Welcome To Ambetter of North Carolina Inc.

Your Partner In Better Healthcare

2026 Provider Orientation

ambetter HEALTH

PROVIDER ORIENTATION

2026

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 Experience
~ Public Website and Secure Portal
~ Verification Member Eligibility, Benefits and Cost Shares
~ Prior Authorization
~ Claims, Billing and Payments
~ Complaints, Grievances and Appeals
~ Specialty Companies and Vendors

QUESTIONS & ANSWERS

2026 Provider Orientation

OVERVIEW

WE ARE

AMBETTER HEALTH

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

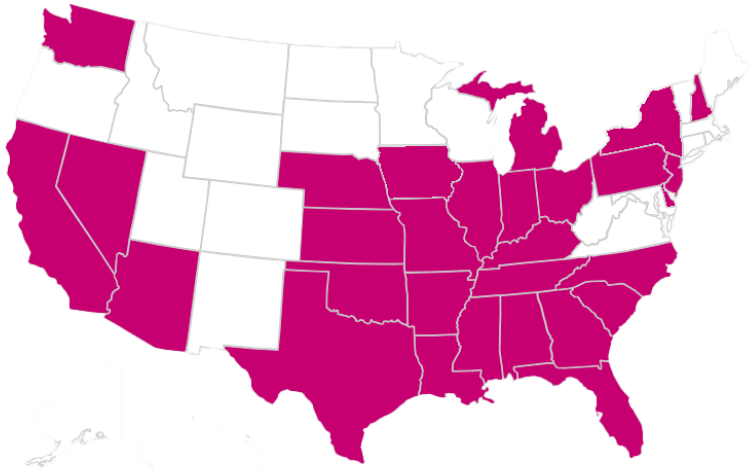
#1 carrier
on the Health Insurance Marketplace*

5.7M+
members insured

**Statistical claims and the #1 Marketplace Insurance statement are in reference to national on-exchange marketplace membership and based on national Ambetter data in conjunction with findings from 2023 Rate Review data from CMS, 2023 State-Level Public Use File from CMS, state insurance regulatory filings, and public financial filings.*

2014
Year Ambetter launched it's first Marketplace plans

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, previously uninsured or Medicaid-eligible individuals and families**

Ambetter of North Carolina Inc.

2019

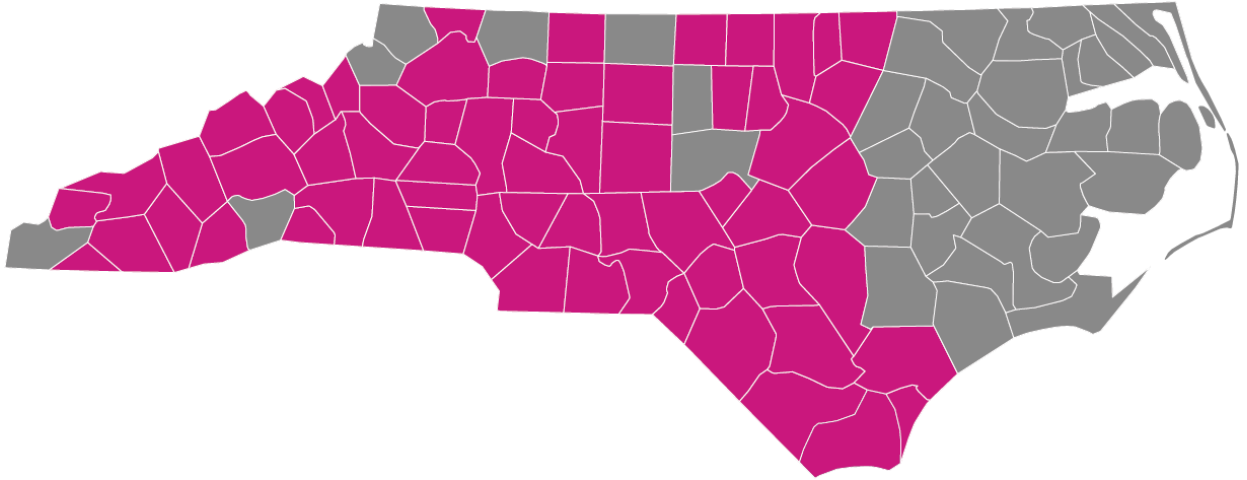
Year that Ambetter of North Carolina Inc. began in just 19 counties!

~132K

members insured

63

counties



View our coverage map!

PARTNERSHIP

- The **Ambetter Health plan designs** are built to support subsidy-eligible individuals and families purchasing coverage through the Health Insurance Marketplace.
- **Ambetter Health products** offer a range of cost-sharing options, including plans with low or no copays, tailored to meet the financial and healthcare needs of our members.
- The **emphasis on reducing barriers and improving access to care** mitigates the risk of individuals showing up without insurance (uncompensated care). Ambetter Health's cost-sharing lowers member costs and eases provider collections at care.
- Most importantly, Ambetter plans encourage members to establish relationships with their primary care providers to **achieve favorable health outcomes**.

