Welcome To Ambetter
Ambetter of Alabama

Your Partner In Better Healthcare

2025 Provider Orientation

ambetter HEALTH

PROVIDER ORIENTATION

2025

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 & Secure Portal
- Appointment Availability
- Verification of Eligibility, Benefits & Cost Shares
- Referrals
- Prior Authorization
- Corrected Claims, Requests for Reconsideration, & Claim Disputes
- Specialty Companies & Vendors

QUESTIONS & ANSWERS

2025 Provider Orientation

OVERVIEW

WE ARE AMBETTER

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

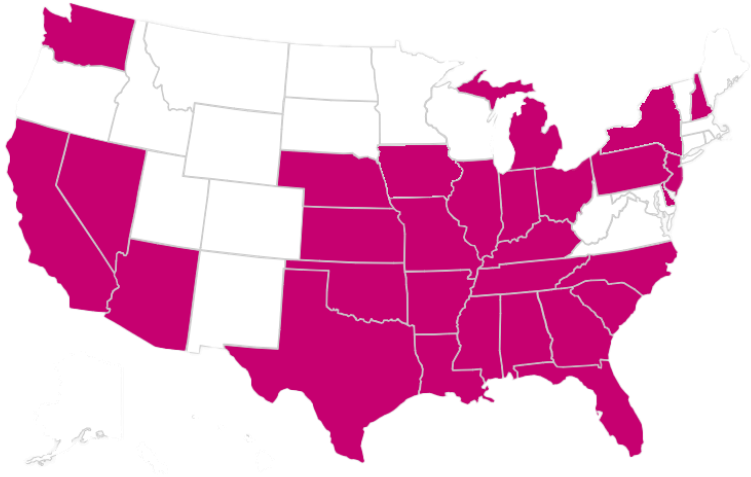
#1 carrier
on the health insurance marketplace*

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.

We

- **Target a focused demographic**
- **Lower income, underinsured and uninsured**

WE ARE PROUD TO BE YOUR PARTNER

- 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**.

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 — **Alabama *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.

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

Networks Build To Offer More

- 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.

Our Innovative Networks

PREMIER: 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.

SOLUTIONS: Ambetter's dedicated 'off-exchange only' product designed to meet the needs of individuals purchasing individual health insurance through a defined contribution / HRA, such as ICHRA or QSEHRA.

What is off-exchange health insurance?

Off-exchange health insurance is a plan that is purchased directly from an insurance provider, or through a broker. Though these are considered private plans, they also fall under ACA compliance, which ensures minimum coverage and essential health benefits. ACA financial help by way of premium subsidies are only available for plans purchased on-exchange and for those who qualify.

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.

