Welcome to Ambetter of Tennessee

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 Engagement
- Public Website and Secure Portal
- Verification Member Eligibility, Benefits and Cost Shares
- Referrals
- Appointment Availability
- Prior Authorization
- Claims, Billing and Payments
- Corrected Claims 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.

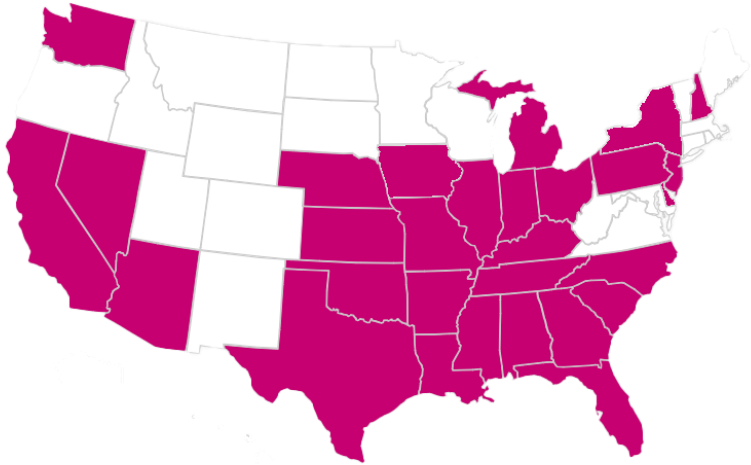
#1 carrier
on the Health Insurance Marketplace*

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, underinsured and uninsured**

WE ARE PROUD TO BE YOUR PARTNER

- 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**.

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 issues.
- 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 - ***Tennessee is a Federally Facilitated Marketplace.***

The Health Insurance Marketplace allows individuals to receive subsidies. Qualified Health Plans (QHPs) can be purchased through Healthcare.gov, or a direct enrollment platform.

HEALTH INSURANCE MARKETPLACE

FINANCIAL COMES IN THE FORM OF:

- Advanced Premium Tax Credits (APTC)
- Cost-Sharing Reductions (CSR)

All 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

NETWORKS BUILT TO OFFER MORE

- 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.

OUR INNOVATIVE NETWORKS

PREMIER*: The Ambetter core network – our broadest network of healthcare providers and hospitals offering affordable care to individuals or families that need to purchase healthcare coverage on their own. Referrals are not required.

DIABETES CARE SILVER*: Lower out of pocket costs for certain medications, supplies, and clinical support. Members may have access to $0 copays for preferred insulin and select medications used to manage diabetes, high blood pressure, high cholesterol, and mental health. These plans also include $0 copays on certain diabetic supplies and labs such as lancets, glucose test strips, ketone and urine test strips, insulin syringes, pen needles as well as routine A1c labs.

What is off-exchange health insurance?

Off-exchange health insurance is a plan that is purchased directly from an insurance provider, or through a broker. Though these are considered private plans, they also fall under ACA compliance, which ensures minimum coverage and essential health benefits. ACA financial help by way of premium subsidies are only available for plans purchased on-exchange and for those who qualify.

Each Ambetter Health network is designed to offer members a unique type of coverage option specific to their state. This means that member plans and benefits can vary, and there may be referral requirements for certain types of care to be covered. As a provider, it is important you confirm which network and plan a member is in before extending care. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

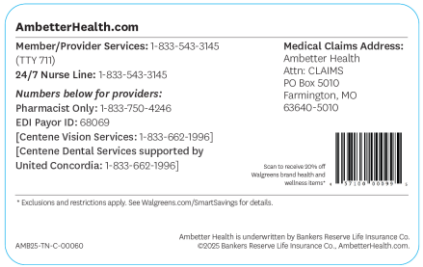
**Network availability varies by state.*

HOW TO IDENTIFY A MEMBER'S NETWORK

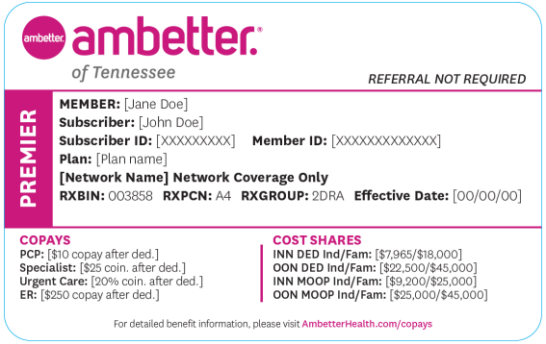
All members receive an Ambetter member identification card. Ambetter member ID cards include key information such as:

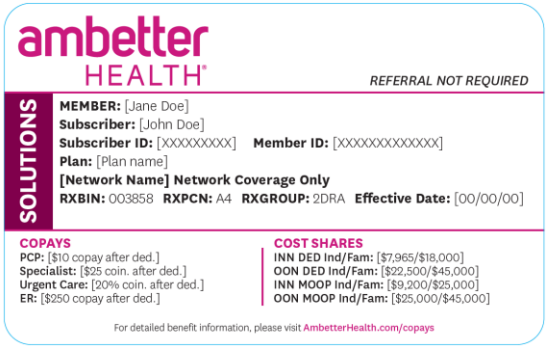
- The specific **Ambetter Health plan** selected by the member.
- The **Provider Network** associated with the member's plan.

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 Tennessee

PHONE
1-833-709-4735

TTY/TDD
1-833-709-4735 (Relay 711)

WEB
www.AmbetterHealth.com/EN/TN/

PORTAL
Ambetter Secure Provider Portal

AMBETTER PROVIDER MANUAL

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

The manual includes a wide-range of important information relevant to providers doing business with Ambetter. Key information includes:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives

The Provider Manual can be found in the Provider section of the **Ambetter of Tennessee website**.

PROVIDER ENGAGEMENT

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

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

By calling Ambetter of Tennessee Provider Services at **1-833-709-4735 (Relay 711)**, providers are able to access real time assistance for all their service needs. Or contact via email ProviderRelationsTN@centene.com

PROVIDER ENGAGEMENT

- As an **Ambetter of Tennessee** provider, you will have a dedicated Network Performance Advisor available to assist you.
- Our Provider Engagement Account Managers and Network Performance Advisors serve as the primary liaisons between Ambetter 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, PaySpan**
- ✓ **Provider education**
- ✓ **HEDIS/care gap reviews**
- ✓ **Financial analysis**
- ✓ **EHR Utilization**

PROVIDER NETWORK OPERATIONS

- Participating providers who need to make changes to their current roster and provider directory (additions, terms, demographic updates) should submit data using our Provider Demographics Update page or email AmbetterTNOps@CENTENE.com within **30 days** of the change.
- Forms to add new practitioners can be found on our website and should be submitted along with all credentialing documentation to AmbetterTNNetwork@CENTENE.com.
- Enrollments are effective **30 days** from the date all clean documents are received by Ambetter.

Please send the following items to AmbetterTNNetwork@CENTENE.com :

- **Contract Clarification**
- **Initiate credentialing of a new practitioner (not contracted)**
- **Inquiries related to the status of a new practitioner or Join Our Network request**

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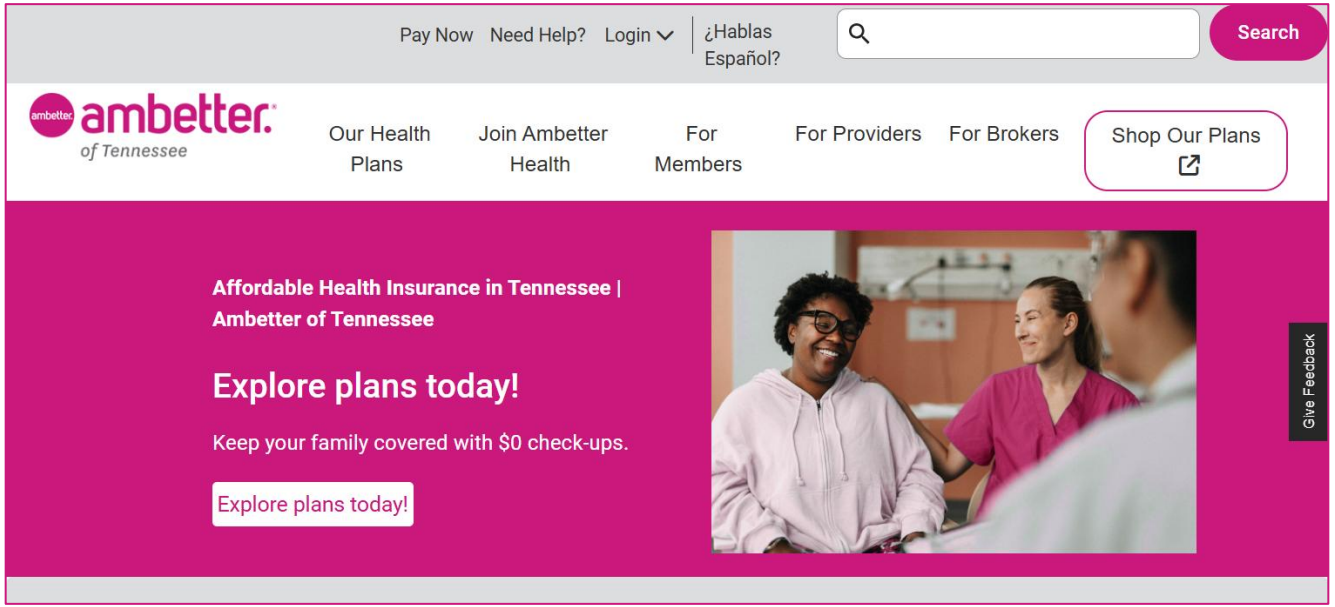
PUBLIC WEBSITE & SECURE PORTAL

