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Contact information

Important telephone numbers

Resource	Contact information
AmeriHealth Administrators Provider Relations (Direct all inquiries or issues directly to AmeriHealth Administrators)	1-800-841-5328 *provrelations@amerihealth-tpa.com*
Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707
Baby FootSteps® Perinatal case management	1-800-598-BABY [2229]
Carelon Medical Benefits Management (Carelon) Preapproval/Precertification requests for CT/CTA, MRI/MRA, PET, nuclear cardiology, facility sleep studies, continuous positive airway pressure titration, sleep equipment (APAP, BPAP, CPAP), related supplies, Cardiology Utilization Management Program, and Musculoskeletal Utilization Management Program	1-866-745-1791
Clinical Services – Utilization Management Requests for authorization of services should be entered through Practice Management on the Provider Engagement, Analytics & Reporting (PEAR) portal.	1-800-275-2583
Credentialing Credentialing violation hotline Credentialing and re-credentialing inquiries Credentialing application corrections	Phone: 215-988-1413 *CredInquiries@amerihealth.com* Fax: 215-238-2549
Customer Service Hours: Mon. – Fri., 8 a.m. – 6 p.m.	1-800-275-2583
Language Assistance Services Language assistance services are offered for Members who prefer a language other than English.	Customer Service: see telephone number above. TTY/TDD: 711
eviCore healthcare (eviCore) Preapproval/Precertification requests for nonemergent outpatient radiation therapy services Preapproval/Precertification and/or prepayment reviews for genetic/genomic tests, certain molecular analyses, and cytogenetic tests	1-866-686-2649
FutureScripts® (Pharmacy Benefits) Hours: Mon. – Fri., 8 a.m. – 6 p.m.	Phone: 1-888-678-7012 Fax: 1-888-671-5285
FutureScripts® Secure (Medicare Part D) Hours: Mon. – Fri., 8 a.m. – 6 p.m.	1-888-678-7015
Blood Glucose Meter Hotline	1-888-678-7012

Resource	Contact information
Health Coaching Case and Condition management Hours: 24 hours a day, 7 days a week	1-800-313-8628
Highmark EDI Operations Hours: Mon. – Fri., 8 a.m. – 5 p.m.	1-800-992-0246
Mental Health/Substance Abuse	
Magellan Healthcare, Inc. Customer Service and Preapproval/Precertification	1-800-688-1911
AmeriHealth Administrators Hours: 24 hours a day, 7 days a week	1-800-634-5334
PEAR portal support	1-833-444-PEAR (1-833-444-7327)

Claims mailing addresses

For a complete list of claims submission addresses, refer to the professional payer ID grid at *www.amerihealth.com/edi*. There, claims submission information is broken out by prefix/product name.

Appeals mailing addresses

Inpatient Appeals
P.O. Box 13985
Philadelphia, PA 19101-3985

Member Appeals
P.O. Box 41820
Philadelphia, PA 19101-1820

Provider Billing Disputes/Grievances
P.O. Box 7930
Philadelphia, PA 19101-7930

General mailing addresses

Magellan Healthcare, Inc.
P.O. Box 1958
Maryland Heights, MO 63043

Provider Data Administration (PDA)
P.O. Box 41431
Philadelphia, PA 19101-1431

Provider Network Services

The Provider Network Service's (PNS) team within AmeriHealth supports hospitals, individual community professional Providers, and ancillary entities across nine counties within the greater Philadelphia area. PNS's primary customers are its Provider communities that are dedicated to serving the health and well-being of AmeriHealth Members.

The PNS team plays a critical role in educating our network Providers and their office staff on policies, procedures, and specific billing processes. Network Coordinators within PNS also serve as a liaison for network Providers and may promote or suggest workflow solutions.

In an effort to continue to build and sustain a strong working relationship with Participating Providers, PNS supports the Provider community with regard to the following types of inquiries:

- claim payment discrepancies for primary care physicians and specialist offices;
- practice demographic updates/changes that cannot be submitted via the online Provider Change Request form;
- capitation roster and/or payment-related inquiries;
- medical policy and procedural issues related to claim payments;
- long-term care (LTC) panel set-up and Member movement coordination efforts;
- general education regarding products, networks, and procedural guidelines.

While we encourage our Providers to utilize the self-service tools available through PEAR Practice Management (PM) to expedite requests involving verification of Member eligibility, claims status, and claim inquiry submission, we realize there are occasions when Providers may need to escalate their issues to PNS.

Note: The PNS team cannot revise claims submissions.