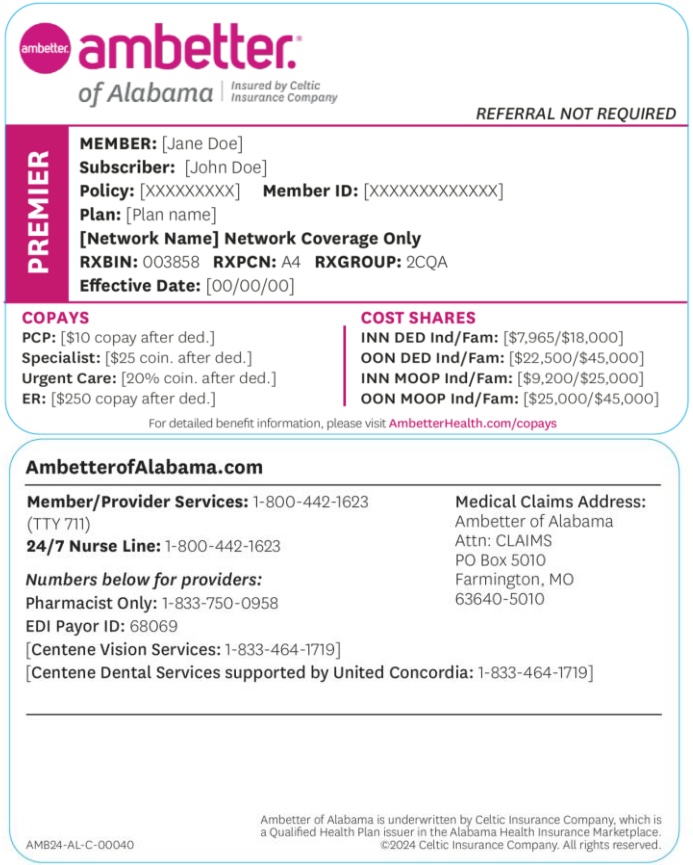
HOW TO IDENTIFY A MEMBER'S NETWORK

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 of Alabama

PHONE
1-800-442-1623

TTY/TDD
1-800-442-1623 (TTY 711)

WEB
www.AmbetterofAlabama.com

PORTAL
Ambetter Secure Provider Portal

AMBETTER PROVIDER MANUAL

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

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 Alabama website.**

PROVIDER ENGAGEMENT

The **Ambetter of Alabama** Provider Engagement team includes trained staff available to respond quickly and efficiently to all provider inquiries:

AmbetterAL_ProviderRelations@CENTENE.COM

By calling **Ambetter of Alabama Provider Services** at **1-800-442-1623 (TTY 711)**, providers can access real time assistance for all their service needs.

PROVIDER ENGAGEMENT

- As an **Ambetter of Alabama** provider, you will have a dedicated Network Performance Advisor available to assist you
- Our Provider Engagement Account Managers serve as the primary liaisons between our health plan and the provider network
- Your Network Performance Advisor 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**

PROVIDER NETWORK OPERATIONS

- Providers should submit updates to demographic data to SM_AmbetterALOps@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 SM_AmbetterALOps@centene.com
- Enrollments are effective 30 days from the date all clean documents are received by Ambetter.

Please send the following items to SM_AmbetterALOps@centene.com :

- **Demographic information updates**
- **Initiate credentialing of a new practitioner**
- **Inquiries related to the status of a new practitioner**

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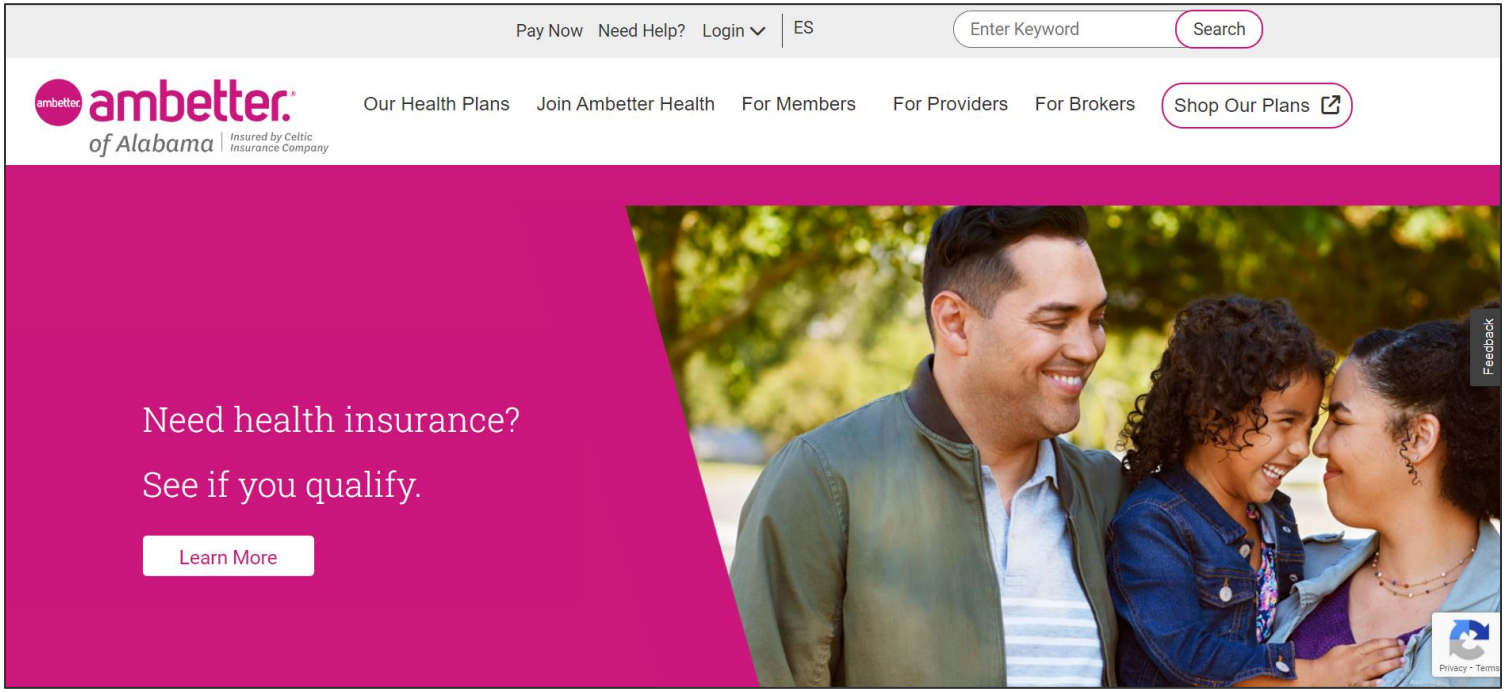
PUBLIC WEBSITE & SECURE PORTAL