AMBETTER PUBLIC WEBSITE



AMBETTER PUBLIC WEBSITE

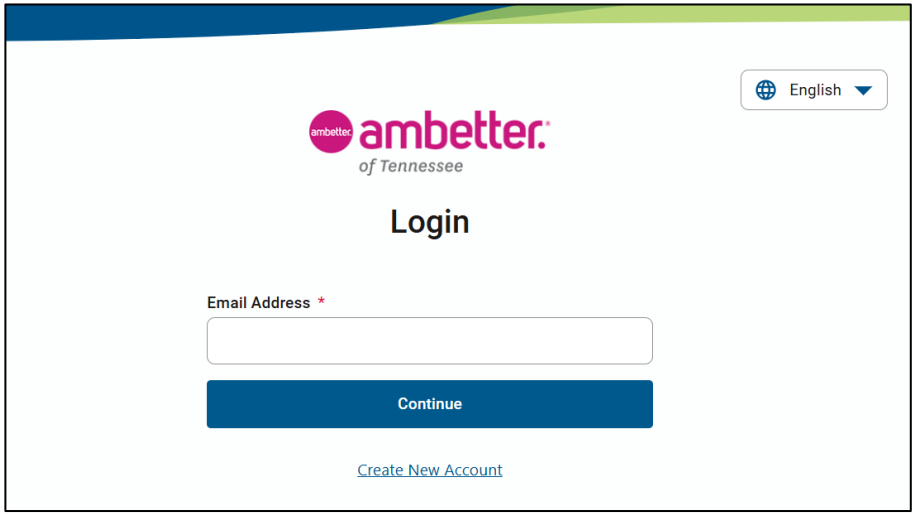
WHAT'S ON THE PUBLIC WEBSITE?

- 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)

SECURE PROVIDER PORTAL

REGISTRATION IS FREE AND EASY!

Contact your Network Performance Advisor or Provider Engagement Account Manager to begin registration.



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 of Tennessee Secure Provider Portal**

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 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 representative.

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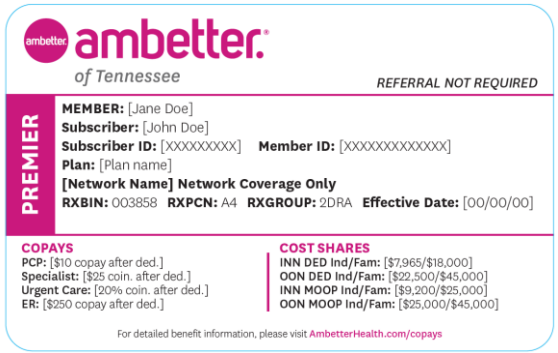
VERIFICATION OF ELIGIBILITY, BENEFITS, & COST SHARES