To better serve our Provider network, PNS aligns its resources into two distinct teams:

- **IDS.** Our Integrated Delivery System (IDS) team supports practice administrators and payor relations management staff within an IDS, inclusive of owned hospitals, physicians, ancillaries, and other care facilities.
- **Community Providers.** Our Community team supports practitioners or practice administrators (PCP and/or Specialist offices) that are **not owned** by an IDS as well as Independent facility and ancillary Providers.

PNS Contact Tool (for IDS only)

The PNS Contact Tool identifies the Network Coordinator that is designated to support each IDS. The tool will display the Network Coordinator's name, direct telephone number, fax number, manager, and the Medical Director who supports the IDS. Inquiries can also be submitted directly to your IDS's designated Network Coordinator through this tool.

To use the PNS Contact Tool, go to *www.amerihealth.com/providers* and select Contact Information from the "For Providers" drop-down menu. The tool will require that you enter your specialty and either your National Provider Identifier (NPI) or your tax ID number to perform a search. The information for your IDS's Network Coordinator will then be displayed.

Inquiry submission guidelines

Below are the steps to follow when submitting an inquiry to PNS.

For claim payment discrepancies:

IDSs	Community Providers
Step 1: Submit your inquiry via PEAR PM. If you are unsuccessful in reaching a satisfactory resolution and require further assistance, please go to Step 2.	**Step 1:** Submit your inquiry via PEAR PM. If you are unsuccessful in reaching a satisfactory resolution and require further assistance, please go to Step 2.
Step 2: Contact Provider Services at 1-800-275-2583 and follow the voice prompts. If you are unsuccessful in reaching a satisfactory resolution and require further assistance, please go to Step 3.	**Step 2:** Contact Provider Services at 1-800-275-2583 and follow the voice prompts. If you are unsuccessful in reaching a satisfactory resolution and require further assistance, please go to Step 3.
Step 3: Contact your IDS's designated Network Coordinator.	**Step 3:** Complete a *Provider Network Services inquiry request* form. A Network Coordinator will be assigned to respond to your inquiry.

For any of the following inquiry types, please follow the steps outlined below:

- capitation roster and/or payment-related inquiries
- medical policy and procedural issues related to claim payments
- general education regarding products, networks, and procedural guidelines

IDSs	Community Providers
Step 1: Contact Provider Services at 1-800-275-2583 and follow the voice prompts. If you are unsuccessful in reaching a satisfactory resolution and require further assistance, please go to Step 2.	**Step 1:** Contact Provider Services at 1-800-275-2583 and follow the voice prompts. If you are unsuccessful in reaching a satisfactory resolution and require further assistance, please go to Step 2.
Step 2: Contact your IDS's designated Network Coordinator.	**Step 2:** Complete a *Provider Network Services inquiry request* form. A Network Coordinator will be assigned to respond to your inquiry.

LTC panel changes

For LTC panel set-up and member movement coordination efforts, please complete a *Request to change PCP to LTC PCP panel* form.

Demographic changes

Community Providers should use the online Provider Change Request form for practice demographic updates/changes.

For IDSs, facilities, skilled nursing facilities, and ancillary Providers, notice of all changes must be submitted in writing to our contracting and legal departments at the following addresses, or as provided in your Agreement.

Network Coordinators within PNS serve multiple Provider offices in the network. All inquiries regarding your office are important to us. A Network Coordinator will address your questions in as timely a manner as possible.

Provider Services

Provider Services also serves as a valuable resource to you, in addition to your Network Coordinator. The role of Provider Services is to:

- service Provider telephone inquiries in an accurate and timely manner;
- educate Providers and facilitate effective communications between Providers and AmeriHealth by providing timely, accurate responses to telephone inquiries;
- educate Providers with self-service utilization;
- assist Providers in the identification and resolution of claim inquiries.

To reach Provider Services, call Customer Service at 1-800-275-2583 and follow the voice prompts.

Provider Communications

To access the most current and updated information regarding AmeriHealth and our policies, procedures, and processes, refer to our Provider News Center at *www.amerihealth.com/providers*, PEAR portal, and this *Provider Manual*. These resources are designed to work in unison to provide your office with timely informational updates.

To receive email updates that provide you with the latest information, including Partners in Health Update and news alerts, simply complete our email address submission form at *www.amerihealth.com/providers/email*. Allow up to two weeks for us to process your request and remember to add AmeriHealth (*providercommunications@amerihealth.com*) to your email address book. We respect your privacy and will not make your email address available to third parties. For more information about our privacy policy, go to *www.amerihealth.com/privacy*.

amerihealth.com/providers

Find important information and resources, such as forms and billing guidelines specific to our Provider network. You can also find pharmacy information and resources for patient management.