Ambetter Public Website



Ambetter Public Website

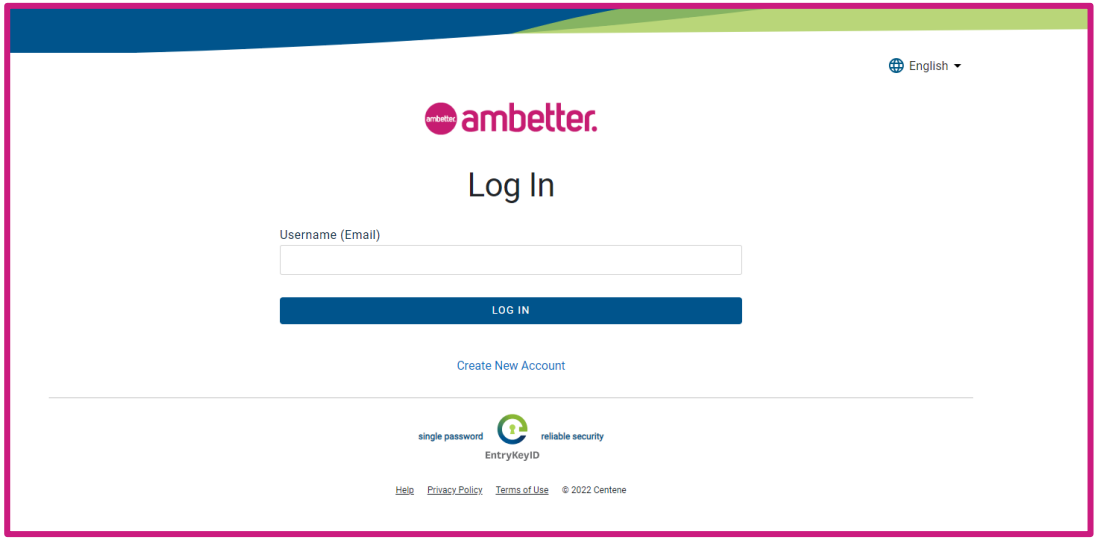
WHAT'S ON THE PUBLIC WEBSITE?

- 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!

Contact your Provider Engagement Administrator to get started!



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 of Alabama 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

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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APPOINTMENT AVAILABILITY

APPOINTMENT AVAILABILITY

Ambetter follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Ambetter monitors participating provider compliance with these standards at least annually.