NAVIGATING THE MEMBER ID CARD: Premier

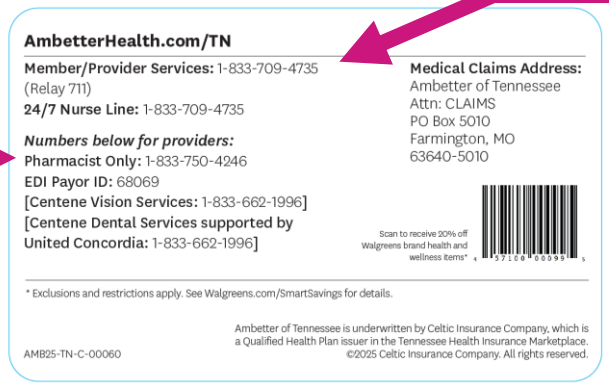
PREMIER PLAN



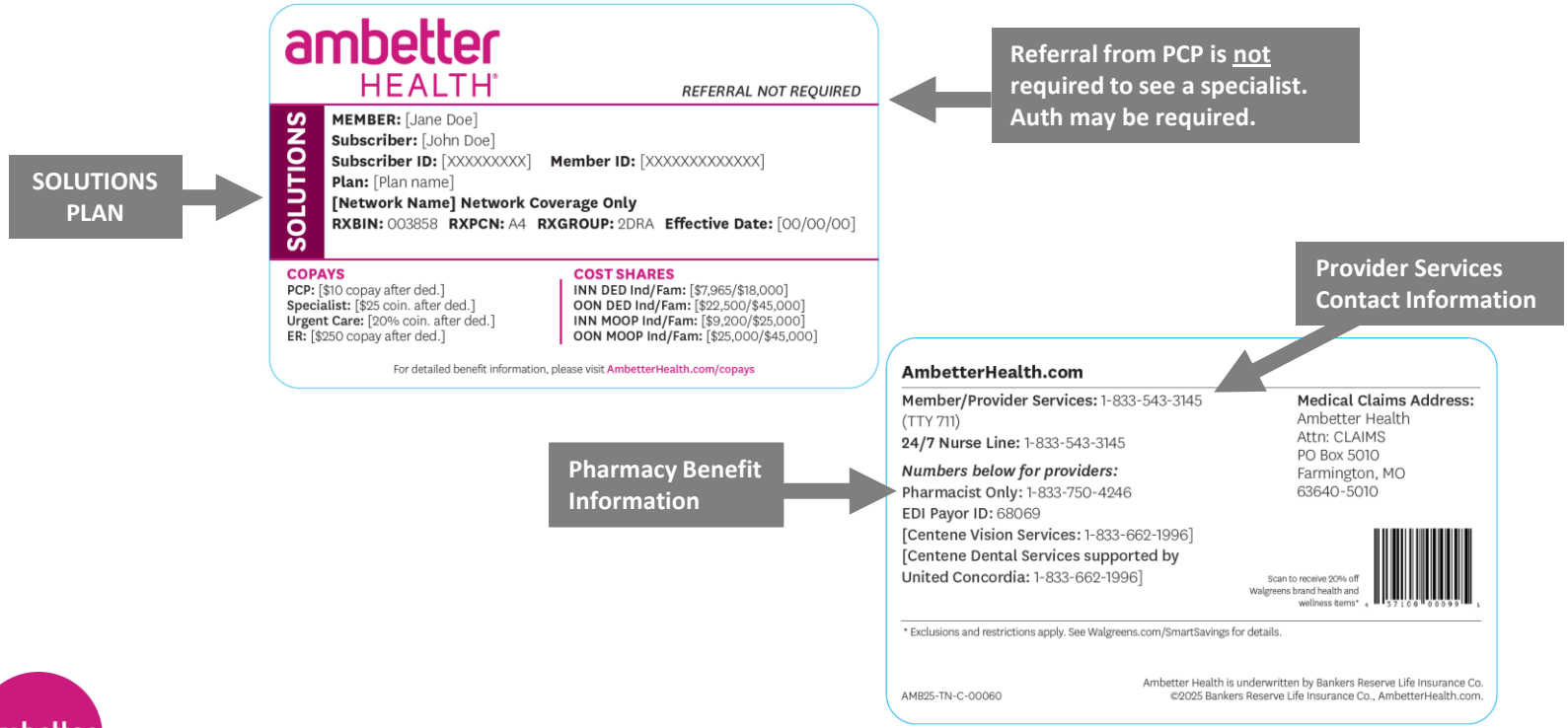
Referral from PCP is not required to see a specialist. Auth may be required.

