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Contact information

Important telephone numbers

Resource	Contact information
AmeriHealth Administrators (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	1-800-859-5288
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	
AmeriHealth HMO/PPO Hours: Mon. – Fri., 8 a.m. – 6 p.m.	1-888-YOUR-AH1
AmeriHealth Medigap Hours: Mon. – Fri., 8 a.m. – 6 p.m.	1-866-365-5345
Language Assistance Services Language assistance services are offered for Members who prefer a language other than English.	Customer Service: see telephone numbers 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	1-800-809-9954
AmeriHealth Administrators Hours: 24 hours a day, 7 days a week	1-800-634-5334
Provider Engagement, Analytics & Reporting (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 facility payer ID grid at *www.amerihealthnj.com/html/providers/claims_billing/edi.html*. There, claims submission information is broken out by prefix/product name.

The following are other claims-related addresses:

AmeriHealth Administrators
P.O. Box 21545
Eagan, MN 55121
Note: Submit AmeriHealth Administrators new claims or adjustment requests directly to AmeriHealth Administrators. Do not submit AmeriHealth Administrators claims to the AmeriHealth HMO/POS, PPO claims addresses. Reference the back of the Member ID card for specific claim mailing instructions.

Magellan Behavioral Health Claims Submission
Magellan Behavioral Health, Inc.
P.O. Box 1958
Maryland Heights, MO 63043-1958
This address is for the following claims: HMO/Referred (In-Network) POS, POS Plus with the National Access Rider, and New Jersey with the National Access Rider (In-Network and Out-of-Network).

AmeriHealth Processing Center
P.O. Box 41574
Philadelphia, PA 19101-1574
This address is for all HMO/POS and PPO claims and Magellan Behavioral Health, Inc. claims for the following products: Self-Referred (Out-of-Network) POS, New Jersey without the National Access Rider Standard and Flex PPO, and CMM.

Appeals mailing addresses

Claims Medical Review /Emergency Room Review
AmeriHealth New Jersey
Claims Medical Review Department
1901 Market Street, 30th Floor
Philadelphia, PA 19103

Member Medical Necessity and Administrative Appeals
AmeriHealth New Jersey Member Appeals Unit
P.O. Box 41820
Philadelphia, PA 19101

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

Provider Claims Appeals – NJ HMO/PPO
Claims Payment Appeals Unit
P.O. Box 7218
Philadelphia, PA 19101

Provider Partnership Associates

Provider Partnership Associates play a critical role in educating our network Providers and their office staff on policies, procedures, and specific billing processes. These associates also serve as a liaison for the facility office and may promote or suggest workflow solutions.

In an effort to build and sustain a strong working relationship with you, Provider Partnership Associates will contact you regularly to:

- resolve issues
- review clinical and claim payment policies
- discuss new policy implementation
- explain new products and programs
- investigate and assist in resolution of inquiries
- explain procedures for requesting claims adjustments or initiating appeals

Note: Provider Partnership Associates cannot revise claims submissions or change Provider data.

We encourage you to contact your Provider Partnership Associate for help in making day-to-day office operations run smoothly as possible and help you work efficiently and effectively with us.

Provider Partnership Associate Locator Tool

The Provider Partnership Associate Locator Tool identifies your Provider Partnership Associate, his or her direct telephone number, fax number, manager, and the Medical Director who supports your practice or facility. Inquiries can also be submitted directly to your Provider Partnership Associate through this tool.

To use the Provider Partnership Associate Locator Tool, go to *www.amerihealthnj.com/html/providers/contact.html* and select the link at the bottom of the page. When you open the tool, you will be prompted to enter either your AmeriHealth corporate ID number or your tax ID number. Your Provider Partnership Associate's contact information will

be displayed. If you receive an error message, or if your Provider Partnership Associate's information is unavailable, contact Provider Services for assistance.

Provider Services

Provider Services also serves as a valuable resource to you, in addition to your Provider Partnership Associate. 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 responding to telephone inquiries in a timely and accurate way;
- educate Providers about self-service utilization;
- assist Providers in the identification and resolution of claim inquiries.

To reach Provider Services, call Customer Service at 1-888-YOUR-AH1 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.amerihealthnj.com*, PEAR portal, and this *Hospital Manual*. These resources are designed to work in unison to provide your office with timely informational updates.

To receive email updates providing you with the latest information, including 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.amerihealthnj.com* and select the Privacy Policy link at the bottom of the page.

amerihealthnj.com

Visit the "Providers" section of our website to find important information and resources 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.amerihealthnj.com*, 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 facility.

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 latest Provider news and announcements;
- links to fee schedule information and resources;

- helpful documents and tools;
- 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 "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 to health plans for treatment, payment, or health care operations and includes disclosure of Members' medical records. 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.amerihealthnj.com* via the Privacy Policy link 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* on our website at *www.amerihealthnj.com* via the Privacy Policy link at the bottom of the page.

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 New Jersey 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.

AHNJ On the Go mobile app

We encourage both Members and Providers to download our free smartphone app, AHNJ On the Go. Offered on both iPhone and Android mobile platforms, AHNJ On the Go is a convenient, fast, and secure way to access plan information and manage health information wherever you go.

Some of AHNJ On the Go features include:

- **Plan Information:** Subscribers and dependents can quickly access basic benefits information, such as Copayment amounts, and contact information for their PCP and ancillary medical Providers.
- **Finders:** Robust search engines help users locate in-network hospitals, Physicians, Patient-Centered Medical Homes, urgent care centers, and pharmacies.
- **Doctor's Visit Assistant:** Members can view their open Referrals; display, email, or fax an ID card to their Provider; and record notes from conversations with their Physician.
- **My Health Assistant:** Users can set health goals and build an activity plan to get and stay healthy. Trackers help users monitor their progress and manage their activity plan on the go.
- **Medicine Cabinet:** Members can view and keep track of all their medications and identify them with pictures.
- **Medication Reminders:** Users are able to set daily or weekly reminders to take their medications.
- **Food and Drug Interactions:** Members can check their current medications for potentially dangerous combinations with foods or other medications to avoid complications.
- **Shop for Insurance:** Consumers can learn about various AmeriHealth New Jersey benefit plans.

The AHNJ On the Go mobile app is available as a free download for iPhones and all Android devices at Apple's App Store and the Google Play Store.

Cost and quality transparency tools

Our Member portal at *amerihealthexpress.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.

We enhanced our Find a Doctor tool focusing our design on how Members actually use the tool. The platform 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, treatments, and 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 measurement 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.

**This tool is not a guarantee of payment or the actual cost to a Member, as cost will depend on services submitted for payment by Provider, Member eligibility at the time services were provided, and Member benefits.*