Appointment Type	Access Standard
PCPs – Routine Visits	15 business days
PCPs – Urgent Care Appointments	24 hours
PCPs – Adult Sick Visit	48 hours
PCPs – Pediatric Sick Visit	48 hours
Urgent Care Providers	24 hours
After Hours Care	Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician.

Appointment Type	Access Standard
Specialist – Routine Visit (High Volume)	Within 30 business days
Specialist – Urgent Care (High Volume)	Within 24 hours
Specialist – Routine Visit (High Impact)	Within 30 business days
Specialist – Urgent Care (High Impact)	Within 24 hours
Behavioral Health – Non-life-Threatening Emergency	Within 6 hours
Behavioral Health Urgent Care	Within 48 hours
Behavioral Health Initial Visit for Routine Care	Within 10 business days
Behavioral Health Follow-up Routine Care	Within 10 business days

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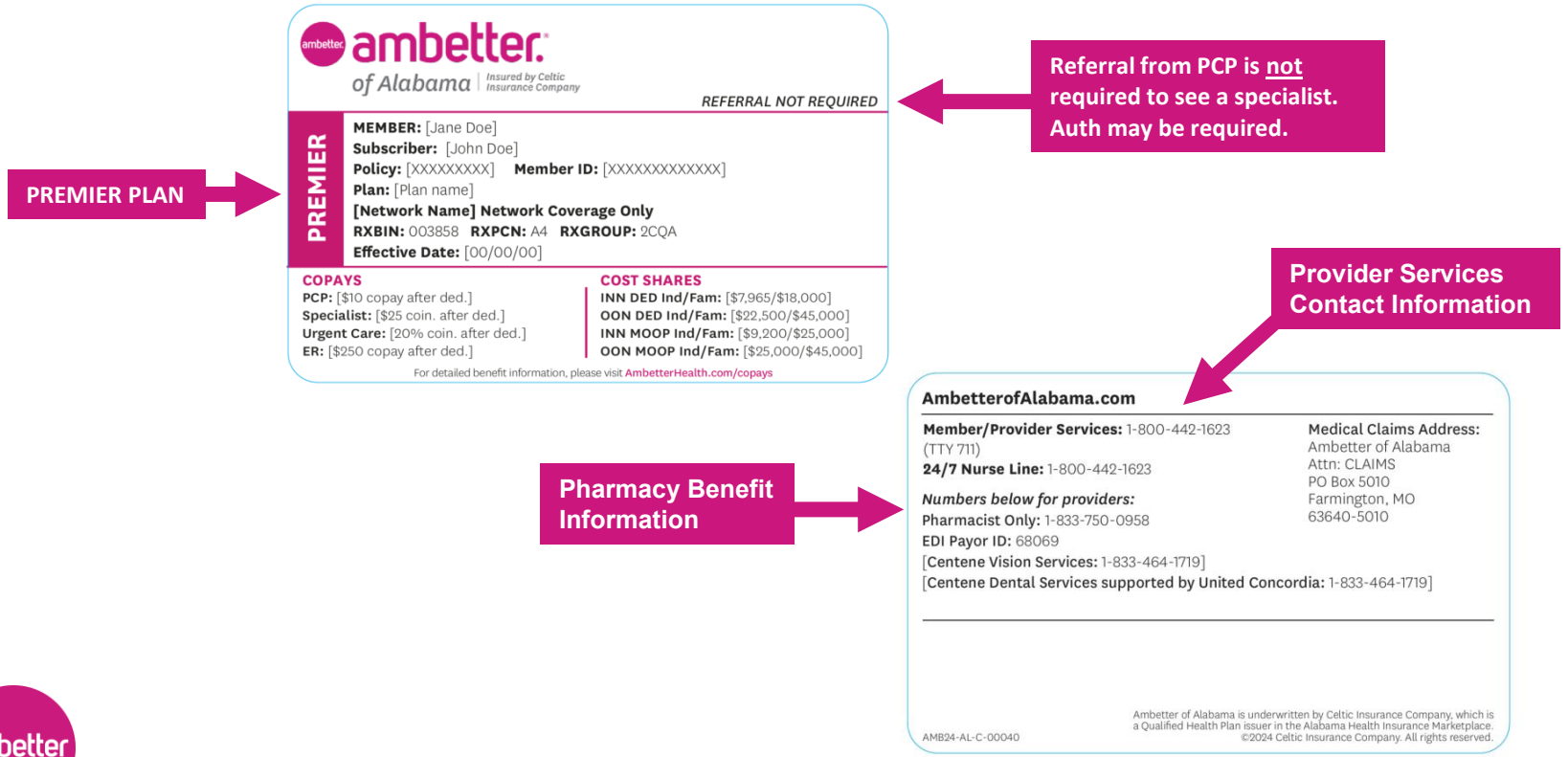
VERIFICATION OF ELIGIBILITY, BENEFITS & COST SHARES