We are proud to be your partner.

AFFORDABLE CARE ACT

AFFORDABLE CARE ACT (ACA): Key Objectives

- Expand access to affordable, quality health coverage for individuals & families
- Make healthcare more affordable through subsidies and cost-sharing reductions

ADDITIONAL PARAMETERS:

- Coverage for dependents up to age 26*
- No lifetime maximum benefits
- Preventative care covered at 100% when provided by in-network providers
- 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 federal tax penalty for not having minimum essential coverage; however, some states may impose their own penalties.
- 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
  ~ The subsidy cap has been extended through Plan Year 2026 under current federal policy.
- Cost-Sharing Reductions (CSRs) are available to eligible individuals/families with household incomes between 100% and 250% of the Federal Poverty Level (FPL), based on family size.

**States may enact tax penalties for not purchasing insurance*

HEALTH INSURANCE MARKETPLACE

The Health Insurance Marketplace is a service available in every state that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace (HealthCare.gov) for most states, but some states run their own Marketplaces, also called Exchanges.

The Health Insurance Marketplace provides health plan shopping and enrollment services through websites, call centers, and in-person help.

Potential members can:

- Register for the Exchange
- Determine eligibility for all health insurance programs (including Medicaid)
- Shop for plans
- Enroll in a plan
- Exchanges may be state-based, federally facilitated, or a federal-state hybrid — **North Carolina *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 Ambetter Health plans include cost shares such as copays, coinsurance, and deductibles, which vary by plan type and subsidy eligibility

Members may qualify for Cost-Sharing Reductions (CSRs) based on household income and family size.

Eligible individuals can receive financial assistance in the form of Advanced Premium Tax Credits (APTCs) and CSRs when purchasing Qualified Health Plans (QHPs) through Healthcare.gov or approved direct enrollment platforms.

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OUR NETWORKS

OUR NETWORKS

- Ambetter Health offers a diverse suite of network options tailored to meet the coverage and budget needs of Marketplace members.
- By offering increased product options, Ambetter also benefits providers by giving them exclusive access to new patient populations.
- Each Ambetter Health network is designed to meet the specific coverage needs of members in their respective states. Plan structures, covered benefits, and referral requirements may vary by state and network type.
- Providers must confirm the member's network and plan before delivering services to ensure coverage and compliance with referral or authorization requirements. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

Networks Build To Offer More

OUR NETWORKS

Ambetter Health Premier Plans: 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.

Ambetter Health offers diabetes-specific plan designs in select markets for Plan Year 2026:

In NC Ambetter Health provides members managing diabetes with additional healthcare options and savings. Members will have lower out-of-pocket costs for certain medications, supplies, and clinical support. Members of these plans may have access to $0 copays for preferred insulin, as well as $0 copays for select mental health medications

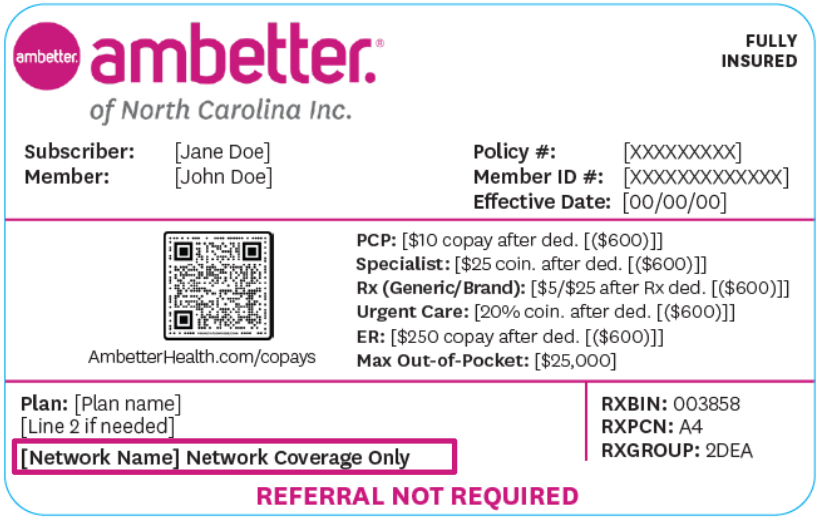
Our Innovative Networks

HOW TO IDENTIFY A MEMBER'S NETWORK

All members receive an Ambetter member identification card. Ambetter member ID cards include key information such as:

- The specific **Ambetter Health plan** selected by the member.
- The **Provider Network** associated with the member's plan.
- **Referral requirements** , if applicable, based on the member's network type.

Note: *Member ID cards do not guarantee eligibility. Providers must verify eligibility on the date of service using the Secure Provider Portal or Provider Services.*



Back of Member ID Card

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WHAT YOU NEED TO KNOW

KEY CONTACT INFORMATION

Ambetter of North Carolina Inc.

PHONE

Phone: 1-833-863-1310
(Relay 711)

WEB

https://www.ambetterofnorthcarolina.com/

PORTAL

Provider.AmbetterofNorthCarolina.com

AMBETTER PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER OF NORTH CAROLINA INC.

