospective/Non-Urgent	Within 3 business days of receipt of all information needed to complete the review, not to exceed 15 calendar days from receipt of the request.
Concurrent/Urgent	Within 1 calendar day of receipt of request.
Concurrent/Non-Urgent	Concurrent determinations are made within twenty-four (24) hours of receipt of request when all necessary information is available.
Retrospective	30 calendar days

Utilization Determination 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

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CLAIMS, BILLING AND PAYMENTS

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CLAIMS

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 <INSERT NUMER> days from the date of service, or date of primary payment, when Ambetter is secondary.

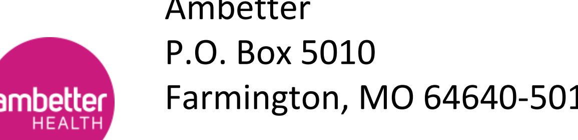
CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. **The Secure Provider Portal**
   provider.ambetterofnorthcarolina.com

2. **Availity Essentials**

3. **Electronic Clearinghouse**
   ~ Payor ID 68069
   ~ Clearinghouses currently utilized by Ambetter will continue to be utilized
   ~ For a listing of our clearinghouses, visit our website at **ambetterofnorthcarolina.com**

4. **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. Providers may use the Request for Reconsideration form found on our website (preferred method).
- Must be submitted within 180 days of the Explanation of Payment.
- Mail claim reconsiderations to:
  P.O. Box 5010
  Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within 180 days of the Explanation of Payment
- A claim dispute/claim appeal should be used only when a provider has received an unsatisfactory response to a request for reconsideration
- A Claim Dispute form can be found on our website at ambetterofnorthcarolina.com
- Mail completed Claim Dispute form to:
  P.O Box 5010
  Farmington, MO 63640-5010

CLAIM SUBMISSION
SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- After the first 30 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 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

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CLAIM SUBMISSION
SUSPENDED STATUS

EXAMPLE TIMELINE OF A MEMBER IN SUSPENDED STATUS

- **January 1st**
  Member pays premium
- **February 1st**
  Premium due – member does not pay
- **March 1st**
  Member placed in suspended status
- **April 1st**
  Member remains in suspended status
- **May 1st**
  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 EDI claims
- Claims will be rejected if the CLIA number is not on the claim

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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 at https://provider.ambetterofnorthcarolina.com/
- 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 days

PAYSPAN®: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan® Health, 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 www.payspanhealth.com 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

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COMPLAINTS, GRIEVANCES AND APPEALS

CLAIMS

- If the Complaint/Grievance is related to claim(s) payment, the provider must follow the process for claim reconsideration and claim dispute prior to filing a Complaint/Grievance.

COMPLAINT/GRIEVANCE

- A Complaint/Grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Ambetter's policies, procedure, or any aspect of Ambetter's functions.
- A provider has 30 calendar days from the date of the incident, such as the original Explanation of Payment date, to file a Complaint/Grievance.
- If we are unable to resolve an issue via phone, the provider may elect to file a verbal Grievance with Provider Services by calling 1-833-863-1310 or in writing through the Secure Provider Portal.
- After research and a full review of the Complaint/Grievance has been completed, Ambetter shall provide a written notice to the provider within 30 calendar days from the date we receive the provider's Complaint/Grievance.

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COMPLAINTS, GRIEVANCES AND APPEALS

PROVIDER CLAIM APPEAL PROCESS

- Claim Appeal requests must follow the **claim reconsideration and claim dispute process.**
- A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

MEMBER APPEALS PROCESS

- **Medical necessity and authorization denials are handled through the Member Appeal process.** The provider may file a medical necessity or authorization denial appeal on behalf of the member. (Written consent may be required.)
- Must be filed within 180 days from the Notice of Action.
- Ambetter shall acknowledge receipt within 3 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 72 hours.

ambetter HEALTH ™

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, located on our website at https://ambetterofnorthcarolina.com/

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ACCESS STANDARDS

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Access Standards

After Hours – All Providers

After Hours (Passing Standards)

- Answering service or system that will page physician
- Answering system with option to page physician
- Advice nurse with access to physician
- Answering service that will page the provider after a message is left

Appointment Access and Availability Standards

PRIMARY CARE & PEDIATRIC	SPECIALIST	OBGYN	BEHAVIORAL HEALTH
➢ **Urgent Care:** Within 24 hours of member's call ➢ **Non-Urgent/Sick Care:** Within 48 hours ➢ **Routine**: Within 15 business days of request	➢ **Urgent Care:** Within 24 hours ➢ **Routine:** Within 30 business days	➢ **Urgent Care:** Within 24 hours ➢ **Routine:** Within 30 business days	➢ **Non-Life-Threatening Psychiatric Emergency:** Within 6 hours ➢ **Urgent:** Within 48 hours ➢ **Routine (Initial Assessment):** Within 10 business days ➢ **Routine Follow Up Care:** Within 10 business days

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HEALTH EQUITY

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Health Equity Resources

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to:

- Address historical and contemporary injustices,
- Overcome economic, social, and other obstacles to
- health and healthcare; and
- Eliminate preventable health disparities

Ambetter of North Carolina Inc. provides a variety of Health Equity and Cultural Humility learning opportunities on our website. We have cultural humility training info, health equity trainings, as well as the Choosing Wisely initiative available and ready for use.

- Health Literacy & Cultural Competency resources can be found under Providing Quality Care on our website
- Toolkit: Help Your Patients Understand Their Health and Health Care

To achieve health equity, we must change the systems and policies that have resulted in the generational injustices that give rise to racial and ethnic health disparities. For more information about Culturally and Linguistically Appropriate Services (CLAS) Standards, see: https://thinkculturalhealth.hhs.gov/clas

Ambetter of North Carolina Inc. encourages our providers to engage in Cultural Humility trainings and education to promote positive interaction with diverse cultures.

For more information about the Cultural and Linguistic Competency e-Learning Program from the Office of Minority Health (OMH), see https://minorityhealth.hhs.gov/cultural-and-linguistic-competency. This program is designed to build knowledge, skills, and awareness of cultural and linguistic competency and CLAS as a way to improve quality of care.

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SPECIALTY SERVICES & VENDORS

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SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services, Specialty Therapies and Interventional Pain Management	Evolent (Formerly National Imaging Associates)	1-800-424-4948 www.radmd.com
Oncology/Supportive Drugs	Evolent (Formerly New Century Health (NCH))	1-888-999-7713 https://my.newcenturyhealth.com
Vision Services	Centene Vision Services	www.centenevision.com
Dental Services	Centene Dental Services	www.centenedental.com
Pharmacy Services	Pharmacy Services	1-833-863-1310 (Phone) 1-866-399-0929 (Fax)

OUR SPECIALTY COMPANIES AND VENDORS

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Questions & Answers

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