Provider News Center

The Provider News Center, located at *www.amerihealth.com/providers*, is our Provider-dedicated website that features up-to-date news and information of interest to Providers and the health care community. The site has a user-friendly interface that allows you to easily navigate the latest news and information of interest to you and your office.

Provider Engagement, Analytics & Reporting (PEAR) portal

In addition to fast, secure, and HIPAA-compliant access to Provider and Member information and real-time transactions, Providers have access to a valuable source of information on our PEAR portal. The portal contains important tools and resources, including:

- the most current version of our publications and Provider manuals;
- links to fee schedule information and resources;
- contact information.

Privacy and confidentiality

Provider obligations

Contracted Providers are required to maintain confidentiality of Member protected health information (PHI) and records, in accordance with applicable laws.

Access to PHI

The Health Insurance Portability and Accountability Act (HIPAA) and its implemented privacy regulations permit a HIPAA-Covered Entity, such as AmeriHealth, to request and obtain our Members' individually identifiable health information from third parties. An example of a "third party" would be a HIPAA-Covered Entity such as a health care Provider. When such PHI is requested for purposes of treatment, payment, and/or health care operations, the Member's authorization is not required. HIPAA specifically permits health care Providers to disclose PHI, including Members' medical records, to health plans for treatment, payment, or health care operations. AmeriHealth uses this information to promote Members' ready access to treatment and the efficient payment of Members' claims for health care services.

Other AmeriHealth activities that can be categorized as "treatment, payment, or health care operations" under HIPAA include, but are not limited to, the following:

- Treatment includes the provision, coordination, and management of the treatment. It also includes consultation and the Referral of a Member between and among health care Providers.
- Payment includes review of various activities of health care Providers for payment or reimbursement; to fulfill the health benefit plans' coverage responsibilities and provide appropriate benefits; and to obtain or provide reimbursement for health care services delivered to its Members. Activities that fall into this category include, but are not limited to, determination of Member eligibility, reviewing health care services for Medical Necessity, and utilization review.
- Health care operations includes certain quality improvement activities, such as case management and care coordination, quality of care reviews in response to Member or State/federal queries, and prompt response to Member complaints/grievances; site visits as part of Provider credentialing and recredentialing; medical record reviews to conduct clinical and service studies to measure compliance; administrative and financial operations, such as conducting Healthcare Effectiveness Data and Information Set (HEDIS®) reviews and Customer Service activities; and legal activities, such as audit programs, including fraud and abuse detection, and to assess Providers' conformance with compliance programs.

Privacy policies

Protecting the privacy of our Members' information is very important to us. That is why we have taken numerous steps to see that our Members' PHI, whether in oral, written, or electronic form, is kept confidential.

We have implemented policies and procedures regarding the collection, use, and disclosure of PHI by and within our organization and with our business associates. We continually review our policies and monitor our business processes to ensure that Member information is protected, while continuing to make the information available as needed for the provision of health care services. For example, our procedures include processes designed to verify the identity of someone calling to request PHI, procedures to limit who on our staff has access to PHI, and policies that require us to share only the minimum necessary amount of information when PHI must be disclosed. We also protect any PHI transmitted electronically outside our organization by using only secure networks, or by using encryption technology when the information is sent

by email.

We do not use or disclose PHI without the Member's written authorization unless we are required or permitted to do so by law. If use or disclosure of a Member's PHI is sought for purposes that are not specifically required or permitted by law, the Member's written authorization is required. To be deemed valid, Member authorizations must include certain elements required by State and/or federal law. Members may print a copy of our *Authorization to Disclose Health Information* form from *www.amerihealth.com/privacy* or request a copy by calling Customer Service.

Any PHI sent to AmeriHealth should be sent in compliance with the Provider's HIPAA privacy and security obligations as a Covered Entity. *Note:* Providers should *not* submit Member Social Security numbers in communications to AmeriHealth. Providers should use the Member's unique Member ID (UMI), which is located on the front of each AmeriHealth Member's ID card.

When submitting faxes, please ensure the following Member information is included:

- name
- UMI
- address
- age
- Primary Care Physician name
- admission date

For more detailed information about our Members' privacy rights and how we may use and disclose PHI, review our *Notice of Privacy Practices*, which is available on our website at *www.amerihealth.com/privacy*.