Provider Services Contact Information

Pharmacy Benefit Information



NAVIGATING THE MEMBER ID CARD: Solutions



VERIFICATION OF ELIGIBILITY, BENEFITS, & COST SHARE

PROVIDER MUST VERIFY MEMBER ELIGIBILITY

- Every time a member schedules an appointment
- When the member arrives for the appointment

PANEL STATUS

- PCPs should confirm that a member is assigned to their patient panel 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, & COST SHARE

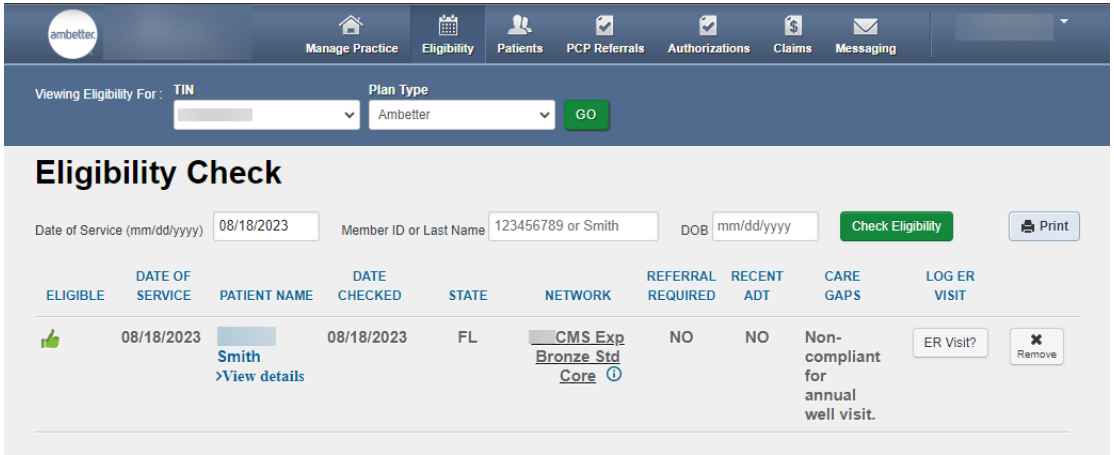
ELIGIBILITY, BENEFITS AND COST SHARES CAN BE VERIFIED IN THREE WAYS:

✓ **The Ambetter Secure Portal** If you are already a registered user of the Ambetter of Tennessee secure portal, you do NOT need a separate registration!

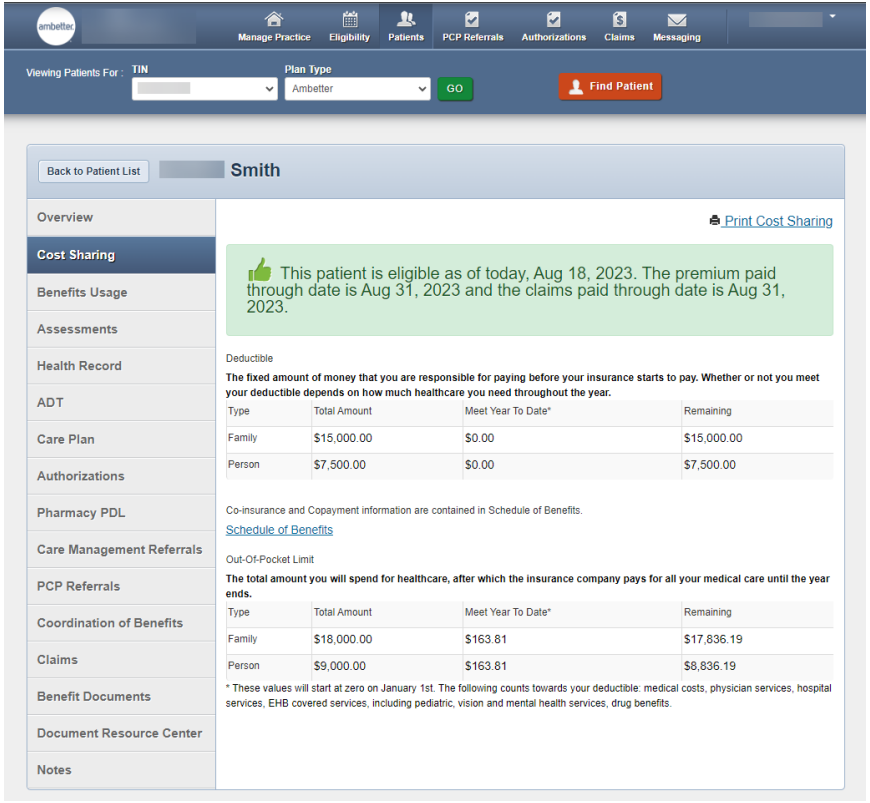
✓ **24/7 Interactive Voice Response System**
Enter the Member ID Number and the month of service to check eligibility

