Welcome To Ambetter of Tennessee

Your Partner In Better Healthcare

2025 Provider Orientation

Confidential and Proprietary Information

ambetter
HEALTH

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

QUESTIONS & ANSWERS

2025 Provider Orientation

OVERVIEW

WE ARE AMBETTER

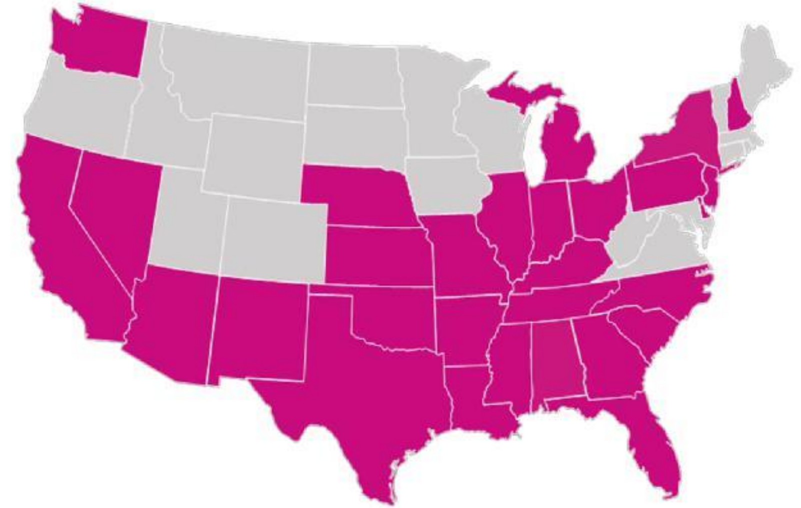
We provide market-leading, affordable health insurance on the marketplace.

#1 carrier
on the health insurance marketplace

2014
Year that Ambetter began

3.3M+
members insured

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**

ambetter of Tennessee

Confidential and Proprietary Information

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 budgets 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*

ambetter HEALTH

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 — ***Tennessee 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.

2025 Provider Orientation

OUR NETWORKS

Confidential and Proprietary Information

NETWORKS BUILT 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.

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.

**Network availability varies by state.*

OUR INNOVATIVE NETWORKS

Ambetter Health is offering diabetes specific plan designs in five markets in plan year 2025:

Ambetter Health Premier Plans in Tennessee provide members managing diabetes with additional healthcare options and savings. Members on these plans will have lower out of pocket costs for certain medications, supplies, and clinical support. Members may have access to $0 copays for preferred insulin and select medications used to manage diabetes, high blood pressure, high cholesterol, and mental health. These plans also include $0 copays on certain diabetic supplies and labs such as lancets, glucose test strips, ketone and urine test strips, insulin syringes, pen needles as well as routine A1c labs.

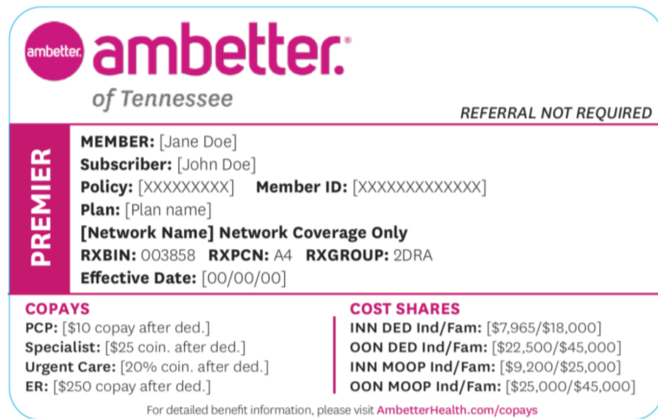
**Network availability varies by state.*

HOW TO IDENTIFY A MEMBER'S NETWORK

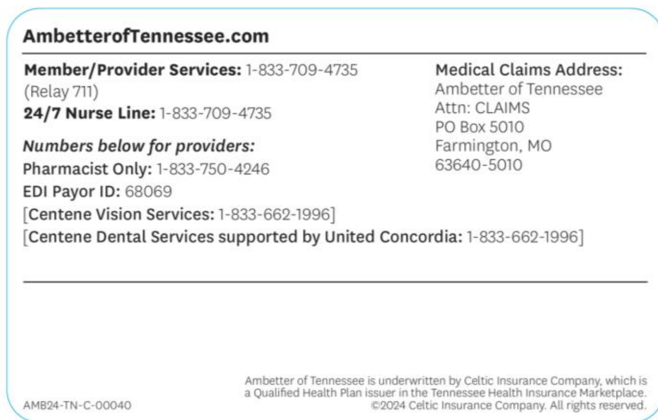
All members receive an Ambetter member identification card. The ID card includes new information that includes:

- 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



2025 Provider Orientation

WHAT YOU NEED TO KNOW

Confidential and Proprietary Information

KEY CONTACT INFORMATION

Ambetter of Tennessee

PHONE

1-833-709-4735

TTY/TDD

1-833-709-4735 (Relay 711)

WEB

www. AmbetterofTennessee.com

PROVIDER PORTAL

Ambetter Secure Provider Portal

AMBETTER PROVIDER MANUAL

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

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 Tennessee** website.