Email

New software that secures outbound email containing PHI encrypts the message so that it is unintelligible to unauthorized parties. Instead of receiving an email with Member PHI directly to your inbox, you will receive an email stating that there is a secure message waiting for you on a secure server. A link will take you, via a secured browser, to that server, where you will receive instructions for opening the email.

We have implemented this secured email system to meet the requirements of HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). While this process requires some extra steps, we are making every effort to ensure that there is no significant disruption to your communications with us.

Additionally, you will need to inform AmeriHealth in writing on your company letterhead of any third-party vendors you have granted permission to act on your behalf and submit inquiries pertaining to credentialing, practitioner linkages, claim status, and claim investigations.

Providing PHI for Member appeals of enrollees in self-insured group health plans

Employers and health and welfare funds are called "Plan Sponsors" when they sponsor self-insured group health plans that have a large number of enrollees. When they make elections about claim fiduciary status, they also determine the entity ultimately responsible for final decisions on benefits and other issues in Member appeals for these plans. Sometimes their elections require special arrangements for processing Member appeals for their self-insured group health plans. Because self-insured group health plans are HIPAA-Covered Entities, we have summarized the following points that network Providers need to know about requests for

PHI for Member appeals of enrollees in self-insured group health plans.

- Network Providers may receive requests for PHI for the Member appeals of enrollees in self-insured group health plans offered through AmeriHealth from (1) AmeriHealth, (2) employers or health and welfare funds that sponsor the self-insured group health plan, and/or (3) other entities.
- A response to these PHI requests satisfies HIPAA privacy requirements when the PHI is released to an authorized entity as part of the self-insured group plan's treatment, payment, and/or health care operations (TPO).
- Requests by AmeriHealth for PHI of enrollees involved in these Member appeals will always qualify for release as TPO because AmeriHealth is a HIPAA-authorized entity for these self-insured group health plans. Plan Sponsors authorize the initial filing of all Member appeals for self-insured group plans that they offer through AmeriHealth to be submitted to AmeriHealth. Beyond that, the Plan Sponsor's claims fiduciary election determines whether AmeriHealth acts in these Member appeals in (a) its full, standard role as processor and decision-maker for all internal levels of review or (b) a more limited role that facilitates review by other designated entities.
- Employers, health and welfare funds, and other designated entities may only obtain PHI for enrollees involved in Member appeals of self-insured group health plans if they have proper authorization. The Plan Sponsor may authorize them to obtain PHI for these Member appeals by designating them to handle processing and/or decision-making at certain levels of the self-insured group plan's Member appeals process. When this occurs, PHI may be released to them as TPO consistent with the Plan Sponsor's authorization.

Network Providers should rely on their own internal resources and established protocols for handling PHI requests. Any PHI sent electronically to AmeriHealth should be sent securely in compliance with the Provider's HIPAA privacy and security obligations as a Covered Entity. Provider Services and other AmeriHealth departments will only be able to give you limited information about the role of AmeriHealth in processing Member appeals for self-insured group health plans that are offered through AmeriHealth.

Third-party payment policy

Our position

AmeriHealth has a policy to not accept premium payments or Copayments, Deductibles, or other cost-sharing payments (collectively, Cost-Sharing Payments) made by certain third parties, including, without limitation, payments made directly or indirectly by a health care Provider or supplier.

Please carefully review the AmeriHealth policy below to ensure that you are not in violation of the policy. It should be noted that reimbursement to health care Providers or suppliers for services provided to such Members may be subject to retroactive adjustments by AmeriHealth to the extent such premium funding is or was in violation of this policy.

Our policy

The following policy applies to all AmeriHealth-Participating Providers.

Direct and/or Indirect Third-Party Payments of Member Premiums and Cost-Sharing

AmeriHealth will not accept premium payments or Cost-Sharing Payments made by third parties on behalf of its Commercial Members except as noted below.

Accepted Third-Party Payments

In accordance with applicable laws, regulations, and regulatory guidance, this policy does not apply to premium payments or Cost-Sharing Payments made by:

1. the Ryan White HIV/AIDS Program under title XXVI of the PHS Act;
2. an Indian tribe, tribal organization, or urban Indian organization; or
3. a local, state, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

In addition, AmeriHealth will accept third-party payments:

1. from family members.
2. made by bona fide religious institutions and other bona fide not-for-profit organizations only when each of the following criteria is met:
    a. the assistance is provided on the basis of the insured's financial need,
    b. the institution or organization is not a health care Provider or supplier,
    c. the premium payments and any Cost-Sharing Payments cover an entire policy year, and
    d. the institution or organization does not have any direct or indirect financial interests. For illustrative purposes only:
        i. a direct financial interest may exist if the third-party itself has a financial interest in the payment of health insurance claims;
        ii. an indirect financial interest may exist, for example, if the third-party receives funding from other individuals or entities that have a financial interest in the payments of the health insurance claims; and
        iii. in the case of a nonprofit foundation or other charitable entity (including without limitation a religious organization), a financial interest may exist if the entity receives a financial contribution from a health care Provider or supplier.