NAVIGATING THE MEMBER ID CARD



Verification of Eligibility, Benefits & 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 & COST SHARE

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

✓ **The Ambetter Secure Portal**

If you are already a registered user of the Ambetter of Alabama secure portal, you do NOT need a separate registration.

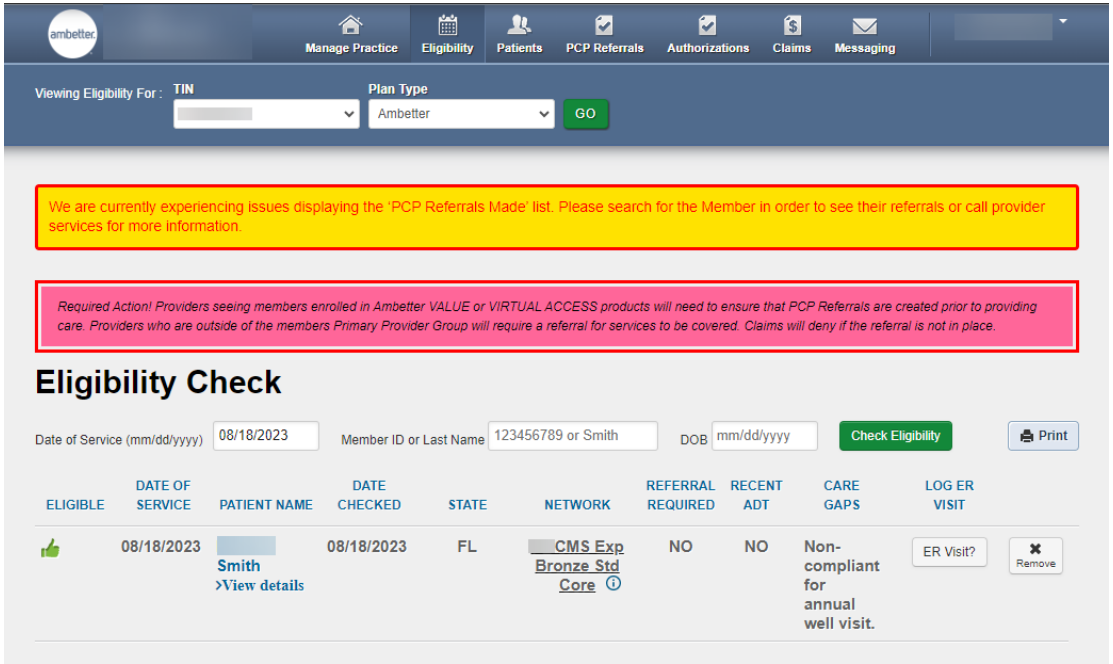
✓ **24/7 Interactive Voice Response System**

Enter the Member ID Number and the month of service to check eligibility.

