



ambetter.[®]

of Alabama | *Insured by Celtic
Insurance Company*

Welcome To Ambetter of Alabama

Your Partner In Better Healthcare
2024 Provider Orientation

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

2024 Provider Orientation

OVERVIEW

WE ARE AMBETTER

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

#1 carrier

on the health insurance marketplace

2014

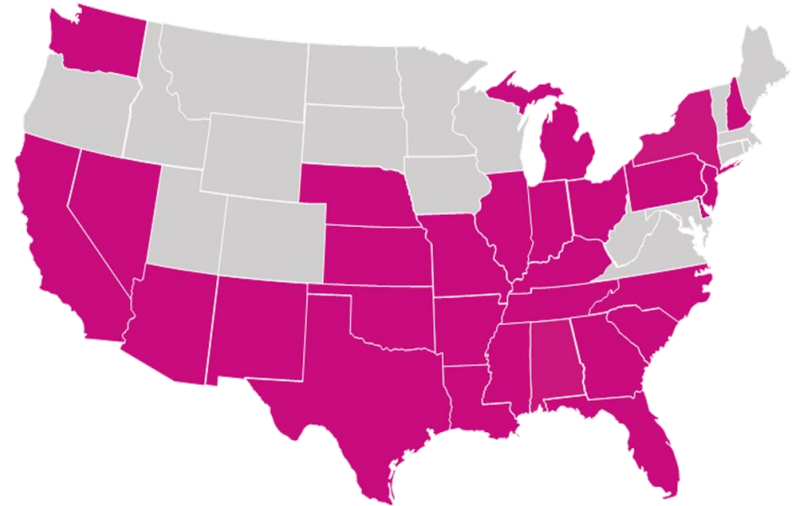
Year that Ambetter began

3.3M+

members insured

29

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 THE COMMERCIAL INSURANCE MARKET – MARKETPLACE OR EXCHANGES

- No more underwriting – guaranteed issue
- There is no longer a Federal tax penalty associated with not having minimum essential coverage.*
- Minimum standards for coverage: 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.

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 is the ONLY WAY to purchase insurance and receive subsidies.

HEALTH INSURANCE MARKETPLACE

FINANCIAL ASSISTANCE 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 is the ONLY WAY to purchase insurance and receive subsidies.

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OUR NETWORKS

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

Bronze | Silver | Gold*: 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.

**Network availability varies by state.*

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WHAT YOU NEED TO KNOW

KEY CONTACT INFORMATION

Ambetter of Alabama

WEB

www.AmbetterofAlabama.com

PORTAL

[Ambetter Secure Provider Portal](#)

PHONE

1-800-442-1623 (TTY 711)



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 Resources section of [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, or requests, including:

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

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 Network Performance Advisors 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

- Providers should submit updates to demographic data to AmbetterAL_ProviderRelations@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 AmbetterAL_ProviderRelations@CENTENE.COM
- Enrollments are effective **30 days** from the date all clean documents are received by Ambetter.



Please send the following items to AmbetterAL_ProviderRelations@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 & SECURE PORTAL

AMBETTER PUBLIC WEBSITE

www.AmbetterofAlabama.com

The screenshot shows the homepage of the Ambetter of Alabama website. At the top, a dark navigation bar contains the text "HAVE AN ENROLLMENT NEED? [SHOP OUR PLANS](#)" and a close button. Below this is a light gray header with "Pay Now", "Need Help?", "Login", and "ES" on the left, and a search icon on the right. The main navigation area features the Ambetter of Alabama logo on the left and a list of menu items: "Our Health Plans", "Join Ambetter Health", "For Members", "For Providers", "For Brokers", and "Shop Our Plans" (which is highlighted with a rounded rectangle). The main content area is split into two columns. The left column has a magenta background and contains the text "Open Enrollment starts Nov. 1!", "Get the quality, affordable healthcare coverage you deserve with America's #1 Marketplace health insurance*", and a yellow "Learn More" button. The right column features a large photograph of a man with glasses and a beard, wearing a blue denim jacket and a white patterned shirt, standing outdoors on a city street.

AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

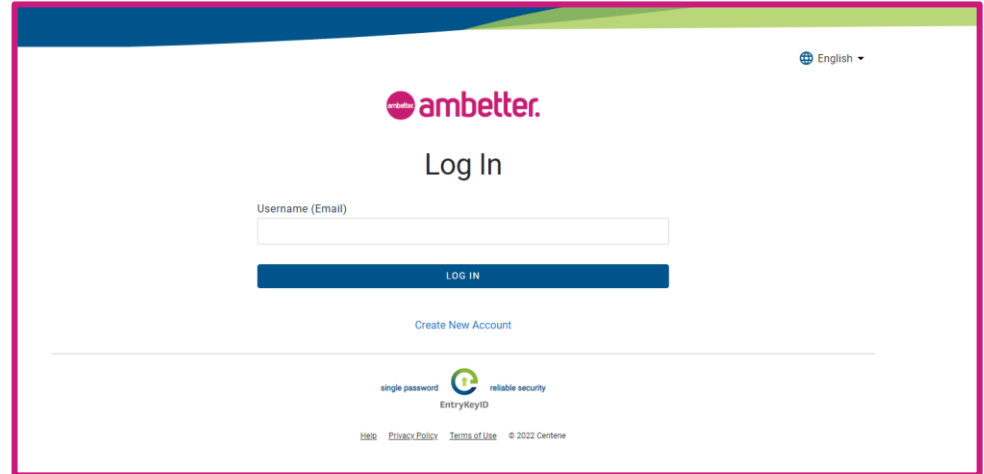
- Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing

SECURE PROVIDER PORTAL

REGISTRATION IS FREE AND EASY!