✓ **Contact Provider Services** 1-833-709-4735 (Relay 711)

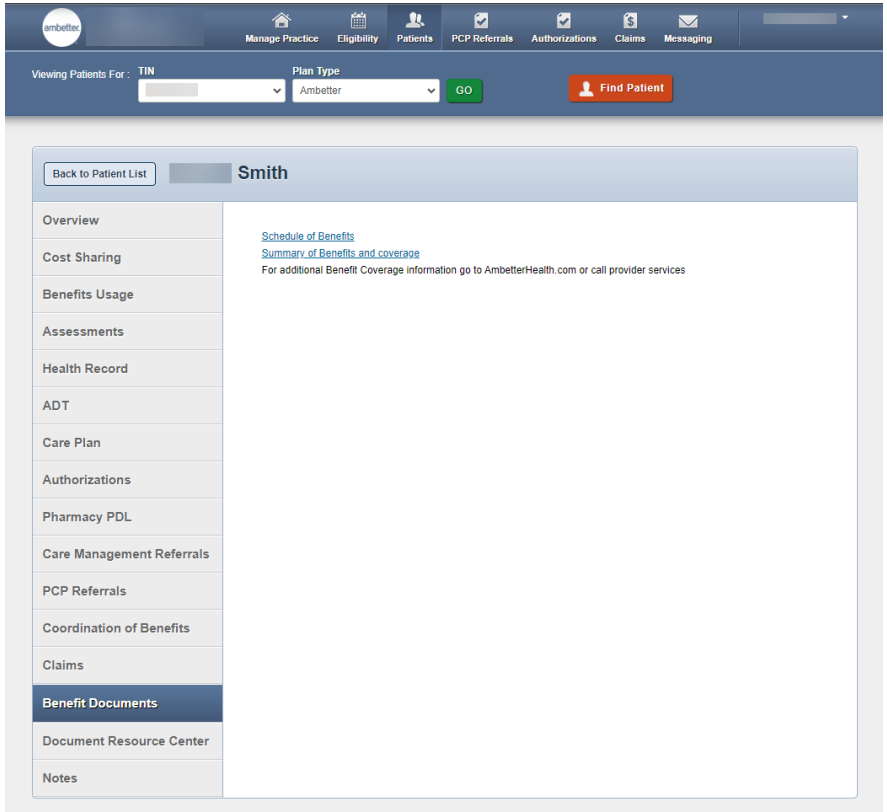
VERIFICATION OF ELIGIBILITY ON THE PORTAL



VERIFICATION OF COST SHARES ON THE PORTAL



VERIFICATION OF BENEFITS ON THE PORTAL



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APPOINTMENT AVAILABILITY

APPOINTMENT AVAILABILITY

Ambetter follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Ambetter monitors participating provider compliance with these standards at least annually.

Appointment Type	Access Standard
PCPs – Routine Visits	15 business days
PCPs – Urgent Care Appointments	24 hours
PCPs – Adult Sick Visit	48 hours
PCPs – Pediatric Sick Visit	48 hours
Urgent Care Providers	24 hours
After Hours Care	Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician.

Appointment Type	Access Standard
Specialist – Routine Visit (High Volume)	Within 30 business days
Specialist – Urgent Care (High Volume)	Within 24 hours
Specialist – Routine Visit (High Impact)	Within 30 business days
Specialist – Urgent Care (High Impact)	Within 24 hours
Behavioral Health – Non-life-Threatening Emergency	Within 6 hours
Behavioral Health Urgent Care	Within 48 hours
Behavioral Health Initial Visit for Routine Care	Within 10 business days
Behavioral Health Follow-up Routine Care	Within 10 business days

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PRIOR AUTHORIZATION

HOW TO SECURE A PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION?