In addition, Providers are required to comply with applicable rules and regulations.

Violation of Policy

AmeriHealth will monitor third-party payments to assure compliance with this policy and long-standing anti-fraud regulations. Any premium payments or Cost-Sharing Payments received in violation of this policy will not be applied to the Member's benefit plan. If premium payments or Cost-Sharing Payments have been made by third parties in violation of this policy, the Member will be provided with an opportunity to secure alternative funding through qualified sources. Reimbursement to health care Providers or suppliers for services provided to such Members may be subject to retroactive adjustment by AmeriHealth to the extent such premium funding is or was in violation of this policy or the earlier version of this policy.

AmeriHealth maintains sole discretion with respect to its acceptance of third-party payments that are permitted under this policy and may make changes to its administration of this policy at any time to the extent needed to support compliance with the law and/or applicable regulatory guidance. This policy may be updated from time to time.

The AmeriHealth Member Website and App

We encourage our Members to utilize our digital tools via our member website, *amerihealth.com*, and the AmeriHealth mobile app, our free smartphone app, which is available for both iPhone and Android phones. Members can easily manage health plan benefits for themselves and covered dependents.

- View benefits and see what's covered
- Review out-of-pocket costs and deductible amounts
- Access and organize claims
- View, share, or order a member ID card
- Get answers specific to a member's plan using an enhanced Ask IBX search bar
- Pay online if a member purchases insurance on their own plan

The member site also offers expanded Provider search capabilities so members can manage their health. Members can:

- easily find in-network doctors, hospitals, pharmacies, labs and other providers;
- select or change a primary care physician;
- view open referrals;
- find designated sites for labs, radiology, and more.

AmeriHealth Wire

AmeriHealth Wire® is a private, HIPAA-compliant, digital tool that leverages the accessibility of text messaging and the security of the Web to deliver practical and usable plan- and service-based information. Independence Members are invited to sign up for AmeriHealth Wire, a free communication service, when they receive their health plan ID card.

AmeriHealth Wire focuses on preventive health screening reminders, such as flu shots and cervical and colorectal cancer screenings, as well as important news related to Health Care Reform.

In addition, content includes HEDIS® gaps in care for the following:

- asthma control
- breast cancer screening
- cardiovascular disease management
- chlamydia screening
- diabetes management

AmeriHealth Wire is not currently available for Medicaid or Children's Health Insurance Program (CHIP) Members.

Cost and Quality Transparency Tools

Our Member website, *amerihealth.com,* has been optimized across various browsers and is accessible through a Member's desktop, mobile phone, and tablet. We have redesigned the entire user interface to drive more Member engagement and have introduced new, innovative capabilities while continuing to provide access to the same existing features Members use most.

The Find a Doctor tool and Care Cost Estimator has been developed through ongoing usability testing, where Members are asked what they want, how the tools are working for them, and whether their needs are met. As a result, the tools within the platform are intuitive and simple to use. Being able to easily research Providers, procedures, and have access to crucial decision-making information allows Members to feel confident in their health care choices.

Some of the most notable features of the tool include:

- A single search bar helps Members find doctors, facilities, treatments, and services with common, everyday language.
- All-in-one search results provide the essential information a Member needs to make an informed decision from nearby doctors to cost estimates, quality ratings and patient reviews, network designations, and more.
- Quick-glance comparisons point to cost-effective options for Providers, treatments, and facilities.
- Patient review and ratings offer insights into fellow Members' actual experiences with Providers.
- Informative Provider profiles and nationally recognized quality measurements help Members find the right fit for care.
- Enhanced cost estimator allows Members to search and compare Providers by estimated price, based on the Member's specific health plan. Cost estimates can be found for a variety of common procedures by taking into consideration a Member's current Deductible balance, Copayment amounts, out-of-pocket limits, and, if applicable, Coinsurance.* The tool also displays Provider details and quality information, such as reviews, allowing Members to make more informed decisions about how to spend their health care dollars.

** These estimated costs are not a guarantee of your liability. Payment of claims and member liability are based on the terms of your health benefit plan, eligibility at the time the services are provided, co-payments and co-insurance, and the actual services submitted for payment by your provider.*