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 North Carolina Inc. website at **https://www.ambetterofnorthcarolina.com/.**

PROVIDER EXPERIENCE TEAM

The **Provider Relations** 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 North Carolina Inc. Provider Services at **1-833-863-1310,** providers are able to access real time assistance for all their service needs. You may also email NetworkRelations@cch-network.com.

PROVIDER EXPERIENCE TEAM

You will have a **Provider Engagement Administrator** available to assist you.

- Our Provider Engagement Administrators serve as the primary liaisons between Ambetter and the provider network to find out who your Provider Engagement Administrator is please email, ProviderEngagement@cch-network.com.

- 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, PaySpan enrollment, and Availity Essentials onboarding support**
- ✓ **Provider education**
- ✓ **HEDIS/care gap reviews**
- ✓ **Financial analysis**
- ✓ **EHR Utilization**
- ✓ **Demographic information updates**
- ✓ **Initiate credentialing of a new practitioner**

2026 Provider Orientation

Practitioner Enrollment & Provider Demographics Updates

Practitioner Enrollment

- To add a new facility to an existing application or to submit location changes, please download and fill out the Ambetter Facility Roster Template (Excel | .xlsm) and submit these forms along with all credentialing documentation to AmbetterNCProviderDirectoryRequest@CENTENE.COM.

- To add a new practitioner to your practice, please download and fill out the Ambetter Practitioner Roster Template (Excel | .xlsm) and submit these forms along with all credentialing documentation to AmbetterNCProviderDirectoryRequest@CENTENE.COM.

PROVIDER NETWORK OPERATIONS

Providers should submit updates to demographic data to AmbetterNCProviderDirectoryRequest@CENTENE.COM within 30 days of the change.

Examples of Changes That Require Updates:

- ✓ **Adding or removing a practitioner from a location or all together**
- ✓ **Adding, closing, or relocating a practice site**
- ✓ **Updating address, phone number, or fax or email address**
- ✓ **Ownership or tax ID changes**
- ✓ **Modifying office hours or accepting new patients**

Enrollments are effective 30 days from the date all clean documents are received by Ambetter.

- **Please send the following items to AmbetterNCProviderDirectoryRequest@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**

2026 Provider Orientation

ACCESS STANDARDS

Access Standards

24-Hour Access to Providers (A member must be able to access provider after normal hours & on weekends)

After Hours (Passing Standards)

- A covering physician
- An answering service
- A triage service or voicemail message that provides a second
- number that is answered
- Use of a telephonic care provider as directed by the providers after hours messaging.
- If the provider's practice includes a high population of Spanish speaking members, it is recommended that the message be recorded in both English and Spanish.

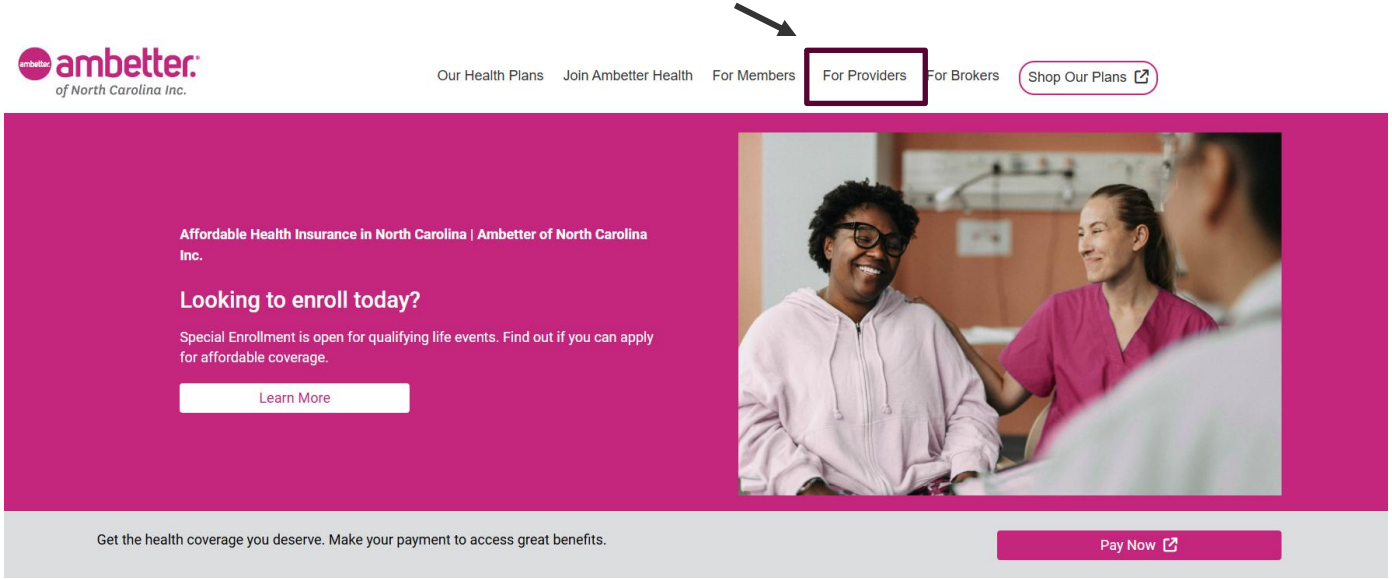
Appointment Access and Availability Standards