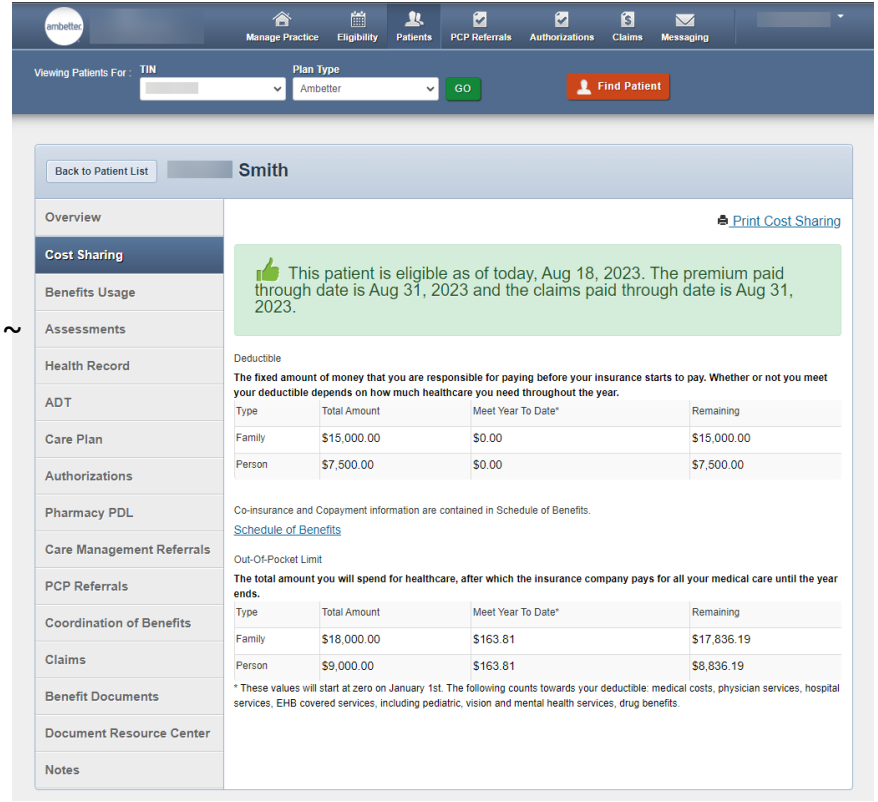
✓ **Contact Provider Services**

1-800-442-1623 (TTY 711)

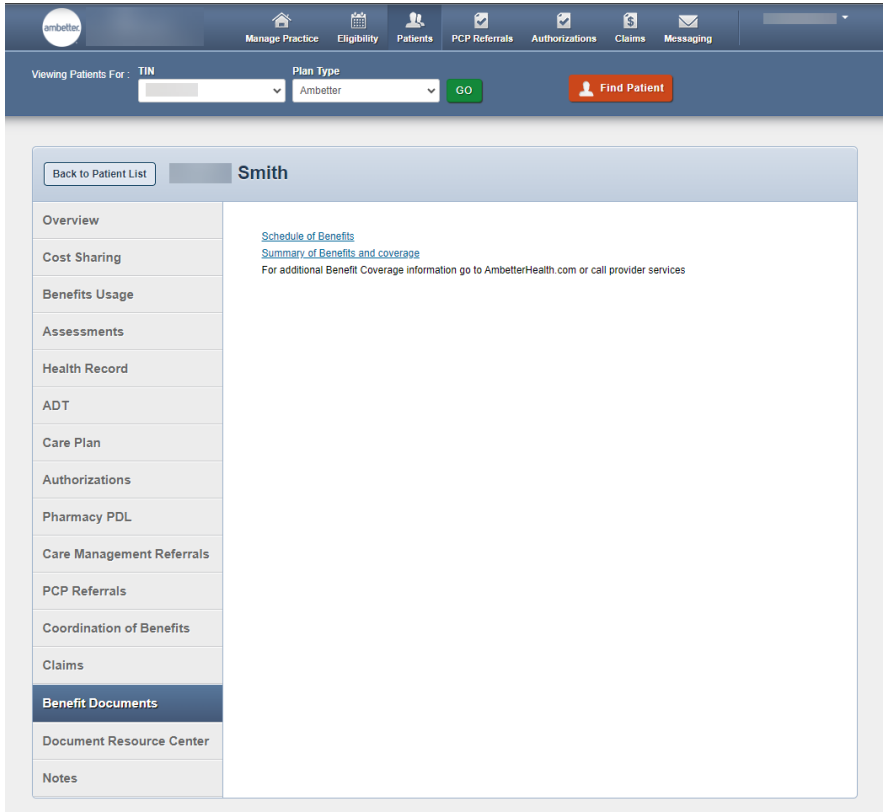
VERIFICATION OF ELIGIBILITY ON THE PORTAL