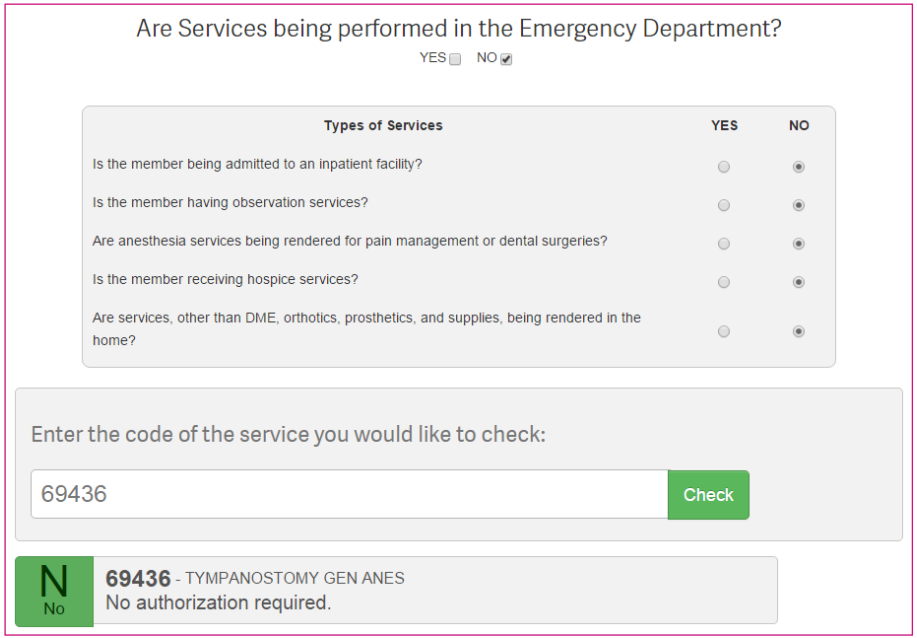
Submit requests using one of the following methods:

- ✓ **Secure Provider Portal** (This is the preferred and fastest method.)
- ✓ **Phone:** Contact the Utilization Management Department using the number listed on the member's ID card **1-833-709-4735 (Relay 711)**.
- ✓ **Fax:** Use the Prior Authorization Fax Forms available on the Ambetter website. Fax submissions are reviewed during business hours only **1-844-811-8467**.

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

IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Available on the provider section of the **Ambetter of Tennessee** website at **www.AmbetterHealth.com/en/TN/**



PRIOR AUTHORIZATION 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

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 within **1 business day**.
- Emergent Inpatient Admissions notification within **1 business day** following the date of admission.

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

PRIOR AUTHORIZATION REQUIREMENTS

ANCILLARY SERVICES 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 TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required **5 days** prior to the scheduled admission date
Elective outpatient services	Prior Authorization required **5 days** prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within **1 business day**
Observation – 48 hours or less	Notification within **1 day** for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within **1 business day**
Maternity admissions	Notification within **1 day**
Newborn admissions	Notification within **1 day**
Neonatal Intensive Care Unit (NICU) admissions	Notification within **1 day**
Outpatient Dialysis	Notification within **1 day**

UTILIZATION DETERMINATION TIMEFRAMES

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

CORRECT CODING FOR PRIOR AUTHORIZATION

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.

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CLAIMS, BILLING, & 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 **90 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**

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 **www.AmbetterHealth.com/en/TN/**.

3. **Mail**

Ambetter
Attn: Claims Department
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:
  Ambetter
  Attn: Request for Reconsideration
  P.O. Box 5010
  Farmington, MO 64640-5010

CLAIM DISPUTES

- Must be submitted within **180 days** of the Explanation of Payment
- A Claim Dispute form can be found on the **Provider Resource page** on our website.
- 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 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, & 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 **Ambetter Secure Provider Portal**.

- 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.

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COMPLAINTS/GRIEVANCES & APPEALS

COMPLAINTS/GRIEVANCES & APPEALS

CLAIMS

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

COMPLAINT

- Must be filed within **30 days** from the date of the incident, such as the original Explanation of Payment date, to file a Complaint. Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within **30 days** of receiving complete information to evaluate the request.

COMPLAINTS/GRIEVANCES & 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 **5 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 from the date Ambetter receives the appeal**.
- 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 and appeals processes can be found in our Provider Manual, located on our website at **www.AmbetterHealth.com/en/TN/**.

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SPECIALTY SERVICES & VENDORS

OUR SPECIALTY COMPANIES & VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	Evolent©	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	Centene Pharmacy Services	1-833-472-1281 (Phone) 1-866-399-0929 (Fax)

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Questions & Answers