PRIMARY CARE & PEDIATRIC	SPECIALIST	OBGYN	BEHAVIORAL HEALTH
➢ **Urgent Care:** Within 24 hours of member's call ➢ **Non-Urgent/Sick Care:** Within 48 hours ➢ **Routine**: Within 15 business days of request	➢ **Urgent Care:** Within 24 hours ➢ **Routine:** Within 30 business days	➢ **Urgent Care:** Within 24 hours ➢ **Routine:** Within 30 business days	➢ **Non-Life-Threatening Psychiatric Emergency:** Within 6 hours ➢ **Urgent:** Within 48 hours ➢ **Routine (Initial Assessment):** Within 10 business days ➢ **Routine Follow Up Care:** Within 10 business days

2026 Provider Orientation

PUBLIC WEBSITE AND SECURE PORTAL

AMBETTER PUBLIC WEBSITE



Ambetter Public Website

AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

- Provider Manual
- Provider Quick Reference Guides
- Important Forms such as Notification of Pregnancy, Prior Authorization Request Forms, and more.
- Pre-Authorization Lookup Tool
- Preferred Drug List (PDL)

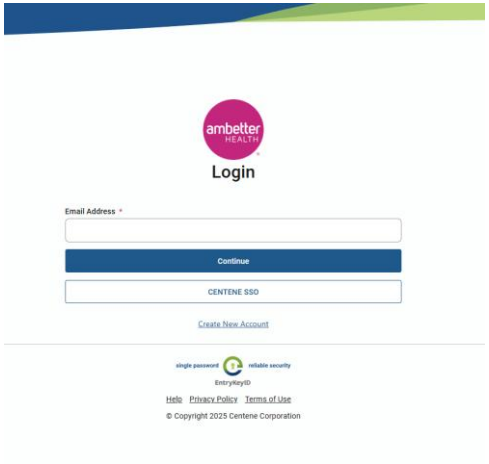
Ambetter Public Website

SECURE PROVIDER PORTAL

provider.ambetterofnorthcarolina.com

REGISTRATION IS FREE AND EASY!

Contact your Network Performance Advisor or Provider Engagement Administrator for additional support
ProviderEngagement@cch-network.com



Secure Provider Portal

SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility verification and patient panel listings
- Care gap reports and quality measure tracking
- Submit and track prior authorizations
- Submit claims and check claim status
- Submit corrected claims and request adjustments
- Payment history
- Monthly PCP performance and cost reports
- Provider performance and utilization analytics
- Referral submission for Value network plans

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

AVAILITY ESSENTIALS

Ambetter Health, a Centene company, has transitioned to Availity Essentials as its secure provider portal for eligibility, claims, authorizations, and payer resources.

- The legacy Ambetter Secure Provider Portal remains available for select functions during the phased transition.
- 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.
- Practice administrators can register for Availity Essentials at:
  - **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 Administrator.
- Payor ID is **68069**

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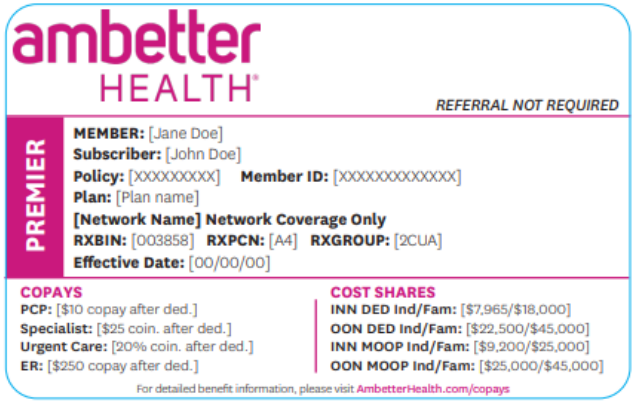
VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

MEMBER ID CARD



Plans can include:
- PREMIER
- SELECT
- VALUE
- SOLUTIONS

Certain plans may have a referral requirement. Please note:

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

Provider Services Contact Information

Pharmacy Benefit Information

Navigating the Member ID Card

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 using Secure Provider Portal. The patient list includes member name, ID number, date of birth, care gaps, disease management enrollment, and product enrollment.
- PCPs may administer services even if the member is not currently assigned to their panel, and request reassignment for future care.