Contact your Network Performance Advisors
to get started!



The screenshot shows the login page for the Ambetter Secure Provider Portal. At the top right, there is a language selector set to "English". The Ambetter logo is centered at the top. Below it, the text "Log In" is displayed. A form field for "Username (Email)" is provided, followed by a blue "LOG IN" button. Below the button is a link for "Create New Account". At the bottom, there is a logo for "EntryKeyID" with the tagline "single password reliable security". The footer contains links for "Help", "Privacy Policy", and "Terms of Use", along with the copyright notice "© 2022 Centene".

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

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.


PCP REPORTS INCLUDE:

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

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VERIFICATION OF ELIGIBILITY, BENEFITS & COST SHARES

NAVIGATING THE MEMBER ID CARD



Subscriber: [Jane Doe]
Member: [John Doe]

Policy #: [XXXXXXXXXX]
Member ID #: [XXXXXXXXXXXXXXXXXX]
Effective Date: [00/00/00]



PCP: [\$10 copay after ded. [(\$600)]]
Specialist: [\$25 coin. after ded. [(\$600)]]
Rx (Generic/Brand): [\$5/\$25 after Rx ded. [(\$600)]]
Urgent Care: [20% coin. after ded. [(\$600)]]
ER: [\$250 copay after ded. [(\$600)]]
Max Out-of-Pocket: [\$25,000]

AmbetterHealth.com/copays

Plan: [Plan name]
[Line 2 if needed]
[Network Name] Network Coverage Only

RXBIN: 003858
RXPCN: A4
RXGROUP: 2CQA

REFERRAL NOT REQUIRED

Pharmacy Benefit Information

Provider Services Contact Information

AmbetterofAlabama.com

Member/Provider Services: 1-800-442-1623 (TTY 711)
24/7 Nurse Line: 1-800-442-1623

Numbers below for providers:
Pharmacist Only: 1-833-750-0958
EDI Payor ID: 68069
[Envolve Vision: 1-833-464-1719]
[Envolve Dental Powered by United Concordia: 1-833-464-1719

Medical Claims Address:
 Ambetter of Alabama
 Attn: CLAIMS
 PO Box 5010
 Farmington, MO
 63640-5010

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit AmbetterofAlabama.com.

Ambetter of Alabama is underwritten by Celtic Insurance Company, which is a Qualified Health Plan issuer in the Health Insurance Marketplace. This is a solicitation for insurance. ©2023 Celtic Insurance Company. All rights reserved.

AMB23-AL-C-00048

Plans can include:

- Ambetter Gold / Silver / Bronze

Please note: Referral from PCP is **not** required to see a specialist. Auth may be required.

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

ELIGIBILITY, BENEFITS & COST SHARE

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

- ✓ **Ambetter Secure Provider 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

Viewing Eligibility For: TIN Plan Type: Ambetter

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) Member ID or Last Name DOB

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	STATE	NETWORK	REFERRAL REQUIRED	RECENT ADT	CARE GAPS	LOG ER VISIT
	08/18/2023	<input type="text" value="Smith"/> View details	08/18/2023	FL	<input type="text" value="CMS Exp Bronze Std Core ⓘ"/>	NO	NO	Non-compliant for annual well visit.	<input type="button" value="ER Visit?"/> <input type="button" value="Remove"/>

VERIFICATION OF COST SHARES ON THE PORTAL

ambetter Manage Practice Eligibility Patients PCP Referrals Authorizations Claims Messaging

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

[Back to Patient List](#) **Smith** [Print Cost Sharing](#)

Cost Sharing

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

Deductible

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

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

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

Out-Of-Pocket Limit

The total amount you will spend for healthcare, after which the insurance company pays for all your medical care until the year ends.

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

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

VERIFICATION OF BENEFITS ON THE PORTAL

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

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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 Provider 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 at www.AmbetterofAlabama.com

Are Services being performed in the Emergency Department?
YES NO

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member having observation services?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management or dental surgeries?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving hospice services?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>

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

69436

N
No **69436 - TYMPANOSTOMY GEN ANES**
No authorization required.

PRIOR AUTHORIZATION REQUIREMENTS

PROCEDURES / SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Potentially cosmetic
- Experimental or investigational
- Complex imaging (e.g. CT, MRI, PET)
- Musculoskeletal services (spine, hip, knee)
- 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/substance use
 - 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.
- Newborn deliveries must include birth outcomes.
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP).

**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 (<i>meaning scheduled inpatient in a hospital, extended care facility or rehabilitation facility, hospice facility, or residential treatment facility</i>)	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 clean 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 circumstances 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 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 [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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COMPLAINTS, GRIEVANCES & APPEALS

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 **30 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.AmbetterofAlabama.com.

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SPECIALTY SERVICES & VENDORS

SPECIALTY COMPANIES & VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	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)

2024 Provider Orientation

Questions & Answers

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2509761_AL3PMKTPRSE

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