Confidential and Proprietary Information

PROVIDER ENGAGEMENT

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

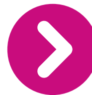
- Credentialing/Network status
- Claims
- Request for adding/deleting physicians to an existing group

By calling Ambetter of Tennessee Provider Services at **1-833-709-4735 (Relay 711)**, providers can access real time assistance for all their service needs.

Confidential and Proprietary Information

PROVIDER ENGAGEMENT

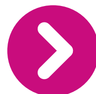
- As an **Ambetter of Tennessee** provider, you will have a dedicated Network Performance Advisor available to assist you
- Our Provider Engagement Account Managers serve as the primary liaisons between our health plan and the provider network
- Your Network Performance Advisor is here to help you operate 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**
- ✓ **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 to AmbetterTNNetwork@CENTENE.com
- Existing Providers should submit updates to demographic data to AmbetterTNOps@CENTENE.com within **30 days** of the data change becoming effective.
- Enrollments are effective **30 days** from the date all clean documents are received by Ambetter.



Please send the following items to AmbetterTNNetwork@CENTENE.com

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

Confidential and Proprietary Information

2025 Provider Orientation

PUBLIC WEBSITE & SECURE PORTAL

Confidential and Proprietary Information

AMBETTER PUBLIC WEBSITE

Pay Now Need Help? Login ES

Enter Keyword Search

ambetter of Tennessee

Our Health Plans Join Ambetter Health For Members For Providers For Brokers Shop Our Plans

Need health insurance?

See if you qualify.

Learn More

Give Feedback

Privacy - Terms

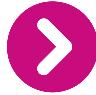
AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

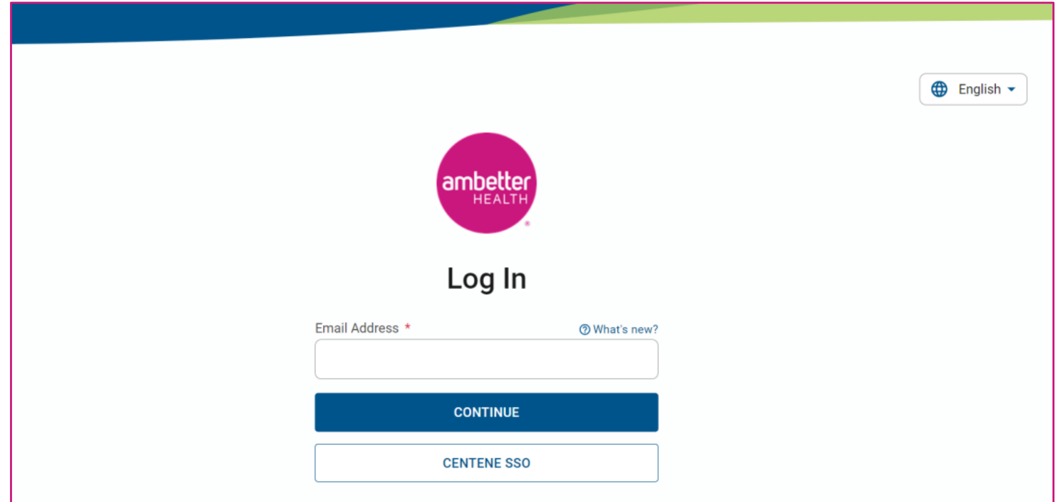
- Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing

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 Tennessee 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.

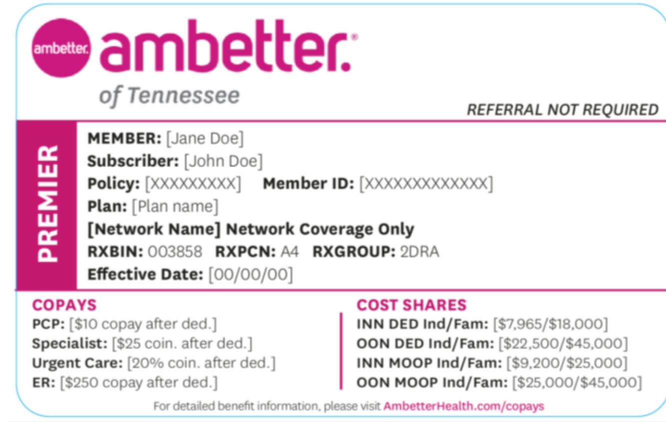
2025 Provider Orientation

VERIFICATION OF ELIGIBILITY, BENEFITS & COST SHARES

Confidential and Proprietary Information

NAVIGATING THE MEMBER ID CARD

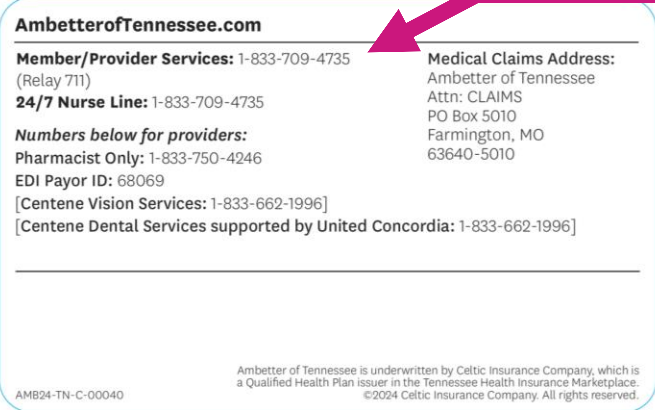
PREMIER PLAN



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

Provider Services Contact Information

Pharmacy Benefit Information



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 AND COST SHARES CAN BE VERIFIED IN THREE WAYS:

✓ **The Ambetter Secure Portal**

If you are already a registered user of the Ambetter of Ambetter of Tennessee 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**

1-833-709-4735 (Relay 711)

Confidential and Proprietary Information

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

Confidential and Proprietary Information

VERIFICATION OF COST SHARES ON THE PORTAL

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

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

ambetter HEALTH

Confidential and Proprietary Information

2025 Provider Orientation

APPOINTMENT AVAILABILITY

Confidential and Proprietary Information

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

2025 Provider Orientation

PRIOR AUTHORIZATIONS

Confidential and Proprietary Information

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 1-833-709-4735 (Relay 711)**
- ✓ **Fax 1-844-811-8467**

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.

Confidential and Proprietary Information

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 Tennessee** website at **www.AmbetterHealth.com/en/TN/**

Are Services being performed in the Emergency Department?

YES ☐ NO ☑

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	◉
Is the member having observation services?	○	◉
Are anesthesia services being rendered for pain management or dental surgeries?	○	◉
Is the member receiving hospice services?	○	◉
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	◉

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

69436 | Check

N
No

69436 - TYMPANOSTOMY GEN ANES
No authorization required.

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.*

Confidential and Proprietary Information

MARKETPLACE ACCESS STANDARDS

In-office wait times for all standards shall not exceed 30 minutes.

Type of Appointment	Access Standard
PCPs – Routine visits	30 calendar days
PCPs – Adult Sick Visit	48 hours
PCPs – Pediatric Sick Visit	24 hours
Behavioral Health – Non-life Threating Emergency	6 hours
Specialist	Within 30 calendar days
Urgent Care Providers	24 hours
Behavioral Health Urgent Care	48 hours
After Hours Care	Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician

PRIOR AUTHORIZATION TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required **5 days** prior to the scheduled admission date
Elective outpatient services	Prior Authorization required **5 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 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**

Confidential and Proprietary Information

UTILIZATION DETERMINATION TIMEFRAMES

Type	Timeframe
Prospective/Urgent	**2 Business days**
Prospective/Non-Urgent	**2 Business days**
Concurrent/Urgent	**1 Calendar day**
Retrospective	**30 Calendar days**

Confidential and Proprietary Information

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.

2025 Provider Orientation

CLAIMS, BILLING & PAYMENTS

Confidential and Proprietary Information

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

Confidential and Proprietary Information

HOW TO SUBMIT A CLAIM

The timely filing deadline for initial claims is **90 days** from the date of service, or date of primary payment, when Ambetter is secondary.

CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. **The Ambetter Secure 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.AmbetterHealth.com/en/TN/**

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 at Provider Resource page.
- Mail completed Claim Dispute form to:
  Attn: Claims Department
  P.O. Box 5010
  Farmington, MO 63640-5010

Confidential and Proprietary Information

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.

Confidential and Proprietary Information

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**.

ambetter HEALTH

CLAIMS PAYMENTS

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).

Confidential and Proprietary Information

2025 Provider Orientation

COMPLAINTS, GRIEVANCES & APPEALS

Confidential and Proprietary Information

COMPLAINTS, GRIEVANCES & APPEALS

CLAIMS

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

COMPLAINT/GRIEVANCE

- Must be filed within **30 days** of the **Notice of Action**.
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within **30 days.**

COMPLAINTS, GRIEVANCES & 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 **30 days** from the Notice of Action.
- Ambetter shall acknowledge receipt within **10 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 **20 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.**

COMPLAINTS, GRIEVANCES & 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 **www.AmbetterHealth.com/en/TN/**

2025 Provider Orientation

SPECIALTY SERVICES & VENDORS

Confidential and Proprietary Information

SPECIALTY COMPANIES & VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	1-866-214-2569 www.radmd.com
Vision Services	Envolve Vision	1-800-334-3937 www.envolvevision.com
Dental Services	Envolve Dental	1-800-334-3937 www.envolvedental.com
Pharmacy Services	Pharmacy Services	1-866-399-0928 (Phone) 1-866-399-0929 (Fax)

2025 Provider Orientation

Questions & Answers

Ambetter of Tennessee is underwritten by Celtic Insurance Company, which is a Qualified Health Plan issuer in the Tennessee Health Insurance Marketplace. ©2024 Celtic Insurance Company. All rights reserved.

INTERNAL APPROVED 11192024
©2025 Ambetter of Tennessee. All rights reserved.
3563211_NA5PEMKTPRSE

Confidential and Proprietary Information