Verification of Eligibility, Benefits and Cost Share

ELIGIBILITY, BENEFITS AND COST SHARE

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

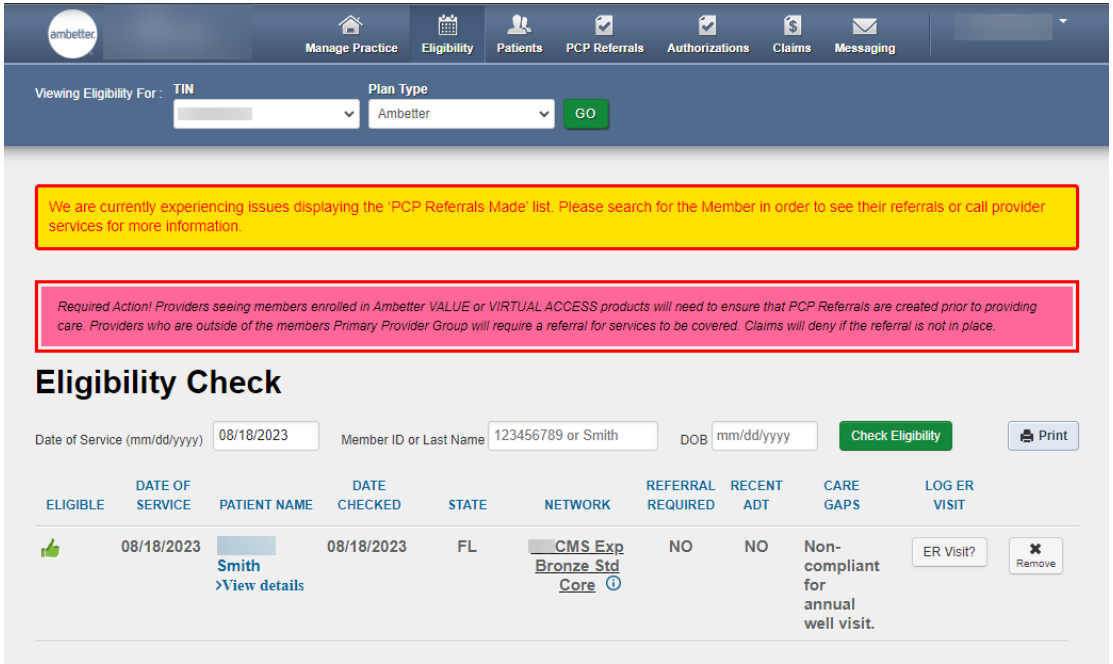
✓ **The Ambetter Secure Portal:** https://provider.ambetterofnorthcarolina.com
If you are already a registered user of the Ambetter of North Carolina Inc. secure portal, you do NOT need a separate registration!

✓ **24/7 Interactive Voice Response System**
Enter the Member ID Number and the month of service to check eligibility

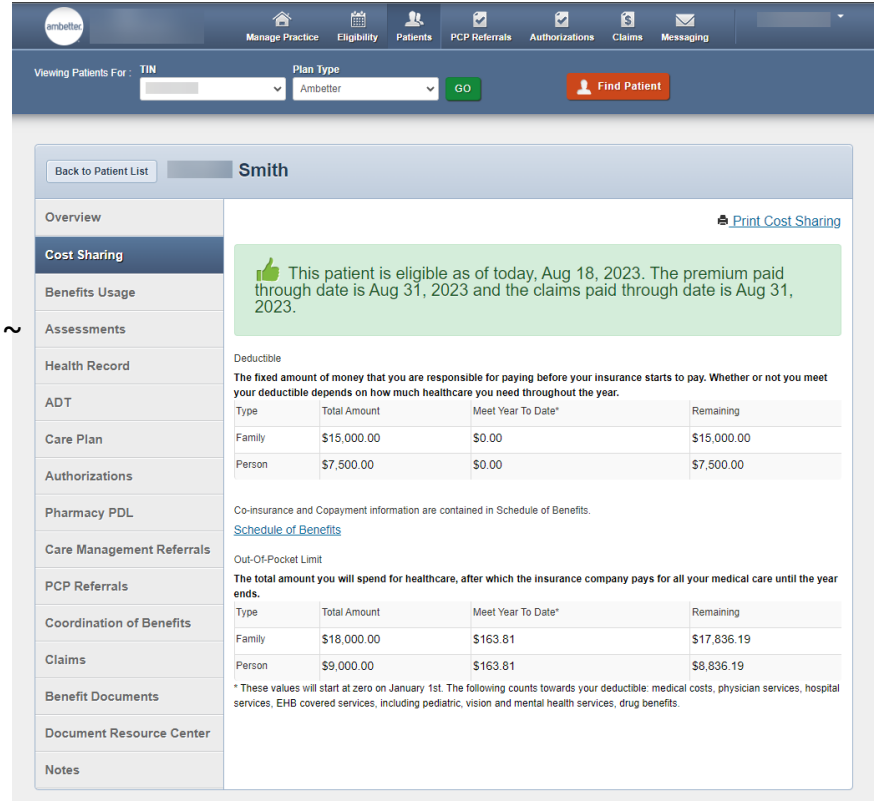
Contact Provider Services: 1-833-863-1310