VERIFICATION OF COST SHARES ON THE PORTAL



VERIFICATION OF BENEFITS ON THE PORTAL



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PRIOR AUTHORIZATION

HOW TO SECURE A PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION?

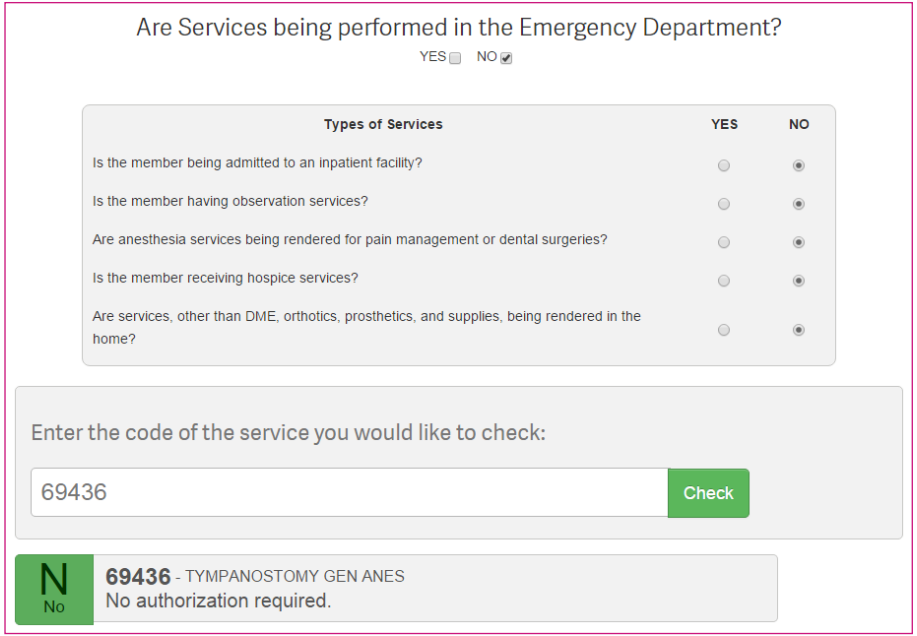
It can be requested in the following ways:

- ✓ **Ambetter Secure Web Portal** (This is the preferred and fastest method.)
- ✓ **Phone 1-800-442-1623 (TTY 711)**
- ✓ **Fax 1-833-423-1441**

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 Alabama website at **www.AmbetterofAlabama.com**



PRIOR AUTHORIZATION 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.*

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 23 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

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 TIMEFRAMES

Type of Request	Determination Timeframe	Notification Timeframe
Nonurgent Pre-Service	2 Business days from receipt of all information necessary to complete the review, not to exceed 15 calendar days from receipt of the request.	Notification not to exceed 15 calendar days from receipt of request.
Urgent Pre-Service	2 Business days from receipt of all information necessary to complete the review not to exceed 3 calendar days from receipt of the request.	Notification not to exceed 3 calendar days from receipt of request.
Urgent Concurrent	1 calendar day from the receipt of the request.	Notification not to exceed 1 calendar day from receipt of request.
Retrospective	Within 30 calendar days of receipt of the request.	Not to exceed 30 calendar days from receipt of the request.