Verification of Eligibility, Benefits and Cost Share

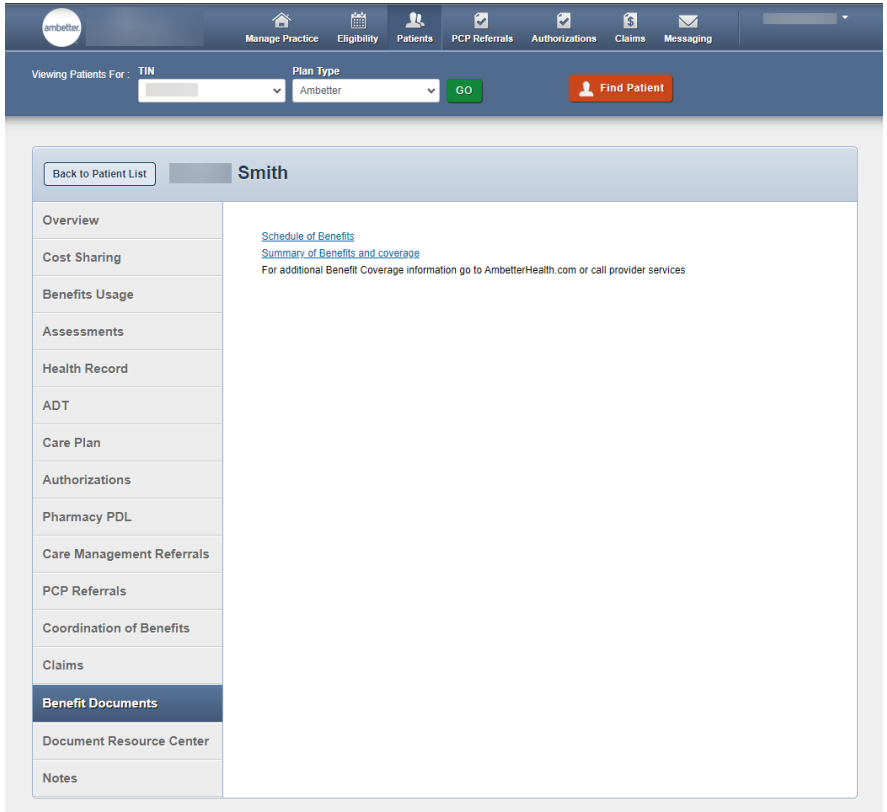
VERIFICATION OF ELIGIBILITY ON THE PORTAL



VERIFICATION OF COST SHARES ON THE PORTAL



VERIFICATION OF BENEFITS ON THE PORTAL



2026 Provider Orientation

PRIOR AUTHORIZATION

HOW TO SECURE A PRIOR AUTHORIZATION

Prior Authorization Submission Methods

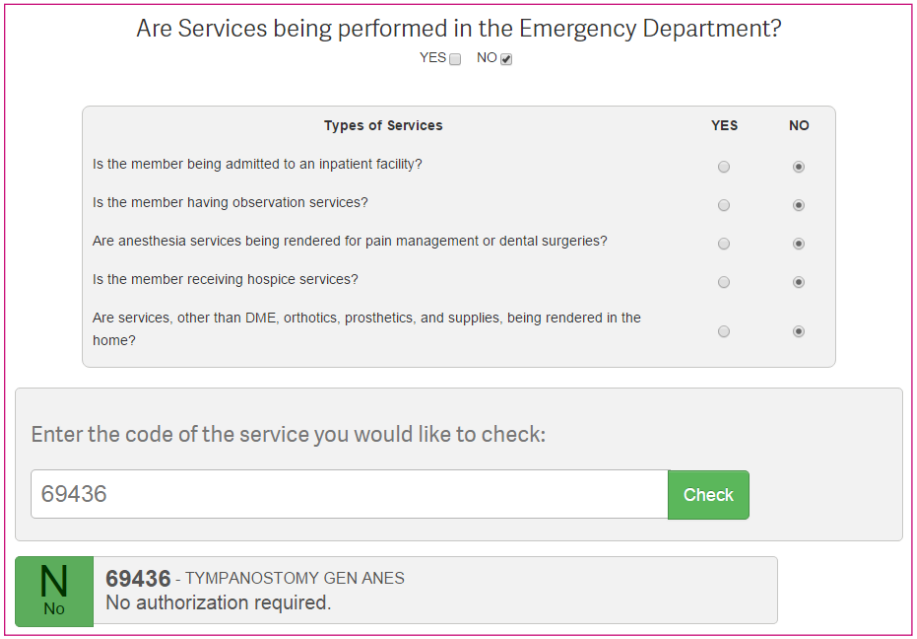
Electronic submission is the fastest and preferred method for prior authorization requests. Providers may submit prior authorization requests using **one of the following options**:

- ✓ Secure Provider Portal: **https://provider.ambetterofnorthcarolina.com**
- ✓ Availity Essentials
- ✓ Phone: Contact the Utilization Management Department using the number listed on the member's ID card. **1-833-863-1310**
- ✓ Fax: Use the Prior Authorization Fax Forms available on the Ambetter website. Fax submissions are reviewed during business hours only. **1-844-536-2412**

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned via phone, fax, or web.

IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Available on the provider section of the Ambetter of North Carolina Inc. website at ambetterofnorthcarolina.com.



REQUIREMENTS

Services that require prior authorization include:

- All inpatient admissions
- Selected outpatient services
- Experimental or investigational treatments
- High-tech imaging (e.g. CT, MRI, PET)
- Infertility services
- Pain Management procedures
- Organ transplant evaluations
- Clinical trial services
- Out-of-network services (excluding emergency care)

**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

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 **48** 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

REQUIREMENTS

ANCILLARY SERVICES REQUIRING PRIOR AUTHORIZATION INCLUDE*:

- Non-emergent air ambulance transport (fixed-wing)
- Durable Medical Equipment (DME)
- Home health care services:
  - ~ Home infusion therapy
  - ~ Skilled nursing care
  - ~ Physical, occupational, and speech therapy
  - ~ Private duty nursing
  - ~ Adult medical day care
  - ~ Hospice care
  - ~ Medical supplies and equipment furnished in the home

**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

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 24 hours
Observation –48 hours or less	Notification within one (1) business day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within 1 business day
Organ Transplant - Initial Evaluation	Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services
Maternity admissions	Notification within 24 hours
Newborn admissions	Notification within 24 hours
Neonatal Intensive Care Unit (NICU) admissions	Notification within 24 hours
Outpatient Dialysis	Notification within 24 hours
Clinical trials services	Prior Authorization required at least 30 days prior to receiving clinical trial services

Prior Authorization Timeframes

TIMEFRAMES

Type	Timeframe
Prospective/Urgent	Within 3 business days of receipt of the request. If all information is not received by the end of the 3rd calendar day, a determination will be made based on available information.
Prospective/Non-Urgent	Within 3 business days of receipt of all information needed to complete the review, not to exceed 15 calendar days from receipt of the request. If all information is not received by the 15th calendar day of the request, a determination will be made based on available information.
Concurrent/Urgent	Within 1 calendar day of receipt of request. Extension: A onetime extension may be granted of up to 3 calendar days from receipt of the request if additional information is needed. If all information is not received by the end of the 3rd calendar day, a determination will be made based on available information.
Retrospective	30 calendar days

Utilization Determination Timeframes

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 does **not** retro-authorize services.
  ~ Claims submitted without updated authorization will be denied.
  ~ Providers may appeal if extenuating circumstances prevented timely authorization.

CORRECT CODING FOR PRIOR AUTHORIZATION

2026 Provider Orientation

CLAIMS, BILLING AND PAYMENTS

CLAIMS

WHAT IS A CLEAN CLAIM?

- A clean claim is one submitted in a nationally accepted format using current CPT, ICD-10, and HCPCS codes, without defects or missing documentation, and that meets all billing requirements for 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 days from the date of service, or date of primary payment, when Ambetter is secondary.

CLAIMS MAY BE SUBMITTED IN THE FOLLOWING WAYS:

1. **The Secure Provider Portal**
   provider.ambetterofnorthcarolina.com

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 **ambetterofnorthcarolina.com**

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

4. Availity Essentials

CLAIM RECONSIDERATIONS AND 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:

  P.O. Box 5010
  Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within 180 days of the Explanation of Payment
- A claim dispute/claim appeal should be used only when a provider has received an unsatisfactory response to a request for reconsideration
- A Claim Dispute form can be found on our website at ambetterofnorthcarolina.com
- Mail completed Claim Dispute form to:

  P.O Box 5010
  Farmington, MO 63640-5010

CLAIM SUBMISSION SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- After the first month of non-payment, the member enters a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- Under the ACA, members receiving Advanced Premium Tax Credits (APTCs) are granted a three-month grace period to pay outstanding premiums before coverage is terminated.
- During suspended status (months 2 and 3 of the grace period), claims may be pended or denied depending on payment status.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium by the end of the grace period, coverage is terminated retroactively, and providers may bill the member directly for services rendered during suspended status.

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 enters suspended status (Month 2 of grace period)
- **April 1st**
  Member remains in suspended status (Month 3 of grace period)
- **May 1st**
  If premium remains unpaid, coverage is terminated retroactively. Provider may bill member directly for services rendered during suspended status.

Claims for members in suspended status may be pended or denied depending on payment status and are not considered "clean claims."

HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE!

- Claims **must** include the rendering provider's taxonomy code.
- Claims submitted without a valid taxonomy code will be rejected upfront and will not enter the adjudication system.
- For paper claims, include the taxonomy code in in Box 24J and 33b.
- For electronic claims, include it in loop 2310B/2420A and 2010AA.

REMINDER: DO NOT FORGET THE CLIA NUMBER!

- For CLIA-certified or CLIA-waived services, the CLIA number **must** be entered in **Box 23** of the CMS 1500 paper claim form.
- For electronic claims, report the CLIA number in loop 2300 or 2400 (REF02 with REF01 = X4).
- Claims missing CLIA numbers will be rejected upfront.

BILLING THE MEMBER

COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, coinsurance, and any unpaid portion of the deductible may be collected at the time of service. Providers must verify the member's benefit design and cost share responsibility prior to rendering services.
- Deductible information, including the amount paid toward the deductible, can be accessed via the Secure Provider Portal at https://provider.ambetterofnorthcarolina.com/
- If the amount collected from the member exceeds the actual liability after claim adjudication, the provider must reimburse the member within 45 days.

ELECTRONIC FUNDS TRANSFER- CLAIMS PAYMENTS

PAYSPAN®: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan® Health, a free solution that enables providers to receive electronic payments (EFT) and electronic remittance advices (ERA) for faster, more efficient claims reimbursement.

- If you currently utilize PaySpan®, you must register specifically for Ambetter from Fidelis Care to receive payments.

- **Set up your PaySpan® account:**
  ~ Visit **www.payspanhealth.com** and click Register to begin the enrollment process
  ~ You will need your National Provider Identifier (NPI) and Tax ID Number (TIN) or Employer Identification Number (EIN) to complete registration

ELECTRONIC FUNDS TRANSFER

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COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS, GRIEVANCES AND APPEALS

CLAIMS

- If the Complaint/Grievance is related to claim(s) payment, the provider must follow the process for claim reconsideration and claim dispute prior to filing a Complaint/Grievance.

COMPLAINT/GRIEVANCE

- Must be filed within 30 days from the date of the incident, such as the original Explanation of Payment date, to file a Complaint/Grievance. Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 calendar days from the date we receive the provider's Complaint/Grievance.

COMPLAINTS, GRIEVANCES AND APPEALS

PROVIDER CLAIM APPEAL PROCESS

- Claim Appeal requests must follow the **claim reconsideration and claim dispute process.**
  A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

MEMBER APPEALS PROCESS

- Must be filed within **180** days from the Notice of Action.
- Ambetter shall acknowledge receipt within **3 business** 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 calendar** 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 from the initial receipt of the appeal or after the member provides any specified information required to complete the review.

COMPLAINTS, GRIEVANCES AND 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 ambetterofnorthcarolina.com

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SPECIALTY SERVICES & VENDORS

SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	Evolent	www.radmd.com
Vision Services	Centene Vision	www.centenevision.com
Dental Services	Centene Dental	www.centenedental.com
Pharmacy Services	Centene Pharmacy Services	1-866-399-0928 (Phone) 1-866-399-0929 (Fax)
Interventional Pain Management, Therapy Services (Speech Therapy, Occupational Therapy, Physical Therapy), Cardiac Imaging, Advanced Imaging (MRI, CT, PET)	Evolent	1-800-424-4948 http://www.radmd.com/
Cardiac Surgeries and Procedure	Turning Point	1-984-377-8573 & 1-855-909-5444 www.myturningpoint-healthcare.com Fax: 1-833-986-1059
Oncology/Radiation Oncology	Evolent	1-888-999-7713 my.newcenturyhealth.com

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Health Equity

Health Equity Resources

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to:

- Address historical and contemporary injustices,
- Overcome economic, social, and other obstacles to health and healthcare; and
- Eliminate preventable health disparities

Ambetter of North Carolina Inc. provides a variety of Health Equity and Cultural Humility learning opportunities on our website. We have cultural humility training info, health equity trainings, as well as the Choosing Wisely initiative available and ready for use.

- Health Literacy & Cultural Competency resources can be found under Providing Quality Care on our website
- Toolkit: Help Your Patients Understand Their Health and Health Care (PDF)

To achieve health equity, we must change the systems and policies that have resulted in the generational injustices that give rise to racial and ethnic health disparities. For more information about Culturally and Linguistically Appropriate Services (CLAS) Standards, see: https://thinkculturalhealth.hhs.gov/clas

Ambetter of North Carolina Inc. encourages our providers to engage in Cultural Humility trainings and education to promote positive interaction with diverse cultures.

For more information about the Cultural and Linguistic Competency e-Learning Program from the Office of Minority Health (OMH), see https://thinkculturalhealth.hhs.gov/ . This program is designed to build knowledge, skills, and awareness of cultural and linguistic competency and CLAS as a way to improve quality of care.

New Provider Checklist

☐ **Register with Payspan EFT** (Ambetter-specific code required if already with CCH)

Payspan Quick Reference Flyer (PDF)
Payspan Training and User Guide (PDF)
Payspan Website or call 1-877-331-7154

☐ **Register for the Ambetter Secure Provider Portal**: Ambetter Secure Portal
☐ **Register for Availity**: Availity Getting Started Guide
☐ **Bookmark the Provider Resources Page**:
Ambetter Provider Resources
☐ **Stay updated with Provider News**: Provider News subscribe here,
https://www.surveymonkey.com/r/AmbetterNCNews

* ***We value your feedback, please feel our brief survey*** https://www.surveymonkey.com/r/YQVKL8N

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Questions & Answers