UTILIZATION DETERMINATION TIMEFRAMES

Service Type	Timeframe
Elective Admissions *(meaning scheduled inpatient in a hospital, extended care facility or rehabilitation facility, hospice facility, or residential treatment facility)*	At least 5 days prior to the elective admissions
Admission for Inpatient Mental Health or Substance Use Disorder	Within 24 hours of an admission
Organ transplants initial evaluation	At least 30 days prior to the initial evaluation for organ transplant services
Clinical Trial Services	At least 30 days prior to receiving clinical trial services
Home Health Care	At least 5 days prior to the start of care
Emergency Admission Notifications	Within 24 hours of an admission

PRIOR AUTHORIZATION: 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.

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CLAIMS, BILLING & PAYMENTS

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 180 calendar days from the date of service, or date of primary payment, when Ambetter is secondary.

CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. **Secure Ambetter Provider Portal**

2. **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 **www.AmbetterofAlabama.com**

3. **Mail**
   Ambetter
   P.O. Box 5010
   Farmington, MO 64640-5010

CLAIM RECONSIDERATIONS & 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 **180 days** of the Explanation of Payment.
- Mail claim reconsiderations to:
  Attn: Claims Department
  P.O. Box 5010
  Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within **180 days** of the Explanation of Payment.
- A Claim Dispute form can be found on our website **Provider Resources page**.
- Mail completed Claim Dispute form to:
  Attn: Claims Department
  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

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.

BILLING THE MEMBER

COPAYS, CO-INSURANCE & 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 Ambetter 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 days**.

CLAIMS PAYMENTS

ELECTRONIC FUNDS TRANSFER

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)

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Corrected Claims, Requests for Reconsideration & Claim Disputes

Corrected Claims

A Corrected Claim is when a provider makes a change to a previously submitted claim.

All requests for Corrected Claims must be received within **180 days** from the date of the original explanation of payment or denial.

A Corrected Claim can be submitted in the following ways:

- Ambetter Secure Provider Portal
- Electronically via the Clearinghouse
- Mail Paper Claim to:

Ambetter
Attn: Corrected Claims
P.O. Box 5010
Farmington, MO 63640-5010

Request for Reconsideration

A Request for Reconsideration is when a provider disagrees with the original claim outcome (payment amount, denial reason, etc.).

All Requests for Reconsiderations must be received within **180 days** from the date of the original explanation of payment or denial.

Not all requests need medical records included. But if the request is related to a code audit, code edit, or authorization denial then medical records must accompany the request.

The Request for Reconsideration can be submitted in the following ways:

- The Ambetter Secure Provider Portal
- Request for Reconsideration form found on our website
- Mail a written request to:

Ambetter
Attn: Request for Reconsideration
P.O. Box 5010
Farmington, MO 63640-5010

Claim Dispute

A Claim Dispute/Appeal is when a provider disagrees with the outcome of the Request for Reconsideration.

All requests for Claim Disputes must be received within **180 days** from the date of the original explanation of payment or denial.

Request must include the Claim Dispute/Appeal Form found on our website. Then mail all appropriate documentation to:

Ambetter
Attn: Claim Dispute
P.O. Box 5010
Farmington, MO 63640-5010

A Claim Dispute/Appeal will be resolved within **30 calendar days**. The provider will receive a letter detailing the decision to overturn or uphold the original decision.

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SPECIALTY SERVICES & VENDORS

SPECIALTY COMPANIES & VENDORS

Service	Specialty Company/Vendor	Contact Information
• Advanced Imaging Services (MRI, CT, PET) • Cardiac Imaging • Musculoskeletal Care	Evolent	1-800-278-0103 www.radmd.com
Vision Services	Envolve Vision©	1-800-442-1623 www.envolvevision.com
Dental Services	Envolve Dental©	1-800-442-1623 www.envolvedental.com
Pharmacy Services	Pharmacy Services	1-800-442-1623 (Phone) 1-866-399-0929 (Fax)

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Questions & Answers